University Hospitals Bristol
NHS Foundation Trust

Public Trust Board Meeting Papers

Date: 30 July 2019

Time: 11.15 – 13.45

Venue: Conference Room, Trust Headquarters

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Embracing change
Recognising success
Working together
Our hospitals.

Conference Room, Trust HQ, Marlborough St, Bristol, BS13NU

University Hospitals Bristol
NHS Foundation Trust

Board of Directors (in Public)

Meeting of the Board of Directors to be held in Public 30 July 2019 11.15 – 13.45
Conference Room, Trust HQ, Marlborough St, Bristol, BS1 3NU
AGENDA

NO.	AGENDA ITEM	PURPOSE	SPONSOR
Preliminary Business			
1.	Apologies for Absence – *Verbal update*	Information	Chair
2.	Declarations of Interest – *Verbal update*	Information	Chair
3.	Patient Story	Information	Chief Executive
4.	Minutes of the Last Meeting • **24 May 2019**	Approval	Chair
5.	Matters Arising and Action Log	Approval	Chair
6.	Chief Executive's Report	Information	Chief Executive
Patient Care and Clinical Outcomes			
7.	Quality and Performance Report	Assurance	Deputy Chief Executive and Chief Operating Officer, Chief Nurse, Medical Director, Director of People
8.	Quality and Outcomes Committee - Chair's Report	Assurance	Chair of the Quality and Outcomes Committee
9.	People Committee – Chair's Report	Assurance	Chair of the People Committee
10.	Audit Committee – Chair's Report	Assurance	Chair of Audit Committee
11.	Emergency Preparedness, Resilience and Response Annual Report	Assurance	Deputy Chief Executive and Chief Operating Officer
12.	Clinical Negligence Scheme for Trusts (CNST) Compliance Report	Approval	Chief Nurse
13.	Safeguarding Annual Report	Information	Chief Nurse
14.	Safe Working Hours Guardian Report	Assurance	Medical Director

NO.	AGENDA ITEM	PURPOSE	SPONSOR
15.	Annual Fire Report	Assurance	Deputy Chief Executive and Chief Operating Officer
16.	Patient Experience Q4 Report	Information	Chief Nurse
17.	Patient Complaints • Q4 Report • Annual Report	Information	Chief Nurse
18.	Infection Prevention Control Annual Report	Assurance	Chief Nurse
Strategic Performance and Oversight			
19.	People Strategy	Approval	Director of People
20.	Arts and Culture Strategy	Approval	Director of People
21.	Risk Management Strategy	Approval	Chief Executive
22.	WAHT Partnership and Merger Update	Assurance	Director of Strategy and Transformation
23.	Healthier Together Update	Information	Chief Executive
24.	Transforming Care Programme Board Report – Q1	Information	Director of Strategy and Transformation
25.	Phase 5 Strategic Capital Update	Information	Director of Strategy and Transformation
26.	Corporate Objectives Update – Q1	Information	Director of Strategy and Transformation
Financial Performance			
27.	Finance Report	Information	Director of Finance and Information
28.	Finance Committee – Chair's Report	Assurance	Chair of Finance Committee
Governance			
29.	West of England AHSN Board Report	Information	Chief Executive
30.	Register of Seals Report	Information	Trust Secretary
31.	NIHR CRN (hosted body report): • Annual Report • Annual Plan	Approval	Medical Director
32.	Self-Assessment of Board Cycle	Approval	Trust Secretary
33.	Reimbursement of Expenses for the Council of Governors Policy	Approval	Trust Secretary

NO.	AGENDA ITEM	PURPOSE	SPONSOR
34.	Governors' Log of Communications	Information	Trust Secretary
Concluding Business			
35.	Any Other Urgent Business – *Verbal Update*	Information	Chair
36.	Date and time of next meeting • **27 September 2019**	Information	Chair

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Meeting of the Board of Directors in Public on Tuesday 30 July 2019 in the Conference Room, Trust Headquarters

Report Title	**Patient Story**
Report Author	**Tony Watkin, Patient and Public Involvement Lead**
Executive Lead	**Carolyn Mills, Chief Nurse**

1. Report Summary

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

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

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

In this story we will meet Bob Golding. Bob's story starts in June 2018 when in his own words he was, "...suddenly and unexpectedly, while going about my business and living my life, stricken by a dreadful illness about which I knew very little at the time and which resulted in my being admitted to two Bristol hospitals consecutively for a total period of more than nine weeks."

Bob's care began at Southmead Hospital where he started to receive treatment for sepsis. After a short stay, he was transferred to the Bristol Heart Institute for additional specialist care with respect to a heart arrhythmia alongside continued care for his sepsis.

In sharing his story Bob will explain what it felt like to be a patient at the Bristol Heart Institute over a long period of time and the impact this had on him. He will comment on the challenges he faced to stay occupied and the observations he made about the staff going about their every-day business. In doing so he will touch on the quality of the personalised care the nurses offered him and how a diverse group of staff worked as one to ensure he was cared for well. In developing this theme Bob will comment on the importance of receiving clear and consistent messages from doctors. In doing so he will explain how, as his infection cleared, different and contradictory treatment programmes for his heart condition were discussed with him by various doctors, the uncertainty of which had left him feeling anxious and stressed.

Finally, Bob will reflect on what it felt like to be discharged from the Bristol Heart Institute as an in-patient and share the emotions he felt the moment he returned home.

"the day Bob was discharged from the Bristol Heart Institute several of the staff came to say good-bye"
Photo re-produced with the permission of Bob Golding

2. Key points to note
(Including decisions taken)

The story allows us to reflect on the needs of patients with complex health needs as they access care across a range of different organisations.

3. Risks
If this risk is on a formal risk register, please provide the risk ID/number.

The risks associated with this report include:
N/A

4. Advice and Recommendations
*(Support and Board/Committee decisions requested)***:**

- This report is for **INFORMATION**.
- The Board is asked to **NOTE** the report.

5. History of the paper
Please include details of where paper has previously been received.

N/A

Minutes of the Board of Directors Meeting held in Public
University Hospitals Bristol NHS Foundation Trust (UH Bristol)

Friday 24 May 2019 at 11:00 – 13:00, Conference Room, Trust Headquarters, Marlborough Street, Bristol, BS1 3NU

Present:
Board Members

Name	Job Title/Position
Jeff Farrar	Chair of the Board
Robert Woolley	Chief Executive
David Armstrong	Non-Executive Director
Madhu Bhabuta	Non-Executive Director (Designate)
Paula Clarke	Director of Strategy and Transformation
Julian Dennis	Non-Executive Director
Matt Joint	Director of People
Paul Mapson	Director of Finance and Information
John Moore	Non-Executive Director
Guy Orpen	Non-Executive Director
William Oldfield	Medical Director
Mark Smith	Deputy Chief Executive and Chief Operating Officer
Martin Sykes	Non-Executive Director
Steve West	Non-Executive Director

In Attendance:

Name	Job Title/Position
Helen Morgan	Deputy Chief Nurse (attending in place of Carolyn Mills, Chief Nurse)
Eric Sanders	Trust Secretary
Sarah Green	Associate Director of Education
Matthew Thackray	Press Officer
Mo Phillips	Public Governor
John Rose	Public Governor
Jonathan Seymour-Williams	Public Governor
Malcolm Watson	Public Governor
Tom Frewin	Public Governor
Ray Phipps	Patient Governor
Rashid Joomun	Patient Governor
Sue Milestone	Patient/Carer Governor
Garry Williams	Patient/Carer Governor
Florene Jordan	Staff Governor
Jane Sansom	Staff Governor
Sophie Jenkins	Appointed Governor (Joint Union Committee)
Tony Watkin	Patient and Public Involvement Lead (for Item 3)
Claire	Patient (for item 3)
James Watson	Member of the public

Elisa Lerchbaum	Member of the public
Olivia Sinclair	Member of the public
Barbara Needham	Member of the public
Ed Duncan	Member of staff
Liam Driver	Member of staff
Adam Postans	Member of the press

Minutes:
Sarah Murch: Membership and Governance Administrator

The Chair opened the Meeting at 11:10

Minute Ref	Item Number	Action
Preliminary Business		
18/05/2019	**1. Welcome and Introductions/Apologies for Absence**	
	The Chair of the Board, Jeff Farrar, welcomed everyone to the meeting. Apologies had been received from Carolyn Mills, Chief Nurse, with Helen Morgan, Deputy Chief Nurse, attending in her place.	
19/05/2019	**2. Declarations of Interest**	
	There were no new declarations of interest.	
20/05/2019	**3. Patient Story**	
	The meeting began with a Patient Story from Claire. Claire told the Board about her different experiences of health care provision by virtue of her multiple and complex health conditions. As a child, Claire had been diagnosed with a condition whereby the blood vessels in her brain had not formed properly. As a result, she had an increased susceptibility to having brain hemorrhages and epileptic fits. She had also been diagnosed with insulin-dependent diabetes and, more recently, with heart failure. Now in her thirties, she worked full-time but also had to be able to 'project manage' her own health in order to juggle the different aspects of her care. Having several conditions meant that she received care from various different organisations: at one time she had needed to deal with 14 different health professionals in different parts of the NHS. Her experiences highlighted the communication challenges between different specialties, for example, clinicians were not always aware of medication that she had been prescribed for her other conditions. Around five years ago, she had started working in a project with Bristol Community Health and other organisations to promote shared decision-making. This involved encouraging clinicians and patients to work together with the aim of helping people with long-term conditions to manage their own health. She pointed out that with 15.4m people in the UK living with at	

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	least one long-term condition, helping them to self-manage was going to become increasingly important. She spoke of the need for clinicians to be prepared to involve patients in decisions about their care. Sometimes it could be difficult for health professionals to accept that a patient could be an expert in their own condition, particularly in specialist fields such as cardiology. She gave examples of approaches that had worked well and not so well and suggested that clinicians needed to be able to think outside the box for some patients. Board members discussed the issues raised by Claire's story particularly in relation to understanding patient need and communication issues within and across different organisations. Paula Clarke, Director of Strategy and Transformation, noted that Claire had received training in navigating across the health system, and asked whether she had any suggestions for making this easier for others who were not as capable of speaking up. Claire responded that it would be easier if patients felt able to talk honestly with clinicians so that they were not afraid to ask if things could be done differently. Mark Smith, Deputy Chief Executive and Chief Operating Officer enquired how the co-ordination across departments could be improved with regard to medication challenges. Claire suggested that it would be helpful if patient administration systems were joined up across organisations, so that each specialism could immediately view her patient record and medication information. This would also save time having to explain them at each appointment. William Oldfield, Medical Director, apologised on behalf of the medical profession for its shortcomings when it came to working with patients and recognising their expertise. Claire had shared a video with Board members highlighting the value of shared decision-making, and he offered to share this with the Trust's medical staff. Steve West, Non-Executive Director, emphasised the importance of expert patients such as Claire engaging with students to help the clinicians of the future improve their understanding of how to empower patients and the Board agreed to take this forward. The Chair, Jeff Farrar, thanked Claire for her story. *Claire left the meeting.* **Public Question – Patients Not Passports** Before embarking on the business of the meeting, the Chair, Jeff Farrar, noted that several members of the public had come to the meeting to ask a question and he invited them to speak. Dr James Watson read out a statement on behalf of Bristol Patients Not Passports, a campaign group which advocated for people facing charges for	

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	NHS care and took action to end immigration checks and upfront charging in the NHS. He explained that the purpose of the campaign was to oppose the changes to the law introduced by the government in 2014 and 2017 to expand charging regulations for 'overseas visitors', which placed a duty on NHS Trusts to check the eligibility of all patients before providing treatment. Their petition, which had gained around 31,000 signatures, called for Robert Woolley as Chief Executive to suspend ID checks at UH Bristol, suspend upfront charging in the Trust and to call on Government to suspend charging in the NHS. The campaign group had submitted a question of this nature in advance to the Board, but had been dissatisfied with the response, which they felt was too focussed on the Trust's legal duties rather than the concerns that the group had raised about the financial, ethical, safety and healthcare aspects of upfront charges. Jeff Farrar, Trust Chair, thanked James Watson and his fellow campaigners for attending the meeting in person. He expressed an understanding of the issues raised by the group. He acknowledged that while the Trust had to comply with legal requirements there were other considerations to take into account, and he undertook to revisit the Trust's response to the group on this basis. It was noted that the question and response would be circulated to the whole Board and it was agreed that it could also be shared with governors. **Action: Circulate Patients Not Passports question and response to Board and Governors.** *The representatives of Patients Not Passports left the meeting.*	Trust Secretary
21/05/2019	**4. Minutes of the last meeting**	
	Board members reviewed the minutes of the meeting held on 30 April 2019. There were no amendments. **Members RESOLVED to:** • **Receive** the minutes of the Board of Directors meeting held in public on 30 April 2019 as a true and accurate record.	
22/05/2019	**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: **06/04/2019 Quality and Performance Report** **Consideration to be given as to whether cancelled operations metrics**	

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	in the Quality and Performance Report should be changed to provide further detail of the types of operations cancelled. The Board noted that the Trust's quality, access and workforce indicators were currently being reviewed and that a response would be provided in June. **10/04/2019 Healthier Together Sustainability and Transformation Partnership Update: UH Bristol's response to system working to be included in future Board seminar.** It was confirmed that this would be included in a future Board seminar. **180/11/2018 Report from the Chair of the People Committee** **Trust Chair to review People Committee membership and Executive Director attendance.** This would be reviewed when the new chair of the People Committee had been appointed. David Armstrong, Non-Executive Directors, noted that several actions had been closed on the basis that the Board intended to take action on them at some point in the future. He asked that actions remain open until there was assurance that they were being resolved so that they did not get lost. This was agreed. **Members RESOLVED to:** • **Note** the updates against the action log.	
23/05/2019	**6. Chief Executive's Report**	
	The Board received a summary report of the key business issues considered by the Senior Leadership Team in May 2019. Robert Woolley, Chief Executive, provided updates on the following matters: • **Care Quality Commission Inspection**: All elements of the CQC inspection had now concluded. The final report was expected in mid-August. Informal feedback had highlighted that inspectors had been impressed with the sense of pride among staff, and also with the quality of challenge from Board members and governors. Robert Woolley thanked all staff who had assisted with the co-ordination and support for the inspections. • **Operating Plan:** The Trust had been required to resubmit its operating plan the previous day. There had been minor adjustments to the plan since the Board had approved it. The adjustments were not material, but the final plan would be re-circulated to the Board for information. The Trust had still not signed its contract with Bristol, North Somerset and South Gloucestershire Clinical Commissioning Group, as there were still outstanding issues to resolve, particularly around the sharing of financial risk. A collective system plan for improving the management of urgent and emergency care outside of hospitals was being produced, and the system's Partnership Board would be the oversight board which would hold each organisation to	

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	account for their part in delivering those improvements. **Action**: Final version of Operating Plan to be circulated to the Board for information. **Members RESOLVED to:** • **Receive** the Chief Executive's Report for assurance.	Trust Secretary
Patient Care and Clinical Outcomes		
24/05/2019	**7. Quality and Performance Report**	
	Mark Smith, Deputy Chief Executive and Chief Operating Officer, presented the Quality and Performance Report, the purpose of which was to enable the Board to review the Trust's performance on Quality, Workforce and Access standards in the past month. **Access Standards:** • Mark Smith reported a broadly satisfactory performance. However, the percentage of Emergency Department patients seen in less than 4 hours was 78.3% for April which was disappointing, though there had been a similar deterioration in the position of Emergency Departments across the country. The high numbers of attendances and resulting deterioration in position had highlighted a need to consider longer-term assumptions around emergency care, and he undertook to carry out further analysis on this and report back to the Board. • The percentage of Referral To Treatment (RTT) patients waiting under 18 weeks had been maintained for 12 months in a row (89.0% at the end of April). The Trust was managing its waiting lists well which was linked to its ongoing work in capacity and demand modelling and critical care. • The Trust had achieved performance of 83.8% for its 62-day cancer standard for GP referrals in quarter 4. • Among recent developments to improve performance, he highlighted that the Clinical Utilisation Review was now embedded across the organisation. This was a system that enabled the Trust to assess whether patients were receiving the right care in the appropriate setting and it was helping to identify where delays were happening. The Trust had also agreed a 'silver trauma' business case which would help reduce length of stay for elderly patients in trauma and orthopaedics. **Action**: **Mark Smith to review Emergency Department performance and improvement measures in the light of ever-increasing demand and to report back to Board.** **Quality Standards:** • William Oldfield, Medical Director, reported that there had been no medication incidents resulting in moderate or higher level of harm in the month. However, he advised the Board that the Trust's recently-implemented electronic prescribing service had been suspended due	Deputy Chief Executive /Chief Operating Officer

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	to a server issue, and re-implementation was planned for mid-August. • He clarified that while the Board had previously noted higher than expected omitted doses of medication, having examined it in more detail, the issue now appeared to be one of poor data. • Mortality figures remained with the expected range but continued to be monitored. • Recruitment had commenced to support the new 'silver trauma' unit. **Workforce Standards**: • Matt Joint, Director of People, highlighted recent work carried out by the Trust with the aim of improving staff psychological wellbeing, given that depression, anxiety and stress were the biggest causes of staff absences. • The Trust had finalised the Trust's diversity and inclusion strategy. • Work was ongoing to evaluate the results of last year's staff survey and determine the focus for action plans. • Recruitment checks had begun for the August intake of doctors. • The Trust was slowly recovering its position in relation to staff annual appraisals, following issues with the system. Garry Williams, Patient/Carer Governor referred to the pressures on the Emergency Department and asked that the Trust's champions for carers and more vulnerable patients positively ensure that their needs were still being adequately met even when services were busy, for example in terms of appropriate discharge. This was noted. John Moore, Non-Executive Director, expressed concern that it would take four months to get the electronic prescribing system up and running again. Paul Mapson, Director of Finance and Information, explained that the system had evolved over time with additions to suit the Trust's requirements and that there were conflicts with the patient administration system which would take some time to resolve. John Rose, Public Governor, referred to the Trust's report on its staff survey results. Governors had questioned why it presented a much more positive assessment of staff satisfaction than had been previously revealed through other data, for example in relation to the challenges faced by the Trust on equality issues. He enquired as to whether the People Committee were aware of staff perceptions on this issue. Matt Joint responded that while the Trust was satisfied with the progress that it was making overall, it recognised that there was still some serious work to do in some areas. **Members RESOLVED to:** • **Receive** the Quality and Performance Report for assurance.	

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25/05/2019	**8. Quality and Outcomes Committee Chair's Report**	
	Julian Dennis, Chair of the Quality and Outcomes Committee, highlighted the following key issues from the Committee's meetings in May: • The committee had received an update on the Trust's performance against key targets and considered the key risks allocated to the committee. • The committee had discussed the Trust's deterioration in performance in relation to the Emergency Department 4-hour target. They had highlighted that more information was required in order to understand this. • They had asked questions about the suspension of the electronic prescribing system and had sought assurance that this would be relaunched and monitored effectively. • The committee had considered the Trust's mortality rates and although overall they were within the expected range they had requested more information on the rates at weekends. • They had received and reviewed the annual Quality Report. **Members RESOLVED to:** • **Receive** the Quality and Outcomes Committee Chair's report for assurance.	
26/05/2019	**9. Report from the Chair of the People Committee**	
	John Moore, Non-Executive Director and interim Chair of the People Committee, reported the following key issues from the Committee's meeting in May: • The committee had received an update on workforce performance including progress against Key Performance Indicators. • The committee had reviewed the draft framework for reporting workforce and education performance. • The committee had received the Trust's Organisational Development plans and had welcomed the breadth of these, as they included diversity, inclusion, engagement, leadership management and development, performance management, staff recognition, bullying and harassment, and staff wellbeing. In particular, the committee was assured that significant progress was being made to put in place measures which aimed to improve the wellbeing of staff. • A presentation on the Trust's library services had impressed the committee, particularly as the library was the most efficient service in the south west, and its strategy set out its ambitious aims. • An update had been received on the impact of the Community Outreach programme, which involved work with schools, particularly in underprivileged areas, to talk about careers in healthcare. Feedback from schools was very good and this could have an impact	

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	on the Trust's long-term recruitment agenda. Board members welcomed the progress made by the People Committee in determining appropriate metrics for measuring workforce performance Jeff Farrar asked Matt Joint to thank Sam Chapman, Head of Organisational Development, for her work in this regard. It was noted that the People Committee terms of reference were aligned to the Trust's new five-year strategy, and it was suggested that other Committees also ensure their alignment with this. Board members welcomed the achievements of both the community outreach initiative and the library service and highlighted the enthusiasm of the staff leading these. The potential for developing the library service even further was noted, particularly in relation to collaboration with the universities. **Action**: **Review Terms of Reference for Board Committees to ensure alignment with the new Trust five-year strategy.** **Members RESOLVED to:** • **Receive** the People Committee Chair's report for assurance.	Trust Secretary/ Committee Chairs
27/05/2019	**10. Freedom to Speak Up Strategy and Annual Report**	
	Eric Sanders, Freedom to Speak Up Guardian, presented his second annual report of the Freedom to Speak Up initiative, including progress against its agreed objectives, and a draft strategy for the Board's approval. Key points were as follows: • Good progress had been made against the objectives however further work was required to ensure that all staff were aware of Freedom to Speak Up and had confidence in it. • There had been a focus on promotion in the second half of the year, supported by a network of more than 30 members of staff who had volunteered to become Freedom to Speak Up Advocates. • Greater promotion of the initiative had led to a significant increase in the number of concerns raised. There had been 32 concerns raised in 2018/19 compared with 13 in 2017/18. Themes included clinical practice, culture in teams, implementation of HR policy, and decision-making in the organisation. The National Guardian's Office had completed five case reviews from these cases and the learning from these was summarised in the report. • Eric Sanders highlighted that in all cases closed there had been a thorough investigation of the issues and no staff had identified any detriment for speaking up. • The latest annual staff survey results had shown improvements in the relevant metrics around staff raising concerns, but it had also shown	

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	that there was more to do in this area. Jeff Farrar, Trust Chair, noted that Care Quality Commission had described that the Trust's approach to Freedom to Speak Up initiative as passionate and determined. It was important to the Trust and the increase in numbers was a sign of success in that more staff felt confident to use it and more issues were being exposed. Julian Dennis, Non-Executive Director, noted his role as the Trust's Senior Independent Director in supporting the Freedom to Speak Up programme. He referred to a current lack of non-pay resources to support publicity and suggested that perhaps this work was of such importance that the Trust should not need to seek outside support for this. This was noted. Garry Williams, Patient/Carer Governor, added that the scheme's achievements were a sign of the confidence that Eric Sanders had inspired as Freedom to Speak Up Guardian in the past year and he asked that the Board ensure that there was continuity in the funding of this post. **Members RESOLVED to:** • **Receive** the Freedom to Speak Up Annual Report to note. • **Approve** the Freedom to Speak Up strategy.	
Strategic Performance and Oversight		
28/05/2019	**11. Healthier Together Partnership Board – Terms of Reference**	
	Robert Woolley, Chief Executive, introduced the terms of reference for the new Partnership Board for the Healthier Together Sustainability and Transformation Partnership (STP - the collaboration between health and care organisations across Bristol, North Somerset and South Gloucestershire - BNSSG). As UH Bristol was one of the partner organisations of Healthier Together, the Board was asked to consider the terms of reference for approval. He explained that the new board would replace the Healthier Together sponsoring board currently chaired by Sir Ron Kerr. It would comprise Chief Executives and Chairs of partner organisations and would be responsible for setting the strategic direction of the system. He drew the Board's attention to the fact that the new board would have responsibility for collective decision-making on behalf of the health system in BNSSG, and that this would include decisions required as the result of any shifts in authority for the system, performance monitoring or resources allocated to the system. However, it would have no formal delegated authority in itself. Constituent Partner Organisation Boards therefore remained accountable for all aspects of their business in line with statutory frameworks, though sovereign boards could delegate a service, budget or items for decision making to the Partnership Board. This reflected the national drive to allocate resources to regional systems rather than to separate organisations.	

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	In seeking Board approval for this approach, he explained the significance of this development. While the new board would not at present dilute the sovereignty of its partners, it reflected a clear intention to move towards collective decision-making which would develop over time. Board members discussed the terms of reference. It was welcomed as a positive step forward, though the need for further refinement was recognised. David Armstrong, Non-Executive Director, noted that they would benefit from a more detailed stakeholder analysis and a more explicit explanation of how the system was managing policy and process, finance and estates. Madhu Bhabuta, Non-Executive Director (Designate), noted that it was still unclear exactly how funding would arrive into the STP and how it would be managed. In response to a question about the mechanisms for reporting back, it was that clarified that Chief Executives and Chairs would report back to their constituent boards, and all partner boards would also receive meeting minutes and key messages. In response to a question from Steve West, Non-Executive Director, about the need to develop a collective response to workforce planning, Robert Woolley confirmed that this had been recognised and that UH Bristol was represented on the joint workstream to progress this. Guy Orpen, Non-Executive Director, also asked that consideration be given to the BNSSG footprint, as it did not include some nearby localities such as Bath. The misalignment between the local authority areas, local enterprise partnership areas and the BNSSG STP was noted. **Members RESOLVED to:** • **Approve** the establishment of the Healthier Together Partnership Board and its Terms of Reference.	
29/05/2019	**12. Diversity and Inclusion Strategy**	
	Matt Joint, Director of People, introduced the Trust's new Workforce Diversity and Inclusion Strategy (2020-2025), which was before the Board for approval. The strategy was a culmination of extensive stakeholder work conducted over the last three months in partnership with the National Workforce Race Equality team, including a staff workshop in February and input from governors, Staff Side, Trust forums, and a task and finish group. It was intended that this would be an action-led strategy and he asked the Board to note that the outline action plan included would become more detailed in due course. **Members RESOLVED to:** • **Approve** the Workforce Diversity and Inclusion Strategy 2020-2025	
30/05/2019	**13. Research and Innovation Strategy**	
	William Oldfield, Medical Director, introduced the Trust's Research and Innovation Strategy 2020-2025, which had been refreshed in line with the	

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	Trust's new five-year strategy. It had been the result of extensive consultation internally and externally. There was little change from the Trust's existing strategy, as it was found to be fit for purpose. The Trust would continue to focus on its particular strengths, but would also work to further embed the culture throughout the organisation that 'research was everybody's business', and would continue to prioritise collaboration with its partners in the region. Guy Orpen and Steve West, Non-Executive Directors, voiced particular support for this strategy in the context of their university roles. Guy Orpen recommended strengthening the key performance indicators and the ownership of them, in both this and also the new Education Strategy (Item 14). These should describe how the research culture would be embedded through the Trust (for example, by emphasising that staff could benefit their careers through involvement in research and including a stronger focus on research in recruitment processes). This was agreed. Steve West, Non-Executive Director, asked that the strategy also include reference to the Local Enterprise Partnership and the local industrial strategy, in which there was likely to be an increasing focus on health research and which could become a route for funding streams. **Action: Review and strengthen key performance indicators in the Research and Innovation Strategy to include more detail on their ownership and their reach throughout the organisation. Include reference to the Local Enterprise Partnership and West of England Combined Authority.** **Members RESOLVED to:** • **Approve the Trust's Research and Innovation Strategy 2020-2025.**	Medical Director
31/05/2019	**14. Education Strategy**	
	Sarah Green, Associate Director of Education, introduced the Education Strategy for 2020-2025 for approval. This had previously been discussed by the Board through the People Committee. It had been developed with engagement internally and externally and with reference to benchmarking and best practice. It reflected the importance of education and training in the Trust's vision and refreshed strategic priorities. It also reflected the increasing importance that education would have in relation to the recruitment and retention of staff. The strategy encompassed education for both clinical and non-clinical staff and also the Trust's role in providing training and its relationships with other organisations in this regard. Board members expressed appreciation of the Education Strategy, as it was something that the Trust had previously been lacking. David Armstrong, Non-Executive Director welcomed the format of the report, and asked that the metrics include a more granular level of detail. Steve West, Non-Executive Director, again suggested a reference to the Local Enterprise	

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	Partnership and the combined authority as a key source for skills and funding. Madhu Bhabuta, Non-Executive Director (Designate), suggested that the interplay between the Research and Innovation Strategy and the Education Strategy could be more clearly demonstrated. Matt Joint, Director of People, noted these comments and sought Board approval for the strategy. **Action: Review and strengthen key performance indicators in the Education Strategy. Include reference to the Local Enterprise Partnership and West of England Combined Authority.** **Members RESOLVED to:** • **Approve the Trust's Education Strategy 2020-2025.**	**Director of People**
Financial Performance		
32/05/2019	**15. Finance Report**	
	Paul Mapson, Director of Finance and Information, introduced the Finance Report which informed the Board of the financial position of the Trust in April. He advised the Board that the month one (April) position should be regarded as indicative only as not all funding had yet been received, but the Trust was already reporting an adverse position mostly in relation to activity delivery. The Month 2 report would show a more reliable position. Jeff Farrar, Trust Chair, publicly recorded the Board's thanks to Paul Mapson, as this would be his last Board meeting in public in the position of Director of Finance. His expertise and experience would be greatly missed by the Trust and all who had worked with him over the years. **Members RESOLVED to:** • **Receive** the Finance Report for assurance.	
33/05/2019	**16. Finance Committee Chair's report**	
	Martin Sykes, Finance Committee Chair, introduced a report from the meeting of the Finance Committee on 21 May, including the following key points: • The committee had discussed service efficiency and profitability and had sought further assurance in this regard. • In discussing strategic financial risks to the Trust, it was noted that the Board had recently reviewed its risk appetite and tolerance in relation to strategic risk. The financial risk scores would therefore be reviewed to ensure that the target and actual scores remained realistic and achievable and in line with the Trust's stated tolerance.	

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	Members RESOLVED to: • **Receive** the Finance Committee Chair's report for assurance.	
Governance		
34/05/2019	**17. Audit Committee Chair's Report**	
	David Armstrong, Non-Executive Director and Chair of the Audit Committee, reported back from the committee's meeting on 23 May. Key points were as follows: • The meeting had been dedicated to a thorough review of the Trust's Annual Report and Accounts and the opinion of internal and external auditors on these. • The committee had been advised by the external auditor that their audit had found no issues with the Annual Report and Accounts 2018/19, and in their opinion the Trust's financial statements for the year 2018/19 gave a true and fair view of the state of the Trust's affairs and of the Trust's income and expenditure and cash flows, and had been prepared in accordance with the Department of Health and Social Care Group Accounting Manual 2018/19. The committee noted that there were no strong recommendations for this year. • The committee had received the internal auditor's overall opinion that significant assurance could be given that there was a generally sound system of internal control within the Trust. • The committee had been impressed with the smooth running of this year's annual reporting process and had recommended approval of the Annual Report and Accounts 2018/19 and the approval of Quality Report 2018/19. **Members RESOLVED to:** • **Receive** the Audit Committee Chair's report for assurance.	
35/05/2019	**18. Audit Committee Terms of Reference**	
	Eric Sanders, Trust Secretary, presented a revised set of Terms of Reference for the Audit Committee for review and approval by the Board. He highlighted that there had been some significant changes to the Terms of Reference, as they had been thoroughly reviewed by the Chair of the Committee and the Trust Secretary to ensure that they reflected best practice and guidance. A new stakeholder analysis section had been included which sought to identify the inputs into and requirements of the committee. A new provision had also been included to clarify the committee's role around information governance and data protection. **Members RESOLVED to:** • **Approve** the revisions to the Audit Committee Terms of Reference.	

Minute Ref	Item Number	Action
36/05/2019	**19. Transforming Care Programme Board Report**	
	Paula Clarke, Director of Strategy and Transformation, introduced the Transforming Care Programme Board Report. The report described the highlights for the period January-March 2019 (quarter 4) against the three priority areas agreed for the Transformation Board and the Transformation Team: Digital Transformation, Productivity Improvement and the Quality Improvement programme. It also outlined the agreed Transforming Care priorities for 2019/20. Paula noted that these priorities aligned with many of the key issues discussed at the Board meeting today both internally and working within the local system. **Members RESOLVED to:** • **Receive** the Transforming Care Programme Board Report to note.	
37/05/2019	**20. Register of Seals – Q4**	
	Eric Sanders, Trust Secretary, introduced the quarterly report showing applications of the Trust Seal and informed the Board that there had been no new applications of the Trust Seal in quarter 4. **Members RESOLVED to:** • **Receive** the Register of Seals report to note.	
38/05/2019	**21. Provider Licence Self-Certification**	
	Eric Sanders, Trust Secretary, presented the Trust's proposed self-certifications against the NHS Provider Licence conditions for approval by the Board. The report provided evidence that the Trust was compliant with all four of the specific provisions of the licence. Once approved by the Board, this would be published on the Trust's website. **Members RESOLVED to:** • **Approve** the Trust's provider licence self-certifications.	
Items for Information		
39/05/2019	**22. Governors' Log of Communications**	
	The purpose of this report was to provide the Board with an update on all questions asked by governors to officers of the Trust through the Governors' Log of Communications. **Members RESOLVED to:** • **Receive** the Governors' Log of Communications for information.	
40/05/2019	**23. West of England Academic Health Science Network Board Report**	
	This was the quarterly report of the March 2019 Board meeting for the member organisations of the West of England Academic Health Science	

Minute Ref	Item Number	Action
	Network. It was included for information and Board awareness. **Members RESOLVED to:** • **Receive** the West of England Academic Health Science Network Board Report for information.	
Concluding Business		
41/05/2019	**24. Any Other Urgent Business**	
	There was no further business. The Chair closed the meeting at 13:05.	
42/05/2019	**25. Date and time of Next Meeting**	
	The date of the next meeting was confirmed as **11.00 – 13.00, Tuesday 30 July 2019, Conference Room, Trust HQ, Marlborough Street, Bristol, BS1 3NU.**	

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

University Hospitals Bristol
NHS Foundation Trust

Public Trust Board of Directors meeting
30 July 2019
Action Tracker

Outstanding actions from the meeting held on 24 May 2019					
No.	**Minute reference**	**Detail of action required**	**Responsible officer**	**Completion date**	**Additional comments**
1.	20/05/2019	**Patient Story** Circulate Patients Not Passports question and response to Board and Governors.	Trust Secretary	July 2019	Completed The Board and Governors were sent the question and response via email.
2.	24/05/2019	**Quality and Performance Report** Mark Smith to review Emergency Department performance and improvement measures in the light of ever-increasing demand and to report back to Board.	Deputy Chief Executive and Chief Operating Officer	July 2019	Work in Progress Work with executive directors and divisions to develop plan to mitigate position and improve flow.
3.	26/05/2019	**Report from the Chair of the People Committee** Review Terms of Reference for Board Committees to ensure alignment with the new Trust five-year strategy.	Trust Secretary/ Committee Chairs	July 2019	Work in Progress This review is in progress.
4.	30/05/2019	**Research and Innovation Strategy** Review and strengthen key performance indicators in the Research and Innovation Strategy to include more detail on their ownership and their reach throughout the organisation. Include reference to the Local Enterprise Partnership and West of England Combined Authority.	Medical Director	July 2019	Work in Progress Update to be provided at the July 2019 meeting.
5.	31/05/2019	**Education Strategy** Review and strengthen key performance indicators in the Education Strategy. Include reference to the Local Enterprise Partnership and West of England Combined Authority.	Director of People	July 2019	Work in Progress Update to be provided at the July 2019 meeting.

6.	06/04/2019	**Quality and Performance Report** Consideration to be given as to whether cancelled operations metrics in the Quality and Performance Report should be changed to provide further detail of the types of operations cancelled.	Deputy Chief Executive and Chief Operating Officer	July 2019	Work in Progress The Trust's quality, access and workforce indicators were currently being reviewed and that a response would be provided in July.
7.	10/04/2019	**Healthier Together Sustainability and Transformation Partnership Update** UH Bristol's response to system working to be included in future Board seminar.	Trust Secretary	July 2019	Work in Progress This item is being considered as part of the 2019/20 Board Development plan.
8.	214/03/2019	**Quality and Performance Report** Connection between demand, capacity and estate to be explored at a future Board Seminar.	Trust Secretary	July 2019	Work in Progress This item is being considered as part of the 2019/20 Board Development plan.
9.	217/03/2019	**Six-Monthly Nurse Staffing Report** Model Hospital digital tool to be demonstrated to the Board.	Trust Secretary	July 2019	Work in Progress This item is being considered as part of the 2019/20 Board Development plan.
Closed actions from the meeting held on 24 May 2019					
No.	**Minute reference**	**Detail of action required**	**Responsible officer**	**Completion date**	**Additional comments**
1.	180/11/2018	**Report from the Chair of the People Committee** Trust Chair to review People Committee membership and Executive Director attendance	Chair /Trust Secretary	May 2019	Completed Trust Chairman will review with the new Chair of the People Committee once they are in post.
2.	180/11/2018	**Report from the Chair of the People Committee** Trust Chair to review People Committee membership and Executive Director attendance	Chair /Trust Secretary	May 2019	Completed Trust Chairman will review with the new Chair of the People Committee once they are in post.

Meeting of the Board of Directors in Public on Tuesday 30 July 2019 in the Conference Room, Trust Headquarters

Report Title	**Chief Executive Report**
Report Author	**Robert Woolley, Chief Executive**
Executive Lead	**Robert Woolley, Chief Executive**

1. Report Summary
To report to the Board on matters of topical importance, including a report of the activities of the Senior Leadership Team.
2. Key points to note *(Including decisions taken)*
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 2019.
3. Risks **If this risk is on a formal risk register, please provide the risk ID/number.**
N/A
4. Advice and Recommendations *(Support and Board/Committee decisions requested)*:
• This report is for **INFORMATION**. • The Board is asked to **NOTE** the report.
5. History of the paper **Please include details of where paper has previously been received.**
N/A

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Respecting everyone
Embracing change
Recognising success
Working together
Our hospitals.

APPENDIX A

SENIOR LEADERSHIP TEAM

REPORT TO TRUST BOARD – JULY 2019

1. INTRODUCTION

This report summarises the key business issues addressed by the Senior Leadership Team in June and July 2019.

2. QUALITY, PERFORMANCE AND COMPLIANCE

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

3. STRATEGY AND BUSINESS PLANNING

The group **received** an update on the management of waiting list initiative payments and supported the proposed implementation plan.

The group received an update on the current position in respect of the merger with Weston Area Health Trust.

The group **approved** the Outline Business Case for future neonatal care services in Bristol for onward submission to the Trust Board and progress to the Full Business Case.

The group **approved** the Full Business Case for additional generator capacity to support the proposed Phase 5 strategic programme.

The group **noted** the Business Case for the convergence of Information Management and Technology service operations and the adoption of operational information technology based systems and digital practices used by UH Bristol with Weston Area Health Trust.

The group received an update on NHS pensions and annual tax allowances and requested that work be undertaken to clarify and communicate the position inside the Trust.

The group **supported** system-wide proposals to deliver a significant reduction in high cost agency usage in the 2019/2020 financial year.

4. RISK, FINANCE AND GOVERNANCE

The group **received** updates on the financial position.

The group **received** an update on the Workplace Culture Review of the Dental Hospital and School and noted next steps.

The group **supported** the use of the Medway Venous Thromboembolism Prevention (VTE) risk assessment as the sole system for completing inpatient VTE risk

assessments, enabling improved performance monitoring, reporting and prevention. It was agreed to review again in three months.

The group **noted** plans to appoint an Associate Medical Director for Primary Care to develop the intent to integrate local hospital services with our local communities and localities to support joint working between acute and primary care teams and improve patient experience.

The group **approved** the People Strategy, Risk Management Strategy, Arts and Culture Strategy and Acute Care Collaboration Strategy for onward submission to the Trust Board.

The group received the Annual report on Junior Doctor Rota Gaps and Vacancies and **supported** its onward submission to the Trust Board.

The group **approved** the Emergency Preparedness Annual Report for onward submission to the Trust Board.

The group **approved** revised Terms of Reference for the Clinical Quality Group, Phase 5 Programme Board and Risk Management Group.

The group **received** the Quarter 4 Complaints and Patient Experience Reports for onward submission to the Trust Board.

The group **approved** the Annual Complaints report for onward submission to the Trust Board.

The group **approved** the revised Local Access Policy.

The group **approved** the Quarter 1 Strategic Risk Report for onward submission to the Trust Board.

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

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

The group **noted** the Quarter 1 Corporate Objectives update report.

The group **noted** the Quarter 1 Corporate Quality Objectives update report.

The group **received** an update on Healthier Together/Integrated Care Services.

The group **received** an update on use of the Happy App.

The group **received** an update on the Patient Safety Improvement Programme 2019/2021.

The group **received** one satisfactory Internal Audit Report in relation to Quality of Appraisals (non-Medical), an update on outstanding recommendations and the 2019/2020 Internal Audit Plan.

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

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

The group **received** an update report from the Congenital Heart Disease Network.

The group **received** the Clinical Research Network West of England Annual Report 2018/2019.
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.

Mark Smith
Deputy Chief Executive/Chief Operating Officer
July 2019

Meeting of the Board of Directors in Public on Tuesday 30 July 2019 in the Conference Room, Trust Headquarters

Report Title	**Quality and Performance Report**
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/William Oldfield, Medical Director** **Workforce – Matt Joint, Director of People**

1. Report Summary	
To review the Trust's performance on Quality, Workforce and Access standards.	
2. Key points to note *(Including decisions taken)*	
Please refer to the Executive Summary in the report.	
3. Risks **If this risk is on a formal risk register, please provide the risk ID/number.**	
None	
4. Advice and Recommendations *(Support and Board/Committee decisions requested)***:**	
• This report is for **ASSURANCE**. • The Board is asked to **NOTE** the report.	
5. History of the paper **Please include details of where paper has previously been received.**	
Quality and Outcomes Committee	25 July 2019
People Committee	25 July 2019

University Hospitals Bristol
NHS Foundation Trust

Quality and Performance Report

July 2019

1.1 OVERVIEW – Executive Summary

Single Oversight Framework

- The 62 Day Cancer standard for GP referrals achieved 86.0% for May which has achieved the national standard of 85%
- The measure for percentage of A&E patients seen in less than 4 hours was 81.5% for June. This did not achieve the 95% national standard or the improvement trajectory target of 90.5%.
- The percentage of Referral To Treatment (RTT) patients waiting under 18 weeks was 87.5% as at end of June. This did not achieve the national 92% standard or the improvement trajectory target of 87.9%. This was the first time in 14 months that the recovery trajectory was missed, albeit narrowly.
- The percentage of Diagnostic patients waiting under 6 weeks at end of June was 93.5%, with 579 patients waiting 6+ weeks. This is lower than the national 99% standard. The maximum allowed breaches to achieve 99% was 90.

Headline Indicators

There were two Clostridium Difficile cases in June which keeps the Trust below the maximum allowed for the financial year of 57 cases. In addition, there were no MRSA cases in June. Pressure ulcer and patient falls incidence remained below target in June with zero grade 3 or 4 pressure ulcers and no falls resulting in harm.

The headline measures from the monthly patient surveys and the Friends and Family Test remain above their minimum target levels in June 2019. In Complaints, 96% of formal complaints were responded to within deadline which achieved the 95% standard. 12% of April's complaint responses were re-opened due to complainant being dissatisfied with the original response.

Last Minute Cancelled Operations (LMCs) were at 1.8% of elective activity and equated to 117 cases. 8 patients were not re-admitted within 28 days following an LMC.

Workforce

June 2019 compliance for Core Skills (mandatory/statutory) training remained at 90% overall across the eleven programs, for the third consecutive month.

In June 2019, total staffing was at 8900 full time equivalents (FTE). Of this, 5.0% was Bank (449 FTE) and 1.2% was Agency (110 FTE). With system partners and the neutral vendor for nurse agency supply, communication plans are underway for the system wide programme to reduce high cost agency use. Turnover increased slightly to 13.3% from 13.2% last month, with increases in four divisions – Diagnostics and Therapies, Medicine, Trust Services, and Women's and Children's. Overall vacancies increased to 5.5% compared to 5.2% in the previous month, with tree staff group increases, the largest being within Admin and Clerical increasing to 108.2 FTE from 95.34 FTE the previous month.

In June, 3.9% of all available days were lost to staff sickness. Deep dive and hotspot reports are being provided as appropriate, to support areas to develop action plans. Over 300 staff and managers have attended the workplace wellbeing training which supports staff with stress related issues supported by a suite of self-help guides.

Overall appraisal compliance reduced to 73.4% (from 73.9%). However, there were increases in two divisions; Medicine and Women's & Children's, although all divisions are now non-compliant. With the drop in compliance this month, a recovery plan continues to be in place to focus on direct action with areas of low compliance. Support includes: 1) fortnightly communications to all managers with a targeted message and all staff communications via Newsbeat to promote Appraisal resources, 2) Appraisal Training frequency has now increased to enable 30 managers to attend each month and 3) review of HR Web and supporting Appraisal documentation has commenced with a number of new guides for staff and managers.

1.2 OVERVIEW – Single Oversight Framework

Financial Year 2018/19

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	83.96%	91.14%	92.84%	90.26%	90.07%	85.00%	89.16%	84.24%	83.05%	84.50%	81.05%	81.23%
	"Trust Footprint" (Year To Date)	92.05%			91.77%			90.84%			89.84%		
	Trajectory	90%	90%	90%	90.53%	91.26%	90.84%	90.06%	90.33%	87%	84%	87%	90%
	"Trust Footprint" Trajectory	90.0%			90.0%			90.0%			95.0%		
Cancer 62-day GP Standard: 85%	Actual (Monthly)	84.1%	82.4%	86.0%	85.7%	88.9%	87.4%	85.5%	87.9%	86.5%	85.1%	83.5%	82.9%
	Actual (Quarterly)	84.2%			87.3%			86.6%			83.8%		
	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%	88.9%	88.7%	88.5%	89.6%	90.1%	89.3%	89.4%	89.1%	89.2%
	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%	97.9%	97.1%	98.1%	98.4%	96.9%	93.8%	93.3%	96.9%	95.5%
	Trajectory	97.9%	97.9%	97.9%	98.4%	99.0%	98.0%	98.0%	98.0%	98.0%	98.0%	99.0%	99.0%

GREEN rating = national standard achieved
AMBER rating = national standard not achieved, but STF trajectory achieved (with Walk In Centre uplift for A&E 4 Hour standard).
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 (WIC) and Minor Injury Units (MIU) in their region. This apportionment is carried out and published by NHS England as "Acute Trust Footprint" data. This data is being used to assess whether a Trust achieved the recovery trajectory for each quarter. The A&E "Trust Footprint" data above relates to Trust performance after WIC and MIU data has been added.

1.2 OVERVIEW – Single Oversight Framework

Financial Year 2019/20

Access Key Performance Indicator		Quarter 1 2019/20			Quarter 2 2019/20			Quarter 3 2019/20			Quarter 4 2019/20		
		Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20
A&E 4-hours **Standard: 95%**	Actual	78.3%	78.0%	81.5%									
	Trajectory	84.5%	90.5%	90.5%	90.5%	90.5%	85.5%	89.7%	84.7%	83.5%	85.0%	81.6%	81.7%
Cancer 62-day GP **Standard: 85%**	Actual (Monthly)	86.8%	86.0%										
	Actual (Quarterly)												
	Trajectory (Monthly)	85%	85%	85%	83%	85%	85%	85%	85%	85%	85%	85%	85%
	Trajectory(Quarterly)	85%			85%			85%			85%		
Referral to Treatment **Standard: 92%**	Actual	89.0%	88.1%	87.5%									
	Trajectory	87.9%	87.9%	87.9%	87.9%	87.9%	87.9%	87.9%	87.9%	86.9%	86.9%	86.9%	87.9%
6-week wait diagnostic **Standard: 99%**	Actual	95.3%	93.4%	93.5%									
	Trajectory	96%	96%	97%	97%	98%	99%	99%	99%	99%	99%	99%	99%

GREEN rating = national standard achieved
AMBER rating = national standard not achieved, but STF trajectory achieved (with Walk In Centre uplift for A&E 4 Hour standard).
RED rating = national standard not achieved, the STF trajectory not achieved

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	• Delivering the 62 day GP national standard in April and sustaining this in May (both months >86%). • The diagnostic echocardiography service is predicting a return to delivering the 99% 6-week standard by end of quarter 2. Significant reduction in breach numbers has been delivered: 379 in January 2019, with 80 predicted for end of July. • The non-obstetric ultrasound waiting list has shown significant improvement in 6 week breaches: 153 at end of March, predicting 30 for end of July. • The implementation of electronic Referral Service (eRS) is being moved from project phase to business as usual. Negotiations with commissioners for certain clinics to be exempt are ongoing. 11 appointments had paper referrals in May 2019. • The teledermatology service went live on eRS on 3rd June 2019; this enables GPs to request diagnostic advice for dermatological conditions by sending photographs to a consultant for review. This replaces the existing platform and is more cost effective for both GPs and the Trust. • The system-wide (Bristol, North Somerset, South Glocs) outpatient transformation workshop took place on the 25th June for clinical and managerial staff. UHBristol was well represented at the event and lots of good ideas were proposed for improving outpatient services. • The work with our commissioners to review the local patient access policy is now complete.	• Sustaining delivery of the GP Cancer 62 Day standard of 85% in quarter 1 • Recovering performance against the 31 day first definitive treatment standard by preventing further surgical cancellations and recovering from the impact of previous cancellations • Recover performance against the subsequent radiotherapy standard following deterioration due to the extensive cleaning required following 2018's major fire in the department • June's Referral To Treatment performance was slightly below the 97.9% standard; the Trust achieved 97.5%. Focus is on returning to standard for July. • The divisional focus remains on reducing Outpatient follow-ups that are overdue by more than 6 months • There is a system-wide (Bristol, North Somerset, South Glocs) outpatient transformation workshop on the 25th June for clinical and managerial staff. This will guide future opportunities to work smarter within outpatients. • Much greater cross Trust working with NBT and Weston on outpatient transformation, it is hoped to achieve standardisation of pathways within identified specialities. • The changes to the local access policy will be included into an internal Standard Operating Procedure (SOP), to be presented at Senior Leadership Team on 17th July for approval.

