PUBLIC TRUST BOARD
Meeting to be held on 31st October 2016, 11:00-1:00pm, Conference Room, Trust HQ, Marlborough St, Bristol, BS1 3NU

AGENDA

NO.	AGENDA ITEM	PURPOSE	SPONSOR	PAGE NO.
1.0	**Preliminary Business**			
1.1	Apologies for absence	Information	*Chairman*	Verbal
1.2	Patient Experience Story	Information	*Chief Nurse*	Verbal/To follow
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1.4	Matters arising and Action Log	Approval	*Chairman*	15
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2.0	**Research and Innovation**			
2.1	Research and Innovation Quarterly Update Report	Assurance	Medical Director (David Wynick presenting)	45
3.0	**Care and Quality**			
3.1	Independent Review of Children's Cardiac Services in Bristol	Assurance	Chief Nurse	52
3.2	Quality Strategy	Approval	Chief Nurse/ Medical Director	78
3.3	Quality and Performance Report To receive and consider the report for assurance: a) Performance Overview b) Board Review – Quality, Workforce, Access	Assurance	Chief Operating Officer	106
3.4	Quality and Outcomes Committee Chair's report	Assurance	Quality & Outcomes Committee Chair	Tabled
3.5	Winter Planning	Assurance	Interim Chief Operating	165

NO.	AGENDA ITEM	PURPOSE	SPONSOR	PAGE NO.
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4.2	Quarterly Risk Assessment Framework	Approval	Chief Executive	194
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5.0	**Organisational and System Strategy and Transformation**			
5.1	Trust Strategic Planning and Implementation Framework - Refreshed Approach from 2016/17	Assurance	Director of Strategy and Transformation	209
6.0	**Financial Performance**			
6.1	Finance Report	Assurance	Director of Finance & Information	233
6.2	a) Finance Committee Chair's Report b) Finance Committee Terms of Reference	Assurance Approval	Finance Committee Chair	Tabled 278
6.3	Quarterly Capital Projects status report	Note	Interim Chief Operating Officer	286
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8.0 Concluding Business				
8.2	Any Other Urgent Business		*Chairman*	Verbal
8.3	Date and time of next meeting **29th November 2016, 11-1pm, Conference Room, Trust HQ, Marlborough St Bristol BS1 3NU**		*Chairman*	Verbal

Cover report to the Trust Board meeting to be held on 31 October 2016 at 11:00 am – 1:00 pm in the Conference Room, Trust HQ, Marlborough St, Bristol, BS1 3NU

		Agenda Item	1.2
Meeting Title	Trust Board	**Meeting Date**	31 October 2016
Report Title	Patient Experience Story		
Author	Tony Watkin		
Executive Lead	Carolyn Mills, Chief Nurse		
Freedom of Information Status		Open	

Strategic Priorities (please select any which are impacted on / relevant to this paper)
Strategic Priority 1 : We will consistently deliver high quality individual care, delivered with compassion services.
Strategic Priority 2: We will ensure a safe, friendly and modern environment for our patients and our staff.
Strategic Priority 4: We will deliver pioneering and efficient practice, putting ourselves at the leading edge of research, innovation and transformation

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

Executive Summary

Purpose

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

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

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

Key issues to note

This story charts the experience of a long-standing patient of the UH Bristol Rheumatology service.

The story describes a journey that started in 1996. It explores how the quality of care at the Trust has improved over twenty years and how developments in research have impacted on the care provided. It considers the implications of living with a long term condition and the importance that continuity of care offers patients.

The story ends with a reflection on the role patients can play in working alongside clinicians to

improve services and the hopes for the service as it moves into new premises later this year.
Recommendations
Members are asked to: • To receive the patient story, and **note** any learning and actions from it.

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

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

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

Impact Upon Corporate Risk
None

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

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

Minutes of the Meeting of the Trust Board of Directors held in Public on Thursday 29th September 11am, Conference Room, Trust Headquarters, Marlborough Street, Bristol, BS1 3NU

Board members present:
John Savage, Chairman
Robert Woolley, Chief Executive
Paul Mapson, Director of Finance and Information
Sean O'Kelly, Medical Director
Alison Ryan, Non-Executive Director
John Moore, Non-Executive Director
Julian Dennis, Non-Executive Director
Lisa Gardner, Non-Executive Director
Emma Woollett, Vice-Chair
Carolyn Mills, Chief Nurse
Owen Ainsley, Interim Chief Operating Officer
Paula Clarke, Director of Strategy and Transformation
Guy Orpen, Non-Executive Director (left the meeting after agenda item 6)
Alex Nestor, Acting Director Workforce and Organisational Development

In attendance:
Pam Wenger, Trust Secretary
Zainab Gill, FOI and Governance Administrator (minutes)
Sabrina Lee, Communications Manager
Tony Watkins, Patient and Public Involvement Lead
Judith Reed, Voluntary Services Manager
Stuart Taylor, Volunteer
Sarah Murch, Membership & Governance Administrator
Angelo Micciche, Patient Governor (joint Lead Governor)
Malcolm Watson, Public Governor
Rashid Joomun, Patient Governor
Graham Briscoe, Patient Governor
Clive Hamilton, Patient Governor
Carole Dacombe, Public Governor

83/09/16 Chairman's Introduction and Apologies (Item 1)
John Savage, Chairman, welcomed everyone to the meeting. Apologies for absence were received from Jill Youds, Non-executive Director.

84/09/16 Patient Story (Item 2)
The meeting began with a Patient Story, from Stuart Taylor, one of the Trust's volunteers. The story explored the importance of volunteering in providing great care to our patients and how the support and development of Trust volunteers is central to that. It considered the motivations behind joining the Trust as a volunteer, how the role of the volunteer had developed over the years, the way in which volunteers are portrayed in the organisation and touched on some of the day to day pressures volunteers faced as they support patients and carers.

The story ended with a personal reflection on planning for elective surgery and how the volunteer's observations of our Trust had influenced his expectations of the care he will receive.

MEMBERS RESOLVED TO:
- **Receive** the patient story

Stuart Taylor left the meeting.

85/09/16 Declarations of Interest (Item 3)
In accordance with Trust Standing Orders, all Board members present were required to declare any conflicts of interest with items on the meeting agenda. There were no new declarations made.

86/09/16 Minutes from previous meeting (Item 4)
The Board considered the minutes of the meeting held in public on 28th July 2016.

A few minor amendments were noted as follows:

- Item 68/07/16 – Independent Review of Children's Cardiac Services in Bristol: Page 5 - the actions at the end of the item had not included the Chief Executive's undertaking to regularly update the Board with evidence of the assurance processes for the closure of each action. It was noted that the Steering Group would report progress at each Board Meeting.

- Julian Dennis re-joined the meeting after briefly leaving.

MEMBERS RESOLVED TO:
- **Approve** the minutes of the meeting held on 28th July 2016 as a true and accurate record of proceedings subject to these amendment.

87/09/16 Matters Arising (Item 5)
Members received the action tracker and noted the outstanding and completed actions.

The Chief Executive asked Sean O'Kelly to update the Board on the action in relation to the high risk complaint (minute reference 70/07/16). Sean O'Kelly updated the Board on the actions taken in response to this investigation, he said a number of meetings had taken place with the family since the last meeting of the Trust Board to define a set of outstanding questions for him to consider further, the last of which is due to take place in October.

Robert Woolley informed the Board that the Trust and University of Bristol had been awarded biomedical research centre status and would receive £21 million over 5 years to develop 5 themes, which included the two existing biomedical research units in cardiovascular disease and in lifestyle, nutrition and obesity. The Board expressed their satisfaction at this major achievement.

Robert Woolley informed the Board that the Trust had been selected by NHS England to be one of 12 national digital exemplars, driving forward new ways of using digital technology to support staff and improve patient care, in line with the recommendations of the Wachter Review. Members agreed to receive a report at the next meeting.

MEMBERS RESOLVED TO:

•**Receive** the digital exemplar report at next Public Trust Board meeting.

88/09/16 Chief Executives Report (Item 6)
The Board received a report summarising the key business issues considered by the Senior Leadership Team in August and September.

Members noted that the national planning guidance was issued in September which requires the Trust to produce a two year plan by the 23rd of December 2016. Robert Woolley said the Board would need to consider the timetable to approve this plan before the 23rd of December, he also said the Trust would need to ensure their two year contract with Commissioners was also signed by this date. Members noted that the planning round had therefore been brought substantially forward than previous years. He went on to confirm that the Trust had been asked to make a direct link with the sustainability and transformation plan for Bristol, North Somerset and South Gloucestershire. This 5 year plan will be reported to the Board in October 2016.

He advised the Board that the single oversight framework would be issued on the 13th September 2016, this was NHS Improvement adopting an integrated approach to oversee both Foundation Trusts and NHS trusts.

Members noted that planned industrial action by Junior Doctors over their new national contract had been called off. Members confirmed that the Trust would be implementing the new National Contract.

Robert Woolley informed the Board that all current year contracts with Commissioners had now been signed.

Members discussed the national cancer experience survey as noted in the Chief Executive's report. It was confirmed that this would be considered at the next Quality and Outcomes Committee, and that there has been a significant improvement to previous years.

MEMBERS RESOLVED TO:
- **Note** the report from the Chief Executive.

Guy Orpen left the meeting

89/09/16 Independent Review of Children's Cardiac Service in Bristol (Item 7)
Members received a report from Carolyn Mills in relation to the progress against the implementation of the recommendations, the proposals in relation to the governance/reporting arrangements and the processes for the engagement of the clinical leaders and service users (young people and family members) in the development and delivery of the action plans.

Member approved that the Steering Group would report directly to the Trust Board and that a report would be considered at each meeting. The terms of reference for the Steering Group were approved.

Carolyn Mills confirmed that the three subgroups had been established and terms of reference agreed. It was noted that the next report would include update on the work programmes for these sub groups.

There was a discussion regarding the membership of the steering groups and clarification was sought whether there would be any external membership on the group. Carolyn Mills provided the Board with clarification that as this was about the Trust's delivery against the recommendations that it was not appropriate to include external parties as part of the membership. She clarified that the commissioners were invited to attend as observers.

Clive Hamilton, Patient Governor commented on the lack of governor involvement in the Paediatric Cardiac Review and asked if there would be scope to have governor representation at the steering group. John Savage responded stating that whilst he understood the rationale the relevance of Governor Representation, this would need to be considered further.

Carolyn Mills in response to this question assured Governors that she would be attending a Governors' meeting to provide a briefing of the recommendations and actions being taken to ensure that Governors are sighted and aware of key issues resulting from the report.

Robert Woolley confirmed that Governor Involvement had been considered in initial stages but felt this would make it difficult for Governors to hold the non-executive directors (NEDs) to account and challenge where necessary. It was considered that this may be outside of the role of the Governors as this was an operational matter.

Clive Hamilton, Public Governor shared concerns about Governor insight into timelines and timescales around agreed actions following on from the report, and John Savage confirmed Trust Board meetings would be the appropriate place to raise these concerns and to hold the NEDs to account.

Robert Woolley confirmed that the Trust Board would require assurance that actions and agreed changes are implemented promptly and actions that are developmental or cultural are also appropriately timed.

Alison Ryan provided further assurance that the Quality and Outcomes (QOC) had tightened its processes and are now far more robust, Robert Woolley concluded by informing the Trust Board that 27 letters of apology had been sent to families and that few responses to these letters had been received. It was noted that the Trust had received a request from one family asking for involvement in steering groups and two families expressing dissatisfaction with the apology letters, it was further noted that communication would continue with these families. Robert Woolley confirmed that the Trust had been sent copies of the reports of two investigations by the Parliamentary and Health Service Ombudsman into complaints about care received in the children's cardiac service. These reports are confidential to each family and are not made public by the Ombudsman but the findings from each report had been incorporated into action plans and progress would be monitored by the Steering Group and reported to the Board and shared with the families concerned.

It was noted that the recommendations in the report for the Trust had been actioned.

Angelo Micciche asked for assurances in relation to the processes in place to respond to any issues raised in the Public Health Service Ombudsman Reports. Carolyn Mills confirmed that the responses to areas that are upheld are addressed through the Divisions Any Trust wide learning would be feedback through the Patient Experience Group and relevant reports to QOC and Board. It was also noted that this process was currently being reviewed.

MEMBERS RESOLVED TO:

- **Receive** the report from the Independent Review of Children's Cardiac Service in Bristol for assurance;
- **Note** the actions taken since the publication of the Independent Review of Children's Cardiac Services and the CQC report;
- **Approve** the terms of reference for the Steering Group; and
- **Approve** the revised governance structure.

90/09/16 Quality and Performance Report (Item 8)

Owen Ainsley provided an overview of the performance for August and reported that levels of demand have remained high, and in contrast to last month, performance against the headline measures of patient access has in some cases deteriorated. Members noted that performance in August remains above the year to date trajectory with particularly strong performance in the Children's Hospital. There was an 11 percent increase in referrals in the BRI, and it was noted that work was being progressed within Trust and with its system partners to deal with this. Members noted that ORLA, virtual ward programme had helped with bed occupancy and cancelled operations, the Trust was above trajectory for 6 week performance, and disappointingly, the percentage of patients waiting under 18 weeks Referral to Treatment (RTT) dipped below the 92% national standard for the first time since December 2015, following further increases in the number of patients on the waiting list. Performance against both the A&E 4-hour and 6-week diagnostic waiting times standard have, however, been maintained above the recovery trajectory.

The Board agreed to take questions after receiving the Quality and Outcomes Committee Chairs report.

91/09/16 Quality and Outcomes Committee Chairs Report (Item 9)

Alison Ryan, Chair of the Quality and Outcomes Committee provided a brief update on the issues discussed at the last meeting. She reported that although the dashboard for August was showing as red, progress was been made and that an improvement is expected next month. Members noted that there was a positive improvement in staff engagement and the Committee were assured of the robustness of the serious incident reporting. Alison Ryan concluded by assuring the Board that although the Trust is currently facing a number of high pressures, safety and quality is in a strong position.

Lisa Gardner queried the projections on the improvements in histopathology reporting; Owen Ainsley stated that North Bristol NHS Trust (NBT) were slightly behind in relation to a few tumour sites however the main indicators show that the overall turnaround had seen

a significant improvement. Emma Woollett asked whether the Trust undertook individual risk assessments for patients due to the current backlog issues at NBT, Owen Ainsley confirmed that individual risk assessments are carried out and escalated when necessary.

John Moore inquired whether the Trust tracked and monitored the number of patient appointment cancellations. Owen Ainsley confirmed that the overall indicator is based on day to day cancellations and the 28 day readmission policy tracks standard cancellations.

There were no further questions from the Board.

Members **RESOLVED** to:

- **Receive** the Quality Performance Report for the month of August 2016; and
- **Receive** a report from the Chair of the Quality and Outcome Committee for assurance.

92/09/16 Six Monthly Staffing Report (Item 10)

Carolyn Mills presented the report and confirmed that the purpose of the paper was to provide assurance to the Trust Board that wards have been safely staffed over the last 8 months.

She confirmed a detailed version of this report is considered by the QOC monthly for assurance and oversight. Members noted that increased staffing levels have been agreed in a number of areas, with a clear rationale for the changes, all with the aim of providing safe and efficient staffing numbers and skill mix. Carolyn Mills provided assurance that the outstanding actions from the last six monthly report have now been actioned and concerns raised by the CQC on Ward 800 and staffing figures have now been addressed. Carolyn Mills confirmed that there were no risks in terms of staffing levels.

It was noted that the Trust level quality performance dashboard for the last eight months indicates that overall the standard of patient care during this period was of good quality (safety/clinically effective/patient experience), with a decrease in the overall numbers of falls and pressure ulcers per 1000 bed days.

Robert Woolley queried staffing incidents in June for specialised services, and Carolyn Mills agreed that she would review the data and provide and update.

MEMBERS RESOLVED TO:

- **Receive** the report on the Six Monthly Staffing for assurance; and
- **Receive** further information staffing incidents for June for the Specialised Services Division.

93/09/16 Quarterly Complaints Report (Item 11)

Carolyn Mills presented the quarterly complaints report and highlighted that 520 complaints were received in Quarter 1, which equates to 0.26% of patient activity. She confirmed that 76.2% of complaints were responded to within the timescales agreed with the complainant. Carolyn Mills provided assurance that no complaints that went to the Ombudsmen for this quarter were upheld. Members noted that the report had been considered by the QOC.

Julian Dennis asked as the Trust is not meeting targets around "responded to complaints within timescales" are the actions detailed in the Quality Performance Report robust enough. Carolyn Mills provided assurance that the actions were robust; however other unavoidable factors had affected response rates.

MBERS RESOLVED TO:
- **Receive** assurance on the Quarterly Complaints Report

94/09/16 Quarterly Patient Experience Report (Item 12)
Carolyn Mills presented the report and provided an overview of patient feedback received by the Trust in the first quarter of 2016/17, including any themes arising and actions taken to address. Members noted that this report had been considered by the QOC.

Members noted that in addition to Quarter 1 survey data and, as a new development, this quarterly report incorporates a summary of recent current Patient and Public Involvement activity. She highlighted that the Trust's key patient-reported experience indicators remained "green" in Quarter 1. It was also noted that the Trust successfully achieved its improvement trajectory for the inpatient and day case Friends and Family Test survey response rate. The improvement notice issued by the Clinical Commissioning Group in January 2016 has therefore now been closed.

The Board had no questions or concerns on this item.

MEMBERS RESOLVED TO:
- **Receive** the report on Quarterly Patient Experience for assurance

95/09/16 Finance Report (Item 13)
Paul Mapson, Director of Finance, provided an update to the Board on the Trust's financial position. The summary income and expenditure statement shows a surplus of £6.722m (before technical items) for the first five months of the year. This includes £5.308m of sustainability funding – the position represents a surplus of £1.414m without this funding.

Members noted that at month five the Trust is £0.883m adverse against plan. The deterioration from last month reflects the continued run rate in Clinical Divisions, particularly driven by the reduced level of activity over the summer months and high levels of pay expenditure. The agreed NHS Improvement plan required a surplus of £6.719m at month 5, the Trust has just achieved this.

Members noted that the August position was particularly concerning as it represented one of the biggest monthly deteriorations experienced in recent years. Paul Mapson stated that if the financial position recovered in September then the run rate would go back down however if the position did not improve then then the Trust would experience further deterioration in coming months. Members noted the improvement on nursing vacancies in comparison to last year; however, the use of agency staff was still causing concerns.

The Board agreed to take questions on items 13 after receiving item 14 the Finance Committee Chair's Report.

MEMBERS RESOLVED TO:
- **Receive** the report on Finance for assurance

96/09/16 Finance Committee Chairs Report (Item 14)
The Board received this report for assurance from Lisa Gardner for the months of August and September. She talked through the key agenda items explored by the Committee, including agency controls, financial position, savings programme and capital programme, She confirmed that the Committee had discussed in some detail the controls and actions to optimise the use of the substantive nursing workforce, and control agency nursing spend. In particular they had discussed the agency cap breaches and the high costs for nursing. Lisa Gardner reported that the Committee were assured of the plans in place to reduce the spend on agency staff.

Julian Dennis asked if we had been optimistic when looking at the planning for the income streams or had there been changes since the planning took place. Paul Mapson responded stating that it was a combination of both and an interim review would be taking place to investigate further.

Members noted that all the contracts signed by commissioners were at the expected cost as anticipated in the planning stages.

John Moore sought clarification around agency costs and how much saving could the Trust make if it was within the new national guidelines. Paul Mapson confirmed that at a rough calculation the saving would be between one to two million, however, the market was driven by supply and demand so it was difficult to tackle the rise in external agency costs.

In response to Alison Ryan, Paul Mapson confirmed that the majority of the monies for Biomedical Sciences go directly towards the service.

Clive Hamilton, Patient Governor asked whether North Bristol and South Gloucestershire being in special measures would have a direct impact on the Trust. Members noted that this does not have a direct impact on the Trust. Clive Hamilton, Patient Governor, queried if subsiding the return to nursing course would attract retired nurses back to practice and help to improve nurse staffing issues. Carolyn Mills advised that the Trust already commissions this course for nurses returning to practice.

MEMBERS RESOLVED TO:
- **Receive** the Finance Committee Chairs Report for assurance

97/09/16 NHS Improvements Q1 Risk Assessment (item 15)
Members received the report noting the NHS Improvement's analysis of the Trust's Quarter 1 submission. Robert Woolley advised it was the routine feedback that the Trust receive from NHS Improvement and confirmed the process would change going forward with the introduction of the Oversight Framework. He confirmed that NHS Improvement had confirmed the Trust rating as Continuity of Services Risk Rating – 4 and Governance Risk Rating – Green. Members noted that a meeting had been requested by NHS Improvement to discuss cancer performance which has not yet taken place.

The Board had no comments for this item.

MEMBERS RESOLVED TO:
- **Receive** the NHS Improvements Q1 Risk Assessment for assurance

98/09/16 Freedom to Speak Up (item 16)
Alex Nestor presented the report outlining the requirement for the Trust Board to confirm the appointment of the Freedom to Speak Up Local Guardian by 1 October 2016. She confirmed that the appointment of an independent National Guardian for the National Health Service (NHS) was highlighted in Sir Robert Francis's *Freedom to Speak Up* review in February 2015.

Members noted that every Trust will be required to have a *Freedom To Speak Up (FTSU)* guardian in place by 01 October 2016.

Emma Woollett confirmed that she supported the approach that the Trust Secretary be appointed as the Local Guardian and that these arrangements are reviewed in 6 months. It was noted that there had been agreement to backfill the Trust Secretary for 2 days per week to enable her to discharge the functions of the Local Guardian. Emma Woollett stated that she had noted that there were various examples of how other Trusts have appointed to Guardian roles, including shared roles. She considered the approach being taken by the Trust was the correct approach.

MEMBERS RESOLVED TO:
- **Note** the report;
- **Support** the action being taken following the Freedom to Speak Up Review; and
- **Agree** to appoint the Trust Secretary as the Local Guardian and note the agreement to back fill the Trust Secretary to enable the functions to be discharged as outlined in this report; and
- **Review** these arrangements in 6 months.

99/09/16 Governors Log of Communication (Item 17)
The report provided the Trust Board with an update on governors' questions and responses from Executive Directors.

100/09/16 Any Other Business (Item 18)
John Savage advised that Pam Wenger had been working on a more common format of presentation for Board papers and this would be implemented going forward.

Meeting close and Date and Time of Next Meeting

The Chair declared the meeting closed at 11:55pm. The next meeting of the Trust Board of Directors will take place on 31st October 9-1pm in the Conference Room, Trust Headquarters, Marlborough Street, Bristol, BS1 3NU.

University Hospitals Bristol NHS
NHS Foundation Trust

Trust Board of Directors meeting held in Public 29 September 2016
Action tracker

Outstanding actions following meeting held 29 September					
No.	**Minute reference**	**Detail of action required**	**Responsible officer**	**Completion date**	**Additional comments**
1	**74/07/16**	**Quarterly Report on Research and Innovation** Review Research and Innovation reporting structures, potentially to include comparisons with other Trusts.	Medical Director	October 2016	**Work in progress.** Update to be provided as part of agenda item 2.1.
2	**79/07/16**	**Transforming Care Report** Governors to be provided with an update on patient appointment letters and emails**.**	Interim Chief Operating Officer	October 2016	**Work in progress.** Alison Grooms is attending the Quality Focus Group on 10 January to provide the Governors with an update on the patient letters.
3	**85/07/16**	**Board Assurance Framework Report** Consider via the information technology group how near misses and minor incidents relating to the failure of new digital systems could be captured and reported.	Director of Finance and Information	October 2016	**Work in progress.** Scheduled discussion at next Information Management & Technology Group.
4	**92/09/16**	**Six Monthly Staffing Report** Receive further information on staffing incidents for June for the specialised services division.	Chief Nurse	October 2016	**Work in progress** Update to be provided to the Quality and Outcomes Committee.
5	**87/09/16**	**High Risk Complaint** Receive update on Verita Report in relation to minute ref 20/07/17	Medical Director	November 2016	**Work in progress.** Updated to be provided at the Trust Board in November 2016.

Completed actions following meeting held 29th September 2016					
6	**181/02/16**	The Board to receive an update on the major strategic schemes for consideration and prioritisation.	Director of Strategy & Transformation	October 2016	**Complete** Update provided on approach to strategic capital programme within Strategy Refresh papers at October Board.
7	**87/09/16**	**Matters Arising** Receive Digital Exemplar report at next Private Trust Board Meeting	Chief Executive	October 2016	**Complete** On private trust board agenda under item 3.1
8	**71/07/16**	**Quality and Performance Report** Receive a report on the Fractured Neck of Femur action plans at the Sept/Oct Quality and Outcomes Committee. Receive a report detailing the marketing plan for vacancies.	Interim Chief Operating Officer Acting Director Workforce and Organisational Development	October 2016 November 2016	**Complete** Agenda for the Quality and Outcome Committee in October 2016. Scheduled for an update at the Board Seminar in November and report to the next Board Meeting.

Cover report to the Trust Board meeting to be held on 31 October 2016 at 11.00 am -1.00 pm in the Conference Room, Trust HQ, Marlborough St, Bristol, BS1 3NU

		Agenda Item	1.5
Meeting Title	Trust Board	**Meeting Date**	31 October 2016
Report Title	Chief Executive Report		
Author	Robert Woolley, Chief Executive		
Executive Lead	Robert Woolley, Chief Executive		
Freedom of Information Status		Open	

Strategic Priorities (please select any which are impacted on / relevant to this paper)
Strategic Priority 1 : We will consistently deliver high quality individual care, delivered with compassion services.
Strategic Priority 2: We will ensure a safe, friendly and modern environment for our patients and our staff.
Strategic Priority 3: We will strive to employ the best staff and help all our staff fulfil their individual potential
Strategic Priority 4: We will deliver pioneering and efficient practice, putting ourselves at the leading edge of research, innovation and transformation
Strategic Priority 5: We will provide leadership to the networks we are part of, for the benefit of the region and people we serve.
Strategic Priority 6: We will ensure we are financially sustainable to safeguard the quality of our services for the future and that our strategic direction supports this goal.
Strategic Priority 7: We will ensure we are soundly governed and are compliant with the requirements of NHS Improvement.

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

Executive Summary
Purpose To report to the Board on matters of topical importance, including a report of the activities of the Senior Leadership Team. Key issues to note The Board will receive a verbal report of matters of topical importance to the Trust, in addition to the attached report summarising the key business issues considered by the Senior Leadership Team in September 2016.

Recommendations
The Trust Board is recommended to note the key issues addressed by the Senior Leadership Team in the month and to seek further information and assurance as appropriate about those items not covered elsewhere on the Board agenda. Members are asked to: • **Note** the report.

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

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

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

Impact Upon Corporate Risk
N/A

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

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

APPENDIX A

SENIOR LEADERSHIP TEAM

REPORT TO TRUST BOARD – OCTOBER 2016

1. INTRODUCTION

This report summarises the key business issues addressed by the Senior Leadership Team in October 2016.

2. QUALITY, PERFORMANCE AND COMPLIANCE

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

The group **supported** the recommendation to declare the standards failed in quarter 2 to be the Accident and Emergency 4-hour standard, the Referral to Treatment Incomplete pathways standard, the 62-day GP and 62-day Screening cancer standards, and to acknowledge ongoing risks to achievement of the 62-day screening and 62-day GP cancer standards, the Referral to Treatment Incomplete pathways and the Accident and Emergency 4-hour standard.

The group **received** an update on the current financial position for 2016/2017.

3. STRATEGY AND BUSINESS PLANNING

The group **noted** an update on the Operating Plan 2016/2017 and forward look for 2017/2018.

The group **received** an update on, and supported, the work being undertaken on strategic engagement and retention, while expressing the desire to make faster progress.

The group received and **approved** the Quality Strategy 2016-2020 for onward submission to the Quality and Outcomes Committee and Trust Board.

The group **approved** the revised Complaints and Concerns Policy.

The group **noted** an update on the formation of Cancer Alliances.

The group **received** a status report on the implementation of the 2016 junior doctor contract.

4. RISK, FINANCE AND GOVERNANCE

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

The group received and **noted** the Quarter 2 2016/2017 Themed Serious Incident Report, prior to submission to the Quality and Outcomes Committee.

The group received and **noted** the Quarter 2 2016/2017 update on Corporate Quality Objectives.

The group **received** the Board Assurance Framework 2016/2017 Quarter 2 update prior to onward submission to the Trust Board.

The group **approved** changes to the Corporate Risk Register.

The group **approved** the terms of reference for both the Service Delivery Group and Clinical Quality Group as part of their annual review.

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

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

5. RECOMMENDATIONS

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

Robert Woolley
Chief Executive
October 2016

Cover report to the Trust Board meeting to be held on 31 October 2016 at 11:00 am – 1.00 pm in the Conference Room, Trust HQ, Marlborough St, Bristol, BS1 3NU

		Agenda Item	1.6
Meeting Title	Trust Board	**Meeting Date**	31 October 2016
Report Title	Board Assurance Framework Report Q2 2016-17		
Author	Pam Wenger, Trust Secretary Sarah Wright, Head of Risk Management		
Executive Lead	Robert Woolley, Chief Executive		
Freedom of Information Status		Open	

Strategic Priorities (please select any which are impacted on / relevant to this paper)
Strategic Priority 1: We will consistently deliver high quality individual care, delivered with compassion services.
Strategic Priority 2: We will ensure a safe, friendly and modern environment for our patients and our staff.
Strategic Priority 3: We will strive to employ the best staff and help all our staff fulfil their individual potential
Strategic Priority 4: We will deliver pioneering and efficient practice, putting ourselves at the leading edge of research, innovation and transformation
Strategic Priority 5: We will provide leadership to the networks we are part of, for the benefit of the region and people we serve.
Strategic Priority 6:We will ensure we are financially sustainable to safeguard the quality of our services for the future and that our strategic direction supports this goal.
Strategic Priority 7: We will ensure we are soundly governed and are compliant with the requirements of NHS Improvement.

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

Executive Summary

Purpose

To provide assurance that the organisation is on track to achieve its strategic and annual objectives for the current year. Importantly, the Board Assurance Framework describes any risks to delivery that have been identified to date and describes the actions being taken to control such risks so as to ensure delivery is not compromised.

The Board Assurance Framework (BAF) forms part of the Trust's risk management strategy and is the framework for identification and management of strategic risks. The BAF provides detail on key activities underway to achieving each annual objective; progress as it currently stands in-year; risks to achieving objectives; actions and controls in place to mitigate those risks; and internal and external sources of assurance to ensure the risks are being mitigated appropriately.

Key Points

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

- Principal Risk 1 - Failure to maintain the quality of patient services.
  Second line of assurance robust forms of assurance, some gaps in controls around business continuity arrangements.
  Action Plan in place to address the issues around business continuity.
  Previous Risk Rating 9, Current Risk Rating 9, static trajectory.
  13 associated Corporate Risks.

- Principal Risk 3 - Failure to act on feedback from patients, staff and our public.
  First Line level of assurance but gaps due to lack of real time patient feedback system
  Funding has been identified to procure a new patient feedback system during 2016/17.
  Previous Risk Rating 9, Current Risk Rating 9, static trajectory.

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

- Principal Risk 2 - Failure to develop and maintain the Trust estate.
  Second line level of assurance in relation to Health and safety issues, third line in respect of Internal Audit work programme. Gaps in assurance around roof and drain maintenance being addressed via operational and capital work programme for 2016/17.
  Previous Risk Rating 8, Current Risk Rating 8, static trajectory.

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

- Principal Risk 4 - Failure to recruit, train and sustain an engaged and effective workforce.
  First & second line assurance around reporting arrangements. Metrics highlight risk around staff retention, although improving (see corporate risk 674).
  Previous Risk Rating 12, Current Risk Rating 12, static trajectory.

3 associated Corporate Risks.

STRATEGIC PRIORITY 4: We will deliver pioneering and efficient practice, putting ourselves at the leading edge of research, innovation and transformation.

- Principal Risk 5 - Failure to enable and support transformation and innovation, to embed research and teaching into the care we provide, and develop new treatments for the benefit of patients and the NHS.
  Second line assurance in place but gaps identified Trust wide around supporting innovation and improvement, to be addressed by implementation of Transformation Strategy.
  Previous Risk Rating 9, Current Risk Rating 9, static trajectory.

STRATEGIC PRIORITY 5: We will provide leadership to the networks we are part of, for the benefit of the region and people we serve.

- Principal Risk 6 - Failure to take an active role in working with our partners to lead and shape our joint strategy and delivery plans, based on the principles of sustainability, transformation and partnership working.
  Second line assurance currently in place with potential for feedback via STP from BNSSG.
  Previous Risk Rating 6, Current Risk Rating 6, static trajectory.

STRATEGIC PRIORITY 6: We will ensure we are financially sustainable to safeguard the quality of our services for the future and that our strategic direction supports this goal.

- Principal Risk 7 - Failure to sustain financial sustainability
  Second line assurance in place via internal reporting and divisional reporting arrangements, weak controls and gaps in assurance identified.
  Previous Risk Rating 12, Current Risk Rating 9 an improving trajectory.
  2 associated Corporate Risks.

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

- Principal Risk 8 - Failure to comply with targets, statutory duties and functions
  Robust second level assurance in place and third level in respect of NHS Improvement returns and CQC inspections.
  No significant gaps identified in either controls or assurance, 7 associated corporate risks.
  Previous Risk Rating 9, Current Risk Rating 9, static trajectory.

Summary

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

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

Recommendations
Members are asked to: • **Receive** the report for assurance.

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

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

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

Impact Upon Corporate Risk
None identified.

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

Date papers were previously submitted to other committees				
Audit Committee	**Finance Committee**	**Quality and Outcomes Committee**	**Remuneration & Nomination Committee**	**Risk Management Group**
18 October 2016				12 October 2016

BOARD ASSURANCE FRAMEWORK QUARTER 2

SITUATION

The Board Assurance Framework (BAF) forms part of the Trust's risk management strategy and is the framework for identification and management of strategic risks. This report provides the Board with an update on the development of the BAF and the associated monitoring mechanisms and invites further discussion about the Trust's principle risks identified.

BACKGROUND

The Board Assurance Framework and Risk Register reflect the organisation's risk profile. They contain the strategic (principle) risks identified by the Trust, describe the controls in place and give the strength and quality of assurance available on how well the risks are being managed. These documents support the Board in making a declaration on the effectiveness of the Trust's system of internal control in the Annual Governance Statement.

ASSESSMENT

The Board Assurance Framework sets out the key threats to achieving the Trust's strategic priorities for 2016/17. Risks may be escalated from the Trust Wide Corporate Risk Register following the process established in the Risk Management Policy and associated procedures, ensuring that the Board is aware of strategic risks emerging from directorates.

Currently, high level risks in the Corporate Risk Register (scoring 12 or above), are reported to the Board alongside the BAF for consideration and oversight. The attached BAF framework ensures that some of these risks would continue to be transferred to the BAF, following approval and review from the Senior Leadership Team.

As the BAF would be used to identify and review these corporate level risks, it would also allow the Board to review the Corporate Risk Register in further detail in the Board of Directors private session. This would allow all risks scoring 12 and above to be reviewed in private session via the Corporate Risk Register supporting the Board to have sightedness and exposure to high level organisational risks (as opposed to only corporate level risks). This provides an integrated approach to the management of risk and internal and control.

Principle Risks

- **Principle Risk 1:** Failure to maintain the quality of patient services.
- **Principle Risk 2**: Failure to develop and maintain the Trust estate.
- **Principle Risk 3:** Failure to act on feedback from patients, staff and our public.
- **Principal Risk 4:** Failure to recruit, train and sustain an engaged and effective workforce

- **Principle Risk 5:** Failure to enable and support transformation and innovation, to embed research and teaching into the care we provide, and develop new treatments for the benefit of patients and the NHS.
- **Principle Risk 6:** Failure to take an active role in working with our partners to lead and shape our joint strategy and delivery plans, based on the principles of sustainability, transformation and partnership working.
- **Principal Risk 7:** Failure to maintain financial sustainability
- **Principle Risk 8:** Failure to comply with targets, statutory duties and functions

Position at as at end of September 2016

	Risk rating as at 30 June 2016	Risk rating as at 30 September 2016	Trend
Principal Risk 1	9	9	→
Principal Risk 2	8	8	→
Principal Risk 3	9	9	→
Principal Risk 4	12	12	→
Principal Risk 5	9	9	→
Principal Risk 6	6	6	→
Principal Risk 7	12	9	↓
Principal Risk 8	9	9	→

The Board Assurance Framework (Appendix one) sets out the key threats to achieving the Trust's strategic priorities for 2016/17. Risks may be escalated from the Trust Wide Risk Register following the process established in the Risk Management Policy and associated procedures, ensuring that the Board is aware of strategic risks emerging from directorates. The risks appearing in both the Assurance Framework and Trust Wide Risk Register are cross-referenced.

In this reporting period the BAF analysis shows that there are no extreme risks (scoring 15 and above).

RECOMMENDATIONS

Members are asked to:

- **Note** the report and the Board Assurance Report as at 30 September 2016.

University Hospitals Bristol NHS
NHS Foundation Trust

BOARD ASSURANCE FRAMEWORK

Q2 2016-17

1. Board Assurance Framework for the delivery of Objectives.

The Board has overall responsibility for ensuring systems and controls are in place, sufficient to mitigate any significant risks which may threaten the achievement of the strategic objectives. Assurance may be gained from a wide range of sources, but where ever possible it should be systematic, supported by evidence, independently verified, and incorporated within a robust governance process. The Board achieves this, primarily through the work of its Assurance committees, through use of Audit and other independent inspection and by systematic collection and scrutiny of performance data, to evidence the achievement of the objectives.

2. The Trust Strategy

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

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

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

- Children's services;
- Accident and Emergency (and urgent care);
- Older people's care;
- Cancer services;
- Cardiac services;
- Maternity services;
- Planned care and long term conditions;
- Diagnostics and therapies; and
- Critical Care.

2.1 Trust Strategic Priorities

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

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

3. 2016/17 Priorities

The following priorities are outlined in our 2016/17 annual NHS Improvement Operational Plan.

	1. Care and Quality
1.1	Delivery of 12 Quality Objectives as follows; • Reducing cancelled operations; • Ensuring patients are treated in the right ward for their clinical condition; • Improving management of sepsis; • Improving timeliness of patient discharge; • Reducing patient-reported in-clinic delays for outpatient appointments, and keeping patients informed about how long they can expect to wait; • Reducing the number of complaints received where poor communication is identified as a root cause; • Ensuring public-facing information displayed in our hospitals is relevant, up-to-date, standardised and accessible; • Ensuring inpatients are kept informed about what the next stage in their treatment and care will be, and when they can expect this to happen; • Fully implementing the Accessible Information Standard, ensuring that the individual needs of patients with disabilities are identified so that the care they receive is appropriately adjusted; • Increasing the proportion of patients who tell us that, whilst they were in hospital, we asked them about the quality of care they were receiving; • Reducing avoidable harm to patients; and • Improving staff-reported ratings for engagement and satisfaction.
1.2	Achievement of our 'Sign up to Safety' priorities as follows; • Early recognition and escalation of deteriorating patients to include early recognition and management of sepsis and acute kidney injury; • Medicines safety at the point of transfer of care with cross system working with healthcare partners; • Developing our safety culture to help us work towards, for example, zero tolerance of falls; and • Reducing never events for invasive procedures.
1.3	Delivery of the two objectives identified in the Medical Royal Colleges 2014 "*Guidance for taking responsibility: Accountable clinicians and informed patients" as follows;* "*A patient's entire stay in hospital should be coordinated and caring, effective and efficient with an individual named clinician – the Responsible Consultant/Clinician – taking overall responsibility for their care whilst retaining the principles of multidisciplinary team working"; and* "*Ensuring that every patient knows who the Responsible Consultant/Clinician, with this overall responsibility for their care is and also who is directly available to provide information about their care – the Named Nurse".*
1.4	Participate in the annual publication of avoidable deaths.
1.5	Demonstrate affordable progress towards delivery of the four key seven day services

	standards by 2020.
1.6	Further embed hosted Operational Delivery Networks (ODN), including paediatric neurosciences, Congenital Heart Disease and Critical Care.
1.7	Delivery of agreed specialised and local CQUIN targets.
	2. Non-Financial Performance
2.1	Deliver the agreed performance trajectories for Referral To Treatment (RTT), 6 week diagnostic, Cancer and the Accident and Emergency (A&E) four hour waiting standard.
2.2	Effective cross sector and patient flow remains a challenge due to external system wide factors. Work actively with our partners and through the STP, Better Care Programme and Urgent Care Network to develop and implement plans to improve flow and materially reduce the number of patients with a delayed discharge.
2.3	Successful implementation of the Orla Healthcare community based 'virtual ward'.
	3. IM&T and Estates
3.1	Continue with the necessary upgrading of the Estate along with medical equipment replacement.
3.2	During the coming year we will continue to deploy new digital capability throughout the Trust, further embedding and extending existing functions with particular emphasis on: • Rolling out digital case notes across our other hospital sites together with the implementation of e-forms and workflow automation; • Commencing delivery of a new nursing e-observations and replacement e-rostering systems; • Going live across the Trust with electronic prescribing and medicines administration; • Providing more convenient access to our systems and services through the wider use of mobile technology and telehealth techniques; and • Delivering the objectives of the Clinical Utilisation Review (CUR) by using existing systems rather than purchasing duplicate systems which are not supported by Clinicians or the IT function.
3.3	Development of our innovation and technology strategy
	4. Financial Performance
4.1	Maintain sound financial control working to a surplus plan for the 14th year running, albeit caveated with significant remaining risks – both from Commissioner SLAs and internal pressures.
4.2	Delivery of 16/17 income plans and Cost Improvement Programme.
4.3	Delivery of 16/17 capital programme, including the prioritisation and allocation of strategic capital.

5. Organisational and System Strategy and Transformation	
5.1	Complete a full refresh of our Trust strategy in Autumn 2016, along with the development of a new governance structure for strategic planning and implementation, to ensure that we are aligned to the system wide Sustainability and Transformation Plan (STP) and maintain the recommendations of the Well Led Governance Review.
5.2	Further evaluate opportunities to continue to develop our specialised services portfolio throughout 2016/17.
5.3	Development of the system Sustainability and Transformation Plan - take an active role in working with our partners to lead and shape our joint strategy and delivery plans, based on the principles of sustainability, transformation and partnership working.
6. Workforce and Engagement	
6.1	Further development and implementation of strategic workforce plans, linked to the evolving STP.
6.2	Achieve NHS Improvement's locum and agency expenditure requirements.
6.3	Successful implementation of workforce recruitment and retention plan.
6.4	Delivery of agreed workforce KPIs.
6.5	Development and delivery of staff engagement plan, linked to the learning from the results of the 2015 staff survey.

4. Principal Risks

- **Principal Risk 1:** Failure to maintain the quality of patient services.
- **Principal Risk 2**: Failure to develop and maintain the Trust estate.
- **Principal Risk 3:** Failure to act on feedback from patients, staff and our public.
- **Principal Risk 4:** Failure to recruit, train and sustain an engaged and effective workforce.
- **Principal Risk 5:** Failure to enable and support transformation and innovation, to embed research and teaching into the care we provide, and develop new treatments for the benefit of patients and the NHS.
- **Principal Risk 6:** Failure to take an active role in working with our partners to lead and shape our joint strategy and delivery plans, based on the principles of sustainability, transformation and partnership working.
- **Principal Risk 7:** Failure to maintain financial sustainability.
- **Principal Risk 8:** Failure to comply with targets, statutory duties and functions.

Risk scoring = consequence x likelihood

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

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

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

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

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

University Hospitals Bristol Control Framework

Vision, organisational priorities and outcomes, aims, values and behaviours, policies and procedures, budget and budget control, performance measures and trajectories and management of associated risks

Leadership | Staff | Systems and Processes | Finances | Technology

Controls and Assurance Mechanisms

High Quality Care

Controls: **evidenced within**

- Operational Plan 2016/17 – Strategic and annual objectives
- Commissioning
- Annual Quality Objectives
- intentions and plans
- Capital and Estates Strategy
- Quality Impact Assessment protocol
- Equality Impact Assessment

Assurance: gained via

- Quality and Outcome Committee
- Divisional Quality Groups
- Senior Leadership Team
- Annual Quality Statement
- Annual Report and Annual Governance Statement
- Chairs Reports
- Visits and Inspections

Performance Management

Controls:

- Objectives and Appraisals
- Performance targets
- Performance Dashboards and monthly reporting
- Regular Performance and Quality reports
- Concerns and Patient Experience Reports
- Serious Incident Reporting

Assurance: gained via

- Divisional Boards, Service/Ward levels
- Escalation arrangements
- Audits, visits
- Executive Director and Senior Leadership Team meetings
- Quality and Outcomes, Finance and Audit Committees
- Internal/External Audits

Risk Management

Controls:

- Risk management strategy and Policy
- Board Assurance Framework
- Corporate Risk Register
- Divisional Risk Register

Reports to the Board, Senior Leadership Team and sub committees
Policies and Procedures
Scheme of Delegation

Assurance: gained via

- Divisional Boards, Service/Ward levels
- Escalation arrangements
- Internal/External Audits, visits
- Executive Director and Senior Leadership Team meetings
- Quality and Outcomes, Finance and Audit Committees
- Risk Management Group

Levels of Assurance

VISION AND CORPORATE PRIORITIES

First Line
Operational

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

Second Line
Risk and Compliance

Assurance and Oversight Committees

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

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

Third Line
Independent

- Internal Audit Plan 2016-17
- External Audits (eg. Annual Accounts and Annual Report)
- CQC Inspections/NHS Improvement
- Visits by Royal Colleges
- Independent Reviews – Verita Investigations
- Independent Review Paediatric Cardiac Surgery
- Well Led Governance Review

REGULATORS

EXTERNAL AUDIT

Key

The Assurance Framework has the following headings:

Principal Risk	What could prevent the objective from being achieved? Which area within organisation does this risk primarily impact on – clinical, organisational or financial?
Key Controls	What controls / systems do we have in place to assist secure delivery of the objective?
Form of Assurance	How are the controls monitored?
Level of Assurance	What does the evidence tell us in relation to the effectiveness of the controls / systems which are being relied on
Gaps in Controls	Gaps in control: Are there any gaps in the effectiveness of controls/ systems in place?
Gaps in assurance	Where can we improve evidence about the effectiveness of one or more of the key controls / systems which we are relying on?
Actions Agreed for any gaps in controls or assurance	Plans to address the gaps in control and / or assurance
Current Risk Rating	Assessment of the risk taking into account the strength of the controls currently in place to manage the risk
Direction of travel	Are the controls and assurances improving? ↑ ↓ ↔
Ref	This should include the reference to the Strategic Priorities and also align with the top corporate risk register

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

OPERATIONAL PLAN 2016/17 PRIORITIES	**Quality and Care** • Delivery of 12 Quality Objectives • Achievement of our 'Sign up to Safety' priorities • Delivery of the two objectives identified in the Medical Royal Colleges 2014 "*Guidance for taking responsibility: Accountable clinicians and informed patients* • Participate in the annual publication of avoidable deaths. • Demonstrate affordable progress towards delivery of the four key seven day services standards by 2020. • Further embed hosted Operational Delivery Networks (ODN), including paediatric neurosciences, Congenital Heart Disease and Critical Care. • Delivery of agreed specialised and local CQUIN targets.				**Non Financial Performance** • Deliver the agreed performance trajectories for Referral To Treatment (RTT), 6 week diagnostic, Cancer and the Accident and Emergency (A&E) four hour waiting standard. • Effective cross sector and patient flow remains a challenge due to external system wide factors. Work actively with our partners and through the STP, Better Care Programme and Urgent Care Network to develop and implement plans to improve flow and materially reduce the number of patients with a delayed discharge. • Successful implementation of the Orla Healthcare community based 'virtual ward'.				
Principal Risk description	**Key Controls**	**Form of Assurance**	**Level of Assurance**	**Gaps in controls**	**Gaps in assurance**	**Actions Agreed for any gaps in controls or assurance**	**Executive Lead and Assuring Committee**	**Current Risk Rating**	**Direction of travel**
Principal Risk 1 - *Failure to maintain the quality of patient services.*	Serious Incident Reporting process Risk Management Strategy and Policy Professional Standards and Code of Practice/Clinical Supervision Whole system approach being delivered through the Urgent Care Network. Trust Values Quality Objectives Sign up Safely Campaign Business Continuity and Emergency planning arrangements NICE guidelines self-assessments/ Clinical Audit Programme. Monitoring of RTT Performance Productive theatre initiative to reduce the number of cancelled Operations	Reports to Quality and Outcomes Committee. Annual Governance Statement providing assurance on the strength of Internal Control regarding risk management processes, review and effectiveness Annual Report. Quality metrics demonstrate that despite operational pressures, our patients are receiving good quality care despite delays in their discharge. Quality Account. Quality Strategy Reports to Clinical Quality Group. External - EPRR assessment (NHSE) Internal - self assessment Clinical Quality Group/Clinical Audit Group reporting mechanisms. Reports to SDG, SLT Trust Board	Internal performance reports form first line assurance. Reports to: • Trust Board, • Service Delivery Group • Senior Leadership Team • Audit Committee • Quality & Outcomes Committee • Clinical Quality Group Form second line assurance External audit/review forms third line assurance.	Emergency Preparedness, Resilience and Response (EPRR) externally assessed as partially compliant.	Awaiting formal confirmation from NHSE of improved position (from non-compliant to partially compliant).	Action Plan in place to address the issues around business continuity	Chief Nurse & Chief Operating Officer **Quality and Outcomes Committee**	Possible x Moderate 9	↔

Principal Risk description	Key Controls	Form of Assurance	Level of Assurance	Gaps in controls	Gaps in assurance	Actions Agreed for any gaps in controls or assurance	Executive Lead and Assuring Committee	Current Risk Rating	Direction of travel
Principal Risk 3 - *Failure to act on feedback from patients, staff and our public.*	**Stakeholder feedback:** Participation in the national patient surveys. Comments cards available on wards and in clinics. The Friends and Family Test administered at discharge in day case, inpatient and Emergency Department settings Teams of volunteers visit wards to interview patients whilst at UH Bristol A monthly post-discharge inpatient, outpatient, parent and maternity survey is undertaken and volunteers who undertake the 15 Step Challenge in wards. Patient Stories are a monthly item on the Trust Board agenda. **Staff feedback:** National Staff Survey Regular staff workshops are held to gather feedback and views from staff members in an informal setting. The Staff Friends and Family Test. Other, local or more specific surveys/focus groups also take place sickness and turnover). Monitoring of progress in the achievement of KPI's.	Programme of regular quality reports and reporting to committees and Board including: patient safety, workforce; patient experience; serious incidents; complaints; and trust wide learning Quality meetings with commissioners and information shared as part of the annual quality schedule; including serious incident investigation outcomes. Regular attendance of Trust staff at local authority overview and scrutiny committee meetings. Appointed governors on the Council of Governors from partner organisations including the local authority and universities. Council of Governor meetings Governor focus groups Non-Executive Director Counsel meetings Governors log of queries and concerns Internal Audit of Staff Engagement	Regular reports and KPI's form first line assurance. Reports to: • Trust Board, • Quality & Outcomes Committee • Meeting with Commissioners • Local Authority Overview & Scrutiny Committee • Council of Governor Meetings • Governor Focus Groups • NED Counsel Form second line assurance Internal Audit forms third line assurance.	None identified.	Although some of the patient feedback collected corporately is made available directly to inpatient wards (e.g. via posters and circulation of spreadsheets), there is an opportunity to make this more rapidly available and more accessible to ward staff.	The Patient Experience & Involvement Team is continuing to explore a solution to this, with a focus on responsiveness to patients' needs. Funding has been identified to procure a new patient feedback system during 2016/17.	Chief Nurse & Director of Human Resources and Organisational Development **Quality and Outcomes Committee**	Possible x Moderate 9	↔

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

OPERATIONAL PLAN 2016/17 PRIORITIES

IM&T and Estates

- Continue with the necessary upgrading of the Estate along with medical equipment replacement
- During the coming year we will continue to deploy new digital capability throughout the Trust, further embedding and extending existing functions with particular emphasis on:
  - Rolling out digital case notes across our other hospital sites together with the implementation of e-forms and workflow automation;
  - Commencing delivery of a new nursing e-observations and replacement e-rostering systems;
  - Going live across the Trust with electronic prescribing and medicines administration;
  - Providing more convenient access to our systems and services through the wider use of mobile technology and telehealth techniques; and
  - Delivering the objectives of the Clinical Utilisation Review (CUR) by using existing systems rather than purchasing duplicate systems which are not supported by Clinicians or the IT function.

Principal Risk description	Key Controls	Form of Assurance	Level of Assurance	Gaps in controls	Gaps in assurance	Actions Agreed for any gaps in controls or assurance	Executive Lead and Assuring Committee	Current Risk Rating	Direction of travel
Principal Risk 2 - *Failure to develop and maintain the Trust estate*	Incident reporting and risk assessments at Divisional and Departmental level. Regular inspections Internal Audit work programme. Recent PLACE (Patient-led assessments of the care environment) inspection reports did not surface any key risks.	Reports to Audit Committee, Risk Management Group, Divisional Boards and Health and Safety Groups Findings from inspections are included in reports to assurance committees. External audit of the Trust's Annual Accounts and Annual Report. Findings from independent assessments are included in reports to assurance committees.	Regular inspections form first line assurance. Reports to: • Trust Board, • Audit Committee • Divisional Boards Form second line assurance External assessment and audit forms third line assurance.	No significant gaps in controls.	Incident reporting in relation to aspects of estate, reveal limited assurance in respect of drain blockages and roofs	Operational and capital works programme for 16/17 provides resources to address issues in relation to drains and roofs (both to improve controls and mitigate future risks).	Chief Operating Officer **Service Delivery Group**	Major x Unlikely 8	↔

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

OPERATIONAL PLAN 2016/17 PRIORITIES

Workforce and Engagement

- Further development and implementation of strategic workforce plans, linked to the evolving STP.
- Achieve NHS Improvement's locum and agency expenditure requirements.
- Successful implementation of workforce recruitment and retention plan.
- Delivery of agreed workforce KPIs.
- Development and delivery of staff engagement plan, linked to the learning from the results of the 2015 staff survey.

Principal Risk description	Key Controls	Form of Assurance	Level of Assurance	Gaps in controls	Gaps in assurance	Actions Agreed for any gaps in controls or assurance	Executive Lead and Assuring Committee	Current Risk Rating	Direction of travel
Principal Risk 4 - *Failure to recruit, train and sustain an engaged and effective workforce.*	HR Policies and Procedures Clear accountability at Divisional level Trust wide learning opportunities Monthly compliance reports on Essential Training are sent to Divisions and include trajectories to achieve compliance. Appraisal Process/Personal Development Plan Corporate and Local Induction Quality objective on staff engagement Agency Controls Group. Divisional Reviews including performance against workforce plans Health and Wellbeing Programme (to include delivery of the NHS Staff Health and Wellbeing CQUIN 2016/17). Comprehensive development plans at Divisional and trust wide level. Staff Recognition Awards.	Metrics in relation to key controls are reviewed by the Senior Leadership Team, QOC and Trust Board: Staff survey results/ Exit Interviews. Review of ET compliance. Annual learning and development report. Health and Safety Reports. Friends and Family Test. Weekly returns agency staffing.	Regular internal reports form first line assurance. Reports to: • Trust Board, • Senior Leadership Team • Quality Outcome Committee Form second line assurance .	Metrics indicate we have a risk around staff retention, although improving.	Limited assurance primarily around achieving compliance with essential training rates.	Refresh of the Workforce and Retention Strategy. Mid-year review of workforce KPIs to understand forecast out turn.	Director of Workforce and Organisational Development **Trust Board**	Major x Possible 12	↔

STRATEGIC PRIORITY 4 : We will deliver pioneering and efficient practice, putting ourselves at the leading edge of research, innovation and transformation.									
OPERATIONAL PLAN 2016/17 PRIORITIES	• Development of our innovation and technology strategy								
Principal Risk description	**Key Controls**	**Form of Assurance**	**Level of Assurance**	**Gaps in controls**	**Gaps in assurance**	**Actions Agreed for any gaps in controls or assurance**	**Executive Lead and Assuring Committee**	**Current Risk Rating**	**Direction of travel**
Principal Risk 5 - *Failure to enable and support transformation and innovation, to embed research and teaching into the care we provide, and develop new treatments for the benefit of patients and the NHS.*	Memorandum of agreement with University of Bristol. Joint Posts. Clinical Networks. Research Standing Operating Procedures. Process in place for corrective and preventative actions where breaches of GCP/protocol are identified to support learning by PI/CI and research team. Regular review of research recruitment on a trust-wide level. Staff engagement embedded in planning service improvement and transformation work via direct involvement and variety of communication mechanisms. Transformation and other service improvement leads networked across the divisions – role includes identifying and supporting local innovation. Partnership with the Academic Health Science Network to train a cohort of improvement coaches to add capacity to this support network. Programmes such as Bright Ideas. During 16/17 review of approach to supporting innovation across the Trust planned (take stock of current work, identify gaps in support, develop solutions). Research grants, Research Capability Funding, commercial and delivery income maintained. SPAs recognised in consultant job plans.	Trust Research Group. Divisional research committees/groups. Regular reports to the Board KPI reviews (trust wide & divisional) Board metrics. Audit/inspections. Education and Training Annual Report Project steering groups /reporting to Transformation Board & Senior Leadership Team. Regular reports to the Trust Board. Evidence of wide range of innovation and improvement programmes completed/underway. Good response to Bright Ideas/Trust Recognising Success awards. NIHR award £21m over 5 years for Biomedical Research Centre to Trust and UoB partnership	Regular reviews form first line assurance. Reports to: • Trust Board, • Quality & Outcomes Committee • Divisional Groups • Transformation Board Form second line assurance Internal/External Audit/inspections forms third line assurance.	Medicine, Surgery, Head and Neck divisional research committees/groups in setup/upgrade. Gap expected to be closed by end of q2 16/17. Key Performance Indicators at divisional level (bed holding only) to be finalised and form part of regular divisional review. Gap expected to be closed by end q3 16/17. Need to better connect scope of activity underway across all aspects of improvement and innovation and clarify routes to support for proposals. Consider provision of access to basic improvement toolkit via e-learning. Better communication and promotion of improvement priorities required to provide mechanisms for increased staff input to these priorities (e.g. Happy App).	Clear mechanism for protecting time for non-medical PIs recruiting to National Institute of Health Research portfolio trials not in place. Additional methods of assurance to be identified in review of innovation.	Work in progress to address the divisional research committee's gaps. Review of Trust approach to supporting innovation and improvement to identify and address specific gaps. (Sept 2016) Workshops held in May and June to establish degree of connectedness of wide range of innovation/improvement work underway, identify gaps/duplication and develop proposals for further testing. Plan/strategy to be developed for consideration at Transformation Board with final approval by end of October 2016. Plan for supporting Innovation & Improvement presented to Transformation Board in October. Recommendations were fully supported, and team given go ahead for implementation. Action plan agreed and mobilisation of work now underway.	Medical Director **Trust Board**	Moderate x Possible 9	↔

STRATEGIC PRIORITY 5 : We will provide leadership to the networks we are part of, for the benefit of the region and people we serve.									
OPERATIONAL PLAN 2016/17 PRIORITIES	**Organisational and System Strategy and Transformation** • Complete a full refresh of our Trust strategy in Autumn 2016, along with the development of a new governance structure for strategic planning and implementation, to ensure that we are aligned to the system wide Sustainability and Transformation Plan (STP) and maintain the recommendations of the Well Led Governance Review. • Further evaluate opportunities to continue to develop our specialised services portfolio throughout 2016/17. • Development of the system Sustainability and Transformation Plan - take an active role in working with our partners to lead and shape our joint strategy and delivery plans, based on the principles of sustainability, transformation and partnership working.								
Principal Risk description	**Key Controls**	**Form of Assurance**	**Level of Assurance**	**Gaps in controls**	**Gaps in assurance**	**Actions Agreed for any gaps in controls or assurance**	**Executive Lead and Assuring Committee**	**Current Risk Rating**	**Direction of travel**
Principal Risk 6 - *Failure to take an active role in working with our partners to lead and shape our joint strategy and delivery plans, based on the principles of sustainability, transformation and partnership working.*	Executive to Executive meetings with NBT. Partnership Programme Board. Chief Executive agreed as local system leader for STP for BNSSG with other Executives playing lead roles within the STP processes. Staff involved in wide range of external activities e.g. Bristol Health Partners, Better Care Bristol, CLAHRC West, BNSSG System Leadership Group.	Board Partnership Reports. Reports to Trust Board. Staff survey feedback. Appraisal process KPI. "Critical Friend" approach being considered within STP process. Tender Framework in place from April 2016 explicitly addressing partnership opportunities. Evidence in recent tenders that Trust is a sought after partner - Children's Community Services; Sexual Health National feedback on Sustainability and Transformation Plan processes and leadership. No indication in current self-assessment within STP of adverse perceptions.	Internal reviews and monitoring of KPI's form first line assurance. Reports to: • Trust Board, Form second line assurance	Complete visibility of scope of staff engagement in external activities challenging and not necessarily required.	No significant gaps. Ability to harness soft information.	None.	Director of Strategy and Transformation **Trust Board**	Moderate x Unlikely 6	↔

STRATEGIC PRIORITY 6 : We will ensure we are financially sustainable to safeguard the quality of our services for the future and that our strategic direction supports this goal									
OPERATIONAL PLAN 2016/17 PRIORITIES	**Financial Performance** • Maintain sound financial control working to a surplus plan for the 14th year running, albeit caveated with significant remaining risks – both from Commissioner SLAs and internal pressures. • Delivery of 16/17 income plans and Cost Improvement Programme • Delivery of 16/17 capital programme, including the prioritisation and allocation of strategic capital.								
Principal Risk description	**Key Controls**	**Form of Assurance**	**Level of Assurance**	**Gaps in controls**	**Gaps in assurance**	**Actions Agreed for any gaps in controls or assurance**	**Executive Lead and Assuring Committee**	**Current Risk Rating**	**Direction of travel**
Principal Risk 7 - *Failure to sustain financial sustainability*	Budgetary control systems in place. Scheme of delegation and agreed budget holders. Financial Control Procedures. Standing Financial Instructions. Monthly Divisional CIP reviews. Monthly Finance & Operational Divisional Performance reviews. Divisional Board monthly scrutiny of operational and financial performance. Monthly review of financial performance with Divisional budget holders. Monthly Divisional contract income and activity reviews, savings reviews. Monthly savings work stream reviews. Monthly review by Savings Board Divisional control of vacancies and procurement monitored at monthly performance meetings. Income and Expenditure performance, capital expenditure, the statement of financial position and cash flow statement scrutiny at the Finance Committee.	Delivery of 16/17 capital programme, including the prioritisation and allocation of strategic capital. Regular Reporting to the Finance Committee and Trust Board. Monthly management scrutiny of capital expenditure at the Capital Programme Steering Group. Rolling 5 year Medium Term Capital Programme (source and applications of funds) approved annually by the Finance Committee and Board. Monthly Pay Controls Group, Non Pay Controls Group and Nursing Controls Group scrutiny of Divisions performance. Detailed monthly submission of financial performance submitted to the Regulator, NHS Improvement. Capital expenditure for year to date at 85% within the 85% to 115% tolerance specified by the Regulator. Strong statement of financial position. Liquidity metric of 4 (highest) and FSRR of 4 (highest rating) for 2016/17 year to date.	Regular divisional board scrutiny and reviews form first line assurance. Reports to: • Trust Board, • Finance Committee • NHSI Form second line assurance External review of financial position forms third line assurance.	Evidence that staffing controls are weak in some areas Evidence that income and activity performance controls are weak e.g. inpatient and outpatient activity planning and delivery performance. . Underperformance, shortfall in savings delivery and high levels of nursing and medical expenditure.	Lack of assurance that pay expenditure controls are fully effective. Lack of assurance that activity capacity planning and income performance controls are fully effective. Lack of assurance that new savings ideas will be developed. Lack of assurance that capital expenditure controls for operational capital and major medical equipment are fully effective Limited assurance that all controls are effective in light of continued spend above plan in some areas e.g. agency spend. Weak assurance in Divisions given adverse positions to Operating Plans largely due income.	Prioritised Executive review at Divisional Reviews. Transformation Board and productivity review process via Savings Board to identify further savings. Trust Capital Group to be established to scrutinise delivery of capital plans.	Chief Operating Officer **Finance Committee**	Moderate x Possible 9	↓

STRATEGIC PRIORITY 7 : **We will ensure we are soundly governed and are compliant with the requirements of our regulators**									
OPERATIONAL PLAN 2016/17 PRIORITIES	• Implementation of the recommendations from the Well Led Governance Review								
Principal Risk description	**Key Controls**	**Form of Assurance**	**Level of Assurance**	**Gaps in controls**	**Gaps in assurance**	**Actions Agreed for any gaps in controls or assurance**	**Executive Lead and Assuring Committee**	**Current Risk Rating**	**Direction of travel**
Principal Risk 8 - *Failure to comply with targets, statutory duties and functions*	Trust Board and all committees have an annual forward plan aligned to their terms of reference, Trust's Standing Orders and Standing Financial Instructions to ensure appropriate annual reporting against plans is in place. Regular reporting to NHS Improvement following Board approval. Monitoring of CQC inspection action plans via Clinical Quality Group, Senior Leadership Team, QOC	Annual Report, Annual Governance Statement, and Annual Quality Report, Annual Account submitted to Trust Board. NHS Improvement returns signed off by the Trust Board. Internal Audit Reports on Governance, risk management and financial accounts reported to Audit Committee. Self-assessment. Monthly Board Reports. Performance and Finance Reports at each Board Meeting. Committee Reports at each Board Meeting. Independent reports from CQC on Inspection Visits.	Regular reviews form first line assurance. Reports to: • Trust Board, • Quality & Outcomes Committee • Audit Committee Form second line assurance CQC Inspection Report provides third level assurance into areas inspected.	No significant gaps in control.	Partial assurance of effectiveness of controls, in light of on-going failure of some standards.	None.	Chief Executive **Trust Board**	Moderate x Possible 9	↔

Appendix 2: Links to the Corporate Risk Register

Strategic Objective	Principal Risk	Corporate Risk Register	Current Risk Rating
STRATEGIC PRIORITY 1: We will consistently deliver high quality individual care, delivered with compassion.	**Principal Risk 1:** Failure to maintain the quality of patient services.	**423 -** Risk that length of stay does not reduce in line with planning assumptions resulting in an increase in bed occupancy. **588** - Risk of patients coming to harm or having sub-optimal outcomes due failure to recognise and respond to deterioration. **674 -** Risks of excessive agency and bank costs, low staff morale and service impact arising from higher than sector turnover of staff. **856 -** Risk that the emotional & Mental Health needs of children and young people are not being fully met. **888** - Risk of failure to deliver the agreed recovery trajectories for all RTT standards **919 -** Risk that the Trust does not meet the national standard for cancelled operations. **932 -** Risk of failure to deliver care that meets National Cancer Waiting Time Standards. **949 -** Risk that perinatal mental health services are not adequate to the needs of those requiring to access the service. **961 -** Risk of harm to patients awaiting discharge, once medically fit **1497 -** Risk of Delays in transfer of North Somerset patients due to temporary closure of Clevedon Hospital. **1595 -** Risk that patients detained under s136 may be brought to ED due to lack of capacity in community provision **1598 -** Risk of Patients Falls Resulting in Harm. **1640 -** Risk of poorer quality service for patients due to delays with reporting of histology samples following service transfer.	9
	Principal Risk 3: Failure to act on feedback from patients, staff and our public.	No corporate risk identified	9
STRATEGIC PRIORITY 2: We will ensure a safe, friendly and modern environment for our patients and our staff.	**Principal Risk 2:** Failure to develop and maintain the Trust estate.	No corporate risk identified	8
STRATEGIC PRIORITY 3: We will strive to employ the best staff and help all our staff fulfil their individual potential**.**	**Principal Risk 4:** Failure to recruit, sustain an engaged and effective workforce.	**674 -** Risks of excessive agency and bank costs, low staff morale and service impact arising from higher than sector turnover of staff. **793 -** Risk of work related stress affecting staff across the organisation. **921 -** Risk of not achieving 90% compliance for Essential Training for all Trust staff.	12
STRATEGIC PRIORITY 4: We will deliver pioneering and efficient practice, putting ourselves at the leading edge of research, innovation and transformation.	**Principal Risk 5:** Failure to enable and support transformation and innovation, to embed research and teaching into the care we provide, and develop new treatments for the benefit of patients and the NHS.	No corporate risk identified	9
STRATEGIC PRIORITY 5: We will provide leadership to the networks we are part of, for the benefit of the region and people we serve.	**Principal Risk 6:** Failure to take an active role in working with our partners to lead and shape our joint strategy and delivery plans, based on the principles of sustainability, transformation and partnership working.	No corporate risk identified	6
STRATEGIC PRIORITY 6: We will ensure we are financially sustainable to safeguard the quality of our services for the future and that our strategic direction supports this goal.	**Principal Risk 7:** Failure to sustain financial sustainability.	**674 -** Risks of excessive agency and bank costs, low staff morale and service impact arising from higher than sector turnover of staff. **959 -**Risk that Trust does not Deliver 2016/17 financial plan due to Divisions not achieving their current year savings target	9
STRATEGIC PRIORITY 7: We will ensure we are soundly governed and are compliant with the requirements of our regulators.	**Principal Risk 8:** Failure to comply with targets, statutory duties and functions.	**801 -** Risk that the Trust does not maintain a GREEN Monitor Governance Rating **869 -** Risk of Reputational Damage Arising From Adverse Media Coverage of Trust Activities **919 -** Risk that the Trust does not meet the national standard for cancelled operations **932 -** Risk of failure to deliver care that meets National Cancer Waiting Time Standards **970 -** Potential risk of non-compliance with some of Monitor's core 4-hour Wait Clinical Indicator **1413 -** Risk of non-compliance with IG Toolkit at Level 2 2016/17 **1530 -** Risk of adverse operational impact arising from unplanned closure of Weston Emergency Department due to staffing shortages	9

Cover report to the Trust Board meeting to be held on 31 October 2016 at 11-1pm in the Conference Room, Trust HQ, Marlborough St, Bristol, BS1 3NU

		Agenda Item	2.1
Meeting Title	Trust Board	**Meeting Date**	31 October 2016
Report Title	Research and Innovation Quarterly Update Report		
Author	David Wynick		
Executive Lead	Sean O'Kelly, Medical Director		
Freedom of Information Status		Open	

Strategic Priorities (please select any which are impacted on / relevant to this paper)
Strategic Priority 4: We will deliver pioneering and efficient practice, putting ourselves at the leading edge of research, innovation and transformation

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

Executive Summary
<u>Purpose</u> The purpose of this report is to provide an update on performance and governance for the Board. <u>Key issues to note</u> See executive summary in report.
Recommendations
Members are asked to: • receive the report for **assurance**

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

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

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

Impact Upon Corporate Risk

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

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

Executive Summary

Performance:

We have been awarded a Biomedical Research Centre to the value of £21m. An updated business plan is in preparation, following which we will enter into contractual arrangements and the setup phase. The business plan will describe how the amount awarded (vs £33m bid for) will be used. The BRC will draw in grant income during 2017/18 and based on this spend, Research Capability Funding will be generated during 2018.

The percentage of studies meeting the 70d benchmark remained good, at 88% (Q1 validated figure). We expect that this level may reduce as the impact of the HRA changes to the processes to approve research in England are felt. This is likely to impact across the country and the NIHR is conscious of this likelihood. The transparent reporting systems we have in place will allow visibility of where this has had an impact.

We are now focussing our efforts on increasing the percentage of commercial and non-commercial trials that recruit to time and target. For, closed commercial trials our validated performance is 30%.There are a number of enablers that will help us to improve our performance. These include ensuring robust project feasibility is carried out, ensuring principal investigators agree appropriate targets and supporting principal investigators in gaining their colleagues' support in identifying and recruiting patients. Alongside this, we are seeking to identify best practice from trusts performing best in the league for commercial trials, and to plan our activities based on this. We will monitor performance once plans have been implemented.

Recruitment levels continue to be lower than previous years. The NIHR data cut was taken on 22nd October 2016 for the reporting period 01/10/2015 – 30/09/2016. This will have a negative impact on delivery funding allocations for 2017/18 and robust contingency planning is under way to deal with this. Alongside this, planning discussions for 2017/18 with LCRN and other partners within the operational management group are under way. Our trust portfolio is complex and we are looking at ways to identify more studies that are observational and have a lower burden of follow up, as well as opening up new areas of research. This should help our future performance delivering to time and target, and in recruitment.

Partnerships and Governance:

The outcome of the Biomedical Research Centre Bid is an excellent example of our partnership working (see presentation by Prof Wynick at the Trust Board meeting on 31st October 2016). The BRC project board continues to oversee the setup of the BRC, and will hand over to the planned joint governance structures when the BRC goes live. A key leadership post, the Bristol BRC Chief Operating Officer, is in the process of being appointed to, with interviews taking place in early November.

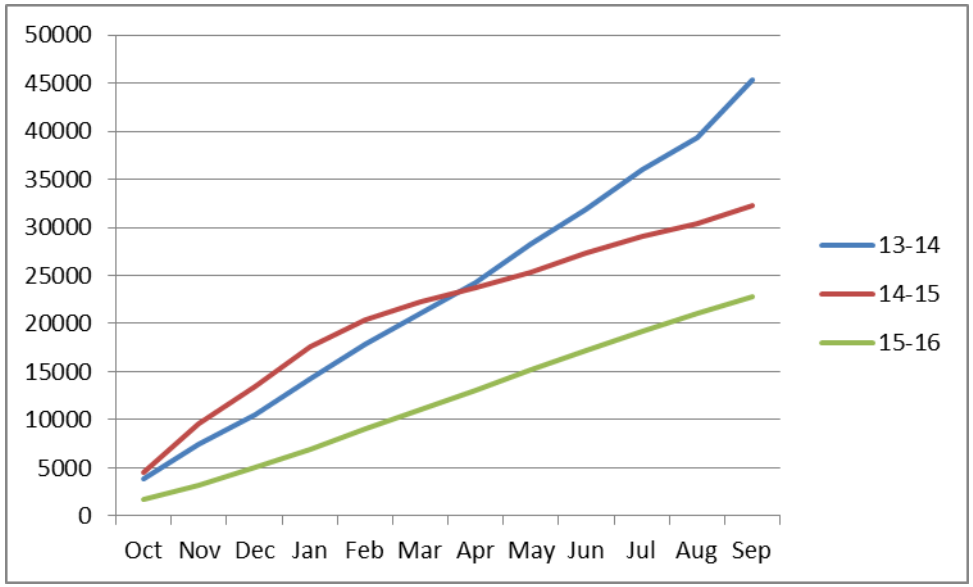
Overview

Successes	Priorities
• UH Bristol was successful in its bid for a Biomedical Research Centre with £20.8million being awarded to support five themes: Cardiovascular disease, Nutrition Diet and Lifestyle, Mental Health, Surgical Innovation (with orthopaedic surgery) and Reproductive and Perinatal Health. The grant will commence in April 2017. • Performance in initiating and delivering research continues to be maintained at a good level for 5 successive quarters.	• Appoint to the Biomedical Research Centre Chief Operating Officer post so that the setup of the BRC can commence in good time. This includes ensuring appropriate governance, admin and management structures are in place. • Continue to support researchers through the recent implementation of changes to research approval systems by the Health Research Authority in order to ensure they are not deterred from carrying out research. • Deliver engagement plan for R&I as part of the trust services plan. • Focus on improving performance to time and target in both commercial and non-commercial research.
Opportunities	**Risks and Threats**
• Ensure close oversight of existing Above and Beyond and RCF-funded small grants in order to identify opportunities for grant development. • Undertake work with neighbouring trusts, in particular NBT, to identify areas of research/studies already being carried out that can be opened in UHBristol. Introduce systems to allow easy identification of such studies as we receive them, and flag to other partners. • Review our portfolio and aim to increase the proportion of band 2 research taking place (observational), compared to band 3 (complex, interventional).	• Lower levels of weighted recruitment than previous years will impact on delivery funding for 2017/18. The size of the reduction is not yet known. • Ongoing issues with new system for approving research continue to increase burden of work for R&I core team. The impact will be slower setup times, which are likely to affect all trusts across the country.

Performance Overview

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

a) Cumulative weighted recruitment into NIHR portfolio studies in 15-16. NB. There is a 6 week lag of data from the portfolio.



Please note the reporting period in this graph is based on what the NIHR use to determine funding allocations.

