University Hospitals Bristol
NHS Foundation Trust

Public Trust Board Meeting Papers

Date: 28th September 2017

Time: 11:00 – 13:00

Venue: Conference Room, Trust Headquarters

University Hospitals Bristol NHS Foundation Trust

PUBLIC TRUST BOARD

Meeting to be held on Thursday 28 September 2017, 11.00-13.00, Conference Room, Trust HQ, Marlborough St, Bristol, BS1 3NU

AGENDA

NO.	AGENDA ITEM	PURPOSE	SPONSOR	PAGE NO.
Preliminary Business				
1.	Apologies for absence	Information	*Chairman*	**Verbal**
2.	Declarations of Interest	Information	*Chairman*	**Verbal**
3.	Chairman's Report	Information	*Chairman*	**Verbal**
4.	Minutes of the last meeting	Approval	*Chairman*	**4**
5.	Matters arising and action log	Approval	*Chairman*	**23**
6.	Chief Executive's Report	Information	*Chief Executive*	**24**
7.	Patient Story	Information	*Chief Executive*	**29**
Care and Quality				
8.	Quality and Performance Report	Assurance	*Chief Operating Officer*	**32**
9.	Quality and Outcomes Committee - Chair's Report	Assurance	*Quality & Outcomes Committee Chair*	**87**
10.	Quality and Patient Experience a) Quarterly Complaints Report – Q1 b) Quarterly Patient Experience Report – Q1	Assurance	*Chief Nurse*	**90** **121**
11.	Six-monthly Staffing Report			**149**
Financial Performance				
12.	Finance Report	Assurance	*Director of Finance & Information*	161
13.	Finance Committee Chair's Report	Assurance	*Finance Committee Chair*	**To be tabled**
Items for Information				
14.	Governors' Log of Communications	Information	*Chairman*	**179**
Governance				
15	Transforming Care Report	Information	*Chief Executive*	**184**

NO.	AGENDA ITEM	PURPOSE	SPONSOR	PAGE NO.
Concluding Business				
15.	Any Other Urgent Business	Information	*Chairman*	**Verbal**
21.	Date and time of next meeting **31 October 2017, 11.00 – 13.00, Conference Room, Trust Headquarters**	Information	*Chairman*	**Verbal**

Minutes of the Public Trust Board Meeting

Held on Thursday 28th July 2017, 11:00am-1:00pm, Conference Room, Trust HQ, Marlborough St, Bristol,BS1 3NU

Present
Board Members

Member Name	Job Title/Position
John Savage	Chairman
Julian Dennis	Non-Executive Director
Alison Ryan	Non-Executive Director
Steve West	Non-Executive (Designate)
Madhu Bhabuta	Non-Executive (Designate)
David Armstrong	Non-Executive Director
Jill Youds	Non-Executive Director
Robert Woolley	Chief Executive
Carolyn Mills	Chief Nurse
Mark Smith	Chief Operating Officer/ Deputy Chief Executive
Alex Nestor	Acting Director of Workforce and Organisational Development
Sean O'Kelly	Medical Director
Paul Mapson	Director of Finance and Information

In Attendance

Name	Job Title/Position
Pam Wenger	Trust Secretary
Brenda Dowie	Chaplaincy Team Leader (for Item 3)
Fiona Reid	Head of Communications
Ray Phipps	Patient Governor
Jo Roberts	Staff Governor
Jane Westhead	Staff Governor
Kathy Baxter	Patient Governor
Florene Jordan	Staff Governor
Neil Morris	Patient Governor
Carole Dacombe	Public Governor
Derek Wholey	Patient Governor
David Jamean	Paediatric Registrar
David Wynick	Director of Research
John Rose	Public Governor
Clive Hamilton	Member of the Public

Minutes:

Zainab Gill	Corporate Governance & FOI Administrator

The Chair opened the Meeting at 11:00am

Minute Ref	Item Number	Action
115/07/17	**1. Welcome and Introductions**	
	The Chairman welcomed everyone to the meeting, in particular Madhu Bhabuta and Steve West, who had recently joined the Trust as Non Executive (designates). Apologies for absence were noted from Emma Woollett, John Moore, Lisa Gardner and Guy Orpen. The Board thanked and said goodbye to Sean O'Kelly (Medical Director), who was leaving the Trust to start a new position with NHS Improvement and Alison Ryan who was leaving the Trust for a year's sabbatical.	
116/07/17	**2. Declarations of Interest**	
	There were no declarations of interest.	
117/07/17	**3. Patient Experience Story**	
	The meeting began with a patient story, introduced by Carolyn Mills Chief Nurse. In this story the Board heard from Brenda Dowie (team leader, chaplaincy) she helped the Board to recognise and reflect on the importance of the treatment of spiritual pain. The story drew on an encounter between a UH Bristol Chaplain and a war veteran who had lived with an unresolved issue for many years. The story recognised that, in the face of illness, patients may find the need to resolve long held and unaddressed issues and may use the privacy a hospital affords them to do so. It underlined how compassion, hope, understanding and relationships are crucial elements of the healing process and work hand in glove with more technical aspects of care. This agenda item included the Chaplaincy annual report for 2016-17. The Board were moved by the story they heard from Brenda Dowie and thanked her for attending, and her continued support. The Board asked for assurance around how the service supported diversity. Brenda Dowie explained that the Trust had appointed an Iman (Religious leader), and had close links with key contacts from various faiths for support. The Board congratulated the Trust on their well	

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	supported and successful Chaplaincy service. The Board in particular thanked Brenda Dowie for her hard work over the years and wished her well in the future as she leaves the Trust. **Members RESOLVED to:** • **Receive** the patient story.	
118/07/17	**4. Minutes of the last meeting**	
	The minutes of the meetings held on the 29th June 2017 were agreed as a true and accurate record. Pam Wenger informed the Board that since issuing the minutes that a small number of changes had been noted as follows: - Page 2 (of the minutes), minute ref 102/06/17-replace full stop, with comer, in second paragraph. - Page 3 (of the minutes), minute ref 105/06/17- 3rd paragraph, amend sentence to read "Robert Woolley confirmed to the Board that all hospitals on the estate with cladding had been reviewed, and all materials in the new BRI façade. - Page 4, (of the minutes), minute ref 105/06/17-last paragraph, replace word "and" to "with". - Page 7, minute ref: 107/06/17 (of the minutes)- second paragraph- replace word "from to "them, once surgery is complete…", same paragraph, 11th line remove "in this training". - Page 8- 109/06/17 (of the minutes)-- first paragraph- sentence to read "The Board welcomed the results of the National Inpatient Survey and were pleased to note that UHBristol inpatient's overall rating of their experience in hospital was the top equal to any similar general acute Trust in the country. - Page 10 (of the minutes), minute ref 112/06/17– last paragraph amend type "Robert Woolley" - Page 12 (of the minutes), minute ref 115/06/17- last paragraph amend sentence to read "Paul Mapson explained that CQUINs had been made more difficult nationally and they were now largely related to the system control total. He confirmed that the Trust was looking into renegotiating the CQUINs into something that was more appropriate and achievable." **Members RESOLVED to:** • **Approve** the minutes as a true and accurate record from the meeting held on 29th June 2017 subject to the agreed amendments.	

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119/07/17	**5. Matters arising and Action Log**	
	Members received and reviewed the action log. The progress against completed actions was noted, there were no outstanding actions to review in this meeting. <u>Hospital Cladding</u> Robert Woolley provided a further update in relation to this issue, explaining that on review and consultation there was no requirement for an external contractor to test the cladding directly as the Trust had received sufficient assurance that all buildings on the Trust campus meet fire safety standards. **Members RESOLVED to:** • **Note** the update against the action log.	
120/07/17	**6. Chief Executive's Report**	
	Robert Woolley, Chief Executive, discussed the highlights from the Chief Executive's report and updated the Board on several further matters which were not covered in the report: Robert Woolley informed that Board that sadly Dr Angela Jones who was a consultant radiologist at the Trust for many years had passed away after a long illness. <u>Weston Area NHS Trust</u> Robert Woolley provided an updated to the Board in relation to the continuing discussions and collaboration with Weston Area NHS Trust as part of the Partnership Agreement. It was noted that a Board to Board meeting was held in July and that the Partnership Programme Board was working well. Robert Woolley confirmed that the Programme Board had responsibility for overseeing a work programme that consolidates joint working in a number of specialities across both Trusts, largely relating to clinical services. Both Boards confirmed their commitment to this Partnership. Both Trusts continued to work on plans for joint working which including exploring a number options including a potential merger by acquisition. The Board noted that no decision had been made to date and that further discussions were in progress with the Regulators and the Commissioners. The Board noted that the Trust had been responding well to the impact of the Weston Are Health ED department closure.	

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	Medical Director Interviews Robert Woolley reported to the Board that following the recent Medical Director interviews the Trust was not yet in a position to make an announcement and that they were anticipating coming to a decision early next week. Emergency Department Safety Checklist Robert Woolley reported to the Board that the emergency department safety checklist had won a further award from the West of England Academic Health Science Network (AHSN). It was noted that with the support of the West of England AHSN, this tool had been adopted by all seven EDs in the region, spanning six trusts and the ambulance service, in order to address the shared challenge of ensuring patient safety during periods of crowding. In additional to the above updates, Robert Woolley confirmed that the academic health science network would be licenced for a further 7 years. **Members RESOLVED to:** • **Receive** the Chief Executive report for information.	
121/07/17	**7. Board Assurance Framework (Quarter 1)**	
	Members received the Board Assurance Framework setting out the key risks to delivery of the Trust's strategic objectives. There were no changes of significance to note. The Board noted that the Board Assurance Framework had been reviewed in detail at the Audit Committee and Quality and Outcomes Committee before submission to Trust Board. David Armstrong thanked Pam Wenger on the development of the Board Assurance Framework and stated that this format and content was much clearer in aligning the strategic priorities against the operational priorities and risks to delivery. He suggested that it was important to review the operational plan that was signed off by the Board and to receive progress against the delivery of the agreed objectives in the plan. **Members RESOLVED to:** • **Receive** the Board Assurance Framework 2016/17 (Quarter 1) for assurance; and • **Agreed** to receive an update against the progress of the operational plan.	

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122/07/17	**8. Research and Innovation Quarterly Report**	
	Sean O'Kelly introduced the report and David Wynick provided an overview of the key achievements in the last quarter. Highlights from the report were as follows: • The Trust had a further improvement of its closed commercial trials achieving 55% (from 47% previous quarter). • Performance in achieving the 70 day benchmark has decreased this quarter following the introduction of HRA approval instead of NHS permission. • The Trust has modelled their predicted weighted recruitment for 2017/18 financial year. • The clinical trials that took place in relation to juvenile arthritis had proven so successful that they had been stopped early, to ensure that the drug was made available to patients in the placebo group. David Wynick explained that NICE had approved the Drug and it had been licensed for usage. The Board were pleased to note that from the start of the study to completion it had taken only 5 years, which was remarkable in terms of trialling and licencing drugs. Jill Youds asked for clarity around the priorities section on page 2(of the report) which stated that "Focus attention on optimising our performance in delivering research to time and target, for both commercial and non-commercial trials." David Wynick explained that this related to the total number of patients being recruited into trials, which would be slightly lower than previous year and would have an effect on income, over the last few years trials had become more complex and smaller. The Board noted that this would mean that the all trials would need to be supported by the Trust. Robert Woolley advised the Board that Tony Gallaghar, Chair of the Genomics Medicine Centre (GMC) which UHBristol hosts had resigned and that his successor was being recruited. He thanked Tony Gallagher for the contribution he had made as Chair of the GMC. **Members RESOLVED to:** • **Receive** the Research and Innovation Report for assurance.	

Minute Ref	Item Number	Action
123/07/17	**9. Quality and Performance Report** Members agreed to take item 9 and 10 together.	
	Mark Smith, Chief Operating Officer and Deputy Chief Executive presented this report. It was noted that challenges remain in restoring performance against the national access standards due to high levels of demand across a range of services. However, performance against the A&E 4-hour standard continued to improve and remained above the Trust's recovery trajectory. Although the recovery trajectory for the Referral to Treatment (RTT) time standard continued to not be met in the month, the number of over 18 week waiters reduced in the period, as did the total number of ongoing RTT pathways. Mark Smith provided assurance in terms of the work taking place in and around the Trust to help improve the target, included "breaking the cycle week" and the working being taken forward by the urgent care programme. *Members noted:* • Performance against the 62-day GP cancer standard remained below the 81% trajectory for the quarter, due to the continuing critical care bed pressures and elective capacity constraints. • Although there was a small deterioration in performance against the diagnostic 6-week wait standard, the Trust performed above the recovery trajectory and is on track to report a further improvement in performance next month. • The number of patients seen for a new outpatient appointment remained above last year's levels. However, this was not sufficient to offset a 16% increase in new outpatient referrals received in June, relative to the same period last year. • As a result, for the first time since May 2016, there was a significant rise in the size of the outpatient waiting list. In contrast, the size of the elective waiting list showed the normal seasonal decrease, although remains significantly above the same period last year. Despite this, the number of patients on ongoing RTT pathways decreased in the month, as did the number of patients waiting over 18 weeks for treatment. • The overall level of emergency admissions into the Bristol Children's Hospital (BCH) in June was similar to the same period last year. The BCH performed well above the national A&E 4-hour 95% standard, at 97.1%. The number of emergency admissions into the BRI was 15.3% higher than June last year, and 4.6% above the levels reported last month. • There was a further 5% improvement in 4-hour performance at the BRI relative to May. This improvement in performance was despite bed occupancy remaining high.	

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	• There were improvements in a number of the headline measures of quality that sit within the Trust Summary Scorecard in the month, reversing the deteriorations seen last month. This included the Safety Thermometer measure of No New Harms and the Non-purposeful Omitted doses of Critical Medication being restored to a Green rating. Other noteworthy improvements in performance against Quality metrics included the highest reported performance against the WHO Surgical Checklist since October 2016. • The improved performance against the metric for patients who have sustained a fractured neck of femur going to theatre within 36 hours was maintained, with performance reported at 85% against the 90% national standard. The Trust's Performance against the fracture neck of femur metrics continues to be the focus of significant attention. Jill Youds commented on the action plan in relation to neck of femur and felt that although the action plan was detailed, there were little up to date updates on the plan. The Committee noted that they the Quality and Outcomes Committee would receive a further update from the clinical chair on this target at the next quarterly review. • Challenges also remain in maintaining the improvements seen in some of the workforce metrics in recent months. The headline changes in workforce metrics this month include the rise in agency usage, which reflects the rises in sickness and vacancies rates. The current recruitment strategy for the Trust was discussed in some detail and assurance was provided by the various approaches that the Trust had taken as part of the 'Love Life Love Bristol' Strategy; and whilst the level of dissatisfied complaints reported was above target, assurance was provided that all dissatisfied cases are reviewed for learning. Sean O'Kelly updated the Board on the sepsis target, which was a new feature in the report. He explained that the figures showed an improvement, however there was working going on in the Trust to meet the guidance and main it, whilst ensuring that the Trust is working within the correct perimeters. Carolyn Mills highlighted the patient falls target to the Board, she assured the Board that the patient fall target was being thoroughly investigated to understand reasons for falls and ensure learning is understood. Members noted that whilst the dissatisfied complainants had also increased, processes were in place to review these and the progress was being closely monitored by the quality and Outcomes Committee.	

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	The Board congratulated the Trusts performance in responding to the impact of the overnight A&E closure of Weston Area Hospital. Mark Smith commented on the Trusts systematic approach to the closure, the preparation and engagement of all the Divisions had contributed to the performance. **Members RESOLVED to:** • **Receive** the Quality and Performance Report for assurance. •	
124/07/17	**10. Quality and Outcomes Committee Chair's Report** Members agreed to take item 9 and 10 together.	
	Members received a written report following the meeting of the Quality and Outcomes Committee held on the 28th July 2017. Members also received a verbal account of the meeting held on the 28th July 2017 from Alison Ryan, Non-executive Director and Chair of the Quality and Outcomes Committee (QoC). **Members RESOLVED to**: • **Receive** the Quality and Outcomes Committee Chair's Report for assurance.	
125/07/17	**11. Independent Review of Children's Cardiac Services progress report**	
	The Board received a progress report relating to the recommendations from the Independent Review of Children's Cardiac Services and a CQC expert review of clinical outcomes of the service published on 30 June 2016. The key highlights from the report were that the July 2017 Steering Group approved the closure of a further recommendations and there were two outstanding recommendations remaining, relating to Management of follow up appointments and risk assessment of cancellations .The Board would receive a final report on the delivery of the recommendations at the October meeting of the Trust Board. This will detail ongoing assurance work planned. **Members RESOLVED to:** • **Receive** the Independent Review of Children's Cardiac Services progress report.	

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126/07/17	**12. Equality and Diversity Annual Report 2016/17**	
	The Board received the Equality and Diversity annual report 2016/17, the report formed part of the Trust's compliance with the Public Sector Equality Duty. It provided an update on progress against achievement of the Trust's Strategic Equality & Diversity Objectives for 2016-2019, progress in relation to regulatory requirements and d emographic information about staff and patients. Members noted in particular the work undertaken between Public Health England staff, the TB nurses at Bristol Community Health and the Trust TB team together with the Find & Treat team, to try to evaluate the amount of "hidden" TB in the homeless. Jill Youds asked for assurance around the focus of the organisation on equality and diversity and the impact changes were having. Alex Nestor explained that there was on-going work required to help raise the profile of quality and diversity across the Trust. David Armstrong asked for clarity around the process of the report, and why it was reviewed at so many different committees, Alex Nestor advised that this was part of raising the profile of the report and also the agreed governance arrangements for the Trust. **Members RESOLVED to:** • **Receive** the Equality and Diversity Annual Report for assurance.	
127/07/17	**13. National Staff Survey Results 2016**	
	The Board received the report, which was to formally share the results of the 2016 staff survey and highlighted a number of key areas as set out below: • It provided a summary of the Staff Survey Results 2016 against both the National and Acute average • Highlights the key improvements made from 2015 • Presents the top 5 improvement areas and bottom 5 ranked scores, which included improvement in staff engagement and the friends and family recommendation. • Key Priorities for 17/18	

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	Jill Youds congratulated the team for the demonstrable improvement shown in the results of the survey. She asked what steps were needed to improve engagement. Alex Nestor explained that additional momentum was needed as well as the improvement of quality of appraisals. She explained that the Happy App had helped to address "local" actions and deal with these directly. The Board noted that that target relating to physical violence in the Trust, included staff on staff violence and violence experienced from patients. **Members RESOLVED to:** • **Receive** the National Staff Survey Results 2016 for assurance.	
128/07/17	**14. Speaking Up Annual Report 2016/17**	
	The Board received the Speaking Up Annual Report, which provided an overview of the work that had been progressed during the year since the appointment of the Freedom to Speak Up Guardian. The Board noted that the report had already been reviewed at the Audit Committee and the Quality Assurance Committee in depth and that the Audit Committee would receive regular updates. The Committee were pleased to note the progress made in relation to speaking up and that the Trust had begun to identify key advocates across the Trust to help implement this and encourage staff to engage. The next year would be spent on raising the profile in the Trust and embedded into existing systems and processes including induction training. Members noted that the National Guardian Office had developed a national policy and the Trust was working on progressing the review of the current policy to align with national requirements. **Members RESOLVED to:** • **Receive** the Speaking Up Annual Report 2016/17 for assurance.	
129/07/17	**15. Medical Revalidation Annual Report 2016/17**	
	The Board received the report, which was to inform the Board of Directors that Medical Revalidation processes are operating satisfactorily. The report summarised the last years activity. Key issues to note from the report were: • Revalidation of a doctors' licence to practice has now been operational for four years and 486 Doctors have been revalidated in that period.	

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	• 31 recommendations of revalidation were made in 2016/2017. 6 doctors were deferred. The reasons for deferral are outlined in the full report. • NHSE performed a Higher Level Responsible Officer Quality Review (HLROQR) in April 2016 which was deemed favourable and an action plan was agreed and implemented. • The contract with Premier IT for the e-portfolio system (PReP) for appraisal was extended through a single tender action for 2 years at a cost saving of £6300 for 2016/2017 and £12600 for 2017/2018. In early 2018 UHBristol will go out to tender for renewal of the e-portfolio system. • A new Assistant Medical Director in Revalidation, was appointed and took up post from 1st June 2016 **Members RESOLVED to:** • **Receive** the Medical Revalidation Annual Report 2016/17 for assurance.	
130/07/17	**16. Safeguarding Annual Report 2016/17**	
	The Board received the safeguarding annual report, which was to both provide assurance and evidence that the Trust was fulfilling its statutory responsibilities to safeguard adults, children and young people. Carolyn Mills explained that the annual report provided an overview of key activity, achievements, risks and the mitigations in place, across all areas of service delivery, for safeguarding adults, children and young people. This report reviewed the Trust's progress on meeting national and local priorities. The highlights from the report included: • The increase in safeguarding activity continues, particularly in relation to children's safeguarding and Deprivation of Liberty Safeguards applications for adults. • The robustness of the Trust's safeguarding governance arrangements which were led by the Safeguarding Steering Group chaired by the Chief Nurse and the children's team of safeguarding professionals.	

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	• There risks in relation to safeguarding adults and children and assurance that these are monitored by the Safeguarding Steering and Operational Groups; and • Objectives to support activities and outline further improvements in safeguarding of adults, children and young people within the Trust, are detailed in the Safeguarding work and audit plans for 2017/18 **Members RESOLVED to:** • **Receive** the Safeguarding Annual Report 2016/17 for assurance.	
131/07/17	**17. Infection Control Annual Report 2016/17**	
	The Board received the report for assurance that the Trust was maintaining Infection Prevention and Control in line with the Health and Social Care Act. Key issues to note were achievement of local CQUIN and the roll out of the start of the Surgical Site Infection Surveillance Programme. Carolyn Mills brought to the Board attention, the error on page 308 which mentioned 5 risks however only listed 4, the risk which was missing related to laboratory information and FFP training. Assurance in relation to these risks had been provided in the Quality Outcomes Committee. **Members RESOLVED to:** • **Receive** the Infection Annual Report 2016/17 for assurance.	
132/07/17	**18. Education and Development Annual Report 2016/17**	
	Members received the Education and Training Annual Report 2016/17. The report described the high level context and background to how UH Bristol delivered against its education and teaching priorities during 2016/17. The report demonstrated that there were a vast number of education and teaching programmes delivered across the Trust to ensure the experience of all our learners and staff is of high quality and contributes to providing exceptional care for patients.	

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	The Board were pleased to note that learner satisfaction had remained high for 2016/17 and external regulatory assessment visits have been extremely positive with excellent feedback. The Education, Learning and Development delivery plan for 2017/18 had been developed by education/professional leads with the support of and endorsement from the Executive Director with relevant accountability for the various professional staff groups. Members noted in particular the progress that had been made in relation to Apprenticeship Schemes and received assurance that the process was being embedding across the Trust, with the appointment of an Apprenticeship lead. **Members RESOLVED to:** • **Receive** the Education and Training Annual Report 2016/17 for assurance.	
133/07/17	**19. Finance Report** **(The Board agreed to take questions for item 19 and 20 together.)**	
	Paul Mapson, Finance Director presented the Finance Report. It was noted that the summary income and expenditure statement (appendix 1) showed a deficit for the period to the end of June 2017 (before technical items) of £0.070m. The position is therefore adverse to plan by £0.291m. The Trust's Operational Plan for June is a surplus of £0.221m (before technical items). After technical items the planned deficit is £0.169m and the actual deficit is £0.112m. **Members RESOLVED to:** • **Receive** the Finance Report for assurance.	
134/07/17	**20. Finance Committee Chair's Report** **(The Board agreed to take questions for item 19 and 20 together.)**	
	Members received reports from the meetings of the Finance Committee held on 24th July 2017. Members also received a verbal account of the meeting held on the 24th July 2017 from Jill Youds, Non-executive Director covering the following key areas: The Divisional Financial Reports- The unexpected deterioration in	

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	the month, related to three key issues including: nursing position, medical staffing and activity underachievement in the Women's and Children's Division. Assurance was provided that controls were in place in relation nursing and that a review of the current controls for medical staffing was required. Detailed recovery plans from divisions were to be received at the next Finance Committee meeting. And this item was discussed in some detail at the meeting. • The Committee had received detail around the financial challenges and pressures within the Divisions. Assurance was provided that work was being progressed in refreshing the Trust's Performance Management Framework which would provide clear accountability and escalation in relation to the delivery of the Divisional Operating Plans. - The Committee had an update on the progress towards delivering the Trust's Cost Improvement Target for 2016/17. For month ending June 2017, the Trust has achieved savings of £2.328m against a plan of £2.818m, leaving a shortfall of £0.490m. - The Committee had received The Divisional Financial Reports which were received, and it was noted that the Clinical Divisions and Corporate Services are £1.147m adverse to plan. **Members RESOLVED to:** • **Receive** the Finance Committee Chair's report for assurance.	
135/07/17	**21. Audit Committee Chair's Report**	
	Members received report from the meeting of the Audit Committee held on the 11th July 2017. Julian Dennis provided an update from the meeting on behalf of John Moore. The following key issues were noted: - The Committee had received an follow up report in relation to Estates and Facilities and agreed to receive a report at the next Audit Committee in relation to the actions to address the outstanding recommendations and to adopt best practice in relation to procurement. - The Committee had received annual report in respect of counter	

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	fraud activity during 2016/17. The report provided evidence of the Trust's compliance with NHS Protect's Fraud, Corruption and Bribery standards for provider organisations. - The Committee had received the draft Risk Management Strategy 2017/18 which had been updated following the Board Seminar in June 2017. - The Committee had received the forward plan for 2017/18 and quarter one update on the progress against the plan during the 2017/18 financial year. **Members RESOLVED to:** • **Receive** the Audit Committee Chairs Report for assurance.	
136/07/17	**22. Risk Management Strategy**	
	The Board received the revised Strategy, which presented a high-level strategic statement on the management of risk, including the Risk Appetite statement to be considered by the Board. The Risk Management Strategy had been approved for submission by the Risk Management Group, Audit Committee and Senior Leadership Team in July 2017. The Board approved the Risk Appetite Statement and the Risk Management Strategy. **Members RESOLVED to:** • **Approve the** Risk Appetite Statement and the Risk Management Strategy. .	
137/07/17	**23. Transforming Care Report**	
	Members received the report, which was to update Trust Board on progress with Trust wide programmes of work under the Transforming Care programme. The report highlighted the progress over the last quarter and the next steps, including the positive actions taking place to address leadership behaviours. **Members RESOLVED to:** • **Receive** the Transforming Care Report for information.	

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138/07/17	**24. Congenital Heart Disease Network Annual Report**	
	The Board received the Congenital Heart Disease (CHD) Network Annual Report, which set out the key achievements of the network in its first year of operation, the key priorities for future years, and identifies risks to the delivery of NHS England's CHD standards It was noted that the Congenital Heart Disease (CHD) standards were agreed by NHS England in July 2015 mandating that all CHD care be delivered through formal networks. The South Wales and South West Congenital Heart Disease Network was established in April 2016. Members received assurance that the Network funding had been agreed by the Trust. **Members RESOLVED to:** • **Receive** the Congenital Heart Disease Network Annual Report for information.	
139/07/17	**25. Clinical Research Network Annual Report**	
	Members received the Annual Report 2016/17 and the Annual Plan 2017/18 for the Clinical Research Network: West of England Annual Report 2016/17 and Annual Plan 2017/18 as the host organisation. It was noted that the report had been approved in principle by the National Institute of Health Research (NIHR), Clinical Research Network, Coordinating Centre (CRN CC). A review of progress against the report was completed on the 29 June 2017. **Members RESOLVED to:** **Receive** the Clinical Research Network Annual Report for assurance.	
140/07/17	**26. Governors' Log of Communications**	
	The report provided the Board with an update on governors' questions and responses from Executive Directors. **Members RESOLVED to:** • **Note** the Governors' Log of Communications.	
141/07/17	**27. Changes to UH Bristol Constitution**	
	Pam Wenger presented the report and informed the Board of the minor changes to the Constitution that have been reviewed by the Constitution Focus Group.	

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	Members agreed to support the changes to the Constitution which included: **<u>Non-executive Director Designate role</u>** – to add further clarity to the role, an additional point to be added to the section on Board of Directors – Composition, to follow 25.2.3 on p. 14, to read: **'***25.2.4 Non-executive Directors (Designate) will attend Board of Director meetings and relevant Committee meetings playing an active role by providing advice and appropriate challenge across the range of Trust healthcare services and supporting business areas. However, Non-executive Director (Designates) are not formally appointed as a board member and should circumstances arise, will not be eligible to vote.'* **<u>Appointed Governor Voluntary & Community Sector</u>** – in lieu of an appropriate and equitable appointing body it is recommended that the role is removed from the Constitution. Engagement with the voluntary and community sector will continue via other stakeholders internal and external to the Trust. *Remove reference to the Voluntary & Community Sector role in Annex 4, p. 27.* The Board agreed to approve the changes and noted that the changes to the constitution would be considered at the meeting of the Council of Governor that afternoon. **Members RESOLVED to:** • **Receive** the Changes to UH Bristol Constitution for approval.	
142/07/17	**28. Any Other Business**	
	Carole Dacombe, Public Governor asked for her support to be noted in relation to the chaplaincy service and suggested that a strategic view was required to support the service. John Rose, Public Governor- suggested including a "how do we feel" refection after every Board meeting, Robert Woolley advised that the current feeling of the Trust was "proud of plenty and plenty to improve on, in areas such as quality, operational, performance, financials.	
143/07/17	**29. Date of Next Meeting**	

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	28th September 2017, 11:00am-1:00pm, Conference Room, Trust HQ, Marlborough Street, Bristol, BS1 3NU.	

Chair's Signature: ..... Date: .....

University Hospitals Bristol
NHS Foundation Trust

Public Trust Board of Directors meeting
28 September 2017
Action tracker

Outstanding actions following meeting held in June 2017					
No.	**Minute reference**	**Detail of action required**	**Responsible officer**	**Completion date**	**Additional comments**
1.	**91/05/17**	**Independent Review of Children's Cardiac Services progress report** **Receive** the closure report in September 2017 and invite the Divisional Director and the families to the meeting.	Chief Nurse	October 2017	**Work in Progress.** The final report will not be available until October, therefore added to the agenda plan for October 2017.
2.	**115/06/17**	**Finance Chairs Report** Schedule a session on CQUINS at a Board Seminar.	Trust Secretary	September 2017	**Work in Progress.** To be added to the Board Development Programme.
3.	**121/07/17**	**Board Assurance Framework (Q1)** Receive an update against the progress of the Operational Plan	Trust Secretary	September 2017	**Completed** The Board Assurance Framework has been aligned to the operational priorities as agreed within the Operational Plan. Updates will be included in the quarterly report on the Board Assurance Framework to the Board.

Cover report to the Public Trust Board. Meeting to be held on 28 September 2017 at 11.00 – 13.00, Conference Room, Trust HQ, Marlborough St, Bristol, BS1 3NU

		Agenda Item	6
Meeting Title	Public Trust Board	**Meeting Date**	Thursday, 28 September 2017
Report Title	Chief Executive Report		
Author	Robert Woolley, Chief Executive		
Executive Lead	Robert Woolley, Chief Executive		
Freedom of Information Status		Open	

Strategic Priorities (please choose 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 5: We will provide leadership to the networks we are part of, for the benefit of the region and people we serve.	☐
Strategic Priority 2: We will ensure a safe, friendly and modern environment for our patients and our staff.	☐	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 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.	☐
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> To report to the Board on matters of topical importance, including a report of the activities of the Senior Leadership Team. <u>Key issues to note</u> The Board will receive a verbal report of matters of topical importance to the Trust, in addition to the attached report summarising the key business issues considered by the Senior

Leadership Team in August and September 2017.
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	**Finance**	**Quality and**	**Remuneration**	**Other (specify)**

Committee	Committee	Outcomes Committee	& Nomination Committee	

SENIOR LEADERSHIP TEAM

REPORT TO TRUST BOARD – SEPTEMBER 2017

1. INTRODUCTION

This report summarises the key business issues addressed by the Senior Leadership Team in August and September 2017.

2. QUALITY, PERFORMANCE AND COMPLIANCE

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

The group **received** an update on the financial position for 2017/2018.

3. STRATEGY AND BUSINESS PLANNING

The group **approved** the approach to business planning and proposed timings for the Operating Planning Process 2018/2019, noting that further national guidance was pending which may require changes to the proposed content or timing.

The group received a briefing on nursing pay controls and **supported** a proposal on the use of high cost, off framework nursing agency use, which would inform wider discussion and decision making across Bristol North Somerset and South Gloucestershire.

The group **supported** a proposal to be put forward to commissioners for an enhanced intravenous therapy service in collaboration with Bristol Community Health.

4. RISK, FINANCE AND GOVERNANCE

The group received an update on the recent nomination progress for Freedom to Speak Up Advocates and **approved** terms of reference for the Network.

The group **approved** the Quarter 1 Complaints Report for onward submission to the Quality and Outcomes Committee and Trust Board.

The group **approved** the Quarter 1 Patient Experience and Involvement Report for onward submission to the Quality and Outcomes Committee and Trust Board.

The group **approved** the Workforce Race Equality Standard Progress Report 2016/2017 for onward submission to the Quality and Outcomes Committee and Trust Board.

The group **noted** an update on recent developments and activity related to the pathway issues across primary and secondary care.

The group **received** an update on clinical engagement with the procurement consortium to reduce spend and costs of procurement.

The group **approved** revision of the Trust's Standard Operating Procedures for the signature and application of the Trust Seal to documents.

The group **approved** revised terms of reference for the Senior Leadership Team and Service Delivery Group.

The group **noted** an update on the patient catering services, providing assurance of the plan to align patient catering services to national productivity and skill mix.

The group **received** five medium impact Internal Audit Reports in relation to Cancer Performance Improvement Plan, Workforce Planning, Business Continuity and Emergency Planning and Payroll and one low impact report in relation to Patient Safety Improvement Programme.

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

The group **received** an update on the Register of External Agency Visits, Inspections and Accreditations.

Reports from subsidiary management groups were **noted,** including updates on the current position following the transfer of Cellular Pathology to North Bristol NHS 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
September 2017

Cover report to the Public Trust Board meeting to be held on Thursday, 28 September 2017 at 11.00 am -1.00 pm in the Conference Room, Trust HQ, Marlborough St, Bristol, BS1 3NU

		Agenda Item	3
Meeting Title	Public Trust Board	**Meeting Date**	Thursday, 28 September 2017
Report Title	Patient Story		
Author	Tony Watkin, Patient and Public Involvement Lead		
Executive Lead	Carolyn Mills, Chief Nurse		
Freedom of Information Status		Open	

Strategic Priorities (please chose 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 5: We will provide leadership to the networks we are part of, for the benefit of the region and people we serve.	☒
Strategic Priority 2: We will ensure a safe, friendly and modern environment for our patients and our staff.	☐	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 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.	☐
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

Tariq is a resident of south Bristol. He has a range of complex health needs and is a patient at UH Bristol where he accesses cardiac services. He is also a patient with North Bristol NHS Trust (NBT) where he travels on public transport to attend a vascular clinic. He is an active member of the Bristol Jamia Mosque, Dhek Bhal Elderly Men's Group for the over 50 and has recently joined Bristol Community Health (BCH) as a volunteer with their new community navigator service. He is married to Rawshan, who receives care at the Bristol Eye Hospital, and has two daughters both of whom are on track to develop careers in health care.

In this story, Tariq will talk about how his health conditions impact on his life and his experiences of the care he receives both from UH Bristol and NBT as part of his care package. He will touch on some of the challenges that receiving care across two sites presents and will share reflections on the relationship between the South East Asian community and our hospitals. Tariq will end by talking about the support he receives from his community and why it is important to him that he contributes to health care initiatives that benefit others.

By way of context, Dhek Bhal is a voluntary sector organisation dedicated to promoting the health and social well-being of South Asian people living in Bristol & South Gloucestershire through a range of services.

The BCH Community Navigator Service is a new signposting and support service for older people in south, east and central Bristol.

Recommendations

Members are asked to:

- Note the patient story

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 s ustain an engaged and effective workforce.	☐
Failure to enable and s upport 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 del ivery 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)**

Cover report to the Public Trust Board. Meeting to be held on 28 September 2017 at 11.00 – 13.00, Conference Room, Trust HQ, Marlborough St, Bristol, BS1 3NU

		Agenda Item	8
Meeting Title	Public Trust Board	**Meeting Date**	Thursday, 28 September 2017
Report Title	**Quality and Performance Report**		
Author	James Rabbitts, Head of Performance Reporting Anne Reader, Head of Quality (Patient Safety) Alex Nestor, Interim Director of Workforce & Organisational Development		
Executive Lead	Overview and Access – Mark Smith, Deputy Chief Executive and Chief Operating Officer Quality – Carolyn Mills, Chief Nurse and Sean O'Kelly, Medical Director Workforce – Alex Nestor		
Freedom of Information Status		Closed	

Strategic Priorities **(please choose 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 5: We will provide leadership to the networks we are part of, for the benefit of the region and people we serve.	☐
Strategic Priority 2: We will ensure a safe, friendly and modern environment for our patients and our staff.	☐	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 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.	☐
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> 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.

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)**
		26th September 2017		

University Hospitals Bristol NHS
NHS Foundation Trust

Quality & Performance Report

September 2017

Executive Summary

Single Oversight Framework
None of the four measures were achieved. The measure for percentage of A&E patients seen in less than 4 hours did achieve the Sustainability and Transformation Fund (STF) target of 90% for July and August but not the national 95% standard. The measure for percentage of GP Referred Cancer patients seen within 62 days did not achieve either the national standard or the STF trajectory for Quarter 1 or July. Similarly the measure for the percentage of Referral To Treatment (RTT) patients waiting under 18 weeks did not achieve the national 92% standard or the recovery trajectory for end of August.

The percentage of Diagnostic patients waiting under 6 weeks at month end did not achieve the national 99% standard. The recovery trajectory has been re-calculated to show a delivery of the 99% standard by December (as opposed to September in the current trajectory). This is due to changes in Sleep Studies and Cardiac CT capacity. There is also an issue regarding unplanned transfer of ultrasound work from the Musculoskeletal Assessment and Treatment Service (MATS).

There is a continuing weekly review of management of longest waiting patients through RTT Operations Group, a refresh of the Trusts' capacity and demand modelling through the NHS Interim Management and Support ("IMAS") Model and a focus on chronological booking.

Two Contract Penalty Notices (CPNs) has been issued by Bristol Clinical Commissioning Group (CCG). One is regarding the Trust's level of RTT patients waiting 52+ weeks at month-end and the other regarding Cancer 62 Day performance. Responses and recovery plans are being developed.

Headline Indicators
Performance CDiff Cases, Medication Errors, Early Warning Scores and Patient Experience remain consistently above target. The Safety Thermometer measure of New Harms fell below the target level in August but it was not a significant deterioration and has been above target consistently for previous year. The Heart Reperfusion measure (90 minute "Door To Balloon Time) fell below the 90% threshold in August but only by less than 3% and the measure has been consistently achieved since January. The latest Summary Hospital Mortality Indicator (SHMI) has been released for 12 month period April 2016 to March 2017. It is at 97 showing the Trust with fewer deaths than expected.

Last Minute Cancelled (LMC) Operations remain slightly above the required threshold of 0.8% of admissions. However for the last three months, number of LMCs has been sustained below 62 per month which is the lowest level since December 2016. Also the 28 day readmission standard was achieved in August for a second month. The level of patients outlying also remains below planned levels.

Length of Stay increased in August and is above plan. The total number of Green to Go (delayed discharge) patients in hospital is over double the jointly agreed planning assumption of 30 patients. The number of 14-day stays has increased and remains above the level required to maintain effective flow. Outpatient Hospital Cancellation Rates remain static. Work is being undertaken through Productivity and Efficiency Groups to assess if there are productivity opportunities in these areas.

Workforce measures remain Red or Amber rated this month. Agency Usage, Sickness and Turnover all reduced in August, but not enough to achieve the required Green threshold. Vacancy levels have remained static.

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
(March 2017)

	Safe	Effective	Caring	Responsive	Well-led	Overall
Urgent & Emergency Medicine	Good	Outstanding	Good	Requires improvement	Outstanding	Good
Medical care	Good	Good	Good	Good	Good	Good
Surgery	Good	Good	Outstanding	Good	Outstanding	Outstanding
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 & Diagnostic Imaging	Good	Not rated	Good	Good	Good	Good
Overall	Good	Outstanding	Good	Requires improvement	Outstanding	**Outstanding**

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	Mortality rate (within 30 days)	Food choice & Quality
BCH	5 stars	OK	OK	✓ 98.5%
STM	4.5 stars	OK	OK	✓ 98.4%
BRI	4 stars	OK	OK	✓ 96.5%
BDH	3 stars	OK	OK	Not available
BEH	4.5 Stars	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.

NHS Improvement Single Oversight Framework

For the latest month reported (i.e. August for A&E, RTT and 6-weeks, and July for 62-day GP) the Trust failed to achieve the national standard in all four of the Single Oversight Framework (SOF) measures.

However, the Sustainability & Transformation Funds (STF) trajectory of 90% was achieved for the A&E 4 hours standard. However the STF trajectory for the 62-day GP cancer standard was not achieved. For the 6-week diagnostic standard, the Trust did not achieve the recovery trajectory of 98.8%. The Referral to Treatment (RTT) performance remains below the national standard and the recovery trajectory.

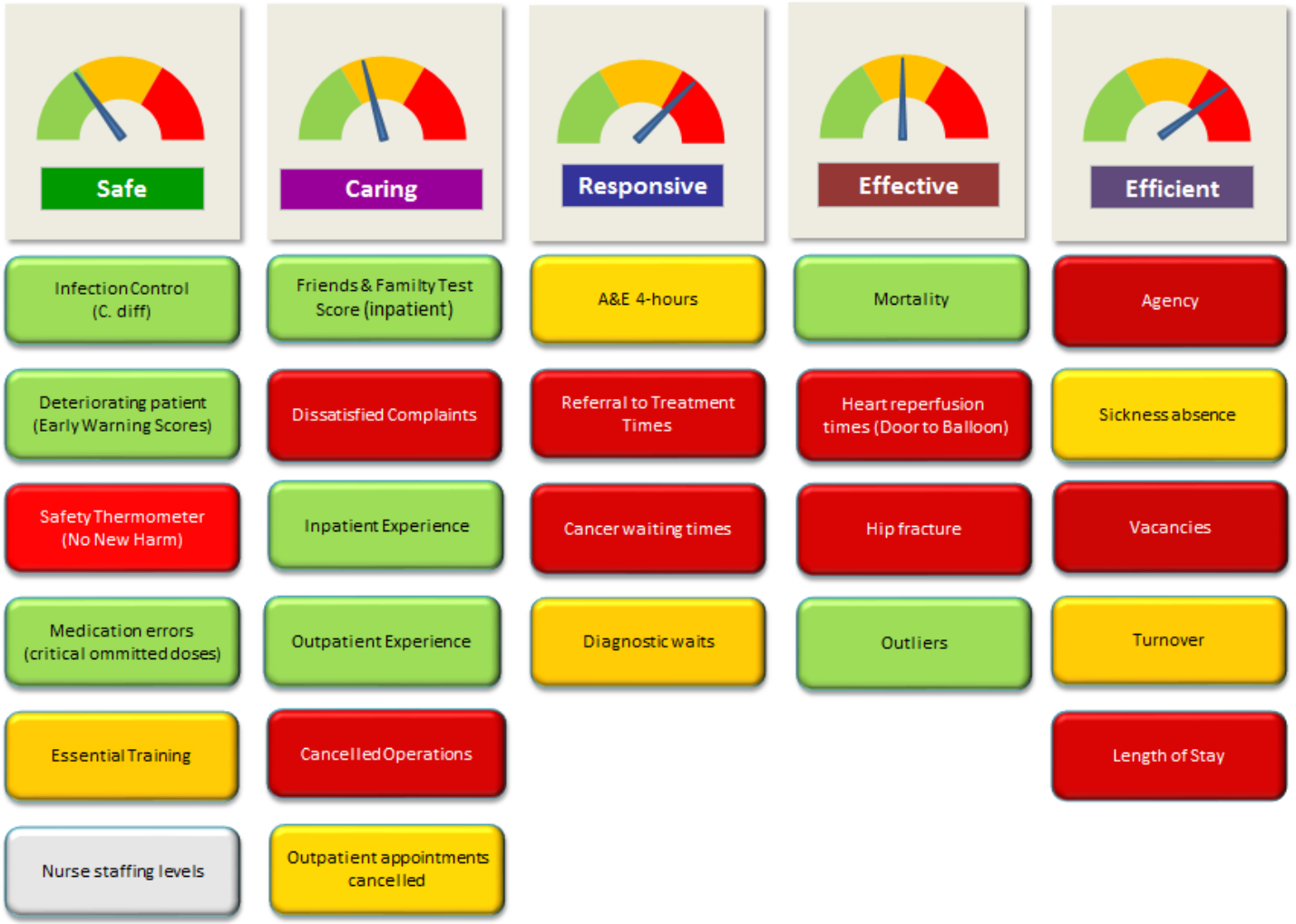
Access Key Performance Indicator		Quarter 4 2016/17			Quarter 1 2017/18			Quarter 2 2017/18		
		Feb 17	Mar 17	Dec 16	Apr 17	May 17	Jun 17	Jul 17	Aug 17	Sep 17
A&E 4-hours	Actual	80.4%	80.7%	83.3%	82.3%	84.2%	87.9%	90.5%	91.3%	
	STF trajectory	88.5%	87.4%	91.0%	82.5%	83.5%	85.0%	90.0%	90.0%	90.0%
62-day GP cancer	Actual	84.3%	78.8%	81.2%	76.5%	77.8%	81.7%	74.7%		
	STF trajectory	83.6%	85.7%	85.9%	81.0%	81.0%	81.0%	83.6%	83.6%	83.6%
Referral to Treatment Time (RTT)	Actual	92.2%	92.0%	91.1%	91.1%	91.1%	91.0%	90.2%	89.9%	
	STF trajectory*	92.8%	92.8%	93.0%	92.0%	92.0%	92.0%	92.0%	92.0%	92.0%
6-week wait diagnostic	Actual	98.4%	98.7%	98.7%	98.6%	98.8%	98.6%	98.5%	97.6%	
	STF trajectory*	99.2%	99.2%	99.2%	99.0%	99.0%	99.0%	99.0%	99.0%	99.0%

*minimum requirement for securing Sustainability & Transformation Funds (STF) is achievement of the national standard

GREEN rating = national standard achieved
AMBER rating = national standard not achieved, but STF trajectory and/or recovery trajectory (where agreed) achieved
RED rating = national standard not achieved, the STF trajectory not achieved, and the recovery trajectory (where agreed) not achieved

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:

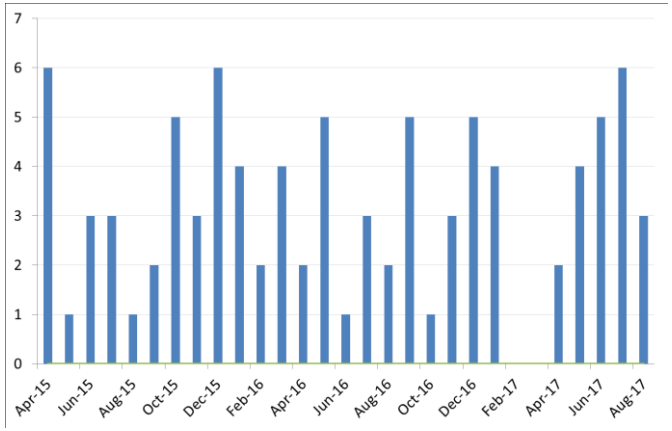
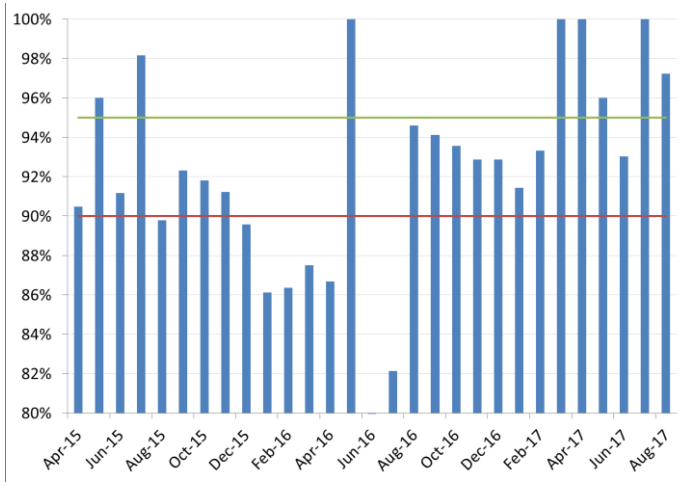
GREEN to RED
Safety Thermometer (New Harms)
Heart Reperfusion
Length of Stay

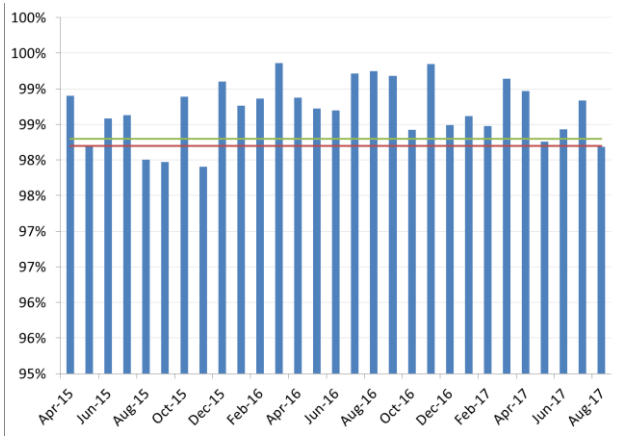
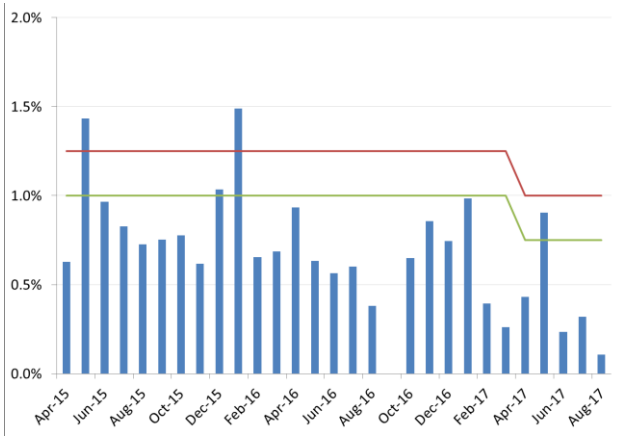
REPORTED
Dissatisfied Complaints
(*Not reported last month)*

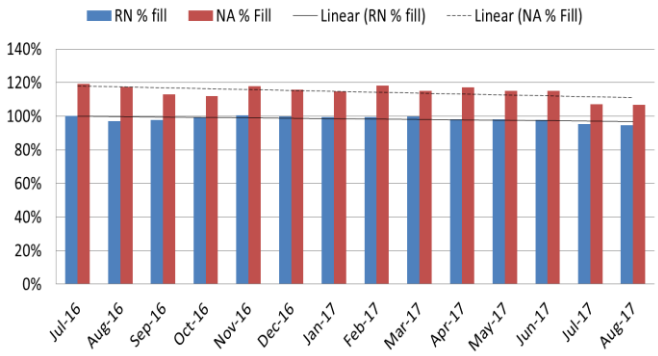
Overview

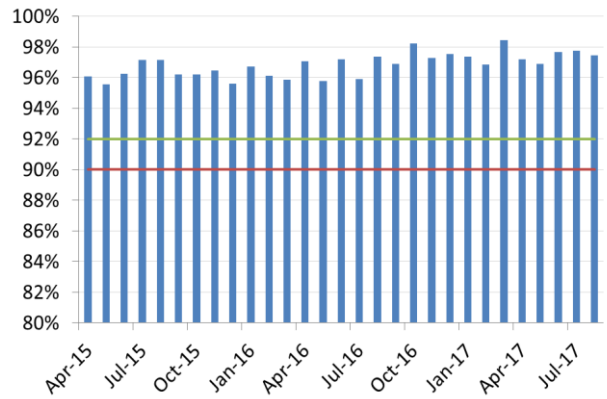
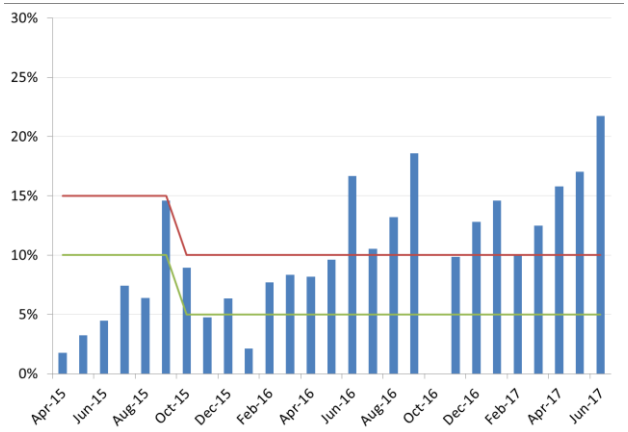
The following summarises the key successes in August 2017, along with the priorities, opportunities, risks and threats to achievement of the quality, access and workforce standards in quarter 2 2017/18.

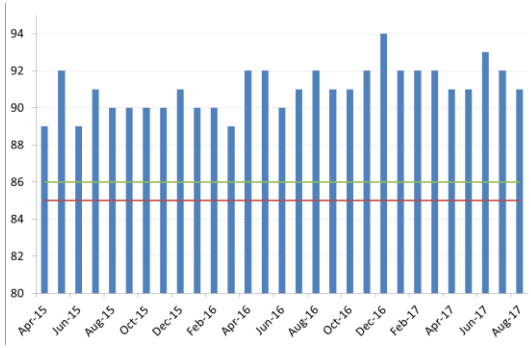
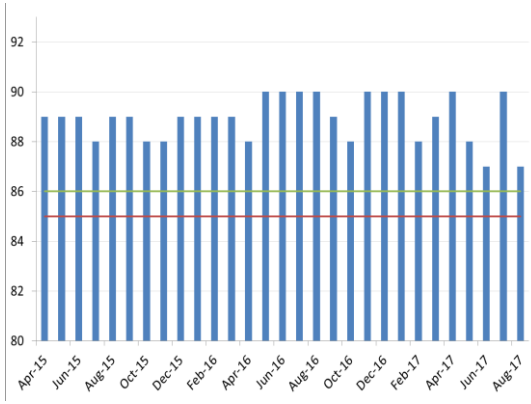
Successes	Priorities
• In August 2017 the figure for non-purposeful omitted doses of listed critical medicines was 0.11%. This is the lowest reported performance figure since September 2016. • Roll out of the leadership behaviours to the Senior Leaders across the Trust in August. Cascade to the all staff to be carried out from September 2017. • Achievement of the 28-day readmission standard for last minute cancelled operations and a continued improved performance in the number of last-minute cancellations. • A continued improvement has been seen in the performance against the A&E 4hr target leading to achievement of the STF trajectory for August. • Sustained reduction in outlier bed days. The target for August (562) was achieved (537 bed days).	• Flu campaign planning (CQUIN achievement) commencing early. • Recovery of performance against the 6-week diagnostic waiting times standard by the end of December, with achievement of the recovery trajectory each month. • Restore performance against the 62-day GP cancer waiting times standard to the national 85% standard by quarter 1 18/19 and achieve the recovery trajectory during 2017/18. • Further improvements in A&E 4-hour performance against trajectory.
Opportunities	**Risks & Threats**
• Engagement with staff to determine wellbeing priorities and to promote staff wellbeing, support retention and reduce sickness absence. • Locum endoscopist and consultant hepatologist starting in October 2017. • Pilot in Cardiac CT to increase throughput on lists is proceeding well. • Sustaining improvements seen in the A&E 4hr target as we move into the winter period.	• In August 2017 there were 14 patients who were reported as having new harm. The two most significant increases within the category were an increase in the number of new VTE treatments (six) and new pressure ulcers (five). • The workforce targets agreed as part of the 2017/18 operating planning cycle will be challenging to achieve. • The size of the current elective and outpatient waiting lists could make recovery of the 92% RTT national waiting times standard challenging. • Patients are exercising the 'patient choice' element of the access policy which results in an added risk of RTT breaches for long waiters. • The number of over 6-week waiters for Cardiac CT scans and Sleep Studies is expected to remain high and above current capacity. • Capacity issues in MSK ultrasound due to transfer of referrals following MATS cessations of GP Care contract. • Late referrals from other providers continue to impact on achievement of the 62-day GP cancer waiting times standard.

Description	Current Performance	Trend	Comments
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).	There were three cases of *Clostridium difficile* (C. diff) attributed to the Trust in August 2017. This gives 20 cases for the year-to-date.	**Total number of C. diff cases**  .	The annual limit for the Trust for 2017/18 is 45 avoidable cases. The monthly assessment of cases continues with the Clinical Commissioning Group. The cases that have been assessed to date are *four* unavoidable and *two* avoidable. The cases for June onwards have yet to be assessed by the Clinical Commissioning Group.
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%.	Performance in August 2017 was 97% against a three-year improvement goal of 95%. This is a slight deterioration from July's position of 100 %. There was one breach which occurred in the Division of Surgery. The patient had a verbally agreed revised trigger in place for their blood pressure, but nothing was documented in their notes or observation chart. The patient came to no harm as a result of this breach.	**Percentage of early warning scores acted upon** 	This is measured by a monthly point prevalence audit. 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 1G).

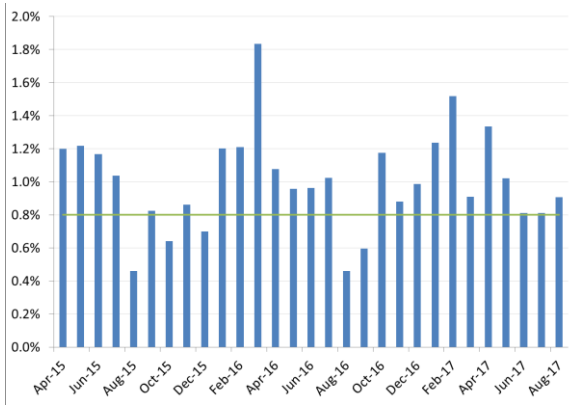
Description	Current Performance	Trend	Comments
Safety Thermometer – No new harm. The NHS Safety Thermometer comprises a monthly audit of all eligible inpatients for 4 types of harm: pressure ulcers, falls, venous-thromboembolism and catheter associated urinary tract infections. New harms are those which are evident after admission to hospital.	In August 2017, the percentage of patients with no new harms was 98.2% (14 patients had new harms), against an upper quartile target of 98.3% (GREEN threshold) of the NHS Improvement patient safety peer group of Trusts, a deterioration from 98.8% in July 2017.	**The percentage of patients surveyed showing No New Harm each month** 	The August 2017 Safety Thermometer point prevalence audit showed one new catheter associated urinary tract infections, two falls with harm, five new pressure ulcer and six new venous thrombo-emboli. Threshold was narrowly missed in August, but has been consistently above Red threshold since start of 2016.
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 August 2017, 0.11% of patients reviewed (1 out of 946) had one or more omitted critical medications in the past three days. The target for omitted doses is no more than 0.75%. The 0.11% for August 2017 is a significant improvement from the July 2017 figure of 0.32% (2 out of 625).	**Percentage of omitted doses of listed critical medicines** 	The target for omitted doses in 2017/2018 has been revised and is now set at 0.75% (previous target was 1%). Actions being taken are described in the actions section (Actions 2A and 2B).