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

	Opportunities	Risks and Threats
ACCESS	• Opportunity to maintain cancer performance with new national rules for allocation of performance between providers – rules came into place from April 2019 and positive impact has been seen, impact evaluation and management is ongoing • The improvement work around the Medway patient administration system (PAS) continues. An options paper will be written during June to document our proposal and is reliant on increasing the staffing levels in the corporate Performance team in order to see the work and developments required to be achieved. • The Division of Medicine is recruiting into the agreed key ED roles for this year, which will include an additional middle grade doctor overnight in the ED, additional resuscitation nurses and an expansion in the ED consultant workforce (2 new WTE consultants start in the team in October 2019 and we are advertising for a third). • Medicine are recruiting to a multi-disciplinary front door frailty team consisting of a consultant geriatrician, specialist nurses and a pharmacist • The outpatients BNSSG STP has been chosen to be part of the national Elective Care Transformation Programme, led by NHSI. This will enable whole system transformation and provided training and networking opportunities to staff and patients representatives. • A system-wide review of Endoscopy services is underway, across BNSSG, to assess potential for better utilisation of capacity across the region and improving pathway flow. • Three specialities that have been identified to review reducing follow-ups across the system: Ophthalmology, haematology and T&O. Clinicians in all three are being contacted to engage them in designing the proposed change. • Further evaluation of advice and guidance is planned for 2019/20, it is hoped that this can be used to put forward a business case to support a tariff for advice and guidance for 20/21.	• Surgical cancellations of cancer patients have affected the 62 day GP, 31 day first definitive treatment, and 31 day subsequent surgery standards for cancer. 33% 62 day GP breaches, 58% first definitive breaches and 100% subsequent surgery breaches in April were a direct result of surgical cancellation. Preventing further cancellations (which mainly occur due to lack of critical care beds) and recovering from the impact of previous cancellations are a high priority to return to compliance with all standards. • The impact of specialist cleaning in the radiotherapy department following the major fire in 2018 has affected capacity and the subsequent radiotherapy standard in particular. Recovery has been hampered by the lack of qualified agency staff available to re-provide activity. Gradual recovery is expected over the summer and into autumn. • CT Cardiac diagnostics presents a challenge to the delivery of the 6 week wait standard. A new cardiac-enabled scanner is due to be installed during Quarter 3 but the full benefits are unlikely to be realised until February Quarter 4. • The Trust continues to report 52 week breaches in Paediatric Services and Division of Surgery due to a number of cancellations by parents of children (Paediatric) and last minute cancellations due to other emergencies in Surgery. A revised plan has been agreed with commissioners to ensure that we have no 52 week waiting patients by September 2019. • The local commissioners and NHSE/I have confirmed that there is no waiver for patients who have resulted in a 52 week breach due to patient choice. The fine is £2,500 per breach. • Although the local access policy has been revised; the policy still includes a focus on allowing the patient to exercise their right to choice. This may result in difficulty in achieving ZERO long waiting patients so focus on this will continue at the weekly performance meetings chaired by the Deputy COO

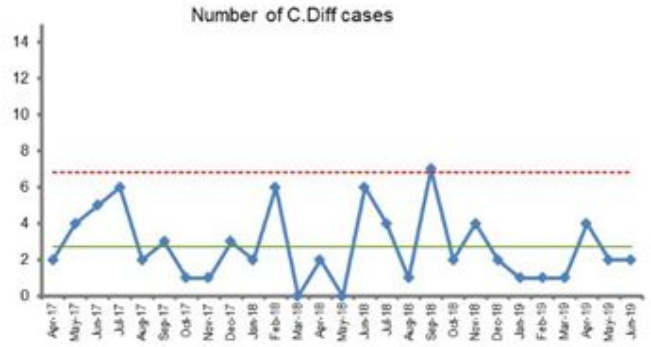
1.4 OVERVIEW – Successes, Priorities, Opportunities, Risk & Threats

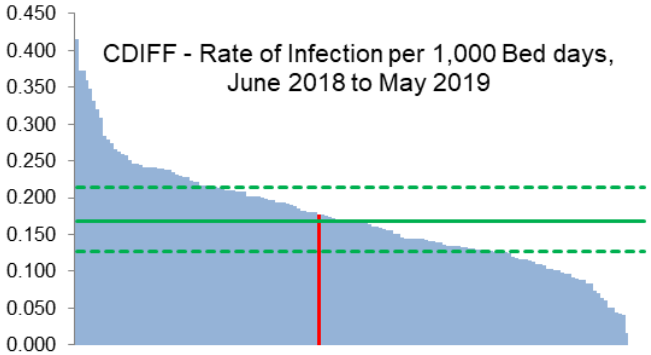
	Successes	Priorities
QUALITY	• Our patient experience indicators continue to suggest that the majority of patients have a good experience when using our services. The Trust's new electronic patient and visitor feedback system, Optimum Contact, went live – with six touchscreen feedback points installed in the Bristol Royal Infirmary in Quarter 4 2018/19, providing an additional option for patients and their families to give feedback. It is planned for this to be extended to other areas of the Trust.	• One "wrong implant" never event was reported in June at Unity Sexual Health service whereby a different type of intrauterine device was fitted from the one intended. The error was identified and rectified at the same appointment in accordance with the patient's wishes and a sincere apology was offered. A full investigation is underway, the outcome of which will be reported to the Quality and Outcomes Committee in due course.
	Opportunities	**Risks and Threats**
QUALITY	• Although compliance with the WHO surgical safety checklist remains above 99%, we have identified further opportunities to improve the quality of how the checklist is used which will be taken forward a part of our Patient Safety Improvement Programme.	• The previously reported plan to change the method of recording venous thromboembolism (VTE) risk assessments will take place on 1st August. The method of VTE risk assessments currently takes place retrospectively on discharge by reviewing the paper drug chart for a risk assessment and recording a "tick box" on Medway. The switch to VTE risk assessments using clinical noting will provide a more thorough method of recording compliance with each aspect of the VTE risk assessment and it is anticipated the percentage compliance will initially reduce below the national requirement of 95%. This risk is recorded on the Trust's corporate risk register. Mitigation is largely focussed on education in the new method of recording VTE risk assessments, including that of new doctors in training when they join the Trust at the end of July/beginning of August.

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

	Successes	Priorities
WORKFORCE	• A Workplace Wellbeing Advocate event took place to mark the one year anniversary of this role, upskilling these staff on the internal support of psychological wellbeing for colleagues. • Successful appointment to the Trust's new Clinical Talent Acquisition Manager role who will take up post in September 2019. • Strong interest to the Nursing Assistant apprenticeship role with 90 applicants received during June. • Return rates for Exit Interview questionnaires have significantly improved this month following a campaign to promote the importance of asking for feedback from leavers. • June 2019 compliance for Core Skills (mandatory/statutory) training remained at 90% overall across the eleven programs, and also at 95% for 'Remaining Essential Training' - both for the third consecutive month.	• Planning for the implementation of the 2019/20 flu programme to meet the CQUIN Indicator of £681,892. • Working with Divisions to ensure there is a robust plan in place for Diversity & Inclusion to support the delivery of the strategic objectives. • Recruitment to the medical rotation of doctors for the August changeover. • Work continues on the Trust's new starter process. This work will allow early release from much face-to-face training at corporate induction for eLearning, and as early as day two for many staff. • Continue to drive compliance in appraisal through the appraisal recovery plan.
	Opportunities	**Risks and Threats**
WORKFORCE	• The new delegation functionality in the e-appraisal system can now go live after testing. This is planned for August 2019. A further enhancement to the system which will be welcomed by managers. • Further development of the Happy App is planned to increase usage and response times in order for this tool to be used more meaningfully to support appropriate interventions/activities. • Improved promotion of the online Supporting Attendance training following its review to ensure new and existing managers are fully briefed on roles and responsibilities in accordance with the policy.	• Further decrease in appraisal compliance. • Lack of resource allocated within UHB to undertake Weston's recruitment activity is now effecting both UHB's time to hire and levels of sickness within the UHB Resourcing Team. • Lack of resources within Employee Services to support the high caseload for sickness absence and increased waiting times for staff referral to Occupational Health. • Resuscitation compliance, holding at 76 %, is a continuing focus for improvement. Improvement recommendations are being formed and are based on a review of local provision against national benchmarks. • The impact of the pension tax and annual allowance continues to cause concern for the sustainability of the workforce.

Infections – Clostridium Difficile (C.Diff)	
Standards:	Number of Trust Apportioned C.Diff cases to be below the national trajectory of 57 cases for 2019/20. Review of these cases with commissioners' alternate months to identify if there was a "lapse in care".
Performance:	There were two trust apportioned C.Diff cases in June 2019, giving eight cases year-to-date.
Commentary/ Actions:	There were two cases of C. Difficile identified in May 2019. These cases require a review with our commissioners before determining if the cases will be Trust apportioned due to lapse in care. These cases are now attributed to the Trust after patients have been admitted for two days (day 3 of admission) This is new criteria from NHSI which started in April 2019 and a new Trust limit has been set of 57 cases for 2019/20. The old criteria attributed cases to the Trust after three days of admission, (day four of admission).
Ownership:	Chief Nurse





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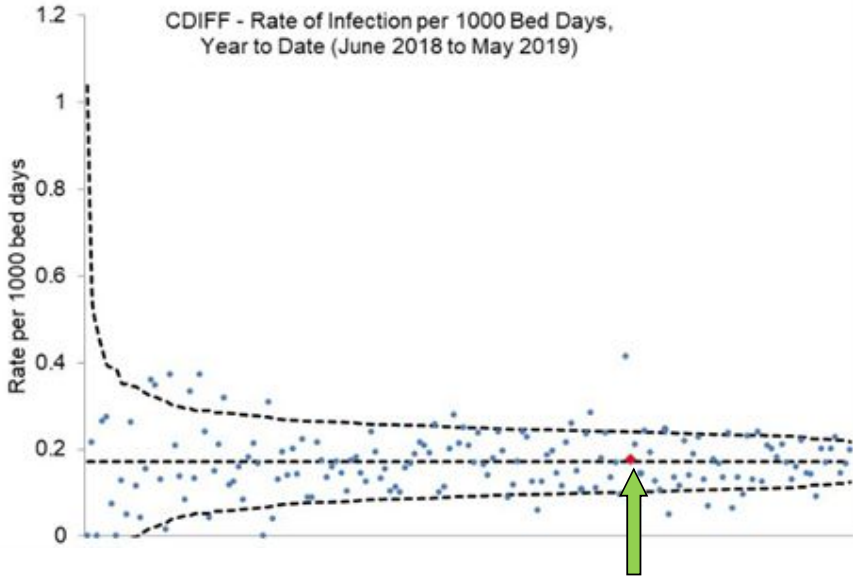
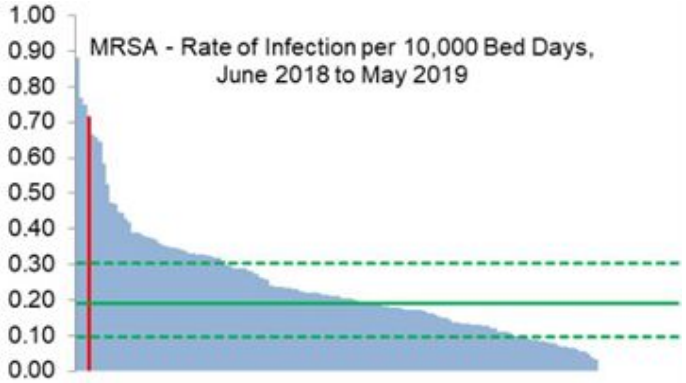


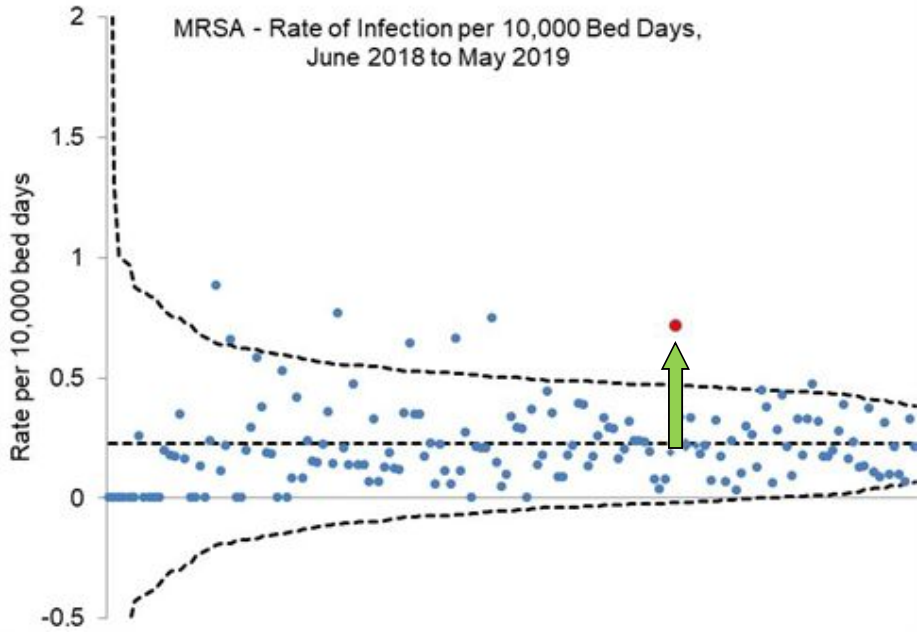
CDIFF Cases	Jun-19	2019/2020
Medicine	1	2
Specialised Services	0	0
Surgery	0	1
Women's and Children's	1	5
Grand Total	2	8

2.1 PERFORMANCE – Safe Domain

Infections – Methicillin-Resistant Staphylococcus Aureus (MRSA)	
Standards:	No Trust Apportioned MRSA cases.
Performance:	There were no Trust apportioned MRSA cases in June 2019 and so zero cases year to date.
Commentary/ Actions:	Ongoing training and reporting mechanisms are continually being reviewed.
Ownership:	Chief Nurse

MRSA	Jun-19	2019/2020
Medicine	0	0
Specialised Services	0	0
Surgery	0	0
Women's and Children's	0	0
Grand Total	0	0

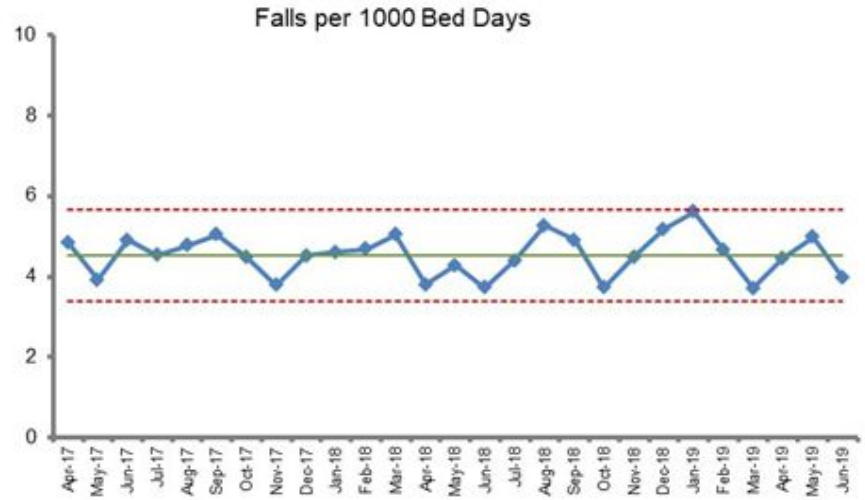




Unbroken horizontal line is England median; dotted lines are upper & lower quartiles

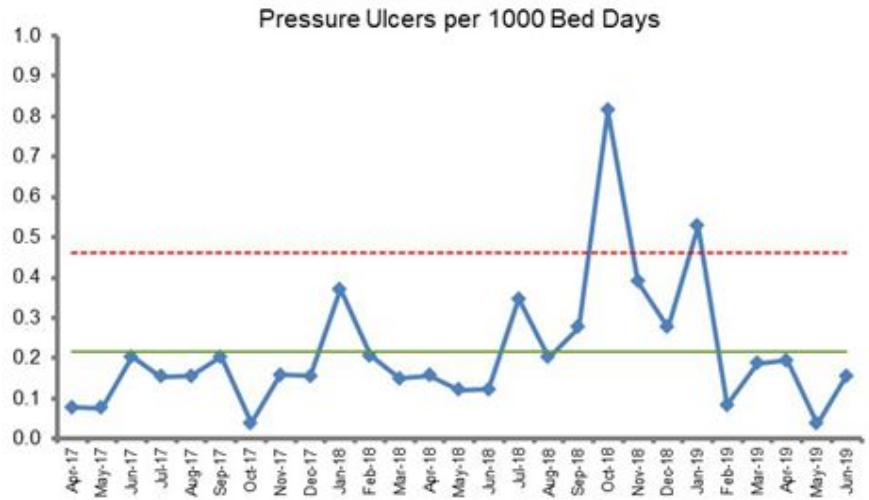
2.1 PERFORMANCE – Safe Domain

Patient Falls	
Standards:	Inpatient Falls per 1,000 beddays to be less than 4.8. Less than 2 per month resulting in Harm (Moderate or above)
Performance:	Falls rate for June was 3.97 per 1,000 beddays. This was 102 falls with zero resulting in harm.
Commentary/ Actions:	The number of falls decreased from 133 in May to 102 in June. For a second month in a row there were no falls resulting in harm The actions being taken remain as: 1. Implementing actions required to achieve new 2019/20 Falls CQUIN has commenced, which include: a. The revised draft multifactorial falls risk assessment, including a vision check will be approved at the next Falls Group in July. b. Measuring lying and standing blood pressure measurement for all patients 65 and over c. Ensuring no anti-psychotic, anxiolytics or hypnotics, are given during hospital stay or if required there should be documentation of rationale d. Ensuring patient mobility assessment is documented within 24hrs or mobility aid provided within 24hrs 2. The 2019/20 Falls Group work and audit plans were approved at the May meeting and will be closely monitored and reviewed at each meeting.
Ownership:	Chief Nurse



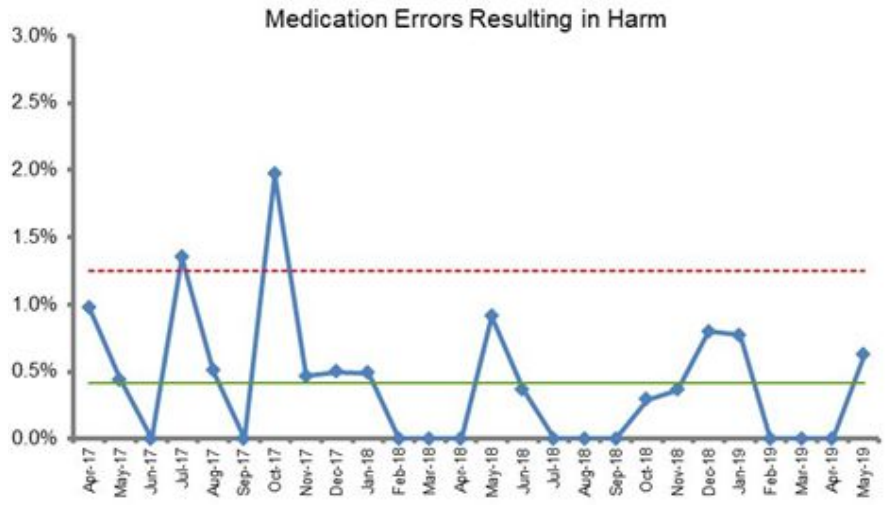
2.1 PERFORMANCE – Safe Domain

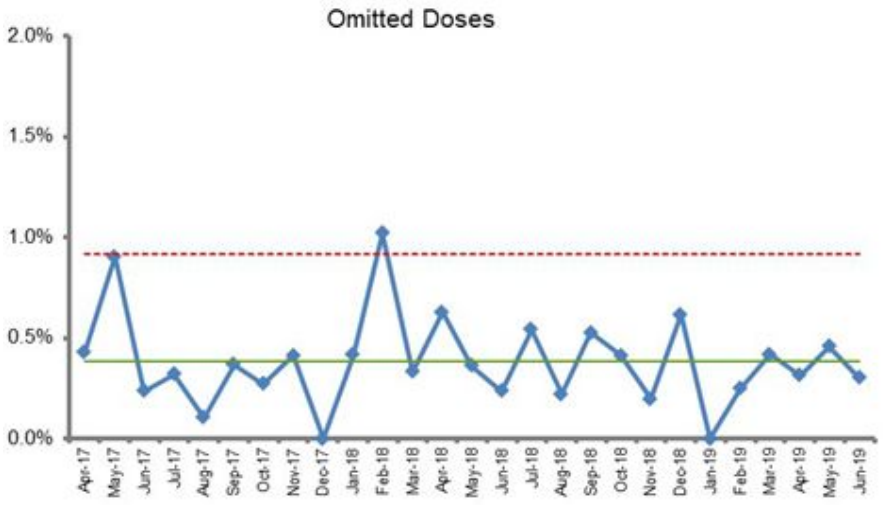
Pressure Ulcers	
Standards:	Hospital acquired Pressure Ulcers to be below 0.4. No Grade 3 or 4 Pressure Ulcers
Performance:	Pressure Ulcers rate for June was 0.156 per 1,000 beddays. There were four Pressure Ulcers in June, which were all Grade 2. So there were no grade 3 or 4 pressure ulcers
Commentary/ Actions:	The aim of the 2019/20 Tissue Viability Group work plan is to reduce the number of pressure ulcers developed on wards. • The Tissue Viability Team continue to deliver monthly pressure ulcer training sessions and monthly wound assessment training sessions for staff. The team also deliver targeted/bespoke training to individual wards when indicated following an incident or on request • Continue work on documentation revision • Work to revise maternity and paediatric care plans for consistency. • Update training materials - e-learning to meet NHS Improvement's core curriculum standards All actions are monitored through the Tissue Viability Steering Group.
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:	Two moderate harm medication incidents were reported in May 2019, out of 321 cases audited (0.62%) Omitted doses were at 0.30% in June (1 case out of 331 reviewed in areas using paper drug charts).
Commentary/ Actions:	Of the medication incidents, one was in relation to an infiltration injury for an outpatient attending for an intravenous iron infusion. Unfortunately due to the colouring of the iron infusion, the patient's arm is now stained brown permanently. The second incident involved a patient who was co-prescribed two very similar drugs in error. This had the effect of precipitating an acute kidney injury level 3. As a result of the patient's acute kidney injury, therapeutic anticoagulant was withheld and the patient suffered a stroke in June (both incidents are subject to a root cause analysis investigation.) The non-purposeful omitted critical medicines audit in areas using paper drug charts identified three unintentional omissions of medicines, returning a figure of 0.30% for June. This is well below the target of 0.75%. The unintentional omission of medicine was a single dose of oral antifungal medicine in a paediatric oncology patient. There was a failure to follow the 'Preventing Delayed And Omitted Doses Of Medicines' SOP as the medicine was not ordered during the day while the pharmacy was open, and neither was the on call pharmacist contacted to supply the medicine out of hours.
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 2019 the compliance for Core Skills (mandatory/statutory) training remained at 90% overall across the eleven programs, for the third consecutive month. (This reporting always excludes Child Protection Level 3).
Commentary/ Actions:	June 2019 compliance for Core Skills (mandatory/statutory) training remained at 90% overall across the eleven programs, for the third consecutive month. There were two reductions, of 1%, for Health, Safety and Welfare, and NHS Conflict Resolution Training. There was one increase, of 1%, for Moving and Handling. Overall compliance for 'Remaining Essential Training' is also holding at 95% overall for the third month. • Resuscitation compliance, still at 76 %, is a continuing focus for improvement, with recommendations being formed that are based on a review of local provision against national benchmarks. • Of the 'Remaining Essential Training', the biggest increase (3%) was seen in the Staff Local Induction Workbook, now at 60%. In comparison, in July 2018 the workbook compliance (and therefore local induction for corporate staff) was only 49%. • Work continues on the Trust's new starter process; new e-forms are now in final stages of checking and approval. This work will allow early release from much face-to-face training at corporate induction for eLearning, and as early as day two for many staff. • Inputs for the revalidation of all Essential Training have been received and will be collated for decisions and action by the Corporate Education Governance Group. This review will focus on both training requirements and quality assurance, with improvements to be actioned in induction or updates by year's end.
Ownership:	Director of People

Essential Training	Jun-19	KPI
Equality, Diversity and Human Rights	97%	90%
Fire Safety	88%	90%
Health, Safety and Welfare (formerly Health & Safety)	93%	90%
Infection Prevention and Control	86%	90%
Information Governance	86%	95%
Moving and Handling (formerly Manual Handling)	89%	90%
NHS Conflict Resolution Training	93%	90%
Preventing Radicalisation	95%	90%
Resuscitation	76%	90%
Safeguarding Adults	94%	90%
Safeguarding Children	93%	90%

Essential Training	Jun-19	KPI
UH Bristol NHS Foundation Trust	90%	90%
Diagnostics & Therapies	92%	90%
Medicine	89%	90%
Specialised Services	91%	90%
Surgery	90%	90%
Women's & Children's	88%	90%
Trust Services	94%	90%
Facilities & Estates	93%	90%

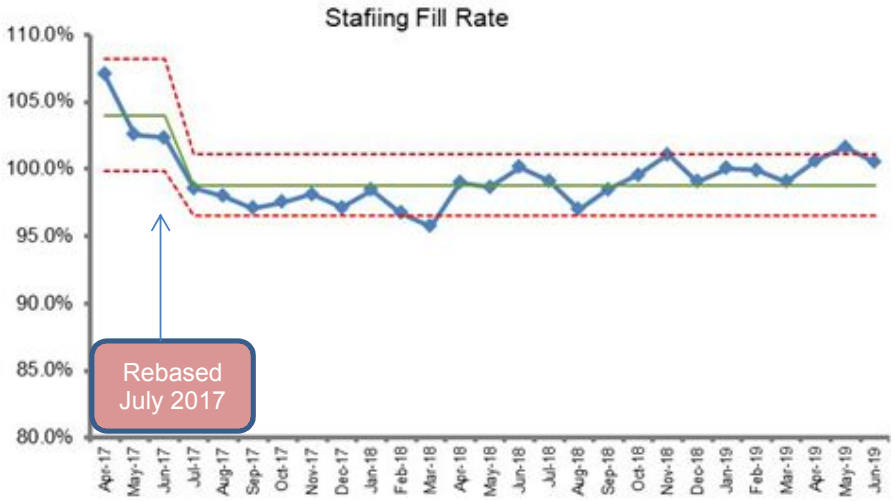
2.1 PERFORMANCE – Safe Domain

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 100.5% (233,148 hours worked against 232,001 planned). Registered Nursing (RN) level was at 97.0% and Nursing Assistant (NA) level was at 109.4%
Commentary/ Actions:	Overall for the month of June 2019, the trust had 96% cover for RN's on days and 98% RN cover for nights. The unregistered level of 104% for days and 117% for nights reflects the activity seen in June 2019. This was due primarily to NA specialist assignments to safely care for confused or mentally unwell patients in adults particularly at night. Ongoing Actions: • Continue to validate temporary staffing assignments against agreed criteria.
Ownership:	Chief Nurse

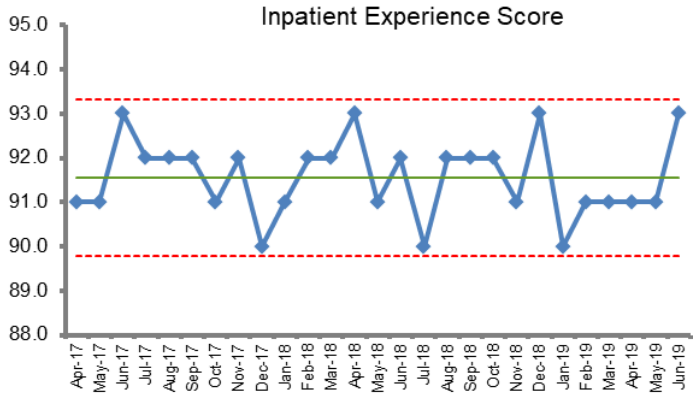
JUNE 2019 DATA

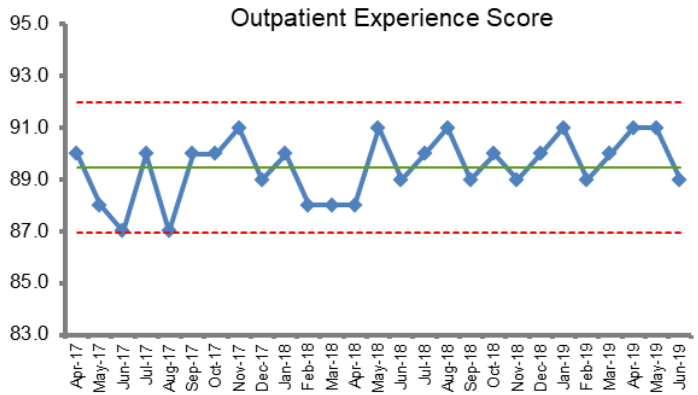
	Day	Night	TOTAL
Registered Nurses	96.4%	97.8%	97.0%
Nursing Assistants	103.8%	117.3%	109.4%
TOTAL	**98.6%**	**102.9%**	**100.5%**

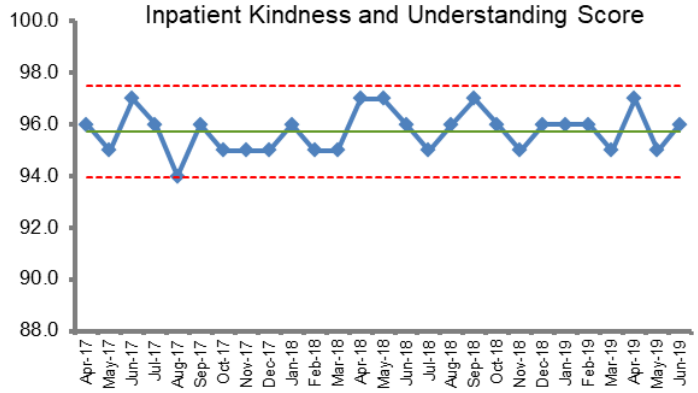
Medicine	107.2%
Specialised Services	102.9%
Surgery	103.8%
Women's and Children's	93.0%
TOTAL	**100.5%**



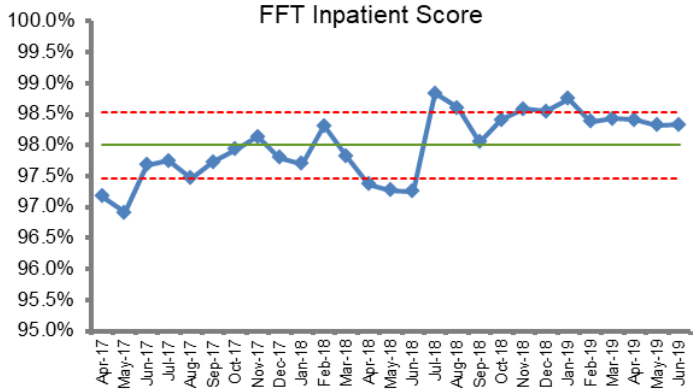
Monthly Patient Survey	
Standards:	For the inpatient and outpatient Survey, 5 questions are combined to give a score out of 100. For inpatients, the target is to achieve 87 or more. For outpatients the target is 85. For inpatients, there is a separate measure for the kindness and understanding question, with a target of 90 or over.
Performance:	For June 2019, the inpatient score was 93/100, for outpatients it was 89. For the kindness and understanding question it was 96.
Commentary/ Actions:	The headline measures from these surveys remained above their minimum target levels, indicating the continued provision of a positive patient experience at UH Bristol.
Ownership:	Chief Nurse

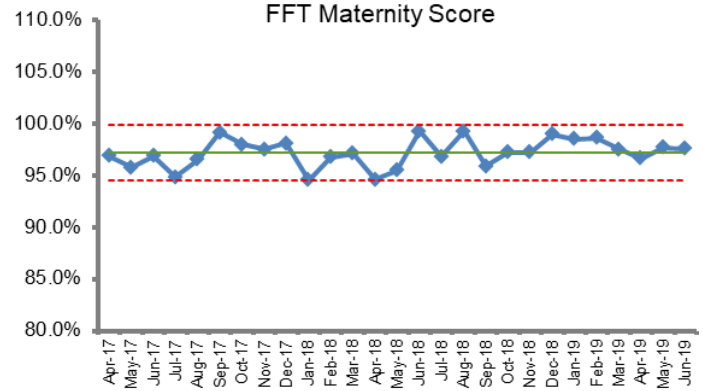


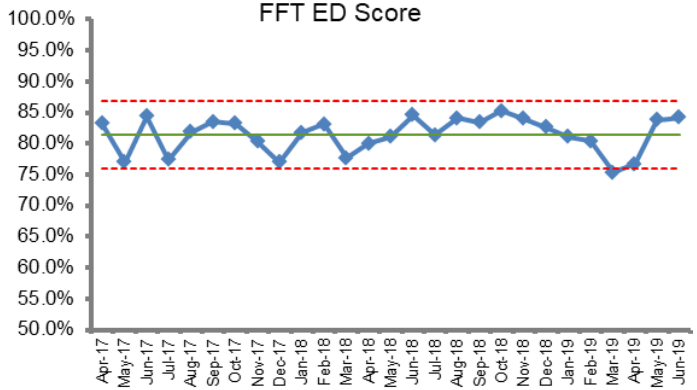




Friends and Family Test (FFT) Score	
Standards:	The FFT score is the number of respondents who were likely or very likely to recommend the Trust, as a percentage of all respondents. Standard is that the score for inpatients should be above 90%. The Emergency Department minimum target is 70%.
Performance:	June's FFT score for Inpatient services was 98.3% (2006 out of 2040 surveyed). The ED score was 84.2% (1350 out of 1603 surveyed). The maternity score was 97.6% (326 out of 334 surveyed).
Commentary/ Actions:	The headline measures from these surveys remained above their minimum target levels, indicating the continued provision of a positive patient experience at UH Bristol.
Ownership:	Chief Nurse



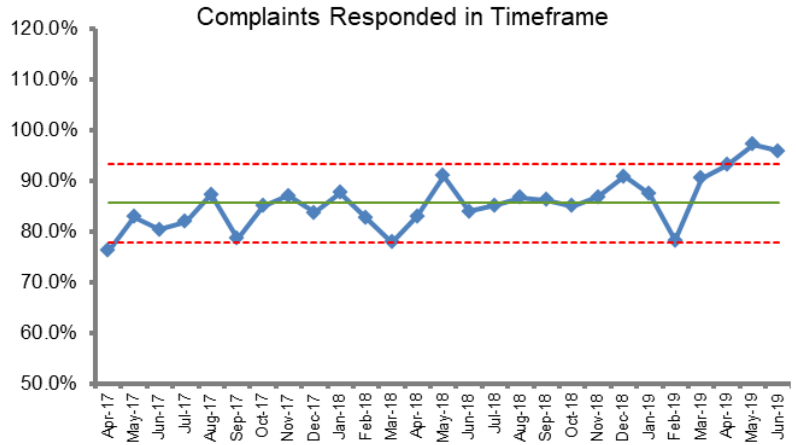


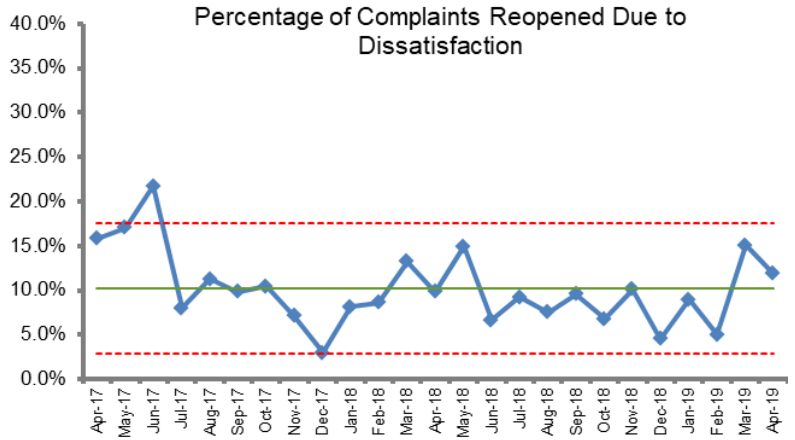


	Response Rate		Score	
	Jun-19	2019/2020	Jun-19	2019/2020
Inpatients				
Medicine	46.2%	43.3%	97.4%	97.9%
Surgery	30.2%	35.8%	98.8%	98.6%
Specialised Services	32.5%	39.9%	100.0%	98.8%
Women's and Children's	30.8%	34.2%	98.0%	98.2%
TOTAL	**34.4%**	**37.7%**	**98.3%**	**98.4%**
Emergency Department				
Bristol Royal Infirmary	13.0%	11.6%	68.8%	64.1%
Children's Hospital	16.7%	16.9%	84.5%	83.8%
Eye Hospital	31.9%	26.3%	95.6%	94.8%
TOTAL	**18.7%**	**16.8%**	**84.2%**	**82.0%**
Maternity				
TOTAL	**24.1%**	**27.7%**	**97.6%**	**97.4%**

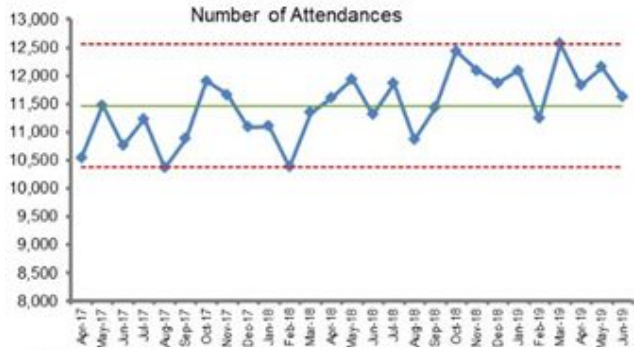
2.2 PERFORMANCE – Caring Domain

Patient Complaints	
Standards:	For all formal complaints, 95% of them should have the response posted/sent to the complainant within the agreed timeframe, with a lower tolerance (Red) of 85%. Of all formal complaints responded to, less than 8% should be re-opened because complainant is dissatisfied, with an upper tolerance (Red) of 12%.
Performance:	In June, 47 out of 49 formal complaints were responded to with timeframe (95.9%) Of the 59 formal complaints responded to in April, 7 resulted in the complainant being dissatisfied with the response (11.9%)
Commentary/ Actions:	There were two breaches from the 49 formal responses sent out in June; one each for the Divisions of Specialised Services and Medicine. One breach was caused by a delay in the Patient Support and Complaints Team (Specialised Services) and the other breach (for Specialised Services) was caused by a delay in the Patient Support & Complaints Team and the Executive Team. The Trust's performance in responding to complaints via informal resolution within a timescale agreed with the complainant was 89.8% in June. This equates to 9 breaches from the 88 responses sent out in June. Of the 9 breaches recorded, five were from the Division of Surgery, two from the Division of Medicine and one each for the Divisions of Diagnostics and Therapies and Trust Services. The rate of dissatisfied complaints in April (this measure is reported two months in arrears) was 11.9%. This represents seven cases from the 59 first responses sent out during that month and is a slight increase on the 11.3% reported last month in respect of responses sent out in March.
Ownership:	Chief Nurse





Emergency Department (ED) 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 90.5% for June.
Performance:	Trust level performance for June was 81.48% (11625 attendances and 2153 patients waiting over 4 hours).
Commentary/ Actions:	Performance at the Children's Hospital was 93.6% in June. The Bristol Royal Infirmary achieved 68.8% in June and the Eye Hospital achieved 97.6%. Performance at the Bristol Royal Infirmary remains below trajectory. One of the key drivers of this is sustained high levels of attendances, some of which is associated with key events during the summer in Bristol, such as St Paul's Carnival and the various music festivals. The Division of Medicine is recruiting into the agreed key roles for this year, which will include an additional middle grade doctor overnight in the ED, additional resuscitation nurses and an expansion in the ED consultant workforce: 2 new whole time equivalent (wte) consultants start in the team in October 2019 and the department is advertising for a third. The department is also recruiting to a multi-disciplinary front door frailty team consisting of a consultant geriatrician, specialist nurses and a pharmacist. The Division is also receiving support from the Transformation Team to review the medical take (admission) processes with the aim of working more efficiently and exploring new roles which could support the team. Linked to this they are recruiting for 6 WTE Physicians Associates who will work across the Division, but who will have a key role to play at the front door into Medicine.
Ownership:	Chief Operating Officer



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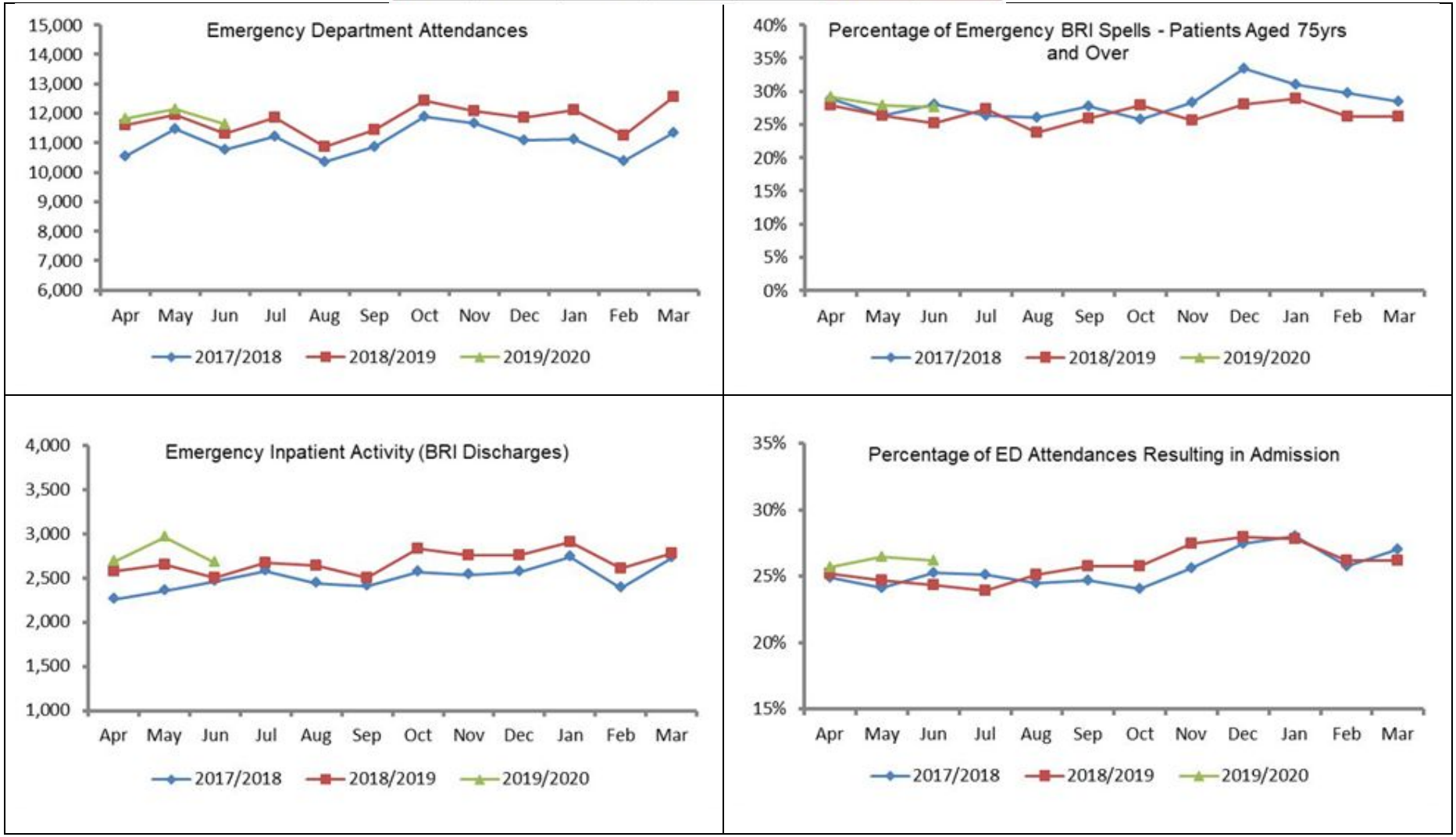
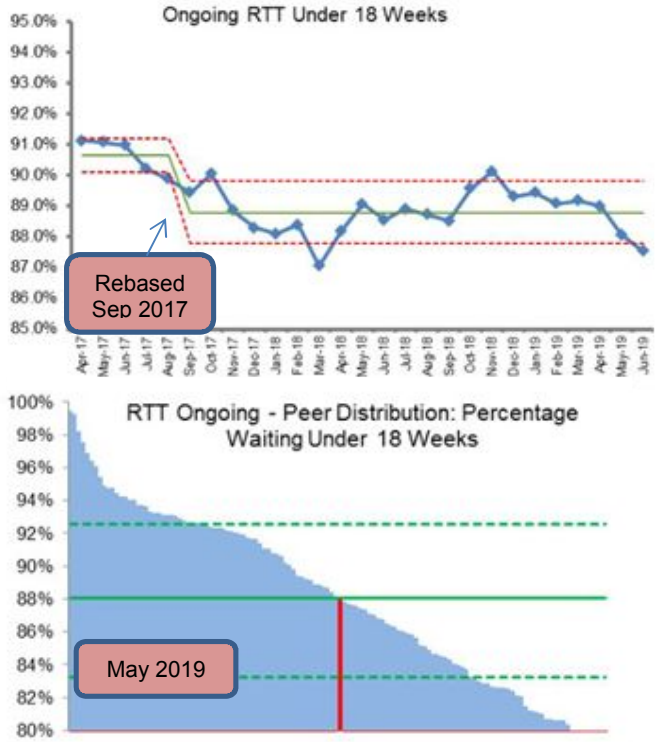
2.3 PERFORMANCE – Responsive Domain

	Attendances		Under 4 Hours		Performance	
	Jun-19	2019/2020	Jun-19	2019/2020	Jun-19	2019/2020
BRI	6010	18375	4134	12013	68.79%	65.38%
Trust	11625	35596	9472	28193	81.48%	79.20%



2.3 PERFORMANCE – Responsive Domain

Referral to Treatment (RTT)	
Standards:	At each month-end, the Trust reports 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 87.9% for end of June. In addition, no-one should be waiting 52 weeks or over at the end of March 2019.
Performance:	At end of June, 87.5% of patients were waiting under 18 week (27,211 out of 31,085 patients). 11 patients were waiting 52+ weeks
Commentary/ Actions:	The 92% national standard was not met at the end of June and the improvement trajectory of 87.9% was narrowly missed (by 0.4%). However the Trust had achieved, for 14 consecutive months, the RTT set recovery trajectory prior to June. Key actions for 2019/20: • Achieve zero 52 week waiting patients by September 2019 • Ensure the total waiting list size is below the March 2018 level of 29,207 at March 2020 • Ensure performance is restored to trajectory levels, reviewed and managed through the weekly performance meetings with divisions. All divisions have agreed a trajectory for their area that delivers the overall Trust target when aggregated. Focus will be on ensuring there is sufficient capacity to admit the required number of patients or to see them in outpatients.
Ownership:	Chief Operating Officer



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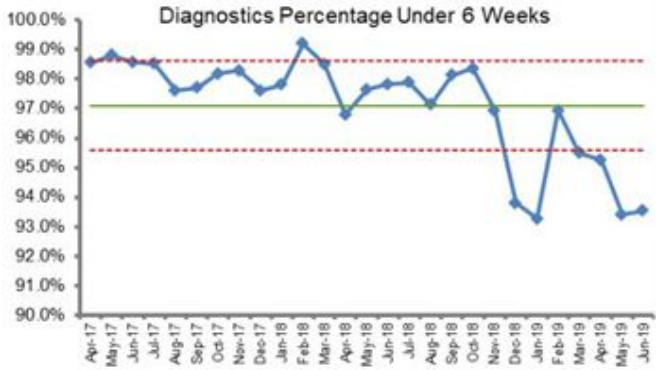
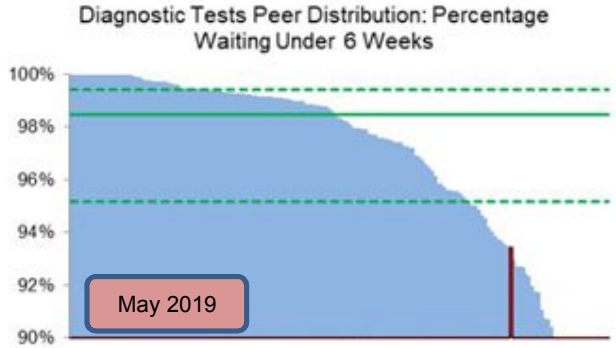
Ongoing Pathways at Jun-19

	Ongoing Pathways	Ongoing Over 18 Weeks	Ongoing Performance
Cardiology	2,521	485	80.8%
Cardiothoracic Surgery	345	85	75.4%
Dermatology	2,680	327	87.8%
ENT	1,884	122	93.5%
Gastroenterology	1,017	17	98.3%
General Medicine	6	0	100.0%
Geriatric Medicine	58	0	100.0%
Gynaecology	1,490	209	86.0%
Neurology	271	20	92.6%
Ophthalmology	3,915	310	92.1%
Oral Surgery	3,188	439	86.2%
Other (Clinical Genetics)	782	14	98.2%
Other (Dental)	2,723	369	86.4%
Other (General Surgery)	1,690	432	74.4%
Other (Haem/Onc)	202	5	97.5%
Other (Medicine)	562	22	96.1%
Other (Other)	476	5	98.9%
Other (Paediatric)	5,402	883	83.7%
Other (Pain Relief)	61	1	98.4%
Other (Thoracic Surgery)	121	14	88.4%
Plastic Surgery	0	0	0.0%
Rheumatology	459	18	96.1%
Thoracic Medicine	602	14	97.7%
Trauma & Orthopaedics	630	83	86.8%
TOTAL	**31,085**	**3,874**	**87.5%**

