University Hospitals Bristol
NHS Foundation Trust

Public Trust Board Meeting Papers

Date: 27 July 2018

Time: 11:00 – 13:00

Venue: Conference Room, Trust Headquarters

NHS
University Hospitals Bristol
NHS Foundation Trust

Board of Directors (in Public)

Meeting to be held in Public on Friday 27July 2018, 11.00 – 13.00
Conference Room, Trust HQ, Marlborough St, Bristol, BS1 3NU
AGENDA

NO.	AGENDA ITEM	PURPOSE	SPONSOR	PAGE NO.
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5.	Matters arising and action log	Approval	Chair	20
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9.	Annual Safe Working Hours Guardian Report	Assurance	Acting Medical Director	44
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25.	Any Other Urgent Business		Chair	Verbal
26.	Date and time of next meeting **27 September 2017, 11.00 – 13.00, Conference Room, Trust HQ.**		Chair	Verbal

Cover report to the PublicTrust Board. Meeting to be held on 27 July 2018 at 11.00 – 13.00, Conference Room, Trust HQ, Marlborough St, Bristol, BS1 3NU

		Agenda Item	3
Meeting Title	Public Trust Board	**Meeting Date**	Friday, 27 July 2018
Report Title	Patient Story		
Author	Mark Read Chaplaincy Team Leader		
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.	☒	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

At this meeting the Board will receive the Annual Report of the Spiritual and Pastoral Care Service. The report will detail how, last year, hospital chaplains supported over 6000 people in some significant way and performed over 1700 rites. 33% of the people supported did not express any religious belief or faith yet they valued the care the Service has been able to provide. Often, it is the stories behind those statistics that can often be the most revealing.

This story recognises and reflects the importance of the treatment of spiritual pain. It draws on an encounter between a UH Bristol Chaplain and the parent of a child at the end of his life and demonstrates many of the complexities that we respond to day in and day out.

The story recognises that, in the face of illness and end of life care, we have a responsibility to support relatives and staff through difficult decision making processes as much as we have a duty of care to the patient. It underlines how compassion, hope, understanding, relationships and existential awareness are crucial elements of the healing process and an important aspect of providing holistic rather than purely medical care.

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 research and teaching into the care we provide, and develop new treatments for the benefit of patients and the NHS.	☐	Failure to take an active role in working with our partners to lead and shape our joint strategy and delivery plans, based on the principles of sustainability, transformation and partnership working.	☐
Failure to maintain financial sustainability.	☐	Failure to comply with targets, statutory duties and functions.	☐

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

Impact Upon Corporate Risk
N/A

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

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

Minutes of the Trust Board Meeting Held in Public

Held on Thursday 28 June 2018, 11:00-13:00, Conference Room, Trust Headquarters

Present

Board Members

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

In Attendance

Name	Job Title/Position
Eric Sanders	Trust Secretary
Tony Tanner	Governor
Rachel McKendry	Staff Member
Clive Hamilton	Member of the Public
Carole Dacombe	Governor
Paul Kearney	Member of the Public
Emma Riley	Staff Member
Nikki Evans	CQC
Lucas James	Member of the Public
Liz Hood	Staff Member
Matt Bell	Staff Member
Mary Whittington	Governor
Jon Hayes	CCG
John Kirk	Communications Manager
Shaun Carr	Deputy Chief Operating Officer (*attended for item 8)*
Dr Steven Falk	Clinical Director, Local Clinical Research Network *(attended for item 16, 17 and 18)*

Minutes:

Sophie Melton Bradley	Deputy Trust Secretary

The Chair opened the Meeting at 11.00

Minute Ref	Item Number	Action
Preliminary Business		
99/06/2018	**1. Welcome and Introductions/Apologies for Absence**	
	The Chair, Jeff Farrar, welcomed everyone to the meeting. Apologies were received from Deputy Chief Executive & Chief Operating Officer Mark Smith, Non-Executive Director Steve West and Honorary Non-Executive Director Sue Evans.	
100/06/2018	**2. Declarations of Interest**	
	There were no declarations of interest.	
101/06/2018	**3. Patient Story**	
	The meeting began with a patient story, introduced by the Chief Nurse, Carolyn Mills. Lucas James was introduced as the parent of a patient of the Trust, Kai - now 17 years old - who had had complex medical challenges since birth and for whom she was the carer. Her son had a unique chromosome disorder which had led to walking and development issues. However he had no awareness that he was 'different' in any way, or any feelings that he was less worthy, and he and his mother had recently participated in the Bristol 10k race together. She noted that the previous week had been Carers' Week, which was to help raise awareness of what life was like for carers. She emphasised the point that carers were not *just* carers: they had their own lives, careers and interests in addition to their caring responsibilities, and equally not all carers were the same, and she could only speak to her own experience and not for everyone. For example, a lot of carers who had engagement with the Trust might have their own challenges and issues to deal with, including health issues, learning disabilities and so on. Many might also not feel comfortable speaking at events (such as this meeting) about their personal experience, so she had taken on a role of representing other carers who perhaps were not able to do so. It was important to understand that most carers needed support. For example, when they experienced illness this impacted on their ability to carry out caring responsibilities, and might have repercussions for the care receiver. She felt that engagement by carers with the Children's Special Needs Learning and Disability Working Group, which she was involved in, was	

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	really important for ensuring carers got the support they needed. She recognised that there were always constraints on money and time, but having parent carers involved in forums like these, helping to understand what interventions worked for them, or what they would like introduced, was a vital method of improving things for carers. She was also involved in the Carers' Strategy Implementation Group, and working with Corona advising students from the University of Bristol how to support carers and patients. In terms of small steps, that Trust staff engaging with patients and carers could take, she emphasised that it was very important that if staff didn't know the answers to patients' questions that they were clear about this: carers and patients needed honest information, even if it was something along the lines of, "we just don't know yet," or "I'll have to check with a colleague". Carers were much more likely to trust and respect what medical professionals had to say if they felt there was transparency, and would therefore be much more likely to co-operate with any care regime. She noted from her own experience that comments from medical professionals could have a profound effect on patients and carers, so it was important that information given was right, and that they were honest when they didn't have the answers. She noted that medical staff she had worked with and given this advice to had fed back that when they had followed this approach they had seen positive results in their patient interactions. Giving patients a choice, even over small things, could make a profound difference to how they felt about their treatment. She mentioned a recent positive interaction with the Trust where her son had been engaged with well by staff, given choices (such as a choice of stickers after his treatment) which made him feel calmer and more in control. Front line staff could (and did) do small things like this to make hospital visits and other treatment easier for patients and carers. She noted that the hospital 'passport' scheme in use at the Children's Hospital had made a huge positive difference to the continuity and communications involved in her son's treatment. She noted that there had been a change from the more 'old school' paternalistic approach to patients of the past, towards a more interactive approach which recognised the importance of listening to patients and carers. She felt there was still a divide between the old and new styles of approach, but that things were improving over time. Members of the Board discussed the following: • The Chair of the Board thanked Lucas James and agreed that the point about clinicians listening to patient and carer needs and concerns was key. He asked how she felt overall about the	

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	treatment her son had received. She noted that there had been problems: for example, her son had both hips fully dislocated and this had not been picked up until he was seven years old as everyone treated him had assumed 'someone else' was checking this. However as a direct consequence of this she had seen changes in Trust policy to ensure improvement were made in future. There had also been some really excellent clinicians providing outstanding care to her son, and really focussing on communicating with him on a personal level, and they had built many positive relationships throughout the Trust. She recognised that things were going to go wrong sometimes and that it wasn't possible to eradicate all risk. Overall, she felt that everyone they interacted with was trying to do their best within the constraints they were operating in. In answer to a query as to how she had found Trust communications, she noted they were sometimes good and she had experienced some really great information sharing around care, but sometimes extremely poor: for example, she had received a letter notifying her of her son's X-ay appointment the day after the appointment was due. Broader interactions between the Trust and her GP/other support mechanisms had largely been smooth, although she had seen communication effectiveness differ between different GP practices. She noted that she made a point of taking the name, job title and contact details of anyone she talked to about her son's care, which meant she could co-ordinate communications and get hold of people directly, which probably helped general communications. She noted that not every carer would be in a position or have the resources or abilities to do this, for example due to the pressure of dealing with family issues or their own health problems. These carers were much more vulnerable when things went wrong in Trust care, whether with communications or in other ways • Members asked what one change would help her most as a carer. She noted again the challenge that more traditionally trained clinicians sometimes struggled to take on board the views of others: and in particular the views of less experienced staff or those with more recent training. A willingness to hear ideas, whether from patients, their families and carers, or other colleagues, was absolutely essential. She wanted there to be a more level playing field so those less experienced colleagues felt they were able to speak up and give input. • Members noted her praise of the 'passport' system, and asked if this was applied across the Children's Hospital. It was clarified that this system was applied to patients with long term complex care issues, and had come out of work to ensure patients transferring from the Children's Hospital to adult care saw good continuity of care.	

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	• The Chair thanked Lucas James on behalf of the Board for sharing her experience and insights, and asked if he might personally shadow her and Kai during an interaction with the Trust to help understand how things worked for them. It was agreed that this would be arranged. **Action: The Chief Nurse Carolyn Mills to liaise with Lucas James to arrange a shadowing session for the Chair with her and her son Kai at an upcoming hospital appointment.** **Members RESOLVED to:** • **Receive** the patient story or information.	
102/06/2018	**4. Minutes of the last meeting**	
	Members reviewed the minutes of the meeting held on 24 May 2018: there were no amendments to the minutes. **Members RESOLVED to:** • **Receive** the minutes of the meeting held on the 24 May 2018 as a true and accurate record subject to the above amendment.	
103/06/2018	**5. Matters arising and Action Log**	
	Members received and reviewed the action log. Completed actions were noted and updates against outstanding actions were noted as follows: **Min reference** 85/05/18: Quality and Outcomes Committee Chair's report May 2018: *A greater level of assurance in relation to staff turnover was requested. The Board would be provided with information on the proportion of staff leaving the NHS entirely, proportion retiring early and the proportion moving on to other organisations.* **This action would be picked up through the Quality and Outcomes Committee, and could now be closed.** **Min reference** 62/04/18: Quality and Performance Report: *Acting Medical Director Mark Callaway to update Board on progress with establishing cohorting of the Trauma and Orthopaedic ward.* **It was confirmed that a task and finish plan had been set up across the Medicine, Diagnostics & Therapies and Surgery Divisions. A business plan had been developed and would be reviewed shortly.** **Min reference** 08/01/18: Quality and Performance Report *Acting Medical Director to share the annual report on the genomics project with the Board.* **The genomics project team had now produced quite a technical quarterly report. The Acting Medical Director Mark Callaway was liaising with Trust Secretary Eric Sanders to develop**	

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	a more user friendly annual report to be shared with the Board, hopefully at the July 2018 meeting. **Members RESOLVED to:** • **Note** the updates against the action log.	
104/06/2018	**6. Chief Executive's Report**	
	Chief Executive Robert Woolley presented his report to the Board, and provided updates on several further matters including the following: The following week would be the 70th birthday of the NHS, which would provide opportunities for staff and visitors to share their thoughts and feelings about the NHS. Among other events, a number of tea parties were being held in the Trust to celebrate the event. It was noted that the Prime Minister had announced an additional £20billion of investment in the NHS over the next five years, but details were still needed on how this would be translated into specific funding. At the staff open meeting the previous day (27 June), the Chief Executive had reminded staff about the Freedom to Speak Up (FTSU) initiative, and the importance of staff feeling able to speak up about concerns they saw, including anonymously. The Trust Secretary Eric Sanders was the Trust's Freedom to Speak Up Guardian, and there were now a range of advocates amongst staff, who were able to advise and direct staff about FTSU issues, across the Trust. The Trust needed to be clear that it would take staff concerns raised in this way seriously, and would take action where appropriate. The Trust was now moving to the next phase of the Strategic Review. The Board had now had the opportunity to look at the proposed corporate and strategic aims, and the Director of Strategy and Transformation and her team would now be going out to the Divisions to engage with them in building a detailed vision of how individual services were going to be shaped for the future. This second phase would continue into October 2018, and results were expected to come to a Board Seminar for further Board review in November 2018. The Chief Executive reminded the Board of the four priorities he had set for this work and future Trust planning: around staff engagement and wellbeing development; improving the quality of care for patients; working smarter and more effectively across the Trust; and, crucially, increasing capacity before the next winter period. Planning to address this last point was already underway, and there would be 16 additional beds introduced across South Bristol and the Bristol Royal Infirmary. The Trust was also increasing assessment capacity and looking at new models of ambulatory care. A Board to Board meeting had taken place with Weston Area Health	

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	NHS Trust (WAHT) the previous week, at which the intention to pursue a merger approved earlier this year by the Board had been reaffirmed. However, due to complexities and issues in the wider environment it was now unlikely that any merger would take place before October 2019 at the earliest. In the meantime both Trusts were committed to continuing to work in increasing partnership across a range of clinical and non-clinical services to ensure that the best care possible was being provided to the community. The Trust had now issued a press release confirming plans for a new transport hub which would create new patient and visitor parking spaces, as well as 400 new cycle spaces and a stop for the Above and Beyond hospital transport bus. The intention was to apply formally for planning permission in the summer. Members of the Board discussed the following: • It was agreed that increasing hospital capacity was important, not just to winter planning but to the Trust's ability to deliver more elective activity. It was noted that there were efforts to develop rules to ensure activity would not be cancelled due to winter pressures wherever possible. Members asked whether it would be possible to accelerate elective work activity in the summer months to relieve winter pressures: it was noted that some specialities already did this, but it could prove difficult in practice due to leave annual rates in the summer. **Members RESOLVED to:** • **Receive** the Chief Executive's Report for assurance.	
Care and Quality		
105/06/18	**7. Major incident in Bristol Haematology and Oncology Centre**	
	The Chief Executive gave an update to the Board on the Major Fire Incident in the Bristol Haematology and Oncology Centre (BHOC) which had occurred in May 2018. Investigations into the fire were at an early stage, but it was understood that a key issue had been smoke filtering throughout the whole BHOC building, leading to a major incident. The Trust recognised that the Board had previously asked for assurance that staff were being well supported following the incident, and confirmed that support had been put in place for staff who had been affected by the incident. Work to review the impact on patient care had also been stepped up: for example, the harm panel of oncologists and radiotherapists convened for the on-hold patients issue had had its remit extended to examine the impact of any delays to care due to the incident on patients. Patients and their families were also being involved in the discussions.	

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	A suite of investigations had been commissioned, including the following: • A Serious Incident investigation was being led by the local Head of Emergency Response in NHS England, looking at the Trust's management of the incident, including the effectiveness of systems. • An internal investigation into the causes of the fire was being led by the Director of Facilities and Estates Andy Headdon. • An independent review had been initiated by Avon Fire and Rescue Service to explore the causes of the fire and the adequacy of the Trust's prevention and containment measures. The Trust had supplied them with documentation they had requested. • Additionally, the Chief Executive had asked for an independent audit of the Trust's fire system policies and process, to be carried out by the Trust's (external) fire engineers Capitec. The outcomes of these investigations would be reported back to the Audit Committee and the Board. Members of the Board discussed the following: • The Chair of the Board noted that the response of staff to the incident on the day, including Acting Medical Director Mark Callaway who had been on site at the time, had been outstanding. Members agreed that staff had responded extremely well and should be congratulated, and were aware of anecdotal evidence that patients whose treatment had been transferred to other locations in the Trust following the fire had received excellent care despite the disruption. Consultants had also noted that where they had had to carry out care in 'decant' areas of the hospital due to the fire they had been made to feel welcome, which reflected the sense of a shared, supportive culture across the Trust. The Chief Executive fully endorsed the praise for staff and noted that letters were being issued expressing appreciation for the staff's response both on the day and in the time after the incident. • Members asked what support was being offered to patients in terms of their psychological wellbeing following the impact. The harm panel would be focusing on the impact on their treatment, but would it address any potential patient trauma caused by the fire itself? The Chief Nurse confirmed that patients were being advised (through staff and on-site posters) that they could refer themselves for further support of this kind if it was needed. • Members were supportive of the strands of the investigation which were taking place, and asked to be kept updated on timescales and	

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	progress, particularly of the Avon Fire and Rescue Service investigation. **Members RESOLVED to:** • **Receive** the Major Incident Report for assurance.	
106/06/2018	**8. Quality and Performance Report**	
	Deputy Chief Operating Officer Shaun Carr presented the Quality and Performance Report, the purpose of which was for the Board to review the Trust's performance on Quality, Workforce and Access standards. He highlighted the following key points: It was noted that this was the first presentation of the report to the Board in its new format. Some guidance on the key changes had been shared with the Board; however there would be a more structured presentation on the changes at a future Board Seminar. The Trust was showing sustained improvement across the performance metrics, though it was noted that the BHOC incident (see **Item 7**) had had an impact on the 'green to go' position. The fire had also impacted on radiotherapy performance: an update on progress had therefore been shared with the Clinical Commissioning Group (CCG) and the regulators. There were continuing challenges to meeting the 4 hour A&E waiting time target, including vacancies in junior doctor and registrar posts putting pressure on the system. The additional capacity planned (see **Item 6**) would help the Trust protect cancer elective surgery during the winter period, so this should help with improvements against the cancer metric. The Deputy Chief Executive and Chief Operating Officer Mark Smith had been chairing Clinical Utilisation Review (CUR) workshops, which should help improve productivity. It was noted that progress was being made with support from Paula Clarke, Director of Strategy & Transformation and Mark Smith regarding closer integration between the Cardiac Intensive Care Unit and the General Intensive Care Unit that would support improved productivity, and there had been good progress on automatic sends for theatres, more detail on which would be reported to the Quality and Outcomes Committee (QoC). The Trust was also launching a virtual fracture clinic on 10 July 2018. The Chief Nurse noted that there was sustained performance on quality of care, and the new report style helped demonstrate where there were any significant variations in performance in-month: areas such as fractured neck of femur (NoF) were showing sustained improvement. The Board had previously been advised that gaps in safety data had	

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	been identified in the report, which would be resolved in the July 2018 report. The QOC had received the Q4 report on patient safety improvement, which had showed sustained improvement around meeting performance (e.g. in sepsis). Director of People Matt Joint noted that there was continued focus on essential training rates, which was taking up a lot of his team's time. Compliance with essential training was key, and the Trust was over the 90% compliance threshold, which was positive. This was a composite score of 13 measures, so there was now focus on those where there wasn't consistently high performance – such as Information Governance Training – where further efforts were needed. A report on staff turnover was due to come to QOC shortly, and interventions to address this needed careful consideration, including career opportunity and development options. Sickness rates were markedly down, at 3.3%. Members of the Board discussed the following: • Members agreed that the new report style was much clearer. They noted however that fractured NOF rates continued to be in the red on performance, which was a longstanding issue. A report would be coming to the August meeting of QOC drilling down on the NOF issue and interventions to improve performance. The Acting Medical Director was confident performance would continue to improve, and noted that the overall trend was upwards, despite a few 'blips'. The work around this was fitting into the broader delivery of silver trauma, and rethinking the Trust's delivery around trauma. The Trust had now recruited to the orthogeriatrican role previously vacant, and was working on a seven day basis in this area. It was also noted that the activity coming into the Trust in this area had increased, in part due to the overnight closure of Weston Area Health NHS Trust's A&E department. Members underlined that they were keen to understand the timeline expected for the figures on NOF to 'go green', and asked that QOC and the Board continued to receive regular updates on progress. **Members RESOLVED to:** • **Receive** the Quality and Performance Report for assurance.	
107/06/2018	**9. Quality and Outcomes Committee - Chair's Report**	
	Julian Dennis, Chair of the Quality and Outcomes Committee, introduced the report of the Committee from the 26 June 2018 meeting: Key points to note were: The Chair recommended the new style Quality and Performance Report as a step forward, particularly with the introduction of the statistical	

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	process control charts which enabled the Committee to see trends more clearly. The Serious Incident Report has also been refined and improved. The Committee had noted that the Trust had achieved 90% of the 4hr A&E waiting time target in May 2018, and were at 89% for the quarter. The Committee had been pleased to note that the harm panel commissioned to identify potential harm caused by the on-hold patient issue had not found any evidence of harm in any of the cases it had reviewed, which was positive news. The Committee had received a report on follow-up work to the National Staff Survey 2017, and had also discussed the effectiveness of staff appraisals as an important issue. The Committee had requested regular updates on progress from the Director of People Matt Joint. Members of the Board discussed the following: • It was noted that the Committee did actively explore areas around which the Board were expressing concern, including sepsis rates and fractured NOF. The Committee was trying to refocus its work to shift from looking retrospectively at outcomes to reviewing opportunities and planning. • The Chair of the Committee also noted that the Governors' Quality Forum had been extremely helpful in feeding back views and input from the Governors into the Committee. **Members RESOLVED** to: • **Receive** the Quality and Outcomes Committee Chair's report for Assurance.	
Organisational and System Strategy and Transformation		
108/06/2018	**10. Patient Experience and Complaints Report**	
	The Board received the following reports: a) Patient Experience Report – Q4 There was a sustained, continued high level of satisfaction, including through the 'Family and Friends' Test. There were a couple of exceptions to this which were being explored in depth in line with normal escalations processes: both related to staff satisfaction. It was noted that the Quality and Outcomes Committee (QOC) would also be focusing on the 'noise at night' issue at a future meeting.	

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	ai) National Maternity Survey Results It was one of the Trust's Quality Objectives to move from 'among the pack' to the top of the pack on maternity survey performance. b) Patient Complaints Report – Q4 It was noted that this had been covered by QOC, who had specifically asked for more detail on the SPORT report. Issues to be addressed included getting responses to patients and carers in good time, which was still work in progress, as well as work with dissatisfied complainants, which would remain a priority. c) Patient Complaints Annual Report - 2017/18 It was noted that this was a retrospective look of facts and figures from 2017/18, and this did not cover anything the Board had not previously reviewed. **Members RESOLVED to:** • **Receive** the Patient Experience Report for Quarter 4; • **Receive** the National Maternity Survey Results; • **Receive** Patient Complaints Report for Quarter 4; and • **Receive** the Patient Complaints Annual Report for 2017/18 for assurance.	
109/06/2018	**11. Safeguarding Annual Report**	
	Safeguarding Lead Carole Sorkin presented the Safeguarding Annual Report to the Board. Key points highlighted were: The Board had a statutory responsibility to have oversight of safeguarding of adults and children. A summary of key relevant risks was held on the Corporate Risk Register. A significant issue was that of the Children's Hospital operating as a place of safety for those with mental health issues: the Trust had had to deal with some very challenging issues over the last year. There had been lots of work with partners to try and resolve this, including improving the level of specialist training in the Children's hospital (a 90% rate of level 3 compliance had not yet been achieved), but there was also a national issue on the provision of beds for young people. Members of the Board discussed the following: • Members noted that there was quite a way to go before the Trust achieved 90% compliance with Level 3 training on Safeguarding. All staff received Level 2 training on joining the Trust, but the quick rotation of staff through divisions (e.g. of junior doctors) was a challenge to ensuring Level 3 compliance. Actions were being	

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	taken, including scrutinising non-compliance reports to understand reasons for and areas of non-compliance. **Members RESOLVED to:** • **Receive** the Safeguarding Annual Report for assurance.	
110/06/18	**12. Freedom to Speak Up Report**	
	The Trust Secretary presented the annual Freedom to Speak Up Report for 2017/18. Key issues included the following:` A Freedom to Speak Up Guardian (FTSU) had first been appointed in 2017, and there was now a new Non-Executive lead: Julian Dennis. The Executive Lead on FTSU was Director of People Matt Joint. There had been 13 cases raised through FTSU during 2017/18. A lot of work was ongoing to raise awareness of the purpose and profile of FTSU among staff, including banners, posters and word-of-mouth engagement. Importantly, there were now 20 FTSU advocates across the Trust who could advise and refer colleagues with concerns, and the aim was to have advocate cover across all areas of the Trust, which was a work in progress: the FTSU Guardian was currently working with the Medicine division to make sure there was coverage at South Bristol, for example. Among the concerns raised through the scheme, there was no specific focus on one particular location in the Trust, but it was notable that a theme of concerns covered the behaviours of managers and colleagues. The Guardian would also be working with bullying and harassment champions and union representatives to make sure FTSU work was connecting properly with these areas. All cases raised had been investigated and followed up, with support offered to those raising concerns. Those related to patient safety had been shared with the Chief Nurse and Acting Medical Director, and follow-up action taken. There was new national guidance for Boards which had been shared, and a new self-review tool available, which had been completed. The Staff Survey demonstrated that the Trust wasn't where it would like to be on issues such as 'I would feel secure raising concerns about clinical bad practice'; 'I feel confident concerns I raised would be responded to' and so on. The FTSU could help with this, but was only one of the ways to encourage staff to raise concerns and feel safe in doing so. A key objective for 2018/19 would be looking at what the strategy for Freedom to Speak Up should be for the Trust, including how it should link into the developing Trust Strategy. This issue would be considered	

Minute Ref	Item Number	Action
	at the next FTSU Advocates meeting in August 2018. Members of the Board discussed the following: • Members agreed this was a good report and FTSU was a vital area. Staff should feel able to raise concerns around issues, including clinical practice, without fear of repercussions. It was noted that part of the communications around the scheme was to do with making people aware of the protections available to them, and it was part of the Trust's cultural strategy to get the approach to people raising concerns right. The Chief Nurse noted that the patient safety culture assessment, last done three years previously, was going to be redone, and would have a focus on whether people feel enabled in raising patient safety concerns, and what might discourage them from raising concerns. **Members RESOLVED to:** • **Receive** the Freedom to Speak Up Annual Report for assurance • **Agreed** the self review outcome	
Financial Performance		
111/06/2018	**13. Finance Report**	
	Director of Finance and Information Paul Mapson introduced the Finance Report, the purpose of which was to inform the Board of the financial position of the Trust for May 2018. The financial position for the Trust was broadly on track, and slightly above trajectory, showing a £1.4million surplus. It assumed sustainability funding would be paid as the Trust had hit its core targets. There were some continued issues on nursing spend, partly driven by high costs around mental health, particularly in the Children's Hospital. Medical pay continued to be a difficulty: there had been £750million overspend on medical pay nationally across the sector last year, two thirds of which related to Junior Doctors and a third to consultants. There were some non-pay control issues to be explored, which would hopefully be reported on at the July 2018 meeting. The BHOC fire incident had led to a £0.5million loss of income, but more activity in cardiac meant there hadn't been an overall loss of income: this demonstrated how the hospital had managed to successfully maintain activity levels despite the incident. **Members RESOLVED to:** • **Receive** the Finance Report for assurance.	

Minute Ref	Item Number	Action
112/06/2018	**14. Finance Committee Chair's Report**	
	Non-Executive Director and Chair of the Finance Committee Martin Sykes introduced this report. He highlighted the following key points: The Committee had had a detailed look at the Trust's financial risks and were satisfied that they were correctly assessed. Members of the Board discussed the following: • Members asked for clarity on the basis for releasing reserves. It was noted that this varied according to the circumstances, with some decisions based on the previous year's outcomes, as funds could only be released in some areas when historical issues were finally resolved. The key judgements on this were made in Q1, and considered in more detail by the Finance Committee. **Members RESOLVED to:** • **Receive** the Finance Committee Chair's Report for assurance.	
Governance		
113/06/2018	**15. Audit Committee Chair's Report**	
	Chair of the Audit Committee David Armstrong noted that he had reported verbally on the Committee at the last Board meeting, and this written report was a formal record of this.	
114/06/2018	**16. Local Clinical Research Network (LCRN) West of England Annual Plan 2018/19 (hosted body report)**	
	Clinical Director Stephen Falk presented the Local Clinical Research Network (LCRN) West of England Annual Plan 2018/19 (hosted body report), the LCRN West of England Annual Report (hosted body report) and the National Institute for Health Research Host Agreement Variation to Contract to the Board (**Items 16 - 18**). Key items included the following: The project was initially from 2015 to 2018, and NHS Improvement had now asked for it to be extended until 2022 (which the Trust's Chief Executive had signed off on). The support the Network received from the Trust was excellent. The report outlined key objectives in terms of recruitment and stakeholder engagement. There was also thinking about broader NHS engagement, for example, there was work to collaborate with the third sector (Virgin, Bristol Community Health, etc.) and to engage with academic partners in Bristol and the wider South West.	

Minute Ref	Item Number	Action
	Members RESOLVED to: • **Receive** the NIHR CRN Annual Plan and Annual Report (hosted body report) for assurance.	
115/06/2018	**17.** LCRN, National Institute for Health Research Host Agreement Variation to Contract	
	Members RESOLVED to: • **Receive** the National Institute for Health Research Host Agreement Variation to Contract for assurance.	
116/06/2018	**18.** LCRN, West of England Annual Report (hosted body report)	
	Members RESOLVED to: • **Receive** the LCRN West of England Annual Report (hosted body report) for assurance.	
Items for Information		
117/06/2018	**19. Governors' Log of Communications**	
	• This item was received for **information**.	
Concluding Business		
118/06/2018	**20. Any Other Urgent Business**	
	Public Governor Carole Dacombe expressed concern about staff's apparent lack of confidence in the organisation to deal appropriately with issues raised via Freedom to Speak Up, and noted it would be important for staff to see positive outcomes arising from concerns raised to prove there was value in coming forward. The Board agreed that this was important, and it was noted that there were discussions with the regional network about whether examples of positive outcomes could be shared across the region and not just the Trust (in part to help protect confidentiality).	
119/06/2018	**21. Date and time of Next Meeting**	
	The date of the next meeting was confirmed as **11.00 – 13.00, 27 July 2018, Conference Room, THQ**	

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

Public Trust Board of Directors meeting
27 July 2018
Action tracker

Outstanding actions from the meeting held on 28 June 2018					
No.	**Minute reference**	**Detail of action required**	**Responsible officer**	**Completion date**	**Additional comments**
1.	62/04/18	**Quality and Performance Report** Chief Nurse Carolyn Mills to provide an update to the Board on Patient Safety Improvement at the end of the programme in September 2018. Acting Medical Director Mark Callaway to update Board on progress with establishing cohorting of the trauma and orthopaedic ward.	Chief Nurse Acting Medical Director	September 2018 July 2018	**Work in Progress** Update to be provided to the Board in September 2018 **Work in Progress** The Board received an update at the May Board. This was ongoing and a proposal would be provided to a Board meeting in the near future. - **Update June 2018:** a task and finish plan had been set up across the Medicine, Diagnostics & Therapies and Surgery Divisions. A business plan had been developed and would be reviewed shortly.
2.	08/01/18	**Quality and Performance Report** Acting Medical Director to share the annual report on the genomics project with the Board.	Acting Medical Director	July 2018	**Work in Progress** The Acting Medical Director would circulate the final report to the Board when available. - **Update June 2018:** The genomics project team had now produced a quarterly

					report. The Acting Medical Director Mark Callaway was liaising with Trust Secretary Eric Sanders to develop a more user friendly annual report to be shared with the Board, hopefully at the July 2018 meeting. - **Update July 2018: Genomic Report included on the July agenda under item 14.**
3.	101/06/2018	**Patient Story – June 2018** Chief Nurse to liaise with Lucas James to arrange a shadowing session for the Chair with her and her son Kai at an upcoming hospital appointment.	Chief Nurse	July 2018	**Work in Progress** Update to be provided at the July 2018 board meeting.
Closed actions from the meeting held on 28 June 2018					
No.	**Minute reference**	**Detail of action required**	**Responsible officer**	**Completion date**	**Additional comments**
1.	85/05/18	**Quality and Outcomes Committee Chair's Report May 2018** A greater level of assurance in relation to staff turnover was requested. The Board would be provided with information on the proportion of staff leaving the NHS entirely, proportion retiring early and the proportion moving on to other organisations.	Director of People	June 2018	**Complete** This action would be picked up through the Quality and Outcomes Committee and was now closed from the Board Action Log.

Cover report to the PublicTrust Board. Meeting to be held on 27 July 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**	Friday, 27 July 2018
Report Title	**Chief Executive's Report**		
Author	Robert Woolley, Chief Executive		
Executive Lead	Mark Smith, Chief Operating Officer/Deputy 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.	☐	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 July 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 – JULY 2018

1. INTRODUCTION

This report summarises the key business issues addressed by the Senior Leadership Team in July 2018

2. QUALITY, PERFORMANCE AND COMPLIANCE

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

The group **received** updates on the financial position for 2018/2019.

3. STRATEGY AND BUSINESS PLANNING

The group noted an update on the progress of the Primary Care Engagement process and **supported** the proposed next steps.

The group **supported** proposals for a Strategic Capital Investment Programme and associated Medium Term Financial Plan for the period 2018/2019 to 2022/23 prior to presentation to the Trust Board.

The group **approved** a proposal for the 2019/2021 prioritisation process for Operational capital, as part of the Trust's annual planning round, and **agreed** the requirement for further discussion on next steps for major medical equipment.

4. RISK, FINANCE AND GOVERNANCE

The group **received** the annual report on rota gaps for junior doctors and dentists in training from the Guardian of Safe Working, prior to submission to the Trust Board.

The group **noted** an overview of how the Trust was monitoring compliance with the Care Quality Commission standards and planning for future inspection readiness.

The group **noted** progress on the project and implementation plan for a rapid-time feedback system which would allow people to give feedback about their experiences electronically in real-time.

The group **received** the Quarter 1 Themed Serious Incident update report, prior to submission to the Quality and Outcomes Committee.

The group **received** the Quarter 1 Corporate Quality Objectives update report, prior to submission to the Quality and Outcomes Committee.

The group **approved** the Quarter 1 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 **approved** the stakeholder mapping tools which were presented in response to the internal audit around the Trust's approach to stakeholder management.

The group **received** three Internal Audit Reports with satisfactory assurance in relation to Well Led Review, Learning from Complaints and Information Management and Technology Service Desk and Engineers Response Times. An update on progress against agreed recommendations was also **received.**

The group **approved** revised Terms of Reference for the Cancer Board.

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

Reports from subsidiary management groups were **noted,** including an update on the current position following the transfer of Cellular Pathology to North Bristol NHS 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
July 2018

Cover report to the PublicTrust Board. Meeting to be held on 27 July 2018 at 11.00 – 13.00, Conference Room, Trust HQ, Marlborough St, Bristol, BS1 3NU

		Agenda Item	7
Report Title	Board Assurance Framework 2018-19 (Quarter 1)		
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

The Board Assurance Framework (BAF) forms part of the Trust's risk management framework and is the mechanism for reporting **strategic risks** - *risks to the achievement of the Trusts strategic objectives*.

The BAF provides assurance that risks to the achievement of the Trusts strategic objectives:

- Are identified and assessed
- Have mitigation; proportionate to the risk in place; and that there is assurance that this mitigation is adequate
- Have actions identified where required to further control or mitigate the risks

The BAF and Corporate Risk Register CRR are undergoing a review to ensure the BAF contains strategic risk and the CRR contains the high risk operational risks. All strategic risks are being moved onto Datix and will be assigned a unique identification number.

The following risks have been carried over from 2017/18:

- Principal Risk 1 - Risk that the Trust will be unable to maintain the quality of patient services.
  - There has been further development on the QIA implementation to support changes to service provision and External proposals and QIAs are now shared with commissioners for joint risk assessment as part of the operating plan process and has been reported to SLT, CoG and QOC.
  - The Recommendations in relation to the paediatric cardiac review was implemented and assurance report finalised in Q3 2017/18 - further assurance received via commissioned internal audits.
  - Additional gap identified around a lack of assurance around CAMHS patient's this is a system issue leaving the Trust unable to provide assurance that these patients are getting the "right" care.
  - Actions ongoing in regards to procurement of a real time patient feedback system and requirement to develop QIA process.
  - Impacting on Strategic priority 1: We will consistently deliver high quality individual care, delivered with compassion
  - **Chief Operating Officer**

- Principal Risk 2 - Risk that the Trust will be unable to develop and maintain the Trust estate due to lack of funding
  - Controls have been updated to reflect new financial year
  - Actions required have been updated to include that the Trusts Capital Group provides the interface between divisions, estates, IM&T, MEMO and partners in Bristol and Western Procurement Consortium.
  - And that Backlog Maintenance expenditure is reporting monthly through Trust Capital Group and Capital Programme Steering Group.
  - Gaps in controls are ongoing through evidence of slippage of the capital programme due to the inability of procurement to respond to programme requirements
  - Divisions continue to prioritise clinical procurement.
  - Impacting on Strategic priority 2: We will ensure a safe, friendly and modern environment for our patients and our staff
  - **Director of Finance**

- Principal Risk 3 - Risk that the Trust will be unable to recruit, train and sustain an engaged and effective workforce.
  - The Happy App has now been rolled out across the whole organisation and reports based on the data will be analysed at Divisional Reviews.
  - First & second line assurance around reporting arrangements and agency action plan remain in place.
  - Additional action relating to E-appraisal system issues.
  - Impacting on Strategic priority 3: We will strive to employ the best staff and help all our staff fulfil their individual potential
  - **Director of People**

- Principal Risk 4 - Risk that the Trust will not be able to support transformation and innovation.
  - During 16/17 a review of the approach to supporting innovation across the Trust was completed and an Approved Innovation & Improvement Strategic Framework is now in place.
  - Digital Transformation included as a key priority within Transformation programme for 2018/19.
  - Second line assurances in place but gaps remain around supporting innovation and improvement, to be addressed by implementation of Innovation Strategy.

- Impacting on Strategic priority 4: We will deliver pioneering and efficient practice, putting ourselves at the leading edge of research, innovation and transformation.
- **Director of Strategy & Transformation**

➢ Principal Risk 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.

- The new Strategic Planning Governance Process has now been implemented as an additional method of assurance
- Controls have been updated to include: Executive involvement in Primary and Secondary Care Interface Group and some of the GP Locality Boards. Workshop held March 2018 with 6 GP Locality Boards. And development of 2025 Vision for Trust Strategy with engagement of partners.
- Reflection of partnership working is included in draft strategic priorities and objectives for 2025 has been added as a form of assurance, as has Internal audit review of stakeholder management and development of a new and standard approach to stakeholder management.
- There has been an internal audit and the recommendations have been implemented.(PC)
- A short term gap in controls was noted to be that the Approach to stakeholder management needs to be approved by SLT July 2018 (PC)
- Impacting on Strategic priority 5: We will provide leadership to the networks we are part of, for the benefit of the region and people we serve.
- **Director of Strategy & Transformation**

➢ Principal Risk 6 - Risk of being unable to deliver the financial strategy

- Controls updated to reflect new financial year
- Second line assurance in place via internal reporting and divisional reporting arrangements, weak controls and gaps in assurance identified.
- Impacting on 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.
- **Director of Finance & Information**

➢ Principal Risk 7 - Risk of failing to comply with targets, statutory duties and functions

- Work continues to address the gaps around the preparation for the implementation of European General Data Protection Regulation.
- Ongoing limited assurance around the 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.
- Impacting on Strategic priority 7: We will ensure we are soundly governed and are compliant with the requirements of our regulators
- **Chief Executive**

Summary

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

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

Recommendations
Members are asked to: • **Review** the information on existing risks

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**
28/03/2018	03/04/2018	18/04/2018	20/04/2018	24/04/2018	26/04/2018

University Hospitals Bristol
NHS Foundation Trust

BOARD ASSURANCE FRAMEWORK

Q1 2018-19

1. Strategic 5 Year Plan

The Board Assurance Framework (BAF) forms part of the Trust's risk management framework and is the mechanism for reporting **strategic risks** - *risks to the achievement of the Trusts strategic objectives* that will deliver the strategic 5 year plan.

The Board has overall responsibility for ensuring systems and controls are in place and 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. Strategic Objectives

Strategic Objectives are the long-term organisational goals that help to convert a mission statement from a broad vision into more specific plans and projects.

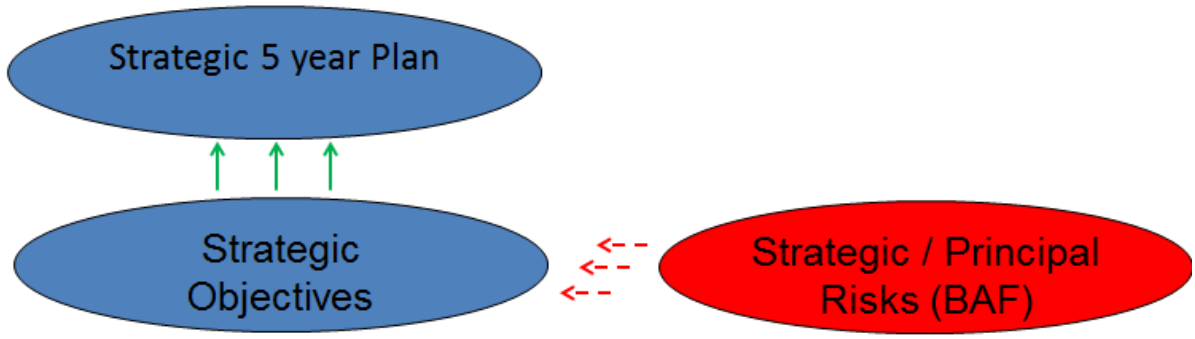
The current 5 year plan outlines seven strategic priorities, structured according to the characteristic of our Trust Vision outlined above. Our strategic priorities are:

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.

3. Strategic (Principal) Risks

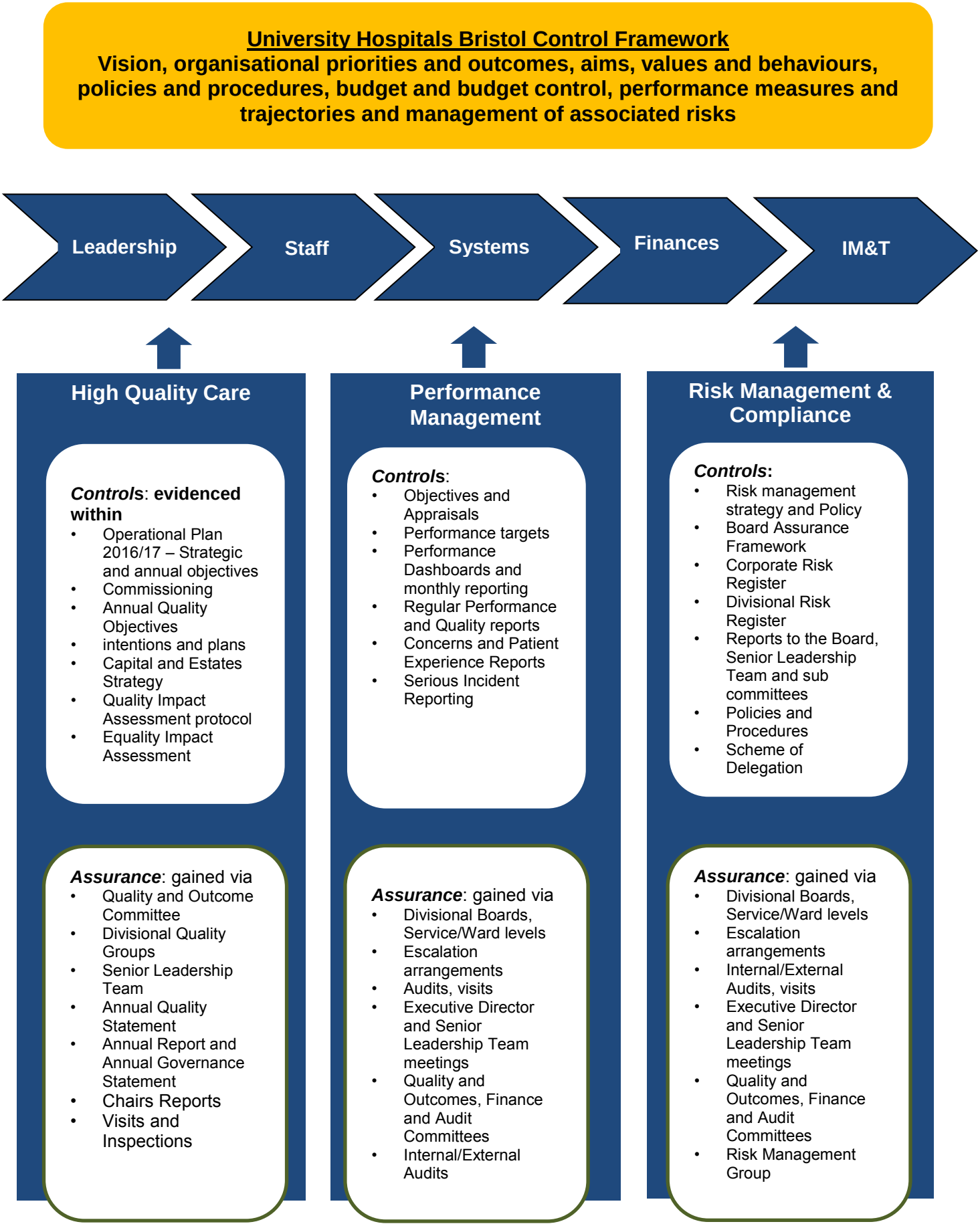
Strategic risks are the events and uncertainties, affected by internal and external events or scenarios that could impede the organisation's ability to achieve its strategic objectives, and its overarching long term strategy.

These risks could force the organisation to change its future strategic direction.



4. Controls Framework

The following diagram describes controls in place and how assurance is gained that they are in place and having the desired effect.



5. Approach to Risk Assessment

Risks are assessed using a 5x5 matrix of likelihood of risk and the severity of its consequences.

	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

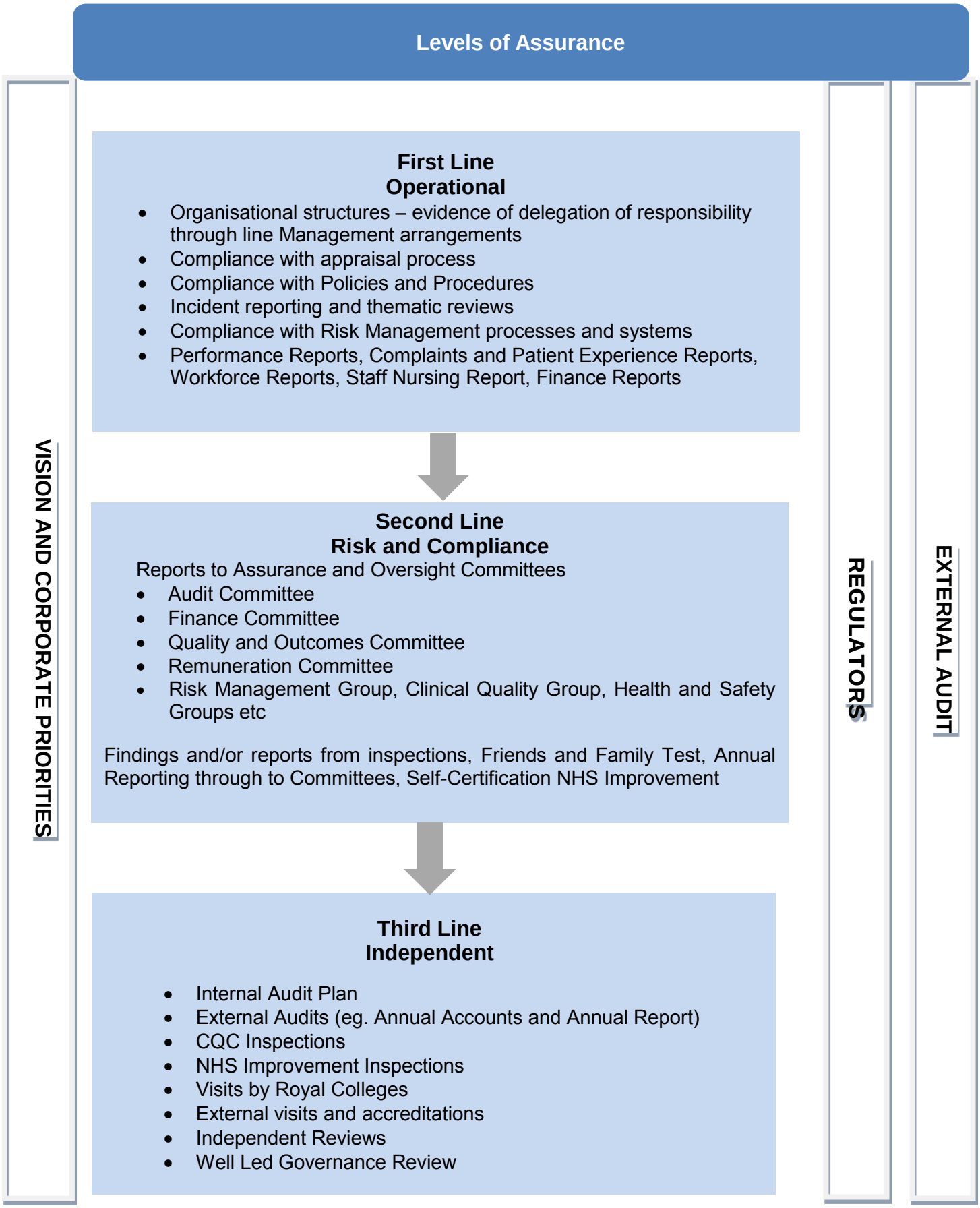
6. Principal Risks

The following risks have been carried over from 2017/18:

Principal Risk	Q1 2017/18	Q2 2017/18	Q3 2017/18	Q4 2017/18	Q1 2018/19
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**	Possible x Moderate **= 9**
2. Risk that the Trust will be unable to develop and maintain the Trust estate	Unlikely x Major **= 8**	Likely x Moderate = **12**	Likely x Moderate = **12**	Likely x Moderate = **12**	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**	Possible x Major **= 12**
4. Risk that the Trust will not be able to support transformation and innovation.	Possible x Moderate **= 9**	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	Unlikely x Moderate **= 6**	Unlikely x Moderate **= 6**	Unlikely x Moderate **= 6**	Unlikely x Moderate **= 6**	Unlikely x Moderate **= 6**
6. Risk of being unable to deliver the financial plan	Possible x Moderate **= 9**	Almost Certain x Catastrophic = **25**	Likely x Catastrophic = **20**	Unlikely x Moderate **= 6**	Unlikely x Moderate **= 6**
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**	Possible x Moderate **= 9**

7. Risk Assurance

The Following '3 lines of defence' model provides examples of types of levels of assurance.



8. 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	

*the Risk Management strategy for 2019 will require risk appetites to be assigned to each strategic priority

9. Key

- The Assurance Framework has the following headings:
- *Principal Risk* - Events that 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 existing controls and assurances adequately mitigating the risk
- *Assurance Committee* - The committee of the Trust Board that seeks assurance on the adequacy of controls of strategic risk through its work program.

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

Executive Lead - Chief Nurse & Chief Operating Officer **Assuring Committee -** Quality and Outcomes 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 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 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 management of an internal Urgent Care Plan which will be overseen by the Urgent Care Steering Group Professional Standards and Code of Practice/Clinical Supervision. Quality Impact Assessment (QIA) process for savings schemes meeting specific criteria for internal and external investment proposals and to support decisions not to invest. Monitoring of Performance via: • Divisional Access performance scorecards • Divisional Monthly Reviews with Executive Team and Specific subgroups Emergency Planning Resilience and Response in place. 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 / Cancer Performance Group • Cancer PTL Meetings • Cancer Steering Group • Urgent Care Operational 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 and assurance received commissioned internal audits. Business Continuity and Emergency planning arrangements reporting to Civil Contingencies Steering Group	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 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.	Lack of assurance around c/o CAMHS patients as per corporate risk 856 this is a system issue that leaves the Trust unable to provide assurance that these patients are getting the "right" care.	Procurement of a real-time patient feedback system. External proposals and QIAs shared with commissioners for joint risk assessment.	Moderate x Possible = 9	⟷

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

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 2018/19 capital programme, including the prioritisation and allocation of strategic capital. Delivery of the 2018/19 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. It provides the interface between divisions, estates, IM&T, MEMO and partners in Bristol and Western Procurement Consortium. Clinical Divisions have prioritised their clinical procurement priorities with the procurement team. Backlog Maintenance expenditure reporting monthly through Trust Capital Group and Capital Programme Steering 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

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. Delivery of the People Strategy Quality objective for staff engagement which is 4.0 by 2020 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 to monitor compliance. Divisional reviews include performance against workforce plans and HR KPI's to improve staff experience. Reporting of Occupational Health KPI's E- Appraisal launched in May 2017 along with a new policy and revised training. Workplace Health and Wellbeing delivery plan in place to deliver the NHS Staff Health and Wellbeing CQUIN The annual staff survey supported by the quarterly Staff Friends and Family Test. Happy App to measure real time staff feedback across more than 150 teams Leadership Behaviours continue to be embedded in our recruitment, Induction and all management and leadership development.	Metrics in relation to key controls are reviewed by the Senior Leadership Team, QOC and Trust Board: Improving staff experience plans are in place, targeting hotspot areas with bespoke interventions to improve staff engagement. Monthly essential training compliance data are provided to divisions, with focus now on the nationally-recognised 11 Core Skills. Compliance for wider training which the Trust considers Essential (mandatory) continues to be reported. Increased quality of appraisal from 3.08 in 2016 to 3.11 in 2017 Staff Survey. Work continues to improve system issues and user confidence. Reporting of results on achievement of staff wellbeing CQUIN Staff engagement has increased for the 4th consecutive year to 3.85. Friends and family test is now a targeted department approach in response to the heat map data. Happy app reporting has been further developed and this will be embedded into Divisional performance reviews as of August 2018 Leadership behaviours being used in psychometric assessment as part of the Executive Leadership Development programme being launched in September 2018 Externally accredited Health & Safety audit and Workplace Wellbeing Charter. Annual learning and development report. Weekly returns reflecting agency staffing activity. Agency action plan. Reports to Agency Controls Group Health & Safety Reports to Trust Health, Safety and Fire Committee and Risk Management Group.	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 • Trust Partnership forum 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, moving into the People Strategy	End of quarter reporting reflects achievement of 90% overall compliance. Only 4 of the 11 Core Skills programmes have not yet achieved their individual compliance targets of at least 90%, but all are in the 80 percentile range. Limited assurance around levels of staff retention.	Director of People has been identified as the Board Wellbeing Champion Refresh of the Workforce and OD Strategy through the formalisation of the People Strategy. Mid-year review of workforce KPIs to understand forecast out turn. Report Happy App to Divisional Reviews There have been significant system issues with the E-Appraisal system which has affected user confidence and compliance reporting	**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.

Executive Lead - Medical Director & Director of Strategy 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. Approved Innovation & Improvement Strategic Framework in place. 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 , Quality Improvement Hub and QI annual forum and achievement of local / national awards etc. Audit and inspections. Transformation reports to the Trust Board and annual Trust Board Seminar focus on Innovation & Improvement and QI Hub. 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. Digital Transformation a key priority within Transformation programme from 2018/19. 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, • Senior Leadership Team • Transformation Board • IT Management Group • Divisional Groups • 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 Direct reporting of the benefits realisation from the implementation and use of digital technology.	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 on the 1st April 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 Exemplar initiatives and embedding as an integral part of the Trust's business and benefits realisation reporting.	**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.

Executive Lead - Director of Strategy 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 and pursue potential for organisational merger. 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 joint lead for Healthier Together STP with other Executives playing lead roles Range of senior staff involvement in Healthy Weston programme. Staff involved in wide range of external activities e.g. Bristol Health Partners, Better Care Bristol, CLAHRC West, BNSSG System Delivery Oversight Group. Strategic Planning Governance Process Development of internal STP Leads meeting to improve visibility of staff engagement in external activities, reporting into Strategy Steering Group Executive involvement in Primary and Secondary Care Interface Group and some of the GP Locality Boards. Workshop held March 2018 with 6 GP Locality Boards. Development of 2025 Vision for Trust Strategy with engagement of partners.	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 National feedback on Sustainability and Transformation Plan processes and leadership. Bristol NIHR Biomedical Research Centre successful partnership. Executive leadership roles in system Task and Finish Groups. Establishment of UHB System leaders group. Internal audit review of stakeholder management and development of a new and standard approach to stakeholder management. Reflection of partnership working in draft strategic priorities and objectives for 2025.	Internal reviews and monitoring form first line assurance. Reports to: • Trust Board, Form second line assurance. External audit recommendations implemented.	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. Further development of 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 savings control centres and Task and Finish groups. Primary and community business development approach being further developed 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

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 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) achieved for 2017/18. 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 2018/19 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 the 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 It provides the interface between divisions, estates, IM&T, MEMO and partners in Bristol and Western Procurement Consortium.	**Moderate x Unlikely = 6**	⟷

STRATEGIC PRIORITY 7 :	**We will ensure we are soundly governed and are compliant with the requirements of our regulators**							
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. **1009** - Risk that patients may fail to receive timely treatment due to being 'On hold' **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**	**416 -** Risk that the Trust's Financial Strategy may not be deliverable (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.**	No corporate risks identified.	**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 financial plan.**	**416 -** Risk that the Trust's Financial Strategy may not be deliverable **951** - Risk of the loss of Provider Sustainability Funding (PSF) **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 Operational Plan Control Total surplus	**6** **Moderate**
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 PublicTrust Board. Meeting to be held on 27 July 2018 at 11.00 – 13.00, Conference Room, Trust HQ, Marlborough St, Bristol, BS1 3NU

		Agenda Item	8
Meeting Title	Public Trust Board	**Meeting Date**	Friday, 27 July 2018
Report Title	**Quality and Performance Report**		
Author	James Rabbitts, Head of Performance Reporting Anne Reader, Head of Quality (Patient Safety) Deborah Tunnell, Associate Director of HR Operations		
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		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> 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 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)**
		25th July 2018		

University Hospitals Bristol
NHS Foundation Trust

Quality and Performance Report

July 2018

1.1 OVERVIEW – Executive Summary

Single Oversight Framework

- The 62 Day Cancer standard for GP referrals achieved 82.4% for May. This is below the national standard of 85% and is below the improvement trajectory target of 83%. Quarter 1 is at 83.2% which is above the quarter 1 improvement trajectory of 82.5%
- The measure for percentage of A&E patients seen in less than 4 hours was 92.8% for June. This did not achieve the 95% national standard but is above the improvement trajectory target of 90%. The Children's Hospital has sustained its consistently good performance and exceeded the 95% standard in June, at 96.3%. The Bristol Royal Infirmary performance had risen to 89.1% in May.
    - Quarter 1 A&E data was 89.3% at Trust level. NHS England adds in data from local Walk In Centres for each acute Trust, as an "Acute Trust Footprint" measure. This data gives a quarter 1 performance of 92.1%.
- The percentage of Referral To Treatment (RTT) patients waiting under 18 weeks was 88.6% as at end of June. This did not achieve the national 92% standard. The improvement trajectory target for this measure has been set at 88.5% so this was achieved. The Trust was 1016 patients away from the national compliance of 92%.
- The percentage of Diagnostic patients waiting under 6 weeks at end of June was 97.8%, with 198 patients waiting 6+ weeks. This is lower than the national 99% standard, but the improvement trajectory was set at a maximum of 190 breaches, so this was narrowly missed. The maximum allowed breaches to achieve 99% was 92.

Headline Indicators

There have been two MRSA trust-apportioned cases so far this year. Following review, no significant lapses in care were identified for the first case. For the second case, additional staff training regarding documentation, sample management and Infection Prevention and Control principles has been implemented. There were six cases of *C. Difficile* identified in June 2018 that require review with our commissioners before determining if any of these are Trust apportioned.

Performance against patient falls; hospital acquired pressure ulcers and patient experience remain consistently above target.

Last Minute Cancelled (LMC) Operation performance was below the threshold of 0.8% of admissions, with 39 such cancellations in June, which equated to 0.6% of admissions. Also the 28 day readmission standard of 95% was not achieved in May, with 12 patients not re-admitted within 28 days.

There has been a significant reduction in overdue follow-ups in Outpatients, with divisions undertaking review, validation and actioning of Outpatients who are overdue by more than 12 months. Did Not Attend (DNA) and hospital cancellation rates have shown sustained improvement in June.

Workforce

Percentage agency usage is slightly above target at 1.0%, an increase of 13.0 full time equivalents (fte).
Overall vacancies increased to 5.4% compared to 5.3% in the previous month. The biggest reduction in this area was seen in Facilities and Estates where Ancillary staff vacancies reduced to 80.3 FTE from 83.1 FTE the previous month. The overall medical vacancy position increased to 15.2 FTE from 1.7 FTE the previous month.

Turnover reduced to 14.1% from 14.2% last month. The largest increase in staff group was seen in Add Prof Scientific and Technical (0.3 percentage points). The biggest reduction in staff group was seen in Allied Health Professionals (0.7% percentage points).

Staff Sickness absence increased from 3.3% to 3.5%, with increases in four Divisions. Medicine saw the largest increase to 4.1% from 3.7% the previous month. Stress/Anxiety continues to be the cause for the most of amount of sickness days lost

June 2018 compliance for Core Skills (mandatory/statutory) training increased to 90% overall across the eleven core skills programmes, with no reductions in compliance in any of the eleven core skills programmes, four of which increased.

1.2 OVERVIEW – Single Oversight Framework

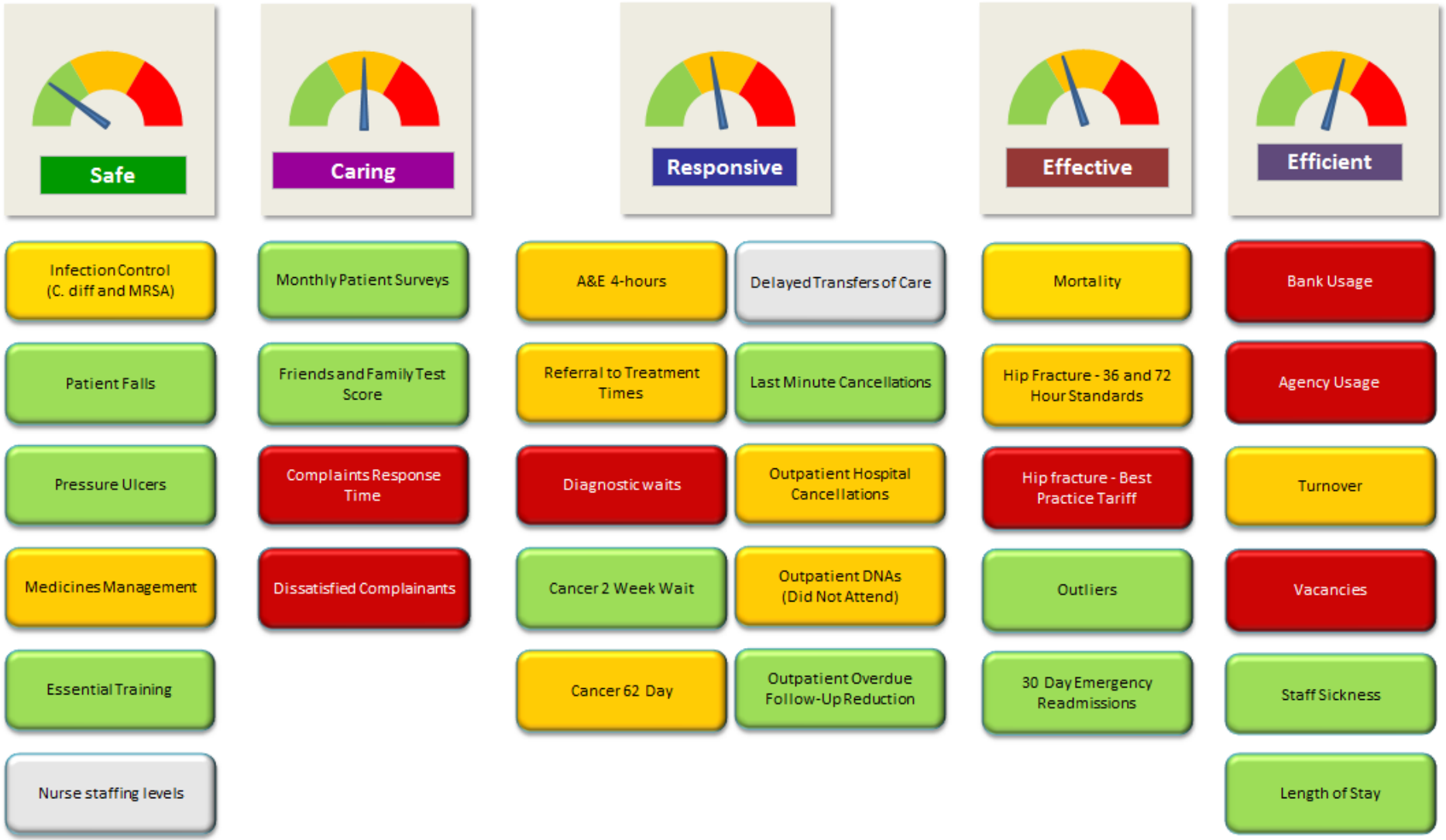
Access Key Performance Indicator		Quarter 1 2018/19			Quarter 2 2018/19			Quarter 3 2018/19			Quarter 4 2018/19		
		Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19
A&E 4-hours Standard: 95%	Actual	84.0%	91.1%	92.8%									
	Trust "Footprint"	92.05%											
	Trajectory	90%	90%	90%	90.53%	91.26%	90.84%	90.06%	90.33%	87%	84%	87%	90%
Cancer 62-day GP Standard: 85%	Actual (Monthly)	84.1%	82.4%										
	Actual (Quarterly)												
	Trajectory (Monthly)	81%	83%	79%	83%	85%	85%	85%	85%	85%	85%	85%	85%
	Trajectory(Quarterly)	82.5%			85%			85%			85%		
Referral to Treatment Standard: 92%	Actual	88.2%	89.1%	88.6%									
	Trajectory	88%	88%	88.5%	88.5%	88.7%	88.5%	88.5%	88.0%	87.0%	86.0%	87.0%	87.0%
6-week wait diagnostic Standard: 99%	Actual	96.8%	97.6%	97.8%									
	Trajectory	97.9%	97.9%	97.9%	98.4%	99.0%	99.0%	99.0%	99.0%	99.0%	99.0%	99.0%	99.0%

GREEN rating = national standard achieved
AMBER rating = national standard not achieved, but STF trajectory achieved
RED rating = national standard not achieved, the STF trajectory not achieved

Note on A&E 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 and 4. The above table shows the Trust achieved the required level, after apportionment, in Quarter 3 but not in Quarter 4.

1.3 OVERVIEW – Key Performance Indicators Summary

Below is a summary of all the Key Performance Indicators reported in Section 2.



1.4 OVERVIEW – Successes, Priorities, Opportunities, Risk & Threats

	Successes	Priorities
ACCESS Emergency	• 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 92.1% for Quarter 1 and so achieved the Sustainability & Transformation Funds (STF) target of 90%. Performance without this apportionment was 89.3%. • Performance for June was 92.8%. • The Children's Hospital continues to meet the STF trajectory for 4hr performance	• Sustain A&E 4 hour performance particularly at the Bristol Royal Hospital for Children where increased growth in attendances has been seen.
ACCESS Cancer	• Discounting the direct impact of the BHOC fire, May 62 day GP performance would have exceeded the recovery trajectory and likely achieved the national standard • On track to achieve 62 day GP recovery trajectory • Introduced new cancer performance management framework with greater focus on outcomes and better integration with management of other Trust access standards • Two week wait first appointment standard for quarter 1 achieved despite 21% more demand than forecast (mostly dermatology)	• Recovery of the national threshold for the 62 day GP standard (85%) by August 2018 and sustaining this thereafter • Recovery of the subsequent radiotherapy and chemotherapy standards by end of quarter 2 following the oncology centre fire • Sustaining the first appointment target, working towards achieving internal stretch targets to further decrease the length of this part of the pathway • Ensuring all processes are in place to report against the amended national rules for allocating performance between providers (in place from October 2018)
	Opportunities	**Risks and Threats**
ACCESS Emergency	• Increasingly embedding Clinical Utilisation Review into patient flow meetings to improve real-time information and action. • Increased focus on delayed patients across adult services, with weekly review led by Divisional Directors. • Refreshed plan around DTOC in place, with delivery expected from BCC social care in June of changes to care home tendering re-ablement provision and home care services. • Continued delivery against plan and maximise capacity for change across the summer period.	• Sustained performance, particularly evening pressure points in adult services and growth in children's
ACCESS Cancer	• New performance management structure designed to improve the speed and success of operational action completion and encourage 'getting it right first time' (by booking activity in the right timescale first time – more convenient for patients and frees up staff time to focus on other work to improve patient pathways) • New national rules for allocation of performance between providers could reduce the impact of late referrals on the Trust's performance, and provides new impetus to encourage engagement in pathway improvement from other providers	• Capacity challenges in some areas – notably chemotherapy provision (due to high levels of nursing absence) and gynaecology surgery (due to 50% increase in demand in May and June from average) • Impact of surgical cancellations are a risk if these recur at high levels (currently not) • New national performance allocation rules greatly increase administrative burden on staff without directly changing patient pathways • Rapidly rising demand in several areas (including gynaecology and dermatology) puts services under strain

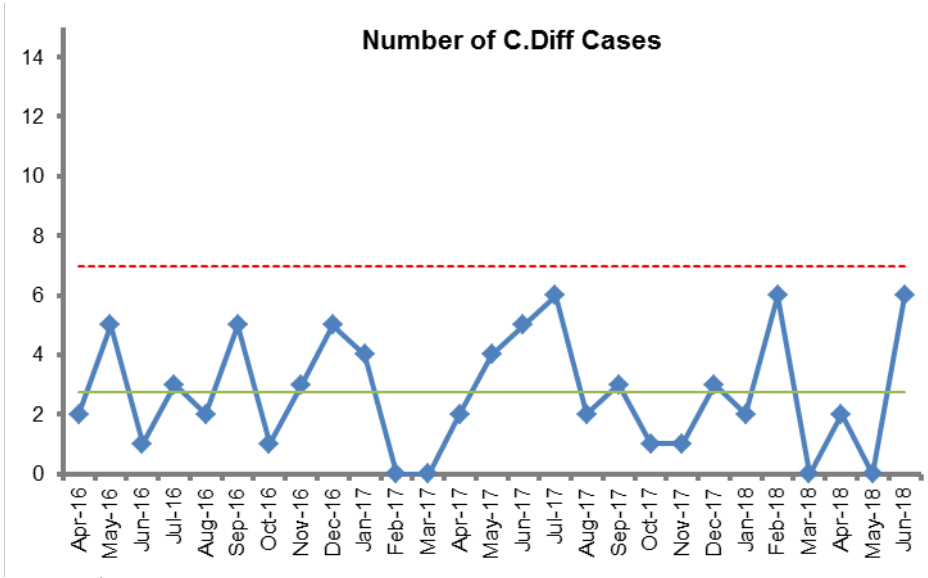
1.4 OVERVIEW – Successes, Priorities, Opportunities, Risk & Threats

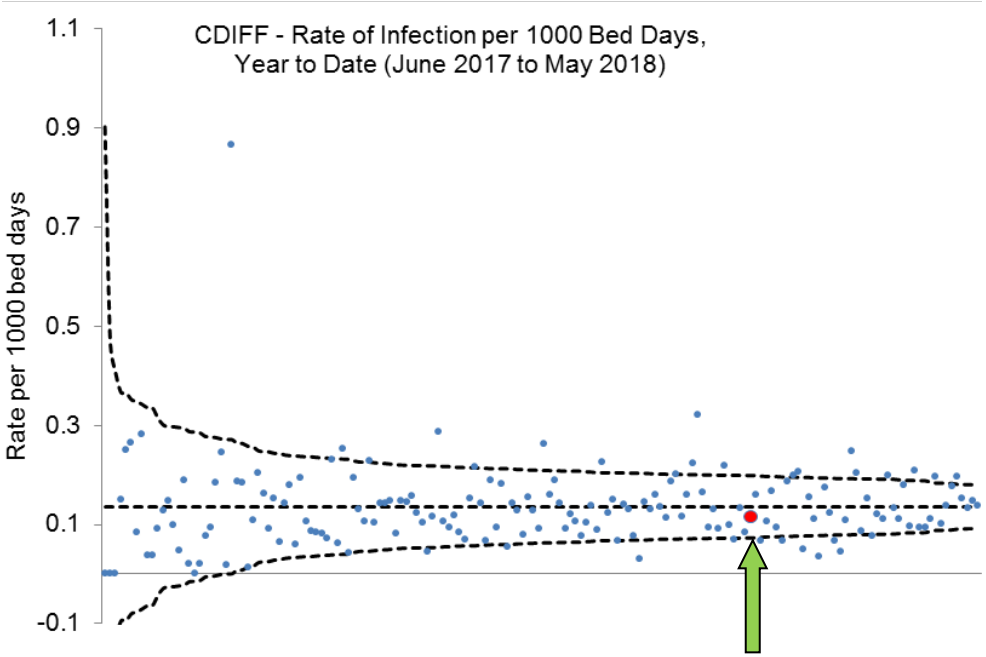
	Successes	Priorities
ACCESS Planned Care	• The Trust continues to achieve RTT performance at month-end above the set trajectory of 88% • Last Minute Cancelled Operations were below the national standard of 0.8% of admissions. There were 39 last minute cancellations in June. • New functionality in our Patient Administration System (PAS) allows better management of on-hold status flags by removing the previous on hold flag when the next activity has been undertaken. This does not mitigate the risk of on hold patients added to Medway. • As a result of this new functionality, we are beginning to see reductions in the volume of on hold pathways being added, which is a major step forward. • The sampling process for all cohorts identified as part of the "on hold "project has now been completed, to either full validation, or to the expected 95% standard identified by the IST. Aside from one cohort, all cohorts passed the 95% standard and no next steps in the pathway missed. • Following a tele-conference call with IST on 2nd July and the results of the sampling process the recommendation was that block closure of the on-hold flags can be undertaken on 10 of the 23 cohorts. Further analysis is now required to be undertaken on the remaining 13 cohorts as although the 95% standard was met, the recommendation from IST is that we assess the risk of 'missed' steps in the pathway prior to further sign off and block closure.	• Continue to hold steady state on Referral To Treatment (RTT) performance • Focus continues on clearing off long waiting breaches and RTT backlog to achieve ZERO over 52 week waiters by end of July reporting position particularly in Pediatric Services and Dentistry services (Zero long waiters excludes those who exercise patient choice and patients associated with the on-hold long project). • IST recommendations have resulted in all long waiting patients reported at each month end are sent to the harm panel for review. This is a monthly process associated to any patients who are at 52+-week waiting • Deliver the Diagnostic Target of 99% of patients waiting under 6 weeks, by end of August. • Ensure a reduction in the number of 28 Day Readmission breaches for last-minute cancelled operations. Commissioner agreed plan of no more than 45 breaches for the year.
	Opportunities	**Risks and Threats**
ACCESS Planned Care	• The review of the local Access Policy has commenced, our comments have been sent back to the commissioners. We are working towards a first draft at the end of August 2018. • Further enhancements to the PTL (patient tracking list) for waiting patients continue based on feedback from the IST. The final result is for the Trust to have one PTL that is Trustwide and includes RTT patients, non-RTT patients, planned patients, Cancer patients and those waiting for a diagnostic test. We will review progress made with the IST on 24th July.	• 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 our Patient Administration System allows better management of 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. • At end of May there were 12 Referral to Treatment (RTT) patients waiting 52+ weeks, seven of which have already been treated, four have been dated and one has declined the dates offered at this stage in the process. • Capacity issues in Cardiac diagnostics threatens delivery of the 6 week wait Diagnostic standard.

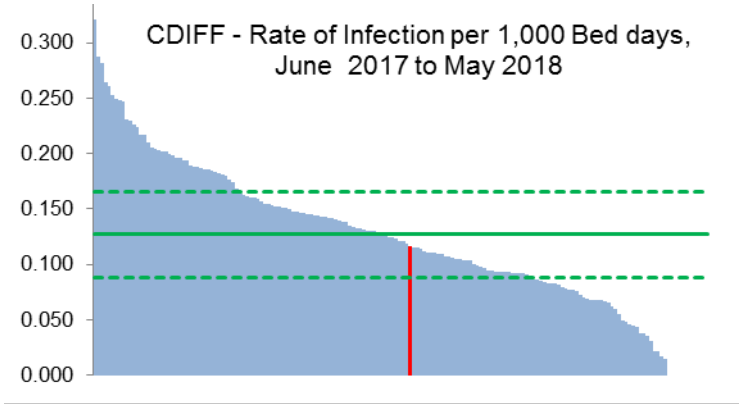
1.4 OVERVIEW – Successes, Priorities, Opportunities, Risk & Threats

	Successes	Priorities
QUALITY	• Sustained improvement in the ortho-geriatrcian review of patients with fractured neck of femur over the past four months • Continuing reduction since January to zero in May in patients readmitted as an emergency within 30 days of discharge from hospital	• To reduce the number of cases of MRSA both by focussing on internal actions to address learning points from investigations of cases, but also in the longer term working with our system partners towards a reduction in MRSA incidence across the city. • Close monitoring of Summary Hospital Mortality Indicator, although currently in the "as expected" category. • Work to restore the coverage of the maternity friends and family test to above 15%.
WORKFORCE	• E-learning on the Supporting Attendance policy is now fully live and available on the learning portal. • 47 workplace wellbeing advocates (voluntary role) recruited from multi-disciplinary teams across the Trust to extend communications on preventative and targeted wellbeing interventions. • High cost non-framework agency now signed up to operate through the neutral vendor model for nursing allowing a single report of all agency activity and spend. • Further improvement in exit questionnaire response rate to 57% against a target of 50%. • Development of the Civic Welcome Pack for the doctor's induction in August.	• Addressing smoking hot spots and common causes of complaints ahead of the Trust gaining smoke free status. • Efficient and streamlined recruitment and induction for the Medical and Dental August changeover. • Recruitment to the E-rostering implementation team to enable e-rostering & e-job planning data collection to commence ahead of the rollout of Allocate. • A national reduction in the sign-off limit for high cost agency bank and agency shifts from £120ph to £100ph, to further increase controls around high costing shift activity. • With an identified fix to the e-appraisal system, focus on increasing user confidence to ensure appraisals are appropriately recorded and an improvement in compliance reporting is realised.
	Opportunities	**Risks and Threats**
QUALITY	• To develop medicines safety measurement as the Electronic Prescribing and Administration System is implemented over the medium to long term. • To improve assessment and management of patients with VTE now that a new medical VTE lead has been appointed.	
WORKFORCE	• NHS Improvement began working in partnership with the Trust with the 'Reducing Sickness Absence Direct Support Programme' in relation to health and wellbeing. • With a further increase in exit data from leavers, report redesign is underway to improve the quality of data provided to Divisions to better understand why staff are leaving the organisation. • Ongoing partnership with North Bristol Trust with a joint focus on the streamlining of mandatory/statutory training, transfer of training records, efficiencies with staff access to the Employee Staff Record (ESR) and eLearning at induction. • Development of a wellbeing website.	• Continued operational pressure could further increase high cost agency use. • Divisional engagement with exception reporting for junior doctors continues to be a challenge. Furthermore, due to software configuration there are difficulties with producing reports to support Divisions in identifying trends and issues.