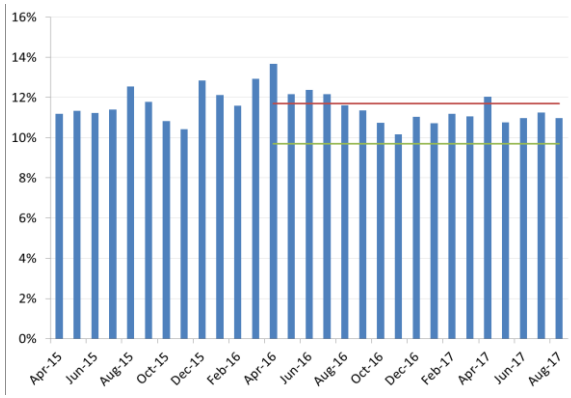
Description	Current Performance	Trend	Comments
Essential Training measures the percentage of staff compliant with the requirement for core essential training. The target is 90%	Overall compliance is 88% (excluding Child Protection Level 3). Compliance with each of the reporting categories is provided below. **August 2017 / UH Bristol** **Total: 88%** Three Yearly (14 topics): 86% Annual (Fire): 87% Annual (IG): 82% Induction & Orientation: 98% Doctors induction: 67% Resuscitation: 80% Safeguarding: 87%	Performance against target for Fire and Information Governance has improved since last month and are included in Appendix 2. The revised target audience for Dementia Awareness has now been confirmed and work to upload the relevant staff training portals is underway.	Recovery plans to achieve 90% compliance by end of October 2017 have been developed by Divisional HRBPs and are reviewed at divisional performance reviews (see Actions 3A-3C).
Nurse staffing levels unfilled shifts reports the level of registered nurses and nursing assistant staffing levels against the planned.	The report shows that in August 2017 the Trust had rostered 233,466 expected nursing hours, with the number of actual hours worked of 228730. This gave a fill rate of 98%. **Division / Actual Hours / Expected Hours / Difference** Medicine: 66,535 / 62,107 / +4428 Specialised Services: 40,236 / 40,557 / -320 Surgery: 43,631 / 44,523, / -891 Women's & Children's: 78,327 / 86,280 / -7952 **Trust: 228,730 / 233,466 / -4736** .	**The percentage overall staffing fill rate by month** 	Overall for the month of August 2017, the Trust had 94% cover for Registered Nurses (RN) on days and 96% RN cover for nights. The unregistered level of 103% for days and 112% for nights reflects the activity seen in August 2017. This was due primarily to Nurse Assistant specialist assignments to safely care for confused or mentally unwell patients in adults particularly at night. Close monitoring continues. (See Action 4A)

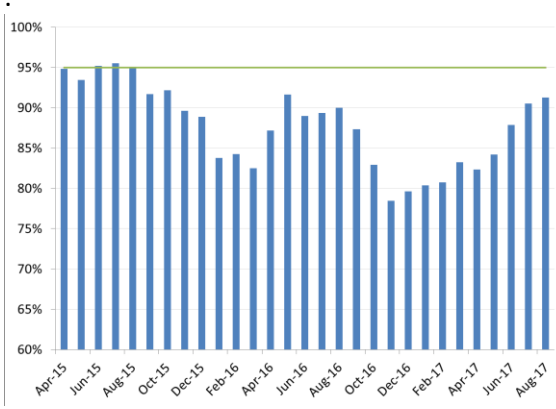
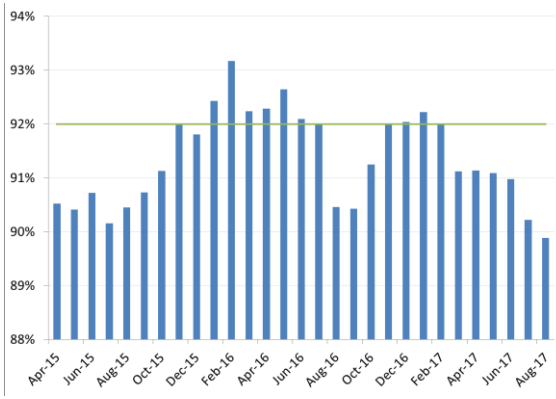
Description	Current Performance	Trend	Comments
Friends & Family Test inpatient score is a measure of how many patients said they were 'very likely' to recommend a friend or family to come to the Trust if they needed similar treatment. The scores are calculated as per the national definition, and summarised at Division and individual ward level.	Performance for August 2017 was 97.5%. 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 score** 	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. Our goal is for less than 5% of complainants to report that they are dissatisfied with our response to their formal complaint.	Dissatisfied cases are now measured as a proportion of complaints sent out in any given month and are reported two months in arrears. This means that the latest data in the board dashboard is for the month of June 2017. As of 15th September 2017, 10 of the 46 responses sent out in June had resulted in dissatisfied replies (21.7% against a target of 5%).	**Percentage of compliantaints dissatisfied with the complaint response each month** 	In relation to formal complaints responded to in 2016/17 as a whole, 65 complainants expressed dissatisfaction with one or more aspects of our response to their concerns; this represented a small increase on 59 cases relating to responses sent in 2015/16 (measured in May each year and published in our annual Quality Report). Previous informal benchmarking with other NHS Trusts suggests that the rates of dissatisfied complainants are typically in the range of 8% to 12%. Actions continue as previously reported to the Board (Actions 5A to 5E).

<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 August 2017, the score was 91 out of a possible score of 100, and 91 for Q2 as a whole. Divisional level scores are provided on a quarterly basis to ensure sample sizes are sufficiently reliable.
<table>
<tr><th></th><th>Q1 2017/18</th><th>Q2 2017/18</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</td><td>93</td><td>91</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>93</td></tr>
<tr><td>Women's & Children's (Postnatal wards)</td><td>92</td><td>93</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 87 in August 2017 (out of score of 100). Divisional scores for latest completed quarters are provided below. The number of responses each month is not sufficient for a monthly divisional breakdown to be meaningful.
<table>
<tr><th></th><th>Q4 2016/17</th><th>Q1 2017/18</th></tr>
<tr><td>Trust</td><td>89</td><td>88</td></tr>
<tr><td>Medicine</td><td>90</td><td>89</td></tr>
<tr><td>Specialised Services</td><td>86</td><td>87</td></tr>
<tr><td>Surgery</td><td>89</td><td>88</td></tr>
<tr><td>Women's & Children's (Children’s Hospital)</td><td>87</td><td>84</td></tr>
<tr><td>Diagnostics & Therapies</td><td>93</td><td>92</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.

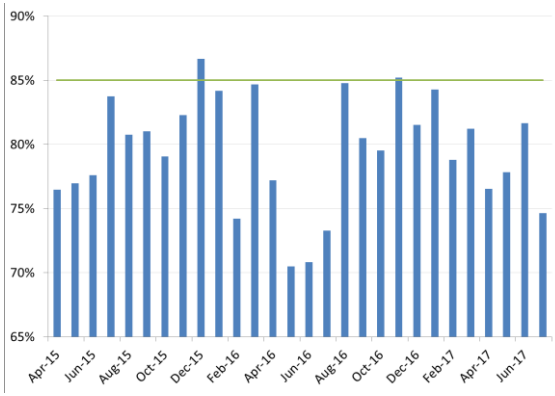
This metric turns red if outpatient experience begins to deteriorate to a statistically significant degree – alerting the Trust Board and senior management that remedial action is required. In the year to date the Trust score remains green. Divisional scores are examined in detail in the Trust’s Quarterly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

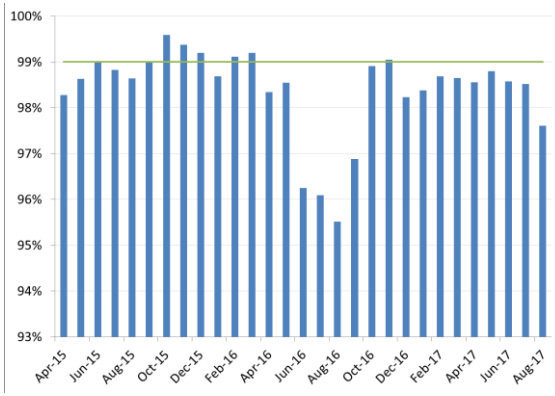
<table>
<tr><th>Description</th><th>Current Performance</th><th>Trend</th><th>Comments</th></tr>
<tr>
<td>Last Minute Cancellation is a measure of the percentage of operations cancelled at last minute for non-clinical reasons. The national standard is for less than 0.8% of operations to be cancelled at last minute for reasons unrelated to clinical management of the patient.</td>
<td>In August the Trust cancelled 61 (0.91% of) operations at last-minute for non-clinical reasons. The top reasons for the cancellations are shown below:
<table>
<tr><th>Cancellation reason</th><th>Number</th></tr>
<tr><td>No Theatre Staff</td><td>25</td></tr>
<tr><td>Other patient prioritised</td><td>16</td></tr>
<tr><td>No Beds Available</td><td>8</td></tr>
<tr><td>No CICU Beds</td><td>8</td></tr>
</table>
One of the 54 patients cancelled in August was not readmitted within 28 days. Meaning 98.1% were re-admitted within 28 days. This means the Trust achieved the former national standard of 95%.</td>
<td>Percentage of operations cancelled at last-minute
 
</td>
<td>Sustained good performance through August, and only narrowly missed the target for the second month running. See Actions 6A-6B for further details.</td>
</tr>
<tr>
<td>Outpatient appointments cancelled is a measure of the percentage of outpatient appointments that were cancelled by the hospital. This includes appointments cancelled to be brought forward, to enable us to see the patient more quickly.</td>
<td>In August 11.0% of outpatient appointments were cancelled by the hospital, which is below the revised Red threshold of 11.7%. This is a similar level of performance to last month. The level of cancellation remains lower than the same period last year.

Please note: the RED and GREEN thresholds have been revised for 2017/18, with the Green threshold representing a 2% improvement on 2015/16, and the RED threshold being the same average performance in 2015/16 of 11.7%.</td>
<td>Percentage of outpatient appointments cancelled by the hospital
 
</td>
<td>Cancellation rates are monitored monthly at Outpatient Steering Group. This includes detailed discussion around what further actions could be taken to reduce cancellations (Actions 7A-7G).</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 August. However, Trust-level performance improved to 91.3%, and was above the in-month trajectory (90%). Performance and activity levels for the BRI and BCH Emergency Departments are shown below.
<table>
<tr><th>BRI</th><th>Jun 2017</th><th>Jul 2017</th><th>Aug 2017</th></tr>
<tr><td>Attendances</td><td>5,568</td><td>5930</td><td>5684</td></tr>
<tr><td>Patients managed < 4 hours</td><td>4,399
79.0%</td><td>5,047
85.1%</td><td>4935
86.8%</td></tr>
<tr><th>BCH</th><th>Jun 2017</th><th>Jul 2017</th><th>Aug 2017</th></tr>
<tr><td>Attendances</td><td>3,283</td><td>3,373</td><td>2687</td></tr>
<tr><td>Patients managed < 4 hours</td><td>3,189
97.1%</td><td>3,259
96.6%</td><td>2589
96.4%</td></tr>
</table>
</td>
<td>Performance of patients waiting under 4 hours in the Emergency Departments
.
 
</td>
<td>A significant improvement has been seen and sustained in the performance against the A&E 4hr target leading to achievement of the STF trajectory for August. The BRHC has sustained its consistently good performance and there has been marked improvement in the BRI with a renewed focus on patient flow out of ED, and through the ambulatory care assessment units. August performance represents both the best trust wide performance and the best BRI performance since May 2016 (91.66% and 87.73% respectively).</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 met at the end of August, with performance reported at 89.9%. The number of patients waiting over 52 weeks RTT has increased due to capacity pressures in Women's & Children's, a re-validation of some RTT pathways within the Dental Hospital following errors having been identified with more patients exercising their rights to patient choice.
<table>
<tr><th></th><th>Jun</th><th>July</th><th>Aug</th></tr>
<tr><td>Numbers waiting > 40 weeks RTT</td><td>193</td><td>198</td><td>240</td></tr>
<tr><td>Numbers waiting > 52 weeks RTT</td><td>46</td><td>30</td><td>32</td></tr>
</table>
</td>
<td>Percentage of patients waiting under 18 weeks RTT by month
 

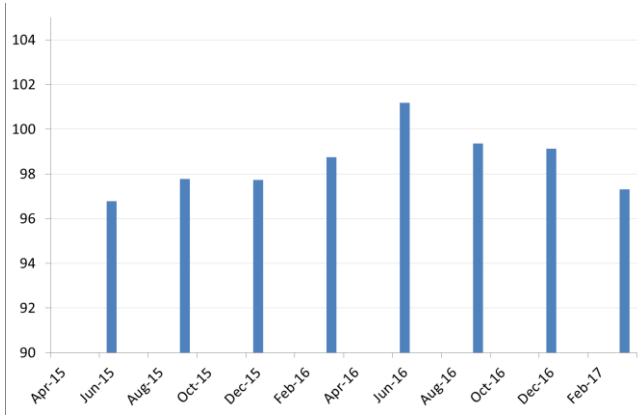
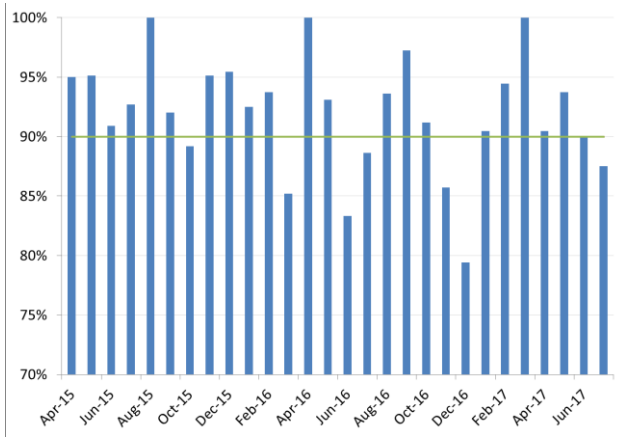
Forecast for September will continue to be below the 92% standard, due to rising demand.</td>
<td>Performance against the RTT standard has worsened in August due to rising demand. The total number of patients on an incomplete RTT pathway and those patients waiting over 18 weeks continues to be higher than 16/17. The size of the elective waiting list remains high, which in combination with the now rising outpatient waiting list, poses risks to recovery of the 92% standard. See the actions which continue to be taken to restore performance (Action 9A to 9G).</td>
</tr>
</table>

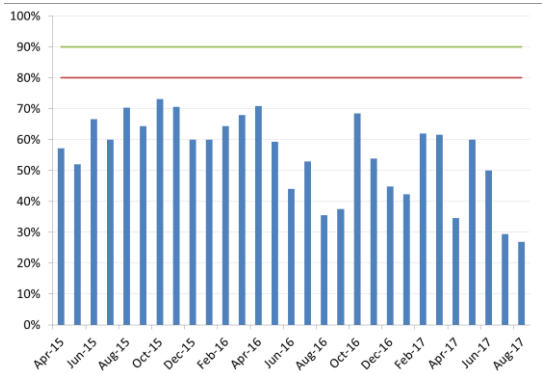
<table>
<tr><th>Description</th><th>Current Performance</th><th>Trend</th><th>Comments</th></tr>
<tr>
<td>Cancer Waiting Times are measured through eight national standards. These cover a 2-week wait to see a specialist, a 31 day wait from diagnosis to treatment, and a 62-day wait from referral to treatment. There are different standards for different types of referrals, and first and subsequent treatments.</td>
<td>July's performance was 74.7% against the 85% 62-day GP standard, and a trajectory of 83.6%. July's 62-day GP breach reasons were:
<table>
<tr><th>Breach reason</th><th>Jul 17</th></tr>
<tr><td>Medical deferral/clinical complexity</td><td>7.5</td></tr>
<tr><td>Late referral by/delays at other provider</td><td>9.5</td></tr>
<tr><td>Other causes (eight reasons)</td><td>10.5</td></tr>
<tr><td>TOTAL</td><td>27.5</td></tr>
</table>
There were 0.5 breaches of the 62 day GP screening standard in July, due to patient choice.</td>
<td>Percentage of patients treated within 62 days of GP referral
 

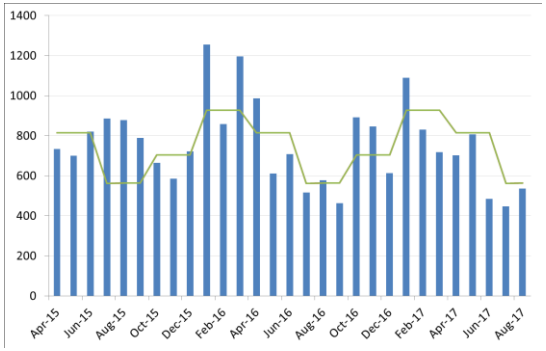
.</td>
<td>July performance against the 62 day GP standard deteriorated due to a range of factors, but the forecast position for August is significantly improved. A remedial action plan has been developed, focussing on actions within or partially within the Trust's control. Avoiding cancellation is the single most important high impact action for the Trust to improve and sustain performance against the cancer standards. It should be noted that the majority of 'breaches' are due to unavoidable factors such as late referral and medical deferral. New issues for quarters 2 and 3 are gynaecology capacity shortfalls and PET scanning delays caused by problems with the change to provider (national commissioning decision).</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 was 97.6% in August, which is below the 99% national standard, but was on the recovery trajectory for the month. The number of over 6-week waiters at month-end, is below:
<table>
<tr><th>Diagnostic test</th><th>Jul</th><th>Aug</th></tr>
<tr><td>MRI</td><td>13</td><td>19</td></tr>
<tr><td>Sleep</td><td>26</td><td>67</td></tr>
<tr><td>Endoscopies</td><td>27</td><td>26</td></tr>
<tr><td>CT</td><td>38</td><td>76</td></tr>
<tr><td>Echo</td><td>9</td><td>3</td></tr>
<tr><td>Other</td><td>8</td><td>10</td></tr>
<tr><td>TOTAL</td><td>121</td><td>201</td></tr>
<tr><td>Percentage</td><td>98.6%</td><td>97.6%</td></tr>
<tr><td>Recovery trajectory</td><td>97.9%</td><td>97.6%</td></tr>
</table></td>
<td>Percentage of patients waiting under 6 weeks at month-end
 

.</td>
<td>Trajectory has been revised, with achievement expected in December 2017.
There are 3 main causes:

Demand for Cardiac CT remains high. Pilot for increasing capacity commenced in July, however delivery of the planned additional capacity will take longer than initially planned.
The unplanned transfer of MSK ultrasound from the MATS service, following cessation of contract with GP Care has resulted in unexpected ultrasound breaches. An AQN (activity query notice) was called with commissioners and actions being undertaken on both sides.
High demand for Sleep Studies tests, and ongoing shortfall in recurrent capacity
</td>
</tr>
</table>

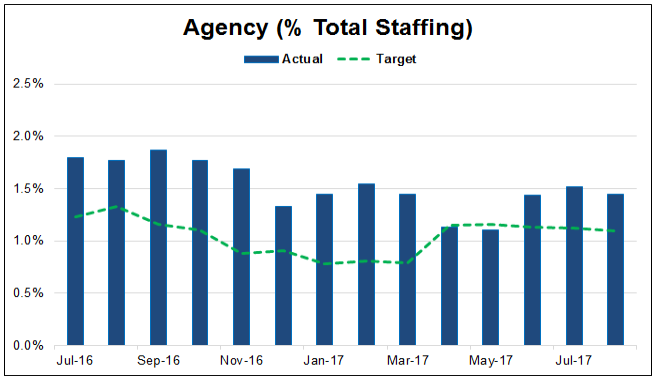
Description	Current Performance	Trend	Comments
Summary Hospital Mortality Indicator is the ratio of the actual number of patients who died in hospital or within 30 days of discharge and the number that were 'expected' to die, calculated from the patient case-mix, age, gender, type of admission and other risk factors. This is nationally published quarterly, six months in arrears.	Summary Hospital Mortality Indicator (SHMI) for March 2017 was 97.3. This covers the 12 month period April 2016 to March 2017 This statistical approach estimates that there were 47 fewer actual deaths than expected deaths in the 12-month period. Actual number of deaths was 1737.	**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. 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 July, 28 out of 32 patients (87.5%) were treated within 90 minutes of arrival in the hospital. Performance for 2016/17 as a whole ended above the 90% standard at 91.7%. Performance for 2017/18 is currently at 90.4%	**Percentage of patients with a Door to Balloon Time < 90 minutes by month** 	There was a slight dip in performance in August but year to date remains above the 90% target.

<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 August 2017 we achieved 26.9% (7/ 26 patients) overall performance in Best Practice Tariff (BPT), against the national standard of 90%. The time to theatre within 36 hours performance was 84.6% (22/26 patients).
<table>
<tr><th>Reason for not going to theatre within 36 hours</th><th>Number of patients</th></tr>
<tr><td>Patents required medical optimisation before they could undergo surgery.</td><td>1</td></tr>
<tr><td>Delay due to theatre capacity</td><td>3</td></tr>
</table>
</td>
<td>Percentage of patients with fracture neck of femur whose care met best practice tariff standards
 
</td>
<td>Eighteen patients did not receive any ortho-geriatrician review due to sickness and the clinician having to cover the Older Person Assessment Unit.

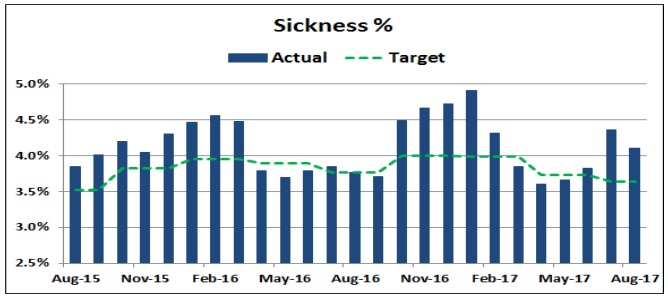
Actions are being taken to establish a future service model across Trauma & Orthopaedics, and ensure that consistent, sustainable cover is provided (Actions 12A to 12E).</td>
</tr>
<tr>
<td>Outlier bed-days is a measure of how many bed-days patients spend on a ward that is different from their broad 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 August 2017 there were 537 outlier bed-days against a target of 562 outlier bed-days.
<table>
<tr><th>Outlier bed-days</th><th>August 2017</th></tr>
<tr><td>Medicine</td><td>232</td></tr>
<tr><td>Surgery</td><td>198</td></tr>
<tr><td>Specialised Services</td><td>91</td></tr>
<tr><td>Women's & Children's Division</td><td>5</td></tr>
<tr><td>Diagnostics and Therapies</td><td>11</td></tr>
<tr><td>Total</td><td>537</td></tr>
</table>
</td>
<td>Number of days patients spent outlying from their specialty wards
 
</td>
<td>The quarter two target has been set at 562 bed days per month and this was achieved in August 2017 by 25 bed days.
Ongoing actions are shown in the action plan section of this report. (Action 13A).</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 reduced by 5.3 FTE, with the largest reductions in Admin and Clerical. Nursing & Midwifery usage reduced by 3.2 FTE in month, with bookings to cover vacancies having the biggest reduction amongst the reasons for use within the staff group.	**Agency usage as a percentage of total staffing by month**	See actions 14A-14C for a summary of key actions to target agency use.
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 reduced from 4.4% to 4.1%, with reductions in all Divisions except Women's and Children's. Reductions were also seen across most staff groups, although rates in registered nursing increased by 0.7 percentage points.	**Sickness absence as a percentage of full time equivalents by month**	See action 15A-15F for the sickness action plan.

August 2017	FTE	Actual %	KPI
UH Bristol	**125.3**	**1.5%**	**1.1%**
Diagnostics & Therapies	12.3	1.2%	0.9%
Medicine	31.6	2.4%	1.2%
Specialised Services	14.2	1.4%	1.6%
Surgery	14.3	0.8%	1.0%
Women's & Children's	30.0	1.5%	0.5%
Trust Services	13.7	1.7%	2.1%
Facilities & Estates	9.2	1.2%	1.1%



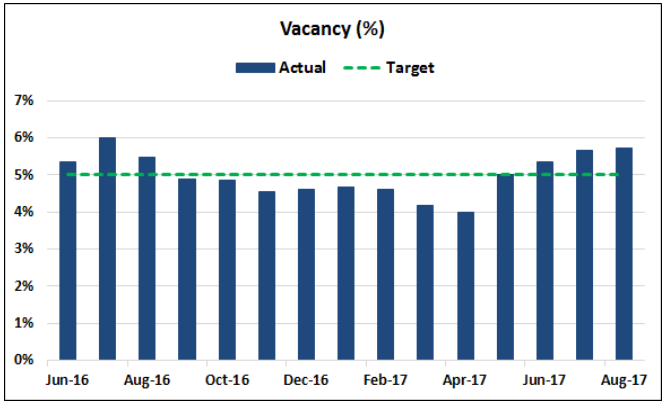
August 2017	Actual	KPI
UH Bristol	**4.1%**	**3.6%**
Diagnostics & Therapies	3.2%	2.7%
Medicine	5.2%	4.4%
Specialised Services	3.2%	3.6%
Surgery	3.6%	3.6%
Women's & Children's	4.1%	3.4%
Trust Services	2.6%	2.8%
Facilities & Estates	7.5%	5.2%



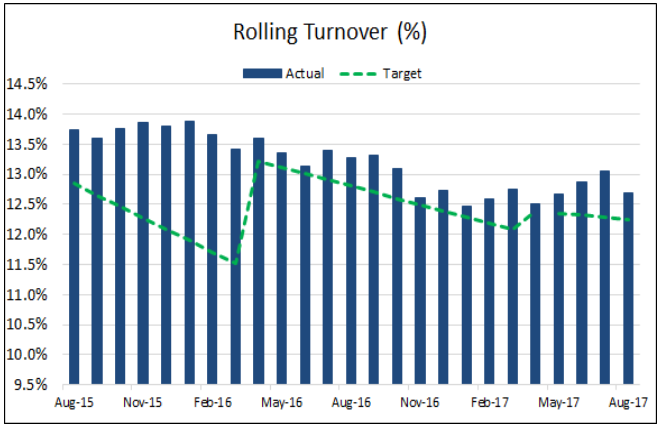
Please note: Sickness data is refreshed retrospectively to capture late data entry, and to ensure the data is consistent with the Trust's final submission for national publication

Description	Current Performance	Trend	Comments
Vacancies - vacancy levels are measured as the difference between the Full Time Equivalent (FTE) budgeted establishment and the Full Time Equivalent substantively employed, represented as a percentage, compared to a Trust-wide target of 5%.	Overall vacancies remained static, at 5.7%. Nursing vacancies increased by 15.0 FTE in month to 235.6 (7.4%), largely due to increases in Women`s and Children`s Division. .	**Vacancies rate by month**	See Actions 16A-16B for further details of the plans that continue to be implemented to reduce the vacancy rate.
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 12.1% by the end of 2016/17. The red threshold is 10% above monthly trajectory**.**	Turnover reduced from 13.0% to 12.7%, due to reductions in month in Medicine, Surgery, Trust Services and Women's and Children's Divisions. Reductions were seen across all staff groups except Admin and Clerical and Healthcare Scientists	**Staff turnover rate by month**	See Action 17A-17B for further details of the plans that continue to be implemented to reduce turn-over.

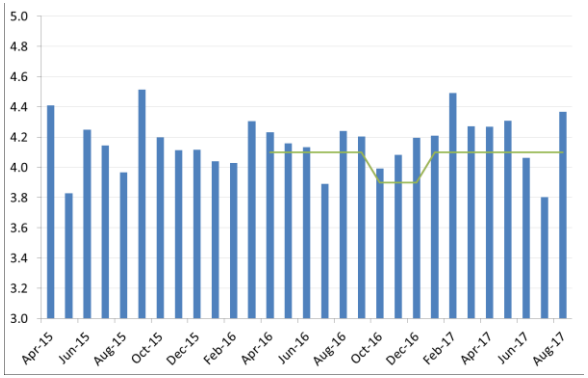
August 2017	Rate
UH Bristol	**5.7%**
Diagnostics & Therapies	5.4%
Medicine	7.8%
Specialised Services	5.2%
Surgery	5.1%
Women's & Children's	3.4%
Trust Services	6.7%
Facilities & Estates	9.6%



August 2017	Actual	KPI
UH Bristol	**12.7%**	**12.3%**
Diagnostics & Therapies	11.3%	11.8%
Medicine	13.8%	14.5%
Specialised Services	14.5%	12.0%
Surgery	11.6%	11.7%
Women's & Children's	11.0%	10.9%
Trust Services	13.3%	12.3%
Facilities & Estates	16.1%	14.2%



<table>
<tr><th>Description</th><th>Current Performance</th><th>Trend</th><th>Comments</th></tr>
<tr>
<td>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.</td>
<td>In August the average length of stay for inpatients was 4.4 days, which is below the RED threshold of 4.1 days.

Number of patients in hospital at month-end with a “long” Length of Stay is below:
<table>
<tr><th></th><th>Jun-17</th><th>Jul-17</th><th>Aug 17</th></tr>
<tr><td>7+ Days</td><td>354</td><td>392</td><td>399</td></tr>
<tr><td>14+ Days</td><td>227</td><td>250</td><td>256</td></tr>
<tr><td>21+ Days</td><td>168</td><td>166</td><td>188</td></tr>
</table>
</td>
<td>Average length of stay (days)
 
</td>
<td>The total number of Green to Go (delayed discharge) patients in hospital is 68 as at end of August (over double the jointly agreed planning assumption of 30 patients). The number of 14-day stays has increased and remains above the level required to maintain effective flow and meet the 95% standard for A&E 4-hour waits.</td>
</tr>
</table>

Improvement Plans

Action number	Action	Timescale	Assurance	Improvement trajectory
SAFE – Deteriorating Patient, Early Warning Scores Acted Upon				
1A	Further targeted teaching for areas where NEWS incidents have occurred.	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.	On-going	As above	Sustained improvement to 95% by 2018.
1C	Conduct 1:1 debriefs 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.	Completed. Actions in response to thematic analysis now under consideration.	As above	Sustained improvement to 95% by 2018.
1D	Spreading point of care simulation training in adult general ward areas to address human factors elements of escalating deteriorating patients and use of structured communication.	On-going	As above	Sustained improvement to 95% by 2018.
1E	Additional time allocated for patient safety in doctors' induction to train new appointees on resetting triggers safely and human factors awareness of escalation conversations.	Ongoing	As above	Sustained improvement to 95% by 2018.
1F	Review and response to outputs of mapping exercise of coverage of responders to escalation calls out of hours actions.	May 2017 review completed. Actions being fed into Urgent Care Group.	As above	Sustained improvement to 95% by 2018.
1G	Procurement of e observations system to enable automatic calculation of NEWS and notification of elevated NEWS to responder.	To be confirmed.	As above	Sustained improvement to 95% by 2018.

Action number	Action	Timescale	Assurance	Improvement trajectory
SAFE – Non-purposeful omitted doses of critical medication				
2A	Datix dashboard being developed to capture omitted doses, to allow detailed thematic analysis.	Commenced February 2017 and ongoing	Improvement under development	Maintain current improvement and sustain performance below 0.75%
2B	Teaching session to be run for new Pharmacists on data collection and background	Commenced February 2017 and ongoing	Teaching session under development	Maintain current improvement and sustain performance below 0.75%
SAFE – Essential Training				
3A	Continue to drive 90% compliance in all subjects, providing additional training sessions as required	October 2017	Oversight of training compliance by the Education Board.	A detailed recovery plan to achieve 90% compliance against all ET was agreed by the Interim Director of Workforce and OD on 14 July. Divisional HRBPs were supplied with data extractions, on non-compliance, and are tasked to progress the recovery action plan (monitored at divisional performance reviews). Data extraction focuses upon non-compliance by division within 3 specific ET subjects. The Education Board is considering supporting enforcement of 4 Trust policies (annual leave, study leave, etc.) on compliance. The ET Core Group will propose a move to the UK Core Skills on 'Essential Training' to be reported to the Education Board in November 2017.
3B	Compliance reviewed at Divisional quarterly Performance Review meetings.	August 2017	Monthly and quarterly Divisional Performance Review meetings.	

Action number	Action	Timescale	Assurance	Improvement trajectory
3C	Divisional recovery plans are available and monitored at monthly performance reviews. Automated reminders for non-compliant staff have been increased to 90, 60, 30 days prior to expiry Weekly Newsbeat alerts for how to access and book training requirements. Medical and dental induction face to face attendance is now recorded separately to e-induction, enabling more accurate situation reports	October 2017		
SAFE – Nursing Staffing Levels				
4A	Continue to validate temporary staffing assignments against agreed criteria.	Ongoing	Monitored through agency controls action plan	Action plan available on request.
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.	Achieve and maintain a green RAG rating for this indicator
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		Achieve and maintain a green RAG rating for this indicator

Action number	Action	Timescale	Assurance	Improvement trajectory
5D	In January 2017, the Head of Quality (Patient Experience and Clinical Effectiveness) and Acting Patient Support and Complaints Manager undertook a detailed review of all dissatisfied cases from August and September 2016.	Ongoing.	From June 2017 (reviewing March cases), all dissatisfied cases are now retrospectively reviewed on a monthly basis for learning by the Head of Quality (Patient Experience and Clinical Effectiveness) and Patient Support and Complaints Manager. Findings are reported to the Patient Experience Group and Divisional Management Teams.	Achieve and maintain a green RAG rating for this indicator
5E	The Trust will be establishing a new complaints review panel in 2017.	Terms of Reference established March 2017	Evidence that the panel is in place and learning identified and shared with Divisions	Achieve and maintain a green RAG rating for this indicator
CARING – Cancelled Operations				
6A	Continued focus on recruitment and retention of staff to enable all adult BRI HDU/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.	Ongoing End August	Monthly Divisional Review Meetings; Senior Leadership Team sign-off	Sustained reduction in critical care related cancellations in 2017/18. As above.
6B	Specialty specific actions to reduce the likelihood of cancellations.	Ongoing	Monthly review of plan with Divisions by Associate Director of Operations.	As above.
CARING – Hospital Cancelled Outpatient Appointments				
7A	Explore option of increasing required notice of annual leave from six to eight weeks to reduce the number of cancelled clinics	Agreed in principle but process of how to communicate this out and enact it being worked through	Senior Leadership Team	Review of progress requested

Action number	Action	Timescale	Assurance	Improvement trajectory
7B	Full service-level review of the electronic Referral Service (eRS) Directory of Services, to limit the number of required re-bookings.	Complete - full improvement plan in place around ERS to comply with the CQUIN and NHSE Paper Less initiative; Milestones across each quarter	Outpatient Steering Group	Ongoing delivery of plan continues in line with CQUIN milestones
7C	Implement changes to the way capacity is managed to support eRS appointment bookings and limit cancellations.	Working through as part of the ERS plan. NHS Digital to undertake one capacity review on one service for us by September	Outpatient Steering Group	Linked in to ERS plan. Outpatients Operating Model being developed which clearly identifies levels of responsibility and action between divisions, corporate team and IM&T
7D	eRS Improvement Plan to be developed, following review by NHS Digital, to help improve eRS access for patients and reduce un-necessary re-arrangement of outpatient appointments.	Complete.	Outpatient Steering Group	In place as per 6b above
7E	Deep dive reviews of follow-ups in 5 specialities planned: Gastroenterology, Haematology, ENT, Gynaecology and Paediatric T&O. This is aimed at reducing the number of follow-up appointments made in each service. This should free up capacity to see patients in a timely manner, reducing the need to move patients to accommodate urgent patients.	Project plan to be reviewed and signed off at OSG in September 17	Outpatient Steering Group	Ongoing work with divisions to identify specialities to support the reduction in follow-up work at CCG level.
7F	Re-build clinics in Medway to ensure they correctly reflect appointment slots available and are clearly named. This should prevent cancellations due to incorrect booking.	It was agreed at OSG in August to bid for a band 5 to be part of the central outpatients team to support the divisions to do re-build work.	Outpatient Steering Group	Recruitment underway

Action number	Action	Timescale	Assurance	Improvement trajectory
7G	On the 14th August clinic cancellation codes have been updated in Medway to remove 'hospital cancellation' as a reason and add 'short notice leave' as a reason. 3 months following the change a report will be produced to look at how often clinics are cancelled as a result of leave booked with less than 6 weeks' notice.	Report to be tabled at December OSG	Outpatient Steering Group	
RESPONSIVE – A&E 4 Hour Wait				
8A	Urgent Care Steering Group Improvement plan (BRI) has been refreshed to focus on the high impact schemes initially. Pilot underway in AMU to increase ambulatory capacity Model agreed with team for adult ED streaming – going to UCSG in August Specialty pathway work ongoing with other divisions	Ongoing	Oversight through Urgent Care Steering Group monthly, plus with partners through UHB Hospital Flow group and Access Performance Group	Aiming to sustain 90% target for September
8B	One day a week support from ECIP has commenced – focussing on support IDS work and implementing trusted assessor	Ongoing	Progress tracked through Urgent Care Steering Group	
8C	Detailed work commenced to support winter planning and ensure services are robust and resilient	August	Service Delivery Group and A&E Delivery Board	
RESPONSIVE – Referral to Treatment Times				
9A	Weekly monitoring of reduction in RTT over 18 week backlogs against trajectory. Continued weekly review of management of longest waiting patients through RTT Operations Group. Additional request from the CCGs has resulted in reporting all of our 46 to 52 week waiters on a weekly and monthly basis	Ongoing	Oversight by RTT Steering Group; routine in-month escalation and discussion at monthly Divisional Review meetings. The request from the Clinical Commissioning Groups (CCGs) will need to be taken to the relevant groups for sign off against the 18 weeks best practice guides that have been issued.	Achievement of 92% standard from the end of October/November. Achievement of 92% standard from end of July has not been met.

Action number	Action	Timescale	Assurance	Improvement trajectory
9B	Contract performance notice received against our level of 52 week breaches	End of December	A RAP will be issued to the CCGs to give assurance that our level of 52 week waiters will reach 'zero' by the end of December 2017	Achieve '0' 52 week waiters by End of December 2017
9C	Implementation of RTT Sustainability Plan for the first half of 2017/18, which focuses on areas of recent growth and those specialties whose backlogs are still above sustainable levels	Ongoing	Fortnightly meetings between Divisions and Associate Director of Performance, and Access Improvement Manager	
9D	Refresh of IMAS Capacity and Demand modelling for key specialties (including Clinical Genetics, Paediatric Cardiology and Sleep Studies).	Complete except for Clinical Genetics (now end of July)	Modelling to be reviewed by Associate Director of Performance Review completed for Clinical Genetics on 27/7/17 The outcome of the review is that the position is Improving and the service is confident from the findings from a capacity point of view. The service feel that that they have enough recurrent capacity in place based on current backlog position.	
9E	Chronological booking report to be developed to challenge inefficient booking practices for outpatients and elective procedures.	End July	Sign-off of report by Chief Operating Officer completed	
9F	Implementation of chronological booking report.	End August	Divisional PTL meetings making use of this report This could be monitored at the Weekly RTT OPS Group meeting chaired by Access Improvement Manager once sign off has been agreed by the Chief Operating Officer of the content. (see item 9D)	
9G	Dental administrative management improvement plan to be developed.	Complete	Sign-off of plan by Associate Director of Performance	

Action number	Action	Timescale	Assurance	Improvement trajectory
RESPONSIVE – Cancer Wait Times				
10A	Ensure there is sufficient thoracic surgery outpatient capacity to meet demand in a timely way	End November 17	Oversight of implementation by Cancer Performance Improvement Group, with review at Cancer Steering Group.	Achievement of 85% standard by the end of 2017/18
10B	Ensure thoracic surgery operating capacity is adequate for the longer term, in face of rising demand	End November 17	As above	As above
10C	Ensure adequate elective bed capacity to reduce cancellations and capacity issues for cancer resections (to keep cancellations at the level seen in Q2 2016/7)	End March 2018	As above	As above
10D	Undertake necessary work for Trust to become lead provider for adult dermatology in Taunton	End March 2018	As above	As above
10E	Resolve the short term capacity issues for chemotherapy treatment delivery	End October 17	As above	As above
10F	Put in place more formal processes and guidance for managing the impact of MDT/planning meeting cancellations, for instance due to bank holiday	End January 2017	As above	As above
10G	Reduce delays in the colorectal pathway due to capacity and pathway management issues	End February 2018	As above	As above
10H	Reduce delays for radiological diagnostics, in particular CT colonography, head and neck ultrasound, and PET	End November 2017	As above	As above
10I	Work with partners to reduce late referrals	Ongoing	As above	As above
10J	Resolve capacity shortfall in gynaecology following staff sickness	End October 2017	As above	As above

Action number	Action	Timescale	Assurance	Improvement trajectory
RESPONSIVE – Diagnostic Waits				
11A	Additional Sleep Studies waiting list sessions to be established to minimise residual backlog of long waiters.	End December	Weekly monitoring by corporate team, with escalation to monthly Divisional Review meetings as required.	
11B	Changes made to Cardiac CT scanning sessions to improve utilisation. Pilot commenced in July, slots increased/session to 10 by end of September, and to 12 by the end of October	End December	Weekly monitoring by corporate team, with escalation to monthly Divisional Review meetings as required.	Achievement of 99% standard again for this diagnostic modality by the end of January1
11C	AQN (Activity Query Notice) called with CCG regarding unplanned transfer of MSK ultrasound from MATS service. Actions agreed include CCG investigating additional short term capacity; establishment of diagnostic control centre to reduce demand; UHBristol to audit suitability of referrals.	Actions to be completed in September with progress review meeting in November	Weekly monitoring by corporate team, with escalation to monthly Divisional Review meetings as required. Involvement of Trust Commissioning and Planning team in discussions with commissioners	Achievement of 99% standard against this diagnostic modality by end of November
EFFECTIVE – Fracture Neck of Femur				
12A	Middle grade orthogeriatric support – to submit a proposal to establish a dedicated middle grade orthogeriatric role (ST3+) to provide additional support to the orthogeriatric consultants and wards. This post will also contribute to improvements in cross-cover.	Business case submitted on the 21st April. Funding confirmed with the executive team on 16th August. The Division of Medicine is progressing to advertisement with interviews in October / November.	Proposal for investment included in BOA business case. Recruitment lead time difficult to determine as this may be a difficult role to recruit to	Successful funding bid and subsequent recruitment to post

Action number	Action	Timescale	Assurance	Improvement trajectory
12B	Consultant orthogeriatric capacity – there are currently vacancies within the COTE service that is impacting on the capacity of the orthogeriatric service.	Anticipated some improvement in orthogeriatric capacity from November.	The Division of Medicine has two COTE consultant vacancies. One of these vacancies is being covered by two clinical fellows. It is not anticipated that this will provide any additional capacity for the orthogeriatric service. However, the second vacancy has been appointed to and a new consultant will be starting in November. This appointment will release the two orthogeriatric consultants from undertaking sessions in OPAU and other COTE ward work. However, the service will still only be staffed by 2 rather than 3 orthogeriatric consultants and will, therefore, continue to struggle at times with cross-cover. The Divisions of Medicine and Surgery have discussed the COTE job plans.	Improvements in time to review by an orthogeriatrician.
12C	Physiotherapy the day after surgery – to ensure that there is physiotherapy support available to the orthopaedic wards on Sundays	An options appraisal was received on the 4th August from the D&T Division presenting different staffing models to satisfy this standard. An on-call model for #NOF patients is the most cost	There are potential benefits associated with reduction in patient length of stay with earlier mobilisation. The D&T Division have indicated a four month lead time to consult and give notice to their staff members. Therefore, the on-call physiotherapy cover will not be in place until the new calendar year.	Improvements against the new quality standard measure of therapy review the day after surgery.

Action number	Action	Timescale	Assurance	Improvement trajectory
		effective, however, this will mean that other types of elderly fracture patients will not receive a physiotherapy review on a Sunday. Investment proposal pending approval by executive team.		
12D	Time to surgery – to improve trauma throughput and to expedite the surgery of fractured neck of femurs patients within 36 hours.	The Division of Surgery is trialling ways to increase theatre productivity including scheduling an additional theatre porter to reduce downtime on the trauma lists.	The throughput of trauma surgery is being tracked to demonstrate an improvement. New SOPs have been introduced to ensure that there is a clear process for escalating any delays for surgery. The measure for hours to surgery on the NHFD website indicates that the Trust is tracking national average performance.	Improvements against time to theatre standard
EFFECTIVE - Outliers				
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

Action number	Action	Timescale	Assurance	Improvement trajectory
EFFICIENT – Agency Usage				
14A	**Effective rostering**: "Healthroster" –Ongoing review of agreed KPIs through e-rostering project board and Nursing Agency Controls Group.	Ongoing	KPI Performance monitored through Nursing Agency Controls Group.	A KPI has been agreed for 2017/18 of 1% through the Divisional Operating Planning. Divisional Performance against plan is monitored at monthly and quarterly Divisional Performance review meetings.
14B	**Controls and efficiency**: • Tighter agency controls being drawn up with the Heads of Nursing with implementation in October. • Neutral Vendor model arrangement for the management of nurse agency provision has now been signed off by the BNSSG partnership and implementation plans now being drawn up with implementation schedule for 6th November 2017. • Operating plan agency trajectories monitored by divisional reviews.	• October 2017 • November 2017 • Monthly/ quarterly reviews		
14C	**Enhancing bank provision:** • Personalised letter sent to every substantive RN and NA to encourage joining the TSB now being followed up to measure success • Major advertising campaign to encourage candidates to join the UHB Bank commenced with 3 month large scale public advertising running through to December.	• October 2017 • With effect from the end of September 2017. Marketing activity now being actively deployed.		
EFFICIENT – Staff Sickness				
15A	**Supporting Attendance Policy:** Ongoing discussions with Staff side regarding Policy. Further amendments were discussed at TPF on 19th September. Communications plan, implementation and training programme to support the revised policy have been prepared and will be shared with stakeholders	December 2017 Ongoing	Oversight by Workforce and Organisational Development (OD) Group via the Staff Health and Well Being Sub Group A KPI has been agreed for 2017/18 of 3.8% Divisional	A KPI has been agreed for 2017/18 of 3.8% Divisional Operating Planning Process. Divisional Performance against plan is monitored at monthly and

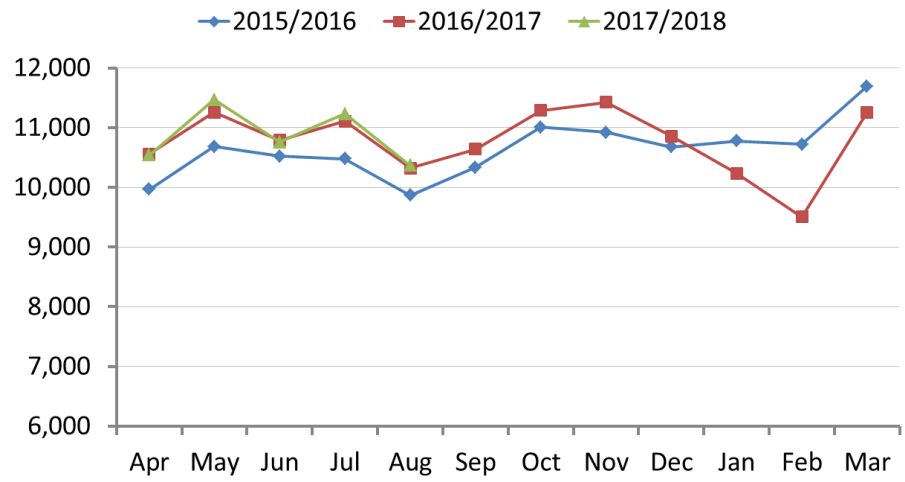
Action number	Action	Timescale	Assurance	Improvement trajectory
	once the policy is approved. **Supporting Attendance Surgeries:** To expedite cases where possible.		Operating Planning Process	quarterly Divisional Performance review meetings. Where divisions are above target an extensive deep dive into the data with a recovery plan
15B	**Musculo-skeletal:** Interventions by Occupational Health, Physio Direct, and Manual Handling Team	Senior Leadership Team Oct 2017	Workplace Wellbeing Steering Group (quarterly) /CQUIN Delivery Group	
15C	**Mental health:** Draft Stress management strategy framework being developed.	Jan 2016 – March 2019		
15D	**Staff Health and Well Being:** Trust review of model for well-being including healthy food and beverages. To address the top 3 reasons for sickness absence, Health and Wellbeing are offering Care First workshop on tackling stress (W&C), 3 new cohorts of the Step into Health programme (physical activity, nutrition & weight management and stress management modules) and Over 40's NHS health checks. • Latest additions = Midwives, NICU, Dietetics. Scheduled = Dental staff, 1st year Med Students in NA role, Occ Health) Meet with Department Managers and Manual Handling Risk Assessors in order to service their need.	Ongoing		
15E	**Manual Handling:** Continue to build on 'targeted' and in-loco compliance training (to give training with greater relevance to environment and role.			
EFFICIENT - Vacancy				
16A	**Recruitment Performance:** Divisional Performance and Operational Review Meetings monitor vacancies and performance against KPI of 45 days to recruit.	Reviewed quarterly	Workforce and OD Group/ Recruitment Sub Group. Divisional Performance and	The target for vacancies continues to be 5% in 2017/18. Divisional Performance against

Action number	Action	Timescale	Assurance	Improvement trajectory
16B	**Marketing and advertising:** Recruitment and marketing plan for nursing, Radiology and Domestic Assistants is in place for 2017/18, maximizing the new recruitment website. Divisional Nurse Recruitment Leads in bed-holding divisions. "Head-hunter" agency approach has been extended to hard to fill areas e.g. Sonography, Trauma & Orthopaedics and Care of the Elderly nursing. Robust annual plan of jobs fayres/careers events in place to support profile of the Trust as an employer of choice	Ongoing April 2017-18 From April 2017 Ongoing	Operational Review Meetings.	plan is monitored at monthly and quarterly Divisional Performance review meetings.
EFFICIENT - Turnover				
17A	In response to staff survey feedback, robust Improving Staff Experience plans are in place to ensure we focus on improving the culture of the organisation through various engagement initiatives (including E-Appraisal, Leadership behaviours, and a staff recognition framework)	March 2017-2018	Transformation Board Senior Leadership Team/Board. Divisional Boards/ Senior Leadership Team/Workforce and OD Group.	
17B	Exit interview process has been reviewed to improve quality of information received to help identify and address reasons for turnover	March 2017-2018	Workforce Management Group Workforce and OD Board	

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.

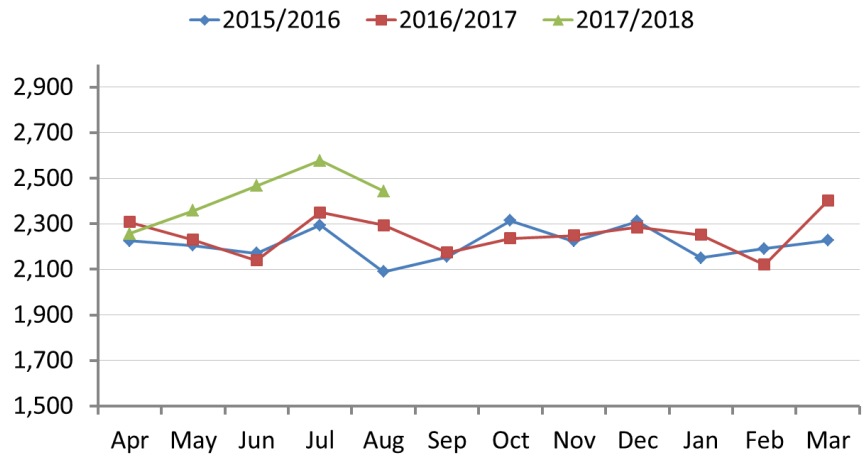
Emergency Department (ED) attendances



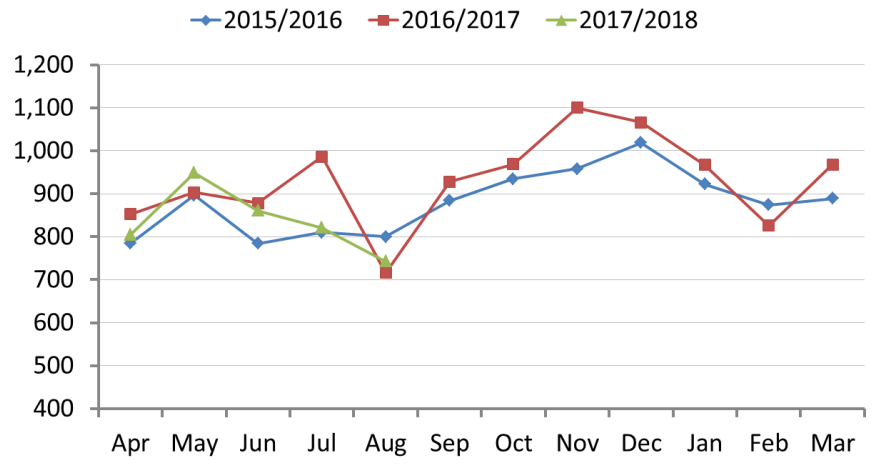
Summary points:

- Emergency Department attendances remain similar to last year's levels
- Total number of emergency admissions into the BRI is above the seasonal norm but has reduced from last month. This is being driven by a rise in short stay (0 or 1 day) Medical admissions in Ambulatory Care and Acute Medicine Unit.
- The number of new outpatient attendances has remained above previous year's level.
- The number of elective admissions has returned to seasonal norm levels for August.

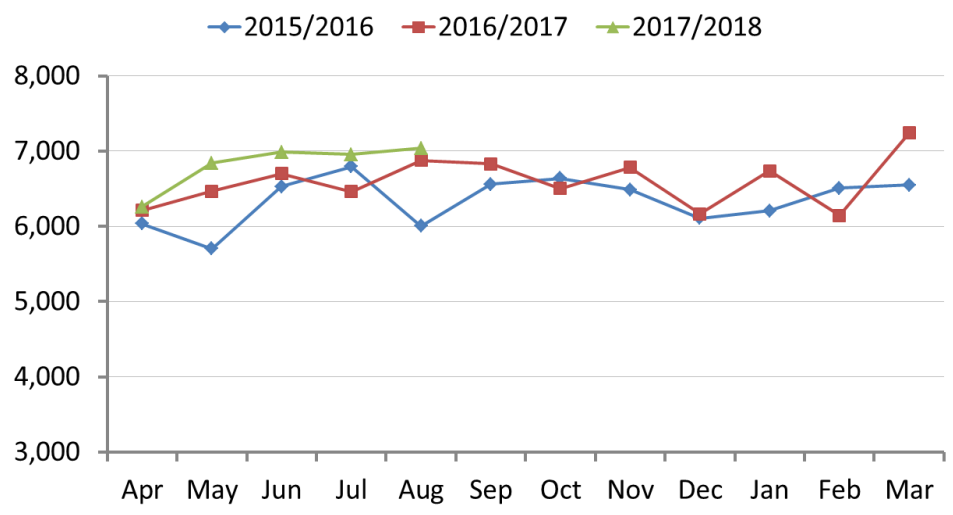
Emergency Inpatient Activity (BRI Discharges)



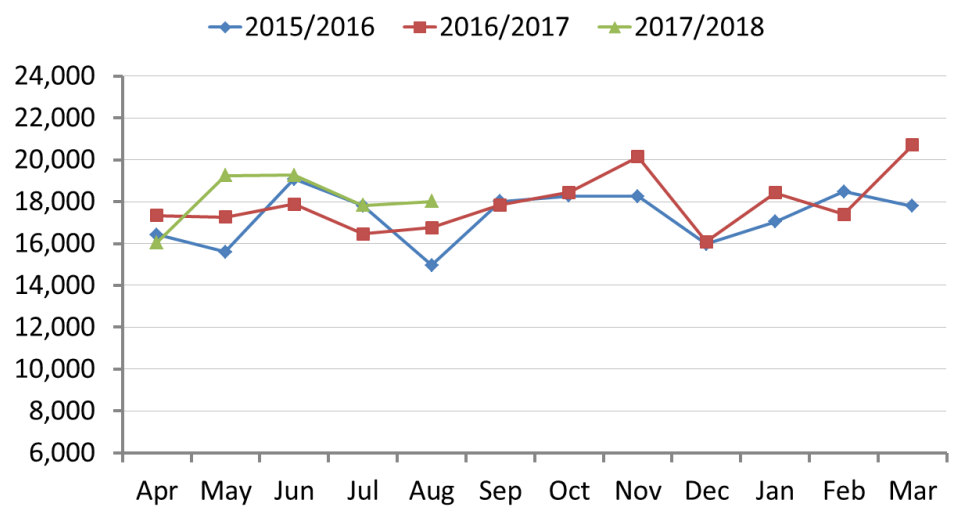
Emergency Inpatient Activity (BCH Discharges)



Elective Inpatient/Day Cases (number of Discharges)



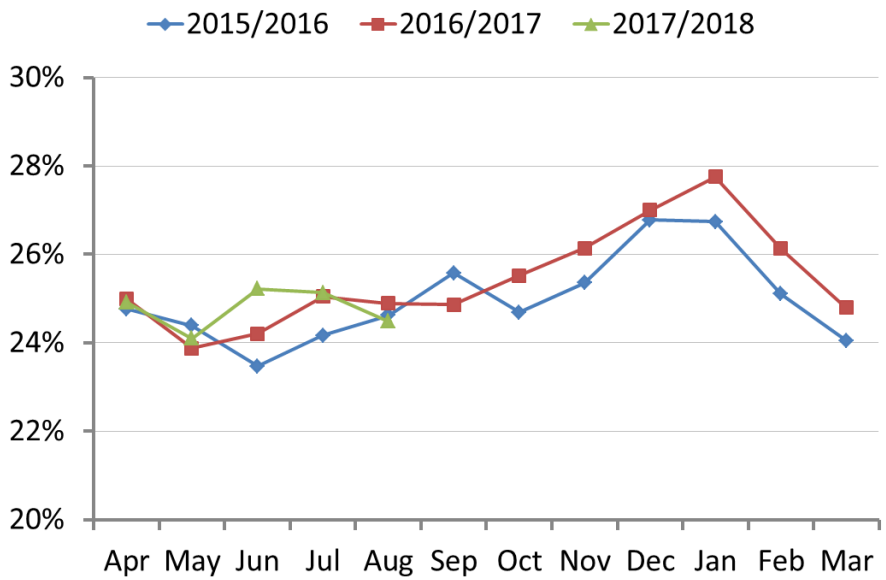
New outpatient attendances



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.