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 has committed to recovery by beginning of Quarter 3 2019/10
Performance:	At end of June, 93.5% of patients were waiting under 6 weeks (8,386 out of 8,965 patients). There were 579 breaches of the 6-week standard.
Commentary/ Actions:	The Trust did not achieve the 99% national standard at end of June. The maximum number of breaches needed to achieve 99% was 90 breaches. • Echos is on track to deliver the standard by end of Quarter 2, due to continued outsourcing until internal vacancies are filled and waiting list backlogs cleared. July is predicting 73 breaches but recovery is still on track for end of September. This will be a significant improvement from the 379 breaches in January 2019. • For Ultrasound, staff vacancies have caused a reduction in available capacity. The service has been running waiting list initiatives and utilising agency and locum sonographers to cover vacancies while permanent staff are recruited. The service is predicting 10 breaches for end of July and should now be in "business as usual", now that the backlog has been cleared. • MRI breach volumes are in Cardiac MRI (54) and Paediatrics (63). Cardiac MRI are running waiting list initiatives to clear the one-off backlog by September. Paediatric MRI recovery is being assessed by the division for review in the weekly performance meeting 24th July. • CT Cardiac recovery is reliant on the installation/upgrade of a new cardiac-compatible CT scanner, which is due during Quarter 3. Division will be assessing the impact of this installation, and resulting down-time, to ensure compliance in quarter 4.
Ownership:	Chief Operating Officer



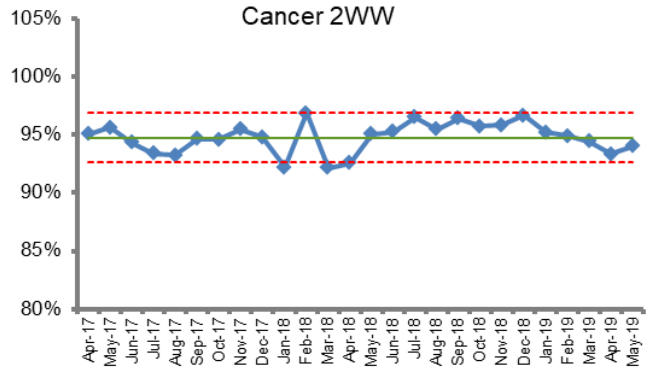


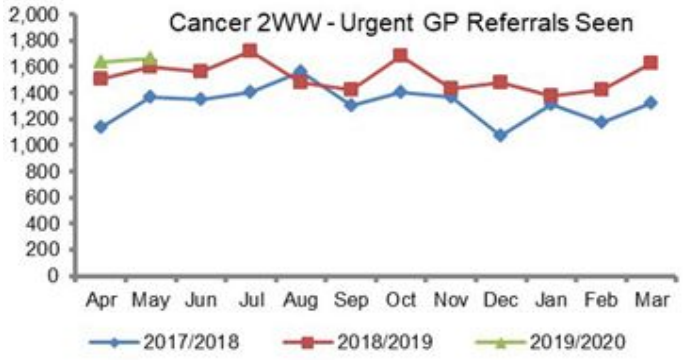
Unbroken horizontal line is England median: dotted lines are upper & lower quartiles

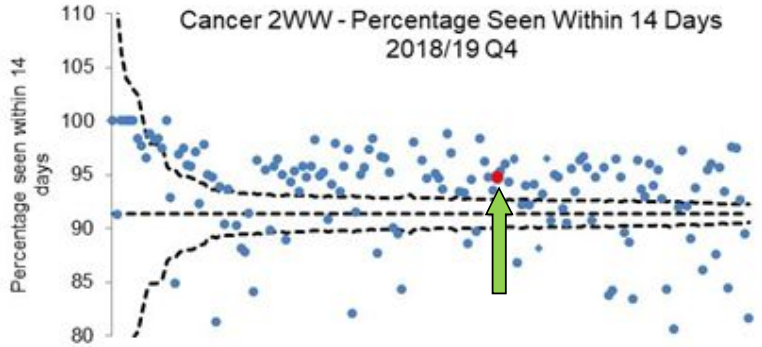
Diagnostic Tests Waiting List at Jun-19	Under 6 Weeks	6+ Weeks	Total Waiting	Percentage Under 6 Weeks
Audiology	690	0	690	100.0%
Colonoscopy	227	34	261	87.0%
CT	1,287	83	1,370	93.9%
Cystoscopy	3	0	3	100.0%
DEXA Scan	212	0	212	100.0%
Echocardiography	898	98	996	90.2%
Flexi Sigmoidoscopy	85	12	97	87.6%

	Under 6 Weeks	6+ Weeks	Total Waiting	Percentage Under 6 Weeks
Gastroscopy	206	28	234	88.0%
MRI	1,960	143	2,103	93.2%
Neurophysiology	223	1	224	99.6%
Sleep Studies	196	1	197	99.5%
Ultrasound	2,399	179	2,578	93.1%
Grand Total	**8,386**	**579**	**8,965**	**93.5%**

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, 94.0% of patients were seen within 2 weeks (1563 out of 1663 patients). Quarter 1 2019/20 is currently achieving 93.7%.
Commentary/ Actions:	The standard has been achieved in all four quarters in 2018/19 and for the first two months of 2019/20. It is expected to continue complying. The current robust performance management actions will continue through the weekly performance meetings. The Trust will comply in quarter 1 of 2019/20 and is on track for July.
Ownership:	Chief Operating Officer





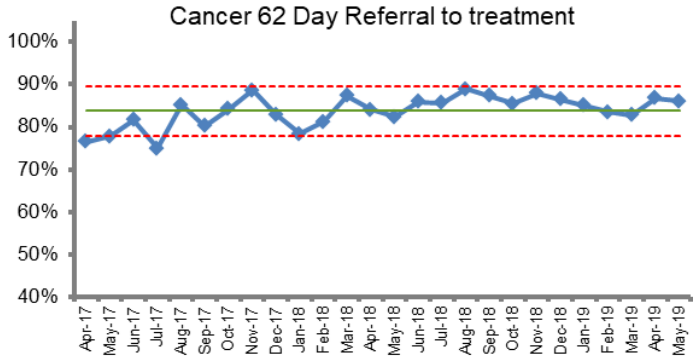


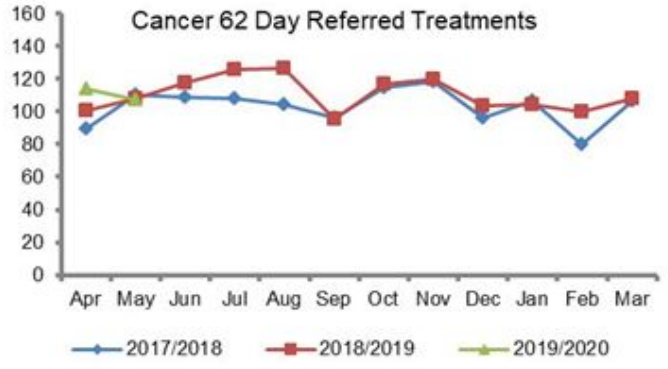
Cancer 2WW - May-19

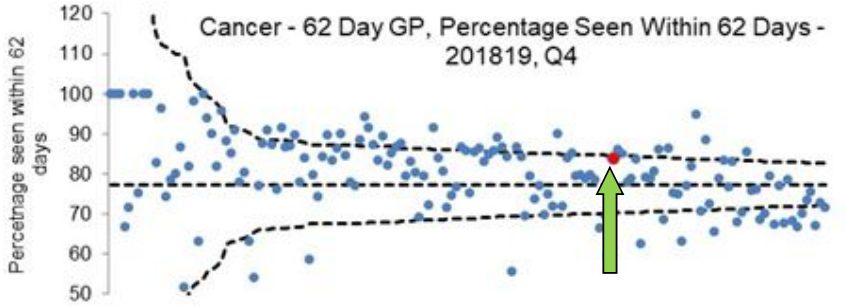
	Under 2 Weeks	Total Pathways	Performance
Other suspected cancer	3	3	100.0%
Suspected children's cancer	25	29	86.2%
Suspected gynaecological cancers	105	123	85.4%
Suspected haematological malignancies e	13	13	100.0%
Suspected head and neck cancers	404	419	96.4%
Suspected lower gastrointestinal cancers	167	182	91.8%
Suspected lung cancer	25	25	100.0%
Suspected skin cancers	712	752	94.7%
Suspected upper gastrointestinal cancers	109	117	93.2%
Grand Total	**1,563**	**1,663**	**94.0%**

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, as submitted to NHS Improvement, has also been set at 85%.
Performance:	For May, 86.0% of patients were seen within 62 days (92.5 out of 107.5 patients). Quarter 1 2019/20 is currently achieving 86.5%
Commentary/ Actions:	The Trust returned to compliance in April 2019 (86.8%) and sustained this in May (86.0%) following changes to the national waiting times rules for allocating performance on shared pathways between providers. This reduced the impact of delays at other providers (which made up over half of all breaches in February and March 2019). To maintain compliance, the Trust must ensure it continues its strong management of all patients on cancer pathways, focussing on early pathways and diagnostics. Achieving the new '24 day' standard following receipt of a tertiary referral is also important in order to see the benefit of the changed rules. Preventing surgical cancellations and recovering from the impact of previous cancellations is essential to maintaining compliance.
Ownership:	Chief Operating Officer



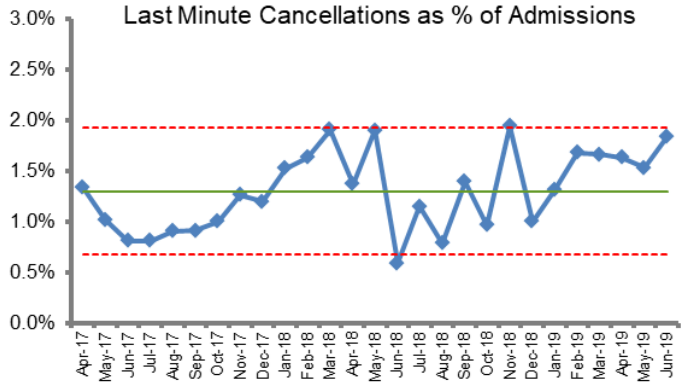


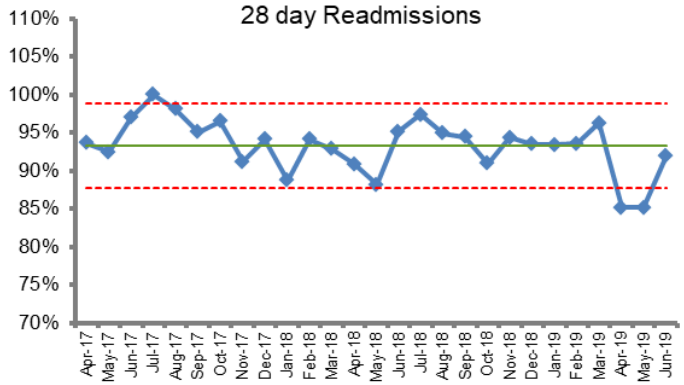


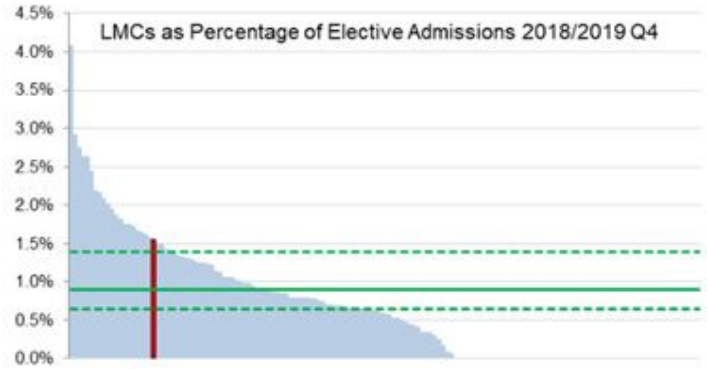
Cancer 62 Day - May-19

	Within Target	Total Pathways	Performance
Breast	3.5	3.5	100.0%
Gynaecological	5.5	7.0	78.6%
Haematological	4.5	6.5	69.2%
Head and Neck	9.5	13.5	70.4%
Lower Gastrointestinal	4.0	6.0	66.7%
Lung	8.0	12.0	66.7%
Other	3.0	4.0	75.0%
Sarcoma	0.5	0.5	100.0%
Skin	47.5	47.5	100.0%
Upper Gastrointestinal	6.5	7.0	92.9%
Grand Total	**92.5**	**107.5**	**86.0%**

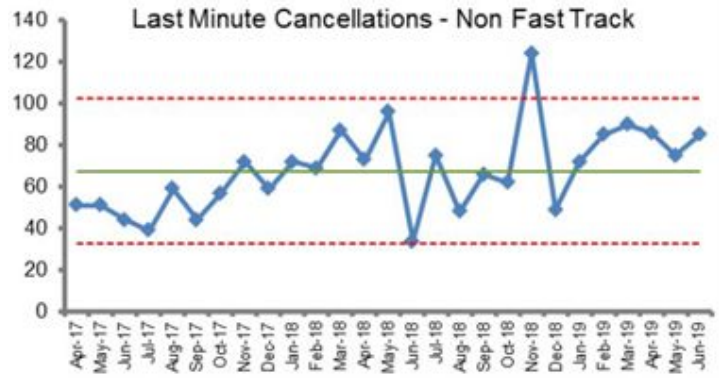
Last Minute Cancelled Operations	
Standards:	This covers elective admissions that are cancelled on the day of admission by the hospital, for non-clinical reasons. The total number for the month should be less than 0.8% of all elective admissions. Also, 95% of these cancelled patients should be re-admitted within 28 days
Performance:	In June there were 117 last minute cancellations, which was 1.8% of elective admissions. Of the 100 cancelled in May, 92 (92.0%) had been re-admitted within 28 days. This means 8 patients breached the 28 day readmission standard.
Commentary/ Actions:	The most common reason for cancellation was "No beds available" (34 cancellations). There were 7 in Medicine, 17 in Cardiac Services, 13 in ENT & Thoracics, 27 in Gastrointestinal Surgery, 13 in Ophthalmology, 4 in Trauma & Orthopaedics, 11 in Dental Services and 8 in Paediatrics. Of the sixteen 28 day breaches: 5 were Dental, 6 were ENT/Thoracics, 3 were General Surgery, 1 was Ophthalmology and 1 was Gynaecology.
Ownership:	Chief Operating Officer







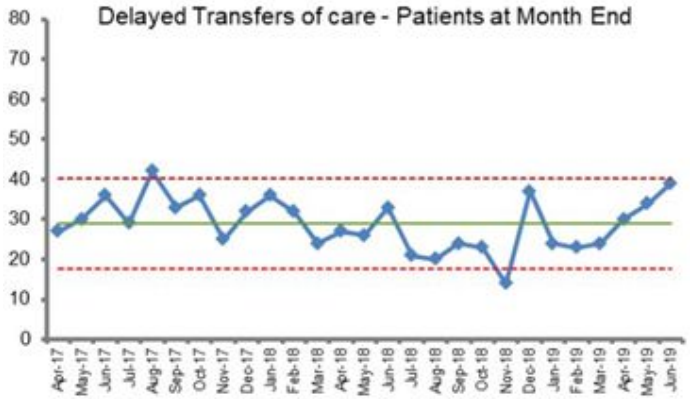
Unbroken horizontal line is England median; dotted lines are upper & lower quartiles

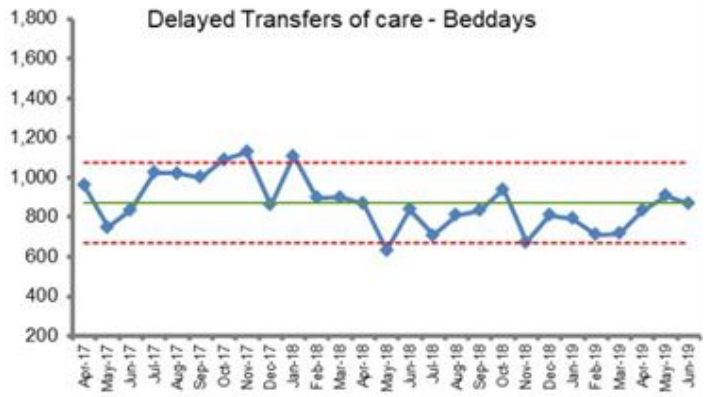


Cancellation Reason	Fast Track	Routine	Urgent	TOTAL
No Beds Available	4	13	9	26
Other Emergency Patient Prioritised	5	14	4	23
No HDU Beds	10	1	3	14
Equipment Failure	0	10	0	10
Surgeon Unavailable	1	6	2	9
AM list over-ran	1	4	2	7
Surgeon Taken Ill	4	2	0	6
Other clinically complicated Patient in theatre	2	2	0	4
Equipment Unavailable	1	2	1	4
Booking Error	1	1	1	3
No Theatre Staff	0	3	0	3
No ITU Beds	3	0	0	3
Other Non Emergency Patient Prioritised	0	1	0	1
No Critical Care Bed	0	0	1	1
List Overbooked	0	1	0	1
Anaesthetist Unavailable	0	1	0	1
Patient to be treated at another Trust	0	1	0	1
TOTAL	**32**	**62**	**23**	**117**

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 39 Delayed Transfer of Care patients as at month-end (including 12 at South Bristol), and 868 beddays consumed by DToC patients.
Commentary/ Actions:	The Integrated Care Bureau (ICB) model continues to work well in relation to early identification of patients approaching discharge ready and agreement with partners regarding the most appropriate pathway for discharge. This is clearly demonstrated by consistently high number of patients on the Green To Go (G2G) list, however the number of formal Delayed Transfers of Care remains stable at approximately 30-40. Where community capacity is available the ICB facilitates a smooth and timely discharge. However demand for HomeFirst in particular is exceeding capacity and patients are experiencing delays in hospital as a result. At the end of June there were 7 patients delayed awaiting HomeFirst.17 patients were either waiting for Social Care allocation or being assessed, and there were 16 patients waiting for a domiciliary package of care split between self-funders and those funded by social care. This is an increase and currently includes some of our longest delays. Introducing the Single Referral Form for rehabilitation transfers to South Bristol Hospital has enabled a small number of patients to go straight home with HomeFirst or to an alternative, less acute, rehab setting. Beds at South Bristol Hospital which are not required for care of the elderly patients or rehab patients are being used for patients awaiting HomeFirst as their discharge plan is already agreed and the therapy available can ensure their functionality is maintained whilst waiting to go home. The issue with HomeFirst is mainly availability of the homecare element as there is capacity to deliver therapy assessments.
Ownership:	Chief Operating Officer

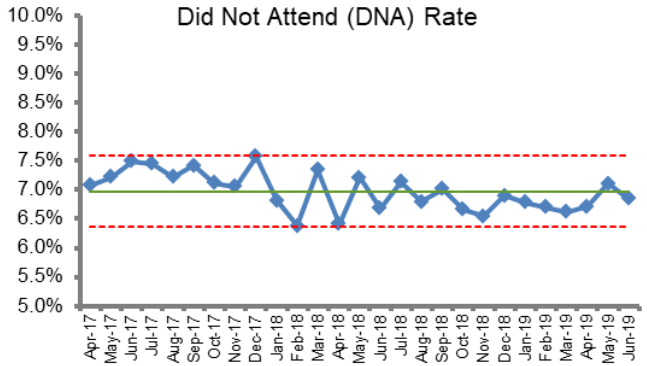




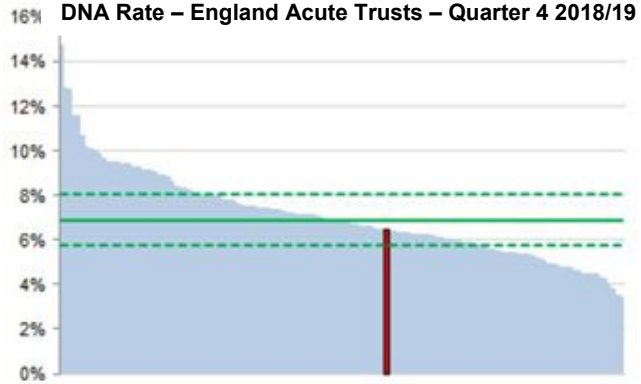
			Jun-19			
Code	Reason	Accountable	Patients (Acute)	Beddays (Acute)	Patients (Non-Acute)	Beddays (Non-Acute)
A	Completion of assessment	Both	4	36	4	95
		NHS	1	6	0	1
		Social Care	4	88	2	72
C	Further non acute NHS care	NHS	1	8	0	0
Di	Care Home Placement	NHS	0	34	1	9
		Social Care	0	4	0	2
Dii	Care Home Placement	NHS	1	74	0	8
		Social Care	5	120	1	15
E	Care package in own home	NHS	3	89	0	0
		Social Care	5	111	4	33
F	Community equipment / adaptions	NHS	1	4	0	0
		Social Care	1	35	0	0
G	Patient or family choice	NHS	1	16	0	8
TOTAL			27	625	12	243

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. DNA Target at Trust level is to be below 6.7%, with an amber tolerance of between 6.7% and 7.2%. 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 9,027 hospital-cancelled appointments, which was 10.1% of all appointments made. There were 4,380 appointments that were DNA'ed, which was 6.8% of all planned attendances.
Commentary/ Actions:	All divisions have set targets to reduce DNA's in specific specialities as part of the productivity workstreams for 2019/20. The Outpatient Steering Group (OSG) will monitor progress towards the targets set by each division and reviewing the Trust DNA rate on a monthly basis. The trend towards a more stable DNA rate is thought to be due to patients having greater choice over when and where they are seen for their first outpatient appointment through e-RS and the ongoing work to reduce the number of patients who are overdue their follow-up by more than 6 months. The increase in hospital cancellation rate is due to the introduction of e-RS, which whilst it allows the patient to book an appointment, if they require a different speciality or a particular clinic their original appointment will be cancelled to allow the correct appointment to be booked. Patients are informed their appointment is not confirmed until they receive confirmation following triage. Work is ongoing to review description of services to improve the number of appointments booked to the correct service first time.
Ownership:	Chief Operating Officer



DNA Rate – England Acute Trusts – Quarter 4 2018/19



Hospital Cancellations – England Acute Trusts – Quarter 4 2018/19

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

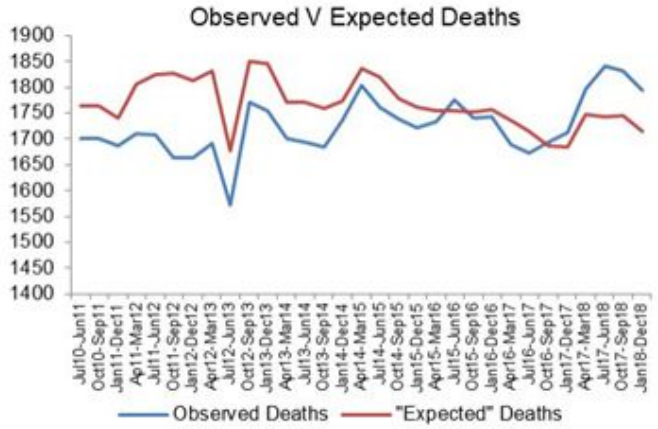
2.3 PERFORMANCE – Responsive Domain

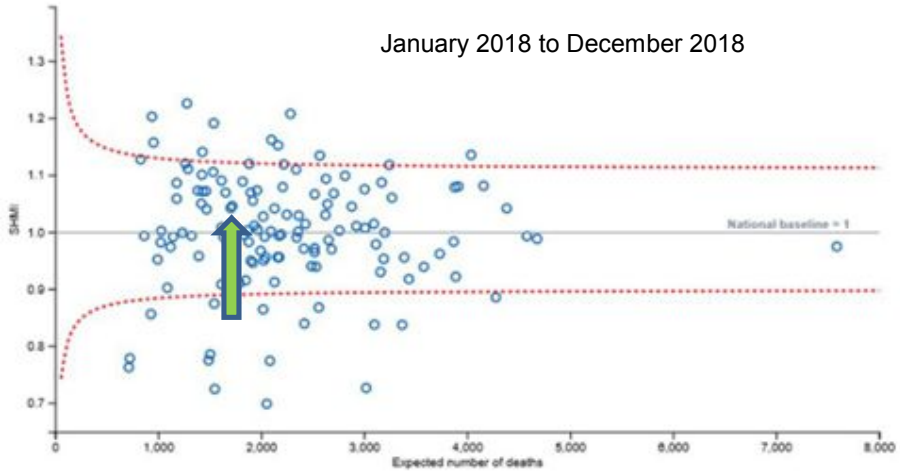
Outpatient – Overdue Follow-Ups	
Standards:	This measure looks at referrals where the patient is on a "Partial Booking List", which indicates the patient is to be seen again in Outpatients but an appointment date has not yet been booked. Each patient has a "Date To Be Seen By", from which the proportion that are overdue can be 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 is 134 and overdue by 9+ months is 744.
Commentary/ Actions:	Significant progress has been made by the divisions, through regular weekly review at the Wednesday performance meeting. Focus has now moved to the 9+ month's overdue patients for surgery, specialised services and Women's and Children's. Medicine division are focusing on the patients who have waited more than 6 months. To re-focus attention on this area, divisions have now signed-up to recovery trajectories for key specialties, and an operational scorecard has been created for review at the weekly divisional performance meetings. This will allow a managed and targeted approach to reducing overdue follow-ups across all divisions and specialties. Further transformation work is planned with BEH who now have a project manager in post for 1 year; this work will be supported by the CCG.
Ownership:	Chief Operating Officer

		Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19
Outpatients Overdue by 12+ Months	Diagnostics and Therapies	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	Medicine	461	133	23	5	7	3	3	2	3	4	3	3	3	3	3
	Specialised Services	188	206	214	208	95	58	67	7	5	8	12	0	0	34	62
	Surgery	444	221	92	17	3	0	0	0	0	11	23	49	61	62	66
	Women's and Children's	756	526	387	387	371	375	322	323	350	351	360	282	150	46	3
	TRUST TOTAL 12+ months	**1,849**	**1,086**	**716**	**617**	**476**	**436**	**392**	**332**	**358**	**374**	**398**	**334**	**214**	**145**	**134**
Outpatients Overdue by 9+ Months	Diagnostics and Therapies								3	2	0	0	0	0	0	2
	Medicine								20	4	4	3	4	4	3	3
	Specialised Services								125	95	142	247	253	181	261	278
	Surgery								125	124	108	146	216	264	272	333
	Women's and Children's								565	620	640	629	530	349	174	128
	TRUST TOTAL 9+ months								**838**	**845**	**894**	**1025**	**1003**	**798**	**710**	**744**

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 January 2018 to December 2018. The SHMI was 104.6 (1796 deaths and 1716 "expected"). Data is updated quarterly by NHS Digital.
Commentary/ Actions:	The latest published Summary Hospital Mortality Indicator was for 12 months to December 2018 and was 104.6 and in NHS Digital's "as expected" category. The Trust Quality Intelligence Group maintains surveillance of all mortality indicators, drilling down to speciality level if required. Please also see narrative for HSMR below.
Ownership:	Medical Director

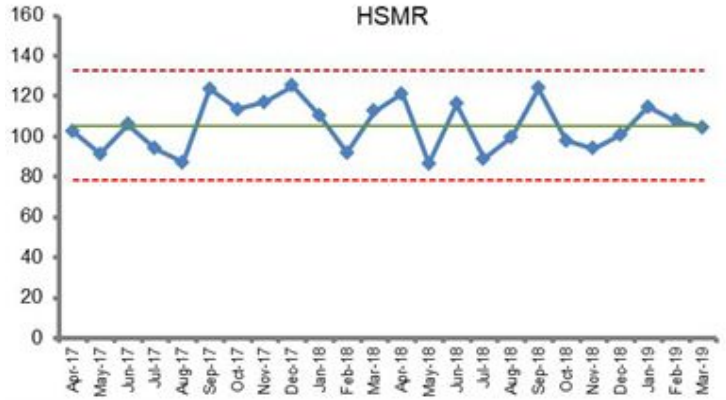
Timeframe	Banding	Observed Deaths	"Expected" Deaths	SHMI
Jul15-Jun16	As Expected	1,775	1,754	101.2
Oct15-Sep16	As Expected	1,741	1,752	99.4
Jan16-Dec16	As Expected	1,743	1,758	99.1
Apr16-Mar17	As Expected	1,690	1,737	97.3
Jul16-Jun17	As Expected	1,674	1,714	97.6
Oct16-Sep17	As Expected	1,693	1,686	100.4
Jan17-Dec17	As Expected	1,712	1,684	101.7
Apr17-Mar18	As Expected	1,796	1,748	102.7
Jul17-Jun18	As Expected	1,841	1,744	105.6
Oct17-Sep18	As Expected	1,833	1,745	105.0
Jan18-Dec18	As Expected	1,795	1,715	104.7

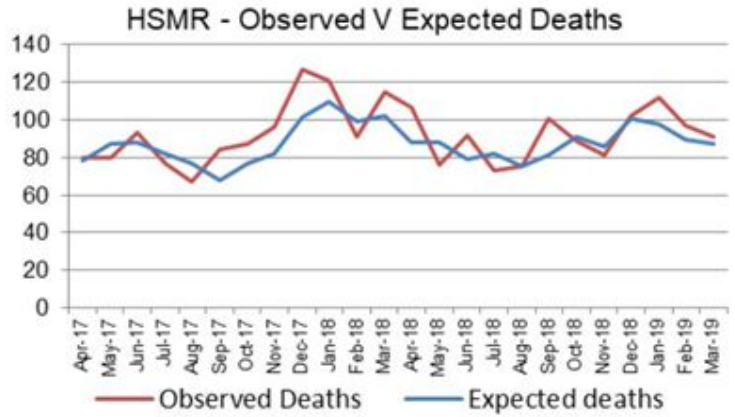




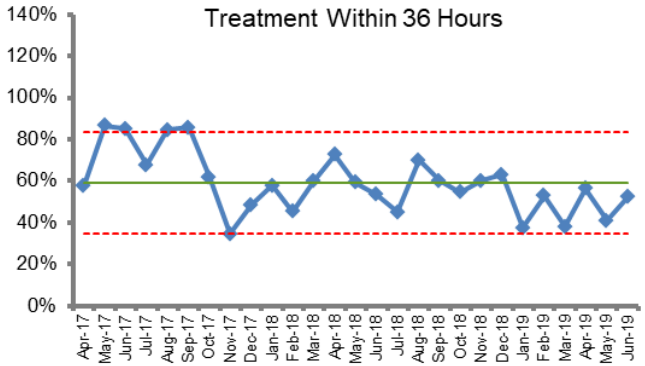
2.4 PERFORMANCE – Effective Domain

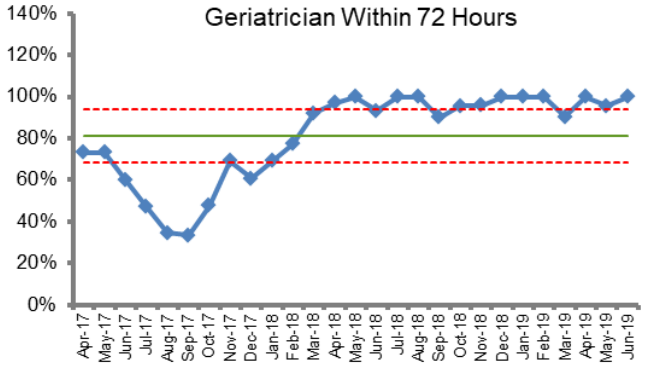
Mortality – Hospital Standardised Mortality Ratio (HSMR)	
Standards:	This is the national measure published by Dr Foster .It is the number of actual deaths divided by "expected" deaths, multiplied by 100. The Hospital Standardised Mortality Ratio (HSMR) is in-hospital deaths for conditions that account for 80% of hospital deaths
Performance:	Latest HSMR data is for March 2019. The HSMR was 105 (91 deaths and 87 "expected")
Commentary/ Actions:	As previously reported, actions are being taken in response to the detailed report into the Trust's HSMR and mortality for acute myocardial infarction. These actions include improving palliative care coding and improvements in repatriating patients to their local hospital following acute coronary intervention. It will take several months before the impact of actions is seen in HSMR
Ownership:	Medical Director

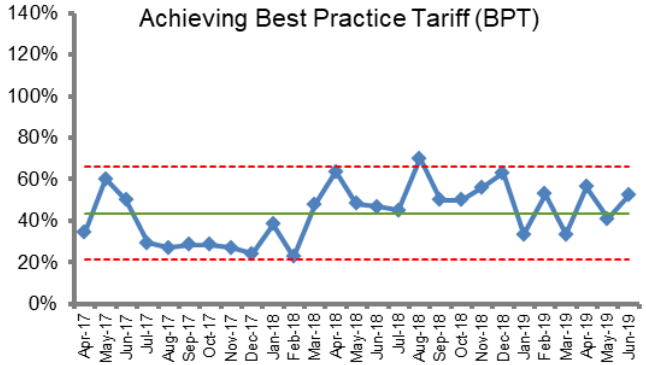




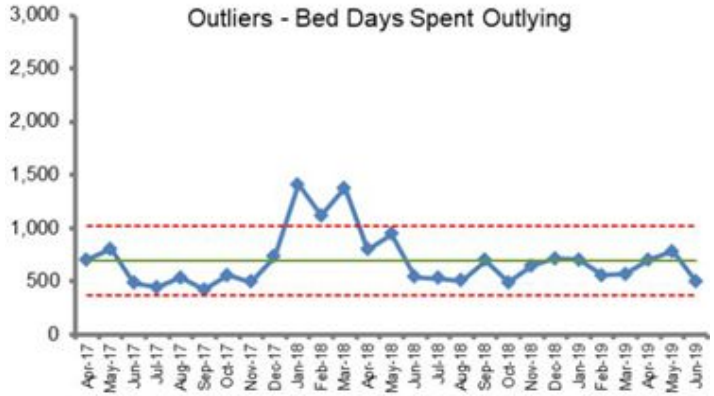
Fracture Neck of Femur	
Standards:	Best Practice Tariff (BPT), is a basket of indicators covering eight elements of what is considered to be best practice in the care of patients that have fractured their hip. 90% of patients should achieve Best Practice Tariff. Two key measures are being treated within 36 hours and seeing an orthogeriatrician within 72 hours. Both these measures should achieve 90%.
Performance:	In June, there were 24 patients discharged following an admission for fractured neck of femur, of which 21 were eligible for Best Practice Tariff (BPT). For the 36 hour target, 52% (11 patients) were seen with target. For the 72 hour target, 100% were seen within target. 11 patients (52%) achieved all elements of the Best Practice Tariff.
Commentary/ Actions:	Challenges resulting in patients not being seen within 36 hours: • Access to trauma operating theatre • Consultant availability to operate Actions : • Reviewing ability to provide full day trauma operating to allow for prioritisation of fractured neck of femur on trauma lists • Reviewing ability to accommodate trauma overruns as required • Continue to create additional capacity for trauma as possible by taking down other lists or using vacant theatre sessions • Additional consultants being recruited who will support the fractured neck of femur pathway. Interviews are planned for the end of July. • Appointment of an ortho-geriatrician. Interviews planned for then end of July 2019. • On-call service now split out from trauma operating – ensuring consultants are always available to do trauma lists whilst ensuring wards are supported to improve flow of patients.
Ownership:	Medical Director

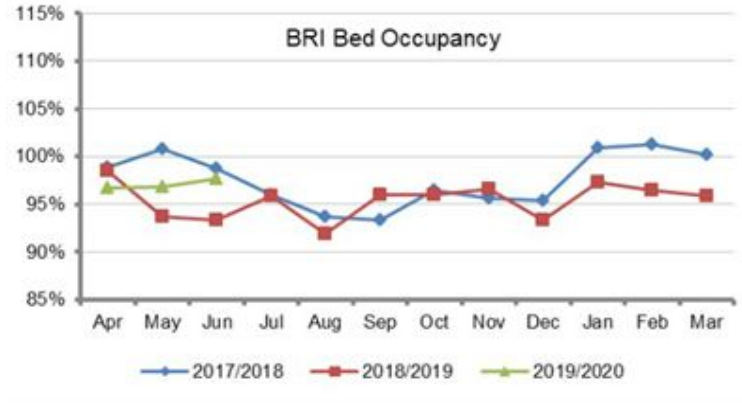


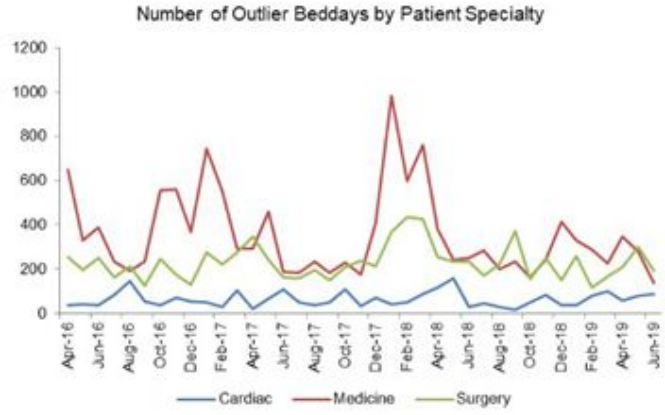




Outliers	
Standards:	This is a measure of how many bed-days patients spend on a ward that is different from their broad treatment speciality: medicine, surgery, cardiac and oncology. Our target is a 15% reduction which equates to a 9029 bed-days for the year with seasonally adjusted quarterly targets.
Performance:	In June there were 503 outlying beddays (1 bedday = 1 patient in a bed at 12 midnight).
Commentary/ Actions:	The June target of no more than 815 beddays was achieved. Of all the outlying beddays 136 were Medicine patients, 167 were Specialised Services patients and 191 were Surgery patients. All adult Divisions continue to outlie and Medicine are still using the extra capacity ward (A512). Looking ahead to winter 2019/20, the division has confirmed the winter consultant (working January to April) will be back again this year, and they are also advertising for a second.
Ownership:	Chief Operating Officer

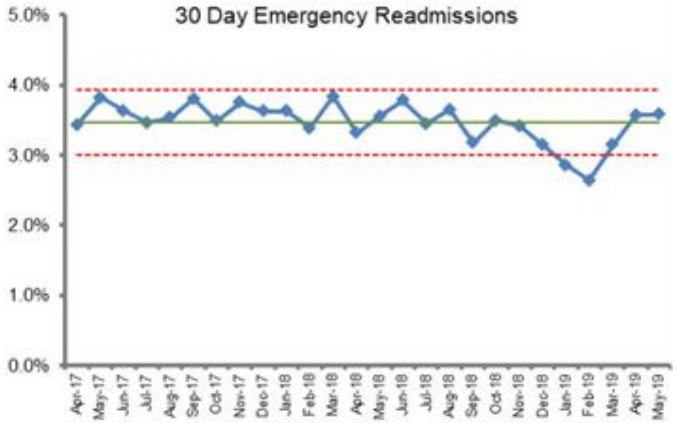






2.4 PERFORMANCE – Effective Domain

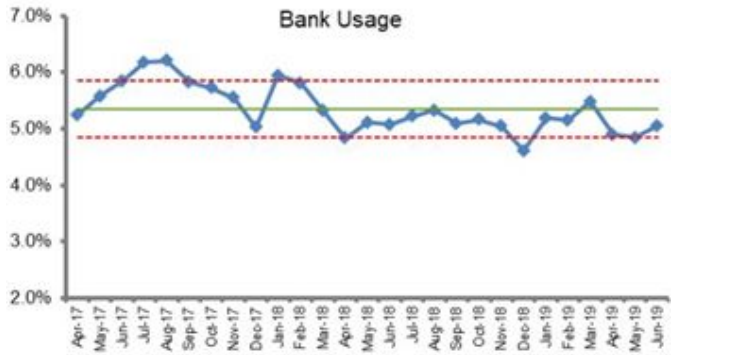
30 Day Emergency Readmissions	
Standards:	This reports on patients who are re-admitted as an emergency to the Trust within 30 days of being discharged. This can be in an unrelated specialty; it purely looks to see if there was a readmission. This uses Payment By Results (PbR) rules, which excludes certain pathways such as Cancer and Maternity. The target for the Trust is to remain below 2017/18 total of 3.62%, with a 10% amber tolerance down to 3.26%.
Performance:	In May, there were 12,960 discharges, of which 464 (3.58%) had an emergency re-admission within 30 days.
Commentary/ Actions:	8.7% of Medicine division discharges were re-admitted within 30 days as an emergency, 4.1% from Surgery and 0.9% from Specialised Services. Data is monitored on a regular basis through divisional performance reviews and is included on the speciality performance reports. The Colorectal team have recently undertaken an audit looking at Surgical Site Infections and plan to develop a business case which should see a reduction in length of stay and readmission rates. Plans within the emergency care pathway should prevent readmissions, for example, nurse led follow-up telephone calls 24 hours post discharge.
Ownership:	Chief Operating Officer

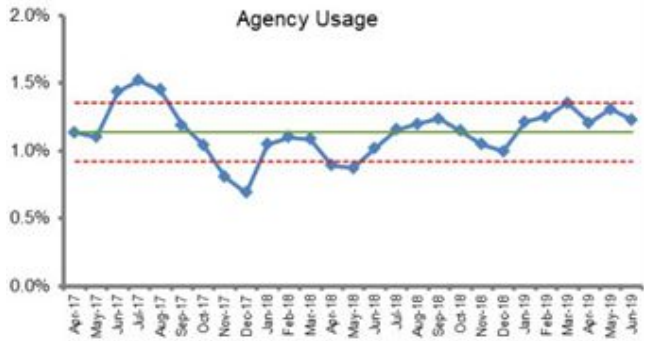


Discharges in May 2019

	Emergency Readmissions	Total Discharges	% Readmissions
Diagnostics and Therapies	0	40	0.00%
Medicine	240	2,762	8.69%
Specialised Services	25	2,804	0.89%
Surgery	130	3,150	4.13%
Women's and Children's	69	4,198	1.64%
TRUST TOTAL	**464**	**12,960**	**3.58%**

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 2019, total staffing was at 8900 FTE. Of this, 5.0% was Bank (449 FTE) and 1.2% was Agency (110 FTE)
Commentary/ Actions:	**Agency usage** reduced by 6.0 FTE. The largest reduction was seen in the division of Medicine, decreasing to 31.5 FTE from 39.5 FTE the previous month. The largest increase was seen in the division of Specialised Services with 19.4 FTE compared to 14.1 FTE in the previous month. The largest staff group increase was within Medical increasing to 8.3 FTE from 5.8 FTE in the previous month. **Bank usage** increased by 20.0 FTE. The largest increase was seen in the division of Surgery, increasing to 107.7 FTE from 95.2 FTE the previous month. The largest reduction was seen in Specialised Services, decreasing to 64.2 FTE from 68.3 FTE the previous month. The largest staff group increase was within Nursing and Midwifery increasing to 291.8 FTE from 279.2 FTE in the previous month. • With BNSSG partners and the neutral vendor for nurse agency supply, communication plans are underway for the system wide programme to reduce high cost agency use. • A review to develop an improved sustainable RMN nurse bank is underway, together with other considerations to increase the size of nurse bank pool. • Supported by the Trust's 'Get Set for Summer' recruitment campaign, active recruitment continues to all staff groups for the Trust's Bank pool. • All new appointments will be auto-enrolled to the medical locum bank with effect from August as part of the locum bank development plan.
Ownership:	Director of People



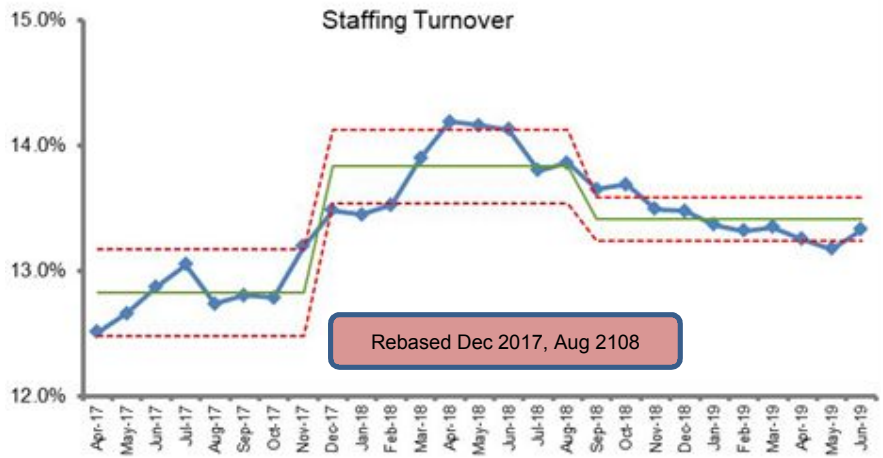


Bank	Jun FTE	Jun Actual %	KPI
UH Bristol NHS Foundation Trust	449.2	5.0%	4.5%
Diagnostics & Therapies	13.3	1.3%	1.5%
Medicine	116.0	9.0%	8.9%
Specialised Services	64.2	6.1%	6.1%
Surgery	107.7	5.9%	5.2%
Women's & Children's	69.3	3.3%	1.6%
Trust Services	32.5	3.8%	3.1%
Facilities & Estates	46.2	6.1%	6.3%

Agency	Jun FTE	Jun Actual %	KPI
UH Bristol NHS Foundation Trust	109.5	1.2%	0.8%
Diagnostics & Therapies	8.0	0.8%	1.0%
Medicine	31.5	2.4%	1.7%
Specialised Services	19.4	1.8%	1.0%
Surgery	18.8	1.0%	0.6%
Women's & Children's	23.3	1.1%	0.4%
Trust Services	8.3	1.0%	0.8%
Facilities & Estates	0.3	0.0%	0.5%

2.5 PERFORMANCE – Efficient Domain

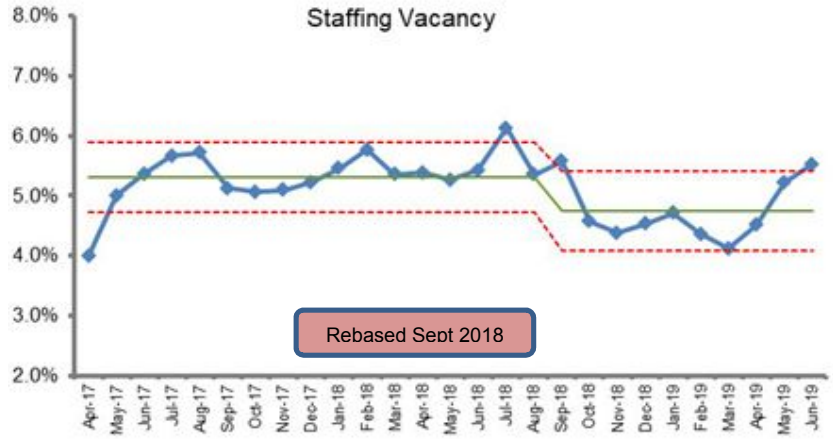
Staffing Levels (Turnover)	
Standards:	Turnover is measured as total permanent leavers (FTE) as a percentage of the average permanent staff over a rolling 12-month period. The Trust target is the trajectory to achieve 12.3% by the end of 2018/19. The red threshold is 10% above monthly trajectory.
Performance:	In June 2019, there had been 950 leavers over the previous 12 months with 7123 FTE staff in post on average over that period; giving a Turnover of 950 / 7123 = 13.3%
Commentary/ Actions:	Turnover increased to 13.3% from 13.2% last month, with increases in four divisions – Diagnostics and Therapies, Medicine, Trust Services, and Women's and Children's. The largest divisional reduction was seen within Facilities and Estates reducing to 13.0% from 13.5% the previous month. The largest divisional increase was seen within Trust Services increasing to 14.5% from 13.6% the previous month. The biggest reduction in staff group was seen within Estates and Ancillary (0.6 percentage points). The largest increase in staff group was seen within Nursing and Midwifery Unregistered (0.7 percentage points). • Work with divisional colleagues is underway to support interventions required from the improving staff experience plans to ensure there is a focus on engagement as we work towards the 'You said we did' in the Autumn. • 2019/20 Q1 Exit Interview report is being finalised and will be published by the end of July. The data shows that return rates have improved dramatically over the past 2 months. • Dissatisfaction with job, dissatisfaction with ward/department, dissatisfaction with pay/hours make up 36.72% of Q1's reasons for leaving. This will be fed back through the Retention Group and also Divisional HRBP's. • Stress, workload and poor/unsupportive management also continue to feature highly in the data.
Ownership:	Director of People



Turnover	Jun-19	KPI
UH Bristol NHS Foundation Trust	13.3%	13.2%
Diagnostics & Therapies	10.7%	10.6%
Medicine	15.6%	14.7%
Specialised Services	16.5%	15.0%
Surgery	13.1%	13.4%
Women's & Children's	11.8%	11.8%
Trust Services	14.5%	14.3%
Facilities & Estates	13.0%	14.9%

2.5 PERFORMANCE – Efficient Domain

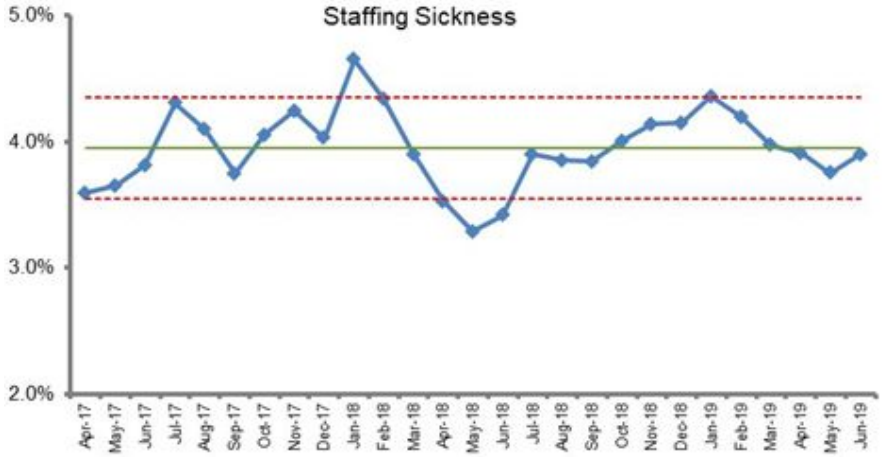
Staffing Levels (Vacancy)	
Standards:	Vacancy levels are measured as the difference between the Full Time Equivalent (FTE) budgeted establishment and the Full Time Equivalent substantively employed, represented as a percentage, compared to a Trust-wide target of 5%.
Performance:	In June 2019, funded establishment was 8830 FTE, with 489 FTE as vacancies (5.5%).
Commentary/ Actions:	Overall vacancies increased to 5.5% compared to 5.2% in the previous month. There were three staff group increases, the largest being within Admin and Clerical increasing to 108.2 FTE from 95.34 FTE the previous month. The largest staff group vacancy reduction was seen within Ancillary staff reducing to 65.4 FTE from 70.6 FTE the previous month. Diagnostics and Therapies had the largest Divisional reduction to 61.8 FTE from 66.2 FTE the previous month. • Strong interest to the apprentice Nursing Assistant role has been seen with 90 applicants during June. Weston College apprentice induction day planned for July for first cohort. • New Trust Clinical Talent Acquisition Manager was successfully appointed and is due to start in September 2019. • Continued use of EU head hunters for targeted PIN- ready RN's • Good progress being made in filling medical vacancies in time for the August rotation.
Ownership:	Director of People