Infections – Clostridium Difficile (C.Diff)	
Standards:	Number of Trust Apportioned C.Diff cases to be below the national trajectory of 44 cases for 2018/19. Review of these cases with commissioners' alternate months to identify if there was a "lapse in care".
Performance:	There were six C.Diff cases in June 2018, making eight cases year-to-date. The review of whether there are any "lapses in care" is not yet completed; they require clinical review with commissioners.
Commentary:	The Trust performed well in this area in 2017/8 and in the 12 months June 2017 to May 2018 the rate of *C. Difficile* Infection per 1,000 bed days is low, remaining below the benchmark value. There were six cases of *C. Difficile* identified in June 2018 that require review with our commissioners before determining if any of these are Trust apportioned. Once reviewed in August, if any are deemed attributable to the Trust then any outstanding appropriate actions will be implemented.
Ownership:	Chief Nurse





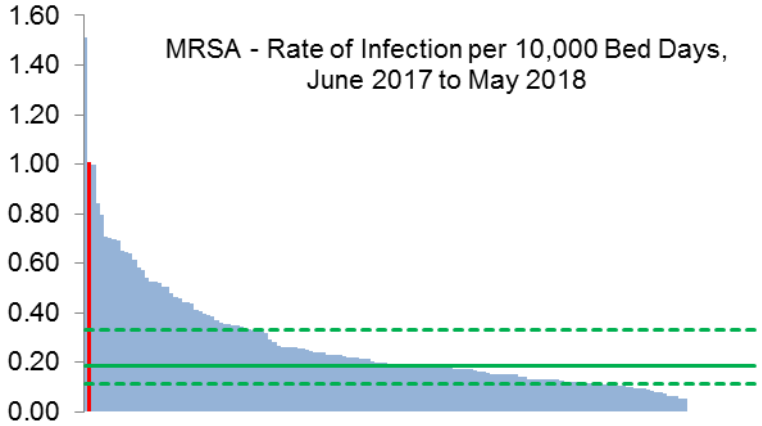


Unbroken horizontal line is England median; dotted lines are upper & lower quartiles

CDIFF Cases	Jun-18	2018/2019
Medicine	1	1
Specialised Services	3	3
Surgery	1	2
Women's and Children's	1	2
Grand Total	0	8

Infections – Methicillin-Resistant Staphylococcus Aureus (MRSA)	
Standards:	No Trust Apportioned MRSA cases.
Performance:	There were two trust-apportioned MRSA case in June, making three cases year-to-date.
Commentary:	There were two Trust apportioned cases of MRSA in June 2018. Following review, no significant lapses in care were identified for the first case and no learning identified. For the second case, additional staff training regarding documentation, sample management and Infection Prevention and Control principles has been implemented.
Ownership:	Chief Nurse

MRSA	Jun-18	2018/2019
Medicine	1	2
Specialised Services	0	0
Surgery	1	1
Women's and Children's	0	0
Grand Total	2	3



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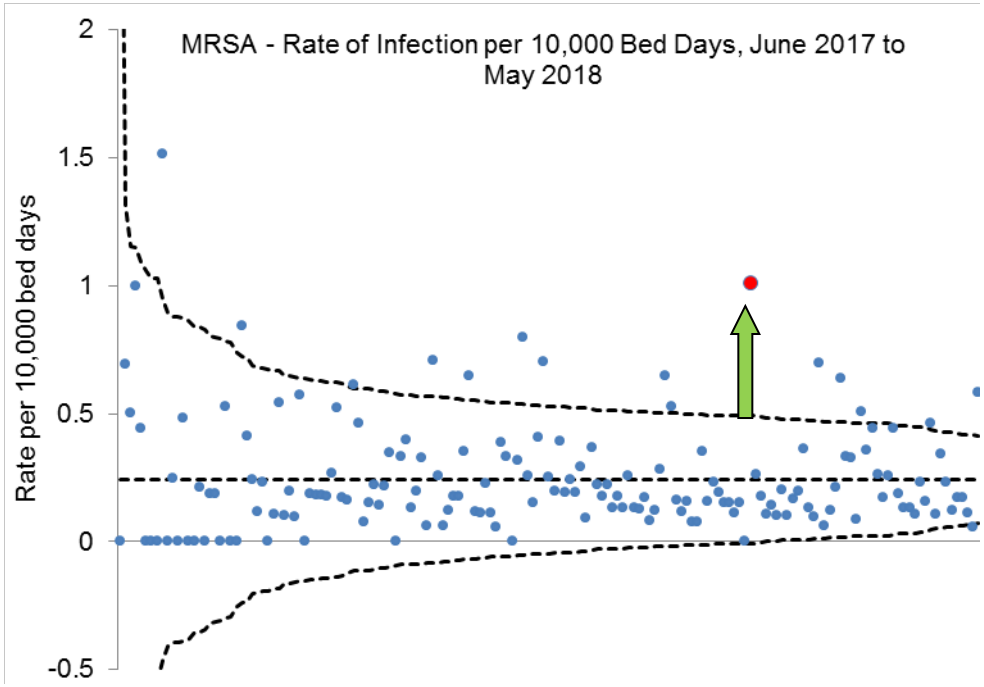
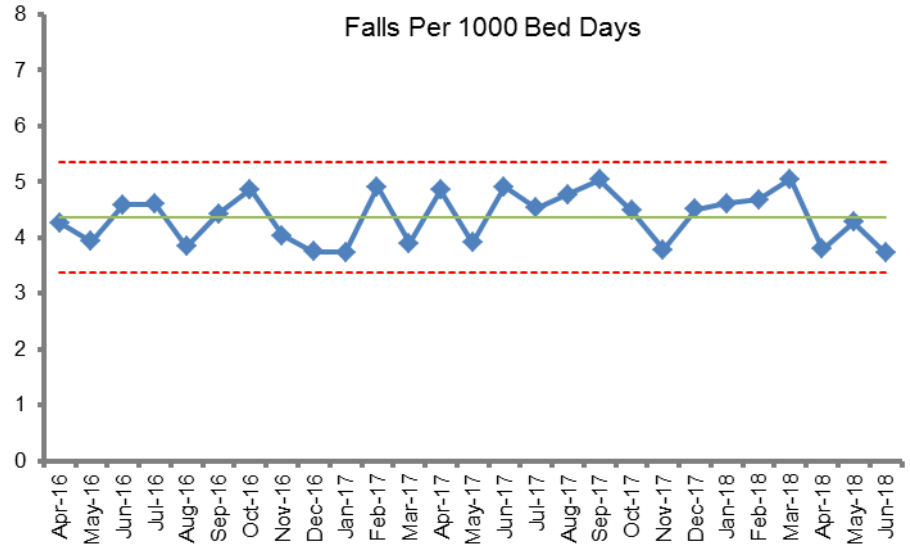
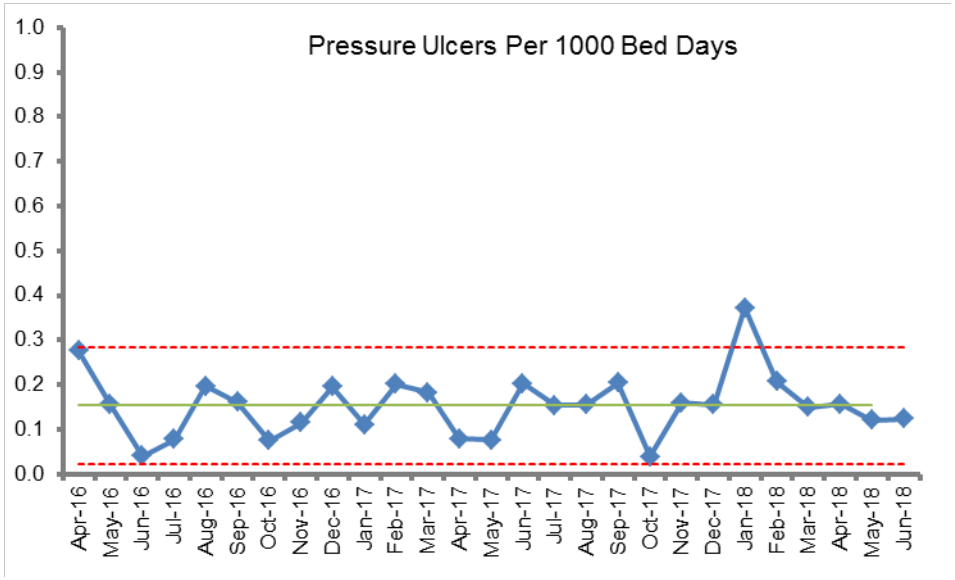


2.1 PERFORMANCE – Safe Domain

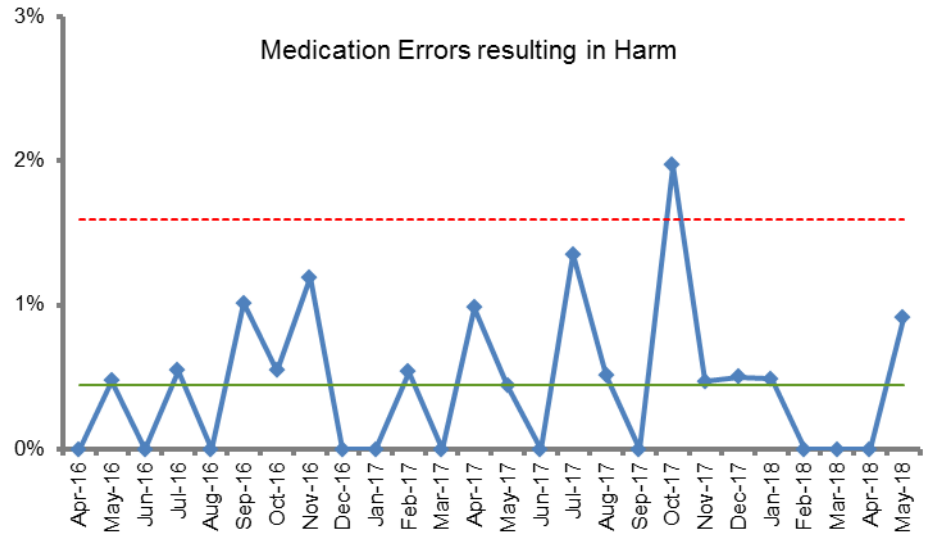
Patient Falls and Pressure Ulcers	
Standards:	Inpatient Falls per 1,000 beddays to be less than 4.8. Less than 2 per month resulting in Harm (Moderate or above) Hospital acquired Pressure Ulcers to be below 0.4. No Grade 3 or 4 Pressure Ulcers
Performance:	Falls rate for June was 3.72 per 1,000 beddays. This was 91 Falls with one resulting in harm. Pressure Ulcers rate for June was 0.12 per 1,000 beddays. There were three Pressure Ulcers in June, with none at Grades 3 or 4.
Commentary:	The overall number of falls per 1,000 bed days remains below the limit of 4.8 in June at 3.27. There were fewer falls with harm in June, one compared to four in May. The aim of the 18/19 work plan is to see an overall reduction in the number of falls and falls with harm by delivering a number of practice and education and training related objectives. Pressure ulcer performance for June remains below our internal limit of 0.4 per 1,000 bed days at 0.123 (three new category 2 pressure ulcers). Pressure ulcer prevention and reduction work 18/19 will focus on the ambition to reduce pressure ulcers category 1-3 across the organisation by 50% – actions have been identified to deliver this ambition.
Ownership:	Chief Nurse

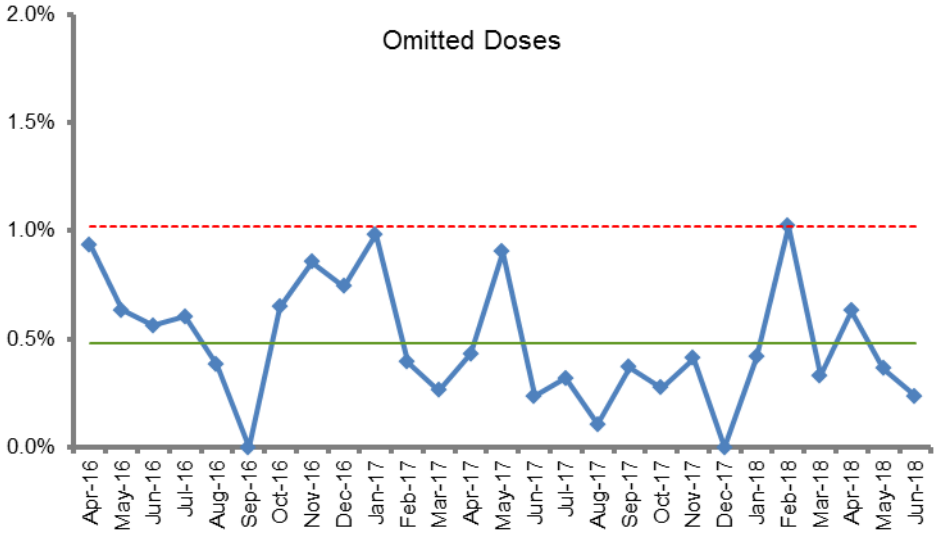




2.1 PERFORMANCE – Safe Domain

Medicines Management	
Standards:	Number of medication errors resulting in harm to be below 0.5%. Note this measure is a month in arrears. Of all the patients reviewed in a month, under 0.75% to have had a non-purposeful omitted dose of listed critical medication
Performance:	0.91% of medication errors in May resulted in harm (two errors out of 220 cases reviewed). Omitted doses were at 0.24% in June (1 case out of 425 reviewed).
Commentary:	**Errors Resulting in Harm.** Currently above our internal limit of 0.5% due to two moderate harm incidents being reported in June. However the ratio of harm : no harm medication incidents is below the national target figure of 0.14. These incidents are reviewed monthly by the pharmacy department and risk management leads for the Divisions and bi-monthly by the Medicines Governance Group; with actions for the Divisions as appropriate. **Omitted Doses.** This measure is currently in two parts with the majority of wards subject to previous data sampling of paper drug charts, but our Electronic Prescribing and Medicines Administration (EPMA) has been implemented in adult cardiology wards which uses a different methodology for measuring non-purposeful omitted critical medication. The figure from sampling paper drug charts is below our internally set stretch limit of 0.5% at 0.24%. The figure for cardiology areas using Medway EPMA is derived from real time data, but 'Critical' medicines cannot be immediately identified in Medway, only through Business Intelligence reporting. This measure is new for the Trust so no internal benchmark has been set; and there is no current gauge for a national benchmark figure. The calculated figure is the omitted medicines due to for no stock being available at the time. This can be investigated to patient level to review stock medication on wards or the availability of these medicines out-of-hours though emergency drug cupboards etc. Administrations that are later than the prescribed time can also be measured from EPMA which is an additional benefit.
Ownership:	Medical Director





2.1 PERFORMANCE – Safe Domain

Essential Training	
Standards:	Essential Training measures the percentage of staff compliant with the requirement for core essential training. The target is 90%
Performance:	In June Essential Training overall compliance increased to 90% compared with 89% in the previous month (excluding Child Protection Level 3).
Commentary:	June 2018 compliance for Core Skills (mandatory/statutory) training increased to 90% overall across the eleven core skills programmes, with no reductions in compliance in any of the eleven core skills programmes, four of which increased. Compliance for all other Essential Training increased to 93% compared to 92% last month overall.
Ownership:	Director of People

Essential Training	Jun-18	KPI
Conflict Resolution Training	94%	90%
Equality, Diversity and Human Rights	92%	90%
Fire Safety	88%	90%
Health, Safety and Welfare (formerly Health & Safety)	94%	90%
Infection Prevention & Control	94%	90%
Information Governance	86%	95%
Moving and Handling (formerly Manual Handling)	82%	90%
Preventing Radicalisation	92%	90%
Resuscitation	86%	90%
Safeguarding Adults	90%	90%
Safeguarding Children	90%	90%

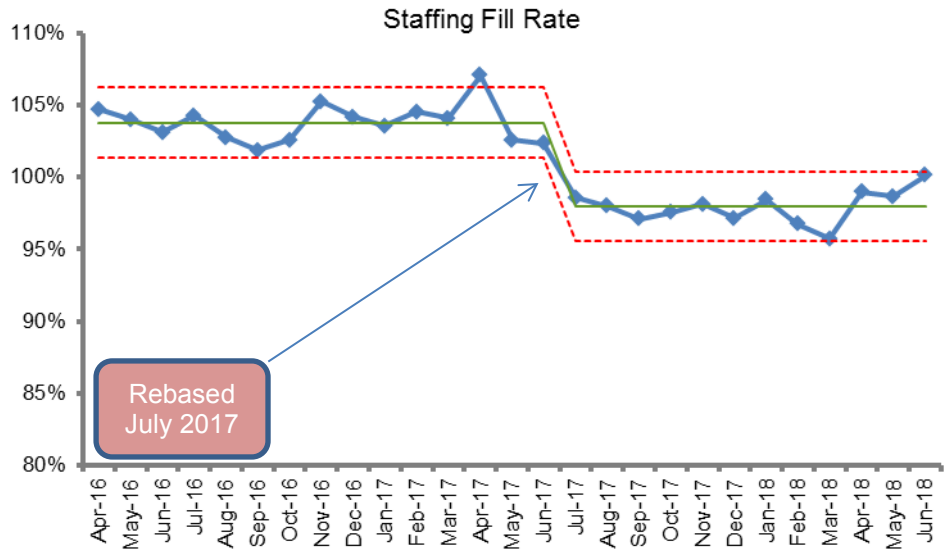
Essential Training	Jun-18	KPI
UHBristol NHS Foundation Trust	**90%**	**90%**
Diagnostics & Therapies	90%	90%
Facilities & Estates	91%	90%
Medicine	89%	90%
Specialised Services	90%	90%
Surgery	90%	90%
Trust Services	91%	90%
Women's & Children's	89%	90%

2.1 PERFORMANCE – Safe Domain

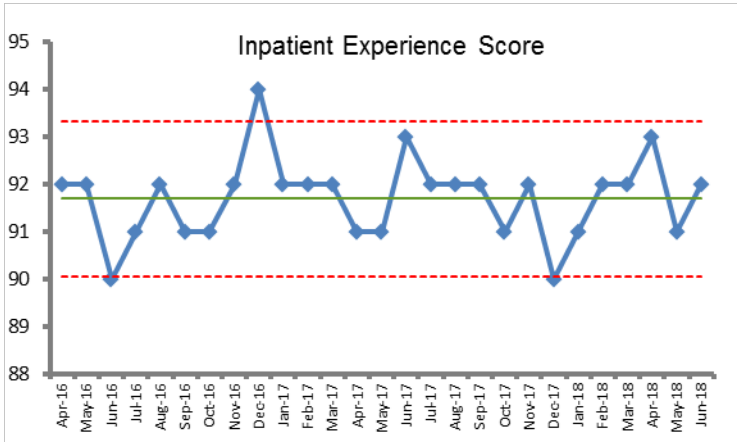
Nursing Staffing Levels	
Standards:	Staffing Fill Rate is the total hours worked divided by total hours planned. A figure over 100% indicates more hours worked than planned. No target agreed
Performance:	June's overall staffing level was at 100.1% (231,048 hours worked against 230,740 planned). Registered Nursing (RN) level was at 94.3% and Nursing Assistant (NA) level was at 115.1%
Commentary:	Overall for the month of June 2018, the trust had 94% cover for registered nurses on days and 95% registered nurse cover for nights. The unregistered nurse level of 109% for days and 123% for nights reflects the activity seen in June 2018. This was due primarily to nursing assistant specialist assignments to safely care for confused or mentally unwell patients in adults particularly at night.
Ownership:	Chief Nurse

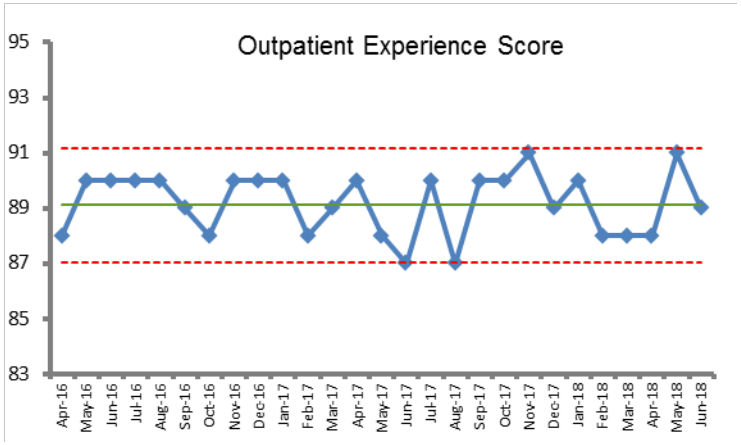
	Day	Night	TOTAL
Registered Nurses	93.6%	95.1%	94.3%
Nursing Assisstant	109.4%	123.1%	115.1%
TOTAL	**98.3%**	**102.5%**	**100.1%**

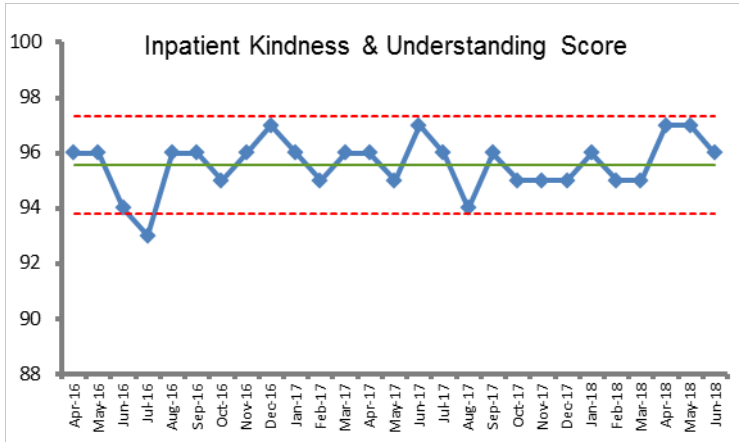
Medicine	111.1%
Surgery	101.0%
Specialised Services	100.1%
Women's and Children's	91.9%



Monthly Patient Survey	
Standards:	For the inpatient and outpatient Survey, 5 questions are combined to give a score out of 100. For inpatients, the target is to achieve 87 or more. For outpatients the target is 85. For inpatients, there is a separate measure for the kindness and understanding question, with a target of 90 or over.
Performance:	For June 2018, the inpatient score was 92/100, for outpatients it was 89. For the kindness and understanding question it was 96.
Commentary:	The headline measures from these surveys remained above their minimum target levels in June 2018, indicating the continued provision of a positive patient experience at UH Bristol.
Ownership:	Chief Nurse

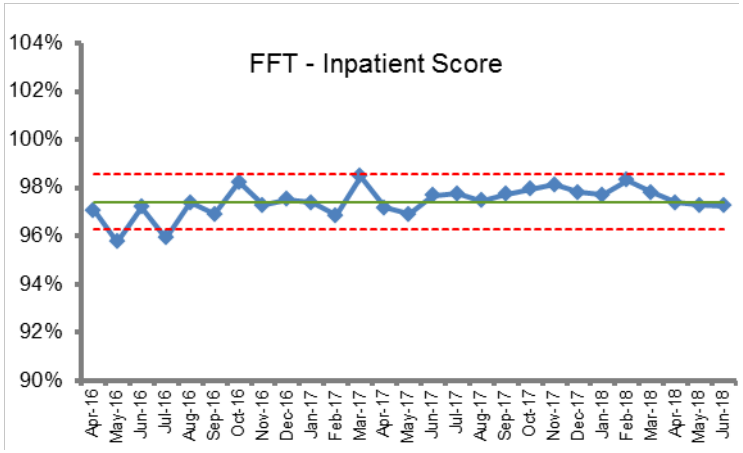


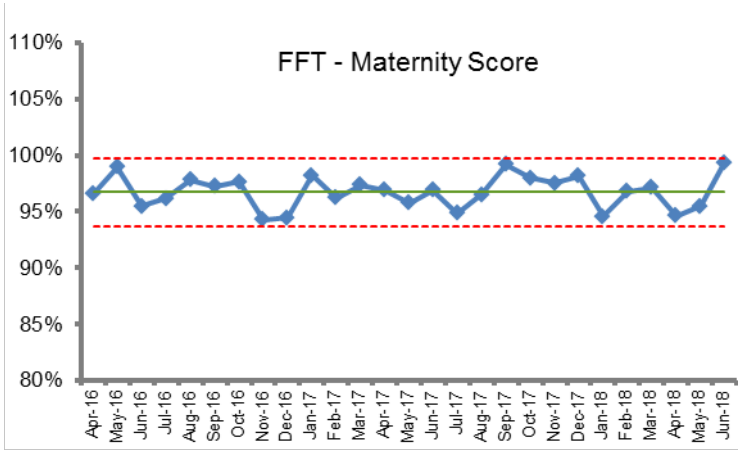


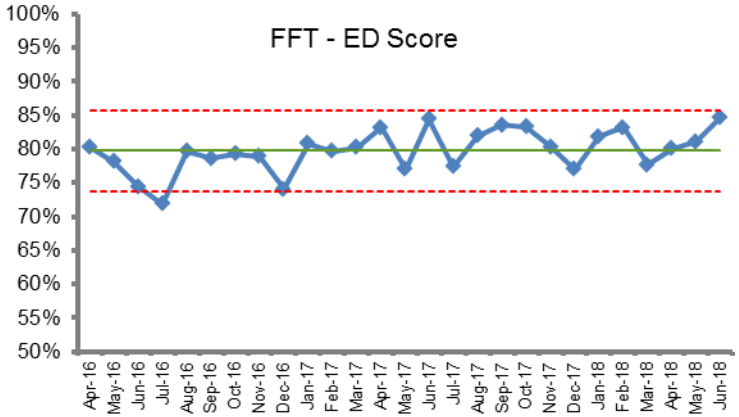


2.2 PERFORMANCE – Caring Domain

Friends and Family Test (FFT) Score	
Standards:	The FFT score is the number of respondents who were likely or very likely to recommend the Trust, as a percentage of all respondents. Standard is that the score for inpatients should be above 90%. The Emergency Department minimum target is 60%.
Performance:	June's FFT score for Inpatient services was 97.3% (2055 out of 2113 surveyed). The ED score was 84.6% (1328 out of 1570 surveyed). The maternity score was 95.3% (138 out of 139 surveyed).
Commentary:	The Trust's scores on the Friends and Family Test were above their target levels in June 2018.
Ownership:	Chief Nurse



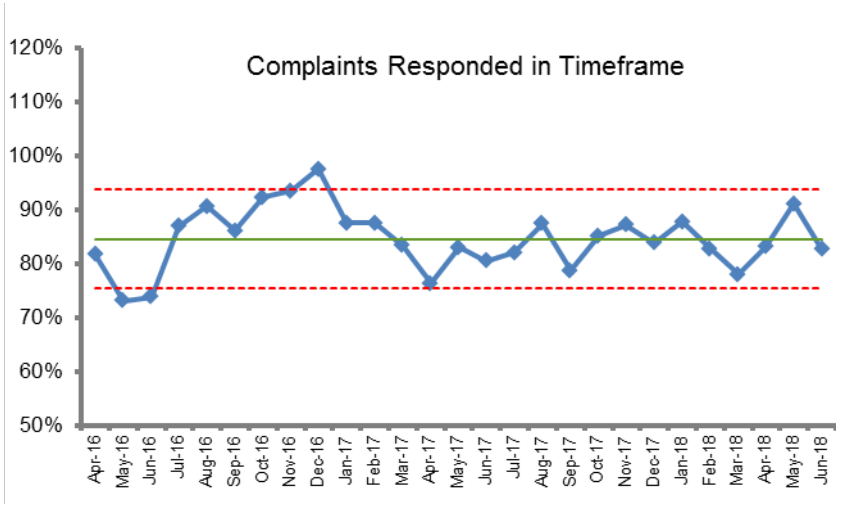


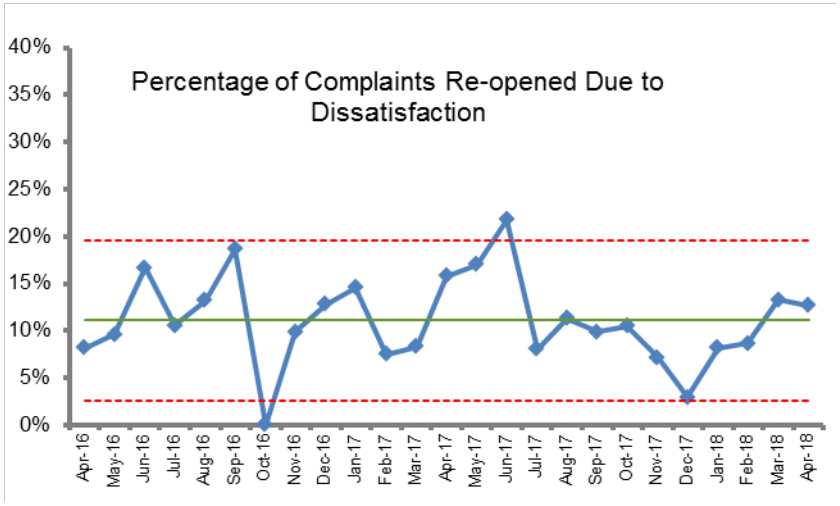


Score		Jun-18	2018/2019	Score		Jun-18	2018/2019
Inpatient	MDC	96.4%	96.6%	ED	BCH	88.3%	85.2%
	SHN	98.0%	98.1%		BEH	91.4%	92.4%
	SPS	94.7%	96.2%		BRI	70.8%	67.1%
	WAC	98.4%	97.2%		Total	84.6%	81.9%
	Total	97.3%	97.4%	Maternity		99.3%	96.0%

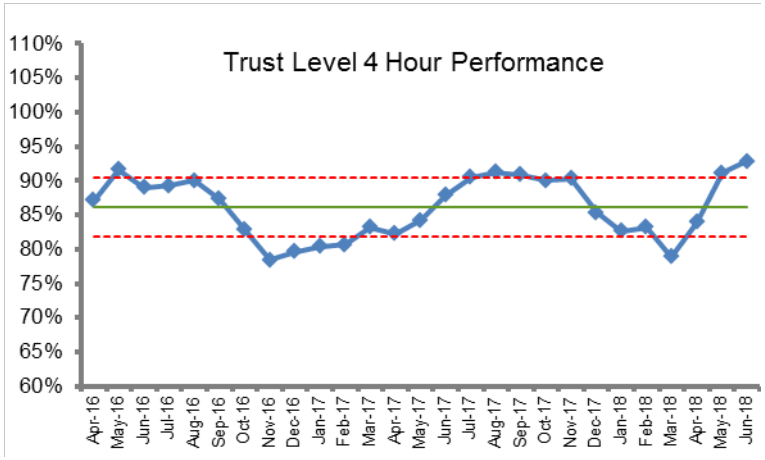
2.2 PERFORMANCE – Caring Domain

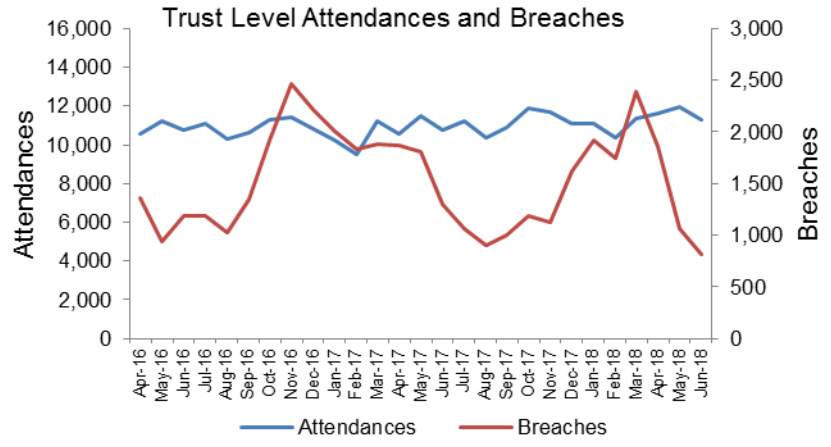
Patient Complaints	
Standards:	For all formal complaints, 95% of them should have the response posted/sent to the complainant within the agreed timeframe. Of all formal complaints responded to, less than 5% should be re-opened because complainant is dissatisfied.
Performance:	In June, 63 out of 75 formal complaints were responded to with timeframe (84.0%) Of the 71 formal complaints responded to in April, 9 resulted in the complainant being dissatisfied with the response (12.9%)
Commentary:	The rate of dissatisfied complaints increased to 12.7% in April, having remained below the amber 10% threshold for six consecutive months previously. This represents nine cases. The Trust's performance in responding to complaints via formal resolution within a timescale agreed with the complainant was 83% in June. This represents 13 breaches. Starting on 2nd August, Clinical Quality Group will receive a monthly report providing details of all breaches and causes to identify learning.
Ownership:	Chief Nurse

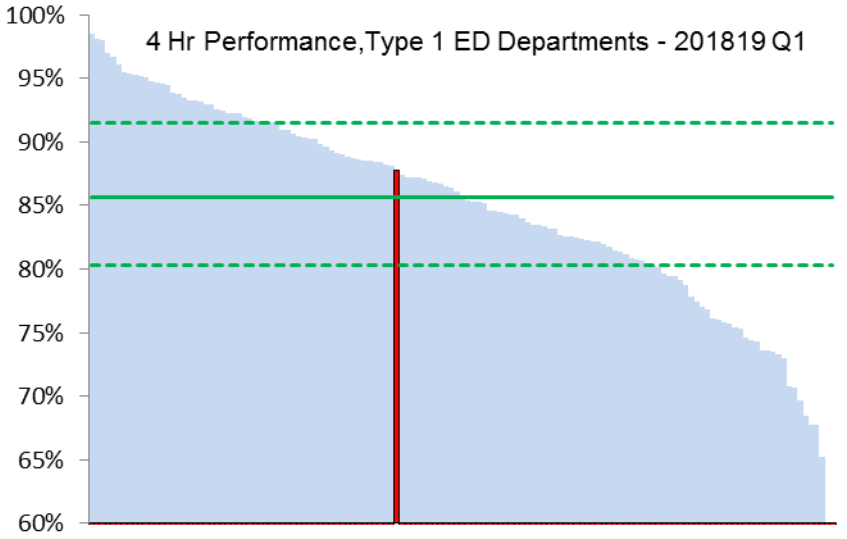




Emergency Department 4 Hour Wait	
Standards:	Measured as length of time spent in the Emergency Department from arrival to departure/admission. The national standard is that at least 95% of patients should wait under 4 hours. The Trust's improvement trajectory is 90% for each month in Quarter 1.
Performance:	Trust level performance for June was 92.84% (11306 attendances and 809 patients waiting over 4 hours). Quarter 1 finished at 89.30%. NHS England publishes "Acute Trust Footprint" data where Walk In Centre data is added to local Acute Trusts. This data showed UHBristol at 92.05% for Quarter 1.
Commentary:	Significant improvement in performance in both adult and children's services sustained across the month and quarter with a 5% point improvement on the same period last year. Delivery of work streams against the UCSG action plan continues. Children's services highlighted increased growth in attendances outside plan and following discussion at A&E Delivery Board, a system diagnosis has been completed and a discussion forum set up to review this. This needs to be followed with actions to help mitigate this growth across primary and community services.
Ownership:	Chief Operating Officer



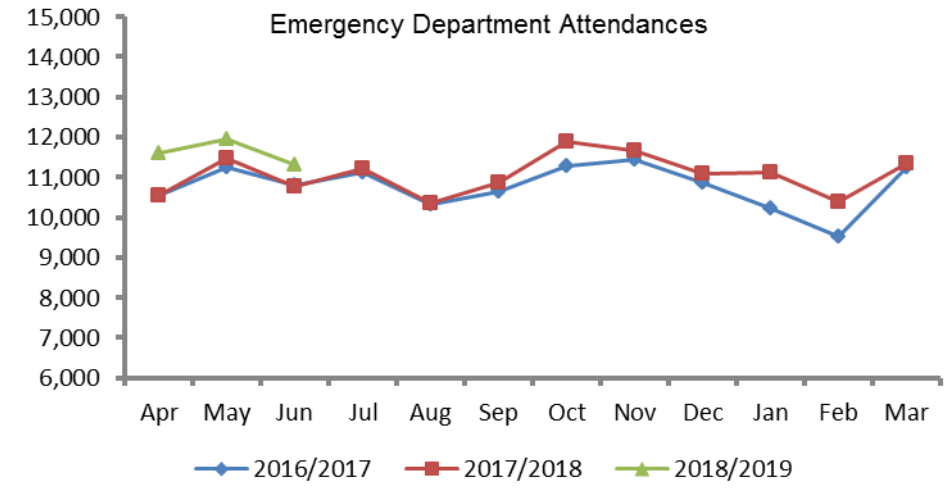


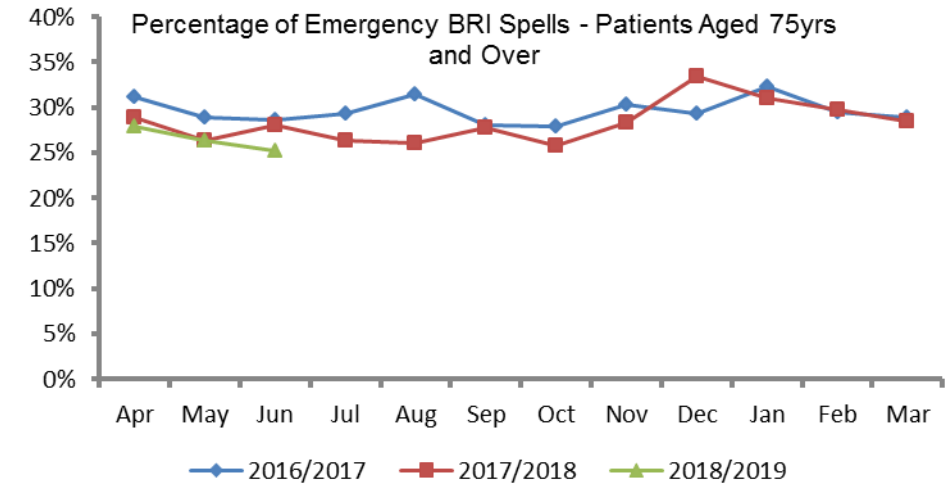


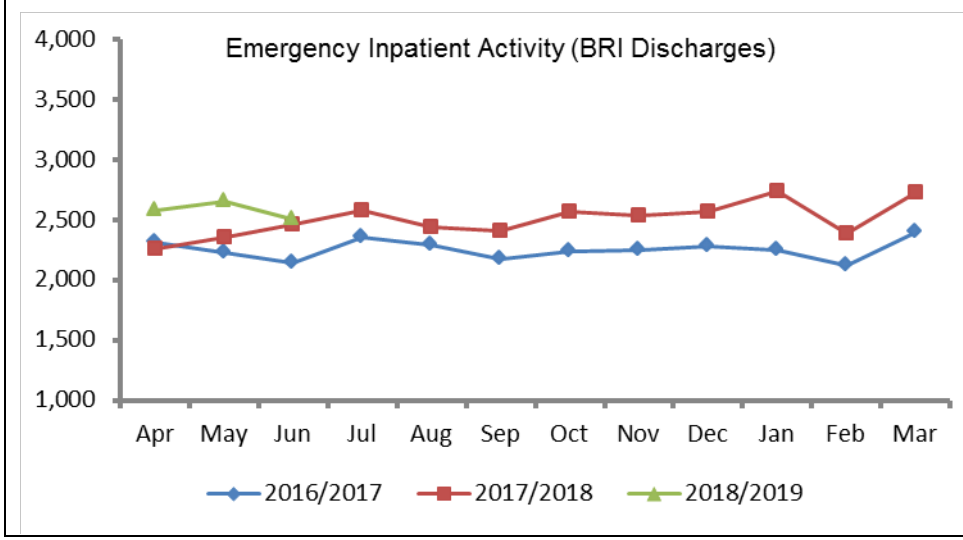
Unbroken horizontal line is England median;
dotted lines are upper & lower quartiles

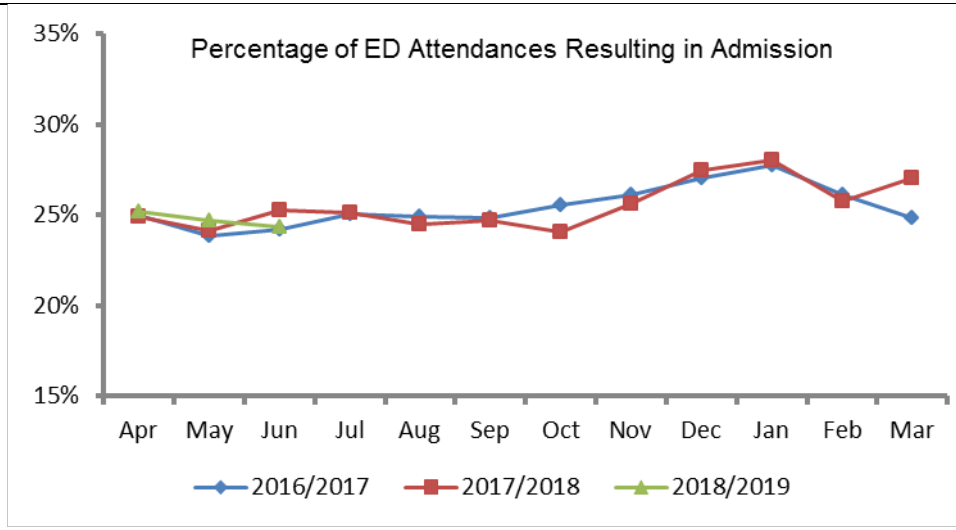
	Attendances		Under 4 Hours		Performance	
	Jun-18	2018/2019	Jun-18	2018/2019	Jun-18	2018/2019
BRI	5751	17741	5123	14692	89.08%	82.81%
Trust	11306	34851	10497	31122	92.84%	89.30%

2.3 PERFORMANCE – Responsive Domain



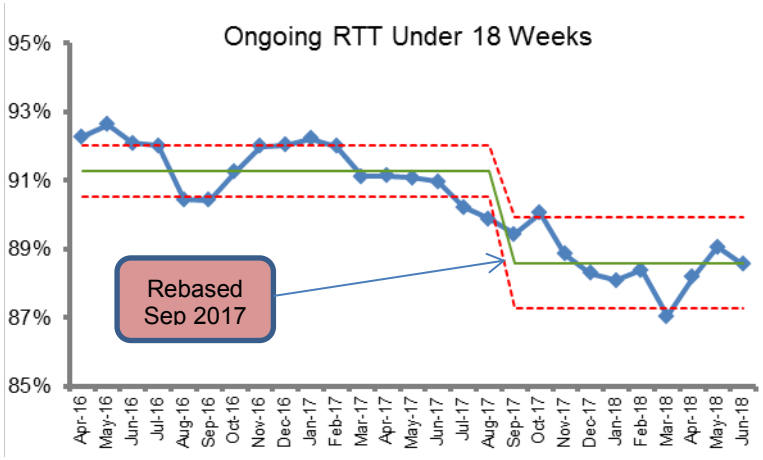


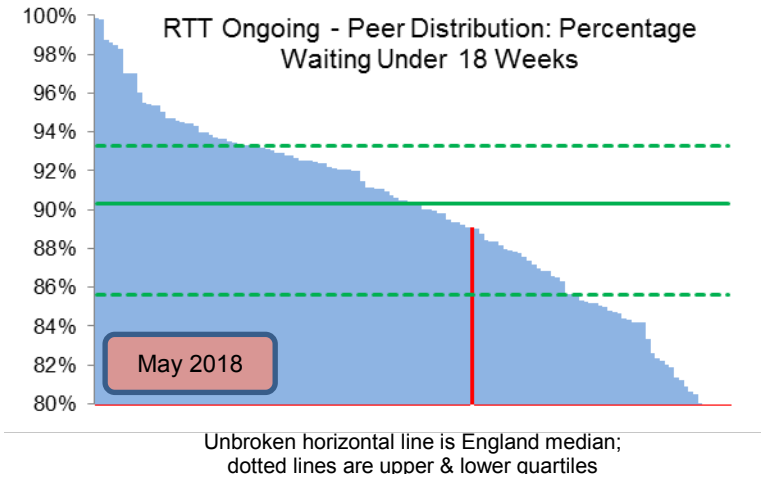




2.3 PERFORMANCE – Responsive Domain

Referral to Treatment (RTT)	
Standards:	At each month-end, we report the number of patients on an ongoing RTT pathway and the percentage that have been waiting less than 18 weeks. The national standard is that over 92% of the patients should be waiting under 18 weeks. The Trust's improvement trajectory has been set at 88.5% for end of June. In addition, no-one should be waiting 52 weeks or over.
Performance:	At end of June, 88.6% of patients were waiting under 18 week (26,126 out of 29,503 patients). 9 patients were waiting 52+ weeks
Commentary:	The 92% national standard was not met at the end of June, with performance at 88.6%%. However, this was above the recovery trajectory target of 88.5%.. Early sight for June is holding at 89%.
Ownership:	Chief Operating Officer





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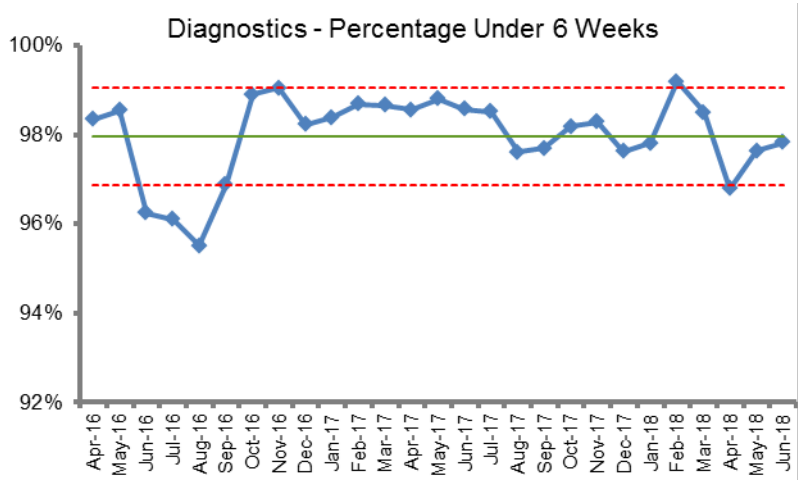
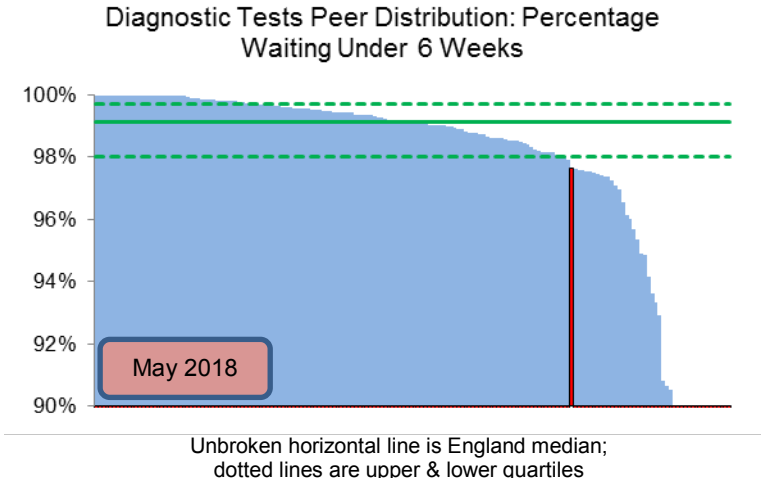
	Ongoing Pathways	Ongoing Over 18 Weeks	Ongoing Performance
Cardiology	2,011	329	83.6%
Cardiothoracic Surgery	298	48	83.9%
Dermatology	2,384	153	93.6%
ENT	2,096	92	95.6%
Gastroenterology	605	2	99.7%
General Medicine	18	0	100.0%
Geriatric Medicine	61	2	96.7%
Gynaecology	1,223	131	89.3%
Neurology	375	148	60.5%
Ophthalmology	4,451	408	90.8%
Oral Surgery	2,806	297	89.4%
Other (Clinical Genetics)	1,253	181	85.6%
Other (Dental)	2,147	184	91.4%
Other (General Surgery)	1,273	267	79.0%
Other (Haem/Onc)	136	1	99.3%
Other (Medicine)	640	64	90.0%
Other (Other)	439	6	98.6%
Other (Paediatric)	5,278	919	82.6%
Other (Pain Relief)	138	0	100.0%
Other (Thoracic Surgery)	125	25	80.0%
Plastic Surgery	1	0	100.0%
Rheumatology	482	28	94.2%
Thoracic Medicine	558	11	98.0%
Trauma & Orthopaedics	705	81	88.5%
TOTAL	**29,503**	**3,377**	**88.6%**

2.3 PERFORMANCE – Responsive Domain

Diagnostic Waits	
Standards:	Diagnostic tests should be undertaken within a maximum 6 weeks of the request being made. The national standard is for 99% of patients referred for one of the 15 high volume tests to be carried-out within 6 weeks, as measured by waiting times at month-end. The Trust's improvement trajectory was set at no more than 190 breaches at end of June, which would equate to approximately 98%.
Performance:	At end of June, 97.8% of patients were waiting under 6 weeks (8,913 out of 9,111 patients). There were 198 breaches of the 6-week standard.
Commentary:	The Trust did not achieve the 99% national standard at end of June and was 8 patients above the recovery trajectory of having fewer than 190 breaches. The Trust needed fewer than 92 breaches to achieve the 99% standard. The areas carrying the largest volume of breaches are Paediatric MRI, Cardiac MRI and Cardiac Echos. The Trust is now required to deliver 99% by end of August.
Ownership:	Chief Operating Officer





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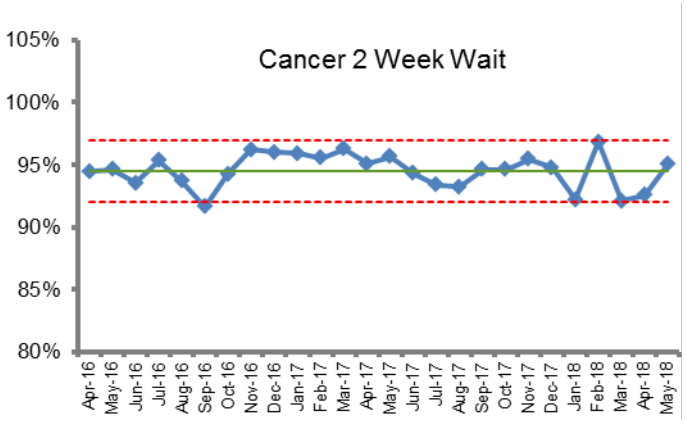
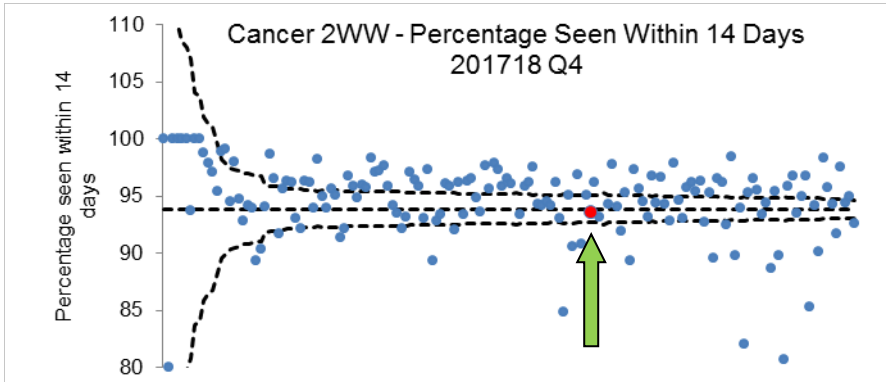
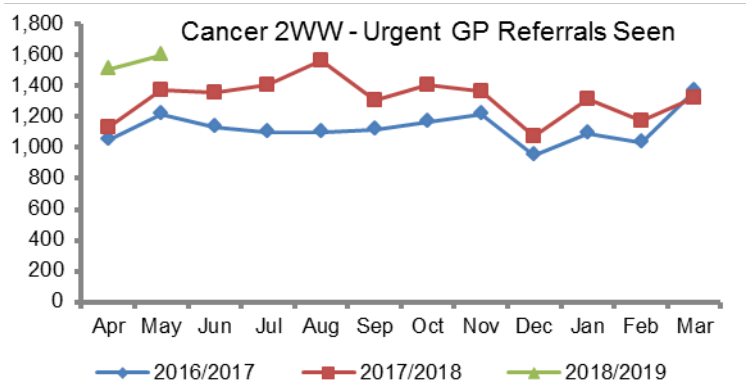
	Under 6 Weeks	6+ Weeks	Total Waiting	Percentage Under 6 Weeks
Audiology	1,277	6	1,283	99.5%
Colonoscopy	160	1	161	99.4%
CT	1,039	1	1,040	99.9%
Cystoscopy	3	1	4	75.0%
DEXA Scan	339	17	356	95.2%
Echocardiography	913	44	957	95.4%
Flexi Sigmoidoscopy	38	0	38	100.0%
Gastroscopy	191	1	192	99.5%
MRI	2,015	112	2,127	94.7%
Neurophysiology	243	0	243	100.0%
Sleep Studies	171	13	184	92.9%
Ultrasound	2,524	2	2,526	99.9%
Grand Total	**8,913**	**198**	**9,111**	**97.8%**

2.3 PERFORMANCE – Responsive Domain

Cancer Waiting Times – 2WW	
Standards:	Urgent GP-referred suspected cancer patients should be seen within 2 weeks of referral. The national standard is that each Trust should achieve at least 93%
Performance:	For May, 95.1% of patients were seen within 2 weeks (1518 out of 1597 patients). Quarter 1 is currently at 93.8%. Both the month and quarter-to-date have achieved the national standard.
Commentary:	The standard will be achieved in quarter 1 2018/19 and is on track for quarter 2. Rapidly rising demand is a challenge, however innovative pathways are being introduced to manage this, for example tele-dermatology hubs (also provide closer to home care)
Ownership:	Chief Operating Officer



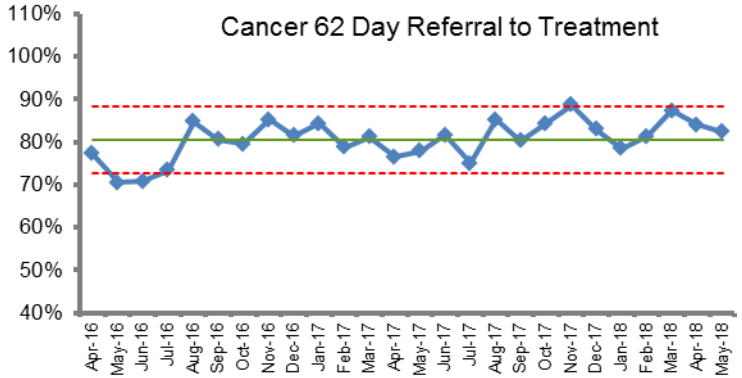


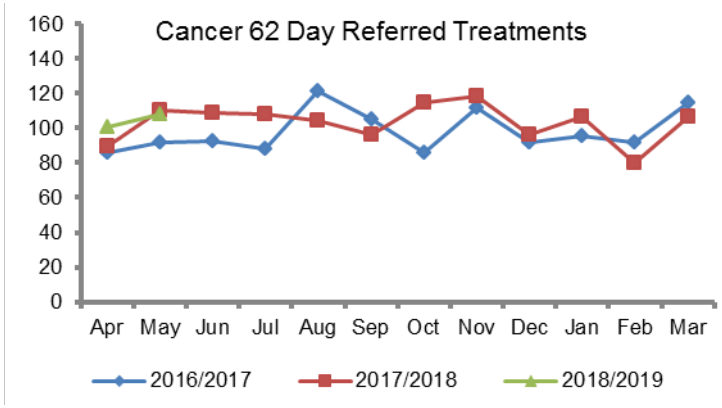


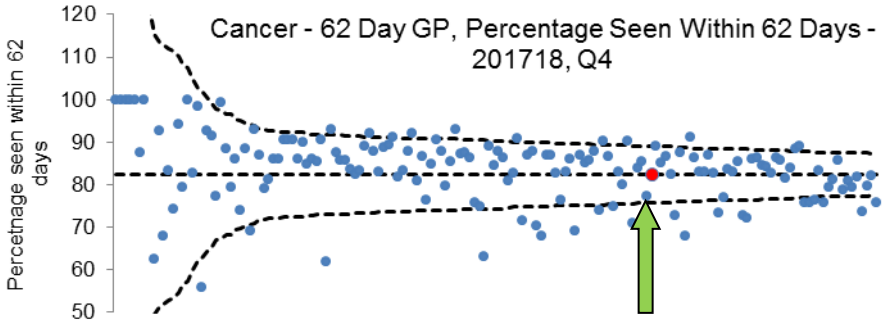
	Cancer 2WW - May-18		
Cancer Site	Under 2 Weeks	Total Pathways	Percentage
Other suspected cancer	6	6	100.0%
Suspected children's cancer	25	27	92.6%
Suspected gynaecological cancers	108	119	90.8%
Suspected haematological malignancies excluding ac	15	17	88.2%
Suspected head and neck cancers	405	419	96.7%
Suspected lower gastrointestinal cancers	181	188	96.3%
Suspected lung cancer	27	27	100.0%
Suspected skin cancers	652	689	94.6%
Suspected upper gastrointestinal cancers	99	105	94.3%
Grand Total	1,518	1,597	95.1%

2.3 PERFORMANCE – Responsive Domain

Cancer Waiting Times – 62 Day	
Standards:	Urgent GP-referred suspected cancer patients should start first definitive treatment within 62 days of referral. National standard is that Trusts should achieve at least 85%. The improvement trajectory is 83% for May and 82.5% for Quarter 1.
Performance:	For May, 82.4% of patients were seen within 62 days (89 out of 108 patients). The quarter-to-date is currently at 83.2%
Commentary:	Performance is recovering according to the revised post-fire trajectory. National standard to be recovered by August 2018 and sustained thereafter. Changes to the way performance against this standard is allocated between providers (from October 2018) provide an opportunity to increase engagement from other providers on improving shared pathways but also present a significant increase in the administrative burden on the organisation without directly changing pathways for patients.
Ownership:	Chief Operating Officer

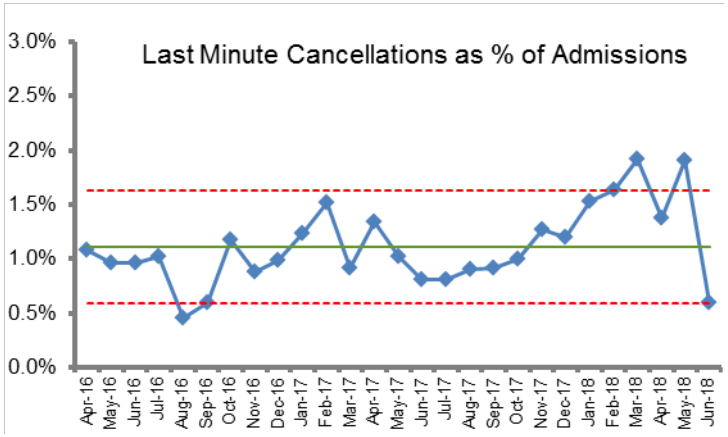


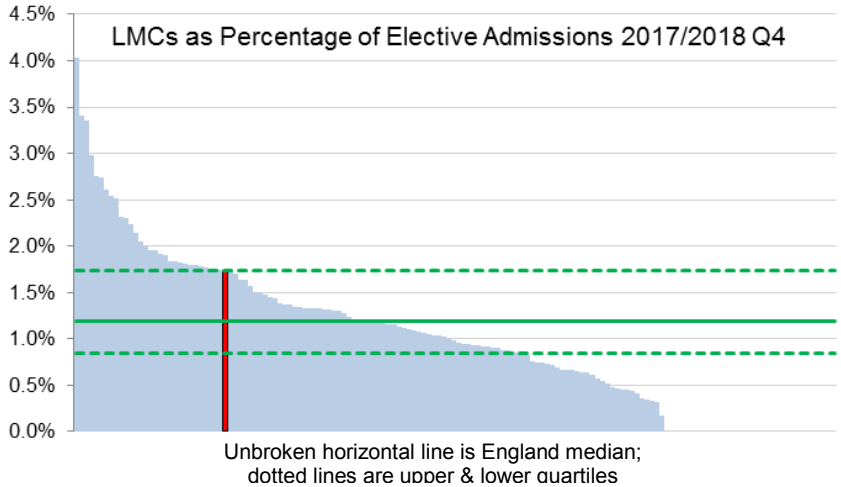




	Cancer 62 Day - May-18		
Cancer Site	First Treatment - Within Target	First Treatment - Total	First Treatment - Performance
Acute leukaemia	1.0	1.0	100.0%
Breast	1.5	1.5	100.0%
Gynaecological	3.5	4.0	87.5%
Haematological	4.0	4.0	100.0%
Head and Neck	4.0	6.0	66.7%
Lower Gastrointestinal	4.0	8.5	47.1%
Lung	11.5	18.0	63.9%
Other	2.5	3.5	71.4%
Sarcoma	1.5	1.5	100.0%
Skin	47.5	50.0	95.0%
Upper Gastrointestinal	7.5	8.5	88.2%
Urological	0.5	1.5	33.3%
Grand Total	89.0	108.0	82.4%

Last Minute Cancelled Operations	
Standards:	This covers elective admissions that are cancelled on the day of admission by the hospital, for non-clinical reasons. The total number for the month should be less than 0.8% of all elective admissions. Also, 95% of these cancelled patients should be re-admitted within 28 days
Performance:	In June there were 39 cancellations, which was 0.6% of elective admissions. Of the 125 cancelled in May, 119 (95.2%) had been re-admitted within 28 days.
Commentary:	June saw a significant reduction in last minute cancelled operations, to levels below the 0.8% standard. The "Start The Day" theatre project ensuring first session starts by 08:15; utilisation of capacity at South Bristol and improved cataract booking practices have contributed to this improved performance. The Trust continues to be monitored by commissioners on its 28 day readmissions and this aspect of performance is now monitored with divisions through the weekly Performance meetings.
Ownership:	Chief Operating Officer





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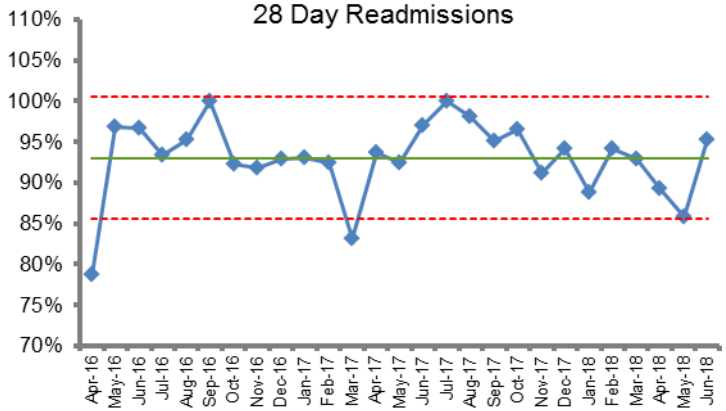
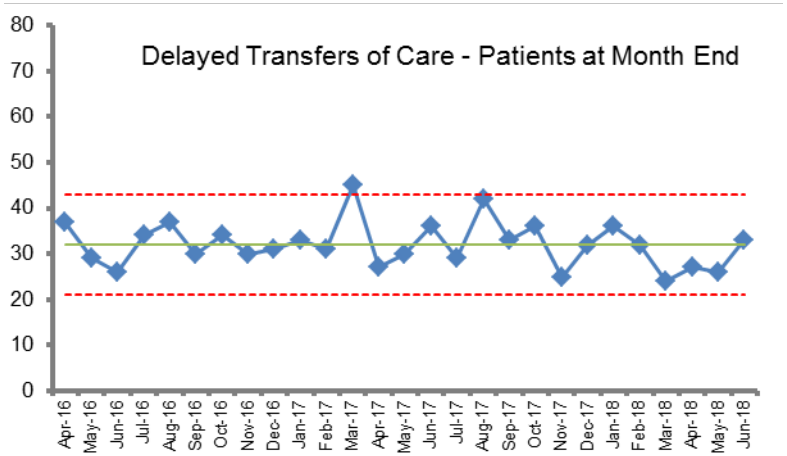
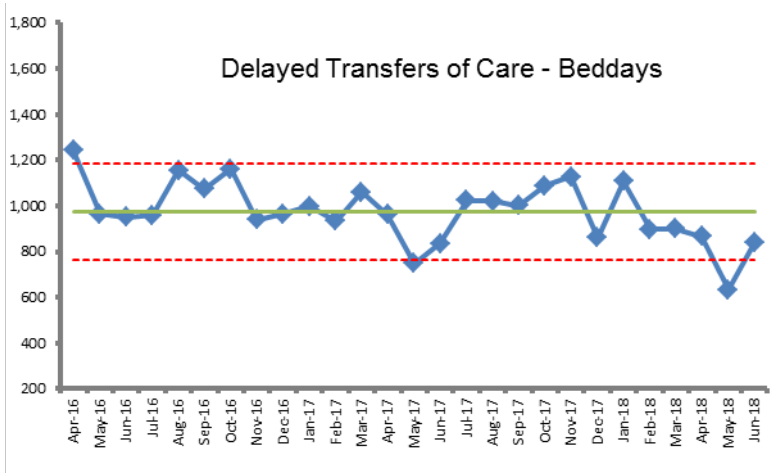


Cancellation Reason	Total
AM list over-ran	5
Booking Error	3
Equipment Failure	5
No Beds Available	2
No HDU Beds	3
No Ward Staff	1
Other clinically complicated Patient in theatre	1
Surgeon Taken Ill	1
Surgeon Unavailable	7
Technician Not Available	1
Grand Total	39

2.3 PERFORMANCE – Responsive Domain

Delayed Transfers of Care (DToC)	
Standards:	Patients who are medically fit for discharge should wait a "minimal" amount of time in an acute bed.
Performance:	In June there were 33 Delayed Transfer of Care patients as at month-end, and 839 beddays consumed by DToC patients,
Commentary:	Renewed focus at a divisional level, using information from Clinical Utilisation Review is being implemented to improve the understanding, escalation and actions required to reduce delayed patients both internally and externally. Three key initiatives with Bristol City Council – changes to the provider care home market procurement processes, improved access to home care providers and increased capacity in re-ablement are expected to see responses in July. Trajectory agreed for improvement of target against actions by December 2018 being linked to our overarching plans for this improvement.
Ownership:	Chief Operating Officer





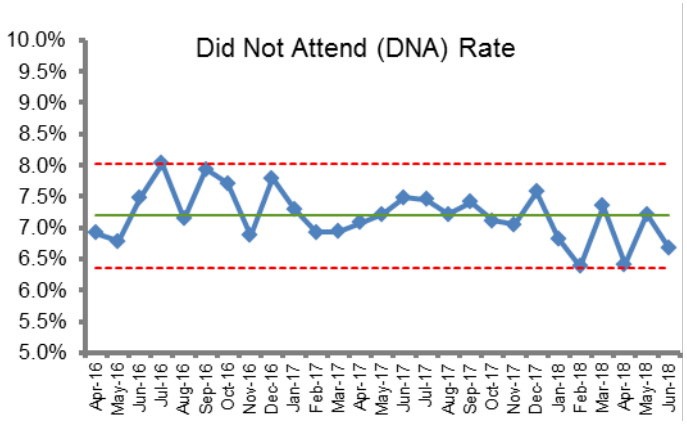
National DTOC Code	National DTOC Reason	Accountable	Patients (Acute)	Beddays (Acute)	Patients (Non-Acute)	Beddays (Non-Acute)
A	Completion of assessment	Both	0	22	0	5
		NHS	0	19	1	3
		Social Care	8	196	3	38
B	Public Funding	Social Care	0	0	1	3
C	Further non acute NHS Care	NHS	2	24	0	0
Di	Care Home Placement	NHS	2	51	1	33
		Social Care	4	57	0	9
Dii	Care Home Placement	NHS	1	39	1	29
		Social Care	2	40	0	16
E	Care package in own home	NHS	0	16	0	30
		Social Care	3	71	1	16
F	Community equipment / adaptions	Both	0	14	0	0
		Social Care	0	6	0	12
G	Patient or family choice	NHS	2	33	0	13
H	Disputes	Social Care	0	2	0	0
I	Housing - patient not covered by NH	NHS	1	42	0	0
Grand Total			25	632	8	207

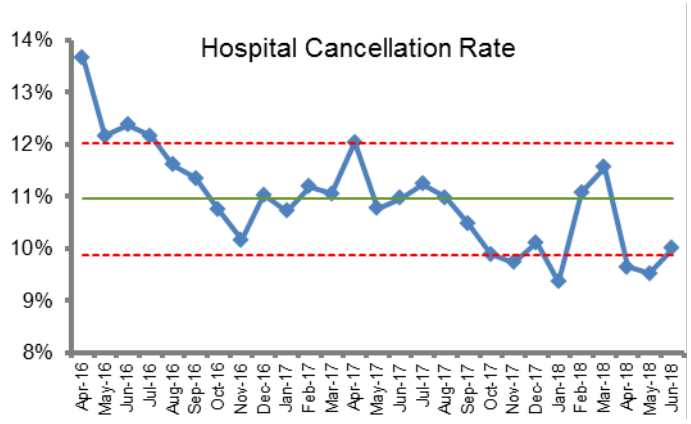
Length of Stay of Inpatients at month-end

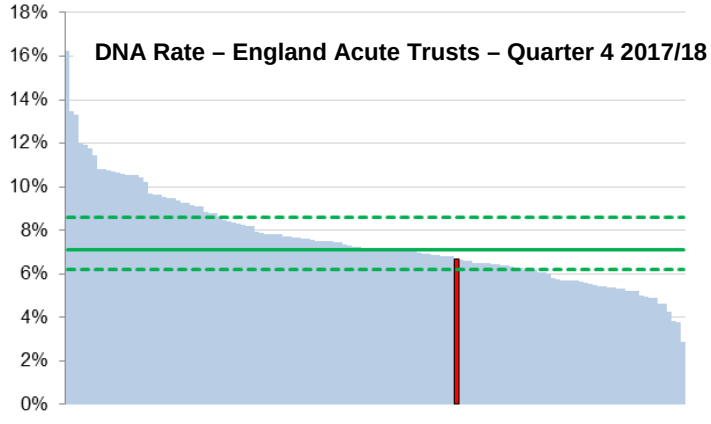
Jun-18	7+ Days	14+ Days	21+ Days	28+ Days
Bristol Children's Hospital	56	40	31	28
Bristol Haematology & Oncology Centre	23	10	4	4
Bristol Royal Infirmary	210	128	86	50
South Bristol Hospital	54	47	40	35
St Michael's Hospital	25	17	11	8
TRUST TOTAL	369	243	172	125
Bristol Royal Infirmary Divisional Breakdown:				
Medicine	117	78	61	36
Specialised Services	45	25	11	6
Surgery, Head & Neck	48	25	14	8

2.3 PERFORMANCE – Responsive Domain

Outpatient Measures	
Standards:	The Did Not Attend (DNA) Rate is the number of outpatient appointments where the patient did not attend, as a percentage of all attendances and DNAs The Hospital Cancellation Rate is the number of outpatient appointments cancelled by the hospital, as a percentage of all outpatient appointments made. The target for DNAs is to be below 5%, with an amber tolerance of between 5% and 10%. For Hospital Cancellations, the target is to be on or below 9.7% with an amber tolerance from 10.7% to 9.7%..
Performance:	In June there were 9110 hospital-cancelled appointments, which was 10.0% of all appointments made. There were 4369 appointments that were DNA'ed, which was 6.7% of all planned attendances.
Commentary:	Speciality level DNA targets reviewed monthly at Outpatient Steering Group (OSG). The need to manage GP referrals through e-RS and setting polling ranges to match waiting times may impact on hospital cancellations. This will be closely monitored at OSG and will be added to the weekly performance meeting agenda with divisions.
Ownership:	Chief Operating Officer







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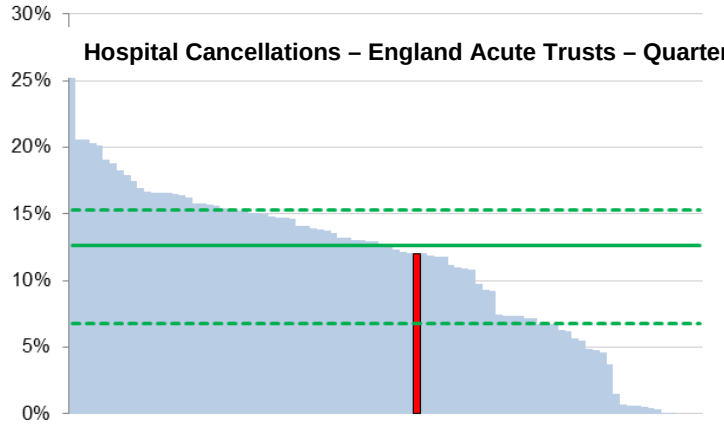

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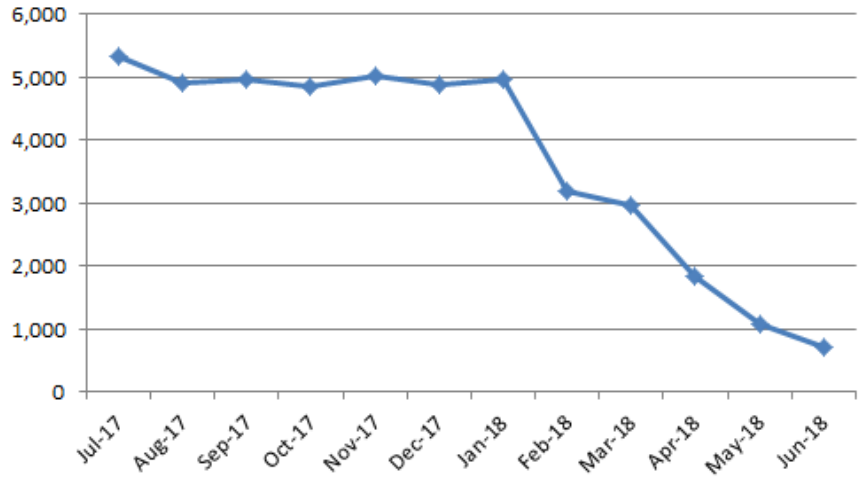
2.3 PERFORMANCE – Responsive Domain

Outpatient – Overdue Follow-Ups	
Standards:	This measure looks at referrals where the patient is on a "Partial Booking List", which indicates the patient is to be seen again in Outpatients but an appointment date has not yet been booked. Each patient has a "Date To Be Seen By", from which the proportion that are overdue can b reported. The current aim is to have no-one more than 12 months overdue
Performance:	As at end of June, number overdue by 12+ months has fallen to 716.
Commentary:	Significant progress has been made by the divisions, through regular weekly review at the Wednesday performance meeting. The Trust aims to have eliminated the number of 12+ month overdue follow-ups by end of August. Targets will then be set to remove the 6+ month overdue follow-ups.
Ownership:	Chief Operating Officer

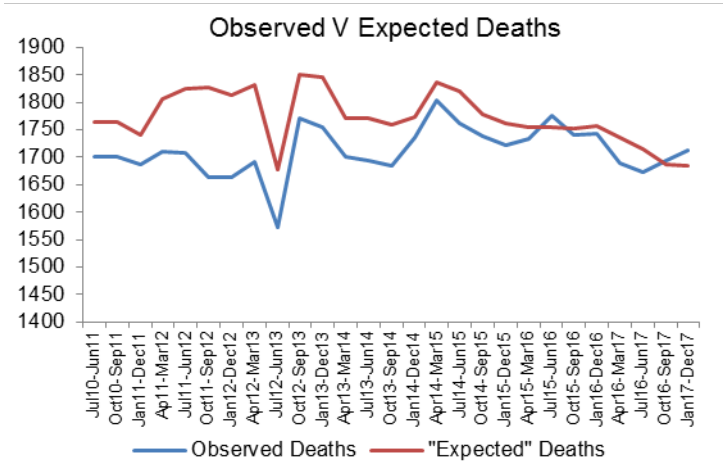
Number of Outpatients Overdue by 12+ Months as at Month End

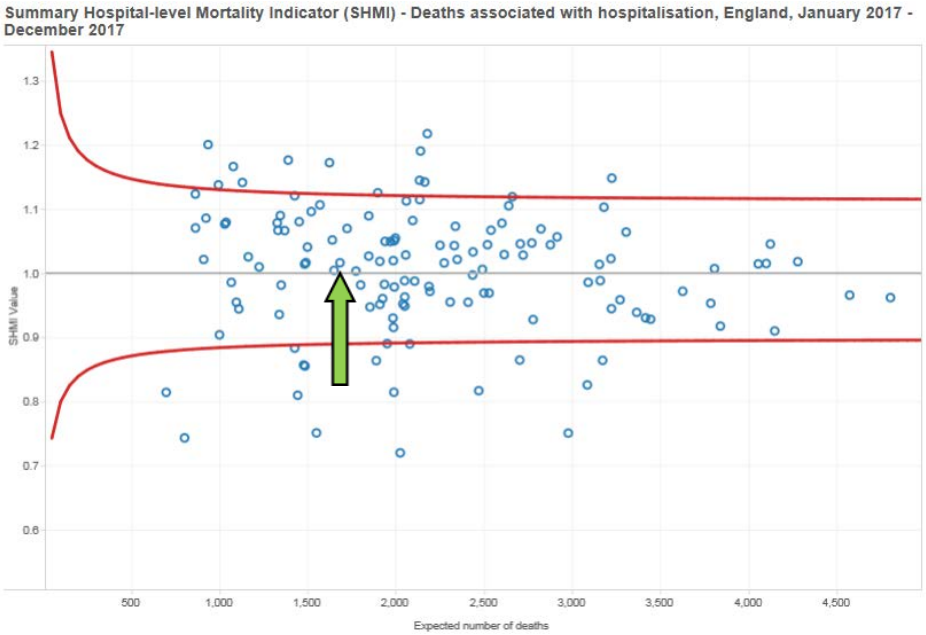
	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18
Diagnostics and Therapies	0	0	0	0	0	0	0	0	0	0	0	0
Medicine	1,113	1,045	1,111	1,252	1,336	1,276	1,345	1,245	1,105	461	133	23
Specialised Services	563	432	442	295	353	387	400	367	383	188	206	214
Surgery	1,200	1,058	1,015	934	947	922	887	717	573	444	221	92
Women's and Children's	2,451	2,364	2,400	2,381	2,398	2,299	2,330	868	888	756	526	387
TRUST TOTAL	**5,327**	**4,899**	**4,968**	**4,862**	**5,034**	**4,884**	**4,962**	**3,197**	**2,949**	**1,849**	**1,086**	**716**



Mortality - Summary Hospital Mortality Indicator (SHMI)	
Standards:	This is the national measure published by NHS Digital .It is the number of actual deaths divided by "expected" deaths, multiplied by 100. The Summary Hospital Mortality Indicator (SHMI) covers deaths in-hospital and deaths within 30 days of discharge. It is published quarterly as covers a rolling 12 –month period. Data is published 6 months in arrears.
Performance:	Latest SHMI data is for 12 month period Jan-17 to Dec-17. The SHMI was 101.7 (1712 deaths and 1684 "expected")
Commentary:	Although the Trust SHMI is 101.7 but is still in the "SHMI As Expected" category and statistically there are insufficient data points to determine any trend. Mortality alerts and outliers continue to be monitored through the Quality Intelligence Group, chaired by the Medical Director.
Ownership:	Medical Director

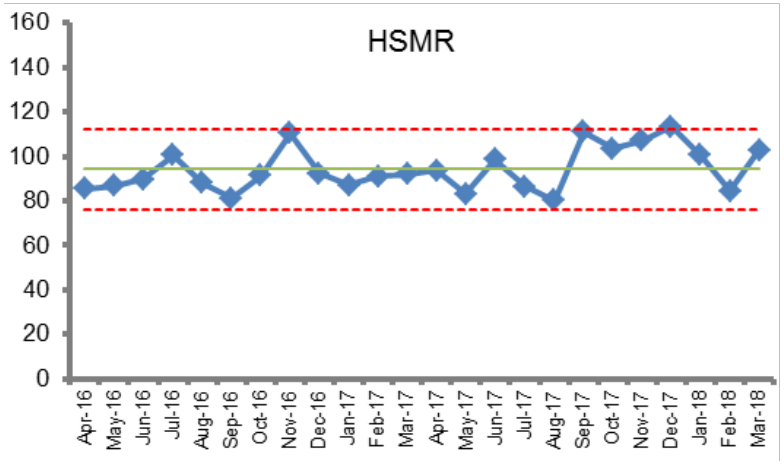
Time Period	Observed Deaths	"Expected" Deaths	SHMI	Banding
Jul15-Jun16	1,775	1,754	101.2	As Expected
Oct15-Sep16	1,741	1,752	99.4	As Expected
Jan16-Dec16	1,743	1,758	99.1	As Expected
Apr16-Mar17	1,690	1,737	97.3	As Expected
Jul16-Jun17	1,674	1,715	97.6	As Expected
Oct16-Sep17	1,693	1,686	100.4	As Expected
Jan17-Dec17	1,712	1,684	101.7	As Expected

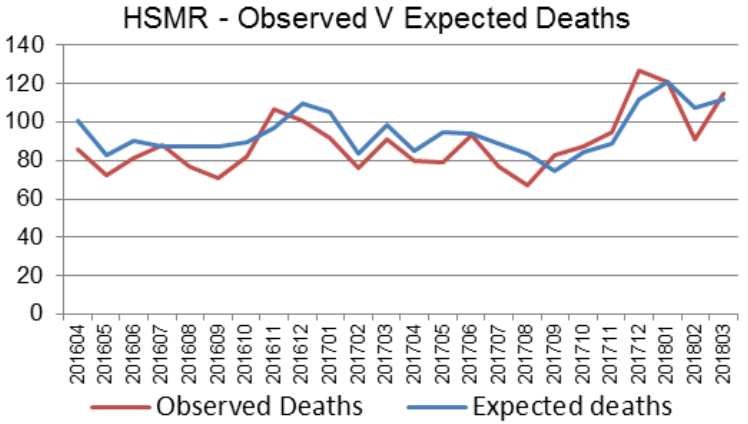




2.4 PERFORMANCE – Effective Domain

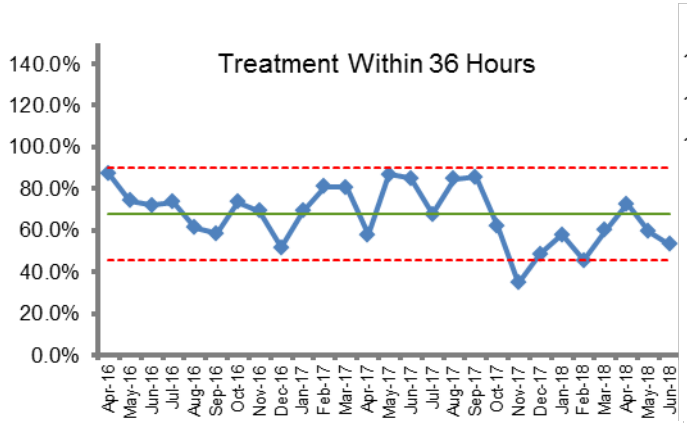
Mortality – Hospital Standardised Mortality Ratio (HSMR)	
Standards:	This is the national measure published by Dr Foster .It is the number of actual deaths divided by "expected" deaths, multiplied by 100. The Hospital Standardised Mortality Ratio (HSMR) is in-hospital deaths for conditions that account for 80% of hospital deaths
Performance:	Latest HSMR data is for March 2018. The HSMR was 102.8 (115 deaths and 112 "expected")
Commentary:	The 12 month rolling HSMR remains below 100. Mortality alerts and outliers continue to be monitored through the Quality Intelligence Group, chaired by the Medical Director.
Ownership:	Medical Director

