University Hospitals Bristol
NHS Foundation Trust

Public Trust Board Meeting Papers

Date: 31 January 2018

Time: 11:00 – 13:00

Venue: Conference Room, Trust Headquarters

NHS
University Hospitals Bristol
NHS Foundation Trust

PUBLIC TRUST BOARD

Meeting to be held on Wednesday 31 January 2018, 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	*Chair*	**Verbal**
2.	Declarations of interest	Information	*Chair*	**Verbal**
3.	Patient Story	Information	*Chief Executive*	**3**
4.	Minutes of the last meeting • **29 November 2017**	Approval	*Chair*	**7**
5.	Matters arising and action log	Approval	*Chair*	**23**
6.	Chief Executive's Report	Information	*Chief Executive*	**25**
7.	Board Assurance Framework – Q3	Assurance	*Chief Executive*	**29**
Care and Quality				
8.	Quality and Performance Report	Assurance	*Deputy Chief Executive and Chief Operating Officer*	**50**
9.	Quarterly Patient Complaints and Experience Reports a) Quarterly Patient Complaints Report – Q2 b) Quarterly Patient Experience Report – Q2	Assurance	*Chief Nurse*	**108** **150**
10.	Learning from Deaths Report	Assurance	*Acting Medical Director*	**176**
11.	Quality and Outcomes Committee - Chair's Reports - December 2017 - January 2018	Assurance	*Quality & Outcomes Committee Chair*	**196** **To be tabled**
Organisational and System Strategy and Transformation				

NO.	AGENDA ITEM	PURPOSE	SPONSOR	PAGE NO.
12.	Weston Partnership - Strategic Outline Case	Assurance	*Chief Executive*	**To be tabled**
13.	Transforming Care Programme Board Report – Q3	Assurance	*Director of Strategy and Transformation*	**200**
14.	Renewing the Trust 5 Year Strategy	Assurance	*Director of Strategy and Transformation*	**207**
15.	North Bristol / UHBristol Partnership Management Board Update	Information	*Chief Executive*	**219**
Research and Innovation				
16.	Research and Innovation Report	Assurance	*Acting Medical Director*	**225**
Financial Performance				
17.	Finance Report - NHS Improvement Return	Assurance	*Director of Finance & Information*	**233**
18.	Ratification of Standing Financial Instructions (SFIs)	Assurance	*Director of Finance & Information*	**253**
19.	Finance Committee Chair's Report - December 2017 - January 2018	Assurance	*Finance Committee Chair*	**338** **To be tabled**
Governance				
20.	Register of Seals	Assurance	*Chief Executive*	**To follow**
21.	Audit Committee Chair's Report	Assurance	*Chair of the Audit Committee*	**To be tabled**
Items for Information				
22.	Governors' Log of Communications	Information	*Chair*	**341**
Concluding Business				
23.	Any other urgent business	Information	*Chair*	**Verbal**
24.	Date and time of next meeting • **28 February 2018, 11.00, Conference Room, Trust HQ**		*Chair*	**Verbal**

University Hospitals Bristol
NHS Foundation Trust

Cover report to the Public Trust Board meeting to be held on Wednesday, 31 January 2018 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**	Wednesday, 31 January 2018
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

Homelessness is a growing problem in the UK, and Bristol is also seeing an increasing number of homeless and vulnerably housed people. We await the official figures to be published in February 2017, but it is estimated by the St Mungo's homeless outreach team that there are over 100 rough sleepers every night in Bristol. Bristol also has significant numbers of people experiencing daily life in homeless hostels, night shelters, squats, vans and sofa surfing.

Homelessness has serious implications for the health and wellbeing of individuals. This is reflected in the average age of mortality being 45 years. 78% of homeless people report experiencing physical health problems, often multi- facetted and 86% report having mental health problems. Due to these horrifying figures, homeless people tend to visit the Emergency Department more frequently and require admission to hospital for acute medical treatment.

The BRI Homeless Support Team has come about in reaction to these health and homelessness related issues. It is a multi-disciplinary/ multi agency team based on the Pathways model which originated in London and works to provide enhanced care coordination for homeless people while in hospital. Our team works to support homeless people during their hospital admission, aid access to accommodation on discharge and in supporting access to ongoing healthcare in the community. The work of the team helps to improve the overall health of homeless people and in turn can help to reduce the numbers of Emergency Department and hospital admissions. It is currently an 18 month pilot due to end in July 2018 and is funded by the Clinical Commissioning Group (CCG).

Collecting feedback from clients and staff is playing an integral part in informing how the team works on a day to day basis and will also be an important part of the final evaluation on the pilot later this year. Lucy Harrison, Clinical Co-ordinator for the Homeless Support Team, will present a short film made in November 2017 which includes feedback from both clients and staff and explores the impact the service is having for them.

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 sustain an engaged and effective workforce.	☐
Failure to enable and support transformation and innovation, to embed	☐	Failure to take an active role in working with our partners to lead and shape our	☐

research and teaching into the care we provide, and develop new treatments for the benefit of patients and the NHS.		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)**

Minutes of the Public Trust Board Meeting

Held on Wednesday 29 November 2017, 11:00-13:00, Conference Room, Trust Headquarters

Present

Board Members

Member Name	Job Title/Position
John Savage	Chairman
Julian Dennis	Non-Executive Director
Lisa Gardner	Non-Executive Director
John Moore	Non-Executive Director
Guy Orpen	Non-Executive Director
Martin Sykes	Non-Executive Director
Jill Youds	Non-Executive Director
Madhu Bhabuta	Non-Executive (Designate)
Jeff Farrar	Chair (Designate)
Robert Woolley	Chief Executive
Mark Callaway	Acting Medical Director
Paula Clarke	Director of Strategy and Transformation
Matt Joint	Director of People
Paul Mapson	Director of Finance and Information
Carolyn Mills	Chief Nurse
Mark Smith	Chief Operating Officer and Deputy Chief Executive

In Attendance

Name	Job Title/Position
Pam Wenger	Trust Secretary
Sophie Melton Bradley	Deputy Trust Secretary
Sara Kirby	Corporate Governance Administrator
Shaun Carr	Interim Deputy Chief Operating Officer
Jamie Cargill	Staff member
Flo Jordan	Staff Governor
Clive Hamilton	Member of the Trust
Jeanette Jones	JUC Officer
Garry Williams	Public Governor
Eric Sanders	Member of the public
Ray Phipps	Patient Governor
Derek Wholey	Patient Governor
Bob Skinner	Member of the public
Anne Skinner	Member of the public
Malcolm Watson	Lead Governor
Kathy Walsh	Patient Governor
Carole Dacombe	Public Governor

Minutes:

Sophie Melton Bradley	Deputy Trust Secretary

The Chair opened the Meeting at 11.00

Minute Ref	Item Number	Action
Preliminary Business		
180/11/17	**1. Welcome and Introductions/Apologies for Absence**	
	The Chairman welcomed everyone to the meeting. Apologies for absence were noted from Non-Executive Directors David Armstrong and Emma Woollett, and Non-Executive Director (Designate) Steve West.	
181/11/17	**2. Declarations of Interest**	
	There were no declarations of interest.	
182/11/17	**3. Minutes of the last meeting**	
	The minutes of the meeting held on the 31 October 2017 were agreed as a true and accurate record. **Members RESOLVED to:** • **Approve** the minutes as a true and accurate record from the meeting held on 31 October 2017.	
183/11/17	**4. Patient Story**	
	The meeting began with a patient story, introduced by the Chief Nurse, Carolyn Mills. • In this story the Chair John Savage gave his perspective on working for and being treated by UH Bristol, and how it had influenced him in his role as Chair. John noted that his views had been influenced by his faith throughout his life, including during his time with UH Bristol. • John had received treatment at the Trust for a heart attack, and had had stents fitted. He had seen first-hand the enthusiasm of staff, and how modern health interventions made such a huge impact on so many patients. • He had always valued direct interface with patients, and the opportunities the Board had been given to hear their stories personally – the Chief Nurse Carolyn Mills had played a key role in facilitating	

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	this. He recognised that there was a risk of those in the health sector treating patients as somehow 'different from us', especially those patients who were challenging, however it was important to remember that they were the same. UH Bristol staff had a great opportunity and indeed privilege in treating patients to make a unique connection with them, and the Board needed to continue to ensure that all staff were making the most of that connection, and exhibiting the right behaviours to support Trust values and understanding patients better. The world was increasingly 'high threat' and there were many factors the Trust could not directly control, but getting behaviours right was very important to achieving its aims. • Leadership was also incredibly important, including the ability to recognise and forgive flaws, and support those you led. It was unreasonable to expect perfection, and it should be recognised that everyone made mistakes. Leaders needed to guide staff in generating a sense of a two-way passage between staff and those they care for, as well as ensuring the same between leaders and staff. Responsiveness and reciprocity was vital. • It was also important that UH Bristol did not take for granted that the wider public automatically understood its values and what it was trying to do. The Trust had a duty of humanity to the public it served, and needed to ensure it was getting its point across. This was not just about the Trust, but its role in a wider community. Members of the Trust Board discussed the following:- • Members supported the Chair's comments, in particular agreeing it was important that the Board did not forget its 'higher purpose' of serving the community, or risk focusing too much on reporting and detail at the expense of the 'big picture'. **Members RESOLVED to:** • **Receive** the patient story for information.	
184/11/17	**5. Matters arising and Action Log**	
	Members received and reviewed the action log. The progress against completed actions was noted, and there was one outstanding action from the Public Trust Board meeting of 28 September 2017: Minute ref. 153/09/17 – *"Chief Nurse to investigate whether the report could be amended to include an executive summary in future."* It was confirmed that an executive summary would be included in the next quarterly report to the Board.	

Minute Ref	Item Number	Action
	Members RESOLVED to: • **Note** the updates against the action log.	
185/11/17	**6. Chief Executive's Report**	
	Robert Woolley, Chief Executive, discussed highlights from the Chief Executive's report and updated the Board on several further matters which were not covered in the report, including the following: • The Chancellor's Autumn Budget had been announced on 22 November 2017. It did recognise the challenges facing the NHS, including with £3.5billion of capital investment in the NHS, as well as £28million revenue funding which would be targeted at patient waiting times and winter pressures. These investments were welcome, but far lower than what was needed, as had been noted by NHS advocates in the media. • UH Bristol had received a visit from the Secretary of State for Health the previous week as part of a national launch of the patient safety campaign, which was seeking to reduce avoidable deaths in hospitals. The Secretary of State's ambition was to make the NHS the safest and most efficient health sector in the world, but also the most transparent in terms of avoiding and reducing patient deaths. He thanked UH Bristol staff for their hard work, especially in support of the CQC 'outstanding' rating, and recorded a short film with Emma Redfern on the national rollout of the patient safety checklist. • Winter preparations were in place, and the Trust was starting to see pressures building, especially in Children's Services. UH Bristol anticipated bidding against the revenue funding announced in the Budget, but was still awaiting details of this. • There had been great progress on staff flu vaccinations, with some divisions achieving more than 70% vaccinations rates. • UH Bristol participated in Fab Change Week, and were visited by Roy Lilley and Terry Porritt, who were very complimentary about what they saw on the ground. The Trust's stoma nurses had now become Fab Change Champions. • The Staff Recognition Awards took place on 24 November 2017, including the new Patient Star awards, to recognise outstanding staff across the Trust.	

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	• UH Bristol had received national press coverage: the BBC's The One Show did two pieces on a young couple whose baby had a prenatal heart condition, which followed the birth and care, including an operation. The parents had also publicly expressed their gratitude to the Trust. Additionally, Horizon had filmed UH Bristol's service for young people with cancer for spring broadcast. • The Chief Executive noted that it was the Chair's and Non-executive Director Lisa Gardner's final meeting of the Board. The Board joined the Chief Executive in expressing their appreciation for their hard work on behalf of the Trust and the Board. Members of the Trust Board discussed the following:- • Public Governor Garry Williams wished to endorse the Board's appreciation for John Savage and Lisa Gardner's service to the Trust. • Public Governor Garry Williams sought assurance that the Trust was using every avenue available to ensure it was in a good position to bid for the government funding announced in the Budget, and that UH Bristol would not risk being overlooked because of its 'outstanding' CQC rating. The Chief Executive confirmed that the Executive Team were working with the regulators and also local partners to ensure the Trust's needs were clear in this regard. It was anticipated that any funding would be allocated by NHS England, however details were still awaited. There was likely to be an extremely tight turnaround for any bid. **Members RESOLVED to:** • **Receive** the Chief Executive's Report for information.	
Care and Quality		
186/11/17	**7. Quality and Performance Report**	
	Chief Operating Officer and Deputy Chief Executive Mark Smith presented the Quality and Performance Report. It was noted that: • UH Bristol was performing consistently going into winter. There were increasing pressures, especially in Children's Services, which was however holding steady on performance, indicating that winter planning was working. • It was noted that UH Bristol was achieving 90.2% of the 4 hour A&E target, 20% higher than at the same time last year.	

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	• The Trust had achieved its Sustainability and Transformation funding (STF) funding for quarter 2 of £1million. It was still on track to achieve quarter 3 funding also, which would be around the same amount. • UH Bristol had undertaken a desktop exercise to stress test surgeon escalation, which had picked up a few problems to be addressed. It had also been making use of Clinical Utilisation Review (CUR) to identify why patients are on-ward, to help reduce length of stay and liberate capacity. • Preparations for a pandemic flu were progressing well, and the Trust was confident it was in a good position on this. • UH Bristol had received a contract penalty notice on the 52 week Recording and reporting referral to treatment (RTT) deadline, due to delays in treatment. It was ahead of schedule to clear the backlog for December 2017 – January 2018, and was discussing the implementation of RTT4. A shadow run of processes during the first 2 weeks of November 2017 had not raised any major issues. The Trust was now reporting on the new reporting platform, and the Quality and Outcomes Committee would receive updates on progress. The RTT review would be extended to all patients (around 250,000), and processes were being put in place to help improve outpatient cancellations, to help hit Commissioning for Quality and Innovation (CQUIN) targets. • The new cancer performance trajectory had been agreed with the regulator. The new Interim Deputy Chief Operating Officer Shaun Carr was addressing issues in relation to this – in particular, inter-Trust delays, which related to a third of current issues. There were also capacity issues in some specialties, including thoracics outpatient capacity, which was being addressed through job planning and other productivity measures. • With regard to the 6-week diagnostic target, the team were now back up to strength on respiratory support. The Clinical Commissioning Group (CCG) would be visiting to look at pre-treatment measures, and with quality improvement methodology the Trust had manged to improve Cardiac CTs. • The Chief Nurse noted that there was 60-70% compliance with inpatient sepsis screenings. Failures in compliance related to human factors, and there was a lot of work to do to ensure staff were undertaking sepsis screening whenever the score was triggered (and	

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	not e.g. disregarding the trigger when there were other conditions recorded). There would be a system change to include an automatic trigger, which should support this. • The Acting Medical Director noted that there was good progress in relation to fractured neck of femur (NOF) performance, which had been reviewed by the Quality and Outcomes Committee. • The Director of People noted that there had been a seasonal spike in sickness absence, including staff suffering from stress and anxiety which were not necessarily work related The increase in measures to help support staff psychologically would seek to mitigate this. Members of the Trust Board discussed the following:- • Non-Executive Director Lisa Gardner commented that several of the non-executive directors had participated in a visit to Specialised Services, the Emergency Department (ED), and the Emergency Multidisciplinary Unit recently, and had met the Clinical Chair of Surgery Dr Sanjoy Shah. The non-executive directors had been reassured by the visit that actions to mitigate current issues, such as the appointment of new staff, were proving effective, and should 'come through' in improved performance in the report in future. • Members questioned whether there were any plans to increase staff numbers to respond to the impact of patients coming to UH Bristol overnight from Weston. It was confirmed that there were plans to expand the consultant presence in ED, as well as the continuing moves to provide a seven day a week service in the departments (recruitment for new posts would take place in February 2018). The Acting Medical Director noted that it was important to have senior clinical decision-makers present to make the right decisions regarding patient care, both to help reduce unnecessary inflow/check in, and to support junior doctors' learning. • Members noted that the improvement in A&E performance over the last year, especially given winter pressures, demonstrated that the new approach was clearly working. The Board asked that their appreciation and thanks were passed on to the A&E team for all their hard work on this. • The Board noted that there were still areas of concern regarding some staff failing to complete essential training: the message needed to be communicated explicitly to staff that this training was not optional. The Director of People noted that a new policy was being	

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	implemented from 1 January 2018 whereby for staff who did not complete essential training, managers reserved the right to deny leave requests until training was completed. • The use of e-prescribing was raised: it was noted that the current focus was on processes for documenting and logging paperwork, especially for discharge admissions. However there was evidently waste around failures to adequately record data here. This was something which should come back to the Quality and Outcomes Committee for consideration in future. • It was noted that the Deputy Chief Executive and Chief Operating Officer's team was working on direct interface on communications with primary healthcare colleagues. There needed to be strategic consideration on how best use was made of capacity on this: this could perhaps be helpfully considered at a future Board Seminar. Public Governor Carole Dacombe noted that governors would be pleased to hear there that direct interface with primary healthcare colleagues on communications issues was occurring, as there were a longstanding historical issues around this which patients had communicated to governors. **Action: Trust Secretary to include discussion of communications interface with primary healthcare colleagues as an item on the Board Seminar business cycle.** **Members RESOLVED to:** • **Receive** the Quality and Performance Report for assurance.	
187/11/17	**8. Quality and Outcomes Committee - Chair's Report**	
	Members received a written report of the meeting of the Quality and Outcomes Committee of 27 November 2017. Members also received a verbal account of the meeting from Non-Executive Director and Chair of the Quality and Outcomes Committee (QoC) Julian Dennis: • Under the Workforce and Organisational Development Report, the Committee had considered the current vacancy issues flagged by the Director of People, and had also discussed the importance of leadership issues (which was timely given the Chair's comments today on the Patient Story regarding the importance of leadership). The Committee had noted issues around the completion of essential	

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	training by staff, and the measures being taken to address this, as well as to address rates of completion of appraisals. • 2 'never' events had been reported to the Committee as Serious Incidents, and it had been noted that a total of 6 'never' events that had occurred this year had been highlighted in a Clinical Commissioning Group (CCG) performance notice. • The Committee had received an excellent presentation on the Bristol Orthopaedic Association Recommendations from the Divisional Director and Clinical Chair of the Surgery Division. The Committee had felt encouraged by the actions taken and proposed, and were keen to see the next steps on this progressed. • The Divisional Director and Head of Nursing of the Women's and Children's Division had updated the committee on improvements in Children's Theatres. There had been the usual challenges in recruiting/retaining clinical staff, and the Division had also been impacted by the long-term absence of its clinical director. There was however a clear action plan on addressing recruitment and other issues going forward. • The Committee had received the Quality and Performance Report (as seen today by the Board) and had been pleased to note an increase in 'green' and 'amber' indicators, which was a sign of progress. • The Director of Pharmacy had attended the meeting to talk through the Trust's response to the Carter Pharmacy Transformation Report, and the implementation of its recommendations. It was noted that recruitment of pharmacists continued to be a challenge. **Members RESOLVED to:** • **Receive** the Quality and Outcomes Committee Chair's Report for assurance.	
Financial Performance		
188/11/17	**9. Finance Report**	
	The Director of Finance and Information Paul Mapson presented the Finance Report to the Board. It was noted that: • Whilst the Trust's month six position had shown an improvement (to a £0.5million run-off rate per division) the month seven position had deteriorated, which was disappointing. The Finance Team were working with divisions to try and identify whether the month seven	

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	deterioration was a 'blip' or a trend, but this was not yet clear. Although the Trust was still showing as on-plan, and was still reporting to the regulators that it would hit plan, significant improvement would be needed for the rest of year to do so, so this continued to be a high risk approach. • The Trust was working to reduce £5million current costs on nursing and medical pay, but it would take a while for any impact to come through. • In financial terms, UH Bristol was doing comparatively well nationally, as many trusts were simply in deficit, but the £1million run rate was nevertheless a major concern, especially as there were likely to be increased efficiency expectations from Government next year. There was effectively a non-pay overspend, and there were no financial 'margins' for the Trust at this stage. The Trust did not want to end up in deficit, as this would require significant management action, and Commissioners would become heavily involved. • The Trust would continue to bear down on overspends, but would require a major programme of productivity to improve its position, including minimising the underuse of resources. Meeting efficiencies was increasingly difficult each year as requirements were getting tougher. Members of the Trust Board discussed the following:- • It was queried whether nursing cost challenges were related to the impact of Brexit. It was noted that the Quality and Outcomes Committee had looked at this in September 2017, but there was no evidence that the two were associated – it was possible the impact was being more directly felt in the community sector than in health. • Members of the Board felt that the narrative of the Finance Report needed to be very clear on the serious position the Trust was in (the Report noted that the Trust was in surplus, despite not meeting plan, which was a consequence of the control total regime). The Board needed to ensure it understood the very serious risks the Trust was facing financially: particularly that there was a high risk of not hitting plan, and that this was an issue both in the current financial year and very probably in the next, as there would be no offsets available for 2018/19. The Executive Team was clear that issues needed to be addressed now, and would continue to update the Board on the financial position and actions taken to address it.	

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	• It was noted that Non-executive Director (Designate) Steve West, as Vice Chancellor of a university with a major nurse recruitment programme, had previously flagged to the Board that there was a risk that nurse recruitment would be imperilled by the move from a grants-based to a loans based system. The full impact was anticipated to be felt in 2 year when the first graduates of the loans-based system would emerge, which might impact the Trust's (and others') ability to recruit nurses. • Members of the Board asked whether there had been any progress on implementing apprenticeships. The Director of People noted that the Trust was somewhat 'behind the curve' on this but was working to establish trailblazer status on apprenticeships now: there had been challenges as some of the apprenticeships involved were extremely technical, and there had been very short notice from government to implement a scheme. Scheme auditors had now visited the Trust to review progress, including on working with suppliers if they were implemented correctly, but there was still a long way to go to achieve this. It was noted that working with the Government on the apprenticeships levy in the university sector had proved challenging, so the Trust should be aware of this. • The Chief Nurse noted that there was a national debate ongoing around registered nurse apprenticeships. The Trust would not at present be able to meet the standards required by the Nursing and Midwifery Council, and apprenticeships could cost up to £150,000 each with no guarantee of a return for the Trust. Whilst providing a small number of such apprenticeships might be the 'right thing to do' to support the Trust's nurses, but it would not be a notable income stream. **Members RESOLVED to:** • **Receive** the Finance Report for assurance.	
189/11/17	**10. Finance Committee Chair's Report**	
	Members received a written report of the meeting of the Finance Committee of 24 November 2017. Members also received a verbal account of the meeting from Martin Sykes, Non-executive Director and Chair of the Finance Committee. • The Committee had received an update on the financial position of the Trust from the Director of Finance and Information, who had flagged	

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	the significant risks going forward, particularly into quarter 4. The Committee was therefore looking to the Executive Team for reassurance that best efforts were being taken to address the position. The Committee noted productivity activity that was taking place, as well as delivery to date against the nursing pay control plans. • The Committee received a report on service line reporting, focusing on speciality income and expenditure, which helped provide an idea of where savings might be identified, especially longer term efficiencies. • The Committee had received the quarterly Workforce and Organisational Development report, and had been pleased with the holistic approach to the issues identified. The Committee felt there were also potential financial benefits to successfully addressing these. • The Committee reviewed current progress against the savings programme: the Trust was doing reasonably well against savings requirements, but focus was now starting to shift to the next financial year when even greater savings were likely to be required. **Members RESOLVED to:** • **Receive** the Finance Committee Chair's Report for assurance.	
190/11/17	**11. Quarterly Update on Capital Projects**	
	Chief Operating Officer and Deputy Chief Executive Mark Smith presented the Quarterly Update on Capital Projects to the Board. Members of the Trust Board discussed the following:- • The Chair noted that the Trust's future plans on capital projects were entirely dependent on its current financial performance. • Public Governor Garry Williams questioned what the Trust was doing to attract charitable contributions to capital or technical schemes. It was noted that Above and Beyond were fundraising for the Bristol Heart Institute, and additionally talking to other grant making bodies.. The Trust had begun early investigations into possible access to social capital also, including companies interested in investing in social causes for 'minimal; returns. This was at a very early stage but remained an options for consideration. Non-Executive Director Guy Orpen, noted that there was potentially a mutual interest between hospital trusts and universities in considering whether they might jointly develop projects which were of interest to funders, which they would not be able to bring forward as sole ventures (it was noted that	

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	he had an interest here as the Deputy Vice Chancellor of the University of Bristol, but would not in any case be involved in any such discussions). It was difficult for foundation trusts to provide banks with the level of assurance they wanted for large capital loans – i.e. guarantees from the Secretary of State, which a foundation trust could not provide. There were real challenges in accessing funds from the public sector. The Chief Executive noted that despite the obstacles to capital developments the Trust faced, the successful achievement of phase 4 of the capital plan was a major success. **Members RESOLVED to:** • **Receive** the Quarterly Update on Capital Projects for Assurance.	
Organisational and System Strategy and Transformation		
191/11/17	**12. Sustainability Strategy – Update and Action Plan**	
	The Director of Strategy and Transformation, Paula Clarke, presented the Report to the Board. It was noted that: • Sustainability was fundamental to UH Bristol's strategic approach going forward, and needed to be embedded in Trust activity: it was not estates- or strategy-led but should be led across all Trust activities. There was clear value in helping to improve the welfare of the community, but a robust sustainability strategy would also help UH Bristol reach its key objectives. • A vision and strategy document had been agreed some time ago (and was closely related to the Big Green Initiative), and this report gave the Board a short update on progress against it, to ensure there was clarity on 'where we are' as a Trust. Support from the Board to ensure the Trust was delivering on sustainability objectives was key. • There were continued challenges to delivery, and it was incumbent on the Trust to continue balancing cost and benefit, via the Sustainability Forum, which included representatives from across all the divisions. Members of the Trust Board discussed the following:- • Members agreed there had been a great effort to get staff 'on board' with sustainability as part of everyday work. • It was noted that the report stated the Trust had chosen to work to a lower BREEAM standard than proposed by the government guidelines: i.e. 'excellent' on new build premises but 'very good' on refurbishments. Members argued that this was a false economy, and the decision should be actively reviewed. The Director of Strategy and	

Minute Ref	Item Number	Action
	Transformation confirmed this was not a fixed position, and would be kept under active review. • It was noted by members that the report asked for Board support in achieving remaining CO2 emissions targets, but it was not clear what support exactly the Board was being asked for. The Director of Strategy and Transformation would clarify this. • It was noted that capacity limitations on the Bristol and Weston Purchasing Consortium (BWPC) meant it was unable to complete an update on the action plan on procurement actions. UH Bristol had been working alongside North Bristol Trust to support BWPC on ways it could embed sustainability into current procurement processes. The Board were assured that this was being addressed, but had been delayed by resource and capacity constraints. **Action: Director of Strategy and Transformation to clarify what support was being sought from the Board for the achievement of the Trust's remaining CO2 emissions target.** **Members RESOLVED to:** **Receive** the Report for assurance.	
Governance		
192/11/17	**13. Audit Committee Terms of Reference**	
	The Trust Secretary presented the Audit Committee Terms of Reference to the Board. • It was noted that the Audit Committee reviewed its own Terms of Reference on an annual basis, to ensure that they remain fit for purpose, accurate to the committee's function, and in compliance with regulatory requirements and governance best practice. The Audit Committee therefore reviewed its current Terms of Reference at its last meeting on 30 October 2017: no major changes were proposed, but there were some minor amendments to: a) Clarify existing practice, b) Ensure the terms of reference reflect ICSA guidance/best practice; c) Reflect input from the Internal and External Auditors; d) Reflect input from the Chair of the Committee; d) Include minor grammatical corrections. **Members RESOLVED to:**	

Minute Ref	Item Number	Action
	• **Approve** the Audit Committee update Terms of Reference for 2017-18.	
Items for Information		
193/11/17	**14. Governors' Log of Communications**	
	The report provided the Board with an update on governors' questions and responses from Executive Directors. **Members RESOLVED to:** • **Approve** the Governors' Log of Communications.	
Concluding Business		
194/11/17	**15. Any Other Urgent Business**	
	• The Chief Executive noted that NHS Improvement now had a new Chief Executive, Ian Dalton, previously Chief Executive of Imperial Healthcare. The Board also welcomed Shaun Carr to his first meeting of the board as the Trust's new Director of Performance and Interim Deputy Chief Operating Officer. • The Chair noted that it was Trust Secretary Pam Wenger's final Board meeting. Members joined the Chair in expressing their appreciation for her hard work and support of the Board.	
195/11/17	**16. Date and time of Next Meeting**	
	• 31 January 2018, 11.00 – 13.00, Conference Room, Trust **Headquarters**	

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

University Hospitals Bristol
NHS Foundation Trust

Public Trust Board of Directors meeting
31 January 2018
Action tracker

Outstanding actions from the meeting held on 29 November 2017					
No.	**Minute reference**	**Detail of action required**	**Responsible officer**	**Completion date**	**Additional comments**
1.	191/11/17	**Sustainability Strategy – Update and Action Plan** Director of Strategy and Transformation to clarify what support was being sought from the Board for the achievement of the Trust's remaining CO2 emissions target.	Director of Strategy and Transformation	January 2018	**Work in Progress** Director of Strategy and Transformation to provide an update to the Board in January 2018: • Board support is needed in providing scrutiny of the CO2 emissions reduction strategy and specifically to identify through their networks, any additional opportunities to achieve the targets through cross-organisational collaborations for sustainable development. The leadership role of all Board members as champions for energy efficiency will also be needed to support achievement of the 28% reduction in CO2 emissions by 2020 (from 2013 baseline).
2.	186/11/17	**Quality and Performance Report** Trust Secretary to include discussion of	Trust Secretary	December 2017	**Work in Progress** To be included in the Board

		communications interface with primary healthcare colleagues as an item on the Board Seminar business cycle			Seminar Business Cycle for the upcoming year.
3.	153/09/17	**Quality and Patient Experience Report** Chief Nurse to investigate whether the report could be amended to include an executive summary in future.	Chief Nurse	December 2017	**Work in Progress** To be included in the next quarterly report to the Board.
Closed actions from the meeting held on 31 October 2017					
No.	**Minute reference**	**Detail of action required**	**Responsible officer**	**Completion date**	**Additional comments**
1.	165/10/17	Australian Flu Vaccine Chief Operating Officer to request the Emergency Planner to re-look at the Emergency Resilience Plan to provide assurance to the board that preparations are in place.	Chief Operating Officer	October 2017	**Complete** The Board were assured at the October meeting that preparations were in place in case a flu pandemic occurred.
2.	169/10/17	Quality and Outcomes Committee - Chair's Report Chief Nurse to provide a report to the Quality and Outcomes Committee on the impact of implementing the enhanced care observation policy at a future meeting.	Chief Nurse	December 2017	**Complete** This action has been added to the Quality and Outcomes committee business cycle as part of the Monthly Nurse Safe Staffing Report.

University Hospitals Bristol
NHS Foundation Trust

Cover report to the Public Trust Board. Meeting to be held on 31 January 2018 at 11.00 – 13.00, Conference Room, Trust HQ, Marlborough St, Bristol, BS1 3NU

		Agenda Item	6
Meeting Title	Public Trust Board	**Meeting Date**	Wednesday, 31 January 2018
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

Purpose

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

Key issues to note

The Board will receive a verbal report of matters of topical importance to the Trust, in addition to the attached report summarising the key business issues considered by the Senior Leadership Team in December 2017 and January 2018.

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 recruit, train and sustain an engaged and effective workforce.	☐	Failure to comply with targets, statutory duties and functions.	☐
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.	☐		

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)**

SENIOR LEADERSHIP TEAM

REPORT TO TRUST BOARD – JANUARY 2018

1. INTRODUCTION

This report summarises the key business issues addressed by the Senior Leadership Team in December 2017 and January 2018.

2. QUALITY, PERFORMANCE AND COMPLIANCE

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

The group **received** updates on the financial position for 2017/2018, including the position in respect of Operating Plans for 2018/2019.

The group **approved** the national mandatory contract variation for contracts with NHS England and Bristol Clinical Commissioning Group (the co-ordinating commissioner for Bristol North Somerset and South Gloucestershire Clinical Commissioning Group and non-Bristol North Somerset and South Gloucestershire associate commissioners).

3. STRATEGY AND BUSINESS PLANNING

The group **supported** proposals for marking the NHS's 70th birthday throughout 2018, acknowledging that there was further work with Divisions required to take forward.

The group received an update on the Leadership Behaviours post the launch week in August and **supported** proposed next steps to embed these into the organisational culture.

The group **approved** the Managed Equipment Service Strategic Outline Case for progression to Outline Business Case, for the renewal of the contract in Laboratory Medicine after 1 January 2020.

4. RISK, FINANCE AND GOVERNANCE

The group **received** the Quarter 3 update reports around Patient Safety and Complaints, prior to submission to the Quality and Outcomes Committee and Trust Board.

The group **received** the Quarter 3 Themed Serious Incident update report, prior to submission to the Quality and Outcomes Committee.

The group **received** the Quarter 3 Corporate Quality Objectives update report, prior to submission to the Quality and Outcomes Committee.

The group **approved** the Quarter 3 Board Assurance Framework for onward submission to the Trust Board.

The group **approved** the Corporate Risk Register for onward submission to the Trust Board.

The group received a briefing on requirements of the General Data Protection Regulations which would come into force in May 2018, and **supported** next steps to ensure readiness, including the appointment of a Data Protection Officer.

The group **received** three satisfactory Internal Audit Reports in relation to Temporary Staffing Standard Operating Procedures, Staff Engagement and the Board Assurance Framework. The group also received and **supported** changes to the Internal Audit Plan for 2017/2018.

The group **received** an update on the continuing development of the Congenital Heart Disease Network hosted by UH Bristol.

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

The group **received** an update on the Register of Interests, Gifts and Hospitality.

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
January 2018

University Hospitals Bristol
NHS Foundation Trust

Cover report to the Public Trust Board
to be held on Wednesday, 31 January 2018 at 11.00 -13.00
in the Board Room, Trust HQ, Marlborough St, Bristol, BS1 3NU

		Agenda Item	7
Report Title	Board Assurance Framework 2017-18 (Quarter 3)		
Author	Sarah Wright, Head of Risk Management		
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.	☒	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 assurance that the organisation is on track to achieve its strategic and annual objectives for the current year. Importantly, the Board Assurance Framework describes any risks to delivery that have been identified to date and describes the actions being taken to control such risks so as to ensure delivery is not compromised.

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

Key Changes

STRATEGIC PRIORITY 1:
We will consistently deliver high quality individual care, delivered with compassion
Principal Risk 1 - Failure to maintain the quality of patient services.

- Gaps in compliance with Emergency planning (EPRR) arrangements have been resolved. The Trust is now substantially compliant.
- Quality Impact Assessment process in place for ICP's, ERP's and specific transformation/service change projects as per risk assessments.
- Recommendations in relation to the paediatric cardiac review have been implemented and the assurance report has been finalised.
- Previous Risk Rating 9, Current Risk Rating 9, static trajectory.
- 7 associated Corporate Risks.

STRATEGIC PRIORITY 2:
We will ensure a safe, friendly and modern environment for our patients and our staff
Principal Risk 2 - Failure to develop and maintain the Trust estate.

- The assessment of the risk to achievement of the strategic objective has been reassessed during Q3 in line with the 2017-19 financial position.
- Second line level of assurance in relation to committee reports, third line in respect of Internal Audit work programme provides evidence of good estate maintenance.
- Gaps in controls have been identified through evidence of slippage of the capital programme due to the inability of procurement to respond to programme requirements
- Divisions are now prioritising clinical procurement.
- Previous Risk Rating 20, Current Risk Rating 12, decreased trajectory.
- 1 associated Corporate Risk.

STRATEGIC PRIORITY 3:
We will strive to employ the best staff and help all our staff fulfil their individual potential
Principal Risk 3 - Failure to recruit, train and sustain an engaged and effective workforce.

- No material changes.
- First & second line assurance around reporting arrangements and agency action plan remain in place.
- Previous Risk Rating 12, Current Risk Rating 12, static trajectory.
- 6 associated Corporate Risks.

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

- Inclusion of Trust Board annual focus on Innovation & Improvement and QI hub
- Second line assurances in place but gaps remain around supporting innovation and improvement, to be addressed by implementation of Innovation Strategy.
- Previous Risk Rating 9, Current Risk Rating 9, static trajectory.
- No associated Corporate Risks.

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

- Inclusion of reference to Healthy Weston programme in controls.
- Assurance identified as being required in relation to developing relationships and networks with emerging Primary Care locality hubs.
- Additional action identified around Executive involvement in Primary and Secondary Care Interface Group and progression of Primary and community business development approach via the Strategy Steering Group.
- Previous Risk Rating 6, Current Risk Rating 6, static trajectory.
- 1 associated Corporate Risks.

STRATEGIC PRIORITY 6:
We will ensure we are financially sustainable to safeguard the quality of our services for the future and that our strategic direction supports this goal.
Principal Risk 6 - Risk of being unable to deliver the 2017/18 financial plan.

- The probability score has been reassessed downwards from “almost certain” to “likely” in light of the promising financial results for November 2017
- Second line assurance in place via internal reporting and divisional reporting arrangements, weak controls and gaps in assurance identified.
- Previous Risk Rating 25, Current Risk Rating 20, decrease in trajectory.
- 4 associated Corporate Risks

STRATEGIC PRIORITY 7:
We will ensure we are soundly governed and are compliant with the requirements of our regulators
Principal Risk 7 - Failure to comply with targets, statutory duties and functions

- Actions identified to address gaps around the preparation for the implementation of GDPR
- Ongoing limited assurance around the of effectiveness of controls in relation to achievement of elements of the Single Oversight Framework..
- Robust second level assurance in place and third level in respect of NHS Improvement returns and findings from CQC inspections.
- Previous Risk Rating 9, Current Risk Rating 9, static trajectory.
- 4 associated corporate risks.

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

- There has been 1 amendment this quarter SP6, from 25 to 20.
-

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

Recommendations
Members are asked to: • **Review** the information contained within 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 comply with targets, statutory duties and functions.	☒	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.			☒

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

Impact Upon Corporate Risk
As detailed in the report.

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

Date papers were previously submitted to other committees					
Executive Director Meeting	**Risk Management Group**	**Senior Leadership Team**	**Audit Committee**	**Quality and Outcomes Committee**	**Trust Board**
13/12/2017	09/01/2018	17/01/2018	26/01/2018	29/01/2018	31/01/2018

University Hospitals Bristol
NHS Foundation Trust

BOARD ASSURANCE FRAMEWORK

Q3 2017-18

1. Board Assurance Framework (BAF) for the delivery of the Trusts Strategic Objectives.

The Board has overall responsibility for ensuring systems and controls are in place, sufficient to mitigate any significant risks which may threaten the achievement of the strategic objectives. Assurance may be gained from a wide range of sources, but where ever possible it should be systematic, supported by evidence, independently verified, and incorporated within a robust governance process.

The Board achieves this, primarily through the work of its Assurance committees, through use of Audit and other independent inspection and by systematic collection and scrutiny of performance data, to evidence the achievement of the objectives.

2. The Trust Strategic Plan

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

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

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

Our strategy outlines nine key clinical service areas:

1. Children's services;
2. Accident and Emergency (and urgent care);
3. Older people's care;
4. Cancer services;
5. Cardiac services;
6. Maternity services;
7. Planned care and long term conditions;
8. Diagnostics and therapies; and
9. Critical Care.

3. Our 2014-19 five year Strategic Plan

The 5 year plan outlines seven strategic priorities, structured according to the characteristic of our Trust Vision outlined above. Our strategic priorities are:

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

4. The Trusts Operational Plan 2017-19

The focus of strategic and operational plans over the next two year period will be the following from section three of the Operational Plan:

3. Care and Quality and Health and Wellbeing

***3.1.1 Delivery of our quality objectives as agreed in our new quality strategy** (SP1)*
Including delivery against requirements outlined in the nine 'must dos' and NHS mandate to close our identified gaps in care and quality. For our organisation; this will include a specific focus on;

- *ensuring timely access to services*
- *delivering safe and reliable care*
- *improving patient and staff experience*
- *improving outcomes and reducing mortality*

***3.1.2 Independent Children's Cardiac Review** (SP1)*

- *full delivery of the recommendations*

***3.1.3 Staff strategic engagement and retention strategy** (SP3)*

- *focus on staff engagement and wellbeing,*
- *supported by real-time feedback, using innovative approaches such as the 'Happy App' (2016 HSJ winner) and;*
- *the on-going development of leadership capacity and capability.*

***3.1.4 Access standards** (SP7)*

- *Improving performance and delivery of our performance trajectories in the four core standards.*

3.2 Finance and Efficiency

***3.2.1 Operational and financial sustainability** (SP6)*

- *with a specific focus on internal specialty level productivity and the efficient delivery of activity aligned to our capacity modelling,*
- *along with the implementation of Carter recommendations,*
- *including a system view of corporate overheads, estates and pathology.*

***3.2.2 Maximising the impact from partnership system working** (SP5)*

- *service redesign and strategic partnerships within region*
- *development of shared leadership and associated opportunities to improve system and service level productivity.*

***3.2.3 Estates and capital strategy for 2017-19** (SP2)*

- *continue to align the modernisation and development of our estate to our evolving clinical strategy and*
- *support delivery of the emerging strategic planning new model of care.*

***3.2.4 Maximising workforce productivity** (SP3)*

- *including controlling agency and locum costs.*

3.3 Strategy, Transformation, Innovation and Technology

***3.3.1 Refresh our existing Trust Strategy** (SP1)*

- *to reflect the need to respond to local and national changes to our operating environment and*
- *with a specific focus on developing our clinical strategy*

***3.3.2 Exploring options to continue to develop our specialist portfolio** (SP4)*

- *in the context of potential changes to Specialised Commissioning approaches across the south*

***3.3.3 Maximise our opportunity to continue to develop our research capacity and capability** (SP4)*

- *associated with the significant grant secured from the National Institute for Health Research to fund a Biomedical Research Centre undertaking cutting edge studies that will improve care and treatment in the future.*

***3.3.4 Development of an Innovation and Improvement Strategy for the organisation** (SP4)*

- *including maximising the opportunities for innovation and transformational change associated with our successful appointment as a National Digital Exemplar site,*
- *with clear alignment to organisational and STP digital priorities / local digital roadmap.*

***3.3.5 Continued development and delivery of our Transforming Care Programme** (SP5)*

- *focussing on transforming the way in which we deliver care through service and workforce redesign,*
- *with a focus over the next two years on real time internal processes to support patient flow alongside engaging in and supporting STP processes to develop effective system care pathways and patient flow.*

5. Principal Risks

- **Risks to SP 1**: Risk that the Trust will be unable to maintain the quality of patient services**.**
- **Risks to SP 2**: Risk that the Trust will be unable to develop and maintain the Trust estate.
- **Risks to SP 3:** Risk that the Trust will be unable to recruit, train and sustain an engaged and effective workforce.
- **Risks to SP 4:** Risk that the Trust will not be able to support transformation and innovation and that the Trust will not be able to embed research and teaching into the care we provide, and develop new treatments for the benefit of patients and the NHS.
- **Risks to SP 5:** Risk of failing 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.
- **Risks to SP 6:** Risk of being unable to deliver the 2017/18 financial plan.
- **Risks to SP 7:** Risk of failing to comply with targets, statutory duties and functions.

6. Approach to Risk Assessment - Risk scoring = consequence x likelihood

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

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

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

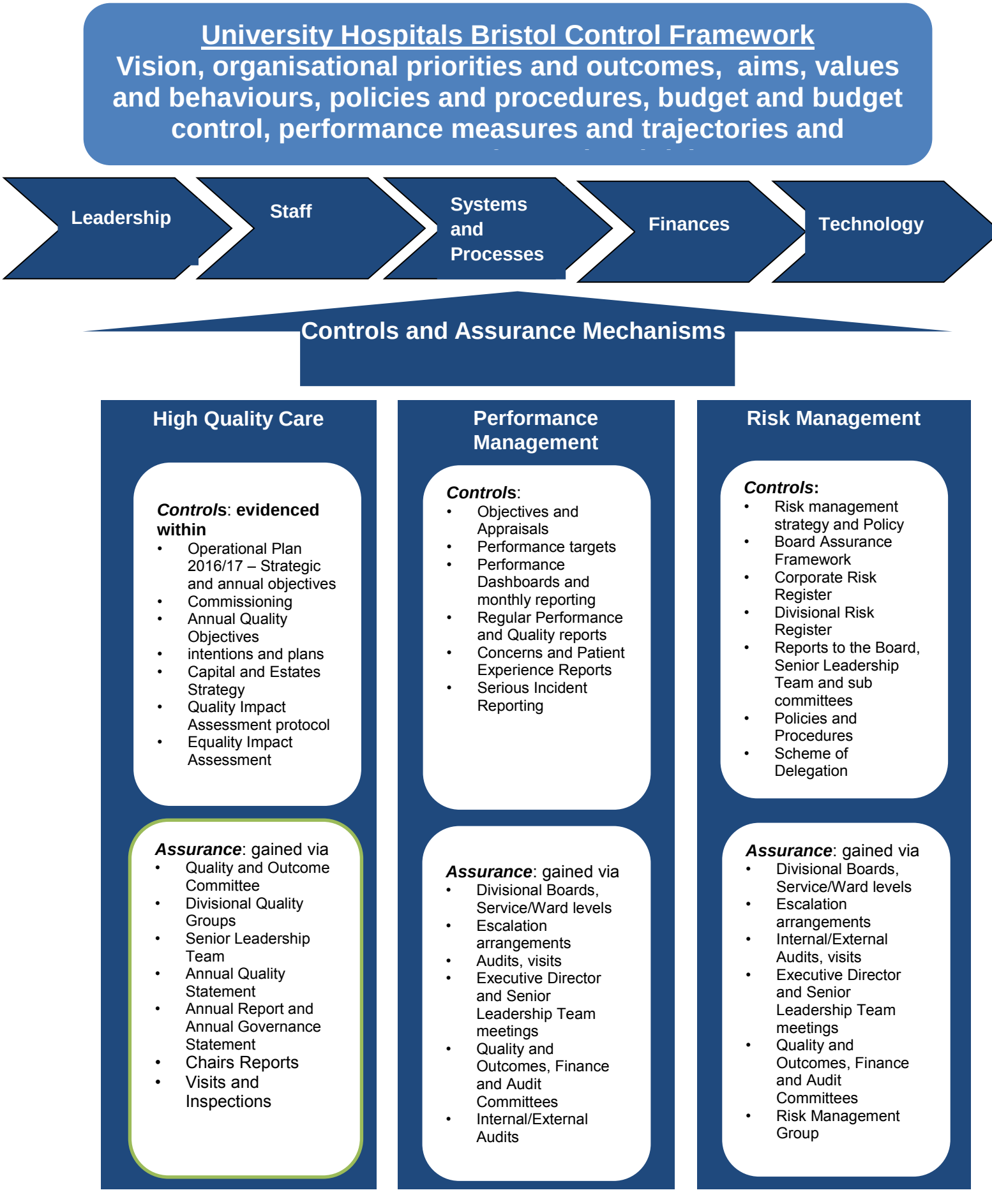
The current scores for principal risks are summarised in the following heat map.

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

The progress summary of the principal risks are as follows.

Principal Risk	**Q1 2017/18**	**Q2 2017/18**	**Q3 2017/18**	**Q142017/18**
1. Risk that the Trust will be unable to maintain the quality of patient services.	Possible x Moderate **= 9**	Possible x Moderate **= 9**	Possible x Moderate **= 9**	Possible x Moderate **= 9**
2. Risk that the Trust will be unable to develop and maintain the Trust estate	Unlikely x Major **= 8**	Unlikely x Major **= 8**	Likely x Catastrophic **= 20**	Likely x Moderate = **12**
3. Risk that the Trust will be unable to recruit, train and sustain an engaged and effective workforce.	Possible x Major **= 12**	Possible x Major **= 12**	Possible x Major **= 12**	Possible x Major **= 12**
4. Risk that the Trust will not be able to support transformation and innovation and that the Trust will not be able to embed research and teaching into the care we provide, and develop new treatments for the benefit of patients and the NHS.	Possible x Moderate **= 9**	Possible x Moderate **= 9**	Possible x Moderate **= 9**	Possible x Moderate **= 9**
5. Risk of failing 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.	Unlikely x Moderate **= 6**	Unlikely x Moderate **= 6**	Unlikely x Moderate **= 6**	Unlikely x Moderate **= 6**
6. Risk of being unable to deliver the 2017/18 financial plan	Possible x Moderate **= 9**	Possible x Moderate **= 9**	Almost Certain x Catastrophic **= 25**	Likely x Catastrophic **= 20**
7. Risk of failing to comply with targets, statutory duties and functions	Possible x Moderate **= 9**	Possible x Moderate **= 9**	Possible x Moderate **= 9**	Possible x Moderate **= 9**

7. Controls Framework



8. Risk Assurance

Levels of Assurance

VISION AND CORPORATE PRIORITIES

First Line
Operational

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

Second Line
Risk and Compliance

Reports to Assurance and Oversight Committees

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

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

Third Line
Independent

- Internal Audit Plan
- External Audits (eg. Annual Accounts and Annual Report)
- CQC Inspections
- NHS Improvement Inspections
- Visits by Royal Colleges
- External visits and accreditations
- Independent Reviews
- Well Led Governance Review

REGULATORS

EXTERNAL AUDIT

9. Risk Appetite

Risk Domain	Definition	Risk Appetite	Risk Rating
Safety	Impact on the safety of patients, staff or public	Low	
Quality	Impact on the quality of our services. Includes complaints and audits.	Moderate	
Workforce	Impact upon our human resources (not safety), organisational development, staffing levels and competence and training.	Moderate	
Statutory	Impact upon on our statutory obligations, regulatory compliance, assessments and inspections.	Low	
Reputation	Impact upon our reputation through adverse publicity.	High	
Business	Impact upon our business and project objectives. Service and business interruption.	Moderate	
Finance	Impact upon our finances.	Moderate	
Environmental	Impact upon our environment, including chemical spills, building on green field sites, our carbon footprint.	Moderate	

10. Key

The Assurance Framework has the following headings:

Principal Risk	What could prevent the objective from being achieved?
Key Controls	The systems/processes/strategies that we have in place to assist secure delivery of the objective
Gaps in Controls	Gaps in the effectiveness of controls in place
Form of Assurance	Evidence of how the controls are monitored e.g. reporting mechanism
Gaps in assurance	Gaps in the evidence required to provide assurance or failure of the monitoring/reporting process
Level of Assurance	Robustness of the assurance which is being relied on - 1st line, 2nd line, 3rd line.
Actions Agreed for any gaps in controls or assurance	Plans to address the gaps in control and / or assurance and reference to any related risks.
Current Risk Rating	Assessment of the principal risk taking into account the strength of the controls currently in place to manage the risk
Direction of travel	Are the controls and assurances improving? ↑ ↓ ↔

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

Operational Plan 2017/19 Focus	**3.1.1 - Delivery of our quality objectives as agreed in our new quality strategy**, including delivery against requirements outlined in the nine 'must dos' and NHS mandate to close our identified gaps in care and quality. For our organisation; this will include a specific focus on; ➢ Ensuring timely access to services ➢ Delivering safe and reliable care ➢ Improving patient and staff experience ➢ Improving outcomes and reducing mortality	**3.1.2 -** Full delivery of the recommendations from the **Independent Children's Cardiac Review**. **3.3.1** - **Refresh our existing Trust Strategy** to reflect the need to respond to local and national changes to our operating environment and with a specific focus on developing our clinical strategy.

Executive Lead - Chief Nurse & Chief Operating Officer **Assuring Committee -** Quality and Outcomes Committee & Service Delivery Group

Principal Risk description	Key Controls	Form of Assurance	Level of Assurance	Gaps in controls	Gaps in assurance	Actions Agreed for any gaps in controls or assurance	Current Risk Rating	Direction of travel
Risk that the Trust will be unable to maintain the quality of patient services.	Trust wide Risk Management arrangements including incident reporting and investigation processes to identify areas of failure and implement corrective actions. Patient Safety Strategy and delivery of Patient Safety Improvement Programmes, including Sign Up to Safety initiative Implementation and monitoring of Quality Strategy objectives and metrics. And implementation of updated Volunteers Strategy UH Bristol survey programme to measure and monitor the quality of service-user reported experience. This programme will be further developed in 2017/18 with the procurement of a real-time patient feedback system. Clinical Audit Programme, including process for the self -assessment against NICE guidance Productive theatre initiative to reduce the number of cancelled Operations. Whole system approach being delivered through the Urgent Care Network and development of an internal Urgent Care Plan which will be overseen by the newly created Urgent Care Steering Group Professional Standards and Code of Practice/Clinical Supervision. Quality Impact Assessment (QIA) process for savings schemes meeting specific criteria. Monitoring of RTT Performance via: • Emergency Access Performance • Divisional Access performance scorecards • Divisional Monthly Reviews with Executive Team Business Continuity and Emergency planning arrangements Roll out of Evolve to provide ready availability of electronic patient records	Annual Governance Statement providing assurance on the strength of internal control regarding risk management processes, review and effectiveness Corporate reporting structure to Trust Board and Quality and Outcomes Committee via Clinical Quality Group. Quality metrics demonstrate that despite operational pressures, our patients are receiving good quality care despite delays in their discharge. Reports to SLT & Audit Committee/ via Clinical Quality Group/Clinical Audit Group/ Clinical Effectiveness Group, Patient Experience Group. Reporting functions in place to SDG, SLT Trust Board, via: • RTT Operations Group • RTT Steering Group • Cancer PTL Meetings • Cancer Performance Improvement Group • Cancer Steering Group • Urgent Care Steering Group External - EPRR assessment (NHSE) and Internal - self assessment -Substantially compliant. Recommendations in relation to the paediatric cardiac review implemented and assurance report finalised.	Internal performance reports form first line assurance. Reports to: • Trust Board, • Senior Leadership Team • Audit Committee • Quality & Outcomes Committee • Risk Management Group • Service Delivery Group • Clinical Quality Group • Patient Experience Group Form second line assurance External audit/review forms third line assurance.	Although some of the patient feedback collected corporately is made available directly to inpatient wards (e.g. via posters and circulation of spread sheets), there is an opportunity to make this more rapidly available and more accessible to ward staff. QIA Process requires development.	None identified.	Procurement of a real-time patient feedback system. Further development of the QIA process to cover /support changes to service provision/stopping of services .	**Moderate x Possible = 9**	↔

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

Operational Plan 2017/19 Focus	**3.2.3 - Estates and capital strategy for 2017-19** • continue to align the modernisation and development of our estate to our evolving clinical strategy and • Support delivery of the emerging strategic planning new model of care.

Executive Lead - Chief Operating Officer & Director of Finance **Assuring Committee -** Finance Committee & Trust Board

Principal Risk description	Key Controls	Form of Assurance	Level of Assurance	Gaps in controls	Gaps in assurance	Actions Agreed for any gaps in controls or assurance	Current Risk Rating	Direction of travel
Risk that the Trust will be unable to develop and maintain the Trust estate due to lack of funding	Maintenance of the estate: Approved Annual Backlog Maintenance funding Annual Planned Preventive Maintenance Programme Reactive Maintenance system (Agility) Internal Capital Project & Estates Team in place with adequate training. Internal Audit work programme. Development of the estate (investment): Approved Estates Strategy. Trust Capital Group Chaired by Deputy COO, receives monthly status reports on Capital Projects from Divisions and Director of Estates. Financial Control Procedures, including the scheme of delegation and Standing Financial Instructions in place. Approved Five year Medium Term Capital Programme. Delivery of the 2017/18 capital programme, including the prioritisation and allocation of strategic capital. Delivery of the 2017/18 Operational plan without significant deterioration in the underlying run rate to ensure availability of strategic capital is available for future investment.	Internal audit reports. Monthly KPI report through Divisional Board on Reactive maintenance. Prioritisation of backlog maintenance through Capital Programme Steering Group Reports from Trust Capital Group to Capital Programme Steering Group. Chairs reports from Capital Programme Steering Group to Finance Committee. Rolling 5 year Medium Term Capital Programme (source and applications of funds) approved annually by the Finance Committee and Board. Monthly management scrutiny of capital expenditure at the Capital Programme Steering Group. Regular Reporting to the Finance Committee and Trust Board.	Reports to: • Trust Board • Audit Committee • Finance Committee • Capital Programme Steering Group • Trust Capital Group • Divisional Boards Form second line assurance Outcome of internal audit reports form third line assurance.	Evidence that the delivery of capital investment plans are weak in terms of programming and financial profiling. Evidence that the delivery of the operational plan without significant deterioration in underlying run rate is at risk of being achieved. Evidence of capital programme slippage due to procurement inability to respond to programme requirements. Backlog Maintenance only prioritised annually	Lack of assurance that capital expenditure controls for delegated Divisional and Operational Capital are fully effective.	The Trust Capital Group has been established to scrutinise delivery of capital plans and has met since November 2016. Clinical Divisions have prioritised their clinical procurement priorities with the procurement team. Backlog Maintenance expenditure reporting monthly through Trust Capital Group	Moderate x Likely = 12	↓

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

Operational Plan 2017/19 Focus	**3.1.3 Staff strategic engagement and retention strategy**, • Focus on staff engagement and wellbeing, • Supported by real-time feedback, using innovative approaches such as the 'Happy App' (2016 HSJ winner) and; • The on-going development of leadership capacity and capability.	**3.2.4 Maximising workforce productivity** • Including controlling agency and locum costs.

Executive Lead - Director of People **Assuring Committee -** Trust Board

Principal Risk description	Key Controls	Form of Assurance	Level of Assurance	Gaps in controls	Gaps in assurance	Actions Agreed for any gaps in controls or assurance	Current Risk Rating	Direction of travel
Risk that the Trust will be unable to recruit, train and sustain an engaged and effective workforce.	Delivery of the Workforce and Organisational Development Strategy Quality objective on staff engagement HR Policies and Procedures support a framework for clear accountability at Divisional level for staff engagement. Monthly compliance reports on Essential Training are sent to Divisions and include trajectories to achieve compliance and divisional Reviews include performance against workforce plans and HR KPI's to improve staff experience Appraisal Process/Personal Development Plan moving towards E-Appraisal in May 2017 in order to measure quality and support comprehensive development plans at Divisional and trust wide level. E-Appraisal launched in May 2017. Phase 2 now focuses on the quality of the experience and the introduction of a 360 degree feedback mechanism in 2018. Workplace Health and Wellbeing Framework delivery plan to include the NHS Staff Health and Wellbeing CQUIN National Staff Survey Robust improving staff experience plans are in place which target hotspot areas with bespoke interventions to improve staff engagement. This includes training and focus groups. The Staff Friends and Family Test. Other, local or more specific surveys/focus groups also take place sickness and turnover). The FTT has been targeted in hotspot areas for Q2 in order to be able to use the data from the questionnaire to improve staff experience. Happy App available in clinical areas Leadership Behaviours launched 14th August by Executive Directors. Local launches and training is in place until mid-November.	Metrics in relation to key controls are reviewed by the Senior Leadership Team, QOC and Trust Board: Annual learning and development report. Weekly returns agency staffing. Agency action plan. Reports from new E-Appraisal system in place August 2017 Dashboard reports will be developed in the future to support managers completing appraisals in a timely way Reports to Agency Controls Group. Health & Safety Reports to Trust Health, Safety and Fire Committee and Risk Management Group. Externally accredited Health & Safety audit and Workplace Wellbeing Charter. Reporting of results on achievement of staff wellbeing CQUIN Reporting of Occupational Health KPI's Reporting on results of Staff survey/ friends and family tests. This will now be in a targeted department approach in response to the heat map data Divisional improving staff experience plans in place focusing on hotspot areas in response to the divisional heat maps Leadership behaviours Developed by Trust leaders and approved at SLT for roll out in August 2017 Draft Dignity at Work policy has been approved with a roll out plan in place to support staff understanding the Trusts	Regular internal reports form first line assurance. Reports to: • Trust Board, • Senior Leadership Team • Quality Outcome Committee • Risk Management Group • Workforce and OD • Health, Safety & Fire Safety Committee Form second line assurance External audit/review forms third line assurance.	Workplace Wellbeing Framework requires a shared strategic vision with a view to establishing a Board Wellbeing Champion Workplace Wellbeing and Health & Safety to be more explicitly determined within the Workforce and Organisational Development Strategy. Happy App not available in all areas.	Limited assurance primarily around achieving compliance with essential training rates. Limited assurance around levels of staff retention.	Identification of a Board Wellbeing Champion Refresh Workplace Wellbeing Strategy with focus on psychological wellbeing at work Refresh of the Workforce and OD Strategy. Mid-year review of workforce KPIs to understand forecast out turn. Staff Recognition Awards and rewards framework being developed Roll out Happy App across whole organisation.	**Major x Possible = 12**	↔

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

Operational Plan 2017/19 Focus	**3.3.2 Exploring options to continue to develop our specialist portfolio** • in the context of potential changes to Specialised Commissioning approaches across the south **3.3.3 Maximise our opportunity to continue to develop our research capacity and capability** associated with the significant grant secured from the National Institute for Health Research to fund a Biomedical Research Centre undertaking cutting edge studies that will improve care and treatment in the future.	**3.3.4 Development of an Innovation and Improvement Strategy for the organisation** • including maximising the opportunities for innovation and transformational change associated with our successful appointment as a National Digital Exemplar site, • with clear alignment to organisational and STP digital priorities / local digital roadmap.

Executive Lead - Medical Director & Director of Strategic Development & Transformation **Assuring Committee -** Trust Board

Principal Risk description	Key Controls	Form of Assurance	Level of Assurance	Gaps in controls	Gaps in assurance	Actions Agreed for any gaps in controls or assurance	Current Risk Rating	Direction of travel
Risk that the Trust will not be able to support transformation and innovation. and that the Trust will not be able to embed research and teaching into the care we provide, and develop new treatments for the benefit of patients and the NHS.	Memorandum of agreement with University of Bristol. Joint Posts and Clinical Networks. Research Standing Operating Procedures. Process in place for corrective and preventative actions where breaches of GCP/protocol are identified to support learning by PI/CI and research team. Regular review of research recruitment on a trust-wide level. Key Performance Indicators at divisional level (bed holding only) finalised for regular divisional review. Staff engagement embedded in planning service improvement and transformation work. Transformation and other service improvement leads networked across the divisions – role includes identifying and supporting local innovation. Partnership with the Academic Health Science Network to train a cohort of improvement coaches to add capacity to this support network. During 16/17 review of approach to supporting innovation across the Trust completed and Innovation & Improvement strategic Framework developed Quality Improvement Academy established 2017 Research grants, Research Capability Funding, commercial and delivery income maintained. SPAs recognised in consultant job plans NIHR award £21m over 5 years for Biomedical Research Centre to Trust and UoB partnership. Trust chosen as Global Digital Exemplar, securing the opportunity to progress our Digital Transformation plans at pace	Reporting structures for divisional research committees/groups to Trust Research Group. Regular reports to the Board on KPI reviews (trust wide & divisional) Education and Training Annual Report Project steering groups /reporting to Transformation Board & Senior Leadership Team. Regular reports to the Trust Board. Evidence of wide range of innovation and improvement programmes completed/underway including good response to programmes such as Bright Ideas, Trust Recognising Success awards etc. Audit and inspections. Trust Board Seminar focus annually on Innovation & Improvement and QI hub Digital Strategy presented to Trust Board, Including updated objectives and additional functional scope. Clinical Systems Board (incorporating GDE programme components) providing overall governance on digital delivery projects reporting to Trust Board and Senior Leadership Team Routine departmental assurance by programme management office for all digital and IM&T projects and activities reported to IM&T Management Group.	Regular reviews and departmental programme management forms first line assurance. Reports to: • Trust Board, • Transformation Board • Senior Leadership Team • IT Management Group • Divisional Groups • Transformation Board • NHS Digital for GDE and Tech-funded project boards Form second line assurance Internal/External Audit/inspections forms third line assurance.	No significant gaps.	Clear mechanism for protecting time for non-medical PIs who do not hold funded research role recruiting to National Institute of Health Research portfolio trials not in place. Evidence that Improvement & Innovation Strategic Framework approach further promotes and encourages innovation and improvement, in order that staff with good ideas can bring them to life for the benefit of patients, staff, the Trust and the wider NHS There is currently lack of evidence that the use of digital technology renders direct benefits. The proposed direct reporting of benefits realization will address this gap.	Very low numbers of non-medical PIs not supported by research funding. Address on a case by case basis. Work in progress to address the divisional research committee's gaps - Appointment of new research lead in Surgery made and will commence in January 2018. Implementation of plan for supporting Innovation & Improvement in line with action plan agreed by Transformation Board and supported by SLT with focus on three aims: • To support and connect people with our structured programmes • To provide support to staff with good ideas outside these programmes • To build capability to support staff to lead improvement independently of these programmes Full implementation of Digital Transformation, including Global Digital initiatives and embedding as an integral part of the Trust's business	**Moderate x Possible = 9**	↔

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

Operational Plan 2017/19 Focus	**1.2.2 Maximising the impact from partnership system working** • service redesign and system wide re-configuration, with • Development of shared leadership and associated opportunities to improve system and service level productivity.	**3.3.5 Continued development and delivery of our Transforming Care Programme** • focussing on transforming the way in which we deliver care through service and workforce redesign, • with a focus over the next two years on real time internal processes to support patient flow alongside engaging in and supporting STP processes to develop effective system care pathways and patient flow.

Executive Lead - Director of Strategic Development & Transformation **Assuring Committee -** Trust Board

Principal Risk description	Key Controls	Form of Assurance	Level of Assurance	Gaps in controls	Gaps in assurance	Actions Agreed for any gaps in controls or assurance	Current Risk Rating	Direction of travel
Risk of failing 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.	Formal Partnership Agreement with Weston Area Health NHS Trust (WAHT) to increase joint working between the two Trusts. Formal Partnership Agreement with North Bristol NHS Trust (NBT) to increase joint working between the two Trusts. Programme Partnership Boards in place and regular reporting through to the Trust Board. 4 way Partnership meeting with NBT, UoB, UWE Chief Executive agreed as local system leader for regional joint working/collaboration planning with other Executives playing lead roles Range of senior staff involvement in NS Sustainability Board Healthy Weston programme. Staff involved in wide range of external activities e.g. Bristol Health Partners, Better Care Bristol, CLAHRC West, BNSSG System Leadership Group. Implementation of new Strategic Planning Governance Process Development of new internal STP Leads meeting to improve visibility of staff engagement in external activities, reporting into Strategy Steering Group	Reports to the Trust Board following each of the Partnership Board Meetings. Tender Framework and business case templates in place from April 2016 explicitly addressing partnership opportunities. Evidence in recent tenders that Trust is a sought after partner - Children's Community Services; Sexual Health No indication in current self-assessment within STP of adverse perceptions. National feedback on Sustainability and Transformation Plan processes and leadership. Bristol NIHR Biomedical Research Centre successful partnership bid for funding 2016.	Internal reviews and monitoring form first line assurance. Reports to: • Trust Board, Form second line assurance	Complete visibility of scope of staff engagement in external activities challenging and not necessarily always required.	Ability to harness soft information. Ensuring forums are established to co-ordinate Trust approach into, and secure communication output from key system groups. Developing relationships and networks with emerging Primary Care locality hubs.	Co-ordinated approach to key system processes overseen by Executive Directors – to include new internal urgent care steering group and action to target input into CEP/savings control centres. Executive involvement in Primary and Secondary Care Interface Group. Primary and community business development approach being progressed under Strategy Steering Group.	**Moderate x Unlikely = 6**	↔

STRATEGIC PRIORITY 6 : We will ensure we are financially sustainable to safeguard the quality of our services for the future

Operational Plan 2017/19 Focus	**3.2.1 Operational and financial sustainability** • with a specific focus on internal specialty level productivity and the efficient delivery of activity aligned to our capacity modelling, • along with the implementation of Carter recommendations, • Including a system view of corporate overheads, estates and pathology.
Executive Lead - Director of Finance	**Assuring Committee -** Finance Committee

Principal Risk description	Key Controls	Form of Assurance	Level of Assurance	Gaps in controls	Gaps in assurance	Actions Agreed for any gaps in controls or assurance	Current Risk Rating	Direction of travel
Risk of being unable to deliver the 2017/18 financial plan.	Measurement of financial performance against planned performance covering revenue income and expenditure performance, capital expenditure, the statement of financial position and cash flow statement. Monthly Finance & Operational Divisional Performance reviews involving Executives and Divisional Boards. Monthly review by Savings Board. Monthly Divisional Board scrutiny of operational and financial performance. Monthly Divisional CIP reviews. Monthly Divisional contract income and activity reviews, savings reviews. Monthly savings work stream reviews. Divisional control of vacancies and procurement monitored at monthly performance meetings. Agreed budget holders and budgetary control systems in place. Monthly review of financial performance with Divisional budget holders. Financial Control Procedures, including the scheme of delegation and Standing Financial Instructions in place. Approved Five year Medium Term Capital Programme Monthly Capital Programme Steering Group.	Detailed monthly submission of financial performance submitted to the Regulator, NHS Improvement. Strong statement of financial position. Liquidity metric of 1 (highest) and Use of Resources Rating of 1 (highest rating) for 2017/18 year to date. Regular Reporting to the Finance Committee and Trust Board. Monthly Pay Controls Group, Non Pay Controls Group and Nursing Controls Group scrutiny of Divisions performance. Rolling 5 year Medium Term Capital Programme (source and applications of funds) approved annually by the Finance Committee and Board. Monthly management scrutiny of capital expenditure at the Capital Programme Steering Group. Delivery of the 2017/18 capital programme, including the prioritisation and allocation of strategic capital.	Regular Executive and Divisional Board scrutiny and reviews form first line assurance. Reports to: • Trust Board, • Audit Committee • Finance Committee • Senior Leadership Team • Savings Board • Capital Programme Steering Group Form second line assurance Annual External audit and monthly NHS Improvement submissions of financial position forms third line assurance.	Evidence that staffing controls are weak in some areas, particularly nursing and medical staffing. Evidence that divisions are not able to deliver their agreed Operating Plans nor formulate the actions necessary to mitigate expenditure in order to deliver their agreed Operating Plan trajectories. Evidence that income and activity performance controls are weak e.g. inpatient activity planning and delivery performance. Evidence that the delivery of capital investment plans are weak.	Lack of assurance that pay expenditure controls are fully effective in light of continued spend above plan in some areas e.g. nursing and medical staffing spend. Weak assurance in Divisions given adverse positions to Operating Plans largely due to elective income underperformance and high levels of nursing and medical expenditure. Lack of assurance that activity capacity planning and income performance controls are fully effective. Lack of assurance that capital expenditure controls for operational capital and major medical equipment are fully effective.	Prioritised Executive review at Divisional Reviews. Executive Directors recently agreed a suite of actions summarised in the "Review of 2017/18 Financial Position" paper are which necessary to deliver expenditure reductions, for example: • Nursing staff; • Medical staff; • Non pay Transformation Board and productivity review process via Savings Board to identify further savings. The Trust Capital Group has been established to scrutinise delivery of capital plans and has met since November 2016.	Catastrophic x Likely = 20	↓

STRATEGIC PRIORITY 7 : We will ensure we are soundly governed and are compliant with the requirements of our regulators								
Operational Plan 2017/19 Focus	**3.1.4 Access standards** • Improving performance and delivery of our performance trajectories in the four core standards.							
Executive Lead - Chief Executive	**Assuring Committee - Trust Board**							
Principal Risk description	**Key Controls**	**Form of Assurance**	**Level of Assurance**	**Gaps in controls**	**Gaps in assurance**	**Actions Agreed for any gaps in controls or assurance**	**Current Risk Rating**	**Direction of travel**
Risk of failing to comply with targets, statutory duties and functions	Trust Board and all committees have an annual forward plan aligned to their terms of reference, Trust's Standing Orders and Standing Financial Instructions to ensure appropriate annual reporting against plans is in place. Monitoring of CQC inspection action plans via Clinical Quality Group, Senior Leadership Team, QOC.	Annual Report, Annual Governance Statement, and Annual Quality Report, Annual Account submitted to Trust Board. Regular reporting to NHS Improvement following Board approval. NHS Improvement returns signed off by the Trust Board. Internal Audit Reports on Governance, risk management and financial accounts reported to Audit Committee. Self-assessment. Monthly Board Reports. Performance and Finance Reports at each Board Meeting. Committee Reports at each Board Meeting. Independent reports from CQC on Inspection Visits.	Regular reviews form first line assurance. Reports to: • Trust Board, • Quality & Outcomes Committee • Audit Committee • Risk Management Group Form second line assurance CQC Inspection Report provides third level assurance into areas inspected.	No significant gaps	Partial assurance of effectiveness of controls, in light of on-going failure of some standards. Insufficient assurance that preparation for implementation of General Data Protection Regulations is adequate.	GDPR working group formed to address gaps in systems and processes.	**Moderate x Possible = 9**	↔

Appendix 2: Links to the Corporate Risk Register

Strategic Objective	Principal Risk	Corporate Risk Register	Risk Ranking
STRATEGIC PRIORITY 1: We will consistently deliver high quality individual care, delivered with compassion.	**Risk that the Trust will be unable to maintain the quality of patient services.**	**423** - Risk that length of stay does not reduce in line with planning assumptions resulting in an increase in bed occupancy. **856** - Risk that the emotional & Mental Health needs of children and young people are not being fully met. **949** - Risk that perinatal mental health services are not adequate to the needs of those requiring to access the service. **1595** - Risk that patients detained under s136 may be brought to ED due to lack of capacity in community provision **1598** - Risk of Patients Falls Resulting in Harm. **2037** - Risk of delayed care and decision making to patients due to difficulty accessing external images **2198** - Risk that patients may fail to receive timely test results and treatment due to new clauses within National Hospital Contract	**9** **High**
STRATEGIC PRIORITY 2: We will ensure a safe, friendly and modern environment for our patients and our staff.	**Risk that the Trust will be unable to develop and maintain the Trust estate due to lack of funding**	**1843** -Risk of failing to achieve the Trust's 2017/18 Operational Plan Control Total surplus (SP6)	**12** **High**
STRATEGIC PRIORITY 3: We will strive to employ the best staff and help all our staff fulfil their individual potential**.**	**Risk that the Trust will be unable to recruit, train and sustain an engaged and effective workforce.**	**422** - Potential harm to staff and patients from violent and aggressive behaviour from patients or members of the public **674** - Risk of increased agency spend due to significant non-compliance with national agency caps. **737** - Risk of continuity of service due to inability to recruit sufficient numbers of substantive staff **793** - Risk of work related stress affecting staff across the organisation. **920** - Risk of Non-compliance with both the New Deal and junior doctors contract requirements **921** - Risk of not achieving 90% compliance for Essential Training for all Trust staff.	**12** **High**
STRATEGIC PRIORITY 4: We will deliver pioneering and efficient practice, putting ourselves at the leading edge of research, innovation and transformation.	**Risk that the Trust will not be able to support transformation and innovation and that the Trust will not be able to embed research and teaching into the care we provide, and develop new treatments for the benefit of patients and the NHS.**	No corporate risks identified.	**9** **High**
STRATEGIC PRIORITY 5: We will provide leadership to the networks we are part of, for the benefit of the region and people we serve.	**Risk of failing 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.**	**1640** - Risk of poorer quality service for patients due to delays with reporting of histology samples following service transfer.	**6** **Moderate**
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.	**Risk of being unable to deliver the 2017/18 financial plan.**	**416 -** Risk that the Trust's Financial Strategy may not be deliverable **951** - Risk of the loss of Sustainability and Transformation Funding (STF) **959 -** Risk that Trust does not Deliver the operational plan due to Divisions not achieving their current year savings target **1843** -Risk of failing to achieve the Trust's 2017/18 Operational Plan Control Total surplus	**20** **Very High**
STRATEGIC PRIORITY 7: We will ensure we are soundly governed and are compliant with the requirements of our regulators.	**Risk of failing to comply with targets, statutory duties and functions**	**801 -** Risk that the Trust does not maintain a GREEN single oversight framework Rating **869 -** Risk of Reputational Damage Arising From Adverse Media Coverage of Trust Activities **2242** - Risk that the Trust will be non-compliant with statutory requirements in relation to water safety (HTM 04-01 & ACoP L8) **2303** - Risk of Non-compliance with European General Data Protection Regulations (GDPR)	**9** **High**

University Hospitals Bristol
NHS Foundation Trust

Cover report to the Public Trust Board Meeting to be held on 31 January 2018 at 10.00 – 12.30 in the Conference Room, Trust HQ

		Agenda Item	8
Meeting Title	Trust Board	**Meeting Date**	Wednesday, 31 January 2018
Report Title	**Board Quality and Performance Report**		
Author	James Rabbitts, Head of Performance Reporting Anne Reader, Head of Quality (Patient Safety) Matt Joint, Director of People		
Executive Lead	Overview and Access – Mark Smith, Deputy Chief Executive and Chief Operating Officer Quality – Carolyn Mills, Chief Nurse Workforce – Matt Joint, Director of People		
Freedom of Information Status		Closed	

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
<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** report for Assurance

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

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

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

Impact Upon Corporate Risk

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

Date papers were previously submitted to other committees				
Audit Committee	**Finance Committee**	**Quality and Outcomes Committee**	**Remuneration & Nomination Committee**	**Other (specify)**
		29 January 2018		

University Hospitals Bristol NHS
NHS Foundation Trust

Quality & Performance Report

January 2018

Executive Summary

Single Oversight Framework

- The 62 Day Cancer standard for GP referrals achieved 88.4% for November (national target 85%). Commissioners have agreed the Trust's remedial action plan and recovery trajectory which aims to sustain 85% from March 2018. The recovery trajectory has been met and exceeded throughout the quarter.
- The measure for percentage of A&E patients seen in less than 4 hours was 85.3% for December and Quarter 3 achieved 88.6%. This did not achieve the Sustainability and Transformation Fund (STF) target of 90% or the national 95% standard for UHBristol performance alone
- When UHBristol A&E performance is uplifted by the apportionment of local Walk In Centres (as published by NHS England), the Trust achieved 92.8% and so achieved the STF target of 90%.
- The percentage of Referral To Treatment (RTT) patients waiting under 18 weeks was 88.9% as at end of November. This did not achieve the national 92% standard or the recovery trajectory. Total numbers waiting and numbers waiting over 18 weeks remain above last year's levels. Early sight for January is holding at 88% against a back drop of winter pressures and elective cancellations. For end of April 2018 we plan to deliver compliance of the 92% standard.
- The percentage of Diagnostic patients waiting under 6 weeks at end of December was 97.6%. This did not achieve the national 99% standard. The current recovery trajectory (of having fewer than 242 patients waiting 6+ weeks) was achieved. The recovery trajectory now delivers 99% performance by April 2018, in light of recovery plans being developed to improve the position in Sleep Studies, Cardiac Computed Tomography (CT) Scans, Non-obstetric ultrasound and Paediatric Magnetic Resonance Imaging (MRI) scans.

Headline Indicators

Performance against Clostridium difficile Cases, Omitted Doses Medication Errors and Patient Experience remain consistently above target. The Deteriorating Patient measure (Early Warning Scores) dipped below the 95% level in October and November but has risen to 97% in December. Volumes are small and this measure has not fallen below the RED threshold of 90% all year. The Safety Thermometer measure of New Harms and Heart Reperfusion measure (90 minute "Door To Balloon Time) have been achieved consistently since September. In December, falls per 1,000 beddays remained below the red threshold of 5.0 following a small deterioration in September.

Last Minute Cancelled (LMC) Operations remains above the required threshold of 0.8% of admissions, with 71 such cancellations in December. Also the 28 day readmission standard of 95% was not in December (94.1% - 5 patients not re-admitted within 28 days).

In relation to Flow metrics, the number of beddays spent outlying (730) exceeded the maximum planned threshold of 705. Also, the total number of Green to Go (delayed discharge) patients in hospital remains over double the jointly agreed planning assumption of 30 patients.

In the Workforce measures, percentage Agency Usage was below the 1.0% target in December, at 0.8%. Agency usage reduced by 10.4 whole time equivalents (wte), with the largest divisional reduction seen in Women's & Children's, which reduced by 46%. Further reductions have been seen in Nursing & Midwifery usage this month and it remains the lowest it has been for over three years. However the other key measures remain Red or Amber rated this month. Sickness levels fell slightly to 4.1%, Vacancy levels rose slightly to 5.2% and Turnover rose to 13.4%.

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	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

A&E 4 Hours
The national standard is for 95% of A&E patients to be discharged or admitted within 4 hours of arrival. This standard was not achieved in Quarter 3. The Sustainability & Transformation Funds (STF) trajectory of 90% was not achieved either for the quarter, although it was achieved in October and November.

A&E 4 Hours (Trust "Footprint")
In agreement with NHS England and NHS Improvement, each Acute Trust was apportioned activity from Walk In Centres and Minor Injury Units in their region. For UHBristol this was the Bristol, North Somerset and South Gloucestershire (BNSSG) region. The result of this apportionment was carried out and published by NHS England as "Acute Trust Footprint" data. This data is being used to assess whether a Trust achieved the STF target for Quarter 3. UHBristol's performance after apportionment was 92.8%. So, for the purposes of assessing achievement at national level, the Trust has achieved the STF target of 90% for Quarter 3.

Cancer 62 Day
The national standard is for 85% of cancer patients to begin first treatment within 62 days of urgent referral from GP. This standard was achieved in November and the Quarter to date (October and November) is achieving the standard at 86.4%.

Referral To Treatment (RTT)
The national standard is to have 92% of patients on a Referral to Treatment (RTT) Pathway waiting under 18 weeks at month-end. This standard was not achieved in December and was achieved for Quarter 3. The STF trajectory is also at 92% so was not achieved.

Diagnostic 6 Week Wait
The national standard is to have 99% of patients waiting for one of 15 "key diagnostic tests" to be waiting under 6 weeks at month-end. This standard was not achieved in December. The STF trajectory is also at 99% so was not achieved. The Trust's recovery trajectory was to have fewer than 242 patients waiting over 6 weeks, which was achieved with 203 patients waiting 6+ weeks.

Access Key Performance Indicator		Quarter 1 2017/18			Quarter 2 2017/18			Quarter 3 2017/18		
		Apr 17	May 17	Jun 17	Jul 17	Aug 17	Sep 17	Oct 17	Nov-17	Dec-17
A&E 4-hours	Actual	82.3%	84.2%	87.9%	90.5%	91.3%	90.8%	90.1%	90.3%	85.3%
	Trust "Footprint"							92.8%		
	STF trajectory	82.5%	83.5%	85.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%
62-day GP cancer	Actual	76.5%	77.8%	81.7%	74.7%	85.2%	80.2%	84.1%	88.4%	
	STF trajectory	81.0%	81.0%	81.0%	83.6%	83.6%	83.6%	82.5%	82.5%	
Referral to Treatment Time (RTT)	Actual	91.1%	91.1%	91.0%	90.2%	89.9%	89.4%	90.0%	88.9%	88.3%
	STF trajectory*	92.0%	92.0%	92.0%	92.0%	92.0%	92.0%	92.0%	92.0%	92.0%
6-week wait diagnostic	Actual	98.6%	98.8%	98.6%	98.5%	97.6%	97.7%	98.2%	98.3%	97.6%
	STF trajectory*	99.0%	99.0%	99.0%	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:

AMBER to GREEN:
Deteriorating Patient

AMBER to RED
Dissatisfied Complaints
A&E 4 Hours
Turnover

GREEN to RED
Outliers

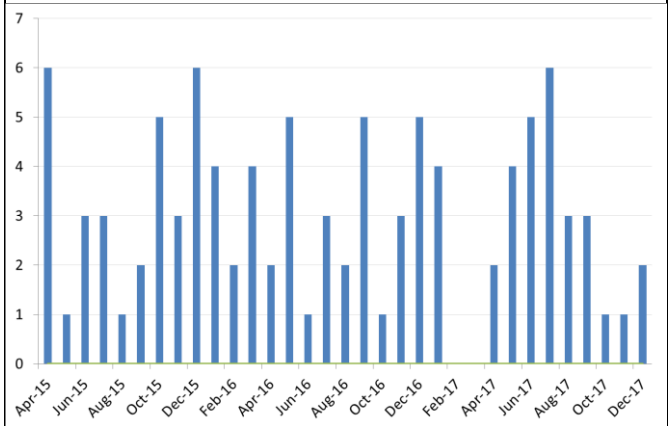
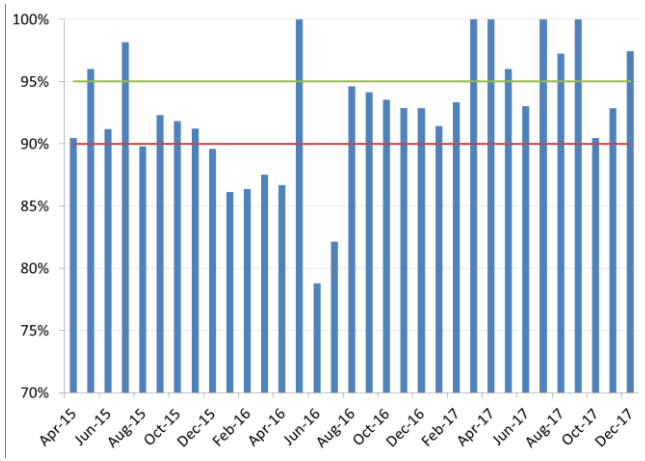
RED to GREEN
Length of Stay

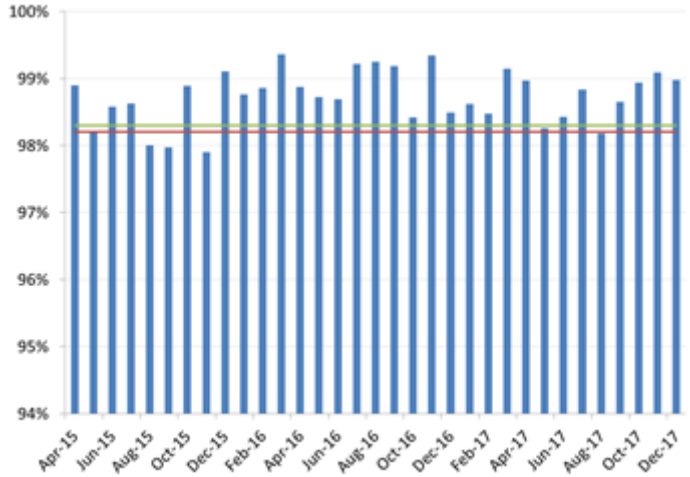
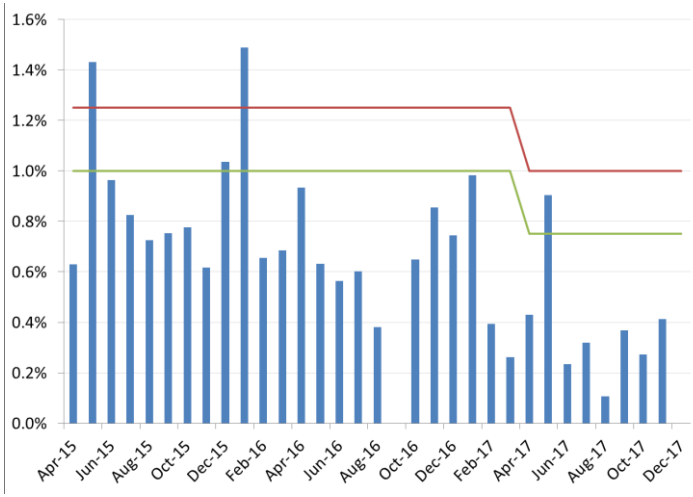
Overview

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

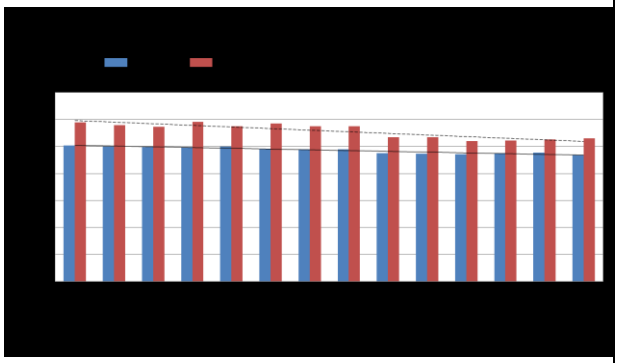
Successes	Priorities
• When the Trust's A&E 4 hour performance is uplifted by the apportionment of local Walk In Centres (as published by NHS England), the Trust achieved 92.8% for Quarter 3 and so achieved the Sustainability & Transformation Funds (STF) target of 90%. • In December 2017 there were no non-purposeful omitted doses of listed critical medication (0%). This is the first time this has been achieved since September 2016. • New functionality in Medway 4.8 allows better management of on-hold status flags by removing the previous on hold status flag when the next activity has been undertaken. This does not mitigate the risk of on hold patients being added to Medway. • The weekly performance meetings launched on 20th December which targets sub- speciality performance monitoring, target setting and forecasting for 6 weeks in advance. • 88.3% was the submitted RTT position for December, early sight for January is holding at 88% currently against a back drop of winter pressures and elective cancellations. • Recovery trajectory for 62 day GP performance has been met and exceeded in every month since it was established in July 2017, including the national target having been met in two of the five months • 4 of the 7 major cancer standards consistently being achieved at a monthly and quarterly level • Trust awarded £8k STP grant towards implementation of the Making Every Contact Count (MECC) programme for a potential roll out from spring 2018. • Performance was within target for both external and internal recruitment. • Nurse agency fill has not deteriorated with the implementation of the new neutral vendor contract arrangements or despite significant operational pressures across the healthcare system.	• Restore achievement of the 92% Referral to Treatment national standard at end of April 2018 (new trajectory figures for Divisions will be agreed at end of January). • Additional pathway sampling is currently underway to test the original Referral To Treatment business rules that were applied at switch-on 17th November 2017. This is necessary to check correct application of the new business rules. • Focus continues on clearing of long waiters breaches and clearing in the RTT backlog, particularly in Pediatric Services and Dentistry services • Roll-out of Chronological bookings report to Divisions to focus on better management when dating patients • Develop a strategy for revisiting and cleaning the legacy on-hold status flags within Medway – commence in January 2018. Cohorts have now been identified for review, sampling of key issue areas has commenced with validation already in place. Timelines will be agreed once all of the cohorts have been sampled and risks have been identified. • 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. • Sustain A&E 4 hour performance particularly at the Bristol Royal Infirmary, given operational winter pressures. • Minimise surgical cancellations of cancer patients and take actions to recover quickly when cancellations occur. • The Executive Board have agreed for the Trust to sign the Time to Change Employer Pledge and commence delivery of an accompanying workplace mental health action plan on Time to Talk Day on 1 February 2018. • Implementation of new Supporting Attendance Policy targeted for 1st March 2018.

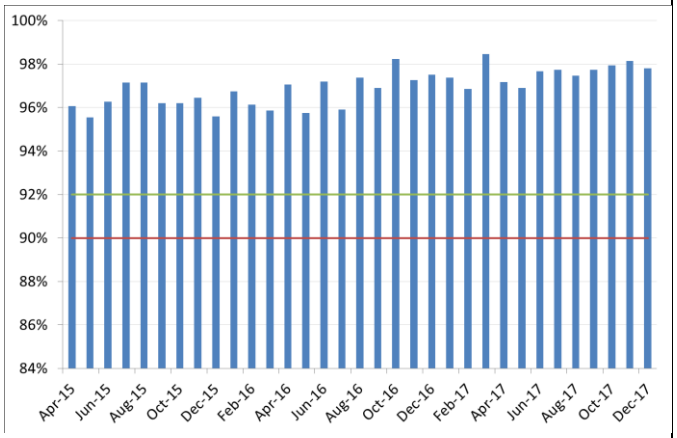
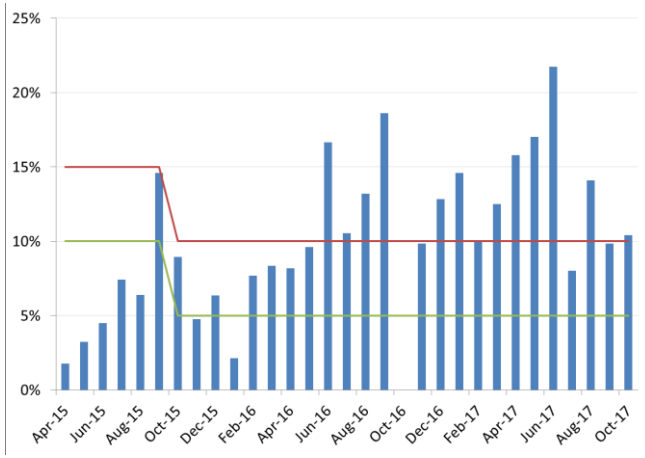
Opportunities	Risks & Threats
• System C (our Patient Administration System supplier) has made us aware of additional Medway functionality, including something that could be used to reduce the risk of patients not being added to the waiting list following a decision to list at outpatients (which otherwise can result in patients' procedures being delayed and patients waiting over 52 weeks). • 52 week position at the end of December has resulted in 9 remaining patients that have decided to take dates beyond the end of December time line (patient choice). • Avoiding cancellation is the single most important high impact action for the Trust to improve and sustain performance against the cancer standards. • A 'virtual PTL' (waiting list meeting) is being set up with referring providers to discuss shared cases and potential new referrals. A planning meeting was held in early January with a further meeting on 24th January and launch in w/c 29th January. • Workplace Wellbeing team to collaborate and input to Public Health teams overseeing implementation of a new 10-year mental health programme (Bristol Thrive) and Bristol Healthy Weight strategy to maximise opportunities for health promotion to colleagues. • Initial steps and plans underway to create a medical locum bank within the Temporary Staffing Bureau. To be fully operationalised in 2018/19.	• In December 2017 the figure for fracture neck of femur patients achieving best practice tariff was 24.2% (8 out of 33). This is the lowest reported figure since April 2015. • In December 2017 there were five patient falls resulting in moderate or a higher level of harm, all of which are currently subject to serious incident investigations. • The percentage of patients received VTE risk assessments and appropriate thrombo-prophylaxsis has reduced in recent months. The reduction in VTE risk assessments has been seen across all bed-holding divisions. A new medical VTE lead is being sought and a ward round checklist (which includes VTE) is being tested as part of a junior doctor QI project. • Focused review of the on-hold patients will continue and will be expanded as the risks identified during the process are likely to increase. • Although the new functionality in Medway 4.8 allows better management in the on-hold status flags this does not remove the on-hold backlog. This will be monitored and addressed on a weekly basis at the RTT Performance meeting to prevent a further backlog being created. Update from 17th January meeting: Divisions provided with details of patients with an on-hold status with the remit of ensuring that no patient has an on-hold status for longer than 2 months. • Late referrals from other providers continue to impact on achievement of the 62-day GP cancer waiting times standard. • Deterioration of number of overnight outliers (patients not on a suitable specialty ward). • Surgical cancellations are a high risk to achievement of several cancer standards as well as to patient experience and quality. These are being incurred again this January due to operational pressures and knock on capacity impact is being seen in particular for patients with cancer whose operations exceeded half a day. • PET scanning service (provided by a private provider, at commissioners' choice) leading to delays and patient dissatisfaction due to poor referral processes and shortages of administration/call centre staff • Continued system issues with E-Appraisal resulting in delays in completion and complexity in reporting. • Contractual requirements of the 2016 Junior Doctor Contract are not being fulfilled in the absence of a robust e-rostering system.

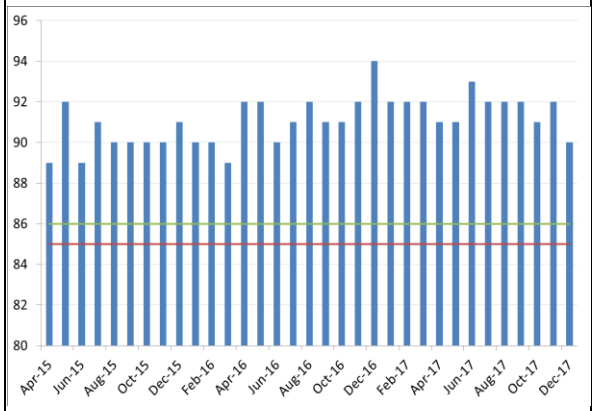
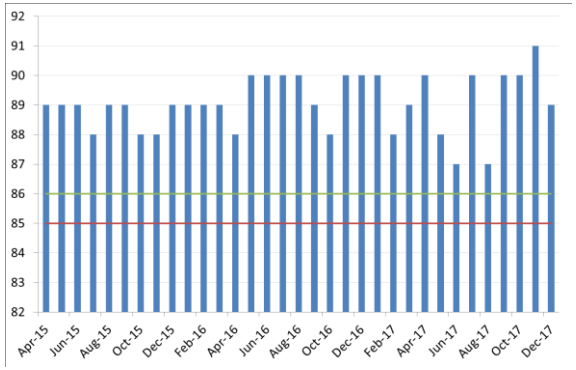
Description	Current Performance	Trend	Comments
Infection control The number of hospital-apportioned cases of Clostridium difficile infections. The Trust limit for 2016/17 is 45 avoidable cases of clostridium difficile (the same as 2015/16).	Performance in Trust acquired Clostridium *difficile* (C. diff) is good with low numbers of cases in relation to the limits set. There were two cases of C. diff attributed to the Trust in December 2017. However, these cases are awaiting review by the CCG therefore these may have been unavoidable so may not be included within the limit. To date, this year, we have three hospital apportioned avoidable cases of clostridium difficile.	**Total number of C. diff cases** 	Monthly meetings between the infection control team and Clinical Commissioning Group (CCG) aim to review all cases of clostridium difficile and apportion these appropriately. There is a time delay for these meetings and therefore Trust attributed cases may not be agreed for some time after the infection was identified. There are higher rates of clostridium difficile within three ward areas. A business case is currently under review to trial screening on admission within these three wards to identify the appropriate source of the infection.
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 December 2017 was 97% (one breach) against a three-year improvement goal of 95%. The breach occurred within the Division of Specialised Services and occurred due to the observations not being consistently recorded. The patient was escalated to the medical team but actions taken were not recorded in the patient's notes. The patient came to no harm.	**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.

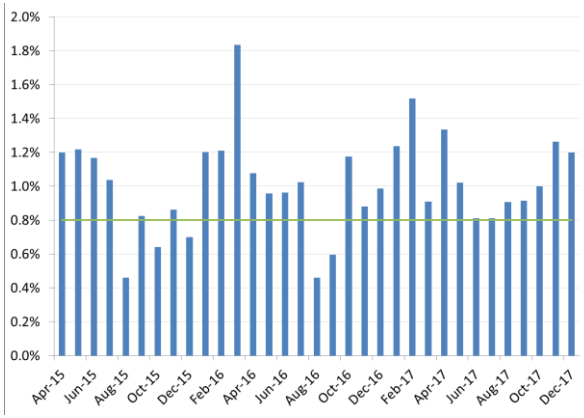
Description	Current Performance	Trend	Comments
Safety Thermometer – No new harm. The NHS Safety Thermometer comprises a monthly audit of all eligible inpatients for 4 types of harm: pressure ulcers, falls, venous-thromboembolism and catheter associated urinary tract infections. New harms are those which are evident after admission to hospital.	In December 2017, the percentage of patients with no new harms was 99 % (8 patients had new harms), against an upper quartile target of 98.3% (GREEN threshold) of the NHS Improvement patient safety peer group of Trust.	**The percentage of patients surveyed showing No New Harm each month** 	The December 2017 Safety Thermometer point prevalence audit showed three new catheter associated urinary tract infections, no falls with harm, two new pressure ulcer and three new venous thrombo-emboli.
Non-purposeful omitted doses of listed critical medicines Monthly audits by pharmacy incorporate a review of administration of critical medicines: insulin, anti-coagulants, Parkinson's medicines, injected anti—infectives, anti-convulsants, short acting bronchodilators and 'stat' doses.	In December 2017, none of the 613 patients reviewed 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 % for December 2017 is an improvement from the November 2017 figure of 0.41% (3 out of 728).	**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%).

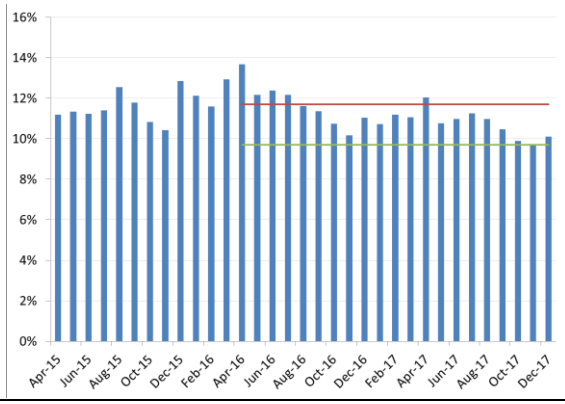
<table>
<tr><th>Description</th><th>Current Performance</th><th>Trend</th><th>Comments</th></tr>
<tr>
<td>Essential Training measures the percentage of staff compliant with the requirement for core essential training. The target is 90%</td>
<td>Overall compliance is 89% (excluding Child Protection Level 3). Compliance with each of the reporting categories is provided below.

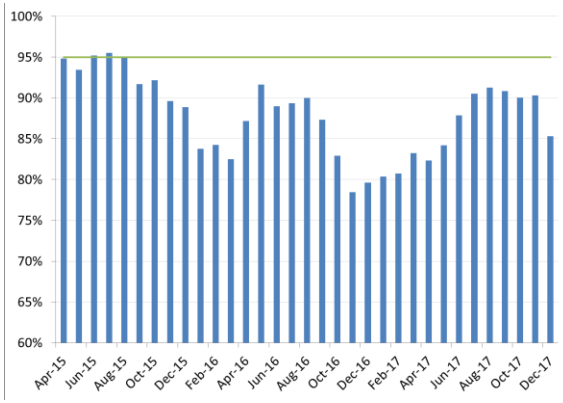
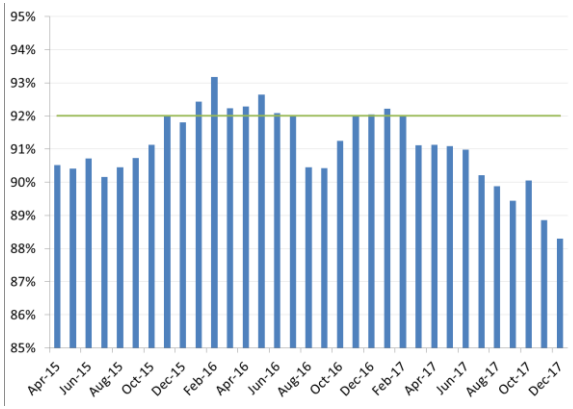
<table>
<tr><th>December 2017</th><th>UH Bristol</th></tr>
<tr><td>Total</td><td>89%</td></tr>
<tr><td>Three Yearly (14 topics)</td><td>87%</td></tr>
<tr><td>Annual (Fire)</td><td>87%</td></tr>
<tr><td>Annual (IG)</td><td>82%</td></tr>
<tr><td>Induction & Orientation</td><td>97%</td></tr>
<tr><td>Doctors induction</td><td>58%</td></tr>
<tr><td>Resuscitation</td><td>84%</td></tr>
<tr><td>Safeguarding</td><td>87%</td></tr>
</table>
</td>
<td>Overall the compliance for the Trust has reduced in comparison to last month.</td>
<td>See Appendix 1 to see action.</td>
</tr>
<tr>
<td>Nurse staffing levels unfilled shifts reports the level of registered nurses and nursing assistant staffing levels against the planned.</td>
<td>The report shows that in December 2017 the Trust had rostered 239,345 expected nursing hours, with the number of actual hours worked of 232,536. This gave a fill rate of 97%.
<table>
<tr><th>Division</th><th>Actual Hours</th><th>Expected Hours</th><th>Difference</th></tr>
<tr><td>Medicine</td><td>66,331</td><td>63,082</td><td>+3250</td></tr>
<tr><td>Specialised Services</td><td>40,265</td><td>40,842</td><td>-577</td></tr>
<tr><td>Surgery</td><td>44,585</td><td>44,518</td><td>+67</td></tr>
<tr><td>Women’s & Children’s</td><td>81,356</td><td>90,903</td><td>-9548</td></tr>
<tr><td>Trust</td><td>232,537</td><td>239,345</td><td>-6808</td></tr>
</table>
.
</td>
<td>The percentage overall staffing fill rate by month
  </td>
<td>Overall for the month of December 2017, the Trust had 93% cover for Registered Nurses (RN) on days and 94% RN cover for nights. The unregistered level of 102% for days and 112% for nights reflects the activity seen in December 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</td>
</tr>
</table>

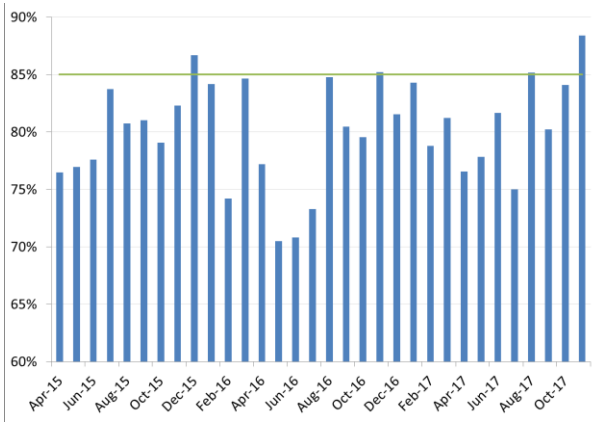
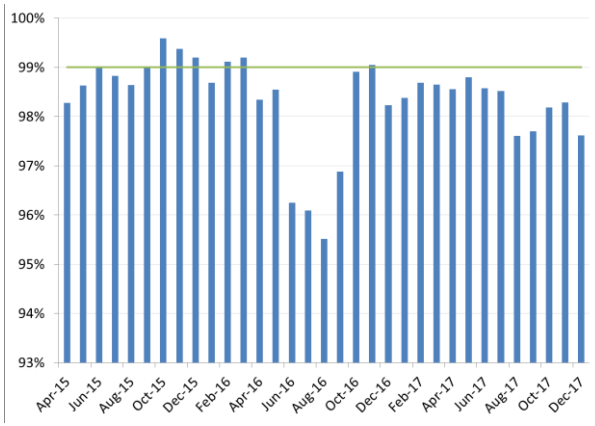
Description	Current Performance	Trend	Comments
Friends & Family Test inpatient score is a measure of how many patients said they were 'very likely' to recommend a friend or family to come to the Trust if they needed similar treatment. The scores are calculated as per the national definition, and summarised at Division and individual ward level.	Performance for December 2017 was 97.8%. 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. Note there is an Amber threshold between 5% and 10%	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 October 2017. As of 12th January 2017, 7 of the 67 responses sent out in October had resulted in dissatisfied replies (10.4% 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). 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 5D).

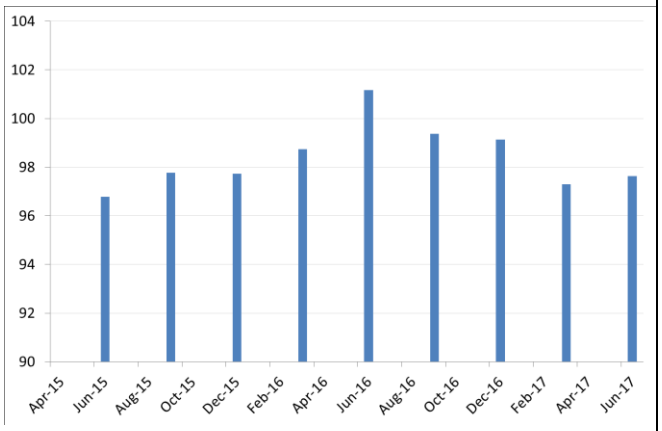
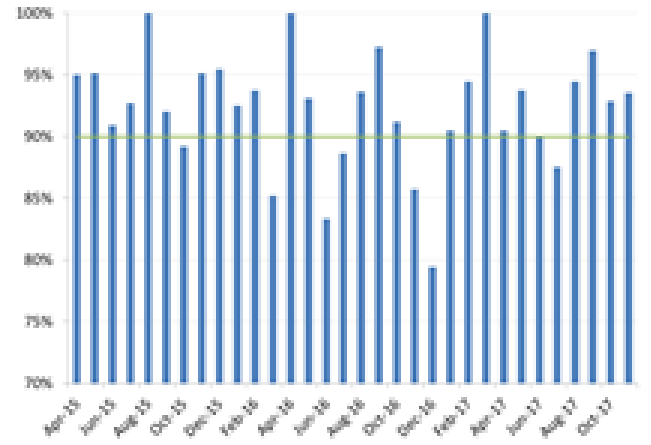
Description	Current Performance	Trend	Comments
Inpatient experience tracker comprises five questions from the monthly postal survey: ward cleanliness, being treated with respect and dignity, involvement in care decisions, communication with doctors and with nurses. These were identified as "key drivers" of patient satisfaction via analysis and focus groups.	For the month of December 2017, the score was 90 out of a possible score of 100. Divisional level scores are provided on a quarterly basis to ensure sample sizes are sufficiently reliable. Trust: Quarter 2 2017/18: 92; Quarter 3 2017/18: 91 Medicine: 89; 88 Surgery: 91; 93 Specialised Services: 92; 91 Women's & Children's (Children's Hospital): 94; 91 Women's & Children's (Postnatal wards): 94; 91	**Inpatient patient experience scores (maximum score 100) each month** 	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.
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.	The score for the Trust as whole was 89 in December 2017 (out of score of 100). Divisional scores for quarter 3 are provided as numbers of responses each month are not sufficient for a monthly divisional breakdown to be meaningful. Trust: Quarter 2 2017/18: 89; Quarter 3 2017/18: 90 Medicine: 88; 91 Specialised Services: 88; 88 Surgery: 88; 89 Women's & Children's (Children's Hospital): 86; 87 Diagnostics & Therapies: 93; 95	**Outpatient Experience Scores (maximum score 100) each month** 	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. The score for Bristol Royal Hospital for Children was red-rated in July, but recovered to 86 in August (green-rated and BRHC's best score since April).

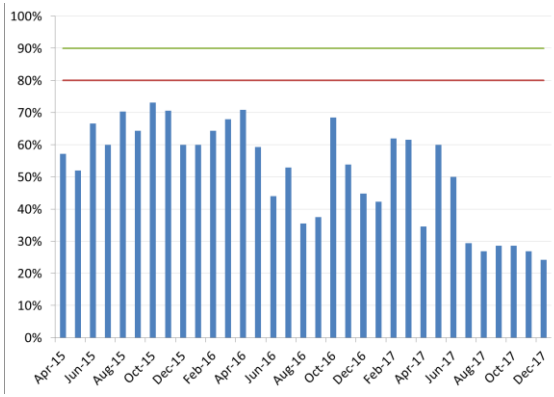
<table>
<tr><th>Description</th><th>Current Performance</th><th>Trend</th><th>Comments</th></tr>
<tr>
<td>Last Minute Cancellation is a measure of the percentage of operations cancelled at last minute for non-clinical reasons. The national standard is for less than 0.8% of operations to be cancelled at last minute for reasons unrelated to clinical management of the patient.</td>
<td>In December the Trust cancelled 71 (1.2%) 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 Beds Available</td><td>12</td></tr>
<tr><td>Other Emergency Patient Prioritised</td><td>11</td></tr>
<tr><td>AM List over-ran</td><td>10</td></tr>
<tr><td>No HDU Beds</td><td>10</td></tr>
<tr><td>No CICU Beds</td><td>4</td></tr>
</table>
Of the 85 patients cancelled in November, 5 were not readmitted within 28 days. Meaning 94.1% were re-admitted within 28 days. This means the Trust just missed the former national standard of 95%.</td>
<td>Percentage of operations cancelled at last-minute
 
</td>
<td>Deterioration in performance in month. Concern continues to be around the availability of HDU capacity to support complex surgery and ongoing operational pressures during January.
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 December 10.1% 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 (December 2016 was 11%)

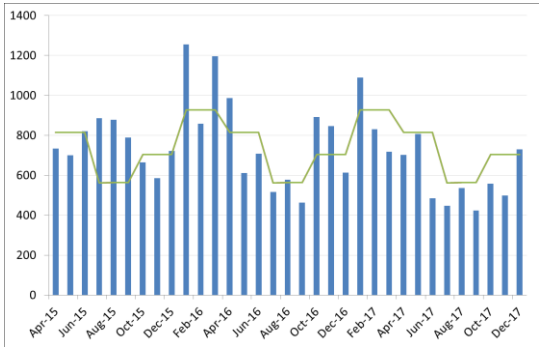
Please note: the RED and GREEN thresholds have been revised for 2017/18, with the Green threshold representing a 2% improvement on 2015/16, and the RED threshold being the same average performance in 2015/16 of 11.7%.</td>
<td>Percentage of outpatient appointments cancelled by the hospital
 
</td>
<td>Cancellation 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 Trust achieved 85.3% in December which is below both the national standard (95%) and the recovery trajectory (90%). Performance and activity levels for the BRI and BCH Emergency Departments are shown below.
<table>
<tr><th>BRI</th><th>Oct 2017</th><th>Nov 2017</th><th>Dec 2017</th></tr>
<tr><td>Attendances</td><td>6288</td><td>5782</td><td>5843</td></tr>
<tr><td>Patients managed < 4 hours</td><td>5289
84.1%</td><td>5101
88.2%</td><td>4513
77.2%</td></tr>
<tr><th>BCH</th><th>Oct 2017</th><th>Nov 2017</th><th>Dec 2017</th></tr>
<tr><td>Attendances</td><td>3629</td><td>3997</td><td>3617</td></tr>
<tr><td>Patients managed < 4 hours</td><td>3496
96.3%</td><td>3659
91.5%</td><td>3348
92.6%</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 in Quarter 2. The Children's Hospital 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. Some risk remains around sustaining this performance based on a recent pattern of increase in minors.</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 December, with performance reported at 88.3%. The 52 week trajectory resulted in 9 remaining waiters at the end of December due to patients who opted to exercise their right to patient choice and decline dates offered.
<table>
<tr><th></th><th>Oct</th><th>Nov</th><th>Dec</th></tr>
<tr><td>Numbers waiting > 40 weeks RTT</td><td>155</td><td>136</td><td>158</td></tr>
<tr><td>Numbers waiting > 52 weeks RTT</td><td>10</td><td>13</td><td>9</td></tr>
</table>
</td>
<td>Percentage of patients waiting under 18 weeks RTT by month
 
</td>
<td>Performance against the RTT standard is currently at 88.3% this indicates we are 1032 patients away from the national compliance of 92%. Early sight for January is holding at 88% against a back drop of winter pressures and elective cancellations. For end of April 2018 we plan to deliver compliance of the 92% standard, which will be updated as we progress across the winter pressure period.</td>
</tr>
</table>

Description	Current Performance	Trend	Comments
Cancer Waiting Times are measured through eight national standards. These cover a 2-week wait to see a specialist, a 31 day wait from diagnosis to treatment, and a 62-day wait from referral to treatment. There are different standards for different types of referrals, and first and subsequent treatments.	November's performance against the 62 day standard was 88.4% against a national standard of 85% and a recovery trajectory of 79%. Only 1 breach was deemed potentially avoidable. December's performance is forecast to meet the recovery trajectory, with a drop from November mainly due to the lower activity in month January's performance is at risk from cancellations and impact on capacity.	**Percentage of patients treated within 62 days of GP Referral** 	The recovery trajectory has been met and exceeded throughout the quarter. 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. The Trust is setting up a 'virtual PTL' (waiting list meeting) with referring providers – this has reduced late referrals in other providers. See Actions 10A-10J in Improvement Plans section for more details
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.	Performance was 97.62% at end of December, which is below the 99% national standard. The recovery trajectory of fewer than 190 patients waiting 6+ weeks was achieved. The number of over 6-week waiters at month-end is: **Diagnostic test / Nov / Dec** MRI 42 34 Sleep 65 71 Endoscopies 10 8 CT 32 22 Echo 1 0 Ultrasound 0 63 Other 0 5 **TOTAL 150 203** Percentage **98.3% 97.6%**	**Percentage of patients waiting under 6 weeks at month-end** 	November needed to have under 85 breaches to achieve 99%; whereas there were 203 as at end of December. The main areas that are not delivering are Paediatric MRI, Adult Cardiac CT, Sleep Studies and Non-obstetric ultrasound. The Trust is committed to a return to 99% performance by April 2018. See Actions 11A-11D in Improvement Plans section

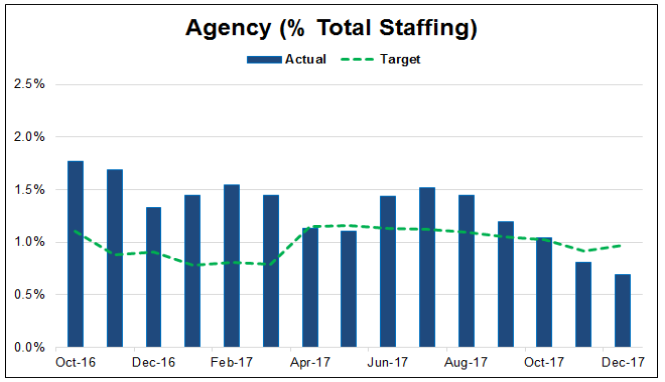
Description	Current Performance	Trend	Comments
Summary Hospital Mortality Indicator is the ratio of the actual number of patients who died in hospital or within 30 days of discharge and the number that were 'expected' to die, calculated from the patient case-mix, age, gender, type of admission and other risk factors. This is nationally published quarterly, six months in arrears.	Summary Hospital Mortality Indicator (SHMI) for June 2017 was 97.6 This statistical approach estimates that there were 41 fewer actual deaths than expected deaths in the 12-month period up to June 2017	**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 November, 29 out of 31 patients (93.5%) 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 92.4%	**Percentage of patients with a Door to Balloon Time < 90 minutes by month** 	There was a slight dip in performance in July but year to date remains above the 90% target and performance recovered to above 90% from August.

<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 December 2017 performance was 24.2% (8/33 patients) for overall Best Practice Tariff (BPT), against the national standard of 90%. The time to theatre within 36 hours performance was 48.5% (16/33 patients).
<table>
<tr><th>Reason for not going to theatre within 36 hours</th><th>Number of patients</th></tr>
<tr><td>Patients not operated on within the 36 hour timeframe due to other urgent trauma cases being prioritised</td><td>13</td></tr>
<tr><td>Patient required medical optimisation before proceeding to surgery.</td><td>1</td></tr>
<tr><td>Patient required a specialist surgeon to undertake the procedure</td><td>3</td></tr>
</table>
</td>
<td>Percentage of patients with fracture neck of femur who met best practice tariff
 
</td>
<td>Thirteen patients also did not receive any ortho-geriatrician review due to annual leave, and clinician having to provide cover for Older Person Assessment Unit.

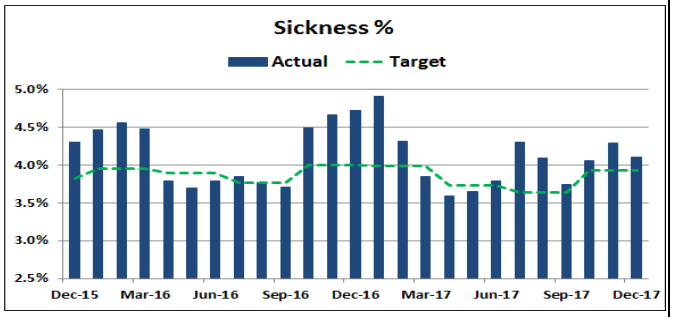
Actions are being taken to establish a future service model across Trauma & Orthopaedics, and ensure that consistent, sustainable cover is provided (Actions 12A to 12D).</td>
</tr>
<tr>
<td>Outlier bed-days is a measure of how many bed-days patients spend on a ward that is different from their broad 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 December 2017 there were 730 outlier bed-days against a target of 704 outlier bed-days.
<table>
<tr><th>Outlier bed-days</th><th>December 2017</th></tr>
<tr><td>Medicine</td><td>411</td></tr>
<tr><td>Surgery</td><td>216</td></tr>
<tr><td>Specialised Services</td><td>94</td></tr>
<tr><td>Women's & Children's Division</td><td>6</td></tr>
<tr><td>Diagnostics and Therapies</td><td>3</td></tr>
<tr><td>Total</td><td>730</td></tr>
</table>
</td>
<td>Number of days patients spent outlying from their specialty wards
 
</td>
<td>The quarter three target has been set at 704 bed days per month and this was achieved in October and November, but not in December. However the average number of outliers each month is below 704, at 596 beddays on average.
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 10.4 FTE, with the largest divisional reduction seen in Women's & Children's, which reduced by 45.9% (14.7 FTE). Further reductions have been seen in Nursing & Midwifery usage this month (reduced by 12.6 FTE), and it remains the lowest it has been for over three years.	Agency usage as a percentage of total staffing by month.	A summary of compliance with agency caps is attached in Appendix 2. See action 14 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 4.3% to 4.1%, with the only Divisional increase seen in Facilities and Estates. Stress/Anxiety remains the biggest reason for sickness, although absence as a result of this has reduced by 5.2% compared with last month. Sickness due to cold/cough/flu continues to increase, although at a lesser rate compared with last month (6.9%, compared with 9.1%).	**Sickness absence as a percentage of full time equivalents by month**	See Appendix 2, action 15 for the sickness action plan.

December 2017	FTE	Actual %	KPI
UH Bristol	**59.6**	**0.7%**	**1.0%**
Diagnostics & Therapies	3.7	0.4%	0.6%
Medicine	16.3	1.3%	1.3%
Specialised Services	2.0	0.2%	1.6%
Surgery	6.1	0.3%	0.9%
Women's & Children's	17.4	0.9%	0.5%
Trust Services	10.1	1.3%	1.6%
Facilities & Estates	4.0	0.5%	0.9%



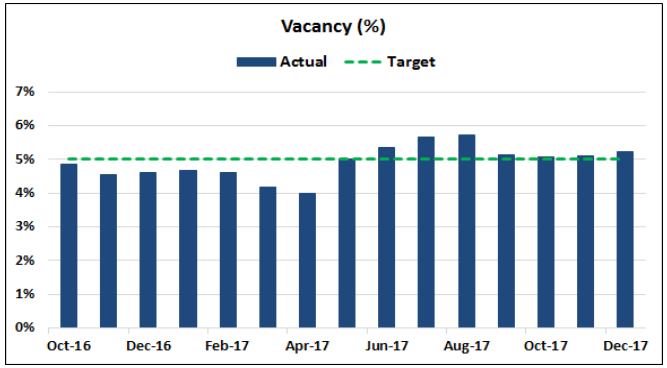
December 2017	Actual	KPI
UH Bristol	**4.1%**	**3.9%**
Diagnostics & Therapies	2.8%	2.8%
Medicine	4.8%	4.4%
Specialised Services	3.1%	3.7%
Surgery	3.9%	3.6%
Women's & Children's	4.1%	4.0%
Trust Services	3.3%	3.4%
Facilities & Estates	7.2%	6.0%



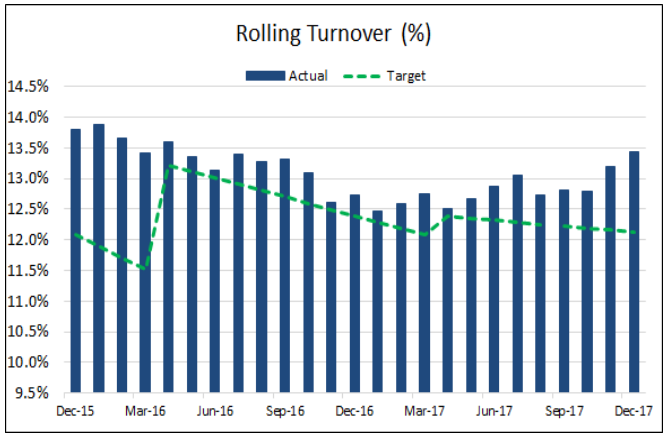
Please note: Sickness data is refreshed retrospectively to capture late data entry, and to ensure the data is consistent with the Trust's final submission for national publication.