Vacancy	Jun-19	KPI
UH Bristol	5.5%	5.0%
Diagnostics & Therapies	5.8%	5.0%
Medicine	7.3%	5.0%
Specialised Services	7.2%	5.0%
Surgery	6.2%	5.0%
Women's & Children's	1.9%	5.0%
Trust Services	5.7%	5.0%
Facilities & Estates	7.9%	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 252,524 of which 9,881 (3.9%) were lost to staff sickness
Commentary/ Actions:	Sickness absence increased to 3.9% from 3.8%, with reductions in two divisions. The largest divisional reduction was seen in Diagnostics and Therapies reducing to 2.7% from 3.0% the previous month. Women's and Children's saw the largest divisional increase to 3.9% from 3.3% the previous month. The largest staff group increase was seen in Nursing and Midwifery Unregistered, rising to 8.9% from 7.5% the previous month. The largest staff group reduction was seen within Add Prof Scientific and Technic reducing to 3.2% from 3.9% the previous month. • Deep dive and hotspot reports are being provided as appropriate, to support areas to develop action plans. • Over 300 staff and managers have attended the workplace wellbeing training which supports staff with stress related issues supported by a suite of self-help guides. • The online Supporting Attendance training is currently under review and will be publicised by the beginning of August. It will act as a refresher for all managers to complete. Face to face training and absence surgeries are available upon request.
Ownership:	Director of People



Sickness	Jun-19	KPI
UH Bristol	**3.9%**	**3.6%**
Diagnostics & Therapies	2.7%	3.0%
Medicine	3.8%	3.7%
Specialised Services	3.5%	3.3%
Surgery	4.1%	3.6%
Women's & Children's	3.9%	3.6%
Trust Services	3.5%	2.5%
Facilities & Estates	6.3%	5.8%

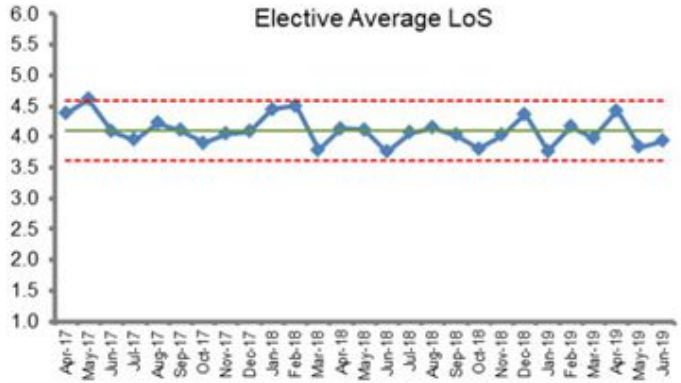
2.5 PERFORMANCE – Efficient Domain

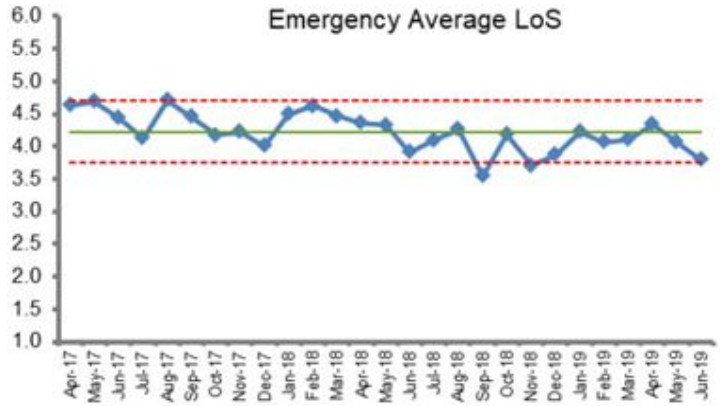
Staff Appraisal	
Standards:	Staff Appraisal in measured as a percentage of staff excluding consultants who have had their appraisal signed-off. The target is 85% Trust-wide.
Performance:	In June 2019, 6,060 members of staff were compliant out of 8,254 (73.4%)
Commentary/ Actions:	Overall appraisal compliance reduced to 73.4% (from 73.9%). However, there were increases in two divisions; Medicine and Women's & Children's. With the largest divisional increase seen in Women's and Children's increasing to 71.7% (from 70.4% the previous month). The largest divisional reduction was seen within Facilities and Estates, reducing to 76.0% (from 78.2% the previous month). All divisions are now non-compliant. • With the drop in compliance this month, a recovery plan continues to be in place to focus on direct action with areas of low compliance. Support includes: – Fortnightly communications to all managers with a targeted message and all staff communications via Newsbeat to promote Appraisal resources – Appraisal Training frequency has now increased to enable 30 managers to attend each month. – Review of HR Web and supporting Appraisal documentation has commenced with a number of new guides for staff and managers. • Hotspot reporting was focused on Women's and Children's this month which has impacted on compliance. This focussed reporting will continue through July and August. • The delegation functionality in the e-appraisal system can now go live after testing. This is planned for August 2019. This will be welcomed by managers with large teams, giving them the ability to delegate appraisals within the system without changing the line manager.
Ownership:	Director of People

Appraisal (Non-Consultant)	Jun-19	May-19	KPI
UH Bristol NHS Foundation Trust	73.4%	73.9%	85.0%
Diagnostics & Therapies	84.9%	86.3%	85.0%
Medicine	67.1%	66.2%	85.0%
Specialised Services	83.3%	84.9%	85.0%
Surgery	67.6%	68.3%	85.0%
Women's & Children's	71.7%	70.4%	85.0%
Trust Services	68.5%	70.0%	85.0%
Facilities & Estates	76.0%	78.2%	85.0%

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 6,416 discharges that consumed 23,164 beddays, giving an overall average length of stay of 3.61 days.
Commentary/ Actions:	There has been a reduction in Surgery in June following a significant number of their delayed discharges being discharged to the appropriate place. 21+ day length of stay for Non-Medically Fit patients continues to be high particularly on A800. This is due to the acuity and complexity of the patients on the ward and is mainly driven by emergency patients not elective. The Length of Stay Group continue to review Clinical Utilisation Review (CUR) and are working with Trust IT lead for CUR to understand how we can use it better within our specialities.
Ownership:	Chief Operating Officer





Average Length of Stay – England Trusts - 2018/19 Quarter 4

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

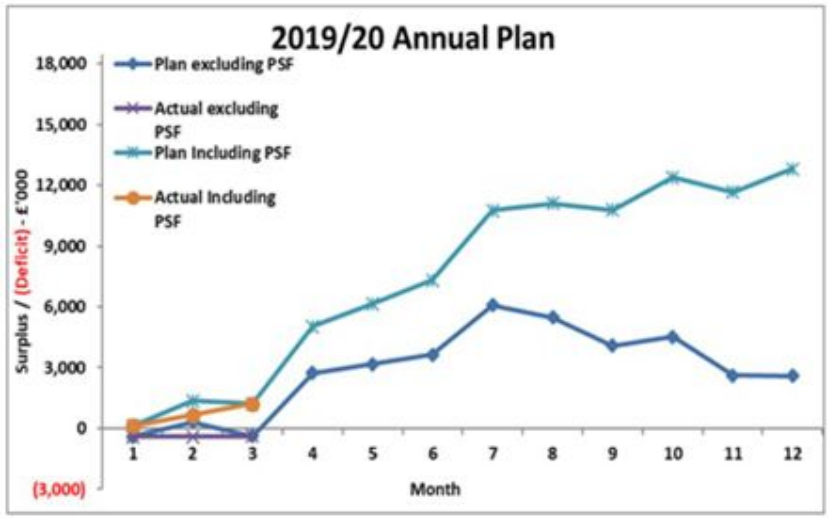
2.5 PERFORMANCE – Efficient Domain

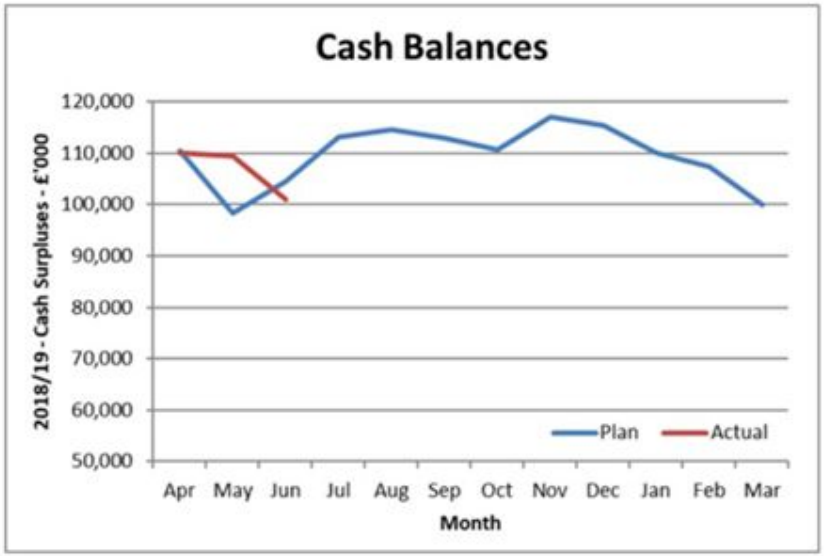
Length of Stay of Inpatients at month-end

Jun-19	7+ Days	14+ Days	21+ Days	28+ Days
Bristol Children's Hospital	59	39	31	22
Bristol Haematology & Oncology Centre	28	15	10	5
Bristol Royal Infirmary	239	142	90	63
South Bristol Hospital	59	51	37	31
St Michael's Hospital	23	15	13	11
TRUST TOTAL	409	262	181	132

Bristol Royal Infirmary Divisional Breakdown:

Medicine	121	75	46	34
Specialised Services	49	25	18	8
Surgery, Head & Neck	69	42	26	21

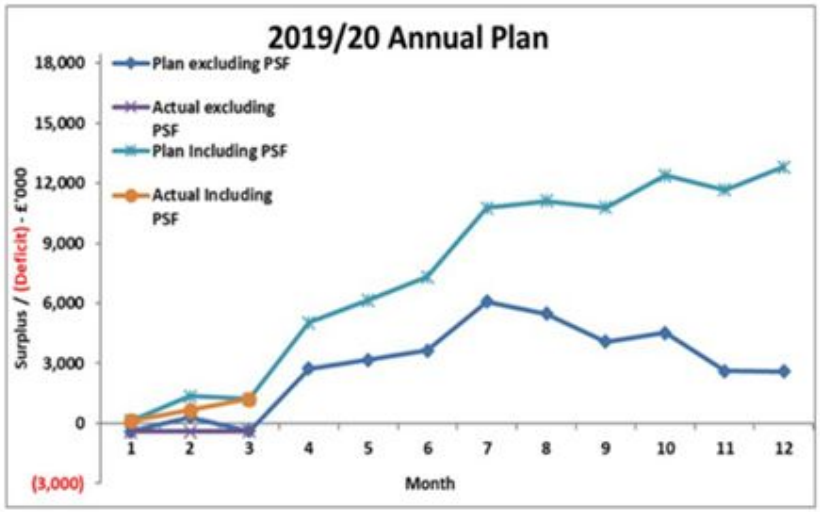




Divisional Actual Spend - £'000					
	In Month			Plan for	FOT
Divisional Agency	Apr	May	Jun	Year	Outturn
Nursing & Midwifery	684	660	648	6,499	8,064
Medical					0
Consultants	72	82	92	644	924
Other Medical	56	20	85	212	456
Other	140	144	131	1,384	1,704
Total	952	906	956	8,739	11,148

YTD Variance to Budget Surplus/(Deficit) - £'000			
Division	Apr	May	Jun
Diagnostics & Therapies	(4)	(39)	(56)
Medicine	(167)	(320)	(502)
Specialised Services	(54)	13	201
Surgery	(175)	(659)	(1,168)
Women's & Children's	(215)	(311)	(407)
Estates & facilities	(5)	(9)	(13)
Trust Services	4	3	(33)
Other Corporate Services	42	29	(85)
Total	(574)	(1,293)	(2,063)

In Month Variance to Budget Surplus/(Deficit) - £'000			
Subjective Heading	Apr	May	Jun
Nursing & Midwifery Pay	(604)	(491)	(484)
Medical & Dental Pay	(360)	(187)	(445)
Other Pay	243	197	109
Non Pay	954	189	356
Income from Operations	(173)	(94)	(2)
Income from Activities	(632)	(336)	(301)
Total	(572)	(722)	(767)



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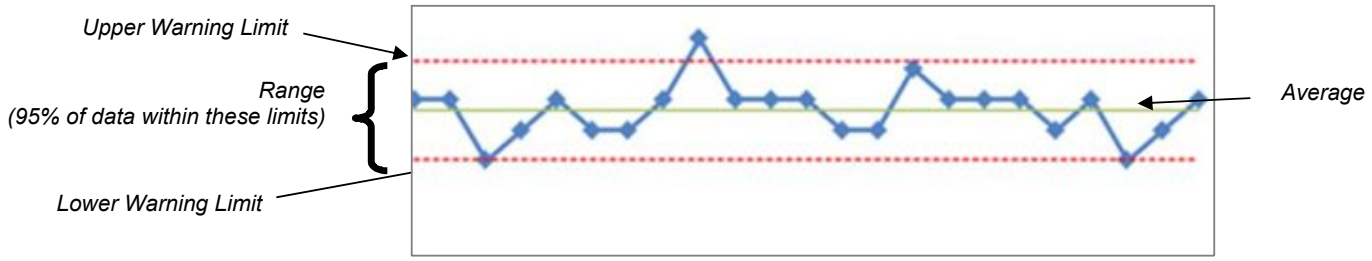
Income from Activities	(632)	(336)	(301)
Total	(572)	(722)	(767)

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.

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 18/19	Annual 19/20 YTD	Monthly Totals Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Quarterly Totals 18/19 Q2	18/19 Q3	18/19 Q4	19/20 Q1
Patient Safety																				
Infections	DA01	MRSA Trust Apportioned Cases	6	0	0	0	1	1	0	0	0	1	0	0	0	0	1	1	1	0
	DA02	MSSA Trust Apportioned Cases	34	16	2	3	1	1	3	3	3	2	4	5	6	5	6	7	9	16
	DA03	CDiff Trust Apportioned Cases	31	8	4	1	7	2	4	2	1	1	1	4	2	2	12	8	3	8
	DA06	EColi Trust Apportioned Cases	83	23	7	8	12	7	0	7	5	5	8	6	8	9	27	14	18	23
C.Diff "Avoidables"	DA03B	CDiff Trust Apportioned Cases - Lapse in Care	9	0	2	0	2	1	0	1	0	0	1	0	0	0	4	2	1	0
	DA03D	CDiff Trust Apportioned Cases - Still Under Review	3	6	0	1	2	0	0	0	0	0	0	2	2	2	3	0	0	6
Infection Checklists	DB01	Hand Hygiene Audit Compliance	97%	95.9%	97.7%	97.2%	98%	97%	96.5%	96.8%	96.3%	96.6%	96.7%	95.6%	95.7%	96.6%	97.6%	96.8%	96.6%	95.9%
	DB02	Antibiotic Compliance	78.9%	79.1%	84.6%	77.4%	75.1%	76.7%	75.7%	85%	79.1%	66.3%	68%	76.1%	84.2%	80.2%	79.6%	77.6%	72.2%	79.1%
Cleanliness Monitoring	DC01	Cleanliness Monitoring - Overall Score	-	-	95%	95%	95%	95%	96%	95%	96%	96%	95%	96%	96%	95%	-	-	-	-
	DC02	Cleanliness Monitoring - Very High Risk Areas	-	-	97%	97%	97%	98%	98%	97%	97%	98%	98%	98%	98%	98%	-	-	-	-
	DC03	Cleanliness Monitoring - High Risk Areas	-	-	96%	95%	95%	96%	96%	96%	96%	97%	97%	97%	96%	96%	-	-	-	-
Serious Incidents	S02	Number of Serious Incidents Reported	70	18	4	8	8	4	10	4	3	7	5	7	3	8	20	18	15	18
	S02a	Number of Confirmed Serious Incidents	63	1	4	8	6	4	8	3	2	6	5	1	-	-	18	15	13	1
	S02b	Number of Serious Incidents Still Open	5	17	-	-	1	0	2	0	1	1	0	6	3	8	1	2	2	17
	S03	Serious Incidents Reported Within 48 Hours	98.6%	100%	100%	100%	100%	100%	90%	100%	100%	100%	100%	100%	100%	100%	100%	94.4%	100%	100%
	S03a	Serious Incidents - 72 Hour Report Completed Within Timescale	94.3%	94.4%	75%	100%	100%	100%	80%	75%	100%	100%	100%	85.7%	100%	100%	95%	83.3%	100%	94.4%
	S04	Serious Incident Investigations Completed Within Timescale	96.8%	100%	100%	100%	100%	100%	100%	100%	100%	80%	100%	100%	100%	100%	100%	100%	93.8%	100%
	S04a	Overdue Exec Commissioned Non-SI Investigations	10	3	2	2	0	0	0	0	1	0	0	1	1	1	4	0	1	3
Never Events	S01	Total Never Events	5	1	0	1	0	0	1	2	0	0	1	0	0	1	1	3	1	1
Patient Safety Incidents	S06	Number of Patient Safety Incidents Reported	17839	4165	1566	1539	1510	1517	1511	1371	1520	1551	1570	1373	1027	1765	4615	4399	4641	4165
	S06b	Patient Safety Incidents Per 1000 Beddays	58.56	53.28	60.39	62.35	59.72	58.92	58.92	54.11	57.27	64.61	58.94	53.22	38.47	68.73	60.81	57.33	60.13	53.28
	S07	Number of Patient Safety Incidents - Severe Harm	88	14	5	3	9	9	7	5	7	4	10	7	1	6	17	21	21	14
Patient Falls	AB01	Falls Per 1,000 Beddays	4.48	4.48	4.4	5.27	4.9	3.73	4.48	5.17	5.61	4.67	3.72	4.46	4.98	3.97	4.85	4.46	4.66	4.48
	AB06a	Total Number of Patient Falls Resulting in Harm	27	3	1	5	2	2	1	2	3	1	3	3	0	0	8	5	7	3
Pressure Ulcers Developed in the Trust	DE01	Pressure Ulcers Per 1,000 Beddays	0.295	0.128	0.347	0.203	0.277	0.816	0.39	0.276	0.527	0.083	0.188	0.194	0.037	0.156	0.277	0.495	0.272	0.128
	DE02	Pressure Ulcers - Grade 2	80	9	8	4	7	18	8	7	13	2	5	4	1	4	19	33	20	9
	DE04A	Pressure Ulcers - Grade 3 or 4	10	1	1	1	0	3	2	0	1	0	0	1	0	0	2	5	1	1
Venous Thrombo-embolism (VTE)	N01	Adult Inpatients who Received a VTE Risk Assessment	98.3%	98.3%	98.3%	98.7%	98.4%	98.4%	98%	98.3%	98.2%	98%	98.7%	98.5%	98.2%	98.2%	98.5%	98.2%	98.3%	98.3%
	N02	Percentage of Adult Inpatients who Received Thrombo-prophylaxis	92.6%	93.5%	95%	93.4%	89.6%	87.8%	92.2%	95.5%	91.4%	88.6%	94.5%	93.4%	93.2%	94.2%	92.9%	91.1%	91.9%	93.5%
	N04	Number of Hospital Associated VTEs	39	-	4	6	3	2	2	6	6	-	-	-	-	-	13	10	6	-
	N04A	Number of Potentially Avoidable Hospital Associated VTEs	2	-	1	0	0	0	0	0	0	-	-	-	-	-	1	0	0	-
	N04B	Number of Hospital Associated VTEs - Report Not Received To Date	16	-	2	2	0	1	1	4	5	-	-	-	-	-	4	6	5	-
Nutrition Audit	WB10	Fully and Accurately Completed Screening within 24 Hours	91.1%	84.4%	-	-	90.4%	-	-	92.1%	-	-	89.9%	-	-	84.4%	90.4%	92.1%	89.9%	84.4%
Safety	Y01	WHO Surgical Checklist Compliance	99.8%	99.8%	99.9%	99.8%	99.8%	99.8%	99.8%	99.8%	99.8%	99.8%	99.9%	99.9%	99.6%	99.9%	99.8%	99.8%	99.8%	99.8%
Medicines	WA01	Medication Incidents Resulting in Harm	0.29%	0.35%	0%	0%	0%	0.29%	0.36%	0.8%	0.77%	0%	0%	0%	0.62%	-	0%	0.46%	0.28%	0.35%
	WA03	Non-Purposeful Omitted Doses of the Listed Critical Medication	0.37%	0.37%	0.54%	0.22%	0.53%	0.41%	0.2%	0.62%	0%	0.25%	0.42%	0.31%	0.46%	0.3%	0.4%	0.39%	0.24%	0.37%

Topic	ID	Title	Annual 18/19	Annual 19/20 YTD	Monthly Totals Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Quarterly Totals 18/19 Q2	18/19 Q3	18/19 Q4	19/20 Q1
Deteriorating Patient	AR03	National Early Warning Scores (NEWS) Acted Upon	88%	-	88%	84%	90%	93%	96%	87%	83%	91%	85%	-	-	-	87%	92%	86%	-
Out of Hours	TD05	Out of Hours Discharges (8pm-7am)	8.7%	8.3%	10.3%	9.5%	9.4%	9.2%	8.7%	8.7%	7.9%	6.4%	7%	8.3%	8.3%	8.3%	9.7%	8.9%	7.1%	8.3%
Timely Discharges	TD03	Percentage of Patients With Timely Discharge (7am-12Noon)	23.9%	22.7%	24.1%	24.5%	24.3%	23.7%	25.1%	23.1%	23%	23.1%	22.8%	22.5%	23.5%	22.1%	24.3%	24%	23%	22.7%
	TD03D	Number of Patients With Timely Discharge (7am-12Noon)	9815	2259	810	824	804	832	926	816	821	718	839	749	805	705	2438	2574	2378	2259
Staffing Levels	RP01	Staffing Fill Rate - Combined	99.3%	100.9%	99.1%	97%	98.5%	99.6%	101.1%	99.1%	100.1%	99.9%	99.1%	100.6%	101.6%	100.5%	98.2%	99.9%	99.7%	100.9%
Clinical Effectiveness																				
Mortality	X04	Summary Hospital Mortality Indicator (SHMI) - National Data	105.1	-	-	-	105	-	-	104.6	-	-	-	-	-	-	105	104.6	-	-
	X02	Hospital Standardised Mortality Ratio (HSMR)	104.7	-	89.1	99.8	123.9	97.9	94	101	114.7	108	103.4	-	-	-	104.4	97.8	108.9	-
Readmissions	C01	Emergency Readmissions Percentage	3.3%	3.58%	3.45%	3.65%	3.17%	3.49%	3.42%	3.15%	2.85%	2.64%	3.15%	3.57%	3.58%	-	3.43%	3.36%	2.89%	3.58%
Fracture Neck of Femur	U02	Fracture Neck of Femur Patients Treated Within 36 Hours	56.3%	49.2%	45%	70%	60%	54.5%	60%	63.2%	37.5%	52.9%	38.1%	56.3%	40.9%	52.4%	58.3%	59.1%	41.9%	49.2%
	U03	Fracture Neck of Femur Patients Seeing Orthogeriatrician within 72 Hours	97%	98.3%	100%	100%	90%	95.5%	96%	100%	100%	100%	90.5%	100%	95.5%	100%	96.7%	97%	96.8%	98.3%
	U04	Fracture Neck of Femur Patients Achieving Best Practice Tariff	51.3%	49.2%	45%	70%	50%	50%	56%	63.2%	33.3%	52.9%	33.3%	56.3%	40.9%	52.4%	55%	56.1%	38.7%	49.2%
	U05	Fracture Neck of Femur - Time To Treatment 90th Percentile (Hours)	-	-	61.3	79.3	63.6	-	-	-	-	-	-	-	-	-	-	-	-	-
Stroke Care	O01	Stroke Care: Percentage Receiving Brain Imaging Within 1 Hour	51.1%	49.2%	34.3%	48.3%	51.9%	53.8%	51.3%	45.7%	51.1%	48.3%	69.2%	52.8%	44.4%	-	44%	50.4%	56.6%	49.2%
	O02	Stroke Care: Percentage Spending 90%+ Time On Stroke Unit	84.2%	77.8%	82.9%	89.7%	92.6%	66.7%	92.3%	85.7%	80%	100%	82.1%	72.2%	85.2%	-	87.9%	81.4%	85.8%	77.8%
	O03	High Risk TIA Patients Starting Treatment Within 24 Hours	58.6%	50%	30.8%	66.7%	46.7%	55.6%	73.3%	50%	50%	84.6%	90%	69.2%	43.8%	28.6%	47.5%	63.3%	75.5%	50%
Dementia	AC01	Dementia - FAIR Question 1 - Case Finding Applied	83%	85.8%	74.7%	80.2%	79.8%	79%	89%	86.8%	88.2%	86.4%	81.5%	84.2%	87.6%	85.8%	78%	84.7%	85.4%	85.8%
	AC02	Dementia - FAIR Question 2 - Appropriately Assessed	94.3%	92.9%	94.9%	97.7%	91.2%	93.6%	92.6%	89.1%	98%	95.9%	100%	94.1%	95.8%	85.2%	94.9%	91.8%	97.9%	92.9%
	AC03	Dementia - FAIR Question 3 - Referred for Follow Up	85.7%	81.8%	100%	100%	100%	100%	100%	100%	100%	50%	71.4%	83.3%	66.7%	100%	100%	100%	75%	81.8%
Outliers	J05	Ward Outliers - Beddays Spent Outlying.	7708	1989	531	507	697	492	649	716	702	559	567	704	782	503	1735	1857	1828	1989
Patient Experience																				
Monthly Patient Surveys	P01d	Patient Survey - Patient Experience Tracker Score	-	-	90	92	92	92	91	93	90	91	91	91	91	93	91	92	91	91
	P01g	Patient Survey - Kindness and Understanding	-	-	95	96	97	96	95	96	96	96	95	97	95	96	96	96	96	96
	P01h	Patient Survey - Outpatient Tracker Score	-	-	90	91	89	90	89	90	91	89	90	91	91	89	90	90	90	90
Friends and Family Test Coverage	P03a	Friends and Family Test Inpatient Coverage	35.1%	37.7%	35.6%	35.4%	29.1%	36.5%	27.8%	38.7%	32.2%	40.5%	34.6%	36.3%	42.4%	34.4%	33.5%	34.1%	35.5%	37.7%
	P03b	Friends and Family Test ED Coverage	16%	16.8%	17.3%	17.4%	17%	16.9%	14.6%	13.6%	16%	15.2%	11.6%	13.8%	18.1%	18.7%	17.2%	15.1%	14.2%	16.8%
	P03c	Friends and Family Test MAT Coverage	18.3%	27.7%	14%	9.8%	23.1%	31.4%	19.2%	14.1%	20.2%	23%	20.6%	28.5%	30.4%	24.1%	15.6%	21.6%	21.2%	27.7%
Friends and Family Test Score	P04a	Friends and Family Test Score - Inpatients	98.2%	98.4%	98.8%	98.6%	98.1%	98.4%	98.6%	98.5%	98.7%	98.4%	98.4%	98.4%	98.3%	98.3%	98.5%	98.5%	98.5%	98.4%
	P04b	Friends and Family Test Score - ED	82.1%	82%	81.4%	84.1%	83.4%	85.2%	84%	82.6%	81.1%	80.4%	75.4%	76.7%	83.8%	84.2%	82.9%	84.1%	79.2%	82%
	P04c	Friends and Family Test Score - Maternity	97.3%	97.4%	96.8%	99.3%	95.9%	97.2%	97.3%	99%	98.5%	98.7%	97.5%	96.7%	97.7%	97.6%	96.9%	97.6%	98.3%	97.4%
Patient Complaints	T01	Number of Patient Complaints	1845	511	148	143	152	169	193	101	167	155	171	184	161	166	443	463	493	511
	T03a	Formal Complaints Responded To Within Trust Timeframe	86.1%	95.5%	85.2%	86.8%	86.3%	85.1%	86.9%	90.9%	87.5%	78.3%	90.6%	93.2%	97.2%	95.9%	86.1%	87.1%	85.2%	95.5%
	T03b	Formal Complaints Responded To Within Divisional Timeframe	85.5%	96.6%	85.2%	86.8%	82.2%	90.5%	84.8%	88.6%	87.5%	85%	92.5%	93.2%	98.6%	98%	84.4%	87.6%	88.2%	96.6%
	T05A	Informal Complaints Responded To Within Trust Timeframe	83.7%	89%	87.5%	83.3%	86.8%	73.6%	84.2%	81.5%	80%	89.9%	81.7%	90.6%	86.9%	89.8%	85.9%	80.1%	84%	89%
	T04c	Percentage of Responses where Complainant is Dissatisfied	9.11%	11.86%	9.26%	7.55%	9.59%	6.76%	10.1%	4.54%	8.93%	5%	15.09%	11.86%	-	-	8.89%	7.83%	9.47%	11.86%

RESPONSIVE

Topic	ID	Title	Annual		Monthly Totals												Quarterly Totals			
			18/19	19/20 YTD	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	18/19 Q2	18/19 Q3	18/19 Q4	19/20 Q1
Referral to Treatment (RTT) Performance	A03	Referral To Treatment Ongoing Pathways Under 18 Weeks	-	-	88.9%	88.7%	88.5%	89.6%	90.1%	89.3%	89.4%	89.1%	89.2%	89%	88.1%	87.5%	-	-	-	-
	A03a	Referral To Treatment Number of Ongoing Pathways Over 18 Weeks	-	-	3208	3290	3354	3000	2810	2975	2915	3100	3081	3161	3578	3874	-	-	-	-
Referral to Treatment (RTT) Wait Times	A06	Referral To Treatment Ongoing Pathways Over 52 Weeks	144	36	11	7	10	9	14	7	16	21	13	14	11	11	28	30	50	36
	A07	Referral To Treatment Ongoing Pathways 40+ Weeks	-	-	126	119	113	113	111	139	147	161	119	115	136	128	-	-	-	-
Cancer (2 Week Wait)	E01a	Cancer - Urgent Referrals Seen In Under 2 Weeks	95.3%	93.7%	96.5%	95.5%	96.4%	95.7%	95.8%	96.6%	95.2%	94.9%	94.4%	93.4%	94%	-	96.1%	96%	94.8%	93.7%
	E01c	Cancer - Urgent Referrals Stretch Target	56.5%	44.7%	60.6%	66.4%	68.8%	57%	62.8%	54.2%	63.7%	46.5%	49%	43.8%	45.6%	-	65.2%	58%	52.7%	44.7%
Cancer (31 Day)	E02a	Cancer - 31 Day Diagnosis To Treatment (First Treatments)	97.2%	94.8%	97.4%	99.2%	99.1%	98.8%	98.5%	98.6%	97%	96.5%	98.3%	95.4%	94.1%	-	98.5%	98.6%	97.2%	94.8%
	E02b	Cancer - 31 Day Diagnosis To Treatment (Subsequent - Drug)	98.4%	98.2%	96.1%	100%	99.1%	99.4%	97.2%	99%	99.2%	99.1%	100%	98.4%	97.9%	-	98.4%	98.6%	99.5%	98.2%
	E02c	Cancer - 31 Day Diagnosis To Treatment (Subsequent - Surgery)	96.1%	93.5%	98.2%	96.2%	98.1%	100%	98.3%	96.2%	95%	96.3%	97.6%	95.9%	90.9%	-	97.5%	98.2%	96.2%	93.5%
	E02d	Cancer - 31 Day Diagnosis To Treatment (Subsequent - Radiotherapy)	95.8%	93.1%	97.1%	97.4%	95.6%	97.6%	98.1%	98.2%	95.7%	98%	94.1%	96.4%	89.6%	-	96.8%	97.9%	96%	93.1%
Cancer (62 Day)	E03a	Cancer 62 Day Referral To Treatment (Urgent GP Referral)	85.6%	86.5%	85.7%	88.9%	87.4%	85.5%	87.9%	86.5%	85.1%	83.5%	82.9%	86.8%	86%	-	87.3%	86.6%	83.8%	86.5%
	E03b	Cancer 62 Day Referral To Treatment (Screenings)	66.7%	81.8%	100%	60%	100%	100%	100%	90%	35.7%	75%	66.7%	71.4%	100%	-	83.3%	96%	47.6%	81.8%
	E03c	Cancer 62 Day Referral To Treatment (Upgrades)	83.7%	92.5%	77.7%	84.7%	86.8%	85.6%	91.3%	88.5%	86.8%	74.7%	91.8%	95%	89.6%	-	82.6%	88.4%	84.6%	92.5%
	E03f	Cancer Urgent GP Referrals - Numbers Treated after Day 103	54	7	2	5.5	4	7.5	3.5	4	4	3	7	3.5	3.5	-	11.5	15	14	7
Cancelled Operations	F01	Last Minute Cancelled Operations - Percentage of Admissions	1.31%	1.67%	1.15%	0.79%	1.39%	0.97%	1.94%	1%	1.31%	1.68%	1.66%	1.63%	1.53%	1.84%	1.1%	1.31%	1.54%	1.67%
	F01a	Number of Last Minute Cancelled Operations	1059	325	79	54	89	71	138	61	94	109	115	108	100	117	222	270	318	325
	F02	Cancelled Operations Re-admitted Within 28 Days	93.4%	87.3%	97.4%	94.9%	94.4%	91%	94.4%	93.5%	93.4%	93.6%	96.3%	85.2%	85.2%	92%	95.3%	93%	94.7%	87.3%
Admissions Cancelled Day Before	F07	Percentage of Admissions Cancelled Day Before	1.67%	1.89%	0.41%	1.53%	2.05%	1.82%	1.91%	1.37%	1.75%	2.17%	0.85%	1.65%	2.39%	1.62%	1.31%	1.72%	1.58%	1.89%
	F07a	Number of Admissions Cancelled Day Before	1348	368	28	105	131	134	136	83	126	141	59	109	156	103	264	353	326	368
Primary PCI	H02	Primary PCI - 150 Minutes Call to Balloon Time	73.2%	72.3%	70.6%	79.3%	72%	69%	71.1%	62.5%	71.4%	76.7%	65.2%	83.9%	61.8%	-	73.9%	67.5%	70.3%	72.3%
	H03a	Primary PCI - 90 Minutes Door to Balloon Time	91.9%	92.3%	91.2%	93.1%	96%	92.9%	89.5%	90%	88.6%	93.3%	87%	96.8%	88.2%	-	93.2%	90.8%	89.2%	92.3%
Diagnostic Waits	A05	Diagnostics 6 Week Wait (15 Key Tests)	-	-	97.88%	97.13%	98.13%	98.36%	96.94%	93.81%	93.28%	96.93%	95.5%	95.27%	93.41%	93.54%	-	-	-	-
Outpatients	R03	Outpatient Hospital Cancellation Rate	10.1%	10.6%	9.6%	10%	10.1%	9.9%	9.8%	10.4%	10.2%	11.6%	11.2%	11.3%	10.4%	10.1%	9.9%	10%	11%	10.6%
	R05	Outpatient DNA Rate	6.8%	6.9%	7.1%	6.8%	7%	6.7%	6.5%	6.9%	6.8%	6.7%	6.6%	6.7%	7.1%	6.8%	7%	6.7%	6.7%	6.9%
Outpatient Ratio	R01	Follow-Up To New Ratio	2.12	2.13	2.1	2.11	2.13	2.14	2.17	2.14	2.2	2.25	2.13	2.09	2.1	2.21	2.11	2.15	2.19	2.13
ERS	BC01	ERS - Available Slot Issues Percentage	16.5%	15.5%	22.9%	22.1%	15.5%	10.9%	13.8%	13.5%	12.5%	16.8%	17.3%	13.9%	16.9%	15.8%	19.9%	12.6%	15.5%	15.5%

Topic	ID	Title	Annual 18/19	Annual 19/20 YTD	Monthly Totals Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Quarterly Totals 18/19 Q2	18/19 Q3	18/19 Q4	19/20 Q1
Delayed Discharges	Q01A	Acute Delayed Transfers of Care - Patients	216	72	17	11	16	18	10	26	20	13	20	22	23	27	44	54	53	72
	Q02A	Non-Acute Delayed Transfers of Care - Patients	80	31	4	9	8	5	4	11	4	10	4	8	11	12	21	20	18	31
	Q01B	Acute Delayed Transfers of Care - Beddays	6744	1841	503	586	513	691	482	568	653	550	519	609	607	625	1602	1741	1722	1841
	Q02B	Non-Acute Delayed Transfers of Care - Beddays	2590	768	204	225	321	250	191	243	138	161	198	223	302	243	750	684	497	768
Green To Go List	AQ06A	Green To Go List - Number of Patients (Acute)	-	-	54	42	55	39	47	51	48	65	62	53	56	61	-	-	-	-
	AQ06B	Green To Go List - Number of Patients (Non Acute)	-	-	17	19	24	21	14	26	7	30	19	26	25	27	-	-	-	-
	AQ07A	Green To Go List - Beddays (Acute)	-	-	1571	1621	1562	1608	1620	1693	1814	1894	1962	1882	2435	1916	-	-	-	-
	AQ07B	Green To Go List - Beddays (Non-Acute)	-	-	618	570	753	681	580	616	463	631	819	759	842	830	-	-	-	-
Length of Stay	J03	Average Length of Stay (Spell)	3.79	3.8	3.8	3.92	3.52	3.87	3.62	3.76	3.83	3.74	3.78	4.05	3.73	3.61	3.75	3.75	3.79	3.8
	J04D	Percentage Length of Stay 14+ Days	6.3%	6.6%	6.5%	6.5%	5.8%	6.9%	6%	6%	6.6%	6.4%	6.4%	7.2%	6.5%	6%	6.2%	6.3%	6.5%	6.6%
14 Day LOS Patients	C07	Number of 14+ Day Length of Stay Patients at Month End	-	-	234	211	233	224	212	200	221	234	222	247	256	262	-	-	-	-
AMU	J35	Percentage of Cardiac AMU Wardstays	3.6%	4.7%	1.3%	0.5%	0%	3.4%	4.1%	3.7%	4%	6.3%	5.6%	3.6%	3.7%	6.9%	0.6%	3.8%	5.2%	4.7%
	J35A	Percentage of Cardiac AMU Wardstays Under 24 Hours	36.1%	25.2%	25%	25%	-	23.3%	45.9%	52.9%	55.6%	24.5%	24%	39.3%	18.8%	21.6%	25%	41.6%	32.6%	25.2%

Emergency Department Indicators

ED - Time in Department	B01	ED Total Time in Department - Under 4 Hours	86.34%	79.2%	90.26%	90.07%	85%	89.16%	84.24%	83.05%	84.5%	81.05%	81.23%	78.25%	77.95%	81.48%	88.44%	85.53%	82.27%	79.2%
		This is measured against the national standard of 95%																		
ED - Time in Department (Differentials)	BB14	ED Total Time in Department - Under 4 Hours (STP)	86.34%	79.2%	90.26%	90.07%	85%	89.16%	84.24%	83.05%	84.5%	81.05%	81.23%	78.25%	77.95%	81.48%	88.44%	85.53%	82.27%	79.2%
	BB07	BRI ED - Percentage Within 4 Hours	78.39%	65.38%	84.8%	83.37%	75.44%	81.79%	78.89%	73.49%	74.67%	69.23%	70.33%	63.57%	63.86%	68.78%	81.27%	78.07%	71.46%	65.38%
	BB03	BCH ED - Percentage Within 4 Hours	93.05%	91.96%	96.39%	97.9%	94.16%	95.05%	85.39%	91.02%	92.92%	90.46%	89.39%	91.96%	90.38%	93.61%	96.02%	90.38%	90.9%	91.96%
	BB04	BEH ED - Percentage Within 4 Hours	97.38%	97.32%	96.19%	98.75%	97.46%	98.67%	97.34%	97.12%	97.7%	98.02%	97.07%	96.1%	98.39%	97.55%	97.49%	97.76%	97.58%	97.32%
		This is measured against the trajectories created to deliver the Sustainability and Transformation Fund targets																		
Trolley Waits	B06	ED 12 Hour Trolley Waits	1	0	0	0	0	1	0	0	0	0	0	0	0	0	0	1	0	0
Time to Initial Assessment	B02	ED Time to Initial Assessment - Under 15 Minutes	95.6%	97.4%	94.8%	95.3%	96.2%	95.4%	93.4%	92.1%	97.7%	97.9%	96.5%	96.8%	97%	98.3%	95.4%	93.6%	97.3%	97.4%
	B02b	ED Time to Initial Assessment - Data Completness	97.2%	98%	97.2%	96.1%	97.3%	97.2%	97.6%	95.2%	96.5%	97.4%	99%	97.6%	98.4%	98%	96.9%	96.6%	97.6%	98%
Time to Start of Treatment	B03	ED Time to Start of Treatment - Under 60 Minutes	49.3%	47.9%	50.8%	55.6%	48%	53.1%	44.8%	46.9%	48.9%	45.2%	43.9%	46.1%	47.6%	49.9%	51.4%	48.3%	46%	47.9%
	B03b	ED Time to Start of Treatment - Data Completeness	96.9%	96.2%	96.8%	97.1%	96.6%	97.1%	97%	97%	97.5%	96.7%	96.4%	96.6%	96%	96.1%	96.8%	97.1%	96.9%	96.2%
Others	B04	ED Unplanned Re-attendance Rate	3.3%	3.3%	2.9%	2.7%	3.2%	3.9%	4.4%	3.8%	3.2%	3.3%	3.6%	3.5%	3.2%	3.1%	2.9%	4%	3.3%	3.3%
	B05	ED Left Without Being Seen Rate	1.7%	1.7%	1.9%	1.6%	2.2%	2.1%	1.8%	1.6%	1.3%	1.6%	2.1%	1.6%	1.8%	1.6%	1.9%	1.8%	1.7%	1.7%
Ambulance Handovers	BA09	Ambulance Handovers - Over 30 Minutes	698	238	45	58	71	74	65	59	42	57	50	96	87	55	174	198	149	238
Acute Medical Unit (AMU)	J35	Percentage of Cardiac AMU Wardstays	3.6%	4.7%	1.3%	0.5%	0%	3.4%	4.1%	3.7%	4%	6.3%	5.6%	3.6%	3.7%	6.9%	0.6%	3.8%	5.2%	4.7%
	J35a	Percentage of Cardiac AMU Wardstays Under 24 Hours	36.1%	25.2%	25%	25%	-	23.3%	45.9%	52.9%	55.6%	24.5%	24%	39.3%	18.8%	21.6%	25%	41.6%	32.6%	25.2%

FINANCIAL MEASURES

Topic	Title	Monthly Totals											
		Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20
Year To Date Annual Plan Surplus / (Deficit) £'000	Annual Plan excluding PSF	(416)	302	(389)	2,740	3,171	3,633	6,086	5,489	4,521	4,521	2,622	2,593
	Actual excluding PSF	(416)	(410)	(378)	0	0	0	0	0	0	0	0	0
	Annual Plan including PSF	117	1,368	1,209	5,030	6,153	7,308	10,773	11,118	10,793	12,402	11,674	12,815
	Actual Plan including PSF	117	656	1,220	0	0	0	0	0	0	0	0	0
Year to Date Variance Divisional Position Favourable / (Adverse) £'000	Diagnostics & Therapies	(4)	(39)	(56)									
	Medicine	(167)	(320)	(502)									
	Specialised Services	(54)	13	201									
	Surgery	(175)	(659)	(1,168)									
	Women's & Children's	(215)	(311)	(407)									
	Estates & facilities	(5)	(9)	(13)									
	Trust Services	4	3	(33)									
	Other Corporate Services	42	29	(85)									
	Total	**(574)**	**(1,293)**	**(2,063)**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Year To Date Savings Actuals £'000	Diagnostics & Therapies		299	438									
	Medicine		231	324									
	Specialised Services		381	555									
	Surgery		572	788									
	Women's & Children's		660	941									
	Estates & facilities		120	183									
	Trust Services		134	202									
	Other Corporate Services		195	292									
	Total	**0**	**2,591**	**3,723**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
In Month Variance Subjective Analysis Favourable / (Adverse) £'000	Nursing & Midwifery Pay	(604)	(491)	(484)									
	Medical & Dental Pay	(360)	(187)	(445)									
	Other Pay	243	197	109									
	Non Pay	954	189	356									
	Income from Operations	(173)	(94)	(2)									
	Income from Activities	(632)	(336)	(301)									
	Total	**(572)**	**(722)**	**(767)**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
In Month Agency Expenditure Actuals £'000	Nursing & Midwifery	684	660	648									
	Medical												
	Consultants	72	82	92									
	Other Medical	56	20	85									
	Other	140	144	131									
	Total	**952**	**906**	**956**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Cash £'000	Actual Cash	**110,000**	**109,402**	**100,954**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Capital Spend £'000	Actual Capital Expenditure	**916**	**2,300**	**4,704**									

A4 APPENDIX 4 – Clinical Correspondence 7 Day Turnaround Compliance

Divisional Compliance	Jan	Feb	Mar	Apr Q1	May Q1
Division of Medicine	70%	61%	55%	61%	70%
Specialised Services	80%	60%	61%	71%	86%
Division of Surgery	68%	68%	75%	79%	74%
Women's & Children's	76%	76%	70%	66%	64%
Diagnostics & Therapies	96%	96%	90%	72%	91%
Trust	**72%**	**65%**	**66%**	**70%**	**73%**

Division of Medicine Medical Secretaries have now recovered the typing backlogs and the turnaround figure has increased from 61% in April to 70% for May. This improvement trend should continue in June if all the work that has been done comes to fruition. Management are actively working with clinicians to ensure approvals are cleared within 48 hours of receipt of letter from secretary.

Division of Surgery have slipped back slightly to 74% in May from 79% in April. Clinician outstanding approvals remain the challenge.

Specialised Services have managed to increase their compliance from 71% in April to 86% in May. This is a stunning result mainly brought about by the move to producing letters using Medway Clinical Noting in Oncology and Haematology.

Women's & Children's have still not formally started their improvement programme - Worryingly, their percentage compliance has fallen from 76% in January to 64% in May. On a positive note, there should be a major opportunity to reduce the medical secretary workload in Children's Services through the introduction this month of the Synertec letter service, this means they will no longer need to put the majority of their patient letters in envelopes.

Diagnostics & Therapies are back on track at 91% compliance up from 72% in April.

Meeting of the Quality and Outcomes Committee on 25 July 2019 in the Conference Room, Trust Headquarters

Reporting Committee	**Quality and Outcomes Committee**
Chaired By	**Julian Dennis, Non-Executive Director**
Executive Lead	**Mark Smith, Chief Operating Officer and Deputy Chief Executive** **Carolyn Mills, Chief Nurse** **William Oldfield, Medical Director**

For Information

The Committee received an update on performance against key measures in June 2019, including benchmarking against other providers in the South West region, which showed that the Trust's performance remained steady - it was noted there was a regional deterioration in cancer target performance. It was flagged that the Trust is now mobilising the frailty plan and the 'silver trauma' plan, which would both particularly support orthopaedic performance.

The Trust had been chosen to participate in the Elective Care Standard Trial for Referral To Treat (RTT). This would mean a move away from the 92% target to an average waiting time assessment, and the Trust would need to report on performance in 4 months.

The Committee received an update on the Urgent Care Action plan for the Bristol Royal Infirmary (BRI) Emergency Department from Lucy Parsons and Kathryn Bateman from the Division of Medicine: this related to continued deterioration of performance in ED: challenges had included getting the right number and breadth of staff, and managing the discharge of patients requiring a care package following treatment. A strategic vision had therefore been created to set the direction for investment for recovery over a three year period. A robust internal recovery plan was in place, which would deliver in parallel with a system-wide action plan aligned to Trust Strategic Plan. It was noted that resolving estates issues would be absolutely critical to improvement planning. The Committee were supportive of the Action Plan, and noted the impact on the challenges of the ED to staff morale, as well as that some issues, such as managing admission avoidance, would require engagement with stakeholders outside the Trust.

The Committee received the Clinical Negligence Scheme for Trusts (CNST) Compliance Report setting out the Trust's performance against the 10 standards. It was noted this had been through the Divisional Governance Group and the Clinical Quality Group, and would come through the Board for final sign off.

The Committee received the Quality Impact Assessment Report for Q1. The Chief Nurse noted that quality impact assessments for External Revenue Proposals (ERPs) had been shared with the Clinical Commissioning Group. A formal response has been received from the Commissioners, however they had not accepted the risks identified and further discussions were ongoing to agree a joint position.

For Board Awareness, Action or Response

The Committee agreed that the estates issues affecting the performance in the BRI Emergency Department were of significant concern, and should be considered as a

matter of priority in the review of the Estates Strategy.

The Committee received the Clinical Negligence Scheme for Trusts (CNST) Compliance Report, which was coming to the July meeting of the Board for formal sign off.

It was noted that the Infection Control Report would be circulated to the Committee for information, and was also coming to the July meeting of the Public Board.