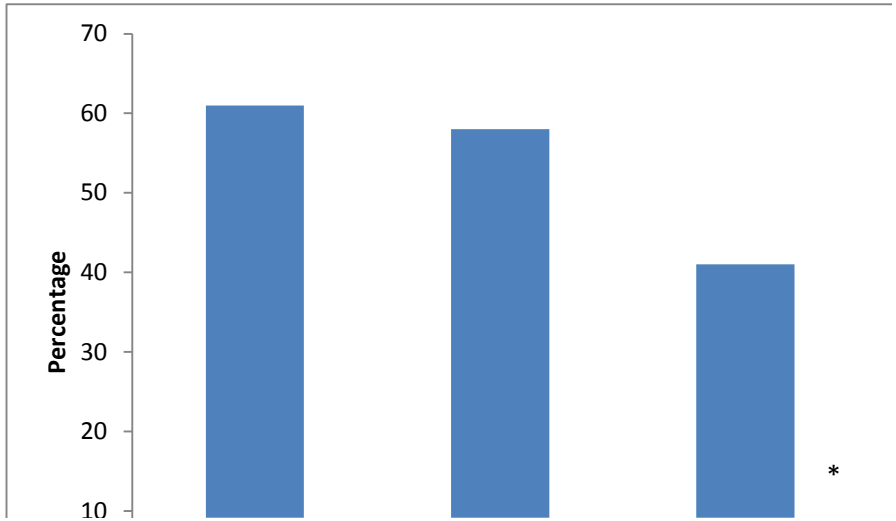
b) Performance in meeting the 70 day first patient first visit benchmark adjusted by NIHR in comparison to other Trusts

NIHR PID report- latest received Q1 16/17

87%	92%	91%	88%
Q2 15/16	Q3 15/16	Q4 15/16	Q1 16/17

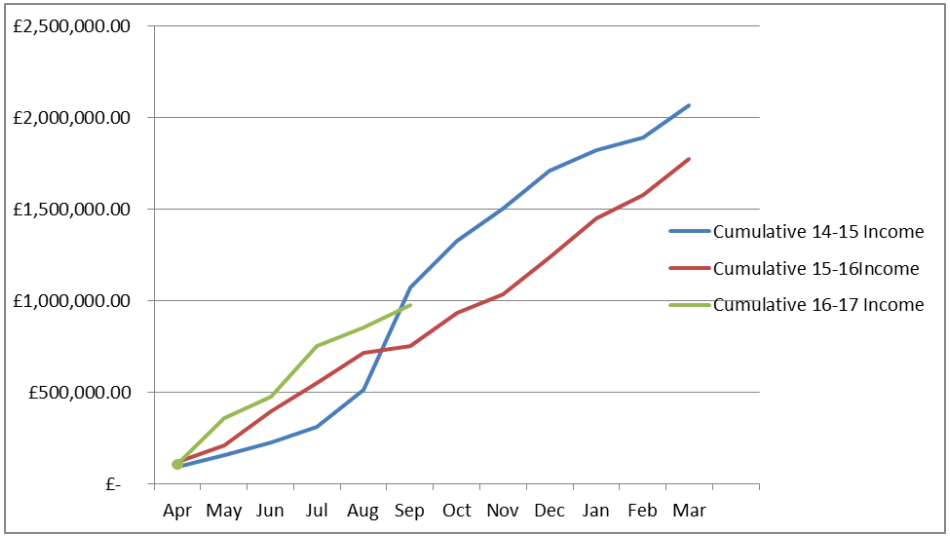
Green: >81.4% (Upper Quartile)
Red: <70.7% (Median)

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

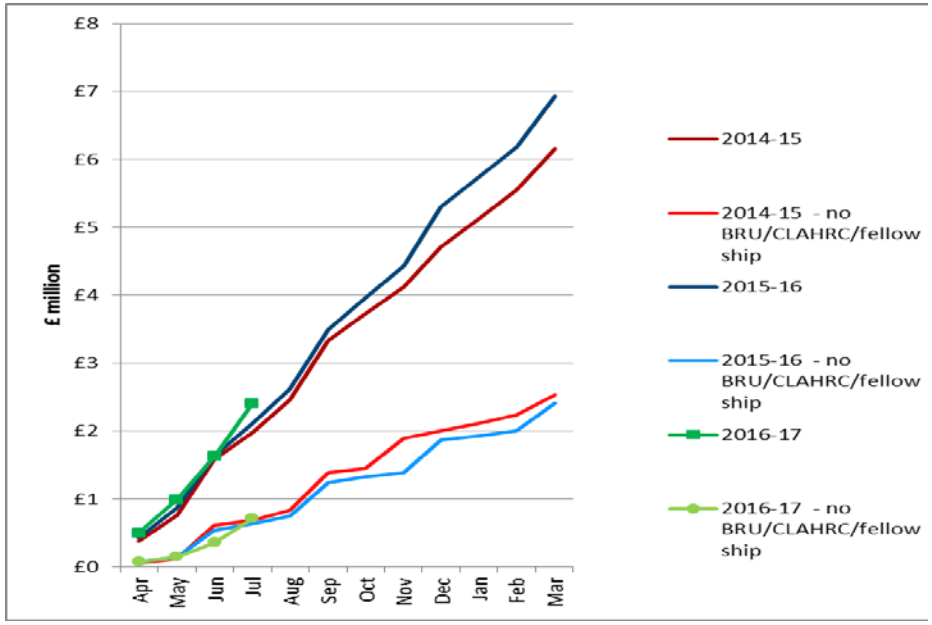


*DH changed the way the reporting metrics were analysed in Q1 16/17

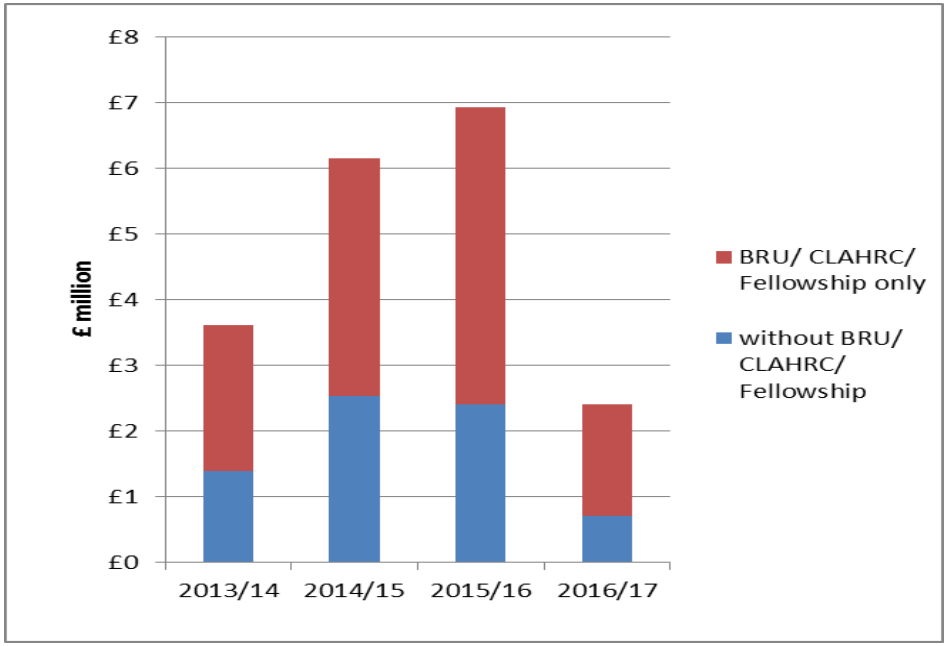
d) Monthly commercial income



NIHR monthly grant income – year on year comparison



NIHR grant income – drives research capability funding.



Cover report to the Trust Board meeting to be held on 31 October 2016 at 11-1pm in the Conference Room, Trust HQ, Marlborough St, Bristol, BS1 3NU

		Agenda Item	3.1
Meeting Title	Trust Board	**Meeting Date**	31 October 2016
Report Title	Independent Review of Children's Cardiac Services progress report		
Author	Helen Morgan, Deputy Chief Nurse/Cat McElvaney, Cardiac Review Programme Manager		
Executive Lead	Carolyn Mills, Chief Nurse		
Freedom of Information Status		Open	

Strategic Priorities (please select any which are impacted on / relevant to this paper)
Strategic Priority 1 : We will consistently deliver high quality individual care, delivered with compassion services.
Strategic Priority 2: We will ensure a safe, friendly and modern environment for our patients and our staff.

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

Executive Summary

Purpose

This paper provides a brief progress report on the actions taken in the last month to:

- Implement the programme plan, which addresses the recommendations set out in the Independent Review of Children's Services at the BRCH.
- Ensure that the programme plan describes and updates the detailed actions, timescales and responsibilities that will ensure recommendations are fully responded to.
- Ensure that clinical leaders and service users (young people and family members) are engaged and involved in the development and delivery of the action plans.

Key issues to note

- The three Key Delivery Groups are meeting on a monthly basis to monitor progress against the action plans.
- An assurance framework for the closure of a recommendation has been developed.
- There are no risks to the delivery of the actions identified in the plan.
- A plan is in place for involving families with improvement work and also in the Parents and Young Persons reference group, with the first listening event held on October 13th 2016.

Recommendations
Members are asked to: - Receive the report for **assurance** and **Note** the actions taken since the publication of the Independent Review of Children's Cardiac Services and the CQC report. - Receive the progress report

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

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

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

Impact Upon Corporate Risk
Risk ID

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

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

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

1.0 Introduction

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

2.0 Programme management

Work to develop a programme plan which responds to all the recommendations for University Hospitals Bristol NHS Foundation Trust and South West and Wales Congenital Heart Network to improve care and support to children and their families has been completed. The plan describes the detailed actions, timescales and responsibilities that will ensure recommendations are fully responded to. It details where families will be involved to ensure that the actions fully address the body and spirit of the review and meet the needs of families and young people.

There are four key elements to the programme plan reflecting the four delivery groups. Three of the delivery groups have a Senior Responsible Officer (SRO). These are Mr Ian Barrington Divisional Director Women's and Children's Division who is the SRO for the Women's and Children's independent review delivery group, Dr Jane Luker Deputy Medical Director is the SRO for the trust wide consent independent review delivery group, and Ms Helen Morgan Deputy Chief Nurse is the SRO for the trust wide incident and complaints independent review delivery group.

The Women's & Children's Delivery Group is responsible for leading, coordinating and delivering the actions that will be implemented in the Women's & Children's division. The Consent Delivery Group is responsible for leading and co-ordinating and delivering the actions related to consent. The Incidents and Complaints Delivery Group is responsible for leading and co-ordinating the delivery of the actions that relate to incident and complaint management.

The fourth delivery group is the parent and young person's reference group. This group will provide a structure (actual and virtual) that will enable parents and young people to be involved and engaged in the implementation of the recommendations and the shaping of future cardiac services. It also has a role to assure the Independent Review of Children's Cardiac Service Steering Group that the views of Parents and Young Persons have been heard and that the development of the actions to implement the recommendations reflects what is important to patients and families.

The tables below details a high level progress update for the whole programme and for the three of the delivery groups. The detailed plan is in appendix 1. The plan shows that all actions will be complete by 30th June 2017.

Table 1: Status overall Trust position (total=32)

MONTH	Red	Amber	Blue- on target	Green- completed	TBC	Not started
Sept '16	0	0	16	1	11	4
Oct '16	0	0	26	5	1	0

Table 2: Status Women's & Children's Delivery Group (total= 18)

MONTH	Red	Amber	Blue- on target	Green- completed	TBC	Not started
Sept '16	0	0	13	1	4	0
Oct '16	0	0	15	3	0	0

Table 3: Status Consent Delivery Group (total= 5)

MONTH	Red	Amber	Blue- on target	Green- completed	TBC	Not started
Sept '16	0	0	1	0	1	3
Oct '16	0	0	5	0	0	0

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

MONTH	Red	Amber	Blue- on target	Green- completed	TBC	Not started
Sept '16	0	0	1		4	
Oct '16	0	0	5	0	0	0

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

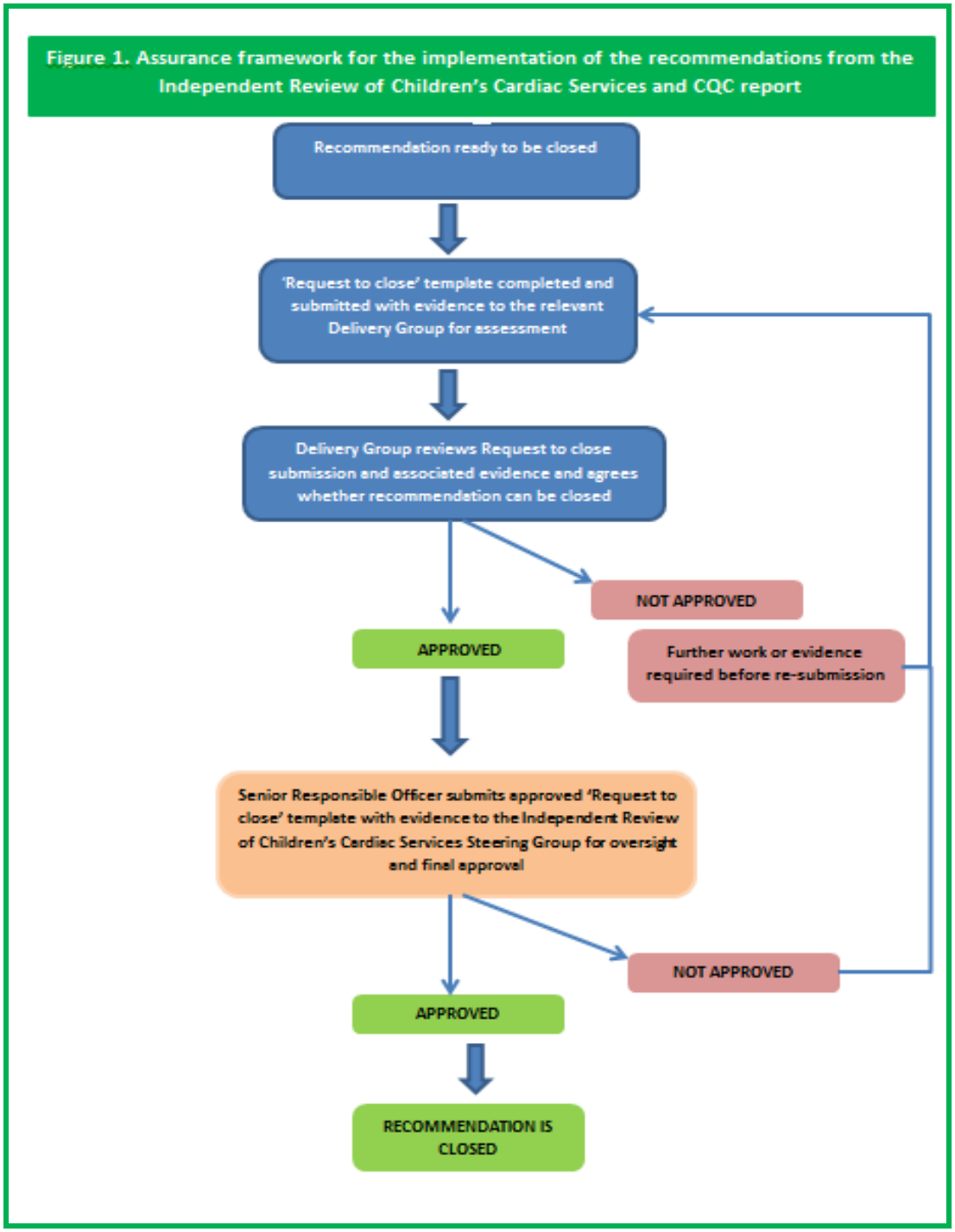
MONTH	Red	Amber	Blue- on target	Green- completed	TBC	Not started
Sept '16	0	0	1	0	2	1
Oct '16		0	1	2	1	0

3.0 Risks to Delivery

There are no risks to delivery of the actions identified in the plan.

4.0 Assurance Framework

A key responsibility of the Independent Review of Children's Cardiac Service Steering Group is to ensure recommendations have been fully implemented and that there is robust evidence to support implementation, before a recommendation is closed. An assurance framework has been developed to ensure that there is a clear and rigorous process for the closure of a recommendation (see fig 1). The request to close a recommendation template can be found in appendix 2.



5.0 Parent and young person's reference group and family involvement activities

A working group has been set up to lead and coordinate family involvement in the implementation of the recommendations from the Independent Review of Children's Cardiac Services and the CQC report. The working group includes the Women's and

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Children's Clinical Director, the Children's Hospital Patient and Family Support Team Manager and a Specialist Clinical Psychologist. It builds on the strong family involvement work that is already in existence in the Children's hospital.

A listening event was held for parents and families on the 13th of October to engage with families in the service and to understand how they would like to be involved in both overseeing and implementing the review and CQC report recommendations. Families were invited to this event via the Cardiac Support Groups, the Congenital Heart Disease (CHD) Network, the Children's hospital website and Facebook site, as well as flyers in the ward and outpatient areas. Following a very positive event, Parents have indicated the areas they wish to be involved in which include, membership of the Steering Group, a virtual parent's reference group, and reviewing documentation, processes and design work.

Further recruitment will continue via the support groups, the network and the children's cardiac services to ensure inclusivity. The Senior Responsible Officers for the Delivery Groups have been updated on the agreed mechanisms for getting families involved, so they can begin this process of involvement. The next listening event is currently being organised in the South Wales region.

6.0 Recommendations closed

No recommendations were closed during this reporting period.

The Trust Board is recommended to:

- Receive the progress report

University Hospitals Bristol NHS
NHS Foundation Trust

PROGRESS REPORT AGAINST UH BRISTOL RECOMMENDATIONS FROM THE INDEPENDENT REVIEW OF CHILDREN'S CARDIAC SERVICES – October 2016

1. Women's and Children's Delivery Group Action Plan, Senior Responsible Office: Ian Barrington, Divisional Director

	Progress overview						Detailed actions				
No.	**Recommendation**	**Lead Officer**	**Completion date of recommendation**	**Status**	**Delivery Risks**	**Revised timescale & reason**	**Actions to deliver recommendations**	**By**	**When**	**Status**	**Evidence**
2	That the Trust should review the adequacy of staffing to support National Congenital Heart Disease Audit (NCHDA) audit and collection of data.	General Manager for Cardiac Services	Apr '17	**Blue- on target**	None	n/a	Review of staffing	Assistant General Manager for Cardiac Services	Sept '17	**Green- complete**	Staffing review report
							Results and recommendations reported at Women's and Children's Delivery Group in Sept. '16.	Assistant General Manager for Cardiac Services	Sept '17	**Green- complete**	Women's and Children's Delivery Group Agenda and minutes 20.09.16
							Requirement for additional staff will feed into business round 2016-17	Assistant General Manager for Cardiac Services	Apr' 17	**Blue- on target**	Expression of interest form and Women's and Children's Operating Plan
3	That the Trust should review the information given to families at the point of diagnosis (whether antenatal or post-natal), to ensure that it covers not only diagnosis but also the proposed pathway of care. Attention	Specialist Clinical Psycholog ist	Apr '17	**Blue- on target**	Risk that we are unable to complete a visual diagram of pathway due to technical constraints and permission to change website and	n/a	Information given to families at the point of diagnosis reviewed by the clinical team and the cardiac families – remaining information for Catheter Procedures and Discharge leaflet. Website and leaflets updated to reflect improvements	Clinical Team & Cardiac Families	Jan' 16	**Green- complete**	Revised patient information leaflets
							Review and amendment of Catheter and Discharge leaflet	Cardiac CNS team	Feb' 17	**Blue- on target**	Revised Catheter and Discharge leaflet
							Enhance existing information with a visual diagram displaying pathways of care.	Specialist Clinical Psychologist	Apr' 17	**Blue- on target**	Pathway of Care accessible visual

	Progress overview						Detailed actions				
No.	**Recommendation**	**Lead Officer**	**Completion date of recommendation**	**Status**	**Delivery Risks**	**Revised timescale & reason**	**Actions to deliver recommendations**	**By**	**When**	**Status**	**Evidence**
	should be paid to the means by which such information is conveyed, and the use of internet and electronic resources to supplement leaflets and letters.				funding to do it		Website proposal to be written for new Children's website including cardiac information similar to Evelina to improve accessibility of our information. This will be additional and not essential for delivery of the recommendation	Specialist Clinical Psychologist and LIASE Team leader	tbc		
4	That the Commissioners and providers of fetal cardiology services in Wales should review the availability of support for women, including for any transition to Bristol or other specialist tertiary centres. For example, women whose fetus is diagnosed with a cardiac anomaly and are delivering their baby in Wales should be offered the opportunity, and be supported to visit the centre in Bristol, if there is an expectation that their baby will be transferred to Bristol at some point following the birth	Congenital Heart Disease (CHD) Network Clinical Director	Apr '17	**Blue- on target**	Risk that we are unable to get commitment / agreement on the changes that are required across the two hospitals / commissioning bodies	n/a	Meeting arranged for 18th November with English and Welsh commissioners as well as Bristol and Cardiff trusts to establish: a. Commissioner oversight of network b. Commissioner support for IR actions (4,5 &11) c. Establishment of working group(s) to address the specific changes in practices required	CHD Network Clinical Director and Network Manager	Nov '16	**Blue- on target**	Agreed pathway of care in line with new CHD standards and in line with patient feedback
							Ahead of the meeting: define specifics of recommendation (e.g. approaches to diagnosis and counselling); options for patient involvement (survey then focus group); CHD standards that relate to this recommendation; examples of practice from other centres	CHD Network Clinical Director and Network Manager	Nov '16	**Blue- on target**	
							Working groups to define changes / new pathways, taking account of patient feedback	Working groups	Jan '17	**Not started**	
							Undertake patient survey and focus groups (FI)	CHD Network Manager	Jan '17	**Not started**	
							New pathways in place (Jan – Apr)	CHD Network Clinical Director and Network Manager	Apr '17	**Not started**	Summary paper showing previous and new ways of working, detailing an assessment of the benefits

	Progress overview						Detailed actions				
No.	**Recommendation**	**Lead Officer**	**Completion date of recommendation**	**Status**	**Delivery Risks**	**Revised timescale & reason**	**Actions to deliver recommendations**	**By**	**When**	**Status**	**Evidence**
5	The South West and Wales Network should regard it as a priority in its development to achieve better co-ordination between the paediatric cardiology service in Wales and the paediatric cardiac services in Bristol.	CHD Network Clinical Director	April '17	**Blue- on target**	As above	n/a	Linked to recommendation no. 4. Actions detailed under recommendation no. 4 will also achieve recommendation no. 5				
7	The paediatric cardiac service in Bristol should carry out periodic audit of follow-up care to ensure that the care is in line with the intended treatment plan, including with regards to the timing of follow-up appointments.	General Manager Cardiac Services	Jan '17	**Blue- on target**	None	n/a	Audit proposal submitted to the audit facilitator for inclusion on the Children's annual audit plan (completed Aug '16)	Patient Safety Manager	Aug '16	**Green- complete**	Audit proposal
							Conduct 1st annual audit into follow up care for cardiac patients as per recommendation	Patient Safety Manager	Nov '16	**Blue- on target**	Audit report
							Report findings of the audit	Patient Safety Manager	Jan '17	**Not started**	Audit presentation and Cardiac Clinical Governance Agenda and minutes January meeting
							System developed for the regular reporting and review of follow up waiting lists at monthly Cardiac Business meeting (completed Aug '16)	Assistant General Manager for Cardiac Services	Aug '16	**Green- complete**	Follow up backlog report, Cardiac Monthly Business meeting standard agenda
8	The Trust should monitor the experience of children and families to ensure that	Chief Nurse and Project Lead for Children's	Oct '16	**Green- complete**		n/a	Baseline assessment (monthly outpatient survey) of current experience of children and families in outpatients reviewed)	Outpatients Experience working group	Aug '16	**Green- complete**	Outpatient Experience Review paper September 2016, Women's and

	Progress overview						Detailed actions				
No.	**Recommendation**	**Lead Officer**	**Completion date of recommendation**	**Status**	**Delivery Risks**	**Revised timescale & reason**	**Actions to deliver recommendations**	**By**	**When**	**Status**	**Evidence**
	improvements in the organisation of outpatient clinics have been effective.	Services					Gap analysis of current monitoring vs monitoring required to understand patients experience of the organisation of outpatient's completed	Outpatients Experience working group	Sept '16	**Green- complete**	Children's Delivery Group meeting agenda and minutes 20.09.16
							Systems in place for regular and specific monitoring, and reviewing and acting on results (FI)	Outpatients & CIU Service Delivery Group	Oct '16	**Blue- on target**	Women's and Children's Outpatients and Clinical Investigations Unit standard agenda
9	In the light of concerns about the continuing pressure on cardiologists and the facilities and resources available, the Children's Hospital should benchmark itself against comparable centres and make the necessary changes which such an exercise demonstrates as being necessary.	Women and Children's Divisional Director	Jan'17	**Blue- on target**	Risk that other sites are unable to share data required to complete a comprehensive benchmarking exercise Dependent on the action required to address the gaps it may not be possible to have implemented all the changes in the timescale.	n/a	Undertake benchmarking exercise with other CHD Networks, reviewing a defined list of criteria including aspects such as: job planning, IT and imaging links, information governance. To include site visits as appropriate (Jan)	CHD Network Manager	Jan '17	**Blue- on target**	
							Identification of actions required to address the gaps (end Jan)	CHD Network Manager	Jan '17	**Blue- on target**	
							Progress to implementing any changes in practice that are deemed necessary	Women and Children's Divisional Director and CHD Network Manager	Jan '17	**Blue- on target**	
11	That the paediatric cardiac service benchmarks its	Network Clinical Director	Jan'17	**Blue- on target**	Linked to recommendation no.9. Actions detailed under recommendation no. 9 will also achieve recommendation no. 11. Risks to delivery, timescales, progress against delivery and evidence will be the same as per recommendation no. 9						

	Progress overview						Detailed actions				
No.	**Recommendation**	**Lead Officer**	**Completion date of recommendation**	**Status**	**Delivery Risks**	**Revised timescale & reason**	**Actions to deliver recommendations**	**By**	**When**	**Status**	**Evidence**
	current arrangements against other comparable centres, to ensure that its ability, as a tertiary 'Level 1' centre under the NCHD Standards, to communicate with a 'Level 2' centre, are adequate and sufficiently resourced. Benchmarking would require a study both of the technical resources underpinning good communication, and the physical capacity of clinicians to attend planning meetings such as the JCC (Links to recommendation no. 5)										
16	As an interim measure pending any national guidance, that the paediatric cardiac service in the Trust reviews its practice to ensure that there is consistency of approach in the information provided to parents about the involvement of other operators or team members.	Clinical Lead for Cardiac Services and Paediatric Cardiac Surgeon	Dec '16	**Blue- on target**			Enhance existing guidance to describe team working and in particular the involvement of other operators and team members in patient care. Review by the Trust wide consent group and Cardiac Clinical Governance for approval and then implement.	Paediatric Cardiac Surgeon and Specialist Clinical Psychologist	Dec '16	**Blue- on target**	

	Progress overview						Detailed actions				
No.	**Recommendation**	**Lead Officer**	**Completion date of recommendation**	**Status**	**Delivery Risks**	**Revised timescale & reason**	**Actions to deliver recommendations**	**By**	**When**	**Status**	**Evidence**
18	That steps be taken by the Trust to review the adequacy of the procedures for assessing risk in in relation to reviewing cancellations and the timing of re-scheduled procedures within paediatric cardiac services.	General Manager for Cardiac Services	Nov '16	**Blue- on target**			Assessment of current process of risk assessing patients who have been cancelled and the timing of their rescheduled procedure (completed Aug '16)	Cardiac Review Programme Manager	Aug '16	**Green- complete**	Current process review report
							Develop new and improved process for risk assessing cancelled patients ensuring outcomes of this are documented (Nov '16)	Paediatric Cardiac Surgeon and Cardiac Review Programme Manager	Nov '16	**Blue- on target**	
20	That the Trust should set out a timetable for the establishment of appropriate services for end-of-life care and bereavement support.	General Manager for Cardiac Services	Nov '16	**Blue- on target**	None		End-of-life care and bereavement support pathway developed (FI)	General Manager for Cardiac Services	Sept '16	**Green- complete**	End-of-life and bereavement support pathway
							Implementation and roll out of new pathway	General Manager for Cardiac Services	Dec '16	**Blue- on target**	
21	Commissioners should give priority to the need to provide adequate funds for the provision of a comprehensive service of psychological support	Commissioners					Previous submission to commissioners for psychological support updated (Sept '16)	Consultant Clinical Psychologist	Sept '16	**Green- complete**	Submission to Commissions
							Expression of Interest for increased resource to be submitted as part of business planning	Consultant Clinical Psychologist and General Manager for Cardiac Services	Apr '17	**Blue- on target**	Expression of interest and W&C Business plan
23	That the BRHC confirm, by audit or other suitable means of review, that effective action has been taken to ensure that staff possess a shared understanding of the	General Manager Cardiac Services	Dec '17	**Blue- on target**	None		Review results of Trust wide Manchester Patient Safety (MAPSAF) to understand current baseline for both team level and divisional staff views on patient safety incident reporting and management	General Manager for Cardiac Services	Sept '16	**Green- complete**	
							Annual programme- Targeted approach to all staff groups to be developed with implementation of bespoke training and regular updates to clinical staff (on going)	Patient Safety Team Manager	Dec '16	**Blue- on target**	

	Progress overview						Detailed actions				
No.	**Recommendation**	**Lead Officer**	**Completion date of recommendation**	**Status**	**Delivery Risks**	**Revised timescale & reason**	**Actions to deliver recommendations**	**By**	**When**	**Status**	**Evidence**
	nature of patient safety incidents and how they should be ranked.										
CQ C.2	Provision of a formal report of transoesophageal or epicardial echocardiography performed during surgery	Cardiology Clinical Lead	Nov '17	**Blue- on target**			ECHO form for reporting in theatres implemented	Consultant Cardiologist	Aug '16	**Green- complete**	
							Audit to assess implementation (Nov'16) and request to Steering Group to close	Patient Safety Manager	Nov '16	**Blue- on target**	
CQ C. 3	Recording pain and comfort scores in line with planned care and when pain relief is changed to evaluate practice	Ward 32 Manager	Aug '16	**Green- complete**			Documentation developed to record pain scores more easily	Ward Manager	tbc	**Green- complete**	Nursing documentation
							Complete an audit on existing practise and report findings	Ward Manager	Aug '16	**Green- complete**	Audit of nursing documentation
CQ C. 4	Ensuring all discussions with parents are recorded to avoid inconsistency in communication. This includes communications with the Cardiac Liaison Nurses, who should record contacts with families in the patient records (links with review recommendation 12)	Head of Nursing, Women's and Children's	Dec '16	**Blue- on target**			Work with Cardiac Nurse Specialists to improve recording communication in the patients' medical records and review option of Medway proforma's to support recording in notes	Head of Nursing	Dec '16	**Blue- on target**	
CQ C. 5	Providing written material to families relating to diagnosis and recording this in the records. (links to review recommendation 3)	Cardiology Clinical Lead	Apr '17	**Blue- on target**			*Links to cardiac review recommendation no.3*				

	Progress overview						Detailed actions				
No.	**Recommendation**	**Lead Officer**	**Completion date of recommendation**	**Status**	**Delivery Risks**	**Revised timescale & reason**	**Actions to deliver recommendations**	**By**	**When**	**Status**	**Evidence**
CQ C.6	Ensuring that advice from all professionals involved with individual children is included in discharge planning to ensure that all needs are addressed.	Head of Allied Health Professional	Jan '17	**Blue- on target**		Agreed mechanism for including AHP advice into discharge planning for children within Cardiac Services	Assessment of current Allied Health Professionals input into discharge planning for Cardiac Services (Oct '16). Audit completed and results to be formulated 27th October 2016.	Head of Allied Health Professional	Oct '16	**Blue- on target**	Assessment documentation
							Agree with Cardiac Services Team an effective mechanism for including Allied Health Professionals into discharge planning for Cardiac Services. Meeting setup for 4th November.	Head of Allied Health Professional and Cardiology Clinical Lead	Nov'16	**Not started**	Agreed mechanism for including AHP advice into discharge planning for children within Cardiac Services
							Implement agreed mechanism for including Allied Health Professionals into discharging planning for Cardiac Services	Head of Allied Health Professional and Cardiology Clinical Lead	Jan 17	**Not started**	Implementation plan delivery report

Key	
R	Red - Milestone behind plan, impact on recommendation delivery date and/or benefits delivery
A	Amber - Milestone behind plan, no impact on recommendation delivery date and benefits delivery
B	Blue - Activities on plan to achieve milestone
TBC	To be confirmed
G	Complete / Closed
FI	Indicates family involvement in the action(s)

2. Trust wide Incidents and Complaints Delivery Group Action Plan – Senior Responsible Officer; Helen Morgan, Deputy Chief Nurse

	Progress overview						Detailed actions				
No	**Recommendation**	**Lead Officer**	**Completion date of recommendation**	**Status**	**Delivery risks**	**Revised timescale & reason**	**Actions to deliver recommendations**	**By**	**When**	**Status**	**Evidence**
26.	That the Trust should explore urgently the development of an integrated process for the management of complaints and all related investigations following either a death of a child or a serious incident, taking account of the work of the NHS England's Medical Directorate on this matter. Clear guidance should be given to patients or parents about the function and purpose of each element of an investigation, how they may contribute if they so choose, and how their contributions will be reflected in reports. Such guidance should also draw attention to any sources of support which they may draw upon.	Chief Nurse	Jan '17	**Blue- on target**			**26.1** Develop an appendix to the Serious Incident (SI) policy defining "link" between Child Death Review (CDR), complaints and SI investigations / reporting.	General Manager for Paediatric Cardiac Services	July '16	**Green- Complete**	
							26.2 Develop and implement guidance for staff on standards procedures / practices that need to be followed to provide a high quality and equitable service for all patients / families in the event of a bereavement.	General Manager for Paediatric Cardiac Services	Dec '16	**Blue- on target**	
							26.3 Develop 'guidance' / information for **families** how the x3 processes of Child Death Review (CDR) / Serious Investigation (SI) / Root Cause Analysis (RCA) investigation inquests and complaints are initiated / managed and integrate ***(FI)***	Patient Safety Team Manager	April '17	**Blue- on target**	
							26.4 Develop 'guidance' / information for **staff** on how the x3 processes of CDR / SI / RCA investigation inquests and complaints are initiated / managed and integrate	General Manager for Paediatric Cardiac Services	Dec '16	**Blue- on target**	
							26.5 Develop the above **staff** guidance for adult patients and families (minus CDR).	Head of Quality (Patient Safety)	tbc	**Not started**	
							26.6 Develop the above **family** guidance for adult patients and families (minus CDR).	Head of Quality (Patient Safety)	tbc	**Not started**	
							26.7 Develop a process of identification of a 'case manager' / 'key worker' and 'medical lead' for families / patients undergoing / involved in a number of complex process to be a defined point of contact co-ordinating a communication with the family / patient- **Adult** services	Head of Quality (Patient Safety) and Head of Quality (Patient	Apr '17	**Not started**	

	Progress overview						Detailed actions				
No	**Recommendation**	**Lead Officer**	**Completion date of recommendation**	**Status**	**Delivery risks**	**Revised timescale & reason**	**Actions to deliver recommendations**	**By**	**When**	**Status**	**Evidence**
								Experience and Clinical Effectiveness)			
							26.8 As above- **Children's** services	General Manager for Paediatric Cardiac Services	Dec '16	**Blue- on target**	
							26.9 Review options for how patients / families can participate (if they want to) with the SI RCA process implement preferred options ***(FI)***.	Head of Quality (Patient Safety)	June '17	**Not started**	
							26.10 Implement a process for gaining regular feedback from patients / families involved in a SI RCAs process to understand what it felt like for them and how we can improve the process for them	Head of Quality (Patient Safety)	Jan '17	**Not started**	
27	That the design of the processes we refer to should take account also of the need for guidance and training for clinical staff as regards liaising with families and enabling effective dialogue.	Chief Nurse	June '17	**Blue- on target**			**27.1** Guidance developed to medical staff to ensure patients and families are given the option to record conversations when a diagnosis, course of treatment, or prognosis is being discussed	Medical Director	Aug '16	**Green- completed**	
							As per actions 26.4 and 26.5, included in recommendation no. 26 to develop guidance for staff				
							Develop a framework for training staff to support them to effectively and sensitively manage processes relating to CDR/SI's and complaints	Tbc	June '17	**Not started**	
28	That guidance be drawn up which identifies when, and if so, how, an 'independent element' can be introduced into the handling of those complaints or	Chief Nurse	Dec '16	**Blue- on target**			To review UHBristol's previous use of independent review / benchmarking from other trusts to inform above. - Complaints - RCA's	Patient Support and Complaints Manager and Patient Safety Manager	 Nov '16 Nov '16	**Green- complete**	Report of the review undertaken
							Develop guidance for when to access 'independent	Head of		**Blue- on**	

	Progress overview						Detailed actions				
No	**Recommendation**	**Lead Officer**	**Completion date of recommendation**	**Status**	**Delivery risks**	**Revised timescale & reason**	**Actions to deliver recommendations**	**By**	**When**	**Status**	**Evidence**
	investigations which require it.						advise / review' for - Complaints - SI RCAs	Quality (Patient Experience and Clinical Effectiveness) And Head of Quality (Patient Safety)	Oct '16 Dec '16	**target**	Complaints policy SI policy
29	That as part of the process of exploring the options for more effective handling of complaints, including the introduction of an independent element, serious consideration be given to offering as early as possible, alternative forms of dispute resolution, such as medical mediation.	Chief Nurse	Apr '17	**Blue-on target**			Consider how an independent review can be introduced for 2nd time dissatisfied complainants / involve users in developing a solution.	Head of Quality (Patient Experience and Clinical Effectiveness)	Oct '16	**Green-complete**	Complaints policy
30	That the Trust should review its procedures to ensure that patients or families are offered not only information about any changes in practice introduced as a result of a complaint or incident involving them or their families and seek feedback on its	Chief Nurse	Dec '16	**Blue-on target**			Develop a clear process with timescales trust-wide for feedback to families / patients outcomes involved in SI panels / review and actions ongoing from this and staff ***(FI)***	Head of Quality (Patient Safety)	Apr '17	**Not started**	
							Inclusion in complaints to get responses as to how complainants can get (where appropriate) involved in developing local solutions to issues raised ***(FI)***	Head of Quality (Patient Experience and Clinical Effectiveness)	Oct '16	**Green-complete**	

	Progress overview						Detailed actions				
No	**Recommendation**	**Lead Officer**	**Completion date of recommendation**	**Status**	**Delivery risks**	**Revised timescale & reason**	**Actions to deliver recommendations**	**By**	**When**	**Status**	**Evidence**
	effectiveness, but also the opportunity to be involved in designing those changes and overseeing their implementation.										

Key	
R	Red - Milestone behind plan, impact on recommendation delivery date and/or benefits delivery
A	Amber - Milestone behind plan, no impact on recommendation delivery date and benefits delivery
B	Blue - Activities on plan to achieve milestone
TBC	To be confirmed
G	Complete / Closed
FI	Indicates family involvement in the action(s)

3. Trust wide Consent Delivery Group Action Plan – Senior Responsible Officer: Jane Luker, Deputy Medical Director

	Progress overview						Detailed actions				
No.	**Recommendation**	**Lead Officer**	**Completion date of recommendation**	**Status**	**Delivery Risks**	**Revised timescale & reason**	**Actions to deliver recommendations**	**By**	**When**	**Status**	**Evidence**
12	That clinicians encourage an open and transparent	Medical Director	Dec '16	**Blue on target**			**12.1** Guidance developed to medical staff to ensure patients and families are given the option to record conversations when a diagnosis, course of treatment, or prognosis is being discussed	Medical Director	Aug '16	**Green-completed**	Medical Staff Guidance

	Progress overview						Detailed actions				
No.	**Recommendation**	**Lead Officer**	**Completion date of recommendation**	**Status**	**Delivery Risks**	**Revised timescale & reason**	**Actions to deliver recommendations**	**By**	**When**	**Status**	**Evidence**
	dialogue with patients and families upon the option of recording conversations when a diagnosis, course of treatment, or prognosis is being discussed.						**12.2** Review of new existing guidance to reflect the recommendation	Deputy Medical Director	Nov '16	**Blue- on target**	
							12.3 Incorporate new guidance into existing Children's Consent pathway (existing letter that goes to families before their surgical appointment) (FI)	Consultant Paediatric Cardiac Surgeon	Dec '16	**Blue- on target**	
13	That the Trust review its Consent Policy and the training of staff, to ensure that any questions regarding the capacity of parents or carers to give consent to treatment on behalf of their children are identified and appropriate advice sought	Deputy Medical Director	Jan '17	**Blue- on target**	E-learning lead is currently on learn term sick which has led to a delay in updating e-learning material		**13.1** Trust wide Consent delivery group set up	Deputy Medical Director	Sept '17	**Green- Completed**	Terms of reference for Trust Wide Consent Group
							13.2 Review the consent policy and agree a re-write policy or amend existing policy to ensure patients and clinicians are supported to make decisions together	Consent Group	Oct '16	**Blue-on target**	Revised consent policy ratified by COC
							13.3 Develop training and communication plan	Deputy Medical Director	Dec '16	**Blue on Target**	Training and communications plan
							13.4 Advice from legal team and safeguarding on revised consent policy and e-learning	Deputy Medical Director	Dec '16	**Blue on track**	Legal and safeguarding assurance confirmation
							13.5 Update e-learning for any changes to consent policy and process	Deputy Medical Director	Jan '17	**Blue on track**	Updated E-learning package for consent
14	That the Trust reviews its Consent Policy to take account of	Deputy Medical Director	**Linked to recommendation no. 13, actions, timescales and status as detailed under this recommendation – Blue on target, date completion scheduled Jan '17**								

	Progress overview						Detailed actions				
No.	**Recommendation**	**Lead Officer**	**Completion date of recommendation**	**Status**	**Delivery Risks**	**Revised timescale & reason**	**Actions to deliver recommendations**	**By**	**When**	**Status**	**Evidence**
	recent developments in the law in this area, emphasising the rights of patients to be treated as partners by doctors, and to be properly informed about material risks										
17	That the Trust carry out a review or audit of (I) its policy concerning obtaining consent to anaesthesia, and its implementation; and (ii) the implementation of the changes to its processes and procedures relating to consent	Deputy Medical Director	May'17	**Blue- on target**			**17.1** Anaesthetic group to be set up to review current practise in pre-op assessment in relation to consent for anaesthesia and how they can implement a consent for anaesthesia process trust wide (FI)	Consultant Paediatric Cardiac Anaesthetist	Dec '16	**Blue on target**	
							17.2 Liaise with Royal College of Anaesthesia and other appropriate professional bodies with regarding national policy	Paediatric Anaesthesia consent group	Jan' 17	**Not started**	
							17.3 Implementation plan for trust wide consent process	Paediatric Anaesthesia consent group	May '17	**Not started**	
CQC. 1	Recording the percentage risk of mortality or other major complications discussed with parents or carers	Deputy Medical Director	Jan' 17	**Blue- on target**			**1.1** Review trust wide consent form in use to agree whether they should be amended to improve recording of risk	Consent Group	Dec '17	**Blue- on target**	

	Progress overview						Detailed actions				
No.	**Recommendation**	**Lead Officer**	**Completion date of recommendation**	**Status**	**Delivery Risks**	**Revised timescale & reason**	**Actions to deliver recommendations**	**By**	**When**	**Status**	**Evidence**
	on consent forms						**1.2** Paediatric Cardiac Services to agree whether service would benefit from a bespoke cardiac consent form that includes percentage risk	Consultant Paediatric Cardiac Surgeon	Nov '16	**Blue- on target**	
							1.3 Cardiac Services- agree and implement process for discussing percentage risk with families (FI)	Consultant Paediatric Cardiac Surgeon	Nov '16	**Blue- on target**	

Key	
R	Red - Milestone behind plan, impact on recommendation delivery date and/or benefits delivery
A	Amber - Milestone behind plan, no impact on recommendation delivery date and benefits delivery
B	Blue - Activities on plan to achieve milestone
TBC	To be confirmed
G	Complete / Closed
FI	Indicates family involvement in the action(s)

4. Other Actions Plan – governed by the Independent Review of Childrens Cardiac Services Steering Group

	Progress overview						Detailed actions				
No.	**Recommendation**	**Lead Officer**	**Completion date of recommendation**	**Status**	**Delivery Risks**	**Revised timescale & reason**	**Actions to deliver recommendations**	**By**	**When**	**Status**	**Evidence**
22	That the Trust review the implementation of the recommendation of the Kennedy Report that a member of the Trust's Executive, sitting on the Board, has responsibility to ensure that the interests of children are preserved and protected, and should routinely report on this matter to the Board.	Trust Secretary	Sept '16	**Green-complete**			Review of current arrangements and processes (Sept '16)	Trust Secretary	Sept '16	**Green-complete**	Executive Lead Role description
24	That urgent attention be given to developing more effective mechanisms for maintaining dialogue in the future in situations such as these, at the level of both the provider and commissioning organisations.	Commissioners and Trust	Tbc	Tbc			Discussion with commissioners on how best to achieve this	Commissioners and Trust	Oct '16	**Tbc**	
31	That the Trust should review the history of recent events and the contents of this report, with a view to acknowledging publically the role which parents have played in bringing about significant changes in practice and in improving the provision of care.	Chief Nurse	Oct '16	**Green-complete**			Trust board paper presented in July acknowledging the role which parents have played in bring about significant changes in practice and in improving the provision of care	Chief Executive	July '16	**Green-complete**	Trust Board Paper and Trust Board Agenda, July '16
							Presentation to Health and Overview Scrutiny Committee	Chief Executive, Medical Director, Chief Nurse and Women's and Children's Divisional	Aug '16	**Green-complete**	

	Progress overview						Detailed actions				
No.	**Recommendation**	**Lead Officer**	**Completion date of recommendation**	**Status**	**Delivery Risks**	**Revised timescale & reason**	**Actions to deliver recommendations**	**By**	**When**	**Status**	**Evidence**
								Director			
							Presentation to the Bristol Safeguarding Children's Board	Chief Nurse	Oct '16	**Green- complete**	
32	That the Trust redesignate its activities regarding the safety of patients so as to replace the notion of "patient safety" with the reference to the safety of patients, thereby placing patients at the centre of its concern for safe care.	Medical Director	Dec '16	**Blue- on target**			Adoption of the term "Safety of Patients" in place of "Patient Safety" going forward and communication of preferred term Trust wide (Dec '16)	Medical Director	Dec '16	**Blue- on target**	

Key	
R	Red - Milestone behind plan, impact on recommendation delivery date and/or benefits delivery
A	Amber - Milestone behind plan, no impact on recommendation delivery date and benefits delivery
B	Blue - Activities on plan to achieve milestone
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INDEPENDENT REVIEW OF CHILDRENS CARDIAC SERVICES STEERING GROUP REQUEST TO CLOSE RECOMMENDATION FORM

PURPOSE This document is a request to the Independent Review of Childrens Cardiac Services Steering Group to close a recommendation from the Independent Review action plan. The request to close will have already been presented to, and approved by the relevant delivery group. The Steering Group is responsible for assuring the Trust Board that recommendations have been completed fully with robust evidence to support closing.

REQUESTED BY

RECOMMENDATION

DATE REQUESTED

1.	**Recommendation no. and detail .**
2.	**Summary of why recommendation should be closed?**
	Please provide a summary of why the recommendation should be closed/how it has been fulfilled.
3.	**Evidence to enable closure.**
	Please detail the evidence to support the recommendation being closed and attach to the email along with this request form
4.	**Actions completed .**
5.	**Please give details of staff and family representatatives who have been involved in the actions.**
6	**Benefits of implementing this recommendation**
	Please detail any benfits from implementing this recommendation including any patient, family, staff, organisation benefits
7	**Please indicate if there is any ongoing evaluation or audit planned**

For completion by Independent Review of Childrens Cardiac Services Steering Group

Date reviewed	Decision agreed	Rationale

Cover report to the Trust Board meeting to be held on 31 October 2016 at 11-1pm in the Conference Room, Trust HQ, Marlborough St, Bristol, BS1 3NU

		Agenda Item	3.2
Meeting Title	Trust Board	Meeting Date	31 October 2016
Report Title	Quality Strategy		
Author	Chris Swonnell, Head of Quality (Patient Experience & Clinical Effectiveness)		
Executive Lead	Carolyn Mills, Chief Nurse	Sean O'Kelly, Medical Director	
Freedom of Information Status		Open	

Strategic Priorities (please select any which are impacted on / relevant to this paper)
Strategic Priority 1: We will consistently deliver high quality individual care, delivered with compassion.
Strategic Priority 4: We will deliver pioneering and efficient practice, putting ourselves at the leading edge of research, innovation and transformation
Strategic Priority 3: We will strive to employ the best staff and help all our staff fulfil their individual potential

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

Executive Summary

Purpose

The Quality Strategy for 2016-2020 replaces the following documents:

- The existing Quality Strategy 2014-2017
- Patient Safety Strategy
- Patient Experience & Involvement Strategy
- Clinical Effectiveness & Outcomes Strategy

Key issues to note

The new strategy takes a broader view of quality than previous versions, in line with the scope of recent annual Quality Reports (Accounts), embracing staff experience and timeliness of access to services. The strategy is therefore structured around the following four revised quality themes:

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

Earlier drafts of the strategy were reviewed by members of the Board, Strategic SLT, our governors, and Clinical Quality Group (and its sub-groups). In response to feedback, the

strategy was developed to place a greater emphasis on ambitions and supporting activities which represent a step-change in our ambitions for improving quality, whilst noting the vital 'business as usual' activities which will underpin these efforts. Where possible, measurable targets have been included for 2020. As a result of a suggestion arising from discussions at SLT, the strategy includes a section where UH Bristol staff have described what "quality" means to them (around 300 staff shared their thoughts with us).
Recommendations
Members are asked to: • **Agree** the Strategy for onward approval at the Trust Board.

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

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

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

Impact Upon Corporate Risk

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

Date papers were previously submitted to other committees				
Audit Committee	**Finance Committee**	**Quality and Outcomes Committee**	**Remuneration & Nomination Committee**	**Other (specify)**
0T	0T	27/10/2016	0T	Senior Leadership Team, 19/10/16. Clinical Quality Group, 6/10/16

University Hospitals Bristol NHS
NHS Foundation Trust

We are proud to care:
Quality Strategy 2016-2020

1. Quality – our number one priority

University Hospitals Bristol NHS Foundation Trust (UH Bristol) is one of the country's largest acute NHS Trusts with an annual income of half a billion pounds. We provide general hospital services to the population of central and south Bristol and the north of North Somerset - a population of about 350,000 patients. The Trust provides specialist services to a wider population throughout the South West and beyond, serving populations typically between one and five million people.

The Trust employs more than 8,000 staff who deliver over 100 different clinical services across nine different sites. With services from the neonatal intensive care unit to care of the elderly, we provide care to the people of Bristol and the South West from the very beginning of life until its end.

The quality of service that we provide is our overriding priority and the common purpose that brings all of our staff together, no matter what roles they do and where they work, and this is rightly central to both our mission and vision as an organisation. In common with the rest of the NHS, we face a significant challenge: delivering the highest quality of services for our patients whilst ensuring future financial sustainability. This means doing more for less, doing it better and doing it smarter.

We are also writing this strategy at a time when our Board is continuing to digest the findings of the independent review of children's cardiac services in Bristol. The review has affirmed the Trust's record on clinical outcomes, whilst raising important questions about transparency and how we communicate effectively with patients and their families. The review report acknowledges that much has changed for the better in the time which has passed since the period under scrutiny: this strategy makes an important contribution to the Trust's ongoing learning.

This strategy has been developed by the Board in discussion with Governors, staff and members of our Involvement Network.

2. Purpose

The purpose of the Quality Strategy is to articulate our ambitions for quality in a way that is meaningful and serves as a statement of intent that patients, carers, staff, commissioners and other stakeholders can use to hold the Trust Board to account for the delivery of high quality services. To this end, we have also produced a quick-read summary of this strategy which will be available on the Trust's web site and around our hospitals.

By implementing this strategy, we want to enhance our reputation for providing the best possible treatment, delivered with care and compassion.

3. Strategic alignment and drivers

The quality strategy sets out our ambitions for improving quality for the next four years, whilst also recognising that quality is a constantly moving target. Research knowledge is ever-expanding. The state of our local health and social care economy is also likely to change significantly during the lifetime of this strategy as our Sustainability and Transformation Plan (STP) is developed and implemented: our ambitions may not always be within our own gift to deliver and we will need to review them on an annual basis. In addition, we will agree set a set of annual quality objectives, published via our Quality Accounts, which will determine where we direct our focus and energy.

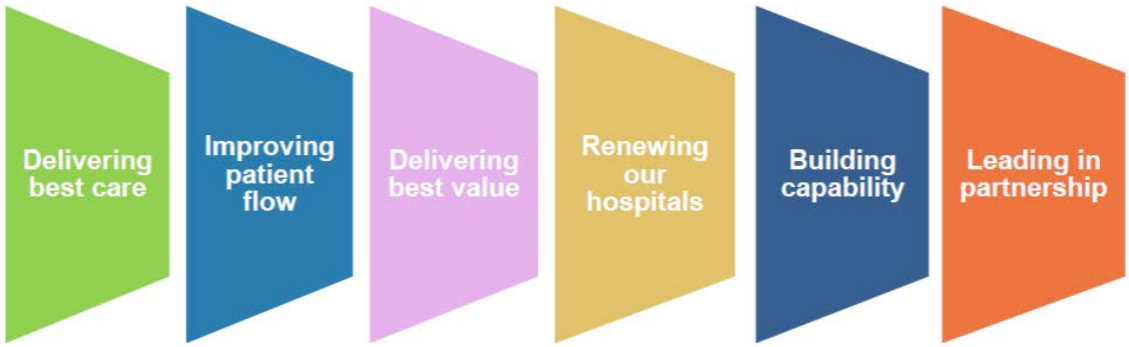
Our **mission** as a Trust is to improve the health of the people we serve by delivering exceptional care, teaching and research, every day.

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

This strategy supports achievement of the Trust's strategic priorities, namely:

- We will consistently deliver high quality individual care, delivered with compassion
- We will ensure a safe, friendly and modern environment for our patients and our staff
- We will strive to employ the best and help all our staff fulfil their individual potential
- We will deliver pioneering and efficient practice, putting ourselves at the leading edge of research, innovation and transformation
- We will provide leadership to the networks we are part of, for the benefit of the region and people we serve
- We will ensure we are financially sustainable to safeguard the quality of our services for the future and that our strategic direction supported this goal
- We will ensure we are soundly governed and are compliant with the requirements of our regulators

This strategy also supports delivery of the delivering best care 'pillar' of the Trust's Transforming Care programme, whilst also contributing to delivering of the pillars for improving patient flow and leading in partnership.



Our desire to deliver the highest quality care is driven by a range of local and national factors, some of which are described in the table below:

Meeting regulatory requirement, e.g. CQC Fundamental Standards	Providing evidence to support appraisal and revalidation of clinicians	Sign up to Safety initiative
Quality as a driver of reputation and patient choice	Quality as a source of income (CQUINs)	Knowing what matters most to patients and the public
Implementing the NHS Quality Framework	Quality as the check and balance to necessary efficiency savings	Implementing recognised best practice, e.g. NICE standards and guidance
The need to learn from our mistakes	Meeting quality standards agreed with our commissioners	Being open, transparent and candid about quality (Duty of Candour)
Underpinning the transformation of our hospitals	Supporting the Government's Mandate to the NHS	Responding to patient feedback and concerns

4. Defining quality and our ambitions

4.1 'What quality means to me'

'Rising to the challenge', the Trust's 2020 vision, has previously laid the groundwork for this strategy, committing the Trust to addressing the aspects of care that matter most to our patients. These include improving the hospital environment, a focus on individual needs and ensuring that they achieve the best clinical outcomes possible for them. This message is affirmed every year when members of our Involvement Network convene to help the Trust shape its annual quality goals, published in our Quality Accounts. It's vital that patients can see their priorities for healthcare within the pages of this document.

We also want this strategy to mean something to every one of our staff. Its success will depend upon on our staff being able to recognise their own contribution to quality. As part of developing our strategy, we invited our staff to tell us what quality means to them. More than 400 people replied: their inspirational words have been used to create the word cloud on the front page of this document.

This is what some of our staff said quality meant to them:

> "Safe, compassionate and efficient care of every patient and their families" (staff nurse)
>
> "That everything I do and say should be contributing to the greater good to improve people's lives" (senior manager)
>
> "The contribution of every member of the team" (executive director)
>
> "Providing the best service possible and utilising all our resources to their full potential" (clinical photographer)
>
> "Making patients feel comfortable, welcome and well cared for" (newly qualified nurse)
>
> "The best service – whatever the time of day or day of the week" (trainee nurse)
>
> "Safe and effective care that puts the patient at the centre" (pharmacist)
>
> "An open and honest experience for patients" (staff nurse)
>
> "A professional service with highly skilled professionals" (referrals co-ordinator)
>
> "Caring for others when they are at their most vulnerable" (senior nurse)
>
> "Making every encounter with patients or staff meaningful and productive, and aimed at delivering the best possible outcome" (consultant)
>
> "Quality means doing that little bit extra every day that makes a difference to someone's life" (clinical chair)
>
> "Providing the highest standards of care, taking into consideration the specific needs of each patient and their family" (staff nurse)
>
> "Delivering effective, evidence-based care to patients that also encompasses their needs" (consultant)
>
> "Everything we do!" (radiographer)

> "Giving your all to meet individual needs" (paediatric staff nurse)
>
> "It's in the small things - the way we do things as much as the safety and effectiveness of what we do" (senior manager)
>
> "Getting it right for everyone, every time" (senior manager)

We asked our chief executive too. He said:

> "For me, quality means doing our best at all times to make a personal, human connection, and to recognise the enormous privilege of being able to help people in their hour of need"

The message from these quotes, and hundreds more like them which we received, is that there is a range of diverse, but equally important, facets to quality:

- defining and meeting measurable standards of care
- attitudes and behaviours
- professionalism
- empathy and compassion
- working as a team
- giving of your best at all times
- transparency and honesty.

At the beginning of 2016, we met with members of our Trust's Involvement Network to hear what patients and members of the public had to say about quality priorities. The overriding message from this event was that we cannot divorce the concept of quality from the process of waiting to access health services as somehow being an 'administrative' process, be that in one of our emergency departments, in an outpatient clinic, or whilst waiting on a list for cancer treatment or planned surgery.

We have listened to these messages from our staff and the people who use our services, and used them to shape this strategy, beginning by embracing a wider view of what quality means.

4.2 A wider view of quality

The Trust's previous quality strategies adopted the model of quality proposed by Lord Darzi: first and foremost, ensuring patients are safe in our care; secondly, providing patients with the best possible clinical outcomes for their individual circumstances; and thirdly, delivering an experience of hospital care which is as good as it possibly can be. In our last strategy, we recognised that access to services is integral to, not separate from patient experience, and also that great patient experience happens when staff feel valued, supported and motivated. In this revision of our strategy, we have gone a step further by making this wider view of quality integral to our definition.

Our strategy is therefore structured around four core quality themes:

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

Quality at UH Bristol:

Threads running through each of these core quality themes are research, education, innovation and improvement.

And underpinning the strategy are our Trust's values – respecting everyone, working together, embracing change and recognising success.

The commitments we make in this strategy also need to be financially deliverable. In July 2016, the 'reset' publication *Strengthening Financial Performance and Accountability in 2016/17 in the NHS* underscored the responsibilities of individual NHS bodies to live within the funding available. Although there will be increased resources available for the NHS in 2017/18 and 2018/19, the level of growth is significantly less than has previously been available to the NHS. Therefore, our relentless focus on quality must be accompanied by an equally relentless focus on efficiency – the message is "affordable excellence".

4.3 A summary of our ambitions

In the next part of our strategy, you will read about the commitments we are making against each of our four core quality themes.

In summary, we will:

- Cancel fewer operations
- Reduce patient waiting times
- Improve the safety of patients by reducing avoidable harm

- Strengthen our patient safety culture
- Create new opportunities for patients, families and staff to give us feedback about their experiences, and in a way which enables concerns to be addressed in real-time
- Develop a customer service mind set across the organisation, including how we handle and respond to complaints
- Take a lead role in the development of a new national system of rapid peer review of unexpected patient deaths, implementing learning about the causes of preventable deaths
- Significantly improve staff satisfaction, making UH Bristol an employer of choice

Our plans will be built on a foundation of:

- The patient-centred principle of "nothing about me without me"
- Partnership working
- Evidence-based treatment and care derived from high-class research – some of it led by us
- Effective teamwork
- Systematic benchmarking of our practice and performance against the best
- Learning when things go wrong
- Intelligent use of clinical audit and quality improvement activities
- Learning from internal and external review

5. Ensuring timely access to services

The national Strategy and Transformation framework sets out a clear direction for trusts' priorities for timely access to services. Four key areas are expected to form the basis of the Oversight Framework for NHS trusts, which are:

- A&E 4-hour maximum wait
- Incomplete pathways Referral to Treatment (RTT) standard
- 62-day GP day referral to treatment cancer wait
- 6-week diagnostic waiting times standard

These four national access standards, along with other standards that measure waiting times for specific parts of a patient's pathway or different groups of patients, apply to a very high proportion of the patients who come through our doors. Our Trust has an absolute commitment to achieving these national standards.

However, over and above these standards, our patients consistently tell us that two things really matter to them:

- reducing cancelled operations – particularly at the last minute
- reducing cancelled clinics and delays in-clinic when attending an outpatient appointment

For the last two financial years, the Trust has set corporate quality objectives, via its annual Quality Accounts, to address these challenges. During the lifetime of this strategy, we will continue to set stretching annual targets to reduce cancellations and waiting times.

As part of this strategy, we are also committing ourselves to ensuring timely access to mental health services for people who are seen in our Trust's emergency departments.

5.1 Reducing cancelled operations

We recognise that the cancellation of a patient's operation can be very distressing for patients and their families and detracts from the high quality patient experience that we want to deliver. It is also very frustrating for our staff who have worked alongside the patient in preparation for their surgery to have to cancel at short notice. The Trust continues to work to minimise the number of occasions on which a patient's operation is cancelled for non-clinical reasons, taking into consideration all the steps across the patient's pathway from initial listing through to admission. Alongside the national target of operations cancelled on the day, we are also recording and trying to reduce the number of operations or admissions cancelled the day before the patient was due to be admitted. One of the areas of greatest challenge is the availability of an appropriate specialist bed on the day of admission, pivotal to which is the way we use our annual planning cycle to ensure that our capacity meets demand. Our plans for addressing variation in emergency demand are another crucial determinant of success in reducing cancelled operations during the lifetime of this strategy.

In our Quality Accounts, we will set stretching but achievable annual targets for reducing numbers of cancelled operations for each year of this strategy.

Improvement goals:

- We will achieve the national target of no more than 0.8 per cent of patients operations cancelled on the day of admission.
- We will agree yearly performance targets to reduce the number of patients who are cancelled the day before their 'To come in' date. This is not a nationally mandated requirement, but we recognise that the impact of this form of cancellation is equally significant for patients. Our target is the same as for operations cancelled on the day of admission, i.e. no more than 0.8 per cent of elective admissions cancelled the day before.

5.2 Reducing outpatient appointments cancellations and in-clinic waits on the day of the appointment

Nearly all patients will have outpatient contact with our services, often on multiple occasions. In total, we deliver approximately 650,000 outpatient attendances every year. It follows that outpatient services must form a key part of our ambitions for quality over the next four years. Ensuring timeliness of appointments, easy and clear communication and a responsive interface between the patient and our services, are essential components of our ambitions for improvement and will have a positive impact on a huge number of our patients.

The Trust coordinates its improvements for outpatients through its Outpatient Steering Group, delivering a programme of transformation work whilst dealing with trust-wide operational issues. Partnership working with our Information Management and Technology team is embedded into our programme to enable improvements in processes for booking and scheduling clinics, and in identifying and acting upon delays in clinic when they arise. We recognise that we can improve usage of the national Electronic Referral System to reduce the amount of times patients are moved to different clinic slots, resulting in cancellations and the risk of miscommunication. As well as improving the visible display of any in-clinic delays, we are developing tools within the patient administration system allowing real-time tracking of how clinics are running.

We will set stretching but achievable annual targets for reducing outpatient clinic cancellations and clinic waiting times for each year of this strategy, published in our Quality Accounts.

Improvement goals:

- We will reduce the percentage of outpatient appointments cancelled by the Trust to less than 6 per cent by 2020.
- We will achieve year-on-year reductions in the percentage of patients waiting more than 30 minutes after their clinic appointment time.
- We will achieve year-on-year reductions in the percentage of patients who report a delay in their clinic start time through patient reported measures.

5.3 Timely access to mental health services

Ensuring timely access to mental health services for adults and children who are seen in our emergency departments and maternity services at times of acute personal distress is a key priority for the Trust. Psychiatric liaison services provide mental health care to people of all ages who are being treated for physical health conditions. This service is a vital element of the delivery of a modern, responsive and integrated service to patients. We will work with partners to ensure that when patients are identified as requiring onward specialist mental healthcare, we minimize the delays and maintain the patient's safety while they await their transfer.

However some adult and paediatric patients who do not require treatment for their physical health are brought to the hospitals under section 136 of the Mental Health Act, as a place of safety. This can result in them being cared for by staff who are not trained to manage patients with mental health needs. We will therefore be working closely with commissioners and other agencies to ensure they understand the risks of the current system and to influence the provision of mental health crisis care and support.

6. Delivering safe and reliable care

By 'safe', we mean that no avoidable harm should come to patients whilst they are in our care. And by 'reliable', we mean the delivery of consistent care to a standard that patients can trust. At its simplest, we want as few things as possible to go wrong and as many things as possible go right.

6.1 Our overall aims and targets

We want to improve the safety of patients by building on the successes of our previous Trust patient safety improvement programmes and developing and embedding a mature safety culture at every level of the organisation. Our strategic direction for the next four years will continue to be the reduction of avoidable harm to patients and the proactive implementation of improvements to keep patients safe.

Our overall target is to reduce avoidable harm to patients by 50 per cent[1] and to reduce mortality by a further 10 per cent by 2018[2] (also see section 8 of this document). We are setting this stretching target in the context of promoting an open and transparent culture when things go wrong and a mind-set of seeking continuous learning and improvement.

[1] The Trust implemented a new global trigger tool in Quarter 1 of 2016/17. Data gathered in the first six months of the year will be used to establish a baseline and to set our improvement goal.
[2] Note that this target is the subject of review at the time of writing due to the challenges of measurement.

6.2 Our priorities for improving safety of patients

a) Developing our safety culture to help us embed safety and quality improvement in everything thing we do

Our aim, by March 2018, is to develop the Trust's safety culture using the Manchester Patient Safety Framework continuum, moving from the baseline assessment towards a generative safety culture.

In 2015/16, we conducted baseline safety culture assessments of clinical teams, divisional boards and the Trust Board of Directors, seeking their assessment of their culture as a team and of the organisation as a whole. The majority of staff who participated in safety culture assessments considered that their team and the Trust's safety culture was proactive, the second highest level on the scale of maturity below:

1 – Pathological ("Why do we need to waste our time on patient safety issues?")
2 – Reactive ("We take patient safety seriously and do something when we have an incident")
3 – Bureaucratic ("We have systems in place to manage patient safety")
4 – Proactive ("We are always on the alert / thinking about patient safety issues that might emerge")
5 – Generative ("Managing patient safety is an integral part of everything we do")

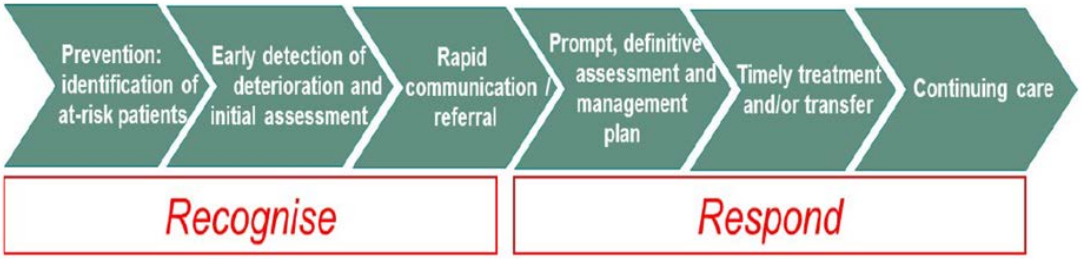
Improvement goals:

- We will achieve a 5 per cent improvement in the number of staff assessing the safety culture of the Trust as a whole at 'proactive' or 'generative' in each of the ten domains of the MaPSaF safety culture assessment.
- We will sustain upper quartile rate of reported incidents per 1,000 bed days: an indicator of an open reporting and just culture.

b) Early recognition and escalation of deteriorating patients to include early recognition and management of sepsis and acute kidney injury (AKI)

Early recognition and prompt management of deteriorating patients is a national priority, with a particular focus on two of the commonest causes of unrecognised deterioration, sepsis and acute kidney injury. Deterioration generally (and due to these two specific causes) has been prioritised as one of the key work streams of our Trust's patient safety improvement programme, working with our local partners in the West of England Patient Safety Collaborative

There are six key points in a deteriorating patient's pathway that provide opportunities for action by healthcare professionals to improve the patient's chances of a good outcome.



Our improvement activities will be based around: reviewing systems for recognition and escalation of deteriorating patients, thereby making it easier for staff to do the right thing; staff education and training, with a specific focus on the use of National Early Warning Scores (NEWS) and screening and

treating patients for sepsis, use of the 'SBAR'[3] structured communication tool for escalation and structured ward rounds. Our efforts to improve the recognition and management of sepsis and AKI will also centre on the local adoption of national guidance.

Our aim is to reduce harm arising from lack of recognition and management of the deteriorating patient by 50 per cent by 2018.

Improvement goals:

- Our target is for there to have fewer than seven cardiac arrest call incidents from general ward areas each month.
- By the end of 2016, we will also set specific improvement targets for:
    - Unplanned admissions to ITU from general ward areas due to deterioration not recognised and acted upon
    - Worsening AKI e.g. deterioration from stage 1 to stage 2 or 3
    - Mortality due to sepsis

c) Medicines safety including at the point transfer of care (medicines optimisation)

Medicines are used to treat the majority of patients, so it is vital that the most effective medicines are used, and that patients are kept safe. Nationally, up to 600,000 (11 per cent) non-elective hospital admissions are due to medicines and 20 per cent of people over 70 years old take five or more medicines.

Our aim is to work with patients to deliver safer and better outcomes from medicines, with a primary focus to improve medicines safety at the point transfer of care. Our improvement activity will focus on medicines reconciliation ('getting the medicines right'), the quality of medicines information shared a points of handover, and the safety of high risk medicines processes (e.g. insulin, anticoagulation). This will require staff training, appropriate use of new technology coupled with patient involvement.

Improvement goals:

- Zero medication incidents involving insulin resulting in moderate or severe harm.
- By the end of 2016, we will also set a target for the number of patients with complex medicines referred for a post discharge community pharmacy review.

d) Preventing peri-procedure never events

Never events are a type of incident which should never happen, providing that the known controls to minimise the chance of them happening have been fully implemented. Nationally, the three most common never events all relate to surgical procedures: wrong site surgery, retained foreign object and wrong implant (peri-operative never events)[4]. Nationally-driven work to reduce such never events was initially focussed on the operating theatre environment, the main preventative measure being the implementation of the World Health Organisation surgical safety checklist. Through analysis of reported incidents at a national level it has been recognised that these never events occur in other invasive procedures conducted outside the operating theatre environment. New National Safety Standards for Invasive Procedures have been produced to inform the development of local standards for both "in" and "out of" theatre invasive procedures.

Our aims are to eliminate peri-operative never events and to increase the quality of engagement with the World Health Organisation (WHO) checklist in all theatre/interventional environments. We want

[3] Situation, Background, Assessment, Recommendation
[4] NHS Improvement Never Events data

to reduce the level and frequency of inattention at the 'time-out' section of the WHO checklist across all theatre/interventional environments to less than 1 per cent (Baseline: September 2014 mild inattention in 16 per cent of staff in time-outs in the main theatre suite).

Our approach will be to develop and implement local safety standards for invasive procedures which align with national guidance. This will include invasive procedures which take place in 'out of theatre' environments such as wards and departments.

Improvement goals:

- Zero peri-procedure never events for a year
- We will also sustain 95 per cent compliance in the use of the WHO surgical Safety Checklist

e) Learning from patient safety incidents

Incident identification, reporting, analysis and learning is a key pillar of keeping patients safe which informs improvement actions and harm reduction. This is supplemented by other systematic measures such as adverse event identification and safety thermometer audits to help us know and understand when things have gone wrong, where risk reduction measures need to be focussed and to monitor the effectiveness of improvement actions.

Improvement goals:

- We will review our processes for working with patients and their families when things go wrong, i.e. ensure that patient safety incidents, complaints, mortality and morbidity reviews are joined up from the patient/family perspective and they have a key and clear point of contact.
- We will review and strengthen our arrangements for learning from serious incidents. We will also continue to focus on encouraging incident reporting and systematic incident analysis, implementation of risk reduction actions.
- We will increase the breadth of our Safety Bulletins and to review and strengthen our systems for sharing organisation-wide learning.

7. Improving patient and staff experience – developing a customer service culture

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

Patient experience is an established cornerstone of an NHS understanding of quality, however it is becoming increasingly recognised that great patient experience doesn't happen without happy, motivated staff who take pride in their work. Patients notice when staff are dissatisfied – this impacts on how patients feel about our hospitals and undermines reputation. As one of our matrons has said, "As staff, we want to be good at what we do, but we also want to *feel* good about what we do". So we believe that improving staff experience is integral to our quality strategy and will be reflected in way we prioritise annual quality objectives during the lifetime of this strategy.

7.1 Patient Experience

Patient experience can be described as the sum of all interactions and 'touch points' that the patient and their family has with our organisation: it's about what happens at those touch points and how it makes patients feel. The Department of Health has described patient experience as:

> "Getting good treatment in a **comfortable**, **caring**… environment, delivered in a **calm** and **reassuring** way; having **information** to make **choices**, to feel **confident** and feel **in control**; being **talked to** and **listened to** as an **equal** and being treated with **honesty**, **respect** and **dignity**".

Before we can improve patients' experiences of our care, we firstly need to engage and involve them. We need to maximise channels of communication with patients and the people who care for them. Our strategy for improving patient experience is underpinned by a commitment to four core principles: creating new opportunities for patients and the public to get involved with our Trust; actively seeking and responding positively to feedback; actively encouraging patients to raise questions and concerns at point of care, and; handling and resolving complaints effectively.

Although we already do all of these things, we want to see an organisational step-change during the lifetime of this strategy. We understand that patient experience is subjective and that we won't always get it right, but we want to develop a culture of partnership working and customer care where the slogan "nothing about me without me" is truly reflective of the way we work and communicate. We want to develop our listening ear – as an organisation, and as individuals – to ensure that the patient's voice is heard at every level of our organisation.

a) Creating new opportunities for patient and public involvement

Patient and public involvement helps us to understand people's experiences, as well as being *part of* a good experience. Over the next four years, University Hospitals Bristol is committed to building a new and dynamic relationship with patients and the public – helping us to deliver the right services both now and in the years to come. Strengthening our engagement model is a key priority and we recognise

that significant ongoing focus is required in this area to build trust and confidence with the communities we serve.

It is important that we make it easier for patients and the public to navigate and understand the different access points and roles they can play along the involvement and engagement pathway. For example, these currently include:

- Playing an active role in Healthwatch
- Taking part in Involvement Network events
- Becoming a member of UH Bristol
- Becoming a volunteer
- Taking part in the 15 Steps Challenge
- Joining our *Face2face* interview team
- If you've made a complaint, helping to create the solution
- Sharing your story of care with the Trust Board

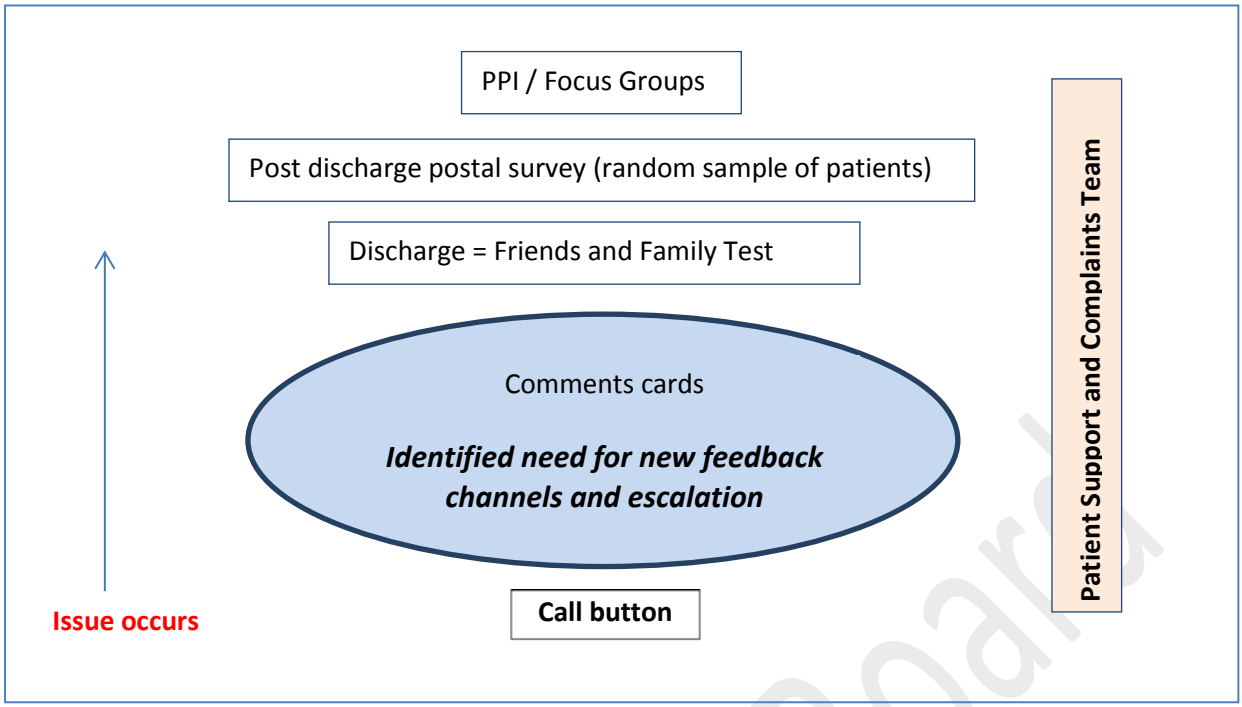
Improvement goals:

- We will create new opportunities including a patient and community leaders' programme.
- We will create new touch-points including mystery shopping and 'You Said We Did' events where we share changes and improvements that have resulted from listening to the patient voice.
- We will use social media as a tool for involving patients and the public in our work.
- We will continue to develop the role of our Involvement Network as the 'go to' way for local communities of interest to engage with our Trust: we will develop a planned programme of events and 'big conversations', including key questions about how the Trust can best serve its diverse population.
- We will develop a Trust patient and public involvement toolkit, and train and empower staff to carry out effective involvement activities using a core set of methodologies and resources; these include the 15 Steps Challenge, *Face2face* interviews and Patient Experience at Heart workshops.

b) Actively seeking and responding positively to feedback

As a result of implementing our previous patient experience strategies, the Trust already has access to a huge amount of patient feedback data that allows us to understand how people experience our services. However, it currently takes too long to receive the feedback – the majority of which comes from a post-discharge survey – and too long for the feedback to be shared with wards and clinics. We need to make feedback more accessible, meaningful and usable for our staff, and we need to do it faster. We also need to ensure that our feedback systems are accessible to everyone, regardless of language or disability. This will enable us to identify and act upon emerging themes in a more timely way and to know that we are hearing a broad and representative patient voice.

The figure below describes our core feedback systems and the current 'hole' in real-time feedback, currently filled only by on-ward comments cards plus access to the Trust's Patient Support and Complaints Team (or the LIAISE service in the Bristol Royal Hospital for Children).



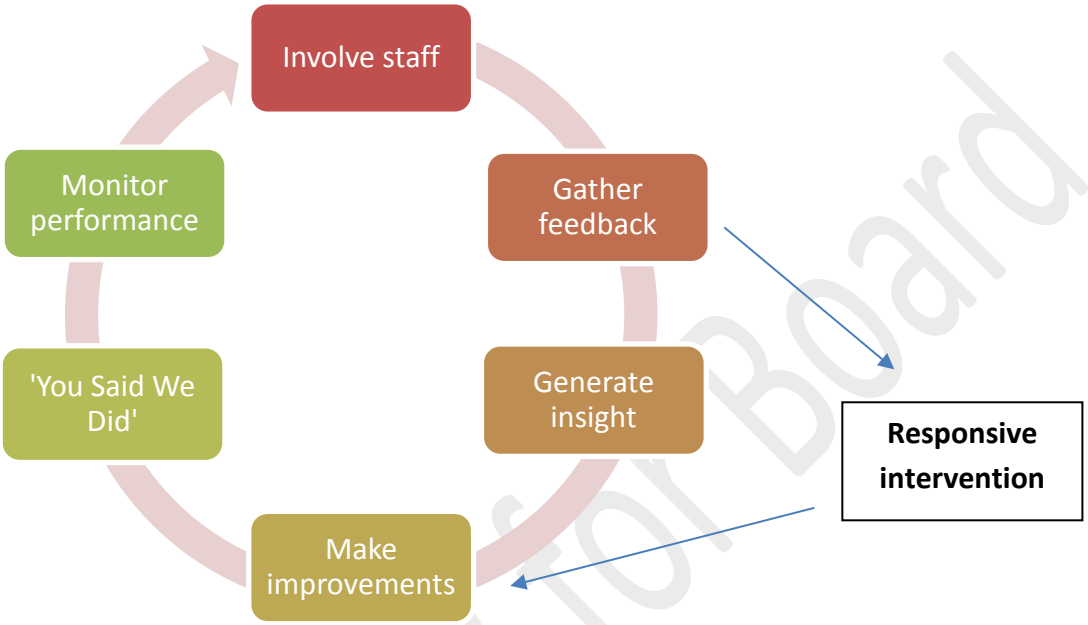
During 2016/17, we will begin the process of procuring a new information system for gathering, analysing and responding to patient feedback. We want to maximise opportunities for people to give feedback, where possible in real-time at point of care. However, more than simply being an advanced 'number cruncher', the new system will need to contribute significantly to our ambitions for achieving a step-change in developing a customer service culture within UH Bristol: a culture where staff understand the importance of providing a great patient experience and take personal responsibility for making this happen. So the way we gather feedback needs to move from merely being a process to becoming a core part of what we do and who we are.
Our new feedback system will therefore need to:

- Enable people to give us feedback at the time that suits them best.
- Present feedback in a way which creates positive competition and drives service improvement.
- Facilitate multi-professional engagement in seeking, hearing and acting upon patient feedback: the new system must enable medical staff to become fully engaged in this process – we want see patient feedback becoming a routine part of how doctors measure success, not just an activity linked to five-yearly revalidation.
- Support transparency, putting feedback directly into the public domain, allowing people to make informed choices about their health care, inspiring confidence in our organisation and, where necessary, holding the Trust to account.
- Deliver or facilitate a clearly recognisable corporate brand articulating our desire to hear from patients: patients coming into our hospitals or visiting our web site, will get a clear sense that we value and use their feedback and that we take pride in being a listening organisation.
- Enable us to identify and celebrate successes as well as highlight problems.
- Support the message to our staff that **every patient encounter matters**.