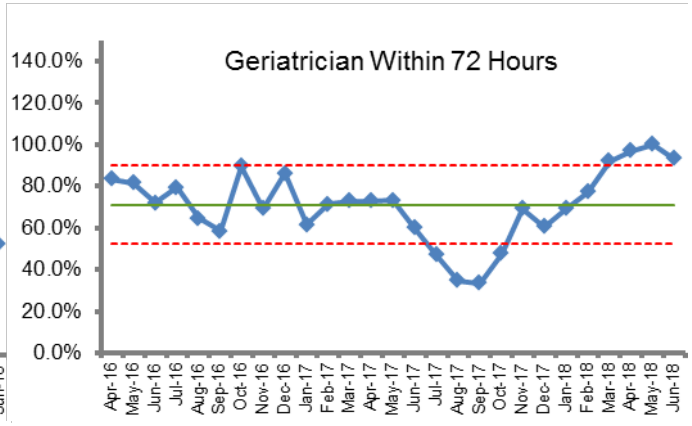


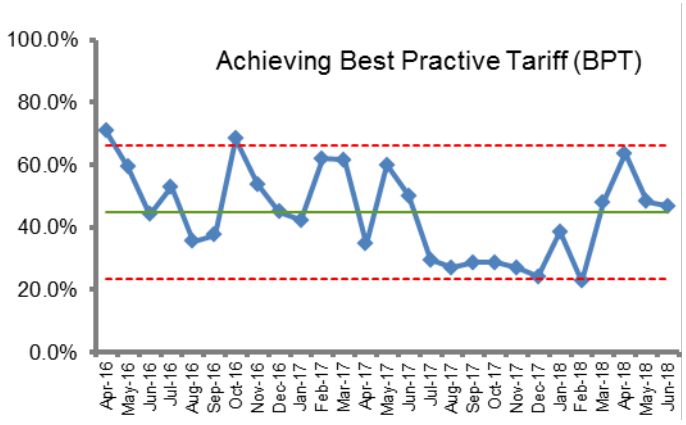


2.4 PERFORMANCE – Effective Domain

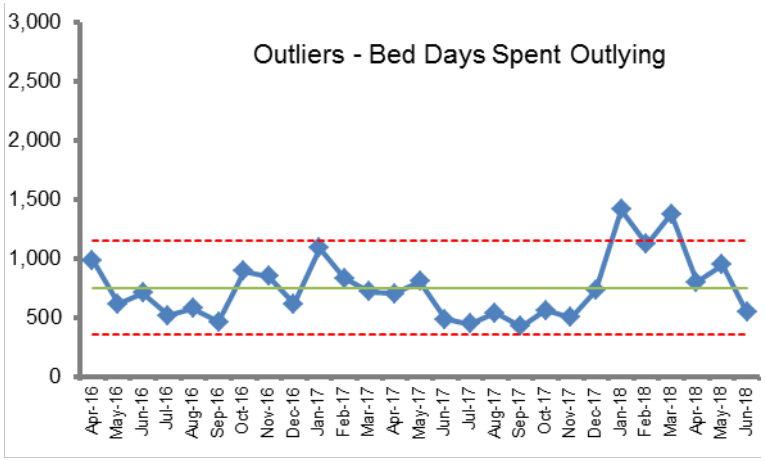
Fracture Neck of Femur	
Standards:	Best Practice Tariff (BPT), is a basket of indicators covering eight elements of what is considered to be best practice in the care of patients that have fractured their hip. 90% of patients should achieve Best Practice Tariff. Two key measures are being treated within 36 hours and seeing an orthogeriatrician within 72 hours. Both these measures should achieve 90%.
Performance:	Latest data is June, where 15 Fracture NOF patients were admitted. For the 36 hour target, 53% were seen with target. For the 72 hour target, 93% were seen within target 7 patients (47%) achieved all elements of the Best Practice Tariff.
Commentary:	In June, there were eighteen patients discharged following an admission for fractured neck of femur, and fifteen of them were eligible for best practice tariff. Seven of these patients were not operated on in theatre within the required 36 hours. Two patients were also not reviewed by a Physiotherapist on the day of or the day after surgery. Therefore eight patients did not qualify for best practice tariff. Further details are provided below: The list below outlines the details of the seven patients who were not treated in theatre within 36 hours: • One patient required a specialist surgeon, • Six patients were not operated on within the 36 hour timeframe due to other urgent trauma cases being prioritised. The two patients that were not reviewed by a Physiotherapist were admitted prior to the commencement of a Physiotherapist service on a Sunday.
Ownership:	Medical Director

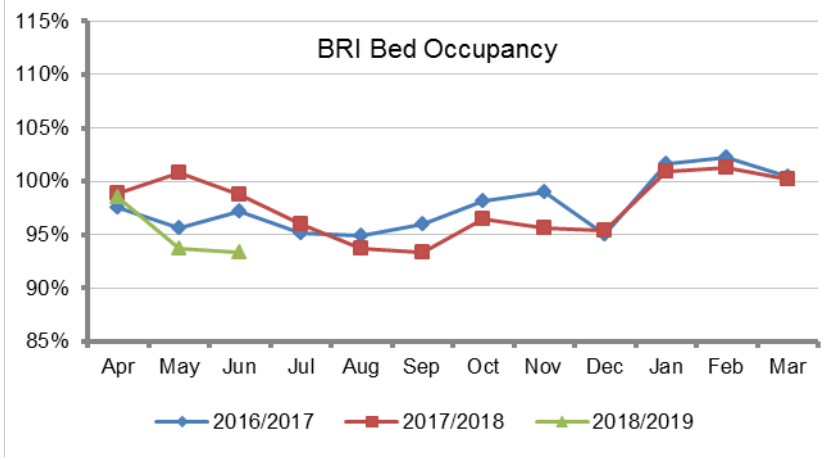


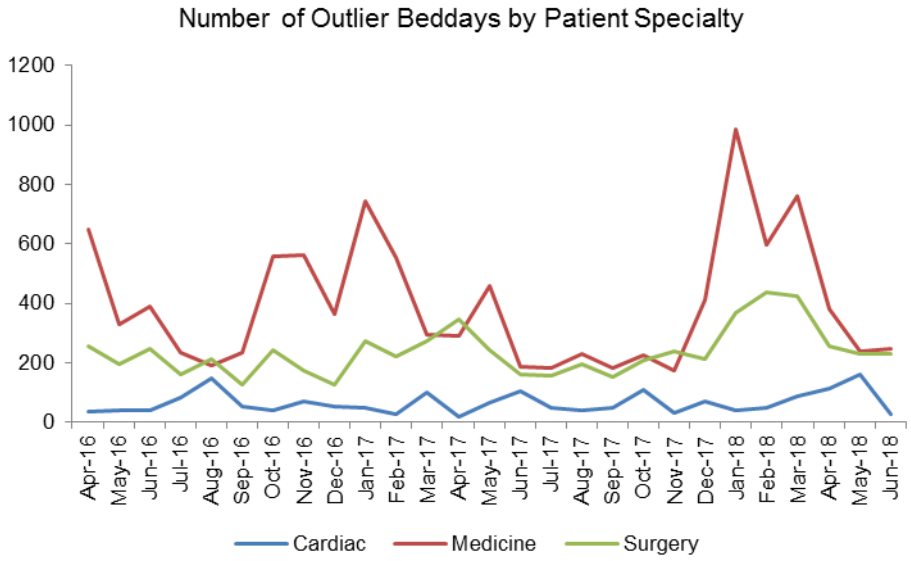




Outliers	
Standards:	This is a measure of how many bed-days patients spend on a ward that is different from their broad treatment speciality: medicine, surgery, cardiac and oncology. Our target is a 15% reduction which equates to a 9029 bed-days for the year with seasonally adjusted quarterly targets.
Performance:	In June there were 543 outlying beddays (1 bedday = 1 patient in a bed at 12 midnight) Of these 249 were Medicine beddays, 60 were Specialised Services patients and 234 were Surgery patients.
Commentary:	The June target of no more than 815 was achieved. Quarter 1 had 2,318 outlying beddays, which came in slightly below the combined quarterly target of 2445 beddays. May's performance was significantly impacted by Oncology patients outlying due to the BHOC fire. Implementation of Clinical Utilisation Review ongoing with a focus on increasing the use of this data at all patient flow meetings, and divisional targets to reduce the number of internal delays.
Ownership:	Chief Operating Officer

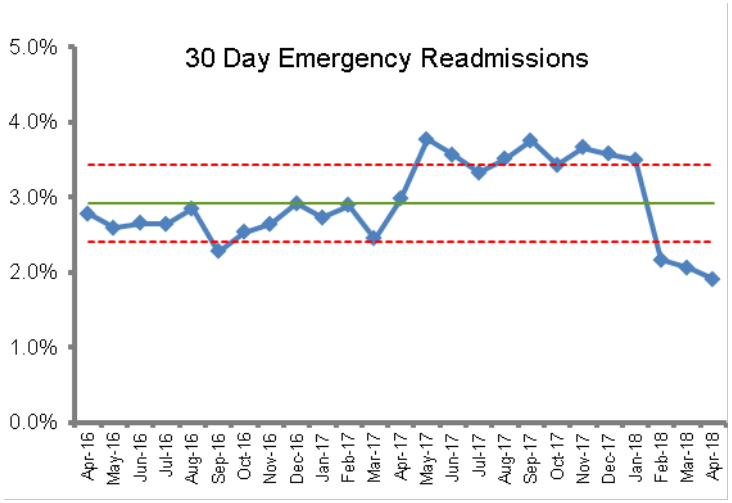






2.4 PERFORMANCE – Effective Domain

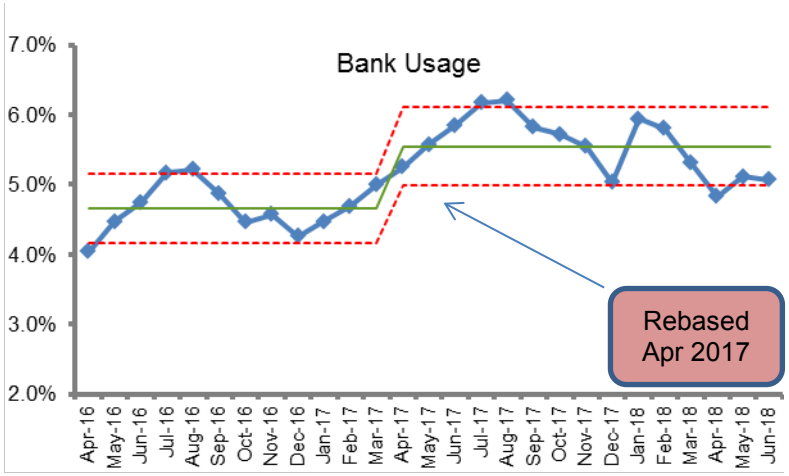
30 Day Emergency Readmissions	
Standards:	This reports on patients who are re-admitted as an emergency to the Trust within 30 days of being discharged. This can be in an unrelated specialty; it purely looks to see if there was a readmission. This uses Payment By Results (PbR) rules, which excludes certain pathways such as Cancer and Maternity. The target for the Trust was to remain below 2014/15 levels of 2.7%.
Performance:	In April, there were 12229 discharges, of which 233 (1.91%) had a re-admission within 30 days.
Ownership:	Chief Operating Officer

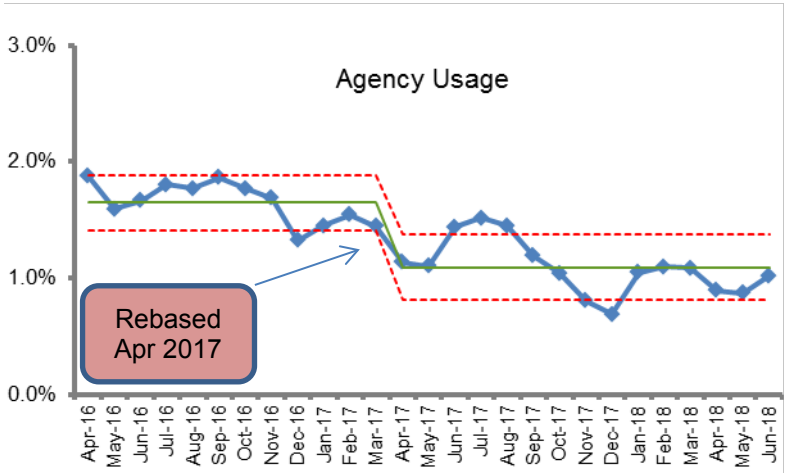


Discharges in April 2018

	Emergency Readmissions	Total Discharges	% Readmissions
Diagnostics and Therapies	0	31	0.00%
Medicine	112	2,250	4.98%
Specialised Services	11	2,629	0.42%
Surgery	71	3,269	2.17%
Women's and Children's	39	4,050	0.96%
TRUST TOTAL	**233**	**12,229**	**1.91%**

Bank and Agency Usage	
Standards:	Usage is measured as a percentage of total staffing (FTE - full time equivalent) based on aggregated Divisional targets for 2018/19. The red threshold is 10% over the monthly target.
Performance:	In June, total staffing was at 8628 FTE. Of this, 5.1% was Bank (437 FTE) and 1.0% was Agency (88.1 FTE)
Commentary:	**Agency usage** increased by 13.0 FTE, with the largest increase seen in Women's and Children's with 30.0 FTE compared to 22.2 FTE in the previous month. The largest reduction was seen in Surgery, decreasing to 14.6 FTE from 16.7 FTE the previous month. The largest staff group increase was within Nursing & Midwifery increasing to 70.0 FTE from 59.2 FTE in the previous month. **Bank usage** reduced by 3.6 FTE, with the largest increase seen in Medicine; 131.4 FTE compared to 116.2 FTE in the previous month. The largest reduction was seen in Trust Services, decreasing to 29.6 FTE from 49.0 FTE the previous month. The largest staff group reduction was within Admin & Clerical decreasing to 88.6 FTE from 106.9 FTE in the previous month.
Ownership:	Director of People



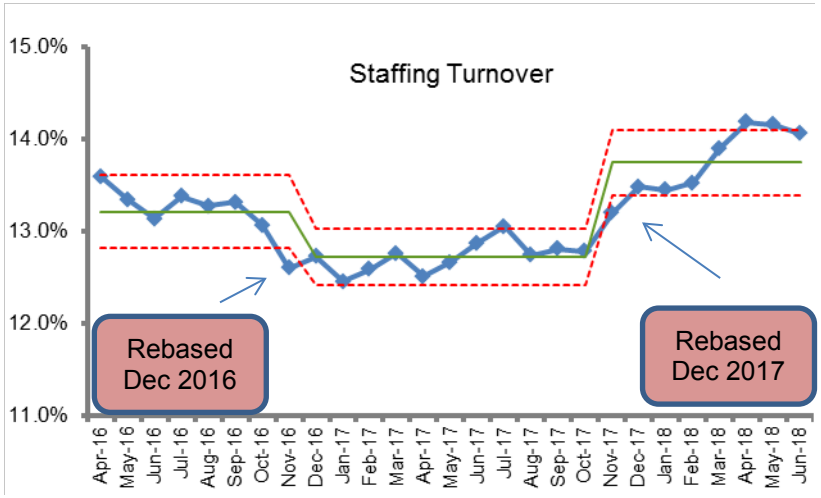


Bank	FTE	Actual %	KPI
UHBristol	**437.14**	**5.1%**	**4.4%**
Diagnostics & Therapies	13.7	1.4%	1.5%
Facilities and Estates	46.6	6.3%	6.6%
Medicine	131.4	10.2%	10.9%
Specialised Services	68.9	6.9%	5.5%
Surgery	83.9	4.7%	3.1%
Trust Services	29.6	3.6%	2.7%
Women's & Children's	63.0	3.2%	1.9%

Agency	FTE	Actual %	KPI
UHBristol	**88.1**	**1.0%**	**0.9%**
Diagnostics & Therapies	4.0	0.4%	1.1%
Facilities and Estates	1.6	0.2%	0.7%
Medicine	23.6	1.8%	1.8%
Specialised Services	10.2	1.0%	0.9%
Surgery	14.6	0.8%	0.7%
Trust Services	4.2	0.5%	0.3%
Women's & Children's	30.0	1.5%	0.6%

2.5 PERFORMANCE – Efficient Domain

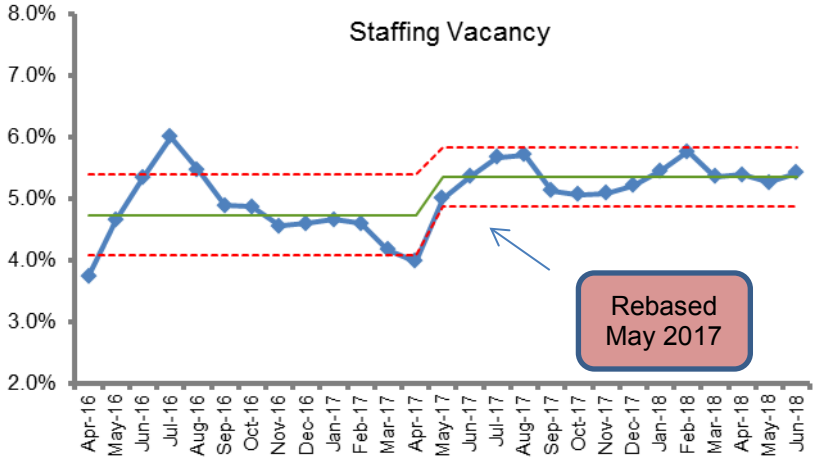
Staffing Levels (Turnover)	
Standards:	Turnover is measured as total permanent leavers (FTE) as a percentage of the average permanent staff over a rolling 12-month period. The Trust target is the trajectory to achieve 12.3% by the end of 2018/19. The red threshold is 10% above monthly trajectory.
Performance:	In June, there had been 980 leavers over the previous 12 months with 6969 FTE staff in post on average over that period; giving a Turnover of 980 / 6969 = 14.1%
Commentary:	Turnover reduced to 14.1% from 14.2% last month, with decreases across 4 divisions: Diagnostic & Therapies (0.6%), Facilities & Estates (0.4%), Surgery (0.1%), and Trust Services (0.3%). The largest increase in staff group was seen in Add Prof Scientific and Technical (0.3 percentage points). The biggest reduction in staff group was seen in Allied Health Professionals (0.7% percentage points).
Ownership:	Director of People



Turnover	Jun-18	KPI
UH Bristol NHS Foundation Trust	**14.1%**	**13.5%**
Diagnostics & Therapies	11.0%	11.6%
Facilities & Estates	18.3%	17.6%
Medicine	14.5%	14.3%
Specialised Services	16.0%	14.9%
Surgery	14.0%	12.6%
Trust Services	15.7%	15.6%
Women's & Children's	12.1%	11.5%

2.5 PERFORMANCE – Efficient Domain

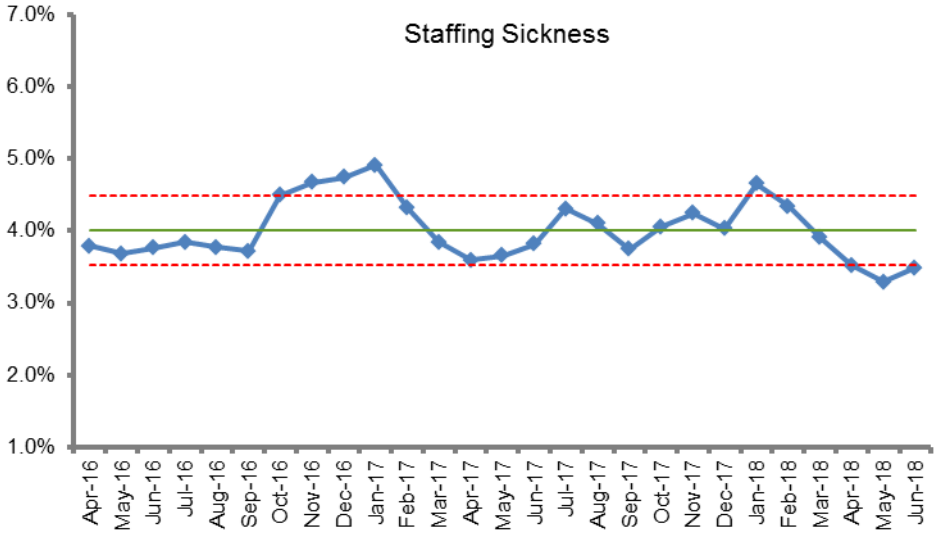
Staffing Levels (Vacancy)	
Standards:	Vacancy levels are measured as the difference between the Full Time Equivalent (FTE) budgeted establishment and the Full Time Equivalent substantively employed, represented as a percentage, compared to a Trust-wide target of 5%.
Performance:	In June, funded establishment was 8568, with 465 as vacancies (5.4%).
Commentary:	Overall vacancies increased to 5.4% compared to 5.3% in the previous month. Ancillary staff Trust-wide reduced to 87 FTE from 92 FTE. The biggest reduction in this area was seen in Facilities and Estates where Ancillary staff vacancies reduced to 80.3 FTE from 83.1 FTE the previous month. The overall medical vacancy position increased to 15.2 FTE from 1.7 FTE the previous month. The biggest increase in this area was seen in the Medicine division where medical vacancies increased to 6.3 FTE from -0.5 FTE the previous month.
Ownership:	Director of People



Vacancy	Jun-18	KPI
UH Bristol	**5.4%**	**5.0%**
Diagnostics & Therapies	6.3%	5.0%
Medicine	7.1%	5.0%
Specialised Services	8.0%	5.0%
Surgery	5.1%	5.0%
Women's & Children's	2.0%	5.0%
Trust Services	2.6%	5.0%
Facilities & Estates	10.4%	5.0%

2.5 PERFORMANCE – Efficient Domain

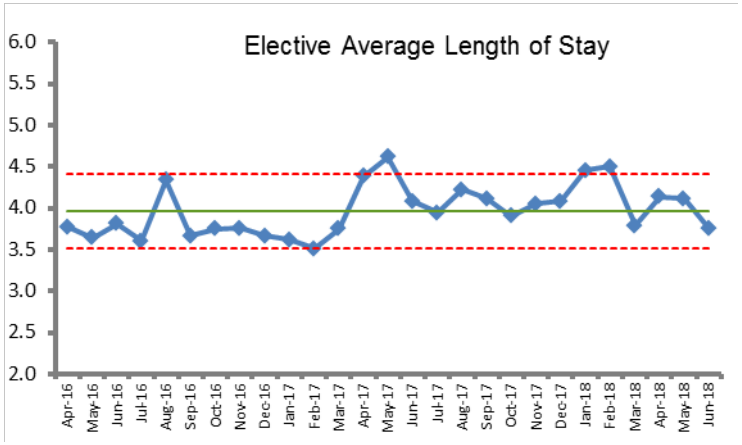
Staff Sickness	
Standards:	Staff sickness is measured as a percentage of available Full Time Equivalents (FTEs) absent, based on aggregated Divisional targets for 2018/19. The red threshold is 0.5% over the monthly target.
Performance:	In June, total available FTE days were 242365 of which 8449 (3.5%) were lost to staff sickness
Commentary:	Sickness absence increased from 3.3% to 3.5%, with increases in four Divisions. Medicine saw the largest increase to 4.1% from 3.7% the previous month. The largest staff group increase was seen in unregistered nursing, rising to 6.6% from 5.9%. The largest staff group reduction was seen within Estates & Ancillary as well as Healthcare Scientists, both reducing by 0.2%. Stress/Anxiety continues to be the cause for the most of amount of sickness days lost, however this reduced by 2.6% compared with last month. Gastrointestinal problems are the second highest cause of sickness and this reason increased by 19.1% compared with last month. The third highest reason, other musculoskeletal problems also increased by 18.1% compared to the previous month.
Ownership:	Director of People

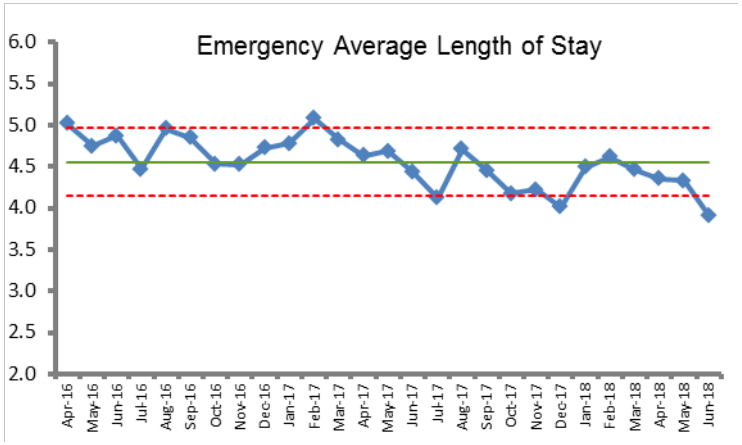


Sickness	Jun-18	KPI
UH Bristol NHS Foundation Trust	**3.5%**	**3.6%**
Diagnostic & Therapies	2.7%	3.0%
Facilities & Estates	4.6%	6.2%
Medicine	4.1%	3.5%
Specialised Services	2.8%	3.3%
Surgery	3.8%	3.6%
Trust Services (excl Facilities & Estates)	2.3%	2.9%
Women's & Children's	3.7%	3.6%

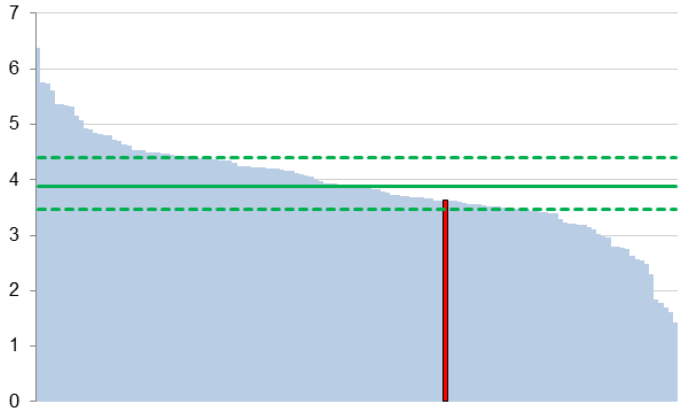
2.5 PERFORMANCE – Efficient Domain

Average Length of Stay	
Standards:	Average Length of Stay is the number of beddays (1 beddays = 1 bed occupied at 12 midnight) for all inpatients discharged in the month, divided by number of discharges.
Performance:	In June there were 6314 discharges that consumed 23,125 beddays, giving an overall average length of stay of 3.66 days.
Ownership:	Chief Operating Officer

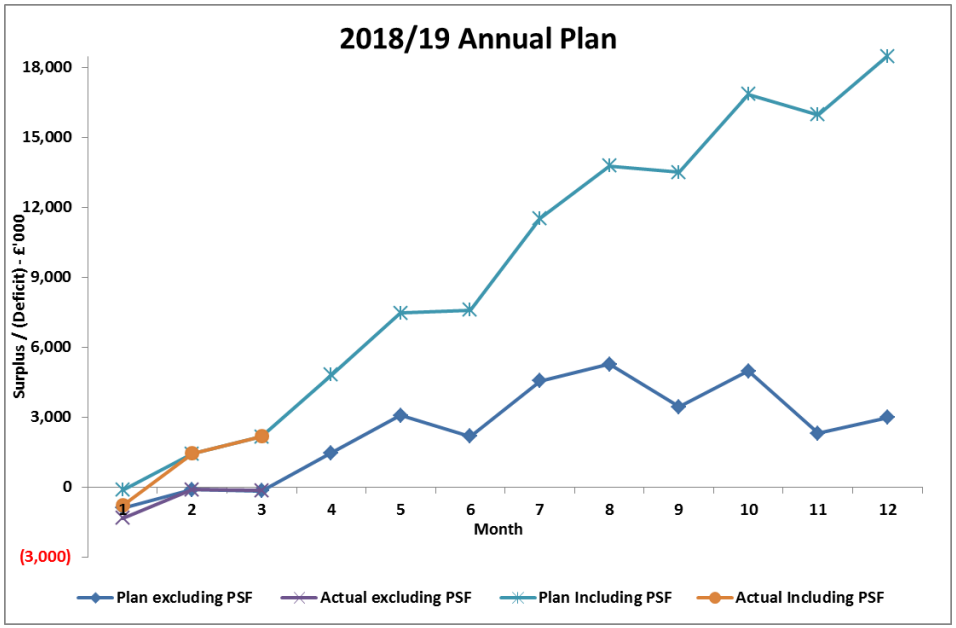


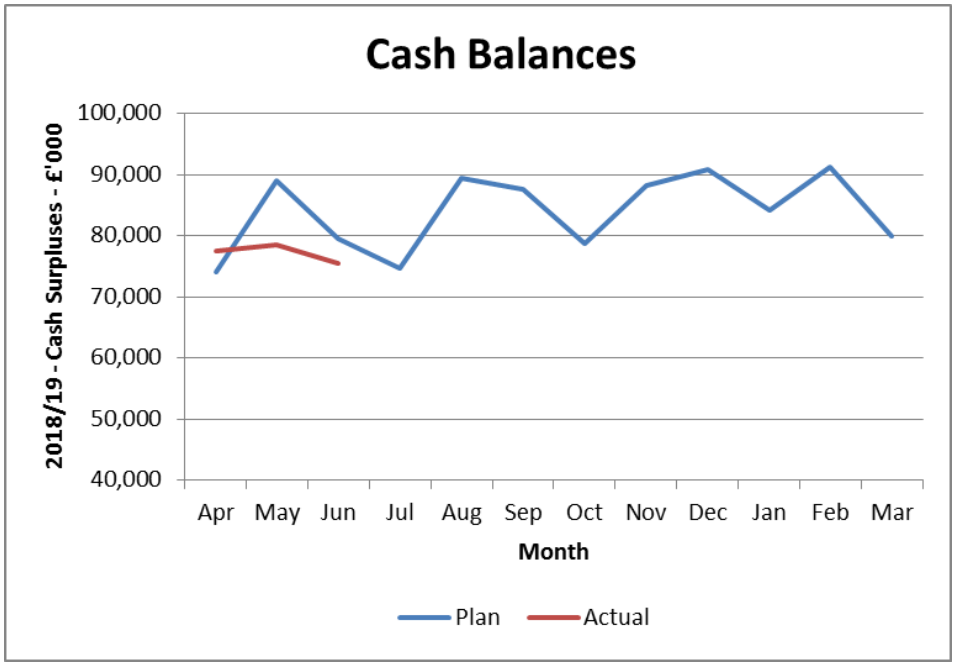


Average Length of Stay – England Acute Trusts – 2017/18 Quarter 4



Unbroken horizontal line is England median; dotted lines are upper & lower quartiles

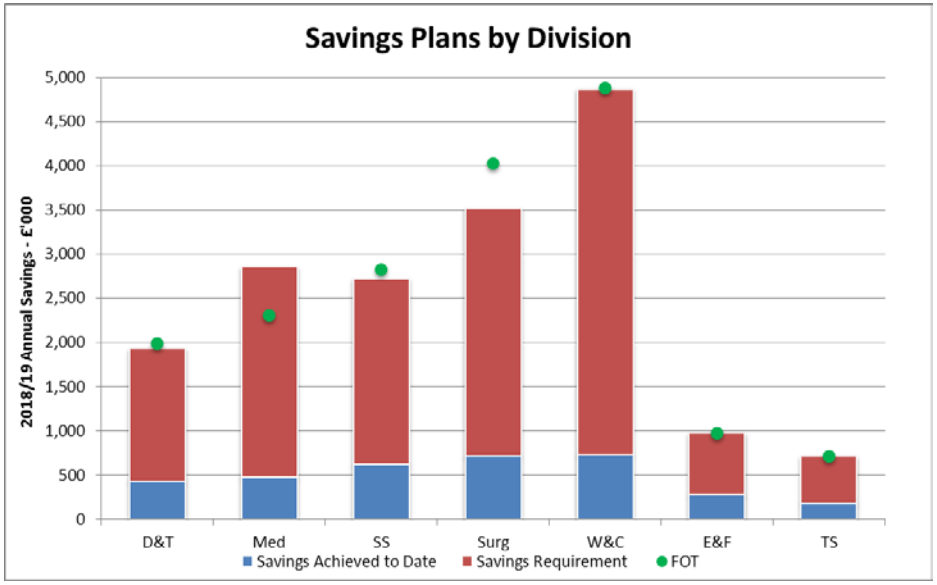




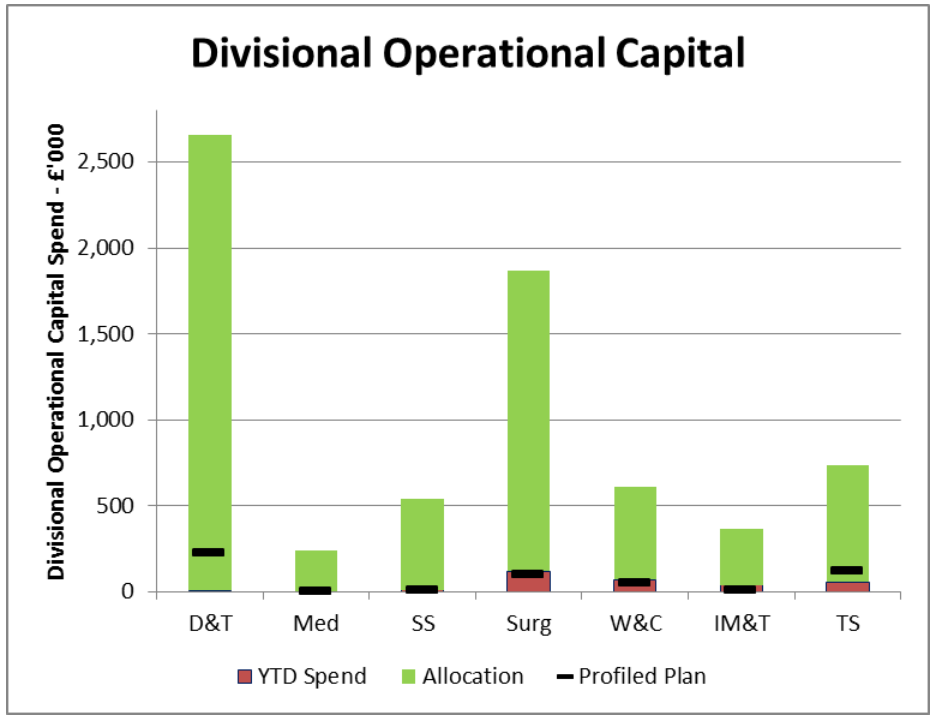
Actual Spend - £'000					
Agency	In Month			Plan for Year	Straight Line Projection
	Apr	May	Jun		
Nursing & Midwifery	438	422	499	**3,277**	**5,436**
Medical					**0**
Consultants	17	25	14	**184**	**220**
Other Medical	17	35	54	**276**	**424**
Other	42	106	91	**1,701**	**933**
Total	**514**	**482**	**567**	**5,438**	**7,013**

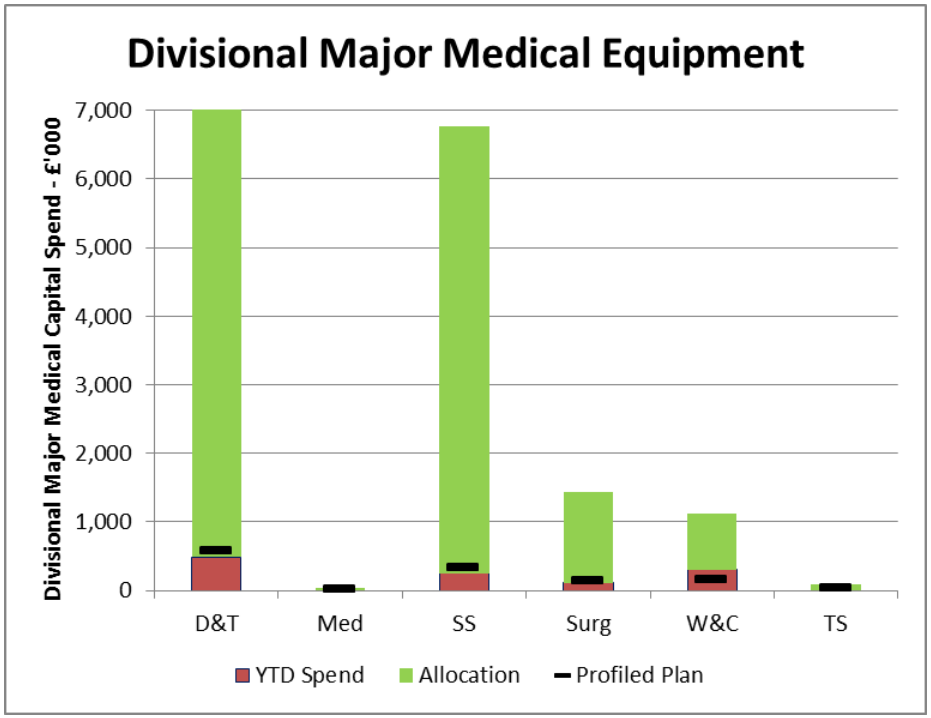
YTD Variance to Budget Surplus/(Deficit) - £'000			
Division	Apr	May	Jun
Diagnostics & Therapies	12	71	156
Medicine	(72)	(145)	(449)
Specialised Services	(175)	65	335
Surgery	(75)	(191)	(651)
Women's & Children's	(145)	(332)	(78)
Estates & facilities	3	(6)	(18)
Trust Services	(8)	(10)	(18)
Other Corporate Services	18	127	152
Total	**(442)**	**(421)**	**(571)**

Variance to Budget Surplus/(Deficit) - £'000				
Subjective Heading	In Month			YTD
	Apr	May	Jun	Total
Nursing & Midwifery Pay	(248)	(315)	(420)	**(983)**
Medical & Dental Pay	(358)	(322)	(353)	**(1,033)**
Other Pay	120	60	116	**296**
Non Pay	2	(728)	(361)	**(1,087)**
Income from Operations	(69)	0	42	**(27)**
Income from Activities	111	1,327	825	**2,263**
Total	**(442)**	**22**	**(151)**	**(571)**



2018/19 Capital Programme			Year To Date		
Operational Plan	Subjective Heading	Internal Plan	Internal Plan	Actual spend	Variance (over) /under
£'000		£'000	£'000	£'000	£'000
	Sources of Funding				
1,600	PDC	1,600			
3,189	Loan	3,189			
3,000	Donations	3,000	451	198	(253)
	Cash:				
24,338	Depreciation	24,338	5,925	5,884	(41)
14,962	Cash balances	15,026	(2,311)	(2,323)	(12)
47,089	**Total Funding**	**47,153**	**4,065**	**3,759**	**(306)**
	Application/Expenditure				
(11,618)	Strategic Schemes	(11,368)	(273)	(71)	202
(17,620)	Medical Equipment	(17,697)	(1,234)	(1,179)	55
(16,415)	Operational Capital	(15,772)	(1,396)	(834)	562
(7,468)	Information Technology	(7,715)	(780)	(1,374)	(594)
(2,367)	Estates Replacement	(2,311)	(382)	(301)	81
(55,488)	**Gross Expenditure**	**(54,863)**	**(4,065)**	**(3,759)**	**306**
8,399	In-Year Slippage	7,710			
(47,089)	**Net Expenditure**	**(47,153)**	**(4,065)**	**(3,759)**	**306**

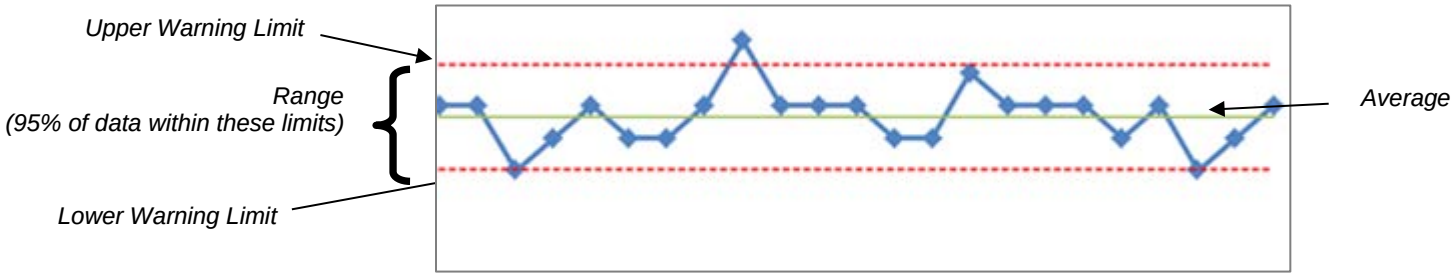




A1 APPENDIX 1 – Explanation of SPC Charts

In Section 2, some of the metrics are being presented using Statistical Process Control (SPC) charts

An example chart is shown below:



The blue line is the Trust's monthly data and the green solid line is the monthly average for that data. The red dashed lines are called "warning limits" and are derived from the Trust's monthly data and is a measure of the variation present in the data. If the process does not change, then 95% of all future data points will lie between these two limits.

If a process changes, then the limits can be re-calculated and a "step change" will be observed. There are different signals to look for, to identify if a process has changed. Examples would be a run of 7 data points going up/down or 7 data points one side of the average. These step changes should be traceable back to a change in operational practice; they do not occur by chance.

A2 APPENDIX 2 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.

SAFE, CARING & EFFECTIVE

Topic	ID	Title	Annual 17/18	Annual 18/19 YTD	Monthly Totals Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Quarterly Totals 17/18 Q2	17/18 Q3	17/18 Q4	18/19 Q1
Patient Safety																				
Infections	DA01	MRSA Trust Apportioned Cases	4	3	0	0	0	0	1	1	1	0	0	1	0	2	0	2	1	3
	DA02	MSSA Trust Apportioned Cases	25	12	0	3	0	5	4	1	2	3	3	3	5	4	3	10	8	12
	DA03	CDiff Trust Apportioned Cases	35	8	6	2	3	1	1	3	2	6	0	2	0	6	11	5	8	8
C.Diff "Avoidables"	DA03B	CDiff Trust Apportioned Cases - Lapse in Care	7	1	2	1	1	0	0	0	0	0	0	1	0	0	4	0	0	1
	DA03D	CDiff Trust Apportioned Cases - Still Under Review	12	6	0	0	0	0	1	3	2	6	0	0	0	6	0	4	8	6
Infection Checklists	DB01	Hand Hygiene Audit Compliance	97.6%	97.3%	97.2%	97.7%	96.3%	96.4%	97.6%	97.3%	98.4%	98.2%	96.9%	96.8%	97.8%	97.4%	97%	97.1%	97.8%	97.3%
	DB02	Antibiotic Compliance	86.4%	82.5%	87.8%	81.3%	84.4%	85.1%	89.1%	85.4%	85.2%	89.6%	85.3%	82.8%	81.3%	83%	84.3%	86.4%	86.6%	82.5%
Cleanliness Monitoring	DC01	Cleanliness Monitoring - Overall Score	-	-	96%	97%	97%	96%	96%	95%	98%	94%	95%	95%	96%	95%	-	-	-	-
	DC02	Cleanliness Monitoring - Very High Risk Areas	-	-	98%	98%	98%	98%	98%	98%	96%	97%	98%	97%	97%	98%	-	-	-	-
	DC03	Cleanliness Monitoring - High Risk Areas	-	-	97%	97%	97%	96%	97%	96%	93%	96%	96%	96%	95%	96%	-	-	-	-
Serious Incidents	S02	Number of Serious Incidents Reported	57	17	5	3	9	2	4	4	6	2	7	3	10	4	17	10	15	17
	S02a	Number of Confirmed Serious Incidents	53	2	5	3	9	2	3	4	6	2	6	2	-	-	17	9	14	2
	S02b	Number of Serious Incidents Still Open	-	15	-	-	-	-	-	-	-	-	-	1	10	4	-	-	-	15
	S03	Serious Incidents Reported Within 48 Hours	100%	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	94.7%	100%	100%	100%	100%	100%	50%	100%	100%	100%	100%	100%	100%	100%	100%	80%	100%	100%
	S04	Serious Incident Investigations Completed Within Timescale	96.2%	92.9%	100%	100%	100%	100%	100%	100%	83.3%	100%	100%	100%	75%	100%	100%	100%	93.3%	92.9%
	S04a	Overdue Exec Commissioned Non-SI Investigations	19	5	1	1	2	1	1	3	3	1	1	2	2	1	4	5	5	5
Never Events	S01	Total Never Events	8	0	1	0	0	2	0	0	1	0	1	0	0	0	1	2	2	0
Patient Safety Incidents	S06	Number of Patient Safety Incidents Reported	15656	4184	1288	1249	1229	1311	1332	1193	1347	1379	1480	1428	1311	1445	3766	3836	4206	4184
	S06b	Patient Safety Incidents Per 1000 Beddays	50.86	55.92	49.49	48.38	49.91	50.19	52.96	46.38	50.04	57.11	55.29	55.84	52.85	59.13	49.25	49.82	54.04	55.92
	S07	Number of Patient Safety Incidents - Severe Harm	92	29	6	7	7	4	9	9	10	7	7	6	13	10	20	22	24	29
Patient Falls	AB01	Falls Per 1,000 Beddays	4.59	3.93	4.53	4.76	5.04	4.48	3.78	4.51	4.61	4.68	5.04	3.79	4.27	3.72	4.77	4.26	4.78	3.93
	AB06a	Total Number of Patient Falls Resulting in Harm	25	7	0	0	3	2	2	5	2	0	2	2	4	1	3	9	4	7
Pressure Ulcers Developed in the Trust	DE01	Pressure Ulcers Per 1,000 Beddays	0.162	0.134	0.154	0.155	0.203	0.038	0.159	0.156	0.372	0.207	0.149	0.156	0.121	0.123	0.17	0.117	0.244	0.134
	DE02	Pressure Ulcers - Grade 2	45	8	2	4	4	1	4	4	10	5	4	2	3	3	10	9	19	8
	DE04A	Pressure Ulcers - Grade 3 or 4	5	2	2	0	1	0	0	0	0	0	0	2	0	0	3	0	0	2
Venous Thrombo-embolism (VTE)	N01	Adult Inpatients who Received a VTE Risk Assessment	98.4%	98.3%	98.8%	97.4%	98.3%	98.4%	98.2%	98%	98%	98.3%	98.3%	98.1%	98.4%	98.5%	98.2%	98.2%	98.2%	98.3%
	N02	Percentage of Adult Inpatients who Received Thrombo-prophylaxis	95%	93.8%	97.4%	94.9%	92.3%	97.1%	94%	92.3%	91.4%	94.4%	97.1%	93.8%	96.1%	91.1%	94.7%	94.5%	94.1%	93.8%
	N04	Number of Hospital Associated VTEs	50	7	4	2	3	6	1	3	8	3	7	3	4	-	9	10	18	7
	N04A	Number of Potentially Avoidable Hospital Associated VTEs	2	0	0	0	0	1	0	0	0	0	0	0	0	-	0	1	0	0
	N04B	Number of Hospital Associated VTEs - Report Not Received To Date	4	4	0	0	0	0	0	1	0	1	2	1	3	-	0	1	3	4
Nutrition	WB03	Nutrition: 72 Hour Food Chart Review	92.1%	-	96.2%	94.6%	92.6%	91%	95.2%	88.8%	95%	91%	93.7%	-	-	-	94.5%	91.3%	93%	-
Nutrition Audit	WB10	Fully and Accurately Completed Screening within 24 Hours	89.9%	-	-	-	92%	-	-	88.9%	-	-	86.3%	-	-	-	92%	88.9%	86.3%	-
Safety	Y01	WHO Surgical Checklist Compliance	99.7%	99.7%	99.8%	99.8%	99.9%	99.8%	99.2%	99.8%	100%	99.8%	99.7%	99.9%	99.7%	99.6%	99.8%	99.6%	99.8%	99.7%

APPENDIX 3 – Trust Scorecards

Topic	ID	Title	Annual 17/18	Annual 18/19 YTD	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	17/18 Q2	17/18 Q3	17/18 Q4	18/19 Q1
Medicines	WA01	Medication Incidents Resulting in Harm	0.55%	0.45%	1.35%	0.51%	0%	1.97%	0.47%	0.5%	0.49%	0%	0%	0%	0.91%	-	0.64%	0.97%	0.15%	0.45%
	WA03	Non-Purposeful Omitted Doses of the Listed Critical Medication	0.4%	0.43%	0.32%	0.11%	0.37%	0.27%	0.41%	0%	0.42%	1.02%	0.33%	0.63%	0.36%	0.24%	0.25%	0.24%	0.57%	0.43%
Safety Thermometer	AK03	Safety Thermometer - Harm Free Care	97.9%	-	97.7%	96.9%	97.7%	97.5%	98.8%	98.3%	98.8%	98.2%	98.2%	-	-	-	97.4%	98.2%	98.4%	-
	AK04	Safety Thermometer - No New Harms	98.8%	-	98.8%	98.2%	98.7%	98.9%	99.1%	99%	99.9%	98.4%	98.5%	-	-	-	98.6%	99%	98.9%	-
Deteriorating Patient	AR03	National Early Warning Scores (NEWS) Acted Upon	96%	-	100%	97%	100%	90%	93%	97%	95%	91%	100%	-	-	-	99%	94%	95%	-
Out of Hours	TD05	Out of Hours Discharges (8pm-7am)	8.7%	9.3%	8.4%	10.9%	9.7%	9.1%	9.4%	9.1%	8.7%	8.2%	9%	10.2%	8.8%	8.9%	9.7%	9.2%	8.6%	9.3%
Timely Discharges	TD03	Percentage of Patients With Timely Discharge (7am-12Noon)	22.4%	21.5%	22.9%	21.9%	24%	24.2%	24%	20.8%	20.5%	20.9%	21.9%	20.3%	22.4%	21.7%	22.9%	23%	21.1%	21.5%
	TD03D	Number of Patients With Timely Discharge (7am-12Noon)	11138	2672	962	909	983	1024	1010	863	867	814	945	834	963	875	2854	2897	2626	2672
Staffing Levels	RP01	Staffing Fill Rate - Combined	98.9%	99.2%	98.6%	98%	97.1%	97.5%	98.1%	97.2%	98.5%	96.8%	95.7%	99%	98.7%	100.1%	97.9%	97.6%	97%	99.2%
Clinical Effectiveness																				
Mortality	X04	Summary Hospital Mortality Indicator (SHMI) - National Data	99.9	-	-	-	100.4	-	-	101.7	-	-	-	-	-	-	100.4	101.7	-	-
	X02	Hospital Standardised Mortality Ratio (HSMR)	97.2	-	86.4	80.2	111.2	103.6	107.2	113.5	100.4	84.4	102.8	-	-	-	91.8	108.6	96.1	-
Readmissions	C01	Emergency Readmissions Percentage	3.28%	0.94%	3.33%	3.51%	3.76%	3.43%	3.66%	3.57%	3.5%	2.17%	2.07%	1.91%	0%	-	3.53%	3.55%	2.6%	0.94%
Sepsis (Inpatients)	AG02a	Percentage of Patients Meeting Criteria Screened for Sepsis (Inpatients)	51.1%	95.7%	21.1%	50%	16.7%	20%	33.3%	46.7%	64.7%	87%	83.3%	87.1%	100%	100%	29.7%	35.5%	79.7%	95.7%
	AG03a	Sepsis Patients Percentage Commencing Antibiotics Within 1 Hour (Inpatient	77.4%	57.1%	66.7%	100%	100%	50%	-	100%	-	100%	50%	75%	-	33.3%	88.9%	75%	75%	57.1%
	AG04a	Sepsis Patients Percentage with a 72 Hour Review (Inpatients)	93.3%	100%	100%	100%	100%	66.7%	-	75%	-	100%	-	100%	-	-	100%	71.4%	100%	100%
Sepsis (Emergency Department)	AG02b	Percentage of Patients Meeting Criteria Screened for Sepsis (ED)	83.4%	89.3%	93.8%	95%	92.9%	91.7%	76%	68%	86%	88%	88%	80%	89.2%	92.8%	94%	75.8%	87.3%	89.3%
	AG03b	Sepsis Patients Percentage Commencing Antibiotics Within 1 Hour (ED)	85.5%	81.1%	84.6%	88.2%	100%	94.1%	86.2%	91.7%	90%	74.2%	94.1%	75%	91.3%	76.9%	90%	90%	83.8%	81.1%
	AG04b	Sepsis Patients Percentage with a 72 Hour Review (ED)	93.1%	94.9%	100%	100%	100%	88.9%	84%	90.9%	100%	82.1%	100%	100%	95.1%	92.9%	100%	87.7%	91.2%	94.9%
Maternity	G01	Percentage of Low Weight Babies	2.5%	3.1%	1.5%	3.3%	3.4%	0.9%	2%	4.6%	3.2%	2%	3.2%	3.2%	2.1%	4.2%	2.7%	2.5%	2.8%	3.1%
	G01A	Number of Low Weight Babies	119	35	6	13	13	4	7	18	13	7	12	12	8	15	32	29	32	35
Fracture Neck of Femur	U02	Fracture Neck of Femur Patients Treated Within 36 Hours	64.2%	64%	67.6%	84.6%	85.7%	61.9%	34.6%	48.5%	57.7%	45.5%	60%	72.7%	59.3%	53.3%	77.8%	47.5%	54.8%	64%
	U03	Fracture Neck of Femur Patients Seeing Orthogeriatrician within 72 Hours	61.6%	97.3%	47.1%	34.6%	33.3%	47.6%	69.2%	60.6%	69.2%	77.3%	92%	97%	100%	93.3%	39.5%	60%	79.5%	97.3%
	U04	Fracture Neck of Femur Patients Achieving Best Practice Tariff	34.8%	54.7%	29.4%	26.9%	28.6%	28.6%	26.9%	24.2%	38.5%	22.7%	48%	63.6%	48.1%	46.7%	28.4%	26.3%	37%	54.7%
	U05	Fracture Neck of Femur - Time To Treatment 90th Percentile (Hours)	-	-	45.9	43.8	37.1	53.3	75.9	58.6	64.8	65.7	81.5	48.7	72.7	50.6	-	-	-	-
Stroke Care	O01	Stroke Care: Percentage Receiving Brain Imaging Within 1 Hour	62.6%	45.1%	72.9%	61.9%	70%	60.7%	55.6%	60.9%	57.9%	61.3%	54.3%	58.1%	30.8%	-	68.5%	59.1%	57.4%	45.1%
	O02	Stroke Care: Percentage Spending 90%+ Time On Stroke Unit	85.8%	79.3%	83.3%	81%	92.5%	96.4%	83.3%	87%	84.2%	93.5%	80.4%	81.4%	76.9%	-	85.4%	88.2%	85.2%	79.3%
	O03	High Risk TIA Patients Starting Treatment Within 24 Hours	54.6%	46.5%	27.3%	66.7%	75%	66.7%	70%	42.9%	50%	36.4%	20%	15.4%	54.5%	63.2%	55.9%	62.9%	34.2%	46.5%
Dementia	AC01	Dementia - FAIR Question 1 - Case Finding Applied	89.3%	83.6%	91.1%	89.9%	93.5%	87.7%	93.7%	87.9%	90.7%	87.3%	86.3%	87.3%	84.8%	77.6%	91.5%	89.6%	88.2%	83.6%
	AC02	Dementia - FAIR Question 2 - Appropriately Assessed	96.2%	92.2%	100%	97.7%	97.9%	94%	97.4%	100%	93.8%	86%	96.5%	95%	91.9%	89.5%	98.6%	96.9%	92%	92.2%
	AC03	Dementia - FAIR Question 3 - Referred for Follow Up	92.9%	50%	100%	100%	100%	75%	100%	100%	100%	-	100%	-	0%	100%	100%	87.5%	100%	50%
	AC04	Percentage of Dementia Carers Feeling Supported	60%	100%	-	-	-	-	-	-	100%	-	33.3%	-	-	100%	-	-	50%	100%
Outliers	J05	Ward Outliers - Beddays Spent Outlying.	9098	2288	448	537	424	558	499	730	1411	1120	1377	800	945	543	1409	1787	3908	2288

APPENDIX 3 – Trust Scorecards

Topic	ID	Title	Annual		Monthly Totals												Quarterly Totals			
			17/18	18/19 YTD	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	17/18 Q2	17/18 Q3	17/18 Q4	18/19 Q1
Patient Experience																				
Monthly Patient Surveys	P01d	Patient Survey - Patient Experience Tracker Score	-	-	92	92	92	91	92	90	91	92	92	93	91	92	92	91	92	92
	P01g	Patient Survey - Kindness and Understanding	-	-	96	94	96	95	95	95	96	95	95	97	97	96	95	95	96	96
	P01h	Patient Survey - Outpatient Tracker Score	-	-	90	87	90	90	91	89	90	88	88	88	91	89	89	90	89	89
Friends and Family Test Coverage	P03a	Friends and Family Test Inpatient Coverage	35%	37.2%	35.8%	35.1%	35.3%	39.5%	33.2%	28.4%	34.9%	36.2%	30.3%	40.7%	37.6%	33.7%	35.4%	33.9%	33.7%	37.2%
	P03b	Friends and Family Test ED Coverage	17.3%	17.6%	17.2%	18.5%	18.3%	17.9%	17.9%	14.6%	17.8%	17.4%	15.2%	17.3%	17.2%	18.4%	18%	16.9%	16.8%	17.6%
	P03c	Friends and Family Test MAT Coverage	19%	14.8%	20%	17.3%	18.3%	21%	12.4%	23.1%	17.5%	17.7%	18.2%	19.8%	13.2%	11.2%	18.6%	19%	17.8%	14.8%
Friends and Family Test Score	P04a	Friends and Family Test Score - Inpatients	97.7%	97.3%	97.7%	97.5%	97.7%	97.9%	98.1%	97.8%	97.7%	98.3%	97.8%	97.4%	97.3%	97.3%	97.6%	98%	97.9%	97.3%
	P04b	Friends and Family Test Score - ED	81%	81.9%	77.4%	81.9%	83.5%	83.3%	80.3%	77%	81.8%	83.2%	77.7%	80.1%	81.1%	84.6%	81%	80.5%	81%	81.9%
	P04c	Friends and Family Test Score - Maternity	96.9%	96%	94.9%	96.5%	99.2%	98%	97.5%	98.1%	94.6%	96.8%	97.1%	94.6%	95.5%	99.3%	96.8%	98%	96.1%	96%
Patient Complaints	T01	Number of Patient Complaints	1815	446	146	146	138	154	155	98	143	121	159	149	157	140	430	407	423	446
	T01a	Patient Complaints as a Proportion of Activity	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
	T03a	Complaints Responded To Within Trust Timeframe	83%	85.9%	82%	87.3%	78.7%	85.1%	87.1%	83.8%	87.8%	82.8%	77.9%	83.1%	91%	84%	83%	85.4%	82.3%	85.9%
	T03b	Complaints Responded To Within Divisional Timeframe	83.8%	81.7%	90%	81.7%	86.9%	83.6%	90%	82.4%	91.8%	82.8%	77.9%	85.9%	82.1%	77.3%	85.7%	85.4%	83.4%	81.7%
	T04c	Percentage of Responses where Complainant is Dissatisfied	10.68%	12.68%	8%	11.27%	9.84%	10.45%	7.14%	2.94%	8.16%	8.62%	13.23%	12.68%	-	-	9.89%	6.83%	10.29%	12.68%
Cancelled Operations	F01q	Percentage of Last Minute Cancelled Operations (Quality Objective)	1.19%	1.29%	0.81%	0.91%	0.91%	1%	1.26%	1.2%	1.53%	1.63%	1.92%	1.37%	1.9%	0.59%	0.88%	1.15%	1.69%	1.29%
	F01a	Number of Last Minute Cancelled Operations	919	249	54	61	58	68	85	71	102	98	121	85	125	39	173	224	321	249

RESPONSIVE

			Annual Target		Annual		Monthly Totals												Quarterly Totals			
Topic	ID	Title	Green	Red	17/18	18/19 YTD	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	17/18 Q2	17/18 Q3	17/18 Q4	18/19 Q1
Referral to Treatment (RTT) Performance	A03	Referral To Treatment Ongoing Pathways Under 18 Weeks	92%	87%	89.6%	88.6%	90.2%	89.9%	89.4%	90%	88.9%	88.3%	88.1%	88.4%	87%	88.2%	89.1%	88.6%	89.8%	89.1%	87.8%	88.6%
	A03a	Referral To Treatment Number of Ongoing Pathways Over 18 Weeks	-	-	-	-	3317	3372	3524	3300	2927	3085	3138	3308	3783	3510	3244	3377	-	-	-	-
Referral to Treatment (RTT) Wait Times	A06	Referral To Treatment Ongoing Pathways Over 52 Weeks	0	1	209	36	30	32	19	10	13	9	1	15	18	15	12	9	81	32	34	36
	A07	Referral To Treatment Ongoing Pathways 40+ Weeks	-	-	-	-	198	240	182	155	136	158	160	148	164	154	141	129	-	-	-	-
Cancer (2 Week Wait)	E01a	Cancer - Urgent Referrals Seen In Under 2 Weeks	93%	93%	94.3%	93.8%	93.4%	93.2%	94.6%	94.6%	95.5%	94.8%	92.2%	96.9%	92.1%	92.6%	95.1%	-	93.7%	95%	93.6%	93.8%
	E01c	Cancer - Urgent Referrals Stretch Target	80%	80%	58.9%	47.6%	63.6%	62.4%	59.9%	64.2%	57.6%	54.4%	58.8%	59.6%	54.6%	41.3%	53.1%	-	62%	59%	57.7%	47.6%
Cancer (31 Day)	E02a	Cancer - 31 Day Diagnosis To Treatment (First Treatments)	96%	96%	95.8%	94.7%	97%	97.9%	96.9%	95.4%	98.1%	96.7%	92.9%	95.1%	95.8%	94.4%	95%	-	97.3%	96.7%	94.5%	94.7%
	E02b	Cancer - 31 Day Diagnosis To Treatment (Subsequent - Drug)	98%	98%	98.6%	97.1%	98.6%	98.6%	98.5%	99.3%	98.7%	98.9%	98.7%	98.6%	98.4%	97.6%	96.6%	-	98.6%	99%	98.6%	97.1%
	E02c	Cancer - 31 Day Diagnosis To Treatment (Subsequent - Surgery)	94%	94%	92%	89.2%	91.7%	96.3%	94.7%	95.7%	96.8%	93%	96.6%	87.7%	79.5%	93%	85%	-	94.3%	95.2%	89%	89.2%
	E02d	Cancer - 31 Day Diagnosis To Treatment (Subsequent - Radiotherapy)	94%	94%	96.3%	92.5%	93.9%	97.3%	98%	96.4%	96.1%	97.6%	92.9%	97.9%	96.4%	98.5%	85.4%	-	96.3%	96.6%	95.6%	92.5%
Cancer (62 Day)	E03a	Cancer 62 Day Referral To Treatment (Urgent GP Referral)	85%	85%	81.7%	83.2%	75%	85.2%	80.2%	84.3%	88.6%	82.9%	78.4%	81.3%	87.3%	84.1%	82.4%	-	80.1%	85.4%	82.4%	83.2%
	E03b	Cancer 62 Day Referral To Treatment (Screenings)	90%	90%	74.8%	45.5%	87.5%	100%	100%	66.7%	76.5%	71.4%	100%	58.3%	28.6%	66.7%	37.5%	-	96.3%	73.3%	61.5%	45.5%
	E03c	Cancer 62 Day Referral To Treatment (Upgrades)	85%	85%	85.4%	78.5%	78.6%	84.8%	90.7%	74.7%	88.5%	85.7%	88.7%	83.9%	90.9%	79.3%	77.9%	-	84.6%	83%	87.9%	78.5%
	E03f	Cancer Urgent GP Referrals - Numbers Treated after Day 103	-	-	47.5	8	8	5	3	3.5	2	4.5	3	2.5	2	3	5	-	16	10	7.5	8
Cancelled Operations	F01	Last Minute Cancelled Operations - Percentage of Admissions	0.8%	0.8%	1.19%	1.29%	0.81%	0.91%	0.91%	1%	1.26%	1.2%	1.53%	1.63%	1.92%	1.37%	1.9%	0.59%	0.88%	1.15%	1.69%	1.29%
	F01a	Number of Last Minute Cancelled Operations	-	-	919	249	54	61	58	68	85	71	102	98	121	85	125	39	173	224	321	249
	F02	Cancelled Operations Re-admitted Within 28 Days	95%	85%	94.2%	90.6%	100%	98.1%	95.1%	96.6%	91.2%	94.1%	88.7%	94.1%	92.9%	89.3%	85.9%	95.2%	97.6%	93.8%	92.3%	90.6%
Admissions Cancelled Day Before	F07	Percentage of Admissions Cancelled Day Before	-	-	1.61%	2.1%	1.2%	0.88%	1.73%	1.28%	1.9%	1.38%	1.81%	2.08%	2.31%	2.26%	2.36%	1.67%	1.26%	1.53%	2.06%	2.1%
	F07a	Number of Admissions Cancelled Day Before	-	-	1244	405	80	59	110	87	128	82	121	125	146	140	155	110	249	297	392	405
Primary PCI	H02	Primary PCI - 150 Minutes Call to Balloon Time	90%	70%	76.1%	82.6%	75%	80.6%	84.8%	73.8%	77.4%	63.8%	80.9%	71.1%	65.2%	86.2%	80%	-	80.2%	70.8%	74.1%	82.6%
	H03a	Primary PCI - 90 Minutes Door to Balloon Time	90%	90%	93.2%	92.8%	87.5%	94.4%	97%	92.9%	93.5%	93.6%	95.7%	97.4%	91.3%	93.1%	92.5%	-	93.1%	93.3%	95.4%	92.8%
Diagnostic Waits	A05	Diagnostics 6 Week Wait (15 Key Tests)	99%	99%	98.29%	97.41%	98.52%	97.61%	97.7%	98.19%	98.28%	97.62%	97.81%	99.19%	98.51%	96.8%	97.64%	97.83%	97.94%	98.03%	98.53%	97.41%
Outpatients	R03	Outpatient Hospital Cancellation Rate	9.7%	11.7%	10.7%	9.7%	11.2%	11%	10.5%	9.9%	9.7%	10.1%	9.4%	11.1%	11.6%	9.7%	9.5%	10%	10.9%	9.9%	10.6%	9.7%
	R05	Outpatient DNA Rate	5%	10%	7.2%	6.8%	7.4%	7.2%	7.4%	7.1%	7.1%	7.6%	6.8%	6.4%	7.3%	6.4%	7.2%	6.7%	7.4%	7.2%	6.8%	6.8%
Outpatient Ratio	R01	Follow-Up To New Ratio	2.03	2.03	2.19	2.03	2.25	2.26	2.16	2.1	2.15	2.2	2.22	2.17	2.1	2.06	1.99	2.05	2.22	2.15	2.16	2.03
ERS	BC01	ERS - Available Slot Issues Percentage	-	-	20.2%	21.4%	18.8%	16.8%	15.8%	20.2%	22.3%	20.8%	20.8%	22.6%	14.6%	18.6%	21.5%	23.8%	17.1%	21.1%	19.4%	21.4%

APPENDIX 3 – Trust Scorecards

Topic	ID	Title	Annual Target Green	Annual Target Red	Annual 17/18	Annual 18/19 YTD	Monthly Totals Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Quarterly Totals 17/18 Q2	17/18 Q3	17/18 Q4	18/19 Q1
Delayed Discharges	Q01A	Acute Delayed Transfers of Care - Patients	-	-	279	65	18	31	22	26	17	23	27	23	19	22	18	25	71	66	69	65
	Q02A	Non-Acute Delayed Transfers of Care - Patients	-	-	103	21	11	11	11	10	8	9	9	9	5	5	8	8	33	27	23	21
	Q01B	Acute Delayed Transfers of Care - Beddays	-	-	8466	1679	745	647	757	774	854	606	836	715	696	576	471	632	2149	2234	2247	1679
	Q02B	Non-Acute Delayed Transfers of Care - Beddays	-	-	3106	659	278	374	243	315	273	255	272	182	204	291	161	207	895	843	658	659
Green To Go List	AQ06A	Green To Go List - Number of Patients (Acute)	-	-	-	-	46	51	36	46	44	47	53	54	52	59	56	60	-	-	-	-
	AQ06B	Green To Go List - Number of Patients (Non Acute)	-	-	-	-	15	17	22	22	11	13	15	26	17	18	14	21	-	-	-	-
	AQ07A	Green To Go List - Beddays (Acute)	-	-	-	-	1430	1580	1502	1461	1555	1532	1757	1652	1989	1832	1574	1836	-	-	-	-
	AQ07B	Green To Go List - Beddays (Non-Acute)	-	-	-	-	401	572	515	671	451	479	593	453	501	614	451	459	-	-	-	-
Length of Stay	J03	Average Length of Stay (Spell)	-	-	4.05	3.87	3.8	4.37	4.12	3.87	4	3.74	4.15	4.15	3.96	4.01	3.93	3.66	4.09	3.87	4.08	3.87
	J04D	Percentage Length of Stay 14+ Days	-	-	6.8%	6.4%	6.2%	7%	6.8%	6.8%	6.9%	6%	6.6%	6.9%	7.1%	6.5%	6.4%	6.3%	6.7%	6.5%	6.9%	6.4%
14 Day LOS Patients	C07	Number of 14+ Day Length of Stay Patients at Month End	-	-	-	-	250	255	237	240	213	243	242	252	238	234	207	243	-	-	-	-
AMU	J35	Percentage of Cardiac AMU Wardstays	-	-	4.2%	5%	4.2%	4.3%	4.2%	4.9%	6.4%	5.6%	2.5%	4.2%	3.4%	7%	6%	2%	4.2%	5.6%	3.3%	5%
	J35A	Percentage of Cardiac AMU Wardstays Under 24 Hours	-	-	47%	36.5%	39.5%	50%	32.4%	44.2%	60%	38.8%	61.9%	61.3%	29.6%	31%	38.5%	50%	40.9%	48.3%	50.6%	36.5%

Emergency Department Indicators

ED - Time In Department	B01	ED Total Time in Department - Under 4 Hours	95%	90%	86.48%	89.3%	90.53%	91.26%	90.84%	90.06%	90.33%	85.33%	82.69%	83.2%	78.89%	83.95%	91.14%	92.84%	90.87%	88.64%	81.54%	89.3%
	This is measured against the national standard of 95%																					
ED - Time in Department (Differentials)	BB14	ED Total Time in Department - Under 4 Hours (STP)	-	-	86.48%	89.3%	90.53%	91.26%	90.84%	90.06%	90.33%	85.33%	82.69%	83.2%	78.89%	83.95%	91.14%	92.84%	90.87%	88.64%	81.54%	89.3%
	BB07	BRI ED - Percentage Within 4 Hours	-	-	78.35%	82.81%	85.11%	86.82%	86.53%	84.11%	88.22%	77.24%	71.39%	73.24%	65.06%	73.92%	85.56%	89.08%	86.14%	83.2%	69.78%	82.81%
	BB03	BCH ED - Percentage Within 4 Hours	-	-	94.89%	95.67%	96.62%	96.35%	94.99%	96.34%	91.54%	92.56%	93.91%	94.5%	95.08%	94.45%	96.25%	96.26%	95.97%	93.42%	94.49%	95.67%
	BB04	BEH ED - Percentage Within 4 Hours	99.5%	99.5%	96.26%	96.7%	96.58%	97.04%	96.58%	97.43%	94.21%	98.34%	96.63%	94.35%	92.9%	94.4%	98.11%	97.66%	96.74%	96.59%	94.62%	96.7%
	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	8	0	0	0	0	0	0	5	3	0	0	0	0	0	0	5	3	0
Time to Initial Assessment	B02c	ED Time to Initial Assessment - Under 15 Minutes (Excludes BCH)	95%	95%	97.9%	96.7%	98.5%	99.3%	97.8%	98.8%	98.6%	98.2%	97.6%	96.5%	96.3%	96.8%	94.8%	98.4%	98.5%	98.5%	96.8%	96.7%
	B02b	ED Time to Initial Assessment - Data Completness	95%	95%	94.4%	91.6%	91.8%	92.6%	90.7%	94.2%	94.8%	99.4%	99.4%	98.4%	93.7%	91.9%	90.2%	92.8%	91.7%	96.2%	97.2%	91.6%
Time to Start of Treatment	B03	ED Time to Start of Treatment - Under 60 Minutes	50%	50%	52.2%	51.6%	54%	55.4%	54.1%	53.2%	48.4%	51%	54.4%	52.4%	48%	49.5%	53.8%	51.3%	54.5%	50.8%	51.6%	51.6%
	B03b	ED Time to Start of Treatment - Data Completeness	95%	95%	97.4%	96.8%	97.4%	97.3%	97.5%	97.1%	97.8%	98%	98%	97.6%	96.5%	96.5%	96.7%	97.3%	97.4%	97.6%	97.4%	96.8%
Others	B04	ED Unplanned Re-attendance Rate	5%	5%	2.8%	2.9%	2.7%	1.9%	2.3%	2.9%	3.3%	3.3%	3.1%	2.9%	2.9%	3%	3%	2.8%	2.3%	3.2%	3%	2.9%
	B05	ED Left Without Being Seen Rate	5%	5%	1.9%	1.5%	2%	2.1%	3.7%	1.1%	1.1%	1%	1%	1.1%	1.5%	1.4%	1.6%	1.7%	2.6%	1.1%	1.2%	1.5%
Ambulance Handovers	BA09	Ambulance Handovers - Over 30 Minutes	-	-	840	177	46	54	44	63	63	87	62	59	85	75	48	54	144	213	206	177
Acute Medical Unit (AMU)	J35	Percentage of Cardiac AMU Wardstays	-	-	4.2%	5%	4.2%	4.3%	4.2%	4.9%	6.4%	5.6%	2.5%	4.2%	3.4%	7%	6%	2%	4.2%	5.6%	3.3%	5%
	J35a	Percentage of Cardiac AMU Wardstays Under 24 Hours	-	-	47%	36.5%	39.5%	50%	32.4%	44.2%	60%	38.8%	61.9%	61.3%	29.6%	31%	38.5%	50%	40.9%	48.3%	50.6%	36.5%

Cover report to the PublicTrust Board. Meeting to be held on 27 July 2018 at 11.00 – 13.00, Conference Room, Trust HQ, Marlborough St, Bristol, BS1 3NU

		Agenda Item	9
Meeting Title	Public Trust Board	**Meeting Date**	Friday, 27 July 2018
Report Title	**Annual Safe Working Hours Guardian Report**		
Author	Dr Alistair Johnstone, Guardian of Safe Working		
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 2016 junior doctor contract mandates that an annual summary of “rota gaps” (those rotas where there are below optimal numbers of junior medical staff) is made to the Trust Board. This report follows the nationally agreed format and describes the position over the previous year and, where the data is available, over the coming six months.

Rota gaps are a major concern to junior medical staff as they result in the requirement to provide internal cover to ensure the delivery of safe patient care. They are a key factor in morale and wellbeing in this group of staff. The causes of rota gaps are complex and many of these are ourside the immediate control of the Trust. Several major projects to address these gaps have been initiated by the Trust in the previous 12 months.

Key issues to note

In keeping with most NHS Trusts, there are several rotas with intermittent gaps throughout the year. Some of the reasons for these gaps are described towards the end of the report.

Recommendations

I ask the Board notes the considerable challenges being faced by the Trust and the significant work being undertaken to address these. The support of the Board in the introduction of the eRostering system for junior doctors will also be vital for its long term success.
Finally, I would ask that the Board note the significant efforts being made by junior doctors across the Trust in ensuring the delivery of high quality safe healthcare to our patients.

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)**
		25 July 2018		

ANNUAL REPORT ON ROTA GAPS AND VACANCIES: DOCTORS AND DENTISTS IN TRAINING

Executive summary

This paper describes the rota gaps and vacancies for junior doctors and dentists across the Trust and some of the actions taken to address them. It is mandated that this annual report is presented to the Board and it is likely to form part of future CQC and HEE inspections. It will be available publicly on the Trust Website.

Introduction

The 2016 junior doctors contract has increased recognition of the effect that rota gaps can have on the quality of training and wellbeing. Gaps in rotas are frequently cited as a leading concern of our junior medical workforce and can have a significant effect on morale.

High level data

Number of doctors / dentists in training (including fellows)	c690
Number of doctors / dentists in training on 2016 TCS (total):	563
Annual sickness absence rate among this staff group:	c1%

Annual data summary

Rota Gaps

Many of the rotas across the Trust have suffered from intermittent gaps due to fluctuations in numbers of deanery trainees, sickness, maternity leave or failure to attract suitable candidates at interviews. There have also been some relatively short notice resignations from our Trust grade doctors. The resulting gaps and steps taken to cover these, where this information has been available, is summarised in appendix A.

As shown in the table many of these gaps have been covered using internal locums (doctors already working on the rota undertaking additional shifts) or by the use of external agency shifts. It is disappointing that we continue to have as many gaps across the year especially as the Trust invested in an additional 25 “trust grade” posts from August 2017 in anticipation of increased rota gaps resulting from stricter working hours regulations in the new contract.

Having to cover gaps using internal locum staff increases the number of doctors breaching safe working limits, increases fatigue and sickness and makes it harder for doctors in training to access educational activities and study leave.

Internal Locum Usage

As stated above the Trust continues to rely on our junior doctors undertaking additional locum shifts to cover rota gaps. This additional work results in a significant cost pressure on divisions. At present we have no mechanism for monitoring this additional activity in “real time” to ensure that these additional hours do not result in junior doctors breeching safe working limits set by the 2016 contract. This data does not include external locum agency usage as this is lower and does not impact our own staff in the same way.

Division	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Total 2017-18	Apr-18	May-18	Total Year to Date 2018-19
D&T	2,810	4,140	2,120	2,460	-585	4,720	-175	8,401	990	2,760	3,113	853	**31,606**	-	-	**-**
Medicine	14,604	7,750	10,943	25,881	27,360	6,205	3,171	6,608	23,394	13,733	26,226	16,935	**182,808**	20,640	16,225	**36,865**
Specialsied	11,467	35,986	4,596	12,670	8,034	8,634	8,705	22,952	12,031	2,209	7,368	24,184	**158,833**	13,539	25,939	**39,478**
Surgery	28,136	35,286	29,644	33,223	12,000	48,729	21,958	20,740	20,488	34,134	52,943	39,766	**377,046**	36,403	43,746	**80,149**
Women's and Children's	26,554	31,098	28,324	53,123	42,210	41,004	23,300	50,975	18,616	40,093	42,199	38,165	**435,659**	29,190	22,914	**52,104**
Trust Services	633	-633	-	-	-	-	-	-	-	-	-	275	**275**	-	-	**-**
Total (£)	**84,203**	**113,627**	**75,627**	**127,355**	**89,019**	**109,291**	**56,959**	**109,675**	**75,519**	**92,928**	**131,848**	**120,177**	**1,186,228**	**99,771**	**108,824**	**208,595**

Cost of additional internal locum work by junior doctors

Sickness absence

Recorded sickness rates remains remarkably low in the junior doctor staff groups and well below that seen in other groups of staff. Whilst it is reassuring that the intensity of workload does not appear to be causing sickness it is also clear that the majority of rota gaps are likely to be caused by other factors. There may also be an element of failure to record sickness correctly on central HR databases with this group of staff.

		Cumulative % Abs Rate (FTE)
387 UH Bristol NHS Foundation Trust		1.27%
	387 Diagnostics And Therapies	0.57%
	387 Medicine	1.35%
	387 Specialised Services	0.76%
	387 Surgery	1.81%
	387 Trust Services	0.40%
	387 Womens And Childrens	1.02%

GMC training survey

This years GMC survey contains several questions which give an insight into the intensity of the workload undertaken by junior doctors and the effect that rota design and rota gaps has on their wellbeing.