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 increased to 5.2%, still slightly higher than the Trust target of 5%. Nursing vacancies increased by 8.7 FTE in month to 197.1 (6.1%), with the biggest divisional increase (8.9 FTE) seen in Specialised Services.	**Vacancies rate by month**	See Appendix 2, Action 16 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 increased to 13.4%, compared with 13.2% last month. There have been increases in all divisions except Diagnostics & Therapies and Facilities & Estates, with the largest increase seen in Specialised Services. The largest increase in staff group was seen in Registered Nursing, where it rose by 0.8 percentage points.	**Staff turnover rate by month**	See Appendix 2, Action 17 for further details of the plans that continue to be implemented to reduce turn-over.

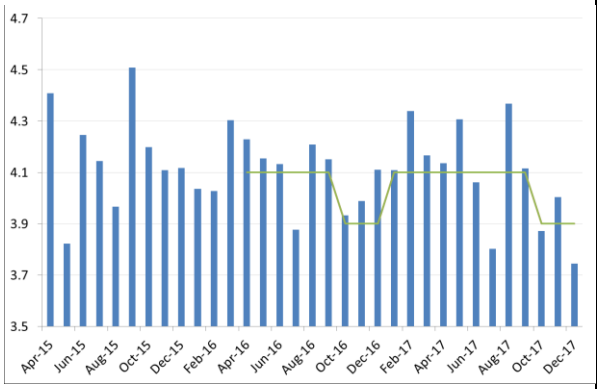
December 2017	Actual	KPI
UH Bristol	**5.2%**	**5.0%**
Diagnostics & Therapies	5.7%	5.0%
Medicine	6.1%	5.0%
Specialised Services	5.5%	5.0%
Surgery	5.2%	5.0%
Women's & Children's	1.9%	5.0%
Trust Services	5.4%	5.0%
Facilities & Estates	11.2%	5.0%



December 2017	Actual	KPI
UH Bristol	**13.4%**	**12.1%**
Diagnostics & Therapies	11.4%	12.1%
Medicine	14.1%	14.5%
Specialised Services	15.5%	11.8%
Surgery	12.8%	11.9%
Women's & Children's	11.6%	10.4%
Trust Services	15.2%	12.0%
Facilities & Estates	16.8%	13.8%



<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 December the average length of stay for inpatients was 3.74 days, which is just below the RED threshold of 3.9 days.

Number of patients in hospital at month-end with a “long” Length of Stay is below:
<table>
<tr><th></th><th>Oct-17</th><th>Nov-17</th><th>Dec-17</th></tr>
<tr><td>7+ Days</td><td>381</td><td>363</td><td>378</td></tr>
<tr><td>14+ Days</td><td>240</td><td>212</td><td>243</td></tr>
<tr><td>21+ Days</td><td>169</td><td>139</td><td>170</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 60 as at end of December (double the jointly agreed planning assumption of 30 patients).</td>
</tr>
</table>

Improvement Plans

Number	Action	Timescale	Assurance	Improvement trajectory
SAFE – Deteriorating Patient, National Early Warning Scores (NEWS) 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	Implementation of E-observations providing additional opportunities for doctor education to assist with resetting triggers safely.	April 2018	As above	Sustained improvement to 95% by 2018.
1C	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. New training programme in place for 2018.	On-going	As above	Sustained improvement to 95% by 2018.
1D	Implementation of e observations system to enable automatic calculation of NEWS. This will be followed by a further system implementation for notification of elevated NEWS to responder.	April 2018 To be confirmed	As above	Sustained improvement to 95% by 2018.
SAFE – Non-purposeful omitted doses of critical medication				
2A	The implementation of electronic prescribing will allow continuous data monitoring from exact dose administration prescription and administration times. Reasons for omission have to be recorded.	Full rollout anticipated by autumn 2018	Improvement under development	All omitted medication to be recorded and reported on, with reasons for omission and if fully omitted with no reason entered
2B	Pilot stage to be used to develop reporting suite. Data to be reviewed for ease of reporting, ability to amalgamate data and for conciseness. 'Critical' medication to be looked at as well as all medication.	Pilot Stage October 2017 to February 2018	Improvement under development	All omitted medication to be recorded and reported on, with reasons for omission and if fully omitted with no reason entered

Number	Action	Timescale	Assurance	Improvement trajectory
SAFE – Essential Training				
3A	Overall compliance for the Trust is at 88%, with aim of 90% compliance in all subjects.	January 2018	Divisional Performance Review meetings.	December 2017 saw compliance increases in 15 individual programmes, with decreases in only 2. Some programme gains resulted from recent adjustments to update requirements for many consultant job roles. The February compliance report will reflect a change in compliance for Equality, Diversity, and Human Rights (ED&HR), which is currently at 99%, but this is based on ED&HR being a 'one off' piece of training, accomplished any time in the past. A mid-2017 Trust decision requires that ED&HR is updated every 3 years, and the effects of this decision will be reflected in February's report. This report will credit ED&HR accomplishment via induction, e-learning, or face-to-face sessions, but only those attended or accomplished in the last 3 years. Accordingly, ED&HR compliance is expected to re-set, in February, at approx. 78%.
3B	The January Education Board meeting will consider focusing the monthly compliance report from the 35 current topics to 11 Core Skills of the UK Core Skills Framework.	January 2018	Oversight of training compliance by the Education Board and Senior Leadership Team (SLT).	

Number	Action	Timescale	Assurance	Improvement trajectory
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	Current complaints training is being reviewed to incorporate learning from exchange visit with Sheffield Teaching Trust.	March 2018	Improvement under development	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. 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.	Ongoing		Achieve and maintain a green RAG rating for this indicator
5D	The Trust has established a new complaints review panel as a pilot in 2017.	Panels have taken place in Medicine and Diagnostics and Therapies and Surgery.	Evidence that the panel is in place and learning identified and shared with Divisions	Achieve and maintain a green RAG rating for this indicator

Number	Action	Timescale	Assurance	Improvement trajectory
CARING – Cancelled Operations				
6A	Continued focus on recruitment and retention of staff to enable all adult BRI Critical Care beds to be kept open, at all times. Training package developed to support staff retention. Staff recruited and in post. Bid for winter funds submitted to support the permanent use of the 21st bed	Ongoing December	Monthly Divisional Review Meetings; Funding agreed to staff 21st bed	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 Deputy Chief Operating Officer	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
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 NHS England (NHSE) Paper Less initiative; Milestones across each quarter	Outpatient Steering Group	Ongoing delivery of plan continues in line with CQUIN milestones (CQUIN is "Commissioning for Quality and Innovation")
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.	Outpatient Steering Group	Linked in to eRS plan. Outpatients Operating Model 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 outpatients	Complete.	Outpatient Steering Group	In place as per 7B above

Number	Action	Timescale	Assurance	Improvement trajectory
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 monitored through Outpatient Steering Group	Outpatient Steering Group	Ongoing work with divisions to identify specialities to support the reduction in follow-up work at Clinical Commissioning Group (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 outpatient team to support the divisions to do re-build work.	Outpatient Steering Group	Recruitment underway
7G	On the 14th August clinic cancellation codes were 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 Outpatient Steering Group	Outpatient Steering Group	
RESPONSIVE – A&E 4 Hour Wait				
8A	Urgent Care Steering Group (UCSG) Improvement plan for the BRI has been refreshed to focus on the high impact schemes initially. Pilot underway in Acute Medical Unit (AMU/A300) to increase ambulatory capacity. Model agreed with team for adult ED streaming which is 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 quarter 3
8B	Increased support from NHS Improvement's Emergency Care Improvement Programme (ECIP) has commenced; focussing on support Integrated Discharge work and implementing trusted assessor	Ongoing	Progress tracked through Urgent Care Steering Group	

Number	Action	Timescale	Assurance	Improvement trajectory
RESPONSIVE – Referral to Treatment (RTT) Times				
9A	Weekly monitoring of reduction in RTT over 18 week backlogs against trajectory. Continued weekly review of longest waiting patients through new weekly Performance meeting. Additional request from the Clinical Commissioning Groups (CCGs) has resulted in reporting all of our 46 to 52 week waiters on a weekly and monthly basis	Ongoing	Oversight at the RTT weekly performance meeting. Routine weekly 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.	For April 2018 we plan to deliver compliance of the 92% standard, which will be updated as we progress across the winter pressure period.
9B	Contract performance notice received against our level of 52 week breaches	End of December	A Recovery Action Plan (RAP) will be issued to the CCGs to give the detail of the 9 remaining 52 week waiters who exercised their right to patient choice.	Achieve zero 52 week waiters by End of December 2017 excluding those patients who have decided to take a dates beyond that time line (patient choice)
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	Complete	Fortnightly meetings between Divisions and Associate Director of Performance, and Access Improvement Manager	RTT weekly performance meeting have been implemented.
9D	Refresh of the Trust's Capacity and Demand modelling for key specialties (including Clinical Genetics, Paediatric Cardiology and Sleep Studies).	Complete	Modelling to be reviewed by Associate Director of Performance	
9E	Chronological booking report to be developed to challenge inefficient booking practices for outpatients and elective procedures.	Complete	Sign-off of report by Chief Operating Officer completed	

Number	Action	Timescale	Assurance	Improvement trajectory
9F	Implementation of chronological booking report.	Ongoing	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)	Incorporate into the weekly performance meetings as of 20th December 2017
9G	Dental administrative management improvement plan to be developed.	Complete	Signed-off of plan by Associate Director of Performance	
RESPONSIVE – Cancer Wait Times				
10A	Ensure there is sufficient thoracic surgery outpatient capacity to meet demand in a timely way	End March 2018 (in line with business planning)	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	Complete	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 (resolved)	As above (resolved and for ongoing monitoring)	As above (achieved as planned)
10F	Put in place more formal processes and guidance for managing the impact of planning meeting cancellations, for instance due to bank holiday	End January 2018	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 (completed)	As above	As above

Number	Action	Timescale	Assurance	Improvement trajectory
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 (resolved)	As above (resolved)	As above (achieved as planned)
RESPONSIVE – Diagnostic Waits				
11A	Corporate PTL (Patient Tracking List) weekly meeting established with Divisions. Divisions will review weekly, with central Performance team, the Referral to Treatment (RTT) and Diagnostic waiting lists. It will review by sub-speciality and cover performance monitoring, target setting and forecasting for 6 weeks in advance	Commenced December 2017	Monthly Briefing Paper to Chief Operating Officer	Delivery of 99% performance by April 2018
11B	Revised guidance on appropriate referrals to Sleep Studies has been agreed with commissioners. This should to reduce demand	From January 2018	Analysis of referrals and activity to be reviewed at Weekly PTL Meetings to ensure a reduction in referrals is being delivered.	Delivery of sustainable performance by April 2018
11C	Provision of additional, one-off capacity for Paediatric MRI sessions being agreed between Women's & Children's and Diagnostics & Therapies division. Then agreement on capacity needed to meet ongoing demand	From February 2018	Weekly review at PTL Meeting (see 11A)	Delivery of sustainable performance by April 2018
11D	Additional waiting list sessions being run in Ultrasound and Cardiac MRI	Ongoing	Weekly review at PTL Meeting (see 11A).	Delivery of sustainable performance by April 2018

Number	Action	Timescale	Assurance	Improvement trajectory
EFFECTIVE – Fracture Neck of Femur				
12A	Consultant orthogeriatric capacity – there are currently vacancies within the Care of the Elderly service that is impacting on the capacity of the orthogeriatric service. The Division of Medicine has two Care of the Elderly consultant vacancies. One of is being covered by two clinical fellows. It is not anticipated that this will provide any additional capacity for the orthogeriatric service. A new consultant has now started. This will release the two orthogeriatric consultants from Care of the Elderly sessions, 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.	Anticipated some improvement in orthogeriatric capacity from November.	Improvements in dashboard measures. Update reports to the Quality and Outcomes Committee	Improvements in time to review by an orthogeriatrician.
12B	Establishment of an elderly trauma and hip fracture ward – to cohort frail elderly trauma patients on A604, to facilitate direct admission from ED to ring-fenced fractured neck of femurs beds. There also needs to be sufficient capacity to maintain ring fenced hip fracture admission beds and medical ward capacity to accommodate step down patients. The Deputy Chief Operating Officer will lead the planning process to establish the elderly trauma and hip fracture ward. The proposed ward staffing enhancements at the weekend has been included in the Division of Surgery 2018/19 OPP as a cost pressure.	This is contingent upon amending care pathways and admission protocols.	Improvements in dashboard measures. Update reports to the Quality and Outcomes Committee	Improvements to the quality and coordination of patient care.

Number	Action	Timescale	Assurance	Improvement trajectory
12C	Physiotherapy the day after surgery – to ensure that there is physiotherapy support available to the orthopaedic wards on Sundays There are potential benefits associated with reduction in patient length of stay with earlier mobilisation. The D&T Division are planning to commence a consultation process with a significant body of physiotherapy staff to facilitate Sunday on-call cover in the new year.	An on-call model for #NOF patients is the most cost 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.	Improvements in dashboard measures. Update reports to the Quality and Outcomes Committee	Improvements against the new quality standard measure of therapy review the day after surgery.
12D	Time to surgery – to improve trauma throughput and to expedite the surgery of fractured neck of femur 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 trial of a dedicated theatre porter for trauma theatres has concluded by has not demonstrated a significant improvement in waiting times. The audit demonstrated the most significant factor was theatres not starting on time because of waiting for beds. Therefore, a proposal is being developed to introduce automatic sending for trauma cases. This means that trauma cases will be treated in the same way as emergency surgery. Automatic sending commenced on the 8th December and the plan is to review at the end of January.	Improvements against time to theatre standard
12A	Consultant orthogeriatric capacity – there are currently vacancies within the Care of the Elderly service that is impacting on the capacity of the orthogeriatric service. The Division of Medicine has two Care of the Elderly consultant vacancies. One of is being covered by two clinical fellows. It is not anticipated that this will provide any additional capacity for the orthogeriatric service. A new	Anticipated some improvement in orthogeriatric capacity from November.	Improvements in dashboard measures. Update reports to the Quality and Outcomes Committee	Improvements in time to review by an orthogeriatrician.

Number	Action	Timescale	Assurance	Improvement trajectory
	consultant has now started. This will release the two orthogeriatric consultants from Care of the Elderly sessions, 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.			
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 and development of Clinical Utilisation Review (CUR)	Linked to increased and timely use of discharge lounge
EFFICIENT – Agency Usage				
14A	**Effective rostering**: "Healthroster" – implemented and Key Performance Indicators (KPIs) in place. The new Safe Staffing module is now being rolled out across the Trust which will make it easier to move staff across the organisation in a timely manner to minimise agency usage.	Ongoing	KPI Performance monitored through Nursing 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**: Revised agency rules now in place for Nursing from with a particular focus on driving out high cost non-framework agency spend. Neutral Vendor contract for nurse agency supply is now live across the BNSSG area, helping support an improved achievement with the national agency price caps. Fill has been maintained despite challenges across the healthcare system Operating plan agency trajectories monitored by divisional reviews.	Ongoing Ongoing Monthly/ quarterly reviews	Nursing agency: oversight by Savings Board and Nursing Agency Controls Group. Medical agency: oversight through the Medical Efficiencies Group	

Number	Action	Timescale	Assurance	Improvement trajectory
14C	**Enhancing bank provision:** Bank recruitment and marketing plans for all staff groups in place for 2017/18. Employee On-Line access (for Bank-only RNs, Nursing Assistants, Domestics) is now live so staff can view available shifts and give their availability to work. Direct booking through the employee on-line functionality is being further explored.	Ongoing April 2018	Performance against target for Bank recruitment is monitored by the Recruitment Sub Group.	
EFFICIENT – Staff Sickness				
15A	**Supporting Attendance Policy** Implementation plan and a training programme are in place for delivery once the policy is agreed. Provisional agreement has been reached on the revised 'triggers', pending approval from Policy Group in January and ratification from Trust Partnership Forum in February.	March 2018	Oversight by Workforce and Organisational Development (OD) Board	Divisional Performance against plan is monitored at monthly and quarterly Divisional Performance review meetings. Where divisions are above target an extensive deep dive into the data with a recovery plan.
15B	**Supporting Attendance Surgeries** Ongoing to expedite individual cases. Monthly deep dives continue to support areas where exception reporting is required.	Ongoing		
15C	**Occupational Health** The Occupational Health referral portal is now active which will facilitate a faster referral process and turn-around of advisory reports to assist in the management of sickness absence cases.	Ongoing		
15D	**Musculo-skeletal** 1000 extra moving and handling training places offered for clinical staff, promoted via Teaching and Learning Approximately 1800 role profiles have been redefined and will only need to complete moving and handling eLearning (to be facilitated by Teaching and Learning)	Ongoing Ongoing		

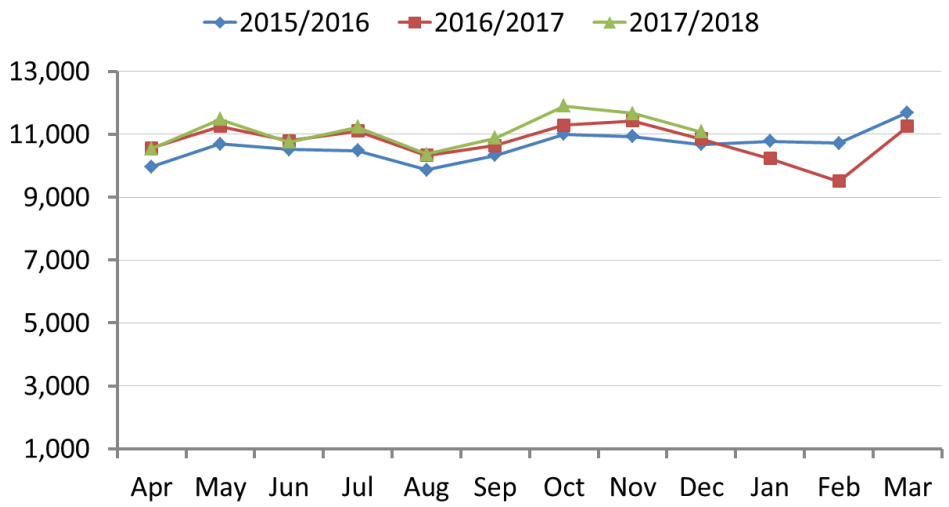
Number	Action	Timescale	Assurance	Improvement trajectory
15E	**Psychological wellbeing** The Executive Board have agreed for the Trust to sign the Time to Change Employer Pledge and commence delivery of an accompanying workplace mental health	February 2018	Oversight by Workforce and Organisational Development (OD) Board via the Workplace Wellbeing Sub Group	
15F	**General wellbeing** Trust awarded £8k STP grant towards implementation of the Making Every Contact Count (MECC) programme. The flu vaccination rate of frontline workers is 71.0% with the programme being actively communicated to colleagues until end of February. This meets the national CQUIN target 2017/18. 44 colleagues have registered for the next cohort of the Step into Health distance learning programme to improve their own health and wellbeing in relation to stress management, physical activity and nutrition and weight management.	From Spring 2018 Ongoing Ongoing	Workplace Wellbeing Steering Group (quarterly) /CQUIN Assurance Group	
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 Organisational Development Group/ Recruitment Sub Group.	The target for vacancies continues to be 5% in 2017/18. Divisional Performance against plan is monitored at monthly and quarterly Divisional Performance review meetings.
16B	**Marketing and advertising** Recruitment and marketing plans for Nursing, Radiology and Domestic Assistants are in place for 2017/18. Marketing plans are now being developed for 2018/19 campaigns, focusing on hard to fill areas.	Ongoing April 2018/19	Divisional Performance & Operational Review Meetings and the Recruitment Sub Group.	

Number	Action	Timescale	Assurance	Improvement trajectory
	"Head-hunter" agency approach has been extended to hard to fill areas e.g. Sonography. A review is currently being undertaken of the scope and success outcomes of this approach to recruitment. Active attendance at careers events continues, with a particular focus in the last month on local career fairs.	From April 21017 April 2018 Ongoing		
EFFICIENT - Turnover				
17A	The exit interview process is under review in order to improve uptake and our understanding of reasons for staff turnover, with benchmarking of other Trusts to share learning and practice.	January 2018	Workforce and OD Group	Divisional performance is monitored monthly at Performance and Operational Reviews
17B	Robust Improving Staff Experience plans are in place and local initiatives are undertaken in hot spot areas as identified in the staff survey. Supporting corporate programs of work include; E-Appraisal, Leadership behaviours, Dignity at work policy and a staff recognition framework which will go live in 2018.	January 2018		

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.

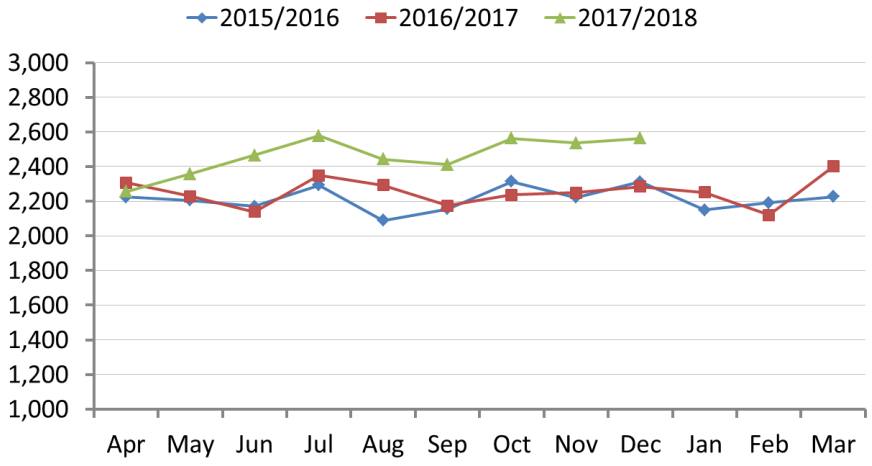
Emergency Department (ED) attendances



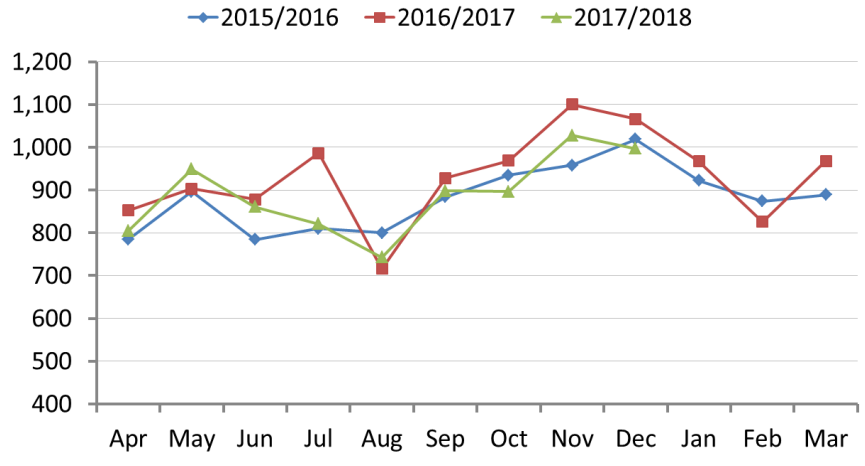
Summary points:

- Emergency Department attendances are following seasonal trends
- Total number of emergency admissions into the Bristol Royal Infirmary has remained consistently above levels in previous years. This is being driven by a rise in short stay (0 or 1 day) Medical admissions in Ambulatory Care and Acute Medicine Unit (AMU).
- Emergency admissions to the Children's Hospital remain consistent with seasonal trends.
- Elective admissions (Trust level) fell in December. Although they fell to levels consistent with December levels in previous years.
- New Outpatient attendances showed a significant reduction in December but, in a similar vein to Elective admissions, the levels fell to similar levels from previous Decembers.

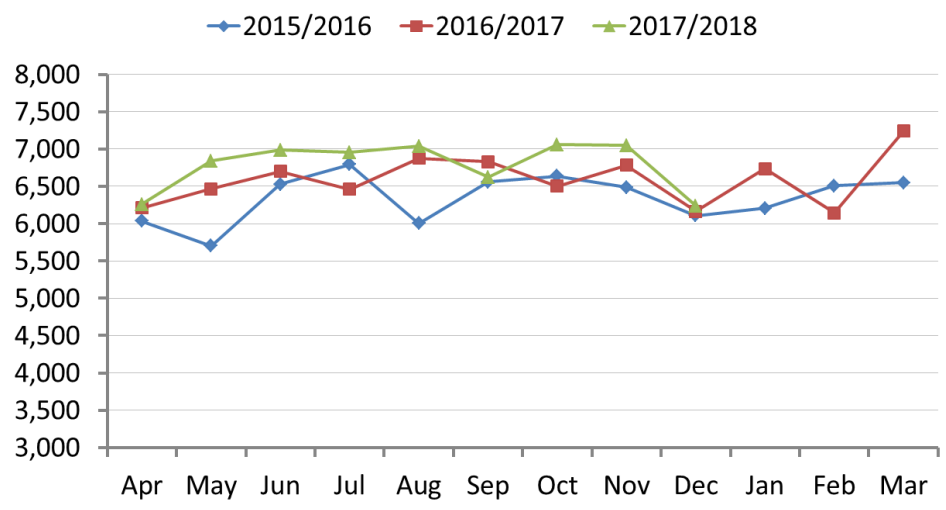
Emergency Inpatient Activity (BRI Discharges)



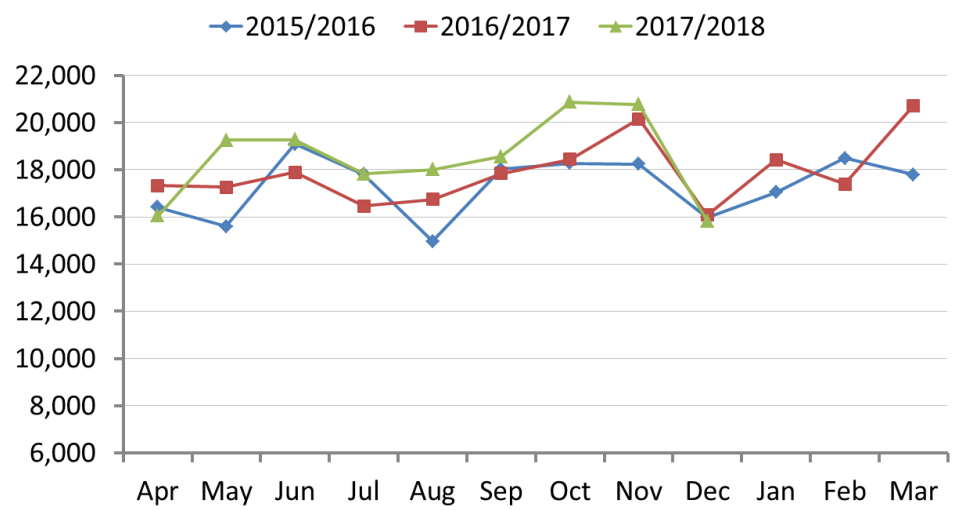
Emergency Inpatient Activity (BCH Discharges)



Elective Inpatient/Day Cases (number of Discharges)



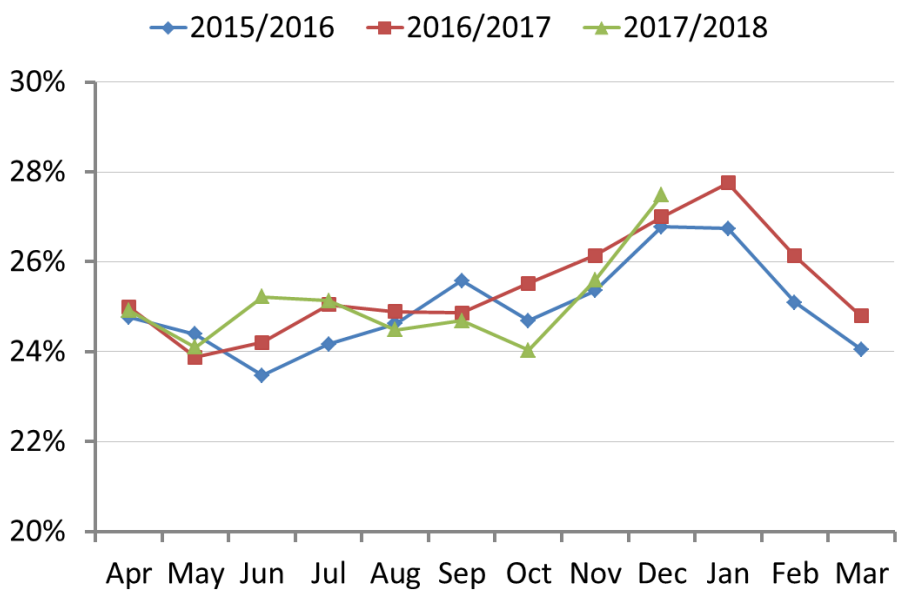
New outpatient attendances



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.

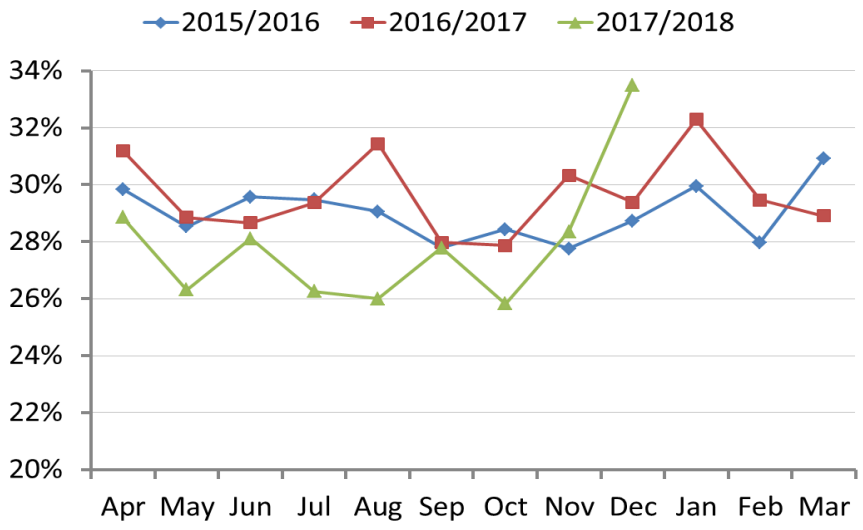
Percentage ED attendances resulting in admission



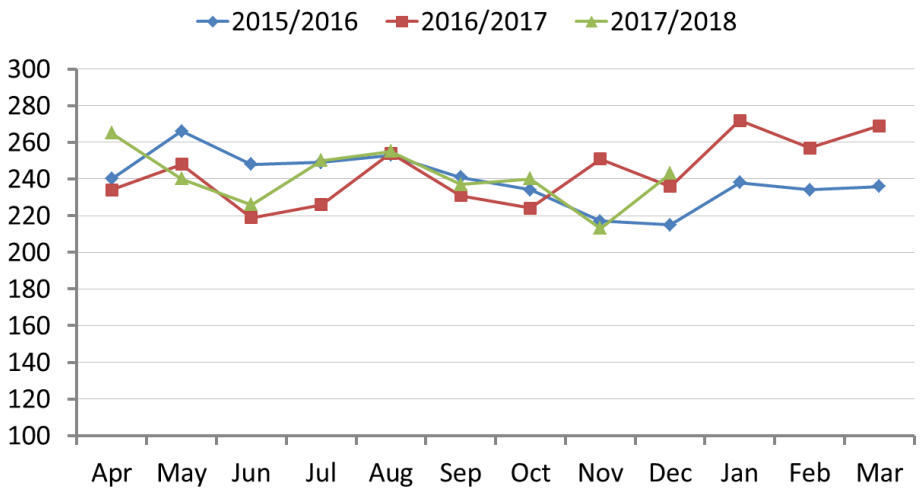
Summary points:

- The percentage of patients arriving in our Emergency Departments and converting to an admission has risen in November and December. Although this increase has occurred in previous years.
- Percentage of BRI Emergency patients aged 75+ is at a three year high of almost 34%.
- Number of patients in hospital for 14+ days and the number of Delayed Transfer of Care (DToC) patients remains consistent with previous months and seasonal trends.
- Bristol Royal Infirmary (including the Heart Institute) bed occupancy remains around 95%
- Elective waiting list remains above 2016/17 levels.
- Number of Referral To Treatment (RTT) patients waiting over 18 weeks rose in December, alongside a seasonal drop in activity (Clock Stops).
- The number of patients referred by their GP with a suspected cancer (2-week waits) has remained above 2016/17 levels all year.

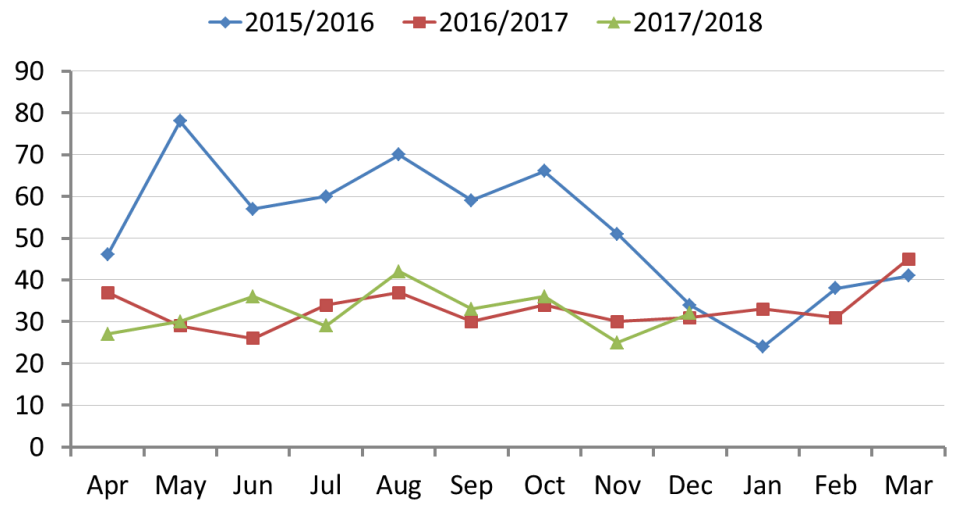
Percentage of Emergency BRI spells patients aged 75 years and over



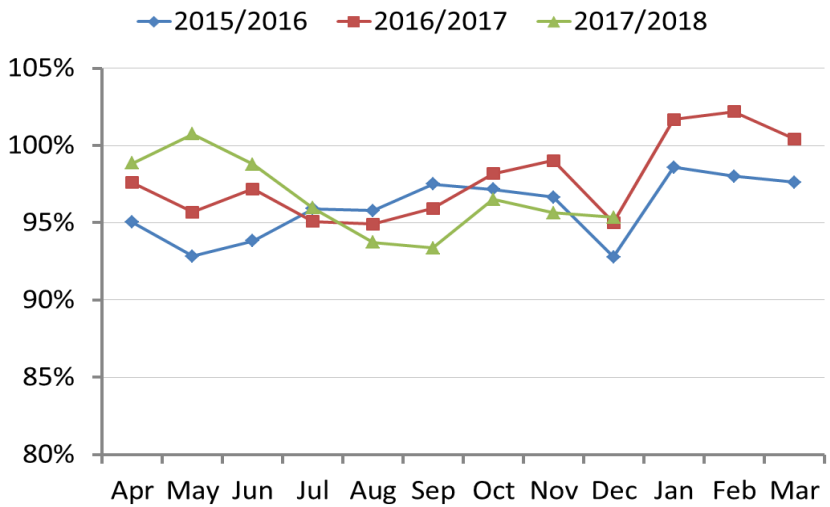
Over 14 day stays , at month-end



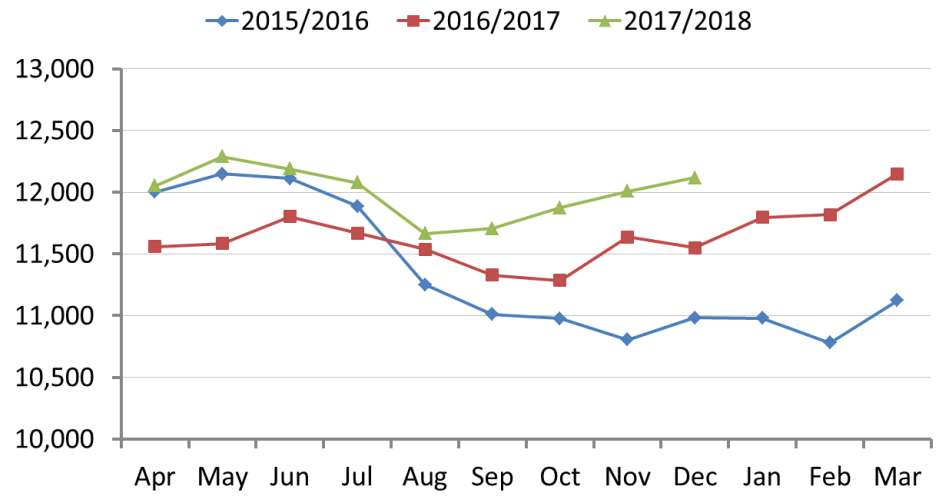
Delayed Transfers of Care (Number of patients at month-end)



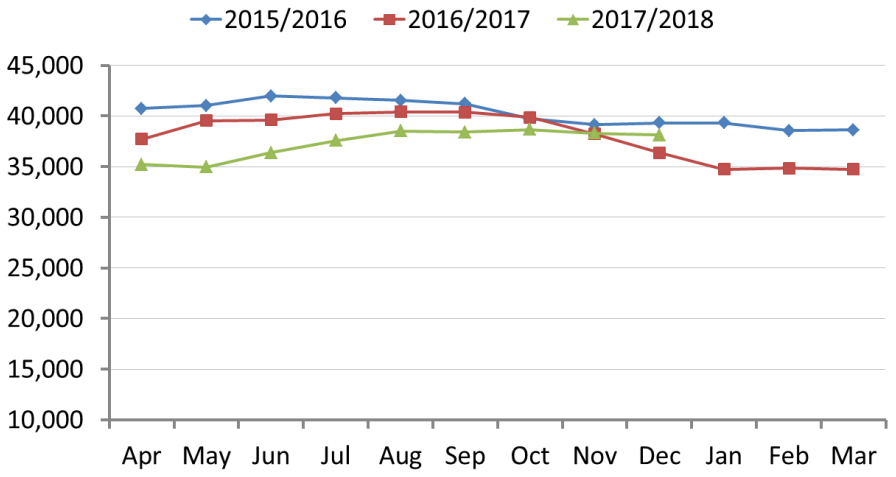
BRI Bed Occupancy (Overnight)



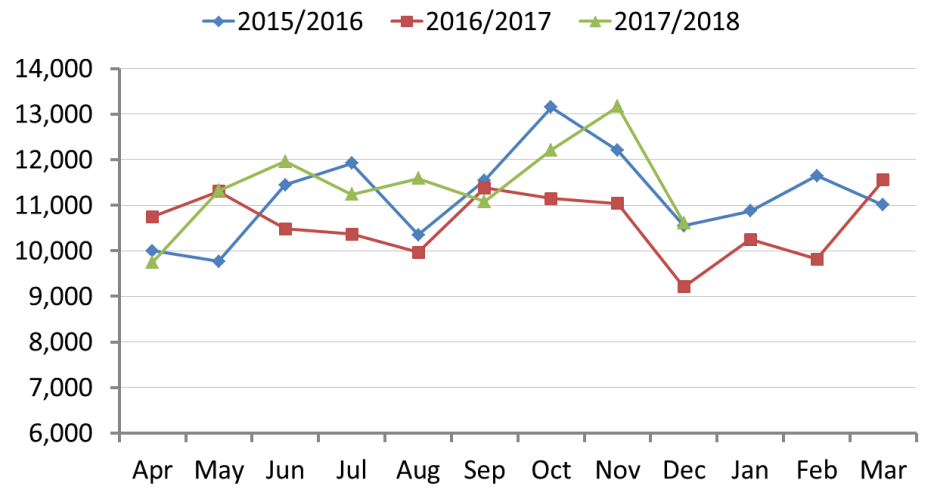
Elective waiting list size



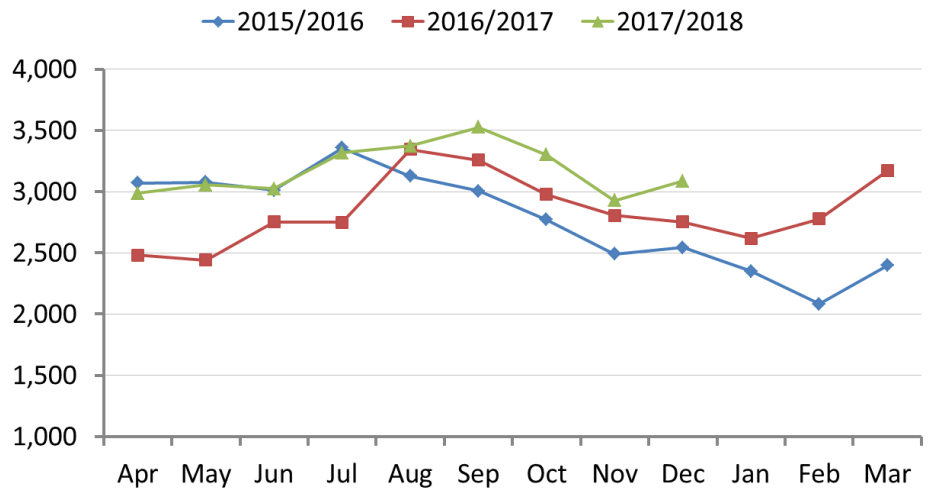
Outpatient waiting list size



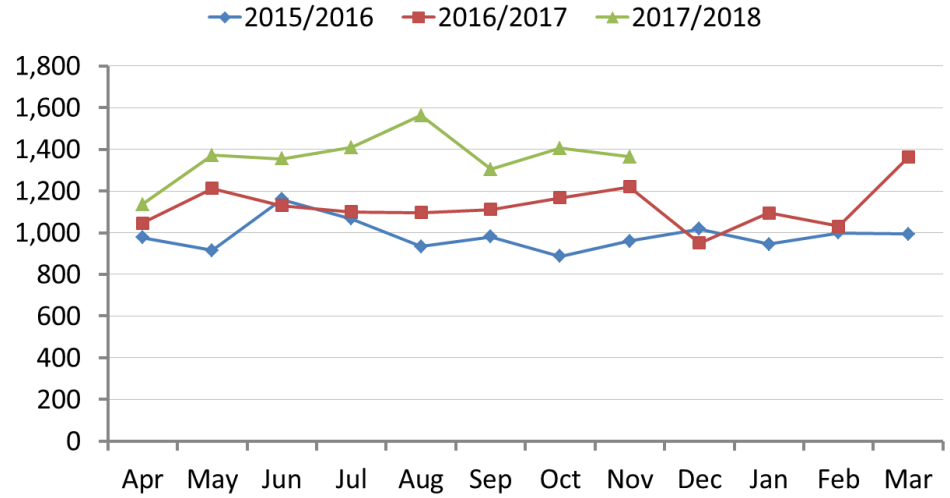
Number of RTT pathways stopped (i.e. treatments)



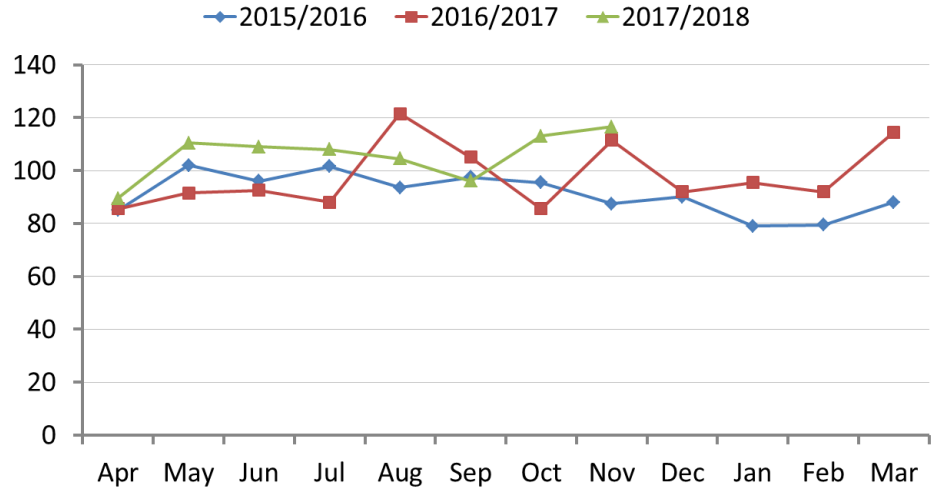
Number of RTT pathways over 18 weeks



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	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	16/17 Q4	17/18 Q1	17/18 Q2	17/18 Q3
Patient Safety																				
Infections	DA01a	MRSA Bloodstream Cases - Cumulative Totals	-	-	1	1	1	-	0	1	1	2	3	3	3	4	-	-	-	-
	DA01	MRSA Bloodstream Cases - Monthly Totals	1	4	0	0	0	0	0	1	0	1	1	0	0	1	0	1	2	1
	DA03	C.Diff Cases - Monthly Totals	31	27	4	0	0	2	4	5	6	3	3	1	1	2	4	11	12	4
	DA02	MSSA Cases - Monthly Totals	37	17	3	3	2	0	1	3	0	3	0	5	4	1	8	4	3	10
C.Diff "Avoidables"	DA03c	C.Diff Avoidable Cases - Cumulative Totals	-	-	10	10	10	0	2	2	3	-	-	-	-	-	-	-	-	-
Infection Checklists	DB01	Hand Hygiene Audit Compliance	96.6%	97.6%	95.5%	95.4%	97%	98.4%	98.1%	98.4%	97.2%	97.7%	96.2%	96.4%	97.6%	97.3%	96%	98.3%	97%	97.1%
	DB02	Antibiotic Compliance	88.3%	86.3%	91.7%	92%	88.1%	87.7%	89.6%	87.4%	87.8%	81.3%	84.4%	85.1%	89.1%	85.4%	90.8%	88.3%	84.3%	86.4%
Cleanliness Monitoring	DC01	Cleanliness Monitoring - Overall Score	-	-	96%	94%	95%	96%	96%	96%	96%	97%	97%	96%	96%	95%	-	-	-	-
	DC02	Cleanliness Monitoring - Very High Risk Areas	-	-	98%	97%	97%	98%	98%	98%	98%	98%	98%	98%	98%	98%	-	-	-	-
	DC03	Cleanliness Monitoring - High Risk Areas	-	-	96%	96%	95%	96%	96%	97%	97%	97%	97%	96%	97%	96%	-	-	-	-
Serious Incidents	S02	Number of Serious Incidents Reported	52	42	5	2	5	2	7	6	5	3	9	2	4	4	12	15	17	10
	S02a	Number of Confirmed Serious Incidents	49	27	5	2	5	2	6	6	5	3	5	-	-	-	12	14	13	-
	S02b	Number of Serious Incidents Still Open	-	14	-	-	-	-	-	-	-	-	4	2	4	4	-	-	4	10
	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%	92.9%	100%	100%	100%	100%	100%	83.3%	100%	100%	100%	100%	50%	100%	100%	93.3%	100%	80%
	S04	Serious Incident Investigations Completed Within Timescale	98%	97.4%	100%	100%	100%	100%	75%	100%	100%	100%	100%	100%	100%	100%	100%	91.7%	100%	100%
	S04a	Overdue Exec Commissioned Non-SI Investigations	-	14	-	-	-	1	2	2	1	1	2	1	1	3	-	5	4	5
Never Events	S01	Total Never Events	2	6	0	0	0	0	1	2	1	0	0	2	0	0	0	3	1	2
Patient Safety Incidents	S06	Number of Patient Safety Incidents Reported	14866	10257	1335	1211	1332	1203	1315	1330	1288	1249	1229	1311	1332	-	3878	3848	3766	2643
	S06b	Patient Safety Incidents Per 1000 Beddays	47.82	50.21	48.94	48.67	48.47	47.02	49.94	53.99	49.49	48.38	49.91	50.19	53	-	48.69	50.27	49.25	51.57
	S07	Number of Patient Safety Incidents - Severe Harm	95	59	10	7	5	7	11	8	6	7	7	4	9	-	22	26	20	13
Patient Falls	AB01	Falls Per 1,000 Beddays	4.23	4.53	3.74	4.9	3.89	4.85	3.91	4.91	4.53	4.76	5.04	4.48	3.78	4.51	4.16	4.55	4.77	4.26
	AB06a	Total Number of Patient Falls Resulting in Harm	36	21	3	3	5	2	3	4	0	0	3	2	2	5	11	9	3	9
Pressure Ulcers Developed in the Trust	DE01	Pressure Ulcers Per 1,000 Beddays	0.148	0.135	0.11	0.201	0.182	0.078	0.076	0.203	0.154	0.155	0.203	0.038	0.159	0.156	0.163	0.118	0.17	0.117
	DE02	Pressure Ulcers - Grade 2	40	26	3	3	3	1	1	5	2	4	4	1	4	4	9	7	10	9
	DE04A	Pressure Ulcers - Grade 3 or 4	6	5	0	2	2	1	1	0	2	0	1	0	0	0	4	2	3	0
Venous Thrombo-embolism (VTE)	N01	Adult Inpatients who Received a VTE Risk Assessment	99.1%	98.4%	99.1%	98.9%	99.1%	98.9%	98.9%	98.7%	98.8%	97.4%	98.3%	98.4%	98.2%	98%	99%	98.8%	98.2%	98.2%
	N02	Percentage of Adult Inpatients who Received Thrombo-prophylaxis	96.4%	95.2%	97.8%	98%	96.6%	94.5%	97.6%	97%	97.4%	94.9%	92.3%	97.1%	94%	92.3%	97.4%	96.3%	94.7%	94.5%
	N04	Number of Hospital Associated VTEs	63	35	11	3	2	5	3	5	4	2	3	6	2	5	16	13	9	13
	N04A	Number of Potentially Avoidable Hospital Associated VTEs	7	2	2	0	0	0	0	1	0	0	0	1	0	0	2	1	0	1
	N04B	Number of Hospital Associated VTEs - Report Not Received To Date	13	9	3	1	0	0	1	0	0	0	0	1	2	5	4	1	0	8
Nutrition	WB03	Nutrition: 72 Hour Food Chart Review	89.6%	91.9%	92.7%	89.1%	90.2%	89.9%	87.7%	91.5%	96.2%	94.6%	92.6%	91%	95.2%	88.8%	90.6%	89.7%	94.5%	91.3%
Nutrition Audit	WB10	Fully and Accurately Completed Screening within 24 Hours	86.9%	91.1%	-	-	87.9%	-	-	92.2%	-	-	92%	-	-	88.9%	87.9%	92.2%	92%	88.9%
Safety	Y01	WHO Surgical Checklist Compliance	99.1%	99.8%	98.4%	98%	97.8%	99.5%	99.7%	99.8%	99.8%	99.8%	99.9%	99.8%	-	-	98.1%	99.7%	99.8%	99.8%

SAFE, CARING & EFFECTIVE (continued)

			Annual		Monthly Totals												Quarterly Totals			
Topic	ID	Title	16/17	17/18 YTD	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	16/17 Q4	17/18 Q1	17/18 Q2	17/18 Q3
Medicines	WA01	Medication Incidents Resulting in Harm	0.37%	0.76%	0%	0.53%	0%	0.98%	0.44%	0%	1.35%	0.51%	0%	1.97%	0.94%	-	0.16%	0.46%	0.64%	1.44%
	WA03	Non-Purposeful Omitted Doses of the Listed Critical Medication	0.59%	0.35%	0.98%	0.39%	0.26%	0.43%	0.9%	0.24%	0.32%	0.11%	0.37%	0.27%	0.41%	0%	0.52%	0.53%	0.25%	0.24%
Safety Thermometer	AK03	Safety Thermometer - Harm Free Care	97.9%	97.8%	98%	97.3%	98.3%	97.9%	97.3%	97.9%	97.7%	96.9%	97.7%	97.5%	98.8%	98.3%	97.9%	97.7%	97.4%	98.2%
	AK04	Safety Thermometer - No New Harms	98.9%	98.7%	98.6%	98.5%	99.1%	99%	98.3%	98.4%	98.8%	98.2%	98.7%	98.9%	99.1%	99%	98.7%	98.6%	98.6%	99%
Deteriorating Patient	AR03	National Early Warning Scores (NEWS) Acted Upon	92%	96%	91%	93%	100%	100%	96%	93%	100%	97%	100%	90%	93%	97%	95%	96%	99%	94%
Out of Hours	TD05	Out of Hours Discharges (8pm-7am)	7%	8.7%	7.4%	8%	5.8%	7.6%	7%	6.7%	8.4%	10.9%	9.7%	9.1%	9.4%	9.1%	7%	7.1%	9.7%	9.2%
Timely Discharges	TD03	Percentage of Patients With Timely Discharge (7am-12Noon)	22.3%	22.9%	21.7%	21.6%	21.3%	22.3%	22.6%	23.3%	22.9%	21.9%	24%	24.2%	24%	20.8%	21.5%	22.7%	22.9%	23%
	TD03D	Number of Patients With Timely Discharge (7am-12Noon)	11063	8512	887	799	914	867	950	944	962	909	983	1024	1010	863	2600	2761	2854	2897
Staffing Levels	RP01	Staffing Fill Rate - Combined	103.7%	99.5%	103.6%	104.5%	104.1%	107.1%	102.6%	102.4%	98.6%	98%	97.1%	97.5%	98.1%	97.2%	104%	103.7%	97.9%	97.6%
Clinical Effectiveness																				
Mortality	X04	Summary Hospital Mortality Indicator (SHMI) - National Data	99.2	97.6	-	-	97.3	-	-	97.6	-	-	-	-	-	-	97.3	97.6	-	-
	X02	Hospital Standardised Mortality Ratio (HSMR)	91.4	88.5	87.2	90.9	92.1	88.6	80.4	93	81.3	75.8	106.8	96.7	-	-	89.9	87.3	87.1	96.7
Mortality Review	tbc	Number of Deaths										229							229	
	tbc	Number of Deaths Subject to Casenote Review										55							55	
	tbc	Number of Deaths Reviewed Under Serious Incident Framework										14							14	
	tbc	Number of Deaths With More Than 50:50 Chance of Being Avoidable										1							1	
Readmissions	C01	Emergency Readmissions Percentage	2.66%	2.88%	2.73%	2.89%	2.45%	2.98%	3.77%	3.57%	3.33%	2.32%	2.46%	2.23%	2.37%	-	2.68%	3.45%	2.71%	2.3%
Sepsis (Inpatients)	AG02a	Percentage of Patients Meeting Criteria Screened for Sepsis (Inpatients)	21.6%	34.2%	27.8%	28.6%	41.7%	38.5%	37.5%	38.1%	21.1%	50%	16.7%	-	-	-	31.8%	38.1%	29.7%	-
	AG03a	Sepsis Patients Percentage Commencing Antibiotics Within 1 Hour (Inpatient	65.7%	78.3%	100%	50%	42.9%	100%	50%	62.5%	66.7%	100%	100%	-	-	-	68%	71.4%	88.9%	-
	AG04a	Sepsis Patients Percentage with a 72 Hour Review (Inpatients)	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%	87%	90%	80%	100%	85.7%	76.9%	78.3%	93.8%	95%	92.9%	-	-	-	90%	80%	94%	-
	AG03b	Sepsis Patients Percentage Commencing Antibiotics Within 1 Hour (ED)	56.3%	83.1%	77.8%	70%	25%	85.7%	63.6%	77.8%	84.6%	88.2%	100%	-	-	-	59.3%	76.7%	90%	-
	AG04b	Sepsis Patients Percentage with a 72 Hour Review (ED)	94.3%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	-	-	-	100%	100%	100%	-
Maternity	G01	Percentage of Low Weight Babies	2.7%	2.5%	2.4%	3.9%	3.3%	2.3%	3.5%	0.5%	1.5%	3.3%	3.4%	0.9%	2%	4.6%	3.2%	2.2%	2.7%	2.5%
	G01A	Number of Low Weight Babies	137	87	10	14	14	9	15	2	6	13	13	4	7	18	38	26	32	29
Fracture Neck of Femur	U02	Fracture Neck of Femur Patients Treated Within 36 Hours	70.5%	67.1%	69.2%	81%	80.8%	57.7%	86.7%	85%	67.6%	84.6%	85.7%	61.9%	34.6%	48.5%	76.7%	76.3%	77.8%	47.5%
	U03	Fracture Neck of Femur Patients Seeing Orthogeriatrician within 72 Hours	74%	56.1%	61.5%	71.4%	73.1%	73.1%	73.3%	60%	47.1%	34.6%	33.3%	47.6%	69.2%	60.6%	68.5%	69.7%	39.5%	60%
	U04	Fracture Neck of Femur Patients Achieving Best Practice Tariff	51.9%	34.2%	42.3%	61.9%	61.5%	34.6%	60%	50%	29.4%	26.9%	28.6%	28.6%	26.9%	24.2%	54.8%	48.7%	28.4%	26.3%
	U05	Fracture Neck of Femur - Time To Treatment 90th Percentile (Hours)	-	-	48.8	43.3	37.3	67.4	38	37.1	45.9	43.8	37.1	53.3	75.9	58.6	-	-	-	-

SAFE, CARING & EFFECTIVE (continued)

			Annual		Monthly Totals												Quarterly Totals			
Topic	ID	Title	16/17	17/18 YTD	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	16/17 Q4	17/18 Q1	17/18 Q2	17/18 Q3
Stroke Care	O01	Stroke Care: Percentage Receiving Brain Imaging Within 1 Hour	58.6%	64.9%	52.4%	50%	64.3%	80.8%	51.4%	66.7%	72.9%	61.9%	70%	60.7%	55.6%	-	55.5%	64.9%	68.5%	57.8%
	O02	Stroke Care: Percentage Spending 90%+ Time On Stroke Unit	90.2%	85.8%	90.5%	84.1%	88.6%	90.9%	80.6%	81.8%	83.3%	81%	92.5%	96.4%	83.3%	-	87.7%	84.3%	85.4%	89.1%
	O03	High Risk TIA Patients Starting Treatment Within 24 Hours	66.8%	60.8%	51.7%	72.2%	61.5%	56.3%	50%	77.3%	27.3%	66.7%	75%	66.7%	70%	42.9%	60%	62.5%	55.9%	62.9%
Dementia	AC01	Dementia - FAIR Question 1 - Case Finding Applied	90.4%	89.8%	80.8%	80.1%	84%	87.2%	88.3%	89.4%	91.1%	89.9%	93.5%	87.7%	93.7%	87.9%	81.6%	88.3%	91.5%	89.6%
	AC02	Dementia - FAIR Question 2 - Appropriately Assessed	97.2%	97.9%	97.6%	88.9%	100%	97.3%	97.6%	100%	100%	97.7%	97.9%	94%	97.4%	100%	96.2%	98.3%	98.6%	96.9%
	AC03	Dementia - FAIR Question 3 - Referred for Follow Up	94.7%	92%	100%	100%	100%	100%	66.7%	100%	100%	100%	100%	75%	100%	100%	100%	88.9%	100%	87.5%
	AC04	Percentage of Dementia Carers Feeling Supported	75%	100%	-	-	-	-	-	100%	-	-	-	-	-	-	-	100%	-	-
Outliers	J05	Ward Outliers - Beddays Spent Outlying.	8854	5190	1089	830	717	702	807	485	448	537	424	558	499	730	2636	1994	1409	1787
		Patient Experience																		
Monthly Patient Surveys	P01d	Patient Survey - Patient Experience Tracker Score	-	-	92	92	92	91	91	93	92	92	92	91	92	90	91	91	92	91
	P01g	Patient Survey - Kindness and Understanding	-	-	96	95	96	96	95	97	96	94	96	95	95	95	95	96	95	95
	P01h	Patient Survey - Outpatient Tracker Score	-	-	90	88	89	90	88	87	90	87	90	90	91	89	89	88	89	90
Friends and Family Test Coverage	P03a	Friends and Family Test Inpatient Coverage	35.5%	35.4%	31.7%	34.8%	36.8%	34.6%	38.3%	37.4%	35.8%	35.1%	35.3%	39.5%	33.2%	28.4%	34.5%	36.8%	35.4%	33.9%
	P03b	Friends and Family Test ED Coverage	16.4%	17.5%	21.2%	17.7%	18.4%	15.9%	16.1%	20.9%	17.2%	18.5%	18.3%	17.9%	17.9%	14.6%	19.1%	17.6%	18%	16.9%
	P03c	Friends and Family Test MAT Coverage	22.5%	19.4%	24.6%	29.7%	25.3%	23.6%	17.1%	21.8%	20%	17.3%	18.3%	21%	12.4%	23.1%	26.4%	20.7%	18.6%	19%
Friends and Family Test Score	P04a	Friends and Family Test Score - Inpatients	97.2%	97.6%	97.4%	96.9%	98.5%	97.2%	96.9%	97.7%	97.7%	97.5%	97.7%	97.9%	98.1%	97.8%	97.6%	97.3%	97.6%	98%
	P04b	Friends and Family Test Score - ED	78.2%	81%	80.8%	79.6%	80.2%	83.2%	77%	84.4%	77.4%	81.9%	83.5%	83.3%	80.3%	77%	80.2%	81.7%	81%	80.5%
	P04c	Friends and Family Test Score - Maternity	96.8%	97.1%	98.2%	96.2%	97.4%	96.9%	95.8%	96.9%	94.9%	96.5%	99.2%	98%	97.5%	98.1%	97.3%	96.6%	96.8%	98%
Patient Complaints	T01	Number of Patient Complaints	1875	1392	129	144	168	247	158	150	146	146	138	154	155	98	441	555	430	407
	T01a	Patient Complaints as a Proportion of Activity	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
	T03a	Complaints Responded To Within Trust Timeframe	86.1%	83.2%	87.5%	87.5%	83.3%	76.3%	83%	80.4%	82%	87.3%	78.7%	85.1%	87.1%	83.8%	86%	80.2%	83%	85.4%
	T03b	Complaints Responded To Within Divisional Timeframe	86.6%	84%	85.4%	85%	72.9%	76.3%	83%	78.3%	90%	81.7%	86.9%	83.6%	90%	82.4%	80.9%	79.4%	85.7%	85.4%
	T04c	Percentage of Responses where Complainant is Dissatisfied	11.41%	9.85%	14.58%	10%	12.5%	15.79%	17.02%	21.74%	8%	14.09%	9.84%	10.45%	-	-	12.5%	18.32%	10.99%	3.42%
Cancelled Operations	F01q	Percentage of Last Minute Cancelled Operations (Quality Objective)	0.98%	1.02%	1.24%	1.52%	0.91%	1.34%	1.02%	0.81%	0.81%	0.91%	0.91%	1%	1.26%	1.2%	1.2%	1.05%	0.88%	1.15%
	F01a	Number of Last Minute Cancelled Operations	734	598	79	89	63	80	67	54	54	61	58	68	85	71	231	201	173	224

RESPONSIVE

Topic	ID	Title	Annual Target		Annual		Monthly Totals												Quarterly Totals			
			Green	Red	16/17	17/18 YTD	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	16/17 Q4	17/18 Q1	17/18 Q2	17/18 Q3
Referral to Treatment (RTT) Performance	A03	Referral To Treatment Ongoing Pathways Under 18 Weeks	92%	92%	91.7%	90.1%	92.2%	92%	91.1%	91.1%	91.1%	91%	90.2%	89.9%	89.4%	90%	88.9%	88.3%	91.8%	91.1%	89.8%	89.1%
	A03a	Referral To Treatment Number of Ongoing Pathways Over 18 Weeks	-	-	-	-	2619	2777	3171	2985	3056	3023	3317	3372	3524	3300	2927	3085	-	-	-	-
Referral to Treatment (RTT) Wait Times	A06	Referral To Treatment Ongoing Pathways Over 52 Weeks	0	1	11	175	3	3	2	5	11	46	30	32	19	10	13	9	8	62	81	32
	A07	Referral To Treatment Ongoing Pathways 40+ Weeks	-	-	696	1580	86	106	133	153	165	193	198	240	182	155	136	158	325	511	620	449
New Outpatient Wait List	L02L	New Outpatient List (RTT Specialties) - Numbers Waiting 12+ Weeks	-	-	-	-	7372	7068	6307	6723	7105	7586	7453	9537	11273	12709	7273	7672	-	-	-	-
	L02M	New Outpatient List (RTT Specialties) - Percentage Waiting 12+ Weeks	-	-	-	-	28.5%	28.9%	27.5%	27.6%	28.7%	28.3%	25.6%	30.4%	34.7%	38.3%	29.8%	32.5%	-	-	-	-
Cancer (2 Week Wait)	E01a	Cancer - Urgent Referrals Seen In Under 2 Weeks	93%	93%	94.8%	94.5%	95.9%	95.5%	96.3%	95.1%	95.6%	94.3%	93.4%	93.2%	94.6%	94.7%	95.5%	-	95.9%	95%	93.7%	95%
	E01c	Cancer - Urgent Referrals Stretch Target	80%	80%	68.4%	59.8%	75.3%	76%	79.7%	52.5%	55.4%	62.1%	63.6%	62.4%	59.9%	64.1%	57.6%	-	77.2%	56.8%	62%	60.8%
Cancer (31 Day)	E02a	Cancer - 31 Day Diagnosis To Treatment (First Treatments)	96%	96%	96.7%	96.1%	96.5%	96.8%	97.4%	91.3%	96.6%	95.1%	97%	97.9%	96.9%	95.3%	98%	-	96.9%	94.5%	97.3%	96.6%
	E02b	Cancer - 31 Day Diagnosis To Treatment (Subsequent - Drug)	98%	98%	98.7%	98.6%	100%	100%	98.4%	99.2%	97.5%	98.7%	98.6%	98.6%	98.5%	99.3%	98.7%	-	99.5%	98.4%	98.6%	99%
	E02c	Cancer - 31 Day Diagnosis To Treatment (Subsequent - Surgery)	94%	94%	94.4%	93%	93.8%	92.3%	96.5%	83.3%	92.2%	93.2%	91.7%	96.3%	94.7%	95.6%	96.6%	-	94.3%	89.5%	94.3%	96.2%
	E02d	Cancer - 31 Day Diagnosis To Treatment (Subsequent - Radiotherapy)	94%	94%	96.6%	96.4%	96.9%	97.6%	96.7%	98.1%	96.6%	95.9%	93.9%	97.3%	98%	96.4%	96.1%	-	97%	96.7%	96.3%	96.3%
Cancer (62 Day)	E03a	Cancer 62 Day Referral To Treatment (Urgent GP Referral)	85%	85%	79.3%	81.3%	84.3%	78.8%	81.2%	76.5%	77.8%	81.7%	75%	85.2%	80.2%	84.1%	88.4%	-	81.5%	78.8%	80.1%	86.3%
	E03b	Cancer 62 Day Referral To Treatment (Screenings)	90%	90%	69.4%	79.7%	57.1%	100%	83.3%	71.4%	44.4%	100%	87.5%	100%	100%	66.7%	75%	-	77.8%	65%	96.3%	72.7%
	E03c	Cancer 62 Day Referral To Treatment (Upgrades)	85%	85%	87.9%	84.2%	93.2%	77.8%	88.4%	93%	77.7%	87%	78.6%	84.8%	90.7%	75%	88.3%	-	86.8%	85.5%	84.6%	81.6%
	E03f	Cancer Urgent GP Referrals - Numbers Treated after Day 103	-	-	62	39	5.5	4.5	7.5	4	5	5	8	5	3	7	2	-	17.5	14	16	9
Cancelled Operations	F01	Last Minute Cancelled Operations - Percentage of Admissions	0.8%	0.8%	0.98%	1.02%	1.24%	1.52%	0.91%	1.34%	1.02%	0.81%	0.81%	0.91%	0.91%	1%	1.26%	1.2%	1.2%	1.05%	0.88%	1.15%
	F01a	Number of Last Minute Cancelled Operations	-	-	734	598	79	89	63	80	67	54	54	61	58	68	85	71	231	201	173	224
	F02c	Number of LMCs Not Re-admitted Within 28 Days	29	29	72	29	4	6	15	4	6	2	0	1	3	2	6	5	25	12	4	13
Admissions Cancelled Day Before	F07	Percentage of Admissions Cancelled Day Before	-	-	1.36%	1.46%	0.67%	1.16%	1.13%	1.05%	1.86%	1.82%	1.2%	0.88%	1.73%	1.28%	1.9%	1.38%	0.99%	1.59%	1.26%	1.53%
	F07a	Number of Admissions Cancelled Day Before	-	-	1021	852	43	68	78	63	122	121	80	59	110	87	128	82	189	306	249	297
Primary PCI	H02	Primary PCI - 150 Minutes Call to Balloon Time	90%	70%	72.4%	78.8%	69%	86.1%	83.3%	83.3%	78.1%	77.5%	75%	80.6%	84.8%	73.8%	77.4%	-	79.2%	79.8%	80.2%	75.3%
	H03a	Primary PCI - 90 Minutes Door to Balloon Time	90%	90%	91.7%	92.4%	90.5%	94.4%	100%	90.5%	93.8%	90%	87.5%	94.4%	97%	92.9%	93.5%	-	95%	91.2%	93.1%	93.2%
Diagnostic Waits	A05	Diagnostics 6 Week Wait (15 Key Tests)	99%	99%	97.79%	98.21%	98.38%	98.69%	98.65%	98.56%	98.8%	98.58%	98.52%	97.61%	97.7%	98.19%	98.28%	97.62%	98.58%	98.65%	97.94%	98.03%
Outpatients	R03	Outpatient Hospital Cancellation Rate	9.7%	11.7%	11.5%	10.7%	10.7%	11.2%	11.1%	12%	10.8%	11%	11.2%	11%	10.5%	9.9%	9.7%	10.1%	11%	11.2%	10.9%	9.9%
	R05	Outpatient DNA Rate	5%	10%	7.3%	7.3%	7.3%	6.9%	6.9%	7.1%	7.2%	7.5%	7.4%	7.2%	7.4%	7.1%	7.1%	7.6%	7%	7.3%	7.4%	7.2%
Outpatient Ratio	R01	Follow-Up To New Ratio	2.03	2.03	2.24	2.2	2.29	2.3	2.27	2.2	2.25	2.23	2.25	2.26	2.16	2.1	2.15	2.2	2.28	2.23	2.22	2.15
ERS	BC01	ERS - Available Slot Issues Percentage	-	-	31%	20.5%	26.1%	25.2%	26.4%	24.4%	24%	21.7%	18.8%	16.8%	15.8%	20.2%	22.3%	20.8%	25.9%	23.4%	17.1%	21.1%

RESPONSIVE (continued)

Topic	ID	Title	Annual Target Green	Annual Target Red	Annual 16/17	Annual 17/18 YTD	Monthly Totals Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Quarterly Totals 16/17 Q4	17/18 Q1	17/18 Q2	17/18 Q3
Delayed Discharges	Q01A	Acute Delayed Transfers of Care - Patients	-	-	-	-	29	29	29	19	24	30	18	31	22	26	17	23	-	-	-	-
	Q02A	Non-Acute Delayed Transfers of Care - Patients	-	-	-	-	4	2	16	8	6	6	11	11	11	10	8	9	-	-	-	-
	Q01B	Acute Delayed Transfers of Care - Beddays	-	-	10232	6219	891	750	809	655	604	577	745	647	757	774	854	606	2450	1836	2149	2234
	Q02B	Non-Acute Delayed Transfers of Care - Beddays	-	-	2167	2448	106	183	252	306	145	259	278	374	243	315	273	255	541	710	895	843
Green To Go List	AQ06A	Green To Go List - Number of Patients (Acute)	-	-	-	-	59	52	47	43	42	43	46	51	36	46	44	47	-	-	-	-
	AQ06B	Green To Go List - Number of Patients (Non Acute)	-	-	-	-	6	9	22	14	13	11	15	17	22	22	11	13	-	-	-	-
	AQ07A	Green To Go List - Beddays (Acute)	-	-	-	-	1937	1575	1716	1400	1371	1403	1430	1580	1502	1461	1555	1532	-	-	-	-
	AQ07B	Green To Go List - Beddays (Non-Acute)	-	-	-	-	189	334	450	503	383	419	401	572	515	671	451	479	-	-	-	-
Length of Stay	J03	Average Length of Stay (Spell)	-	-	4.11	4.04	4.11	4.34	4.17	4.14	4.31	4.06	3.8	4.37	4.12	3.87	4	3.74	4.2	4.17	4.09	3.87
	J04D	Percentage Length of Stay 14+ Days	-	-	6.9%	6.8%	6.6%	7.6%	7.1%	7%	7.8%	6.7%	6.2%	7%	6.8%	6.8%	6.9%	6%	7.1%	7.2%	6.7%	6.5%
14 Day LOS Patients	C07	Number of 14+ Day Length of Stay Patients at Month End	-	-	-	-	272	257	269	265	240	226	250	255	237	240	213	243	-	-	-	-
AMU	J35	Percentage of Cardiac AMU Wardstays	-	-	4.1%	4.5%	2.9%	2.2%	4.1%	1.4%	3.9%	5.2%	4.2%	4.3%	4.2%	5%	6.4%	5.6%	3.2%	3.5%	4.2%	5.7%
	J35A	Percentage of Cardiac AMU Wardstays Under 24 Hours	-	-	39.2%	48.7%	57.1%	57.1%	44.1%	63.6%	61.3%	37.2%	39.5%	50%	32.4%	63.6%	60%	38.8%	50.7%	49.4%	40.9%	54.1%

Emergency Department Indicators

ED - Time In Department	B01	ED Total Time in Department - Under 4 Hours	95%	95%	85.01%	88.11%	80.37%	80.73%	83.25%	82.31%	84.21%	87.89%	90.53%	91.26%	90.84%	90.06%	90.33%	85.33%	81.53%	84.81%	90.87%	88.64%
	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%	88.11%	80.37%	80.73%	83.25%	82.31%	84.21%	87.89%	90.53%	91.26%	90.84%	90.06%	90.33%	85.33%	81.53%	84.81%	90.87%	88.64%
	BB07	BRI ED - Percentage Within 4 Hours	-	-	77.42%	81.19%	68.86%	68.15%	73.89%	69.16%	73.76%	79.01%	85.11%	86.82%	86.53%	84.11%	88.22%	77.24%	70.4%	73.99%	86.14%	83.2%
	BB03	BCH ED - Percentage Within 4 Hours	-	-	89.89%	95.03%	90.19%	92.11%	88.92%	96.83%	94.05%	97.14%	96.62%	96.35%	94.99%	96.34%	91.54%	92.56%	90.28%	95.93%	95.97%	93.42%
	BB04	BEH ED - Percentage Within 4 Hours	99.5%	99.5%	98.97%	96.78%	98.56%	99%	99.18%	96.52%	96.57%	97.9%	96.58%	97.04%	96.58%	97.43%	94.21%	98.34%	98.93%	97%	96.74%	96.59%
	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	5	19	5	0	0	0	0	0	0	0	0	0	5	24	0	0	5
Time to Initial Assessment	B02c	ED Time to Initial Assessment - Under 15 Minutes (Excludes BCH)	95%	95%	97.6%	98.3%	98%	98.5%	98.8%	98.9%	96.3%	98.3%	98.5%	99.3%	97.8%	98.8%	98.6%	98.2%	98.4%	97.8%	98.5%	98.5%
	B02b	ED Time to Initial Assessment - Data Completness	95%	95%	92.8%	93.5%	93.6%	94.1%	93.9%	92.1%	91.6%	92.8%	91.8%	92.6%	90.7%	94.2%	94.8%	99.4%	93.8%	92.1%	91.7%	96.2%
Time to Start of Treatment	B03	ED Time to Start of Treatment - Under 60 Minutes	50%	50%	52.6%	52.4%	53.3%	54.3%	51%	50.8%	52.3%	52.8%	54%	55.4%	54.1%	53.2%	48.4%	51%	52.8%	52%	54.5%	50.8%
	B03b	ED Time to Start of Treatment - Data Completeness	95%	95%	98.5%	97.5%	98.7%	98.1%	98.1%	97.8%	97.2%	97.1%	97.4%	97.3%	97.5%	97.1%	97.8%	98%	98.3%	97.4%	97.4%	97.6%
Others	B04	ED Unplanned Re-attendance Rate	5%	5%	2.6%	2.7%	2.5%	3.1%	2.5%	2.6%	2.6%	2.7%	2.7%	1.9%	2.3%	2.9%	3.3%	3.3%	2.7%	2.6%	2.3%	3.2%
	B05	ED Left Without Being Seen Rate	5%	5%	2.2%	2.1%	1.4%	1.8%	2%	2.8%	2.6%	2.5%	2%	2.1%	3.7%	1.1%	1.1%	1%	1.8%	2.6%	2.6%	1.1%
Ambulance Handovers	BA09	Ambulance Handovers - Over 30 Minutes	-	-	1216	634	138	83	11	111	82	84	46	54	44	63	63	87	232	277	144	213
Acute Medical Unit (AMU)	J35	Percentage of Cardiac AMU Wardstays	-	-	4.1%	4.5%	2.9%	2.2%	4.1%	1.4%	3.9%	5.2%	4.2%	4.3%	4.2%	5%	6.4%	5.6%	3.2%	3.5%	4.2%	5.7%
	J35a	Percentage of Cardiac AMU Wardstays Under 24 Hours	-	-	39.2%	48.7%	57.1%	57.1%	44.1%	63.6%	61.3%	37.2%	39.5%	50%	32.4%	63.6%	60%	38.8%	50.7%	49.4%	40.9%	54.1%

EFFICIENT

Topic	ID	Title	Annual		Monthly Totals												Quarterly Totals			
			16/17	17/18 YTD	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	16/17 Q4	17/18 Q1	17/18 Q2	17/18 Q3
Sickness	AF02	Sickness Rate	3.9%	4.0%	4.9%	4.3%	3.8%	3.6%	3.7%	3.8%	4.4%	4.1%	3.7%	4.1%	4.3%	4.1%	3.8%	3.8%	3.7%	4.1%
		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	8648.5	8434.2	8436	8446.1	8367.1	8479.3	8491.6	8499.7	8547.6	8557.9	8599.7	8665.5	8648.5	8446.1	8491.6	8557.9	8648.5
	AF09A	Actual Staff FTE (Including Bank & Agency)	8566.5	8602.9	8458.1	8496.4	8566.5	8510.5	8546.3	8584.7	8602.5	8641.4	8642	8665.1	8679	8602.9	8566.5	8584.7	8642	8602.9
	AF13	Percentage Over Funded Establishment	1.4%	-0.5%	0.3%	0.7%	1.4%	1.7%	0.8%	1.1%	1.2%	1.1%	1%	0.8%	0.2%	-0.5%	1.4%	1.1%	1%	-0.5%
		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	432.4	378.3	398.9	427.9	446.7	476.6	501.8	531	536.4	503.4	495.3	481.4	432.4	427.9	501.8	503.4	432.4
	AF11A	Percentage Bank Usage	5%	5%	4.5%	4.7%	5%	5.2%	5.6%	5.8%	6.2%	6.2%	5.8%	5.7%	5.5%	5%	5%	5.8%	5.8%	5%
		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	59.6	122.5	131	123.7	96.7	94.1	123.4	130.6	125.3	102.9	90.4	70	59.6	123.7	123.4	102.9	59.6
	AF11B	Percentage Agency Usage	1.4%	0.7%	1.4%	1.5%	1.4%	1.1%	1.1%	1.4%	1.5%	1.5%	1.2%	1%	0.8%	0.7%	1.4%	1.4%	1.2%	0.7%
		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	446.8	389.4	384	349.8	331.4	420.4	451	477.3	483.8	434.4	431.3	436.1	446.8	349.8	451	434.4	446.8
	AF07	Vacancy Rate (Vacancy FTE as Percent of Funded FTE)	4.2%	5.2%	4.7%	4.6%	4.2%	4%	5%	5.4%	5.7%	5.7%	5.1%	5.1%	5.1%	5.2%	4.2%	5.4%	5.1%	5.2%
		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	180	170	148	157	177	174	148	189	365	226	133	194	180	157	148	226	180
	AF10	Workforce Turnover Rate	12.8%	13.4%	12.5%	12.6%	12.8%	12.5%	12.7%	12.9%	13.1%	12.7%	12.8%	12.8%	13.2%	13.4%	12.8%	12.9%	12.8%	13.4%
		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%	87%	89%	89%	85%	85%	89%	89%	88%	86%	87%	87%	87%	87%	85%	89%	87%	87%
	AF21b	Essential Training Compliance - Annual Training (Fire & IG)	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
	AF21f	Essential Training Compliance - Fire Safety	83%	87%	82%	82%	83%	82%	84%	84%	86%	87%	87%	87%	87%	87%	83%	84%	87%	87%
	AF21g	Essential Training Compliance - Information Governance	76%	82%	76%	77%	76%	75%	75%	75%	80%	82%	82%	82%	82%	82%	76%	75%	82%	82%
	AF21c	Essential Training Compliance - Induction	97%	97%	96%	97%	97%	98%	98%	98%	98%	98%	98%	98%	97%	97%	97%	98%	98%	97%
	AF21d	Essential Training Compliance - Resuscitation Training	75%	84%	85%	85%	75%	75%	71%	71%	77%	80%	81%	83%	84%	84%	75%	71%	81%	84%
	AF21e	Essential Training Compliance - Safeguarding Training	91%	87%	90%	90%	91%	90%	90%	90%	89%	87%	87%	87%	87%	87%	91%	90%	87%	87%
		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
CT	Computed Tomography
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
MRI	Magnetic Resonance Imaging
NA	Nursing Assistant

NBT	North Bristol Trust
NICU	Neonatal Intensive Care Unit
NOF	Abbreviation used for Neck of Femur
NRLS	National Learning & Reporting System
PET	Positron Emission Tomography
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 DECEMBER 2017:

All Essential Training

	UH Bristol	Diagnostic & Therapies	Facilities & Estates	Medicine	Specialised Services	Surgery	Trust Services	Women's & Children's
Three Yearly	87%	87%	88%	88%	87%	87%	89%	86%
Annual Fire	87%	88%	87%	87%	89%	88%	91%	85%
Annual IG	82%	86%	84%	83%	84%	82%	87%	76%
Induction & Orientation	97%	98%	98%	97%	97%	97%	98%	97%
Medical & Dental Induction	58%	39%	N/A	55%	57%	64%	50%	56%
Resuscitation	84%	79%	N/A	88%	87%	86%	79%	82%
Safeguarding	87%	87%	87%	91%	84%	85%	91%	86%

Timeline of Trust Essential Training Compliance:

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

Safeguarding Adults and Children

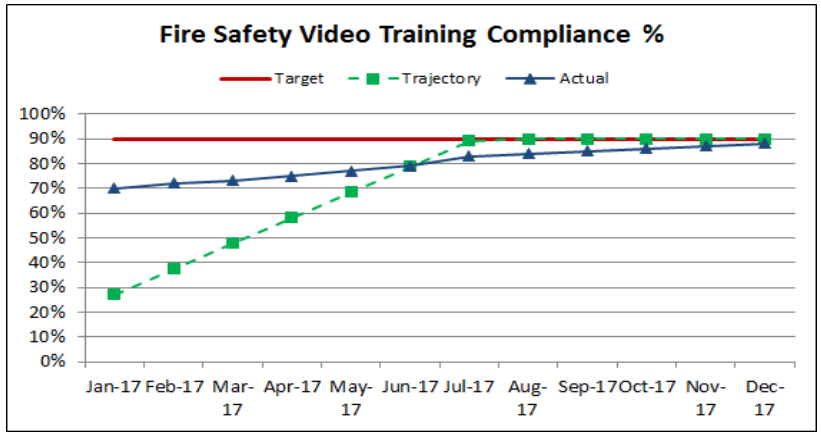
	UH Bristol	Diagnostics & Therapies	Facilities & Estates	Medicine	Specialised Services	Surgery	Trust Services	Women's & Children's
Safeguarding Adults L1	88%	85%	86%	89%	87%	85%	91%	89%
Safeguarding Adults L2	87%	89%	86%	91%	85%	86%	86%	85%
Safeguarding Adults L3	87%	80%	N/A	87%	92%	92%	80%	100%
Safeguarding Children L1	91%	91%	85%	94%	94%	90%	93%	N/A
Safeguarding Children L2	85%	81%	95%	90%	81%	82%	76%	91%

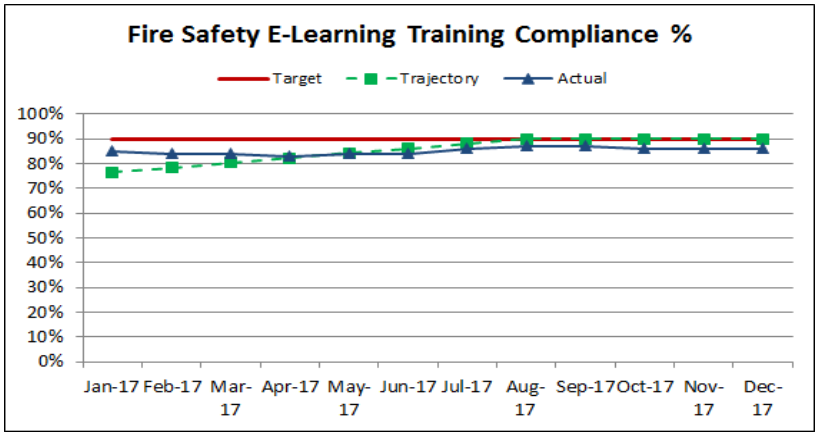
Child Protection Level 3

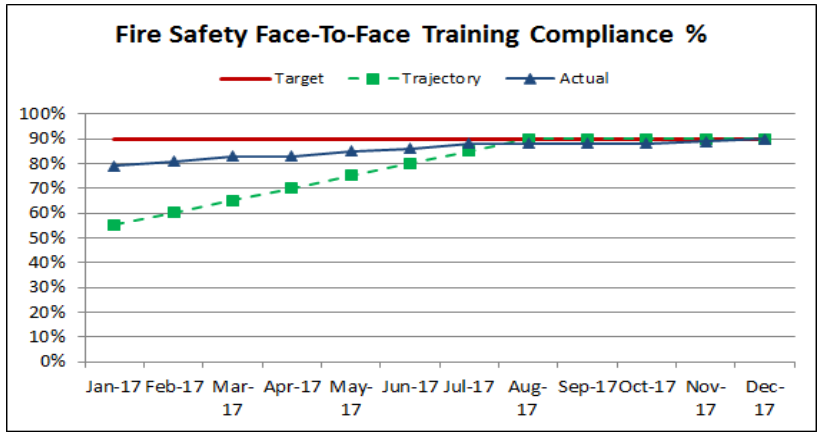
	UH Bristol	Diagnostic & Therapies	Medicine	Specialised Services	Surgery	Trust Services	Women`s & Children`s
Core	75%	76%	69%	87%	73%	100%	76%
Specialist	83%	N/A	N/A	N/A	N/A	100%	83%

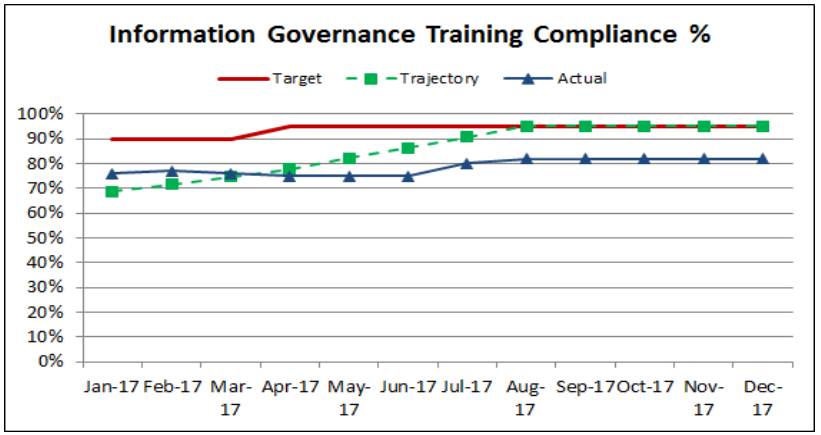
Appendix 2 (continued)

PERFORMANCE AGAINST TARGET FOR FIRE AND INFORMATION GOVERNANCE









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 (13/11/17 – 10/12/17)

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	468	193		82		743
Health Care Assistant & Other Support	4	29		30		63
Medical & Dental	3	19				22
Scientific, Therapeutic/ Technical Allied Health Professional (AHP) & Healthcare Science		0			0	0
Administrative & Clerical and Estates	748					748

Appendix 3

Access standards – further breakdown of figures

A) 62-day GP standard – performance against the 85% standard, the Sustainability and Transformation Partnership Trajectory, and the recovery trajectory

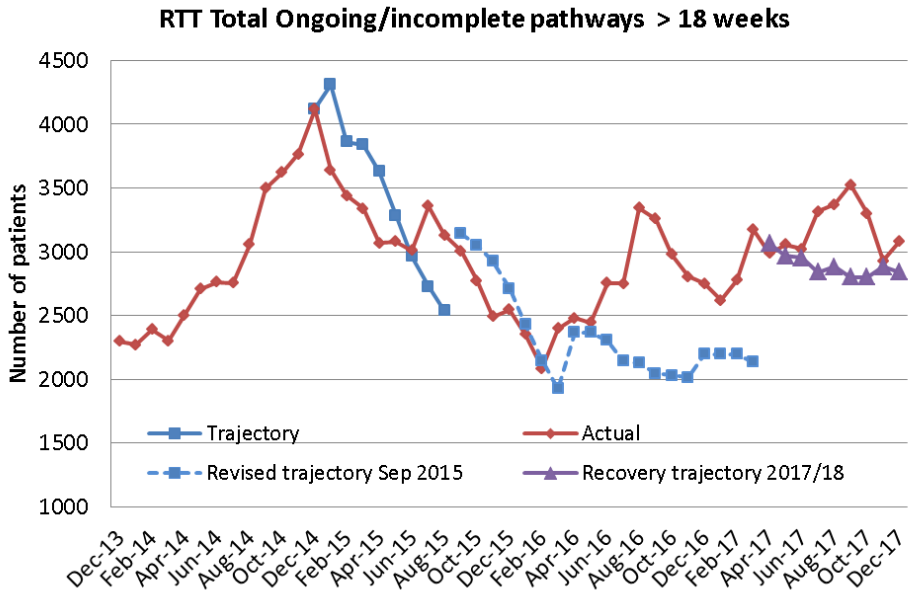
	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18
Actual 62-day GP performance	76.7%	78.0%	81.7%	75.0%	85.2%	80.2%	84.1%	88.4%				
STP trajectory	81.0%	81.0%	81.0%	83.6%	83.6%	83.6%	82.5%	82.5%	82.5%	82.6%	82.6%	82.6%
Recovery trajectory	-	-	-	-	81.0%	80.0%	80.5%	79.0%	80.6%	81.4%	81.6%	85.0%
Quarter performance recovery trajectory	-			79.0%			80.0%			82.5%		
Quarter performance STF trajectory	81.0%			83.6%			82.5%			82.6%		
Quarter performance actual	78.8%			80.1%								

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 November 2017

RTT Specialty	Ongoing Over 18 Weeks	Ongoing Pathways	Ongoing Performance
Cardiology	327	1,920	**83.0%**
Cardiothoracic Surgery	59	296	**80.1%**
Dermatology	97	1,630	**94.0%**
E.N.T.	68	2,052	**96.7%**
Gastroenterology	21	626	**96.6%**
General Medicine	0	10	**100.0%**
Geriatric Medicine	10	90	**88.9%**
Gynaecology	127	1,101	**88.5%**
Neurology	81	403	**79.9%**
Ophthalmology	437	3,780	**88.4%**
Oral Surgery	194	1,742	**88.9%**
Other	1,541	10,787	**85.7%**
Rheumatology	15	520	**97.1%**
Thoracic Medicine	16	718	**97.8%**
Trauma & Orthopaedics	92	676	**86.4%**
Grand Total	**3,085**	**26,351**	**88.3%**



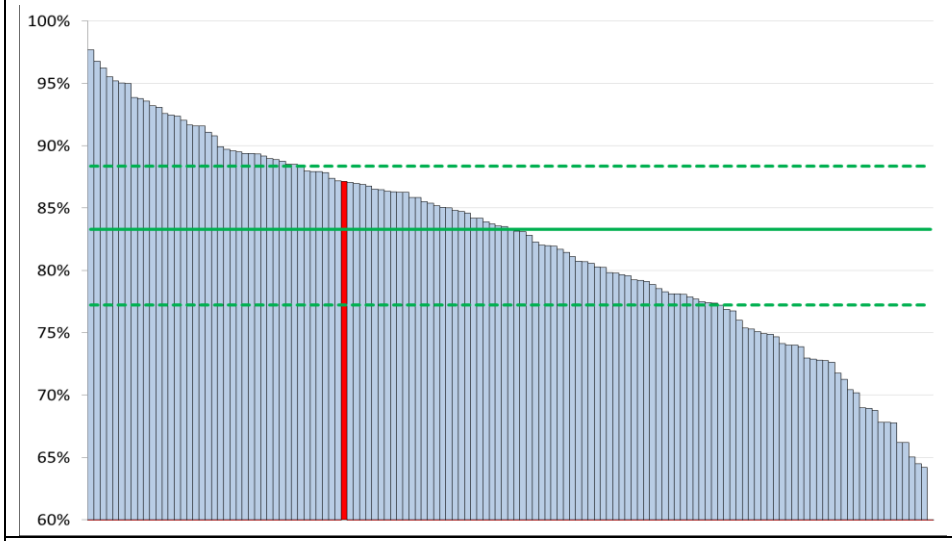
	Apr 17	May 17	Jun 17	Jul 17	Aug 17	Sep 17	Oct 17	Nov 17	Dec 17
Non-admitted pathways > 18 weeks	1705	1744	1750	2006	2107	2221	1962	1711	1783
Admitted pathways > 18 weeks	1280	1312	1273	1311	1265	1303	1338	1216	1302
Total pathways > 18 weeks	2895	3056	3023	3317	3372	3524	3300	2927	3085
Actual % incomplete < 18 weeks	91.1%	91.1%	91.0%	90.2%	89.9%	89.4%	90.0%	89.5%	88.3%
Recovery forecast	90.9%	91.4%	91.8%	92.0%	92.0%	92.0%	92.0%	92.0%	92.0%

Note: 2017/18 Recovery Trajectory is currently under review.

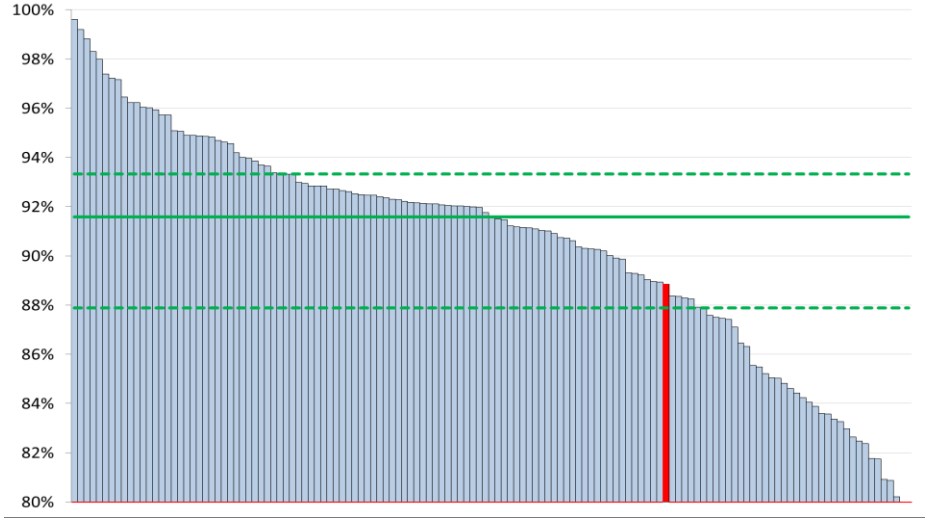
Appendix 4

Benchmarking Reports

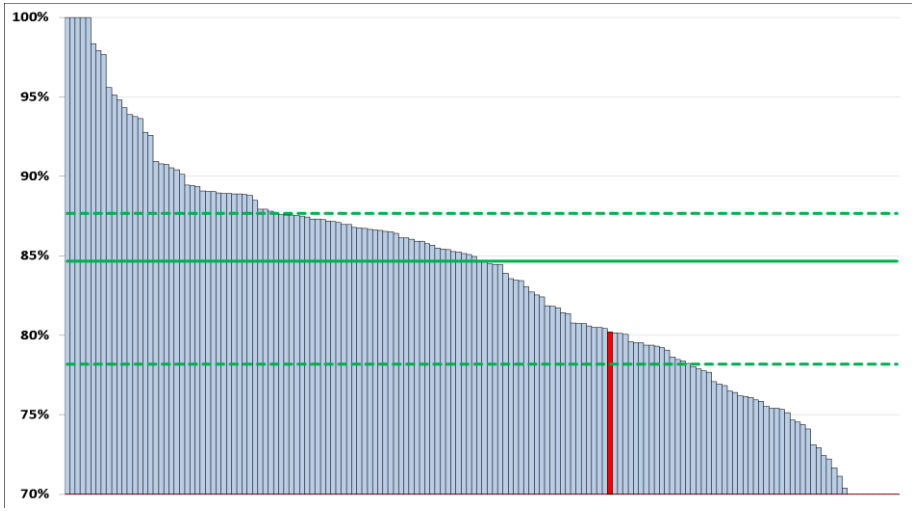
A&E 4-hours – Type 1 Departments (Quarter 3 – Oct to Dec 2017)



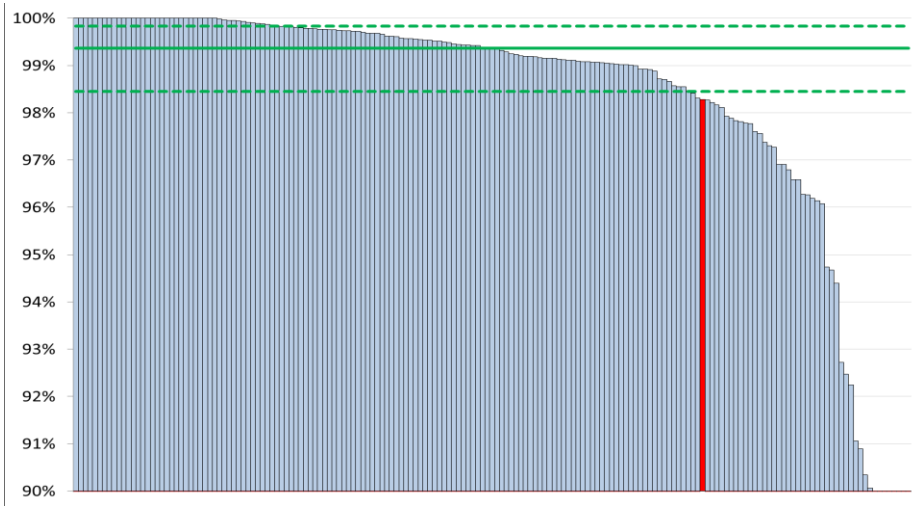
Referral to Treatment Time (November 2017)



62-day GP cancer (Quarter 2 2017/18)



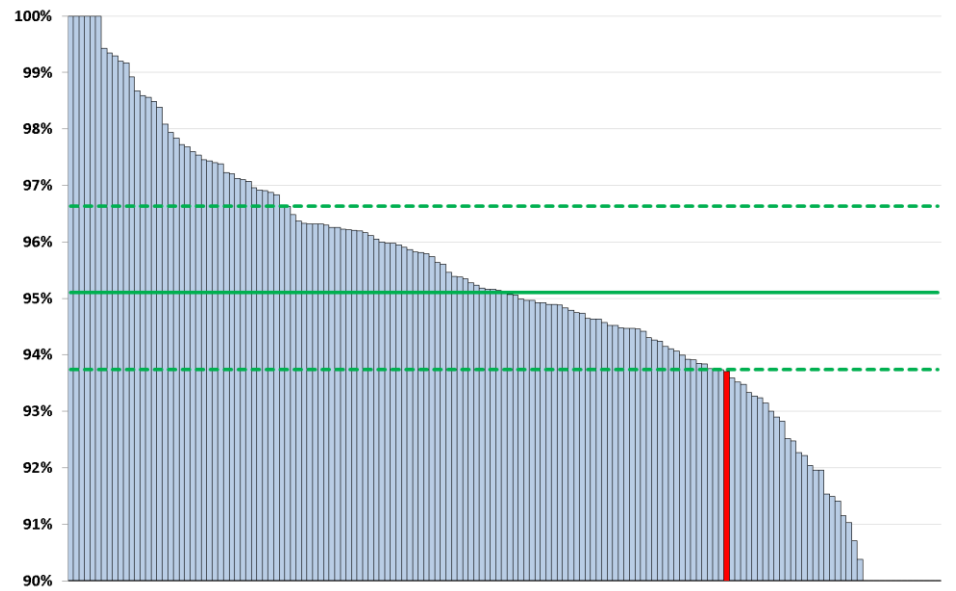
6-week diagnostic (End of November 2017)



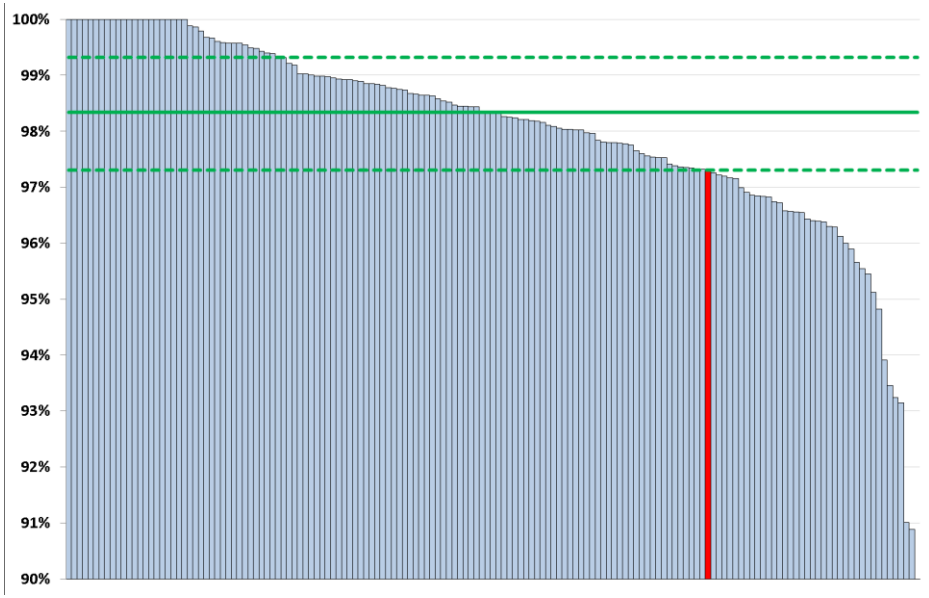
Appendix 4 (continued)

Benchmarking Reports

Cancer 2-Week wait (Quarter 2 2017/18)



31-day first definitive cancer (Quarter 2 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.

University Hospitals Bristol
NHS Foundation Trust

Cover report to the Public Trust Board Meeting to be held on 31 January 2018 at 11.00 – 13.00 in the Conference Room, Trust HQ, Marlborough St, Bristol, BS1 3NU

		Agenda Item	9a
Meeting Title	Trust Board	**Meeting Date**	Wednesday, 31 January 2018
Report Title	**Quarterly Complaints Report – Q2**		
Author	Tanya Tofts, Patient Support and Complaints Manager		
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.	☒	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 second 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

In Q2:

- The Trust received 430 complaints
- The most common causes for complaint related to 'appointments and admissions'; this is a change from Q1 when the most common causes related to 'attitude and communication'
- 10% of complainants (formal resolution) were dissatisfied with the investigation of their

concerns

Improvements in Q2:

- There was a 15% decrease in complaints regarding appointments and admissions compared to Q1
- There was a 20% reduction in the overall number of complaints received by the Bristol Heart Institute compared to Q1

However:

- The trend in complaints about appointment administration issues continued into Q2, with 45 complaints received in the quarter, compared to 46 in Q1.
- Timeliness in investigating complaints remained below target – in Q1, 83% of formal complaints were responded to within the agreed timeframe.
- There is an emerging trend of increased complaints about Bristol Eye Hospital (although the level of complaints remains better than during the year prior to May 2017)
- Complaints about 'attitude of nursing/midwifery staff' and 'clinical care (nursing/midwifery) both rose in Q2

Corporate plans include:

- Completion of a collaborative project with the Patients Association which has led to the development of complaints toolkit which will be made nationally available. This will include guidance about achieving objectivity and obtaining independent views within the context of the complaints resolution process.

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 recruit, train and sustain an engaged and effective workforce.	☐	Failure to comply with targets, statutory duties and functions.	☐
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.	☐		

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)**
		22/12/2017		Patient Experience Group 30/11/17, Senior Leadership Group 20/12/17

University Hospitals Bristol
NHS Foundation Trust

Complaints Report

Quarter 2, 2017/2018

(1 July 2017 to 30 September 2017)

Author: Tanya Tofts, Patient Support and Complaints Manager

Overview

Successes	Priorities
• In quarter 2, the Patient Support & Complaints Team acknowledged receipt of 100% of complaints within the agreed standard for timeliness. • There was a 15% decrease in complaints regarding appointments and admissions compared to quarter 1. • There was a 20% reduction in the overall number of complaints received by the Bristol Heart Institute compared to quarter 1.	• To increase divisional focus on ensuring timely complaints responses – in quarter 2, 83% of formal complaints and 65.8% of informal complaints were responded to within the agreed timeframe. • To continue to focus on getting the tone and substance of response letters right. Quarter 2 saw a reduction in the number of dissatisfied responses to our complaints investigations (9.9% compared to 18.2% in the previous quarter).
Opportunities	**Risks & Threats**
• Work has commenced with the Patients Association to develop a toolkit for complaints investigations; this will be made available nationally and will be launched at a complaints conference hosted by UH Bristol in March 2018. • The Trust's new complaints review panel met twice in quarter 2 (in October and November 2017 with the Divisions of Medicine and Diagnostics & Therapies respectively), including lay representation. Feedback from both sessions has been very positive; points of learning have been welcomed and embraced by the divisions.	• The trend in complaints about appointment administration issues continued into quarter 2, with 45 complaints received in the quarter, compared to 46 in quarter 1. • Although complaints about Bristol Eye Hospital remain lower than they were for much of the year prior to May 2017, there is an emerging pattern of monthly increases in complaints since that time which the division is monitoring closely. • Complaints about 'attitude of nursing/midwifery staff' and 'clinical care (nursing/midwifery) both rose in quarter 2.

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.

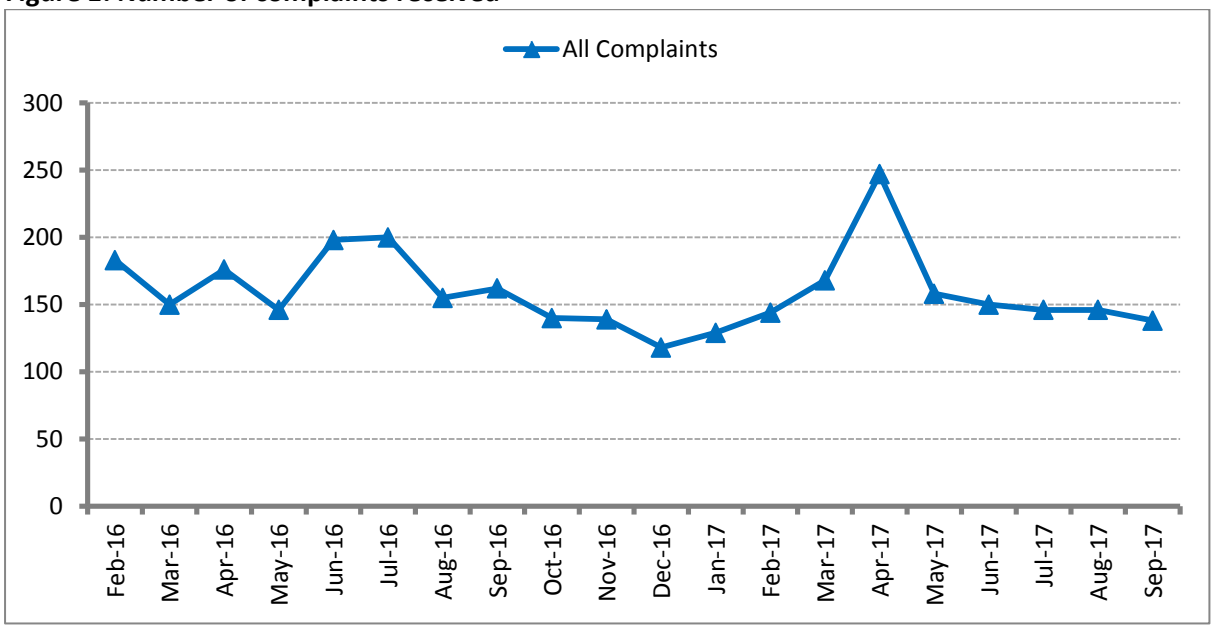
As complaints can be about inpatient stays, Emergency Department (ED) attendances, outpatient appointments, diagnostic tests, or matters indirectly linked to that, such as car parking, toilets, catering, portering, websites, call centres, etc., we now report complaints as a proportion of activity separately for inpatient, outpatient, ED and other. The data for this measure is shown later in this report at section 3.2.1.

1.1 Total complaints received

We received 430 complaints in Q2 of 2017/18. The total figure of 430 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 Q2 represents a decrease of 22.5% compared to Q1 of 2017/18, the latter of which was particularly high at 555, due to a special cause variation in April 2017 (as reported in Q1). However, the Q2 total of 430 is also a decrease of 16.8% on the corresponding period one year previously.

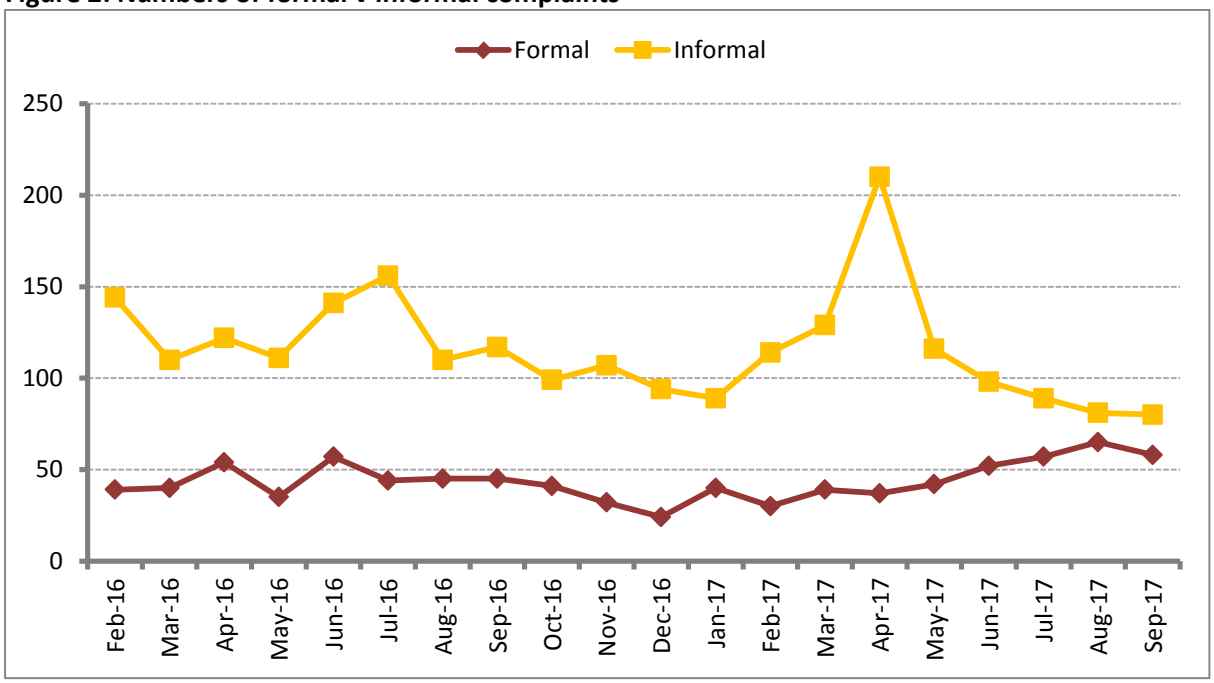
Figure 1 shows the pattern of complaints received in the last 20 months, which is when the Trust commenced recording complaints on the Datix system. Figure 2 shows complaints dealt with via the formal investigation process compared to those dealt with via the informal investigation process, over the same period.

Figure 1: Number of complaints received



[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 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.

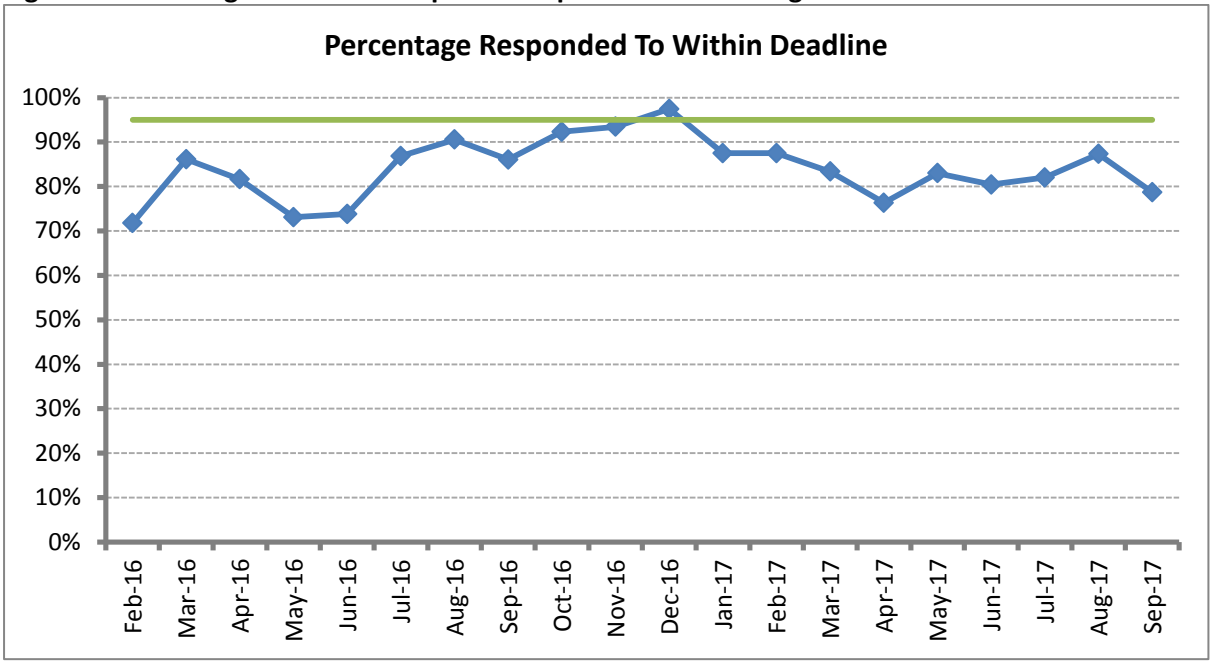
When a complaint is managed through the informal resolution process, the Trust and complainant also agree a timescale and this is usually 10 working days.

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 Q2 of 2017/18, 83.0% of responses were posted within the agreed timescale, compared to 80.2% in Q1 2017/18, 86.0% in Q4 of 2016/17 and 88.1% during the same period one year previously. This represents 36 breaches out of 182 formal complaints which received a response during Q2 of 2017/18[2]. Figure 3 shows the Trust's performance in responding to complaints since February 2016.

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

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



1.2.2 Informal Investigations

In Q2 2017/18, the Trust received 250 complaints that were investigated via the informal process. During this period, 237 informal complaints were responded to and 65.8% of these (156 of 237) were resolved within the time agreed with the complainant.

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 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].

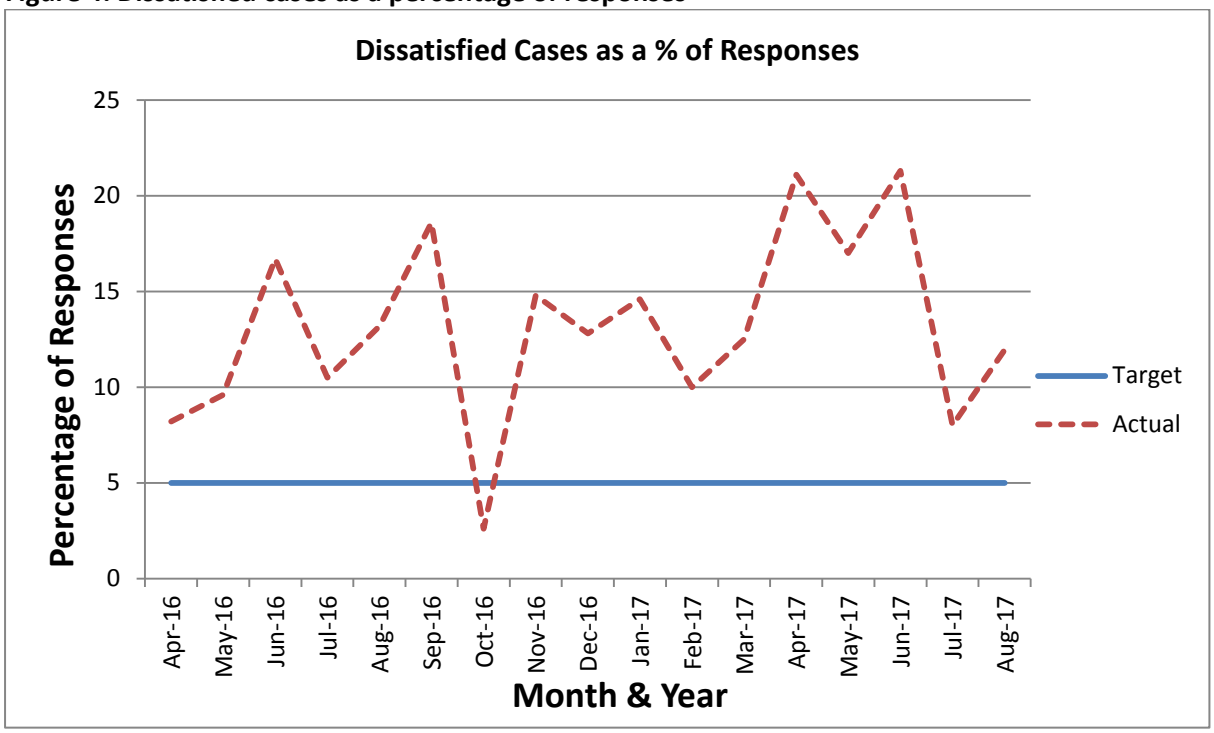
The way in which dissatisfied cases are reported is expressed as a percentage of the responses the Trust has sent out in any given month and our target is for less than 5% of complainants to be dissatisfied. This data is reported two months in arrears in order to capture the majority of cases where complainants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

In Q2, by the cut-off point of mid-November 2017 (the date by which the dissatisfied data for July and August 2017 was finalised), 12 people had contacted us to say they were dissatisfied. This represents 9.9% of the 121 responses sent out during those months. Previously, in Q1, of a total of 132 responses sent out in the quarter, 24 had received a dissatisfied response at the point when monthly data was frozen for board reporting. This represented 18.2% of the responses sent out.

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

Figure 4 shows the percentage of complainants who were dissatisfied with aspects of our complaints response up until July 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;
- 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 Q2 2017/18 compared to Q1. In Q2, complaints in most of the major categories/themes decreased, including appointments and admissions (decreased from 159 complaints to 136). There were only slight increases in complaints about access and information & support.

Table 1: Complaints by category/theme

Category/Theme	Number of complaints received in Q2 (2017/18)	Number of complaints received in Q1 (2017/18)
Appointments & Admissions	136 (31.6%) ↓	159 (28.6% of total complaints) ↑
Clinical Care	121 (28.1%) ↓	129 (23.2%) ↑
Attitude & Communication	107 (24.9%) ↓	191 (34.4%) ↑
Information & Support	25 (5.8%) ↓	37 (6.7%) ↓
Facilities & Environment	17 (4%) ↑	16 (2.9%) ↓
Discharge/Transfer/Transport	15 (3.5%) ↓	17 (3.1%) ↑
Documentation	6 (1.4%) =	6 (1.1%) ↑
Access	3 (0.7% of total complaints) ↑	0 (0%) =
Total	**430**	**555**

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 almost three quarters of the complaints received in Q2 (310/430).

Table 2: Complaints by sub-category

Sub-category	Number of complaints received in Q2 (2017/18)	Q1 (2017/18)	Q4 (2016/17)	Q3 (2016/17)
Cancelled/delayed appointments and operations	68 (9.3% decrease compared to Q1) ↓	75	54	66
Clinical care (Medical/Surgical)	58 (17.1% decrease compared to Q1) ↓	70	70	54
Appointment administration issues	45 (2.2% decrease compared to Q1) ↓	46	35	152
Clinical care (Nursing/Midwifery)	28 (55.6% increase compared to Q1) ↑	18	13	13

Attitude of medical staff	28 (3.4% decrease compared to Q1) ↓	29	27	14
Failure to answer telephones/failure to respond	25 (13.6% increase compared to Q1) ↑	22	22	24
Communication with patient/relative	18 (20% increase compared to Q1) ↑	15	20	25
Attitude of nursing/midwifery staff	16 (433.3% increase compared to Q1) ↑	3	4	5
Discharge arrangements	13 (30% increase compared to Q1) ↑	10	12	13
Lost/misplaced medical records and/or test results	11 =	11	5	9

Complaints about 'discharge arrangements' and 'lost medical notes and test results' have been included for the first time in Q2 as these two sub-categories have replaced 'transport' and 'attitude of administrative staff' in the list of most frequently reported complaints themes.