Most of our current surveys are retrospective and not at point of care. There are good reasons for this. For example, some patients may take a different view about their care (either positively or negatively) having had time to reflect on their experience; and other patients may be reluctant to speak frankly whilst they are in a position where they are still receiving care. For this reason, we will continue to run a post-discharge postal survey in order to guarantee a consistent flow of reliable, robust, feedback, which we can use to measure progress.

However, we will shift our primary focus to asking patients about their experiences at point of care. Critically, we hope that this will give us the opportunity to put things right – if we can – for anyone who gives us negative feedback or raises specific concerns. A further key attribute of our new system will therefore be the added ability not just to capture feedback in real-time, but to create the potential for staff to respond positively and to feed this back personally and publicly.

'Breaking into' the patient feedback cycle to respond to individual concerns in real time:



We also remain committed to maximising learning associated with the Friends and Family Test (FFT) in its various forms. This includes continuing our recently established practice of publishing any negative comments received via the FFT, with a considered response from the Trust.

Through the programme described here, we will continue to find out what kind of service people received from our organisation, how they feel about this, and what we can learn about delivering great customer service. The aim is that our new programme will also enable us to respond, not just to patterns and themes of feedback, but to feedback from individual patients and family members in real-time. This will represent a step change in two-way communications.

Improvement goals:

- We will improve our overall ratings of care in the national inpatient survey, becoming one of the ten highest-scoring trusts nationally (this means moving from a current overall score of 84 points to a projected requirement of 90 points).
- We will also achieve an NHS top-ten rating for the proportion of patients who say they are asked about the quality of their care whilst in hospital (this means moving from a current score of 15 points to a projected requirement of 35 points).
- We will achieve Friends and Family Test scores and response rates which are consistently in the national upper quartile, meeting and exceeding any targets agreed with our commissioners.
- We will achieve the widespread use patient experience insight at all levels of the organisation – personally, within teams, and as an organisation – to shape and improve care. This will be recognised by a top-ten rating for the proportion of UH Bristol staff saying that patient feedback is used to inform decision making in their department (this

means moving from a current score of 55 per cent to a projected requirement of 65 per cent).

c) Encouraging patients and families to raise concerns and seek help at point of care

One of the central themes of our strategy for patient experience is responsive care – enabling and encouraging patients to raise questions and concerns about their care, here and now. Patients occasionally give negative feedback about our services after they have gone home from hospital. When this happens, there is always a sense of regret that we missed the opportunity to talk, and perhaps, to put things right. We have described how one of the requirements of our new patient feedback system will be the ability to bring negative real-time feedback to the attention of staff to create the possibility of having conversations and addressing concerns as they arise. However, this is just one of the ways in which we need to be connecting with patients.

During the lifetime of this strategy, as part of developing a recognisable brand for patient experience at UH Bristol, we will publicise to patients and the people who care for them the different ways that they can seek help if they are unhappy, concerned, or worried about any aspect of treatment and care. We will do this in a way which *gives patients permission*, and it becomes *what staff expect* – "it's OK to ask". In practice, this covers a wide spectrum of activities from on-ward/in-clinic conversations with staff, to the use of call bells, to access to the Trust's Patient Support & Complaints Team and the LIAISE service at the Bristol Royal Hospital for Children (our PALS services). Our plans for real-time feedback will be developed with the concept of 'ePALS' in mind, so that the same system that the Trust uses to elicit feedback will also a route for patients to seek help.

Improvement goals:

- We will achieve a top 10 score in the national staff survey for the proportion of staff saying that the Trust acts on concerns raised by patients (this means moving from a current overall score of 72 per cent to a projected requirement of 80 per cent).

d) Handling and resolving complaints effectively

We have recognised how engagement and involvement activities are a way of understanding the 'what' and 'how' of patient experience, as well as *themselves* being part of the 'what' and 'how'. The same is true of how we handle complaints about our services: complaints enable us to learn about patient experience, but how we enable people to complain, and how we respond when they do, is itself a vital part of patient experience; it speaks volumes about our values and the kind of organisation we aspire to be. We will be considering carefully the findings of the recent independent review of children's cardiac services in Bristol insofar as they relate to lessons about the complaints process and what they tell us about how we can become a more patient-focussed organisation. As part of our conscious move towards a customer service culture, more than ever we want to convey the message that patients and their families are encouraged to raise concerns without prejudice. In particular, we want to look at ways of involving patients in helping to design the solutions to the concerns they raise, and in wider quality improvement activities in the Trust. We are also committing to explore how we might offer appropriate independent review of patient concerns and what the trigger points for this would be.

Over the last year, we have seen a slow but steady shift towards informal resolution of complaints. We want to see this pattern continue, with as many concerns as possible identified and resolved swiftly at point of care. We understand and respect that 30 working days (or standard timescale for formal complaints investigations) can be a long time for patients and family members when they are seeking answers to important questions.

Finally, recent ground-breaking NHS research by the London School of Economics suggests that healthcare providers who receive higher than average levels of low-severity complaints have fewer than average high severity complaints, as well as lower levels of patient mortality: in other words, the same patterns that are now well recognised and embraced in the reporting of patient safety incidents. During the lifespan of this strategy, we therefore also want to develop a more intelligent approach to how we monitor complaints. By opening doors and encouraging feedback, we enter into our new strategy expecting that we will receive more complaints – as such, developing routine measurement of severity of complaints will become particularly important as we attempt to discern success.

Improvement goals:

- We will achieve a top 10 score in the national inpatient survey for the proportion of inpatients saying that they saw information about how to complain (this means moving from a current overall score of 23 points to a projected requirement of 40 points)
- 95 per cent of complaints will consistently be responded to within 30 working days, with extensions to deadlines made by exception only.
- Less than five per cent of complainants will tell us that they are dissatisfied with our response to, and the resolution of, their concerns.

7.1.1 Customer service training and accreditation

As well as being supported through the plans described in this chapter, our step-change towards a customer service culture will also need to be supported by training delivered throughout our hospitals. The Trust currently provides customer service training which is accessible to all staff groups and is available on a monthly basis. As part of our quality strategy, we are committing ourselves to extending the reach of this training to all staff groups and to making attendance compulsory. We recognise that 'great customer service' will mean different things to different staff groups, and this will be explored as part of the course.

Improvement goal:

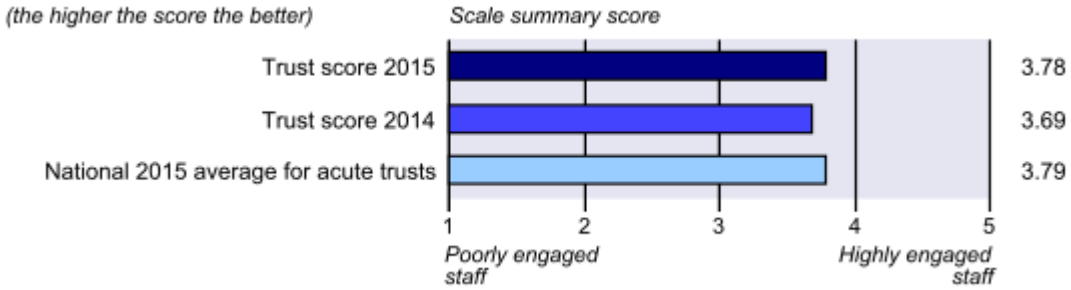
- To achieve a recognised customer service accreditation within the lifetime of this strategy

7.2 Improving staff experience

UH Bristol already has a highly skilled workforce, committed to delivering compassionate, high quality individual care, but we know from successive NHS staff survey results that there is more we can do to support and engage our staff. The figure below shows that, for 2015, the Trust's staff engagement score in the national survey was similar to the NHS average[5]. Possible scores range from 1 to 5, with 1 indicating that staff are poorly engaged (with their work, their team and their trust) and 5 indicating that staff are highly engaged. The Trust's score of 3.78 was also average when compared with trusts of a similar type.

In response to this challenge, key initiatives have already begun include developing a culture of 'collective leadership' through staff listening events, leadership development masterclasses, regular surveys and 'pulse' checks to monitor staff morale and job satisfaction, and focussed activities aimed at reducing work-based stress and bullying and harassment.

[5] Possible scores range from 1 to 5, with 1 indicating that staff are poorly engaged (with their work, their team and their trust) and 5 indicating that staff are highly engaged. The Trust's score of 3.78 was average when compared with trusts of a similar type.



It is also important to recognise the challenges we face recruiting to specialist areas/roles, set in a national context of a diminishing supply of trained and experienced professionals, and recognising that our turnover rates are slightly above average within the NHS. It is vital that we focus on key areas of improvement to attract and retain staff.

Earlier in this strategy, we shared a quote from one of our executive directors, who described quality as "the contribution of every member of the team". In 2015, the Trust established a partnership with Aston OD, an organisation which exists to promote the benefits of team-based working. Based on research evidence that effective team-based working improves staff morale, patient satisfaction, and overall patient mortality, the Aston Team Journey is a team assessment and development tool for team leaders to use with their teams: it improves performance by giving teams a structured, evidence-based experience they value and enjoy. In 2015, the Trust trained and commissioned twenty coaches to facilitate the Aston team journey at UH Bristol. These coaches have been working with various teams in the organisation to improve their ways of working and to ensure all of their outcomes are related to improving the patient and staff experience. The Trust recognises that the team journey is time and resource intensive, both for coaches and teams. As part of this quality strategy, the Trust is making a commitment to create the environment which enables staff to participate in what we believe could be a transformational process.

Finally, the Trust also understands the important role that physical and psychological initiatives can play in creating a healthy workplace. We will continue and broaden a range of local initiatives to support our staff: from building resilience, to pregnancy workshops and seasonal flu vaccinations.

Improvement goals:

- By 2020, we will be recognised as being in the top 20 NHS trusts to work for, as measured by the following aspects of the NHS staff survey:
  - Staff engagement (rising from a score of 3.78 in the 2015 NHS staff survey to a projected minimum score of 4.00 by 2020[6]).
  - Quality of staff appraisals (rising from a score of 2.99 to a projected minimum score of 3.4 by 2020[7]).
  - Incidents of bullying and harassment towards staff by other staff (reducing by a quarter, from 26 per cent to 20 per cent by 2020[8]).
- We will also achieve year on year improvements in the following areas:
  - The Friends and Family Test, measuring whether staff would recommend UH Bristol as a place to work.

[6] We will review this target annually, in line with national data, to keep us on track to achieve our 'top 20' ambition. Based on the 2015 survey, a score of 4.00 would place us third in the league table of NHS trusts (best score 4.02).

[7] Based on the 2015 survey, a score of 3.4 would place us first in the league table of NHS trusts for this indicator (best score 3.39).

[8] Based on the 2015 survey, a score of 20% would place us seventh in the league table of NHS trusts for this indicator (best score 16%).

- Turnover rates, reducing this by a minimum of 2 per cent by 2020 (from 13.1 per cent to no more than 11.1 per cent).
- Leadership behaviours, measured through 360 degree feedback at appraisal (we have identified over 800 leaders with management responsibilities who will receive this feedback annually).

- During the lifetime of this strategy, we want to see at least 20 teams undertaking the full Aston team journey and a minimum of 100 teams in total experiencing supported Aston interventions.
- By 2020, we will have rolled out the use of the 'Happy App' to measure real-time staff experience in all clinical areas of the Trust.

8. Improving outcomes and reducing mortality

We recognise that, for some patients, life cannot be extended and clinical outcomes cannot be improved. In these situations, quality is about compassion, dignity and the way share bad news. For other patients, however, the totality of the activity described in this strategy has the potential to make a profound impact on outcomes of care, including our efforts to extend life. This section of our quality strategy describes how we will measure, monitor and seek to reduce patient mortality and morbidity during the lifetime of this strategy. In particular, we will:

- Participate in all relevant national clinical audits, registries and PROMs
- Implement evidence-based clinical guidance, supported by a comprehensive programme of local clinical audit, and by working in partnership with our regional academic partners to facilitate research into practice and evidenced based care/commissioning
- Use benchmarking intelligence to understand variation in outcomes
- Focus on learning from unexpected hospital deaths
- Deliver programmes of targeted activity in response to this learning

8.1 National audits, registries, confidential enquiries and PROMs

In our 2015/16 Quality Account, we published details of the Trust's participation in national clinical audits. We took part in all 41 of the audits, registries and national confidential enquiries which were relevant to services provided by the Trust. This ongoing commitment to benchmarking and learning forms an important part of our quality strategy, in particular enabling the publication of consultant-level clinical outcomes data[9].

Patient reported outcome measures (PROMs) can help us understand the outcomes which matter most to patients (including quality of life), highlight areas with significant variation in outcome and indicate potential areas for service improvement. Since 2009, PROMs data has been collected by all NHS providers for four common elective surgical procedures: groin hernia surgery, hip replacement, knee replacement and varicose vein surgery. Only one of these procedures - groin hernia surgery - is currently carried out at the Bristol Royal Infirmary, part of UH Bristol. At the time of writing, NHS England is in the process of renewing the national PROMs programme to possibly include further surgical specialties.

[9] The Consultant Outcomes Publication (COP) is an NHS England initiative, managed by the Healthcare Quality Improvement Partnership (HQIP), to publish quality measures - primarily mortality - at the level of individual consultant doctors using national clinical audit and administrative data.

8.2 Evidence-based practice and local clinical audit

Our aim is to ensure that clinical care is delivered in accordance with patients' preferences, and in line with the best available clinical evidence, including NICE[10] standards, royal college guidelines and recommendations arising from national confidential enquiries. By understanding our current position in relation to national guidance (for example through clinical audit) and by working with our regional academic partners (such as Bristol Health Partners and The National Institute for Health Research Collaboration for Leadership in Applied Health Research and Care West) to facilitate research into practice and evidenced based care/commissioning, we can work towards minimising any variations in practice.

UH Bristol has developed regional and national influence and leadership in the field of clinical audit practice over a period of more than 15 years. Over the course of the next four years, we will continue to develop the way we use participation in local clinical audit to drive improvement in clinical services.

Improvement goals:

- All clinical services (at sub-specialty level) will participate regularly in clinical audit (measured by registered clinical audit activity during each year of this strategy).
- 95 per cent of relevant published NICE guidance[11] will formally reviewed by the Trust within 90 days of publication.
- We will develop and implement new internal systems for identifying and monitoring compliance with national guidance other than those published by NICE and NCEPOD[12] (for which systems already exist).

8.3 Using benchmarking intelligence to understand variation in outcomes

Understanding the impact of our care and treatment by monitoring mortality and outcomes for patients is an important element of improving the quality of our services. Our strategic approach is two-fold:

- To conduct routine surveillance of our quality intelligence information at Trust, divisional and speciality level to identify, investigate and understand statistical variation in outcomes, taking action to improve services where required; and
- To respond to any alerts regarding the quality of our services identified by external sources and to investigate in a similar manner as described above.

We have constituted a Quality Intelligence Group (QIG) whose purpose is both to identify and be informed of any potential areas of concern regarding mortality or outcome alerts, to commission appropriate investigations and to receive the outcomes of such investigations. The investigation will comprise an initial data quality review followed by a clinical examination of the cases involved if required. QIG will either receive assurance regarding the particular service or specialty with an explanation of why a potential concern has been triggered or will require the service or specialty to develop and implement an action plan to address any learning. The impact of any action is monitored through routine quality surveillance. QIG also retains the option to commission an external or independent review where required.

[10] The National Institute for Health and Care Excellence
[11] i.e. clinical guidelines, quality standards and technology appraisal guidance
[12] The National Confidential Enquiry into Patient Outcome and Death

8.4 Understanding, measuring and reducing patient mortality

Approximately half of all deaths in the UK take place in hospital. Many deaths that occur in acute hospitals are predicted: the conclusion of natural disease processes, frailty of old age, and complex patients with multiple comorbidities. However, we know that in all healthcare systems, things can, and do, go wrong. Research tells us that around three per cent of hospital deaths are potentially preventable.

8.4.1 HSMR and SHMI

There are two main tools available to the NHS to compare mortality rates between different hospitals and trusts: the Hospital Standardised Mortality Ratio (HSMR) produced by Dr Foster Intelligence, and the Summary Hospital Mortality Indicator (SHMI) produced by the Health and Social Care Information Centre. The HSMR includes only the 56 diagnosis groups (medical conditions) which account for approximately 80 per cent of in-hospital deaths. Our Trust tends to lend greater weight to the SHMI as it includes all diagnosis groups as well as including deaths occurring in the 30 days following hospital discharge whereas the HSMR includes only in-hospital deaths. SHMI data published in our 2015/16 Quality Account suggests that fewer than expected patients die in the care of our hospitals.

Taking 2015 as a whole, SHMI data shows that UH Bristol had 1,721 deaths compared to 1,761 expected deaths, when compared against rest of England: a SHMI score of 97.7.

The latest HSMR data available at the time of writing is for the period June 2015 to May 2016. This shows 1,091 patient deaths, compared to 1,211 expected deaths: an HSMR of 90.1.

8.4.2 Local mortality review

Because the vast majority of deaths are expected and are 'acceptable' outcomes, at best, the SHMI and HSMR provide only a broad measure of the quality of care provided at a hospital. As the inherent limitations of global measures of death rate become more apparent, our desire to continually improve the care we provide has led us to focus our efforts on achieving a better understanding of unexpected and potentially preventable death. The way we are doing this is through individual case note review of deceased patients: a personalised approach which facilitates broad base organisational learning.

If a hospital knows and understands the common causes of potentially avoidable mortality in the patients for whom it is responsible, it can also use this knowledge to direct clinical audit and quality improvement activity. Furthermore, this information can form the basis of integrated learning with partners in primary care and can be used as an effective learning tool, in combination with the Deanery, to support post graduate education. This cross system involvement allows the construction

of an integrated healthcare programme, where understanding and preventing potentially avoidable death becomes the highest safety and quality priority

The Trust's current process for adult mortality review was established for adult inpatient deaths in May 2014 with the aim of reviewing all inpatient deaths occurring in the organisation. The review is carried out by the lead consultant for each patient. However, this is now being revised and relaunched, with a new emphasis on peer review, in line with national guidance. UH Bristol has been selected as one of seven pilot sites for early adoption of the Royal College of Physicians' model of structured judgement case note review. Questions are based on the findings of the Preventable Incidents and Survivable Mortality study (PRISM2). Through the pilot, UH Bristol will play a lead role in shaping and developing this important quality and safety process at national level.

Given that the majority of hospital deaths are expected, rather than review all deaths, we will instead develop a process of rapid and full review of potential high risk cases. This will include all deaths of elective admission patients and all deaths of patients with learning difficulties.

This process will also allow us to co-ordinate and integrate already established pockets of excellence such as the ICNARC[13] data which demonstrates we have one of the safest intensive carer units in the country. This co-ordinated approach will allow us to accurately identify areas where improvements will save lives.

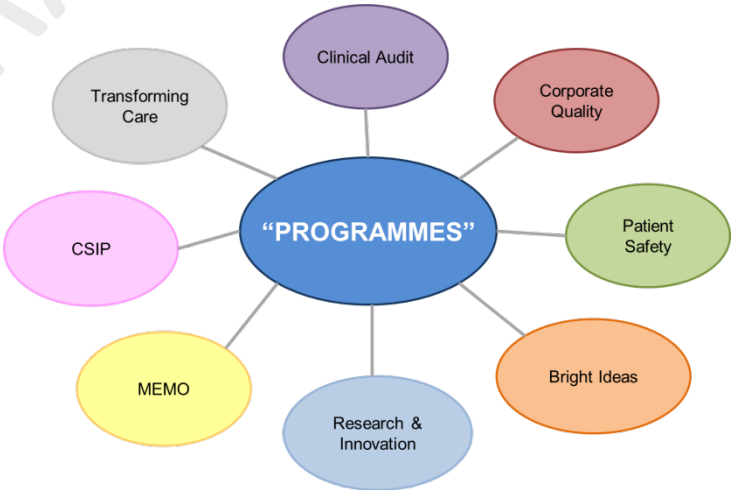
Full integration with the Coroner's office will be established so that pertinent information from patients undergoing Coroners' post mortem is fed back into our mortality review group to maximise the learning. In addition, we already have an established process of reviewing both child and maternal deaths. All three of these processes will be fully integrated across the organisation, particularly where there is overlap or transition from childhood to adult.

Improvement goals:

- We will identify the top ten causes of adult mortality within the organisation.
- From this, we will develop multi-disciplinary learning to support and enhance our patient safety and quality improvement programmes.

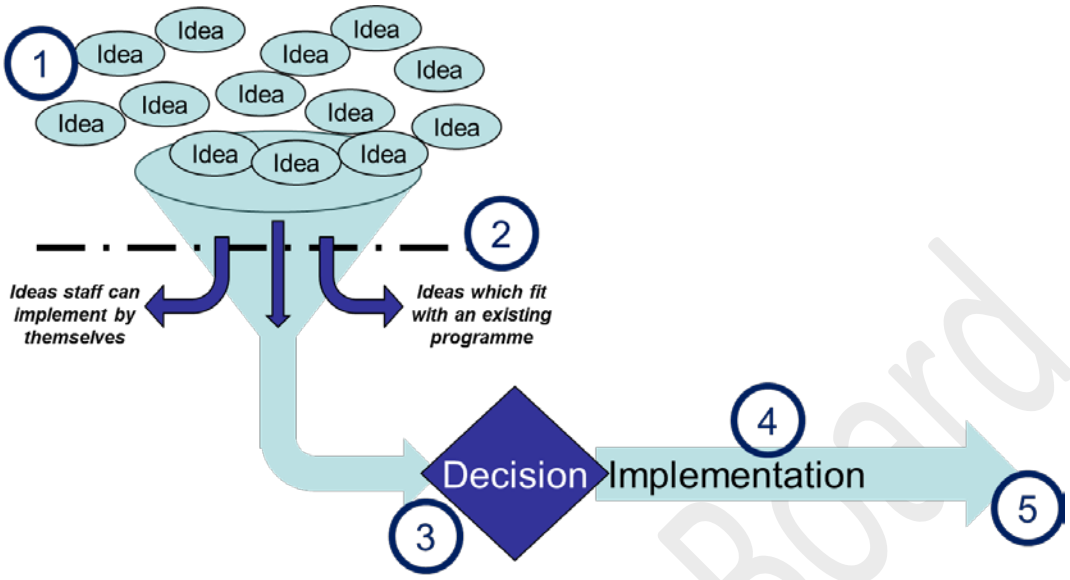
9. Working together to innovate and improve

This strategy is testimony to UH Bristol's investment in a wide range of programmes and approaches to innovate and to improve, some of which are highlighted in the figure below.



[13] Intensive Care National Audit and Research Centre

We therefore propose to establish a new innovation and improvement support programme based on the model shown below: a 'one stop shop' approach where staff can bring their ideas for improvement and be directed to the most appropriate support.



1. We encourage and capture ideas for innovation and improvement
2. We sort and classify ideas – encouraging staff who can implement themselves to do so, or helping them connect to an existing programme
3. Where ideas need support, we decide which to prioritise
4. We provide support in implementation of the best ideas. Support could include resource capacity, capability development, coaching in tools/methods, or support in developing a case for funding.
5. We publicise and celebrate implementation of good ideas

Part of this approach will involve the creation of a new multi-professional quality forum where representatives from these programmes meet to review proposals, exchange ideas, and seek opportunities to add value through collaborative working.

10.Monitoring our progress

The Trust Board's responsibilities in respect of quality are:

- To ensure that minimum standards of quality and safety are being met by every service within the organisation;
- To ensure that the organisation is striving for continuous quality improvement and excellence in every service, and;
- To ensure that every member of staff is supported and empowered to deliver our vision for quality

In discharging these responsibilities, the board has an absolute commitment to the vision set out in this strategy.

Each month, our board will receive a range of performance data demonstrating progress towards achieving our goals, enabling the board to exercise challenge where necessary. In seeking continuous improvement, the Board will constantly be guided by five key questions:

- Are we targeting and measuring what matters most to patients?
- Do we know how good we are?
- Do we know where we stand relative to the best?
- Do we know how much variation in practice we have and where that variation exists?
- Do we have the right capabilities, tools and engagement to deliver the changes we need to make?

Our board will also continue its existing practice of receiving a patient story at the start of its meetings – where possible, from the patient in person. The purpose of the story is to remind the board about the people it serves and to create a context for the vital discussions and decision-making that follows.

At the end of 2016/17, 2017/18 and 2018/19, the Board will review and, if necessary, adjust our 2020 goals. The board will also agree a set of annual quality objectives to keep us moving towards our vision. We will do this in consultation with staff, patients, members, partners and governors. The objectives, which will relate to the four core themes of our strategy, will be published in our annual Quality Account; and every quarter, the board will receive a report detailing the progress we have made towards achieving them.

Cover report to the Trust Board meeting to be held on 31 October 2016 at 11:00 am – 1:00 pm in the Conference Room, Trust HQ, Marlborough St, Bristol, BS1 3NU

		Agenda Item	3.3
Meeting Title	Trust Board	**Meeting Date**	31 October 2016
Report Title	Quality and Performance Report		
Author	• Xanthe Whittaker, Associate Director of Performance • Anne Reader, Head of Quality (Patient Safety) • Heather Toyne, Head of Workforce Strategy & Planning		
Executive Lead	Owen Ainsley, Interim Chief Operating Officer		
Freedom of Information Status		Open	

Strategic Priorities (please select any which are impacted on / relevant to this paper)
Strategic Priority 1: We will consistently deliver high quality individual care, delivered with compassion services.
Strategic Priority 2: We will ensure a safe, friendly and modern environment for our patients and our staff.
Strategic Priority 3: We will strive to employ the best staff and help all our staff fulfil their individual potential
Strategic Priority 7: We will ensure we are soundly governed and are compliant with the requirements of NHS Improvement.

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

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

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

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

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

Impact Upon Corporate Risk
No change required to the following risks (recently reviewed): Risk 810 – Failure to maintain a Green Risk Rating – score 16 Risk 888 – Failure to meet recovery trajectories – score 16 Risk 932 – Failure to meet national cancer waits – score 20

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

Date papers were previously submitted to other committees				
Audit Committee	**Finance Committee**	**Quality and Outcomes Committee**	**Remuneration & Nomination Committee**	**Other (specify)**
		27 October 2016		

University Hospitals Bristol NHS
NHS Foundation Trust

Quality & Performance Report

October 2016

Executive Summary

Whilst challenges remain there have been some encouraging improvements in performance against several of the access standards this month. These include a reduction in the number of patients waiting over 6 weeks for a diagnostic test, in line with the recovery trajectory, an increase in the percentage of patients being treated within 62 days following GP referral for a suspected cancer, and the last-minute cancelled operations standard being met for a second consecutive month. Whilst the percentage of patients waiting under 18 weeks Referral to Treatment (RTT) has not improved and remains well below the 92% national standard, there has been a decrease in the number of over 18 weeks waiters and positive signs that waiting list sizes are starting to reduce. Disappointingly, performance against A&E 4-hour was below the in-month trajectory, although we are currently performing above the year-to-date trajectory. The Overview page of this report provides further details of the priorities, risks and threats for the coming months, along with noteworthy successes in the period.

The overall level of Emergency Department attendances was 3% higher in September than the same period last year, with the most significant increases being in the BRI (3.0%) and Bristol Eye Hospital (6.8%). The level of emergency admissions was similar to that of the seasonal norm. Delayed discharges have reduced slightly, but remain at twice the level agreed in the community-wide plan. Although there was an increase in the percentage of patients discharged who were long waiters, the number of over 14 day stays has remained high, potentially as a result of increased patient acuity following the increase in the number of over 75 year-old patients admitted in August. This likely explains the increase in BRI bed occupancy above the lower levels seen in July and August, and the deterioration in 4-hour performance. Despite the rise in bed occupancy, and hence deterioration in bed availability levels, the 0.8% national standard for the percentage of operations cancelled at last minute for non-clinical reasons was achieved for a second consecutive month.

Following an increase in outpatient attendance levels back to the seasonal norm, the outpatient waiting has stopped increasing. Whilst elective activity has remained at a similar level to that seen in August, the elective waiting has decreased again, which should over the coming months reduce the level of demand that has to be met for patients on admitted RTT pathways. The number of patients waiting over 18 weeks from Referral to Treatment decreased slightly at the end of September, which in combination with the improved waiting lists positions and the recovery plan which is now in place, provides some assurance that further improvements against the 92% national standard should be realisable in quarter 3. Although performance against the 62-day GP cancer waiting times standard continued to be impacted by residual factors outside of the Trust's control, including increases in late referrals from other providers and delayed reporting of histopathology results following the transfer of the service to North Bristol Trust (NBT), there was a significant improvement in performance in August. This was partly driven by an increase in the total number of treatments in the period due to an increase in two-week wait urgent suspected cancer referrals in quarter 1, and some catch-up (within target) of cases delayed due to the aforementioned issues.

Some of the more noteworthy changes in other areas of performance this month include, zero missed doses of critical medication in the period, a further month's improved performance against the National Early Warning Scores (NEWS) measure of our management of deteriorating patients, and vacancy rates being restored to a green rating. 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. The recent improvement

in turn-over and vacancy rates reflects the continued strong internal focus on recruitment and retention of staff, in order to stay responsive to rising demand. We 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

Ratings for the main University Hospitals Bristol NHS Foundation Trust sites

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

NHS Choices

Website

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

Site	User ratings	Recommended by staff	Open and honest	Infection control	Mortality rate (within 30 days)	Food choice & Quality
BCH	5 stars	OK	OK	OK	OK	✓ 98.5%
STM	4 stars	OK	OK	OK	OK	✓ 98.4%
BRI	3.5 stars	OK	OK	OK	OK	✓ 96.5%
BDH	3 stars	OK	OK	OK	OK	Not avail
BEH	4.5 Stars	OK	OK	OK	OK	✓ 91.7%

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

NHS Improvement Risk Assessment Framework

During quarter 2 as a whole the Trust did not achieve four of the standards in the NHS Improvement 2016/17 Risk Assessment Framework, as shown in the table below. Overall the Trust has a Service Performance Score of 3.0 against Monitor's Risk Assessment Framework, including the two 62-day cancer waiting times standards which are scored as a single standard.

Although the A&E 4-hour standard and 62-day standards continue to not be met, Monitor restored the Trust to a GREEN risk rating in quarter 1 2015/16, 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.

Please note: The NHS Improvement Framework will be replaced by the Single Oversight Framework for quarter 3 onwards. No formal declaration of performance is required for quarter 2.

NHS Improvement Risk Assessment Framework - dashboard

Number	Target	Weighting	Target threshold	Reported Year To Date	Risk Assessment Framework: Q2 15/16	Q3 15/16	Q4 15/16*	Q1 16/17*	Q2 16/17*	Q2 Actual	Notes	Q2 Draft Risk Assessment Risk rating
1	Infection Control - C.Diff Infections Against Trajectory	1.0	< or = trajectory	4	✓	✓	✓	✓	2**	✓	Limit to the end of Q4 = 45 cases	Achieved
2a	Cancer - 31 Day Diagnosis To Treatment (Subsequent - Drug)	1.0	98%	98.0%	✓	✓	✓	✓	98.0%	✓		Achieved
2b	Cancer - 31 Day Diagnosis To Treatment (Subsequent - Surgery)		94%	91.7%	✓	✓	✓	✗	95.1%	✓		
2c	Cancer - 31 Day Diagnosis To Treatment (Subsequent - Radiotherapy)		94%	97.0%	✓	✓	✓	✓	94.5%	✓		
3a	Cancer 62 Day Referral To Treatment (Urgent GP Referral)	1.0	85%	75.7%	✗	✗	✗	✗	79.3%	✗	62-day GP standard lower than expected in Q2 due to late referrals and histopathology delays.	Not achieved
3b	Cancer 62 Day Referral To Treatment (Screenings)		90%	51.9%	✗	✗	✗	✗	55.6%	✗		
4	Referral to treatment time for incomplete pathways < 18 weeks	1.0	92%	91.6%	Not achieved	Not achieved	Achieved	Achieved	91.0%	✗	92% standard not achieved in August or September.	Not achieved
5	Cancer - 31 Day Diagnosis To Treatment (First Treatments)	1.0	96%	96.1%	✓	✓	✓	✗	97.1%	✓		Achieved
6a	Cancer - Urgent Referrals Seen In Under 2 Weeks	1.0	93%	94.4%	✓	✓	✓	✓	93.6%	✓		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%	89.1%	✗	✗	✗	✗	88.9%	✗	95% standard not achieved but trajectory met for Q2.	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	GREEN	GREEN	GREEN	GREEN	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 NHS Improvement will investigate the issue to identify whether there are any governance concerns. For A&E 4-hours, escalation will occur if the target is failed in two quarters in a twelve-month period and is then failed in the subsequent nine-month period or for the year as a whole.

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

3.0
To be confirmed (see narrative)

Summary Scorecard

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

Key changes in indicators in the period:

AMBER to RED
- A&E 4-hours

RED to GREEN:
- Heart reperfusion times
- Outliers
- Vacancies

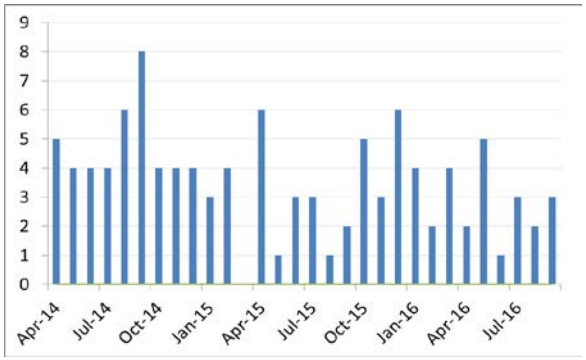
RED to AMBER:
- Cancer Waiting Times

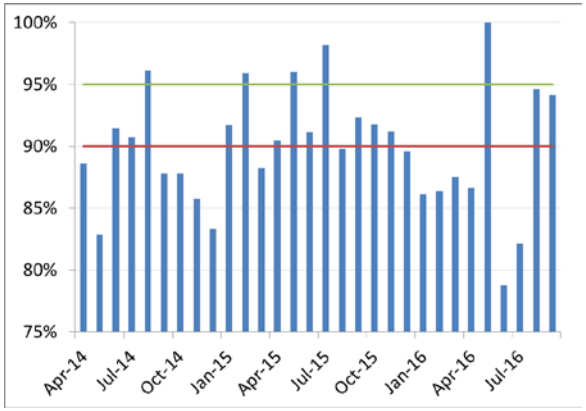
Please note: Sickness absence was reported as Amber rated last month, but with the refreshed data fell below the Green threshold. For this reason the Green rating for Sickness absence this month has not been reported as a 'change'.

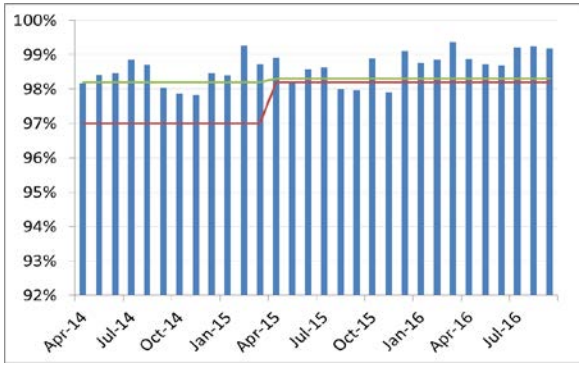
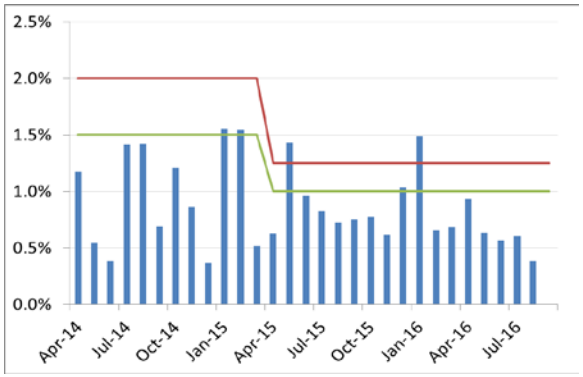
Overview

The following summarises the key successes in September 2016, along with the priorities, opportunities, risks and threats to achievement of the quality, access and workforce standards in quarter 3 2016/17.

Successes	Priorities
• This month is the first time that zero critical missed doses occurred in the Trust. This is based on a random audit sample of 1014 patients; • Significant improvement in Outpatient experience scores in quarter 2 for Specialised Services and Women's and Children's Divisions; • In September there was a significant reduction in the number of outlier bed days, outlier 461 bed days compared to 616 in August; • Registered nurse vacancies reduced by 42.8 FTE compared with last month, due to large numbers of newly qualified nurses starting with the Trust; • Average monthly sickness absence for 2016/17 year to data stands at 3.8%, compared with 4% for the same period last year; • Percentage of last minute cancelled operations remained below the 0.8% national standard; • Improvement in performance against the 62-day GP cancer waiting times standard; • Reduction in the number of patients waiting over 18 weeks Referral to Treatment (RTT), although remaining below the 92% standard.	• Improvement in care of patients with fractured neck of femur, including timeliness to theatre; • There is a continued focus on the reduction of staff turnover and vacancies with the development of action plans to support the achievement of the 2016/17 KPIs; • Reduction in the number of patients waiting over 18 weeks Referral to Treatment (RTT), by delivering additional activity in each month in quarter 3; • Continued improvement in performance against the 62-day GP cancer waiting times standard during quarter 3; • Implementation of a recovery plan for restoring performance against the 6-week wait diagnostic standard by the end of November.
Opportunities	**Risks & Threats**
• 2770 were vaccinated in the first two weeks of the campaign 42% of which are reportable and therefore contribute to the 75% target required for CQUIN.	• Changes in the requirements to achieve compliance in Information Governance and Fire Safety means levels have reduced. A recovery trajectory to achieve compliance by March 2017 has been developed; • Although an improving picture the existing size of the waiting lists due to an increase in outpatient referrals will make recovery of the 92% RTT national waiting times standard more challenging; • Delays in histopathology reporting, following centralisation of the service at North Bristol Trust, continues to impact on performance against the cancer waiting times standards, although to a lesser extent.

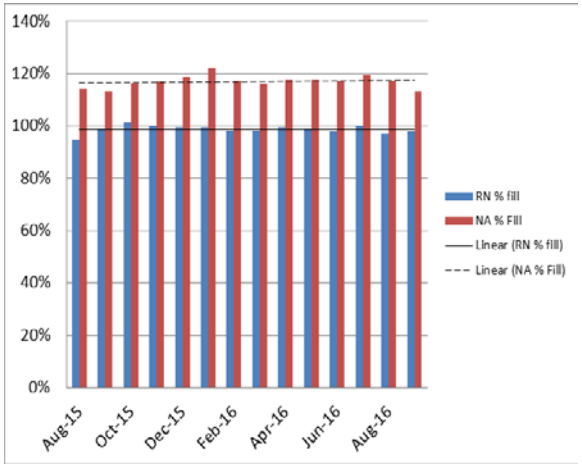
<table>
<tr><th>Description</th><th>Current Performance</th><th>Trend</th><th>Comments</th></tr>
<tr>
<td>Infection control
The number of hospital-apportioned cases of Clostridium difficile infections. The Trust limit for 2016/17 is 45 avoidable cases of clostridium difficile (the same as 2015/16).</td>
<td>There were five case of Clostridium difficile (C. diff) attributed to the Trust in September. These were attributed to divisions as shown in the table below.
<table>
<tr><th></th><th>C. difficile</th></tr>
<tr><td>Medicine</td><td>2</td></tr>
<tr><td>Surgery, Head and Neck</td><td>1</td></tr>
<tr><td>Specialised Services</td><td>1</td></tr>
<tr><td>Women’s & Children’s</td><td>1</td></tr>
</table>
</td>
<td>Total number of C. diff cases
 

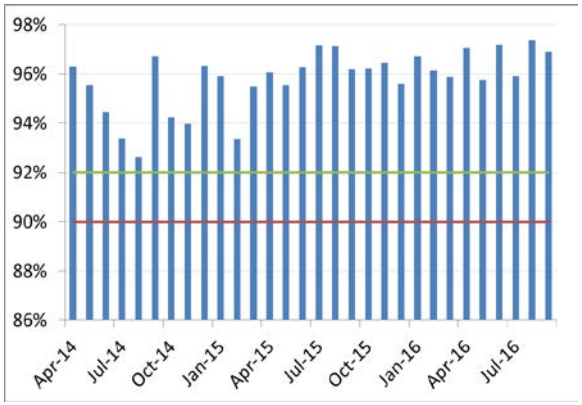
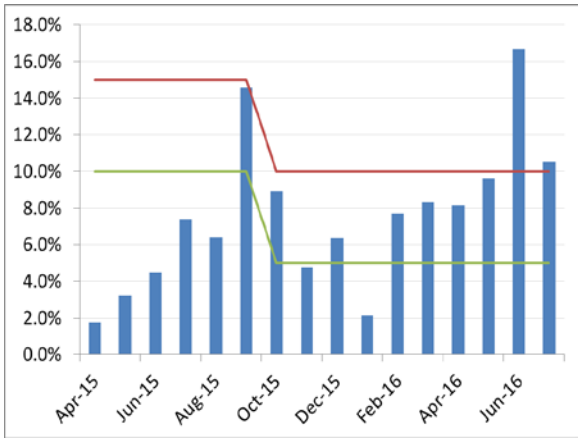
A total of 18 cases (unavoidable + avoidable) have been reported in the year to date against a limit of 45 for April 2016 to March 2017.</td>
<td>The annual limit for the Trust for 2016/17 is 45 avoidable cases. The monthly assessment of cases continues with the Clinical Commissioning Group. The total number of cases to date attributed to the Trust is eighteen. Nine cases have been assessed as unavoidable, and four cases assessed as avoidable. Five cases for September are still to be assessed.
There have been no MRSA bacteraemia cases attributed to the Trust to date since August 2015.</td>
</tr>
<tr>
<td>Deteriorating patient
National early warning scores (NEWS) acted upon in accordance with the escalation protocol (excluding paediatrics). This is an area of focus for our Sign up to Safety Patient Safety Improvement Programme. Our three year goal is sustained improvement above 95%.</td>
<td>Performance in September was 94.1% (one breach) against a three year improvement goal of 95%. This slight deterioration from August’s position of 94.6% (two breaches 94.6%) and is partly due to a significant decrease in the denominator from an average of 36 deteriorating patients a month to 18 in September.
The single breach occurred in the Division of Medicine and is under investigation.</td>
<td>Deteriorating patient: percentage of early warning scores acted upon
 
</td>
<td>Work continues in the deteriorating patient work stream of our patient Safety Improvement Programme and is reported in detail to the Programme Board.
Details of the actions being taken are described in the actions section (Actions 1A to 1E).</td>
</tr>
</table>

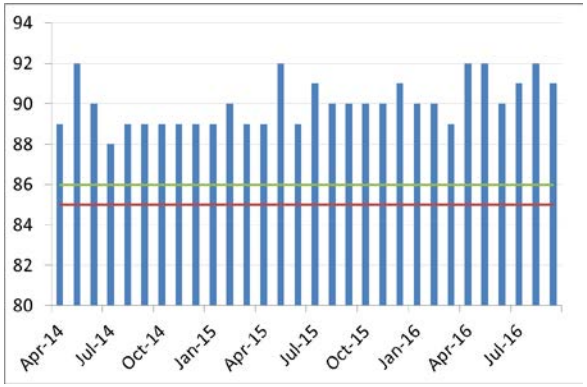
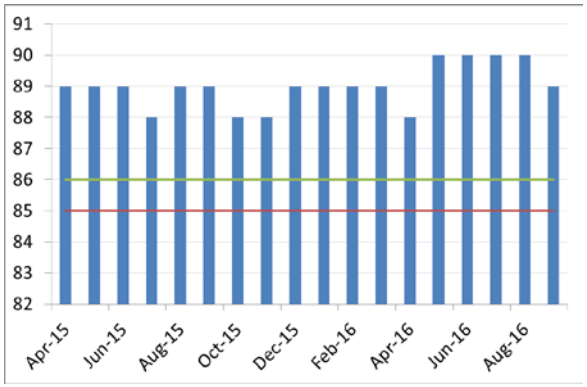
Description	Current Performance	Trend	Comments
Safety Thermometer – No new harm. The NHS Safety Thermometer comprises a monthly audit of all eligible inpatients for 4 types of harm: pressure ulcers, falls, venous-thromboembolism and catheter associated urinary tract infections. New harms are those which are evident after admission to hospital.	In September 2016, the percentage of patients with no new harms was 99.2%, against an upper quartile target of 98.26% (GREEN threshold) of the NHS Improvement patient safety peer group of trusts.	**The percentage of patients surveyed showing No New Harm each month** 	The September 2016 Safety Thermometer point prevalence audit showed three new catheter associated urinary tract infections, one fall with harm, one new pressure ulcer and one incidence of a new venous thrombo-emboli.
Non-purposeful omitted doses of listed critical medicines Monthly audits by pharmacy incorporate a review of administration of critical medicines: insulin, anti-coagulants, Parkinson's medicines, injected anti—infectives, anti-convulsants, short acting bronchodilators and 'stat' doses.	In September 2016, zero patients had one or more omitted critical medications in the past three days. The target for omitted doses is 1% on average for the year to date (0.55%). The zero percentage for September compares with 0.38% of patient with one or more omitted medications reported in August 2016. The September figures were based on a review of 1014 patients.	**Percentage of omitted doses of listed critical medicines** 	Month-on-month this figure has been decreasing during 2016-17 with eight months in a row below 1%. September is the first month since auditing began in July 2012 that there have been no omitted critical medications in the audit sample. Actions being taken are described in the actions section (Actions 2A and 2B)

<table>
<tr><th>Description</th><th>Current Performance</th><th>Trend</th><th>Comments</th></tr>
<tr>
<td>Essential Training measures the percentage of staff compliant with the requirement for core essential training. The target is 90%</td>
<td>Achievement of the Green threshold for this indicator depends on all five categories of Essential Training achieving 90%. Overall compliance is 86% (excluding Child Protection Level 3). Compliance with each of the new reporting categories is provided below.

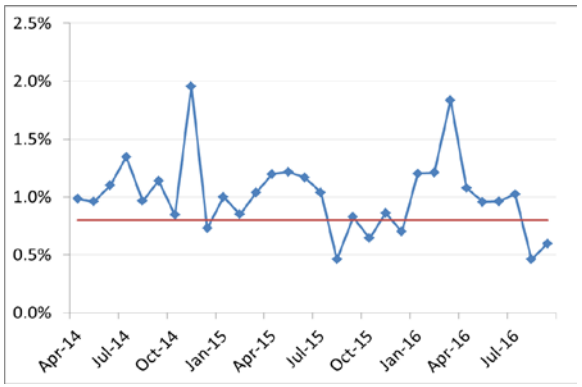
<table>
<tr><th>September 2016</th><th>UH Bristol</th></tr>
<tr><td>Total</td><td>86%</td></tr>
<tr><td>Three Yearly (14 topics)</td><td>88%</td></tr>
<tr><td>Annual (Fire & IG)</td><td>73%</td></tr>
<tr><td>Induction</td><td>96%</td></tr>
<tr><td>Resuscitation</td><td>81%</td></tr>
<tr><td>Safeguarding</td><td>88%</td></tr>
</table>
</td>
<td>There are four graphs included in Appendix 2 which show the performance for Fire and Information Governance (IG), which are the most challenged topics, against the new trajectories that have been set. It should be noted that the reporting for Fire has now been refined due to the changes in the training requirements, and is no longer comparable with previous months.</td>
<td>Action plan 3 provides details of the ongoing work to achieve compliance across all topics.</td>
</tr>
<tr>
<td>Nurse staffing levels unfilled shifts reports the level of registered nurses and nursing assistant staffing levels against the planned.</td>
<td>The report shows that in September the Trust had rostered 213,996 expected nursing hours, with the number of actual hours worked of 218,009. This gave a fill rate of 102%.

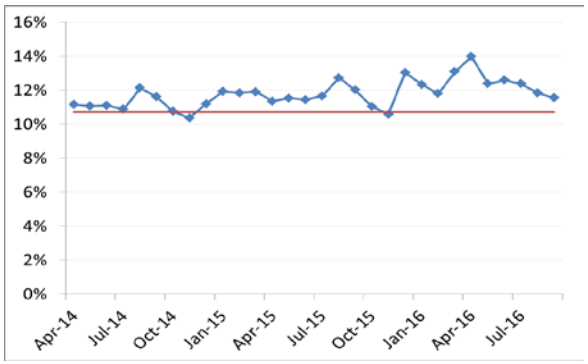
<table>
<tr><th>Division</th><th>Actual Hours</th><th>Expected Hours</th><th>Difference</th></tr>
<tr><td>Medicine</td><td>61,486</td><td>56,390</td><td>+5,096</td></tr>
<tr><td>Specialised Services</td><td>39,508</td><td>38,869</td><td>+639</td></tr>
<tr><td>Surgery Head & Neck</td><td>42,490</td><td>41,263</td><td>+1,227</td></tr>
<tr><td>Women’s & Children’s</td><td>74,525</td><td>77,474</td><td>-2949</td></tr>
<tr><td>Trust - overall</td><td>218,009</td><td>213,996</td><td>+4013</td></tr>
</table>
</td>
<td>The percentage overall staffing fill rate by month
 
</td>
<td>Overall in September, the Trust had 98% cover for registered nurses on days and 97% for nights. The unregistered nursing level of 110% for days and 117% for nights reflects the activity seen in September. This was due primarily to nursing assistant specialist assignments. The Women’s & Children’s Division staffing reflects a planned reduction in services for the month, particularly in relation to paediatric oncology and neurosciences. In addition, both NICU and PICU had reduced demand in the month. Please also see Action 4.</td>
</tr>
</table>

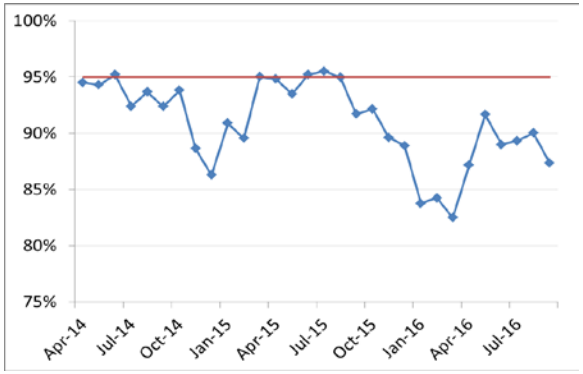
Description	Current Performance	Trend	Comments
Friends & Family Test inpatient score is a measure of how many patients said they were 'very likely' to recommend a friend or family to come to the Trust if they needed similar treatment. The scores are calculated as per the national definition, and summarised at Division and individual ward level.	Performance for September 2016 was 96.9%. This metric combines Friends & Family Test scores from inpatient and day-case areas of the Trust, for both adult and paediatric services. Division and hospital-level data is provided to the Trust Board on a quarterly basis in the quarterly Patient Experience and Involvement report.	**Inpatient Friends & Family scores each month** 	The scores for the Trust are in line with national norms. A very high proportion of the Trust's patients would recommend the care that they receive to their friends and family. These results are shared with ward staff and are displayed publically on the wards. Division and hospital-level data is provided to the Trust Board and is explored within the Quarterly Patient Experience report.
Dissatisfied Complainants. By October 2015 we are aiming for less than 5% of complainants to report that they are dissatisfied with our response to their complaint by the end of the month following the month in which their complaint response was sent.	Following an agreed change, dissatisfied cases are now measured as a proportion of complaints responses and reported two months in arrears. This means that the latest data in the board dashboard is for the month of July 2016. Performance for July was 10.5% against a green target of 5%. As of 13th October, four of the thirty eight complaints responses sent out in July had resulted in dissatisfied replies. Two cases were for the Division of Medicine, one case was for the Division of Women's & Children's, and one was for the Division of Specialised Services.	**Percentage of compliantaints dissatisfied with the complaint response each month** 	Our performance for 2015/6 was 6.15% compared with 11.19% in 2014/15. Informal benchmarking with other NHS Trusts suggests that rates of dissatisfied complainants are typically in the range of 8% to 10%. Actions continue as previously reported to the Board (Actions 5A to 5C).

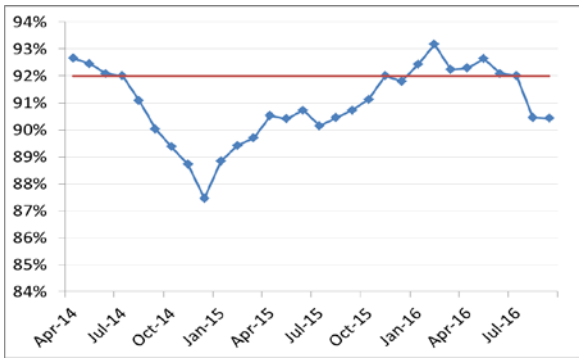
<table>
<tr><th>Description</th><th>Current Performance</th><th>Trend</th><th>Comments</th></tr>
<tr>
<td>Inpatient experience tracker comprises five questions from the monthly postal survey: ward cleanliness, being treated with respect and dignity, involvement in care decisions, communication with doctors and with nurses. These were identified as “key drivers” of patient satisfaction via analysis and focus groups.</td>
<td>For the month of September, the score was 91 out of a possible score of 100. Divisional scores are broken down for Q2 below.
<table>
<tr><th></th><th>Q1 2016/2017</th><th>Q2 2016/2017</th></tr>
<tr><td>Trust</td><td>91</td><td>91</td></tr>
<tr><td>Medicine</td><td>87</td><td>88</td></tr>
<tr><td>Surgery, Head & Neck</td><td>92</td><td>92</td></tr>
<tr><td>Specialised Services</td><td>92</td><td>92</td></tr>
<tr><td>Women's & Children's (Bristol Royal Hospital for Children)</td><td>92</td><td>92</td></tr>
<tr><td>Women's & Children's Division (Postnatal wards)</td><td>90</td><td>91</td></tr>
</table></td>
<td>Inpatient patient experience scores (maximum score 100) each month
 
</td>
<td>UH Bristol performs in line with national norms in terms of patient-reported experience. This metric would turn red if patient experience at the Trust began to deteriorate to a statistically significant degree – alerting the Trust Board and senior management that remedial action was required. In the year to date the score remains green. A detailed analysis of this metric (down to ward-level) is provided to the Trust Board in the Quarterly Patient Experience Report.</td>
</tr>
<tr>
<td>Outpatient experience tracker comprises four scores from the Trust’s monthly survey of outpatients (or parents of 0-11 year olds):
1) Cleanliness
2) Being seen within 15 minutes of appointment time
3) Being treated with respect and dignity
4) Receiving understandable answers to questions.</td>
<td>The score for the Trust as whole was 90 in September 2016 (out of score of 100). Divisional scores for quarter 2 are provided as numbers of responses each month are not sufficient for a monthly divisional breakdown to be meaningful.
<table>
<tr><th></th><th>Q1 2016/2017</th><th>Q2 2016/2017</th></tr>
<tr><td>Trust</td><td>89</td><td>90</td></tr>
<tr><td>Medicine</td><td>93</td><td>89</td></tr>
<tr><td>Specialised Services</td><td>85</td><td>87</td></tr>
<tr><td>Surgery, Head & Neck</td><td>87</td><td>92</td></tr>
<tr><td>Women's & Children's (Bristol Royal Hospital for Children)</td><td>80</td><td>89</td></tr>
<tr><td>Diagnostics & Therapies</td><td>94</td><td>94</td></tr>
</table></td>
<td>Outpatient Experience Scores (maximum score 100) each month
 
</td>
<td>The Trust’s performance is in line with national norms in terms of patient-reported experience.

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

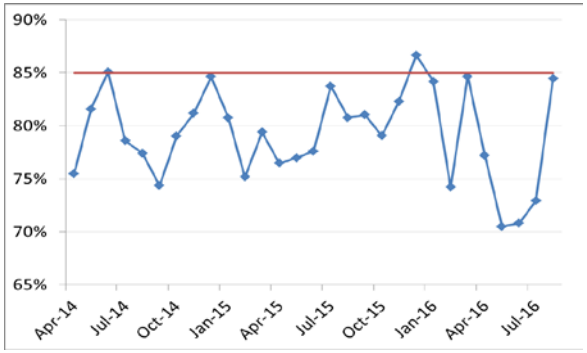
<table>
<tr><th>Description</th><th>Current Performance</th><th>Trend</th><th>Comments</th></tr>
<tr>
<td>Last Minute Cancellation is a measure of the percentage of operations cancelled at last minute for non-clinical reasons. The national standard is for less than 0.8% of operations to be cancelled at last minute for reasons unrelated to clinical management of the patient.</td>
<td>In September the Trust cancelled 39 (0.60% of) operations at last-minute for non-clinical reasons. The reasons for the cancellations are shown below:
<table>
<tr><th>Cancellation reason</th><th></th></tr>
<tr><td>No HDU/ITU bed available</td><td>15 (38%)</td></tr>
<tr><td>Emergency patient prioritised</td><td>11 (28%)</td></tr>
<tr><td>No ward bed available</td><td>3 (8%)</td></tr>
<tr><td>Lack to time</td><td>3 (8%)</td></tr>
<tr><td>Other causes (6 different breach reasons - no themes)</td><td>7 (18%)</td></tr>
</table>
No patients cancelled in August were readmitted outside of 28 days. This equates to 100% of cancellations being readmitted within 28 days, which is above the former national standard of 95%.</td>
<td>Percentage of operations cancelled at last-minute
 

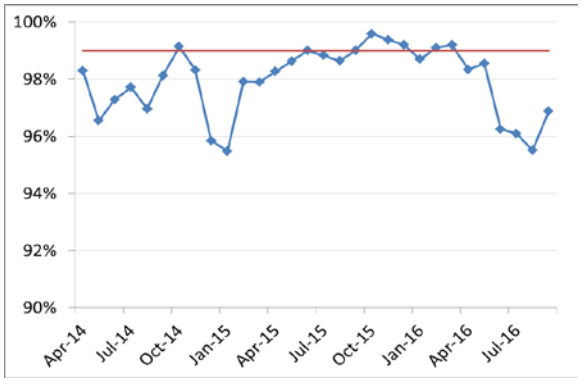
The national 0.8% standard is currently not forecast to be met in October due to emergency pressures.</td>
<td>Emergency pressures continues to be the predominant cause of cancellations this month, with emergency patients needing to be prioritised and a lack of High Dependency / Intensive Therapy Unit beds (due to these being occupied by emergency patients), making-up 66% of all cancellations. An action plan to reduce elective cancellations continues to be implemented (Actions 6A and 6B). However, please also see actions detailed under A&E 4 hours (8A to C) and outlier bed-days (13A).</td>
</tr>
<tr>
<td>Outpatient appointments cancelled is a measure of the percentage of outpatient appointments that were cancelled by the hospital. This includes appointments cancelled to be brought forward, to enable us to see the patient more quickly.</td>
<td>In September 11.6% of outpatient appointments were cancelled by the hospital, which is similar to the level of performance reported for the last four months.
The Patient Administration System has a large number of different reasons for cancellation which can be selected by users. This creates confusion and impacts on the consistency of reporting of causes of cancellation. For this reason a new, simplified list of cancellations reasons had been proposed. However, it has become apparent that many of these reasons feed the national Electronic Referral System and cannot therefore be removed from Medway.</td>
<td>Percentage of outpatient appointments cancelled by the hospital
 
</td>
<td>Ensuring outpatient capacity is effectively managed on a day-to-day basis is a core part of the improvement work overseen by the Outpatients Steering Group. The improvement plan for this key performance indicator was recently refreshed, prioritising those actions that are likely to reduce the current underlying rate of cancellation by the hospital (Actions 7A to D).</td>
</tr>
</table>

<table>
<tr><th>Description</th><th>Current Performance</th><th>Trend</th><th>Comments</th></tr>
<tr>
<td>A&E Maximum 4-hour wait is measured as the percentage of patients that are discharged, admitted or transferred within four hours of arrival in one of the Trust's three Emergency Departments (EDs). The national standard is 95%.</td>
<td>The 95% national standard was not achieved in September. Trust-level performance at 87.3% was also below the in-month trajectory (92.2%). Performance and activity levels for the BRI and BCH Emergency Departments are shown below.
<table>
<tr><th>BRI</th><th>Sep 2015</th><th>Aug 2016</th><th>Sep 2016</th></tr>
<tr><td>Attendances</td><td>5363</td><td>5723</td><td>5525</td></tr>
<tr><td>Emergency Admissions</td><td>1795</td><td>1889</td><td>1808</td></tr>
<tr><td>Patients managed < 4 hours</td><td>4706
87.8%</td><td>4791
83.7%</td><td>4463
80.8%</td></tr>
<tr><th>BCH</th><th>Sep 2015</th><th>Aug 2016</th><th>Sep 2016</th></tr>
<tr><td>Attendances</td><td>3200</td><td>2655</td><td>3228</td></tr>
<tr><td>Emergency Admissions</td><td>835</td><td>661</td><td>823</td></tr>
<tr><td>Patients managed < 4 hours</td><td>3002
93.8%</td><td>2583
97.3%</td><td>2956
91.6%</td></tr>
</table>
</td>
<td>Performance of patients waiting under 4 hours in the Emergency Departments
 

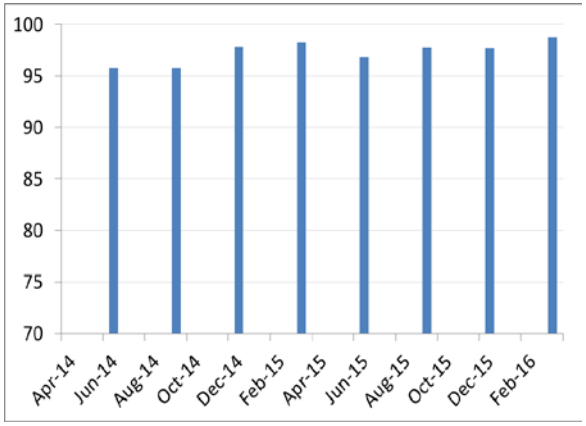
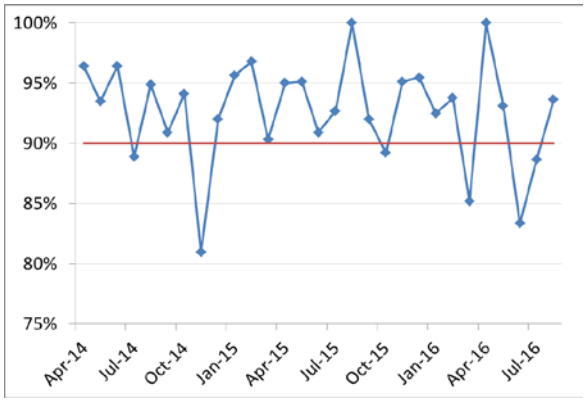
Trajectory of 93.3% not forecast to be met in October, due to a rise in emeregency admissions.</td>
<td>Levels of emergency admissions into both the BRI and BCH were similar to the same period in 2015. The number of patients on the Green to Go (delayed discharge) list decreased slightly, from 69 at the end of August, to 60 at the end of September. However, BRI bed occupancy increased above the levels seen in the last two months, potentially due to the increase in admissions in the over 75 year old age group, experienced in August. Actions continue to be taken to manage demand and reduce delayed discharges / length of stay (Actions 8A to 8C).</td>
</tr>
<tr>
<td>Referral to Treatment (RTT) is a measure of the length of wait from referral through to treatment. The target is for at least 92% of patients, who have not yet received treatment, and whose pathway is considered to be incomplete (or ongoing), to be waiting less than 18 weeks at month-end.</td>
<td>The 92% national standard was not achieved at the end of September, with the Trust reporting 90.4% of patients waiting less than 18 weeks at month-end. However, there was a decrease in the number of patients waiting over 18 weeks on a non-admitted pathway (see Appendix 3).
The number of patients waiting over 40 weeks RTT at month-end also decreased in September, against the trajectory of zero, although 1 over 52-week waiter was reported.
<table>
<tr><th></th><th>Jul</th><th>Aug</th><th>Sep</th></tr>
<tr><td>Numbers waiting > 40 weeks RTT</td><td>27</td><td>33</td><td>27</td></tr>
<tr><td>Numbers waiting > 52 weeks RTT</td><td>0</td><td>0</td><td>1</td></tr>
</table>
</td>
<td>Percentage of patients waiting under 18 weeks RTT by month
 

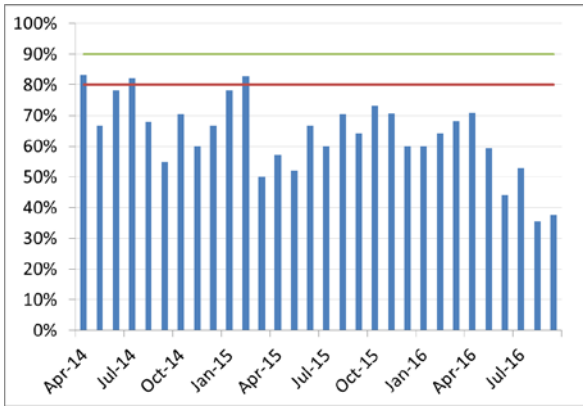
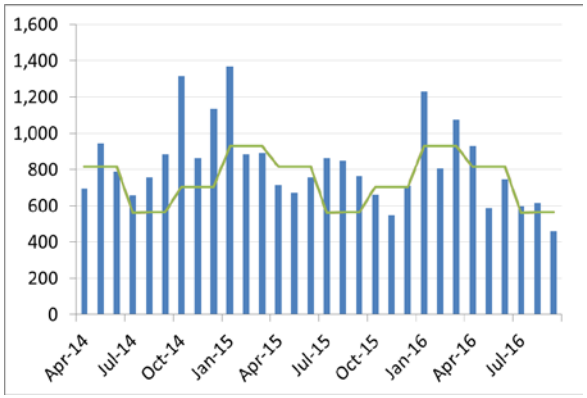
Revised forecast for Oct, Nov and Dec = 90.8%, 91.4% and 91.6% respectively, with achievement of 92% for each month in Q4.</td>
<td>In addition to the number of over 18 week waiters having decreased, the size of the elective waiting list has continued to decrease. The outpatient waiting list is also no longer increasing, which suggests the 'bulge' in the waiting list is now starting to pass and demand is now being met. A recovery plan has been developed, which is monitored through weekly escalation meetings with Divisions. The weekly RTT Operational Group continues to oversee the management of the longest waiting patients (Action 9A and 9B).</td>
</tr>
</table>

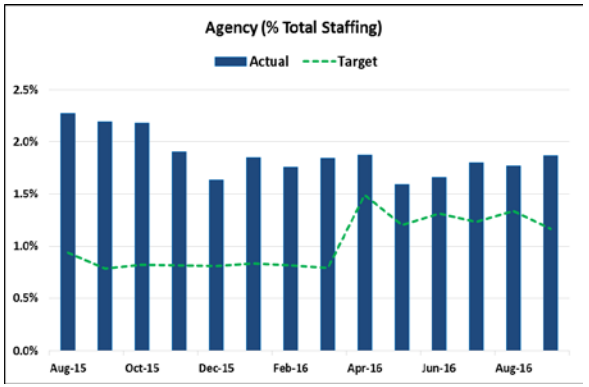
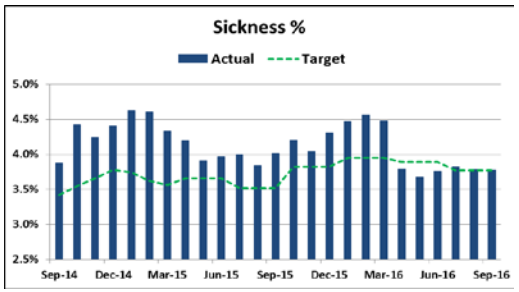
<table>
<tr><th>Description</th><th>Current Performance</th><th>Trend</th><th>Comments</th></tr>
<tr>
<td>Cancer Waiting Times are measured through eight national standards. These cover a 2-week wait to see a specialist, a 31 day wait from diagnosis to treatment, and a 62-day wait from referral to treatment. There are different standards for different types of referrals, and first and subsequent treatments.</td>
<td>August's performance was 84.5% against the 85% 62-day GP standard, and a trajectory of 81.7%. The 85% standard was also met for internal pathways. The main reasons for failure to achieve the 85% 62-day GP standard are shown below.
<table>
<tr><th>Breach reason</th><th>Aug 16</th></tr>
<tr><td>Late referral by/delays at other provider</td><td>6.0</td></tr>
<tr><td>Medical deferral/clinical complexity</td><td>5.5</td></tr>
<tr><td>Histopathology delay</td><td>2.0</td></tr>
<tr><td>Outpatient appointment delay</td><td>1.0</td></tr>
<tr><td>Delayed diagnostic scan/procedure</td><td>2.0</td></tr>
<tr><td>Other reasons (three different causes)</td><td>2.0</td></tr>
<tr><td>TOTAL</td><td>18.5</td></tr>
</table>
</td>
<td>Percentage of patients treated within 62 days of GP referral
 

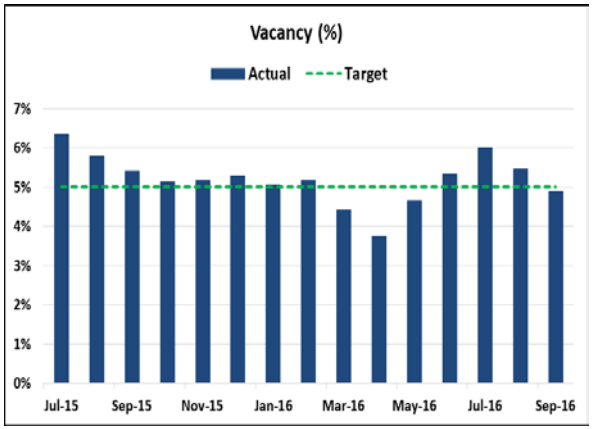
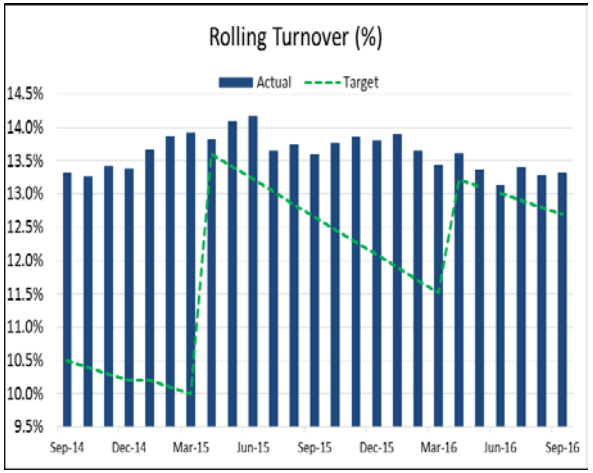
Performance against the 90% 62-day screening standard was 55.6%, with 2 breaches for the following reasons: patient choice (1.0), histology reporting delay (0.5) and late referral (0.5).</td>
<td>Performance continues to be impacted by high levels of late referrals, medical deferrals, and histopathology reporting delays, following the transfer of the service to NBT. Performance is, expected to be circa 80% in September. A local CQUIN came into effect on the 1st October, along with a national policy supporting 'automatic' breach reallocation for late referral and treatments not carried-out within specified times. An improvement plan continues to be implemented to minimise avoidable delays (Action 10A to 10B).</td>
</tr>
<tr>
<td>Diagnostic waits – diagnostic tests should be undertaken within a maximum 6 weeks of the request being made. The national standard is for 99% of patients referred for one of the 15 high volume tests to be carried-out within 6 weeks, as measured by waiting times at month-end.</td>
<td>Performance against the 99% national standard was 96.9% in September, against the recovery trajectory of 96.7%. The number and percentage of over 6-week waiters at month-end, is shown below:
<table>
<tr><th>Diagnostic test</th><th>Jul</th><th>Aug</th><th>Sep</th></tr>
<tr><td>MRI</td><td>17</td><td>7</td><td>14</td></tr>
<tr><td>Ultrasound</td><td>9</td><td>23</td><td>10</td></tr>
<tr><td>Sleep</td><td>47</td><td>86</td><td>109</td></tr>
<tr><td>Endoscopies</td><td>223</td><td>208</td><td>97</td></tr>
<tr><td>Audiology</td><td>9</td><td>12</td><td>0</td></tr>
<tr><td>Echo</td><td>17</td><td>16</td><td>24</td></tr>
<tr><td>Other</td><td>9</td><td>4</td><td>3</td></tr>
<tr><td>TOTAL</td><td>331</td><td>356</td><td>257</td></tr>
<tr><td>Percentage</td><td>96.1%</td><td>95.5%</td><td>96.9%</td></tr>
<tr><td colspan="2">Recovery trajectory</td><td>95.2%</td><td>95.2%</td></tr>
</table>
</td>
<td>Percentage of patients waiting under 6 weeks at month-end
 

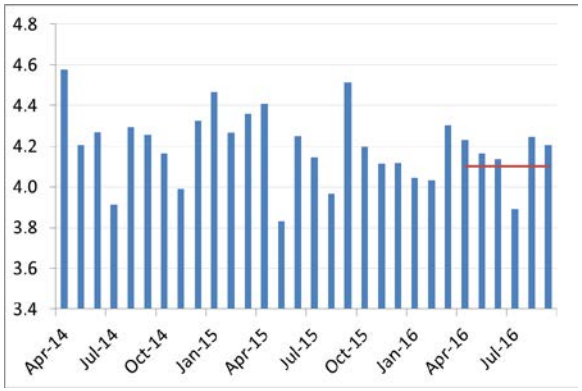
Achievement of the 99% standard is at risk for the end of October, with potential, although not certain, recovery for the end of November.</td>
<td>There was a decrease in the number of patients waiting over 6 weeks for a diagnostic test between August and September as predicted, with performance remaining above trajectory. The 99% standard was achieved for all except three types of tests (endoscopy, sleep studies and echo). The number of patients waiting over 6 weeks is expected to reduce by a further 50 by the end of September as a result of the actions being taken (Action 11A to 11C).</td>
</tr>
</table>

Description	Current Performance	Trend	Comments
Summary Hospital Mortality Indicator is the ratio of the actual number of patients who died in hospital or within 30 days of discharge and the number that were 'expected' to die, calculated from the patient case-mix, age, gender, type of admission and other risk factors. This is nationally published quarterly, six months in arrears.	Summary Hospital Mortality Indicator (SHMI) for March 2016 was 98.7. As reported last month, further discussions have taken place regarding mortality reporting and the impact of periodic rebasing. It has been agreed that we will report national SHMI which is available quarterly, but six months in arrears, and is rebased every publication providing a more accurate indication of our comparative mortality rates. Threshold have been set on the following basis: Red = SHMI above 100 and Lower Confidence Interval above 100 Amber = SHMI above 100 but Lower Confidence Interval below 100 Green = SHMI below 100	**Summary Hospital Mortality Indicator (SHMI) for in hospital deaths each month** 	Our overall performance continues to indicate that fewer patients died in our hospitals than would have been expected given their specific risk factors. The Quality Intelligence Group continues to conduct assurance reviews of any specialties that have an adverse SHMI score in a given quarter. Coronary atherosclerosis alerts remain under investigation. We will continue to track Hospital Standardised Mortality Indicator monthly to give earlier warning of a potential concern.
Door to balloon times measures the percentage of patients receiving cardiac reperfusion (inflation of a balloon in a blood vessel feeding the heart to clear a blockage) within 90 minutes of arriving at the Bristol Heart Institute.	In August (latest data), 44 out of 47 patients (93.6%) were treated within 90 minutes of arrival in the hospital. Performance for the year as a whole remains above the 90% standard at 92.0%.	**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. No common themes were identified in July.

<table>
<tr><th>Description</th><th>Current Performance</th><th>Trend</th><th>Comments</th></tr>
<tr>
<td>Fracture neck of femur Best Practice Tariff (BPT), is a basket of indicators covering eight elements of what is considered to be best practice in the care of patients that have fractured their hip. For details of the eight elements, please see Appendix 1.</td>
<td>In September 2016 we achieved 37.5% (9/24 patients) overall performance in Best Practice Tariff (BPT), against the national standard of 90%. The time to theatre within 36 hours performance was 58.3% (14/24 patients).
<table>
<tr><th>Reason for not going to theatre within 36 hours</th><th>Number</th></tr>
<tr><td>Lack of theatre capacity</td><td>Eight patients. Only five went to theatre within 48 hrs.</td></tr>
<tr><td>Anaesthetist unwell on the day</td><td>One patient. As a result of the anaesthetist illness, the operating list had to be revised and extra cover provided.</td></tr>
<tr><td>Further advice required for a complex case.</td><td>One patient. This was a complex case and the weekend surgical team needed further specialist advice.</td></tr>
</table>
</td>
<td>Percentage of patients with fracture neck of femur whose care met best practice tariff standards.
 
</td>
<td>Eight patients did not receive any ortho-geriatrician review due to annual leave. Two patients were not reviewed because the ortho-geriatrician was on-call covering the Older Person Assessment Unit and was not able to cover the Trauma & Orthopaedic Wards.
Actions are being taken to establish a future service model across Trauma &Orthopaedics, and ensure that consistent, sustainable cover is provided (Actions 12A to 12E).</td>
</tr>
<tr>
<td>Outlier bed-days is a measure of how many bed-days patients spend on a ward that is different from their broad treatment speciality: medicine, surgery, cardiac and oncology. Our target is a 15% reduction which equates to a 9029 bed-days for the year with seasonally adjusted quarterly targets.</td>
<td>In September 2016 there were 461 outlier bed-days against a target of 563 outlier bed days. Performance improved significantly in September with a reduction of 155 bed-days over August’s figure of 616. Continuing improvement can be seen in Surgery Head and Neck and Specialised Services, with a relatively static position in Medicine.
<table>
<tr><th>Outlier bed-days</th><th>September 2016</th></tr>
<tr><td>Medicine</td><td>225</td></tr>
<tr><td>Surgery, Head & Neck</td><td>118</td></tr>
<tr><td>Specialised Services</td><td>102</td></tr>
<tr><td>Women's & Children's Division</td><td>16</td></tr>
<tr><td>Total</td><td>461</td></tr>
</table>
</td>
<td>Number of days patients spent outlying from their specialty wards
 
</td>
<td>In quarter 2 a revised target was set which was narrowly missed in August. This month has seen that improvement continue with the revised target being exceeded by 102 bed days. The figure of 461 is the lowest reported figure since April 2014.
Ongoing actions are shown in the action plan section of this report. (Actions 12A and 13B).</td>
</tr>
</table>

Description	Current Performance	Trend	Comments
Agency usage is measured as a percentage of total staffing (FTE - full time equivalent) based on aggregated Divisional targets for 2015/16. The red threshold is 10% over the monthly target.	Agency usage increased by 8.9 FTE, increasing from 1.8% to 1.9% of total staffing. There was a slight increase in nursing usage (1.7 FTE), but the biggest increases were among the Administrative and Clerical (4.5 FTE) and Allied Health Professional (3.4 FTE) staff groups. **September 2016** / **FTE** / **Actual %** / **KPI** **UH Bristol** / **157.4** / **1.9%** / **1.2%** Diagnostics & Therapies / 6.6 / 0.7% / 0.7% Medicine / 37.4 / 3.0% / 2.3% Specialised Services / 26.5 / 2.7% / 1.6% Surgery, Head & Neck / 30.4 / 1.7% / 0.8% Women's & Children's / 25.7 / 1.3% / 0.6% Trust Services / 20.5 / 2.8% / 2.3% Facilities & Estates / 10.3 / 1.3% / 1.3%	**Agency usage as a percentage of total staffing by month** 	The agency action plans continue to be implemented and the headlines are in the improvement plan (Action 14). A summary of compliance with agency caps is attached in Appendix 2.
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 remained unchanged from last month at 3.8% (target: 3.8%), despite small changes between Divisions and staff groups. **September 2016** / **Actual** / **KPI** **UH Bristol** / **3.8%** / **3.8%** Diagnostics & Therapies / 2.6% / 2.7% Medicine / 5.0% / 4.6% Specialised Services / 3.1% / 3.7% Surgery, Head & Neck / 3.2% / 3.7% Women's & Children's / 3.8% / 3.5% Trust Services / 3.0% / 3.2% Facilities & Estates / 5.8% / 5.2%	**Sickness absence as a percentage of full time equivalents by month**  *Please note: Sickness data is refreshed retrospectively to capture late data entry, and to ensure the data are consistent with what we finally submit for national publication*	Average monthly sickness absence for the year to date stands at 3.8%, compared with 4% for the same period last year. Action 15 describes the ongoing programme of work to address sickness absence.