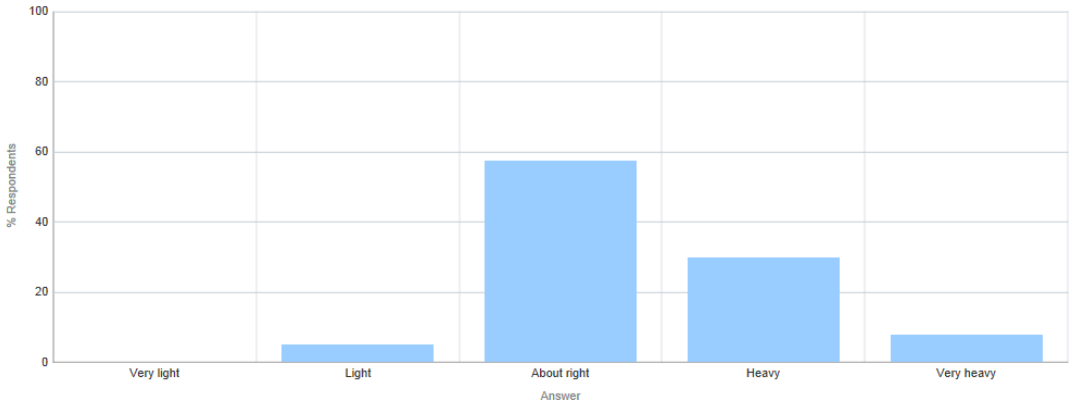
Although we are similar to many Trusts in this regard (and not an outlier in any of these data fields) there are some results which are concerning – especially around adequate rest and intensity of workload. There also appears to be a trend towards less satisfaction overall.

Trust / Board	Indicator	2012	2013	2014	2015	2016	2017	2018
University Hospitals Bristol NHS Foundation Trust	Overall Satisfaction	82.31	81.05	80.69	81.04	80.98	79.40	76.73
	Work Load	45.20	44.46	46.44	46.30	42.55	46.16	48.38
	Teamwork						77.06	74.55
	Study Leave	62.14	60.29	58.82	60.90	60.49	52.92	55.23
	Rota Design							55.16

GMC Training survey results (Each box above contains a score out of 100, which represents how positively or negatively trainees answered the questions for that indicator.)

How would you rate the intensity of your work by day in this post?

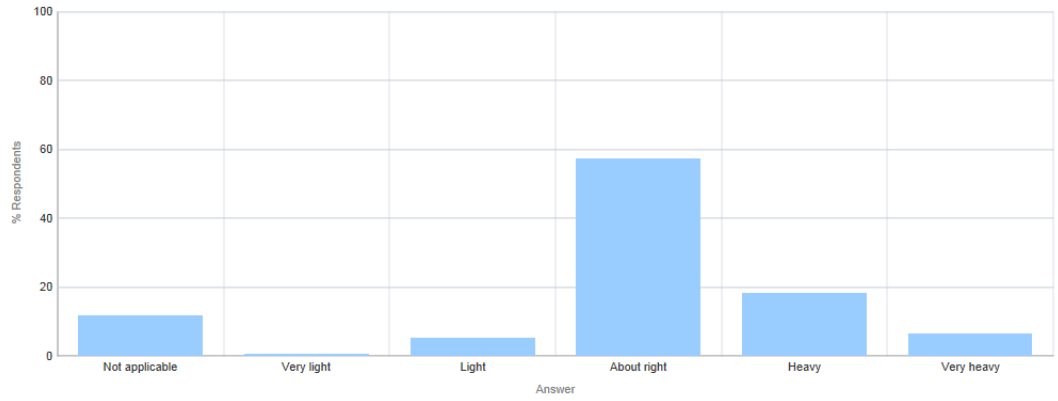
Q: How would you rate the intensity of your work, by day in this post?
n Range: 336 to 340



Answer	% Respondents
Very light	0.30
Light	5.04
About right	57.27
Heavy	29.67
Very heavy	7.72
Grand Total	100.00

How would you rate the intensity of your work by night in this post?

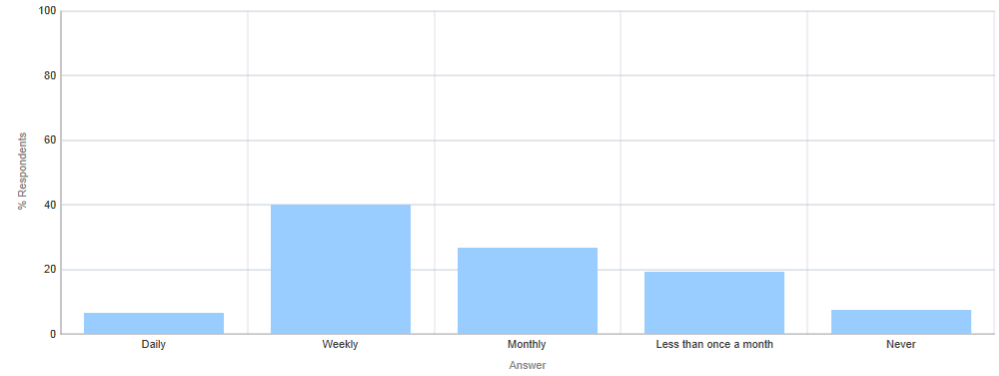
Q: How would you rate the intensity of your work, by night in this post?
n Range: 336 to 340



Answer	% Respondents
Not applicable	11.87
Very light	0.59
Light	5.34
About right	57.27
Heavy	18.40
Very heavy	6.53
Grand Total	100.00

In this post how often have you worked beyond your rostered hours?

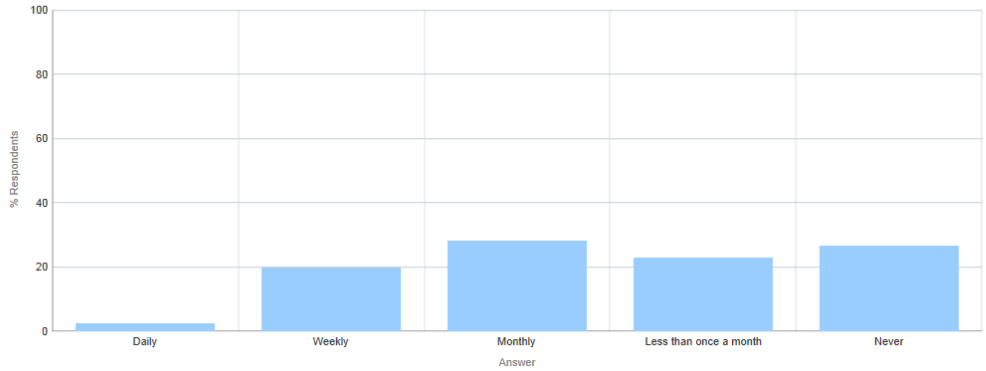
Q: In this post, how often (if at all) have you worked beyond your rostered hours? (Excl. Pharmaceutical Medicine)
In this post, how often (if at all) have you worked beyond your contracted hours? (Pharmaceutical Medicine only)
n Range: 336 to 340



Answer	% Respondents
Daily	6.53
Weekly	40.06
Monthly	26.71
Less than once a month	19.29
Never	7.42
Grand Total	100.00

In this post how often did your working pattern leave you feeling short of sleep when at work?

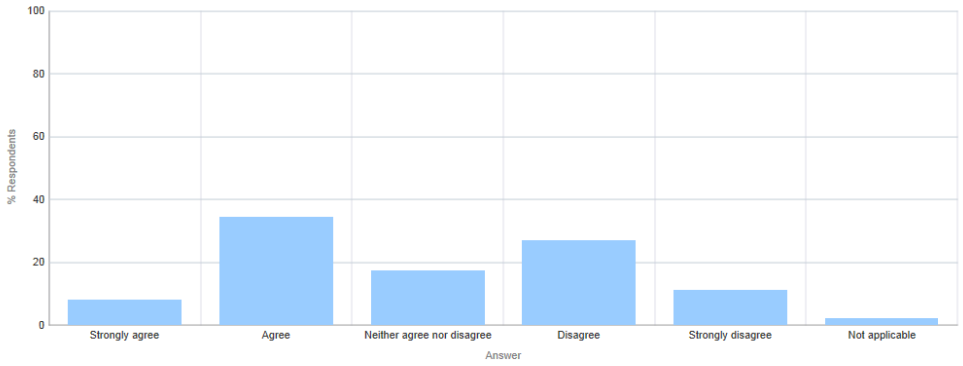
Q: In this post, how often (if at all) did your working pattern leave you feeling short of sleep when at work?
n Range: 336 to 340



Answer	% Respondents
Daily	2.37
Weekly	19.88
Monthly	28.19
Less than once a month	22.85
Never	26.71
Grand Total	100.00

To what extent do you agree: In my current post education / training opportunities are RARELY lost due to gaps in the rota

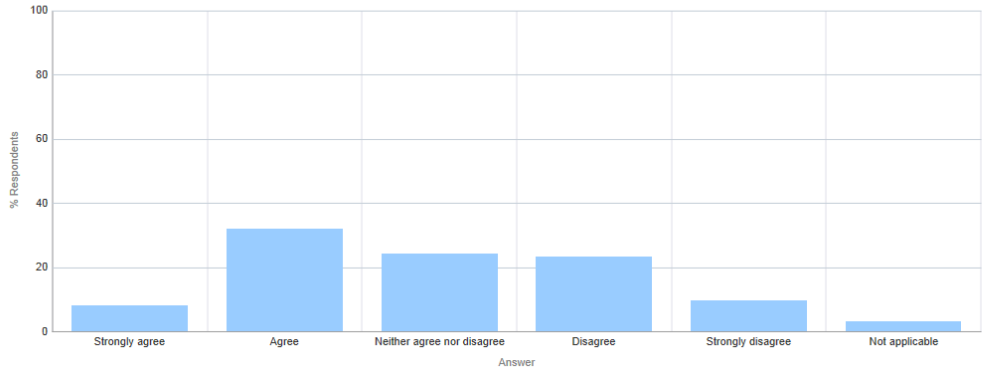
Q: To what extent do you agree or disagree with the following statement?
In my current post, educational/training opportunities are RARELY lost due to gaps in the rota.
n Range: 321 to 325



Answer	% Respondents
Strongly agree	8.05
Agree	34.37
Neither agree nor disagree	17.34
Disagree	26.93
Strongly disagree	11.15
Not applicable	2.17
Grand Total	100.00

To what extent do you agree: In my current post gaps in the rota are dealt with appropriately to ensure my education and training is not adversely affected

Q: To what extent do you agree or disagree with the following statement?
In my current post, gaps in the rota are dealt with appropriately to ensure my education and training is not adversely affected.
n Range: 321 to 325



Answer	% Respondents
Strongly agree	8.05
Agree	31.89
Neither agree nor disagree	24.15
Disagree	23.22
Strongly disagree	9.60
Not applicable	3.10
Grand Total	100.00

Issues arising

As discussed above the reason for the gaps across the rotas in the Trust are complex and multifactorial. Some of these are more predictable than others.

Fluctuating numbers of trainees from the Deanery and delays in information being sent to the Trust.

Competency based training means that there may be some trainees who have training needs that can be achieved elsewhere. This was a particular issue on our paediatric neurosurgery rota this year when the Deanery sent no trainees in February – this almost resulted in having to intermittently close the service or reduce elective work. This is currently covered by external locums from across the South West.

We also continue to get information about which trainees are coming (or not) very late from the Deanery on occasion. For the latest rotation the Trust only had information on 68% of rotas within the 12 week deadline set out in the new contract. Recruiting into posts at such short notice, especially in highly specialised areas, is extremely challenging.

Trust grade doctors resigning before the end of their contract

Many of the doctors who undertake Trust grade posts do so as a "bridge" to a Deanery training post. This inevitably means that some will resign before the end of their posts to take up a training number. We have also had a small number resign due to unhappiness with their training or workload over the past year.

It is important to stress that in most areas these additional Trust grade doctor posts have been a great success and have contributed additional capacity on vulnerable rotas. Without their hard work our rota gaps would have been much worse over the past year.

Reduced willingness / ability to undertake additional activity

In some areas junior doctors are increasingly reluctant to undertake additional activity to cover rota gaps – often because they are already tired from working additional hours (either at the end of each day or as internal locum) over previous months. There is increasing frustration about being asked to cover gaps at short notice and feeling pressure to do so to ensure the service keeps running. This is likely to be made worse by a reduction in rates of pay for these shifts mandated in the 2016 contract.

Lack of a central staff locum bank

Currently the Trust does not have a central locum bank or an easy way to match up junior doctors willing to undertake extra work with available shifts. There is also no mechanism to monitor additional hours undertaken against the safe working limits mandated in the 2016 contract. It is likely that some junior doctors are working in excess of these limits as a result of internal locum cover.

Limited pool of doctors to recruit into vacant posts

In many specialities there seems to be a very small pool of doctors available to employ into vacant posts. Anecdotally this has become much worse since the contract dispute of 2016 and may reflect an increasing number of doctors who choose to go abroad for training or take time out rather than staying in the UK. Most Trusts in the UK have been having similar problems and it also seems that increased "competition" for the small number of doctors available may be having an effect. Finally, there have also been issues with restrictions on recruiting international medical graduates caused by

restricted numbers of visas being issued, although I believe this has recently been resolved at a national level. There have been several jobs which have been advertised but have failed to attract any suitable candidates.

Actions taken to resolve issues

In addition to the immediate actions described in the table of Appendix A, the Trust have undertaken significant efforts over the past year to address some of the organisational issues. I hope that many of these will have an observable effect over the coming year.

Deanery issues

There is ongoing communication with NHS Employers and feedback to Heath Education England around the fluctuations in numbers and the delays in information coming to the Trust. The Trust was due to be part of a national streamlining pilot but I understand that this may have been delayed nationally due to unforeseen complexities.

Allocate eRostering system

The Trust has made a significant investment in an eRostering system for medical staff, similar to that used for nursing staff. This should allow greater visibility of rota gaps and will improve compliance with the safe working rules within the new contract. It will also allow the Trust to have a centralised locum bank for the first time. This will be a major change in working for many of the departments in the hospital and there is likely to be a significant bedding in process. There is a risk that it may, paradoxically, make rota gaps worse in the short term as it will require more stringent observance of rota rules than currently exists. I will monitor this over the coming year.

This system is being gradually introduced from September 2018

Reorganisation of Medical HR functions and increased resource

There has been a significant redesign of the medical HR function and an increase in resilience following changes instigated by the Director of people earlier this year. There is also ongoing work in improving the flow of data from divisional management to the Medical HR team with the aim of anticipating and addressing potential rota gaps more quickly.

Focus on wellness and improving communication with junior doctors

There are several major projects underway to address wellbeing being lead by both the Trust Executive and the medical education team under the direction of Dr Aspinall the Director of Medical Education. There are also projects looking at improving communication with junior doctors and trying to make them feel more integrated with the strategic objectives of the Trust. These are all extremely positive and have my full support.

Summary

Like all major NHS Trusts there are a number of rotas with gaps caused by a range of complex factors. I am reassured by many of the actions taken by the Trust to resolve these and am pleased to see the importance that is being placed on addressing some of the structural issues which have affected junior doctor rotas for many years.

I am concerned by some of the results from the GMC training survey – especially those showing the effect of rota gaps on tiredness and access to training – however, it is positive that the Trust is making major efforts to improve this situation.

Questions for consideration

I ask the Board notes the considerable challenges being faced by the Trust and the significant work being undertaken to address these. The support of the Board in the introduction of the eRostering system for junior doctors will also be vital for its long term success.

Finally, I would ask that the Board note the significant efforts being made by junior doctors across the Trust in ensuring the delivery of high quality safe healthcare to our patients.

Appendix A – Summary of rota gaps table

Division	Rotas	Rota slots (WTE)	Post Funding Deanery	Post Funding Trust	Current WTE on Rota	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Comments: was the gap covered and how?
Surgery	F1 General Surgery	11 WTE	11 - Deanery Funded	0 WTE	11																	F1 Deanery Gap	No gaps until December 2018.
Surgery	F2 General Surgery	11 WTE	11 Deanery Funded (4 x F2's, 5 x CT1/2).	2 Trust Funded posts (1 x Clinical Fellow, 1 x ACF)	10							1 Deanery gap (Feb - Aug)											1st Gap covered by Clinical fellow, 2nd Gap covered by Locum and agency as no one was appointmentable at interview.
Surgery	ST3-8 General Surgery	12 WTE	8 Deanery Funded (7 x Deanery ST3-8, 1 ACF)	4 Trust funded Fellows	12		1 Deanery gap (Sep - Oct)							1 Fellow Gap (Apr - Jun)							1 Fellow Gap		1 ACF gap due to maternity this was covered by clinical fellow. However, we received 1 supernumery in May so no actual gap on the rota as there were 13 people. Fellow Gap in Nov (resignation), PCP requested to recruit.
Surgery	F2 & CT1/2 T&O	12 WTE	6 Deanery Funded (3 x F2's, 3 x CT1/2)	6 Trust Funded (4 x Clinical Fellows, 2 x ACF)	6.6		4.5 CF gaps (Aug - Dec)			3.5 CF gaps (Dec 17 - Feb18)		4.5 CF gaps (Feb - Apr)		3.5 CF gaps (Apr - Aug)									Unable to fil all CF gaps. Gaps largely covered with Locum shifts.
Surgery	ST3-8 T&O	12 WTE	12 Deanery Funded	0 WTE	12			1 Gap (27 Oct-13 Nov)															Short gap as there was a delay in deanery recruiting into deanery gap.
Surgery	GP ENT	5 WTE	5 Deanery Funded (5 x GPVTs)	0 WTE	5					1 Gap (Dec - Apr 18)				0.4 Gap (Apr - Aug)									Gap filled by 2 x 0.8 LTFT GPs creating a 0.4 gap. Gaps filled with Locum shifts.
Surgery	ST1-2 ENT	5 WTE		5 Trust Funded (3 x Clinical fellows, 1 x ACF)	5					2 Gaps (Dec 17 - Feb 18)		3 Gaps (Feb - Apr 18)		4 Gaps (Apr-Aug 18)									NBT Neurosurgery post now withdrawn; Gaps filled with locum shifts.
Surgery	ST3-8 ENT	7 WTE	7 Deanery Funded	0 WTE	7																		No gaps, received and additional WTE in Feb 2018.
Surgery	GP Ophthalmology	2 WTE	2 Deanery Funded	0 WTE	1		1 Gap (Aug - Dec)							1 Gap April - July)									Episodes of long term sickness. All reported to the Deanery. Locum insitu for August - November 17 gap. No suitable locum available to cover gap from April - August.
Surgery	ST3-8 Ophthalmology 1st on-call	6 WTE	6 Deanery Funded	0 WTE	4					2 Gaps (Apr - Mar)			1.2 Gap (Feb - May)	2 Gaps (May - Aug)				1 Gap (Aug - Dec)					2.0 wte doctors (1 x LTS and 1 x unfit on OH advice) from April 17 - March 18. Reduced to 1.2 wte gap from Feb - May 18. 2.0 wte gap from May - Aug 18 due to OH recommendation and maternity leave. Aug 18 - clinical fellow joining the rota to cover ST gap for rotation Aug 18-Feb 19 for maternity leave. Currently 1.0 wte ST gap (OH recommendation) hopefully to be coverd by SAS doctor awaiting confirmation. Cover provided by clinical fellow and SAS doctor filling the gaps and not permanent. PCP'd gaps and covered inhouse by current on-call team.
Surgery	ST3-8 Ophthalmology 2nd on-call	6 WTE	3 Deanery Funded	3 Trust funded	5					1 Gap (Dec 17 - Apr 18)				1 Gap (Apr - Aug)									1.0 gap Dec 17 - Apr 18 due to clinical fellow coming off rota to take up consultant role. Clinical Fellow joined rota on 09.05.18 to cover this ST gap. Replaced by ST joining rota Aug 18. 1.0 ST gap Apr - Aug 18 due to maternity leave. Clinical Fellow to join rota on 29.06.18 to cover maternity leave. All gaps pcp'd and covered inhouse by on-call team.
Surgery	ST3-8 Paediatric Anaesthesia	8 WTE	4 Deanery Funded	4 Trust funded (fellows)	8.8						2.5 Gap			3.5 Gap									Vagaries of Deanery rotations makes this very difficult to define as there can be gaps in some areas and surplus in others depending on the training needs of trainees in any particular rotation. Paeds also had a gap in clinical fellows.
Surgery	ST3-8 General Anaesthesia 1st on-call	8 WTE	Usually plan for 10-12.	Deanery Funded, 10-12 fellows / post-CCT fellows across these	8.6																		
Surgery	ST3-8 General Anaesthesia 2nd on-call	8 WTE			9.6																		
Surgery	ST3-8 Obstetrics Anaesthesia	6 WTE			5				1 Gap			1 Gap			1 Gap				0.4 Gap				
Surgery	ST3-8 Cardiac Anaesthesia	8 WTE	6 Deanery Funded	2 Trust funded (fellows)	7.6										0.4 Gap								
Surgery	ST3-8 Intensive Care Advanced	3 WTE	1.0 Deanery Funded	2 Trust funded	3.6																		
Surgery	ST3-4 Intensive Care/CT1/2 Intensive Care	10 WTE	4 Deanery Funded	6 Trust funded (specialty doctors & fellows)	6				1 Gap (Nov)	2 Gap (Dec 17 - Feb 18)		2 Gaps (Feb - Apr)		2 Gaps (Apr)	3 Gaps (May - Jul)		4 Gaps (Jul)						Combination of issues - trainees from the Deanery not needing ICM training and not being able to appoint to fellow posts. Using agency specialty doctor as well.
SPS	FY2 and CMT Heam/Onc	8 WTE	2 x FY2 and 6 CMT's	0 WTE	8																		No Gaps the MHR are aware of - Unconfimed by the department
SPS	Haematology Out of hours	8.5 WTE	8.5 Deanery funded	0 WTE	7.6		1 ACF Gap															1.4 Gap	Shared rota, see bellow
SPS	Haematology SpR	12 WTE	6	6 Trust funded posts 2 x SAS, 4x fellows	10							1 Gap		2 Gaps									- The main impact on service delivery has been vacancies in Fellow posts which are used both to provide service and to backfill the lieu time post on call – one post was only created to start in Aug 2017 and was filled until Jan 2018 then has been vacant since Feb 2018 mainly due to visa restriction incoming post. - There has been a gap since March of this year again a visa issue so someone is appointed to it.
SPS	Medical/Clinical Oncology SpR	22 WTE	17 Deanery funded	5 Trust Funded (2 x Clinical fellows, 2 x CEF 1 x Research fellow)	13.5	4 x deanry gaps, 2.6 x fellow gaps		4 x deanry gaps, 2.6 x fellow gaps			4 x deanry gaps, 3.6 x fellow gaps	2 x deanery, 3.6 x fellow gaps	2 x deanery, 3 x fellow gaps	1 x deanery, 2 x fellow gaps	1 x deanery, 2.8 x fellow gaps			1 x fellow gaps				Gaps in Apr - May 18/Apr-Jul 18/ Jan 17 - July 18/ Mar 17 - Mar 18/ Jun - July 18/ Jul - May 18/ Sep 17 - Sep 18 - due to Maternity Leave. - Unconfimed by the department
SPS	Cardiology SpR	17 WTE	9	8 WTE	17		0.6 Deanery Gap																0.6 gaps that MHR are aware of. - Unconfimed by the department
SPS	Cardiac Surgery SpR	13	7	6	13			1 CF Gap															Recruited CF to cover the gap. Appointed in Feb.
Medicine	General Medicine F1 (including Cardiology)	21 WTE	21	0 WTE											0.5 Gap	0.5 GAP							0.5 Long Term Sickness. Locums for ward and on-call shifts.
Medicine	General Medicine SHO	31 WTE	30	1 WTE	31		1 GAP (LTS)		1 GAP (LTS) 1 ML (covered by CF)	2 GAPS (LTS)		2 GAP (LTS - 1 CF appointed)		2.5 GAPS (1 reduction to LTFT (health) 2 resignations)									1 ML - CF APPOINTED IN OCT. 1 CF covering GP gap Aug-Feb and Feb - Aug. 1 CF appointed to cover ACCS gap Deanery withdrew funding. Aug - 31 mar. One junior doctor resigned March.
Medicine	General Medicine Higher	18 WTE	15	3 WTE	18	1 GAP (MAT LEAVE) not covered,	1 GAP (MAT LEAVE) covered by CRF	1 GAP (ACTING UP) not covered				1 GAP (1 TO NBT - NO REPLACEMENT) managed rota with this knowledge.					1 GAP (MAT LEAVE) not covered. Covered with locums						
Medicine	ED SHO	14 WTE	2 ACCS / 4 GPVTS / 1 Deanery (2017-18 only) / 1 Military	7 WTE	12.15	2 wte Gaps	1.25 wte Gaps (75/25 split posts)				1.65 wte Gaps (75/25 split posts) + LTFT		2.4 Gap (split posts / LTFT / sick)	3.4 Gap (split posts / LTFT / sick)									14 people needed to cover gaps and split posts. Locums / rota tweaking to cover gaps
Medicine	ED Middle Grade	10 WTE	6 wte	4 wte	8.1	0.6 Gap	0.4 Gap	0.2 Gap					0.6 Gap	2 Gaps									Many Maternity leave gaps. Deanery sent 1 person from February. Advertised for 3 CF to cover deanery gaps but only 1 appointed and this person unable to work nights. Locums cover where needed.

Medicine	Dermatology	6	4.6 wte	2 wte	5.6							1.4 wte Gaps. (2 wte resignations)	0.4 gap.										Gaps managed by re-writing rota. New recruitment episodes for 2 CFs from August 2018.
W&C	O&G FY2 & ST1-2	11 WTE	11 WTE	0 WTE	11																		
W&C	O&G ST3-5	10	8 WTE	2 WTE	6																		
W&C	O&G ST6+	9	6 WTE	3 WTE	6																		
W&C	PICU ST1-2	3	3 WTE	0 WTE	3	0.4 Gap (LTFT)																	Gaps covered by locums
W&C	PICU ST3-8	15	7.5	9 WTE	15	1 Deanery Gap						1.4 Deanery Gap	1.4 Deanery Gap	1.7 deanery gap	0.8 Deanery Gap	0.8 Deanery Gap	0.8 Deanery Gap						Gaps filled by locums
W&C	Paeds Cardiac Surgery	3	0 WTE	3 WTE	3		1 CF Gap																Unconfimed by the department
W&C	Paeds Neurosurgery	6	2 WTE	4 WTE	3	1 wte deanery Gap			2 wte deanery Gap			2 denery wte gaps		2 Deanery wte gaps / 1 CF									Ad hoc Locum shifts to cover gaps. Recruitment underway (Visas required)
W&C	Paeds Surgery FY2 & ST1-2	7	1 F2 / 3 ST1-2	3 CF	7																		No Gaps the MHR are aware of - Unconfimed by the department
W&C	Paeds Surgery ST3+	9	5 wte	4 wte	8	1 gap						2 gaps			1 gap								Covered by locums
W&C	NICU ST1-3	9	6 wte	4 wte	9																		No Gaps the MHR are aware of - Unconfimed by the department
W&C	NICU ST4+		6 wte	3 wte																			No Gaps the MHR are aware of - Unconfimed by the department
W&C	Paediatric Oncology ST6-8	6	3 wte	3 wte	6																		No Gaps the MHR are aware of - Unconfimed by the department
W&C	Paediatric Cardiology ST3-8	6	6 wte	3 wte (1 CF st1-2, 2 ST3-8)	6																		No Gaps the MHR are aware of - Unconfimed by the department
W&C	General Paeds F2 & GPVTS	6 wte	6 WTE 3 F2 / 3 GPVTS	0 wte	6 wte					0.5 gap (LTFT)													filled with locums
W&C	General Paeds ST1-3	13 wte	13 wte (2 ED F2s / 11 ST1-	0 wte	13		0.5 gap (LTFT)						0.5 gap for nights only										0.6 gap from Sep-Mar covered with float. Locums covering Mar-July.
W&C	General Paeds ST3-8	27 WTE	23 wte	4 wte	25		2.5 wte Deanery Gap and LTFT	3.5 wte Gap (2.5 Deanery + 1 LTS)	3.5 wte Gap (2.5 Deanery + 1 LTS)	4 wte Gaps. 1 Maternity , 1 LTS, LTFT	1 resignation, filled by 0.6 / 1 LTS / LTFT	4.5 wte gaps. 1 resignation / 1 maternity / 1 LTS / LTFT	3.5 wte gaps. 0.5 Maternity / 0.5 resignation / LTFT	2.5 wte gap. 1 deanery gap / 0.5 maternity / 1 gap due to health	2.5 wte gap. 1 deanery gap / 0.5 acting up / 1 gap due to health	2 wte gaps. 0.5 acting up / 0.5 health / 1 deanery gap	2.5 wte gap. 0.5 ML / 0.5 Health / 0.5 Acting up/ 1 deanery gap					Appointed 0.6 CF from November to cover 0.6 gap from September to Oct. Other gaps managed by locums.
D&T	Radiology	9	9	0	9																		
D&T	Chemical Pathology	2	2	0	2																		No Gaps the MHR are aware of - Unconfimed by the department
Key																							
	No rota gaps during month																						
empty	No data at present																						

Cover report to the Public Trust Board. Meeting to be held on 27 July 2018 at 11.00 – 13.00, Conference Room, Trust HQ, Marlborough St, Bristol, BS1 3NU

		Agenda Item	10
Meeting Title	Public Trust Board	**Meeting Date**	Friday, 27 July 2018
Report Title	**Mortality and Learning from Deaths Annual Report**		
Author	Mark Callaway, Acting Medical Director		
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
<u>Purpose</u> To gain board approval for the Annual Report of the Learning from Adult Deaths team. <u>Key issues to note</u> The majority of the care provided was of a high standard. Several themes were identified Including early senior review Early initiation of end of life pathway This information has been fed back to the Divisions and is forming the basis of a QI project
Recommendations

Members are asked to:

- **Approve 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)**
		25 July 2018		

University Hospitals Bristol
NHS Foundation Trust

Adult Mortality and Learning From Deaths Report

April 2017 – March 2018

Dr M Callaway (July 2018)

Contents

Introduction

Since the beginning of April 2017 all adult inpatient mortality has been subject to review to enable learning from deaths. This annual report sets out the process by which all deaths are reviewed in UHBristol, the process of monitoring the outcome and learning from death, and documents the results from the first year of this process.

In April 2017 a grant was obtained from the charity, Above & Beyond, to enable the recruitment of a team to establish and develop processes for adult learning from deaths at UH Bristol. The team consists of the following:

Non-Executive Director Lead

Julian Dennis

Co-Leads

Dr Mark Callaway and Dr Emma Redfern

Divisional Mortality Leads

Medicine: Dr Amanda Beale and Dr Rebecca Maxwell

Surgery: Mr Paul Wilkinson

Specialised Services: Dr Colette Reid

Lead Mortality Nurse

Tina Whiting

ITU Mortality Lead

Dr Sarah Sanders

Learning Disabilities Lead

Helen Bishop (to May 2018)

Mental Health Lead

Dr Nicola Taylor

Mortality Clinical Fellow

Dr Sarah Kyle

Background

In December 2016 the Care Quality Commission (CQC) 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, one of which (recommendation seven) 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 recommends 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 are 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 Trust Board level, acted upon and reported in annual Quality Accounts
- 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.

This document is the first annual report of the process from learning from adult deaths in UH Bristol. It describes the process at UH Bristol whereby all adult in-patient deaths are screened, investigated and reviewed. Learning from a review of the care provided to patients who die is now an integral part of our clinical governance and quality improvement work. UH Bristol is ensuring its governance arrangements and processes include, facilitate and give due focus to the reporting and investigation of all deaths.

This report describes the methodology behind the introduction of this process, and the structure by which the process is managed, it also reports on the outcomes from this process in the year 2017-2018.

UH Bristol has a clear policy for engagement with bereaved families and carers, including giving them the opportunity to raise questions or share concerns in relation to the quality of care received by their loved ones. It is a priority to work more closely with bereaved families and carers and ensure that a consistent level of timely, meaningful and compassionate support and engagement is delivered and assured at every stage, from notification of the death to an investigation report and its lessons learned and actions taken.

Initial feedback at the start of the process suggested that the level of avoidable death in the inpatient environment would be in the region of between 3-10%. At UH Bristol our review has found that the majority of care provided is good or very good and the proportion of avoidable deaths lower than expected. Every organisation found a lower proportion of avoidable deaths than the figure expected at the introduction of this process.

However, several themes have been identified from the process. Where there has been care which is at a lower level than expected, there has often been inconsistent senior input leading to a slow introduction of the patient onto an end of life pathway. This is particularly important in order to move the patient onto a pathway which maximises the treatment of symptoms.

UH Bristol has been part of the wider collaborative within the healthcare community coordinated by the West of England Academic Health Science Network, and all eight acute providers within the region have been contributing results and sharing the learning from this process.

Dr Mark Callaway
Interim Medical Director
July 2018

Adult Mortality Review Process

From April 1 2017 all adult inpatient deaths, excluding out of hospital cardiac arrests, were screened by the senior nurse leading the mortality process. If there were any aspects of care that triggered a further review, the notes were sent to the Mortality Leads in each of the adult bed holding divisions to co-ordinate a review using the Royal College of Physicians Structured Case Note Review (SCNR) process.

Criteria set by NHS England for deaths requiring an SCNR are;

- Unexpected death e.g. after an elective procedure
- Where the family/carer/staff raise concerns about the overall care
- Patients with learning disabilities
- Patients with a history of severe mental illness
- Patients aged between 16-18
- Where an alarm has been raised by the Trust regarding a service specialty
- Death is related to an area of planned improvement work.

In addition a local screening tool was developed to include deaths identified in local areas of potential concerns, such as multiple ward moves, queuing, or outlying could be factors that would trigger an SCNR.

All Intensive Therapy Unit (ITU) cases are reviewed by ITU consultants and if appropriate sent to the mortality team for a further review by SCNR.

Reviews for deaths of patients with learning disabilities are viewed by the Learning Disabilities Lead Nurse.

Reviews for patients with a serious mental health issue are undertaken by the Trust Mental Health Lead.

Following the structured case note review, if any aspects of care raise concern, or the reviewer felt the death was potentially avoidable, the case was referred for a second review undertaken by the Medical Director or Deputy Medical Director.

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

- The co-ordination of the SCNR will be undertaken by the divisional mortality leads. It will be the responsibility of the divisional lead to distribute the review to the reviewers, co-ordinate the response and co-ordinate the learning and outcome from the review.
- 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 undergo a second SCNR by a trained member of the Medical Director's team. 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 this further detailed review.

This process allows the senior medical team to be sighted on all deaths within the organisation where poor care has been identified, and to assess all potentially avoidable deaths. The themes and learning from this additional review are co-ordinated and fed back by the Medical Director's team to both the division and the mortality surveillance group. A judgement regarding the avoidability of death will be made following the Medical Director's 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 that duty of candour can be undertaken as soon as possible where any issues have been identified.

- 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 evidence of poor care or avoidable death, and duty of candour has not been undertaken, then the medical director's office will undertake duty of candour.

Mortality Review Operational Group

- The membership of the Mortality Review Operational Group is; the Deputy Medical Director, Associate Medical Director for Patient Safety, divisional leads for mortality (two in the division of medicine, one in specialised services, and one in surgery), the nurse lead for mortality screening, the leadership fellow for mortality and administrative support.
- The Mortality Review Operational Group is responsible for managing the review process. The group meets monthly and is responsible for the co-ordination of all the data surrounding the screening and review process. The data is held on the Mortality Dashboard. Every month the group reviews the total number of deaths, the total number of deaths which triggered a SCNR, the results of the reviews on a divisional basis, the total number of SCNR that triggered a second SCNR, and the total number of avoidable deaths. In addition, the group co-ordinates learning from any themes emerging from the SCNRs. These themes are then fed back to the divisions for integration into the divisional mortality and morbidity process. These themes are then fed into the Mortality Surveillance Group, which also receives a monthly report of these figures and actions for learning.
- The Mortality Review Operational Group is responsible for the training and co-ordination of case note reviewers. The list of trained reviewers will be held by this group and the number of reviews conducted by each reviewer noted. No reviewer should perform more than two reviews per month and no reviewer should go more than two months without undertaking a review. The number of reviews for an individual is recorded and on an annual basis fed back to the individual to inform the annual job planning process.

Mortality Surveillance Group

- The Mortality Surveillance Group is the governance group for co-ordinating all information regarding adult mortality and is responsible for the governance from the learning from death programme and reports to the Quality and Outcomes Group.
- The Mortality Surveillance Group is chaired by the medical director and its other members are the deputy medical director, the associate medical director for patient safety, the deputy chief nurse, the Trust lead for patients with learning disabilities, a representative from adult mental health, the divisional leads for mortality, the lead nurse for mortality screening, leads for mortality from ITU and the Children's Intensive Care Unit (CICU), the lead for child death review, and the lead for obstetric deaths.
- The Mortality Surveillance Group co-ordinates all reports into adult inpatient deaths within the organisation. Most of this information is obtained via the Adult Mortality Review Group but there are

further reports from investigations into maternal deaths, Serious Untoward Incidents (SUIs) and Root Cause Analyses (RCAs), adult mortality on ITU and CICU, and patients with learning disabilities via the Learning Disabilities Mortality Review programme (LeDeR) process.

- All deaths in patients in whom a Serious Incident (SI) has been initiated will be subject to a SCNR.
- Other sources of information will also feed into this group, such as coroner reports. This information will be co-ordinated by this group who will identify the most important learning points. This group will produce a quarterly report that will be presented to the Quality and Outcomes Group
- The role of this group is to co-ordinate and identify themes of learning from all the mortality data provided by various sources within the organisation, as described above and this group will produce a list of the most important areas for learning: this list will be shared with the divisions, who will need to demonstrate that practice has been changed and where appropriate actions will be incorporated into the organisation's Quality Improvement programme.
- In addition, it is likely that several themes will be cross-divisional in nature and may require changes in organisational practice such as induction for junior doctors. This work will be co-ordinated through the medical director's office.

Mortality Review Results

Statistics for 1 April 2017 to 31 March 2018

Overview

There were 1,346 adult deaths in the organisation between April 1 2017 and March 31 2018. We have screened patient notes for 1,216 deaths (all but Out Of Hospital Cardiac Arrests [OOHCA]) and identified 327 cases (27%) that required a structured case note review according to the categories above. The majority of these cases were in the division of medicine (215 cases - 66%), with smaller numbers of cases within both the divisions of specialised services (64 cases) and the division of surgery (48 cases). The mandatory fields for investigation of learning from deaths generated 124 reviews whereas the additional fields added as part of the screening process developed in UH Bristol generated a further 205 reviews. A total of 16% of all inpatient deaths occurred on ITU.

Table 1: *Adult inpatient deaths at UH Bristol from April 2017 to March 2018*

Description	Number of deaths
Total deaths	**1,346**
Out Of Hospital Cardiac Arrests (OOHCA)	**130**
Deaths in critical care	**204**
Case notes screened	**1216**
Deaths identified for review	**327**
Reviews allocated to Division of Medicine	**215**
Reviews allocated to Division of Specialised Services	**64**
Reviews allocated to Division of Surgery	**48**

Screening: One year analysis

Of the adult deaths that triggered a SCNR the group was broken down as follows; the largest group of cases reviewed were as a result of the local screening process. The following mandatory groups were reviewed:

Table 2: *Screened deaths – Of the 1,346 deaths, 1,216 notes were screened. The following shows how many of these triggered a review – shown by category – note some cases triggered in more than one category.*

Description		Cases	Percentage
Category 1	**Family/carer/staff have highlighted concern over quality of care provision**	**52**	**4%**
Category 2	**Patient has learning disabilities**	**16**	**1%**
Category 3	**An alarm has been raised by the Trust regarding this service speciality via audit/CQC/HSMR mortality alert**	**0**	**0%**
Category 4	**Death is unexpected [Elective procedures and # NOFs]**	**30**	**2%**
Category 5	**Death is related to an area of planned improvement work [Invasive procedure never events, deteriorating patient: NEWS and escalation, sepsis, AKI, Insulin safety]**	**7**	**0.6%**
Category 6	**Age 16-18 years old**	**0**	**0%**
Category 7	**Other issue highlighted during screening process**	**218**	**18%**
Category 8	**Serious Untoward Incident**	**15**	**1%**
Category 9	**Patient with serious mental health issue**	**10**	**0.8%**
SCNR not required	**Deaths which did not trigger a SCNR**	**889**	**73%**

Chart 1 : *Breakdown of screened deaths.*

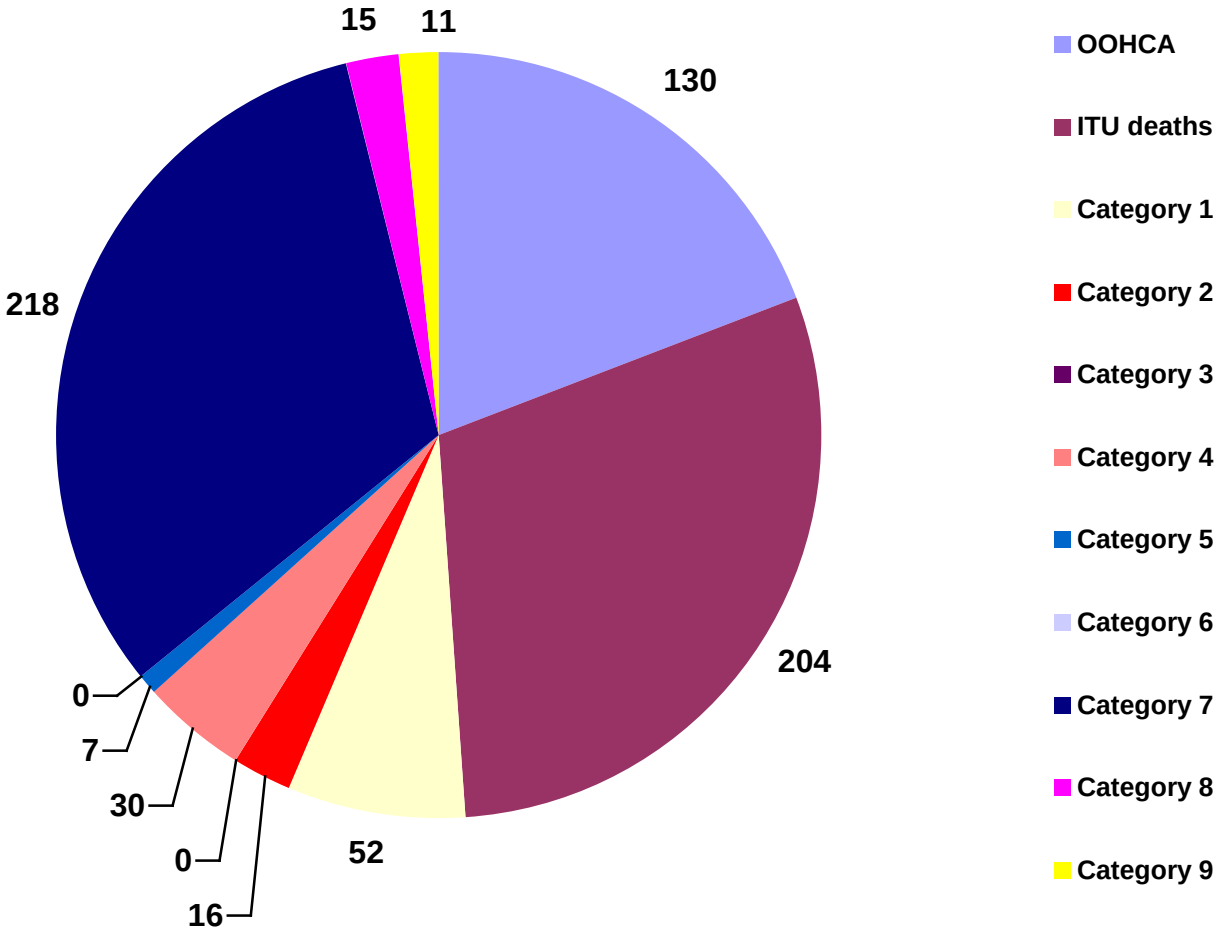
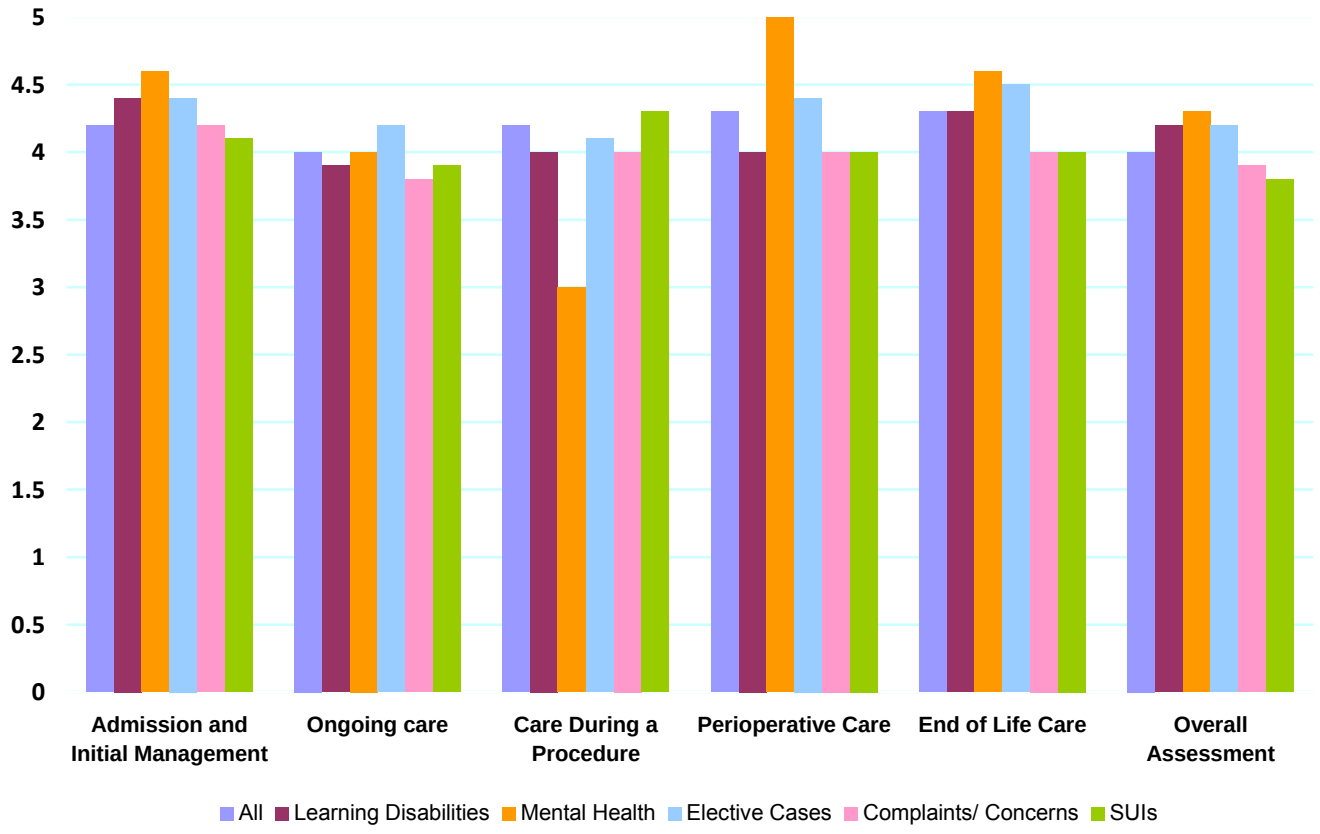


Table 3 and chart 2: *Phases of care – mean scores by category of review*

Score	1	2	3	4	5
Definition	Very poor	Poor	Adequate	Good	Excellent

SCNR Category	Admission and Initial Management	Ongoing care	Care During a Procedure	Perioperative Care	End of Life Care	Overall Assessment
All	**4.2**	**4**	**4.2**	**4.3**	**4.3**	**4**
Learning Disabilities	**4.4**	**3.9**	**4**	**4**	**4.3**	**4.2**
Mental Health	**4.6**	**4.0**	**3**	**5**	**4.6**	**4.3**
Elective Cases	**4.4**	**4.2**	**4.1**	**4.4**	**4.5**	**4.2**
Complaints/ Concerns	**4.2**	**3.8**	**4**	**4**	**4**	**3.9**
SUIs	**4.1**	**3.9**	**4.3**	**4**	**4**	**3.8**

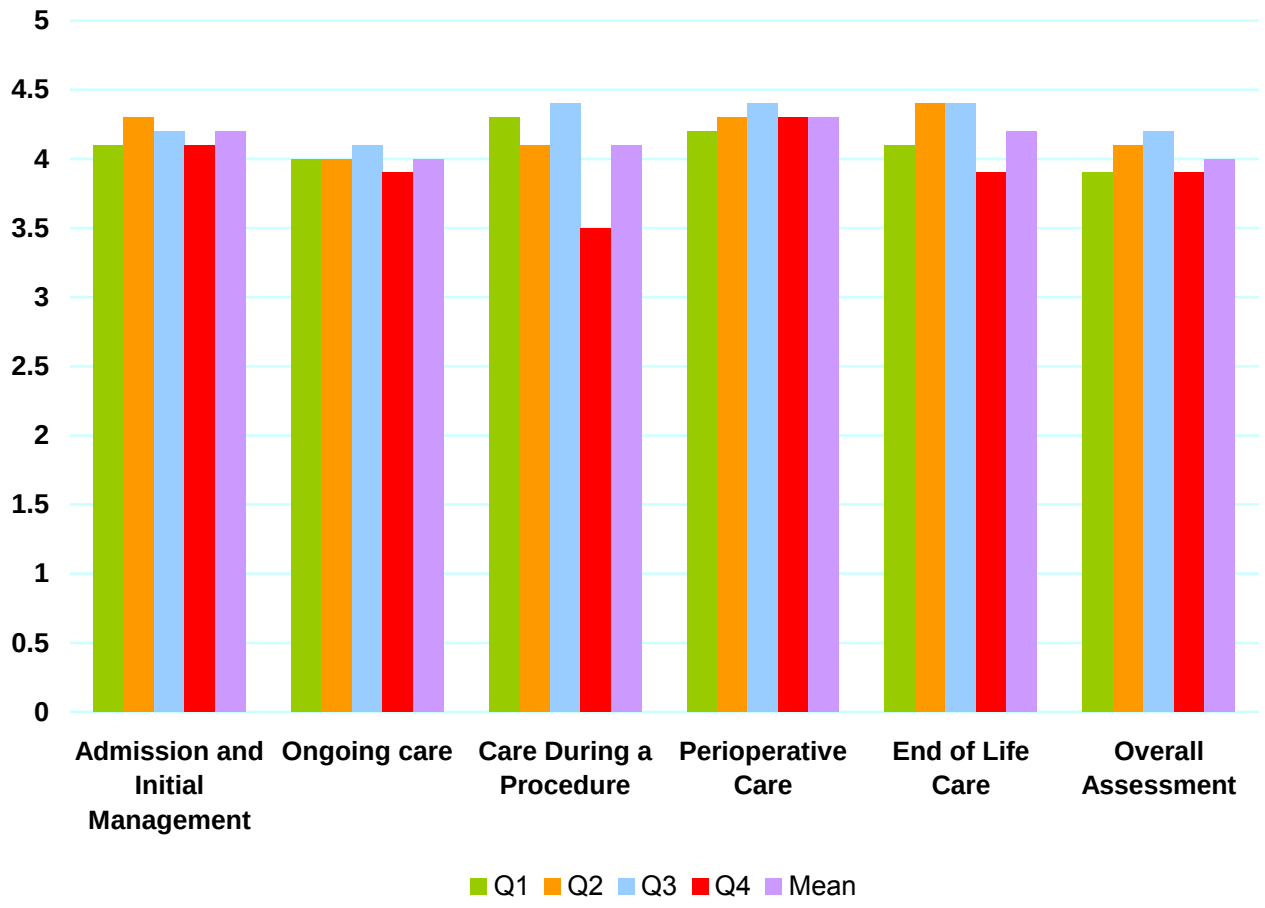


All deaths undergoing a SCNR have been grouped into quarters and the level of care assessed.

One of the aspects of care that raised a potential concern was whether there was an identifiable difference in the level of care provided in each quarter, particularly quarter 4 when the Trust faces increased demand due to the winter pressures. Although a slight drop in mean care ratings was found in all care phases for quarter 4, mean scores were between 3.5 (adequate- good) and 4.1 (good) for this period.

Table 4 and chart 3: *Mean scores for each Phase of Care by quarter 2017 – 2018 - All deaths*

Quarter	Admission and Initial Management	Ongoing care	Care During a Procedure	Perioperative Care	End of Life Care	Overall Assessment
Q1	**4.1**	**4**	**4.3**	**4.2**	**4.1**	**3.9**
Q2	**4.3**	**4**	**4.1**	**4.3**	**4.4**	**4.1**
Q3	**4.2**	**4.1**	**4.4**	**4.4**	**4.4**	**4.2**
Q4	**4.1**	**3.9**	**3.5**	**4.3**	**3.9**	**3.9**
Mean	**4.2**	**4**	**4.1**	**4.3**	**4.2**	**4**



Avoidability of Death

Second Review

Eleven of the 212 completed review cases (data June 2018) underwent a second review by the medical director team, and four potentially avoidable deaths were identified. In three deaths anticoagulation was a factor; in two patients the review suggested that the anticoagulation was not sufficient, and in one patient over anticoagulation was a contributing factor. All these cases were reported at the time as incidents and underwent formal review as part of the Serious Incident Policy.

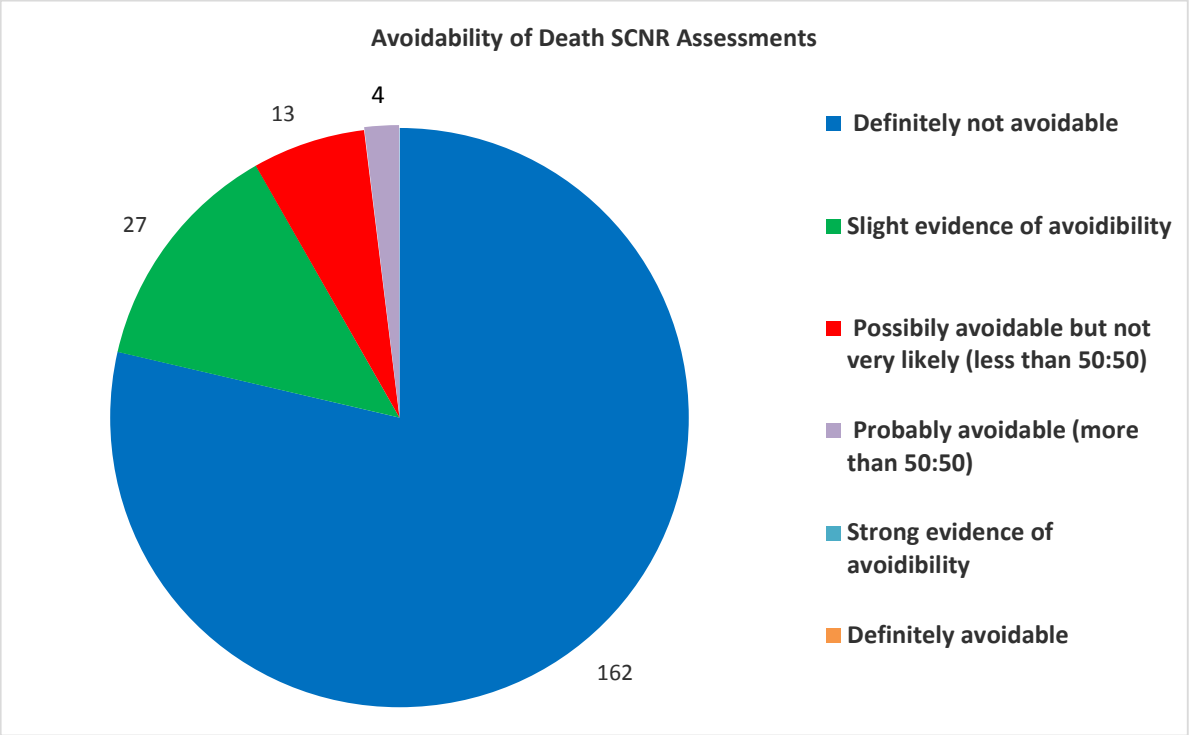
The second review also consolidated the learning from deaths, and highlighted areas where improvement could be undertaken. The two major areas requiring improvement were timely senior input and decision-making and the instigation of the patient onto the end of life pathway. These are two important aspects of end of life care as the decision to move to an end of life pathway means there is a move from physiological triggering of investigation to a symptom-based patient pathway.

A surgical case where a nasogastric tube was not placed in a patient with small bowel obstruction who was not suitable for surgical intervention found that whilst the placement of the tube would not have prevented the patient's death, this potentially could have relieved symptoms. This death was sent via the division's mortality and morbidity meeting to the surgical team responsible for the patient's care.

This information regarding senior input has been fed back to divisions who are reviewing processes and the work around the end of life pathway has been developed with the involvement of a quality improvement fellow.

Table 5 and chart 4: *Avoidability of death (assessments for all deaths reviewed 2017-18)*

	6: Definitely not avoidable	5: Slight evidence of avoidability	4: Possibly avoidable but not very likely (less than 50:50)	3: Probably avoidable (more than 50:50)	2: Strong evidence of avoidability	1: Definitely avoidable	Total
Avoidability of Death (all)	**162**	**27**	**13**	**4**	**0**	**0**	**206**



Cases where care could have been improved

The SCNR highlighted that only a small proportion of the deaths reviewed scored low in an aspect of care; 21 deaths scored either one (very poor) or two (poor) at some point during their care.

The major consistent finding in these cases was the lack of senior review and this information has been fed back to the divisions to direct an improvement in care:

- 11 of these were cases that were mandatory to review (priority category)
- 10 of these were picked up through our screening process
- One case scored 1 (very poor care) in 'Admission and Initial Management'
- In the division of medicine there were 10 cases that had poor scores (scores of 1 or 2); in specialised services there were four cases that had a score of 2; and in surgery there were seven cases that had a score of 2
- One of these patients had learning disabilities.

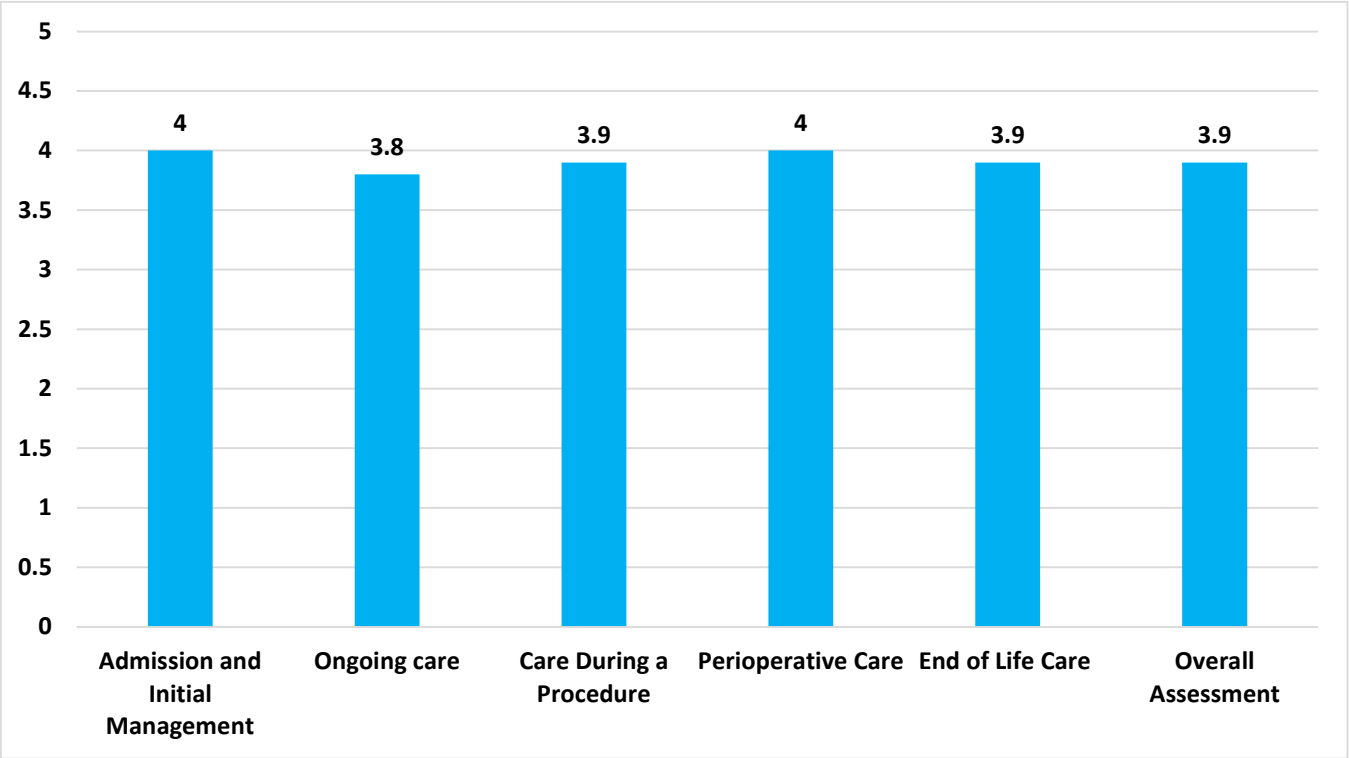
Assessments of phase of care by review criteria:

Category 1: Complaints or concerns raised by relatives or friends

This was the largest group of cases subject to SCNR and is defined as any case where concerns or complaints are raised. This occurs via the bereavement office. There has been a modification to the information leaflet supplied to families to facilitate this process.

Several common themes were identified, although there were no avoidable deaths in this group of patients. The consistent themes included a lack of senior decision-making at an early stage in patients' illnesses, and issues with movement of patients for such reasons as waiting for a cubicle or the movement of a patient at night. Several issues with the administration of medications including anticoagulation were raised, the perceived delay of transfer of patients to an appropriate end of life pathway with the associated management of symptoms, and most commonly, issues around communication and clarity regarding the patients' pathway.

Chart 5: *Category 1 – Complaints / concerns (mean scores for phases of care)*

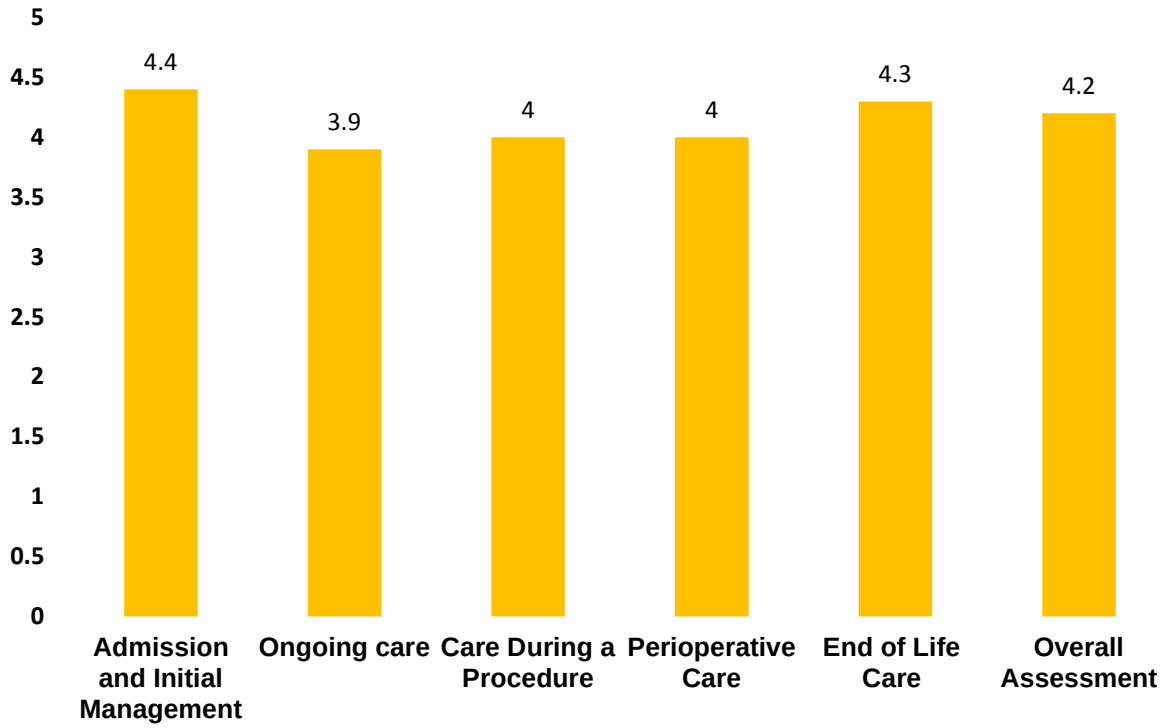


Category 2: Learning disabilities

The definition used for a patient with learning disabilities is any patient who has a learning disability highlighted either on an alert through Medway and is known to the learning disabilities team, or who has a learning difficulty documented in their past medical history anywhere in their case notes

There have been 16 deaths in patients with learning disabilities. SCNR indicates the majority of the care care received for patients with learning disabilities was good or very good and no death in this category was defined as avoidable. There was evidence of poor care in one patient within this cohort where the patient's 'This is me' document was not brought in at admission which led to initial poor communication. This issue has been addressed.

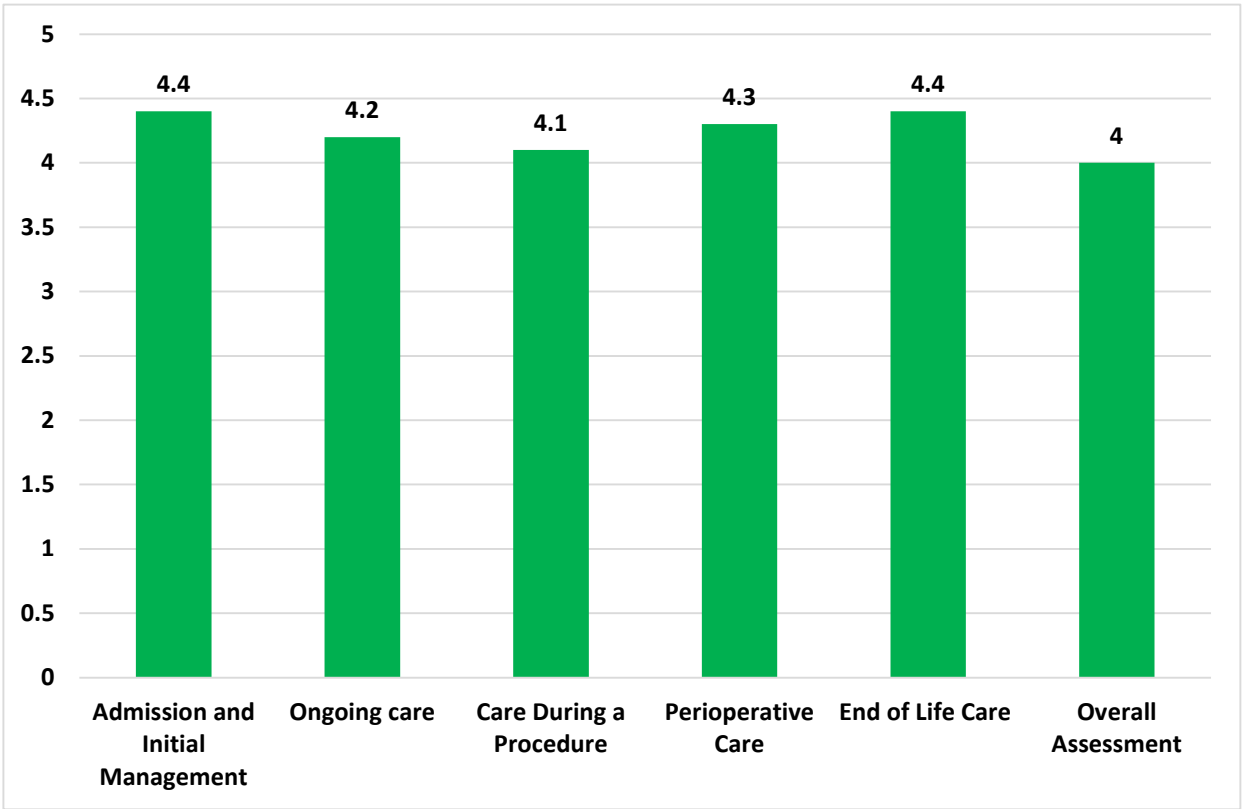
Chart 6: *Category 2 – Learning disabilities (mean scores for phases of care)*



Category 4: Elective Surgery Cases

All cases in which the death occurs following an elective procedure are reviewed using the SCNR. In this group 68% of these deaths following review were assessed as definitely not avoidable and no death following an elective procedure was considered avoidable. This was the largest category of deaths identified on the ICU and often occurred following complex surgery.

Chart 7: *Category 4 - Elective Surgery Cases (mean scores for phases of care)*



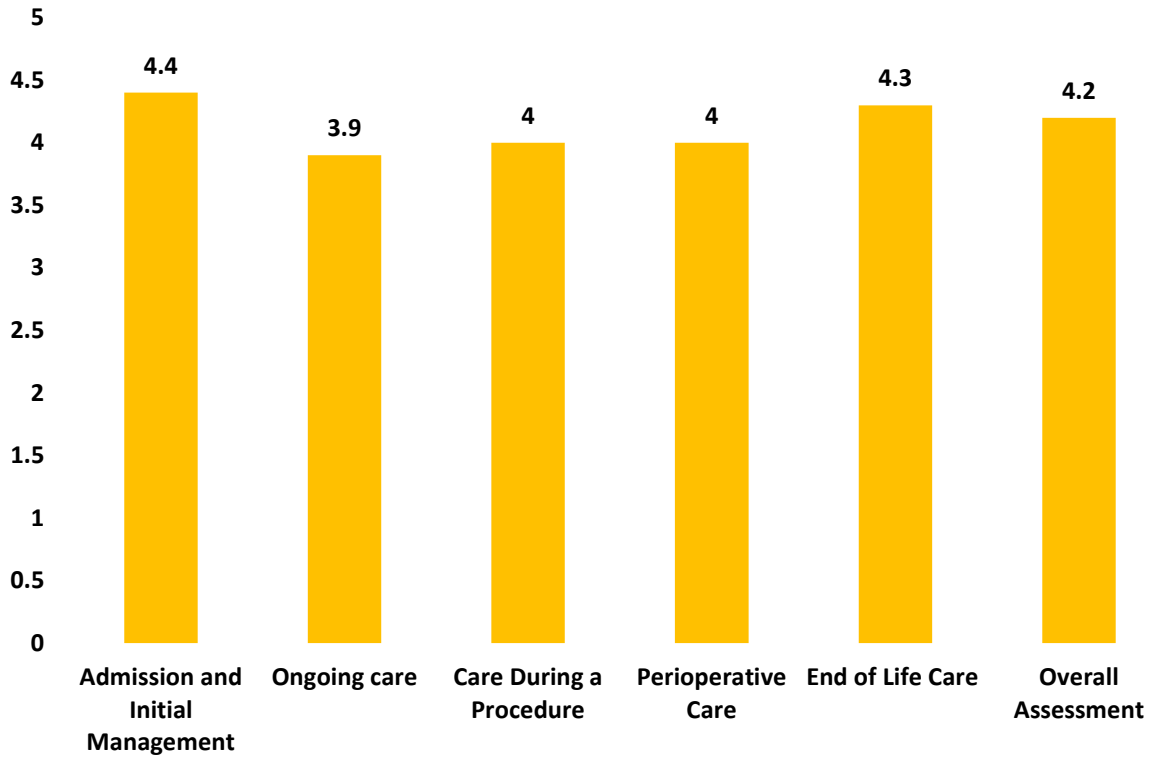
Category 8 - Serious Untoward Incidents

There have been deaths associated with a Serious Untoward Incident (SUI) in 15 cases. In one of these cases the SUI was triggered by the mortality review and in this case the death was, on review, considered to be potentially avoidable.

The mortality review highlighted this death which occurred a short time after the patient's discharge and had not been identified by any other process within the organisation. Patients in whom a SUI is generated following their death also have a SCNR to assess the overall package of care during this last admission as an SUI often has a specific term of reference and does not review all aspects of the overall patient care

Several themes are consistent in this group of patients; there were several SUIs related to patient falls, to the use of anticoagulation and either over or under anticoagulation of a patient.

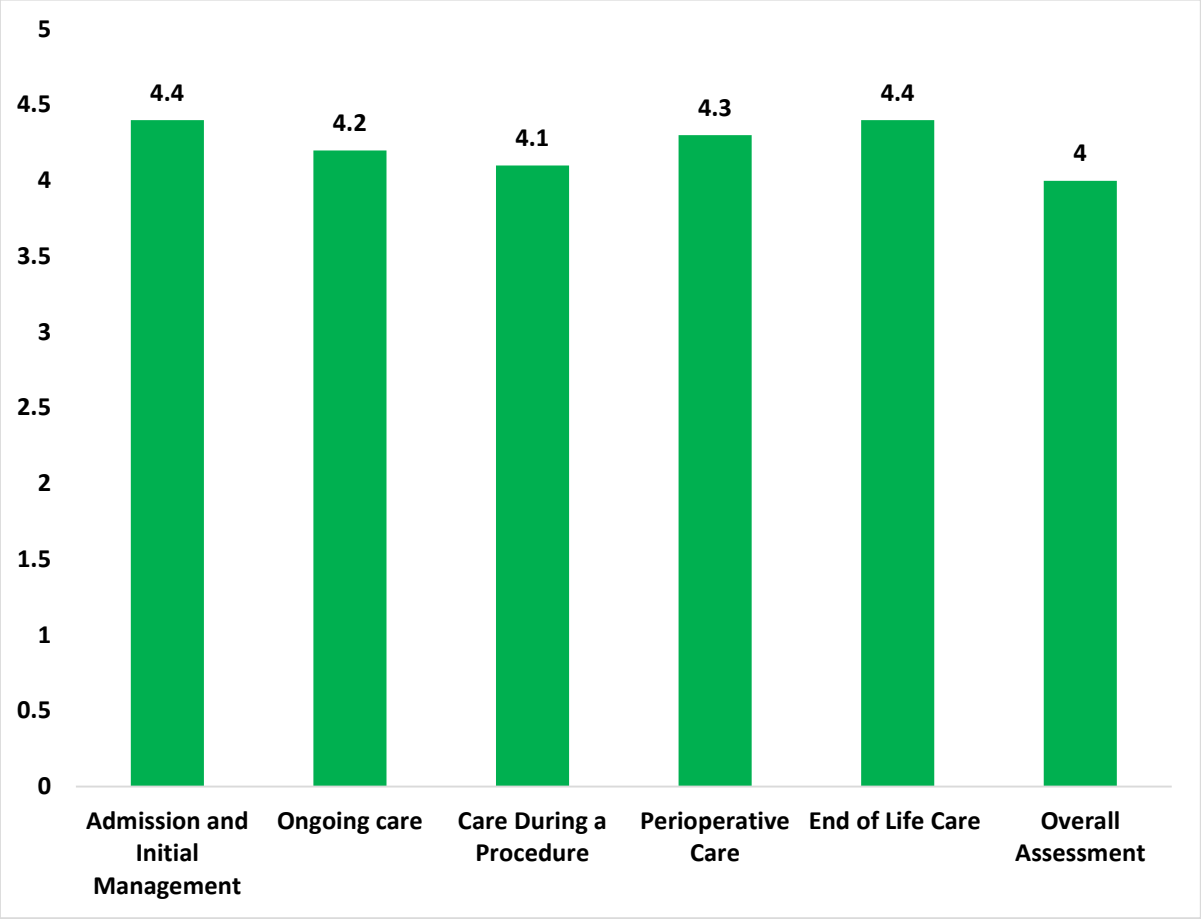
Chart 8: *Category 8 - Serious Untoward Incidents (mean scores for phases of care)*



Category 9: Mental Health

At UH Bristol a review of patients with a history of mental health is carried out if there is evidence of a current severe mental health issue that requires the input of mental health services during the patient's admission. This includes those under section. During the year there have been 10 deaths of patients who have had a severe mental health condition. No patient had evidence of scores in any domain on SCNR that caused major concern and there was no evidence of avoidable death.

Chart 9: *Category 9 - Mental Health*



Intensive Care

The Intensive Care Unit (ICU) has screened deaths on its unit in conjunction with the National Guidance On Learning From Deaths (NGOLD) document produced by NHS England which sets out the criteria to identify deaths that should undergo a mortality review. ICU reviews all deaths on the unit by a different process and does not use the SCNR proforma.

The following table shows the data the unit has collected from April 2017 to March 2018.

Table 7: *ICU data 2017-18*

Month	Admitted	Deaths	OOHCA deaths	Concerns pre- ICU admission care	Elective deaths	16-18 deaths	Learning disabilities	Mental health	Complaints	Review score inadequate
April 17	105	12	6	0	0	0	0	0	0	0
May	109	16	5	0	1	0	0	0	0	0
June	108	16	9	1	0	0	0	0	0	0
July	98	15	7	1	1	0	0	0	0	0
Aug	124	22	9	3	2	0	0	1	1	0
Sept	96	24	8	1	0	0	0	0	0	0
Oct	99	15	6	0	3		1	0	1	0
Nov	109	18	8	4	1	0	1	0		0
Dec	120	14	2	5	0	0	0	1		0
Jan 18	112	22		1	0	0	0	0	0	0
Feb	100	14	7	0	0	0	0	0	1	0
March	106	16	8	1	3	0	0	0	0	0

Deaths within 30 days of discharge from hospital

One of the other areas of interest was the investigation of learning from the deaths of patients within 30 days of their discharge from hospital. This group initially provided a challenge in identification. However, we have developed a process that allowed us to identify these cases. These patients were subject to a review following their death.

This group proved to be larger than we had expected. The national guidance on learning from deaths advises that “trusts should include cases of people who had been an inpatient but died within 30 days of leaving hospital”. At present no other hospital in the South West has had the capacity to start looking at this subgroup yet.

We started to look at this in November 2017 to get a better understanding of what this group looked like and the numbers that were involved, with a view to setting up a process that would allow us to review these deaths. We include a summary of the findings.

See the flow chart on the following page.

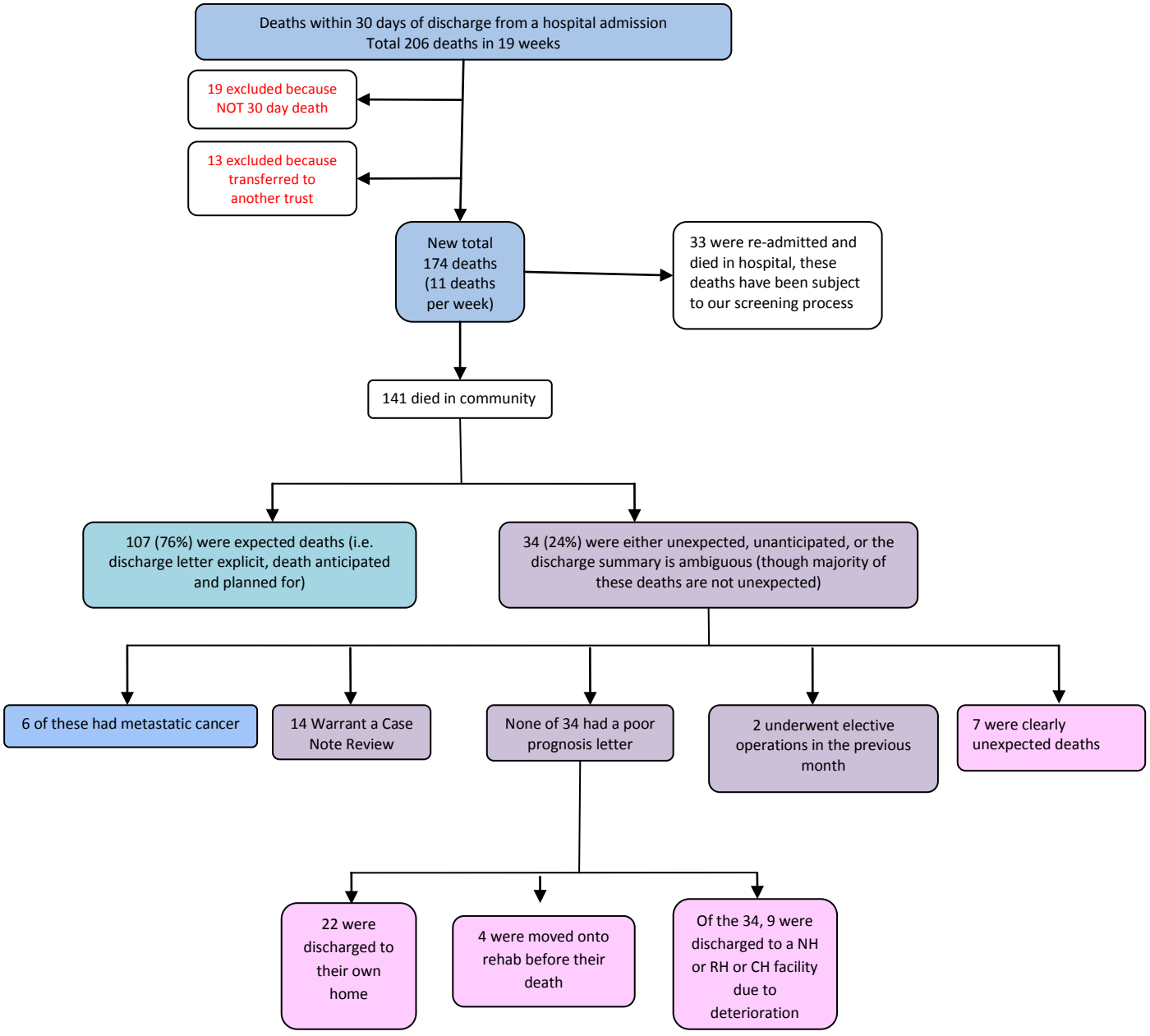
There were 206 deaths of patients within 30 days of discharge over the 19 week period of this review. This was a much higher number than had been expected. The deaths in patients in this group were then further reviewed and assessed to the number that fulfilled the criteria for SCNR.