There were increases in Q2 in respect t of complaints received about 'clinical care (nursing/midwifery)' - from 18 in Q1 to 28 in Q2; and in complaints received about 'attitude of nursing/midwifery', from 3 in Q1 to 16 in Q2.

Complaints about 'clinical care (nursing/midwifery)' were received by all bed-holding Divisions: Women & Children – 12; Medicine – 9; Surgery – 5; and Specialised Services – 2.

Complaints about 'attitude of nursing/midwifery' were also received by all bed-holding Divisions: Medicine – 7; Surgery – 4; Women & Children – 3; and Specialised Services – 1.

In Q1, the number of complaints in respect of 'appointment administration issues' was flagged as a potential concern. This pattern was sustained in Q2, with only a 2% decrease compared to Q1.

In Q2, complaints in this sub-category were received by all clinical Divisions, as follows:

- Surgery – 21
- Medicine – 8
- Specialised Services – 7
- Women & Children – 5
- Diagnostics & Therapies – 4

The complaints in this category were received by:

- Bristol Royal Infirmary – 14
- Bristol Dental Hospital – 12
- Bristol Heart Institute – 7
- Bristol Eye Hospital – 4
- Bristol Royal Hospital for Children – 4
- St Michael's Hospital – 3
- South Bristol Community Hospital – 1

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

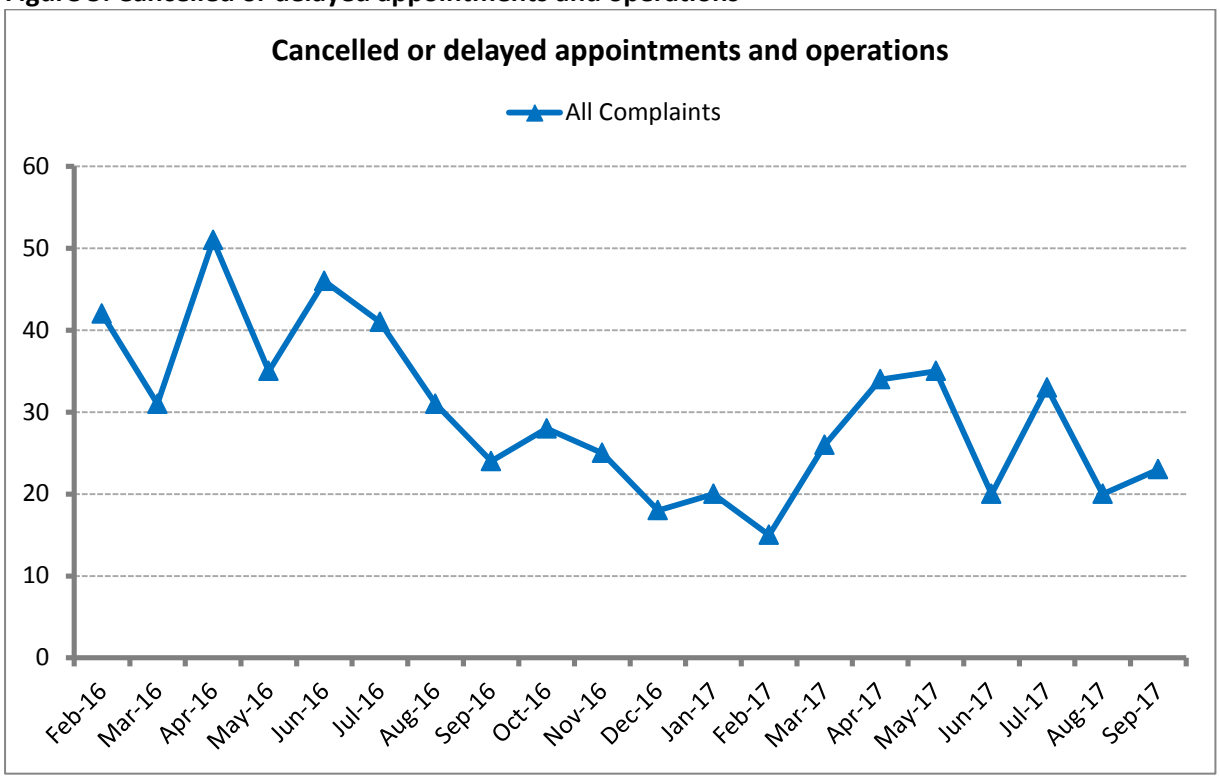


Figure 6: Clinical care – Medical/Surgical

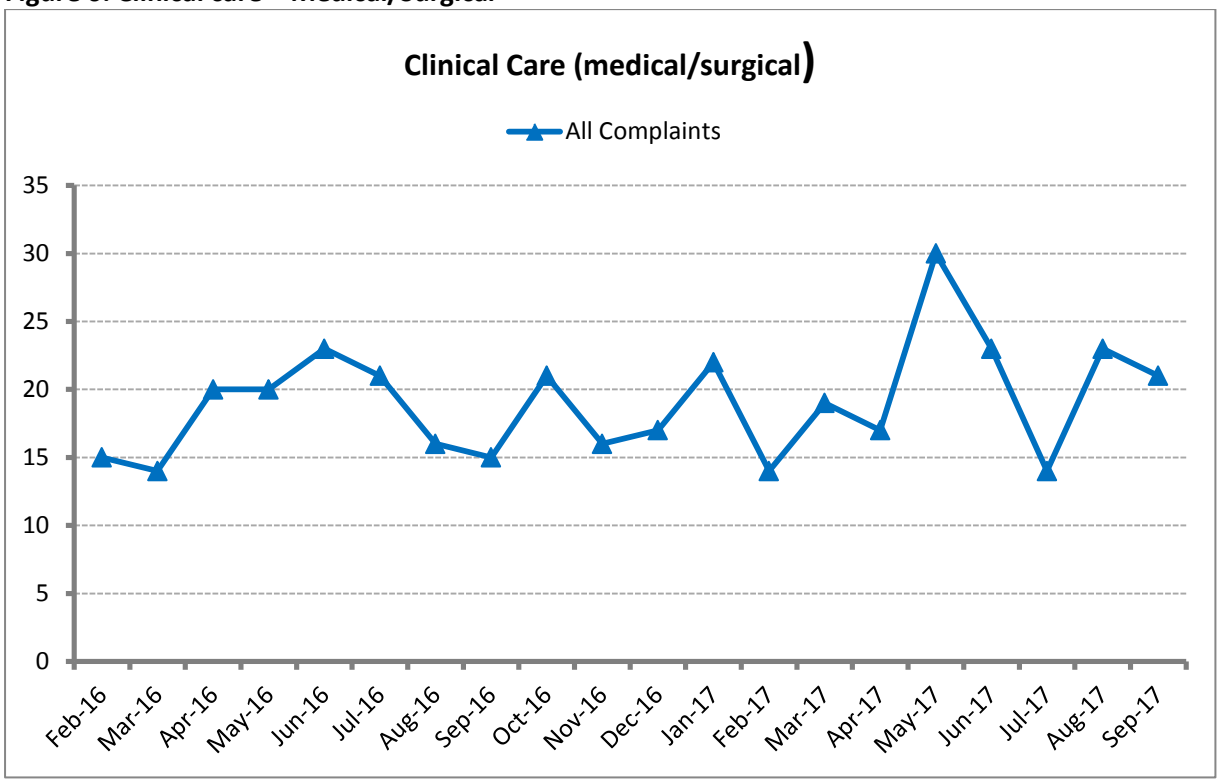
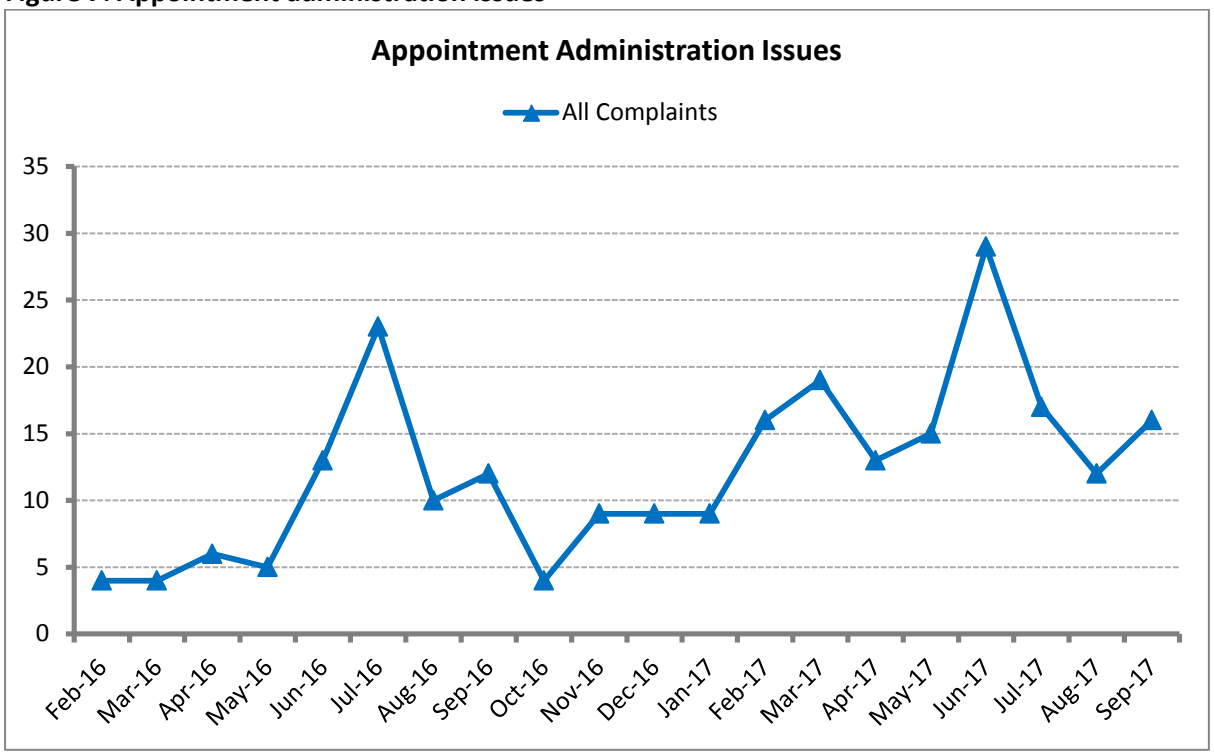


Figure 7: Appointment administration issues



3. Divisional Performance

3.1 Divisional analysis of complaints received

Table 3 provides an analysis of Q2 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	150 (175) ↓	108 (102) ↑	57 (70) ↓	74 (73) ↑	18 (13) ↑
Number of complaints about appointments and admissions	66 (94) ↓	19 (13) ↑	23 (31) ↓	22 (18) ↑	6 (3) ↑
Number of complaints about staff attitude and communication	29 (30) ↓	34 (27) ↑	13 (9) ↑	16 (19) ↓	7 (1) ↑
Number of complaints about clinical care	35 (36) ↓	36 (42) ↓	15 (19) ↓	31 (26) ↑	4 (5) ↓
Area where the most complaints have been received in Q4	Bristol Dental Hospital – 52 (79) Bristol Eye Hospital – 30 (25) Trauma & Orthopaedics – 11 (8) ENT – 13 (10) Lower GI – 4 (9) Upper GI – 8 (7)	Emergency Department (BRI) – 18 (28) Dermatology – 15 (9) Sleep Unit 7 (9) Ward A300 (AMU) – 5 (9) Ward A400 – 5 Ward A515 – 5 Ward A522 – 5	BHI (all) – 40 (50) BHI Outpatients – 18 (12) BHI Waiting List Office – 11 (8) Ward C708 – 2 (6) Appointments Dept (BHOC) – 3 (10)	Children's ED & Ward 39 (BRHC) – 6 (4) Gynaecology Outpatients (StMH) – 6 (6) Paediatric Orthopaedics – 6 (2) Central Delivery Suite (STMH) – 2 (6)	Radiology – 6 (4) Physiotherapy – 5 (3) Audiology – 2 (2)
Notable deteriorations compared to Q1	None	Dermatology – 15 (9)	BHI Outpatients – 18 (12)	None	Physiotherapy – 5 (3)
Notable improvements compared to Q1	None	Emergency Department – 18 (28)	BHI (all) – 40 (50) Appointments Dept (BHOC) – 3 (10)	Paediatric Orthopaedics – 6 (2)	None

3.1.1 Division of Surgery

In Q2, the Division of Surgery experienced a decrease of 14.5% in the total number of complaints received. There was a marked decrease in complaints about appointments and admissions (including cancelled or delayed appointments and operations), with 66 compared to 94 in Q1. Complaints about Bristol Dental Hospital also decreased from 79 in Q1 to 52 in Q2. Complaints about clinical care (nursing) and attitude of nursing staff both increased in Q2, as did complaints in respect of discharge arrangements. Although complaints about Bristol Eye Hospital remain lower than they were for much of the year prior to May 2017, there is an emerging pattern of monthly increases in complaints since that time which the division is monitoring closely.

Table 4: Complaints by category type

Category Type	**Number and % of complaints received – Q2 2017/18**	**Number and % of complaints received – Q1 2017/18**
Access	3 (2% of total complaints) ↑	0 (0% of total complaints) =
Appointments & Admissions	66 (44%) ↓	94 (53.7%) ↑
Attitude & Communication	29 (19.3%) ↓	30 (17.1%) ↓
Clinical Care	35 (23.3%) ↓	36 (20.6%) ↑
Facilities & Environment	2 (1.3%) ↑	1 (0.6%) ↓
Information & Support	9 (6%) ↓	11 (6.3%) ↓
Discharge/Transfer/ Transport	5 (3.3%) ↑	2 (1.1%) ↑
Documentation	1 = (0.7%)	1 (0.6%) =
Total	**150**	**175**

Table 5: Top sub-categories

Category	**Number of complaints received – Q2 2017/18**	**Number of complaints received – Q1 2017/18**
Cancelled or delayed appointments and operations	39 ↓	42 ↑
Clinical care (medical/surgical)	21 ↓	22 ↑
Appointment administration issues	22 ↓	33 ↑
Clinical care (nursing)	5 ↑	2 ↑
Attitude of medical staff	8 ↓	9 ↓
Failure to answer telephones/ failure to respond	11 ↑	10 ↑
Communication with patient/relative	3 =	3 ↓
Attitude of nursing staff	4 ↑	0 =
Discharge arrangements	5 ↑	1 ↓
Lost/misplaced medical records and/or test results	3 =	3 ↑

Table 6: Divisional response to concerns highlighted by Q2 data

Concern	Explanation	Action
In Q1, the Division reported that a significant proportion of complaints about the BDH related to concerns about telephone communications and attitude of administrative staff. The Division was seeking to identify which telephone numbers were the source of the problem and customer training was being arranged for administrative staff. Complaints about the Bristol Dental Hospital (BDH) decreased from 79 in Q1 to 52 in Q2, however this still accounted for a third of all complaints received by the Division in this period. The majority of BDH complaints were about Adult Restorative Dentistry (18), Administration Department 14), Child Dental Health (7) and Oral Surgery (7). Of the 52 complaints received, 19 related to cancelled or delayed appointments or procedures; 12 related to appointment administration issues and 9 were about failure to answer telephones.	We believe that the reduction in complaints in Q2 is, at least in part, due to the positive actions described in the Q1 report. We are continuing to monitor the telephone numbers that are being used by patients so that any delays in responding can be followed up. A complaints triage process has also been put in place, resulting in improvements in the timeliness of responding to informal complaints about BDH. A specific issue has been identified regarding a member of staff not answering their phone/messages. This has been addressed and the performance of the staff member is being managed and monitored.	Answer phones are on reception and in the patient access (outpatient booking) team are closely monitored. Administration teams are being restructured - due to be completed in Q3. Two new operational staff have also been appointed, providing more support for the admin teams. Patient access (outpatient booking team) is being relaunched with a focus on team working and effective cross-cover, with the aim of improving the overall performance. A 'BDH the Voice' competition has been held. The winner of the completion will use their voice to standardise all answerphone messages within the BDH. We are looking at various telephonic solutions to improve the flow of calls throughout the hospital. A consultant-led task and finish group met for the first time in November, focussing on the telephone communication pathway to help resolve patient concerns. The organisational development team is supporting the BDH in designing a bespoke customer service package to improve the performance of the receptionists.
The number of complaints about the Ear Nose and Throat service increased slightly from 10 in Q1 to 13 in Q2. These were all received by ENT Outpatients at St Michael's Hospital and were mainly in respect of cancelled or delayed appointments and appointment administration issues.	No specific patterns or trends have been identified.	Continue to monitor.

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

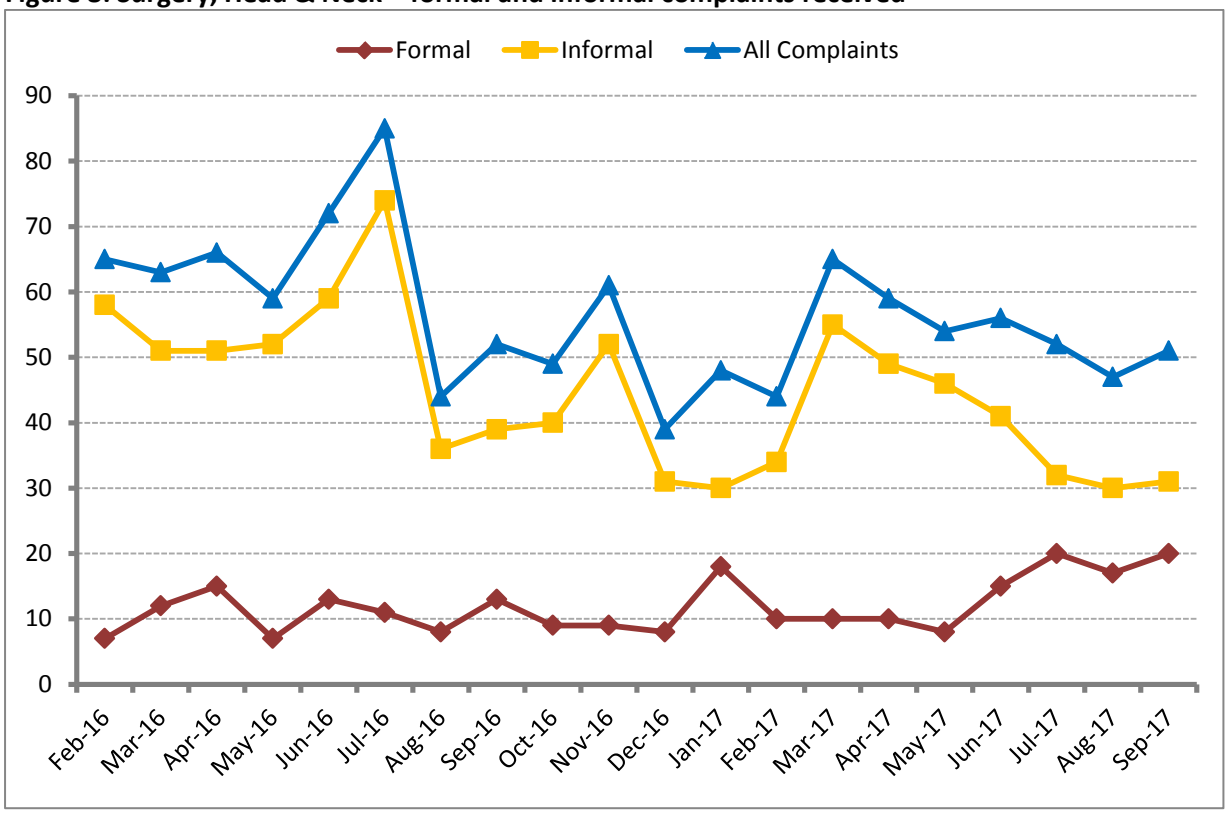


Figure 9: Complaints received by Bristol Dental Hospital

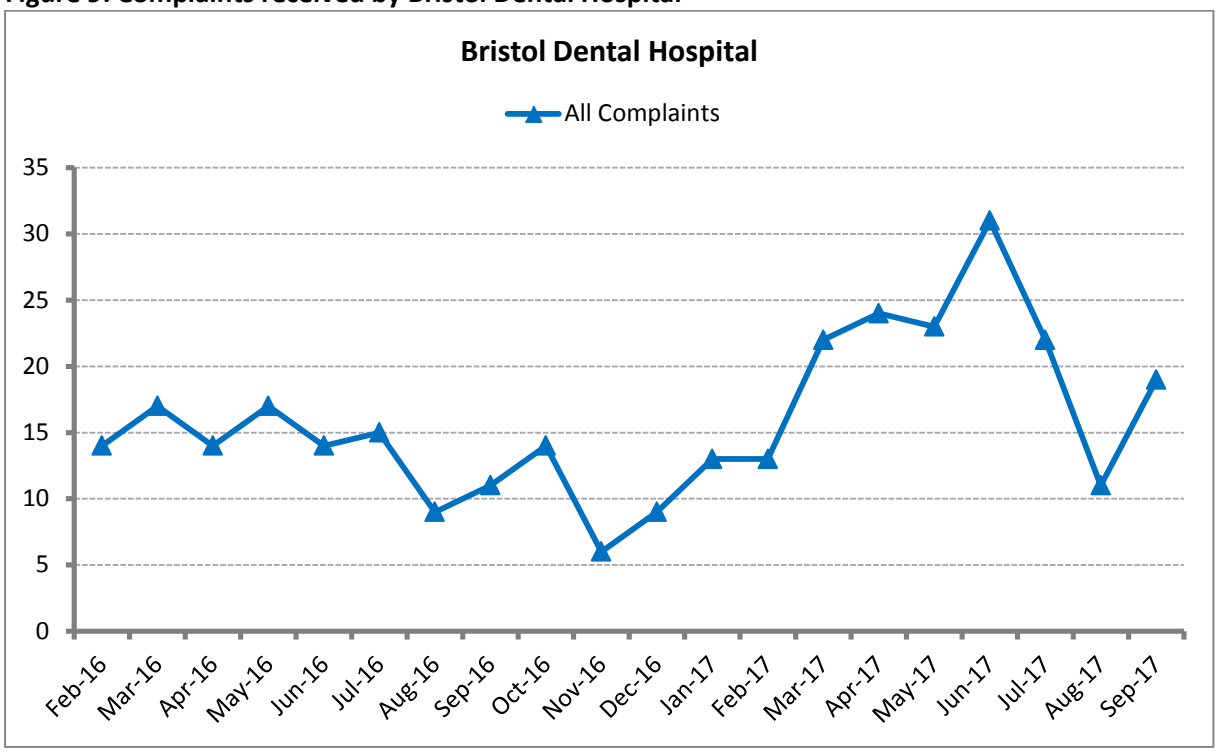
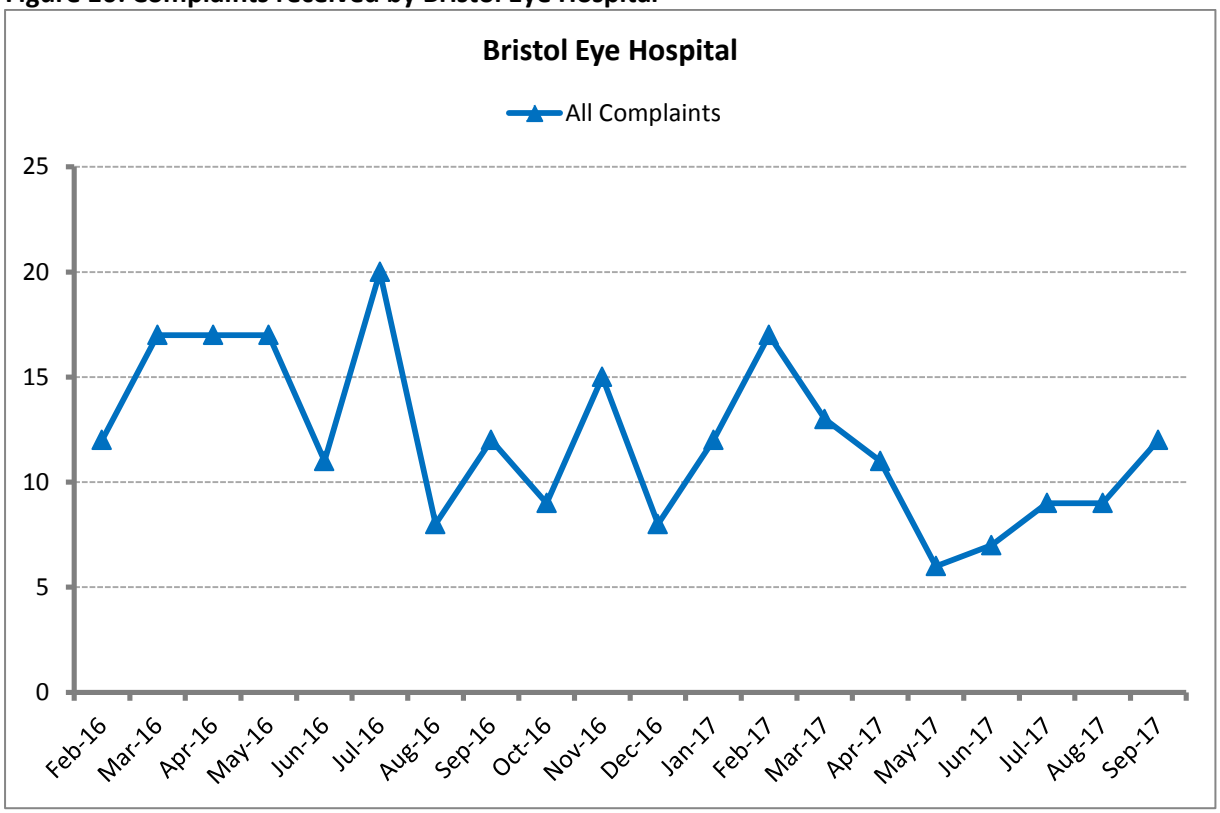


Figure 10: Complaints received by Bristol Eye Hospital



3.1.2 Division of Medicine

In Q2, the Division of Medicine received a similar amount of complaints as in Q1. There were increases in the number of complaints received in respect of appointments and admissions, information and support and discharge/transfer/transport. Complaints in respect of clinical care and facilities and environment both decreased.

Table 7: Complaints by category type

Category Type	Number and % of complaints received – Q2 2017/18	Number and % of complaints received – Q1 2017/18
Access	0 (0% of total complaints) =	0 (0% of total complaints) =
Appointments & Admissions	19 (17.6%) ↑	13 (12.7%) ↓
Attitude & Communication	34 (31.5%) ↑	27 (26.5%) ↑
Clinical Care	36 (33.3%) ↓	42 (41.2%) ↑
Facilities & Environment	2 (1.9%) ↓	4 (3.9%) ↓
Information & Support	7 (6.5%) ↑	4 (3.9%) =
Discharge/Transfer/ Transport	9 (8.3%) ↑	8 (7.8%) ↑
Documentation	1 (0.9%) ↓	4 (3.9%) ↑
Total	**108**	**102**

Table 8: Top sub-categories

Category	Number of complaints received – Q2 2017/18	Number of complaints received – Q1 2017/18
Cancelled or delayed appointments and operations	9 ↑	5 ↓
Clinical care (medical/surgical)	19 ↓	26 ↑
Appointment administration issues	8 ↑	6 ↓
Clinical care (nursing)	9 ↑	7 ↑
Attitude of medical staff	12 =	12 ↑
Failure to answer telephones/failure to respond	5 =	5 ↑
Communication with patient/relative	6 ↑	2 ↓
Attitude of nursing staff	7 ↑	2 ↑
Discharge arrangements	8 ↑	3 ↓
Lost/misplaced medical records and/or test results	3 ↓	4 ↑

Table 9: Divisional response to concerns highlighted by Q2 data

Concern	Explanation	Action
The Dermatology service received 15 complaints in Q2, compared to 9 in Q1, with 7 of these being about appointment issues. A further 4 related to attitude and communication.	The Dermatology service now incorporates services at Weston and Taunton. A significant quality focus of the expanded service is therefore on ensuring effective communication.	Complaints relating to communication and access to appointments continue to be closely monitored, with prompt action taken where themes emerge.

Figure 11: Medicine – formal and informal complaints received

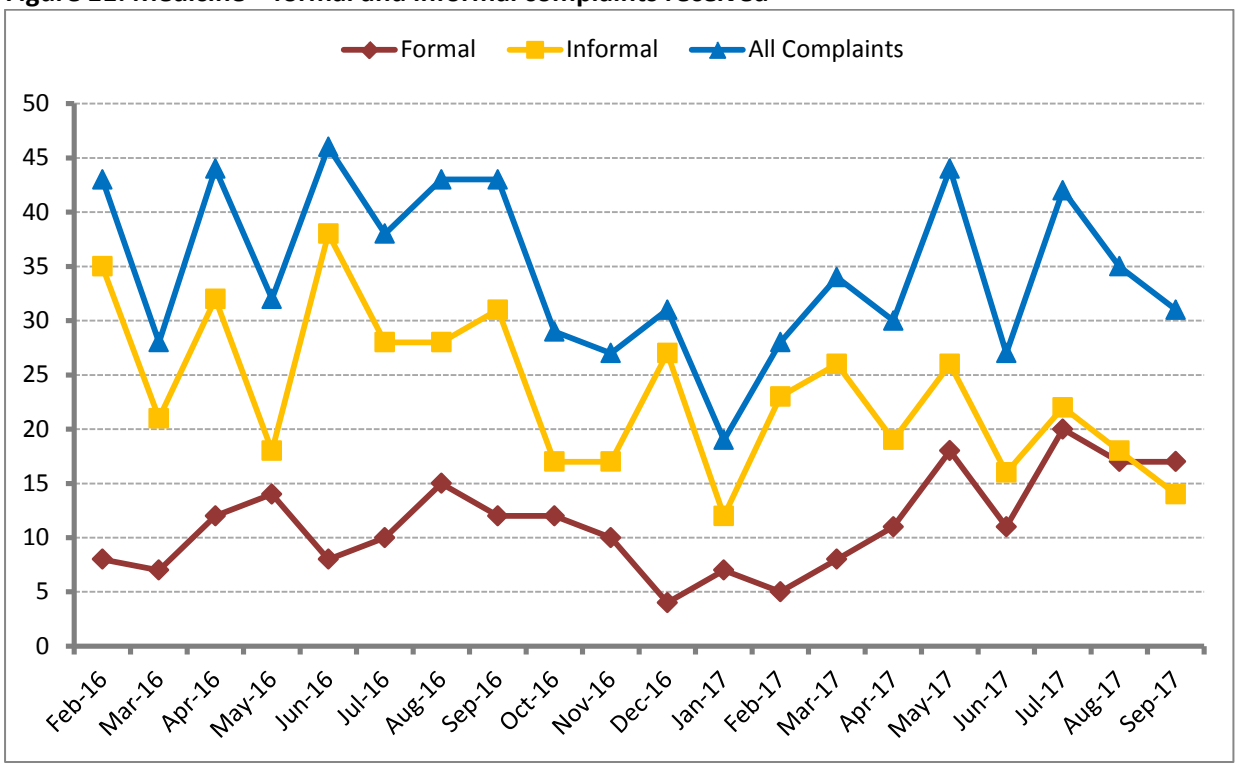


Figure 12: Complaints received by BRI Emergency Department

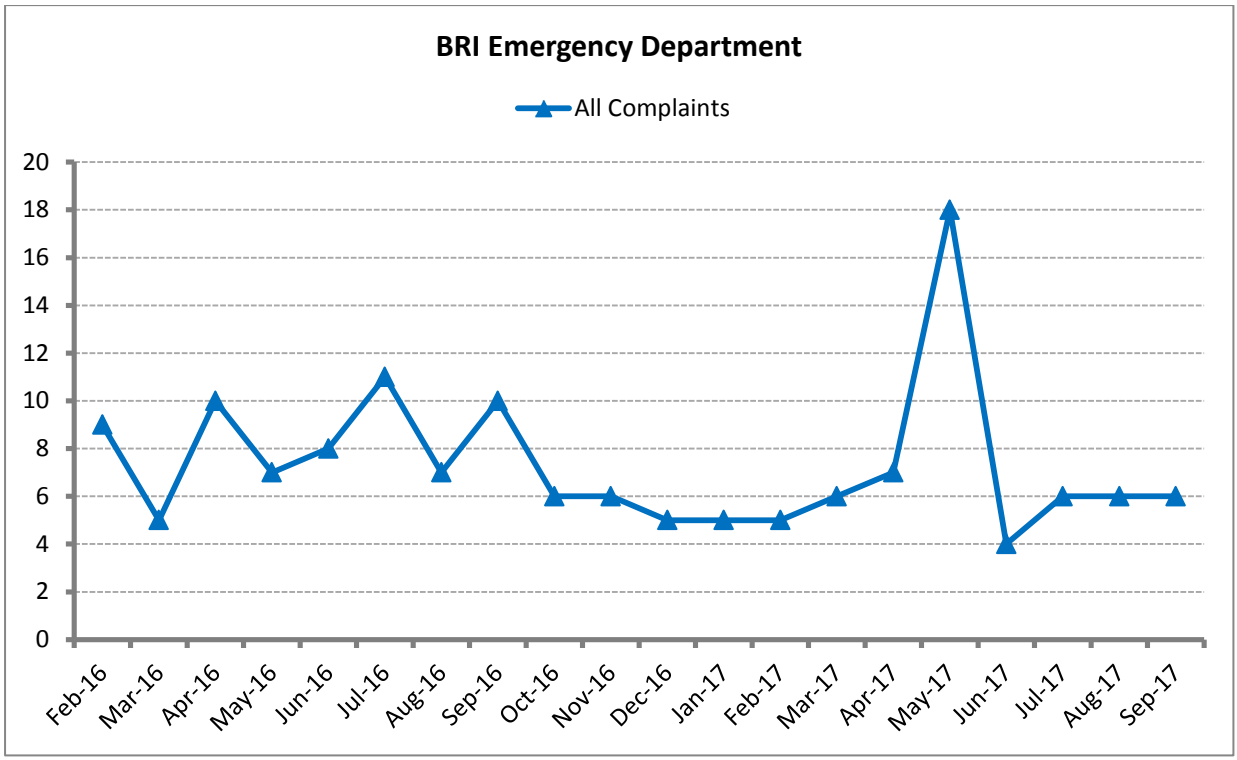
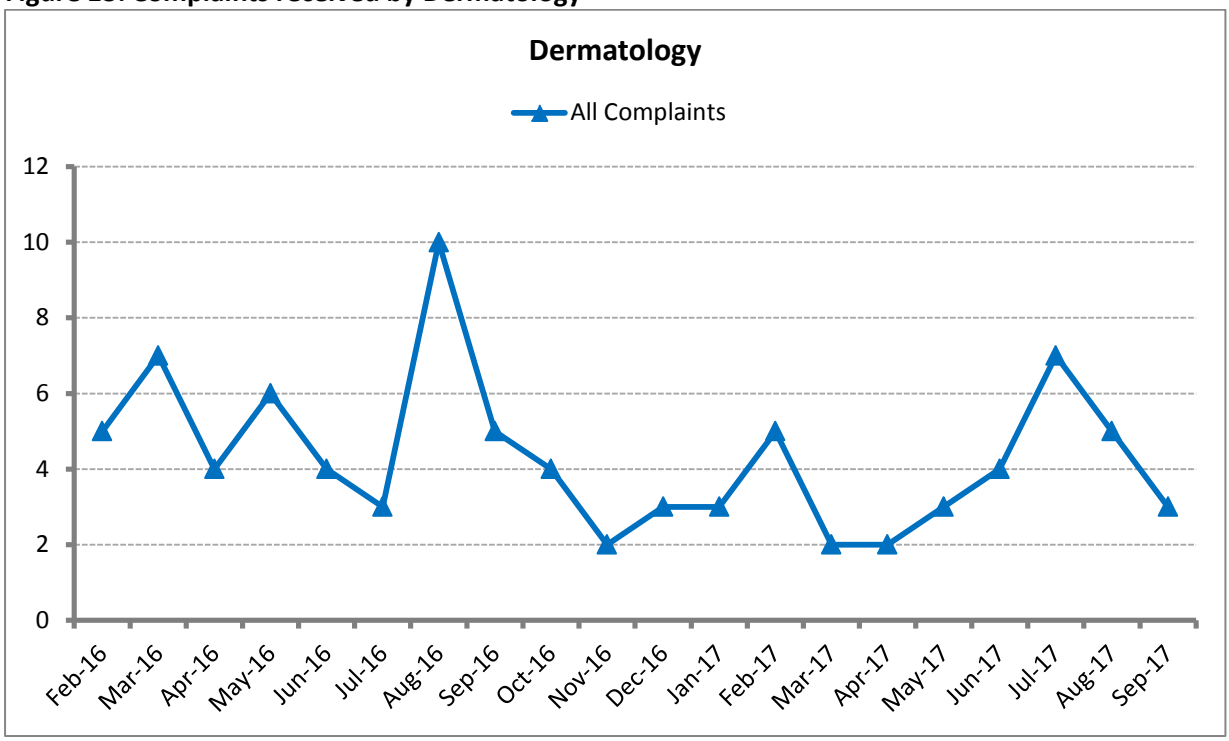


Figure 13: Complaints received by Dermatology



3.1.3 Division of Specialised Services

In Q2, the Division of Specialised Services saw a decrease in the total number of complaints received for the third consecutive quarter. The only category where the division experienced an increase in complaints was in relation to attitude and communication. The number of complaints about clinical care (medical surgical) was half the number received in Q1. Approximately two thirds of complaints received in Q2 were resolved via an informal investigation.

Table 10: Complaints by category type

Category Type	**Number and % of complaints received – Q2 2017/18**	**Number and % of complaints received – Q1 2017/18**
Access	0 (0% of total complaints) =	0 (0% of total complaints) =
Appointments & Admissions	23 (40.4%) ↓	31 (44.3%) ↑
Attitude & Communication	13 (22.8%) ↑	9 (12.9%) ↓
Clinical Care	15 (26.3%) ↓	19 (27.1%) ↓
Facilities & Environment	2 (3.5%) ↓	3 (4.3%) ↑
Information & Support	3 (5.3%) ↓	6 (8.6%) ↓
Discharge/Transfer/Transport	1 (1.8%) ↓	2 (2.9%) ↓
Documentation	0 (0%) =	0 (0%) =
Total	**57**	**70**

Table 11: Top sub-categories

Category	Number of complaints received – Q2 2017/18	Number of complaints received – Q1 2017/18
Cancelled or delayed appointments and operations	13 ↓	16 ↑
Clinical care (medical/surgical)	5 ↓	10 ↑
Appointment administration issues	7 ↓	11 ↑
Clinical care (nursing)	2 ↑	1 =
Attitude of medical staff	3 =	3 =
Failure to answer telephone/failure to respond	5 =	5 ↓
Communication with patient/relative	3 ↑	1 ↓
Attitude of nursing staff	1 ↑	0 ↓
Discharge arrangements	0 =	0 ↓
Lost/misplaced medical records and/or test results	4 ↑	3 ↑

Table 12: Divisional response to concerns highlighted by Q2 data

Concern	Explanation	Action
Of the 57 complaints received by the Division in Q2, 18 (32%) were for the Bristol Heart Institute Outpatients Department. 8 of these 18 complaints were in respect of clinical care; 6 were about appointments and admissions; and the remaining 4 related to attitude and communication.	Themes arising from complaints about the BHI OP department in Q2 include delays to outpatient follow up appointments, communication of test results and responding to telephone messages left.	To address the backlogs in outpatient follow up clinics the division has appointed additional medical staff, increased the number of clinics available, and reviewed all patients to ensure that all those on the follow up list require face to face follow up and to identify any high risk patients to ensure that they are prioritised. With respect to test results, work has been undertaken to address typing backlogs; the division is now typing clinics letters within 7 days. The Division has also volunteered to undertake a pilot project which will involve typing clinic letters on the day of clinic, which will help further with overall typing times. There was a problem with staff sickness in the outpatient administration team throughout Q2,

	There were also a number of complaints relating to procedures which are not funded by the NHS.	but this has now resolved. Staff now have daily timetables which include checking and responding to voicemails. Clinicians in the division have been involved in the commission by evaluation process and have communicated the outcomes and information to patients and referring hospitals in order to manage expectations; however patients continue to highlight their concerns through the complaints process.
In Q1, the Division reported that they were working with Healthcare at Home to increase capacity for the delivery of chemotherapy. There were also plans in place to increase capacity in the Day Unit and to work with Diagnostics & Therapies to develop a service covering bank holidays. In Q2, 10 complaints were received by the Chemo Day Unit/Outpatients department, an increase for the third consecutive quarter, although there was a reduction in complaints towards the end of the quarter. Of these 10 complaints, 4 were in respect of attitude and communication and 3 were about clinical care.	Of the 10 complaints received in Q2, 3 were related to delays in chemotherapy appointments. There were no specific patterns in the remaining 7 cases, although they tended to reflect the challenges of delivering difficult and often complex information to patients and relatives and the need for patients to revisit questions at different points in their journey.	In addition to actions outlined in Q1, the unit has also launched a new way of running its service (booking to chair) which has increased the capacity for chemotherapy delivery. The number of patients waiting for chemotherapy has reduced significantly. The team will be working a new shift pattern in the new year which will further support an increase in the numbers of treatments the department can deliver across the working day. One of the complaints raised concerns about the approach of a staff member which has since been addressed through supervision. In respect of the complaints which pertained to delivering difficult and complex information, key components of these complaints will be used in the training delivered to staff both across the division and across the trust. Further to this, Clinical Nurse Specialist teams are increasing their follow up phone calls to facilitate the process of information giving following the provision of diagnosis to improve the opportunity for patients to ask questions or raise queries at an early stage.

In Q2, the Division received 11 complaints about the Bristol Heart Institute Waiting List Office. Of these complaints, 9 were in respect of appointments and admissions and 2 were about attitude and communication.	Whilst the number of cancellations has decreased overall within cardiac services, the appointment and admissions complaints reflect delays to, or cancellation of, cardiac procedures during Q2. 2 complaints were received in relation to delays to responding to telephone messages left.	The division has commenced additional scheduling meetings to ensure scheduling reflects the bed availability within the critical care areas and so that teams can realistically and supportively manage patients' expectations. Further to this, letters have been reviewed to articulate more clearly the expected waiting times for procedures. The number of complaints regarding unanswered telephones is reducing and reflects the recruitment and training of new staff within the team.

Figure 14: Specialised Services – formal and informal complaints received

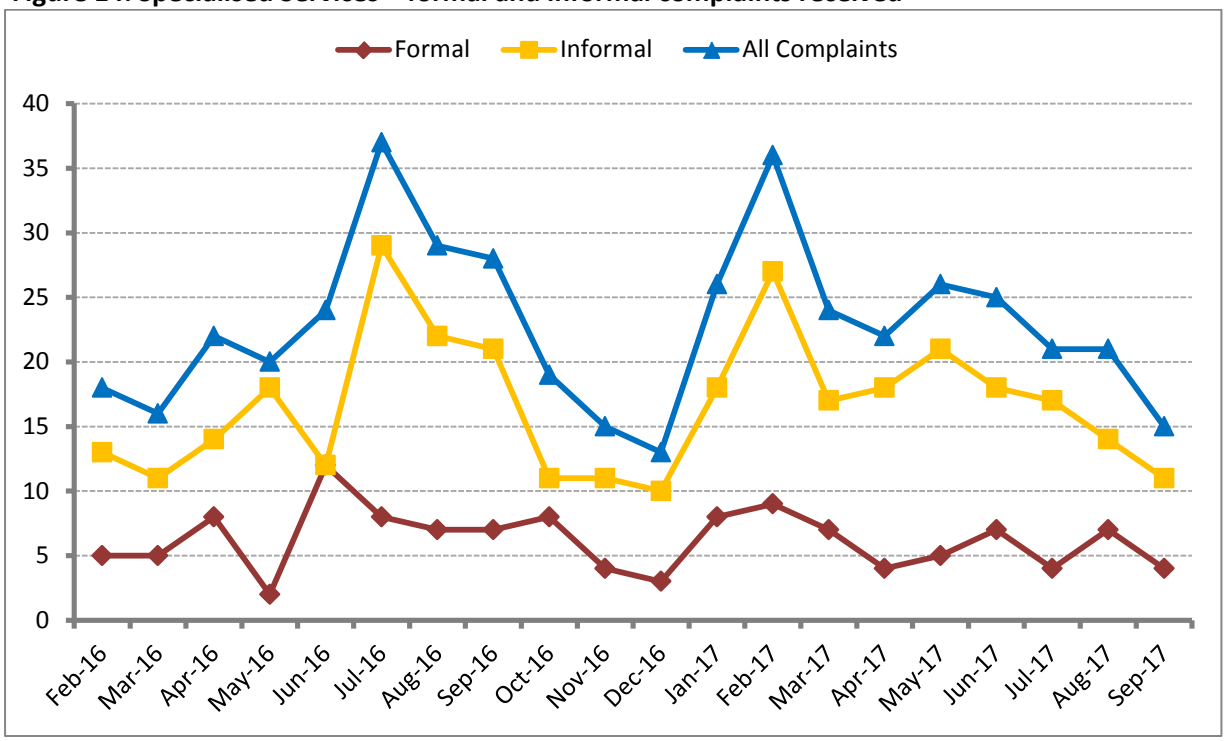
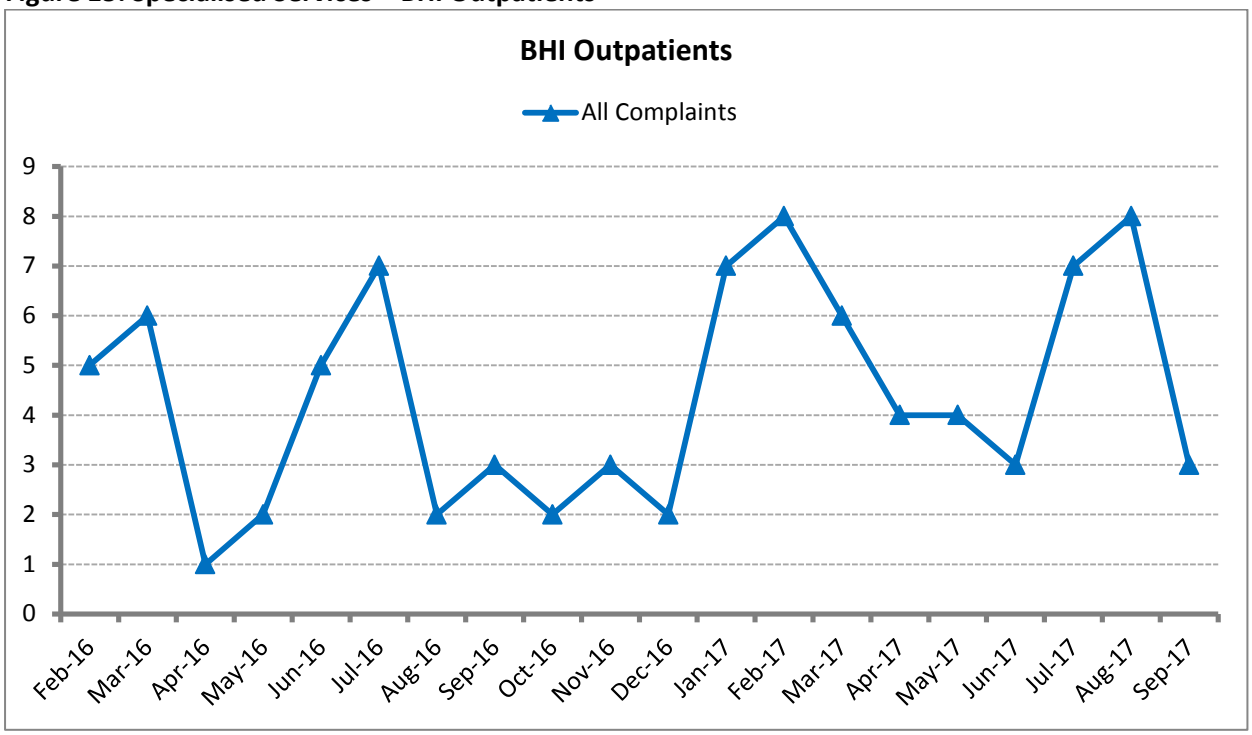


Figure 15: Specialised Services – BHI Outpatients



3.1.4 Division of Women's and Children's Services

The total number of complaints received by the Division remained similar for the third consecutive quarter, with a decrease in complaints in all categories with the exception of appointments and admissions and clinical care. This is the only division where the majority of complaints received in Q2 were resolved via the formal investigation process (42 formal compared to 32 informal).

Table 13: Complaints by category type

Category Type	Number and % of complaints received – Q2 2017/18	Number and % of complaints received – Q1 2017/18
Access	0 (0% of total complaints) =	0 (0% of total complaints) =
Appointments & Admissions	22 (29.7%) ↑	18 (24.7%) ↑
Attitude & Communication	16 (21.6%) ↓	19 (26.1%) ↓
Clinical Care	31 (41.9%) ↑	26 (35.6%) ↓
Facilities & Environment	0 (0%) ↓	2 (2.7%) ↑
Information & Support	4 (5.4%) ↓	5 (6.8%) ↑
Discharge/Transfer/Transport	0 (0%) ↓	2 (2.7%) ↑
Documentation	1 (1.4%) =	1 (1.4%) =
Total	**74**	**73**

Table 14: Top sub-categories

Category	Number of complaints received – Q2 2017/18	Number of complaints received – Q1 2017/18
Cancelled or delayed appointments and operations	13 ↑	11 ↑
Clinical care (medical/surgical)	12 ↑	11 ↓
Appointment administration issues	5 ↑	4 ↑
Clinical care (nursing/midwifery)	12 ↑	8 =
Attitude of medical staff	4 ↓	5 ↓
Failure to answer telephones /failure to respond	2 =	2 ↑
Communication with patient/relative	4 ↓	8 ↑
Attitude of nursing/midwifery	3 ↑	1 ↓
Discharge arrangements	0 ↓	2 ↑
Lost/misplaced medical records and/or test results	3 ↑	2 ↓

Table 15: Divisional response to concerns highlighted by Q2 data

Concern	Explanation	Action
31 (42%) complaints received by the Division in Q2 related to clinical care. Of these. 20 were received by the Bristol Royal Hospital for Children and 11 were received by St Michael's Hospital.	**St Michael's** In maternity and gynecology, many of the complaints related to very complex cases. On occasion, patients have not understood what has happened to them; complaints are sometimes arising in situations where what patients really need is further clarification about their care and treatment. One complaint related to a medication error on NICU and one complaint in Midwifery related to a practice issue.	**St Michael's** As part of the work of the Local Maternity System (LMS), the role of an "after birth thoughts "service is being considered. The medication error is being reviewed and investigated by the divisional patient safety team. Maternity support workers in the community have been re-trained on testing urine.
Of the 74 complaints received by the Division in Q2, the highest numbers by	**St Michael's** In gynaecology, complaints were due to process issues, e.g. waiting	**St Michael's** Process issues are being revisited and aligned. Partial booking list is in

department were received in the following areas: 6 each for Children's Emergency Department; Paediatric Orthopaedics; Gynaecology Outpatients; and 5 for NICU. 7 for the Bristol Royal Hospital for Children Outpatients Department.	times and lack of follow up. The unit has had a problem with gaps in the junior doctor rota, with consultants having to act down. **BRHC** Complaints received by the outpatient department and emergency department were mostly about waiting times and clinician attitude.	the process of being revalidated. The unit is also to review family involvement at ward rounds. **BRHC** The waiting times concern relates to an ongoing capacity issue which is the subject of a strategic review. Attitude concerns are dealt with through direct feedback from line managers.
A total of 15 breaches of the formal response deadline were recorded for the Division in Q2. This represents more than a third of responses sent out by the Division during that period. 9 were responses from Bristol Royal Hospital for Children; the remaining 6 were from St Michael's Hospital.	**BRHC** The majority of the breaches were as a result of delays in getting clinician feedback on the complex clinical nature of the complaints.	**BRHC** Response times to complaints are discussed at the quality assurance committee; senior clinicians who are present at this meeting are expected to give feedback to their respective teams regarding the importance of timely responses to complaints and concerns.

Figure 16: Women & Children – formal and informal complaints received

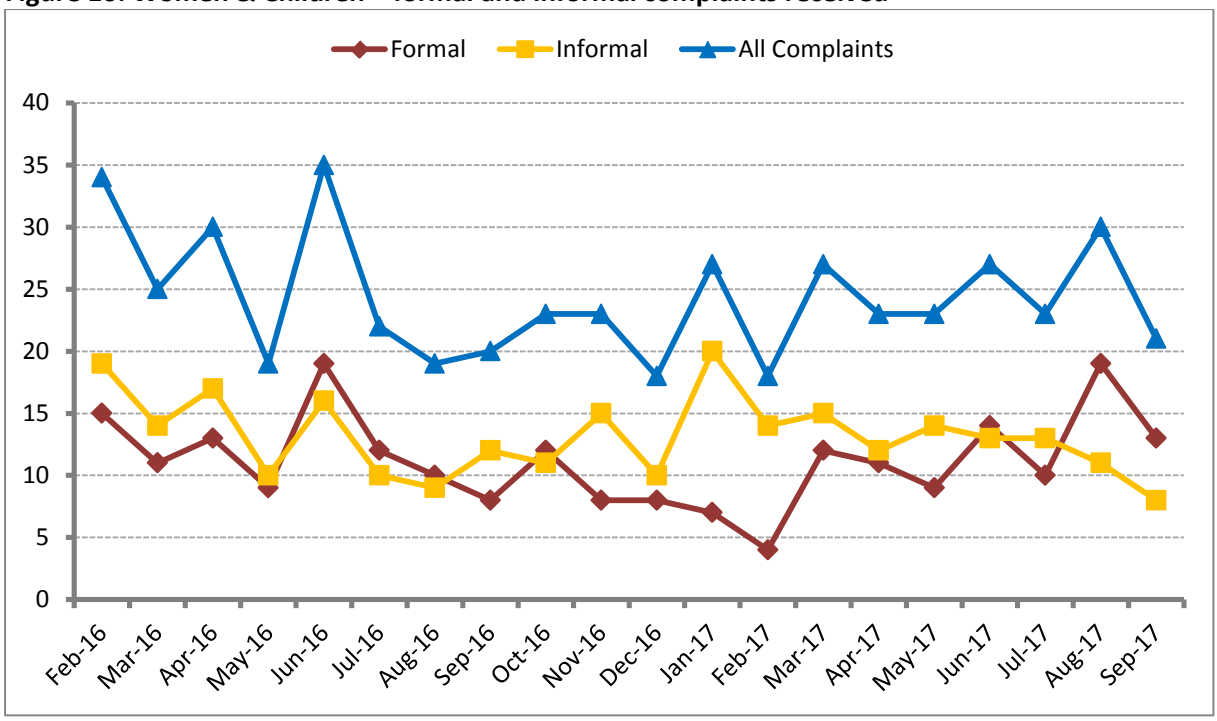


Figure 17: Complaints received by Bristol Royal Hospital for Children

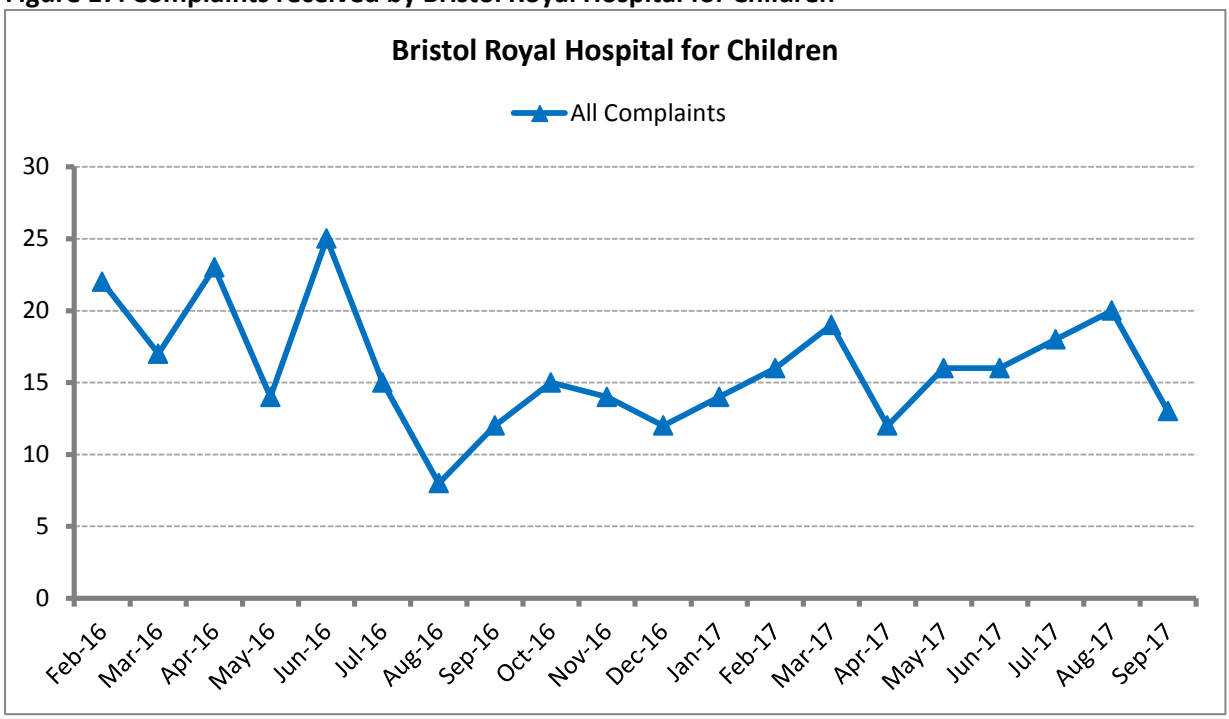
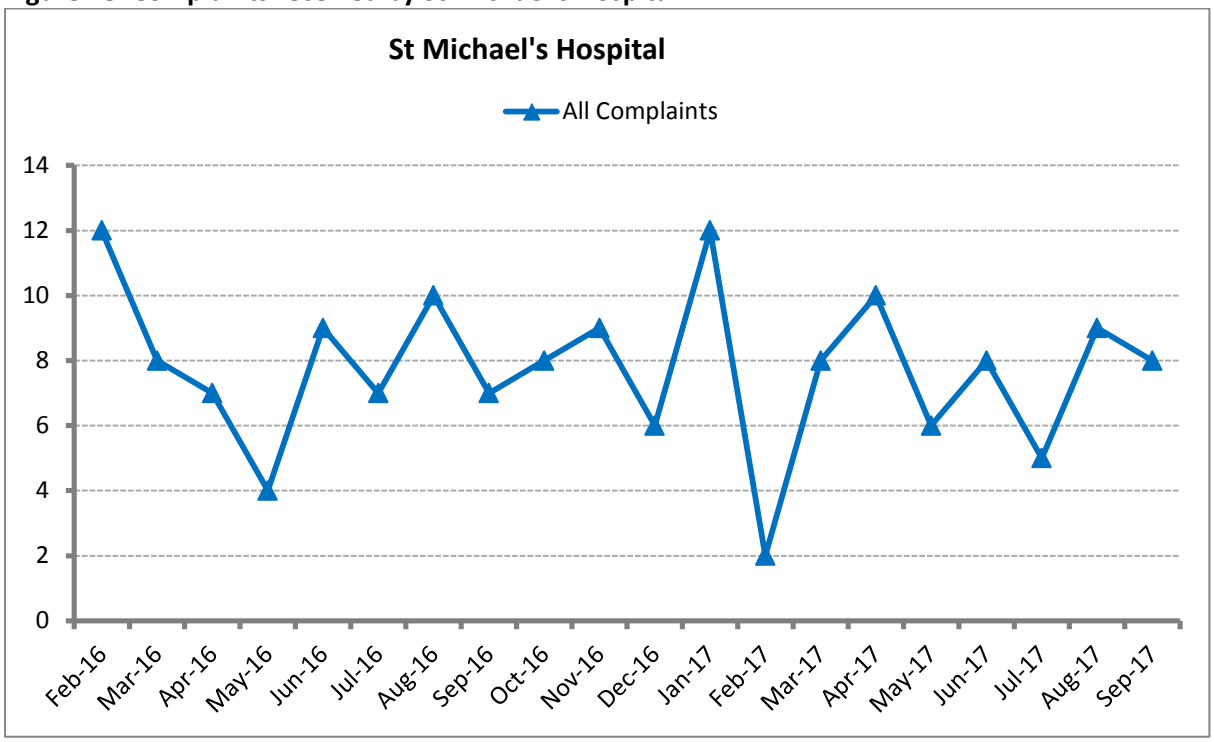


Figure 18: Complaints received by St Michael's Hospital



3.1.5 Division of Diagnostics & Therapies

Complaints received by the Division of Diagnostics and Therapies increased from 13 in Q1 to 18 in Q2, with seven received being about attitude and communication and six about appointments and admissions. The Division continued its trend of resolving the majority of complaints via the informal complaints process.

Table 16: Complaints by category type

Category Type	Number and % of complaints received – Q2 2017/18	Number and % of complaints received – Q1 2017/18
Access	0 (0% of total complaints) =	0 (0% of total complaints) =
Appointments & Admissions	6 (33.3%) ↑	3 (23.1%) ↓
Attitude & Communication	7 (38.9%) ↑	1 (7.7%) ↓
Clinical Care	4 (22.2%) ↓	5 (38.4%) ↑
Facilities & Environment	0 (0%) ↓	2 (15.4%) ↑
Information & Support	0 (0%) ↓	2 (15.4%) ↑
Discharge/Transfer/Transport	0 (0%) =	0 (0%) ↓
Documentation	1 (5.6%) ↑	0 (0%) =
Total	**18**	**13**

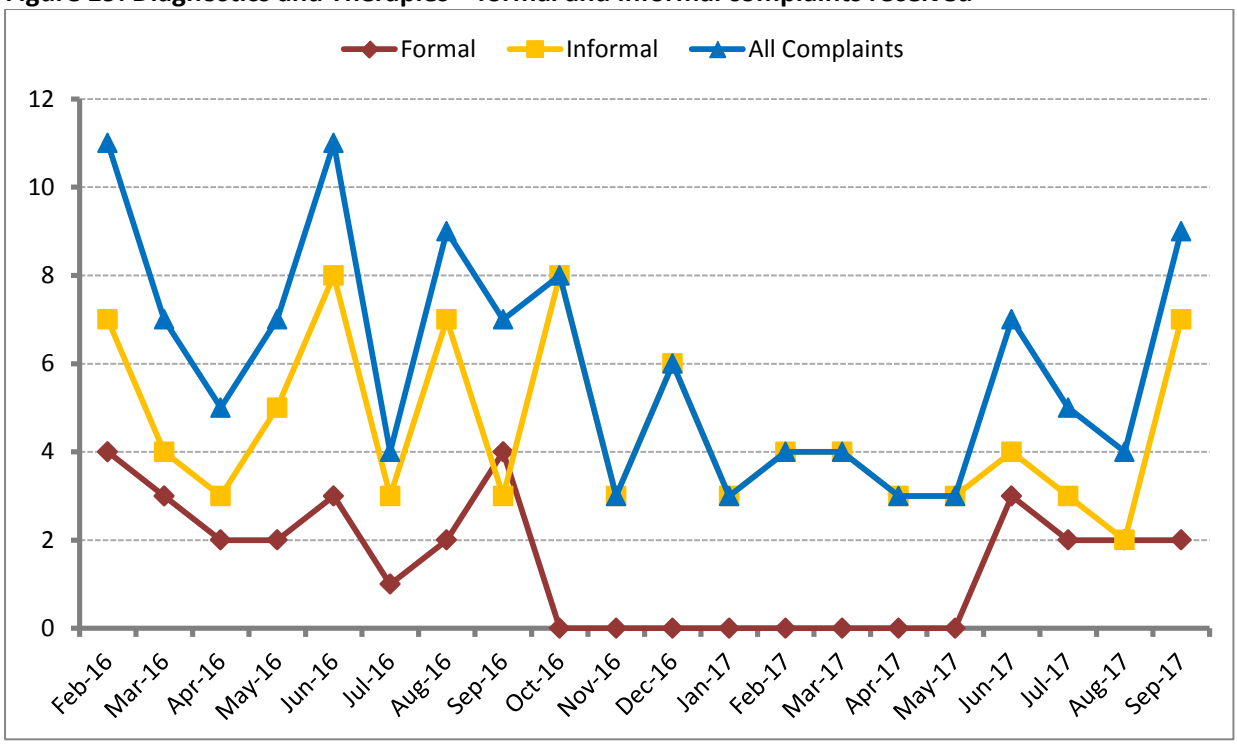
Table 17: Top sub-categories

Category	Number of complaints received – Q2 2017/18	Number of complaints received – Q1 2017/18
Cancelled or delayed appointments and operations	2 ↑	0 ↓
Clinical care (medical/surgical)	1 =	1 ↑
Appointment administration issues	4 ↑	2 =
Clinical care (nursing)	0 =	0 =
Attitude of medical staff	1 ↑	0 ↓
Failure to answer telephones /failure to respond	1 ↑	0 ↓
Communication with patient/relative	1 =	1 ↑
Attitude of nursing/midwifery	1 ↑	0 =
Discharge arrangements	0 =	0 =
Lost/misplaced medical records and/or test results	2 ↑	1 ↑

Table 18: Divisional response to concerns highlighted by Q2 data

Concern	Explanation	Action
Of the 18 complaints received in Q2, 5 were received by the Physiotherapy service at Bristol Royal Infirmary, compared to 3 in Q1 and 2 in Q4 of 2016/17. 3 of the 5 complaints were in respect of appointment administration issues and 2 were about failure to answer telephones.	High levels of staff sickness and ongoing recruitment during Q2 led to difficulties in making appointments and communicating with the department.	Admin review and project in place to simplify systems and train staff. A new phone system has been implemented, additional bank staff are now in place to answer calls, and the service is also looking to appoint to a permanent position.

Figure 19: Diagnostics and Therapies – formal and informal complaints received



3.1.6 Division of Trust Services

The Division of Trust Services, which includes Facilities & Estates, received 23 complaints in Q2, compared to 121 in Q1. However there was a spike in Q1 when the Trust received over 100 complaints about security officers being asked to remove union jack badges from their uniforms (this was explained fully in the Q1 report). A comparison with the activity for this Division during a "normal" quarter would be the 32 complaints received in Q4 of 2016/17.

Figure 20: Trust Services – formal and informal complaints received

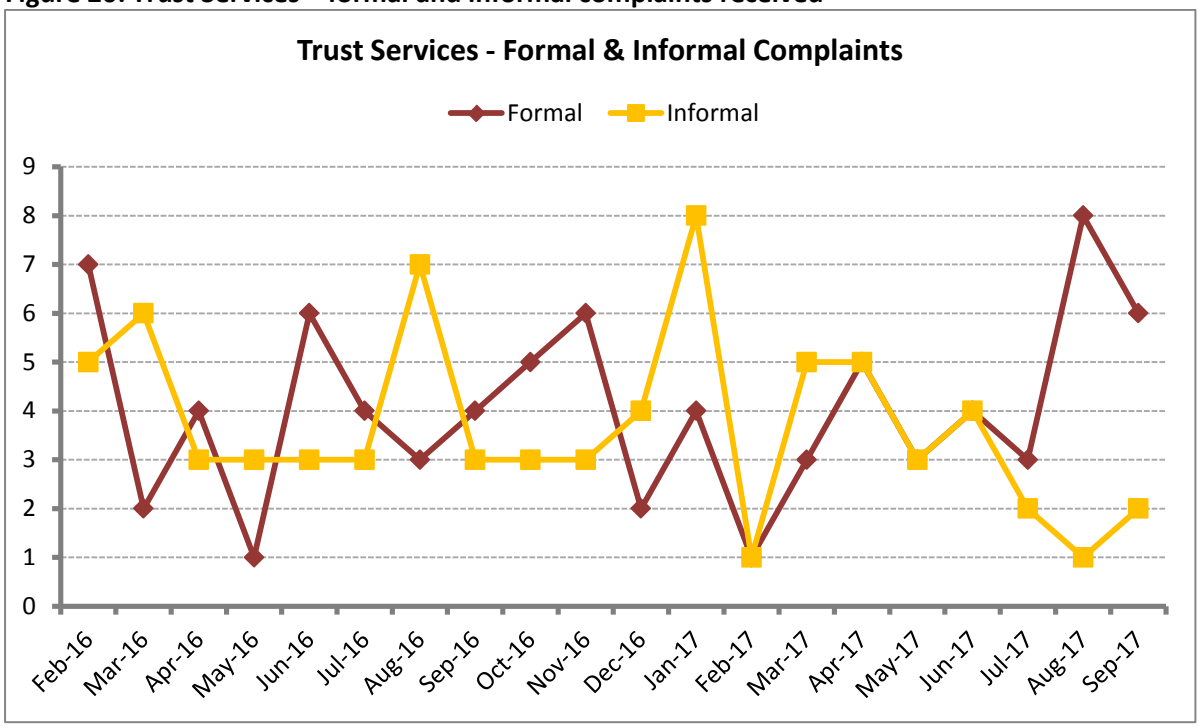


Figure 21: Trust Services – car parking complaints

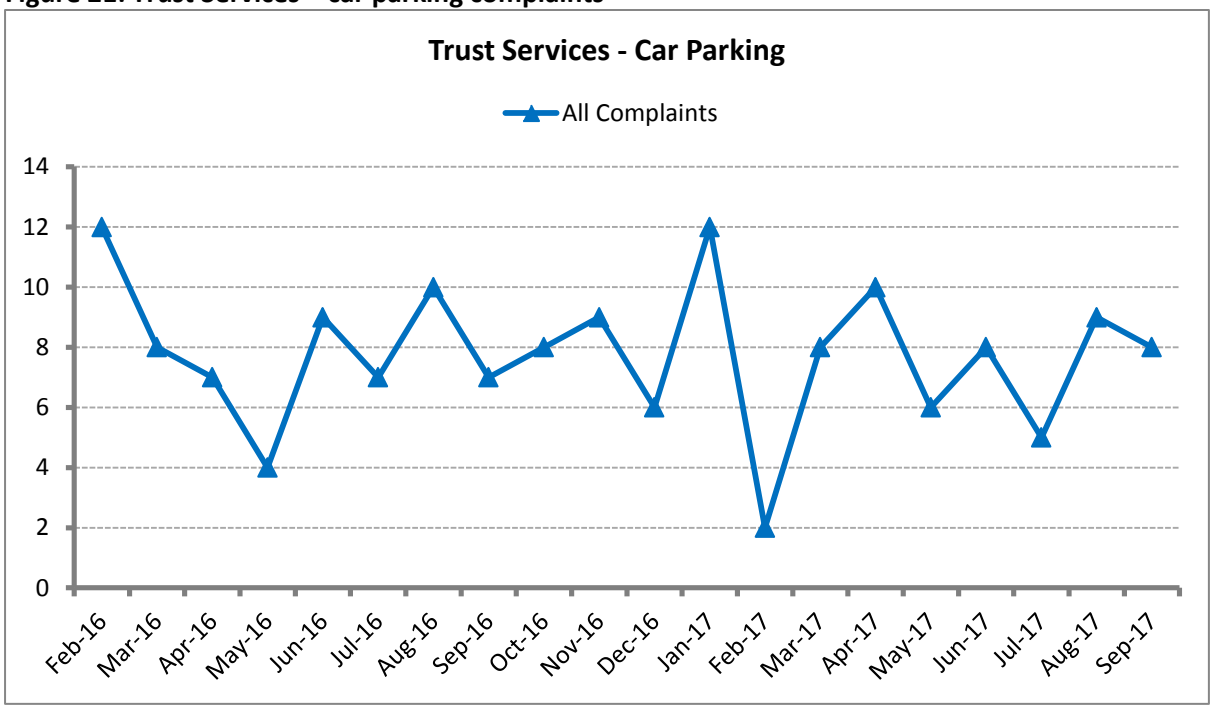
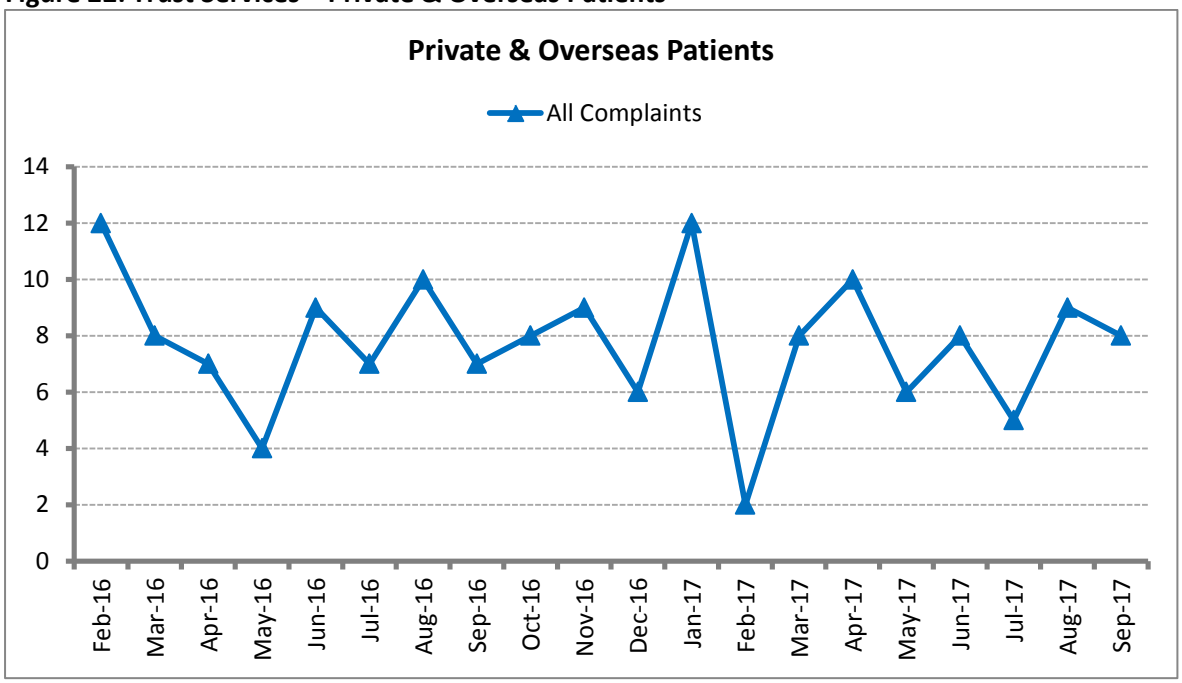


Figure 22: Trust Services – Private & Overseas Patients



3.2 Complaints by hospital site

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

Table 19: Breakdown of complaints by hospital site

Hospital/Site	Number and % of complaints received in Q2 2017/18	Number and % of complaints received in Q1 2017/18
Bristol Royal Infirmary	180 ↓	279 (50.3%) ↑
Bristol Dental Hospital	52 ↓	79 (14.2%) ↑
Bristol Royal Hospital for Children	51 ↑	44 (7.9%) ↓
Bristol Heart Institute	40 ↓	50 (9.0%) ↓
St Michael's Hospital	39 ↑	37 (6.7%) ↑
Bristol Eye Hospital	30 ↑	25 (4.5%) ↓
Bristol Haematology & Oncology Centre	20 ↓	21 (3.8%) =
South Bristol Community Hospital	7 =	7 (1.3%) ↑
Community Midwifery Services	1 ↓	3 (0.5%) ↑
Central Health Clinic	3 =	3 (0.5%)
Southmead Hospital (UH Bristol services)	1 ↓	3 (0.5%) ↑
Other Trust	1 ↓	2 (0.4%) ↓
Community Dental Sites	1 =	1 (0.2%) =
Trust Headquarters	1 =	1 (0.2%) ↑
Adult Audiology Service (Community)	1 ↑	0
Estates & Facilities Building	1 ↑	0
Off Trust Premises	1 ↑	0
TOTAL	**430**	**555**

3.2.1 Breakdown of complaints by inpatient/outpatient/ED status

In order to more clearly identify the number of complaints received by the type of service, Figures 23-27 below show data differentiating between inpatient, outpatient, Emergency Department and other complaints. The category of 'other' includes complaints about non-clinical areas, such as car parking, cashiers, administration departments, etc.

In Q2, 46.5% of complaints received were about outpatient services, 31% related to inpatient care, 6.3% were about emergency patients; and 16.3% fell into the category of 'other' (as explained above).

Figure 23: All patient activity

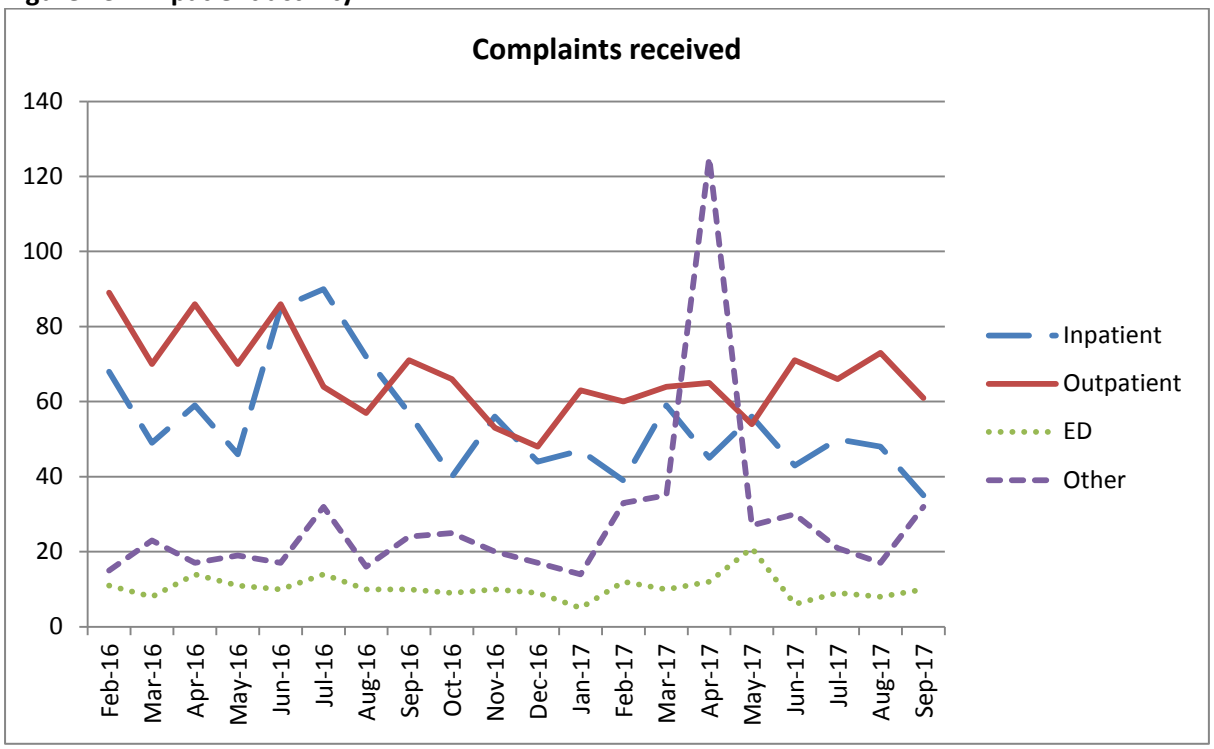


Figure 24: Complaints received from inpatients

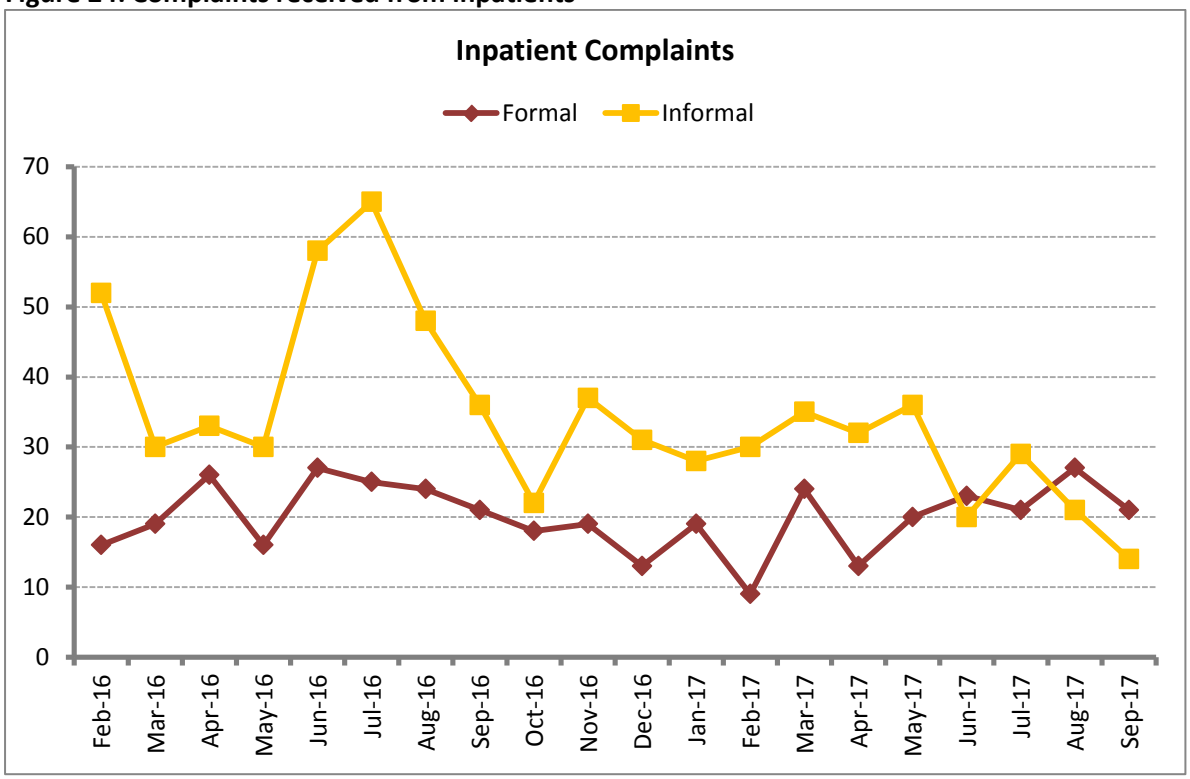


Figure 25: Complaints received from outpatients

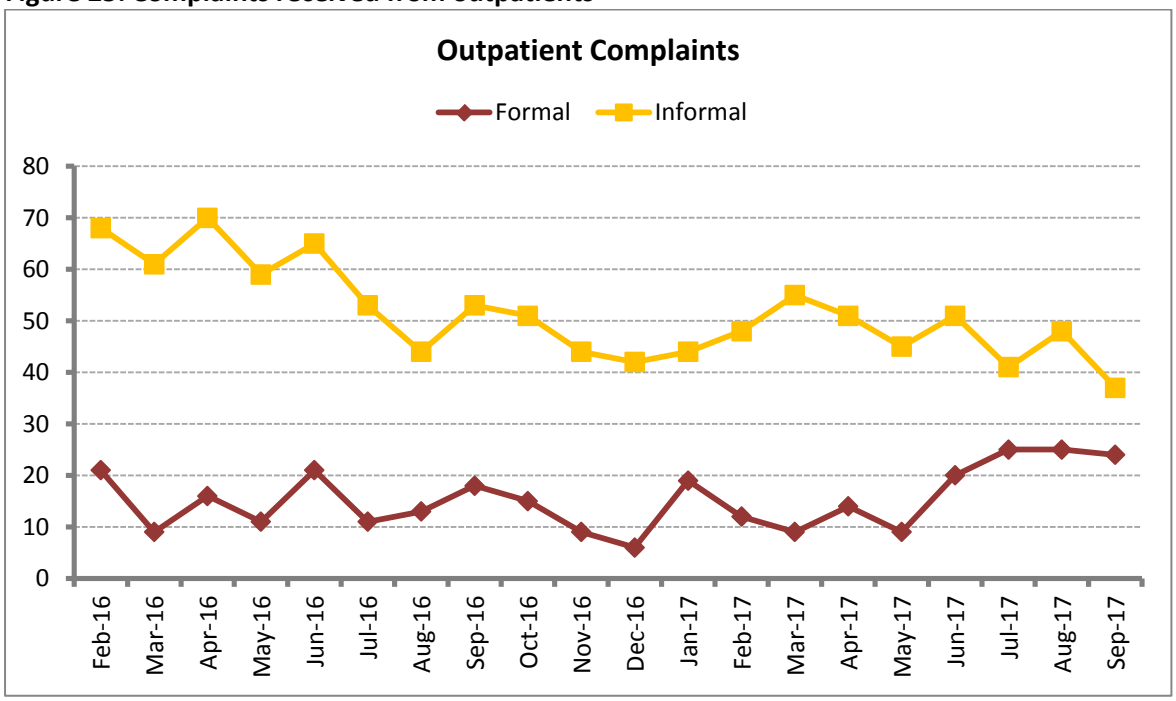


Figure 26: Complaints received from emergency department patients

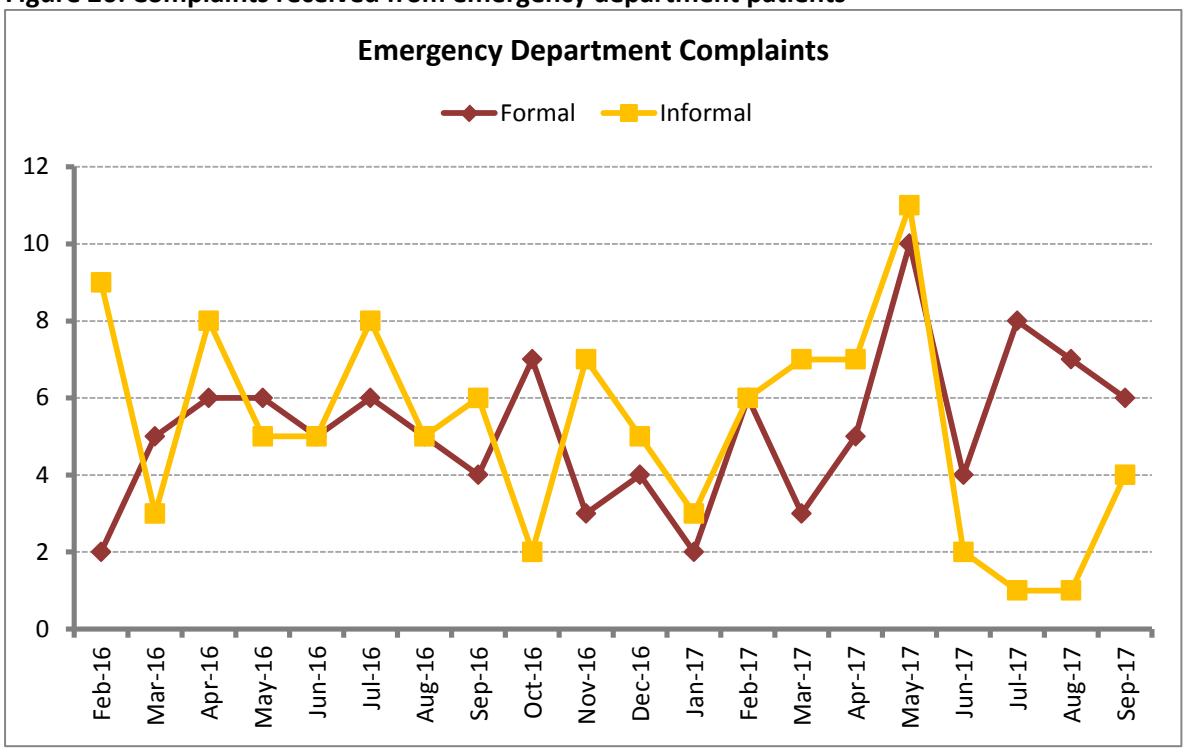


Figure 27: Complaints received from other patients (not inpatient, outpatient or emergency patients)

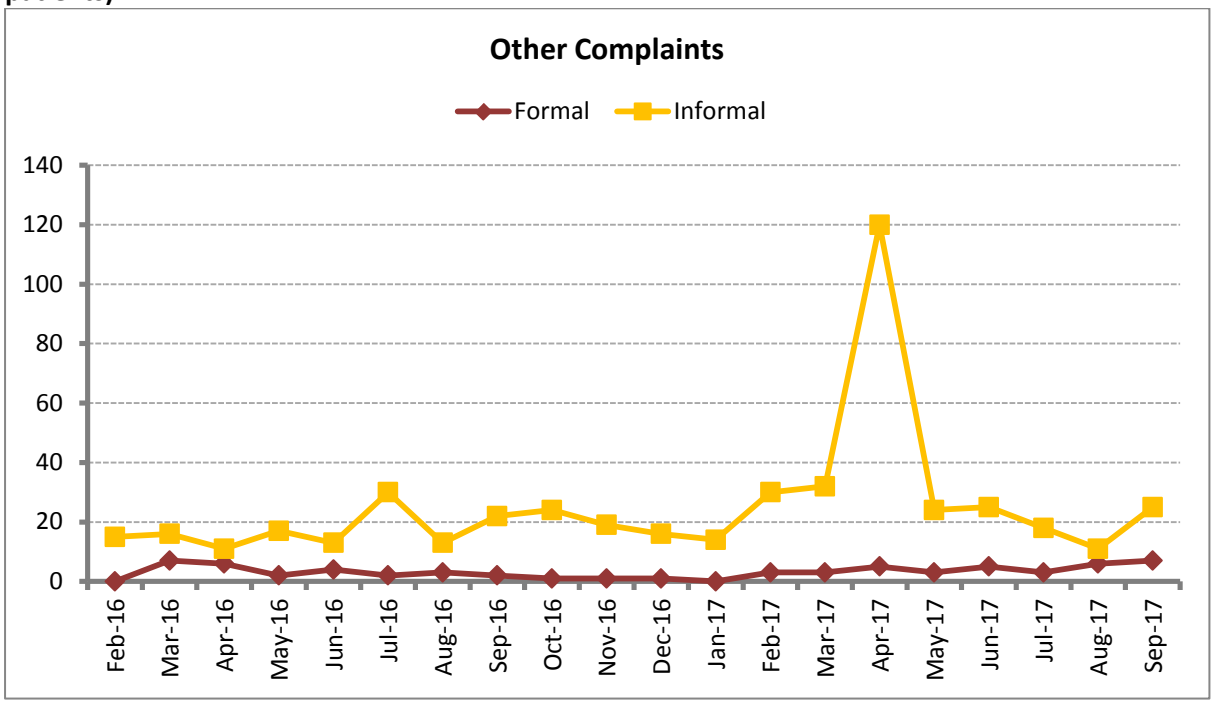


Table 20: Breakdown of Area Type

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
Jul-17	9	50	66	21	146
Aug-17	8	48	73	17	146
Sep-17	10	35	61	32	138
Grand Total	**190**	**971**	**1,178**	**521**	**2,860**

3.3 Complaints responded to within agreed timescale

All Divisions, with the exception of Diagnostics and Therapies, reported breaches in Q2, totalling 36, which is an increase on the 26 breaches recorded in Q1. The largest increase in breaches (when compared to Q1) was for the Division of Women & Children. Details of this increase are included in table 13 under section 3.1.4 of this report.

Table 21: Breakdown of breached deadlines

Division	Q2 (2017/18)	Q1 (2017/18)	Q4 (2016/17)	Q3 (2016/17)
Surgery	8 (14.3%)	6 (14.6%)	7 (14.3%)	1 (0.7%)
Medicine	5 (11.1%)	6 (22.2%)	4 (15.4%)	0 (0%)
Specialised Services	3 (12%)	6 (24%)	2 (6.4%)	4 (8.9%)
Women & Children	15 (38.5%)	6 (18.2%)	6 (24%)	3 (4.7%)
Diagnostics & Therapies	0 (0%)	0 (0%)	0 (0%)	0 (0%)
Trust Services	5 (45.5%)	2 (50%)	0 (0%)	0 (0%)
All	**36 breaches**	**26 breaches**	**19 breaches**	**8 breaches**

(So, as an example, there were eight breaches of timescale in the division of Surgery in Q2, which constituted 14.3% of the complaint responses which were sent out by that division in Q2.)

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. Table 22 shows a breakdown of where the delays occurred in Q2.

Table 22: Reason for delay

Breach attributable to	**Surgery**	**Medicine**	**Specialised Services**	**Women & Children**	**Diagnostics & Therapies**	**Trust Services**
Division	5	4	3	14	0	5
Patient Support & Complaints Team	1	1	0	1	0	0
Executives/sign-off	2	0	0	0	0	0
All	**8**	**5**	**3**	**15**	**0**	**5**

3.4 Outcome of formal complaints

In Q2 we responded to 182 formal complaints[4]. Tables 23 and 24 below show a breakdown, by Division, of how many cases were upheld, partly upheld or not upheld in Q2 of 2017/18 and Q1 of 2017/18.

Table 23: Outcome of formal complaints – Q2 2017/18

	Upheld	**Partly Upheld**	**Not Upheld**
Surgery	15 (26.8%)	26 (46.4%)	15 (26.8%)
Medicine	13 (28.9%)	25 (55.6%)	7 (15.5%)
Specialised Services	6 (24%)	17 (68%)	2 (8%)
Women & Children	9 (23.1%)	25 (64.1%)	5 (12.8%)
Diagnostics & Therapies	2 (33.3%)	2 (33.3%)	2 (33.3%)
Trust Services	2 (18.2%)	7 (63.6%)	2 (18.2%)
Total	**47 (25.8%)**	**102 (56%)**	**33 (18.1%)**

Table 24: 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

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 Q2, the team dealt with 183 such enquiries, compared to 174 in Q1. These enquiries can be categorised as:

- 147 requests for advice and information (138 in Q1)
- 31 compliments (34 in Q1)[5]
- 4 requests for support (2 in Q1)

Table 21 below shows a breakdown of the 183 requests for advice, information and support dealt with by the team in Q1.

Table 25: Enquiries by category

Category	Enquiries in Q2 2017/18
Hospital information request	25
Information about patient	24
Medical records requested	21
Signposting	19
Appointments administration issues	8
Clinical care	8
Clinical information request	6
Admissions arrangements	6
Employment and volunteering	4
Invoicing	3
Personal property	3
Accommodation enquiry	2
Communication	2
Benefits and social care	2
Car parking	2
Expenses claim	2
Failure to answer phone/respond	2
Travel arrangements	1
Translating & Interpreting	1
Cleanliness (internal)	1
Medication incorrect/not received	1
Aids and appliances	1
Delayed response	1
Emotional support	1

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

Transfer arrangements	1
Availability of wheelchairs	1
Freedom of information request	1
Total	**151**

In addition to the enquiries detailed above, in Q2 the Patient Support and Complaints team recorded 151 enquiries that did not proceed (compared with 203 in Q1). 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.

Including complaints, requests for information or advice, requests for support, compliments and cases that did not proceed, the Patient Support and Complaints Team dealt with a total of 764 separate enquiries in Q2 2017/18.

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 Q2, 186 complaints were received in writing (email, letter or complaint form) and 244 were received verbally (51 in person via drop-in service and 193 by telephone). Of the 430 complaints received in Q2, 100% met the Trust's standard of being acknowledged within two working days (verbal) and three working days (written).

6. PHSO cases

During Q2, the Trust was advised of new Parliamentary and Health Service Ombudsman (PHSO) interest in three complaints. During the same period, four existing cases were closed and one existing case remains ongoing. Of the four cases closed, one was partly upheld by the PHSO.

Table 26: Complaints opened by the PHSO in Q2

Case Number	Complainant (patient unless stated)	On behalf of (patient)	Date complaint received by Trust [and date notified by PHSO]	Site	Department	Division
3438	SC	SC	05/09/2016 [17/07/2017]	STMH	Fetal Medicine Unit	Women & Children
Complaint file and medical records sent to PHSO on 21/07/2017. Advised by PHSO on 12/10/2017 of the scope of their investigation. Currently pending further contact from the PHSO.						
2096	SA	ZH	16/06/2016 [21/09/2017]	STMH	Gynaecology Outpatients	Women & Children
Details requested by PHSO sent to them on 28/09/2017 – they initially only requested certain documentation rather than the usual complaint file and medical records. On 02/10/2017, the PHSO advised us they would not be taking the case any further, however the patient had asked them to review their decision. The PHSO confirmed that we could close our file and that they would notify us if we needed to re-open it following their review.						
1380	SD	DD	26/04/2016 [23/08/2017]	STMH	Ear, Nose & Throat	Surgery
The PHSO initially advised that they were investigating this matter and explaining the scope of their investigation. They subsequently requested documentation (complaint file and medical records), which were sent to them on 13/11/2017. Currently pending further contact from the PHSO.						

Table 27: Complaints ongoing with the PHSO during Q2

Case Number	Complainant (patient unless stated)	On behalf of (patient)	Date complaint received by Trust [and date notified by PHSO]	Site	Department	Division
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 28: Complaints formally closed by the PHSO in Q2

Case Number	Complainant (patient unless stated)	On behalf of (patient)	Date complaint received by Trust [and date notified by PHSO]	Site	Department	Division
2096	SA	ZH	16/06/2016 [21/09/2017]	STMH	Gynaecology Outpatients	Women & Children
Details requested by PHSO were sent to them on 28/09/2017 – they initially only requested certain documentation rather than the usual complaint file and medical records. On 02/10/2017, the PHSO advised us they would not be taking the case any further, however the patient had asked them to						

<table>
<tr><td colspan="7">review their decision. The PHSO confirmed that we could close our file and that they would notify us if we needed to re-open it following their review. Not upheld.</td></tr>
<tr><td>4537</td><td>EB</td><td>MB</td><td>10/11/2016 [25/05/2017]</td><td>BRI</td><td>Ward A515</td><td>Medicine</td></tr>
<tr><td colspan="7">PHSO’s final report received 30/08/2017. They found following failings:
A failure to provide pain relief to patient for a short period; and
A failure to contact the family when his condition deteriorated.
PHSO recommended that within four weeks of the date of their report, the Trust should write to the patient’s family to apologise for the failings identified in the report and to apologise for the impact this had.
This recommendation was carried out and on 12/10/2017. The PHSO confirmed that the Trust had fully complied with their recommendations and that the case was closed. Partly upheld.</td></tr>
<tr><td>2624</td><td>CC</td><td>RC</td><td>14/07/2016 [19/05/2017]</td><td>BRI</td><td>Ward A600 (ITU/HDU)</td><td>Surgery</td></tr>
<tr><td colspan="7">PHSO’s final report received on 26/09/2017 confirming that they are taking no further action and the case is closed. Not upheld.</td></tr>
<tr><td>2870</td><td>AM</td><td>PM</td><td>03/11/2016 [07/03/2017]</td><td>BHOC</td><td>Ward D603</td><td>Specialised Services</td></tr>
<tr><td colspan="7">Final report received from PHSO 02/11/2017 advising that they are taking no further action and the case is closed. Not upheld.</td></tr>
</table>

Cover report to the Public Public Trust Board Meeting to be held on 31 January 2018 at 11.00 – 13.00 in the Conference Room, Trust HQ, Marlborough St, Bristol, BS1 3NU

		Agenda Item	9b
Meeting Title	Trust Board	**Meeting Date**	Wednesday, 31 January 2018
Report Title	**Quarterly Patient Experience Report – Q2**		
Author	Paul Lewis, Patient Experience and Involvement Team Manager		
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.	☒	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

This report presents patient survey data received to the end of Quarter 2 2017/18 and provides an update on recent corporate patient and public involvement activity.

Key issues to note

- All of UH Bristol's headline Trust-level patient satisfaction survey measures were above their target levels in Quarter 2, indicating the continued provision of high quality care as experienced by patients.
- UH Bristol received a very positive set of results in the Care Quality Commission's 2016 national Accident and Emergency survey: 9 out of 45 scores were classed as being better than the national average. This puts UH Bristol among the top 10 of all English trusts in respect of the number of "better than average" scores achieved in the survey.
- Notable Patient and Public Involvement activities in Quarter 2 included:

- Establishing, with the local deaf community, a new Bristol Deaf Patient Experience Group
- In collaboration with the Palliative and Supportive Care Team, involving patients and relatives in the design of the Trust's new "butterfly" end of life personalised care plan
- In collaboration with the Trust's Transformation Team, development of "customer service principles" for UH Bristol, derived through staff, patient and stakeholder engagement

- The inpatient postal survey scores improved for South Bristol Community Hospital during Quarter 2, but were still below the Trust average. This does not correlate with a range of other quality monitoring data being reviewed by the Division of Medicine for this hospital. Improvement work continues to be carried out at the hospital, including a planned programme of Trust Values training for all staff in Quarter 4 2017/18.
- Ward A518 received relatively low scores on two key survey measures. This is a fairly new ward established in June 2017. There is a now a substantive senior nursing team in place and we anticipate that this will impact positively on the survey results going forward.

Recommendations

Members are asked **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 recruit, train and sustain an engaged and effective workforce.	☐	Failure to comply with targets, statutory duties and functions.	☐
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.	☐		

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)**
		22 December 2017		Patient Experience Group 30/11/17, Senior Leadership Team, 20/11/17

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 2 2017/18

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

Patient Experience and Involvement Team

Paul Lewis, Patient Experience and Involvement Team Manager (paul.lewis@uhbristol.nhs.uk)
Tony Watkin, Patient and Public Involvement Lead (tony.watkin@uhbristol.nhs.uk)
Anna Horton, Patient Experience and Regulatory Compliance Facilitator (anna.horton@uhbristol.nhs.uk)

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

Successes	Priorities
• All of UH Bristol's headline Trust-level patient satisfaction survey measures were above their target levels in Quarter 2, indicating the continued provision of high quality care as perceived by patients • UH Bristol received a very positive set of results in the 2016 national Accident and Emergency survey: 9 out of 45 scores were classed as being better than the national average (Table 1). This puts UH Bristol among the top 10 of all English trusts on this measure of patient-reported experience • UH Bristol continues to receive positive scores in our local surveys, with 98% of patients rating their care as excellent, very good or good • The Patient Experience and Involvement Team worked with representatives of the local deaf community to establish a new forum for engagement and discussion. This forum will meet formally for the first time in February 2018 and will include a range of local health and social care organisations.	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 hospital visit / stay. This will involve installing 10-15 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 an appropriate 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. Following a delay in publishing the tender for this system, we now anticipate that the contract will be awarded for this system in Quarter 4 2017/18.
Opportunities	**Risks & Threats**
• As part of UH Bristol's corporate quality objective related to delivering a consistently excellent customer service, a set of draft "customer service principles" has been developed for the Trust in collaboration with stakeholders and staff. The next stage of this project is to test these principles in a number of live contexts, including with the Patient Support and Complaints Team and Outpatient Transformation Project	The key negative outliers identified in this report are: • South Bristol Community Hospital: survey scores improved in Quarter 2 but are still below the Trust average. This does not correlate with a range of other quality data for the hospital, which remain positive. Improvement work continues to be carried out at the hospital, including a planned programme of Trust Values training for all staff • Ward A518 received relatively low scores on two key survey measures. This is a fairly new ward established in June 2017. There is a now a substantive senior nursing team in place and we anticipate that this will impact positively on the survey results going forward • "Communication" in the Division of Medicine continues to be a theme in the survey data – which is likely to reflect the challenges of caring for a patient group with a high proportion of complex / long-term care needs. The Division is currently working to increase the use of the Discharge Lounge, which now has dedicated pharmacy support in place to provide additional communication / advice to patients about their medications.

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

2.1 UH Bristol Involvement Network

The UH Bristol Involvement Network connects the Trust to a diverse range of voluntary/community organisations across Bristol. In November 2017, a group of Sixth Form students from Ashton Park School visited UH Bristol. The students all had some degree of learning disability or additional educational need. Over the course of the day these "hospital detectives" were able to give the Patient Experience and Involvement Team insights into what it feels like to visit clinical and non-clinical areas of the Trust. These insights are currently being collated and will be shared with Divisions via the Trust's Patient Experience Group. Where necessary improvement opportunities will be identified and addressed.

2.2 Bristol Deaf Community

During Quarter 2, the Patient Experience and Involvement Team took a lead role with Healthwatch Bristol and the local deaf community, to establish a new Bristol Deaf Patient Experience Group. The Group will meet in February 2018 and every four months thereafter. It will bring together a number of different meetings into a single forum, to better understand patient experience for our deaf patients and to identify opportunities for collaborative working.

2.3 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[1]. This work is being led by the Transformation Team with support from the Patient Experience and Involvement Team. The latest stage of this project has seen the development of a draft set of customer service principles for UH Bristol, based on a number of staff and stakeholder workshops. These principles were shared with the Trust's Senior Leadership Team in November and positive feedback was received. The next stage of this project is to pilot the application of these principles in live contexts – in particular the Trust's Patient Support and Complaints Team and the Outpatient Transformation Project. A further update will be provided in the next Quarterly Patient Experience and Involvement Report.

2.4 Cross-organisational working

The Patient Experience and Involvement Team continues to engage with a range of health and social care organisations, including:

- UH Bristol, Bristol Community Health and North Bristol NHS Trust are jointly leading a patient and community leadership programme, with support from The King's Fund. This programme has provided training and support to members of the public who want to shape healthcare services locally. This work continues to evolve, with the development of the "Healthcare Change Maker" forum, which is now working in an advisory role to local commissioning and the Sustainable Transformation Partnership (STP). In addition, UH Bristol is directly benefiting from the programme, having placed participants in a number of roles, including the new Complaints Review Panel, the paediatric cardiac review steering group, and the Bristol Deaf Patient Experience Group (see above).
- Providing guidance and support about Patient and Public Involvement to the Sustainable Transformation Partnership (STP)
- Supporting the development of patient reported outcome measures to evaluate a planned redesign of respiratory and diabetes pathways across Bristol, North Somerset, and South Gloucestershire.

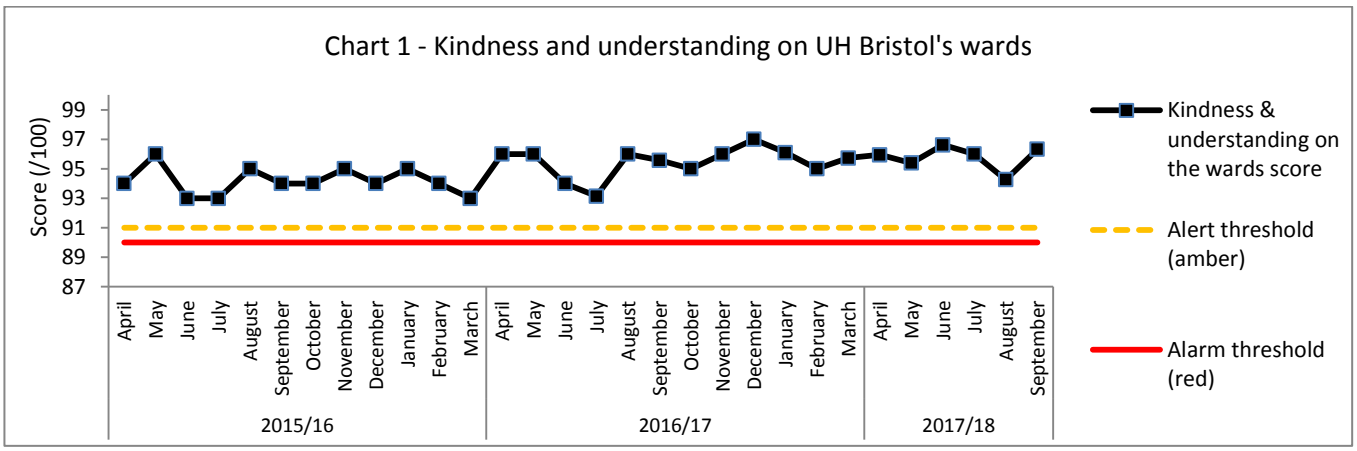
[1] Corporate quality objectives are improvement priorities for the Trust.

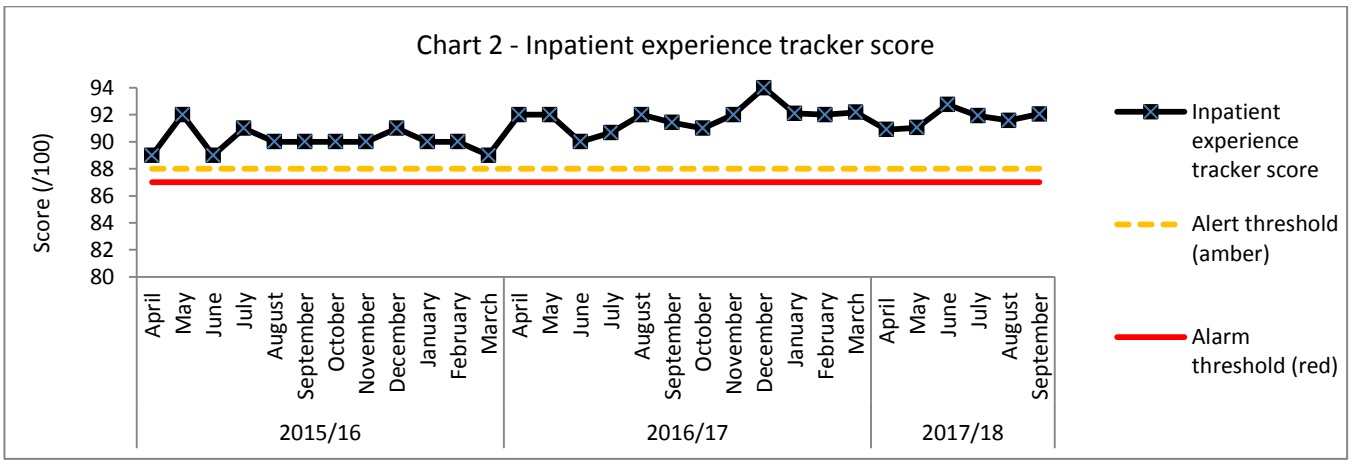
2.5 local Patient and Public Involvement activity

One of the roles of the Patient Experience and Involvement team is to support the development of a culture of patient involvement throughout the Trust. A notable recent project was carried out in collaboration with the Supportive and Palliative Care Team. In this project, patients and relatives were involved in the successful design of the Trust's new "butterfly" end of life personalised care plan.

3 Patient survey data to Quarter 2

The Trust's Patient Experience and Involvement Team is responsible for measuring patient-reported experience, primarily via the Trust's patient survey programme[2]. 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. All of our Trust-level patient survey scores were above their target levels in Quarter 2 (Charts 1-10).





[2] A description of the key Trust surveys is provided in Appendix B. The headline survey scores 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.

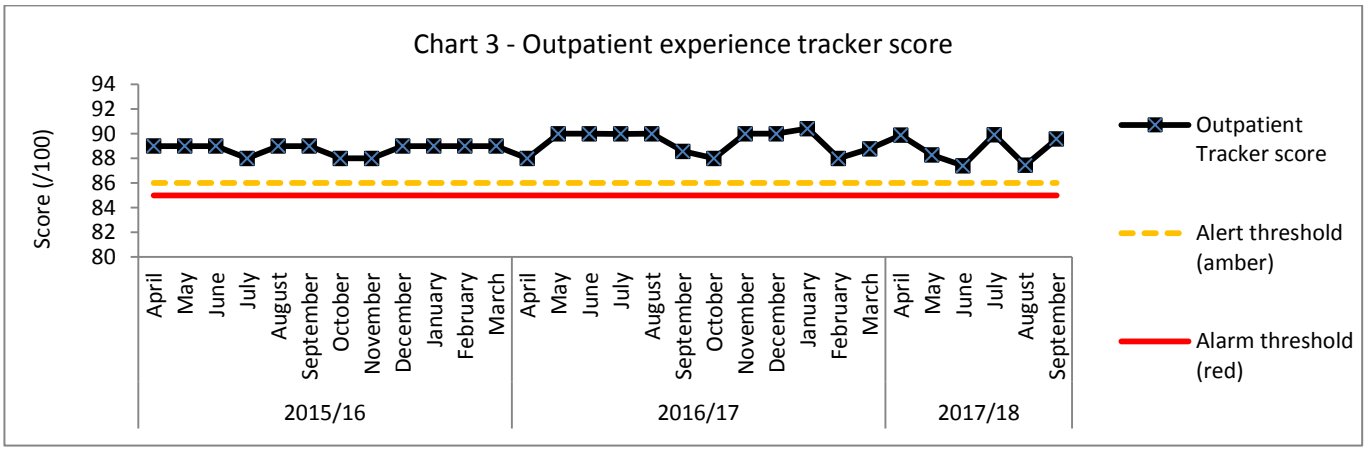


Chart 3 - Outpatient experience tracker score
Score (/100)
94
92
90
88
86
84
82
80
April May June July August September October November December January February March
2015/16
2016/17
2017/18
Outpatient Tracker score
Alert threshold (amber)
Alarm threshold (red)

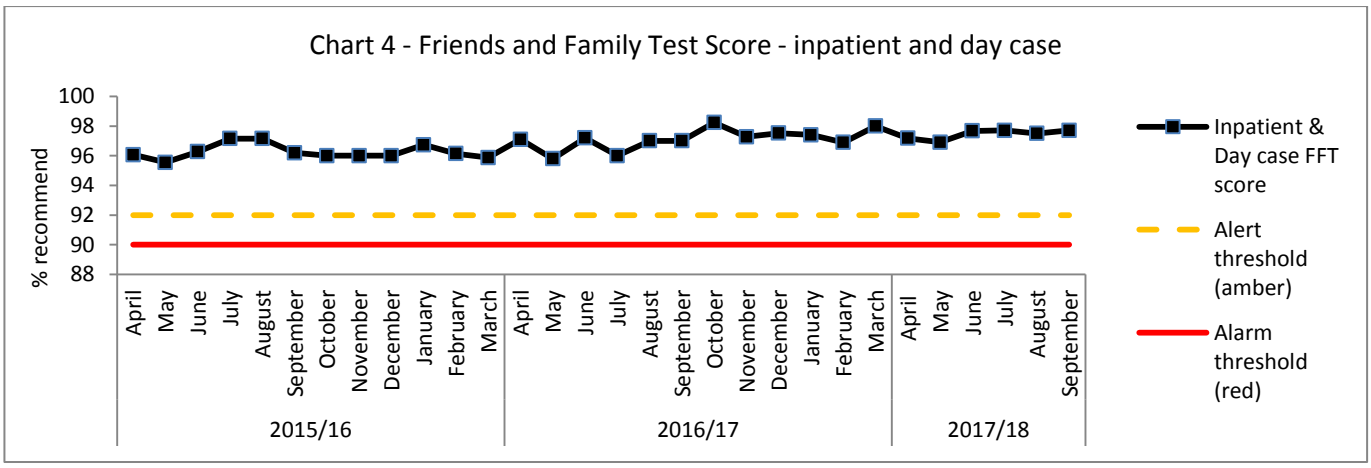


Chart 4 - Friends and Family Test Score - inpatient and day case
% recommend
100
98
96
94
92
90
88
April May June July August September October November December January February March
2015/16
2016/17
2017/18
Inpatient & Day case FFT score
Alert threshold (amber)
Alarm threshold (red)

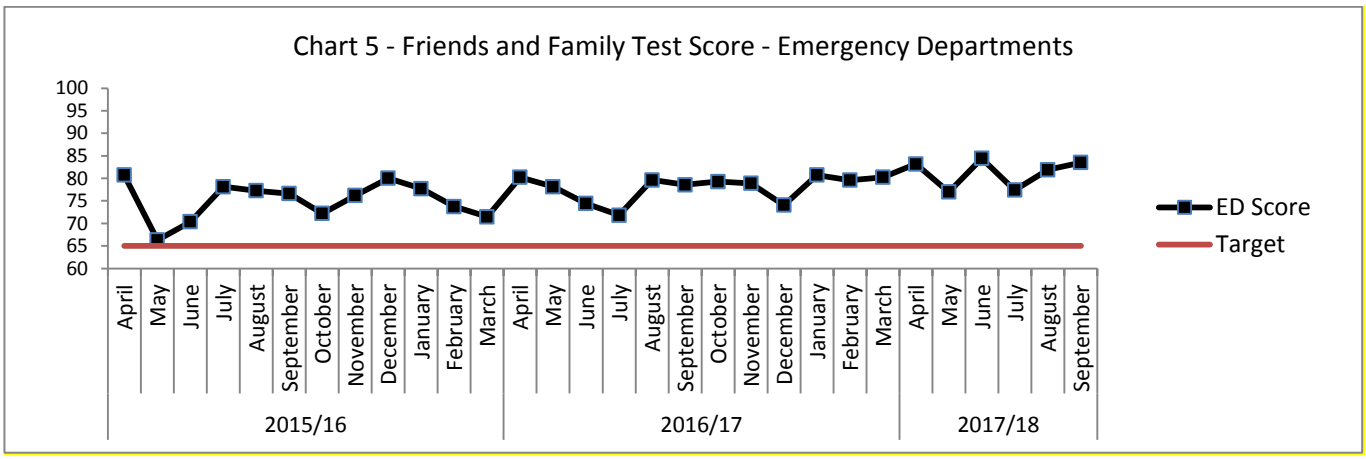


Chart 5 - Friends and Family Test Score - Emergency Departments
100
95
90
85
80
75
70
65
60
April May June July August September October November December January February March
2015/16
2016/17
2017/18
ED Score
Target

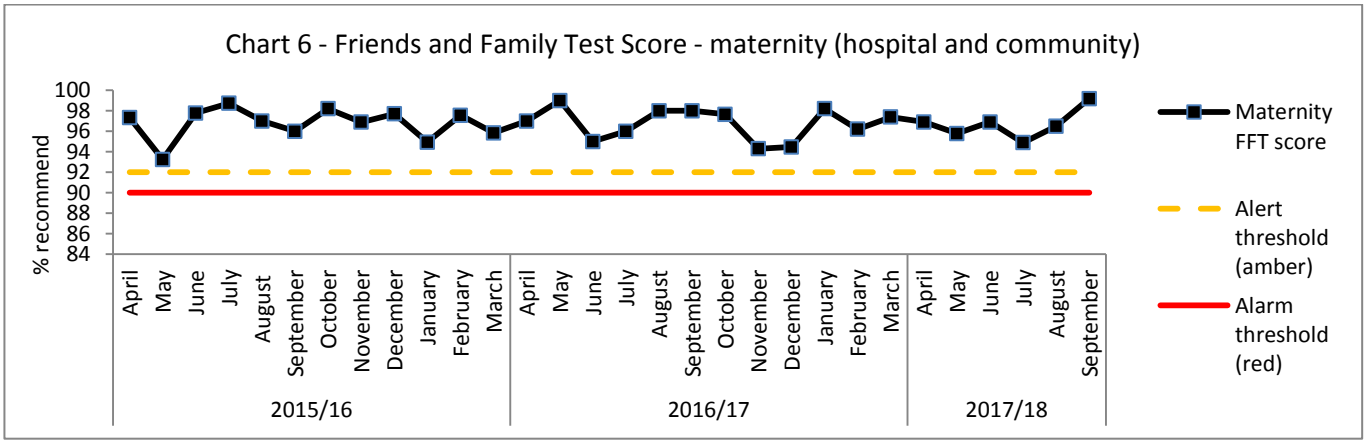


Chart 6 - Friends and Family Test Score - maternity (hospital and community)
% recommend
100
98
96
94
92
90
88
86
84
April May June July August September October November December January February March
2015/16
2016/17
2017/18
Maternity FFT score
Alert threshold (amber)
Alarm threshold (red)

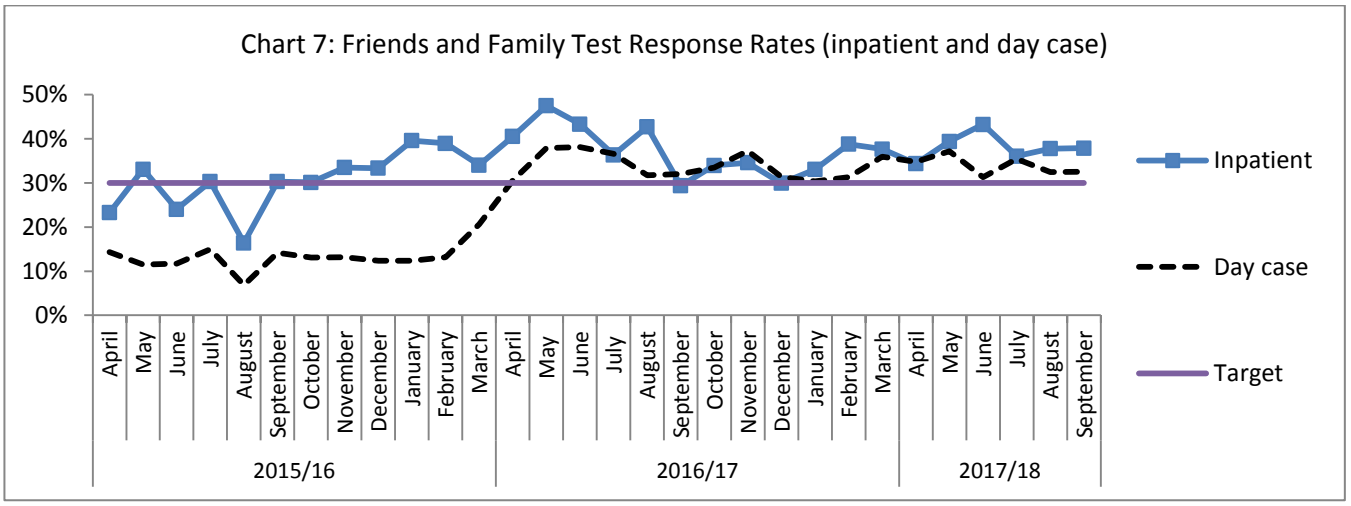


Chart 7: Friends and Family Test Response Rates (inpatient and day case)
50%
40%
30%
20%
10%
0%
April May June July August September October November December January February March April May June July August September October November December January February March April May June July August September
2015/16
2016/17
2017/18
Inpatient
Day case
Target

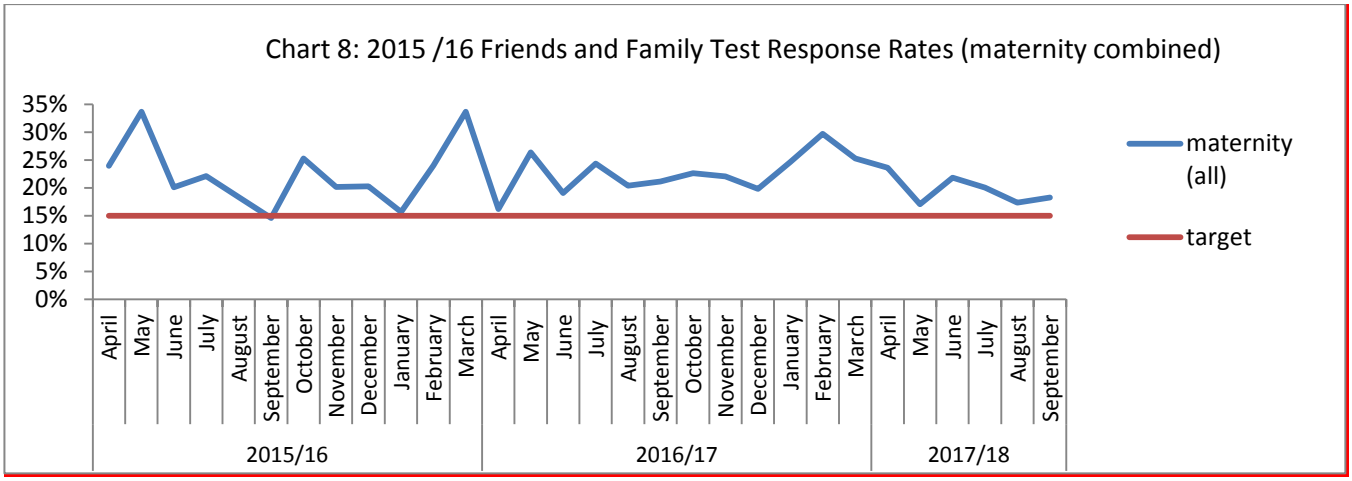


Chart 8: 2015 /16 Friends and Family Test Response Rates (maternity combined)
35%
30%
25%
20%
15%
10%
5%
0%
April May June July August September October November December January February March April May June July August September October November December January February March April May June July August September
2015/16
2016/17
2017/18
maternity (all)
target

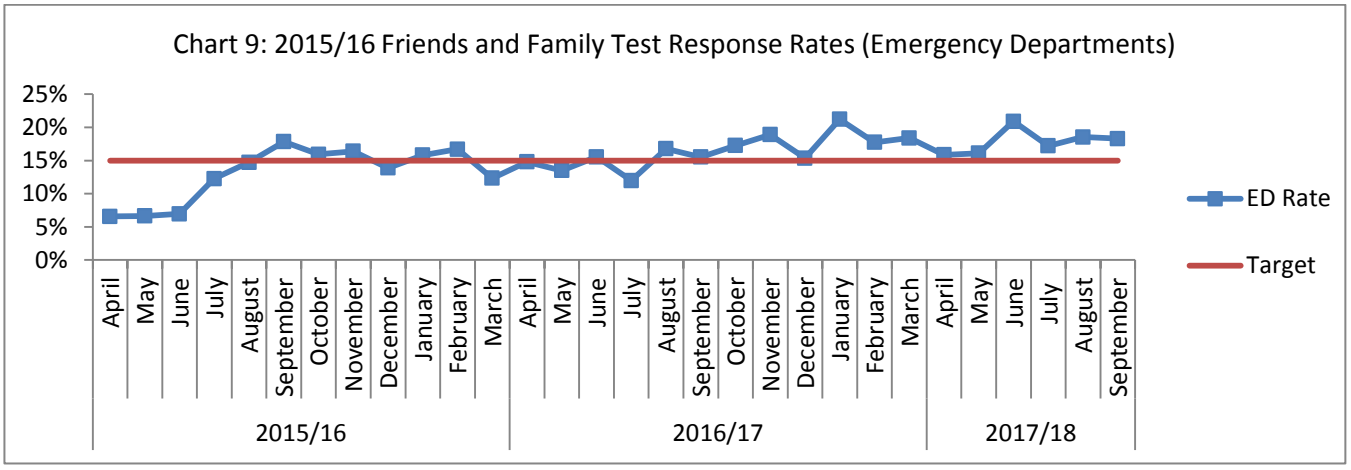


Chart 9: 2015/16 Friends and Family Test Response Rates (Emergency Departments)
25%
20%
15%
10%
5%
0%
April May June July August September October November December January February March April May June July August September October November December January February March April May June July August September
2015/16
2016/17
2017/18
ED Rate
Target

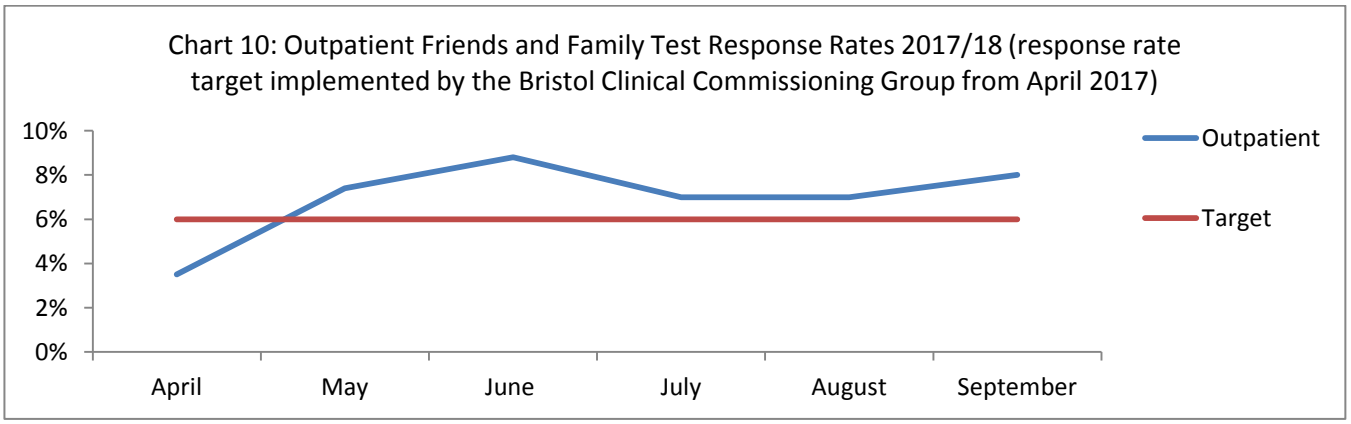


Chart 10: Outpatient Friends and Family Test Response Rates 2017/18 (response rate target implemented by the Bristol Clinical Commissioning Group from April 2017)
10%
8%
6%
4%
2%
0%
April
May
June
July
August
September
Outpatient
Target

3.1 Survey data / themes at Division, hospital and ward level

Charts 11-21 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 (for wards, 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 results are provided in Tables 1 and 2 (pages 11-13). The key negative outliers in these data sets are:

South Bristol Community Hospital

South Bristol Community Hospital (wards 100 and 200) received low scores on both of our key inpatient postal survey measures (Charts 16-17, 19-20). As noted in previous Quarterly Patient Experience and Involvement Reports, this is a relatively consistent trend, but it does not correlate with other quality data being received by the Division of Medicine, complaints data, or the Friends and Family Test survey score (which are much more positive / within the expected range). The scores are, however, consistent with research at a national level, which has found lower experience ratings among patients who have long-term stays for chronic conditions (South Bristol Community Hospital has a high proportion of patients being provided with rehabilitation care e.g. following a stroke). Nevertheless, there continues to be a focus on exploring and improving these scores:

- Staff engagement is a key driver for improving patient satisfaction scores: planning is currently taking place to deliver Trust Values training for all staff at South Bristol Community Hospital during Quarter 4
- In parallel with the Trust Values training, the Patient Experience and Involvement team will deliver a series of *Face2Face* patient and relative interviews and on-site group discussions to explore in depth patient and relative perspectives of the care provided on the wards
- A new patient leaflet for South Bristol Community Hospital is being developed which will set out what the rehabilitation model of care "looks like", helping to ensure that this is clearly communicated and that expectations are set at an early stage of care

Ward A518

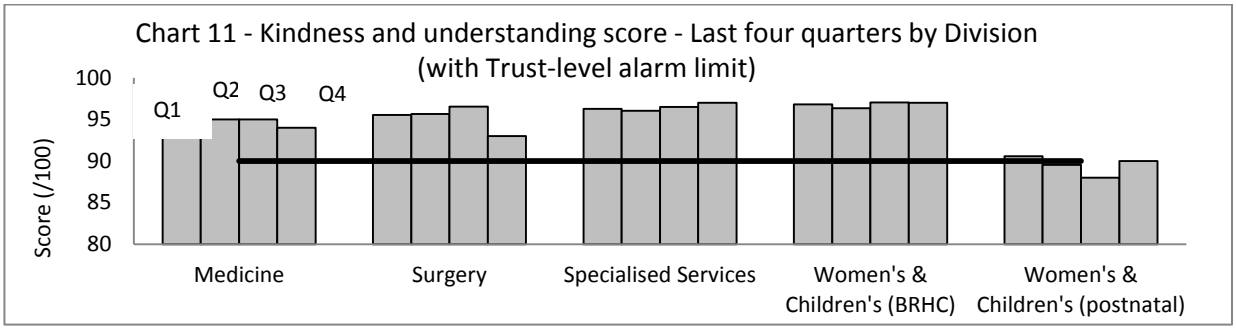
Ward A518 received relatively low scores on two key survey measures (Charts 20/21). This ward was established in June 2017 (previously it was open only when extra inpatient capacity was needed). There is now a senior nursing team in place and so we would expect to see an improvement in the patient survey scores. The scores will continue to be closely monitored alongside other quality data collected by the Division.