<table>
<tr><th>Description</th><th>Current Performance</th><th>Trend</th><th>Comments</th></tr>
<tr>
<td>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%.</td>
<td>Vacancies reduced from 5.5%, to 4.9% (404.5 FTE). This was largely due to newly qualified nurses joining the Trust - registered nursing vacancies reduced by 42.8 FTE to 4.6%. Vacancies also reduced among Allied Health Professions/Scientific and Technical and Ancillary staff compared with August.
<table>
<tr><th>September 2016</th><th>Rate</th></tr>
<tr><td>UH Bristol</td><td>4.9%</td></tr>
<tr><td>Diagnostics & Therapies</td><td>6.1%</td></tr>
<tr><td>Medicine</td><td>5.5%</td></tr>
<tr><td>Specialised Services</td><td>5.1%</td></tr>
<tr><td>Surgery, Head & Neck</td><td>6.2%</td></tr>
<tr><td>Women's & Children's</td><td>1.6%</td></tr>
<tr><td>Trust Services</td><td>7.5%</td></tr>
<tr><td>Facilities & Estates</td><td>4.6%</td></tr>
</table>
</td>
<td>Vacancies rate by month
 
</td>
<td>The recruitment action plan is summarised in Action 16.
Appendix 2 details progress in reducing specialist nursing vacancies. Planned and some in-month starters are not reflected in these graphs. In Coronary Intensive Care, 13.8 FTE were due to start between September and October, leaving a gap of 6 FTE as the budget will increase by 4.25 FTE. Heygroves Theatres are expecting 10 to start between September and December.</td>
</tr>
<tr>
<td>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.</td>
<td>Turnover remained static at 13.3% overall, reducing in all Divisions except Diagnostics & Therapies and Specialised Services. Registered nurse turnover reduced, but Unregistered Nursing and Allied Health Professional turnover increased significantly.
<table>
<tr><th>September 2016</th><th>Actual</th><th>Target</th></tr>
<tr><td>UH Bristol</td><td>13.3%</td><td>12.7%</td></tr>
<tr><td>Diagnostics & Therap.</td><td>12.5%</td><td>12.7%</td></tr>
<tr><td>Medicine</td><td>14.7%</td><td>13.8%</td></tr>
<tr><td>Specialised Services</td><td>11.7%</td><td>13.3%</td></tr>
<tr><td>Surgery, Head & Neck</td><td>14.1%</td><td>13.0%</td></tr>
<tr><td>Women's & Children's</td><td>12.1%</td><td>10.8%</td></tr>
<tr><td>Trust Services</td><td>15.2%</td><td>13.5%</td></tr>
<tr><td>Facilities & Estates</td><td>13.8%</td><td>13.7%</td></tr>
</table>
</td>
<td>Staff turnover rate by month
 
</td>
<td>Programmes to support staff recruitment remain a key priority for the Divisions and the Trust (Action 17).</td>
</tr>
</table>

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 September the average length of stay for inpatients was 4.21 days, which is above the RED threshold. This is a 0.03 day decrease on the previous month. At the end of September the number of Green to Go delayed discharges was similar to that of the same period last year, but lower than the number at the end of August (69 August versus 60 in September). The jointly agreed planning assumption of 30 patients continues to not be met. The percentage of patients discharged in September who were long-stay stay patients, was higher than in the last three months. However, the number of long stay patients in hospital remains high, potentially related to the increase in over 75 year olds admitted in August. This suggests that length of stay will remain above plan.	**Average length of stay (days)**  Length of stay is forecast to remain above the RED threshold in October.	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 8A to 8C and 13A to 13B).

Improvement Plan

Domain	Action number	Action	Timescale	Assurance	Improvement trajectory
Safe					
Deteriorating patient Early warning scores for acted upon.	1A	Further targeted teaching for areas where NEWS incidents have occurred.	Commenced February 2016 and on-going	Monthly progress reviewed in the deteriorating patient work stream and quarterly by the Patient Safety Improvement Programme Board, Clinical Quality Group and Quality and Outcomes Committee	Sustained improvement to 95% by 2018.
	1B	Accessing doctor education opportunities to assist with resetting triggers safely	Commenced April 2016 and on-going	As above	Sustained improvement to 95% by 2018.
	1C	Convening of a focus group to further understand the reasons why nurses and doctors are unable to escalate or respond to escalation and address these accordingly. Also please see 1E below.	November 2016	As above	Sustained improvement to 95% by 2018.
	1D	Testing approach to point of care simulation training in adult general ward areas to address human factors elements of escalating deteriorating patients and use of structured communication.	September 2016 and on-going	As above	Sustained improvement to 95% by 2018.
	1E	Additional time allocated for patient safety in doctors'	From September 2016 and ongoing	As above	Sustained improvement to 95% by 2018.

Domain	Action number	Action	Timescale	Assurance	Improvement trajectory
		induction to train new appointees on resetting triggers safely and human factors awareness of escalation conversations.			
Non-purposeful omitted doses of critical medication	2A	Datix dashboard being developed to capture omitted doses, to allow detailed thematic analysis.	October 2016	Improvement under development	Maintain current improvement and sustain performance below 1%
	2B	Trust-wide bulletin on medicines for Parkinson's disease. Information to be sent to Matrons for dissemination to ward staff.	October 2016	Highlight this issue and the drug availability.	Maintain current improvement and sustain performance below 1%
Essential Training	3	Continue to drive compliance including increasing e-learning.	Ongoing	Oversight by Workforce and OD Group via the Essential Training Steering Group	Divisional Trajectories show compliance by the end of March 2017.
		Detailed plans focus on improving the compliance of Safeguarding Resuscitation, Information Governance (IG) and Fire Safety.	Ongoing	Oversight of safeguarding training compliance by Safeguarding Board /Workforce and Organisational Development Group.	
		Newly developed trajectories for Fire and IG will be monitored at a divisional level at monthly and quarterly Performance and Operations meetings	September 2016 to March 2017.	Monthly and quarterly Divisional Performance Reviews.	
Monthly Staffing levels	4	Continue to validate temporary staffing assignments against agreed criteria.	Ongoing	Monitored through agency controls and action plan.	Action plan available on request.

Domain	Action number	Action	Timescale	Assurance	Improvement trajectory
Caring					
Dissatisfied complainants	5A	Response writing training continues to be rolled-out to Divisions	Ongoing	Completion of training signed-off by Patient Support & Complaints Team and Divisions.	Achieve and maintain a green RAG rating for this indicator.
	5B	Upon receipt of written response letters from the Divisions, there is a thorough checking process, whereby all letters are firstly checked by the case-worker handling the complaint, then by the Patient Support & Complaints Manager. The Head of Quality for Patient Experience & Clinical Effectiveness also checks a selection of response letters each week. All responses are then sent to the Executives for final approval and sign-off.	Ongoing	Senior Managers responsible for drafting and signing off response letters before they leave the Division are named on a Response Letter Checklist that is sent to the Executives with the letter. Any concerns over the quality of these letters can then be discussed individually with the manager concerned and further training provided if necessary.	
	5C	Dissatisfied responses are now routinely checked by the Head of Quality (Patient Experience & Clinical Effectiveness) to identify learning where appropriate. All cases where a complaint is dissatisfied for a second time are escalated to and reviewed by the Chief Nurse.	Implemented September 2015 and ongoing		
Last minute cancelled operations	6A	Continued focus on recruitment and retention of staff to enable all	Ongoing	Monthly Divisional Review Meetings;	Improvement to be evidenced by a continued reduction in

Domain	Action number	Action	Timescale	Assurance	Improvement trajectory
		adult BRI ITU beds to be kept open, at all times. Training package developed to support staff retention. Staff recruited and in post. Development and implementation of a strategy for managing ITU/HDU beds across general adult and cardiac units, to improve ability to manage peaks in demand.	To be confirmed – expected to be by quarter 4, when virtual ward up to full impact, relieving ward bed pressures	Relevant Steering Group to be confirmed, but likely to be Cancer Steering Group, due to the recent impact on cancer	cancellations in Q3. Achievement of quality objective on a quarterly basis.
	6B	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	7A	Review and revise cancellation reasons available on Medway to improve consistency of reporting and improve the Trust's understanding of the root cause of cancellations.	Review completed but many of the changes not able to be implemented due to being required by the national Electronic Referral System (eRS).	Changes approved through Change Board and Medway revised.	See action 7C
	7B	Produce summary analysis of first month's use of the new cancellation codes, and test the reasonableness of the target thresholds currently set. This analysis will include a break-down of the reasons for cancellation, and the percentage of cancellations	End November	Report provided for Outpatient Steering Group;	Outpatient Steering Group to identify any new actions arising from this analysis, which may alter performance trajectory.

Domain	Action number	Action	Timescale	Assurance	Improvement trajectory
		that relate to patients being able to book on the national Electronic Referral Service, beyond the period of notification for annual leave.			
	7C	Select six highest hospital cancellation specialities and investigate reasons for cancellations with frontline staff and Performance & Operations Managers. Share learning with all over specialities via the Outpatient Steering Group.	End of November	Report provided for Outpatient Steering Group	Amber threshold expected to be achieved by the end of October.
	7D	Using the new cancellations codes set-up on Medway, confirm that no leave is being agreed within six weeks (or timescale locally agreed).	End of November	Report provided for Outpatient Steering Group	See action 6C

Domain	Action number	Action	Timescale	Assurance	Improvement trajectory
Responsive					
A&E 4-hours	8A	Commissioner-led task and finish group established in January (and re-formed in July), to understand drivers of increase in paediatric emergency demand and to identify possible demand management solutions.	Ongoing	Urgent Care Board	Achievement of recovery trajectory each month.
	8B	Delivery of internal elements of the community-wide resilience plan.	Ongoing	Emergency Access Steering Group	Achievement of recovery trajectory each month.
	8C	Working with partners to continue to mitigate shortfalls in social services provision and other causes of higher levels of delayed discharges. See also actions 12A to 12E relating to delayed discharges and flow.	Ongoing	Urgent Care Board	Achievement of recovery trajectory each month.
Referral to Treatment Time (RTT)	9A	Recovery plan to be developed, including actions to increase capacity, manage demand and improve adherence to correct administrative processes	Complete	Oversight by RTT Steering Group	Reduction in over 18 week RTT pathways through to the end of December.
	9B	Weekly monitoring of reduction in RTT over 18 week backlogs against trajectory. Continued weekly review of management of longest waiting patients through RTT Operations	Ongoing	Oversight by RTT Steering Group; routine in-month escalation and discussion at monthly Divisional Review meetings.	Reduction in over 18 week RTT pathways through to the end of December.

Domain	Action number	Action	Timescale	Assurance	Improvement trajectory
		Group.			
Cancer waiting times	10A	Implementation of Cancer Performance Improvement Plan, including ideal timescale pathways, and reduced waits for 2-week wait appointments.	Ongoing	Oversight of implementation by Cancer Performance Improvement Group, with escalation to Cancer Steering Group.	Achieve monthly recovery trajectory submitted for quarter 3 2016/17
	10B	Escalate issues and seek assurance on North Bristol Trust's (NBT) plan to reduce delays in histopathology reporting post service transfer	Ongoing	Exec to Exec escalation complete; action plan provided.	NBT meeting the agreed Service Level Agreement standards (currently on track).
Diagnostic waits	11A	Increase adult endoscopy capacity by recruiting to the Nurse Endoscopist post, completing the in-house training of a nurse endoscopist, booking additional waiting list initiatives and sessions through Glanso, and outsourcing as much routine work as possible to a private provider through the contract which has recently been agreed.	Ongoing	Weekly monitoring by Associate Director of Performance, with escalation to month Divisional Review meetings as required.	Recovery of 99% standard by end of October.
	11B	GP with Specialist Interest undertaking additional Sleep Studies outpatient sessions (late June to September), to help address the bulge in demand; additional waiting list sessions also being undertaken.	Ongoing	Weekly monitoring by Associate Director of Performance, with escalation to month Divisional Review meetings as required.	As above
	11C	Establish additional sessions for	Ongoing	Weekly monitoring by Associate Director of	Recovery of 99% standard for total Radiology (including

Domain	Action number	Action	Timescale	Assurance	Improvement trajectory
		Echo, Ultrasound and MRI.		Performance, with escalation to month Divisional Review meetings as required.	Ultrasound and MRI) by end July (now achieved) and Echo by the end of November (revised from September).

Domain	Action number	Action	Timescale	Assurance	Improvement trajectory
Effective					
Fracture neck of femur Best Practice Tariff (BPT)	12A	Live flow tracker in situ across Division from June to increase visibility and support escalation standards.	Ready to trial in February with full implementation in June 2016 (deadline revised again from April 2016 to October 2016)	Inclusion of three new fields to include all trauma patients waiting without a plan, all fractured Neck of Femur (NOF) patients waiting, and all fractured NOF patients over 24 hours. IM&T needs to build a new system in order to be able to retrieve this information into the live tracker. Deadline slipped. Ongoing project in IM&T.	Improve in overall fractured neck of femur pathway
	12B	Build and submit case for middle grade medical ortho-geriatric support (1.0 WTE 1-year fixed term with focus on quality/pathway work relating to Fractured Neck of Femur). This will enable consistent and regular ortho-geriatric cover across orthopaedic wards, and avoid breaches due to annual leave etc.	September 2016	Successful funding bid and subsequent recruitment to post.	Being worked up – but expected to be influenced by the recommendations in the final BOA report. Agreement to fund has been provided by the Division of Surgery.
	12C	Build and submit case for specialist acute fracture nurse support (Band 6 permanent).	April 2017	Successful funding bid and subsequent recruitment to post.	Being worked up – but expected to be influenced by the recommendations in the final BOA report. Expected to form part of investment proposal for the 2017/18 operating plan.

Domain	Action number	Action	Timescale	Assurance	Improvement trajectory
	12D	Review the ward structure to see whether separate wards with protected beds and capacity for fractured neck of femurs will allow additional focus to meet patient's needs	April 2017	Focussed care consolidated in each ward, suitable to meet the patients' needs. Improved recruitment and retention of ward staff.	Proposals have been submitted to split the wards into one elderly trauma and fractured neck of femur ward (A604), and one young trauma and elective ward (A602). Awaiting full feedback, but the initial reaction was positive.
	12E	Review and make the case to increase physiotherapy services to support fractured neck of femurs patients on the trauma and orthopaedic wards across seven days	April 2017	Earlier physiotherapy and nutritional support, earlier mobilisation and better chest management.	Proposals being worked up with Division of D&T, and have been submitted as an ICP for 2017/18 contract.
Outlier bed-days	13A	Ward processes to increase early utilisation of discharge lounge to facilitate patients from Acute Medical Unit getting into the correct speciality at point of first transfer.	Ongoing	Oversight in Ward Processes Project Group	Linked to increased and timely use of discharge lounge

Domain	Action number	Action	Timescale	Assurance	Improvement trajectory
Efficient					
Agency Usage	14	Corporate actions to directly target agency expenditure (in addition to sickness absence, recruitment and turnover actions – see section 14,15 and 16) are detailed below:		Nursing agency: oversight by Savings Board through its sub group (Nursing Controls Cost Improvement Group). Medical agency: oversight through the Medical Efficiencies Group.	An annual workforce KPI of 1.1% for agency as a percentage of total staffing was agreed through the operating planning process. Divisional Performance against plan is monitored at monthly and quarterly Divisional Performance reviews.
		Effective rostering: Ensuring annual/study leave, and sickness absence are planned and monitored appropriately. Actions include:			

		• "Allocate" implementation will provide:
		  • Acuity and dependency to match staffing with demand.
		  • Improved rostering and booking functionality for both ward managers and staff
		  • Robust management information
			Pilot November 2016, go live April 2017		

		• Pending the new rostering system, a staffing dashboard is in place	June 2016 to April 2017		
		Controls: • Robust Escalation policy with clear sign off process	Ongoing		

Domain	Action number	Action	Timescale	Assurance	Improvement trajectory
		• Operating plan agency trajectories monitored and tracked through divisional reviews	Monthly and quarterly reviews		
		Enhancing bank provision: • External marketing drive • Internal communications (messages in payslips/contacting inactive bank workers) • Bank incentive payment under review	November 2016		
Sickness Absence	15	**A dedicated lead**: To develop a sickness absence management plan: • Reviewing current strategies and develop impact assessment measures; • Making further recommendations, supported by an action plan. Current actions include:	Recommendations approved by Senior Leadership Team in September 2016, action plan to follow.	Oversight by Workforce and Organisational Development (OD) Group via the Staff Health and Well Being Sub Group	A KPI for 2016/17 of 3.9% has been set through the operating planning process.
		Pilot of self-certification for absences of 1-3 days: Targets the 11% of sickness which is for 3 days or less, and ensuring timely return to work interviews are undertaken.	To be spot audited in Q2 16/17		

Domain	Action number	Action	Timescale	Assurance	Improvement trajectory
		Supporting Attendance Policy: • Audit Action plan to be implemented; • Full review of policy including simplifying content/ structure, sign-posting and tools to assess attendance.	September 2016 to March 2017 January 2017		
		Training for managers: Training review complete to ensure training meets the needs of managers and achieves improved competence/confidence	To commence January 2017		
		Resource allocation: Ensuring that the Employee Services resource is focussed appropriately and targeted at areas of greatest need.	Ongoing		
		Supporting Attendance Surgeries: Process to be reviewed as part of policy review in Q2. To support managers to expedite cases where possible	Ongoing		
		Musculo-skeletal: As a significant cause of absence, targeted actions include continued interventions by Occupational Health Musculo-skeletal services, Physio direct, and Manual Handling Team	Ongoing		

Domain	Action number	Action	Timescale	Assurance	Improvement trajectory
		Staff Health and Well Being: Annual action plan, including the following: • Free on site health checks - target of reaching 2000 staff; • Combined back care week and staff health and wellbeing week.	January 2016 to January 2018 October 2016		
		Flu Vaccination: A communications plan has been launched and Costa/ Deli Marche in BRI and SBCH are funding a free drinks voucher for all staff who have been vaccinated by the 100+ vaccinators in UH Bristol. 2770 were vaccinated in the first two weeks of the campaign, converting to 42% reportable staff compared with 75% CQIN target.	Campaign October 2016 to February 2017		
		Staff Health and Well Being CQUIN: Implementation plan has been developed, focussed on improving health and wellbeing. Three posts to assist in delivery of CQUIN recruited - a physiotherapist, Associate Counsellor and Administrative and Clerical support.	October 2017 (Peer review Bristol Clinical Commissioning Group) Funded until March 2017	CQUIN short term working group	
Vacancies	16	Recruitment action plan includes		Workforce and OD Group	Detailed trajectories are in

Domain	Action number	Action	Timescale	Assurance	Improvement trajectory
		the following activities.		/Recruitment Sub Group.	place for key recruitment hotspots, including theatres; critical care, haematology and ancillary staff
		Marketing and advertising: • Divisional Performance and Operations Meetings monitor performance against operating plan requirements and ongoing vacancies.	Review quarterly		
		• A new nursing recruitment website as part of the Nurse Marketing Strategy is being developed. This includes videos of staff promoting working at UH Bristol. Similar approaches are being developed with radiography and sonography. • An overview of the impact of the Marketing Plan on vacancies will be provided to Trust Board	November 2016 October 2016	Divisional Performance and Operational Reviews	
		Service level agreements and KPIs for recruitment have been developed to measure performance against the agreed KPI of 45 days, tracked through divisional reviews. Performance can now also be measured at specialty level.	Reviewed quarterly		

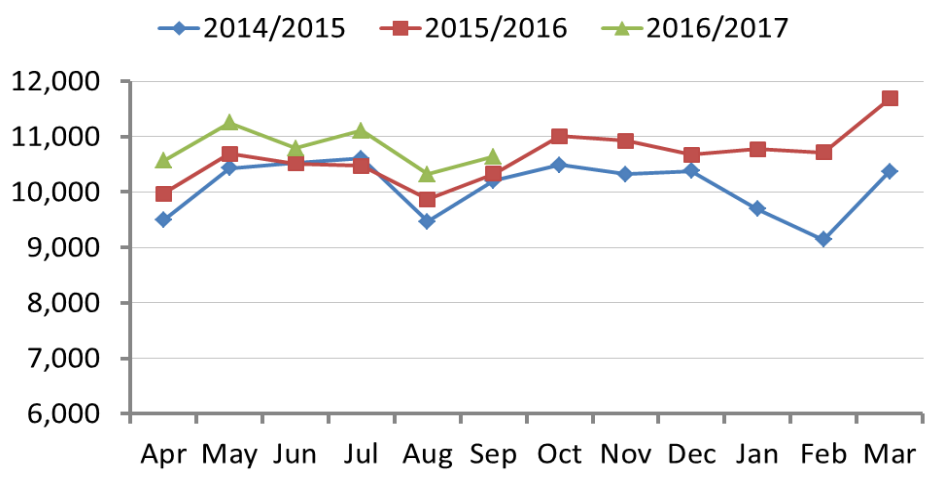
Domain	Action number	Action	Timescale	Assurance	Improvement trajectory
		Support for recruitment and retention initiatives in specialist areas - Heygroves Theatres, Ward D703 and CICU. Trajectories are shown in appendix 3.	Reviewed monthly		
Turnover	17	Key corporate and divisional actions include the following:	January 2017	Workforce and OD Group	The KPI for 2016/17 has been set at 12.1%.
		Complete review of appraisal: To improve their quality and application, in response to feedback from the staff survey 2014, including: • Revised policy, in conjunction with staff side; • E-Appraisal, working with our Learning and Development portal supplier; • Engaging staff through feedback sessions.			
		Targeted leadership and management development programme: Includes Healthcare Leadership Model training and Learning and Leading Together - target of 800 managers trained annually was met for 2015.	Second cohort of Leadership for supervisors will commence in October following a review of the first cohort	Transformation Board	

Domain	Action number	Action	Timescale	Assurance	Improvement trajectory
		Team building and local decision making: Work with Aston Organisational Development to develop team coaches, taking teams through a programme of work-based activities. Findings from the pilot will be evaluated to inform future roll-out.	October 2016 (Diagnostic and Therapies pilot Divisional Board) Evaluation in January 2017		
		Staff experience workshops: Divisions have incorporated actions with detailed milestones into their operating plans.	November 2015 - March 2017	Divisional Boards/ Senior Leadership Team/Workforce and OD Group.	
		Transformational Engagement and retention: A short life working group established to develop high impact projects to improve staff experience and improve retention in response to 2015 Staff Survey. The Group drafted plans for workshops during the autumn across the Trust to identify and develop expected behaviours of our leaders.	Paper being presented to Senior Leadership Team in October Workshops planned for December 2016 to January 2017.	Senior Leadership Team/Board	
		Staff Survey: Staff survey distributed in September. Results will be available in March/April.	March/April 2017	Workforce and OD 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.

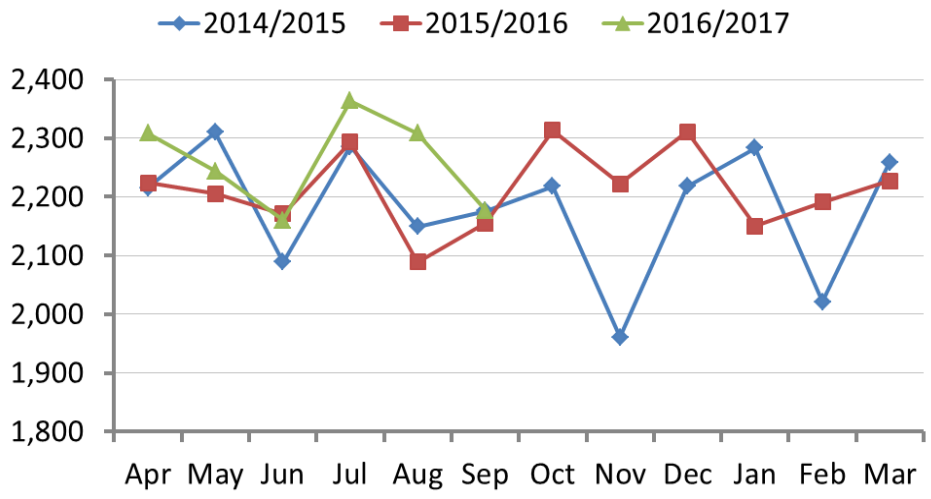
Emergency Department (ED) attendances



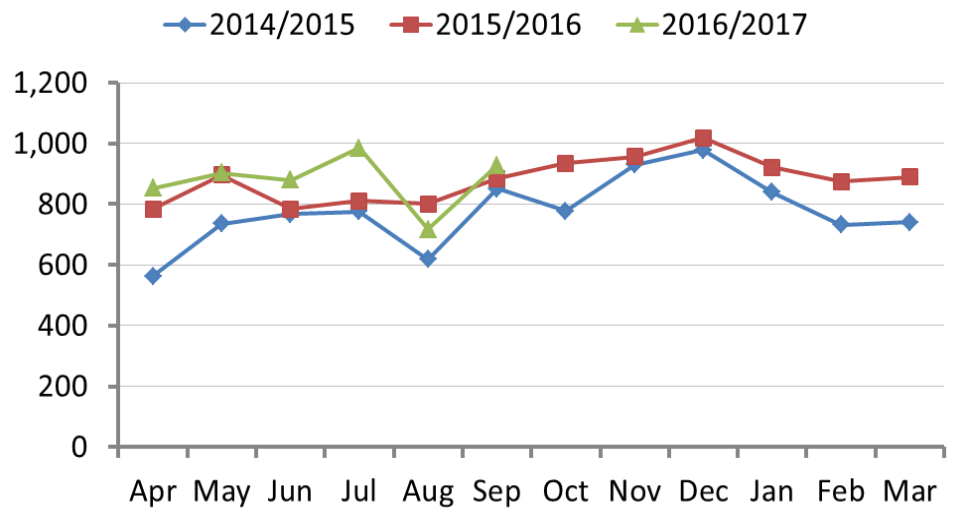
Summary points:

- Emergency attendances remain slightly above the same period last year; emergency admissions into the BRI have returned to the seasonal norms, with BCH levels being slightly above (see the A&E 4-hour report);
- The number of new outpatient attendances increased up to the level of the seasonal norm, with the outpatient waiting list no longer rising as a result of demand now being met (i.e. additions and removals from the list being in balance);
- The number of elective admissions remained at a similar level to August, but at the seasonal norm; however, as will be seen from the Assurance section, the number of patients on the elective waiting list has continued to decrease, despite elective activity remaining flat and the number of outpatients being seen for their new outpatient appointment having increased significantly.

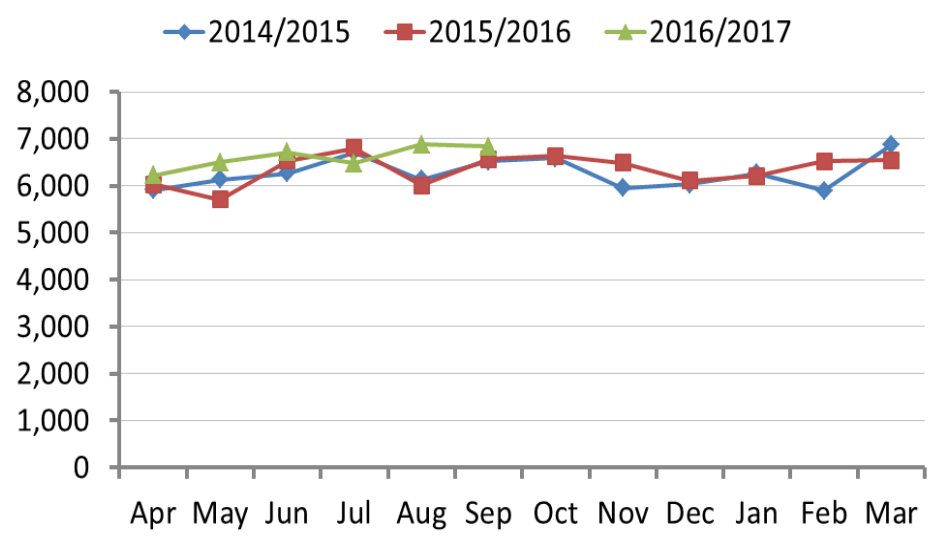
Emergency admissions (BRI)



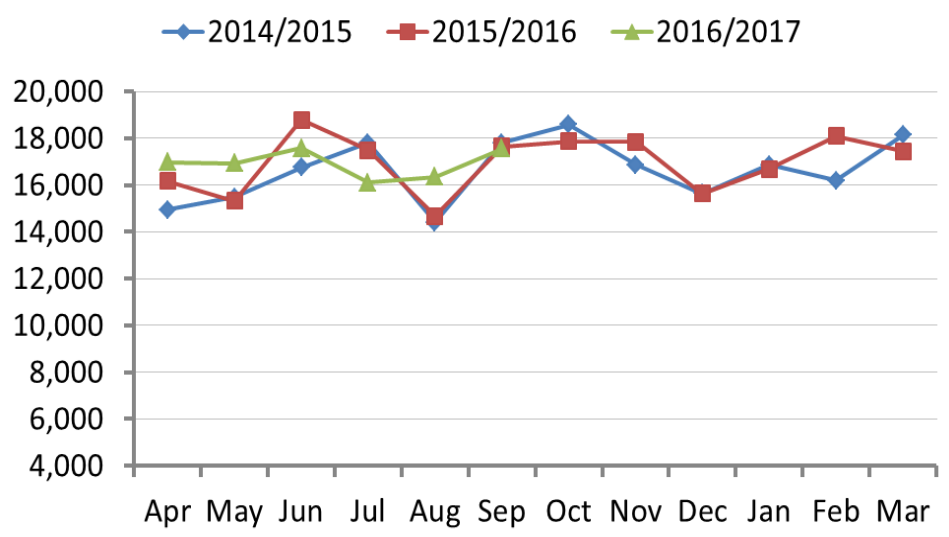
Emergency admissions (BCH)



Elective admissions



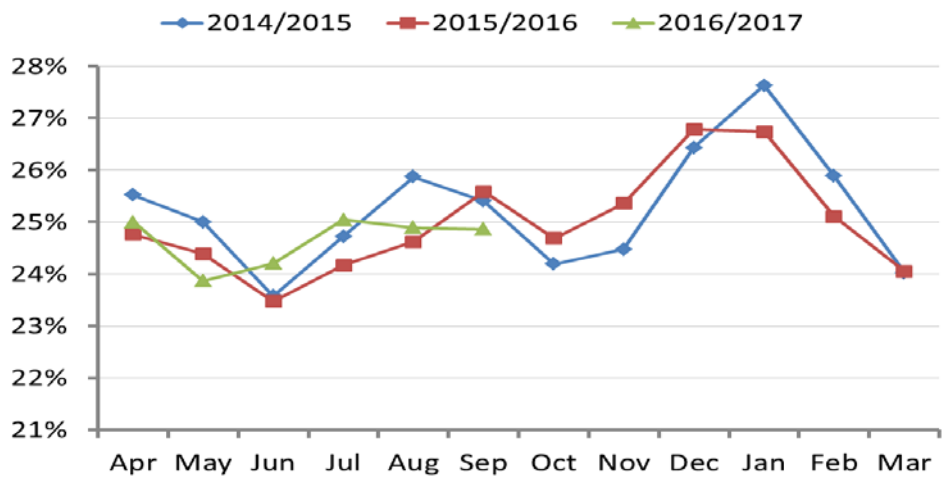
New outpatient attendances



Assurance and Leading Indicators

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

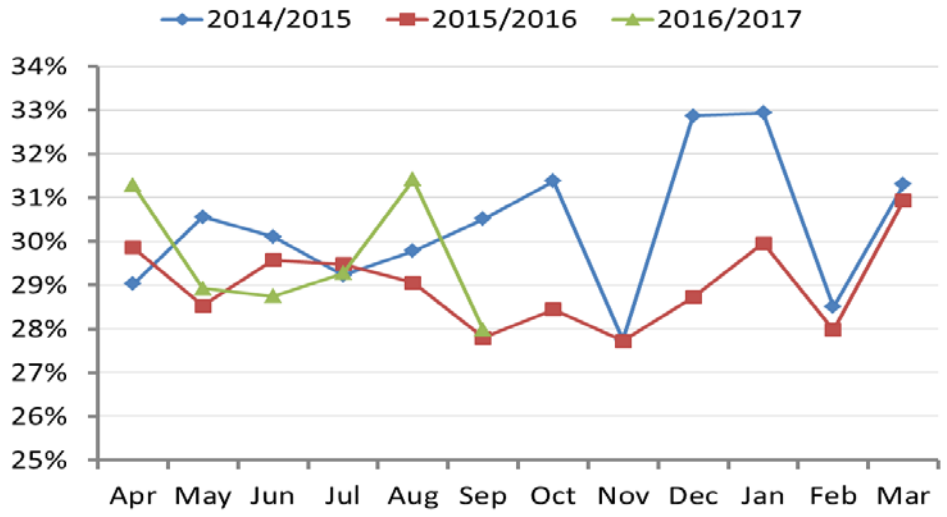
Percentage ED attendances resulting in admission



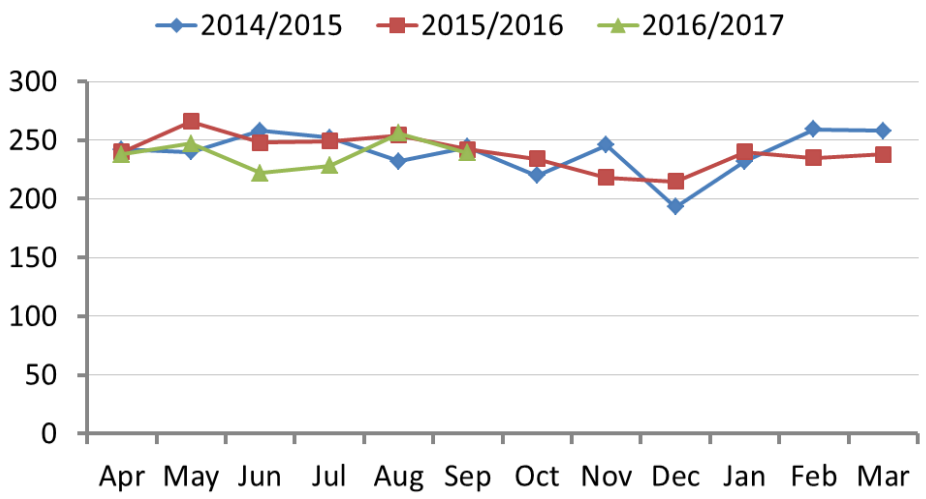
Summary points:

- The percentage of patients arriving in our Emergency Departments and converting to an admission was below the same period last year; however, the percentage of patients admitted aged 75 years and over has returned to the seasonal norm;
- The number of delayed discharges was similar to last year's level, but BRI bed occupancy has increased;
- The number of patients on the outpatient waiting list has decreased for the first time in five months; consistent with this and the higher number of RTT clock stops, the number of patients on non-admitted pathways waiting over 18 weeks RTT decreased slightly (see Appendix 3);
- The number of patients being referred by their GP with a suspected cancer (2-week waits) is significantly above the same period last year; 62-day GP cancer treatments have risen, as expected, following the higher levels of 2-week wait referrals in quarter 1.

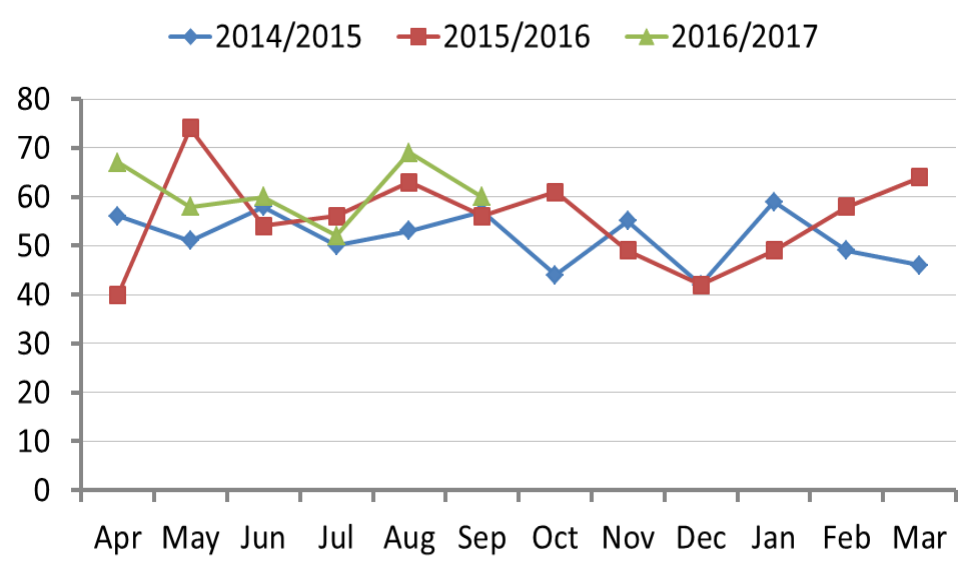
Percentage of Emergency BRI spells patients aged 75 years and over



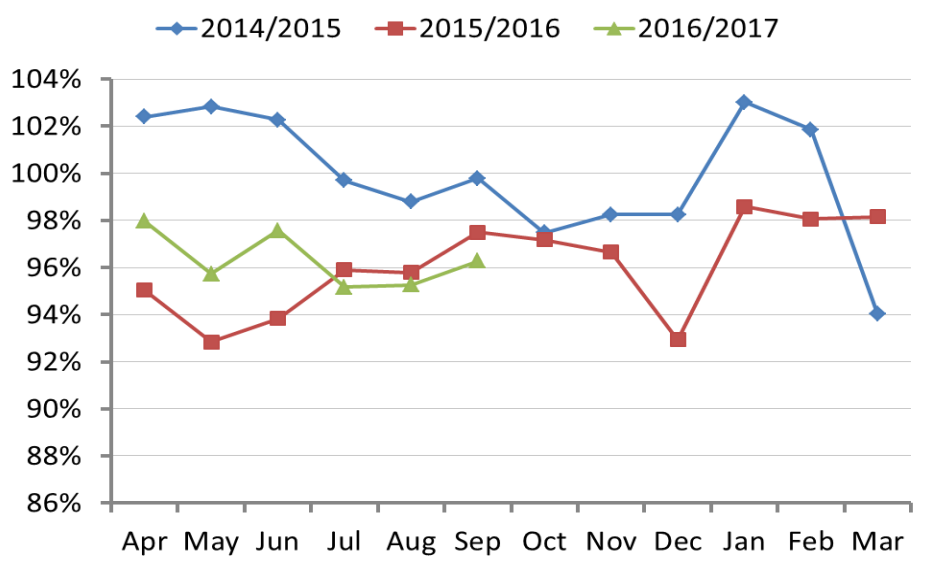
Over 14 day stays



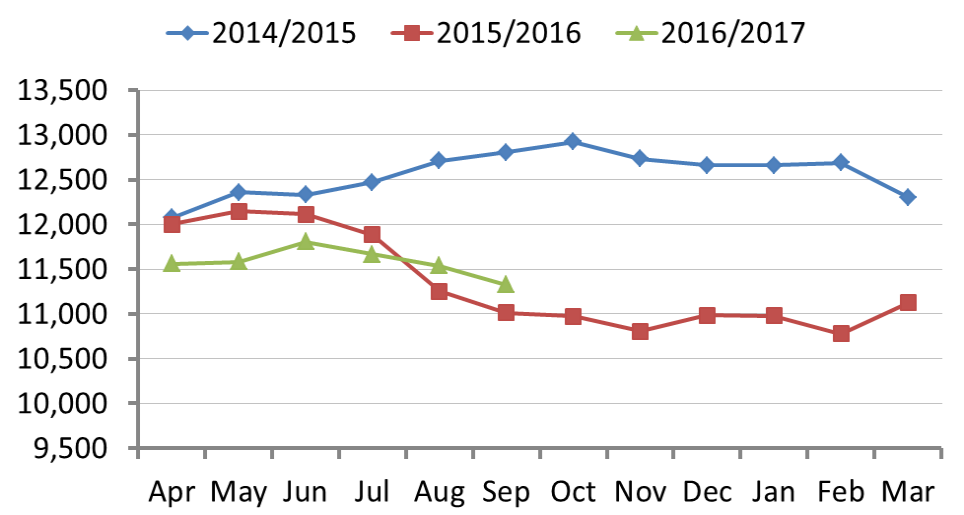
Delayed discharges (Green to Go)



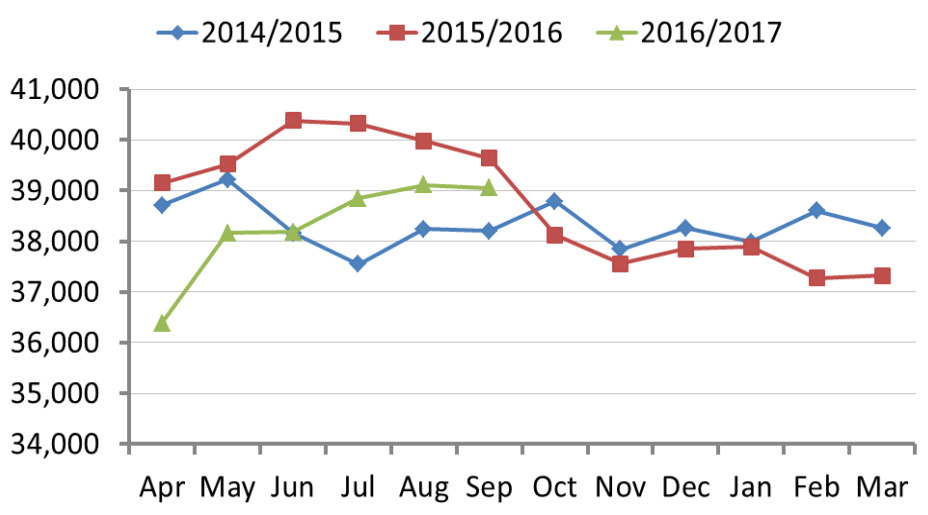
BRI Bed Occupancy



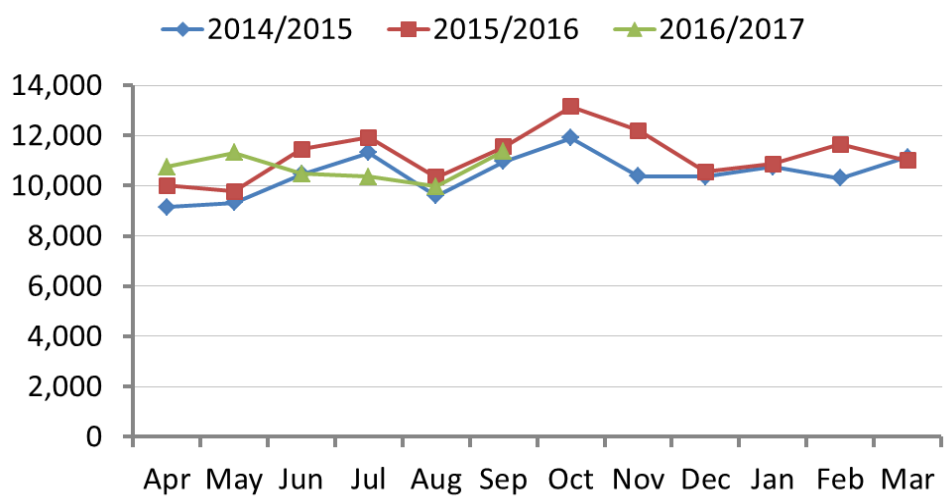
Elective waiting list size



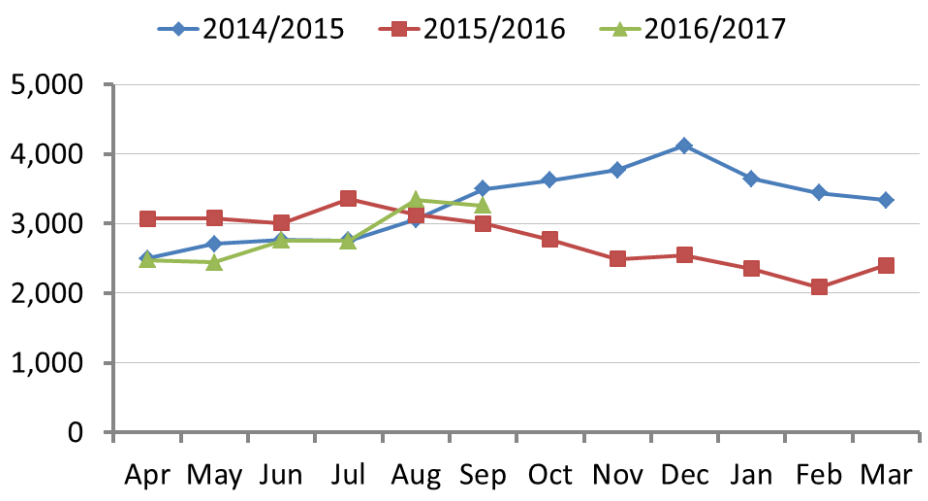
Outpatient waiting list size



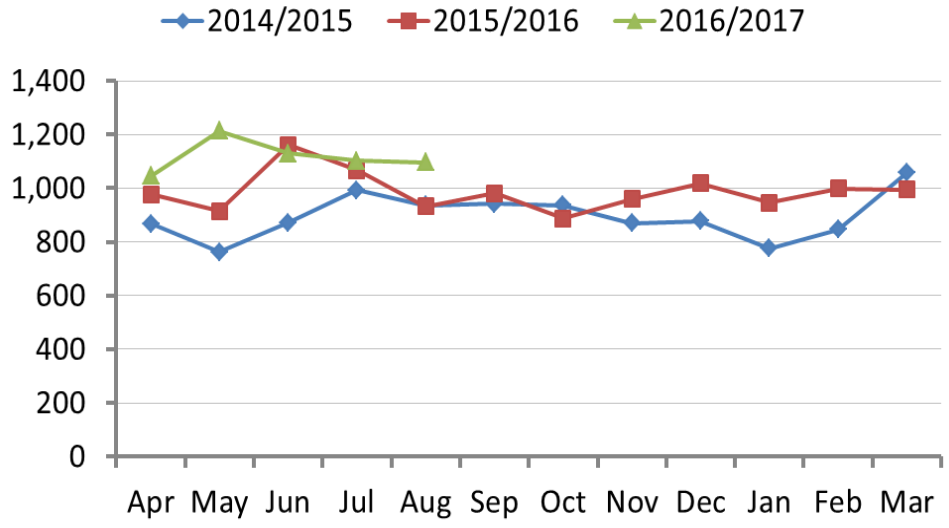
Number of RTT pathways stopped (i.e. treatments)



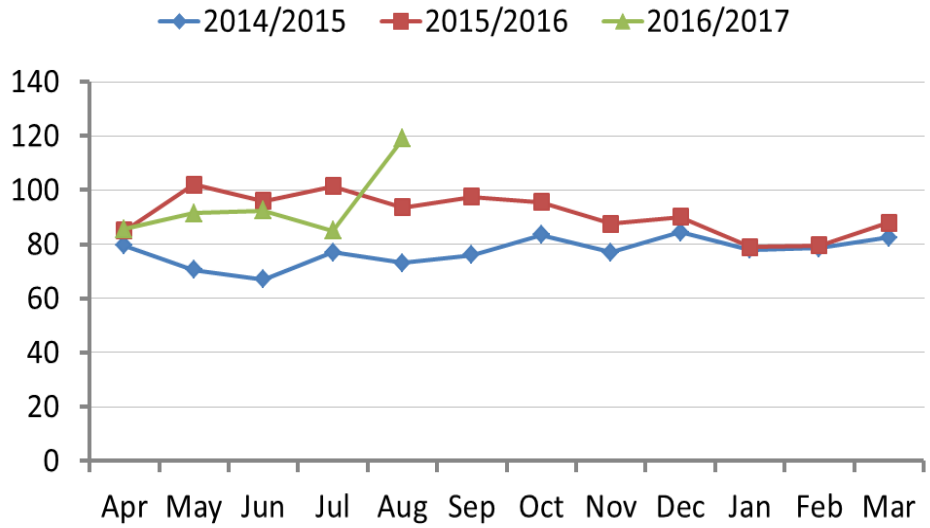
Number of RTT pathways over 18 weeks



Cancer 2-week wait – urgent GP – referrals seen



Cancer 62-day GP referred treatments



Trust Scorecards

SAFE, CARING & EFFECTIVE

Topic	ID	Title	Annual 15/16	Annual 16/17 YTD	Monthly Totals Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Quarterly Totals 15/16 Q3	15/16 Q4	16/17 Q1	16/17 Q2
Patient Safety																				
Infections	DA01a	MRSA Bloodstream Cases - Cumulative Totals	-	-	3	3	3	3	3	3	0	0	0	0	0	0	-	-	-	-
	DA01	MRSA Bloodstream Cases - Monthly Totals	3	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	DA03	C.Diff Cases - Monthly Totals	40	18	5	3	6	4	2	4	2	5	1	3	2	5	14	10	8	10
	DA02	MSSA Cases - Monthly Totals	26	21	3	2	2	2	1	0	2	3	3	7	4	2	7	3	8	13
C.Diff "Avoidables"	DA03c	C.Diff Avoidable Cases - Cumulative Totals	-	-	7	7	9	12	14	17	0	1	2	3	4	-	-	-	-	-
Infection Checklists	DB01	Hand Hygiene Audit Compliance	97.3%	97%	95.8%	98.1%	98.1%	96.4%	97.7%	96.8%	96.6%	97.3%	98%	96.9%	98.4%	94.9%	97.3%	97%	97.3%	96.8%
	DB02	Antibiotic Compliance	87.6%	86.2%	85.7%	86%	90.6%	86.5%	88.2%	86.1%	84.4%	85.3%	83.9%	88.2%	86.5%	86.8%	87.2%	86.9%	84.5%	87.4%
Cleanliness Monitoring	DC01	Cleanliness Monitoring - Overall Score	-	-	93%	94%	94%	94%	95%	94%	95%	95%	95%	96%	97%	95%	-	-	-	-
	DC02	Cleanliness Monitoring - Very High Risk Areas	-	-	96%	97%	97%	97%	98%	98%	98%	98%	98%	98%	98%	98%	-	-	-	-
	DC03	Cleanliness Monitoring - High Risk Areas	-	-	95%	95%	95%	95%	96%	95%	96%	96%	96%	96%	97%	97%	-	-	-	-
Serious Incidents	S02	Number of Serious Incidents Reported	69	28	4	9	5	6	4	10	3	8	2	6	8	1	18	20	13	15
	S02a	Number of Confirmed Serious Incidents	55	12	4	8	4	5	4	5	3	7	1	1	-	-	16	14	11	1
	S02b	Number of Serious Incidents Still Open	5	14	0	1	1	1	0	0	0	1	1	4	7	1	2	1	2	12
	S03	Serious Incidents Reported Within 48 Hours	84.1%	89.3%	100%	44.4%	100%	100%	100%	100%	66.7%	100%	100%	83.3%	87.5%	100%	72.2%	100%	92.3%	86.7%
	S03a	Serious Incidents - 72 Hour Report Completed Within Timescale	-	92.9%	-	-	-	-	-	-	66.7%	100%	100%	100%	87.5%	100%	-	-	92.3%	93.3%
	S04	Percentage of Serious Incident Investigations Completed Within Timescale	74.1%	100%	85.7%	66.7%	60%	60%	63.6%	100%	100%	100%	100%	100%	100%	100%	72.2%	66.7%	100%	100%
Never Events	S01	Total Never Events	3	1	0	1	1	0	0	0	0	0	0	1	0	0	2	0	0	1
Patient Safety Incidents	S06	Number of Patient Safety Incidents Reported	13787	5931	1142	1149	1167	1190	1196	1226	1145	1216	1258	1173	1139	-	3458	3612	3619	2312
	S06b	Patient Safety Incidents Per 1000 Beddays	44.72	46.19	43.98	45.34	46.17	44.59	48.19	46.64	44.93	46.85	49.96	45.02	44.27	-	45.15	46.43	47.23	44.64
	S07	Number of Patient Safety Incidents - Severe Harm	97	39	13	8	15	5	6	3	2	8	9	10	10	-	36	14	19	20
Patient Falls	AB01	Falls Per 1,000 Beddays	3.94	4.25	3.54	3.79	4.15	3.56	3.59	4.15	4.24	3.93	4.57	4.57	3.81	4.38	3.83	3.77	4.24	4.25
	AB06a	Total Number of Patient Falls Resulting in Harm	30	17	4	3	5	2	3	5	1	4	3	3	3	3	12	10	8	9
Pressure Ulcers Developed in the Trust	DE01	Pressure Ulcers Per 1,000 Beddays	0.221	0.15	0.193	0.079	0.158	0.15	0.242	0.114	0.275	0.154	0.04	0.077	0.194	0.159	0.144	0.167	0.157	0.143
	DE02	Pressure Ulcers - Grade 2	61	22	4	2	4	3	6	3	7	3	1	2	5	4	10	12	11	11
	DE03	Pressure Ulcers - Grade 3	7	1	1	0	0	1	0	0	0	1	0	0	0	0	1	1	1	0
	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	98.2%	99.1%	98.4%	98.1%	97.4%	97.1%	95.6%	96.9%	99.3%	99.1%	99%	99.1%	99.1%	99%	98%	96.5%	99.2%	99.1%
	N02	Percentage of Adult Inpatients who Received Thrombo-prophylaxis	94.6%	95.8%	94%	93.5%	94%	93.6%	96%	94.5%	94.8%	96.3%	96.6%	97.3%	95.7%	94.1%	93.9%	94.7%	95.8%	95.8%
Nutrition	WB03	Nutrition: 72 Hour Food Chart Review	90.4%	89%	91.5%	91.6%	93.2%	90.4%	89.9%	91.4%	83.6%	94%	86.3%	89.4%	89.8%	89.7%	92.1%	90.6%	88.5%	89.6%
Nutrition Audit	WB10	Fully and Accurately Completed Screening within 24 Hours	-	84.5%	-	-	-	-	-	-	-	-	80.8%	-	-	88%	-	-	80.8%	88%
Safety	Y01	WHO Surgical Checklist Compliance	99.9%	99.7%	100%	99.8%	100%	99.9%	99.9%	100%	99.8%	100%	98.9%	99.6%	99.9%	100%	99.9%	99.9%	99.6%	99.9%

SAFE, CARING & EFFECTIVE (continued)

Topic	ID	Title	Annual 15/16	Annual 16/17 YTD	Monthly Totals Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Quarterly Totals 15/16 Q3	15/16 Q4	16/17 Q1	16/17 Q2
Patient Safety																				
Medicines	WA01	Medication Incidents Resulting in Harm	0.8%	0.2%	0%	1.39%	1.2%	1.28%	0.42%	0.41%	0%	0.51%	0%	0.55%	0%	-	0.91%	0.7%	0.16%	0.26%
	WA03	Non-Purposeful Omitted Doses of the Listed Critical Medication	0.87%	0.55%	0.78%	0.62%	1.03%	1.49%	0.66%	0.69%	0.93%	0.63%	0.56%	0.6%	0.38%	0%	0.8%	0.92%	0.73%	0.33%
Safety Thermometer	AK03	Safety Thermometer - Harm Free Care	97.1%	98.1%	97.3%	95.9%	97.9%	97.2%	96.7%	97.3%	97.1%	97.7%	98.3%	98.4%	98.6%	98.6%	97.1%	97.1%	97.7%	98.6%
	AK04	Safety Thermometer - No New Harms	98.6%	99%	98.9%	97.9%	99.1%	98.8%	98.9%	99.4%	98.9%	98.7%	98.7%	99.2%	99.2%	99.2%	98.6%	99%	98.8%	99.2%
Deteriorating Patient	AR03	National Early Warning Scores (NEWS) Acted Upon	90%	90%	92%	91%	90%	86%	86%	88%	87%	100%	79%	82%	95%	94%	91%	86%	89%	90%
Out of Hours	TD05	Out of Hours Departures	10.7%	7.8%	13%	11.1%	9.6%	11%	9.6%	9.6%	8.1%	7.5%	7.2%	7.8%	8.7%	7.3%	11.2%	10.1%	7.6%	7.9%
Timely Discharges	TD03	Percentage of Patients With Timely Discharge (7am-12Noon)	20.3%	22.5%	19.1%	19.2%	22.1%	21.9%	22.3%	23.3%	23%	22.3%	23.4%	23.1%	21.1%	22.3%	20.2%	22.5%	22.9%	22.2%
	TD03D	Number of Patients With Timely Discharge (7am-12Noon)	10444	5769	856	836	1002	911	926	990	971	952	991	1007	909	939	2694	2827	2914	2855
Staffing Levels	RP01	Staffing Fill Rate - Combined	103.1%	103.4%	105.8%	104.8%	104.8%	105.9%	103.2%	103.1%	104.7%	104%	103.1%	104.3%	102.7%	101.9%	105.1%	104.1%	103.9%	103%
Clinical Effectiveness																				
Mortality	X04	Summary Hospital Mortality Indicator (SHMI) - National Data	97.7	-	-	-	97.7	-	-	98.7	-	-	-	-	-	-	97.7	98.7	-	-
	X02	Hospital Standardised Mortality Ratio (HSMR)	90	80.4	95.3	95.4	76.4	97.7	97	95.9	79.4	80.8	81.2	-	-	-	88.7	96.8	80.4	-
Readmissions	C01	Emergency Readmissions Percentage	2.74%	1.75%	2.83%	2.82%	2.87%	2.67%	2.66%	1.5%	1.74%	1.56%	1.7%	1.76%	2%	-	2.84%	2.27%	1.67%	1.88%
Maternity	G04	Percentage of Spontaneous Vaginal Deliveries	62.1%	61.1%	61.3%	63.9%	63.4%	62.7%	60.1%	62.5%	66.6%	61%	56.4%	62%	61.5%	59.6%	62.9%	61.8%	61.2%	61%
Fracture Neck of Femur	U02	Fracture Neck of Femur Patients Treated Within 36 Hours	75.9%	70.9%	80.8%	76.5%	66.7%	76%	78.6%	80%	87.5%	74.1%	72%	73.5%	61.3%	58.3%	74%	78.2%	77.6%	65.2%
	U03	Fracture Neck of Femur Patients Seeing Orthogeriatrician within 72 Hours	82.5%	73.3%	92.3%	94.1%	86.7%	80%	78.6%	84%	83.3%	81.5%	72%	79.4%	64.5%	58.3%	90.4%	80.8%	78.9%	68.5%
	U04	Fracture Neck of Femur Patients Achieving Best Practice Tariff	63.5%	49.7%	73.1%	70.6%	60%	60%	64.3%	68%	70.8%	59.3%	44%	52.9%	35.5%	37.5%	67.1%	64.1%	57.9%	42.7%
	U05	Fracture Neck of Femur - Time To Treatment 90th Percentile (Hours)	-	-	42.4	44.4	44.8	50.2	47.5	40.5	35.8	61.4	44.1	44.4	72.2	53.5	-	-	-	-
Stroke Care	O01	Stroke Care: Percentage Receiving Brain Imaging Within 1 Hour	61.5%	63.2%	57.5%	59.5%	56.8%	62.5%	77.4%	60.6%	69.2%	67.6%	65.9%	59%	51.4%	-	57.9%	66.1%	67.7%	55.4%
	O02	Stroke Care: Percentage Spending 90%+ Time On Stroke Unit	93.5%	89.7%	90.2%	91.9%	91.9%	91.7%	96.8%	84.8%	88.5%	88.2%	93.2%	92.3%	85.7%	-	91.3%	91.1%	90%	89.2%
	O03	High Risk TIA Patients Starting Treatment Within 24 Hours	66.4%	70.7%	54.5%	62.5%	47.1%	71.4%	80%	80%	58.3%	68.8%	61.5%	76.5%	71.4%	80%	52.8%	77.3%	63.4%	76.5%
Dementia	AC01	Dementia - FAIR Question 1 - Case Finding Applied	91.6%	95.4%	97.6%	97.2%	95%	93.4%	94.7%	96.7%	94.5%	95.8%	94.1%	98%	96.3%	93.2%	96.6%	94.9%	94.8%	96%
	AC02	Dementia - FAIR Question 2 - Appropriately Assessed	95.8%	98%	98.4%	96.9%	98.4%	95.7%	96.3%	96.8%	96.8%	97.8%	98.1%	98.1%	97.8%	100%	97.9%	96.2%	97.5%	98.6%
	AC03	Dementia - FAIR Question 3 - Referred for Follow Up	92.3%	95.9%	100%	83.3%	100%	100%	100%	100%	95.2%	100%	100%	100%	100%	85.7%	91.3%	100%	97.2%	92.3%
	AC04	Percentage of Dementia Carers Feeling Supported	88.3%	75%	100%	72.7%	72.7%	-	93.8%	100%	75%	-	-	-	-	-	84.2%	96.2%	75%	-
Outliers	J05	Ward Outliers - Beddays Spent Outlying.	9651	3941	661	548	712	1232	805	1073	930	589	745	600	616	461	1921	3110	2264	1677

SAFE, CARING & EFFECTIVE (continued)

Topic	ID	Title	Annual		Monthly Totals												Quarterly Totals			
			15/16	16/17 YTD	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	15/16 Q3	15/16 Q4	16/17 Q1	16/17 Q2
Patient Experience																				
Monthly Patient Surveys	P01d	Patient Survey - Patient Experience Tracker Score	-	-	90	90	91	90	90	89	92	92	90	91	92	91	90	90	91	91
	P01g	Patient Survey - Kindness and Understanding	-	-	94	95	94	95	94	93	96	96	94	93	96	96	94	94	95	95
	P01h	Patient Survey - Outpatient Tracker Score	-	-	88	88	89	89	89	89	88	90	90	90	90	89	88	89	89	90
Friends and Family Test Coverage	P03a	Friends and Family Test Inpatient Coverage	19.5%	37.2%	19.3%	20.4%	20.6%	21.9%	22%	26.3%	35.2%	42.4%	40.5%	36.5%	36.8%	31.8%	20.1%	23.3%	39.4%	35%
	P03b	Friends and Family Test ED Coverage	13%	14.7%	15.9%	16.4%	13.9%	15.8%	16.7%	12.3%	14.8%	13.5%	15.5%	12%	16.8%	15.5%	15.4%	14.9%	14.6%	14.7%
	P03c	Friends and Family Test MAT Coverage	22.7%	21.2%	25.3%	20.2%	20.3%	15.7%	24%	33.7%	16.2%	26.3%	19%	24.4%	20.4%	21.1%	21.8%	24.3%	20.5%	21.9%
Friends and Family Test Score	P04a	Friends and Family Test Score - Inpatients	96.3%	96.7%	96.2%	96.5%	95.6%	96.7%	96.1%	95.9%	97.1%	95.8%	97.2%	95.9%	97.4%	96.9%	96.1%	96.2%	96.6%	96.7%
	P04b	Friends and Family Test Score - ED	75.4%	77.3%	72.2%	76.2%	80%	77.7%	73.7%	71.5%	80.2%	78.1%	74.4%	71.8%	79.6%	78.6%	75.9%	74.4%	77.5%	77.1%
	P04c	Friends and Family Test Score - Maternity	96.6%	97.1%	98.2%	96.9%	97.7%	94.9%	97.6%	95.8%	96.6%	98.9%	95.5%	96.2%	97.8%	97.3%	97.6%	96.2%	97.2%	97%
Patient Complaints	T01	Number of Patient Complaints	1941	1037	182	148	116	143	183	150	176	146	198	200	155	162	446	476	520	517
	T01a	Patient Complaints as a Proportion of Activity	0.252%	0.264%	0.267%	0.219%	0.19%	0.225%	0.268%	0.221%	0.272%	0.218%	0.296%	0.315%	0.246%	0.24%	0.227%	0.238%	0.262%	0.266%
	T03a	Complaints Responded To Within Trust Timeframe	75.2%	81.9%	60.7%	59.5%	50.8%	68.1%	71.8%	86.1%	81.6%	73.1%	73.8%	86.8%	90.6%	86%	56.5%	74.6%	76.2%	88.1%
	T03b	Complaints Responded To Within Divisional Timeframe	91.3%	90.3%	80.4%	81%	90.5%	91.5%	84.6%	100%	87.8%	92.3%	95.2%	89.5%	94.3%	81.4%	84.5%	91.8%	91.6%	88.8%
	T04c	Percentage of Responses where Complainant is Dissatisfied	6.15%	11.05%	8.93%	4.76%	6.35%	2.13%	7.69%	8.33%	8.16%	9.62%	16.67%	10.53%	-	-	6.83%	5.74%	11.19%	10.53%
Cancelled Operations	F01q	Percentage of Last Minute Cancelled Operations (Quality Objective)	1.03%	0.84%	0.64%	0.86%	0.7%	1.2%	1.21%	1.84%	1.08%	0.96%	0.96%	1.03%	0.46%	0.6%	0.73%	1.42%	1%	0.69%
	F01a	Number of Last Minute Cancelled Operations	713	315	40	51	39	68	71	108	63	59	61	63	30	39	130	247	183	132

RESPONSIVE

Topic	ID	Title	Annual Target Green	Annual Target Red	Annual 15/16	Annual 16/17 YTD	Monthly Totals Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Quarterly Totals 15/16 Q3	15/16 Q4	16/17 Q1	16/17 Q2
Referral to Treatment (RTT) Performance	A03	Referral To Treatment Ongoing Pathways Under 18 Weeks	92%	92%	91.3%	91.6%	91.1%	92%	91.8%	92.4%	93.2%	92.2%	92.3%	92.6%	92.1%	92%	90.5%	90.4%	91.6%	92.6%	92.3%	91%
	A03a	Referral To Treatment Number of Ongoing Pathways Over 18 Weeks	-	-	-	-	2772	2491	2544	2349	2083	2397	2480	2442	2753	2749	3344	3256	-	-	-	-
Referral to Treatment (RTT) Wait Times	A06	Referral To Treatment Ongoing Pathways Over 52 Weeks	0	1	8	1	0	0	0	2	0	0	0	0	0	0	0	1	0	2	0	1
	A07	Referral To Treatment Ongoing Pathways 40+ Weeks	-	-	471	147	25	22	15	15	14	26	24	22	14	27	33	27	62	55	60	87
	A09	Referral To Treatment Ongoing Pathways 35+ Weeks	-	-	1738	654	96	81	86	75	68	77	80	80	85	117	113	179	263	220	245	409
Cancer (2 Week Wait)	E01a	Cancer - Urgent Referrals Seen In Under 2 Weeks	93%	93%	95.9%	94.4%	97.5%	95.8%	94.8%	93.7%	98%	96.6%	94.5%	94.6%	93.5%	95.3%	93.9%	-	96%	96.1%	94.2%	94.6%
	E01c	Cancer - Urgent Referrals Stretch Target	93%	93%	-	66.9%	-	-	-	-	-	-	64.8%	68%	65.3%	67.9%	68.4%	-	-	-	66.1%	68.2%
Cancer (31 Day)	E02a	Cancer - 31 Day Diagnosis To Treatment (First Treatments)	96%	96%	97.5%	96.1%	98.7%	98.6%	97.8%	98.5%	97%	97.7%	91.5%	96.2%	96.7%	99%	96.8%	-	98.4%	97.8%	94.9%	97.8%
	E02b	Cancer - 31 Day Diagnosis To Treatment (Subsequent - Drug)	98%	98%	98.9%	98%	99.1%	100%	98.9%	96.1%	100%	99%	97.7%	100%	97.3%	97.5%	97.6%	-	99.3%	98.3%	98.3%	97.6%
	E02c	Cancer - 31 Day Diagnosis To Treatment (Subsequent - Surgery)	94%	94%	96.8%	91.7%	97.9%	100%	98%	97.6%	97.9%	95%	80%	94%	97.7%	97.1%	92.2%	-	98.5%	96.9%	90.2%	94.2%
	E02d	Cancer - 31 Day Diagnosis To Treatment (Subsequent - Radiotherapy)	94%	94%	97.1%	97%	96.1%	97.6%	97.4%	97.9%	96.7%	98.6%	97.9%	98.4%	96.8%	96.6%	95.2%	-	97%	97.8%	97.7%	95.9%
Cancer (62 Day)	E03a	Cancer 62 Day Referral To Treatment (Urgent GP Referral)	85%	85%	80.6%	75.7%	79.1%	82.3%	86.7%	84.2%	74.2%	84.7%	77.2%	70.5%	70.8%	72.9%	84.5%	-	82.6%	81.1%	72.7%	79.7%
	E03b	Cancer 62 Day Referral To Treatment (Screenings)	90%	90%	68.6%	51.9%	14.3%	71.4%	50%	50%	60%	70%	41.7%	35.3%	85.7%	66.7%	55.6%	-	51.9%	64.6%	47.2%	61.1%
	E03c	Cancer 62 Day Referral To Treatment (Upgrades)	85%	85%	91.1%	88.7%	93.6%	92.7%	100%	81%	92.9%	100%	75.9%	86.6%	96.9%	90%	91.1%	-	95.7%	92.1%	86.8%	90.5%
Cancelled Operations	F01	Last Minute Cancelled Operations - Percentage of Admissions	0.8%	0.8%	1.03%	0.84%	0.64%	0.86%	0.7%	1.2%	1.21%	1.84%	1.08%	0.96%	0.96%	1.03%	0.46%	0.6%	0.73%	1.42%	1%	0.69%
	F01a	Number of Last Minute Cancelled Operations	-	-	713	315	40	51	39	68	71	108	63	59	61	63	30	39	130	247	183	132
	F02c	Number of LMCs Not Re-admitted Within 28 Days	18	18	76	34	5	3	2	1	6	12	23	2	2	4	3	0	10	19	27	7
Admissions Cancelled Day Before	F07	Percentage of Admissions Cancelled Day Before	-	-	1.28%	1.37%	1.17%	1.67%	1.18%	1.86%	1.36%	1.68%	1.35%	1.82%	1.14%	1.5%	1.12%	1.33%	1.34%	1.63%	1.43%	1.31%
	F07a	Number of Admissions Cancelled Day Before	-	-	887	515	73	99	66	105	80	99	79	112	72	92	73	87	238	284	263	252
Primary PCI	H02	Primary PCI - 150 Minutes Call to Balloon Time	90%	70%	75.4%	71.7%	75.7%	78%	81.8%	75%	59.4%	63%	83.8%	55.2%	66.7%	70.5%	76.6%	-	78.7%	66.7%	69.8%	73.6%
	H03a	Primary PCI - 90 Minutes Door to Balloon Time	90%	90%	93.3%	92%	89.2%	95.1%	95.5%	92.5%	93.8%	85.2%	100%	93.1%	83.3%	88.6%	93.6%	-	93.4%	90.9%	92.7%	91.2%
Diagnostic Waits	A05	Diagnostics 6 Week Wait (15 Key Tests)	99%	99%	98.97%	96.92%	99.59%	99.37%	99.2%	98.69%	99.11%	99.2%	98.34%	98.55%	96.25%	96.09%	95.51%	96.88%	99.39%	99.01%	97.68%	96.17%
Outpatients	R03	Outpatient Hospital Cancellation Rate	6%	10.7%	11.9%	12.5%	11%	10.6%	13%	12.3%	11.8%	13.1%	14%	12.4%	12.6%	12.4%	11.8%	11.6%	11.5%	12.4%	13%	11.9%
Delayed Discharges	Q01A	Acute Delayed Transfers of Care - Patients	-	-	-	-	54	41	30	19	33	31	34	23	22	29	31	25	-	-	-	-
	Q02A	Non-Acute Delayed Transfers of Care - Patients	-	-	-	-	12	10	4	5	5	10	3	6	4	5	6	5	-	-	-	-
Green To Go List	AQ01	Numbers on the Green to Go List (Acute)	-	-	-	-	50	39	33	42	49	48	59	48	50	46	60	45	-	-	-	-
	AQ02	Numbers on the Green to Go List (Non-Acute)	-	-	-	-	11	10	9	7	9	16	8	10	10	6	9	15	-	-	-	-
Length of Stay	J03	Average Length of Stay (Spell)	-	-	4.16	4.14	4.2	4.11	4.12	4.04	4.03	4.3	4.23	4.16	4.14	3.89	4.24	4.21	4.14	4.13	4.18	4.11

RESPONSIVE (continued)

Topic	ID	Title	Annual Target		Annual		Monthly Totals												Quarterly Totals			
			Green	Red	15/16	16/17 YTD	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	15/16 Q3	15/16 Q4	16/17 Q1	16/17 Q2
ED - Time In Department	B01	ED Total Time in Department - Under 4 Hours	95%	95%	90.43%	89.11%	92.16%	89.6%	88.89%	83.76%	84.23%	82.49%	87.17%	91.66%	88.99%	89.33%	90.01%	87.33%	90.23%	83.47%	89.32%	88.89%
		This is measured against the national standard of 95%																				
ED - Time in Department (Differentials)	BB14	ED Total Time in Department - Under 4 Hours (STP)	-	-	90.43%	89.11%	92.16%	89.6%	88.89%	83.76%	84.23%	82.49%	87.17%	91.66%	88.99%	89.33%	90.01%	87.33%	90.23%	83.47%	89.32%	88.89%
	BB07	BRI ED - Percentage Within 4 Hours	-	-	87.4%	82.97%	89.34%	89.43%	86.83%	75.72%	79.13%	75.11%	79.8%	87.73%	81.8%	83.73%	83.71%	80.78%	88.55%	76.61%	83.17%	82.77%
	BB03	BCH ED - Percentage Within 4 Hours	-	-	90.56%	93.98%	93.12%	84.97%	86.7%	89.12%	84.67%	85.59%	93.02%	93.84%	95.11%	93.58%	97.29%	91.57%	88.18%	86.39%	94.01%	93.94%
	BB04	BEH ED - Percentage Within 4 Hours	99.5%	99.5%	99.48%	99.1%	99.23%	99.83%	99.71%	99.83%	99.6%	98.94%	99.33%	99.54%	99.24%	98.65%	98.61%	99.26%	99.59%	99.44%	99.37%	98.84%
		This is measured against the trajectories created to deliver the Sustainability and Transformation Fund targets																				
Trolley Waits	B06	ED 12 Hour Trolley Waits	0	1	12	3	0	0	0	6	0	6	0	1	0	0	0	2	0	12	1	2
Time to Initial Assessment	B02c	ED Time to Initial Assessment - Under 15 Minutes (Excludes BCH)	95%	95%	99%	96.9%	98.4%	99.6%	99%	98.8%	99.3%	97.5%	96.2%	98.2%	94.7%	97%	97.9%	97.3%	99%	98.5%	96.4%	97.4%
	B02b	ED Time to Initial Assessment - Data Completness	95%	95%	93%	92.4%	93.2%	94.1%	93.8%	92.7%	92.9%	94.1%	93.3%	94.2%	92.1%	91.7%	91.8%	91.2%	93.7%	93.2%	93.2%	91.6%
Time to Start of Treatment	B03	ED Time to Start of Treatment - Under 60 Minutes	50%	50%	52.8%	53.5%	52.8%	49.8%	53.1%	52.6%	45.3%	45.8%	55.2%	51.7%	51.7%	51.1%	56.5%	55.2%	51.9%	47.8%	52.8%	54.2%
	B03b	ED Time to Start of Treatment - Data Completeness	95%	95%	98.9%	98.7%	98.8%	99%	98.9%	98.7%	98.6%	98.6%	98.8%	98.9%	98.5%	98.3%	98.9%	98.5%	98.9%	98.7%	98.7%	98.6%
Others	B04	ED Unplanned Re-attendance Rate	5%	5%	3%	2.4%	2.7%	3.1%	3.5%	3%	3.7%	3.1%	3%	2.4%	2.3%	2.2%	2.2%	2.3%	3.1%	3.3%	2.6%	2.3%
	B05	ED Left Without Being Seen Rate	5%	5%	2.4%	2.3%	2.4%	2.4%	2.2%	2.6%	2.7%	2.5%	2.1%	2%	2.5%	2.9%	1.8%	2.2%	2.3%	2.6%	2.2%	2.3%
Ambulance Handovers	BA09	Ambulance Handovers - Over 30 Minutes	-	-	1102	590	96	86	104	236	153	140	62	72	114	77	125	140	286	529	248	342