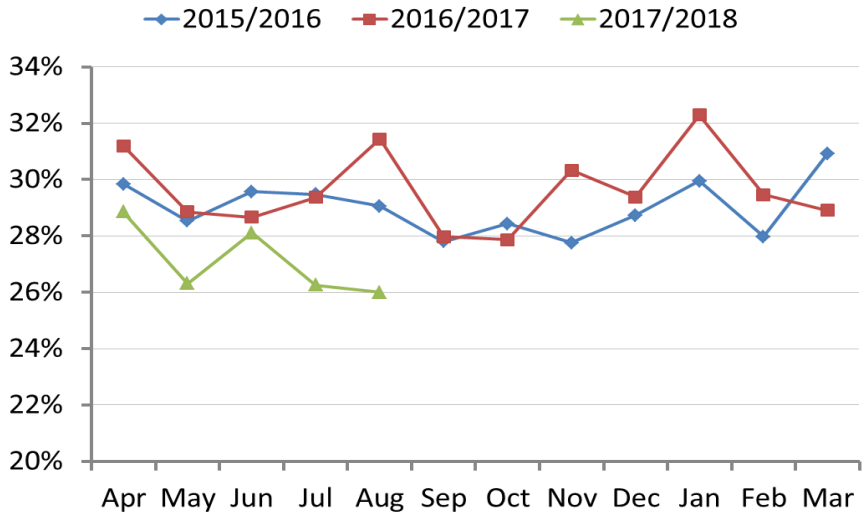
Percentage ED attendances resulting in admission



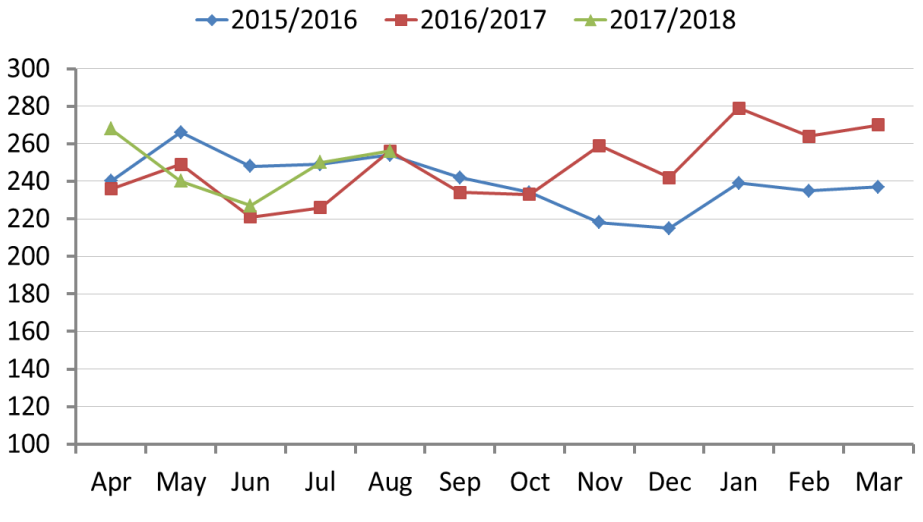
Summary points:

- The percentage of patients arriving in our Emergency Departments and converting to an admission remains at seasonal norm levels; the percentage of patients admitted aged 75 years and over continues, however, to be below the levels seen in the last two years
- The number of over 14 days stays rose slightly this month but is in-line with last year's level. The BRI bed occupancy level continues to fall, and is now below 2016/17 levels
- The number of patients on the outpatient waiting list continues to rise, but remains below previous year levels.
- Number of RTT patients waiting over 18 weeks has risen, but there has also been a slight increase in Clock Stops
- The number of patients referred by their GP with a suspected cancer (2-week waits) remains above the seasonal norm, as does the number of 62-day GP cancer treatments.
- Elective waiting list continues to fall in size

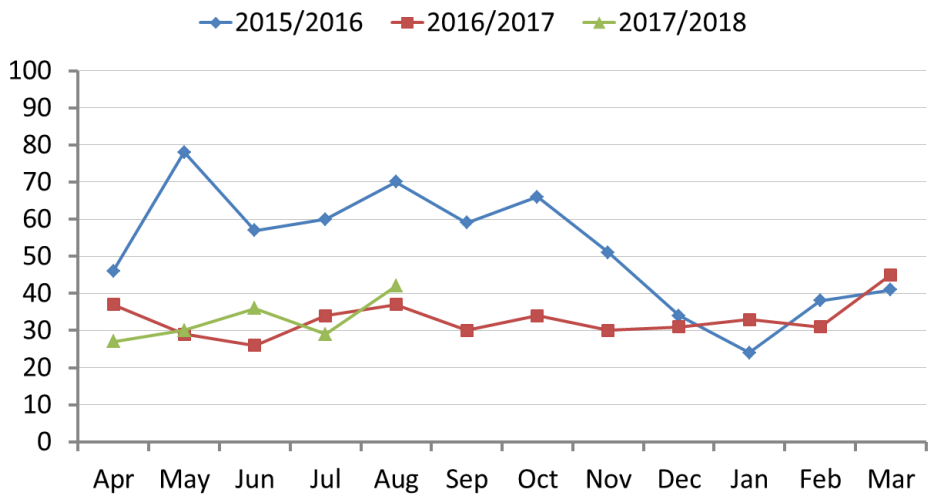
Percentage of Emergency BRI spells patients aged 75 years and over



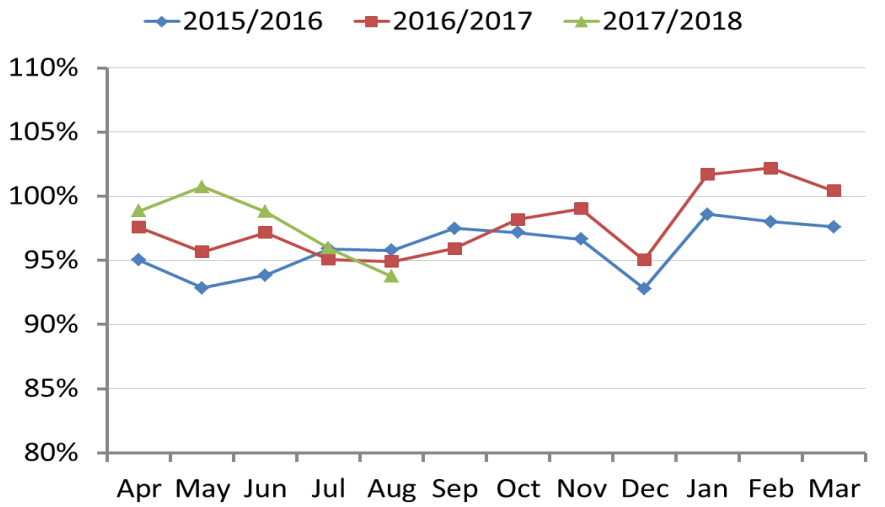
Over 14 day stays , at month-end



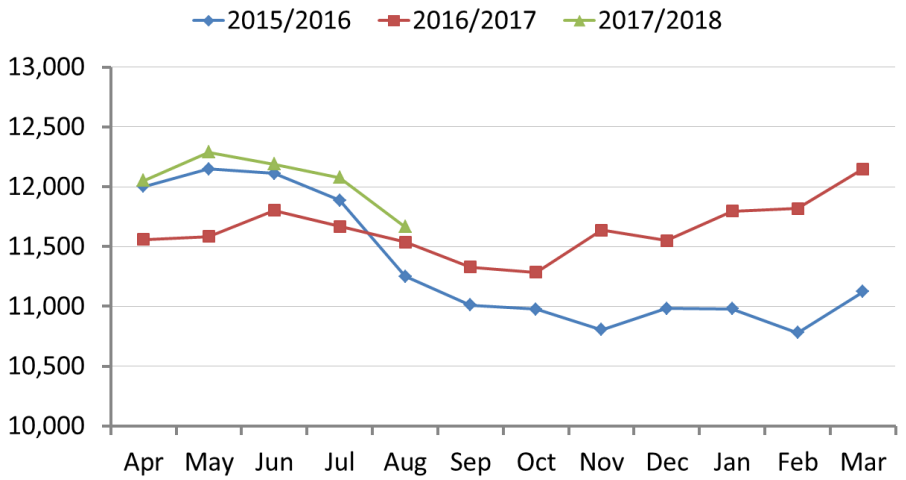
Delayed Transfers of Care (Number of patients at month-end)



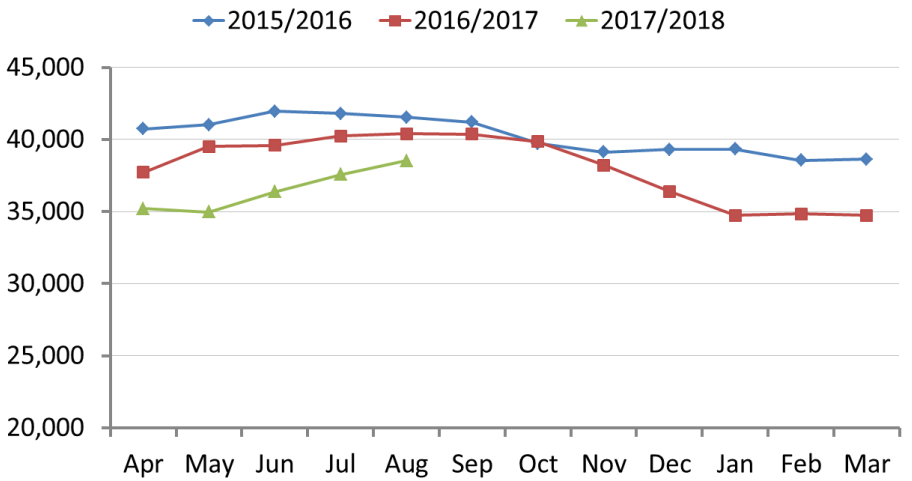
BRI Bed Occupancy



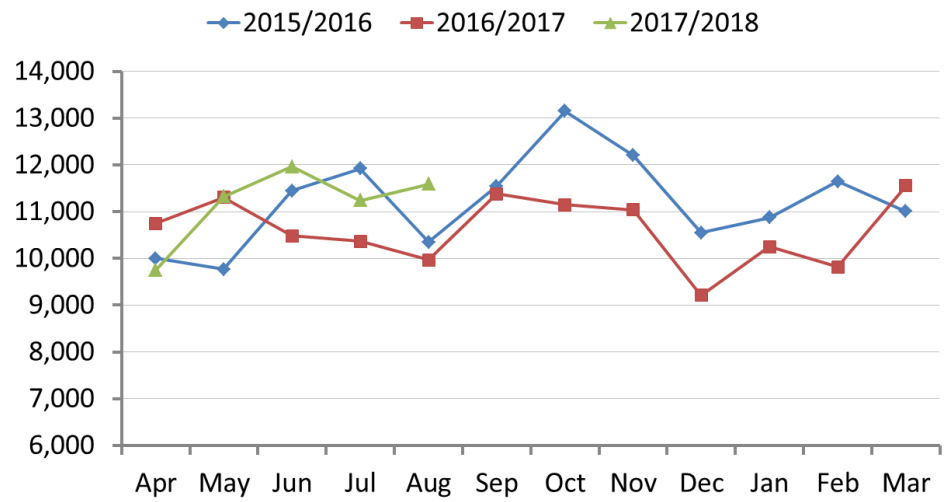
Elective waiting list size



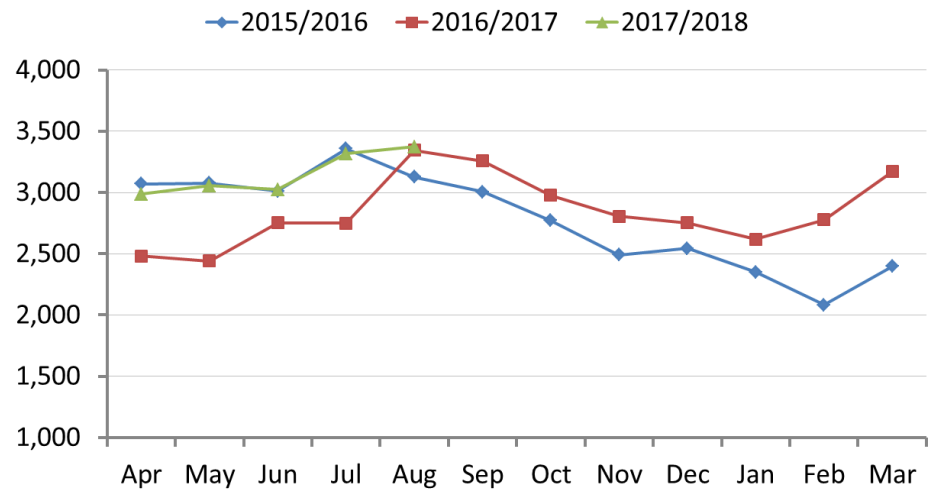
Outpatient waiting list size



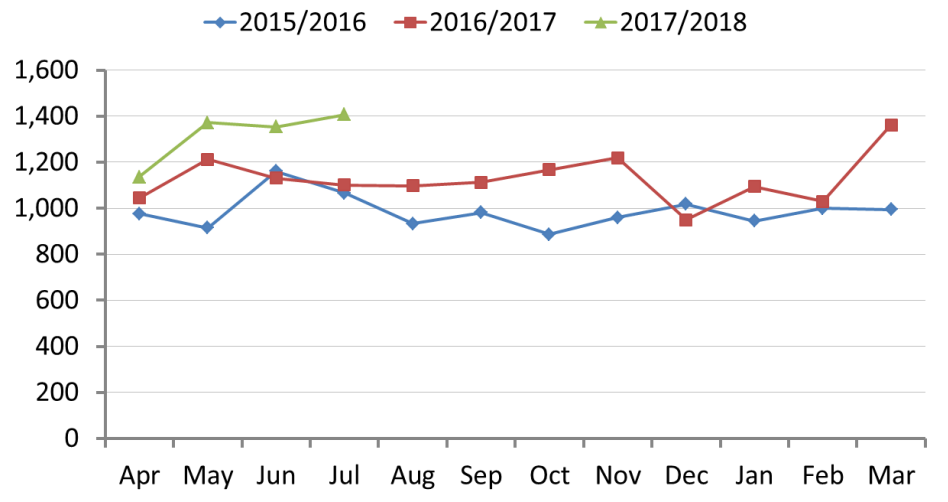
Number of RTT pathways stopped (i.e. treatments)



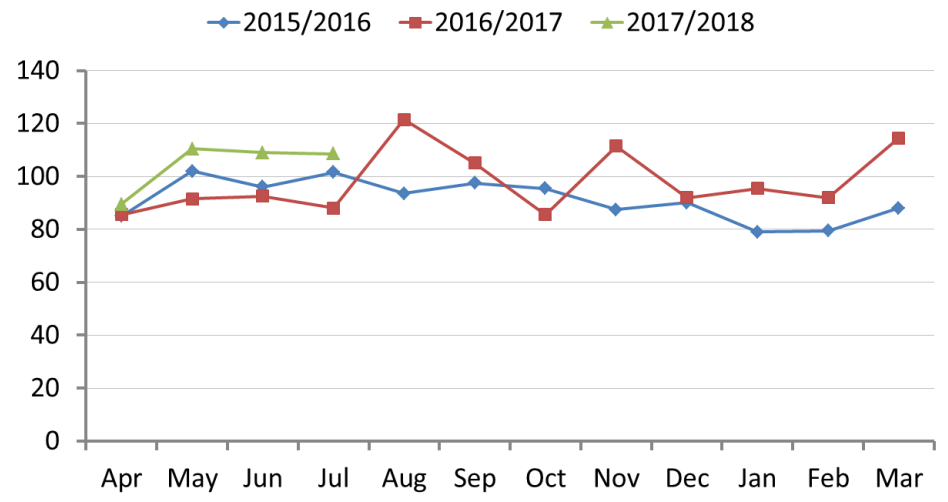
Number of RTT pathways over 18 weeks



Cancer 2-week wait – urgent GP – referrals seen



Cancer 62-day GP referred treatments



Trust Scorecards

SAFE, CARING & EFFECTIVE

Topic	ID	Title	Annual		Monthly Totals												Quarterly Totals			
			16/17	17/18 YTD	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	16/17 Q3	16/17 Q4	17/18 Q1	17/18 Q2
Patient Safety																				
Infections	DA01a	MRSA Bloodstream Cases - Cumulative Totals	-	-	0	0	1	1	1	1	1	-	0	1	1	2	-	-	-	-
	DA01	MRSA Bloodstream Cases - Monthly Totals	1	2	0	0	1	0	0	0	0	0	0	1	0	1	1	0	1	1
	DA03	C.Diff Cases - Monthly Totals	31	20	5	1	3	5	4	0	0	2	4	5	6	3	9	4	11	9
	DA02	MSSA Cases - Monthly Totals	37	7	2	0	6	2	3	3	2	0	1	3	0	3	8	8	4	3
C.Diff "Avoidables"	DA03c	C.Diff Avoidable Cases - Cumulative Totals	-	-	5	5	8	9	10	10	10	0	2	-	-	-	-	-	-	-
Infection Checklists	DB01	Hand Hygiene Audit Compliance	96.6%	98%	94.9%	97%	96.5%	95.7%	95.5%	95.4%	97%	98.4%	98.1%	98.4%	97.2%	-	96.4%	96%	98.3%	97.2%
	DB02	Antibiotic Compliance	88.3%	86.5%	86.8%	90.9%	90.3%	91.2%	91.7%	92%	88.1%	87.7%	89.6%	87.4%	87.8%	81.3%	90.8%	90.8%	88.3%	84.3%
Cleanliness Monitoring	DC01	Cleanliness Monitoring - Overall Score	-	-	95%	95%	96%	96%	96%	94%	95%	96%	96%	96%	96%	97%	-	-	-	-
	DC02	Cleanliness Monitoring - Very High Risk Areas	-	-	98%	97%	97%	97%	98%	97%	97%	98%	98%	98%	98%	98%	-	-	-	-
	DC03	Cleanliness Monitoring - High Risk Areas	-	-	97%	96%	96%	97%	96%	96%	95%	96%	96%	97%	97%	97%	-	-	-	-
Serious Incidents	S02	Number of Serious Incidents Reported	52	23	1	4	5	3	5	2	5	2	7	6	5	3	12	12	15	8
	S02a	Number of Confirmed Serious Incidents	49	9	1	4	5	3	5	2	5	2	5	2	-	-	12	12	9	-
	S02b	Number of Serious Incidents Still Open	-	13	-	-	-	-	-	-	-	-	1	4	5	3	-	-	5	8
	S03	Serious Incidents Reported Within 48 Hours	94.2%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
	S03a	Serious Incidents - 72 Hour Report Completed Within Timescale	90.4%	95.7%	100%	75%	80%	66.7%	100%	100%	100%	100%	100%	83.3%	100%	100%	75%	100%	93.3%	100%
	S04	Serious Incident Investigations Completed Within Timescale	98%	95%	100%	100%	100%	75%	100%	100%	100%	100%	75%	100%	100%	100%	93.3%	100%	91.7%	100%
	S04a	Overdue Exec Commissioned Non-SI Investigations	-	7	-	-	-	-	-	-	-	1	2	2	1	1	-	-	5	2
Never Events	S01	Total Never Events	2	5	0	1	0	0	0	0	0	0	1	2	2	0	1	0	3	2
Patient Safety Incidents	S06	Number of Patient Safety Incidents Reported	14866	5136	1263	1220	1389	1185	1335	1211	1332	1203	1315	1330	1288	-	3794	3878	3848	1288
	S06b	Patient Safety Incidents Per 1000 Beddays	47.82	50.07	50.77	45.61	52.93	46.21	48.94	48.67	48.47	47.02	49.94	53.99	49.49	-	48.25	48.69	50.27	49.49
	S07	Number of Patient Safety Incidents - Severe Harm	95	32	2	10	12	10	10	7	5	7	11	8	6	-	32	22	26	6
Patient Falls	AB01	Falls Per 1,000 Beddays	4.23	4.58	4.42	4.86	4.04	3.74	3.74	4.9	3.89	4.85	3.91	4.91	4.5	4.76	4.22	4.16	4.55	4.63
	AB06a	Total Number of Patient Falls Resulting in Harm	36	9	3	2	2	4	3	3	5	2	3	4	0	0	8	11	9	0
Pressure Ulcers Developed in the Trust	DE01	Pressure Ulcers Per 1,000 Beddays	0.148	0.132	0.161	0.075	0.114	0.195	0.11	0.201	0.182	0.078	0.076	0.203	0.154	0.155	0.127	0.163	0.118	0.154
	DE02	Pressure Ulcers - Grade 2	40	13	4	1	3	5	3	3	3	1	1	5	2	4	9	9	7	6
	DE04A	Pressure Ulcers - Grade 3 or 4	6	4	0	1	0	0	0	2	2	1	1	0	2	0	1	4	2	2
Venous Thrombo-embolism (VTE)	N01	Adult Inpatients who Received a VTE Risk Assessment	99.1%	98.5%	99%	99%	99.4%	99%	99.1%	98.9%	99.1%	98.9%	98.9%	98.7%	98.8%	97.4%	99.1%	99%	98.8%	98.1%
	N02	Percentage of Adult Inpatients who Received Thrombo-prophylaxis	96.4%	96.2%	94.1%	97%	96.5%	97%	97.8%	98%	96.6%	94.5%	97.6%	97%	97.4%	94.9%	96.8%	97.4%	96.3%	95.9%
	N04	Number of Hospital Associated VTEs	63	18	5	2	9	7	11	3	2	5	3	6	4	-	18	16	14	4
	N04A	Number of Potentially Avoidable Hospital Associated VTEs	7	0	1	1	0	1	2	0	0	0	0	0	0	-	2	2	0	0
	N04B	Number of Hospital Associated VTEs - Report Not Received To Date	13	7	1	0	4	2	3	1	0	0	3	2	2	-	6	4	5	2
Nutrition	WB03	Nutrition: 72 Hour Food Chart Review	89.6%	92%	89.7%	86.5%	87.1%	94.3%	92.7%	89.1%	90.2%	89.9%	87.7%	91.5%	96.2%	94.6%	89.4%	90.6%	89.7%	95.5%
Nutrition Audit	WB10	Fully and Accurately Completed Screening within 24 Hours	86.9%	92.2%	88%	-	-	91.2%	-	-	87.9%	-	-	92.2%	-	-	91.2%	87.9%	92.2%	-
Safety	Y01	WHO Surgical Checklist Compliance	99.1%	99.8%	100%	99.6%	-	97.7%	98.4%	98%	97.8%	99.5%	99.7%	99.8%	99.8%	99.8%	98.7%	98.1%	99.7%	99.8%

SAFE, CARING & EFFECTIVE (continued)

Topic	ID	Title	Annual		Monthly Totals												Quarterly Totals			
			16/17	17/18 YTD	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	16/17 Q3	16/17 Q4	17/18 Q1	17/18 Q2
Medicines	WA01	Medication Incidents Resulting in Harm	0.37%	0.68%	1.01%	0.55%	1.19%	0%	0%	0.53%	0%	0.98%	0.44%	0%	1.35%	-	0.64%	0.16%	0.46%	1.35%
	WA03	Non-Purposeful Omitted Doses of the Listed Critical Medication	0.59%	0.4%	0%	0.65%	0.86%	0.74%	0.98%	0.39%	0.26%	0.43%	0.9%	0.24%	0.32%	0.11%	0.75%	0.52%	0.53%	0.19%
Safety Thermometer	AK03	Safety Thermometer - Harm Free Care	97.9%	97.5%	98.6%	97.6%	97.5%	97.4%	98%	97.3%	98.3%	97.9%	97.3%	97.9%	97.7%	96.9%	97.5%	97.9%	97.7%	97.3%
	AK04	Safety Thermometer - No New Harms	98.9%	98.5%	99.2%	98.4%	99.3%	98.5%	98.6%	98.5%	99.1%	99%	98.3%	98.4%	98.8%	98.2%	98.7%	98.7%	98.6%	98.5%
Deteriorating Patient	AR03	National Early Warning Scores (NEWS) Acted Upon	92%	97%	94%	94%	93%	93%	91%	93%	100%	100%	96%	93%	100%	97%	93%	95%	96%	98%
Out of Hours	TD05	Out of Hours Departures	7.8%	9.3%	7.4%	7.2%	7.8%	8.1%	8.4%	9.2%	6.5%	8.5%	8.2%	7.9%	9.3%	12.3%	7.7%	8%	8.2%	10.8%
Timely Discharges	TD03	Percentage of Patients With Timely Discharge (7am-12Noon)	22.1%	22.4%	22.1%	21.8%	22.3%	22.1%	21.6%	21.4%	21.1%	22%	22.3%	23%	22.9%	21.7%	22.1%	21.3%	22.5%	22.3%
	TD03D	Number of Patients With Timely Discharge (7am-12Noon)	11293	4743	932	974	970	935	905	816	934	885	971	962	996	929	2879	2655	2818	1925
Staffing Levels	RP01	Staffing Fill Rate - Combined	103.7%	101.3%	101.9%	102.6%	105.3%	104.2%	103.6%	104.5%	104.1%	107.1%	102.6%	102.4%	98.6%	98%	104%	104%	103.7%	98.3%
Clinical Effectiveness																				
Mortality	X04	Summary Hospital Mortality Indicator (SHMI) - National Data	99.2	-	99.4	-	-	99.1	-	-	97.3	-	-	-	-	-	99.1	97.3	-	-
	X02	Hospital Standardised Mortality Ratio (HSMR)	91.4	87.6	81.2	91.3	110.4	92.2	87.2	90.9	92.1	88.8	80.7	93.3	-	-	97.9	89.9	87.6	-
Mortality Review	tbc	Number of Deaths																		
	tbc	Number of Deaths Subject to Casenote Review																		
	tbc	Number of Deaths Reviewed Under Serious Incident Framework																		
	tbc	Number of Deaths With More Than 50:50 Chance of Being Avoidable																		
Readmissions	C01	Emergency Readmissions Percentage	2.66%	2.49%	2.28%	2.54%	2.64%	2.92%	2.73%	2.89%	2.45%	2.98%	2.44%	2.39%	2.18%	-	2.7%	2.68%	2.59%	2.18%
Sepsis (Inpatients)	AG02a	Percentage of Patients Meeting Criteria Screened for Sepsis (Inpatients)	21.6%	38.1%	16.7%	20%	21.7%	27.3%	27.8%	28.6%	41.7%	38.5%	37.5%	38.1%	-	-	22%	31.8%	38.1%	-
	AG03a	Sepsis Patients Percentage Commencing Antibiotics Within 1 Hour (Inpatie	65.7%	71.4%	33.3%	66.7%	85.7%	71.4%	100%	50%	42.9%	100%	50%	62.5%	-	-	73.9%	68%	71.4%	-
	AG04a	Sepsis Patients Percentage with a 72 Hour Review (Inpatients)	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	-	-	100%	100%	100%	-
Sepsis (Emergency Department)	AG02b	Percentage of Patients Meeting Criteria Screened for Sepsis (ED)	74.4%	80%	100%	60%	80%	80%	90%	80%	100%	85.7%	76.9%	78.3%	-	-	73.3%	90%	80%	-
	AG03b	Sepsis Patients Percentage Commencing Antibiotics Within 1 Hour (ED)	56.3%	76.7%	90%	40%	50%	60%	77.8%	70%	25%	85.7%	63.6%	77.8%	-	-	50%	59.3%	76.7%	-
	AG04b	Sepsis Patients Percentage with a 72 Hour Review (ED)	94.3%	100%	100%	100%	100%	70%	100%	100%	100%	100%	100%	100%	-	-	84.2%	100%	100%	-
Maternity	G01	Percentage of Low Weight Babies	2.7%	2.3%	2.6%	3.1%	3.3%	2.3%	2.4%	3.9%	3.3%	2.3%	3.5%	0.5%	1.5%	3.3%	2.9%	3.2%	2.2%	2.4%
	G01A	Number of Low Weight Babies	137	45	11	14	13	9	10	14	14	9	15	2	6	13	36	38	26	19

SAFE, CARING & EFFECTIVE (continued)

			Annual		Monthly Totals												Quarterly Totals			
Topic	ID	Title	16/17	17/18 YTD	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	16/17 Q3	16/17 Q4	17/18 Q1	17/18 Q2
Fracture Neck of Femur	U02	Fracture Neck of Femur Patients Treated Within 36 Hours	70.5%	75.7%	58.3%	73.7%	69.2%	51.7%	69.2%	81%	80.8%	57.7%	86.7%	85%	67.6%	84.6%	63.5%	76.7%	76.3%	75%
	U03	Fracture Neck of Femur Patients Seeing Orthogeriatrician within 72 Hours	74%	57.4%	58.3%	89.5%	69.2%	86.2%	61.5%	71.4%	73.1%	73.1%	73.3%	60%	47.1%	34.6%	81.1%	68.5%	69.7%	41.7%
	U04	Fracture Neck of Femur Patients Achieving Best Practice Tariff	51.9%	39.7%	37.5%	68.4%	53.8%	44.8%	42.3%	61.9%	61.5%	34.6%	60%	50%	29.4%	26.9%	54.1%	54.8%	48.7%	28.3%
	U05	Fracture Neck of Femur - Time To Treatment 90th Percentile (Hours)	-	-	53.5	49.4	51.7	53.2	48.8	43.3	37.3	67.4	38	37.1	45.9	43.8	-	-	-	-
Stroke Care	O01	Stroke Care: Percentage Receiving Brain Imaging Within 1 Hour	58.6%	64.1%	63.4%	56.8%	61.8%	35.3%	52.4%	50%	64.3%	61.5%	51.4%	66.7%	72.9%	-	51.4%	55.5%	59.6%	72.9%
	O02	Stroke Care: Percentage Spending 90%+ Time On Stroke Unit	90.2%	84%	92.7%	97.3%	88.2%	94.1%	90.5%	84.1%	88.6%	90.9%	80.6%	81.8%	83.3%	-	93.3%	87.7%	84.3%	83.3%
	O03	High Risk TIA Patients Starting Treatment Within 24 Hours	66.8%	58.5%	80%	60%	65.2%	81.8%	51.7%	72.2%	61.5%	56.3%	50%	77.3%	27.3%	66.7%	68.2%	60%	62.5%	50%
Dementia	AC01	Dementia - FAIR Question 1 - Case Finding Applied	90.4%	89.1%	93.2%	93.1%	88.9%	89.1%	80.8%	80.1%	84%	87.2%	88.3%	89.4%	91.1%	89.9%	90.2%	81.6%	88.3%	90.5%
	AC02	Dementia - FAIR Question 2 - Appropriately Assessed	97.2%	98.6%	100%	96.8%	94.1%	97.6%	97.6%	88.9%	100%	97.3%	97.6%	100%	100%	97.7%	96.3%	96.2%	98.3%	98.9%
	AC03	Dementia - FAIR Question 3 - Referred for Follow Up	94.7%	92.3%	85.7%	100%	100%	71.4%	100%	100%	100%	100%	66.7%	100%	100%	100%	88.2%	100%	88.9%	100%
	AC04	Percentage of Dementia Carers Feeling Supported	75%	100%	-	-	-	-	-	-	-	-	-	100%	-	-	-	-	100%	-
Outliers	J05	Ward Outliers - Beddays Spent Outlying.	8854	2979	464	892	847	614	1089	830	717	702	807	485	448	537	2353	2636	1994	985
Patient Experience																				
Monthly Patient Surveys	P01d	Patient Survey - Patient Experience Tracker Score	-	-	91	91	92	94	92	92	92	91	91	93	92	91	92	91	91	91
	P01g	Patient Survey - Kindness and Understanding	-	-	96	95	96	97	96	95	96	96	95	97	95	94	95	95	96	95
	P01h	Patient Survey - Outpatient Tracker Score	-	-	89	88	90	90	90	88	89	90	88	87	90	87	90	89	88	89
Friends and Family Test Coverage	P03a	Friends and Family Test Inpatient Coverage	35.5%	36.3%	30.7%	33.7%	35.9%	30.6%	31.7%	34.8%	36.8%	34.6%	38.3%	37.4%	35.8%	35.1%	33.5%	34.5%	36.8%	35.5%
	P03b	Friends and Family Test ED Coverage	16.4%	17.7%	15.5%	17.3%	18.9%	15.4%	21.2%	17.7%	18.4%	15.9%	16.1%	20.9%	17.2%	18.5%	17.2%	19.1%	17.6%	17.9%
	P03c	Friends and Family Test MAT Coverage	22.5%	19.9%	21.1%	22.6%	22.1%	19.8%	24.6%	29.7%	25.3%	23.6%	17.1%	21.8%	20%	17.3%	21.6%	26.4%	20.7%	18.8%
Friends and Family Test Score	P04a	Friends and Family Test Score - Inpatients	97.2%	97.4%	96.9%	98.2%	97.3%	97.5%	97.4%	96.9%	98.5%	97.2%	96.9%	97.7%	97.7%	97.5%	97.7%	97.6%	97.3%	97.6%
	P04b	Friends and Family Test Score - ED	78.2%	80.9%	78.6%	79.3%	78.9%	74.1%	80.8%	79.6%	80.2%	83.2%	77%	84.4%	77.4%	81.9%	77.6%	80.2%	81.7%	79.6%
	P04c	Friends and Family Test Score - Maternity	96.8%	96.2%	97.3%	97.7%	94.3%	94.5%	98.2%	96.2%	97.4%	96.9%	95.8%	96.9%	94.9%	96.5%	95.6%	97.3%	96.6%	95.6%
Patient Complaints	T01	Number of Patient Complaints	1875	847	162	140	139	118	129	144	168	247	158	150	146	146	397	441	555	292
	T01a	Patient Complaints as a Proportion of Activity	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
	T03a	Complaints Responded To Within Trust Timeframe	86.1%	82.5%	86%	92.3%	93.4%	97.4%	87.5%	87.5%	83.3%	76.3%	83%	80.4%	82%	87.3%	94.2%	86%	80.2%	85.1%
	T03b	Complaints Responded To Within Divisional Timeframe	86.6%	77.8%	81.4%	92.3%	85.2%	76.9%	85.4%	85%	72.9%	76.3%	83%	78.3%	70%	80.3%	84.9%	80.9%	79.4%	76%
	T04c	Percentage of Responses where Complainant is Dissatisfied	11.41%	9.52%	18.61%	0%	9.84%	12.82%	14.58%	10%	12.5%	15.79%	17.02%	21.74%	-	-	7.91%	12.5%	18.32%	0%
Cancelled Operations	F01q	Percentage of Last Minute Cancelled Operations (Quality Objective)	0.98%	0.97%	0.6%	1.18%	0.88%	0.99%	1.24%	1.52%	0.91%	1.34%	1.02%	0.81%	0.81%	0.91%	1.01%	1.2%	1.05%	0.86%
	F01a	Number of Last Minute Cancelled Operations	734	316	39	73	57	58	79	89	63	80	67	54	54	61	188	231	201	115

RESPONSIVE

Topic	ID	Title	Annual Target Green	Annual Target Red	Annual 16/17	Annual 17/18 YTD	Monthly Totals Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Quarterly Totals 16/17 Q3	16/17 Q4	17/18 Q1	17/18 Q2
Referral to Treatment (RTT) Performance	A03	Referral To Treatment Ongoing Pathways Under 18 Weeks	92%	92%	91.7%	90.7%	90.4%	91.2%	92%	92%	92.2%	92%	91.1%	91.1%	91.1%	91%	90.2%	89.9%	91.8%	91.8%	91.1%	90.1%
	A03a	Referral To Treatment Number of Ongoing Pathways Over 18 Weeks	-	-	-	-	3256	2978	2805	2751	2619	2777	3171	2985	3056	3023	3317	3372	-	-	-	-
Referral to Treatment (RTT) Wait Times	A06	Referral To Treatment Ongoing Pathways Over 52 Weeks	0	1	11	124	1	0	1	1	3	3	2	5	11	46	30	32	2	8	62	62
	A07	Referral To Treatment Ongoing Pathways 40+ Weeks	-	-	696	949	27	53	78	93	86	106	133	153	165	193	198	240	224	325	511	438
New Outpatient Wait List	L02L	New Outpatient List (RTT Specialties) - Numbers Waiting 12+ Weeks	-	-	-	-	9562	9295	7986	8521	7372	7068	6307	6723	7105	7586	7453	9537	-	-	-	-
	L02M	New Outpatient List (RTT Specialties) - Percentage Waiting 12+ Weeks	-	-	-	-	35.5%	33.7%	29.8%	32.3%	28.5%	28.9%	27.5%	27.6%	28.7%	28.3%	25.6%	30.4%	-	-	-	-
Cancer (2 Week Wait)	E01a	Cancer - Urgent Referrals Seen In Under 2 Weeks	93%	93%	94.8%	94.6%	91.6%	94.3%	96.2%	96%	95.9%	95.5%	96.3%	95.1%	95.6%	94.3%	93.4%	-	95.5%	95.9%	95%	93.4%
	E01c	Cancer - Urgent Referrals Stretch Target	80%	80%	68.4%	58.4%	67%	55.1%	71%	60.8%	75.3%	76%	79.7%	52.5%	55.4%	62.1%	63.6%	-	62.4%	77.2%	56.8%	63.6%
Cancer (31 Day)	E02a	Cancer - 31 Day Diagnosis To Treatment (First Treatments)	96%	96%	96.7%	95.2%	97.4%	97.8%	98.3%	96.1%	96.5%	96.8%	97.4%	91.3%	96.6%	95.1%	97.1%	-	97.4%	96.9%	94.5%	97.1%
	E02b	Cancer - 31 Day Diagnosis To Treatment (Subsequent - Drug)	98%	98%	98.7%	98.4%	99.1%	97.5%	100%	99.1%	100%	100%	98.4%	99.2%	97.5%	98.7%	98.6%	-	98.9%	99.5%	98.4%	98.6%
	E02c	Cancer - 31 Day Diagnosis To Treatment (Subsequent - Surgery)	94%	94%	94.4%	89.8%	98.4%	96.4%	98%	95.9%	93.8%	92.3%	96.5%	83.3%	92.2%	93.2%	90.7%	-	96.8%	94.3%	89.5%	90.7%
	E02d	Cancer - 31 Day Diagnosis To Treatment (Subsequent - Radiotherapy)	94%	94%	96.6%	96.4%	92%	95.4%	98.1%	98.2%	96.9%	97.6%	96.7%	98.1%	96.6%	95.9%	95.4%	-	97.3%	97%	96.7%	95.4%
Cancer (62 Day)	E03a	Cancer 62 Day Referral To Treatment (Urgent GP Referral)	85%	85%	79.3%	77.7%	80.5%	79.5%	85.2%	81.5%	84.3%	78.8%	81.2%	76.5%	77.8%	81.7%	74.7%	-	82.4%	81.5%	78.8%	74.7%
	E03b	Cancer 62 Day Referral To Treatment (Screenings)	90%	90%	69.4%	71.4%	44.4%	100%	83.3%	100%	57.1%	100%	83.3%	71.4%	44.4%	100%	87.5%	-	94.3%	77.8%	65%	87.5%
	E03c	Cancer 62 Day Referral To Treatment (Upgrades)	85%	85%	87.9%	83.8%	92.5%	88%	90.1%	82.1%	93.2%	77.8%	88.4%	93%	77.7%	87%	78.6%	-	86.5%	86.8%	85.5%	78.6%
	E03f	Cancer Urgent GP Referrals - Numbers Treated after Day 103	-	-	62	22	5	4	6.5	4	5.5	4.5	7.5	4	5	5	8	-	14.5	17.5	14	8
Cancelled Operations	F01	Last Minute Cancelled Operations - Percentage of Admissions	0.8%	0.8%	0.98%	0.97%	0.6%	1.18%	0.88%	0.99%	1.24%	1.52%	0.91%	1.34%	1.02%	0.81%	0.81%	0.91%	1.01%	1.2%	1.05%	0.86%
	F01a	Number of Last Minute Cancelled Operations	-	-	734	316	39	73	57	58	79	89	63	80	67	54	54	61	188	231	201	115
	F02c	Number of LMCs Not Re-admitted Within 28 Days	16	16	72	13	0	3	6	4	4	6	15	4	6	2	0	1	13	25	12	1
Admissions Cancelled Day Before	F07	Percentage of Admissions Cancelled Day Before	-	-	1.36%	1.37%	1.33%	2.11%	1.61%	1.38%	0.67%	1.16%	1.13%	1.05%	1.86%	1.82%	1.2%	0.88%	1.7%	0.99%	1.59%	1.04%
	F07a	Number of Admissions Cancelled Day Before	-	-	1021	445	87	131	104	81	43	68	78	63	122	121	80	59	316	189	306	139
Primary PCI	H02	Primary PCI - 150 Minutes Call to Balloon Time	90%	70%	72.4%	78.8%	75%	73.5%	57.1%	64.7%	69%	86.1%	83.3%	83.3%	78.1%	77.5%	75%	-	65%	79.2%	79.8%	75%
	H03a	Primary PCI - 90 Minutes Door to Balloon Time	90%	90%	91.7%	90.4%	97.2%	91.2%	85.7%	79.4%	90.5%	94.4%	100%	90.5%	93.8%	90%	87.5%	-	85.4%	95%	91.2%	87.5%
Diagnostic Waits	A05	Diagnostics 6 Week Wait (15 Key Tests)	99%	99%	97.79%	98.41%	96.88%	98.91%	99.05%	98.23%	98.38%	98.69%	98.65%	98.56%	98.8%	98.58%	98.52%	97.61%	98.74%	98.58%	98.65%	98.06%
Outpatients	R03	Outpatient Hospital Cancellation Rate	9.7%	11.7%	11.5%	11.2%	11.4%	10.7%	10.2%	11%	10.7%	11.2%	11.1%	12%	10.8%	11%	11.2%	11%	10.6%	11%	11.2%	11.1%
	R05	Outpatient DNA Rate	5%	10%	7.3%	7.3%	7.9%	7.7%	6.9%	7.8%	7.3%	6.9%	6.9%	7.1%	7.2%	7.5%	7.4%	7.2%	7.4%	7%	7.3%	7.3%
Outpatient Ratio	R01	Follow-Up To New Ratio	2.03	2.03	2.24	2.24	2.25	2.17	2.17	2.2	2.29	2.3	2.27	2.2	2.25	2.23	2.25	2.26	2.18	2.28	2.23	2.25
ERS	BC01	ERS - Available Slot Issues Percentage	-	-	31%	21.1%	35.8%	21.6%	25.3%	34.3%	26.1%	25.2%	26.4%	24.4%	24%	21.7%	18.8%	16.8%	26.2%	25.9%	23.4%	17.8%

RESPONSIVE (continued)

Topic	ID	Title	Annual Target Green	Annual Target Red	Annual 16/17	Annual 17/18 YTD	Monthly Totals Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Quarterly Totals 16/17 Q3	16/17 Q4	17/18 Q1	17/18 Q2
Delayed Discharges	Q01A	Acute Delayed Transfers of Care - Patients	-	-	-	-	25	30	28	28	29	29	29	19	24	30	18	31	-	-	-	-
	Q02A	Non-Acute Delayed Transfers of Care - Patients	-	-	-	-	5	4	2	3	4	2	16	8	6	6	11	11	-	-	-	-
	Q01B	Acute Delayed Transfers of Care - Beddays	-	-	10232	3228	889	927	802	834	891	750	809	655	604	577	745	647	2563	2450	1836	1392
	Q02B	Non-Acute Delayed Transfers of Care - Beddays	-	-	2167	1362	184	233	138	131	106	183	252	306	145	259	278	374	502	541	710	652
Green To Go List	AQ06A	Green To Go List - Number of Patients (Acute)	-	-	-	-	44	55	54	51	59	52	47	43	42	43	46	51	-	-	-	-
	AQ06B	Green To Go List - Number of Patients (Non Acute)	-	-	-	-	16	6	8	8	6	9	22	14	13	11	15	17	-	-	-	-
	AQ07A	Green To Go List - Beddays (Acute)	-	-	-	-	1505	1706	1864	1691	1937	1575	1716	1400	1371	1403	1430	1580	-	-	-	-
	AQ07B	Green To Go List - Beddays (Non-Acute)	-	-	-	-	396	372	249	270	189	334	450	503	383	419	401	572	-	-	-	-
Length of Stay	J03	Average Length of Stay (Spell)	-	-	4.17	4.16	4.2	3.99	4.08	4.19	4.21	4.49	4.27	4.27	4.31	4.06	3.8	4.37	4.09	4.32	4.21	4.08
	J04D	Percentage Length of Stay 14+ Days	-	-	7%	7%	7%	6.3%	6.6%	7.2%	6.9%	7.9%	7.4%	7.3%	7.8%	6.7%	6.2%	7%	6.7%	7.4%	7.2%	6.6%
14 Day LOS Patients	C07	Number of 14+ Day Length of Stay Patients at Month End	-	-	-	-	234	233	259	242	279	264	270	268	240	227	250	256	-	-	-	-
AMU	J35	Percentage of Cardiac AMU Wardstays	-	-	4.1%	3.8%	6.2%	4.8%	5.6%	2.8%	2.9%	2.2%	4.1%	1.4%	3.9%	5.2%	4.2%	4.3%	4.4%	3.2%	3.5%	4.2%
	J35A	Percentage of Cardiac AMU Wardstays Under 24 Hours	-	-	39.2%	47.2%	37.2%	30.3%	52.6%	33.3%	57.1%	57.1%	44.1%	63.6%	61.3%	37.2%	39.5%	50%	40.2%	50.7%	49.4%	44.7%

Emergency Department Indicators

ED - Time In Department	B01	ED Total Time in Department - Under 4 Hours	95%	95%	85.01%	87.22%	87.33%	82.94%	78.45%	79.64%	80.37%	80.73%	83.25%	82.31%	84.21%	87.89%	90.53%	91.26%	80.35%	81.53%	84.81%	90.88%
	This is measured against the national standard of 95%																					
ED - Time in Department (Differentials)	BB14	ED Total Time in Department - Under 4 Hours (STP)	-	-	85.01%	87.22%	87.33%	82.94%	78.45%	79.64%	80.37%	80.73%	83.25%	82.31%	84.21%	87.89%	90.53%	91.26%	80.35%	81.53%	84.81%	90.88%
	BB07	BRI ED - Percentage Within 4 Hours	-	-	77.42%	78.86%	80.78%	73.39%	71.69%	73.47%	68.86%	68.15%	73.89%	69.16%	73.76%	79.01%	85.11%	86.82%	72.85%	70.4%	73.99%	85.95%
	BB03	BCH ED - Percentage Within 4 Hours	-	-	89.89%	96.14%	91.57%	90.65%	78.6%	79.38%	90.19%	92.11%	88.92%	96.83%	94.05%	97.14%	96.62%	96.35%	82.63%	90.28%	95.93%	96.5%
	BB04	BEH ED - Percentage Within 4 Hours	99.5%	99.5%	98.97%	96.92%	99.26%	98.06%	99.06%	99.15%	98.56%	99%	99.18%	96.52%	96.57%	97.9%	96.58%	97.04%	98.74%	98.93%	97%	96.81%
	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	40	0	1	2	1	11	19	5	0	0	0	0	0	0	14	24	0	0
Time to Initial Assessment	B02c	ED Time to Initial Assessment - Under 15 Minutes (Excludes BCH)	95%	95%	97.6%	98.3%	97.3%	98.3%	97.9%	97.9%	98%	98.5%	98.8%	98.9%	96.3%	98.3%	98.5%	99.3%	98%	98.4%	97.8%	98.9%
	B02b	ED Time to Initial Assessment - Data Completness	95%	95%	92.8%	92.1%	91.2%	91.8%	92.7%	93.7%	93.6%	94.1%	93.9%	92.1%	91.6%	92.8%	91.8%	92.6%	92.7%	93.8%	92.1%	92.2%
Time to Start of Treatment	B03	ED Time to Start of Treatment - Under 60 Minutes	50%	50%	52.6%	53%	55.2%	52.8%	48.2%	50.5%	53.3%	54.3%	51%	50.8%	52.3%	52.8%	54%	55.4%	50.5%	52.8%	52%	54.6%
	B03b	ED Time to Start of Treatment - Data Completeness	95%	95%	98.5%	97.4%	98.5%	98%	98.5%	98.3%	98.7%	98.1%	98.1%	97.8%	97.2%	97.1%	97.4%	97.3%	98.3%	98.3%	97.4%	97.3%
Others	B04	ED Unplanned Re-attendance Rate	5%	5%	2.6%	2.5%	2.3%	2.4%	2.5%	3.3%	2.5%	3.1%	2.5%	2.6%	2.6%	2.7%	2.7%	1.9%	2.7%	2.7%	2.6%	2.3%
	B05	ED Left Without Being Seen Rate	5%	5%	2.2%	2.4%	2.2%	2.6%	2.2%	2.4%	1.4%	1.8%	2%	2.8%	2.6%	2.5%	2%	2.1%	2.4%	1.8%	2.6%	2%
Ambulance Handovers	BA09	Ambulance Handovers - Over 30 Minutes	-	-	1216	377	140	161	119	114	138	83	11	111	82	84	46	54	394	232	277	100
Acute Medical Unit (AMU)	J35	Percentage of Cardiac AMU Wardstays	-	-	4.1%	3.8%	6.2%	4.8%	5.6%	2.8%	2.9%	2.2%	4.1%	1.4%	3.9%	5.2%	4.2%	4.3%	4.4%	3.2%	3.5%	4.2%
	J35a	Percentage of Cardiac AMU Wardstays Under 24 Hours	-	-	39.2%	47.2%	37.2%	30.3%	52.6%	33.3%	57.1%	57.1%	44.1%	63.6%	61.3%	37.2%	39.5%	50%	40.2%	50.7%	49.4%	44.7%

EFFICIENT

Topic	ID	Title	Annual 16/17	Annual 17/18 YTD	Monthly Totals Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Quarterly Totals 16/17 Q3	16/17 Q4	17/18 Q1	17/18 Q2
Sickness	AF02	Sickness Rate	3.9%	3.9%	3.7%	4.5%	4.7%	4.7%	4.9%	4.3%	3.8%	3.7%	3.8%	3.9%	4.4%	4.1%	4.7%	3.8%	3.9%	
		For 2017/18, the Trust average for the year is 3.8%. Divisional targets are: 2.7% (DAT), 5.7% (FAE), 4.5% (MDC), 3.6% (SPS), 3.6% (SHN), 3.7% (WAC), 3.1% (THQ). 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 by quarter.																		
Staffing Numbers	AF08	Funded Establishment FTE	8446.1	8547.6	8364.5	8393.1	8402.2	8407.6	8434.2	8436	8446.1	8367.1	8479.3	8491.6	8499.7	8547.6	8407.6	8446.1	8491.6	
	AF09A	Actual Staff FTE (Including Bank & Agency)	8566.5	8641.4	8436.4	8427.7	8468.8	8412.7	8458.1	8496.4	8566.5	8510.5	8546.3	8584.7	8602.5	8641.4	8412.7	8566.5	8584.7	
	AF13	Percentage Over Funded Establishment	1.4%	1.1%	0.9%	0.4%	0.8%	0.1%	0.3%	0.7%	1.4%	1.7%	0.8%	1.1%	1.2%	1.1%	0.1%	1.4%	1.1%	
		Green is below 0.5%. Amber is 0.5% to below 1% and Red is 1% or above																		
Bank Usage	AF04	Workforce Bank Usage	427.9	536.4	410.7	376.3	387	358.5	378.3	398.9	427.9	446.7	476.6	501.8	531	536.4	358.5	427.9	501.8	
	AF11A	Percentage Bank Usage	5%	6.2%	4.9%	4.5%	4.6%	4.3%	4.5%	4.7%	5%	5.2%	5.6%	5.8%	6.2%	6.2%	4.3%	5%	5.8%	
		Bank Percentage is Bank usage as a percentage of total staff (bank+agency+substantive). Trust annual average for 17/18 is 3.9% with separate divisional averages.																		
Agency Usage	AF05	Workforce Agency Usage	123.7	125.3	157.4	149.1	142.7	111.5	122.5	131	123.7	96.7	94.1	123.4	130.6	125.3	111.5	123.7	123.4	
	AF11B	Percentage Agency Usage	1.4%	1.5%	1.9%	1.8%	1.7%	1.3%	1.4%	1.5%	1.4%	1.1%	1.1%	1.4%	1.5%	1.5%	1.3%	1.4%	1.4%	
		Agency Percentage is Agency usage as a percentage of total staff (bank+agency+substantive). Trust annual average for 17/18 is 1.0% with separate divisional averages.																		
Vacancy	AF06	Vacancy FTE (Funded minus Actual)	349.8	483.8	404.5	404.5	379.6	383.7	389.4	384	349.8	331.4	420.4	451	477.3	483.8	383.7	349.8	451	
	AF07	Vacancy Rate (Vacancy FTE as Percent of Funded FTE)	4.2%	5.7%	4.9%	4.9%	4.6%	4.6%	4.7%	4.6%	4.2%	4%	5%	5.4%	5.7%	5.7%	4.6%	4.2%	5.4%	
		Vacancy is Funded Establishment minus Staff as a percentage of Funded Establishment. Before Apr-15, this was all Funded Establishment; from Apr-15 it was substantive staff only. Green is < 5% with Red >= 5%																		
Turnover	AF10A	Workforce - Number of Leavers (Permanent Staff)	146	359	205	128	109	133	165	111	146	173	172	147	187	359	133	146	147	
	AF10	Workforce Turnover Rate	12.8%	12.7%	13.3%	13.1%	12.6%	12.7%	12.5%	12.6%	12.8%	12.5%	12.7%	12.9%	13%	12.7%	12.7%	12.8%	12.9%	
		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.																		
Essential Training 2016/17	AF21a	Core Essential Training (Three Yearly)	85%	86%	88%	88%	88%	89%	89%	89%	85%	85%	89%	89%	88%	86%	89%	85%	89%	
	AF21b	Essential Training Compliance - Annual Training (Fire & IG)	-	-	73%	75%	-	-	-	-	-	-	-	-	-	-	-	-	-	
	AF21f	Essential Training Compliance - Fire Safety	83%	87%	-	-	80%	81%	82%	82%	83%	82%	84%	84%	86%	87%	81%	83%	84%	
	AF21g	Essential Training Compliance - Information Governance	76%	82%	-	-	76%	76%	76%	77%	76%	75%	75%	75%	80%	82%	76%	76%	75%	
	AF21c	Essential Training Compliance - Induction	97%	98%	96%	96%	96%	96%	96%	97%	97%	98%	98%	98%	98%	98%	96%	97%	98%	
	AF21d	Essential Training Compliance - Resuscitation Training	75%	80%	81%	81%	81%	83%	85%	85%	75%	75%	71%	71%	77%	80%	83%	75%	71%	
	AF21e	Essential Training Compliance - Safeguarding Training	91%	87%	88%	89%	90%	90%	90%	90%	91%	90%	90%	90%	89%	87%	90%	91%	90%	
		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
AHP	Allied Health Professional
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
BOA	British Orthopaedic Association
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 AUGUST 2017:

All Essential Training

	UH Bristol	Diagnostic & Therapies	Facilities & Estates	Medicine	Specialised Services	Surgery	Trust Services	Women's & Children's
Three Yearly	86%	87%	88%	88%	86%	87%	87%	84%
Annual Fire	87%	89%	88%	86%	89%	88%	90%	85%
Annual IG	82%	86%	82%	80%	84%	83%	87%	78%
Induction & Orientation	98%	99%	99%	96%	97%	98%	98%	98%
Medical & Dental Induction	67%	100%	N/A	43%	64%	57%	N/A	96%
Resuscitation	80%	71%	N/A	84%	83%	82%	75%	77%
Safeguarding	87%	88%	86%	89%	85%	86%	89%	87%

Timeline of Trust Essential Training Compliance:

	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17
Target	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%
Compliance	87%	85%	86%	87%	88%	88%	89%	87%	87%	89%	89%	89%	88%

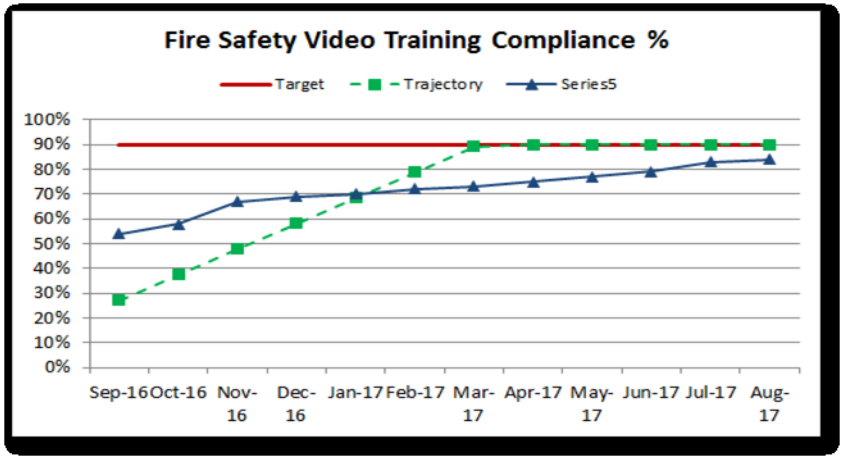
Safeguarding Adults and Children

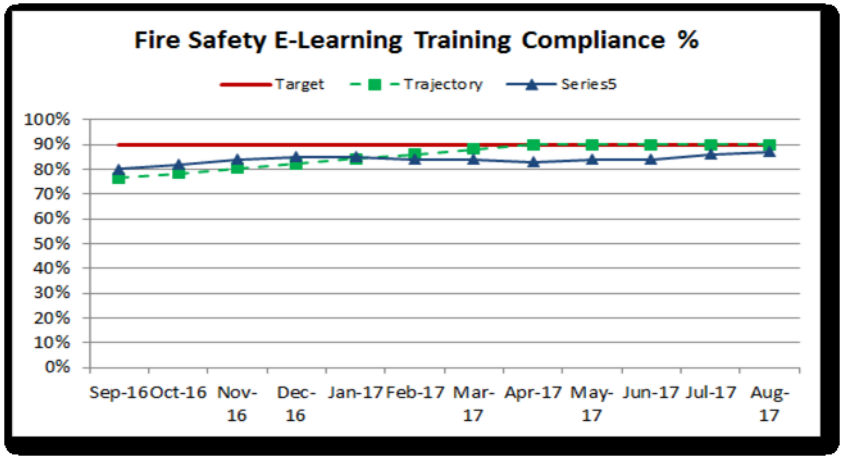
	UH Bristol	Diagnostics & Therapies	Facilities & Estates	Medicine	Specialised Services	Surgery	Trust Services	Women's & Children's
Safeguarding Adults L1	86%	86%	87%	80%	84%	85%	88%	90%
Safeguarding Adults L2	88%	91%	82%	91%	87%	88%	86%	86%
Safeguarding Adults L3	85%	75%	N/A	86%	100%	82%	94%	55%
Safeguarding Children L1	88%	88%	83%	87%	91%	88%	91%	N/A
Safeguarding Children L2	86%	87%	94%	89%	82%	85%	78%	93%

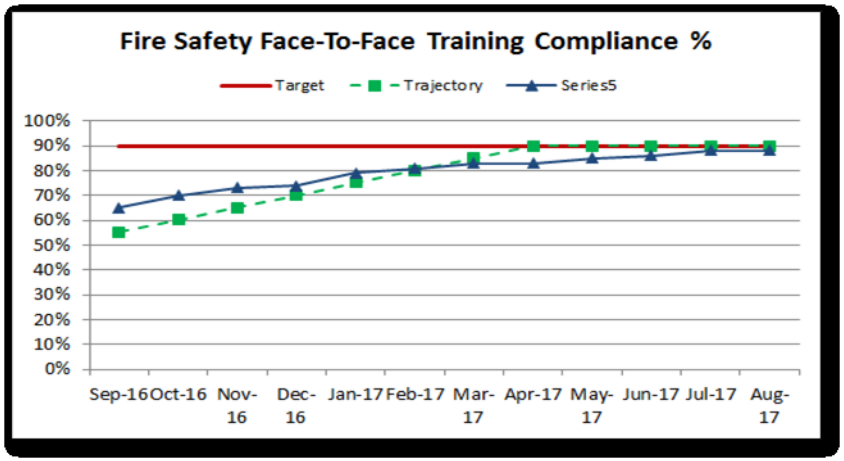
Child Protection Level 3

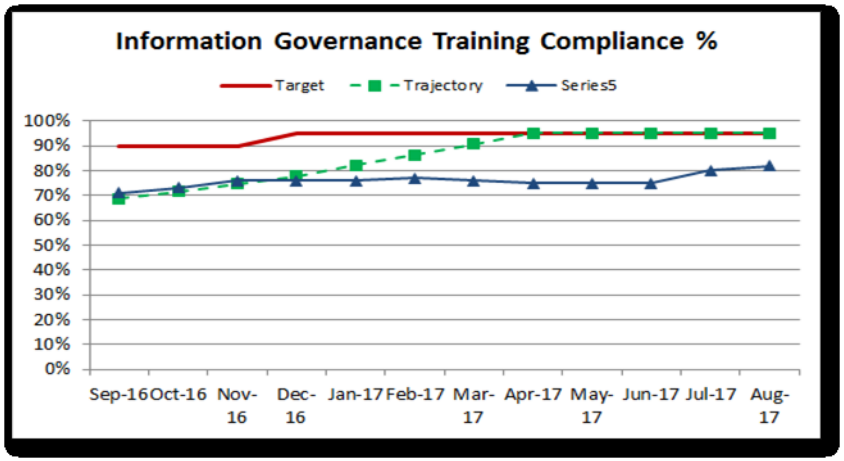
	UH Bristol	Diagnostic & Therapies	Medicine	Specialised Services	Surgery	Trust Services	Women`s & Children`s
Core	79%	68%	68%	90%	88%	100%	80%
Specialist	70%	N/A	N/A	N/A	N/A	100%	69%

Appendix 2 (continued)









Note: there are two types of fire training represented in these graphs, two yearly and annual, with different target audiences. In addition, there are a number of staff who require an additional training video under the previous fire training requirements. The agreed Trust target for all essential training continues to be 90%, except Information Governance, which has a national target of 95%.