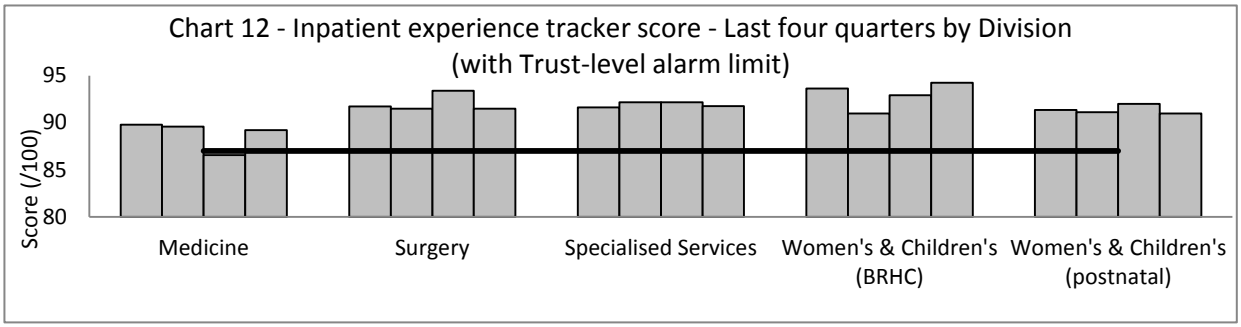
Communication in the Division of Medicine

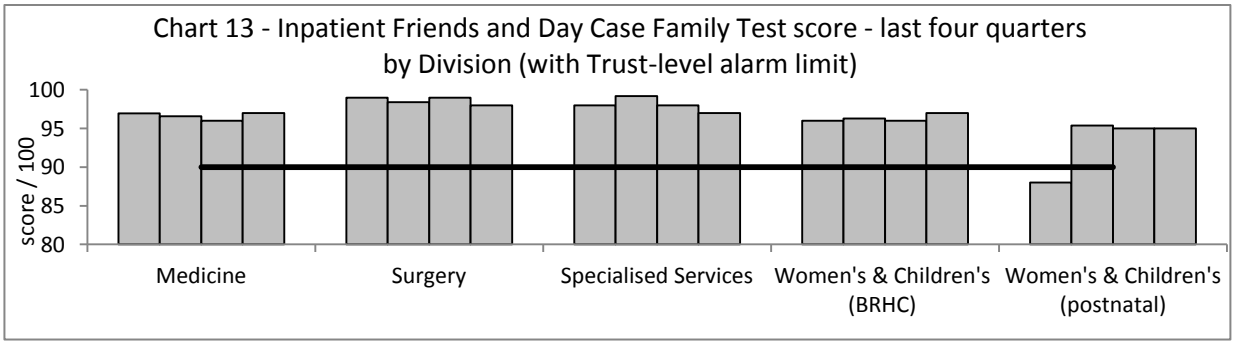
A consistent theme in our inpatient survey data (Table 1) relates to communication in the Division of Medicine. Whilst patients are given key information at appropriate points during their stay, the Division cares for a relatively high proportion of patients who have a cognitive impairment and / or complex long-term health conditions (e.g. care of the elderly services). The previous (Quarter 1) Patient Experience and Involvement Report contained bespoke analysis of Care Quality Commission national inpatient survey data, which provided assurance that older patients rated UH Bristol's care as being better than the national average. However, it is recognised by the Division that there is always scope to improve patient experience. For example, ensuring that patients understand potential side effects of the medications they take home has been particularly difficult to resolve, given the number and complexity of treatment regimens that many of their patients have to adhere to. The Division is currently focussing on increasing the use of the Trust's Discharge Lounge when discharging patients out of hospital, as there is now dedicated pharmacy support within the Lounge to facilitate swift and supportive discharge planning and provide patient with additional medications information where this is needed.

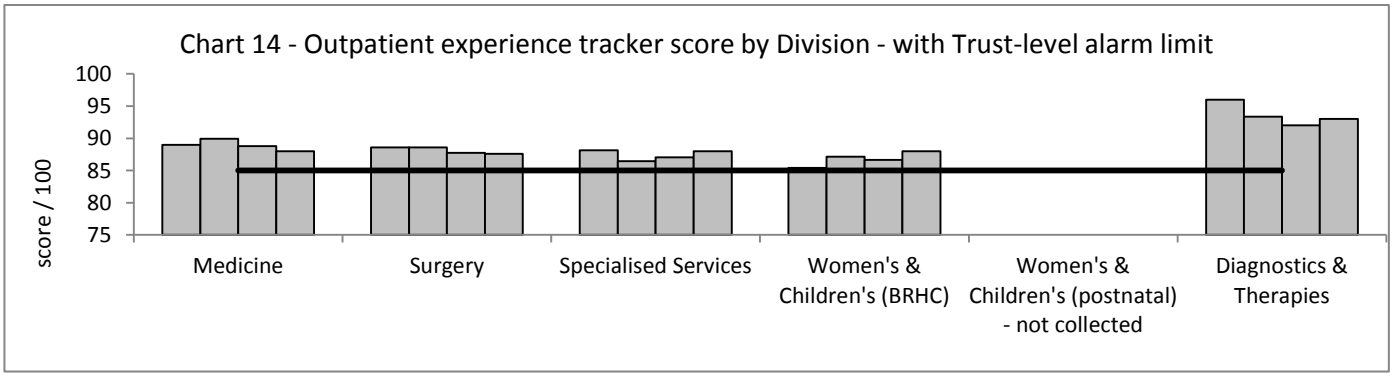
Informing patients about delays in outpatient clinics

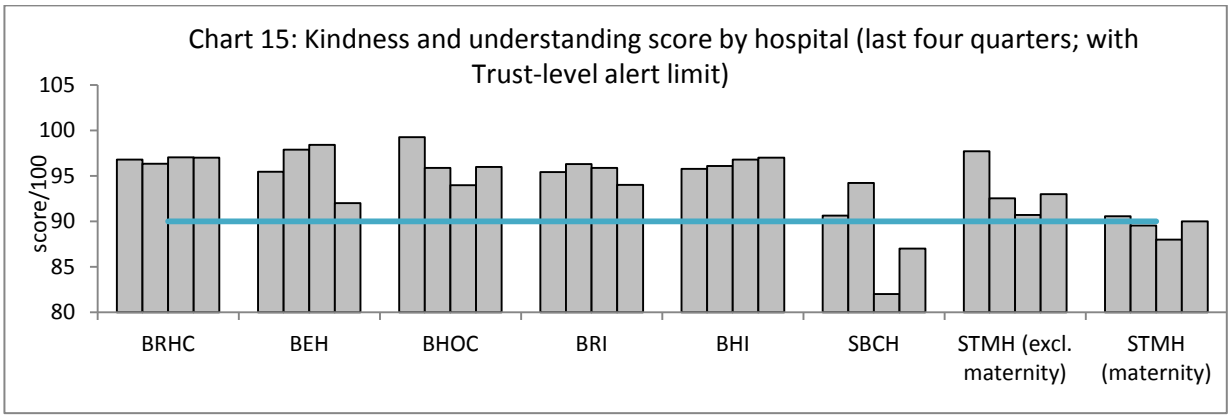
A cluster of low survey scores is present in the outpatient survey data (Table 2), relating to ensuring patients are kept informed about any delays in clinic. In Quarter 2, the Bristol Royal Hospital for Children had a *particularly* low score in this respect (the Outpatient Sister has been advised of this and has reminded her staff about the importance of keeping patients/parents informed), but it is an issue that affects all Divisions. This is currently the focus of a corporate quality (improvement) objective. Actions include the implementation of standardised clinic information boards in a large number of outpatient departments. It should be noted that, whilst the Diagnostics and Therapies Division doesn't generally have information boards in place (hence their particularly low survey score on this question in Table 2), relatively few of their patients report delays in clinic.

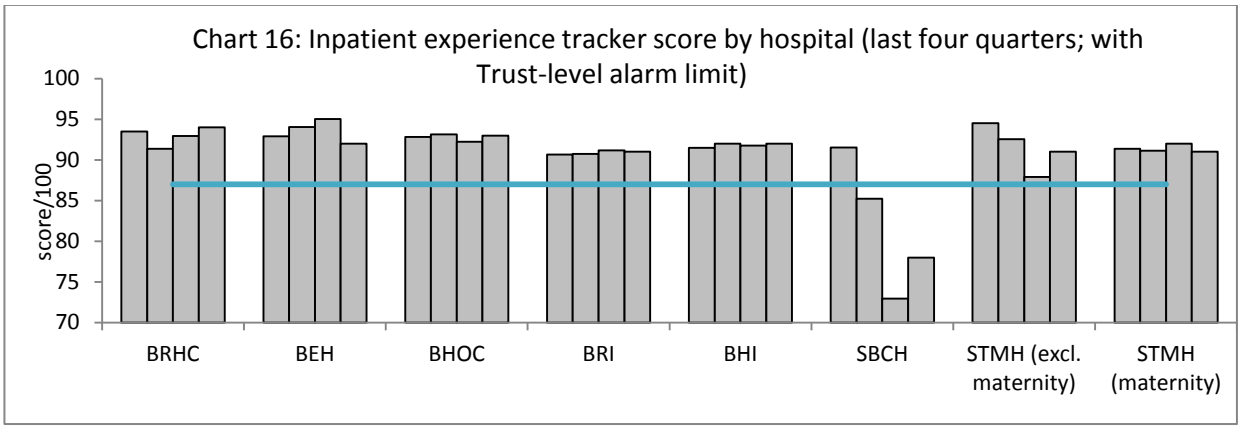


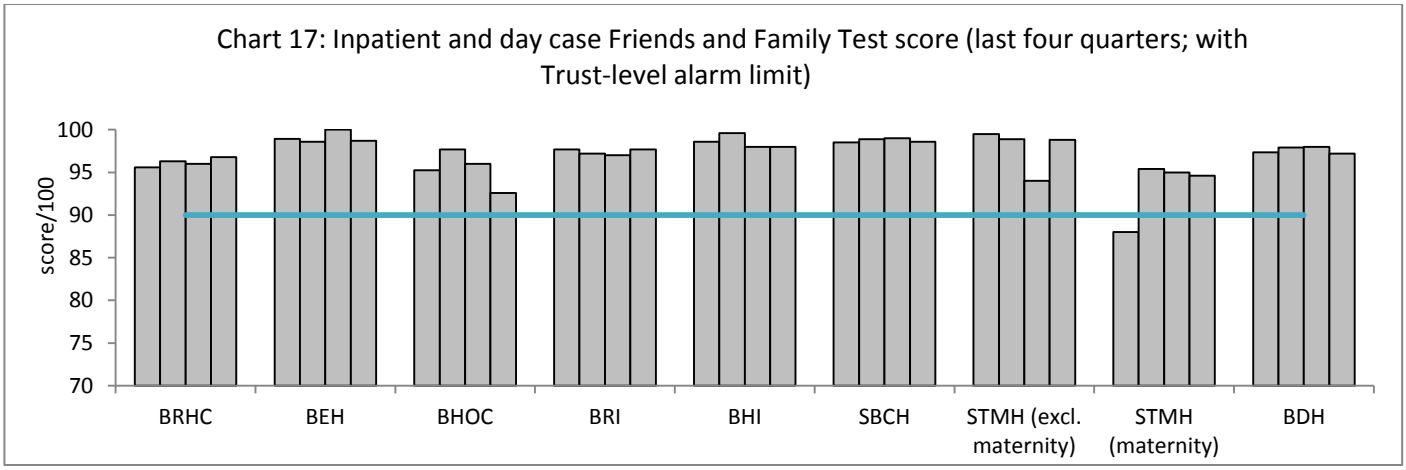


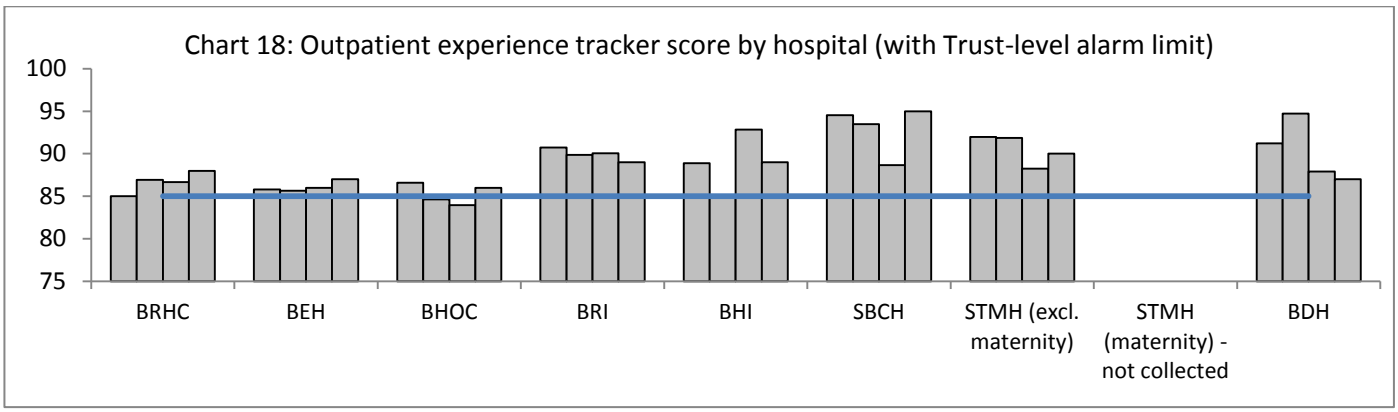




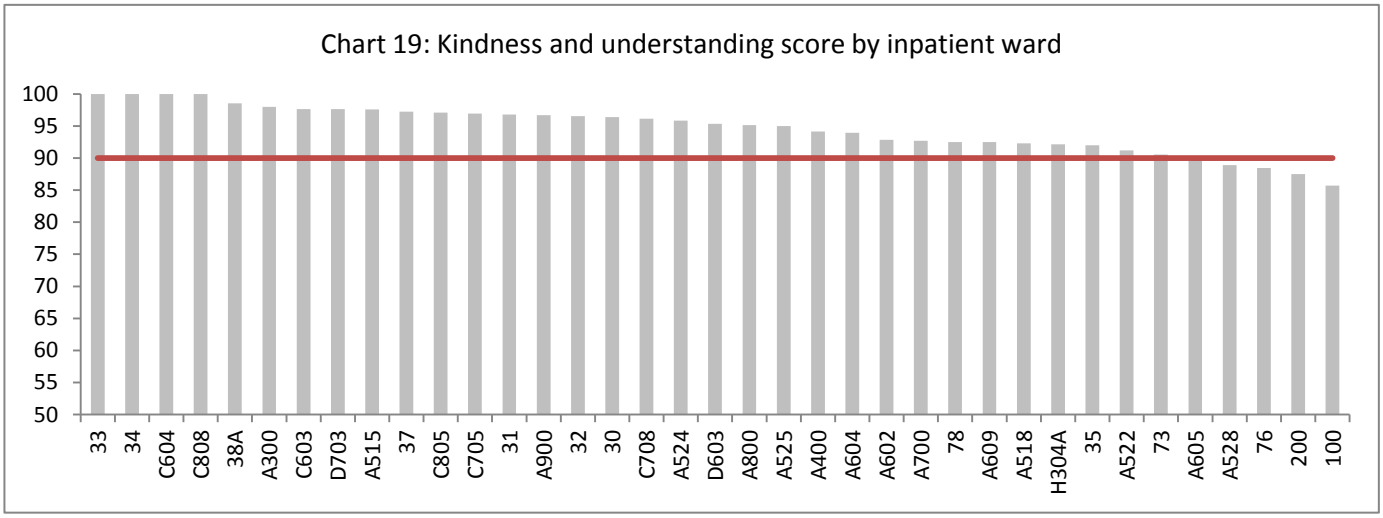


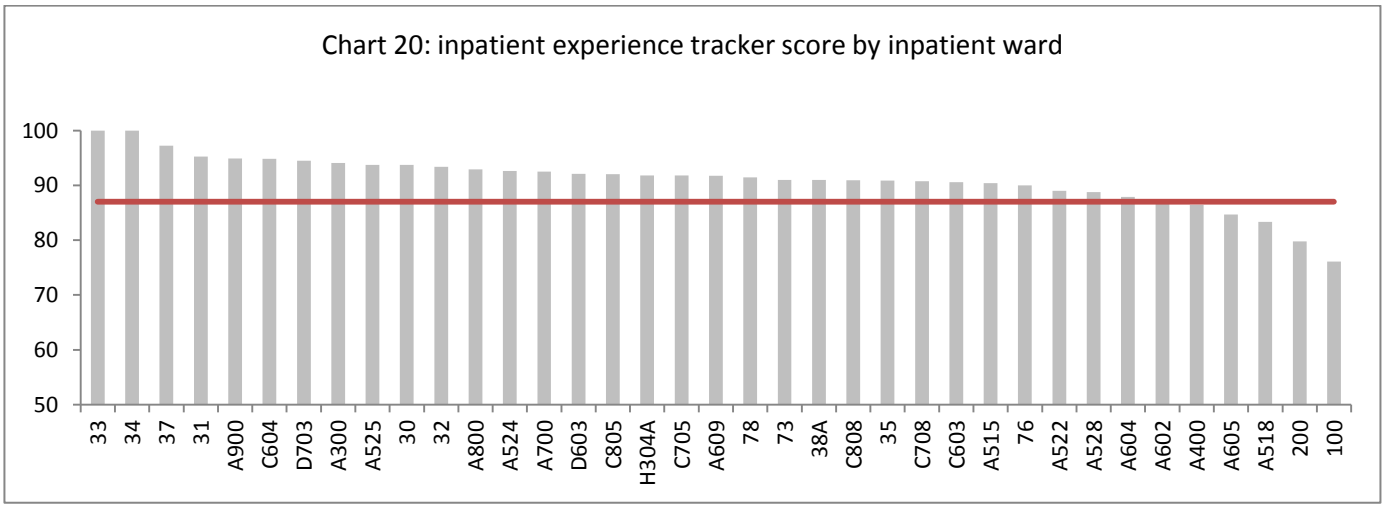


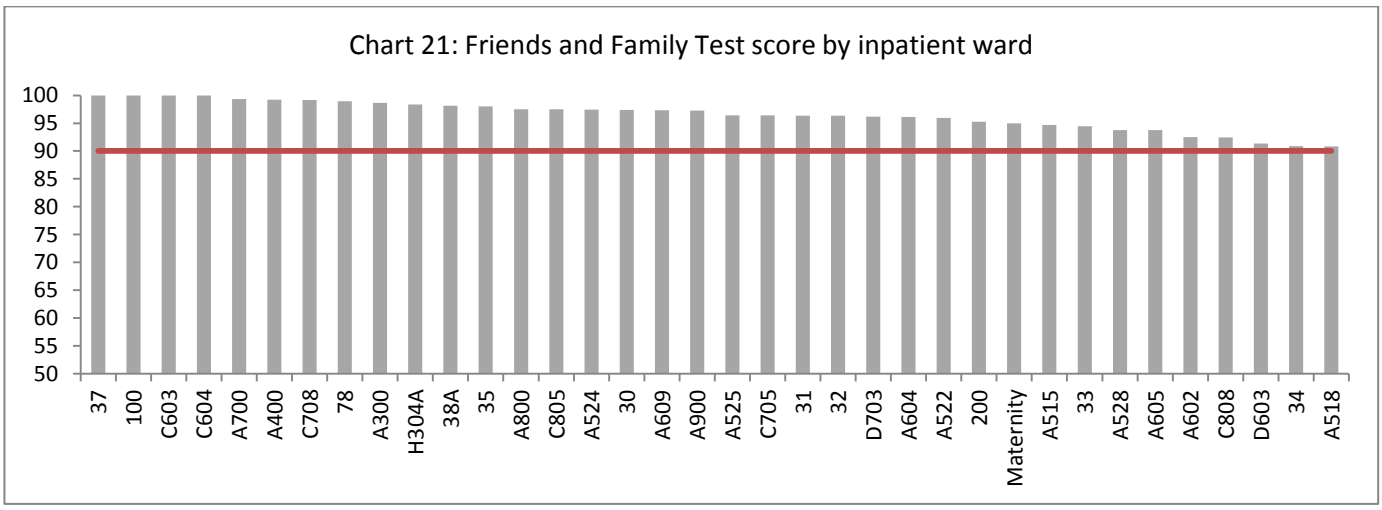




Key: BRHC (Bristol Royal Hospital for Children), BEH (Bristol Eye Hospital), BHOC (Bristol Haematology and Oncology Centre), BRI (Bristol Royal Infirmary), BHI (Bristol Heart Institute), SBCH (South Bristol Community Hospital), STMH (St Michael's Hospital), BDH (Bristol Dental Hospital)







(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?	88	94	93	94		93
How would you rate the hospital food?	61	59	66	62	56	61
Did you get enough help from staff to eat your meals?	80	84	79	87		83
In your opinion, how clean was the hospital room or ward that you were in?	95	95	95	96	88	95
How clean were the toilets and bathrooms that you used on the ward?	91	93	93	92	79	92
Were you ever bothered by noise at night from hospital staff?	79	82	85	88		84
Do you feel you were treated with respect and dignity by the staff on the ward?	96	98	97	95	94	96
Were you treated with kindness and understanding on the ward?	94	97	97	93	90	95
Overall, how would you rate the care you received on the ward?	86	91	93	90	83	90
When you had important questions to ask a doctor, did you get answers that you could understand?	88	89	92	90	89	90
When you had important questions to ask a nurse, did you get answers that you could understand?	88	91	93	90	91	91
If your family, or somebody close to you wanted to talk to a doctor, did they have enough opportunity to do so?	79	74	79	75	74	76
If your family, or somebody close to you wanted to talk to a nurse, did they have enough opportunity to do so?	83	88	92	84	86	87
Were you involved as much as you wanted to be in decisions about your care and treatment?	80	85	93	86	90	86
Do you feel that the medical staff had all of the information that they needed in order to care for you?	90	89	87	91		90
Did you find someone on the hospital staff to talk to about your worries or fears?	64	76	86	75	81	76
Did a member of staff explain why you needed these test(s) in a way you could understand?	81	84	92	88		86

	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?	77	85	89	86		85
Were you told when this would happen?	77	83	82	83		82
Before your operation or procedure, did a member of staff explain the risks/benefits in a way you could understand?	80	91	94	93		92
Before your operation or procedure, did a member of staff explain how you could expect to feel afterwards?	73	74	86	81		80
Were staff respectful of any decisions you made about your care and treatment?	90	94	94	93		93
During your hospital stay, were you ever asked to give your views on the quality of your care?	31	32	35	31	29	32
Do you feel you were kept well informed about your expected date of discharge from hospital?	76	88	87	87		86
On the day you left hospital, was your discharge delayed for any reason?	63	60	68	65	62	64
Did a member of staff tell you about medication side effects to watch for when you went home?	50	56	69	70		62
Did hospital staff tell you who to contact if you were worried about your condition or treatment after you left hospital?	62	82	92	82		81

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 12 points or more 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
Was the appointment cancelled and re-arranged by the hospital?	95	96	97	94	93	95
If you contacted the hospital, was it easy to get through to someone who could help you?	63	63	74	66	60	66
How would you rate the courtesy of the receptionist?	87	83	86	85	84	85
Were you and your child able to find a place to sit in the waiting area?	100	99	99	99	98	99
In your opinion, how clean was the outpatient department?	94	93	95	92	91	93
How long after the stated appointment time did the appointment start? (% on time or within 15 minutes)	85	70	65	72	63	72
Were you told how long you would have to wait?	42	36	43	29	18	35
Were you told why you had to wait?	62	55	55	54	54	56
Did you see a display board in the clinic with waiting time information on it?	33	60	49	41	41	45
Did the medical professional have all of the information needed to care for you?	87	90	90	88	86	88
Did he / she listen to what you had to say?	95	95	97	95	93	95
If you had important questions, did you get answers that you could understand?	92	92	92	88	88	91
Did you have enough time to discuss your health or medical problem?	89	91	90	92	94	91
Were you treated with respect and dignity during the outpatient appointment?	99	99	98	98	98	99
Overall, how would you rate the care you received?	91	93	92	91	91	92
If you had any treatment, did a member of staff explain any risks and/or benefits in a way you could understand?	83	95	82	86	84	86
Did a member of staff explain your test results in a way you could understand?	72	76	81	82	75	78
Did a member of staff tell you about medication side effects to watch for after leaving?	n/a	74	73	53	73	65

3.1.1 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)[3]

	Theme	*Sentiment*	*Percentage of comments containing this theme*
Trust (excluding maternity[4])	Staff	Positive	68%
	Communication/information	Negative	10%
	Food	Negative	9%
Division of Medicine	Staff	Positive	60%
	Food / catering	Negative	11%
	Staff	Negative	10%
Division of Specialised Services	Staff	Positive	67%
	Food /catering	Negative	8%
	Communication/information	Negative	8%
Division of Surgery	Staff	Positive	69%
	Communication/information	Negative	13%
	Staff	Negative	12%
Women's and Children's Division (excluding Maternity)	Staff	Positive	70%
	Communication/information	Negative	9%
	Food / catering	Negative	7%
Maternity	Staff	Positive	68%
	Care during labour and birth	Positive	22%
	Postnatal care	Positive	16%
Outpatient Services	Staff	Positive	59%
	Communication/information	Negative	9%
	Waiting / delays	Positive	9%

[3] 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).

[4] 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
Medicine	Ward A518	Constant noise. Patients have to be seen to but staff talking quite loudly at night-very little sleep.	As a result of this comment, this issue was addressed with staff at their Safety Briefing. This was followed up by an email to staff. Senior staff nurses are now rotated onto nights, which will ensure high standards (including noise levels) are consistently upheld.
	Bristol Royal Infirmary, Emergency Department	There were a number of comments about the cleanliness of the Bristol Royal Infirmary Emergency Department in Quarter 2.	We have 24 hour, 7 days a week cleaning cover within the Department, however at peak times it is extremely challenging to maintain all areas. A Housekeeper has now been recruited and this will help to ensure that cleaning issues are quickly identified and resolved. The Facilities Department also carried out a review which has identified a need to improve the public toilets in the main reception area. These actions are being taken forward by the Facilities Department.
Specialised Services	Ward D603	As I am on a iodine diet I was surprised when I was told there was no soya milk for my coffee	We are sorry that this occurred - soya milk is available on D603, but the hotel services team were not aware of how to access this. The relevant staff are now aware how to obtain the milk.
	Ward D603	Very dismal situation of bed 3, not much natural light and depressing	The Matron is reviewing the use of natural lighting simulation in this clinical area, to see if the environment can be improved.
	Ward D703	The shower in the isolation room was leaking and the soap dispenser did not work in the bathroom.	The matron has reported this to the Estates Department and the shower will be repaired.

Division	Area	Comment	Response from ward / department
Surgery	Outpatient, Bristol Dental Hospital	The dentist I saw inspired confidence but there was a problem with the automatic check in and I had to engage 2 desk staff to assist. After I had waited 45 minutes past my appointment time I asked a receptionist how long the delay was likely to be. She checked the system and found that I had been recorded as "did not attend". She was abrupt, gave no eye contact, and was patronising with no sympathy that I had waited for so long and certainly made no apology.	We are very sorry to hear about this patient's experience. During this period we had staffing issues and had to cover the reception desk with staff from the Medical Records department; who although are sufficiently trained for this role, are sometimes not as efficient at front of house duties. Nevertheless, we expect a high standard of customer service to be delivered at all times, regardless of the situation. This comment has been fed back to the Reception Supervisor as a point of learning for the staff concerned. We are also working with the Organisational Development Team to deliver bespoke customer service training for our staff.
	Ward A700	The ward nurses during the night are very noisy and getting sleep was very difficult. The day staff very quiet and caring.	The ward sister has e-mailed all staff about this comment to raise awareness and to remind them of the importance of a good nights' sleep for patients and their recovery.
	Outpatient, Bristol Dental Hospital	Great Dentist. Awful admin - can not call through to desk, answer machine messages not returned	We are very sorry that this patient could not get through to speak to someone in our department. Complaints about telephone contact / response have reduced overall for the Bristol Dental Hospital due to actions previously implemented. However, improvements continue to be carried out in this respect, including: Answer phones are now checked on reception and within the patient access team every morning Two new operational staff have been appointed, which will enable more support for the administration teams The Organisational Development team are supporting the hospital to design a bespoke customer service package to improve the performance of the receptionists. Relaunching the outpatient booking team to focus on team working and cross-cover

Division	Area	Comment	Response from ward / department
Women's and Children's	Bristol Royal Hospital for Children – Clinical Investigations Unit (CIU)	Need to update patients when running late. Board not filled out.	The board is used on a daily basis and we allocate a member of staff to keep this up to date. We are not able to determine when exactly this feedback relates to, but it will be shared within the next staff meeting reiterating clearer communication once the board is changed. i.e. updating patients verbally as well as updating the board. We will also review what reception staff are communicating to patients on their arrival.

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 and Involvement report.

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

Issue / area	*Outcome*
Trust-level outpatient experience tracker had declined for three consecutive months	This was not statistically significant and was within the bounds of our "normal range", and there was no corroborating evidence of a decline in service standards. This trend was therefore attributed to chance fluctuation in the survey score. This explanation was subsequently supported by an increase score the following month (again within the normal range) and no further declining trend has been apparent.
Relatively low inpatient postal survey scores for South Bristol Community Hospital	See current (Quarter 2) report.
Slightly below target "kindness and understanding" score on postnatal maternity wards in Quarter 1	The score is above target in Quarter 2. It was noted in the Quarter 1 report that "patient experience at heart" staff workshops would take place in maternity services in early Quarter 2. However an alternative initiative was undertaken instead, with a week-long staff engagement focus on understanding the "human factors" behind working in maternity services. These workshops were well attended by a range of staff both from within Maternity and other services located in St Michaels Hospital.
Ward C604 at the Bristol Heart Institute score had the lowest score in the inpatient Friends and Family Test in Quarter 1	This appeared to be an artefact of the survey scoring system, skewed by a small sample, rather than a reflection of service quality. The scores have reverted to being very positive in Quarter 2.

Ward A605 had a relatively low score on two survey measures in Quarter 1	We couldn't identify a specific reason for this within the data. The scores are more positive in Quarter 2 and will continue to be monitored.
The Bristol Haematology and Oncology Centre had a below target score on the outpatient experience tracker in Quarter 1.	Within this aggregate survey measure, it was "delays in clinic" that dragged down the overall score in Quarter 1. The "tracker" is now above target in Quarter 2, but the hospital has seen significant levels of demand in outpatient clinics which will continue into the foreseeable future. The hospital management team is working to ensure these needs can be met.
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).	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.

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 22 provides a broad summary of the Trust's position in these surveys[5]. For each national survey, the Trust Board receives a full report containing an analysis / response (see Appendix A for a summary).

In Quarter 2 UH Bristol received the latest (2016) national Accident and Emergency Survey. This reflects the experiences of 265 patients who attended the Bristol Royal Infirmary Emergency Department (BRI ED)[6] in September 2016. The BRI ED achieved a very positive set of results in this survey:

- 9 out of 45 scores were classed as being better than the national average (Table 1). This puts UH Bristol among the top 10 of all English trusts on this measure of patient-reported experience
- Five UH Bristol scores were the best of any trust score nationally
- No UH Bristol scores were classed as being below the national average
- UH Bristol achieved the top score nationally in the section of the survey relating to the quality of care provided by doctors and nurses
- In terms of how good overall the patient experience is at the BRI ED[7], patients gave UH Bristol a score of 8.3/10, which was among the best 20% of trusts nationally.

[5] 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.

[6] The survey focussed on Type 1 adult services, therefore Bristol Eye Hospital and Bristol Royal Hospital for Children Emergency Departments were not covered by the survey.

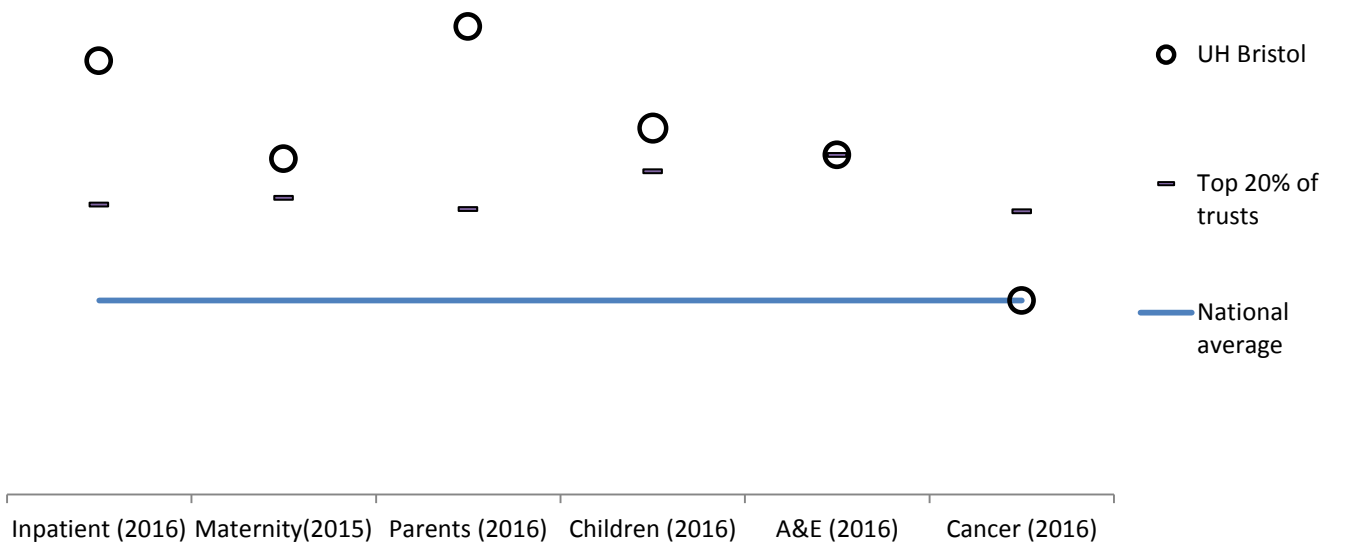
[7] There is only a fairly modest correlation (0.58) across trusts, between the number of scores classed as better than the national average and overall experience rating.

The 2016 national cancer patient experience survey results were released in July 2017. The headline results for UH Bristol were as follows:

- Two UH Bristol scores were classed as being better than the national average to a statistically significant degree:
- One UH Bristol score was classed as being below the national average to a statistically significant degree:
- For the remaining 43 questions in the survey, that relate to UH Bristol care, the scores are in line with the national average.

Overall, UH Bristol was in line with the national average on this survey (Chart 22). Whilst the Trust aspires to deliver a patient experience of cancer care that is among the very best nationally, it should be noted that these results represent an improving direction of travel: in previous years the Trust was below the national average in this survey on a number of questions. This is a result of sustained improvement work led by the Lead Cancer Nurse in collaboration with patients and their families / carers. The Quality and Outcomes Committee of the Trust Board has reviewed a full analysis of these results and the action plan in response.

Chart 22: Overall experience ratings: UH Bristol performance in the most recent national surveys, relative to the national average and top performing trust thresholds



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

Please note that the National Children's Survey was published shortly before the current Quarterly report was written. The results were very positive for UH Bristol and the headline satisfaction scores for parents and children have been incorporated into Chart 22 (above). A full analysis / response report is currently being written by the Patient Experience and Involvement Team in collaboration with the Bristol Royal Hospital for Children. This analysis report will be provided to the Quality and Outcomes Committee of the Trust Board in February 2018.

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*	*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	• 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	• 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	• Support from partner health and social care organisations • Providing patients with a care plan • Coordination of care with the patient's GP	July 2018
2016 National Accident and Emergency surveys		To be reviewed by the Quality and Outcomes Committee in January 2018	• 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 2019
2016 National Children's Survey		To be reviewed by the Quality and Outcomes Committee in February 2018	• Information provision • Communication • Facilities / accommodation for parents	November 2019
2011 National Outpatient Survey	All scores in line with the national average	March 2012	• 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.

University Hospitals Bristol
NHS Foundation Trust

Cover report to the Public Trust Board Meeting to be held on 31 January 2018 at 11.00 – 13.00 in the Conference Room, Trust HQ

		Agenda Item	10
Meeting Title	Trust Board	**Meeting Date**	Wednesday, 31 January 2018
Report Title	Learning from Deaths		
Author	Mark Callaway, Acting Medical Director		
Executive Lead	Mark Callaway, Acting Medical Director		
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.	☒	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 Adult Learning from Deaths policy was introduced nationally in April 2018. This is the second report to the Quality and Outcomes Committee from the Mortality Surveillance Group chaired by the Medical Director
The format of the report is in evolution, but does report the number of deaths in, the number of deaths subject to Structured Case Note Review, and the number of avoidable deaths during Quarter 1 and 2 .
The structured case note reviews have also been assessed in all 5 aspects of assessment of patient care and this information reviewed on a Divisional basis

Key issues to note

1. Number of deaths in quarter 1 and quarter 2 - 569
2. Number of deaths subject to SCNR - 105

3. Number of avoidable deaths - 1 4. Themes from Learning from Deaths - Instigation of end of life care and Senior Decision making to instigate end of life care 5. Positive aspects of review - The majority of reviews concluded that the care was assessed as 3-5 on scoring scale
Recommendations
Members are asked to: • Note the Report. • Comment on the format and presentation of data

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 recruit, train and sustain an engaged and effective workforce.	☐	Failure to comply with targets, statutory duties and functions.	☐
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.	☐		

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)**
		29 January 2018		Trust Board 31/01/18

Adult Mortality Report January 2018

Dr Mark Callaway

Summary

Since April 2017 all in patient adult mortality has been subject to review with the aim of learning from deaths.
This report reviews the results from the first two quarters of 2017.

Introduction

In December 2016 the Care Quality Commission published a review of how NHS trusts review and investigate deaths of patients in care. 'Learning, candour and accountability' provides helpful insight into the system level and local challenges to effective investigations, greater candour and transparency, and learning from deaths across the NHS. The CQC's report made a number of recommendations and recommendation number 7 is directed towards acute providers. This states that provider organisations and commissioners must work together to review and improve their local approach following the death of people receiving care from their services. Provider boards should ensure that national guidance is implemented at a local level, so that deaths are identified, screened and investigated when appropriate and that learning from deaths is shared and acted on. Emphasis must be given to engaging families and carers. The CQC recommend that Provider boards should ensure:

• Patients who have died under their care are properly identified.
• Care records of all patients who have died are screened to identify concerns and possible areas for improvement and the outcome documented.
• Staff and families/carers are proactively supported to express concerns about care given to patients who died.

• Appropriately trained staff are employed to conduct investigations

• Where serious concerns about a death are expressed, a low threshold should be set for commissioning an external investigation.

• Investigations conducted in a timely fashion, recognising that complex cases may require longer than 60 days.

• Families and carers are involved in investigations to the extent they wish.

• Learning from reviews and investigations is effectively disseminated across the organisation, and with other organisations where appropriate.

• Information on deaths, investigations and learning is regularly reviewed at board level, acted upon and reported in annual Quality Accounts.

• That particular attention is paid to patients with a learning disability or mental health condition.

• Provider boards should strongly consider nominating a non-executive director to lead on mortality and learning from deaths.

Mortality Review Process

1. All adult inpatient deaths will be screened

The notes of all adult in patient deaths will be screened for criteria that will trigger a Structured Case Note Review (SCNR). These criteria are;

i. Where the family raise concerns about the overall care
ii. Deaths in patients with learning difficulties and in patients with a history of mental illness, those patients who are under section of the mental health act
iii. Deaths in patients following an organisational alert
iv. Deaths following an elective procedure
v. patients aged between 16-18

In addition, a random selection of deaths that would not have triggered a review by the above criteria will be selected and subjected to a SCNR.

If a death triggers a SCNR the Divisional lead will be informed and the case notes will be subject to a SCNR by a trained reviewer.

2. All deaths meeting the screening tool criteria will be subject to a SCNR

UH Bristol has developed a screening tool which allows additional criteria for triggering a SCNR to be assessed; factors such as multiple ward moves, queuing or outlying could be factors that would be used to trigger a SCNR.

The outcome of a Structured Case Note Review

The Structured Case Note Review results in two outcomes, the first is an overall score for the quality of the care provided; this is on a 1 to 5 scale with 5 representing excellent care and 1 poor care. The next is assessment of avoidability of death; this is on a 1 to 6 scale. These scores are also supported by statements from the case note reviewer that indicate the reasons behind the scoring and produce learning points from the review.

The SCNR will be performed by a senior doctor, senior nurse or senior trainee who has undergone training in SCNR using the Royal College of Physicians' methodology

The SCNR will be performed by a Senior Clinician. All consultants are eligible to be involved in SCNR once they have completed the appropriate training. This includes Consultants in non-bed holding

specialties, such as Radiologists and Anaesthetists.

1. The co-ordination of the SCNR

The co-ordination of the structured case note review will be undertaken by the Divisional mortality leads. It will be the responsibility of the Divisional lead to distribute the review to the reviewers, coordinate the response and co-ordinate the learning and outcome from the review.

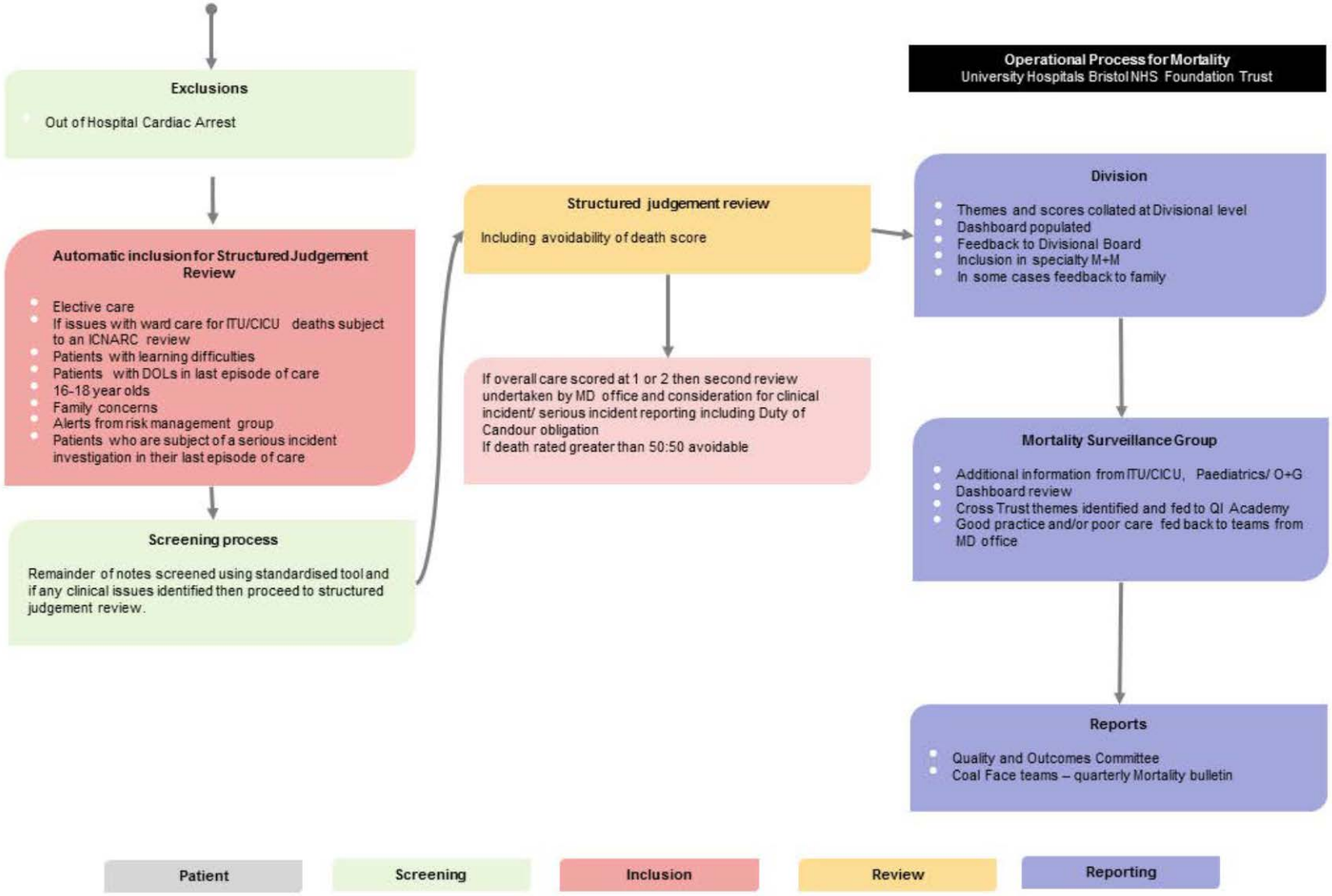
2. All SCNRs that trigger a score of 1-2 for the overall provision of care or 1-3 on the avoidability of death score will trigger a second SCNR by a trained member of the Medical Director's team. All adult inpatient deaths which score a one or two for the overall provision of care, or 1-3 on the avoidability of death score on the initial review will trigger a second SCNR by the MD office. This is so patients where the overall standard of care provided has been assessed as poor or where there was a greater than 50% probability of avoidability are subject to a further detailed review. This process allows the Senior Medical team to be sited on all deaths within the organisation where concerns have been raised. This also allows the Medical Director's team to assess all potentially avoidable deaths. The themes and learning from this additional review will be co-ordinated and fed back by the Medical Directors team to both the Division and the mortality surveillance group

3. A judgement regarding the avoidability of death will be made following the second review

The final judgement around the avoidability of death will be made following the second review by the Medical Director's team. This will be carried out in a timely way so any issue arising from the avoidability of death result in a duty of candour can be undertaken as soon as possible following the death.

4. Where appropriate, the duty of candour will be carried out by the Medical Director's office, unless it has already been completed. If there is either evidence of poor care or avoidable death and duty of candour has not been undertaken then the Medical Directors office with undertake duty of candour

5. This data is reviewed monthly by the Mortality Survelliance group which is chaired by the Medical Director


Operational Process for Mortality
University Hospitals Bristol NHS Foundation Trust
Exclusions
Out of Hospital Cardiac Arrest
Automatic inclusion for Structured Judgement Review
Elective care
If issues with ward care for ITU/CICU deaths subject to an ICNARC review
Patients with learning difficulties
Patients with DOLs in last episode of care
16-18 year olds
Family concerns
Alerts from risk management group
Patients who are subject of a serious incident investigation in their last episode of care
Screening process
Remainder of notes screened using standardised tool and if any clinical issues identified then proceed to structured judgement review.
Structured judgement review
Including avoidability of death score
If overall care scored at 1 or 2 then second review undertaken by MD office and consideration for clinical incident/ serious incident reporting including Duty of Candour obligation
If death rated greater than 50:50 avoidable
Division
Themes and scores collated at Divisional level
Dashboard populated
Feedback to Divisional Board
Inclusion in specialty M+M
In some cases feedback to family
Mortality Surveillance Group
Additional information from ITU/CICU, Paediatrics/ O+G
Dashboard review
Cross Trust themes identified and fed to QI Academy
Good practice and/or poor care fed back to teams from MD office
Reports
Quality and Outcomes Committee
Coal Face teams – quarterly Mortality bulletin
Patient
Screening
Inclusion
Review
Reporting

BRI Mortality Review Process – current figures up to the end of November 2017

	Quarter 1 (Apr – Jun 17)	Quarter 2 (July – Sept 17)	Quarter 3 (Oct – Dec 17)	Totals
Number of deaths	300	269	211 Incomplete	792
Total SCNR identified	55 (18%)	50 (18%)	42	147 (18.6%)
Medicine	35 (65%)	30 (60%)	26	91
complete	34	23	2	
pending	1	6	24	29
Surgery	6 (9%)	7 (14%)	2	14
complete	6	5	0	
pending	0	2	2	5
Specialised Services	13 (17%)	13 (32%)	6	30
complete	11	6	0	
pending	2	7	6	14
Obstetric	0	0	1	1
Number triggering MDO Review	4	**1**	**0**	**5**
Number of SI's related to patient death	6	**1**	**4**	**11**
Number of avoidable deaths	1	**0**	**0**	**1**
Number of deaths in patients with Learning Difficulty	4	**6**	**3**	**13**

Medicine:

Quarter 1 : one pending review because patient was only identified as an SUI this month (added retrospectively)

Quarter 2 : one inquest, one coroners case, one awaiting second review, three incomplete and reasons unclear

Surgery:

Quarter 1 : all complete

Quarter 2 : two pending reasons unclear

Specialised Services

Quarter 1 : two pending reasons unclear (one LD death)

Quarter 2 : six pending reasons unclear

Total Number of deaths = 792							
Automatic Structured Review = 147 (18%)							
Criteria ***Note more than one category can occur in a single patient**	**Family have raised a concern**	**Learning difficulties/severe mental illness**	**Deaths following an organisational alert** **(via audit etc)**	**Death is Following an elective procedure**	**Age 16-18 year olds**	**Trigger resulting from screening process**	**SUI**
Total	**31**	**13**	**0**	**22**	**0**	**100**	**11**
% of total SCNRs	**21%**	**9%**	**0%**	**15%**	**0%**	**68%**	**7%**

Deaths In patients with Learning Difficulties

All deaths in patients with learning difficulties are reviewed in association with the LEDER process – with involvement from the learning difficulties team. All patients who die with learning difficulties will have a review by this team and a comment made on the care that the patient received, highlighting any issues to the Mortality Surveillance Group. A full mechanism is in place to ensure any patients undergoing a serious incident review following death also have a structured case note review. This methodology has been implemented in retrospect in seven patients with an SI in the first two quarters.

Deaths in Patients with History of Mental Health

The definition of patients with mental health for the purpose of this review, is patients that are known to secondary care with mental health issues. There has been a single death in this group of patients

Deaths within 30 days of discharge

In collaboration with the IT depart a method using Medway to identify patients who have died within 30 days of discharge has been established and since 1st November this cohort of patients has been identified. There is ongoing work to establish the best method of conducting a review for these patients as this work will involve both primary and secondary care.

An analysis of the initial data will be available at the end of quarter 3.

This work is ongoing in combination with the Academic Health Science Network.

The initial pilot work has identified 68 deaths in this group between November 16th and December 31st 2017

Learning from Deaths

Overall, the care received and reviewed is good with only one avoidable death identified.

Two major themes have emerged from the review of the first and second quarter deaths using the structured case note review. These are the instigation of end of life care and the need for appropriate senior decision making to instigate an end of life pathway.

I have corresponded with the Chair of the end of life steering group, Prof Karen Forbes and the end of life pathway. How to improve the instigation of this pathway using a cross divisional approach is now forming the basis of a major piece of work being undertaken by the Quality Improvement Academy for the forthcoming year.

Appointments have been made with each of the Divisional Boards to begin to feedback from the learning form deaths from the first 2 quarters and to develop the appropriate mechanisms by which this information can be fully integrated into the Divisional mortality and morbidity meetings.

Appendix 1

Structured Case Note Review Assessment

This appendix demonstrates the breakdown of the assessment of care in patients undergoing a Structured Judgement Case Note review for the first and second quarter.

The Scoring system for the assessment of care is 1-5 with 5 representing the top level of care. An overall assessment of care is also undertaken by the reviewer.

The scores are also broken down into the 3 divisions.

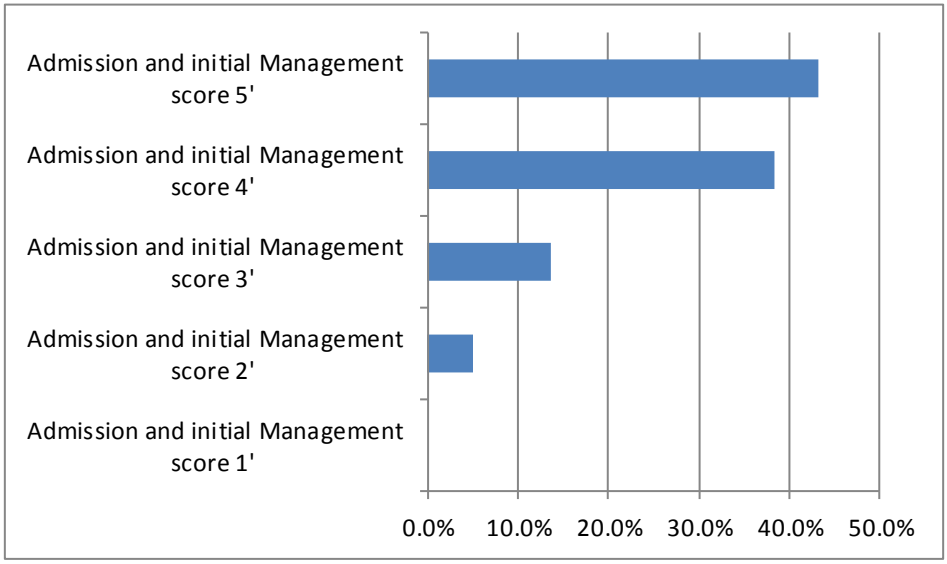
- Medicine
- Specialised Services
- Surgery/ITU

The scoring system for avoidability of death is 1 - 6:

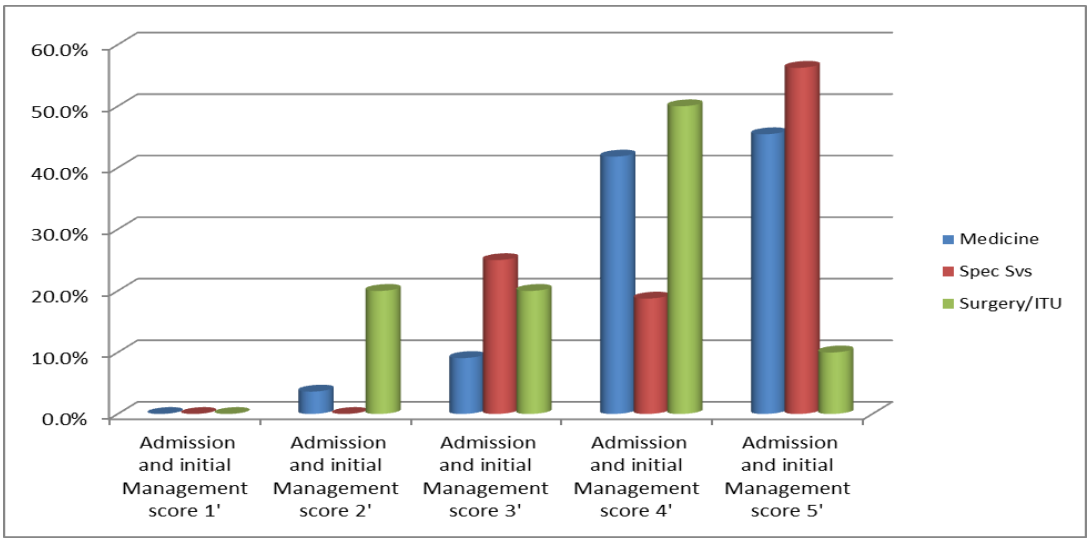
- A score of 3 is the level where avoidability is deemed to be 50:50,
- A score of 6 represents an unavoidable death.

Scores according to phase of care - Admission and initial management

	Admission and initial Management **score 1'**	Admission and initial Management **score 2'**	Admission and initial Management **score 3'**	Admission and initial Management **score 4'**	Admission and initial Management **score 5'**
TOTALS	0.0%	4.9%	13.6%	38.3%	43.2%

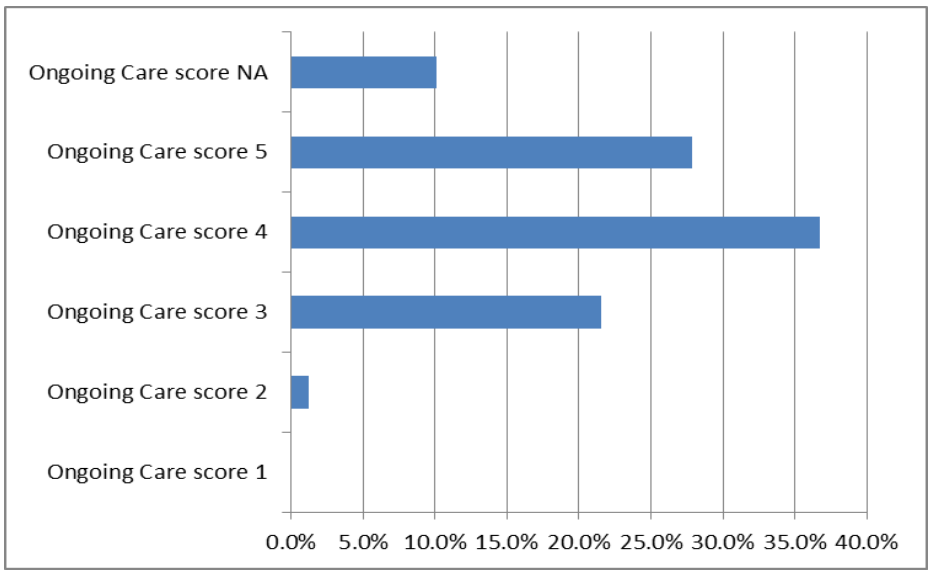


BY DIVISION	Admission and initial Management **score 1'**	Admission and initial Management **score 2'**	Admission and initial Management **score 3'**	Admission and initial Management **score 4'**	Admission and initial Management **score 5'**
Medicine	0.0%	3.6%	9.1%	41.8%	45.5%
Spec Svs	0.0%	0.0%	25.0%	18.8%	56.3%
Surgery/ITU	0.0%	20.0%	20.0%	50.0%	10.0%

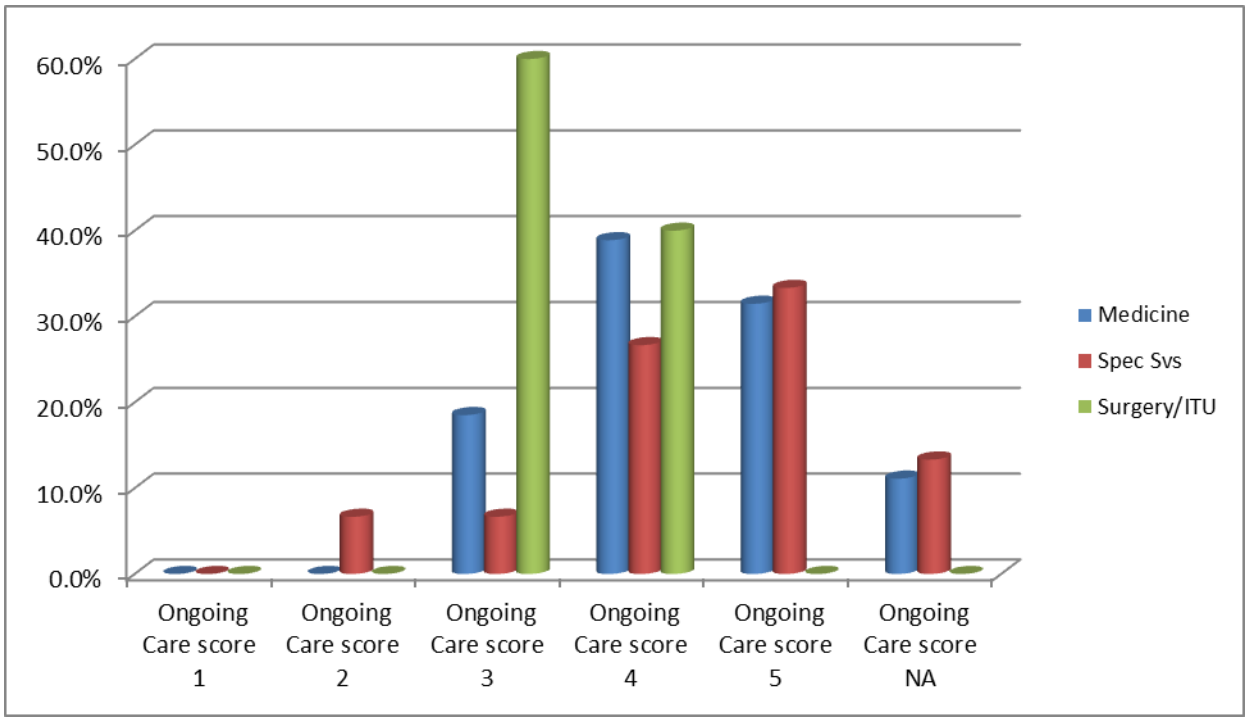


Scores according to phase of care – Ongoing Care

	Ongoing Care score 1	Ongoing Care score 2	Ongoing Care score 3	Ongoing Care score 4	Ongoing Care score 5	Ongoing Care score NA
TOTALS	0.0%	1.3%	21.5%	36.7%	27.8%	10.1%

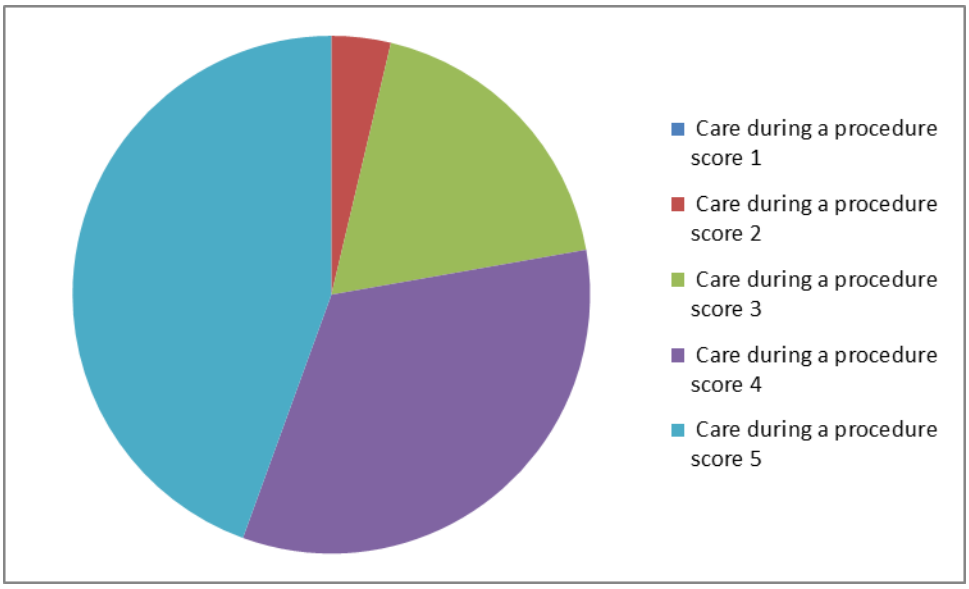


BY DIVISION	Ongoing Care score 1	Ongoing Care score 2	Ongoing Care score 3	Ongoing Care score 4	Ongoing Care score 5	Ongoing Care score NA
Medicine	0.0%	0.0%	18.5%	38.9%	31.5%	11.1%
Spec Svs	0.0%	6.7%	6.7%	26.7%	33.3%	13.3%
Surgery/ITU	0.0%	0.0%	60.0%	40.0%	0.0%	0.0%

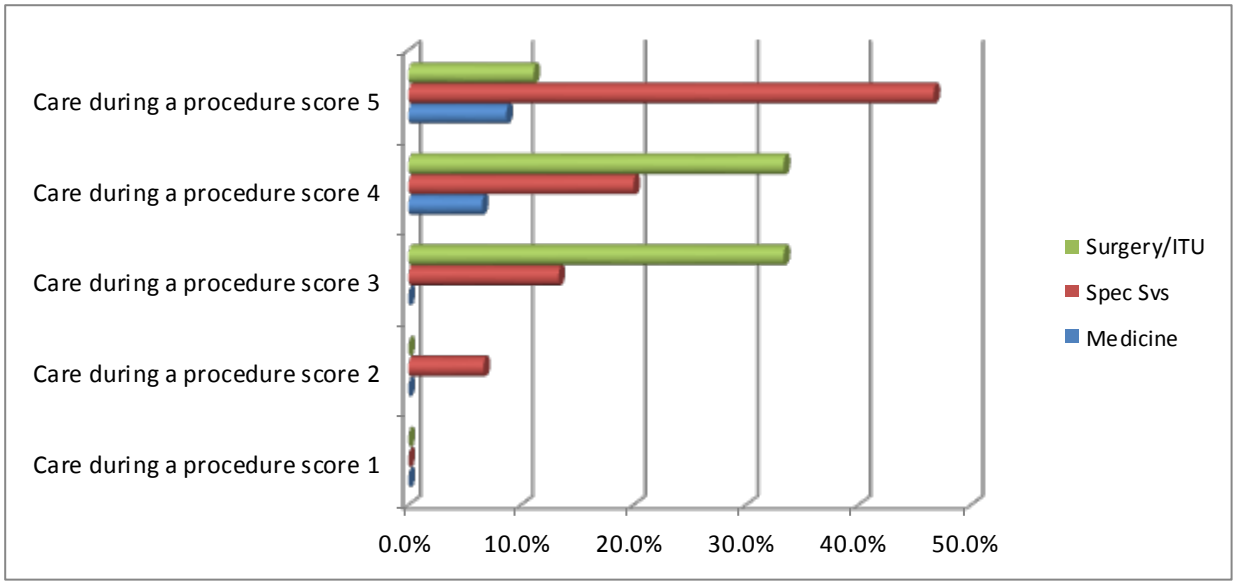


Scores according to phase of care – Care During a Procedure

	Care during a procedure score 1	Care during a procedure score 2	Care during a procedure score 3	Care during a procedure score 4	Care during a procedure score 5	Care during a procedure score NA
TOTALS	0.0%	1.4%	7.1%	12.9%	17.1%	61.4%

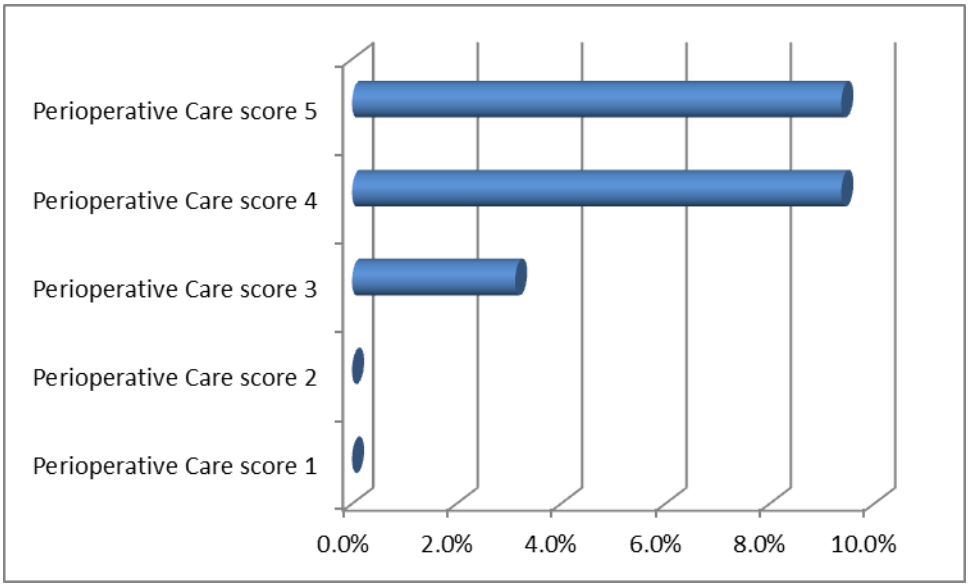


BY DIVISION	Care during a procedure score 1	Care during a procedure score 2	Care during a procedure score 3	Care during a procedure score 4	Care during a procedure score 5	Care during a procedure score NA
Medicine	0.0%	0.0%	0.0%	6.5%	8.7%	84.8%
Spec Svs	0.0%	6.7%	13.3%	20.0%	46.7%	13.3%
Surgery/ITU	0.0%	0.0%	33.3%	33.3%	11.1%	22.2%

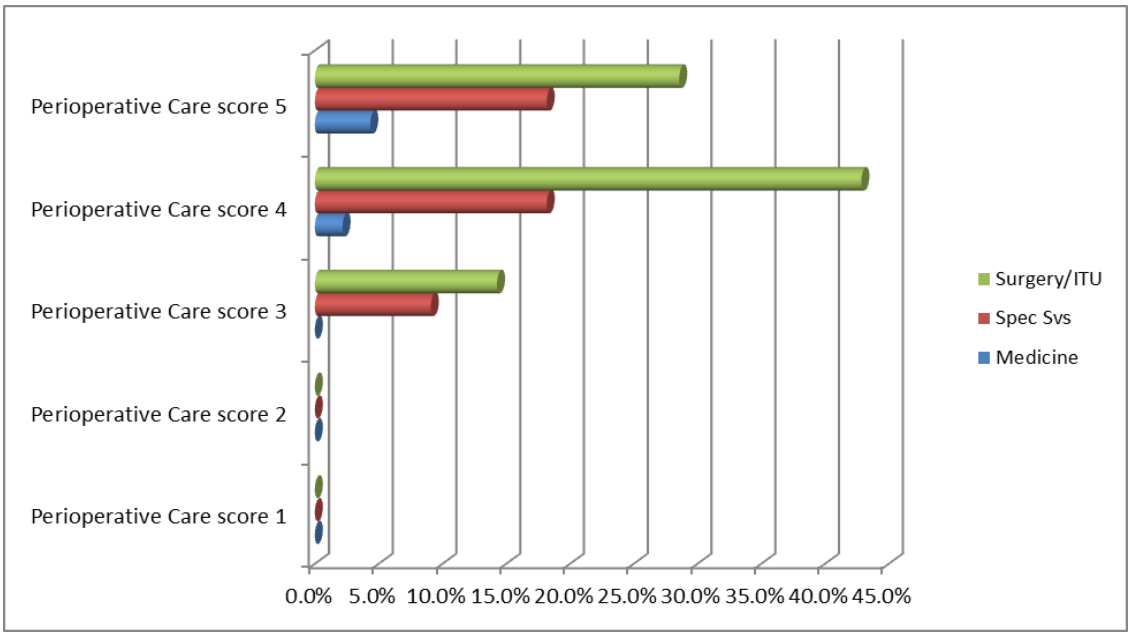


Scores according to phase of care – Perioperative care score

	Perioperative Care score 1	Perioperative Care score 2	Perioperative Care score 3	Perioperative Care score 4	Perioperative Care score 5	Perioperative Care score NA
TOTALS	0.0%	0.0%	3.1%	9.4%	9.4%	78.1%

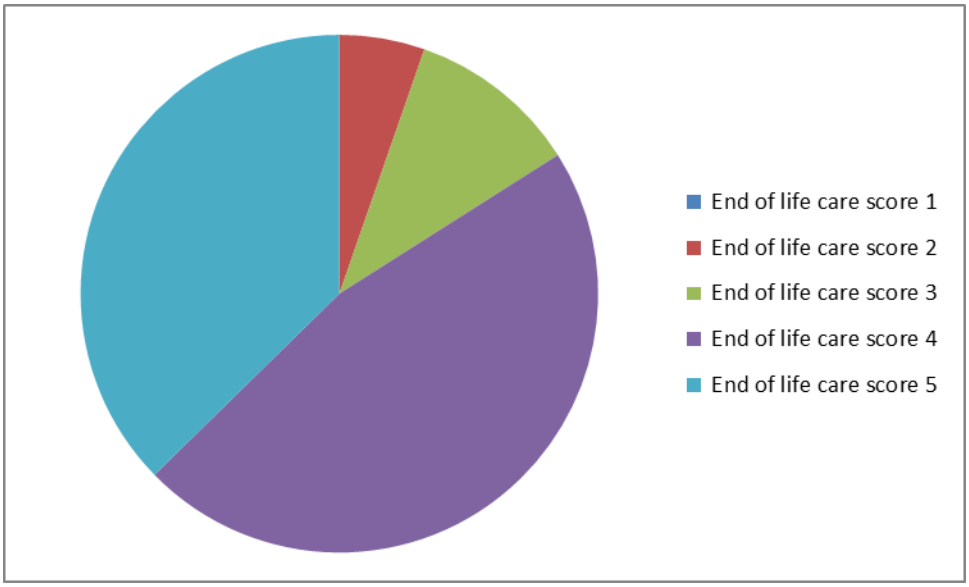


BY DIVISION	Perioperative Care score 1	Perioperative Care score 2	Perioperative Care score 3	Perioperative Care score 4	Perioperative Care score 5	Perioperative Care score NA
Medicine	0.0%	0.0%	0.0%	2.2%	4.3%	93.5%
Spec Svs	0.0%	0.0%	9.1%	18.2%	18.2%	54.5%
Surgery/ITU	0.0%	0.0%	14.3%	42.9%	28.6%	14.3%

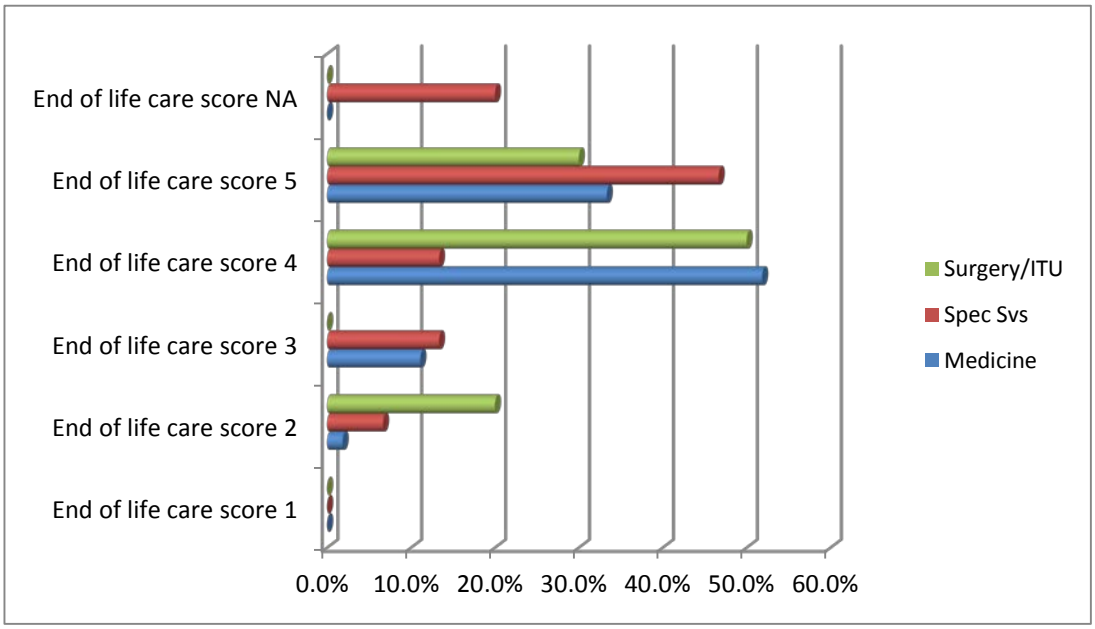


Scores according to phase of care – End of Life Score

	End of life care score 1	End of life care score 2	End of life care score 3	End of life care score 4	End of life care score 5	End of life care score NA
TOTALS	0.0%	5.1%	10.1%	44.3%	35.4%	3.8%

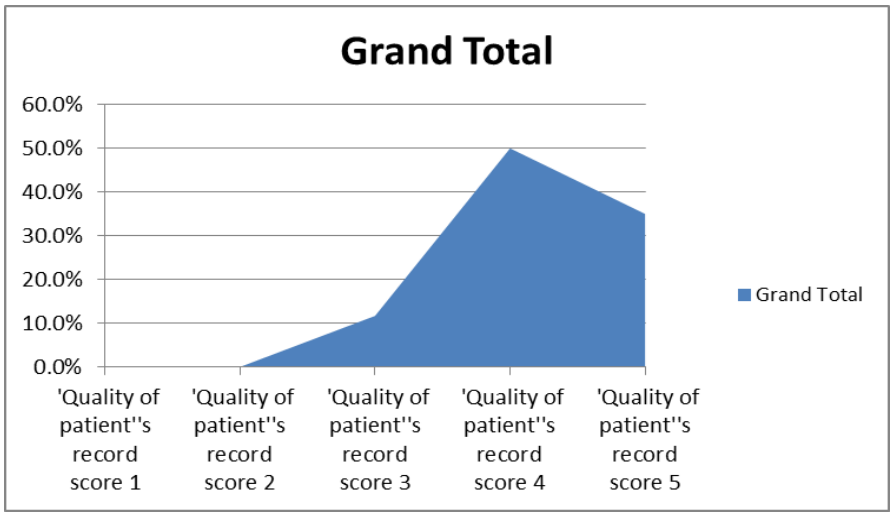


BY DIVISION	End of life care score 1	End of life care score 2	End of life care score 3	End of life care score 4	End of life care score 5	End of life care score NA
Medicine	0.0%	1.9%	11.1%	51.9%	33.3%	0.0%
Spec Svs	0.0%	6.7%	13.3%	13.3%	46.7%	20.0%
Surgery/ITU	0.0%	20.0%	0.0%	50.0%	30.0%	0.0%

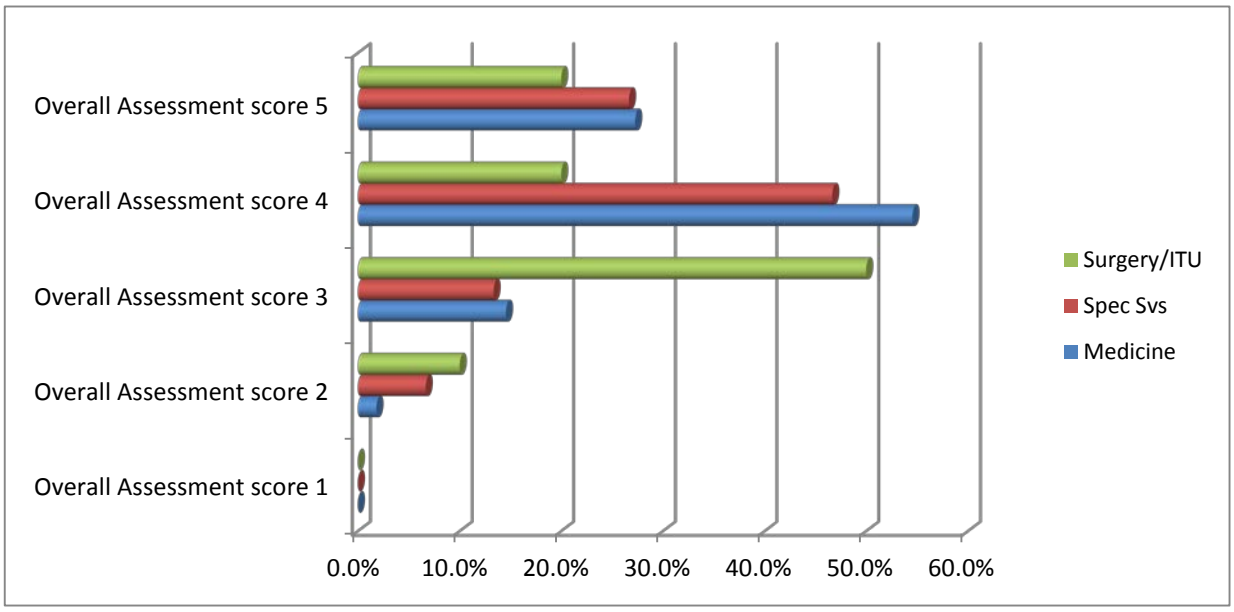


Scores according to phase of care – Overall Assessment Score

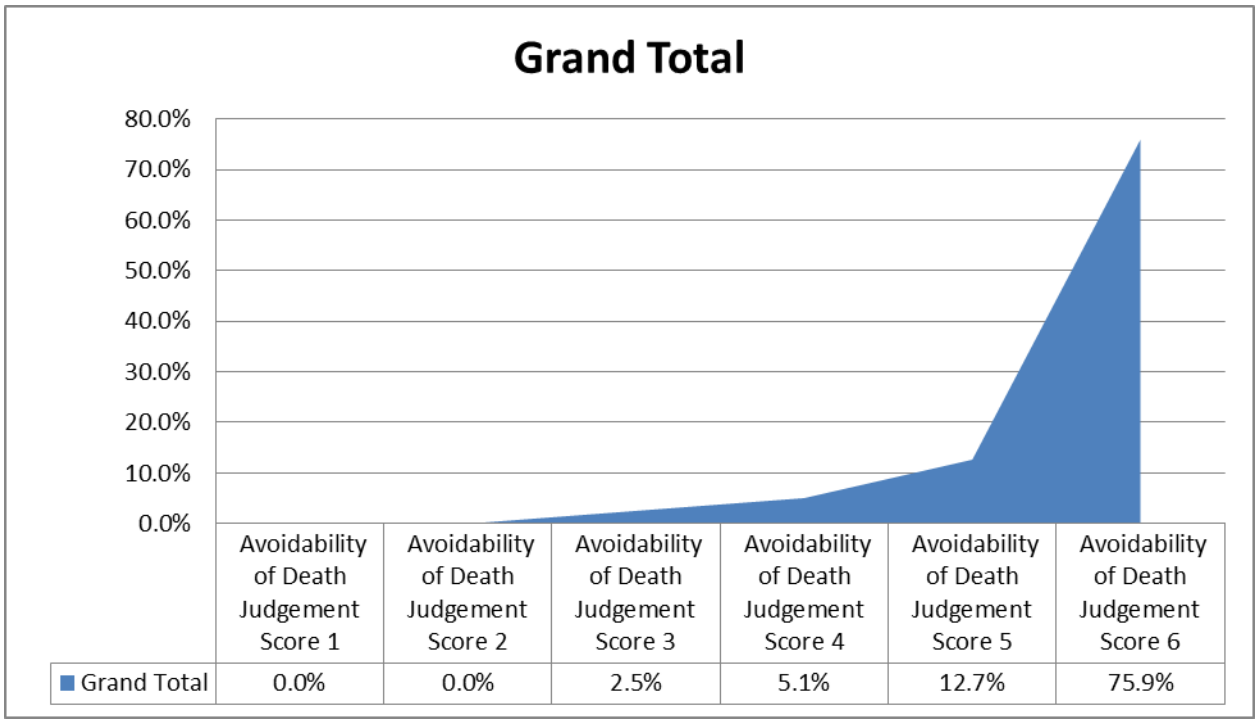
	Overall Assessment score 1	Overall Assessment score 2	Overall Assessment score 3	Overall Assessment score 4	Overall Assessment score 5
Grand Totals	0.0%	3.8%	18.8%	48.8%	26.3%



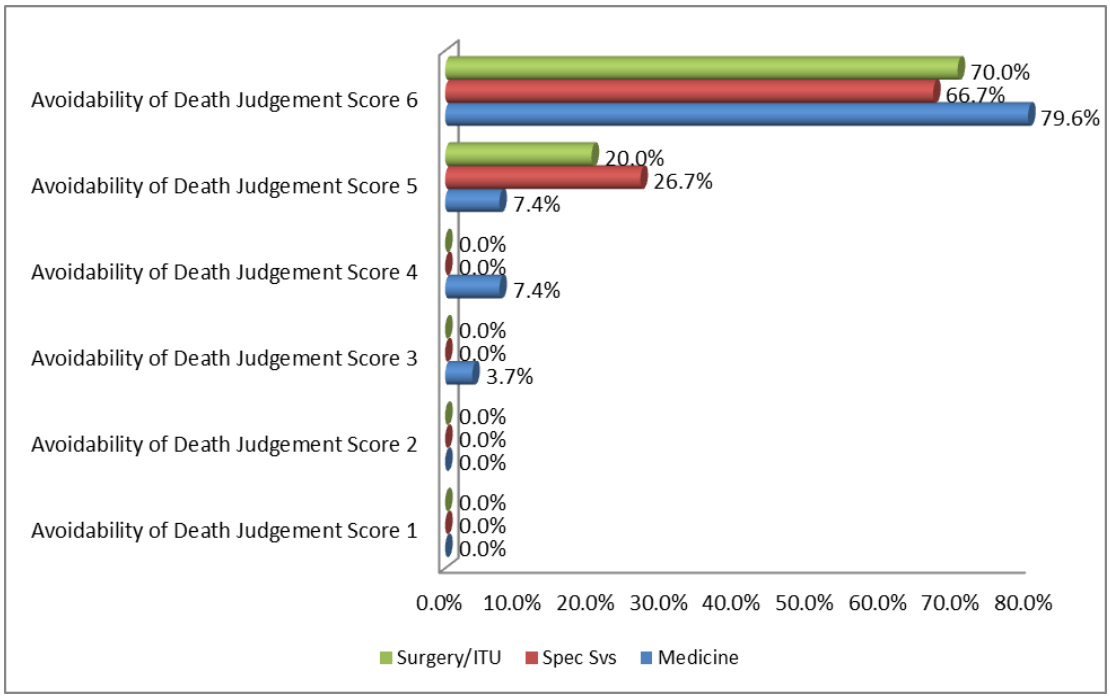
BY DIVISION	Overall Assessment score 1	Overall Assessment score 2	Overall Assessment score 3	Overall Assessment score 4	Overall Assessment score 5
Medicine	0.0%	1.8%	14.5%	54.5%	27.3%
Spec Svs	0.0%	6.7%	13.3%	46.7%	26.7%
Surgery/ITU	0.0%	10.0%	50.0%	20.0%	20.0%



Scores according to phase of care – Avoidability of Death Judgement Score



BY DIVISION	Avoidability of Death Judgement Score 1	Avoidability of Death Judgement Score 2	Avoidability of Death Judgement Score 3	Avoidability of Death Judgement Score 4	Avoidability of Death Judgement Score 5	Avoidability of Death Judgement Score 6
Medicine	0.0%	0.0%	3.7%	7.4%	7.4%	79.6%
Spec Svs	0.0%	0.0%	0.0%	0.0%	26.7%	66.7%
Surgery/ITU	0.0%	0.0%	0.0%	0.0%	20.0%	70.0%



University Hospitals Bristol
NHS Foundation Trust

Cover report to the Public Trust Board meeting to be held on Wednesday 31 January 2018 at 11:00 – 13:00 in the Conference Room, Trust HQ, Marlborough St, Bristol, BS1 3NU

		Agenda Item	11
Report Title	**Chair's Report Quality and Outcomes Committee**		
Author	**Julian Dennis, Non- Executive Director**		
Executive Lead(s)	Carolyn Mills, Chief Nurse	Robert Woolley, Chief Executive	
Freedom of Information Status	Open		

Reporting Committee	Quality and Outcomes Committee
Chaired by	Julian Dennis, Non-Executive Director
Date of last meeting	22 December 2017

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

Serious Incident Report

Four serious incidents were reported in November 2017. All four incidents were reported within the 48 hour timescale and two of the four 72 hour reports were completed within the 72 hour timeframe. The two breaching was caused by the failure to submit completed reports to the CCG within timescale due to a divisional administrative vacancy.

At the end of November 2017 there were 13 serious incident investigations open, 12 within the 60 day timescale and one within the extended timescale agreed with commissioners.

Monthly Nurse Safe Staffing Levels

Key points included:

- Planned versus actual nursing hours within the inpatient areas showed Registered Nurse (RN) staffing was below the planned levels for the month. NA hours were above planned levels.
- The Trust Level Quality Performance dashboard indicated that the standard of patient care provided in November 2017 was safe.
- UH Bristol Governors had feedback regarding poor morale within the Eye Hospital A&E department. Julian Dennis noted that he had also been approached by a former member of Eye Hospital staff concerning poor morale. The Chief Nurse undertook to investigate these concerns and update members at the next Committee meeting.

Patient Safety Improvement Programme (2015-18)– Q2

- The Committee was noted that there was evidence of steady progress despite some the slippage in some work streams
- The Committee discussed how IT can support this agenda. The Committee suggested that members consider the issue of digitisation at a future meeting. It was agreed that this would be best discussed at a future Board Seminar.

Patient Complaints and Experience Reports – Q2

Key points included:

- The Committee considered ways in which learning from the reports could be addressed. Members agreed that looking at patient expectations and the management of expectations was a good idea. It was noted that The Admin Transformation Programme would look at morale, administration errors, system process and the training provided
- The inpatient postal survey scores had improved for South Bristol Community Hospital during Quarter 2, but were still below the Trust average. This did not correlate with a range of other quality monitoring data being reviewed by the Division of Medicine for this hospital. Improvement work continued to be carried out at the hospital, including a planned programme of Trust Values training for all staff in Quarter 4 2017/18.

Quality and Performance Report

Key points included:

- None of the four national standards were met for the last month. However, recovery trajectories were achieved in three of the four standards (62 Day Cancer standard; A&E 4 hour target; RTT).
- The Committee noted the early closure of Weston ED over the Christmas break is likely to impact on the Trust's performance (January report)
- Meetings to discuss RTT within each division had been set up were now being embedded. The opportunity to attend these meetings was being given to the Non-Executive Directors.
- A detailed update on the actions being taken to address fractured neck of femur was presented.
- The Committee discussed the impact on staff of system pressures in terms of stress and queried the engagement with Commissioners. There was no mechanism to re-allocate funding based on diverts. Reassurance was given adequate notice for closures was received enabling the Trust to plan accordingly.
- Safety and staffing triggers were being put in place to ensure that departments ran safely.
- It was noted that there was an ongoing review to identify what exactly constituted 'essential' training. It was also noted that sanctions in terms of failure to complete training were now in place.

Referral to Treat Business Rules and Overview

Mark Smith provided the Committee with an update on RTT a large number of patients "on hold" have recently been identified. He outlined the challenges, especially the number of patients involved. Mark outlined the actions required to deal with the problem

Key points included:

- The Committee noted that there was a clear understanding of the scale of the issue. Whilst the current position is not good, plans are in place to resolve the "on hold" problem.

• The Committee noted that the main issues related to administrative processes. • Members emphasised the importance of understanding the governance of the RTT processes, as reports to the Board were limited and did not currently include detailed action plans. The Committee also felt that RTT issues should be reflected on the Trust's Corporate Risk Register. **Reports received for assurance included:** • Clinical Quality Group Meeting Report • Quarterly Never Events National Report – Q3 • Single Oversight Framework • Quarterly Inquest Report – Q3
Matters requiring Committee level consideration and/or approval
None.
Matters referred to other Committees
None.

Date of next meeting	29 January 2018

University Hospitals Bristol
NHS Foundation Trust

Cover report to the Trust Board meeting to be held on Wednesday 31 January 2018 at 11:00 – 13:00 in the Conference Room, Trust HQ, Marlborough St, Bristol, BS1 3NU

		Agenda Item	**11**
Report Title	Chair's Report Quality and Outcomes Committee		
Author	Julian Dennis, Non- Executive Director		
Executive Lead(s)	Carolyn Mills, Chief Nurse	Robert Woolley, Chief Executive	
Freedom of Information Status	Open		

Reporting Committee	Quality and Outcomes Committee
Chaired by	Julian Dennis, Non-Executive Director
Date of last meeting	29 January 2018

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

Quality and Performance Report

- The report is reviewed annually to ensure content is appropriate and relevant The current review is proposing to use more sophisticated analysis (such as SPC charts) to ensure trend analysis is reported. The Committee will receive an example of the proposed changed version in due course.
- The Trust is currently working to rebook elective operations cancelled in December: prioritising re-bookings with a focus on acuity. 20% of cancellations were due to the non-availability of staff, which is within the Trust's control to resolve.
- Fractured neck of femur shows a continuing deterioration, which is disappointing. Mark Callaway noted that a key issue was recruitment. There is a national shortage of orthogeriatricians, which makes recruitment particularly difficult.
- Matt Joint noted that there was work ongoing to address the Trust's sickness/absence rates (UH Bristol performed comparatively well against peers). Vacancy rates continued to be one of the biggest issues impacting the Trust and the sector.
- Work is underway to develop 'first line' leaders to ensure they have the right leadership skills, including coaching.

Remedial Action for the 62 day GP Cancer Standard

- The 62-day GP Cancer Standard of 85% had not been achieved at UH Bristol since 2013. Reasons for breaches include late referrals, patient choice and delayed outpatients appointments. The Trust has been working on an improvement trajectory and has implemented actions, such as ensuring adequate elective bed capacity and improving operating capacity.

Learning from Deaths

- Serious Incident Reports and structured notes reviews are part of an integrated process, but are not always linked in practice. It was agreed that they should both be done, when required as part of an integrated processs.
- The report is helpful and contained the right information to provide assurance on the Trust's learning from deaths reviews and the outcomes/actions identified.

'On-hold' patients

- There is concern that the Trust had a significant volume of patients with an inappropriate transaction listed on Medway. This has left them with an inappropriate 'on-hold' status. As this is a significant issue the Committee has asked to receive regular updates on appropriate actions and progress in resolving this issue.
- Mark Smith said that the Trust was focusing on 'at-risk' patients, had identified the priority cohorts to be addressed (those for adding to waiting lists, awaiting clinical review/test results and awaiting consultant review. He was confident no patients had come to harm due to this issue.
- It was recognised that addressing this issue appropriately using the national methodology would take time and UH Bristol was also working on a communications strategy. Executives would also shortly be meeting with CQC to discuss this issue.

Serious Incident Report

Four serious incidents were reported in December 2017. All four incidents were reported within the 48 hour timescale. All 72 hour reports for these four serious incidents were completed on time. Four serious incident investigations were due for completion in December 2017, all four were completed within the 60 day limit.

- NHS Improvement has published a new 'never' events framework, effective 1 February 2018.
- A potential 'never' event, a wrong tooth extraction at the Dental Hospital was reported. This incident has been referred to the CCG and the Trust was awaiting confirmation of it as a 'never' event'. Following this incident, NHS Improvement has been in touch with further details of the review of the Dental Hospital, which the Trust has requested. An external expert has now been identified to undertake the review.

National A&E Survey Results

- The national survey results (2016) were only one of a number of patient surveys the Trust has undertaken, although not recent , the results were positive and UH Bristol.
- The Committee agreed that the results were very positive, and should be highlighted both to staff and externally.

Board Assurance Framework/Corporate Risk Register – Q3

- Clarity on ownership of risks presented in the Board Assurance Framework was sought. It was noted that as these were strategic risks, ownership sat with a number of Executives, although the Chief Executive had overall responsibility. Operational risks, under the Corporate Risk Register, did have individual executive owners.
- The Committee questioned whether the issue of 'on-hold' patients discussed at the meeting should be reflected in the Board Assurance Framework (it was reflected in the Corporate Risk Register). It was noted that this was being addressed.

Reports received for assurance included:

- **Monthly Nurse Safe Staffing Levels**
- **Quarterly Impact Assessment Report – Q3**
- **Progress Report against quality objectives – Q3**

Matters requiring Committee level consideration and/or approval	
None.	
Matters referred to other Committees	
None.	
Date of next meeting	29 January 2018

University Hospitals Bristol
NHS Foundation Trust

Cover report to the Public Trust Board. Meeting to be held on 31 January 2018 at 11.00 – 13.00, Conference Room, Trust HQ, Marlborough St, Bristol, BS1 3NU

		Agenda Item	12
Meeting Title	Public Trust Board	**Meeting Date**	Wednesday, 31 January 2018
Report Title	**Weston Partnership – Strategic Outline Case**		
Author	Paula Clarke, Director of Strategy and Transformation		
Executive Lead	Paula Clarke, Director of Strategy and Transformation		
Freedom of Information Status		Open	

Strategic Priorities (please choose any which are impacted on / relevant to this paper)			
Strategic Priority 1: We will consistently deliver high quality individual care, delivered with compassion.	☒	Strategic Priority 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 paper is to provide evidence that a sufficiently compelling case exists for University Hospitals Bristol NHS Foundation Trust (UH Bristol) and Weston Area Health Trust (WAHT), to develop our partnership working further and pursue an organisational merger, through acquisition.

Key issues to note

1. **The case for organisational merger**

The recommendation to pursue an organisational merger builds on the formal partnership between the two trusts that has been in place since May 2017, enabling greater joint working between the organisations and more seamless care to patients. It also builds on the long history of joint working at clinical service level where the trusts share some joint staff in a number of services, including oncology, cardiology, general surgery and maternity services.

It also supports the work of *'Healthy Weston: joining up services for better care in the Weston area'* led by North Somerset Clinical Commissioning Group. A key aim of *Healthy Weston* is to create a sustainable hospital at Weston General Hospital that remains at the heart of the community and provides the services it is best placed to do in order to meet the needs of local people. Pursuing an organisational merger will enable the development of a solid platform across both organisations, upon which the stabilisation and improvement of clinical services can be progressed at pace.

The key drivers for both organisations to consider merging are summarised as follows;

- Securing the clinical sustainability of appropriate services at WAHT.
- Growing demand and population growth, particularly within North Somerset.
- The need to optimise use of all available NHS capacity to meet growing demand.
- Strategic and operational risks to UH Bristol and to the quality of care for Bristol and North Somerset patients, of failure to support the resilience of services at Weston General Hospital
- The need for financial sustainability, through the delivery of productivity, efficiency and affordable service quality.
- Supporting the strategic vision of Bristol, North Somerset and South Gloucestershire (BNSSG) Sustainability and Transformation Programme (STP) and delivering the Healthy Weston vision.

The shared goal of both trusts is to ensure hospital-based services in Bristol and North Somerset provide high quality care to patients and families which are clinically and financially sustainable. Progressing towards a merger offers the opportunity to achieve this goal.

2. **Benefits to patients, staff and the organisations**

The SOC identifies and evaluates the risks and the benefits of proceeding with an organisational merger and concludes that there is significant potential for the delivery of benefits to staff and patients and securing service sustainability, from proceeding with the merger. These expected benefits are summarised as;

- **Sharing learning and best practice** across both organisations to give **patients**

better access to services and improve the quality of those services

- Meeting the challenges, including the **recruitment of staff**, **timely access to services** and increasing demand for hospital services, that are compromising the delivery of hospital services for patients in North Somerset
- Giving staff in both trusts **access to a greater range of training and development**, **education and research opportunities** across a wider organisation
- More opportunities to make **better use of facilities and buildings** by working across a larger campus.
- **Improving the financial stability** of hospital services in North Somerset through efficiency gains across a larger organisation, in order to **protect services for patients in the future**.

3. Technical Requirement for a Strategic Outline Case (SOC)

The SOC must satisfy the technical requirements of the NHS Improvement *Transactions Guidance for Trusts undertaking transactions, including mergers and acquisitions*, published in November 2017. This technical process requires that, *'at the strategic case stage, both trusts and NHS Improvement have the opportunity to determine whether the case for a proposed transaction is robust and workable enough for it to proceed to the business case stage'* (p25 of the aforementioned guidance). It is for this purpose that specific technical elements and financial appraisal, as well as the evidence to demonstrate the case for change and the preferred option, are included.

It is important to note that should the recommendation be approved, there a number of further requirements to be met before a merger would go ahead, including the development of a substantial Full Business Case.

4. Communication and Engagement

It is important that staff, patients and wider stakeholders understand what this proposal to become a combined organisation means for them and that the benefits as well as the risks are clear. A communication and engagement plan is in place and will continue to be developed to support this goal.

Recommendations

Members are asked to:

- **Approve** the Strategic Outline Case for organisational merger, through acquisition of WAHT by UH Bristol.
- **Note** that the next stage in the process will be to complete a comprehensive appraisal of the future model of acute care within the context of the 'Healthy Weston' programme and vision. Depending on the outcome of this appraisal process, a Full Business Case (FBC) will be developed. The FBC will be the document upon which the final decision by the UH Bristol Trust Board and Council of Governors to proceed with any future transaction will be made. Any final decision would also require the approval and support of NHS regulators and the Competition and Markets Authority.
- **Note** that identification of sufficient resources to support the development of a Full

Business Case and, subsequently, to make the transition to a merged organisation effective, will remain under discussion with Regulators.

Intended Audience									
Board/Committee Members	☒	Regulators	☒	Governors	☒	Staff	☒	Public	☒

Board Assurance Framework Risk			
Failure to maintain the quality of patient services.	☒	Failure to develop and maintain the Trust estate.	☒
Failure to recruit, train and sustain an engaged and effective workforce.	☒	Failure to comply with targets, statutory duties and functions.	☒
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.	☒		

Corporate Impact Assessment							
Quality	☒	Equality	☐	Legal	☒	Workforce	☒

Impact Upon Corporate Risk
Risks are detailed in the document

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)**

Weston Partnership

Strategic Outline Case (SOC)

31 January 2018
Version 2.2

CONTENTS

1. Executive Summary

The aim of this Strategic Outline Case (SOC) is to establish to what extent there is a sufficiently compelling case demonstrating that the long-standing issues of clinical and financial sustainability of services at Weston Area Health NHS Trust (WAHT)may be addressed through further development of the partnership with University Hospitals Bristol NHS Foundation Trust (UH Bristol).

The SOC describes the drivers and potential benefits for patients, staff and the wider stakeholders of both organisations of greater collaboration between UH Bristol and WAHT, considers the fit with UH Bristol's clinical strategy and the potential clinical and non-clinical benefits and risks of partnership options, and recommends the preferred option of organisational merger by acquisition.

1.1 Sustainability challenge for WAHT

Over a number of years it has been increasingly clear that WAHT, as one of the smallest NHS Trusts in England, would not achieve stand-alone Foundation Trust status. In addition, it has continued to experience challenges in maintaining the financial and clinical sustainability of its services. A number of attempts to develop a viable long term plan have failed, most recently in 2014 when an attempt to tender WAHT for acquisition did not complete.

Despite the commitment and hard work of staff, the prolonged periods of uncertainty created by these processes and the continuing deterioration in WAHT's ability to recruit to clinical posts in key service areas with a context of national workforce shortages, have already resulted in temporary service changes. Furthermore, WAHT have identified a number of other services which may present sustainability risks in the short to medium term, which themselves reinforce the recruitment and retention challenge, creating a potential overreliance on temporary staff, substantial costs and care continuity implications.

The WAHT Care Quality Commission (CQC) report published in June 2017 provides a clear rationale for the need for significant pace behind actions to improve service resilience and quality. Weston General Hospital received an overall rating of 'requires improvement' with its urgent and emergency care services rated as 'inadequate', medicine and older people rated as 'requires improvement' and surgery and critical care rated as 'good'.

The report demonstrates that the continued sustainability risk in key clinical services is adversely affecting the quality of care it is possible for staff to provide for patients. The deterioration from the previous inspection, particularly in the areas of emergency care and patient flow, demonstrates that previous attempts to address difficulties, primarily through the recruitment and retention of substantive staff, have been of limited success.

1.2 Partnership Working

There are currently well established and strong links between services at WAHT and UH Bristol, with a number of joint service models already in place providing evidence that working collaboratively provides the opportunity to secure local access to quality care for appropriate District General Hospital (DGH) services.

UH Bristol has formal and informal links to WAHT at a number of levels. Service Level Agreements for services provided to WAHT by UH Bristol are in place for consultant medical staff across a number of specialities including laboratory medicine, surgery, cardiology, oncology, paediatrics and dermatology. The most significant are haematology and ophthalmology. There are also established joint clinical leadership models in place, including the UH Bristol Head of Midwifery providing leadership for maternity staff in UH Bristol and in Weston.

UH Bristol has also provided increased support in a number of clinical areas over the past twelve months, notably in paediatrics and oncology. This support ranges from giving clinical advice, to providing medical cover at times of planned or unplanned leave of WAHT Consultants. More recently, gynaecology services are being delivered via a joint model with inpatient gynaecology treatment and care being provided at UH Bristol, and daycase work planned to transfer to Weston, so North Somerset patients currently travelling to Bristol for this service can access it locally in Weston.

Building on the long-standing, positive working relationships which give local people access to a range of services delivered or supported by Bristol and Weston clinicians, both Trust Boards approved a formal interim partnership agreement in May 2017.

This Strategic Outline Case is the culmination of the work developed through this partnership arrangement to outline and evaluate the options to achieve financial and clinical sustainability for services at Weston General Hospital.

1.3 The Healthy Weston Programme and the Local Commissioning Context

In autumn 2017, Bristol, North Somerset and South Gloucester (BNSSG) Clinical Commissioning Groups (CCGs) published '*Healthy Weston; Joining up services for better care in the Weston area'*(Ref 1) which provides an outline of the intended commissioning context for the population of North Somerset for the period 2017/18 to 2020/21. This document focusses on the needs of the North Somerset population and sets out the challenge of addressing the issues of financial and clinical sustainability for the region.

It describes an intention to work together in more effective ways and to integrate local services and pathways to tackle the identified health inequalities and better meet the needs of the local population. The three key strands within the vision are:

1. Primary Care (General Practice) working at scale and providing strong system leadership.
2. Stronger, more integrated community services supported by a 'Care Campus' model at the Weston General Hospital (WGH) site.
3. A stronger, more focussed Acute Trust and acute care model at WGH.

The programme is structured around these three key workstreams and WAHT and UH Bristol clinical and non-clinical teams are involved in the joint planning and redesign of the acute care model for WGH.

This SOC is being developed within the context of the Healthy Weston programme and it is the intention that the output of the acute workstream and wider Healthy Weston service

model, will inform the basis upon which any final recommendation, through a Full Business Case (FBC), to move to acquisition would be made.

1.4 Case for Change and Benefits

The key drivers for both organisations to consider merging are as follows (detail in section 4 of SOC):

- Securing the clinical sustainability of appropriate services at WAHT
- Growing demand and population growth, particularly within North Somerset
- The need to optimise use of all available NHS capacity to meet growing demand
- Strategic and operational risks to UH Bristol and to the quality of care for Bristol and North Somerset patients, of failure to support the resilience of services at Weston General Hospital
- The need for financial sustainability through the delivery of productivity, efficiency and affordable service quality
- Supporting the strategic vision of Bristol, North Somerset and South Gloucestershire (BNSSG) Sustainability and Transformation Programme (STP) and delivering the Healthy Weston vision

There is clear strategic alignment between the UH Bristol and WAHT strategies. UH Bristol currently has significant capacity limitations, particularly in the delivery of general and emergency services to the local population, which are placing constraints both on access to general services and UH Bristol's ability to continue to develop its specialist and tertiary portfolio as planned within our strategic intent. Further alignment of Weston and UH Bristol could provide an opportunity to strengthen a joint DGH offer by increasing the critical mass of these services and also by using estate flexibly across the two sites to maximise benefit.

Strategically, the proposal to become a single organisation also provides an opportunity to demonstrate progress towards the stated strategic vision for the STP to move towards a much more integrated health and care system. An organisational merger would specifically progress the key principles agreed by the two Trusts and North Bristol NHS Trust within the Acute Care Collaboration workstream to deliver:

- A collaborative provider model, supported by a single commissioning approach
- Reducing use of the acute hospital bed base
- Using our acute hospital resources to support the wider health and care system

The key strategic benefits expected from the single organisation option are assessed as follows (detail in Section 6):

Domain	Strategic benefits
Operational	Providing a clinically and financially sustainable and viable platform for future services
Clinical	Providing a strengthened workforce with improved flexibility, recruitment and retention
Financial	Achieve economies of scale in corporate services, facilities, functional and clinical areas

The primary benefit to patients and staff will be addressing the operational, safety, quality and access issues highlighted in the recent CQC report and delivering the following:

Key Patient Benefits
Access to a range of local DGH services is retained, for the current and future population of North Somerset
Weston General Hospital has a sustainable future with the scope and opportunity for development
The quality and safety of services will improve through partnering with an outstanding teaching and Foundation Trust
Variation in clinical care and outcomes for patients will be reduced through shared learning and application of best practice models

1.5 Key Findings of the Strategic Outline Case (SOC)

The SOC demonstrates that scope exists to deliver a range of benefits to patients and staff and ensure that hospital-based services in Bristol and North Somerset provide high quality care to patients and families which are clinically and financially sustainable.

The SOC also presents an initial financial case, reflecting current and historic financial performance of WAHT, its potential future financial prospects going forward five years as a standalone entity, and the key drivers behind the track record of financial deficits at WAHT and provides an early assessment of the extent to which these can be mitigated under the preferred option, assessing a number of scenarios. These include an assessment of UH Bristol's financial position going forward, taking into consideration the potential net financial benefits of organisational merger.

This initial financial assessment indicates that whilst integration will support mitigation of the WAHT deficit, primarily through workforce and structural changes, the full deficit cannot be resolved within the current service model.

This is due to the infrastructure costs associated with the provision of a full DGH suite of services (including a Type 1 ED service), with a relatively small scale of activity which cannot be provided within funding tariffs on an ongoing basis. This assessment is further supported by evidence from a number of similar sites to Weston across the country.

The assessment of whether this situation can be further mitigated or eliminated will require clarity on the outcomes from the Healthy Weston programme and the associated confirmation of commissioning intentions. The process and timescales for this work will be key to informing the Boards' decision to commence a Full Business Case analysis.

1.6 Recommendation

The Board of UH Bristol is asked to:

- **Approve** the Strategic Outline Case for organisational merger, through acquisition of WAHT by UH Bristol.
- **Note** that the next stage in the process will be to complete a comprehensive appraisal of the future model of acute care within the context of the *'Healthy Weston'* programme and vision. Depending on the outcome of this appraisal process, a full business case (FBC) will be developed. The FBC will be the document upon which

the final decision by the UH Bristol Trust Board and Council of Governors to proceed with any future transaction will be made. Any final decision would also require the approval and support of NHS regulators and the Competition and Markets Authority.

- Note that identification of sufficient resources to support the development of a Full Business Case and, subsequently, to make the transition to a merged organisation effective, will remain under discussion with Regulators.

2. Introduction and background

2.1 Introduction

This document describes the drivers, options and potential benefits of greater collaboration between University Hospitals Bristol NHS Foundation Trust (UH Bristol) and Weston Area Health NHS Trust (WAHT). The development of this SOC was agreed in a formal partnership agreement between both organisations committing to explore how increasing the level of joint working between the two Trusts could address long-standing issues of clinical and financial sustainability at Weston Area Health NHS Trust.

In May 2017, the Trust Boards of UH Bristol and WAHT signed an Interim Partnership Agreement to work in collaboration to:

1. *Develop a joint service strategy setting out proposed areas for co-operation and for UH Bristol to provide management support to WAHT with the aim of ensuring sustainable and financially viable services are provided at WAHT alongside securing the ongoing integrity of service provision at UH Bristol; and*
2. *Progress proposals for a long term arrangement (the "LTA"), which, subject to satisfactory completion of the required business cases, due diligence processes, final Board decisions and regulatory/statutory approvals where required, the Boards of both Trusts agree would involve an organisational merger of the two Trusts (effected by an acquisition of WAHT by UH Bristol).*

This Strategic Outline Case (SOC) considers the options for a long term arrangement and recommends a preferred option for organisational form to support achievement of sustainable and financially viable services at WAHT and secure the ongoing integrity of services at UH Bristol.

In the context of the continued challenges faced by Weston General Hospital and the increasing risk to resilience of some services, it was agreed with the Boards of both organisations and with the Regulator NHS Improvement, to undertake an accelerated business case process, recognising the constraints of time and resource. This SOC therefore also incorporates a limited level of analysis similar to that normally included in an Outline Business Case (OBC).

The recommendation to approve the SOC is based on the findings of this accelerated SOC and supported by an interim Due Diligence (DD) exercise examining the viability of and requirements, for proceeding with a formal transaction.

The next steps in the process will require development of a Full Business Case (FBC). The FBC will be the document upon which the final decision by the UH Bristol Trust Board and Council of Governors to proceed with any future transaction will be made.

The main purpose of the FBC ahead of the organisational merger via acquisition and contract signature is to test that the principles, assumptions and basis for recommending the preferred option at the SOC stage, remain valid and also to further evidence that the preferred option is the optimal course of action to address the issue of WAHT's clinically

non-sustainable and financially non-viable services. Essentially, the FBC allows for a more detailed review of the case for change, opportunities, risks and benefits.

In addition, the FBC will explain in more detail UH Bristol's fundamental requirements both financially and non-financially in order to produce a viable case for the acquisition of WAHT that can be approved by UH Bristol's Board and Council of Governors. UH Bristol's requirements will specify the content and values for negotiation with Commissioners and the Regulator, NHS Improvement. The FBC will also describe in detail the robust management arrangements for pre and post-merger project delivery that will drive the service changes that are required for clinically sustainable service provision at WAHT and ensure that staff are fully engaged in developing a shared vision for the new organisation.

2.2 Background

Over the last 10-15 years, it has been increasingly clear that Weston Area Health NHS Trust (WAHT), as one of the smallest NHS Trusts in England, would not achieve stand-alone Foundation Trust status. In addition, it has continued to experience increasing challenges in maintaining the financial and clinical sustainability of its services. A number of attempts to develop a viable long term plan to address this underlying issue have failed, most recently in 2014 when an attempt to tender WAHT for acquisition did not proceed.

In 2012, North Somerset Council, North Somerset Community Partnership and Weston Area Health Trust developed an integrated business plan that set out proposals for an Integrated Care Organisation (ICO) to be the principal provider of acute and community health services, and adult and children's social care services in North Somerset. This did not subsequently proceed. The business plan stated that the financial plan did not demonstrate how services would be delivered within the available resource and that further work would be required to resolve how to deliver long term financial sustainability and financial balance for both the provider and commissioner.

Work undertaken by WAHT prior to 2014 in partnership with North Somerset Clinical Commissioning Group (NSCCG) has demonstrated that WAHT, as a standalone entity, and as an integrated care organisation in partnership with other local health and social care provider organisations, was unable to satisfy the financial requirements necessary to achieve foundation status.

In 2014, WAHT and the local health economy therefore determined that an NHS only transaction process would offer the best and most timely solution for WAHT. In August 2014, WAHT and the Trust Development Authority (TDA) began an open NHS only transaction process to find the most suitable NHS Foundation Trust to acquire WAHT. An Invitation to Participate (ITP) in a process to find "A statutory recipient for the assets and liabilities of WAHT" was issued on 5th August 2014. Expressions of interest were received from UH Bristol, Taunton and Somerset NHS Foundation Trust (TSFT) and Somerset Partnership NHS Foundation Trust. Taunton and Somerset NHS Foundation Trust proceeded to FBC for the proposed acquisition of Weston Area Health NHS Trust but ultimately the acquisition did not proceed. The FBC did not demonstrate a financially sustainable solution.