EFFICIENT

Topic	ID	Title	Annual		Monthly Totals												Quarterly Totals			
			15/16	16/17 YTD	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	15/16 Q3	15/16 Q4	16/17 Q1	16/17 Q2
Sickness	AF02	Sickness Rate	4.2%	3.8%	4.2%	4%	4.3%	4.5%	4.6%	4.5%	3.9%	3.7%	3.8%	3.8%	3.8%	3.8%	4.3%	4.5%	3.8%	3.8%
		For 2015/16, the Trust target for the year is 3.7%. Divisional targets are: 3.0% (DAT), 5.5% (FAE), 4.1% (MDC), 3.7% (SPS), 3.5% (SHN), 3.9% (WAC), 2.6% (Trust Services, excl FAE)																		
		Different targets were in place in previous years. There is an amber threshold of 0.5 percentage points above the target. These annual targets vary each quarter.																		
Staffing Numbers	AF08	Funded Establishment FTE	8258.8	8364.5	8168.6	8197.6	8199.8	8224.1	8229.4	8258.8	8241.7	8239	8304	8334.2	8364.5	8364.5	8199.8	8258.8	8304	8364.5
	AF09A	Actual Staff FTE (Including Bank & Agency)	8319.4	8436.4	8249.7	8198	8180	8233.9	8246.6	8319.4	8339.7	8277.5	8315.7	8322.1	8398.3	8436.4	8180	8319.4	8315.7	8436.4
	AF13	Percentage Over Funded Establishment	0.7%	0.9%	1%	0%	-0.2%	0.1%	0.2%	0.7%	1.2%	0.5%	0.1%	-0.1%	0.4%	0.9%	-0.2%	0.7%	0.1%	0.9%
		Green is below 0.5%. Amber is 0.5% to below 1% and Red is 1% or above																		
Bank Usage	AF04	Workforce Bank Usage	350.9	410.7	377.6	339.3	336.1	342.8	361.7	350.9	337.2	370	394.7	429.9	437.9	410.7	336.1	350.9	394.7	410.7
	AF11A	Percentage Bank Usage	4.2%	4.9%	4.6%	4.1%	4.1%	4.2%	4.4%	4.2%	4%	4.5%	4.7%	5.2%	5.2%	4.9%	4.1%	4.2%	4.7%	4.9%
		Bank Percentage is Bank usage as a percentage of total staff (bank+agency+substantive). Target is an improvement trajectory going from 4.7% in Apr-15 to 2.7% in Mar-16																		
Agency Usage	AF05	Workforce Agency Usage	153.4	157.4	180	156.1	134	152.1	144.9	153.4	156.4	131.9	138.3	149.8	148.5	157.4	134	153.4	138.3	157.4
	AF11B	Percentage Agency Usage	1.8%	1.9%	2.2%	1.9%	1.6%	1.8%	1.8%	1.8%	1.9%	1.6%	1.7%	1.8%	1.8%	1.9%	1.6%	1.8%	1.7%	1.9%
		Agency Percentage is Agency usage as a percentage of total staff (bank+agency+substantive). Target is an improvement trajectory going from 1.6% in Apr-15 to 0.8% in Mar-16																		
Vacancy	AF06	Vacancy FTE (Funded minus Actual)	361	404.5	416.4	420.1	431.3	412	422.3	361	305.8	380	439.2	494.8	452.7	404.5	431.3	361	439.2	404.5
	AF07	Vacancy Rate (Vacancy FTE as Percent of Funded FTE)	4.4%	4.9%	5.1%	5.2%	5.3%	5.1%	5.2%	4.4%	3.8%	4.7%	5.3%	6%	5.5%	4.9%	5.3%	4.4%	5.3%	4.9%
		For 2015/16, target is below 5% for Green, 5% or above for Red																		
Turnover	AF10A	Workforce - Number of Leavers (Permanent Staff)	148	190	146	148	120	137	154	148	229	191	137	169	367	190	120	148	137	190
	AF10	Workforce Turnover Rate	13.4%	13.3%	13.7%	13.9%	13.8%	13.9%	13.6%	13.4%	13.6%	13.3%	13.1%	13.4%	13.3%	13.3%	13.8%	13.4%	13.1%	13.3%
		Turnover is a rolling 12 months. It's number of permanent leavers over the 12 month period, divided by average staff in post over the same period. Average staff in post is staff in post at start PLUS stafff in post at end, divided by 2.																		
		Green Target is an improvement trajectory going from 13.6% in Apr-15 to 11.5% in Mar-16.There is an Amber threshold of 10% of the Green threshold (i.e. 15% in Apr-15, falling to 12.7% in Mar-16)																		
Training	AF20	Essential Training Compliance	91%	-	91%	91%	91%	92%	92%	91%	-	-	-	-	-	-	91%	91%	-	-
		Green is above 90%, Red is below 85%, Amber is 85% to 90%																		
Essential Training 2016/17	AF21a	Essential Training Compliance - Three Yearly Training	-	88%	-	-	-	-	-	-	-	88%	88%	88%	85%	88%	-	-	88%	88%
	AF21b	Essential Training Compliance - Annual Training	-	73%	-	-	-	-	-	-	-	56%	63%	66%	67%	73%	-	-	63%	73%
	AF21c	Essential Training Compliance - Induction	-	96%	-	-	-	-	-	-	-	96%	95%	96%	94%	96%	-	-	95%	96%
	AF21d	Essential Training Compliance - Resuscitation Training	-	81%	-	-	-	-	-	-	-	78%	79%	79%	77%	81%	-	-	79%	81%
	AF21e	Essential Training Compliance - Safeguarding Training	-	88%	-	-	-	-	-	-	-	88%	88%	89%	86%	88%	-	-	88%	88%
		Green is above 90%, Red is below 85%, Amber is 85% to 90%																		

Appendix 1

Glossary of useful abbreviations, terms and standards

Abbreviation, term or standard	Definition
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
DVLA	Driver and Vehicle Licensing Agency
FFT	Friends & Family Test This is a national survey of whether patients said they were 'very likely' to recommend a friend or family to come to the Trust if they needed similar treatment. There is a similar survey for members of staff.
Fracture neck of femur Best Practice Tariff (BPT)	There are eight elements of the Fracture Neck of Femur Best Practice Tariff, which are as follows: 1. Surgery within 36 hours from admission to hospital 2. Multi-disciplinary Team rehabilitation led by an Ortho-geriatrician 3. Ortho-geriatric review within 72 hours of admission 4. Falls Assessment 5. Joint care of patients under Trauma & Orthopaedic and Ortho-geriatric Consultants 6. Bone Health Assessment 7. Completion of a Joint Assessment 8. Abbreviated Mental Test done on admission and pre-discharge

GI	Gastrointestinal – often used as an abbreviation in the form of Upper GI or Lower GI as a specialty or tumour site relating to that part of the gastrointestinal tract
ICU / ITU	Intensive Care Unit / Intensive Therapy Unit
LMC	Last-Minute Cancellation of an operation for non-clinical reasons
NA	Nursing Assistant
NBT	North Bristol Trust
NICU	Neonatal Intensive Care Unit
NOF	Abbreviation used for Neck of Femur
NRLS	National Learning & Reporting System
PICU	Paediatric Intensive Care Unit
RAG	Red, Amber Green – the different ratings applied to categorise performance for a Key Performance Indicator
RCA	Root Cause Analysis
RN	Registered Nurse
RTT	Referral to Treatment Time – which measures the number of weeks from referral through to start of treatment. This is a national measure of waiting times.
STM	St Michael's Hospital

Appendix 2

Breakdown of Essential Training Compliance for September 2016:

All Essential Training

	UH Bristol	Diagnostics & Therapies	Facilities & Estates	Medicine	Specialised Services	Surgery Head and Neck	Trust Services	Women's and Children's
Three Yearly	**88%**	91%	90%	88%	90%	88%	89%	84%
Annual (Fire and IG)	**73%**	86%	66%	73%	78%	68%	79%	70%
Induction	**96%**	97%	98%	95%	96%	94%	97%	95%
Resuscitation	**81%**	78%	N/A	84%	82%	80%	86%	78%
Safeguarding	**88%**	92%	88%	91%	89%	87%	92%	81%

Safeguarding Adults and Children

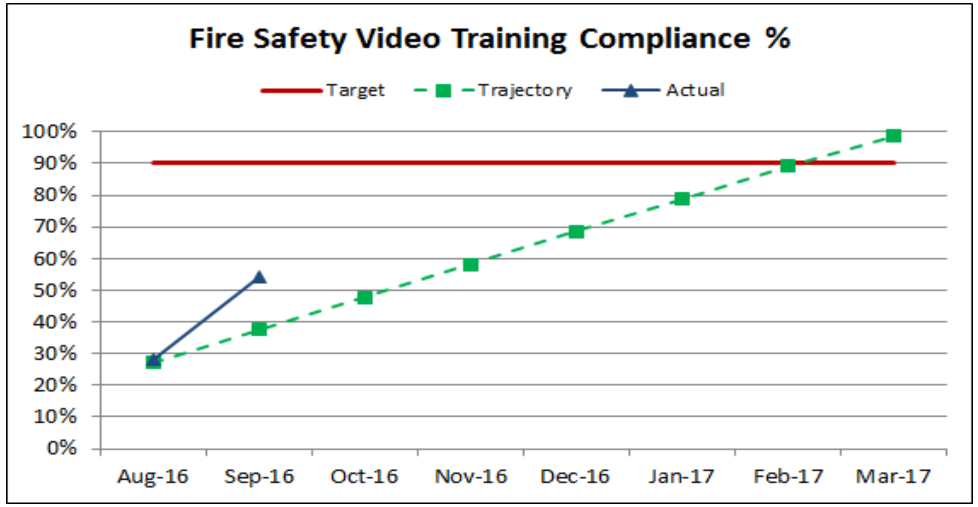
	UH Bristol	Diagnostics and Therapies	Facilities And Estates	Medicine	Specialised Services	Surgery Head and Neck	Trust Services	Women's And Children's
Safeguarding Adults L1	**91%**	94%	91%	89%	87%	86%	93%	86%
Safeguarding Adults L2	**86%**	91%	76%	91%	91%	88%	85%	79%
Safeguarding Adults L3	**61%**	100%	-	65%	70%	54%	71%	25%
Safeguarding Children L1	**92%**	94%	91%	94%	93%	88%	94%	
Safeguarding Children L2	**87%**	88%	76%	90%	87%	86%	87%	92%

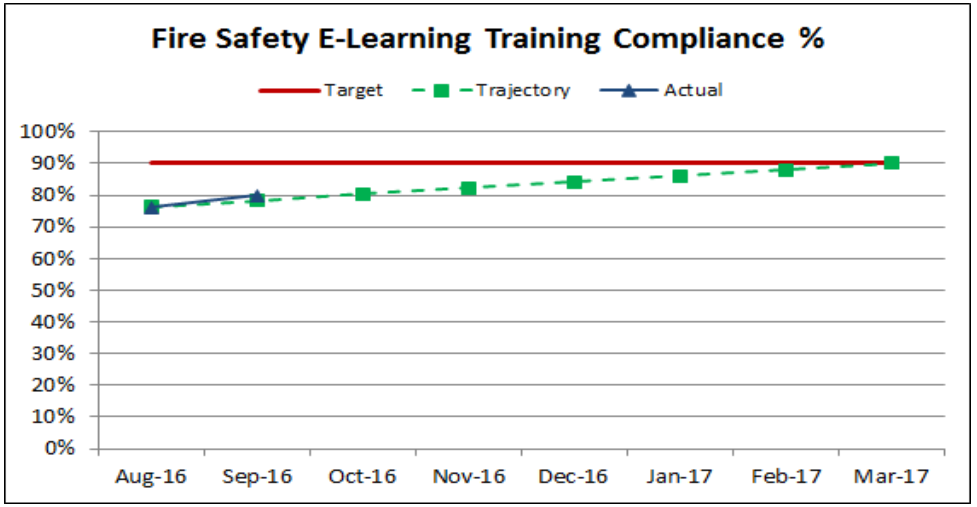
Child Protection level 3

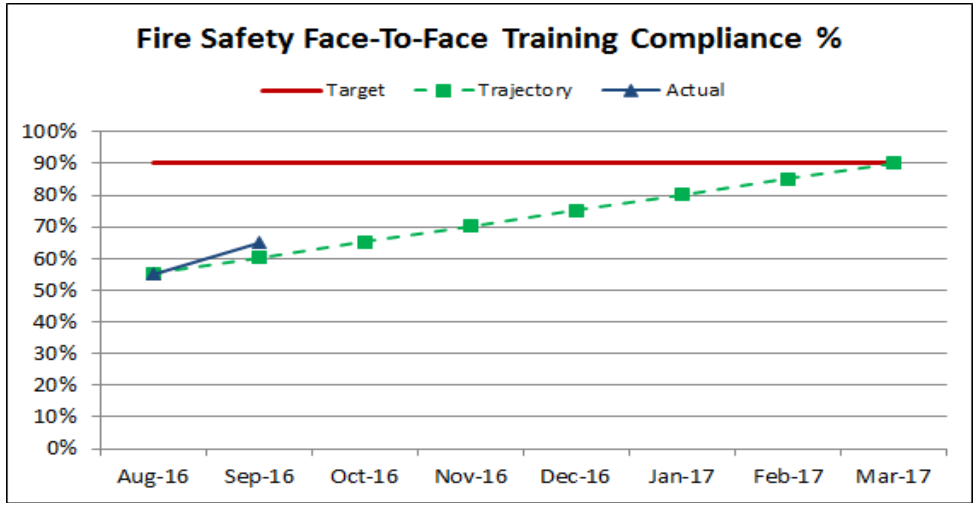
	UH Bristol	Diagnostic & Therapies	Medicine	Specialised Services	Surgery Head & Neck	Trust Services	Women`s and Children`s
Core	**75%**	91%	63%	-	56%	100%	76%
Specialist	**72%**	-	-	-	-	100%	72%

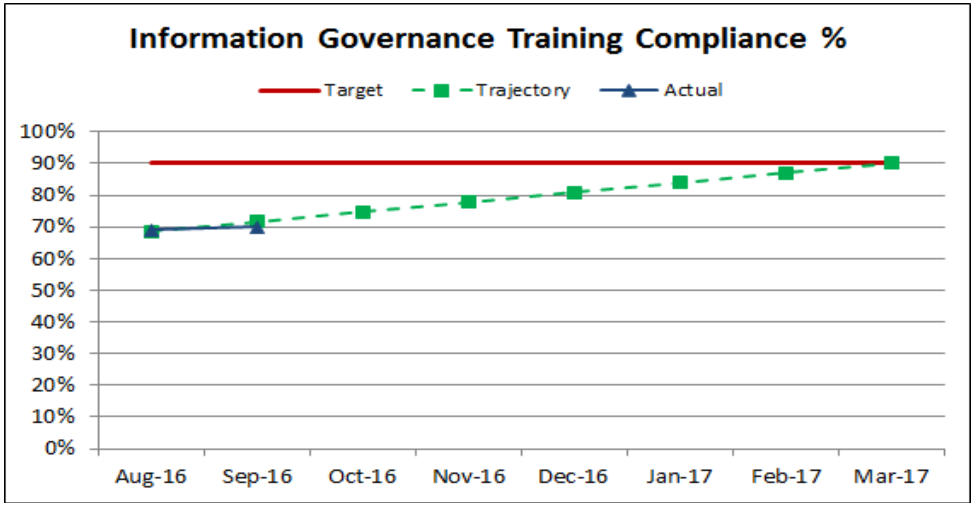
Appendix 2 (continued)

Performance against Trajectory for Fire and Information Governance









Note, there are two types of fire training represented in these trajectories, two yearly and annual fire training, with different target audiences. In addition, there are a fixed number of staff who require an additional training video under the previous fire training requirements. This will not be a requirement in the future once all are trained. The starting point for the trajectories is the same as the actual compliance figure for August 2016.

Appendix 2 (continued)

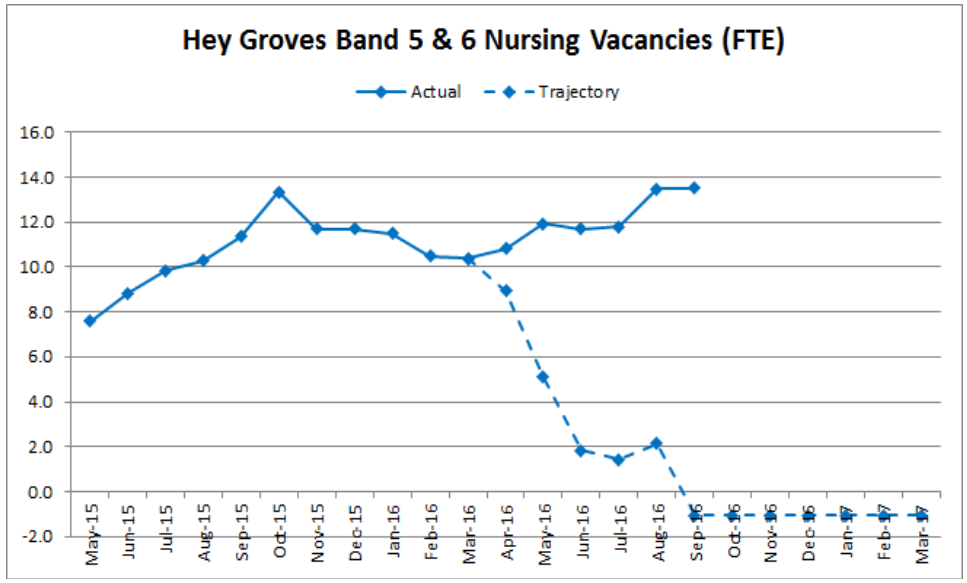
Agency shifts by staff group for 29th August to 25th Sept 2016

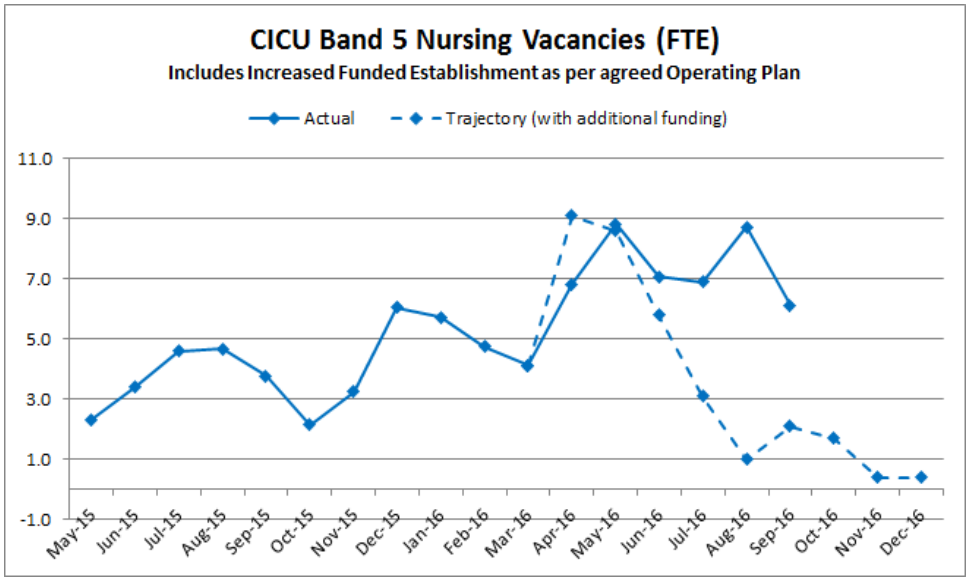
This report provides the Trust with an opportunity to do a retrospective submission to NHS Improvement of all our agency activity for the preceding four calendar week period, confirming over-rides with agency rates, worker wage rates and frameworks.

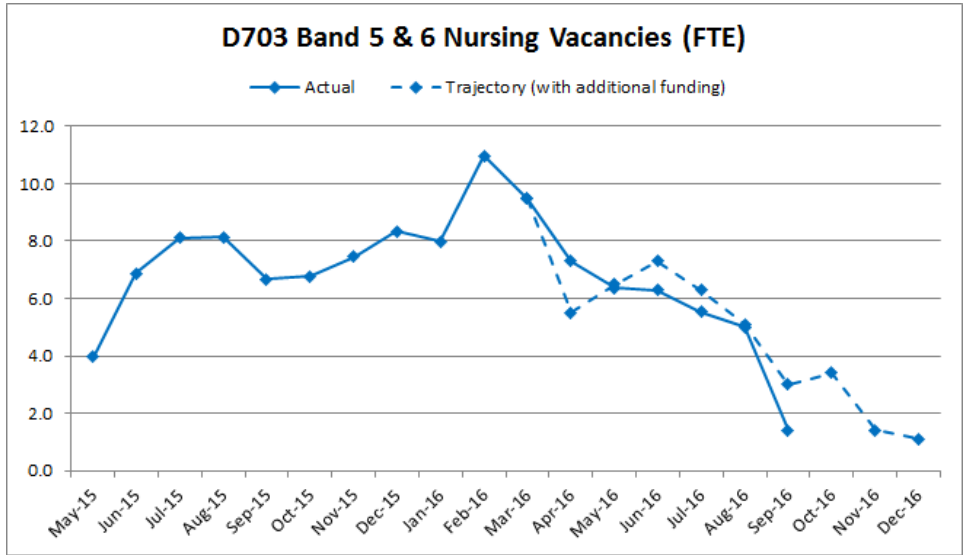
Staff Group	Within framework and price cap	Exceeds price cap	Exceeds wage cap	Non framework	Non framework and above both price and wage cap	Non framework and above price cap	Exceeds price and wage cap	Non framework and exceeds wage cap	Total
N&M /Health visiting	20	109	1	0	402	0	826	0	1358
HCA & other Support	11	27	70	0	9	0	26	0	143
Medical & Dental	0	0	21	0	0	0	96	0	117
Scientific , therapeutic and technical (AHP)	31	0	82	0	0	0	18	0	131
Healthcare Science	0	0	0	0	0	0	0	0	0
A&C and Estates	895	0	0	0	0	0	0	0	895
Other	0	0	0	0	0	0	0	0	0

Appendix 2 (continued)

Recruitment compared with trajectory for Heygroves Theatres, CICU and Ward D703







Appendix 3

Access standards – further breakdown of figures

A) 62-day GP standard – performance against the 85% standard at a tumour-site level for August 2016, including national average performance for the same tumour site

Tumour Site	UH Bristol	Internal operational target	National
Breast†*	83.3%	-	94.8%
Gynaecology	75.0%	85%	77.1%
Haematology (excluding acute leukaemia)*	86.7%	85%	79.3%
Head and Neck	100%	79%	69.6%
Lower Gastrointestinal	81.8%	79%	74.1%
Lung	67.6%	79%	72.2%
Other*	60.0%	-	78.5%
Sarcoma*	80.0%	-	71.4%
Skin	93.4%	96%	95.4%
Upper Gastrointestinal	78.9%	79%	75.8%
Urology*†	100%	-	77.2%
Total (all tumour sites)	**84.5%**	**85.0%**	**82.6%**
Improvement trajectory	**81.7%**		
Performance for internally managed pathways	**89.5%**		
Performance for shared care pathways	**64.6%**		

*3 or fewer patients treated in accountability terms

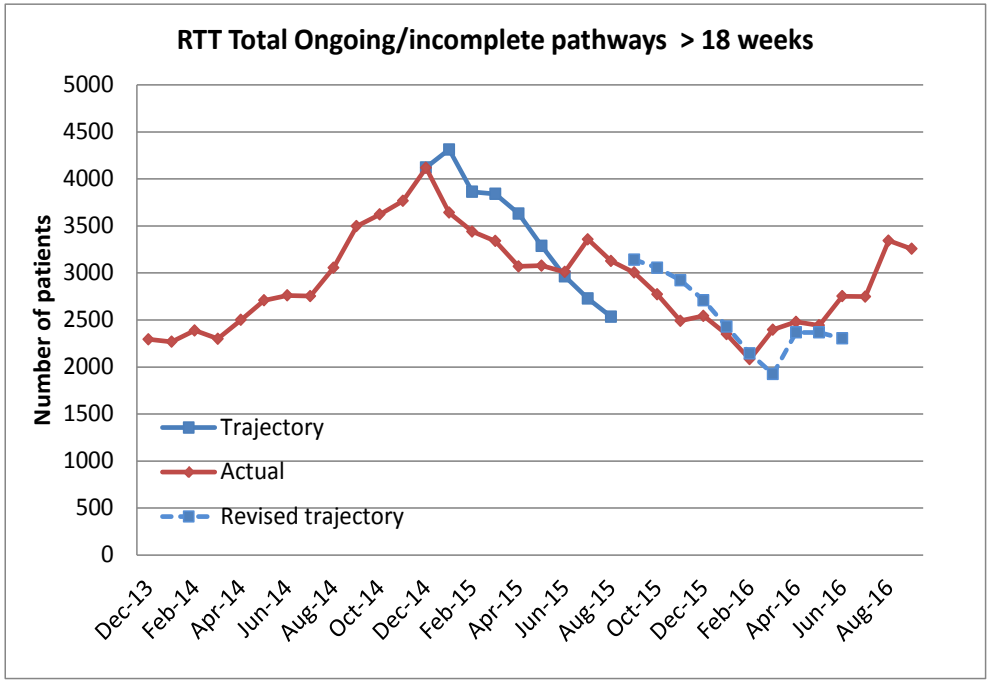
†Tertiary pathways only (i.e. no internally managed pathways), with management of waiting times to a great extent outside of the control of the Trust

Appendix 3 (continued)

Access standards – further breakdown of figures

B) RTT Incomplete/Ongoing pathways standard – numbers and percentage waiting over 18 weeks by national RTT specialty in September 2016

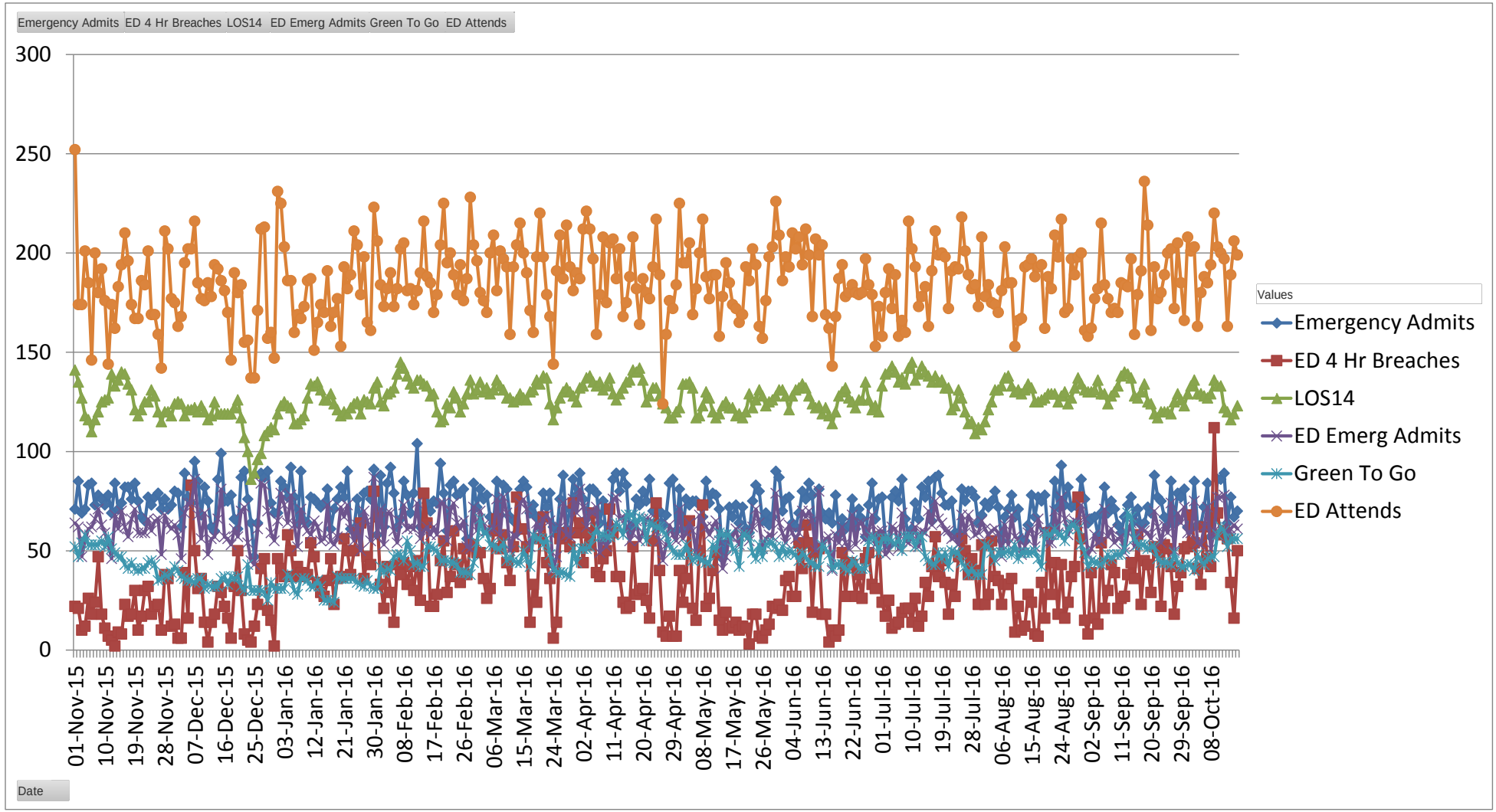
RTT Specialty	Ongoing Over 18 Weeks	Ongoing Pathways	Ongoing Performance
Cardiology	180	2,017	91.1%
Cardiothoracic Surgery	8	221	96.4%
Dermatology	170	2,252	92.5%
E.N.T.	83	2,343	96.5%
Gastroenterology	44	489	91.0%
General Medicine	0	51	100.0%
Geriatric Medicine	1	165	99.4%
Gynaecology	179	1,593	88.8%
Neurology	55	378	85.4%
Ophthalmology	247	4,475	94.5%
Oral Surgery	196	2,285	91.4%
Other	1,976	15,144	87.0%
Rheumatology	25	479	94.8%
Thoracic Medicine	29	969	97.0%
Trauma & Orthopaedics	63	1,149	94.5%
Grand Total	**3256**	**34010**	90.4%



	Feb 16	Mar 16	Apr 16	May 16	Jun 16	Jul 16	Aug 16	Sep 16
Non-admitted pathways (target/actual)	1313/1222	1190/1460	1364/1479	1364/1480	1364/1796	1202/1741	1185/2189	1106/2060
Admitted pathways (target/actual)	832/861	735/937	1004/1001	1004/962	940/957	940/1008	940/1155	940/1196
Total pathways (target/actual)	2145/2083	1925/2397	2368/2480	2368/2442	2304/2753	2142/2749	2125/3344	2046/3256
Target % incomplete < 18 weeks	93.2%	93.9%	92.6%	92.6%	92.8%	93.2%	93.2%	93.4%
Actual target % incomplete < 18 weeks	93.2%	92.2%	92.3%	92.6%	92.1%	92.0%	90.5%	90.4%

Appendix 3 (continued)

BRI Flow metrics



Cover report to the Trust Board meeting to be held on 31 October 2016 at 11-1pm in the Conference Room, Trust HQ, Marlborough St, Bristol, BS1 3NU

		Agenda Item	3.5
Meeting Title	Trust Board	**Meeting Date**	31 October 2016
Report Title	Winter Planning		
Author	Alison Grooms, Associate Director of Operations and Owen Ainsley, Interim Chief Operating Officer		
Executive Lead	Owen Ainsley, Interim Chief Operating Officer		
Freedom of Information Status		Open	

Strategic Priorities (please select any which are impacted on / relevant to this paper)
Strategic Priority 1 : We will consistently deliver high quality individual care, delivered with compassion services.

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

Executive Summary
Purpose To provide the Trust Board with assurance information around the winter planning processes for 2016/17.
Recommendations
The Trust Board are asked to note the update.

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

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

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

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

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

Briefing on Winter Planning October 2016

Governance of Winter Planning:

Winter planning is led by the Associate Director of Operations & Deputy Chief Operating Officer. All divisions have a nominated lead and local winter planning templates are being populated on the Patient flow management workspace, which are collated to form our Trust wide plan. Fortnightly winter planning meetings have commenced to support the planning process which is overseen by the Service Delivery Group (SDG).

From a wider system perspective we are seeking (via the Urgent Care Working Group) the support of partner organisations to ensure resilience in terms of GPSU cover, enhanced social services and primary and intermediate care availability. A Bristol, North Somerset and South Gloucestershire (BNSSG) System wide winter planning event will take place on 29th November 2016 with all partners sharing plans and considering overall resilience.

The winter planning process more widely will be overseen by the newly formed "A&E Delivery Boards" which are in place across the country. UHBristol is part of the BNSSG A&E Delivery Board whose brief is to oversee the following priorities set by NHS England:

- *Bank holiday period service availability (across both the acute sector and additional CCG commissioned services), and out of hospital urgent care. This should also include plans for how availability of services will be communicated to patients to ensure care is accessed at the most appropriate place;*
- *Reducing delayed transfers of care, and lowering acute bed occupancy to 85% from 19 December 2016 to 16 January 2017;*
- *Elective pacing plans to ensure activity is maximised to prepare for increased non-elective care pressures;*
- *Uptake of healthcare workers Flu Vaccination Programme;*
- *Aligning local escalation systems with the new framework (to be progressed during the autumn, but then to be in place on-going);*
- *Ensuring daily sitrep reporting requirements are met.*

Capacity Planning and Escalation

The Trust has well established protocols for adult escalation capacity which identify inpatient areas that can be used for escalation. Standard Operating Procedures (SOPs), grouping and priorities were reviewed and updated at the SDG winter planning meeting on 17 October 2016 and updated documentation will be approved at the SDG on the 7 November 2016. Escalation areas have been risk assessed and prioritised based on these assessments and fall into 3 categories:

- Group 1 is first level of escalation and includes areas such as the Bristol Eye Hospital and St Michaels;
- Group 2 is second level of escalation and includes areas such as protected beds, A600 and CCU;
- Extreme Escalation areas (only to be used once group 1 & 2 are exhausted) include the Therapy Gym, Queens Day Unit and the Cath Lab day case area.

A key part of our adult capacity planning for the winter period is the ORLA Virtual Ward. Under this model, which has been operating since July 2016, patients with a Decision to Admit can be transferred for hospital care at home. The target number of beds from ORLA (and the increase on last year's position) is:

- From 1st October 20 beds(net increase +3 vs 15/16)
- From 1st November 25 beds (net increase +8 vs 15/16)
- From 1st December 35 beds (net increase +18 vs 15/16)

Children's Hospital Plan

The Children's Hospital has its own detailed plan focused on strengthening workforce and capacity which includes:

- Banding of GP junior doctors in ED to work out of hours
- Additional ED nursing shifts and ENP post (0.5wte)
- ED consultant (0.5wte)
- Funding to open 6 beds in winter on general medical ward
- Additional general paediatric consultant shifts to double up ward rounds, focus on discharge & increase rapid access clinics
- Introducing 7 beds for use of 1 night stays three times a week for both elective and emergency patients
- Weekend additional trainee for discharge & extra shifts in ED
- Additional OT cover
- Increased PICU physio cover
- Additional site team, matron and outreach support

Winter Funding

On an incremental basis developments are made in divisional operating plans to enhance winter resilience, with changes such as the investment in flow matron roles and enhanced weekend medical cover made on a substantive basis.

As in previous years, £100k has been allocated internally for non-recurrent support for winter pressures. In 2015/16 this funding was utilised for areas such as additional deep cleaning support, enhanced portering, and matron resource to support patient flow. This process is being repeated in 2016/17 with bids currently being considered. Bids will be prioritised on the basis of those that have the highest direct impact on patient flow and that support across divisions.

Whilst not all bids will be able to be prioritised, we have encouraged the development and documentation of resilience proposals so we can respond rapidly if external funding sources become available. Whilst acknowledging this is unlikely in the current climate, in previous years opportunities have arisen whereby national funding becomes available at short notice, so having a ready bank of schemes on which to draw is advantageous.

Christmas and New Year Period Day by Day Plan:

The Trust has an established and iterative annual process of detailed daily plans for the Christmas and New Year Period. These plans outline the key contact details, on call and cover arrangements, service enhancements and other specific arrangements for all key clinical and support services. These include:

- Additional medical and nursing resource to support discharge;
- Greater ring-fenced capacity to facilitate inpatient flow (e.g. theatres, cath lab lists etc.);
- Elective plans to manage occupancy
- Additional on call management support over peak periods.

Given the way dates fall, this plan will cover the three week period from 19th December 2016.

Planning Events:

There are two focused events planned for this winter. These will use the 'breaking the cycle' methodology and be supported by the Transformation Team and system partners.

- A pre-Christmas event with the objective of reducing occupancy ahead of the holiday period;

- A post new year event to support discharge and patient flow.

Communications:

The first BNSSG winter resilience communications planning meeting was held on Friday 21st October in which CCGs shared their initial ideas with the group which included the proposed slogan of 'right care, first time' and key messages around what each of the services (Pharmacies, NHS 111, Minor Injury Units, Urgent Care Centres and Emergency Departments) can offer.

The UHBristol communications team have fed back to the CCGs and we now await updated proposals and the overall communications strategy to finalise. This in turn will inform our internal communications plan.

Owen Ainsley
Interim Chief Operating Officer

Alison Grooms
Associate Director of Operations

Cover report to the Trust Board meeting to be held on 31 October 2016 at 11-1pm in the Conference Room, Trust HQ, Marlborough St, Bristol, BS1 3NU

		Agenda Item	3.6
Meeting Title	Trust Board	**Meeting Date**	31 October 2016
Report Title	Transforming Care Programme Board		
Author	Simon Chamberlain, Director of Transformation		
Executive Lead	Robert Woolley, Chief Executive		
Freedom of Information Status		Open	

Strategic Priorities (please select any which are impacted on / relevant to this paper)
Strategic Priority 1: We will consistently deliver high quality individual care, delivered with compassion services.
Strategic Priority 4: We will deliver pioneering and efficient practice, putting ourselves at the leading edge of research, innovation and transformation
Strategic Priority 6: We will ensure we are financially sustainable to safeguard the quality of our services for the future and that our strategic direction supports this goal.
0T

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

Executive Summary
<u>Purpose</u> The purpose of this report is to update Trust Board on progress with Trust wide programmes of work under the Transforming Care programme. <u>Key issues to note</u> The report sets out the highlights of progress over the last quarter and the next steps
Recommendations
The Board is recommended to receive the report for assurance.

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

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

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

Impact Upon Corporate Risk

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

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

Transforming Care

Transforming Care Update to Trust Board

October 2016

The purpose of this report is to update the Trust Board on progress over the last quarter with the Trust wide programmes of work within the Transforming Care programme.

1. Our Operating Model programme brings together our work on improving patient flow through a number of programmes. Within this, over the last quarter our Ward Processes & Real Time programme has continued to work with multi-disciplinary ward teams across our hospitals to further roll out Ward Processes workshops, and then to follow up with teams to embed their improvement work. This work is central to achievement of key quality objectives and the sustained work on ward processes continues to have a positive impact on timely discharges and use of the Discharge Lounge.

2. We have mobilised a specific workstream to further improve both use of the Discharge Lounge to improve flow. An important strand of this will be better communication of discharges for the next day to allow the Discharge Lounge staff to proactively “pull” patients into the Discharge Lounge. Alongside this a clinically led team is developing practical tools to improve our use of Estimated Dates of Discharge (EDD) in conjunction with development of IT tools. Pilot work on better adoption of EDD is underway on some of our wards in the Division of Medicine. Finally a revised process for review of >7 day length of stay patients has been launched.

3. An important strand of this work is the development of operational reporting based on real time information. Each of the projects above will work closely with our IM&T staff to support improved real time operational reporting through better data quality and through the development and better use of our IT tools.

4. In the last quarter the Children’s Flow programme has mobilised workstreams focussed on winter planning, improved flow through the Clinical Investigations Unit, improved discharge processes, and maintaining access to surgery during the winter period. Alongside this the Paediatric ward teams have been enthusiastic participants in the ward processes work to improve ways of working in their wards.

5. Our Theatres Transformation work has focussed during the last quarter on preparations for the integration of the new Bluespier theatre management system. The system will enable better use of data in scheduling and real time theatre management and better visibility of emergency surgical patient flow, all supported by

wider access to the system for staff. The Bluespier system will go live at the beginning of November.

6. Within our Outpatients Transformation programme, staff have continued to support the renewal of the Outpatient Standards. An electronic portal has been created which will allow staff easy access to the standards relevant to their job. The programme has also planned improvements to the Outpatients Appointment Centre which should move to a larger location in the next quarter allowing its scope of coverage to grow. The programme is also working on improved use of information and IT, supporting improved operational performance management and seeking to remove paper from the referral triage process, to reduce the time taken to process referrals.

7. Our Admin Teams Transformation programme has now completed workshops to agree competencies and develop standardised job descriptions for a number of key admin roles – including Clinic Coordinators, Call Handlers, Receptionists and Inpatient booking teams. The team has agreed an approach to assessment centre recruitment for admin staff and a 3 month pilot of the approach is being planned. This work will support improvements to recruitment, training and quality management procedures, and is aimed at improving staff satisfaction and the quality of service provided by admin teams and reducing staff turnover among these groups. A strand of work is also underway to ensure we have better arrangements in place to ensure availability of bank staff to support admin vacancies, and to make it easier to match available staff with requests

8. In our work to improve communications with patients, following extensive testing the first wave of the new standardised patient letters has been launched in the BHI. Plans are in place to extend this work to SH&N once final sign off is received on the supporting patient leaflets. A second Letters Champions week is being planned to seek detailed feedback from patients on the changes. Alongside this the practical implementation of the procedures to use email to send Medway generated appointment letters to patients is underway and we are working through the technical and procedural changes required.

9. Scoping work has taken place to prioritise work in support of our quality objective of reducing complaints related to verbal and telephone communications. Our Admin Teams programme will roll out training to improve call handling skills, but alongside this further work has been identified to address issues related to call routing, ensuring calls are answered in a timely manner, and making sure we provide accurate information about departments and phone numbers both internally and externally.

10. Our work to improve staff engagement has been supported by the roll out of the Happy App, a real time staff engagement and feedback tool developed locally. This is now in use in 36 areas across the Trust and nearly 6,000 comments have been

left by staff so far. We were delighted to learn that the Happy App project has been shortlisted in two categories (Acute Care Innovation and Staff Engagement) for this year's Health Service Journal Awards. The results of judging will be revealed on November 23rd.

11. In September the BRHC held its "Conversations" event with the aim of driving engagement with staff, patients and families. The event, which ran over 10 days, included a wide variety of activities which proved very popular, including a fancy dress competition, a garden fete, staff recognition awards and a job-swap/shadowing event. The event proved to be a great success, and hundreds of on-line responses were received to vote for the winners of the fancy dress competition. A structured review of the event will capture the learning to be taken into further engagement activities.

12. In 2015 we ran a Bright Ideas competition to seek out and support good ideas from staff for improving our services. We have repeated the competition this year. 43 entries were received, and the final panel on 4 October received presentations from 10 short-listed projects. Three winners were selected: These were "Steps to" presented by Rachel Hamblin, "Pre-Vid Bristol" by Tom Woodward, Alex Looseley, Mat Molyneux, Natasha Joshi and Claire Dowse, and "Get up and move" by Kate Harty. Initial meetings with sponsors and transformation support have been set up to plan the work to take these ideas forward.

13. By coincidence, the work of one of last year's winners - "Virtual Tours of UH Bristol" – was featured in the Bristol Evening Post on the same day as shortlisting. Our Google street view of the entrance to the BHOC topped their list of buildings in Bristol which use this technology to allow the public a view of the entry to the building. Another of last year's winners – "A Good Night's Sleep" led by Damien Leith was featured in the last edition of Voices".

14. Our Transformation Board meeting in October considered how we could further encourage and support Innovation and Improvement across the Trust, and in particular how we support improvement ideas which fall outside the remit of any of our structured programmes of work (such as the ideas generated through Bright Ideas). A group of improvement programme leads brought forward recommendations covering how we might encourage and equip staff to take on change themselves, how we should signpost staff to existing programmes which may support their idea, and how we might manage a pipeline of improvement ideas, and provide support where we can to the best ideas. A plan of work to take this forward was supported, including support to wider development of quality improvement skills among staff in partnership with the West of England Academic Health Science Network.

15. The latest update of progress on our programmes of work as provided to Transformation Board and the Senior Leadership Team is provided at Appendix 1

16. Next steps: Over the next quarter our focus will be on project delivery and maximising the impact of the planned improvements and changes.

Simon Chamberlain

Director of Transformation

21st October 2016

Appendix 1: Transforming Care progress update – October 2016

Pillar	Details	Purpose	Status	Milestone review last month - September	Key deliverables going forward	Planned Month	Benefits / Measures	Risks
Delivering best care	**Project:** Patient Communications **Exec lead:** Carolyn Mills **Project lead:** Alison Grooms **Transformation lead:** Stephanie Smith-Clarke **Project phase:** implementation	**Patient Letters** To improve and standardise the quality of all appointment letters that are sent by UHBristol to patients, guardians and carer (both electronically and non-electronically generated) in line with the Trust's Objective 5 - 'To improve how the Trust communicates with patients'.	G A A A	• Pilot implementation of standard letters in BH underway • Plan agreed for roll out of letter quality standards across Trust • Children's outpatient letter pack drafted • Elective surgery leaflet signed off by Heads of Nursing	• Letters champion week follow up for pilot areas • SH&N Letter Pilot commenced • Develop further roll out programme	Oct Nov Nov	• To improve patient experience and reduce patient communication related complaints and DNA's	• Ability to resource the rewriting of letters Trust wide against the letter quality standards. • Costs associated with sending of new Outpatient and Inpatient leaflets. Costs will be established during pilot phase. Divisions to agree to spend for further roll out. • High number of letter templates required to provide correct telephone numbers per specialty.
		Medway based email correspondence To provide our patients with the option of receiving their appointment letter via email instead of post, as preferred by many of our patients, especially those with visual impairment.	G A	• Advert out for email account validation staff • Synertec account set up agreed	• Appointment of Validation staff • Training of validators, receptionists and booking coordinators in SOPs for email correspondence. • Go-live coms in place prior to project launch • Creation of inboxes, Medway functionality for administrators and letter templates copied to email actioned by IM&T • Commence patient Email address collection	Oct Nov Nov Nov Dec	• To provide our patients with the choice of receiving their appointment letter via email. • To reduce printing and postage costs	• Low up-take of email option • Staff training in SOP
	Project: CSIP **Exec lead:** Paul Mapson **Project lead:** Steve Gray **Project phase:** implementation	Implementation of a cohesive set of clinically-focused applications and technologies that will transform business processes and provide users with tools and opportunities to improve patient care and achieve efficiencies.	G G A	• Joint Pathology LIMS System Live (revised go-live date agreed - October) • The Connecting Care document sharing pilot passed testing and the CSU are commencing a soft launch with a small group of users • Development of Ward view Interactive Electronic Whiteboards to support Real Time data recording and reporting. First area to receive ward view will be STAU (Oct)	• Bluespier live in theatres • Connecting Care document sharing pilot (The pilot will enable UHBristol to share its discharge letters with partner organisations) • EDM Project Ready to go-live in BRI, BHI and SBCH (actual go-live date will be agreed with BRI, BHI and SBCH) • EPMA Pilot begins	Oct Nov Apr-17 TBC	• Improved patient safety and experience through ready access to timely, accurate information • Improved efficiency for all staff involved in handling/viewing/creating patient information • Increased security of patient information (e.g. patient images)	Risk of poor performance of IT infrastructure may impact usability of new systems.
	Project: Sign up to Safety Patient Safety Programme **Exec lead:** Sean O'Kelly **Project lead:** Caroline Beale **Project phase:** implementation	To reduce avoidable harm by 50% and to reduce mortality by a further 10% by 2018.	G A G A G	• Peri-operative never events work stream: LocSSIP implemented for endoscopy. Testing of chest drain and ascitic drain LocSSIPs complete. Trust wide agreement for chest drain insertion kit reached, including removal of sharp trocars. Quality of WHO checklist re-audit completed. Paediatric theatre LocSSIP agreed. • Medicines safety work stream milestone: in Q2 the 'PharmOutcomes' referral pilot completed and U500 insulin prescription chart and guidelines produced • Safety culture workstream: in Q2, Divisional Board and team level safety culture analysis completed and feedback to Boards/teams commenced • Deteriorating patient work stream: Sepsis screening tool and pathway implemented and audits recommenced. Automated sepsis screening in CED in place. Joint education in place for deteriorating patient, sepsis and AKI. • Leadership work stream: in Q2 pilot ward round checklist developed for testing	• Continue developing, testing and implementing WHO checklists and LocSSIPs for other invasive procedures. • Make OPP funding bid for IT link to improve speed of PharmOutcomes referrals (currently 20 mins per patient to complete for all, but those with simple dosette box, referrals). • Complete safty culture feedback to clinical teams end November 2016 (risks slippage) • AKI workstream refresh. Deliver Q3 sepsis CQUIN targets. Produce NEWS credit cards. Focus doctor education on resetting triggers. Complete human factors thematic assessment of NEWS related incidents. • Plan for 2017 walk rounds by all Executive Directors. Complete tests of change for ward round checklist in Oncology and Haemtology.	Q3 Q3 Q3 Q3	• Reduction in mortality and avoidable harm • Earlier recognition and management of deteriorating patients • Prevention of peri-procedure never events Reduction in insulin medication errors and readmissions due to poor medicines compliance • Increased sustained compliance with patient safety risk assessments and controls	• Risk front line staff cannot release sufficient time to enagage and participate in quality and safety improvement • Risk that the Patient Safety Improvement Programme objectives, corporate quality objectives and sepsis CQUIN are not achieved if funding for patient safety audit and quality improvement nurse is not secured beyogn March 2017 • Risk of slippage of programme due to long term absence of Programme Manager • Risk of inabilty to effectively measure improvements for some workstreams due to availability of valid and reliable data sources or need for significant manual audit
	Project: Outpatients **Exec lead:** Owen Ainsley **Project lead:** Candice Tyers **Transformation lead:** Marjolein Vries **Project phase:** implementation	To deliver a high quality service through a friendly, accessible, consistent and timely service.	R A A G G G	• Working groups for each work stream set up • Updated Standards drafted & circulated for feedback • Outpatient Standards - updated versions available • Outpatient productivity review carried out in one specialty per Division • Slot utilisation report circulated and data accuracy assessed • Portal for Outpatients standards set up and tested	• Demo of electronic referral triaging and decision whether to implement made • Referral working group re-commenced • Review and sign off of first wave of revised standards • Outcome of Patient Association pilot for telephone follow ups in Dermatology reviewed • Appointment Centre moved to new location	Oct Oct Nov Nov Jan-17	• Improved patient experience due to services working according to the standards, improved training of outpatients staff and one single place to call for appointments • Income generation via 1% DNA reduction/activity increase in 6 specialties who pilot reworded text reminder • Utilisation targets to be agreed	• Delays in workstream progress due to vacancies and long term asickness in key outpatient lead positions

Pillar Delivering	Details	Purpose	Status	Milestone review last month - September	Key deliverables going forward	Planned Month	Benefits / Measures	Risks
Improving patient flow	**Project:** Operating Model **Exec lead:** Owen Ainsley **Project leads:** TBC **Transformation Leads:** Caroline Daley, Kirstie Corns **Project phase:** planning	**Integrated Discharge Service** To establish a fully integrated Discharge Service which reduces occupied bed days whilst improving patient outcomes and **Ward Processes and Real Time** Roll out an integrated Ward Processes and Real Time programme **ORLA** Establish a Virtual Ward **>7 day senior review** All patients with a >LoS of 7 days with have a senior review – business as usual.	A A G G A A G A G A G G	• Integrated Discharge Service lead appointed • Pilot of Homelessness Support team project • Integrated ward processes and real time project plan developed • Electronic ward whiteboard technical development recommenced • Electronic ward whiteboard roll out plan developed • First electronic ward whiteboard (STAU) ready for user acceptance testing • Discharge Lounge project scoped • Overall plan for Ward Processes and Real Time signed off • Further three ward processes workshops held in Children's hospital • Project on a page completed • Terms of reference for >7 day review meeting written • 1st review meeting taken place	• Discharge to assess pathways 2 & 3 relaunched • Workshop to agree IDS measures held • Surgical Flow & BHI flow tracker implemented and roll out across SWN and BHI (refine escalation SOP) • Mobilisation of phase 2 projects (EDD, ?Home and Discharge Lounge) • Completion of phase 1 (ward processes workshops and follow up plans) across all bed holding Divisions • Evaluation and reporting of performance • Divisional Standard Operating Procedure development, implementation and monitoring • Review of meetings • KPIs developed	Q2 Oct Q3 Q3 Q4 Ongoing Oct Oct Oct	• Achievement of A'S18 (17 beds) closure • Achievement of occupancy at 92% in Medicine Division • Reduction in number of Green to Go patients • Increase in before 12 noon discharges to 1100 pts per month • Increase in number of patients using the discharge lounge • Reduction in last minute cancellations to 0.8% • Start on time 90% achievement • Turnaround Time 85% achievement • Theatre utilisation 85% achievement	• Insufficient resilience and capacity in community partner services • Risk that the green to go list does not fall as expected in • Capacity within Divisions to lead and support programmes cross divisionally given operational demands and winter pressures • ORLA activity supports bed base reduction rather than occupancy re-design
	Project: Theatre Transformation Programme **Exec Lead:** Paul Mapson **Project Lead:** Jan Belcher **Project phase:** implementation	To provide individualised safe quality patient care with maximum efficiency in responsive operating theatres Trust wide. Which in turn will support the capacity demands for surgical intervention.	G G G G	• Bluespier trauma and emergency whiteboard configuration sign off • Bluespier hardware roll out commenced • Training programme signed of and commenced	• Bluespier phase 1 roll out completed • SBCH theatres utilisation options analysis undertaken • Golden case for all theatre lists • Bluespier hardware roll out completed	Nov Oct Dec Dec	• Start on time 90% achievement • Turnaround Time 85% achievement • Theatre utilisation 85% achievement	• Theatre Staff recruitment and retention will impact capacity to implement change • Further delays to Bluespier implementation
	Project: Real Time Staff Engagement (The Happy App) **Exec Lead:** Alex Nestor **Project Lead:** Anne Frampton, Andrew Hollowood **Transformation Lead:** Stephanie Smith-Clarke **Project phase:** implementation	To provide a method for staff to leave real- time feedback regarding how they are feeling and the related causes. By doing so we will improve engagement with staff, and in turn we believe this will help us to provide a better quality of care to our patients.	A G G	• Submission of paper to BMJ • Roll out of website to a further 10 new areas across the Trust (now live in 36 areas across the Trust) • HSJ presentation and supporting material created for Shortlisting Panel on 12th October.	• Roll out of website to a further 10 new areas across the Trust • Trial of app for Junior Doctor feedback in BCH following GMC survey	Nov Oct	• Use of app (number of hits a day per area) • No of areas using website • No of resolved & closed actions per area • Improved staff Friends and Family	• Availability of IT support/resource • Willingness of staff to engage • Administrator resource to respond to comments
Building capability	**Project:** Appraisal improvement project **Exec Lead:** Alex Nestor **Project Lead:** Sam Chapman **Project phase:** implementation	• Staff appraisals are considered valuable and worthwhile • Staff receive an annual appraisal and regular reviews which integrate objectives, development, performance and career discussions • Staff appraisals link to the overall strategic direction of the organisation	G G	• New system upload (Mon 3rd October) • Meeting held with IM&T 8th September to mitigate PC access risk	• Trust wide comms plan in place • Product testing session held to map electronic appraisal on new system • eLearning for appraises and appraisers developed and pilot with stakeholder group held • Follow up meeting with IM&T regarding PC access risk following IM&T developing options appraisal • Electronic appraisal system implementation trust wide	Oct - Dec Oct Oct Oct Q4	• Improved Staff Experience • Reduction in staff turn over • Able to monitor the quality of appraisals • Support a culture of Collective Leadership	• Challenges IT could delay project roll out - mitigated through the HRIS subgroup and weekly AIP meeting
	Project: Admin Teams Transformation Trust Wide **Exec Lead:** Alex Nestor **Project Lead:** **Transformation Lead:** Stephanie Smith-Clarke **Project phase:** implementation	To join up the work going on across the Trust in relation to our admin teams and realise the benefits that we could be recognising in our savings programme.	A G G A	• Paper drafted on recruitment process for Workforce and OD sign off • Clinic Clerk (Receptionists and preppers) role competencies and training needs workshop held • Inpatient Booking Coordinator role competencies and training needs workshop held • Database and e-form for bank staff approved and implementation plan designed	• Ward Clerk role competencies and training needs workshop held • Approved (and matched) standardised job descriptions held centrally by HR • Design of training programmes per role	Oct Oct Nov	• Reduction in bank and agency spend • Reduction in manager time spent recruiting admin roles • Reduction in staff turnover • Improved staff retention • Improved friends and family score/trust survey from A&C staff • Reduction in stress-related sick days	• Divisional ability to resource project • Possibility for consultation required for changes to job descriptions

Updated: 14.10.2016

Milestone complete / Activities on track to achieve milestone
Milestone behind plan, with action to remedy
Milestone behind plan, project/programme risk

Cover report to the Trust Board meeting to be held on 31 October 2016 at 11.00 am – 1.00 pm in the Conference Room, Trust HQ, Marlborough St, Bristol, BS1 3NU

		Agenda Item	4.1
Meeting Title	Audit Committee	**Meeting Date**	18 October 2016
Report Title	Chairs Report		
Author	Pam Wenger, Trust Secretary		
Executive Lead	Robert Woolley, Chief Executive		
Freedom of Information Status		Open	

Reporting Committee	Audit Committee
Chaired by	John Moore, Non Executive Director
Lead Executive Director	Pam Wenger, Trust Secretary
Date of last meeting	18 October 2016

Summary of key matters considered by the Committee and any related decisions made.

Counter Fraud
Members received a report in respect of counter fraud activity and received an update on national developments and areas of interest in relation to counter fraud.

Internal Audit
Members received an update on the progress against the Internal Audit Plan and noted that the current position on the outstanding internal audit recommendations has shown a reduction. The Internal Auditors informed the Committee that the processes that the Trust had in place in relation to WIFI was considered to be good practice.

Members received an update in relation to the audit work completed/currently being undertaken. It was noted that 7 reports have been issued and 3 of those were graded as amber and 4 were graded as green.

Members discussed in some detail the amber graded reports for policy management, infection control and sickness management. Members recognised the progress in relation to policy management and that the previous audit was graded as red. Members sought assurance in relation to the actions required as a result of this latest audit. In respect of the Infection Control Report an update and clarification on the progress would be reported to the next Audit Committee. Members discussed the sickness report and whilst accepting that sickness was being appropriately managed in most areas across the Trust it was noted that sickness reporting was not consistent across the Trust and that actions were required to address this.

Members discussed and approved the changes to the timings of audits in the 2016/17 plan.

Board Assurance Framework (BAF) – Quarter 2
Members received and the BAF and were pleased with the development of the report and the clear alignment with the Corporate Risk Register. Members agreed that this report should feature high on the agenda at the Board Meetings.

Corporate Risk Register
Members received the Corporate Risk Register as at the end of September 2016.

Corporate Governance Statement
Members received a report providing assurance to the Audit Committee of the progress in relation to the agreed actions for 2016/17 to ensure continued compliance with the Corporate Governance Statement, and to inform the annual declaration by the Trust Board in June 2017.

Gifts and Hospitality Register and Register of Interests
Members received the annual monitoring report as set out in the policy. There was a discussion regarding the submissions to the two Registers and where the responsibility for approving these entries sat. Members agreed to receive a further assurance report at the next meeting to ensure compliance with the policy.

Risk Management Group
Members received the minutes from the previous meeting and an overview of the latest meeting that had taken place in October 2016. Members welcomed receiving the minutes of the Risk Management Group as it demonstrated the comprehensiveness of the agenda and the Group's ability to review and discuss risk issues and to scrutinise the Divisional Risk Registers.

Clinical Audit
Members received the Clinical Audit Annual Report and noted that this had been considered at the Quality and Outcomes Committee. Members expressed their thanks to the team for the hard work in the development of the report and in particular the link to outcomes. It was noted that the number of audits undertaken in the year was significant.

Members received the quarterly clinical audit report and noted that 36/39 (96%) of Priority 1 projects commenced or been completed and 107/151 (71%) of projects commenced according to planned timescale.

Speaking Out Policy
Members received a report outlining the processes for reporting compliance against the policy to the Audit Committee. The number of cases and the key themes were reported and it was agreed for future reports to ensure that the lessons learnt are included. It was noted that work was now required in the next 6 months as part of the appointment of the Local Guardian.

Terms of Reference
Members reviewed the terms of reference for onward approval by the Trust Board.

Appointment of External Auditors
Members supported a report outlining the process for the appointment of the External Auditors for consideration by the Council of Governors.

Members noted routine assurance reports including:

- Single Tender Action
- Losses and Special Payments
- Chair Reports from Finance Committee and Quality and Outcomes Committee. In particular the triangulation between the Audit Committee and the Quality and Outcomes Committee was noted in relation to serious incident reporting as highlighted in the latest audit report.

Key risks and issues/matters of concern and any mitigating actions

None identified.	
Matters requiring Committee level consideration and/or approval	
None identified.	
Matters referred to other Committees	
None identified.	
Date of next meeting	16 January 2017

University Hospitals Bristol NHS
NHS Foundation Trust

Cover report to the Trust Board meeting to be held on 31 October 2016 at 11:00 am – 1:00 pm in the Conference Room, Trust HQ, Marlborough St, Bristol, BS1 3NU

		Agenda Item	4.1b
Meeting Title	Trust Board	**Meeting Date**	31 October 2016
Report Title	Audit Committee Terms of Reference		
Author	Pam Wenger, Trust Secretary		
Executive Lead	Robert Woolley, Chief Executive		
Freedom of Information Status		Open	

Strategic Priorities (please select any which are impacted on / relevant to this paper)
Strategic Priority 7: We will ensure we are soundly governed and are compliant with the requirements of NHS Improvement.

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

Purpose

This report contains the proposed revised Terms of Reference for the Audit Committee, in line with the delegated authority from the Trust Board of Directors.

Key issues to note

The Audit Committee reviewed the terms of reference on 18th October 2016 and have recommended minor amendments.

Recommendations

Members are asked to:

- **Approve** the terms of reference.

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

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

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

Impact Upon Corporate Risk
Failure to have in place terms and reference and a clear work plan would have an impact on the robust governance processes and procedures in place.

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

Date papers were previously submitted to other committees				
Audit Committee	**Finance Committee**	**Quality and Outcomes Committee**	**Remuneration & Nomination Committee**	**Other (specify)**
18 October 2016				

University Hospitals Bristol NHS
NHS Foundation Trust

Terms of Reference – Audit Committee

Document Data	
Corporate Entity	Audit Committee
Document Type	Terms of Reference
Document Status	Draft
Executive Lead	Trust Secretary
Document Owner	Trust Secretary
Approval Authority	Board of Directors
Review Cycle	12 months
Next Review Date	01/09/2017

Document Change Control				
Date of Version	**Version Number**	**Lead for Revisions**	**Type of Revision (Major/Minor)**	**Description of Revisions**
16/02/2011	1	Trust Secretary	Draft	Draft for consideration by the members of the Audit and Assurance Committee
08/03/2011	2	Trust Secretary	Draft	Draft for consideration by the Audit and Assurance Committee
04/05/2011	3	Trust Secretary	Draft	Draft for consideration by the Audit Committee on 09 May 2011
09/05/2011	4	Trust Secretary	Draft	Revisions by Audit Committee
26/05/2011	5	Trust Secretary	Draft	For Approval by Trust Board of Directors
26/05/2011	6	Trust Secretary	Approved version	Approved by the Trust Board of Directors
01/09/2015	7	Trust Secretary	Major	Revised terms of reference for consideration by the Audit Committee 9th September 2015
05/10/2016	8	Trust Secretary	Minor	Revised terms of reference for consideration by the Audit Committee 18 October 2016.

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1. Constitution of the Committee

The Audit Committee is a statutory Committee established by the Trust Board of Directors to monitor, review and report to the Board on the suitability and efficacy of the Trust's provisions for Governance, Risk Management and Internal Control.

2. Purpose and function

The purpose and function of the Committee is to:

2.1 Monitor the integrity of the financial statements of the Trust, any formal announcements relating to the trust's financial performance, and reviewing significant financial reporting judgements contained in them;

2.2 Assist the Board of Directors with its oversight responsibilities and independently and objectively monitor, review and report to the Board on the adequacy of the processes for governance, assurance, and risk management, and where appropriate, facilitate and support through its independence, the attainment of effective processes;

2.3 Review the effectiveness of the Trust's internal audit and external audit function; and

2.4 In discharging its role and function, the Committee shall provide assurance to the Board of Directors that an appropriate system of internal control is in place to ensure that business is conducted in accordance with the law and proper standards, and affairs are managed to secure economic, efficient and effective use of resource with particular regard to value for money.

3. Authority

The Committee is:

3.1 Authorised by the Board to investigate any activity within its terms of reference and to seek any information it requires from any officer of the Trust and to call any employee to be questioned at a meeting of the Committee as and when required;

3.2 Authorised to obtain whatever professional advice it requires (as advised by the Trust Secretary); and

3.3 A Non-executive Committee of the Trust Board of Directors and has no executive powers, other than those specifically delegated in these Terms of Reference.

4. Membership and attendance

4.1 Members of the Committee shall be appointed by the Board of Directors and shall be made up of at least four members. All members of the Committee shall be independent Non-executive Directors at least one of whom shall have recent and relevant financial experience.

4.2 The chairman of the Board of Directors shall not be a member of the Committee.

4.3 Only members of the Committee have the right to attend Committee meetings.

4.4 The chair of the Committee shall not be the Chairman, or Senior Independent Director of the Board of Directors.

4.5 In the absence of the Committee Chair and/or an appointed deputy, the remaining members present shall elect one of themselves to chair the meeting.

4.6 External Audit and Internal Audit representatives shall be invited to attend meetings of the Committee on a regular basis. At least once a year the Committee should meet privately with the External and Internal Auditors.

4.7 The Director of Finance shall normally attend meetings.

4.8 The Chief Executive and other executive directors should be invited to attend as appropriate. The Chief Executive should be required to attend, at least annually, to discuss the process for assurance that supports the Annual Governance Statement.

5. Quorum

5.1 The quorum necessary for the transaction of business shall be three members, all of whom must be independent Non-executive Directors.

5.2 A duly convened meeting of the Committee at which a quorum is present shall be competent to exercise all or any of the authorities, powers and discretions vested in or exercisable by the Committee.

6. Duties

The Committee shall undertake the duties detailed in the NHS Audit Committee Handbook and shall have regard to the Audit Code for NHS Foundation Trusts. The Committee should carry out the duties below for the Foundation Trust and major subsidiary undertakings as a whole, as appropriate. These duties shall include:

6.1 Financial Reporting

The Committee shall:

6.1.1 Monitor the integrity of the annual report and financial statements of the Trust, and any other formal announcements relating to its financial performance, reviewing significant reporting issues and judgements which they contain;

6.1.2 Review summary financial statements, significant financial returns to regulators and any financial information contained in other official documents, including the Annual Governance Statement;

6.1.3 Review the consistency of, and changes to, accounting policies both on a year on year basis and across the Trust and its subsidiary undertakings;

6.1.4 Review the methods used to account for significant or unusual transactions where different approaches are possible (including unadjusted mis-statements in the

financial statements);

6.1.5 Review whether the Trust has followed appropriate accounting standards and made appropriate estimates and judgements, taking into account the views of the External Auditor; and

6.1.6 Review the clarity of disclosure in the Trust's financial reports and the context in which statements are made.

6.2 Governance, Risk Management and Internal Control

The Committee shall

6.2.1 Review the establishment and maintenance of an effective system of integrated governance, risk management and internal control, across the whole of the Trust's activities (both clinical and non-clinical), that supports the achievement of the organisation's objectives;

6.2.2 Review the adequacy of risk and control related disclosure statements, in particular the Annual Governance Statement, together with any accompanying Head of Internal Audit statement, External Audit opinion or other appropriate independent assurances, prior to endorsement by the Board;

6.2.3 Review the Board Assurance Framework and processes that indicate the degree of the achievement of corporate objectives, the effectiveness of the management of principal risks and the appropriateness of the above disclosure statements;

6.2.4 Review the policies for ensuring compliance with relevant regulatory, legal and code of conduct requirements, any related reporting and self-certifications, and work related to counter fraud and security as required by NHS Protect;

6.2.5 Receive assurance from Internal Audit, External Audit, directors and managers, including evidence of compliance with systems of governance, risk management and internal control, together with indicators of their effectiveness.

6.3 Internal Audit and Counter Fraud

The Committee shall:

6.3.1 Ensure that there is an effective Internal Audit function that meets the *Public Sector Internal Audit Standards 2013* and provides appropriate independent assurance to the Committee, Chief Executive and Board of Directors;

6.3.2 Consider and approve the Internal Audit strategy and annual plan and ensure it has adequate resources and access to information, including the Board Assurance Framework, to enable it to perform its function effectively and in accordance with the relevant professional standards. The Committee shall also ensure the function has adequate standing and is free from management or other restrictions;

6.3.3 Review promptly all reports on the Trust from the Internal and External Auditors, review and monitor the Executive Management's responsiveness to the findings and

recommendations of reports, and ensure coordination between Internal and External Auditors to optimise use of audit resource;

6.3.4 Meet the Head of Internal Audit at least once a year, without management being present, to discuss their remit and any issues arising from the internal audits carried out. The Head of Internal Audit shall be given the right of direct access to the Chair of the Committee, Chief Executive, Board of Directors and to the Committee;

6.3.5 Conduct a review of the effectiveness of Internal Audit and Counter Fraud services once every five years; and

6.3.6 Satisfy itself that the Trust has adequate arrangements in place for counter fraud and security that meets the *NHS Protect* standards and shall review the outcomes of work in these areas.

6.4 External Audit

The Committee shall:

6.4.1 Consider and make recommendations to the Council of Governors, in relation to the appointment, re-appointment and removal of the Trust's External Auditor;

6.4.2 Work with the Council of Governor to manage the selection process for new auditors and, if an auditor resigns, the Committee shall investigate the issues leading to this, and make any associated recommendations to the Council of Governors;

6.4.3 Receive assurance of External Auditor compliance with the Audit Code for NHS Foundation Trusts;

6.4.4 Approve the External Auditor's remuneration and terms of engagement including fees for audit or non-audit services and the appropriateness of fees, to enable an adequate audit to be conducted;

6.4.5 Agree and review the policy regarding the supply of non-audit services by the External Auditor and monitor that service, taking into account relevant ethical guidance;

6.4.6 Review and monitor the External Auditors' independence and objectivity and the effectiveness of the audit process. In particular, the Committee will review the work and findings of the External Auditors and consider the implications and management's responses to their work;

6.4.7 Meet the external auditor at least once a year, without management being present; to discuss their remit and any issues arising from the audit;

6.4.8 Discuss and agree with the External Auditors, before the audit commences, the nature and scope of the audit, as set out in the annual plan;

6.4.9 Discuss with the External Auditors their evaluation of audit risks and assessment of the Trust, and the impact on the audit fee; and

6.4.10 Review all External Audit reports, including the report to those charged with governance (before its submission to the Board of Directors) and any work undertaken outside the annual audit plan, together with the appropriateness of management responses;

6.5 Other Board Assurance Functions

6.5.1 The Committee shall review the findings of other significant assurance functions, both internal and external to the Trust and consider the implications to the governance of the Trust. These will include, but not be limited to, any reviews undertaken by the Department of Health Arms-Length Bodies, Regulators, and professional bodies with responsibility for the performance of staff or functions.

6.5.2 The Committee shall review the work of other Committees within the organisation, whose work can provide relevant assurance to the Audit Committee's own scope of work and in relation to matters of quality affecting the Board Assurance Framework, including the Quality and Outcomes Committee and the Finance Committee; and

6.6 Annual Report and Annual Members Meeting

6.6.1 The annual report should include a statement referring to any non-audit services provided by the external auditors, and if so, how auditor objectivity and independence is safeguarded;

6.6.2 The annual report should include details of the full auditor appointment process, and where the Council of Governors decide not to accept the recommendations of the Committee, a statement setting out those reasons.

6.6.3 Where the external auditor's contract is terminated in disputed circumstances, the annual report should include detail on the removal process and the underlying reasons for removal.

6.6.4 The Committee chair shall attend the Annual Members Meeting/Annual General Meeting and prepared to respond to any stakeholder questions on the Committee's activities.

6.7 Clinical Audit

6.7.1 The Committee shall review issues around clinical risk management and satisfy itself on the assurance that can be gained from the Clinical Audit function.

6.7.2 The Committee will receive the Clinical Audit Annual Plan and Annual Report and receive regular updates on progress made by clinical audit throughout the year.

6.8 Speaking Out Policy and Fraud

6.8.1 The Committee shall monitor and receive assurance on compliance with the Trust's Speaking Out Policy, and ensure that the policy allows for proportionate and independent investigation of such matters and appropriate follow-up action.

7. Reporting and Accountability

7.1 The Committee chairman shall report formally to the Trust Board of Directors on its proceedings after each meeting on all matters within its duties and responsibilities, and make whatever recommendations to the Board of Directors it deems appropriate on any area within its remit where action or improvement is needed.

7.2 The Committee shall report to the Trust Board annually on its work in support of the Annual Governance Statement.

7.3 The Committee shall make necessary recommendations to the Council of Governors on areas relating to the appointment, re-appointment and removal of External Auditors, the level of remuneration and terms of engagement as it deems appropriate.

7.4 The chair of the Committee shall write to the Independent Regulator of NHS Foundation Trusts (NHS Improvement) in those instances where the services of the External Auditor are terminated in disputed circumstances.

7.5 Where exceptional, serious and improper activities have been revealed by the Committee, the chair shall write to NHS Improvement, if insufficient action has been taken by the Board of Directors after being informed of the situation.

7.6 The Committee shall produce a statement to be included in the Trust's Annual Report which describes how the Committee has fulfilled its terms of reference and discharged its responsibilities throughout the previous year.

7.7 Outside of the written reporting mechanism, the Committee chair should attend the Annual Members Meeting and be prepared to respond to any questions on the Committee's area of responsibility.

8. Administration

8.1 The Trust Secretary shall provide secretariat services to the Committee and shall provide appropriate support to the Chair and Committee members as required.

8.2 Meetings of the Committee shall be called by the secretary of the Committee at the request of the Committee chair. The Board of Directors, Chief Executive, External Auditors or Head of Internal Audit may request an additional meeting if they consider it necessary.

8.3 Notice of each meeting confirming the venue, time and date, together with an agenda of items to be discussed, shall be made available to each member of the Committee, no less than five working days before the date of the meeting. Supporting papers shall be made available no later than three working days before the date of the meeting.

8.4 The secretary shall minute the proceedings of all Committee meetings, and draft minutes of Committee meetings shall be made available promptly to all members of the Committee.

8.5 The secretary shall ascertain, at the beginning of each meeting, the existence of any conflicts of interest and minute them accordingly.

9. Frequency of Meetings

9.1 The Committee shall meet a minimum of four times a year and at such other times as the Chair of the Committee shall require to allow the Committee to discharge all of its responsibilities.

10. Review of Terms of Reference

10.1 The Committee shall, at least once a year, review its own performance to ensure it is operating at maximum effectiveness. The Committee shall use the Audit Committee Self-assessment Checklist for this purpose.

Cover report to the Trust Board meeting to be held on 31 October 2016 at 11-1pm in the Conference Room, Trust HQ, Marlborough St, Bristol, BS1 3NU

		Agenda Item	4.2
Meeting Title	Trust Board	**Meeting Date**	31 October 2016
Report Title	Quarterly Risk Assessment Framework		
Author	Xanthe Whittaker, Associate Director of Performance		
Executive Lead	Robert Woolley, Chief Executive		
Freedom of Information Status		Open	

Strategic Priorities (please select any which are impacted on / relevant to this paper)
Strategic Priority 1 :We will consistently deliver high quality individual care, delivered with compassion services.
Strategic Priority 7: We will ensure we are soundly governed and are compliant with the requirements of NHS Improvement.

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

Executive Summary

Purpose

To brief the Committee on the Trust's performance against the standards in the NHS Improvement Risk Assessment Framework in quarter 2.

To inform the Committee of the changes to regulatory requirements around performance, and associated monitoring arrangements.

To brief the Committee on the Trust's risks to achievement of the standards in the NHS Improvement Single Oversight Framework (SOF) in quarter 3.

Key issues to note

The Trust failed four of the standards in the NHS Improvement Risk Assessment Framework in quarter 2, which equates to a Service Performance Score of 3.0. The failed standards are listed below:

- A&E 4-hours
- 18-week Referral to Treatment Times (RTT)
- 62-day GP cancer
- 62-day Screening

We have been advised trusts are not required to make a declaration of compliance with access/targets and governance standards for the end of quarter 2, due to the Single Oversight Framework now being in effect (as if the 1st October 2016).

The four core access standards being used to assess performance as part of the SOP are those linked to Sustainability & Transformation Funds (STF), which are:

- A&E 4-hours
- 18-week Referral to Treatment Times (RTT)
- 62-day GP cancer
- 6-week wait diagnostics

Achievement of the required standard (i.e. trajectory or national standard) is considered high risk for all four standards in quarter 3, further details of which can be found in the Finance Report as part of the STF section.

Recommendations

This briefing is for Assurance and Information

Members are asked to:

- **Note**

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

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

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

Impact Upon Corporate Risk
No change required to the following risks (recently reviewed): Risk 810 – Failure to maintain a Green Risk Rating – score 16 Risk 888 – Failure to meet recovery trajectories – score 16 Risk 932 – Failure to meet national cancer waits – score 20.

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

Date papers were previously submitted to other committees				
Audit Committee	**Finance Committee**	**Quality and Outcomes Committee**	**Remuneration & Nomination Committee**	**Other (specify)**
		27 October 2016		

NHS Improvement Quarter 2 declaration against the 2016/17 Risk Assessment Framework for Governance

1. Context

Following quarter-end, trusts have previously been required to make a declaration of compliance against the 2016/17 NHS Improvement Risk Assessment Framework. For quarter 2 this would have been due by the 31st October 2016.

However, the Trust was advised by NHS Improvement on the 18th October, that no declaration was required for performance against access or governance standard, due to the new NHS Improvement Single Oversight Framework (SOF) coming into effect from the start of quarter 3 (further details of which can be found in section 4.0). Reporting of performance against the new standards which form part of the SOF is now already in place, further details of which can be found in the STF section of the Finance Report.

However, as part of the Trust's own governance process, the following represents the declaration which the Board would have been recommended to make at the end of October. This briefing also provides further details on the access standards included within the SOF and the risks to achievement of these standards in quarter 3.

2. Quarter-end declarations

The Trust's scores against the Risk Assessment Framework are used to derive a Governance Rating for quarter 2, by counting the number of 'Governance Concerns' that have been triggered in the period. These Governance Triggers at present include the following:

- Service Performance Score of 4 or greater (i.e. four or more standards failed in the period)
- A single target being failed for three consecutive quarters
- The A&E 4-hour standard being failed for two quarters in any four-quarter period *and* in any additional quarter over the subsequent three-quarter period
- Breaching the annual *Clostridium difficile* objective by failing three consecutive year-to-date quarters *or* failing the full-year objective at any point in the year
- CQC warning notices

NHS Improvement also uses other information to signal potential Governance Concerns, using patient and staff metrics such as satisfaction rates, turn-over rates, levels of temporary staffing and other information from third party organisations. The resultant Governance Rating that NHS Improvement publishes will depend on further investigations it conducts following Governance Concerns being triggered.

Each quarterly declaration to NHS Improvement must take account of performance in the quarter, and also note expected performance risks in the coming quarter. The forecast risks will be declared to NHS Improvement as part of the narrative that accompanies the submission.

NHS Improvement compares the quarterly declarations a trust makes with its Annual Plan risk assessment. If a trust declares a standard as not met as part of its quarterly declaration, which it did not declare at risk in the annual plan risk assessment, the trust may be required to commission an independent review of its self-certification and associated processes. In the Trust's Annual Plans the standards declared to be at risk of failure in quarter 2 and quarter 3 2016/17 were as shown below:

	Quarter 2 2016/17	**Quarter 3 2016/17**
Standards not forecast to be met	A&E 4-hours 62-day GP cancer 62-day Screening cancer	A&E 4-hours 62-day Screening cancer
Score	**2.0**	**2.0**

3. Performance in the period

Table 1 shows the performance in quarter 2 against each of the standards in NHS Improvement's Risk Assessment Framework. The following standards were not achieved in the quarter:

- A&E 4-hour standard (score 1)
- 62-day GP and 62-day Screening cancer standards (combined score of 1)
- Referral to Treatment (RTT) Incomplete pathways standard (score 1)

Overall the Trust scores 3 against the Risk Assessment Framework, although under the rules set-out within the Risk Assessment Framework which was in existence in quarter 2, the failure of the 62-day GP and screening standards, and the A&E 4-hour standard, in quarter 2 would trigger Governance Concerns for repeated failures of the same standard. However, NHS Improvement has restored the Trust to a GREEN rating but will continue to NHS Improvement progress with achievement of recovery trajectories.

Please note that performance against the cancer standards is still subject to final national reporting at the beginning of November and therefore the position shown in Table 2 remains draft.

4. NHS Improvement Single Oversight Framework (SOF)

On the 1st October 2016 the new NHS Improvement Single Oversight Framework (SOF) came into effect. One of five themes under the SOF is Operational Performance. NHS Improvement has indicated that it is likely to continue to collect information on Trust's performance and governance through the same format it currently does. However, in targets and indicators terms the focus will be on reviewing performance against the four core standards against which the allocation of Sustainability & Transformation Funds (STF) is linked. These standards are:

- A&E 4-hour standard
- RTT Incomplete pathways standard
- 62-day GP cancer standard[1]
- 6-week diagnostic wait (no fund attached in 2016/17, but agreed trajectory in place)

On the basis of performance against these four standards, trusts will be put into different segments. The allocation of a trust to a segment determines the level of support a trust is deemed to need in order to improve its performance, but also the level of monitoring and autonomy it has. NHS Improvement will consider whether a trust needs to be moved into a different segment (i.e. receive more support or more frequent monitoring) if it fails to meet a STF trajectory for a standard for **two consecutive months**. However, a decision regarding the need for additional support may be taken sooner, if a trust shows a more rapid deterioration in performance. There are in addition, an agreed list of quality metrics against which a Trust's performance will be monitored to determine whether support is required to improve the quality of a trust's services (see Appendix 1).