There were 14 deaths that were identified as requiring a structured case note review. In one patient the death occurred in another trust, this was reviewed by the Emergency Department. Nine patients were medical cases which have had full structured case note reviews. Three patients were reviewed by Specialised Services, one patient with the Cardiothoracic Team (as this was a post Coronary Artery Bypass Graft death) and two patients have been reviewed by the Oncology Team because they were a chemotherapy related death. One patient of the 14 subsequently did not require a review on further investigation.

This short review highlighted several issues at the interface between primary and secondary care around the flow of patient information. Reviewing these patients has proved challenging due to accessibility to deceased patients’ notes in primary and secondary care.

The SCNR reviews highlighted the issue of discharge summaries and the use and integration of the poor prognosis letter.

Chart 10: *Process for reviewing the deaths of patients who died within 30 days of discharge from hospital*



Conclusion

Over the period April 2017 – March 2018, the mortality team has screened 1,281 deaths (all inpatient deaths except out of hospital cardiac arrests) and identified 25% that required a structured case note review according to the criteria set.

We have developed our own screening process which identifies more than 50% of these patients requiring a review.

Our report shows pleasing results: in the majority of cases that we reviewed the care given has been good or very good.

We have had four deaths that were probably avoidable (score 3: probably avoidable, more than 50:50). These cases have all had second reviews by the Medical Director's team.

The two major themes associated with patients subject to SCNR in all divisions were the instigation of the End of Life Pathway, and the early involvement of senior decision-making to adopt this pathway. The instigation of the End of Life Pathway is a major cross-divisional issue and has now formed the basis of an active and ongoing project within the Quality Improvement Academy for the year 2018/19.

This project will assess the integration of the End Of Life Pathway in the overall management of patients within the Trust. The Summary Hospital-level Mortality Indicator (SHMI) data is a year behind, and as such will start to impact on data collection from 2018/19.

As part of the West of England Academic Health Science Network collaborative we feedback all our results and the themes from learning from deaths, and these are the common areas for learning from all the hospitals within the region.

We have widened our training programme to increase the number of reviewers and plan an annual review of the process in May following the completion of the first year.

Another positive outcome of the process has been encountering the examples of truly excellent care found when reviewing patient notes. The Divisional leads have been able promote these elements of best practice by sharing with teams and having those clinicians acknowledged the Medical Director.

List of reviewers

Division of Specialised Services	
Specialised Services Lead	**Cardiac anaesthetists**
Colette Reid	Ian Ryder
	James Hillier
Cardiac surgeons	Richard Bateman
Hunaid Vohra	Tim Lovell
Cha Rajakaruna	
Umberto Benedetto	**Oncologists**
Alan Bryan	Charlie Comins
Franco Cuilli	Vivek Mohan
Raimondo Ascione	Jess Jenkins
Andrew Parry	Jilly McClean
Mark Yeatman	
	Haematologists
Cardiologists	Amanda Clark
Ihab Diab	Rachel Protheroe
Radwa Bedair	Laura Percy
Mark Turner	Lisa Wolger
Yasmin Ismail	
Mandie Townsend	**Oncology SpRs**
Tom Johnson	Philippa Closier
Julian Strange	Helen Brook
Ed Duncan	Hannah Reed
Steve Dorman	
Glyn Thomas	**Cardiac Matrons**
Palash Barman	Julie Crawford
Stephanie Curtis	

Division of Surgery	
Paul Wilkerson – Surgery Lead	David Messenger
Jane Blazeby	Jamshed Shabir
James Skipworth	Paul Sylvester
Jonathan Rees	Mike Thomas
Andrew Strickland	Rob Longman
Jon Randall	Evelyn Internullo
Dan Titcomb	Gianluca Casali
Paul Barham	Doug West
Chris Streets	Michael Schiller (OG fellow)
Andrew Hollowood	Elaine Toh (Thoracic Fellow)
Meg Finch-Jones	

Division of Medicine	
Consultants	**Juniors**
Rebecca Maxwell (Medicine Lead, ED)	Sophie James
Amanda Beale (Medicine Lead, Gastro-Hep)	Mark Houston Millet (SpR ED)
Jim Orr (gastro-hep)	Steve Dixon (SpR gastro)
Sarah Kyle (SpR lead – acute medicine)	Jodie Sabin (endo SpR)
Bushra Ahmad (Endo)	Hazel Morrison
Emma Kate Reed (COE)	Miranda Cole
Emily Bowen (COE)	
Katrina Curtis (respiratory)	**Learning Difficulties Lead**
Dave Wilson (radiology)	Helen Bishop
Louise Newell (dermatology)	
	Matrons
Mental Health Lead	Sally Wilson Medicine
Nicola Taylor	Karen Holliwell
	Lynne Myers
Management Reviewers (third reviews)	Sarah Jenkins
Mark Callaway	Jo Lloyd-Rees
Emma Redfern	

Cover report to the Public Trust Board. Meeting to be held on 27 July 2018 at 11.00 – 13.00, Conference Room, Trust HQ, Marlborough St, Bristol, BS1 3NU

		Agenda Item	11
Meeting Title	Public Trust Board	**Meeting Date**	Friday, 27 July 2018
Report Title	**CNST Compliance Report**		
Author	Jackie Moxham, Patient Safety / Sarah Windfeld, Head of Midwifery		
Executive Lead	Carolyn Mills, Chief Nurse		
Freedom of Information Status		Open	

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

In January 2018, the Clinical Negligence Scheme for Trusts (CNST) maternity incentive scheme was introduced to support the delivery of the Department of Health and Social Care's Maternity Safety Strategy. This strategy sets out an ambition to reward those who have taken action to improve maternity safety and 10 maternity actions were developed to support this aim. These actions were agreed by the National Maternity Safety Champions as reflecting best practice in Maternity Safety improvement which could be evidenced to demonstrate progress against them.

The aim of the scheme is to incentivise the implementation of good practice across all maternity units. By meeting the 10 criteria, Trusts are likely to deliver safer maternity services and be expected to have fewer cases of harm which can lead to negligence claims. Trusts' compliance with the criteria will be assessed through a verification process that will be completed by the end of June 2018. Discounts for successful trusts will be confirmed by NHS Resolution by August.

Key issues to note
The Trust maternity service is compliant with all 10 criteria and has robust evidence to demonstrate this.

Recommendations

The Trust Board is asked to note the review of evidence as listed in Appendix A which has taken place of the Trust's progress against 10 safety actions, and approve the self-certification of the requirements for the CNST incentive scheme

Members are asked to:

- **Approve** 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
Failure to comply with 10 criteria would impact on quality care and safety of patients and failure to comply with criteria would impact on the element of the Trusts contribution relating to the CNST maternity incentive fund and its share of any unallocated funds.

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

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

Board report on University Hospitals Bristol (NHS) Foundation Trust progress against the Clinical Negligence Scheme for Trusts (CNST) incentive scheme maternity safety actions

Date: 25th June 2018

Introduction

University Hospitals Bristol (NHS) Foundation Trust has seven hospitals and is managed via five divisions one of which is Women's and children's Services. Women's service includes both maternity and neonatal services. The Trust has been given 'outstanding' by the CQC in 2017.

Background

The maternity service provides care for women who live in Bristol, North Somerset and South Gloucester, but also provides a regional fetal and maternal medicine service.

The maternity service undertakes approximately 5100 deliveries per year.

The maternity service has a 13 bedded delivery suite, an alongside midwifery led unit, day assessment unit, antenatal and postnatal wards and transitional care ward. The unit has a level 3 neonatal intensive care unit (NICU). The NICU offers intensive care, high dependence and special care.

There is an integrated community midwifery service.

SECTION A: Evidence of Trust's progress against 10 safety actions:

Safety action – please see the guidance for the detail required for each action	Evidence of Trust's progress	Action met? (Y/N)
1). Are you using the National Perinatal Mortality Review Tool (NPMRT) to review perinatal deaths?	The maternity and neonatal service has been reporting all appropriate cases to MBRRACE and has used the National Perinatal Mortality Review Tool (NPMRT) for all babies who died from 1/1/18 to date. **Evidence of compliance:** 1.1. Perinatal Mortality TOR 1.2. Currently up to date with reporting to MBRRACE between 1st January 2018 and 30th April 2018 Note to Divisional and Trust Board Validation is:- 1. Self-certification to Trust Board 2. NHS Resolution will also use data from MBRRACE to verify the Trust's progress against this action.	**Yes**
2). Are you submitting data to the Maternity Services Data Set (MSDS) to the required standard?	The maternity service is submitted data to the MSDS and also complies with data quality standards. **Evidence of compliance:** **2.1.** Excel spreadsheets of submitted MSDS data Jan to March 2018	**Yes**

	2.2. Email from NHS Digital highlighting compliance CNST standard 2 Note to Divisional and Trust Board Validation is:- 1. Self-certification to Trust Board 2. NHS Resolution will also use data from NHS Digital to verify the Trust's progress against this action.	
3). Can you demonstrate that you have transitional care facilities that are in place and operational to support the implementation of the ATAIN Programme?	The service set up a working party to work towards achieving the ATAIN standards of reducing term admissions to NICU. The service has a designated *Transitional Care Ward* which is staff by appropriately trained healthcare professional which supports the mother as '*the primary care giver'* for her baby. On each shift there is a *neonatal intensive care trained nurse who is able to administer intravenous antibiotics*. *All registered nurses and midwives are trained and have appropriate guidelines in place to support practice to care for late preterm babies and give complementary nasogastric feeds.* **Evidence of compliance**: 3.1. Action plan for ATAIN alert 20-8-17 3.2. Action plan for ATAIN alert 1-3-18 3.3. University hospital ATAIN data 3.4. South west ATAIN matrix and unit actions 2017 3.5. ATAIN Poster showing reduction in term admissions to NICU December 2017	**Yes**

	3.6. ATAIN Poster showing reduction in term admissions to NICU 31st January 2018 3.7.1 – 3.7.4. Staffing rota for the transitional care unit demonstrating the presence of a NICU trained nurse on each shift. 3.8. Ward 76 Criteria for admission to Transitional care (ward 76) clinical guideline. Note to Divisional and Trust Board Validation is:- 1. Self-certification to Trust Board 2. NHS Resolution will cross-check trusts' self-reporting with Neonatal Operational Delivery Networks to verify the Trust's progress against this action.	
4). Can you demonstrate an effective system of medical workforce planning?	The medical staff undertook a four week audit to demonstrate that ≤ 20% of middle grade sessions on labour ward were filled by consultants acting down **Evidence of compliance:-** 4.1. Completion of RCOG workforce monitoring tool for 5/3/18 to 1/4/18 (including audit of consultant staffing) 4.2. Labour ward staffing guideline **Note to Divisional and Trust Board** Validation is:- 1. Self-certification to Trust Board	**Yes**

5). Can you demonstrate an effective system of midwifery workforce planning?	The maternity service can demonstrate effective maternity workforce planning by undertaking BirthratePlus. Midwifery staffing allows for the delivery suite coordinator to be supernumerary (e.g. does not have a direct patient care) and the transitional care ward has a rostered neonatal nurse on each shift. **Evidence of compliance:** 5.1. Birthrate Plus results (dated 2017) for 2016-2017 5.2. Midwifery establishment comparison to Birthrate 5.3. CDS midwife staffing 26-2-18 to 25-3-18 5.4. Labour ward staffing – Clinical guideline 5.5. Midwifery Led Unit (MLU) staffing 26/2/18 to 25/3/18 5.6. Agenda for Women's services annual; staffing review 15-3-18. 5.7. Women's services annual staffing review undertaken with Chief Nurse. Note to Divisional and Trust Board Validation is:- 1. Self-certification to Trust Board showing receipt of Birthrate Plus	**Yes**
6). Can you demonstrate compliance with all 4 elements of the Saving Babies' Lives (SBL) care bundle?	This data is submitted by the Head of Midwifery to NHS England. **Evidence of compliance**: 6.1. Survey 9 Saving Babies Lives March 2018 with data up to November 2017 where the service demonstrated 100% compliance or an alternative	**Yes**

	intervention had been put in place. 6.2 Minutes of antenatal working party meetings (October 2015) evidencing discussion of an alternative interventions to identify fetal growth restriction 6.3. Small for gestational age fetus risk assessment in pregnancy guideline (November 2017) Note to Divisional and Trust Board Validation is:- 1. Self-certification to Trust Board 2. NHS Resolution to cross-check Trust's self-reporting to NHS England	
7). Can you demonstrate that you have a patient feedback mechanism for maternity services, such as the Maternity Voices Partnership Forum, and that you regularly act on feedback?	The maternity service actively and regularly uses feedback from users of the service to enhance care. There is a Lay Representative on the patient information group Maternity service also use the Trust patient feedback survey 'Friends and family'. This information is provided monthly to all wards and departments and themes are taken to working party. **Evidence of compliance:** 7.1. Divisional Quality Assurance Committee July 2017 (Discussion of Maternity Voices) 7.2. Maternity Voice Meeting minutes September 2017 7.3. Patient experience report for Divisional Quality Assurance Committee	**Yes**

	for 1st quarter 2017-2018 7.4. The maternal and neonatal health collaborative quality improvement plan 7.5. Email CQC 2017 survey – women's experience of maternity care 7.6. Maternity services – maternity voices – action plan **Note to Divisional and Trust Board** Validation is:- 1. Self-certification to Trust Board	
8). Can you evidence that 90% of each maternity unit staff group have attended an 'in-house' multi-professional maternity emergencies training session within the last training year?	The service offers multi-professional maternity emergencies training sessions which include midwives, maternal care assistances, obstetrician, obstetric anaesthetists and maternity theatre staff. The training syllabus reflects current evidence and national guidelines and is regularly reviewed to ensure that training reflects local practice and actions from audit and patient safety incidents **Evidence of compliance 25th June 2018** 8.1.1.Training needs analysis for maternity skills drill training – revised March 2018 8.1.2. Obstetric emergency pre course reading. V10 - Revised March 2018 8.2.1- 8.2.5. Obstetric emergency training records. Compliance with attendance of 'in-house' multi-professional maternity emergencies training 2017-2018.	Yes 25/6/18

	8.3.Email:- Midwives, nurses, maternity care assistants obstetric doctors and theatre staff obstetric emergency training records as of 25/6/18 ➢ Midwives 94% ➢ Obstetricians 94% ➢ Theatre staff 94 % ➢ Maternity care assistants 93% ➢ Obstetric anaesthetist 94% **Note to Divisional and Trust Board** Validation is:- 1. Self-certification to Trust Board	
9). Can you demonstrate that the trust safety champions (obstetrician and midwife) are meeting bi-monthly with Board level champions to escalate locally identified issues?	The Head of Midwifery and the medical lead for delivery suite are the midwife and obstetrician Patient Safety Champions. They have regular monthly meetings with the Trust Patient Safety Team, Trust Programmes Board, Trust Quality Outcomes Committee and the Chief Nurse who is the Trust's Maternity Patient Safety Champion. **Evidence of compliance:** 9.1. Governance structure 9.2. Patient safety programme board minutes 4-9-17 9.3. Patient safety programme board minutes 8-5-17	Yes

	9.4. Patient Safety Improvement board TOR 9.5. One to One meetings between Head of Midwifery and Chief Nurse 9.6. Meeting notes with the medical and midwifery (Head of Midwifery) patient safety champions with the trust patient safety champion (Chief Nurse) May 2018 **Note to Divisional and Trust Board** Validation is:- 1. Self-certification to Trust Board	
10). Have you reported 100% of qualifying 2017/18 incidents under NHS Resolution's Early Notification scheme?	The patient safety team have reported all qualifying incidents that occurred in 2017-2018 financial year to NHS Resolutions under the Early Notification scheme criteria Evidence of compliance:- 10.1. Incidents reported to NHS Resolutions under the early notification scheme criteria. 10.2. Quality assurance committee meeting minutes (August 2017) NHS R 10.3. Standard operating procedure for reporting to the NHS R Validation is:- 1. Self-certification to Trust Board 2. NHS Resolution will also use data from the National Neonatal Research Database to verify the Trust's progress against this action.	**Yes**

SECTION B: Further action required:

Action plan for meeting standard 8. (19th Feb 2018) Can you evidence that 90% of each maternity unit staff group have attended an 'in-house' multi-professional maternity emergencies training session within the last training year?

Action	By whom	By when	Progress	Expected evidence of compliance
Practice development to provide adequate training sessions to allow all appropriate staff to attend annual multi-professional maternity emergency training	Practice development midwives – A Tomlinson and R Morgan	28th February 2018	Additional training sessions have been put in place to ensure that all appropriate staff can attend multi-professional maternity emergency training. Action completed. Additional training sessions have been put in place increasing compliance with obstetric emergency training to 90%	Completed training excel spreadsheet Completed CNST training forms
Ensure that all anaesthetist attend annual multi-professional	Dr Muchatuta,	22nd June 2018	All appropriate staff have been booking on to	Completed training forms showing attendance of obstetric anaesthetist at

maternity emergency training			training before 22/6/18 Action completed. Training shows 94% compliance with anaesthetists attending obstetric emergency training	multi-profession maternity emergency training
Ensure that all delivery suite maternity care assistants attend annual multi-professional maternity emergency training	CDS Matron	22nd June 2018	All appropriate staff have been booking on to training before 22/6/18. Training compliance 93% Action completed.	Completed training forms showing attendance of delivery suite maternity care assistants at multi-profession maternity emergency training. Compliance 93%
Ensure that all obstetric theatre staff attend annual multi-professional maternity emergency training	Theatre suite manager	22nd June 2018	All appropriate staff have been booking on to training before 22/6/18 Training compliance 94% Action completed	Completed training forms showing attendance of obstetric theatre staff at multi-profession maternity emergency training
Ensure that all trainee and consultant obstetrician attend annual multi-professional	Clinical lead for delivery suite	22nd June 2018	All appropriate staff have been booking on to	Completed training forms showing attendance of trainee and consultant

maternity emergency training			training before 22/6/18 Training compliance 94% Action completed	obstetrician at multi-profession maternity emergency training

SECTION C: Sign-off

……. **……..**

For and on behalf of the Board of University Hospitals Bristol (NHS) Foundation Trust confirming that:

- **The Board are satisfied that the evidence provided to demonstrate compliance with/achievement of the maternity safety actions meets the required standards and that the self-certification is accurate.**
- **The content of this report has been shared with the commissioner(s) of the Trust's maternity services**
- **If applicable, the Board agrees that any reimbursement of CNST funds will be used to deliver the action(s) referred to in Section B**

Position: Chief Nurse, University Hospitals Bristol

Date: 25th June 2018

We expect trust Boards to self-certify the Trust's declarations following consideration of the evidence provided. Where subsequent verification checks demonstrate an incorrect declaration has been made, this may indicate a failure of board governance which the Steering group escalate to the appropriate arm's length body/NHS System leader.

SECTION D: Appendices

Please list and attach copies of all relevant evidential appendices:

See attachments against each standard for those standards which require self-certification

University Hospitals Bristol
NHS Foundation Trust

Cover report to the Trust Board meeting to be held on Friday 27 July, 10:00 – 12:30 in the Board Room, Trust HQ, Marlborough St, Bristol, BS1 3NU

		Agenda Item	12
Report Title	Quality and Outcomes Committee Chair's Report		
Author	Julian Dennis, Non- Executive Director		
Executive Lead(s)	Carolyn Mills, Chief Nurse/Dr Mark Callaway Acing Medical Director	Mark Smith, Deputy Chief Executive and Chief Operating Officer	
Freedom of Information Status	Open		

Reporting Committee	Quality and Outcomes Committee
Chaired by	Julian Dennis, Non-Executive Director
Date of last meeting	25 July 2018

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

This report provides a summary of the key issues considered at the Quality and Outcomes Committee on 25 July 2018.

Quality and Performance Report
Deputy Chief Operating Officer Shaun Carr presented the report to the Committee. The following key points were highlighted:

- Emergency departments across the Trust performed well in June and July, especially in light of the challenges with the Junior Doctors rota, and St Paul's Carnival and other events in Bristol City Centre.
- Compliance against the cancer target is up to 83% in June, and the Trust hopes to be on/above trajectory in July. The early position is 83%.
- The Trust has submitted a request to NHS England for Band 5 funding for an operational role to help support performance improvements against the cancer target. . The outcomes should be known very shortly, and it is expected this will make a real difference on performance against cancer.
- There was a marginal drop in RTT performance in June 2018, but was still on delivery. Overall, management of waiting lists and performance on electives were showing sustained good performance.
- Last minute cancellations in June were reduced to below 1%.
- It was noted that there were ongoing challenges with recruiting sonographers, due to a national shortage. The Trust continued to recruit proactively, as well as carrying out training in-house, in response to this.
- It was agreed a progress report on the virtual fracture clinic would come back to the Committee following the launch on 10 July 2018
- Director of People Matt Joint noted that e-appraisal issues with Kallidus have now

been definitively resolved.

- It was agreed that an agenda item for the first meeting of the new People Committee should cover the issue of the Trust's high vacancy rate - 87 FTE – for ancillary staff. These staff play a key supportive role and it is essential that the Committee explored this issue.

On-hold Update
Deputy Chief Executive and Chief Operating Officer Mark Smith presented this update to the Committee. Key points discussed included the following:

- From an original 87,000 on-hold patients there are now just 1200 remaining, and it is expected that those remaining will be signed off within 4 to 6 weeks. There has been very positive feedback from NHS Improvement on the success of this piece of work, and the performance team have been asked to present nationally as an excellent example of addressing this kind of issue.
- The Committee praised the hard work that had gone into resolving this issue. They particularly noted the importance of ensuring that the right processes are in place to prevent the same problems happening again, and also ensuring there were lessons learned in setting up other new systems (such as the upcoming junior doctor e-rostering) so that similar issues didn't arise. Mark Smith noted the Trust was confident that the new procedures now in place would prevent these specific issues reoccurring, and it was agreed that there should be 'lessons learned' review especially for e-rostering.

Clinical Negligence Scheme for Trusts (CNST) Compliance Report
Chief Nurse Carolyn Mills presented this update to the Committee. Key points discussed included the following:

- The Trust had completed and submitted a self-assessment against compliance with 10 safety actions set out in the document This had been signed off by the Chief Nurse Carolyn Mills and submitted to NHS Resolution who will undertake external verification of the submission. The Committee approved the submission

Staff Turnover
Associate Director of HR Operations Debbie Tunnell gave a presentation to the Committee on staff turnover.

Annual Safe Working Hours Guardian Report
Guardian for Safe Working Alistair Johnstone presented this report to the Committee. Key points discussed included the following:

- Gaps in the junior doctor rota in year had been a significant problem. Reasons for the issues included challenges with the Deanery in the overall supply of juniour Drs, short notice for placements, and the need to manage other challenges such as maternity cover.
- There were plans to introduce e-rostering to help streamline co-ordination of rota management, and this would support transparency of junior doctors working hours
- The Committee requested that updates on the project plan for the implementation

of e –rostering for medical staff is a regular agenda item for the new People Committee.
- It was agreed the Director of People Matt Joint would add a risk to the Trust risk register related to the supply of junior Drs to the Trust.

Education Performance Report
a) 2017-18 Delivery Plan and b) Quarter Q4 Report

Director of People Matt Joint presented progress against that annual education delivery plan and quarterly report to the committee. Key points included the following:

- There had been good progress against apprenticeships, including a lot of time put into developing foundation policies, such as the safe working policy. The Trust was using apprenticeships as part of its external offer and was externally recruiting apprentices. It was noted that there were a high volume of BAME apprentices being recruited. The Committee asked what divisional engagement had been like with apprenticeships – it varied across the divisions, but the workforce team were working to support engagement across all of them.
- It was noted that the library had been doing excellent work and had received awards for this.
- It was noted that the Trust to date had not been required to submit a Local Delivery Agreement to HEE.
- It was noted that the 2018/19 Education Annual Plan would be ready by September 2018, and would be considered by the new People Committee.

Mortality and Learning from Deaths Annual Report
Acting Medical Director Mark Callaway presented the first annual report of learning from deaths. Key points highlighted was that the data provided assurance that a robust process from learning from deaths had been established in the Trust

This report indicated the following

- There was a high standard of care across all groups reviewed; including patients with learning difficulties or history of mental illness
- There was no difference in the standard of care between quarters despite the impact of winter pressures
- That early instigation of end of life care pathway is a key learning point.

Progress report against Quality Objectives – Q1
The Committee received a progress report against Quality Objectives for the quarter. At the end of quarter 1, six of the eight objectives were rated as being 'on plan' to achieve by year-end. The two remaining objectives were rated amber.

Quarterly Impact Assessment report –Q1
This report provided an update on the QiA process, which aims to ensure risks associated with savings and investment schemes are identified and mitigated so as to ensure the delivery of projects does not adversely impact the quality of patient care. Divisions have submitted assessments for 43 2018/19 savings schemes. Of these, 31 have a mitigated risk score of 3 or lower (low or no risk) and 10 have a risk score of 4-6 (moderate). A

formal review of all of these assessments by the Medical Director and Chief Nurse will be carried out by the end of July.

2017 National Inpatient Survey results: Local Analysis Report
The committee received a summary of UH Bristol's performance in the Care Quality Commission's 2017 National Inpatient Survey. Four UH Bristol survey scores were classed as being better than the national average to a statistically significant degree, including information about inpatient condition received during their stay, and feeling treated that they had been treated with respect and dignity by the hospital. One score was classed as being below the national average to a statistically significant degree, for whether admission date was changed by the hospital.

Reports also received by the Committee included:

- **Serious Incident Report**
- **Root Cause Analysis Reports**
- **Monthly Nurse Safe Staffing Report**
- **Quarterly Inquest Report – Q1**
- **Board Assurance Framework and Corporate Risk Register – Q1**
- **Clinical Quality Group Meeting Report**

Matters requiring Committee level consideration and/or approval	
None.	
Matters referred to other Committees	
None.	
Date of next meeting	28 August 2018

Cover report to the PublicTrust Board. Meeting to be held on 27 July 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**	Friday, 27 July 2018
Report Title	**Transforming Care Programme Report – Q1**		
Author	Simon Chamberlain, Transformation Programme Director		
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 report is to update Trust Board on progress with Trust wide programmes of work under the Transforming Care programme.

Key issues to note

The report sets out the highlights of progress over the last quarter and the next steps. A new reporting format has been developed to provide focus on the priority areas agreed for the Transformation Board and the Transformation Team - Digital Transformation, Working Smater/Productivity Improvement and the Quality Improvement programme.
Board members' feedback on this format is welcomed.

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
None

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

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

University Hospitals Bristol
NHS Foundation Trust

Transforming Care

Transforming Care Update to Trust Board

July 2018

This Transforming Care update describes the highlights over the last quarter against the three priority areas agreed for the Transformation Board and the Transformation Team:

- Digital Transformation,
- Working Smarter/Productivity Improvement and the
- Quality Improvement programme.

Progress in digital transformation has been driven by continued close joint working between the IM&T and Transformation Teams, ensuring good engagement of staff in implementation of the new systems in the GDE programme and in the identification and realisation of the benefits. Through this approach we continue to identify new areas of benefit from the digital systems and are realising actual improvement. During the last quarter the roll out of the eObservations system across adult wards has been completed, which has driven improvement in correctly recorded Early Warning Scores, greater assurance that scores have been acted upon as required, and achievement of 100% sepsis screening. Our opportunity over the next quarter is to build on this by integrating with Careflow to automate escalation of results in real time.

A third productivity workshop was held which focussed on the use of the Clinical Utilisation Review tool, which gives daily objective data on patient care delays and patients who are in the wrong setting for their care requirements. Having driven the adoption of the tool, we have developed regular routine reporting to Divisions. As a result we have developed reporting using the data to escalate therapy delays, to redesign how we track patients in the Integrated Discharge Service, and to introduce the data into the daily Site Operations reporting.

We continue to build on the success of the QI programme. The breadth of QI work across the Trust was demonstrated earlier in July by the success of our 2nd QI Forum, a poster competition designed to showcase QI work which attracted nearly 70 entries, demonstrating the breadth of QI work taking place across the Trust. Our challenge for the next quarter is to further develop our support to a broader range of Innovation beyond quality improvement, and to further increase the reach of our QI Academy to wider staff groups and to staff with more complex problems to address

Overleaf is a summary of the highlights of progress over the last quarter and priorities for the next quarter. A more detailed description of progress against key projects is attached at Appendix 1.

Transforming Care – Progress Summary Q1 2018-19

Successes	Priorities
• Deployment of eObservations in adult inpatient areas, supporting improved compliance with Early Warning Scores and sepsis screening • The growth in use of data from the Clinical Utilisation Review tool which gives objective and timely data on patient flow delays, prompting specific process changes • Productivity workshops with senior leaders have supported development of detailed divisional improvement programmes • A 2-day Rapid Improvement Workshop with the BEH Cataract pathway team identified a range of improvements to the service • Introduction of the electronic Single Referral Form for joint assessment of patients with complex discharge needs • The 2nd QI Forum attracted nearly 70 entries to our poster competition • Delivery of QI Bronze to two nurse preceptorship events.	• Pilot the use of Careflow aligned to eObs to automate the escalation of results from eObservations • Automate the CUR routine reporting and introduce develop its use in repatriations and the Integrated Discharge Service • Expand the use of CUR into the Children's Hospital • Further expand electronic operational reporting into the Operations Centre • Refine the benefits identified from digital transformation to deliver specific improvement targets for the digital work • Roll out of eTriage broadly across specialties to make referral triage paperless • Implementation of the Cataract service improvement projects • Complete the second cohort of the QI Silver programme and mobilise a 3rd cohort
Opportunities	**Risks and Threats**
• Work with clinical teams on different types of IT hardware to support wider use of the digital systems and to better fit with working arrangements and patterns • Better define roles and responsibilities in clinical decision escalation and reporting, so as to support automatic escalation of results from eObservations • Design of a model of Real Time Outpatients clinic aimed at completing documentation and onward appointments on the day of clinic • Further develop support to Innovation and Improvement – via a QI Gold programme and improved support to broader Innovation opportunities	• The capacity of our teams to engage with the level of and pace of change being brought about by the Digital Transformation we are going through. This places even more importance on our approach which focuses on staff engagement to identify and realise benefits • The opportunity for clinical staff to engage with the QI Academy and undertake improvement work. This challenges us to find different ways to bring the QI Academy to different staff groups and support them in improvement work

Pillars: Delivering Best Care | Improving Patient Flow | Building Capability

Appendix 1: Transforming Care Report

July 2018

Aims Status Key: On Track | Behind | Delays | Scoping | Completed

Project & Aim	Progress Last Month	Aims for Next 3 Months	When		Benefits delivered or expected	Current Challenges	Key Comments for Awareness/Discussion
Electronic Observations To improve the recognition, response and management of deteriorating patients with the use of an E-Observation system	• Post rollout reviews with adult inpatient wards – feeding back improvement suggestions to IT • E-Obs now on FlowTracker in BHI for 3 months	• E-Obs data is utilized to continue quality and safety improvements using a BI dashboard	Aug		• Correctly recorded early warning scores (EWS) across Trust 100% March 2018 • EWS acted upon appropriately 100% across Trust • SBAR communication 82.9% (increase from Feb) more work to be done here • Achieved 100% sepsis screening in May (from 33% in Nov 2016) • All based on system data	• Consulting with teams to trial new IT equipment to ensure that it supports new ways of working • eObs use beyond observations (e.g. pain, Aseptic Non Touch Technique) would require a bespoke solution which may not be possible	• Infrastructure e.g. Wi-Fi, multiple logins, locating IT equipment on wards, lack of single sign on to multiple systems is impacting on the time with patients • Successful implementation of E-Obs in ED will facilitate successful rollout of other IT systems (e.g. EPMA)
		• Comms and engagement plan to communicate the benefits to staff/patients while finding ways to better support challenges which have been fed back	Aug				
		• Scoping completed to link Careflow with E-Obs	Aug				
		• Engagement and rollout in adult ED	Sep				
EPMA Implement an Electronic Safe Effective Patient Centred Prescribing and Medication Administration System	• New EPMA functionality has been rolled out in the BHI (including VTE assessment) • ED Requirements for EPMA are now understood, options being considered • New eLearning delivered prior to roll out in Medicine	• Medway ED and Medway EPMA fully investigated, resolution found to enable project progression within potentially adjusted and agreed scope	Jul		• Recognition by nursing staff using EPMA of improved quality of prescribing (verbal feedback) • Ensure timely administration of medication • Streamline discharge medication processes, reduce time wasted through manual processes for prescribing and dispensing • Reporting and Dashboard mechanisms will support action prioritization and efficiency	• EPMA still requires link with Medway ED and community medication information – work ongoing • Some access issues/frustrations (e.g. staff requiring multiple log-ins, access across devices) still remain	• The roll out of EPMA in BHI has resulted in a reduction in Medication errors. However the speed of the system has caused frustration particularly for medical staff. • Dual systems for medication administration are creating additional workload for clinicians in EPMA-live areas.
		• Roll out in Medicine commenced within an agreed structure	Jul				
Careflow To have effective communication systems across teams to deliver timely, safe and effective patient care	• Rollout continuing across all services • Feedback regarding potential use and workflow redesign being obtained	• Working with teams to optimise the use of Careflow in their processes	TBC		• Reduction of communication incidents on DATIX • Reduction in bleeps (moving non-urgent communication from the bleep system, improving efficiency of communication)	• IT infrastructure (e.g. Wi-Fi coverage and mobile reception) can impact efficiency of the Careflow system	• Solution required regarding how best to encourage staff to report the (infrastructure) problems to IT
		• Continued rollout and tracking of teams to understand when flow processes could be redesigned	TBC				
		• To pilot escalation from eObs via Careflow	Sep				
Clinical Utilisation Review To increase the percentage of inpatients receiving the right level of care in the right care setting, for the right duration.	• Engagement and training commenced with 6 wards at BRHC • Productivity flow workshop using CUR data held with SLT • Communication of CUR progress circulated to Trust	• Pilot and refine the processes for using CUR data in all areas (D&T, IDS)	Sep		• Beds occupied by patients requiring acute care (% of qualified reviews with no delays) • Robust management of patients awaiting discharge external reasons • Robust management of patients with internal delays in their care pathway	• BRHC impact of an additional system for nurses to complete being discussed by the BRHC leadership team. Similar systems being assessed to see if duplication can be removed	• Top four key areas of transformation work: repatriations, flow, and IDS (internal and external).
		• Automated CUR report providing trust, division, speciality and ward breakdown developed	Jul				
		• Rolling CUR out in the BRHC	Jul				
		• Design and implement process for using CUR to support repatriations from UH Bristol	Sep				
eOperational Reporting Deliver a digital bed flow communication tool, initially for adult BRI services with the potential of being Trust wide.	• All Surgical wards have been trained in the basic use of the tool - accuracy of the information is improving • SBCH using the tool to good effect. Reporting is near 100% accurate, facilitated patient flow to SBCH, thus vacating beds at BRI earlier in the day	• Further focussed with Cardiac Wards	Jun		• Improve communication between ward staff and bed management teams. Reducing duplication • Replacing walk rounds, telephone ring rounds, and other ward interruptions with a live report • Improve the accuracy of data by replacing potential human written errors with Medway data • As a by-product being more paperless	• Relies on staff completing Medway in real-time • Divisional ownership	• Staff feedback states the biggest barrier to this work is a perceived “lack of time”
		• Further focussed work with Surgery	Aug				
		• Design electronic boards for the Ops Centre	Jun				
		• Attend the Urgent Care Steering group to present the report and to embed the electronic processes to become ‘business as usual’	Jun				
Ward View To improve patient experience, safety & quality and ensure effective teamwork to improve patient flow.	• Temporary mitigation in place whilst awaiting permanent fix to issue with patients disappearing from Ward View	• Engagement meetings with wards to introduce upgrade to ward view which will standardise columns (flagged as a patient safety issue)	Jul		• Positive feedback from users when system is fully working – increasing transparency of MDT working • Increased visibility of potential discharges due to real-time data available	• Ward View boards awaiting technical fix to be applied (due July)	• Wardview boards still experiencing issues where they are not correctly updating • If able to change EDDs on the Ward View (Ward View input to Medway) this would be able to help the teams with discharge reporting (support Operational Reporting)
		• Comms to celebrate achievements of ward process work stream and Move existing connect resources to a new page to house all resources developed	Jul				
Personal Health Record Patients to have direct electronic access to their health records. Enabling patients to engage with their care and treatment.	• Project group continuing to meet fortnightly • System C working on fixing Phase 2 issues • Design / patient involvement approach agreed in principle	• Phase 2 issues completed and fixing underway	Jul		• Patients to have view of Medway records, to include inpatients, outpatients, emergency attendances • Patients will have access to general information about UHB and lifestyle advice • There will be two way communication between patients and clinicians	• System C delays in fixing Phase 2 issues are delaying project • Improved registration process needs to be developed	• Phase one has proved to be more complex that initially anticipated. A more structured project approach has been discussed and stakeholder engagement is developing.
		• Agree and commence design phase with patient involvement	Jul				
		• Outline comms developed for patient and clinician involvement	Aug				

Project & Aim	Progress Last Month	Aims for Next 3 Months	When	Benefits	Current Challenges	Key Comments for Awareness/Discussion
Outpatients Transformation To deliver a high quality service through a friendly, accessible, consistent and timely service.	• Paper-rejection process is now live • Polling ranges and list of all clinics linked to e-RS sent to all divisions • Final services being set up on e-RS in advance of 4th June • 2018/19 programme signed off	• Switch off paper GP referrals on 4th June 2018 • Progress the appointment centre transfer • Roll out of e-triage • Create and circulate outpatients baseline questionnaire • Appoint to Advice & Guidance CQUIN support post	Jun Sep Jun Jul Jun	• Achievement of paper switch off • Achievement of centralised appointment booking • Roll out of e-triage commenced – less waste in the patient journey	• Organisation support for Appointment Centre plans • Capacity of Divisions to complete key actions	• Lack of Transformation support has stalled progress on some of the work
Improving Discharge To establish a Discharge Service which reduces occupied bed days whilst improving patient outcomes and experience	• Final preparation for single referral form go live achieved • Pilot of patient owned information document (My life outside hospital) on C808 successful use will be continued • Diamond Discharge project now being led by discharge lounge lead nurse	• Roll out single referral form trust wide • Larger scale roll out of patient-owned information sharing document • Established Diamond Discharge process trust wide • Relaunch and transfer Weekend Registrar Discharge report onto Medway for greater efficiency – future plan to use Careflow	Jul Jul Jul Aug	• Trusted assessment approach between partners • Consistent discharge information resource to support timely progression to discharge • 'Earlier in the day' discharge achieved accommodating flow • 'Timely discharge' has improved from an average of 32 per week (in April 2017) to an average of 40 per week (in April 2018)	• Single referral form in Medway cannot currently transfer outside of Medway well (e.g. LAS, paper systems)	• Inconsistencies across BNSSG adds challenge to partnership working • Launching single referral form in its current • format, but cognisant that the ICB may require adjustments to the form going forward
Improving Flow To improve patient flow at BRHC so that children and young people receive quality healthcare at the right time in the right place with no delays by Dec 2018.	• 'Making every bed day count' workshop arranged for 30th July • 'Getting the right consultant' guidance distributed	• 3 Month Clinical Investigations Unit follow-up project review • Pilot of "your child's stay at BRHC" parent booklet with 60 families • Expand the use and format of criteria led discharge • Hold a ward processes/think discharge workshop to launch new processes	Aug Aug Aug Jul	• Support the delivery of the 4-hour performance • Support the achievement or admitted RTT performance (Aim: 92%) • Supporting the ability to accept regional referrals in the required clinical timescale (% of priority 1 and 2 timescales achieved)	• Clinical engagement with the focus on discharge	• Capacity of project team (both divisional and transformation) remains a challenge. • Capacity of staff on the wards to trial additional new systems.
Optimising Diagnostics To ensure that patient diagnostic pathways are necessary, timely and lean by April 2019	• Expanded productivity tracker to include current programmes of work • Discussion in progress about the benefits of Medway order comms and Driver Diagram completed.	• Timelines and scoping for programme agreed • Re-audit blood test requests, following education PDSA in C808 • CT Scanner BHOC Outpatients second session and improvement work scoped	Aug Jul Jul	• Less unnecessary testing • Better utilisation of staff and equipment • Support diagnostics productivity improvement	• Governance of the overall programme – cross-divisional leadership is required	• Further scoping and understanding of the projects are still required
QI Academy To provide staff with the knowledge and skills to conduct their own Quality Improvement projects.	• An additional QI Faculty member has now been trained and facilitated • Forth session for Silver 2 completed • 2 of 3 QI Bronze first preceptorship sessions conducted	• Expand QI Faculty to 12 members (currently 10) • QI Silver cohort 2 graduated and cohort 3 commenced • Final QI Bronze for the preceptorship pilot completed	Aug Sep Aug	• Deliver more sessions with expanded faculty • Additional sessions increases the amount of staff who have QI tools and knowledge • Preceptorship session guarantees engagement with 160 newly qualified nurses each year	• Not enough capacity to meet with demand of QI Academy and QI Hub • Fast expansion could result in increased variation of delivery – structured training and presenter guidance should mitigate	• Staff feedback states the biggest barrier to QI work is a perceived "lack of time" • Feedback from preceptorship indicates a large percentage do not feel they have 'permission' to make changes until they get promoted
Innovation & Improvement To promote and encourage innovation and improvement, so that patients, staff, the Trust and the wider NHS will benefit.	• Received 57 abstract submissions for the QI Forum	• QI Forum 2018 to take place July 10th • Develop QI network within the Trust • Develop 'Fab Stuff' network at UH Bristol • Develop system to capture 'innovation ideas' from staff which are not QI – Utilising 'Bright Ideas' brand	Jul Aug Aug Aug	• Recognition of good practice by staff • Promotion of growth in innovation and hub activity • A QI network will engage and reinforce QI work with members	• Not enough capacity of faculty to meet with growing demand of QI sessions and QI Hub submissions	• Engagement from influential staff from all divisions would be critical to ensure the success of the QI Forum, Hub and network. Staff need to be provided with the time, resources and permissions to make changes.
Customer Service To develop a consistent customer service mind-set in all our interactions with patients and their families	• Customer Service questions added to interview process and plan to include in staff training • New audit tool and case study shared • Stakeholder workshop to shape communications strategy and accreditation programme	• Branding for customer service initiative will be aligned with real time patient feedback • Customer Service accreditation will be designed following input from a range of stakeholders • Pilot sites identified for advanced training • Automatic reports configured for departments undertaking telecoms improvement work	Aug Aug Jul Aug	• Wards and departments recognised for good practice through accreditation programme and reduction in complaints • Improved patient & staff experience • Improved clinic utilisation due to efficient handling of cancellations	• Fail to align effectively with other programmes causing duplication of effort • Staff may perceive principles to overlap with values and leadership behaviours	• Competing priorities in IM&T telecoms (faults prioritised over transformation) could delay configuration of automatic reports • Reason for delay in aligning branding with real-time patient feedback design was clarifying and agreeing the quote provided by designers and settling budget
Patient Comms Every patient receives clear, timely and coherent written appointment information.	• Letters roll-out approaching 90% across the Trust • BDH receptionists trained in email address collection. • IRMG signed off investigating opportunity to expand email process to other patient groups such as carers	• Comms and rollout starts 11th June • Receptionists completed e-learning • Starting to update CRIS generated letters • Continue to support authors to update letters • Evaluation planned upon completion of work • Patients audited to check emails received	Jul Sep Jul Sep Sep Jul	• Clearer, timely communications for patients • Less complaints about communications • Emails are more accessible than paper letters • Patients have requested emails	• Appointment centre capacity to validate email addresses • There are bottlenecks in the letter authorisation process; letter author capacity, support, sign-off, and uploading to Medway	• Email collection – rollout delayed due to concerns raised regarding the process
Admin Transformation To deliver safe, effective, responsive and high quality admin services to patients and professionals.	• Redesigned new starter form • 15 Staff drop-in events took place • Roll profile and guidance signed off and 30 day comment period launched • Training redesign next steps agreed	• Trust-wide panel sign off job descriptions • Redesign training based on feedback • Annual update days for admin staff planned • Final new starter process to be finalised • Evaluation of toolkit	Aug Oct Aug	• Less complaints about admin services • Better trained and engaged admin staff • Better quality of staff recruited	• A greater level of Division engagement in job description rollout is required	• Staff response to the Job description rollout is broadly positive • Plan to design eLearning, telling the story of the patient journey by the end of the summer.

Cover report to the PublicTrust Board. Meeting to be held on 27 July 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**	Friday, 27 July 2018
Report Title	**Genomics Annual Report**		
Author	Mr Owen Ainsley, Divisional Director, Specialised Services		
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 - Provide an update on the progress of the national 100,000 Genomes Project and developments towards delivery of a genomic medicine service - Provide an update regarding local delivery of the 100,000 Genomes Project and developments as part of the West of England Genomic Medicine Centre. - Outline key achievements of the WE GMC in the past 12 months. - Outline proposal for short term and longer term delivery of legacy work associated with the 100,000 Genomes Project and move towards Key issues to note - Existing Genomic Medicine Centre contracts expire 31st December 2018. Income based on samples submitted will cease end of October 2018 by NHS England. - On Friday 13th July the Trust received notification from NHSE that they are seeking to

extend the cancer enrolment period to December 2018 (rather than September). The rare disease plan remains unchanged. The closure plan outlined in this paper reflects the original timescales and will be updated in light of this announcement. - The specification for an 'evolved Genomic Medicine Centre' has yet to be shared and the re-procurement procedure is as yet unknown.
Recommendations
The WE GMC are seeking **approva**l from the Board for: - The project closure approach, to facilitate completion of the 100,000 Genomes Project across the WE GMC. (Subject to final timing adjustments when cancer enrolment deadline is confirmed). - Subject to a satisfactory commissioning specification from NHSE, support in principle, the objective for Bristol to host an 'evolved GMC' noting that this will require subsequent decision making regarding the most appropriate host organisation.

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)**

West of England Genomic Medicine Centre: Project Briefing June 2018

1. Summary of 100,000 Genomes Project and Genomic Medicine Centres

The 100,000 Genomes Project was launched nationally through a network of Genomic Medicine Centres (GMCs) in December 2014 with two key objectives:

1. Collect 100,000 samples from rare disease and cancer patients and analyse by whole genome sequencing.
2. Transform genome sequencing into mainstream clinical practice.

The 100,000 Genomes Project will reach target and close in December 2018. This document summarises the West of England GMC (WE GMC) achievements to date (focussed on the last 12 months) and summarises the current operational plan for the final 6 months of the 100,000 Genome Project highlighting several important uncertainties and risks relating to regional transition to the nationally proposed genomic medicine service.

2. Background - National position

Since launch, the 13 English GMCs have collected over 57,000 rare disease and 20,000 cancer samples and will complete enrolment of patients in September 2018.

Table 1: Activity per Genomic Medicine Centre (as of 2nd July 2018)

NHS GMC	Approximate Size of Population Covered (Million)	Rare Disease Samples Collected	Cancer Collected (All QC'd samples: Blood, FFPE, Fresh Frozen)	Total Samples Collected	*Total Samples at UKB*
South London	7	6,953	3,251	10,204	*9,451*
East of England	6.1	5,262	2,669	7,931	*7,570*
North Thames	6	14,641	2,770	17,411	*15,889*
West Midlands	5.6	7,491	3,701	11,192	*10,998*
Yorkshire & Humber*	5.3	3,688	886	4,574	*3,491*
North West Coast	4.3	2,305	1,218	3,523	*2,706*
Wessex	3.5	3,133	1,047	4,180	*4,098*
Greater Manchester	3.5	3,796	888	4,684	*3,747*
North East & N. Cumbria	3.1	1,601	175	1,776	*1,710*
Oxford	3	3,356	1,761	5,117	*4,776*
West of England*	**2.8**	**2,218**	**514**	**2,732**	***2,218***
West London	2.5	1,429	1,228	2,657	*2,108*
South West	2.2	1,870	646	2,516	*2,151*
Total	**54.9**	**57,743**	**20,754**	**78,497**	***70,913***

*Yorkshire & Humber and West of England GMC were Phase 2 Genomic Medicine Centres established in 2016. All other GMCs established in 2015 and certain centres had previously worked as pilot sites for the piloting phase of the project in 2014.

Contracts with the GMCs for delivery of the 100,000 Genomes Project will end on 31st December 2018.

The 100,000 Genomes Project closure coincides with a national reconfiguration of genetics laboratories to a network of Genomic Laboratory Hubs (GLHs) which will provide nationally commissioned genetic tests according to a standardised test directory. NHSE propose that *'evolved GMCs'* will continue after the end of the 100,000 Genomes Project alongside the GLHs, clinical genetics and cancer services as a unified 'Genomic Medicine Service'.

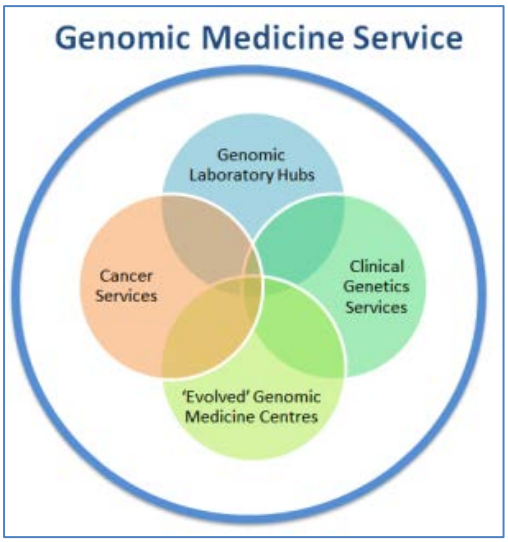


Diagram 1 (left): NHSE proposed model for unified 'Genomic Medicine Service'

The national launch for the GLHs will be 1st October 2018, although the re-procurement process is ongoing and significant areas of uncertainty remain.

Creation of the 'evolved GMCs' is substantially delayed. On 19th June 2018, NHSE indicated that designation of evolved GMCs will require a competitive re-procurement process. There was no timescale for launch or service specification for evolved GMCs.

3. Background - local position

University Hospitals Bristol (UHB) is the lead organisation of the WE GMC which has four recruiting sites (UHB, North Bristol Trust (NBT), Royal United Hospitals, Bath (RUH) and Gloucestershire Hospitals NHS Trust (GHNFT)). Funding for patient identification, consent, sample processing, analysis of results and WEGMC management and governance costs is activity based (£200 per sample) supplemented by individually negotiated bespoke funding awards from NHSE, HEE, AHSN and NIHR CRN and by funding by providers for core posts.

The WEGMC funded staff comprise the chair of board, clinical director, programme manager, lead genomics practitioner, leads for training and for informatics, 4 WTE laboratory staff, 4.5 WTE administrative staff and 8 WTE consenting staff shared between 30 NHS staff. There has been **substantial additional input** across region from existing NHS staff within existing job plans.

Governance is provided through a WE GMC Partnership Board supported by 20 member organisations. Locally each of the recruiting sites holds regular Genomics Steering Group meetings supported by the core WE GMC team.

3a. Delivery of Samples for the 100,000 Genomes Project

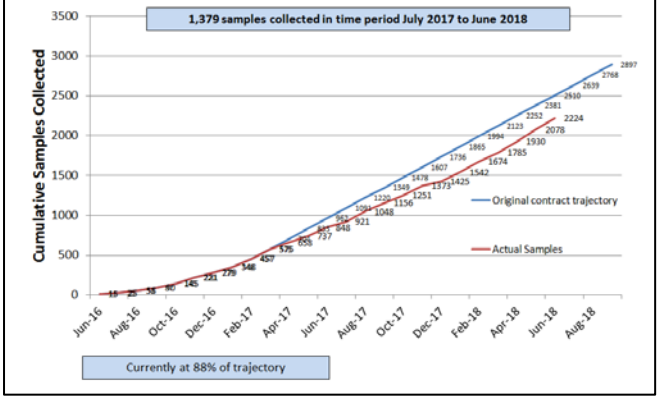
The WEGMC contract for delivery of the 100,000 Genomes Project was established in July 2016 and defined that 4,163 samples be collected and submitted by 31st October 2018. Since launch in June 2016, the WEGMC has collected approximately 3,100 samples. We have capacity to enrol a further 420 rare disease and 150 cancer patients (yielding 420 and 300 samples respectively) by close of project. Our projected total activity at end of programme is 3,750 samples (2,605 rare disease plus 1,145 cancer samples; delivering 90% of original contract).

Principle reasons behind variation from contract include:

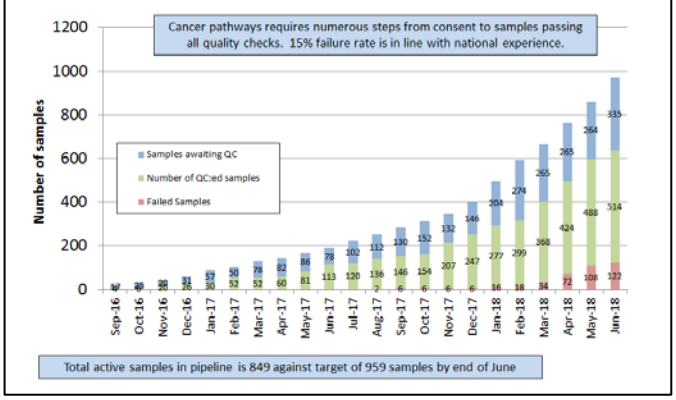
- Changes required by NHS England to tumour sampling requirements resulting in Fresh Frozen samples being required by Phase 2 GMCs (requiring a change to clinical practice for tumour sample collection)
- Changes to focus of delivery from rare diseases sample collection to focus on opening of multiple cancer pathways to support national under-delivery of cancer arm of project
- NHS England decision not to extend non-recurrent funding for rare disease consent staff beyond March 2018

Despite challenges presented the WE GMC has been commended on the speed of sample recruitment (commended as being the fastest national recruiting GMC, noting that the GMC started 12 months later than other GMCs). Our strategic approach included ensuring all provider organisations contributed to the project and our methodical roll out of multiple cancer pathways across the region was also regarded as a national exemplar.

Graph 1. Rare Disease Samples – 2,224 samples collected to date



Graph 2. Cancer samples – approx. 971 samples collected (122 failed & 335 awaiting QC process)



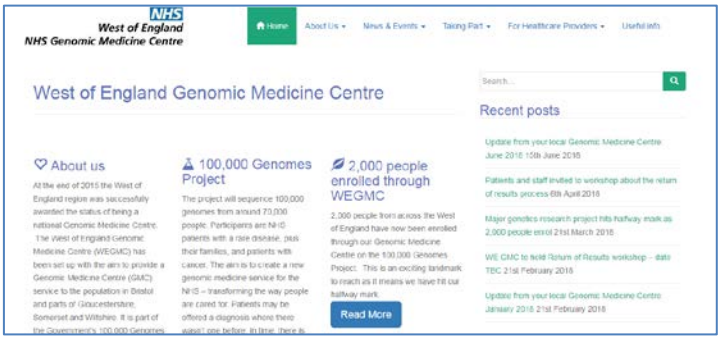
3b. Transformation and engagement activities

In additional to sample collection a key objective of the national programme has been preparation for the mainstreaming of a future genomic medicine service. The national team has regularly commended the WE GMC core team on our approach to many of these initiatives and we have been asked to present on numerous

occasions at national GMC events to share our best practice in areas of education, sample transport and patient and public involvement. The WE GMC has focussed on supporting wider transformation activities and key achievements over the last 12 months include:

- Delivery of a competency framework and training package for consenting staff delivered to over 40 staff across the region (assist mainstreaming expertise)
- Collaboration with Health Education England and University of the West of England to develop and deliver 'Lego' genomes training package for children and public delivered to over 10,000 individuals (and shared nationally)
- Provision of dedicated information sessions; WE GMC Annual Conference (01/09/2017), Molecular Pathology Round Table (27/11/2017) and Return of Results Workforce for clinicians and public (24/04/2018)
- Updates at >100 engagement sessions including regional cancer and disease speciality meetings updates and bespoke sessions to clinical teams
- Active press and social media campaign (including website & twitter) and participation in local Trusts facebook updates and newsletters
- Promotion of educational opportunities through biannual education leaflet

Imagines below clockwise from top left: Lego probots used in local schools to facilitate genomics education, faces of GMC poster shared by social media across region, WE GMC education & training leaflet, screen shot of WE GMC website, presentation at April Return of Results Workshop & article released by Cheltenham Echo



4. Next steps & planning for local closure of the 100,000 Genomes Project

The 100,000 Genomes Project is entering its final stage and there are seven main areas of activity required to complete delivery (Diagram 2). Tasks 1-4 and parts of tasks 5-7 occur within the lifespan of the current contract. Most of tasks 5-7 will occur after the end of the existing contract for the WEGMC and this represents a risk.

1. **Complete enrolment of cases (by 30th Sep 18)**
2. **Complete submission of samples (by 31st Oct 18)**
3. **Complete data queries (by 30th Nov 18)**
4. **Governance and formal closure tasks (by 31st Dec 18)**
5. **Manage return of 100,000 Genomes Project results (no fixed deadline)**
6. **Aftercare of 100,000 Genome Project families (no fixed deadline)**
7. **Manage transition to new genetic testing service from 1st Oct 18**

Diagram 2. Gant chart summarising key activities for project closure

The overall strategy for closure is:

i. 1st Jul to 30th Sep 2018

Our current staffing model will continue all tasks until completion of task 1. At this point, most of the current enrolment and administrative team will finish their secondments with the WEGMC and return to clinical roles. It should be noted that all posts associated with the project have been managed via secondments and fixed term roles.

ii. 1st Oct to 31st Dec 2018

We propose to retain a streamlined core team to complete tasks 2-4 and to continue tasks 5-7. We propose the following posts, modelled on geographical distribution of activity during enrolment phase (appendix 1).

Proposed post for October to December 2018	**WTE (Band)**
Chair of Board	existing
Clinical Director	0.2 (Cons)
Programme manager	1.0 (8a)
Lead genomics practitioner	0.2 (7)
Cancer genomics practitioners	1.3 (6-7)

Rare disease genomics practitioners	0.5 (6-7)
Rare disease patient coordinator	1.0 (4)
Administrator	1.2 (3)
Pathologist	0.125 (Cons)
Laboratory administrative and processing	1.2 (3)
Informatics lead	0.8 (7)
Training and education lead	0.6 (8a)
Patient contributors	existing

iii.1st Jan 2019 onwards

Tasks 5-7 of the 100,000 Genomes Project will be on-going. These tasks require input from the rare disease and cancer clinical teams who enrolled 100,000 Genomes Project patients but also central leadership and coordination.

We anticipate that central coordination of tasks 5-6 will be core activities for a regional evolved GMC working in partnership with a regional GLH.

There is uncertainty about planning and funding this phase because:

1. Contracting arrangements for the 'SW Regional GLH' are not yet confirmed
2. There is no national service specification or funding plan for evolved GMCs

In particular, it is uncertain whether these tasks will be within the remit of staff already proposed within the SW regional GLH bid.

5. Detailed modelling of return of results and aftercare of families

Return of results (task 5) refers to the process by which provisional genome sequence results are returned by Genomics England to local laboratories and then undergo a process of local evaluation. Selected results are then confirmed by reanalysis in local labs before reports are issued to enrolling clinicians who are responsible for returning any results to their patient. Aftercare of families (task 6) includes co-ordinating re-consent for patients turning 16 who joined the 100,000 Genomes Project as children, and managing late patient withdrawals and queries.

The WEGMC has developed return of results pathways for rare diseases and for cancer (appendix 2) and has piloted these using early results released to us by Genomics England. Release of results is expected to accelerate during Q3 and Q4 2018. We estimate that >75% of results will be released between 31st Dec 2018 (end of WEGMC contract) and 31st March 2019.

5.1 Rare disease return of results and aftercare

The projected final number of results anticipated is approximately 1,100 results from patients with rare diseases and family members (from a total of 2,600 samples submitted). The largest clinical areas of responsibility for return of results will be Clinical Genetics at UHB (approximately 51% of all rare disease results), paediatric neurology at UHB (8%) and cardiology at UHB (5%) (appendix 1).

The return of results pathways for 100,000 Genomes patients has been based on existing clinical pathways for return of standard genetic test results. The activities required for this process are: (see appendix 3 for detailed analysis)

1. Laboratory staff time for initial evaluation of results, reanalysis of some samples, discussion with clinical team, attend MDT meeting and issue of reports (100% of results require analysis)
2. Clinical staff time for discussion of results with laboratory team and/or review at MDT meeting (approximately 20% of results)
3. Administration time for delivery of clinical MDT meetings
4. Clinical staff time to provide results appointments to patients within their existing clinical practice (% of additional clinic appointments will depend on existing patient pathways)
5. Aftercare support for enrolled patients to manage reconsent, withdrawal and queries
6. Core support infrastructure to facilitate informatics requirements, workforce development and potential governance and oversight requirements

It is envisaged that existing clinical MDTs; Clinical Genetics, Cardiology and Paediatric neurology would be utilised to discuss complex patients and based on projected enrolling speciality figures, we anticipate a requirement for creating a new 'general' genomic MDT meeting for the remaining specialties at UHB and for NBT, RUH and GHNFT for discussion of complex patient results.

5.2 Return of cancer results

Resources have been modelled on the projected final sample number of 1,145 samples from patients with cancer. Since two samples are submitted for each patient, return of results is required for approximately 650 patients.

The largest clinical areas of responsibility for return of results will be breast cancer at NBT (16% of all cancer results), colorectal cancer at NBT (12%) and breast at GHFNT (11%) (see appendix 1 for breakdown)

The main elements required for cancer return of results are (see appendix 4 for detailed analysis):

1. Laboratory staff time for initial evaluation of all results. Contribute to GTAB, local re-analysis and issue of report for results.
2. Clinical staff time for identifying whether patients are on active treatment pathway (all results) and attendance at GTAB (approximately 20% of patients with returned results)
3. Administration and clinical oversight for the GTAB
4. Clinical staff time to manage results for patients on active pathways as part of existing clinical practice
5. Aftercare support for enrolled patients to manage reconsent, withdrawal and queries
6. Core support infrastructure to facilitate informatics requirements, workforce development and potential governance and oversight requirements

A key element of the cancer results pathway is a Genomics Tumour Advisory Board (GTAB) which will evaluate all pathogenic germline results and tumour results from patients on active treatment pathways. This is currently being facilitated by the core team and requires ongoing support in the future genomic medicine service.

5.3 Broader impact of return of 100,000 Genomes Project results

The resource implications included in this briefing document do not include operational planning for individual specialities or teams. We have not formally evaluated the impact to individual clinical services of the return of results to patients or how this alters subsequent care pathways. We are able to provide detailed breakdown of referrals per clinical team and then work will need to be undertaken alongside current operational planning activities to consider potential work load implications for identified clinical groups.

6. Summary & next steps

The WE GMC and 100,000 Genomes Project has been successfully delivered as a regional service and we are keen for support for future delivery of a genomic medicine service. The WE GMC has developed a comprehensive closure plan, as summarised above, and although many elements are being managed risks exist around ongoing aftercare services to consented patients and delivery of ongoing infrastructure to manage return of results both of which are not covered by existing commissioning arrangements. The WE GMC is seeking approval from the Board for:

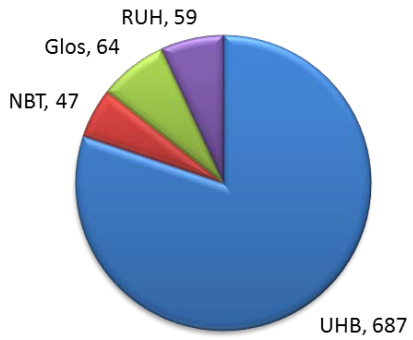
- The project closure approach, to facilitate completion of the 100,000 Genomes Project across the WE GMC. (Subject to final timing adjustments when cancer enrolment deadline is confirmed).

- Subject to a satisfactory commissioning specification from NHSE, support in principle, the objective for Bristol to host an ‘evolved GMC’ notifying that this will require subsequent decision making regarding the most appropriate host organisation.

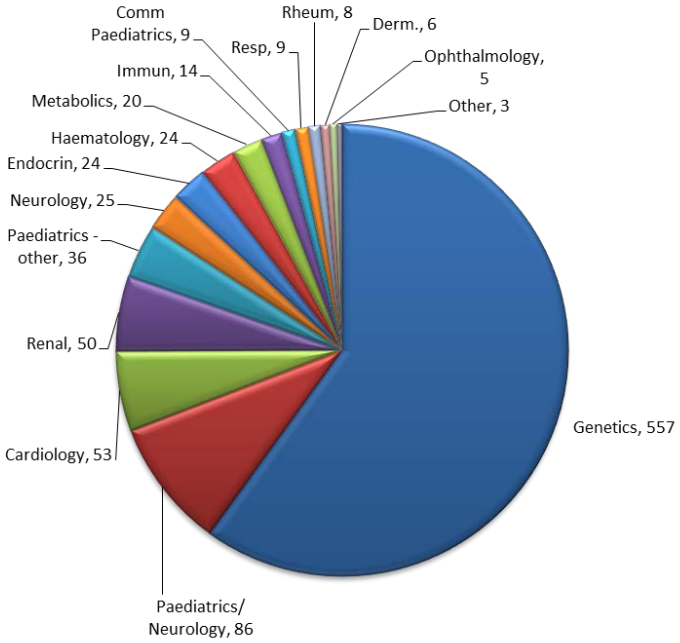
Appendix 1: Break down of enrolment by Trust & specialty

A. Rare diseases

Consented patients by referring organisation



Consented patients by clinician's specialty

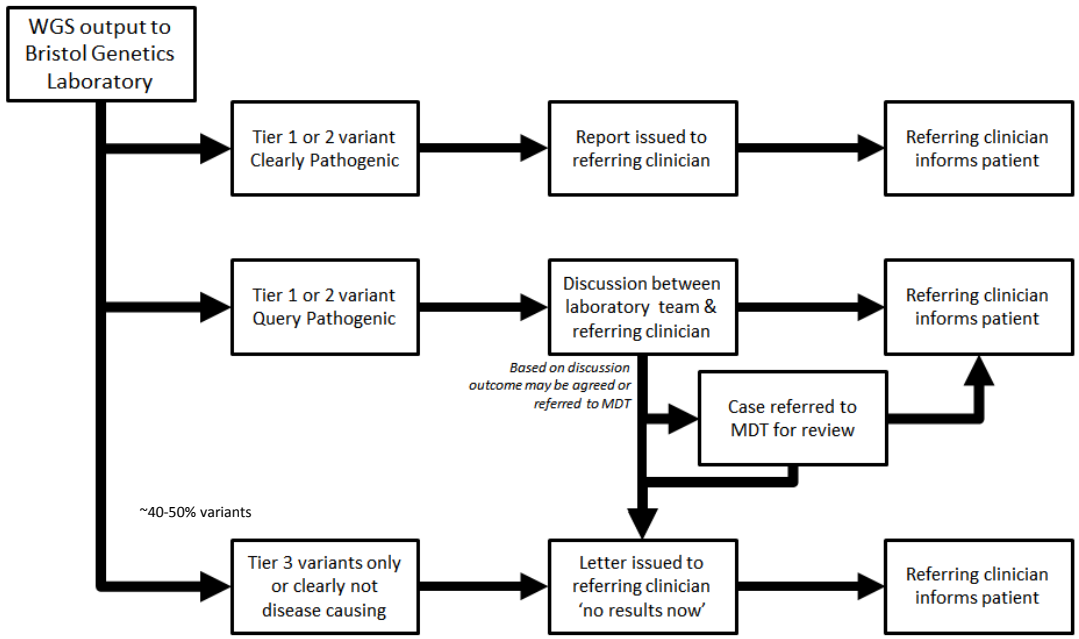


B. Cancer

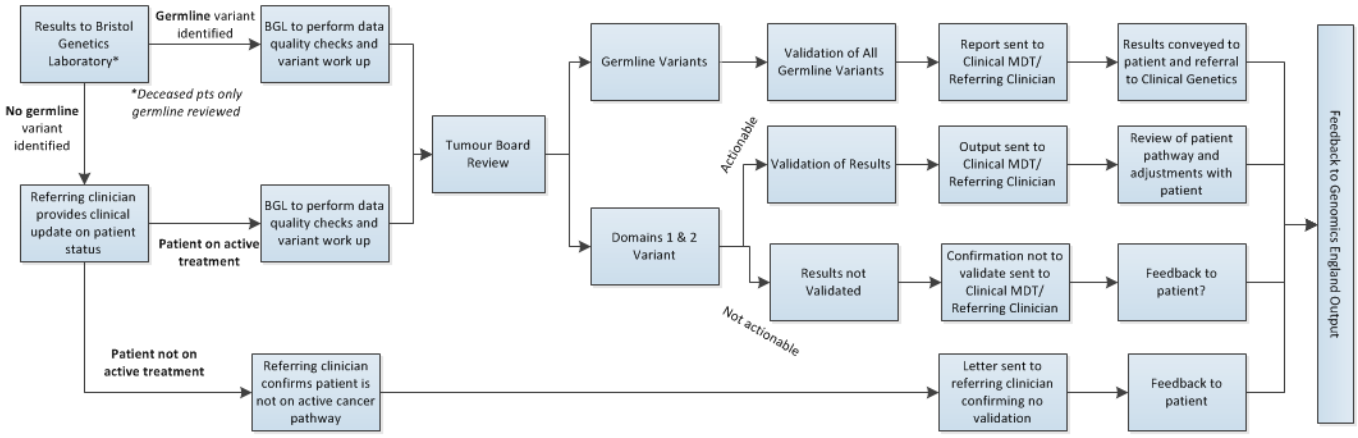
Patients per pathway		
Trust	Pathway	Estimate of total consented patients
GHNFT	Breast	72
	Gynae	68
	Uro - Renal & Bladder	66
	Head & Neck	6
GHNFT total		**212**
NBT	Breast	106
	Colorectal	75
	Brain	12
	Haem Onc	15
	Sarcoma	5
	Skin	5
NBT Total		**218**
RUH	Breast	42
	Gynaecology	65
	Renal	25
	Colorectal	13
RUH total		**145**
UHB	Colorectal	47
	Haem Onc	10
	Paed Onc	10
	Head & Neck	7
UHB total		**74**

Appendix 2: Summary return of results pathways

A. Rare diseases



B. Cancer



Appendix 3. Rare disease- estimated resource for return of results and after care for 100,000 Genomes Project cases

Tasks	Resource Required	Patient Volume	Resource Estimation
Analysis & interpretation of genomic data	Clinical Scientist time to review results and provide results back to clinical teams and Advisory Board	~1,100 patients	WTE Clinical Scientist for 1 year full time (time to include attendance & support to MDTs as highlighted below)
Clinic capacity to inform patient of results & initiate next steps	Clinical teams	~1,100 patients	Aim to deliver as part of routine clinical pathways Assume patients will be seen in standard follow up clinics under existing tariffs. Will require resource in key clinic and areas to deliver.
MDTs for review of complex results requiring scientist and clinical interface	Administration	~1,100 patients assume approx. 10% to 20% will require MDT discussion	Aim to deliver results in existing MDTs as appropriate: - Cardiac MDT - Neurology MDT - Clinical Genetics MDT (these require adequate resource and support) Additional MDT required for wider engagement programme – resources required to facilitate continuation of NBT MDT. - MDT Chair/Lead - Administrative Support
Trust Support for Rare Diseases Enrolled Patients	Ongoing support to queries and concerns by enrolled patients. Reconsenting patients turning 16 years old Managing withdrawals. Potential data or Genomics England queries	UHB – 925 patients approx NBT – 80 patients approx GHNFT – 60 patients approx RUH – 45 patients approx	Modest estimate of approx. 3 hours per patient enrolled: UHBristol- 2 days per week for 1 year NBT support - limited? GHNFT support – limited? RUH support – limited?
Informatics support	TBC – dependent on GLH & 'evolved' GMC scope	Regional	Required delivery of Gel2MDT or similar tool to facilitate results return
Workforce Development	TBC – as above	Regional	Opportunity to upskill local teams and support wider training
Oversight & governance	TBC – as above	Regional	Needs to be determined as part of interface between GLH & 'evolved' GMCs

Appendix 4: Cancer- estimated resource for return of results and after care for 100,000 Genomes Project cases

Tasks	Resource Required	Patient Volume	Resource Estimation
Analysis & interpretation of genomic data	Clinical Scientist time to review results and provide results back to clinical teams and Advisory Board	~650 patients	1 WTE Clinical Scientist for 1 year full time (time to include attendance & support to GTAB as highlighted below)
Genomics Tumour Advisory Board	Administration Senior Clinical Leadership Clinical Scientist Local Trust & MDT Leads	~650 patients (approx. 10% to 20% to have formal review?)	GTAB administrator (query WTE) 1 p.a. for Clinical Chair of GTAB for 1 year 1 p.a. for Genetics Consultant for Advisory Board 1 p.a. for Oncology Lead for GTAB 1 p.a. for Molecular Pathology Lead for GTAB (to include Clinical Scientist and Trust Leads)
Trust Leads for Cancer Return of Results (including support to GTAB)	Clinical Leads to co-ordinate and manage active patients. Each cancer result requires review of patient pathway to ensure triage, an update on clinical status and follow up contact to confirm outcome and ensure results embedded in clinical care. Ongoing support to queries from enrolled patients.	NBT – 220 patients approx GHNFT – 220 patients approx RUH – 150 patients approx UHB – 75 patients approx	Modest estimate of approx. 3 hours per patient enrolled: NBT support – 2 days per week for 1 year GHNFT support – 2 days per week for 1 year RUH support – 1 day per week for 1 year UHBristol – ½ day per week for 1 year
MDT specific leads or just liaison role	Engagement per MDT		Required engagement from each MDT to support results
Informatics support	TBC – dependent on GLH & 'evolved' GMC scope	Regional	Required delivery of Gel2MDT or similar tool to facilitate results return
Workforce Development	TBC – as above	Regional	Opportunity to upskill local MDTs and support wider training
Oversight & governance	TBC – as above	Regional	Needs to be determined as part of interface between GLH & 'evolved' GMCs

Cover report to the Public Trust Board. Meeting to be held on 27 July 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**	Friday, 27 July 2018
Report Title	**Corporate Objectives Q1 Update**		
Author	All Executives		
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 an update to Trust Board on the delivery of the Trust's Corporate Objectives for Quarter 1.
- This includes an overview of the actions completed against all objectives in Quarter 1(Q1) and identification of key milestones for delivery in Quarter 2 (Q2).

Key issues to note

- The organisational Corporate Objectives for 2018/2019 were approved as part of the Trust NHS Improvement (NHSI) Operational Plan in April 2018 and represent the key areas of focus in the year ahead to support delivery of our strategic priorities. These are detailed overleaf.

Strategic Priority	Corporate Objective 2018/19
We will consistently deliver high quality individual care, delivered with compassion.	• Ensure patients have access to the right care when they need it and are discharged as soon as they are medically fit. • Improve performance against access standards and delivery of our performance trajectories in the four core standards. • Improve patient and staff experience • Improve outcomes and reduce mortality • Improve patient safety
We will ensure a safe, friendly and modern environment for our patients and our staff.	• Develop the Estates and capital strategy during 2018-19 to continue to align the modernisation and development of our estate to our evolving clinical strategy and support delivery of the emerging system wide new models of care. • Maximise the productivity and utilisation of our estate and facilities.
We will strive to employ the best and help all our staff fulfil their individual potential	• Develop our Leadership and Management Capability through delivery of a comprehensive programme of leadership and management training and development. • Continue to improve staff engagement and experience. • Recruiting and Retaining the Best. Continue to market all vacancies with innovative, cost effective solutions, utilising the strong employer brand. • Love Life Love Bristol to deliver a highly skilled and productive workforce that is as diverse as the community that we serve. • Reward and Performance Management: Improve the quality and application of staff appraisal. • Transform and optimise workforce efficiency: control agency and locum costs, review the Strategic Workforce Plan for the Trust and, in collaboration with BNSSG Workforce Advisory Board, support the strategic workforce activity of the Healthier Together programme.
We will deliver pioneering and efficient practice, putting ourselves at the leading edge of research, innovation and transformation.	• Maximise the opportunity provided by our successful appointment as a National Digital Exemplar site to continue to deliver a programme to support the long-term vision of the Trust's Clinical Systems Strategy - *that every member of our staff will have access to the information they need, when they need it, without having to look for a piece of paper, wait to use a computer or ask the patient yet again.* • Maintain performance in initiating and delivering high quality clinical trials, demonstrated by remaining within the upper quartile of trusts within our league (as reported to Department of Health via NIHR); maintain our performance in initiating research and remain the top recruiting trust within the West of England Clinical Research Network and within the top 10% of Trusts nationally (published annually by NIHR). • Maintain NIHR grant applications at a level required to maintain

	Department of Health allocated Research Capability Funding within the upper quartile nationally (published annually by NIHR). • Continue to develop our research capacity and capability building on 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. • Deliver our Transforming Care Programme focussing on working smarter, eliminating waste and transforming the way in which we deliver quality care through service and workforce redesign enabled through digital transformation.
We will provide leadership to the networks we are part of, for the benefit of the region and people we serve	• Lead and collaborate through the BNSSG Healthier Together partnership to make our services fit for the future. • Continue to develop our partnerships with Weston Area Health Trust and North Bristol Trust to support our collective clinical and financial sustainability • Play an active part in the research and innovation landscape through our contribution to Bristol Health Partners, West of England Academic Health Science Network and Collaborative for Leadership and Applied Research and HealthCare (CLARHC). • Effectively host the Networks that we are responsible for including Operational Delivery Networks, the CLARHC and Clinical Research Network.
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.	• Deliver agreed financial plan for 2018/19. • Deliver minimum cash balance. • Deliver the annual Cost Improvement Plan (CIP) programme. • Implement an Executive led productivity programme to eliminate waste and add value from : - Outpatients; Length of stay; Theatres; Consultant productivity; and Diagnostics.
We will ensure we are soundly governed and are compliant with the requirements of our regulators.	• Re-commit to and renew our Trust Strategy, setting the strategic direction for the Trust from 2019-2025, and ensure we integrate our clinical, teaching and research capabilities to maximise the benefit for the people we serve • Implement General Data Protection Regulations. • Ensure all principles of good governance are embedded in practice and policy. • Achieve regulatory compliance against CQC fundamental standards.

- This report should be read in conjuction with the Q1 Board Assurance Framework (BAF) update, which provides assurance on the management of risks to the delivery of the Trust strategic priorities.
  - On further review, an additional objective was added in support of Strategy Priority 7 – "We will ensure we are soundly governed and are compliant with the requirements of

our regulator" – relating to our communications function.

- The format and reporting of the corporate objectives is replicated through the Divisional operating plans, via the Operational Planning Process (OPP).
- Divisions will be providing assurance on the delivery of their annual objectives in the same format as the Corporate Objectives through the Executive-led quarterly Divisional review framework. This provides the cascade of assurance through the organisation, from Trust level strategic priorities, to annual corporate objectives, through to Divisional annual objectives.

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
The Q1 corporate objectives update should be considered alongside the Q1 BAF update which provides assurance on the mananagemet of risks to the delivery of the Trust's strategic priorites.