In late 2015, after the Taunton acquisition was halted, leaders of the local health and social care system came together to form a partnership called the North Somerset Sustainability Board. Its aim was to take a fresh approach to this issue. Instead of looking for a solution that starts with organisational restructure, it has engaged a wide range of local expert clinicians to review the current models of care and service pathways. The North Somerset Sustainability Board initiated a three phase programme to deliver clinically and financially sustainable acute services in North Somerset, within the wider context of a sustainable health and social care system.

Phase 1: GE Finnamore was commissioned in early 2016 to complete a review of all the previous assessments of the local system's challenges;
Phase 2: The Programme for Sustainable Services developed a set of options/ proposals based on the Finnamore's work to put to the Sustainability Board;
Phase 3: The programme moved into a phase of engagement, consultation and implementation.

In February 2017, North Somerset and Somerset Clinical Commissioning Groups (CCG's) engaged the public on 4 option 'ideas' for Weston at the start of its programme phase 3. These were:

1. *change the urgent and emergency care service model overnight from 10pm – 8am*
2. *bring day to day non-complex planned operations back to weston general hospital*
3. *transfer some emergency surgery to other hospitals*
4. *increase the number of beds in the critical care unit on the weston general hospital site*

They also sought views on two enabling strategies, one of which was integrated working within acute care. This was based upon the work of the Acute Care Collaboration (ACC) within the BNSSG STP process which involves the three local hospital Trusts (Weston Area Health NHS Trust, University Hospitals Bristol NHS Foundation Trust and North Bristol NHS Trust (NBT)) as well as community partners. The ACC has agreed the following four objectives to guide its work:

- To ensure the best use of capacity and resources across the three hospitals (staff, facilities etc)
- To develop strong effective clinical pathways (the patient's journey through all necessary health services)
- To develop and support specialist services
- To secure sustainable services at Weston General Hospital

Following a joint Trust Board to Board meeting in January 2017, the Boards of Weston Area Health NHS Trust (WAHT) and University Hospitals Bristol NHS Foundation Trust (UH Bristol) announced on 8 February 2017 that they had agreed to establish a formal partnership arrangement, increasing the level of joint working between the two Trusts to address long-standing issues of unsustainability of clinical services and financially unviable services at Weston General Hospital.

This new collaboration was created in line with the NHS vision of developing networks between smaller and larger Trusts (Ref 2) and reflects the aim of the North Somerset Sustainability programme to build a strong future for Weston General Hospital (Ref 3). It also represents a step-up in acute care collaboration across Bristol North Somerset and South Gloucestershire (BNSSG), reflecting the commitments made within the Sustainability and Transformation Plan (STP) and progress towards the shared medium term objective of developing a BNSSG Integrated Health and Care system (Ref 4).

Building on the long-standing, positive working relationships which give local people access to a range of services delivered or supported by Bristol and Weston clinicians, the two Trust Boards approved a formal interim partnership agreement in May 2017.

This Strategic Outline Case is the culmination of the work developed through this partnership arrangement to outline and evaluate the options to achieve financial and clinical sustainability for services at Weston General Hospital.

In October 2017, BNSSG CCGs published their commissioning context document, *'Healthy Weston – Joining up services for better health care in the Weston Area'. (Ref 1).* This document outlines the context of the current challenges facing the "place" of Weston and the approach to developing the optimal clinical model for future services to inform commissioner decisions. Further detail is provided in section 3.2.2.

The prolonged periods of uncertainty created by the context outlined above have clearly been highly challenging for WAHT staff and undoubtedly have led to a further deterioration in recruitment and retention of clinical staff, underpinning the clinical service viability challenge. There has also been a further deterioration in the quality of emergency services and access for patients, outlined in the recent Care Quality Commission (CQC) report (Ref 5). It is therefore critical that a solution for the future of WAHT services is agreed quickly, so that the quality of services for patients does not further deteriorate and that a period of support and engagement can begin with staff.

3. Strategic and Local Context

This section outlines the strategic, national and local context for the Strategic Outline Case.

3.1 National Context

NHS England's (NHSE) Five Year Forward View document published in October 2014 outlines the clear direction for the NHS. The report focuses on models of care and sets out a vision for 2020 intended to close 3 key health, quality and financial "gaps" and ensure that the needs of future patients are addressed in a sustainable way.

The current financial challenge within the NHS is significant, with the 2014 Carter report (Ref 6: Carter Report, 2014) stating how the "*NHS is expected to deliver efficiencies of 2-3%, effectively setting a 10-15% real terms cost reduction target for achievement by April 2021'* (Ref 6). It is of note that the 2-3% relates to annual efficiency savings.

The national response to this position is outlined in the document, *The Next Steps on the NHS Five Year Forward View' (March 2017).* This key NHSE document describes how *'pressures on the NHS are greater than they have ever been',* and sets out an expectation that organisations will need to evolve. This SOC is being developed firmly within the strategic context of this national challenge for the NHS.

One of the key vehicles outlined to transform the NHS are changes to the traditional and established organisational forms. There are 13 Vanguards which have been established to review alternative models, including Acute Care Collaboration (ACC), as well as a number of other cross sector models.

In a speech to the Confederation of British Industry in London on the 25th September 2015, Simon Stevens (Chief Executive Officer of the NHS) stated that, "*the era of go-it-alone individual hospitals is now being superseded by more integrated care partnerships"* and that*, "our new approach to hospital partnerships will help sustain the viability of local hospitals, share clinical and management expertise across geographies , and drive efficient beyond the walls of individual organisations" (2015).*

In addition, the 2014 Dalton Review, *'Examining new options and opportunities for providers of the NHS'* identifies five key themes underpinning successful changes to organisational form within the NHS (Ref 7). These can be summarised as:

- One size does not fit all;
- Quicker transformational and transactional change is required;
- Ambitious organisations with a proven track record should be encouraged to expand their reach and have greater impact;
- Overall sustainability of the provider section is a priority; and
- A dedicated implementation programme is needed to make change happen.

The Five Year Forward View strongly signposts the need for new models of care to respond to the challenges faced by the NHS and that providers will struggle to meet the challenges faced by the NHS without looking outside of traditional organisational boundaries.

The proposal outlined in this SOC will represent the first steps towards developing a more integrated health system in BNSSG.

3.2 Regional and Commissioning Context

3.2.1 Regional context

Weston Area Health NHS Trust and University Hospitals Bristol NHS Foundation Trust along with a third acute provider, North Bristol NHS Trust, form part of the BNSSG healthcare system. The system is developing a Sustainability and Transformation Plan (STP) designed to address the national drivers outlined above and has also provided the overarching framework for the North Somerset Sustainability Programme and Healthy Weston programme.

"Healthier Together" is the local Sustainability and Transformation Partnership (STP). It covers the three local authority areas of Bristol, North Somerset and South Gloucestershire (BNSSG). 13 local health and care organisations sit on the Healthier Together board, but the partnership goes beyond just these organisations. The views of the public, patients, and voluntary sector form an important role in shaping the future.

There are around 1million people living within BNSSG. Similar to other areas of the UK, the local population is expected to grow significantly in the next few years, with a large increase in people aged over 75. Generally the population enjoys good health and life expectancy is increasing, but this also means there are a greater number of people living with long term conditions – such as diabetes and dementia. There are some significant pockets of deprivation within BNSSG, which in turn results in illness and average life expectancy can vary by about six years because of this.

Local authorities have faced unprecedented levels of funding cuts in recent years, despite increasing demand and this has affected the level of service they can provide to those who need social care and residential care. Funding for the NHS is growing year on year but is very challenged in keeping pace with demand for services. On average, every month our local NHS services overspend by £8m. The STP predicted that if this isn't addressed, BNSSG will be £325m overspent by 2021.

The STP includes three major transformational workstreams:

- Prevention, Early Intervention and Self-Care,
- Integrated Primary and Community Care, and
- Acute Care Collaboration.

The Acute Care Collaboration workstream has established three key principles for the development of effective and high quality acute services in BNSSG. This SOC has been developed in the context of these underpinning principles and with the aim of supporting the system to work towards the delivery of these aims. These principles can be summarised as:

A collaborative provider model, supported by a single commissioning approach

- Eliminate variation from best practice for both quality and efficiency.

- Provide services locally where possible, centralised where necessary making best use of available estate and workforce.
- Working together across care pathways so that patients receive right care first time in the most appropriate setting.
- Support primary and community care with a consistent offer from all Trusts.
- Improve patient care across pathways by improving speed and quality of information sharing.

Reducing use of acute hospital bed base

- Ambulatory care maximised.
- Hospitals including paediatric and acute mental health have bed occupancy that allows efficient flow of patients.
- Best practice in whole hospital flow embedded to include optimal theatre utilisation, avoiding cancellations and flow from acute hospital to mental health settings.
- Efficient outpatient work delivered in a place that patients want, which avoids waste and supports community based case.

Using our acute hospital resources to support the wider health and care system

- Sharing the acute and mental health hospital facilities, physical assets, clinical skills and staff to support patients to stay out of hospital when possible.
- Using our scale to provide resilience to the health and care system including infrastructure, shared corporate services and workforce development.

The future success and stability of WAHT is a key priority for the BNSSG STP. UH Bristol, as an acute system leader within the STP, accepts a level of responsibility for supporting a sustainable solution for the benefit of residents requiring acute healthcare in North Somerset.

3.2.2 Commissioning context

The BNSSG CCG commissioning context document '*Healthy Weston: Joining up services for better care in the Weston Area'* (Ref 1) focusses on the needs of the North Somerset Population and sets out the challenge of addressing the issues of financial and clinical sustainability for the region. The purpose of the document was to;

1. Set out the needs of the local population, why the current health and care system needs to change and the key priority areas for system transformation.
2. Describe a vision for local services with a specific focus on the 'place' of Weston to improve the way health and care services are delivered to the local population, setting out commissioning requirements for local service transformation.
3. Outline what will be different this time around verses previous unsuccessful attempts to reform the local hospital system, and how the CCG intends to explore new and innovative ways of encouraging greater collaboration across organisational boundaries and systems of care to deliver the necessary changes.

The Commissioning Context document identifies three priority population groups as;

1. Frail and Older People
2. Children, Young People and Pregnant Women
3. Vulnerable Groups (for example people with mental health needs, learning difficulties and those who struggle with drug and alcohol addiction)

It describes an intention to work together in more effective ways and integrating local services and pathways to join-up patient care to tackle the identified health inequalities and better meet the needs of the local population.

The Commissioning Context document outlines the operational and financial challenge facing Weston. Describing the growth in demand, alongside challenges in the recruitment and retention of staff required to sustain clinical services, it outlines the significant financial pressures in the region and within the BNSSG system and the commissioning approach described is set within this context.

It describes three key strands to its vision;

1. Primary Care (General Practice) working at scale and providing strong system leadership.
2. Stronger, more integrated community services supported by a 'Care Campus' model at the WGH site.
3. A stronger, more focussed Acute Trust and acute care model at WGH.

The Healthy Weston Programme was established by BNSSG CCG to progress the delivery of the vision outlined above. The programme has workstreams shaped around the three key themes and UH Bristol and WAHT have been integral to the development of the Integrated Acute Care Model workstream. This workstream includes clinical and non-clinical representatives from UH Bristol and WAHT, along with NBT, community and primary care providers and is focussing on developing a sustainable acute clinical model for Weston. This includes establishing how viability can be improved through maximising the productivity and utilisation of current services as well as developing new clinical models of care to achieve the vision outlined above.

Following the development of these models of care, BNSSG CCG will develop a business case to inform public consultation on the future service model for the population of Weston.

This SOC is being developed within the context of the Healthy Weston programme and its outputs will be fundamental in gaining certainty over the commissioning intentions for acute services for Weston GH and the associated impact on the robustness of the case for organisational merger

3.3 Local Context and Current Services

3.3.1 Comparative Data

The tables below outline the relative volume and value of services between WAHT and UH Bristol**.**

Table 1: Selected Key Comparative Reference Costs Data (WAHT and UH Bristol)

2015/16 data	UH Bristol	WAHT
Catchment population	450,000	202,000
ED attendances - Type 1	101,000	54,000
Outpatient attendances	690,000	144,000
Inpatient - day cases	42,100	10,500
Inpatient - elective	13,700	1,500
Inpatient - non elective	60,800	15,200
Number of beds	899	270
2016/17 Outturn	**£'m**	**£'m**
Turnover	639.0	105.0
Net surplus / (deficit)	16.6	(7.2)
Agency expenditure	11.2	11.7
Agency expenditure - percentage of pay cost	3.0%	15.5%
Cash balance	65.4	1.6
Reference Cost Index	**96**	**104**

3.3.2 University Hospitals Bristol NHS Foundation Trust (UH Bristol)

University Hospitals Bristol NHS Foundation Trust is one of the country's largest NHS acute Trusts and a major teaching and research centre for the South West of England. As a specialist teaching Trust, it works in partnership with the University of Bristol, the University of the West of England and several other higher education institutions to provide medical, nursing, midwifery and allied health professional education at pre and post-graduate levels. UH Bristol's mission is *to improve the health of the people it serves by delivering exceptional care, teaching and research every day.*

3.3.2.1 Key facts (UH Bristol)

- UH Bristol has over 9,000 staff and offers over 100 different clinical services across nine different sites.
- UH Bristol provides general medical and emergency services to the local population of Central and South Bristol, and a broad range of specialist services across a region that extends from Cornwall to Gloucestershire, into South Wales and beyond.
- UH Bristol is one of the country's largest acute NHS Trusts with a 2017/18 planned income of £657 million.
- UH Bristol provided treatment and care to 72,000 inpatient and day case elective patients, 60,000 non-elective inpatients and saw 126,000 patients in our emergency departments during 2016/17 It also provided approximately 663,000 outpatient appointments.
- With strong links to the University of Bristol and University of West of England, UH Bristol is the major medical research centre in the region, ensuring a focus on continually improving our patient care. These academic links also make UH Bristol the largest centre for medical training in the South West.
- UH Bristol was rated Outstanding by the CQC following an inspection in November 2016.
- As a Foundation Trust, UH Bristol is accountable to the local community and patients. The community and patients are invited to become members of the Trust and currently UH Bristol has 8,500 members.

- University Hospitals Bristol provides regional and tertiary services to a population of circa 5.3 million across the geographically and economically diverse South West region of England;
- 55% of UH Bristol activity is commissioned by CCGs, within 45% commissioning by NHSE Specialised. The split of contract financial value by commissioner for UH Bristol is outlined below;

Table 2: The split of contract financial value by commissioner for UH Bristol

Commissioner	% contract financial value
NHS Bristol	30.52%
South West Specialised Commissioning Hub	44.62%
NHS North Somerset	7.87%
NHS South Gloucestershire	5.42%
Other CCG	5.25%
NHSE Other	6.32%

UH Bristol's structure is based on five autonomous Clinical Divisions:

- Medicine and Emergency Care
- Surgical Division
- Women's and Children's Services
- Specialised Services
- Diagnostic and Therapy Services

3.3.2.2. UH Bristol Strategy

The UH Bristol *Vision* is 'for Bristol and our hospitals, to be among the best and safest places in the country to receive care', with the *Strategic Intent* 'to provide excellent local, regional and tertiary services, and maximise the benefit to our patients that comes from providing this range of services'.

The current UH Bristol Trust Strategy - Rising to the Challenge 2020 (Ref 8) states that our key challenge is 'to maintain and develop the quality of our services, whilst managing within the finite available resources, with our focus being on "affordable excellence'. It also clear that UH Bristol operates as part of a wider health and care community and the strategic intent sets out our position with regard to how we will optimise our collective resources to deliver sustainable quality care into the future.

UH Bristol has identified six key strategic priorities for the period 2014 to 2019. These are:

- We will consistently deliver high quality individual care, delivered with compassion;
- We will ensure a safe, friendly and modern environment for our patients and for our staff;
- We will strive to employ the best and help our staff fulfil their potential;
- We will provide leadership to the networks we are part of, for the benefit of the region and the people we serve;

- We will ensure we are financially sustainable to safeguard the quality of our services for the future and that our strategic direction support this goal; and
- We will ensure we are soundly governed and are complaint with the requirements our regulators.

3.3.3 Weston Area Health NHS Trust (WAHT)

Weston Area Health NHS Trust was established in April 1991. It is a 270 bedded district general hospital which includes general, acute midwife-led beds and 5 critical care beds. The hospital provides acute emergency services for adults including Emergency department, critical care, medicine and surgery together with supporting diagnostic services. In addition, the site provides a range of planned services including general surgery, urology, orthopaedics, and other planned treatments such as endoscopy, haematology and some cancer care.

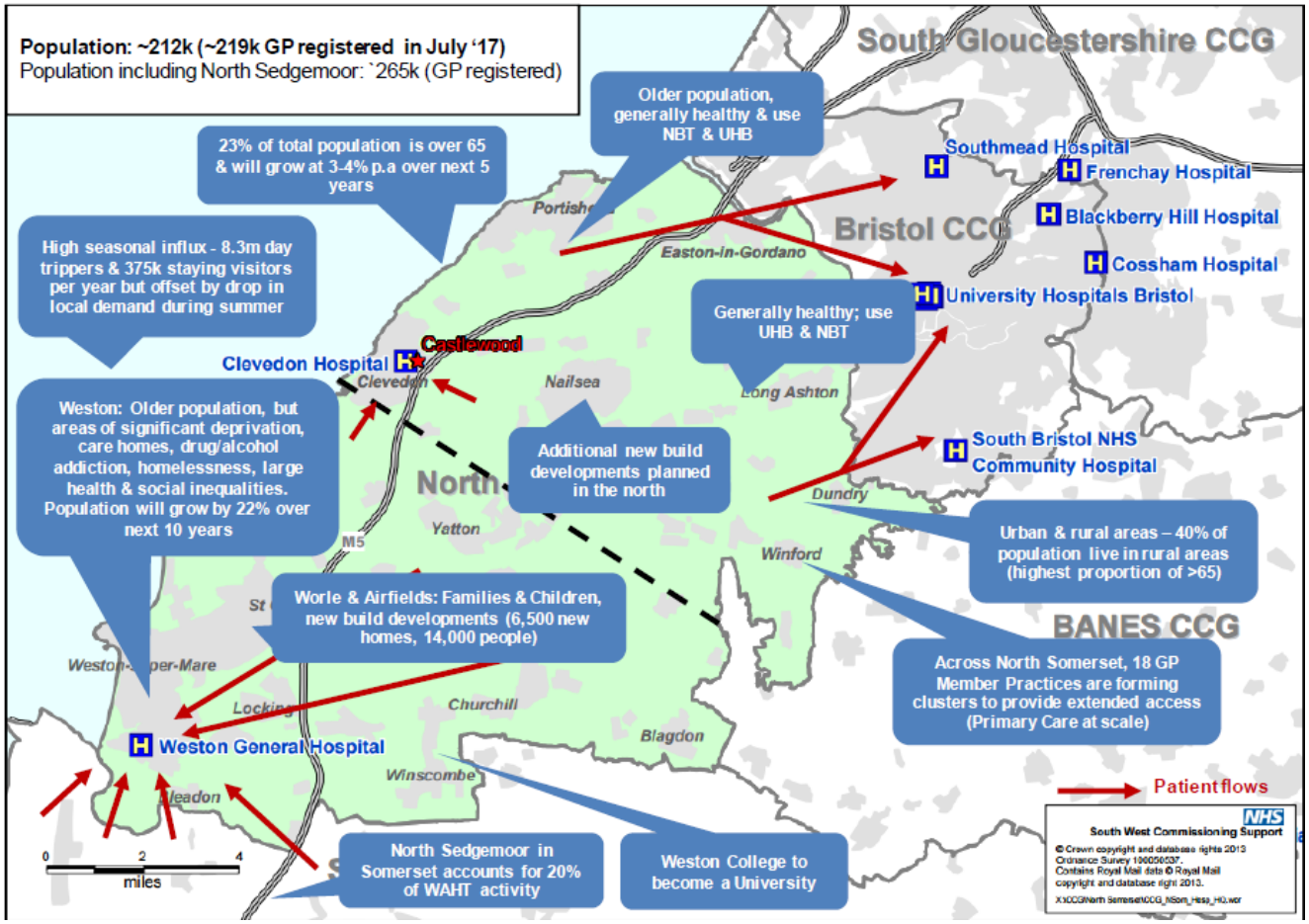
3.3.3.1 Key Facts

- WAHT has been operating a 24 hour emergency department at Weston General Hospital. The unit is busy, seeing circa 54,000 attendances in 2015/16, which is above the average number expected for the size of the hospital and local area. From the 4th July 2017 the Emergency Department (ED) at WAHT has instigated a temporary closure of its ED department from 10pm to 8am daily, due to the on-going inability to safely staff the unit during these hours. Since the implementation of the planned overnight closure of ED in Weston, patients have instead been accessing emergency care in alternative local providers, primarily UH Bristol, Taunton and Somerset NHS Foundation Trust and North Bristol NHS Trust. All organisations involved have applied effective partnership working to enact and manage this change, including jointly agreed operational protocols and repatriation policies to ensure patients receive ongoing care as close to home as possible where clinically appropriate, as well as joint structures through which risks can be escalated within the system.
- WAHT provides, in general, non-complex inpatient and day case surgical procedures and outpatient services. In 2016/17, WAHT carried out 10,500 planned day cases, 15,200 non-elective inpatients, and 1,500 elective inpatients, together with 144,000 outpatient attendances. In addition, WAHT currently operates a 5 bedded Critical Care Unit supported by an anaesthetic team. During 2016/17 the maternity unit delivered 190 babies.
- North Somerset Clinical Commissioning Group is WAHT's main commissioner accounting for approximately 73% of WAHT's income from patient care activities, with NHS Somerset accounting for 16% and other patient related income of 11%.
- WAHT works closely with other hospitals in Bristol as part of 'clinical networks' including, for example, cancer, pathology and cardiology.
- WAHT serves a resident population in North Somerset of circa 202,000 people (source: Mid-2014 population estimate: ONS), with over 70% of people living in the four main towns of Weston, Clevedon, Portishead and Nailsea. A further 3.3 million day trippers and 375,000 staying visitors increase this base population each year during the summer period.

- WAHT also provides services to North Sedgemoor which has an estimated population of 48,400 (Mid 2014 GP registered population). The largest town is Bridgewater, followed by Burnham-on-Sea and Highbridge.
- Children's and Young People's Community Health Services including Child and Adolescent Mental Health Services are provided from two children's centres located in Weston-Super-Mare and Clevedon.
- WAHT is managed operationally on a directorate basis. Each directorate is managed by a Directorate Director (Clinical), Directorate Manager (General Management) and supported by an Operational Head of Nursing. All are accountable on a day-to-day basis through the Director of Operations to the Chief Executive for delivery of operational and financial performance. The Directorates do not have the equivalent of UH Bristol's model of Divisional Finance and HR partners in place supporting clinical directorates.

The figure below is taken from the Healthy Weston commissioning context document and provides some key facts about North Somerset and context relevant to the future development of WAHT (Ref 1, p.15)

Figure 1: North Somerset Key Facts



3.3.3.2 WAHT Strategy

The WAHT Trust vision is 'to work in partnership to provide outstanding healthcare'. The Strategic plan describes a new business model that 'is necessary for WAHT to develop

sustainable and financially viable services for the local population (place) and support North Somerset's provision of sustainable health and wellbeing services'.

There is a significant emphasis in the latest WAHT strategy on the sustainability of services, with partnership working identified as a key factor in achieving this sustainability.

The 2016 WAHT strategy outlines the challenges to the resilience of services, which are summarised in the three points below:

- WAHT faces an ongoing challenge concerning the recruitment of medical staff across a number of key specialities including emergency medicine, potentially placing at risk the clinical safety and sustainability of services provided.
- This has led to an increasing reliance on locum clinical staff and some problems with clinical care standards in a number of areas including Emergency Care for Paediatrics, Community Paediatric and Safeguarding Services, Dermatology and Neurology services. These challenges cannot be met by WAHT working in isolation.
- Current tariffs do not meet the real costs of emergency care at WAHT.

3.4 Strategic Rationale for Preferred Option

UH Bristol and WAHT strategies are broadly compatible and this presents opportunity for the development of a single organisation. The WAHT service strategy clearly asserts their priority to be the development of sustainable clinical services, with a focus on 'core services', defined as emergency care for local patients and all services associated.

UH Bristol strategic priorities are orientated around the further development and expansion of the tertiary and specialist offer, whilst maintaining high quality District General Hospital (DGH) services for the local population. The opportunities these complementary strategic positions offer are further considered in section 4 (Case for Change).

3.5 Current Joint Clinical Service Models

There are currently well established and strong links between services at WAHT and UH Bristol, with a number of joint clinical service models already in place and working well**.**

UH Bristol has formal and informal links to WAHT. Service Level Agreements for services provided to WAHT by UH Bristol amount to c£1.0m and are largely charges for clinical time for UH Bristol consultant medical staff who deliver services from WAHT across a number of specialities including laboratory medicine, surgery, cardiology, oncology, paediatrics and dermatology. The most significant are haematology and ophthalmology. UH Bristol also has a Service Level Agreement (SLA) for provision of a small number of services by WAHT to UH Bristol.

There are also established joint clinical leadership models in place, including the UH Bristol Head of Midwifery providing professional leadership for maternity staff at UH Bristol and at WAHT.

UH Bristol has also provided increased support in a number of clinical service areas over the past twelve months, most notably in paediatrics and obstetrics & gynaecology. This ranges from clinical advice, to providing medical cover at times of planned or unplanned leave of WAHT Consultants. From July 2017, a new joint model was implemented for gynaecology. This has involved gynaecology inpatient emergency care transferring to UH Bristol, and from October 2017 being replaced in Weston with access to day case surgery for women who are currently having to travel into Bristol. Due to the on-going inability to recruit into consultant posts at WAHT, additional support has also been provided to the clinical haematology service in the form of joint appointments through UH Bristol.

Under the current interim Partnership Agreement, there are opportunities for the development of a new joint clinical services model to further consolidate and extend the established models currently working across both Trusts. This is further outlined in section 7.

3.6 Operational Performance and Access

Both Weston Area Health Trust and UH Bristol are challenged in the delivery of regulatory access standards.

In particular, the current lack of resilience in clinical staffing levels is impacting on WAHT's performance against a number of different national access standards, most notably 4-hours and 62-day GP cancer.

The assessment of the impact of WAHT's performance on UH Bristol performance, should the merger proceed, has been undertaken using nationally available data submitted by WAHT (see Appendix 7). Comparing UH Bristol's performance for each quarter of 2016/17 with WAHT performance by simply aggregating WAHT and UH Bristol's performance together for the same periods, suggests that there is potential for a small deterioration in performance against the 62-day GP cancer target, but a more material deterioration for A&E 4-hours, the latter also being impacted by a comparatively worse length of stay for inpatients at WAHT.

3.6.1 4 Hours ED Standard

There are potentially regulatory, financial and clinical risks associated with a worsening 4-hour performance. It is not at present clear the extent to which mitigations can be effected and how quickly this would turn performance around. It should however be noted that performance in both organisations has improved in 2017/18.

Table2a: A&E 4 Hours

	UHBristol (RA7)				Weston (RA3)				Combined			
	Under 4 Hours	4+ Hours	Attendances	Performance	Under 4 Hours	4+ Hours	Attendances	Performance	Under 4 Hours	4+ Hours	Attendances	Performance
2016/2017 Q1	29,251	3,482	32,733	89.36%	11,465	2,045	13,510	84.86%	40,716	5,527	46,243	88.05%
2016/2017 Q2	28,506	3,564	32,070	88.89%	11,975	2,590	14,565	82.22%	40,481	6,154	46,635	86.80%
2016/2017 Q3	26,972	6,598	33,570	80.35%	9,293	3,748	13,041	71.26%	36,265	10,346	46,611	77.80%
2016/2017 Q4	25,269	5,726	30,995	81.53%	8,538	3,568	12,106	70.53%	33,807	9,294	43,101	78.44%
2017/2018 Q1	27,788	4,978	32,766	84.81%	12,160	1,716	13,876	87.63%	39,948	6,694	46,642	85.65%
2017/2018 Q2	29,507	2,965	32,472	90.87%	10,349	1,197	11,546	89.63%	39,856	4,162	44,018	90.54%
2017/2018 Q3	30,708	3,937	34,645	88.64%	9,423	1,699	11,122	84.72%	40,131	5,636	45,767	87.69%

3.6.2 62-day GP cancer standard

A combined workforce, together with improved pathway models and management, should be sufficient to off-set a small deterioration in 62-day GP cancer standard performance and may even allow an overall improvement in performance above that currently reported by UH Bristol, given UH Bristol's skewed case-mix and the small but measurable impact late referrals from WAHT has.

Table 2b: 62-day GP cancer

	UHBristol (RA7)				Weston (RA3)				Combined			
	Non Breaches	Breaches	Total Seen	Performance	Non Breaches	Breaches	Total Seen	Performance	Non Breaches	Breaches	Total Seen	Performance
2016/2017 Q1	196	74	270	72.73%	67	17	84	80.24%	263	90	353	74.50%
2016/2017 Q2	253	63	316	80.19%	66	24	90	73.74%	319	86	405	78.77%
2016/2017 Q3	238	51	289	82.35%	77	20	97	79.38%	315	71	386	81.61%
2016/2017 Q4	247	56	303	81.49%	66	20	86	76.61%	312	76	388	80.41%
2017/2018 Q1	245	66	310	78.87%	71	29	99	71.21%	315	94	409	77.02%
2017/2018 Q2	250	62	311	80.23%	66	25	91	72.93%	316	86	402	78.58%

3.6.3. Other standards [6-week wait diagnostic; Referral to Treatment Times (RTT) and 31-day first and subsequent treatment cancer standards]

By simply aggregating WAHT and UH Bristol's performance together for the same periods, a negligible or small positive impact could be achieved in a merged organisation, relative to UH Bristol's own performance on the following indicators

- 2WW cancer
- 31-day first definitive cancer and other 31-day cancer standards
- RTT
- 6-week diagnostics
- Last-minute cancelled operations (LMCs)
- Follow-up to New ratios
- Length of Stay (LOS)
- hospital cancellation rates

There are clearly existing challenges within both Trusts to the delivery of regulatory standards and both WAHT and UH Bristol experience particular operational pressures associated with emergency demand and bed capacity, as well as ability to discharge patients from hospital. It is also apparent however, that there are opportunities in functioning as a single organisation to combine pathways and learning and to maximise use of capacity to potentially improve the combined position.

4. Case for Change

This section sets out the case for change to address the long term clinical and financial sustainability issues at WAHT.

4.1 Introduction

The key driver of the case for change is the sustained challenge to the clinical and financial sustainability of services at Weston General Hospital, and the adverse impact upon all acute service providers across the BNSSG region.

As outlined in WAHT's 2017/18 Operational Plan, this is driven by the continuing deterioration in the ability to recruit to clinical posts in key areas, which is also driving an increasing challenge in delivering consistently high quality and clinically effective care on an affordable basis. An over reliance on temporary staff to try to address this issue is in turn resulting in substantial and escalating staff pay costs, one of the key factors behind WAHT's recurring financial deficits.

This deteriorating position, with costs escalating and clinical services increasingly being unable to function independently, results in short term unplanned changes to services which can, without the correct capacity and resource planning adversely impact both WAHT and Bristol patients. It may also result in service changes which are not strategically aligned in the longer term. It is clear from the scale of deterioration that doing nothing to address the situation is not an option and moreover, that the pace at which action is taken is also critical to prevent further deterioration of services for patients.

It is apparent from past experience of joint working between UH Bristol and WAHT, that working collaboratively provides the opportunity to secure local access for appropriate DGH services. Clinical leaders from both Trusts participated in clinical expert groups as part of the Phase 2 North Somerset Sustainability Programme. The Programme Board have confirmed the following key factors driving the case for change for the programme and the same factors can be considered as driving this SOC. (Ref 9)

- *The growing demand for services particularly from an increasingly elderly population.*
- *Difficulties in recruiting sufficient medical staff in key clinical areas, leading to a high number of locums and consultant post vacancies. This is resulting in increasing challenges in sustaining viable clinical rotas (necessary to deliver high quality care) in a number of areas.*
- *Reduced numbers of permanent consultants in posts causing issues for medical training. For example: the inability to provide the necessary consultant oversight in the emergency department caused the withdrawal of FY2 doctors from that department, further adding to the pressures of running the department sustainably and maintaining clinical rotas.*
- *Continuing uncertainty over the strategic future of services at the Trust has exacerbated the challenge of recruitment to key posts.*
- *Unless there is a major change in the service delivery and operational model all key emergency and inpatient services will continue to face sustainability challenges, with*

the loss of a small number of key individuals rapidly leading to a need for immediate action to safeguard service quality.

- *The North Somerset Sustainability programme has identified that the long term service sustainability depends on substantially greater integration of clinical teams at Weston with those from other BNSSG providers. Attempts to improve sustainability through an "informal partnership" approach, with the aim of joint appointments or ad hoc mutual aid to shore up rotas have not delivered anywhere near enough of an impact to enable a sustainable and robust staffing model in some specialities*
- *Progressing with a long-term collaboration between the Trusts offers the potential to build confidence in the future for Weston General Hospital, improve morale and recruitment and reduce reliance on temporary locum and agency staff.*

4.2 Strategic Drivers of Change

Within the context above, this section summarises the 5 key strategic drivers for a collaborative acute services partnership between UH Bristol and WAHT as follows:

4.2.1 **Clinical sustainability of services at WGH** - There have been a number of attempts to address the sustainability and resilience of clinical services at WAHT over the past six years, none of which have been fully successful. Some clinical services are no longer sustainable to be delivered locally, with others likely to become unsustainable in the near future without formal collaboration. There is a growing imperative for change at pace.

4.2.2 **Growing demand /population growth** – all of the partners in the North Somerset Sustainability programme have agreed the need to strengthen the resilience of Weston General Hospital as an important local hospital and a permanent part of the health system which provides appropriate services local people need close to home. The demographic growth over recent years and expected over the next decade underpins this position.

4.2.3 **Need to optimise use of available NHS capacity to meet growing demand** – nationally and locally there are clear drivers to ensure value for money is secured from all NHS resources. The current configuration and utilisation of clinical capacity is not optimised and opportunities for improvement exist that support the objectives of both Trusts and the BNSSG STP.

4.2.4 **Strategic and operational risks to UH Bristol and potential impact on quality of care for Bristol and North Somerset patients, of failure to take a leadership role in supporting the resilience of services at Weston General Hospital** – the ability of UH Bristol to fulfil its strategic intentions is impacted on by the strength of service provision across its system partners. Failure to take a lead role in supporting the resilience of services at Weston General Hospital could lead to unplanned operational impact on services at UH Bristol hospitals as well as at WGH, affecting performance and patient experience and constraining UH Bristol's strategic objective to expand specialist / tertiary services for the wider regional population.

4.2.5 Financial sustainability - Delivering productivity, efficiency and affordable service quality – WAHT is financially unsustainable driven largely by the fact it is one of the smallest acute Trust hospitals in England and has struggled with delivery of recurrent savings and the long-term recruitment of doctors in some specialties and delivering services within budget. Both Trusts need to ensure corporate services are delivered as efficiently as possible and opportunities exist through collaboration to secure savings.

4.2.6 Supporting the strategic vision of STP and delivery of the Healthy Weston vision– There is both a need and opportunity to demonstrate progress towards the stated strategic vision for the STP for an Integrated Health and Care system and progressing acute care collaboration as a key step in the journey. The March 2017 document, Next Steps on the NHS Five Year Forward View (Ref 10: Next Steps on the NHS Five Year Forward View, March 2017), clearly indicates the aim to, 'use the next several years to make the biggest national move to integrated care of any major western country' (Ref 10: p31) and that the development of Accountable Care System (ACS)' is the vehicle to achieve this. It describes a number of key characteristics of an ACS, including being able to demonstrate how, 'provider organisations will operate on a horizontally integrated basis, whether virtually or through actual mergers' (Ref 10: p36).

The Healthy Weston commissioning context document describes the need to establish, *A stronger more focussed Acute Trust and acute care model at WGH*. It describes how this will be achieved by, *'working in closer collaboration with other Acute Trusts and across BNSSG as part of a wider Acute Trust Network" (*Ref 1, p34). The development of this SOC is a key step in the move towards great integration and collaboration between acute services in BNSSG.

Each of these drivers is considered in more detail below:

4.2.1 Clinical sustainability

As detailed in section 2.2 and 3.3.2, there are long-standing issues with the clinical effectiveness of some services provided at Weston General Hospital primarily driven by its size which means that it is operating below 'critical mass' for a number of its clinical services.

Despite the commitment and hard work of staff, the continuing deterioration in WAHT's ability to recruit to clinical posts in key service areas has already resulted in temporary service changes, with a number of other services identified by WAHT as at risk of being sustainable in the short to medium term. In addition, an over reliance on temporary staff to try to address the recruitment issues is resulting in substantial and escalating costs as well as an increasing lack of stability, continuity and consistency of care. WAHT identifies the following challenge in its 2017/18 Operational Plan;

"The recruitment of medical staff in the Trust continues to be the greatest recruitment challenge faced by the Trust and some of these difficulties can be attributed to a UK wide skills shortage for certain positions, e.g. Consultants in Histopathology, Emergency Medicine, Respiratory, Acute and Community Paediatrician. As a result, there are clinical sustainability issues associated with a number of services in the Trust".

The North Somerset Sustainability Programme summarised the position in relation to the clinical viability of services in the following statement:

'The North Somerset health system, together with Weston Area Health Trust has been operating for a number of years now under the label of being unsustainable. This has caused a good deal of concern for patients, staff and the wider public, compounded by the fact that there have been a number of unsuccessful attempts to agree a package of reforms that can deliver a sustainable future for the services provided at Weston General Hospital.'

The Healthy Weston commissioning document builds on the above analysis and clarifies some specific long standing issues in relation to clinical services which need to be addressed. It outlines these as: (Ref 1. p13);

- *The provision of A&E services is a high profile local issue. We must look carefully at population need to identify the most effective long term solution for local urgent care provision.*

- *The ability to recruit to key clinical specialties; and issues with trainee doctor placements (supervision and satisfaction) are significant challenges, putting service delivery at risk. This is compounded by the continued delay in finding a longer term solution for the sustainability of WGH.*

- *The local Midwife led maternity service at WGH is not chosen by enough women to make it clinically or financially viable in its current form. The number of deliveries is currently ~170 per year, but the minimum level for a clinically appropriate unit of this type is considered to be ~ 500.*

- *There are questions as to whether other services may be more appropriately delivered elsewhere at scale, such as emergency general surgery and Level 3 ICU.*

The WAHT CQC report published in June 2017 providers a clear driver for the need for significant pace behind the actions to improve service resilience at WAHT. Weston General Hospital received an overall rating of 'requires improvement with the urgent and emergency care services rated as "inadequate", medicine and older people as "requires improvement" and surgery and critical care as "good""'(Ref 5).

It was noted that there had been some progress since the previous inspection with surgery and critical care moving from requires improvement to good overall. Medical care also demonstrated improvement with the domains of 'safety' and 'well-led' is now rated as 'requires improvement from inadequate'.

The report outlines how '*the ongoing pressures on the emergency department continued to be reflected in the ratings with safety remaining as inadequate and responsive and well led failing to improve also being rated inadequate. Patient flow had not been sufficiently improved since our last inspection and responsive in medical care was rated as inadequate'.*

The report notes, '*serious concerns that systems or processes to manage patient flow through the hospital were not operating effectively and did not ensure care and treatment was being provided in a safe way for service users'.*

The key findings in the CQC report are summarised below:

- *'We found the trust had been under increasing pressure to manage flow in the hospital for several months and the emergency department was under sustained pressure from an increase in attendances.*
- *There was a lack of support for the emergency department from the wider hospital services and a lack of trust wide ownership around patient flow. This means patients were frequently and consistently not able to access services in a timely way and some patients experienced unacceptable waits for some services.*
- *There was a fragile medical infrastructure in the emergency department with a crucial reliance on locum medical staff at consultant and middle grade positions. However, shortly after our on-site inspection a recent partnership with another local acute trust had secured some input for clinical leadership one day a week.*
- *The corridor area in the emergency department was frequently used when there were more patients than cubicles available. This was not a suitable or safe environment for patients to receive emergency care and treatment and was not fit for purpose.*
- *The trust mortality rate had been higher than the expected level for the recent reporting periods of July 2015 to June 2016. A review of mortality and an associated action plan were in place; however the lack of recorded minutes and actions in specialty mortality review meetings was of concern. It was unclear if learning was shared or action taken as a result of reviews of patient deaths.*
- *Since our previous inspection there had been some changes to the executive team with some people now in permanent roles and others being interim positions. More changes were due in April 2017 with a new medical director and director of operations starting in post. While the current executives worked well together they had been drawn into managing operational pressures in the emergency department on a regular basis. The new executives could lead to further change and approach to a team already under pressure and 'wearing many hats' due to the small trust and less senior roles.*
- *A review of governance had begun to implement change but was immature and lacking in clinical leadership at directorate level to provide robust assurance'.*

The key findings outlined above clearly demonstrate that the continued unsustainability of clinical services is impacting on the quality of care it is possible for staff to provide for patients. The deterioration from the previous inspection, particularly in the areas of emergency care and patient flow demonstrate that previous attempts to address difficulties, particularly in the recruitment and retention of substantive staff, have not been successful. This clearly demonstrates the need for pace behind the delivery of actions to improve the sustainably of these core clinical services.

4.2.2 Growing demand / population growth

The assumption underpinning this SOC is that Weston-Super-Mare is too large to exist without a district general hospital and too far from Taunton and Bristol for its population to be

expected to travel there routinely. The North Somerset Programme for Sustainable Services Phase 2: Part A report, December 2016 asserts that; *'all stakeholders agree that the Weston General Hospital forms a key part of the BNSSG system, and that it is essential it continues to provide a broad range of emergency and elective care services to the local population'* (Ref 9: p.16).

The Healthy Weston Programme commissioning context document (Ref 1, p17) identifies significant predicted growth for the North Somerset population, along with notable existing health inequalities. It summarises the key challenges from a North Somerset population perspective as;

- *The long-term projections based on ONS data suggest the population of North Somerset (and North Sedgemoor) will increase over the next decade at an annual rate of 1% across all age groups. These figures take into account planned housing developments, and are the same figures used by North Somerset Council's Planning Department.*

- *However, estimates obtained from Hampshire Council's small area population forecast[7] service, which takes into account housing development, suggests growth in the Weston locality in the 10-year period from 2014-2024 will be 22% (i.e. 2.2% per year on average), compared to background growth across the whole of North Somerset of 13%.*

- *The largest increase in population over the next ten years is set to be in the 75-84 age group (50% vs. 36% in England), followed by the over 85s (~46% vs. 42% in England).*

- *In respect of the younger age groups, the population is projected to rise in the 0-14 age group by ~12% (vs. ~8% in England), which equates to an additional ~4,000 children in total within the next 10 years.*

- *Life expectancy varies considerably across North Somerset. WsM Central Ward has the lowest life expectancy, where the respective figures are 67.5 years for males and 76 years for females. Conversely, Clevedon Yeo has the highest life expectancy for both males and females, at 86.1 years and 92.5 years respectively. A gap in male life expectancy therefore between these wards of 18.6 years; the equivalent gap for females in this example is 16.5 years.*

- *The main causes of the gap in life expectancy are circulatory diseases (such as coronary heart disease (CHD) and stroke), cancers and respiratory disease (COPD).*

- *Using data from Public Health England, it is estimated that 46% of male deaths and 36% of female deaths in the most deprived areas were considered 'excess'; in other words, these deaths would not have occurred if all areas in North Somerset had the same mortality profile as the least deprived areas[9]. Standardised Mortality Ratios range from 57% in Clevedon Yeo to 161% in Central Ward – much better and much worse than England respectively.*

- *The leading causes of premature mortality in North Somerset are circulatory diseases, respiratory diseases (COPD), cancer and liver disease. These are also the leading causes of premature mortality and years of life lost in North Sedgemoor.*

- *The potential years of life lost from treatment amenable cancers, i.e. cancers that could possibly be prevented through early detection and treatment (including breast, colorectal and skin cancer) in North Somerset, have been increasing and are above national figures. Treatment amenable cancers are now the primary cause of years of life lost from amenable causes in North Somerset, representing more than a third of total years of life lost.*

- *Across North Somerset, the leading causes of disability adjusted life years (DALY) lost are cancer (neoplasms), mental health and behavioural disorders, musculoskeletal conditions and cardiovascular disease.*

- *Compared with 2015, it is estimated that by 2030 in North Somerset, there will be over 1,700 more people living with CHD; around 750 more people will have had a stroke; over 10,000 more people will be living with hypertension; 6,000 more people will have diabetes; and around 6,000 people will be living with COPD.*

4.2.3. Need to optimise use of available NHS capacity to meet growing demand

The BNSSG STP analysis as referenced in section 3.2, confirms the commitment of acute providers to maximise use of collective hospital resources alongside a broader STP vision of reducing demand through greater focus on prevention, early intervention and self-care and enhanced primary and community services.

UH Bristol and WAHT both currently operate at high levels of bed occupancy. Both Trusts need to improve patient flows across the system as there are substantial capacity pressures on the hospitals leading, for example, to elective operations being cancelled because of emergency patients occupying acute hospital beds.

The WAHT 2017/18 Operational Plan indicates under-utilisation of theatres and opportunities to reduce length of stay to reduce bed occupancy. This presents an important opportunity to enhance overall viability through increasing elective care provision at the Trust. The WAHT plan also demonstrates that operating at 95% occupancy, provides potential to release circa 17 beds within medicine (6,205 bed days) and 13 beds within surgery (4,745 bed days). This could enable anticipated demographic growth to be managed within existing capacity and deliver further growth within elective surgery.

UH Bristol theatre capacity is constrained by limitations in physical expansion options. Potential flexible use of estate across both organisations could enable redistribution of services, maximise productivity and support UH Bristol to develop its specialist portfolio. Complementary to this would be the critical mass of the larger single organisation supporting the resilience of core services at WAHT. The opportunity to maximise capacity by effectively planning utilisation across both organisations could offer operational and strategic opportunities.

4.2.4 Strategic and operational risks to UH Bristol and potential impact on quality of care for Bristol and North Somerset patients, of failure to take a leadership role in supporting the resilience of services at Weston General Hospital

There is significant strategic and operational risk to UH Bristol of a continuing deterioration in services at WAHT and failure to take a leadership role to seek to resolve a long-term plan for the resilience of WAHT. Examples such as the temporary closure of WAHT ED overnight from the 4th of July and the need for clinical support in areas such as gynaecology,

cardiology and oncology, leading to short term arrangements, including joint appointments to clinical posts, demonstrate the fragility of some services. There is potential risk of the unplanned transfer of patients and activity to UH Bristol in circumstances where UH Bristol would not have had the opportunity to jointly plan the most appropriate clinical pathways with WAHT and would not have had the opportunity to make required plans for capacity, both in terms of workforce and physical space.

A recent example of this is the lung cancer pathway, where WAHT patients have been diverted for oncological treatment to the Bristol Haematology and Oncology Centre (BHOC) at short notice due to the inability of services to be maintained at WAHT. This has resulted in a loss of access to local services for North Somerset patients and has also placed unplanned pressure on the BHOC, potentially compromising access to services for existing patients. Continuation of these types of circumstances in other services could result in a suboptimal solution for North Somerset patients, but also could potentially deteriorate services for Bristol patients and significantly impact on UH Bristol's operating and strategic plans.

There is strategic alignment between the UH Bristol and WAHT strategies. The UH Bristol Strategic Intent is to; *provide excellent local, regional and tertiary services, and maximise the benefit to our patients that comes from providing this range of services (2014).* UH Bristol currently has significant capacity limitations, particularly in the delivery of general and emergency services to the local population. These capacity limitations are placing constraints both on access to general services and UH Bristol's ability to continue to develop its specialist and tertiary portfolio.

Further alignment of WAHT and UH Bristol could provide an opportunity to strengthen the overall DGH offer by increasing the critical mass of these services and also using estate flexibly across the two sites to maximise benefit.

It would also offer the ability to take a level of control, not only over the risk of unplanned deterioration of WAHT services and the subsequent operational impact, but also to influence the future shaping of health and social care services within BNSSG, to the ongoing benefit of the organisation, as well as the system. The future of UH Bristol is increasingly dependent on the broader health and social care system operating well. Given the current strength of the UH Bristol position within the system, the opportunity to take a role in leading the resolution of one of the key challenges to financial and clinical sustainability, would be to the strategic benefit of both the STP, UH Bristol and WAHT.

The closer collaboration also presents a tangible opportunity for UH Bristol to extend its strategic approach to transformation and innovation beyond the organisation. Innovation and ambition is a key characteristic of the organisation and one that was recognised in the recent CQC Outstanding rating. Closer collaboration not only presents the opportunity of learning to enable WAHT to access the approach and expertise that has demonstrated success at UH Bristol, but also provides a platform for innovation for both organisations to develop and evaluate new delivery models, particularly around more integrated out of hospital care to the benefit of both patient populations.

4.2.5 Financial sustainability - Delivering productivity, efficiency and affordable service quality

WAHT has reported financial deficits since 2008 in the range of -5% to -8% of turnover ranging from £4.7m in 2010/11 to £8.9m in 2016/17 excluding external revenue support and sustainability & transformation funding. The financial deficits have grown in recent years largely due to the poor delivery of recurrent savings and workforce recruitment and retention difficulties which have resulted in excessive and increasing agency expenditure to maintain services.

The financial position of WAHT is such that it cannot live within its means with the current service configuration and provision. The financial track record of the Trust indicates that a structural deficit exists under the current National Tariff arrangements and so the Trust is unable to live within its means on a recurrent basis despite securing additional support subsidies of £3.3m in 2016/17 and 2017/18 for specific services. The history of financial deficits has resulted in the Trust having a very weak balance sheet, poor liquidity and very limited cash to meet its financial obligations. The planned deficit for 2017/18 continues the recent trend of financial deficits and further weakens the Trust's financial standing.

Every year since 2010, the Trust has relied on cash support in a variety of forms from the Department of Health (DoH). More recently, the Trust has secured its cash support with short term and long term loans provided by the DoH. For example, the Trust's 2017/18 initial planned deficit of £6.0m is supported in cash terms with a commensurate increase in loan financing which is yet to be formally agreed. It should be noted that the DoH loans incur interest charges and the loan principal must be repaid at some point in the future.

The fundamental driver of the case for change underpinning this SOC is that WAHT is clinically non-sustainable and financially non-viable due to its small scale and physical location for the services currently provided. The underlying financial deficit of the Trust is further compounded by ongoing staff recruitment and retention difficulties which has resulted in rapidly escalating and extremely high agency staff expenditure. The Trust incurred agency expenditure of £11.7m in 2016/17. This position represents 20% of all expenditure on pay and an increase of 180% on 2015/16.

The financial case for change for the benefit of taxpayers and patients is overwhelming and there are clear opportunities to make inroads into the current position, with the high level opportunities identified at this initial stage of the SOC summarised as:

- Reduction in reliance on high cost staffing solution in medical and nursing posts through use of UH Bristol brand to improve recruitment.
- Consolidation of corporate services across both sites.
- Standardisation of operational processes and terms and conditions across organisations.
- Improved productivity and use of physical assets to improve utilisation and throughput of activity on both sites.

- Development of new longer term clinical models, building on existing partnership arrangements and utilising the new opportunity of a greater critical mass of services to realise longer term clinically and financially sustainable clinical services.

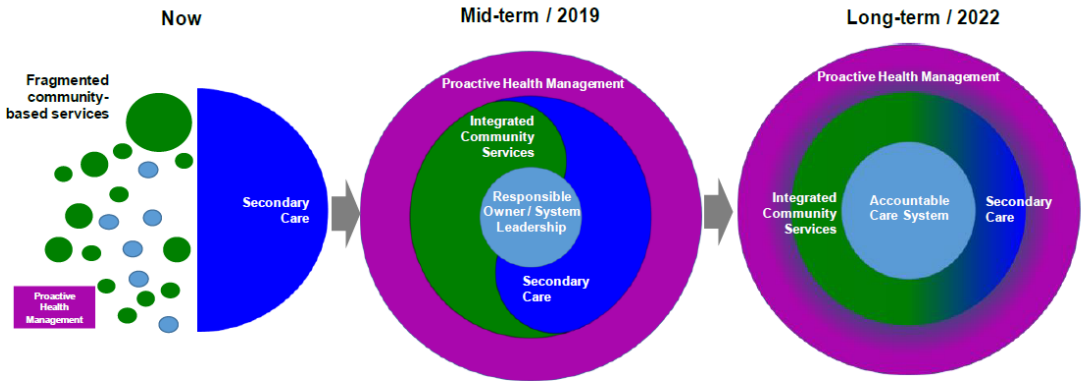
4.2.6 Supporting the strategic vision of STP and the delivery of Healthy Weston vision

A key strand of the UH Bristol strategy is that; '*We will provide leadership to the networks we are part of, for the benefit of the region and the people we service'.* Closer collaboration with WAHT presents an opportunity for UH Bristol to demonstrate this leadership within BNSSG, making a clear statement that UH Bristol is not only an ambitious and outward looking organisation but is also prepared to step above its single organisational perspective to take a level of responsibility for the quality and sustainability of health services for patients not only in Bristol but across BNSSG.

This would not only reinforce UH Bristol position as a strong and influential partner within BNSSG and capitalise on the reputation gained to date as an outstanding organisation with a history of delivery but strategically, proceeding with the preferred option would also be a step on the journey for BNSSG towards the development of an Integrated Health and Care system, a key national and local priority.

The development of new and fully integrated care models is a key aim of the Healthy Weston programme. The figure below, taken from the document illustrates at a high level the proposed shift from fragmented services to a model of greater integration across secondary care, community and primary care and proactive health management and ultimately the development of an Integrated Health and Care system; (Ref 1, p33).

Figure 2: Development of an Integrated Health and Care system



5. Options Formulation and Appraisal

5.1 Options Appraisal Process

The aim of options appraisal is to identify the preferred option for the partnership model of acute care collaboration between UH Bristol and WAHT.

The assessment of options has been undertaken in the context of a significant number of reviews and business cases over the past 10 years (discussed in section 3 above) seeking to identify a package of reforms that can deliver a sustainable future for the services provided at Weston General Hospital and the more recent development of a vision for the BNSSG STP footprint.

These include the following key contextual reviews:

- 2012 - Proposals for an ICO
- 2014 - WAHT acquisition on an “As Is” basis and subsequent Taunton business case
- Late 2015 - North Somerset Programme for Sustainable Services
- April 2016 The Finnamore report - Meta-analysis of 9 previous reports
- 2016 - BNSSG STP

The STP long term vision describes aspirations to work towards an Integrated Health and Care system model, with support for incremental progress towards this vision through a number of horizontal integrations, such as three CCGs into single commissioner and acute care collaboration models.

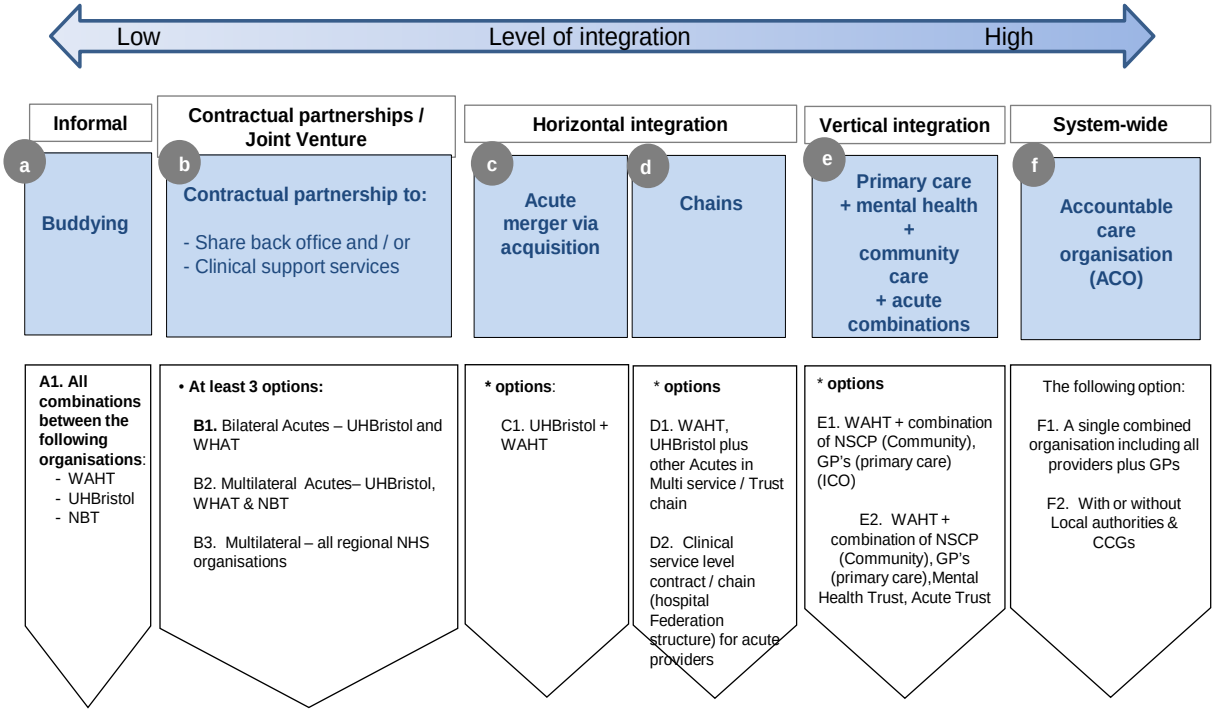
The case for change set out above in section 4, describes the imperative for action at pace to prevent further deterioration in sustainability of services at WAHT that in turn, would impact on the integrity and performance of the wider acute system. This context supports identification and assessment of the long list of options below.

5.2 Long list formulation and options appraisal process

During the development of the strategic outline case, a long list of options were identified as a possible means to addressing the objectives and challenges of the local health economy referred to in section 1 and 2. The Dalton Review (Ref 7*)* also informed the possible range of options for organisational form changes across the local health economy.

Figure 3 below sets out the long list of options considered by type and level of integration.

Figure 3: Long list options by type and level of integration



Given the scale of the clinical and financial challenges in our local health economy, successive reviews agree that significant transformational change is required to address the system wide financial challenges and improve the pattern and provision of care for the population of North Somerset.

5.2.1 The long list: inclusions and exclusions

The long list has appraised a wide range of possible options. Each of these options was considered against their ability to address the factors of **pace and deliverability**, and with reference to the previous reconfiguration context and future STP intentions.

The table below summarises the inclusions, exclusions and possible option (s) for next stage:

Table 3: Summary of long list findings by type, model and option

Type	Models	Options	Long list finding
Informal	**A. Buddying**	A1. All combinations between the following organisations: - WAHT - UH Bristol - NBT	A1. Discounted – because considered inadequate to achieve pace and deliverability required i.e. attempts to improve sustainability through an "informal partnership" approach, with the aim of joint appointments or ad hoc mutual aid to shore up rotas have not delivered sufficient impact to enable a sustainable and robust staffing model in some specialities.
Contractual Partnership / joint venture	**B. Contractual partnerships**	**B1.** Bilateral Acutes – UHBristol and WAHT B2. Multilateral	**B1 Possible –to support either a clinical and / or corporate shared service model or a one Board, two organisation model**

Type	Models	Options	Long list finding
		Acutes– UH Bristol, WAHT & NBT B3. Multilateral – all regional NHS organisations	B2 and B3 – Discounted at this stage because inadequate to achieve pace and deliverability required. Increased acute hospital collaboration across the region is active as are other forms of closer organisational collaboration under the STP process. These are considered medium to long term options.
Horizontal integration	**C** **Acute merger via acquisition**	C1. UH Bristol + WAHT	**C1 Possible – because has the potential to achieve pace and deliverability required**
Horizontal integration	**D.** **Hospital Chains**	D1. WAHT, UH Bristol plus other Acutes in Multi service / Trust chain D2. Clinical service level contract / chain (hospital Federation structure) for acute providers	D1& D2. – Discounted at this stage because inadequate to achieve pace and deliverability required. Increased acute hospital collaboration across the region is active as are other forms of closer organisational collaboration under the STP process. These are considered medium to long term options.
Vertical integration	**E.** **Integrated care Organisation models** **Primary care + mental health or community care + acute combination**	E1. WAHT + combination of NSCP (Community), GP's (primary care) (ICO) E2. WAHT + combination of NSCP (Community), GP's (primary care),Mental Health Trust, Acute Trust	E1 and E2 – Discounted at this stage because inadequate to achieve pace and deliverability required. Increased acute hospital collaboration across the region is active as are other forms of closer organisational collaboration under the STP process. These are considered medium to long term options. Further work to clarify the commissioning context and consult with the public on new models of care under the Healthy Weston programme will inform the added value from increased organisational integration vs integrated services delivery models that drive increased integration (vertical and horizontal) without organisational change
System wide	**Integrated Health and Care system**	F1. A single combined organisation including all providers plus GPs F2. With or without Local authorities & CCGs	F1 and F2 – Discounted at this stage because inadequate to achieve pace and deliverability required. Increased acute hospital collaboration across the region is active as are other forms of closer organisational collaboration under the STP process. These are considered medium to long term options. Further work required through the Healthy Weston programme to clarify the commissioning context and consult with the public on new models of care to drive increased integration (vertical and horizontal)

5.3 Short-listing: Critical success factors (CSF's) (financial and non-financial assessment criteria) formulation

The UH Bristol and WAHT Partnership Management Board approved the short list for options appraisal and associated critical success factors (CSF).

The critical success factors are based on UH Bristol business case appraisal criteria, adjusted to reflect the nature of the proposed business case. In addition, the adopted criteria take due notice of:

- The North Somerset Sustainability Programme success criteria
- A Guide to Investment Appraisal in the Public Sector - Extract from Capital Investment Manual and requirements of HM Treasury's Green Book 2015 (Ref 11)
- Taunton FBC 2014: Critical Success Factors for the acquisition
- NHS Improvement advice
- Learning from evaluation criteria used in range of other NHS transactions

These CSFs have been used to evaluate the short listed options.

Table 4: Critical Success Factors

1. Strategic Alignment - Must align to organisational priorities & BNSSG Sustainability and Transformation Plan
2. Deliverability and clinical sustainability - Must have scope to enable delivery of improvement and be acceptable to patients and stakeholders
3. Financial Sustainability - Must have the scope to live within its means on a recurrent basis
4. Affordability - Must be affordable, making the best use of public funds
5. Pace - The extent to which the option enables UH Bristol to effect significant change within a short timeframe to mitigate risk of further deterioration in service sustainability at WAHT impacting adversely on patients and the wider system

The evaluation was undertaken in accordance with how well each option met the critical success factors. The goal was to seek the option (s) that best balance the costs in relation to the benefits and risks.

5.3.1 Options Short List

The 'preferred' and 'possible' options identified above in long listing have been carried forward for further appraisal and evaluation. All the options that were discounted have been excluded at this stage. On the basis of this analysis, the recommended short list for further appraisal / business case development is as follows:

Table 5: Short list for further appraisal

Option	Option description	Categorisation	Via
1.	**Do nothing**	Partnership model	Interim Partnership Agreement (until. 31.03.18)
2.	**Shared services** • specific clinical services • Specific Corporate functions	Partnership model	Bi-lateral Contractual Partnership arrangement (medium term)
3.	**Two boards, one executive team and one "operational" organisation**	Single management model	Bi-lateral Contractual Partnership arrangement (medium term)
4.	**One merged organisation** (through Acquisition)	horizontal integration	Single organisation

5.3.2 Critical Success Factors

The Partnership Management Board agreed the following high level critical success factors, to be used to frame the options appraisal process:

Against the CSF's a number of sub areas and questions were developed to support the appraisal process:

Table 6: Critical Success Factors and sub areas

Critical Success Factors	Areas	Questions to consider
1. Strategic alignment - Must align to organisational priorities & BNSSG Sustainability and Transformation Plan (Quality)	1.1 Aligned with organisational strategy	1.1.1. Does the option align with the BNSSG STP key priorities and vision for future service model / Integrated health and care system?[1]
		1.1.2. Does the option align with the Trust's strategic priorities?
	1.2 Impact on organisational reputation	1.1.3. How will option impact on organisational reputation?
	1.3 Political acceptability	1.1.4. Assessment of attractiveness of the approach to the partners in a "local political sense"
2. Deliverability and clinical sustainability -Must have scope to enable delivery of improvement and be acceptable to patients and stakeholders	2.1 Impact on performance	2.1.1. To what extent does the option provide scope to address the current operational sustainability issues at WAHT and at minimum sustain performance at UH Bristol?
	2.2 Market and Demand	2.1.2. To what extent does the option meet commissioning plans?
		2.1.3. To what extent does the option impact on the relative market positions of both Trusts?
	2.3 Deliverability	2.1.4. How practical is it to implement? – (the organisation's ability to adapt, introduce, support and manage the

Critical Success Factors	Areas	Questions to consider
		required level of change, including the management of associated risks and the need for supporting skills)
		2.1.5. Will the proposed model be acceptable to clinical stakeholders?
	2.4 Access to Care	2.1.6. To what extent does the option impact upon timely access to services?
	2.5 Impact on Workforce	2.1.7. To what extent does the option impact positively upon recruitment and retention?
	2.6 Quality of Patient Care	2.1.8. To what extent does the option support deliver of high-quality patient care and address safety and quality concerns?
		2.1.9. To what extent does the option create the conditions to address regulatory risks?
		2.1.10. To what extent does the option create the conditions to achieve all key quality and safety targets, National Outcomes, Framework operational targets, NHS Constitution commitments, CQC Outcomes standards and appropriate National / Professional standards?
3. Financial Sustainability - Must have the scope to live within its means on a recurrent basis	3.1 Financially sustainable - recurrent expenditure within recurrent income	3.1.1. Continue high quality services within the financial envelope
		3.1.2. Ensure long term financial viability of any new provider forms
		3.1.3. Significant financial savings through synergies and better use of physical capacity
4. Affordability - Must be affordable, making the best use of public funds	4.1 Affordable - cost of the transaction, which may require capital expenditure and one-off revenue costs?	4.1.1. The cost of investment must not be excessive relative to the financial benefits
		4.1.2. The payback period should be reasonable
		4.1.3. Must consider what/whether central funding will be available within the Local health community
5. Pace - The extent to which the option enables UH Bristol to effect significant change within a short timeframe to mitigate risk of further deterioration in service sustainability at WAHT impacting adversely on patients and the wider system	5.1 Pace of implementation	5.1.1. The extent to which the option enables UH Bristol to effect significant change from a final decision to merge

5.3.3. Weighting

The Partnership Management Board agreed weightings for the assessment criteria, set out in the table below, with quality and finance equally weighted.

Table 7: Score Weighting

	Critical Success Factors (CSF's)	Weighting / 100
Quality	**Strategic Alignment**	10
Quality	**Deliverability and clinical sustainability**	20
Quality	**Pace**	20
		Quality – 50/100
Finance	**Affordability**	15
Finance	**Financial Sustainability**	35
		Finance - 50/100
		Total - 100/100

5.3.4. Scoring

Appraisers allocated up to 100 points to each of the 4 options based upon how well each meets the CSF's. Scores were collated and any significant variation between scorers was discussed and recorded. The weights and scores are then multiplied to provide a total average weighted score for each option. The options were then ranked in terms of meeting the appraisal CSF's and the preferred option is identified on the basis of the highest score.

Options were appraised by representatives from both Trusts.

5.3.5 Appraisal Group Membership

The Partnership Management Board agreed the weightings for the assessment criteria with quality and finance equally weighted. The Appraisal group membership was as follows:

- Executive Director Strategy & Transformation (UH Bristol)
- Executive Director of Strategic Development (WAHT)
- Medical Director (WAHT)
- Clinical Lead for Strategy and Productivity (UH Bristol)
- Associate Director of Strategy and Business Planning (UH Bristol)
- Associate Director of Finance (UH Bristol)

Observer: Head of Delivery & Improvement (NHSI) South West - South Region
Facilitator: Project Manager (UH Bristol)

5.3.6 Options appraisal exercise outcome

The outcome of the options appraisal exercise is summarised as follows:

Table 8: Summary Scoring Matrix

Scoring sheet (Options Appraisal) - 27th June SUMMARY Critical Success Factors (CSFs)	Maximum Score Possible for each question	Maximum Weighting possible for each question	Option 1 Do Nothing Av. Weighted score	Option 2 Shared Services Av. Weighted score	Option 3 1 Executive Av. Weighted score	Option 4 Merger Av. Weighted score
1. Strategic Alignment - Must align to organisational priorities & BNSSG Sustainability and Transformation Plan	100	10%	1.7	4.0	5.8	7.8
2. Deliverability and clinical sustainability -Must have scope to enable delivery of improvement and be acceptable to patients and stakeholders	100	20%	4.3	8.3	11.8	15.7
3. Financial Sustainability - Must have the scope to live within its means on a recurrent basis	100	35%	3.2	9.6	17.2	24.5
4. Affordability - Must be affordable, making the best use of public funds	100	15%	12.5	9.9	7.5	5.6
5. Pace - The extent to which the option enables UHBristol to effect significant change from 1st April 2018 to mitigate risk of further deterioration in service sustainability at WAHT impacting adversely on wider system	100	20%	2.2	6.7	11.5	16.3
TOTALS	**500**	**100%**	**23.9**	**38.5**	**53.8**	**70.0**
Final Ranking (where a rank of 1 most meets the CSF's)			**4**	**3**	**2**	**1**

The short listing exercise identified organisational merger via acquisition as the most likely option to achieve the required critical success factors. The following points were made by the members of the appraisal group in the closing session:

- The degree of option desirability increased in even steps from do nothing through to organisational merger.
- If this case proceeds to FBC, a fuller benefits and risks appraisal exercise will be required as this was not undertaken at SOC stage.
- The WAHT members of the appraisal group reported their satisfaction with the appraisal process and confirmed that they felt their voice was fully heard in the process.
- The NHSI representative confirmed agreement with and support for with the appraisal process and the disciplined way in which the exercise was undertaken.

6. Benefits and risks of the preferred option

6.1 Benefits and risks

This section sets out the benefits that the recommended option will bring to patients, staff, and the wider NHS; particularly through making services more sustainable and hence safer whilst continuing to offer local access.

It also considers the risks of closer collaboration through an organisational merger and the issues that will require further examination during the FBC stage to establish the robustness of mitigations.

A systematic appraisal of the relative expected benefits from each of the 4 shortlisted options has not been undertaken at this stage. More information on the preliminary analysis of financial benefits and risks can also be found in section 9 'Financial Plan'.

The prime benefits expected from the combined Trust option may be summarised as follows:

Table 9: Expected Strategic Benefits

	Strategic benefits
Operational	Providing a clinically and financially sustainable and viable platform for future services
Clinical	Providing a strengthened workforce with improved flexibility, recruitment and retention
Financial	Achieves economies of scale in corporate services, facilities, functional and clinical areas

6.2 Benefits

There are expected benefits to both Trusts of closer integration as set out in the table below:

Table 10: General Expected Benefits

Benefits	**WAHT**	**UH Bristol**
Critical mass – increasing the resilience of WAHT as an organisation through being part of a larger organisation	✓	
Recruitment and retention – providing a strengthened workforce with improved flexibility, recruitment and retention through maximising opportunity of UH Bristol's reputation and brand.	✓	
Pace and impact – the preferred option enables alignment of ways of working and benefit to changes to clinical models at pace, as part of a single organisation.	✓	✓
Clinical alignment and reduction in variation – Realising benefits of alignment of clinical services and opportunities to reduce variation, improve productivity and to reduce operational and quality risks currently associated with some services.	✓	✓
Addressing in a controlled manner the current known risks to the resilience of acute clinical services across Bristol and North	✓	✓

Benefits	WAHT	UH Bristol
Somerset.		
Enabling the wider health system to protect its future services for the benefits of patients, by **improving the financial sustainability of acute services** in North Somerset	✓	✓
Supporting staff to access a greater range of training and development, education, training and research opportunities across a wider organisation	✓	✓
Sharing learning across both organisations **to improve access to and quality** of clinical services for patients	✓	✓
Greater scope to **make best use of the combined available capacity and buildings** in order to deliver our service goals	✓	✓
Corporate synergies – realising efficiencies in shared corporate services	✓	✓

6.3 Benefits to Patients and Staff

The primary benefit to patients and staff will be addressing the operational, safety, quality and access issues highlighted in the recent CQC report. The main benefits of a WAHT organisational merger with UH Bristol are expected to be as follows:

Table 11: Expected Patient and Staff Benefits

Key Patient and Staff Benefits
Access to a range of local DGH services is retained, for the current and future population of North Somerset
Weston General Hospital has a sustainable future with the scope and opportunity for development of a range of services for patients
The quality and safety of services will improve through partnering with an outstanding teaching and research-oriented Trust
Variation in clinical care and outcomes for patients will be reduced through shared learning and application of best practice models

A key part of the FBC process will be to undertake benefits analysis in more detail to establish a robust benefits portfolio and benefits realisation plan and process.

In developing a FBC, learning will be taken from the evidence about mergers across healthcare organisations. This learning will be applied to support effective management of the risks to proceeding with the transaction. A summary of the most recent evidence is included in Appendix 9.

6.4 Risks and issues

This section discusses the key risks to delivering the preferred option; focussing upon how the identified risks will be managed as the organisations progress through the business case planning process, to implementation of the preferred option, including risks to delivering its stated benefits.

Section 10 describes in more detail the proposed programme approach to risk management.

6.5 Key risks to delivering the preferred option

The key risks that could present to delivering on the preferred option of organisational merger via acquisition are set out below:

Table 12: Key risks to delivering the preferred option

No.	Area	Key risks identified	Mitigations
1.	Financial	The organisational merger by acquisition is not financially viable and therefore compromises the UH Bristol Strategic and Operational Plan	To be assessed in detail through the FBC process.
2.	Regulatory	The Competition and Markets Authority (CMA) rules that there are significant competition and choice issues that require full review	Process to manage is set out in section 8.
3.	Project Management	Capacity to mobilise and deliver the required project outputs are not fully in place, supported by robust governance and a fully funded resource plan.	External support for resourcing an effective Programme Management Office (PMO) will be sought
4.	Workforce	The Staff consultation and TUPE transfer process timetable is not deliverable within the required timescale	Effective planning and dedicated resource within PMO to deliver process (see 11.3.3)
5.	Public Engagement	Public concern regarding an organisational merger proposal adversely affects the timetable and / or the preferred option	Effective communication and engagement plans developed and managed
6.	Operational	UH Bristol business as usual activities and performance are adversely affected by management attention turned to the acquisition project	Dedicated senior resources required within PMO. Regular assessment of impact by Trust Senior Team
7.	Operational	WAHT services deteriorate ahead of the planned transaction date, resulting in UH Bristol requirement to support services in an unplanned way with adverse impact on existing services	Partnership management Board (PMB) to identify emergent risks and take key actions across system partners to mitigate.
8.	Commissioning	the outcomes of the Healthy Weston commissioning process are not compatible with a viable transaction	- UH Bristol and WAHT providing lead roles within the HW process and ensuring

No.	Area	Key risks identified	Mitigations
			interdependencies between the overall population service model and the acute service model are identified. - External capacity commenced January 2018 under direction of PMB to develop and test viability of acute service model within HW context.

The controls and mitigations will be further developed as a priority during development of the FBC.

7. Joint Clinical Services Strategy

7.1 Introduction

This section outlines the current UH Bristol and WAHT Clinical Strategies, highlighting the alignment and compatibility of the current approaches of the two organisations. It also provides an outline of the emerging approach to developing a joint clinical services strategy.

The current UH Bristol and WAHT partnership arrangement has identified that there is clear scope for the partnership to optimise and standardise clinically driven pathways around the patient and reduce clinical variation. Whilst work to develop some areas of collaborative clinical pathways is being undertaken within the BNSSG STP, there are a number of local priority areas of work where the degree of risk to resilience of services merit solutions being developed at pace between WAHT and UH Bristol.

7.2 Current Alignment in Clinical Strategies

There is alignment between the existing clinical strategies at WAHT and UH Bristol. The key priorities relating to clinical services outlined in both organisational strategies are outlined below.

Figure 4: WAHT Clinical Model

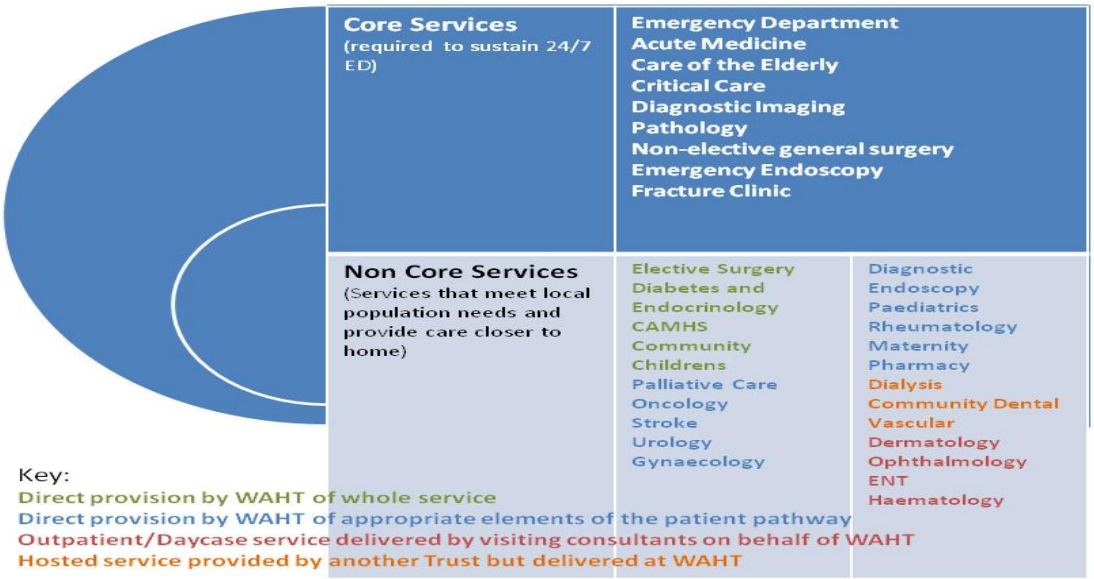


Figure 5: UH Bristol Clinical Model

Key Service Areas

- Children's Services
- Accident and Emergency (and Urgent Care)
- Older Peoples Care
- Cancer Services
- Cardiac Services
- Maternity Services
- Planned Care and Long Term Conditions
- Diagnostics and Therapies
- Critical Care

WAHT summarises the core clinical services at WAHT as those associated with the delivery of urgent care services for the local population. UH Bristol describes the delivery of a range of local and regional services, but also a clear strategic intent to continue to develop UH Bristol's specialist service portfolio. There are synergies between both organisations clinical strategies which could present opportunities in the development of future models of care. The preferred option outlined in this SOC presents the opportunity to accelerate the benefits of a combined clinical strategy.

7.3 The Development of a Future Vision for Clinical Services

The working principle through this SOC is that the clinical model developed as part of the proposed preferred option will be based on the commissioning intentions developing through the Healthy Weston Programme which states the ongoing need for a district general hospital for the population of North Somerset.

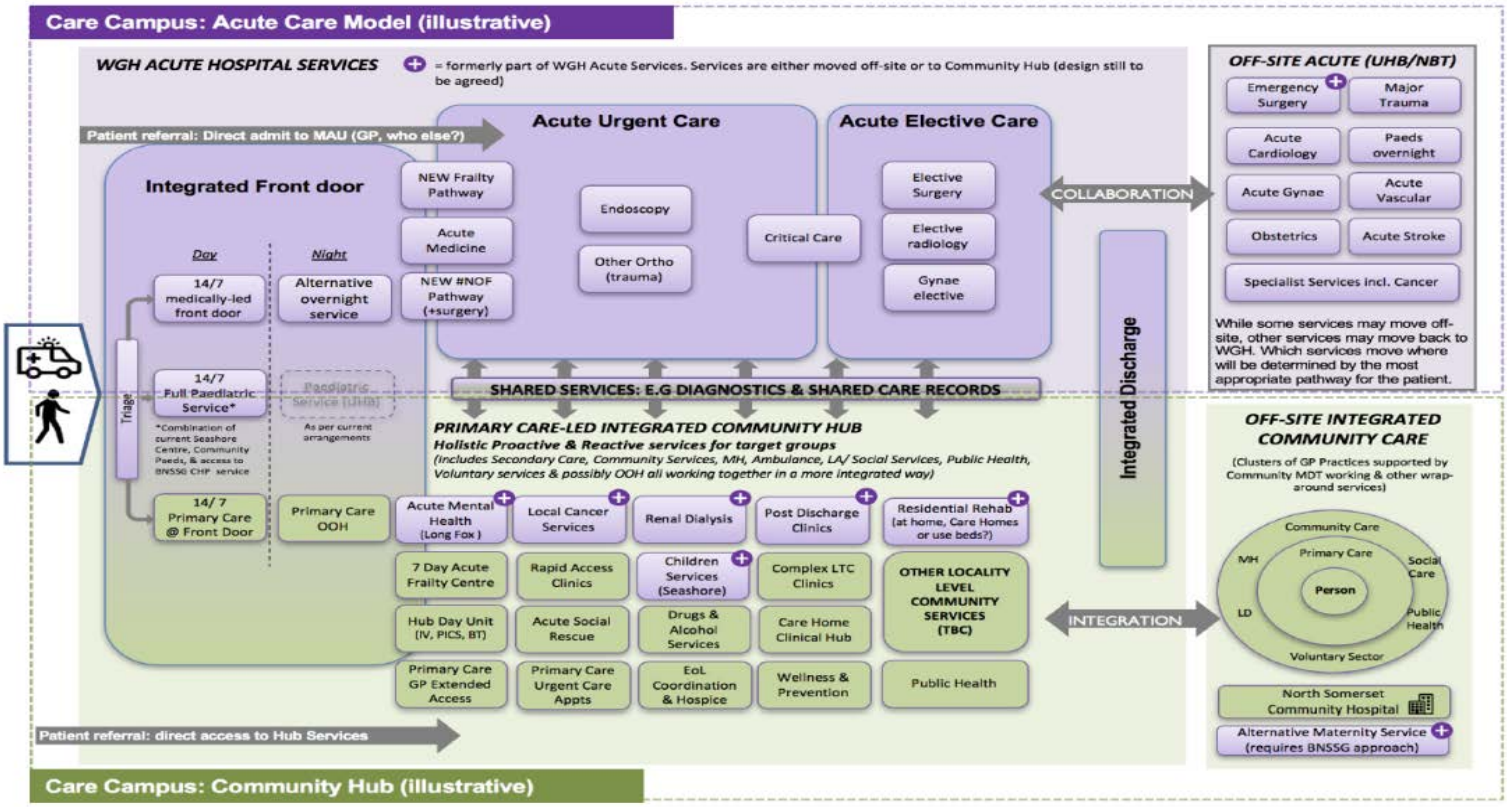
Prior to publication of the Healthy Weston commissioning context, the primary vehicle for the development of this clinical model had been through the North Somerset Sustainability Process, which also stated in its December 2016 Phase 2 report that, '*All stakeholders agree that Weston General Hospital forms a key part of the BNSSG system, and that it is essential it continues to provide a broad range of emergency and elective services to the local population'.*

The Healthy Weston programme is taking a more system wide approach to the future development of services for WAHT and the North Somerset population, building on the work completed within the North Somerset Sustainability Programme.

The proposal described through the Healthy Weston programme, is to move towards the delivery of care through an Integrated Care Campus model.

An illustration of how this could function is outlined in the Healthy Weston document (Ref 1, pg 39) and the work of the Healthy Weston programme is to establish the basis upon which this proposed high level model could effectively function to deliver the overall aims of the programme.

Figure 6: Care Campus: Acute Care Model



In order to implement this model successfully, the document describes how. '*WAHT needs to redefine the role of WGH within the BNSSG landscape and we must collectively take this opportunity to address long-standing issues of clinical and financial sustainability for a number of different services'* (Ref 1, p. 45).

The Healthy Weston commissioning context also establishes a set of key design principles for a new acute care model (outlined in full in Appendix 8). The core themes of these are integration in key areas such as urgent care and paediatrics and also with primary and community care, using the opportunities presented in Weston to develop centres of excellence in areas such as frailty and elective care and greater and more effective collaboration across Acute Trusts.

The organisational alignment between UH Bristol and WAHT would clearly provide a platform to accelerate the successful integration of clinical services and partnership models to deliver this vision. More detailed work is however required to assess the level of service change and the associated impact on clinical sustainability and financial viability that this model could bring.

This transformation work involved may present direct opportunities for UH Bristol, not only to support the development and delivery of high quality and sustainable services at WAHT, but also to develop innovative models from which learning can be translated back to UH Bristol, for the benefit of the organisation and Bristol patients.

Full delivery of a vision for WAHT services to create a fully sustainable model is clearly a longer term piece of work, which will develop over the next three to five years. The next step is for the Healthy Weston process to conclude the detailed analysis of the options for future services to inform the development of a pre-consultation business case to be progressed by the BNSSG CCGs. The output from this process will inform the basis upon which any final recommendation, through a Full Business Case (FBC), to move to acquisition would be made.

8. Competition considerations

8.1 Competition

Mergers can benefit patients by helping providers improve the efficiency and quality of their services. At the same time, choice and competition also have an important role in encouraging providers to deliver better services. The merger review process allows for both the competition effects and the benefits of mergers to be taken into account in order to determine what is in the overall best interests of patients. NHSI and the CMA work together to ensure that the interests of patients are always at the heart of the merger review process.

8.2 NHS Improvement's role with regard to Competition

NHS Improvement's role is to provide expert advice and guidance on the regulatory framework governing transactions in the NHS; and assess merger benefits and provide expert advice on benefits to the CMA. NHS Improvement would be the regulator of any merged UH Bristol - WAHT organisation.

8.3 Competition and Markets Authority (CMA)

The CMA is the UK's primary competition and consumer authority. It is an "independent non-ministerial government department with responsibility for carrying out investigations into mergers, markets and the regulated industries and enforcing competition and consumer law."

8.4 The Process

There are three phases to the CMA evaluation:

- **Pre-notification,**
- **Phase 1,**
- **Phase 2** (only needed if the evidence supplied at phase 1 is not sufficient to eliminate any competition concerns).

8.4.1 Pre-notification has no time limit but is an opportunity to liaise informally with regulators and the CMA to provide data analysis, mitigating factors and patient benefits that are considered what their data analysis may suggest is an area of concern. It is a two way dialogue that is an opportunity to prepare sufficiently well that a phase 2 referral is not required.

Once a merger has been formally notified to the CMA by NHSI, the review process is as follows:

8.4.2 Phase 1: (Lasts up to 40 working days). As part of a phase 1 review, the CMA must decide whether there is a realistic prospect that the merger will result in a substantial lessening of competition and have an adverse effect on patients and/or commissioners by significantly reducing their choice of provider, and consider NHSI's expert advice on the benefits of the merger.

If the CMA believes that the merger will not result in a realistic prospect of a substantial lessening of competition, or if the benefits of the merger outweigh any lessening of

competition, it will not refer the merger for a Phase 2 review and that would conclude the CMA's review of the merger.

If a merger is not cleared at Phase 1, the review progresses to Phase 2.

8.4.3 Phase 2: (Limited to 24 weeks). In Phase 2, the CMA conducts a detailed assessment and must decide whether the merger is reviewable and whether it is expected to result in a substantial lessening of competition.

As part of their process to understand if competition issues exist with collaborative working, the CMA will undertake a service by service analysis of emergency and elective work and where GP's refer patients to.

8.5 Data Analysis

Work has already commenced with NHS Improvement's Competition and Co-operation Department, which has been acting as an advisor to the collaboration project to help understand the likely level of interest from CMA in the proposed organisational merger.

The CMA will consider as part of pre-notification and phase 1, whether the merger reduces patient choice and competition. Should it be necessary, there will be an opportunity to provide evidence to the CMA to support the case in terms of patient benefits of the proposed organisational merger, and measures that we might put in place to ensure that patients would not be disadvantaged by a reduction in choice.

The NHSI (Competitions and Markets Team) have undertaken an economic analysis based upon the CMA's methodology for identifying potentially problematic overlaps. This establishes a case for whether or not the proposed transaction meets the CMA thresholds for formal stage 1 review.

The Trust has received the NHSI (CMA team) report for review and approval. This will then be sent to the CMA for their consideration and next steps agreed.

8.6 Competition - next steps

If the CMA conclude that proposed transaction does not require a stage 1 review, then no further action is required.

Should the CMA identify the requirement for a stage 1 submission, then the NHSI economic analysis report will form part of this submission, together with a detailed analysis of the benefits case. Typically it can take 4 – 6 weeks to prepare the detailed submission and then a further 40 working days for the CMA to complete their stage 1 review.

If a Phase 2 review should subsequently be required, this will have a significant impact on the transaction and implementation timetable (up to 24 week process). An FBC decision cannot be ratified without CMA approval.

9. Financial Appraisal and Resources Plan

9.1 Introduction

The Financial Appraisal section of the SOC outlines the current and historic financial performance of WAHT and looks at its future financial prospects going forward five years as a standalone entity. It also describes the key drivers behind the track record of financial deficits at WAHT and provides an early assessment of the extent to which these could be mitigated under the preferred option. The financial case also outlines the financial track record of UH Bristol and provides an assessment of UH Bristol's financial position going forward taking into consideration the potential net financial benefits of a merger through acquisition and the effect on the viability of a combined organisation.

To support assessment of the case for merger at this stage, all of the analysis is based on 2018/19 as an indicative base year for a merged organisation (year one). The analysis is also based on an "as is" service model at WAHT, resulting in identification of the requirement for financial support to ensure that the financial performance and financial standing of the combined organisation is not unduly diluted and that the combined organisation has the ability to be financially viable and deliver the assessed benefits.

The financial appraisal is described in detail in Appendix 5. It should be noted that this was based on information available earlier in the 2017/18 financial year. The comprehensive appraisal to be completed on a future acute service model within the Healthy Weston programme will update this assessment and include a comprehensive productivity review. This will be used in the FBC financial case.

In summary, the financial appraisal at this stage describes a structural net deficit, after initial assessed mitigations, of £9.7 million at WAHT due to the provision of a Type 1 Emergency Department and the full suite of DGH services operating from a relatively remote location twenty-five miles from Bristol and Taunton. There is little likelihood of this requirement being affordable going forward within the context of a significant current overspend by the CCG for the North Somerset population (Ref 1). The FBC will further assess the impact and potential mitigation of the need for such support resulting from the development of a new acute service model developed within the Healthy Weston process.

In addition, the financial appraisal identifies that a viable merger proposition would require a non-recurrent public dividend cash (PDC) injection of £32.4 million to address WAHT's historic debt, alongside a PDC capital investment of £7 million in year one of a combined organisation, to replace and integrate WAHT's and UH Bristol's wider information technology. A requirement for £5 million non-recurrent investment to secure the resources needed to effectively deliver a combined organisation and ensure a successful transition is also identified.

The need for and level of financial support will be reassessed in the FBC.

10. Execution Plan

10.1 Introduction

It is important that the ability of both organisations to effectively take forward the preferred option is demonstrated. This section sets out plans to ensure that sufficient resources and management structures are in place to achieve this and produce a full business case which will set out the detailed arrangements required to successfully deliver the organisational merger through acquisition.

A summary of the high level milestone plan for the transaction execution period is included below. A detailed implementation blueprint and plan will be developed during the FBC phase and will set out what will be delivered through this programme structure.

The following section also sets out in high level terms a proposed governance structure post-merger and what the focus would be for day 1 of the merged organisation. A priority activity following approval of the SOC will be to work up the post transaction implementation plan (PTIP) in detail. This will include key milestones, interdependencies and risks to the smooth transition to a new organisation from day 1. It will also focus on realising the clinical and non-clinical benefits through improvement plans for year 1, alongside a clear implementation plan for how services would be developed and changed over time in line with the commissioning decisions made within the Healthy Weston programme and following commissioner-led consultation, if required. Investment in these activities has been evidenced to be critical to the success of merger acquisitions nationally.

A key priority of the process must be the safe integration of operational services across both sites. In addition the Trust needs to ensure that performance is monitored as part of the benefits realisation strategy through the transition and integration period.

High quality communication and engagement with staff, patients and the public will be fundamental throughout the implementation of the transaction. A developed communications and engagement plan will be in place to shape with staff the new organisation's brand and to develop joint and consistent staff ownership of culture and values. This is addressed in section 11.

10.2 Programme Management and Governance arrangements

10.2.1 Programme management

The process to manage the organisational merger will become an integral part of the UH Bristol transformation programme, which comprises a portfolio of projects for the delivery of the Trust's strategic priorities.

10.2.2 Programme management arrangements

Developing a FBC (phase 2) will require a dedicated project team supplemented with significant additional dedicated resource to deliver the more detailed outputs required. For example, there will need to be significant focus on staff and public engagement, and an implementation plan developed to cover each and every corporate and clinical service across both organisations, together with work to ensure that the necessary assurance is in place to support regulatory review and approval at each stage. Feedback from other similar NHS transactions is that it is imperative that there is dedicated project / programme management and implementation planning resource to support this work.

It is proposed therefore that a dedicated Programme Management Office (PMO) is established, accountable to a newly formed Transition Programme Board to coordinate and track each work stream's progress. Prince 2 methodology will primarily be used.

Links to other programmes of work that impact upon this proposed organisational merger will be established, with formal memorandum of understanding (MoU) developed where required to provide clarity of role, purpose and areas of collaboration, and to ensure alignment in goals and vision.

10.2.3 Programme plan and implementation timeline

The following table presents the key stages and milestones within a transaction execution plan and reflects NHS Improvement *Transactions Guidance for Trust's undertaking transactions, including mergers and acquisitions*. Specific timescales will be set following Board approval of the SOC and subsequent consideration of the outcome from the comprehensive appraisal of the future model of acute care within the context of the 'Healthy Weston' programme and vision.

Table 34: Draft Project Plan and Milestones

DRAFT PROJECT PLAN
Phase 1 - Following SOC approval
NHSI SOC Review process
Regional NHS Improvement team reviews SOC and provides formal feedback
Comprehensive appraisal of the future model of acute care within the context of the *'Healthy Weston'* programme and vision
MILESTONE REVIEW – proceed to FBC
Phase 2 - Full business Case
Phase 2 project team resources assembled
Full Business Case (FBC) production process
Full Due diligence undertaken by UH Bristol
FBC brought forward for approval by WAHT and UH Bristol Trust Boards
Regulatory approval process (post FBC approval)
FBC approved by WAHT and UH Bristol Trust Boards
NHS Improvement - transaction assurance process
Board to Board Meeting with NHSI to discuss transaction risk rating
NHS Improvement issue a Transaction Risk Rating
Both Trust boards confirm the acquisition is to proceed
UH Bristol Board of Governors formal vote and approval of transaction application
Joint application is made to NHSI and Secretary of State (SoS) containing application and outcome of Governors vote
Secretary of State approves the transaction (letter)
NHSI issues Statutory Order allowing organisational merger by acquisition
Workforce (TUPE transfer process)
TUPE Transfer process
Consultation period (staff and staff side representatives)

DRAFT PROJECT PLAN
Notice of transfer (letter to WAHT staff confirming transfer of employment from WAHT to UH Bristol)
WAHT staff transfer employment
CMA indicative timeline
NHSI Report and Analysis sent to the CMA for review
CMA holds meeting with UH Bristol to discuss findings and provides a steer on requirement or not for stage 1 submission
If stage 1 submission required then:
Preliminary case prepared by UH Bristol with NHSI (4 – 6 week process depending upon resources)
Stage 1 submission made to CMA (40 working day process once accepted by CMA)
If stage 2 submission required, the above timescales will require to be extended
Stage 2 case prepared by UH Bristol with NHSI (4 – 6 week process depending upon resources)
Stage 2 submission made to CMA (up to 120 working days process once accepted by CMA)

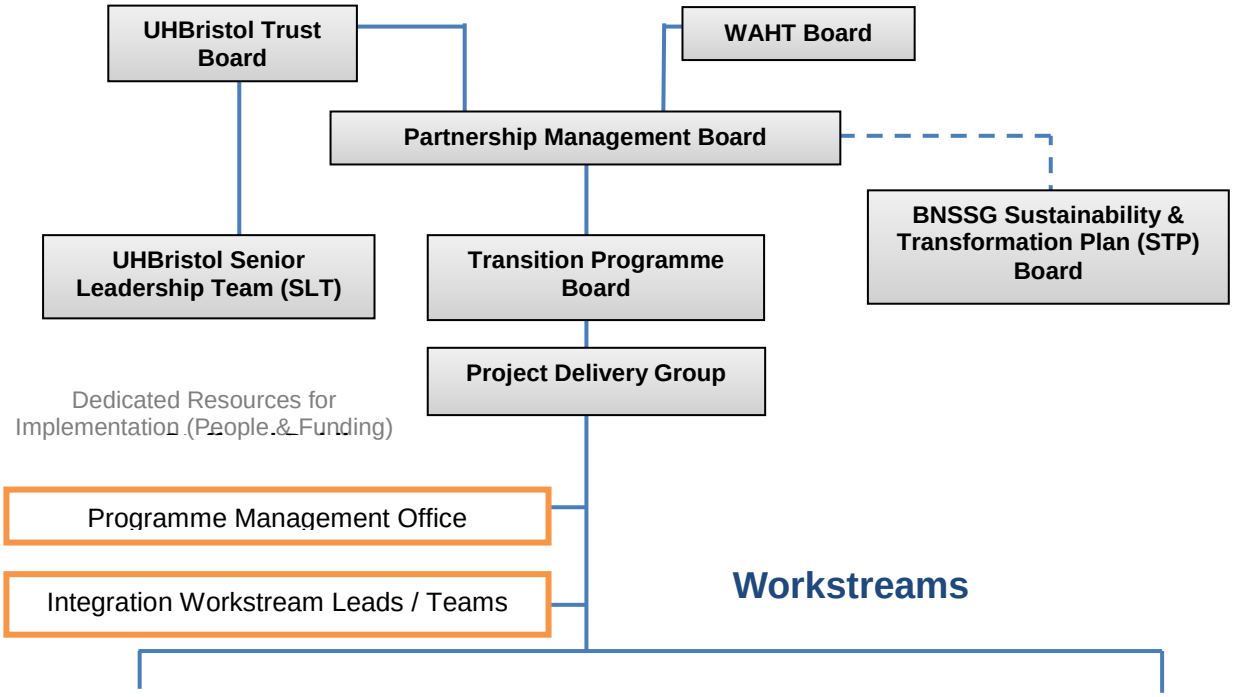
10.2.4 Transition Programme Board

The current Weston Partnership Steering Group will be replaced with a Transition Programme Board with overall responsibility for delivery of the programme's desired outcomes. The following diagram sets out the reporting arrangements:

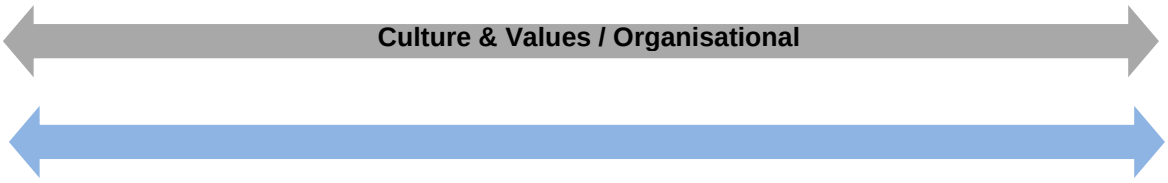
10.2.5 Programme reporting structure

The reporting organisation and the reporting structure for the programme are as follows:

Figure 7: Programme Reporting Structure

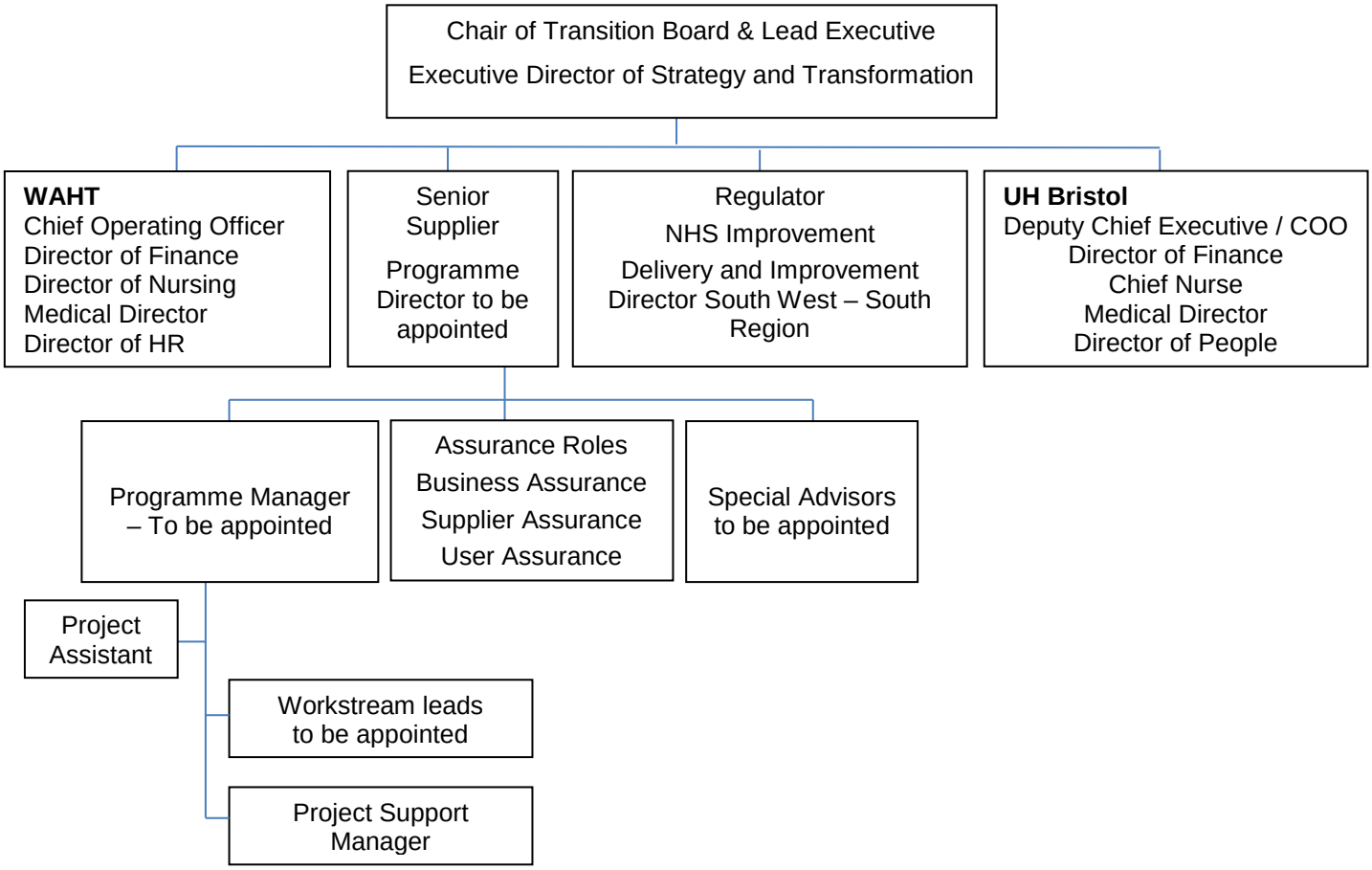


Procurement and contracting	Competition considerations	Finance and commissioning	Corporate governance	Corporate support services	Communications	Clinical integration and new models of care	Clinical quality and operations	Workforce and engagement	Information Management and Technology
Additional capacity/ expertise, due diligence, assurance. • Financial models • FBC • Quality • Governance • Legal • Commercial/ contracts	Patient benefits case and Phase 1 sign off if required.	• Long term financial models • Implementation and transition costs. • Reporting • Budget integration. • Standardisation of processes and systems • Assets and liabilities • Contracting arrangements	• Driving new membership • Board appointment and development • Legal advice • Heads of Terms • Business transfer agreement	• IM&T • Estates • Procurement • Finance • HR	• Staff Communications • Stakeholder mapping • Public communications • Rebranding • Social media	• Clinical vision • New models of care • Service integration • Integration of clinical teams	• Quality performance plan • Performance management arrangements • External reporting • Operational amalgamation of services. • Operational standardisation of processes • Risk management	• TUPE arrangement • Consultations and workforce changes. • Risk registers. • External reporting. • Staff Side • Staff Engagement.	• Integration of administrative systems. • Integration of clinical systems • Coding and recording processes • IM&T strategy • Joint functionality • Align corporate systems and access



All reviews of successful acquisitions identify the skills and expertise of the programme team as critical for transaction success. The indicative Transition Board and supporting PMO lead roles are outlined below:

Figure 8: Transition Board responsibilities



10.2.6 Workstream arrangements

A workstream approach will be taken to support the delivery of the FBC and process to acquisition. It will also be critical to driving achievement of the expected benefits for patients and staff and translating the change to a new organisation into the future new business as usual.

The work programme for each workstream will be determined by the key deliverables within the project plan. The work programme will be specified in detailed work packages. Each workstream will have a nominated chair who will have dedicated time for leadership and management activities. In consultation with the Programme Director and Programme Manager, the workstream chair will assemble the team required to deliver the workstream programme. This will be a combination of in house staff and external advisors. The workstream chair will be a member of the Delivery Group and will be accountable to the Programme Director for delivery.

Within the first 100 days following the transaction, the Trust will need to ensure delivery against key aims of the transaction and to ensure staff are fully engaged with the process, as well as ensuring clinical services continue to be delivered effectively.

The following workstreams will be established and the priorities for day 1, month 1 and first 100 days will be clearly established for each as part of the FBC.

- Procurement and contracting
- Competition considerations

- Finance and commissioning
- Corporate governance
- Corporate support services
- Communications
- Clinical integration and new models of care
- Clinical quality and operations
- Workforce and engagement
- IM&T

10.2.7 Resource Plan

The Financial appraisal section sets out the financial envelope for the expected transaction costs of an organisational merger. This includes costs of special advisors, legal and other advisory fees.

The Trust believes that the project has the best chance of success, and uses public funds most efficiently, if programme resources are predominantly drawn from within the current UH Bristol and WAHT staffing capacity and expertise. This approach will require posts to be backfilled to release staff from business as usual duties and additional in house project management training.

The risk of adverse impact upon business-as-usual activities is considerable and is assessed within the benefits and risks section.

10.2.8 Use of special advisers

In phase 1, the Trust has used in house resources (except for an interim project manager) and not special advisors to prepare the strategic outline case and interim due diligence.

External project consultation and advice has been provided by NHSI. This consists of advice on transactions, mergers and the acquisition process, together with regulatory requirements. The NHSI Competition and Markets team has also provided advice and guidance on the requirements to submit a stage 1 CMA review.

The requirement for external special advisors is stated in the NHSI guidance on mergers and acquisitions, and the resource requirement has formed part of the Trust's financial case for non-recurrent financial support.

Special advisers will be appointed and used in a timely and cost-effective manner in accordance with the Treasury Guidance: 'Use of Special Advisers' (Ref 11).

A full resource plan is being developed and will reflect this requirement.

10.3 Outline arrangements for change and contract management

A procurement and contract workstream will be established which will be responsible for all contractual and procurement aspects of the transaction. This workstream will be supported by specialist acquisition and merger legal advisors.

Following a decision to proceed to FBC, the current Interim Partnership Agreement will be updated and a Transition Board will be established in line with the project requirements for acquisition. The timing for the Transition Board and PMO will be dependent on the

identification of appropriate resources and associated funding being secured, as well as the timeline for commissioning decisions to be progressed within the HW programme. These two factors are key milestones in the transaction critical path.

10.4 Outline arrangements for benefits realisation

The expected high level benefits of the proposed organisational merger by acquisition were set out earlier in the case (section 6).

In order to ensure a clear focus on realising these benefits, a benefits realisation strategy will be developed through the FBC phase to form a central part of the overall integration plan.

The costs of realising the benefits will be assessed as part of the implementation planning process and built into the FBC submission.

As implementation proceeds, the forecast benefits will be cross-referenced with work stream project plans, risk management plans and the corporate vision and objectives to which each benefit relates.

The potential benefits will be identified and quantified using the following processes:

- Development of SOC identified benefits,
- Discussion through the work streams, with Transition Board oversight,
- Work with members of the programme management team and external advisers,
- Undertaking a benefit and metric identification and mapping exercise.

The benefits realisation plan will sit under the benefits strategy and will contain:

- A schedule detailing when each benefit or group of benefits will be realised,
- The identification of appropriate milestones when a programme benefit review could be undertaken,
- The details of any handover activities, beyond the mere implementation of a deliverable or output, to sustain the process of benefits realisation after the programme is closed.

The benefits realisation plan will be used to track the delivery of benefits across the programme. It will be owned initially by the PMO but over time it is intended to integrate this into the routine business management processes of the combined Trust.

10.5 Outline arrangements for risk management

The risks to achieving a preferred option for collaboration that is jointly agreed by both Trust Boards have been identified, documented, and tracked throughout the development of the SOC. These risks and mitigations have been reviewed by the Partnership Management Board.

The identified risks to delivering the preferred option, and realising the stated benefits were covered in the Benefits and Risks (section 6).

Risk assessment is a fundamental management tool and forms part of the governance and decision making process at all levels of this organisation. The risk register is a risk management tool whereby identified risks are described, scored, controls identified, mitigating actions planned and a narrative review is recorded.

The identification and accurate reporting of risks is embedded into the UH Bristol staff culture at all levels, along with an understanding that risks reported will be acted upon appropriately by those in more senior positions. This will be vital throughout any collaborative work, in order to ensure day to day performance on quality, finance and operational performance does not slip, and in order to support the integration processes of merging the two organisations.

Following approval, the programme will continue to adopt sound and tested risk management processes based on both Trusts' risk management policies to allow the Transition Board to understand the programme risks and put in place mitigation measures to manage those risks.

10.6 Quality assurance

Quality assurance and control are key disciplines of successful projects. For this project, details of quality assurance control will be included in each group of tasks leading to a completed element of the project or work package. Aspects of quality will be assessed using the following approaches:

- Peer review,
- Internal audit assessment,
- Board approval,
- OGC Gateway Review.

10.7 Outline arrangements for post project evaluation

During the FBC phase, arrangements will be established for post implementation review (PIR) and project evaluation reviews (PER) in accordance with best practice.

10.8 Post Transaction Implementation Plan (PTIP)

The PTIP is a key document alongside the FBC that sets out details of the post-transaction organisation after it has completed all activities necessary for consolidation. It is also a document that is scrutinised as part of the NHSI assurance and risk rating process post FBC approval for all significant transactions.

The intention is to develop outline integration plans which will account for the Organisational Development, staff consultation and cultural aspects of the organisational change, as well as the technical. These will be developed and driven via the workstreams identified above.

The learning from the case studies undertaken in the Aldwych Partners Report (Ref 13), regarding the importance of post-merger planning and clinical involvement and leadership of these plans will be used to support this process ensuring an early focus on delivering a single organisational culture.

10.9 Governance of the Merged Organisation

Initial plans for the new organisation governance below Board level have been considered but require development within an FBC.

With regard to Clinical Services, during the initial post-merger stabilisation period and to ensure effective management of risk, WAHT clinical services would be operated in a similar way as a Division of UH Bristol led on site by a Divisional Director and Clinical Chair, supported by a Head of Nursing, HR and Finance Partner.

This Divisional team would be supported by a dedicated Transition Team whose responsibility it would be to lead on delivery of the transformation programme.

With regard to the Corporate and Support Services of both organisations, these could be integrated from day 1. This is considered practicable and enables the early delivery of shared services benefits.

The detailed planning for the successful organisational merger will ensure clear accountability for the delivery of the business as usual activity in the interim. An accountability and responsibility matrix will be developed to provide organisational and individual role certainty.

The Resources plan being developed includes the staffing requirement for the year 1 post-merger stabilisation period.

In general, achieving a successful organisational merger and a stable financial and operational future requires early and detailed planning. The actions required to achieve a smooth transition to the new organisation on Day 1 must be clear, in order to have effective control of the combined organisation, and become a fully integrated organisation as quickly as possible.

Underpinning all implementation plans will be an emphasis on developing a single, consolidated, centralised structure and a single set of systems, processes and policies. The development of the PTIP will be done in an inclusive manner that ensures that all workstream leads own and deliver these plans as part of their day-to-day activities.

Performance across all domains during the organisational merger must be sustained, so there needs to be an early focus on developing a shared understanding of the performance and activity at service line level. Identifying and addressing differences in organisational culture will also be key component. An early focus will also be developing a comprehensive organisational development approach as part of the pre-merger process.

This is further addressed in the section below.

11. Communication and Engagement

11.1 Introduction

This section considers the communication and engagement strategy and approach that will be undertaken during the next phase of the project (full business case development and work through to organisational merger).

This section considers:

- Communications,
- Staff Engagement,
- Stakeholder Engagement and Involvement.

11.2 Communications Strategy Aims and Objectives

The Joint Partnership Management board approved the Communications Strategic Aims and Objectives, as part of the communications and engagement plan. These are summarised as follows:

11.2.1 The aim of Strategic communications

To provide communications and engagement support to all identified audiences on behalf of the programme in its development of the potential merger that:

- Builds understanding and support for change and closer working between the two Trusts for the benefit of patients,
- Builds confidence in plans for more closer working between the two Trusts,
- Supports the development of a common vision, values and culture for closer working,
- Enables staff of both organisations to shape and become advocates of the closer working or new organisation,
- Maintains and improves the reputation of UH Bristol, WAHT and ultimately, the new organisation.

In order to achieve this, communications and engagement will:

- Provide open, robust and effective communication and engagement,
- Ensure communication and engagement from both Trusts is joined up, consistent, credible, timely and well co-ordinated,
- Be sufficiently resourced and deliverable, using existing channels whenever possible; ensuring value for money and appropriate use of public funds at all times,
- Ensure communication on potential organisational merger, Healthy Weston and the Sustainability and Transformation Partnership external stakeholder processes are aligned,
- Support formal consultation with staff on any changes that may affect them as required.

11.2.2 Communications and engagement – governance arrangements

A communications and engagement work stream will be established to oversee the development of the strategy set out above and ensure it delivers against the timelines and key milestones. This group will also oversee coordination of plans with the wider health economy and will include leads from the following organisations:

- UH Bristol,
- WAHT,
- Bristol, North Somerset and South Gloucestershire CCGs,
- North Bristol NHS Trust,
- NHS Improvement,
- Healthier Together [formerly STP].

To ensure coordination of plans with the wider health economy, links would be established with leads from the following organisations through the existing STP infrastructure:

- Taunton and Somerset NHS Foundation Trust,
- South Western Ambulance Service,
- Bristol Community Health,
- Avon and Wiltshire Mental Health Partnership,
- Bristol City Council,
- North Somerset Council,
- NHS England.

11.2.3 Communications and Engagement Approach

The approach for communications and engagement to support this project will use milestones within the project to differentiate specific phases of communications and engagement activity.

To support every phase of work there will be a detailed communications and engagement plan that sets out what needs to be achieved during that phase of the project, the key messages, methods of communication and engagement, and the activity that will be put in place. It will explain the context of this work and its relationship with other cross-organisational work such as the STP.

For each phase of work, stakeholder analysis will provide insight into which audiences need particular focus and the methods of communication and engagement that will be used. The plan to support each phase will include:

- Stakeholder analysis,
- Key messages,
- Methods of communication and engagement (including internal communication channels, methods of engagement, media relations, briefings etc.),
- Timetable of activity,
- Methods of evaluation.

The communications and engagement plan to support this work will address the communications and engagement needs of these audiences, putting in place appropriate communication and engagement opportunities and methods.

11.2.4 Key messages

Key messages for each phase of the project will be developed and will be set out in the communication and engagement plan. In each case they will:

- Set out how far the project has progressed, what has been done and what still needs to be done,
- Put the project in context by explaining its relationship to other relevant work, for example Healthy Weston
- Set out clearly the benefits of partnership working,
- Set out clearly the opportunities for engagement and involvement.

The communications and engagement plan for each phase of the project will consider tailoring the key messages for each audience, in line with the stakeholder analysis, where appropriate.

11.3 HR Strategy

11.3.1 Key Principles

The challenges inherent in enacting organisational change are fully appreciated by both organisations and in order to address these issues effectively the following principles will be adopted;

- All affected staff will be supported throughout the change process and will have the opportunity to seek clarity, responsibility and recognition for what they do.
- All affected staff will be fully consulted regarding changes however, the process will also be mindful of the need to move quickly to ensure we minimise disruption and uncertainty for staff and continue to deliver high quality services for patients
- All reasonable steps will be taken to minimise redundancies to ensure that key valuable skills and experience across staff groups are not lost to the organisations.
- Any process required to appoint to posts as a result of the merger will be fair and transparent and will seek to match individuals' skills and ability with available posts.
- All appointment and selection processes will be fair and transparent and will comply with equal opportunities best practice and legislation.
- A partnership approach will be taken with trade unions throughout the transition, which will involve views of Staff Side being considered and taken into account within the change process, as well as Staff Side representatives being kept informed and involved throughout.

11.3.2 Staff communication and engagement

The key communication objective is to involve stakeholders in the progress of the merger process, highlight the benefits to both Trusts, allay concerns from internal and external stakeholders and present a clear vision for the new organisation.

A key element of successfully integrating the two organisations will be the communication and engagement with staff across both organisations. It is particularly acknowledged that there has been a prolonged period of uncertainty and difficulty for staff and WAHT and there is need to gain the confidence of staff in the benefits of the merger in order to secure their engagement. It will also be important to secure the confidence of staff at UH Bristol that there are benefits to both organisations and in particular, that the stability and success of UH Bristol will not be compromised by the transition and conversely that working together as organisation, could present potential opportunity to improve services for patients of both Trusts.

A full communications and engagement approach will be developed to deliver the above and the importance of getting this right will not be underestimated, both in terms of the overall short and long term success of the programme and also on the individual staff involved.

One of the communications and engagement aims is to support the development of a common vision, values and culture for closer working between UH Bristol and WAHT that enables staff of both organisations to shape and become advocates of the benefits of working together.

11.3.3 Establishing the New Organisation through Transfer of Undertakings of Employment (TUPE)

When a new organisation is created, there is a requirement for communication and consultation to support a smooth Transfer of Undertakings (Protection of Employment) (TUPE) of WAHT staff.

The effect of the TUPE Regulations is to preserve the employment and terms and conditions of those employees who are transferred to a new employer when a transfer takes place.

Both employers will have a duty to inform and consult appropriate representatives of their employees who may be affected by the transfer, however, the engagement would be led by WAHT as the transferor and UH Bristol as the transferee.

To effect a smooth TUPE transfer of WAHT staff, both organisations will need to undergo a period of information exchange and meaningful consultation with both staff and trade unions, prior to an effective transfer date and in accordance with both the TUPE Regulations and internal policy requirements.

The stages of this process following a decision to proceed will include.

- A pre-consultation process including briefing meetings at WAHT with all staff groups.
- A formal consultation process over a minimum two month period, followed by consideration of the consultation feedback.
- Finalisation of the transfer proposal
  Providing transferring staff with three months' notice of transfer prior to the transfer date.

Prior to the consultation stage, a proposal document will be written detailing the transfer proposal, special measures and the transfer timetable. The proposal document will be consulted upon with both staff and representative Trade Unions at collective consultation

meetings. Feedback would be received and considered at the end of the consultation period. A final proposal document will then be prepared, approved through existing governance arrangements and published.

Full details of the transfer mechanism will be provided in the Full Business Case.

11.4 Outline public communication and engagement approach

UH Bristol has a strong patient centred culture and sees public engagement and involvement as essential in developing services for the communities it serves.

This section considers the communication and engagement approach that will be undertaken during the next phase of the project to Full Business Case including the principles which will underpin post-acquisition activities.

In summary, a public communication and engagement process will be developed and delivered which runs in parallel with developing plans by BNSSG CCGs to consult on clinical commissioning options within Healthy Weston.

From a technical perspective, Section 56A of the Health and Social Care Act 2012 provides for a Foundation Trust to acquire an NHS Trust or another Foundation Trust. It is a tried and tested and legally certain transaction route. There is no requirement in section 56A for a public consultation prior to undertaking the merger through acquisition. Notwithstanding, and central to our approach, is the recognition of the value of effective public engagement. From the outset, UH Bristol and WAHT will develop processes and take actions that establish and develop effective relationships with community stakeholders building a climate of shared value, trust and transparency that will define future interactions. This includes those required to fulfil statutory and regulatory duties, specifically the involvement of patients and the public, under section 242 (duty to involve) of the National Health Service Act 2006 (as amended by the Health and Social Care Act 2012).

UH Bristol and WAHT will work pro-actively with North Somerset Healthwatch to advise on the planning and delivery of public participation activities, including a focus on ensuring engagement with seldom heard groups and providing assurances that we are listening and responding to the views of patients, carers and stakeholders. This will integrate with the Healthy Weston communication and engagement processes which also targets the engagement of three priority population groups including Frail and Older People; Children, Young People and Pregnant Women; Vulnerable Groups (for example people with mental health needs, learning difficulties and those who struggle with drug and alcohol addiction).

UH Bristol and WAHT recognise the complexity of current developments in the local health economy and that parallel public participation exercises can be seen as duplication and result in confusion amongst the local community. We will work with partners to join up conversations and ensure that engagement activities and any subsequent consultation activities are co-ordinated. In addition we will establish and communicate clear objectives for public participation exercises ensuring a shared understanding of expectations.

Our commitment to best practice and to assisting stakeholders to participate fully in this and any future consultation and involvement processes will be achieved by adopting the

'Consultation Charter Principles' from the Consultation Institute (Ref 14). This will include applying consistent and appropriate methods of engagement with an emphasis on inclusive dialogue and consensus building. Activities may include:

- Targeted activities with patient interest groups though, for example "The For All Healthy Living Company",
- Healthwatch led meetings,
- Social media and on-line engagement activities,
- Public information events,
- Public meetings.

11.4.1 Resources and Budgets

We recognise that a commitment to public communication and engagement, subsequent consultations and other involvement activities requires resourcing.

An assessment of the resources required to undertake effective public communication and engagement will include:

- Anticipated cost for planning, delivering and evaluation activities. This may include commissioning third party organisations such as Healthwatch to undertake work and costs incurred for translation and interpreting,
- The anticipated capacity required in terms of people.

11.4.2 Stakeholder engagement Post-merger

Communications post-merger will remain key to the success of the project and so a detailed communications strategy, with similar focus on the stakeholders in previous phases, will need to be put in place during the immediate post-merger stages.