Appendix 2 (continued)

AGENCY SHIFTS BY STAFF GROUP (24/07/17 – 20/08/17)

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 and above both price and wage cap	Exceeds price and wage cap	Total
Nursing and Midwifery	0	212	0	301	636	1149
Health Care Assistant & other Support	8	10	14	5	0	37
Medical & Dental	0	0	0	0	36	36
Scientific, Therapeutic/ Technical Allied Health Professional (AHP) & Healthcare Science					4	4
Administrative & Clerical and Estates	1298					1298

Appendix 3

Access standards – further breakdown of figures

A) 62-day GP standard – performance against the 85% standard at a tumour-site level for July 2017, including national average performance for the same tumour site

Tumour Site	UH Bristol	Internal operational target	National
Brain*†	-	-	-
Breast†	85.7%	-	93.7%
Gynaecology	44.4%	85%	73.8%
Haematology (excluding acute leukaemia)	88.9%	85%	80.6%
Head and Neck	100%	79%	64.3%
Lower Gastrointestinal	43.8%	79%	70.8%
Lung	31.0%	79%	70.0%
Other*	60.0%	-	72.1%
Sarcoma*†	-	-	-
Skin	94.2%	96%	96.1%
Upper Gastrointestinal	73.9%	79%	74.0%
Urology*†	50.0%	-	76.2%
Total (all tumour sites)	**74.7%**	**85.0%**	**81.3%**
Improvement trajectory	**83.6%**		
Performance for internally managed pathways	**77.6%**		
Performance for shared care pathways	**63.8%**		
Performance with breach reallocation applied	**76.1%**		

*3 or fewer patients treated in accountability terms

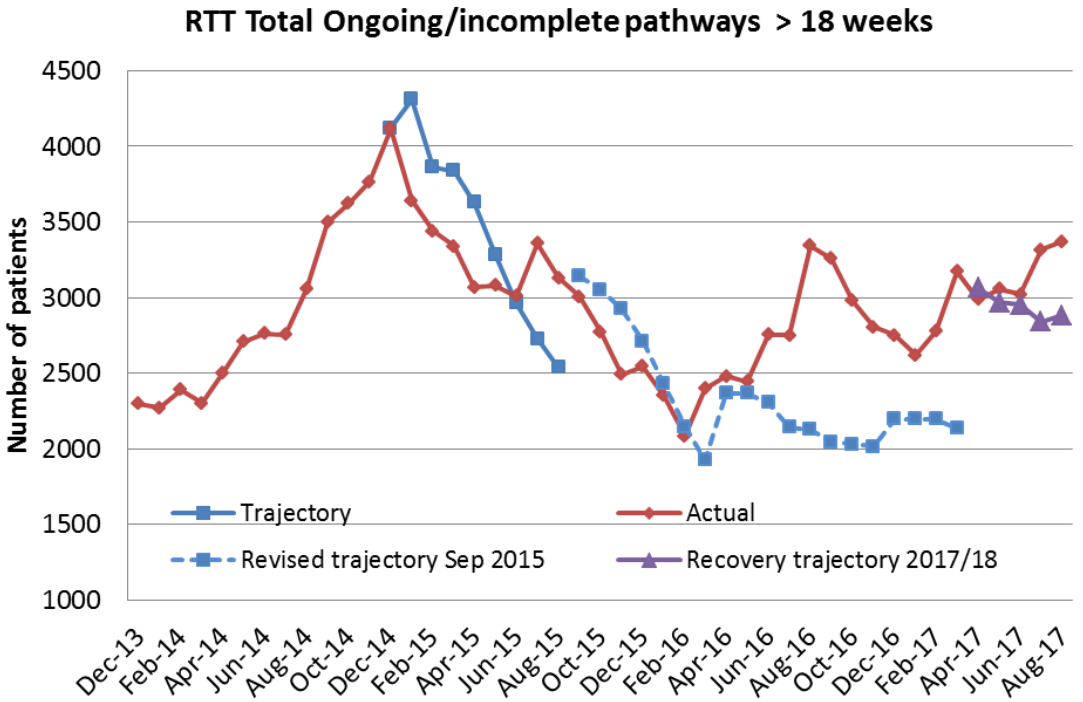
†Tertiary pathways only (i.e. no internally managed pathways), with management of waiting times to a great extent outside of the control of the Trust

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 August 2017

RTT Specialty	Ongoing Over 18 Weeks	Ongoing Pathways	Ongoing Performance
Cardiology	385	2,319	83.4%
Cardiothoracic Surgery	24	361	93.4%
Dermatology	95	2,513	96.2%
E.N.T.	70	2,123	96.7%
Gastroenterology	27	374	92.8%
General Medicine	0	45	100.0%
Geriatric Medicine	0	178	100.0%
Gynaecology	157	1,509	89.6%
Neurology	57	405	85.9%
Ophthalmology	267	4,641	94.2%
Oral Surgery	127	1,842	93.1%
Other	2,060	14,445	85.7%
Rheumatology	5	481	99.0%
Thoracic Medicine	15	1,155	98.7%
Trauma & Orthopaedics	83	938	91.2%
Grand Total	**3,372**	**33,329**	**89.9%**

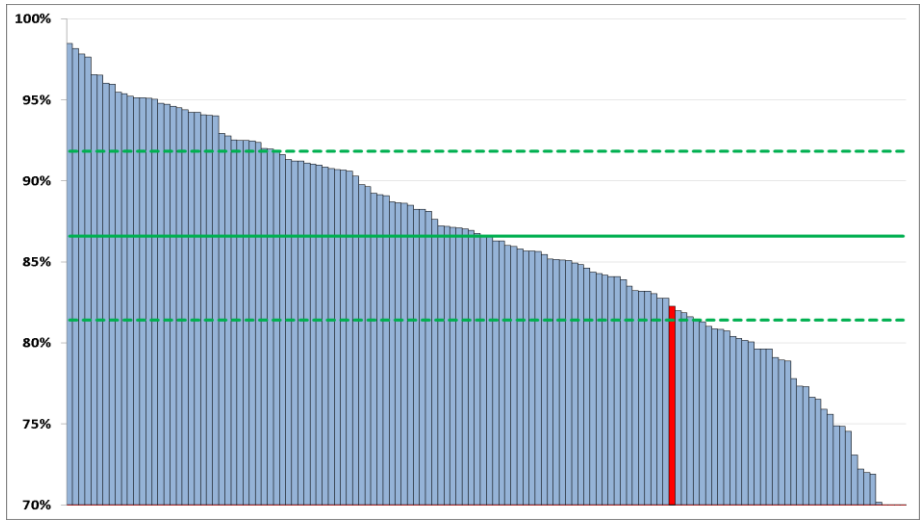


	Dec 16	Jan 17	Feb 17	Mar 17	Apr 17	May 17	Jun 17	Jul 17	Aug 17
Non-admitted pathways > 18 weeks	1594	1528	1592	1826	1705	1744	1750	2006	2107
Admitted pathways > 18 weeks	1157	1091	1185	1345	1280	1312	1273	1311	1265
Total pathways > 18 weeks	2751	2619	2777	3171	2895	3056	3023	3317	3372
Actual target % incomplete < 18 weeks	92.0%	92.2%	92.0%	91.1%	91.1%	91.1%	91.0%	90.2%	89.9%
Recovery forecast	91.6%	92.0%	92.0%	92.0%	90.9%	91.4%	91.8%	92.0%	92.0%

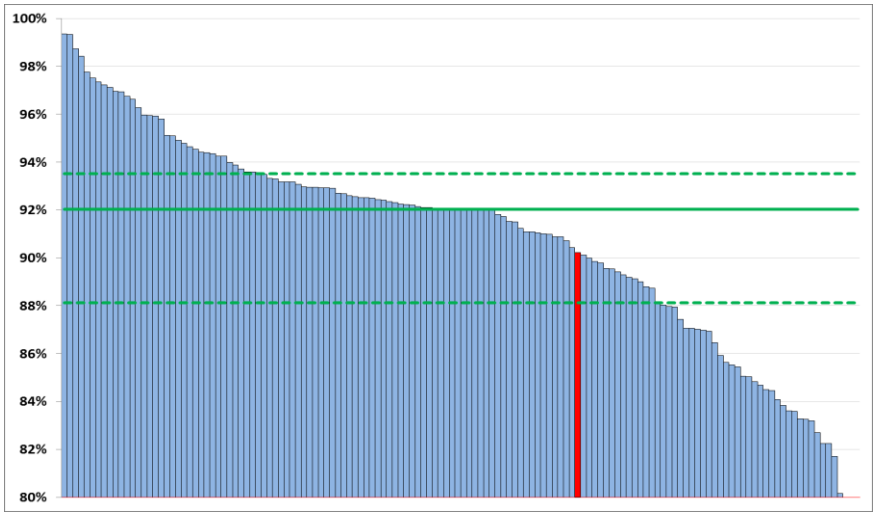
Appendix 4

Benchmarking Reports

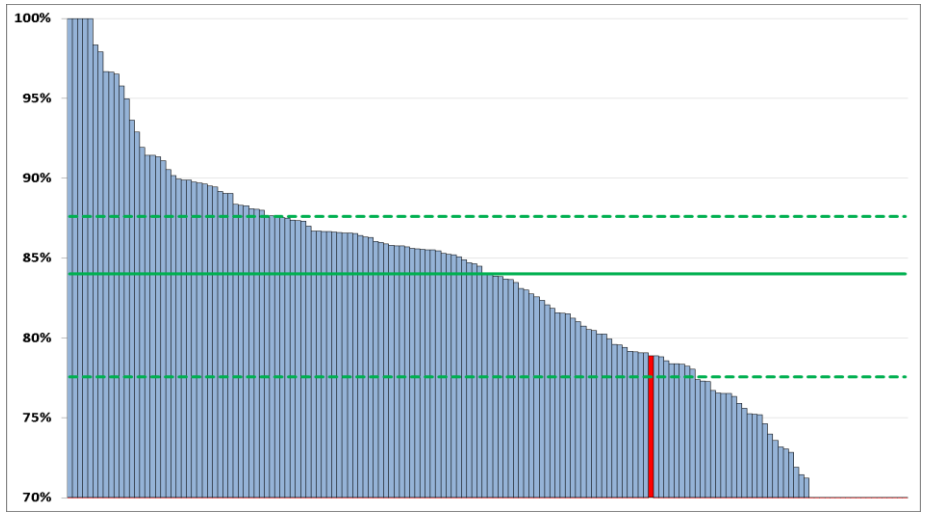
A&E 4-hours (Year To Date – Apr to Jun 2017)



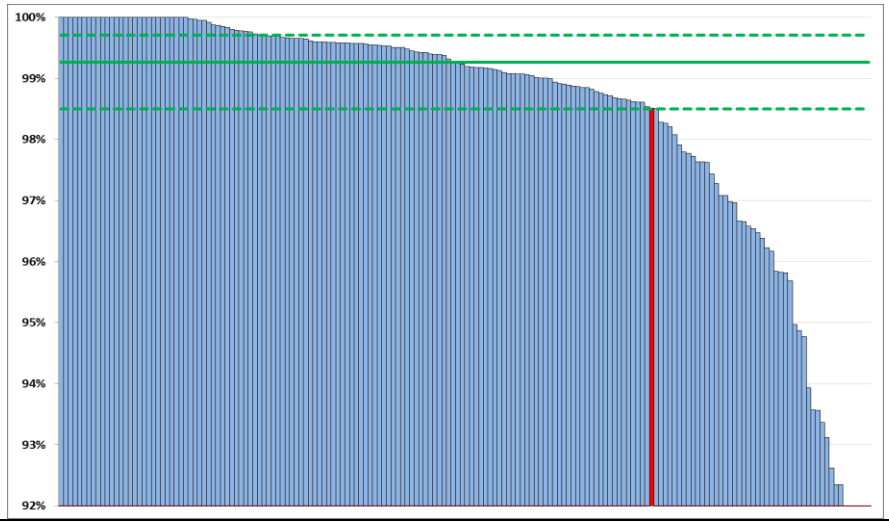
Referral to Treatment Time (July 2017)



62-day GP cancer (Quarter 1 2017/18)



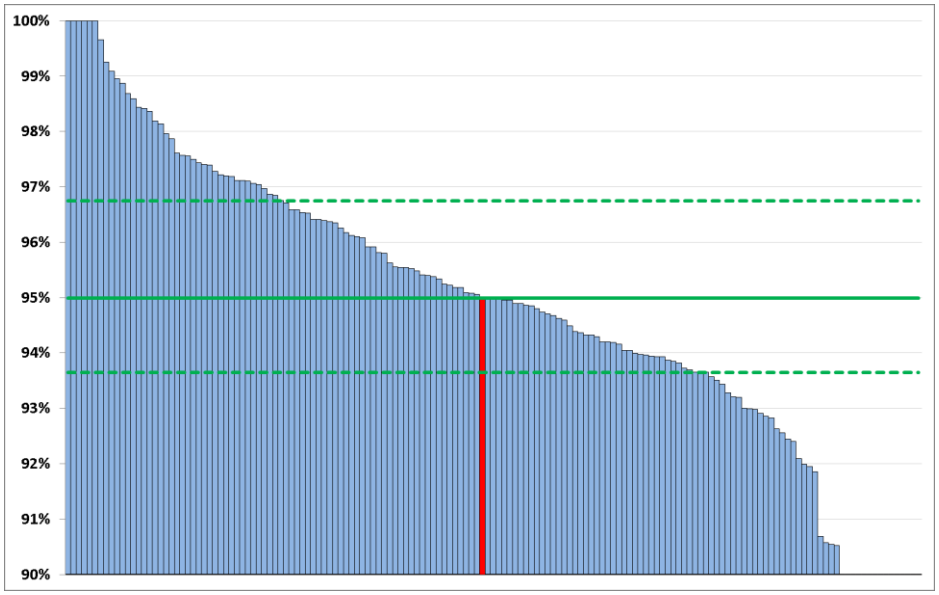
6-week diagnostic (July 2017)



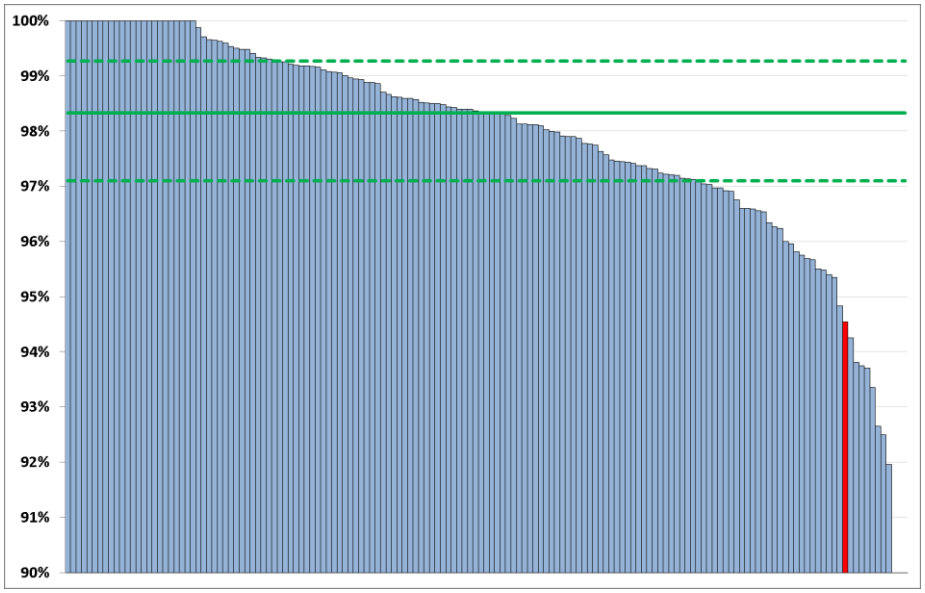
Appendix 4 (continued)

Benchmarking Reports

2-Week wait (Quarter 1 2017/18)



31-day first definitive cancer (Quarter 1 2017/18)



In the above graphs the Trust is shown by the Red bar, with other trusts being shown as pale blue bars. For the A&E 4-hour benchmarking graph, only those trust reporting type 1 (major) level activity are shown.

Note:

Cancer and ED data is published quarterly, so next update to these graphs will be at the end of October.

University Hospitals Bristol NHS
NHS Foundation Trust

Cover report to the Trust Board meeting to be held on Thursday 28 Septemner 2017 at 11:00 am – 1:00 pm in the Conference Room, Trust HQ, Marlborough St, Bristol, BS1 3NU

		Agenda Item	8
Report Title	Chairs Report Quality and Outcomes Committee		
Author	Alison Ryan, Non- Executive		
Executive Lead(s)	Carolyn Mills, Chief Nurse	Sean O'Kelly, Medical Director	
Freedom of Information Status		Open	

Reporting Committee	Quality and Outcomes Committee	
Chaired by	Julian Dennis, Non Executive Director	
Lead Executive Director (s)	Carolyn Mills, Chief Nurse	Mark Callaway, Acting Medical Director
Date of last meeting	29 August 2017	

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

This report provides a summary of the key issues considered at the Quality and Outcomes Committee on 29 August 2017.

Serious Incident Report

- Serious Incidents were reviewed.

The key points raised included:

- *Lack of documentation* - Issues identified included the fact that there had been no documentation of an Abbreviated Mental Test Score assessment being completed for one SI; and manual handling guidelines had not been followed by staff after the fall; and
- *Reflective Learning* - The need to ensure that appropriate reflective learning from all incidents had been actioned and that further assurance was required in relation to learning following incidents.

Quality Performance Report

Members received the performance report for assurance prior to consideration by the Trust Board.

Key points to note included:

- The 4 hour A&E wait target achieved STF trajectory in July 2017 (90.5% against a 90% target).
- The six-week diagnostic wait target achieved local recovery trajectory, but did not hit the 99% target.
- The 62 day cancer referral target achieved STF trajectory in June, but did not achieve for the quarter.
- RTT remained below the 92% national standard and recovery trajectory. It was noted that the Chief Operating Officer was fairly confident that there was some scope to improve the RTT position within existing capacity in the future once the new reporting system was embedded.

Monthly Nurse Staffing Report
Members received the monthly staffing report and it was noted that there were 21 areas where overall staffing fell below planned hours and 21 areas where actual nursing hours were above planned hours.

The Committee noted that there was some considerable negative variance in Women's and Children's nurse staffing hours for July, however the explanatory narrative given for this in the report was quite generic, and it would be helpful to have a more specific narrative.

Six Monthly Staff Nursing Report
Members received the Six-monthly Nurse Staffing Report, which highlighted the following:-

- UH Bristol's funded establishments had no significant changes in nurse staffing levels between February and July 2017 and continued to provide a ratio of patients to Registered Nurses of 2.3 - 8 on both day and night shifts;
- No requests from the Care Quality Commission (CQC) for staffing information were received during this time period;
- The Trust-level quality performance dashboard indicated an overall good quality standard of patient care during this time period; and
- There were no nurse staffing risks on the Corporate Risk Register (though some were held on Divisional Risk Registers, and regularly reviewed at Divisional Board meetings/the Trust Risk Management Group).

Quarterly Workforce Report
Members received the Quarterly Workforce and Organisational Development Report for Quarter 1, 1 April – 30 June 2017. The report focussed on the differences in turnover and sickness rates by age and ethnicity.

Key issues included:

- At the end of quarter 4, the sickness absence figure of 4.4% for UH Bristol compared with an average of 4.5% for 40 other large acute Trusts and 4.1% for 33 University Hospitals Trusts;
- The vacancy target of 4.2%, , whilst high, compared favourably with Peer trusts, with an average rate of around 8%;
- Turnover rate was just below the AUKUH average (12.8% compared to a 13.4% average). Reasons for leaving supplied were largely the same across different ethnic groups, although White Non-British leavers gave relocation as their reason for leaving at a far higher rate than any other group (40%); and
- The Leadership Behaviours had now been launched.

Assurance Reports
Members received the following assurance reports:
- Clinical Quality Group

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

None.

Matters requiring Committee level consideration and/or approval	
None.	
Matters referred to other Committees	
None	
Date of next meeting	26 September 2017

Cover report to the Public Trust Board. Meeting to be held on 28 September 2017 at 11.00 – 13.00, Conference Room, Trust HQ, Marlborough St, Bristol, BS1 3NU

		Agenda Item	10
Meeting Title	Public Trust Board	**Meeting Date**	Thursday, 28 September 2017
Report Title	**Quarterly Complaints Report – Q1**		
Author	**Head of Quality (Patient Experience)**		
Executive Lead	Carolyn Mills, Chief Nurse		
Freedom of Information Status		Closed	

Strategic Priorities **(please choose 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 5: We will provide leadership to the networks we are part of, for the benefit of the region and people we serve.	☐
Strategic Priority 2: We will ensure a safe, friendly and modern environment for our patients and our staff.	☐	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 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.	☐
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

To provide the Board with information about complaints received during the first quarter of 2017/18, the Trust's performance in handling those complaints, and assurance about how Divisions have been responding to any 'hot spots' identified.

Key issues to note

Improvements in Q4:

- Complaints received by Bristol Eye Hospital continued a positive downwards trend in quarter 1
- Complaints received by the department of Trauma & Orthopaedics reduced notably in quarter 1.

- The overall number of complaints received by the Bristol Heart Institute fell by 22% compared to quarter 4.

However:

- The total number of complaints received in quarter 1 was 26% more than in quarter 4, due to a one-off incident which attracted public interest as a result of adverse press coverage (a decision to ask security staff to remove Union Jack badges from their uniform) – this generated more than a hundred complaints.
- In quarter 1, complaints about appointments and admissions rose in all bed-holding divisions with the exception of Medicine, ending a previously long-term downwards trend.
- Complaints about Bristol Dental Hospital rose significantly in quarter 1, driven largely by an increase in complaints about contacting the hospital by phone.

Corporate plans include:

- To continue to work with the Patients Association to develop a potential model for independent review of high-risk complaints.

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)**
				SLT 20/9/17

University Hospitals Bristol
NHS Foundation Trust

Complaints Report

Quarter 1, 2017/2018

(1 April 2017 to 30 June 2017)

Author: Tanya Tofts, Patient Support and Complaints Manager

Overview

Successes	Priorities
• Although the total number of complaints received in quarter 1 was 26% more than in quarter 4, this was largely due to a one-off incident which attracted public interest as a result of adverse press coverage. • Complaints received by Bristol Eye Hospital continued a positive downwards trend in quarter 1 • Complaints received by the department of Trauma & Orthopaedics reduced notably in quarter 1. • The overall number of complaints received by the Bristol Heart Institute fell by 22% compared to quarter 4. • Information about Trust Services complaints has been included in this quarterly report for the first time • For the first time, this quarterly report includes a split of inpatient, outpatient and ED complaints, an analysis we will develop further in subsequent quarterly reports.	• To re-focus on ensuring timely complaints responses – in quarter 1, 80.2% of formal complaints and 76.7% of informal complaints were responded to within the agreed timeframe. • To continue to focus on getting the tone and substance of response letters right. Despite our efforts, in 2016/17 as a whole, more complainants expressed dissatisfaction with our initial response to their formal complaints than in 2015/16 (65 compared to 59). All dissatisfied cases are now being formally reviewed on a monthly basis with learning shared with Divisions and the Patient Experience Group.
Opportunities	**Risks & Threats**
• To continue to work with the Patients Association to develop a potential model for independent review of high-risk complaints. An interim report from the Patients Association was discussed at the Patient Experience Group in August 2017. • The Trust's new complaints review panel is due to meet for the first time in October 2017 (Division of Medicine), including lay representation.	• In quarter 1, complaints about appointments and admissions rose in all bed-holding divisions with the exception of Medicine, ending a previously long-term downwards trend. This included an increase in complaints about the appointments department at Bristol Haematology and Oncology Centre. • Complaints about Bristol Dental Hospital rose significantly in quarter 1, driven largely by an increase in complaints about contacting the hospital by phone.

1. Complaints performance – Trust overview

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

- Total complaints received;
- Proportion of complaints responded to within timescale; and
- Numbers of complainants who are dissatisfied with our response.

Previous quarterly reports have provided data around the number of complaints received as a percentage of patient activity. However, it is very difficult to define a meaningful measure of "activity" across all the areas that complaints cover. Complaints can be about inpatient stays, Emergency Department (ED) attendances, outpatient appointments, diagnostic tests, or matters indirectly linked to that, such as car parking, toilets, catering, portering, websites, call centres, etc. In the past activity (admissions + outpatients + ED) has been counted, which gives equal weighting to a 20 day inpatient stay and a 10 minute outpatient consultation, for example. This implies both are equally likely to generate a complaint, which is clearly not likely to be the case. This resulted in distorted figures, especially when comparing across sites and specialties which have differing activity profiles.

Going forward we therefore intend to report complaints as a proportion of activity separately for inpatient, outpatient and ED. Whilst no solution is ever ideal (you might argue that within inpatients, a Dental Hospital day case should count "less than" a cardiac surgery admission for example), this approach does move us into a better place for reporting complaints as a proportion of activity. The first example of this data is shown later in this report at section 3.2.1.

1.1 Total complaints received

We received 555 complaints in Q1 of 2017/18. However, there was a special cause variation in April 2017, when 101 complaints were received from the public following national press coverage relating to Trust security staff being asked to remove union jack badges from their uniforms. The total figure of 555 includes complaints received and managed via either formal or informal resolution (whichever has been agreed with the complainant)[1]. This figure does not include concerns which may have been raised by patients and dealt with immediately by front line staff. The number of complaints received in Q1 represents an increase of 25.9% compared to Q4 of 2016/17 and an increase of 6.7% on the corresponding period one year previously.

Figure 1 shows the pattern of complaints received in the last 17 months, which is when the Trust commenced recording complaints on the Datix system. Figure 2 shows complaints dealt with via the formal investigation process compared to those dealt with via the informal investigation process, over the same period.

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

Figure 1: Number of complaints received

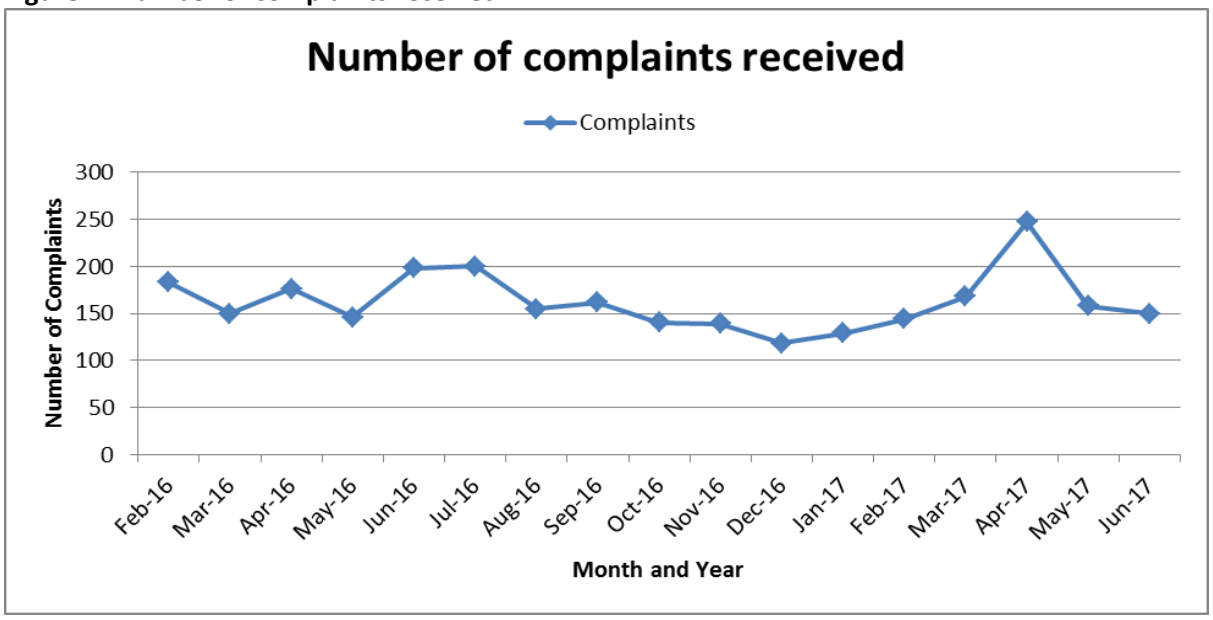
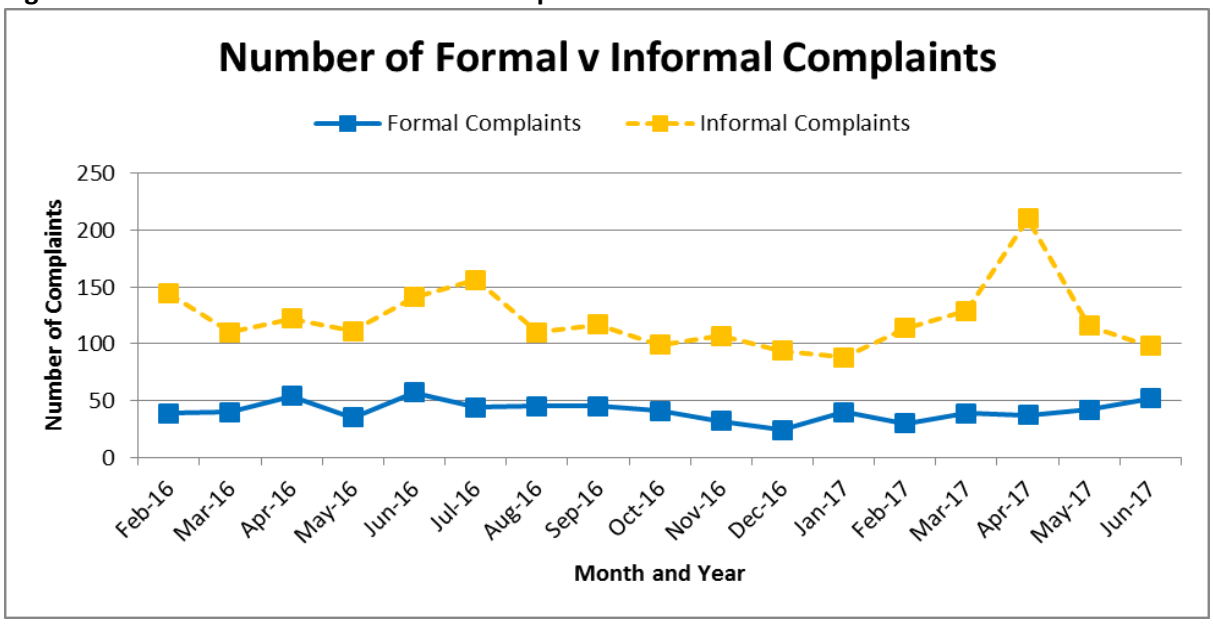


Figure 2: Numbers of formal v informal complaints



1.2 Complaints responses within agreed timescale

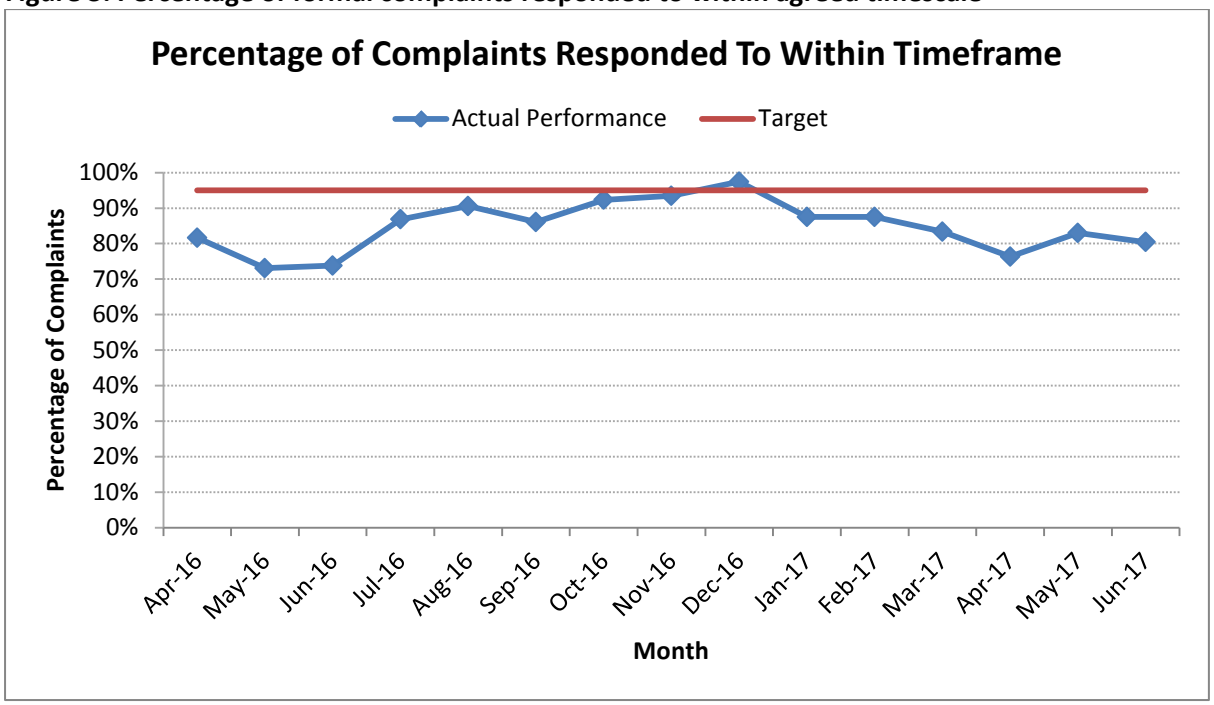
Whenever a complaint is managed through the formal resolution process, the Trust and the complainant agree a timescale within which we will investigate the complaint and write to the complainant with, or arrange a meeting to discuss, our findings. The timescale is agreed with the complainant upon receipt of the complaint and is usually 30 working days.

When a complaint is managed through the informal resolution process, the Trust and complainant also agree a timescale and this is usually 10 working days.

1.2.1 Formal Investigations

The Trust's target is to respond to at least 95% of complaints within the agreed timescale. The end point is measured as the date when the Trust's response is posted to the complainant. In Q1 of 2017/18, 80.2% of responses were posted within the agreed timescale, compared to 86.0% in Q4 of 2016/17 and 76.2% during the same period one year previously. This represents 26 breaches out of 132 formal complaints which were due to receive a response during Q1 of 2017/18[2]. Figure 3 shows the Trust's performance in responding to complaints since February 2016.

Figure 3: Percentage of formal complaints responded to within agreed timescale



1.2.2 Informal Investigations

In Q1 2017/18, the Trust received 314 complaints that were investigated via the informal process. This quarter, for the first time, we are reporting on how the Trust performed in respect of resolving these complaints within the agreed timescale.

In Q1, 76.7% of informal complaints (241 of 314) were resolved within the time agreed with the complainant. Data relating to past performance is not available (not previously recorded).

1.3 Dissatisfied complaints

Reducing numbers of dissatisfied complainants was one of the Trust's corporate quality objectives for 2015/16, remained a priority throughout 2016/17 and will continue to be closely monitored in 2017/18. We are disappointed whenever anyone feels the need to complain about our services; but especially so if they are then dissatisfied with the quality of our investigation into and response to their concerns. For every complaint we receive, our aim is to identify whether and where we have

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

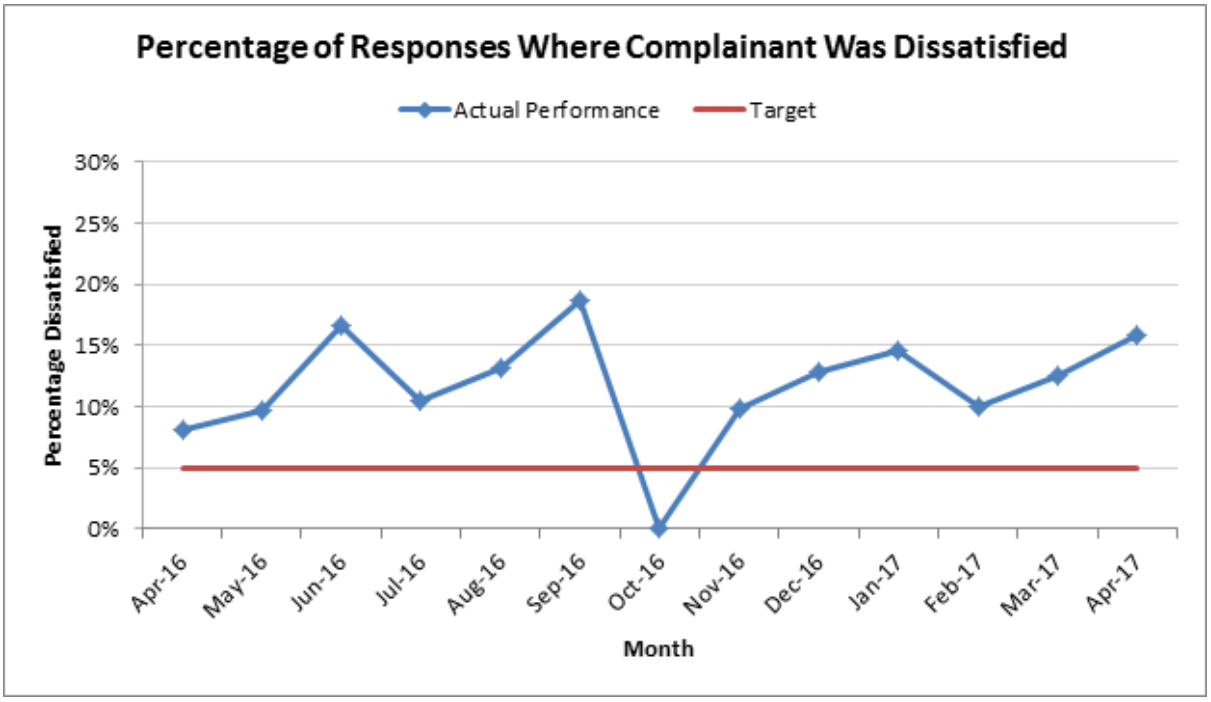
made mistakes, to put things right if we can, and to learn as an organisation to that we do not make the same mistake again. Our target is that nobody should be dissatisfied with the quality of our response to their complaint[3].

The way in which dissatisfied cases are reported is expressed as a percentage of the responses the Trust has sent out in any given month. Since Q3 2015/16, our target has been for less than 5% of complainants to be dissatisfied. This data is now reported two months' in arrears in order to capture the majority of cases where complainants tell us they were not happy with our response.

In Q1, of the responses sent out in April 2017 and by the cut-off point of mid-June 2017 (the date on which the dissatisfied data for April 2017 was finalised), six people had contacted us to say they were dissatisfied. This represents 15.8% of the responses sent out that month. Previously, in Q4, of a total of 136 responses sent out in the quarter, 17 had received a dissatisfied response at the point when monthly data was frozen for board reporting. This represents 12.5% of the responses sent out.

Figure 4 shows the percentage of complainants who were dissatisfied with aspects of our complaints response up until April 2017.

Figure 4: Dissatisfied cases as a percentage of responses



For each case where a complainant advises they are dissatisfied, the case is reviewed by a Patient Support and Complaints Officer, leading to one of the following courses of action, according to the complainant's preference:

- The lead Division is asked to reinvestigate the outstanding concerns and send a further response letter to the complainant addressing these issues;

[3] Please note that we differentiate this from complainants who may raise new issues or questions as a result of our response.

- The lead Division is asked to reinvestigate the outstanding concerns and arrange to meet with the complainant to address these issues
- On rare occasions, a letter may be sent to the complainant advising that the Trust feels that it has already addressed all of the concerns raised and reminding the complainant that if they remain unhappy, they have the option of asking the Ombudsman to independently review their complaint. This option might be appropriate if, for example, if a complainant was disputing certain events that had been captured on CCTV and were therefore incontrovertible.

In the event that we do not have enough information to initiate the process outlined above, the allocated caseworker from the Patient Support and Complaints Team will contact the complainant to clarify which issues remain unresolved and, where possible, identify some specific questions that the complainant wishes to be answered. Following this, the process noted above would then be followed.

In all cases where a further written response is produced, the draft is reviewed by the Patient Support and Complaints Manager and by the Head of Quality (Patient Experience and Clinical Effectiveness) before sending it to an Executive Director for signing.

In the event that a complainant comes back to us again, having received two responses (whether in writing or by way of a meeting), the case will be escalated to an Executive Director (usually the Chief Nurse) to review. As part of the escalation, Divisions are asked to consider whether some form of independent input might assist with achieving resolution and to discuss this with the Executive Director.

All dissatisfied cases are now reviewed by the Patient Support and Complaints Manager and the Head of Quality (Patient Experience and Clinical Effectiveness) on a monthly basis and learning from this review is shared with the Divisions. Those reports are then shared with the Patient Experience Group for information each quarter.

2. Complaints themes – Trust overview

Every complaint received by the Trust is allocated to one of eight major categories, or themes. Table 1 provides a breakdown of complaints received in Q1 2017/18 compared to Q4 2016/17. In Q1, complaints in most of the major categories/themes increased, including appointments and admissions (increased from 132 complaints to 159). The large increase in complaints related to attitude and communication (104 to 191) was due to the complaints received in respect of the removal of union jack badges from security officers' uniforms, as mentioned in section 1.1, which generated media interest. There were only slight increases in complaints about clinical care, discharge/transfer/transport and documentation. Complaints about facilities & environment and information & support both showed small decreases.

Table 1: Complaints by category/theme

Category/Theme	Number of complaints received in Q1 (2017/18)	Number of complaints received in Q4 (2016/17)
Access	0 (0%) =	0 (0%) ↓
Appointments & Admissions	159 (28.6% of total complaints) ↑	132 (29.9%) ↑
Attitude & Communication	191 (34.4%) ↑	104 (23.6%) ↑
Clinical Care	129 (23.2%) ↑	126 (28.6%) ↑

Discharge/Transfer/Transport	17 (3.1%) ↑	15 (3.4%) ↓
Documentation	6 (1.1%) ↑	4 (0.9%) ↑
Facilities & Environment	16 (2.9%) ↓	21 (4.8%) ↑
Information & Support	37 (6.7%) ↓	39 (8.8%) ↑
Total	**555**	**441**

Each complaint is also assigned to a more specific sub-category, for which there are over 100. Table 2 lists the ten most consistently reported sub-categories. In total, these sub-categories account for slightly over half of the complaints received in Q1 (285/555). Complaints relating to attitude of security staff (totalling 101) have been excluded from Table 2 as this was considered a 'one-off' event.

Table 2: Complaints by sub-category

Sub-category	Number of complaints received in Q1 (2017/18)	Q4 (2016/17)	Q3 (2016/17)	Q2 (2016/17)
Cancelled/delayed appointments and operations	75 ↑ (38.9% increase compared to Q4)	54	66	106
Communication with patient/relative	15 ↓ (25% decrease compared to Q4)	20	25	23
Clinical Care (Medical/Surgical)	70 =	70	54	60
Failure to answer telephones/failure to respond	22 =	22	24	27
Clinical Care (Nursing/Midwifery)	18 ↑ (38.5% increase compared to Q4)	13	13	19
Attitude of Medical Staff	29 ↑ (7.4% increase compared to Q4)	27	14	24
Attitude of Admin/Clerical Staff	4 ↓ (77.8% decrease compared to Q4)	18	11	11
Attitude of Nursing Staff	3 =	4	5	17
Appointment Administration Issues	46 ↑ (31.4% increase compared to Q4)	35	15	38
Transport (Late/Non Arrival/Inappropriate)	3 ↑ (50% increase compared to Q4)	2	2	11

Complaints about 'cancelled or delayed appointments or operations/procedures' rose in Q1, having previously decreased for three consecutive quarters. There was also a rise in complaints in respect of 'appointment and administration issues' in Q1, and we will undertake a more detailed analysis if the reporting pattern is sustained in Q2 of 2017/18. Complaints about 'attitude of nursing staff' have reduced for three consecutive quarters, whilst the Q4 upturn in complaints about 'attitude of admin/clerical staff' was reversed in Q1.

Figures 5, 6, and 7 show the four most commonly recorded sub-categories of complaint as detailed above, tracked since February 2016.

Figure 5: Cancelled or delayed appointments and operations

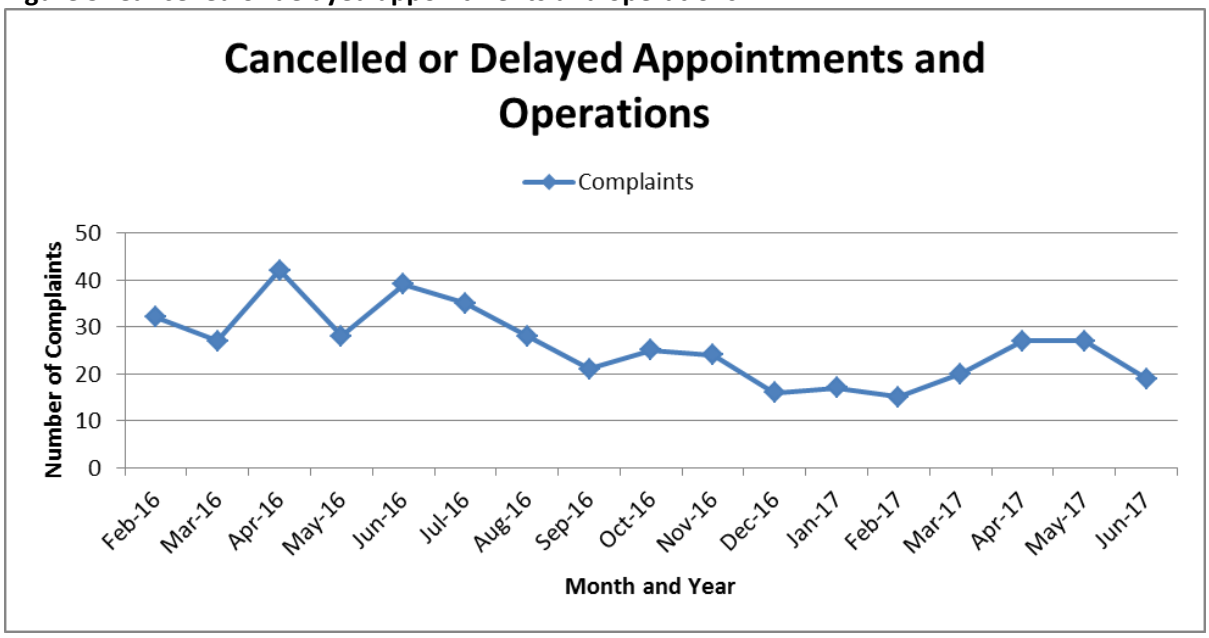


Figure 6: Clinical care – Medical/Surgical

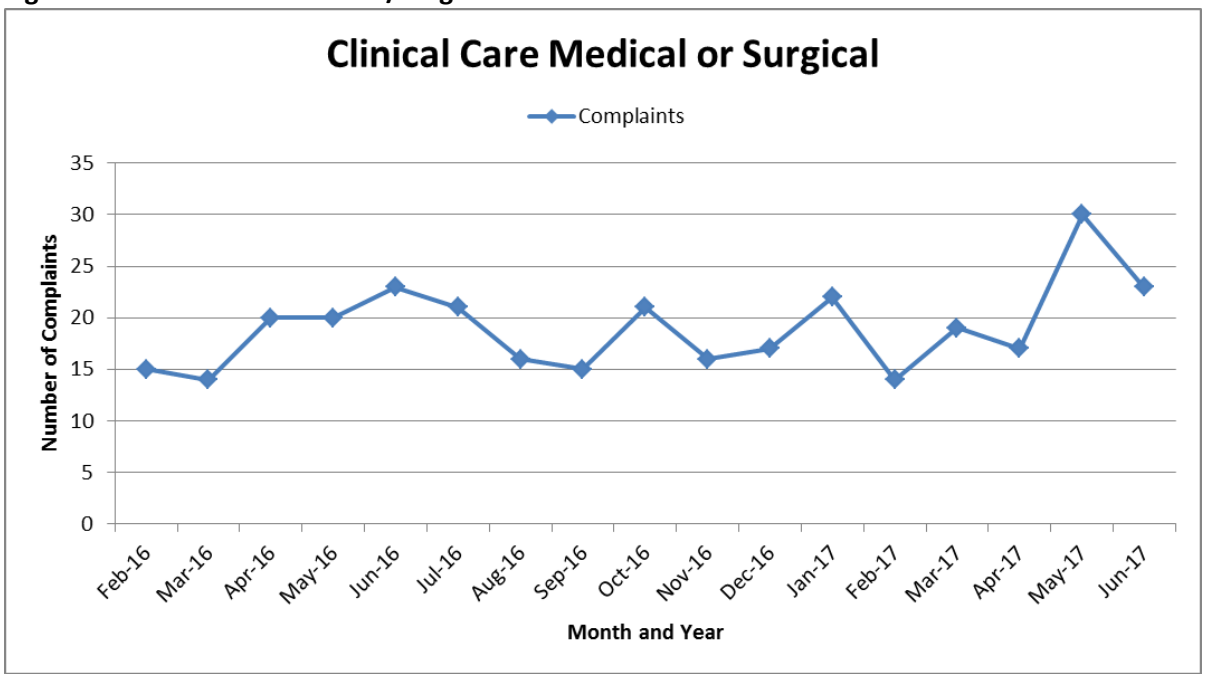
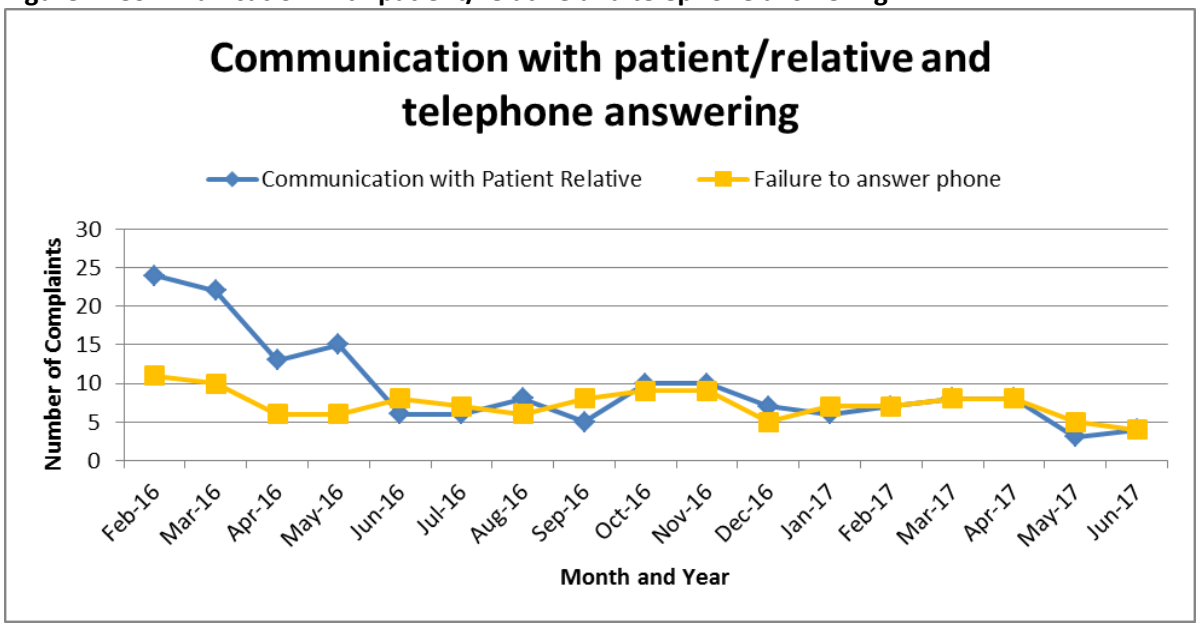


Figure 7: Communication with patient/relative and telephone answering



3. Divisional Performance

3.1 Divisional analysis of complaints received

Table 3 provides an analysis of Q1 complaints performance by Division. In addition to providing an overall view, the table includes data for the three most common reasons why people complain: concerns about appointments and admissions; concerns about staff attitude and communication; and concerns about clinical care. Data for the Division of Trust Services is not included in this table but is summarised in section 3.1.6 of the report.

Table 3	**Surgery**	**Medicine**	**Specialised Services**	**Women & Children**	**Diagnostics & Therapies**
Total number of complaints received	175 (155) ↑	102 (88) ↑	70 (82) ↓	73 (67) ↑	13 (11) ↑
Number of complaints about appointments and admissions	94 (72) ↑	13 (19) ↓	31 (17) ↑	18 (15) ↑	3 (7) ↓
Number of complaints about staff attitude and communication	30 (37) ↓	27 (17) ↑	9 (17) ↓	19 (22) ↓	1 (2) ↓
Number of complaints about clinical care	36 (29) ↑	42 (34) ↑	19 (35) ↓	26 (27) ↓	5 (1) ↓
Area where the most complaints have been received in Q4	Bristol Dental Hospital – 79 (48) Bristol Eye Hospital – 25 (44) Trauma & Orthopaedics – 8 (15) ENT – 10 (10) Lower GI – 9 (7) Upper GI – 7 (12)	Emergency Department (BRI) – 28 (18) Dermatology – 9 (10) Sleep Unit 9 (7) Ward A300 (AMU) – 9 (5)	BHI (all) – 50 (64) BHI Outpatients – 12 (20) BHI Waiting List Office - 8 (8) Ward C708 – 6 (6) Appointments Dept (BHOC) – 10 (2)	Children's ED & Ward 39 (BRHC) – 4 (9) Gynaecology Outpatients (StMH) – 6 (7) Paediatric Orthopaedics – 2 (7) Central Delivery Suite (STMH) – 6 (3)	Radiology – 4 (3) Physiotherapy – 3 (2) Audiology – 2 (1)
Notable deteriorations compared to Q4	Bristol Dental Hospital - 79 (48)	Emergency Department (BRI) – 28 (18) Ward A300 (AMU) – 9 (5)	Appointments Dept (BHOC) – 10 (2)	None	None
Notable improvements compared to Q4	Bristol Eye Hospital - 25 (44) Trauma & Orthopaedics – 8 (15)	None	BHI (all) – 50 (64) BHI Outpatients – 12 (20)	Paediatric Orthopaedics – 2 (7) Children's ED & Ward 39 (BRHC) – 4 (9)	None

3.1.1 Division of Surgery

In Q1, the Division of Surgery experienced an increase in complaints about appointments and admissions, including an increase in complaints about cancelled or delayed appointments and operations. The downward trend in complaints about trauma and orthopedics continued in Q1 (down from 37 in Q3 and 15 in Q4, to 8 in Q1). Complaints relating to the Bristol Dental Hospital rose significantly to 79 in Q1, compared to 48 in Q4 and 31 in Q3. Complaints about Bristol Eye Hospital continued their downward trend in Q1. Q1 data also shows a continued positive shift toward informal resolution of concerns within the division.

Table 4: Complaints by category type

Category Type	Number and % of complaints received – Q1 2017/18	Number and % of complaints received – Q4 2016/17
Access	0 (0% of total complaints) =	0 (0% of total complaints) =
Appointments & Admissions	94 (53.7%) ↑	72 (46.6%) ↑
Attitude & Communication	30 (17.1%) ↓	37 (23.9%) ↓
Clinical Care	36 (20.6%) ↑	29 (18.7%) ↑
Facilities & Environment	1 (0.6%) ↓	2 (1.29%) =
Information & Support	11 (6.3%) ↓	13 (8.39%) ↑
Discharge/Transfer/ Transport	2 (1.1%) ↑	1 (0.64%) ↓
Documentation	1 (0.6%) =	1 (0.64%) ↑
Total	**175**	**155**

Table 5: Top sub-categories

Category	Number of complaints received – Q1 2017/18	Number of complaints received – Q4 2016/17
Cancelled or delayed appointments and operations	42 ↑	30 ↓
Clinical Care (Medical/Surgical)	22 ↑	16 =
Communication with patient/relative	3 ↓	6 ↓
Attitude of Medical Staff	9 ↓	10 ↑
Attitude of Nursing/Midwifery	0 =	0 ↓
Attitude of Admin/Clerical Staff	3 ↓	7 ↑
Clinical Care (Nursing/Midwifery)	2 ↑	0 ↓
Failure to answer telephones	10 ↑	9 ↓
Transport (late/non arrival/inappropriate	0 =	0 ↓

Table 6: Divisional response to concerns highlighted by Q1 data

Concern	Explanation	Action
Complaints about the Bristol Dental Hospital increased significantly in Q1 (48 to 79). Of these 78 complaints, the majority were about Adult Restorative Dentistry (20), Child	A significant proportion of complaints received about BDH in Q1 related to concerns about telephone communications (mostly informal complaints): difficulties experienced by	In respect of the reported difficulties in contacting BDH by phone, the division is currently seeking to identify which phone numbers are the source of the problem (identified either

Dental Health (18), the Administration Department (16) and Oral Surgery (16).	patients when attempting to phone BDH to discuss their appointments and/or the attitude of administration staff when calls were answered.	retrospectively from patient letters or prospectively by asking the Patient Support and Complaints Team and Communication Team (re. concerns raised via social media) to record/seek this information)). This will identify whether the complaints relate to the Trust's outpatient call centre or direct lines into the BDH (and which ones). Customer services training is also being arranged for BDH admin staff.