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)**

ANNUAL CORPORATE PLAN 2018/19

Plan Owner:
Paula Clarke

Version Number/Date:
V8. 180718

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

Ref	Strategic Priorities	Corporate Objectives 2018/19	Goals for the Organisation (ideally these should be measurable goals)	Q1 Update	RAG	Q2 Milestones	Executive Owner
		Describe the overall result that you want to achieve, e.g., reduce outpatient activity	**Describe the specific outcomes and target to be achieved, e.g., reduce dermatology outpatient activity by 5% by 2015**				
1	We will consistently deliver high quality individual care, delivered with compassion.	Ensure patients have access to the right care when they need it and are discharged as soon as they are medically fit.	Implement CUR across all wards and use to improve flow and reduce patient delis in progressing care	All wards have implemented CUR. The next implementation phase will be the BCH. Draft reports now being produced.	**G**	Fully implement across BCH, develop new reports and automate from data warehouse using Microsoft BI. Form part of the monthly Finance and Ops reviews with Executives and performance management of data at Divisional Boards.	COO
			Focus on improving timely discharge (time of day) and reducing delayed discharges through continued development of the discharge hub, IDS processes and increasing UHBristol access to home care and reablement capacity	Complete redesign of the Urgent Care Strategy. Now developed the Flow Programme presented at Board seminar. Increase in physical capacity business case accepted by SLT. Task and Finish groups proposed bids on REACT, ICB and homlessness - signed off by SDOB July 2018. New format for system-wide dashboard agreed.	**G**	Implement next phase of Flow programme. Tranche 1 of Acute care assembly, bank holiday planning and flow modelling.	COO
		Improve performance against access standards and delivery of our performance trajectories in the four core standards.	Develop and deliver Urgent Care recovery plan and achieve the 95% access standard Q4 2019	Achievement of Q1 trajectory delivering the 90% for the 4 hour standard. GPSU function now part of Acute care assembly plan and agreed by SLT to proceed.	**G**	Review of internal escalation documents, escalation triggers, recruitment to posts for Acute care assembly.	COO
			Agree clear recovery plans by specialty to delivery RTT performance for admitted, non-admitted and on-going pathways	On hold backlog reduction in line with plans, signed off by national IST team. New reporting infrastructure in place. Automatic sends have marked improvement in theatre productivity.	**G**	Ensure Trust does not go below 87 as agreed with commissioners. Full review of ourt of order booking. Paper to QOC on theatre productivity.	
			Sustain and improve cancer performance to ensure delivery of all key cancer targets	New reporting PTL for cancer that reports into weekly perforamnce oversight meeting. Main impact: BHOC fire has impacted significantly on delivery. New trajectory agreed with NHSI and commisioners.	**R**	Re-profile capacity and demand planning to accommodate backlog and create sustainable 62day delivery target. Trajectories to be added to performance report.	
			Delivery the 99% diagnostic handover access standard	Underachievement of plan. Divisions have poor visibility of issues and not escalating quickly enough fo recovery. New diagnostic PTL.	**A**	Review of internal reporting arangements within each Division, escalation process and performance management arrangements within Divisional Boards.	
		Improve patient satisfaction and experience.	To be in the upper quartile performance for all national patient surveys	The following national surveys are currently top quintile: Inpatient (2016), Parents (2016), Children (2016), A&E (2016). The following national surveys are currently not top quintile: Maternity (2017), Cancer (2016). • Results from the 2017 national inpatient survey are currently being analysed. • Improving maternity service – BNSSG 'Better births' programme work streams in place; discharge audit findings have been reviewed, improving understanding of reasons for delayed discharge. • progress towards embedding a customer service mind-set/standards in key Trust programme and activities – Trust work programmes have been identified for introducing our customer service principles; stakeholder workshop took plan in June to discuss project communications strategy and options for customer service accreditation.	**G**	• #conversations week planned at St Michael's w/c 9 July • ongoing actions within customer service mind-set work programmes delivery	CN
			To increase the number of people saying that it was clear how to raise concerns/the Trust was responsive	• Rapid time patient feedback system implementation progressed – preferred system provider has been identified; on-site testing completed successfully. • intent to develop a recognisable brand for feedback of patient experience at UH Bristol agreed to mirror UH Bristol Welcome Guide – the same branding will also be used for customer services mind-set project. • Complaints about attitude and communication rose to 136 in Q1 (includes June data as yet un-validated) with notable increases in all bed-holding divisions – data currently being analysed for themes in Q1 complaints report to support targetted actions in Q2	**G**	• Contracts to be signed for patient feedback system and system roll-out from September. • Mystery shopper programme to progress - initial work stream will involve Face2Face volunteer interview team carrying out mystery shopping exercises at key touch points around the Trust, primarily "front of house" services such as receptions and telephone contacts.	

Ref	Strategic Priorities	Corporate Objectives 2018/19	Goals for the Organisation (ideally these should be measurable goals)	Q1 Update	RAG	Q2 Milestones	Executive Owner
			Develop numbers and breadth of volunteers in the Trust	• focus is on increasing the number of young people volunteering in the Trust . As of 16 July 2018, we have a total of 252 registered volunteers. The small decrease compared to the end of 2017/18 is accounted for by student volunteers who leave us at this time of year. • As of 16 July 2018, we have engaged with 19 young people in volunteering activities since the start of 2018/19. The young people have been a mixture of students from the City of Bristol College, Ashton Park School, University of Bristol, plus young people in work.	A	• Focus on ensuring anticipated increase in number of volunteers throughout the Autumn.	
		Improve patient outcomes and reduce mortality.	Reduce no. of never events in Trust				MD
			Refine/expand mortality review processes (adults) evidence actions taken to reduce mortality				
			Improve process/outcomes of organisational learning from serious incidents				
		Deliver safe and reliable care	Achieve and sustain adverse event rate of 3.23per 1000 bed days (rolling average)	Data shows sustained improvement since May 2017.	G	Continued sustained improvement.	MD/CN
			For the organisation's safety culture to develop along the Manchester Patient Safety Framework (2006) continuum from the baseline assessment towards a generative safety culture.	Safety culture reassessment underway - analysis being undertaken July / August 2018.	G	• Safety culture results reviewed and shared. • Any learning themes identified.	
2	We will ensure a safe, friendly and modern environment for our patients and our staff	Develop the Estates and capital strategy during 2018-19 to continue to align the modernisation and development of our estate to our evolving clinical strategy and support delivery of the emerging system wide new models of care.	Develop a major capital investment programme to 2022 to modernise our estate for the benefit of staff, patients and visitors with delivery of a phased programme for investment in specific prioritised schemes in 18/19	• Strategic Capital Investment Programme and Medium Term Financial Plan developed in draft • Individual scheme business cases being developed by Divisions and considered via relevant governance routes assessing options appraisals for clinical services models and Capital solutions • Discussions commenced with charitable partners to assess aligned support for Individual larger scale schemes	G	• Board approval to be sought to the Strategic Capital Investment Plan September 2018 • Commissioner discussions to commence • Alignment with 2025 Strategy Development to be kept under review	DoS&T
			Complete an Estates Plan to support the Board in assessing options and making decisions for the strategic investment programme	Suite utilisation mapping has now been completed and will be finalised in July with options appraisal.	A	The review of site utilisation plan completed mid-July. To be shared at next CPSG and aligned with Phase 5 capital plan and new strategy. Ensure plan refreshed on a bi-annual basis.	COO
		Maximise the productivity and utilisation of our estate and facilities.	Improve our productivity performance against key benchmarking indicators, such as Carter and the Model Hospital, and realise efficiency savings and improved throughput and access through increased utilisation of our facilities.	Discussions commenced with Weston through the Partnership Management Board. Full benchmarking of E&F against ERIC / model hospital. OGIM plan produced, outlining productivity opportunities.	A	E&F OGIM productivity plan monitored through Divisional Finance and Ops meetings with Executive Directors and also Savings Board.	COO
3	We will strive to employ the best and help all our staff fulfil their individual potential.	Develop our Leadership and Management Capability through delivery of a comprehensive programme of leadership and management training and development.	Talent Management and Succession Planning - Develop Strategy and implement process to support Succession planning at least to Divisional leadership level.	- First draft of Executive Directors succession plan compelted and tabled at June RemCom meeting	G	- Talent reviews to be completed for Band 9s, 8ds and 8cs with talent calibration late August. '- Revised Executive Directors succession plan to be tabled at September RemCom meeting.	DoP
			Design and launch Executive Leadership Development programme for top 100 leaders.	- ELDP design completed and shared with SLT and Board. Contributors and venue confirmed.	G	- Module 1 scheduled for 17 and 18 September	
			Continue to implement and embed Apprenticeships and integrate with management development programme.	- 192 apprentices by the end of Q1 - Significant growth but more divisional engagement needed to support the growth, in numbers, to fully realise the levy set in 17/18. - The Healthier Together education group agreed a consortium approach to the delivery of the levels 2 and 4 Healthcare Science apprenticeship, level 7 Advanced Clinical Practitioner Apprenticeship and levels 6 and 7 leadership and management apprenticeship officer.	A	- Significant update of integrated leadership and management apprenticeship. '- Appointment of training supplier for the consortium.	
		Continue to improve staff engagement and experience.	Complete and deliver Health & Wellbeing strategic framework, including a co-ordinated Trust-wide approach to psychological health.	- Team reviewed, and reporting moved to Head of OD. More focused strategy and team now includes Arts Programme Director and Psychological Wellbeing Manager.	A	- Appointment of Psychological Wellbeing Manager. '- Evidence of a more integrated wellbeing strategy.	DoP
			Develop UH Bristol Arts Strategy.	- Arts Programme Director appointed. - Consultation with key stakeholders to develop strategy.	G	- Arts Programme strategy signed off.	

Ref	Strategic Priorities	Corporate Objectives 2018/19	Goals for the Organisation (ideally these should be measurable goals)	Q1 Update	RAG	Q2 Milestones	Executive Owner
			Staff Survey 2018. Reduce level of reported bullying and harassment by 30%.	- Improving staff experience plans are in place, targeting hotspot areas with bespoke interventions to improve engagement. - Focus on *You Said, We Did*	G	- Happy App reporting has been improved and will be embedded into Divisional performance reviews from August.	
		Recruiting and Retaining the Best. Continue to market all vacancies with innovative, cost effective solutions, utilising the strong employer brand Love Life Love Bristol to deliver a highly skilled and productive workforce.	Significant increase in the percentage of staff who are BAME, particularly at management levels.	- Meeting with external partners in Bristol to plan BAME recruitment event for the Trust. - Review of external recruitment materal to ensure people see 'people like us'. - Establishing baseline data for recruitment of BAME. - Action to ensure recruiting managers have completed unconcious bias training,	A	- Exeternal Recruitment event. - Launch of reverse mentoring scheme for BAME.	DoP
		Love Life Love Bristol to deliver a highly skilled and productive workforce that is as diverse as the community that we serve.	Creation of a Trust-wide Recruitment Lead for the medical workforce, offering a co-ordinated and focussed recruitment approach to hard to fill posts and elevating the Trust onto both a national and international platform as an employer of choice.	- Business case written for *spend to save* for new role of Recruitment Lead. - Head of Recruitment initiated recruitment of senior consultants.	A	- Approval for Business case and appointment of Lead.	DoP
		Reward and Performance Management: Improve the quality and application of staff appraisal.	Strategic framework for reward to the Senior Leadership Team.	- Strategic Reward strategy drafted. - Revised ToR and processes for TPAG.	G	- Comprehensive staff briefing for new terms and conditions (Agenda for Change).	DoP
			Review of local Clinical Excellence Awards Framework.	- Head of Medical HR working with Medical Director's team, Finance and BMA to develop Trust's approach to local awards.	A	- Agreed approach to CEAs and development of briefings and communications to target population.	
		Transform and optimise workforce efficiency: control agency and locum costs, review the Strategic Workforce Plan for the Trust and, in collaboration with BNSSG Workforce Advisory Board, support the strategic workforce activity of the Healthier Together Programme.	Work with Medical Director's team to review and transform the Trust's approach to medical recruitment, including Consultant recruitment and assessment.	- New consultant recruitment process agreed.	G	- Frances Forrest and Abi Sleight will manage the first pilot assessment and evaluate.	DoP
			Procure and implement an e-rostering system that supports job planning, absence management, develops a locum bank and provides effective oversight of the junior doctor contract.	Establishment of an Implementation Board for the roll out of "Allocate" e-rostering system across all Divisions to allow a consistent approach to job planning and recording activity. Several pilot areas to be defined.	G	Allocate being utilised for both doctors in training and senior doctors in several pilot areas completed and comprehensive roll out undertaken.	MD/DoP
			Embed robust IT solutions with support managers with the effective deployment of HR best practice, creating efficiencies in ways of working and an improved customer experience.	- Kallidus Perform issue diagnosed and rectified for the beginning of Q2. - Engagement with suppliers to investigate alternative systems and upgrades to support 19/20 performance management strategy.	A	- HR Web review and plan for overhaul completed. - Piloting of Allocate (as above).	
			Engage and involve staff in solutions which will require different ways of working, such as clinical teams joining up to deliver pathways of care, new roles, changes in skills mix, and development of new competences, in support of Healthier Together Programme.	- Approach revised to provide a greater pace and focus. - Facilitated focus group approach piloted in D&T. - Results of pilot and proposed method for Divisions shared at SLT. - STP Strategic Workforce Group has been initiated, which should provide co-ordinatiion for workforce challenges across the Trusts.	A	- Divisions commence facilitated focus groups to produce strategic workforce plans. - Progress of Trust wide workforce plans eg junior doctors. - Divisional succession plans completed.	
4	We will deliver pioneering and efficient practice, putting ourselves at the leading edge of research, innovation and transformation.	Maximise the opportunity provided by our successful appointment as a National Digital Exemplar site to continue to deliver a programme to support the long-term vision of the Trust's Clinical Systems Strategy that every member of our staff will have access to the information they need, when they need it, without having to look for a piece of paper, wait to use a computer or ask the patient yet again.	Deployment of CSIP and GDE allocations.	GDE Milestones 1-3 met. • CSIP programme on track • issues re EDM & EPMA rollout	G	• Medway V14.8 major upgrade August • Vitalpack V2 • Weston IT Programme	DoF
			Establish effective cyber security arrangements.	Successful procurement of tools	G	• New tools fully implemented • Progress towards CareCert +	DoF
		Maintain our performance in initiating and delivering high quality clinical trials, demonstrated by remaining within the upper quartile of trusts within our league (as reported to Department of Health via NIHR)maintain our performance in initiating research) and remaining the top recruiting trust within the West of England Clinical Research Network and within the top 10% of Trusts nationally (published annually by NIHR).	To develop the close working relationship with West of England Clinical Research network at both a Governance and delivery level to maintain the position of the Network supported by us as the host and to continue to be the top recruiting organisation	On trajectory to meet organisational stretch recruitment target agreed with NIHR LCRM	G	Maintain trajectory	MD

Ref	Strategic Priorities	Corporate Objectives 2018/19	Goals for the Organisation (ideally these should be measurable goals)	Q1 Update	RAG	Q2 Milestones	Executive Owner
		Maintain NIHR grant applications at a level required to maintain Department of Health allocated Research Capability Funding within the upper quartile nationally (published annually by NIHR).	Work closely with all research partners to maintain allocated research capability funding in the upper quartile.	Levels of grant income maintained at previous levels. RCF allocations maintained in levels to place UH Bristol within the upper quartile nationally.	G	Support submission of ARC bid (replacement for CLAHRC) during Q2 in line with published deadlines.	MD
		Continue to develop our research capacity and capability building on 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.	Work with Bristol Health Partners in support of a potential proposal to become an Academic Health Science Centre.	Informal liaison with University partners pending national process.	G	Maintain informal liaison.	MD
			Genomics - to continue to build and develop the research to include and maximise the input from all partner organisations.	Successful recruitment with the fastest pattern of recruitment nationally. Clarification of funding sought during Q1 and the indication that the non-laboratory component will cease from March 2019.	A	Construct and begin to implement a closure plan for the non-laboratory component of the Genomics progect.	MD
		Deliver our Transforming Care Programme focussing on working smarter, eliminating waste and transforming the way in which we deliver quality care through service and workforce redesign and digital transformation	Priorities and associated objectives and actions established for 18/19 across the 6 pillars	• Priorities agreed for 2018/19 and communicated widely within the organisation • Clarity on monitoring and assurance processes agreed and implemented for all areas • Board report redesigned for Q1 (july 2018 board)	A	On-going review of Board reporting to ensure effective and engaging	DoS&T
			Establish Digital Transformation as a core programme within the Transforming Care Programme and build a quantitative and qualitative benefits realisation plan to underpin Global Digital Exemplar (GDE) deployment requirements	• GDE clinical and transformation leads group established • Transformation team capacity aligned with every GDE system deployment • Processes to identify and capture benefits from individual system deployment (CUR;e-observations etc) in place and monitored via Transformation Board and IMT Management Group	G	• Refine the statement of planned benefits with clear benefit measures for each system. • Further develop operational reporting as systems are rolled out. • Happy App feedback established at deployment and post-deployment stages as a measure of impact on staff	DoS&T
			Deliver evidence of transformation support enabling delivery of savings in trust wide productivity themes	• Clarity of Divisional reporting on productivity actions established alongside priorities for transformation team support • Third productivity workshop held, focussing on CUR to support improved patinet flow. • Held 2-day Rapid Process Improvement Workshop to re-design the Cataract pathway. Eleven projects are to be mobilised as a result	G	• Detailed planning for Real Time Outpatients pilots; Roll out of e-Triage and Single Referral Form Trust-wide. • In support of CUR, further work on IDS reporting, handling repatriations and daily reporting of delays in Diagnostics and Therapies. Roll out of CUR to Children's Hospital. • Progress the Cataracts improvement projects.	DoS&T
			Grow further continuous improvement capacity and capability through Quality Improvement programme training and project delivery via our QI Academy, alongside support for progressing good ideas from staff via our QI Hub.	• On track to achieve the activity targets (+300 staff trained through Bronze progrmme and 20projects supported through silver prgarmme in 2018/19). • Two of three sessions for the nurse preceptorship programme held • Hub activity remains constant. 17 submitted ideas are live at present. • The 2nd QI Forum held (10 July) with nearly 70 posters on display.	G	• Continue monthly open Bronze sessions and run Bronze for the new cohort of Foundation doctors. • Silver cohort 2 will graduate and cohort 3 will launch. • Develop a curriculum for QI Gold. • Commence planning for a QI network event to take place during Q3.	DoS&T
5	We will provide leadership to the networks we are part of, for the benefit of the region and people we serve	Lead and collaborate through the BNSSG *Healthier Together* partnership to make our services fit for the future .	Demonstrate alignment of our internal strategic programme with the processes, pathways and structures developing as part of Healthier Together	• Healthier Together high-level strategic objectives refined and launched at June conference. • Phase3 of Trust strategic review (Divisional planning) launched internally	A	• Healthier Together to refine key objectives and work programme for Acute Care Collaboration. • Stage 3 of Trust strategic review concludes. • Assurance about alignment will depend on progress but will be subject to specific review.	DoS&T
			Develop stronger provider to provider partnerships with primary and community care	• Workshop held March 2018 with GP Locality provider Boards and involving NBT deputy MD • Attendance sought at S Bristol Locality Board on monthly basis and meet & greet session help with Medical Division clinicians • S Gloucester Locality confimation of joint work to manage urgent care demand for children secured • OneCare relationship strengthened and agreement to use GP Team Net as means to improve Trust communications with practices	G	• Second workshop arranged mid August with Locality Provider Boards • Scope and action plans to be in place for test and learn specific schemes with South Bristol and South Gloucester • Particpation in system workshop to influence scope of community services procurement in 2020	DoS&T
		Continue to develop our partnerships with Weston Area Health Trust and North Bristol Trust to support our collective clinical and financial sustainability.	Progress our formal partnership and Board approved intention to pursue a merger by acquisition of Weston Area Health Trust through 2018/19	• Opportunity analysis completed with Weston Trust via the Partnership Management Board • Joint clinical service plans developed to support resilience of existing services locally at Weston General Hospital • Peer support secured targeted at priority areas for improvement and learning across both Trusts • Continued engagement with commissioer led Healthy Weston programme	A	• Identify clear milestones aligned with the Healthy Weston CCG led programme • Enhance communication into both Trusts regarding the focus and objectives of the PMB and support for clinical and non-clinical teams to work together where this could potentially secure improvement	DoS&T

Ref	Strategic Priorities	Corporate Objectives 2018/19	Goals for the Organisation (ideally these should be measurable goals)	Q1 Update	RAG	Q2 Milestones	Executive Owner
			Agree and deliver a collaborative programme of corporate and clinical service improvements with NBT	• Executive to Executive team met and agreed 4 priorities for joint working • Joint workshop held with clinical leaders to develop more regular interface forum • Joint programme Board in place to assess the future model of care for Bristol-delivered neonatology services to optimse qulaity of care and outcomes for mothers and babies	G	• Regular Executive to Executive team meeting to be held to track progress • Clinical leaders forum TOR developed	DoS&T
		Play an active part in the research and innovation landscape through our contribution to Bristol Health Partners, West of England Academic Health Science Network and Collaborative for Leadership and Applied Research and Care.	Fully engage with Bristol Health Partners agenda and governance and support achievement of Trust objectives through engagement with and securing support from, the west of England AHSN	• Continued hosting of BHP team and particpation in BHP Board and Executive with influence into 2018/19 BHP priorities • Priorities for funding and investment into Health Integration Teams (HITs) agreed with alsignment to Healthier Togather STP priorities • Link Executive Director now in place to maximise opportunities provided through the AHSN Innovation and Growth resources	G	• Continue to evaluate the HITs impact and the leverage of funding into the BNSSG system	DoS&T
		Effectively host the networks we are responsible for including the Operational Delivery Networks, the CLARHC and Clinical Research Network.	To continue to host the operational networks we are responsible for, to ensure efficient clinical support, to maximise research opportunities.				MD
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	Deliver agreed financial plan for 2018/19.	Achieve positive contract settlement with CCG and NHSE commissioners. Deliver Divisional Operating Plans.	• Q1 on Plan • SLAs signed	G	Q2 Plan delivery	DoF
				FOT confirmed e.g. delivery plan	G	Divisional delivery of recovery plans	
		Deliver minimum cash balance.	To remain solvent and avoid the need for external cash support.	Achieved by the delivery of the financai plan	G		DOF
		Deliver the annual Cost Improvement Plan (CIP) programme.	Develop and deliver robust CIP plans to secure £22.7m or 4.5% of operational budgets	Productivity plans completed and monitored., CIP on trajectory to deliver.	G	Divisional delivery of recovery plans	COO
		Implement an Executive led programme to eliminate waste and add value from • Out patients; • Length of stay; • Theatres; • Consultant productivity; and • Diagnostics.		Completed gap analysis for each workstream and opportunities outlined. Each Division now has a consolidated OGIM plan to deliver productivity opportunities. Cardiac CT and Ophthalmology RPIWs have taken place. Monitored Divisional Finance and Ops meetings, Savings Board and updates to Finance sub-committee.	G		COO and Exec Lead Directors for individual work streams
7	We will ensure we are soundly governed and are compliant with the requirements of our regulators	Recommit to and renew our Trust Strategy, setting the strategic direction for the Trust from 2019-2025, and ensure we integrate our clinical, teaching and research capabilities to maximise the benefit for the people we serve.	Secure Board approval to the Trust Strategy *Embracing Change, Proud to Care - Our 2025 Vision* by quarter four of the financial year.	• Completed strategic analysis, SWOT/PESTLE and case for change • Developed and delivered programme of engagement March-May 2018 including feedback and engagement event for c.85 senior Trust leaders 2/5 • Video developed and avaiable to staff on intranet to raise awreness and secure involvement • Board agreement secured to draft strategic priorities and objectives that set framework for Divisional and enabling strategies	G	• Divisional and enabling strategies to be developed by October • Continued communication and engagement process with wide range of stakeholders • Continued horizon scanning and adaptation (10 year NHS Plan)	DoS&T
			Ensure wide engagement of staff and stakeholders in the development of the strategy to secure ownership and delivery assurance				
		Ensure our communications function is resilient, equipped to support the Trust to achieve its ambitions, and supports the Trust to achieve its ambitions.	To have an appropriately resourced communications function in place with effective plans to support the Trust to achieve the goals set out in the refreshed strategy, against which the function's performance is assessed. Build our reputation as a regional centre for tertiary services, research and development and teaching. Promotes the "UH Bristol" brand whilst celebrating organisational and individual success. Effective media, public relations function supported by social media presence.	Out to advert to recruit a Band 7 to augment the team. Conducted a review of web publication. Allocated £50k for website and refresh.	R	Reprocure our web content providers. Development of a staff brief.	Deputy CEO

Ref	Strategic Priorities	Corporate Objectives 2018/19	Goals for the Organisation (ideally these should be measurable goals)	Q1 Update	RAG	Q2 Milestones	Executive Owner
		Implement General Data Protection Regulations.	Ensure compliance with the new Data Protection Regulations from 25 May 2018	New policy framework approved New Privacy Notice in place Communications plan completed including guides for managers and staff New Privacy Impact Assessment process agreed, piloted and implemented Updated approach to Subject Access Requests in place New Head of Information Governance appointed (role includes the Data Protection Officer role)	G	Schedule Internal Audit of compliance with GDPR Induction of Head of Information Governance	Deputy CEO
		Ensure all principles of good governance are embedded in practice and policy.	Positive outcome from the Well-led Framework assessment with high levels of self-awareness	Well-led assessment process started and procurement initiated for an external reviewer Self-assessment process started and all internal leads briefed	G	Board agreement of self-assessment ratings Procurement completed	Deputy CEO
		Achieve regulatory compliance against CQC fundamental standards.	To maintain CQC outstanding rating following next CQC inspection.	Provider Information Return (PIR) not received frm the CQC, however the Trust has begun preparation for receipt of the PIR by pre-populating any static data / information using a blank template. The self-assessment element of the PIR has been completed and agreed with Execs.	G	Continued focus on action plans for areas requiring improvement.	CN

Cover report to the PublicTrust Board. Meeting to be held on 27 July 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**	Friday, 27 July 2018
Report Title	**Equality and Diversity Annual Report**		
Author	Teresa Sullivan, Equality & Diversity Officer		
Executive Lead	Matt Joint, Director of People		
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 Annual Report forms part of the Trust's compliance with the Public Sector Equality Duty. It provides an update on progress against achievement of the Trust's Strategic Equality & Diversity Objectives for 2016-2019, highlights successes during the past year, progress in relation to regulatory requirements and the Trust's commitment to promoting a culture of inclusion for patients and staff through plans for the future.

Key issues to note

(Relating to each Strategic E&D Objective)

Objective: To improve access to services for our local communities

Some of the things we've done:

- *Patient Inclusion and Diversity Group*
- *Refreshed Equality Impact Assessment Guidance*
- *Estates Audit of Main Entrances*

Success stories and initiatives

- *Access to Services – focus on Division of Medicine*
- *Support for patients living with dementia*
- *Patient and Public Involvement*

Next steps

- *Patient Inclusion & Diversity Group programme of work*
- *Equality Impact Assessment audit*

Objective: To improve the opportunities for members of our diverse communities to gain employment with and progress within the Trust

Some of the things we've done:

- *Disability Confident Employer*
- *Recruitment – Local Events, Drop-in sessions for managers*
- *Apprenticeships*

Success stories and initiatives

- *Opportunities for Development – focus on Facilities*

Regulatory reporting measures – Workforce Race Equality Standard, Gender Pay Gap report

Next steps

- *Disability confident employer -*
- *Reverse mentoring*
- *ISE plans to include look at equal opportunities*
- *Culture Work Plan & gender pay gap*

Objective: To work towards a more inclusive and supportive working environment for all of our staff

Some of the things we've done:

- *Dignity at Work – policy, Dignity at Work week*

Success stories and initiatives

- *Divisional actions and activities*
- *LAWDII reasonable adjustments review*
- *Support for Staff : Spiritual & pastoral Care, Wellbeing initiatives, H&B Advisors, Freedom to Speak Up Guardian and Advocates*
- *Staff Forums annual update (BAMEW Forum, LGBT Forum, LAWDII)*

Staff Survey results – bullying & harassment

Next steps

- *Culture Work Plan re Dignity at Work*
- *Work Plan for reasonable adjustments*
- *Guide to support for staff – violence, abuse from patients*

Delivery of actions to support all of these Objectives is monitored by the Trust's Equality & Diversity Group and reported by exception to senior groups through this annual report and the Workforce Race Equality Standard (WRES) progress report.

Recommendations

Members are asked to:
Note the report. **(**For assurance of compliance with the Trust's regulatory duties under the Equality Act.)

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)**
		25th July 2018		Equality & Diversity Group – 06/06/2018 WF&OD Group 27/06/2018

University Hospitals Bristol
NHS Foundation Trust

Equality and Diversity Annual Report

2017 - 2018

INTRODUCTION

From birth to care of the elderly, University Hospitals Bristol NHS Foundation Trust provides care to the socially and ethnically diverse population of Bristol and the south west from the very beginning of life to its later stages, and specialist services to a wider population through the south west and beyond.

Each of our patients and members of staff is a unique individual with different needs and aspirations. The Trust aims to recognise and celebrate these differences by providing an environment which is inclusive for patients, carers, visitors and staff.

We are a diverse workforce, working together to serve a diverse community.

25% of our workforce are from black, Asian or other non-white British backgrounds

3% of our workforce tell us that they have a disability

2% of our workforce tell us that they are lesbian, gay or bisexual

77% of our workforce are female

42% of our workforce say that they belong to one of the major world faiths

The Trust is fully committed to adherence to the Equality Act 2010, and undertaking action under the Public Sector Equality Duties (PSED) as defined within the Act. More information about the Equality Act and measures to improve equality are included at Appendix A.

EQUALITY & DIVERSITY STRATEGIC OBJECTIVES 2016 - 2019

In 2016 the Trust's Board agreed three strategic objectives developed by the Equality & Diversity Group. They are designed to have a positive impact on the Trust's continuing commitment to improve both patient and staff experience:

To improve access to services for our local communities;

To improve the opportunities for members of our diverse communities to gain employment with and progress within the Trust;

To work towards a more inclusive and supportive working environment for all of our staff.

This Annual Report will show how we are working to make a positive difference for our patients and staff through these objectives. It will highlight some of our success stories and initiatives, tell you about our performance in regulatory areas, and say what we plan to do next, acknowledging that our aspiration to be an organisation that treats people differently - in the sense that there is something special about how we care for people, whether they are patients or members of staff – requires constant attention.

Actions to support delivery of the objectives are part of a plan which is reviewed and updated to respond to the experience of staff as reported in the National Staff Survey and the Workforce Race Equality Standard, and feedback from staff and patients through other channels. The most recent version of the plan is included at Appendix B.

To improve access to services for our local communities

We need to continue to examine whether the services we provide and access to those services meet the needs of the changing communities we serve. The first three items in this section show steps we are taking to scrutinise our response to those needs, and what we plan to do during the coming year.

Patient Inclusion and Diversity Group

We have established a Patient Inclusion and diversity Group (PIDG) which acts as the key group in relation to all equality and diversity issues affecting patients and service users. It works in partnership with the Trust Equality and Diversity Group and leads a patient facing equality and diversity group agenda concentrating on how the Trust can meet the needs of all our patients and families.

The key themes for PIDG in the coming year will include:

- Ongoing delivery of the requirements of the Accessible Information Standard
- Re-provision of interpreting services
- Responding to the needs of Deaf people who use our services
- Mapping and improving physical access to our hospitals
- Exploring the place of spiritual and pastoral care within our hospitals

In addition, members of the Group have worked with organisations representing the D/deaf[1] community to take a leading role in establishing the Bristol Deaf Health Partnership – the purpose of which is to provide a single forum enabling us to work together to understand and improve the experience of Deaf, hard of hearing and deaf blind people in our hospitals and across the health community in Bristol.

Refreshed Equality Impact Assessment Guidance

Making sure the Trust considers the needs of patients and staff from all protected groups as part of our decision-making process shows that we have an understanding of the effect of our activities and decisions on different people. Equality Impact Assessments (EIAs) are a way of

[1] Big D deaf people are those who are born deaf or experience hearing loss before spoken language is acquired and regard their deafness as part of their identity and culture rather than as a disability. They form the Deaf Community and are predominantly British Sign Language (BSL) users.
Small d deaf people are those who have become deafened or hard of hearing in later life, after they have acquired a spoken language and so identify themselves with the hearing community. Small d deaf people are more likely to use hearing aids and develop lipreading skills. *(ageUK)*

exploring the potential impact on patients, service users and staff of a policy, operational decision, strategy, service development or change, or consultation. In particular they look at the likely impact on service users and/or staff who have one or more characteristic protected by the Equality Act 2010.

In March of this year the Trust agreed refreshed Equality Impact (EIA) guidance and forms to make the process clearer and more straightforward. During October an audit of policies, strategies and processes agreed across the Trust during April to September *need* will be carried out to evaluate the effective use of Equality Impact Assessments.

Estates Audit of Main Entrances

In response to a question from the Board about access to Trust premises, an Entrance Audit Survey of the main entrances to the buildings on the Trust's central Bristol sites was carried out by the Estates Department in November 2017. This was to establish whether the main entrances to Trust buildings comply with the British Standard Code of Practice on the design of approaches to buildings to meet the needs of disabled people. The audit found that the Trust is compliant with many elements, and needs to remedy colour contrast between some doors and their frames, and ensure that plain glass doors include a broken line or logo or other suitable indication for blind or partially sighted people. The next step is to obtain costings to enable compliance in all areas.

Success stories and initiatives

We know that a huge amount of work which is difficult to measure goes on throughout the Trust to improve the experience of patients and service users. Here are just a few examples.

Access to Services – Division of Medicine

The Homelessness Support Team was introduced in early 2017 to help provide a specialist service to homeless patients, focussing on their post-discharge arrangements. Since then, the Team has received over five hundred referrals.

A series of mini access audits is being conducted in the Division of Medicine's inpatient and outpatient areas to assess basic physical access (including to staff areas), signage to clinics, clarity of information boards, provision of induction and counter loops and staff understanding of how and when to book interpreters.

New appointment cards have been designed for patients with Tuberculosis who have limited English. The usual outpatient procedure for booking follow-up appointments has also been adapted for these patients, with Divisional agreement that these can be booked beyond the 8 week cut off, so that patients with limited English can walk away from the clinic with their next appointment confirmed.

The Integrated Discharge Service (IDS) provides specialist support for patients needing post-discharge care through the integration of acute and community sectors (Bristol City Council, Bristol Community Health and UH Bristol). Analysis of the existing services identified a gap in some of the areas of support provided to patients who are not entitled to Social Care funding. So, in February 2018, the IDS piloted a discharge co-ordination service for self-funding patients requiring post-discharge care home placements or packages of care. The feedback from users has been so positive that the three-month pilot has been extended.

The Care Quality Commission National Accident and Emergency Survey 2016 Results for type 1 centres and patients aged 16+ put the Trust's Emergency Department in the top 10 of all English Trusts on measures of patient reported experience.

Five of our scores were the best of any trust score nationally. These were:

- Treating patients with respect and dignity
- Patients having confidence and trust in our doctors and nurses
- Doctors and nurses giving patients a clear explanation of the condition and treatment
- Our staff involving patients in decisions about their care and treatment
- Explaining the purpose of medications that patients take home with them

In terms of next steps, a more detailed analysis of the results will be carried out and areas for improvement will be identified with relevant actions developed to address these.

Support for patients living with dementia

The Trust uses a specific care plan to ensure that the care we provide for those living with dementia is tailored to suit their needs. It covers all aspects of care, from eating to communication and making sure the environment is dementia friendly.

A visual identification system - the Forget-Me-Not - is used in the hospital to make all staff aware that someone has a diagnosis of dementia, or has a current cognitive impairment.

The Trust's Dementia Champions are staff, of any grade or profession, who want to improve the experience, care, treatment and outcomes for people with dementia. Champions can be identified by a Forget-Me-Not pin on their lanyard or uniform and are always happy to help.

The Trust has piloted the use of an activity box with patients and iPads for reminiscence - connecting to apps for games, and YouTube for film and music clips - with the aim to roll these out across our hospitals after evaluation. And there has been some very positive feedback on knitted or crocheted muffs and blankets, sent in by staff and members of the public since May 2016. These 'Twiddles' provide a source of visual, tactile and sensory stimulation, while also keeping patients warm.

Patient and Public Involvement

A quarterly report incorporating Patient and Public Involvement activities is published on the Trust's website: What patients tell us about UH Bristol.

Next steps

As well as the programme of work identified by the Patient Inclusion & Diversity Group, the evaluation of the effective use of Equality impact Assessments will show how far we have come in improving access to services for our local communities.

Objective: To improve the opportunities for members of our diverse communities to gain employment with and progress within the Trust

Bristol is a diverse community and we mustn't miss out on the talent available on our doorstep. We said that we will focus on two areas in particular, one regarding local recruitment, encouraging people from all backgrounds to view the Trust as an employer of choice, and the other supporting equality of access to development for existing staff.

These are some of the key achievements of the past year:

Disability Confident Employer

The Trust has been re-accredited for a further two years as a Disability Confident Employer as part of the government's disability confident scheme. This means that we have committed to ensuring that disabled people and those with long term health conditions have the opportunities to fulfil their potential and realise their aspirations.

As part of this commitment:

- Our recruitment process is free of discrimination with anonymised shortlisting and open assistance for candidates requiring any form of adaptation or support.
- We offer a guaranteed interview scheme fully supported and included in all recruitment training. Information about this is also included in the Recruitment policy with active prompts to managers.
- Candidates are prompted at the interview invite stage to flag any reasonable adjustments they might need. The recruitment team have regular training on this support.
- We have a very active relationship with Jobentreplus and Bristol City Council to actively support the long-term unemployed with a variety of challenges into the work place.
- The Trust has signed the Time to Change Employer Pledge and is developing a mental wellbeing action plan which will be aligned to a 3-year Workplace Wellbeing Strategy. Wellbeing services and interventions are designed to be inclusive and accessible.
- The Trust has a full time work experience coordinator who actively works with the local schools, and a work experience policy

Local Recruitment Events

Members of the Resourcing team regularly attend local recruitment events and careers fairs. During the past year these have included events in conjunction with Jobcentreplus and Bristol City Council in areas of the city which have supported targeted recruitment of black, Asian and minority ethnic staff.

Recruitment Drop-in Sessions

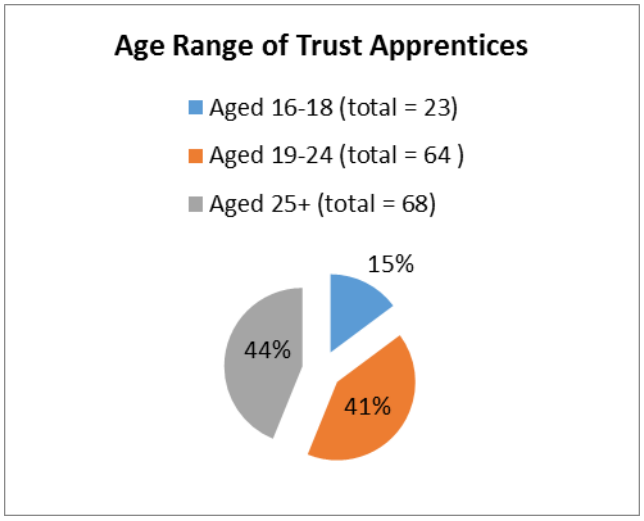
The Resourcing team held drop-in sessions during NHS Equality, Diversity and Human Rights week in May. The sessions were designed to give managers a clearer understanding of the service provided by the Resourcing Team and how reasonable adjustments can be made in line with being a Disability Confident Employer. Managers were able to meet key members of the team and ask questions about the process.

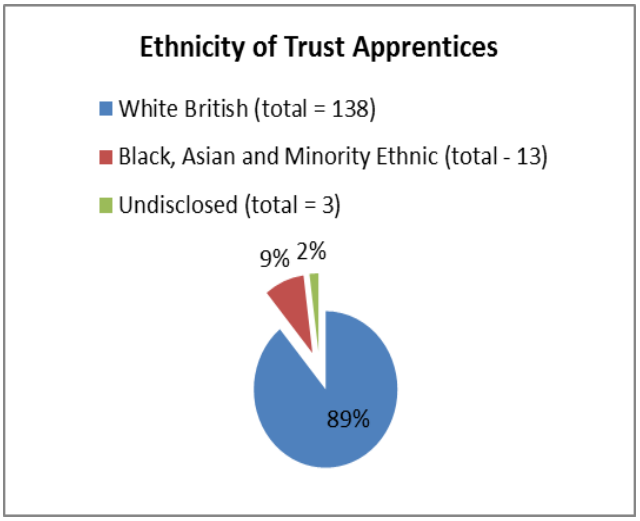
Apprenticeships

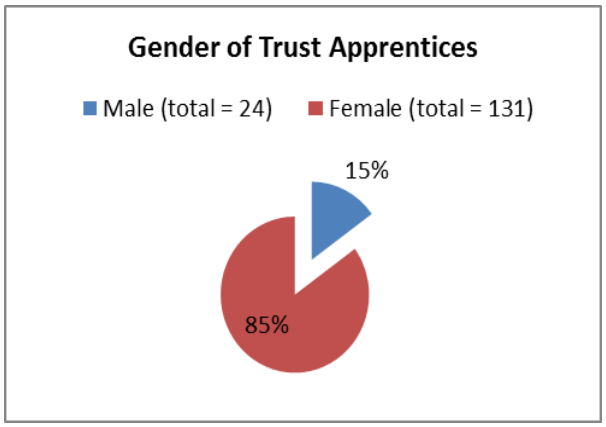
The Trust is an official main provider of apprenticeships and offers a wide range of career opportunities in clinical and support services. These work-based training programmes are available to anyone aged 16 to retirement age who is looking for a new opportunity to train, develop and further their career. They allow people to gain professional skills, knowledge and UK-recognised accreditations while in a paid job.

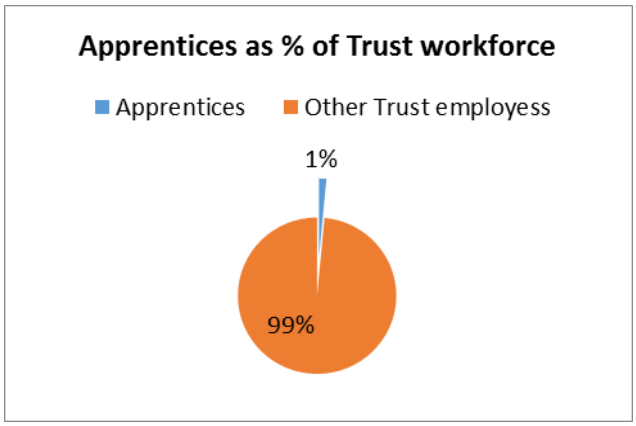
UH Bristol supports life-long learning and apprenticeships are also available for existing staff who want to develop new skills or to have the skills they have developed in their role acknowledged as they look for career recognition and progression.

The Trust employed their first apprentice under the new apprenticeship levy scheme in July 2017. As at April 2018 155 new apprentices have started on their new career pathways through a variety of apprenticeship programmes. These are being delivered either in-house or using specially selected external training providers. As part of the Talent for Care and Widening Participation Policy the following demographic data was compiled in March 2018 on all our new start apprentices. Information about disabilities has not been included as none have been disclosed.









The apprenticeships offered across the Trust provide ideal opportunities for career development and staff retention. It is essential that people from all staff groups are aware of and have access to these opportunities. Working with the Apprenticeship Team and the Head of Education to make sure that this is extended to all staff is a priority for the forthcoming year. Alongside this, the Trust will work with Weston College to enable any members of staff who wish to take advantage of the numeracy and literacy skills training being offered in the Trust to do so.

Success stories and initiatives

Opportunities for Development

Our Hotel Services and other Facilities teams are among the most diverse of our workforce. Without the cleaners, porters and catering staff our hospitals would not be able to function, so this section focuses on them.

A new Hotel Services Assistant had support from her line manager and a MENCAP support worker to achieve the competencies needed for her role. Talking to everyone involved on the medical ward where she works and agreeing on a reasonable adjustment to daily duties has meant that the new member of staff has flourished and become an integral part of the service. This team member continues to acquire a wide range of professional experience and the Trust has gained a dedicated and highly motivated professional, who is proving to be very helpful with her colleagues, patients and visitors.

In partnership with N-Gaged and the Restore Trust, the Division of Estates & Facilities has run two Sector Based Work Academies in the form of a two-week course, where individuals can obtain two qualifications - Customer Services and Introduction to Facilities & Cleaning. Participants also obtain a Level 2 Food Hygiene certificate. The course is aimed at the long-term unemployed, in lower socio-economic areas, and has a particular remit to support those who have spent criminal convictions. As a result of two successful courses, thirteen people have been offered employment. The course is funded by the European Social Fund, whose primary focus is to support our community in obtaining employment and a better life in general, and more courses are planned in the near future.

Estates & Facilities are also working closely with the Learning & Development Team to offer a number of new apprenticeships. These will give staff the opportunity to develop under a managed educational scheme, whilst attaining ‘on the job’ experience and gaining a qualification which will increase their potential for future roles. In an area where traditionally the proportion of male employees is very high, the Estates Department has recruited a female Mechanical Apprentice and a female Decontamination Engineer.

To make sure that all employment and development opportunities reach the widest audience of staff from these groups who work across all sites of the Trust, details are circulated by the Divisional Recruitment Manager so that managers and team leaders can print and display them on staff notice boards.

Regulatory reporting measures

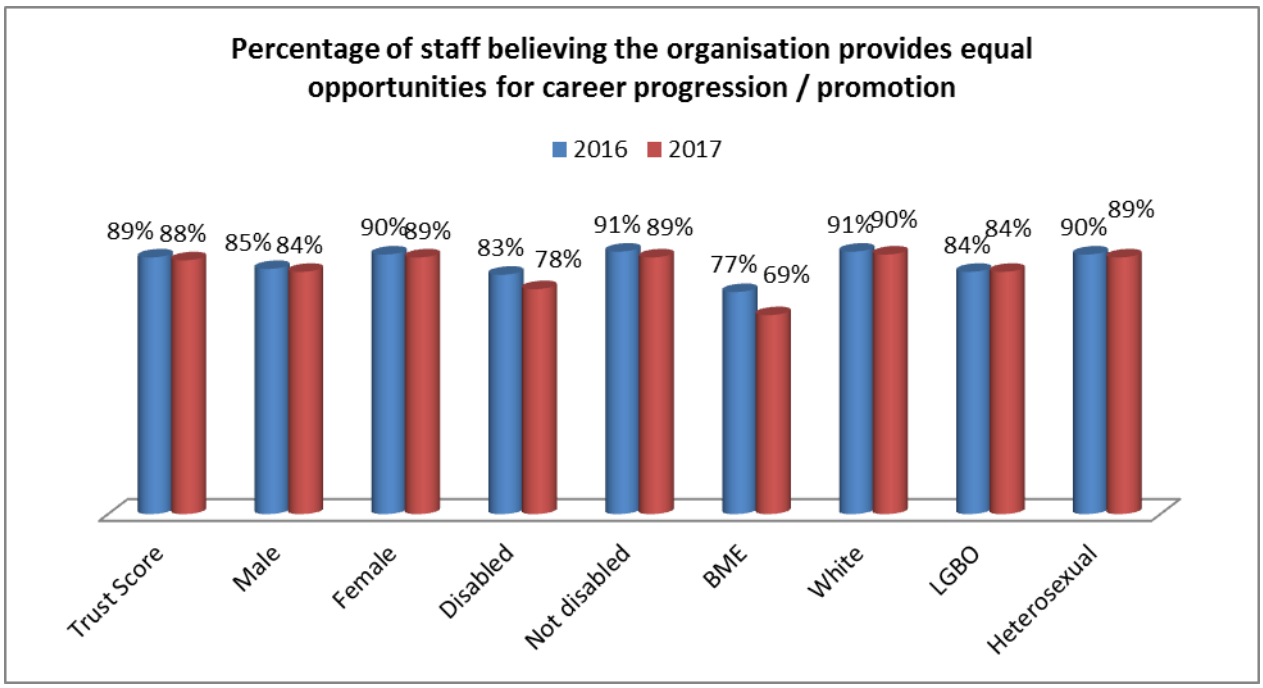
The Workforce Race Equality Standard reporting provides two measures of progress for black, Asian and minority ethnic (BAME) staff in the area of recruitment and progression within the Trust.

The first is the relative likelihood of BAME staff being appointed from shortlisting compared to that of white staff being appointed from shortlisting across all posts.

The Trust data for 2017 showed that white staff were 1.9 times more likely to be appointed from shortlisting than BAME staff, compared with 1.54 times more likely in 2016. This is a disappointing decrease but it should be noted that, for system reasons, the 2017 data did not include medical & dental appointments. (In March 2018, medical & dental staff made up 13.76% of the workforce.) The data for this year will include medical & dental appointments.

Whilst some recruiting managers are receiving training to raise awareness of unconscious bias in the recruitment process, more work needs to be done in this area.

The second measure is taken from responses to the National Staff Survey, which represent what staff say about their experience of working for the Trust. Whilst 88% of Trust staff who responded to the survey believed that the organisation acts fairly with regard to career progression/promotion (regardless of ethnic background, gender, religion, sexual orientation, disability or age), only 69% of BAME staff who responded agreed.



(National Staff Survey 2017 – responses to Question 16.
(Note: Transgender is not given as an option for identifying in the staff survey returns, hence LGBO (Lesbian, Gay, Bisexual, Other), and BME is used instead of BAME.)

Although the Trust score is still in the top 20% of acute trusts, following three years of improving responses to this question (from 62.8% in 2014 to 77.49% in 2016) from BAME staff, this year's results are very disappointing and indicate that there is an increased perception that there are barriers to progression for BME staff and disabled staff within the Trust.

Gender Pay Gap Reporting

Along with other public sector organisations, the Trust published its first Gender Pay Gap Report in March 2018.

The gender pay gap is different to equal pay and is a measure of the difference between the average earnings of men and women, expressed as a percentage of men's earnings. For all non-medical and dental staff except very senior managers, the Trust uses Agenda for Change terms and conditions of employment, job evaluation and levels of pay which have been legally recognised to abide by the principles of equal pay for work of equal value. Job evaluation evaluates the job and not the post holder. It makes no reference to gender or any other personal characteristics of existing or potential job holders.

Analysis of the Gender Pay Gap Report to understand any action required will take place during the next year.

Next steps

To make sure that we continue to improve the opportunities for members of our diverse communities to gain employment with and progress within the Trust, we will be working on the following:

A review of our actions and plans as a Disability Confident Employer to ensure that the Trust is taking all necessary steps to provide appropriate support to potential and existing employees with a disability.

A Reverse Mentoring scheme involving staff from black, Asian and minority ethnic backgrounds and senior managers. This will act as a development tool for BAME staff, increase the cultural competence and understanding of senior managers, and help to improve recruitment and retention levels of BAME staff across the Trust. The programme is being developed in partnership with Bristol City Council and will be introduced in autumn 2018.

Divisional action, through Improving Staff Experience Plans, to find out why staff from some protected groups believe that the organisation does not provide equal opportunities for career progression or promotion, and what will be done to remedy this.

Analysis of the Gender Pay Gap Report to understand any action required, as identified as part of the Culture Work Plan for the forthcoming year.

Objective: To work towards a more inclusive and supportive working environment for all of our staff.

Our Board said that they wanted to see an emphasis on providing an environment free from harassment, bullying or abuse from colleagues or service users. Key to this is promoting a culture of dignity and respect so, in partnership with Staff Side and colleagues from the Employee Services Team, the Trust's Tackling Harassment & Bullying at Work Policy was revised and re-launched in September 2017 as the **Dignity at Work Policy (incorporating bullying & harassment at work)**. Presentations to introduce the revised policy were delivered to more than 220 leaders and team members.

By placing an emphasis on the positive, Values-based behaviours we expect from all colleagues it is anticipated that use of the policy will promote the culture of respect and inclusion which contributes to improved staff experience. This is supported by the Leadership Behaviours and other Organisational Development interventions within the Trust's Improving Staff Experience plans.

To support and publicise the introduction of the policy, and to promote the sources of support available to staff who may wish to raise a concern, a series of events took place to co-incide with national anti-bullying week.

The theme chosen by the Anti-bullying Alliance for 2017 was All Different, All Equal. The Trust adopted this theme and combined it with the title of the Policy to celebrate our differences and ask what Dignity at Work means to our staff.

Success stories and initiatives

The Dignity at Work roadshows in November 2017, which visited as many of the Trust's sites as possible, were followed in April 2018 by You Said We Did Together – a series of pop-up events which picked up on some of the themes from Dignity at Work Week and the National Staff Survey Results.

The Division of Specialised Services held a Health & Wellbeing Day, and the Dental Hospital has invited staff to celebrate positive behaviours and opportunities during a month of events under the badge of PositiviTeeth.

In response to the 2017 Staff Survey results, the Division of Specialised Services has identified the need to develop and introduce some staff workshops to focus on supporting managers to deal with complaints of bullying and harassment. This project will also involve working with colleagues in Human Resources to offer more support and guidance around resilience building and managing behaviours associated with stress.

To make sure that all staff have access to the Trust's Equality, Diversity & Human Rights training package, a face-to-face version is available to teams and individuals. Between October 2017 and the end of May 2018, face-to-face sessions were delivered to 417 members of staff. As Equality, Diversity & Human Rights is one of the eleven Core Skills mandated in the UK Core Skills Training framework, this has helped the Trust to achieve a 90% compliance rate.

The Divisional representatives on the Trust's Equality & Diversity Group routinely distribute information about local and national diversity and inclusion activities. Some areas cascade updates via email, and the Facilities teams have developed a monthly briefing document. This is to try to ensure that all of their staff – the majority of whom are not desk-based – receive information about current issues and initiatives.

The Division of Medicine has adopted a new flexible working process to ensure consistency across the board with a panel meeting monthly to discuss any new requests or amendments to existing ones.

Staff champions meetings are held every six weeks for Facilities staff. Nominated staff representatives from all staff groups are invited to attend and bring with them any operational issues and ideas for improvement. If any advice or assistance is needed to achieve the desired outcomes, senior managers and Human Resources are available to help. All actions on the action log are followed through to conclusion. As a result, a "You Said – We Did" document can be presented back to staff, demonstrating that their issues and ideas are listened to, discussed, and addressed or realised where at all possible.

The Chair and other members of the Living & Working with Disability, Illness or Impairment (LAWDII) Staff Forum carried out a review of the provision of reasonable adjustments for staff. They found that there are some areas of very good practice, and others where more awareness, guidance and support is needed. Their review includes several recommendations – including a team who can be contacted for advice - which will be developed over the next few months.

Support for Staff

During the past year and as part of conversations about Dignity at Work, the message that there are individuals and groups who can provide support to staff has been reinforced. This section gives an idea of the vital role they perform.

Spiritual and Pastoral Care (Chaplaincy)

It is a commonly held perception that chaplains are only available to support patients and in particular those with strong religious views or those who are close to death. Whilst this forms part of the work of chaplains, their remit is much broader and importantly, they play a key support role for members of staff too.

The Spiritual and Pastoral Care Department is made up of chaplains and chaplaincy volunteers from a range of faith groups who work to support the Trust in meeting the spiritual, religious and pastoral needs of its patients, visitors and staff.

The Chaplaincy Team is producing a leaflet to highlight how chaplains support staff in the workplace, and is keen to promote the support they can provide, including:

Spiritual and pastoral support for staff
Facing challenges in the workplace
Religious information, support and advice for staff
Sanctuary, Quiet and Reflective Spaces
Bereavement support for staff

Confidential Harassment and Bullying Advisors Service

Harassment & Bullying Advisors play a vital role in supporting colleagues who may be experiencing harassment, bullying or other unacceptable behaviour at work.

The Advisory Service offers colleagues the opportunity to discuss, in confidence, any concerns about bullying or harassment at work and provides support and objective advice on the options available to reach a resolution.

During the past year the advisors – who are all volunteers – have continued to provide this vital service and have embraced the changes in emphasis and process in the new Dignity at Work Policy.

Workplace Health & Wellbeing

Time to Change Employer Pledge

Time to Change is a growing movement of employers across all sectors who are demonstrating their commitment to changing how we think and act about mental health in the workplace. With one in four employees affected by anxiety, depression, and stress every year, mental ill health is the leading cause of sickness absence in the UK. The Trust signed the Time to Change Employer Pledge on Time to Talk Day in February 2018 to demonstrate its commitment to make sure colleagues who face mental health issues feel supported. To promote a culture of openness, the Trust provides a range of initiatives to promote workplace wellbeing to staff, students and volunteers.

Workplace Mental Wellbeing Lead

The Trust is committed to challenging mental health stigma. Staff, students and volunteers have access to reliable information, guidance, training and resources which promote positive workplace wellbeing and the Trust is seeking to extend its provision of psychological wellbeing services for individual colleagues and managers through the introduction of the new post of Workplace Mental Wellbeing Lead. The aim of the role will be to provide an accessible advisory and triage service to colleagues and act as the key point of contact and expertise to individuals, managers and senior leads employed at the Trust, to provide timely, reliable information and informed advice across the full spectrum of workplace issues experienced.

Freedom to Speak Up Guardian and Advocates

The Trust has fully implemented the national requirements as recommended by Sir Robert Francis in his Freedom to Speak Up review. The Trust has appointed the Trust Secretary as the Freedom to Speak Up Guardian, and has approved a Freedom to Speak Up Policy which provides a framework of support for members of staff who wish to raise concerns. The Guardian is supported by a number of Freedom to Speak Up Advocates who operate across the Trust and are accessible to all staff. The Trust is compliant with the requirements as set out by the National Freedom to Speak Up Guardian and ensure that all training and quarterly returns are achieved.

An annual report on issues and learning from the Freedom to Speak Up process is presented to the Board by the Guardian. In summary for 2017/18 there were 13 referrals to the Freedom to Speak Up Guardian, all of which were investigated and responses provided to the individual's raising the concerns. Where possible learning to ensure issues were not repeated were identified and shared. The issues raised related to a range of concerns which included attitude and behaviour of staff, staffing issues, and application of Trust policy.

Further actions are planned during 2018/19 to ensure that a positive speaking up culture is maintained and developed. The Trust has worked with its charity, Above and Beyond, to produce and circulate publicity materials to promote the Freedom to Speak Up Guardian and Advocate roles and the key messages about Speaking Up. There is enhanced information in the Trust induction for all staff, and the Trust is planning to increase the number of Advocates who are locally accessible to staff. The Guardian is also ensuring that he is visible across the Trust by attending key meetings and talking to staff groups to promote the messages.

STAFF FORUMS

The Trust supports and commends the work of the Staff Forums, actively encourages staff to join and has developed guidance to set out clearly the arrangements for paid release time for duties associated with membership of one of the Trust Staff Forums.

The Trust currently has three Staff Forums which, among other activities, provide peer support to colleagues. The Lead for each Forum is a member of the Trust's Equality & Diversity Group, and they have provided the following updates.

Lesbian, Gay, Bisexual & Transgender (LGBT) Forum 2017-18

The forum is for Lesbian, Gay, Bisexual and Transgender members of Trust staff and supporters within UHBristol. We are a safe space for staff to discuss issues and assist in advising HR on staff policy relating to LGBT issues within the organisation.

We have been working on improving membership numbers and interactions with other forums. We have taken part in activities for LGBT History month with members attending Bristol LGBT History month activities. We also took part activities around the Trust Inclusion and Diversity week as well as meetings and social events.
Over the next year we aim to form closer links with our local NHS partners LGBT forums as well as continuing the work with LAWDI and BAME forums to increase participation across the board.

Black, Asian & Minority Ethnic Workers (BAMEW) Forum 2017 -2018

The BAME (Black & Minority Ethnic) Workers Forum is open to all workers at UH Bristol from Black, Asian and minority ethnic groups, including staff from other European countries and further afield.

The Forum is a network of UH Bristol staff from different staff groups across the Trust which meets to discuss issues in the workplace that affect the working lives of black and minority

ethnic workers. It also works with other groups and individuals to develop best practice within and outside the Trust.

Our objectives for 2017-2018 were as follows:-

- Develop strategies to encourage BAME staff to become more actively involved in forum meetings.
- Re-design and re-launch of the BAME Forum, promoted through leaflets and posters for distribution to BAME staff via the all staff electronic newsletter, staff noticeboards and available at corporate induction; and refresh the BAME page(s) on the Trust staff intranet.
- Development and promotion of three BAME forum meetings, bi-monthly core group meetings and an annual general meeting
- Revisit the Reverse mentoring scheme.
- Revisit Black History Month

We achieved most of our objectives apart from the Reverse mentoring scheme which is scheduled for later in 2018. We have submitted regular reports to Equality and Diversity Group to update them on our progress. The forum has had some good success with the following:

- Working with the Equality & Diversity Officer on a number of cross staff group events
- Supporting the Equality & Diversity Officer in developing a leaflet for all staff group forums.
- Finding ways of raising awareness of BAME staff Forum
- Establishing an assurance that BAME staff are entitled to protected time to attend forum events.
- Establishing our first draft Terms of Reference
- Creating an internal database in order build up our contacts of BAME staff within the Trust

In conclusion, it has been a good year: attendance has improved, interest has increased, and we are very proud of those who have made positive contributions to our success so far. Finally we still have a long way to go but we are encouraged with what has been achieved so far.

Living & Working with Disability, Illness or Impairment (LAWDII) 2017 – 2018

The Trust LAWDII Forum (Living and Working with Disability, Illness or Impairment - formerly the Staff Disability Forum), enables staff and volunteers with physical, sensory or mental impairments to raise awareness of any issues they may have encountered at work.

LAWDII is a group of UH Bristol staff with visible and non-visible disabilities and impairments from various multi-disciplinary backgrounds across the whole of the Trust. We are of different gender, ethnicity, religion/faith, age and sexual orientation.

The Forum acts as a network for sharing best practice and the empowerment of staff members, supporting non-disabled staff and managers by raising awareness of issues relating to disability, illness and injury, and ensuring that the Trust benefits from its disabled employees - using members' experiences to inform policy and practice as a result. We act as a consultative group for improved accessibility and as a resource for staff and managers in the field of 'Reasonable Adjustments'.

We are an open group with a democratic structure and a focus on engaging with and listening to staff and managers, and we are supported by the Trust - with interest and active support coming from the Trust Chairman and Director of People. This ensures links to the Trust board and Council of Governors.

We are great believers in 'One size doesn't fit all!' and to this end have championed chair safety (particularly for staff who need specially adapted chairs), Dyslexia, and Mental Health awareness and support so far this year. We will be building on our successes next year by

providing support for implementation of the Workforce Disability Equality Standard in the Trust, and continuing to promote support available for reasonable adjustments.

We know that staff can play a key part in problem solving and resolving concerns around any forms of discrimination, including physical access problems, barriers to communication and any lack of consideration or understanding from colleagues. Staff are often the best resource to resolve issues - LAWDII is making full use of this resource!

Staff Survey Results

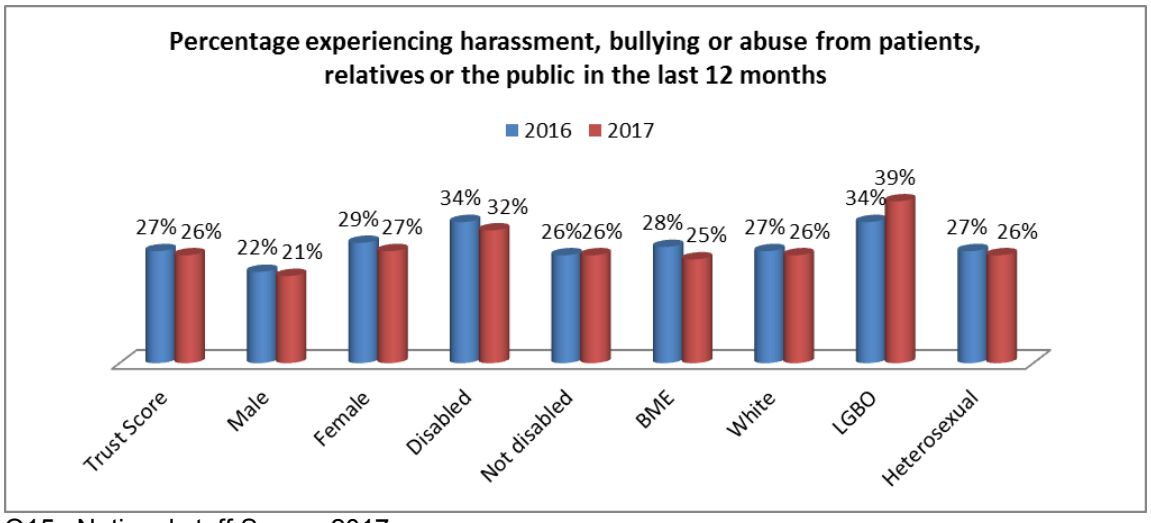
All of the initiatives described above show ways in which we are trying to provide a more inclusive and supportive working environment for all of our staff. We can measure what staff tell us about their experiences through their responses to the National Staff Survey.

Each year, NHS organisations are given the opportunity to ask all of their staff about what it's like to work for that organisation. The results of the annual National Staff Survey are regarded as a good indicator of overall staff experience and also provide an insight into the experience of staff from some of the protected groups.

The 2017 National Staff Survey questionnaires were sent to all substantively employed staff across University Hospitals Bristol NHS Foundation Trust and 3,752 staff completed and returned the survey – a response rate of 44%.

Because the results of the Staff Survey are used as an important measure of staff experience, it is helpful to know how the demographic make-up of staff who responded to the Staff Survey compares to the make-up of the workforce as a whole. You can find this information at Appendix G.

We said that providing a working environment free from harassment, bullying or abuse from colleagues or service users is a key measure of whether we are achieving this objective. The graphs below show the responses to questions in the National Staff Survey. (For example, 27% of female staff who responded to the Staff Survey said they had experienced harassment, bullying or abuse from patients, relatives or the public in the last 12 months.)

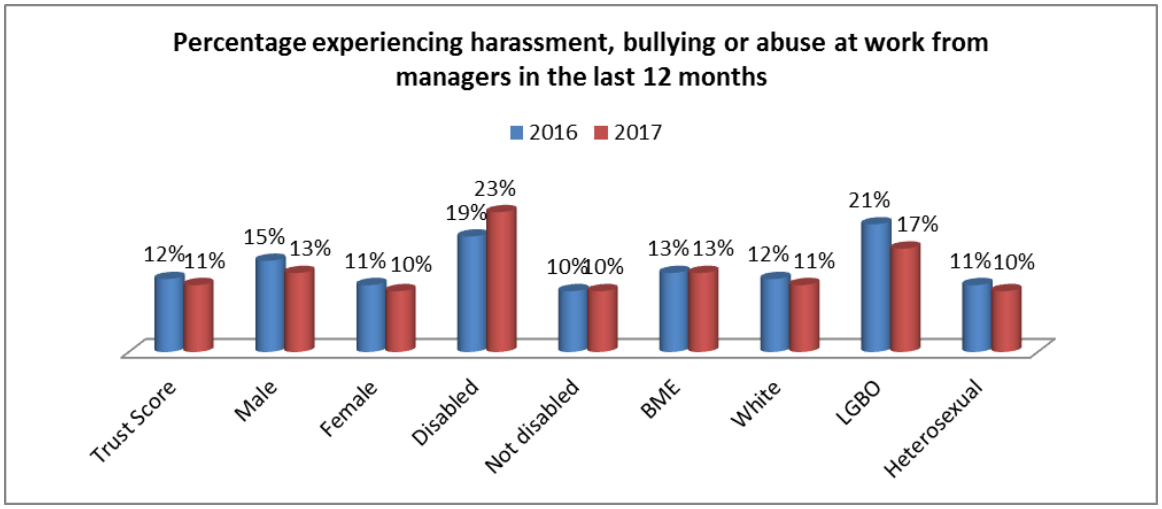


Q15a National staff Survey 2017

The Trust's incident reporting system also shows that some of our front-line staff are subject to verbal and, sometimes, physical abuse from patients, their relatives or other visitors. Whilst it is often not reported on the system whether the abuse is directed at a member of staff

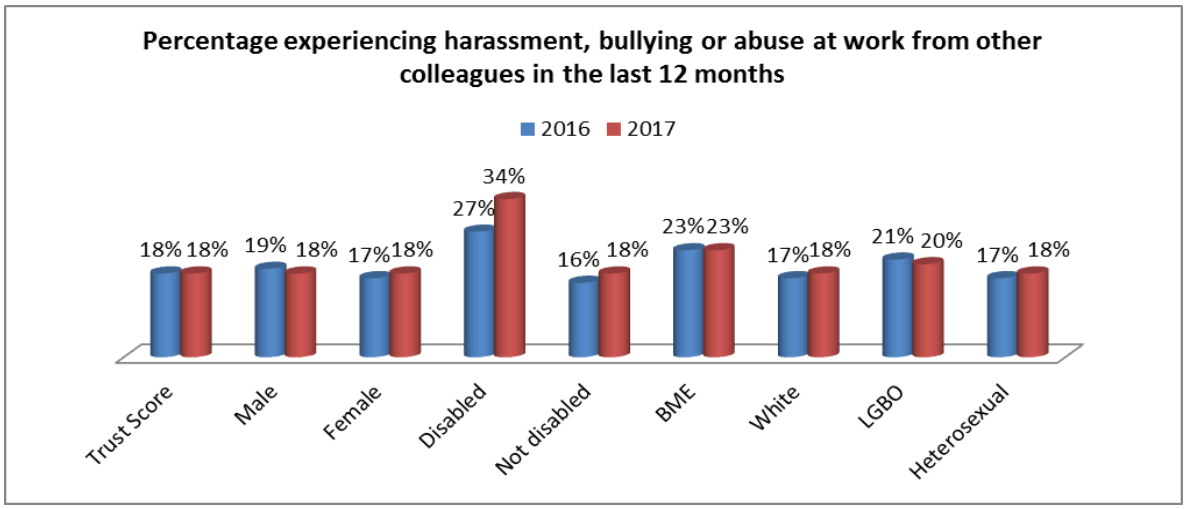
because of a protected characteristic, the number of incidents and the responses to the question in the Staff Survey show that levels are unacceptably high.

In response to an increase in the number and severity of violent and aggressive incidents towards staff, both verbal and physical, an Emergency Department violence and aggression group has been established. The purpose of the group is to offer local monitoring with appropriate and responsive action-planning to optimise the controls in place within the Emergency Department to minimise the number of incidents occurring, increase protection of our staff and offer support to those who have been affected by such incidents.



Q15b National Staff Survey 2017

(The 23% of disabled staff who said they experienced harassment, bullying or abuse at work from managers equates to 26 staff who responded to the National Staff Survey and said they have a disability or long-term impairment.)



Q15c National Staff Survey

(The 23% of BME staff who said they experienced harassment, bullying or abuse at work from other colleagues equates to 97 BME staff who responded to the National Staff Survey.)

We are continuing to promote the ethos behind Dignity at Work to staff and to leaders at all levels, either through ad hoc training and other events like the Wellbeing Day in the BHI and the Dental Hospital's Positiviteeth month, or through our Leadership for Leaders training programmes.

Next steps

To continue to work towards a more inclusive and supportive working environment for all of our staff, these are some of the steps which will be taken:

The Culture Work Plan for the forthcoming year will include work with staff side colleagues to build confidence to challenge unacceptable behaviour using the Trust Values, Leadership Behaviours and the Dignity at Work Policy.

The LAWDII review of provision of reasonable adjustments for all staff will be developed into a work plan.

A simple guide in the form of a poster for use Trust-wide will be developed, laying out the steps for staff to follow if they have been subject to verbal or physical abuse and showing what support is available

Workforce Race Equality Standard (WRES)

There are nine WRES indicators which are used to highlight any differences between the experiences of white staff and black & minority ethnic (BME) staff in the NHS. Four of the indicators focus on workforce data, four are based on data from the national NHS Staff Survey questions, and one indicator focuses upon BME representation on Boards.
NHS organisations are required to submit and publish their data in August of each year, together with their action plans outlining the practical approach needed to continuously improve their respective organisation with regard to workforce race equality.

The Trust's Workforce Race Equality Standard reports and action plans are published on the UH Bristol website: Equality & Diversity - Measures to improve equality

Workforce Race Equality Standard (WRES) – 2018 Report

The data for this year's report against the nine metrics which are indicators of workforce race equality is due for submission to NHS England between 2nd July and 10th August. It will inform the Trust's WRES report and action plan for publication in September 2018.

The information already available shows little change in the make-up of the Trust's workforce. The experience of BME staff as measured by the Staff Survey results which are included in the WRES has not shown the improvement we would wish this year, so we are more than ever aware that there is still much to be done to ensure an equally positive experience for all.

PLANS FOR THE FUTURE

Equality, Diversity & Human Rights are about people, so we must be responsive to their changing needs. This means that some of the actions we thought were the best way to deliver our Strategic Objectives when they were agreed in 2016 have been succeeded and superceded by others better suited to their achievement. Our plans evolve in response to suggestions from the people we work with about what would contribute to a more inclusive and supportive working environment, or improve access to services for our local communities.

So, whilst the detailed update to our corporate action plan is a work in progress at the time of writing, we are clear that the next year will see:

- Ongoing delivery of the requirements of the Accessible Information Standard
- Re-provision of interpreting services
- Responding to the needs of d/Deaf people who use our services
- Mapping and improving physical access to our hospitals
- Exploring the place of spiritual and pastoral care within our hospitals
- Re-introduction of a Reverse Mentoring scheme involving staff from BME backgrounds and senior managers
- Introduction of UH Bristol Staff Listening & Advice Bureaux
- Establishment of a 'one stop shop' for information about reasonable adjustments for staff and applicants with a disability
- Continuing promotion of Dignity at Work, including a week of activities in November 2018

The Workforce Disability Equality Standard, which was likely to be mandated for reporting in 2018, will now be reported on in 2019. Members of Trust staff, including the lead for the Living & Working with Disability, Illness or Impairment Staff Forum, took part in an NHS England consultation event in March 2018, and we look forward to the extra focus this reporting will bring to the work experience of disabled colleagues.

CONCLUSION

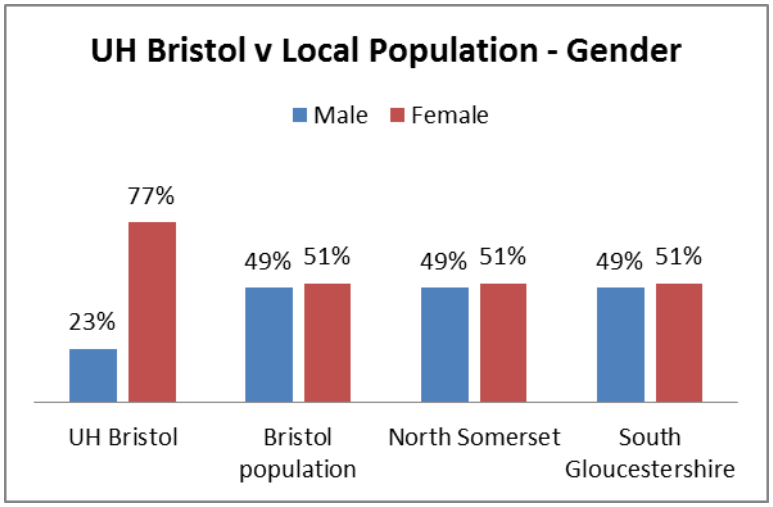
The introduction of the Patient Inclusion and Diversity Group is pivotal in enabling us to deliver on our objective of improving access to services for our local communities, and its workplan for the forthcoming year will allow the Trust to make significant progress in this area.

The activities during Dignity at Work (anti-bullying) week, and the face-to-face Equality, Diversity & Human Rights training provided opportunities for real engagement with staff. Whilst we might not like all that we hear, we are listening, and what our staff have told us about their experience of working for the Trust will continue to inform our plans to improve staff experience.

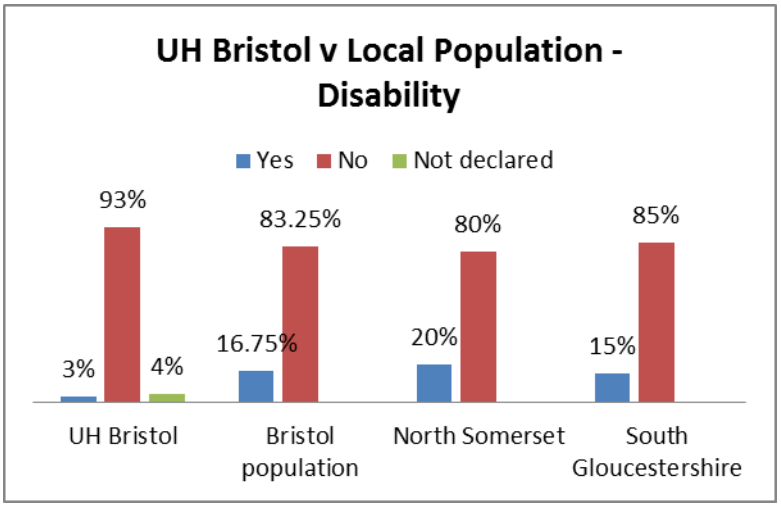
Local Population, Workforce, and Patients – a snapshot

Local Population

Sex: 77% of UH Bristol staff are female, compared with 51% of the local population (but note that it is usual for NHS organisations to have a higher proportion of female staff)

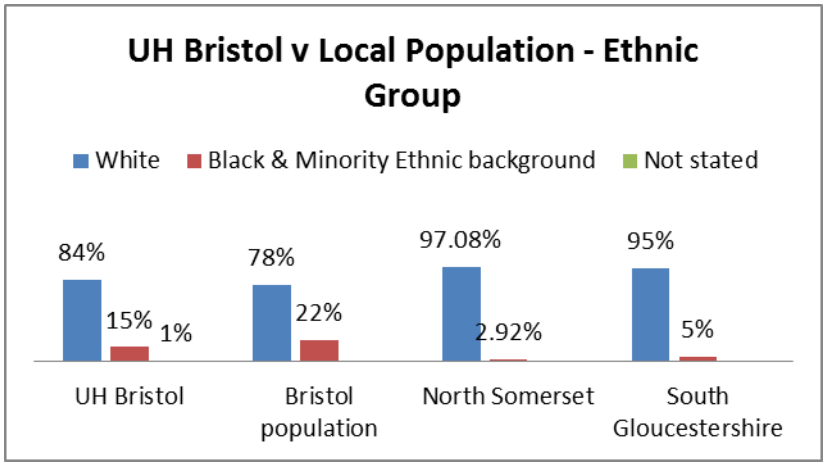


Disability: 3% of UH Bristol staff compared with 15 – 20% of local population

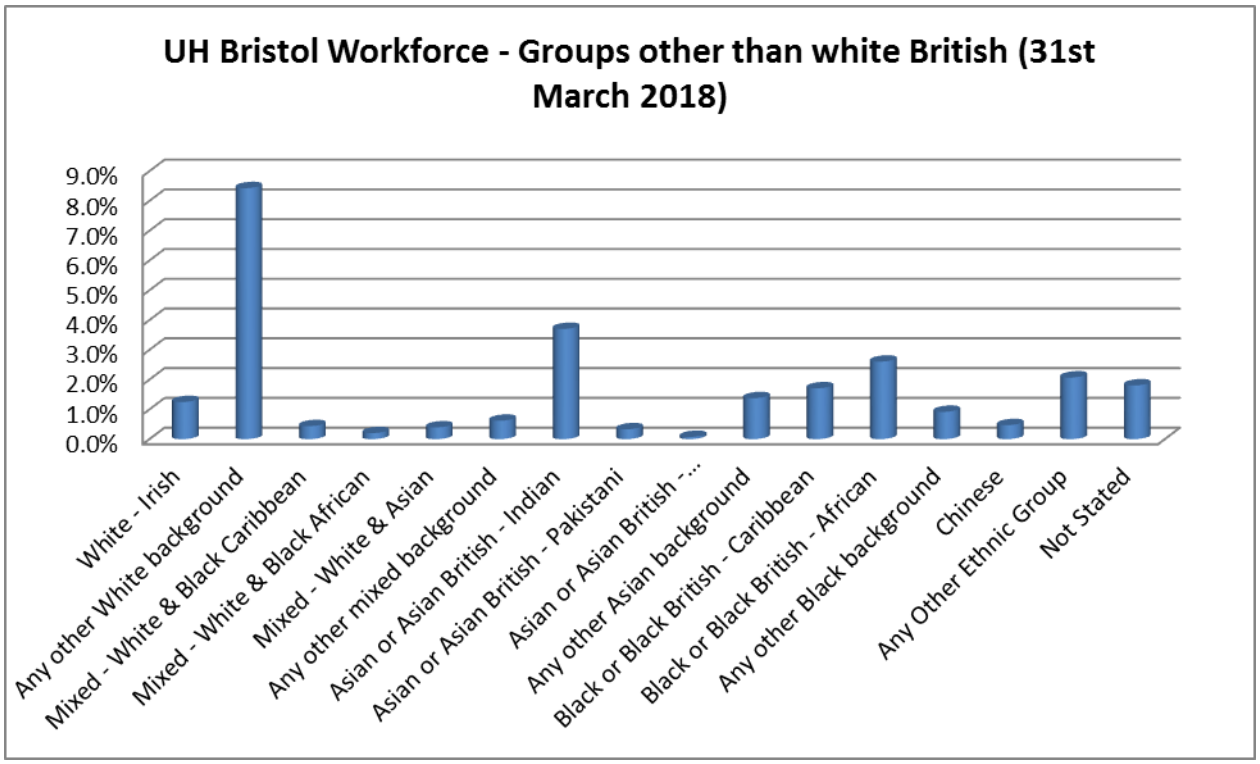


Race: 15% of UH Bristol staff are from a BME background, compared with 22% of the Bristol population

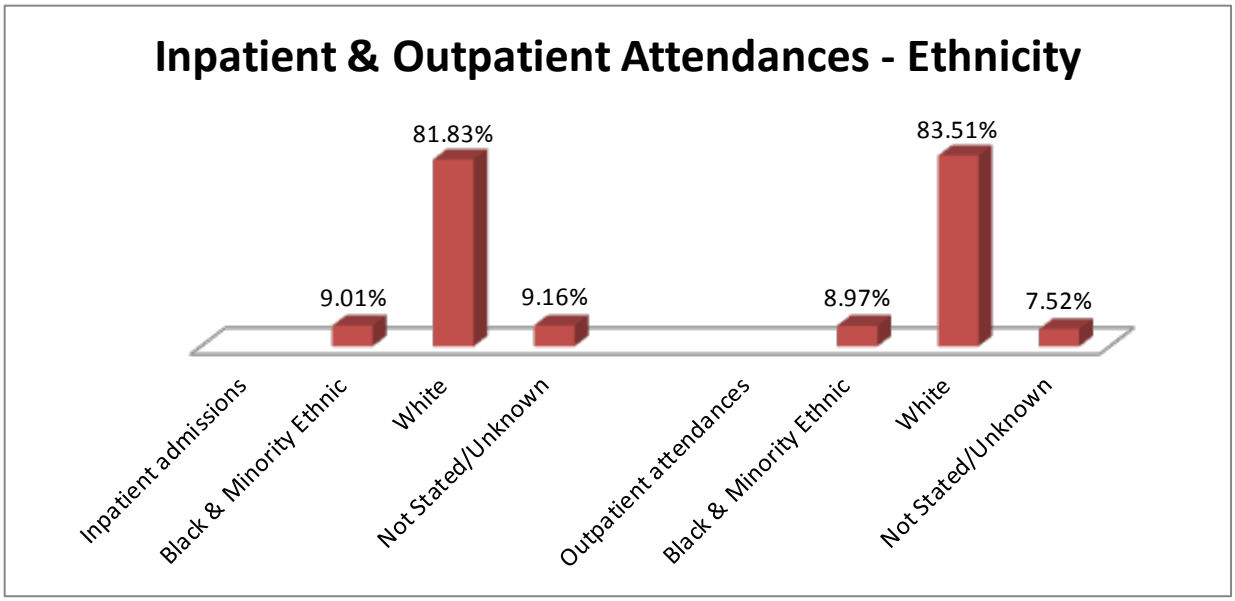
(76% of UH Bristol staff declare as White British)

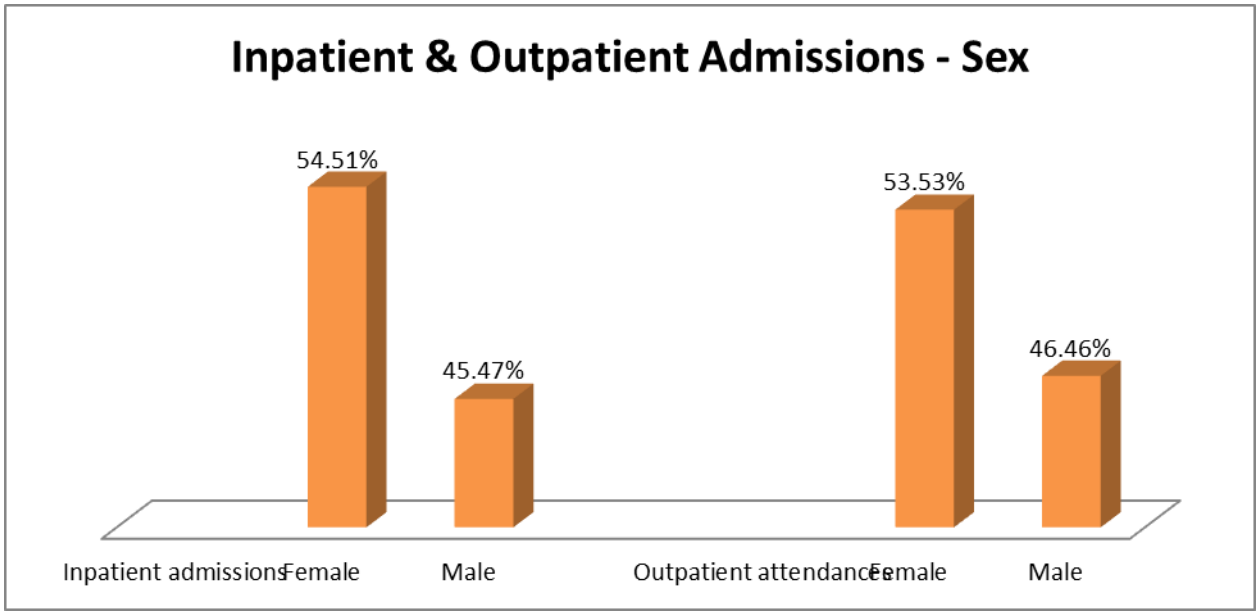


Our Workforce – Non-White British



Our patients and service users (data from January to December 2017)





Appendices

Appendix A The Equality Act 2010 and measures to improve equality

Appendix B Integrated Equality & Diversity Action Plan

Appendix C Demographic Analysis of Patient Surveys 2017-2018

Appendix D Staff Survey Respondents v Workforce demographics

Acknowledgements

With thanks to colleagues across the Trust who have contributed to this report.