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4.	BNSSG Sustainability and Transformation Plan: October 2016 Submission	2.2
5.	CQC Inspection Report (WAHT), Care Quality Commission, June 2017	2.2
6.	Lord Carter Review, April 2014	3.1
7.	Dalton review: options for providers of NHS care, Department of Health, January 2015	3.1
8.	Rising to the challenge - our 2020 vision, UH Bristol	3.3.2.2
9.	North Somerset Programme for Sustainable Services, Phase 2, December 2016	4.1
10.	Next Steps for the Five Year Forward View, NHS England, March 2017	4.2.6
11.	Public Sector Business Cases - Using the Five Case Model -Green Book Supplementary Guidance, HM Treasury, 2015	5.3
12.	Foundation Trust and NHS Trust Mergers – 2010-2015, The Kings Fund,	6.5

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	September 2015	
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14.	https://www.consultationinstitute.org/ - 2010	11.3

Appendix 4: Glossary of Terms

Abbreviation	Full Title
A&E	Accident & Emergency
ACC	Acute Care Collaboration
AHP	Allied Health Professionals
BHOC	Bristol Haematology and Oncology Centre
BNSSG	Bristol North Somerset and South Gloucestershire
CQC	Care Quality Commission
CCG	Clinical Commissioning Group
CMA	Competition and Markets Authority
CSF	Critical Success Factors
DoH	Department of Health
DGH	District General Hospital
DD	Due Diligence
ED	Emergency Department
EPR	Electronic Patient Record
FBC	Full Business Case
ICO	Integrated Care Organisation
ITFF	Independent Trust Financing Facility
ITP	Invitation to Participate
KPI	Key Performance Indictors
LMCs	Last-minute cancelled operations
LOS	Length of Stay
LTA	Long Term Arrangement
LTFM	Long Term Financial Model
MFFD	Medically Fit For Discharge
MoU	Memorandum of Understanding
NPSA	National Patient Safety Agency
NBT	North Bristol NHS Trust
NHSE	NHS England
NHSI	NHS Improvement
NSCCG	North Somerset Clinical Commissioning Group
OBC	Outline Business Case
PIR	Post Implementation Review
PTIP	Post Transaction Implementation Plan
PMO	Programme Management Office
PER	Project Evaluation Reviews
PDC	Public Dividend Capital
RTT	Referral to Treatment Times
SoS	Secretary of State
SLT	Senior Leadership Team
SLA	Service Level Agreement
SOC	Strategic Outline Case
S&T	Sustainability & Transformation (Funding)

Abbreviation	Full Title
STP	Sustainability and Transformation Plan
TSFT	Taunton and Somerset NHS Foundation Trust
TDA	Trust Development Authority
TUPE	Transfer of Undertakings (Protection of Employment)
UH Bristol	University Hospitals Bristol NHS Foundation Trust
VTE	Venous Thrombo-Embolism
WAHT	Weston Area Health NHS Trust

APPENDIX 5: Financial Appraisal Analysis

This section provides the detail for the financial appraisal analysis reference in section 9 of the SOC. The analysis is based on information available earlier in the 2017/18 financial year and on an "as is" service model at WAHT, resulting in identification of the requirement for financial support to ensure the financial performance and financial standing of UH Bristol is not unduly diluted through an organisational merger and that the merged organisation has the ability to be financially viable and deliver the assessed benefits.

The comprehensive appraisal to be completed on a future acute service model within the Healthy Weston programme will update this assessment and include a comprehensive productivity review. This will be used in the FBC financial case.

9.2 Summary

9.2.1 Scenarios

There are a large number of variables included in the various scenarios – most based on estimates but with these estimates being backed up by experience and realism. Therefore, the scenarios can be relied upon with some confidence. The scenarios can be described in two ways:

- WAHT impact only,
- Combined UH Bristol / WAHT impact with and without financial support.

9.2.2 WAHT impact

The WAHT impact scenarios can be shown in table 13 below:

Table 13: WAHT impact

	2017/18		2021/22		
Statement of Comprehensive Income (SoCI) £'million	**Plan**	**UHB View**	**Do Nothing**	**With mitigations without financial support**	**With mitigations, with financial support**
Operating income from patient care activities	92.4	89.3	93.2	92.9	92.9
Operating income from patient care activities - income support	3.3	3.3	0.0	0.0	9.7
Other operating income - project costs	0.0	0.0	0.0	0.0	0.0
Other operating income - transitional support	0.0	0.0	0.0	0.0	0.0
Other operating income excluding STF	7.9	7.9	6.6	6.6	6.6
Sustainability & Transformation Funding (STF)	3.1	0.5	3.1	3.1	3.1
Total income	**106.7**	**100.9**	**102.9**	**102.6**	**112.3**
Operating expenses	(111.0)	(114.5)	(114.4)	(110.7)	(111.2)
Net operating surplus / (deficit)	**(4.3)**	**(13.5)**	**(11.5)**	**(8.1)**	**1.1**
Net financing costs	(1.9)	(1.9)	(1.9)	(1.6)	(1.1)
Net surplus / (deficit) for period excluding technicals	**(6.0)**	**(15.2)**	**(13.4)**	**(9.7)**	**0.0**
Statement of Financial Position (SoFP) £'million					
Net current assets/(liabilities)	**(5.3)**	**(4.9)**	**(5.0)**	**6.8**	**0.0**
Non current liabilities - existing DH loan	(17.9)	(17.9)	(45.8)	(45.8)	0.0
Non current liabilities - new DH loan to fund future year deficit	0.0	(9.6)	(50.3)	(50.3)	0.0
Total liabilities	**(23.3)**	**(32.4)**	**(101.1)**	**(89.3)**	**0.0**

It can be seen that the WAHT position is likely to deteriorate substantially as a result of an increased net I&E deficit to c£13.4 million per year in the period to 2021/22. This results in total liabilities of £23.3 million as at 31st March 2018 increasing to total liabilities of £101.1 million as at 31st March 2022, an increase of £77.8 million. This would result in an increased requirement for matching loan funding of £101.1 million. The interest rate impact has not been included in this assessment but with current short term loan rates, raising this would result in a further significant deterioration.

In addition, the WAHT underlying position assumes that national efficiency savings are met each year from 2018/19. Given the actual delivery record of the past few years this assumption is probably not realistic. Hence if, for example, a 2.0% national efficiency requirement plus 0.5% for unavoidable cost pressures is in place and only 1% recurrent savings are delivered, (the actual performance has been well below this in the past few years), the do nothing deficit would build as follows as shown in table 14 below:

Table 14: Adjusted net surplus / deficit including savings risk

Statement of Comprehensive Income (SoCI) £'million	2018/19	2019/20	2020/21	2021/22
Net surplus / (deficit) excluding technicals	**(13.4)**	**(13.4)**	**(13.4)**	**(13.4)**
Impact of further savings shortfall	(1.5)	(3.0)	(4.5)	(6.0)
AdjustedNet surplus / (deficit) including savings risk	**(14.9)**	**(16.4)**	**(17.9)**	**(19.4)**
Statement of Financial Position (SoFP) £'million	**2018/19**	**2019/20**	**2020/21**	**2021/22**
Total liabilities - total existing and new	**(51.0)**	**(69.3)**	**(87.7)**	**(101.1)**
Impact of further savings shortfall	(1.5)	(4.5)	(9.0)	(15.0)
Adjusted total liabilities - total existing and new	**(52.5)**	**(73.8)**	**(96.7)**	**(116.1)**

As the issue of scale and size are the biggest factor preventing delivery of efficiency savings at WAHT this adjusted scenario is therefore highly likely. Hence the scale of deficit and cash shortfalls would become unsustainable

9.2.3 Combined Organisation impact

The combined organisation impact (assuming the UH Bristol component is unchanged) with financial support results in a surplus of £13.0 million and total liabilities of £76.5 million i.e. an undiluted position for UH Bristol.

The combined organisation impact shown on the next page as table 18 (assuming the UH Bristol component is unchanged) but without financial support, the UH Bristol position is diluted to a net I&E surplus of £3.3 million and total liabilities of £171.7 million (a deterioration of £95.2 million). This is not a sustainable position. For a combined entity with turnover of £782.9 million in 2018/19 (indicative year one of a combined organisation), a planned surplus of c2% of turnover or c£15.7 million is required. This ensures a reasonable level of working capital is available to meet the ongoing revenue costs of staff and suppliers, capital investment requirements and provide a degree of financial resilience going forward.

For the combined organisation, the distinction for consideration is simply the impact upon UH Bristol either with or without financial support. The position is summarised in table 15 below.

Table 15: Combined Trust with and without financial support

	Combined Trust 2018/19		Combined Trust 2019/20		Combined Trust 2020/21		Combined Trust 2021/22	
	With support	Without support	With support	Without support	With support	Without support	With support	Without support
Statement of Comprehensive Income (SoCI) £'million								
Operating income from patient care activities	659.1	659.1	663.9	663.9	664.4	664.4	664.9	664.9
Operating income from patient care activities - subsidy	9.7	0.0	9.7	0.0	9.7	0.0	9.7	0.0
Other operating income - project costs	2.0	0.0	1.0	0.0	0.0	0.0	0.0	0.0
Other operating income - transitional support	3.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Other operating income excluding STF	92.7	92.7	96.8	96.8	98.9	98.9	101.2	101.2
Sustainability & Transformation Funding (STF)	16.4	16.4	16.4	16.4	16.4	16.4	16.4	16.4
Total income	**782.9**	**768.2**	**787.8**	**777.1**	**789.4**	**779.7**	**792.2**	**782.5**
Operating expenses	(757.8)	(757.2)	(763.3)	(762.8)	(765.1)	(764.5)	(765.9)	(765.3)
Net operating surplus / (deficit)	**25.1**	**11.0**	**24.5**	**14.3**	**24.3**	**15.2**	**26.3**	**17.2**
Net financing costs	(13.8)	(14.4)	(14.4)	(14.9)	(14.5)	(15.1)	(14.7)	(15.3)
Net surplus / (deficit) for year	**11.3**	**(3.4)**	**10.1**	**(0.6)**	**9.8**	**0.1**	**11.6**	**1.9**
Excluding Technicals	1.7	1.7	2.9	2.9	3.2	3.2	1.5	1.5
Net surplus / (deficit) for year excluding technicals	**13.0**	**(1.7)**	**13.0**	**2.3**	**13.0**	**3.3**	**13.0**	**3.3**
Statement of Financial Position (SoFP) £'million								
Net current assets/(liabilities)	**21.1**	**12.3**	**10.0**	**3.8**	**9.4**	**6.8**	**4.0**	**5.0**
Non current liabilities - existing DH loan	(77.3)	(113.1)	(82.1)	(122.9)	(81.3)	(127.1)	(80.5)	(126.3)
Non current liabilities - new DH loan to fund future year deficit	0.0	(10.2)	0.0	(23.5)	0.0	(36.9)	0.0	(50.3)
Sub total liabilities - total existing and new	**(56.2)**	**(111.0)**	**(72.1)**	**(142.6)**	**(71.9)**	**(157.2)**	**(76.5)**	**(171.7)**

Table 16: The deterioration from the 'with support' to the 'without support' position is accounted for as follows:

Surplus / (Deficit) excluding technicals	Combined Trust 2018/19	Combined Trust 2019/20	Combined Trust 2020/21	Combined Trust 2021/22
Net surplus / (deficit) for year - with financial support	**13.0**	**13.0**	**13.0**	**13.0**
Remove recurrent revenue income support	(9.7)	(9.7)	(9.7)	(9.7)
Remove non-recurrent income funding for project costs	(2.0)	(1.0)	0.0	0.0
Remove non-recurrent income funding for transitional costs	(3.0)	0.0	0.0	0.0
Subtotal - financial support	**(14.7)**	**(10.7)**	**(9.7)**	**(9.7)**
Net surplus / (deficit) for year - without financial support	**(1.7)**	**2.3**	**3.3**	**3.3**

9.2.4 Conclusion

It is clear that based on the “as is” service position of WAHT, that financial support which takes the combined organisation through to 2021/22 (indicative year 4) is required to make the proposal to merge WAHT with UH Bristol, viable financially.

The potential to mitigate this requirement for financial support needs to be developed in an FBC reflecting the opportunities for both planned productivity and efficiency benefits from an organisational merger and from the impact of a new acute service model for WGH alongside an integrated “care campus”.

9.3 WAHT’s historic financial track record

9.3.1 Net income and expenditure deficit

In 2008/9, WAHT reported a net deficit of £16.8 million. Since this time, whilst the Trust had showed some signs of financial recovery, WAHT also received additional financial support as additional non-recurring revenue funding that was classified as other operating revenue as follows: £7.4 million in 2010/11; £9.2million in 2011/12; and £6.6 million in 2012/13. Nil non-recurring support was received in 2013/14. However, Public Dividend Capital (PDC) cash support of £5.0 million was received in 2013/14 to address cash flow difficulties resulting from the 2013/14 reported deficit of £5.1 million.

WAHT's net income and expenditure deficit excluding non-recurring revenue support and Sustainability & Transformation (S&T) funding ranges from a net deficit of £4.7 million in 2010/11 to a net deficit of £8.9 million in 2016/17. The historic net deficit is in the range of -5% to -8% of turnover. A summary of recent financial performance is provided in table 17 below:

Table 17: WAHT historic financial performance

WAHT's historic net I&E position and cash support	2010/11 £'m	2011/12 £'m	2012/13 £'m	2013/14 £'m	2014/15 £'m	2015/16 £'m	2016/17 £'m
Turnover	93.3	95.3	96.7	96.8	100.4	98.5	105.6
Reported net surplus/(deficit)	**2.7**	**3.5**	**1.3**	**(5.1)**	**(3.9)**	**(7.0)**	**(7.2)**
Less Revenue support	(7.4)	(9.2)	(6.6)	0.0	0.0	0.0	0.0
Less S&T Funding	0.0	0.0	0.0	0.0	0.0	0.0	(1.8)
Adjusted net surplus/(deficit)	**(4.7)**	**(5.7)**	**(5.3)**	**(5.1)**	**(3.9)**	**(7.0)**	**(8.9)**
Loan and PDC cash support							
Loans	0.0	0.0	0.0	0.0	0.0	7.7	4.2
PDC	0.0	0.0	0.0	5.0	5.1	1.8	0.0
Total loan and PDC cash support	**0.0**	**0.0**	**0.0**	**5.0**	**5.1**	**9.5**	**4.2**

This shows a deteriorating position over the past few years with 2017/18 accelerating this further (see section 9.4).

9.3.2 Savings delivery

WAHT has a consistent pattern of substantial under-delivery against the annual savings requirement particularly the delivery of recurrent savings. This provides a legacy of undelivered savings each year that simply rolls over into the following year resulting in an ever-increasing cumulative underlying deficit. For example, in 2016/17, WAHT delivered recurrent savings of £0.5 million against a target of £4.1 million. This is attributed to the small scale of services making efficiency savings difficult to identify and deliver.

9.3.3 Statement of Financial Position (Balance Sheet), cashflow and liquidity

WAHT has a weak balance sheet with net current liabilities of £12.9m as at 31st March 2017. Liquidity is a major concern with liquidity of minus 48 days. This position is the result of historic deficits since 2013/14 despite a PDC cash injection of £5.0 million in that year. Since this time, WAHT has managed its cash position with short term and long-term loans provided by the Department of Health (DoH).

It is clear that WAHT is unable to meet its ongoing obligations without recourse to cash loans. For example, the Trust is funding the 2017/18 planned net deficit of £6.0 million with a further extension of loan funding from the DoH. This highlights the Trust's inability to generate sufficient cash from ongoing trading and is a serious concern. Nonetheless, going concern was adopted by the Trust for completion of the 2016/17 annual accounts that were subsequently audited by Grant Thornton UK LLP.

9.3.4 Financial Summary – WAHT's historic financial track record

The financial summary below in table 18 provides the three primary financial statements: Statement of Comprehensive Income (net income & expenditure position); the Statement of Financial Position (balance sheet) and a Cash flow Statement relating to the three most recent financial years.

Table 18: WAHT's historic financial performance

Statement of Comprehensive Income (SoCI) £'million	2014/15	2015/16	2016/17
Operating income from patient care activities	90.7	89.0	95.7
Other operating income excluding STF	9.7	9.5	8.1
Sustainability & Transformation Funding (STF)	0.0	0.0	1.8
Total income	**100.4**	**98.5**	**105.6**
Operating expenses - pay	(67.8)	(68.4)	(75.7)
Operating expenses - non-pay	(35.1)	(35.7)	(35.3)
Net operating surplus / (deficit)	**(2.6)**	**(5.6)**	**(5.4)**
Net financing costs	(1.9)	(1.9)	(1.9)
Net surplus / (deficit) for year	**(4.4)**	**(7.5)**	**(7.3)**
Remove capital donations/grants I&E impact	0.6	0.5	0.1
Net surplus / (deficit) for period excluding technicals	**(3.9)**	**(7.0)**	**(7.2)**
Operating surplus/ (deficit) Margin %	***-3%***	***-6%***	***-5%***
Net I&E Margin %	***-4%***	***-7%***	***-7%***
Statement of Financial Position (SoFP) £'million	**2014/15**	**2015/16**	**2016/17**
Non current assets	66.9	69.7	72.3
Current assets excluding cash	4.2	4.4	5.4
Cash and cash equivalents	3.0	3.9	1.6
Current liabilities	(9.8)	(10.3)	(19.9)
Net current assets/(liabilities)	**(2.6)**	**(2.1)**	**(12.9)**
Non current liabilities - DH Loan	0.0	(7.7)	(4.2)
Sub - total (liabilities)	**(2.6)**	**(9.8)**	**(17.1)**
Non current liabilities - Provisions	(0.2)	(0.4)	(0.4)
Total net assets employed	**64.1**	**59.5**	**54.9**
Statement of Cashflow (SoCF) £'million	**2014/15**	**2015/16**	**2016/17**
Opening cash b/fwd	0.8	3.0	3.9
Net cash generated from / (used in) operations	2.6	(1.4)	(1.5)
Capital cash (outflow)/inflow	(3.5)	(5.4)	(3.6)
Other	0.0	0.0	0.0
Net PDC (outflow)/inflow	3.2	(0.1)	(1.2)
Loans received from DH	0.0	7.7	4.2
Loans repaid to DH	0.0	(0.0)	0.0
Interest paid to DH	0.0	(0.0)	(0.1)
Sub-total net cash (outflow)/inflow	2.3	0.8	(2.2)
Closing cash c/fwd	**3.0**	**3.9**	**1.6**

WAHT's financial track record of year on year net income and expenditure deficits and the consequential requirement for external cash support has not been successfully resolved for more than a decade. It is universally accepted that WAHT is currently financially non-viable due to its small-scale provision of District General Hospital (DGH) services and difficulties faced with staff recruitment and retention.

After a phase of relative stability over the period of 2010/11 to 2013/14 with net deficits excluding support at c£5.0 million, the financial position has significantly deteriorated in 2015/16 and 2016/17 with the recent (2017/18) run rate deficit accelerating (once S&T funding is adjusted for). There is little prospect of this trend recovering under current arrangements.

9.4 WAHT's underlying financial position

The following section describes UH Bristol's assessments of the WAHT 2017/18 Operational Plan as submitted to NHS Improvement and the forecast underlying position going forward as the do nothing option. (**NB**: based on assessment early in 2017/18 to provide indicative financial scenarios of options to merge).

9.4.1 Income and Expenditure

WAHT submitted a revised 2017/18 Operational Plan to NHS Improvement on 12th April 2017 and was subsequently approved by the WAHT Board on 2nd May 2017. The 2017/18 plan is a net income and expenditure deficit of £6.0 million in line with the control total required by NHS Improvement. However, it should be noted that the control total for 2018/19 has not been agreed. Key factors underpinning the delivery of the planned deficit are: planned savings of £4.5 million and the full receipt of S&T funding of £3.1 million.

UH Bristol has reviewed WAHT's 2017/18 Operational Plan and have assessed the likely 2017/18 outturn deficit at £15.2 million, a deterioration of £9.2 million. The deterioration is due to a range of factors including:

£million

- (2.8) Temporary closure of the Emergency Depart. from 4th July 2017 (currently under review);
- (2.6) Loss of S&T funding from Q2 (due to failure to meet control total - core & performance);
- (2.4) Savings shortfall;
- (0.5) Removal of assumed agency nursing reduction per Safer Staffing review (double count);
- (0.5) 25% removal of a repatriation margin/contribution for Orthopaedic activity;
- (0.4) Imposition of national core fines due to the loss of S&T funding.

(9.2) Total – increase in WAHT deficit

UH Bristol's assessment of WAHT's underlying or recurrent net deficit in 2018/19 is £13.4 million. For simplicity and in the absence of WAHT developing and maintaining a Long Term Financial Model (LTFM), UH Bristol has modelled financial deficits until 2021/22 using this figure as the base position. However, this presents a considerable risk as WAHT's track record of recurrent savings delivery is poor. A recurrent savings under-delivery of c£1.5 million in each year from 2018/19 would accumulate resulting in a further deterioration of £6.0m by 2021/22 and a potential deficit of £19.4 million.

A summary of WAHT's 2017/18 Operational Plan and the projected financial position without merger is summarised in table 19 below as the "Do Nothing" scenario:

Table 19: WAHT's 2017/18 operational plan and financial performance "Do Nothing" scenario

Statement of Comprehensive Income (SoCI) £'million	2017/18	2018/19	2019/20	2020/21	2021/22
Operating income from patient care activities	89.3	93.2	93.2	93.2	93.2
Operating income from patient care activities - subsidy	3.3	0.0	0.0	0.0	0.0
Other operating income excluding STF	7.9	6.6	6.6	6.6	6.6
Sustainability & Transformation Funding (STF)	0.5	3.1	3.1	3.1	3.1
Total income	**100.9**	**102.9**	**102.9**	**102.9**	**102.9**
Operating expenses - pay	(77.1)	(76.4)	(76.4)	(76.4)	(76.4)
Operating expenses - non-pay	(37.3)	(38.3)	(38.3)	(38.3)	(38.3)
Net operating surplus / (deficit)	**(13.5)**	**(11.8)**	**(11.8)**	**(11.8)**	**(11.8)**
Net financing costs	(1.9)	(1.8)	(1.8)	(1.8)	(1.8)
Net surplus / (deficit)	**(15.3)**	**(13.5)**	**(13.5)**	**(13.5)**	**(13.5)**
Remove capital donations/grants I&E impact	0.1	0.1	0.1	0.1	0.1
Net surplus / (deficit) excluding technicals	**(15.2)**	**(13.4)**	**(13.4)**	**(13.4)**	**(13.4)**
Risk of deterioration from recurrent savings under-delivery		*(1.5)*	*(1.5)*	*(1.5)*	*(1.5)*
Cumulative		*(1.5)*	*(3.0)*	*(4.5)*	*(6.0)*
Net surplus / (deficit) including savings risk		***(14.9)***	***(16.4)***	***(17.9)***	***(19.4)***
Operating surplus/(deficit) Margin %	***-13.8%***	***-11.4%***	***-11.4%***	***-11.4%***	***-11.4%***
Net I&E Margin %	***-15.6%***	***-13.0%***	***-13.0%***	***-13.0%***	***-13.0%***

The assessed impact of the temporary closure of WAHT's Emergency Department overnight is included in the £15.2 million estimated deficit for 2017/18 at £2.75 million (based on information provided by WAHT).

It should be noted that, for simplicity at this stage, values included in the Statement of Comprehensive income are rolled forward on a flat cash basis from 2018/19 and therefore exclude inflation.

9.4.2 Savings delivery

The delivery of recurrent savings is a significant issue for WAHT. Savings plans provided by WAHT have been reviewed and risk assessed by the Trust. The risk assessed savings forecast is £2.2 million against a target of £4.5 million, a shortfall of £2.3 million. Plans to deliver recurrent savings of £2.4 million to meet the National Tariff requirement of 2.0% plus an addition 0.4% for local cost pressures have been identified but UH Bristol's risk assessment indicates likely recurrent savings delivery of only £1.0 million. UH Bristol's current assessment suggests non-recurring savings of £1.3 million are likely. Recurrent savings plans for an additional 2% or £2.1 million required to deliver the planned deficit of £6.0 million have not been identified by WAHT.

With national efficiency requirements of 2% pa expected over the medium term this pattern of delivery will continue to grow the WAHT underlying deficit.

9.4.3 Statement of Financial Position (Balance Sheet), cashflow and liquidity

UH Bristol's assessment of the WAHT's forecast 2017/18 outturn deficit of £15.2 million further weakens the balance sheet with projected total liabilities of £32.4 million by 31st March 2018 meaning further cash advances or loans will need to be obtained from the DoH. This includes a long-term loan of £4.2 million with the DoH. WAHT's planned net deficit of £6.0 million currently assumes a commensurate increase in loan funding.

UH Bristol's assessment of the underlying net deficit at WAHT of £13.4 million per year from 2018/19 until 2021/22 would result in the requirement for further revenue cash support of £53.6 million bringing the total cash support required up to £86.0 million plus the £15.0m IT Capital loan assumed i.e. £101.1m total liabilities. The do nothing option presents an unsustainable prospect.

A summary of WAHT's Statement of Financial Positon and Statement of Cashflow is provided in the table 20 below:

Table 20: WAHT Statement of financial position and statement of cashflow

Statement of Financial Position (SoFP) £'million	2017/18	2018/19	2019/20	2020/21	2021/22
Non current assets	70.8	75.8	80.6	85.5	85.3
Current assets excluding cash	4.9	4.5	4.5	4.5	4.5
Cash and cash equivalents	1.6	1.6	1.6	1.6	1.6
Current liabilities	(11.4)	(11.2)	(11.2)	(11.2)	(11.1)
Net current assets/(liabilities)	**(4.9)**	**(5.1)**	**(5.1)**	**(5.0)**	**(5.0)**
Non current liabilities - existing DH loan per WAHT plan	(17.9)	(35.8)	(40.8)	(45.8)	(45.8)
Non current liabilities - new DH loan to fund future year deficit	(9.6)	(10.1)	(23.5)	(36.9)	(50.3)
Sub total liabilities - total existing and new	**(32.4)**	**(51.0)**	**(69.3)**	**(87.7)**	**(101.1)**
Non current liabilities - Provisions	(0.4)	(0.4)	(0.4)	(0.4)	(0.4)
Total net assets employed	**38.0**	**24.5**	**10.9**	**(2.6)**	**(16.2)**

Statement of Cashflow (SoCF) £'million	2017/18	2018/19	2019/20	2020/21	2021/22
Opening cash b/fwd	**1.6**	**1.6**	**1.6**	**1.6**	**1.6**
Net cash generated from / (used in) operations	(9.9)	(7.6)	(8.1)	(8.1)	(8.1)
Capital cash (outflow)/inflow	(4.5)	(8.9)	(8.5)	(8.5)	(3.5)
Other	0.0	0.0	0.0	0.0	0.0
Net PDC (outflow)/inflow	(1.0)	(1.2)	(1.2)	(1.2)	(1.2)
Loans received from DH - Existing	6.0	25.6	5.0	5.0	0.0
Loans received from DH - New to fund future year deficit	9.6	0.5	13.4	13.4	13.4
Loans repaid to DH	0.0	(7.7)	0.0	0.0	0.0
Interest paid to DH	(0.3)	(0.6)	(0.6)	(0.6)	(0.6)
Sub-total net cash (outflow)/inflow	(0.0)	(0.0)	0.1	0.0	(0.0)
Closing cash c/fwd	**1.6**	**1.6**	**1.6**	**1.6**	**1.6**

9.5 UH Bristol's historic and planned financial performance

The following section describes UH Bristol's financial track record and financial outlook over the period to 2021/22.

9.5.1 Income and expenditure

UH Bristol has an excellent record of financial delivery. 2016/17 was the UH Bristol's fourteenth year of delivering financial surpluses. UH Bristol ended the 2016/17 financial year with a net surplus of £16.6 million. UH Bristol submitted its revised 2017/18 Operational Plan to NHS Improvement on 30th March 2017 following its acceptance of NHS Improvement's control total net surplus of £13.0 million including S&T funding of £13.3 million.

It should be noted that the control total for 2018/19 has not been agreed. The delivery of the planned net surplus in 2017/18 is a prerequisite to the Trust's plans for further essential capital investment in its estate. The Trust has set aside Phase 5 capital funding of £18.0 million to further develop and enhance UH Bristol's clinical services. UH Bristol is clear that

the rewards for delivering the 2017/18 planned surplus are high and the key factors necessary to deliver it are of paramount importance. Therefore, continued focus on, and discipline regarding the delivery of Divisional Operating Plans will be vital going forward.

UH Bristol's financial outlook builds on the Trust's financial track record. In line with the Trust's Financial Strategy net surpluses are planned at approximately 2% of total income. A planned net income and expenditure surplus of £13.0 million is assumed over the period to 2021/22. A summary of UH Bristol's planned financial performance is provided below in table 21:

Table 21: Planned financial performance

Statement of Comprehensive Income (SoCI) £'million	2017/18	2018/19	2019/20	2020/21	2021/22
Operating income from patient care activities	557.7	566.2	571.0	571.5	572.0
Other operating income excluding STF	86.7	86.0	90.1	92.2	94.6
Sustainability & Transformation Funding (STF)	13.3	13.3	13.3	13.3	13.3
Total income	**657.7**	**665.6**	**674.5**	**677.1**	**679.9**
Operating expenses - pay	(378.6)	(384.8)	(385.1)	(386.6)	(387.8)
Operating expenses - non-pay	(256.9)	(256.7)	(266.0)	(267.2)	(266.9)
Net operating surplus / (deficit)	**22.2**	**24.1**	**23.4**	**23.3**	**25.2**
Net financing costs	(12.1)	(12.6)	(13.1)	(13.3)	(13.5)
Net surplus / (deficit) for year	**10.1**	**11.5**	**10.3**	**10.0**	**11.7**
Remove capital donations/grants I&E impact/Impairments/reversals	2.9	1.5	2.7	3.1	1.3
Net surplus / (deficit) for period excluding technicals	**13.0**	**13.0**	**13.0**	**13.0**	**13.0**
Operating surplus/(deficit) Margin %	***3.4%***	***3.6%***	***3.5%***	***3.4%***	***3.7%***
Net I&E Margin %	***2.0%***	***2.0%***	***1.9%***	***1.9%***	***1.9%***

9.5.2 Savings delivery

UH Bristol has a reasonably good track of delivering recurrent savings. In 2016/17, UH Bristol delivered savings of £13.2 million against a target of £17.4 million. For 2017/18, the Trust has a low and deliverable savings requirement at 2.5% or £11.9 million due to its low relative cost base (Reference Cost Index of 96) for a large tertiary, teaching and research hospital. Savings plans of £11.3 million have been identified leaving a shortfall of £0.6 million. In recognition of the low saving requirement and UH Bristol's track record, the Trust expects full delivery of the savings target in 2017/18.

9.5.3 Statement of Financial Position (Balance Sheet), cashflow and liquidity

UH Bristol has a strong balance sheet with net current assets of £35.3 million as at 31st March 2018. The position contrasts significantly with WAHT's balance sheet and is the result of net income and expenditure surpluses achieved over the previous fourteen years. UH Bristol also has long term loan finance of £76.2 million as at 31st March 2018 which supported the Trust's capital investment plans over the past decade.

Going forward, the Trust maintains good liquidity with cash balances in excess of £40 million over the period to 2021/22 after planned capital investment of £200 million. The Trust has secured additional loan funding of £19 million in principle with the Independent Trust Financing Facility (ITFF) for the Trust's Multi-Storey Car Park scheme. The Trust's liquidity rating is 1 until 2018/19 and 2 from 2019/20 onwards due to capital expenditure.
UH Bristol's strong historic financial track record and sound financial planning presents the required financial foundations that are necessary to secure the stability and long term financial sustainability of any integration with WAHT.

A summary of UH Bristol's Statement of Financial Positon and Statement of Cashflow is provided in table 22 below:

Table 22: UH Bristol's statement of financial position and statement of cashflow

Statement of Financial Position (SoFP) £'million	2017/18	2018/19	2019/20	2020/21	2021/22
Non current assets	413.5	448.0	484.8	494.3	510.4
Current assets excluding cash	38.6	38.6	38.0	38.0	38.0
Cash and cash equivalents	66.8	51.4	47.9	46.0	40.5
Current liabilities	(70.0)	(69.3)	(76.7)	(75.5)	(75.5)
Net current assets/(liabilities)	**35.3**	**20.6**	**9.3**	**8.6**	**3.0**
Non current liabilities - DH Loan	(70.4)	(77.3)	(82.1)	(81.3)	(80.6)
Sub total (liabilities)	**(35.1)**	**(56.8)**	**(72.8)**	**(72.8)**	**(77.6)**
Non current liabilities - Provisions / Other	(4.4)	(4.1)	(3.7)	(3.3)	(2.9)
Total net assets employed	**374.0**	**387.1**	**408.2**	**418.2**	**429.9**

Statement of Cashflow (SoCF) £'million	2017/18	2018/19	2019/20	2020/21	2021/22
Opening cash b/fwd	65.4	66.8	51.4	47.9	46.0
Net cash generated from / (used in) operations	51.7	49.2	49.2	48.5	48.8
Capital cash (outflow)/inflow	(35.8)	(60.2)	(40.4)	(30.0)	(33.9)
Net PDC (outflow)/inflow	(5.4)	(8.4)	(8.7)	(10.8)	(11.2)
Loans received	0.0	12.8	6.2	0.0	0.0
Loans repaid	(5.8)	(5.8)	(6.6)	(6.6)	(6.6)
Net Interest paid/received	(2.9)	(2.6)	(2.8)	(2.5)	(2.3)
Capital element of finance lease	(0.3)	(0.3)	(0.4)	(0.4)	(0.4)
Sub-total net cash (outflow)/inflow	1.3	(15.4)	(3.5)	(1.9)	(5.6)
Closing cash c/fwd	**66.8**	**51.4**	**47.9**	**46.0**	**40.5**

9.6 Impact of WAHT upon Combined Organisation

This section describes the potential dilutive effect of WAHT in a combined organisation. This simple consolidation of section 9.4 and 9.5 provides the baseline financial position.

9.6.1 Income and expenditure

The consolidated position is shown notionally from 2017/18 with a likely net forecast deficit of £2.2 million (UH Bristol £13 million surplus and WAHT £15.2 million deficit). This position is £9.2 million adrift of the combined control total net surplus of £7.0 million (i.e. UH Bristol's control total net surplus of £13.0 million plus WAHT's control total net deficit of £6.0 million).

The consolidated position combining UH Bristol and WAHT's 2018/19 planned net income and expenditure position's results in a combined entity with a planned net deficit of £0.4 million. This position is £18.4 million adrift of the combined (proposed but not agreed) individual Trust control total net surplus of £18.0 million (£24.0m net surplus for UH Bristol and a £6.0 million net deficit for WAHT).

The combined net deficit position is entirely due to WAHT's underlying net deficit of £13.4m which exceeds UH Bristol's planned net surplus of £13.0 million. For a combined entity with turnover of £768.5m, a planned surplus of c2% of turnover or c£15.0 million is required to ensure a reasonable level of working capital is available to meet the ongoing revenue costs of staff and suppliers, capital investment requirements and provide a degree of financial resilience going forward.

The dilutive effect of WAHT in a combined organisation is significant and does not meet the requirements of UH Bristol's Financial Strategy going forward and in particular would necessitate the cancellation of the UH Bristol's Phase 5 capital programme over the period.

A summary of the impact of an organisational merger with WAHT upon UH Bristol's financial performance is provided below in table 23:

Table 23: impact of WAHT in a combined organisation

Statement of Comprehensive Income (SoCI) £'million	2017/18	2018/19	2019/20	2020/21	2021/22
Operating income from patient care activities	647.0	659.4	664.2	664.7	665.2
Operating income from patient care activities - subsidy	3.3	0.0	0.0	0.0	0.0
Other operating income excluding STF	94.6	92.7	96.8	98.9	101.2
Sustainability & Transformation Funding (STF)	13.8	16.4	16.4	16.4	16.4
Total income	**758.6**	**768.5**	**777.4**	**780.0**	**782.8**
Operating expenses - pay	(455.6)	(461.2)	(461.5)	(463.0)	(464.2)
Operating expenses - non-pay	(294.3)	(295.0)	(304.2)	(305.4)	(305.2)
Net operating surplus / (deficit)	**8.7**	**12.3**	**11.6**	**11.5**	**13.5**
Net financing costs	(14.0)	(14.4)	(14.9)	(15.1)	(15.3)
Net surplus / (deficit)	**(5.2)**	**(2.1)**	**(3.2)**	**(3.6)**	**(1.8)**
Remove capital donations/grants I&E impact/Impairments/reversals	3.0	1.7	2.9	3.2	1.4
Net surplus / (deficit) excluding technical	**(2.2)**	**(0.4)**	**(0.4)**	**(0.4)**	**(0.4)**
Operating surplus/ (deficit) Margin %	***1.2%***	***1.6%***	***1.5%***	***1.5%***	***1.7%***
Net I&E Margin %	***-0.3%***	***-0.1%***	***-0.1%***	***0.0%***	***0.0%***

9.6.2 Savings delivery

The combined savings requirement in 2018/19 is £16.4 million or 2.5% with 2.0% anticipated for National Tariff efficiency which all NHS Trusts are subject to plus 0.5% for cost pressures. The key concern is WAHT's historically very low level of recurrent savings delivery at £0.5 million in 2016/17 and £0.8 million in 2015/16. UH Bristol cannot support this low level of recurrent delivery and a full understanding of the reasons behind such a poor savings delivery record will require to be explored in the FBC process.

9.6.3 Statement of Financial Position (Balance Sheet), cashflow and liquidity

The combined Balance Sheet presents a weak position with total liabilities of £67.5 million as at 31st March 2018 falling to £178.6 million by 31st March 2022. Again, the combined position is entirely due the impact of WAHT's very weak and deteriorating balance sheet. The dilutive effect of WAHT in a combined organisation is significant and results in a combined entity with very limited liquidity going forward to meet its ongoing revenue commitments without external cash support. External cash support using loan finance would be required at £178.6 million.

This position is not financially sustainable and would require one-off reductions in capital investment in the short term and thus significantly impact on UH Bristol's Phase 5 capital investment plans. This measure, however, would be short lived and would not address the underlying drivers of the very weak balance sheet. The combined entity would not be financially sustainable and is highlighted by the combined entity's liquidity metric of 4, the lowest rating, over the period.

UH Bristol's strong historic financial track record and sound financial planning presents the required financial foundations and stability that are necessary in order to secure stability and long term financial sustainability of WAHT but this must be maintained post-merger to avoid key clinical services not being compromised going forward.

A summary of the potential impact of WAHT in a combined organisation is provided in table 24 below:

Table 24: the potential impact of WAHT in a combined organisation

Statement of Financial Position (SoFP) £'million	2017/18	2018/19	2019/20	2020/21	2021/22
Non current assets	484.3	523.8	565.4	579.8	595.6
Current assets excluding cash	43.5	43.1	42.6	42.6	42.6
Cash and cash equivalents	68.3	52.9	49.5	47.7	42.1
Current liabilities	(81.4)	(80.6)	(87.9)	(86.7)	(86.7)
Net current assets/(liabilities)	**30.4**	**15.4**	**4.2**	**3.5**	**(2.0)**
Non current liabilities - DH Loan	(88.4)	(113.1)	(122.9)	(127.1)	(126.3)
Non current liabilities - new DH loan to fund future year deficit	(9.6)	(10.1)	(23.5)	(36.9)	(50.3)
Sub total - (liabilities)	(67.5)	(107.8)	(142.1)	(160.5)	(178.6)
Non current liabilities - Provisions / Other	(4.8)	(4.4)	(4.1)	(3.7)	(3.3)
Total net assets employed	**412.0**	**411.5**	**419.2**	**415.6**	**413.7**

Statement of Cashflow (SoCF) £'million	2017/18	2018/19	2019/20	2020/21	2021/22
Opening cash b/fwd	67.0	68.3	52.9	49.5	47.7
Net cash generated from / (used in) operations	41.8	41.5	41.1	40.3	40.7
Capital cash (outflow)/inflow	(40.3)	(69.1)	(48.9)	(38.5)	(37.4)
Other	0.0	0.0	0.0	0.0	0.0
Net PDC (outflow)/inflow	(6.4)	(9.6)	(9.9)	(12.0)	(12.4)
Loans received from DH - Existing	6.0	38.3	11.2	5.0	0.0
Loans received from DH - New to fund future year deficit	9.6	0.5	13.4	13.4	13.4
Loans repaid	(5.8)	(13.5)	(6.6)	(6.6)	(6.6)
Net Interest paid/received	(3.2)	(3.2)	(3.4)	(3.1)	(2.9)
Capital element of finance lease	(0.3)	(0.3)	(0.4)	(0.4)	(0.4)
Sub-total net cash (outflow)/inflow	1.3	(15.4)	(3.4)	(1.8)	(5.6)
Closing cash c/fwd	**68.3**	**52.9**	**49.5**	**47.7**	**42.1**

9.7 The financial mitigations and costs of the combined organisation

9.7.1 Financial mitigations - Summary

UH Bristol has undertaken a high level assessment of the financial mitigations available to a combined entity using 1st April 2018 as indicative year one scenario. It should be noted that the assessment has been informed by an interim financial Due Diligence (DD) and is predicated on an "as is" basis for services currently provided by WAHT. Any financial mitigations or costs arising from any potential redesign or reconfiguration of clinical services are not provided in this financial assessment but would feature in the Full Business Case (FBC) should the transaction proceed beyond the SOC stage.

Potential financial mitigations of £5.0 million with £2.0 million deliverable in 2018/19 (indicative year one of the acquisition) and £3.0 million in 2019/20 (indicative year two) have been identified. This is deemed to be a realistic assessment. However, a comprehensive productivity review and full financial DD may highlight further opportunity for financial savings in due course or it could demonstrate that these savings are not deliverable for a variety of reasons.

9.7.2 Financial mitigations – Savings from medical staffing expenditure

An assessment of medical staffing expenditure has revealed significant medical agency expenditure of £6.5 million in 2016/17 primarily due to excessive medical staffing vacancies. UH Bristol estimates it can help to address the issue of medical staffing recruitment under

the UH Bristol branding and potentially reduce agency expenditure by £0.5 million in year one of a merged organisation and a further £1.5 million in year two.

This assessment assumes that the level of medical staffing vacancies reported by WAHT during the interim financial DD is appropriate - no assessment has been made in relation to clinical activity volumes, rota requirements or job plans.

9.7.3 Financial mitigations – Savings from nursing agency savings

Reported nursing agency expenditure was £4.5 million in 2016/17 primarily due to very high levels of registered nursing vacancies. UH Bristol estimates it would have a negligible impact on nursing recruitment under the UH Bristol branding as the issue of nursing recruitment is not isolated to WAHT and is faced by all NHS Trusts. However, the interim financial DD has identified opportunities for reducing agency expenditure through improved rostering and financial controls. UH Bristol has assessed the financial opportunity as £0.5 million in year one and a further £0.5 million in year two. Again, this assessment assumes that the level of nursing vacancies reported by WAHT and reviewed during the interim financial DD is accurate.

9.7.4 Financial mitigations – Savings from corporate overheads

UH Bristol has undertaken an assessment of the possible savings primarily arising from efficiencies in corporate overheads across both Trusts. Savings of £2.0 million have been notionally identified. This would need to be tested in the FBC.

9.7.5 Financial costs – Nursing staffing levels

The interim financial DD and non-financial DD has identified a potential requirement for further investment in registered nursing staffing levels at WAHT to bring the position into line with UH Bristol ratios The investment would be required recurrently from year one at a cost of £1.0 million per year.

This investment is required to ensure consistency of nursing staffing across both sites and assumes that the current volume of beds and the reported acuity at WAHT is appropriate. The quality issues described in the Care Quality Commission's (CQC) latest inspection report, higher than expected level of mortality and key concerns relating to hospital acquired pressure ulcer etc. identified in the non-financial DD would be addressed through this investment. Further costs may be identified as part of a full financial DD and included in the FBC.

9.7.6 Financial costs – Impact of joined spells

This issue relates to inpatient transfers between UH Bristol and WAHT. Currently, inpatients that are transferred between both sites for care are recorded as separate "spells" of activity with each Trust recording a date of admission and a date of discharge. This result in two inpatient "spells", one at each site. Post-merger, such transfers would take place within one Trust only meaning a single inpatient or joined "spell" would be recorded. The impact of lost income due to joined spells has been assessed at £0.3 million per year based on a detailed analysis of both Trusts' patient datasets.

9.7.7 Financial mitigations and costs – summary

The potential financial mitigations are summarised in table 25 below. These financial mitigations are partly offset by the potential requirement to invest in nursing levels at £1.0 million and the impact of joined spells at £0.3 million. The total net financial mitigation identified is therefore £0.7 million in year one and £3.7 million in year two. Further scope for mitigations may become available following a comprehensive productivity appraisal and a full financial DD and non-financial DD.

Table 25: Net financial mitigations and costs of the merger

Financial mitigations £'million	2018/19	2019/20
Financial Costs		
Joined spells estimated loss of income	(0.3)	(0.3)
Nursing staffing levels levelling up	(1.0)	(1.0)
Sub total - financial costs	**(1.3)**	**(1.3)**
Financial mitigations identified		
Corporate overhead savings	1.0	2.0
Savings from medical staff premium costs	0.5	2.0
Nursing agency savings	0.5	1.0
Sub total - financial mitigations	**2.0**	**5.0**
Total - net financial mitigations	**0.7**	**3.7**

9.8 The Resources Plan

9.8.1 Project Costs

An initial assessment of the non-recurrent project costs directly associated with delivering a successful organisational merger acquisition is estimated at £3.0 million. The sum includes estimates relating to project management, governance and delivery. Specific pre- and post-merger transaction costs relating to the external professional legal and financial fees relating to a full financial DD and non-financial DD diligence exercise are also included.

Provision has also been made for clinical lead roles, operational management roles and supporting Finance and Human Resources roles. Pre-merger costs are estimated at £2.0 million and post-merger costs are estimated at £1.0 million. A summary of the estimated project costs are provided in the summary below.

These are estimates only and further intelligence from other mergers is being sought. The total estimate of £3.0 million is, however, in the order of costs quoted from other transactions and the evidence demonstrates that successful mergers require dedicated input to ensure that clinical and non-clinical benefits are delivered and staff are supported and engaged during the transition period.

9.8.2 Transitional Workforce Costs

Non-recurrent costs are estimated at £2.0 million with £1.0 million assumed in year one and £1.0 million assumed in year two. Transitional workforce costs primarily relate to the delivery of corporate overhead savings. A further detailed assessment could be provided at a full financial DD and non-financial DD stage and detailed in an FBC. Every effort will be made to avoid redundancy costs by redeployment and natural wastage.

9.8.3 Summary

The Resources Plan totals £5.0 million shown below in table 26. Estimated expenditure of £2.0 million per year is assumed in the year of acquisition and year one, with. £1.0 million assumed in year two.

Table 26: Summary of the non-recurrent costs

Project costs £'million	2017/18	2018/19	2019/20
Project costs – pre merger	(2.0)	0.0	0.0
Project costs – post merger	0.0	(1.0)	0.0
Transitional workforce costs	0.0	(1.0)	(1.0)
Total	**(2.0)**	**(2.0)**	**(1.0)**

9.9 Combined organisation position post-merger including financial mitigations and the Resources Plan

This section describes the consolidated position including the potential net financial mitigations of £3.7 million described in section 9.7 and the Resources Plan costs of £5.0 million described in section 9.8. The combined position represents the position without external financial support.

9.9.1 Income and expenditure

The consolidated position is shown from 2017/18 to illustrate the financial impact of the transaction in notional terms pre-merger. The 2017/18 forecast net deficit increases by £2.0 million to £4.2 million compared with the "do nothing" position. The deterioration is due to unfunded pre-merger project costs of £2.0 million. The combined net control total surplus of £7.0 million would be missed by £11.2 million.

The indicative year 1planned net income and expenditure position deteriorates by £1.3 million to a net deficit of £1.7 million. The deterioration is due to unfunded post-merger project costs and transitional workforce costs of £1.0 million each offset by net financial mitigations of £0.7 million.

The Year 2 planned net deficit improves by £2.7 million to a net surplus of £2.3 million compared with the "do nothing" position. This is due to the full impact of the net financial mitigations of £3.7 million offset by £1.0 million for transitional workforce costs.

From Year 3, the planned net deficit improves by the full net financial mitigations of £3.7 million to a net surplus of £3.3 million. Nil project costs are anticipated in 2020/21. The position is summarised in the table 27 below:

Table 27: Combined net (deficit) / surplus – no financial support

Combined net (deficit) / surplus £'million	2017/18	2018/19	2019/20	2020/21
Net (deficit) – do nothing	**(2.2)**	**(0.4)**	**(0.4)**	**(0.4)**
Unfunded pre-merger project costs	(2.0)	0.0	0.0	0.0
Unfunded post-merger costs	0.0	(1.0)	0.0	0.0
Unfunded post-merger transitional workforce costs	0.0	(1.0)	(1.0)	0.0
Net financial mitigations	0.0	0.7	3.7	3.7
Subtotal – net (cost) / benefit	(2.0)	(1.3)	2.7	3.7
Net (deficit) / surplus do nothing	**(4.2)**	**(1.7)**	**2.3**	**3.3**
UH Bristol control total	13.0	24.0	TBC	TBC
WAHT control total	(6.0)	(6.0)	TBC	TBC
Combined control total	**7.0**	**18.0**	**TBC**	**TBC**
Adverse position against combined control total	**(11.2)**	**(19.7)**	**TBC**	**TBC**

The effect of consolidating the WAHT position including the phased £5.0 million Resources Plan and the net financial mitigations of £3.7 million result in a marginally improved net income and expenditure performance with a planned net surplus of £2.3m in year 2 and £3.3 million from year 3.

For a combined entity with turnover of £768.2m in year 1, a planned surplus of c2% of turnover or c£15.0 million is required to ensure a reasonable level of working capital is available to meet the ongoing revenue costs of staff and suppliers, capital investment requirements and provide a degree of financial resilience going forward.

The position without financial support significantly impacts on the combined organisation and does not meet the requirements of UH Bristol's Financial Strategy going forward and in particular would necessitate the cancellation of the UH Bristol's Phase 5 capital programme over the period. This is summarised in table 28 below:

Table 28: Statement of Comprehensive Income (SoCI)

Statement of Comprehensive Income (SoCI) £'million	2017/18	2018/19	2019/20	2020/21	2021/22
Operating income from patient care activities	646.9	659.1	663.9	664.4	664.9
Operating income from patient care activities - subsidy	3.3	0.0	0.0	0.0	0.0
Other operating income excluding STF	94.6	92.7	96.8	98.9	101.2
Sustainability & Transformation Funding (STF)	13.8	16.4	16.4	16.4	16.4
Total income	**758.6**	**768.2**	**777.1**	**779.7**	**782.5**
Operating expenses - pay	(455.7)	(460.8)	(458.5)	(460.0)	(461.2)
Operating expenses - non-pay	(296.2)	(296.4)	(304.2)	(304.4)	(304.2)
Net operating surplus / (deficit)	**6.7**	**11.0**	**14.3**	**15.2**	**17.2**
Net financing costs	(14.0)	(14.4)	(14.9)	(15.1)	(15.3)
Net surplus / (deficit) for year	**(7.2)**	**(3.4)**	**(0.5)**	**0.1**	**1.9**
Remove capital donations/grants I&E impact/Impairments/reversals	3.0	1.7	2.9	3.2	1.5
Net surplus / (deficit) for period excluding technical	**(4.2)**	**(1.7)**	**2.3**	**3.3**	**3.3**
Operating surplus/ (deficit) Margin %	***0.9%***	***1.4%***	***1.8%***	***2.0%***	***2.2%***
Net I&E Margin %	***-0.6%***	***-0.2%***	***0.3%***	***0.4%***	***0.4%***

9.9.2 Savings delivery

The combined savings requirement in Year 1 is £16.4 million or 2.5%, 0.5% for cost pressures in addition to the assumed efficiency requirement within National Tariff. The key concern is WAHT's historically very low level of recurrent savings delivery at £0.5 million in 2016/17 and £0.8 million in 2015/16.

9.9.3 Statement of Financial Position (Balance Sheet), cashflow and liquidity

The combined balance sheet continues to present a weak position with total liabilities of £69.4 million as at 31st March 2018 increasing to £171.7 million by 31st March 2022 (indicative year 4). Again, the combined position is primarily due the impact of WAHT's very weak and deteriorating balance sheet. The dilutive effect of WAHT in a combined organisation is significant and results in a combined entity with very limited liquidity going forward to meet its ongoing revenue commitments without external cash support.

The position is not financially sustainable and would require one-off reductions in capital investment in the short term and thus significantly impact on UH Bristol's Phase 5 capital investment plans. This measure, however, would be short lived and would not address the underlying drivers of the very weak balance sheet. The combined entity would not be financially sustainable.

A summary of the impact of WAHT in a combined organisation including financial mitigations is provided below in table 29:

Table 29: Combined organisation financial position post-merger including financial mitigations

Statement of Financial Position (SoFP) £'million	2017/18	2018/19	2019/20	2020/21	2021/22
Non current assets	484.3	523.8	565.4	579.8	595.6
Current assets excluding cash	43.5	43.1	42.6	42.6	42.6
Cash and cash equivalents	66.5	49.8	49.1	50.9	49.1
Current liabilities	(81.4)	(80.6)	(87.9)	(86.7)	(86.7)
Net current assets/(liabilities)	**28.6**	**12.3**	**3.8**	**6.8**	**5.0**
Non current liabilities - existing DH Loan	(88.4)	(113.1)	(122.9)	(127.1)	(126.3)
Non current liabilities - new DH Loan to fund future deficit	(9.6)	(10.1)	(23.5)	(36.9)	(50.3)
Sub total (liabilities) - existing & new	**(69.4)**	**(110.9)**	**(142.6)**	**(157.2)**	**(171.7)**
Non current liabilities - Provisions / other	(4.8)	(4.4)	(4.1)	(3.7)	(3.3)
Total net assets employed	**410.2**	**408.4**	**418.7**	**418.8**	**420.7**

Statement of Cashflow (SoCF) £'million	2017/18	2018/19	2019/20	2020/21	2021/22
Opening cash b/fwd	67.0	66.5	49.8	49.1	50.9
Net cash generated from / (used in) operations	39.9	40.2	43.8	44.0	44.4
Capital cash (outflow)/inflow	(40.3)	(69.1)	(48.9)	(38.5)	(37.4)
Other	0.0	0.0	0.0	0.0	0.0
Net PDC (outflow)/inflow	(6.4)	(9.6)	(9.9)	(12.0)	(12.4)
Loans received	6.0	38.3	11.2	5.0	0.0
Loans received from DH - New to fund future year deficit	9.6	0.5	13.4	13.4	13.4
Loans repaid	(5.8)	(13.5)	(6.6)	(6.6)	(6.6)
Net Interest paid/received	(3.2)	(3.2)	(3.4)	(3.1)	(2.9)
Capital element of finance lease	(0.3)	(0.3)	(0.4)	(0.4)	(0.4)
Sub-total net cash (outflow)/inflow	(0.6)	(16.7)	(0.7)	1.9	(1.9)
Closing cash c/fwd	**66.5**	**49.8**	**49.1**	**50.9**	**49.1**

9.10 The financial support required for a viable acquisition

This section describes the level of financial support currently assessed as required for a viable merger. In addition to the requirement to renegotiate the Year 1 Control Total for a combined entity, the level of financial support required is to mitigate the dilutive impact of WAHT in a combined organisation as described in section 12.6. The financial support considers a number of elements: the underlying structural deficit at WAHT; the very weak balance sheet; and the costs identified in the Resources Plan.

The requirement for this support is predicated on analysis and assessment of an "as is" service model at WAHT, and is necessary in this context, to ensure the merged organisation has the ability to be financially viable and deliver the assessed benefits.

The comprehensive appraisal to be completed on a future acute service model within the Healthy Weston programme will update this assessment and include a comprehensive productivity review. This will be used in the FBC financial analysis which will further assess the impact and potential mitigation of the need for such support.

9.10.1 Recurrent income support

Following the interim financial DD, UH Bristol has assessed WAHT's underlying or recurring net financial deficit at £13.4 million in 2017/18. For year 1 (of a combined organisation), the position reduces to a recurrent deficit of £12.7 million including the net financial mitigations of £0.7 million. From year 2, the full impact of the net financial mitigations are realised at £3.7 million hence the recurrent deficit reduces by a further £3.0 million to £9.7 million.

The residual position of £9.7 million represents UH Bristol's assessment of the structural net deficit at WAHT due to the small scale of full District General Hospital (DGH) suite of services including a type 1 Emergency Department twenty-five miles from Bristol and Taunton. All indications are that whilst the WAHT deficit can be mitigated by £3.7 million, the structural net deficit cannot be resolved as this level of infrastructure cannot be provided "as is", within National Tariff on an ongoing basis.

The interim financial DD identified that WAHT currently receives a recurrent support of £3.3 million:

£million	
• 1.3	For Emergency Department excess costs;
• 1.1	For a "Medically Fit For Discharge" (MFFD) ward;
• 0.7	For critical care; and
• 0.2	For haematology and oncology services.
3.3	Total – existing recurrent income support

Assuming the existing support of £3.3 million is confirmed and therefore remains in place; this can be offset against WAHT's structural deficit of £9.7 million leaving a residual structural deficit of £6.4 million. This residual structural deficit would need to be met with new recurrent support of £6.4 million from year 1. This assessment will be reassessed in the analysis associated with the development of a new service model resulting from the Healthy Weston process.

9.10.2 Non-recurrent transitional income support

UH Bristol has assessed WAHT's underlying or recurring net financial deficit at £13.4 million in 2017/18. For Year 1, the position reduces to a recurrent deficit of £12.7 million. Section 9.10.1 describes the requirement for a new recurrent subsidy of £6.4 million in addition to the current support of £3.3 million from Year 1, a total of £9.7 million. This position leaves a gap of £3.0 million in Year 2 hence a requirement for transitional, non-recurrent support of £3.0 million in order to bridge the gap.

9.10.3 Cash (Public Dividend Capital) injection – Balance Sheet

UH Bristol has reviewed WAHT's audited balance sheet as at 31st March 2017. The audited position reports net current liabilities of £12.9 million and a long term loan with the DoH of £4.2 million, a total liabilities position of £17.1 million. WAHT's approved 2017/18 Operational Plan net deficit of £6.2 million including technical items as submitted to NHS Improvement would increase the total liabilities position to £23.2 million as at 31st March 2018.

UH Bristol's assessment of WAHT's 2017/18 net deficit is £15.2 million excluding technical items, an increased deficit of £9.2 million. The increased deficit of £9.2 million would therefore increase the total liabilities position from £23.2 million to £32.4 million as at 31st March 2018.

WAHT's very weak balance sheet containing total liabilities of £32.4 million is the result of cumulative deficits incurred without revenue income support since 2013/14. Liabilities on this scale would eliminate UH Bristol's balance sheet strength accumulated from UH Bristol's excellent financial track record over the previous fourteen years. Therefore, a viable merger proposition would l require a non-recurrent PDC cash injection of £32.4 million that effectively writes-off WAHT's historic debt.

9.10.4 Cash (Public Dividend Capital) injection – Capital investment

WAHT's 2017/18 Operational Plan submitted to NHS Improvement included the requirement for PDC of £15.0 million over three years until 2019/20 for capital investment in Information Technology hardware and software including the replacement of WAHT's Electronic Patient Record (EPR). UH Bristol's assessment requires PDC cash for capital investment of £7.0 million in Year 1 to secure the replacement of WAHT's EPR and to replace and integrate WAHT's wider Information Technology provision with UH Bristol's. This investment is considerably lower than that required for WAHT under the do nothing scenario as a standalone organisation.

9.10.5 Summary position

The financial support necessary for a viable merger based on an "as is" service model is shown below in table 30:

Table 30: Financial support required for a viable merger:

Non-recurrent support funding:	£'m	Comment
Cash (PDC) injection	28.2	Write-off of WAHT's historic debt
Cash (PDC) injection	4.2	Repayment of existing long term loan with DoH
Subtotal - Cash (PDC) injection	32.4	
Cash (PDC) for capital investment in IT	7.0	Cash funding required for IT integration
Total - PDC Funding	**39.4**	
Revenue funding i.e. income to pay for:		
Resources Plan - project costs	3.0	Next stage costs of acquisition e.g. professional fees
Resources Plan - redundancies / restructuring costs	2.0	Initial estimate - subject to confirmation at FBC stage
Transitional support	3.0	Over and above recurrent income (existing support) in year 1 of acquisition
Total - non-recurrent income support	**8.0**	
Recurrent support funding:		
Recurrent income - existing support	3.3	Required to cover structural net deficit at WAHT
Recurrent income - new support	6.4	
Total - recurring income support	**9.7**	

It should be noted it is assumed that the full receipt of S&T funding of £16.4 million is made available throughout the period from Year 1 to Year 3. The comprehensive appraisal to be completed on a future acute service model within the Healthy Weston programme will update this assessment for support and will include a comprehensive productivity review. This will be used in the FBC financial analysis which will further assess the impact and potential mitigation of the need for such support.

9.11 Combined organisation position post-merger including financial support

This section describes the consolidated position including the net financial mitigations of £3.7 million described in section 9.7, the Resources Plan costs of £5.0 million described in section 9.8 and the financial support required for a viable transaction detailed in section 9.10.

9.12 Income and expenditure

The consolidated position is shown from 2017/18 to illustrate in the financial impact of the transaction in notional terms pre-merger. The notional 2017/18 forecast net deficit of £2.2 million returns to the "do nothing" position as a result of additional non recurring funding in support of project costs of £2.0 million in 2017/18. The combined net control total surplus of £7.0 million would be missed by £9.2 million and would require a re-negotiated control total for the combined entity to ensure the full receipt of S&T funding in 2017/18.

The Year 1 planned net income and expenditure is restored to the combined organisation planned surplus of £13.0 million. This position includes a permanent subsidy of £9.7 million, a further £2.0 million for non-recurrent project costs and £3.0m non-recurrent transitional support funding. S&T funding of £16.4 million is also assumed on the basis that a revised 2018/19 control total can be agreed at £13.0 million. The position is summarised in table 31 below:

Table 31: Combined net surplus / (deficit) including financial support

Combined net (deficit) / surplus - including financial support £'million	2017/18	2018/19	2019/20	2020/21
Net (deficit) - do nothing	**(2.2)**	**(0.4)**	**(0.4)**	**(0.4)**
Unfunded pre-acquisition project costs	(2.0)	0.0	0.0	0.0
Unfunded post-acquisition project costs	0.0	(1.0)	0.0	0.0
Unfunded post-acquisition redundancy costs	0.0	(1.0)	(1.0)	0.0
Net financial mitigations	0.0	0.7	3.7	3.7
Subtotal - net (cost) / benefit	**(2.0)**	**(1.3)**	**2.7**	**3.7**
Funding for pre-acquisition project costs	2.0	0.0	0.0	0.0
Funding for post-acquisition project costs	0.0	1.0	0.0	0.0
Funding for post-acquisition redundancy costs	0.0	1.0	1.0	0.0
Transitional funding	0.0	3.0	0.0	0.0
Recurrent subsidy	0.0	9.7	9.7	9.7
Subtotal - net funding	**2.0**	**14.7**	**10.7**	**9.7**
Net (deficit)/surplus - UH Bristol undiluted	**(2.2)**	**13.0**	**13.0**	**13.0**
UH Bristol control total	13.0	24.0	TBC	TBC
WAHT control total	(6.0)	(6.0)	TBC	TBC
Combined control total	**7.0**	**18.0**	**TBC**	**TBC**
Adverse position against combined control total	**(9.2)**	**(5.0)**	**TBC**	**TBC**

The combined organisation position post-merger including the financial support is summarised in table 32 below:

Table 32: Combined organisation position with financial support

Statement of Comprehensive Income (SoCI) £'million	2017/18	2018/19	2019/20	2020/21	2021/22
Operating income from patient care activities	647.0	659.1	663.9	664.4	664.9
Operating income from patient care activities - subsidy	3.3	9.7	9.7	9.7	9.7
Other operating income - project costs	2.0	2.0	1.0	0.0	0.0
Other operating income - transitional support	0.0	3.0	0.0	0.0	0.0
Other operating income excluding STF	94.6	92.7	96.8	98.9	101.2
Sustainability & Transformation Funding (STF)	13.8	16.4	16.4	16.4	16.4
Total income	**760.6**	**782.9**	**787.8**	**789.4**	**792.2**
Operating expenses - pay	(455.7)	(460.8)	(458.5)	(460.0)	(461.2)
Operating expenses - non-pay	(296.1)	(297.0)	(304.8)	(305.0)	(304.7)
Net operating surplus / (deficit)	**8.8**	**25.1**	**24.5**	**24.3**	**26.3**
Net financing costs	(14.0)	(13.8)	(14.3)	(14.5)	(14.7)
Net surplus / (deficit) for year	**(5.1)**	**11.3**	**10.1**	**9.8**	**11.6**
Remove capital donations/grants I&E impact/Impairments/reversals	3.0	1.7	2.9	3.2	1.5
Net surplus / (deficit) for period excluding technical	**(2.2)**	**13.0**	**13.0**	**13.0**	**13.0**

The effect of consolidating the WAHT position after the inclusion of the £5.0 million Resources Plan, the £3.0 million transitional support and the net recurrent support funding of £9.7 million, a total of £17.7 million, presents an undiluted income and expenditure position for UH Bristol post-merger.

However, it should be noted that whilst UH Bristol's planned net surplus of £13.0 million remains unaffected it is c£2.0 million short of the c£15.0 million or c2% of turnover required in line with UH Bristol's financial strategy.

9.13 Savings requirement

The key concern is WAHT's historically very low level of recurrent savings delivery. As mentioned previously, UH Bristol cannot support this low level of recurrent delivery and a full understanding of the reasons behind such a poor savings delivery record will need to be understood in due course following a full financial DD exercise. This scenario assumes the combined organisation will be able to deliver national efficiency savings hence the WAHT component is a risk.

9.14 Statement of Financial Position (Balance Sheet), cashflow and liquidity

The combined balance sheet presents a stronger position with forecast total liabilities as at 31st March 2022 (Year 4) reducing by £95.2 million from £171.7 million without financial support to £76.5 million with financial support. The combined entity is forecast to remain in a net current asset position of £4.0 million as at Year 4. The dilutive effect of WAHT in a combined organisation is mitigated with financial support and provides sufficient liquidity going to meet its ongoing revenue commitments without external cash support. The position is financially sustainable going forward.

A summary of the impact of WAHT in a combined organisation including financial support is provided below in table 33:

Table 33: impact of WAHT in a combined organisation including financial support

Statement of Financial Position (SoFP) £'million	2017/18	2018/19	2019/20	2020/21	2021/22
Non current assets	484.3	524.2	560.7	569.9	585.7
Current assets excluding cash	43.5	43.1	42.6	42.6	42.6
Cash and cash equivalents	58.9	58.6	55.3	53.6	48.1
Current liabilities	(81.4)	(80.6)	(87.9)	(86.7)	(86.7)
Net current assets/(liabilities)	**21.0**	**21.1**	**10.0**	**9.4**	**4.0**
Non current liabilities - DH Loan	(88.4)	(77.3)	(82.1)	(81.3)	(80.6)
Sub-total (liabilities)	**(67.4)**	**(56.3)**	**(72.1)**	**(71.9)**	**(76.5)**
Non current liabilities - Provisions / Other	(4.8)	(4.4)	(4.1)	(3.7)	(3.3)
Total net assets employed	**412.2**	**463.5**	**484.5**	**494.3**	**505.9**

Statement of Cashflow (SoCF) £'million	2017/18	2018/19	2019/20	2020/21	2021/22
Opening cash b/fwd	67.0	58.9	58.6	55.3	53.6
Net cash generated from / (used in) operations	41.9	54.4	54.0	53.3	53.6
Capital cash (outflow)/inflow	(40.3)	(70.5)	(43.9)	(33.5)	(37.4)
Net PDC (outflow)/inflow	(6.4)	29.8	(9.9)	(12.0)	(12.4)
Loans received	6.0	12.8	6.2	0.0	0.0
Loans repaid	(5.8)	(23.8)	(6.6)	(6.6)	(6.6)
Net Interest paid/received	(3.2)	(2.6)	(2.8)	(2.5)	(2.3)
Capital element of finance lease	(0.3)	(0.3)	(0.4)	(0.4)	(0.4)
Sub-total net cash (outflow)/inflow	(8.2)	(0.3)	(3.3)	(1.7)	(5.5)
Closing cash c/fwd	**58.9**	**58.6**	**55.3**	**53.6**	**48.1**

9.15 Sensitivity Analysis

As the values at the SOC stage are mainly estimates with many being subject to significant uncertainty, a sensitivity analysis has not been undertaken at this stage. This will be introduced in the FBC.

9.16 Conclusion

The financial appraisal describes the financial support required for a viable merger that does not unduly dilute the financial performance and financial standing of a combined organisation. It describes the level of financial support currently assessed as required for a

viable merger predicated on analysis and assessment of an "as is" service model at WAHT

The financial support presents a significant investment but the worst case scenario remains 'do nothing'.

The comprehensive appraisal to be completed on a future acute service model within the Healthy Weston programme will update this assessment and include a comprehensive productivity review. This will be used in the FBC financial analysis which will further assess the impact and potential mitigation of the need for such support.

Appendix 6: Equality Impact Assessment (EIA) SCREENING TOOL

Name of the Document: **Weston Partnership Strategic Outline Case (SOC)**

The main purpose of the document is to consider the strategic outline case for long term arrangements between WAHT and UH Bristol.

This paper considers options for different organisational forms including organisational merger by acquisition of WAHT by UH Bristol. This option would entail UH Bristol taking ownership of the WAHT, including transfer of staff to UH Bristol's contracts of employment.

At this stage, the proposed option does not include changes to roles and responsibilities of staff or clinical services changes. Should these be proposed in the future, separate EIA's will be completed as part of a consultation process for each individual proposal.

The standard UH Bristol EAI screening tool has been used to test the preferred option.

Both organisations are NHS employers and subject to national terms and conditions and common regulatory frameworks.

Who is it likely to have an impact on?

In global terms it will affect the following groups: Staff / Patients / Visitors / Carers

Could the document/proposal have a significant **negative** impact on equality in relation to each of these characteristics?	YES	NO	Please explain why, and what evidence supports this assessment.
Age (including younger and older people)		No	Simply by changing organisational ownership and transferring employment from one NHS organisation to another does not negatively impact upon these groups. For patients, visitors or carers there are no clinical pathway changes proposed in this document that would have a negative impact.
Disability (including physical and sensory impairments, learning disabilities, mental health)		No	
Gender reassignment		No	
Pregnancy and maternity		No	
Race (includes ethnicity as well as gypsy travelers)		No	
Religion and belief (includes non-belief)		No	
Sex (male and female)		No	
Sexual Orientation (lesbian,		No	

Could the document/proposal have a significant **negative** impact on equality in relation to each of these characteristics?	YES	NO	Please explain why, and what evidence supports this assessment.
gay, bisexual, other)			
Groups at risk of stigma or social exclusion (e.g. offenders, homeless people)		No	
Human Rights (particularly rights to privacy, dignity, liberty and non-degrading treatment)		No	

Will the document create any problems or barriers to any community or group? NO
Will any group be excluded because of this document? NO
Will the document result in discrimination against any group? NO

If the answer to any of these questions is YES, you must complete a full Equality Impact Assessment (Form B).

Could the document/proposal have a significant **positive** impact on inclusion by reducing inequalities?	YES	NO	If yes, please explain why, and what evidence supports this assessment.
Will it promote equal opportunities for people from all groups?		No	
Will it help to get rid of discrimination?		No	
Will it help to get rid of harassment?		No	
Will it promote good relations between people from all groups?		No	
Will it promote and protect human rights?		No	

On the basis of the information / evidence so far, do you believe that the document will have a positive or negative impact on equality? - NIL IMPACT.

Is a full equality impact assessment required? NO

Date assessment completed: 20th July 2017

Person completing the assessment: Rob Gittins, Programme Manager; Sarah Nadin, Associate Director of Strategic and Business Planning

Person responsible for the document: Paula Clarke, Executive Director of Strategy and Transformation

Appendix 7: 2016-2017 Key Performance Indicator comparative Analysis (UHBristol and WAHT)

62-day GP cancer

Table 1: Quarter 1 2016/17

	Non Breaches	Breaches	Total Seen	%
UH Bristol	196.0	73.5	269.5	72.7%
Weston	67.0	16.5	83.5	80.2%
Combined	263.0	90.0	353.0	74.5%

Table 2: Quarter 2 2016/17

	Non Breaches	Breaches	Total Seen	%
UH Bristol	253.0	62.5	315.5	80.2%
Weston	66.0	23.5	89.5	73.7%
Combined	319.0	86.0	405.0	78.8%

Table 3: Quarter 3 2016/17

Non Breaches	Breaches	Total Seen	%
238.0	51.0	289.0	82.4%
77.0	20.0	97.0	79.4%
315.0	71.0	386.0	81.6%

Table 4: Quarter 4 2016/17

Non Breaches	Breaches	Total Seen	%
246.5	56.0	302.5	81.5%
65.5	20.0	85.5	76.6%
312.0	76.0	388.0	80.4%

62-day Screening cancer

Table 5: Quarter 1 2016/17

	Non Breaches	Breaches	Total Seen	%
UH Bristol	8.5	9.5	18.0	47.2%
Weston	1.0	0.0	1.0	100%
Combined	9.5	9.5	19.0	50.0%

Table 6: Quarter 2 2016/17

	Non Breaches	Breaches	Total Seen	%
UH Bristol	7.5	6.0	13.5	55.6%
Weston	0.5	0.0	0.5	100.0%
Combined	8.0	6.0	14.0	57.1%

Table 7: Quarter 3 2016/17

Non Breaches	Breaches	Total Seen	%
16.5	1.0	17.5	94.3%
0.5	0.0	0.5	100.0%
17.0	1.0	18.0	94.4%

Table 8: Quarter 4 2016/17

Non Breaches	Breaches	Total Seen	%
14.0	4.0	18.0	77.8%
1.0	0.0	1.0	100.0%
15.0	4.0	19.0	78.9%

31-day First Definitive

Table 9: Quarter 1 2016/17

	Non Breaches	Breaches	Total Seen	%
UH Bristol	628	34	662	94.9%
Weston	113	1	114	99.1%
Combined	741.0	35.0	776.0	95.5%

Table 10: Quarter 2 2016/17

	Non Breaches	Breaches	Total Seen	%
UH Bristol	685	17	702	97.6%
Weston	137	1	138	99.3%
Combined	822.0	18.0	840.0	97.9%

Table 11: Quarter 3 2016/17

Non Breaches	Breaches	Total Seen	%
677	18	695	97.4%
152	0	152	100.0%
829.0	18.0	847.0	97.9%

Table 12: Quarter 4 2016/17

Non Breaches	Breaches	Total Seen	%
697	22	719	96.9%
128	0	128	100.0%
825.0	22.0	847.0	97.4%

2-Week Wait

Quarter 1 2016/17

	Non Breaches	Breaches	Total Seen	%
UH Bristol	3,192	196	3,388	94.2%
Weston	1,315	60	1,375	95.6%
Combined	4,507.0	256.0	4,763	94.6%

Quarter 2 2016/17

	Non Breaches	Breaches	Total Seen	%
UH Bristol	3,097	213	3,310	93.6%
Weston	1,043	66	1,109	94.0%
Combined	4,140.0	279.0	4,419.0	93.7%

Quarter 3 2016/17

Non Breaches	Breaches	Total Seen	%
3,186	151	3,337	95.5%
1,240	80	1,320	93.9%
4,426.0	231.0	4,657.0	95.0%

Quarter 4 2016/17

Non Breaches	Breaches	Total Seen	%
3,344	142	3,486	95.9%
1,099	228	1,327	82.8%
4,443.0	370.0	4,813.0	92.3%

A&E 4-hours

Table 13: Quarter 1 2016/17

	Non Breaches	Breaches	Total Seen	%
UH Bristol	29,251	3,482	32,733	89.4%
Weston	11,465	2,045	13,510	84.9%
Combined	40,716	5,527	46,243	88.0%

Table 14: Quarter 2 2016/17

Non Breaches	Breaches	Total Seen	%
28,506	3,564	32,070	88.9%
11,975	2,590	14,565	82.2%
40,481.0	6,154.0	46,635.0	86.8%

Table 15: Quarter 3 2016/17

Non Breaches	Breaches	Total Seen	%
26,972	6,598	33,570	80.3%
9,293	3,748	13,041	71.3%
36,265.0	10,346.0	46,611.0	77.8%

Table 16: Quarter 4 2016/17

Non Breaches	Breaches	Total Seen	%
25,269	5,726	30,995	81.5%
8,538	3,568	12,106	70.5%
33,807.0	9,294.0	43,101.0	78.4%

RTT

Table 17: Quarter 1 2016/17

	Total Under 18 Weeks	Total Pathways	Percentage Under 18 Weeks
UH Bristol	92,460	100,135	92.3%
Weston	15,822	17,173	92.1%
Combined	108,282	117,308	92.3%

Table 18: Quarter 2 2016/17

Total Under 18 Weeks	Total Pathways	Percentage Under 18 Weeks
94,111	103,460	91.0%
16,748	17,639	94.9%
110,859	121,099	91.5%

Table 19: Quarter 3 2016/17

Total Under 18 Weeks	Total Pathways	Percentage Under 18 Weeks
95,119	103,653	91.8%
17,740	19,018	93.3%
112,859	122,671	92.0%

Table 20: Quarter 4 2016/17

Total Under 18 Weeks	Total Pathways	Percentage Under 18 Weeks
95,523	104,090	91.8%
16,583	17,607	94.2%
112,106	121,697	92.1%

Diagnostics

Table 21: Quarter 1 2016/17

	Waiting Under 6 Weeks	Total Waiting List Size	Percentage Under 6 Weeks
UH Bristol	24,137	24,711	97.7%
Weston	6,832	6,876	99.4%
Combined	30,969	31,587	98.0%

Table 22: Quarter 2 2016/17

Waiting Under 6 Weeks	Total Waiting List Size	Percentage Under 6 Weeks
23,701	24,645	96.2%
6,616	6,706	98.7%
30,317	31,351	96.7%

Table 23: Quarter 3 2016/17

Waiting Under 6 Weeks	Total Waiting List Size	Percentage Under 6 Weeks
23,625	23,929	98.7%
6,249	6,253	99.9%
29,874	30,182	99.0%

Table 24: Quarter 4 2016/17

Waiting Under 6 Weeks	Total Waiting List Size	Percentage Under 6 Weeks
24,630	24,985	98.6%
5,735	5,737	100.0%
30,365	30,722	98.8%

Last minute cancelled operations

Table 25: Quarter 1 2016/17

	Last Minute Cancelled Operations	Elective Admissions	LMC Rate
UH Bristol	183	18,071	1.01%
Weston	50	3,699	1.35%
Combined	233	21,770	1.07%

Table 26: Quarter 2 2016/17

	Last Minute Cancelled Operations	Elective Admissions	LMC Rate
UH Bristol	132	18,990	0.70%
Weston	31	3,759	0.82%
Combined	163	22,749	0.72%

Table 27: Quarter 3 2016/17

	Last Minute Cancelled Operations	Elective Admissions	LMC Rate
UH Bristol	188	18,399	1.02%
Weston	56	3,711	1.51%
Combined	244	22,110	1.10%

Table 28: Quarter 4 2016/17

	Last Minute Cancelled Operations	Elective Admissions	LMC Rate
UH Bristol	231	18,931	1.22%
Weston	39	3,772	1.03%
Combined	270	22,703	1.19%

Length of Stay

Table 29: Quarter 1 2016/17

	Total Beddays	Total Spells	Average LOS
UH Bristol	72,934	19,765	3.69
Weston	21,669	4,276	5.07
Combined	94,603	24,041	3.94

Table 30: Quarter 2 2016/17

	Total Beddays	Total Spells	Average LOS
UH Bristol	72,254	19,782	3.65
Weston	22,364	4,310	5.19
Combined	94,618	24,092	3.93

Table 31: Quarter 3 2016/17

	Total Beddays	Total Spells	Average LOS
UH Bristol	74,921	20,087	3.73
Weston	23,712	4,099	5.78
Combined	98,633	24,186	4.08

Table 32: Quarter 4 2016/17

	Total Beddays	Total Spells	Average LOS
UH Bristol	76,252	19,277	3.96
Weston	24,501	3,879	6.32
Combined	100,753	23,156	4.35

Outpatient efficiency measures

Table 33: DNA rates 2016/17

	Attendances	DNAs	DNA rate
UH Bristol	704,000	55,066	7.3%
Weston	148,054	9,504	6.0%
Combined	852,054	64,570	7.6%

Table 34: Follow-up rates 2016/17

	Follow-up Attendances	New Attendances	Follow-up ratio
UH Bristol	488022	215978	2.26
Weston	96714	51340	1.88
Combined	584,736	267,318	2.19

Table 35: Hospital cancellation rates 2016/17

	Appointments	Hosp cancellations	Cancellation rate
UH Bristol	1,014,966	119,575	11.8%
Weston	213,668	28,737	13.4%
Combined	1,228,634	148,312	12.1%

Appendix 8 Key Design Principles for a new Acute Care Model

- Quality is the overriding consideration for the new model that we are developing, including the ability to routinely and sustainably meet relevant national safety, staffing and clinical standards.
- The WGH site operating as a clinically and financially sustainable 'Care Campus' model that brings together in one place the best of the Acute Trust with the best of primary care, community services, mental health, social services, the ambulance service, the local authority and the voluntary sector to support the creation of an integrated primary care led Community Hub working in close alignment with a new Acute Care Model.
- An Integrated Urgent Care Front Door service to effectively meet the urgent and emergency care needs of the local and visitor populations, acknowledging that more complex and life threatening conditions may be better treated elsewhere in the system.
- An Integrated Community and Acute Children's Paediatric service, that works closely with the new urgent care service model. Consider partnership options with other children's healthcare providers to improve service resilience and the potential to recruit scarce specialist staff.
- WGH operating as a recognised 'centre of excellence' for the effective treatment of frailty, including the development of new pathways – for example, a specific integrated acute and community frailty pathway.
- Integrated working with primary and community care services to help proactively manage frail and older patients and help them stay healthy and out-of-hospital for as long as possible. Frail and older patients who do need to be admitted to an acute hospital ned are enable to go home as soon as possible and that patients' experience of rehabilitation services both in and out of hospital is as seamless as possible.
- WGH operating as a recognised regional centre for NHS elective care, with a co-ordinated strategy to encourage more local people to choose it for their routine and non-complex elective care.
- Integrated services for patients by working jointly with local primary care and community colleagues, for example through joint LTC clinics in the community and / or the Community Hub, telemedicine / advice, and encouraging community services to routinely walk wards to "pull" patients through to discharge.
- The ability to use IT to appropriately share patient data and records, thereby improving co-ordination and efficiency of patient care.
- Integrated working with mental health services, including substance and alcohol misuse services, to ensure a joined-up service for vulnerable groups.
- Greater collaboration across Acute Trusts – working under the guidance of the Acute Care Collaboration workstream of the STP and further enabled by greater partnership working between UHB and WAHT and collaboration with NBT.

Appendix 9 Learning from the evidence: the challenges to realising the desired benefits from organisational mergers

A multi-site Trust is the most common organisational form for larger organisations in the NHS. This is where, through a series of transactions, mostly contiguous; one provider owns and operates a number of hospital facilities in close geographical proximity. Dalton (Ref 7) identifies the potential for 'infrastructure, clinical, and corporate synergies that can be realised through the merger or acquisition of neighbouring or nearby organisations'. He also goes on to say that 'as this model involves full change of management control to the acquiring organisation or the newly formed Trust Board of the merged organisation, there are considerable opportunities to standardise practices'.

There is however, considerable evidence in the literature that the expected benefits of merger are often overstated and often not fully realised. The Kings Fund (Ref 12) state for example that the 'widespread belief in the benefits of achieving 'critical mass'… is not supported by the available evidence'. Neither is sufficient 'recognition given to the disadvantages of creating larger, more complex organisations with conflicting cultures or business models'.

In 2016, Monitor commissioned Aldwych Partners (Ref 13) to produce a report called 'Benefits from mergers: lessons from recent NHS transactions'. This report identifies the benefits to patients and commissioners that were realised by NHS Trusts following the six case study mergers; discusses the extent to which these mergers facilitated the realisation of these benefits; and identifies factors common to those Trusts that experienced success in realising merger benefits (see below).

The report does not seek to balance the costs and benefits that arose in the six merger case studies. It carried out a more limited consideration of the post-merger benefits that were achieved. Given this approach, 'the report may come across as more positive about NHS mergers than may be the case in other studies. However, care should be taken in reading this report to remember that it does not seek to review each of these transactions as a whole'.

Key summary findings (Aldwych Partners Report 2016)

- In the six case studies, we have identified efficiencies and service delivery improvements that were realised after each merger; the extent of these benefits varies across the case studies. Savings in corporate overheads and clinical support services of around 1-3% of a merged Trusts turnover were generally realised relatively quickly post-merger,
- Service delivery improvements were also made by each Trust post-merger, and were frequently accompanied by further cost savings. A variety of post-merger initiatives led to service improvements, including consolidating services onto fewer sites where larger numbers of patients are treated, improvements in treatment processes, and investment in estate and infrastructure,
- Service improvements generally took longer to realise than savings from the rationalisation of corporate overheads and clinical support services (e.g. at least 2-3 years compared with 12 months). This was due to the greater complexity of these.

University Hospitals Bristol
NHS Foundation Trust

Cover report to the Public Trust Board. Meeting to be held on 31 January 2018 at 11.00 – 13.00, Conference Room, Trust HQ, Marlborough St, Bristol, BS1 3NU

		Agenda Item	13
Meeting Title	Public Trust Board	**Meeting Date**	Wednesday, 31 January 2018
Report Title	Transforming Care Programme Board report – Q3		
Author	Simon Chamberlain, Director of Transformation		
Executive Lead	Paula Clarke, Director of Strategy and Transformation		
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.	☒	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> The purpose of this report is to update Trust Board on progress with Trust wide programmes of work under the Transforming Care programme. <u>Key issues to note</u> The report sets out the highlights of progress over the last quarter and the next steps
Recommendations

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 recruit, train and sustain an engaged and effective workforce.	☒	Failure to comply with targets, statutory duties and functions.	☒
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.	☐		

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

January 2018

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. The Ward Processes & Real Time programme continues to embed ward process good practices across our wards. During the last quarter, a Think discharge campaign on adult wards has been run to act as a prompt to ensure that at board rounds, we are identifying and progressing discharges where possible. Progress has also been made by changes in how we manage 'To Take Away' (TTA's) medications. We have established a new process whereby a discharge pharmacist is based in the discharge lounge to distribute TTAs. As well as making pharmacists more productive (by reducing the time spent visiting wards), this has boosted the number of patients using our discharge lounge significantly, so we have ended 2017 with higher numbers than ever before using the discharge lounge and being discharged before noon. This has also supported a continued fall in the length of stay for emergency patients.

2. Alongside this, our Real Time reporting work has progressed. The Division of Medicine has led this work and during December the Division held a paper free day to pilot full paperless patient flow reporting. This demonstrated that the reporting tools work successfully, and with training now well advanced in Surgery and Specialised Services, we hope to make daily flow reporting by wards fully electronic across these three divisions by the end of this quarter. All of this work helps us to make better and faster decisions in moving patients through our hospitals.

3. This work aligns fully with the increasing adoption of digital tools on our wards as part of our Global Digital Exemplar (GDE) opportunity. Transformation and IM&T staff are continually working more closely on the detailed implementation and benefits realisation of this deployment. The new systems – including Electronic Pharmacy and Medicines Administration, eObservations, Careflow and Clinical Utilisation Review (CUR) - all provide opportunities to integrate with our Ward Processes and Real Time work. Over the next quarter, this programme will change in scope and aim as it increasingly focusses on driving the realisation of the benefits of digital transformation by supporting changes in processes and working routines and ensuring we make the best use of the increasing amount of data available in real time.

4. On 3rd and 4th January, we held the first of two Multi Agency Discharge Events (MADE). The aim of the event was to accelerate discharge where possible by inviting clinical staff from our community partners to engage in ward/board rounds and identify patients who may be suitable for discharge with support in the community.

The event had strong support from Bristol Community Health (BCH) who provided a team of community nurses and therapists across the two days. We also had the support of a GP each day, and the Bristol CCG had representatives in attendance. The MADE teams were able to directly influence the discharge of over 20 patients over the course of the event. Most of these were as a result of input from BCH staff. In one case, a BCH staff member was able to carry out an assessment of a patient on the spot to confirm their suitability for community support. In many cases, the BCH staff were able to link the patient with BCH staff and services in the community to accelerate existing discharge plans. Overall the event was very well received, with positive feedback from ward staff for the help they received. Wash up events each day ensured we captured the learning identified by participants, some of which will be implemented ahead of a second event planned for 24th-25th January.

5. During 2017 two teams from the Trust – the Integrated Discharge Service (IDS) and the Paediatric Neuro Rehab service – have taken part in a Flow Coaching programme hosted by the RUH in Bath and using the methods developed by the Micro Systems Academy at Sheffield Teaching Hospitals. To mark the end of the programme, the two teams presented the learning from their work at the closure event in Bath, alongside nine other teams from across the south west who had participated in the programme. Both UHB teams fed back positive benefits from the process. In particular, both teams derived significant benefit from the way that Big Room methodology has driven engagement from staff in supporting development of the service. In Paediatric Neuro Rehab, the project leads reported that this engagement has markedly improved the morale of staff working in the service as they have helped to identify improvements and have received regular feedback on the progress of improvement actions.

For the IDS, the method has driven engagement in the whole area of complex discharge, growing understanding of the issues, addressing roles and responsibilities and giving all the staff involved a greater understanding of actions they can take to improve flow by supporting complex discharge. It has resulted in specific changes – the adoption of the “My Life Outside Hospital” tool for gathering patient information, the development of eLearning for complex discharge, the further roll out of the Managing Expectations eLearning, and further improvements to team working in planning discharge. December has also seen the launch of the pilot of the electronic Single Referral Form. This form provides a common on line tool supported by all of the community partners for onward referral which prevents re-assessment of the patient. The design has been agreed between partners and piloted on ward A528. Some IT revisions will be made ahead of roll out later this quarter.

6. The Children’s Flow Programme continues to drive improvements in pathways through the BRHC. The hospital has adopted the Think Discharge campaign and is using it to drive embedding accurate Estimate Dates of Discharge on wards. The Children’s teams have also become one of the first adopters of CareFlow, an IT tool supporting secure real time communications between clinical teams. This tool aims to improve patient care by speeding up communications between busy colleagues. Another project in the Flow Programme is the improved scheduling of the Clinical Investigations Unit. Detailed study work has led to the design of a new bed scheduling tool which will be rolled out shortly.

7. Over the last quarter the Outpatients team have grown the use of the nationally mandated electronic referral system (eRS) for handling referrals from GPs. Adopting this is a requirement supported by a CQUIN target, and we are on track to meet the roll out trajectory. We are also underway with a pilot to manage and triage those referrals electronically which will also address delays in planning appointments. The limited pilot trial was launched in ENT in November and has been successful to date. We expect to expand the pilot later in January.

8. Our roll out of new standardised appointment letters is progressing towards completion. A further evaluation of the letters is planned for February to test the patient response to these letters. The programme has been focussed to date on Medway originated letters, but letters for Radiology appointments are separately generated from the CRIS system. In January, we are therefore commencing training in Radiology and planning to re-apply the same common standards to these letters. Work on these will then commence in February.

9. The Quality Improvement (QI) Academy was launched last year to provide training in QI skills and methods to staff who wish to undertake improvement work themselves. Our initial target to train 100 staff this year has been exceeded and we have now trained over 130 members of staff through our bronze programme which continues to receive excellent feedback from participants. During the last quarter, we delivered specific programmes focussed on junior doctors. As many of our medical trainees are required as part of their training to complete a QI project, we provided a bronze programme specifically for these groups and then organised an event to join them up with project opportunities which can support existing organisational improvement initiatives. The programme was well supported and over this quarter we are running follow up events to support the junior doctors with their projects.

10. Our initial QI Silver cohort was launched last September, aimed at providing training and support to teams with an agreed project to deliver. The programme runs over a 6 month period and nine teams are taking part with projects covering a wide range of subjects and areas. This first wave is planned to graduate from the programme in April, and we have opened bookings for a second cohort to launch in the spring.

11. Our project to develop a customer service mind-set within our teams continues to progress. A set of principles of good customer service have been developed in staff workshops and SLT members endorsed these in November. We have since been working with communications and OD teams to plan how these will be communicated and embedded into existing training systems. Alongside this a Telecoms working group has continued to meet regularly to identify how best to support improvement in the service we provide to patients phoning into the trust. We have extensively reviewed call and complaints data in order to better understand how call handling performance correlates with complaints. We are now planning workshops with specific teams with the greatest and fewest complaints to confirm good practice and to further develop the training and support we should offer to support improvement in this area.

12. During Quarter 4 we renew our Transformation priorities for the new financial year to ensure they align with the challenges and opportunities facing the Trust as

well as supporting division priorities. Our aim will be to ensure we align these priorities with the need to drive productivity and support savings, while maximising the benefits from our investments in digital technology. This will include consideration of the current transformation schemes to decide which should continue to have corporate support in 2018/19.

13. 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.

Pillar	Details	Purpose	Key deliverables	Planned month		Forecast month	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	• Staff workshop to develop customer service principles • Senior Leadership Team engagement on principles • Develop communications messages and staff engagement approach • Meet with complaints team to plan adoption of the principles in their work • Plan Outpatients development programme based on agreed prnciples • Use customer service principles to review current customer service training	Sep Oct Oct Jan Feb Dec	G A A G G A	Nov Jan Feb	• Draft principles have been developed based on workshop outputs • SLT agreed the principles on 2nd November	• Fail to align effectively with other programmes causing duplication of effort	Programme measures to be signed off
	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)	• Phased roll out of letter upgrades underway in SHN, BHI, D&T, Med & BHOC • Radiology letters via CRIS to be improved • Ongoing governance of patient letters to be agreed • Evaluation of letters project	Sep Jan-Apr Sep Feb	A G A G	Feb Feb	• Capacity of authors has led to delays • Training for PACS manager in how to update CRIS letters planned for Jan • CRIS letters for radiology patients to be updated following training • This will include a Champions Week in addition to data from complaints and staff feedback	• 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	• IT changes to Medway made to allow email validation • Adding email address collection to self check-in kiosks • Email collection commenced	May Jan-Feb Feb	R R R	Feb Apr Apr	• IT changes are not yet complete. Full review of system build required. • Dependent on the IT changes above • Email address collection will commence once IT changes have been made and the email addresses already collected have been validated	• 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	• Action Planning • Setting Performance Measures • Qualitative Work	Jan Dec Feb	G A G	Feb	• Planning workshops with teams idneitied from data review • Measures are likely to be: number of calls, number answered/abandoned/busy • Staff focus groups being organised - either via the admin transformation work, or directly with the teams used in the data analysis	• Improving telecomms quality might drive calls up • Staff don't have capacity to answer the phone or respond to queries, so quality improvement limited	• Reduced complaints • Increased patient satisfaction • Reduction in number of unanswered calls and increase in callers getting through first time
	Innovation & "Bright Ideas" **Exec lead:** Paula Clarke **Project lead:** Anne Frampton **Transformation:** Stephen Brown **Project phase:**	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 - Communications Plan • QI hub will be utilised by the QI Steering Group and embed in business as usual • QI Forum 2018 Implemented	Dec Dec Jul	A G G	Jan Jan	• QI hub now live and has been piloted • Advertising via multiple channels and on transformation boards from Dec until end of Jan • Steering group to monitor activity of hub and review submissions in monthly meetings • Monitor different types of innovations submitted through the hub to identify most common themes and develop framework to deal with those themes • Plan for next QI Forum to take place on 13th July in BHI Atrium	Development of the intranet pages reliant on one staff member	• Recognition of good practice by staff • Promotion of growth in innovation and Hub activity
	Outpatients Transformation **Exec lead:** Alison Grooms **Project lead:** Nina Stock **Transformation:** Alex Layard **Project phase:** Implementation	To deliver a high quality service through a friendly, accessible, consistent and timely service.	• Outpatient standards audit report completed • 90% of GP to Consultant referral clinics available on eRS by Q4 • e-learning package for eRS live • Learning package for eRS available • Electronic triage pilot • Outpatient standards e-learning drafted and piloted • Children's appointment booking transferred to appointment centre • Appointments booking centralised for all Divisions	Oct Jan Oct Nov Oct Nov Apr Dec	R G A G A A A A	Feb Jan Jan Jan Feb Jan Mar tbc	• Majority of audit visitis completed, audit to be written up and presented at OSG Feb 18 • To achieve the Q2 CQUIN target we need to be at 80% by Q3 - on track to achieve 90% • IT training team currently developing e-learning package and NHS Digital will deliver train the trainer sessions for their materials • Drop-in training sessions successfully delivered to original timeframe in Nov • Additional face-to-face training with IT trainers being set up until Jan due to increased demand • ENT pilot went live 27/11 with one consultant, extend to all ENT in January and then roll-out across Trust • January meeting scheduled to establish content of training • Paediatric T&O to transfer first and then process scaled up for remaining specilaities to transfer • Deputy OP Manager and Transformation Lead to take forward with Divisions based on learning from Children's	• Organisation support for Appointment Centre plans • Capacity of Divisions to complete key actions • 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:**	**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 • Think Discharge campaign (30 days) launched in October to sustain and embed ward processes • Criteria led discharge pilot review • Pharmacy process review - all 'on the day' decision for discharge patient TTAs will be managed via and delivered to the Discharge Lounge • Band 6 pilot project to deliver improvement in timely Discharge Lounge use completed • Operational Reporting and Bed Management: New reports rolled out to Surgery and specialised services • Ward View roll out • BHI flow tracker implemented across BHI (including escalation SOP)	Mar Nov Dec Dec Mar Dec Dec Nov	A A A G G G A A	Mar Dec Jan Mar	• Ward processes workstream leads are completing a summary and evaluation of work completed • Ward staff have been evaluating their performance against the current Ward Processes. From Walkabouts, common themes have arisen regarding the TTA & Discharge Summary process which impacts on the timelyness of the patients discharge and how best to run Board Rounds. •Review progress on pilot wards and to agree how to roll out Trust wide. • Increased patient discharge via discharge lounge has beeen consistently maintained. Nov figures = 612 patients • Previous month activities continue - patient experience survey completed. General feedback on patinet experience positive • Specialised Serivces to be supported by an additional trainer. • Surgery - in process of undertaking training • Meetings have taken place with South Bristol and training is going to be arranged. • Now Live on 25 Wards - 11 more to go, including SBCH still • Configuration being finalised by BHI team	• Capacity within Divisions to lead and support programmes cross divisionally given operational demands and winter pressures	• 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 • Patient experience by reduction in duplication of questioning • Single referral form will promote improved quality and timeliness of information, supporting trusted assessment
		Integrated Discharge Service To establish a fully Integrated Discharge Service which reduces occupied bed days whilst improving patient outcomes and experience	• Single Referral Form - PDSA Cycle 3 • Single Referral Form roll out Trustwide to replace CM7 completed • Larger scale roll out of multi-disciplinary patient information sharing document completed • A discharge education and resource site for staff available via the intranet	Nov Apr Mar Dec	G G G A	Complete Jan	• Has been piloted on ward A528 • The reporting and sharing mechanism is currently being developed with IM&T • Post Pilot review completed. • Need to address document flow queries to test now working correctly with IM&T • Document renamed now under final reformatting prior to wider roll out • First four topics prepared, ready for go-live final technical elements being addressed . Further monthly rollout plan in place	• Insufficient capacity in the community • Insufficient resilience in community	
	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.	• CIU clinic scheduling tool and standardised scheduling processes implemented to improve access and utilisation of clinics. •Divisional EDD today and tomorrow action plan - 'Think Discharge' campaign implemented • Revised BRHC SAFER bundle launched alongside BRHC Professional Standards • "Your Child's Stay at BRHC" booklet to support families during their stay and after discharge developed and implemented • Early adoption of Careflow communication system implemented in the Haem-Onc-BMT service, followed by roll-out across all BRHC	Feb Sep Sep Mar May	G A A G G	Dec Mar	• Expanding the implementation of CIU bed scheduling processes work is dependant on the outcome of the CIU coordinator business case. Review of clinic scheduling has commenced. • Go-Live on Ward 30 commenced 04/12, daily monitoring of EDD accuracy underway. Next steps to improve performance are being planned. Further roll-out to be agreed. • Implementation delayed due to winter pressures, plan to align with CUR implementation • Amended booklet awaiting project team feedback. • Planned expansion to ward 34-35 being developed. Whole hospital being designed. Kick off meetings in Jan.	• Capacity of Programme Lead and Transformation Lead slows down delivery of programme	• Improvement in 4 hour target • Reduction in last minute cancellations
Renewing Our Hospitals	**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 rolled out across trust • Careflow live in pilot locations • Nursing Electronic Observations go live in initial areas • EPMA live in first areas • EDM go-live in remaining sites	Mar Sep Oct Feb Mar	G A A A A	Jan-18 Mar-18 Feb-18 Mar-18	• CUR is now live on 8 wards with a further 11 wards in process/training • Project on target to be Trust Wide by Mar 2018 • Careflow is live and in use • Expanding the use of Careflow to include handover for clinicians • There is an extensive plan for the BRHC following on from the Paediatric Hemotology pilot. • E-Observations is live in the first wards and is performing well • Rollout across all wards by March 2018 (subject to confirmation) • EPMA Wider roll out planned for Q4 after C805 pilot evaluation • Since the 11th December 17 EPMA has been implimented on C705, CCU and Cardiac Cath labs. • Evaluating the pilot lessons and preparing for a wider roll out. • Go live (paper-light) at the BRI/BHI/SBCH is complete • Go live planned for BDH (Jan); BEH (Feb) and BHOC (Mar) • Process planning in BEH/BDH is being wrapped up.	• The Scanning bureau is working to full capacity but this is not achieving scanning 100% of evolve patient notes across the BRI/BHI/SBCH. This will also affect the scanning for BDH, BEH and BHOC	• Assurance that patients are receiving the correct level of care Identify opportunities for efficiency savings. • Improved Patient Safety by reducing the risk of errors occurring when calculating Early Warning Scores and by supporting clinicians to ensure they conduct patient observations on time. • Reduction in avoidable harm from medication errors through legible prescriptions and decision support
Building capability	**Improving Staff Experience - "Happy App" roll out**	To provide a method for staff to leave real-time feedback regarding how they are feeling	• UHB governance ongoing to be agreed • Happy app relaunch and promotion campaign	Apr Dec	R G	TBC Jan-Mar	• Trust-wide governance of the Happy App is still TBC • Working with comms to plan trust-wide comms campaign to launch in Jan • Relaunch campaign to coincide with system upgrade in Jan	• Availability of IT support/resource • Willingness of staff to engage • Administrator resource to respond to	• Use of app (number of hits a day per area) • No of areas using website
	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.	• 6th Bronze programme held • Continued QI support sessions for junior doctors launched • Silver programme initial cohort complete	Jan Mar Mar	A G A	Feb Apr	• January Bronze programme cancelled as non-essential training - Rearranged for February, March and April. February fully booked. • Final QI training and 'Project Ideas Workshop' evening session held on 29th Nov • Follow-up session for Drs to present their progress and troubleshoot planned for March • January Silver programme cancelled as non-essential training • Forth session of six planned for Feb • Second Cohort to begin in March	• 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:** Matt Joint **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.	• Continued embedding of the leadership behaviours following rollout • Executive leadership development programme launched (Leadership behaviours will be integral to this programme).	Dec Q1 - 18	G G	Complete	• Outcome of leadership behaviours roll out to feed into 360 feedback appraisal programme • Leadership behaviours embedded in induction and recruitment as of Nov/Dec • Monthly rollout sessions communicating LB are planned • LB embedded in leadership and management courses • Launch event for programme on Jan 26th - with programme commencing Q1 2018. • Leadership programme currently being finalised.	• 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 • Support a culture of compassion
	Admin Teams Transformation **Exec Lead:** Matt Joint **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.	• Remaining training plans and competency frameworks per role designed • Training redesign proposal developed • Roll out of new job descriptions • SOPs for each role created • 'Phase 2' launch • Assessment Centre alternative to be explored	Sep Dec Feb-Apr Mar Feb Jan-Mar	A A G A G G	Jan Feb Feb	• Working with OD team to discuss how these can be linked in with appraisal and performance management systems • Med Sec training competency frameworks in development • Proposal to redesign Medway ERS and RTT training for new starters as well as introduce annual update days has been developed. This will go to the steering group for sign off in early Feb. • Working with HRBPs to plan the roll out in each Division • Engagement events to be booked Feb-Mar • BHOC inpatient SOPs finalised and will be published on role information info web page • Medicine inpatient SOPs to be picked up once live • The road map of admin, outpatients, customer care, communications improvement and digital dictation projects to be finalised. • Assessment centre model will finish end of Mar 2018, due to budget restraints. Working group to develop plan of action.	• 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:** Matt Joint **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	• Continue to embed system for remainder of the year - until e-appraisal becomes 'business as usual' • Indicative timescales have been develped for a feedback-mechanism for staff appraisals to go live Q4 17-18 • Indicative timescales have been developed for introduction for 360 degree feedback for leadership behaviours to go live Q1 18-19	Mar-18 Mar-18 Apr-18	A G G		• Have been encountering significant problems with the e-appraisal system losing connectivity and not saving user updates. Identified as supplier issue. Kalidus are working towards 12th Dec as deadline for fix. • Scoping meeting held and timetables agreed • Scoping meeting held and timetables agreed	• 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 • Support a culture of compassion

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

Updated: 10/1/2018

University Hospitals Bristol
NHS Foundation Trust

Cover report to the Public Trust Board. Meeting to be held on 31 January 2018 at 11.00 – 13.00, Conference Room, Trust HQ, Marlborough St, Bristol, BS1 3NU

		Agenda Item	14
Meeting Title	Public Trust Board	**Meeting Date**	Wednesday, 31 January 2018
Report Title	**Renewing the Trust 5 year Strategy**		
Author	Sarah Nadin, Associate Director of Strategy & Business Planning and Paula Clarke, Director of Strategy and Transformation		
Executive Lead	Paula Clarke, Director of Strategy and Transformation		
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.	☒	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							
For Decision	☐	For Assurance	☒	For Approval	☐	For Information	☒

Executive Summary

Purpose

The purpose of this paper is to outline the proposed approach to recommit to and renew our overall Trust Strategy and long-term ambition for the period from 2019-2025.

Key issues to note

The paper sets out:

- The aims and objectives of the renewal programme.
- The key drivers informing the need to review and refresh our strategy.
- The method that will be used to achieve the objectives over a phased programme.

This is a 12-18 month programme of work with the objective of the programme being:

- to set the strategic direction for the Trust from 2019-2025, setting out a clear position on what we want to achieve and how we will do this and ensuring our organisational vision remains fit for purpose.

The approach will ensure involvement and engagement of our staff and our stakeholders and will be developed in the context of the Bristol, North Somerset and South Gloucester Sustainability and Transformation Programme.

Recommendations

Members are asked to:

- **note and support** the content of the programme and the proposed approach to delivering a renewed and integrated organisational strategy

Intended Audience									
Board/Committee Members	☒	Regulators	☐	Governors	☒	Staff	☒	Public	☒

Board Assurance Framework Risk			
Failure to maintain the quality of patient services.	☒	Failure to develop and maintain the Trust estate.	☒
Failure to recruit, train and sustain an engaged and effective workforce.	☒	Failure to comply with targets, statutory duties and functions.	☒
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.	☒		

Corporate Impact Assessment							
Quality	☒	Equality	☐	Legal	☐	Workforce	☒

Impact Upon Corporate Risk
N/A

Resource Implications

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)**

UH Bristol – Our 5 Year Strategy Renewal Programme

1. Introduction

The purpose of this paper is to outline the proposed approach to recommit to and renew our overall Trust Strategy and long-term ambition for the period from 2019-2025.

This paper will provide the following;

- The aims and objectives of the renewal programme.
- The key drivers informing the need to review and refresh our strategy.
- The method that will be used to achieve the objectives over a phased programme

The objective of the programme is to set the strategic direction for the Trust from 2019-2025, setting out a clear position on what we want to achieve and how we will do this and ensuring our organisational vision remains fit for purpose.

This is a 12-18 month programme of work with the following key aims:

- ✓ To understand and pro-actively manage our responses to our significantly changed and changing national and local environment .
- ✓ To provide a framework for securing the ongoing success of the organisation and, where needed, to think radically about our approach to achieve this.
- ✓ To make explicit, evidence-based choices about maximising our opportunities and addressing our increasing challenges to delivering our stated strategic intent.
- ✓ To use the process of developing our strategy to further grow staff, patient and wider stakeholder engagement.
- ✓ To secure ownership and understanding of the final outputs and delivery actions
- ✓ To have learned from, and built upon, the successes and gaps in our current strategy.
- ✓ To align with our Operational Planning Process and have measurable milestones to determine successful delivery of strategic priorities.

2. Background

The environment the Trust is operating in now and into the future is significantly different from the environment that prevailed at the time of our last major strategic development processes (2010/2014) and the development of our current strategic plan '*The 2020 Vision*- (2014-2019).

We also face a number of new performance challenges driven by increasing demand across both non-elective and elective acute services, with new and potentially radical solutions required to manage the balance of delivery effectively and efficiently in future years.

We have set out the work to renew our Trust's strategy over the next year in the programme of work which follows. We have designed this approach taking account of Senior Leadership Team (SLT) feedback, previous strategy development programmes, our Well-Led Governance Review recommendations and have taken into consideration the NHSI (Monitor) Strategy Development Toolkit.

3. Strategy Development Overview

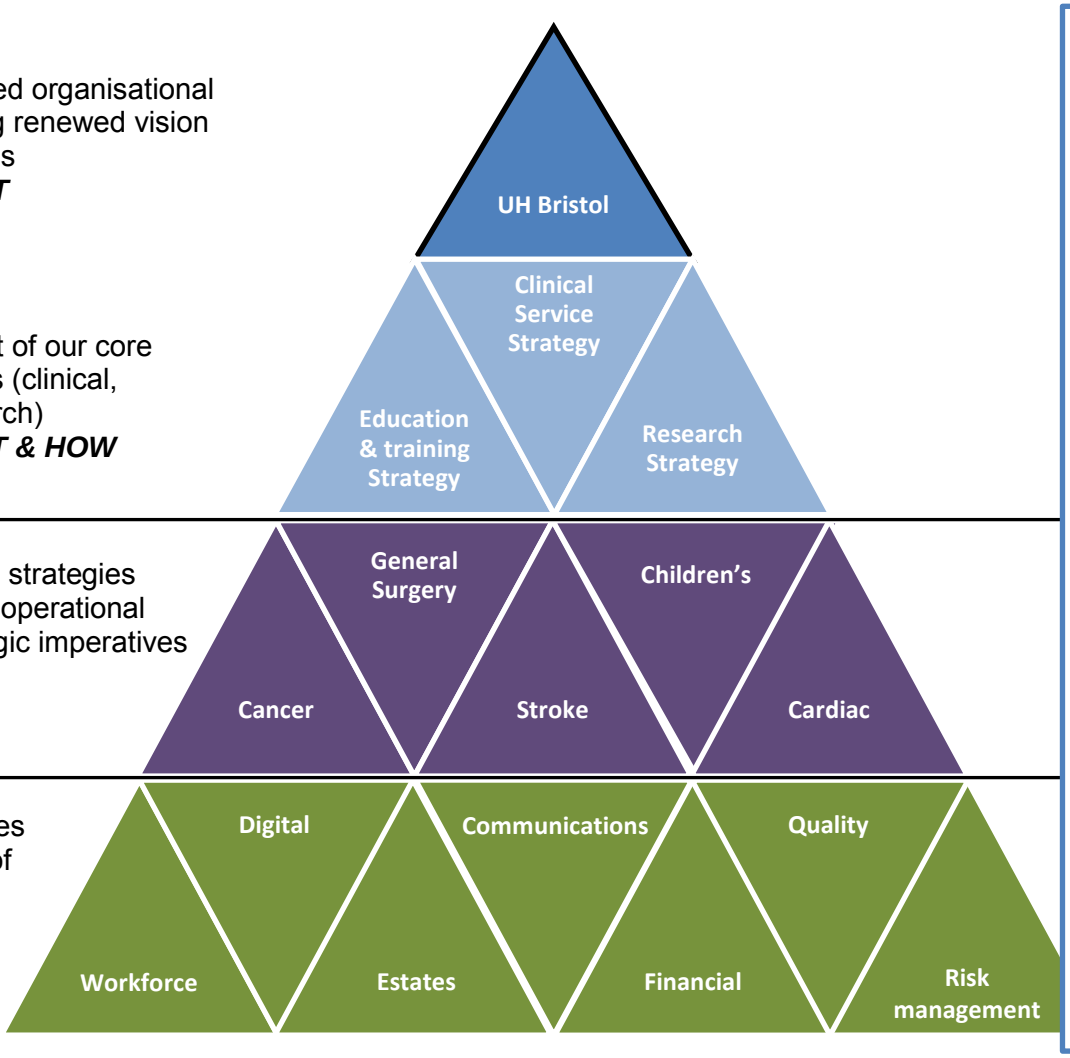
An overview of what we want to achieve is outlined below;

Develop integrated organisational strategy including renewed vision and strategic aims
Clarity on WHAT

Ensure alignment of our core service strategies (clinical, education, research)
Clarity on WHAT & HOW

Individual service strategies must reflect both operational reality and strategic imperatives
Clarity on HOW

Enabling strategies align to delivery of core strategies
Clarity on HOW



Responding to and influencing our context and environment - Healthier Together (STP Plan)

4. Our Approach - Summary

The outputs and approach to be adopted in the 4 phases of our strategy development is set out against the high level timeframe below:

Phase 1:
Agree the Strategic Context & Drivers (A Case for Change)

- Set out the strategic context and case for change which our new strategy must respond to
- Understand our past & current performance & productivity
- Trust SWOT/PESTLE *
- Identify key drivers (importance/impact)
- Identify initial set of possible strategic responses (choices) to key strategic drivers

Complete by: February 2018

***SWOT:** Strengths, Weaknesses, Opportunities, Threats
PESTLE: Political, Economic, Social, Technological, Legal, Environmental

Phase 2:
Renew our Vision and Strategic aims

- Engage with a broad range of internal and external stakeholders on the context and drivers for change
- Deploy a wide range of engagement approaches to secure views on our possible responses and key strategic choices
- Identify key points staff would wish to see in our vision
- Strategic analysis/financial assumptions developed to support decisions on our draft strategic aims

Complete by: May 2018

Phase 3:
Develop core service delivery and supporting strategies

- Develop service and enabling strategies that respond to the drivers, context, vision and draft strategic aims
- Focus on key areas of change we will have to make and how we plan to achieve this
- Ensure we have an integrated and consistent set of plans to inform the final Trust strategy
- Support alignment of early actions into the 2019/20 Operating Plans. (embed ownership)

Complete by: October 2018

Phase 4:
Finalise and launch our Integrated Strategy

- Finalise strategic aims and actions to deliver over the strategic period
- Develop an integrated strategy document
- Consult on this for a limited period
- Launch an agreed communications plan
- Deliver, monitor and flex

Complete by: January 2019

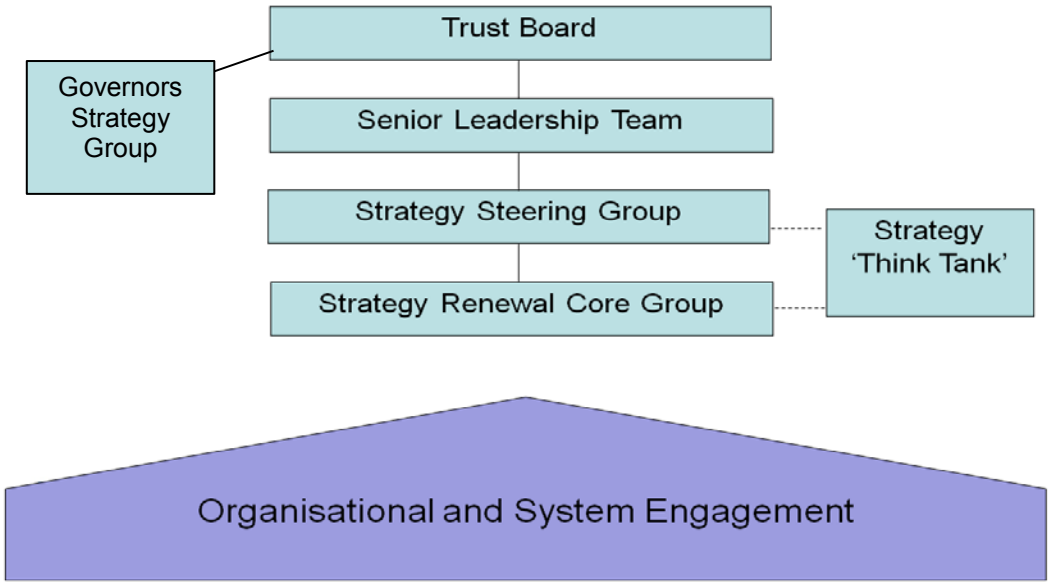
Throughout the process continue to adapt to and influence emerging drivers & system plans

Key success criteria for how we complete our strategy renewal will include:

Success Criteria	Where we will address this
• Ownership and understanding of the strategy	Tested at phases 2, 3 and 4 via feedback tools. Check in at 9 months and years 2 and 3
• Securing engagement and involvement of staff and stakeholders	Primarily phases 2 & 3
• Clarity of delivery milestones/key actions	Phases 3 & 4
• Alignment into Operating Plans	For 2019/20 plans going forward

5. Governance

The diagram below outlines the governance of the programme. This will be driven by the Strategy Renewal Core Group with the Strategy Steering Group providing a key leadership role, alongside oversight from the Senior Leadership team and Trust Board.



The strategy "Think-Tank" will provide a small group of stakeholders both internal and external, to help challenge and shape our approach throughout.

6. Our Current Five Year Strategy

6.1 Summary of Key Aspects of Current Strategy

Our current strategy outlines the UH Bristol Vision is 'for Bristol and our hospitals, to be among the best and safest places in the country to receive care', with the Strategic Intent ***'to provide excellent local, regional and tertiary services, and maximise the benefit to our patients that comes from providing this range of services'.***

Our strategy identifies six key strategic priorities for the period 2014 to 2019. These are:

- We will consistently deliver high quality individual care, delivered with compassion;
- We will ensure a safe, friendly and modern environment for our patients and for our staff;
- We will strive to employ the best and help our staff fulfil their potential;
- We will provide leadership to the networks we are part of, for the benefit of the region and the people we serve;
- We will ensure we are financially sustainable to safeguard the quality of our services for the future and that our strategic direction support this goal; and
- We will ensure we are soundly governed and are compliant with the requirements our regulators.