Figure 8: Surgery, Head & Neck – formal and informal complaints received

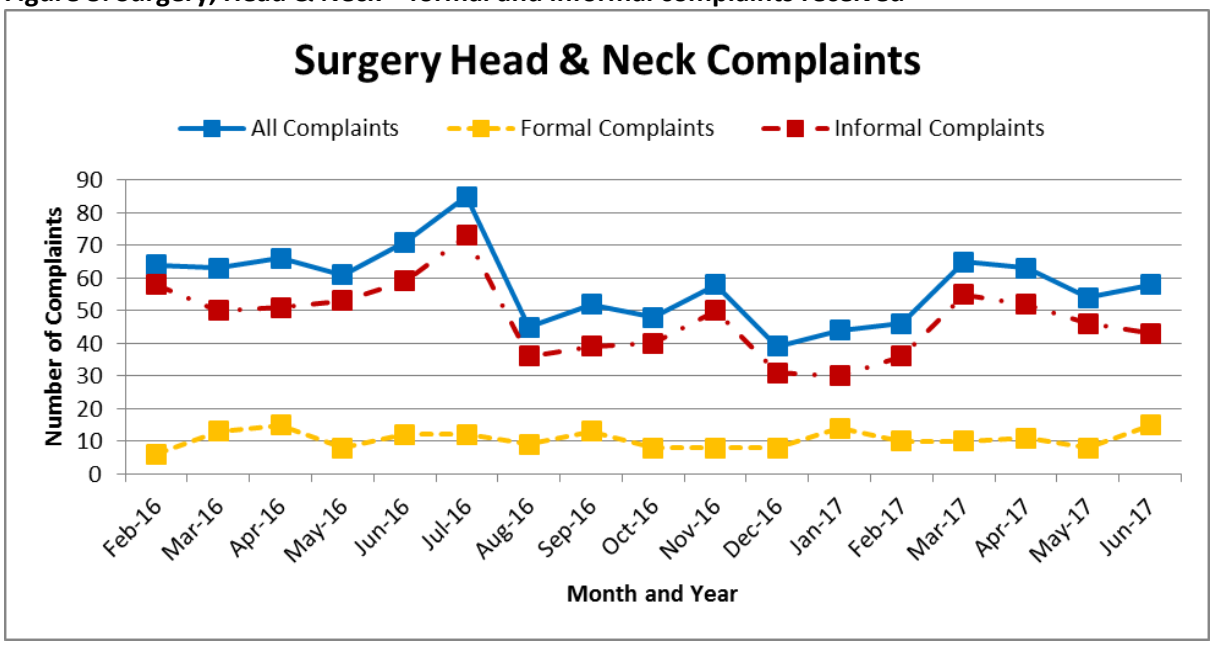


Figure 9: Complaints received by Bristol Dental Hospital

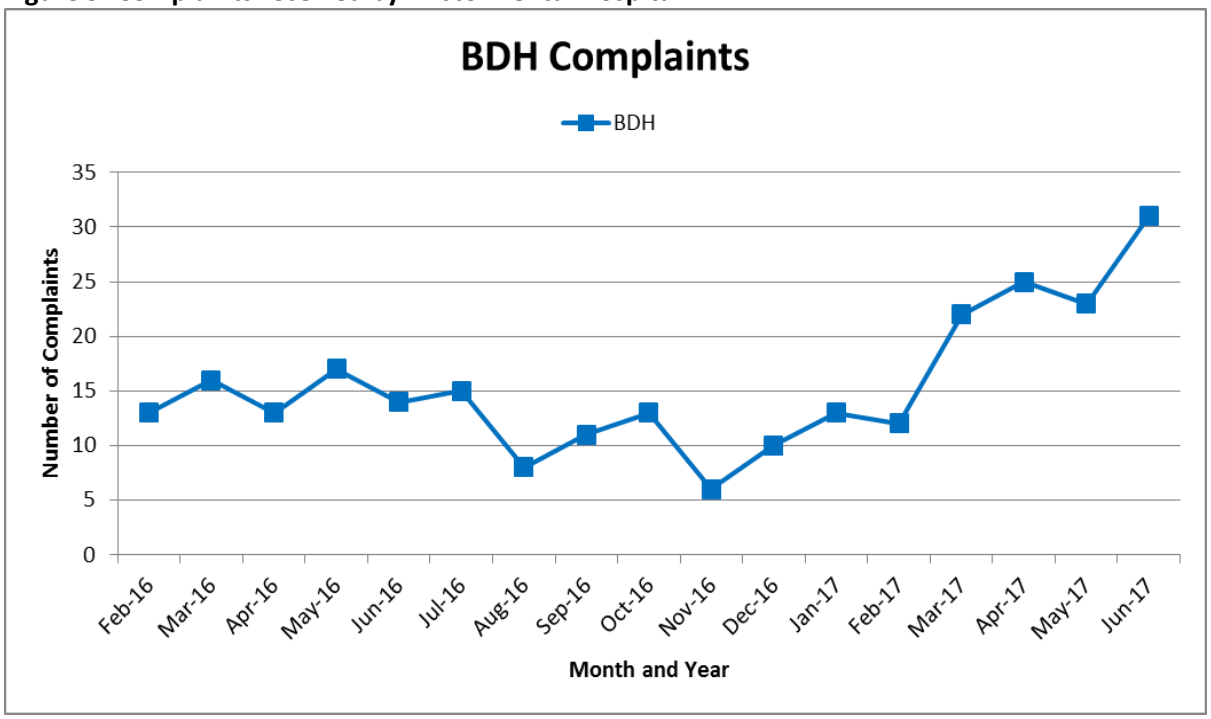
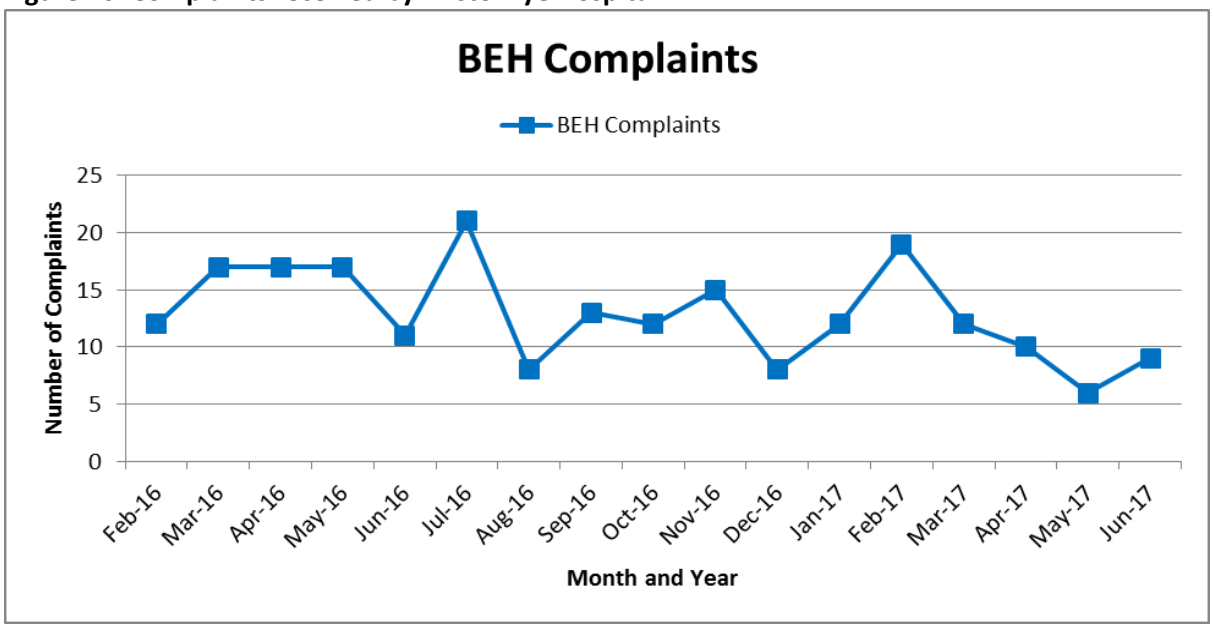


Figure 10: Complaints received by Bristol Eye Hospital



3.1.2 Division of Medicine

In Q1, there were increases in the number of complaints received in respect of 'clinical care (medical/surgical)' and 'attitude of medical staff'. However, unlike the other bed-holding Divisions, there was a decrease in the number of complaints about 'appointments and admissions'. Q1 data continued the trend identified in Q4 of a concerted shift toward informal resolution of concerns.

Table 7: Complaints by category type

Category Type	Number and % of complaints received – Q1 2017/18	Number and % of complaints received – Q4 2016/17
Access	0 (0% of total complaints) =	0 (0% of total complaints) =
Appointments & Admissions	13 (12.7%) ↓	19 (21.6%) ↓
Attitude & Communication	27 (26.5%) ↑	17 (19.3%) ↓
Clinical Care	42 (41.2%) ↑	34 (38.6%) ↑
Facilities & Environment	4 (3.9%) ↓	6 (6.8%) =
Information & Support	4 (3.9%) =	4 (4.5%) ↑
Discharge/Transfer/ Transport	8 (7.8%) ↑	6 (6.8%) ↑
Documentation	4 (3.9%) ↑	2 (2.3%) ↑
Total	**102**	**88**

Table 8: Top sub-categories

Category	Number of complaints received – Q1 2017/18	Number of complaints received – Q4 2016/17
Cancelled or delayed appointments and operations	5 ↓	6 ↓
Clinical Care (Medical/Surgical)	26 ↑	17↑
Communication with patient/relative	2 ↓	3 ↓
Attitude of Medical Staff	12 ↑	7 ↑
Attitude of Nursing/Midwifery	2 ↑	0 ↓
Attitude of Admin/Clerical Staff	0 ↓	2 ↓
Clinical Care (Nursing/Midwifery)	7 ↑	4 ↓
Failure to answer telephones	5 ↑	4 ↓

Table 9: Divisional response to concerns highlighted by Q1 data

Concern	Explanation	Action
There was an increase in the number of complaints under the category of 'clinical care (medical/surgical)' from 17 in Q4 to 26 in Q1. 10 of these related to the Emergency Department (BRI), five to Ward A300 (AMU) and four to the Dermatology Centre.	A review of these cases has taken place there are no identified themes other than within ED.	A continued focus on embedding the learning from these complaints and continued review of any identified themes will continue.
In addition to the concern noted above, there was a general increase in the number of complaints for the Emergency Department (ED) and Ward A300 (AMU). Eight complaints in the ED were in respect of 'attitude and communication'.	A theme was identified in ED regarding identification of injuries and subsequent requirement to return for ED for ongoing treatment.	The ED lead consultant has reviewed the six cases and identified that four relate to radiology and the reporting or results. This will be discussed in the departmental management meeting to raise awareness and plan any appropriate actions.

Figure 11: Medicine – formal and informal complaints received

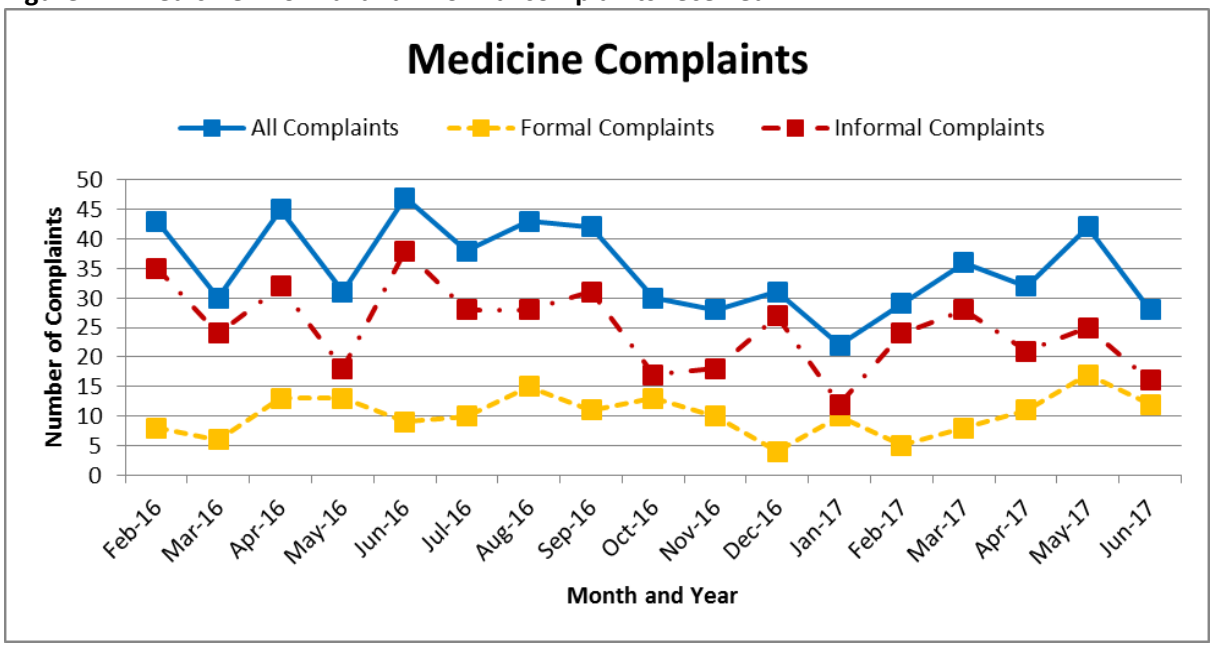
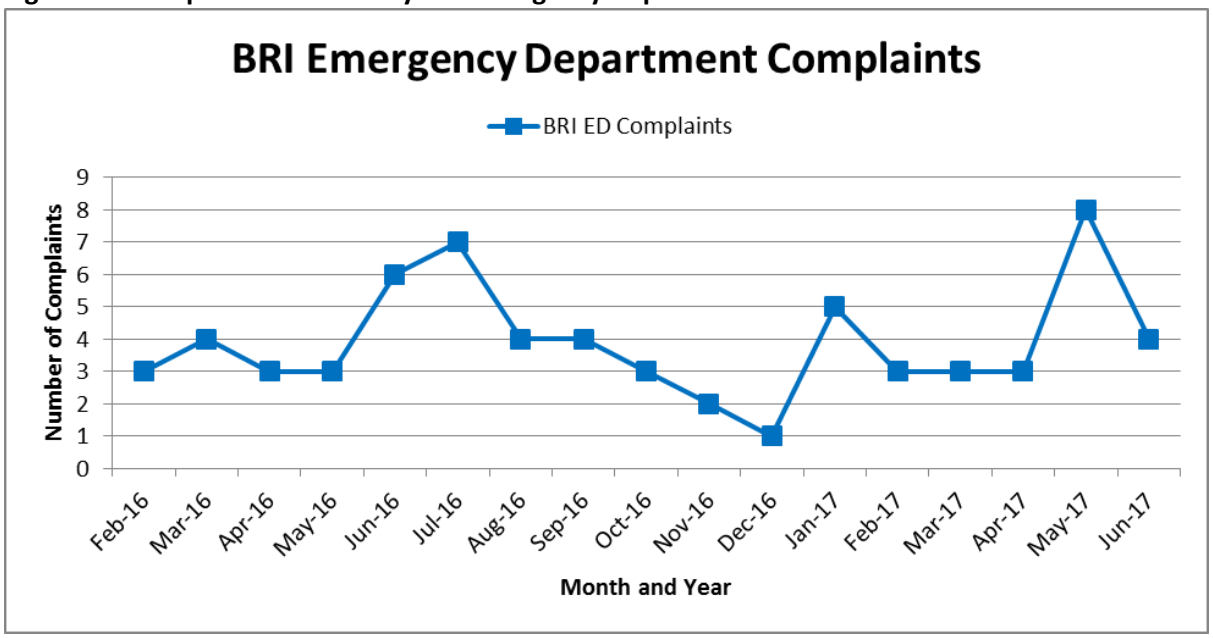


Figure 12: Complaints received by BRI Emergency Department



3.1.3 Division of Specialised Services

In Q1, the Division of Specialised Services experienced significant decreases in complaints about 'attitude and communication' and 'clinical care' when compared to Q4. In line with the other bed-holding Divisions (with the exception of Medicine), the Division did see an increase in the number of complaints relating to 'appointments and admissions' (from17 in Q4 to 31 in Q1).

Table 10: Complaints by category type

Category Type	Number and % of complaints received – Q1 2017/18	Number and % of complaints received – Q4 2016/17
Access	0 (0% of total complaints) =	0 (0% of total complaints) =
Appointments & Admissions	31 (44.3%) ↑	17 (20.7%) ↑
Attitude & Communication	9 (12.9%) ↓	17 (20.7%) ↑
Clinical Care	19 (27.1%) ↓	35 (42.7%) ↑
Facilities & Environment	3 (4.3%) ↑	1 (1.2%) ↓
Information & Support	6 (8.6%) ↓	7 (8.5%) ↓
Discharge/Transfer/Transport	2 (2.9%) ↓	5 (6.1%) ↓
Documentation	0 (0%) =	0 (0%) =
Total	**70**	**82**

Table 11: Top sub-categories

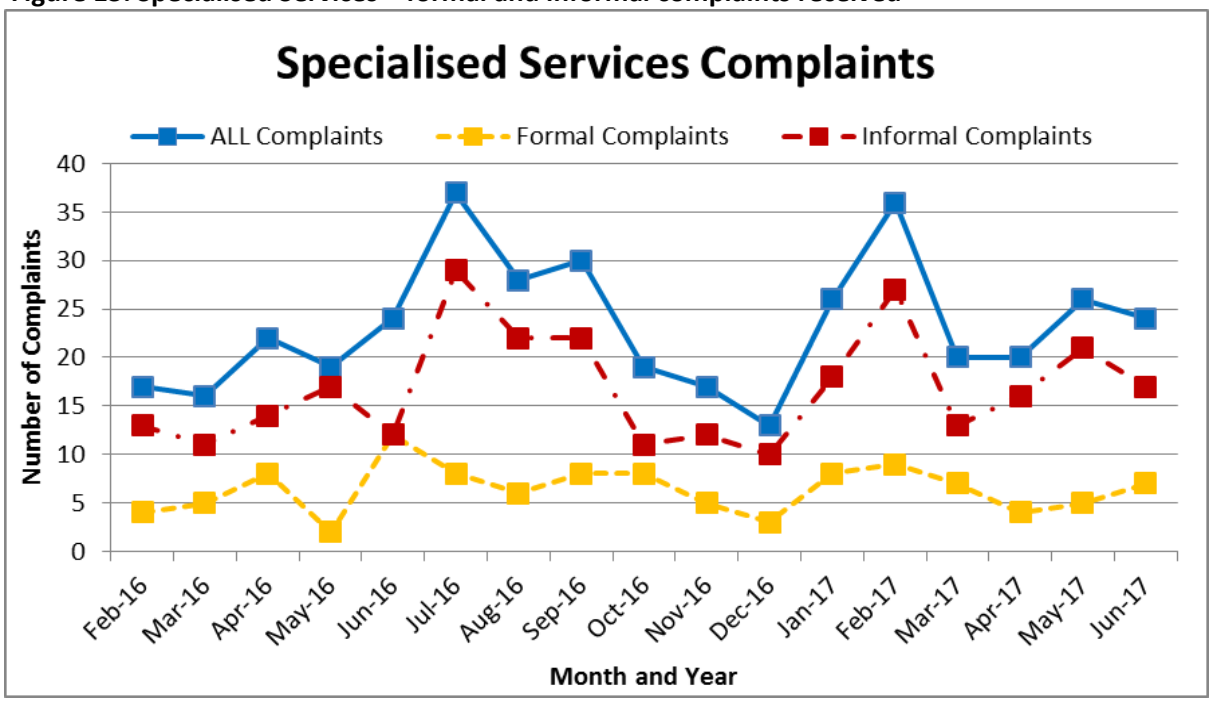
Category	Number of complaints received – Q1 2017/18	Number of complaints received – Q4 2016/17
Cancelled or delayed appointments and operations	16 ↑	8 =
Clinical Care (Medical/Surgical)	10 ↑	3 ↓
Communication with patient/relative	1 ↓	5 ↑
Attitude of Medical Staff	3 =	3 ↑
Attitude of Nursing/Midwifery	0 ↓	1 ↑
Attitude of Admin/Clerical Staff	0 =	0 =
Clinical Care (Nursing/Midwifery)	1 =	1 ↓
Failure to answer telephones	5 ↓	7 ↑

Table 12: Divisional response to concerns highlighted by Q4 data

Concern	Explanation	Action
The Division has seen an increase in complaints about 'appointments and admissions' in Q1. Seven of these complaints were about the BHI Waiting List Office and six were received in respect of the BHOC Appointments Department.	There was significant sickness absence across the waiting list and admin teams in the BHI in Q1 which was also compounded by vacancies in the cardiac waiting list team; this led to delays in answering telephones and responding to patients queries. See below for BHOC appointments	The sickness has resolved across both teams and therefore the expected service has resumed.
In addition to the above point, the BHOC Appointments Department saw an increase from two complaints in Q4 to 10 complaints in Q1.	The BHOC is experiencing a significant rise in the number of patients requiring chemotherapy which has been compounded by a reduction of the number of	The Division is working with health care at home to increase capacity for the delivery of chemotherapy during September. In October, a new method of managing patients

	chemotherapy slots available as a result of bank holidays.	will be introduced to increase capacity in the Chemotherapy Day Unit. The Division is also working with the Division of Diagnostics and Therapies to develop a service covering bank holidays.

Figure 13: Specialised Services – formal and informal complaints received



3.1.4 Division of Women's and Children's Services

In Q1, the Division of Women's and Children's Services received a similar number of complaints to Q3. Complaints about Attitude and Communication rose (up from 15 to 22), however, there were no discernable patterns within this group of complaints.

Table 13: Complaints by category type

Category Type	Number and % of complaints received – Q1 2017/18	Number and % of complaints received – Q4 2016/17
Access	0 (0% of total complaints) =	0 (0% of total complaints) =
Appointments & Admissions	18 (24.7%) ↑	15 (22.4%) =
Attitude & Communication	19 (26.1%) ↓	22 (32.8%) ↑
Clinical Care	26 (35.6%) ↓	27 (40.3%) ↑
Facilities & Environment	2 (2.7%) ↑	1 (1.5%) =
Information & Support	5 (6.8%) ↑	1 (1.5%) ↓
Discharge/Transfer/Transport	2 (2.7%) ↑	0 (0%) ↓
Documentation	1 (1.4%) =	1 (1.5%) ↑
Total	**73**	**67**

Table 14: Top sub-categories

Category	Number of complaints received – Q1 2017/18	Number of complaints received – Q4 2016/17
Cancelled or delayed appointments and operations	11 ↑	8 ↑
Clinical Care (Medical/Surgical)	11 ↓	15 ↑
Communication with patient/relative	8 ↑	6 ↑
Attitude of Medical Staff	5 ↓	6 ↑
Attitude of Nursing/Midwifery	1 ↓	3 =
Attitude of Admin/Clerical Staff	0 ↓	3 ↑
Clinical Care (Nursing/Midwifery)	8 =	8 ↑
Failure to answer telephones	2 ↑	1 =

Figure 14: Women & Children – formal and informal complaints received

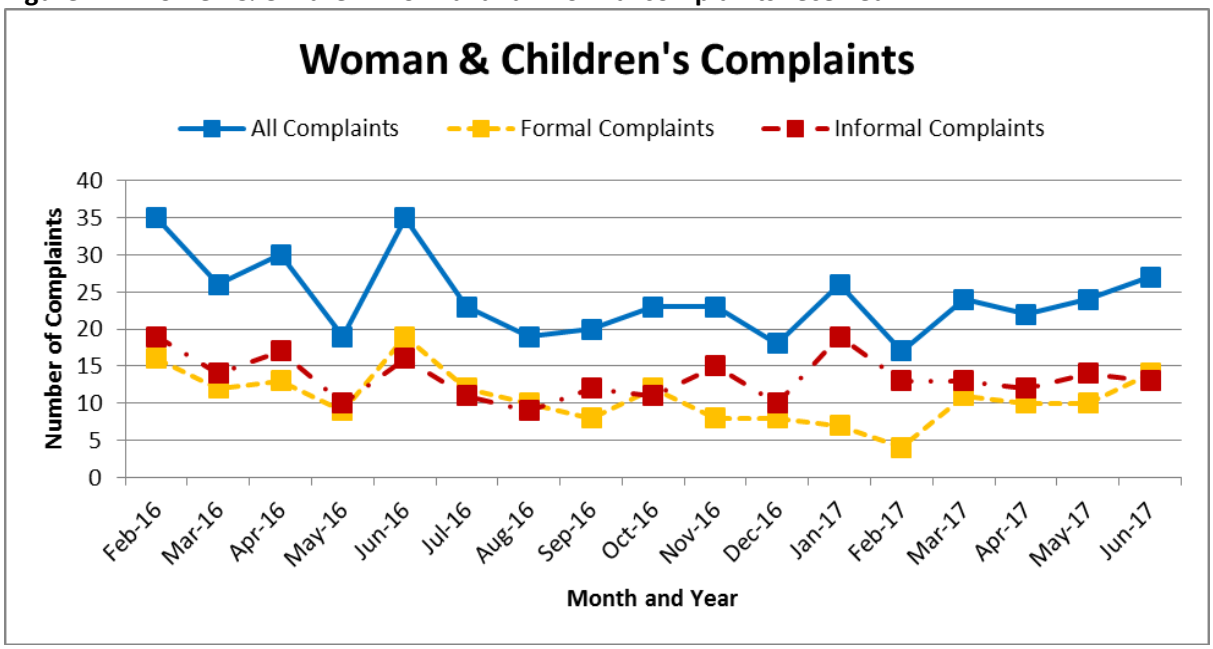
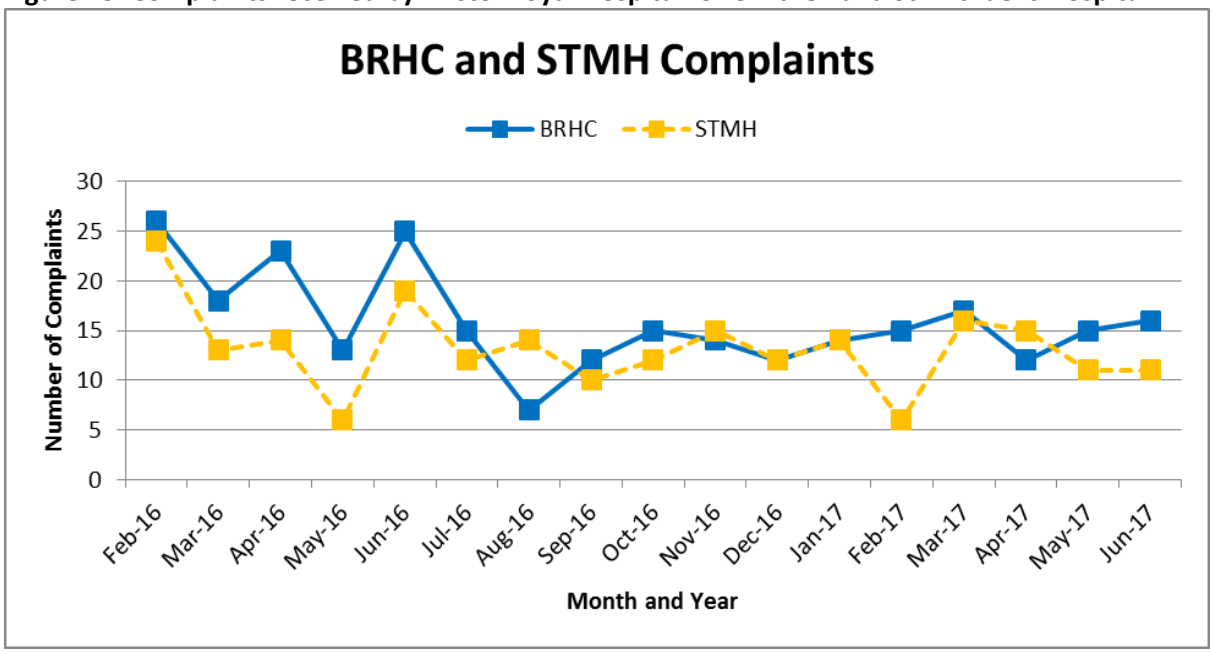


Figure 15: Complaints received by Bristol Royal Hospital for Children and St Michael's Hospital



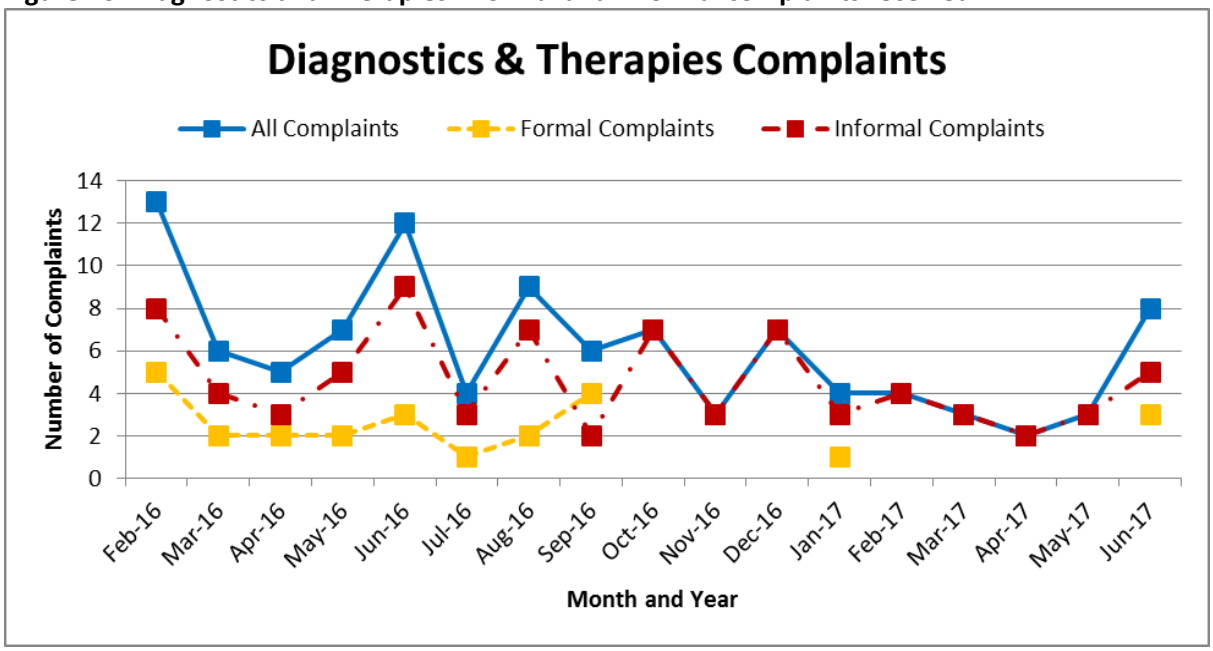
3.1.5 Division of Diagnostics & Therapies

In Q1, complaints received by the Diagnostics and Therapies Division increased slightly, with 13 complaints in Q1 compared to 11 in Q4. This remains lower than the 17 complaints reported in Q3 and 19 in Q2.

Table 15: Complaints by category type

Category Type	**Number and % of complaints received – Q1 2017/18**	**Number and % of complaints received – Q4 2016/17**
Access	0 (0% of total complaints) =	0 (0% of total complaints) =
Appointments & Admissions	3 (23.1%)	7 (63.6%) ↓
Attitude & Communication	1 (7.7%)	2 (18.9%) ↓
Clinical Care	5 (38.4%)	1 (9%) ↓
Facilities & Environment	2 (15.4%)	0 (0%) =
Information & Support	2 (15.4%)	0 (0%) ↓
Discharge/Transfer/Transport	0 (0%)	1 (9%) ↑
Documentation	0 (0%) =	0 (0%) =
Total	**13**	**11**

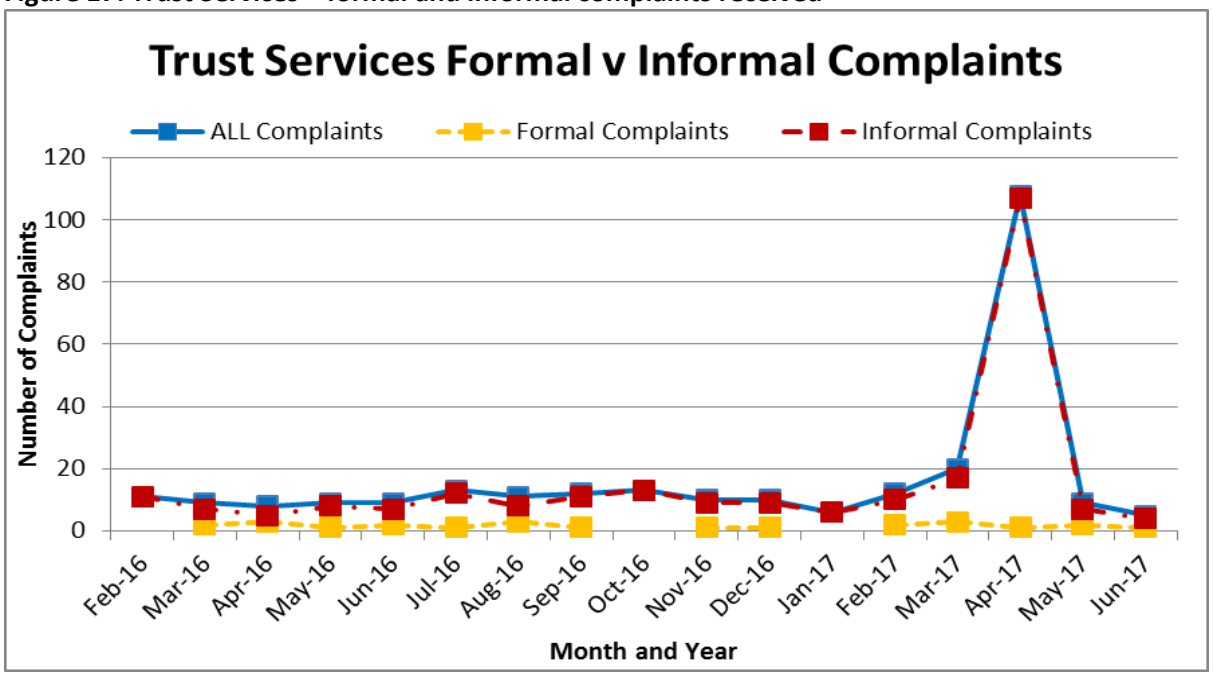
Figure 16: Diagnostics and Therapies – formal and informal complaints received



3.1.6 Division of Trust Services

For the first time this quarter (Q1 2017/18), we are including data relating to complaints received by Trust Services, which includes the Facilities & Estates department. Figure 17 below shows the number of complaints received by the Division since February 2016 and clearly shows the spike in complaints in April 2017 when the Trust received over 100 complaints about security officers being asked to remove wearing union jack badges.

Figure 17: Trust Services – formal and informal complaints received



3.2 Complaints by hospital site

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

Table 16: Breakdown of complaints by hospital site

Hospital/Site	Number and % of complaints received in Q1 2017/18	Number and % of complaints received in Q4 2016/17
Bristol Royal Infirmary	279 (50.3%) ↑	164 (37.2%)
Bristol Dental Hospital	79 (14.2%) ↑	48 (10.9%)
Bristol Heart Institute	50 (9.0%) ↓	64 (14.5%)
Bristol Royal Hospital for Children	44 (7.9%) ↓	49 (11.1%)
St Michael's Hospital	37 (6.7%) ↑	36 (8.2%)
Bristol Eye Hospital	25 (4.5%) ↓	43 (9.8%)
Bristol Haematology & Oncology Centre	21 (3.8%) =	21 (4.8%)
South Bristol Community Hospital	7 (1.3%) ↑	6 (1.4%)
Community Midwifery Services	3 (0.5%) ↑	1 (0.2%)
Central Health Clinic	3 (0.5%) =	3 (0.7%)
Southmead Hospital (UH Bristol services)	3 (0.5%) ↑	1 (0.2%)
Other Trust	2 (0.4%) ↓	4 (0.8%)
Community Dental Sites	1 (0.2%) =	1 (0.2%)
Trust Headquarters	1 (0.2%) ↑	0 (0%)
TOTAL	**555**	**441**

The large increase in complaints relating to the BRI is due to the 'union jack' complaint described elsewhere in this report, i.e. all 101 related complaints are included in the BRI total of 279.

3.2.1 Breakdown of complaints by inpatient/outpatient/ED status

Also for the first time, this quarterly report includes data differentiating between inpatient, outpatient and Emergency Department complaints.

Figure 18: Complaints received broken down by inpatients and outpatients

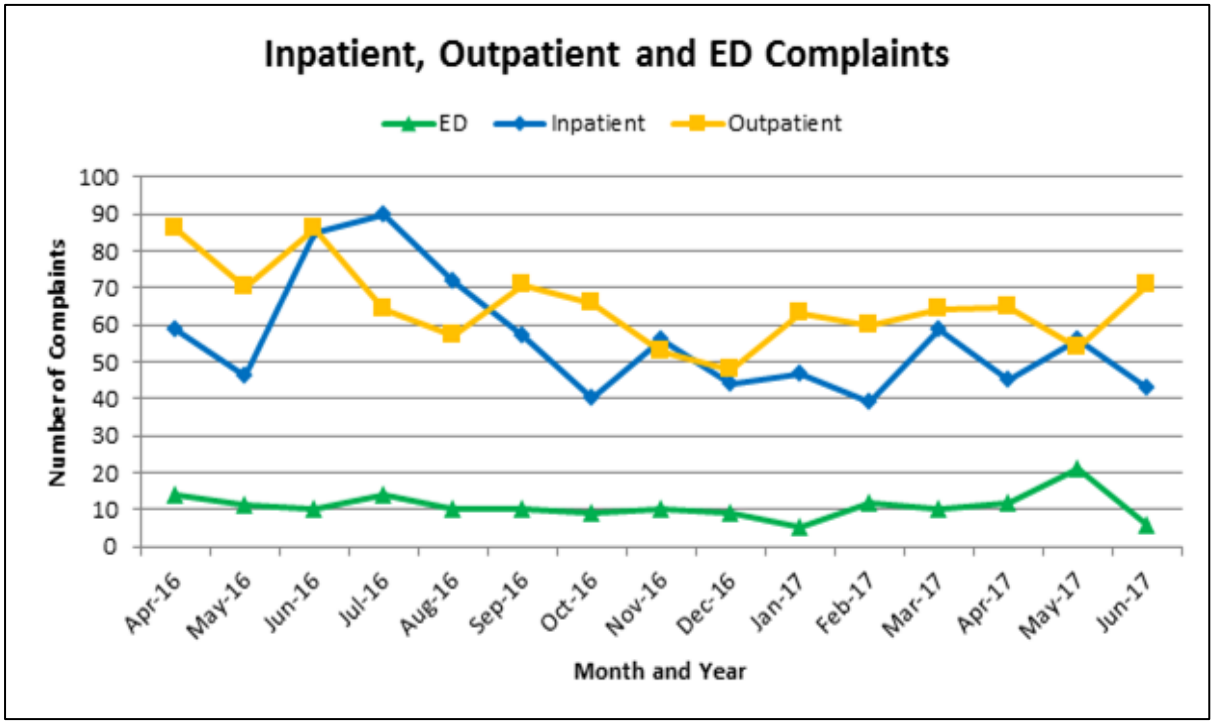


Table 17: Breakdown of Area Type

Complaints	**Area Type**				
Month	**ED**	**Inpatient**	**Outpatient**	**Other**	**Grand Total**
Apr-16	14	59	86	17	176
May-16	11	46	70	19	146
Jun-16	10	85	86	17	198
Jul-16	14	90	64	32	200
Aug-16	10	72	57	16	155
Sep-16	10	57	71	24	162
Oct-16	9	40	66	25	140
Nov-16	10	56	53	20	139
Dec-16	9	44	48	17	118
Jan-17	5	47	63	14	129
Feb-17	12	39	60	33	144
Mar-17	10	59	64	35	168
Apr-17	12	45	65	125	247
May-17	21	56	54	27	158
Jun-17	6	43	71	30	150
Grand Total	163	838	978	451	2430

3.3 Complaints responded to within agreed timescale

All Divisions, with the exception of Diagnostics and Therapies, reported breaches in Q1, totalling 26, which is an increase on the 19 breaches recorded in Q4. These breaches are spread across all of the

bed-holding Divisions, with the largest increase within the Division of Specialised Services (when compared to Q4). Comments on this increase are included in table 12 in section 3.1.3.

Table 18: Breakdown of breached deadlines

Division	Q1 (2017/18)	Q4 (2016/17)	Q3 (2016/17)	Q2 (2016/17)
Surgery	6 (14.6%)	7 (14.3%)	1 (0.7%)	0 (0%)
Medicine	6 (22.2%)	4 (15.4%)	0 (0%)	4 (11.1%)
Specialised Services	6 (24%)	2 (6.4%)	4 (8.9%)	1 (4.5%)
Women & Children	6 (18.2%)	6 (24%)	3 (4.7%)	5 (16.7%)
Diagnostics & Therapies	0 (0%)	0 (0%)	0 (0%)	0 (0%)
Trust Services	2 (50%)	0 (0%)	0 (0%)	2 (66.7%)
All	**26 breaches**	**19 breaches**	**8 breaches**	**12 breaches**

(So, as an example, there were six breaches of timescale in the division of Specialised Services in Q1, which constituted 24% of the complaints responses which had been due in that division in Q1).

Breaches of timescale were caused either by late receipt of draft responses from Divisions which did not allow adequate time for Executive review and sign-off; delays in processing by the Patient Support and Complaints Team; delays during the sign-off process itself; and/or responses being returned for amendment following Executive review.

3.4 Outcome of formal complaints

In Q1 we responded to 132 formal complaints[4]. Tables 19 and 20 below show a breakdown, by Division, of how many cases were upheld, partly upheld or not upheld in Q1 of 2017/18 and Q4 of 2016/17.

Whilst the number of responses in Q1 was similar to Q4 (132 compared to 136), 15 more complaints were upheld, with a corresponding reduction in cases recorded as partly upheld. This shift applied to responses in all Divisions, however there is no discernible reason for this change.

Table 19: Outcome of formal complaints – Q1 2017/18

	Upheld	Partly Upheld	Not Upheld
Surgery	6 (14.6%)	28 (68.3%)	7 (17.1%)
Medicine	6 (22.2%)	15 (55.6%)	6 (22.2%)
Specialised Services	3 (12%)	17 (68%)	5 (20%)
Women & Children	7 (21.2%)	21 (63.6%)	5 (15.2%)
Diagnostics & Therapies	1 (100%)	0 (0%)	0 (0%)
Trust Services	1 (20%)	3 (60%)	1 (20%)
Total	**24 (18.2%)**	**84 (63.6%)**	**24 (18.2%)**

[4] Note: this is different to the number of formal complaints we *received* in the quarter

Table 20: Outcome of formal complaints – Q4 2016/17

	Upheld	Partly Upheld	Not Upheld
Surgery	3 (6.1%)	34 (69.4%)	12 (24.5%)
Medicine	3 (11.5%)	21 (80.8%)	2 (7.7%)
Specialised Services	1 (3.2%)	26 (83.9%)	4 (12.9%)
Women & Children	2 (8%)	17 (68%)	6 (24%)
Diagnostics & Therapies	0 (0%)	1 (50%)	1 (50%)
Trust Services	0 (0%)	2 (66.7%)	1 (33.3%)
Total	**9 (6.6%)**	**101 (74.3%)**	**26 (19.1%)**

4. Information, advice and support

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

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

In Q1, the team dealt with 174 such enquiries, compared to 191 in Q4. These enquiries can be categorised as:

- 138 requests for advice and information (142 in Q4)
- 34 compliments (47 in Q4)[5]
- 2 request for support (4 in Q4)

Table 21 below shows a breakdown of the 138 requests for advice, information and support dealt with by the team in Q1.

Table 21: Enquiries by category

Category	Number of enquiries
Information about patient	35
Hospital information request	23
Signposting	15
Medical records requested	8
Appointments administration issues	6
Clinical care	4
Clinical information request	4
Transport request	4
Employment and volunteering	4
Delayed operation/procedure	3
Freedom of information request	3
Accommodation enquiry	3
Travel arrangements	3
Invoicing	2

[5] This figure includes compliments added directly to the Datix system by Divisions.

Translating & Interpreting	2
Lost/misplaced test results	2
Failure to answer phone/respond	2
Admissions arrangements	2
Cleanliness (internal)	2
Telecommunications	1
Signage	1
Medication incorrect	1
Follow up treatment	1
Expenses claim	1
Confidentiality	1
Discharge arrangements	1
Bereavement support	1
Waiting time in clinic	1
Appointment letter not received	1
Car parking	1
Total	**138**

In addition to the enquiries detailed above, in Q1 the Patient Support and Complaints team recorded 203 enquiries that did not proceed. This is where someone contacts the department to make a complaint or enquiry but does not leave enough information to enable the team to carry out an investigation, or they subsequently decide that they no longer wish to proceed with the complaint.

5. Acknowledgement of complaints by the Patient Support and Complaints Team

One of the Key Performance Indicators (KPIs) used to monitor the performance of the Patient Support and Complaints Team is the length of time between receipt of a complaint and sending an acknowledgement.

The Trust's Complaints and Concerns Policy states that when the Patient Support and Complaints Team reviews a complaint following receipt:

- a risk assessment will be carried out;
- agreement will be reached with the complainant about how we will proceed with their complaint and a timescale for doing so;
- The appropriate paperwork will be produced and sent to the Divisional Complaints Coordinator for investigation; and
- An acknowledgement letter confirming how the complaint will be managed will be sent to the complainant.

The NHS Complaints Procedure (2009) states that complaints must be acknowledged within three working days. This is also a requirement of the NHS Constitution. The Trust's own policy states that complaints made in writing (including emails) will be acknowledged within three working days and that complaints made orally (via the telephone or in person) will be acknowledged within two working days.

In Q1, 333 complaints were received in writing (email, letter or complaint form) and 222 were received verbally (35 in person via drop-in service and 187 by telephone). Of the 555 complaints received in Q1, 515 (92.8%) met the Trust's standard of being acknowledged within two working days (verbal) and three working days (written).

The reasons why 40 cases missed the standard have been investigated; the vast majority (38/40) related to the 'union jack' complaint and were due to the sheer volume of complaints being handled by the team in response to that issue.

6. PHSO cases

During Q1, the Trust was advised of new Parliamentary and Health Service Ombudsman (PHSO) interest in three complaints. During the same period, five existing cases were closed and one existing case remains ongoing. Of the five cases closed, two were partly upheld by the PHSO.

Table 22: Complaints opened by the PHSO in Q1

Case Number	Complainant (patient unless stated)	On behalf of (patient)	Date complaint received by Trust [and date notified by PHSO]	Site	Department	Division
4537	EB	MB	10/11/2016 [25/05/2017]	BRI	Ward A515	Medicine
Copy of complaint file and medical records sent to the PHSO. Pending further contact from the PHSO.						
2624	CC	RC	14/07/2016 [19/05/2017]	BRI	Ward A600 (ITU/HDU)	Surgery
Copy of complaint file and medical records sent to the PHSO. Pending further contact from the PHSO.						
679	LH		02/03/2016 [09/05/2017]	BEH	Outpatients	Surgery
Copy of complaint file and medical records sent to the PHSO. Contacted by PHSO to advise us that they intend to investigate. Further information subsequently requested by the PHSO and provided by the Trust. Awaiting PHSO's draft report.						

Table 23: Complaints ongoing with the PHSO during Q1

Case Number	Complainant (patient unless stated)	On behalf of (patient)	Date complaint received by Trust [and date notified by PHSO]	Site	Department	Division
2870	AM	PM	3/11/16 [7/3/17]	BHOC	Ward D603	Specialised Services
Copy of complaint file and medical records sent to the PHSO. PHSO notified us that they plan to issue a draft report in early August 2017.						

Table 24: Complaints formally closed by the PHSO in Q1

Case Number	Complainant (patient unless stated)	On behalf of (patient)	Date complaint received by Trust [and date notified by PHSO]	Site	Department	Division
3604	GV	PV	16/09/2016 [17/01/2017]	BRI/StMH	Lower GI/Ward 78	Surgery & Women's & Children's
Final report received from PHSO – complaint **not upheld**						
2095	NH	MH	16/6/16 [26/10/16]	BRI	Lower GI	Surgery
Final report received from PHSO – complaint **partly upheld** and the following recommendations made for the Trust to: • Acknowledge the failings summarised in the report and apologise for the anxiety, distress and discomfort these caused; and • Provide assurances to the patient and the Ombudsman that it will take additional remedial action to more effectively manage future patients presenting with similar symptoms to prevent unnecessary delays in their further assessment and admittance, and to ensure they are appropriately hydrated at these times in accordance with relevant guidance.						
3983	AG	LCY	29/9/15 [7/9/16]	BRI	Trauma and Orthopaedics	Surgery
Final report received from PHSO – complaint **not upheld**						
4841	AJ		9/11/15 [30/9/16]	BEH	Outpatients	Surgery
Final report received from PHSO – complaint **partly upheld** and the following recommendations made for the Trust to: • Within one month of the date of the final report, write to the patient to acknowledge the communication failings identified in the report (both in the consent process and in communication with us), and apologise for the impact that these failings had on her The PHSO's draft report included a recommendation of financial recompense due to the Trust not being able to provide evidence that Mrs J had signed a consent form in October 2014. During subsequent conversations between the Division and the PHSO, the Division was able to provide a copy of this missing evidence. Therefore, the PHSO altered their report to withdraw the recommendation of financial recompense, but still partly upheld the complaint. The patient is currently appealing the PHSO's decision, which she does not agree with.						
18856	SC	VP	22/5/15 [15/2/16]	BRI	Ward B501	Medicine
Final report received from PHSO – complaint **not upheld**						

Cover report to the Public Trust Board. Meeting to be held on 28 September 2017 at 11.00 – 13.00, Conference Room, Trust HQ, Marlborough St, Bristol, BS1 3NU

		Agenda Item	**10b**
Meeting Title	Public Trust Board	**Meeting Date**	**Insert Date**
Report Title	Quarterly Patient Experience Report – Q1		
Author	**Head of Quality (Patient Experience)**		
Executive Lead	Carolyn Mills, Chief Nurse		
Freedom of Information Status		Closed	

Strategic Priorities (please choose 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 5: We will provide leadership to the networks we are part of, for the benefit of the region and people we serve.	☐
Strategic Priority 2: We will ensure a safe, friendly and modern environment for our patients and our staff.	☐	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 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.	☐
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

To provide the Board with a summary of what patients said about their experience of services provided by the Trust during the first quarter of 2017/18.

Key issues to note

The key positive messages from this report are:

- UH Bristol continues to receive positive scores in our local surveys, with 98% of patients rating their care as excellent, very good or good
- Praise for Trust staff remains by far the most common type of feedback that we receive
- In Quarter 1, the Patient Experience and Involvement Team had a focussed theme exploring patient / carer / family experience on the Trust's "care of the elderly" wards. This was primarily in response to relatively low survey scores being received for these areas.

The feedback received from service-users about the quality of care was very positive. Bespoke analysis of the national inpatient survey data set indicates that UH Bristol is providing good care to older age patients compared to national norms

There are three negative outliers to highlight from the survey data:

- The postnatal wards "kindness and understanding" score dipped slightly in Quarter 1, taking it slightly below the target level
- South Bristol Community Hospital received relatively low inpatient scores compared to the Trust's other hospitals
- Outpatients at the Bristol Haematology and Oncology Centre reported relatively long waiting times in clinic

Actions in response to these scores are presented in the report.

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)**
				SLT 20/9/17

University Hospitals Bristol
NHS Foundation Trust

Quarterly Patient Experience and Involvement Report

Incorporating current Patient and Public Involvement activity and patient survey data received up to Quarter 1 2017/18

Author: **Paul Lewis, Patient Experience and Involvement Team Manager**

Patient Experience and Involvement Team

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1. Overview of patient-reported experience at UH Bristol: update since the last Quarterly Report

Successes	Priorities
• UH Bristol received an excellent set of results in the 2016 national inpatient survey: achieving better than average scores on 20 survey questions and the best overall patient experience rating of any general acute trust in the country • UH Bristol continues to receive positive scores in our local surveys, with 98% of patients rating their care as excellent, very good or good • A focus on care of the elderly wards in Quarter 1, primarily as a result of relatively low survey scores for these areas, generated very positive feedback from patients and families about the care being provided • UH Bristol's new SMS (text message) outpatient Friends and Family Test survey was successfully introduced during April 2017. As a result, the new 6% target response rate target set for the Trust by the Bristol Clinical Commissioning Group was exceeded in Quarter 1 (6.6%)	As outlined in the UH Bristol Quality Strategy (2016-20), the Trust is committed to providing patients / visitors with more opportunities to give feedback during their hospitals visit / stay. This will involve installing electronic feedback points at a number of high-visibility public areas across the Trust (e.g. the Bristol Royal Infirmary Welcome Centre), and a comprehensive "marketing" campaign on wards and clinics to signpost service-users to give feedback through their personal devices or via a comments card. Negative feedback received via this system will trigger an automated alert to a relevant UH Bristol member of staff, potentially providing an opportunity to resolve the issue before it escalates into a poor overall experience and / or a complaint. In addition, the system will provide a reporting hub to give our staff better access to the wealth of patient feedback collected at UH Bristol. Internal funding was approved for this project in April 2017 and an IM&T business case was approved in May 2017. The tender process is currently being finalised with the Procurement Department. We anticipate the tender process commencing in September 2017.
Opportunities	**Risks & Threats**
The Trust's new SMS (text message) based outpatient Friends and Family Test survey is currently providing trust-level data for adult services. This provides an opportunity to "test the concept" of SMS surveying in this context and to refine our methodology. The next step is to trial this approach in the Bristol Royal Hospital for Children. The Patient Experience and Involvement Team will also be seeking to procure a more sophisticated system that will allow service-level data to be generated. This is likely to be linked to the Trust's SMS appointment reminder system, which is scheduled for re-tendering during 2017/18.	• The postnatal wards "kindness and understanding" score dipped slightly in Quarter 1, taking it below the target level. This has been discussed with the Head of Midwifery, who has asked that ward staff attend "living the values" training. • South Bristol Community Hospital received relatively low inpatient scores compared to the Trust's other hospitals. This has been a reasonably consistent trend, but does not correlate with wider quality data received by the Division of Medicine, or a Healthwatch "enter and view" inspection carried out in 2016. "Patient Experience @ Heart" staff workshops will be convened at the hospital in Quarter 3 to explore this further. • Outpatients at the Bristol Haematology and Oncology Centre reported relatively long waiting times in clinic. The management team is working to relieve the capacity issues and has reminded clinic staff of the important of telling patients if there are delays.

2. Update on recent and current Patient and Public Involvement (PPI) Activity

2.1 Quarter 1 focus on care of the elderly wards

As noted in previous Quarterly Patient Experience and Involvement Reports, there has been a consistent trend of the Trust receiving *relatively* lower inpatient survey scores for wards which have a high proportion of older patients. This feedback is still generally very positive, and analysis carried out by the Patient Experience and Involvement Team supports the view that these results reflect the real challenges of caring for patients with complex / chronic conditions, rather than being a reflection of poor quality care. To further test this, during Quarter 1 the Patient Experience and Involvement Team worked with the Division of Medicine to carry out a focussed piece of work on "care of the elderly" inpatient services. The main aims of this exercise were to:

- Provide further reassurance about the quality of care in these areas of the Trust
- Examine whether the relatively lower patient satisfaction scores seen at UH Bristol in older age groups is in line with national norms
- Identify service improvement opportunities.

The Patient Experience and Involvement Team used the *Face2Face* volunteer interview team to talk to over 50 patient / family / carer interviews. We also carried out desk research, engagement with the Trust's Involvement Network, and a "patient experience at heart" staff workshop. This activity was focussed on inpatient wards in the Bristol Royal Infirmary[1], to build on the collaborative work already undertaken with Healthwatch at South Bristol Community Hospital[2].

The feedback received from patients and families was generally extremely positive. The following comments were typical:

"Excellent: I felt welcomed after initially feeling apprehensive"

"I feel very well looked after."

"Excellent. They spend time with you when they can. Very kind."

The positive feedback that we received about the Bristol Royal Infirmary's "care of the elderly" wards, particularly about the dedication of staff on the wards, very much echoes the Healthwatch findings at South Bristol Community Hospital.

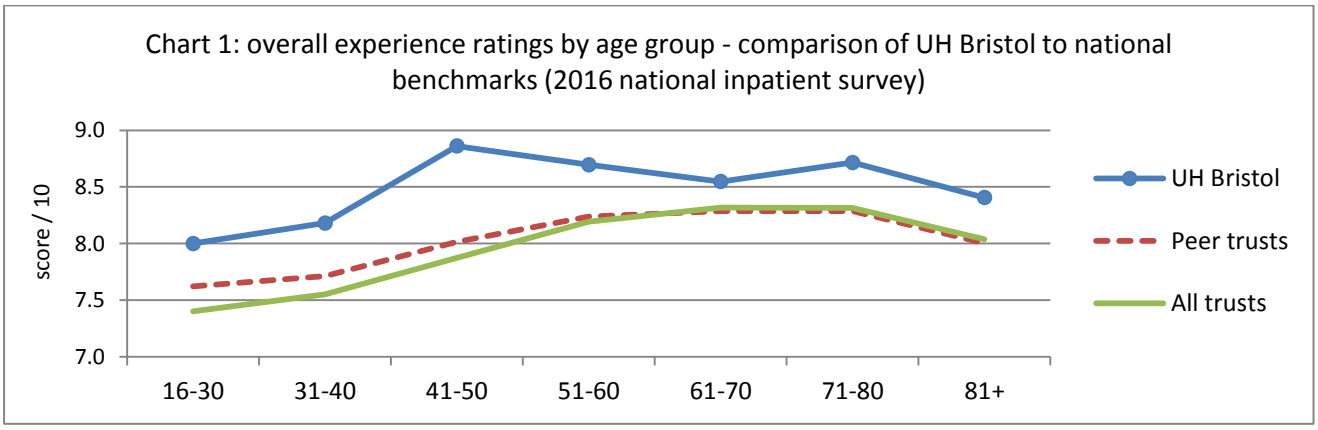
Research at a national level has shown that patient experience ratings increase with age, then decline in the oldest age groups. UH Bristol's data shows a similar general trend, but we are not able to use this national research to directly benchmark UH Bristol's performance. The Trust's Patient Experience and Involvement Team therefore requested a bespoke national inpatient survey dataset from the Care Quality Commission, to analyse this effect in more detail. This data showed that the rate of decline in ratings in the oldest age group was the same at UH Bristol as it was nationally. Furthermore, in every age group (including 81+ years), UH Bristol outperformed national and peer[3] trust averages, and there was also less variation in UH Bristol's scores[4]. **In other words, in this highly robust national data set, UH Bristol was shown to provide a consistently better experience for older patients than most other trusts (see Chart 1 - over).**

[1] Wards: A605, C808, A515, A518, A400, A528.