APPENDIX A

The Equality Act 2010 and measures to improve equality

Equality Act 2010 and the Public Sector Equality Duty (PSED)

The Equality Act 2010 gives the NHS and its organisations responsibilities to work towards eliminating discrimination and reducing inequalities in care. The Public Sector Equality Duty applies to public bodies and others carrying out public functions, and requires these organisations to publish information to show their compliance with the Equality Duty. The information (including strategic Equality & Diversity objectives) must show that the organisation has had due regard to the need to:

- eliminate unlawful discrimination, harassment and victimisation;
- advance equality of opportunity between people who share a protected characteristic and people who do not;
- foster good relations between people who share a protected characteristic and people who do not share it

Protected Characteristics

The protected characteristics covered by the Equality Act and PSED are:
Age
Disability
Gender reassignment
Marriage and civil partnership
Pregnancy and maternity
Race (including ethnic or national origins, colour or nationality
Religion or belief (including lack of belief)
Sex
Sexual orientation

The Trust's information in relation to its members of staff and its service users is published on the UH Bristol Website: Equality Duty Monitoring

Measures to improve equality

The Workforce Race Equality Standard (WRES)

The Workforce Race Equality Standard requires organisations to publish information against a number of indicators of workforce equality, and to demonstrate progress against them. The WRES highlights any differences between the experience and treatment of White staff and Black & Minority Ethnic (BME) staff in the NHS with a view to closing those gaps through the development and implementation of action plans focused upon continuous improvement over time.
The Trust's results for 2015, 2016 and 2017 are available on the Trust's website. You can read the 2017 report here: Workforce Race Equality Standard Progress Report 2017

The Equality Delivery System (EDS2)

The EDS2 is a toolkit which aims to help organisation improve the services they provide for their local communities and provide better working environments for all groups. There are four goals within the EDS2:

Goal 1 – Better Health Outcomes
Goal 2 – Improved Patient Access and Experience
Goal 3 – A Representative & Supported Workforce
Goal 4 – Inclusive Leadership

The goals are divided into eighteen outcomes. For most of these outcomes, the key question is "How well do people from protected groups fare, compared with people overall?"

The Trust is continuing with the extensive piece of work required to grade its performance against these goals and outcomes (and to have the self-assessment commented on by internal and external stakeholders.)

The Accessible Information Standard

The Accessible Information Standard (SCCI1605 NHS England, 2015) places a mandatory requirement on NHS and Adult Health and Social Care providers to develop a standardised approach to identify, record, flag, meet and share information relating to patients and their information and/or communication needs, where those needs relate to a disability, cognitive impairment or sensory loss.

The Equality Act (2010) strengthened existing legislation which protected specific groups including disability. However, the reality is that many service users receive information from their healthcare providers in a format that they are unable to read and do not always receive communication support.

There is a legal requirement for all Trust staff, volunteers and others representing University Hospitals Bristol NHS Foundation Trust to provide every possible reasonable adjustment with regards to communication and information support when related to disability, impairment or sensory loss.

Those with information and/or communication support needs should not be put at disadvantage as compared to those who do not have any information or communication support needs.

Gender Pay Gap Reporting

From 2017, any organisation that has 250 or more employees must publish and report specific figures about their gender pay gap to show the pay gap between their male and female employees. The figures must be calculated using a specific reference date – the 'snapshot date' – which is 31st March each year for public sector organisations. The figures must be published within a year of this date – by 30th March each year. Organisations must publish these figures annually.

The Trust's first Gender Pay Gap report is available on the Trust's website: Gender Pay Report

APPENDIX B

Integrated Equality & Diversity Action Plan (reviewed & updated for January - June 2018)

Planned actions	Planned Completion Date/Frequency	Supports Objective/EDS2 Goal/WRES	RAG rating
TRAINING			
Resource pack on Equality and Diversity available for all staff to access via HR Web	Ongoing (as information is provided/becomes available)	**To work towards a more inclusive and supportive working environment for all of our staff**. EDS2 Outcome 4.3 Middle managers and other line managers support their staff to work in culturally competent ways within a work environment free from discrimination	
Training and briefings/seminars for the Senior Leadership Team to be implemented	End of December 2017 (and ongoing as appropriate)	**To improve the opportunities for members of our diverse communities to gain employment with and progress within the Trust.** EDS2 Outcome 3.1 Fair NHS recruitment and selection processes lead to a more representative workforce at all levels EDS2 Goal 4: Inclusive Leadership WRES Indicator 2 - Relative likelihood of staff being appointed from shortlisting across all posts	Board Seminar in October 2017 included presentation on 3 forthcoming priorities.
Equality & Diversity online training in place for all staff. Face to face version of Equality, Diversity & Human Rights training to be available from October 2017 to ensure training is accessible to all.	End of May 2017 October 2017	**To work towards a more inclusive and supportive working environment for all of our staff**. EDS2 Outcome 3.6 Staff report positive experiences of their membership of the workforce. WRES Indicators 6 & 8 re experience of harassment, bullying, discrimination from staff	On-line training added to all staff portfolios Feb 17. Inclusion in 3-yearly Corporate Updates approved by ETSG April 2017. Face-to-face version available & delivered from Oct 2017.
Promotion of Apprenticeships and functional skills to all staff groups. (To include awareness-raising among managers in the Trust.)	Jan to June 2018 and ongoing	**To improve the opportunities for members of our diverse communities to gain employment with and progress within the Trust.**	Ongoing

		To work towards a more inclusive and supportive working environment for all of our staff. EDS2 Outcome 3.3 Training and development opportunities are taken up and positively evaluated by all staff WRES Indicator 4 (Relative likelihood of staff accessing non-mandatory training and CPD) and 7 (Percentage believing the Trust provides equal opportunities for career progression/promotion Workforce Disability Equality Standard	
Introduction of Reverse Mentoring Scheme involving staff from BAME backgrounds and senior managers.	Autumn 2018	**To improve the opportunities for members of our diverse communities to gain employment with and progress within the Trust.** **To work towards a more inclusive and supportive working environment for all of our staff.** EDS2 Outcome 3.3 Training and development opportunities are taken up and positively evaluated by all staff WRES Indicator 4 (Relative likelihood of staff accessing non-mandatory training and CPD) and 7 (Percentage believing the Trust provides equal opportunities for career progression/promotion	
IMPROVING STAFF EXPERIENCE			
Support the introduction of a 'Dignity at Work Policy'	November 2017	**To work towards a more inclusive and supportive working environment for all of our staff.** EDS2 Outcome 3.4 When at work, staff are free from abuse, harassment, bullying and violence from any source, and 3.6 Staff report positive experiences of their membership of the workforce WRES Indicators 5, 6 and 8 re experience of harassment, bullying and discrimination	Policy approved Sept 2017. Rollout of introductory sessions starting late September. Anti-bullying week (13th - 17th November 2017) used for further promotion.
Develop a 'one stop shop' for information about Reasonable Adjustments for staff with disabilities.	By end Oct 2018	**To improve the opportunities for members of our diverse communities to gain employment with and**	Working towards completion.

Promote the information to HR teams, managers, and staff.		**progress within the Trust** **To work towards a more inclusive and supportive working environment for all of our staff.** **EDS2 Outcome 3.1 Fair NHS recruitment and selection processes lead to a more representative workforce at all levels** **Workforce Disability Equality Standard**	
Develop and publish support for staff who are verbally or physically abused by patients. (Includes promotion of existing materials/processes.)	By end Oct 2018	**To work towards a more inclusive and supportive working environment for all of our staff.** **EDS2 Outcome 3.4 When at work, staff are free from abuse, harassment, bullying and violence from any source.** **WRES Indicators 5, 6 and 8 re experience of harassment, bullying and discrimination** **Workforce Disability Equality Standard**	
Work in partnership with other HR Teams to introduce regular drop-in sessions across the Trust to allow staff to ask for advice about policies, terms & conditions or other issues.	End June 2018	**To work towards a more inclusive and supportive working environment for all of our staff.**	Going live July 2018
PATIENT EXPERIENCE			
To enable equalities reporting for patients in line with the Public Sector Equality duty (PSED)	End of June 2017	**To improve access to services for our local communities** EDS2 Goals: Better health outcomes Improved patient access and experience	To be incorporated into PIDG workplan
EQUALITY DELIVERY SYSTEM (EDS2)			
Completion of the EDS2 self-assessment (Representative & supported workforce) & publication on external website for comment.	End of December 2016	**To improve access to services for our local communities** **To improve the opportunities for members of our diverse communities to gain employment with and progress within the Trust.**	Completed April 2017
Develop and implement timeframe for roll-out of EDS2 self-assessment across the Trust	End of August 2018	**To work towards a more inclusive and supportive working environment for all of our staff.** And all EDS2 Goals & Outcomes: Better health outcomes Improved patient access and experience A representative and supported workforce	

		Inclusive leadership	
Completion of the EDS2 self-assessment (Inclusive Leadership)	End of August 2018		
GOVERNANCE			
Review and refresh the Equality Objectives for the Trust to give us a clear, measurable framework for our activities.	Completed and published August 2016	**Public Sector Equality Duty**	Due for update 2019
Support the Trust in fulfilling its obligation under the PSED, by reporting on and publishing equalities data for workforce and service users. (Includes Annual Equality & Diversity report, and reporting on the WRES, EDS2, AIS and other regulatory requirements.)	Annually (June/July) and as required.	**All Trust E&D Strategic Objectives** All EDS2 Goals & Outcomes All WRES Indicators and outcomes	On track for 2018
To provide a six-monthly update on Equality, Diversity & Human Rights to QOC (Quality & Outcomes Committee)	End of Feb 2018	**All Trust E&D Strategic Objectives** **All EDS2 Goals & Outcomes** **All WRES Indicators and outcomes**	QOC 26th Feb 2018
Complete scheduled review of the Trust's Equality, Diversity & Human Rights Policy	End of June 2018	**To work towards a more inclusive and supportive working environment for all of our staff.**	Approved June 2018.
Review and introduce a refreshed process for undertaking and completing equality impact analysis Trust-wide.	End of June 2018	**To improve access to services for our local communities** **To work towards a more inclusive and supportive working environment for all of our staff** **EDS2 Outcome 4.2**	Appropriate approval route and endorsed by SDG March 2018
MONITORING & ASSURANCE			
Work in partnership with other HR Teams to ensure equalities information is recorded for all staff	End of June 2018	**To improve the opportunities for members of our diverse communities to gain employment with and progress within the Trust** **EDS2 Outcome 3.1 Fair NHS recruitment and selection processes lead to a more representative workforce at all levels** **WRES Indicator 1 (Percentage of staff in each of the AfC Bands and VSM) & 7 (Percentage believing that Trust provides equal opportunities for career progression or promotion)** **Workforce Disability Equality Standard**	

APPENDIX C

University Hospitals Bristol NHS
NHS Foundation Trust

Demographic analysis of UH Bristol's monthly inpatient postal survey (2017-18)

1. Purpose of this report

This report presents a breakdown of overall patient-reported care ratings by the demographic variables collected via UH Bristol's monthly inpatient postal survey (age, sex, ethnicity, sexuality, religion, and disability). The analysis aims to identify trends in the data to generate further discussion about equality and diversity issues in the delivery of care at UH Bristol. Due to the complexity of the issues being considered, and that it draws on data from a survey that is not specifically designed to measure these factors, the report cannot be used to *prove* whether differences exist between demographic groups or provide insight on why any differences are occurring.

Please note that, whilst comparisons are provided to previous years, a change in the methodology for 16/17 generally led to slightly higher satisfaction scores from that year onwards. Unless otherwise stated, the charts presented in this report refer to the proportion of inpatients aged 12 and over who rate the care they received at UH Bristol as excellent, very good, or good[2].

Margins of error in the data mean that scores fluctuate naturally over time and between groups. Unless otherwise stated in the report, it should be assumed that differences in scores are not statistically significant.

This report is marked as "draft" because it is not scheduled to be reviewed by the Trust's Patient Experience Group until August 2018.

2. Executive summary

- Patient ratings of UH Bristol's care are positive across all demographic groups analysed in this report.

- The most consistent demographic effect in the data is that older age groups tend to report a more negative experience. This is mirrored at a national level. UH Bristol's Patient Experience and Involvement Team studied this effect in detail in 2017/18. It was found that feedback from service-users is generally very positive about our "care of the elderly" services, and that our scores compare favourably compared to national and peer benchmarks.

- Patients from the Sikh community give care ratings that are consistently less positive than other religious groups in our survey. The Patient Experience and Involvement Team will carry out a focussed piece of work to better understand this effect during Quarter 2 2018/19.

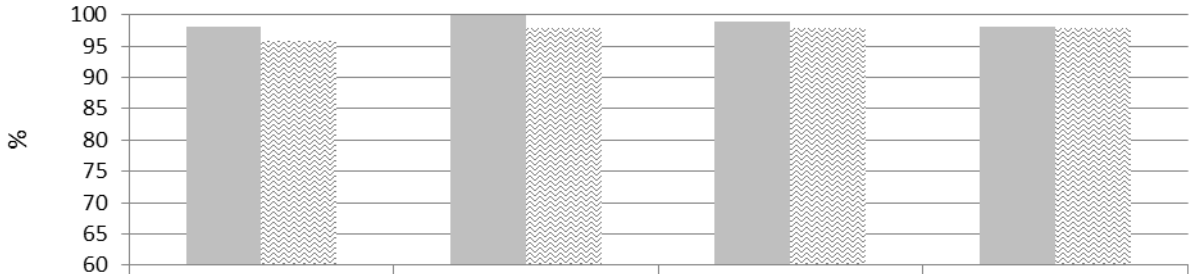
[2] UH Bristol's inpatient survey is mailed to people aged 12 years and over, and to the parents of 0-11 year olds.

3. Overall inpatient care ratings by demographic group

Sex

Females tend to report slightly lower satisfaction with their hospital care than males. This is in line with trends seen at a national level. The reasons for this are unclear and it could be linked to a number of other factors (e.g. women tend to live longer and experience different hospital services). In 2017-18, no difference between males and females was observed on this measure – until further data is available next year, this should be considered to be a reflection of chance fluctuation in the data, rather than a genuine change in the overall trend.

Chart 6: Overall care rating by sex

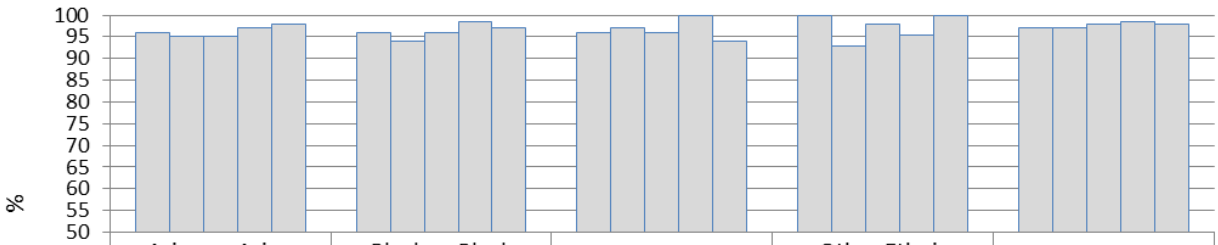


	2014-15	2015-16	2016-17	2017-18
Male	98	100	99	98
Female	96	98	98	98

Ethnicity

The scores given by UH Bristol's patients from non-white ethnic groups tend to fluctuate considerably. This is likely to be a reflection of relatively small sample sizes impacting on data accuracy each year, rather than a real-world effect. Care ratings are positive across all groups.

Chart 2: Overall care rating by ethnic group

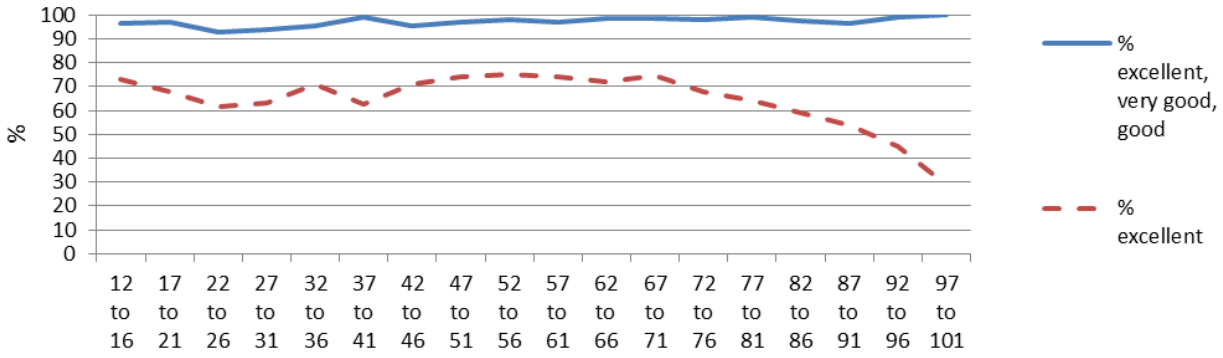


	Asian or Asian British	Black or Black British	Mixed	Other Ethnic Groups	White
2013-14	96	96	96	100	97
2014-15	95	94	97	93	97
2015-16	95	96	96	98	98
2016-17	97	99	100	95	98
2017-18	98	97	94	100	98

Age

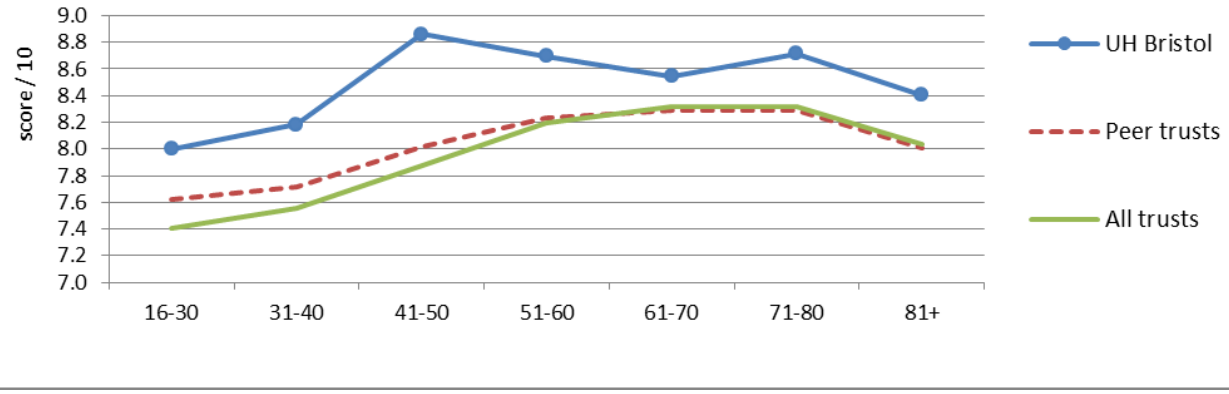
The proportion of patients rating their care as excellent, very good, or good, is consistent across age groups (Chart 3). However, within this, if you look at the "top-box" score, the proportion of patients rating their care as excellent declines steeply from around 67 years of age onwards. This broad effect is seen at a national level too.

Chart 3: Overall care rating by age group



In Quarter 1 2017/18, the Trust's Patient Experience team had a specific focus on "care of the elderly" patients and families to better understand their experience and identify improvement opportunities. We used the *Face2Face* volunteer interview team to talk to over 50 patient / family / carer interviews. We also carried out desk research, engagement with the Trust's Involvement Network, and a "patient experience at heart" staff workshop. The feedback received from patients and families was generally very positive. In addition, the Patient Experience and Involvement Team carried out a bespoke analysis of the Care Quality Commission's 2016 national inpatient survey. This analysis showed that in every age group, overall experience ratings at UH Bristol were more positive than both the national average and a benchmark of peer trusts (Chart 4).

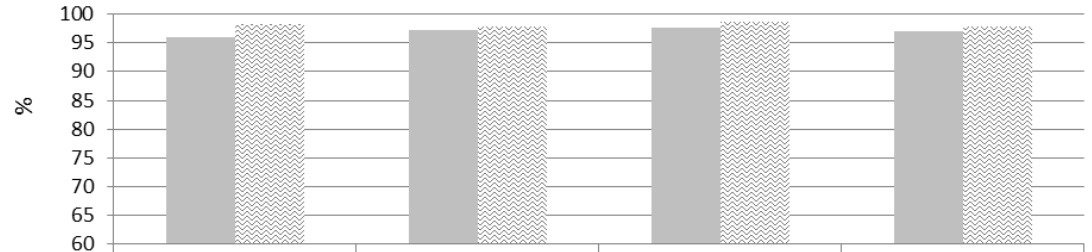
Chart 4: overall experience ratings by age group - comparison of UH Bristol to national benchmarks (2016 national inpatient survey)



Disability

In our questionnaire, patients are asked to state whether they consider themselves to have a disability. It can be seen in Chart 5 that patients with a disability are slightly less likely to rate their care as excellent, very good, or good. This is a statistically significant finding, primarily due to the large sample sizes available for this question: in a real-world sense, the scores are all very positive and the difference between them is marginal.

Chart 5: Overall care rating by disability

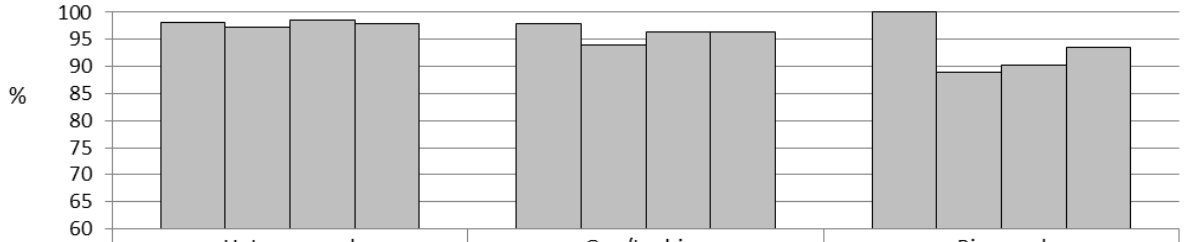


	2014-15	2015-16	2016-17	2017-18
With disability	96	97	98	97
Without disability	98	98	99	98

Sexuality

The sample sizes for the gay and bi-sexual groups are very small in Chart 7 and so we can see quite large fluctuations in the data. The differences do not reach statistical significance however.

Chart 7: % rating care as excellent, very good, or good (by sexuality)

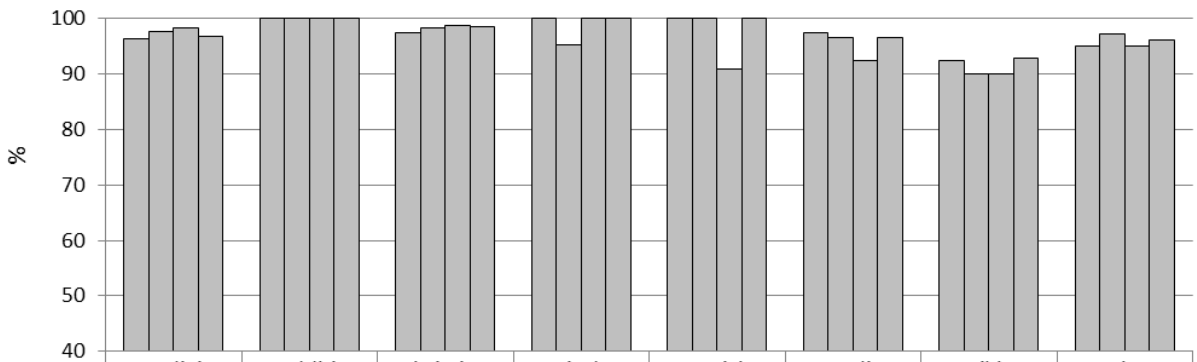


	Heterosexual	Gay/Lesbian	Bi-sexual
2014-15	98	98	100
2015-16	97	94	89
2016-17	99	96	90
2017-18	98	96	94

Religion

Again the sample sizes are very low for some of the groups shown in Chart 8. There is no statistically significant difference evident in this data. However, it is interesting that the data for Sikh patients is consistent, both in itself, and in that these scores are always lower than the other religious groupings. Based on this finding, the Patient Experience and Involvement Team will have a specific focus on understanding the experience of Sikh patients during Quarter 2 2018/19.

Chart 8: % rating care as excellent, very good, or good (by religion)



	No religion	Buddhist	Christian	Hindu	Jewish	Muslim	Sikh	Other
2014-15	96	100	97	100	100	97	92	95
2015-16	98	100	98	95	100	97	90	97
2016-17	98	100	99	100	91	92	90	95
2017-18	97	100	98	100	100	97	93	96

4. Conclusions

The data presented in this report does not in itself provide evidence of an "equalities and diversities" bias in the delivery of UH Bristol's inpatient care. Even where a difference is identified between demographic groups in this analysis, it is not possible to isolate the various factors that may be influencing the outcome, and therefore to identify where to target improvements. Nevertheless, the Patient Experience Group will consider the key findings of this report and identify potential opportunities to improve care.

Paul Lewis, Patient Experience and Involvement Team Manager, UH Bristol. 0117 342 3638 / paul.lewis@uhbristol.nhs.uk

APPENDIX D - Staff Survey Respondents v Workforce Demographics

Staff in Post as at 31st March 2017			Staff Survey 2016 (42% returns)		Staff Survey 2017 (43% returns)	
Gender	**Headcount**	**% of Total**	**Number returned**	**Percentage of survey respondents**	**Number returned**	**Percentage of survey respondents**
Female	7,113	77.1%	2,721	78%	2,856	77%
Male	2,111	22.9%	759	22%	773	21%
Prefer to self-describe					22	1%
Prefer not to say					60	2%
Did not specify			117		111	
Grand Total	9,230	100.0%	3,597	100%	3,822	

Disabled	**Headcount**	**% of Total**	**Number returned**	**Percentage of survey respondents**	**Number returned**	**Percentage of survey respondents**
Yes	255	2.8%	512	15%	623	17%
No	8,689	94.1%	2,942	85%	2,941	83%
Not Declared/Did not specify	286	3.1%	143		188	
Grand Total	9,230	100.0%	3,597	100%	3,752	

Ethnic Group	**Headcount**	**% of Total**	**Number returned**	**Percentage of survey respondents**	**Number returned**	**Percentage of survey respondents**
White	7,729	83.7%	3,136	90%	3,215	88%
Black & Minority Ethnic background	1,414	15.3%	365	10%	442	12%
Not stated / did not specify	87	0.9%	96		95	
TOTAL	9,230	100.0%	3,597	100%	3,752	

Staff in Post as at 31st March 2017

Staff Survey 2016 (42% returns)

Staff Survey 2017 (43% returns)

Sexual Orientation	Headcount	% of Total	Number returned	Percentage of survey respondents	Number returned	Percentage of survey respondents
Heterosexual	6,451	69.9%	3,185	87%	3,312	88%
LGBO	142	1.5%	120	3%	138	4%
Do not wish to disclose / did not specify	2,637	28.6%	292	8%	302	8%
TOTAL	9,230	100.0%	3,597		3,752	

Age Range	Headcount	% of Total	Number returned	Percentage of survey respondents	Number returned	Percentage of survey respondents
16 - 20	74	0.8%				
21 - 25	803	8.7%				
26 - 30	1,431	15.5%	659	19%	686	19%
31 - 35	1,355	14.7%				
36 - 40	1,206	13.1%	818	23%	879	24%
41 - 45	1,066	11.5%				
46 - 50	997	10.8%	830	24%	919	25%
51 - 55	1,036	11.2%				
56 - 60	803	8.7%				
61 - 65	357	3.9%				
66 - 70	81	0.9%				
71 - 80	21	0.2%	1,214	34%	1,157	32%
Did not specify			76		111	
Grand Total	9,230	100.0%	3,597	100%	3,752	100%

Cover report to the PublicTrust Board. Meeting to be held on 27 July 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**	Friday, 27 July 2018
Report Title	**Research 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)**
N/A	N/A	N/A	N/A	N/A

Executive Summary

Performance:

We continue to demonstrate good performance in delivering commercial trials to time and target at 67%. Our performance in recruiting the first patient within the 70 day benchmark has increased to 76%. Changes to the reporting requirements implemented by the Department of Health, via NIHR mean that whilst poor performance against the benchmark will no longer incur penalties, transparency expectations require us to continue to publish the performance data. Focus this year is on improving performance in recruiting the target number of patients on time for both commercial and non- commercial research.

Funding:

A reduction of 10% in the available national Research Capability Funding budget has been reflected in our RCF allocation. The small increase in delivery funding reported last quarter and other income sources, allows us to continue our biannual small grants scheme and to hold a small budget to support backfill to maintain operational activity.

The call for Applied Research Collaborations (ARC), the next iteration of the CLAHRC, has been received. The deadline for submission is August 20th and we are planning for an application to be submitted in which we are named as contracting party and host. The bid is being led by Professor Jenny Donovan.

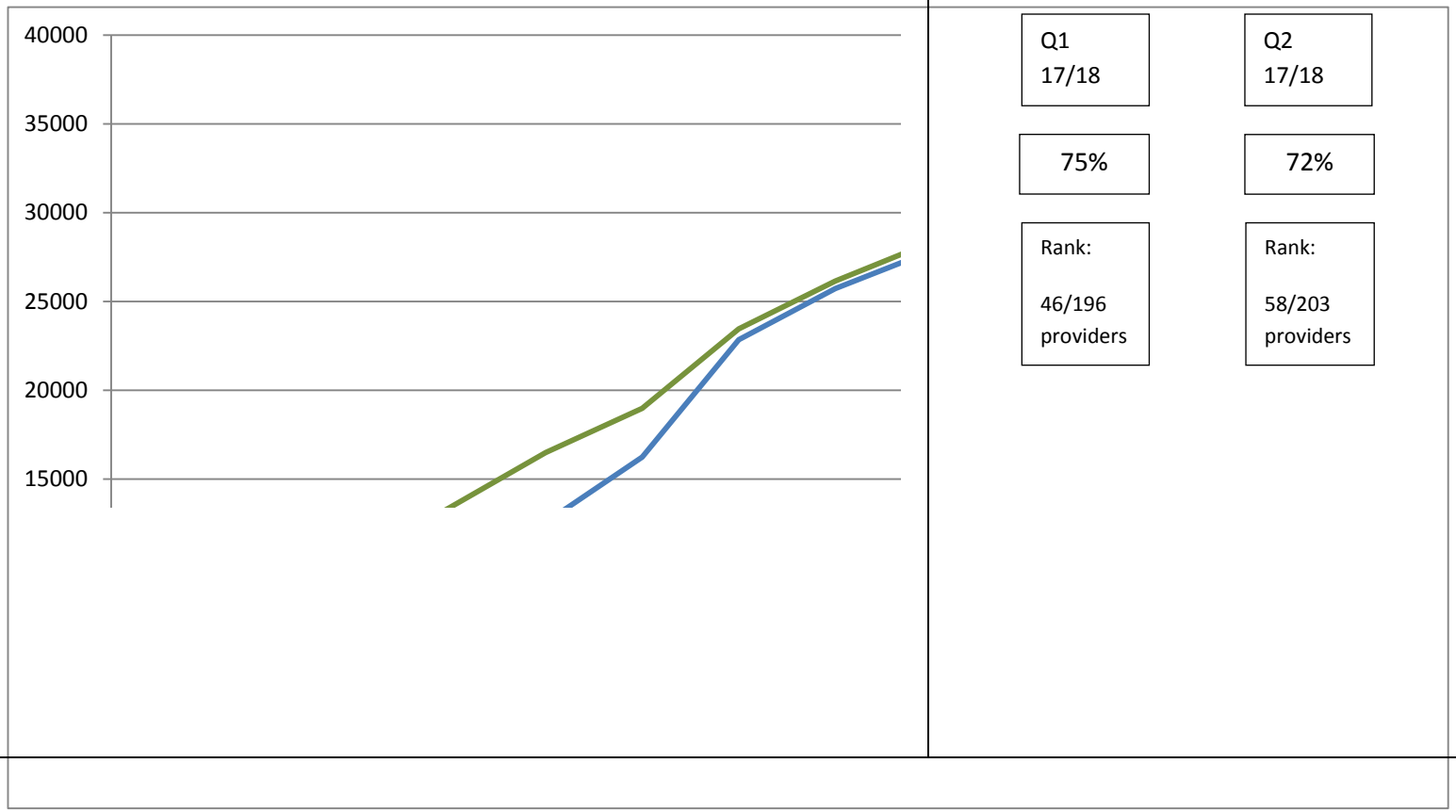
Overview

Successes	Priorities
• Following the introduction on 6th January 2018 of the new PICU Research Programme we have already opened 3 new NIHR studies, SANDWICH (Sedation and Weaning in Children), NEUROPACK (Cardiac arrest pre-PICU follow-up study), and DEPICT (Differences in access to Emergency Paediatric Intensive Care and care during Transport). The latter two recruited within a week of going live. This promises to be an exciting time for research of critical illness and injury of children in Bristol as we open further studies in the coming months. • UHBristol researchers, led by Prof Ramanan, will join MRC-funded scientists from across the UK to begin a five year study of childhood arthritis and its linked eye inflammation, uveitis. The grant, awarded to UCL Great Ormond Street Institute of Child Health, for nearly £5 million, will fund the CLUSTER childhood arthritis study, following the health trajectories of 5,000 children with the condition. • The first UK patient for a national non-small cell lung cancer trial was recruited in Bristol, by the BHOC research staff. • Introduction of research sessions onto trust-wide staff development programmes such as preceptorship training, general induction and doctors' induction has taken place.	• Continue to plan a bid for an NIHR Clinical Research Facility in 2021 • Support the development of a strong bid for an NIHR Applied Research Collaboration (to replace CLAHRC) • Continue to support the Medical Research Team to develop a strong and sustainable portfolio of research • Identify opportunities for joint working with Weston Area Health Trust • Improve performance in recruiting the target number of patients on time for both commercial and non-commercial research.
Opportunities	**Risks and Threats**
• Increase engagement and input of medical and non-medical clinicians into research, ensuring allocated time in job plans translates into research activity which is visible and measurable. • Work with UWE to develop research capacity in non-medical staff groups via recent joint appointment.	• Ongoing clinical pressures deprioritise research across the trust and limit opportunities to maintain activity and increase in new areas of potential. • Expectation that research capability funding will decrease further during 2019/20, reducing ability to make strategic funding allocations.

Performance Overview

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

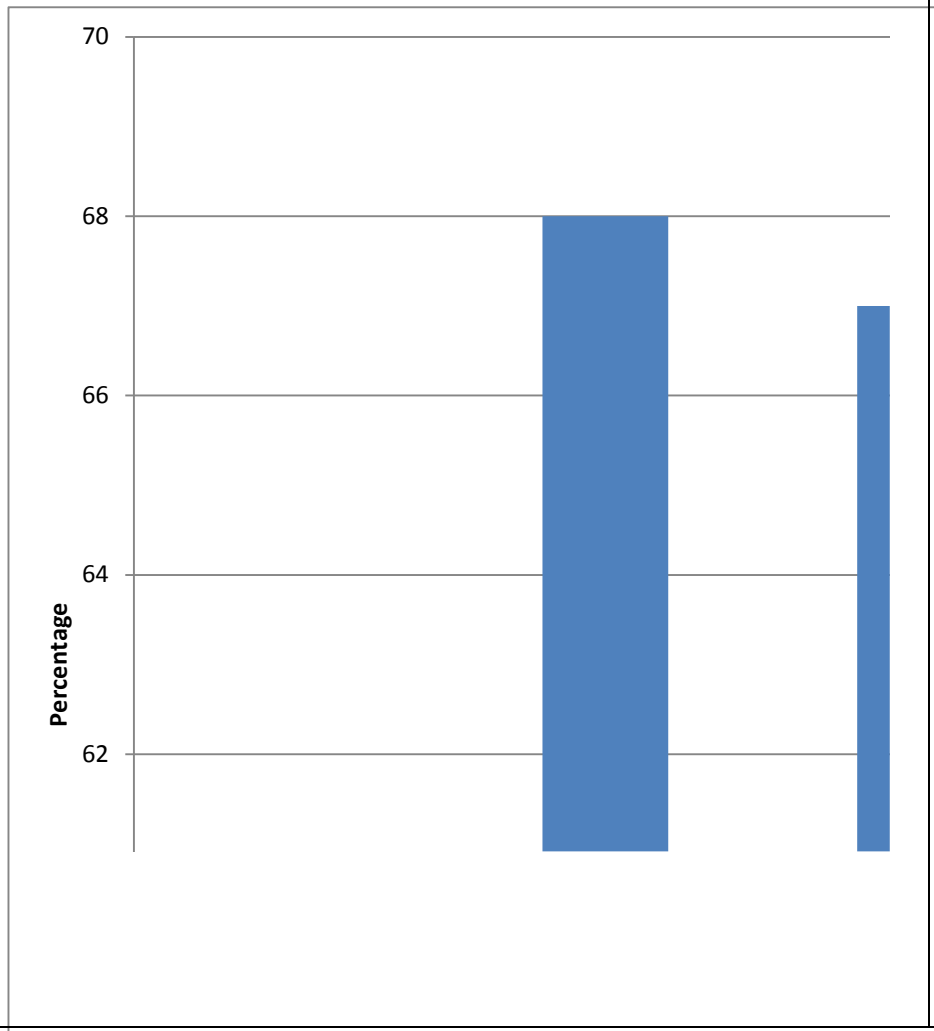
a) Cumulative weighted recruitment into NIHR portfolio studies 17-18. [NB. There is a 6 week lag in recruitment data becoming visible on the system.]



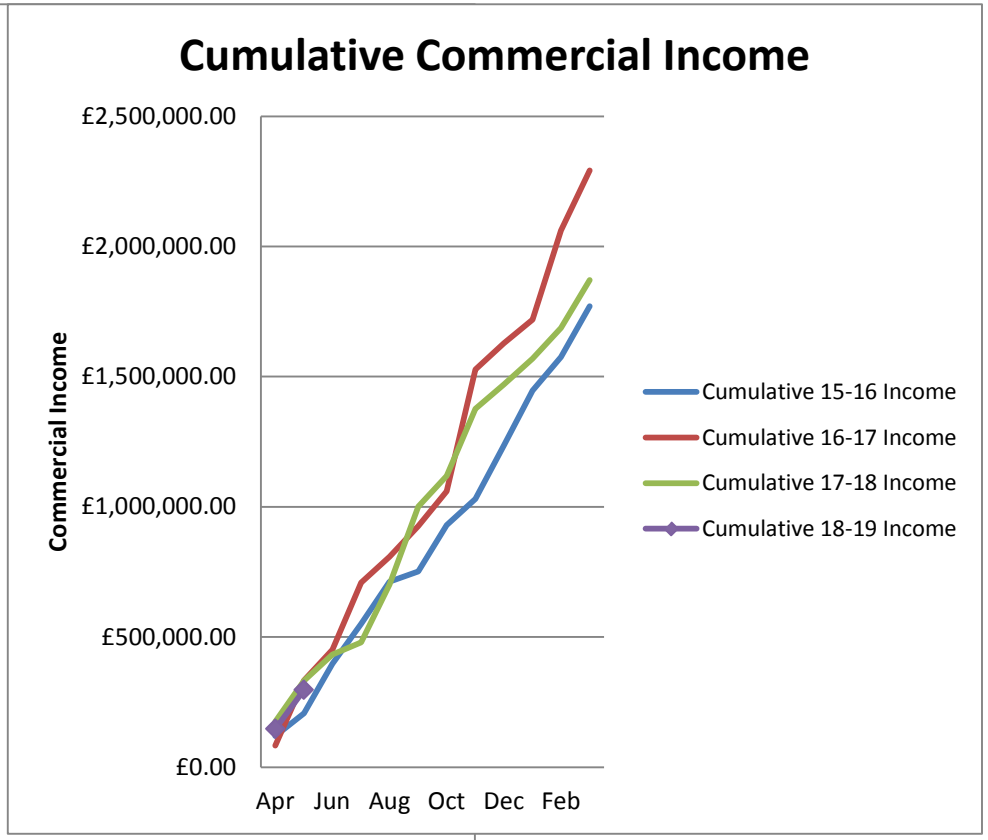
b) Percentage of clinical trials meeting the 70-day first patient first visit benchmark, adjusted by NIHR in comparison to other Trusts

Q1 17/18	Q2 17/18	Q3 17/18	Q4 17/18
75%	72%	64%	76%
Rank: 46/196 providers	Rank: 58/203 providers	Rank: 81/207 provider	Rank: 57/205 provider

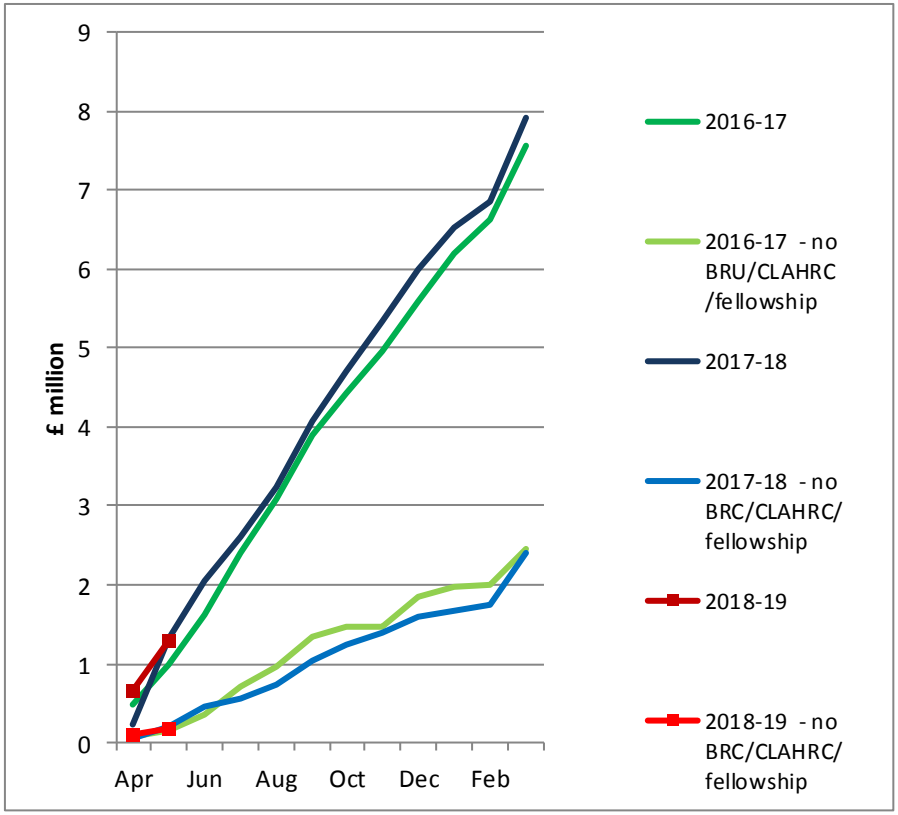
c) Percentage of closed commercial studies recruiting to time and target



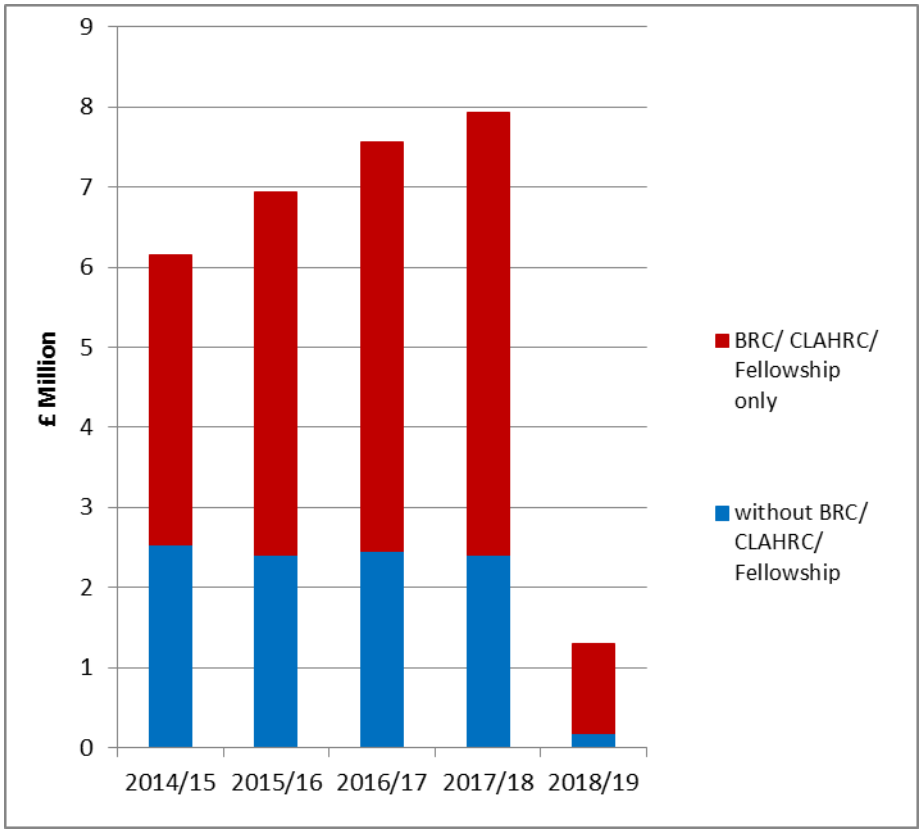
d) Monthly commercial income



NIHR monthly grant income – year on year comparison



NIHR grant income – drives research capability funding.



Cover report to the PublicTrust Board. Meeting to be held on 27 July 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**	Friday, 27 July 2018
Report Title	**Finance Report**		
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 the Trust Board of the financial position of the Trust for June Key issues to note The Operational Plan requirement to June is a surplus of £2.171m excluding technical items The Trust is reporting a surplus of £2.181m, £0.010m favourable to plan. This is due to : • Divisional and Corporate overspends of £0.572m, offset by • Corporate share of income over performance £0.159m • Release of Corporate Reserves of £0.371m • Financing underspends of £0.052m The Clinical Divisional deficit in June is £0.687m, compared to £0.532m last month, a

deterioration of £0.155m. However there was a significant deterioration in the month in both Medicine (£0.304m) and Surgery (£0.460m). Support funding of £1.936m has been provided to Divisions in June allocated equally over the remaining ten months of the year PSF core and performance funding is shown as achieved for the quarter. The Trust is reporting a £0.010m favourable variance against the core control total and ED performance was 91.63% against a target of 90.00% including Walk in Centre data.
Recommendations
Members are asked to: • Note the contents of this 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
Risk 951 – Risk of the loss of S&T funding due to the failure to achieve the “core” control total from quarter 2.

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

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

University Hospitals Bristol NHS Foundation Trust

Section 1 – Executive Summary

	2018/19 Annual Plan £m	Income / (Expenditure) Plan to date £m	Income / (Expenditure) Actual to date £m	Variance Favourable /(Adverse) £m
Corporate Income	617.463	155.713	155.872	0.159
Divisions & Corporate Services	(572.776)	(146.595)	(147.167)	(0.572)
Financing	(35.592)	(8.898)	(8.846)	0.052
Reserves	(6.095)	(0.371)	-	0.371
Surplus/(deficit) excl PSF	**3.000**	**(0.151)**	**(0.141)**	**0.010**
PSF Core Funding	10.836	1.625	1.625	-
PSF Performance Funding	4.644	0.697	0.697	-
Surplus/(deficit) incl PSF	**18.480**	**2.171**	**2.181**	**0.010**

The costs include an accrual for the Agenda for Change (AFC) pay award backdated to 1st April based on the 1% tariff funding. The national pay award was agreed on the 27th June. NHS Improvement confirmed that the additional costs of the agreement should not be included for the first quarter.

Funding of £5.6m has now been confirmed by NHS Improvement for the additional costs of the AFC award. The implications and methodology for allocation are currently being evaluated.

Whereas there are significant variances from plan the overall position is currently broadly satisfactory and the forecast is that the Trust will deliver its planned surplus. However, there will need to be a reduction in the adverse spend position on certain headings (e.g. nursing and non-pay) to achieve this.

- The Operational Plan for the year is a surplus of £18.480m excluding technical items. This includes £15.480m of Provider Sustainability Funding (PSF).
- The Operational Plan requirement to June is a surplus of £2.171m excluding technical items.
- The Trust is reporting a surplus of £2.181m, £0.010m favourable to plan. This is due to :
  - Divisional and Corporate overspends of £0.572m, offset by
  - Corporate share of income over performance £0.159m
  - Release of Corporate Reserves of £0.371m
  - Financing underspends of £0.052m
- The Clinical Divisional deficit in June is £0.687m, compared to £0.532m last month, a deterioration of £0.155m. However there was a significant deterioration in the month in both Medicine (£0.304m) and Surgery (£0.460m). Support funding of £1.936m has been provided to Divisions in June allocated equally over the remaining ten months of the year.
- PSF core funding is shown as achieved for the quarter. The Trust is reporting a £0.010m favourable variance against the core control total.
- PSF performance funding has been achieved for the quarter. ED performance was 91.63% against a target of 90.00% including Walk in Centre data.

Forecast Out-turn

Favourable / (Adverse)	Operating Plan £m	To Month 3 £m	Straight Line Projection £m	Forecast Out-turn £m
Clinical Divisions				
Diagnostics & Therapies	0.303	0.156	0.624	0.309
Medicine	(0.491)	(0.449)	(1.796)	(0.501)
Specialised Services	0.028	0.335	1.340	0.026
Surgery	0.020	(0.651)	(2.604)	(0.460)
Women's & Children's	0.085	(0.078)	(0.312)	0.085
Sub-Total	(0.055)	(0.687)	(2.748)	(0.539)
Non-Clinical Divisions				
Estates and Facilities	-	(0.018)	(0.072)	-
Corporate Services	-	(0.021)	(0.084)	(0.044)
Misc Support Services	-	0.149	0.596	0.217
Trading Services	-	0.004	0.016	0.054
Sub-Total	-	0.114	0.456	0.227
GRAND TOTAL	**(0.055)**	**(0.573)**	**(2.292)**	**(0.312)**

- The Trust is required to assess its forecast out-turn at the end of each quarter. The results are published by NHS Improvement.
- The Divisions have been requested to produce their own forecast out-turn to facilitate the Trust's overall assessment.
- It should be noted that non-recurring support of £1.9m was issued to Clinical Divisions in June. Hence Operating Plans have been improved to take this into account.
- As can be seen Clinical Divisions are forecasting a total adverse variance of £0.539m. This compares to a straight-line projection of £2.748m adverse variance. The forecasts therefore assume a major improvement in performance for the last three quarters of the year.
- The two Divisions with the largest required improvements are Medicine and Surgery. Hence these two Divisions have been required to produce recovery plans to provide assurance to Executive Directors.
- To manage the position where Divisions (Clinical & Corporate) are likely to produce adverse variances of anything between £0.3m and £2.3m at year end, an assessment of possible contingency funds has been made. Whereas it is very early in the year to make realistic forecasts, the Trust can be fairly confident of delivering its pre-PSF control total. A full assessment will be included in the Quarter 2 (September) finance report.
- If, however, the forecast out-turn deteriorates during the year the confidence level will reduce. The key is the delivery of actions to reduce adverse spend variances and not to rely on income over-performance.
- Provider Sustainability funding (PSF) is still based on a) delivering the pre-PSF core control total (£3.0m surplus) and b) achieving the A&E performance trajectory. The current projection is that the Trust will achieve Quarters 1 -3 but not Quarter 4.
- The forecast out-turn submitted to NHS Improvement is therefore:

	Operating Plan £m	Forecast Out-turn £m
Income – patient care activities	581.582	581.582
Other operating income	90.156	90.156
Employee expenses	(391.732)	(397.732)
Other operating expenditure	(265.117)	(259.119)
Financing	(11.889)	(11.887)
Net surplus/(deficit) excl PSF & technical	3.000	3.000
PSF – core	10.836	10.836
PSF - performance	4.644	3.019
Net surplus/(deficit) excl technical	18.480	16.855
Technical items	2.110	2.110
Net reported surplus/(deficit)	20.590	18.965

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 31 May £m	June £m	To 30 June £m	To 30 June £m	Var £m
Diagnostic & Therapies	0.071	0.085	0.156	0.059	0.097
Medicine	(0.145)	(0.304)	(0.449)	(0.203)	(0.246)
Specialised Services	0.065	0.270	0.335	(0.182)	0.517
Surgery	(0.191)	(0.460)	(0.651)	(0.169)	(0.482)
Women's & Children's	(0.332)	0.254	(0.078)	(0.391)	0.313
Estates & Facilities	(0.006)	(0.012)	(0.018)	0.023	(0.041)
Trust Services	(0.010)	(0.008)	(0.018)	-	(0.018)
Other Corporate Services	0.127	0.025	0.152	-	0.152
Total	**(0.421)**	**(0.150)**	**(0.571)**	**(0.863)**	**0.292**

Clinical Divisions and Corporate Services were adverse to plan by £0.571m at the end of the first quarter. This compares with the Operating Plan trajectory of an adverse variance of £0.863m. However whilst Specialised Services and Women's and Children's improved their position within June and are significantly better than their Operating Plan trajectories at quarter one, Medicine and Surgery worsened significantly in the month and are adverse to their Operating Plan trajectories.

Medicine and Surgery Divisions have been requested to provide recovery plans to rectify their positions before the year end.

- Diagnostic and Therapies – a favourable variance of £0.156m slightly ahead of the Operating Plan trajectory. This is mainly driven by clinical staffing vacancies and income from activities which offsets a non pay overspend.

- Medicine – an adverse variance of £0.449m, £0.246m higher than the Operating Plan trajectory. Pay was £0.268m adverse in month and £0.583m to date of which £0.360m relates to nursing controls and £0.220m to medical pay, particularly covering sickness and maternity leave in the ED. Income from activities was flat this month, with a cumulative over performance of £0.327m.

- Specialised Services – a favourable variance of £0.335m, £0.517m favourable to Operating Plan trajectory. Income from activities is £0.373m above plan of which £0.437m relates to Cardiology.

- Surgery – an adverse variance of £0.651m which is £0.482m adverse to Operating Plan trajectory. Pay deteriorated by £0.167m in June and is £0.491m adverse to date. Additional hours payments are driving the medical and dental pay overspend of £0.286m. Nursing is £0.159m adverse to plan. Non pay deteriorated by £0.336m in June and is £0.819m adverse to date. Income from activities was broadly on plan in month with the cumulative over performance remaining at £0.660m.

- Women's & Children's – an adverse variance of £0.078m year to date, which is £0.313m favourable to Operating Plan trajectory. Pay is £0.995m adverse of which £0.494m relates to medical pay and £0.370m to nursing and midwifery. Non pay is £0.266m favourable reflecting development slippage and some funding yet to be allocated. Income from activities was £0.450m favourable in month and is £0.570m above plan cumulatively.

Section 2 – Division and Corporate Services Performance continued

Performance by subjective heading:

	Monthly Average 2017/18	2017/18 Outturn £m	April 2018 £m	May 2018 £m	June 2018 £m	2018/19 To date £m
Nursing & midwifery pay	(0.328)	(3.941)	(0.248)	(0.315)	(0.420)	(0.983)
Medical & dental pay	(0.353)	(4.233)	(0.358)	(0.322)	(0.353)	(1.033)
Other pay	0.076	0.912	0.120	0.060	0.116	0.296
Non-pay	(0.388)	(4.655)	0.002	(0.728)	(0.361)	(1.088)
Income from operations	(0.003)	(0.030)	(0.069)	0.000	0.042	(0.027)
Income from activities	0.396	4.753	0.111	1.327	0.825	2.263
Total	**(0.600)**	**(7.195)**	**(0.442)**	**0.022**	**(0.151)**	**(0.572)**

- The level of overspend on nursing and medical pay and clinical non-pay is concerning and requires detailed investigation.
- The level of activity and hence income is potentially masking a significant spend control issue which could compromise the delivery of the year's plan if not addressed.
- Nursing pay overspend has continued to increase with an adverse variance of £0.420m in June. Women's and Children's worsened by £0.124m and Medicine by £0.183m. The cumulative overspend of £0.983m is from Medicine (£0.360m), Women's and Children's (£0.370m) and Surgery (£0.159m).
- Medical and dental pay variances have been broadly similar to the first three months of the year, reflecting the average run rate from 2017/18. Of the £1.033m cumulative adverse variance, £0.494m is within Women's and Children's, £0.286m in surgery and £0.220m in Medicine.
- The adverse non pay variance in June of £0.361m shows an improvement of £0.367m compared to May. This reflects £0.086m of non-recurrent support funding issued to Divisions, funding for prior months costs incurred managing the BHOC fire of £0.039m and release of Divisional reserves in Medicine and Surgery. Non pay expenditure increased slightly compared to May as such without the funding changes the overall position would be more in line with May. Surgery was £0.336m adverse in month and accounts for £0.819m of the cumulative overspend of which £0.271m is due to clinical supplies and services (and in part activity related so offset by income increases) with £0.311m due to the underlying divisional deficit.
- Income from Activities showed a significant favourable variance of £0.825m in June. The cumulative over performance of £2.263m reflects significant over performance on critical care bed days, Emergency Inpatients and Outpatient Procedures.

Section 3 – Subjective Analysis Detail

a) Nursing (including ODP) and Midwifery Pay

Favourable/ (Adverse)	January 2018 £m	February 2018 £m	March 2018 £m	2017/18 Outturn	April 2018 £m	May 2018 £m	June 2018 £m	2018/19 To date £m
Substantive	0.854	0.903	0.940	10.046	0.775	0.830	0.847	2.452
Bank	(0.716)	(0.690)	(0.876)	(7.997)	(0.595)	(0.723)	(0.772)	(2.090)
Agency	(0.421)	(0.409)	(0.510)	(5.988)	(0.428)	(0.422)	(0.495)	(1.345)
Total	**(0.283)**	**(0.196)**	**(0.446)**	**(3.939)**	**(0.248)**	**(0.315)**	**(0.420)**	**(0.983)**

- Nursing pay variance was £0.420m adverse in the month, £0.105m worse than May and a continued deterioration in position for the first quarter. This reflects both a higher price and volume variance.
- Whilst the nursing worked hours percentages remained overall at 126% the continued deterioration in Medicine from 122% in April to 128% in June gives real cause for concern.
- With the exception of Surgery all Division's worsened in the month, with the increase in agency costs being a significant driver. The number of hours worked increased as did the use of more expensive (Thornbury) bookings.
- Sickness increased overall slightly in month both for registered and unregistered nurses.
- Enhanced observation costs increased compared to May with the exception of Surgery where there was a reduction. Total spend in June was £0.079m higher than plan, the cumulative position year to date is £0.162m adverse to plan with the highest impact in Medicine Division.

b) Medical and Dental Pay

Favourable/ (Adverse)	January 2018 £m	February 2018 £m	March 2018 £m	2017/18 Outturn	April 2018 £m	May 2018 £m	June 2018 £m	2018/19 To date £m
Consultant								
substantive	0.065	(0.134)	0.317	0.768	0.037	0.125	0.059	0.220
additional hours	(0.182)	(0.178)	(0.187)	(2.143)	(0.138)	(0.173)	(0.163)	(0.473)
locum	(0.114)	(0.140)	(0.158)	(0.736)	(0.112)	(0.096)	(0.132)	(0.340)
agency	0.005	(0.006)	(0.041)	(0.190)	0.004	(0.013)	0.002	(0.007)
Other Medical								
substantive	0.138	0.096	0.306	0.932	0.100	0.160	0.214	0.475
additional hours	(0.123)	(0.181)	(0.146)	(1.575)	(0.133)	(0.150)	(0.118)	(0.402)
Jr Dr exception	0.000	0.000	0.000	(0.007)	(0.001)	(0.001)	(0.001)	(0.003)
locum	(0.075)	(0.077)	(0.097)	(1.059)	(0.096)	(0.140)	(0.160)	(0.398)
agency	0.023	(0.003)	(0.203)	(0.224)	(0.017)	(0.034)	(0.054)	(0.105)
Total	**(0.263)**	**(0.623)**	**(0.221)**	**(4.927)**	**(0.358)**	**(0.322)**	**(0.353)**	**(1.033)**

- The adverse medical pay variance in June of £0.353m is a slight worsening from May. There has a been a small improvement on additional hours payments, but locum costs remain high as gaps and the cost of maternity cover and sickness continue to impact the positions in particular within Surgery and Women's and Children's Divisions.
- All clinical Division's positions with exception of Diagnostics and Therapies worsened in the month.

Section 3 – Subjective Analysis Detail continued

c) Non pay

Favourable/ (Adverse)	January 2018 £m	February 2018 £m	March 2018 £m	2017/18 Outturn £m	April 2018 £m	May 2018 £m	June 2018 £m	2018/19 To date £m
Blood	(0.086)	0.031	(0.058)	(0.248)	(0.055)	(0.029)	0.021	(0.063)
Clinical supplies & services	(0.185)	0.032	(0.083)	(0.950)	(0.007)	(0.190)	(0.342)	(0.539)
Drugs	(0.115)	(0.179)	(0.212)	(0.961)	0.037	(0.123)	(0.081)	(0.167)
Establishment	(0.079)	0.037	(0.010)	(0.166)	(0.010)	(0.003)	0.013	0.000
General supplies & services	(0.024)	0.019	(0.005)	0.007	0.044	(0.004)	0.027	0.067
Outsourcing	(0.039)	(0.054)	(0.026)	(1.117)	(0.072)	0.022	(0.053)	(0.103)
Premises	(0.064)	0.054	(0.124)	(0.067)	0.034	0.002	0.010	0.046
Services from other bodies	(0.120)	(0.136)	(0.068)	(1.031)	(0.042)	(0.139)	(0.109)	(0.289)
Research	(0.100)	0.040	(0.016)	0.034	0.008	(0.029)	(0.007)	0.030
Other non-pay expenditure	(0.007)	(0.472)	(0.076)	(1.526)	0.065	(0.293)	0.160	(0.069)
Tranche 1 Winter Funding	0.457	0.457	0.456	1.370	-	-		-
Total inc CIP	**(0.343)**	**(0.171)**	**(0.222)**	**(4.655)**	**0.002**	**(0.729)**	**(0.361)**	**(1.088)**

- There was a reduction in the monthly adverse non pay position in June with an adverse variance of £0.361m, predominantly within clinical supplies and services.
- Non-recurrent funding to support delivery of operating plans (£0.086m) and to cover the cost of the BHOC fire to date (£0.038m) plus Divisional reserves being released to the position are the main drivers for this improvement in variance.
- Of the £1.088m cumulative overspend, 65% relates to drugs and clinical supplies expenditure. Some of this reflects higher than planned activity levels and will in part be offset by income. However improved controls, including through the introduction of the managed inventory system within theatres, continues to be key. Surgery non pay overspend is £0.819m of which £0.306m is within drugs and clinical supplies.
- Services from other bodies continues to overspend with the main areas of adverse variance being Diagnostics and Therapies, £0.112m year to date and Women's and Children's £0.123m year to date.
- Further analysis on the clinical supplies and services is required.
- Blood inflation of £0.200m for the year was issued in June, hence the variance moved to a favourable position in month.

Section 4 – Clinical and Contract Income

Contract income by work type: (further detail at agenda item 2.2)

	In month variance Fav/(Adv) £m	Year to Date Plan £m	Year to Date Actual £m	Year to Date Variance Fav/(Adv) £m
Activity Based:				
Accident & Emergency	0.059	4.647	4.881	0.234
Bone Marrow Transplants	0.262	1.975	2.124	0.149
Critical Care Beddays	0.341	10.939	11.261	0.322
Day Cases	0.039	9.817	9.992	0.175
Elective Inpatients	0.416	14.129	14.578	0.449
Emergency Inpatients	(0.306)	23.631	24.624	0.994
Excess Beddays	(0.199)	1.374	1.307	(0.067)
Non-Elective Inpatients	(0.038)	8.019	7.600	(0.420)
Other	(0.261)	23.248	23.040	(0.209)
Outpatients	(0.011)	20.067	20.536	0.469
Total Activity Based	**0.301**	**117.846**	**119.942**	**2.096**
Contract Penalties	0.346	(0.536)	(0.629)	(0.093)
Contract Rewards	(0.013)	2.469	2.468	(0.001)
Pass through payments	(0.721)	23.420	21.501	(1.919)
Prior Year Income	0.083	-	0.083	0.083
S&T Funding	-	2.322	2.322	-
2018/19 Total	**(0.004)**	**145.521**	**145.686**	**0.165**

- The 2017/18 income has now been finalised and results in an additional £0.332m being invoiced to Commissioners. This is now being reported with three twelfths shown above.

- Outstanding debts / disputes with Commissioners have also been settled reducing the level of risk in 2018/19 from previous year's income receipts.

- Activity based income was £0.301m favourable in June, resulting in a £2.096m favourable position year to date.

- Urgent care income to date is £1.228m above plan of which A&E is £0.234m above plan (£0.134m is adult and £0.100m paediatric). Emergency inpatients is £0.994m above plan of which £0.431m is within cardiac and £0.607m within surgery.

- Critical care activity was higher than plan in June for both adult and paediatric high dependency units. To date cardiac is broadly on plan, paediatric is above plan by £0.089m and adult is above plan by £0.221m.

- Bone Marrow Transplants were above plan by £0.262m. The adult service improved by £0.156m in June and is now broadly on plan, the paediatric service is £0.120m ahead of plan to date.

- Outpatients is £0.469m above plan to date over several specialties.

- The Trust has received penalties of £0.629m year to date, £0.093m greater than planned. This includes cancelled operations (£0.040m), marginal rate emergency tariff rebate (£0.430m) and avoidable emergency re-admissions (£0.120m).

- CQUIN reporting continues to be reported in line with plan. CQUIN contracts are being finalised and performance will be reported next month.

- Income relating to pass through payments was £0.721m below plan in June, taking the cumulative variance to £1.919m adverse, of this £1.175m relates to excluded drugs, predominately Hepatology and £0.361m excluded devices.

Section 5 – Savings Programme

Analysis by work streams: (further detail at agenda item 2.4)

	2018/19 Annual Plan £m	Year to date		
		Plan £m	Actual £m	Variance fav/(adv) £m
AHP productivity	0.779	0.195	0.199	0.005
Diagnostic Testing	0.156	0.000	0.000	-
Estates & Facilities	0.746	0.230	0.221	(0.009)
Healthcare Scientists Productivity	0.120	0.034	0.034	0.001
Income, Fines, External	2.290	0.500	0.429	(0.071)
Medical Pay	0.625	0.070	0.067	(0.003)
Medicines	0.751	0.181	0.131	(0.049)
Nursing Pay	1.061	0.250	0.201	(0.049)
Other / Corporate	7.874	1.969	1.969	-
Productivity	3.267	0.592	0.573	(0.019)
Non-Pay	5.020	1.140	1.184	0.044
HR Pay and Productivity	0.097	0.025	0.025	-
Trust Services	0.653	0.164	0.161	(0.003)
Blood	0.046	0.008	0.004	(0.004)
Support funding	1.936	0.194	0.194	-
Unidentified	0.055	0.014	-	(0.014)
Total	**25.474**	**5.565**	**5.393**	**(0.172)**

Analysis by Division:

	2018/19 Annual Plan £m	Year to date			Year end
		Plan £m	Actual £m	Variance fav/(adv) £m	FOT £m
Diagnostics & Therapies	1.934	0.376	0.426	0.050	1.991
Medicine	2.858	0.723	0.479	(0.243)	2.312
Specialised Services	2.727	0.537	0.623	0.086	2.829
Surgery	3.521	0.697	0.719	0.022	4.025
Women's & Children's	4.869	0.805	0.725	(0.081)	4.888
Facilities &Estates	0.976	0.267	0.270	0.003	0.977
Finance	0.186	0.049	0.047	(0.002)	0.186
Human Resources	0.126	0.032	0.034	0.002	0.126
IM&T	0.201	0.054	0.050	(0.004)	0.201
Trust HQ	0.203	0.057	0.052	(0.006)	0.205
Corporate	7.874	1.969	1.969	-	7.874
Total	**25.474**	**5.565**	**5.393**	**(0.172)**	**25.614**

- The savings requirement for 2018/19 is £25.474m. The Trust has achieved savings of £5.393m against a plan of £5.565m. This includes the Divisional support funding of £1.936m which has been allocated over the ten months June to March.
- Medicine is £0.243m behind plan. This is primarily due to productivity gains not yet realised and savings yet to be identified. The Division's current forecast is an underachievement of £0.546m at year end.
- Women's and Children's is £0.081m behind plan of which £0.042m is within nursing pay, and £0.031m income. Whilst delivery of income is improving the control of nursing pay is challenging and key to achieving the forecast year end savings.
- The Trust is forecast to make savings of £25.614m by year end. With the exception of Medicine, all Divisions are forecasting to meet their target. Surgery is expected to exceed their target by £0.504m.

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		24.3	25.7
Metric Rating	20%	1	1
Capital servicing capacity			
Metric Result – times		1.89	1.90
Metric Rating	20%	2	2
Income & expenditure margin			
Metric Result		1.30%	1.30%
Metric Rating	20%	1	1
Distance from financial plan			
Metric Result		0.0%	0.0%
Metric Rating	20%	1	1
Variance from agency ceiling			
Metric Result		56.07%	40.23%
Metric Rating	20%	1	1
Overall URR (unrounded)		**1**	**1.2**
Overall URR (rounded)		**1**	**1**
Overall URR (subject to override)		**1**	**1**

- The Trust's Use of Resources Rating for the period to 30th June 2018 is 1 against a plan of 1.

- The Trust is reporting a favourable variance against the control total of £0.010m. The Trust has assumed full achievement of quarter one ED performance. The year to date Provider Sustainability Funding (PSF) assumed for ED performance is £0.697m and Core PSF assumed is £1.625m.

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		
		Internal Plan £m	Actual £m	Variance £m
	Sources of Funding			
1.600	PDC	-	-	-
3.189	Loan	-	-	-
3.000	Donations	0.451	0.198	(0.253)
	Cash:			
24.338	Depreciation	5.925	5.884	(0.041)
14.962	Cash Balances	(2.311)	(2.323)	(0.012)
47.089	**Total Funding**	**4.065**	**3.759**	**(0.306)**
	Application/Expenditure			
(11.618)	Strategic Schemes	(0.273)	(0.071)	0.202
(17.620)	Medical Equipment	(1.234)	(1.179)	0.055
(16.415)	Operational Capital	(1.396)	(0.834)	0.562
(7.468)	Information Technology	(0.780)	(1.374)	(0.594)
(2.367)	Estates Replacement	(0.382)	(0.301)	0.081
(55.488)	**Gross Expenditure**	**(4.065)**	**(3.759)**	**0.306**
8.399	In-year Slippage			
(47.089)	**Net Expenditure**	**(4.065)**	**(3.759)**	**0.306**

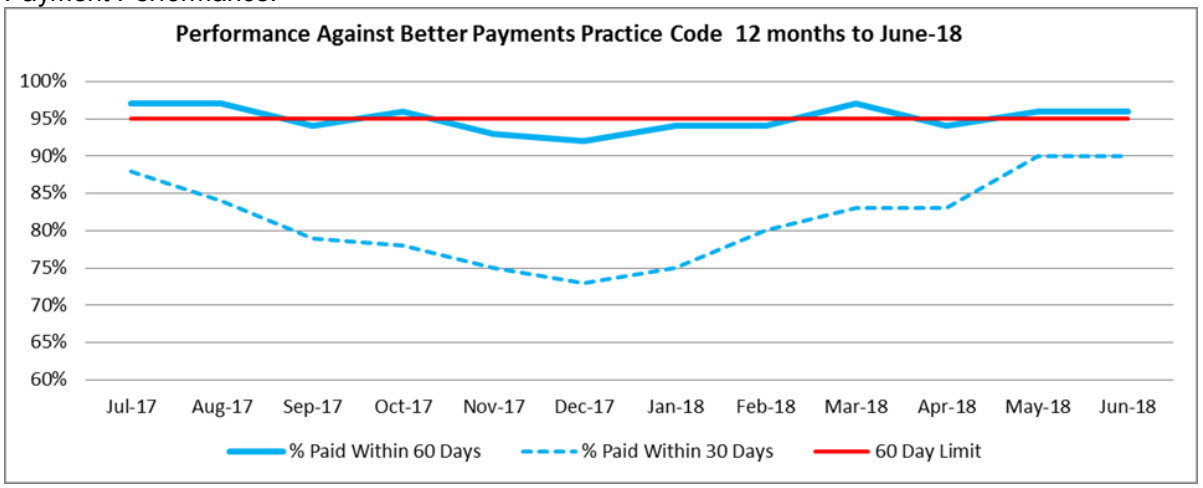
- A full forecast spend will be prepared for the Quarter 2 (month 6) report which is submitted to NHS Improvement. The reason being that the programme is not yet fully established hence reliable year end forecasts are not yet possible.
- The Trust has developed a detailed internal profiled plan which reflects expenditure monthly profiles provided through the Trust Capital Group.
- Capital expenditure was £3.759m to the end of June against an internal plan of £4.065m, £0.306m behind plan.
- Donated income will be received as the specific schemes being funded are completed.
- The key variances are Strategic Schemes and Operational Capital which are behind plan by £0.202m and £0.562m respectively and Information Technology which is ahead of plan by £0.594m.
- The Strategic Schemes slippage reflects timing delays on feasibility fees for Phase 5 schemes.
- The Operational Capital slippage reflects timing delays on active schemes.
- The Cyber Security scheme is reporting expenditure of £0.398m ahead of profile. Unfunded VAT is causing a variance of £0.265m compared to plan. The Capital Programme Finance Manager is meeting with the Trust's VAT advisors to confirm the VAT recovery position on IT schemes.

Section 8 – Statement of Financial Position and Cashflow

Statement of Financial Position: (further information is at agenda item 4.1)

	Plan as at 30 June £m	Actual as at 30 June £m	Variance £m
Inventories	12.590	12.704	0.114
Receivables	25.153	41.730	16.577
Accrued Income	26.130	14.232	(11.898)
Debt Provision	(10.112)	(6.004)	4.108
Cash	79.508	75.537	(3.971)
Other assets	3.523	5.135	1.612
Total Current Assets	136.792	143.334	6.542
Payables	(40.311)	(32.570)	7.741
Accruals	(23.822)	(36.935)	(13.113)
Borrowings	(6.170)	(6.167)	0.003
Deferred Income	(6.481)	(4.621)	1.860
Other Liabilities	(5.210)	(5.218)	(0.008)
Total Current Liabilities	(81.994)	(85.511)	(3.517)
Net Current Assets/(Liabilities)	**54.798**	**57.823**	**3.025**

Payment Performance:



- Net current assets as at 30 June 2018 were £57.823m, £3.025m higher than the Operational Plan. Current assets and liabilities are higher than plan by £6.542m and £3.517m respectively.
- Inventories were £12.704m, slightly higher than plan but lower than last month as expected reflecting the use of cath lab stocks.
- Receivables are £16.577m higher than plan. Invoices have been raised for quarter 4 activity which is reflected in the accrued income variance and the quarter 4 STF invoice for £7.334m was not paid until the start of July.
- The Trust's cash and cash equivalents balance at 30 June 2018 was £75.537m. This is £3.971m lower than the Operating Plan resulting from the net effect of higher than planned receivables balance, slippage on the capital programme and higher opening balance.
- The total value of debtors was £39.075m (£29.099m SLA and £9.976m non-SLA). This represents an increase in the month of £5.053m (£4.763m SLA increase and £0.290m non-SLA increase). Debts over 60 days old have decreased by £18.785m (£19.308m SLA decrease and £0.523 non-SLA increase) to £8.165m (£2.587m SLA and £5.578m non-SLA). The SLA estimate invoices for 2017/18 raised in March have now been credited and re-issued with actual activity. Non-SLA aged debt increase reflects the lack of progress with NBT.
- In June, 96% of invoices were paid within the 60 day target set by the Prompt Payments Code and 90% were paid within the 30 day target set by the Better Payment Practice Code. Both levels were sustained for two consecutive months.

Section 9 – Risk

There are 4 financial risks on the corporate risk register (see appendix 4). The following summarises the current risk assessment and any changes following internal finance review and consideration at Risk Management Group.