6.2 Progress in the Delivery of our Current Strategy

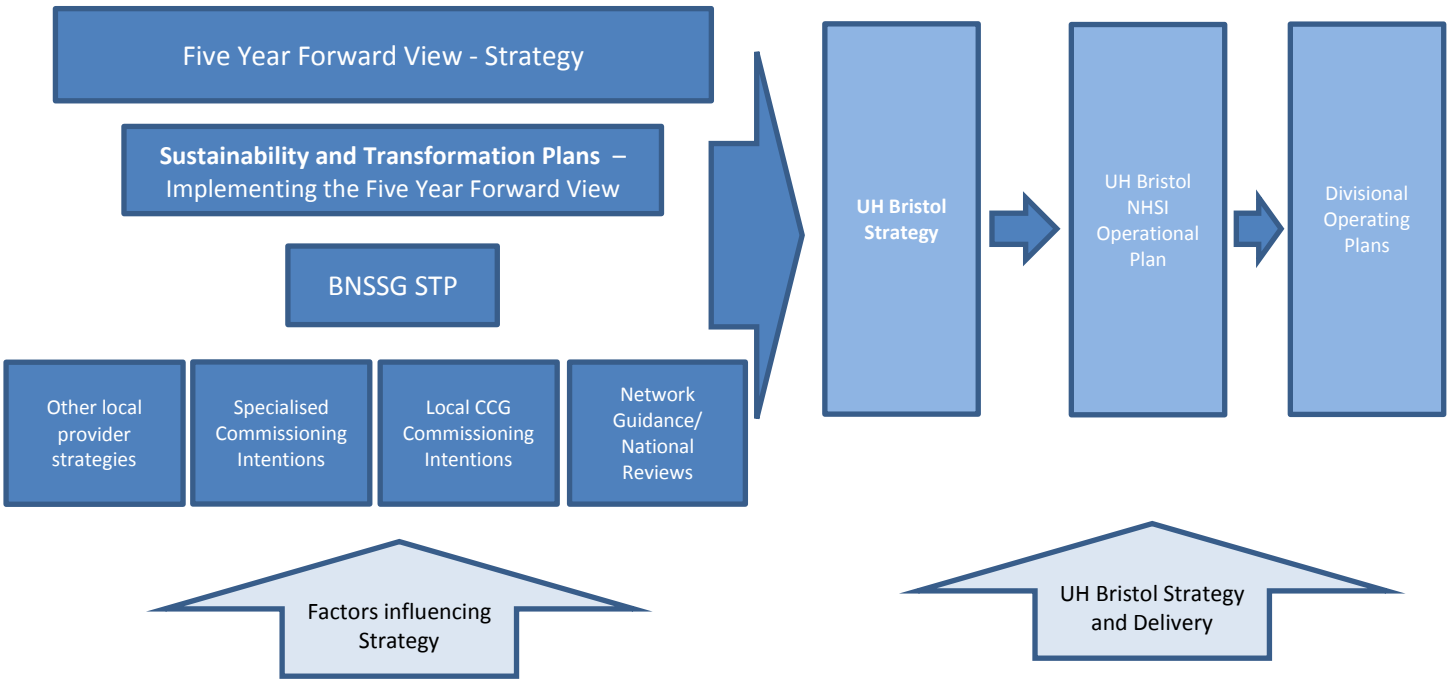
It is of note that significant and tangible progress has been made in the delivery of the priorities outlined in our current strategy. Some examples include;

- **Achievement of a CQC rating of Outstanding** in 2017, being the only Trust in the country which has moved from a rating of Requires Improvement to Outstanding.
- **Development and delivery of our new quality strategy and objectives.**
- **Financial sustainability** – Throughout the planning period, the Trust has continued to operate an annual financial surplus in the context of increasing demand and financial constraints both locally and nationally.
- **Maximising the impact from STP system working** – UH Bristol has provided leadership within the BNSSG STP, working collaboratively to ensure we have a shared vision and plan to respond to changing and increasing healthcare demand.
- **Estates and capital strategy** - Phases 1 to 4 of the redevelopment programme has been completed.
- **Service reconfiguration** – The Trust has successfully delivered the reconfiguration of a number of clinical services across the city, including the full centralisation of specialist paediatric services in the Bristol Royal Hospital for Children and the transfer of Breast, vascular surgery, cellular pathology and Urology Services to North Bristol Trust.
- **Service Development** – The Trust has continued to be at the forefront of innovation in the development of new services for our patients, this includes the development of the Icon gamma knife which was installed in July 2015 – only the second such installation in the world.
- **Research and Innovation –** The Trust secured a significant grant from the National Institute for Health Research to fund a Biomedical Research Centre undertaking cutting edge studies that will improve care and treatment in the future
- **Innovation in patient safety -** The Bristol Royal Infirmary Emergency Department is leading the way in the regional/national development of an ED safety checklist, implemented as part of the SHINE project during 2015.
- **Values and Leadership Behaviours –** The Trust has developed core values with staff and embedded these across our activities and training programmes. The newly developed Leadership Behaviours programme establishes the behaviours expected by all leaders and managers within the organisation.
- Awarded **National Digital Exemplar site** status and investment.
- Continued development and delivery of our **Transforming Care Programme** focussing on transforming the way in which we deliver care through service and workforce redesign, including the development of a **QI academy.**

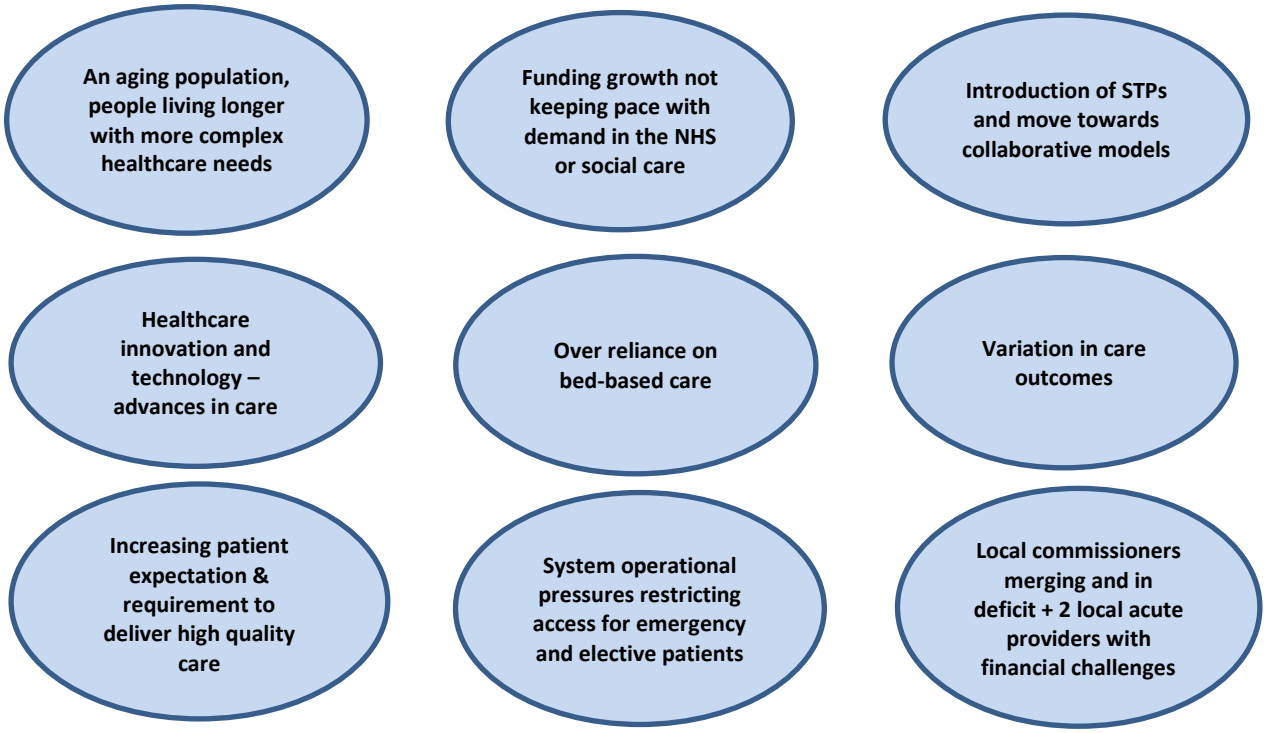
7. The Case for Change – why we need to renew our strategy

7.1 Our Operating Environment

There is a clear and fundamental relationship between the development of our organisational strategy and the environment in which we operate. The diagram below outlines the key external factors, which drive the development of our plan, along with the relationship to our Operational Planning Process.



7.2 Key characteristics of our **external** operating environment include;



7.3 Key characteristics of our **Internal** operating environment

The key operational features of our organisation, which we will need to build on and address through the development of our new strategy include;

7.4 The work in Phase 1 of the programme will develop our assessment and understanding of these key characteristics to determine their relative priority in impacting on our strategic aims.

8 Conclusion

Trust Board to note and support the content of the programme and the proposed approach to delivering a renewed and integrated organisational strategy. As the programme progresses, updates will be brought to the Board and to Governors Strategy group.

University Hospitals Bristol
NHS Foundation Trust

Cover report to the Public Trust Board. Meeting to be held on 31 January 2018 at 11.00 – 13.00, Conference Room, Trust HQ, Marlborough St, Bristol, BS1 3NU

		Agenda Item	15
Meeting Title	Public Trust Board	**Meeting Date**	Wednesday, 31 January 2018
Report Title	Partnership Programme Board Update		
Author	Eric Sanders, Trust secretary NBT		
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

Eric Sanders, Trust Secretary at North Bristol NHS Trust has provided this update report for information, following the meeting of the Partnership Programme Board on the 15 January 2018. This report will also be received by North Bristol NHS Trust's Board of Directors for information.

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 recruit, train and sustain an engaged and effective workforce.	☐	Failure to comply with targets, statutory duties and functions.	☐
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.	☐		

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 to:	Trust Board	**Agenda item:**	
Date of Meeting:	1 February 2018		

Report Title:	Partnership Programme Board Update			
Status:	**Information**	**Discussion**	**Assurance**	**Approval**
	X		**X**	
Prepared by:	Eric Sanders, Trust Secretary			
Executive Sponsor (presenting):	Robert Mould, Non-Executive Director			
Appendices (list if applicable):	None			

Recommendation:
The Trust Board is asked to note the update provided from the last meeting of the Partnership Programme Board.

1. Purpose

1.1. To provide an update following the meeting held on 15 January 2018.

2. Background

2.1. The Trust delivers the actions agreed in the Partnership Agreement with University Hospitals Bristol NHS Foundation Trust, through a Partnership Programme Board (PPB).

2.2. This Board is formed through the meeting in common of two Partnership Committees, one from each organisation.

2.3. Each Committee is required to formally report to their Board's after each meeting.

3. Business Undertaken

3.1. The PPB considered and discussed the following items:

3.1.1. Neonatal Intensive Care – good progress had been made between the two teams to develop proposals which would support the network's requirements. This was underpinned by robust governance arrangements. A business case was under development which would need to be reviewed and approved by the two Boards in due course.

3.1.2. Cardiology - although initially good progress had been achieved and a successful workshop had been held between the two teams to consider new models of working, progress had slowed. The PPB discussed the principles to support the project and noted that these focused on ensuring that patients received the best possible care, in the right location and environment. This would mean improving flow between the two units and improved collaboration. It was agreed to reinvigorate the project given the issues and potential benefits.

3.1.3. Pathology – an update was received on the procurement of a Managed Equipment Service, response to the request to tender for the genetics laboratory, and work to develop the pathology collaboration across the new network area as defined by NHS Improvement. An opportunity to potentially align the network with the Academic Health Science Network would be explored.

3.1.4. Healthy Weston – the opportunities around closer collaboration between the three acute Trusts in Bristol, North Somerset and South Gloucestershire (BNSSG) was discussed and how this could support the commissioner's review of services at Weston.

3.1.5. Sustainability & Transformation Partnership (STP) – alignment of the priorities of the PPB and the STP were discussed to ensure benefit delivery and convergence.

4. Key Risks Identified and Impact

4.1. The potential for changes to services at Weston which may impact on services at Southmead and University Hospitals Bristol were discussed. Mitigations included close working through the Healthy Weston project.

5. Key Decisions

5.1. There were no decisions to report.

6. Exceptions and Challenges

6.1. There were no exceptions or challenges identified.

7. Governance and Other Business

7.1. It was agreed that further work was required to ensure that the benefits from the partnership were clearly articulated and signed up to, and that the PPB agenda was then focused on achieving these.

7.2. Dates for future meetings would be set for the year ahead.

8. Future Business

8.1. The PPB will be monitoring progress against the key projects and specifically providing assurance to the respective Boards on the NICU project.

9. Recommendations

9.1. The Trust Board is asked to note the update provided from the last meeting of the Partnership Programme Board.

University Hospitals Bristol
NHS Foundation Trust

Cover report to the Public Trust Board. Meeting to be held on 31 January 2018 at 11.00 – 13.00, Conference Room, Trust HQ, Marlborough St, Bristol, BS1 3NU

		Agenda Item	16
Meeting Title	Public Trust Board	**Meeting Date**	Wednesday, 31 January 2018
Report Title	**Reserch and Innovation Report**		
Author	**David Wynick**		
Executive Lead	Mark Callaway, Acting Medical Director		
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.	☐	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 an update on performance and governance for the Board. Key issues to note See executive summary in 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 recruit, train and sustain an engaged and effective workforce.	☐	Failure to comply with targets, statutory duties and functions.	☐
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.	☐		

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)**

Executive Summary

Performance:

Our confirmed end of quarter 2 2017/18 performance figures showed a further improvement in recruiting patients to time and target into contract commercial trials with 68% meeting the target (Q4 2016/17: 55%; Q1 2017/18: 60%).

We are currently maintaining our position above the trajectory projected at the start of the financial year for weighted patient recruitment into NIHR portfolio clinical studies. However, as reported last quarter due to a decrease in the number of patients being recruited into primary care, the performance of the regional clinical research network as a whole has declined. This in turn presents a financial risk to the Trust for 2018/19 and beyond.

Partnerships and Governance:

Funding for the extension to the CLAHRC has been agreed and contracts have been signed for the period of the extension. The call for the next round of CLAHRCs is expected during 2018, although precise timing is not yet clear.

The official launch of the Biomedical Research Centre takes place on 1st February 2018.

The NIHR Clinical Research Network has indicated that contracts for hosting the Local Clinical Research Networks are likely to be extended by three years (beyond March 2019). We await formal notification of the details.

Preliminary scoping work around the expected call for Academic Health Science Centres in 2018 has commenced, focussing initially on identifying Bristol's areas of excellence in research, education/training/workforce development and clinical delivery.

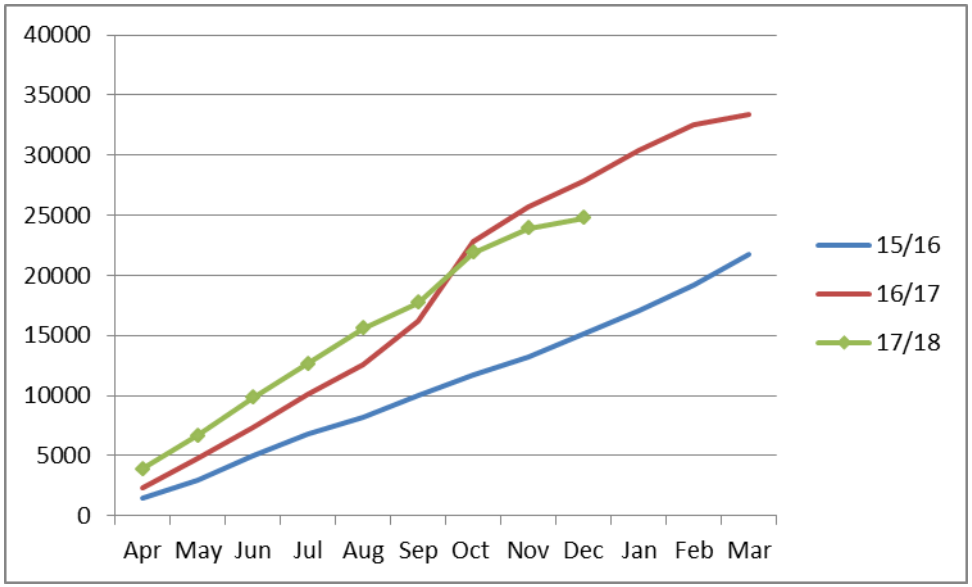
Overview

Successes	Priorities
• Our ongoing improvement in performance in recruiting to time and target for commercial trials has contributed to an increased financial allocation to the West of England CRN. • Bristol Haematology and Oncology Centre recruited the first global patient to a commercial phase 1 trial. The trial was in adults with Graft vs Host disease, and it was led in Bristol by Dr James Griffin.	• Work closely with the Division of Medicine management team and the Medical Research team to achieve a stable model of working that will be clinically and financially sustainable in the long term. • Support the West of England Clinical Research Network in developing a sustainable model of working across all partner organisations in order to protect future income streams and strengthen the network as a whole.
Opportunities	**Risks and Threats**
• Develop plans to increase engagement and input of clinicians into research, ensuring allocated time in job plans translates into research activity which is visible and measurable.	• Ongoing clinical pressures deprioritise research across the trust and limit opportunities to maintain activity, and increase in new areas of potential. The expected “flat cash” research funding means that in order to increase new areas of potential activity, funding has to be removed from other areas.

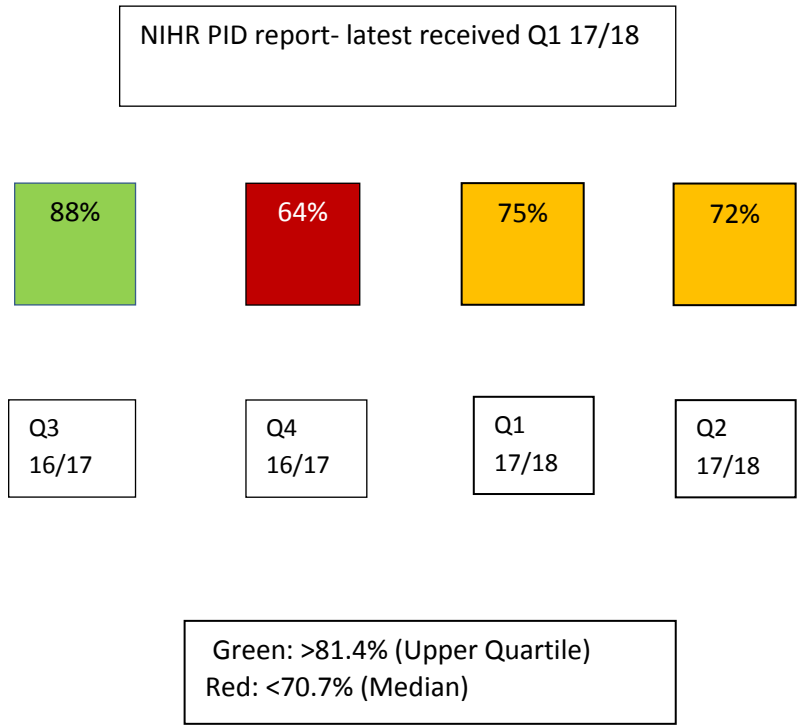
Performance Overview

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

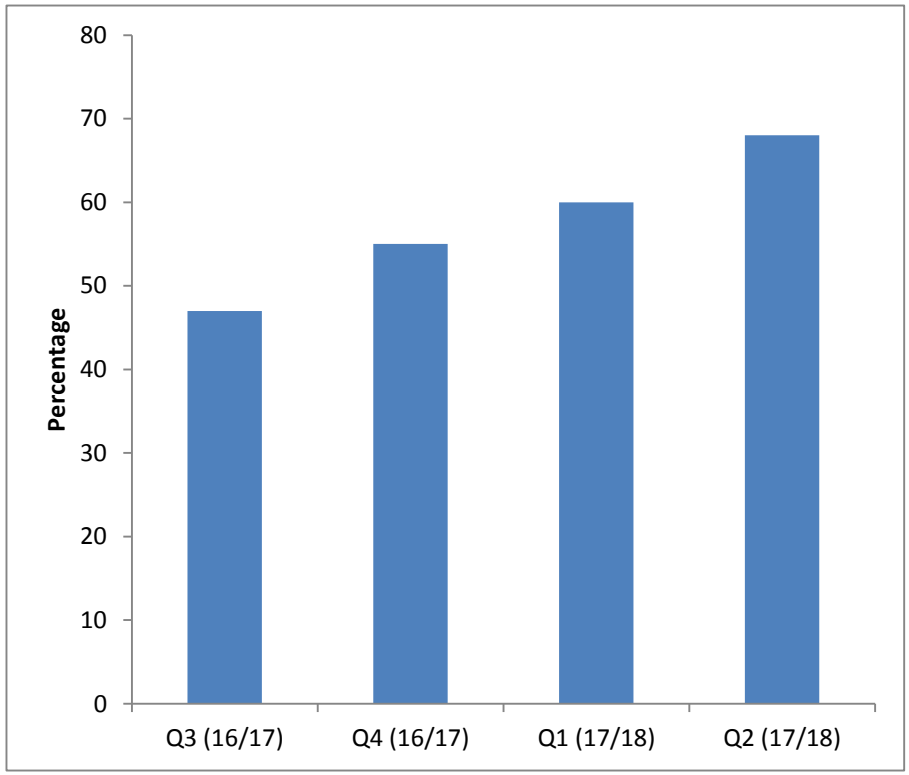
a) Cumulative weighted recruitment into NIHR portfolio studies 17-18. [NB. There is a 6 week lag in recruitment data becoming visible on the system.]



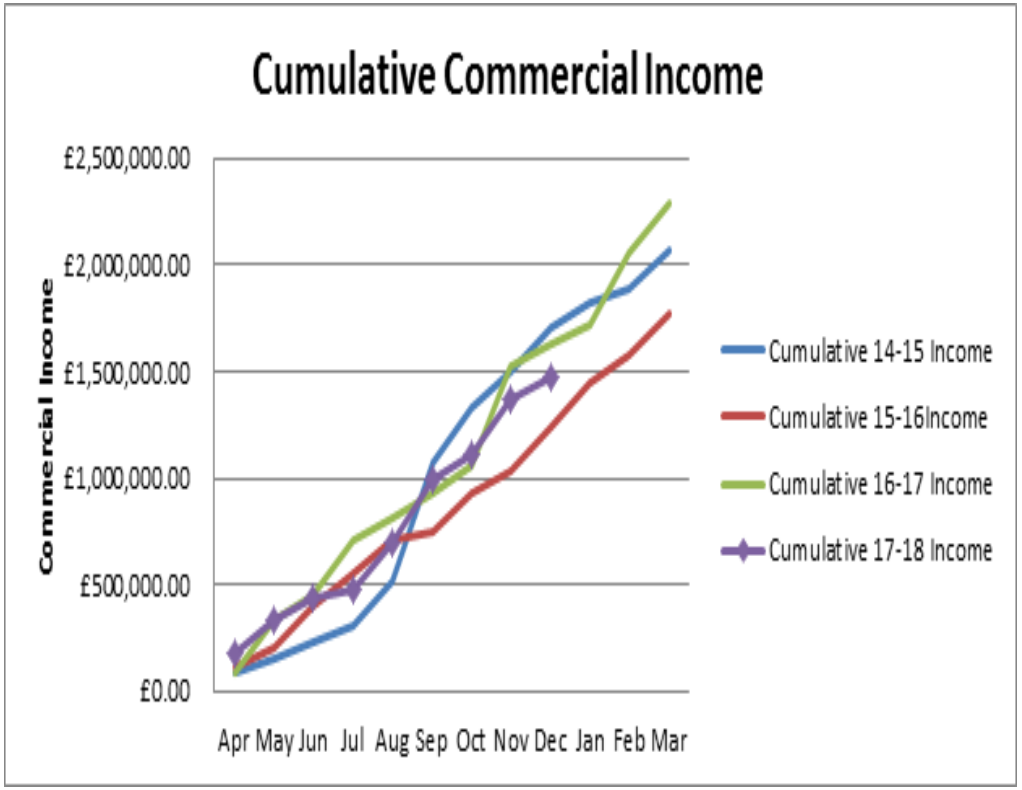
b) Performance in meeting the 70 day first patient first visit benchmark adjusted by NIHR in comparison to other Trusts



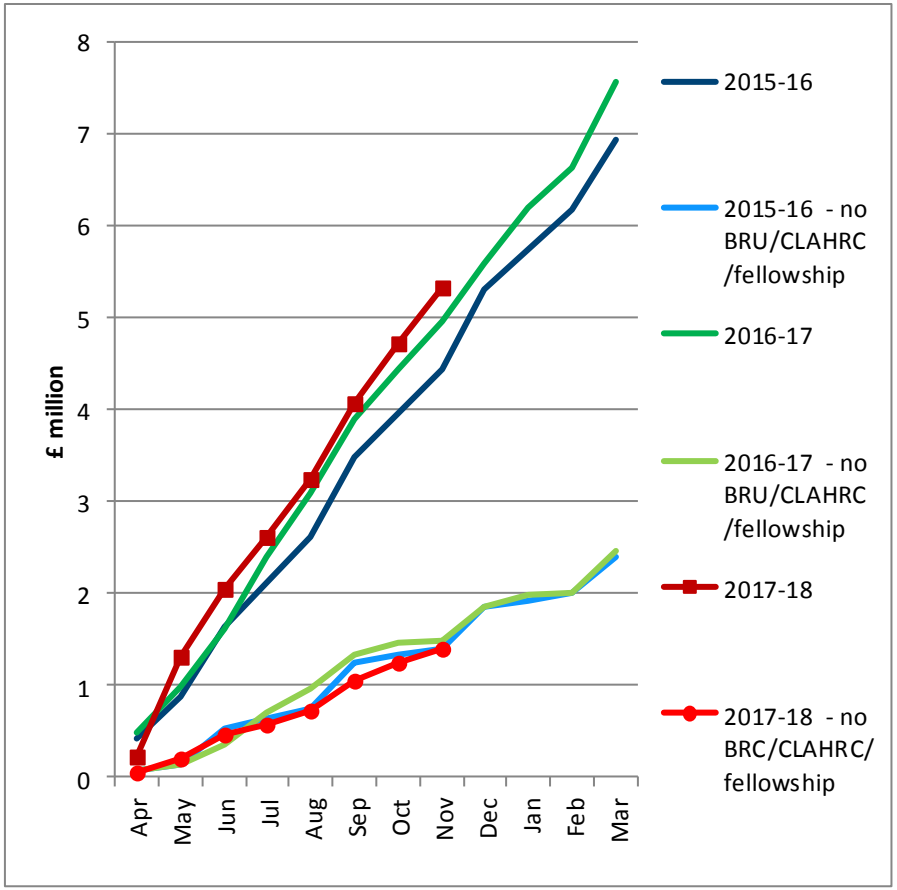
c) Percentage of closed commercial studies recruiting to time and target



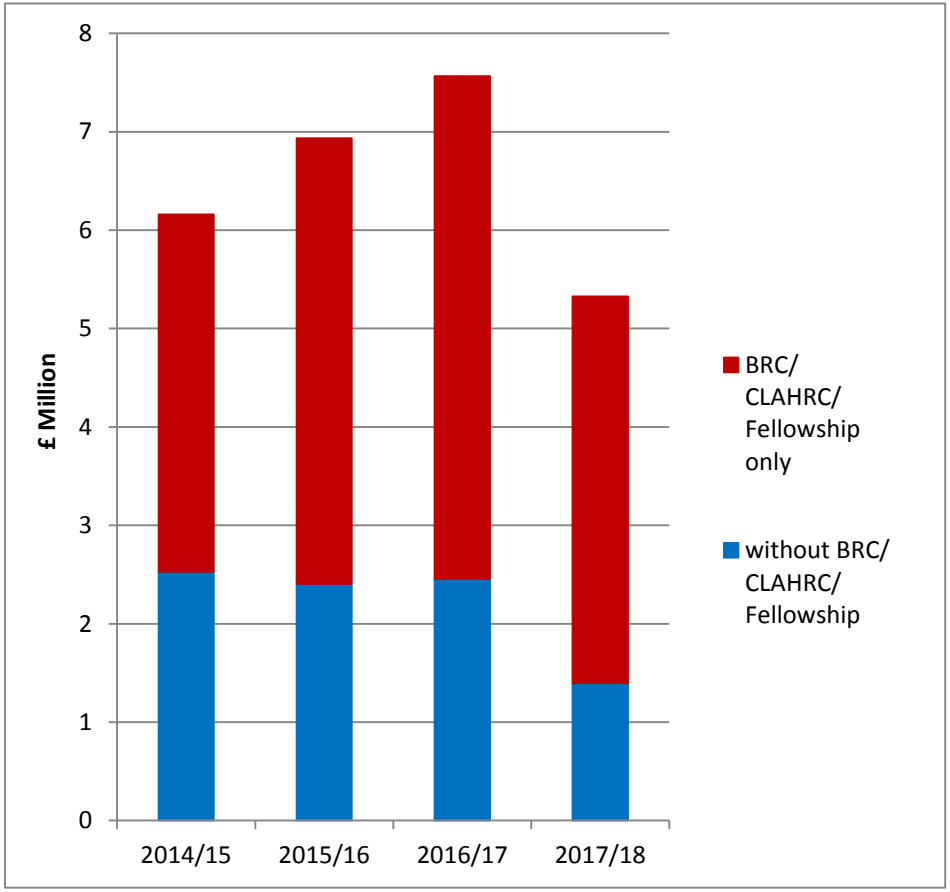
d) Monthly commercial income



NIHR monthly grant income – year on year comparison



NIHR grant income – drives research capability funding.



University Hospitals Bristol
NHS Foundation Trust

Cover report to the Public Trust Board. Meeting to be held on 31 January 2018 at 11.00 – 13.00, Conference Room, Trust HQ, Marlborough St, Bristol, BS1 3NU

		Agenda Item	17
Meeting Title	Public Trust Board	**Meeting Date**	Wednesday, 31 January 2018
Report Title	Finance Report		
Author	Paul Mapson, Director of Finance and Information		
Executive Lead	Paul Mapson, Director of Finance and Information		
Freedom of Information Status		Open	

Strategic Priorities (please choose any which are impacted on / relevant to this paper)			
Strategic Priority 1: We will consistently deliver high quality individual care, delivered with compassion.	☐	Strategic Priority 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 the Board of the financial position of the Trust for December, and to approve the Board self-certificate required by NHS Improvement.

Key issues to note

The Operational Plan for December is a surplus of £9.149m excluding technical items. The Trust achieved a surplus of £8.871m, £0.278m adverse to plan. The Divisional run rate improved significantly in December. The Clinical Divisions and Corporate Services overspend in month was £0.077m, increasing the cumulative adverse variance to £7.351m.

Excluding STF funding the Trust is reporting a surplus of £0.517m against a planned surplus of £0.496m. STF core funding has been achieved at each quarter end. STF performance

funding was not achieved at quarter one (84.8% against target of 90%), but was achieved at quarters two and three (90.9% and 92.8% respectively). STF funding loss of £0.299m is therefore incurred to date.

The month 9 key data return was submitted to NHS Improvement on the 16th January in line with the timetable. The Excel submission (summarised in attachment 1) is provided for information.

The quarter 3 Board self-certificate included in the 23rd January submission is attached as attachment 2.

Recommendations

Members are asked to:

- **Note the contents of the Finance report**
- **Approve the Board self-certificate as required by NHS Improvement (attachment 2)**

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 recruit, train and sustain an engaged and effective workforce.	☐	Failure to comply with targets, statutory duties and functions.	☐
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.	☐		

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

Impact Upon Corporate Risk
Risk 1843 – Failure to deliver the Trust's Operating Plan control total surplus of £12.957m based on the Divisions current rate of overspend. Risk 951 – Risk of the loss of S&T funding due to the failure to achieve the "core" control total.

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)**
	26 January 2018			

Report of the Finance Director

Section 1 – Executive Summary

	2017/18 Annual Plan	Income / (Expenditure)		Variance
		Plan to date	Actual to date	Favourable /(Adverse)
	£m	£m	£m	£m
Corporate Income	592.183	443.286	443.881	0.595
Divisions & Corporate Services	(550.624)	(410.870)	(418.221)	(7.351)
Financing	(34.886)	(26.195)	(25.143)	1.052
Reserves	(7.029)	(5.725)	-	5.725
Surplus/(deficit) excl STF funding	**(0.356)**	**0.496**	**0.517**	**0.021**
STF Core Funding	9.319	6.057	6.057	-
STF Performance Funding	3.994	2.596	2.297	(0.299)
Surplus/(deficit) incl STF funding	**12.957**	**9.149**	**8.871**	**(0.278)**

- The Operational Plan for December is a surplus of £9.149m excluding technical items.
- The Trust achieved a surplus of £8.871m, £0.278m adverse to plan.
- The Divisional run rate improved significantly in December.
- Excluding STF funding the Trust is reporting a surplus of £0.517m against a planned surplus of £0.496m.
- STF core funding has been achieved at each quarter end.
- STF performance funding was not achieved at quarter one (84.8% against target of 90%), but was achieved at quarters two and three (90.9% and 92.8% respectively). STF funding loss of £0.299m is therefore incurred to date.

Year to Date Position

The Clinical Divisions and Corporate Services overspend in month was £0.077m, increasing the cumulative adverse variance to £7.351m. Whilst encouraging, the December position comes with a number of caveats:-

- There is a very high level of un-coded activity due to both the Christmas holiday and continuing coding vacancies therefore a significant amount of December activity (48%) is estimated using average price, the real case-mix once coded may change the position;
- It is the first month of operating the DePoel arrangements for nursing agency and with any change in system, whilst every effort has been made to establish effective information to support accruals, there may be adjustments as the data is reviewed; and
- December is traditionally a month where income is higher than plan (the plan is profiled given there are less 'operating days' in December) and nursing costs are lower (given annual leave and other absences are tightly controlled with less agency use). January typically sees reduced activity and higher pay costs.

Winter Funding
The Trust has received winter pressure funding. Tranche 1 of £1.370m was allocated to Providers on a 'fair shares' basis to reflect the cost of emergency and urgent elective activity across winter already in operational plans. It has been allocated to Divisions as a 5% top slice for Estates and Facilities (for deep cleaning, portering etc) and D&T (10%) with the balance allocated to clinical divisions based on urgent care income. Tranche 2 is for new initiatives to improve A&E performance over winter. The Trust received £0.580m for three schemes: adult flow management (£0.144m); staffing an additional ITU bed (£0.256m); and creating a paediatric short stay observation area (£0.180m).

Forecast Out-turn
Given the improvement to the position reported in recent months, the Trust intends to retain its forecast out-turn surplus of £11.259m (£0.356m deficit excluding Sustainability funding). The Board need to note, however, that there are risks to delivering this position including:

- There is no agreement between NHS Improvement and NHS England to enable the payment of new HRG4+ tariffs by Wales. It is understood that the matter has been escalated to the Department of Health. The potential loss for the Trust is c. £1.5m;
- The extreme pressures being experienced in January 2018 could deteriorate the position, reversing the recent improvement in financial performance. We hope the winter funding will offset this including the loss of elective activity and income; and
- There have been issues associated with the expected improvement in the Provider sector financial position from the direct application of winter funding. The Trust has retained its previous forecast out-turn on the basis that the winter funding will offset the costs of the post-Christmas problems being experienced. There is a risk that such funding could be withdrawn but this is currently assessed as a low risk.

Conclusion
Three out of the last four months have shown an acceptable financial performance. Notable improvements in Nursing spend and clinical activity have been delivered. Medical pay, however, continues to overspend which is disappointing. There has been an improvement in the grip being achieved in Divisions.

The next three months will be challenging but there can now be some confidence in the delivery of the financial plan for the first time this financial year.

Section 2 – Division and Corporate Services Performance

Performance by Division and Corporate Service Area:

	Variance to Budget favourable/(adverse)			Operating Plan trajectory favourable/(adverse)	
	To 30 Nov £m	Dec £m	To 31 Dec £m	Trajectory To Dec £m	Variance £m
Diagnostic & Therapies	0.366	0.188	0.554	0.115	0.439
Medicine	(2.225)	(0.136)	(2.361)	(0.106)	(2.255)
Specialised Services	(0.563)	0.265	(0.298)	0.136	(0.434)
Surgery	(2.493)	(0.290)	(2.783)	(0.143)	(2.640)
Women's & Children's	(2.213)	(0.077)	(2.290)	(0.016)	(2.274)
Estates & Facilities	(0.001)	0.022	0.012	(0.010)	0.022
Trust Services	(0.049)	-	(0.049)	(0.002)	(0.047)
Other corporate services	(0.087)	(0.049)	(0.136)	-	(0.136)
Total	**(7.274)**	**(0.077)**	**(7.351)**	**(0.026)**	**(7.325)**

- Division and Corporate Services overspend in December was £0.077m (compared with £0.240m in November, and £1.246m in October).
- Diagnostic and Therapies – a favourable variance of £0.188m in the month reflects its share of activity income.
- Medicine – reduction in nursing pay particularly agency costs, medical pay remains high, income from activities was £0.360m higher than plan with associated additional non pay costs.
- Specialised Services - income from activities was £0.237m higher than plan, reduction in nursing pay costs particularly within CICU.
- Surgery - reduction in nursing pay particularly agency costs, medical additional hours costs remain high, income from activities was broadly breakeven in the month.
- Women's & Children's – income from activities improved by £0.090m, reduced nursing agency costs but continued medical pay overspending.
- Other corporate – the costs associated with the academic rotations were re-assessed this month following a meeting with HEE.

Division and Corporate Services performance analysed subjectively:

	Quarter 1 £m	Quarter 2 £m	October £m	November £m	December £m	2017/18 to date £m	2016/17 Outturn £m
Nursing & midwifery pay	(1.092)	(1.243)	(0.350)	(0.246)	0.017	(2.914)	(4.606)
Medical & dental staff pay	(0.868)	(1.086)	(0.384)	(0.452)	(0.376)	(3.167)	(1.380)
Other pay	0.183	0.221	0.179	0.196	0.118	0.879	2.140
Non-pay	(0.491)	(0.987)	(0.352)	(1.005)	(0.967)	(3.803)	(6.340)
Income from operations	(0.045)	(0.174)	(0.138)	0.058	0.081	(0.218)	0.751
Income from activities	0.490	0.015	(0.373)	0.950	0.967	2.050	(0.983)
Total including CIP	(1.823)	(3.255)	(1.418)	(0.499)	(0.161)	(7.156)	(10.418)
CIP	(0.552)	(0.158)	0.172	0.258	0.084	(0.195)	(4.231)
Total excluding CIP	(2.375)	(3.413)	(1.246)	(0.241)	(0.077)	(7.351)	(14.649)

- Notable improvement
- Continued overspending
- Includes out-sourcing
- Healthy activity delivery
- Good progress

(Savings have not been allocated across the subjective headings and are shown as one line)

Section 3 – Subjective Analysis

a) Nursing (including ODP) and Midwifery Pay

Favourable/ (Adverse)	Q1 £m	Q2 £m	Oct £m	Nov £m	Dec £m	2017/18 to date £m	2016/17 Outturn £m
Substantive	2.200	2.622	0.791	0.863	0.843	7.319	8.822
Bank	(1.782)	(2.037)	(0.635)	(0.659)	(0.602)	(5.715)	(6.408)
Agency	(1.562)	(1.870)	(0.508)	(0.452)	(0.226)	(4.618)	(7.397)
Total excluding CIP	**(1.144)**	**(1.285)**	**(0.352)**	**(0.248)**	**0.015**	**(3.014)**	**(4.983)**
CIP	(0.052)	(0.042)	(0.002)	(0.002)	(0.002)	(0.100)	(0.300)
Total including CIP	**(1.092)**	**(1.243)**	**(0.350)**	**(0.246)**	**0.017**	**(2.914)**	**(4.683)**

- Nursing pay improved in month by £0.263m, with both price and volume improving equally.
- Lost time percentages improved with the four clinical divisions moving from 125% last month to 122%.
- Trust level spend was below budget by £0.017m of which £0.093m relates to Surgery and £0.093m related to Specialised Services. Women's and Children's services improved by £0.070m in the month.
- Enhanced observation costs decreased significantly from £0.161m in November to £0.083m in December.
- Reduced sickness rates and greater restrictions on annual leave over the Christmas period have further reduced agency costs.

b) Medical and Dental Pay

Favourable/ (Adverse)	Q1 £m	Q2 £m	Oct £m	Nov £m	Dec £m	2017/18 to date £m	2016/17 Outturn £m
Consultant							
- substantive	0.285	0.139	0.039	0.006	0.051	0.520	0.277
- additional hours	(0.465)	(0.665)	(0.179)	(0.124)	(0.163)	(1.596)	
- locum	(0.054)	(0.052)	(0.071)	(0.084)	(0.063)	(0.324)	(0.143)
- agency	(0.112)	(0.045)	0.025	(0.017)	0.001	(0.148)	(0.741)
Other Medical							
- substantive	(0.016)	0.261	0.068	0.076	0.003	0.392	
- additional hours	(0.362)	(0.415)	(0.078)	(0.168)	(0.102)	(1.125)	(0.369)
- Jr Dr exceptions	0.000	(0.001)	(0.004)	(0.001)	(0.001)	(0.007)	
- locum	(0.160)	(0.307)	(0.140)	(0.116)	(0.087)	(0.810)	(0.469)
- agency	0.009	0.001	(0.038)	(0.012)	(0.001)	(0.041)	0.003
Total inc CIP	**(0.875)**	**(1.084)**	**(0.378)**	**(0.440)**	**(0.362)**	**(3.139)**	**(1.442)**
CIP	(0.007)	(0.002)	0.006	0.012	0.014	0.029	(0.062)
Total excl CIP	**(0.868)**	**(1.086)**	**(0.384)**	**(0.452)**	**(0.376)**	**(3.167)**	**(1.380)**

- The adverse variance in December of £0.375m reflects continuing overspends in all Clinical Divisions. Surgery and Women's and Children's remain the most significant, with Medicine also continuing to worsen in the month.
- Additional hours payments and locum expenditure reduced slightly both in December, with a slight increase in agency spend. However the offsetting underspends on substantive posts have reduced.
- Funding issued to date for the Junior Doctor Contract is £1.333m with the expected full year cost being c£2m.

c) Non pay

Favourable/ (Adverse)	Q1 £m	Q2 £m	Oct £m	Nov £m	Dec £m	2017/18 to date £m	2016/17 Outturn £m
Blood	0.066	(0.106)	(0.048)	(0.026)	(0.021)	(0.135)	(0.552)
Clinical supplies & services	(0.400)	0.003	0.076	(0.185)	(0.208)	(0.714)	(1.730)
Drugs	(0.074)	(0.128)	(0.051)	(0.034)	(0.168)	(0.455)	(0.362)
Establishment	0.032	(0.018)	(0.075)	(0.021)	(0.032)	(0.114)	(0.091)
General supplies & services	0.024	(0.002)	0.001	(0.004)	(0.002)	0.017	(0.124)
Outsourcing	(0.438)	(0.317)	(0.090)	(0.114)	(0.039)	(0.998)	(1.241)
Premises	(0.021)	0.077	0.026	0.036	(0.064)	0.054	0.111
Services from other bodies	(0.172)	(0.221)	(0.022)	(0.177)	(0.120)	(0.712)	(2.788)
Research	0.002	(0.004)	0.096	0.000	0.016	0.110	0.030
Other non-pay expenditure	0.160	(0.285)	(0.150)	(0.095)	(0.207)	(0.577)	(2.745)
Presentational changes				(0.394)		(0.394)	
Total inc CIP	(0.821)	(1.002)	(0.237)	(1.014)	(0.845)	(3.919)	(9.492)
CIP	(0.329)	(0.017)	0.117	(0.009)	0.122	(0.116)	(3.152)
Total excl CIP	(0.492)	(0.985)	(0.354)	(1.005)	(0.967)	(3.803)	(6.340)

- Variable costs associated with the delivery of additional activity accounted for the majority of over spending against budget in the month.

- The level of outsourcing was significantly lower in December leaving cumulative adverse variances of £0.373m relating to South West Eye Surgeons (no outsourcing from month 8 onwards), £0.439m to Glanso and £0.161m to Dermatology. The remaining balance relates to the virtual ward provided by Orla, which has now closed.

- Variances on Services from Other Bodies year to date include external tests £0.166m, recharges for Cellular Pathology £0.051m and Dermatology Services £0.052m, Pulse Services £0.107m (ceased from November 2017), supplies consortia costs £0.066m and Sexual Health services £0.088m.

- Effectively outsourcing and services from other bodies are clinical activity related hence the combined adverse variance of £1.710m accounts for the bulk of the non-pay overspend and essentially offsets the income from activities position leaving the income plan in deficit.

- Other non pay includes the apprenticeship levy which is an adverse variance of £0.250m to date.

Section 4 – Clinical and Contract Income

Contract income by work type: (further detail at agenda item 2.2)

	December 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	0.026	13.168	13.708	0.541
Bone Marrow Transplants	0.217	6.194	6.438	0.244
Critical Care Beddays	0.046	33.077	33.579	0.502
Day Cases	0.157	29.169	29.361	0.192
Elective Inpatients	0.618	42.015	42.016	0.002
Emergency Inpatients	1.123	65.664	69.975	4.311
Excess Beddays	(0.121)	4.070	4.030	(0.039)
Non-Elective Inpatients	(0.492)	24.117	22.813	(1.305)
Other	0.014	69.936	68.507	(1.429)
Outpatients	(0.007)	57.778	58.058	0.281
Total Activity Based	**1.582**	**345.188**	**348.486**	**3.299**
Contract Penalties	(0.203)	(0.728)	(1.343)	(0.615)
Contract Rewards	0.086	7.102	7.448	0.347
Pass through payments	(0.648)	64.160	64.839	0.678
S&T Funding	-	8.653	8.354	(0.300)
2017/18 Total	**0.818**	**424.375**	**424.784**	**3.409**
Prior year income	-	-	1.302	1.302
Overall Total	**0.818**	**424.375**	**429.086**	**4.711**

The position includes a higher than usual level of uncoded activity (due to both the Christmas holiday and continuing vacancies). The estimated value of this uncoded activity is £8.97m (compared to £5.61m last month). There is a risk that this value will change once the activity is coded and reported next month.

- Activity based income was £1.582m favourable in December, primarily due to emergency/non-elective inpatients (£0.631m) and elective inpatients (£0.618m).
- The emergency/non-elective inpatient over performance of £0.631m for December was within Medicine (£0.341m) and Women's and Children's (£0.177m)
- Elective inpatient performance in December was £0.411m in Specialised Services for both Cardiac Surgery and Clinical Haematology, and £0.270m in Surgery.
- The cumulative over performance on activity income of £3.299m reflects the level of emergency and non-elective work. The year to date position for other activity includes an underperformance within Radiotherapy (£0.678m), Bowel Cancer Screening (£0.408m), Paediatric Neurosurgery (£0.183m) and Cystic Fibrosis (£0.271m).
- The latest assessment for achievement of CQUINs is 86.1% or £9.9m of the total £11.5m available.
- 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 £1.343m to date, £0.615m worse than plan. This is primarily due to the emergency marginal tariff adjustment, with a smaller impact from avoidable emergency readmissions and cancelled operations.
- Pass through payments were £0.648m below plan in December, reducing the year to date position to £0.678m ahead of plan. This was primarily due to excluded drugs which were £0.52m below plan for the month and are £2.15m ahead of plan cumulatively.
- The key driver is additional emergency activity undertaken in year. Electives are holding up fairly well.

Section 5 – Savings Programme

Analysis by work streams: (further detail at agenda item 2.4)

	2017/18 Annual Plan £m	Year to date Plan £m	Year to date Actual £m	Year to date Variance fav/(adv) £m	Forecast Outturn Variance fav/(adv) £m
Pay	1.823	1.353	1.210	(0.143)	(0.106)
Drugs	0.400	0.309	0.565	0.256	0.316
Clinical Supplies	2.229	1.684	2.075	0.390	0.951
Non Clinical Supplies	3.178	2.680	1.974	(0.706)	(0.744)
Other Non-Pay	0.216	0.160	0.135	(0.025)	(0.028)
Income	2.582	1.689	1.735	0.046	0.323
Capital Charges	1.000	0.750	0.750	-	-
Unidentified	0.092	0.069	-	(0.069)	(0.092)
Total	11.520	8.695	8.445	(0.250)	0.620

Analysis by Division:

	2017/18 Annual Plan £m	Year to date Plan £m	Year to date Actual £m	Year to date Variance fav/(adv) £m	Forecast Outturn Variance fav/(adv) £m
Diagnostics & Therapies	1.386	1.029	0.972	(0.057)	(0.067)
Medicine	2.071	1.522	1.100	(0.423)	(0.495)
Specialised Services	1.192	0.901	1.427	0.526	0.991
Surgery	2.393	1.889	1.393	(0.496)	(0.239)
Women's and Children's	2.036	1.528	1.675	0.147	0.292
Facilities and Estates	0.817	0.604	0.615	0.011	0.066
Trust Services	0.545	0.412	0.388	(0.024)	(0.016)
Corporate	1.080	0.810	0.876	0.066	0.088
Total	11.520	8.695	8.445	(0.250)	0.620

- The savings requirement for 2017/18 is £11.520m.
- To date the Trust has achieved savings of £8.445m against a plan of £8.695m.
- Delivery of savings is £0.250m behind plan with the slippage in non-clinical supplies savings remaining a significant concern.
- The forecast outturn has improved by £0.163m in December. Clinical supplies and income increased by £0.312m and £0.236m respectively offset by a reduction of £0.370m relating to non-clinical supplies.
- Surgery is £0.496m behind plan predominantly due to slippage on outsourcing endoscopy, procurement savings and the repatriation of ophthalmology activity. This is forecast to improve to a year end adverse variance of £0.239m.
- Medicine is £0.423m behind plan largely due to outpatient productivity, commercial income, non-pay and unidentified CIPs. The forecast year end position is £0.495m adverse.
- Specialised Services is £0.526m ahead of plan and their forecast outturn improved by £0.301m, primarily due to additional clinical supplies savings.
- The savings target for 2018/19 is currently 2.8% of budget (2.4% recurring and 0.4% non-recurring), which is £14.378m. £8.093m has been identified to date with a further submission due on January 19th.

Section 6 – Use of Resources Rating

The Trust's Use of Resources Rating is summarised below:

		Year to date	
	Weighting	Plan	Actual
Liquidity			
Metric Result – days		11.7	17.6
Metric Rating	20%	1	1
Capital Servicing Capacity			
Metric Result – times		2.3	2.3
Metric Rating	20%	2	2
Income & expenditure margin			
Metric Result		1.9%	1.8%
Metric Rating	20%	1	1
Variance in I&E margin			
Metric Result		0.0%	-0.1%
Metric Rating	20%	1	2
Variance from agency ceiling			
Metric Result		44.1%	30.3%
Metric Rating	20%	1	1
Overall URR		**1.2**	**1.4**
Overall URR (rounded)		**1**	**1**
Overall URR (subject to override)		**1**	**1**

- The Trust's Use of Resources Rating for the period to 31st December 2017 is 1 against a 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 surplus to date including S&T funding of £8.871m being £0.278m adverse to plan.
- The capital servicing capacity metric scores a rating of 2 in line with plan, down from a score of 1 last month. This is due to the Trust's planned loan principal repayment of £2.787m in December.
- The Trust is forecasting a Use of Resources Risk Rating of 1 in line with plan as at the 31st March 2018.
- Retention of a Use of Resources rating of 1 (the highest possible) is an excellent result.

Section 7 – Capital Programme

The Trust's sources and application of capital funding is summarised below:

2017/18 Annual Plan £m	Subjective Heading	Year to date			Year end		
		Internal Plan £m	Actual £m	Variance £m	Internal Plan £m	Forecast £m	Variance £m
	Sources of Funding						
3.800	PDC	2.200	2.200	-	5.785	5.785	-
	Donations	0.724	0.455	(0.269)	0.964	0.562	(0.402)
	Cash:						
22.764	Depreciation	16.609	16.541	(0.068)	22.346	22.346	-
21.321	Cash balances	5.695	(2.740)	(8.435)	21.993	(1.547)	(23.540)
47.885	**Total Funding**	**25.228**	**16.456**	**(8.772)**	**51.088**	**27.146**	**(23.942)**
	Application/Expenditure						
(16.035)	Strategic Schemes	(1.354)	(1.911)	(0.557)	(19.908)	(2.110)	17.798
(10.278)	Medical Equipment	(6.892)	(3.471)	3.421	(13.341)	(8.117)	5.224
(11.370)	Operational Capital	(7.286)	(3.938)	3.348	(11.097)	(5.885)	5.212
(7.328)	Information Technology	(7.588)	(5.772)	1.816	(9.685)	(8.884)	0.801
(2.874)	Estates Replacement	(2.108)	(1.364)	0.744	(2.591)	(2.150)	0.441
(47.885)	**Gross Expenditure**	**(25.228)**	**(16.456)**	**8.772**	**(56.622)**	**(27.146)**	**29.476**
	In-year Slippage				5.534		(5.534)
(47.885)	**Net Expenditure**	**(25.228)**	**(16.456)**	**8.772**	**(51.088)**	**(27.146)**	**23.942**

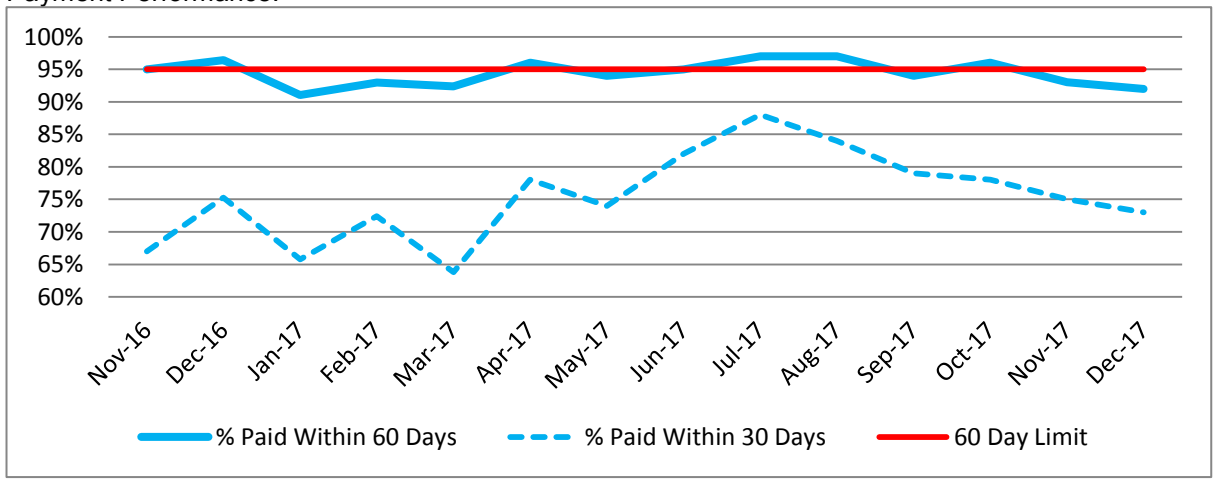
- Capital expenditure was £16.456m to the end of December against an internal plan of £25.228m, £8.772m behind plan.
- Medical Equipment, Operational Capital and Information Technology are behind plan by £3.421m, £3.348m and £1.816m respectively.
- The medical equipment slippage is predominantly due to an issue of staffing within the Bristol and Weston Procurement service. This is being resolved by additional staffing but this may not recover the 2017/18 position.
- The cash received from donations, PDC and depreciation exceeds the expenditure to date resulting in a cash gain of £2.740m.
- Additional approved schemes have increased the plan by £0.083m from last month.
- The forecast outturn has been revised to £27.146m following a detailed review of the quarter three position. This is a reduction of £2.352m and is predominantly due to anticipated slippage on operational capital schemes.

Section 8 – Statement of Financial Position and Cashflow

Statement of Financial Position: (further information is at agenda item 4.1)

	2017/18 Annual plan to date £m	Actual as at 31 Dec £m	Variance £m
Inventories	11.300	13.165	1.865
Receivables	18.250	25.373	7.123
Accrued Income	10.200	18.895	8.695
Debt Provision	(3.000)	(6.121)	(3.121)
Cash	61.047	68.422	7.375
Other assets	3.500	4.714	1.214
Total Current Assets	101.297	124.448	23.151
Payables	(30.128)	(34.168)	(4.040)
Accruals	(23.000)	(27.881)	(4.881)
Borrowings	(6.160)	(6.160)	-
Deferred Income	(3.113)	(5.229)	(2.116)
Other Liabilities	(8.109)	(8.047)	0.062
Total Current Liabilities	(70.510)	(81.485)	(10.975)
Net Current Assets/(Liabilities)	**30.787**	**42.963**	**12.176**

Payment Performance:



- Net current assets as at 31 December 2017 were £42.963m, £12.176m higher than the Operational Plan. Current assets are £23.151 higher than plan and current liabilities are £10.975m higher than plan.
- Receivables are £7.123m higher than plan, primarily due to outstanding income from NHS England for the reconciliation of quarter two activity (£5.5m), Welsh Health Bodies and NBT.
- Accrued income reflects the timing of invoices to Commissioners for contract over performance and income due for the Global Digital Exemplar programme.
- The Trust's cash and cash equivalents balance at the end of December was £68.422m, which is £7.372m higher than the Operating Plan. Forecast cash at the year-end is £70.249m, an increase of £5.262m from last month reflecting the winter pressure funding, Q3 S&T Funding and the revised capital programme forecast.
- The total value of debtors was £21.978m, (£11.293m SLA and £10.685m non-SLA). This represents a decrease in the month of £3.197m (SLA decrease of £1.987m and non-SLA decrease of £1.210m). Debts over 60 days old have increased by £5.749m of which £5.781m related to SLA income, predominantly due to the NHSE quarter two activity above.
- In December, 92% of invoices were paid within the 60 day target set by the Prompt Payments Code and 73% were paid within the 30 day target set by the Better Payment Practice Code.
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UNIVERSITY HOSPITALS BRISTOL NHS FOUNDATION TRUST

Finance Report December 2017- Summary Income & Expenditure Statement

Approved Budget / Plan 2017/18	Heading	Position as at 31st December			Actual to 30th November
		Plan	Actual	Variance Fav / (Adv)	
£'000		£'000	£'000	£'000	£'000
	Income				
555,616	From Activities	418,016	421,857	3,841	376,537
94,691	Other Operating Income (Excluding Sustainability and Transformation funding)	69,307	69,024	(283)	62,412
650,307	**Sub totals income**	**487,323**	**490,881**	**3,558**	**438,949**
	Expenditure				
(377,758)	Staffing	(282,666)	(288,009)	(5,343)	(256,103)
(230,991)	Supplies and Services	(172,241)	(177,212)	(4,971)	(158,332)
(608,749)	**Sub totals expenditure**	**(454,907)**	**(465,221)**	**(10,314)**	**(414,435)**
(7,028)	Reserves	(6,075)	-	6,075	-
-	NHS Improvement Plan Profile	350	-	(350)	-
34,530	Earnings before Interest,Tax,Depreciation and Amortisation	**26,691**	**25,660**	**(1,031)**	**24,514**
5.31	**EBITDA Margin - %**		**5.23**		**5.58**
	Financing				
(22,792)	Depreciation & Amortisation - Owned	(17,094)	(16,541)	553	(14,680)
108	Interest Receivable	81	112	31	73
(268)	Interest Payable on Leases	(201)	(201)	-	(178)
(2,687)	Interest Payable on Loans	(2,046)	(2,046)	0	(1,822)
(9,247)	PDC Dividend	(6,935)	(6,467)	468	(5,749)
(34,886)	**Sub totals financing**	**(26,195)**	**(25,143)**	**1,052**	**(22,356)**
(356)	NET SURPLUS / (DEFICIT) before Technical Items excluding Sustainability and Transformation funding	**496**	**517**	**21**	**2,158**
3,994	Sustainability & Transformation funding - Performance	2,596	2,297	(299)	1,897
9,319	Sustainability & Transformation funding - Core	6,057	6,057	-	5,126
12,957	SURPLUS / (DEFICIT) before Technical Items including Sustainability & Transformation funding	**9,149**	**8,871**	**(278)**	**9,181**
	Technical Items				
-	Profit/(Loss) on Sale of Asset	-	0	0	(2)
-	Donations & Grants (PPE/Intangible Assets)	-	755	755	637
(1,314)	Impairments	(1,314)	(1,431)	(117)	-
-	Reversal of Impairments	-	-	-	-
(1,561)	Depreciation & Amortisation - Donated	(1,171)	(1,174)	(3)	(1,042)
10,082	SURPLUS / (DEFICIT) after Technical Items including Sustainability & Transformation funding	**6,664**	**7,021**	**357**	**8,774**

UNIVERSITY HOSPITALS BRISTOL NHS FOUNDATION TRUST

Finance Report December 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 30th November	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)											
36,588	Contract Income	27,299	27,299	-	-	-	-	-	-	-		
265	Penalties	265	-	-	-	-	(384)	-	(384)	(224)		
-	Contract Rewards	-		-	-	-	347	-	347	261		
-	Overheads	-	561	-	(1,052)	-	1,684	-	632	390		
555,330	NHSE Income	415,722	416,021	-	-	-	-	-	-	-		
592,183	**Sub Total Corporate Income**	**443,286**	**443,881**	**-**	**(1,052)**	**-**	**1,647**	**-**	**595**	**427**		
	Clinical Divisions											
(52,032)	Diagnostic & Therapies	(38,804)	(38,250)	689	(747)	(16)	696	(68)	554	366	115	439
(80,839)	Medicine	(60,344)	(62,705)	(2,030)	(901)	(128)	1,152	(454)	(2,361)	(2,225)	(106)	(2,255)
(111,892)	Specialised Services	(83,787)	(84,085)	(323)	(472)	8	(44)	533	(298)	(563)	136	(434)
(110,071)	Surgery	(82,347)	(85,130)	(2,007)	(1,243)	17	852	(402)	(2,783)	(2,493)	(143)	(2,640)
(126,774)	Women's & Children's	(94,446)	(96,736)	(1,980)	286	(47)	(697)	148	(2,290)	(2,213)	(16)	(2,274)
(481,608)	**Sub Total - Clinical Divisions**	**(359,728)**	**(366,906)**	**(5,651)**	**(3,077)**	**(166)**	**1,959**	**(243)**	**(7,178)**	**(7,128)**	**(14)**	**(7,164)**
	Corporate Services											
(37,161)	Estates and Facilities	(27,618)	(27,606)	75	(115)	13	37	2	12	(10)	(10)	22
(27,420)	Trust Services	(20,622)	(20,671)	375	(315)	(88)	-	(21)	(49)	(49)	(2)	(47)
(4,435)	Other	(2,902)	(3,038)	16	(295)	24	53	66	(136)	(87)	-	(136)
(69,016)	**Sub Totals - Corporate Services**	**(51,142)**	**(51,315)**	**466**	**(725)**	**(51)**	**90**	**47**	**(173)**	**(146)**	**(12)**	**(161)**
(550,624)	**Sub Total (Clinical Divisions & Corporate Services)**	**(410,870)**	**(418,221)**	**(5,185)**	**(3,802)**	**(217)**	**2,049**	**(196)**	**(7,351)**	**(7,274)**	**(26)**	**(7,325)**
(7,029)	Reserves	(6,075)	-	-	6,075	-	-	-	6,075	5,400		
-	NHS Improvement Plan Profile	350	-	-	(350)	-	-	-	(350)	510		
(7,029)	**Sub Total Reserves**	**(5,725)**	**-**	**-**	**5,725**	**-**	**-**	**-**	**5,725**	**5,910**		
34,530	**Earnings before Interest,Tax,Depreciation and Amortisation**	**26,691**	**25,660**	**(5,185)**	**871**	**(217)**	**3,696**	**(196)**	**(1,031)**	**(937)**		
	Financing											
(22,792)	Depreciation & Amortisation - Owned	(17,094)	(16,541)	-	553	-	-	-	553	514		
108	Interest Receivable	81	112	-	31	-	-	-	31	1		
(268)	Interest Payable on Leases	(201)	(201)	-	0	-	-	-	-	-		
(2,687)	Interest Payable on Loans	(2,046)	(2,046)	-	0	-	-	-	0	(1)		
(9,247)	PDC Dividend	(6,935)	(6,467)	-	468	-	-	-	468	416		
(34,886)	**Sub Total Financing**	**(26,195)**	**(25,143)**	**-**	**1,052**	**-**	**-**	**-**	**1,052**	**930**		
(356)	**NET SURPLUS / (DEFICIT) before Technical Items excluding Sustainability and Transformation funding**	**496**	**517**	**(5,185)**	**1,923**	**(217)**	**3,696**	**(196)**	**21**	**(7)**		
3,994	Sustainability & Transformation funding - Performance	2,596	2,297			(299)			(299)	(299)		
9,319	Sustainability & Transformation funding - Core	6,057	6,057			-			-	-		
13,313	**Sub Total Sustainability & Transformation funding**	**8,653**	**8,354**			**(299)**			**(299)**	**(299)**		
12,957	**SURPLUS / (DEFICIT) before Technical Items including Sustainability & Transformation funding**	**9,149**	**8,871**	**(5,185)**	**1,923**	**(516)**	**3,696**	**(196)**	**(278)**	**(306)**		
	Technical Items											
-	Profit/(Loss) on Sale of Asset	-	-	-	-	-	-	-	0	(2)		
-	Donations & Grants (PPE/Intangible Assets)	-	755	-	-	755	-	-	755	637		
(1,314)	Impairments	(1,314)	(1,431)	-	(117)	-	-	-	(117)	1,314		
-	Reversal of Impairments	-	-	-	-	-	-	-	-	-		
(1,561)	Depreciation & Amortisation - Donated	(1,171)	(1,174)	-	(3)	-	-	-	(3)	(1)		
(2,875)	**Sub Total Technical Items**	**(2,485)**	**(1,850)**	**-**	**(120)**	**755**	**-**	**-**	**635**	**1,948**		
10,082	**SURPLUS / (DEFICIT) after Technical Items including Sustainability & Transformation funding**	**6,664**	**7,021**	**(5,185)**	**1,803**	**239**	**3,696**	**(196)**	**357**	**1,642**		

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%	3.1%	4.2%	4.3%	3.4%	3.2%	4.2%	3.9%			
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%	4.2%	3.8%	3.9%	4.0%	3.3%	5.3%			
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%	3.0%	2.8%	4.1%	3.9%	3.4%			
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%	4.3%	4.5%	4.7%	4.6%	3.9%	4.3%	4.4%	4.5%			

Source: HR info available after a weekend- Mth 8 data not available

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%	8.6%	6.8%	7.0%	8.0%			
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%	6.5%	4.2%	3.6%	5.8%			
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%	5.2%	6.5%	7.0%	5.9%			
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%	2.5%	0.5%	2.4%	2.3%			

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%	12.4%	12.9%	13.0%	13.8%			
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%	15.1%	14.7%	14.2%	15.9%	16.8%			
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%	12.3%	12.5%	13.5%	13.8%	13.4%	13.6%			
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%	12.9%	11.8%	11.3%	11.0%	11.6%	12.8%			

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	167.9	145.8	97.8	75.4			
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	73.5	80.9	23.6	7.0			
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	85.6	60.2	60.0	48.0			
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	207.3	215.8	276.1	160.9			
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	534.1	502.6	457.5	291.4	-	-	-

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	24.9	21.6	13.4	14.9			
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	9.1	9.4	2.8	1.7			
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	11.8	7.6	5.1	5.9			
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	23.1	24.6	25.5	14.7			
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	68.9	63.2	46.8	37.2	-	-	-

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%	9.0%	7.8%	5.3%	4.2%			
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%	5.1%	5.2%	1.6%	0.5%			
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%	4.7%	3.4%	3.3%	2.8%			
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%	5.7%	5.8%	7.3%	4.4%			
Trust Total	Actual	5.5%	5.4%	7.8%	7.8%	7.8%	5.9%	5.4%	5.1%	3.3%			

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	8,711	9,260	8,936	9,291			
Specialised Services	Actual	4,392	4,719	4,517	4,626	4,622	4,390	4,658	4,409	4,666			
Surgery, Head & Neck	Actual	4,481	4,616	4,414	4,472	4,471	4,329	4,670	4,427	4,354			
Women's & Children's	Actual	6,179	6,658	5,959	6,821	6,863	6,395	6,646	6,625	6,666			
Trust Total	Actual	24,123	25,535	23,932	25,283	25,054	23,825	25,234	24,397	24,977			

Source: Info web: KPI Bed occupancy

Graph 8 **ECO £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	117	83	93	99	80	73	86	83	58			
Specialised Services	*Target*	*20*	*20*	*20*	*20*	*20*	*20*	*20*	*20*	*20*	*20*	*20*	*20*
Specialised Services	Actual	11	33	29	9	11	10	16	18	21			
Surgery, Head & Neck	*Target*	*43*	*43*	*43*	*43*	*43*	*43*	*43*	*43*	*43*	*43*	*43*	*43*
Surgery, Head & Neck	Actual	43	- 6	31	59	24	20	6	19	19			
Women's & Children's	*Target*	*12*	*12*	*12*	*12*	*12*	*12*	*12*	*12*	*12*	*12*	*12*	*12*
Women's & Children's	Actual	9	7	27	10	5	5	20	41	- 15			
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	179.226	116.591	179.959	176.814	120.219	107.674	127.789	160.6	83.1	-	-	-

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	129	165	201	236			

Source: Service Improvement Team - Amy

UNIVERSITY HOSPITALS BRISTOL NHS FOUNDATION TRUST

Finance Report December 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		Consequence	Probability		
		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 due to a significant deterioration in the Divisions underlying run rate.	20 - Very High	£10m	With the support of Executive Directors and corporate staff, 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	20 - Very High	£5m	4 - Moderate	£0m	0.85%	4	5	20
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's forecast outturn to £0.09m in October's forecast outturn. 100% delivery of these plans will be key. Delivery to date is 97% of the plan. Divisions, Corporate and transformation team are actively working to ensure delivery of savings schemes.	MS	12 - High	£2m	4 - Moderate	£0m	0.34%	3	4	12
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. Approval of the Strategic Finance paper.	PM	20 - Very High	£15m	4 - Moderate	-	2.55%	5	4	20
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	£8.7m	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	20 - Very High	£4.7m	3 - Low	£0m	0.80%	4	5	20
50	Risk of Commissioner Income challenges	6 - Moderate	£3m	The Trust has strong controls of the SLA management arrangements.	PM	9 - High	£2m	3 - Low	£0m	0.34%	3	3	9
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	-				

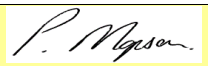
University Hospitals Bristol NHS Foundation Trust (BRISTOL / RA7) **Attachment 1**

Key data summary

Statement of comprehensive income	04PLANYTD Plan 31/12/2017 YTD £'000	04ACTYTD Actual 31/12/2017 YTD £'000	04VARYTD Variance 31/12/2017 YTD £'000	04PLANCY Plan 31/03/2018 Year ending £'000	04FOTCY Forecast 31/03/2018 Year ending £'000	04VARCY Variance 31/03/2018 Year ending £'000
Operating income from patient care activities	418,630	421,857	3,227	557,405	557,405	0
Other operating income	73,904	78,133	4,229	100,311	100,001	(310)
Employee expenses	(283,893)	(287,859)	(3,966)	(378,582)	(377,748)	834
Operating expenses excluding employee expenses	(192,867)	(196,494)	(3,627)	(256,950)	(257,625)	(675)
OPERATING SURPLUS / (DEFICIT)	**15,774**	**15,637**	**(137)**	**22,184**	**22,033**	**(151)**
FINANCE COSTS						
Finance income	75	112	37	100	149	49
Finance expense	(2,247)	(2,247)	0	(2,955)	(2,955)	0
PDC dividends payable/refundable	(6,937)	(6,467)	470	(9,247)	(8,650)	597
NET FINANCE COSTS	**(9,109)**	**(8,602)**	**507**	**(12,102)**	**(11,456)**	**646**
Other gains/(losses) including disposal of assets	0	(14)	(14)	0	(14)	(14)
Share of profit/ (loss) of associates/ joint ventures	0	0	0	0	0	0
Gains/(losses) from transfers by absorption	0	0	0	0	0	0
Movements in fair value of investments, investment property and financial liabilities	0	0	0	0	0	0
Corporation tax expense	0	0	0	0	0	0
SURPLUS/(DEFICIT) FOR THE PERIOD/YEAR	**6,665**	**7,021**	**356**	**10,082**	**10,563**	**481**

Adjusted financial performance	04PLANYTD Plan 31/12/2017 YTD £'000	04ACTYTD Actual 31/12/2017 YTD £'000	04VARYTD Variance 31/12/2017 YTD £'000	04PLANCY Plan 31/03/2018 Year ending £'000	04FOTCY Forecast 31/03/2018 Year ending £'000	04VARCY Variance 31/03/2018 Year ending £'000
Surplus/(deficit) for the period/year	6,665	7,021	356	10,082	10,563	481
Add back all I&E impairments/(reversals)	1,314	1,431	117	1,314	(15)	(1,329)
Adjust (gains)/losses on transfers by absorption	0	0	0	0	0	0
Surplus/(deficit) before impairments and transfers	**7,979**	**8,452**	**473**	**11,396**	**10,548**	**(848)**
Retain impact of DEL I&E (impairments)/reversals	0	0	0	0	0	0
Remove capital donations/grants I&E impact	1,170	419	(751)	1,561	711	(850)
Adjusted financial performance surplus/(deficit)	**9,149**	**8,871**	**(278)**	**12,957**	**11,259**	**(1,698)**
Control total	**9,149**	**9,149**	**0**	**12,957**	**12,957**	**0**
Performance against control total	**0**	**(278)**	**(278)**	**0**	**(1,698)**	**(1,698)**
Adjusted financial performance excluding STF						
Adjusted financial performance surplus/(deficit)	9,149	8,871	(278)	12,957	11,259	(1,698)
Less sustainability & transformation fund (STF)	(8,653)	(8,354)	299	(13,313)	(11,615)	1,698
Adjusted financial performance surplus/(deficit) excluding STF	**496**	**517**	**21**	**(356)**	**(356)**	**0**
Control total excluding STF	**496**	**496**	**0**	**(356)**	**(356)**	**0**
Performance against control total excluding STF	**0**	**21**	**21**	**0**	**0**	**0**

Capital departmental expenditure limits (CDEL) CDEL/funding	18PLANYTD Plan 31/12/2017 YTD £'000	18ACTYTD Actual 31/12/2017 YTD £'000	18VARYTD Variance 31/12/2017 YTD £'000	18PLANCY Plan 31/03/2018 Year ending £'000	18FOTCY Forecast 31/03/2018 Year ending £'000	18VARCY Variance 31/03/2018 Year ending £'000
CDEL calculation						
Gross capital expenditure	25,243	16,456	8,787	47,989	27,146	20,843
Disposals / other deductions	0	0	0	0	0	0
Charge after additions/deductions	**25,243**	**16,456**	**8,787**	**47,989**	**27,146**	**20,843**
Less donations and grants received	0	0	0	0	0	0
Less PFI capital (IFRIC12)	0	0	0	0	0	0
Plus PFI residual interest	0	0	0	0	0	0
Purchase of financial assets	0	0	0	0	0	0
Sale of financial assets	0	0	0	0	0	0
Prior period adjustments (PPAs)	0	0	0	0	0	0
Total CDEL	**25,243**	**16,456**	**8,787**	**47,989**	**27,146**	**20,843**

Self certification		00ACTYTD Self-cert declarations Actual 31/12/2017 YTD DROP-DOWN	Maincode Subcode
1. Declaration of review of submitted data			
The board is satisfied that adequate governance measures are in place to ensure the accuracy of data entered in this submission. We would expect that the template's validation checks are reviewed by senior management to ensure that there are no errors arising prior to submission and that any relevant flags within the template are adequately explained.	*i*	Confirmed	SEL0100
Approved on behalf of the board of directors by:			
Name		Paul Mapson	SEL0112
Job title		Director of Finance and IT	SEL0114
Signature	*i*		
2. Is the return consistent with the board report?			
Please confirm that the financial data reported in the NHSI monthly monitoring forms is/will be consistent with the information reported to and published in the board report	*i*	Yes	SEL0118
Date of board report (Please note that this can be a future date)		31st January 2018	SEL0122
In the exceptional event that the forms are not consistent with the board report, please itemise the reasons why it is different			SEL0124
3. 2017-18 Capital Delegated Limit			
All NHS Trusts have a capital delegated limit of £15m. Foundation Trusts that fulfil any of the distressed financing criteria will have a capital delegated limit of £15m. As set out in the Capital regime, investment and property business case approval guidance for NHS Trusts and Foundation Trusts, providers with delegated capital limits require business case approval from NHS Improvement. Foundation Trusts that do not fulfil any of the distressed financing criteria are subject to existing reporting and review thresholds as per the Supporting NHS Providers: guidance on transactions for NHS foundation trusts (March 2015) Appendix 1 and the Capital regime, investment and property business case approval guidance for NHS trusts and foundation trusts.			
Please complete below.		FT	SEL0130
Are you in Financial Special Measures?	*i*	No	SEL0140
If you are an FT, are you in breach of your licence? Or are you an NHS Trust?	*i*	Not in breach of Foundation Trust license	SEL0150
Have you received distressed financing or are you anticipating receiving this in the current financial year?	*i*	Not in Receipt of Distressed Financing	SEL0160
Delegated capital limit (£000)		Existing reporting and review thresholds apply	SEL0170
Adjusted delegated capital limit (£000)	*i*	N/A	SEL0175
The board agrees to the delegated limit for capital expenditure and business case approvals in line with the Capital regime, investment and property business case approval guidance for NHS Trusts and Foundation Trusts.	*i*	Confirmed	SEL0180
4. 2017-18 Control total			
Control total value		12,957	SEL0185
The board has accepted to deliver its control total in 2017-18		YES	SEL0190
STF allocation		13,313	SEL0195
5. 2017-18 Board assurance statements			
Statement required if FOT is less than plan	*i*	N/A	SEL0200
Statement submitted by trust previously and period to which this relates	*i*		SEL0205
Adverse variance against plan per previously submitted statement	*i*		SEL0210
Further deterioration since month of statement requiring revised statement?	*i*	N/A	SEL0215
Date of revised statement issued / to be issued (the format must be dd/mm/yy)	*i*		SEL0220

University Hospitals Bristol
NHS Foundation Trust

Cover report to the Public Trust Board. Meeting to be held on 31 January 2018 at 11.00 – 13.00, Conference Room, Trust HQ, Marlborough St, Bristol, BS1 3NU

		Agenda Item	18
Meeting Title	Public Trust Board	**Meeting Date**	Wednesday, 31 January 2018
Report Title	**Ratification of Standing Financial Instructions (SFIs)**		
Author	**Kate Parraman, Deputy Director of Finance**		
Executive Lead	Paul Mapson, 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.	☐	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 proposed changes to the Standing Financial Instructions and Scheme of Delegation, previously reviewed and agreed by the Trust's Finance Committee. Key issues to note The changes to be considered are changes to titles of people and groups, changes reflecting revised operational practice and other minor amendments.

Recommendations
[Please provide a clear articulation of what the Board is being asked to agree/discuss/note. Items for information will not be allocated time for consideration within the Board meeting. Members are asked to: Consider and approve the changes to the SFIs and schement of delegation.

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 recruit, train and sustain an engaged and effective workforce.	☐	Failure to comply with targets, statutory duties and functions.	☒
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.	☐		

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)**

	21 December 2017			

University Hospitals Bristol NHS
NHS Foundation Trust

Trust Board – Standing Financial Instructions

1. Introduction

The Standing Financial Instructions (SFIs) and Scheme of Delegation (SoD) are required to be reviewed on an annual basis. Any changes must be considered by the Finance Committee before being recommended for approval at the Trust Board.

The purpose of this report is to inform the Trust Board of the proposed changes to the SFIs and SoD following the annual review process, which have been agreed by the Finance Committee.

The revised SFIs and supporting scheme of delegation as well as the schedule of matters reserved to the Board (unchanged) are attached as a separate document. To enable the committee to review the proposed changes within the SFIs, additions are highlighted in yellow and words being removed are crossed through.

(Note the cross references highlighted in blue are for internal use only to assist with the final check once the SFIs are approved).

2. Proposed Changes

The changes can be considered under the following categories:

- Changes to titles of people/groups
- Changes reflecting revised operational practice
- Other

2.1 Changes to title of people/groups

The following changes have been made throughout the document:

Monitor to NHS Improvement
Monitor Financial Risk Ratios to NHS Improvement's Use of Resource Rating
Monitor's NHS Improvement's Risk Assessment to Single Oversight Framework
Head of Treasury Management to Head of Exchequer Services
Remuneration and Terms of Service Committee to Nomination and Remuneration Committee
Director of Workforce and Organisational Development to Director of People
Procurement department to Trust's Procurement Service
Technology Committee to Clinical Systems Implementation Programme Board

2.2 Changes reflecting operational practice

Section 7 references to postal orders have been removed (7.3.2)

Section 9.5.7 Official orders are not sequentially numbered but they do have a unique number, either generated through EROS or required under the non EROS process. This paragraph has been updated accordingly.

Section 11.6.1g verbal orders follow the same delegated responsibilities as any other orders and therefore to refer to the Chief Executive in this paragraph is not appropriate.

Section 14.8.2 Cheques drawn to cash are never used, nor should they. Therefore any variation to this has been removed.

Section 18.2.10 CPSG are required to approve charitable donations for capital purposes before they are accepted, which is now clearly stated.

Section 20.4.4 The Chief Internal Auditor is accountable to the Chief Executive

Section 22.3 Gift value thresholds have been amended to reflect the revised policy held by the Company Secretary. (£25 to £50 and £40 to £50). Reference has now been made to no acceptance of cash or vouchers reminding staff that such donations must be considered as charitable donations.

2.3 Other

Section 5 References to service agreements have been changed to contracts for the provision of healthcare services

Section 9.5 A specific section on requisitioning has been created, adding the elements that were contained at section 11.3 to those originally in section 9.5. Other aspects of 9.5 have been moved to 9.6 Other.

Section 10.6 Pre-qualification questionnaires have been replaced by standard selection questionnaires and the SFIs now refer to these but refer to the Crown Commercial guidance rather than including the detail which is subject to change.

Section 10.13 The section on contract variations has been rewritten to provide clarity on who can authorise variations in particular circumstances. This was an area on which staff often raised questions. The scheme of delegation has been expanded to include this (see below).

Section 11.3 This has been removed and incorporated into section 9.5 above.

Section 20.6.5 Counter fraud requested that their access rights be specifically referred to and therefore this section added.

Various	Small amendments have been made to improve clarity which require no further explanation.

3. Scheme of Delegation

The scheme of delegation has been amended and is attached. The amendments reflect the changes discussed in section 2. In particular section 10e has been added as referred to under 2.3 above (section 10.13).

Reference 7a has been changed to reflect that the Finance Committee sets the limit for borrowing and the Director of Finance approves it within this limit.

4. Recommendation:

The Trust Board is asked to consider and approve the changes to the SFIs and Scheme of Delegation following approval by the Finance Committee.

5. Next Steps:

Following approval by the Trust Board the revised SFIs will be communicated across the Trust, in particular at Divisional Management Team, Heads of Nursing and Junior Doctor meetings. The 'budget managers' guide to SFIs' will be updated and staff will be reminded of their responsibilities to ensure compliance. The monthly training course for budget managers will use the revised SFIs in the controls section.

Where the title 'Executive' is used it is deemed to include their nominated deputy where they have been duly authorised by them to represent them			
1. OVERALL RESPONSIBILITIES AND DELEGATION			
1a	Financial framework, policies and internal financial control systems. Maintain and update Trust's financial procedures.	Director of Finance	SFIs section 1.2.4
1b	Requirement for all staff to be notified of and understand these instructions Complying with the Trust's Standing Financial Instructions, Scheme of Delegation and financial procedures	Chief Executive, delegated to all managers All staff under contract to the Trust	SFIs section 1.2.4 SFIs section 1.2.5
2. PLANNING AND BUDGETS AND BUDGETARY CONTROL			
2a	Strategic and annual business plans Annual (and longer term) financial plan and budget Divisional/Corporate Service operational plans and budgets	Chief Executive Director of Finance Clinical Chairs/Divisional Directors/Corporate Service Directors	SFIs section 2.2.1 SFIs section 2.2.3 SFIs section 2.2.5
3. BUDGET MANAGEMENT			
3a	Budget Management Responsibility		SFIs sections 2.3
	i. at individual cost centre level	Budget Manager or nominated deputy	
	ii. at departmental level	Departmental Manager or nominated deputy	
	iii. at divisional level	Clinical Chair / members of the Divisional Board as authorised by the Clinical Chair.	
	iv. at corporate service level	Director of Facilities and Estates or delegated deputy Director of Information Management Technology or delegated deputy Corporate Director or delegated deputy	
3b	Budget Virement/Transfer	Virements must be supported by appropriate documentation and approved by the Senior Management Accountant	SFIs section 2.3
	i. Within a cost centre	Budget Manager and Department Manager	
	ii. Within a department/specialty between cost centres	Department Manager	
	iii. Between specialties/departments	Both department managers	
	iv. Between Divisions/Corporate Services below £5k	Both department managers	
	v. Between Divisions/Corporate Services above £5k	Divisional Director / Director of Facilities and Estates / Director of Information Management Technology / Corporate Director by joint agreement	

	vi. To and from Trust reserves	Director of Finance or nominated deputy	
4. ANNUAL ACCOUNTS AND REPORTS			
4a	Preparation of annual accounts and associated financial returns for Board approval	Director of Finance	SFIs section 4.2.1 - 2
4b	Preparation of Annual Report for Board approval	Trust Secretary	SFIs section 4.2.5
4c	Preparation of Quality Report for Board approval	Director of Nursing	SFIs section 4.2.6
5. SERVICE AGREEMENTS FOR THE PROVISION OF HEALTHCARE SERVICES			
5a	Agreeing and signing NHS contracts for the provision of healthcare services to NHS commissioners, other NHS providers or private organisations	Chief Executive, Deputy Chief Executive or Director of Finance	SFIs section 3.2.7
5b	Agreeing changes and developments within existing contracts for healthcare services	Chief Executive, Deputy Chief Executive or Chief Operating Officer with Director of Finance agreement	SFIs section 3.2.8
5c	Service agreement monitoring and reporting	Director of Finance	SFIs section 3.3.2
5d	Service agreement operational management	Clinical Chairs/Divisional Directors/ Corporate Directors	SFIs section 3.3.5
6. BANKING AND CASH MANAGEMENT			
6a	Opening, operating and controlling all bank accounts referencing the Trust's name and/or Trust address.	Director of Finance	SFIs section 5.3.2
6b	Day to day operational management of the Trust's bank accounts	Deputy Director of Finance	SFIs section 5.3.6
6c	Determining when to subject commercial banking services to competitive tendering. Organising and evaluating the tender process.	Director of Finance	SFIs section 5.3.9
6d	Approval of bank signatories	Chief Executive or Director of Finance or nominated Senior Finance Manager	
6e	Approval of direct debit or standing order payment arrangements	Director of Finance	SFIs section 5.3.12
6f	Operation of Trust credit/purchasing cards	Director of Finance	SFIs section 5.3.13
6g	Investment of temporary cash surpluses	Director of Finance	SFIs section 5.5
7. EXTERNAL BORROWING AND PDC			
7a	Approval of short term borrowing	~~Finance Committee~~ Director of Finance within limit set by Finance Committee	SFIs section 6.2.4
7b	Approval of long term borrowing	Trust Board	SFIs section 6.2.7

7c	Application for borrowing	Director of Finance	SFIs sections 6.2.4 and 6.2.8
8. WORKFORCE AND PAYROLL			
8a	Remuneration and terms of service for Directors	Remuneration Committee	SFIs section 7.2.1
8b	Remuneration and allowances of Chair and Non-Executive Directors	Council of Governors	SFIs section 7.2.4
8c	Approval of implementation of national pay directives and local variations	Director of ~~Workforce and Organisational Development~~ People and Director of Finance	SFIs section 7.3.1
8d	Approval of non-payroll rewards to staff	Director ~~of Workforce and Organisational Development~~ People and Director of Finance	SFIs section 7.3.4
8e	Appointment of permanent staff (subject to any vacancy control process in place) or extension of fixed term contract		
	i. to funded established post	Budget holder or nominated deputy ~~and divisional finance manager~~ and HR advisor	
	ii. to post not within formal establishment	Divisional Director or nominated deputy and divisional finance manager and HR advisor	
8f	Granting of additional increments to staff outside of national terms and conditions	HR Business Partner	
8g	Banding of new posts or re-banding of existing posts	Divisional/Corporate Director with Trust review panel scrutiny	
8h	Authorisation and notification to payroll of all starters, leavers and changes of conditions for staff	Budget holder or nominated deputy	SFIs section 7.4.1 - 4
8i	Authorisation of all timesheets, overtime, unsocial, oncall, bank shifts and any other approved form to vary pay	Budget holder or nominated deputy in accordance with agreed policies and processes	SFIs section 7.5.3
8j	Authorisation and notification to payroll of all absences from work including sickness, special leave, maternity leave, paternity leave, time off in lieu,	Line manager in accordance with agreed policies and processes	SFIs section 7.5.3
8k	Authorisation of medical staff leave of absence	Clinical Chair/Medical Director	SFIs section 7.5.3
8l	Approve annual leave applications and carry forwards to next year		
	i. within national or local Trust approved limits	Line manager	SFIs section 7.5.3
	ii. outside of the limits above	Divisional/Corporate/Executive Director	SFIs section 7.5.3
8m	Approve staff departure		
	i. under compromise agreement	Director of ~~Workforce and Organisational Development~~ People and the Director of Finance	SFIs section 15.5.7

	ii. under redundancy scheme	Divisional/Corporate/Executive Director and Director of Finance	
8n	Early retirements in furtherance of efficiency or on ill health grounds.	Director of ~~Workforce and Organisational Development~~ People and the Director of Finance	
8p	Authorise benefits in kind	In accordance with Trust policies:	
	i. new or changes to authorised car users	Budget Manager or nominated deputy	
	ii. mobile phones/land lines	Divisional/Corporate/Director	
8q	Authorisation of travel and subsistence claims	Line/Budget Manager	SFIs section 7.7.1
8r	Authorisation of relocation expenses	Director of Finance or nominated deputy	SFIs section 7.7.1
8s	Engaging staff to undertake work outside of the payroll (subject to contracting/procurement rules):		
	i. for consultancy work (excluding strategic capital projects)	Below £25k gross commitment – Divisional/Corporate Director Above £25k gross commitment – Chief Operating Officer or Corporate Executive Director Over £500k gross commitment – Chief Executive	SFIs section
	ii. to fill a defined post using self-employed, limited company or umbrella professional services agency	For posts on the Trust Board, Divisional Board or those with significant financial responsibility – Chief Executive Other posts over £20 per day and/or over 6 months - Director of Workforce and Organisational Development Other posts below £220 per day and less than 6 months – HR Business Partner	SFIs section 7.6.2 - 3
	iii. using agency or locum staff	Divisional Director or nominated deputy	
9 CONTRACTING TO PROVIDE GOODS AND SERVICES EXCLUDING SERVICE AGREEMENTS FOR HEALTHCARE SERVICES (SEE SECTION 5)			
9a	Setting of fees and charges		SFIs Section 10.2.6
	i. Private Patients	Director of Finance or nominated deputy	SFIs Section 10.2.7
	ii. Overseas Visitors	Director of Finance or nominated deputy	SFIs Section
	iii. Property rental (excluding residences)	Director of Estates and Facilities	SFIs Section
	iv. Residences	Director of Estates and Facilities	SFIs Section
	v. Trading services	Divisional/Corporate Director or nominated deputy	SFIs Section
	vi. Other income generation	Divisional/Corporate Director or nominated deputy	SFIs Section

9b	Agreeing/signing agreement/contract	All require Divisional Finance Manager agreement	SFIs Section 10.2.5
	i. Hosting arrangements	Director of Finance or nominated deputy	
	ii. Research and other grant applications	Director of Finance or nominated deputy	
	iii. Staff secondments	Service Manager	
	iv. Leases	Director of Finance or nominated deputy	
	v. Property rentals (excluding residences)	Below £5k per annum, Service Manager Above £5k and below £100k per annum, Director of Estates and Facilities or nominated deputy Over £100k per annum, Director of Finance or nominated deputy	
	vi. Residences	Residences Manager	
	vii. Peripheral clinics and provider to provider arrangements	Below £25k per annum, Service Manager Above £25k and below £250k per annum, Divisional/Corporate Director or nominated deputy Over £250k per annum, Director of Finance or nominated deputy	
	viii. Trading Services	Below £25k per annum, Service Manager Above £25k and below £250k per annum, Divisional/Corporate Director or nominated deputy Over £250k per annum, Director of Finance or nominated deputy	
	ix. Other income generation	Below £25k per annum, Service Manager Above £25k and below £250k per annum, Divisional/Corporate Director or nominated deputy Over £250k per annum, Director of Finance or nominated deputy	
10 PROCUREMENT OF GOODS AND SERVICES INCLUDING CAPITAL SCHEMES (financial limits exclude VAT and the whole order/contract should be considered) All capital schemes must have been approved as per section 17 before orders/tenders are made Goods/services will only be available for ordering via EROS once matters referred to under 10a to 10d have been followed – therefore staff requisitioning via EROS need only comply with 10e and 10f			
10a	Obtaining quotes/tendering for the provision of Goods and Services		
	i. Below £5k, best value to be demonstrated	Budget holder	SFI section 13.4.3
	ii. Between £5k and £25k, minimum three quotes to be obtained	Budget holder	SFI section 13.4.2
	iii. Over £25k and upto £1m, minimum three tenders to be obtained	Divisional/Corporate Director	SFI section 13.4.1
	iv. Over £1m, minimum three tenders to be obtained	Trust Board	
10b	Single tender actions – best value to be demonstrated		SFI section 13.4.6
	i. Between £5k and £25k	Divisional/Corporate Director and the Director of Purchasing and Supply	
	ii. Between £25k and £100k	As above plus Director of Finance	
	iii. Over £100k	As above plus Chief Executive	
10c	Waiving of tendering and single tender action procedures	Chief Executive, reported to Audit Committee	SFI section 14.2.2

10d	Signing of contract evaluations/contracts/agreements to procure good/services on behalf of the Trust	Following procurement processes described in 10a to 10c above	SFI section 13.2.1
	i. Contract evaluations/contracts/agreements following tendering process above unless specifically referred to below:	Below £25k, service manager Above £25k and below £100k, Divisional Director/Director of Purchasing and Supply Over £100k, ~~Chief Operating Officer~~/Director of Finance or nominated deputy	
	ii. for purchase of healthcare	Below £100k, Divisional Director Over £100k, Chief Operating Officer	
	iii. for property leases	Director of Finance	
	iv. for leases – non property	Director of Finance	
	v. for outsourcing services	Below £100k, Divisional Director Over £100k, Chief Operating Officer and Director of Finance	
	vi. facilities contracts	Director of Estates and Facilities or nominated deputy	
	vii. estates maintenance contracts	Director of Estates and Facilities or nominated deputy	
	viii. capital estates based contracts	Director of Estates and Facilities or nominated deputy, following approval as per section19	
10e	Authorisation of contract variations	Delegation as per section 10d with the added proviso that all variations above £25k require approval by the Director of Finance.	
10f	Requisitioning/ordering after procurement and contract/ agreement is in place:	Authorised requisitioner, ensuring segregation of duties from procuring and receipting	
10g	Receipting	Authorised receiptor, ensuring segregation of duties from procuring and ordering	
11 PAYMENT FOR GOODS AND SERVICES (FOLLOWING APPROPRIATE PROCUREMENTPROCESSES)			
11a	Authorisation of invoices for goods and services procured	(applies to all procurement methods, not just EROS)	SFIs section 8.4.1
	i. Where invoice price = order/quote	Budget holder or authorised signatory for the cost centre with regard to segregation of duties between ordering and approving in line with Trust procedures	
	ii. Where invoice price exceeds order/quote upto the lesser of 10% or £5,000	Budget holder	
	iii. Where invoice price exceeds order/quote over 10% or between £5,000 and £25,000	Divisional/Corporate Services Director	
	iv. Where invoice price exceeds order/quote over 10% or over £25,000	Director of Finance or nominated deputy	
11b	Prepayments	Director of Finance or nominated deputy	SFIs section 8.5.1
11c	Receipting of goods and services procured via EROS	Budget holder or authorised receiptor for the cost centre, with regard to segregation of duties between ordering and approving in line with Trust procedures.	SFIs section 8.4.1
11c	Maintaining the Trust's authorised signature list	Budget holder to review and advise Deputy Director of Finance to update	SFIs section 8.4.2
11d	Authorisation of expenditure reimbursement via petty cash in line with the Trust's policy.	Below £50 budget holder or nominated deputy Over £50, Divisional Manager	SFIs section 8.7, 9.3.3

11e	Agreeing compromise arrangements with suppliers	Below £1k, Deputy Director of Finance Above £1k and below £25k, Director of Finance Above £25k, Finance Committee	SFIs section 8.8
12 STORES AND STOCKS			
12a	System of stock control, receipting, issues, returns and losses	Director of Finance	SFIs section 12.2.5
12b	Control of stores		
	i. Pharmaceutical	Director of Pharmacy	SFIs section 12.2.3
	ii. Fuel stores	Director of Estates and Facilities	SFIs section 12.2.4
	iii. All other stores	Relevant Divisional/Corporate Services Manager	SFIs section 12.2.2
12c	Condemning and disposal of goods (excluding fixed assets – see section x)	All losses must be reported to the Director of Finance in accordance with section 14	
	i. Pharmaceutical Items	Director of Pharmacy	SFIs section 12.2.3
	ii. X-ray films	Head of Radiology	SFIs section 12.2.4
	iii. Computer equipment	Director of Information Management and Technology	
	iv. All other goods with a current/estimate purchase price up to £1k	Relevant Divisional/Corporate Services Manager	SFIs section 12.2.2
	v. All other goods with a current/estimate purchase price between £1k and £25k	Divisional/Corporate Director or nominated deputy	
	vi. All other goods with a current/estimate purchase price over £25k	Director of Finance	
13 LOSSES WRITE OFFS AND SPECIAL PAYMENTS (to be reported to the Audit Committee on a quarterly basis)			
13a	Maintenance of losses and special payments register	Director of Finance	SFIs section 15.2.3
13b	Loss/damage due to theft, fraud, corruption or criminal activity	Chief Executive or Director of Finance	SFIs section 15.2.3
13c	Write off of bad debts, abandoned claims and fruitless payments	Below £1k – Deputy Director of Finance Above £1k and below £50k – Chief Executive Over £50k – Trust Board	SFIs section 15.4.1
13d	Ex-gratia payments to compensate for loss or damage to personal effects or for out of pocket expenses	Below £1k – Deputy Director of Finance Above £1k and below £50k – Chief Executive Over £50k – Trust Board	SFIs section 15.5.2
13e	Personal Injury Claims		SFIs section 15.5.3

	• Up to £10,000	Director of Workforce and Organisational Development or Chief Executive or Director of Finance – without legal advisor	
	• Over £10,000	Director of Workforce and Organisational Development or Chief Executive or Director of Finance – in conjunction with NHS Litigation Authority	
13f	Public Liability Claims		SFIs section 15.5.4
	• Up to £3,000	Divisional/Corporate Director or Chief Executive or Director of Finance – without legal advice	
	• Over £3,000	Divisional/Corporate Director and Chief Executive or Director of Finance – in conjunction with NHS Litigation Authority	
13e	Compensation (no limit) payments made under legal obligation	Chief Executive and Director of Finance	
13f	Maladministration and distress payments where there was no financial loss by the claimant. • Remedy up to £1,000; • Remedy between the value of £1,001 and £50,000; • Remedy over the value of £50,000.	Director of Finance or Deputy Director of Finance Chief Executive Trust Board	SFIs section 15.5.10
13g	Cancellation of NHS debts • Up to £5,000 • Over £5,000	Deputy Director of Finance or Divisional Financial Manager Director of Finance or nominated deputy	
13h	Extra-contractual payments to contractors • Up to £25,000 • Between £25,000 and £100,000 • Over £100,000	Director of Finance or Deputy Director of Finance Chief Executive Trust Board	SFIs section 15.5.11
14 CHARITABLE FUNDS/DONATIONS			
14a	Administration of Trust charitable funds	Above and Beyond	SFIs section 16.2.2
14b	Acceptance of donations of goods or cash from charitable bodies relating to capital defined expenditure	Trust's Capital programme Steering Group	SFIs section 16.2.6
15 AUDIT			
15a	Establishment of an internal audit function	Director of Finance	SFIs section 17.3.1
15b	Appointment of External Auditors	Council of Governors	SFIs section 17.5.2
15c	Implementation of agreed internal and external audit recommendations	Divisional/Corporate Directors	

16 INFORMATION MANAGEMENT AND TECHNOLOGY			
16a	Security and accuracy of Trust computerised financial data	Director of Finance	SFIs section 18.2.1
16b	Implementation of new and amendments to existing financial IT systems and approval of any Trust systems with an impact on financial transactions	Director of Finance	SFIs section 18.2.3
16c	Compliance with Freedom of Information Act	Trust Secretary	SFIs section 18.3.1
16d	Implementation, upgrades or changes to general computer systems	Information Management and Technology Committee	SFIs section 18.3.2
17 CAPITAL INVESTMENT AND PRIVATE FINANCING			
17a	Approval of the Trust's Capital Investment Policy annually.	Trust Board	SFIs section 19.2.2
17b	Business case approval – high risk schemes		Capital Investment Policy
	i. >1% of Trust turnover (£5.87m)	Outline and Full business case to be approved by Trust Board and Council of Governors	
	ii. Between 0.25% and 1% of Trust turnover (between £1.47m and £5.87m)	Comprehensive business case to be approved by Trust Board and Council of Governors	
	iii. Less than 0.25% of Trust turnover (less than £1.47m)	Short form business case to be approved by Trust Board and Council of Governors	
17c	Business case approval – other schemes outside of high risk and less than 1% of trust turnover (£5.87m)		Capital Investment Policy
	i. > 0.5% of Trust turnover (between £2.94m and £5.87m)	Comprehensive business case to be approved by Finance Committee	
	ii. Between 0.25% and 0.5% of Trust turnover (between £1.47m and £2.94m)	Comprehensive business case to be approved by Senior Leadership Team	
	iii. Less than 0.25% of Trust turnover (less than £1.47m)	Short form business case to be approved by Capital Programme Steering Group	
17d	Approval of Trust's Medium Term Capital Programme	Trust Board	
17e	Approval of all finance and operating leases	Director of Finance	SFIs Section 19.3.3
17f	Private Finance Initiative	Trust Board	
18 CAPITAL EXPENDITURE – supported by section 10 re procurement			
18a	Approval of Trust's annual capital programme	Trust Board	
18b	Management of the Trust's annual capital programme	Capital Programme Steering Group	
18c	Approval of procurement based schemes within the annual capital programme	Director of Finance	

18d	Approval of estates based schemes within the annual capital programme	Director of Finance	
18e	Variations to approved capital schemes		
	i. Upto £250k	Capital programme steering Group	
	ii. Between £250k and £500k,	Senior leadership Team	
	iii. Over £500k	Trust Board	
18f	Procurement of main contractors for estates based capital schemes		
	iv. Below £5k, best value to be demonstrated	Requisitioner	
	v. Between £5k and £25k, three quotes to be obtained	Estates Manager	
	vi. Over £25k and upto £1m, three tenders to be obtained	Director of Estates and Facilities	
	vii. Over £1m	Capital Programme Steering Group	
18g	Enabling works for capital schemes		
	Below £5k, best value to be demonstrated	Requisitioner	
	ii. Between £5k and £25k, three quotes to be obtained or medium term contractor can be used	Estates Manager	
	iii. Over £25k and upto £1m, three tenders to be obtained	Director of Estates and Facilities	
	iv. Over £1m	Capital Programme Steering Group	
18h	Feasibility fees given compliance with 10a and 10b	Director of Estates and Facilities	
19 TRUST ASSETS			
19a	Maintenance of a fixed asset register	Director of Finance	SFIs section 20.2.1
19b	Authority to dispose of (sell or transfer to another organisation or scrap) a fixed asset	Director of Finance	SFIs section 20.5
19c	Security of fixed assets and notification of loss or transfer to another department	Budget Manager	SFIs section 20.3
20 RETENTION OF DOCUMENTS			
20a	Retention of records and documents	Relevant Divisional/Corporate Director	
21 RISK MANAGEMENT AND INSURANCE			
21a	Risk management arrangements	Chief Executive	SFIs section 22.2.1
21b	Insurance Policies		
	i. Arranging and ensuring adequate cover	Director of Finance	SFIs section 22.3

	ii. Notifying Director of Finance of new or changed risks	All staff	SFIs section 22.3.2
22 GIFTS HOSPITALITY AND SPONSORSHIP (in conjunction with policy held by Trust Secretary)			
22a	Maintaining a register of gifts, hospitality and sponsorship	Trust Secretary	SFIs section 23.2.3
22b	Acceptance of gifts		SFIs section 23.3
	i. Business articles less than £25 per gift	Receiving member of staff may accept with no requirement to register	SFIs section 23.3.1
	ii. Gifts over £25 but below £40 per gift or several small gifts of a value over £100 from same source over 12 month period	Receiving member of staff may accept with if declared and registered	SFIs section 23.3.2
	iii. Gifts over £40 per gift	Receiving member of staff should decline or seek Trust Secretary advice	SFIs section 23.3.3
22c	Acceptance of hospitality		SFIs section 23.4
	i. Modest hospitality if normal and reasonable in the circumstances	Receiving member of staff may accept but should refer to line manager or relevant Director if in doubt	SFIs section 23.4.1
	ii. Inappropriate hospitality offers	Member of staff should notify Trust Secretary.	SFIs section 23.4.2
22d	Sponsorship		SFIs section 23.5
	i. Commercial sponsorship for attendance at conference or course	Approval from line manager	SFIs section 23.5.1
	ii. Sponsorship of Trust events	Approval by Trust secretary, contractual agreement signed by Director of Finance	SFIs section 23.5.2
22e	Acceptance of preferential rates or benefits in kind for private transactions with companies with which there have been or could be dealings with on Trust business	Not permissible by any member of staff unless a concessionary agreement negotiated by the Trust or NHS on behalf of all staff.	SFIs section 23.5.5
23 Research and Development			
23a	Authorisation or research funding applications	Director of Finance or designated deputy for funding applications	
23b	Authorisation of commercial research contracts, site agreements, sub-contracts with participating organisations, contract variations and contract amendments.	Director of Research & Innovation or designated deputy	

23c	The West of England Clinical Research Network (CRN:WoE) Decision to provide additional funding to an NHS partner of the CRN:WoE following a request for financial support; Of £50,000 or below In excess of £50,000	 Senior Leadership Team Senior Leadership team	
24 Other			
24a	Reporting of incidents to the police	Chief Executive, Director of Finance, Chief Internal Auditor	SFIs Section 15.3.2 & 17.3.1c
	▪ general	Appropriate departmental manager – need to inform Divisional Director or relevant Corporate Director as soon as possible. Also inform Local Security Management Specialist	
	▪ where a fraud is involved	Director of Finance or Local Counter Fraud Specialist	Counter Fraud Policy
24b	Compliance with Freedom of Information Act	Trust ~~Solicitor~~ Secretary	Freedom of Information Policy – December 2009
24c	Grievance procedure/appeals board procedures	Director of Workforce and Organisational Development	Disciplinary Policy Managing Performance Policy Grievance Policy
24d	Dismissal	See Matrix in Disciplinary policy	Disciplinary Policy and Procedure
24e	Authorisation of new drugs or significant change of use of existing drugs	Medicines Advisory Group-- see specific guidelines and terms of reference of this committee	
	▪ Request for new drugs require authorisation before purchase	Senior Pharmacy Manager	
	▪ Orders placed to suppliers over £5,000 to be signed	Director of Pharmacy or Pharmacy Purchasing Manager	
	▪ Pharmacy Payment Lists to be authorised ▪ Copy invoices over £10,000 and invoices from NHS bodies to be sent with the Payments Lists to Creditor Payments	Director of Pharmacy or Pharmacy Purchasing Manager or Senior Pharmacy Clerical Officer	
	▪ Pricing agreements and quotations should be authorised	Director of Pharmacy and Pharmacy Purchasing Manager	
	▪ Authorisation of coding slips for invoices and credits requirement payment to be carried out	Senior Clerical Officer	
24g	Patients' & Relatives' Complaints :		
	▪ Overall responsibility for ensuring that all complaints are dealt with effectively	Chief Nurse	

	▪ Responsibility for ensuring complaints relating to a division are investigated thoroughly	Divisional Director and Head of Nursing / Midwifery	
	▪ Legal Complaints - Co-ordination of their management	Trust Solicitor	
24h	Relationship with the media	Head of Communications who reports to the Chief Executive	
24i	Infection Control and Prevention • Corporate Policy • Divisional and Clinical Delivery	Director of Infection Control and Prevention / Chief Nurse /Clinical Chairs	Standing Orders section 2.10
24j	Governance and Assurance Systems Corporate Risk Register Divisional Risk Registers Quarterly review of Risk Registers Reports on the Risk Registers quarterly Maintenance of the Assurance Framework Quarterly review of Assurance Framework Exception Reports on the Assurance Framework (1/4ly)	 Relevant Executive Directors Divisional Directors and Divisional Managers Risk Management Group Senior Leadership Team Trust Company Secretary Senior Leadership Team Audit Committee	SFIs Section 22
24k	All proposed changes in bed allocation	Chief Operating Officer	
24l	Review of Fire Precautions	Fire Safety Manager	Fire Safety Policy and Fire Standards Procedures and Guidelines
	Review of all statutory compliance: legislation and Health and Safety requirements including control of substances hazardous to health regulations	Director of Estates and Facilities / Health and Safety Advisor	Control of Substances Hazardous to Health (COSHH) Policy
24m	Review of compliance with environmental regulations for example those relating to clean air and waste disposal	Director of Estates and Facilities	Operational Policy for Handling Disposal of Waste – August 2005
24n	Review of Trust's compliance with Data Protection Act	Director of Information Management and Technology	Health Records Policy
24o	Review the Trust's compliance with the Access to Records Act	Director of Information Management and Technology	Health Records Policy
24p	Allocation of sealing in accordance with standing orders	Trust Company Secretary on behalf of the Chief Executive	
24q	The keeping of a Register of Sealing	Trust Company Secretary on behalf of the Chief Executive	Section 8 Standing Orders
24r	Affixing the Seal	Chief Executive (or, should the Chief Executive not be available, another Executive Director not from the contract's originating department) and Director of Finance or Deputy Director of Finance	
24s	Clinical Audit	Medical Director	

24t	Human Rights Act Compliance	Trust Solicitor	
24u	Equality and Diversity Schemes	Director of Workforce and Organisational Development	
24v	Child Protection	Chief Nurse	Section 2.10 Standing Orders

University Hospitals Bristol NHS
NHS Foundation Trust

UNIVERSITY HOSPITALS BRISTOL NHS FOUNDATION TRUST

STANDING FINANCIAL INSTRUCTIONS

DECEMBER 2017

Approved at Finance Committee:
Approved at Trust Board:

Contents

1. Introduction

1.1 Purpose and Content

1.1.1 These Standing Financial Instructions (SFIs) regulate the conduct of the Trust, its members, employees and agents in relation to all financial matters.

1.1.2 These Standing Financial Instructions explain the financial responsibilities, policies and procedures to be adopted by the Trust. They are designed to ensure that the Trust's financial transactions are carried out in accordance with the law, the requirements of the Independent Regulator and best practice in order to achieve probity, accuracy, economy, efficiency and effectiveness in the way the Trust manages public resources. They should be used in conjunction with the Standing Orders, Schedule of Matters Reserved to the Trust Board (appendix 1) and the Scheme of Delegation (appendix 2) adopted by the Trust.

1.1.3 These Standing Financial Instructions identify the financial responsibilities which apply to everyone working for the Trust and its constituent organisations including trading units. They do not provide detailed procedural advice and should be read in conjunction with the relevant departmental guidance and the financial procedure notes (available on the intranet or via the Finance Department). All detailed financial procedures must be approved by the Director of Finance.

1.1.4 These Standing Financial Instructions do not include applicable Regulator's guidance, the current version of all relevant guidance should be consulted. They also do not contain every legal obligation applicable to the Trust.

1.1.5 Each section in the Standing Financial Instructions clearly sets out its objectives and the financial responsibilities, policies and procedures relevant to it which must be complied with. When situations arise which are not specifically covered by this document, staff and Trust Board members are required to act in accordance with the spirit of the instructions as set out in the objectives.

1.1.6 Should any difficulties arise regarding the interpretation or application of any of the Standing Financial Instructions then the advice of the Director of Finance must be sought before acting. The user of these Standing Financial Instructions should also be familiar with and comply with the provisions of the Trust's Standing Orders.

1.1.7 These Standing Financial Instructions have been reviewed by the Trust's Finance Committee and approved by the Trust Board. It is expected that all staff employed by the Trust will comply with these instructions at all times. The failure to comply with the Trust's standing financial instructions and standing orders could result in disciplinary action up to and including dismissal. Should any other guidance or departmental policies appear to conflict with these instructions, these Standing Financial Instructions will prevail. Any apparent conflict should be brought to the attention of the Director of Finance.

1.1.8 If for any reason these Standing Financial Instructions are not complied with, full details of the non-compliance and any justification for non-compliance and the circumstances around the non-compliance shall be reported to the Director of Finance. All members of the Board and staff have a duty to disclose any non-compliance with these Standing Financial Instructions to the Director of Finance as soon as possible. The Director of Finance shall investigate and decide on the appropriate action to be taken. This will be reported to the next formal meeting of the Audit Committee for consideration.

1.1.9 These Standing Financial Instructions and associated scheme of delegation should be reviewed annually.

1.1.10 All references to ~~Monitor~~ NHS Improvement refer to the Independent Regulator of Foundation Trusts as established under the National Health Service Act 2006.

1.2 Responsibilities and Delegation

1.2.1 The Trust Board

1.2.2 The Board has resolved that certain powers and decisions may only be exercised by the Board in formal session. These are set out in the Schedule of Matters Reserved to the Trust Board at Appendix 1. Those aside, all executive powers are invested in the Chief Executive, who is the Accounting Officer.

The Board as a whole, and each member of the Board, is accountable for the financial performance of the Trust.

1.2.3 The Chief Executive and Director of Finance

The Chief Executive and Director of Finance will, as far as possible, delegate their detailed responsibilities, but they remain accountable for financial control.

Wherever the title Chief Executive or Director of Finance is used in these instructions, it is deemed to include the deputies where they have been duly authorised by them to represent them.

The Chief Executive

The Chief Executive is ultimately accountable to the Board, and as Accounting Officer, to the Secretary of State and ~~Monitor~~ NHS Improvement, for ensuring that the Board meets its obligation to perform its functions within the available financial resources. The Chief Executive has overall executive responsibility for the Trust's activities, is responsible to the Chair and the Board for ensuring that its financial obligations and targets are met and has overall responsibility for the Trust's system of internal control.

It is the responsibility of the Chief Executive to ensure that all staff are notified of and are required to understand their responsibilities within these instructions.

The Director of Finance

The Director of Finance is responsible for the implementation and monitoring of the Trust's financial policies and for ensuring any corrective action necessary to further these policies. In particular they will:

- provide financial advice to the Board, managers and other employees of the Trust
- design, implement and supervise systems of financial control
- prepare and maintain such accounts, certificates, financial estimates, records and reports as the Trust may require for the purpose of carrying out its statutory and other duties
- ensure that sufficient records are maintained to show and explain the Trust's transactions, in order to disclose, with reasonable accuracy, the financial position of the Trust at any time

The Director of Finance requires that any officer who carries out a financial function does so in a manner and maintains records in a form that meets with their requirements.

The Director of Finance shall prepare, document and maintain detailed financial procedures and systems incorporating the principles of segregation of duties an internal checks. These procedures should be read as forming part of the Standing Financial Instructions.

1.2.4 All Trust Employees

All Trust Employees are responsible for:

(a) the security of the property of the Trust.
(b) avoiding loss.
(c) ensuring economy, efficiency and value for money in the use of public resources.
(d) complying with the Trust's Standing Orders, Standing Financial Instructions, Financial Procedures and the Scheme of Delegation.

The scheme of delegation at appendix 2 contains all delegated authorities to nominated officers. Whilst these officers remain responsible for these authorities, should they delegate matters to other individuals within their organisational control, evidence should be maintained of this ensuring the understanding by the delegated officer of their associated responsibilities. This must be regularly reviewed.

All references in these instructions to 'employee' or 'officer' shall be deemed to include all salaried staff or those under contract to the Trust. This includes staff supplied using agency contracts even though the terms of supply may be covered in an agreement with the supplying organisation.

It is the responsibility of managers to ensure that both existing staff and new appointees within their management area know and understand their responsibility to comply with these instructions.

1.2.5 Hosting Arrangements

Where the Trust hosts an organisation with a separate management board, the financial transactions supporting the day to day business of the organisation shall be strictly in accordance with the Trust's Standing Financial Instructions, policies and procedures. Responsibility for decision making, planning and reporting will be delegated in accordance with the hosting agreement or as specified in the scheme of delegation.

2. Planning, Budgets and Budgetary Control

2.1 Objective

2.1.1 To ensure the Trust Board is provided with the information required regarding the planning and development of the Trust's activities and finances to enable the Trust's Directors to fulfil their responsibilities. To provide assurance that the Trust exercises proper control of income and expenditure throughout the year. To inform budget managers of their delegated responsibilities

2.2 Preparation and Approval of Annual Plans and Budgets

2.2.1 The Chief Executive will, with the assistance of, other Directors, compile and submit to the Trust Board an annual plan, strategic and operational plans required to support their accountability for the financial performance of the Trust. As a minimum this will meet the requirements laid down by ~~Monitor~~ NHS Improvement. The annual plan will contain a statement of the significant assumptions on which the plan is based and details of major changes in workload, delivery of services or resources required to achieve the plan.

2.2.2 The Chief Executive will, with the assistance of the Director of Finance, compile and submit to ~~Monitor~~ NHS Improvement all strategic and operational plans required by them in accordance with their guidance and submission dates. This information will be prepared by the Trust's Officers who must have regard to the views of the Council of Governors.

2.2.3 Prior to the start of the financial year the Director of Finance will, on behalf of the Chief Executive, prepare and submit financial plan supporting the annual plan for approval by the Board. This will include:

- the expected level of income and the sources of that income
- the planned level of surplus or deficit ~~planned~~
- how expenditure is to be managed in order to achieve the planned surplus or deficit
- the effect on the ~~Monitor Financial Risk Ratios~~ NHS Improvement's Use of Resource Rating
- the impact on the Trust's Statement of Financial Position
- cash flow and levels of borrowing
- the cost pressures faced by the Trust
- savings plans which need to be achieved
- potential risks which may affect the financial position of the Trust

The financial plan will

- be in accordance with the aims and objectives set out in the Trust's annual business plan
- accord with capacity and workforce plans
- be produced in accordance with principles agreed with the Senior Leadership Team as advised by the Director of Finance

2.2.4 The Director of Finance is responsible for the preparation of the overall Trust budget within the total income receivable by the Trust, and in accordance with its agreed strategies and policies. Operational budgets shall be set at the beginning of each financial year by financial and operational managers in line with the Trust's approved budget.

2.2.5 Operational plans shall be compiled for each Division by the Clinical Chairs and Divisional Directors and for each corporate service area by the Head of Service. These plans should reflect the Trust's annual business plan and the budget, and will be approved by the Chief Executive.

2.2.6 Appropriate Trust employees shall provide the Directors with all financial, statistical and other relevant information, as required, in order to enable the compilation of plans and budgets.

2.3 Budgetary Delegation

2.3.1 The Chief Executive may delegate the management of budgets for defined services to the Clinical Chairs/Divisional Directors or Heads of Corporate Services responsible for the management of those services. Delegation and associated responsibilities must be clearly communicated. Control of budgets shall be exercised in accordance with these Standing Financial Instructions and supplementary guidance issued by the Director of Finance.

2.3.2 Clinical Chairs, Divisional Directors and Heads of Corporate Service with budgetary responsibility must ensure that their budgets are structured appropriately to ensure effective budgetary control. Whilst accountable for the overall budget management, Clinical Chairs, Divisional Directors and Heads of Corporate Service are authorised to delegate the management of specific budgets to named budget managers. Delegation and associated responsibilities must be clearly communicated to these budget managers. It is the responsibility of the Head of Division/Corporate Service to ensure the budget structure and delegation to budget managers is maintained in line with organisational and staff changes.

2.3.3 The Chief Executive and delegated budget holders must not exceed the budgetary total set by the Trust Board, except as specified below:

(a) The Chief Executive may vary the budgetary limit of a Division or Service within the Trust's total budgetary limit.
(b) Clinical Chairs, Divisional Directors and Heads of Corporate Services are permitted to authorise expenditure over the budget on individual budgets within their delegated areas provided this does not cause their delegated budget area to overspend or to exceed the financial limit set by (a) above.

2.3.4 Except where otherwise approved by the Chief Executive, taking account of advice of the Director of Finance, budgets shall be used only for the purpose for which they were provided and any budgeted funds not required for their designated purposes shall transfer to the Trust's reserves, unless covered by the delegated powers of virement.

2.3.5 Non-recurring budgets must not be used to finance recurring expenditure unless authorised by the Director of Finance.

2.3.6 Expenditure for which there is no provision in an approved budget and is not subject to funding under the delegated powers of virement, or approved procedures for new funding obtained during the year, may only be incurred if authorised by the Chief Executive.

2.3.7 Budget limits, individual and group responsibilities for the control of expenditure, exercise of virement, and achievement of planned levels of income and expenditure, shall be set out annually in a Resources Book approved by the Trust Board.

2.4 Budgetary Control and Reporting

2.4.1 The Director of Finance is responsible for maintaining an effective system of budgetary control. All Trust staff responsible for the management of a budget or for incurring expenditure or collecting or generating income on behalf of the Trust must comply with these controls.

2.4.2 The Director of Finance is responsible for providing financial information and advice to enable the Board, Chief Executive and other officers to carry out their budgetary responsibilities. This includes:

(a) monthly financial reports to the Board in a form approved by the Board containing:
    (i) income and expenditure to date against plan and forecast year-end position,
    (ii) the statement of financial position, changes in working capital and other material balances,
    (iii) monthly cash flow monitoring of actual against plan and forecast year-end position,

(iv) capital expenditure against plan and forecast year-end position,
(v) achievement against the savings programme
(vi) explanations of any material variances from plan,
(vii) details of any corrective action where necessary and the Chief Executive's and/or Director of Finance's view of whether such actions are sufficient to correct the situation,
(viii) performance against ~~Monitor's~~ NHS Improvement's ~~Risk Assessment~~ Single Oversight Framework

(b) providing timely, accurate and comprehensible advice and financial information to all budget holders, covering the areas for which they are responsible,
(c) providing clear financial processes and procedures governing the operation of budgets,
(d) training and support to budget holders to allow them to undertake their financial responsibilities,
(e) investigation and reporting of variances from financial, activity and workforce budgets,
(f) monitoring of management action to correct variances,
(g) arrangements for the authorisation of budget transfers.

2.4.3 The Director of Finance shall keep the Chief Executive and Board informed of the financial consequences to the Trust of changes in government policy, pay, terms and conditions, accounting standards and any other events affecting the current or future financial plans of the Trust.

2.4.4 All delegated budget managers are responsible for ensuring that:

(a) they check and validate all monthly budget statements,
(b) they fully understand their financial responsibilities and have received the required training and support to understand the financial information presented to them to fulfil these responsibilities,
(c) any likely overspending or reduction of income, which cannot be met by virement, is not incurred without the prior consent of the Head of Division/Service as per 2.3.3 (b) above,
(d) their delegated budget is only used in whole or in part for the purpose it was provided for, subject to the rules of virements,
(e) no permanent employees are appointed without the required approval as set out in section 8.3 and are provided for within the available resources and workforce establishment as approved by the Board,
(f) savings programmes and income generation initiatives are implemented to achieve a balanced budget,
(g) all expenditure is approved and authorised in advance of commitment in line with these standing financial instructions and financial processes and procedures issued by the Director of Finance.

2.4.5 The Chief Executive is responsible for authorising the implementation of savings programmes and income generation initiatives in accordance with the requirements of the Annual Business Plan to secure a balanced budget.

2.5 Capital Expenditure

2.5.1 The Director of Finance is responsible for compiling and submitting to the Board for approval an annual capital programme, ensuring that the planned expenditure is in line with available resources. Performance against the capital programme, forecast out-turn, and changes in capital allocation must be reported to the Board monthly.

2.5.2 The Director of Finance is responsible for submitting to ~~Monitor~~ NHS Improvement all capital programme information required by them in line with their requirements and timescales.

2.5.3 The general rules applying to delegation, control and reporting above shall also apply to capital expenditure, (see section 18 for details relating to capital investment).

3. Annual Accounts and Reports

3.1 Objective

3.1.1 To ensure the production of the Trust's Annual Accounts and Report in accordance with statutory requirements

3.2 General

3.2.1 The Director of Finance, on behalf of the Trust, is responsible for the preparation and submission of financial reports and returns as required by ~~Monitor~~ NHS Improvement and other Government Departments in such form as they require and in accordance with their timetable.

3.2.2 The Director of Finance, on behalf of the Trust, is responsible for the preparation and submission of the Trust's annual accounts as required by ~~Monitor~~ NHS Improvement, in such form as they require and in accordance with their timetable.

3.2.3 The Trust's financial returns and annual accounts will be prepared in accordance with the accounting policies and guidance issued by ~~Monitor~~ NHS Improvement, the Trust's accounting policies, International Financial Reporting Standards and other accounting standards applicable at the time. The Director of Finance is responsible for ensuring the Trust's accounting policies are reviewed annually, updated as required and approved by the Audit Committee.

3.2.4 The Trust's annual accounts must be audited and certified by an independent external auditor (see section 20) and the Director of Finance is responsible for ensuring this happens in accordance with ~~Monitor's~~ NHS Improvement's timetable.

3.2.5 The Trust's Company Secretary, on behalf of the Trust, is responsible for the preparation and submission of the Trust's Annual Report to ~~Monitor~~ NHS Improvement in such form as they require and in accordance with their timetable.