Key Decisions and Actions

The Committee received the following reports for assurance:

- Safeguarding Adult and Children Annual Report for April 2018-2019
- Learning from Deaths Annual Report
- Quarterly Inquest Report Q1
- Q1 Corporate Quality and Patient Safety Risks Reports

Additional Chair Comments

[Any additional comments from yourself as Chair]

Date of next meeting:	**30 August 2019**

Meeting of the People Committee on 25 July 2019 in the Conference Room

Reporting Committee	**People Committee**
Chaired By	**Bernard Galton, Non-Executive Director**
Executive Lead	**Matt Joint, Director of People**

For Information

The Committee received the latest update on workforce and education performance.

Workforce: There had been a small increase month on month in rates of turnover, vacancies and sickness levels, however agency usage had been reduced. It was noted that the Trust had seen an increase in feedback on reasons for leaving given by departing staff, helping to give a clearer understanding of the reasons staff had for leaving the Trust. The team would consider the possibility of aligning this information with the staff survey results, to see whether there wer common themes. It was noted that the 'delegation' mechanism now introduced into the online appraisal system (allowing line managers to delegate their appraisal responsibilities to others in their teams) had had very positive feedback, particularly from managers with large numbers of appraisees. It was also noted that two new item had been added into the report: namely the number of days lost through RIDDOR, and the cost, loss of days, and barriers to resolution for Suspensions– this would enable greater oversight of these issues.

Education: it was noted that a clear governance structure now been set up to ensure strong oversight of compliance, and a full business case for the structure of the education work package would be going to the Senior Leadership Team (SLT) in the autumn. Recent successes in education included the Trust receiving a national award for its trainee programme in partnership with Weston College, as well as being named an HEE National Lead Employer, in partnership with the Training Hub, to be part of the national pilot on behalf of the Clinical Commissioning Group for Placed-Based Commissioning. There was still a big piece of work on streamlining our central training for the Trust to undertake The Committee noted the existing challenges pertaining to apprenticeship provision, and that the corporate risk has now been further escalated. This was largely down to existing pressures making it difficult for staff to give time to 'off the job' training in clinical areas.

The Committee received an update on the Estates and Facilities Organisational Development and Retention Plan. It was noted that the vacancy rate had reduced from 11.9% in November 2018 to 8.1% in June 2019, and bank usage and sickness rates were also down. Among a range of organisational development initiatives, there were currently 25 live apprenticeships across the division (particularly important given the ageing demographic of staff there). Health and wellbeing was noted as a significant issue, and a 'deep dive' was being undertaken to help understand the reasons for this.

The Organisational Development quarterly report was received for information and assurance, and the Diversity and Inclusion activity highlights for quarter one were discussed, and the update report accepted.

For Board Awareness, Action or Response

The Committee received the Arts and Culture Strategy for recommendation to the Board for approval. The Committee were supportive of the strategy, noting that this was a cross cutting strand across a number of other enabling strategies (including Estates, People etc.) but also observed that it was clearly at a high level as the work stream was relatively new, and in

time a more explicit business plan would be needed to clearly set out how the strategic ambitions proposed would be achieved in practice.

The Committee received the People Strategy, and agreed to recommend it for approval to the Board, subject to revisions to the introductory/contextual information in the Strategy (a) making clear the way in which the People Strategy sat within the wider NHS environment, (b) reflecting the current partnership with WAHT and (c) ensuring the Trust's strong appetite for achieving the strategy was sufficiently articulated.

Key Decisions and Actions

The HR team to review current workforce and education reporting to the People Committee meetings to ensure the right information was being shared with the Committee and the purpose of the reporting was clear and effective.

The Committee to receive an update on apprenticeships planning and progress later in the year (around October 2019).

The Committee reviewed the letter on 'Learning lessons to improve our people Practices' from NHS Improvement for information.

Additional Chair Comments

[Any additional commentary from you as Chair not covered by the above: e.g. particular themes of discussion, etc.]

Date of next meeting:	**26 September 2019**

Meeting of the Audit Committee on 25 July 2019 in the Conference Room, Trust Headquarters

Reporting Committee	**Audit Committee**
Chaired By	**David Armstrong, Non-Executive Director**
Executive Lead	**Robert Woolley, Chief Executive**

For Information

The Chairman opened the meeting with a short review of the day's agenda and expressed a desire to focus on:

1. Estates and Facilities Report
2. The numerous Internal Audit Reports

A number of items were carried forward to the October meeting due to the absence of the Trust Secretary whilst other standing items on the agenda required little detailed attention on this occasion.

The Committee commented on the excellence of the Strategic and Operational Risk Reporting processes and the rigorous approach we have to Risk Mitigation.

As part of the overall Estates Report, the Committee received an update on the Fire Safety Project, as well as the Serious Incident Report Actions (in follow up to the May 2018 BHOC fire). The report highlighted progress against the two-year improvement programme, which had identified three key areas requiring further work: electrical fixed wire testing, emergency lighting improvements, and fire door assessments.

The presentations of the Single Tender Actions Report and the Counter Fraud Report both resulted in some discussion and a request for additional insights at the next meeting.

The key discussions points of the meeting were:

1. Seeking possible opportunities to establish the value to the Trust (in terms of risks mitigated and efficiencies secured) of each Internal Audit after completion of all actions.

2. Further development of the metrics used in the Estates and Facilities Report and the development of the 2 year improvement plan to include interim milestones.

3. Development and release of a short report consolidating the work that had been undertaken to address the 31 recommendations of the SI Report relating to the Fire.

4. Improving insights with regard to conflicts of interest that might arise as a consequence of gifts and hospitality received.

5. Discussing how the recently released Enabling Strategies to the Strategic Plan (People, Education, Facilities etc.) required an understanding of funding and resourcing requirements before the Trust could establish success criteria for the forthcoming year, and how the activities contained therein supported

the delivery of the Operational and Strategic Plans and so also the Risk mitigation activities.

For Board Awareness, Action or Response

The Committee recommended the Risk Management Strategy to the Board for **approval**, subject to some additional wording being included in the section on "Responsibilities", so that the role of each Trust Committee was explicitly stated. This update has been included in the version of the strategy shared with the Board for approval.

Key Decisions and Actions

Chairs of the Board Committees to update the Audit Committee to confirm their committees were receiving assurance that the specific funding and risk implications of the Enabling Strategies were clearly articulated and understood.

Director of Finance and Information to bring an update on the Single Tender Actions to the next meeting of the Committee, including information on the current volume of Single Tender Actions and procurement resource.

Audit Committee to receive the full Trust Register of Interests, Gifts and Hospitality for assurance on an annual basis (aligned with reporting to the Senior Leadership Team) – item to be added to the 2019/2020 Annual Business Cycle.

Additional Chair Comments

Date of next meeting:	**28 October 2019**

Meeting of the Board of Directors in Public on Tuesday 30 July 2019 in the Conference Room, Trust Headquarters

Report Title	**Emergency Preparedness Annual Report**
Report Author	**Simon Steele, Resilience Manager**
Executive Lead	**Mark Smith, Deputy Chief Executive and Chief Operating Officer**

1. Report Summary

This report highlights the Trust's position in relation to Emergency Preparedness, Resilience and Response (EPRR) over the past 12 months.

The Trust remains substantially compliant with the NHS England Core Standards for EPRR. Particularly priorities include ensuring the Trust is prepared for a no-deal EU Exit, implementing all lessons identified from the BHOC Evacuation and Major Incident declaration, as well as ensuring all required plans are up to date and staff are trained and ready to implement.

The report lists a summary of key risks as well as training and exercising undertaken over the time period. Priorities for this coming year include maintaining substantial compliance with the NHS England Core Standards as well as undertaking a Trust wide major incident.

2. Key points to note

(Including decisions taken)

2018/19 has been a year where the focus on identifying and putting in places lessons from incidents and exercises which have occurred in the Trust. This includes the response to the BHOC evacuation, severe weather events and a number of emergency exercises.

Priorities for the upcoming year are:

- Maintain substantial compliance in the 2019 EPRR assurance process
- Undertaking Trust wide major incident as last held in April 2017
- Continuing to deliver training and exercises to identified staff and services to support Trust plans.

3. Risks

Risk No.	Category	Description	Current Risk
199	Mass Gatherings	There are a number of large public events which attract a large crowd. An incident at one of these events could result in a major incident declaration impacting on the trusts ability to operate normally.	4
210	Snow and Ice	This is a seasonal risk which could result in an increased number of potential slips and falls or impact on ability of staff and patients to travel to site.	6

800	Pandemic Influenza Outbreak	This is one of the highest risks the UK currently faces. Pandemic Influenza could put the health system under severe pressure due to a number of reasons. Impacts on the trust workforce and its ability to effectively manage an influx of patients with influenza type illness, the ability of the trust to manage an increase in pandemic influenza related deaths.	**4**
802	Heatwave	Demand on Trust services could increase significantly due to heat related illness especially in the elderly. Internal hospital building temperatures could impact on patient wellbeing and staff working environment.	**6**
1909	Incident response whilst in extreme escalation	If during periods of extreme escalation a major incident or business continuity incident were to occur there is the risk of the response being hampered due to pressures faced by the Trust.	**6**
2031	Risk of self-presenting contaminated patients to ED	There is a risk of contamination to patients, staff and the physical environment if the contaminated patient is not identified promptly, isolated and decontaminated by trained staff.	**3**
2453	Lack of a coordinated clinical networks response to a major incident	Whilst the Trust, and other neighbouring trusts, have major incident plans the equivalent plans for the trauma, critical care and burns network are not up to date. If a large scale incident were to happen there is the risk of a lack of coordination across these networks if capacity was stretched beyond individual trusts ability to respond.	**6**
2973 (New Risk)	No Deal EU Exit	Risk a no deal EU Exit would have an adverse impact on services including workforce and supply chain delays.	**9**

4. Advice and Recommendations

- This report is for **ASSURANCE**.
- The Committee is asked to **NOTE** the report.

5. History of the paper
Please include details of where paper has previously been received.

Senior Leadership Team	19th June 2019

Title:	Emergency Preparedness Resilience And Response (EPRR) Annual Report
Owner:	Chief Operating Officer & Accountable Emergency Officer
Version:	V1

Emergency Preparedness, Resilience and Response

Annual Report 2018 – 2019

Prepared by: **Simon Steele,** Resilience Manager

Presented by: **Mark Smith,** Chief Operating Officer and Accountable Emergency Officer

Executive Summary

The NHS needs to be able to plan for and respond to a wide range of emergencies and business continuity incidents that could affect the safe and effective operation of the Trust's services. These could be anything from severe weather to an infectious disease outbreak or a major transport accident.

Under the Civil Contingencies Act (2004), NHS organisations must show that they can effectively respond to emergencies and business continuity incidents while maintaining critical services to patients. This work is referred to in the health service as Emergency Preparedness, Resilience and Response (EPRR).

The Civil Contingencies Act 2004 (CCA) places a number of statutory duties on NHS organisations which are classed as either Category 1 or Category 2 responders.

Category 1 responders are those organisations at the core of an emergency response. As a Category 1 responder, University Hospitals Bristol NHS Foundation Trust (the Trust) is required to prepare for emergencies in line with its responsibilities under;

- The Civil Contingencies Act 2004,
- The Health and Social Care Act, 2012, and
- NHS England Core Standards for Emergency Preparedness Resilience and Response 2016.

The NHS England Core Standards for Emergency Preparedness, Resilience and Response (EPRR) are the minimum standards which NHS organisations and providers of NHS funded care must meet.

The Trust is positioned centrally in what is known as a 'Core' city. This position places an even greater emphasis on there being robust up to date emergency plans in place. This report outlines the position of the Trust in relation to Emergency Preparedness, Resilience and Response and how the trust will meet the duties set out in legislation and associated guidance, as well as any other issues identified by way of risk assessments and identified capabilities. The report also includes information relating to the Trust's position in the NHS England annual EPRR assurance audit led by NHS England.

Title:	Emergency Preparedness Resilience And Response (EPRR) Annual Report
Owner:	Chief Operating Officer & Accountable Emergency Officer
Version:	V1

Acronym's and Definitions

Acronym	Definition
AEO	Accountable Emergency Officer – at UH Bristol this is the Chief Operating Officer & Deputy Chief Executive
BCWG	Business Continuity Working Group *(Internal Group)*
CBRN	Chemical, Biological, Radiological and Nuclear
CCSG	Civil Contingencies Steering Group *(Internal Group)*
EPRR	Emergency Preparedness, Resilience and Response
IRPG	Incident Response Planning Group *(Internal Group)*
ISO 22301	International Standardisation Organisation *(the International Standard for Business Continuity Management)*
LHRP	Local Health Resilience Partnership
LRF	Local Resilience Forum
OCMF	On Call Managers Forum *(Internal Group)*
SWASFT	South Western Ambulance Service NHS Foundation Trust

Title:	Emergency Preparedness Resilience And Response (EPRR) Annual Report
Owner:	Chief Operating Officer & Accountable Emergency Officer
Version:	V1

Contents

Title:	Emergency Preparedness Resilience And Response (EPRR) Annual Report
Owner:	Chief Operating Officer & Accountable Emergency Officer
Version:	V1

1. Introduction

1.1 Purpose

This report outlines the Trust's EPRR activities during the period April 2018 to March 2019 that relate to the requirements of the Civil Contingencies Act 2004, its associated regulations, statutory and non-statutory guidance.

The report is presented to the University Hospitals Bristol NHS Foundation Trust Board in line with the requirements of the NHS Core Standards for Emergency Preparedness, Resilience and Response 2018.

1.2 Background

The Civil Contingencies Act 2004 (CCA) sets out a single framework for civil protection in the United Kingdom. The Civil Contingencies Act provides a statutory framework for civil protection at a local level and divides local responders into two categories depending on the extent of their involvement in civil protection work, and places a set of duties on each.

Category 1 responders are those organisations at the core of emergency response. Acute Trusts are identified as Category 1 responders and are subject to the full set of civil protection duties.

The Trust is therefore required to:

- Assess the risk of emergencies occurring and use this to inform contingency planning,
- Put in place emergency plans,
- Put in place business continuity plans,
- Put in place arrangements to make information available to the public about civil protection matters and maintain arrangements to warn, inform and advise the public in the event of an emergency,
- Share information with other local responders to enhance co-ordination,
- Co-operate with other local responders to enhance co-ordination and efficiency.

1.3 Context

Nationally across EPRR in 2018/19 there has been a continued and increased focus on ensuring incident response plans are fit for purpose, particularly for major incidents categorised as mass casualty events. With recent incidents in Manchester and London and the increasing of the threat level to critical twice, this focus gives an added importance to ensuring the Trust meets its statutory obligations and is able to provide high levels of patient care when responding to incidents.

EPRR within the Trust is overseen by the Deputy Chief Executive and Chief Operating Officer who acts as the Emergency Accountable Officer, supported by the Deputy Chief Operating Officer. They chair the Civil Contingencies Steering Group which drives the EPRR agenda. Under this group are two substantive working groups chaired by the Resilience Manager; the Incident Response Planning Group and the Business Continuity Working Group. An Infection Control group can also be enacted as required.

In the 2018 NHS England EPRR Core Standards review the Trust was deemed to be substantially compliant with the standards having been non-compliant in 2015 and partially compliant in 2016. This audit process required the Trust to complete a self-assessment against each of the core standards for EPRR. This self-assessment was subsequently reviewed by NHS England and Bristol Clinical Commissioning Group in discussion with the Trust and a final rating assigned.

2 Risk Assessment

This section details how the Trust is complying with the duty to undertake risk assessments for the purpose of informing contingency planning activities.

2.1 Community Risk Register (CRR)

University Hospitals Bristol NHS Foundation Trust contributes to the development and maintenance of the Avon and Somerset Community Risk Register (CRR) by the Resilience Manager attending the NHS England Avon & Somerset Local Health Resilience Partnership (Tactical Group), where amongst other areas, health related risks to the community are reviewed and updated.

2.2 Trust Risk Register

The Civil Contingencies Steering Group maintains an EPRR Risk Register for risks identified relating to EPRR. Risks assessed as scoring 12 or above are reviewed by the Trust Risk Management Group and Trust Board.

Risk No.	Category	Description	Inherent Risk	Current Risk	Target Risk
199	Mass Gatherings	There are a number of large public events which attract a large crowd. An incident at one of these events could result in a major incident declaration impacting on the trusts ability to operate normally.	4	**4**	4
210	Snow and Ice	This is a seasonal risk which could result in an increased number of potential slips and falls or impact on ability of staff and patients to travel to site.	6	**6**	6
800	Pandemic Influenza Outbreak	This is one of the highest risks the UK currently faces. Pandemic Influenza could put the health system under severe pressure due to a number of reasons. Impacts on the trust workforce and its ability to effectively manage an influx of patients with influenza type illness, the ability of the trust to manage an increase in pandemic influenza related deaths.	4	**4**	4
802	Heatwave	Demand on Trust services could increase significantly due to heat related illness especially in the elderly. Internal hospital building temperatures could impact on patient wellbeing and staff working environment.	9	**6**	6
1909	Incident response whilst in extreme escalation	If during periods of extreme escalation a major incident or business continuity incident were to occur there is the risk of the response being hampered due to pressures faced by the Trust.	12	**6**	6
2031	Risk of self-	There is a risk of contamination to patients, staff and the physical	5	**3**	3

	presenting contaminated patients to ED	environment if the contaminated patient is not identified promptly, isolated and decontaminated by trained staff.			
2453	Lack of a coordinated clinical networks response to a major incident	Whilst the Trust, and other neighbouring trusts, have major incident plans the equivalent plans for the trauma, critical care and burns network are not up to date. If a large scale incident were to happen there is the risk of a lack of coordination across these networks if capacity was stretched beyond individual trusts ability to respond.	9	**6**	4
2973 (New Risk)	No Deal EU Exit	Risk a no deal EU Exit would have an adverse impact on services including workforce and supply chain delays.	12	**9**	6

3 Emergency Planning

This section details the activities undertaken to develop and maintain arrangements for responding to a major incident. The Trust has a number of EPRR related internal planning groups identified in the governance section.

3.1 Incident Response Plan

The Incident Response Plan (formerly major incident plan) has had a wholesale review incorporating a number of lessons identified from internal and regional major incident exercises as well as comprehensive debrief reports from the London and Manchester major incidents. A large part of this review has focused on areas of the trust previously not engaged in planning with roles now included in the plan for the bereavement team, clinical psychologists, psychiatry liaison, the resuscitation team and therapy services among others.

There is now ongoing training and exercising within the Trust to support preparedness to implement the plan if required.

3.2 Chemical, Biological, Radiological and Nuclear (CBRN) Response Plan

The CBRN plan has been updated by the Adult ED CBRN leads supported by the Resilience Manager. Quarterly training days continue ensuring nursing staff in both EDs are trained in the elements of the plan including wearing the PPE suits and procedures for decontaminating patients. The Powered Respiratory Protective Suits (PRPS) which are the required PPE for any caustic substance were replaced in 2018. These new suits are funded centrally and last for a period of 10 years. A live exercise was also completed in October 2018 testing the pathway for ED in real-time if a contaminated patient presented.

The ambulance service has recently completed an annual audit of the Trust's CBRN response, commissioned by NHS England. This found the Trust is compliant with all 51 requirements.

3.3 Evacuation Planning

Following the evacuation of the Bristol Haematology and Oncology Centre in May 2018 the Trust invited NHS England to undertake an independent review into the Trusts response and plans. The recommendations from the report as well as other internal actions identified have been incorporated into the Trust's Evacuation Plans.

3.4 Severe Weather and Heatwave Plans

Both the Severe Weather and Heatwave Plans were enacted in 2018-19. Both plans are reviewed annually and learning from incidents is being used to further develop plans.

3.5 Lockdown plans

After a successful capital bid the Trust is currently upgrading all the access panels to ensure security are able to remotely lock areas of the hospital if required. ED also have an automated lockdown which can be instigated from reception to control access into and out of the department which is regularly tested.

4 Business and Service Continuity Planning

This section details the Trust's activities to develop, maintain and embed arrangements to ensure the continuity of service provision during an emergency or other disruption.

In previous years the NHS recognised that the British Standard BS25999 was the definitive standard for business continuity management and the Trust aligned all Business Continuity Plans to this standard. This standard has since been updated and has been adopted worldwide. The standard is now known as ISO22301. There are a number of changes with this standard and therefore the NHS England 2018 EPRR assurance identified that Trust Business Continuity Plans did not fully reflect this standard.

Over the course of 2018-19 there has been a large focus on ensuring plans are updated to adhere to this updated standard as well as being fit for operational use in the Trust. In the most recent 2018 assurance NHS England rated the Trusts Business Continuity Plans as being substantially compliant. With the support of divisional leads and the Business Continuity Working Group the ongoing review and updating of the plans is monitored by the Resilience Manager. Incidents and ongoing actions from debriefs are regularly reviewed by the group alongside other business continuity related agenda items.

5 Cooperation

This section details how the Trust engages with regional EPRR groups.

5.1 Local Health Resilience Partnerships (LHRP)

The Local Health Resilience Partnership, chaired by NHS England, brings together all NHS organisations to ensure coordinated and joined up planning across Avon and Somerset.

There is a strategic group which meets quarterly and is attended by the Accountable Emergency Officers (AEO) from all organisations in the Avon and Somerset area. The Chief Operating Officer & Deputy Chief Executive is the UH Bristol Accountable Emergency Officer (AEO) supported by the Deputy Chief Operating Officer. This group defines the strategic direction, the priorities and actively monitors the progress of the Tactical Planning Group.

The Tactical Planning Group also meets quarterly and is attended by the Resilience Manager. It is this group that develops the Avon and Somerset local health community overarching emergency plans and delivers against the Strategic Group work programme.

5.2 Local Health Resilience Partnership Sub-groups

There are a number of LHRP subgroups and task and finish groups; membership of these groups is dependent on the area of focus of the group. For example there is an Acute Provider Sub-group, which focusses on planning and issues which solely affect acute hospitals and the Ambulance Trust. The Resilience Manager attends a number of these groups as required.

5.3 Local Resilience Forum (LRF)

The LRF is a statutory planning group attended by Category 1, 2 and uncategorised responders in Avon and Somerset, as defined by the Civil Contingencies Act 2004. Health is represented by NHS England, who acts in the interests of all providers. This group also informs some of the planning activity undertaken by the LHRP.

6 Warning and Informing

As a Category One responder under the Civil Contingencies Act 2004 the Trust has a "duty, in partnership with others to warn and inform the public".

The Trust Communications Team continue to work in partnership with NHS England and the CCG to inform and warn the public when circumstances warrant it. This includes joint training undertaken at NBT with the national NHS England comms team.

The Communications Team issue messages either directly or in collaboration with the CCG and Public Health England and are part of a local network of NHS Communications teams. In the event of a major incident NHS England would ensure communications are coordinated and link into the Trust communications department.

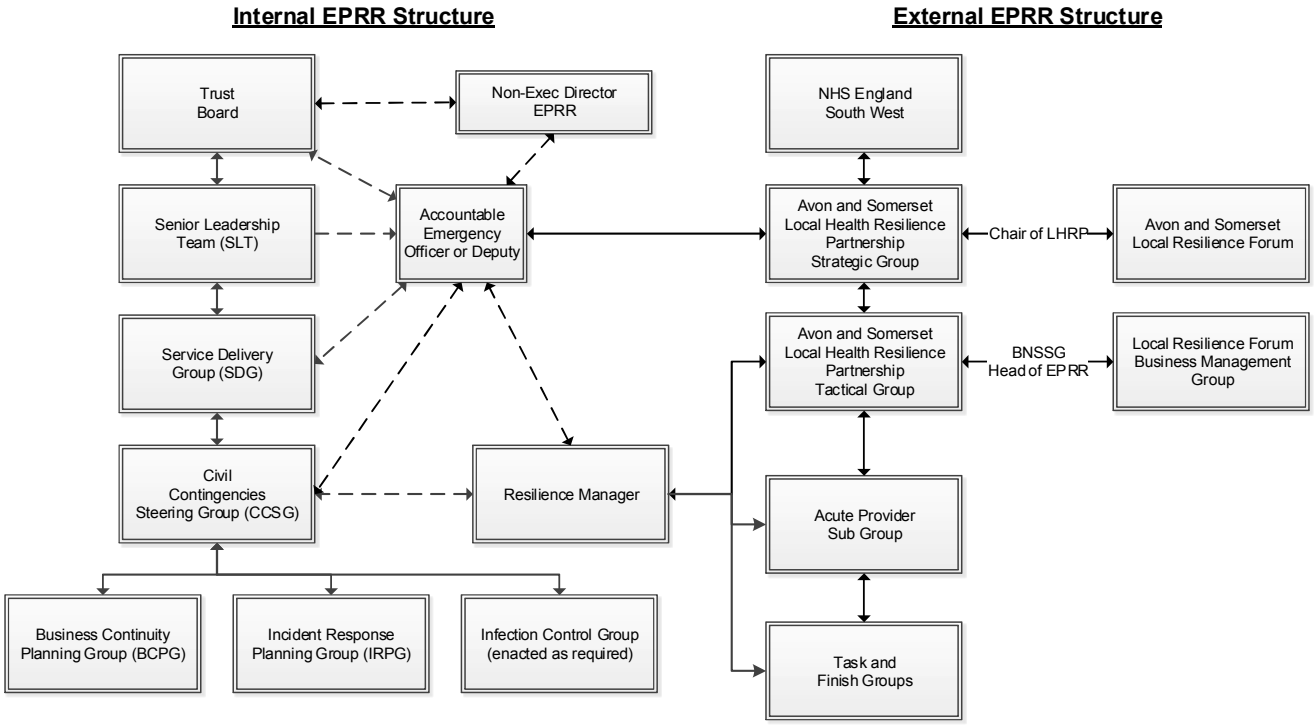
7 Training and Exercising

Below is a summary of EPRR training and exercising which has taken place over the past year:

- The Adult and Children's Major Incident leads supported by the Resilience Manager facilitate regular training for Adult and Children's ED personnel in both Major Incidents and decontamination of members of the public. This training also includes training about safely donning and doffing the Powered Respirator Protective Suit (PRPS) which is a one piece, gas tight, chemical protective suit for use by emergency response personnel after a CBRN incident. A live exercise was also undertaken by Adult and Children's ED to test plans for contaminated patients in a real environment.
- Additional major incident training has been delivered to other key areas in the Trust. This includes adult and children's site teams, theatres, outpatients departments, on call managers and therapy teams.
- A number of clinical staff and the Resilience Manager attended regional workshops and conferences focused on the response to mass casualty incidents and learning lessons from Manchester and London incidents.
- On Call Managers have a monthly forum to review on call matters with alternative forums now being utilised for training in key areas identified internally as well as legislated externally by NHS England.
- All Adult ED reception staff and other ED admin staff have attended major incident training. This looks at their role in a major incident as well as if they suspect self-presenting patients of being contaminated. Major Incident training and an exercise have also been delivered to the ED Registrars.
- Several members of clinical staff attending the Trauma Risk Management course led by March on Stress. Practitioners are trained to perform peer to peer risk assessments for staff involved in traumatic incidents.
- Tabletop exercise exploring the Trust's response to a no deal EU Exit with a particular focus on key supply chain issues in the days following the event.
- Clinical teaching day on blast and ballistic injuries likely to be seen in a major incident with speakers involved in recent Manchester and London Major Incidents and attended by approximately 100 clinical colleagues from the Trust and across the trauma network.

8 Governance

The diagram below represents the internal and external Emergency Planning, Resilience and Response (EPRR) governance structure.



9 Audit and Assurance

The Resilience Manager provides regular updates, assurance and work progress briefings to the Civil Contingencies Steering Group. As mentioned above, NHS England and Bristol CCG conduct an annual EPRR audit and assurance process. This was conducted in October 2018.

10 Recent Major or Significant Events

The Trust has experienced the following untoward events during the April 2018 to March 2019 period. Relevant debriefs have been undertaken with the exception of the learning from the planned heating shutdown which was postponed due to the March snow.

Title	Date	Debrief / RCA Held?
Bristol Haematology and Oncology Fire	10th May 2018	Yes
Extended Heatwave	June 2018	Yes
Heavy overnight snowfall in Bristol	January 30th 2019	Yes

11 Conclusions

2018/19 has been a year where the focus on identifying and putting in places lessons from incidents and exercises which have occurred in the Trust. This includes the response to the BHOC evacuation, severe weather events and a number of emergency exercises.

Priorities for the upcoming year are:

- Maintain substantial compliance in the 2019 EPRR assurance process
- Undertaking Trust wide major incident as last held in April 2017
- Continuing to deliver training and exercises to identified staff and services to support Trust plans

Meeting of the Board of Directors in Public on Tuesday 30 July 2019 in the Conference Room, Trust Headquarters

Report Title	**Clinical Negligence Scheme for Trusts (CNST) Compliance Report**
Report Author	**Sarah Windfeld, Head of Midwifery**
Executive Lead	**Carolyn Mills, Chief Nurse**

1. Report Summary

The report outlines the compliance of the Maternity services within University Hospitals Bristol with the standards to achieve set out by the Clinical Negligence Scheme for Trusts (CNST) which, when implemented, demonstrate a service where safety is a key focus.

These standards also directly align to the Intervention objective in the national five year strategy 'Delivering fair resolution and learning from harm'.

The expectation is that Trusts will be able to demonstrate the required progress against all 10 of the actions in order to qualify for a minimum rebate of their contribution to the incentive fund (calculated at 10% of their maternity premium).

2. Key points to note
(Including decisions taken)

The Board is asked to note that the Maternity service can demonstrate full compliance with the standards and to approve that the Trust can declare full compliance to CNST.

3. Risks
If this risk is on a formal risk register, please provide the risk ID/number.

The risks associated with this report include:
None

4. Advice and Recommendations
*(Support and Board/Committee decisions requested)***:**

- This report is **APPROVAL**.
- The Board is asked to **APPROVE** the report**.**

5. History of the paper
Please include details of where paper has previously been received.

Quality and Outcomes Committee	25 July 2019

Compliance Report July 2019

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

Situation

The Maternity Safety Strategy set out the Department of Health and Social Care's ambition to reward those maternity services who have taken action to improve maternity safety. The Clinical Negligence Scheme Trusts (CNST) has offered an incentive scheme for the second year 2019/20 to encourage maternity services to comply with a set of 10 standards which, when implement, demonstrate a service where safety is a key focus. These standards also directly align to the Intervention objective in our Five year strategy: Delivering fair resolution and learning from harm.

The aim of the scheme is to incentivise the implementation of good practice across all maternity units. The agreed criteria are set below. By meeting the 10 criteria, Trusts are likely to deliver safer maternity services and may 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 which needs to be submitted to NHS Resolution by 15th August 2019 by 12noon.

Criteria for the Maternity Safety Strategy CNST discount
Standard 1. Are you using the National Perinatal Mortality Review Tool to review perinatal deaths? (Y/N)
Standard 2. Are you submitting data to the Maternity Services Data Set (MSDS) to the required standard? (Y/N)
Standard 3. Can you demonstrate that you have transitional care facilities in place and operational to support the implementation of the ATAIN Programme? (Y/N)
Standard 4. Can you demonstrate an effective system of medical workforce planning? (Y/N)
Standard 5. Can you demonstrate an effective system of midwifery workforce planning? (Y/N)
Standard 6. Can you demonstrate compliance with all 4 elements of the Saving Babies' Lives care bundle? (Y/N)
Standard 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? (Y/N)
Standard 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? (Y/N)
Standard 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? (Y/N)
Standard 10. Have you reported 100% of qualifying 2018/19 incidents under NHS Resolution's Early Notification scheme?

The expectation is that Trusts will be able to demonstrate the required progress against all 10 of the actions in order to qualify for a minimum rebate of their contribution to the incentive fund (calculated at 10% of their maternity premium). UHB was able to demonstrate 100% compliance against the standards for CNST in its first year, 2017/2018 and received a £300,000 rebate. Monies from this rebate was allocated to fund a year's secondment of a band 6 midwife to champion the implementation of the perinatal mortality reporting tool and includes additional consultant hours to facilitate this review process. The CNST standard Maternity Contribution for the Trust for 2019/20 is £4,364,000 and the Maternity Incentive contribution is £436,000.

All trusts are expected to provide a report to their Board demonstrating process (with evidence against each of the 10 actions using the template board report for result submission). Completed reports need to be signed off by the Board, discussed with the Commissioners and then submitted to NHS Resolution by noon on 15th August 2019 for review. If the service is unable to demonstrate the required progress against all of the 10 actions, the board report should set out a detailed plan of how the Trust intends to achieve the required progress and over what time period.

The Maternity service has submitted evidence to the Chief Nurse on 11th Jul 2019 for her agreement and sign off that the service has achieved all 10 standards. It should be noted that should any board member wish to review a specific piece of evidence they can request do so.

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

Please note that trusts with multiple sites will need to provide evidence of each individual site's performance against the required standard. (Position at Weston Area Health Trust: On 1st June 2019, the management and lead of obstetric and midwifery services within Western Area Health Trust was taken over by University Hospitals Bristol NHS Foundation Trust. Existing collaborative care of the 1400 women Weston maternity services care for in any given year has been strengthened as a result of this merger. A separate report has been submitted for Weston Area Health Trust Board to sign off).

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?	All stillbirths or neonatal deaths are reported to MBRRACE and reviewed through existing established Perinatal Mortality Meetings at UHBristol. The PMRT is being established as a tool to review these cases for these review meetings. Validation is:- 1. Self-certification to Trust Board NHS Resolution will also use data from MBRRACE to verify the Trust's progress against this action.	**Y**
2). Are you submitting data to the Maternity Services Data Set (MSDS) to the required standard?	UHBristol has an established reporting system for submitting this data. Validation is:- data as submitted to NHS Digital 1. Self-certification to Trust Board NHS Resolution will also use data from NHS Digital to verify the Trust's progress against this action	**Y**
3). Can you demonstrate that you have transitional care facilities that are in place and operational to support the implementation of the ATAIN Programme?	St Michael's Hospital site under UHBristol has a mature established transitional care ward where ATAIN has been fully implemented. Validation is:- Action plan submitted and agreed by the neonatal network 1. Self-certification to Trust Board	**Y**
4). Can you demonstrate an	Assessed through regular review including Deanery input and GMC survey. Full complement	**Y**

effective system of medical workforce planning?	of staff in post in August. Validation is:- 1. Self-certification to Trust Board	
5). Can you demonstrate an effective system of midwifery workforce planning?	New review of maternity staffing using birth-rate plus tool been arranged to ensure service is updated. Validation is:- birth-rate plus report 1. Self-certification to Trust Board	**Y**
6). Can you demonstrate compliance with all 4 elements of the Saving Babies' Lives (SBL) care bundle?	The Trust self-reports quarterly – last submission as per the requirements was April 19. 1) Reduction of smoking in pregnancy – compliant 2) Small for gestational age pathway – compliant. New Local Maternity System (LMS) guideline published and in use 3) Reduced Fetal Movements – compliant 4) Fetal monitoring in labour –compliant quarterly audits undertaken by practice development midwife and presented at working parties and audit meetings *Evidence reviewed: NHS England Quarterly submission* Validation is:- 1. Self-certification to Trust Board NHS Resolution to cross-check Trust's self-reporting to NHS England	**Y**
7). Can you demonstrate that you have a patient feedback mechanism for maternity	Maternity Voices is part of BNSSG CCG cross working and is being progressed to be part of the Local Maternity System project work.	**Y**

services, such as the Maternity Voices Partnership Forum, and that you regularly act on feedback?	Monthly collection of Friends and Family test demonstrates patient satisfaction with service. Evidence reviewed : Maternity Voices – last meeting minutes, Friends and Family test results – reviewed at Trust Board Meetings on Integrated Performance report , BNSSG Local Maternity Services Personalisation and Choice work stream Terms of reference , Agenda / Minutes UHBristol National Maternity Survey 2018 results would have included views of women care in the ante natal period. 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?	Training attended by Midwives, Maternity Support Workers, Maternity Care assistants, obstetricians, theatre staff, anaesthetists Compliance = 93% Evidence reviewed : Ward training records , Training programme Validation is:- 1. Self-certification to Trust Board	**Y**
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?	Quality and Patient Safety Champions, Consultant Obstetrician for Governance and Head of Midwifery, meet bi-monthly with the Director of Nursing. Formal meetings planned going forward to include Neonatal Quality and Patient Safety Champions. Quality improvement work streams presented with progress reports quarterly	**Y**

	to Trust level improvement board meeting which reports into Trust board. All incidents are reported electronically with notification to the Director of Nursing, Head of Midwifery and Head of Quality and Patient Safety. The most recent Maternity Risk and intelligence report was reviewed at the June 2019 Quality Assurance Committee. *Evidence Reviewed: Improvement Board minutes, Maternity Risks and Intelligence report June 2019* 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?	All Cases are reported to UHBristol legal team. Failsafe provided through NICU Intelligence manager to escalate any eligible cases to quality and patient safety team to ensure no cases are accidentally missed. Excel spreadsheet maintained by NICU, shared with legal and quality and patient safety team. Self-certification to Trust Board 1. NHS Resolution will also use data from the National Neonatal Research Database to verify the Trust's progress against this action.	**Y**

SECTION B: Further action required:

If the Trust is unable to demonstrate the required progress against any of the 10 maternity safety actions, please complete an action plan template for each safety action, setting out a detailed plan for how the Trust intends to achieve the required progress and over what time period. Where possible, please also include an estimate of the additional costs of delivering the plan. A

completed action plan is required even where Trusts have already completed this section. However, if this section hasn't been completed, the action plan template alone will be sufficient.

The National Maternity Safety Champions and Steering group will review these details and NHS Resolution, at its absolute discretion, will agree whether any reimbursement of CNST contributions is to be made to the Trust. Any such payments would be at a much lower level than for those trusts able to demonstrate the required progress against the 10 actions and the 10% of the maternity contribution used to create the fund.

In Conclusion

The Trust has demonstrated where it currently is with the progress against the 10 maternity safety actions and included the detailed action plan for the attainment of the outstanding actions. The Trust is compliant with all standards.

Next steps

The Trust Board is advised that in line with the submission requirements the content of this report is being shared with the Commissioners at the Quality and Safety Subcommittee meeting on17th July 2019 Following this the Trust Board is recommended to sign off the self-certification against the evidence submitted which demonstrates compliance with/achievement of the maternity safety actions meets the required standards and that the self-certification is accurate.

Only trusts that meet the required progress against all 10 maternity safety actions will be eligible for a payment of at least 10% of their contribution to the incentive fund. Trusts that do not meet the 10 out of 10 threshold may be eligible for a discretionary payment from the incentive fund to help them to make progress against one or more of the 10 actions. Such a payment would be at a much lower level than the 10% contribution to the incentive fund.

SECTION C: Sign-off

……..

For and on behalf of the Board of University Hospitals Bristol 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: **……**

Date: **……**

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 will escalate to the appropriate arm's length body/NHS System leader.

……..

SECTION D: Appendices

Please list and attach copies of all relevant evidential appendices:

Date 11/07/19

CNST standard	evidence	Lead	Attachment
1. National Mortality Review Tool	CNST Board report Safety Action Report for Standard 1 - April 2019 updated June Perinatal Mortality TOR April 2018 Safety Action Report for Standard 1 - July 2019 SOP for Stillbirth neonatal death and deaths on NICU PDSA	**D. Kerslake and R Bahl**	1.0 1.1 1.2 1.3
2. Maternity Services Data Set.	Maternity data set evidence of submission	**A. Scull**	2.0
3. ATAIN	CNST Action 3 FAQ's Jaundice audit results and recommendations Nov 2018 South West Term Admissions Action Plan UHB v4 June 2019 Term admissions 17-19 UHB ATAIN Action Plan 2019_20 PGedit	**E. Osmond** **C. Bowers** **K. Pullen** **J.Northrop**	3.0 3.1 3.2 3.3 3.4
4. Medical workforce planning	0. W+C_Finance and Ops Review_Agenda_28-05-2019 1. Finance and Operational Review_W+C_DRAFT_minutes_May 2019 2. WC Quarterly Review Minutes 03052019 final draft 2.1. Divisional_Management_Board_W_C_DRAFT_minutes_01-Feb-2019 2.1. Divisional_Management_Board_W_C_DRAFT_minutes_07-06-2019 ACSA-STDS2019 CNST action plan from O&G training review March 2019 GMC NTS Report for Trusts 2018 GMC survey overview Non-NICE Guidance Compliance Checklist - Obsteric Anaesthesia Service Provision 2019 OG Senior Trainee Staffing Briefing April 2019 vFINAL Postgraduate School of Obstetricsand Gynaecology Quality Management Vis.... Postgraduate School ofObstetricsand Gynaecology Quality Management Vis.._ Question Items Adequate Experience Question Items Curriculum Coverage Question Items Educational Supervision Question Items Handover Question Items Overall Satisfaction Question Items Study Leave Question Items Supportive Environment Question Items Teamwork Re CNST RE Postgraduate School of Obstetrics and Gynaecology Quality Management Visit to University Bristol NHS Foundation Trust - 8th March 2019 TEF 2019 Trainees' Trust Summary Report UHB college tutor report March 19 University Hospital Bristol response to trainee feedback Oct 2018	**N. Crouch** **E. Adams** **E. Treloar** **T. Overton**	4.0 4.1 4.2 4.3 4.4 4.5 4.6 4.7 4.8 4.9 4.10 4.11 4.12 4.13 4.14 4.15 4.16 4.17 4.18 4.19 4.20 4.21 4.22 4.23 4.24 4.25

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5. Maternity Workforce planning	08 01 Monthly Nurse Safe Staffing Paper - April 2019 Final 08 01 Staffing Paper - March 2019 08 01 Staffing Paper -May 2019 final Birth Rate Plus Results 2017 Final document. Escalation Guideline first draft EscalationChecklistMaternityService-4 (1) Fw Meeting re BR+ Workforce Planning (WFP) LabourWardStaffing-2_1 LackOfBedsMaternityService-7_1 (1) LackOfMidwivesInHospitalMaternityService-7_1 (1) SafeStaffingEscalation-21	**S. Windfeld**	5.0 5.1 5.2 5.3 5.4 5.5 5.6 5.7 5.8 5.9 5.10
6. Saving babies lives	CA proposal form (Nov 2018) - hypoglycaemia (2).dotx COVER SHEET for Improvement Programme Operational Group mat neo work stream May 2019 cover sheet for Programme Board.210119 Data collection Hypoglycaemia feeding and weight loss.doc Data collection NEWTT (2).doc Fetal monitoring and MEOWS graphs April 2019 Fetal monitoring and MEOWS graphs Dec 2018 Fetal monitoring and MEOWS graphs Sept 2018.ppt Fetal wellbeing Sept 18.pptx Hyperstimulation poster.6.19 hyperstimulation poster Neonatal jaundice audit proposal 2018 (2).docx NEWTT and Hypoglycaemia Audit 2019 ObesityInPregnancy-2_4 QI Working Party Minutes 21st March 2019 Safer Care Action log 18 v1 Safety Workshop mins 01.11.18 SFH Audit Presentation Feb 2019 Smoking in Pregnancy template briefing (midwifery stakeholders only) 19..._ (2)	**R. Bahl**	6.0 6.1 6.2 6.3 6.4 6.5 6.6 6.7 6.8 6.9 6.10 6.11 6.12 6.13 6.14 6.15 6.16 6.17 6.18
7. Maternity Voices	2018 National Maternity Survey Local Briefing Report Complaint Report Women conversations at St Mikes -final as approved at business meeting Aug 18 Friends and Family Test - May 2019 results Mat Voices lay rep Patient experience at heart_April 2019_final STMH_Level E_PPI_v1 The Maternal and Neonatal Health Collaborative Quality Improvement Plan (POSTER) Tony Watkins	**S. Windfeld**	7.0 7.1 7.2 7.3 7.4 7.5 7.6 7.7 7.8
8. Training	Midwife (MA and RGN) Theatre and Doctor Compliance New database - June 2019 (3)	**A. Tomlinson**	8.0
9. Patient Safety Champions	02. PS Programme Board Minutes February 2019 02. PS Programme Board Minutes from December 2018 Draft conversations week 2019V2 Final Maternity Safety Champions Newsletter. July (2) FW Appointment of Trust level Neonatal Safety Champion - RESPONSE REQUESTED	**S.Windfeld and R. Bahl**	9.0 9.1 9.2 9.3 9.4

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	NKTW feedback Womens STMH NKTW Themes across the hospital poster final QI Working Party Minutes 17th January 2019 QI Working Party Minutes 20th Dec 2018 QI Working Party Minutes 21st March 2019 TOR Patient Safety Operational Group APPROVED 0.3 18.02.19 TOR-Womens Quality Improvemt Working Party March 2019 V1		9.5 9.6 9.7 9.8 9.9 9.10 9.11
10. NHS Resolutions	Copy of NICU NHS Resolution Tracker	**A Jain, E. Treloar and I. Henderson**	10.0
Board declaration form		**I. Henderson**	

Meeting of the Board of Directors in Public on Tuesday 30 July 2019 in the Conference Room, Trust Headquarters

Report Title	**Safeguarding Adult and Children Annual Report for April 2018 -2019**
Report Author	**Carol Sawkins, Lead Safeguarding Nurse**
Executive Lead	**Carolyn Mills, Chief Nurse**

1. Report Summary

The Trust safeguarding agenda continues to be underpinned by the Trust values aiming to ensure that a culture exists where safeguarding is everyone's business and areas for learning and improvement are continually identified.

The Safeguarding Adult and Children Annual Report provides University Hospitals Bristol Trust Board, Bristol Clinical Commissioning Group and Local Safeguarding Boards with assurance that the Trust continues to fulfil its statutory and regulatory responsibilities to safeguard the welfare of children and adults across all areas of service delivery.

2. Key points to note

Safeguarding remains a key priority for the Trust and this annual report summarises the key safeguarding activities, developments and achievements in this reporting period.

Full details of the aims and objectives of both safeguarding teams going forward are detailed in the work and audit plans for 2019/20.These are reviewed at both adult and children's operational Safeguarding Groups on a bi monthly basis and the Trust Safeguarding Steering Group on a quarterly basis.

3. Risks

If this risk is on a formal risk register, please provide the risk ID/number.

The risks associated with this report include:
None

4. Advice and Recommendations

*(Support and Board/Committee decisions requested)***:**

- This report is for **INFORMATION**.
- The Board is asked to **NOTE** the report.

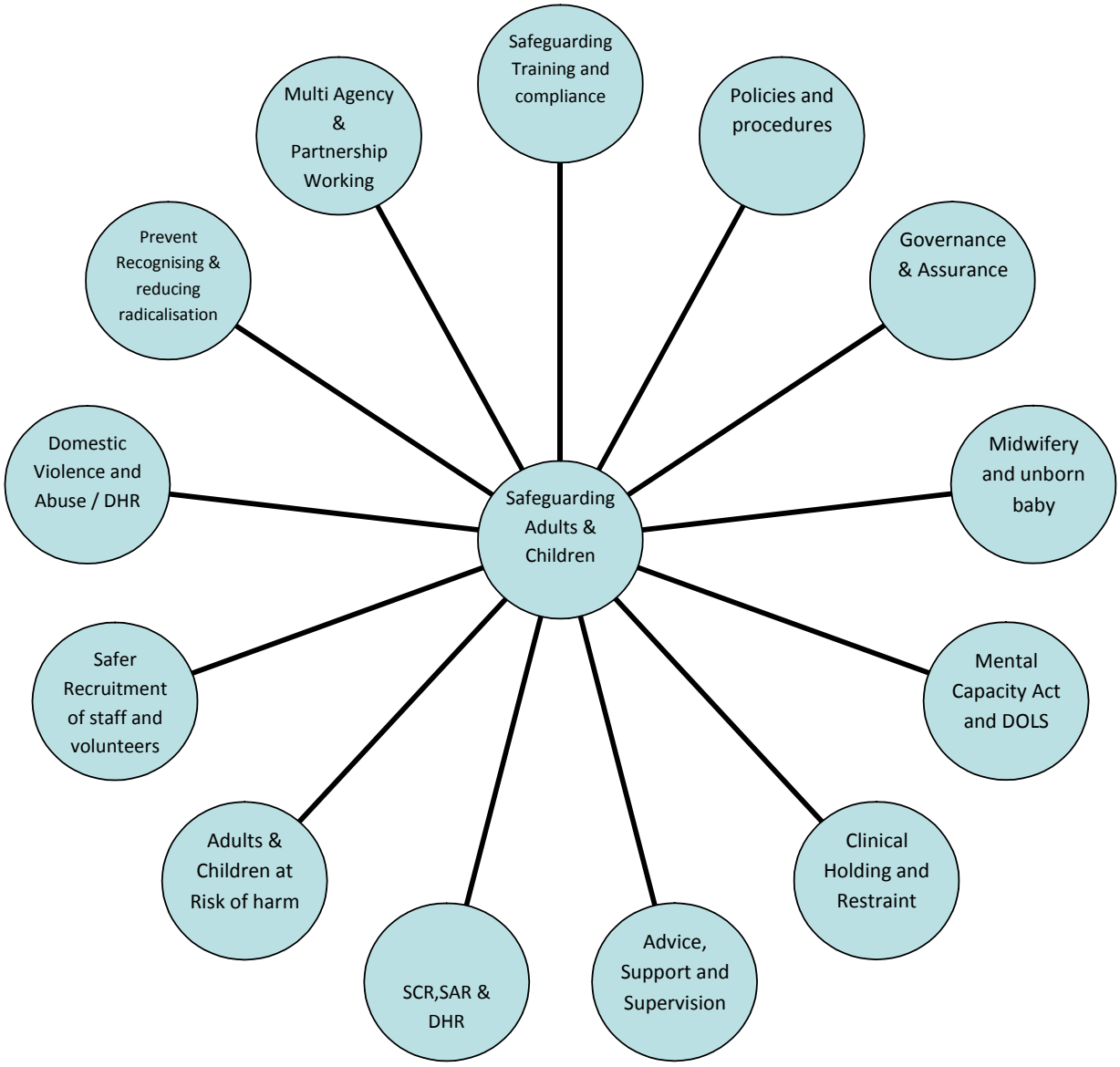
5. History of the paper

Please include details of where paper has previously been received.