[2] In response to relatively low survey scores at South Bristol Community Hospital, the Trust invited Healthwatch to carry out an "enter and view" at this hospital in October 2016. The findings were very positive about the quality of care being provided.

[3] Twenty large city centre acute trusts, identified by CHKS Ltd as being broadly similar to UH Bristol.

[4] In the 81+ age group, UH Bristol had a score of 8.4/10, compared to 8.0 for the benchmark trusts. UH Bristol's standard deviation in this age group was 1.5, compared to 2.0 for peer trusts and 1.9 for all English trusts.



Source: Care Quality Commission Survey Team. Analysis: UH Bristol Patient Experience and Involvement Team

Overall, this focus on care of the elderly areas at the Bristol Royal Infirmary, along with the Healthwatch work at South Bristol Community Hospital, supports the idea that UH Bristol provides a high quality service to our older patients. Nevertheless, it is disappointing that there is *any* tail off in patient satisfaction with age[5]. Our work identified the following areas for improvement:

- better communication with patients, carers and families
- more patient involvement in care and treatment decisions
- relieving boredom for long stay patients
- ensuring patients / families receive UH Bristol's "welcome guide" on arrival at a ward

Initial feedback has been provided to the ward sisters. The next stage is to work with the Division of Medicine Patient Experience Group to identify specific actions in response to these findings. An update will be provided in the next Quarterly Patient Experience and Involvement Report.

2.2 Customer service

Delivering a consistent "customer service mind set" at UH Bristol is a key theme in the Trust's Quality Strategy (2016-20) and is the current focus of a corporate quality objective[6]. A number of activities have taken place to explore this concept with patients, staff, the public, and an expert customer service consultant[7]. Feedback was very positive about the idea of applying customer service principles to a hospital setting. As a result of this work, a number of new initiatives are in development for 2017/18, including:

- A review of the Trust's customer service training
- An improvement programme for voice communications and management of incoming telephone calls
- Defining UH Bristol's Principles of Good Customer Service. (A further staff workshop will be held in September to generate these principles, which will then be tested as part of the Improving Outpatients transformation programme with a view to a wider roll out)
- Ensuring UH Bristol's corporate patient experience programme is aligned to these principles

This work will be led by the Transformation Team with support from the Patient Experience and Involvement Team.

[5] It is interesting to see in Chart 1 that the younger age groups have the lowest of all hospital satisfaction levels. Again, there may be demographic factors influencing this result, but we will have an opportunity to study this in more detail later in 2017 when we receive the results of the latest national children's survey (we expect this to be released in October).
[6] Corporate quality objectives are improvement priorities for the Trust.
[7] Tony Dale, who donated his time free of charge.

2.3 Engaging with the Bristol Deaf Community

UH Bristol had previously committed to signing up to the Bristol Deaf Charter in Quarter 1. The Charter outlines best practice in delivering care to patients who are deaf or hard of hearing. Unfortunately, Bristol City Council has not received funding for this project for 2017/18 and so it has not been possible to formally sign up to it. Options are currently being explored to determine how the Trust can still use the learning contained in the Charter. This is likely to be overseen via the establishment of a new patient-focussed Patient Inclusion and Diversity Group at UH Bristol. In the meantime, the Patient Experience and Involvement Team is working with representatives from the deaf community to re-establish the Bristol Deaf Patient Experience Group. This Group provides a forum for discussion among local healthcare organisations and representatives from the deaf community.

3. Patient survey data to Quarter 1

The Trust's Patient Experience and Involvement Team is responsible for measuring patient-reported experience, primarily via the Trust's patient survey programme[8]. This ensures that the quality of UH Bristol's care, as perceived by service-users themselves, can be monitored on an ongoing basis to ensure that high standards are maintained.

3.1 Changes to local inpatient survey targets

There have been two changes to our inpatient survey targets from Quarter 1:

- We made methodological changes to our local inpatient survey in April 2016[9]. This made the scores slightly more positive, so we've set the target slightly higher this year to account for this effect.
- A minimum target has now been set for the Emergency Department Friends and Family Test. This had proved difficult to do previously because we had been testing difference methods of collecting data in these settings. The new target is applied at Trust level only, because the varying methodologies being used have different effects on the scores at an individual department level[10].

3.2 Trust level patient survey data

- All of the UH Bristol's Trust-level patient survey measures remained above target in Quarter 1, demonstrating the continued provision of a high quality patient experience (Charts 2-7)
- The Trust met all of its response rate targets for the Friends and Family Test (Charts 8-11). In particular, following the implementation of an SMS (text message) survey for outpatient services in April 2017, the Trust's new 6% response rate target was exceeded in Quarter 1 (6.6%)
- The outpatient experience tracker (Chart 4) has declined for three consecutive months. This is not a statistically significant effect as the sample sizes are small: the most likely explanation is random fluctuation in the data. However, it is noted that there was an increase in complaints for outpatient services during Quarter 1 (see accompanying report) and, although a direct correlation with the survey feedback could not be detected, this data will continue to be monitored (the latest survey score, for July, has increased to 90).

[8] A description of the key Trust surveys is provided in Appendix B. The headline metrics that are used to track patient-reported experience are: being treated with kindness and understanding, the inpatient and outpatient trackers (which combine several scores across the surveys relating to cleanliness, respect and dignity, communication, and waiting times), and the Friends and Family Test score. The postal survey target thresholds are set to detect a deterioration of around two standard deviations below the Trust's average (mean) score, so that these measures can act as an "early warning" if the quality of patient experience significantly declines, and action can be taken in response.

[9] We removed the reminder letter to non-responders, in order to speed up the data delivery time by one month.

[10] Cards produce the best scores, touchscreens the lowest, and SMS is somewhere in between. The BRI ED is heavily reliant on touchscreen feedback, whilst the BEH ED is almost all cards. We can see this methodological effect within the same departments and so it is not a reflection of service quality. The target is set at three standard deviations below the mean.

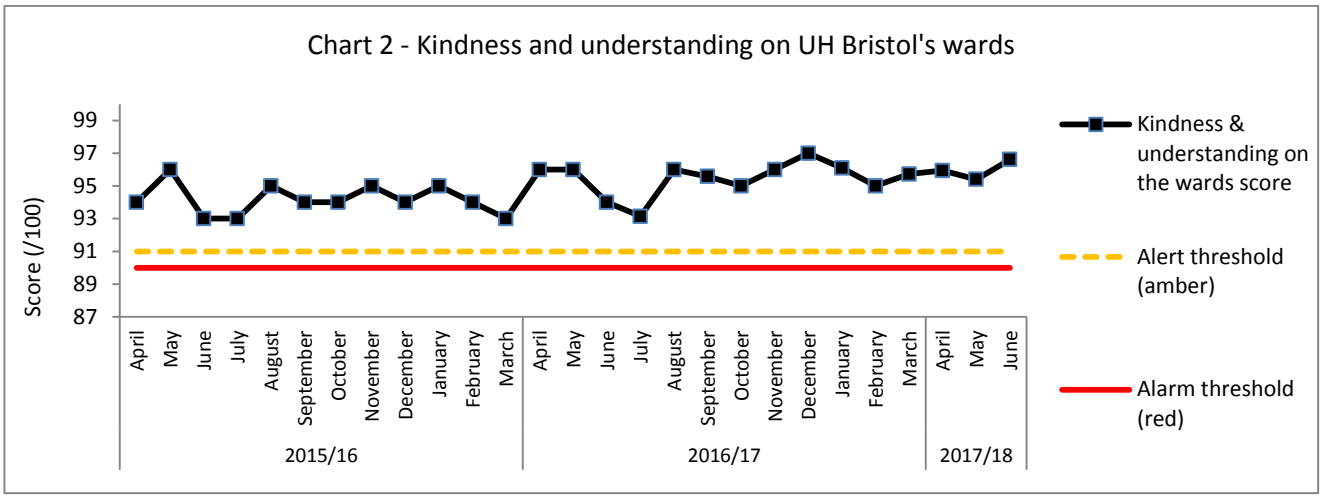


Chart 2 - Kindness and understanding on UH Bristol's wards
Score (/100)
99
97
95
93
91
89
87
April May June July August September October November December January February March
2015/16
April May June July August September October November December January February March
2016/17
April May June
2017/18
Kindness & understanding on the wards score
Alert threshold (amber)
Alarm threshold (red)

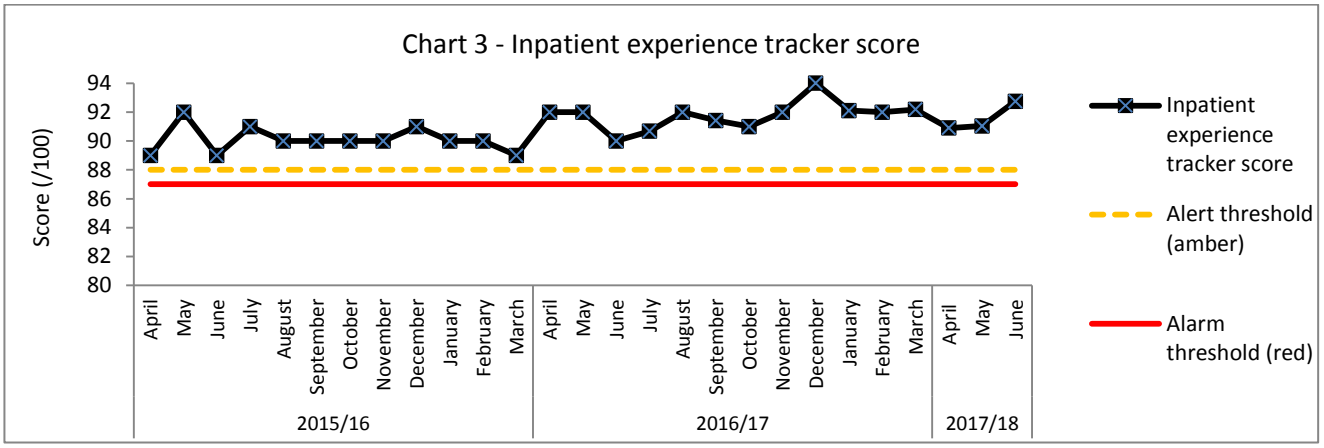


Chart 3 - Inpatient experience tracker score
Score (/100)
94
92
90
88
86
84
82
80
April May June July August September October November December January February March
2015/16
April May June July August September October November December January February March
2016/17
April May June
2017/18
Inpatient experience tracker score
Alert threshold (amber)
Alarm threshold (red)

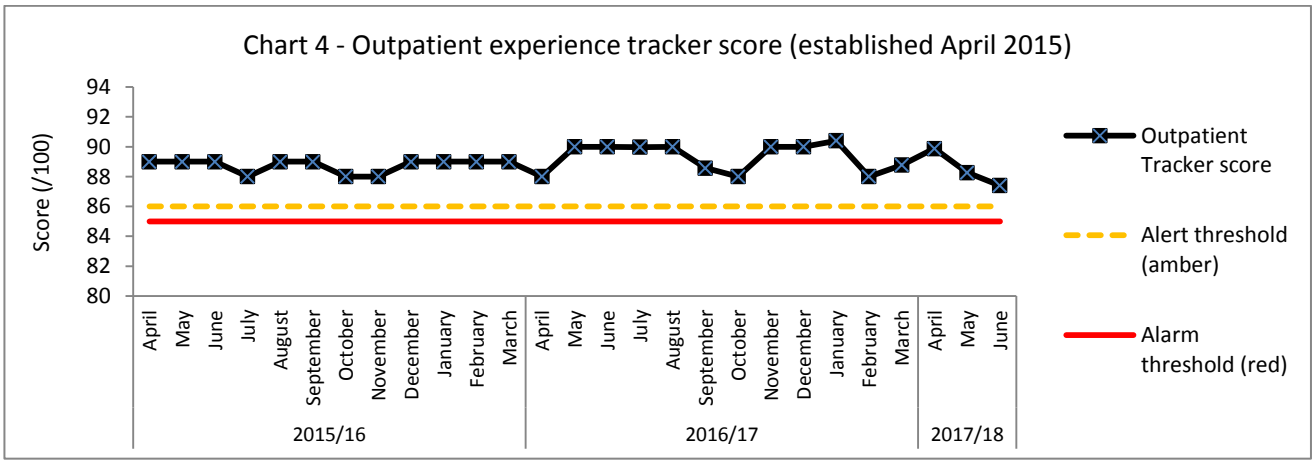


Chart 4 - Outpatient experience tracker score (established April 2015)
Score (/100)
94
92
90
88
86
84
82
80
April May June July August September October November December January February March
2015/16
April May June July August September October November December January February March
2016/17
April May June
2017/18
Outpatient Tracker score
Alert threshold (amber)
Alarm threshold (red)

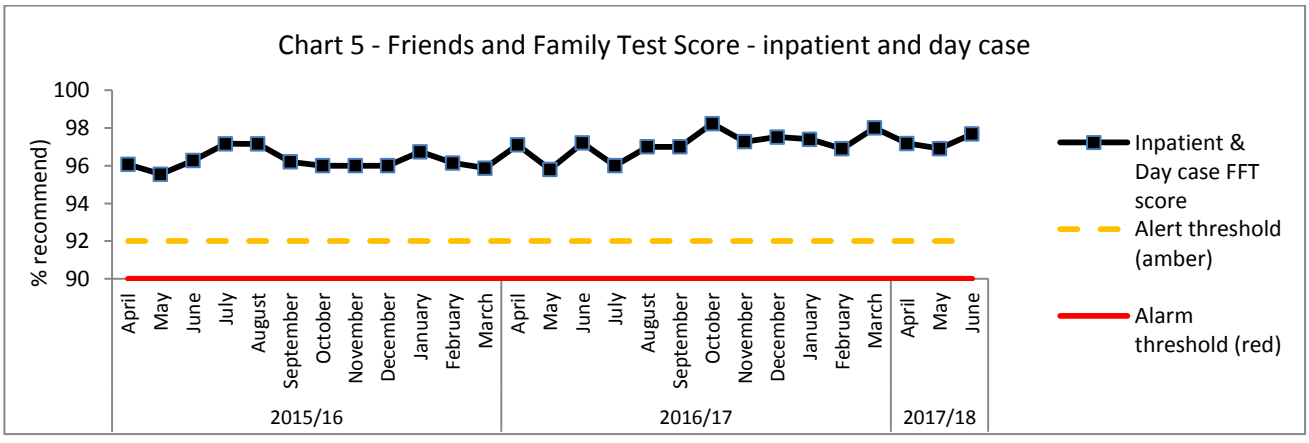


Chart 5 - Friends and Family Test Score - inpatient and day case
% recommend)
100
98
96
94
92
90
April May June July August September October November December January February March
2015/16
April May June July August September October November December January February March
2016/17
April May June
2017/18
Inpatient & Day case FFT score
Alert threshold (amber)
Alarm threshold (red)

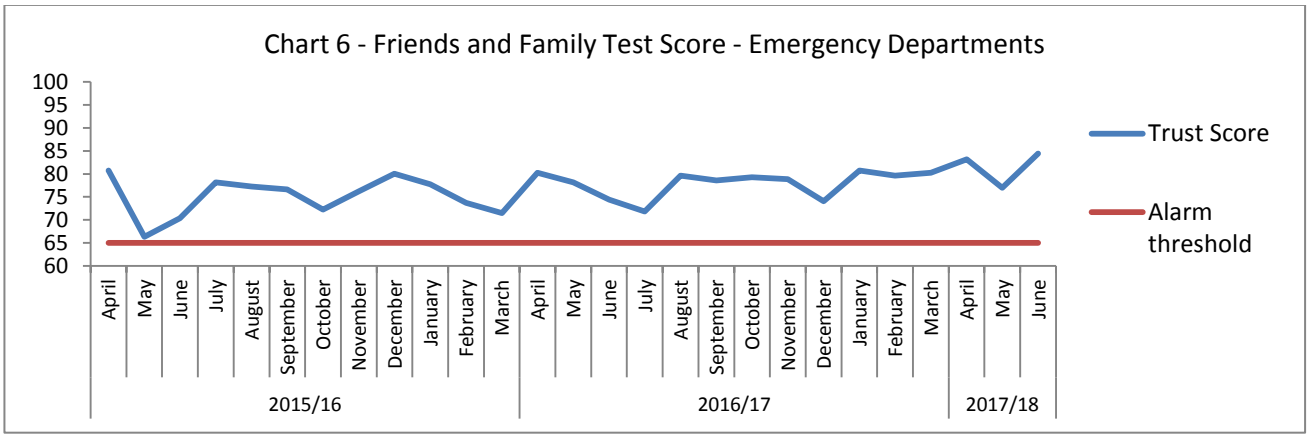


Chart 6 - Friends and Family Test Score - Emergency Departments
100
95
90
85
80
75
70
65
60
April
May
June
July
August
September
October
November
December
January
February
March
2015/16
2016/17
2017/18
Trust Score
Alarm threshold

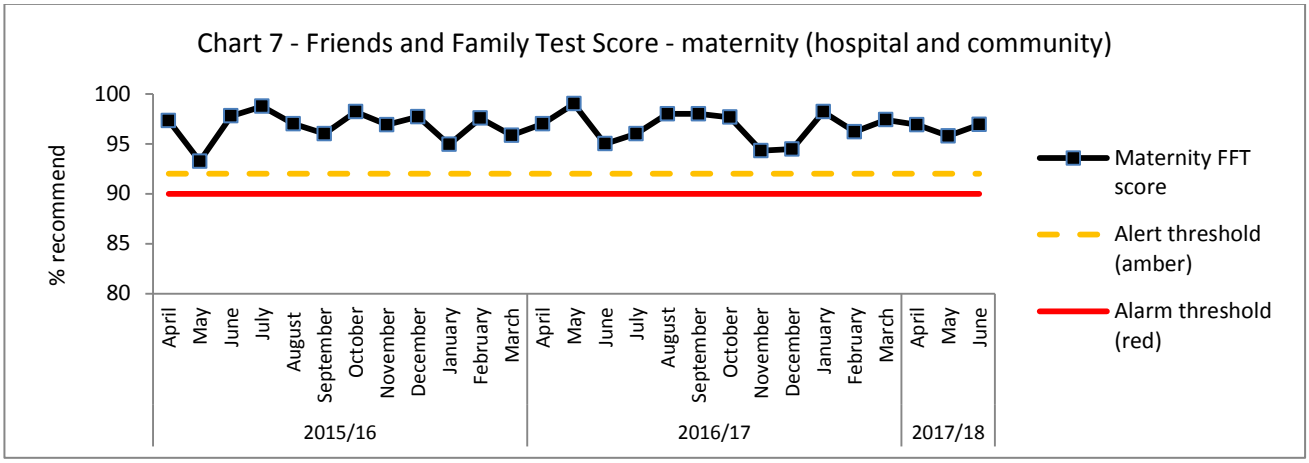


Chart 7 - Friends and Family Test Score - maternity (hospital and community)
% recommend
100
95
90
85
80
2015/16
2016/17
2017/18
Maternity FFT score
Alert threshold (amber)
Alarm threshold (red)

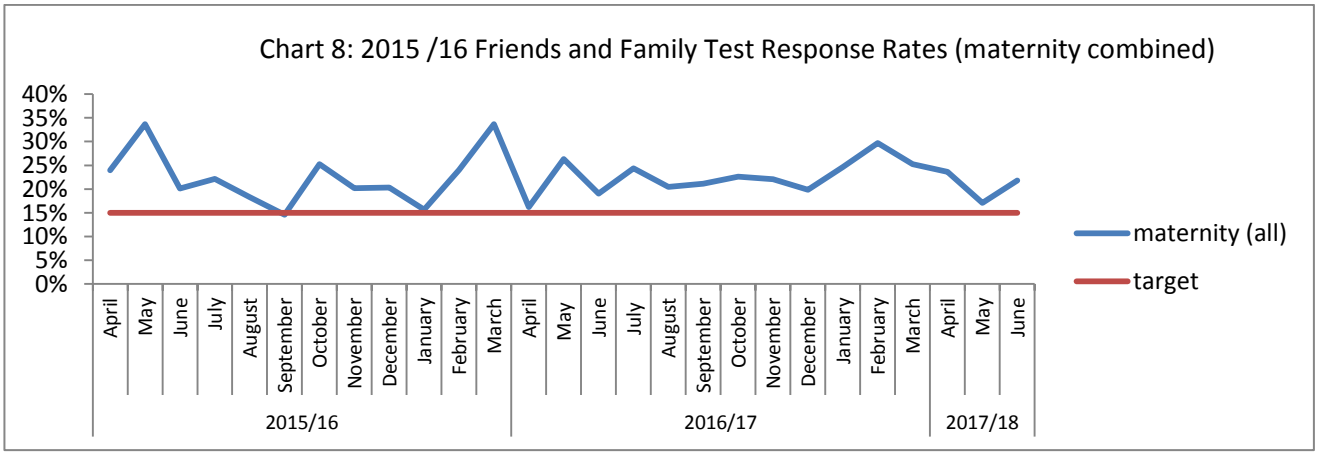


Chart 8: 2015 /16 Friends and Family Test Response Rates (maternity combined)
40%
35%
30%
25%
20%
15%
10%
5%
0%
2015/16
2016/17
2017/18
maternity (all)
target

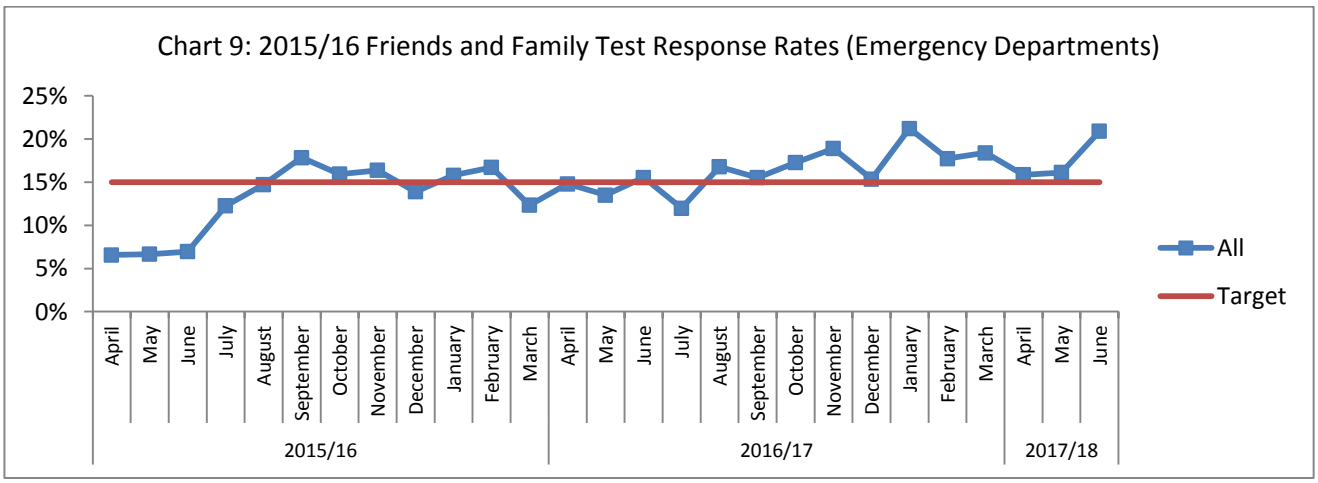
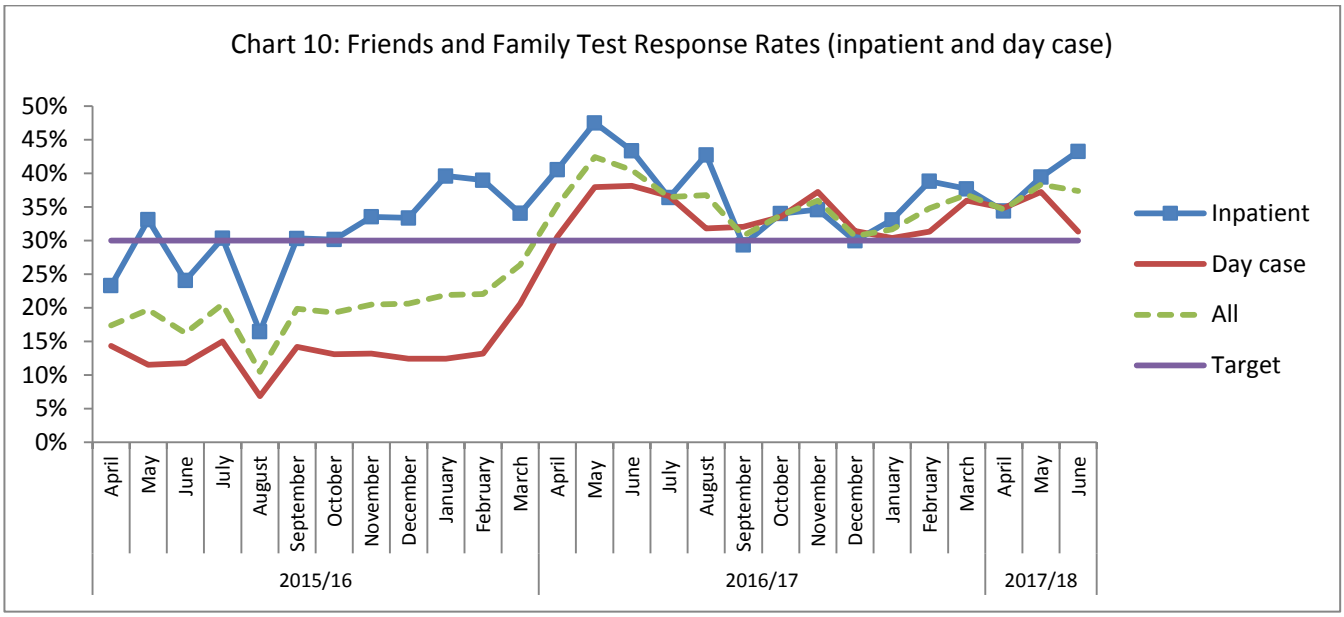
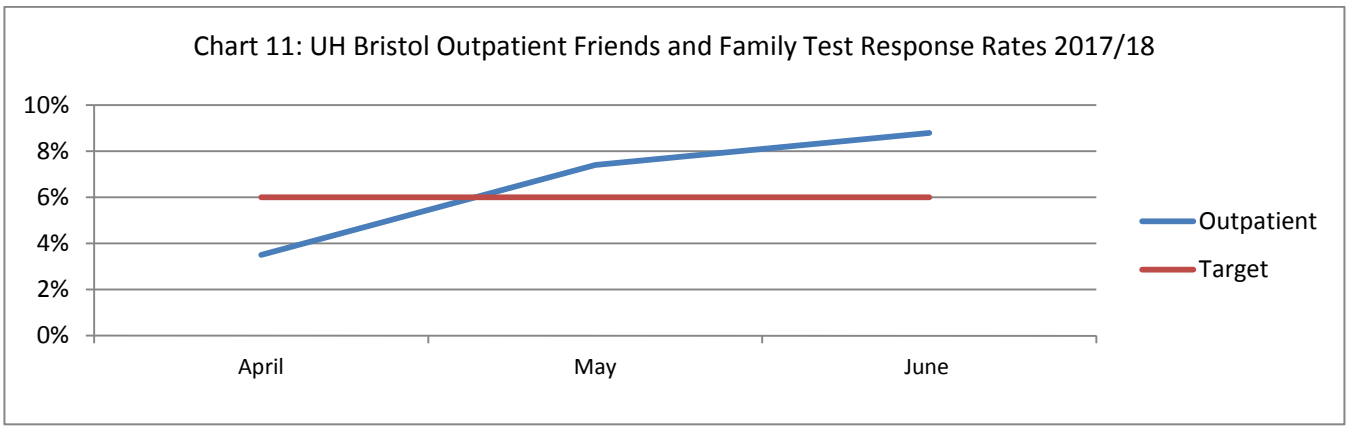


Chart 9: 2015/16 Friends and Family Test Response Rates (Emergency Departments)
25%
20%
15%
10%
5%
0%
2015/16
2016/17
2017/18
All
Target





3.3 Survey scores at Division, hospital and ward level

Charts 12-22 provide a view of patient-reported experience at UH Bristol, from a Division to ward-level. The margin of error gets larger as the data is broken down and so the Trust alert / alarm threshold shown on the charts is only a guide at this level (at a ward level in particular it becomes important to look for consistent trends across more than one of the survey measures). The full Divisional-level inpatient and outpatient survey question data is provided in Tables 1 and 2 (pages 13-15).

South Bristol Community Hospital

South Bristol Community Hospital (wards 100 and 200) received low scores on both of our key inpatient measures (Charts 16-17). The sample sizes are small for this hospital and so we do see fluctuations in the scores. We could not identify a specific reason for the scores being particularly low in Quarter 1, and they do not correlate with other quality data being received by the Division. These trends are consistent with national data that shows lower patient experience ratings amongst long-stay patients (South Bristol Community Hospital inpatient wards specialise in rehabilitation care e.g. for patients who have had a stroke). As noted in Section 1 of the current report, Healthwatch were invited to carry out an “enter and view” at South Bristol Community Hospital in October 2016 and were very positive about the inpatient care being provided there. However, the trend for lower scores at South Bristol Community Hospital is reasonably consistent and so the matron has asked the Patient Experience and Involvement Team to facilitate “patient experience at heart” staff workshops at the

hospital in Quarter 3 2017/18. This approach was successfully employed in maternity services where it had a significant positive effect on their survey scores. An update will be provided in future Quarterly Patient Experience and Involvement Reports.

Postnatal maternity wards

The postnatal wards (wards 73 and 76) scored below the trust level target on treating women with "kindness and understanding" in Quarter 1 (Chart 12). The score was still positive (88/100), and we know that St Michael's Hospital provides a very high quality maternity service - receiving some of the best ratings nationally in the 2015 national maternity survey. The below target performance was a slight decline on Quarter 4 (90) and, combined with the uplift in the target (see Section 3.1), this resulted in a below target score. The Head of Midwifery has asked that ward staff attend a "living the values" training session and has also requested that a further "patient experience at heart" workshop is re-run in Quarter 3 to explore the delivery of a positive experience for service-users.

The postnatal wards also received a relatively low score on cleanliness of toilets and bathrooms in Quarter 1 (Table 1). Further analysis suggested that this was a particular issue on Ward 76. The Operations Manager (Hotel Services) has been alerted to this and has personally checked the cleanliness of the bathrooms.

Division of Medicine – communication

The Division of Medicine received a number of relatively low scores around issues related to "communication" (Table 1). This is in some way reflective of the patients cared for by the Division – many of whom of complex health and social care needs. But, as identified in our focus on care of the elderly in Quarter 1 (see Section 1 of this report), opportunities to improve this aspect of care will be explored by the Division. An update will be provided in the next Quarterly Report.

Ward A605

Ward A605 is a delayed discharge ward and had a relatively low score on two survey measures (Charts 21 and 22). This is disappointing as these scores had improved following service improvement work on the ward. Analysis of the Quarter 1 data has not identified consistent themes, and the results don't correlate with other quality data the Division of Medicine has reviewed: it is therefore hoped that this is a temporary blip in an upward trend. The scores will continue to be closely monitored.

Ward C604

Ward C604 at the Bristol Heart Institute score had the lowest score in the inpatient Friends and Family Test in Quarter 1 (Chart 22). This was an artefact of the Friends and Family Test scoring system: 12/14 patients said they would recommend the care, one person wasn't sure, and a further person said that they would not recommend the care but left the comment "successful treatment" - so may have misinterpreted the question. These latter two scores are counted as "negatives" in the Friends and Family Test scoring and so skewed the result.

Bristol Haematology and Oncology Centre

The Bristol Haematology and Oncology Centre had a below target score on the outpatient tracker in Quarter 1 (Chart 19). Within this aggregate survey measure, it was "delays in clinic" that dragged down the overall score. The hospital has seen significant levels of demand in outpatient clinics and the management team is currently working to ensure these needs can be met. Staff in outpatient clinics have been reminded of the importance of telling patients if there are delays.

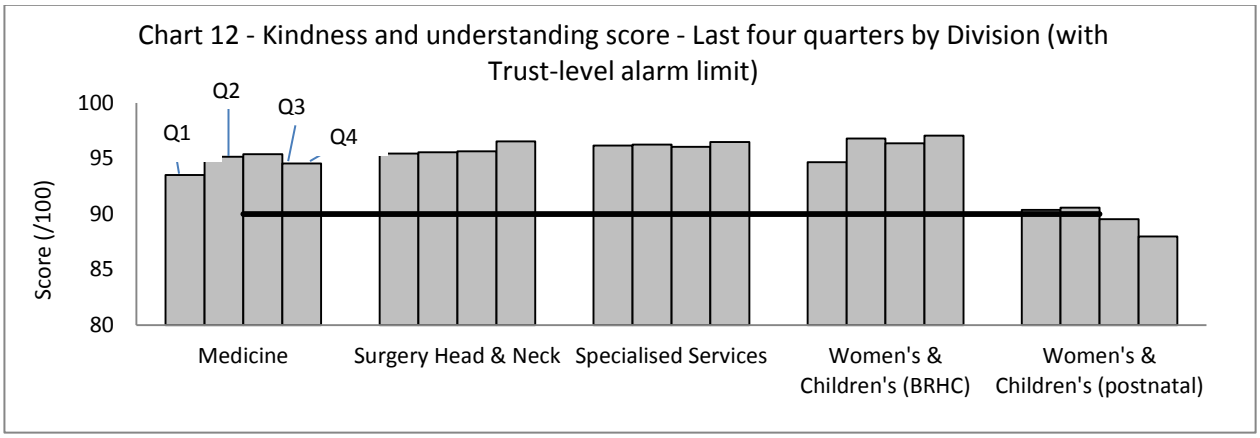


Chart 12 - Kindness and understanding score - Last four quarters by Division (with Trust-level alarm limit)
Q1
Q2
Q3
Q4
100
95
90
85
80
Score (/100)
Medicine
Surgery Head & Neck
Specialised Services
Women's & Children's (BRHC)
Women's & Children's (postnatal)

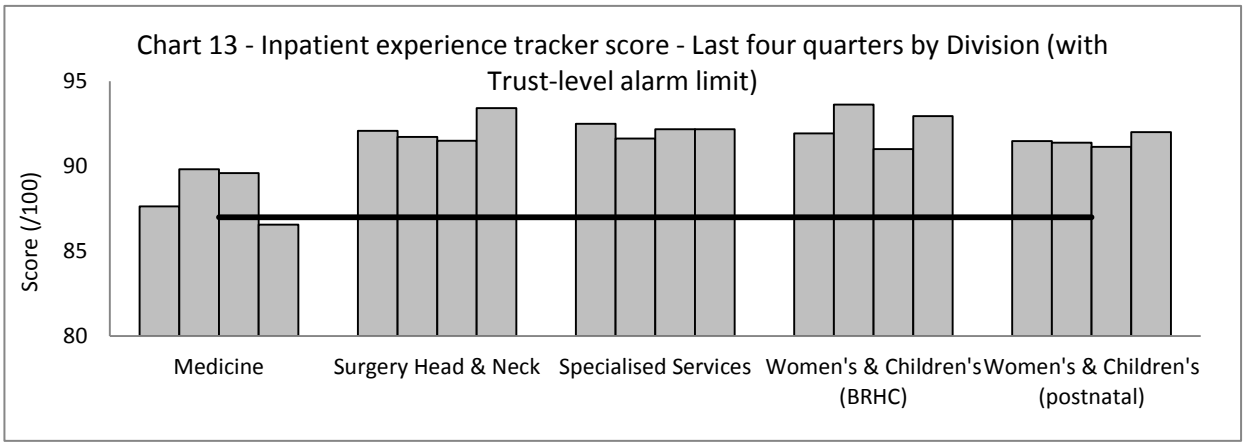


Chart 13 - Inpatient experience tracker score - Last four quarters by Division (with Trust-level alarm limit)
95
90
85
80
Score (/100)
Medicine
Surgery Head & Neck
Specialised Services
Women's & Children's (BRHC)
Women's & Children's (postnatal)

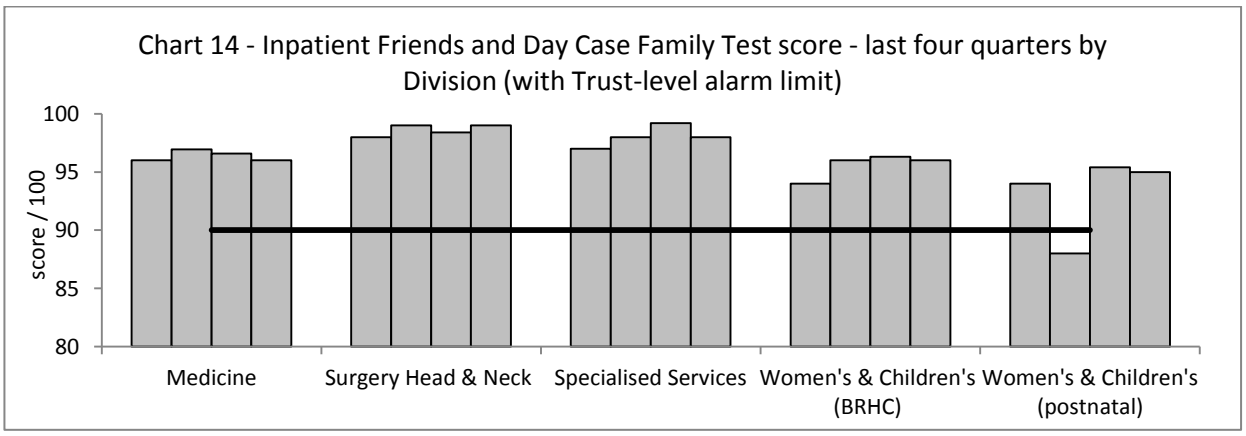


Chart 14 - Inpatient Friends and Day Case Family Test score - last four quarters by Division (with Trust-level alarm limit)
100
95
90
85
80
score / 100
Medicine
Surgery Head & Neck
Specialised Services
Women's & Children's (BRHC)
Women's & Children's (postnatal)

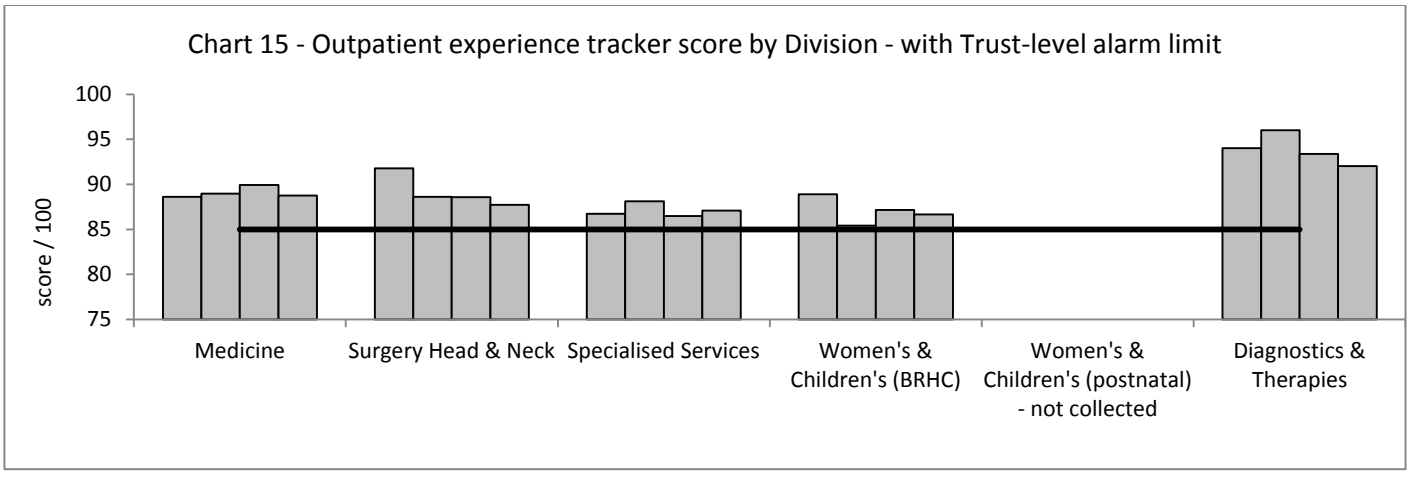


Chart 15 - Outpatient experience tracker score by Division - with Trust-level alarm limit
100
95
90
85
80
75
score / 100
Medicine
Surgery Head & Neck
Specialised Services
Women's & Children's (BRHC)
Women's & Children's (postnatal) - not collected
Diagnostics & Therapies

Chart 16: Kindness and understanding score by hospital (last four quarters; with Trust-level alert limit)

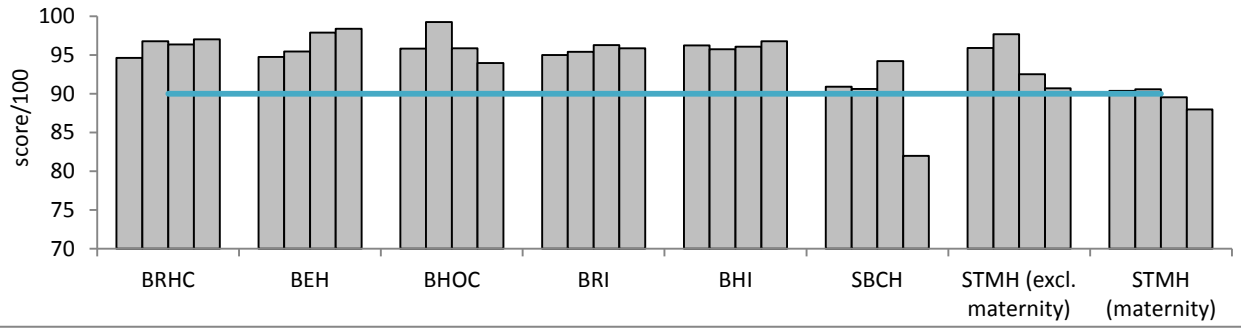


Chart 17: Inpatient experience tracker score by hospital (last four quarters; with Trust-level alarm limit)

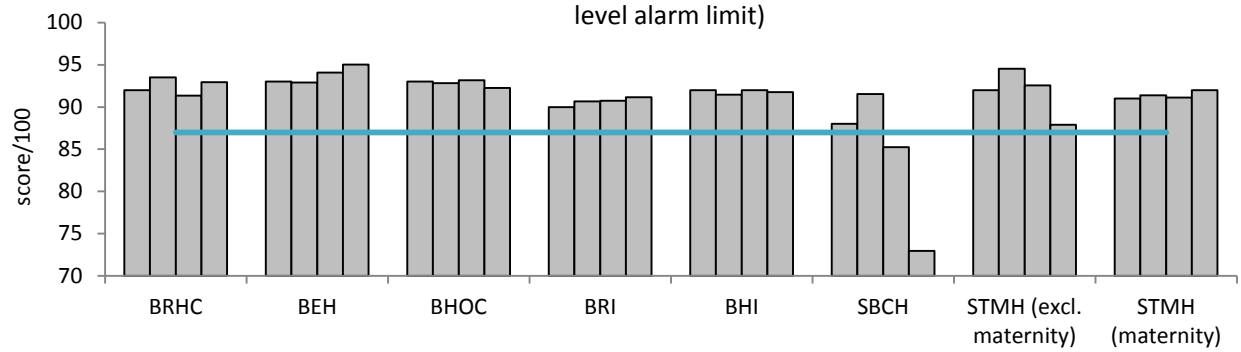


Chart 18: Inpatient and day case Friends and Family Test score (last four quarters; with Trust-level alarm limit)

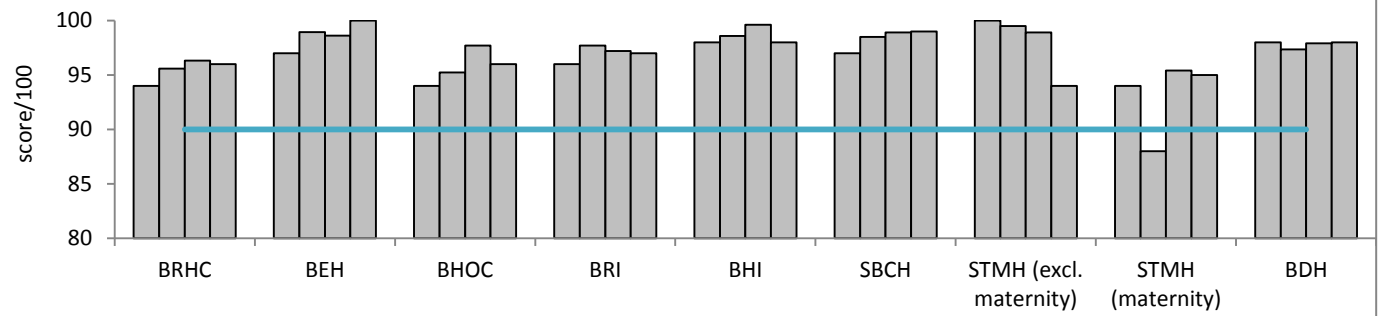
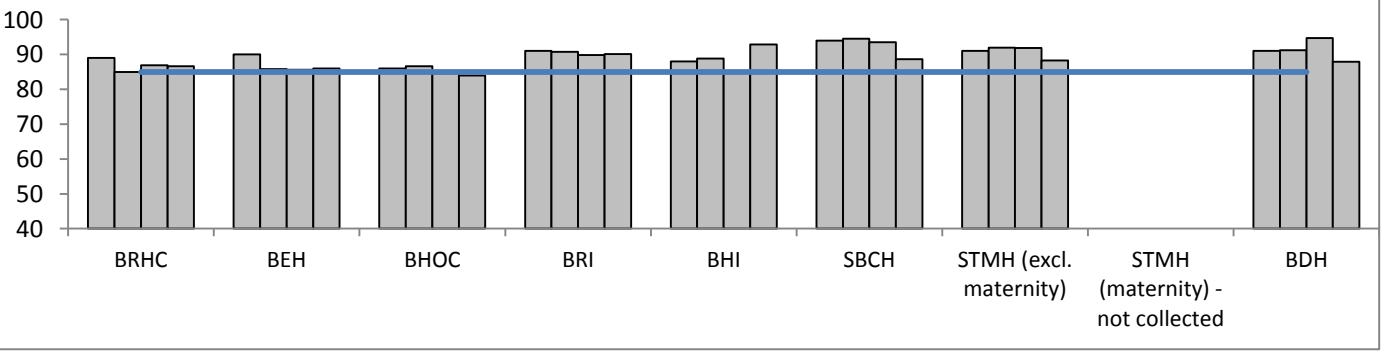
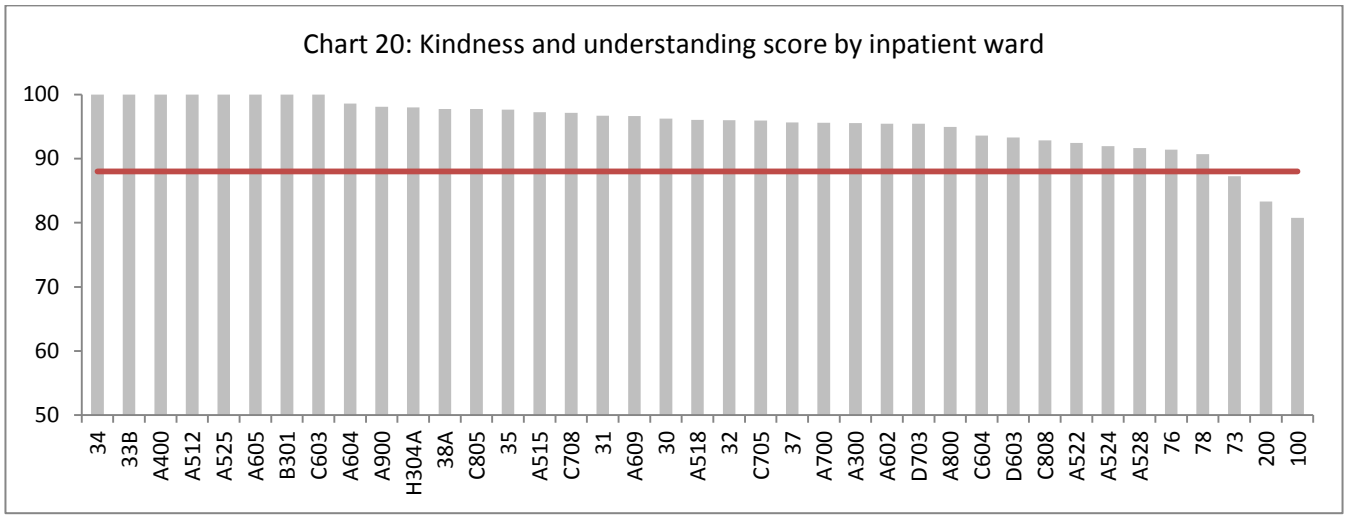
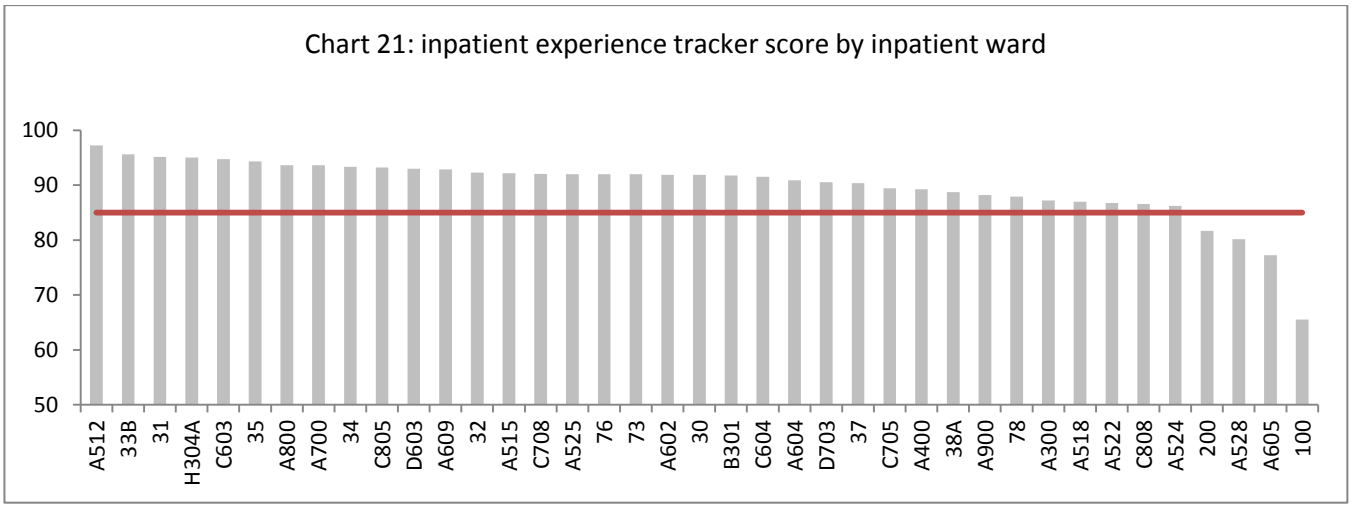


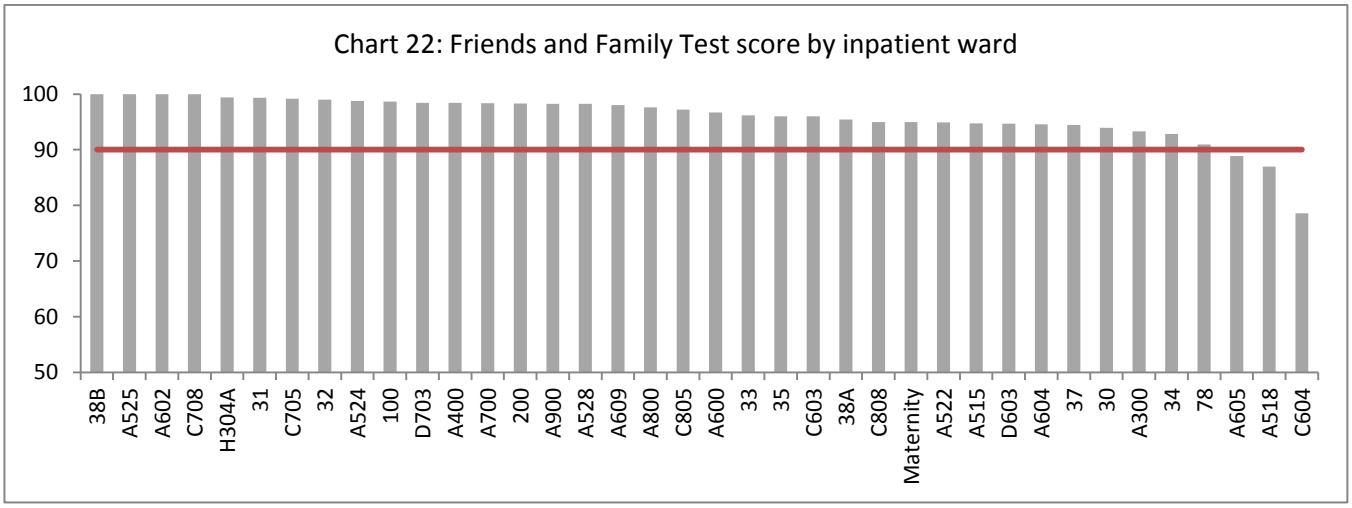
Chart 19: Outpatient experience tracker score by hospital (with Trust-level alarm limit)



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







(Please note that as per NHS England national-level reporting protocol, the maternity Friends and Family Test data is reported at "postnatal ward" level).

Table 1: Full Quarter 1 Divisional scores from UH Bristol's monthly **inpatient** postal survey (cells are highlighted if they are more than 10 points below the Trust score). Scores are out of 100 unless otherwise stated – see appendices for an explanation of the scoring mechanism. Note: not all inpatient questions are included in the maternity survey.

	Medicine	Specialised Services	Surgery	Women's & Children's	Maternity	Trust
Were you given enough privacy when discussing your condition or treatment?	91	94	94	93		**93**
How would you rate the hospital food?	65	63	64	64	58	**64**
Did you get enough help from staff to eat your meals?	79	89	88	77		**84**
In your opinion, how clean was the hospital room or ward that you were in?	94	96	97	94	92	**96**
How clean were the toilets and bathrooms that you used on the ward?	90	92	95	92	82	**93**
Were you ever bothered by noise at night from hospital staff?	81	81	86	83		**83**
Do you feel you were treated with respect and dignity by the staff on the ward?	94	98	97	96	94	**97**
Were you treated with kindness and understanding on the ward?	95	96	97	95	88	**96**
Overall, how would you rate the care you received on the ward?	88	92	91	92	84	**91**
When you had important questions to ask a doctor, did you get answers that you could understand?	83	91	92	89	93	**89**
When you had important questions to ask a nurse, did you get answers that you could understand?	84	91	91	91	92	**90**
If your family, or somebody close to you wanted to talk to a doctor, did they have enough opportunity to do so?	70	80	79	79	79	**77**
If your family, or somebody close to you wanted to talk to a nurse, did they have enough opportunity to do so?	82	90	90	91	88	**89**
Were you involved as much as you wanted to be in decisions about your care and treatment?	77	85	90	89	88	**86**
Do you feel that the medical staff had all of the information that they needed in order to care for you?	84	91	91	87		**89**
Did you find someone on the hospital staff to talk to about your worries or fears?	67	78	78	84	85	**76**
Did a member of staff explain why you needed these test(s) in a way you could understand?	80	86	92	91		**88**

	Medicine	Specialised Services	Surgery	Women's & Children's	Maternity	Trust
Did hospital staff keep you informed about what would happen next in your care during your stay?	76	86	88	86		**84**
Were you told when this would happen?	79	83	86	87		**84**
Beforehand, did a member of staff explain the risks/benefits in a way you could understand?	80	93	95	96		**93**
Beforehand, did a member of staff explain how you could expect to feel afterwards?	69	78	82	88		**80**
Were staff respectful of any decisions you made about your care and treatment?	90	94	96	95		**94**
During your hospital stay, were you ever asked to give your views on the quality of your care?	28	31	32	39	37	**32**
Do you feel you were kept well informed about your expected date of discharge from hospital?	74	80	89	88		**83**
On the day you left hospital, was your discharge delayed for any reason?	59	59	65	66	66	**62**
Did a member of staff tell you about medication side effects to watch for when you went home?	45	56	67	68		**59**
Did hospital staff tell you who to contact if you were worried about your condition or treatment after you left hospital?	65	83	85	90		**82**
How likely are you to recommend our ward to friends and family if they needed similar care or treatment?	86	93	92	93	89	**92**

Table 2: Full six-monthly Divisional-level scores (January –June 2017) from UH Bristol's monthly **outpatient** postal survey (cells are highlighted if they are more than 10 points below the Trust score). Scores are out of 100 unless otherwise stated – please see appendices for an explanation of this scoring mechanism.

	Diagnostic & Therapy	Medicine	Specialised Services	Surgery	Women's & Children's (excl. maternity)	**TOTAL**
When you first booked the appointment, were you given a choice of appointment date and time?	83	73	72	70	68	**74**
Was the appointment cancelled and re-arranged by the hospital?	96	95	96	95	97	**95**
When you contacted the hospital, was it easy to get through to a member of staff who could help you?	69	67	73	69	71	**70**
How would you rate the courtesy of the receptionist?	87	84	86	85	84	**86**
Were you and your child able to find a place to sit in the waiting area?	100	99	98	100	97	**99**
In your opinion, how clean was the outpatient department?	95	95	95	93	89	**94**
How long after the stated appointment time did the appointment start? (% on time or within 15 minutes)	86	70	64	71	66	**71**
Were you told how long you would have to wait?	47	39	37	25	26	**35**
Were you told why you had to wait?	63	56	57	56	61	**58**
Did you see a display board in the clinic with waiting time information on it?	37	62	45	38	42	**45**
Did the medical professional have all of the information needed to care for you?	85	90	90	92	90	**89**
Did he / she listen to what you had to say?	94	95	94	97	94	**95**
If you had important questions, did you get answers that you could understand?	91	93	90	90	89	**91**
Did you have enough time to discuss your health or medical problem?	88	93	89	93	95	**91**
Were you treated with respect and dignity during the outpatient appointment?	98	99	97	98	98	**98**
Overall, how would you rate the care you received?	92	94	91	92	92	**92**
If you had any treatment, did a member of staff explain any risks and/or benefits in a way you could understand?	85	93	78	89	86	**86**
If you had any tests, did a member of staff explain the results in a way you could understand?	78	83	77	81	81	**80**
Did a member of staff tell you about medication side effects to watch for when you went home?	50	76	62	64	78	**67**
How likely are you to recommend the outpatient department to friends and family if they needed similar care or treatment?	92	90	91	90	83	**91**

3.3.1 Themes arising from free-text comments

At the end of the Trust's postal survey questionnaires, respondents are invited to comment on any aspect of their stay. The themes from these comments are provided in Table 3. By far the most frequent type of feedback is praise for staff. Key improvement themes focus on communication, staff behaviour and waiting times. Although these categories do not directly overlap with the way that the Trust classifies complaints, there are similarities between these issues and themes seen in the complaints data (see accompanying Quarterly Complaints Report).