Action required risks:

Risk 416 – Delivery of Trust's Financial Strategy. Current risk – Moderate (6)
This reflects the current assessment of the national environment, local health economy and delivery of the Trust's 2018/19 Operational Plan. Agenda item 6.2 provides further information in mitigating this risk.

Risk 951 – Loss of Provider Sustainability Funding (PSF). Current risk - Very high (15)
The Trust is forecasting achievement of Core PSF through delivery of the financial control total but is expecting to lose Performance PSF for non-delivery of the ED trajectory in the last quarter. This risk will be split between the core and performance elements to better assess each element and describe the different actions required to mitigate each risk. Risk 416 is not increased through the loss of Performance PSF as the Trust's Financial Strategy does not rely upon it.

Risk 959 – Failure to deliver Operational Plan through non-delivery of savings. Current risk – High (12)
The Trust is forecasting to deliver a savings of £25.6m against a target of £25.5m. However this forecast includes a Medicine shortfall of £0.546m and a Surgery over delivery of £0.504m and the Trust's total year to date delivery is £0.172m behind plan. The current risk assessment reflects this position. Risk 416 is not increased by this as it is expected that recovery plans and non-recurring corporate savings will deliver the 2018/19 Operational Plan at this stage.

Risk 1843 – Failure to deliver the Operating Plan Control Total. Current risk – High (9)
The level of risk is driven by the likelihood assessment of possible which was described before the quarter one results were known. At Q1 the Trust has met its control total and is expecting to deliver the year end control total. However Surgery and Medicine are adverse to their operating plan trajectories and Medicine's Operating Plan has yet to be signed off.

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Appendix 1

UNIVERSITY HOSPITALS BRISTOL NHS FOUNDATION TRUST

Finance Report June 2018- Summary Income & Expenditure Statement

Approved Budget / Plan 2018/19	Heading	Position as at 31st May			Actual to 31st May
		Plan	Actual	Variance Fav / (Adv)	
£'000		£'000	£'000	£'000	£'000
	Income				
577,411	From Activities	141,846	144,002	2,156	96,593
93,236	Other Operating Income (excluding Provider Sustainability Funding)	24,474	24,454	(20)	15,883
670,647	**Sub totals income**	166,320	168,456	2,136	112,476
	Expenditure				
(385,086)	Staffing	(100,992)	(102,712)	(1,720)	(66,699)
(240,874)	Supplies and Services	(56,210)	(57,039)	(829)	(39,943)
(625,960)	**Sub totals expenditure**	(157,202)	(159,751)	(2,549)	(106,642)
(6,095)	Reserves	(371)	-	371	-
-	NHS Improvement Plan Profile		-	-	-
38,592	Earnings before Interest,Tax,Depreciation and Amortisation	8,747	8,705	(42)	5,834
5.75	**EBITDA Margin - %**		5.17		5.19
	Financing				
(23,703)	Depreciation & Amortisation - Owned	(5,926)	(5,884)	42	(3,946)
244	Interest Receivable	61	90	29	57
(242)	Interest Payable on Leases	(60)	(61)	(1)	(40)
(2,507)	Interest Payable on Loans	(627)	(645)	(18)	(434)
(9,384)	PDC Dividend	(2,346)	(2,346)	-	(1,564)
(35,592)	**Sub totals financing**	(8,898)	(8,846)	52	(5,927)
3,000	NET SURPLUS / (DEFICIT) before Technical Items excluding Provider Sustainability Funding	(151)	(141)	10	(93)
4,644	Provider Sustainability Funding - Performance	697	697	-	464
10,836	Provider Sustainability Funding - Core	1,625	1,625	-	1,084
18,480	SURPLUS / (DEFICIT) before Technical Items including Provider Sustainability Funding	2,171	2,181	10	1,455
	Technical Items				
3,000	Donations & Grants (PPE/Intangible Assets)	202	198	(4)	24
629	Impairments	-	-	-	-
-	Reversal of Impairments	-	-	-	-
(1,519)	Depreciation & Amortisation - Donated	(380)	(391)	(11)	(264)
20,590	SURPLUS / (DEFICIT) after Technical Items including Provider Sustainability Funding	1,993	1,988	(5)	1,215

Appendix 2

Approved Budget / Plan 2018/19	Division	Total Budget to Date	Total Net Expenditure / Income to Date	Variance [Favourable / (Adverse)]				Total Variance to date	Total Variance 31st May	Operating Plan Trajectory Year to Date	Variance from Operating Plan Year to Date	CIP Variance
				Pay	Non Pay	Operating Income	Income from Activities					
£'000		£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
	Corporate Income (excluding Provider Sustainability Funding)											
577,906	Contract Income	143,199	143,199	-	-	-	-	-	-			
-	Penalties	-	-	-	-	-	(14)	(14)	(385)			
-	Contract Rewards	-	-	-	-	-	(1)	(1)	12			
3,500	Overhead share of income variance	3,500	3,659	-	257	-	(83)	174	439			
36,057	NHSE Income	9,014	9,014	-	-	-	-	-	-			
617,463	**Sub Total Corporate Income**	**155,713**	**155,872**	**-**	**257**	**-**	**(98)**	**159**	**66**			
	Clinical Divisions											
(55,767)	Diagnostic & Therapies	(13,872)	(13,717)	154	(142)	(27)	171	156	71	59	97	(57)
(85,897)	Medicine	(21,435)	(21,884)	(583)	(185)	(8)	327	(449)	(145)	(203)	(246)	(236)
(113,996)	Specialised Services	(28,137)	(27,801)	24	(73)	11	373	335	65	(182)	517	(59)
(110,364)	Surgery	(27,679)	(28,330)	(491)	(819)	(1)	660	(651)	(191)	(169)	(482)	(161)
(127,251)	Women's & Children's	(31,722)	(31,801)	(995)	266	81	570	(78)	(332)	(391)	313	(492)
(493,275)	**Sub Total - Clinical Divisions**	**(122,845)**	**(123,533)**	**(1,891)**	**(953)**	**56**	**2,101**	**(687)**	**(532)**	**(886)**	**199**	**(1,005)**
	Corporate Services											
(36,987)	Estates and Facilities	(9,518)	(9,535)	40	(60)	(15)	17	(18)	(6)	23	(41)	26
(26,656)	Trust Services	(6,623)	(6,641)	113	(118)	(13)	-	(18)	(10)	-	(18)	3
(15,858)	Other	(7,609)	(7,458)	18	43	(55)	145	151	127	-	151	-
(79,501)	**Sub Totals - Corporate Services**	**(23,750)**	**(23,634)**	**171**	**(135)**	**(83)**	**162**	**115**	**111**	**23**	**92**	**29**
(572,776)	**Sub Total (Clinical Divisions & Corporate Services)**	**(146,595)**	**(147,167)**	**(1,720)**	**(1,088)**	**(27)**	**2,263**	**(572)**	**(421)**	**(863)**	**291**	**(976)**
(6,095)	Reserves	(371)	-	-	371	-	-	371	343			
-	NHS Improvement Plan Profile	-	-	-	-	-	-	-	-			
(6,095)	**Sub Total Reserves**	**(371)**	-	-	371	-	-	371	343			
38,592	**Earnings before Interest,Tax,Depreciation and Amortisation**	**8,747**	**8,705**	**(1,720)**	**(459)**	**(27)**	**2,165**	**(42)**	**(12)**			
	Financing											
(23,703)	Depreciation & Amortisation - Owned	(5,926)	(5,884)	-	42	-	-	42	5			
244	Interest Receivable	61	90	-	29	-	-	29	16			
(242)	Interest Payable on Leases	(60)	(61)	-	(1)	-	-	(1)	-			
(2,507)	Interest Payable on Loans	(627)	(645)	-	(18)	-	-	(18)	-			
(9,384)	PDC Dividend	(2,346)	(2,346)	-	-	-	-	-	-			
(35,592)	**Sub Total Financing**	**(8,898)**	**(8,846)**	-	**52**	**-**	**-**	**52**	**21**			
3,000	**NET SURPLUS / (DEFICIT) before Technical Items excluding Provider Sustainability Funding**	**(151)**	**(141)**	**(1,720)**	**(408)**	**(27)**	**2,165**	**10**	**9**			
4,644	Provider Sustainability Funding - Performance	697	697									
10,836	Provider Sustainability Funding - Core	1,625	1,625									
15,480	**Sub Total Provider Sustainability Funding**	**2,322**	**2,322**									
18,480	**SURPLUS / (DEFICIT) before Technical Items including Provider Sustainability Funding**	**2,171**	**2,181**	**(1,720)**	**(408)**	**(27)**	**2,165**	**10**	**9**			
	Technical Items											
3,000	Donations & Grants (PPE/Intangible Assets)	202	198	-	-	(4)	-	(4)	(76)			
629	Impairments	-	-	-	-	-	-	-	-			
-	Reversal of Impairments	-	-	-	-	-	-	-	-			
(1,519)	Depreciation & Amortisation - Donated	(380)	(391)	-	(11)	-	-	(11)	(16)			
2,110	**Sub Total Technical Items**	**(178)**	**(193)**	-	**(11)**	**(4)**	-	**(15)**	**(92)**			
20,590	**SURPLUS / (DEFICIT) after Technical Items including Provider Sustainability Funding**	**1,993**	**1,988**	**(1,720)**	**(419)**	**(31)**	**2,165**	**(5)**	**(83)**			

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*	*3.1%*	*3.1%*	*3.1%*	*4.3%*	*4.3%*	*4.3%*	*3.9%*	*3.9%*	*3.9%*	*3.8%*	*3.8%*	*3.8%*
Medicine	Actual	3.2%	2.1%	4.5%									
Specialised Services	*Target*	*3.6%*	*3.6%*	*3.6%*	*3.5%*	*3.5%*	*3.5%*	*3.8%*	*3.8%*	*3.8%*	*3.9%*	*3.9%*	*3.9%*
Specialised Services	Actual	2.2%	2.3%	2.3%									
Surgery, Head & Neck	*Target*	*3.8%*	*3.8%*	*3.8%*	*3.8%*	*3.8%*	*3.8%*	*3.8%*	*3.8%*	*3.8%*	*3.8%*	*3.8%*	*3.8%*
Surgery, Head & Neck	Actual	3.3%	3.1%	4.5%									
Women's & Children's	*Target*	*4.0%*	*4.0%*	*4.0%*	*4.1%*	*4.1%*	*4.1%*	*4.6%*	*4.6%*	*4.6%*	*4.4%*	*4.4%*	*4.4%*
Women's & Children's	Actual	4.5%	4.2%	4.1%									

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	7.9%	7.7%	9.1%									
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	9.0%	10.1%	9.5%									
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	7.9%	8.2%	7.0%									
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	2.2%	3.8%	5.0%									

Source: HR

Graph 3 **Turnover**

Division	Target/Actual	M1	M2	M3	M4	M5	M6	M7	M8	M9	M10	M11	M12
Medicine	*Target*	*14.0%*	*14.0%*	*14.0%*	*14.0%*	*14.0%*	*14.0%*	*14.0%*	*14.0%*	*14.0%*	*14.0%*	*14.0%*	*14.0%*
Medicine	Actual	14.8%	15.5%	16.5%									
Specialised Services	*Target*	*13.5%*	*13.5%*	*13.5%*	*13.5%*	*13.5%*	*13.5%*	*13.5%*	*13.5%*	*13.5%*	*13.5%*	*13.5%*	*13.5%*
Specialised Services	Actual	17.8%	17.4%	16.2%									
Surgery, Head & Neck	*Target*	*11.8%*	*11.8%*	*11.8%*	*11.8%*	*11.8%*	*11.8%*	*11.8%*	*11.8%*	*11.8%*	*11.8%*	*11.8%*	*11.8%*
Surgery, Head & Neck	Actual	16.2%	16.6%	16.5%									
Women's & Children's	*Target*	*10.1%*	*10.1%*	*10.1%*	*10.1%*	*10.1%*	*10.1%*	*10.1%*	*10.1%*	*10.1%*	*10.1%*	*10.1%*	*10.1%*
Women's & Children's	Actual	12.9%	13.2%	13.4%									

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*	*135.2*	*113.8*	*113.8*	*95.2*	*95.2*	*95.2*	*95.2*	*113.8*	*135.2*	*135.2*	*128.0*	*113.8*
Medicine	Actual	118.0	121.6	134.8									
Specialised Services	*Target*	*50.8*	*50.8*	*50.8*	*50.8*	*50.8*	*50.8*	*36.3*	*36.3*	*36.3*	*36.3*	*36.3*	*36.3*
Specialised Services	Actual	43.0	23.4	55.4									
Surgery, Head & Neck	*Target*	*49.7*	*54.6*	*49.7*	*54.6*	*49.7*	*39.7*	*39.7*	*39.7*	*29.8*	*39.7*	*39.7*	*39.7*
Surgery, Head & Neck	Actual	90.2	104.0	82.4									
Women's & Children's	*Target*	*90.7*	*90.7*	*90.7*	*82.5*	*82.5*	*82.5*	*66.0*	*66.0*	*33.0*	*74.2*	*41.2*	*49.5*
Women's & Children's	Actual	186.4	173.6	226.1									
Trust Total	*Target*	326.4	309.9	305.0	283.2	278.2	268.3	237.2	255.8	234.3	285.5	245.3	239.3
Trust Total	Actual	437.6	422.6	498.7	-	-	-	-	-	-	-	-	-

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*	*24.6*	*21.8*	*21.8*	*19.0*	*19.0*	*19.0*	*19.0*	*21.8*	*24.6*	*24.6*	*24.6*	*21.8*
Medicine	Actual	20.1	19.1	20.7									
Specialised Services	*Target*	*5.0*	*5.0*	*5.0*	*5.0*	*5.0*	*5.0*	*3.5*	*3.5*	*3.5*	*3.5*	*2.0*	*2.0*
Specialised Services	Actual	6.5	3.2	6.9									
Surgery, Head & Neck	*Target*	*10.0*	*11.0*	*10.0*	*11.0*	*10.0*	*8.0*	*8.0*	*8.0*	*6.0*	*8.0*	*8.0*	*8.0*
Surgery, Head & Neck	Actual	10.1	14.5	11.6									
Women's & Children's	*Target*	*11.0*	*11.0*	*11.0*	*10.0*	*10.0*	*10.0*	*8.0*	*8.0*	*3.0*	*9.0*	*5.0*	*6.0*
Women's & Children's	Actual	22.9	22.0	25.6									
Trust Total	*Target*	50.6	48.8	47.8	45.0	44.0	42.0	38.5	41.3	37.1	45.1	39.6	37.8
Trust Total	Actual	59.6	58.8	64.8	-	-	-	-	-	-	-	-	-

Source: Finance GL (excludes NA 1:1)

Graph 6 **Operating plan for nursing agency as a % of total staffing**

Division	Target/Actual	M1	M2	M3	M4	M5	M6	M7	M8	M9	M10	M11	M12
Medicine	*Target*	*7.4%*	*6.3%*	*6.3%*	*5.3%*	*5.3%*	*5.3%*	*5.3%*	*6.2%*	*7.3%*	*7.3%*	*7.0%*	*6.2%*
Medicine	Actual	6.3%	6.5%	7.2%									
Specialised Services	*Target*	*3.6%*	*3.6%*	*3.6%*	*3.6%*	*3.6%*	*3.6%*	*2.5%*	*2.5%*	*2.5%*	*2.5%*	*2.5%*	*2.5%*
Specialised Services	Actual	3.1%	1.6%	3.8%									
Surgery, Head & Neck	*Target*	*2.4%*	*2.7%*	*2.4%*	*2.7%*	*2.4%*	*2.0%*	*1.9%*	*1.9%*	*1.5%*	*1.9%*	*1.9%*	*1.9%*
Surgery, Head & Neck	Actual	5.0%	5.6%	4.4%									
Women's & Children's	*Target*	*2.5%*	*2.5%*	*2.5%*	*2.3%*	*2.3%*	*2.3%*	*1.8%*	*1.8%*	*0.9%*	*2.0%*	*1.1%*	*1.4%*
Women's & Children's	Actual	5.2%	4.8%	6.2%									
Trust Total	Actual	5.0%	4.8%	5.6%									

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	9,172	8,954	8,869									
Specialised Services	Actual	4,580	4,135	4,425									
Surgery, Head & Neck	Actual	4,493	4,456	4,144									
Women's & Children's	Actual	6,647	6,536	6,318									
Trust Total	Actual	24,892	24,081	23,756	-	-	-	-	-	-	-	-	

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	66	69	120									
Specialised Services	*Target*	*20*	*20*	*20*	*20*	*20*	*20*	*20*	*20*	*20*	*20*	*20*	*20*
Specialised Services	Actual	29	19	26									
Surgery, Head & Neck	*Target*	*43*	*43*	*43*	*43*	*43*	*43*	*43*	*43*	*43*	*43*	*43*	*43*
Surgery, Head & Neck	Actual	40	69	21									
Women's & Children's	*Target*	*12*	*12*	*12*	*12*	*12*	*12*	*12*	*12*	*12*	*12*	*12*	*12*
Women's & Children's	Actual	11	19	32									
Trust Total	*Target*	119.6	119.6	119.6	119.6	119.6	119.6	119.6	119.6	119.6	119.6	119.6	119.6
Trust Total	Actual	145.6	176.0	199.000	-	-	-	-	-	-	-	-	-

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*	83	167	250	339	420	495	580	665	773	852	959	1,061
Trust Total	Actual	51	80	70									

Source: Service Improvement Team - Amy

NURSING ASSISTANTS (UNREGISTERED) - 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*	*7.1%*	*7.1%*	*7.1%*	*7.9%*	*7.9%*	*7.9%*	*6.1%*	*6.1%*	*6.1%*	*5.9%*	*5.9%*	*5.9%*
Medicine	Actual	6.1%	5.5%	3.8%									
Specialised Services	*Target*	*6.3%*	*6.3%*	*6.3%*	*5.8%*	*5.8%*	*5.8%*	*7.6%*	*7.6%*	*7.6%*	*6.3%*	*6.3%*	*6.3%*
Specialised Services	Actual	3.9%	2.9%	8.1%									
Surgery, Head & Neck	*Target*	*4.0%*	*4.0%*	*4.0%*	*4.0%*	*4.0%*	*4.0%*	*4.0%*	*4.0%*	*4.0%*	*4.0%*	*4.0%*	*4.0%*
Surgery, Head & Neck	Actual	5.9%	4.7%	3.8%									
Women's & Children's	*Target*	*6.0%*	*6.0%*	*6.0%*	*7.0%*	*7.0%*	*7.0%*	*7.0%*	*7.0%*	*7.0%*	*6.0%*	*6.0%*	*6.0%*
Women's & Children's	Actual	9.1%	8.5%	9.2%									

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	12.5%	11.9%	9.7%									
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	10.4%	10.9%	11.0%									
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	9.1%	10.4%	9.7%									
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	3.0%	2.6%	4.3%									

Source: HR

Graph 3 **Turnover**

Division	Target/Actual	M1	M2	M3	M4	M5	M6	M7	M8	M9	M10	M11	M12
Medicine	*Target*	*18.5%*	*18.5%*	*18.5%*	*18.5%*	*18.5%*	*18.5%*	*18.5%*	*18.5%*	*18.5%*	*18.5%*	*18.5%*	*18.5%*
Medicine	Actual	20.3%	19.2%	14.8%									
Specialised Services	*Target*	*17.0%*	*17.0%*	*17.0%*	*17.0%*	*17.0%*	*17.0%*	*17.0%*	*17.0%*	*17.0%*	*17.0%*	*17.0%*	*17.0%*
Specialised Services	Actual	20.3%	17.7%	19.2%									
Surgery, Head & Neck	*Target*	*16.9%*	*16.9%*	*16.9%*	*16.9%*	*16.9%*	*16.9%*	*16.9%*	*16.9%*	*16.9%*	*16.9%*	*16.9%*	*16.9%*
Surgery, Head & Neck	Actual	16.2%	15.4%	14.8%									
Women's & Children's	*Target*	*12.1%*	*12.1%*	*12.1%*	*12.1%*	*12.1%*	*12.1%*	*12.1%*	*12.1%*	*12.1%*	*12.1%*	*12.1%*	*12.1%*
Women's & Children's	Actual	15.1%	15.0%	15.0%									

ID	Risk Type	Risk Subtype	Title	Description	Consequence (inherent)	Likelihood (inherent)	Rating (inherent)	Risk level (inherent)	Controls in place	Adequacy of controls	Consequence (current)	Likelihood (current)	Rating (current)	Risk level (current)	Synopsis	Due date	Done date	Consequence (Target)	Likelihood (Target)	Rating (Target)	Risk level (Target)	Review date	Approval status
416	Corporate	Financial	Risk that the Trust's Financial Strategy may not be deliverable	If government policy changes affect the NHS and social care funding, Then the Trust may not be able to identify required levels of savings, Resulting in a deficit and inability to invest in strategic capital programmes.	Catastrophic	Likely	20	Very High Risk	Continue to input into national policy to influence the NHS financial environment. Continue to perform at top quartile levels to ensure that the Trust remains viable financially. Maintenance of long term financial model and in year monitoring on financial performance through monthly Divisional operating review, Finance Committee and Trust Board.	Inadequate	Moderate	Unlikely	6	Moderate Risk	Executive sign off of the Division's 2018/19 Operating Plans with clear actions to delivery balanced financial positions in 2018/19. Quarterly review with mitigating actions identified.	31/03/2019		Minor	Unlikely	4	Moderate Risk	07/09/2018	Action Required Risks
															Refresh of medium term financial plan including capital refresh, due to the July Board	27/07/2018							
															Ensure SLAs deliver sufficient income to cover costs within planning for 2019/20 and in year variations.	31/03/2019							
															Deliver productivity improvements - review at six months and Q3.	30/09/2018							
951	Corporate	Financial	Risk of the loss of Provider Sustainability Funding (PSF)	Risk of the loss of £10.836m core PSF due to the failure to achieve the Trust's Operational Plan Core Control Total and £4.644m of performance PSF due to failure to deliver ED 4 hour wait trajectories.	Major	Almost certain	20	Very High Risk	Divisional Operating Plans have been reviewed and signed off with the exception of Medicine. Divisions will be held to account to ensure delivery of their signed-off and approved Operating Plans through finance and operations monthly meetings and quarterly review. Divisions reporting a position that is adverse to their Operating Plan must deliver mitigating actions to recover their financial run rate back to trajectory. ED performance focus includes 4 hour waits. Additional bed capacity is planned for winter. System wide working is in place.	Inadequate	Moderate	Almost certain	15	Very High Risk	Need to establish and agree the performance trajectories required to attain the performance element of PSF. Understand the risks - accepted and those to be mitigated regarding delivery, and establish plans for delivering.	27/07/2018		Moderate	Possible	9	High Risk	07/09/2018	Action Required Risks
															Review and discussion of May's financial position at the Divisional Finance and Ops meetings in June with agreed actions to recover any overspends, with a due date of end of June	27/07/2018							
															Deliver the Q1 core and performance targets to ensure receipt of Q1 funding	27/07/2018							
959	Corporate	Financial	Risk of failure to deliver the Trust's Operational Plan due to Divisions not achieving their savings target	Divisions and corporate services are required to deliver the savings targets identified in their operating plans. Whilst non-recurring savings can be used to balance the current year target, recurring savings are required to be identified. Failure to achieve the current year savings target risks the Trust's ability to deliver its Operational Plan (links to risk 1843)	Major	Likely	16	Very High Risk	•Risk assessment of all savings plans with only those assessed as deliverable being included in forecast plans •Monthly review of Divisional savings plans and delivery through finance and ops reviews and the Trust's Savings Board •Productivity review led by COO •Focus on Carter model hospital and other benchmarking and national initiatives •Support from transformation for challenged areas •Monthly financial reporting of tracked savings including recurring/non-recurring •Focus on savings pipelines •Corporate assessment of in-year non-recurrent measures to mitigate risk	Inadequate	Moderate	Likely	12	High Risk	Divisions, Corporate and Transformation teams working to ensure the delivery of the planned savings schemes completed in line with the expected timelines.	31/03/2019		Minor	Unlikely	4	Moderate Risk	07/09/2018	Action Required Risks
															Divisions to reduce the level of unidentified savings within their plans	31/07/2018							
															Explore options for realising savings through the revaluation of Trust assets - working with professional valuers and auditors	30/09/2018							
															Review of productivity opportunities at divisional level and Trust wide transformation to improve efficiencies and deliver savings	30/09/2018							
															Quarterly review within finance SMT to assess corporate non recurring savings	27/07/2018							
1843	Corporate	Financial	Risk of failure to achieve the Trust's Operational Plan Control Total	Failure to deliver the Trust's 2018/19 Operational Plan Control Total excluding Provider Sustainability Funding (PSF) of £3.000m surplus due to a deterioration in the Divisional run rate and failure to deliver Divisional operating plans.	Major	Almost certain	20	Very High Risk	Divisional Operating Plans have been reviewed and signed off, with the exception of Medicine. Divisions will be held to account to ensure delivery of their signed-off and approved Operating Plans through finance and operational monthly meetings and quarterly reviews. Divisions reporting a position that is adverse to their Operating Plan must deliver mitigating actions to recover their financial run rate back to trajectory.	Inadequate	Moderate	Possible	9	High Risk	Review and discussion of May's financial position at the Divisional Finance and Ops meetings in June with agreed actions to recover any overspends, with a due date of end of June	27/07/2018		Moderate	Unlikely	6	Moderate Risk	07/09/2018	Action Required Risks
															Delivery of the Division's operating plans at quarter one,	27/07/2018							
															Agree and sign off Medicine's Operating Plan	31/07/2018							

Cover report to the PublicTrust Board. Meeting to be held on 27 July 2018 at 11.00 – 13.00, Conference Room, Trust HQ, Marlborough St, Bristol, BS1 3NU

		Agenda Item	19
Meeting Title	Public Trust Board	**Meeting Date**	Friday, 27 July 2018
Report Title	**Capital Investment Policy**		
Author	Kate Parraman, Deputy Director of Finance		
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 Capital Investment Policy is subject to an annual review. The policy has been reviewed by the Capital Programme Steering Group and Finance Committee prior to approval by Trust Board. <u>Key issues to note</u> The policy has been amended to reflect: • Changes to the Trust Policy template • Financial thresholds in line with the 2018/19 plan • Non-financial criteria following feedback from the prior year process
Recommendations

Members are asked to:

- **Approve the updated Capital Investment Policy.**

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
None

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

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

Capital Investment Policy

Introduction

The Capital Investment Policy is subject to annual review by the Trust Board. The current version was considered and approved by the Board in May 2017.

The Capital Investment Policy has been reviewed by the Capital Programme Steering Group and the Finance Committee.

The outcome of the review is that the following changes to the Policy are proposed.

Revisions to the Policy

A revised Capital Investment Policy with track changes is attached as Appendix 1.

- Section 3 Definitions – new section in line with the Trust policy template
- Section 4.1 Finance Committee – delete point (a) as a duplication of (c) and (d)
- Section 6.1 Medium Term Capital Programme – delete point (d) 'Other Equipment' as this isn't a category in the Capital Programme.
- Section 6.2 Identification of Major of High Risk Investments – turnover and major investment limit updated to reflect the 2018/19 plan.
- Section 7 Approval Route – thresholds updated to reflect the 2018/19 plan and a new paragraph included to acknowledge NHS Improvement's Capital Regime.
- Section 8.2 Non Financial Criteria – Major Medical and Operational Capital reported under same heading.
- Section 10 References – new section in line with the Trust policy template
- Section 11 Associated Documentation – new section in line with the Trust policy template
- Section 14 Appendix 3 Operational and Major Medical Capital prioritisation – non financial criteria updated following feedback from prior year process.
- Sections 16-18 - new section in line with the Trust policy template.

Recommendation

The Trust Board is asked to approve the revised Capital Investment Policy.

University Hospitals Bristol
NHS Foundation Trust

Capital Investment Policy

Document Data			
Subject:	Finance		
Document Type:	Policy		
Document Reference	19030		
Document Status:	Approved		
Document Owner:	Director of Strategy and Transformation		
Executive Lead:	Director of Strategy and Transformation		
Approval Authority:	Trust Board of Directors		
Review Cycle:	12		
Date Version Effective From:	01/07/2018	**Date Version Effective To:**	30/06/2018

Introduction

This policy sets out the governance arrangements for capital investments undertaken by the University Hospitals Bristol NHS Foundation Trust (UH Bristol). The policy takes into account NHS Improvement's Single Oversight Framework with effect from 30 September 2016. This policy will be subject to annual review by the Board of Directors.

Document Change Control				
Date of Version	**Version Number**	**Lead for Revisions**	**Type of Revision**	**Description of Revision**
24/06/2008	1		Draft	Draft considered at Trust Board on 1 July
11/05/2015	9	Director of Strategy & Transformation	Minor	Thresholds updated to reflect the Trust's 2015/16 planned turnover of £587m; removal of the reference to NHS Improvement's "Risk Evaluation for Investment Decisions" document; updated Annex 2 to reflect the 2015/16 capital prioritisation process.
12/10/2015	10	Director of Strategy & Transformation	Minor	Additional bullet point included in section 7.1 - 'The cost of the loan principal payments where relevant'
03/05/2017	11	Director of Strategy & Transformation	Minor	Update of section 7.2 to reflect the revised non-financial criteria for prioritisation.
30/06/2018	12	Director of Strategy & Transformation	Minor	Format changes to reflect Trust's standard template. Threshold updated to reflect the Trust's 2018/19 planned turnover of £690m. Update to section 8 to reflect the revised non-financial criteria for prioritisation.

Table of Contents

Do I need to read this Policy?

All staff responsible for requesting, approving, managing, monitoring or reporting capital funds.

Must read the whole policy

1. Purpose

This policy sets out the governance arrangements for capital investments undertaken by the University Hospitals Bristol NHS Foundation Trust (UH Bristol).

The policy takes into account NHS Improvement's Single Oversight Framework (SOF) published 30th September 2016. This policy will be subject to annual review by the Board of Directors.

2. Scope

The policy applies to capital investments by UH Bristol regardless of the source of funding. Charitably funded projects must be prepared and managed therefore in accordance with the policy.

Particular consideration is given to capital investments which impact on the Trust's Use of Resources Rating and are classed as major and / or high-risk accordingly.

The full definition of a major or high-risk investment is given in section 6.2.

3. Definitions

Capital Investment refers to funds invested in the Trust with the understanding it will be used to purchase assets, rather than used to cover operating expenses.

4. Duties, Roles and Responsibilities

4.1 Finance Committee

The Finance Committee will take the role of **capital investment committee** for the purposes of this policy. It will have delegated authority from the Trust Board for:

(a) ~~Approving the investment and borrowing strategy and associated policies~~; (DUPLICATION OF C AND D below)

(b) Setting performance benchmarks and monitoring investment performance;

(c) Reviewing and revising the Capital Investment Policy on an annual basis for Board approval;

(d) Obtaining assurance that there is compliance throughout the Trust with the Capital Investment Policy;

(e) Approving capital investments according to the thresholds outlined in section 6.5 including ensuring that the Trust has the legal authority to enter into a particular investment; and

(f) Approving Project Initiation Documents for all schemes.

4.2 Trust Board of Directors

The Board will provide oversight of the Finance Committee. It will have the final decision over all major schemes (greater than 1% of the Trust's turnover) and high risk investments as defined in this policy.

The Board will approve the Capital Investment Policy on an annual basis.

4.3 Finance Committee

The Finance Committee will have delegated authority to approve business cases with a value greater than 0.5% and up to and including 1% of Trust turnover, which do not qualify as high risk investments. It will report its approvals to the Trust Board including an account of the cumulative value of schemes approved in-year.

It will also consider all business cases classed as major and / or high risk and make recommendations for approval or rejection to the Board.

4.4 Senior Leadership Team

The Senior Leadership Team will have delegated authority to approve investments greater than 0.25% and up to and including 0.5% of turnover, which do not qualify as high risk investments.

It will report its approvals to the Finance Committee, including an account of the cumulative value of schemes approved in-year.

It will also consider schemes between 0.25% and 1.0% of Trust turnover and which do not qualify as high risk investments. It will make recommendations about these proposals to the Finance Committee.

The Senior Leadership Team may choose to delegate approval of capital investments to the Capital Programme Steering Group.

4.5 Capital Programme Steering Group

The Capital Programme Steering Group will report to the Senior Leadership Team.

The Group will be responsible for co-ordinating the capital planning process and issuing internal guidance, ensuring that the appropriate initiation and risk assessment documentation is in place for proposed schemes. It will make recommendations about proposals to the Senior Leadership Team and the Finance Committee in line with their respective approval rights. These recommendations will cover both approval of projects and the programming of related expenditure.

The Group will approve capital investments up to and including 0.25% and will report its approvals to the Senior Leadership Team.

The Capital Programme Steering Group will report performance against the capital programme both to the Finance Committee and the Senior Leadership Team.

5. Policy Statement and Provisions

5.1 Investment Philosophy and Objectives

The Trust will invest in opportunities that are consistent with its purpose, vision and objectives.

The statutory and principal purpose of the Trust is the provision of goods and services for the health service in England.

In fulfilling its core purpose, the Trust's mission is to improve the health of the people we serve by delivering exceptional care, teaching and research every day. When appropriate, the Trust will

make investment decisions in line with the Trust's business and service intent as set out in the Trust's Clinical Strategy, as summarised below:

(a) Our strategic intent is to provide excellent local, regional and tertiary services, and maximising the mutual benefit to our patients that comes from providing this range of services;

(b) Our focus for development remains our specialist portfolio and we aim to expand this portfolio where we have the potential to deliver exceptional, affordable healthcare;

(c) As a University teaching hospital, delivering the benefits that flow from combining teaching, research and care delivery will remain our key advantage. In order to retain this advantage, it is essential that we recruit, develop and retain exceptionally talented and engaged people;

(d) We will do whatever it takes to deliver exceptional healthcare to the people we serve and this includes working in partnership where it supports delivery of our goals, divesting or our sourcing services that others are better placed to provide and delivering new services where patients will be better served;

(e) The Trust's role in community service provision will be focused upon supporting our partners to meet the needs of our patients in a timely way, however, where our patients' needs are not being met, the Trust will provide or directly commission such services;

(f) Our patients – past, present and future - their families, and their representatives, will be central to the way we design, deliver and evaluate our services. The success of our vision to provide "High quality individual care, delivered with compassion" will be judged by them.

The investment policy sets out the criteria which will be used by the Trust to evaluate potential major and / or high risk capital investment decisions (defined in section 8).

The Trust will also take into account the financial, strategic, quality, operational, regulatory and reputational risk and benefit when evaluating potential investment decisions.

The Trust will not enter into any project that would result in a breach of the terms of its NHS provider licence.

6. Capital Budget Setting

6.1 The Medium Term Capital Programme

The Board of Directors will approve both the size of the Medium Term Capital Programme, taking account of the approved long term financial plan, and the budget allocation between classes of investment in the programme, which will include at a minimum:

(a) Major strategic projects;

(b) Operational capital;

(c) Medical equipment;

~~(d) Other equipment~~

(d) Information Technology; and

(e) Works replacement.

A capital planning process will be integrated into the annual business planning round which will determine the approval route for each class of investment.

The Trust will move towards establishing a rolling replacement programme for key assets.

Guidance will be made available about the process to be followed for each class of capital investment.

6.2 *Identification of Major or High Risk Investments*

A proposal will be classed as a major investment if its estimated capital cost including VAT exceeds 1% of Trust's turnover or £6.900 million based on the 2018/19 plan of £690 million.

High risk investments are defined as:

(a) Transactions which trigger the requirement to inform NHS Improvement. The criteria for reportable transactions are described in Annex 1; and

(b) Transactions that may have any one or more of the following characteristics:

(i) Significant reputational risk;

(ii) The potential to destabilise the core business;

(iii) The creation of material contingent liabilities; and

(iv) An equity component involving shares.

6.3 *Business Case Requirements*

All investment proposals will be supported by relevant business case documentation according to the value of the proposed investment as shown in Table 1 below:

Scheme cost as % of Trust turnover	**Documentation required**
Up to 0.25%	Short-form business case
Between 0.25% and 1%	Comprehensive business case
More than 1%	Outline Business Case (OBC) and (subject to OBC approval) a Full Business Case (FBC)

Table 1: Thresholds for business case requirement

Any project requiring financial support for production of the appropriate business case prior to scheme approval must have an approved Project Initiation Document.

Detailed templates and guidance for each form of business case is available from the Director of Strategy & Transformation.

6.4 *Project Sponsor*

Each capital investment proposal will require Executive Director support who will be the Project Sponsor.

The Project Sponsor is responsible for ensuring that the terms of the Capital Investment Policy and other Trust policies are followed and that business cases follow the appropriate approval route (see section 7).

7. Approval Route

Table 2 shows the thresholds used to determine the business case requirement for schemes which fall within the definition of high risk and / or the definition of a major scheme (see section 6.2). It should be noted that the approval route is the same with all high risk and / or major schemes:

Threshold		Business Case format	Capital Programme Steering Group	Senior Leadership Team	Finance Committee	Trust Board	Council of Governors
Percentage of turnover %	Capital expenditure including VAT £m						
>1%	>£6.900m	OBC + FBC	✓	✓	✓	✓	✓
>0.25% <=1%	>£1.725m <= £6.900m	Comprehensive					
<=0.25%	<=1.725m	Short-form					

Table 2: Business case requirement and approval route (high risk or major capital schemes)

For schemes that fall outside of the definition of high risk and / or involve capital expenditure totalling 1% or less than the Trust's turnover of £6.900million, table 3 shows the thresholds, business case requirement and approval route:

Threshold		Business Case form	Capital Programme Steering Group	Senior Leadership Team	Finance Committee	Trust Board
Percentage of turnover %	Capital expenditure including VAT £m					
>0.5% <=1%	>£3.450m <= £6.900m	Comprehensive	✓	✓	✓	
>0.25% <=0.5%	>£1.725m <= £3.450m	Comprehensive	✓	✓		
<=0.25%	<=£1.725m	Short-form	✓			

Table 3: Business case requirement and approval route (all other)

Foundation Trusts in financial distress must also comply with the delegated limits set out in section 3 of the Capital regime, investment and property business case approval guidance for NHS trusts and foundation trusts.

8. Evaluation

Business cases will be evaluated against explicit financial and non-financial criteria outlined below.

8.1 Financial Criteria

Proposals which are not classed as a major investment decision will be assessed for scheme affordability.

Business cases for major capital investment (over 1% of turnover) will be expected to demonstrate as a minimum a neutral recurring revenue position including financing costs as follows:

(a) The cost of loan principal repayments where relevant;

(b) 3.5% interest charge if internally funded or financed through Public Dividend Capital; or

(c) At the cost to the Trust, if financed through borrowing.

The Board may choose to waive the requirement to deliver a neutral recurring revenue position where it deems that exceptional circumstances apply. Such circumstances may include mitigation against significant strategic, statutory, regulatory, operational or reputation risks or a desired investment in a quality improvement.

In this case, the Board will make the final investment decision itself, including explicit approval of the cross-subsidy arrangements which should apply to the capital investment in question.

8.2 Non-Financial Criteria

(a) Strategic Capital

The following non-financial criteria will be used to evaluate all capital investment proposals.

(i) **Strategic Fit** – the extent to which the proposed investment is consistent with the Trust's Clinical Strategy and strategic aims.

(ii) **Risk Mitigation** - the extent to which the proposed investment addresses existing or anticipated strategic, financial, operational, regulatory, and political or reputational risks.

Scoring templates for the non-financial appraisal of major medical and operational capital is attached at Appendix 2.

(b) Major Medical and Operational Capital (MERGED INTO ONE HEADING)

(i) **Technical Resilience -** based on age of asset, maintenance costs and business criticality.

(ii) **Quality** – the extent to which the proposed investment is consistent with the Trust's quality Strategy (including staff well being).

(iii) **Risk Mitigation** - the extent to which the proposed investment addresses existing or anticipated strategic, financial, operational, regulatory, and political or reputational risks.

Scoring templates for the non-financial appraisal of major medical and operational capital is attached at Appendix 3.

9. Risk Management

The non-financial evaluation criteria include risk mitigation and therefore take into account the risk of not entering into a proposed investment.

The Trust will also take into account the risk and return (both financial and non-financial) of making a proposed capital investment. The risks will be fully identified and assessed according to the Trust's standard risk assessment tool. A sample due diligence checklist is attached at Appendix 4.

The Trust will seek to quantify the risks of a proposed investment in financial terms wherever possible. Business cases for major capital investment will include a quantified risk and mitigation assessment.

The Trust will actively monitor the performance of its investments and ensure that adequate risk mitigation is in place.

10. References

NHS Improvement's Single Oversight Framework (SOF) - https://improvement.nhs.uk/resources/single-oversight-framework/

Capital regime, investment and property business case approval guidance for NHS trusts and foundation trusts - https://improvement.nhs.uk/documents/525/NHSI_Capital_Regime_Investment_Property_Business_Case_Main_Comms_V9.0_final_v2.pdf

11. Associated Documentation

Major Medical and Operational Capital Prioritisation Process – link TBC

12. Appendix 1 - Thresholds for reporting investments or divestments to NHSI

Source: *Guidance on transactions for NHS Foundation Trusts*, Monitor, March 2015

If a transaction meets any one of the criteria below, it must be reported to NHS Improvement (NHSI).

Ratio	Description	UK Healthcare	Non Healthcare
Assets	The gross assets* subject to the transaction divided by the gross assets of the foundation trust	> 10 %	> 5 %
Income	The income attributable to: • the assets; or • the contract associated with the transaction divided by the income of the foundation trust	> 10 %	> 5 %
Consideration to total NHS FT capital	The gross capital** or consideration associated with the transaction divided by the total capital*** of the foundation trust following completion.	> 10 %	> 5 %

* Gross assets are the total of fixed assets and current assets.

** Gross capital equals the market value of the target's shares and debt securities, plus the excess of current liabilities over current assets.

*** Total capital of the Foundation Trust equals tax payers equity.

Small, Material or Significant Transaction

Transactions which do not meet the reporting requirements set out above are classified as "small" transactions. All reportable transactions will be classified as either "material" or "significant" by NHS Improvement. NHS Improvement will classify a transaction as significant, and subject to a detailed review, if the transaction meets one of the following criteria:

- A relative size of greater than 40% in any of the tests set out above;
- A relative size of between 25% and 40% of the tests set out above and an additional risk factor has been identified by NHS Improvement and is considered relevant;
- A relative size of between 10% and 25% of the tests set out above and in NHS Improvement's view, one or more major risk or more than one other risk has been identified by NHS Improvement and is considered relevant.

A non-exhaustive list of examples of risk factors are set out overleaf to provide an indication of what NHS Improvement may consider to be a major risk or otherwise.

Risk factor	Example of major risk	Example of other risk
Leverage	Capital servicing capacity of the enlarged organisation is <1.75 (as defined in the SOF)	Capital servicing capacity of the enlarged organisation is <2.5 (as defined in the SOF)
Acquirer's experience of services provided by target	A significant change in scope of activity of acquirer	A minor change in scope of activity of acquirer
Acquirer quality	Governance at the acquirer is rated "red" or subject to narrative with a "formal investigation" underway	Governance at the acquirer is subject to narrative description of some concerns
Acquirer financial	Use of Resources rating of ≤2 in the acquirer	Use of Resources rating of 2/3 in the acquirer
Target quality	Target is rated "inadequate" by CQC	Target is rated "requires improvement" by CQC
Target financial	Target has significant current and/or historical deficits	Target has minor current and/or historical deficits

13. Appendix 2 – Strategic Capital – Non financial appraisal

Assessment of Strategic Alignment

Key – 1 = very low impact to 5 = Significant, specific and tangible impact.

	Strategic Priorities	Score 1-5	Rationale
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 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		
7.	We will ensure we are soundly governed and are compliant with the requirements of our regulators		
	Strategic Intent – Clinical Strategy		
	• Our strategic intent is to **provide excellent local, regional and tertiary services**, and maximising the mutual benefit to our patients that comes from providing this range of services. • Our **focus for development remains our specialist portfolio** and we aim to expand this portfolio where we have the potential to deliver exceptional, affordable healthcare. • The Trust's role in **community service provision will be focused upon supporting our partners** to meet the needs of our patients in a timely way; however, where our patients' needs are not being met, the Trust will provide or directly commission such services.		
8.	Considering the above, the extent to which the scheme impacts on the delivery of the refreshed Trust Clinical Strategy?		
9.	The extent to which the scheme impacts on the delivery of the emerging priorities in the system Sustainability and Transformation Plan (STP)		
	TOTAL /45		

Scoring matrix for non-financial evaluation of STRATEGIC CAPITAL INVESTMENTS

SCORE	STRATEGY FIT	RISK MITIGATION
5	Score of 40-45 against delivery of strategic priorities.	**Very High** risk score (15 to 25) as per Trust's Risk Assessment Matrix
4	Score of 30-40 against delivery of strategic priorities.	**High** risk score (10-12) as per Trust's Risk Assessment Matrix
3	Score of 20-30 against delivery of strategic priorities.	**High** risk score (7-9) as per Trust's Risk Assessment Matrix
2	Score of 10-20 against delivery of strategic priorities.	**Moderate** risk score (4 to 6) as per Trust's Risk Assessment Matrix
1	Score of 0-10 against delivery of strategic priorities.	**Low** risk score (1 to 3) as per Trust's Risk Assessment Matrix
0	**No impact** on strategic priorities	**No risk**, score 0
Scores		
Weighting	*x 50*	*x 50*
Weighted scores		
Total score		

14. Appendix 3 - Operational and Major Medical Capital prioritisation

3a Technical Resilience

3b Quality Strategy (including staff well-being)

3c Risk Mitigation

3d Overall Scoring Matrix

UPDATED FOR V12

JULY 2018

3a – Technical Resilience

Relative age	**Score**	
This is based on the age of the asset in relation to its anticipated lifespan		
2year+ below	1	
2year to 0 year below	2	
0 years (same as lifespan)	3	
0-2 years above	4	
2years+ above	5	
	Relative age score	
Reliability		
This is based on the cost of maintenance which takes account of routine servicing, but also labour and parts associated with failing assets		
Cost	**Score**	
£0	1	
£0-£1,000	2	
£1,001-£5,000	3	
£5,001-£10,000	4	
£10,000+	5	
	Reliability score	
Business Criticality	**Score**	
No disruption to service	1	
Disruption to single-patient treatment	2	
Some disruption to service	3	
Significant disruption to service	4	
Closure of service	5	
	Business criticality score	
	TOTAL SCORE /15	

3b – Quality Strategy (including staff well-being)

Key	
Score	**Impact**
5	Very high (i.e. significant, specific, tangible)
4	High impact
3	Moderate impact
2	Low impact
1	No impact

	Scores 1-5	Rationale
ACCESS		
The extent to which the scheme will deliver improvements in performance on core constitutional standards such as RTT, diagnostic wait, cancer or 4 hour benefits		
SAFE, RELIABLE CARE		
The extent to which the scheme maintains or improves the safety of the service provided to patients.		
The extent to which the scheme delivers improvements in the provision of reliable care, which could include increased/flexible service hours or flexible service locations		
The extent to which the scheme will maintain or improve compliance against NICE, NHS England service specifications and/or other key national guidance/enquiries.		
PATIENT AND STAFF EXPERIENCE		
The extent to which this will maintain or improve the ability to treat patients with honesty, respect and dignity		
The extent to which the scheme responds directly to patient complaints, taking account of the number of complaints received and percentage of patients that complaint (i.e. 100% patients complain scores higher)		
The extent to which the scheme will improve staff experience		
The extent to which the scheme will improve staff wellbeing		
RESEARCH, INNOVATION AND TRANSFORMATION		
The extent to which the scheme will deliver pioneering and efficient practice, putting ourselves at the leading edge of research, innovation and transformation.		
The extent to which the scheme impacts on the delivery of the emerging priorities in the system Sustainability and Transformation Partnership (STP)		
	TOTAL /50	

3c – Risk Mitigation

Top Tips for effective risk management

Define the risk that is worrying you most and decide which domain it sits in;
If there are multiple risks, patient safety trumps all others
It's very hard to score 12 and above – if your risk is scoring a 12, consider calibrating it
Express as a risk, do not describe the cause or an issue

- Risk that…
- Risk of…

Likelihood of Impact:

- You should be driven by actual evidence of occurrence, ideally incident reporting. If it hasn't happened before, what's your evidence that it will happen again
- Impact of the risk you have described; guard against disconnect

Actions and Controls:

- A control is something that is already in place and is actively mitigating the risk;
- An action is something you intend to do in the future to mitigate the risk. It might be a one off and when complete will reduce the risk, or be ongoing and thus becomes a control.

Scoring your risk

Please use the below Risk Assessment Matrix to score your risk(s).

SCORE	RISK MITIGATION
5	**Very high** risk score (**15 to 25**) as per Trust's Risk Assessment Matrix
4	**High** risk score (**10-12**) as per Trust's Risk Assessment Matrix
3	**High** risk score (**7-9**) as per Trust's Risk Assessment Matrix
2	**Moderate** risk score (**4 to 6**) as per Trust's Risk Assessment Matrix
1	**Low** risk score (**1 to 3**) as per Trust's Risk Assessment Matrix
0	**No risk**, score 0
SCORE	

3d – Overall Scoring Matrix

SCORING MATRIX FOR NON-FINANCIAL EVALUATION OF MAJOR MEDICAL AND OPERATIONAL CAPITAL INVESTMENTS			
SCORE	**TECHNICAL RESILIENCE**	**IMPROVING QUALITY & STAFF WELLBEING**	**RISK MITIGATION**
5	15	41 - 50	**Very high** risk score (**15 to 25**) as per Trust's Risk Assessment Matrix
4	13 - 14	36 - 40	**High** risk score (**10-12**) as per Trust's Risk Assessment Matrix
3	10 - 12	31 - 35	**High** risk score (**7-9**) as per Trust's Risk Assessment Matrix
2	7 - 9	21 - 30	**Moderate** risk score (**4 to 6**) as per Trust's Risk Assessment Matrix
1	4 - 6	16 - 20	**Low** risk score (**1 to 3**) as per Trust's Risk Assessment Matrix
0	0 - 3	10 - 15	**No risk**, score 0
Score			
Weighting	X 35	X 25	X 35
Weighted scores			
TOTAL SCORE		Technical resilience **+** Improving quality & staff wellbeing **+** risk mitigation *(weighted scores)*	

NB: Investments that have a mandatory (e.g. legal or regulatory) requirement will be funded without recourse to this matrix.
Examples of these types of investments can be found in the detailed guidance document.

VERSION 11 APPENDICIES - REPLACED WITH APP 3a-3d ABOVE

~~Operational and Major Medical Capital prioritisation – Quality and Strategy Criteria~~
~~Key – 1 = very low impact to 5 = Significant, specific and tangible impact.~~

	~~Weighting~~	~~Scores 1 – 5~~	~~Rationale~~
~~ACCESS~~			
~~The extent to which the scheme will deliver improvements in performance on core constitutional standards such as RTT, diagnostic wait, cancer or 4 hour benefits~~	~~3~~		
~~SAFE, RELIABLE CARE~~			
~~The extent to which the scheme maintains or improves the safety of the service provided to patients.~~	~~3~~		
~~The extent to which the scheme delivers improvements in the provision of reliable care, which could include increased/flexible service hours or flexible service locations~~	~~2~~		
~~The extent to which the scheme will maintain or improve compliance against NICE, NHS England service specifications and/or other key national guidance/enquiries.~~	~~2~~		
~~PATIENT AND STAFF EXPERIENCE~~			
~~The extent to which this will maintain or improve the ability to treat patients with honesty, respect and dignity~~	~~2~~		
~~The extent to which the scheme responds directly to patient complaints, taking account of the number of complaints received and percentage of patients that complaint (i.e. 100% patients complain scores higher)~~	~~1~~		
~~The extent to which the scheme will improve staff experience~~	~~3~~		
~~The extent to which the scheme will improve staff wellbeing~~	~~2~~		
~~RESEARCH, INNOVATION AND TRANSFORMATION~~			
~~The extent to which the scheme will deliver pioneering and efficient practice, putting ourselves at the leading edge of research, innovation and transformation.~~	~~1~~		
~~The extent to which the scheme impacts on the delivery of the emerging priorities in the system Sustainability and Transformation Plan (STP)~~	~~1~~		
	~~TOTAL /100~~		

Annex 3

Operational and Major Medical Capital prioritisation - Risk Criteria

SCORE	RISK MITIGATION
5	**High and Extreme** risk score (12 to 25) as per Trust's Risk Assessment Matrix
4	**High** risk score (8-10) as per Trust's Risk Assessment Matrix
3	
2	**Moderate** risk score (4 to 6) as per Trust's Risk Assessment Matrix
1	**Low** risk score (1 to 3) as per Trust's Risk Assessment Matrix
0	**No risk**, score 0
Scores	
Weighting	*x 20*
TOTAL /100	

Annex 4

Major Medical Capital Prioritisation - Technical Resilience Score

Age score		
This is based on the age of the asset in relation to its anticipated lifespan		
Relative age	**Score**	
2year+ below	1	
2year to 0 year below	2	
0 years (same as lifespan)	3	
0-2 years above	4	
2years+ above	5	
	Unweighted Score	
	Weighting x5	
	Weighted score	
Reliability score		
This is based on the cost of maintenance which takes account of routine servicing, but also labour and parts associated with failing equipment		
Cost	**Score**	
£0	1	
£0-£1000	2	
£1001-£5000	3	
£5001-£10000	4	
£10000+	5	
	Unweighted Score	
	Weighting x5	
	Weighted score	

Business Criticality	**Score**	
No disruption to service	1	
Disruption to single-patient treatment	2	
Some disruption to service	3	
Significant disruption to service	4	
Closure of service	5	
	Unweighted Score	
	Weighting x5	
	Weighted score	
	TOTAL SCORE /100	

15. Appendix 4 - Due Diligence Checklist To Inform Risk Assessment

Typical due diligence items

Type of process	Area	Example Items
Financial and commercial due diligence	▪ Strategy	▪ Rationale for how proposed investment will deliver value ▪ Strategic and business plans ▪ Business strengths and weaknesses ▪ Competitive dynamics
	▪ Finance	▪ Historical normalised earnings ▪ Most recent 5-year projection ▪ Key assumptions and sensitivity analysis ▪ Working capital strategy
	▪ Operations and manufacturing	▪ Business economics ▪ Customer and supplier relationships/contracts
	▪ Organisation and Management	▪ Management capabilities ▪ Organisation structure ▪ Systems integration ▪ Corporate culture and style
Tax and accounting due diligence	▪ Research and development	▪ Key research efforts ▪ Research relationships and contracts
	▪ Information technology	▪ Security and contingency plans ▪ Types of systems ▪ Outsourced services
	▪ Accounting	▪ Financial reporting systems ▪ Contribution margin ▪ Depreciation schedules
	▪ Finance	▪ Capital structure ▪ Covenants triggered by deal
	▪ Tax	▪ Tax liabilities from non-paid taxes ▪ Tax reserve
	▪ Insurance	▪ Claims history and policy status ▪ Contingent liabilities
	▪ Corporate structure	▪ Shares outstanding and shareholder interests (if relevant) ▪ Legal entities
Legal due diligence	▪ Legal	▪ Indemnification provisions ▪ Outstanding and pending limitation ▪ Licences, patents and trademarks
	▪ Labour	▪ Employment contracts and agreements ▪ Pension provisions and funding levels ▪ Non-paid benefits
	▪ Anti-competitive	▪ Potential anti-trust liabilities ▪ Potential remedies/outcomes
	▪ Environment	▪ Existing and future liabilities ▪ Successor liability ▪ Remediation plans

This is not an exhaustive list of areas to be covered within due diligence. The scope of due diligence will vary depending on the proposed transaction and should be discussed and agreed with the NHS foundation trust's professional advisers.

16. Appendix 5 – Monitoring Table for this Policy

The following table sets out the monitoring provisions associated with this Policy.

Objective	Evidence	Method	Frequency	Responsible	Committee
Compliance with thresholds	Business case submission	Report	Ad hoc	-	Capital Programme Steering Group

17. Appendix 6 – Dissemination, Implementation and Training Plan

The following table sets out the dissemination, implementation and training provisions associated with this Policy.

Plan Elements	Plan Details
The Dissemination Lead is:	Head of Financial Services
This document replaces existing documentation:	No
Existing documentation will be replace by:	[DITP - Existing documents to be replaced by]
This document is to be disseminated to:	All Divisional Management Staff and those responsible for requesting managing monitoring or reporting on capital funds
Method of dissemination:	Available to download from FINWEB or on request from the Head of Financial Services
Training is required:	No
The Training Lead is:	[DITP - Training Lead Title]

Additional Comments	None
[DITP - Additional Comments]	

18. Appendix 7 - Equality Impact Assessment

Query	Response	
What is the aim of the document?	To provide guidance for the management of procedural documents within the organisation.	
Who is the target audience of the document (which staff groups)?	Authors of procedural documents and members of approval authorities. Those requesting capital funds. Add ☑ or ☒	
Who is it likely to impact on **and how**?	**Staff**	☒
	Patients	☒
	Visitors	☒
	Carers	☒
	Other	☒
Does the **document** affect one group more or less favourably than another based on the 'protected characteristics' in the Equality Act 2010**:**	**Age** (younger and older people)	☒
	Disability (includes physical and sensory impairments, learning disabilities, mental health)	☒
	Gender (men or women)	☒
	Pregnancy and maternity	☒
	Race (includes ethnicity as well as gypsy travelers)	☒
	Religion and belief (includes non-belief)	☒
	Sexual Orientation (lesbian, gay and bisexual people)	☒
	Transgender people	☒
	Groups at risk of stigma or social exclusion (e.g. offenders, homeless people)	☒
	Human Rights (particularly rights to privacy, dignity, liberty and non degrading treatment)	☒

University Hospitals Bristol
NHS Foundation Trust

Cover report to the Public Trust Board meeting to be held on Friday 27 July 2017 2018 at 11:00 am – 13:00 pm in the Conference Room, Trust HQ, Marlborough St, Bristol, BS1 3NU

		Agenda Item	20
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	25 July 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 25 July 2018.

Finance Director's Report
The Director of Finance and Information Paul Mapson presented the report. Key points of discussion included the following:

- The Trust continued to perform on-plan. There continued to be spending issues particularly around nursing within medicine and medical pay and non-pay within Surgery. Medical pay performance overall in particular had not improved, and work was ongoing to explore this. Junior Doctor pay was a major part of this and continued to be an issue nationally.
- Financial projection assumed the Trust would lose one quarter's A&E STF, but would otherwise achieve forecasts.
- The Trust had shown significant over-performance on income-based activity, but a drop in 'pass-through' income.
- The Agenda for Change pay award had been finalised. The medical pay award had been announced the previous day (24 July) – at 2% from 1st October funded from the 1% annual inflation included for 2018/19.
- The Committee expressed concern about the continued issues of overspending in divisions, especially on non-pay in the Surgery division, and questioned why the divisions could not operate within their budget, and requested assurance that remedial action would be taken. It was agreed this particular issue would need further exploration by Executives.

Contract Income and Activity Reports

- Contract income for 2018/19 was £0.09m lower than plan in June 2018. Activity-based services and contract penalties were higher than plan, whilst pass through payments were lower. Contract rewards and sustainability funding continued on plan.
- It was noted that the HRG4+ funding issue (about reimbursements for activity funded by NHS Wales) discussed at previous Committee meetings had been reflected in planning for this year, as there was still a lack of clear communication from the regulator about whether funding for this year would be forthcoming (as it ultimately was in 2017/18).
- The National Tariff timetable had been delayed, which might have an impact on assumptions for income.

Detailed Divisional Financial Reports

- Across the divisions, there was a year to date deficit of £572k, with an in-month deterioration of £151,000.
- Women's and Children's Services had overachieved on income, but were almost £1m overspent on pay. Diagnostics &Therapies' financial position to 30 June 2018 reported a favourable variance against budget of £156k.
- It was noted that the plan for Medicine was still not approved, because the division hadn't been able to identify the required £0.5m savings. This was because their existing position had deteriorated (mainly due to pay costs). Once a credible recovery plan had been approved, this would become their revised plan.
- The Committee again noted the variation in quality between the different SPORT reports. In particular, Medicine and Women's and Children's SPORT reports could more clearly address risks and threats, and how these were being addressed.

Savings Programme

- With an overall £25.5m savings plan for the year, the Trust had achieved £5.4m to date, against a target of £5.6m, so was broadly on target.
- Forecast outturn had shown an improvement and was expected to deliver the overall savings programme, although there was significant variance between divisions: Surgery had overachieved whilst Medicine had underachieved by £0.5m.
- Medical pay continued to be a problem, but it was hoped the new Medical Director could bring new energy and focus to this area when he began in August 2018.
- The Committee noted that there had been no improvement at all in Women's and Children's diagnostics – this would be further explored.

Capital Income and Expenditure Report

- The Trust had spent £3.759m against £4m plan.
- It was noted that the strategic scheme position related largely to Phase 5 Capital, and it was expected that spending would 'catch up' on this in the next couple of months.
- Medical equipment spending was broadly on plan.
- The Trust was behind plan on operational capital: the plan was based on internal profiles received from individual project managers. There were many different small variances, which were being focused on in detail through the CPSG and the Trust Capital Group. It was disappointing that results of the efforts of the TCG in particular were not yet coming through in performance.
- The cyber security scheme was delivered ahead of schedule, which was good for the Trust, but had impacted on the IT position.
- The Director of Finance and Information noted that he would be assessing the forecast position at Q2 and would report to the Finance Committee at that time.

Statement of Financial Position

Net current assets of £ 57.8m. £8m of 60day + debt at end of quarter. Part of this is significant balance with NBT. Currently we owe them more and are working to rebalance this. Conversations continue to progress outstanding issues. Looking at lessons learned in terms of getting the relationship and arrangements right for future recharges.
The Trust's Performance against the Better Payments Practice Code had been excellent, with 96% of invoices paid within 60 days, and 90% in 30 days thanks to hard work by the Team.

Capital Investment Policy

- The Committee confirmed they were happy to approve the final Capital Investment Policy.

The following were received for assurance:

- **Minutes of Capital Programme Steering Group**
- **Quarterly Treasury Management Report**
- **Month 3 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	28 August 2018

Cover report to the PublicTrust Board. Meeting to be held on 27 July 2018 at 11.00 – 13.00, Conference Room, Trust HQ, Marlborough St, Bristol, BS1 3NU

		Agenda Item	21
Meeting Title	Public Trust Board	**Meeting Date**	Friday, 27 July 2018
Report Title	**Constitution of a People Committee**		
Author	Eric Sanders, Trust Secretary		
Executive Lead	Eric Sanders, Trust Secretary		
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

As previously discussed by the Board, it has been proposed that a new People Committee be introduced into the Board governance structure, to ensure that staff-led issues have given adequate scrutiny by the Trust Board. This Committee will be an additional Committee of the Board.

Key issues to note

Presented here are the proposed Terms of Reference for the new People Committee, reflecting the input of the Executive Team. Key points to note are as follows:

- The Committee shall meet **10 times per year**, in advance of each meeting of the Board of Directors.
- The People Committee is appointed by the Board of Directors from amongst the Non-

Executive Directors of the Board and shall consist of not less than **three** members.The following officers shall be required to **attend** meetings of the People Committee on a standing invitation by the Chair:

- 4.3.1 Director of People
- 4.3.2 Chief Nurse
- 4.3.3 Director of Finance and Information
- 4.3.4 Director of Strategy and Transformation
- 4.3.5 Medical Director

- The People Committee shall discharge the following duties on behalf of the Board of Directors:
  - Developing and advising the Board on a workforce strategy taking into account relevant best practice and alignment with strategic objectives for the Trust;
  - Monitoring, and receiving assurance on, the key areas of the Workforce Strategy which will include but is not limited to: Culture, Development, Resourcing, and People & Systems.
  - Monitoring an agreed set of HR-related Key Performance Indicators;
  -
  - Reviewing other HR-related activity as requested by the Board.

Recommendations

Members are asked to:

- **Approve** the Terms of Reference for the People Committee**.**

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)**

Terms of Reference – People Committee Terms of Reference

Document Data	
Corporate Entity	People Committee Terms of Reference
Document Type	Terms of Reference
Document Status	Draft
Executive Lead	Director of People
Document Owner	Trust Secretary
Approval Authority	Board of Directors
Review Cycle	12 months
Next Review Date	01/08/2019- tbc

Document Change Control				
Date of Version	**Version Number**	**Lead for Revisions**	**Type of Revision (Major/Minor)**	**Description of Revisions**
26/06/2018	1	Trust Secretary	Major	Initial draft for comment
13/07/2018	1.1	Trust Secretary	Minor	Changes following Executive Team discussion

Contents

1.

1. Constitution of the Committee

1.1 The People Committee has been established by the Board of Directors to support the discharge of the Board's responsibilities relating to its workforce.

2. Purpose and function

2.1 The purpose of the People Committee is to ensure:

2.1.1 That the Trust has a clear understating of its strategic workforce needs and that plans are in place to deliver these;

2.1.2 That the Board receive assurance that all legislative and regulatory requirements relating to the workforce are met;

2.1.3 That workforce risks are understood by the Board and that appropriate mitigating actions have been identified and are being implemented.

2.2 To achieve this, the Committee shall:

2.2.1 Support the development and monitoring of a workforce strategy;

2.2.2 Champion workforce issues ensuring adequate oversight of all workforce areas by the Board.

2.3 The Committee shall discharge this function on behalf of the Board of Directors by:

2.3.1 Monitoring key workforce metrics to ensure that the expected standards are being delivered;

2.3.2 Receiving reports to provide assurance around the compliance with legislation and regulations;

2.3.3 Considering workforce plans and improvement plans on behalf of the Board.

3 Authority

3.1 The People Committee will:

3.1.1 Monitor, scrutinise and, where appropriate, investigate any workforce activity considered to be within its terms of reference;

3.1.2 Seek such information as it requires to facilitate this monitoring and scrutiny;

3.1.3 Obtain whatever advice it requires, including external professional advice if deemed necessary (and as advised by the Trust Secretary) and may require Directors or other officers to attend meetings to provide such advice.

3.2 The People Committee is a Non-Executive Committee and has no executive powers.

3.4 Unless expressly provided for in Trust Standing Orders, Trust Scheme of Delegation or Standing Financial Instructions, the People Committee shall have no further powers or authority to exercise on behalf of the Board of Directors.

4. Membership and attendance

4.1 The People Committee is appointed by the Board of Directors from amongst the Non-Executive Directors of the Board and shall consist of not less than three members.

4.2 A Non-Executive Director, appointed by the Board, will chair the meetings of the Committee.

4.3 The following officers shall be required to attend meetings of the People Committee on a standing invitation by the Chair:

4.3.1 Director of People
4.3.2 Chief Nurse
4.3.3 Director of Finance and Information
4.3.4 Director of Strategy and Transformation
4.3.5 Medical Director

4.4 Duly nominated deputies may attend with the permission of the Committee Chair.

4.6 The Trust Secretary shall attend from time-to-time to provide advice to the Directors and to facilitate the formal evaluation of the Committee's performance

5. Quorum

5.1 The quorum necessary for the transaction of business shall be two members of the Committee.

5.2 A duly convened meeting of the People Committee at which a quorum is present shall be competent to exercise all or any of the authorities, powers and discretions vested in or exercisable as set out in these Terms of Reference.

6. Roles and Responsibilities

The People Committee shall discharge the following duties on behalf of the Board of Directors:

6.1 Developing and advising the Board on a workforce strategy taking into account relevant best practice and alignment with strategic objectives for the Trust;

6.2 Monitoring, and receiving assurance on, the key areas of the Workforce Strategy which will include but is not limited to:

Culture

- Engagement
- Reward
- Equality & Diversity

- Bullying & Harassment
- Performance management
- Wellbeing
- Health & Safety
- APOHS

Development
- Management and Leadership Development
- Medical and clinical education
- Apprenticeships
- Essential training

Resourcing
- Strategic workforce planning
- Recruitment and attraction
- Talent management

People and Systems
- Manager self-service
- e-rostering
- e-appraisal
- HR web

6.3 Monitoring an agreed set of HR-related Key Performance Indicators;

6.4 Reviewing other HR-related activity as requested by the Board.

7. Reporting

7.1 The Chair of the People Committee shall report to the Board of Directors on the activities of the Committee.

7.2 The Chair of the People Committee shall make whatever recommendations to the Board deemed by the Committee to be appropriate (on any area within the Committee's remit where disclosure, action or improvement are needed).

7.3 Outside the written reporting mechanism, the Committee Chair should attend the Council of Governors General meeting including the Annual Members Meeting, and be prepared to respond to any questions on the Committee's area of responsibility to provide an additional level of accountability to members.

7.4 Outside the formal reporting procedures, the Governors' Quality Focus Group shall be informed by the People Committee via the Chair and Executive Leads, supported by the Trust Secretariat.

8. Administration

8.1 The Trust Secretariat shall provide administrative support to the Committee.

8.2 Meetings of the People Committee shall be called by the Secretary at the request of the

Committee Chair.

8.3 Unless otherwise agreed, notice of each meeting confirming the venue, time and date, together with an agenda of items to be discussed, shall be made available to each member of the Committee and any other person required to attend, no later than five working days before the date of the meeting.

8.4 Supporting papers shall be made available to Committee members no later than five working days before the date of the meeting.

8.5 The secretary shall minute the proceedings and resolutions of all Committee meetings, including the names of those present and those in attendance.

8.6 Draft minutes of meetings shall be made available promptly to all members of the Committee

9. Frequency of Meetings

9.1 The Committee shall meet 10 times per year, in advance of each meeting of the Board of Directors.

10. Review of Terms of Reference

10.1 The Committee shall, at least once a year, review its own performance and Terms of Reference to ensure it is operating at maximum effectiveness.

Cover report to the PublicTrust Board. Meeting to be held on 27 July 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**	Friday, 27 July 2018
Report Title	**Register of Seals**		
Author	Sophie Melton Bradley, Deputy Trust Secretary		
Executive Lead	Eric Sanders, Trust Secretary		
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 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 January 2018.

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
None.

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

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

Register of Seals – April – June 2018

Reference Number	Date Signed	Document	Authorised Signatory 1	Authorised Signatory 2	Witness
808	02.05.2018	Bristol general Hospital Deed of Subordination	Robert Woolley, Chief Executive	Kate Parraman, Deputy Director of Finance	Sophie Melton Bradley, Deputy Trust Secretary
809	04.05.2018	South Bristol Community Hospital Licence to underlet.	Paul Mapson, Director of Finance	Robert Woolley, Chief Executive	Sophie Melton Bradley, Deputy Trust Secretary
810	11.06.2018	Bristol Hospital Broadcasting Service Lease Room 56-67, Level 10, Queens Building, BRI	Robert Woolley, Chief Executive	Paul Mapson, Director of Finance	Sophie Melton Bradley, Deputy Trust Secretary
811	21.06.2018	A contract between British Heart Foundation and UH Bristol NHS Foundation Trust for provision of a 1wte hypertrophic cardiomyopathy nurse and 0.2wte MDT coordinator	Paul Mapson, Director of Finance	Robert Woolley, Chief Executive	Sophie Melton Bradley, Deputy Trust Secretary
812	22.06.2018	Design and Build Contract – MRI Upgrade, BRI	Paul Mapson, Director of Finance	Robert Woolley, Chief Executive	Sophie Melton Bradley, Deputy Trust Secretary

Cover report to the Public Trust Board. Meeting to be held on 27 July 2018 at 11.00 – 13.00, Conference Room, Trust HQ, Marlborough St, Bristol, BS1 3NU

Agenda Item	23

Meeting Title	Public Trust Board
Report Title	**Audit Committee 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	David Armstrong, Non-Executive Director
Date of last meeting	16 July 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 16 July 2018.

The Board Assurance Framework (BAF) and Corporate Risk Register (CRR)

Members of the Committee were supportive of revisions to the BAF which were under development, to improve its focus and effectiveness. They noted that the Chair of the Committee would be meeting with the Trust Secretary and the Head of Risk Management to discuss further changes to the BAF and Corporate Risk Register to ensure The Trust manages "Enterprise" level risks both effectively and efficiently,

Bristol Haematology and Oncology Centre (BHOC) - Major Incident of May 2018

The Committee discussed the fire incident from May at the BHOC, and noted the suite of investigations which were now ongoing:

- An investigation into the declared major incident – to be led by the local Emergency Response Lead at NHS Improvement. This would focus on the Trust's system response.
- Another serious incident investigation into the fire itself, to be led by the Director of Facilities and Estates Andy Headdon.
- An investigation into the cause of the fire and smoke penetration, which was being carried out independently by Avon Fire and Rescue Service (AFRS). The Trust had submitted requested information to AFRS and was awaiting the outcome of this investigation.
- The harm panel set up to review patients on-hold had extended its remit to look at any potential harm caused by delays in oncological treatment as a result of the incident. This would be a long-term piece of work so outcomes were not expected quickly.
- Robert Woolley had asked for an independent audit to be carried out by Capitec (the Trust's authorised fire engineer) of measures and processes around fire safety

currently in place within the Trust, to seek assurance that no imminent failure was likely.

The Chair of the Committee noted that the key priority for the Committee was to understand how the Executive team and Board were responding to the incident and any possible impact the findings have for ongoing Risk Management / mitigation and additionall Internal Audits.

Fire Safety Compliance Plan

It was agreed that the Plan should be reviewed by the SLT with a view to identifying key risks in relation to fire safety, and establish what the Trust was doing to address them:

Counter Fraud Progress Report

The Committee received the Annual Counter Fraud Progress Report, and noted that there were no current fraud cases ongoing, which was positive, and that some work around time sheet fraud in progress had led to some small-scale savings. The Counter Fraud Team had been providing support and advice on fraud issues to the Trust, and had also helped the Trust develop an anti-bribery statement for the Annual Report (a new requirement for 2017-18). It was also noted that Annual Crime Reduction Day would take place on the 26 July, and awareness of it would be flagged via Connect.

Internal and External Audit

The Committee received the Internal and External Audit reports for the quarter: there were no major matters of concern. The Chair noted that he would be meeting quarterly with the Head of Internal Audit to discuss any issues where he might be able to offer support (e.g. on the escalation of delayed queries from the Internal Audit team to Trust staff members).

It was confirmed that the External Audit for the year had now been formally closed off. The External Auditor noted that this year they were required to produce an Annual Audit Letter, to be made available to the public. The Trust agreed that this would be published via the website

Hosted Services

The Committee received a paper on the Trust's piece of work to establish exactly what hosted services the Trust had, and what records needed to be kept going forward to provide an appropriate audit trail.

The Committee were pleased with the report and requested an evaluation of risks around hosted services be provided, once the full list of hosted services was established. It would be important also to understand the nature of each arrangement – e.g. whether they were fixed term or indefinite hosting arrangements, and what constituted success criteria for the hosting arrangement.

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

There were no further risks or issues identified other than those highlighted above.

Matters requiring Committee level consideration and/or approval

None identified.	
Matters referred to other Committees	
None identified.	
Date of next meeting	30 October 2018

Cover report to the PublicTrust Board. Meeting to be held on 27 July 2018 at 11.00 – 13.00, Conference Room, Trust HQ, Marlborough St, Bristol, BS1 3NU

		Agenda Item	24
Meeting Title	Public Trust Board	**Meeting Date**	Friday, 27 July 2018
Report Title	**Governors' 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**

205 **Carole Dacombe** ***Theme:*** Outpatients ***Source:*** From Constituency/ Members

Query **18/07/2018**

Governors are aware that a FT member has taken the time to offer in-depth and insightful feedback on the running of outpatient clinics at our hospitals – noting some excellent, some good and some very poor practice. Can governors be assured that these comments have been taken on board and that there is a focus on the consistency in the way our outpatient clinics are managed?

Division: Trust-wide ***Executive Lead:*** *Chief Operating Officer* ***Response requested:*** 01/08/2018

Response

Status: *Assigned to Executive Lead*

204 **John Rose** ***Theme:*** Medical recruitment ***Source:*** Project Focus Group

Query **16/07/2018**

How seriously have visa restrictions affected the Trust's ability to recruit doctors and nurses from outside the European Union, and have the pledges to lift restrictions actually taken place?

Division: Trust-wide ***Executive Lead:*** *Director of People* ***Response requested:*** 27/07/2018

Response

Status: *Assigned to Executive Lead*

ID	Governor Name		
203	John Rose	***Theme:*** Single point failure	***Source:*** Project Focus Group

Query **25/05/2018**

The recent fire at the Bristol Haematology and Oncology Centre has been dealt with in an exemplary manner, but it shows how vulnerable any business can be to an accident or single point failure. Does the Trust have an operational risk assessment of all its assets recognising the likelihood and effect of single point failures of buildings, departments, power supplies, steam supplies, heating, cooling and ventilation systems, and have mitigating actions been identified and agreed? In addition, are all emergency and life safety systems regularly and effectively tested and reviewed.

Division: Trust-wide ***Executive Lead:*** *Chief Operating Officer* ***Response requested:*** 08/06/2018

Response **13/06/2018**

We have business continuity plans for all key departments and areas of the Trust. These include any patient facing department as well as any other key services provided by the Trust. These plans contain risk assessments as well as a prioritisation of the functions performed by each service. Additionally there is a focus on the response to impacts of incidents affecting premises, staffing, utilities and resources for each area. Within this process single points of failure are highlighted with mitigating actions put in place. Any high risks will also have an additional action plan as part of the plans. Estates and IM&T also hold plans for key systems which are relied upon across the Trust.

Alongside the business continuity plans MEMO also hold a database of all equipment which requires UPS backup and these are maintained between themselves and estates.

Status: *Awaiting Governor Response*

ID	Governor Name		
202	Malcolm Watson	***Theme:*** Histopathology	***Source:*** From Constituency/ Members

Query **08/05/2018**

There was recent publicity about a former nurse who is terminally ill with cancer after her histopathology samples were negative when examined by Severn Pathology. This is a centralised service which UH Bristol also uses. Is there assurance that everything is being done now to reduce this risk by having sufficiently trained staff and double reporting (peer review) as recommended by the 2010 Mishcon enquiry?

Division: Trust-wide ***Executive Lead:*** *Medical Director* ***Response requested:*** 15/05/2018

Response **16/05/2018**

The commencement of Severn Pathology saw the establishment of specialist teams of Consultant Pathologists who work in a limited number of specialisms rather than the more generalist approach that was practiced previously. This system allows individuals to build up expertise within those fields and was always a key aim of the merging of the services. The concentration of expertise into teams also facilitates a better approach to double-reporting which has been implemented fully and according to the policy developed for Severn Pathology.

Due to a national shortage of suitable applicants, there remain some gaps in total numbers of Consultant staff which mean that some teams have fewer members than would be optimal. However, with the exception of Paediatric / Perinatal Pathology (PPP), all teams have sufficient numbers to be able to maintain a sufficiently high level of expertise and the numbers to support double-reporting. For PPP, there is support from system-specific teams reporting adult pathology and from PP pathologists in other centres to maintain a safe service. A second pathologist in this field will come in to post in August 2018.

Status: *Awaiting Governor Response*

ID	Governor Name		
201	Pauline Beddoes	***Theme:*** Clinic letters	***Source:*** Governor Direct

Query **08/05/2018**

Patients who have hospital clinic appointments are often advised to have further tests, e.g. blood tests, or are prescribed new medication or changed dosages of existing drugs. The letters are then typed by the secretaries, but unfortunately these take days or even weeks to be sent to the patient's GP.

I understand that other Trusts are providing official forms outlining medication changes at the time of the appointment which patients can then bring into the surgery and the GP can action the changes. The official letter can then be sent later, as it usually is. Are there any plans to implement a similar process at UH Bristol?

Division: Trust-wide ***Executive Lead:*** *Chief Operating Officer* ***Response requested:*** 22/05/2018

Response **09/05/2018**

There are national standards for letter turnaround currently being implemented that will reduce the turnaround time to 7 days. There are no plans to make any other changes at present. If it is an urgent prescription change the consultant should give the patient an outpatient prescription before they leave the appointment.

Updated 02/07/18: If consultants make any changes to an outpatient's medication then the UH Bristol medicines code for prescribing states three options:
1. Immediate treatment appropriate. The patient is provided with 28 days' supply unless the course is shorter. The patient's GP is informed by letter.
2. Preparations for which prescribing remains with the Trust – ongoing supply. This means that the hospital provides the medication and repeat prescription for the patient. This usually means the patient will leave with a long enough course of medication to last until their next hospital outpatient appointment. The patient's GP is informed by letter.
3. No change to treatment or follow up needed – no supply. The patient's GP is informed by letter.

UH Bristol does not provide details for any prescription changes for patients to take away following an appointment as there is the possibility the details could be lost or not taken back to the GP. The best way to guarantee this information reaching the GP is via letter, which is uploaded to our Clinical Document Service.

Any requests for blood tests should be managed via ICE (our online Integrated Clinical Environment) by the hospital consultant. GPs and phlebotomists have access to ICE and so can look up patient bloods and results.

Status: *Closed*