5. Quarter 3 2016/17 risk assessment against the SOF

The risk assessment detailed in Table 3 sets-out the performance against each standard in quarter 2, relative to the agreed STF performance trajectory, together with the risks to continued achievement of the trajectory in quarter 3. The mitigating actions that are being taken are also provided, along with the residual risk. Where the residual risk is noted as being High, this indicates there is a high risk of the STF trajectory not being met for two or more consecutive months.

The national standard of at least 92% of patients waiting less than 18 weeks at month-end from Referral to Treatment (RTT) was achieved in July, but not August or September. Analysis undertaken suggests that the failure to meet the national standard and STF trajectory was mainly a

[1] Please note the Single Oversight Document includes the 62-day screening standard in its list of Operational Performance metrics. However, this is not a metric against which STF trajectories have been agreed (or were required). This has been raised as an issue with NHS Improvement.

result of higher than planned levels of demand in specialties whose capacity was constrained by a range of factors, including planned and unexpected retirements, capacity lost earlier in the year due to junior doctor industrial action, routine capacity needing to be reallocated to more urgent patients (such as emergencies and two-week waits patients), and recurrent capacity requirements having been underestimated (the latter in a small number of dental specialties). Efforts to backfill lost recurrent capacity or meet heightened levels of demand were also potentially limited by lower uptake of waiting list initiatives, following a change in additional hours payment rates. A recovery plan has been put in place and a recovery trajectory developed from this.

The A&E 4-hour 95% standard failed to be achieved in the period. However, performance during July and August, and for the quarter as a whole, was significantly above STP performance trajectory. Continuing the trend seen in the last two quarters, emergency demand remained higher than expected in quarter 2, with a 5.2% increase in emergency admissions relative to the same period last year (5.7% up for the BRI and 3.2% up for the BCH). Levels of delayed discharges also increased in quarter 2, remaining above plan. These system factors continue to pose risks to achievement in quarter 3.

The 62-day GP cancer standard was failed again in quarter 2, with the STP trajectory being met in August, but not for the quarter as a whole. Late referrals continued to be the major cause of breaches, accounting for 36% of all breaches of standard in July and August, with an increase in late referrals from North Bristol Trust (NBT) in particular. Histopathology reporting delays, following the transfer of the service to NBT at the beginning of May, also resulted in a high volume of breaches being incurred in quarter 2, and likely contributed to the increase in late referrals from NBT. At the end of September histopathology reporting times were back down to near pre-service transfer levels. It is therefore expected that this and the resulting likely reduction in late referrals will help restore performance close to if not above the 85% standard, in combination with a national breach reallocation policy and associated local CQUIN for timely referral, which came into effect from the 1st October. However, it is recommended that the potential risk to failure of the 62-day GP cancer standard that our case-mix, and late tertiary referrals brings, continues to be flagged as ‘high’ to NHS Improvement and commissioners as part of the routine monitoring process.

6. Recommendation

The Trust Board is asked to note the standards failed in quarter 2 to be the A&E 4-hour standard, the RTT Incomplete pathways standard, the 62-day GP and 62-day Screening cancer standards, which would have formed part of the quarterly declaration to NHS Improvement, and to also note the risks to achievement in quarter 3, of the new standards which form part of the Single Oversight Framework.

Table 1 - Summary of performance in quarter 2 2016/17

Indicator	Standard	Score	Achieved in Q2 2016/17?	Performance for the quarter	Notes
18-weeks Referral to Treatment for incomplete pathways	92%	1.0	No	To be confirmed	Achieved 92%/STF in July but not August and September.
A&E Maximum waiting time 4 hours	95%	1.0	No	88.9%	STF Trajectory met in July and August and in aggregate for the quarter.
Cancer: 62-day wait for first treatment – GP Referred	85%	1.0	No	79.7%	STF Trajectory met in August.
Cancer: 62-day wait for first treatment – Screening Referred	90%		No	63.0%	Standard not achieved in any month.
Cancer: 31-day wait for subsequent surgery	94%	1.0	Yes	95.1%	Achieved for the quarter as a whole.
Cancer: 31-day wait for subsequent drug therapy	98%		Yes	98.0%	Achieved for the quarter as a whole.
Cancer: 31-day wait for subsequent radiotherapy	94%		Yes	94.7%	Achieved for the quarter as a whole.
Cancer: 31-day wait for first definitive treatment	96%	1.0	Yes	97.2%	Achieved each month.
Cancer: Two-week wait for urgent GP referral	93%	1.0	Yes	93.6%	Achieved for the quarter as a whole.
Clostridium difficile	Within the limit	1.0	Yes	Below limit each month	Achieved each month.
Certification against compliance with requirements regarding access to healthcare for patients with a learning disability	Standards met	1.0	Yes	See notes	Standards continue to be met.

Table 3 - Summary of performance in quarter 2 2016/17 against the STF trajectory, and the risks to quarter 3 compliance with the STF trajectory

Indicator	Achieved STF in Q2 2016/17?	New risks to Q3 2016/17?	Risks/Issues	Steps being taken to mitigate risks	Original risk rating	Residual risk rating[2]
18-weeks Referral to Treatment incomplete pathways	July – Yes August – No September - No	No – ongoing risks from Q2	- High levels of demand in specialties that have capacity constraints/challenges; - Non admitted RTT treatments difficult to plan because an RTT clock may or may not stop at each outpatient attendance; - Changes to waiting list initiative payment rates, which continue to reduce the Trust's ability to respond quickly to rising demand and capacity gaps.	- IMAS (Interim Management & Support) Capacity and Demand models currently being re-run to plan activity required for 2017/18, to achieve correct level of recurrent capacity and reduce backlogs in non-achieving specialties; - Escalation meetings for non-achieving specialties, to monitor implementation of recovery plans recently put in place; - Validation of long waiters to improve data quality and waiting list management; - Robust monitoring and escalation to optimise the number of long waiters booked each month.	High	High
A&E Maximum waiting time 4 hours	July – Yes August – Yes September - No	No – ongoing risks from Q2	- Quarter 2 levels of emergency admissions via the Emergency Departments 5.7% up for the Bristol Royal Infirmary, and 3.2% up for the Bristol Children's Hospital, relative to the same period last year and materially above plan; - Delayed Discharges have risen and remain well above plan;	- Wide-ranging internal improvement plan including ORLA community-based patient management (with significant impact expected in the latter half of 2016/17), improved ward-based discharge processes, and changes in the management of particular patient pathways, which should reduce length of stays for a cohort of medical patients; - Escalation of risks relating to delayed discharges to partner organisation Execs; - Continued implementation of system-	High	High

[2] The 'Residual' Risk Rating represents the most likely risk level that will remain once the impact of mitigating actions have been applied to the 'Original' risk. The 'Original' risk is the risk rating before any mitigating actions have been taken. For this reason the terms are different from the 'Current' and Target' risk categories used on the Trust's Risk Register for the management of risk.

			- Other local providers continuing to report a high proportion of over 4-hour waits, increasing the potential for ambulance diverts and high levels of variation in demand.	wide Resilience Plan.		
Cancer: 62-day GP Referral to Treatment	July – No August – Yes September - No	Yes – Closure of Taunton skin cancer service	- Very high levels of late tertiary referrals continuing to be main cause of breaches (circa 36% of breaches); - Delays in histopathology reporting following the transfer of the service to North Bristol Trust (although the risk related to this is decreasing); - High levels of medical deferral, patient choice, and clinical complexity (none of which can be accounted for in waiting times and are difficult to mitigate); - Increasing/high volumes of patients for tumour sites that nationally perform well below the 85% standard - High levels of demand, especially for skin cancer referrals; - Closure of the dermatology service at Taunton & Somerset Trust, including the two-week wait service	- Cancer Performance Improvement Group overseeing action plan, which currently includes further work on 'ideal timescale' pathways and refresher training on pathway tracking and management for relevant administrative and clerical staff; - Monthly and quarterly breach reviews, along with benchmarking against an equivalent peer group, being used to inform further improvement work; - Patients on the cancer patient tracking list continue to be actively managed, with oversight of the waiting list through divisional and Trust-wide weekly meetings, and any delays escalated to Divisional Directors and Chief Operating Officer; - Further capacity and demand modelling for critical care undertaken to inform future operational model and limit future cancellations once in place; - Histopathology recovery plan enacted by NBT and now delivering improvements, with oversight of recovery being also tracked by commissioners and NHS Improvement.	High	High

			from the end of October.			
Diagnostic 6-week wait	July – No August – No September - No	No – ongoing risks from Q2	- High demand for sleep studies and endoscopy; - Options for increasing capacity to meet varying levels of demand constrained, due to competing pressures and variable uptake of waiting list initiatives.	- Additional capacity established for endoscopy through GLANSO and outsourcing; - Routine endoscopy referrals being redirected to independent providers; - Additional sleep studies sessions being established to reduce the number of long waiters.	High	High

Appendix 1: Quality of care (safe, effective, caring, responsive) monitoring metrics

NHS Improvement will use the following indicators below to supplement CQC information in order to identify where providers may need support under the theme of quality.

Quality indicators

Measure	Type	Frequency	Source
Staff sickness	Organisational health	Monthly/quarterly	NHS Digital (publicly available)
Staff turnover	Organisational health	Monthly/quarterly	NHS Digital (publicly available)
Executive team turnover	Organisational health	Monthly	Provider return
NHS Staff Survey	Organisational health	Annual	CQC (publicly available)
Proportion of temporary staff	Organisational health	Quarterly	Provider return
Aggressive cost reduction plans	Organisational health	Quarterly	Provider return
Written complaints - rate	Caring	Quarterly	NHS Digital (publicly available)
Staff Friends and Family Test % recommended - care	Caring	Quarterly	NHSE (publicly available)
Occurrence of any Never Event	Safe	Monthly	NHS Improvement (publicly available)
NHS England/NHS Improvement Patient Safety Alerts outstanding	Safe	Monthly	NHS Improvement (publicly available)
Emergency c-section rate	Safe	Monthly	HES
Mixed sex accommodation breaches	Caring	Monthly	NHSE (publicly available)
Inpatient scores from Friends and Family Test - % positive	Caring	Monthly	NHSE (publicly available)
A&E scores from Friends and Family Test - % positive	Caring	Monthly	NHSE (publicly available)

Measure	Type	Frequency	Source
CQC inpatient/MH and community survey	Organisational health	Annual	CQC (publicly available)
Maternity scores from Friends and Family Test - % positive	Caring	Monthly	NHSE (publicly available)
VTE Risk Assessment	Safe	Quarterly	NHSE (publicly available)
Clostridium Difficile - variance from plan	Safe	Monthly	PHE (publicly available)
Clostridium Difficile - infection rate	Safe	Monthly	PHE (publicly available)
MRSA bacteraemias	Safe	Monthly	PHE (publicly available)
Hospital Standardised Mortality Ratio (DFI)	Effective	Quarterly	DFI
Hospital Standardised Mortality Ratio - Weekend (DFI)	Effective	Quarterly	DFI
Summary Hospital Mortality Indicator	Effective	Quarterly	NHS Digital (publicly available)
Potential under-reporting of patient safety incidents15	Safe	Monthly	NHS England (dashboard)
Emergency re-admissions within 30 days following an elective or emergency spell at the provider	Effective	Monthly	HES

Cover report to the Trust Board meeting to be held on 31 October 2016 at 11-1pm in the Conference Room, Trust HQ, Marlborough St, Bristol, BS1 3NU

		Agenda Item	4.3
Meeting Title	Trust Board	**Meeting Date**	31 October 2016
Report Title	Register of Seals		
Author	Pam Wenger, Trust Secretary		
Executive Lead	Robert Woolley, Chief Executive		
Freedom of Information Status		Open	

Strategic Priorities (please select any which are impacted on / relevant to this paper)
Strategic Priority 7: We will ensure we are soundly governed and are compliant with the requirements of NHS Improvement.

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

Executive Summary
<u>Purpose</u> To report applications of the Trust Seal as required by the Foundation Trust Constitution. <u>Key issues to note</u> 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 October 2016 since the previous report on June 2016.
Recommendations
Members are asked to: • **Note** the report.

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

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

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

Impact Upon Corporate Risk
No risk identified.

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

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

Register of Seals – July 2016 – October 2016

Reference Number	Date Signed	Document	Authorised Signatory 1	Authorised Signatory 2	Witness
783	11/07/16	Contract Engrossment for Upper Maudlin St. Office Refurb	Robert Woolley, Chief Executive	Paul Mapson, Director of Finance	Pam Wenger, Trust Secretary
784	26/07/16	BRI and Condense Diversion	Robert Woolley, Chief Executive	Paul Mapson, Director of Finance	Pam Wenger, Trust Secretary
785	26/07/16	Level 5 Old Building BRI	Robert Woolley, Chief Executive	Paul Mapson, Director of Finance	Pam Wenger, Trust Secretary
786	27/07/16	Lease Rooms 56-62	Robert Woolley, Chief Executive	Paul Mapson, Director of Finance	Pam Wenger, Trust Secretary
787	16/08/16	WARD 30 Children's	Paul Mapson, Director of Finance	Pam Wenger, Trust Secretary	Jeremy Spearing, Associate Director of Finance
788	22/09/16	Lease for 24 Upper Maudlin St, Bristol UHB and Trusts	Robert Woolley, Chief Executive	Paul Mapson, Director of Finance	Pam Wenger, Trust Secretary
789	22/09/16	UHB and NBT Tenancy of – Level 9, Queens Building, BRI, Upper Maudlin St, Bristol BS2 8HW	Robert Woolley, Chief Executive	Paul Mapson, Director of Finance	Pam Wenger, Trust Secretary
790	22/09/16	UHB and NBT Lease of Part-Paediatric Mortuary, St Michaels Hospital, Bristol, BS2 8EG	Robert Woolley, Chief Executive	Paul Mapson, Director of Finance	Pam Wenger, Trust Secretary

Cover report to the Trust Board meeting to be held on 31 October 2016 at 11:00 am – 1.00 pm in the Conference Room, Trust HQ, Marlborough St, Bristol, BS1 3NU

		Agenda Item	5.1
Meeting Title	Trust Board	**Meeting Date**	31 October 2016
Report Title	Trust Strategic Planning and Implementation Framework- Refreshed Approach from 2016/17		
Author	Paula Clarke, Director of Strategy and Transformation		
Executive Lead	Paula Clarke, Director of Strategy and Transformation		
Freedom of Information Status		Open	

Strategic Priorities (please select any which are impacted on / relevant to this paper)
Strategic Priority 1: We will consistently deliver high quality individual care, delivered with compassion services.
Strategic Priority 2: We will ensure a safe, friendly and modern environment for our patients and our staff.
Strategic Priority 4: We will deliver pioneering and efficient practice, putting ourselves at the leading edge of research, innovation and transformation
Strategic Priority 5: We will provide leadership to the networks we are part of, for the benefit of the region and people we serve.
Strategic Priority 6: We will ensure we are financially sustainable to safeguard the quality of our services for the future and that our strategic direction supports this goal.
Strategic Priority 7: We will ensure we are soundly governed and are compliant with the requirements of NHS Improvement.

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

Executive Summary

Purpose

The Trust has a clearly articulated Strategy in place - “Rising to the Challenge 2014-2020” in which we stated our position on a number of key strategic choices To ensure that this strategy remained dynamic, we reviewed progress against implementation (in 2015) and identified a requirement for greater assurance on our processes to drive and support decision-making and implementation plans within the context of our higher level key strategic choices.

As outlined in the paper presented to the Trust Board in June 2016, the aim of the 2016/17 programme of work was therefore to ensure that the Trust has in place a standardised way of approaching strategic decision-making, a clear governance framework within which to develop and assess options and ensure a proactive approach to influencing and assessing strategic reviews, and establishing a route map to progress service-specific preferred options through to implementation.

The purpose of this paper is to provide an update to Trust Board on the development and delivery of a programme of work to revise the Trust's approach to the planning and implementation of strategic change. It is also to provide assurance to the Trust Board, that key activities have been completed through 2016/17 to deliver a step change in how strategic planning and implementation is managed within the Trust and to progress specific strategic decisions identified by Divisions.

This paper will provide the following;

- A recap of the purpose of the programme of work, along with its aims and objectives.
- A summary of the changes to the local and national context informing the process.
- A report on the content and outputs of each element of the programme of work, to include;
  - Changes to the governance structure.
  - The findings and recommendations from the strategy stocktake
  - An outline of the framework and standard methodology developed to support strategic decision-making and effective implementation planning
  - An outline of progress on the development of the Phase 5 capital programme process and next steps.
  - An outline of the plan and recommendations for scope and content of the refresh of our current Trust Strategy (to be completed by end of calendar year).

Key issues to note

The programme consists of five key areas to be developed through 2016/17 and these five areas formed the content of the programme. These were;

- Strategic governance and meeting structure.
- A stocktake of the current and future strategies within the Trust
- A review of our clinical strategy prioritisation and implementation
- Renewing our Hospitals – Phase 5 (strategic) Capital redevelopment process
- A refresh of our Trust strategy

The following pieces of work have been completed and demonstrate the progress to date;

- A Governance framework for decision making and progression of plans produced and agreed (Appendix 1).
- Decision-making tools have been developed and agreed, with training undertaken with divisional teams. These include a standard service development/evaluation/business case template, divestment guidance and tender process.
- Further prioritisation of our clinical strategy using a standard methodology completed by divisional teams and resulting framework supported through Senior Leadership Team (SLT) (Appendix 2).
- Delivery programme developed to drive forward options and identify where decisions are required.
- Eleven service areas identified as priorities by Divisions for development and action and first presentation of options at Clinical Strategy Group in September and Strategy Steering Group in October.
- Prioritisation process for Phase 5 capital established and prioritisation exercise completed,

with a long list of potential schemes established.
- Completion of a stocktake of our existing portfolio of strategies within the Trust.

There are five further priority areas of focus for completion through 2016/17. These can be summarised as;

- Refreshing our current Trust Strategy to reflect these developments and to re-visit the wider strategic choices we made in 2014 (Appendix 4) in the context of the system STP. This refresh will be informed by engagement with our teams and our key stakeholders to ensure shared ownership of our strategy that will support its delivery.
- Full delivery of the action plan established through the strategy stocktake exercise.
- Completion of the Phase 5 capital prioritisation process.
- Progressing actions to inform decisions on our current clinical strategic choice priorities and develop associated implementation plans.
- An on-going programme of training and development through the Trust and oversight through the new governance framework, to ensure that the new route map and methodology for how services are developed and decisions are made becomes embedded.

Following feedback from Trust Board the programme will continue to deliver the next steps outlined in each section of this paper, with oversight through the new governance structure. Specific reference will be given to ensuring the new governance process for progressing strategic decisions is followed, including consideration of decisions of significant impact or scale against the framework at future Trust Board meetings.

A timeline will be developed for the refresh of our current strategy document, “Rising to the Challenge – our 2020 Vision”, planned for completion in Quarter 4 of 2016/17. This will include a programme of engagement within the organisation and our key stakeholders.

Recommendations

Members are asked to:

- **Note** the update and assurance provided on the programme to date and next steps outlined in this paper.

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

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

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

Impact Upon Corporate Risk
There are no direct links between this paper and risks on the corporate risk register

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

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

Trust Strategic Planning and Implementation Framework - Refreshed Approach from 2016/17

1. Introduction

The purpose of this paper is to provide an update to Trust Board on the development and delivery of a programme of work to revise the Trust's approach to the planning and implementation of strategic change. It is also to provide assurance to the Trust Board, that key activities have been completed through 2016/17 to deliver a step change in how strategic planning and implementation is managed within the Trust and to progress specific strategic decisions identified by Divisions.

This paper will provide the following;

- A recap of the purpose of the programme of work, along with its aims and objectives.
- A summary of the changes to the local and national context informing the process.
- A report on the content and outputs of each element of the programme of work, to include;
  - Changes to the governance structure.
  - The findings and recommendations from the strategy stocktake
  - An outline of the framework and standard methodology developed to support strategic decision-making and effective implementation planning
  - An outline of progress on the development of the Phase 5 capital programme process and next steps.
  - An outline of the plan and recommendations for scope and content of the refresh of our current Trust Strategy (to be completed by end of calendar year).

2. Background

The Trust has a clearly articulated Strategy in place - "Rising to the Challenge 2014-2020" in which we stated our position on a number of key strategic choices (Appendix 4). To ensure that this strategy remained dynamic, we reviewed progress against implementation (in 2015) and identified a requirement for greater assurance on our processes to drive and support decision-making and implementation plans within the context of our higher level key strategic choices. As outlined in the paper presented to the Trust Board in June 2016, the aim of the 2016/17 programme of work was therefore to ensure that the Trust has in place a standardised way of approaching strategic decision-making, a clear governance framework within which to develop and assess options and ensure a proactive approach to influencing and assessing strategic reviews, and establishing a route map to progress service-specific preferred options through to implementation.

As summarised in the paper presented to Trust Board in June 2016, the overarching objective of this programme of work was to establish and oversee a strategic planning framework for the Trust which ensures:

- A coherent and co-ordinated programme of strategic review to inform decision-making by Divisions, the Senior Leadership Team and the Trust Board;
- Alignment of goals and strategies, through Trust-wide and divisional strategies to deliver the agreed objectives of the Board;
- A clear structure to oversee the design and implementation of strategic development programmes and projects, approved and designated by the Trust Board.
- Provide assurance that strategic plans are internally aligned and can both influence and respond appropriately to national policy, strategic reviews, commissioning intentions, market developments and the plans of system partners.
- Provide practical tools to divisional teams and a supportive framework in which strategic initiatives can be developed and successfully implemented.
- Provide a prioritised view of the Trust's clinical strategy choices and establish a clear programme of work, with associated timescales to progress these strategic decisions and

agree a route map for implementation.
- Ensure internal alignment to the emerging priorities of the system Sustainability and Transformation Plan (STP) and provide a structure for internal engagement in the STP processes.

3. Summary

To deliver the required outcomes outlined above, it was identified that there were five key areas to be developed through 2016/17 and these five areas formed the content of the programme. These were;

- Strategic governance and meeting structure.
- A stocktake of the current and future strategies within the Trust.
- A review of our clinical strategy prioritisation and implementation.
- Renewing our Hospitals – Phase 5 (strategic) Capital redevelopment process.
- A refresh of our Trust strategy.

The following pieces of work have been completed and demonstrate the progress to date;

- A Governance framework for decision making and progression of plans produced and agreed (Appendix 1).
- Decision-making tools have been developed and agreed, with training undertaken with divisional teams. These include a standard service development/evaluation/business case template, divestment guidance and tender process.
- Further prioritisation of our clinical strategy using a standard methodology completed by divisional teams and resulting framework supported through Senior Leadership Team (SLT) (Appendix 2).
- Delivery programme developed to drive forward options and identify where decisions are required.
- Eleven service areas identified as priorities by Divisions for development and action and first presentation of options at Clinical Strategy Group in September and Strategy Steering Group in October.
- Prioritisation process for Phase 5 capital established and prioritisation exercise completed, with a long list of potential schemes established.
- Completion of a stocktake of our existing portfolio of strategies within the Trust.

There are five further priority areas of focus for completion through 2016/17. These can be summarised as;

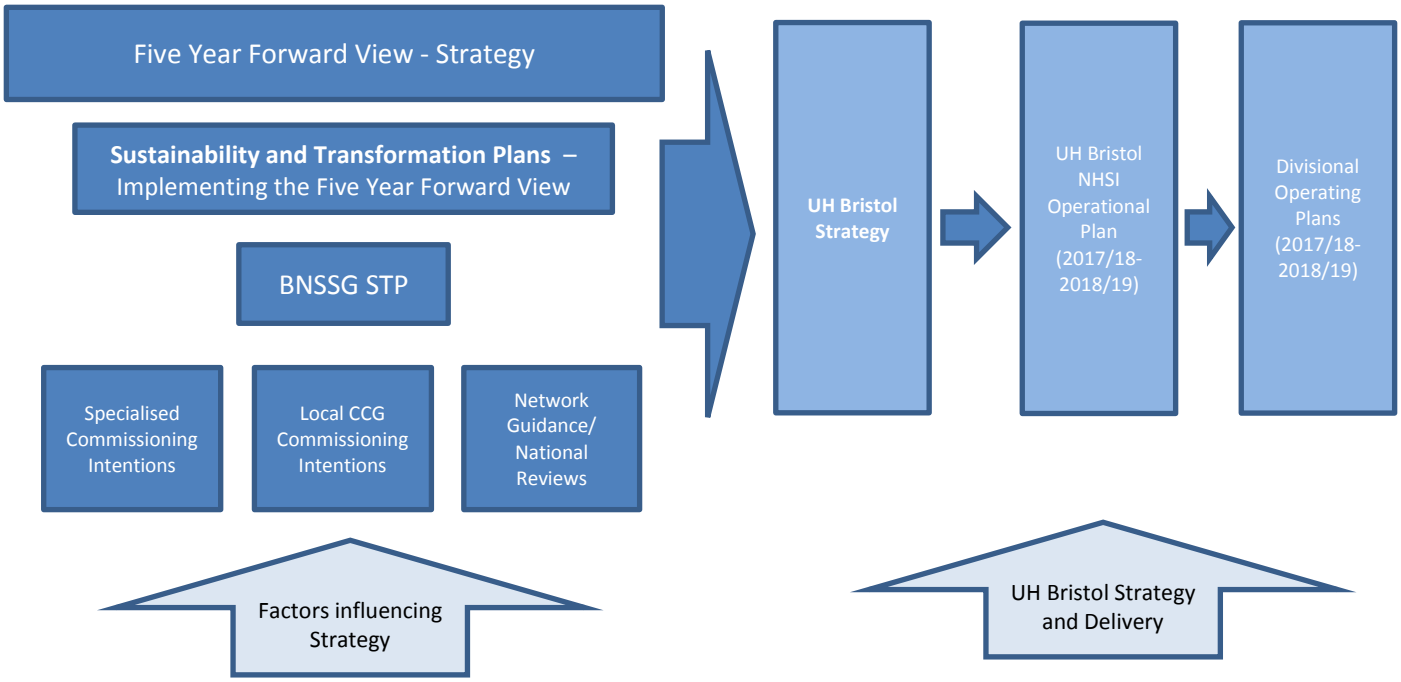
- Refreshing our current Trust Strategy to reflect these developments and to re-visit the wider strategic choices we made in 2014 (Appendix 4) in the context of the system STP. This refresh will be informed by engagement with our teams and our key stakeholders to ensure shared ownership of our strategy that will support its delivery.
- Full delivery of the action plan established through the strategy stocktake exercise.
- Completion of the Phase 5 capital prioritisation process.
- Progressing actions to inform decisions on our current clinical strategic choice priorities and develop associated implementation plans.
- An on-going programme of training and development through the Trust and oversight through the new governance framework, to ensure that the new route map and methodology for how services are developed and decisions are made becomes embedded.

Going forward we will use this new framework to continue to drive a dynamic assessment of strategic decisions that ensure we deliver on our organisational priorities.

4. Our Operating Environment

4.1 National Context

One of the key drivers for this programme of work was the acknowledgement that there are significant changes within both the national and local planning environment. The diagram below demonstrates how there are a number of national and local factors influencing how our strategy needs to develop. It also demonstrates how our internal processes for developing and delivering strategic changes need to respond to these factors, by making decisions that enable us to effectively adapt to our changing environment.



The NHS Five Year Forward View was published on 23 October 2014 and sets out a new shared vision for the future of the NHS based around potential new models of care. It outlines a strategy which establishes the key themes and principles of how the NHS should address the challenge of an increasing demand on health and care, in the context of financial constraint. It describes these widening gaps within the NHS nationally in three categories;

- Care and Quality
- Health and Wellbeing
- Finance and Efficiency.

Further planning guidance published in 2016/17 established the concept of Sustainability and Transformation Plans (STP) as the vehicles through which the principles outlined in the Five Year Forward View are to be developed and delivered, through five year system plans, based on locality 'footprints'. There are 44 'footprints' nationally and the local planning footprint for the STP is comprised of the 14 health and social care organisations in Bristol, North Somerset and South Gloucestershire (BNSSG).

The STPs are required to address the identified gaps in care and quality, health and wellbeing and finance and efficiency specific to each footprint. Further policy published by NHS Improvement on 21 July 2016, "*Strengthening financial performance and accountability in 2016/17*" and operational planning guidance, "*NHS Operational Planning and Contacting*

Guidance 2017-2019" published on 22 September 2016, establish the required link between the system plans outlined in the STPs and the requirements for operational planning over the next two year period. They also set out a series of actions designed to support the NHS to achieve financial sustainability and improve operational performance. These requirements build on the principles established in the Five Year Forward View by describing nine 'Must Dos' (outlined in Appendix 3), which will form the basis for priorities for operational planning and delivery over the next two years. Our two year operational plans (2017/18-2018/19) are required to clearly demonstrate a link to the aims of the STP and form years two and three of delivery and will need to inform our strategic programme over this period.

4.2 Local Context - The BNSSG STP

The local STP has the overall goal of developing a health and care system for Bristol, North Somerset & South Gloucestershire in which:

- Services are responsive to individual needs and relevant to local communities.
- Appropriate care and support is available in the right place at the right time.
- Parity is a golden thread running through the whole of health and social care provision for both mental and physical health needs.
- There is a consistent approach to delivering care at scale.

The BNSSG STP has developed five key principles that will enable the footprint to develop and implement a sustainable health and care system for our local population. These five principles are outlined below;

A transformational programme of change is being established locally through the STP. This is structured via three key system wide workstreams designed to deliver the principles outlined above. These three workstreams are;

- Integrated primary and community care;
- Prevention early intervention and self-care;
- Acute care collaboration.

A key aim in developing our own internal strategic programme is to prioritise our clinical strategy and align our strategic programme with the new processes, pathways and structures developing as part of the local STP and the changing national context. These new approaches provide us with a significant opportunity to progress our strategic priorities

at pace and to work together with our partners to resolve some of the system wide challenges we face.

5. Strategic Planning and Implementation Framework - Content of Programme

As outlined above, this programme of work has been split into five key packages of work. A summary of the scope, outputs and next steps of each of these packages of work is described in the following section.

5.1 Our Approach to Strategic Governance

The purpose of this package of work was to ensure that we have clear and inclusive structure to oversee the design and implementation of strategic development programmes and projects, approved and designated by the Trust Board.

5.1.1 Implementation of new strategic governance and meeting structure

A new governance structure has been established to manage and oversee the development and implementation of the Trust's strategic agenda. This new structure consists of:

- Strategy Steering Group
- Clinical Strategy Group
- IDEA (Image, Design, Environment and Arts Reference Group)

This new meeting structure is now in place, with membership and new Terms of Reference agreed and at least one meeting of each group held by mid October 2016.

The key purpose of this new structure is to ensure clear oversight and governance of the development and delivery of our strategic development programme, with alignment of goals and strategies, through Trust and divisional level plans. It also provides a clear structure for engagement within and between senior divisional teams in the development of the strategic agenda, in broader horizon-scanning and an opportunity for our clinical experts, who often play key leadership roles within clinical networks, to have a clear route through which to provide a real time link to agendas that may be beginning to develop outside of the Trust and that we may wish to influence. This is essential to ensure the Trust is prepared to be able to respond to requirements of external strategic reviews in an effective and timely way.

5.1.2 A stocktake of the content, alignment and consistency of existing and future Trust Strategies

The purpose of the stocktake exercise was to provide assurance that strategic plans are internally aligned and respond appropriately to national policy, commissioning intentions, market developments and the plans of system partners and to ensure the full alignment of goals and strategies, through Trust wide and divisional strategies to deliver the agreed objectives of the Board.

Methodology

The strategy stocktake has been a desk based exercise and has followed the following methodology;

- Established the characteristics of an effective strategy against which the quality and content of all internal strategies can be evaluated – specific recommendations to be provided to document owners outlining where there are gaps in content.
- Review if all internal strategies are consistent and clear alignment to overall Trust strategy.
- Identifying any gaps in our strategy portfolio and agree a work plan to develop strategies where required, with owners and timescales.

- Establishing an on-going process for how and where all strategies will be kept and owned and refreshed on an agreed basis.

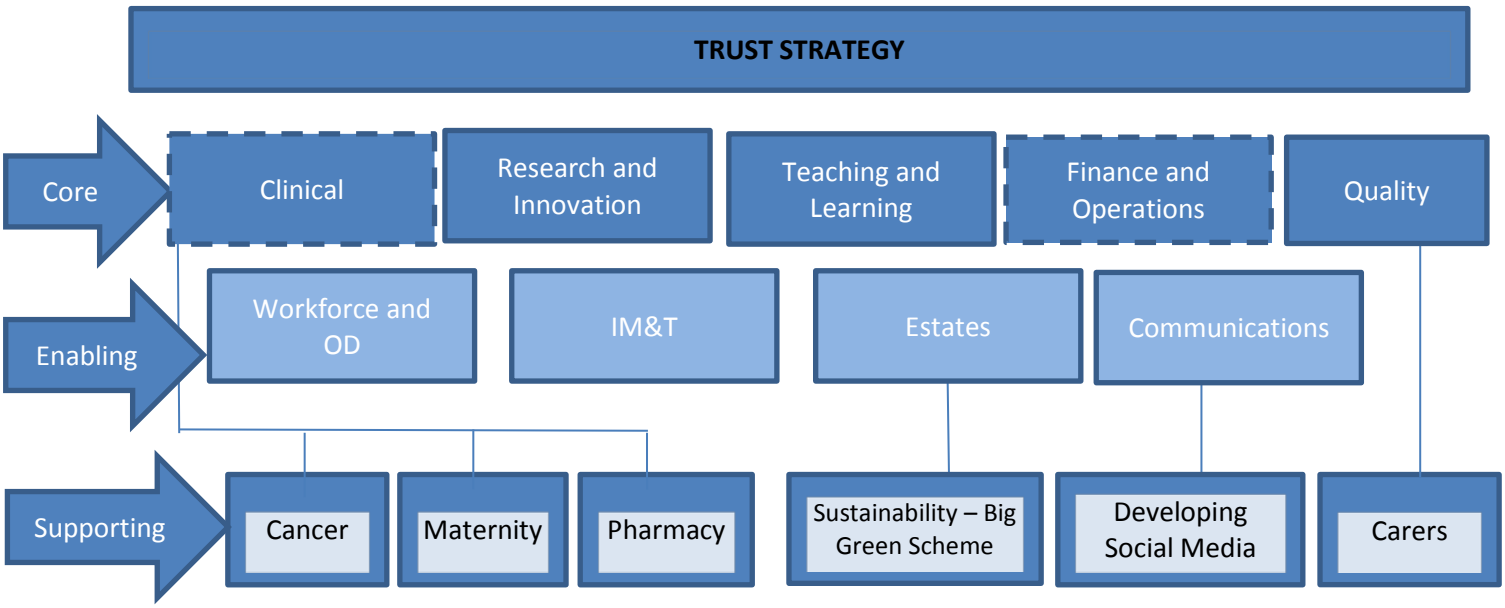
Characteristics of an Effective Strategy
The Deloitte Well Led Governance Review outlined six characteristics of an effective strategy as outlined below.

1.	There is a clear statement of vision and values, driven by quality and safety. It has been translated into a credible strategy and well-defined objectives that are regularly reviewed to ensure that they remain achievable and relevant.
2.	The vision, values and strategy have been developed through a structured planning process with regular engagement from internal and external stakeholders, including people who use the service, staff, commissioners and others.
3.	The challenges to achieving the strategy, including relevant local health economy factors, are understood and an action plan is in place.
4.	Strategic objectives are supported by quantifiable and measureable outcomes which are cascaded through the organisation.
5	There is an effective and comprehensive process in place to identify, understand, monitor and address current and future risks.
6.	Service developments and efficiency changes are developed and assessed with input from clinicians to understand their impact on the quality of care. The impact on quality and financial sustainability is monitored effectively. Financial pressures are managed so that they do not compromise the quality of care.

Internal strategy documents were reviewed against these characteristics, with recommendations to be made to strategy owners.

Scope
Outlined below is a summary of the core, enabling and supporting strategies, which make up the overall Trust Strategy. The scope of this stocktake exercise was to review the strategies outlined below.

It should be noted that there are not separate clinical, financial and operational strategy documents for the Trust, as these are fundamental elements of the overall Trust Strategy and are delivered through the Trust's NHS Improvement Operational Plan, the divisional Operating Plans and the Long Term Financial Plan, along with a set of principles underpinning how the financial aspects of the Trust are managed.



Key Findings

The key findings of the stocktake of strategies are outlined below;

- All core and enabling strategies could be identified, however it is noted that there is not a Stakeholder Strategy.
- There is a new quality strategy in the final stages of development and this combines the three previously separate strategies of Clinical Effectiveness and Outcome, Patient Experience, Patient Safety and Patient and Public Involvement.
- There are five additional enabling and supporting strategies currently in development.
- There are consistently strong statements of a vision and well-defined aims and objectives through strategies, although not all are supported with quantifiable and measureable outcomes to define success.
- There is not always clear evidence of ongoing engagement with key stakeholders, both in developing and delivering the outlined strategy, including clinical engagement.
- Although some place the challenges (a number by using a Strengths, Weaknesses, Opportunities and Threats [SWOT] analysis) in the context of local and health economy factors, not all do.
- Risk factors are well outlined however, not all outline the process by which risks to the delivery of the strategy will be identified, monitored and addressed.
- There is a consistent theme of the enabling strategies not demonstrating how they contribute to the delivery of the overall strategic aims and priorities of the Trust.
- It is noted that the national and local context has changed significantly since a number of the strategies were produced and as a result, some of the alignments identified are now less relevant.
- There are a number of practical improvements identified, which will improve the governance and oversight of our portfolio of strategies, including a common place where they can be accessed and standard review dates.

Next Steps

- A clear action plan has been established to address the findings of the stocktake exercise. Oversight of the delivery of these actions will be provided through the new Strategy Steering Group.

6. Strategic decision-making and effective implementation planning

The purpose of this package of work is to provide a prioritised view of the Trust's clinical strategic choices and establish a clear programme of work, with associated time scales, for the development of a route map for decision making and implementation.

6.1 Development of a prioritised clinical strategy programme

Background

Our current Trust Strategy ("Rising to the Challenge 2020") states that as an organisation, our key challenge is to maintain and develop the quality of our services, whilst managing within the finite available resources. We are also clear that we operate as part of a wider health and care community and our strategic intent sets out our position with regard to the key choices that we and others face.

Our strategic intent is to provide excellent local, regional and tertiary services, and maximise the benefit to our patients that comes from providing this range of services. As stated in our current strategy document, we are committed to addressing the aspects of care that matter most to our patients and the sustainability of our key clinical service areas is crucial to delivering our strategic intent. **Our strategy outlines nine key clinical service areas.** These are:

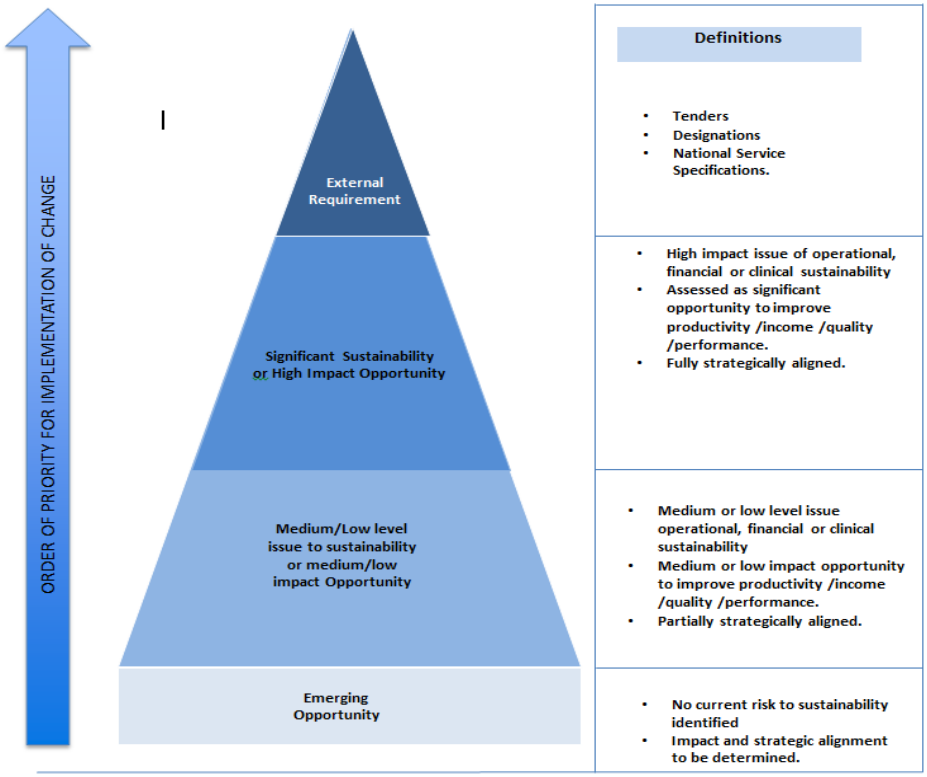
- Children's services;
- Accident and Emergency (and urgent care);
- Older people's care;
- Cancer services;
- Cardiac services;
- Maternity services;
- Planned care and long term conditions;
- Diagnostics and therapies; and
- Critical Care.

The recent Strategic Implementation Process (SIP) exercise and our 2016/17 Operational Planning Process (OPP) have highlighted that within the high level priority areas outlined above, there is a need for a more detailed level of prioritisation. This is required to assist with some of the service specific strategic choices we want to or may be required to, develop in response to internal issues of sustainability or driven by our evolving external local and national environment.

Approach

To support this further prioritisation process a revised methodology, as outlined below, has been developed and applied through close working between the Strategy and Transformation and Divisional teams.

High level framework for prioritising strategic choices within the clinical strategy programme



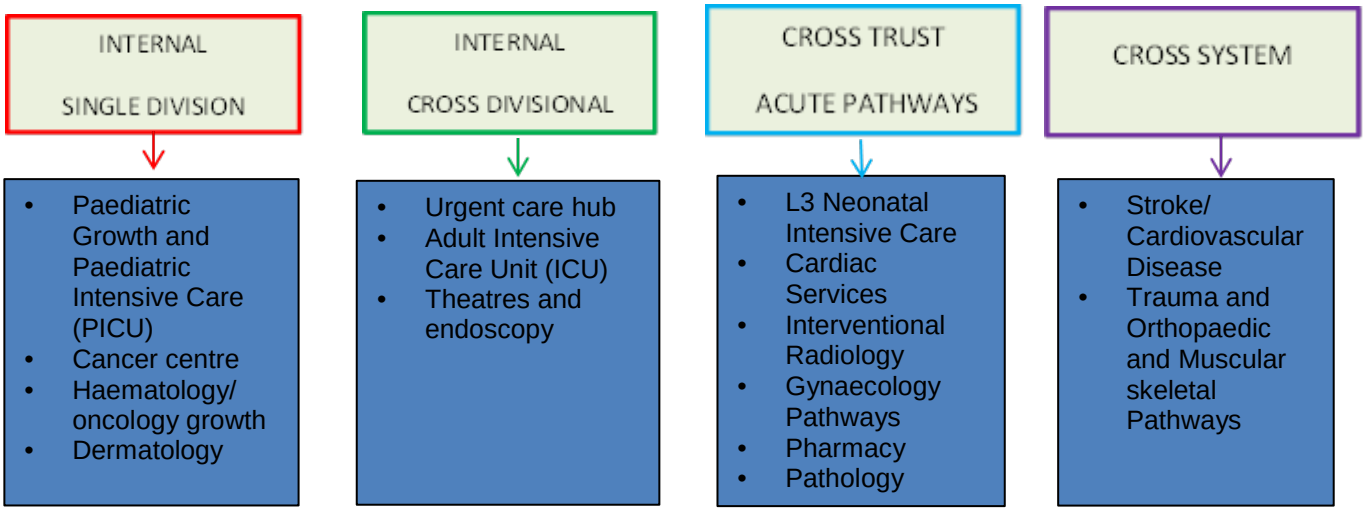
This exercise segmented our core priority clinical services (Appendix 2) and identified a shortlist of services, as outlined below, which now forms the basis for a managed programme of actions and activity in 2016/17 to drive strategic decision-making and support development of implementation plans.

Fifteen services areas have been identified as key priorities for development through 2016/17 through this process. Options within each of these areas are now being developed in line with a new standardised approach outlined below which identifies the need to explore all options and decisions within the most relevant context i.e. within a single divisions, across divisions, across acute providers or across the wider health and care system.

Linkages are being actively made in the system wide Sustainability and Transformation Plan (STP), to ensure cross acute provider and cross system considerations are enabled in parallel to our internal strategic options assessment.

Going forward we will use this new framework to continue to drive a dynamic assessment of strategic decisions that ensure we deliver on our organisational priorities. While the 2016/17 programme is largely expressed in terms of specialties, a number of these encompass whole pathway implications that prompt consideration of options for delivery beyond hospital provision.

We will also use the planned engagement process for the refresh of our Trust Strategy to revisit the position we adopted to our wider strategic choices in 2014 (Appendix 4) and test if these remain realistic and relevant in the evolving local and national context and our continued areas of performance challenge.



6.2 Supporting a standardised approach to strategic decision-making and delivery

To support Divisional Boards with the process of prioritisation, development, implementation and delivery within the strategic priorities, a package of standardised tools have been developed. This package of tools includes the following;

- Summary of delivery routes for the development and implementation of strategic choices, including the interface with STP.
- A framework outlining the process for decision and making and governance.
- A standardised template and framework for evaluating service developments and producing an outline business case to support proposed options. This includes links to the tender process also developed in 2016/17 and the existing divestment processes.

This package of standardised tools has been reviewed and approved through the Clinical Strategy Group and Senior Leadership team and the Strategy and Transformation team have provided support and training through Divisional Boards and other engagement routes. Divisional teams are using the set of tools to develop a set of options to evaluate and progress with strategic choices. The output of the tools has formed the content of the overall programme of work now being delivered through the Clinical Strategy Group.

Embedding this approach within the Divisional teams is also key to ensuring there is a standardised and understood decision-making methodology through which to identify, develop and implement service developments of strategic significance within the Trust. Appendix 1 outlines the governance and process for ensuring that decisions are considered and approved at the appropriate and relevant level, including consideration of decisions of significant impact or scale against the framework at future Trust Board meetings.

7. Renewing our Hospitals – Establish and implement a process for the allocation of Phase 5 Capital

The purpose of this exercise is to ensure that we have a capital estates programme that is aligned to and informed by our clinical strategy

Background

As the Trust's major capital schemes (Phases 1-4) have come to fruition, it was considered timely to include the next set of priorities for capital investment across the site as part of this programme. In support of this work, the Medium Term Capital Programme (MTCP) has been developed to set out the available capital to 2020/2021 and in parallel, the Trust Board

has approved the over-arching Estates Strategy which sets out the estate priorities for the period out to 2020/2021.

Within the Medium Term Capital Programme, there remains provision in each year for 'business as usual' investments in major medical equipment and operational capital. However further provision is also made for the purpose of supporting development of larger scale schemes.

There are two primary drivers to future capital priorities, capital investment to further the Trust's strategy and investments to improve areas of the estate that have not been impacted by the recent major programme of works and which, as a consequence, are now more apparently in need of modernisation and/or refurbishment.

The Phase 5 capital programme was established to consider capital requirement against two key criteria;

i) **Investments to deliver the Trust's Strategy (Strategic Schemes).** These have been surfaced through the Strategic Implementation Planning (SIP) process, the 2016/17 Operating Plan and this strategy refresh. This may be the Trust's clinical strategy, or other elements of the strategy, such as Research and Innovation or Teaching and Learning.

   Consideration also needs to be given to the emerging themes and priorities within the BNSSG STP and any schemes which has a potential capital consequence to the UH Bristol estate.

ii) **Investments to upgrade and/or remodel existing trust estate (Infrastructure Improvement Schemes)**. This relates to the improvement of estates infrastructure and may include the refurbishment of clinical or patient/staff environment. This also explicitly includes the refurbishment and updating of estate not included in Phase 1-4 of the BRI redevelopment and may also include where change to environment could significantly improve productivity and address a significant and known risk.

Process

The following steps have been completed in the Phase 5 capital programme;

- Programme and timeline established and agreed through SLT, including revised prioritisation framework.
- Divisional teams completed bids on standard database to establish a long list of priorities.
- Divisional teams completed scoring completed against revised prioritisation framework.
- Senior review of emerging priorities to agree next steps (10 October).

The process to date has surfaced a number of emerging priorities for future major capital development within the Trust, requiring consideration for future capital investment as part of the Phase 5 programme.

The following next steps are now required to complete the prioritisation and allocation of Phase 5 Capital;

- Develop the scope of the long list of potential priorities listed above to determine high level feasibility and value for money based on impact.
- Using the agreed prioritisation framework agree proposed short list of schemes for recommendation to the Senior Leadership Team (SLT) and the Trust Board, as part of the medium term capital programme.

- Establish the extent of capital funding potentially available to commit to the programme as part of the 2017-19 Operating plan and the 2020 STP processes. While this is currently unclear, surfacing our capital priorities and aligning these to the emerging clinical strategy, is fundamental to effective strategic planning. It is recommended that a judgement on the affordability of part, or all, of the programme will be taken, when the amount of capital available to spend over this period is known.

8. Refresh of the Trust Strategy in the context of the changing national and local environment

The purpose of this exercise is to provide a mid-term refresh of the overall Trust Strategy to ensure it reflects the changes to the national and local context in which we are operating and also reflect the prioritisation of our own clinical strategy.

This will not be a full re-write of our current strategy, as it is considered that our current mission, vision and statements of strategic intent remain correct and relevant. It is considered however, that a refresh of our strategy will provide us with a key opportunity to ensure that, as a Trust we are positioning our strategic choices, as effectively as possible within our evolving context to successfully deliver our intent.

This refresh will also provide an important opportunity for a further programme of engagement with our teams and our key stakeholders to ensure shared ownership of our strategy that will support its delivery over the remaining three years of our current strategy.

Background

Our 2020 five year Strategic Plan outlines seven strategic priorities, structured according to the characteristic of our Trust Vision outlined above. These strategic priorities are:

- We will consistently deliver high quality individual care, delivered with compassion;
- We will ensure a safe, friendly and modern environment for our patients and our staff;
- We will strive to employ the best and help all our staff fulfil their individual potential;
- We will deliver pioneering and efficient practice, putting ourselves at the leading edge of research, innovation and transformation;
- We will provide leadership to the networks we are part of, for the benefit of the region and people we serve;
- We will ensure we are financially sustainable to safeguard the quality of our services for the future and that our strategic direction supports this goal; and
- We will ensure we are soundly governed and are compliant with the requirements of our regulators.

Although we remain confident that our five year strategy is still relevant and sound in the evolving local and national environment, it is recognised that there are a number of notable internal and external developments that now need to be reflected our strategy document. These factors can be summarised as;

External

1. The NHS England *5 Year Forward View* and national policy direction.
2. The emerging Bristol, North Somerset and South Gloucestershire (BNSSG) Sustainability and Transformation Plan (STP).
3. The developing strategies of our local acute providers, notably North Bristol NHS Trust's new 2016/2017 Clinical Strategy.

Internal

4. Our internal Strategic Implementation Planning (SIP) process and prioritised clinical strategy.
5. The outputs of our internal strategy stocktake exercise.
6. Revised internal Quality and Teaching and learning strategies.
7. Our revised Estates Strategy and our Renewing our Hospitals programme, through the revised strategic capital process.
8. Our on-going areas of performance challenge

Process and Content

- A refresh of the content of our current Trust strategy will be completed in Quarter 4, 2016/17, to report to Trust Board at the end of the financial year.
- This refresh of the document will account for the factors outlined above.
- As part of this process, a review will be undertaken of our current position on our key strategic choices (outlined in Appendix 4) considering if our position requires adjustment to ensure we are effective in progressing our organisational and system agenda over the next five year period.
- A programme of engagement with our teams and our key stakeholders will be established to inform the strategy refresh.

9. Conclusion

The purpose of this paper is to provide an update to Trust Board on the development and delivery of a programme of work to revise the Trust's approach to planning and implementation of strategic change. It is also to provide assurance to the Trust Board, that key activities have been completed through 2016/17 to deliver a step change in how strategic planning and implementation is managed within the Trust and to progress specific strategic decisions identified by Divisions.

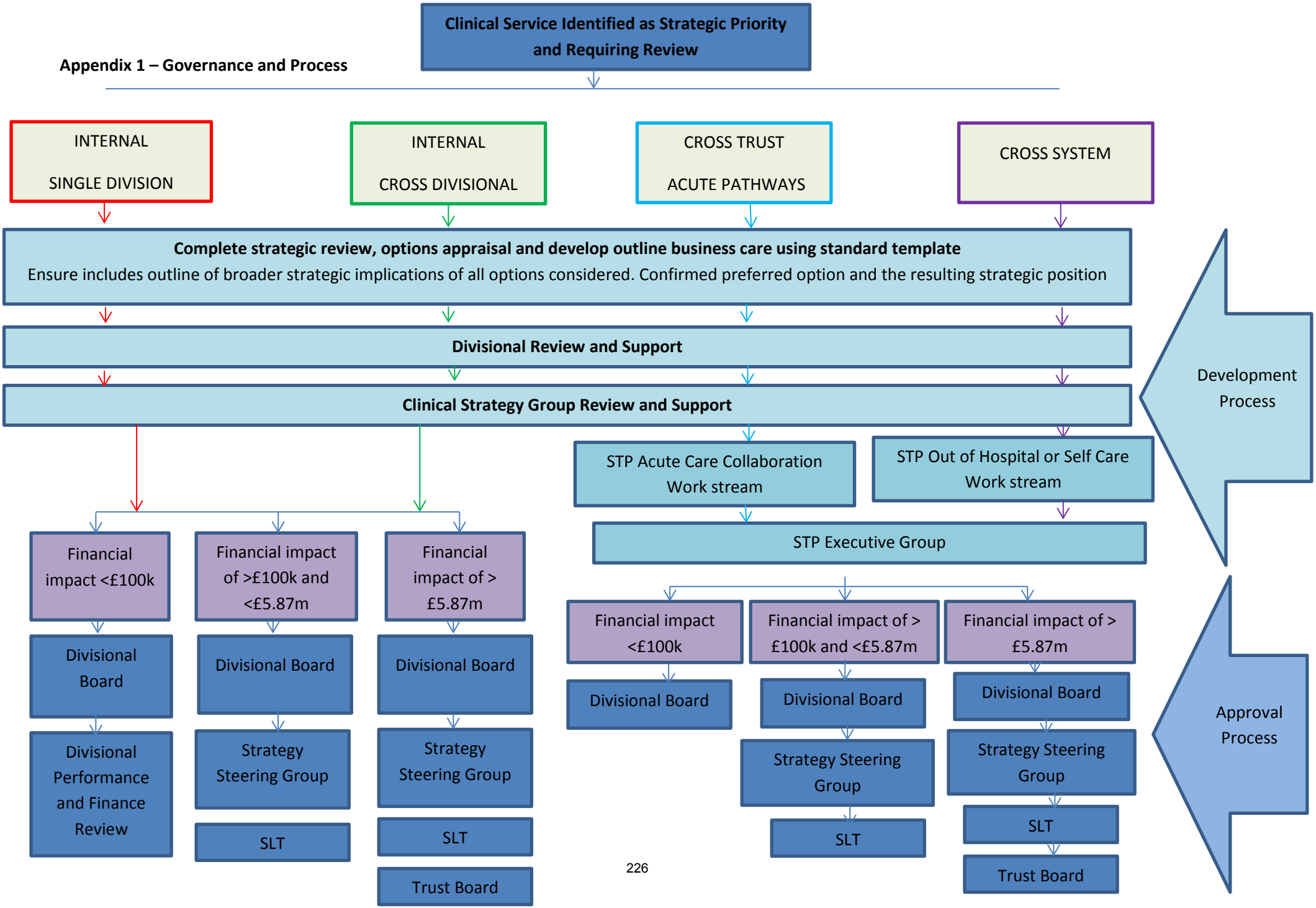
Following feedback from Trust Board the programme will continue to deliver the next steps outlined in each section of this paper, with oversight through the new governance structure. Specific reference will be given to ensuring the new governance process for progressing strategic decisions is followed, including consideration of decisions of significant impact or scale against the framework at future Trust Board meetings.

A timeline will be developed for the refresh of our current strategy document, "Rising to the Challenge – our 2020 Vision", planned for completion in Quarter 4 of 2016/17. This will include a programme of engagement within the organisation and our key stakeholders.

10. List of Appendices

Appendix 1.	Governance Process – Framework for Decision Making
Appendix 2.	Prioritised Clinical Strategy
Appendix 3.	NHS National Planning Guidance 'Must Dos' – 2017/18-2018/19
Appendix 4.	Our Strategic Choices (Rising to the Challenge 2020)

Appendix 1 – Governance and Process



Appendix 2

UH BRISTOL CLINICAL STRATEGY

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

Our strategy outlines nine key clinical service areas:

- **Children's services**
- **Accident and Emergency (and urgent care)**
- **Older people's care**
- **Cancer services**
- **Cardiac services**
- **Maternity services**
- **Planned care and long term conditions**
- **Diagnostics and therapies**
- **Critical Care.**

Live Strategic Projects/Tenders

Core Priority Clinical Services– **Strategic decision required (16/17 programme).**

Core Priority Clinical Services– **Emerging strategic decision required**

Core Priority Clinical Service Portfolio – **No strategic level change required**

Sexual Health
Intestinal Failure
Regional tuberculosis Services
Paediatric Cardiac
Stereotactic radiotherapy (SRS/SRT)
Paediatric and Neonatal surgery – national review.
Paediatric Intensive Care (PICU)– national review
Children's community Health Partnership (CCHP)

Trauma and Orthopaedics
Cardiac Services
Stroke Pathway
Gynaecology pathways
Interventional Radiology
Haematology/oncology
Cancer support centre
Neonatal Intensive Care
Adult Critical Care
Theatres and Endoscopy
Pathology and blood sciences
Dermatology
Urgent Care Hub
Pharmacy Aseptic Services
Growth in paediatric services, including Paediatric Intensive Care (PICU)

Respiratory
Therapy Services
Hepatology
Sleep pathways
Gastrointestinal services
Specialist Non-invasive Ventilation (NIV) services
Dental
Clinical Genetics
Frail Elderly
Diabetes
Radiology
Chronic Pain
Neuroendocrine

Cardiac Surgery
Ophthalmic services
Thoracic surgery
Paediatric Surgery
Maternity Services
Palliative medicine
Oncology and Haematology
Oncology & Haematology
Head and Neck services
Specialist cancer surgery
Paediatric Medicine
Rheumatology
Anaesthetics
Genomic medicine

Completion of evaluation and implementation

Options evaluated to inform strategic decisions and implementation plans developed.

Ongoing development and investment through OPP Process;

- Capital allocation.
- Activity growth and associated investment.
- External Revenue Proposals.
- Workforce development.
- Internal cost pressures.

Appendix 3 - 2017/18 and 2018/19 'must dos'

"NHS Operational Planning and Contracting Guidance 2017-2019" – 22 September 2016

1. STPs

- Implement agreed STP milestones, so that you are on track for full achievement by 2020/21.
- Achieve agreed trajectories against the STP core metrics set for 2017-19.

2. Finance

- Deliver individual CCG and NHS provider organisational control totals, and achieve local system financial control totals. At national level, the provider sector needs to be in financial balance in each of 2017/18 and 2018/19. At national level, the CCG sector needs to be in financial balance in each of 2017/18 and 2018/19.
- Implement local STP plans and achieve local targets to moderate demand growth and increase provider efficiencies.
- Demand reduction measures include: implementing RightCare; elective care redesign; urgent and emergency care reform; supporting self-care and prevention; progressing population-health new care models such as multispecialty community providers (MCPs) and primary and acute care systems (PACS); medicines optimisation; and improving the management of continuing healthcare processes.
- Provider efficiency measures include: implementing pathology service and back office rationalisation; implementing procurement, hospital pharmacy and estates transformation plans; improving rostering systems and job planning to reduce use of agency staff and increase clinical productivity; implementing the Getting It Right First Time programme; and implementing new models

3. Primary care

- Ensure the sustainability of general practice in your area by implementing the General Practice Forward View, including the plans for Practice Transformational Support, and the ten high impact changes.
- Ensure local investment meets or exceeds minimum required levels.
- Tackle workforce and workload issues, including interim milestones that contribute towards increasing the number of doctors working in general practice by 5,000 in 2020, co-funding an extra 1,500 pharmacists to work in general practice by 2020, the expansion of Improving Access to Psychological Therapies (IAPT) in general practice with 3,000 more therapists in primary care, and investment in training practice staff and stimulating the use of online consultation systems.
- By no later than March 2019, extend and improve access in line with requirements for new national funding.
- Support general practice at scale, the expansion of Multispecialty Community Providers or Primary and Acute Care Systems, and enable and fund primary care to play its part in fully implementing the forthcoming framework for improving health in care homes.

4. Urgent and emergency care

- Deliver the four hour A&E standard, and standards for ambulance response times including through implementing the five elements of the A&E Improvement Plan.
- By November 2017, meet the four priority standards for seven-day hospital services for all urgent network specialist services.

- Implement the Urgent and Emergency Care Review, ensuring a 24/7 integrated care service for physical and mental health is implemented by March 2020 in each STP footprint, including a clinical hub that supports NHS 111, 999 and out-of-hours calls.
- Deliver a reduction in the proportion of ambulance 999 calls that result in avoidable transportation to an A&E department.
- Initiate cross-system approach to prepare for forthcoming waiting time standard for urgent care for those in a mental health crisis.

5. Referral to treatment times and elective care

- Deliver the NHS Constitution standard that more than 92% of patients on non-emergency pathways wait no more than 18 weeks from referral to treatment (RTT).
- Deliver patient choice of first outpatient appointment, and achieve 100% of use of e-referrals by no later than April 2018 in line with the 2017/18 CQUIN and payment changes from October 2018.
- Streamline elective care pathways, including through outpatient redesign and avoiding unnecessary follow-ups.
- Implement the national maternity services review, *Better Births*, through local maternity systems.

6. Cancer

- Working through Cancer Alliances and the National Cancer Vanguard, implement the cancer taskforce report.
- Deliver the NHS Constitution 62 day cancer standard, including by securing adequate diagnostic capacity and the other NHS Constitution cancer standards.
- Make progress in improving one-year survival rates by delivering a year-on-year improvement in the proportion of cancers diagnosed at stage one and stage two; and reducing the proportion of cancers diagnosed following an emergency admission.
- Ensure stratified follow up pathways for breast cancer patients are rolled out and prepare to roll out for other cancer types.
- Ensure all elements of the Recovery Package are commissioned, including ensuring that:
- All patients have a holistic needs assessment and care plan at the point of diagnosis;
- A treatment summary is sent to the patient's GP at the end of treatment; and
- A cancer care review is completed by the GP within six months of a cancer diagnosis.

7. Mental health

- Deliver in full the implementation plan for the Mental Health Five Year Forward View for all ages, including:
- Additional psychological therapies so that at least 19% of people with anxiety and depression access treatment, with the majority of the increase from the baseline of 15% to be integrated with physical healthcare;
- More high-quality mental health services for children and young people, so that at least 32% of children with a diagnosable condition are able to access evidence-based services by April 2019, including all areas being part of Children and Young People Improving Access to Psychological Therapies (CYP IAPT) by 2018;
- Expand capacity so that more than 53% of people experiencing a first episode of psychosis

begin treatment with a NICE-recommended package of care within two weeks of referral.

- Increase access to individual placement support for people with severe mental illness in secondary care services by 25% by April 2019 against 2017/18 baseline;
- Commission community eating disorder teams so that 95% of children and young people receive treatment within four weeks of referral for routine cases; and one week for urgent cases; and
- Reduce suicide rates by 10% against the 2016/17 baseline.
- Ensure delivery of the mental health access and quality standards including 24/7 access to community crisis resolution teams and home treatment teams and mental health liaison services in acute hospitals.
- Increase baseline spend on mental health to deliver the Mental Health Investment Standard.
- Maintain a dementia diagnosis rate of at least two thirds of estimated local prevalence, and have due regard to the forthcoming NHS implementation guidance on dementia focusing on post-diagnostic care and support.
- Eliminate out of area placements for non-specialist acute care by 2020/21.

8. People with learning disabilities

- Deliver Transforming Care Partnership plans with local government partners, enhancing community provision for people with learning disabilities and/or autism.
- Reduce inpatient bed capacity by March 2019 to 10-15 in CCG-commissioned beds per million population, and 20-25 in NHS England-commissioned beds per million population.
- Improve access to healthcare for people with learning disability so that by 2020, 75% of people on a GP register are receiving an annual health check.
- Reduce premature mortality by improving access to health services, education and training of staff, and by making necessary reasonable adjustments for people with a learning disability or autism.

9. Improving quality in organisations

- All organisations should implement plans to improve quality of care, particularly for organisations in special measures.
- Drawing on the National Quality Board's resources, measure and improve efficient use of staffing resources to ensure safe, sustainable and productive services.
- Participate in the annual publication of findings from reviews of deaths, to include the annual publication of avoidable death rates, and actions they have taken to reduce deaths related to problems in healthcare.

Appendix 4

Our current stated position on the strategic choices we face as outlined in our current Trust Strategic Plan

Strategic Choice	Our Position (Trust Strategic Plan)
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?	In the course of delivering our "core" business, there are many opportunities to influence the health of the patients we treat, and importantly their families; any future service strategy should embrace these opportunities in more systematic ways. In particular, we want to work with others on those areas where we have a direct impact on people's requirements for the services we provide.
Do we still want to focus - and deepen in some key areas - our tertiary (specialist) services? If so, how do we decide which ones?	Delivery of specialist services is a key part of the Trust's strategic intent. We are uniquely placed to be the provider of choice in the South West region for many specialist services. Our decision to expand our existing services or develop new should be based upon our ability to deliver services to the right standard and within the resources commissioners are willing to pay. UH Bristol should not proceed to diversify into specialist service areas already provided in the City other than in the case of an agreed service reconfiguration.
Out of hospital care – should we influence, commission or provide?	We have no plans for the wholesale diversification into general community services provision. However, where existing community providers cannot meet the Trust's needs (and the needs of our patients for timely discharge) for community services that support our in-hospital services, there is a strong case for the Trust delivering or directly sub-contracting these services and we will do so if necessary.
Are there geographical limitations to our "DGH" offer – how would we describe the catchment area for this element of our service?	The strategic rationale for expansion of our DGH catchment beyond BNSSG is weak and as such we plan that this will remain our defined catchment. Any proposal to expand DGH services within this catchment will only be considered because of a well evidenced, positive contribution to the Trust and/or Divisions strategy or operational plan and where safety, quality, operational and financial impact, are all acceptable.
Should we drive the development of our services under the UH Bristol@ model outside of our current catchment?	Given the operational complexity associated with remote delivery of services, the UH Bristol@ model will be considered where the following key "qualifying conditions" have been met – the development is strategically aligned, it delivers a significant financial contribution to the service and safety, quality and operational impacts are all manageable.

Strategic Choice	Our Position (Trust Strategic Plan)
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?	In principle, where there is a financial and operational benefit to outsourcing a clinical service it should be considered – however the "burden of proof" that this will not impact detrimentally on the service being outsourced or those retained in-house, which rely upon an outsourced service, will be necessarily rigorous.
Does the Trust support divesting in services it currently provides?	Central to our decisions about service configuration should be the interests of patients. Services should not be divested simply because they operate at a loss. If the service in question is strategically aligned to the Trust's portfolio or is interdependent to other services then the priority should be to re-design the service to eliminate or reduce losses. However, where patients would be better served by a service being run by another organisation, divestment will be actively considered.
What is the Trust's approach to partnership working? Compete or collaborate?	Despite the national policy context, there is limited local evidence that competition in the local health system has driven up quality or lowered cost. Where our aims and objectives can be achieved through working collaboratively with other organisations – NHS, independent, third sector - then this should be our default way of working. The Trust recognises the value of working in partnership but also recognises the complexity and loss of agility and pace often associated with partnership working. Not all the work we do will be in partnership, but we will always seek this approach where there is evidence that patients will be better served – and the Trust's objectives will be better met (or only met) - by working in partnership.
Do we have the right model of partnership with our patients and the wider public?	The "modus operandi" for working with our patients, with members and with the wider public is ill-defined and does not currently constitute a major Trust activity. However, recent events have served to highlight the importance of putting patients, their representatives and families at the heart of our approach to planning, delivering and evaluating services.

Cover report to the Trust Board meeting to be held on 31 October 2016 at 11:00 – 1:00 pm in the Conference Room, Trust HQ, Marlborough St, Bristol, BS1 3NU

		Agenda Item	6.1
Meeting Title	Trust Board	**Meeting Date**	31 October 2016
Report Title	Finance Report		
Author	Paul Mapson, Director of Finance and Information		
Executive Lead	Paul Mapson, Director of Finance and Information		
Freedom of Information Status		Open	

Strategic Priorities (please select any which are impacted on / relevant to this paper)
Strategic Priority 6: We will ensure we are financially sustainable to safeguard the quality of our services for the future and that our strategic direction supports this goal.

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

Executive Summary
Purpose To report to the Board on 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 £8.170m (before technical items) for the first six months of the year. This includes £6.337m of sustainability funding – the position represents a surplus of £1.833m without this funding. At month six the Trust is £1.488m adverse against plan. The deterioration from last month reflects the continued adverse run rate in Clinical Divisions. The agreed NHS Improvement plan required a surplus of £8.135m at month 6, the Trust has just achieved this and therefore is able to receive the sustainability and transformation funding subject to activity performance. This position, however, relies on a planned lower run rate in the second half of the year.
Recommendations
Members are asked to: • **Note** the report.

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

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

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

Impact Upon Corporate Risk
.

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

Date papers were previously submitted to other committees				
Audit Committee	**Finance Committee**	**Quality and Outcomes Committee**	**Remuneration & Nomination Committee**	**Other (specify)**
	24 October 2016			

REPORT OF THE FINANCE DIRECTOR

1. Overview

The summary income and expenditure statement shows a surplus of £8.170m (before technical items) for the first six months of the year. This includes £6.337m of sustainability funding – the position represents a surplus of £1.833m without this funding. At month six the Trust is £1.488m adverse against plan. The deterioration from last month reflects the continued adverse run rate in Clinical Divisions. The agreed NHS Improvement plan required a surplus of £8.135m at month 6, the Trust has just achieved this and therefore is able to receive the sustainability and transformation funding subject to activity performance. This position, however, relies on a planned lower run rate in the second half of the year.

The run rate overspend in Clinical Divisions and Corporate Services for September increased again this month to its highest level this year. The adverse variance was £1.706m compared with £1.508m in August. The year to date overspend is now £6.727m compared with the operating plan trajectory to date of £1.477m.

In addition the Corporate share of the income under-performance adds £0.229m to the adverse movement in September, £0.378m in August and £0.302m in July. This makes the effective run rate £1.9m adverse in September which is unprecedented historically and suggests there is now an adverse trend rather than a 'blip' in the summer.

The subjective analysis is shown below:

(Adverse)/Favourable	Sept £m	Aug £m	July £m	Quarter 1 £m	2016/17 to date £m
Nursing & midwifery pay	(0.450)	(0.350)	(0.162)	(1.154)	(2.116)
Medical & dental staff pay	(0.203)	(0.235)	(0.015)	(0.419)	(0.872)
Other pay	0.211	0.144	0.143	0.630	1.128
Non-pay	(0.498)	(0.190)	(0.246)	(0.926)	(1.860)
Income	(0.766)	(0.877)	(0.532)	(0.832)	(3.007)
Totals	**(1.706)**	**(1.508)**	**(0.812)**	**(2.701)**	**(6.727)**

The September position is particularly concerning as, rather than the expected improvement, the overspend increased to one of the biggest monthly deteriorations experienced in recent years. Deterioration was across most headings. The overspending on Nursing and Medical pay continued. The acceleration in nursing overspending is now causing particular concern as well as the increase in non pay spending. Income from activities failed to deliver the improvements expected.

The cumulative income under-performance on activity based SLA lines is now over £3.0m, of which £2.2m relates to elective activity (mainly out-patients). This position risks the delivery of the Trust's Referral to Treatment (RTT) performance in the coming months. If the RTT performance drops below the cumulative required trajectory then this will also result in loss of sustainability funding.

In addition the prospect of cumulative failure of RTT, cancer and A&E trajectories is very real. Hence the delivery of the control total of a £15.9m surplus is now a high risk not only due to the consequential loss of S&T funding but also the concerning run rate overspend. The level of adverse variance against the Divisional Operating plans being £6.7m versus the planned £1.5m to Month 6.

2. Forecast Out-turn

The Trust is required to report a forecast out-turn (FOT) each quarter to its regulator NHS Improvement, the submission date being the middle of the month. Recently a change has been introduced to include full Board governance when a change in the FOT is proposed.

Hence at this point the Trust is still reporting a FOT of £15.9m surplus which meets the Control Total set by the regulator. Over the next few months, however, full consideration will need to be given to the likely position for formal reporting in Quarter 3.

The position after the month 6 results is that delivery of the £15.9m surplus Control Total is high risk and unless significant improvements in spend, activity delivery and performance metrics are delivered in the second half of the year the failure of the Control Total will become likely. For clarity there are two levels of failure to achieve the plan that need to be understood.

a) Failure to deliver the Control Total excluding the performance component of the sustainability funding (70%). To date this has been delivered but there is a high risk for future failure.

b) Failure to delivery performance trajectories and hence earn the remaining 30% sustainability funding. To date only £0.163m has been lost due to the failure of the cancer trajectory. Work on likely performance is in hand to assess the likely loss of sustainability funding. This could be as high as £1.5m. This will be reported next month (November).

The consequences of failure to achieve the Control Total include the following:

- Reputational damage for the organisation.
- Loss of 0.5% of SLA income in 2017/18 as part of the national CQUIN scheme.
- Probable inability to negotiate and agree a Control Total in 2017/18 hence loss of sustainability funding, being subject to performance fines and restrictions on capital spending.

Regarding the position excluding performance funding the September overspend is very concerning and unexpected. The analysis overleaf shows what is required to achieve the Trust's overall plan:

Favourable/ (adverse) £k	Recovery	Q1	Q 2	Year to date	Divisional FOT Year End	Divisional FOT Required Run rate per month	Current Run Rate Q1	Current Run Rate Q 2	Current Run Rate YTD
Divisions									
Diagnostics & Therapies	N	83	0	83	467	64	28	0	14
Medicine	Y	(963)	(1,068)	(2,031)	(2,481)	(75)	(321)	(356)	(339)
Specialised Services	Y	(232)	(467)	(699)	(1,060)	(60)	(77)	(156)	(117)
Surgery, Head & Neck	Y	(882)	(1,352)	(2,234)	(4,367)	(356)	(294)	(451)	(372)
Women's & Children's	Y	(735)	(1,256)	(1,991)	(2,500)	(85)	(245)	(419)	(332)
Estates & Facilities	N	(15)	(28)	(43)	0	7	(5)	(9)	(7)
Trust Services	N	9	(8)	1	5	1	3	(3)	0
Other Corporate	N	34	153	187	0	(31)	11	51	21
		(2,701)	(4,026)	(6,727)	(9,936)	(535)	(900)	(1,343)	(1,112)
Corporate									
Income									
– Prior year		1,010	1,000	2,010	4,000				
– 2016/17		370	(912)	(542)	(1,000)				
Reserves		1,200	2,300	3,500	7,000				
Financing		134	137	271	500				
		2,714	2,525	5,239	11,000				
Headroom					(564)				
Trust Total		13	(1,501)	(1,488)	-				

Hence the plan can be achieved if Divisions hold to their previously reported forecast out-turn of £9.9m. This requires a run rate overspend of £0.535m per month for the rest of the year compared to £0.900m in quarter 1 and £1.343m in quarter 2.

Divisions will be formally required to identify and deliver a recovery plan and be set a control total deficit which cannot be exceeded.

3. Main Financial Drivers

As for previous months, the five significant financial drivers that are key to controlling the Trust's financial position to achieve the 2016/17 financial plan are:

a) Sustainability funding;
b) Nursing and midwifery pay;
c) Medical and dental pay;
d) Clinical activity; and
e) Savings programme.

These are described in the following sections.

a) Sustainability Funding

The Trust's financial position to date includes £6.337m of sustainability funding, £0.163m behind the plan to date of £6.500m. Earning sustainability funding in quarter 1 only required the agreement of the access standards trajectories with NHS Improvement / NHS England.

For September, the Trust assessed its delivery of the net surplus Control Total excluding STF. The year to date net surplus of £1.833m exceeded the Control Total net surplus requirement of £1.636m. Therefore, delivery of the net surplus Control Total in September earned STF of £0.759m and triggers the Trust's eligibility for the remaining 30% of the STF available based on the Trust's performance against the access trajectories.

To date, the Trust delivered the A&E access trajectory for quarter 2 worth £0.405m. The Trust's delivery of the RTT access trajectory for quarter 2 is subject to appeal but the Trust has a reasonable degree of confidence following informal discussions with NHS Improvement on the principles of the formal appeal process, that the appeal will secure the RTT element. The Trust did not deliver the Cancer access standard in September. However, the Trust again has a reasonable degree of confidence of securing the available funds for quarter 2 as a whole, due to the scale of breaches outside of the control of the Trust. The position is summarised in the table below. Further detail is provided in Appendix 9.

Trajectory to date	Quarter 1	July	August	September	Total YTD
Control Total delivery	Achieved	Achieved	Achieved	Achieved	
STF earned	£3.250m	£0.759m	£0.759m	£0.759m	£5.527m
A&E trajectory delivery	Agreed	Achieved	Achieved	Achieved	
STF earned	*£0.405m*	£0.135m	£0.135m	£0.135m	£0.405m
Cancer trajectory delivery	Agreed	Failed**	Failed**	Failed**	
STF earned	*£0.163m*	£0.000m	£0.000m	£0.000m	£0.000m
RTT National target delivery	Agreed	Achieved	Achieved**	Achieved**	
STF earned	*£0.405m*	£0.135m	£0.135m	£0.135m	£0.405m
Total	£3.250m	£1.029m	£1.029m	£1.029m	£6.337m

** subject to appeal
Italics represents notional values

b) Nursing & Midwifery

The nursing and midwifery pay variance for the month is £0.450m adverse. The table below shows the analysis between substantive, bank and agency for each month and year to date. The 2015/16 position is shown for comparison.

	September £m	August £m	July £m	Quarter 1 £m	2016/17 to date £m	2015/16 outturn £m
Substantive	0.786	0.725	0.955	1.264	4.695	10.099
Bank	(0.488)	(0.591)	(0.520)	(1.438)	(3.038)	(6.684)
Agency	(0.748)	(0.484)	(0.598)	(1.945)	(3.775)	(7.691)
Total	**(0.450)**	**(0.350)**	**(0.163)**	**(1.155)**	**(2.118)**	**(4.276)**
Restated for agency accrual		(0.277)	(0.110)	-	(0.387)	
Reversal of 15/16 accrual					0.387	
Total	**(0.450)**	**(0.627)**	**(0.273)**	**(1.155)**	**(2.118)**	**(4.276)**

The increase in agency adverse variance in the month of £0.264m reflects adjustments which impact on previous reported variances. A review of the year to date accrual for unpaid agency shifts in month 6 resulted in an increase of accruals of £0.387m relating to prior periods (£0.110m for month 4 and £0.277m for month 5). This has been offset by funding released from a prior year

accrual, the actual movement, shown in the table above, is therefore a slight decrease from last month. Agency expenditure remains high and significantly above plan.

The position now reported shows a deterioration in the nursing overspend in 2016/17 compared to 2015/16. The issuing of £1.4m for 1:1 costs in 2016/17 makes the increase more significant i.e. 2016/17 projected variances £4.2m versus 2015/16 variance of £2.8m (excluding £1.4m).