Table 3: Quarter 1 themes arising from free-text comments in the patient surveys (the comments are taken from the Trust's postal survey programme, unless otherwise stated)[11]

	Theme	*Sentiment*	*Percentage of comments containing this theme*
Trust (excluding maternity[12])	Staff	Positive	72%
	Staff	Negative	12%
	Communication/information	Negative	9%
Division of Medicine	Staff	Positive	63%
	Information/communication	Negative	17%
	Waiting / delays	Negative	11%
Division of Specialised Services	Staff	Positive	69%
	Information/communication	Negative	18%
	Food/catering	Negative	10%
Division of Surgery, Head and Neck	Staff	Positive	74%
	Communication/information	Negative	14%
	Food/catering	Negative	9%
Women's and Children's Division (excluding Maternity)	Staff	Positive	76%
	Staff	Negative	15%
	Waiting/delays	Negative	7%
Maternity	Staff	Positive	67%
	Care during labour and birth	Positive	28%
	Staff	Negative	15%
Outpatient Services	Staff	Positive	63%
	Waiting/delays	Negative	13%
	Communication/information	Negative	11%

[11] The percentages shown refer to the number of times a particular theme appears in the free-text comments. As each comment often contains several themes, the percentages in Table 1 add up to more than 100%. "Sentiment" refers to whether a comment theme relates to praise ("positive") or an improvement opportunity ("negative).

[12] The maternity inpatient comments have a slightly different coding scheme to the other areas, and maternity is not part of the outpatient survey due to the large number of highly sensitive outpatient clinics in that area of care.

4. Specific issues raised via the Friends and Family Test in Quarter 1

The feedback received via the Trust's Friends and Family Test is generally very positive. Table 4 provides an overview of activity that has arisen from the relatively small number of negative ratings, where that rating was accompanied by a specific, actionable, comment from the respondent.

Table 4: Divisional response to specific issues raised via the Friends and Family Test in Quarter 4, where respondents stated that they would not recommend UH Bristol and a specific / actionable reason was given.

Division	Area	Comment	Response from ward / department
Surgery	Ward 41	Too much thumping noise at night. Sounds like hammering on trash can.	As a result of this feedback, the nurse in charge checked the silent closing bins and confirmed that some of these are not working properly. The Estates Department has been contacted to fix these.
	A800	Majority of staff were lovely but found that the night shift were not as caring. On a couple of occasions there were a few staffing problems and some staff were loud considering patients were trying to settle down.	The ward Sister has shared this feedback with the ward staff and reiterated the importance of being as quiet as possible (particularly in terms of talking). It is difficult to resolve feedback about how caring the night staff are compared to the day staff, because the ward do not have ''night staff'' as such – the same staff rotate onto nights. However, this feedback has shared with all of the ward staff as a point of learning.
Specialised Services	D603	Poor ventilation in toilet. Not enough extra plug sockets for patients use. General poor maintenance of windows and blinds. Mattresses generally uncomfortable. Not enough pillows (I only had one and no others could be found). Need more visitor chairs.	We appreciate that the ward environment is important for our patients and are sorry that this patient experienced these issues. An update to the D603 facilities / environment is currently under discussion with the Executive Team. We are sorry that the patient found the mattress uncomfortable. However, the mattresses used on the ward are the standard mattresses used across the Trust, and they are subject to regular quality checks. As a result of this feedback, the ward Sister is exploring the possibility of increasing the numbers of chairs available for visitors.

Division	Area	Comment	Response from ward / department
Women's and Children's – Bristol Royal Hospital for Children	Ward 30	Facilities need updating and bed spaces in bay small. Not enough toilets and facilities for parents/carers. Parents leave kitchens dirty. Absurd that carers don't get fed, especially breastfeeding mothers. Just because a baby is over 6 months doesn't mean their feeding mother doesn't get hungry. It would be helpful to have a strap-in baby seat in toilet so parents can use toilet without holding a baby.	We apologise for the negative experience that this parent had on our ward. We are in the process of securing funding for our bed spaces to be re-decorated. For the bay that we think this comment refers to, we are planning to attach the monitors to the wall in order to free-up space. For reasons of patient safety, unfortunately we had to remove some of the bathrooms in the High Dependency Unit to allow for easier access to patients. As a result of this feedback we will put notices up in the kitchen about keeping the kitchen facilities clean. The feedback about food provision for breast-feeding Mums has been discussed with the paediatric dietetics team. It is hospital Policy that if a baby aged six months or younger is admitted to the Children's hospital, and is being breast fed or fed expressed breast milk, then the mother can receive free hospital meals during the stay. Unfortunately, due to the costs involved, there has to be a cut off point for this provision. Six months was chosen as the cut off because babies will usually also be getting some nutrition from solid food from this time, and so are less dependent on breast milk as sole source of nutrition. There is a variety of equipment available for babies and our staff are also happy to look after babies for a short time if needed (e.g. for bathroom breaks). We are sorry that this was not explained to this parent.
Medicine	A518	Staff sit around reception area at night talking very loudly about other staff and the activities of the day, not considering patients who want to sleep. Not having enough choice of foods to go around and having to take what's left.	This feedback has been raised at safety briefs with staff on the ward to remind them to respect the patients need to sleep at night, and to reduce noise at night. We are sorry for the lack of food choice – patients should receive the meal of their choice and this patient's experience has been discussed with the ward sister and catering team.

Division	Area	Comment	Response from ward / department
Medicine *(continued)*	A300	I was not introduced to the ward, i.e. not told where the toilet was, shown the button to summon help, shown the light switch etc. The night nurse was extraordinarily uncommunicative	The Matron has had a discussion with the staff nurse that this comment refers to, to convey the importance of good communication skills and how we should welcome new patients onto the unit in the correct manner.
	A300	I was not able to sleep due to the noise in the ward but all the staff are amazing, helpful, know what they're doing.	Unfortunately, due to the nature of the acute medical unit, the ward can be quite noisy, as transferring and admitting patients is an ongoing activity. However, we have reminded our staff of the need to keep noise to a minimum wherever possible – particularly at night.
	Bristol Royal Infirmary Emergency Department	The place was filthy, and the stench was unbearable, the toilet facility was disgusting and there was no antibacterial hand gel anywhere, I asked if there was any and was told "oh there may be some over there", I looked eveywhere and there wasn't	This feedback has been discussed with the Trust's Facilities Department, who have confirmed that there is 24 hours / 7 days a week cleaning cover in the Emergency Department, but that at peak times it is extremely challenging to maintain all areas. A mini-audit was recently carried out by the Facilities Management Team, which corroborated this patient's view that works need to be carried out to improve the condition of the public toilet in the main reception area: this action will now be taken forward by the Estates Department. In addition, the Emergency Department are recruiting to a new "housekeeper" role, which will operate in a similar way to the wards - taking ownership of departmental cleanliness, supervision of the domestic staff and ensuring hand gels are available. The Matron has also reminded staff to check the hand gels and for the reception team to monitor the state of the waiting room and direct the domestic staff to the area when required

5. Update on key issues identified in the previous Quarterly report

Table 5 provides a summary and update on issues identified in the previous Quarterly Patient Experience report.

Table 5: update on key issues identified in the previous Quarterly Patient Experience report

Issue / area	*Outcome*
Ensuring the Trust meets its new 6% target for response rates in the outpatient Friends and Family Test survey	The survey was introduced part-way through April. The response rate target was exceeded for Quarter 1 (6.6%).
Due to the ongoing testing of different methodologies for the Emergency Department Friends and Family Test, we had found it difficult to set a reasonable target score. However, it was stated that a minimum target score would be set from Quarter 1.	This has been done in the current report. It is only possible to set this score at a trust level – applying at hospital level wouldn't work very well because each hospital has a different primary survey methodology – each of which generates different scores and a lot of variation each month. At a Trust level however the data is more stable and a reasonable minimum target has now been applied to this (based on three standard deviations from the mean).
Ward C808 (care of the elderly) had the lowest score across the headline survey measures. It has been a consistent feature of the survey data that care of the elderly areas tend to attract lower patient experience scores. This has led to additional analysis and exploration of the data, which suggests that the scores are a realistic reflection of the challenges of caring for patients (and being a patient / carer) in this setting - rather than a reflection of the quality of care being provided. To further test this theory, in Quarter 1 the Patient Experience and Involvement Team are carrying out a range of patient / family feedback activities on care of the elderly wards.	The focussed work on care of the elderly has taken place. The findings were broadly very positive and an update is provided in the current report.
Ward A602 (trauma and orthopaedics) had relatively low scores on two key survey measures. This was an unusual result for this ward, further analysis did not identify any specific improvement issues, and the number of complaints actually fell over this period. The most likely explanation at present is that this was a statistical "blip", but the ward Sister has been alerted to the result and the score will continue to be monitored to look for any consistent trend.	The scores are back in the normal range and so this appears to have been a blip – but the scores will continue to be monitored.
Patient Experience at Heart staff workshops in care of the elderly wards	This workshop took place in Quarter 1 as part of the focus on care of the elderly. Further workshops are now being planned at South Bristol Community Hospital in Quarter 3.

Issue / area	*Outcome*
More detailed analysis of the 2016 national inpatient survey results.	Further analysis has been provided in the current report. A full analysis was provided to the Trust Board in July 2017.
The Division of Medicine consistently achieves relatively low survey scores around telling patients information about operations / procedures and who to contact if they had concerns after leaving hospital. It has been difficult to explain this result as relatively few patients have operations / procedures in the Division of Medicine and comprehensive information is given at discharge.	The theme of "communication" was explored in Quarter 1 as part of the Patient Experience and Involvement Team's collaboration with care of the elderly wards in the Division of Medicine (see current report).
A cluster of low survey scores are present in the outpatient survey data (Table 3), relating to ensuring patients are kept informed about delays in clinic, either via a member of staff or an information board (ideally both). Although a number of improvement actions were described in the report, the scores have essentially remained static since 2015/16.	This will remain the focus of a Trust quality improvement objective for 2017/18. Updates against these objectives are provided in a separate quarterly report to the Trust's Senior Leadership Team Committee.

6. National Patient Surveys

The Care Quality Commission's (CQC's) National Patient Survey programme is a mandatory survey programme for acute English trusts. It provides a robust national benchmark against which the patient experience at UH Bristol can be compared to other organisations. Chart 21 provides a broad summary of the Trust's position in these surveys[13]. For each national survey, the Trust Board receives a full report containing an analysis / response (see Appendix A for a summary).

In Quarter 1 UH Bristol received the latest (2016) national inpatient survey. The 2016 results represent a significant, positive step-change for UH Bristol in terms of performance in this survey - putting the Trust among the very best nationally:

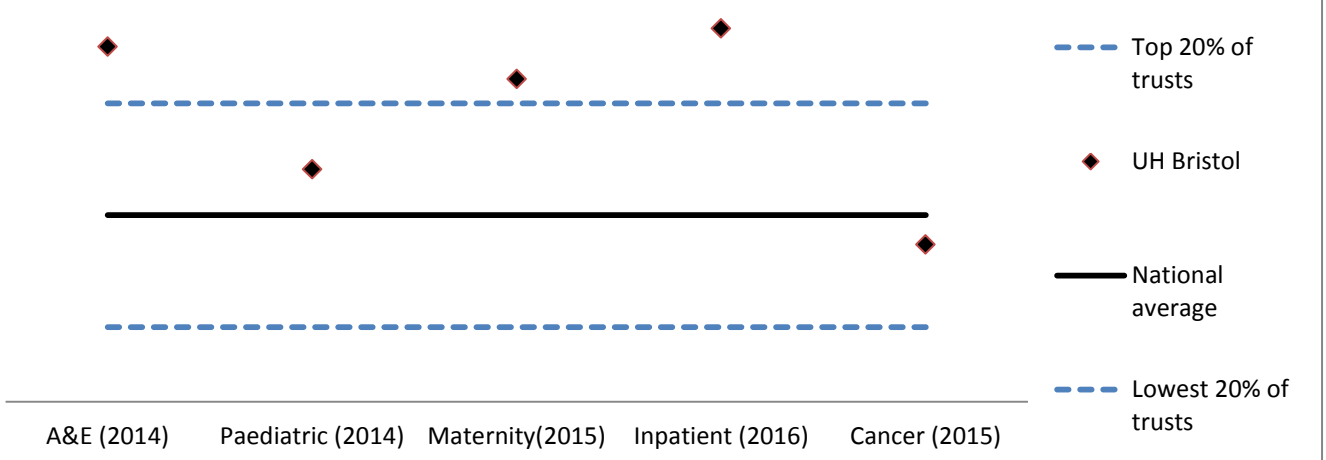
- UH Bristol inpatients' overall rating of their experience in hospital was the best of any general acute trust in the country
- UH Bristol was classed as being better than the national average on 20 out of 65 survey question scores (all of the Trust's remaining scores were in line with the national average)
- UH Bristol's best scores in 2016, as in previous years, primarily relate to the quality of care delivered by staff and themes relating to privacy and dignity.

A report of the results was provided to the Trust Board in July 2017. This report also highlighted how UH Bristol will keep developing an ability to improve patient experience during 2017/18, in particular:

[13] It is difficult to directly compare the results of different surveys, and also to encapsulate performance in a single metric. Chart 21 is an attempt to do both of these things. It should be treated with caution and isn't an "official" classification, but it is broadly indicative of UH Bristol's performance relative to other trusts.

- Through the procurement of a real-time patient feedback and reporting system
- Developing consistent customer service standards
- Enhancing the way we "market" the importance of giving feedback and how we use this insight around our hospitals.

Chart 21: Indication of UH Bristol patient-reported satisfaction relative to the national average



Source: Care Quality Commission / NHS England national surveys; analysis carried out by the Patient Experience and Involvement Team.

Note:

In July 2017 the Trust received the 2016 National Cancer Patient Experience Survey results. The results are broadly in line with the national average. At the time of writing, a full analysis of these results is being undertaken by the Trust's Lead Cancer Nurse and the Patient Experience and Involvement Team. An update will be provided in the next Quarterly Patient Experience and Involvement Report.

Appendix A: summary of national patient survey results and key actions arising for UH Bristol (note: progress against action plans is monitored by the Patient Experience Group)

Survey	*Headline results for UH Bristol*	*Report and action plan approved by the Trust Board*	*Action plan review*	*Key issues addressed in action plan*	*Next survey results due (approximate)*
2016 National Inpatient Survey	20/63 scores better than the national average. None were below this benchmark.	July 2017	Six-monthly	• Awareness of the complaints / feedback processes • Asking patients about the quality of their care in hospital	June 2018
2015 National Maternity Survey	9 scores were in line with the national average; 10 were better than the national average	March 2016	Six-monthly	• Continuity of antenatal care • Partners staying on the ward • Care on postnatal wards	December 2017
2016 National Cancer Survey	All scores in line, with the excepting of two that were better than this benchmark and one that was below (related to communication with the Clinical Nurse Specialist)	September 2016	Six-monthly	• Support from partner health and social care organisations • Providing patients with a care plan • Coordination of care with the patient's GP	July 2018
2014 National Accident and Emergency surveys	33/35 scores in line with the national average; two scores were better than the national average	February 2015	Six-monthly	• Keeping patients informed of any delays • Taking the patient's home situation into account at discharge • Patients feeling safe in the Department • Key information about condition / medication at discharge	October 2017
2015 National Paediatric Survey	All scores in line with the national average, except one which was better than this benchmark	November 2015	Six-monthly	• Information provision • Communication • Facilities / accommodation for parents	October 2017
2011 National Outpatient Survey	All scores in line with the national average	March 2012	n/a	• Waiting times in the department and being kept informed of any delays • Telephone answering/response • Cancelled appointments	No longer part of the national programme

Appendix B – UH Bristol corporate patient experience programme

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

Purpose	Method	Description
Rapid-time feedback	The Friends & Family Test	Before leaving hospital, all adult inpatients, day case, Emergency Department patients, and maternity service users should be given the chance to state whether they would recommend the care they received to their friends and family.
	Comments cards	Comments cards and boxes are available on wards and in clinics. Anyone can fill out a comment card at any time. This process is "ward owned", in that the wards/clinics manage the collection and use of these cards.
Robust measurement	Postal survey programme (monthly inpatient / maternity / outpatient surveys)	These surveys, which each month are sent to a random sample of approximately 2500 patients, parents and women who gave birth at St Michael's Hospital, provide systematic, robust measurement of patient experience across the Trust and down to a ward-level.
	Annual national patient surveys	These surveys are overseen by the Care Quality Commission allow us to benchmark patient experience against other Trusts. The sample sizes are relatively small and so only Trust-level data is available, and there is usually a delay of around 10 months in receiving the benchmark data.
In-depth understanding of patient experience, and Patient and Public Involvement	Face2Face interview programme	Every two months, a team of volunteers is deployed across the Trust to interview inpatients whilst they are in our care. The interview topics are related to issues that arise from the core survey programme, or any other important "topic of the day". The surveys can also be targeted at specific wards (e.g. low scoring areas) if needed.
	The 15 steps challenge	This is a structured "inspection" process, targeted at specific wards, and carried out by a team of volunteers and staff. The process aims to assess the "feel" of a ward from the patient's point of view. Whilst the 15 steps challenge and Face2Face interviews remain stand-alone methodologies, in 2017 they were merged – so that volunteers now carry out the 15 steps challenge whilst in a ward / department to interview patients.
	Involvement Network	UH Bristol has direct links with a range of patient and community groups across the city, who the Trust engages with in various activities / discussions
	Focus groups, workshops and other engagement activities	These approaches are used to gain an in-depth understanding of patient experience. They are often employed to engage with patients and the public in service design, planning and change. The events are held within our hospitals and out in the community.

The methodology for the UH Bristol postal survey changed in April 2016 (inclusive) and so caution is needed in comparing data before and after this point in time. Up until April 2016, the questionnaire had one reminder letter for people who did not respond to the initial mail out. In April we changed the methodology so that the questionnaire had no reminder letters. A larger monthly sample of respondents is now taken to compensate for the lower response rate that the removal of the reminder letter caused (from around 45% to around 30%). This change allowed the data to be reported two weeks after the end of month of discharge, rather than six weeks. It appears to have had a limited effect on the reliability of the results, although at a Trust level they are perhaps marginally more positive following this change (these effects will be reviewed fully later in 2016/17, and the target thresholds adjusted if necessary). The survey remains a highly robust patient experience measure.

Appendix C: survey scoring methodologies

Postal surveys

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

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

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

Friends and Family Test Score

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

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

Cover report to the Public Trust Board. Meeting to be held on 28 September 2017 at 11.00 – 13.00, Conference Room, Trust HQ, Marlborough St, Bristol, BS1 3NU

		Agenda Item	11
Meeting Title	Public Trust Board	**Meeting Date**	Thursday, 28 September 2017
Report Title	**Six Monthly Safe Nursing Levels Report**		
Author	**Carolyn Mills**		
Executive Lead	Carolyn Mills, Chief Nurse		
Freedom of Information Status		Open	

Strategic Priorities (please choose 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 5: We will provide leadership to the networks we are part of, for the benefit of the region and people we serve.	☐
Strategic Priority 2: We will ensure a safe, friendly and modern environment for our patients and our staff.	☐	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 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.	☐
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

The purpose of the paper is to provide assurance to the Trust Board that wards have been safely staffed over the last six months.

Key issues to note

In the last six months the Chief Nurse and Divisional Teams have continued to review and monitor staffing levels in line with UHBristol principles for initiating a staffing review and the principles of safe staffing.

Ward Sisters and Charge Nurses have an understanding of their funded workforce resource, and are aware that if required this will be adjusted to reflect the acuity and dependency of

patients admitted and changes to ward environments. This paper can assure the Board of Directors that UHBristol has had safe staffing levels in the last six months.
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
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)**

Report on Staffing Levels for UHBristol Adult Inpatient Wards, Midwifery and Bristol Children's Hospital (February 17- July 17).
Report to August 2017 Quality and Outcomes Committee

1.0 Introduction

There is a requirement, post the publication of the Francis Report 2013 that all NHS organizations take a six monthly report to their Public Board Boards on nursing and midwifery staffing capacity and capability which has involved the use of an evidence-based tool.

This report details:

a) Any significant changes that have occurred in the last six months
b) How the Trust knows the wards have been safe over the last six months
c) An update on actions detailed in the last report

2.0 Significant Changes to nursing staffing levels in the last six months

As detailed in appendix 2 there are a number of triggers that indicate when a staffing review is required. These would be in addition to the annual divisional reviews of nursing establishments and skill mix with the Chief Nurse.

UH Bristol's funded establishments have had no significant changes in them over the last six months and continue to provide a ratio of the number of patients per RN between 2.3 - 8 on a day shift and 2.3 - 8 on a night shift. The ratio of registered to unregistered staff for UHB for adult inpatient areas continues to range between 50:50 and 90:10. Where the ratio of registered nurses is less than 60% this is based on the professional judgment of the senior nurses and supported by patient acuity and dependency scoring. There have been no changes to the areas that do not fully meet the agreed ratios or the rationale for these variations since the last report.

The table below describes the changes to nurse staffing levels over the last six months within divisions, together with the rationale for the changes

Division	Ward/Unit	Rationale for change
Medicine	A518	Ward 518 has now been re-opened as a substantive ward. Day and night staffing ratios meet the approved UHBristol staffing guidelines. Recruitment to the substantive team of 13.16 Registered Nurses and 10.26 Nursing Assistants continues.
Women's and Children's	Midwifery staffing	An external review of midwifery staffing was undertaken using the Birth Rate Plus workforce assessment tool. Findings showed that the overall clinical establishment recommended for the

		number of births at St Michael's and in the community was 192.82 WTE. The Trust currently has 204.58 WTE. However the Trust skill mix reflects a higher non registered workforce. These findings have been reviewed by the Head of Midwifery and the Divisional Board with no plans to make any changes to the workforce numbers at this time. This will continue to be reviewed.
Specialised Services	D603	Triggered by an increase in activity within the Acute Oncology Unit, an additional registered nurse per night shift was approved in the divisional operating plan for 17/18. Additional staff have been recruited and this is now in place.
	D703	Approval for opening 3 additional beds and 5 registered nurses required to staff this increase, was approved in the divisional operating plan for 17/18. The opening of beds will be phased as staff are recruited. 2 beds have been opened, with the third expected to be open by December 17.

3.0 Care Quality Commission (CQC) Requests for staffing information

No requests for staffing information from the CQC were received during this time. Following a CQC inspection in November 2016, the full report was received in February 2017.Overall the Trust was assessed as outstanding. Nurse staffing levels were found to meet both national and local guidelines. A potential staffing risk was identified in only one area, the Acute Oncology Unit regarding staffing levels at night, which has now been addressed (see section 2).

4.0 How the Trust knows the wards have been safe over the last six months

4.1. Monthly Staffing Reports to Quality and Outcomes Committee.

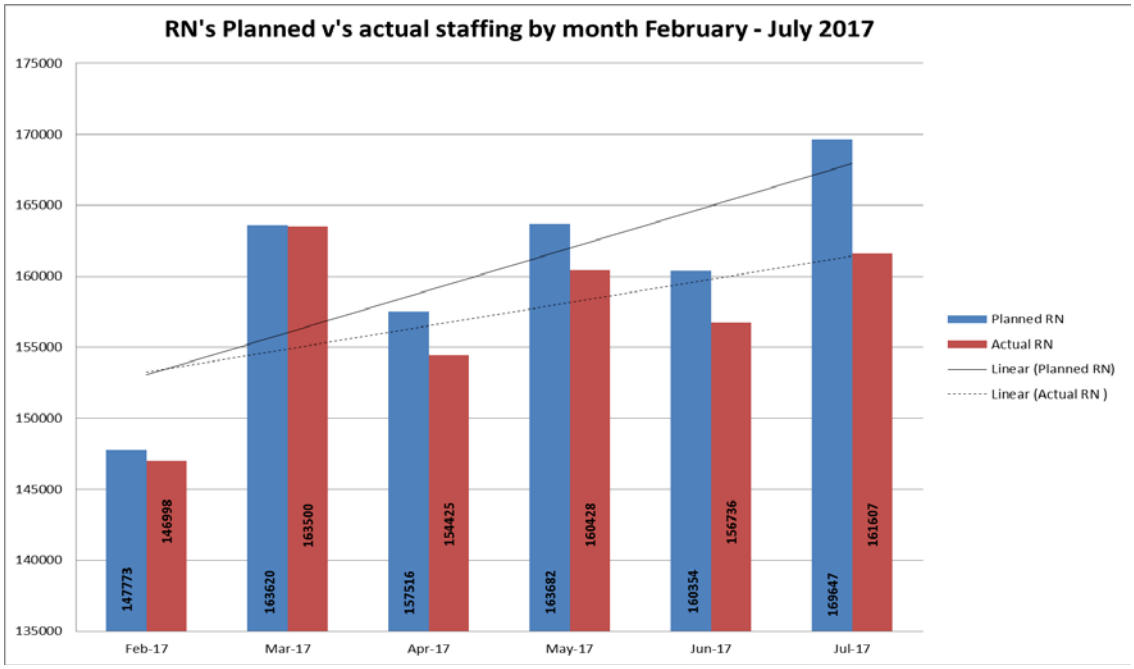
The Trust continues to submit monthly returns of the Department of Health via the NHS national staffing return. This return details the overall Trust position on actual hours worked versus expected hours worked for all inpatient areas, the percentage fill rate for Registered Nurses (RN) and Nursing Assistants (NA) for day and night shifts, together with the overall Trust percentage fill rate. This includes care hours per patient per day (CHPPD). There have been no risks to patient safety identified through these reports in the last six months.

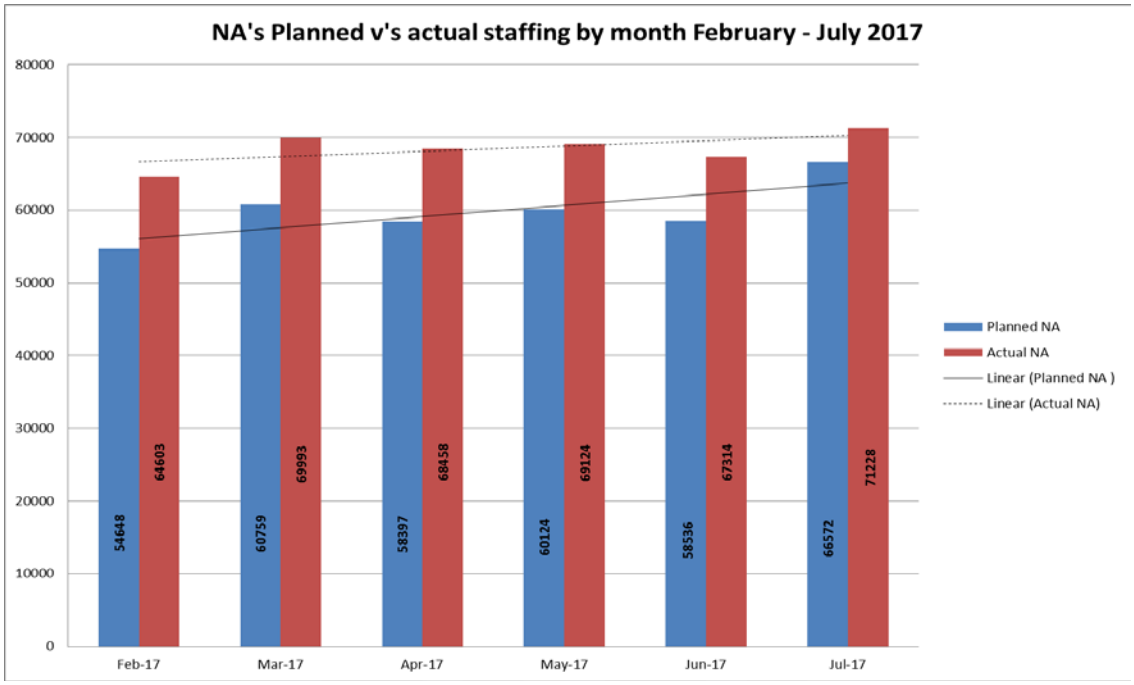
A monthly detailed report is received and reviewed at the monthly at the Quality and Outcomes Committee a Non-Executive sub-committee of the Board. This report gives a detailed breakdown of any variances by Division. The report has been further developed to include information regarding NICE staffing red flags. The number of red flags triggered remains small (37over six months) and whilst this is increase from the

last 6 monthly report the impact of harm to patients remains very low, with actions taken to mitigate any issues identified.

The average level of actual RN Staffing (see fig 1) remains slightly lower than the expected staffing level for the trust over the period. This equates to an average fill rate of 98% across both days and nights. The actual staffing levels for unregistered nurses continues to be above planned staffing levels across days and nights (see fig 1)

Fig 1





4.2 Nurse Staffing Risks held on risk registers

There are no nurse staffing risks on the corporate risk register. A number of nurse staffing risks are held by divisions which are reviewed regularly at monthly Divisional Board meetings and on a rotational basis at the Trust Risk Management Group.

4.3 Quality metrics

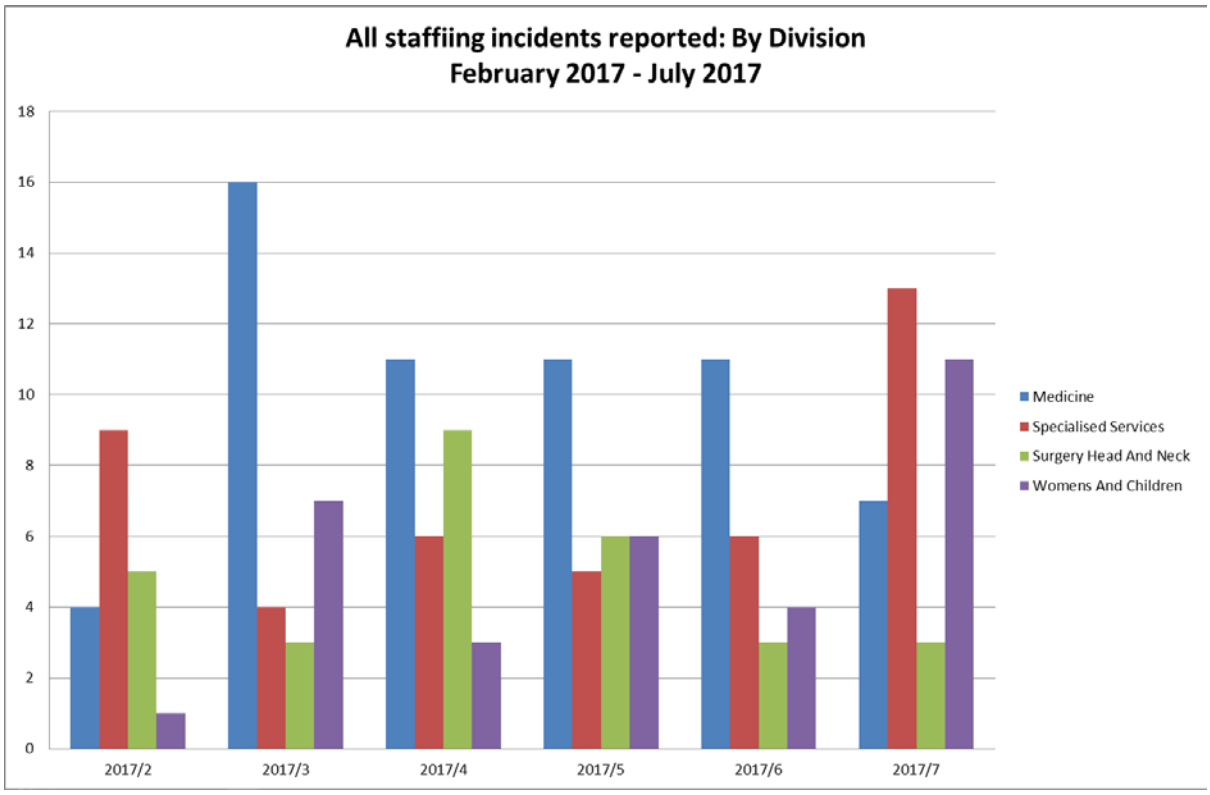
The Trust level quality performance dashboard for the last six months indicates that overall the standard of patient care during this period was of good quality (safety/clinically effective/patient experience).

Over the last six months, the number of falls with harm has remained static. Whilst the overall number of pressure ulcers has decreased over the last 6 months, the number of grade 3 hospital acquired pressure ulcers has increased. Reviews of RCAs to identify good practice, themes and areas requiring improvement continue to be undertaken for both falls and hospital acquired grade 3 pressure ulcers with actions incorporated into both work plans.

4.4 Staffing incidents

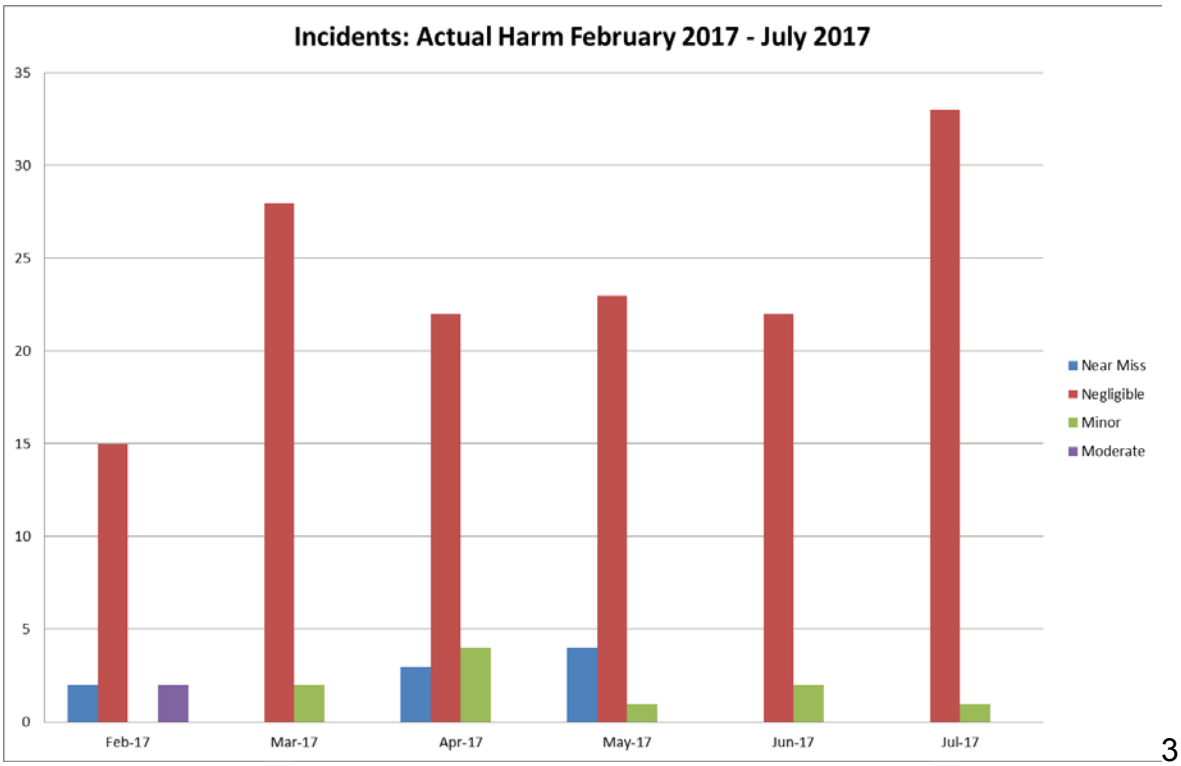
The number, content and any themes arising staffing incidents related to staffing levels are reviewed and discussed monthly and quarterly via Divisional Performance and Ops Reviews. (See fig 2).

Fig 2



Where lower than expected staffing forms are submitted, the actual harm continues to be assessed as near miss to minor, with no moderate actual harm impact seen over the last six months (see fig 3).

Fig 3.



3

5.0 National Updates

- Statutory supervision for midwives ended in March 2017. The new model of supervision A-EQUIP (advocating for education and quality improvement) is being rolled out across the country. The Trust is appointing Professional Midwifery Advocates (PMA's), who will need to undertake a 4 day course if they have previously been Supervisors of Midwives. 7 midwives have been identified to undertake the course. Whist a supervisor of midwives rota is no longer required; the Division has replaced this with a Senior Midwife on call rota to provide support to the service.
- From 1 August 2017, new nursing, midwifery students will no longer receive NHS bursaries. Applications to the University of the West of England are being closely monitored. It is anticipated that places for midwifery, child and adult nursing will be filled for September 17.

6.0 Conclusion

In the last six months the Chief Nurse and Divisional Teams have continued to review and monitor staffing levels in line with UHBristol principles for initiating a staffing review and the principles of safe staffing.

Ward Sisters and Charge Nurses have an understanding of their funded workforce resource, and are aware that if required this will be adjusted to reflect the acuity and dependency of patients admitted and changes to ward environments.

This paper can assure the Board of Directors that UHBristol has had safe staffing levels in the last six months.

Appendix 1:

UHBristol' s principles for initiating a staffing review (2014)

As a minimum a staffing and skill mix ratio review will be undertaken annually for each clinical area.

OR when there is:

- A significant change in the service e.g. changes of specialty, ward reconfiguration, service transfer
- A planned significant change in the dependency profile or acuity of patients within a defined clinical area e.g. demonstrated by sustained high acuity/dependency scores or an increased specialling requirement.
- A change in profile and number of beds within defined clinical area.
- A change in staffing profile due to long term sickness, maternity leave, other leave or high staff turnover
- If quality indicators in the key performance indicators a failure to safeguard quality and/or patient safety.
- A Serious Incident (SI) where staffing levels was identified as a significant contributing factor
- If concerns are raised about staffing levels by patients or staff.
- Evidence from benchmark group that UHBristol is an outlier in staffing levels for specific services.

Appendix 2:

Principles of Safe Staffing for General Inpatient Wards

Ratio of registered to unregistered professionals
Within UHB adult inpatient areas the Trust set staffing levels based on a principle of 60:40 ratio, registered nurse to nursing assistant in general inpatient areas. This will be higher in some specialist ward areas due to the increasing complexity of care, for example medication regimes and the number of intravenous drugs now given and increased dependency and complexity of elderly patients being admitted.

Ratio of number of patients per nurse
In setting wards establishment and skill mix UHB use the principles of one registered nurse per 6 patients on a day shift and one registered nurse to 8 patients on a night shift.

In adult critical care areas the ratio is one nurse per patient adult intensive care (level

3 patient) day and night and one nurse per two patients in adult high dependency (level 2 patients) day and night

Cover report to the Public Trust Board. Meeting to be held on 28 September 2017 at 11.00 – 13.00, Conference Room, Trust HQ, Marlborough St, Bristol, BS1 3NU

		Agenda Item	12
Meeting Title	Public Trust Board	**Meeting Date**	Thursday, 28 September 2017
Report Title	Finance Report		
Author	Paul Mapson, Director of Finance and Information		
Executive Lead	Director of Finance and Information		
Freedom of Information Status		Open	

Strategic Priorities (please choose 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 5: We will provide leadership to the networks we are part of, for the benefit of the region and people we serve.	☒
Strategic Priority 2: We will ensure a safe, friendly and modern environment for our patients and our staff.	☐	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 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.	☐
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

To inform members of the financial position of the Trust in August.

Key issues to note

The summary income and expenditure statement (appendix 1) shows a surplus for the period to the end of August 2017 (before technical items) of £3.046m. The Trust's Operational Plan for August is a surplus of £3.986m (before technical items), therefore the position is £0.940m adverse to plan. After technical items the planned surplus is £3.336m and the actual surplus is £2.797m.

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)**
	25 September 2017			

University Hospitals Bristol
NHS Foundation Trust

REPORT OF THE FINANCE DIRECTOR

1. Summary

The summary income and expenditure statement (appendix 1) shows a surplus for the period to the end of August 2017 (before technical items) of £3.046m. The Trust's Operational Plan for August is a surplus of £3.986m (before technical items), therefore the position is £0.940m adverse to plan. After technical items the planned surplus is £3.336m and the actual surplus is £2.797m.

The £13.313m Sustainability and Transformation funding (STF) for the year is dependent on achieving the 'core' control total excluding STF funding (70%), achieving the A&E performance target (15%) and the A&E streaming target (15%).

Excluding STF funding the Trust is reporting a deficit of £0.427m against a planned (phased) surplus of £0.214m. Therefore the control total for month five excluding STF funding has not been met. Receipt of STF core funding is dependent on achieving the control total at each quarter.

The Trust will be reviewing its income and expenditure provisions fully for the month six / quarter two results. It is clear, however, that the significantly deteriorating position requires the actions already agreed with Clinical Divisions to be implemented so the run-rate can be reduced to a level that will enable the Trust's year-end financial plan to be achieved.

A full review of the financial position for the year is being conducted to enable a proper governance declaration to NHS Improvement to be made next month.

A&E performance was not met for the first quarter with performance of 87.9% against the joint NHS England / NHS Improvement nationally required trajectory of 90.0%, resulting in a loss of STF performance funding of £0.300m. The performance target was met in months four and five and the Trust's A&E front door streaming initiatives have been recognised to date. Therefore, the STF performance funding loss to date is £0.300m.

The position is summarised in the table below:

	Income / (Expenditure)		Variance
	Plan to date £m	Actual to date £m	Favourable /(Adverse) £m
Corporate Income	245.945	246.553	0.608
Divisions & Corporate Services	(227.751)	(232.990)	(5.239)
Financing	(14.567)	(13.990)	0.577
Reserves	(3.413)		3.413
Surplus/(deficit) excluding STF funding	**0.214**	**(0.427)**	**(0.641)**
STF Core Funding	2.641	2.641	-
STF Performance Funding	1.131	0.832	(0.299)
Surplus/(deficit) including STF funding	**3.986**	**3.046**	**(0.940)**

Divisions and Corporate Services are £5.239m adverse to plan after five months, a deterioration of £1.397m in August. Three Divisions were significantly adverse to plan in the month; Surgery (£0.514), Medicine (£0.496m) and Women's and Children's (£0.289m).

The continuing level of overspend is of great concern given that £13.0m corporate support funding was provided at the start of the year to remove underlying deficits to facilitate the delivery of balanced Divisional Operating Plans. Divisional recovery plans were developed and agreed in response to the month three overspend. Two months on it is clear that the recovery plans are not yet being delivered.

This failure now seriously risks the delivery of the Trust's control total and therefore the receipt of core STF funding for the last two quarters. Performance STF Funding can't be earned if the core funding is not received and therefore the Trust risks receipt of £8.652m total STF funding. The loss of STF income brings a risk to the Trust's capital investment programme. The Trust needs to take action to recover the Divisions' to a position to meet the control total for 2017/18 and to break-even thereafter to ensure the Trust can meet its financial plan on a sustainable basis for future years.

2. Division and Corporate Services Performance

Clinical Divisions and Corporate Services overspend against budget increased by £1.397m in August to a cumulative position of £5.239m adverse. All Divisions and Corporate Services are adverse to their Operating Plan trajectory. This is summarised in the table below:

	Variance to Budget favourable/(adverse)			Operating Plan trajectory favourable/(adverse)	
	To 31 July £m	Aug £m	To 31 Aug £m	Trajectory To Aug £m	Variance £m
Diagnostic & Therapies	0.058	0.006	0.064	0.070	(0.006)
Medicine	(1.269)	(0.496)	(1.765)	(0.290)	(1.475)
Specialised Services	(0.437)	(0.071)	(0.508)	0.126	(0.634)
Surgery	(1.131)	(0.514)	(1.645)	(0.079)	(1.566)
Women's & Children's	(0.971)	(0.289)	(1.260)	(0.009)	(1.251)
Estates & Facilities	(0.030)	(0.002)	(0.032)	(0.021)	(0.011)
Trust Services	(0.017)	(0.011)	(0.028)	(0.001)	(0.027)
Other corporate services	(0.045)	(0.020)	(0.065)	-	(0.065)
Total	**(3.842)**	**(1.397)**	**(5.239)**	**(0.204)**	**(5.035)**

Medicine

The Division was £0.496m adverse to plan in the month increasing the cumulative adverse position to £1.765m. Pay was adverse to plan by £0.221m in the month and income from activities £0.299m. The nursing pay overspend was the highest to date with the additional costs in covering sickness, the Enhanced Supervision Team and premium agency costs. Junior Doctor overspending continues through locum cover for vacancies and maternity leave. Whilst contracted activity has been largely delivered in the Division, the plans for additional admissions against the savings plan have not occurred.

The Division is adverse to its revised Operating Plan by £1.475m. This is primarily due to additional nursing and medical staff costs, underperformance against planned activity and a failure to deliver the planned CIP savings to date.

Specialised Services

In month the Division was adverse to plan by £0.071m. Expenditure on drugs, including several not normally used, contributed £0.047m as well as clinical supplies (£0.026m) and nursing (£0.058m).

Non-delivery of cardiac surgery, Bone Marrow Transplant (BMT) and clinical genetics activity are the key drivers for the £0.634m adverse variance to the Operating Plan trajectory to date. In August there was an improvement in the delivery of cardiac surgery and BMT. The adverse variance for Clinical Genetics increased from £0.081m to £0.180m reflecting reduced outpatient capacity due to vacancies and annual leave. This is expected to improve in quarters three and four

Surgery

The Division was £0.514m adverse to plan in August, primarily within pay and non-pay expenditure. Medical and Dental pay costs were adverse to plan by £0.144m due to additional hours payments to deliver activity and cover sickness and nursing agency costs £0.057m. Control issues within theatres for the receipting and stock control of supplies significantly contributed to the £0.114m adverse variance relating to clinical supplies. The implementation of the Managed Inventory System is underway.

The Division is £1.566m adverse against its Operating Plan. This is driven by its share of cardiac surgery activity shortfall of £0.183m and adverse positions on nursing and medical staff and outsourcing. Alternative models of service delivery are being sought with eye surgery outsourcing contracts having already ceased.

Women's and Children's

The Division continues to underperform against its planned activity and incur high pay costs relating to nursing agency, (particularly within theatres), and medical staff additional hours payments. The Division was adverse to plan by £0.289m in the month, with pay expenditure £0.312m adverse to plan.

The Division is £1.251m adverse against its Operating Plan with medical and dental pay accounting for £0.548m and nursing for £0.551m. Despite the increased pay costs, activity based contracts are £0.342m adverse to plan.

Other Corporate Services

This area contains Trust wide budgets and is £0.065m adverse to plan to date which is primarily due to the apprenticeship levy which is £0.110m adverse to plan. The recruitment of apprentices to roles across the Trust has been slower than planned whilst costs continue to be incurred on the implementation.

Further details on Divisional and Corporate Services financial performance is provided under agenda item 2.3.

3. Subjective Analysis

The adverse variances of £1.398m in August and £5.239m to date are analysed subjectively in the table below:

Favourable/(Adverse)	April £m	May £m	June £m	July £m	August £m	2017/18 to date £m	2016/17 Outturn £m
Nursing & midwifery pay	(0.458)	(0.041)	(0.470)	(0.471)	(0.424)	(1.865)	(4.306)
Medical & dental staff pay	(0.205)	(0.272)	(0.391)	(0.350)	(0.289)	(1.508)	(1.380)
Other pay	(0.011)	(0.007)	0.078	(0.041)	0.006	0.025	2.140
Non-pay	0.400	(0.102)	(0.789)	(0.094)	(0.182)	(0.767)	(6.340)
Income from operations	(0.161)	(0.346)	0.462	(0.147)	(0.017)	(0.208)	0.751
Income from activities	(0.188)	0.618	0.061	(0.279)	(0.424)	(0.214)	(0.983)
Savings programme (CIP)	(0.239)	(0.217)	(0.096)	(0.082)	(0.067)	(0.702)	(4.231)
Total	**(0.862)**	**(0.367)**	**(1.146)**	**(1.466)**	**(1.398)**	**(5.239)**	**(14.349)**

The analysis this month identifies the savings separately.

Further information is provided below however savings are not able to be allocated to the detail within this analysis and are therefore shown as one line.

Nursing & Midwifery Pay

The nursing and midwifery pay variance for August is £1.865m adverse which reflects a continued adverse position in the month. The table below shows analysis between substantive, bank and agency:

Favourable/(Adverse)	April £m	May £m	June £m	July £m	August £m	2017/18 to date £m	2016/17 Outturn £m
Substantive	0.599	0.895	0.825	0.868	0.903	4.090	9.130
Bank	(0.630)	(0.520)	(0.625)	(0.693)	(0.666)	(3.134)	(6.340)
Agency	(0.437)	(0.436)	(0.692)	(0.667)	(0.677)	(2.909)	(7.397)
Total	**(0.468)**	**(0.061)**	**(0.492)**	**(0.492)**	**(0.440)**	**(1.953)**	**(4.606)**
CIP	0.010	0.020	0.022	0.021	0.016	0.088	0.300
Total	**(0.458)**	**(0.041)**	**(0.470)**	**(0.472)**	**(0.424)**	**(1.865)**	**(4.306)**

Vacancy levels are high across all Divisions, particularly in Medicine (10.4%) and Surgery (8.2%) reflecting the favourable variance on substantive staff.

With the exception of the Surgery Division, sickness is higher than target across all Divisions, most markedly in Medicine and Women's and Children's.

The use of bank to cover vacancies, sickness and additional capacity requirements continues with the adverse trend of c£0.7m a month.

Despite increased controls on agency spend there is no corresponding reduction in agency costs with on adverse variance of c£0.7m per month.

The nursing control dashboard is attached at appendix 3.

Medical & Dental Pay

The year to date variance on Medical and Dental staff is £1.518m compared with £1.442m for the whole of 2016/17. The adverse variance of £0.289m in August and the year to date position is summarised in the table below:

Favourable/(Adverse)	April £m	May £m	June £m	July £m	August £m	2017/18 to date £m	2016/17 Outturn £m
Consultant							
Substantive costs	0.131	0.135	0.068	0.122	0.164	0.620	0.277
Additional hours payments	(0.157)	(0.149)	(0.208)	(0.243)	(0.272)	(1.029)	
- Locum	(0.023)	0.013	(0.044)	(0.036)	0.015	(0.075)	(0.143)
- Agency	(0.020)	(0.028)	(0.064)	(0.040)	0.008	(0.144)	(0.741)
Other medical							
- Substantive costs	0.095	(0.027)	0.139	0.260	0.133	0.600	(0.369)
- Additional hours payments	(0.192)	(0.197)	(0.196)	(0.300)	(0.244)	(1.129)	
- Exception reporting payments	0.000	0.000	0.000	0.000	0.000	0.000	
- Locum	(0.045)	(0.058)	(0.057)	(0.114)	(0.091)	(0.365)	(0.469)
- Agency	0.003	0.042	(0.036)	(0.003)	(0.002)	0.004	0.003
Totals	**(0.208)**	**(0.269)**	**(0.398)**	**(0.354)**	**(0.289)**	**(1.518)**	**(1.442)**
CIP	0.003	(0.003)	0.007	0.004	(0.001)	0.009	0.062
Totals	**(0.205)**	**(0.272)**	**(0.391)**	**(0.350)**	**(0.290)**	**(1.509)**	**(1.380)**

(note – analysis of additional hours payments was not available throughout 2016/17)

Additional hours are paid on receipt of authorised claims for work to cover additional activity through waiting lists or exceptional demand, gaps in the rota through sickness, maternity leave or vacancies, and other circumstances requiring additional cover. Revised forms were introduced, which included the reason for claim, when payment rates were standardised at the start of 2017/18. Work to analyse the cost of additional hours payments is continuing.

As discussed in section 2, the Divisions of Women's and Children's and Surgery continue to have the most significant overspend. The Women's and Children's adverse variance of £0.181m was attributable to the cost of covering sickness in NICU and Obstetrics and Gynaecology and cover for the junior doctor rotas in PICU.

Surgery's adverse variance of £0.144m included a significant amount of locum and temporary cover for sickness, vacancies and maternity leave as well as to deliver the planned activity.

It is clear that a more detailed understanding of the operational issues driving the level of locum and additional hours payments is required to control the booking and rates of pay in line with the nursing cost and volume analysis. This must include improved information to

prevent unexpected costs through the late submission of claims and Divisional authorisation after the shift is worked.

Non Pay

The non pay variance deteriorated by £0.183m in August. An analysis is shown below:

Favourable/(Adverse)	April	May	June	July	August	2017/18 to date	2016/17 Outturn
	£m	£m	£m	£m	£m	£m	£m
Blood	0.008	(0.027)	0.085	(0.027)	(0.067)	(0.028)	(0.552)
Clinical supplies & services	0.025	(0.210)	(0.215)	0.005	(0.002)	(0.397)	(1.730)
Drugs	(0.111)	0.092	(0.055)	(0.079)	(0.060)	(0.213)	(0.362)
Establishment	0.054	(0.004)	(0.018)	(0.037)	0.011	0.006	(0.091)
General supplies & services	0.023	0.011	(0.010)	0.004	(0.015)	0.013	(0.124)
Outsourcing	(0.098)	(0.176)	(0.164)	(0.163)	(0.105)	(0.706)	(1.241)
Premises	0.003	0.032	(0.056)	(0.015)	(0.019)	(0.055)	0.111
Services from other bodies	(0.209)	0.141	(0.104)	(0.083)	(0.026)	(0.281)	(2.788)
Research	0.245	0.067	(0.310)	(0.006)	0.007	0.003	0.030
Other non-pay expenditure	0.326	(0.198)	0.032	0.283	0.094	0.537	(2.745)
Totals	**0.266**	**(0.272)**	**(0.815)**	**(0.118)**	**(0.183)**	**(1.122)**	**(9.492)**
CIP	0.135	0.168	0.026	0.024	0.003	0.356	3.152
Totals	**0.401**	**(0.104)**	**(0.789)**	**(0.094)**	**(0.180)**	**(0.766)**	**(6.340)**

The Trust continues to outsource work to private sector providers and has cumulative adverse variances of £0.299m relating to South West Eye Surgeons, £0.266m to Glanso, and £0.073m to dermatology. The remaining balance relates to the virtual ward provided by Orla, which has now closed. Alternative service delivery is being explored with notice given to South West Eye Surgeons.

Services from other bodies is adverse by £0.281m year to date. Notable variances include: £0.029m for microbiology testing provided by Public Health England; £0.070m Biochemical tests from other trusts; £0.024m supplies consortia costs; £0.042m Dermatology services; £0.032m for the transfer of PICU patients, £0.026m for Maternity pathway costs; and £0.028m relating to the Cystic Fibrosis pathway.

4. Clinical Activity and Contract Income

The table below summarises the contract income by work type, which is described in more detail under agenda item 2.2.

	August 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	0.020	7.243	7.492	0.249
Emergency Inpatients	0.253	36.275	37.978	1.703
Day Cases	(0.102)	16.222	16.316	0.094
Elective Inpatients	(0.221)	23.366	22.681	(0.686)
Non-Elective Inpatients	(0.065)	13.417	13.169	(0.248)
Excess Beddays	0.239	2.264	2.583	0.319
Outpatients	(0.364)	32.132	32.011	(0.121)
Bone Marrow Transplants	0.042	3.445	3.475	0.031
Critical Care Beddays	0.056	18.398	18.491	0.092
Other	0.027	38.882	38.089	(0.793)
Total Activity Based	**(0.115)**	**191.645**	**192.285**	**0.640**
Contract Rewards	(0.103)	3.954	3.458	(0.496)
Contract Penalties	(0.202)	(0.396)	(0.965)	(0.569)
Pass through payments	0.057	35.696	35.338	(0.358)
Sustainability and Transformation Funding	0.000	3.772	3.472	(0.300)
2017/18 Total	**(0.363)**	**234.671**	**233.588**	**(1.083)**
Prior year income	0.868	0.000	1.302	1.302
Overall Total	**0.504**	**234.672**	**234.891**	**0.219**

Activity based income was £0.115m adverse to plan in August, reducing the cumulative over performance to date to £0.640m.

Outpatient activity was £0.364m below plan in the month. This reflected reduced staff availability particularly within ophthalmology and oral surgery/dentistry and is expected to improve in quarters three and four.

Elective inpatient activity was £0.221m below plan in the month, of which paediatrics accounted for £0.254m. Availability of surgeons continued to affect general surgery whilst cardiac activity was broadly on plan, casemix reduced the income earned. The Trust's year to date position is £0.686m below plan, with Women's and Children's being £0.737m below plan.

Emergency inpatient activity was £0.188m above plan in the month and is £1.455m above plan to date. Surgery and Women's and Children's activity is higher than plan whilst Specialised Services is below.

Excess beddays were £0.239m above plan in the month, of which £0.119m was within Women's and Children's.

Other activity improved in the month by £0.027m reducing the cumulative underperformance to £0.793m The year to date position includes an underperformance within Radiotherapy (£0.304m), Bowel Cancer Screening (£0.208m) and Cancer MDTs (£0.201m).

The plan assumes 82% achievement of CQUINs, which is £9.43m.The latest assessment is that 72.5% or £8.3m is likely to be achieved. The year to date position is £0.496m below plan, primarily due to the national risk reserves and Hepatitis C CQUINs.

Performance continues to be reviewed through the CQUIN Assurance Group and the Trust is negotiating with commissioners regarding varying CQUINs which are considered to have design faults or inappropriately set targets which disadvantage the Trust.

Given the Trust has accepted the control total, national core penalties and local penalties will not apply. Other national penalties will apply and the Trust has received penalties of £0.965m to date, £0.569m worse than plan. This is primarily due to the emergency marginal tariff adjustment.

Pass through payments were £0.057m ahead of plan in August, reducing the year to date position to £0.358m behind plan.

As previously described, month 12 activity for 2016/17 has been fully recognised in the year to date position.

5. Savings Programme

The savings requirement for 2017/18 is £11.520m. In August, achievement of savings is reported as £4.098m against a plan of £4.777m. Divisional performance is summarised in appendix 4. A summary of progress of the key work streams is summarised in the following table. A more detailed report is given under item 2.4 on this month's agenda.

The performance for the year by category is shown in the following table.