3.2.6 The Director of Nursing, on behalf of the Trust, is responsible for the preparation and submission of the Trust's Quality Report to ~~Monitor~~ NHS Improvement in such form as they require and in accordance with their timetable.

3.2.7 The Trust's annual report (including the quality report) must be audited and certified by an independent external auditor (see section 20) and the Company Secretary is responsible for ensuring this happens in accordance with ~~Monitor's~~ NHS Improvement's timetable.

3.2.8 The Trust's annual report and statutory accounts must be presented to the Trust Board for approval. They must be laid before Parliament, after which they cannot be changed. They must be made available for inspection by the public. The annual report and accounts and the auditor's report must be presented at a meeting of the Council of Governors in accordance with the ~~Monitor's~~ NHS Improvement's timetable

3.3 Service Agreement Monitoring and Reporting

3.3.1 The Director of Finance is responsible for ensuring that systems and processes are in place to record patient activity, invoice and collect monies due under the agreements for the provision of healthcare services.

3.3.2 The Director of Finance is responsible for reporting to the Board the Trust's actual contract activity and income due against the agreed contracts with an assessment of the financial impact of any contract under/over achievement.

3.3.3 The Director of Finance is responsible for providing information to Clinical Chairs, Divisional Directors and Heads of Corporate Service for the actual contract activity and income due against the agreed contracts and the associated financial consequences for their service areas to facilitate financial management.

3.3.4 The Director of Finance is responsible for ensuring training and support to the Clinical Chairs, Divisional Directors and Heads of Corporate Service to be able to understand the contracts for their service areas and the information relating to activity and financial performance.

3.3.5 All Clinical Chairs, Divisional Directors and Heads of Corporate Service responsible for the management of service agreement income must ensure they understand and use the contract monitoring information for the financial management of their service areas.

4 Research and Innovation

4.1 Objective

4.1.1 To provide specific instructions relating to research and innovation and reference to general financial instructions and processes governing this area.

4.2 General

4.2.1 The undertaking of research or clinical trials by Trust employees within the Trust's premises shall be strictly in accordance with the Trust's policies and strategies on research governance and shall be subject to approval accordingly.

4.2.2 The Standing Financial Instructions apply equally when undertaking externally funded research activity within the Trust, particularly:

- Section 2 - Planning, Budgets and Budgetary Control
- Section 8 - Payments of Trust Employees and Contractors
- Section 9 - Procurement of Goods and Services
- Section 10 – Tendering Procedure
- Section 11 - Payment of Goods and Services Received
- Section 12 - Stores and Receipt of Goods
- Section 19 – Risk Management and Insurance
- Section 22 – Acceptance of Gifts by Staff and Other Standards of Business Conduct
- Section 24 – Retention of Documents

4.2.3 The principles governing probity and public accountability shall apply equally to work undertaken through externally funded research or clinical trials.

4.3 Research & Innovation Applications

4.3.1 All applications for research and innovation funding require approval from the Director of Finance or a designated deputy. This applies to applications to both NHS funders, such the National Institute for Health Research, and to non-NHS organisations, such as charitable bodies and research councils.

4.3.2 All other documents* relating to Research & Innovation will require approval from the Director of Research & Innovation or a designated deputy, once all the necessary checks have been carried out, including finance checks where applicable.

**other documents include research contracts with funding bodies, collaboration agreements, commercial research contracts, site agreements, sub-contracts with participating organisations, contract variations and contract amendments.*

4.4 Intellectual Property

4.4.1 The agreement covering any undertaking of research shall give cognisance to Trust policies governing Intellectual Property rights. Where there is any lack of clarity this shall be resolved prior to undertaking the project.

5. ~~Service Agreements~~ Contracts for the Provision of Healthcare Services

5.1 Objective

5.1.1 To ensure that the Trust's ~~service agreements~~ contracts for the provision of healthcare services are properly planned and controlled and that all income relating to these agreements is properly accounted for.

5.2 Contracts for the provision of healthcare services

5.2.1 The Chief Executive is responsible for ensuring the Trust enters into suitable ~~legally binding contracts~~ Commissioning Contracts with service commissioners for the provision of NHS services. Appropriate legal advice identifying the Trust's liabilities within the terms of the contract should be considered. In discharging this responsibility, ~~the Chief Executive should take into account:~~

- ~~the standards of service quality expected;~~
- ~~the relevant national service framework (if any);~~
- ~~the provision of reliable information on cost and volume of services; and~~
- ~~any model contracts issued by the Department of Health.~~

Where the Trust makes arrangements for the provision of services by non-NHS providers, the Chief Executive is responsible for ensuring that the agreements put in place have due regard to the quality and the cost-effectiveness of the services provided.

5.2.2 In carrying out these functions, the Chief Executive should take into account the advice of the Director of Finance regarding:

- standard NHS contractual terms and conditions
- costing and pricing of services, ~~including contract currencies~~;
- payment terms and conditions;
- amendments to contracts and extra-contractual arrangements;
- ~~payment by results~~.

5.2.3 Agreements should be devised as to minimise risk whilst maximising the Trust's opportunity to generate income. The Trust will use the National Tariff where appropriate and, for services not covered by the National Tariff, a local tariff agreed with the Commissioners.

5.2.4 All agreements should aim to implement the agreed priorities contained within the annual plan. National guidance on arrangements for contracting should be taken into account.

5.2.5 The Chief Executive shall ensure the contracting process is administered effectively and that appropriate service, quality, safety, clinical and financial input is provided.

5.2.6 The Director of Finance is responsible for agreeing the financial details contained in service contracts.

5.2.7 NHS Contracts with commissioners for the provision of healthcare services can only be signed by the Chief Executive, Director of Finance or Chief Operating Officer, without financial limit.

5.2.8 Service changes and developments initiated within the Divisions must be with the agreement of the Chief Executive or the Chief Operating Officer. The Finance Director must be informed to ensure appropriate financial scrutiny.

6. Banking and Cash Management

6.1 Objective:

6.1.1 To ensure the effective management of the Trust's cash and to ensure it is properly controlled and safeguarded from loss and fraud.

6.2 General

6.2.1 The Director of Finance is responsible for producing a Treasury Management Policy, in accordance with any relevant guidance from ~~Monitor~~ NHS Improvement, for Trust Board approval.

6.2.2 The Director of Finance is responsible for the operation of the commercial bank and Government Banking Service accounts and for the management of accounts receivable, cash flow forecasting and investment of surplus funds. The Director of Finance will ensure that these functions are properly managed and that information is provided to the Trust Board to support this.

6.3 Banking Arrangements

6.3.1 The Director of Finance is responsible for managing the Trust's banking arrangements and for advising the Trust on the provision of banking services and operation of bank accounts. This advice will take into account guidance/directions issued by ~~Monitor~~ NHS Improvement and Treasury requirements for NHS banking.

6.3.2 The Director of Finance is solely authorised to open, operate and control any bank account where Trust funds are received or expended. All such accounts must be held in the name of the Trust. It is a disciplinary offence for any officer of the Trust outside of the organisational control of the Director of Finance to operate such an account with a Trust name or from a Trust address.

6.3.3 All income relating to Trust business must be paid into the Trust's bank account This includes all income from the sale of goods and services, disposal of items, vending machines and courses/lectures/other outside work undertaken in paid Trust time.

6.3.4 Donations are required to be managed via accounts operated by the Trust's charitable body. Such accounts must not be opened by employees. Any donations received must be managed in accordance with section 23.

6.3.5 If a member of staff wishes to set up a bank account with reference to the Trust and/or Trust address for a purpose other than that which has been explicitly prohibited in the sections above, they must write to the Director of Finance for approval.

6.3.6 The Director of Finance shall establish and approve procedural instructions on the operation of all commercial bank accounts, investment accounts and Government Banking Service.

6.3.7 The Finance Committee shall ensure proper safeguards are in place for security of the Trust's funds by:

(a) approving the Trust's commercial bankers, selected by competitive tender.
(b) approving a list of permitted 'relationship' banks and investment institutions.
(c) setting investment limits for each permitted investment institution.
(d) approving permitted types of investments /instruments.
(e) approving the establishment of new/ changes to existing bank accounts.

6.3.8 The Director of Finance is responsible for ensuring approved bank mandates are in place for all accounts and that these are updated regularly for any changes in signatories and authorised limits.

6.3.9 The Director of Finance will review the banking needs of the Trust at regular intervals to ensure that they reflect current business patterns and represent value for money. Following such reviews, the Director of Finance shall determine whether or not re-tendering for services is necessary. The Director of Finance shall be responsible for organising and evaluating bank tendering processes. The Director of Finance shall report the outcome of any tendering exercise for approval by the Finance Committee.

6.3.10 The Director of Finance, on behalf of the Finance Committee, shall advise the Trust's commercial and relationship bankers in writing of the conditions under which each account shall be operated, the limits to be applied to any overdraft, the limitation on single signatory payments and the officers authorised to release money from and draw cheques or other payable orders on each account. This must contain the Chief Executive and Director of Finance. The cancellation of any such authorisation shall be notified promptly to the bank.

6.3.11 Where a new banking relationship is suggested this must be pre-approved by the Director of Finance before a proposal is made to the Finance Committee. The Finance Committee will consider the need for and potential benefit of the new relationship and sanction or reject the proposal. The Trust's bankers shall be notified by the Director of Finance, on behalf of the Finance Committee of any alterations in the conditions of operation of the Trust's accounts that may be required by the Finance Committee.

6.3.12 The Director of Finance is required to approve any direct debit or standing order payment arrangements. The Director of Finance is responsible for the effective control of payments made from the Trust's bank account through bank transfers, cheques and payments by Bank Automated Credits (BACS).

6.3.13 The Director of Finance may operate ~~a~~ credit/purchasing cards on behalf of the Trust. They must be used in accordance with a written policy approved by the Finance Committee.

64 Cash Management

6.4.1 The Director of Finance is responsible for managing and monitoring the cash flow of the Trust and ensuring that it has enough cash balances to meet all its commitments.

6.4.2 Any member of Trust staff aware of significant and unexpected delays in the receipt of cash or of significant unexpected or early payments that will have an effect on the Trust's cashflow position must inform the Director of Finance or other Senior Finance Manager.

6.4.3 The Director of Finance is responsible for providing assurance to the Trust Board and Finance Committee on the management of the Trust's cash position through monthly reporting.

6.5 Investment of Temporary Cash Surpluses

6.5.1 Temporary cash surpluses shall be invested in line with the Treasury Management Policy, subject to the overall cash flow position and in line with any relevant guidance from ~~Monitor~~ NHS Improvement or HM Treasury.

6.5.2 The Director of Finance is responsible for advising the Finance Committee on investments and shall report monthly to the Finance Committee concerning the performance of investments held.

6.5.3 The operation of investment accounts and the records maintained must be in accordance with detailed procedural instructions issued by the Director of Finance and approved by the Finance Committee.

6.5.4 The Finance Committee shall:
(a) approve a list of permitted investments institutions.
(b) set investment limits for permitted investment institutions.
(c) approve a schedule of permitted types of investments and financial instruments

6.5.5 Investments for purely speculative purposes are strictly prohibited.

7. Income

7.1 Objective

7.1.1 To ensure that:

(a) Income due is promptly assessed and collected; and

(b) Income received is promptly banked and fully accounted for.

7.2 Income Due

7.2.1 The Director of Finance is responsible for designing and maintaining systems for the proper recording, invoicing and collection of all income together with systems for financial coding.

7.2.2 The Director of Finance is responsible for the prompt banking of all monies received.

7.2.3 The Director of Finance is responsible for the design and ordering of all receipt books, tickets, agreement forms, or other means of officially acknowledging or recording amounts received or receivable. They will be issued and controlled according to procedures established by the Director of Finance and will be subject to the controls as are applied to cash (Section 14).

7.2.4 Cash payment for charges made by the Trust, for the provision of any goods or services, must not normally be accepted where the value of any single transaction is in excess of £10,000. Should this occur, the Head of ~~Treasury Management~~ Exchequer Services must be notified immediately to ensure the Trust complies with HM Revenue and Customs' regulations.

7.2.5 A contract or agreement must be in place for all income due to the Trust for the provision of goods or services to a third party. The nature of the contract or agreement will depend on the goods or services being provided. The Director of Finance is responsible for signing all contracts and agreements with delegated responsibilities given within the scheme of delegation (appendix 2) and supporting financial limits matrix.

7.2.6 Employees responsible for agreeing the prices of goods and services provided by the Trust should ensure that they cover all costs, including overheads. Support should be sought from the finance department as required. Appropriate, independent professional advice shall be taken on matters of valuation. Prices and charges shall be reviewed at least annually. This paragraph applies equally to:

- ~~tenders for~~ the sale of goods and services;
- ~~quotations for~~ support to commercial research trials and projects; and
- pricing of non-patient care service agreements with other ~~NHS~~ bodies.

7.2.7 The Trust's price tariff for private patient treatment is set by the Director of Finance. The pricing structure ensures that prices are at least equal to those charged to NHS Commissioners and ensures that public funds are not used to subsidise private patient activity. Any proposed variations to the Private Patient Tariff prices must be approved by the Director of Finance before patients are advised of the cost of their treatment.

7.2.8 All Trust employees shall promptly inform the Director of Finance of money due to the Trust arising from transactions which they initiate including all contracts, leases, tenancy agreements, private patient undertakings and other transactions.

7.2.9 The notification of income due shall be as prescribed by procedures established by the Director of Finance, ensuring sufficient details are included to enable the prompt payment by the debtor.

7.2.10 The Director of Finance shall ensure that debtors are invoiced promptly on receipt of the advice of income due.

7.2.11 There must be clear separation of duties so that officers responsible for raising invoices or accounting for amounts due to the Trust shall not handle cash or cheques received by the Trust.

7.2.12 The Director of Finance shall take appropriate recovery action on all outstanding debts and no claims shall be abandoned except as in accordance with Section 16 - Losses and Special Payments.

7.2.13 Income from the disposal of assets, scrap material and items surplus to requirements shall be dealt with in accordance with Section 13 of these Instructions.

7.3 Income Received

7.3.1 All income received into the Trust must be collected, receipted and accounted for in accordance with the procedures established by the Director of Finance. It is the responsibility of all Trust employees responsible for these duties to ensure they comply with these procedures. It is the responsibility of the Senior Managers responsible for areas where income is received to ensure that their staff are complying with these procedures.

7.3.2 All cash and cheques, ~~postal orders, cash, etc~~ shall be banked intact promptly in accordance with the Director of Finance's instructions. Disbursements shall not be made from cash received. Payment by debit or credit card may only be accepted by staff designated by the Director of Finance. All transactions must be processed in accordance with the instructions approved by the Director of Finance.

7.3.3 The opening of incoming post must be undertaken by officers working in pairs and all cash, cheques, ~~postal orders~~ and other forms of payment shall be entered immediately in an approved form of register and certified by both officers.

7.3.4 Every employee authorised to receive remittances in cash or other forms must keep up to date a record of the amounts received in accordance with procedures approved by the Director of Finance. This record must be reconciled with the amount held in accordance with these instructions. Any discrepancy shall be reported immediately to their senior manager and the Director of Finance.

7.3.5 Official receipts shall be issued in all cases involving cash and only where especially requested by the payer for cheques, debit card etc.

7.3.6 All cash received, if not paid directly into the bank, shall be locked as soon as possible in the safe or cash box provided for the purpose, which shall be safeguarded as specified in Section 6.

7.3.7 Collections from cash tills, telephone and other coin boxes and from night safes shall be made at such intervals as shall be prescribed by or with the approval of the Director of Finance. The opening of each such box or safe and the counting and recording of the contents shall be undertaken by two employees together. Both shall sign the record and the keys shall, at other times, be separately held by a senior officer.

7.3.8 The Director of Finance shall ensure that all income received into the Trust's bank accounts is accounted for promptly – as per section 6.

8. Payment of Trust Employees and Contractors

8.1 Objective

8.1.1 To ensure proper control over the appointment and payment of Trust employees and contractors.

8.2 Remuneration and Terms of Service of Directors

8.2.1 In accordance with Standing Orders and the 2006 Act, the Board shall establish a Nomination and Remuneration ~~and Terms of Service~~ Committee consisting of Non-Executive Directors to decide the remuneration and allowances and other terms of office of the Executive Directors, with clearly defined terms of reference, specifying which posts fall within its area of responsibility, its composition, and the arrangements for reporting.

8.2.2 The Committee will:

(a) Advise the Board about appropriate remuneration and terms of service for the Chief Executive and other Executive Directors employed by the Trust including:

(i) All aspects of salary (including any performance-related elements/bonuses);
(ii) Provisions for other benefits, including pensions and cars;
(iii) Arrangements for termination of employment and other contractual terms;

(b) Make such recommendations to the Board on the remuneration and terms of service of Executive Directors of the Board (and other senior employees) to ensure they are fairly rewarded for their individual contribution to the Trust - having proper regard to the Trust's circumstances and performance and to the provisions of any national arrangements for such members and staff where appropriate;

(c) Monitor and evaluate the performance of individual Executive Directors (and other senior employees);

(d) Advise on and oversee appropriate contractual arrangements for such staff including the proper calculation and scrutiny of termination payments taking account of such national guidance as is appropriate.

8.2.3 The Committee shall report in writing to the Board the basis for its recommendations. The Board shall use the report as the basis for their decisions, but remain accountable for taking decisions on the remuneration and terms of service of Executive Directors. Minutes of the Board's meetings should record such decisions.

8.2.4 The Council of Governors will decide the remuneration and allowances and other terms of office of the Chair and Non-Executive Directors.

8.2.5 The Trust will pay allowances to the Chairman and Non-Executive Directors in accordance with all relevant guidance.

8.3 Other Staff Remuneration and Appointments

8.3.1 The implementation of national pay directives relating to the remuneration of staff will be approved by the Chief Executive. Any variation from these or implementation requiring local interpretation or negotiation will be approved by the Chief Executive.

8.3.2 All Trust officers responsible for the engagement, re-engagement and regrading of employees, either on a permanent or temporary contract, or for hiring agency staff or contractors, or agreeing to changes in any aspect of remuneration must comply with the scheme of delegation and act in accordance with the processes designated by the Director of ~~Workforce and Organisational Development~~ People. In particular such actions must be within the limit of their approved budget and funded establishment.

8.3.3 The Board shall delegate responsibility to the Director of ~~Workforce and Organisational Development~~ People for:

(a) ensuring that all employees are issued with a Contract of Employment in a form approved by the Board and which complies with employment legislation;
(b) ensuring processes are in place for dealing with variations to, or termination of, contracts of employment.

8.3.4 The Director of Finance and ~~Director of Workforce and Organisational development~~ People must be informed when a reward (monetary and non-monetary) is being proposed for staff in recognition of their work for the Trust which will not be processed through the payroll. This is to ensure consistency and that appropriate legislation is being complied with. It should be noted that such rewards may constitute a taxable benefit.

8.4 Notification of Information to Payroll

8.4.1 All Trust Officers responsible for the engagement and management of staff must inform the Director of Finance's Payroll Department promptly and in the agreed form of full details in respect of:-

(a) Commencement of employment.
(b) Change to terms and conditions of employment or circumstance.
(c) Termination of employment.

8.4.2 On appointment, a properly authorised appointment form for Direct Hires or an e-Starter form for all staff recruited through ESR and such documents as required by the Director of Finance and/or Director of ~~Workforce and Organisational Development~~ People shall be submitted to the Payroll Department immediately.

8.4.3 A properly authorised change of conditions e-form shall be submitted to the Payroll Department immediately a change in status of employment or personal circumstances of an employee is known.

8.4.4 A properly authorised termination of employment e-form and other relevant information shall be submitted to the Payroll Department immediately the effective date of an employee's resignation, retirement or termination is known. Where an employee fails to report for duty in circumstances which suggest that they have left without notice, the Payroll Department shall be informed immediately.

8.4.5 All absence due to sickness and other reasons as required shall be notified to the Payroll Department in the required form and timescales.

8.4.6 All documents used for payroll purposes such as time sheets and payment sheets must be in a form approved by the Director of Finance and must be properly authorised.

8.5 Processing Of Staff Payments

8.5.1 The Director of Finance is responsible for:

(a) specifying timetables for the submission to the Payroll Department of properly authorised time records and other notifications;
(b) the final determination of pay and allowances;
(c) making payment on agreed dates;
(d) agreeing method of payment.

8.5.2 The Director of Finance will issue instructions regarding:

(a) Verification and documentation of data.
(b) The timetable for receipt of data, preparation of payroll and the payment of staff.
(c) Maintenance of subsidiary records for superannuation, income tax, national insurance, social security and other authorised deductions from pay.
(d) Security and confidentiality of payroll information.
(e) Checks to be applied to completed payroll before and after payment.
(f) Authority to release payroll data under the provisions of the Data Protection Act.
(g) Methods of payment for ALL staff by BACS.
(h) Procedures for payment of BACS and in an emergency cheques, or cash to staff.
(i) Procedures for recall of BACS.
(j) Pay advances and their recovery.
(k) Separation of the duties of initiating and making payments.
(l) A system to ensure the recovery from leavers of sums due by them to the Trust.
(m) Maintenance and regular reconciliation of adequate control accounts with appropriate internal check procedures.

8.5.3 Appropriately nominated managers have delegated responsibility for:

(a) submitting properly authorised time records, and other notifications to the Payroll Department in accordance with agreed timetables;
(b) completing time records and other notifications in accordance with the Director of Finance's instructions and in the form prescribed by the Director of Finance;
(c) submitting termination forms in the prescribed form immediately upon knowing the effective date of an employee's resignation, termination or retirement. Where an employee fails to report for duty or to fulfil obligations in circumstances that suggest they have left without notice, the Director of Finance must be informed immediately.

8.5.4 Regardless of the arrangements for providing the payroll service, the Director of Finance shall ensure that the chosen method is supported by appropriate (contracted) terms and conditions, adequate internal controls and audit review procedures and that suitable arrangements are made for the collection of payroll deductions and payment of these to appropriate bodies.

8.5.5 The Director of Finance shall pay salaries and wages on the currently agreed dates but may vary these when necessary due to special circumstances (e.g. Christmas and other bank holidays). Payments shall not normally be made in advance of the authorised normal pay date.

8.6 'Off Payroll' Arrangements

8.6.1 Off payroll arrangements relate to the payment of individuals for work undertaken on behalf of the Trust which is paid on receipt of invoice rather than through the payroll. It does not include staff employed via employment agencies or those staff being seconded to the Trust, paid by another organisation which then recharges the Trust.

8.6.2 All senior staff must be on the payroll unless there are exceptional temporary circumstances, which will require the Chief Executive's approval. This includes all Trust Board members, members of Divisional Boards and staff with significant financial responsibility.

8.6.3 All other staff engaged to fill a specific role 'off payroll' require the approval of the Director of ~~Workforce and Organisational Development~~ People who may delegate authority in accordance with the scheme of delegation.

8.6.4 All 'off payroll' engagements are required to comply with the relevant requirements of this section of the Standing Financial Instructions and with section 11, recognising that payment is not via the payroll. In particular:

- all staff are required to be issued with a Contract of Employment which complies with employment legislation
- the terms of remuneration should be in line with national pay directives or locally Trust agreed variations. Payment outside of these terms requires Divisional Director and Human Resources approval.

8.6.5 The engagement of staff 'off payroll', gives rise to tax, national insurance and pension implications. It is the responsibility of Trust managers engaging the provision of such staff to ensure that the arrangements comply with the requirements of HM Revenue and Customs.

8.6.6 The Director of Finance is responsible for ensuring there are detailed procedures in place to assist employing managers to assess and select the correct form of contractual relationship required (payable gross on invoice or subject to statutory deductions through PAYE) to comply with HM Revenue and Custom requirements.

8.6.8 All Trust officers responsible for procuring the provision of services by individuals not directly employed by the Trust must ensure that they comply with relevant Trust procedures and should seek guidance if required.

8.7 Travel and Subsistence

8.7.1 Payment of travel and subsistence costs incurred by staff on Trust business shall be made by the Payroll Department in accordance with the current regulations, subject to verification of claim details, upon receipt of the prescribed form, properly completed and authorised by an officer with delegated authorisation for this purpose.

9. Procurement of Goods and Services

9.1 Objective

9.1.1 To ensure that proper control is exercised and value for money is obtained in the procurement of all goods and services on behalf of the Trust.

9.2 General

9.2.1 The Trust Board may enter into contracts on behalf of the Trust within the statutory powers delegated to it. The procedure for ~~making~~ letting all contracts shall comply with these powers and Standing Financial Instructions. A contract or agreement must be in place for all goods, services and works procured by the Trust. The nature of the contract or agreement will depend on the goods or services being provided. The Director of Finance is responsible for signing all contracts and agreements with delegated responsibilities given within the scheme of delegation (appendix 2).

9.2.2 All contracts made shall endeavour to obtain best value for money by using the Trust's procurement ~~department~~ service and processes established by the Director of Finance. The Chief Executive shall nominate a Trust officer who shall be responsible for overseeing and managing each contract on behalf of the Trust.

9.2.3 Goods, services and works shall only be ordered in line with the controls and systems established and approved by the Director of Finance, which must comply with the financial limits and other principles set out in this section. These controls and systems cover all goods and services procured both within and outside of the Trust's Electronic Requisitioning and Ordering System (EROS).

9.2.4 All employees must comply with the processes, systems and controls for procuring all goods and services established by the Director of Finance which are available from the finance department, as well as these Standing Financial Instructions and Scheme of Delegation.

9.3 EU Directives, Legislation and Guidance

9.3.1 The Trust shall comply with all European Union and Government Directives regarding public sector procurement and prescribed procedures for awarding all forms of contracts.

9.3.2 The Trust shall comply as far as is practicable with all guidance and advice issued by the Department of Health and the independent regulator in respect of procurement, capital investment, estate and property transactions and management consultancy contracts.

9.3.3 No order shall be issued to any firm which has made an offer of gifts or rewards to Directors or employees – in line with Section 22.

9.4 Financial Limits

9.4.1 A minimum of three competitive tenders ~~shall be invited~~ is required in accordance with the requirements of Section 10 for any purchase of goods or services over £25,000 (excluding VAT) including:

(a) a specification for equipment, goods, service contract, construction contract or other project;
(b) a period standing order, call-off contract, framework agreement or other purchase of goods or services where the aggregate value exceeds £25,000 in any year.

9.4.2 Where such purchases exceed £5,000 but are less than £25,000 a minimum of three competitive quotations in writing shall be obtained.

9.4.3 Where such purchases do not exceed £5,000, non-competitive quotations in writing may be obtained with value for money being demonstrated on all occasions. Best practice should be a minimum of three such quotations.

9.4.4 Before placing an order for goods or services, potential suppliers and the cost should be adequately investigated and evaluated. This should include consultation with the Trust's procurement service ~~department~~.

9.4.5 Orders shall not be placed in a manner devised to avoid the financial thresholds specified by the Trust Board.

9.4.6 If the Trust's procurement ~~department~~ service is asked to ~~issue~~ place orders outside these thresholds, they will refer the request back to the budget holder. The ordering of goods or services above £5,000 without competitive quotes or £25,000 without competitive tendering will not be allowed but if the budget holder believes there is an exceptional case for doing so, that case must be submitted to the Director of Procurement ~~Purchasing and Supply~~ for consideration of approval as a Single Tender Action via the Trust's Single Tender Action procedure.

For all orders above £5,000 that are not supported by competitive quotations, the case for proceeding must be submitted to the applicable authorising officers shown below to decide whether to approve as a Single Tender Action.

Value of Contract Per Annum (excl VAT)	Authorising Officer
£5,000 to £24,999	Divisional Director and the Director of ~~Purchasing and Supply~~ Procurement
£25,000 to £100,000	As above, plus the Director of Finance
Above £100,000	As above, plus the Chief Executive/Trust Board

9.4.7 For any procurement that takes place outside of the Trust's procurement service ~~purchasing department~~ and/or the Trust's electronic requisitioning and ordering system EROS, the processes referred to in 9.2.3 ~~should~~ must be followed and the limits in 9.4.6 shall apply. The Trust's non EROS purchase to pay process must be followed.

9.5 ~~Other~~ Requisitioning

9.5.1 The Director of Finance is responsible for establishing procedures regarding the requisitioning of goods and services on behalf of the Trust. This will include a list of managers authorised to requisition goods and services, including levels of authorisation.

9.5.2 No requisition or order shall be placed for items for which there is no provision in an authorised budget.

9.5.3 Requisitioners should ensure that they comply with the Trust's procedures in the procurement of goods and services. They should always seek to obtain best value for money for the Trust and ensure that there are no conflicts of interest. In doing this the advice of the Trust's procurement service ~~department~~ should be sought.

9.5.4 Requisitioning is required to be placed using the Trust's electronic requisitioning and ordering system EROS. It is recognised that the procurement of some goods and services is not supported by EROS. These cases are clearly defined within the non-EROS purchase to pay process. Only the goods and services defined within this policy are able to be procured outside of EROS and the prescribed process must be followed.

9.5.5 Access to the Trust's electronic requisitioning and ordering system EROS shall only be granted to budget holders and officers delegated by them though the Trust's Authorised Signatory list.

9.5.6 Information regarding every order shall be notified to the finance department in an agreed format immediately after the order is issued via either the Trust's electronic requisitioning and ordering system EROS or the Trust's non EROS purchase to pay process.

9.5.7 ~~Official orders shall be consecutively numbered~~, Orders must have a unique purchase order number and be in a form approved by the Director of Finance, ~~and shall include such information concerning prices, discounts, and other conditions of trade as they may require~~. The order shall incorporate an obligation on the contractor to comply with the conditions printed thereon as regards delivery, carriage, documentation, variations, etc.

9.5.5 Orders requisitioned through the Trust's electronic requisitioning and ordering system EROS are required to be independently authorised by a second person. The receipt of the goods can therefore be carried out by one of these officers. All orders requisitioned outside of EROS must be certified by a separate person ~~via~~ in accordance with the Trust's non EROS purchase to pay process.

9.6 Other

9.6.1 All contracts, leases, tenancy agreements and other commitments, which may result in a long-term liability, must be notified to the Director of Finance for approval in advance of any commitment being made. The Director of Finance shall nominate a Trust officer who shall be responsible for overseeing and managing each commitment based contract on behalf of the Trust.

9.6.2 Where consultancy advice is being obtained or where supply of staff is being sought via an agency, the procurement of such skills must be in accordance with the latest guidance issued by the NHS Executive, the Department of Health and ~~Monitor~~ NHS Improvement.

10. Tendering Procedure

10.1 Objective

10.1.1 To ensure that major purchases are tendered in a manner which can be demonstrated to ensure fair competition and value for money and to comply with legislation. The Trust shall ensure that competitive tenders are invited for:

- the supply of goods, materials and manufactured articles;
- the provision of services including all forms of management consultancy services ~~(other than specialised services sought from or provided by the DH)~~;
- the design, construction and maintenance of building and engineering works (including construction and maintenance of grounds and gardens).

10.2 Requirement to Tender

10.2.1 The following instructions shall apply to any purchase over £25,000 as required by Section 9.4. The principles in this instruction apply equally to the ~~separate~~ tendering procedures operated by the Estates Department (for capital contracts), Pharmacy (for drugs contracts) and the Procurement Department. Formal tendering procedures may be waived by the Chief Executive, where the supply is proposed under special arrangements negotiated by the DH, in which event the said special arrangements must be complied with.

10.2.2 Formal tendering procedures may be waived by the Chief Executive in the following circumstances:

(a) in very exceptional circumstances where it is decided that formal tendering procedures would not be practicable and the circumstances are detailed in an appropriate Trust record
(b) where the requirement is covered by an existing contract
(c) where national NHS agreements are in place
(d) where a consortium arrangement is in place and a lead organisation has been appointed to carry out tendering activity on behalf of the consortium members;
(e) where specialist expertise is required and is available from only one source;
(f) when the task is essential to complete a project, and arises as a consequence of a recently completed assignment and engaging different consultants for the new task would be inappropriate;
(g) there is a clear benefit to be gained from maintaining continuity with an earlier project. However in such cases the benefits of such continuity must outweigh any potential financial advantage to be gained by competitive tendering;

The waiving of competitive tendering procedures should not be used to avoid competition or for administrative convenience.

Where it is decided that competitive tendering is not applicable and should be waived, the fact of the waiver and the reasons should be documented and recorded in an appropriate Trust record and reported to the Audit Committee ~~at each meeting~~.

10.2.3 Where the tendering procedures are waived under (a) above this must be reported and approved by the Trust Board before being actioned.

10.3 EU Directives, Legislation, Guidance and Public Contract Regulations

10.3.1 EU procurement directives and UK procurement legislation governing procedures for awarding contracts by an NHS body shall have effect as if incorporated in these Standing Financial Instructions.

10.3.2 Contracts above specified thresholds must be advertised and awarded in accordance with EU and other directives and Government legislation. The Procurement Department will advise on these requirements.

10.3.3 The Trust should never enter into a contract which involves a contractor assessing and carrying out work on behalf of the Trust.

10.4 Selection of Suitable Firms to Invite to Tender

10.4.1 The Procurement Department shall ensure that they source suitable suppliers to be invited to provide tenders or quotations for the supply of goods or services to the Trust. Suitability will include the technical and financial competence of the supplier.

10.4.2 The Estates Department will refer to the ~~Government~~ the relevant Register of Contractors in considering suppliers suitable to be invited to provide tenders or quotations for their requirements.

10.4.3 All suppliers deemed suitable to be invited to submit quotations or tenders should comply with the Equality Act 2010, the Health and Safety at Work Act, procurement sustainability, fair and equitable trade policy and all other legislation concerning employment and the health, safety and welfare of workers and other persons. Firms must provide to the appropriate manager a copy of its safety policy and evidence of the safety of plant and equipment, when requested.

10.4.4 The Director of Finance may make or institute any enquiries deemed appropriate concerning the financial standing and financial suitability of approved contractors. The Directors with lead responsibility for clinical governance will similarly make such enquiries as is felt appropriate to be satisfied as to their technical / medical competence.

10.5 Health Care Services

10.5.1 The tendering limits and processes in these standing financial instructions apply equally to the supply of healthcare services.

10.6 ~~Pre-Qualification~~ Standard Selection Questionnaire

10.6.1 ~~Statutory guidance states that the Trust may not include a pre-qualification stage in any procurement where the value of the goods and services is below the EU threshold, thus restricting the use of Prequalification Questionnaires (PQQs). However the Trust should ensure they ask 'suitability assessment questions' relating to a potential supplier making certain that the questions are relevant to the subject matter of the procurement and proportionate.~~

For procurements above the EU threshold, the standardised set of pre-qualification questions should be followed as per the Crown Commercial Service guidance.

10.6.2 ~~Where appropriate supplier self-declarations should be used with only the winning bidder submitting the various certificates and documents to prove their status. The statutory guidance provides a number of grounds for excluding a supplier based on evidence of unsuitability, some of which are mandatory. Those suppliers not excluded must then be assessed on the basis of the economic and financial standing, and on their technical capacity and ability.~~

10.7 Invitation to Tender

10.7.1 The Trust shall ensure that:

(a) invitations to tender are sent to a sufficient number of firms to provide fair and adequate competition, unless this can be evidenced otherwise. In all cases ~~that~~ a minimum of either:

(i) three firms shall be invited to tender or
(ii) the most the market permits

(b) ~~(~~the firms invited to tender are deemed suitable as described above, having regard to their capacity to supply the goods or materials or to undertake the services or works required.

(c) the firms invited to tender area subject to the ~~pre-qualification~~ supplier selection questionnaire (SSQ) described above

(d) invitations to tender shall clearly state the date and time as being the latest time for the receipt of tenders.

(e) invitations to tender shall state that no tender will be accepted unless it meets the submission requirements of the Trust's e-tendering process or for manual tendering unless:

(i) submitted in a plain sealed package or envelope bearing a pre-printed label supplied by the Trust (or the word "tender" followed by the subject to which it relates) by the latest date and time for the receipt of such tender and addressed to the Chief Executive or nominated manager

(ii) the tender envelopes/ packages are free from any names or marks indicating the sender. The use of courier/postal services must not identify the sender on the envelope or on any receipt so required by the deliverer.

10.7.2 Before inviting tenders the appropriate officers shall compile a formal estimate of the probable expense of meeting the specification. Such estimates must quote the value of the relative item in the capital and/or revenue budget for the year approved by the Trust Board.

10.7.3 Every tender for goods, services or disposals shall include such of the NHS Standard Contract Conditions as are applicable.

10.7.4 Every tender for building, engineering works, land and property transactions shall comply with the industry standards for such contracts.

10.7.5 In the case of IT procurements the requirements of relevant industry standards shall be followed.

10.8 Receipt and Safe Custody of Tenders and Records

10.8.1 Tenders received via the e-tendering system will be subject to the controls built into the system regarding the receipt and safe keeping of all tenders and records.

10.8.2 The date and time of receipt of each manual tender shall be endorsed on each unopened tender envelope/package.

10.8.3 The nominated employee shall be responsible for the receipt, endorsement and safe custody of manual tenders received until the time appointed for their opening, and of records maintained in accordance with Section 14.10.

10.9 Opening Tenders

10.9.1 Manual Tenders

(a) Within three working days after the date and time stated as being the latest time for the receipt of tenders, they shall be opened in the presence of persons specified in the separate procedures for Capital and Procurement. In the case of J C T tenders, for capital projects, they shall be opened by:

- Executive members of the Trust Board
- Head of Finance
- Deputy Director of Operations
- Head of Human Resources

(b) Every tender received shall be stamped with the date of opening and initialled by the persons in Section 13.18(a) above, who witnessed the opening.

Every envelope shall be referenced to the tenderer and shall be retained with the tender documents.

(c) All pages of the tender documents containing the tender prices or making specific reference to terms and conditions stipulated by the tenderer shall be stamped in the presence of the persons witnessing the opening, with a uniquely identifiable stamp, which shall be held securely in the charge of a nominated officer.

(d) A record shall be maintained by the Nominated employee for each set of competitive tender invitations despatched, which shall be initialled by the witnesses to the opening of tenders. The register shall contain the following information:-

(i) The names of all the firms invited;
(ii) In the case of building and engineering contracts, the estimate of the probable cost in accordance with Section 13.13
(iii) The names and the number of firms from which tenders have been received and the amount of each tender where applicable;
(iv) The date the tenders were opened;
(v) The persons present at the opening and their signatures;
(vi) Particulars of any anomalies in accordance with Section 13.19(a), 13.19(d) and 13.19(f).

(e) Every price alteration appearing on the tender shall be initialled by two of those present at the opening.

(f) Incomplete tenders, i.e. those from which information necessary for the adjudication of the tender is missing, and amended tenders i.e., those amended by the tenderer upon his own initiative either orally or in writing after the due time for receipt, but prior to the opening of other tenders, should be dealt with in the same way as late tenders.

10.9.2 E-Tenders

Within three working days after the date and time stated as being the latest time for the receipt of tenders, they shall be unlocked and opened in the e-tendering system by two officers within the Procurement Department.

10.10 Admissibility, Evaluation and Acceptance of Tenders

10.10.1 Admissibility

(a) If for any reason it appears that the tendering process has not been carried out on a strictly competitive basis; no contract shall be awarded without the approval of the Chief Executive.

(b) Tenders received after the opening may not be considered unless it is agreed by the Chief Executive that there is adequate reason for the late arrival and that it is in the interest of the Trust so to do and only then if the tenders that have been duly opened have not left the custody of the Chief Executive or his nominated officer or if the process of evaluation and adjudication has not started.

If none of the tenders that were received in time is economically or in other ways acceptable, re-tendering to a new date shall be invited.

While decisions as to the admissibility of late, incomplete or amended tenders are under consideration, the tender documents shall be kept strictly confidential, recorded, and held in safe custody by the Chief Executive or his nominated officer.

10.10.2 Evaluation

(a) Tender evaluation reports will be approved in accordance with the scheme of delegation.

(b) Necessary discussion and consultation with a tenderer to clarify the tender before the award of a contract need not disqualify. However, if such discussions result in clarifications of the specification, which result in a tender price being reduced below what were previously lower prices of other tenderers, a contract shall not be awarded unless all the other tenderers have been given the benefit of any clarification to the specification that has resulted from the discussions, and an opportunity to re-tender if they wish. This is with the exception of a negotiated and competitive dialogue or innovation partnership procedure.

10.10.3 Acceptance

(a) The most economically advantageous tender, shall be accepted unless, for good and sufficient reasons which must be formally recorded, the Chief Executive decides otherwise. This is with the exception of a negotiated and competitive dialogue or innovation partnership procedure.

(b) No tender shall be accepted until the professional officer concerned has formally agreed that it is technically satisfactory.

(c) No tender for building works which is in excess of the budget sum under 10.7.2 by more than 10% or £5,000, whichever is the greater, should be accepted without the approval of the Chief Executive.

(d) All tenders shall be treated as confidential and should be retained for inspection.

10.11 Form of Contract

10.11.1 (a) Every contract including those for building and engineering works shall embody or be in the same terms and conditions of contract as those on the basis of which tenders were invited.

(b) Every contract for building and engineering works, which exceeds the sum of £150,000, shall be executed under the common seal of the Trust (except those executed under the JCT form of contract for minor works). The use of the common seal of the Trust shall be in accordance with Section 16p of the Scheme of Delegation.

10.12 Payments to Contractors by Instalments

10.12.1 (a) Where contractors provide for payment to be made by instalments, the Director of Finance shall keep a contract register to show the state of account on each contract, between the Trust and the contractor, together with any other payments and the related professional fees.

(b) Payment to contractors on account shall be made only on a certificate issued by the appropriate Works Officer, Private Architect or other consultant nominated as Contract Administrator.

~~10.13 Variations~~

~~10.13.1 (a) Subject to the provision of the contract in each case, no extra or variation shall be authorised except in writing by the appropriate employees as in Section 14.13.1(b) above. Such variation or instruction orders must be issued prior to the commencement of the work in question, excepting in the case of emergency when it must be issued on the next working day. All such orders must be priced within one month from the date of issue.~~

~~(b) A report to the Chief Executive must be made when 66% of the contingency sum has been expended and a further report if the contingency sum is 90% expended.~~

~~(c) Any extensions to contracts should be made in writing in accordance with the Trust's scheme of delegation.~~

~~(d) Any variation should not fundamentally change the scope of the procurement or increase the value to over fifty percent of the original contract.~~

10.13 Variations to Contracts

10.13.1 Any contract variation must be considered and authorised in line with the scheme of delegation (appendix 2). Such variations or additional instructions must be issued prior to the commencement of the work in question, except in the case of an emergency when it must be issued on the next working day.

10.13.2 Contract variations shall only apply to works or services, not goods. All contract variations must properly describe the additional work or services to be provided for the agreed additional cost.

10.13.3 Any contract variation must not fundamentally change the scope of the procurement.

10.13.4 Contract variations are not subject to single tender actions.

10.14 Final Certificates and Accounts

10.14.1 (a) The final payment certificate of any contract shall not be issued until the appropriate Contract Administrator, as in Section 10.12.1(b), has certified the accuracy and completeness of the value of the final account submitted by the contractor.

Any final account that is agreed at a figure in excess of the approved sum in the contract shall be reported to:-

(i) The Chief Executive if in excess of 5%;
(ii) The Trust Board if in excess of 10%.

(b) The Director of Finance may examine final accounts for contracts and may make all such enquiries and receive such information and explanations as may be required in order to be satisfied of the accuracy of the accounts.

10.15 Competitive Tendering of Support Services

10.15.1 The costs of support services may be tested by competitive tendering in accordance with appropriate legislation.

10.15.2 For each tendering exercise the following groups shall be set up:-

(a) Service specification group, comprising a nominee of the Chief Executive and a specialist technical officer who will obtain such support from Management Services as is required.

(b) In-house tender group, comprising a nominee of the Chief Executive with technical support as necessary.

(c) Evaluation team, comprising specialist support from the procurement ~~Purchasing~~ department and a Director of Finance's representative.

10.15.3 All groups should work independently of each other. Individual officers may be members of more than one group, although no member of the in-house tender group may participate in evaluation of tenders.

10.15.4 The evaluation team shall make recommendations on the award of contracts to the Trust Board.

10.15.5 The price at which a tender is accepted becomes the new budget for the service and shall not be varied except for:-

(a) Subsequent changes in specification authorised by the Chief Executive (being a different person to the in-house contract manager) at prices to be negotiated by the Divisional Director.

(b) Price variations allowed for in the contract.

10.15.6 Monitoring of performance against the contract shall be the responsibility of the in-line senior manager utilising such advice as is appropriate.

10.15.7 The provisions of this section relating to tendering and contracting shall also be observed in competitive tendering.

11. Payment for Goods and Services Received

11.1 Objective

11.1.1 To ensure that:

(a) Payments are only made for goods and services which have been ordered and received in accordance with these instructions, and are of the appropriate quality and quantity.

(b) Payments are only made once an invoice has been properly checked and authorised by a person with delegated responsibility.

(c) Contract invoices are paid in accordance with contract terms or otherwise in accordance with national guidance.

(d) Invoices and other valid claims are paid promptly.

11.2 General

11.2.1 The Director of Finance is responsible for the payment of all properly authorised invoices and claims.

11.2.2 The Director of Finance is responsible for establishing procedures regarding the prompt notification of all monies payable by the Trust arising from transactions initiated by Trust officers. All Trust employees are responsible for complying with these procedures.

11.2.3 ~~The Director of Finance shall ensure there are procedures covering the provision of professional advice regarding the supply of goods and services, including the tendering of goods and services.~~

11.3 ~~Requisitioning~~

~~11.3.1 The Director of Finance is responsible for establishing procedures regarding the requisitioning of goods and services on behalf of the Trust. This will include a list of managers authorised to requisition goods and services, including levels of authorisation. See also section 13.~~

~~11.3.2 Requisitioners should ensure that they comply with the Trust's procedures in the procurement of goods and services. They should always seek to obtain best value for money for the Trust and ensure that there are no conflicts of interest. In doing this the advice of the Trust's procurement service department should be sought.~~

~~11.3.2 Official Orders must:~~

~~(a) be consecutively numbered;~~
~~(b) be in a form approved by the Director of Finance;~~
~~(c) state the Trust's terms and conditions of trade;~~
~~(d) only be issued to, and used by, those duly authorised by the Chief Executive.~~

~~11.3.3 Requisitioning is required to be placed using the Trust's electronic requisitioning and ordering system EROS. It is recognised that the procurement of some goods and services is not supported by EROS. These cases are clearly defined within the non-EROS purchase to pay process. Only the goods and services defined within this policy are able to be procured outside of EROS and the prescribed process must be followed.~~

11.4 Verification and Payment

11.4.1 The Director of Finance is responsible for designing and maintaining a system for the verification, recording and payment of all amounts payable by the Trust.

This system shall provide by certification or by compliance with an authorised computer system that:-

(a) Goods and services have been ordered in accordance with Section 9.

(b) Goods have been duly received, are in accordance with specification and order and that prices are correct;

(c) Services have been satisfactorily executed in accordance with the order and that the charges are correct;

(d) In the case of contracts based on the measurement of time, materials or expenses, the time charged is in accordance with the time records, that the rates of labour are in accordance with the appropriate rates, that the materials have been checked as regards quantity, quality and price, and that the charges for the use of vehicles, plant and machinery and other expenses have been examined and are reasonable;

(e) The invoice is arithmetically correct;

(f) The account has not been previously passed for payment or paid;

(g) The account is in order for payment.

11.4.2 The Trust will maintain an Authorised Signatory List of budget holders and officers delegated by them who are authorised to certify invoices. All changes to this list must be notified to the finance department through the designated process.

11.4.3 The Director of Finance shall ensure that all invoices and accounts are paid promptly having regard to:

(a) The Trust's cash flow
(b) The possibility of receiving a discount for early payment.
(c) Current Department of Health guidance on prompt payment.

11.4.4 Where an employee authorising invoices for payment relies upon other employees to do preliminary checking they ~~shall, wherever possible~~, must ensure that those who check delivery or execution of work act independently of those who have placed orders and negotiated prices and terms.

11.4.5 In the case of contracts for building or engineering works which require payment to be made on account during the progress of the work, the Director of Finance shall make payment on receipt of a certificate from the appropriate technical consultant or officer. Without prejudice to the responsibility of any consultant or works officer appointed to a particular building or engineering contract, a contractor's account shall be subjected to financial and general examination by the person responsible to the Trust as Project Manager before the final certificate is issued.

11.5 Prepayments

11.5.1 Prepayments are only permitted where exceptional circumstances apply. In such instances:

(a) Prepayments are only permitted where the financial advantages outweigh the disadvantages;

(b) The appropriate employee must provide in writing, the case for a prepayment, setting out all relevant circumstances of the purchase. This must include the effect on the Trust if the

supplier is at some time during the course of the prepayment agreement unable to meet his commitments;

(c) The Director of Finance will need to be satisfied with the proposed arrangements before contractual arrangements proceed ~~(taking into account the EU public procurement rules where the contract is above a stipulated financial threshold~~);

(d) The budget holder is responsible for ensuring that all items due under a prepayment contract are received and they must immediately inform the appropriate Executive Director or Chief Executive if problems are encountered.

11.6 Duties of Managers and Officers

11.6.1 Managers and officers must ensure that they comply fully with the guidance and limits specified by the Director of Finance and that:

(a) all contracts (except as otherwise provided for in the Scheme of Delegation), leases, tenancy agreements and other commitments which may result in a liability are notified to the Director of Finance for approval in advance of any commitment being made;

(b) contracts above specified thresholds are advertised and awarded in accordance with EU rules on public procurement. See also section 10;

(c) where consultancy advice is being obtained or where supply of staff is being sought via an agency, the procurement of such skills must be in accordance with the latest guidance issued by the NHS Executive, the Department of Health and the independent regulator and in line with section 8.6;

(d) no order shall be issued for any item or items to any firm which has made an offer of gifts, reward or benefit to directors or employees, other than:

(i) isolated gifts of a trivial character or inexpensive branded seasonal gifts, such as calendars;
(ii) conventional hospitality, such as lunches in the course of working visits;

This provision needs to be read in conjunction with section 22.

(e) no requisition/order is placed for any item or items for which there is no budget provision unless authorised by the Director of Finance on behalf of the Chief Executive;

(f) all goods, services, or works are ordered on an official order except purchases from petty cash;

(g) verbal orders must only be issued very exceptionally, by an authorised employee ~~designated by the Chief Executive~~ and only in cases of emergency or urgent necessity. The~~se~~ process for emergency ordering must be followed including the issue of ~~confirmed by an official order and clearly marked "~~ a confirmation order~~"~~;

(h) orders are not split or otherwise placed in a manner devised so as to avoid the financial thresholds laid out in section 9;

(i) goods are not taken on trial or loan in circumstances that could commit the Trust to a future uncompetitive purchase;

(j) changes to the Trust's Authorised Signatory List of budget holders and officers delegated by them authorised to certify invoices are notified to the finance department through the designated process;

(k) purchases from petty cash are restricted in value and by type of purchase in accordance with instructions issued by the Director of Finance;

(l) petty cash records are maintained in a form as determined by the Director of Finance;

(m) orders should be placed using either the Trust's electronic requisitioning and ordering system EROS or, where specifically permitted, the Trust's non EROS purchase to pay process as described in the applicable Trust policy.

11.6.2 The Chief Executive and Director of Finance shall ensure that the arrangements for financial control and financial audit of building and engineering contracts and property transactions comply with best practice and guidance issued by the Department of Health and ~~Monitor~~ NHS Improvement. The technical audit of these contracts shall be the responsibility of the relevant Executive Director.

11.7 Imprests

11.7.1 The Director of Finance may authorise advances on the imprest system for petty cash and other purposes as required. Individual payments from such imprests must not exceed an amount authorised by the Director of Finance and must be properly reconciled to petty cash sheets, which are supported by vouchers showing details of the transaction.

11.8 Negotiation with Suppliers

11.8.1 Where there are ongoing disputes with suppliers that require compromise arrangements to resolve, these will be considered and approved as follows:

- £0 - £1,000 Deputy Director of Finance
- £1,001 - £25,000 Director of Finance
- Over £25,000 Finance Committee

12. Stores and Receipt of Goods

12.1 Objective

12.1.1 To ensure that all stockholdings of significant value are properly safeguarded and accounted for.

12.2 Control of Stores

12.2.1 Stores, defined in terms of controlled stores and departmental stores (for immediate use) should be:

(a) kept to a minimum;
(b) subjected to annual stock take;
(c) valued at the lower of cost and net realisable value.

12.2.2 Subject to the responsibility of the Director of Finance for the systems of control, the overall control of stores shall be the responsibility of the appropriate Divisional Manager/Head of ~~Trust~~ Corporate Services function. This responsibility may be further delegated to a service manager or staff member provided this is clearly documented.

12.2.3 The Director of Pharmacy is responsible for the control of pharmaceutical stocks.

12.2.4 The Director of Estates is responsible for the control of fuel stocks (oil and coal).

12.2.5 The Director of Finance shall establish procedures and systems regarding the control of stores including receipting, issues, returns and losses. All staff responsible for the control of stores must comply with these procedures.

12.2.6 The responsibility for security arrangements and the custody of keys for all stores locations shall be clearly defined in writing by the designated employees and agreed with the Director of Finance. Wherever practicable, stocks shall be marked as Trust property.

12.2.7 The Director of Finance shall be informed of any variations in policy that are likely to result in any significant variation in overall stock levels.

12.3 Stocktaking

12.3.1 Stocktaking arrangements shall be agreed with the Director of Finance and there shall be a physical check covering all items in store at least once a year. The physical check shall involve at least one officer other than the designated responsible officer. The stocktaking records shall be numerically controlled and signed by the officers undertaking the check.

12.3.2 Any surpluses or deficiencies revealed on stocktaking shall be reported to the responsible officer for investigation. Evidence of such investigation shall be recorded and all confirmed surpluses or deficiencies shall be reported immediately to the Director of Finance.

12.3.3 All responsible employees shall comply with the arrangements made by the Director of Finance to certify stock values at the 31st March each year.

12.4 Losses and Slow-Moving Items

12.4.1 The responsible employee shall maintain a system approved by the Director of Finance for reviewing slow moving and obsolete items at least annually and for the condemnation, disposal and replacement of all unserviceable items. They shall formally report to the Director of Finance any evidence of significant overstocking and of negligence or malpractice.

12.4.2 Breakages, deteriorations due to overstocking and other losses of goods in stores shall be recorded as they occur, and a summary should be presented to the Director of Finance at quarterly intervals. Tolerance limits shall be established for all stores subject to unavoidable loss, such as certain foodstuffs and natural deterioration of certain goods.

12.4.3 It is a duty of employees responsible for the custody and control of stores to notify all losses including those due to theft, fraud and arson, in accordance with Section 13 and 16 of these instructions.

13. Fixed Asset Register and Security of Assets, Disposal and Accounting of Assets

13.1 Objective

13.1.1 To ensure that assets are properly safeguarded and accounted for.

13.2 Asset Register

13.2.1 The Director of Finance is responsible for the maintenance of the Trust's register of assets and for arranging for a physical check of assets against the asset register to be conducted on a rolling three year programme.

13.2.2 The Director of Finance must ensure the Trust maintains an asset register recording all fixed assets in accordance with the requirements of the Independent Regulator.

13.2.3 Additions to the fixed asset register must be clearly identified to an appropriate officer and be validated by reference to

(a) properly authorised and approved agreements, architect's certificates, supplier's invoices and other documentary evidence in respect of purchases from third parties;
(b) stores, requisitions and wages records for own materials and labour including appropriate overheads and
(c) lease agreements in respect of assets held under a finance lease and capitalised.

The Trust shall maintain an asset register of every relevant asset used for the provision of Commissioner Requested Services in accordance with the guidance issued by the Independent Regulator.

13.2.4 If ~~Monitor~~ NHS Improvement has given notice about the ability of the Trust to carry on as a going concern the Trust shall not dispose of, or relinquish control over any relevant asset without consent in writing of ~~Monitor~~ NHS Improvement. This includes the disposal of part of the property or granting an interest in it.

13.2.5 Where capital assets are sold, scrapped, lost or otherwise disposed of, the responsible officer must notify the Director of Finance, who will ensure that their value is removed from the accounting records. Each disposal must be validated by reference to authorisation documents and invoices (where appropriate).

13.2.6 Assets that are leased by the Trust must not be disposed of.

13.2.7 The Director of Finance shall approve procedures for reconciling the fixed asset balances in the financial ledger with the balances on the fixed asset register.

13.2.8 The value of each asset shall maintained in accordance with the Trust's agreed accounting policies.

13.2.9 The value of each asset shall be depreciated over its expected asset life in accordance with the appropriate accounting standards and any guidance issued by ~~Monitor~~ NHS Improvement.

13.3 Security of Fixed Assets

13.3.1 The Chief Executive is responsible for the overall control of the Trust's fixed assets.

13.3.2 Asset control procedures (including fixed assets, donated assets, cash, cheques and negotiable instruments) must be approved by the Director of Finance. These procedures shall make provision for

(a) recording the managerial responsibility for each asset;
(b) the identification of additions and disposals;

(c) the identification of all repairs and maintenance expenses;
(d) the physical security of assets;
(e) the periodic verification of the existence of, condition of and title to, assets recorded;
(f) identification and reporting of all costs associated with the retention of an asset; and
(g) reporting, recording and safekeeping of cash, cheques and negotiable instruments.

13.3.3 All discrepancies revealed by the verification of physical assets to the fixed asset register shall be notified to the Director of Finance.

13.3.4 Each employee has a responsibility for the security of the Trust's property and should ensure that equipment and property is secured when not attended and should report suspicious incidents and losses to their appropriate manager. It is the responsibility of Directors and senior managers in all disciplines to apply such appropriate routine security practices in relation to NHS property as may be determined by the Trust Board. Any breach of agreed security practices must be reported to the Chief Executive.

13.3.5 Any damage to the Trust's premises, vehicles and equipment, or any loss of equipment, stores or supplies must be reported in accordance with the procedure for reporting losses in section 16.

13.3.6 Where practical, purchased or donated assets should be marked as Trust property.

13.3.7 Where assets are loaned or leased to the Trust, responsible officers should ensure these are notified to the Director of Finance in accordance with prescribed procedures. These assets must be clearly identified and must not be scrapped or otherwise disposed of. An inventory of such assets will be maintained but will not form part of the fixed asset register.

13.4 Restrictions on the disposal of assets

13.4.1 A register of every relevant asset for the provision of Commissioner Requested Services is required to be maintained in accordance with requirements issued by the Independent Regulator.

13.4.2 If ~~Monitor~~ ~~NHS Improvement~~ has given notice to the Trust that it is concerned about the ability of the Trust to carry on as a going concern then the following shall apply.

(a) The Trust shall not dispose of the whole or any part of, or relinquish control over, any relevant asset except with the consent in writing of ~~Monitor~~ NHS Improvement,
(b) The Trust shall inform ~~Monitor~~ NHS Improvement of any proposals to dispose of, or relinquish control over, any relevant asset
(c) Written consent from ~~Monitor~~ NHS Improvement shall not prevent the Trust from disposing of, or relinquishing control over, any relevant asset where:
    i. ~~Monitor~~ NHS Improvement has issued a general consent, or
    ii. The Trust is required by the Care Quality Commission to dispose of a relevant asset.

13.5 Disposal of Assets

13.5.1 The Director of Finance must prepare detailed procedures for the disposal of assets including condemnations and ensure that these are notified to Managers.

13.5.2 When a Department decides to dispose of a Trust asset, the Head of Department, or authorised deputy must comply with the Trust's procedures. In particular by:

(a) establishing whether it is needed elsewhere in the Trust; and if not
(b) determining and advising the Director of Finance of the estimated market value of the item, taking account of professional advice where appropriate.

13.5.3 In the event of a private sale (e.g. to a member of staff) the Head of Department should first follow the procedure in Section 13.5.2. If the private sale is more beneficial the Divisional Manager should be notified of the course of action. Advice should be sought from the Finance Department regarding the VAT liability of the proposed sale.

13.6 Condemnations

13.6.1 All unserviceable articles can only be condemned or otherwise disposed of by an officer authorised for that purpose by the Director of Finance and in accordance with Trust procedures. In particular the condemnation must be appropriately recorded in line with these procedures identifying whether the articles are to be converted, destroyed or otherwise disposed of. All records shall be confirmed by the countersignature of a second employee authorised for the purpose by the Director of Finance.

13.6.2 The officer condemning the item shall establish whether or not there is evidence of negligence in use and shall report such evidence to the Director of Finance who will take appropriate action.

14. Security of Cash, Cheques and Other Negotiable Instruments

14.1 Objective

14.1.1 (a) To ensure that cash, cheques, and similar documents of value are kept securely and properly controlled.

(b) To design and securely control all controlled stationery e.g. receipt books, agreement forms, income books.

14.2 Cash

14.2.1 Cash handling represents an area of high risk, therefore it should be kept to a minimum with banking facilities used whenever possible. All staff responsible for collecting or holding cash must comply with these standing financial instructions and all detailed procedures issued by the Director of Finance, in order to protect themselves and prevent their integrity from being called into question.

14.2.2 The Director of Finance is responsible for establishing systems and procedures relating to cash within the Trust.

14.2.3 The Senior Manager responsible for an area where cash is handled must ensure that all staff:

- are aware of their duty to comply with Standing Financial Instructions and the procedures issued by the Director of Finance.
- comply with the provisions of this section of the Standing Financial Instructions and cash handling procedures.

14.2.4 On every occasion when cash is transferred from the custody of one person to another it shall be the duty of the recipient to check it and of the other to obtain a written acknowledgement. Where this is not possible due to the cash being in sealed packets, the packets shall be counted and acknowledged unopened.

14.2.5 Cash handling procedures should always demonstrate segregation of duties. Where this is not possible, a Senior Manager must oversee the process including conducting regular checks to provide assurance.

14.3 Cash Expenditure

14.3.1 If a Manager considers it necessary for a member of staff to use cash to purchase goods or services on behalf of the Trust, where cheque payment or bank transfer is impractical, they must comply with the 'petty cash' ~~conditions and~~ procedures established by the Director of Finance.

14.3.2 The Trust's money shall not, under any circumstances, be used for the encashment of private cheques or be used for private purposes.

14.3.3 Staff responsible for administering petty cash imprests must ensure that payments are only made in line with the petty cash procedure established by the Director of Finance. Every payment must be recorded and authorised in accordance with these procedures with evidence supporting the transaction.

14.3.4 It is the responsibility of all staff authorised to hold cash to reconcile, at least once a week, the record of transactions with the amount actually in hand, in line with Trust procedures. It is the responsibility of their manager to review and make appropriate checks in line with Trust procedures. Any discrepancy or concerns must be reported to senior management and the Director of Finance without delay.

14.4 Cash Income

14.4.1 Income received shall be handled and accounted for in accordance with the requirements of Sections 6.3 and 7.

14.5 Security of Cash

14.5.1 Staff involved in the handling of cash and their managers are responsible for ensuring that cash is kept securely and in accordance with instructions issued by the Director of Finance. They must ensure that they have notified the finance department of the cash handling within their area.

14.5.2 Safes and/or lockable cash boxes shall be provided for the custody of cash in all places where it is necessary for cash to be held. Coin-operated machines shall wherever possible be fitted with separately lockable compartments for cash.

14.5.3 Cash boxes holding cash shall not be left unattended at any time and shall be kept in a safe when not in use.

14.5.4 The loss of cash, cash boxes, safes or keys should be notified to the finance department immediately.

14.6 Unofficial Funds

14.6.1 The Trust shall not be liable in any circumstances for the loss of unofficial funds (funds not arising from Trust business). The holder of the key of a safe provided for the custody of official cash shall not accept unofficial funds for safe keeping ~~except in identifiable sealed packages or locked containers. When such deposits are made, a written indemnity shall be obtained from the person or organisation concerned absolving the Trust from responsibility for any loss.~~

14.7 Controlled Stationery

14.7.1 The Director of Finance is responsible for approving the design of, and ordering, all controlled stationery such as receipt books, agreement forms, invoices or other means of recording monies received or receivable

14.7.2 All controlled stationery shall be issued and kept securely in accordance with procedures established by the Director of Finance. Any loss of controlled stationery must be reported to the Director of Finance immediately.

14.8 Cheques

14.8.1 All blank cheques or other orders for payment shall be ordered only on the authority of the Director of Finance, who shall make proper arrangements for their safe custody. They shall be subject to the same security precautions as are applied to cash. Any loss of cheques shall be reported to the Director of Finance immediately.

14.8.2 Cheques ~~will only~~ are not permitted to be drawn to "cash" ~~with the specific, written authority of the Director of Finance~~. ~~All cheques drawn to "cash" must have a second authorised signatu~~re.

14.9 Movement of Cash

14.9.1 The Director of Finance shall prescribe the system for the transporting of cash and shall be responsible for making all arrangements with any security company operating under a contract with the Trust. Cash in transit (including cash moved from one office or building to another on Trust premises) and the making up and paying out of cash payments shall be suitably safeguarded. When substantial amounts have to be moved, special security arrangements shall be made.

14.9.2 Any employee who has any indication that the safe custody of cash on the Trust's premises or in transit to or between premises may be at risk shall immediately notify the Director of Finance and the Security Officer confidentially of the circumstances.

14.10 Transfer of Responsibilities for Cash, Cheques and Controlled Stationery

14.10.1 When an employee, whose duties include the holding of cash, cheques or controlled stationery hands over responsibility prior to leave or termination of appointment, both the outgoing and the incoming officer shall sign a handing over certificate stating:-

(a) The composition of the cash;
(b) The consecutive numbers of the cheques or controlled stationery;
(c) Particulars of keys handed over;
(d) Particulars of anything else being held for safekeeping.

14.10.2 In the unavoidable absence of the outgoing employee, one or more other employee shall be appointed to carry out the hand-over to the incoming officer.

14.10.3 Where the responsibility for an imprest changes permanently, this fact shall be notified to the Director of Finance. Hand-over certificates evidencing the change in responsibility should be retained within the area for future reference.

14.10.4 During any absence of the substantive holder of the key to a safe or cash box, the officer or officers appointed to act temporarily shall be fully accountable for the performance of such duties and shall be subject to these Standing Financial Instructions as though they were the substantive key holder.

15. Patients' Property

15.1 Objective

15.1.1 To ensure that property of patients is properly safeguarded and fully accounted for.

15.2 Responsibilities

15.2.1 The Trust has a responsibility to provide safe custody for money or other personal property (hereafter referred to as 'property') handed in by patients, in the possession of unconscious or confused patients, or found in the possession of patients dying in hospital, or dead on arrival.

15.2.2 Staff shall be informed on appointment in writing by the appropriate departmental head or senior officers of their responsibilities and duties for the administration of the property of patients.

15.2.3 The Chief Executive shall be responsible for ensuring that patients or their guardians, as appropriate, are informed before or at admission that the Trust will not accept responsibility or liability for patients' monies and personal property brought into the Trust's premises, unless it is handed in for safe custody and a copy of the patients' property record is obtained as the official receipt.

15.2.4 Where possible patients should be advised to make their own arrangements for the safe custody of their property - outside of the hospital.

These matters shall be drawn to patients' attention by means of:-

(a) Notices and information booklets;
(b) Hospital admission documents and property records; and
(c) The verbal advice of administrative and nursing staff responsible for admissions.

15.2.5 The Director of Finance must provide detailed written instructions on the collection, custody, recording, safekeeping, and disposal of patient property (including instructions on the disposal of the property of deceased patients and patients transferred to other premises) for all staff whose duty it is to administer in any way the property of patients.

15.2.6 Every employee of the Trust into whose personal custody any money or other property of a patient is received must comply with the requirements of these instructions. Valuable items shall be dealt with in the same way as cash and therefore instructions in sections 6 and 7 will apply.

15.2.7 Where Department of Health instructions require the opening of separate accounts for patients' monies, these shall be opened and operated under arrangements specified by the Director of Finance. Monies deposited in excess of the patients' needs shall be invested in accordance with guidance from the Secretary of State and in accordance with arrangements specified by the Director of Finance.

15.2.8 Except as provided below in section 15.3, refunds of property handed in for safe custody shall be returned to the patient, as required, by the employee who has been responsible for its security. The return shall be receipted by the patient or guardian as appropriate, and witnessed.

15.3 Deceased Patients

15.3.1 The disposal of property of deceased patients shall be effected by the Director of Finance and in accordance with Department of Health and Treasury guidance. Disposal to relatives shall be dependent on clarification of the lawful kin or other such person entitled to the possessions in question.

15.3.2 In all cases where property, including cash and valuables of a deceased patient is of a total value of more than £5,000 (or such other amount as may be prescribed by any amendment to the Administration of Estates, Small Payments Act 1965), the production of a Grant of Probate or Letters

of Administration shall be required before any of the property is released. Where the total value of the property is £5,000 or less, forms of indemnity shall be obtained.

15.3.2 In respect of a deceased patient's property, if there is no will and no lawful kin, the property vests with the Crown, and particulars shall, therefore, be notified to the Treasury Solicitor, or to the Duchies of Lancaster and Cornwall, as appropriate.

15.3.3 Any funeral expenses necessarily borne by the Trust are a first charge on a deceased person's estate. Where arrangements for burial or cremation are not made privately, any cash of the estate held by the Trust shall be appropriated towards funeral expenses. No other expenses or debts shall be discharged out of the estate of a deceased patient.

16. Losses and Special Payments

16.1 Objective

16.1.1 To ensure that losses and special payments are properly controlled and fully accounted for.

16.2 General

16.2.1 The Director of Finance is responsible for establishing procedures for the recording of and accounting for losses and special payments.

16.2.3 The Director of Finance shall maintain a losses and special payments register in which all losses shall be recorded without delay. Appropriate officers must undertake a review of systems and processes to reduce the risk of similar losses arising in the future and seek advice where they believe a particular case raises a point of principle

16.2.3 For any loss the Director of Finance shall consider whether any claim can be made against insurers and ensure this is pursued if appropriate

16.3 Losses

16.3.1 Any employee discovering or suspecting a loss of any kind must immediately inform their Head of Department, who must ensure that their Divisional Manager (or Head of Service in the case of Trust Services) is informed.

The Divisional Manager or Head of Service must appropriately inform the Chief Executive, Director of Finance or Chief Internal Auditor. Employees may also report suspicions directly to the Chief Internal Auditor. Where a criminal offence (i.e. theft or arson) or loss due to fraud or corruption is suspected, the Chief Executive, Director of Finance or Chief Internal Auditor must be informed immediately.

16.3.2 The Director of Finance is responsible for ensuring the Trust has a 'Counter Fraud Plan' setting out the action to be taken both by persons detecting a suspected fraud and those persons responsible for investigating it. Where loss due to fraud or corruption is suspected the Trust's countering fraud and bribery policy should be referred to.

16.3.3 Losses arising from accidental breakages, deteriorations due to overstocking and other losses of goods in stores should be recorded and notified as described in section 12.

16.3.4 All losses are required to be reported to the Audit Committee on a quarterly basis.

16.4 Write-Offs

16.4.1 The Trust Board shall approve a scheme of delegation for the approval and authorisation of write-offs within the limits of delegation granted to the Trust by ~~Monitor~~ NHS Improvement. Write offs includes the abandonments of claims and the charging of fruitless payments.

16.4.2 The Director of Finance shall report to the Audit Committee a summary of write offs each quarter with details of all cases for which the Trust Board's specific approval is required.

16.5 Special Payments

16.5.1 Special Payments ~~and are defined by the Foundation Trusts ARM and~~ include:

- Ex-gratia payments
- Compensation payments made under legal obligation
- Extra statutory or extra regulatory payments

- Extra contractual payments to contractors

16.5.2 Ex gratia payments compensate patients, visitors and staff for the loss of personal effects or for incurring unnecessary expense in exceptional circumstances. The authority to make ex-gratia payments and the process for doing so is included in the procedures referred to in section 16.2.1. Key points can be summarised as:

- Ex-gratia payments for loss or damage to employees' or patients' personal effects should only be paid if there has been negligence on the part of the Trust or of any of its employees. Divisional Managers/Heads of Service must confirm that the loss occurred on Trust property and that there was negligence on the Trust's part which contributed to the loss. Reference should be made to Section 15, patient property.

- Accidental damage to an employee's clothes, etc., where no other person is involved does not qualify for compensation unless caused by defects in equipment or conditions which are the responsibility of the Trust and which could not reasonably have been foreseen or avoided by the employee. Accidental damage to staff's personal effects caused by a patient should be dealt with on the merits of the case.

- Reimbursement of unnecessary costs incurred, such as those associated with attending for treatment which is subsequently cancelled, will only be considered in exceptional circumstances and only reasonable expenses as defined in the policy will be considered.

- Ex-gratia payments are only made once properly authorised and reimbursement is limited to actual costs incurred. Receipts are required to support all claims, although reimbursement for amounts below £50 can be made without a receipt at the discretion of the Director of Finance.

- Recommendations for ex-gratia payments should be made to the Director of Finance in accordance with Trust procedures. Only the Director of Finance or delegated deputy can authorise such payments.

- Ex-gratia payments are authorised in accordance with the following delegated limits:

  – Up to £1,000 Director of Finance
  – £1,001 - £50,000 Chief Executive
  – Over £50,000 Trust Board

16.5.3 Personal Injury cases will be dealt with in the following manner:

Over £10,000 – decided in conjunction with the NHS Litigation Authority.
Up to £10,000 – may be settled without legal advice with the approval of the Chief Executive or Director of Finance or the Director of ~~Workforce and Organisational Development~~ People

16.5.4 Public Liability cases will be dealt with in the following manner:

Over £3,000 – decided in conjunction with the NHS Litigation Authority.
Up to £3,000 – may be settled without legal advice with the approval of the Appropriate Divisional/Corporate Services Manager and the Chief Executive or Director of Finance.

16.5.4 All Clinical Negligence Cases are handled and decided by the NHS Litigation Authority (NHSLA) on behalf of the Trust. Whilst the NHSLA are administratively and financially responsible for all clinical negligence cases the legal liability remains with the Trust.

16.5.5 Severance payments or voluntary severance schemes require a supporting business case for submission to the Trust's relationship manager at ~~Monitor~~ NHS Improvement. ~~Monitor~~ NHS Improvement will then forward to HM Treasury for approval.

16.5.6 Special severance payments to staff outside contractual or statutory entitlements (including settlement of employment tribunal claims) in order to terminate employment need to be approved by HM Treasury before settlement is offered. There are no delegated limits for special severance payments, and all cases need to go to HM Treasury.

16.5.7 All applications for severance payments must be approved by the Director of ~~Workforce and Organisational Development~~ People and submitted by the Director of Finance according to Trust procedures and in the appropriate form required by HM Treasury.

16.5.8 The Trust is required to obtain approval for time limited voluntary severance schemes, which obviates the need to make a submission for each individual non contractual or non-statutory payment made under the scheme.

16.5.9 All proposals for payment for maladministration and distress shall be dealt with in accordance with the Trust's policy. Divisional Managers shall sign off all payment requests for approval.

16.5.10 Delegated limits for approving maladministration and distress payments are as follows:

Up to £1,000	Director/DeputyDirector of Finance,
£1,001 - £50,000	Chief Executive,
Over £50,000	Trust Board.

16.5.11 All extra contractual payments to contractors must be approved by the Director of Finance. All payments relating to construction contracts must first be approved by the Director of Estates.

16.5.12 All special payments are required to be reported to the Audit Committee on a quarterly basis.

16.6 Insurance

16.6.1 There is a scheme available, administered by the NHS Litigation Authority, through which the Trust insures. A small number of specified risks are not insurable through the NHS scheme and these may be insured commercially. See section 19. The Director of Finance shall establish procedures ~~so~~ for reporting ~~that~~ claims ~~are~~ made for all insured losses. ~~that are reported~~.

16.7 Bankruptcy and Liquidation

16.7.1 The Director of Finance shall be authorised to take any necessary steps to safeguard the Trust's interests in bankruptcies and company liquidations.

17. External Borrowing and Public Dividend Capital

17.1 Objective:

17.1.1 To ensure that borrowings are properly authorised and controlled and that interest and principal is repaid in accordance with agreed timescales

17.2 External Borrowings:

17.2.1 The Trust can obtain a working capital facility from the commercial banking sector. Short term borrowing should be kept to the minimum period of time possible, consistent with the overall cash flow position, represent good value for money, comply with the Trust's Treasury Management Policy and all guidance issued by ~~Monitor~~ NHS Improvement.

17.2.2 The Director of Finance shall be responsible for advising the Trust Board regarding the Trust's ability to repay public dividend capital (PDC) and long-term loan principal together with the payment of dividends on PDC and interest on such borrowings. The Director of Finance shall also be responsible for reporting periodically to the Trust Board concerning the PDC debt and all loans or short term borrowings.

17.2.3 Any application for a loan or short term borrowing will only be made by the Director of Finance or an officer designated for this purpose following approval by the Finance Committee, and in accordance with the Scheme of Delegation as appropriate.

17.2.4 The Director of Finance shall maintain a schedule of employees (including specimens of their signatories) approved by the Finance Committee who are authorised to make short term borrowings on behalf of the Finance Committee. This must include the Chief Executive and Director of Finance.

17.2.5 Any short-term borrowing must be with the authority of two employees identified in 6.2.5 one of which must be the Chief Executive or the Director of Finance. The Board must be made aware of all short term borrowing at their next meeting.

17.2.6 The Director of Finance will advise the Trust Board on the need for longer term borrowing. Following resolution of the Board, the Director of Finance will make appropriate arrangements with the ~~Foundation~~ Independent Trust Financing Facility or other lender depending on the commercial arrangements available. All long term borrowing in respect of Strategic Capital Schemes must be consistent with the plans outlined in the current Medium Term Capital Programme approved by the Finance Committee.

17.2.7 The Director of Finance must ensure that any loan application is made in accordance with the instructions issued by the lender and ~~Monitor~~ NHS Improvement. Records must be maintained and all interest and loan principal must be repaid in accordance with the lender's loan agreements.

17.2.8 Assets defined as Commissioner Requested Services (CRS) relevant assets shall not be used or allocated for borrowing; non-CRS relevant assets will be eligible as security for loans.

18. Capital Investment and Private Financing

18.1 Objective

18.1.1 To ensure that capital investments are properly planned, approved and controlled.

18.2 Capital Investment

18.2.1 The Trust Board shall approve the funding contained within the Trust's Medium Term Capital Programme as part of the annual budget approval process and any subsequent updates.

18.2.2 The Director of Finance shall ensure that the Trust produces a Capital Investment Policy and this is reviewed annually and approved by the Trust Board.

18.2.3 The Chief Executive

(a) shall ensure that there is an adequate appraisal and approval process in place in line with the Trust's Capital Investment Policy, for determining capital expenditure priorities and the effect of each proposal upon business plans;

(b) is responsible for the ensuring the effective management of all stages of capital schemes and for ensuring that schemes are delivered on time and to cost; and

(c) shall ensure that the capital investment is not undertaken without the availability of resources to finance all revenue consequences, including, the servicing of loan interest, ~~and~~ loan principal repayment and capital charges ~~and potential impairment losses~~.

18.2.4 For every capital expenditure proposal the Chief Executive shall ensure;

(a) that a business case is produced in line with guidance issued by the DoH or Independent Regulator and the Trust's Capital Investment Policy which sets out:

i) an option appraisal of potential benefits compared with known costs to determine the option with the highest ratio of benefits to cost

ii) the involvement of appropriate Trust personnel and external agencies

iii) appropriate project management and governance arrangements.

(b) that the Director of Finance has validated the capital costs and revenue consequences detailed in the business case.

(c) approval of each business case prior to tender

The Chief Executive will issue a scheme of delegation for capital investment management in accordance with appropriate guidance and the Trust's Standing Orders.

18.2.5 For capital schemes requiring stage payments, the Director of Finance shall issue procedures on their management.

18.2.6 The Director of Finance shall ensure that all capital schemes are accounted for in accordance with HM Revenue and Custom guidance.

18.2.7 The Director of Finance is responsible for the regular reporting of donations, expenditure and commitments against the Trust's approved Medium Term Capital Programme via the Trust's Capital Programme Steering Group.

18.2.8 The approval of a Medium Term Capital Programme shall not constitute approval for expenditure on any scheme.

The Chief Executive shall ensure that there are procedures in place identifying managers responsible for each scheme, specifying:

(a) levels of authority to commit expenditure;

(b) authority to proceed to tender.

The Chief Executive will issue a scheme of delegation for capital investment management in accordance with the Trust's Standing Orders.

18.2.9 Schemes must be tendered and managed in accordance with the requirements of Section 10.

18.2.10 Donations (cash and goods) received from charitable parties for the purposes of capital investment will require submission to and the approval of the Capital Programme Steering Group prior to acceptance. Any associated legal agreement containing obligations on the part of the Trust requires signature by the Director of Finance or Director of Strategy and Transformation ~~Strategic Development~~.

18.2.11 The Director of Finance shall issue procedures governing the financial management, including variations to contract, of capital investment projects and valuation for accounting purposes.

18.3 Commercial/Private Finance

18.3.1 The Trust should give consideration to private finance when considering material capital procurement. When the Trust proposes to use private finance the following procedures shall apply:

(a) The Director of Finance shall demonstrate that the use of commercial/private finance represents a balance of value for money compared with using the Trust's own finance and where appropriate, genuinely transfers risk to the private sector.

(b) The proposal must be specifically agreed by the Trust Board.

18.3.2 The Director of Strategy and Transformation ~~Strategic Development~~ is responsible for ensuring that:

(a) a programme of service delivery inspections is in place to ensure contract terms are monitored;

(b) payments to the commercial partners are authorised in accordance with the contracted availability and performance factors;

(c) clearly established dispute resolution procedures are in operation;

(d) effective procedures for agreement of changes to service delivery; and

(e) the service is market tested in line with the contract.

18.4 Leases

18.4.1 All proposals for finance or operating leases must be submitted to the Director of Finance for advice and approval. Leasing proposals must demonstrate value for money. The Director of Finance must sign all leases.

19. Risk Management and Insurance

19.1 Objective

19.1.1 To define the Trust's requirements for risk management and insurance.

19.2 Risk Management

19.2.1 The Chief Executive shall ensure that the Trust has robust risk management arrangements, in accordance with any requirements of ~~Monitor~~ NHS Improvement which must be approved and monitored by the Board.

19.2.2 The programme of risk management arrangements shall include:

(a) a process for identifying and quantifying risks and potential liabilities;

(b) engendering among all levels of staff a positive attitude towards the management of risk;

(c) governance processes to ensure all significant risks and potential liabilities are identified, managed including identifying responsibility, effective systems of internal control, action/mitigation, cost effective insurance cover, and decisions on the acceptable level of mitigated risk;

(d) contingency plans to offset the impact of adverse events;

(e) audit arrangements including; internal audit, clinical audit, health and safety review;

(a) a clear indication of which risks shall be insured;

(g) regular review of the Trust's risk management arrangements.

19.2.3 The existence, integration and evaluation of the above elements will assist in providing a basis to make a statement on the effectiveness of Internal Control within the Annual Report and Accounts as required by ~~Monitor~~ NHS Improvement.

19.3 Insurance

19.3.1 The Chief Executive, in conjunction with the Director of Finance, is responsible for ensuring that adequate insurance cover is held in line with the Trust's risk management policy approved by the Board. This will include insuring through the risk pooling schemes administered by the NHS Litigation Authority, self-insuring for some or all of the risks covered by the risk pooling schemes and purchasing insurance from commercial insurers. If the Board decides not to use the risk pooling schemes for any of the risk areas (clinical, property and employers/third party liability) covered by the scheme this decision shall be reviewed annually.

19.3.2 Trust Officers are required to notify the Director of Finance of all new risks or property which may require to be insured and of any changes that may affect risk or existing insurance.

19.3.3 All insurance policies must be approved by the Director of Finance

19.3.4 The Trust may purchase commercial insurance policies for risks not provided for under the Property Expenses Scheme (PES) and Liabilities to Third Parties Scheme (LTPS). This includes:

- Additional cover over and above the Trust's delegated limit under PES i.e. property (to the full reinstatement value of the property), contract works, fidelity, and business interruptions.

- Providing cover for specific activities outside the LTPS i.e. non-clinical professional indemnity, charitable trustees' liability, and Directors and Officers liability.

- All such insurance policies must be approved by the Director of Finance.

19.3.5 Arrangements to be followed in agreeing insurance cover

a) Where the Board decides to use the risk pooling schemes administered by the NHS Litigation Authority the Director of Finance shall ensure that the arrangements entered into are appropriate and complementary to the risk management programme. The Director of Finance shall ensure that documented procedures cover these arrangements.

b) Where the Board decides not to use the risk pooling schemes administered by the NHS Litigation Authority for one or other of the risks covered by the schemes, the Director of Finance shall ensure that the Board is informed of the nature and extent of the risks that are self-insured as a result of this decision. The Director of Finance will draw up formal documented procedures for the management of any claims arising from third parties and payments in respect of losses which will not be reimbursed.

c) All the risk pooling schemes require scheme members to make some contribution to the settlement of claims (the 'deductible'). The Director of Finance should ensure documented procedures also cover the management of claims and payments below the deductible in each case.

20. Audit and Counter Fraud

20.1 Objective

20.1 To ensure a systematic and effective review of the Trust's financial and management controls to give assurance that resources are used efficiently and safeguarded against misuse or fraud.

20.2 Audit Committee

20.2.1 In accordance with Standing Orders, the NHS Act 2006 and the NHS Foundation Trust Code of Governance as developed by ~~Monitor~~ the Regulator, the Board shall formally establish an Audit Committee, with clearly defined terms of reference and membership consistent with relevant guidance issued by Regulators or the Department of Health, including the NHS Audit Committee Handbook.

20.2.2 The role of the Audit Committee is to provide assurance to the Board on the suitability and efficacy of the Trust's governance, risk management and internal control by obtaining an independent and objective view of the Trust's financial systems, financial information, management controls and compliance with relevant laws and guidance. This will be achieved by:

(a) Monitoring and reviewing the effectiveness of the Trust's Internal and External Audit function, including involvement in the selection process when there is a proposal to review the provision of their services;

(b) Monitoring the integrity of the Trust's financial statements, reviewing significant financial reporting judgements contained in them;

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

(d) Monitoring compliance with Standing Orders and Standing Financial Instructions;

(e) Reviewing schedules of losses and compensations and making recommendations to the Board;

(f) Reviewing the arrangements in place to support the Assurance Framework process prepared on behalf of the Board and advising the Board accordingly;

(g) Reporting to the Council of Governors.

20.2.3 Where the Audit Committee considers there is evidence of ultra-vires transactions, evidence of improper acts, or if there are other important matters that the Committee wishes to raise, the Chair of the Audit Committee should raise the matter at a full meeting of the Board. Exceptionally, the matter may need to be referred to ~~Monitor~~ the Regulator via the Director of Finance in the first instance.

20.3 Responsibilities of the Director of Finance

20.3.1 The Director of Finance is responsible for:

(a) ensuring there are arrangements to review, evaluate and report on the effectiveness of internal financial control including the establishment of an effective Internal Audit function.

(b) ensuring that the Internal Audit is effective and meets the NHS mandatory audit standards and any directions given by the Independent Regulator.

(c) deciding at what stage to involve the police in cases of misappropriation and other irregularities not involving fraud or corruption.

(d) ensuring that an annual internal audit report is prepared for the consideration of the Audit Committee and the Board. The report must cover*:*

(i) a clear opinion on the effectiveness of internal control in accordance with current assurance framework guidance issued by the Department of Health including for example compliance with control criteria and standards;
(ii) major internal financial control weaknesses discovered;
(iii) progress on the implementation of internal audit recommendations;
(iv) progress against plan over the previous year;
(v) strategic audit plan covering the coming three years;
(vi) a detailed plan for the coming year.

20.3.2 The Director of Finance or designated auditors are entitled without necessarily giving prior notice to require and receive:

(a) access to all records, documents and correspondence relating to any financial or other relevant transactions, including documents of a confidential nature;

(b) access at all reasonable times to any land, premises or members of the Board or employees of the Trust;

(c) the production of any cash, stores or other property of the Trust under a member of the Board or an employee's control; and

(d) explanations concerning any matter under investigation.

20.4 Internal Audit

20.4.1 Internal Audit primarily provides an independent and objective opinion to the Chief Executive, the Board and the Audit Committee on the degree to which risk management, control and governance support the achievement of the Trust's objectives. Internal Audit will review, appraise and report upon:

(a) the extent of compliance with, and the financial effect of, relevant established policies, plans and procedures;

(b) the adequacy and application of financial and other related management controls;

(c) the suitability and reliability of financial and other related management data;

(d) the extent to which the Trust's assets and interests are accounted for and safeguarded from loss of any kind, arising from:
    (i) fraud and other offences;
    (ii) waste, extravagance, inefficient administration;
    (iii) poor value for money or other causes.

(e) Internal Audit shall also independently verify the Assurance Statements in accordance with guidance from the Department of Health and/or ~~Monitor~~ NHS Improvement.

20.4.2 Whenever any matter arises which involves, or is thought to involve, irregularities concerning cash, stores, or other property of the Trust or any suspected irregularity in the exercise of any function of a pecuniary nature, the Director of Finance must be notified immediately.

20.4.3 The Chief Internal Auditor will normally attend the Audit Committee meetings and has a right of access to all Audit Committee members, the Chairman and Chief Executive of the Trust.

20.4.4 The Chief Internal Auditor shall be accountable to the ~~Director of Finance~~ Chief Executive. The reporting system for internal audit shall be agreed between the Director of Finance, the Audit Committee and the Chief Internal Auditor. The agreement shall be in writing and shall comply with the guidance on reporting contained in the NHS Internal Audit Standards. The reporting system shall be reviewed at least every three years.

20.4.5 The Chief Internal Auditor is responsible for developing and maintaining an Internal Audit Strategy to provide an objective evaluation of, and opinion on, the effectiveness of the organisation's risk management, control and governance arrangements. The Chief Internal Auditor's opinion is a key element of the framework of assurance the Chief Executive needs to inform the completion of the Annual Statement on Internal Control. The delivery of this strategy will be realised through the delivery of considered and approved annual plans which will systematically review and evaluate risk management, control and governance of all the Trust's operations, resources, services and responsibilities for other bodies.

20.4.6 The Chief Internal Auditor will co-ordinate Internal Audit Plans and activities with line managers, external audit and other review agencies to ensure effective audit coverage is achieved and duplication of effort is minimised.

20.4.7 Internal Audit have the right to access all records, assets, personnel and premises of the Trust in the pursuit of information necessary to fulfil its responsibilities. In any instances of conflict this will be referred for resolution to the Director of Finance, Chief Executive or Chair of Audit Committee as appropriate.

20.4.8 If the Chief Internal Auditor, Chief Executive, Director of Finance or the Audit Committee consider that the level of Internal Audit resources or the terms of reference in any way limit the scope of Internal Audit, or prejudice the ability of Internal Audit to deliver a service consistent with the definition of internal auditing, they should advise the Board accordingly.

20.4.9 Internal Audit provides an independent and objective consultancy service specifically to help line management improve the organisation's risk management, control and governance. The service applies the professional skills of Internal Audit through a systematic and disciplined evaluation of the policies, procedures and operations that management put in place to ensure the achievement of the organisation's objectives, and through recommendations for improvement. Such consultancy work

contributes to the opinion, which Internal Audit provides on risk management, control and governance.

20.4.10 Internal Audit must be sufficiently independent of the activities which it audits to enable auditors to perform their duties in a manner, which facilitates impartial and effective professional judgements and recommendations. Internal Audit will have no Executive responsibilities.

20.4.11 Internal Auditors must have an impartial, unbiased attitude, characterised by integrity and an objective approach to work, and should avoid conflicts of interest. Internal Auditors must declare any conflicts of interest to the Chief Internal Auditor. Any conflicts of interest encountered by the Chief Internal Auditor must be declared to the Director of Finance.

20.4.12 The Director of Finance is responsible for ensuring the Chief Internal Auditor is of sufficient status to facilitate the effective discussion and negotiations of the results of Internal Audit work with senior management.

20.4.13 Appointment at all levels within the Internal Audit team must endeavour to fulfil the four main principles of the code of ethics for Internal Audit, integrity, objectivity, competency (i.e. professional qualifications, skills and experience) and confidentiality.

20.4.14 Within the parameters of the contract for the Internal Audit Service, the Chief Internal Auditor is responsible for ensuring the team is adequately staffed and that there is access to the full range of knowledge, skills, qualifications and experience to deliver the Internal Audit Plan in line with the NHS Internal Audit Standards. The team will undertake regular assessments of professional competence through an on-going appraisal and development programme (Personal Development Plans and Continuing Professional Development) with training provided where necessary.

20.5 External Audit

20.5.1 The External Auditor is appointed by the Council of Governors Representative at a general meeting of the Council of Member Representatives and paid for by the Trust. The Audit Committee must ensure a cost-efficient service. If there are any problems relating to the service provided by the External Auditor, then this should be raised with the External Auditor and reported to the Audit Committee and Council of Governors Representatives.

20.5.2 The Trust will ensure that the external auditor complies with the Audit Code for NHS Foundation Trusts at the date of appointment and on and on-going basis throughout the term of appointments.

20.5.3 The Council of Governors shall determine the terms of the contract for the provision of the External Audit.

20.5.4 The Audit Committee will receive and agree the External Auditor's annual plan.

20.6 Fraud and Corruption

20.6.1 In line with their responsibilities, the Chief Executive and Director of Finance shall monitor and ensure compliance with relevant directions and guidance on countering fraud and corruption within the NHS.

20.6.2 The Trust shall nominate a suitable person to carry out the duties of the Local Counter Fraud Specialist as specified by the NHS Fraud and Corruption Manual and relevant directions and guidance.

20.6.3 The Local Counter Fraud Specialist shall report to the Director of Finance and shall work with staff in NHS Protect in accordance with the NHS Fraud and Corruption Manual.

20.6.4 The Local Counter Fraud Specialist will provide a written report to the Audit Committee, at least annually, on counter fraud work within the Trust.

20.6.5 Counter fraud specialists are entitled without necessarily giving prior notice to require and receive:

a) access to all records, documents and correspondence relating to any relevant transactions, including documents of a confidential nature; (in which case, they shall have a duty to safeguard that confidentiality);

b) access at all reasonable times to any land, premises or members of the Board of Directors or employee of the Trust;

c) the production of any cash, stores or other property of the Trust under an employee's control;

d) explanations concerning any matter under investigation from any employee, agent or any employees of third parties contracted to the Trust when acting on behalf of the Trust.

20.7 Security Management

20.7.1 The Chief Executive is responsible for ensuring compliance with directions issued by the Department of Health relating to NHS security management.

20.7.2 The Trust shall nominate a director at Board level who will have delegated responsibility for security management as required by the Department of Health guidance on NHS security management.

20.7.3 The Trust shall nominate a Non-Executive Director to be responsible to the Board for NHS security management.

21. Information Management and Technology

21.1 Objective

21.1.1 To define responsibilities for the management of the Trust's Information Management and Technology Systems.

21.2 Responsibilities and Duties of the Director of Finance

21.2.1 The Director of Finance is responsible for the accuracy and security of the computerised financial data of the Trust is responsible for:

(a) devising and implementing any necessary procedures to ensure appropriate protection of the Trust's data, programs and computer hardware from accidental or intentional disclosure to unauthorised persons, deletion or modification, theft or damage, having due regard for the Data Protection Act 1998;

(b) ensuring that appropriate controls exist over data entry, processing, storage, transmission and output to ensure security, privacy, accuracy, completeness, and timeliness of the data, as well as the efficient and effective operation of the system;

(c) ensuring that adequate controls exist such that the computer operation is separated from development, maintenance and amendment;

(d) ensuring that an adequate management (audit) trail exists through the computerised system and that such computer audit reviews as they may consider necessary are carried out.

(e) ensuring procedures are in place to limit the risk of, and recover promptly from, interruptions to computer operations.

21.2.2 The Director of Finance is responsible for ensuring that new financial systems and amendments to current financial systems are developed in a controlled manner and thoroughly tested prior to implementation. Where this is undertaken by another organisation, assurances of adequacy must be obtained from them prior to implementation.

21.2.3 Where computer systems have an impact on corporate financial systems, the Director of Finance shall seek assurance that

(a) systems acquisition, development and maintenance are in line with corporate policies including the Clinical Systems Strategy;

(b) data produced for use with financial systems is adequate, accurate, complete and timely, and that there is an audit trail;

(c) Director of Finance staff has access to such data;

(d) appropriate computer audit reviews are undertaken.

21.3 Responsibilities and Duties of Other Directors in Relation to Computer Systems of a General Application

21.3.1 The Legal Services Department (with support from the Head of Information Management and Technology) shall publish and maintain a Freedom of Information (FOI) Publication Scheme, or adopt a model Publication Scheme approved by the Information Commissioner. This describes the information regarding the Trust that is made publicly available.

21.3.2 For the implementation, upgrade or changes to computer systems used generally within the Trust, the responsible manager for the system will present a business case to the Joint ~~Information~~ IT Management Group and Clinical Systems Implementation Programme Board ~~Technology Committee~~ for approval.

21.4 Contracts for Computer Services with NHS Bodies or Outside Agencies

21.4.1 The Director of Finance shall ensure that contracts for computer services for financial applications with another NHS body or any other agency shall clearly define the responsibility of all parties for the security, privacy, accuracy, completeness, and timeliness of data during processing, transmission and storage. The contract should also ensure rights of access for audit purposes.

21.4.2 Where another NHS body or any other agency provides a computer service for financial applications, the Director of Finance shall periodically seek assurances that adequate controls are in operation.

21.5 Risk Assessment

21.5.1 The Director of Finance shall ensure that risks to the Trust arising from the use of IT are effectively identified and considered and appropriate action taken to mitigate or control risk. This shall include the preparation and testing of appropriate disaster recovery plans.

22. Acceptance of Gifts by Staff and Other Standards of Business Conduct

22.1 Objective

To ensure that Trust staff comply with required standards of behaviour when using public funds.

22.2 General

22.2.1 The Chief Executive is responsible for ensuring that the Trust has policies in respect of conflicts of interest and the acceptance of gifts or other benefits in kind conferring an advantage to a member of staff. These policies should be consistent with the Standards of Business Conduct for NHS Staff.

22.2.2 The Chief Executive shall ensure that all Trust employees are aware of these Trust policies and the restrictions in relation to accepting gifts, inducements, benefits in kind or other personal advantage that could be considered to be bribes under the Bribery Act 2010.

22.2.3 The Trust Secretary shall hold and maintain a register of gifts, hospitality and sponsorship. It is the responsibility of all Trust employees to comply with the procedures regarding the disclosure of such gifts, hospitality and sponsorship as well as the policies referred to in 22.2.2.

22.3 Gifts

22.3.1 Casual gifts offered by contractors or others may be construed to be connected with the performance of duties so as to constitute an offence under the Bribery Act 2010 and therefore all such gifts should be declined. Business articles with little intrinsic value (of less than ~~£25~~ £50 per gift) such as diaries, calendars, pens etc need not be refused, nor small tokens of gratitude from patients or their relatives.

22.3.2 Any gift accepted of value greater than ~~£25~~ £50 should be declared in writing to the Trust Secretary. If several small gifts worth a total of over £100 are received by an individual from the same or closely related source in a twelve month period, these should also be declared to the Trust Secretary.

22.3.3 Gifts offered to an individual where the value exceeds ~~£40~~ £50 should be declined. In exceptional circumstances and with the agreement of the line manager, the matter may be referred to the Trust Secretary for a decision as to whether the gift can be accepted.

23.3.4 Under no circumstances may staff accept cash or vouchers, even below the £50.00 threshold. Gifts of cash made to a ward or department are deemed to be charitable donations and should be dealt with as described in section 23. No further declaration is required.

22.4 Hospitality

22.4.1 Suppliers must not attempt to influence business decision making by offering hospitality to trust staff. Modest hospitality provided it is normal and reasonable in the circumstances may be accepted (e.g. lunches in the course of a working visit). If in doubt, advice should be sought from the employee's line manager or relevant Director.

22.4.2 Any offers of inappropriate hospitality should be notified to the Trust secretary for appropriate action.

22.5 Sponsorship

22.5.1 Acceptance by staff of commercial sponsorship for attendance at relevant conferences and courses is acceptable, but only where the employee seeks approval in advance from their line manager.

Approval must depend on whether acceptance will, or could be believed to, compromise current or future purchasing decisions in any way.

22.5.2 The sponsorship of Trust events by existing suppliers to the Trust is acceptable subject to informing the Trust Board Secretary of the agreement for recording the details in the Register of Gifts, Hospitality and Sponsorship. Where the sponsor does not have a contract for supplies or services with the Trust, the Procurement Department should be consulted. The Trust Board Secretary should be informed. In all such cases there must be no favouritism shown to any one supplier in a way that could later be challenged by a competitor. Where this could be the case the same opportunity to sponsor events should be offered to the other interested parties.

22.5.3 Some suppliers offer training as a part of supplying equipment and this should be fully reflected through the contract entered into with the relevant organisation. In such cases no disclosure to the Trust Board Secretary is necessary.

22.5.4 The Trust shall not enter into commercial or charitable sponsorship arrangements which link such sponsorship to the supply of goods or services from any particular source.

22.5.5 Employees must not seek or accept preferential rates or benefits in kind for private transactions carried out with companies with which they have had, or may have, official dealings on behalf of the Trust. This does not apply to concessionary agreements negotiated with companies by the Trust, or the NHS, or by recognised staff interests, on behalf of all staff for example, staff benefit schemes.

23. Funds Held in Trust

23.1 Objective

23.1.1 To ensure that the Trust's charitable funds are properly safeguarded and used for the benefit intended.

23.2 General

23.2.1 'Charitable funds are those gifts, donations and endowments made under the relevant charities legislation and held on trust for purposes relating to the NHS, the objects of which are for the benefit of the NHS in England.

23.2.2 The charitable trusts for the University Hospitals Bristol NHS Foundation Trust are administered by the Trustees of Above & Beyond (hereafter called the Trustees). The Trustees have their own systems of accounting and financial control and operate separate bank accounts to the Trust. Charitable funds should not be confused with those operated by the Trust for its exchequer funds.

23.2.3 All gifts, donations and proceeds of fund-raising activities which are intended for the Trust's benefit shall be handed immediately to either the Trustees or to the Trust's cashier who will bank the money and transfer to the Trustees. Any charitable funds paid in through the Trust's cashier must be clearly identified as such to ensure it is separated from the Trust's exchequer funds. However the funds are passed to the Trustees, there must be clear instruction regarding the donor's intentions or the area to benefit.

23.2.4 The Director of Finance shall be required to advise the Trust Board on the financial implications of any proposal for fund-raising activities which the Trust may initiate, sponsor or approve.

23.2.5 The Trustees will designate a fund advisor for each fund held who must comply with the written procedures issued by the Trustees regarding the use of these funds.

23.2.6 Expenditure of any funds held in trust shall be conditional upon:-

(a) the expenditure being within the terms of the appropriate fund

(b) meeting the delegated limits which are:

<£1,000 approved by the designated fund advisor
>£1,000 approved by the Trustees in accordance with their scheme of delegation

equipment >£5,000 also requires approval in the first instance by the Trust's Capital Programme Steering Group

Expenditure can only be as prescribed by the approval given and can't exceed the value approved.

(c) the prior approval of the Trust's Capital Programme Steering Group being obtained for items falling within the capital definition;

(d) being authorised by the fund advisor in writing, or by a person to whom the fund advisor has delegated authority having advised the Trustees in writing.

24. Retention of Documents

24.1 Objective

24.1.1 To ensure the Trust has appropriate arrangements for retaining documents to comply with legal responsibilities and to enable the effective operation of the Trust.

24.2 General

24.2.1 The Chief Executive shall be responsible for maintaining archives for all records, including electronic records, required to be retained in accordance with Department of Health guidelines.

24.2.2 The documents held in archives shall be capable of retrieval by authorised persons.

24.2.3 Documents held in accordance with Department of Health guidelines shall only be destroyed at the express instigation of the Chief Executive. Records shall be maintained of documents so destroyed.

University Hospitals Bristol
NHS Foundation Trust

Cover report to the Public Trust Board meeting to be held on Wednesday 31 January 2018 at 11:00 am – 13:00 pm in the Conference Room, Trust HQ, Marlborough St, Bristol, BS1 3NU

		Agenda Item	19
Meeting Title	Finance Committee		
Report Title	Chair's Report of the Finance Committee		
Author	Sophie Melton Bradley, Deputy Trust Secretary		
Executive Lead(s)	Paul Mapson, Director of Finance and Information		
Freedom of Information Status		Open	

Reporting Committee	Finance Committee	
Chaired by	Martin Sykes, Non-Executive Director	
Lead Executive Director (s)	Paul Mapson, Director of Finance and Information	
Date of last meeting	21 December 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 Finance Committee on 21 December 2017.

Finance Directors Report

Paul Mapson, Finance Director presented the Finance Report at Month 8, and noted that the Operation Plan for November 2017 showed the Trust achieving a surplus of £9.2million, and therefore being £0.3million adverse to plan. The run rate overspend in divisions had showed a substantial improvement in November, which would help mitigate the risk of failing to deliver the Operational Plan.

Key issues of discussion included:

- Significant improvements in nursing costs had contributed to the run rate improvement, although the position on medical pay had deteriorated, particularly in the Children's Hospital, despite continuing efforts by the Director of Finance and Information and the Deputy Chief Executive & Chief Operating Officer to address this with the divisions.
- The run rate going into the next financial year would be key: the Trust currently had a £7-8million deficit, which made the CIP requirement of 2% extremely challenging to meet.
- NHS Improvement had now allocated NHS funding announced in the Autumn 2017 budget 2 tranches: 'bottom line' funding of £1.37 million for UH Bristol, and £580,000 pro-rata-ed to UH Bristol against specific schemes (A&E front door; ITU beds, increased capacity in CDU).
- Overall, the risk of failing to meet the Operation Plan in Quarter 4 had fallen, given improvements in performance and funding received, however there continued to be risks, and the Trust still had 'more to do' for example on addressing medical pay.

- The Committee agreed that the issue of having appropriate controls and accountability on medical pay costs was an essential one: it was agreed this issue would come back to the Committee for further discussion at a later date.

Contract and Activity Reports
Members received an update in relation to the Trust's contract and activity income and noted that the contract income was £2.48million higher than plan in November 2017. Pass through payments, activity based services and contract rewards were higher than plan, whilst income for contract penalties was lower than plan.

Reasons for big increases in costs included high cost drugs and home care invoices (which are invoiced to UH Bristol by third parties and then invoiced to Commissioners).

Detailed Divisional Financial Reports
Members received the financial reports for the clinical and non–clinical divisions.

Savings Programme
It was noted that all divisions were above savings targets except for Medicine and Surgery. UH Bristol was aiming for a 2.8% savings target for next year (2.4% recurring) of which £7.7million had been identified so far.
The Committee noted that delivering the savings programme for 2018-19 would present a significant challenge.

Capital Income and Expenditure Report
UH Bristol had spent £14.5m to date against an internal capital expenditure plan of £21.5million (so £7million short). The underspend was largely due to the delay in phase 5 and to the purchasing of large-scale medical equipment, as well as in the roll out of some operational capital and IT programmes. It was noted that new recruitment in procurement was helping to strengthen the management team and would help to deliver improvements in procurement delivery.

Statement of Financial Position
Members noted that the Trust continued to have a strong statement of financial position with net current assets of £46.035m, £9.608m higher than plan.

Standing Financial Instructions
It was noted that following discussion with relevant areas of the Trust, including the Trust Secretary and the procurement team, there were no significant changes to these. They would go to the Board for approval in January 2018.

<u>The following were received for assurance:</u>

- **Minutes of Capital Programme Steering Group**
- **Month 8 NHS Improvement Submission**

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

None identified.

Matters requiring Committee level consideration and/or approval

None identified.

Matters referred to other Committees	
None identified.	
Date of next meeting	26 January 2018

University Hospitals Bristol
NHS Foundation Trust

Cover report to the Public Trust Board meeting to be held on Wednesday 31 January 2017 2018 at 11:00 am – 13:00 pm in the Conference Room, Trust HQ, Marlborough St, Bristol, BS1 3NU

		Agenda Item	19
Meeting Title	Finance Committee		
Report Title	Chair's Report of the Finance Committee		
Author	Sophie Melton Bradley, Deputy Trust Secretary		
Executive Lead(s)	Paul Mapson, Director of Finance and Information		
Freedom of Information Status		Open	

Reporting Committee	Finance Committee	
Chaired by	Martin Sykes, Non-Executive Director	
Lead Executive Director (s)	Paul Mapson, Director of Finance and Information	
Date of last meeting	26 January 2018	

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 Finance Committee meeting of 26 January 2018.

Finance Directors Report
Paul Mapson, Director of Finance and Information, presented the Finance Report at Month 9. December 2017 was a good month for the Trust, with a significant improvement in the run rate. Excluding STF funding the Trust was reporting a surplus of £0.517million against a planned surplus of £0.496m. Both income and nursing pay were performing well despite winter pressures, and all divisions were showing signs of progress, although medical pay was not yet seeing signs of improvement. It was noted that the Trust had also now received £1.37million of winter pressures funding from the Department of Health.

Paul Mapson also noted that national guidance for 2018/19 financial planning was still not available (this had been due out originally in December 2017). This meant the Trust was still waiting for clarity from Government and the regulator (conversations between NHS Improvement, NHS England, and the Treasury were ongoing). As Director of Finance and Information he had therefore begun scenario planning to identify issues that might impact on 2018/19 finances, including (potentially) a pay award under agenda for change, changes to control total caps, additional NHS funding, and the delivery of constitutional models.

Key discussion points included the following:

- The Committee were pleased by the positive month 9 position, especially in the context of winter pressures. Three of the past four months had now shown a strong position.
- The Committee agreed that the key challenge in terms of the 2018/19 Financial Plan would be negotiating an acceptable control total with the regulator. The Board would need to exercise robust governance in accepting a formal control total, especially as

there were risks of core fines and lost STF funding for trusts who rejected their control total.

- The Committee understood the case for planning different financial scenarios, given the lack of clarity/guidance from the regulator, but felt it was important that once guidance became available, the Trust sought to establish clarity as to what its Financial Plan for 2018/19 was.
- It was noted that the final financial/operating plans would need to reflect the context of the broader Trust Strategy.

Contract Income and Activity Reports

Members received an update on contract income and activity reports. Contract income was £0.82million higher than plan in December 2017, largely due to higher than planned activity-based services and contract rewards. Pass-through payments and income for contract penalties were lower than plan. Significant variances for December included adult medical inpatients (£0.55m above plan, including an estimated £0.21m against the Weston A&E overnight closure), adult surgical electives (£0.35m above plan, driven by high activity volumes in upper gastrointestinal surgery and ENT), admitted patient activity for adult cardiac services (£0.23m above plan), paediatric emergency activity (£0.33m above plan) and adult bone marrow transplants (£0.23m above plan).

Detailed Divisional Financial Reports

Members received the financial reports for the clinical and non–clinical divisions. It was noted that there was a small overall deterioration of £77,000 in December 2017, an improvement on £240,000 in November, so the run rate was better overall. Specialised Services and Diagnostic and Therapies were both underspent, Women's and Children's Services and Medicine had seen a small overspend, and Surgery had seen a larger deterioration (£300,000 adverse variance – this was largely due to issues with controls, which the Trust was seeking to address). Throughout the Trust there was continued overspend on medical pay, although this was slowing, especially as outsourcing had largely stopped.

Key discussion points included the following:

- The Committee noted that Surgery seemed to have underperformed for a number of years, and members therefore requested some further information as to how the division was being held to account. It was noted that mitigating activities included leadership training to address skills gaps, and face to face meetings with individual specialities. The Committee noted it would be helpful to have more narrative around the reports, for example around what level of success was expected each month, and how this would be measured.

Savings Programme

As of December 2017, the Trust had achieved savings of £8.445m against a plan of £8.695m, leaving a shortfall of £0.250m. The Trust was forecast to make savings of £12.14m by year end, an overachievement against plan of £0.62m. It was noted that the underspend in Specialised Services in particular had supported this.

Medical Staffing Work Stream

The Acting Medical Director Mark Callaway and the Director of Finance and Information Paul Mapson were leading this piece of work to address the continued overspend against medical pay budgets within the Trust. A job planning review was underway, which would be key for helping understand the position on productivity. There would also be transactional reviews in 3 - 4 specialities per division using the internal audit model, to help test whether the sources of transactions were being properly accounted for. Beyond job planning other key areas for consideration would include reviews of additional payments and the use of waiting list

initiatives. The Director of People Matt Joint was also leading work looking at sickness rates, annual leave, and other relevant controls, as well as e-rostering for Junior doctors

Key discussion points included the following:

- The work stream was expected to take some time, but those involved were hopeful that it would lead to positive long-term outcomes.
- The Committee were supportive of this work: there was a known longstanding issue with medical pay with the Trust, but it had always been challenging to understand the manifold causes. This was a major piece of work towards addressing these issues, and the Committee would like to see regular updates on its progress.

Productivity Improvement
The Committee received an update on productivity improvement: the Executive Team had been undertaking a 'root and branch' review of organisational improvement. There were recognised productivity issues, particularly around clinical productivity, which the review and executive engagement were seeking to address.
It was noted that a key problem, besides resourcing, was changing the culture, including addressing a historical lack of appropriate management training, in order to maximize productivity opportunities. This would be a key challenge for the Trust.

Capital Income and Expenditure Report
It was noted that some slippage was expected against the report, but the Deputy Director of Finance was working with the Procurement team to address this.

Quarterly Treasury Management Report
The Deputy Director of Finance Kate Parraman advised the Committee that since the December 2017 meeting there had been progress on work with North Bristol Trust to establish the financial position between the two trusts, including engagement at senior management. The Deputy Directors and Directors would be meeting to agree key issues shortly, egg around maternity pathways, peripheral clinics, and other provider agreements.

The following were received for assurance/information:

- Month 9 NHS Improvement Submission
- Statement of Financial Position
- Minutes of Capital Programme Steering Group

Key risks and issues/matters of concern and any mitigating actions	
None identified.	
Matters requiring Committee level consideration and/or approval	
None identified.	
Matters referred to other Committees	
None identified.	
Date of next meeting	26 February 2018

University Hospitals Bristol
NHS Foundation Trust

Cover report to the Public Trust Board. Meeting to be held on 31 January 2018 at 11.00 – 13.00, Conference Room, Trust HQ, Marlborough St, Bristol, BS1 3NU

		Agenda Item	20
Meeting Title	Trust Board	**Meeting Date**	Wednesday, 31 January 2018
Report Title	Register of Seals		
Author	Sophie Melton Bradley, Deputy Trust Secretary		
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.	☐	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 report applications of the Trust Seal as required by the Foundation Trust Constitution.

Key issues to note

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

The attached report includes all new applications of the Trust Seal since the previous report in

October 2017.
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 recruit, train and sustain an engaged and effective workforce.	☐	Failure to comply with targets, statutory duties and functions.	☒
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.	☐		

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)**

Register of Seals – October 2017 – January 2018

Reference Number	Date Signed	Document	Authorised Signatory 1	Authorised Signatory 2	Witness
805	26.01.18	Lease – Level 8 Queen's Building BRI. NBT/UHBristol	Paul Mapson, Director of Finance	Robert Woolley, Chief Executive	Sophie Melton Bradley, Deputy Trust Secretary

Cover report to the Trust Board meeting to be held on Wednesday, 31 January 2018 at 11.00 am – 13.00 pm in the Conference Room, Trust HQ, Marlborough St, Bristol, BS1 3NU

		Agenda Item	21
Meeting Title	Audit Committee		
Report Title	Chair's Report		
Author	Sophie Melton Bradley, Deputy Trust Secretary		
Executive Lead	Robert Woolley, Chief Executive		
Freedom of Information Status		Open	

Reporting Committee	Audit Committee
Chaired by	John Moore, Non Executive Director
Lead Executive Director	Pam Wenger, Trust Secretary
Date of last meeting	26 January 2018

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 Audit Committee meeting of 26 January 2018.

Non-EROCs procurement
Members received a detailed update on the current progress that had been made. It was highlighted that there were areas of procurement that the EROS system would not support. Further conversations identified that focus was required to include the majority of spend on to EROS rather than looking solely at compliance. It was recognised that this would be a big challenge but the Committee agreed this was the right approach. The internal audit on EROS procurement would be presented to the Committee in April 2018. Members requested quarterly progress updates at the Audit Committee meetings.

Review of Board Assurance Framework (BAF) – Q3
Members received the BAF for quarter 3 for approval. There had been an internal audit of the BAF completed. Recommendations and actions had been signed off and it was agreed these would be taken forward once the new Trust Secretary was in post (for action by April 2018). There was still significant risk to the financial plan, though the risk had been assessed prior to improvements in the month 9 position so this might potentially be lower. It was noted that there was a change to the scoring of strategic priority 6; *risk of being unable to deliver the 2017/18 financial plan,* from 25 to 20: it was acknowledged that there was still a risk to the delivery of the 2017/18 plan. Strategic Priority 2; *failure to develop and maintain the Trust estate,* had been reassessed, following Risk Management Group (RMG) approval, using an environmental criterion as opposed to business criterion. This reduced the risk score to 12.

Review of Corporate Risk Register (CRR)– Q3
Members received the CRR as at the end of December 2017. Members sought assurance that the risks that had been downgraded would not drop off the radar: these risks would still remain under the umbrella of Risk 801: *Risk of failure to achieve on or more access standards*

of the Single Oversight Framework, on the CRR. Lower level risks linked to Risk 801 were applicable to each individual division so that they could be taken forward. The Chief Executive gave reassurance that where risks were downgraded they were first subject to review by the Senior Leadership Team (SLT). Members felt that the process was robust and gave adequate assurance.

Counter Fraud Progress Report
Eli Hayes, who has been the Support Local Counter Fraud Specialist for the past 2 years will replace Sandra Bell, who is leaving Audit South West. He will be supported by John Micklewright, the Counter Fraud Manager. NHS Counter Fraud Authority (NHS CFA) became an independent special health authority on 1 November 2017. This new organisation, previously known as NHS Protect, was tasked with leading the fight against fraud, bribery and corruption in the NHS. The Committee expressed concern that some staff were not aware that working whilst sick was a fraudulent activity. The Trust was clear that it would always act in cases where there was evidence of working whilst sick, and the Committee were reassured that staff were reporting instances of fraud of this kind.

Local Counter Fraud Draft Plan for 2018-19
Members received the Local Counter Fraud Draft Plan for 2018-19. There were two parts to the plan: one phase to enable the Trust to demonstrate it had a good counter fraud plan in place and a second phase looking at proactive work where potential risks were identified. It was noted that the number of audit days provided to UH Bristol were in line with the region. The Committee agreed the proposed plan.

Review of Internal Audit Progress Reports
Members receive the internal audit progress report which included a report on the work completed or in progress and the status of recommendations.

The details of the audits are shown in the table below:

Audit Assurance		**Overall Assurance Opinion**
1	Procurement	Satisfactory
2	Data Quality – Two Week Wait	Satisfactory
3	Temporary Staffing SOPS	Satisfactory
4	Governance & Risk Management – BAF	Satisfactory
5	Staff Engagement	Satisfactory
6	HR KPIs & Timeliness of Process	Satisfactory
7	Outside TSB Booking of Agency Staff	Satisfactory
8	Data Quality – Safety Thermometer	Satisfactory

Audit South West Cyber Security Briefing
Members received the Audit South West Cyber Security Briefing. Members noted the importance of preparation for potential cyber-attacks and were assured by the report.

Audit South West External Assessment Report
Full assurance was received against the standards. There were some small recommendations made which had been taken forward.

Internal Audit Strategic Plan 2018/19 and 2020/2021
The Internal Audit Strategic Plan was presented to the Committee for initial consideration. The Internal Audit Team welcomed Exec input and the opportunity for comments was given until April 2018.

Chair Reports
Members received Chair Reports from Finance Committee, Risk Management Group and

Quality and Outcomes Committee. It was noted that an interim Data Protection Officer had been appointed and would support the implementation of GDPR. <u>The following were received for assurance:</u> • Single Tender Action • Review of losses and special payments • Audit South West External Assessment Report • Review of external audit plan 2017/18
Key risks and issues/matters of concern and any mitigating actions
The committee looks forward to the full report from our Estates Dept on their review of all firefighting equipment and doors across the Trust. This is will be presented at the next Audit Committee meeting.
Matters requiring Committee level consideration and/or approval
None identified.
Matters referred to other Committees
None identified.

Date of next meeting	17 April 2018

University Hospitals Bristol
NHS Foundation Trust

Cover report to the Public Trust Board. Meeting to be held on 31 January 2018 at 11.00 – 13.00, Conference Room, Trust HQ, Marlborough St, Bristol, BS1 3NU

		Agenda Item	22
Meeting Title	Public Trust Board	**Meeting Date**	Wednesday, 31 January 2018
Report Title	Governor's Log of Communications		
Author	Kate Hanlon, Membership Engagement Manager		
Executive Lead	Jeff Farrar, Chair		
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.	☐	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 recruit, train and sustain an engaged and effective workforce.	☐	Failure to comply with targets, statutory duties and functions.	☒
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.	☐		

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)**

ID **Governor Name**

196 **Graham Papworth** ***Theme:*** Contractors ***Source:*** Governor Direct

Query **23/01/2018**

Does Carillion going into liquidation have any impact on UH Bristol? And, in light of this situation, does UH Bristol have contingency plans in place in case any key contractors the trust is dependent on get into difficulties?

Division: Trust Services ***Executive Lead:*** *Chief Operating Officer* ***Response requested:*** 06/02/2018

Response

Status: *Assigned to Executive Lead*

195 **Neil Morris** ***Theme:*** Healthcare Safety Investigations Branch ***Source:*** Governor Direct

Query **03/01/2018**

The newly operational Healthcare Safety Investigations Branch will start looking into cases of unexplained serious harm and death; as an organisation are we aware of this new branch and do we have procedures in place to co-operate as appropriate?

Division: Trust-wide ***Executive Lead:*** *Chief Nurse* ***Response requested:*** 24/01/2018

Response **08/01/2018**

We are aware of the Healthcare Safety Investigations Branch (HSIB) and have been receiving updates for past 18 months on its development via various e-news bulletins and have spoken to their representatives at national events with regards to their future plans. Our Serious Incident Policy references the HSIB as a potential source of independent investigation for serious incidents.

Status: *Awaiting Governor Response*

ID	Governor Name		
194	Neil Morris	***Theme:*** Incident reporting and learning	***Source:*** Governor Direct

Query **03/01/2018**

New NHS Improvement figures show that nationally almost one in five births have an incident recorded for them, how does this compare with UH Bristol? Are there learning processes in place to ensure that any incidents we do record are being used as education/culture improvement opportunities?"

Division: Women's & Children's Services ***Executive Lead:*** *Chief Nurse* ***Response requested:*** 24/01/2018

Response

Status: *Assigned to Executive Lead*