In month 6 the variance on bank staff improved by £0.103m mainly in Surgery, Head and Neck, Medicine and Women's and Children's Divisions due to a reduction in actual expenditure, linked both to number of staff utilised and the value of unsocial payments. A smaller improvement of £0.061m on substantive staff is also seen.

The following table shows the Nursing and ODP price and volume variance for September. Overall, it shows that Nursing and ODPs were £0.473m adverse with £0.376m due to volume above the funded establishment (wte) and £0.097m due to adverse variance on price. The table also shows that the wards in the Clinical Divisions are responsible for the overspend.

Table: Nursing & ODP Variance –

Division	Nursing Category	Price Variance fav/ (adv) £'000	Volume Variance fav/ (adv) £'000	Total Variance fav/ (adv) £'000	Lost Time % (Wards/ED/ Theatres)
Medicine	Ward	73	(121)	(48)	
	Other	(49)	(61)	(110)	
	ED	(10)	(5)	(15)	
Medicine Total		**14**	**(187)**	**(173)**	**125%**
Surgery, Head & Neck	Ward	61	(108)	(46)	
	Theatres	(99)	23	(76)	
	Other	(35)	53	18	
	ED	2	(1)	0	
Surgery, Head & Neck Total		**(71)**	**(33)**	**(104)**	**128%**
Specialised Services	Ward	(9)	(58)	(67)	
	Other	(0)	15	15	
Specialised Services Total		**(9)**	**(43)**	**(52)**	**128%**
Women's & Children's Services	Ward	161	(85)	76	
	Theatres	(40)	26	(14)	
	Other	(192)	(35)	(227)	
	ED	8	(8)	(0)	
Women's & Children's Services Total		**(63)**	**(102)**	**(165)**	**126%**
Clinical Division Total	Ward	290	(375)	(85)	
	Theatres	(138)	48	(89)	
	Other	(283)	(21)	(305)	
	ED	(0)	(14)	(15)	
CLINICAL DIVISIONS TOTAL		**(132)**	**(362)**	**(494)**	**127%**
NON CLINICAL DIVISIONS	Other	35	(14)	21	
NON CLINICAL DIVISIONS TOTAL		**35**	**(14)**	**21**	
TRUST TOTAL		**(97)**	**(376)**	**(473)**	**127%**

The HR Nursing Controls dashboard is attached at appendix 3 and shows the registered nursing position for each Division against eight Key Performance Indicators (KPIs). Highlights from the KPIs are as follows:

- Sickness –Medicine, Surgery, Head and Neck and Women's and Children's Divisions continue to be above trajectory for their sickness levels;

- Vacancies – all but the Women's and Children's Division are above the Trust target of 5% for vacancies with the Division of Medicine being the highest at 7.3% , all areas have reduced the percentage vacancies in September;
- Operating Plan for nursing agency wte – all Divisions are above their Operating Plan position with the Division of Surgery, Head and Neck being the most concerning with an actual position of 28.8wte against a target of 4.1wte. This higher than planned agency run rate is also reflected in Divisions percentage of nursing agency against total nursing spend, with all Divisions being above plan; and
- Nursing assistant, 1:1 and RMN usage where the Medicine Division continues to be above the funded level for NA 1:1's and RMN's, as are Women's and Children's in September.

c) Medical and Dental

The medical and dental pay variance for the month is £0.203m adverse. The table below shows the analysis between substantive, locum and agency each month and year to date. The 2015/16 position is shown for comparison.

	September £m	August £m	July £m	Quarter 1 £m	2016/17 to date £m	2015/16 Outturn £m
Substantive	(0.038)	(0.002)	0.255	0.645	0.860	2.387
Locum	(0.131)	(0.197)	(0.141)	(0.630)	(1.099)	(1.803)
Agency	(0.034)	(0.036)	(0.129)	(0.434)	(0.633)	(2.389)
Totals	**(0.203)**	**(0.235)**	**(0.015)**	**(0.419)**	**(0.872)**	**(1.805)**

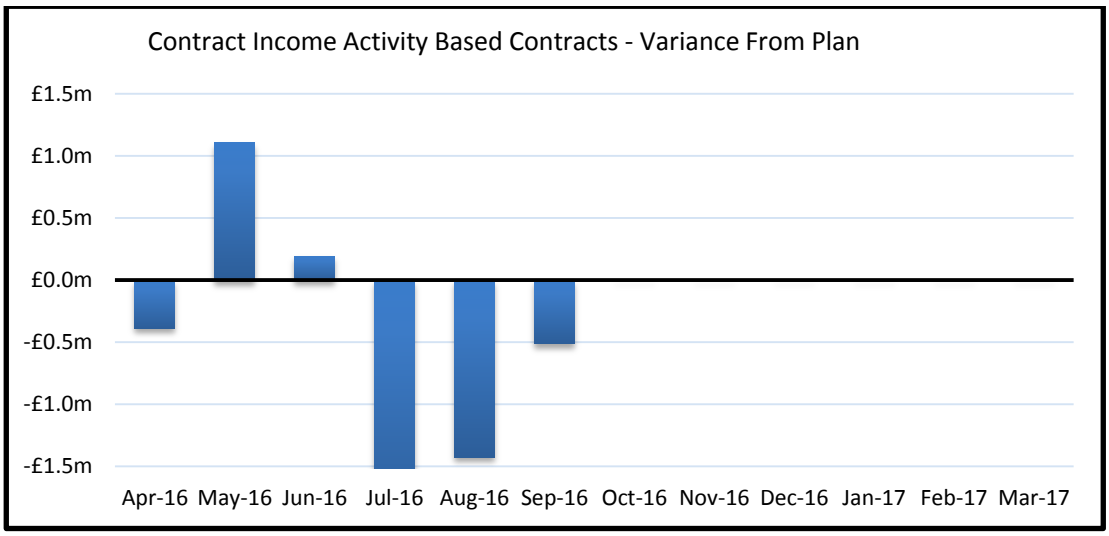
September's variance has remained similar to that in August with a small improvement of £0.032m. The improvement on locum and agency variance reflected a planned increase in funding in Surgery, Head and Neck Division for locums, linked to the operating plan. Actual expenditure did not decrease significantly.

The adverse substantive pay variance increased following successful recruitment to a number of consultant posts and a reduction in gaps in the rota following the most recent rotation of junior medical staff.

d) Clinical Activity

Activity based contract performance worsened by £0.508m in September to give a cumulative under performance of £3.025m. The position worsened for all divisions but particularly within Specialised Services (£0.116m) and Corporate share (£0.228m). Performance at Clinical Divisional level is shown at appendix 5a.

The graph overleaf shows the monthly performance for all activity based contracts.



The table below summarises the overall clinical income by work type, which is described in more detail under agenda item 5.2.

	In Month Variance Fav/(Adv) £m	Year to Date Plan £m	Year to Date Actual £m	Year to Date Variance Fav/(Adv) £m
Activity Based				
Accident & Emergency	0.01	7.79	8.02	0.23
Bone Marrow Transplants	(0.22)	4.17	4.09	(0.08)
Critical Care Bed days	0.19	21.96	21.85	(0.11)
Day Cases	(0.12)	19.73	19.45	(0.28)
Elective Inpatients	(0.32)	25.73	25.25	(0.48)
Emergency Inpatients	0.03	38.80	39.89	1.09
Excess Bed days	(0.01)	3.48	3.23	(0.25)
Non – Elective Inpatients	(0.02)	13.69	12.14	(1.55)
Other	0.10	46.98	46.80	(0.18)
Outpatients	(0.16)	41.69	40.26	(1.43)
Sub Totals	**(0.51)**	**224.02**	**220.98**	**(3.04)**
Contract Penalties	(0.04)	(0.47)	(0.54)	(0.07)
Contract Rewards	0.00	4.69	4.69	0.00
Pass through payments	(0.25)	43.41	41.31	(2.10)
2016/17 Totals	**(0.81)**	**271.63**	**266.44**	**(5.20)**
Prior year income	0.34	-	2.01	2.01
Overall Totals	**(0.47)**	**271.63**	**268.45**	**(3.19)**

Elective inpatients and bone marrow transplants accounted for £0.540m of the deterioration in the month. Elective inpatients were £0.360m behind plan in the month within Women's and Children's primarily due to paediatric spinal surgery and trauma and orthopaedics. Lower activity within bone marrow transplants largely affected Women's and Children's (£0.119m) and Specialised Services (£0.063m).

CQUINs have now been agreed including the Hepatitis C CQUIN with NHS England Specialised Commissioning (worth c£2.6m). However the delays in finalising the agreements and quarterly monitoring for most indicators means that rewards performance will commence at quarter two and is currently set to plan.

Performance against penalties was £0.043m below plan this month, moving the cumulative performance to £0.070m below plan. The cumulative position is predominately due to Remedial Action Plan (RAP) penalties for cancelled operations readmissions within 28 days.

Pass through payments were £0.253m lower than plan in September, increasing the adverse cumulative position to £2.102m. The year to date adverse variance relates to excluded drugs (£1.60m), excluded devices (£0.58m) and blood products (£0.12m).

e) Savings Programme

The savings requirement for 2016/17 is £17.420m. Savings of £6.441m have been realised to date, a shortfall of £2.277m against divisional plan. The shortfall is a combination of unidentified schemes of £1.589m and a further £0.689m for scheme slippage. The 1/12th phasing adjustment reduces the shortfall to date by £0.008m.

The year-end forecast outturn has reduced this month to £13.879m, a shortfall of £3.541m, which represents delivery of 80%.

A summary of progress against the Savings Programme for 2016/17 is summarised below. A more detailed report is given under item 5.4 on this month's agenda.

	Savings Programme to 30th September 2016				
	Plan £m	Actual £m	Variance fav / (adv) £m	Phasing adjustment fav/(adv) £m	Total variance Fav/(adv) £m
Diagnostics and Therapies	0.759	0.813	0.054	(0.062)	(0.008)
Medicine	0.830	0.749	(0.081)	(0.012)	(0.093)
Specialised Services	0.726	0.545	(0.181)	(0.029)	(0.210)
Surgery, Head and Neck	2.415	1.318	(1.097)	(0.063)	(1.160)
Women's and Children's	2.417	1.340	(1.077)	0.098	(0.979)
Estates and Facilities	0.341	0.373	0.032	(0.051)	(0.019)
Corporate Services	0.486	0.453	(0.033)	0.127	0.094
Other Services	0.744	0.850	0.106	-	0.106
Totals	**8.718**	**6.441**	**(2.277)**	**0.008**	**(2.269)**

The performance for the year by category is also shown below.

	Year to Date			Variance Against Adjusted Plan £m	Forecast Outturn		
	Plan £m	Actual £m	Variance £m		Plan £m	Actual £m	Variance £m
Pay	1.258	1.145	(0.113)	(0.153)	2.597	2.571	(0.026)
Drugs	0.623	0.614	(0.009)	0.092	1.044	1.117	0.073
Clinical Supplies	1.535	1.660	0.125	0.123	3.073	3.474	0.401
Non Clinical Supplies	2.061	1.759	(0.302)	(0.361)	4.241	3.806	(0.435)
Other Non Pay	0.028	0.028	-	-	0.057	0.057	-
Income	1.280	0.890	(0.390)	(0.382)	2.543	2.164	(0.379)
Capital Charges	0.345	0.345	-	-	0.690	0.690	-
Unidentified	1.588	-	(1.588)	(1.588)	3.175	-	(3.175)
Totals	**8.718**	**6.441**	**(2.277)**	**(2.269)**	**17.420**	**13.879**	**(3.541)**

4. Divisional Financial Position

Clinical Divisions and Corporate Services overspend against budget increased by £1.706m in September to a cumulative position of £6.727m adverse to plan. The table below summarises the financial performance in September for each of the Trust's management divisions against their budget and against their September Operating Plan trajectory. Further analysis of the variances against budget by pay, non-pay and income categories is provided in Appendix 2.

	Budget Variance favourable/(adverse)			Operating Plan Trajectory favourable/(adverse)	
	To 31 Aug £m	September £m	To 30 Sept £m	Trajectory To Sept £m	Variance £m
Diagnostic & Therapies	0.060	0.023	0.083	(0.062)	0.145
Medicine	(1.565)	(0.466)	(2.031)	(0.354)	(1.677)
Specialised Services	(0.438)	(0.261)	(0.699)	(0.169)	(0.530)
Surgery, Head & Neck	(1.813)	(0.421)	(2.234)	(0.587)	(1.647)
Women's & Children's	(1.395)	(0.596)	(1.991)	(0.271)	(1.720)
Estates & Facilities	(0.036)	(0.007)	(0.043)	(0.052)	0.009
Trust Services	(0.007)	0.008	0.001	0.018	(0.017)
Other corporate	0.173	0.014	0.187	0.000	0.187
Totals	**(5.021)**	**(1.706)**	**(6.727)**	**(1.477)**	**(5.250)**

Variance to Budget:

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

	Budget Variance favourable/(adverse)		
	To 31 Aug £m	September £m	To 31 Sept £m
Pay	(1.271)	(0.429)	(1.700)
Non Pay	0.081	(0.214)	(0.133)
Operating Income	(0.184)	(0.132)	(0.316)
Income from Activities	(1.651)	(0.658)	(2.309)
Sub Total	(3.025)	(1.433)	(4.458)
Savings programme	(1.996)	(0.273)	(2.269)
Totals	**(5.021)**	**(1.706)**	**(6.727)**

Pay budgets have an adverse variance in month of £0.429m increasing the cumulative adverse variance to £1.700m. The significant adverse movements in the month were within Medicine (£0.263m), Specialised Services (£0.110m) and Women's and Children's (£0.279m), offset by a favourable variance in Diagnostic and Therapies (£0.117m). Cumulative adverse variances are within Women's and Children's (£1.408m), Surgery, Head and Neck (£0.232m), Medicine (£0.818m), and Specialised Services (£0.470m) offset by favourable variances in Diagnostic & Therapies (£0.740m) and Trust Services (£0.341m).

For the Trust as a whole, agency spend is £6.238m to date. The monthly average spend of £1.040m compares with a monthly average spend in 2015/16 of £1.260m. Agency spend to date is £1.720m in Medicine, £1.260m in Women's and Children's, £1.442m in Surgery, Head and Neck and

£1.146m in Specialised Services. Waiting List Initiatives (WLIs) costs to date are £1.489m of which £0.588m is within Surgery, Head and Neck, £0.286m in Women's and Children's and £0.222m in Specialised Services.

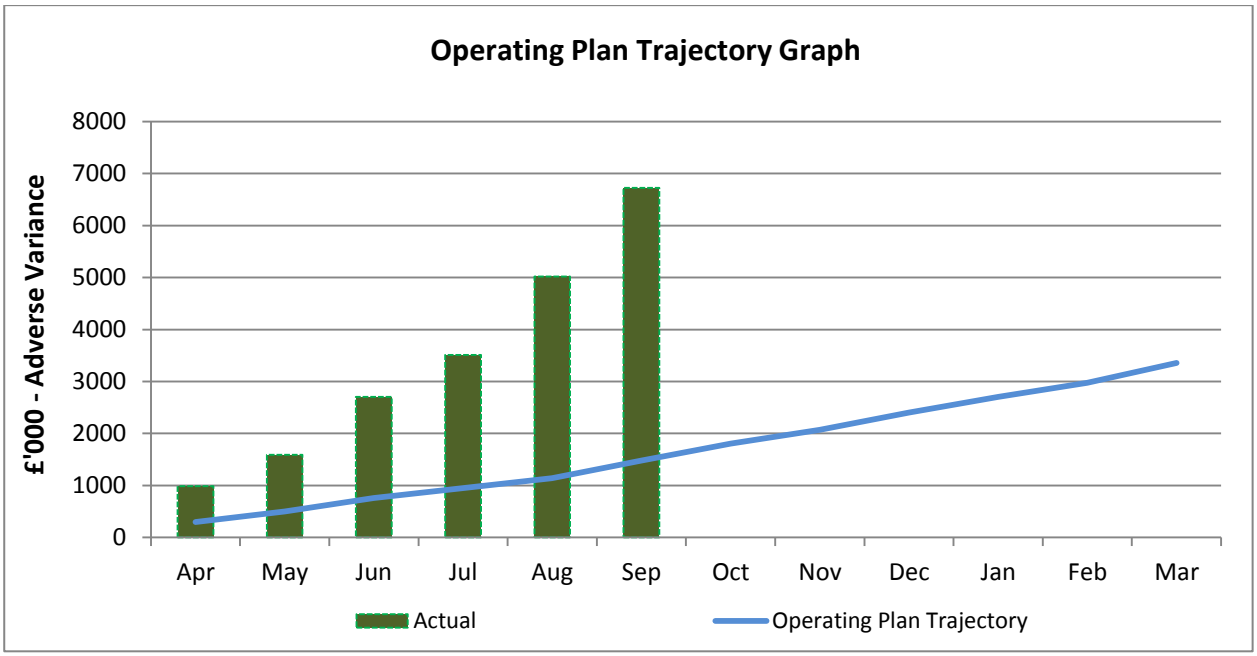
N**on-pay budgets** have an adverse variance of £0.214m in the month changing the cumulative variance to £0.133m adverse.
The movement in the month was primarily within Medicine (£0.173m) and Surgery Head and Neck (£0.218m) offset by Women's and Children's which improved by £0.207m.
Cumulative adverse variances are within Diagnostic & Therapies (£0.531m), Surgery, Head and Neck (£0.433m), Medicine (£0.191m) and Specialised Services (£0.169m) offset by a favourable variance in Women's and Children's of £1.255m.

Operating Income budgets have an adverse variance in the month of £0.132m increasing the cumulative adverse variance to £0.316m. Both the movement in month and cumulative variance is primarily outside of the Clinical Divisions and is offset by non pay.

Income from Activities budgets have an adverse variance in month of £0.658m increasing the cumulative adverse variance to £2.309m.
The most significant adverse variances in month were in Medicine (£0.109m) Specialised Services (£0.102m) and Women's and Children's (£0.347m).
The principal areas of under achievement to date are within Medicine (£0.938m), Women's and Children's (£0.879m) and Surgery, Head and Neck (£0.425m).

Variance to Operating Plan:

Clinical Divisions and Corporate Services have an adverse variance of £6.727m against a combined Operating Plan trajectory of £1.477m. The September position is £5.250m above trajectory as shown in the graph below.



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

5. Divisional Reports

The following is intended to provide a brief update on the Divisional positions including reasons for variances and actions being taken to address adverse positions. As requested at the previous Finance Committee, the divisional reports at item 5.3 provide further detail on the impact of actions being taken and the new actions that have been introduced since the last report.

5.1 Division of Medicine

The Division reports an adverse variance to month 06 of £2.031m; the Division is £1.677m adverse to its Operating Plan trajectory to date. The Division is reporting a savings programme year to date adverse variance of £0.093m and a savings programme forecast outturn favourable variance of £0.274m.

The key reasons for the variance are:

Adverse variances

- An adverse pay variance of £0.818m which represents an in month deterioration of £0.263m. Nursing budgets were adverse by £0.626m; Agency and bank expenditure was higher in September than in August due to increased demand relating to staffing the ED queue, and further increases in the associated costs of 1:1 nursing.
- An adverse variance on non-pay of £0.191m, with an adverse variance in month of £0.173m primarily as a consequence of recognising the net cost of the ORLA initiative.
- An adverse variance on SLA income of £0.938m which represents a deterioration in month of £0.109m, the main reason for the year to date adverse variance being lower than planned Outpatient activity £0.1100m, lower than planned emergency activity £0.432m and the impact of Cystic Fibrosis tear of care.

Favourable variances

- A favourable variance on income from operations of £0.009m.

Actions being taken and mitigation to restore performance include:

Ongoing actions/Priorities

- All patients, following a decision to admit (DTA) in ED, to be referred on ICE to ORLA for consideration;
- To work with commissioners to ensure that the front door pilot, encompassing the urgent care centre, is progressed and rolled out in tandem with the 'high impact users' initiative;
- The ownership, accountability and responsibility for community bed placements is passed to commissioners with immediate effect;
- Increasing and retaining elective activity volumes and delivering at a margin through the cessation of outsourcing arrangements and better use of existing resources.
- Reductions in nursing costs – this is being managed via a programme of close controls with respect to the booking of shifts out of hours, the continued close scrutiny of all agency use and the introduction of dementia 'night clubs' aimed at reducing the number of 1:1 shifts required. The ability to control and manage this action is severely constrained by the lack of mobilisation in the community and the lack of community beds.

Proposed actions /Opportunities

- Specialties have been identified that are able to over-perform against contract, in respect of elective, outpatient activity. These opportunities have been identified with consideration given to the requirement for waiting list initiatives. The planned over-performance will not only assist

the Division in its overall recovery of outpatient performance but can also assist in the achievement of Trust wide RTT targets, facilitating, in turn an ability to earn the STF.
- Development of Emergency Nurse Practitioners (ENPs) and Advanced Nurse Practitioners (ANPs) within the ED.

Key risks to delivery of the Operating Plan and ongoing improvement include:
- The full management of the ORLA programme – It is difficult to project from where a material operational benefit will arise, when referral sources are varied. It is important that the Division is fully educated and informed with respect to the financial and operational issues associated with the programme – at individual ward level, the full scale of issues and consequences will not always be clear;
- Continuing high referral rates from Callington Road – these patients are expensive and resource intensive and often cannot be transferred back to Callington Road, following the provision of General Medical care;
- The belief by commissioners that the ORLA programme becomes a baseline imitative, delivered by the Trust without the input and support from other community initiatives. The associated cost, both of ORLA itself and the continued high demand for and use of 1:1 nurses, will severely impact the ability to financially recover

5.2 Division of Surgery, Head and Neck

The Division reports an adverse variance to month 06 of £2.234m; The Division is £1.647m adverse to its Operating Plan trajectory to date. The key reasons for the variance are:

Adverse variances
- An underachievement of savings resulting in an adverse variance to date of £1.160m. The majority relates to unidentified plans £0.750m the rest relates to schemes having been removed with regards to outsourcing savings and other slippage on schemes.
- An adverse variance on pay of £0.232m primarily due to high nursing agency and bank usage as well as high levels of waiting list expenditure within Medical Staff.
- An adverse variance on non-pay of £0.433m this has been caused by spend on outsourcing work and overspends on clinical supplies offset by underspends relating to support funding.
- An adverse variance on income from activities of £0.425m the most significant adverse year to date variances are within Ophthalmology due mainly to a low number of follow up outpatients £0.130m driven by vacancies in key posts. Oral/Dental services £0.629 and Colorectal services £0.169m. These being offset by a significant favourable variances within Upper GI services £0.228m, ENT services £0.081m and Private/Overseas Patients £0.176m.

Favourable variances
- A favourable variance on income from operations of £0.016m due to higher than planned research and development income.

The key reasons for the variance against the Operating Plan trajectory are:
- Higher than planned nursing spend of £0.307m.
- Higher than planned medical staff spend including WLI payments of £0.203m.
- Higher than planned expenditure on outsourcing of £0.304m.
- Lower than planned income from activities of £0.422m.
- Higher than planned spend on drugs and clinical supplies of £0.356m.
- Slippage on recruitment to vacancies of £0.180m favourable.
- Slippage on CIP delivery.

Key risks to delivery of the Operating Plan and ongoing improvement include:

- There remains risk around delivery of service level agreement income which has the potential to be substantial; there is an increased reliance on outsourcing) and recovery is dependent on swift and successful recruitment particularly around oral and dental services. The income forecast will be fully refreshed at Month 06.
- The division is continuing to develop plans to recover and deliver service level agreement income and the key performance targets required. These plans come at a cost. The team is clear that the financial implications of these plans require close management control.
- Lost activity due to bed pressures and lack of anaesthetic cover remain risks to divisional performance although recruitment has now succeeded in the anaesthetic workforce
- Failure to deliver the required improvements in both recruitment and retention of staff, in particular in the registered nursing and operating department practitioner workforce will drive additional costs in terms of agency spend into the position. (Particularly an issue for the orthopaedic wards, across all theatres and intensive care).
- The Junior Medical and Dental workforce is vulnerable to changes in trainee levels and difficulty has been found in recruitment particularly in Trauma and Orthopaedics. The need to maintain cover on the wards is driving agency costs albeit there has now been a successful round of recruitment to this team.
- The division has been notified that there will be reductions in training numbers into Intensive Care in the autumn which will produce further cost pressures
- Failure to address the appropriate need for 1:1 nursing.
- Failure to work up additional cost improvement.
- Capacity in the procurement team is causing delays in certain procurement projects that could benefit the savings programme.

Actions being taken and mitigation to restore performance include:

Ongoing Actions /Priorities

- The Division is holding fortnightly Finance and Performance Meetings where Service Line Managers are held to account for finance and service performance.
- The Division is holding fortnightly CIP meetings where service lines are clear on their individual savings targets and are presenting news plans and pipeline ideas to meet those targets.
- Review meetings are being held with Divisional Director, Divisional Finance Manager and General Manager, reviewing actual expenditure and challenging spend.
- The Managed Inventory System Project has been approved and there have been further meetings in to date in order to progress the contract terms. This is proving difficult but progress is being made.
- Recruitment plans are under way. The investment in a recruitment/training manager for theatres has been made and is delivering real improvements.
- Reduction of turnover is being approached with additional provision of training and staff development, and career progression opportunities.
- The Division continues to work with other divisions in understanding bed modelling and planning going forward.
- Key review under way re Adult ITU Staffing to inform the operating plan and the ITU/CICU project.
- A non-pay approval process to manage change through divisional board is being developed through the non-pay group.
- Review of delivery plans to mitigate the requirement for outsourcing and waiting lists. in ENT and Endoscopy.
- The Division continues to roll out a formal process of re-engaging with the service teams, the clinical, management and nursing staff. This engagement is required to identify further actions

that can be taken to move the results back towards planned outturn and outcomes for 16/17 and will also be valuable in planning for 2017/18.

Proposed Actions/Opportunities

- Nurse performance meetings are being extended to encompass all nursing teams, with the "hotspots" being reviewed monthly and other departments rotating through.
- The Division is keen to continue engaging with the Service Productivity Reviews and to roll these out across the Division and anticipates that the new CIP programme will derive from this work.
- The Division is targeting improvements to in Dental and Oral services, the leadership that will be delivered through the new General Manager will support this. This new General Manager is taking forward the Admin Review project and will be implementing recommendations such as actively supporting recruitment to vacancies. This post will also progress ongoing recruitment required to deliver activity.
- Work is ongoing re preparing to implement a managed inventory system; this will produce process mapping, improved systems and stores ahead of any implementation.
- Time is being spent reviewing the current pricing and updating private patient tariffs to ensure that this is a financial benefit to the organisation.
- The Theatre performance and operations group is introducing a work stream reviewing and challenging performance at a specialty level led by the Divisional Director. Bluespier data is expected to support this project.
- CIP formation is ongoing and the Division is reviewing the possibilities inherent in the Big Hand and Voice Recognition projects for savings within the Divisional teams.

5.3 The Division of Women's and Children's Services

The Division reports an adverse variance to month 06 of £1.991m. The Division is £1.720m adverse to the Operating Plan trajectory to date.

The key reasons for the variance are:

Adverse variances:

- An adverse variance on pay of £1.408m
- Nursing agency premiums continue to be above cap leading to a cost pressure. Of the £90k overspend against workforce plan on nursing agency £81k was due to the price premium. Usage has reduced on wards and is limited to specialist areas such as Renal; however usage in Children's Theatres continues and leads to the challenge of 8.6wte under establishment with consequent reduced capacity and income, but a £11k overspend due to agency premiums.
- Medical staff reports an adverse variance of £0.551m including costs associated with non-compliant junior rotas and significant agency spend for consultants, there is significant levels of maternity leave and sickness in key junior medical rotas with 11 posts on maternity leave.
- An underperformance on the savings programme resulting in an adverse variance to date of £0.978m. The majority of which relates to the level of unidentified savings in the plan £0.906m.
- An adverse performance on SLA income of £0.978m including ytd adverse variances in Neuro, Cardiac and PICU £601m. And Paediatrics Surgical £40.448m. These adverse variances being offset to some extent by favourable variances in St Michaels.

Favourable variances

- A significant favourable variance on non-pay of £1.255m which includes a share of support funding and capacity growth reserves which offset the underachieved of income and slippage on developments.

Actions being taken and mitigation to restore performance:

Ongoing Actions/Priorities

- Children's Winter Flow programme ensuring that winter pressures are managed without a reduction in elective income
- Ensure that Ward 30 Medical HDU refurbishment re-opens on time
- Delivery of objectives identified in Outpatient Productivity Project on a Page including improved room allocation (including full utilisation of South Bristol Community Hospital rooms), clinic utilisation, reconciliation to job plans, and reducing DNA and hospital cancellation rates

Proposed Actions/Opportunities

- £1,498k of savings have currently been identified for 2017/18. Whilst a number of schemes are only cashable next year such as Commercial research profits and development slippage carried forward from this year, further efforts can be made to bring forward the productivity gains identified into this year.
- Enhancing pay controls and peer review of vacancy control panels to enable delivery of 2% vacancy factor.
- Review the pipeline of Hearing Implant processor replacements to see whether spending can be deferred.

Key risks to delivery of the Operating Plan and ongoing improvement include:

- Continued shortfalls in Children's Theatres leading to reduced elective capacity – mitigated by speeding up recruitment, improving retention, re-invigorated leadership with new Theatres Matron, use of weekend waiting list initiative capacity to recover lost income.
- Maintaining controls on recruitment and additional session payments to junior doctors during transition to new contract

5.4 Division of Specialised Services

The Division reports an adverse variance to month 06 of £0.699m. The Division is £0.530m adverse to the Operating Plan trajectory to date.

The key reasons for the variances are:

Adverse variances:

- Cardiac Surgery activity - the Division reports an adverse variance to date of £0.227m after deterioration this month of £0.115m.
- Medical pay budgets show an adverse variance of £0.142m due to agency and WLI costs.
- Non Pay budgets report an adverse variance of £0.169m mainly within Clinical Supplies but also spread across a number of areas.
- Pay budgets are reporting an adverse variance of £0.470m with nursing reporting an adverse variance of £0.291m.
- A year to date shortfall on the savings programme of £0.210m.

Favourable variances

- Operating income reports a favourable variance of £0.102m.
- Cardiology now reports a favourable SLA variance of £0.143m with an in month

Actions being taken and mitigation to restore performance:

Ongoing Actions/Priorities

- Significant improvements are required for the delivery of Cardiac Surgery activity. Specifically ensuring the availability of beds to deliver required activity levels.
- Reduction of Agency expenditure in Radiotherapy following a catch up on backlogs due to unplanned machine downtime.
- Reductions of nursing overspend in CICU. Six new starters have joined in month which should improve finances moving forwards.
- Reduction of agency expenditure in Perfusion.

Proposed Actions /Opportunities

- Clinical Genetics activity. Plans are in development to address the current waiting list backlogs in this area. Due to the service line being profitable for this area favourable margins are expected.
- Cardiology consumables tender is due for renewal at the end of November. Savings are expected and required out of this process.
- Recruitment to Medical vacancies in the BHOC are expected to increase activity levels further in future months.

Key risks to delivery of the operating plan and future performance include:

- Winter pressures impact on beds and the delivery of activity in the BHI, most notably Cardiac Surgery. The division and trust will need to ensure the protection of Cardiac Surgery beds so as to enable continued throughput through the winter period.
- Continued reliance on agency staff and inability to recruit to specialist areas. Continued effort and focus on recruitment in both the short and long term is required to address current issues being experienced.
- Non pay controls must be maintained to ensure expenditure is minimised and that new policies with regards to the centralisation of high cost devices are adhered to so as to avoid any income losses.

5.5 Trust Services

The Division reports a favourable variance to month 06 of £0.001m. The Division is £0.017m adverse to the Operating Plan trajectory to date.

Two Divisions are rated Green for their performance to date

5.6 Diagnostic and Therapies Division

The Division reports a favourable variance to month 06 of £0.083m. The Division is £0.145m favourable compared to the Operating Plan trajectory to date.

The key reasons for the variance are:

Adverse variances

- An adverse variance on non-pay of £0.531m which includes double running costs associated with LIMS £0.120m, Radiology outsourcing costs £0.293m, and adverse variances on clinical supplies and drugs including £0.144m due to drug wastage.
- An adverse variance on operating income of £0.047m.

- An adverse variance on SLA income of £0.071m, there is a favourable variance on services hosted by Diagnostics and Therapies of £0.253m offset by adverse variances associated with services hosted by other divisions of £0.319m
- The savings programme is £0.08m adverse to month 06.

Favourable variances
- A favourable variance on pay of £0.740m, primarily the result of vacancies in clinical staff. However the run rate on pay is expected to deteriorate for the rest of the year due to recruitment to vacancies in Radiology.
- Adverse variances on non-pay above are offset by a balance of contract transfer funding.

Actions being taken and mitigation to restore performance:

Ongoing actions/Priorities
- Rolling programme of Service Line Reporting meetings being set up with Heads of Service, Radiology have started, order of other services was determined at Divisional Finance Committee.
- Review of Radiology contract income data post HRG move underway, with support from information analyst.
- Specialty review of Radiology, including WLIs

New actions/Opportunities
- Division has submitted the required template on Pathology costs as required by NHSI.

Key risks to delivery of the operating plan and future performance include:

- Other Division's under-performance on contracted activity.
- Non-delivery or under-delivery of savings schemes currently forecast to achieve.
- 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.

5.7 Facilities and Estates Division

The Division reports an adverse variance to month 06 of £0.043m. The Division is £0.009m favourable to the Operating Plan trajectory to date.

6. Financial Sustainability Risk Rating and Use of Resources Rating

The Trust achieved an overall Financial Sustainability Risk Rating (FSRR) of 4 (actual 4.00) against a plan of 4 for the period to September. Each of the four FSRR metrics are in line with the plan to date with actual metric scores of 4. The table below summarises the position.

		30th September 2016		31st March 2017	
	Weighting	Plan	Actual	Plan	Forecast
Liquidity					
Metric Result – days		12.39	14.75	11.96	11.96
Metric Rating	25%	4	4	4	4
Capital Servicing Capacity					
Metric Result – times		2.80	2.75	2.77	2.77
Metric Rating	25%	4	4	4	4
Income & expenditure margin					
Metric Result		3.02%	3.02%	2.70%	2.70%
Metric Rating	25%	4	4	4	4
Variance in I&E margin					
Metric Result		0.32%	0.00%	0.32%	0.01%
Metric Rating	25%	4	3	4	4
Overall FSRR		**4.0**	**3.75**	**4.0**	**4.0**
Overall FSRR (rounded)		**4**	**4**	**4**	**4**

The Single Oversight Framework (SOF), published on 30th September, sets out NHS Improvement's approach to overseeing NHS providers. The SOF comes into effect on 1st October 2016 and will assess the financial performance of providers using the Use of Resources Rating (URR). Providers will be formally assessed based on the URR from October. The URR adds a new fifth metric to the FSRR measuring expenditure on agency staff against the Trust's agency ceiling as set by NHS Improvement. The URR for the Trust to date is 1, the highest rating. The table below summarises the position.

		30th September 2016		31st March 2017	
	Weighting	Plan	Actual	Plan	Forecast
Liquidity					
Metric Result – days		12.39	14.75	11.96	11.96
Metric Rating	20%	1	1	1	1
Capital Servicing Capacity					
Metric Result – times		2.80	2.75	2.77	2.77
Metric Rating	20%	1	1	1	1
Income & expenditure margin					
Metric Result		2.58%	2.61%	2.53%	2.53%
Metric Rating	20%	1	1	1	1
Variance in I&E margin					
Metric Result		0.00%	0.03%	0.00%	0.01%
Metric Rating	20%	1	1	1	1
Variance from agency ceiling					
Metric Result		0.00%	12.83%	0.00%	0.00%
Metric Rating	20%	1	2	1	1
Overall URR		**1.0**	**1.2**	**1.0**	**1.0**
Overall URR (rounded)		**1**	**1**	**1**	**1**

The agency ceiling set by NHSI of £12.793m is based on data submitted in 2015/16 which included medical locums. Following the change in NHSI definition the Trust has split out the locum costs and whilst NHSI support this approach they have yet to confirm whether this requires an adjustment to the ceiling. The recently communicated target for 2017/18 remains unchanged.

At the end of September the Trust is £0.924m adverse against the NHSI ceiling, a deterioration in the month of £0.151m. The table below summarises this position:

	Current month position (September)			Year to date position		
Staff category	NHS I Ceiling £m	Actual £m	Variance fav/(adv) £m	NHS I Ceiling £m	Actual £m	Variance fav/(adv) £m
Medical Agency	-	0.082	-	-	0.953	-
Medical Locum – Zero Hours		0.062			0.485	
Medical Locum – Fixed Term		0.237			1.392	
Nursing Agency (RNs and NAs)	-	0.779	-	-	4.320	-
Other Agency	-	0.201	-	-	0.965	-
Totals	**1.210**	**1.361**	**(0.151)**	**7.191**	**8.115**	**(0.924)**

7. Capital Programme

A summary of income and expenditure for the six months ending 30th September 2016 is provided in the table below. The Operational Plan of £35.0m shows a profiled planned spend to date of £14.143m. A review of the capital programme has identified a number of delays resulting in a re-profiled internal plan, although the forecast outturn remains at £35.0m.

Operational Plan £m	Subjective Heading		Period ended 30th September			Forecast Out-turn £m
		Operational Plan to Date £m	Internal Plan £m	Actual £m	Variance £m	
	Sources of Funding					
0.273	PDC	0.273	0.273	0.272	(0.001)	0.273
2.732	Donations	2.270	2.270	2.169	(0.101)	2.732
	Cash:					
22.054	Depreciation	10.698	10.698	10.666	(0.032)	22.054
9.941	Cash balances	4.623	0.902	0.941	0.039	9.889
35.000	**Total Funding**	**17.864**	**14.143**	**14.048**	**(0.095)**	**34.948**
	Expenditure					
(14.244)	Strategic Schemes	(8.640)	(8.826)	(8.604)	0.222	(11.020)
(11.142)	Medical Equipment	(3.730)	(1.046)	(0.898)	0.148	(10.375)
(4.659)	Information	(2.021)	(1.698)	(1.635)	0.063	(4.162)
(2.815)	Estates Replacement	(1.146)	(1.069)	(0.822)	0.247	(2.755)
(13.191)	Operational Capital	(3.827)	(2.790)	(2.089)	0.701	(9.005)
(46.051)	**Gross Expenditure**	**(19.364)**	**(15.429)**	**(14.048)**	**1.381**	**(37.317)**
2.706	Planned Slippage	1.500	1.286	-	(1.286)	2.369
8.345	I&E Variation from		-	-	-	-
(35.000)	**Net Expenditure**	**(17.864)**	**(14.143)**	**(14.048)**	**0.095**	**(34.948)**

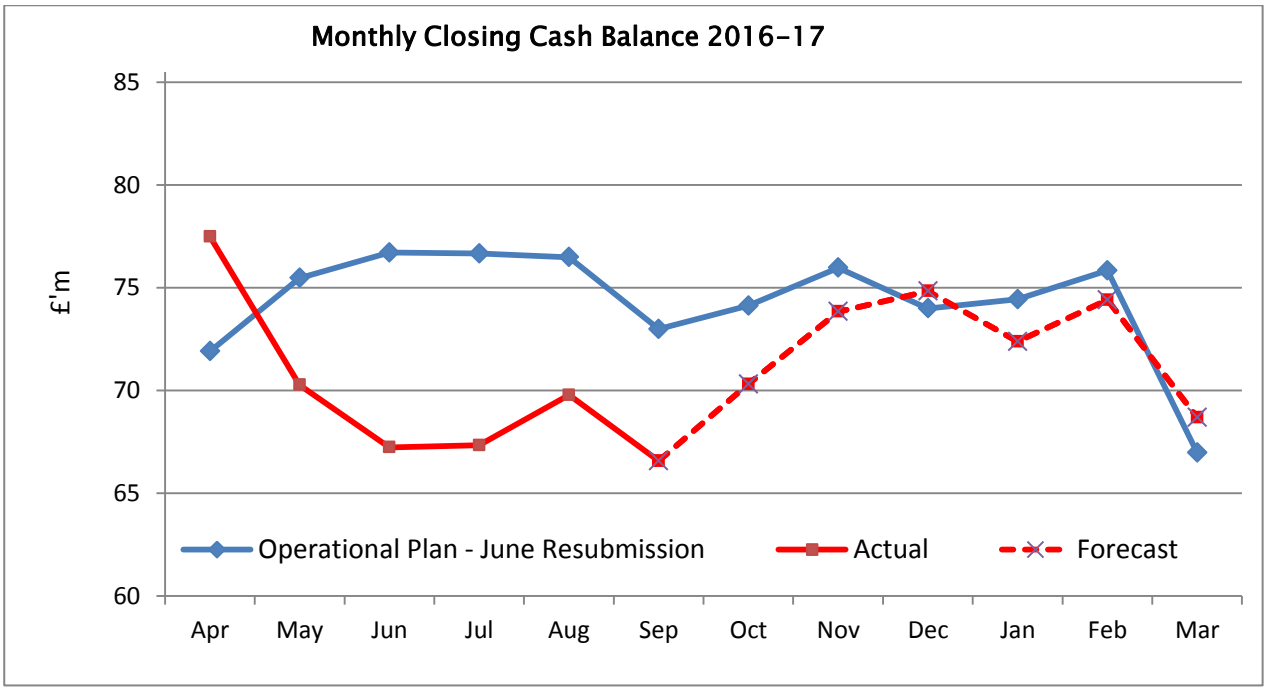
Capital expenditure for the period is £14.048m against an internal plan of £14.143m, a variance of £0.095m. This is largely due to timing issues, particularly medical equipment purchases. Further information is provided under agenda item 6.1.

8. Statement of Financial Position and Cashflow

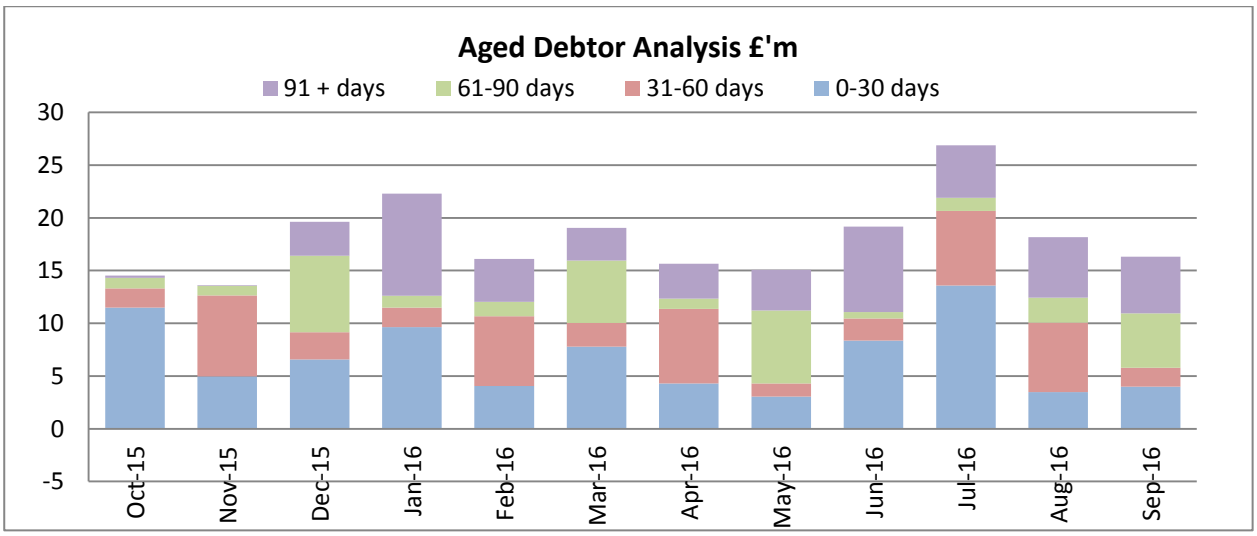
Overall, the Trust had a strong statement of financial position as at 30th September 2016 with net current assets of £34.643m, £3.826m higher than plan.

The Trust held cash and cash equivalents of £66.679m at the end of September, £6.652m lower than last month. The cash balance remains below the plan (£6.314m) reflecting payment to date by Commissioners at 2015/16 contract levels and delayed receipt of Sustainability and Transformation Funding.

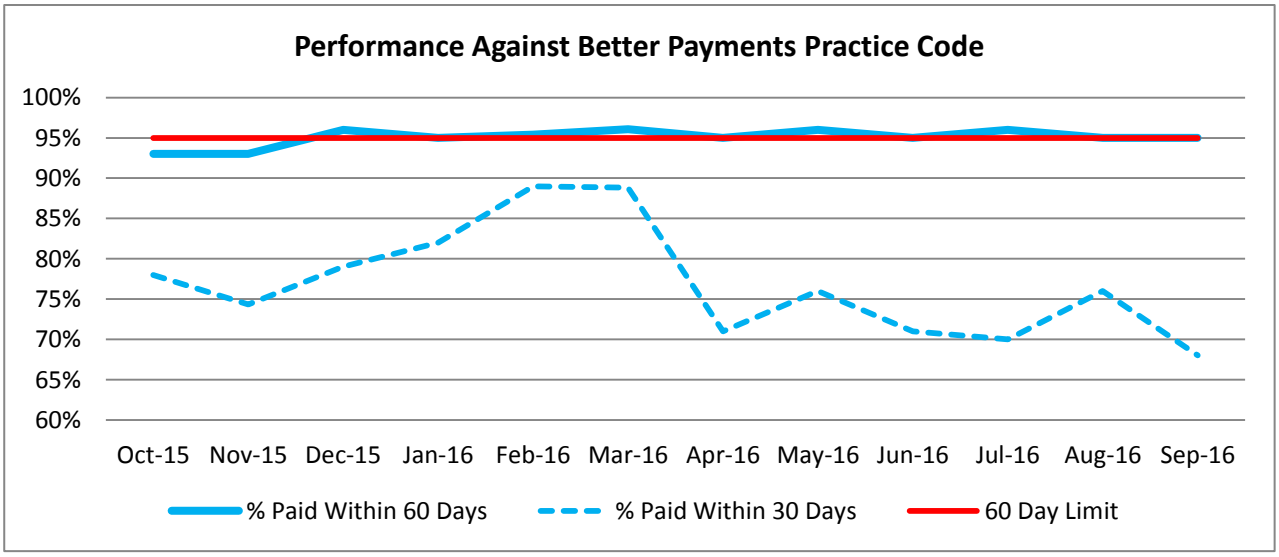
The forecast year end cash balance is £68.692m reflecting the forecast reduction in capital payments. The graph below shows the month end cash balance trajectory for the financial year.



The total value of debtors decreased by £1.866m in September to £16.303m. SLA debtors decreased by £1.958m and non SLA debtors increased by £0.092m. The SLA decrease reflects payment of the Wessex Specialist Commissioning Cancer Drugs Fund reported as over 60 days old last month. The total value of debtors over 60 days old increased by £2.392m to £10.512m. £2.546m increase related to SLA invoices, primarily due to NHS England quarter 1 activity. Non SLA debtors decreased by £0.154m. The position is summarised in the chart overleaf. Further details are provided in agenda item 7.1.



In September the Trust's performance against the 60 day limit remained at 95%. Whilst the number of invoices paid within 30 days dropped to 68%, the total number of invoices paid increased many of which were paid just outside of the 30 days. A chart plotting performance is provided below.



Attachments

Appendix 1 – Summary Income and Expenditure Statement
Appendix 2 – Divisional Income and Expenditure Statement
Appendix 3 – Nursing KPIs
Appendix 4 – Financial Sustainability Risk Rating
Appendix 5a – Key Financial Metrics
Appendix 5b – Key Workforce Metrics
Appendix 6 – Financial Risk Matrix
Appendix 7 – Monthly Analysis of Pay Expenditure
Appendix 8 - Release of Reserves
Appendix 9 – Sustainability funding and access performance trajectories

UNIVERSITY HOSPITALS BRISTOL NHS FOUNDATION TRUST
Finance Report September 2016- Summary Income & Expenditure Statement

Approved Budget / Plan 2016/17	Heading	Position as at 30th September			Actual to 31st August
		Plan	Actual	Variance Fav / (Adv)	
£'000		£'000	£'000	£'000	£'000
	Income (as per Table I and E 2)				
542,196	From Activities	270,293	269,175	(1,118)	224,486
89,296	Other Operating Income	44,852	44,400	(452)	37,116
631,492	**Sub totals income**	**315,145**	**313,575**	**(1,570)**	**261,602**
	Expenditure				
(361,345)	Staffing	(181,527)	(183,379)	(1,852)	(152,240)
(210,987)	Supplies and Services	(103,715)	(105,552)	(1,837)	(88,935)
(572,332)	**Sub totals expenditure**	**(285,242)**	**(288,931)**	**(3,689)**	**(241,175)**
(9,109)	Reserves	(3,500)	-	3,500	-
50,051	**EBITDA**	**26,403**	**24,644**	**(1,759)**	**20,427**
7.93	**EBITDA Margin - %**		**7.86**		**7.81**
	Financing				
(22,472)	Depreciation & Amortisation - Owned	(10,906)	(10,665)	241	(8,886)
244	Interest Receivable	122	123	1	112
(290)	Interest Payable on Leases	(145)	(147)	(2)	(122)
(3,124)	Interest Payable on Loans	(1,562)	(1,470)	92	(1,233)
(8,509)	PDC Dividend	(4,254)	(4,315)	(61)	(3,576)
(34,151)	**Sub totals financing**	**(16,745)**	**(16,474)**	**271**	**(13,705)**
15,900	**NET SURPLUS / (DEFICIT) before Technical Items**	**9,658**	**8,170**	**(1,488)**	**6,722**
	Technical Items				
-	Profit/(Loss) on Sale of Asset	-	(20)	(20)	(20)
2,732	Donations & Grants (PPE/Intangible Assets)	2,270	2,169	(101)	2,169
(6,436)	Impairments	(1,273)	(1,296)	(23)	(1,296)
385	Reversal of Impairments	-	-	-	-
(1,610)	Depreciation & Amortisation - Donated	(805)	(799)	6	(665)
10,971	**SURPLUS / (DEFICIT) after Technical Items**	**9,850**	**8,224**	**(1,626)**	**6,910**

UNIVERSITY HOSPITALS BRISTOL NHS FOUNDATION TRUST

Finance Report September 2016- Divisional Income & Expenditure Statement

Approved Budget / Plan 2016/17	Division	Total Budget to Date	Total Net Expenditure / Income to Date	Variance [Favourable / (Adverse)]					Total Variance to date	Total Variance to 31st August	Operating Plan Trajectory Year to Date	Variance from Operating Plan Year to Date
				Pay	Non Pay	Operating Income	Income from Activities	CIP				
£'000		£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
	Corporate Income											
541,850	Contract Income	271,635	271,635	-	-	(25)	25	-	-	-		
-	Overheads, Fines & Rewards	-	1,468	-	32	-	1,436	-	1,468	1,396		
35,899	NHSE Income	17,950	17,950	-	-	-	-	-	-	-		
577,749	**Sub Total Corporate Income**	**289,585**	**291,053**	**-**	**32**	**(25)**	**1,461**	**-**	**1,468**	**1,396**		
	Clinical Divisions											
(51,542)	Diagnostic & Therapies	(25,735)	(25,652)	740	(531)	(47)	(71)	(8)	83	60	(62)	145
(76,220)	Medicine	(38,438)	(40,469)	(818)	(191)	9	(938)	(93)	(2,031)	(1,565)	(354)	(1,677)
(102,648)	Specialised Services	(51,239)	(51,938)	(470)	(169)	102	48	(210)	(699)	(438)	(169)	(530)
(105,507)	Surgery Head & Neck	(52,792)	(55,026)	(232)	(433)	16	(425)	(1,160)	(2,234)	(1,813)	(587)	(1,647)
(119,512)	Women's & Children's	(59,866)	(61,857)	(1,408)	1,255	19	(879)	(978)	(1,991)	(1,395)	(271)	(1,720)
(455,429)	**Sub Total - Clinical Divisions**	**(228,070)**	**(234,942)**	**(2,188)**	**(69)**	**99**	**(2,265)**	**(2,449)**	**(6,872)**	**(5,151)**	**(1,443)**	**(5,429)**
	Corporate Services											
(36,271)	Facilities And Estates	(17,977)	(18,020)	57	(39)	(14)	(27)	(20)	(43)	(36)	(52)	9
(25,693)	Trust Services	(13,215)	(13,214)	341	(296)	(141)	2	95	1	(7)	18	(17)
(1,196)	Other	(420)	(233)	90	271	(260)	(19)	105	187	173	-	187
(63,160)	**Sub Totals - Corporate Services**	**(31,612)**	**(31,467)**	**488**	**(64)**	**(415)**	**(44)**	**180**	**145**	**130**	**(34)**	**179**
(518,589)	**Sub Total (Clinical Divisions & Corporate Services)**	**(259,682)**	**(266,409)**	**(1,700)**	**(133)**	**(316)**	**(2,309)**	**(2,269)**	**(6,727)**	**(5,021)**	**(1,477)**	**(5,250)**
(20,080)	Reserves	(3,500)	-	-	3,500	-	-	-	3,500	2,500		
(20,080)	**Sub Total Reserves**	**(3,500)**	**-**	**-**	**3,500**	**-**	**-**	**-**	**3,500**	**2,500**		
39,080	**Trust Totals Unprofiled**	**26,403**	**24,644**	**(1,700)**	**3,399**	**(341)**	**(848)**	**(2,269)**	**(1,759)**	**(1,125)**		
	Financing											
(22,472)	Depreciation & Amortisation - Owned	(10,906)	(10,665)	-	241	-	-	-	241	195		
244	Interest Receivable	122	123	-	1	-	-	-	1	10		
(290)	Interest Payable on Leases	(145)	(147)	-	(2)	-	-	-	(2)	(1)		
(3,124)	Interest Payable on Loans	(1,562)	(1,470)	-	92	-	-	-	92	69		
(8,509)	PDC Dividend	(4,254)	(4,315)	-	(61)	-	-	-	(61)	(31)		
(34,151)	**Sub Total Financing**	**(16,745)**	**(16,474)**	**-**	**271**	**-**	**-**	**-**	**271**	**242**		
4,929	**NET SURPLUS / (DEFICIT) before Technical Items**	**9,658**	**8,170**	**(1,700)**	**3,670**	**(341)**	**(848)**	**(2,269)**	**(1,488)**	**(883)**		
	Technical Items											
-	Profit/(Loss) on Sale of Asset	-	(20)	-	(20)	-	-	-	(20)	(20)		
2,732	Donations & Grants (PPE/Intangible Assets)	2,270	2,169	-	-	(101)	-	-	(101)	(1)		
(6,436)	Impairments	(1,273)	(1,296)	-	(23)	-	-	-	(23)	(23)		
385	Reversal of Impairments	-	-	-	-	-	-	-	-	-		
(1,610)	Depreciation & Amortisation - Donated	(805)	(799)	-	6	-	-	-	6	3		
(4,929)	**Sub Total Technical Items**	**192**	**54**	**-**	**(37)**	**(101)**	**-**	**-**	**(138)**	**(41)**		
0	**SURPLUS / (DEFICIT) after Technical Items Unprofiled**	**9,850**	**8,224**	**(1,700)**	**3,633**	**(442)**	**(848)**	**(2,269)**	**(1,626)**	**(924)**		

REGISTERED NURSING - NURSING CONTROL GROUP AND HR KPIs

Graph 1 **Sickness**

Division	Target/Actual	M1	M2	M3	M4	M5	M6	M7	M8	M9	M10	M11	M12
Medicine	*Target*	*3.9%*	*3.9%*	*3.9%*	*4.3%*	*4.3%*	*4.3%*	*4.2%*	*4.2%*	*4.2%*	*4.1%*	*4.1%*	*4.1%*
Medicine	Actual	3.1%	1.9%	2.2%	3.2%	4.5%	4.4%						
Specialised Services	*Target*	*4.0%*	*4.0%*	*4.0%*	*4.0%*	*4.0%*	*4.0%*	*4.2%*	*4.2%*	*4.2%*	*4.0%*	*4.0%*	*4.0%*
Specialised Services	Actual	3.2%	3.5%	3.0%	2.7%	3.2%	2.6%						
Surgery, Head & Neck	*Target*	*3.8%*	*3.8%*	*3.8%*	*3.8%*	*3.8%*	*3.8%*	*3.8%*	*3.8%*	*3.8%*	*3.8%*	*3.8%*	*3.8%*
Surgery, Head & Neck	Actual	3.8%	3.9%	5.1%	4.9%	4.1%	4.5%						
Women's & Children's	*Target*	*3.4%*	*3.4%*	*3.4%*	*3.7%*	*3.7%*	*3.7%*	*4.5%*	*4.5%*	*4.5%*	*4.5%*	*4.5%*	*4.5%*
Women's & Children's	Actual	3.8%	3.9%	3.4%	3.7%	4.0%	4.1%						

Source: HR info available after a weekend

Graph 2 **Vacancies**

Division	Target/Actual	M1	M2	M3	M4	M5	M6	M7	M8	M9	M10	M11	M12
Medicine	*Target*	*5.0%*	*5.0%*	*5.0%*	*5.0%*	*5.0%*	*5.0%*	*5.0%*	*5.0%*	*5.0%*	*5.0%*	*5.0%*	*5.0%*
Medicine	Actual	7.5%	8.7%	8.3%	9.4%	10.6%	7.3%						
Specialised Services	*Target*	*5.0%*	*5.0%*	*5.0%*	*5.0%*	*5.0%*	*5.0%*	*5.0%*	*5.0%*	*5.0%*	*5.0%*	*5.0%*	*5.0%*
Specialised Services	Actual	6.5%	7.7%	7.0%	7.0%	6.8%	5.4%						
Surgery, Head & Neck	*Target*	*5.0%*	*5.0%*	*5.0%*	*5.0%*	*5.0%*	*5.0%*	*5.0%*	*5.0%*	*5.0%*	*5.0%*	*5.0%*	*5.0%*
Surgery, Head & Neck	Actual	3.9%	5.9%	8.1%	8.2%	8.1%	6.6%						
Women's & Children's	*Target*	*5.0%*	*5.0%*	*5.0%*	*5.0%*	*5.0%*	*5.0%*	*5.0%*	*5.0%*	*5.0%*	*5.0%*	*5.0%*	*5.0%*
Women's & Children's	Actual	1.5%	2.6%	3.0%	4.8%	2.5%	2.0%						

Source: HR

Graph 3 **Turnover**

Division	Target/Actual	M1	M2	M3	M4	M5	M6	M7	M8	M9	M10	M11	M12
Medicine	*Target*	*15.1%*	*15.1%*	*15.1%*	*15.1%*	*15.1%*	*15.1%*	*15.1%*	*15.1%*	*15.1%*	*15.1%*	*15.1%*	*15.1%*
Medicine	Actual	16.9%	16.7%	16.0%	17.4%	15.8%	15.2%						
Specialised Services	*Target*	*13.3%*	*13.3%*	*13.3%*	*13.3%*	*13.3%*	*13.3%*	*13.3%*	*13.3%*	*13.3%*	*13.3%*	*13.3%*	*13.3%*
Specialised Services	Actual	15.6%	14.2%	13.2%	13.2%	12.9%	13.3%						
Surgery, Head & Neck	*Target*	*12.1%*	*12.1%*	*12.1%*	*12.1%*	*12.1%*	*12.1%*	*12.1%*	*12.1%*	*12.1%*	*12.1%*	*12.1%*	*12.1%*
Surgery, Head & Neck	Actual	14.6%	13.6%	13.3%	13.9%	11.9%	11.8%						
Women's & Children's	*Target*	*10.6%*	*10.6%*	*10.6%*	*10.6%*	*10.6%*	*10.6%*	*10.6%*	*10.6%*	*10.6%*	*10.6%*	*10.6%*	*10.6%*
Women's & Children's	Actual	9.3%	10.0%	10.5%	10.9%	11.6%	11.1%						

Source: HR - Registered

Note: M4 figs restated

Graph 4 **Operating plan for nursing agency £000**

Division	Target/Actual	M1	M2	M3	M4	M5	M6	M7	M8	M9	M10	M11	M12
Medicine	*Target*	*145.0*	*115.0*	*131.0*	*140.0*	*150.0*	*150.0*	*80.0*	*90.0*	*90.0*	*75.0*	*80.0*	*75.0*
Medicine	Actual	244.6	132.0	169.6	203.8	265.4	179.6						
Specialised Services	*Target*	*54.7*	*54.7*	*54.7*	*36.7*	*36.7*	*32.1*	*32.1*	*27.5*	*18.3*	*18.3*	*18.3*	*18.3*
Specialised Services	Actual	95.0	108.4	107.8	85.2	135.7	129.2						
Surgery, Head & Neck	*Target*	*38.6*	*38.3*	*54.6*	*56.9*	*53.6*	*25.8*	*12.5*	*12.5*	*12.5*	*12.5*	*12.5*	*12.5*
Surgery, Head & Neck	Actual	215.0	201.7	183.4	182.8	245.2	247.3						
Women's & Children's	*Target*	*36.9*	*50.8*	*71.8*	*37.7*	*50.7*	*79.5*	*122.1*	*29.1*	*29.1*	*25.3*	*25.3*	*25.3*
Women's & Children's	Actual	158.8	134.0	109.2	219.1	179.2	173.3						

Source: Finance GL (excludes NA 1:1)

Graph 5 **Operating plan for nursing agency wte**

Division	Target/Actual	M1	M2	M3	M4	M5	M6	M7	M8	M9	M10	M11	M12
Medicine	*Target*	*28.5*	*18.5*	*20.5*	*21.3*	*26.3*	*15.7*	*10.5*	*11.3*	*18.5*	*8.4*	*9.4*	*8.4*
Medicine	Actual	31.3	18.8	24.9	27.9	32.4	27.2						
Specialised Services	*Target*	*8.0*	*8.0*	*8.0*	*8.0*	*8.0*	*7.0*	*7.0*	*6.0*	*4.0*	*4.0*	*4.0*	*4.0*
Specialised Services	Actual	10.6	13.2	13.6	11.7	14.7	14.4						
Surgery, Head & Neck	*Target*	*6.0*	*6.1*	*8.6*	*9.1*	*8.6*	*4.1*	*2.0*	*2.0*	*2.0*	*2.0*	*2.0*	*2.0*
Surgery, Head & Neck	Actual	27.5	29.6	25.9	27.1	30.2	28.8						
Women's & Children's	*Target*	*7.8*	*10.8*	*15.3*	*7.8*	*10.6*	*16.8*	*25.8*	*5.8*	*5.8*	*4.8*	*4.8*	*4.8*
Women's & Children's	Actual	15.4	11.3	10.7	19.7	15.4	19.1						

Source: Finance GL (excludes NA 1:1)

Graph 6 **Operating plan for nursing agency as a % of total staffing**

Division	Target/Actual	M1	M2	M3	M4	M5	M6	M7	M8	M9	M10	M11	M12
Medicine	*Target*	*7.9%*	*6.4%*	*7.2%*	*7.7%*	*8.3%*	*8.1%*	*4.6%*	*5.1%*	*5.2%*	*4.4%*	*4.6%*	*4.4%*
Medicine	Actual	13.4%	7.1%	9.5%	11.4%	14.6%	9.3%						
Specialised Services	*Target*	*4.3%*	*4.3%*	*4.3%*	*2.9%*	*2.9%*	*2.5%*	*2.5%*	*2.1%*	*1.4%*	*1.4%*	*1.4%*	*1.4%*
Specialised Services	Actual	7.3%	7.7%	7.9%	6.4%	9.8%	8.9%						
Surgery, Head & Neck	*Target*	*1.8%*	*1.8%*	*2.6%*	*2.7%*	*2.5%*	*1.2%*	*0.6%*	*0.6%*	*0.6%*	*0.6%*	*0.6%*	*0.6%*
Surgery, Head & Neck	Actual	11.5%	10.5%	10.0%	10.2%	13.2%	12.3%						
Women's & Children's	*Target*	*1.2%*	*1.6%*	*2.3%*	*1.2%*	*1.6%*	*2.5%*	*3.7%*	*0.9%*	*0.9%*	*0.8%*	*0.8%*	*0.8%*
Women's & Children's	Actual	4.7%	3.8%	3.2%	6.4%	5.1%	4.9%						

Source: Finance GL (RNs only)

Graph 7 **Funded bed days vs occupied bed days**

Division	Target/Actual	M1	M2	M3	M4	M5	M6	M7	M8	M9	M10	M11	M12
Medicine	*Target*	*9,270*	*9,579*	*9,270*	*9,579*	*9,579*	*9,270*	*9,579*	*9,270*	*9,579*	*9,579*	*8,652*	*9,579*
Medicine	Actual	9,235	9,359	9,250	9,543	9,238	8,621						
Specialised Services	*Target*	*4,800*	*4,960*	*4,800*	*4,960*	*4,960*	*4,800*	*4,960*	*4,800*	*4,960*	*4,960*	*4,480*	*4,960*
Specialised Services	Actual	4,507	4,639	4,523	4,729	4,829	4,499						
Surgery, Head & Neck	*Target*	*4,740*	*4,898*	*4,740*	*4,898*	*4,898*	*4,740*	*4,898*	*4,740*	*4,898*	*4,898*	*4,424*	*4,898*
Surgery, Head & Neck	Actual	4,657	4,556	4,452	4,431	4,537	4,392						
Women's & Children's	*Target*	*8,790*	*9,083*	*8,790*	*9,083*	*9,083*	*8,790*	*9,083*	*8,790*	*9,083*	*9,083*	*8,204*	*9,083*
Women's & Children's	Actual	7,087	7,399	6,957	6,548	6,070	6,470						

Source: Info web: KPI Bed occupancy

Graph 8 **NA 1:1 and RMN £000 (total temporary spend)**

Division	Target/Actual	M1	M2	M3	M4	M5	M6	M7	M8	M9	M10	M11	M12
Medicine	*Target*	*44*	*44*	*44*	*44*	*44*	*44*	*44*	*44*	*44*	*44*	*44*	*44*
Medicine	Actual	70	66	78	83	84	129						
Specialised Services	*Target*	*20*	*20*	*20*	*20*	*20*	*20*	*20*	*20*	*20*	*20*	*20*	*20*
Specialised Services	Actual	23	27	14	24	30	16						
Surgery, Head & Neck	*Target*	*43*	*43*	*43*	*43*	*43*	*43*	*43*	*43*	*43*	*43*	*43*	*43*
Surgery, Head & Neck	Actual	25	21	31	34	29	30						
Women's & Children's	*Target*	*12*	*12*	*12*	*12*	*12*	*12*	*12*	*12*	*12*	*12*	*12*	*12*
Women's & Children's	Actual	87	31	10	29	11	24						

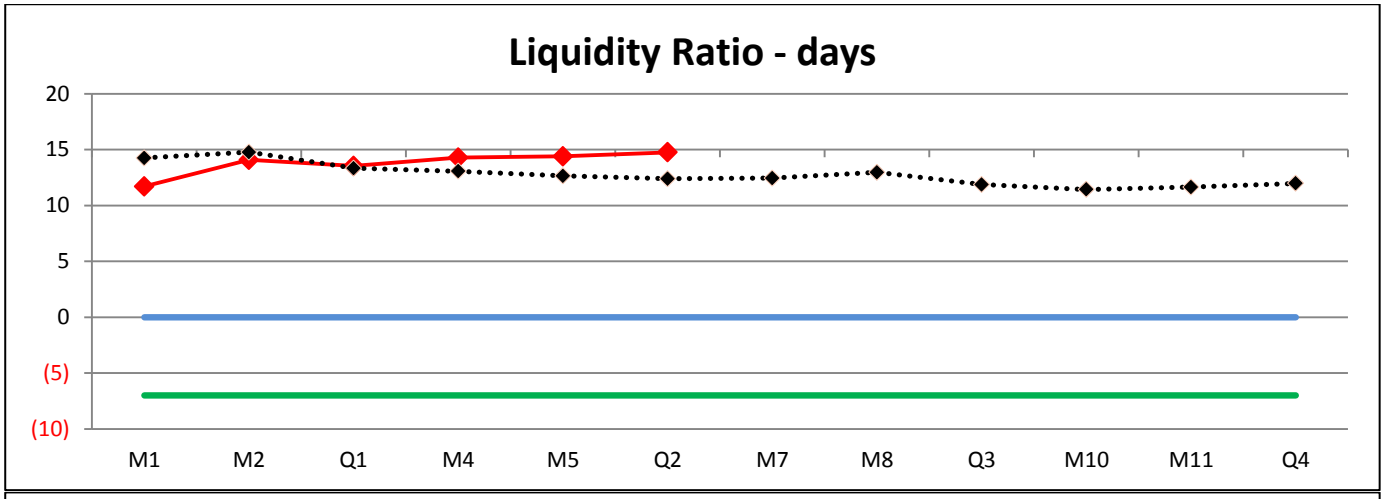
Financial Sustainability Risk Rating – September 2016 Performance

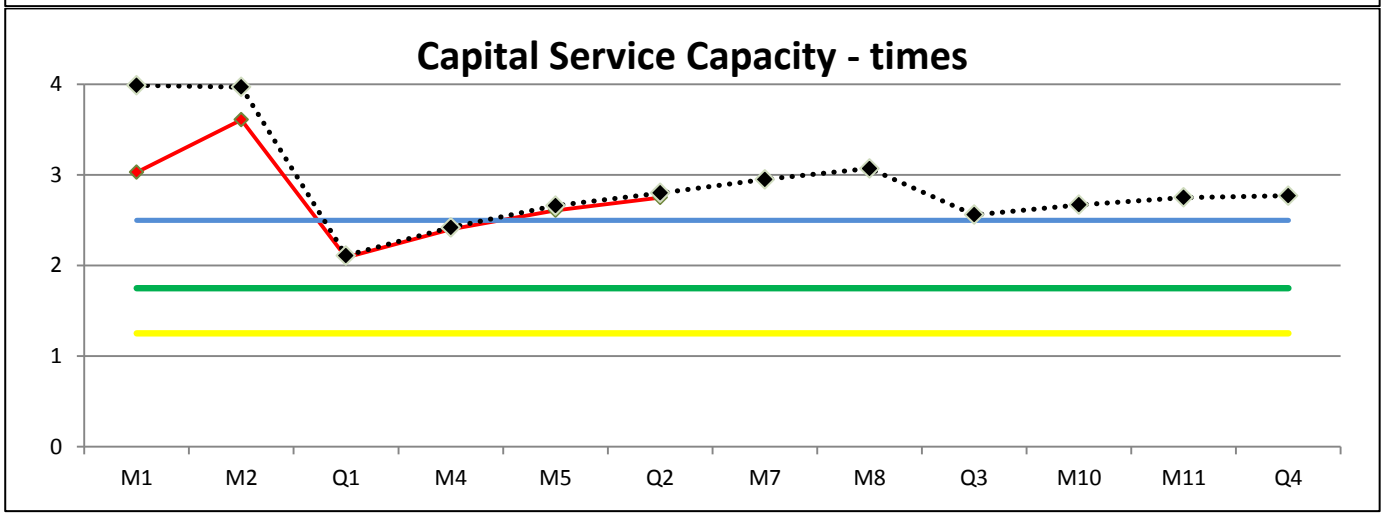
The graphs overleaf show performance against the four Financial Sustainability Risk Rating (FSRR) metrics. For the period to the end of September, the Trust achieved an overall FSRR of 4 (actual 4.00) against a plan of 4.

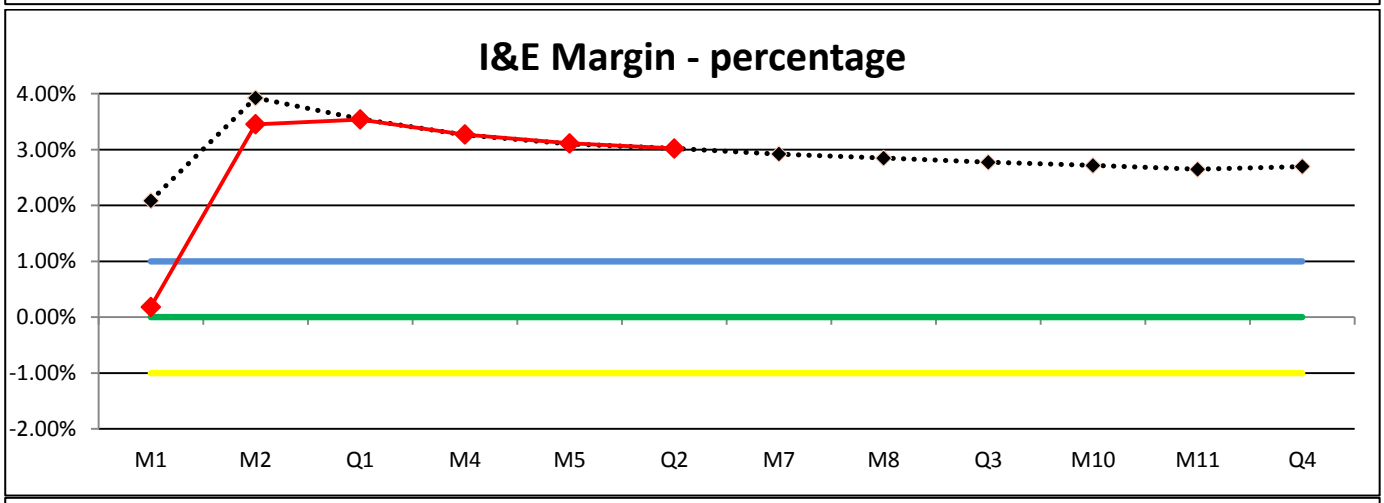
With the exception of variance in I&E margin, all of the FSRR metrics are in line with the plan to date with actual metric scores of 4. A summary is provided in the table below.

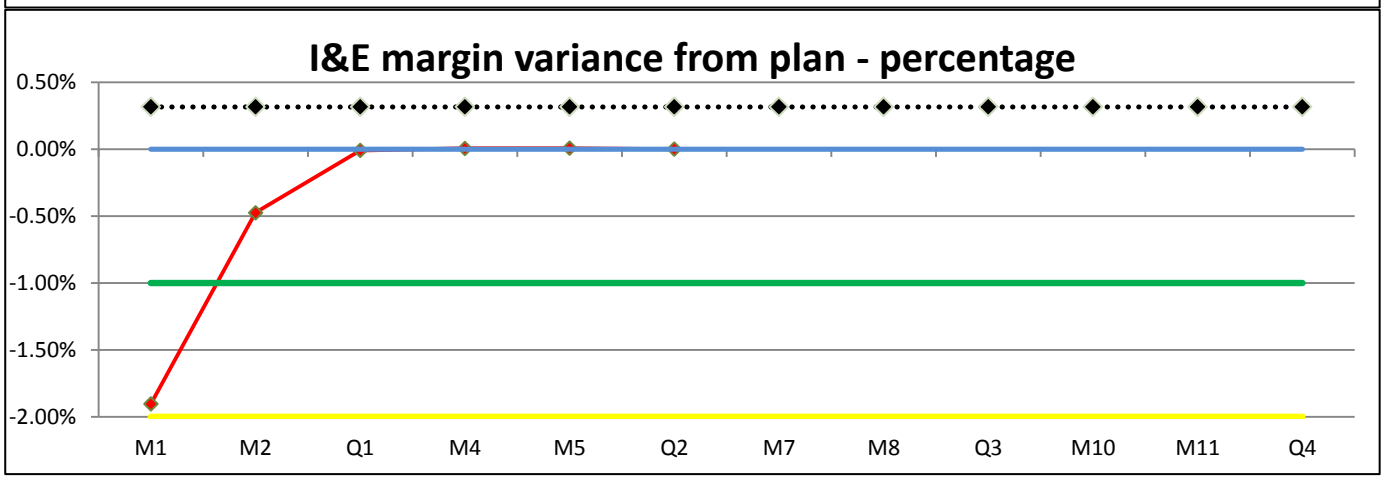
		30th September 2016		31st March 2017	
	Weighting	Plan	Actual	Plan	Forecast
Liquidity					
Metric Result – days		12.39	14.75	11.96	11.96
Metric Rating	25%	4	4	4	4
Capital Servicing Capacity					
Metric Result – times		2.80	2.75	2.77	2.77
Metric Rating	25%	4	4	4	4
Income & expenditure margin					
Metric Result		3.02%	3.02%	2.70%	2.70%
Metric Rating	25%	4	4	4	4
Variance in I&E margin					
Metric Result		0.32%	0.00%	0.32%	0.01%
Metric Rating	25%	4	3	4	4
Overall FSRR		**4.0**	**3.75**	**4.0**	**4.0**
Overall FSRR (rounded)		**4**	**4**	**4**	**4**

The charts presented overleaf show the trajectories for each of the four metrics. The revised 2016/17 Operational Plan submitted to Monitor on 29th June 2016 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
20
15
10
5
0
(5)
(10)
M1
M2
Q1
M4
M5
Q2
M7
M8
Q3
M10
M11
Q4


Capital Service Capacity - times
4
3
2
1
0
M1
M2
Q1
M4
M5
Q2
M7
M8
Q3
M10
M11
Q4


I&E Margin - percentage
4.00%
3.00%
2.00%
1.00%
0.00%
-1.00%
-2.00%
M1
M2
Q1
M4
M5
Q2
M7
M8
Q3
M10
M11
Q4

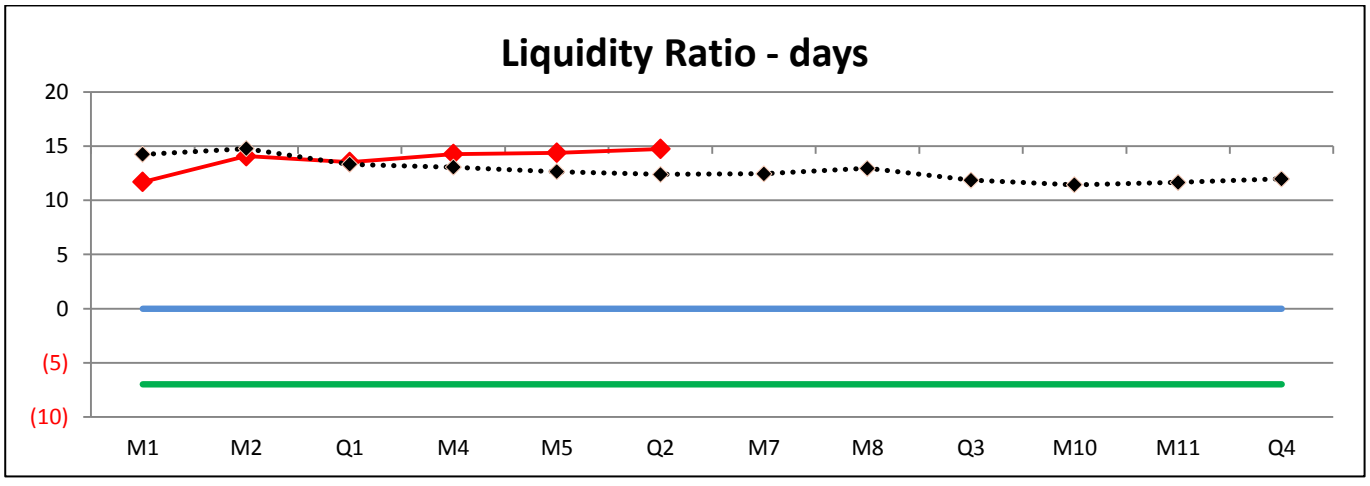

I&E margin variance from plan - percentage
0.50%
0.00%
-0.50%
-1.00%
-1.50%
-2.00%
M1
M2
Q1
M4
M5
Q2
M7
M8
Q3
M10
M11
Q4

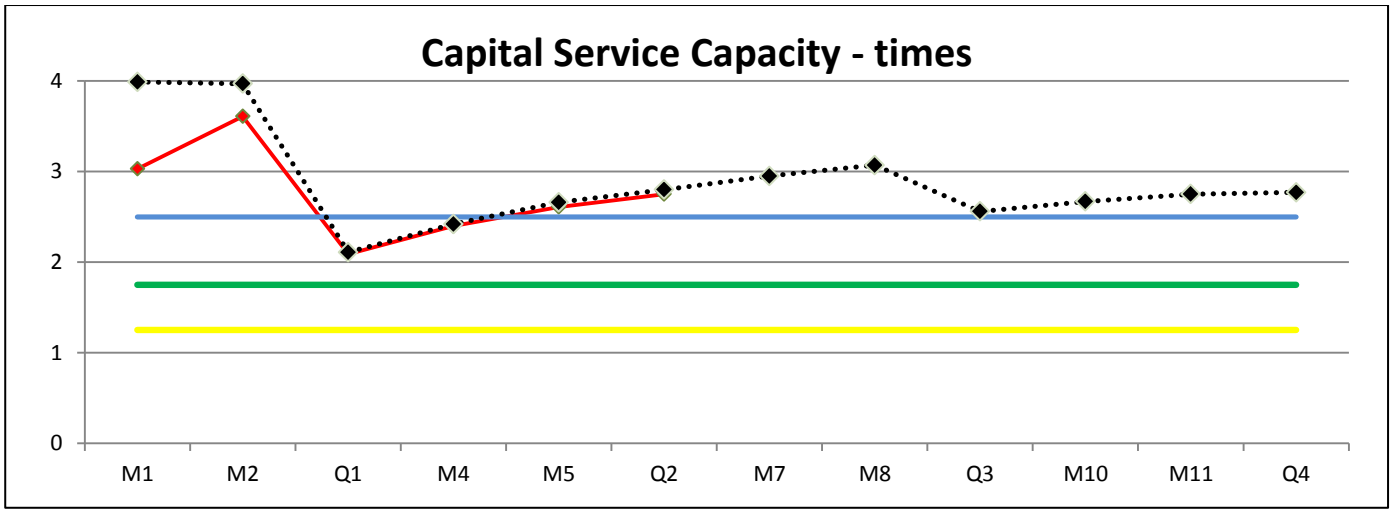
Use of Resources Rating – September 2016 Performance

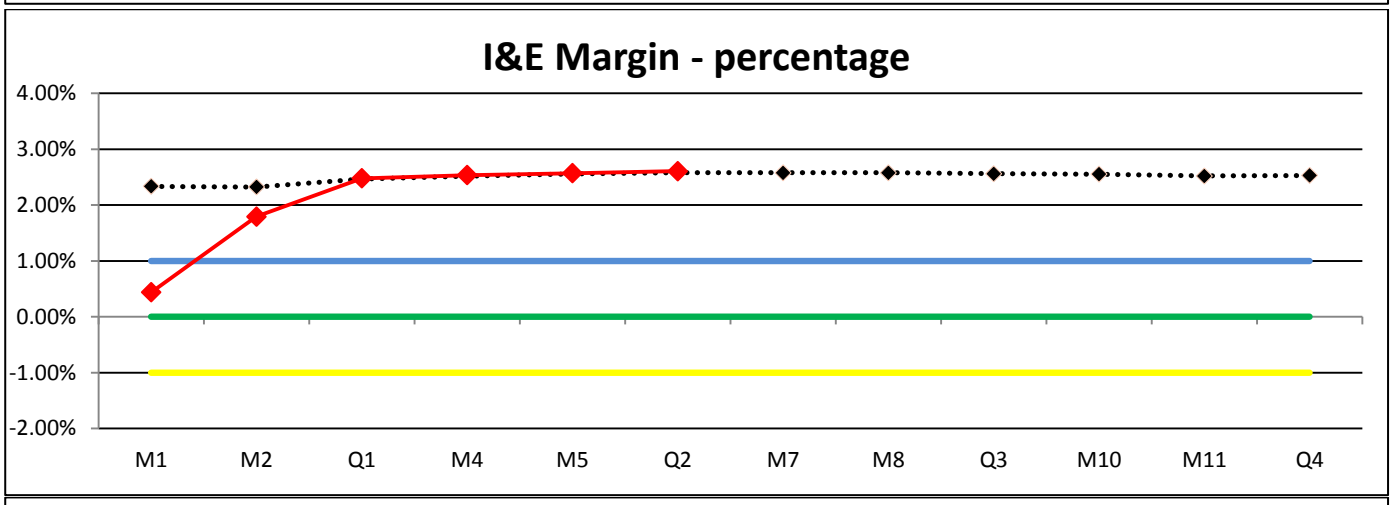
The Single Oversight Framework (SOF), published on 30th September, sets out NHS Improvement's approach to overseeing NHS providers. The SOF comes into effect on 1st October 2016 and will assess the financial performance of providers using the Use of Resources Rating (URR). Providers will be formally assessed based on the URR from October. The URR adds a new fifth metric to the FSRR measuring expenditure on agency staff against the Trust's agency ceiling as set by NHS Improvement. The URR for the Trust to date is 1, the highest rating. The table below summarises the position.