	2017/18 Plan	Year to date			Forecast Outturn
		Plan	Actual	Variance fav / (adv)	Variance fav / (adv)
	£m	£m	£m	£m	£m
Pay	1.823	0.698	0.566	(0.132)	(0.040)
Drugs	0.400	0.167	0.294	0.127	0.292
Clinical Supplies	2.229	0.922	0.931	0.009	0.440
Non Clinical Supplies	3.178	1.335	0.892	(0.443)	(0.480)
Other Non-Pay	0.216	0.087	0.074	(0.013)	(0.029)
Income	2.582	1.113	0.924	(0.189)	0.165
Capital Charges	1.000	0.417	0.417	-	-
Unidentified	0.092	0.038	-	(0.038)	(0.092)
Totals	**11.520**	**4.777**	**4.098**	**(0.679)**	**0.256**

Whilst income is behind plan to date, it is expected that this position will improve and the planned savings will be achieved. Of greatest concern are non-clinical supplies. With regards to unidentified savings, Divisions have £2.577m savings in the pipeline but these are in their very early stages.

The Divisions of Medicine and Surgery are forecasting significant under delivery of savings. Medicine has increased its adverse variance by £0.188m in August whilst Surgery has reduced by £0.115m. The movement from a small forecast overachievement of

£0.012m in July for Trust Services to a forecast underachievement of £0.017m this month is due to two schemes being re-assessed in IM&T.

Savings performance by Division is shown in the table below, with further information provided at agenda item 2.4.

	2017/18 Plan £m	Year to Date			Forecast Outturn Variance fav / (adv) £m
		Plan £m	Actual £m	Variance fav / (adv) £m	
Diagnostics and Therapies	1.386	0.578	0.519	(0.059)	(0.040)
Medicine	2.071	0.785	0.525	(0.260)	(0.351)
Specialised Services	1.192	0.494	0.642	0.149	0.550
Surgery	2.393	1.086	0.612	(0.475)	(0.276)
Women's and Children's	2.036	0.835	0.818	(0.017)	0.238
Facilities and Estates	0.817	0.320	0.285	(0.036)	0.063
Trust Services	0.545	0.229	0.212	(0.017)	(0.017)
Corporate	1.080	0.450	0.487	0.037	0.089
Totals	**11.520**	**4.777**	**4.098**	**(0.679)**	**0.256**

6. Use of Resources Rating

The Use of Resources Rating (URR) for the Trust to date is 1, against the plan of 1. The variance in income and expenditure margin scores a metric rating of 2 compared with a plan of 1 due to the net deficit to date of £0.427m, £0.641m adverse to plan. The following table summarises the position.

		31st August 2017	
	Weighting	Plan	Actual
Liquidity			
Metric Result – days		13.6	16.8
Metric Rating	20%	1	1
Capital Servicing Capacity			
Metric Result – times		2.3	2.2
Metric Rating	20%	2	2
Income & expenditure margin			
Metric Result		1.5%	1.1%
Metric Rating	20%	1	1
Variance in I&E margin			
Metric Result		0.00%	-0.40%
Metric Rating	20%	1	2
Variance from agency ceiling			
Metric Result		42.0%	20.0%
Metric Rating	20%	1	1
Overall URR		**1.2**	**1.4**
Overall URR (rounded)		**1**	**1**
Overall URR (subject to override)		**1**	**1**

7. Capital Programme

The capital programme for the year submitted in the Operational Plan is £47.885m. It includes £16.040m slippage from the previous year and £37.379m of new schemes in 2017/18. Delivery of the programme is challenging and slippage of £5.534m was assumed.

The capital programme has increased by £2.173m, from £47.885m to £50.058m largely due to the receipt of £1.794m Radiotherapy Modernisation Programme funding to purchase a replacement linear accelerator. A further £0.200m increase is in relation to the Tissue Culture Lab scheme funded by a donation from the University of Bristol.

The forecast outturn of £35m is broadly unchanged and will be re-assessed at quarter two. The slippage arises predominantly from the Phase 5 allocation of £15.765m, the strategic scheme contingency of £1.200m, the Medical School allocation of £1.000m and the funding awarded for the linear accelerator of £1.794m.

Expenditure in the month was £1.462m and at the end of August, capital expenditure totalled £8.333m, £2.563m behind plan. Operational capital is £1.105m behind plan and relates to a large number of schemes. Expenditure on medical equipment is £0.913m behind plan, of which £0.353m relates to linear accelerators.

Operational Plan £m	Subjective Heading	Year to date			Year end		
		Internal Plan £m	Actual spend £m	Variance £m	Internal Plan £m	Forecast £m	Variance £m
	Sources of Funding						
3.800	PDC	2.200	2.200	-	5.594	5.594	-
	Donations	0.570	0.400	(0.170)	0.806	0.806	-
	Cash:						
22.764	Depreciation	9.157	9.128	(0.029)	22.447	22.447	-
21.321	Cash balances	(1.031)	(3.395)	(2.364)	21.211	6.406	(14.805)
47.885	**Total Funding**	**10.896**	**8.333**	**(2.563)**	**50.058**	**35.253**	**(14.805)**
	Expenditure						
(16.035)	Strategic Schemes	(0.927)	(0.904)	0.023	(19.933)	(1.900)	18.033
(10.278)	Medical Equipment	(2.129)	(1.216)	0.913	(12.693)	(10.575)	2.118
(11.370)	Operational Capital	(3.086)	(1.981)	1.105	(10.777)	(10.474)	0.303
(7.328)	IT	(4.057)	(3.776)	0.281	(9.257)	(9.365)	(0.108)
(2.874)	Estates Replacement	(0.697)	(0.456)	0.241	(2.932)	(2.939)	(0.007)
(47.885)	**Gross Expenditure**	**(10.896)**	**(8.333)**	**2.563**	**(55.592)**	**(35.253)**	**20.339**
	In-year Slippage				5.534		(5.534)
(47.885)	**Net Expenditure**	**(10.896)**	**(8.333)**	**2.563**	**(50.058)**	**(35.253)**	**14.805**

Further information is provided at agenda item 3.1.

8. Statement of Financial Position and Cashflow

Net current assets at 31 August 2017 were £40.504m, £6.636m higher than the Operational Plan. Current assets are £13.581m higher than plan and current liabilities are £6.944m higher than plan.

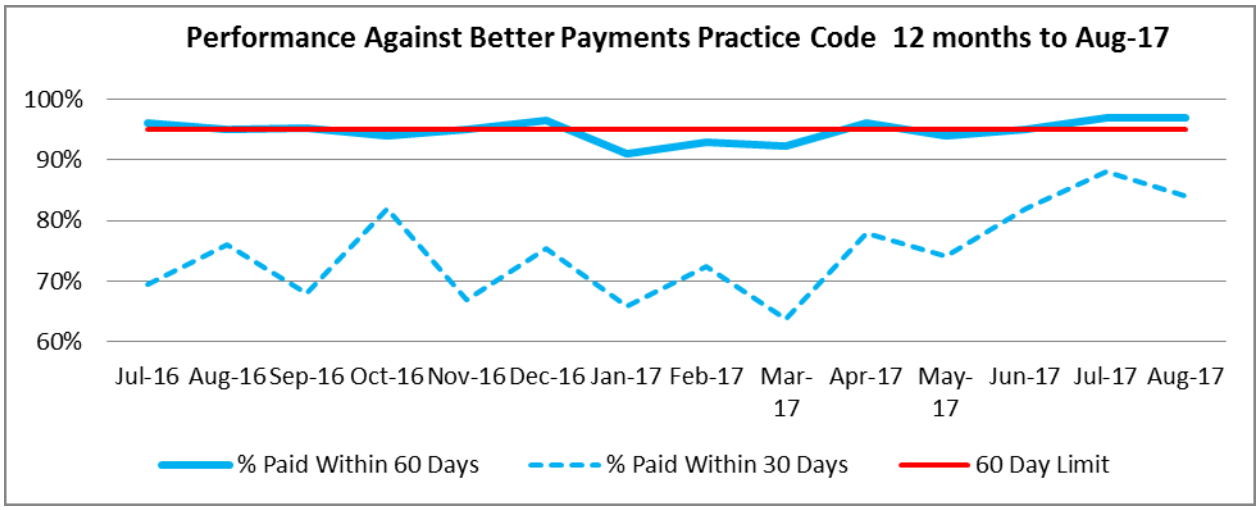
Trade and other receivables are £5.6m higher than plan reflecting the level of outstanding NHS debt. Inventories have not reduced from the opening levels of stock as has been the case in previous years.

The Trust's cash and cash equivalents balance at the end of August was £67.364m, which is £3.929m higher than the Operating Plan primarily due to slippage on capital expenditure. Forecast cash at the year end is £57.3m.

The total value of debtors was £22.896m (£14.307m SLA and £8.589m non-SLA). This represents a decrease in the month of £0.445m (SLA decrease of £0.598m and non-SLA increase of £0.153m). Debts over 60 days old have increased by £2.786m (£2.844m SLA increase and £0.0.58m non-SLA decrease) to £9.713m (£5.966m SLA and £3.747m non-SLA). The SLA increase primarily relates to NHS England with invoices totalling £2.565m for 2016/17 quarter two and four reconciliations and gain sharing charges remaining outstanding.

In August, 97% of invoices were paid within the 60 day target set by the Prompt Payments Code and 81.2% were paid within the 30 day target set by the Better Payment Practice Code.

Performance is shown in the graph below:



Further information is provided at agenda item 4.1.

Attachments *Appendix 1 – Summary Income and Expenditure Statement*
Appendix 2 – Divisional Income and Expenditure Statement
Appendix 3 – Nursing KPIs
Appendix 4 – Key Financial Metrics
Appendix 5 - Risks

UNIVERSITY HOSPITALS BRISTOL NHS FOUNDATION TRUST

Finance Report August 2017- Summary Income & Expenditure Statement

Approved Budget / Plan 2017/18	Heading	Position as at 31st August			Actual to 31st July
		Plan	Actual	Variance Fav / (Adv)	
£'000		£'000	£'000	£'000	£'000
	Income				
555,945	From Activities	231,878	232,113	235	181,733
89,736	Other Operating Income (Excluding Sustainability and Transformation funding)	37,562	37,285	(277)	32,092
645,681	**Sub totals income**	269,440	269,398	(42)	213,825
	Expenditure				
(371,730)	Staffing	(155,870)	(159,413)	(3,543)	(127,282)
(230,287)	Supplies and Services	(95,376)	(96,422)	(1,046)	(77,350)
(602,017)	**Sub totals expenditure**	(251,246)	(255,835)	(4,589)	(204,632)
(9,134)	Reserves	–	–	–	–
–	NHS Improvement Plan Profile	(3,413)	–	3,413	–
34,530	**EBITDA**	14,781	13,563	(1,218)	9,193
5.35	**EBITDA Margin - %**		5.03		5.44
	Financing				
(22,792)	Depreciation & Amortisation - Owned	(9,497)	(9,128)	369	(7,299)
108	Interest Receivable	45	45	–	35
(268)	Interest Payable on Leases	(112)	(112)	–	(89)
(2,687)	Interest Payable on Loans	(1,150)	(1,150)	–	(921)
(9,247)	PDC Dividend	(3,853)	(3,645)	208	(2,916)
(34,886)	**Sub totals financing**	(14,567)	(13,990)	577	(11,190)
(356)	NET SURPLUS / (DEFICIT) before Technical Items excluding Sustainability and Transformation funding	214	(427)	(641)	(1,997)
3,994	Sustainability & Transformation funding - Performance	1,131	832	(299)	566
9,319	Sustainability & Transformation funding - Core	2,641	2,641	–	2,019
12,957	SURPLUS / (DEFICIT) before Technical Items including Sustainability & Transformation funding	3,986	3,046	(940)	588
	Technical Items				
–	Profit/(Loss) on Sale of Asset	–	(2)	(2)	(2)
–	Donations & Grants (PPE/Intangible Assets)	–	400	400	370
(1,314)	Impairments	–	–	–	–
–	Reversal of Impairments	–	–	–	–
(1,561)	Depreciation & Amortisation - Donated	(650)	(647)	3	(516)
10,082	SURPLUS / (DEFICIT) after Technical Items including Sustainability & Transformation funding	3,336	2,797	(539)	440

UNIVERSITY HOSPITALS BRISTOL NHS FOUNDATION TRUST

Finance Report August 2017- Divisional Income & Expenditure Stateament

Approved Budget / Plan 2017/18	Division	Total Budget to Date	Total Net Expenditure / Income to Date	Variance [Favourable / (Adverse)]					Total Variance to date	Total Variance to 31st July	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 (excluding Sustainability & Transformation funding)											
35,473	Contract Income	14,780	14,780	-	-	-	-	-	-	-		
265	Penalties	265	-	-	-	-	(451)	-	(451)	(275)		
-	Contract Rewards	-		-	-	-	(496)	-	(496)	(393)		
-	Overheads	-	574	-	77	-	1,478	-	1,555	741		
553,382	NHSE Income	230,900	231,199	-	-	(292)	292	-	-	-		
589,120	**Sub Total Corporate Income**	**245,945**	**246,553**	**-**	**77**	**(292)**	**823**	**-**	**608**	**73**		
	Clinical Divisions											
(51,328)	Diagnostic & Therapies	(21,308)	(21,244)	369	(324)	(59)	136	(58)	64	58	70	(6)
(79,849)	Medicine	(33,472)	(35,237)	(1,238)	114	(56)	(247)	(338)	(1,765)	(1,269)	(290)	(1,475)
(111,495)	Specialised Services	(46,543)	(47,051)	(305)	(76)	(4)	(269)	146	(508)	(437)	126	(634)
(109,444)	Surgery	(45,866)	(47,511)	(1,308)	(625)	18	656	(386)	(1,645)	(1,131)	(79)	(1,566)
(125,075)	Women's & Children's	(52,310)	(53,570)	(1,120)	427	(22)	(514)	(31)	(1,260)	(971)	(9)	(1,251)
(477,191)	**Sub Total - Clinical Divisions**	**(199,499)**	**(204,613)**	**(3,602)**	**(484)**	**(123)**	**(238)**	**(667)**	**(5,114)**	**(3,750)**	**(182)**	**(4,932)**
	Corporate Services											
(36,883)	Facilities And Estates	(15,548)	(15,580)	57	(44)	3	8	(56)	(32)	(29)	(21)	(11)
(26,733)	Trust Services	(11,518)	(11,546)	186	(158)	(40)	-	(16)	(28)	(17)	(1)	(27)
(4,649)	Other	(1,186)	(1,251)	14	(84)	(49)	17	37	(65)	(46)	-	(65)
(68,265)	**Sub Totals - Corporate Services**	**(28,252)**	**(28,377)**	**257**	**(286)**	**(86)**	**25**	**(35)**	**(125)**	**(92)**	**(22)**	**(103)**
(545,456)	**Sub Total (Clinical Divisions & Corporate Services)**	**(227,751)**	**(232,990)**	**(3,345)**	**(770)**	**(209)**	**(213)**	**(702)**	**(5,239)**	**(3,842)**	**(204)**	**(5,035)**
(9,134)	Reserves	-	-	-	-	-	-	-	-	-		
-	NHS Improvement Plan Profile	(3,413)	-	-	3,413	-	-	-	3,413	2,670		
(9,134)	**Sub Total Reserves**	**(3,413)**	**-**	**-**	**3,413**	**-**	**-**	**-**	**3,413**	**2,670**		
34,530	**Trust Totals Unprofiled**	**14,781**	**13,563**	**(3,345)**	**2,720**	**(501)**	**610**	**(702)**	**(1,218)**	**(1,099)**		
	Financing											
(22,792)	Depreciation & Amortisation - Owned	(9,497)	(9,128)	-	369	-	-	-	369	299		
108	Interest Receivable	45	45	-	0	-	-	-	-	2		
(268)	Interest Payable on Leases	(112)	(112)	-	0	-	-	-	-	-		
(2,687)	Interest Payable on Loans	(1,150)	(1,150)	-	0	-	-	-	-	-		
(9,247)	PDC Dividend	(3,853)	(3,645)	-	208	-	-	-	208	166		
(34,886)	**Sub Total Financing**	**(14,567)**	**(13,990)**	**-**	**577**	**-**	**-**	**-**	**577**	**467**		
(356)	**NET SURPLUS / (DEFICIT) before Technical Items**	**214**	**(427)**	**(3,345)**	**3,297**	**(501)**	**610**	**(702)**	**(641)**	**(632)**		
3,994	Sustainability & Transformation funding - Performance	1,131	832	-	-	(299)		-	(299)	(299)		
9,319	Sustainability & Transformation funding - Core	2,641	2,641	-	-	-	-	-	-	-		
13,313	**Sub Total Sustainability & Transformation funding**	**3,772**	**3,473**	**-**	**-**	**-**		**-**	**(299)**	**(299)**		
12,957	**SURPLUS / (DEFICIT) before Technical Items including Sustainability & Transformation funding**	**3,986**	**3,046**	**(3,345)**	**3,297**	**(800)**	**610**	**(702)**	**(940)**	**(931)**		
	Technical Items											
-	Profit/(Loss) on Sale of Asset	-	(2)	-	(2)	-	-	-	(2)	- 2		
-	Donations & Grants (PPE/Intangible Assets)	-	400	-	-	400	-	-	400	370		
(1,314)	Impairments	-	-	-	-	-	-	-	-	-		
-	Reversal of Impairments	-	-	-	-	-	-	-	-	-		
(1,561)	Depreciation & Amortisation - Donated	(650)	(647)	-	3	-	-	-	3	4		
(2,875)	**Sub Total Technical Items**	**(650)**	**(249)**	**-**	**1**	**400**	**-**	**-**	**401**	**372**		
10,082	**SURPLUS / (DEFICIT) after Technical Items excluding Sustainability & Transformation funding**	**3,336**	**2,797**	**(3,345)**	**3,298**	**(400)**	**610**	**(702)**	**(539)**	**(559)**		175

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*	*3.8%*	*3.8%*	*3.8%*	*4.0%*	*4.0%*	*4.0%*	*4.0%*	*4.0%*	*4.0%*	*3.9%*	*3.9%*	*3.9%*
Medicine	Actual	2.9%	3.3%	3.4%	4.6%	4.5%							
Specialised Services	*Target*	*3.5%*	*3.5%*	*3.5%*	*3.7%*	*3.7%*	*3.7%*	*3.7%*	*3.7%*	*3.7%*	*3.6%*	*3.6%*	*3.6%*
Specialised Services	Actual	3.4%	3.8%	4.4%	4.3%	3.8%							
Surgery, Head & Neck	*Target*	*3.9%*	*3.9%*	*3.9%*	*3.9%*	*3.9%*	*3.9%*	*3.9%*	*3.9%*	*3.9%*	*3.9%*	*3.9%*	*3.9%*
Surgery, Head & Neck	Actual	4.4%	4.0%	3.3%	3.9%	3.1%							
Women's & Children's	*Target*	*3.3%*	*3.3%*	*3.3%*	*3.6%*	*3.6%*	*3.6%*	*4.4%*	*4.4%*	*4.4%*	*4.4%*	*4.4%*	*4.4%*
Women's & Children's	Actual	4.1%	4.4%	4.5%	4.7%	4.6%							

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	6.9%	9.4%	9.9%	10.6%	10.4%							
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	4.0%	4.5%	6.0%	7.3%	7.1%							
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	8.6%	8.4%	8.1%	8.1%	8.2%							
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	2.3%	3.6%	4.4%	4.7%	5.9%							

Source: HR

Graph 3 **Turnover**

Division	Target/Actual	M1	M2	M3	M4	M5	M6	M7	M8	M9	M10	M11	M12
Medicine	*Target*	*15.8%*	*15.8%*	*15.8%*	*15.8%*	*15.8%*	*15.8%*	*15.8%*	*15.8%*	*15.8%*	*15.8%*	*15.8%*	*15.8%*
Medicine	Actual	13.5%	12.8%	13.1%	12.1%	12.4%							
Specialised Services	*Target*	*14.1%*	*14.1%*	*14.1%*	*14.1%*	*14.1%*	*14.1%*	*14.1%*	*14.1%*	*14.1%*	*14.1%*	*14.1%*	*14.1%*
Specialised Services	Actual	13.6%	14.7%	15.0%	15.7%	15.2%							
Surgery, Head & Neck	*Target*	*11.9%*	*11.9%*	*11.9%*	*11.9%*	*11.9%*	*11.9%*	*11.9%*	*11.9%*	*11.9%*	*11.9%*	*11.9%*	*11.9%*
Surgery, Head & Neck	Actual	11.8%	11.8%	12.7%	12.4%	12.3%							
Women's & Children's	*Target*	*10.0%*	*10.0%*	*10.0%*	*10.0%*	*10.0%*	*10.0%*	*10.0%*	*10.0%*	*10.0%*	*10.0%*	*10.0%*	*10.0%*
Women's & Children's	Actual	13.0%	12.6%	12.7%	13.0%	11.8%							

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*	*118.8*	*118.8*	*109.8*	*100.8*	*91.8*	*82.9*	*82.9*	*91.8*	*100.8*	*109.8*	*109.8*	*109.8*
Medicine	Actual	207.9	116.5	215.9	228.7	243.5							
Specialised Services	*Target*	*61.5*	*75.0*	*68.5*	*64.2*	*64.2*	*59.8*	*59.8*	*54.4*	*65.3*	*62.5*	*58.8*	*58.8*
Specialised Services	Actual	20.7	49.6	106.5	84.6	95.1							
Surgery, Head & Neck	*Target*	*64.6*	*69.6*	*79.5*	*85.5*	*80.5*	*89.6*	*89.3*	*55.7*	*64.6*	*69.5*	*69.5*	*64.6*
Surgery, Head & Neck	Actual	158.2	147.6	157.9	166.8	117.7							
Women's & Children's	*Target*	*110.0*	*110.0*	*110.0*	*110.0*	*110.0*	*110.0*	*50.0*	*50.0*	*50.0*	*50.0*	*50.0*	*50.0*
Women's & Children's	Actual	85.3	163.8	216.6	204.4	238.1							
Trust Total	*Target*	354.9	373.4	367.9	360.5	346.5	342.3	281.9	251.9	280.6	291.9	288.1	283.2
Trust Total	Actual	472.1	477.5	696.9	684.5	694.5	-	-	-	-	-	-	-

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*	*14.0*	*14.0*	*13.0*	*12.0*	*11.0*	*10.0*	*10.0*	*11.0*	*12.0*	*13.0*	*13.0*	*13.0*
Medicine	Actual	25.3	26.3	25.4	29.3	30.2							
Specialised Services	*Target*	*9.5*	*12.0*	*10.8*	*10.0*	*10.0*	*9.2*	*9.2*	*8.2*	*10.2*	*9.7*	*9.0*	*9.0*
Specialised Services	Actual	2.4	6.1	11.5	7.9	9.4							
Surgery, Head & Neck	*Target*	*13.0*	*14.0*	*16.0*	*17.2*	*16.2*	*18.2*	*18.2*	*11.2*	*13.0*	*14.0*	*14.0*	*13.0*
Surgery, Head & Neck	Actual	17.8	19.2	15.1	17.9	14.1							
Women's & Children's	*Target*	*11.0*	*11.0*	*11.0*	*11.0*	*11.0*	*11.0*	*5.0*	*5.0*	*5.0*	*5.0*	*5.0*	*5.0*
Women's & Children's	Actual	10.0	10.1	18.3	23.4	26.6							
Trust Total	*Target*	47.5	51.0	50.8	50.2	48.2	48.4	42.4	35.4	40.2	41.7	41.0	40.0
Trust Total	Actual	55.5	61.7	70.2	78.4	80.3	-	-	-	-	-	-	-

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*	*6.6%*	*6.6%*	*6.2%*	*5.7%*	*5.2%*	*4.7%*	*4.7%*	*5.2%*	*5.7%*	*6.2%*	*6.1%*	*6.1%*
Medicine	Actual	11.1%	6.3%	11.2%	12.0%	12.6%							
Specialised Services	*Target*	*4.4%*	*5.4%*	*4.9%*	*4.6%*	*4.6%*	*4.3%*	*4.3%*	*3.9%*	*4.7%*	*4.5%*	*4.2%*	*4.2%*
Specialised Services	Actual	1.5%	3.5%	7.2%	5.9%	6.4%							
Surgery, Head & Neck	*Target*	*3.7%*	*3.9%*	*4.5%*	*4.8%*	*4.5%*	*5.0%*	*5.0%*	*3.2%*	*3.7%*	*3.9%*	*3.9%*	*3.7%*
Surgery, Head & Neck	Actual	8.5%	8.0%	8.3%	8.9%	6.4%							
Women's & Children's	*Target*	*3.4%*	*3.4%*	*3.4%*	*3.4%*	*3.4%*	*3.4%*	*1.5%*	*1.5%*	*1.5%*	*1.5%*	*1.5%*	*1.5%*
Women's & Children's	Actual	2.4%	4.5%	6.0%	5.7%	6.6%							
Trust Total	Actual	5.5%	5.4%	7.8%	7.8%	7.8%							

Source: Finance GL (RNs only)

Graph 7 **Occupied bed days**

Division	Target/Actual	M1	M2	M3	M4	M5	M6	M7	M8	M9	M10	M11	M12
Medicine	Actual	9,071	9,542	9,042	9,364	9,098							
Specialised Services	Actual	4,392	4,719	4,517	4,626	4,622							
Surgery, Head & Neck	Actual	4,481	4,616	4,414	4,472	4,471							
Women's & Children's	Actual	6,179	6,658	5,959	6,821	6,863							
Trust Total	Actual	24,123	25,535	23,932	25,283	25,054							

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	100	80	78	104	87							
Specialised Services	*Target*	*20*	*20*	*20*	*20*	*20*	*20*	*20*	*20*	*20*	*20*	*20*	*20*
Specialised Services	Actual	9	32	29	17	13							
Surgery, Head & Neck	*Target*	*43*	*43*	*43*	*43*	*43*	*43*	*43*	*43*	*43*	*43*	*43*	*43*
Surgery, Head & Neck	Actual	34	30	35	28	23							
Women's & Children's	*Target*	*12*	*12*	*12*	*12*	*12*	*12*	*12*	*12*	*12*	*12*	*12*	*12*
Women's & Children's	Actual	5	9	21	14	5							
Trust Total	*Target*	118.6	118.6	118.6	118.6	118.6	118.6	118.6	118.6	118.6	118.6	118.6	118.6
Trust Total	Actual	146.993	151.738	162.757	163.447	127.823	-	-	-	-	-	-	-

Source: Finance temp staffing graphs (history changes)

Graph 9 **CIP - Nursing & Midwifery Productivity**

Division	Target/Actual	M1	M2	M3	M4	M5	M6	M7	M8	M9	M10	M11	M12
Trust Total	*Target*	31	63	94	126	157	189	220	251	283	314	346	377
Trust Total	Actual	22	33	60	77	99							

Key Financial Metrics -Aug 2017

Appendix 4

		Diagnostic & Therapies	Medicine	Specialised Services	Surgery	Women's & Children's	Facilities & Estates	Trust Services	Corporate	Totals
		£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Contract Income - Penalties										
	Current Month									
	Plan	-	(16)	(2)	(3)	1	-		(49)	(69)
	Actual	-	(20)	(3)	(17)	(7)	-		(225)	(272)
	Variance Fav / (Adv)	-	(4)	(1)	(14)	(8)	-	-	(176)	(203)
	Year to date									
	Budget	-	(82)	(12)	(35)	(15)	-		(251)	(395)
	Actual	-	(116)	(13)	(114)	(20)	-		(703)	(966)
	Variance Fav / (Adv)	-	(34)	(1)	(79)	(5)	-	-	(452)	(571)
Contract Income - Activity based										
	Current Month									
	Plan	3,567	5,071	5,673	7,296	9,345	342		8,010	39,304
	Actual	3,527	4,984	5,677	7,353	9,350	339		7,958	39,188
	Variance Fav / (Adv)	(40)	(87)	4	57	5	(3)	-	(52)	(116)
	Year to date									
	Plan	17,274	24,836	27,275	35,139	46,399	1,670		39,053	191,646
	Actual	17,410	25,197	26,703	35,939	46,057	1,672		39,307	192,285
	Variance Fav / (Adv)	136	361	(572)	800	(342)	2	-	254	639
		Information shows the financial performance against the planned penalties as per agenda item 5.2								
Contract Income - Rewards										
	Current Month									
	Plan	-	-	-	-	-	-	-	801	801
	Actual	-	-	-	-	-	-	-	698	698
	Variance Fav / (Adv)	-	-	-	-	-	-	-	(103)	(103)
	Year to date									
	Plan	-	-	-	-	-	-	-	3,954	3,954
	Actual	-	-	-	-	-	-	-	3,458	3,458
	Variance Fav / (Adv)	-	-	-	-	-	-	-	(496)	(496)
		Information shows the financial performance against the planned rewards as per agenda item 5.2								
Cost Improvement Programme										
	Current Month									
	Plan	123	178	104	217	168	71	46	90	997
	Actual	137	96	150	121	188	61	42	98	893
	Variance Fav / (Adv)	14	(82)	46	(96)	20	(10)	(4)	8	(104)
	Year to date									
	Plan	578	785	494	1,086	835	320	229	450	4,777
	Actual	519	525	642	612	818	285	211	487	4,099
	Variance Fav / (Adv)	(59)	(260)	148	(474)	(17)	(35)	(18)	37	(678)

UNIVERSITY HOSPITALS BRISTOL NHS FOUNDATION TRUST

Finance Report August 2017 - 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
1843	Risk of failing to deliver the Trust's 2017/18 Operational Plan Control Total surplus of £12.957m based on the Divisions rate of overspend to the end of August (month 5).	20 - Very High	£12m	Clinical Divisions are required to deliver the actions detailed in "Review of 2017/18 Financial Position" paper to mitigate expenditure and bring their run rate back to their agreed Operating Plans.	PM	25 - Very High	£15m	4 - Moderate	£0m
959	Risk that Trust does not deliver the Operational Plan due to Divisions not achieving their current year savings target.	16 - Very High	£3m	The Trust has made progress in closing the unidentified savings gap of £0.6m in May to £0.04m in August. 100% delivery of these plans will be key. Delivery to date is 86% of the plan. Divisions, Corporate and transformation team are actively working to ensure delivery of savings schemes.	MS	20 - Very High	£6m	4 - Moderate	£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	20 - Very High	£15m	4 - Moderate	-
951	Risk of the loss of Sustainability & Transformation Funding (STF) due to the failure to achieve the Trust's Operational Plan Control Total from quarter 2 resulting in the loss of all STF in Q3 and Q4 of £8.7m.	20 - Very High	£13.3m	Clinical Divisions are required to deliver the actions detailed in "Review of 2017/18 Financial Position" paper to mitigate expenditure and bring their run rate back to their agreed Operating Plans.	PM	25 - Very High	£8.7m	3 - Low	£0m
50	Risk of Commissioner Income challenges	6 - Moderate	£3m	The Trust has strong controls of the SLA management arrangements.	PM	9 - High	£5m	3 - Low	£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	-

Cover report to the Public Trust Board. Meeting to be held on 28 September 2017 at 11.00 – 13.00, Conference Room, Trust HQ, Marlborough St, Bristol, BS1 3NU

		Agenda Item	**14**
Meeting Title	Public Trust Board	**Meeting Date**	**Thursday, 28 September 2017**
Report Title	Governors Log of Communication		
Author	Kate Hanlon, Membership Engagement Manager		
Executive Lead	John Savage, Chairman		
Freedom of Information Status		Open	

Strategic Priorities (please choose 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 5: We will provide leadership to the networks we are part of, for the benefit of the region and people we serve.	☒
Strategic Priority 2: We will ensure a safe, friendly and modern environment for our patients and our staff.	☐	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 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.	☒
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

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
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)**
n/a	n/a	n/a	n/a	n/a

ID	Governor Name		
190	Carole Dacombe	***Theme:*** 2016/17 Infection Control Annual Report	***Source:*** From Constituency/ Members

Query **16/08/2017**

Page 313 of the July 2017 Board report (page 11 of the Infection Control Annual report) refers to the measures to reduce the risk of spread of infection between staff and patients with an undertaking to "Ensure that healthcare workers are free of and protected from exposure to infections ..... " and "are offered appropriate vaccinations against infectious disease ..... "
The last paragraph of the report states that the BCG vaccination for tuberculosis is currently unavailable for health care workers which appears to contradict the stated policy of protection.

NHS Choices website indicates that BCG vaccinations should be administered to healthcare workers (between the ages of 16 and 35) with an increased risk of exposure to TB but goes on to say that there is a global shortage of the vaccine.

We know that our staff will occasionally come into contact with TB infected patients or TB infected material so what measures are being taken to control the risks to staff and what action is being taken to escalate availability of the BCG vaccine.

Division: Trust-wide ***Executive Lead:*** *Chief Nurse* ***Response requested:*** 16/08/2017

Response **18/09/2017**

There has been a global shortage of BCG vaccine and in the UK the usual supplier has had manufacturing and supply issues. BCG Vaccine availability remains very limited, although an alternative vaccine is now in use. This is not currently licensed in the UK, but has been widely used around the world for many years. Supplies should be starting to be available for the vaccination of healthcare workers and, when accessible, vaccination will be resumed in a programme prioritising higher risk areas initially.

BCG vaccination is of most value in protecting young children against the most severe forms of TB such as meningeal TB. The value in adolescents and adults is less established, to the extent that some countries e.g. Germany, Austria, Netherlands do not recommend BCG for healthcare workers (HCW). This underpins the current UK prioritisation for BCG vaccination, with use for Occupational Health reasons remaining the lowest priority group overall.

Even when BCG vaccine is available this is not the principal factor to control the risk of transmission to HCWs. The mainstay of protection for HCWs, and other inpatients, is the recognition of possible patients with infectious ('open') pulmonary TB and the management of those patients in line with infection control guidelines, with the use of isolation of inpatients in appropriate rooms, and, where required, masks.

Transmission of TB generally requires prolonged close contact with an infective person, and is most likely to occur within the home environment. A study

published in 2016* has shown that TB diagnosed in HCWs in the UK is generally not acquired as a result of UK occupational exposure, concluding:

'The lack of evidence of an increased risk of TB among HCWs in the UK, the evidence of only very rare occurrences of nosocomial transmission in the UK and the majority of HCW TB cases originating from high TB burden countries likely reactivating from latent infection, suggests guidelines on the prevention of TB in HCWs should focus less on preventing infection through BCG vaccination, and more on identifying and treating LTBI, especially in HCWs from high TB burden countries.'

The vaccine shortage does not prevent APOHS screening new staff for latent TB in line with the national guidelines, and this approach continues.

In the event of a failure of the control measures there are processes which are followed to identify possible transmission of infection to patients or HCW, with treatment if needed - TB remains a treatable disease. Again these processes do not rely on the vaccine.

Therefore although the vaccine is not widely available yet, the steps that are actually the most important ones in terms of protecting staff and patients are still in place.

* Davidson JA, et al. Thorax 2016;0:1–6. doi:10.1136/thoraxjnl-2015-208026 TB in healthcare workers in the UK: a cohort analysis 2009–2013 [Thorax online first]

Status: *Awaiting Governor Response*

ID	Governor Name		
189	Neil Morris	***Theme:*** Patient Transport	***Source:*** Governor Direct

Query **08/08/2017**

Please can the Trust provide an update to governors regarding the process by which third party patient transport organisations are appointed and monitored. In addition please can the Trust advise on how these organisations are required to manage complaints, how service users are advised with regards to how they can make a complaint and if the process is to a standard similar to that of the Trust?

Division: Trust-wide ***Executive Lead:*** *Chief Operating Officer* ***Response requested:*** 08/08/2017

Response **29/08/2017**

The Patient Transport Service (PTS) is commissioned by the BNSSG CCGs and the Trust had a new contract which started in April this year. It is an NHS contract but the tender was awarded to EZec, who are an established provider of PTS in other CCG areas. The Trust was involved in the tendering process and contributed to the development of the specification and evaluation process, led by the CCG and delivered through Bristol and Weston Consortium.

As with any provider EZec are required to address patient complaints and report into a monthly contract performance meeting with the CCG lead commissioner. The Trust PTS manager attends this meeting, and additionally forwards any complaints received at UH Bristol which relate to the provision of PTS on to EZec using extract information from Datix.

The Trust also use a small amount of ad hoc private ambulances for exceptional operational pressures, specific journeys etc, and this provider would be expected to respond back to us if any complaints involved their crew.

Status: *Awaiting Governor Response*

Cover report to the Public Trust Board meeting to be held on Friday, 29 September 2017 at 11.00 am - 1.00 pm in the Conference Room, Trust HQ, Marlborough St, Bristol, BS1 3NU

		Agenda Item	15
Meeting Title	Trust Board	**Meeting Date**	29 September 2017
Report Title	Transforming Care Programme Board		
Author	Simon Chamberlain, Transformation Director		
Executive Lead	Robert Woolley, Chief Executive		
Freedom of Information Status		Open	

Strategic Priorities (please chose 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 5: We will provide leadership to the networks we are part of, for the benefit of the region and people we serve.	☐
Strategic Priority 2: We will ensure a safe, friendly and m odern environment for our patients and our staff.	☐	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 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 ar e compliant with the requirements of NHS Improvement.	☐
Strategic Priority 4: We will deliver pioneering and e fficient 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 The purpose of this report is to update Trust Board on progress with Trust wide programmes of work under the Transforming Care programme. Key issues to note The report sets out the highlights of progress over the last quarter and the next steps

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 s upport 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 del ivery 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)**

Transforming Care Update to Trust Board

September 2017

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

1. To support Improving Patient Flow, the Ward Processes & Real Time programme has continued the roll out of Real Time status reporting across our wards. This ensures up to date and accurate information is available to support patient flow. It is supported by the roll out of electronic whiteboards on each ward. Thirteen wards are now live with these and our aim is to complete the roll out of these boards this calendar year. These continue to be well received by staff and help to ensure the information in our computer systems is up to date. As a consequence of this, most Medicine wards are now reporting their status to daily operational meetings using electronic reports, and this will shortly extend to Surgery. All of this work helps us to make better and faster decisions in moving patients through our hospitals.

2. The Ward Processes & Real Time team are preparing an autumn campaign to be launched in October to re-inforce the methods and tools which have been rolled out to wards through the programme over the last 18 months. Experience has shown that the key disciplines support good patient flow, discharge planning and improve timely discharge. The aim of the campaign is to ensure these are uniformly embedded and will feature a communications campaign based round “Think Discharge”. In parallel we are launching a new initiative where TTA drugs for same day discharges will all be made available via the Discharge Lounge. This will save time in processing TTA requests, as well as driving further use of the Discharge Lounge as the default process for all suitable patients.

3. A programme of work is underway to develop the use of Criteria Led Discharge CLD) across wards. Working with an NHS Improvement programme on CLD, and referencing the successful work in Children’s (which was featured in the recent QI Forum) and Medicine, clinical staff from each division are working up plans to launch further use of CLD, which can remove waiting for a final discharge decision. The next pilots will launch shortly in Thoracic Surgery and Oncology.

4. The Integrated Discharge Service (IDS) programme has launched a series of initiatives to improve discharges for patients with complex circumstances. These include the implementation of the revised Managing Expectations Policy for patient discharge, established new team meetings and communication systems for the integrated team, piloting a common electronic Single Referral Form and establishing much greater patient and staff engagement in further development of the service.

5. The team has established a “Big Room” a method for regular engagement of staff from across adult services in improvement work on the IDS. The Big Room approach is centred around a weekly workshop to which all staff in areas with connections to complex discharge are invited, and which has a strong focus on

problem definition and immediate action. Staff have worked on addressing some of the communications issues which delay the management of these patients. This includes development of a “Welcome to our Hospital” questionnaire which staff use with patients and their families to ensure we have all of the information around their personal and home circumstances needed to plan discharge. During the summer staff improved the tool through three PDSA cycles, gathering patient and family feedback along the way. The questionnaire ensures that decisions are based on accurate information, thereby reducing delays when planning discharge. The Big Room team are now working on developing eLearning modules to train new staff in their responsibilities for complex discharge. The Big Room method has benefitted team working across disciplines, and during this period the team demonstrated that the number of long staying patients (> 4 weeks delayed) has steadily declined.

6. The marked improvement in Children’s ED performance this year has been supported by the delivery of the Children’s flow programme, a comprehensive programme of improvement developed with staff input. The team has now launched the “Flow at the BRHC” Connect site. This brings together procedures for patient bookings, flow management, escalation and communications, and makes available to staff in one place common ways of working to cover the majority of flow and appointment management procedures. A separate strand of the programme aims to protect surgical activity in winter and a trial of new procedures is planned for September. This aims to protect the theatre lists with the most urgent and complex cases from being cancelled when capacity is constrained. Ahead of winter the team is now preparing to relaunch the SAFER bundle in the Children’s Hospital, in conjunction with a “Think Discharge” campaign. This will engage staff, patients and families in planning and communicating discharge, and further embedding the use of Estimated Dates of Discharge in the BRHC.

7. Work to further expand the centralised Appointment Centre has been taken forward by the Outpatients Transformation programme. Work to introduce Children’s specialties into the centre is now underway. Alongside this changes to call arrangements in the Appointment Centre have been made to improve call response times.

8. Reducing the number of patients who do not attend (DNA) at clinics has been a continued focus. Each Division has reported back to the programme on performance in specialties where DNAs have been particularly high. Some significant improvements have been reported, and the linkage with the use of text reminders continues to be key to success. New reporting is being produced to identify where text reminders are and are not being employed, and staff responsible for clinic booking can ensure these vital texts are sent.

9. Alongside this, teams have now commenced a programme of audits against the standards for clinic delivery completed earlier this year. Initially focused on Clinic Receptions, the programme will cover key areas of standards over coming months to drive further improvement in quality and flow. Work also continues on the development of an Evolve IT system to support paperless triage of referrals received through the electronic referral system. This is important work to support the achievement of all referrals being received through this system, and also addresses delays in planning appointments. A pilot of the Evolve system is planned for October.

10. Our Admin Teams Transformation programme has focussed on addressing some of the underlying causes of staff turnover in the teams supporting clinical admin. The group has developed a competency framework and common job descriptions for the core clinical admin roles and used these to establish values abased recruitment. This work has also been used to develop a common training programme for admin staff. A stakeholder exercise to gather feedback on the work to date has been undertaken during the summer, which demonstrated very good support for the work to date and pointed to areas still requiring work, which form the basis for proposals for the next phase of work. The recommendations were around 3 areas: Standardising and streamlining admin processes to simplify the work and to allow greater resilience and cross cover between teams; Rolling out the recommended training for admin staff (including more customer service training for all) and rolling out standardised job descriptions to all job holders; and providing improved IT training and support to enable better patient admin processes.

11. Last year we piloted the adoption of new standardised appointment letters. Our pilot work showed these significantly reduced negative comments from patients about our letters. The roll out of these letters is now complete in approximately half of the areas in scope, and is on track to be largely complete by the end of the calendar year. We are planning further audits to ensure we continue to address patient concerns. The progress is in part dependent on revisions to supporting leaflets, but these also have been completed for many areas. The new letters also support a cost saving as they are distributed via a bulk delivery service. And with a related IT development due to be completed later in September, the sending of these letters to patients by email will launch initially in the Dental hospital, the first area to adopt this practice, later this year.

12. Our wider Digital Transformation programme is moving forward rapidly with planning and preparations for future systems innovations over the coming year. This includes the adoption of Care Flow, which provides real time communication and alerting between clinical teams; The VitalPac system for electronic recording of patient Observations; and the electronic prescribing and medicines administration which is now in its final stages of development before its pilot implementation. The IM&T and Transformation teams are working together on these to try to ensure that the implementation is aligned with the Ward Processes & Real Time work and that communications and engagement activities are in pace to make the implementation as successful as possible

13. Following the success of our Quality Improvement (QI) Forum event in July, we have expanded our QI programme of events further.

- During August the QI Hub has been made live on Connect. The Hub aims to provide staff with improvement ideas to access to support and guidance. A staff member can share their idea, seek advice from members of the QI team, get linked to other staff members already working on similar ideas, or seek access to our QI training.
- At the beginning of September the QI Academy launched the Silver level course. Aimed at teams with an agreed project to deliver, this course provides training and support over a 6 month period. The first Silver course kicks off during the first week of October.

- Alongside these we are launching QI courses aimed specifically at foundation doctors. The participants will be supported in setting up specific improvement projects in a focussed session supported by a number of consultants and QI Fellows in October. A course for Core Medial Trainees is also planned for later in the autumn.

14. To support Building Capability among our teams, during August we launched a document which set out the expected Leadership Behaviours at UH Bristol. Based on work carried out with groups of leaders from across our Trust, the launch included a series of presentations led by executive directors to groups of senior leaders laying out the background and purpose of the work, and setting expectations for the further roll out through the organisation. Over the next quarter further events and communications are taking place to share these expected behaviours widely amongst leaders at all levels. Aligned to this, following the roll out of the e-appraisal tool earlier this year a further phase of work has now been launched which will incorporated these expectations into objective setting and review.

15. One of our quality objectives for this year is to develop a consistent customer service mind-set across our organisation. During the summer we have undertaken further work with patient groups to gather more information on what patients would want to see from this work, which has reinforced the views gathered form staff earlier this year and which have formed the aims of the programme. We have also carried out further work with staff groups to draft a set of customer service principles which we will use as the basis for communications and training to be designed in the next quarter. We have also started work on addressing the causes of complaints about telephone contact with the Trust, and have started to integrate the customer service work with the plans already in place to improve patient experience in our Outpatient services. All of this work has been very enthusiastically received by the staff involved to date and we look forward to communicating this more widely later in the year.

16. The latest version of the Transforming Care programme status report as prepared for the Transformation Board is attached at Appendix 1. The report is updated and added to each month as plans are agreed by the relevant project steering group.

Appendix 1 - Transforming Care Programme report - September 2017

Pillar	Details	Purpose	Key deliverables	Planned		Forecast	Current status	Risks	Benefits / Measures
Delivering best care	**Customer Service Mind Set** **Exec lead:** Carolyn Mills **Project lead:** Paul Lewis **Transformation lead:** Simon Chamberlain **Project phase:** Planning	To develop a consistent customer service mind set in all our interactions with patients and their families	• Finalise project objectives and high level mielstones • Staff workshop to develop principles • Work with Outpatinents leads to embed the customer service principles in the Outpatients work • Initiate senior leadership and Board engagement	Jul Sep Sep Oct	G G G G	Jul	• Workshop planned for Sep 19th • Presenting to Outpatients Steering Group in September	• Failure to align effectively with other programmes causing duplication of effort	To be agreed at the end of quarter 2
	Patient Communication • Letters • Email • Telecoms **Exec lead:** Carolyn Mills **Project lead:** Alison Grooms **Transformation:** Caitlin Bateman **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'.	• Phased roll out of letter upgrades underway in SHN, BHI, D&T, Med & BHOC • Elective patient leaflet signed off with patients • Children's outpatient leaflet signed off • Ongoing governance of patient letters to be agreed • Evaluation of letters project	Sep Jun Jul Sep Jan	A G G A G	Dec Aug Aug Dec	• Updated letters being tested by Synertec • leaflet signed off • leaflet signed off	• 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.	• To improve patient experience and reduce patient communication related complaints and DNA's
		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.	• IT changes to Medway made to allow email validation • eLearning training in place for Appointment Centre Staff, Receptionists and Booking Coordinators. • Email collection commenced	May Feb Feb	A A A	Sep Oct Nov	• IT changes are in progress, aim to be complete by 22nd September • First area to go live will be the Dental hospital	• IT capacity to deliver necessary changes to Medway	• To provide our patients with the choice of receiving their appointment letter via email. • To reduce printing and postage costs
		Voice/Telecoms: Project to be re-mobilised	• Kick off meeting held	Sep	G		• Restart work initiated in 2017		
	Innovation & "Bright Ideas" **Exec lead:** Paula Clarke **Project lead:** Anne Frampton **Transformation:** Stephen Brown **Project phase:** Implementation	To promote and encourage innovation and improvement, in order that staff with good ideas can bring them to life, so that patients, staff, the Trust and the wider NHS will benefit	• QI hub go live • Plan developed and agreed on how QI hub will be utilised by the QI Steering Group and embed in business as usual	Aug Dec	G G		• QI hub now live, enabling staff to share quality improvement ideas and projects • This is set for December to allow for adequate time to be used and populated by staff	Development of the intranet pages reliant on one staff member	• Recognition of good practice by staff
	Outpatients Transformation **Exec lead:** Mark Smith **Project lead:** Nina Stock **Transformation:** Marjolein Vries **Project phase:** Implementation	To deliver a high quality service through a friendly, accessible, consistent and timely service.	• Outpatient standards audit visits commenced • Follow up project plan developed & one Specialty per Division identified for 'deep dive' • Trustwide Outpatient Receptionists uniforms in use • 70% of GP to Consultant referral clinics available on eRS • eLearning package for eRS live • Electronic triage pilot • Outpatient standards e-learning drafted and piloted • Follow up 'deep dives' completed and implementation of alternatives agreed • Children's appointment booking transferred to appointment centre • Appointments booking centralised for all divisions	Aug Aug Oct Oct Oct Oct Nov Jan-18 TBC TBC	G G G G G G G G TBC TBC		• August – Reception, September – Coordination, October – Call Handlers • 'Deep dive' to include analysing benchmarking and performance data, engagement with staff in identified Specialties, mapping pathway and exploring alternative follow up options • To achieve the Q2 CQUIN target we need to be at 70% by Oct • IM&T needs to establish link between Medway and eRS learning environments • Currently working with Children's to establish transfer date • Draft timetable to be shared at OSG	• Organisation support for Appointment Centre plans • Capacity to support development of training	• Improved patient experience • Productivity improvement from DNA reduction/activity increase • Achievement of eRS and Advice & Guidance CQUINs quarterly targets
Improving patient flow	**Urgent Care** **• Ward Processes & Real Time** **• Integrated Discharge** **• Capacity in and out of hospital** **Exec lead:** Mark Smith **Transformation Lead:** Jan Belcher & Lucy Morgan **Project phase:** implementing **Project leads:** Dr Rachel Bradley and Sarah Chalkley **EDD and ?Home within 24 hours:** Miss Meg Finch-Jones and Jennifer Pollock **Discharge Lounge:** Trevor Brooks **Operational Reporting:** Dr Rachel Bradley and Jan Sutton **e-Whiteboards and effective board rounds:** TBC **Flow Trackers:** TBC **IDS lead:** Andy Burgess **Capacity in and out of hospital:** Andy Burgess	Achieve agreed trajectories for performance against the 4-hour standard	• Urgent Care Programme monitored by Urgent Care Steering Group		A		• AAU on AMU pilto is succesful to date • Approach to streamin in Adult and Childrens EDs presented • Ward processes pre-winter campaign supported	• Capacity within Divisions to lead and support programmes cross divisionally given operational demands and winter pressures • Short term capacity constraints within the Transformation Team • Divisions do not enact commitment to prioritise governance of ward processes at Divisional level	• Achievement of 4 hour improvement trajectory • Improve patient experience • Improved Bed Occupancy and reduction in outliers • Increase in before 12 noon discharges • Increase nos. to the discharge lounge • Reduced Green to go patient numbers
		Ward Processes and Real Time Roll out an integrated Ward Processes and Real Time programme	• Ward Processes roll out complete and embedded as business as usual	Mar	A	Oct	• W&C 8 Workshops complete, 1 outstanding. • SpS Transformation Team support established •Surgery have appointed project support, current focus remains for the general surgical wards		
			• EDD training delivered at Junior Doctor induction • EDD refresher training delivered • Roles and responsibilities document for EDD is developed and delivered	Aug Jun Jul	G A G	Sep Aug	• Reminder posters to be displayed in staff areas on wards • Document circulated in August		
			• Pharmacy process review - all 'on the day' decision for discharge patient TTAs will be managed via and delivered to the Discharge Lounge • New Discharge Lounge report pilot commenced • Operational Reporting and Bed Management: New reports rolled out to Surgery • Band 6 pilot project to deliver increased and improved timely use of the discharge lounge against planned monthyly trajectory	Ongoing Sep Oct Oct	G G G G		• Proposal for redefined TTA pathway via Discharge Lounge submitted to SDG by Kevin Gibbs in September • Report to focus on earlier use of the Discharge Lounge and provide day by day comparison • Meetings have started to agree roll out		
			• Ward View roll out	Dec	G		• The project is on target to complete phase 2 by 1st Oct 17, which will see 19 screens installed and operational. Phase 3 will install and implement a further 17 screens by Dec 17		
			• Surgical flow tracker implemented across Surgery (including escalation SOP) • BHI flow tracker implemented across BHI (including escalation SOP)	Mar	R TBC		• Review of flow tracker use and futher roll out in both Surgery Division and BHI to be undertaken. Meeting scheduled for Specialised Services in September.		
		Integrated Discharge Service To establish a fully Integrated Discharge Service which reduces occupied bed days whilst improving patient outcomes and experience	• Pilot Single Referral Form • Managing expectations for discharge elearning live • Roll out of multi-disciplinary patient information sharing completed • Roles and responsibilities around complex discharge clarity agreement made	Jun Sep Oct Oct	A G G G	Sep	• Pilot will take place on A528 •Part of the developing and education and resource connect website •Part of the Big Room "Welcome to our Hospital" PDSA about to commence Cycle 3 •Current work in progress within Big Room	• Insufficient capacity in the community • Insufficient resilience in community	
		Capacity in and out of hospital Work collaboratively with UHB stakeholders and system partners to identify the preferred model for out of hospital acute care provision.	• Short-life Task and Finish Group to develop model for acute care at home/IVT services set up • Develop business case for preferred model and present to SLT/Trust Board • Ensure full evaluation of Pulse initiative • Implement acute care at home service	May Jul Jul Oct	G A G		• Business case proposing an enhanced IV therapy service presented to August SLT Business Meeting. Intention would be for the service to be operational during October 2017. • Evaluation of Pulse presented to SLT in July. Service to cease in Spetmebrr 2017	• Funding availability • Time to mobilise • System partner engagement	
	Children's Programme **Exec Lead:** Mark Smith **Project Lead:** Lisa Davies **Transformation:** Melanie Jeffries **Project phase:** Implementation	To improve patient flow at Bristol Children's Hospital so that children and young people receive quality healthcare at the right time, in the right place with no delays.	• Scheduling tool for CIU bed and clinic booking in use at weekly scheduling meeting • 7 day working survey analysis completed and used for business planning • Trial of Surgery in Winter process •Divisional EDD action plan implemented - 'Think Discharge' campaign launched • Revised BRHC SAFER bundle launched alongside BRHC Professional Standards	Aug Jul Aug Sep Sep	A A A A A	 Sep Sep Oct Oct	• Phased roll out planned. Start with bed scheduling, then clinic scheduling. •Survey responses received. Plan to develop options for discussion with key stakeholders, which will feed into business planning • Two theatre lists per day identified 6 weeks in advance as "for cancellation" if no beds or staff available. This will enable lists with non urgent patients to be booked and help flow on the day. • Final sign off underway and campaign being developed • Final sign off underway and campaign being developed	• Capacity of Programme Lead and Transformation Lead slows down delivery of programme	• Improvement in 4 hour target • Reduction in last minute cancellations
Harnessing Our Technology	**Digital Transformation Programme** **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.	• CUR draft roll out plan has been written and a Business case is being sent to the Trust Board • A project plan has been agreed for the paediatric chemotherapy project that will enable the project to meet the September deadline. • Careflow live in pilot locations • Nursing Electronic Observations go live in initial areas • EPMA first area live go live • EDM go-live in remaining sites	Aug Sep Sep Oct Oct Mar-18	G G A G G G	Oct	• There is little leeway in the plan to accommodate any delays. • Merging with Nursing E-obs, projects are being run together • The Trust has procured Vitalpac. First areas for go live are wards A515 and A900 (on basic adult EWS).	• Change management capacity to support changes in clinical areas	• Real time sharing of data between clinical teams • Continued movement towards paper-light operation
Building capability	**Improving Staff Experience - "Happy App" roll out** **Exec Lead:** Alex Nestor **Project Lead:** Anne Frampton, Andrew Hollowood **Transformation:** Caitlin Bateman **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.	• UHB governance ongoing to be agreed • Future roll out plans to be agreed	Apr Jul	A A	Oct Oct	• Recommend governance structure and how Happy App is run within UHB produced. Awaiting decision on governance structure and business as usual model	• Availability of IT support/resource • Willingness of staff to engage • Administrator resource to respond to comments	• 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
	QI Academy **Exec Lead:** Paula Clarke **Project Lead:** Anne Frampton **Transformation:** Stephen Brown **Project phase:** Implementation	To provide an overview of common QI methods, provide staff with the knowledge and skills to conduct their own Quality Improvement projects and signpost staff existing training and teams within the Trust who can help improve care.	• 4th Bronze programme held • Evening training and support session for junior doctors designed • Evening training and support session for junior doctors launched • Silver programme live	Sep Sep Oct Q3	G G G G		• Fully booked	• Teaching resource to deliver the programmes	• Staff feedback on usefulness of Academy programmes • Increased knowledge around QI projects taking place across the Trust
	Leadership Development **Exec Lead:** Alex Nestor **Project Lead:** Sam Chapman **Project phase:** Implementation	To improve staff experience and consistency of leadership behaviours across the Trust this programme is designed to introduce UHBristol Leadership Behaviours in 2017.	• Launch week of Leaderships behaviours • Subsequent briefings and communication sessions • Leadership behaviours roll out programme close	Aug Sep-Nov Dec	G G G		• 134 leaders attended the sessions during launch • 53 leadership behaviour sessions between Sep - Nov 2017, then ongoing 2 sessions a month • Outcome of leadership behaviours roll out to feed into 360 feedback appraisal programme	• Risk that cultural change isn't realised as result of the leadership behaviours. Next steps are in place to mitigate this risk through embedding it through recruitment, induction, leadership and management development sessions and 360 through appraisal.	• Improved Staff Experience • Reduction in staff turn over • Able to monitor leadership behaviours at appraisal • Support a culture of Collective Leadership
	Admin Teams Transformation **Exec Lead:** Alex Nestor **Workstream leads:** Peter Russell, Kate Parraman, Jenny Holly and Simon Walrond **Transformation:** Caitlin Bateman **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.	• Training plans and competency frameworks per role designed and piloted • Scoping the impact of job description roll out to current staff completed by Performance and Operations Managers • SOPs for each role created • Planning of 'phase 2' of the programme, including reviewing scope and structure completed • Face to face feedback sessions on admin recruitment process held	Sep Mar Mar Jul Sep	G A A A G	Sep Sep Sep	• Design complete. Pilot with Medicine Reception in August and SHN admission and clinic coordinator staff in September • Scoping of D&T is complete, Surgery is underway. • Existing SOPs have been edited for additional roles but capacity issues in the divisions is delaying the drafting of new SOPs relevant to each role • The aim of these sessions is to seek further constructive feedback on the admin recruitment process and implement positive changes based on managers' feedback	• Divisional ability to resource project • Possibility for consultation required for changes to job descriptions	• 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
	Appraisal Improvement **Exec Lead:** Alex Nestor **Project Lead:** Sam Chapman **Project phase:** Planning phase 2	• 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	• Scoping meeting phase 2 held • Project milestones agreed	Aug Sep	A G	Sep	• To include leadership behaviours, 360, talent management. Scoping meeting scheduled for 5th September.	• Unknown cost associated with additional licences for 360 as part of the existing Kalidus portal contract.	• Improved Staff Experience • Reduction in staff turn over • Able to monitor the quality of appraisals • Support a culture of Collective Leadership

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

Updated: 29.08.2017