Trust Safeguarding Board	Virtual Circulation
Clinical Quality Group	04 July 2019
Quality and Outcomes Committee	25 July 2019

University Hospitals Bristol NHS
NHS Foundation Trust

Safeguarding Adult & Children Annual Report



April 2018 – March 2019

Index

1. Introduction

Welcome to the Safeguarding Children and Adults Annual Report. This report provides University Hospitals Bristol Trust Board, Bristol Clinical Commissioning Group and Local Safeguarding Boards with assurance that the Trust has continued over the last year to fulfil its statutory responsibilities to safeguard the welfare of children and adults across all areas of service delivery.

The Trust safeguarding agenda continues to be underpinned by the Trust values aiming to ensure that a culture exists where safeguarding is everyone's business and areas for learning and improvement are continually identified. The summary and conclusion of this report describes the key priorities and areas identified for development for safeguarding in 2019/20.

2. Summary of current arrangements for Safeguarding within University Hospitals Bristol NHS Foundation Trust (UHBristol)

The Trust safeguarding arrangements, for both adults and children are supported by the Named Professionals (Doctor, Nurse and Midwife), plus a team of experienced safeguarding nurses and administration staff.

Key governance arrangements comply with the statutory requirements of Section 11 of the Children Act 2004, specifically:

UHBristol Trust Board holds ultimate accountability for ensuring that safeguarding responsibilities for both children and adults are met with the Chief Nurse as Executive Lead for Safeguarding
A team of experienced safeguarding professionals, including the Named Professionals, provide expert advice, support and supervision to practitioners across all areas of the Trust.
The Safeguarding Steering Group reports annually to the Clinical Quality Group which in turn reports to the Quality and Outcomes Committee, the quality sub-committee of the Trust Board.
The Trust has two operational groups: one for Children's Safeguarding and one for Adult Safeguarding, these meet alternative months and report to the Safeguarding Steering Group and are responsible for the operational delivery of safeguarding across the Trust and delivery of an annual work and audit programme.
Safeguarding performance is monitored internally by the Trust Safeguarding Steering Group, chaired by the Chief Nurse and supported by senior representation from all Divisions

3. Safeguarding Assurance including Performance Monitoring and Audit

The Trust's compliance with statutory safeguarding arrangements for children are defined within Section 11 of the Children Act 2004 and for adults within the Care Act 2014, and are monitored externally by the local Safeguarding Children and Adults Boards.

4. Safeguarding and Care Quality Commission (CQC) Regulation 13

The Trust has evidence that it has maintained compliance with CQC Regulation 13 'Protecting Service users from abuse' during this reporting period. Ensuring that those who use the Trust services are safeguarded and that staff are suitably skilled and supported, demonstrating safeguarding leadership and

commitment at all levels of the organisation and being fully engaged in local accountability and assurance structures.

The Lead Nurse for Safeguarding is accountable for ensuring compliance with regulation 13, reporting regularly to the Safeguarding Operational Groups, the Safeguarding Steering Group, and bi annually to the Clinical Quality Group (CQG).

5. Safeguarding Risks

The Safeguarding Steering Group and the Safeguarding Operational Groups maintain oversight of all safeguarding Corporate, Divisional and Departmental risks entered onto Datix. There are three safeguarding risks on the corporate risk register, two of which remain unchanged from the previous year's report. The third risk (risk ID1595), has had its risk rating decreased from 16 to 12 as a result of the controls now in place.

Table 1: Summary of Corporate Safeguarding Risks

<table>
<tr><th>Risk No</th><th>Summary of Risk</th><th>Current Risk Rating</th><th>Current Position and Key mitigating actions</th><th>Owners of Risk / Monitoring Group</th></tr>
<tr><td>856

Corporate</td><td>Risk that the emotional and mental health needs of children and young people admitted to the Children's Hospital (for mental health reasons only), may not be fully met as the Hospital is not a provider of mental health services.</td><td>Risk Rating 12</td><td>This is an ongoing risk related to the number of children and young people being admitted to the BRHC as a place of safety who do not require treatment for any physical health reasons.

Given the significant increase in numbers and waiting time for children to be seen by a mental health practitioner the risk score remains at 12. Commissioning of mental health services for children continues to be reviewed by NHS England locally and nationally.</td><td>Children's Governance & Mental Health Operational Group,

Safeguarding Steering Group.</td></tr>
<tr><td>921

Corporate</td><td>Risk of not achieving 90% compliance for all Essential Training, which includes safeguarding training.</td><td>Risk Rating 12</td><td>If rates of compliance with Essential Training are not met and sustained, then staff may not have the skills, knowledge and experience to deliver effective care and treatment and maintain a safe working environment. Safeguarding Training Compliance rates as at the end of this reporting period (31/3/19)
<table>
<tr><th>Adults Training</th><th>Target Audience</th><th>Compliant</th><th>Compliance %</th></tr>
<tr><td>Level 1</td><td>3023</td><td>2809</td><td>93</td></tr>
<tr><td>Level 2</td><td>6102</td><td>5677</td><td>93</td></tr>
<tr><td>Level 3</td><td>95</td><td>84</td><td>88</td></tr>
<tr><td>Children's Training</td><td>Target Audience</td><td>Compliant</td><td>Compliance %</td></tr>
<tr><td>Level 1</td><td>2803</td><td>2681</td><td>96</td></tr>
<tr><td>Level 2</td><td>4315</td><td>3867</td><td>90</td></tr>
<tr><td>Level 3 (Core)</td><td>1720</td><td>1332</td><td>77</td></tr>
<tr><td>Level 3 (Specialist)</td><td>382</td><td>322</td><td>84</td></tr>
</table></td><td>Executive Lead - Director of Workforce & Organisational Development.

Safeguarding Steering Group</td></tr>
</table>

			Compliance with level 3 children Core training remains unchanged from the previous reporting period. (see section 9)	
1595 **Corporate**	Risk that if patients suffering from mental health disorders spend prolonged time in ED their condition could deteriorate. Patients affected are those detained under S 136 (Mental Health Act)	Risk Rating 9	This risk relates to patients suffering from mental health disorders having a prolonged stay in ED. Patients affected include those detained under Section 136 (Mental Health Act),. There are controls in place and good partnership working with AWP colleagues. The key actions taken since the last report • AWP staff now based at UHBristol overnight which means there is a 22 hour service for mental health patients as per regulatory requirements for acute Trust. • Additional training provided to Trust Liaison Psychiatry Team to support them in assessing and planning for 16 &17 year olds who need a mental health assessment i • Review of the Section 12 Doctor Rota to address the delays in convening MHA due to lack of Section 12 Doctor availability.	Mental Health Operational Groups. Safeguarding Steering Group

6. Summary of key safeguarding achievements

Implementation of the Child Protection Information sharing system (CP-IS) in unscheduled care

Short life working group established to review and improve discharge practice

Mental Capacity Act prompt cards introduced and bespoke training delivered to Consultants and other targeted areas.

Implementation of the Female Genital Mutilation Information Sharing system (FGM-IS)

Broad range of safeguarding practice quality assurance audits completed, including NICE MCA self-evaluation, quality of referrals, baby and child abduction simulation

Safeguarding Adults & Children's referral forms updated, in line with Multi- agency guidelines

Safeguarding Awareness Week and Safeguarding Link Professionals Away Day, specific meeting to promote MCA

Robust multi agency / partnership working, including engagement with Local Safeguarding Adults & Children's Boards and sub groups

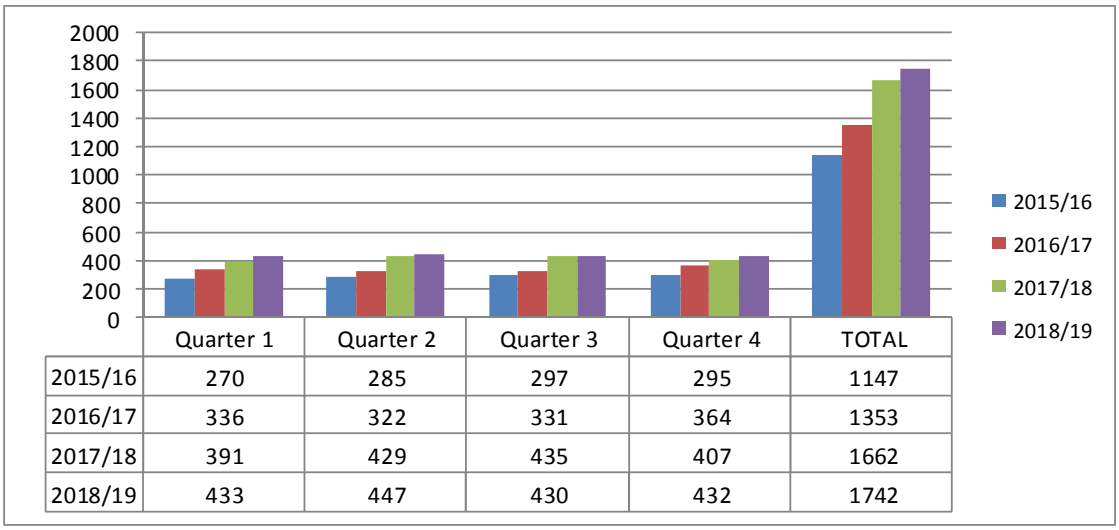
Safeguarding training updated to reflect current risks, including mental health and contextual updates.

7. Safeguarding Children Activity Data

The safeguarding children's activity data continues to reflect a year on year increase in contacts to the safeguarding team from practitioners across the Trust, for advice and support, (See Table two). Contact with the Safeguarding Children team may consist of a face to face conversation, telephone call or an email from a staff member.

Contacts in this reporting period have increased by a further 5 %, a positive reflection of safeguarding training, staff awareness of their individual safeguarding responsibilities and the visibility of the safeguarding team.

Table 2 Number of contacts made with then Safeguarding Children Nursing Team



	Quarter 1	Quarter 2	Quarter 3	Quarter 4	TOTAL
2015/16	270	285	297	295	1147
2016/17	336	322	331	364	1353
2017/18	391	429	435	407	1662
2018/19	433	447	430	432	1742

7.1 Safeguarding Referrals to Children's Social Care

All safeguarding referrals to Children's Social Care are sent via the Safeguarding team. This process enables the team to:

- Review the quality of the information recorded on the referral, ensure relevant information is included and the risk is clearly articulated.
- Ensure referrals are in line with the threshold for Social Care involvement as set out in the Bristol Multi Agency Threshold Guidance - Working together to get the Right Help at the Right Time for the Right Duration (BSCB 2018)
- Collect and collate data for analysis purposes and onward reporting to the Child Protection Operational and Safeguarding Steering Groups.
- Monitor, identify trend/concerns and take necessary action
- Provide direct feedback to practitioners.

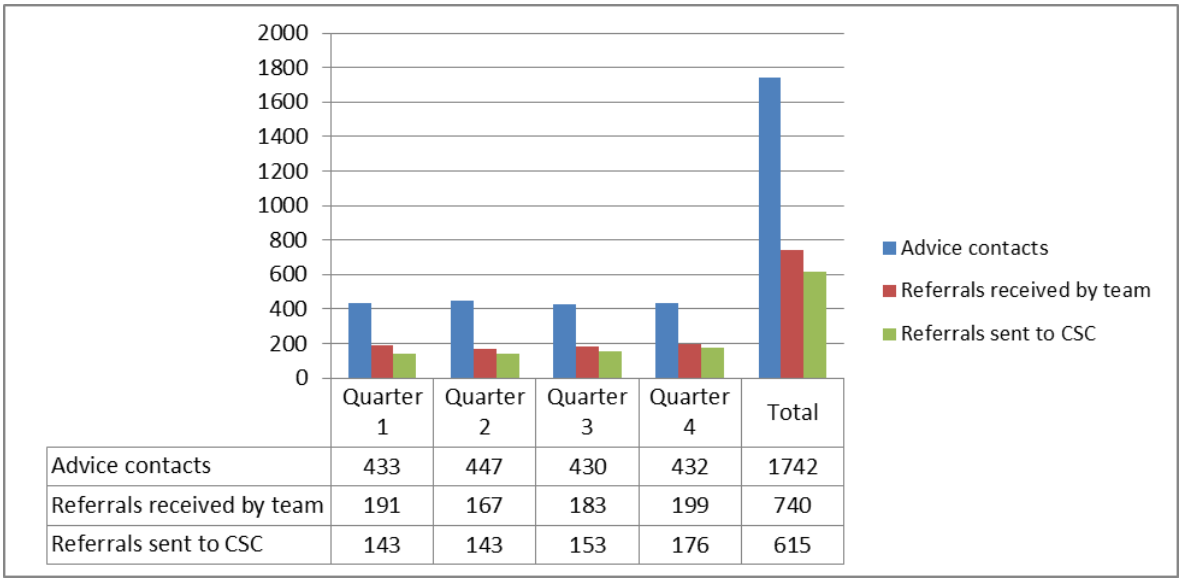
The number of onward referrals to Children's Social Care has remained relatively stable, despite the increase in contacts to the safeguarding team (Table 3).

Approximately 35% of the advice contacts result in a referral to Children's Social Care Team. The total number of referrals to Children's Social Care was 740, and 615 were sent onwards to the appropriate Local Authority.

Of the 125 referrals not sent to Children's Social Care, the majority were shared with other healthcare providers such as GP, School Health Nurse or Health Visiting services or other services that are better situated to assist in addressing the concerns.

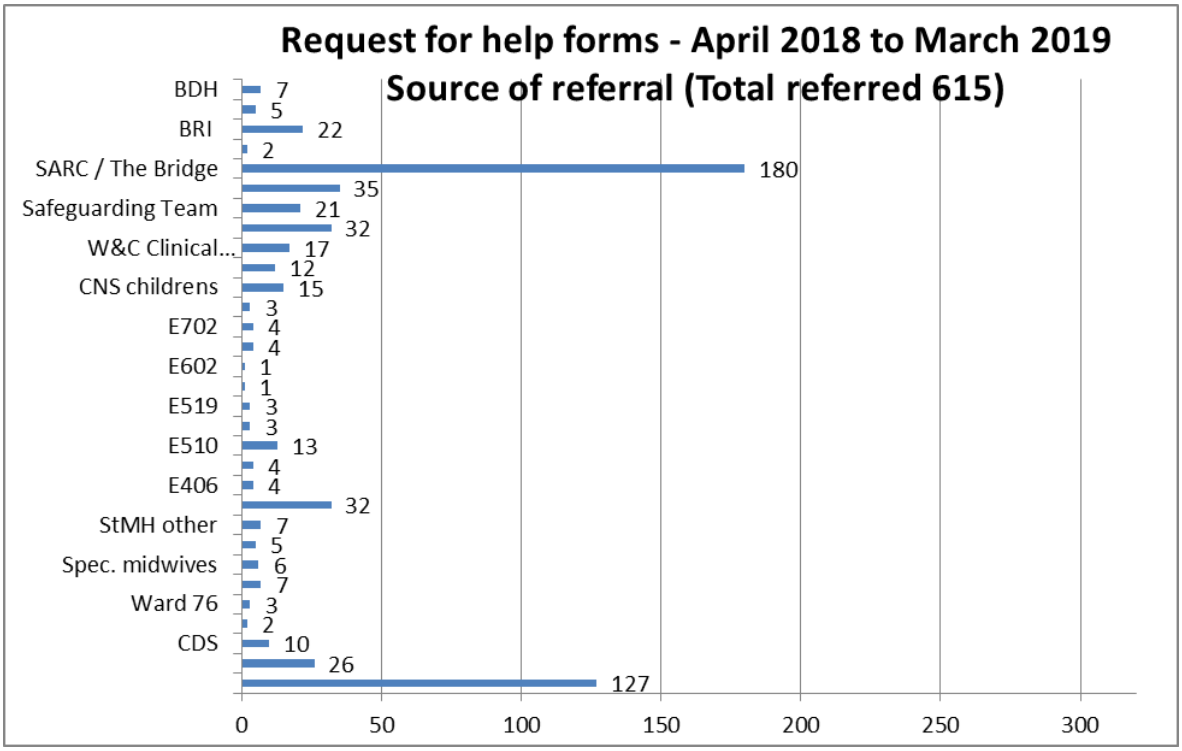
As part of a multi- agency partnership approach to safeguarding children, an annual quality assurance is undertaken to review the quality of the referrals to Children's Social Care. The results this year were positive with improvement in a number of areas. This will remain an area of focus within safeguarding training and will be incorporated in the safeguarding audit plan for 2019/20.

Table 3 Number of Referrals Received and Sent to Children's Social Care



	Quarter 1	Quarter 2	Quarter 3	Quarter 4	Total
Advice contacts	433	447	430	432	1742
Referrals received by team	191	167	183	199	740
Referrals sent to CSC	143	143	153	176	615

Table 4 Source of Referrals



During this reporting period there has been a significant increase in the number of safeguarding referrals from practitioners at 'The Bridge' – The Sexual Assault Referral Clinic (SARC)' 180 referrals, compared to 51 referrals in the previous year. This increase is as a consequence of NHS England's review and re-commissioning of SARC's nationally. The Bristol Centre is now a designated children's SARC, receiving and assessing children from across the South West region for the first time.

As part of this new service, a Paediatric Lead Doctor, experienced in sexual assaults, has recently been appointed to the centre. Regular safeguarding review meetings have been established within the SARC to

ensure there is a robust and cohesive approach to safeguarding children and young people assessed at the centre.

7.2 Safeguarding in the Emergency Departments

The Trust Emergency Departments , at Bristol Royal Infirmary, Bristol Royal Hospital for Children and Bristol Eye Hospital, complete 'Social Care Notification forms' , recognising the time limited contact with a child and family, as opposed to the more detailed Trust wide Request For Help' form. The Emergency Department activity remains broadly in line with previous years.

Table 5 Emergency Department Social Care Notifications

	2011/12	2012/13	2013/14	2014/15	2015/16	2016/17	2017/18	2018/19
BRI ED	1172	885	1275	1362	1494	1326	1360	1301
BRCH ED	514	462	488	593	486	616	779	709

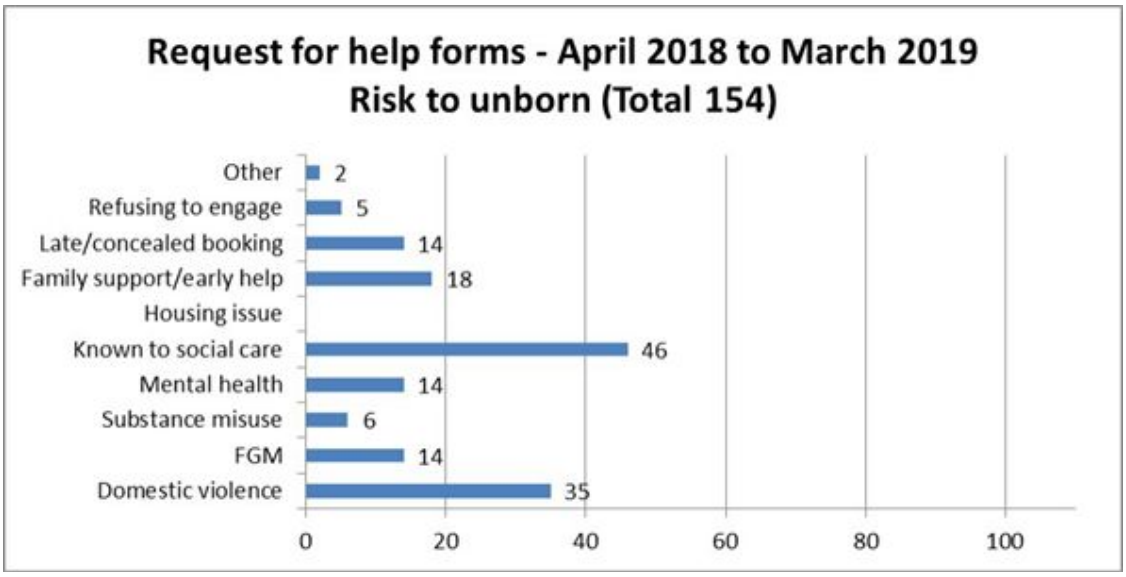
The weekly safeguarding review meeting, between the safeguarding and Emergency department teams, continues to review the notification forms, update on the local outcomes and share any learning.

7.3 Safeguarding, Midwifery and the Unborn Baby

A significant number of safeguarding referrals continues to be made by the Community Midwifery Team and includes an increasing number of challenging and complex cases (See table 6). Close working between the Weston and UHBristol midwifery services continues as women may receive antenatal care in Weston and deliver at St Michaels hospital, particularly when there is a complex social situation.

Referrals for unborn babies are made due to concerns about potential parental risk factors, which may result in occasions where babies have to be removed from their mothers following a multi- agency safeguarding process.

Table 6 Referrals for Unborn Babies



Women are routinely asked about Female Genital Mutilation at their booking appointment and previously if a pregnant woman has had FGM this would trigger an automatic referral to social care. During this reporting period a new nationwide approach to FGM has been introduced, which now requires the Midwife to complete a risk assessment to identify any potential risk of FGM to the unborn. If the assessment highlights potential risk and the baby is female, an alert will be placed on the national information sharing data base (FGM-IS).

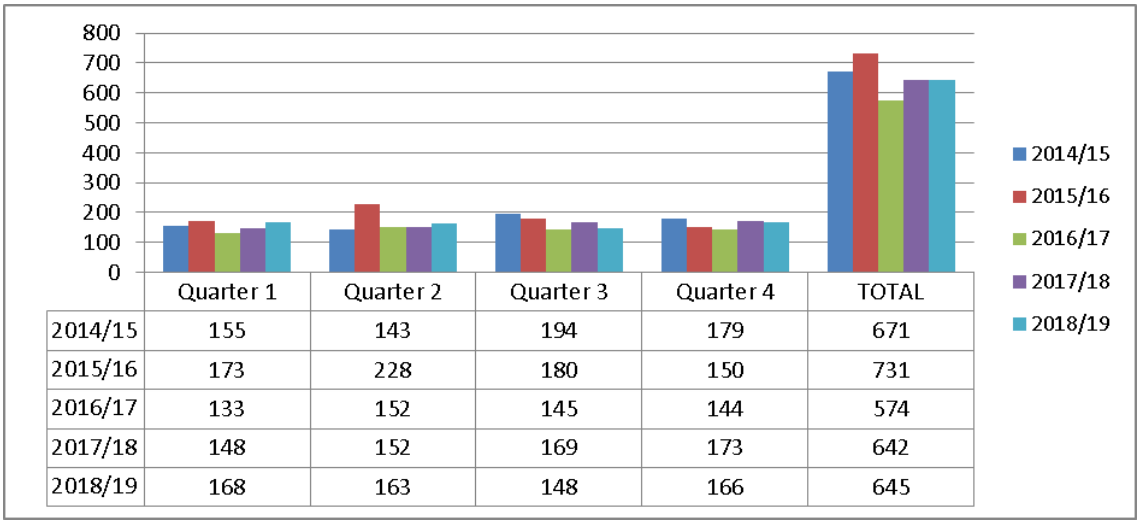
A safeguarding referral to children's social care may also be made. There has been a significant reduction in referrals in this reporting period, 14 safeguarding referrals for potential FGM risks, compared to 106 in the previous twelve months.

Midwives also continue to routinely ask about domestic violence at the booking appointment and other stages during antenatal appointments and if there are concerns a referral will be made to Children's Social Care. The number of referrals for Domestic Abuse has decreased to 35 in this reporting period, compared to 57 previously, any potential significance will be monitored in the next reporting period.

8. Safeguarding Adults Activity Data

The safeguarding adult's activity data, remains largely consistent with previous years, including the total number of concerns raised for safeguarding adults (See table seven below), aside from the spike noted in 2015/16 associated with the implementation of the Care Act 2014.

Table 7: Number of Referrals Received

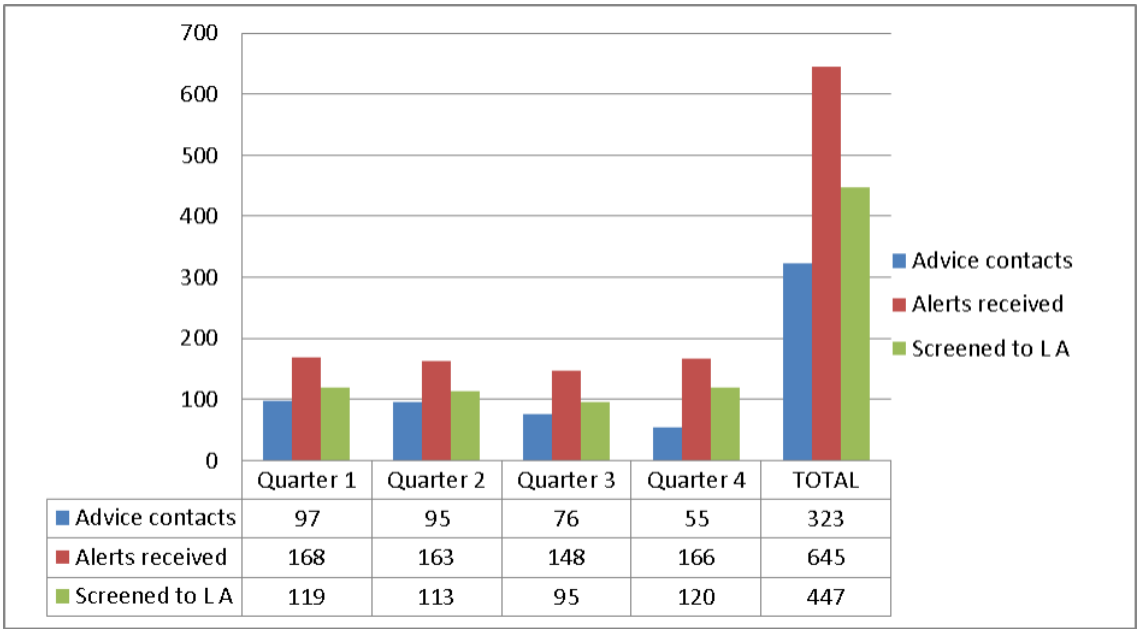


	Quarter 1	Quarter 2	Quarter 3	Quarter 4	TOTAL
2014/15	155	143	194	179	671
2015/16	173	228	180	150	731
2016/17	133	152	145	144	574
2017/18	148	152	169	173	642
2018/19	168	163	148	166	645

The quality assurance process, previously described in relation to safeguarding children's referrals, is mirrored for safeguarding adults. This process ensures that onward referrals are in line with the Bristol Safeguarding Adults Board Threshold Guidance and the Care Act 2014.

During this reporting period, 69% of alerts received met the agreed threshold for referring to the relevant Local Authority for a safeguarding investigation, consistent with last year (Table 8) Alerts not meeting the threshold have been risk assessed and redirected to other appropriate services, such as housing, domestic violence support, or local authority care needs assessments.

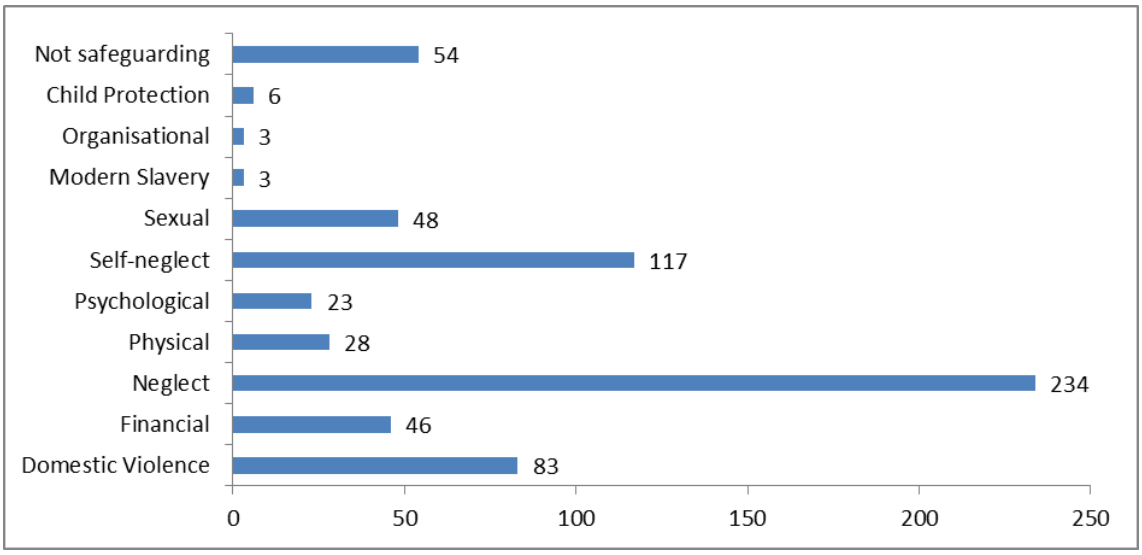
Table 8: Number of Contacts / Referrals screened prior to sending to Local Authority



	Quarter 1	Quarter 2	Quarter 3	Quarter 4	TOTAL
Advice contacts	97	95	76	55	323
Alerts received	168	163	148	166	645
Screened to L A	119	113	95	120	447

The Safeguarding nursing team continues to record the number of requests for advice and support from staff across the Trust. Contacts include advice sought in relation to the application of the Mental Capacity Act and Deprivation of Liberty Safeguards as well as Safeguarding queries. The category of referrals remains largely consistent with last year (Table 9).

Table 9: Category of referrals



Of particular note, three referrals were made under the category of Modern Slavery, the number remains small and consistent with previous reports. The concerns were identified promptly and in line with the Modern Slavery requirements incorporated into Safeguarding training. The referrals were responded to promptly by the Police and protective interventions commenced appropriately.

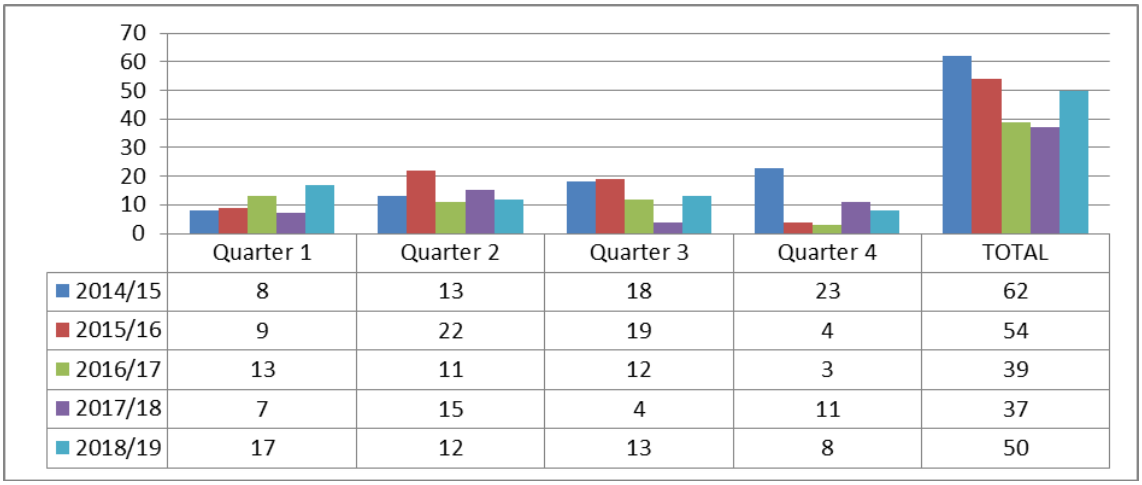
8.1. Internal Safeguarding Alerts

A Safeguarding Internal Alert is raised if it is alleged that the Trust may have caused harm to a patient through the omission or provision of care, underpinned by the Trust's responsibility to be open and transparent in line with the Duty of Candor. Alerts may be raised by practitioners within the Trust or by other agencies or individuals.
There has been an increase in volume of internal cases recorded this year, in part due to concerns raised about the actions of singular carer's affecting more than one patient. These incidents are recorded by the local authority individually based on the individual patient affected.

Of note there were no substantiated incidents of grade 3 or above pressure sores in this reporting period, in comparison to one in the previous year.

Approximately one third of the internal referrals sent to the Local authority did not met a threshold for a safeguarding investigation, or the local authorities were assured by the actions already taken by the Trust and no further intervention was required.

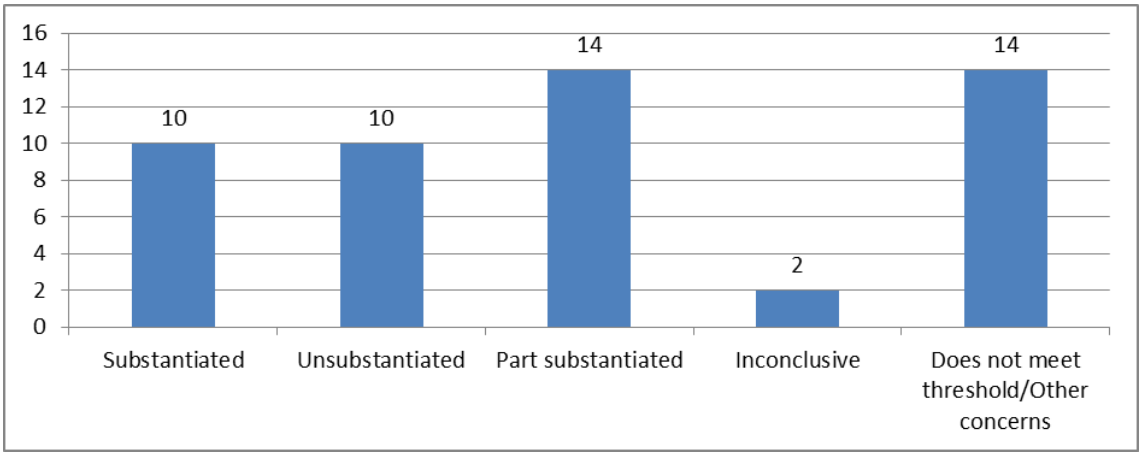
Table 10: Internal Safeguarding Alerts



	Quarter 1	Quarter 2	Quarter 3	Quarter 4	TOTAL
2014/15	8	13	18	23	62
2015/16	9	22	19	4	54
2016/17	13	11	12	3	39
2017/18	7	15	4	11	37
2018/19	17	12	13	8	50

Of the internal cases this year, ten were closed as Substantiated, in comparison with two in the previous reporting period, four cases (40%) were carried forward from the previous reporting period (Table 11)

Table 11: Outcome of internal Safeguarding investigations



An increase was noted during this reporting period in concerns (outcome substantiated or partially substantiated) associated with allegations of poor discharge planning. Consequently a short life working group was implemented to scope and address these concerns. A key outcome has been the

implementation of an updated Discharge checklist and early indications reflect a positive reduction in discharge related concerns.

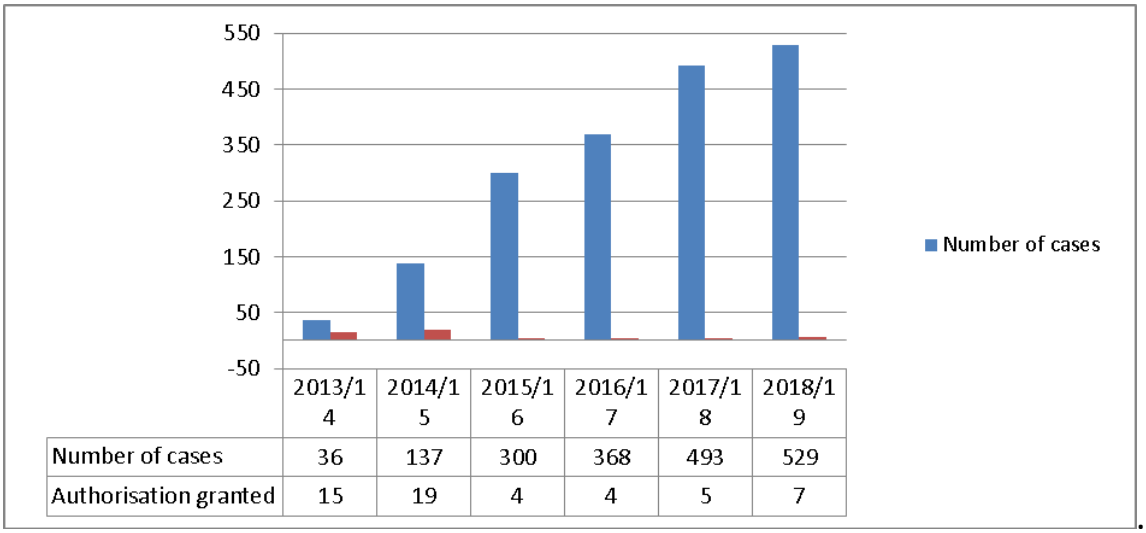
Seven incidents were attributable to members of staff, three of whom were employed by an agency. In respect of the four incidents involving Trust employees; three staff have been supported with additional manual handling and clinical holding training and supervision. The remaining case involved a non - registered employee who left the Trust prior to the investigation being completed, attempts to make contact with the employee were unsuccessful, the case remains unresolved.

The numbers of internal alerts, outcomes, emerging themes or concerns, are robustly monitored by the Safeguarding Team, Divisional Patient Safety Teams and the Adult Operational Group with regular reports submitted to the Safeguarding Steering Group. Learning outcomes are incorporated into staff training updates.

8.2 Mental Capacity Act and Deprivation of Liberty Safeguards (DoLS)

The Deprivation of Liberty Safeguards (DoLS), within the Mental Capacity Act, provides a protective legal framework for those vulnerable / at risk people who are deprived of their liberty. The Supreme Court judgment in 2014 continues to have a significant impact on frontline practice with a year on year increase in the number of DoLS applications (See table thirteen below).

Table 12: Deprivation of Liberty Safeguards (DoLS)



	2013/14	2014/15	2015/16	2016/17	2017/18	2018/19
Number of cases	36	137	300	368	493	529
Authorisation granted	15	19	4	4	5	7

During this reporting period 529 DoLS applications made to the Local Authority, of which, only 7 resulted in progression to an ongoing Standard authorisation. The Trust continues to care for and detain these patients, as it is in their best interests to do so, following the least restrictive option and in line with the Mental Capacity Act measures. This stance continues to mirror the current position of NHS Trusts both locally and nationally which is also reflected in the Trust risk register (Datix Risk no 690).

The anticipated changes to the Deprivation of Liberty Safeguards framework are in the final stages of the legislative change process. The bill is expected to receive Royal Ascent in the very near future and will be followed by a period of implementation and the development of a detailed Code of Practice. The progress of the new legislation is being monitored closely and the new requirements reflected in the safeguarding work plan for 2019/20.

9. Safeguarding Children and Adult Training

The provision and delivery of both children and adults safeguarding training remains a key priority, ensuring that all staff are provided with the appropriate training for their role and responsibilities. The Trust performance standard is currently 90% compliance with all levels of safeguarding training. Whilst the Safeguarding Commissioning Standards for 2019/20 will include a new requirement of 85%, the Trust internal requirement will remain at 90%.

9.1 Level 1 and 2 Training Compliance

Safeguarding Level 1 and 2 training for both children and adults is incorporated into corporate clinical and non-clinical induction and update training. The required 90% target has been maintained during this reporting period, as is detailed in table thirteen below.

Table 13: Level 1 and 2 Safeguarding Training Compliance

	March 2017	March 2018	March 2019
Level 1 Safeguarding Adults	90%	92%	93%
Level 1 Safeguarding Children	91%	93%	96%
Level 2 Safeguarding Adults	91%	86%	93%
Level 2 Safeguarding Children	90%	91%	90%

9.2 Level 3 Core and Specialist Training (Children)

All staff who work regularly with children, young people or the unborn baby must complete Level 3 Core training as a minimum, (approximately 1,700 staff). Staff in a more senior role must complete the more advanced level of Level 3 Specialist training (approximately 370 staff)., which includes staff such as; Paediatric Consultants, Community Midwives and Paediatric Specialist Nurses who are expected to undertake a lead role in safeguarding situations.

The Trust safeguarding Training Matrix states that staff in the Level 3 Core target audience must complete training within six months of starting employment and Specialist target audience completed within twelve months. The Trust training data reporting system is unable to routinely exclude new starters from the overall compliance data. To improve the accuracy of this report, a more detailed manual end of year analysis was completed in March 2019, results detailed in Table 14.

Table 14: Level 3 Safeguarding Children Training Compliance

	March 2018	*March 2018* *(Excluding new starters)*	March 2019	*March 2019* *(Excluding new starters)*
Level 3 Safeguarding Children (Core)	79%	*82%*	77%	*80%*
Level 3 Safeguarding Children (Specialist)	83%	*87%*	84%	*86%*

Non-compliance with Level 3 Children (Core and Specialist) training remains on the Trust Corporate Risk Register (Datix Number 921) and is monitored robustly through the Trust's governance arrangements including the Safeguarding Steering Groups and both Operational Groups.

9.3 Level 3 Safeguarding Training Compliance (Adult)

Towards the end of this reporting period the new Safeguarding Adults Training Guidance (Inter Collegiate Document) was published. The Adults Operational Group is currently reviewing the Trust's existing training strategy to ensure it is closely aligned with the new guidance, work which will be completed in the next reporting period.

Table 15: Level 3 Safeguarding Adult Training Compliance

	March 2017	March 2018	March 2019
Level 3 Safeguarding Adults	78%	91%	88%

10 Prevent, including training

The Counter-Terrorism and Security Act requires that specified bodies, including health, have a legal duty to, "have due regard to the need to prevent people from being drawn into terrorism". As part of these statutory requirements, underpinned by the NHS Commissioning Standards, the Trust is required to train staff so they know what PREVENT is and how to escalate concerns regarding people who may be at risk of radicalisation.

Safeguarding training incorporates the required level of PREVENT /WRAP according to staff role and level of responsibility. Compliance is reported as part of the Trust monthly Essential Training report

Table 16: Prevent/ WRAP Training Compliance

	March 2017	March 2018	March 2019
Prevent training	65%	90%	93%
WRAP training	47%	68%	78%

The compliance target for both PREVENT and WRAP training is 90%. Work towards achieving the WRAP target will continue in the next reporting period, incorporated as part of the objectives to improve Level 3 safeguarding children's training. The Trust is required to have a dedicated PREVENT lead, which has been incorporated within the remit of the Safeguarding Lead Nurse. The Trust made one referral during this reporting period which did not meet the Threshold for further action (the Channel Panel) and was redirected to another support service.

11. Serious Case Reviews, Safeguarding Adult Reviews and Domestic Homicide Reviews

Serious Case Reviews (SCR) for children and Serious Adult Reviews (SAR) are undertaken as part of a statutory multi-agency investigation process:

- following the death or serious harm of a child or an adult (with care and support needs), as the result of abuse or neglect,
- and there have been concerns about the way in which agencies have worked together and lessons can be learnt.

Domestic Homicide Reviews (DHR), are conducted following the death of an individual over the age of 16 years of age as a result of violence within a relationship, either from a partner of another member of the household they live in. Seven requests for DHR information have been actioned during this reporting period and one report Child D (Joint DHR /SRC) has been published.

During this reporting period the following local case reviews have been published:

Table 17: Case Reviews published 2018/19

Serious Case Review	Safeguarding Adults Reviews
Child D (DHR/SCR)	Kamil Ahmed and Mr X
TIA (Child Protection Incident Review)	

One further SCR has been completed and it has been agreed that this will not be made public. Learning and associated actions resulting from these DHR /SCR / SAR s is included and monitored via the safeguarding work and audit plans. Key actions for UHBristol include:

- Ensuring that staff are aware of risks from 'non-intimate partner abuse' including between siblings.
- To consider risk taking behaviour, aggressive or volatile in adolescents, particularly boys, as a potential safeguarding issue
- To consider the impact of unconscious bias and the use of language and terminology such as 'failed' rather than 'refused' asylum seeker
- Maintaining a child focus without being child led
- Recognising the significant risks at times of transition between children's and adult services.

12. Report summary and objectives for 2019/20

The safeguarding agenda for both children and adults is constantly changing and it is essential that the Trust continues to develop a proactive approach to ensure that safeguarding practice remains up to date and in line with new guidance and best practice.

Safeguarding remains a key priority for the Trust and this annual report summarises the key safeguarding activities, developments and achievements in this reporting period. The report aims to provide assurance that the Trust is fulfilling its statutory safeguarding duties and responsibilities and is thereby fulfilling its contractual duty to safeguard children and adults.

Full details of the aims and objectives of both safeguarding teams going forward are detailed in the work and audit plans for 2019/20 available on request.

Meeting of the Board of Directors in Public on Tuesday 30 July 2019 in the Conference Room, Trust Headquarters

Report Title	**Safe Working Hours Guardian Report**
Report Author	**Alistair Johnstone, Guardian of Safe Working Hours**
Executive Lead	**William Oldfield, Medical Director**

1. Report Summary

The 2016 junior doctors contract is now well established for all Junior Doctors in training across the Trust and, from August 2019, will be implemented for all new Locally Employed Doctors.

One of the major concerns raised by doctors during the negotiations for the new contract was the impact that rota gaps had on a Junior Doctors workload and ability to access the educational elements of their post. As a result this annual report summarises the rota gaps across the Trust to highlight areas of concern.

Along with other guardian of Safe Working Hours reports, this report will be available on the Trusts external website. It is also likely to be reviewed as part of future CQC inspections.

2. Key points to note
(Including decisions taken)

There are significant numbers of rota gaps across the Trust and these appear to be increasing in number over the past year. The cause of the rota gaps is a complex mix of variable supply from the Deanery, an increasingly competitive environment for recruiting suitably qualified locally employed (Trust Grade) doctors and locums and stricter rota rules in the new contract.

Rota gaps are a key cause of decreased job satisfaction and poor morale in the junior doctor workforce.

3. Risks
If this risk is on a formal risk register, please provide the risk ID/number.

The risks associated with this report include:
N/A

4. Advice and Recommendations
*(Support and Board/Committee decisions requested)***:**

- This report is for **ASSURANCE**.
- The Board is asked to **NOTE** the report**.**

5. History of the paper
Please include details of where paper has previously been received.

People Committee	25 June 19

ANNUAL REPORT ON ROTA GAPS AND VACANCIES: DOCTORS AND DENTISTS IN TRAINING 2018 / 19

Executive summary

The 2016 junior doctors contract is now well established for all Junior Doctors in training across the Trust and, from August 2019, will be implemented for all new Locally Employed Doctors. One of the major concerns raised by doctors during the negotiations for the new contract were the impact that rota gaps had on a Junior Doctors workload and ability to access the educational elements of their post. As a result this annual report summarises the rota gaps across the Trust to highlight areas of concern. This report will be presented to the public Trust Board and will be available on the Trust external website. It is also likely to be reviewed as part of future CQC inspections.

Introduction

The Trust has a significant number of ongoing rota gaps across the organisation. This is partly due to fluctuations in the number of trainees sent to the Trust from the Deanery and reflects the varying training requirements for different groups of trainees. This is something that the Trust has very little control or influence over. These gaps are further amplified by the large number of specialised rotas with small numbers of doctors on each. Finding suitable Locally Employed Doctors or locum cover is particularly challenging in these specialities.

High level data

Number of doctors / dentists in training (total):	500
Number of doctors / dentists in training on 2016 TCS (total):	340
Number of locally employed doctors on 2002 TCS:	160
Amount of time available in job plan for guardian to do the role:	2 PAs per week
Admin support provided to the guardian (if any):	none
Amount of job-planned time for educational supervisors:	0.25 PAs per 3 trainees (this is less than comparable Trusts locally)

Annual data summary

The following tables detail the rota gaps since the last report and any actions taken to address them. Rota gaps are generally addressed by either rewriting the rota to include less doctors or by using internal locum shifts to cover gaps. Both of these actions increase workload and have a negative impact on job satisfaction and overall morale.