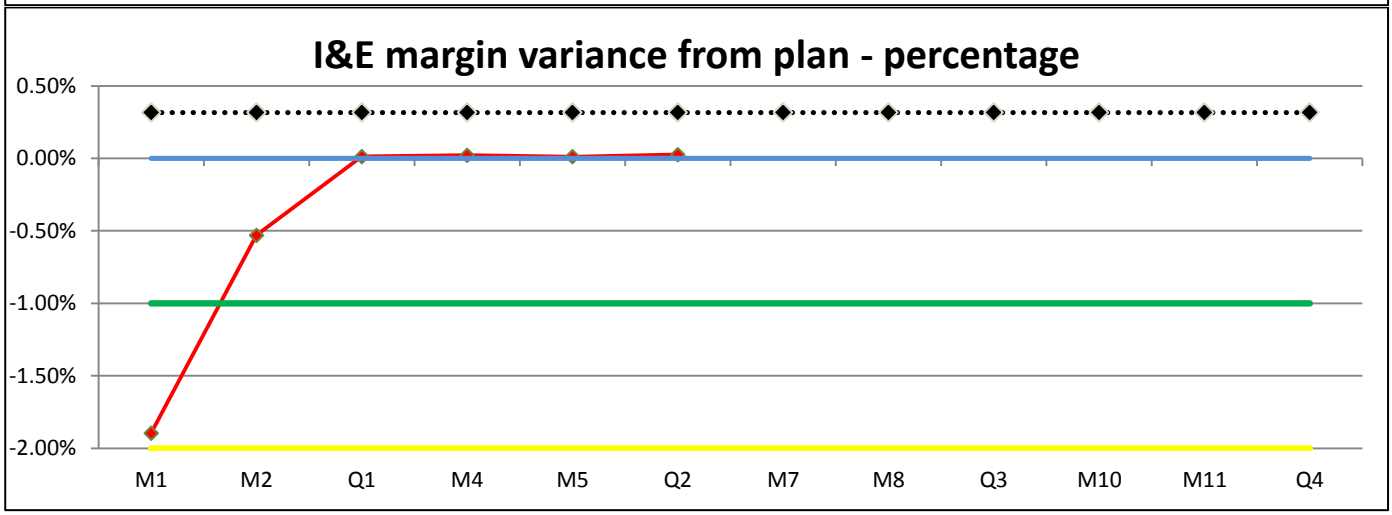
		30th September 2016		31st March 2017	
	Weighting	Plan	Actual	Plan	Forecast
Liquidity					
Metric Result – days		12.39	14.75	11.96	11.96
Metric Rating	20%	1	1	1	1
Capital Servicing Capacity					
Metric Result – times		2.80	2.75	2.77	2.77
Metric Rating	20%	1	1	1	1
Income & expenditure margin					
Metric Result		2.58%	2.61%	2.53%	2.53%
Metric Rating	20%	1	1	1	1
Variance in I&E margin					
Metric Result		0.32%	0.03%	0.32%	0.01%
Metric Rating	20%	1	1	1	1
Variance from agency ceiling					
Metric Result		0.00%	12.83%	0.00%	0.00%
Metric Rating	20%	1	2	1	1
Overall URR		**1.0**	**1.2**	**1.0**	**1.0**
Overall URR (rounded)		**1**	**1**	**1**	**1**

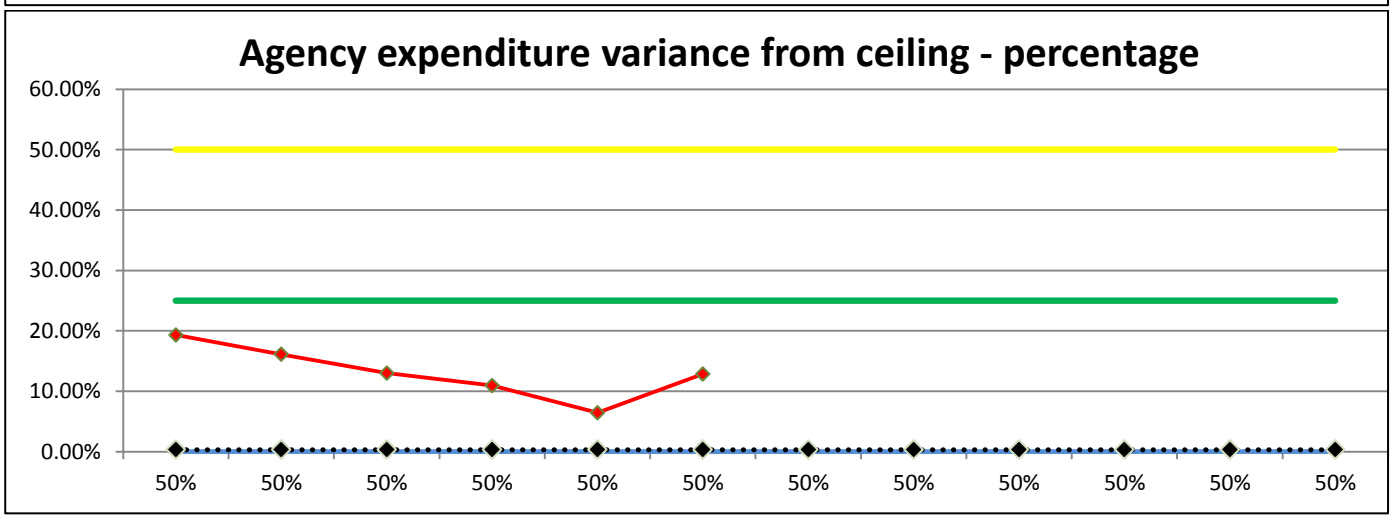
The charts presented overleaf show the trajectories for each of the four metrics. The revised 2016/17 Operational Plan submitted to Monitor on 29th June 2016 is shown as the black dotted line against which actual performance is plotted in red. The metric ratings are shown for **1 (blue line)**; **2 (green line)** and **3 (yellow line)**.




Capital Service Capacity - times
4
3
2
1
0
M1
M2
Q1
M4
M5
Q2
M7
M8
Q3
M10
M11
Q4


I&E Margin - percentage
4.00%
3.00%
2.00%
1.00%
0.00%
-1.00%
-2.00%
M1
M2
Q1
M4
M5
Q2
M7
M8
Q3
M10
M11
Q4


I&E margin variance from plan - percentage
0.50%
0.00%
-0.50%
-1.00%
-1.50%
-2.00%
M1
M2
Q1
M4
M5
Q2
M7
M8
Q3
M10
M11
Q4


Agency expenditure variance from ceiling - percentage
60.00%
50.00%
40.00%
30.00%
20.00%
10.00%
0.00%
50%
50%
50%
50%
50%
50%
50%
50%
50%
50%
50%
50%

Key Financial Metrics - September 2016

Appendix 5a

	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	3,371	4,370	5,153	7,021	8,741	312		8,729	37,697
Actual	3,330	4,333	5,037	7,004	8,679	305		8,501	37,189
Variance Fav / (Adv)	(41)	(37)	(116)	(17)	(62)	(7)	-	(228)	(508)
Year to date									
Budget	20,001	26,228	30,279	41,608	52,160	1,853		51,880	224,009
Actual	20,009	25,490	30,370	41,039	51,050	1,819		51,207	220,984
Variance Fav / (Adv)	8	(738)	91	(569)	(1,110)	(34)	-	(673)	(3,025)

Women's and Children's identified £0.221m of activity related income due for August which was not able to be included due to delayed information. This was brought into their financial position and reduces the in-month deterioration to £0.212m.

Contract Income - Penalties									
Current Month									
Plan	-	(16)	(2)	(8)	(4)			(51)	(81)
Actual	(1)	(14)	1	(16)	(9)			(86)	(125)
Variance Fav / (Adv)	(1)	2	3	(8)	(5)	-	-	(35)	(44)
Year to date									
Plan	-	(98)	(14)	(41)	(16)			(305)	(474)
Actual	(1)	(97)	(10)	(149)	(113)			(175)	(545)
Variance Fav / (Adv)	(1)	1	4	(108)	(97)	-	-	130	(71)

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

Contract Income - Rewards									
Current Month									
Plan								769	769
Actual								769	769
Variance Fav / (Adv)	-	-	-	-	-	-	-	-	-
Year to date									
Plan								4,691	4,691
Actual								4,691	4,691
Variance Fav / (Adv)	-	-	-	-	-	-	-	-	-

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

Cost Improvement Programme									
Current Month									
Plan	122	158	124	418	399	61	80	124	1,486
Actual	120	231	81	236	214	71	73	154	1,180
Variance Fav / (Adv)	(2)	73	(43)	(182)	(185)	10	(7)	30	(306)
Year to date									
Plan	759	830	726	2,415	2,417	341	486	744	8,718
Actual	813	749	545	1,318	1,340	373	453	850	6,441
Variance Fav / (Adv)	54	(81)	(181)	(1,097)	(1,077)	32	(33)	106	(2,277)

Key Workforce Metrics

Appendix 5b

Diagnostic & Therapies

	Operating Plan Target		Actual												
	Annual	Year to date	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Year to date	Year to date variance
Overall agency expenditure (£'000)	355	225	36	(11)	17	39	39	41							161	64
Nursing agency expenditure (£'000)	7	3	12	(6)	-	4	3	4							17	(14)
Overall																
Sickness (%)	2.8%		2.4%	2.4%	2.5%	2.4%	2.8%	2.6%							2.5%	
Turnover (%)	12.5%		13.3%	13.5%	12.6%	12.5%	11.6%	12.5%							12.5%	
Establishment (wte)			1,000.69	958.00	966.08	975.98	979.73	992.70								
In post (wte)			961.64	927.00	928.24	928.28	930.20	950.70								
Under/(over) establishment (wte)			39.05	31.00	37.84	47.70	49.53	42.00	-	-	-	-	-	-		
Nursing:																
Sickness - registered (%)			1.7%	0.0%	0.2%	0.2%	5.2%	6.8%							2.3%	
Sickness - unregistered (%)			0.0%	0.0%	10.0%	0.0%	0.0%	0.0%							1.7%	
Turnover - registered (%)	4.1%		19.9%	19.2%	13.2%	13.3%	13.3%	12.9%							12.9%	
Turnover - unregistered (%)			0.0%	0.0%	0.0%	0.0%	0.0%	0.0%							0.0%	
Starters (wte)			1.00	1.00	-	-	-	1.00							3.00	
Leavers (wte)			-	-	-	-	-	-							-	
Net starters (wte)			1.00	1.00	-	-	-	1.00	-	-	-	-	-	-	3.00	
Establishment (wte)			17.66	17.66	17.66	17.66	17.66	17.66								
In post - Employed (wte)			16.57	18.75	18.24	18.24	17.57	18.37								
In post - Bank (wte)			0.16	1.41	2.35	2.80	3.24	2.89								
In post - Agency (wte)			3.46	0.10	-	0.60	-	-								
In post - total (wte)			20.19	20.26	20.59	21.64	20.81	21.26	-	-	-	-	-	-		
Under/(over) establishment (wte)			(2.53)	(2.60)	(2.93)	(3.98)	(3.15)	(3.60)	-	-	-	-	-	-		

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 2017.
The annual target for turnover, because it is a rolling 12 month cumulative measure, is the position at March 2017.

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 nurse bank continues to be reviewed in light of new data available from Rosterpro.

Medicine

	Operating Plan Target		Actual												
	Annual	Year to date	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Year to date	Year to date variance
Overall agency expenditure (£'000)	1,965	1,433	334	239	290	274	320	264							1,721	(288)
Nursing agency expenditure (£'000)	1,395	872	256	140	176	193	273	229							1,267	(395)
Overall																
Sickness (%)	4.6%		4.4%	3.7%	3.9%	4.4%	5.1%	5.0%							4.4%	
Turnover (%)	13.2%		14.9%	15.2%	14.6%	15.4%	14.8%	14.7%							14.7%	
Establishment (wte)			1,215.16	1,209.00	1,221.06	1,215.64	1,222.99	1,198.71								
In post (wte)			1,253.43	1,230.00	1,246.58	1,256.53	1,272.56	1,267.60								
Under/(over) establishment (wte)			(38.27)	(21.00)	(25.52)	(40.89)	(49.57)	(68.89)	-	-	-	-	-	-		
Nursing:																
Sickness - registered (%)	4.1%		3.1%	1.9%	2.2%	3.2%	4.5%	4.4%							3.2%	
Sickness - unregistered (%)	6.5%		7.8%	7.3%	6.2%	6.0%	6.7%	7.4%							6.9%	
Turnover - registered (%)	15.1%		16.9%	16.7%	16.0%	17.4%	15.8%	15.2%							15.2%	
Turnover - unregistered (%)	25.6%		18.1%	19.4%	19.2%	20.7%	19.6%	21.1%							21.1%	
Starters (wte)			11.19	16.94	4.64	7.00	13.60	5.80							59.17	
Leavers (wte)			13.26	9.16	7.72	12.99	10.31	14.61							68.05	
Net starters (wte)			(2.07)	7.78	(3.08)	(5.99)	3.29	(8.81)	-	-	-	-	-	-	(8.88)	
Establishment (wte)			769.87	767.62	768.14	772.12	767.57	742.13								
In post - Employed (wte)			695.64	686.14	686.33	678.04	674.82	673.98								
In post - Bank (wte)			82.62	88.69	97.90	111.08	100.27	87.21								
In post - Agency (wte)			36.20	21.30	27.03	30.29	35.69	33.80								
In post - total (wte)			814.46	796.13	811.26	819.41	810.78	794.99	-	-	-	-	-	-		
Under/(over) establishment (wte)			(44.59)	(28.51)	(43.12)	(47.29)	(43.21)	(52.86)	-	-	-	-	-	-		

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 2017.
The annual target for turnover, because it is a rolling 12 month cumulative measure, is the position at March 2017.

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 nurse bank continues to be reviewed in light of new data available from Rosterpro.

Key Workforce Metrics

Appendix 5b

Specialised Services

	Operating Plan Target		Actual												
	Annual	Year to date	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Year to date	Year to date variance
Overall agency expenditure (£'000)	1,332	758	182	196	177	166	206	219							1,146	(388)
Nursing agency expenditure (£'000)	410	273	100	110	109	91	134	131							675	(402)
Overall																
Sickness (%)	3.6%		3.4%	3.3%	3.2%	3.8%	3.7%	3.1%							3.4%	
Turnover (%)	12.4%		14.2%	13.4%	12.7%	12.1%	11.4%	11.7%							11.7%	
Establishment (wte)			908.17	937.00	932.51	934.93	946.17	946.48								
In post (wte)			901.55	933.00	938.46	943.79	968.61	967.35								
Under/(over) establishment (wte)			6.62	4.00	(5.95)	(8.86)	(22.44)	(20.87)	-	-	-	-	-	-		
Nursing:																
Sickness - registered (%)	4.1%		3.2%	3.5%	3.0%	2.7%	3.2%	2.6%							3.0%	
Sickness - unregistered (%)	7.4%		7.0%	5.4%	6.6%	9.9%	9.8%	7.7%							7.7%	
Turnover - registered (%)	13.3%		15.6%	14.2%	13.2%	13.2%	12.9%	13.3%							13.3%	
Turnover - unregistered (%)	18.0%		12.2%	12.3%	14.3%	11.8%	14.4%	13.3%							13.3%	
Starters (wte)			6.80	4.60	6.80	8.00	7.13	11.00							44.33	
Leavers (wte)			6.37	3.00	5.05	5.21	9.55	7.13							36.31	
Net starters (wte)			0.43	1.60	1.75	2.79	(2.41)	3.87	-	-	-	-	-	-	8.03	
Establishment (wte)			480.47	486.02	482.51	483.04	487.18	488.74								
In post - Employed (wte)			441.23	438.90	442.49	444.68	457.84	450.18								
In post - Bank (wte)			27.30	37.55	42.33	40.77	34.03	37.71								
In post - Agency (wte)			12.07	14.14	13.93	13.01	15.54	14.42								
In post - total (wte)			480.60	490.59	498.75	498.46	507.41	502.31	-	-	-	-	-	-		
Under/(over) establishment (wte)			(0.13)	(4.57)	(16.24)	(15.42)	(20.23)	(13.57)	-	-	-	-	-	-		

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 2017.
The annual target for turnover, because it is a rolling 12 month cumulative measure, is the position at March 2017.

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 nurse bank continues to be reviewed in light of new data available from Rosterpro.

Key Workforce Metrics **Appendix 5b**

Surgery, Head and Neck

	Operating Plan Target		Actual												
	Annual	Year to date	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Year to date	Year to date variance
Overall agency expenditure (£'000)	978	585	262	252	193	238	242	256							1,443	(858)
Nursing agency expenditure (£'000)	343	268	219	207	186	204	248	233							1,297	(1,029)
Overall																
Sickness (%)	3.7%		3.8%	3.6%	3.9%	3.7%	3.1%	3.2%							3.6%	
Turnover (%)	12.1%		14.1%	13.7%	13.6%	14.3%	14.3%	14.1%							14.1%	
Establishment (wte)			1,741.45	1,756.00	1,796.48	1,810.54	1,818.49	1,820.94								
In post (wte)			1,785.03	1,772.00	1,773.35	1,775.68	1,782.64	1,794.26								
Under/(over) establishment (wte)			(43.58)	(16.00)	23.13	34.86	35.85	26.68	-	-	-	-	-	-		
Nursing:																
Sickness - registered (%)	3.8%		3.8%	3.9%	5.1%	4.9%	4.1%	4.5%							4.4%	
Sickness - unregistered (%)	3.7%		7.7%	5.4%	4.9%	4.3%	4.3%	4.4%							5.2%	
Turnover - registered (%)	12.1%		14.6%	13.6%	13.3%	13.9%	11.9%	11.8%							11.8%	
Turnover - unregistered (%)	21.8%		17.1%	18.1%	16.7%	19.6%	18.6%	19.3%							19.3%	
Starters (wte)			4.00	6.37	7.81	4.53	12.80	5.43							40.95	
Leavers (wte)			8.00	4.50	6.77	10.62	9.59	11.44							50.91	
Net starters (wte)			(4.00)	1.87	1.05	(6.09)	3.21	(6.01)	-	-	-	-	-	-	(9.97)	
Establishment (wte)			695.49	699.86	726.18	739.12	748.05	747.07								
In post - Employed (wte)			662.80	658.55	662.38	661.93	666.11	661.99								
In post - Bank (wte)			49.28	44.54	49.13	58.93	43.57	52.88								
In post - Agency (wte)			28.85	30.80	27.61	28.22	31.37	28.77								
In post - total (wte)			740.93	733.89	739.12	749.08	741.05	743.64	-	-	-	-	-	-		
Under/(over) establishment (wte)			(45.44)	(34.03)	(12.94)	(9.96)	7.00	3.43	-	-	-	-	-	-		

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 2017.
The annual target for turnover, because it is a rolling 12 month cumulative measure, is the position at March 2017.

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 nurse bank continues to be reviewed in light of new data available from Rosterpro.

Key Workforce Metrics

Appendix 5b

Women's and Children's

	Operating Plan Target		Actual													
	Annual	Year to date	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Year to date	Year to date variance
Overall agency expenditure (£'000)	775	423	255	162	131	268	205	239							1,260	(837)
Nursing agency expenditure (£'000)	662	367	217	141	117	229	183	188							1,075	(708)
Overall																
Sickness (%)	3.8%		3.8%	3.8%	3.5%	3.9%	3.7%	3.8%							3.8%	
Turnover (%)	10.8%		10.9%	11.0%	11.2%	11.8%	12.2%	12.1%							12.1%	
Establishment (wte)			1,899.46	1,878.00	1,884.05	1,886.26	1,885.88	1,887.72								
In post (wte)			1,932.95	1,898.00	1,890.48	1,894.56	1,884.31	1,923.25								
Under/(over) establishment (wte)			(33.49)	(20.00)	(6.43)	(8.30)	1.57	(35.53)	-	-	-	-	-	-		
Nursing:																
Sickness - registered (%)	4.0%		3.8%	3.9%	3.4%	3.7%	4.0%	4.1%							3.8%	
Sickness - unregistered (%)	5.0%		8.6%	9.5%	9.6%	13.3%	10.3%	7.9%							9.9%	
Turnover - registered (%)	10.6%		9.3%	10.0%	10.5%	10.9%	11.6%	11.1%							11.1%	
Turnover - unregistered (%)	15.3%		15.3%	12.7%	11.9%	12.6%	12.0%	15.3%							15.3%	
Starters (wte)			4.91	10.22	4.03	5.61	16.60	42.25							83.63	
Leavers (wte)			10.46	11.27	11.91	12.39	23.11	13.75							82.89	
Net starters (wte)			(5.54)	(1.05)	(7.89)	(6.78)	(6.51)	28.51	-	-	-	-	-	-	0.74	
Establishment (wte)			1,112.90	1,118.77	1,122.66	1,123.22	1,118.16	1,120.36								
In post - Employed (wte)			1,078.77	1,075.80	1,075.11	1,067.06	1,072.54	1,086.87								
In post - Bank (wte)			32.38	42.04	37.18	43.56	39.42	41.14								
In post - Agency (wte)			29.91	19.07	11.44	22.66	17.82	18.35								
In post - total (wte)			1,141.06	1,136.91	1,123.73	1,133.28	1,129.78	1,146.36	-	-	-	-	-	-		
Under/(over) establishment (wte)			(28.16)	(18.14)	(1.07)	(10.06)	(11.62)	(26.00)	-	-	-	-	-	-		

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 2017.
The annual target for turnover, because it is a rolling 12 month cumulative measure, is the position at March 2017.

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 nurse bank continues to be reviewed in light of new data available from Rosterpro.

UNIVERSITY HOSPITALS BRISTOL NHS FOUNDATION TRUST

Finance Report September 2016 - Risk Matrix

Datix Risk Register Ref.	Description of Risk	Inherent Risk (if no action taken)		Action to be taken to mitigate risk	Lead	Current Risk		Target Risk	
		Risk Score & Level	Financial Value			Risk Score & Level	Financial Value	Risk Score & Level	Financial Value
TBC	Failure to deliver the Trust's Operating Plan Control Total surplus of £15.9m	16 - Very High	TBC	Divisions will be formally required to identify and deliver a recovery plan and be set a control total deficit which cannot be exceeded.	PM	12 - High	TBC	4 - Moderate	TBC
959	Risk that Trust does not deliver future years financial plan due to under delivery of recurrent savings in year. Only 82% of the required savings have been identified at 30th April 2016, leaving a savings gap of £3.2m.	16 - Very High	£3.2m	Trust is working to develop savings plans to meet 2016/17 target of £17.4m and close the current savings gap of £3.541m. Divisions, Corporate and transformation team are actively working to promote the pipelines schemes into deliverable savings schemes.	OA	12 - High	£3.541m	4 - Moderate	£0.0m
416	Risk that the Trust's Financial Strategy may not be deliverable in changing national economic climate.	9 - High	-	Maintenance of long term financial model and in year monitoring on financial performance through monthly divisional operating reviews and Finance Committee and Trust Board.	PM	9 - High	-	9 - High	-
951	Risk of national contract mandates financial penalties on under-performance against key indicators.	9 - High	£4.0m	30% of the agreed Sustainability & Transformation Funding is subject to forfeit if core targets are not delivered. The current risk of loss is high.	PM	9 - High	£3.0m	3 - Low	£0.0m
50	Risk of Commissioner Income challenges	6 - Moderate	£3.0m	The Trust has strong controls of the SLA management arrangements.	PM	6 - Moderate	£2.0m	3 - Low	£0.0m
408	Risk to UH Bristol of fraudulent activity.	3 - Low	-	Local Counter Fraud Service in place. Pro active counter fraud work. Reports to Audit Committee.	PM	3 - Low	-	3 - Low	-

Analysis of pay spend 2015/16 and 2016/17

Division		2015/16							2016/17											2013/14	2013/14	2014/15	2014/15
		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	Total £'000	Mthly Average £'000	Mthly Average %	Mthly Average £'000	Mthly Average %	Mthly Average £'000	Mthly Average %
Diagnostic & Therapies	Pay budget	10,357	10,483	10,432	10,413	41,686	3,474		3,580	3,350	3,370	10,299	3,365	3,491	3,449	10,305	20,604	3,434		3,294		3,373	
	Bank	82	109	93	88	371	31	0.9%	20	21	25	66	29	32	31	92	158	26	0.8%	26	0.8%	26	0.8%
	Agency	377	242	186	168	972	81	2.4%	36	(11)	18	42	39	32	35	106	149	25	0.8%	28	0.9%	87	2.6%
	Waiting List initiative	98	54	95	95	342	29	0.8%	62	35	53	150	72	35	27	134	284	47	1.4%	19	0.6%	22	0.7%
	Overtime	147	94	100	110	450	38	1.1%	47	37	36	120	30	33	41	104	224	37	1.1%	26	0.8%	34	1.0%
	Other pay	9,572	9,648	9,788	9,920	38,927	3,244	94.8%	3,310	3,119	3,049	9,478	3,082	3,244	3,200	9,526	19,004	3,167	95.9%	3,179	97.0%	3,198	95.0%
	Total Pay expenditure	10,276	10,146	10,261	10,382	41,063	3,422	100.0%	3,475	3,201	3,181	9,857	3,253	3,376	3,334	9,963	19,820	3,303	100.0%	3,278	100.0%	3,367	100.0%
	Variance Fav / (Adverse)	82	337	172	31	623	52		105	149	189	443	112	115	115	342	784	131		16		5	
Medicine	Pay budget	12,841	12,458	12,400	12,606	50,305	4,192		4,306	4,290	4,258	12,853	4,244	4,388	4,191	12,824	25,677	4,279		3,679		4,108	
	Bank	897	935	905	1,039	3,775	315	7.2%	243	319	318	880	338	358	290	986	1,866	311	7.0%	275	6.9%	297	7.1%
	Agency	826	875	814	1,119	3,634	303	7.0%	333	239	290	861	274	320	265	858	1,720	287	6.5%	196	4.9%	291	7.0%
	Waiting List initiative	51	45	56	42	194	16	0.4%	30	30	17	77	3	16	13	32	109	18	0.4%	13	0.3%	16	0.4%
	Overtime	16	21	35	32	105	9	0.2%	8	9	7	23	8	5	5	18	41	7	0.2%	16	0.4%	8	0.2%
	Other pay	11,212	10,941	10,982	11,308	44,443	3,704	85.2%	3,789	3,850	3,796	11,435	3,701	3,784	4,001	11,486	22,921	3,820	86.0%	3,479	87.4%	3,568	85.4%
	Total Pay expenditure	13,002	12,817	12,792	13,539	52,151	4,346	100.0%	4,403	4,447	4,428	13,278	4,324	4,483	4,574	13,380	26,657	4,443	100.0%	3,979	100.0%	4,180	100.0%
	Variance Fav / (Adverse)	(161)	(359)	(391)	(933)	(1,846)	(154)		(97)	(157)	(170)	(424)	(80)	(95)	(383)	(557)	(980)	(163)		(300)		(72)	
Specialised Services	Pay budget	10,135	10,245	10,342	10,557	41,279	3,440		3,657	3,968	3,834	11,459	3,829	3,886	3,812	11,526	22,986	3,831		3,060		3,266	
	Bank	402	404	352	423	1,581	132	3.7%	94	159	172	425	151	176	122	449	874	146	3.7%	99	3.1%	108	3.2%
	Agency	671	710	582	689	2,651	221	6.3%	182	196	177	555	166	206	219	591	1,146	191	4.9%	157	5.0%	228	6.7%
	Waiting List initiative	125	144	156	103	528	44	1.2%	42	58	36	136	21	45	20	86	222	37	0.9%	32	1.0%	42	1.3%
	Overtime	29	29	30	25	114	9	0.3%	8	11	13	32	16	11	9	36	68	11	0.3%	15	0.5%	12	0.4%
	Other pay	9,189	9,222	9,395	9,674	37,480	3,123	88.5%	3,329	3,644	3,515	10,487	3,522	3,587	3,619	10,728	21,215	3,536	90.2%	2,840	90.4%	2,995	88.5%
	Total Pay expenditure	10,415	10,510	10,516	10,913	42,354	3,529	100.0%	3,654	4,068	3,913	11,635	3,876	4,025	3,989	11,889	23,524	3,921	100.0%	3,142	100.0%	3,386	100.0%
	Variance Fav / (Adverse)	(280)	(265)	(174)	(356)	(1,075)	(90)		3	(100)	(79)	(176)	(47)	(139)	(177)	(363)	(539)	(90)		(82)		(120)	
Surgery Head and Neck	Pay budget	19,366	19,669	19,708	19,855	78,598	6,550		6,588	6,629	6,673	19,890	6,739	6,846	6,785	20,371	40,261	6,710		5,911		6,030	
	Bank	559	683	488	624	2,355	196	3.0%	172	176	194	542	229	261	216	706	1,248	208	3.1%	155	2.5%	169	2.7%
	Agency	603	908	738	752	3,000	250	3.8%	262	251	193	707	238	242	256	736	1,442	240	3.6%	67	1.1%	106	1.7%
	Waiting List initiative	407	387	371	249	1,414	118	1.8%	98	154	130	382	90	71	45	206	588	98	1.5%	116	1.9%	139	2.2%
	Overtime	38	47	45	41	171	14	0.2%	11	12	9	33	8	11	7	26	59	10	0.1%	40	0.7%	32	0.5%
	Other pay	17,853	17,860	18,200	18,209	72,122	6,010	91.2%	6,144	6,165	6,159	18,467	6,040	6,202	6,389	18,631	37,098	6,183	91.7%	5,766	93.8%	5,859	92.9%
	Total Pay expenditure	19,461	19,885	19,844	19,875	79,062	6,589	100.0%	6,687	6,758	6,685	20,130	6,605	6,786	6,913	20,304	40,436	6,739	100.0%	6,145	100.0%	6,305	100.0%
	Variance Fav / (Adverse)	(95)	(215)	(136)	(20)	(466)	(39)		(99)	(129)	(12)	(240)	134	60	(128)	66	(174)	(29)		(235)		(275)	

Analysis of pay spend 2015/16 and 2016/17

Division		2015/16							2016/17											2013/14	2013/14	2014/15	2014/15
		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	Total £'000	Mthly Average £'000	Mthly Average %	Mthly Average £'000	Mthly Average %	Mthly Average £'000	Mthly Average %
Women's and Children's	Pay budget	22,562	22,828	23,290	23,780	92,460	7,705		7,944	7,602	7,919	23,465	7,899	7,950	7,870	23,718	47,184	7,864		6,123		7,178	
	Bank	533	582	487	611	2,213	184	2.3%	141	185	172	498	181	194	173	549	1,047	174	2.2%	151	2.5%	181	2.5%
	Agency	703	840	866	719	3,128	261	3.3%	255	162	131	548	269	204	238	711	1,260	210	2.6%	117	1.9%	154	2.1%
	Waiting List initiative	205	169	203	206	783	65	0.8%	33	73	40	146	48	30	62	140	286	48	0.6%	30	0.5%	33	0.5%
	Overtime	23	19	26	35	102	9	0.1%	9	15	17	42	13	11	11	35	77	13	0.2%	19	0.3%	30	0.4%
	Other pay	21,492	21,695	22,409	22,958	88,554	7,379	93.4%	7,749	7,623	7,575	22,947	7,530	7,698	7,735	22,963	45,910	7,652	94.5%	5,843	94.9%	6,793	94.5%
	Total Pay expenditure	22,956	23,305	23,991	24,530	94,780	7,898	100.0%	8,188	8,058	7,935	24,181	8,041	8,137	8,219	24,398	48,579	8,097	100.0%	6,159	100.0%	7,190	100.0%
	Variance Fav / (Adverse)	(393)	(477)	(701)	(750)	(2,320)	(193)		(244)	(456)	(16)	(716)	(142)	(187)	(349)	(679)	(1,395)	(233)		(36)		(12)	
Facilities & Estates	Pay budget	5,057	5,113	5,142	5,070	20,382	1,699		1,708	1,788	1,744	5,239	1,740	1,770	1,780	5,291	10,529	1,755		1,536		1,618	
	Bank	296	320	278	246	1,140	95	5.6%	45	78	72	195	82	107	80	269	463	77	4.4%	46	3.0%	89	5.5%
	Agency	145	189	249	154	738	62	3.6%	32	27	37	96	26	29	28	84	180	30	1.7%	29	1.9%	42	2.6%
	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	0.0%
	Overtime	225	244	207	200	876	73	4.3%	68	68	65	201	66	82	66	213	415	69	3.9%	75	4.9%	80	5.0%
	Other pay	4,406	4,373	4,371	4,499	17,649	1,471	86.5%	1,572	1,609	1,592	4,773	1,546	1,567	1,580	4,693	9,466	1,578	90.0%	1,366	90.1%	1,394	86.9%
	Total Pay expenditure	5,072	5,126	5,106	5,100	20,403	1,700	100.0%	1,717	1,782	1,766	5,265	1,720	1,785	1,754	5,259	10,524	1,754	100.0%	1,516	100.0%	1,605	100.0%
	Variance Fav / (Adverse)	(16)	(12)	36	(30)	(21)	(2)		(9)	6	(22)	(26)	20	(16)	26	31	5	1		20		13	
(Including R&I and (Incl R&I and Support Services)	Pay budget	6,487	6,496	6,977	7,438	27,398	2,283		2,327	2,532	2,398	7,257	2,382	2,218	2,431	7,030	14,287	2,381		2,458		2,478	
	Bank	179	211	232	223	846	70	3.2%	60	61	92	213	70	71	43	184	397	66	2.9%	57	2.4%	57	2.4%
	Agency	69	177	390	367	1,002	83	3.7%	26	98	116	239	35	44	23	102	341	57	2.5%	31	1.3%	59	2.5%
	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	0.0%
	Overtime	22	23	20	16	81	7	0.3%	4	5	3	13	5	9	7	21	34	6	0.2%	9	0.4%	9	0.4%
	Other pay	6,029	5,967	6,201	6,662	24,859	2,072	92.8%	2,190	2,213	2,191	6,594	2,194	1,997	2,283	6,474	13,068	2,178	94.4%	2,285	95.9%	2,223	94.7%
	Total Pay expenditure	6,299	6,378	6,843	7,268	26,788	2,232	100.0%	2,280	2,377	2,403	7,059	2,305	2,120	2,356	6,781	13,840	2,307	100.0%	2,383	100.0%	2,348	100.0%
	Variance Fav / (Adverse)	188	118	134	169	610	51		47	155	(5)	197	77	97	75	249	447	74		75		130	
Trust Total	Pay budget	86,805	87,293	88,292	89,718	352,109	29,342		30,109	30,158	30,194	90,462	30,198	30,548	30,319	91,065	181,527	30,254		26,060		28,050	
	Bank	2,949	3,244	2,834	3,254	12,281	1,023	3.4%	774	998	1,046	2,818	1,080	1,199	955	3,235	6,053	1,009	3.3%	809	3.0%	927	3.3%
	Agency	3,393	3,941	3,824	3,967	15,126	1,260	4.2%	1,127	961	961	3,049	1,047	1,078	1,064	3,188	6,238	1,040	3.4%	625	2.4%	967	3.4%
	Waiting List initiative	886	799	881	695	3,261	272	0.9%	265	350	276	891	234	197	167	598	1,489	248	0.8%	210	0.8%	252	0.9%
	Overtime	499	478	463	460	1,899	158	0.5%	156	157	150	463	146	160	148	454	917	153	0.5%	201	0.8%	204	0.7%
	Other pay	79,752	79,705	81,348	83,230	324,035	27,003	90.9%	28,083	28,223	27,876	84,183	27,616	28,078	28,805	84,500	168,682	28,114	92.0%	24,759	93.1%	26,031	91.7%
	Total Pay expenditure	87,480	88,166	89,352	91,607	356,602	29,717	100.0%	30,405	30,690	30,310	91,404	30,123	30,712	31,139	91,975	183,379	30,563	100.0%	26,603	100.0%	28,381	100.0%
	Variance Fav / (Adverse)	(674)	(873)	(1,058)	(1,889)	(4,493)	(374)		(296)	(532)	(115)	(942)	74	(164)	(821)	(911)	(1,852)	(309)		(543)		(331)	

NOTE: Other Pay includes all employer's oncosts.

	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	700	11,709	38,455	(690)	2,426	3,194	55,794									
April movements	(120)	(8,993)	(31,315)	-	166	(208)	(40,470)	3,694	9,102	8,756	7,388	9,590	1,238	1,749	(1,047)	40,470
May movements	(28)	(6)	(3,529)	7	(588)	(217)	(4,361)	(119)	(22)	1	1,914	47	26	194	2,320	4,361
June movements	97	(9)	87	-	(160)	(366)	(351)	10	165	28	40	83	99	141	(215)	351
July movements	(20)	(45)	447		(119)	(207)	56	9	91	45	27	103	98	218	(647)	(56)
August Movements		(6)	234		(80)	(118)	30	58	31	42	42	59	37	122	(421)	(30)
September																
MPET					(79)		(79)					79				79
SIFT					32		32								(32)	(32)
Spend to Save						(41)	(41)				12	10		19		41
CQUINs			(55)				(55)			7	5			43		55
Strategic Schemes Costs						(16)	(16)						16			16
CSIP						(39)	(39)							39		39
EWTD					(118)		(118)	8	24	16	24	42	2	1	1	118
Other	(17)	(9)	(65)			(9)	(100)			34	2		6	58		100
Month 6 balances	612	2,641	4,259	(683)	1,480	1,973	10,282	3,660	9,391	8,929	9,454	10,013	1,522	2,584	(41)	45,512

Finance Committee
24th October 2016
Appendix 9

2016/17 Sustainability & Transformation Fund – September trajectory performance

In order for the Trust to be eligible for STF, first it must deliver the monthly net surplus Control Total excluding STF. Delivery of the Control Total entitles the Trust to 70% of the STF from July onwards.

Net surplus Control Total

The cumulative net surplus Control Total (excluding STF) was achieved for the period to September with an actual cumulative net surplus excluding STF of £1.833m against a Control Total of £1.636m. Please see Table 1 below.

Table 1: Net surplus Control Total and performance to date

Control Total	Q1 £m	July £m	August £m	Sept £m	Oct £m	Nov £m	Dec £m	Jan £m	Feb £m	Mar £m
Planned net surplus	3.858	5.258	6.719	8.135	9.486	10.850	12.084	13.383	14.475	15.900
Less planned STF	(3.250)	(4.333)	(5.416)	(6.500)	(7.583)	(8.666)	(9.750)	(10.833)	(11.916)	(13.000)
Planned net surplus exc STF	**0.608**	**0.925**	**1.303**	**1.635**	**1.903**	**2.184**	**2.334**	**2.550**	**2.559**	**2.900**
Actual reported net surplus	3.871	5.275	6.722	8.170						
Less STF	(3.250)	(4.279)	(5.308)	(6.337)						
Actual net surplus exc STF	**0.621**	**0.996**	**1.414**	**1.833**						
Control Total delivered / Eligible for STF?	Yes	Yes	Yes	Yes						

A&E waiting times

The Trust did not achieve the A&E waiting times standard trajectory in September with performance of 87.3% against the in-month trajectory of 92.2%. However, cumulative performance was 89.1% and ahead of the agreed trajectory of 86.2%. Therefore, the Trust was eligible for funding of £0.135m for September.

The Trust is currently forecasting ongoing achievement of the cumulative but not in-month A&E trajectory for October and November but predicts failure for December through to March. Failure to achieve the A&E trajectory for the last four months of the financial year would mean a loss of STF of £540k. Table 2 below summarises the position.

Table 2: A&E waiting times trajectories and performance to date

	April	May	June	July	August	Sept	Oct	Nov	Dec	Jan	Feb	Mar
National standard	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%
Agreed in month trajectory	81.9%	84.4%	85.9%	86.6%	88.4%	92.2%	93.3%	90.0%	89.3%	88.5%	87.4%	91.0%
Actual performance	87.2%	91.7%	89.0%	89.3%	90.0%	87.3%						
Agreed cumulative trajectory	81.9%	83.2%	84.1%	84.7%	85.2%	86.2%	87.2%	87.5%	87.7%	87.8%	87.7%	88.1%
Actual - cumulative performance	87.2%	89.5%	89.3%	89.3%	89.5%	89.1%						
Tolerance	N/A	N/A	N/A	1%	1%	1%	0.5%	0.5%	0.5%	0.0%	0.0%	0.0%
Trajectory agreed/delivered	Yes	Yes	Yes	Yes	Yes	Yes						
STF due	*£135k*	*£135k*	*£135k*	£135k	£135k	£135k						

Italics represent notional values relating to the agreement of trajectories only for quarter 1.

Cancer waiting times

The cumulative quarter 2 performance against the 62-day GP standard is 79.5% (subject to validation) compared with a trajectory of 82.8% (inclusive of the 1% tolerance). A formal appeal will be submitted for securing funds for the complete quarter on the basis of the number of breaches outside of the control of the Trust. The appeal will be on the basis of the additional breaches of the 62-day standard related to the histopathology reporting delays following the service transfer to North Bristol NHS Trust at the beginning of May, and the likely associated increase in late referrals from North Bristol NHS Trust experienced during quarter 2.

Current predictions indicate that the Trust may achieve quarter 3 as a whole. But access to the c£163k funds will be subject to appeal, as required in order to take account of breach reallocations that apply under the new national and local CQUIN rules which came into effect on the 1st October 2016. The appeal is expected to have a reasonable chance of success. Quarter 4 is considered a high risk quarter with the achievement of the Cancer standard being unlikely due to higher levels of patient choice and also emergency pressures which often impact to a greater extent in the last quarter of the year than in other quarters. Failure to achieve the Cancer access trajectory for the last quarter of the financial year would mean a loss of STF of c£163k.

Table 3: Cancer waiting times trajectories and performance to date

	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar
National standard	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%
Agreed in month trajectory	72.7%	73.2%	81.8%	84.7%	81.7%	85.0%	85.2%	85.1%	86.9%	83.6%	85.7%	85.9%
Actual performance	77.2%	70.5%	70.8%	73.7%	84.5%	78.6%						
Agreed cumulative trajectory	72.7%	73.0%	76.0%	83.7%	82.3%	82.8%	84.7%	84.6%	85.0%	83.6%	84.7%	85.0%
Actual - cumulative performance	77.2%	73.7%	72.7%	73.7%	79.9%	79.5%						
Tolerance	N/A	N/A	N/A	1%	1%	1%	0.5%	0.5%	0.5%	0.0%	0.0%	0.0%
Trajectory agreed/ delivered	Yes	Yes	Yes	No	No	No						
STF due	*£55k*	*£55k*	*£55k*	£0k	£0k	£0k						

Italics represent notional values relating to the agreement of trajectories only for quarter 1.
Please note: July, August and September figures are still subject to final reporting for the quarter

Referral to Treatment Time (RTT)

RTT performance in September is expected to be confirmed on final reporting at circa 90.0%. This took cumulative delivery for the year-to-date to 91.6%, compared with a trajectory of 92.0% (i.e. the national standard). However, the STF for the RTT element has been assumed for quarter 2 subject to appeal. The Trust has a reasonable degree of confidence following informal discussions with NHS Improvement on the principles of the formal appeal process, that the appeal will secure the RTT funding for quarter 2, due to the high levels of referrals in the period and the STF rules related to the application of the tolerance where a Trust has submitted aspirational trajectories above the national standard to support commissioners plan.

For quarter 3, failure to achieve the RTT trajectory is considered highly likely, due to an inability to recover the cumulative year-to-date position (due to the scale of performance already lost in quarter 2), and a lack of confidence that sufficient additional activity can be established to restore in-month performance to above 92% before January. Failure to achieve the RTT standard in quarter 3 equates to a loss of STF of £405k. Recovery plans are expected to support achievement in each month in quarter 4, but will not be sufficient to earn back the quarter 3's STF. Failure to achieve the RTT access trajectory for quarter 3 would mean a loss of STF of £405k.

Table 4 overleaf summarises the position.

Table 4: RTT waiting times trajectories and performance to date

	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar
National standard	92.0%	92.0%	92.0%	92.0%	92.0%	92.0%	92.0%	92.0%	92.0%	92.0%	92.0%	92.0%
Agreed in month trajectory	92.6%	92.6%	92.8%	93.2%	93.2%	93.4%	93.4%	93.4%	92.8%	92.8%	92.8%	93.0%
Actual performance	92.3%	92.6%	92.1%	92.0%	90.5%	90%**						
Agreed cumulative trajectory	92.6%	92.6%	92.7%	92.8%	92.9%	93.0%	93.0%	93.1%	93.0%	93.0%	93.0%	93.0%
Actual - cumulative performance	92.3%	92.5%	92.3%	92.3%	91.9%	91.6%						
Tolerance	N/A	N/A	N/A	1%	1%	1%	0.5%	0.5%	0.5%	0.0%	0.0%	0.0%
Trajectory / national standard agreed/ delivered	Yes	Yes	Yes	Yes	No*	No*						
STF due	*£135k*	*£135k*	*£135k*	£135k	£135k	£135k						

Italics represent notional values relating to the agreement of trajectories only for quarter 1.
**Subject to appeal*
***Subject to validation*

Diagnostics

The Diagnostics access trajectory does not attract STF and is not therefore considered here.

Summary

The Trust's Operational Plan Control Total surplus of £15.9m assumed full receipt of the STF at £13.0m of which £2.925m relates to the delivery of the Trust's access performance trajectories. The current assessment of performance against the access standard trajectories indicate a potential loss of funding of £1,108k out of the £1,944k available in the last two quarters of the year.

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University Hospitals Bristol NHS
NHS Foundation Trust

Cover report to the Trust Board meeting to be held on 31 October 2016 at 11:00 am – 1:00 pm in the Conference Room, Trust HQ, Marlborough St, Bristol, BS1 3NU

		Agenda Item	6.2b
Meeting Title	Trust Board	**Meeting Date**	31 October 2016
Report Title	Finance Committee Terms of Reference		
Author	Pam Wenger, Trust Secretary		
Executive Lead	Robert Woolley, Chief Executive		
Freedom of Information Status		Open	

Strategic Priorities (please select any which are impacted on / relevant to this paper)
Strategic Priority 7: We will ensure we are soundly governed and are compliant with the requirements of NHS Improvement.

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

Purpose

This report contains the proposed revised Terms of Reference for the Finance Committee, in line with the delegated authority from the Trust Board of Directors.

Key issues to note

The Finance Committee reviewed the terms of reference on 24 October 2016 and have recommended minor amendments.

These proposed amendments include: updating of job titles, reference to Monitor has been updated to reflect NHS Improvement, an additional section (7.2) in relation to quorum and clarity that the Trust Secretary will also attend each meeting to be consistent with the approach taken at the other committees.

Recommendations

Members are asked to:

- **Approve** the terms of reference.

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

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

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

Impact Upon Corporate Risk
Failure to have in place terms and reference and a clear work plan would have an impact on the robust governance processes and procedures in place.

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

Date papers were previously submitted to other committees				
Audit Committee	**Finance Committee**	**Quality and Outcomes Committee**	**Remuneration & Nomination Committee**	**Other (specify)**
18 October 2016				

University Hospitals Bristol NHS
NHS Foundation Trust

Terms of Reference – Finance Committee

Document Data	
Corporate Entity	Finance Committee
Document Type	Terms of Reference
Document Status	Draft
Executive Lead	Chief Executive
Document Owner	Trust Secretary
Approval Authority	Trust Board of Directors
Document Reference	Not Applicable
Review Cycle	12 months
Next Review Date	31/10/17
Estimated Reading Time	7 Minutes

Document Change Control				
Date of Version	**Version Number**	**Lead for Revisions**	**Type of Revision**	**Description of Revision**
November 2007	N/a	Not recorded	Pre-FT	Not recorded
March 2008	N/a	Not recorded	Pre-FT	Not recorded
07 October 2008	N/a	Not recorded	FT	First Foundation Trust version
March 2009	N/a	Not recorded	Not recorded	Not recorded
22 June 2012	1.1	Trust Secretary	Redraft	To ensure congruence with the Terms of Reference of other committees of the Trust Board of Directors as revised at the beginning of 2011-2012. Endorsed by Finance Committee for approval by Trust Board of Directors with addition of footnote 4.
28 June 2012	2.0	Trust Secretary	Major Version	Approved by Trust Board of Directors.
26 September 2014	3.0	Joint Interim Head of Membership & Governance	Redraft	To ensure congruence with the Terms of Reference of other committees of the Trust Board of Directors ahead of the well led Governance Review to be undertaken in late 2014.
28 July 2016	4.0	Trust Secretary	Minor	1. Changes to job titles and quorum for the committee. 2. Change from Monitor to NHS Improvement. 3. Additional section 7.2 in relation to the quorum. 4. Change from the Trust Secretary attending from time to time, to each meeting. (6.6 (b)

Table of Contents

1. Constitution of the Committee

1.1 The Finance Committee (the Committee) is a non-statutory committee established by the Trust Board of Directors to discharge the duties set out in these Terms of Reference.

2. Purpose and role

2.1 The purpose of the Finance Committee is to support the Board's strategic direction and stewardship of the Trust's finances, investments and sustainability. In particular, the Committee is to provide the Board with assurance concerning all aspects of finance and operational performance relating to the provision of care and services in support of getting the best clinical outcomes and experience for patients.

2.2 Additionally, the Finance Committee shall carry out the role of 'investment committee' for the purposes of the Trust's Capital Investment Policy.

3. Function

3.1 The function of the Committee is to review, maintain and monitor, on behalf of the Trust Board of Directors, strategic principles, priorities and performance parameters for:

(a) Delivery of the financial aspects of the ~~Annual~~ Operational Plan

(b) The annual Trust Service and financial plans: revenue, budgets, capital, working and associated targets for savings to ensure sustainability going forward

(f) The availability of financial management information (to ensure a consistent approach to financial management);

(g) Sustainable service commissioning;

(h) Review and maintain an overview of financial and service delivery agreements and key contractual arrangements

(i) Oversee the development, management and deliver of the Trust's annual capital programme [1]

(j) Consider key financial policies e.g. investment policy, issues and developments to ensure that they are shaped, developed and implemented in the Trust appropriately.

(k) To consider and recommend for approval by the Trust Board of Directors any proposed changes to Trust Standing Financial Instructions.

4. Authority

4.1 The Committee is a non-executive committee of the Board and has no executive powers, other than those specifically delegated in these terms of reference. The Committee is authorised by the Board to:

[1] The Finance Committee shall carry out the role of "investment committee" for the purposes of the Trust's Capital Investment Policy.

(a) Review, monitor, and where appropriate, investigate any financial matter within its terms of reference, and seek such information as it requires to facilitate this activity;

(b) Obtain whatever advice it requires, including external professional or legal advice if deemed necessary (as advised by the Trust Secretary). In so doing, it may require directors and other officers, or independent specialists to attend meetings to provide such advice.

4.2 The Committee discharges the authority delegated to the members of the Committee (when present) both in the Scheme of Delegation, and from time to time by the Chief Executive as recorded in the minutes of meetings.

4.3 Additionally, the Committee has delegated authority to:

(a.) Approve the investment and borrowing strategy and associated policies;

(b.) Set financial performance benchmarks;

(c.) Approve Project Initiation Documents (as recommended by the Trust Senior Leadership Team) for capital schemes above the de minimis amount[2];

(d.) Approve capital investments and divestments above the de minimis amount[2];

(e.) Approve business cases with a value between 0.25% and 1% of the Trust's turnover.

4.4 *Limitations*

(a) Unless expressly provided for in Trust Standing Orders or Standing Financial Instructions the Committee shall have no further powers or authority to exercise on behalf of the Trust Board of Directors.

5. Reporting

5.1 The Chair of the Committee shall report to the Trust Board of Directors on the activities of the Committee and shall make whatever recommendations the Committee deems appropriate (on any area within the Committee's remit where disclosure, action or improvement is considered necessary).

5.2 The Committee shall prepare a statement for inclusion in the Annual Report about its activities.

6. Membership

6.1 Members of the Committee shall be appointed by the Trust Board of Directors and shall include:

i. Four Non-executive Directors;

ii. The Chief Executive;

iii. The Director of Finance;

[2] As set out in the Trust's Standing Financial Instructions.

iv. The Chief Operating Officer[3].

6.2 The Chair of the Trust may be a member of the Finance Committee.

6.3 The Chair of the Audit Committee shall not be a member of the Finance Committee.

6.4 One of the Non-Executive members will be appointed Chair of the Committee by the Board and will not Chair any other standing Committee of the Board.

6.5 ***Attendance***

It is expected that members will or a nominated appropriate representative will attend a minimum of 75% of committee meetings a year.

6.6 In - Attendance

(a) The following officers may be required to attend meetings of the Committee at the invitation of the Chair:

(i) Deputy Director of Finance[4]

(ii) Associate Director of Finance

(iii) Head of Financial Management and Service Improvement;

(iv) Head of Contract Management and Costing;

(v) Clinical Chairs;

(vi) Divisional Directors;

(vii) Divisional Finance Managers,

(viii) Only members of the Committee have the right to attend Committee meetings. However, other individuals, including external advisors, may be invited to attend for all or part of any meeting, as and when appropriate.

(b) The Trust Secretary shall attend each meeting to provide advice to the Directors and to facilitate the formal evaluation of the Committee's performance.

7. Quorum

7.1 The quorum necessary for the transaction of business shall be four members, including two Executive Directors (one of whom shall be the Director of Finance or nominated deputy) and two Non-executive Directors.

7.2 In the event the Chief Executive is unable to attend a duly convened meeting, then another Executive Director (other than the Director of Finance) will be nominated to attend on behalf of the Chief Executive.

[3] In circumstances where the Chief Operating Officer is unable to attend a meeting, a suitable deputy shall be designated to attend. Attendance by the designated deputy shall be subject to approval by the Chair of the Finance Committee and the Chief Executive jointly. Their presence shall not contribute to the quorum.

[4] In the event that the Director of Finance is unable to attend, the Deputy Director of Finance is a required attendee. In those circumstances the presence of the Deputy Director of Finance does contribute to the quorum.

7.3 A duly convened meeting of the Committee at which a quorum is present shall be competent to exercise all or any of the authorities, powers and discretions vested in or exercisable by the Committee as set out in these Terms of Reference.

8. Duties

8.1 The duties of the Committee are:

(a) To consider and examine on behalf of, and subject to review by the Trust Board of Directors:

(i) Key financial performance indicators;

(ii) Monthly/annual consolidated financial performance summaries and related budgets;

(iii) The monthly / annual statement of financial position;

(iv) Working capital performance;

(v) Cash flow status;

(vi) Capital investment programme;

(vii) Recommendations from the Capital Programme Steering Group;

(viii) Risks associated with financial plans (finance risk);

(ix) Financial relationships with the Trust's Commissioners;

(x) Financial Risk Ratings applied by ~~Monitor~~; NHS Improvement

(xi) Financial performance forecasts;

(xii) Financial aspects of the Board Assurance Framework document; and,

(xiii) Business cases classed as 'major' or 'high' risk; making recommendations approval or rejection to the Board, and,

(b) To:

(i) Approve the investment and borrowing strategy and associated policies;

(ii) Set financial performance benchmarks and monitor the performance of investments;

(iii) Review proposed revisions to the Capital Investment Policy for approval by the Trust Board of Directors each year;

(iv) Seek and consider evidence of organisational compliance with the Capital Investment Policy;

(v) Approve Project Initiation Documents for all capital schemes above the de minimis amount;

(vi) Approve capital investments and divestments above the de minimis amount, ensuring in each case that the Trust has the legal power to enter into the investment;

(vii) Approve business cases within its delegated authority.

9. Secretariat Services

9.1 The Finance Department Secretariat shall co-ordinate secretariat services to the Committee.

9.2 **Notice and Conduct of Meetings**

(a) Meetings of the Committee shall be called by the secretary of the Committee at the request of the Committee chair.

(b) Unless otherwise agreed, notice of each meeting confirming the venue, time and date, together with an agenda of items to be discussed, shall be made available to each member of the Committee, any other person required to attend and all other non-executive directors, no later than seven working days before the date of the meeting.

(c) Supporting papers shall be made available to Committee members and to other attendees as appropriate, no later than three working days before the date of the meeting.

9.3 **Minutes of Meetings**

(a) The secretary shall minute the proceedings and resolutions of all Committee meetings, including the names of those present and those in attendance.

(b) Draft Minutes of Committee meetings shall be made available promptly to all members of the Committee and, once agreed, to all other members of the Board, unless a conflict of interest exists.

10. Frequency of Meetings

10.1 The Committee shall meet every month, and at such other times as the chair of the Committee shall require.

11. Review of Terms of Reference

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

Cover report to the Trust Board meeting to be held on 31 October 2016 at 11:00 - 1:00pm in the Conference Room, Trust HQ, Marlborough St, Bristol, BS1 3NU

		Agenda Item	6.3
Meeting Title	Trust Board	**Meeting Date**	31 October 2016
Report Title	Quarterly Capital Projects status report		
Author	Andy Headdon, Strategic Development Programme Director		
Executive Lead	Owen Ainsley, Interim Chief Operating Officer		
Freedom of Information Status		Open	

Strategic Priorities (please select any which are impacted on / relevant to this paper)
Strategic Priority 2: We will ensure a safe, friendly and modern environment for our patients and our staff.

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

Executive Summary

Purpose

The purpose of this report is to update the Board on the progress, issues and risks' arising from the Trust's remaining major capital developments which are governed through the Estates Capital Project Team and associated programme infrastructure.

Key issues to note

The programme to vacate the Old Building has changed as Unite failed to secure planning permission for their development causing them a 12 month delay. A variation to the sale agreement has been agreed removing the need for the Trust to vacate the building by 31st October and removing any financial penalties.

This has taken the pressure off the King Edward Building (KEB) project; however it is programmed to completely vacate the Old Building by early December.

Protracted discussions with Bristol City Council regarding final details are preventing the remedial works to the pavement outside the new façade being completed; however this is expected before the end of December.

Public Health England (PHE) have confirmed they will vacate site on the 21st November thus allowing the Level 8&9 works to proceed to their revised programme.

Recommendations

Members are asked to :

- **Note** the report and receive **assurance** that the strategic development is on track and being effectively governed.

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

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

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

Impact Upon Corporate Risk
Programme is not delivered to time or cost with resulting operational impacts for both King Edward Building and level 8&9 Queens Building.

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

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

STRATEGIC DEVELOPMENT QUARTERLY STATUS REPORT
Quarter 2
31st October 2016, Trust Board

1. Introduction

This status report provides a summary update for Quarter 2 on the Trust's strategic capital schemes, all of which are managed through their respective project boards, which in turn report to the Senior Leadership Team.

2. Project Updates

BRISTOL ROYAL INFIRMARY Phase 4 & Queens Facade		
1	**Decisions required**	None
2	**Progress**	**Old Building** The programme to vacate the Old Building site has been changed significantly in the last month due to Unite failing to secure that required planning permission to allow them to progress their development. As such all work has stopped on the site whilst Unite re-evaluate their position. A revision to the sale agreement has been agreed with Unite that removes the requirement for the Trust to vacate the site by the 31st October and removes any financial penalties. This in turn has taken the pressure off the King Edward Building (KEB) scheme, allowing the project to be completed in a more controlled manner. Decommissioning of the Old Building is therefore progressing in line with the revised programme to vacate departments, with the building being completely vacated during early December. Disconnection of all services remains on programme to complete by the required date. **Office accommodation** Revised phasing of the works to progress the conversion of levels 8&9 of the Queens building now reflect the agreed vacation date for Public Health England (PHE) of the 21st November. Works are progressing and on programme to relocate part of the HR team currently in managed desks in Whitefriars, clinical coders from the Old Building and D&T and Medicine management teams from the site village by the end of the calendar year. There are some operational knock on effects to areas such as the Clinical Site Team accommodation. **BRI Phase 4** Refurbishment of King Edward Building is now nearing completion with building works largely completed and commissioning of all systems progressing. The contract programme has experienced some delays mainly with regard to

		design details and asbestos issues and this will delay occupation of the building into end Nov/ early Dec. **Queens Façade** All window replacement and external signage has been completed. There continues to be very protracted discussion with Council Highways officer regarding the pavement, bus stops and tree pits which are hoped to be resolved shortly, but this has delayed these elements of the scheme, until final agreement on the scope of works can be agreed.	
3	**Budget**	A total capital allocation for Phase 4 and the Façade of £28.944m is in the capital programme which includes funding for façade and assumes charitable funding support of £2m.	
4	**Programme**	The phase 4 programme has some slippage on the required vacation date of the Old Building however this has been fully mitigated following agreement with Unite to vary the terms of the Old Building sale agreement.	
5	**Risks**	**Risk**	**Mitigation Actions**
		Programme is not delivered to time or cost with resulting operational impacts for both KEB and level 8&9 Queens	These risks have now reduced due the changes to the Old Building programme and the mitigation regarding office accommodation, that were put in place. Additional external project management support has been retained to oversee largest projects to strengthen project management arrangements. Additionally the Strategic Development Programme Director has temporarily taken over management responsibility for all capital works to support the Director of Facilities and Estates.

3. Conclusion

The Trust Board is requested to receive this report for information, noting the risks that have been identified and the mitigation/contingency plans that have been developed.

Author: Andy Headdon, Strategic Development Programme Director
Date updated: 19.10.2016

Cover report to the Trust Board meeting to be held on 31 October 2016 at 11-1pm in the Conference Room, Trust HQ, Marlborough St, Bristol, BS1 3NU

		Agenda Item	7.1
Meeting Title	Trust Board	**Meeting Date**	31 October 2016
Report Title	Governors Log of Communication		
Author	Kate Hanlon, Interim Head of Membership & Governance		
Executive Lead	John Savage, Chairman		
Freedom of Information Status		Closed	

Strategic Priorities (please select any which are impacted on / relevant to this paper)
Strategic Priority 7: We will ensure we are soundly governed and are compliant with the requirements of NHS Improvement.

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

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

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

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

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

Impact Upon Corporate Risk
None

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

Date papers were previously submitted to other committees				
Audit Committee	**Finance Committee**	**Quality and Outcomes Committee**	**Remuneration & Nomination Committee**	**Other (specify)**
				Council of Governors 31/10/16

ID **Governor Name**

166 **Anne Skinner** ***Theme:*** Nursing staff ***Source:*** Governor Direct

Query **13/10/2016**

Following up from log query no. 62 (relating to arrangements for appropriately qualified cover to be available on wards at night to ensure nursing staff can take their meal breaks) it is good to hear that nursing staff are encouraged and expected to take their breaks. However, what measures are in place to ensure that they actually do take proper breaks?

Division: Trust-wide ***Executive Lead:*** *Chief Nurse* ***Response requested:***

Response

Status: *Assigned to Executive Lead*

165 **Anne Skinner** ***Theme:*** CSSD ***Source:*** Chairman's Counsel

Query **13/10/2016**

On a visit in August 2016 to the Centralised Sterile Services Department, governors were concerned to see staff working in uncomfortable conditions due to a breakdown in the cooling system. Can you explain why this issue is still ongoing and assure governors and the staff within the department when the cooling system will be fixed?"

Division: Trust Services ***Executive Lead:*** *Chief Operating Officer* ***Response requested:***

Response

Status: *Assigned to Executive Lead*

ID	Governor Name		
164	Malcolm Watson	***Theme:*** Processes in divsions for early identification of issues	***Source:*** Project Focus Group

Query **06/10/2016**

In a recent Quality Focus Group meeting, the group received a presentation from Xanthe Whittaker to explain the data in the Quality & Performance reports. While the data in these reports represent aggregated data, I am interested what happens when the 'lower level' data are disaggregated and demonstrate 'aspects that may be falling down'. What processes are in place to identify early identification of issues? What processes are followed within divisions when issues are identified and what actions are taken as a result?

Division: Trust-wide ***Executive Lead:*** *Chief Operating Officer* ***Response requested:***

Response **19/10/2016**

For each of the Trust level scorecards that are presented in the Quality & Performance Report there is an equivalent Divisional version. There are also 'directorate' specific versions of the Scorecards, such as Children's Services, Oncology and Cardiac. The scorecards are used by Divisions to understand and improve their performance.

Like the Trust-level scorecards, Divisions use these scorecards to report their performance each month to their Divisional Boards. Divisions also use these scorecards at their monthly and quarterly Exec-led review meetings, at which there are detailed discussions around specialties/areas/sites that are failing the performance standards.

To complement each of the indicators in the Trust and Divisional-level scorecards we have set up a Key Performance Indicator (KPI) report. This provides a detailed breakdown of the performance against that indicator, at a Trust, Division, specialty/site and/or ward level. These are used by corporate teams and Divisions to delve deeper into the data.

We also have a range of Performance Books, which provide a ward or unit level view of performance against a range of indicators (Access, Quality and Workforce) for a given ward or unit each month. Many wards use their Performance Books to understand what issues they have at a local level and importantly, to understand the potential relationship between different indiactors (such as workforce indicators and quality indicators). The Performance Books were shared with the CQC at the time of the last inspection and were positively noted in the final published report.

In addition to the above we have a range of bespoke reports, which provide more granular detail of performance. How these are used varies dependent upon the area of performance. But as an example, there is a weekly report that is produced on Referral to Treatment Times (RTT) which gives a breakdown of the number of patients waiting over 18 weeks in every specialty across the Trust. This is used by Divisions to understand whether they need to try to establish additional capacity to treat more patients. It is also used by the corporate team to understand how backlogs are changing across time, and what risk that poses to the achievement of the national standard.

ID **Governor Name**

As is the case for many of the Trust's KPIs, there is a steering group which oversees performance against this indicator. The RTT Steering Group meets monthly and uses both weekly and monthly specialty/Divisional level RTT data to understand and improve performance. From this specialty-level information action plans are developed as appropriate, such as the one currently in use as part of a weekly escalation process to try to restore RTT performance back to the national 92% standard as quickly as possible. This is just one example of how more granular data is made available and used. Similar processes exist for a wide range of the Trust's KPIs.

Status: *Awaiting Governor Response*

ID	Governor Name		
163	Clive Hamilton	***Theme:*** Risk Management Policy and guidance	***Source:*** Governor Direct

Query **14/09/2016**

Page 386 of the July 2016 Board report sets out some of the duties, roles and responsibilities of those involved in the risk management process as follows:

"6.14 Wards and department leads
Each manager is responsible for ensuring Risk Assessments are completed with implementation of suitable and sufficient control measures and for communicating the risk assessment to those affected.

Line managers must allocate sufficient time for the risk assessor to ensure that they have enough time to complete their assessor responsibilities within normal working hours."

Firstly, is there a need to define the Ward and Departmental Leads responsibilities more directly?

i.e. "...Risk Assessments are completed and that the resulting control measures are implemented within the agreed time frame and communicated to all staff responsible for implementation."

and

"...Where the Ward Manager or Departmental Lead is unable to ensure suitable and sufficient control measures are implemented, the risk, control measures and time frame target must be escalated to the next in line of supervision and documented to that effect."

Secondly, one of the findings of the Review of Cardiac Services at the Bristol Children's hospital was the inadequate escalation of risks to higher levels of management for mitigation, especially in relation to safe staffing levels on Ward 32.

Are we assured that the current Risk Management policy and guidance is now in place to reduce the likelihood of inadequate risk control escalation procedures?

Division: Trust Services ***Executive Lead:*** *Trust Secretary* ***Response requested:***

Response **25/10/2016**

Thank you for the comments which are helpful. We hope that the recent Governor Development Seminar on risk management provided governors with additional context and assurances in relation to the approach to Risk Management.

The specific responses to your questions are below:

ID **Governor Name**

The roles and responsibilities section of the policies was reviewed following some helpful comments received at Trust Board meeting where the policy was approved. A minor amendment was subsequently made to section 6.14 to strengthen the wording following these comments. Whilst we could see the sense in the challenge we did not identify the need for any further amendment at this point as the process of risk escalation is laid out clearly in section 10.4 and the responsibilities of staff are implicit at this point.

Further practical guidance is given to members of staff with risk management responsibilities during training and ongoing support is provided by the central risk management team.

There have been significant improvements in the way in that the risk management process is monitored following the implementation of a new system that has brought a greater level of transparency at all levels. and escalated and this has been noted by the Board. The process for the escalation of risks is considered monthly by the Senior Leadership Team who receive a detailed report of risks requiring escalation and also an oversight of significant risk that are being managed at a divisional level. On a rolling annual basis divisions are required to provide a report to the Risk Management Group on their divisional risks and reporting processes. The Audit Committee received a copy of the minutes of the Risk Management Group which provides the assurances through to the Board on the implementation of the policy. Furthermore, significant work has been undertaken to align the Corporate Risk Register with the Board Assurance Framework.

Status: *Awaiting Governor Response*

ID	Governor Name		
162	Clive Hamilton	***Theme:*** VTE	***Source:*** Governor Direct

Query **14/09/2016**

On page 133 of the July 2016 Board Report it was reported that there were two incidences of venous thromboembolism in the Children's Hospital and that this was unusual so validation was needed.

Were these cases valid, and if so, is there a case for VTE assessment in the Children's Hospital?

Division: Women's & Children's Services ***Executive Lead:*** *Chief Nurse* ***Response requested:***

Response **19/09/2016**

The validation of the two venous thromboembolism (VTE) cases in the July Board report (June data) has taken place. One of the cases was not validated and one was. For the case that was validated the young person had had the appropriate VTE risk assessments completed and thrombo-prophylaxsis treatment given as per Trust policy.

The current policy states that clinicians should consider thrombo-prophylaxis in paediatric patients over 40kg, the rationale for that is that they are more physiologically akin to an adult.

Status: *Awaiting Governor Response*

ID	Governor Name		
161	Clive Hamilton	***Theme:*** Inpatient Food Safety and Nutritional Standards	***Source:*** Governor Direct

Query **14/09/2016**

The Trust recently took on a new contract for the supply of frozen meals/food.

Microbiological safety and nutritional quality are important for reducing the risk of harm and as aids to enhanced recovery.

Do we have independent assurance that all food supplied to patients meets microbiological safety requirements and adequate nutritional content?

Clarification question submitted 12/10/16: What independent assurance do we have that the food is microbiologically safe and of acceptable nutritional content? My experience of food safety law enforcement covered ascertaining whether the defence of due diligence was available to food supplied to the public - and this involved independent sampling. Are we doing this?

Division: Trust Services ***Executive Lead:*** *Chief Operating Officer* ***Response requested:***

Response **20/09/2016**

Yes. The Trust is undertaking a vigorous procurement process, which encompasses microbiological safety requirements. Our quality in-house dieticians secure and monitor the nutritional standards set by the Trust.

Response updated 19/10/16: We are still in the process of procuring our supplier for patient feeding. However, all the suppliers within the tender process need to adhere to the Health Protection Agency (HPA) guidelines for assessing the microbiological safety of foods (2009), and this would involve the supplier sending their food to be independently tested for microbiological safety.

Status: *Awaiting Governor Response*

ID	Governor Name		
160	Clive Hamilton	***Theme:*** Safe Staffing Levels	***Source:*** Chairman's Counsel

Query **14/09/2016**

The 'Safe Staffing Levels' report for June 2016 indicates that the Women's and Children's Division had a deficit of 1,084 hours from expected levels of staff amounting to 99% cover.

Three wards were showing more substantial deficits:
Ward 32 - 296 hours or 93% of expected
Ward 34 - 803 hours or 84% of expected
Ward 38 - 278 hours or 94% of expected

Can we have assurance that patient safety was not put at risk as a result of these deficiencies and that High Dependency Care was not compromised?

Division: Women's & Children's Services ***Executive Lead:*** *Chief Nurse* ***Response requested:***

Response **22/09/2016**

The UH Bristol 'Monthly Staffing Report of Nursing and Midwifery Levels June 2016' reported that the Women's and Children's Division had a deficit of 1,084 hours from the expected 77,449 nursing hours planned. The Women's and Children's Division report on staffing levels across 15 clinical areas and in June 2016, 3 of these clinical areas (wards 32, 34, 38) reported a negative variance. The reasons for this are explained as follows:

Ward 32
Ward 32 has 16 beds (11 cardiac speciality and 5 High Dependency beds) and to staff these as planned, if all beds are fully occupied 7 days of the week, requires 6 registered nurses and 1 nursing assistant on the day shift. Throughout June, the number of patients who occupied these beds were on average 10/11 patients meaning that 4/5 beds were 'empty' and therefore required less staffing than planned. The negative balance of 296 hours (or 93% fill rate) is appropriate as the bed occupancy was lower than expected in June, and the number of nurses required to staff 16 beds was reduced in response to this. There were no lower than expected staffing level incidents reported in June and the correct ratio of nurse to patient was provided. Therefore assurance is given that patient safety was not put at risk and High Dependency Care not compromised.

Ward 34
Ward 34, has 16 beds (6 Bone Marrow Transplant and 10 Oncology/Haematology) and to staff these as planned, if all beds are fully occupied all of the week, plans to roster 7 registered nurses and 1 nursing assistant on the day shift and 6 registered nurses and 1 nursing assistant on the night shift. Ward 34 temporarily reduced its beds from 16 to 14 over the summer months. Throughout June, the number of patients who occupied the 14 beds available were on average 10/11 patients meaning that 3/4 beds were 'empty' and therefore required less staffing than planned for the 14 beds. The negative balance of 803 hours (or 84% fill rate) is appropriate. There were no lower than expected staffing level incidents reported in June and the correct ratio of nurse to patient was provided. Therefore

ID **Governor Name**

assurance is given that patient safety was not put at risk or compromised.

Ward 38
Ward 38 has 22 beds (16 neurosurgery and neurology and 6 neuro rehabilitation) and to staff these as planned, if all beds are fully occupied 7 nights of the week, requires 5 registered nurses and 2 nursing assistants on the night shift. Throughout June, the number of patients who occupied these beds were on average 13/14 patients meaning that 8/9 beds were 'empty'. The negative balance of 278 hours (or 94% fill rate) is appropriate at weekends/weekend nights the number of nurses required is less as some of the rehabilitation patients go home as part of their recovery plan. There were no lower than expected staffing level incidents reported in June and the correct ratio of nurse to patient was provided. Therefore assurance is given that patient safety was not put at risk or compromised.

Status: *Closed*

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159 **Andy Coles-Driver** ***Theme:*** Renewing our hospitals ***Source:*** Governor Direct

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Query **30/08/2016**

There have been discussions about the redevelopment of Trust Headquarters and the staff car park. How is this work to be funded? Will any new car park be for staff and/or patients and visitors?

Division: Trust Services ***Executive Lead:*** *Chief Operating Officer* ***Response requested:***

Response **13/09/2016**

Response updated 19/10/16 following clarification query from Bob Bennett, public governor: 'Will the car park be restricted to patients, visitors and staff or any combination?'

We are currently undertaking a competitive tender exercise to find a private operator to design, build and operate a car park on the site of the existing staff car park. The new car park would provide approx. 680 car parking spaces for patients and visitors only, and we would seek to re-provide the 140 existing staff car parking spaces. Any proposals resulting from the tender exercise would still be subject to planning.

Status: *Closed*