Division	Rotas	Rota slots (WTE)	Post Funding Deanery	Post Funding Trust	Current WTE on Rota	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Comments: was the gap covered and how?
Surgery	OMFS	7	5	2	3													Rota re-written to accommodate
Surgery	DCT OMFS	14	14	0 although 3 clinical fellows	14													
Surgery	F1 General Surgery	15 WTE	15 - Deanery Funded	0 WTE	15					F1 Deanery Gap								
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									2 Gaps (out to advert)	2 Gaps (out to advert)	2 Gaps (out to advert)	2 Gaps (out to advert)	
Surgery	ST3-8 General Surgery	12 WTE	8 Deanery Funded (7 x Deanery ST3-8, 1 ACF)	4 Trust funded Fellows	12													
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)	8.5	3.5 Fellow Gap (advertising)		2.5 Fellow Gap (advertising)					3 Gaps		5 Gaps			Gaps covered with Locum shifts. Advertising and interviews ongoing with no successful candidates.
Surgery	ST3-8 T&O	12 WTE	12 Deanery Funded	0 WTE	12													
Surgery	GP ENT	5 WTE	5 Deanery Funded (5 x GPVTs)	0 WTE	5									0.4 (Trainee gone LTFT)				Locum shift to fill the gaps from April 2019
Surgery	ST1-2 ENT	5 WTE		5 Trust Funded (3 x Clinical fellows, 1 x ACF)	5	1 x fellow Gap								2 gaps (advertising)				
Surgery	ST3-8 ENT	7 WTE	7 Deanery Funded	0 WTE	6	1 x Gap Aug - Oct											1 Gap July due to resignation	

Surgery	GP Ophthalmology	2 WTE	2 Deanery Funded	• 0 WTE	2													No Gaps from Aug.
Surgery	ST3-8 Ophthalmology 1st on-call	6 WTE	6 Deanery Funded	0 WTE	5.6	1.4 Gap (Aug - Dec)												
Surgery	ST3-8 Ophthalmology 2nd on-call	6 WTE	3 Deanery Funded	3 Trust funded	6													
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 three rotas	8													no gaps - rota written to accommodate
Surgery	ST3-8 General Anaesthesia 2nd on-call	8 WTE			7													
Surgery	ST3-8 Obstetrics Anaesthesia	6 WTE			6.6													
Surgery	ST3-8 Cardiac Anaesthesia	8 WTE	6 Deanery Funded	2 Trust funded (fellows)	7.6													
Surgery	ST3-8 Intensive Care Advanced	2 WTE	2 Deanery Funded	0 WTE	2													
Surgery	ST3-4 Intensive Care/CT1/2 Intensive Care	10 WTE	4 Deanery Funded	6 Trust funded (specialty doctors & fellows)	8													

Division	Rotas	Rota slots (WTE)	Post Funding Deanery	Post Funding Trust	Current WTE on Rota	Aug -18	Sep -18	Oct -18	Nov -18	Dec -18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Comments: was the gap covered and how?
Medicine	General Medicine F1 (including Cardiology)	21 WTE	21	0 WTE	20	2 (1 FT CF recruited from Dec)				1 Gap				1 Gap				Filling gap with Locum (from Dec 2018 - advert pulled)
Medicine	General Medicine SHO	31 WTE	28	2 WTE		1				1 Gap	1 Gap	2 Gaps	2.4 Gaps	2.6 Gap	4 Gap (LTFT gaps & 2 wte vacancy - currently going through employment checks)	3 Gap (LTFT gaps & 1 wte vacancy - currently going through employment checks)	3 Gap (LTFT gaps & 1 wte vacancy - currently going through employment checks)	
Medicine	General Medicine Higher	21	13	5 WTE	18		-1	-2		2 Gap (1 Resignation / 1 Acting Up)				1 Gap (Acting Up)				Recruited however doctor not doing on-calls, filling gaps with locums)
Medicine	ED SHO	14 WTE	2 ACCS / 4 GPVTS / 1 Deanery (2017-18 only) / 1 Military	7 WTE	12.15	2 Trust funded Gaps (Not recruited to)												Over established
Medicine	ED Middle Grade	10 WTE	6 wte	4 wte	8.1	2 Trust funded Gaps (recruitment for 1 clinical fellow from November)			1 Gap (covered by locums / until)		1 Gap (Ellie Day returns)	-1	-1	-1				Rota written to accommodate people
Medicine	Dermatology	6	4.6 wte	2 wte	5.6	0.4 Gap	0.4 Gap	1.4 Gap	1.4 Gap	2 gap	2 gap	1.4	1.4	1.4	1.4	2.4	2.4	Gaps managed by re-writing rota. New recruitment episodes for 2 CFs from August 2018.
Medicine	GUM	0	1 wte	0 wte	1													No on-call rota

Division	Rotas	Rota slots (WTE)	Post Funding Deanery	Post Funding Trust	Current WTE on Rota	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Comments: was the gap covered and how?
W&C	ST3-8 Paediatric Anaesthesia	8 WTE	4 Deanery Funded	4 Trust funded (fellows)	7.6						0.8							
W&C	O&G FY2 & ST1-2	12 WTE	12 WTE	0 WTE	12							1 Gap (Resignation)	1 Gap (Resignation)					
W&C	O&G ST3-5	9	5 WTE	3 WTE	8													No gaps as working to 9 as a minimum
W&C	O&G ST6+	9	6 WTE	2 WTE	6						3 Gaps (Maternity Leave			3.2 Gap (Maternity leave & LTFT)	2.6 Gap	2.2	2.2	Advertising
W&C	PICU ST1-8	18	10.5	9 WTE	18													Rota written to accommodate numbers
W&C	Paeds Cardiac Surgery	3	0 WTE	3 WTE	3													
W&C	Paeds Neurosurgery	6	0 WTE	3 WTE	3		3	3	3	3	3	2	1	1	1	1	1	Recruitment undeerway. Waiting for pre-employment checks
W&C	Paeds Surgery FY2 & ST1-2	5	1 F2 / 1 ST1-2	3 CF	3													
W&C	Paeds Surgery ST3+	9	4 wte	4 wte	8		1	1	1	1	1	1						
W&C	NICU ST1-3	9	7 wte	3 wte	10		-1	-1	-1	-1								
W&C	NICU ST4+	9	7.2 wte	1.7 wte	8.9		0.1	0.1	0.1	0.1								
W&C	Paediatric Oncology ST6-8	6	3 wte	3 wte	5.6		0.6	0.6	0.6	0.6								

W&C	Paediatric Cardiology ST3-8	8	5.6 wte	3 wte (1 CF st1-2, 2 ST3-8)	8.6								0.4 (LTFT Gap)				
W&C	General Paeds F2 & GPVTS	6	6 WTE 3 F2 / 3 GPVTS	0 wte	6		-0.5	-0.5	-0.5	-0.5	-0.5	-0.5					Rota oversubscribed 0.5 Supernumerary F2
W&C	General Paeds ST1-3	13 wte	13 wte (2 ED F2s / 10.8 ST1-3)	0 wte	12.8 wte		0.6	0.6	0.6	0.6	0.6	0.6					
W&C	General Paeds ST4+	27 WTE	25 wte	4 wte	29		-2	-2			1.7	0.7	2	2.9			Rota oversubscribed Sept/Oct, 1x CF and 1x rotational Dr leave in Nov
W&C	Paeds T&O	12	4	0	4												

Division	**Rotas**	**Rota slots (WTE)**	**Post Funding Deanery**	**Post Funding Trust**	**Current WTE on Rota**	**Aug-18**	**Sep-18**	**Oct-18**	**Nov-18**	**Dec-18**	**Jan-19**	**Feb-19**	**Mar-19**	**Apr-19**	**May-19**	**Jun-19**	**Jul-19**	**Comments: was the gap covered and how?**
SPS	FY2 and CMT Heam/Onc	11	10 WTE	1 WTE	2 x FY2 and 9 CMT's	1 Gap (1/8/18 - 12/8/18)												
SPS	Haematology ST3+			8.5 WTE	8.5 Deanery funded	1 ACF Gap						1.4 Gap						
SPS	Medical & Oncology SpR	10	11	0	11.4													
SPS	Cardiology SpR			17 WTE	9													
SPS	Cardiac Surgery SpR	13 WTE	7	6	7			2 Trust Gaps (out to recruitment)										

Division	Rotas	Rota slots (WTE)	Post Funding Deanery	Post Funding Trust	Current WTE on Rota	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Comments: was the gap covered and how?
TS	Occupational Health	3	1	2	3													
D&T	Radiology ST1	5	5	0	4.5	0.5	0.5	0.5	0.5	0.5	0.5							1 wte filled by 0.6wte trainee. Remaining 0.4wte not filled.
D&T	Radiology ST2-5	10	10	0	9				1	1	1	1	1	1	1	1	1	Nov18 - Feb 19 1wte on Mat leave. Feb - Aug 19 Deanery ST3 gap, no replacement found.
D&T	Peadiatric Perinatal Pathology	1	1	0	0	1	1	1	1	1	1	1	1	1	1	1	1	No trainee, deanery aware and trying to find resolution
D&T	Chemical Pathology	2	2	0	1	1					2	2	2	2	1	1	1	ST1-5 Chem Path & Metabolic Medicine post part of national recruitment managed by East Midlands Deanery. This gap has been added to their national recruitment process to be appointed in Aug 2019 if successful.
D&T	Microbiology	5	5 - Funding sits with NBT for these posts	0	5													Honorary contracts for these trainees as NBT pays the salaries

Internal Locum Utilisation

The Trust consistently employs junior doctors to carry out between 4,00 and 5,000 hours of internal locum activity each month. This is equivalent to the work of additional 30 – 37 whole time equivalent staff.

Whilst this additional work is used to cover rota gaps it is also used to cover short notice absence and additional clinical activity such as weekend clinics. However, as shown below, sickness absence is likely to be only responsible for a small part of this additional work.

Sickness data

Medical staff sickness remains significantly lower than other staff groups. As this is a key indicator of staff wellbeing it is something that is monitored and reported on as part of the Guardian role.

387 Absence Timeline_QV M&D - Apr18 -Mar19

		Quarter 4		
		Absence FTE	FTE (Assignment)	Absence %
387 UH Bristol NHS Foundation Trust		**1,523.82**	**109,654.25**	**1.39%**
387 Diagnostics And Therapies		**14.60**	**6,702.71**	**0.22%**
	Consultant	7.00	2,475.24	0.28%
	Other Medical & Dental	7.60	4,227.47	0.18%
387 Medicine		**298.81**	**19,215.70**	**1.56%**
	Consultant	89.45	6,795.17	1.32%
	Other Medical & Dental	209.36	12,420.52	1.69%
387 Specialised Services		**91.51**	**15,449.46**	**0.59%**
	Consultant	40.65	7,289.52	0.56%
	Other Medical & Dental	50.86	8,159.94	0.62%
387 Surgery		**805.39**	**34,332.34**	**2.35%**
	Consultant	295.37	12,665.87	2.33%
	Other Medical & Dental	510.02	21,666.47	2.35%
387 Trust Services		**8.00**	**1,185.08**	**0.68%**
	Consultant	0.00	249.08	0.00%
	Other Medical & Dental	8.00	936.00	0.85%
387 Womens And Childrens		**305.51**	**32,768.97**	**0.93%**
	Consultant	147.20	15,354.46	0.96%
	Other Medical & Dental	158	17,415	0.91%

Discussion of issues arising

As already stated the reasons for rota gaps and the potential solutions for them are complex. There are, however, some important issues to highlight:

1. The Trust has very little control over the number of trainees being sent by the Deanery. There has been a significant increase in the number of Locally Employed Doctor (Trust grade) posts to try and reduce the impact of fluctuating numbers of Deanery trainees. It has been challenging to recruit to these posts in a number of areas as there is significant competition from neighbouring Trusts and a very limited pool of suitable trainees nationally. Several posts have failed to recruit despite repeated attempts at recruitment.

2. Problems are particularly acute in medicine, some surgical and haematology rotas. There are significant changes being made to core medical training which are likely to exacerbate this problem for more senior specialist rotas (although it may improve the picture in the Core Medical rotas)
3. Rota gaps and long standing structural issues mean that many of the rotas across the Trust have less than the recommended number of doctors required to run an effective full shift rota. This means that it can be difficult for doctors to access annual leave and study leave.
4. Under resourcing and complex processes within the medical HR department continue to cause intermittent issues in recruitment of Trust grade positions resulting in difficulties recruiting in a timely fashion.
5. New rota rules mean that the time Junior Doctors are less available to carry out additional work and willingness to carry out additional work to cover gaps and absence is reduced. This has meant that there has been an increased need for acting down by Consultants to ensure safe medical cover is maintained. This has an effect on the ability to deliver core Trust activity.
6. As an organisation we have lower numbers of nurse practitioner and physicians assistant roles than our neighbouring Trusts. This reduces our ability to absorb fluctuations in trainee numbers on rotas.

Actions required to resolve issues

1. There is an urgent need to carry out a major junior medical workforce review with a particular focus on out of hours activity and the possibility of "Hospital at Night" working. This review should also aim to determine the minimum number of doctors required on each rota and actions that could be taken to achieve these staffing levels.
2. The Trust wide workforce strategy needs to develop a strategy for the recruitment and training of advanced practitioner / physician assistant roles. These roles take around 2 years of training before being able to work independently so minimising any further delay in recruiting to these posts should be a priority.
3. Consideration should be given to improving our processes for attracting and recruiting international medical graduates for fellowships and other posts. It has been suggested that a dedicated team (perhaps working city / region wide) could help manage the complexities and increased support required to employ these doctors.
4. Medical HR continue to roll out e-Rostering for junior doctors. Once implemented this will hopefully improve real time information about rota gaps and improve the internal locum processes. It may be beneficial to establish a city wide "Trust Bank" to increase the number of doctors available to cover shifts. It is essential that this project is resourced properly on an ongoing basis (mainly by developing rota manager roles within each division) to ensure it is effective.

Summary

Rota gaps have become a significant issue affecting the Trusts ability to ensure the delivery of safe staffing levels in most areas of the Trust. As this issue appears to worsening it is vital that the Trust take actions to address these as a matter of urgency. These gaps have a significant impact on job satisfaction and overall morale within the junior doctor group and cause difficulties in delivering medical education.

The solutions are likely to be complex and will involve a significant review of current working practices and consideration of recruitment of a “non medical” workforce to reduce the impact of gaps.

Dr Alistair Johnstone

Guardian of safe working

June 2019

Meeting of the Public Board on Tuesday 30 July 2019 in the Conference Room, Trust Headquarters

Report Title	**Annual Fire Report**
Report Author	**Andy Headdon- Director of Estates and Facilities**
Executive Lead	**Mark Smith, Chief Operating Officer**

1. Report Summary

This Report summarises the main fire safety issues for 2018-19 and incorporates all aspects of fire safety relating to UH Bristol and covers the period from 1st April 2018 to 31st March 2019.

2. Key points to note
(Including decisions taken)

A small number of actual incidents have arisen during the reporting period in terms of actual fires, notably the major incident relating to the Bristol Oncology and Haematology Centre. This report does not attempt to fully rehearse all the learning from that incident, as this has been fully reported in detail through other forums.

Within this reporting period, a significant capital investment (£4.5m) has been approved to address the identified compliance issues relating to the 60 minute compartmentation across the estate.

A key recommendation from the Serious Incident report into the BHOC has been the establishment of a dedicated Fire Safety Committee to oversee all fire related issues and has been in place for some months. Avon Fire and Rescue Service is a key member of the committee.

The report also summarises the key risks relating to fire safety, the progress towards reducing unwanted fire signals and the external audits undertaken.
A key requirement of the current guidance is to reduce the number of unwanted fire signals and whilst the year on year trend has been reducing, a peak was experienced in November due to a water leak that affected the system.

A number of external audits have been undertaken, which have reviewed all the current policies and procedures and only relatively minor procedural updates were required to complete the resulting action plans.

3. Risks
If this risk is on a formal risk register, please provide the risk ID/number.

N/A

4. Advice and Recommendations
(Support and Board/Committee decisions requested):

- The report is for **ASSURANCE**.
- The Board is asked to **NOTE** the report.

5. History of the paper
Please include details of where paper has previously been received.

SLT	17th July 2019

Fire Safety Committee	25th June 2019

University Hospitals Bristol
NHS Foundation Trust

Annual Report of Fire Safety 2018/19

Contents

Annual Fire Safety Report 2018-19

1.0 Executive Summary

This Report summarises the main fire safety issues for 2018-19 and incorporates all aspects of fire safety relating to UH Bristol and covers the period from 1st April 2018 to 31st March 2019.

A small number of actual incidents have arisen during the reporting period in terms of actual fires, notably the major incident relating to the Bristol Oncology and Haematology Centre. This report does not attempt to fully rehearse all the learning from that incident, as this has been fully reported in detail through other forums.

Within this reporting period, a significant capital investment (£4.5m) has been approved to address the identified compliance issues relating to the 60 minute compartmentation across the estate.

A key recommendation from the Serious Incident report into the BHOC has been the establishment of a dedicated Fire Safety Committee to oversee all fire related issues and has been in place for some months. Avon Fire and Rescue Service is a key member of the committee.

The report also summarises the key risks relating to fire safety, the progress towards reducing unwanted fire signals and the external audits undertaken.

A key requirement of the current guidance is to reduce the number of unwanted fire signals and whilst the year on year trend has been reducing, a peak was experienced in November due to a water leak that affected the system,

A number of external audits have been undertaken, which have reviewed all the current policies and procedures and only relatively minor procedural updates were required to complete the resulting action plans.

2.0 Introduction

The current fire legislation in the form of the Regulatory Reform (Fire Safety) Order 2005 requires a managed risk approach to fire safety. The process of fire risk assessment, mitigation and review requires a robust system of management capable of identifying hazards, qualifying their impact, devising appropriate mitigation and continual monitoring.

The presence of a robust system of fire safety management is a key influence in fire risk assessment and is the determining factor in evaluating the level of fire risk.

In a healthcare environment with high dependency patients, it is unlikely that any amount of physical fire precautions on their own can reduce fire risks to an acceptable level. Adequate risk mitigation can only be achieved with the provision of a sufficient number of suitably trained staff, an environment in which the fire precautions are well maintained and effective emergency plans that have been sufficiently rehearsed.

The Fire Safety Policy, Procedures and Guidelines were revised and updated and were approved by Fire Safety Committee in April 19.

3.0 Compliance

The following summary gives brief details of the Trusts development towards compliance with the mandatory requirements for the NHS in England, as set out in Health Technical Memorandum 05 Firecode.

Requirement	Progress	R	A	G
Clearly defined fire policy	Compliant			
Board level Director accountable to the Chief Executive for fire safety	Compliant			
Fire Safety Manager to take the lead on all fire safety activities	Compliant			
Adequate means for quickly detecting and raising the alarm in case of fire	Compliant			
Means for ensuring emergency evacuation procedures are suitable and sufficient for all in-patient areas, without reliance on external services	Emergency Evacuation Plans (EEP)'s have been distributed to all wards to aid them in understanding the alternative routes they could take when carrying out Progressive Horizontal Evacuation. Theatre EEP's have also been prepared for Children's. Other Theatres are being prepared. Significant investment has been put into the provision of additional evacuation equipment and training across the estate.			
Requirement	**Progress**	**R**	**A**	**G**
Staff to receive fire safety training appropriate to the level of risk and duties they may be required to perform	Mandatory fire safety training is at 89%			
Reporting of fires and unwanted fire signals	Compliant			
Partnership initiatives with other bodies and agencies involved in the provision of fire safety	Compliant			

4.0 Non-Compliance Notices

A summary the six non-compliance notices issued within the reporting period are included at Appendix 1. These are largely minor operational issues and all non-compliances have been rectified within the period required.

5.0 Inspections and Risk Assessments

5.1 Fire Risk Assessments (FRA) have been reviewed for the Trust's hospital buildings, and the assessments for the thirty associated buildings are part of an ongoing annual rolling programme.

5.2 Avon Fire & Rescue Services (AF&RS) have continued to meet with the Fire Safety Advisor (FSA) on a quarterly basis to review the progress of the enhanced fire precautions works, training and UFS

5.3 In the forthcoming year, Fire Safety Audits will continue to be carried out by the FSA in accordance with Section 6 of the Trust Fire Safety Policy, the results of which will be reviewed by the Fire Safety Committee.

5.4 A summary of the current fire related risks that are managed by the E&F Division are as shown below;

Risk No	Rating	Detail	Controls
398	**4 Moderate**	Risk that fire brigade may experience delays resulting in more damage due poor proximity of fire hydrant placement at South Bristol Community Hospital	Consultation with Landlord to provide necessary fire-fighting medium.
498	**2 Low**	Risk that in the event of a fire, dampers situated in ventilation ducts may fail due to them not being maintained.	Maintenance contract in place and known dampers being serviced
499	**6 Moderate**	Risk that fire door may fail to operate correctly due to them not being maintained	RAG rating of all fire doors being carried out so maintenance can be commenced
972	**12 High**	Risk that the Trust is non-compliant with Fire Safety Regulations	Survey and specification for compartmentation works under way through appointed consultants as part of funded 2 year improvement programme.
1365	**4 Moderate**	Risk of not providing working fire precaution equipment	Sufficient funding approved to provide necessary equipment
1627	**5 Moderate**	Risk of Helicopter crash on helideck or adjoining roofs and subsequent damage and injury	Fire Service familiarisation visits. Staff on duty to deal with such incidents. Incident simulation exercise recently conducted with AFRS
2217	**8 High**	Risk of spread of fire & smoke as a result of damage to fire doors not being reported	Fire Wardens required to check fire doors on regular basis and to report damage on Agility so doors can be repaired/replaced
2550	**12 High**	South Bristol Community Hospital Fire Precautions	Survey carried out by independent Fire Advisor and long list of non-compliances found. Consultation with Landlord to provide necessary fire precautionary works, progress being made to resolve identified

			issues.
2557	**4 Moderate**	Risk of prosecution via the RRO due to Emergency Lighting not being maintained	Survey carried out in all buildings and remedial works and testing in progress
2734 draft	**5 Moderate**	Risk of non-compliance with Fire Safety Regulations	Fire safety training, routine fire checks
2790	**12 High**	Risk that fire alarm may not be triggered due to overload on fire alarm system	Non fire alarm signals being re-routed where possible, funding secured to create alternative network for all non-fire related signals.

6.0 Reducing Unwanted Fire Signals in Healthcare Premises

6.1 All fire signals are received at the Estates Office on a fire alarm terminal and are responded to by the FSA and members of the Estates Fire Team. Reports of alarm activations are also received electronically through the on-line reporting system. These are recorded and trends are monitored and acted upon. (Appendix 2)

6.2 The number of unwanted fire signals during the period 2018-19 was 74, where the Fire Service was called on 30 occasions. The 44 incidents where the Fire Service was not called were during working hours, and were investigated by the Trust Fire Team.

6.3 Firecode Health Technical Memorandum (HTM) 05-03 Part H sets standards which Trusts are expected to meet with regard to reducing false alarms, or UFS in healthcare premises. The UFS received during the period covered by this report have been analysed against these standards, and the following table identifies the frequency for each cause. Overall, as a Trust we have significantly reduced our UFS over the past few years and as a Trust comply with the requirements of HTM 05-03 Part H. It is only two buildings that need to be addressed.

Building	No of false alarms	No of devices	Grading	Annual Improvement Goal
Children's	5	2341	A	To be maintained
Queens	11	4607	A	To be maintained
TSB	5	2348	A	To be maintained
St Mk's	7	2030	A	To be maintained
Dermatology/SSDC	1	127	A	To be maintained
BHOC	6	1495	A	To be maintained
Eye	6	1114	A	To be maintained
BHI	6	1252	A	To be maintained
IM&T	6	169	C	Reduce by 40%
KEB	19	1579	B	Reduce by 10%
THQ	1	188	A	To be maintained
Dental	7	973	A	To be maintained

6.4 The remedial action is determined by dividing the number of fire alarm devices in a building by the number of unwanted fire signals (UFS). The resulting figures are compared to the standard within the HTM. This being:

>100	**=**	**Performance should be maintained**
<100 & >50	**=**	**reduce by 10%**
<50	**=**	**reduce by 40%**

One site is required to reduce by 40% their UFS, and one by 10%, but in practical terms with the way the results are calculated, any building with less than 99 devices will always fail if they have an UFS. The number of UFS is mainly due to environmental issues such as steam and rain penetration and the misuse of manual call points (mcp's) by visitors. Protective covers have now been fitted to mcp's wherever possible to try to reduce this number. Estates and Radio Pharmacy are reported together.

The 74 total UFS received during the year average at 1.4 per week. Performance targets for the year were set to reduce the number of UFS from the previous year. This was not achieved due to the false alarms encountered in November where sever water ingress was encountered in King Edward Building. With that in mind the target for 2018–19 will be set again to reduce the total number.

7.0 Serious Incidents and Fires

During the period covered, there have been 3 small fires, and 1 major incident in BHOC. (Appendix 3)
Two small fires occurred in BHOC and St Michaels that were dealt with locally by Trust staff.
A major incident occurred in BHOC as a result of a catastrophic failure of a power factor correction unit in the main low voltage electrical panel serving the building. The resulting Serious Incident report identified a number of learning points including

- Implementation of a SOP to manage works above ceilings- this is to maintain the integrity of the existing fire compartmentation
- A review of evacuation equipment across the estate- new equipment has been purchased, installed and on-going training is in place
- A review of emergency lighting across the estate- this has been completed and remedial works and testing are now in place.
- The need to implement 5 year fixed wire testing- this has now been specified and is currently at tender stage.

8.0 Fire Strategy

The Fire Strategy Document is the basis for the design of all capital projects, both strategic and operational and is reviewed annually. It was prepared by the Fire Safety Advisor as a model for all Healthcare buildings in 2011, and the latest amendment made in 2016, and is current at the time of this report.

AF&RS have continued with their reduced pre-determined attendance at fire alarm activations. Instead of the four appliances we received in the past, now only one appliance attends initially to assess the situation.

The additional fire extinguishers on trolleys located in the every level in the stairwell/lift lobby for easy access in fire conditions by AF&RS and the Trust Fire Team will remain.

9.0 Schemes carried out during 2018-19 which enhanced fire safety provisions

- Provision of 1hr Fire Resistant (FR) cupboards in Children's goods lift lobbies
- Replacement fire doors where existing asbestos lined doors are damaged
- Provision of evacuation equipment where required
- Provision of 4 fire alarm repeater panels in Children's, Queens and St Michael's
- Provision of additional early warning devices in BHOC ward areas
- Up grading evacuation aids in Education Centre
- Repairing fire stopping where cables etc have been found to have penetrated
- Sprinkler repairs where necessary
- Replacement water damaged damper control panel
- Door hold open devices to assist in ease of movement of patients, visitors and staff with trollies and bins
- Going back over works to capital projects carried out in last 5 yrs. where fire precautionary works were not carried out
- Door number signs to assist in fire alarm investigation
- Provision of replacement fire doors to level 1 Central Health Clinic
- Installation of ceiling hatches where required to allow access to dampers in ceiling voids
- Provision of fire precautionary works for Capital jobs where unforeseen work is uncovered that does not comply with Trust Fire Strategy

10.0 Schemes to be carried out during 2019 - 20 in the rolling programme of fire precautionary works

- Replacing the obsolete fire alarm warning system in Dental Hospital. The detector heads and interfaces are no longer manufactured or serviceable. The system is operating satisfactorily at present.
- Replacement of out of date fire suppression system IM&T Computer Room 1 & Queens Computer Room 2
- Survey of areas where no known fire dampers exist Trust-wide
- Servicing of fire doors Trust-wide
- Fire precautionary works to levels 1 & 4 Queens Building and levels 1, 2 & 3 Eye Hospital
- Replacement fire doors level 1 & 3 Central Health Clinic
- Door hold open devices to assist in ease of movement of patients, visitors and staff with trollies and bins
- Provision of 60min FR waste cupboard at St Michael's
- Provision of 60min linen cupboards around trust to remove portable trolleys from means of escape routes

11.0 Fire Safety Training & Awareness

Fire Safety awareness training for this period has not met the requirements of Firecode HTM 05-01, the Care Quality Commission, the British Safety Council Audit and the Trust standard of 90%. The Trust organised training includes: Induction, Fire Safety Up-dates for both clinical and non-clinical staff. Attendance at these sessions is low, with many non-attendances (DNA's) due to staff not being released, shift patterns, sickness, leave and forgetting.

The training in Fire Safety Awareness to clinical staff was re-instated in January 2016. Ward Evacuation training and live fire extinguisher training, continues within Tyndalls Park Training Centre and has involved AF&RS who use the training sessions for training of their fire fighters should they ever need to attend a serious fire or incident involving evacuation of staff and patients. AF&RS have also attended site to train on rope rescue from the top of St Michael's chimney should any member of staff or contractor have a situation where rescue would be necessary.

In the period 1st April 2018 to 31st March 2019, the Fire Safety Team have provided 29 Fire Warden Courses with 170 attendances, 18 Ward Evacuation Courses with 53 attendances. These numbers attending these courses are approx 70% of those places originally booked, 30% DNA.

Additional training organised by the Fire Safety Team includes:

Fire Safety Up-dates on location
Fire Warden
Ward Evacuation
Fire Extinguishers
Fire Risk Assessments
Evacuation equipment
Shift Engineers fire alarm awareness

12.0 External Audits

During the period covered by this report, there have been four external audits which have looked at fire safety.

The British Safety Council in their audit, item 3.22 Fire Safety Management (protective and preventative controls) rated Fire Safety Management within the Trust at 100% with no observations or requirements.

Our Insurer carried out an inspection and raised several issues, all of which have been concluded.

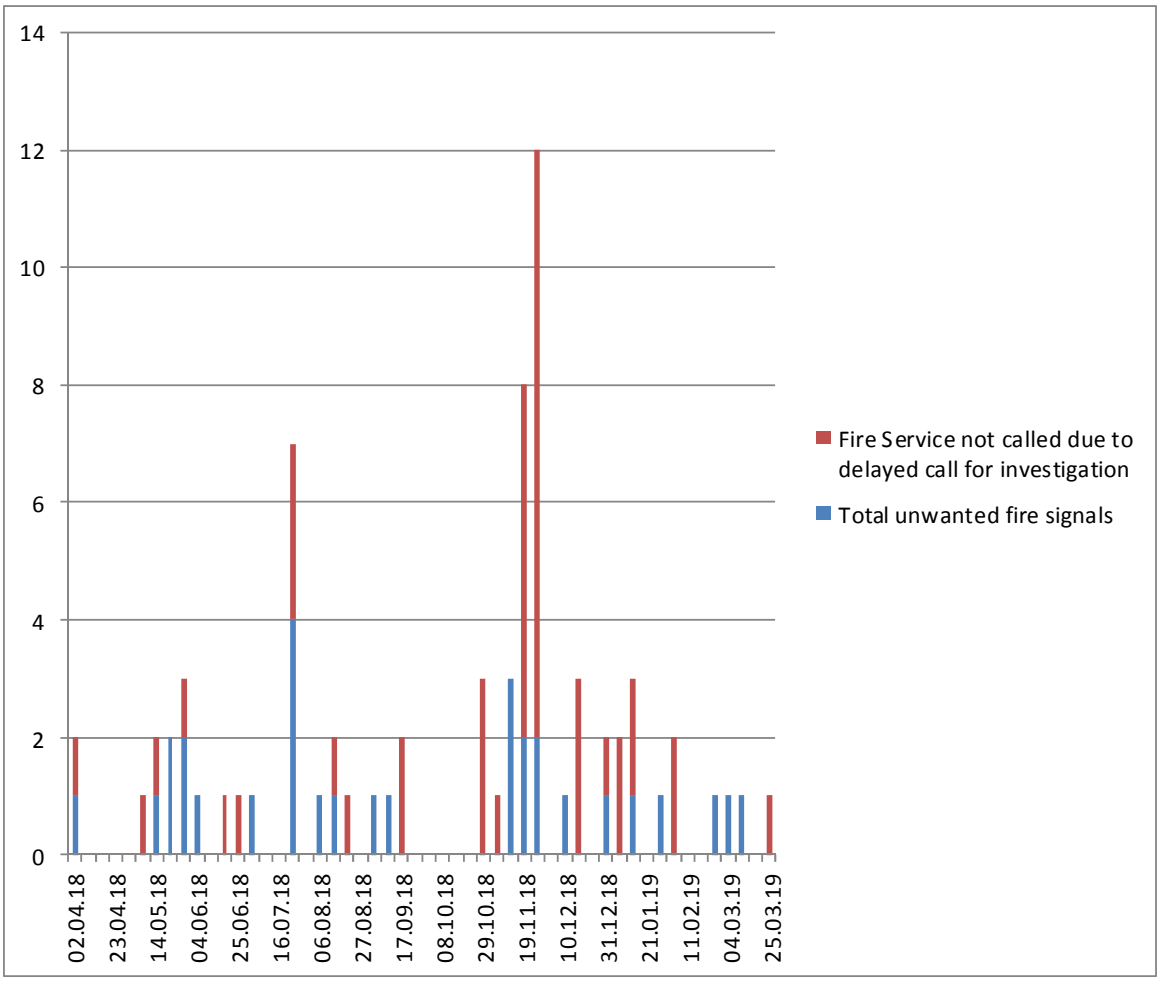
An external auditor inspected the records and procedures relating to fire safety within the Premises Assurance Model and graded as yellow and amber, which require minor improvements.

The external Authorised Engineer (Fire) audited the Fire Safety Advisor as part of the annual audit process and identified issues that only required minor procedural amendments.

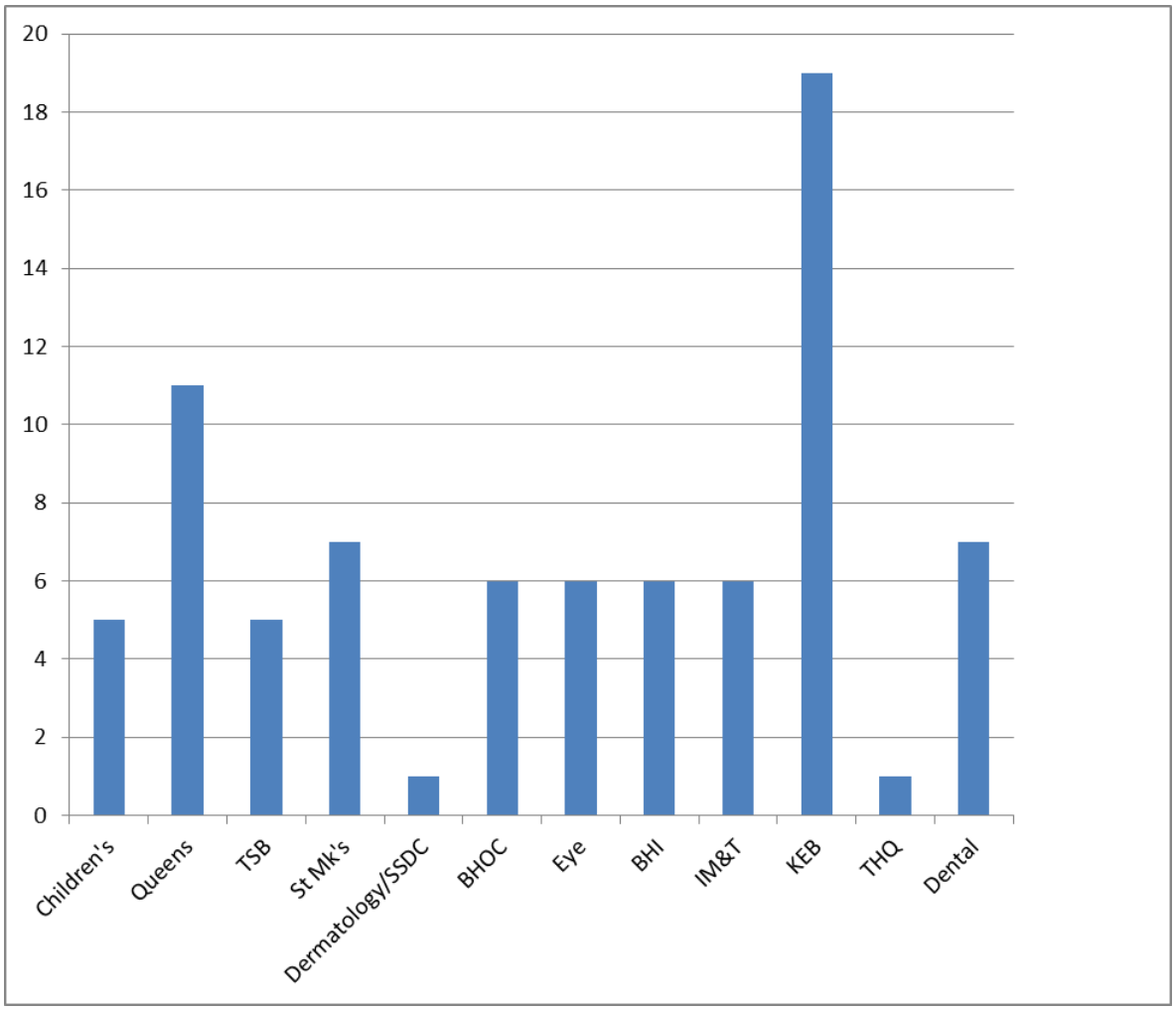
Appendix 1 – Non Compliance Notices

No	Recipient	Non-Compliance
1-00143	Portering Manager	Waste accumulation around liquid oxygen vacuum insulated evaporator (VIE) plant in Estates car park and along Alfred Parade
1-00144	Senior Estates Manager Building	Installation of non-compliant window in 30min fire resisting wall
1-00145 to 1-00152	Hotel Services Operations Manager	Kitchen and Pantry doors being wedged open with metal waste bin whilst room being used but un-occupied, and damaged orders for repair have been placed(8)
1-00153	Dental H&S Manager	Storage of flammable gas canisters and other flammable materials in means of escape corridor
1-00154	External Contractor	Failing to carry out necessary works to prevent unwanted fire signals
1-00155	Hotel Services Manager	Allowing waste bins to be stored on means of escape corridor Allowing waste bins to be left un-locked with flammable waste inside in means of escape corridor Allowing waste bins to smash emergency break glass

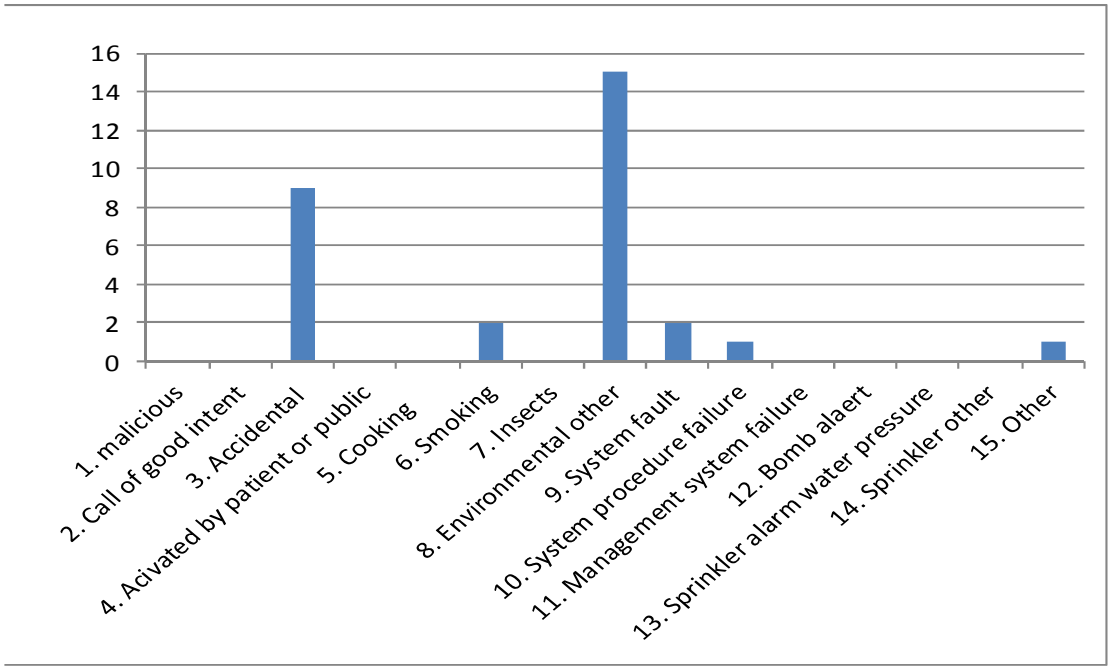
Appendix 2a - Unwanted Fire Signals Analysed by Week 2018 – 19



Appendix 2b - Unwanted Fire Signals Frequency Analysed by Location 2018 - 19



Appendix 2c – Unwanted Fire Signals 2018 – 19 Analysis of Cause & Frequency



Appendix 3 - Fire Incidents

10.05.18	BHOC Fire in LV plant room level 1 resulting in loss of electrical switchgear and sever smoke damage to building. A fire started in the electrical Low Voltage panel on level 1 of the Bristol Oncology and Haematology Centre at 00.50am on the 10th May 2018. The fire destroyed the Low Voltage panel and led to a complete electrical failure to the building. The fire was contained within the Low Voltage Switch room but smoke entered the building affecting all floors.
30.01.19	BHOC D603 A light 'blew off' the wall and there was a small fire. The patient put the fire out due to radiation contamination and restricted access for staff.
10.02.19	Queens, A602 Patient set fire to oxygen pipe whilst smoking in bed.
20.02.19	St Michael's Underground car park. Visitor's car caught fire on entering car park. Driver extinguished fire with Trust powder extinguisher. AF&RS called and confirmed fire extinguished.

Meeting of the Board of Directors in Public on Tuesday 30 July 2019 in the Conference Room, Trust Headquarters

Report Title	**Patient Experience Q4 Report**
Report Author	**Paul Lewis, Patient Experience and Involvement Team Manager**
Executive Lead	**Carolyn Mills, Chief Nurse**

1. Report Summary

This report item provides a review of patient-reported feedback received via the Trust's corporate patient survey programme, up to and including Quarter 4 2018/19. It also includes examples of current patient experience and involvement activity at the Trust.

2. Key points to note

(Including decisions taken)

- All of UH Bristol's headline Trust-level patient satisfaction survey measures were above their target levels in Quarter 4, indicating the continued provision of a high quality experience for our service-users.
- A number of wards in the Bristol Royal Hospital for Children achieved particularly positive survey scores in Quarter 4.
- A number of wards in the Division of Medicine had below target survey scores in Quarter 4 – in particular wards A528 and C808. There are a number of staff vacancies on these wards, leading to a higher-than-usual use of temporary staff. This can have knock-on effects in terms of continuity of care and patient experience. A number of actions are being taken by the Division to mitigate this issue, alongside a recruitment process to fill the vacant posts.
- Four comments received via the Friends and Family Test in Quarter 4 raised issues around support for patients who have mental health problems whilst in hospital. This is already a significant focus at UH Bristol via the Mental Health Steering Group and the Trust's Risk Management processes. A more detailed analysis of patient feedback data from patients with mental health issues is currently being carried out by the Patient Experience and Involvement Team, to help inform the work of the Steering Group and identify further opportunities for improving this aspect of our care.
- The Trust's new electronic patient and visitor feedback system, Optimum Contact, went live – with six touchscreen feedback points installed in the Bristol Royal Infirmary.
- The Trust's new mystery shopping programme, "My Journey", was launched in Quarter 4. Mystery shoppers visited Cardiac and Dermatology services.

3. Risks

If this risk is on a formal risk register, please provide the risk ID/number.

The risks associated with this report include:

None.

4. Advice and Recommendations *(Support and Board/Committee decisions requested)*:	
• This report is for **INFORMATION**. • The Board is asked to **NOTE** the report.	
5. History of the paper **Please include details of where paper has previously been received.**	
Patient Experience Group	23 May 2019
Senior Leadership Team	19 June 2019
Quality and Outcomes Committee	25 June 2019

University Hospitals Bristol
NHS Foundation Trust

Quarterly Patient Experience and Involvement Report

Incorporating current Patient and Public Involvement activity and patient survey data received up to Quarter 4 2018/19

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

Patient Experience and Involvement Team

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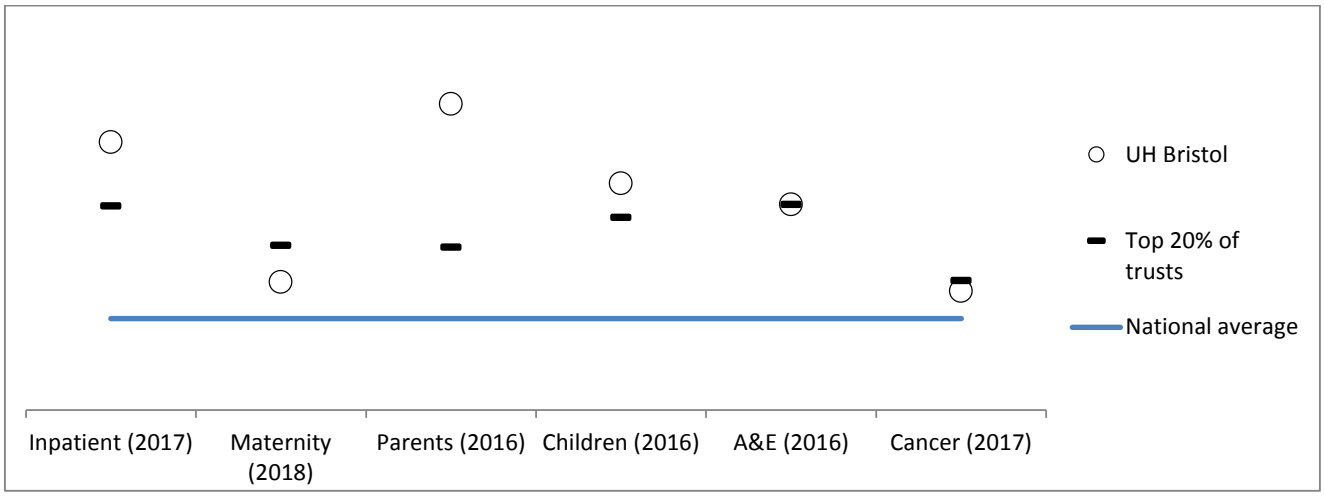
1. Overview of patient-reported experience at UH Bristol

Successes	Priorities
• All of UH Bristol's headline Trust-level patient satisfaction survey measures were above their target levels in Quarter 4, indicating the continued provision of a high quality experience for our service-users • A number of wards in the Bristol Royal Hospital for Children achieved particularly positive survey scores in Quarter 4 • The Trust's new electronic patient and visitor feedback system, Optimum Contact, went live – with six touchscreen feedback points installed in the Bristol Royal Infirmary • The Trust's new mystery shopping programme, "My Journey", was launched in Quarter 4. Mystery shoppers visited cardiac and dermatology services.	New electronic touchscreen feedback points were installed in the Bristol Royal Infirmary in Quarter 4. The Patient Experience and Involvement Team is currently developing the implementation plan for "Phase 2" of this project, with the aim to complete this during the 2019 calendar year. This will see feedback points installed in all of the Trust's hospitals. The Trust's response rates to the Friends and Family Test (FFT) survey in the outpatient and Emergency Departments have dipped in recent months. This was discussed at the Patient Experience Group in May 2019. The Emergency Departments will increase the number of FFT cards being handed out to patients. In addition, new survey touchscreens for the Departments are being sourced to increase opportunities for patients to give feedback via this survey. In respect of the Outpatient FFT, this is primarily carried out by SMS (text message); we are currently working with the Trust's contractor to establish why the rates have declined in recent months.
Opportunities	**Risks & Threats**
The Trust's corporate quality improvement objectives for 2019/20 include a number of ambitions relating to improving patient experience and involvement, including: • Developing training and support for "lay representatives" (patients and members of the public who sit on Trust groups and committees) • Improving the ability of people with a disability to plan their hospital visit in advance, via detailed pictures and accessibility information available on the Trust's website • A focus on better support for young carers.	• A number of wards in the Division of Medicine had below target survey scores in Quarter 4 – in particular wards A528 and C808. There are currently a number of staff vacancies on the ward, leading to a higher-than-usual use of temporary staff. This can have knock-on effects in terms of continuity of care and patient experience. A number of actions are being taken by the Division to mitigate this issue, alongside a recruitment process to fill the vacant posts. • Four comments received via the Friends and Family Test in Quarter 4 raised issues around support for patients who have mental health problems whilst in hospital. This is already a significant focus at UH Bristol via the Mental Health Steering Group and the Trust's Risk Management processes. A more detailed analysis of patient feedback data from patients with mental health issues is currently being carried out by the Patient Experience and Involvement Team, to help inform the work of the Steering Group and identify further opportunities for improving this aspect of our care. An update on this analysis and the response to it will be provided in the next Quarterly Patient Experience and Involvement Report.

2. National benchmarks

The Care Quality Commission's national survey programme provides a comparison of patient-reported experience at UH Bristol against other English NHS hospital trusts. The results show that UH Bristol tends to perform better than the national average in these surveys (Chart 1). There were no national survey results published in Quarter 4 (in Quarter 1 2019/20 we anticipate receiving the 2018 national inpatient survey results). The results of each national survey, along with improvement actions / learning identified from them, are reviewed by the Trust's Patient Experience Group and the Quality and Outcomes Committee of the Trust Board.

Chart 1: UH Bristol's hospital based patient-reported experience relative to national benchmarks



3. UH Bristol survey data – Quarter 4 update

Table 1 provides an overview of UH Bristol's headline survey metrics in Quarter 4. Overall, UH Bristol continues to receive very positive feedback from the people who use our services. An exception report is provided on the next page detailing areas that did not perform at the expected levels.

Table 1: summary of headline survey metrics

	Current Quarter (Quarter 4)	Previous Quarter (Quarter 3)
Inpatient experience tracker score	Green	Green
Inpatient kindness and understanding score	Green	Green
Inpatient Friends and Family Test score	Green	Green
Outpatient experience tracker score	Green	Green
Day case Friends and Family Test score	Green	Green
Emergency Department Friends and Family Test score	Green	Green
Inpatient / day case Friends and Family Test response rate	Green	Green
Outpatient Friends and Family Test response rate	Red	Red
Emergency Department Friends and Family Test response rate	Red	Green

Table 2: Patient survey scores - exception reports for Quarter 4 (the full data can be found in Section 4 of this report)

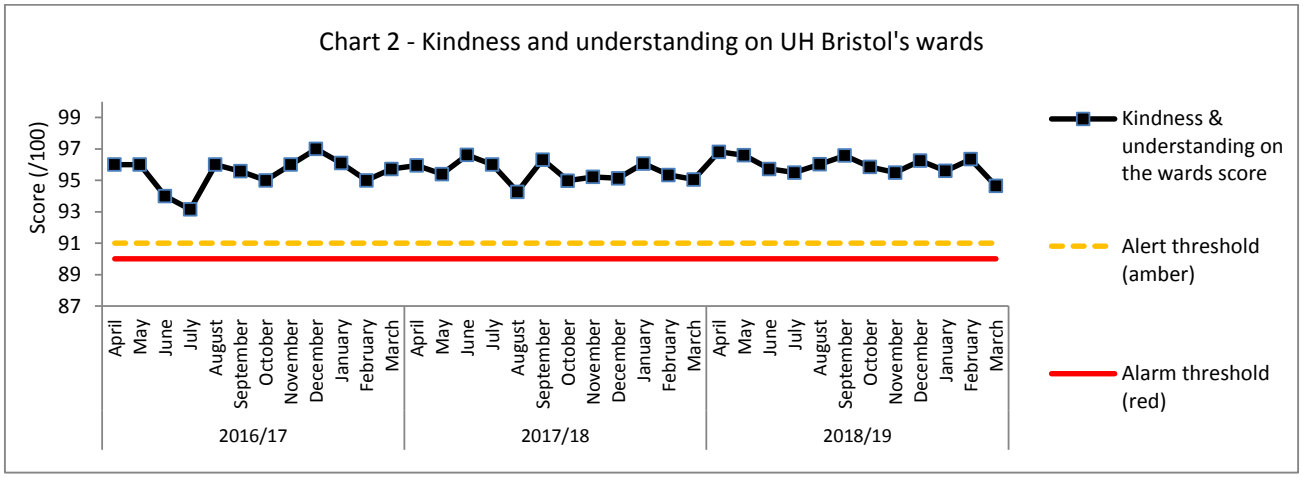
Issue	Description of issue	Response
1. Wards A528 and C808	Both of these Division of Medicine "care of the elderly" wards received relatively low patient survey scores in Quarter 4 – Ward A528 in particular was a significant negative outlier. A detailed analysis of these results has been carried out and discussed with the Divisional Head of Nursing. The sample sizes were small for these wards which appears to have skewed the survey results to some extent, and the majority of feedback was still very positive - but even taking this into account the scores were lower than expected. There appeared to be a particular decline in the survey scores relating to "communication" with patients. Care of the elderly areas do tend to receive lower survey scores than other wards (although during 2018/19 wards A528 and C808 have less frequently been negative outliers in our survey data compared to previous years). This trend is also seen at a national level. However, the *degree* to which A528 was an outlier in Quarter 4 suggested an issue over and above this effect.	Both of these wards currently have a high number of vacancies, leading to an increased use of temporary staff. This may have affected continuity of care, including communication about care and treatment. The Division is actively recruiting to the vacancies. In the meantime, the following actions have been put in place to try and mitigate the effects on patient experience: - Block booking of temporary staff where possible, providing more continuity within the staff team working on the ward - Additional staffing to support the ward staff whilst recruitment takes place In June 2019 a new job role will commence which will see the roll out of an education programme for staff working on care of the elderly wards at UH Bristol. This will include a focus on improving communication with patients / relatives / carers, and also between staff.
2. Ward A605	Ward A605 is a "delayed discharge" ward in the Division of Medicine. During 2018/19 the ward has been a consistent negative outlier in our survey data. This has been attributed to staffing issues on the ward that the Division has been working to address. The scores in Quarter 4 were still towards the lower end of our survey results, but there were encouraging signs of improvement: the kindness and understanding score was positive, the inpatient "tracker" score improved (although was still slightly below target), and, whilst the ward had the lowest inpatient Friends and Family Test score - this was above our minimum target.	Ward A605 appointed a new Ward Sister during Quarter 4, who has significant leadership experience at the Trust. The survey data suggests that this has started to have a positive effect on patient experience. The Ward Sister is beginning to plan a number of new initiatives for the ward, that will focus on staff engagement and improving patient experience. We anticipate that this should continue to positively impact on the survey scores going forwards.

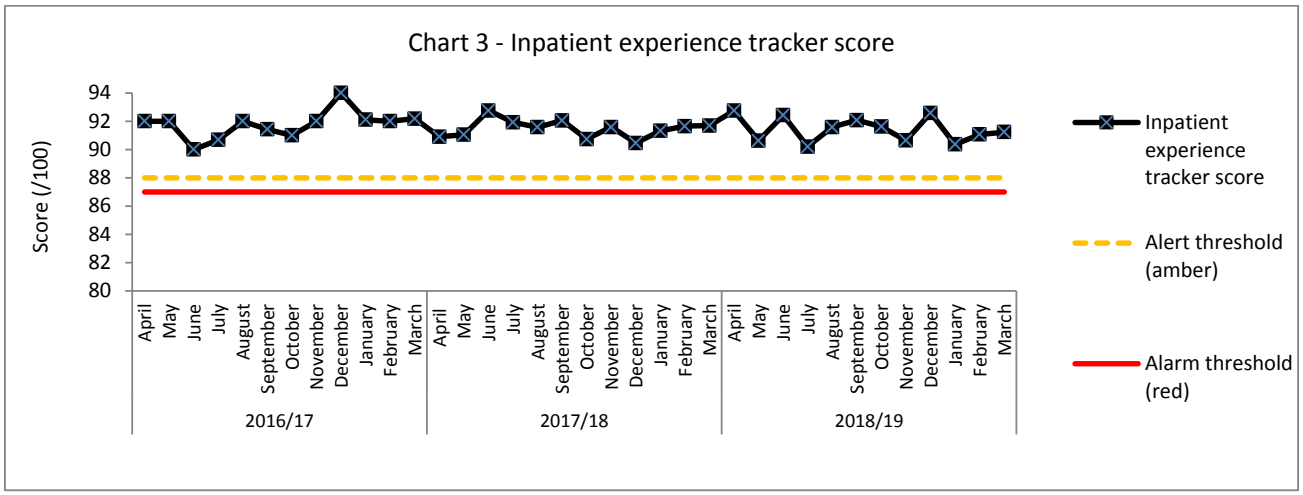
Issue	Description	Response / Actions
3. South Bristol Community Hospital - wards 100 and 200	The inpatient scores for South Bristol Community Hospital (SBCH) were again towards the lower end of our survey ratings in Quarter 4 (although the majority of feedback for the hospital was still positive). This has been a long-term trend in our data.	As noted in previous quarters, these results do not correlate with other management data being received by the Division of Medicine for SBCH. Furthermore, Healthwatch Bristol undertook a follow-up "enter and view" at the hospital in Quarter 3 (having carried out a similar exercise in late 2016) and again reported very positively about the care being provided there. There are currently some staff vacancies at SBCH which are being recruited to, but, whilst this may have affected the scores to some extent in Quarter 4, the lower survey scores precede this issue. Utilising learning from the Trust's "Here to help" customer service project, in Quarter 2 the Patient Experience and Involvement Team will work with the hospital leads at SBCH to carry out "touchpoint mapping" – modelling the care journey with patients to identify areas of this experience that could be the focus of improvement work.
4. Ensuring that inpatients are given key information at discharge from hospital	The Division of Medicine had relatively low scores on the survey measures relating to providing information at discharge about potential medication side effects and who the patient should contact if they have any issues or concerns about their condition / treatment.	The "discharge checklist" used by the Division was updated in 2018 to further ensure that key information is being provided to patients at discharge from hospital. Audits carried out in the Division confirm this checklist is being followed by staff. The survey data is likely to reflect the patients in this Division often having complex / long-term clinical needs, so they can leave hospital with a significant amount of information and medications.
5. Outpatient Friends and Family Test Response Rate	The Trust has a response rate target of 6% for this survey. It has now been below this target in both Quarters 3 and 4 (5.4% and 5.7% respectively). This survey is primarily carried out by SMS text message.	There can be considerable natural fluctuation in the response rate to this survey (the rate target was hit in the latest, March 2019 data, for example). However, there appears to have been a more sustained decline in the rates over recent months: in Quarter 1 2018/19 the rate was 6.3%, whereas in Quarter 4 2018/19 this had fallen to 5.7%. We are engaging with the contractor who carries out this survey on our behalf to rule out any underlying IT issues with the SMS process. Alongside this, the Patient Experience and Involvement Team are going to increase the number of returns collected each month, by adding this question to the Trust's monthly outpatient survey.

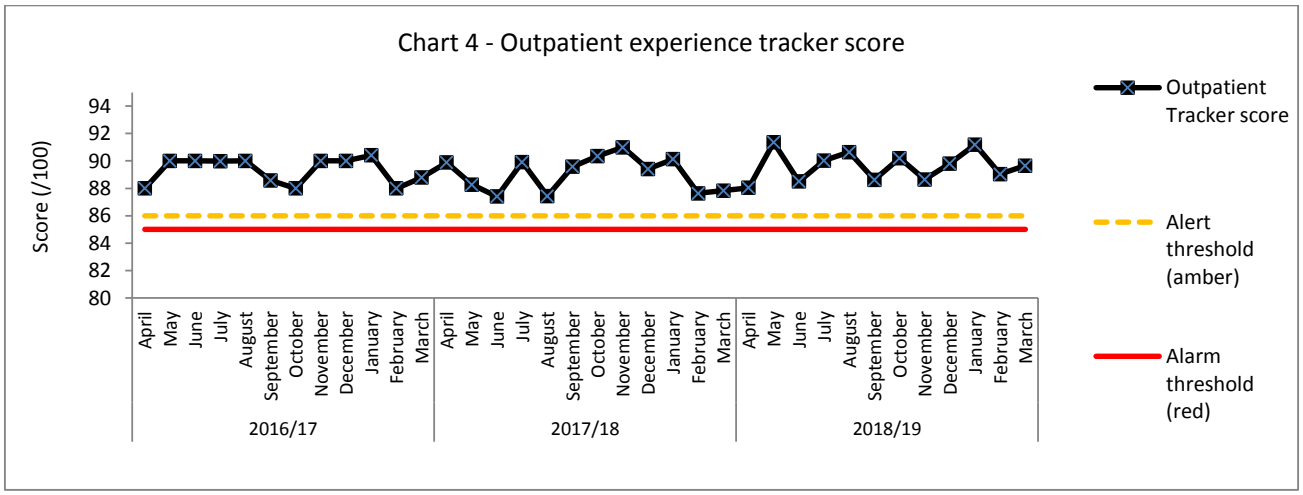
Issue	Description	Response / Actions
6. Emergency Department Friends and Family Test response rate	The Emergency Department element of the Friends and Family Test (FFT) survey was 14.2% in Quarter 4, which is below the 15% response rate target. The target rate was met in both January and February (16% and 15% respectively), but a significant dip in March (11.6%) brought the rate in under target for the quarter as a whole.	The specific reason for the dip in March was a lower rate of return from the Bristol Eye Hospital Emergency Department. This was an unusual result for the Department as they tend to achieve excellent response rates. It was due to a delay in the Department sending off their completed FFT cards to the Trust's data processing company at the end of the month. The Department Sister has discussed this with her team to ensure the correct process is always followed. That aside, there has been a slight dip in response rates across all Emergency Departments (ED's) – in particular in respect of the number of FFT cards being collected in the Departments each month. Whilst our ED patients can complete the survey via electronic touchscreen or SMS, the FFT cards are an important element of the survey and help to ensure that staff are actively involved in collecting feedback about their service. Following discussions at the May 2019 Patient Experience Group meeting, the Emergency Departments will increase the number of FFT cards being handed out to patients. In the FFT survey, the method in which the data is collected is strongly correlated with the overall satisfaction score achieved: card-based responses tend to elicit more positive scores than other methods. Our ED FFT employs three main methods (touchscreen, SMS and cards). This isn't a particular issue if the proportion of responses collected through each channel remains broadly similar each month. However, if the number of cards being collected declines then this is likely to negatively affect our FFT score. This is the most likely reason for the slightly declining trend seen in our ED FFT scores in recent months (Chart 6).

4. Full survey data up to and including Quarter 4

This section of the report provides a full breakdown of the headline survey data to ward level. Caution is needed below Divisional level, as the margin of error becomes larger. At ward level in particular it is important to look for trends across more than one of the survey measures presented.







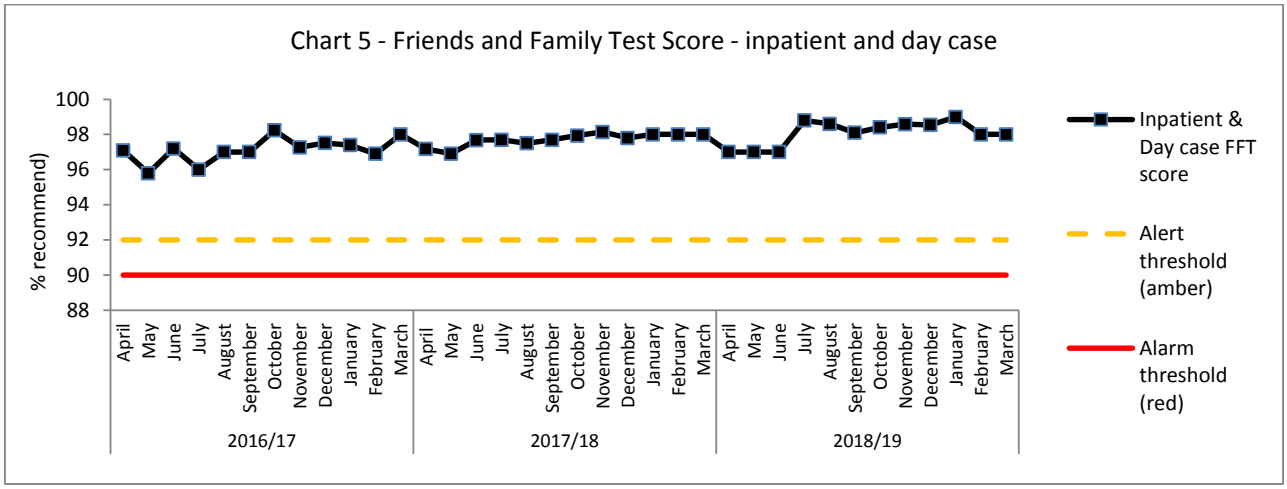


Chart 5 - Friends and Family Test Score - inpatient and day case
% recommend)
100
98
96
94
92
90
88
April May June July August September October November December January February March
2016/17
2017/18
2018/19
Inpatient & Day case FFT score
Alert threshold (amber)
Alarm threshold (red)

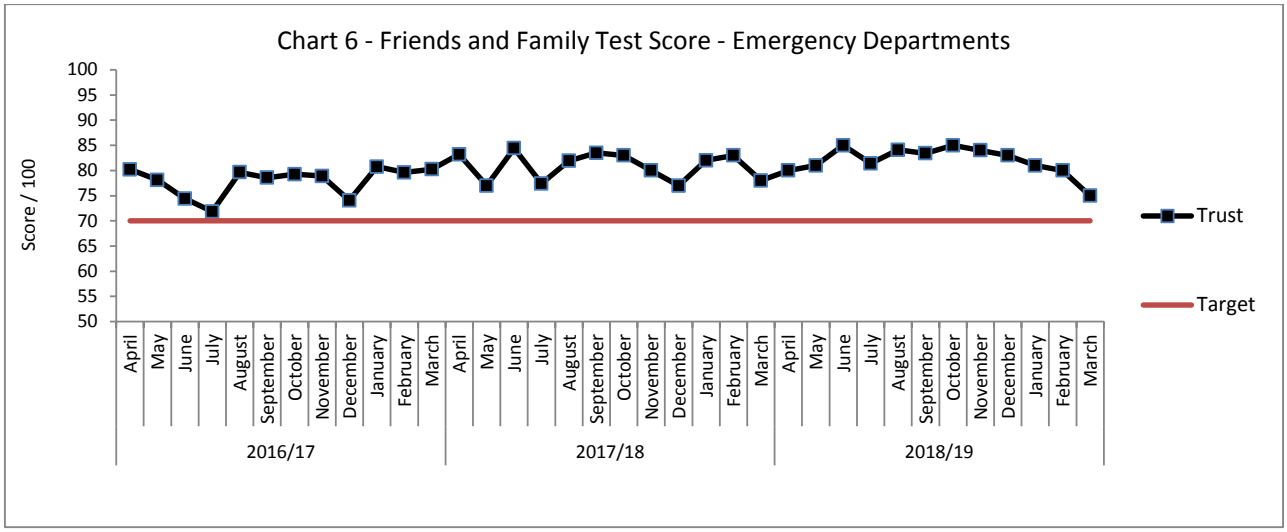


Chart 6 - Friends and Family Test Score - Emergency Departments
Score / 100
100
95
90
85
80
75
70
65
60
55
50
April May June July August September October November December January February March
2016/17
2017/18
2018/19
Trust
Target

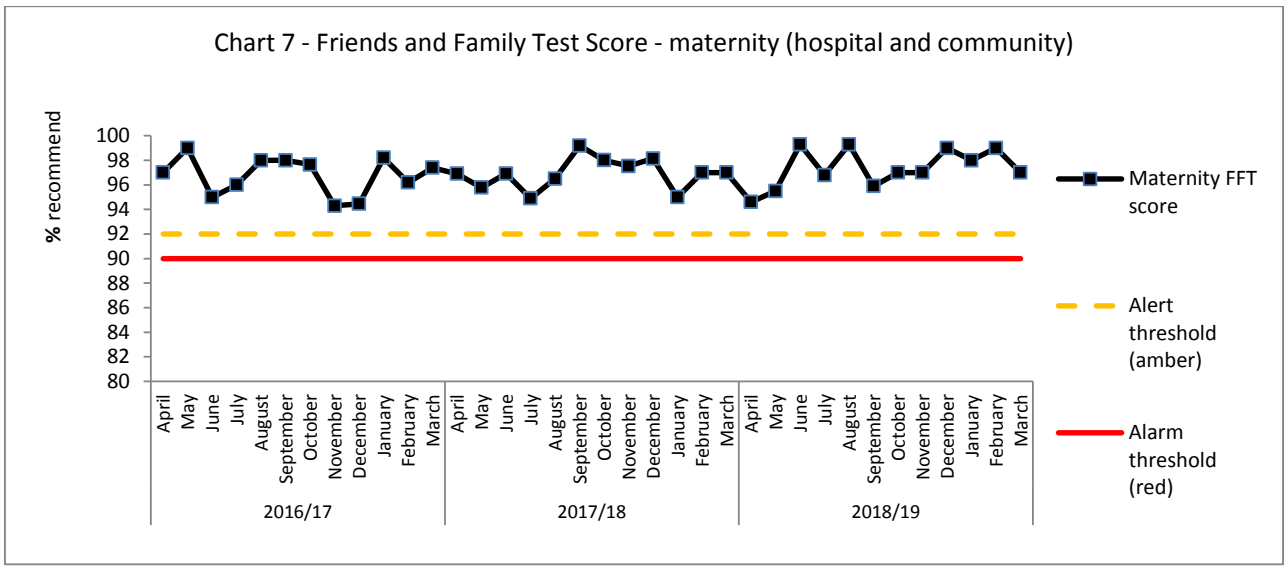


Chart 7 - Friends and Family Test Score - maternity (hospital and community)
% recommend
100
98
96
94
92
90
88
86
84
82
80
April May June July August September October November December January February March
2016/17
2017/18
2018/19
Maternity FFT score
Alert threshold (amber)
Alarm threshold (red)

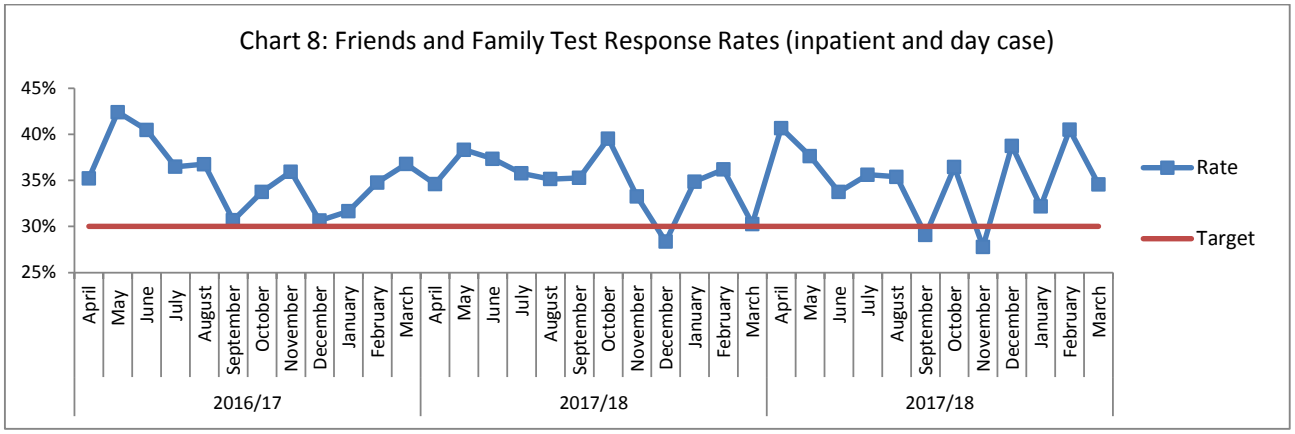


Chart 8: Friends and Family Test Response Rates (inpatient and day case)
45%
40%
35%
30%
25%
April May June July August September October November December January February March
2016/17
2017/18
2017/18
Rate
Target

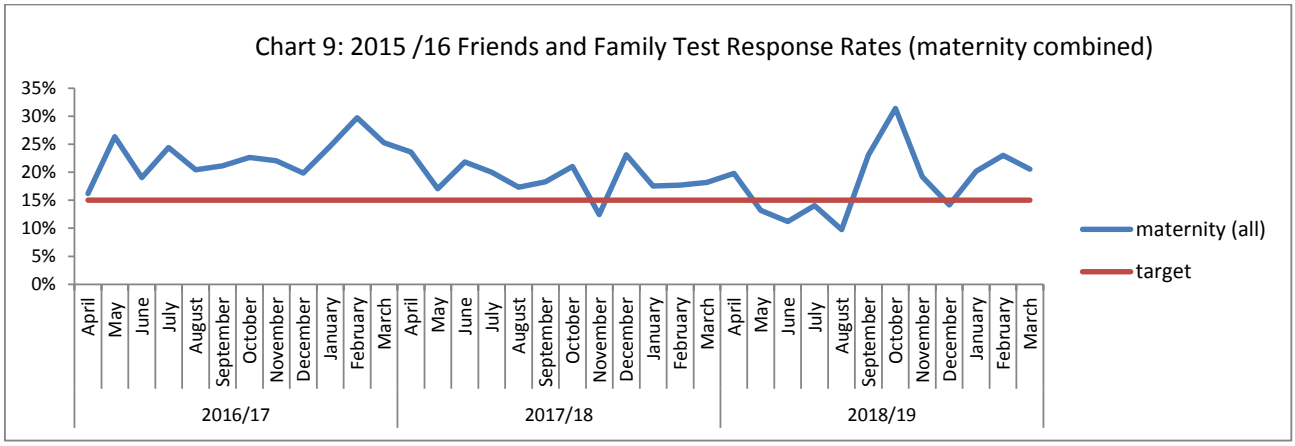


Chart 9: 2015 /16 Friends and Family Test Response Rates (maternity combined)
35%
30%
25%
20%
15%
10%
5%
0%
April May June July August September October November December January February March
2016/17
2017/18
2018/19
maternity (all)
target

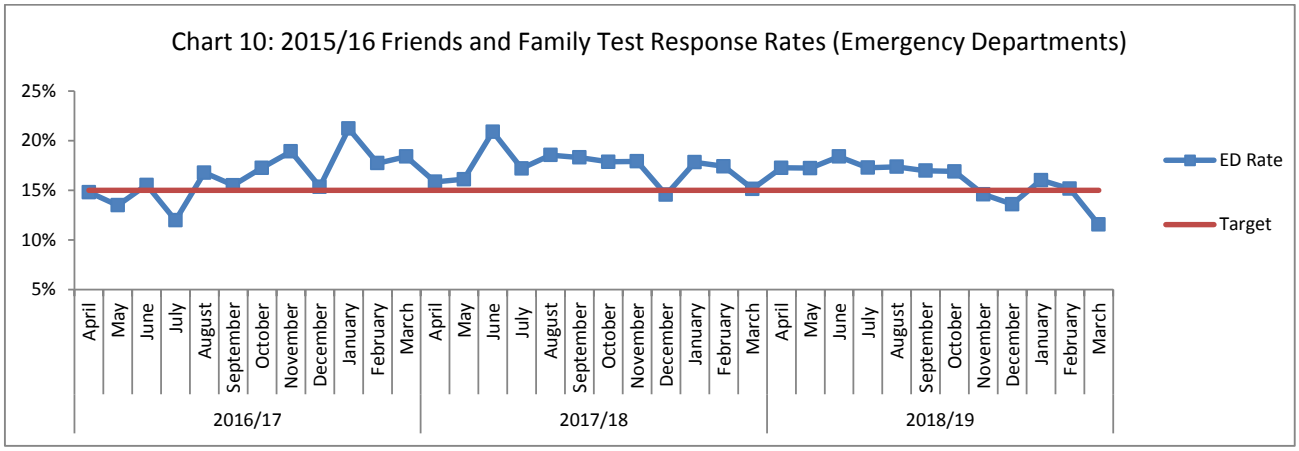


Chart 10: 2015/16 Friends and Family Test Response Rates (Emergency Departments)
25%
20%
15%
10%
5%
April May June July August September October November December January February March
2016/17
2017/18
2018/19
ED Rate
Target

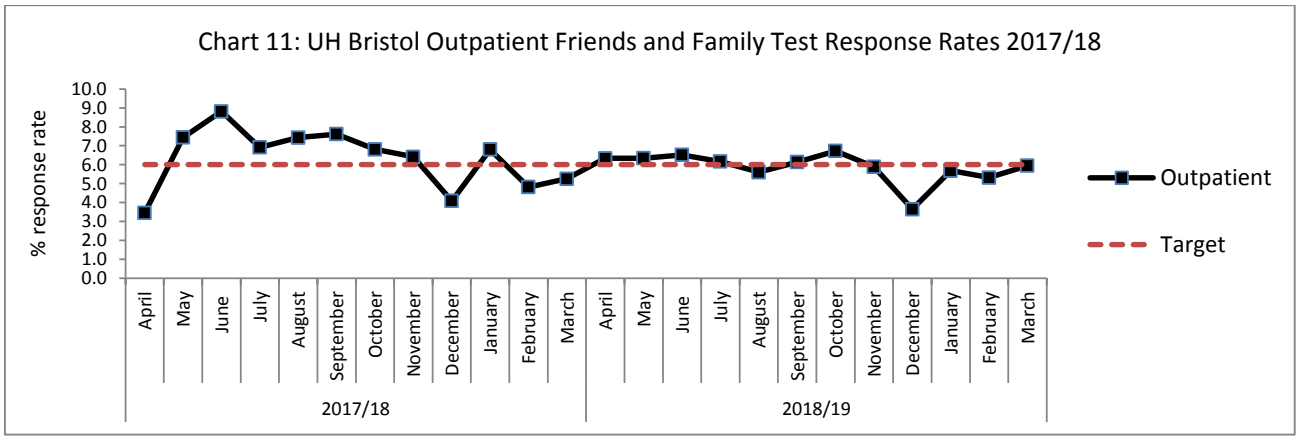
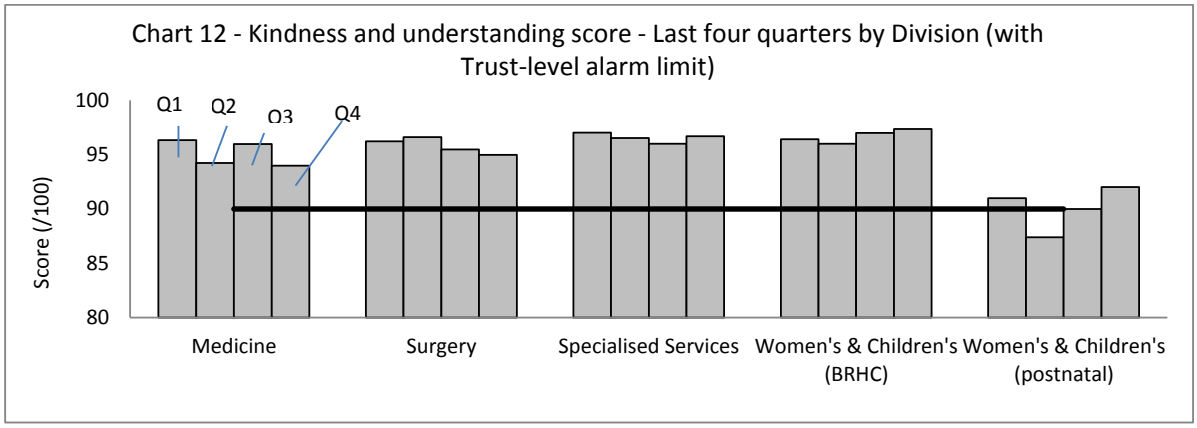
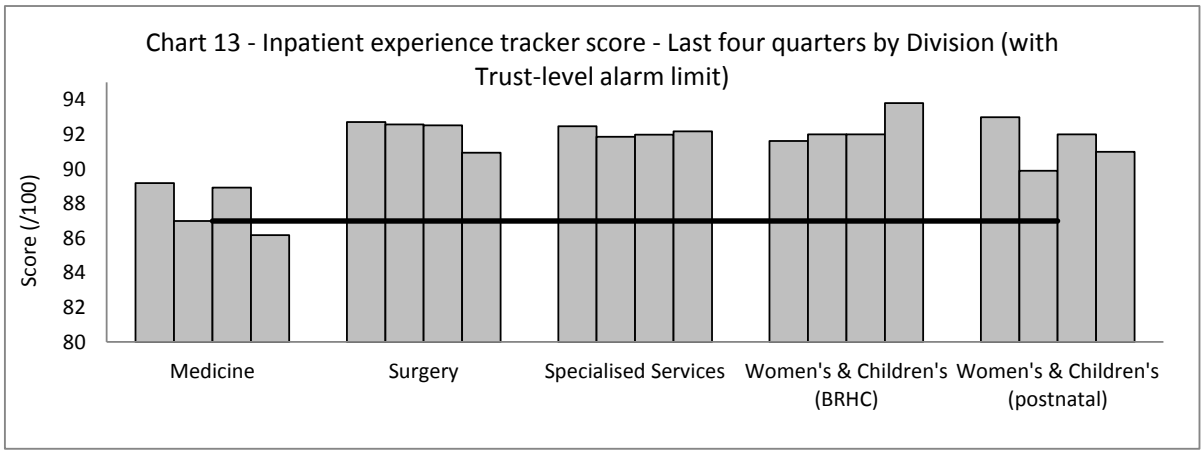
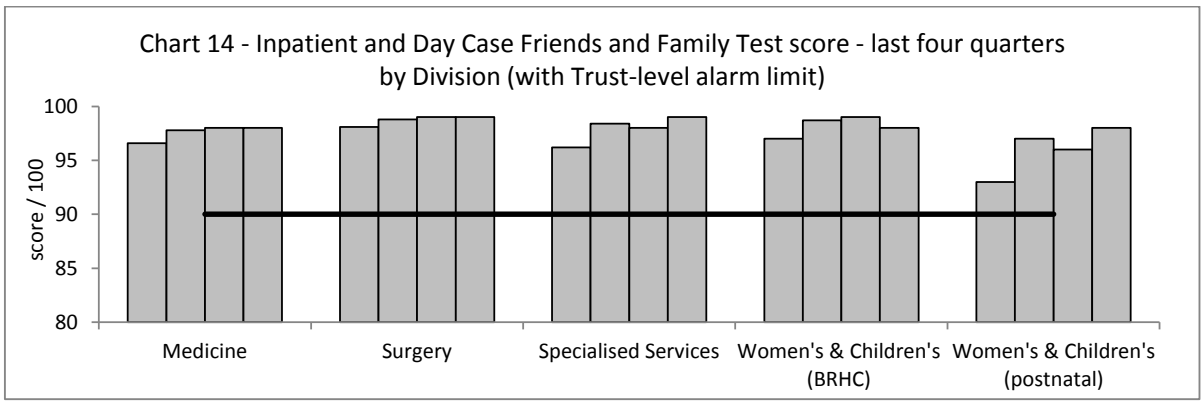


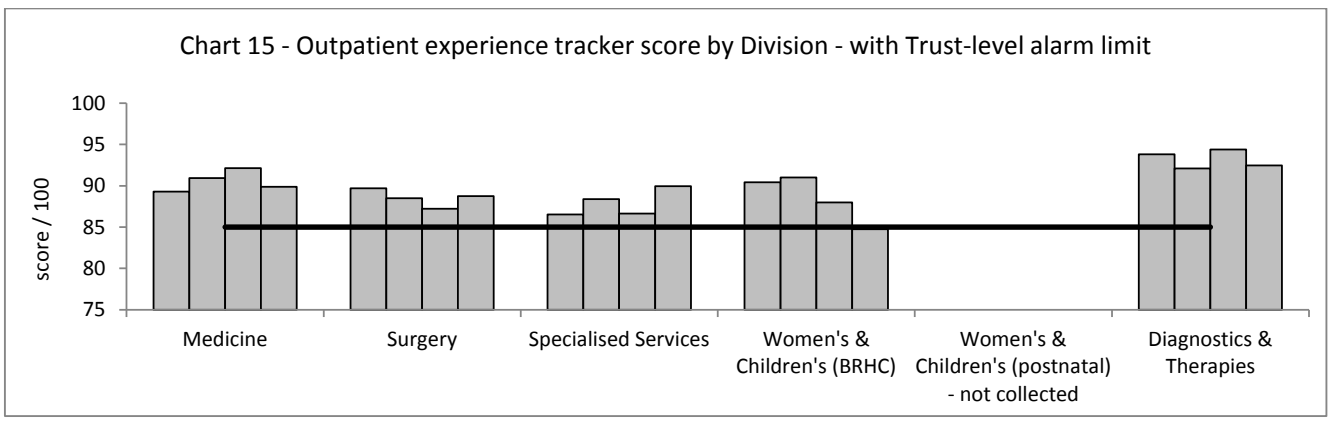
Chart 11: UH Bristol Outpatient Friends and Family Test Response Rates 2017/18
% response rate
10.0
9.0
8.0
7.0
6.0
5.0
4.0
3.0
2.0
1.0
0.0
April May June July August September October November December January February March
2017/18
2018/19
Outpatient
Target

4.1 Divisional level survey results



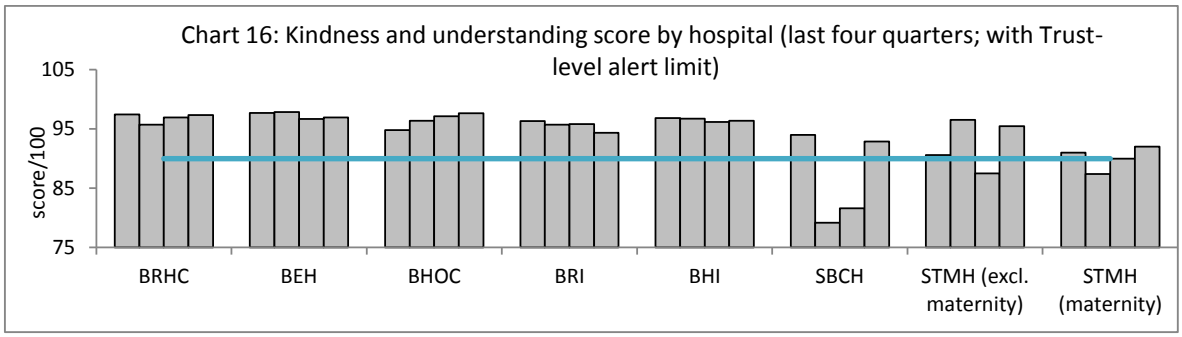


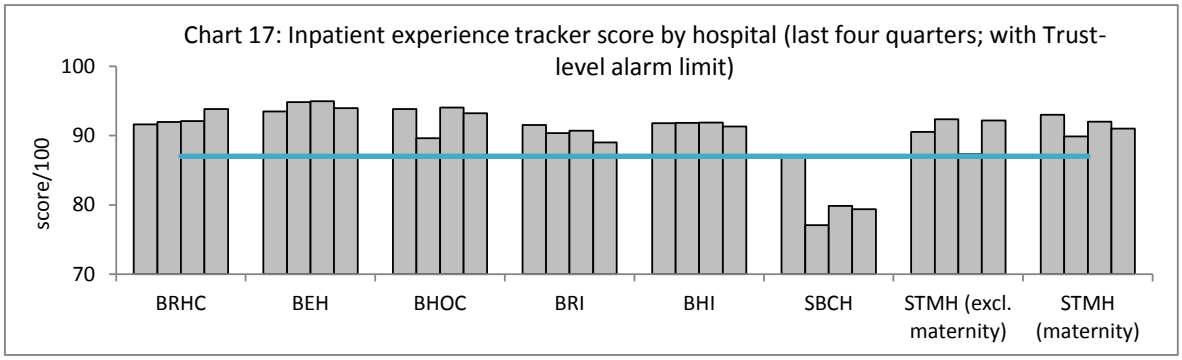


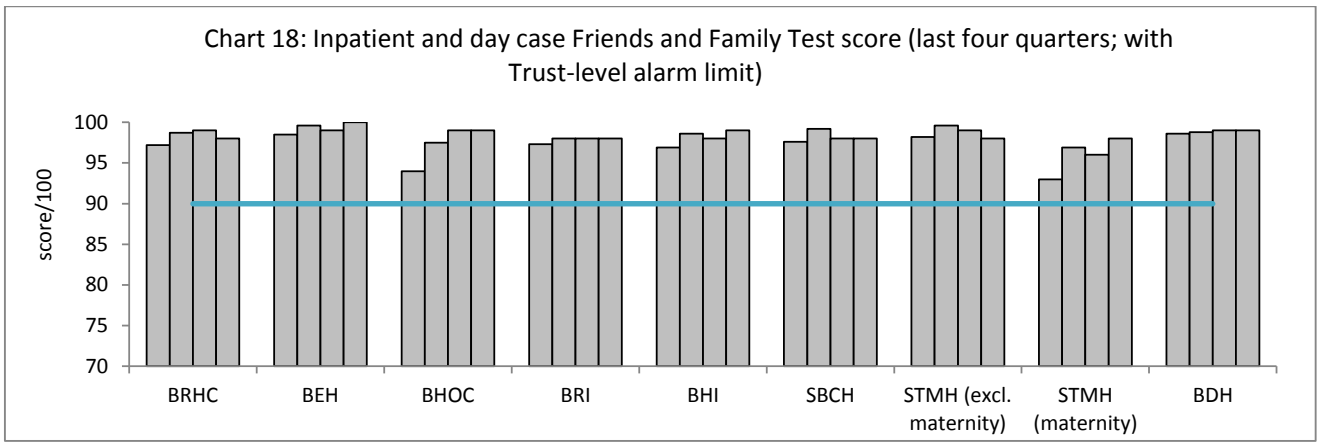


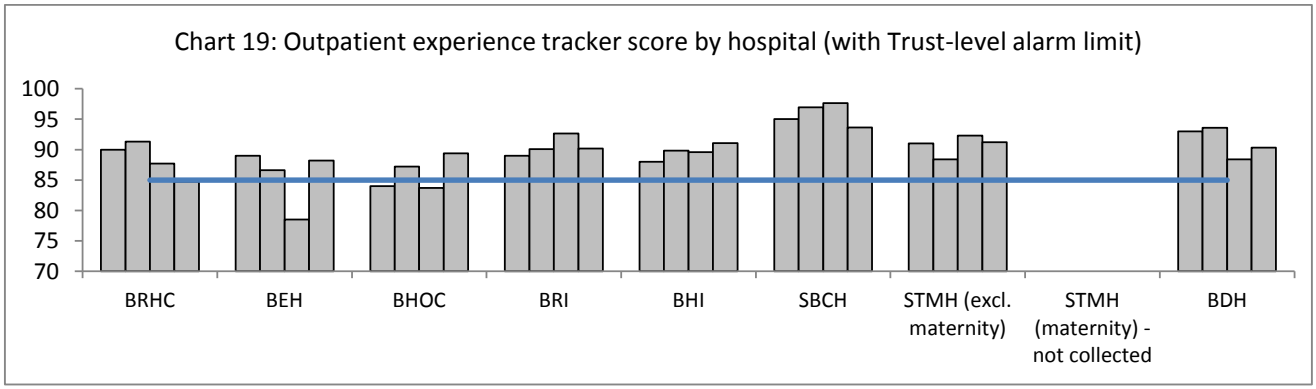
4.2 Hospital level headline survey results

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

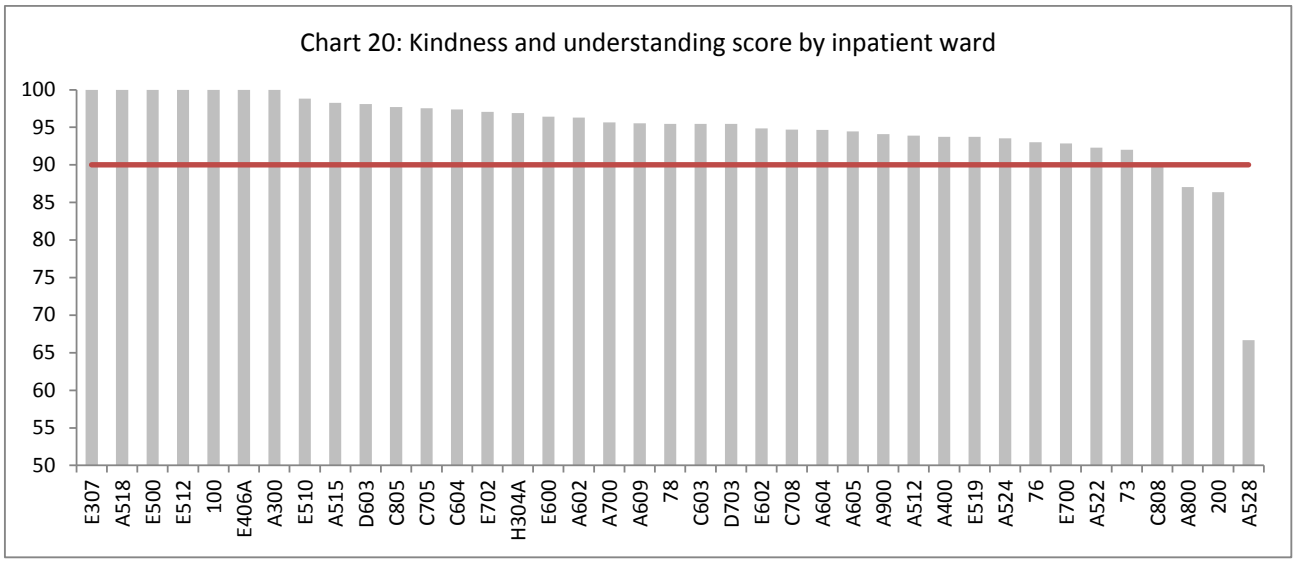


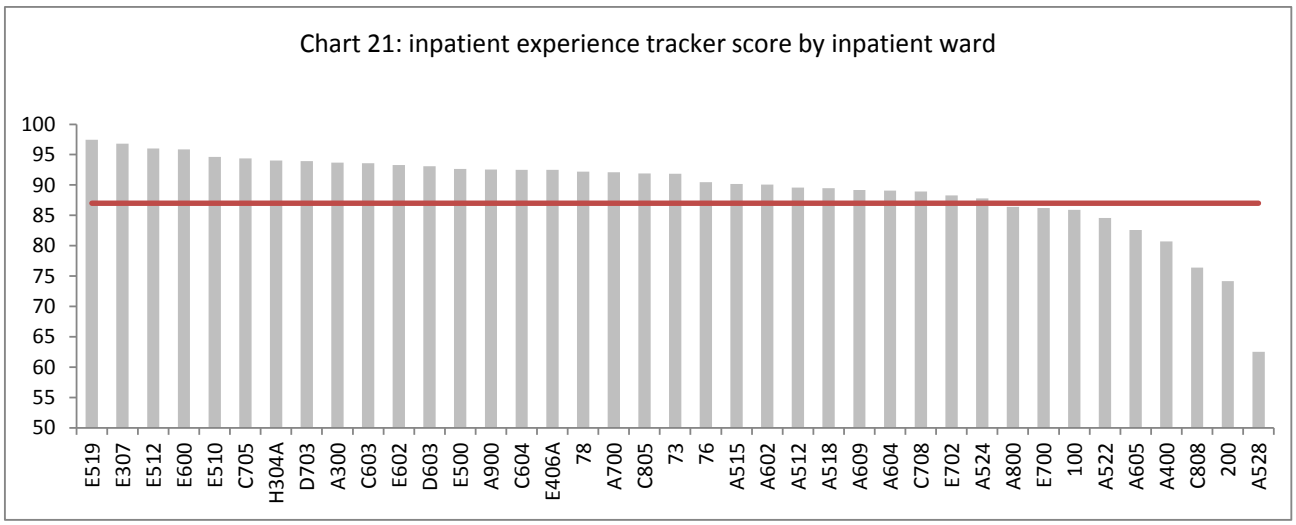


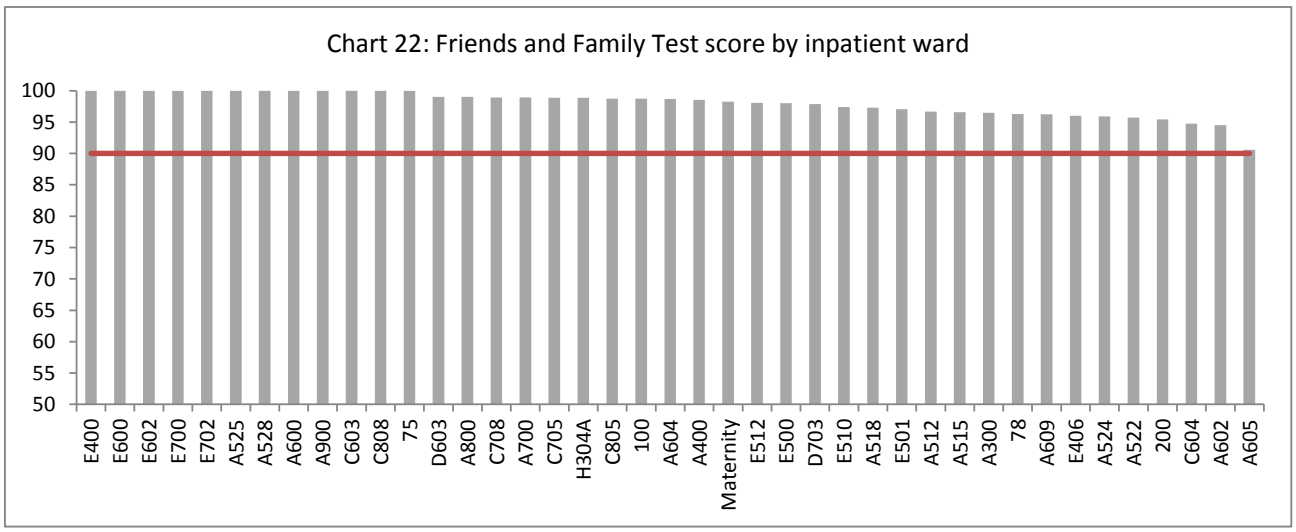




4.3 Ward level headline inpatient survey results







Please note that scores are not published for wards with less than five responses as this is insufficient data to work with.

4.4 Full inpatient survey data by Division

Table 3: Full Quarter 4 Divisional scores from UH Bristol's monthly **inpatient** postal survey (cells are highlighted if they are more than 10 points below the Trust score). Scores are out of 100 unless otherwise stated – see appendices for an explanation of the scoring mechanism.

	Medicine	Specialised Services	Surgery	Women's & Children's (excl. maternity)	Maternity*	TOTAL
Were you given enough privacy when discussing your condition or treatment?	89	93	93	94		93
How would you rate the hospital food?	65	62	62	60	59	62
Did you get enough help from staff to eat your meals?	80	89	80	87		85
In your opinion, how clean was the hospital room or ward that you were in?	94	96	95	96	91	95
How clean were the toilets and bathrooms that you used on the ward?	90	91	91	92	81	91
Were you ever bothered by noise at night from hospital staff?	84	74	87	85		82
Do you feel you were treated with respect and dignity by the staff on the ward?	94	98	98	96	93	97
Were you treated with kindness and understanding on the ward?	94	97	97	95	92	96
Overall, how would you rate the care you received on the ward?	86	92	93	90	92	90
When you had important questions to ask a doctor, did you get answers that you could understand?	83	91	93	88	89	89
When you had important questions to ask a nurse, did you get answers that you could understand?	84	91	92	88	92	89
If your family, or somebody close to you wanted to talk to a doctor, did they have enough opportunity to do so?	71	75	76	75	79	74
If your family, or somebody close to you wanted to talk to a nurse, did they have enough opportunity to do so?	85	86	90	86	90	86
Were you involved as much as you wanted to be in decisions about your care and treatment?	76	86	91	86	89	85
Do you feel that the medical staff had all of the information that they needed in order to care for you?	84	90	91	90		89

	Medicine	Specialised Services	Surgery	Women's & Children's (excl. maternity)	Maternity*	Trust
Did you find someone on the hospital staff to talk to about your worries or fears?	67	77	86	75	83	76
Did a member of staff explain why you needed these test(s) in a way you could understand?	84	89	92	85		87
Did hospital staff keep you informed about what would happen next in your care during your stay?	78	86	90	82		84
Were you told when this would happen?	77	82	83	82		81
Beforehand, did a member of staff explain the risks and benefits of the operation/procedure in a way you could understand?	n/a	93	95	93		93
Beforehand, did a member of staff explain how you could expect to feel afterwards?	72	77	83	79		78
Were staff respectful of any decisions you made about your care and treatment?	91	95	96	94		94
During your hospital stay, were you ever asked to give your views on the quality of your care?	29	32	31	32	35	31
Do you feel you were kept well informed about your expected date of discharge from hospital?	79	79	86	85		82
On the day you left hospital, was your discharge delayed for any reason?	58	54	62	65	67	60
Did a member of staff tell you about medication side effects to watch for when you went home?	49	59	64	68		61
Did hospital staff tell you who to contact if you were worried about your condition or treatment after you left hospital?	65	83	91	82		81

**Not all of the inpatient survey questions are replicated in the maternity survey.*

5. Specific issues raised via the Friends and Family Test

The feedback received via the Trust's Friends and Family Test is generally very positive. Table 5 provides a response from Divisions / services for the relatively small number of negative ratings, where that rating was accompanied by a specific, actionable, comment.

Four comments received via the Friends and Family Test in Quarter 4 raised issues around support for patients who have mental health problems whilst in hospital. This is already a significant focus at UH Bristol via the Mental Health Steering Group and the Trust's Risk Management processes. A more detailed analysis of patient feedback data from patients with mental health issues is currently being carried out by the Patient Experience and Involvement Team, to help inform the work of the Steering Group and identify further opportunities for improving this aspect of our care. An update on this analysis and the response to it will be provided in the next Quarterly Patient Experience and Involvement Report.

Table 5: Divisional response to specific issues raised via the Friends and Family Test, where respondents stated that they would not recommend UH Bristol and a specific / actionable reason was given.

Division	Area	Comment	Response from ward / department
Surgery	A609	*Being someone who suffers from mental health I feel that I was a burden being there. I don't feel I was taken seriously and towards the end of my stay was rushed to leave although still in pain. In the end I felt uncomfortable and just wanted to leave. People with mental health should be treated fairly and not feel they are a burden to the ward.*	We are very sorry to hear that one of our patients felt that they weren't treated with the upmost kindness and compassion - particularly when suffering from mental health problems. Unfortunately it is not possible to investigate this specific situation due to the anonymity of the survey response. However, the Ward Manager has used it as an opportunity to discuss this feedback with the ward team and to raise awareness of the needs of patients being cared for who have mental health issues.
	H304	*Side ward toilets have no hand rails and as a disabled patient found it impossible to use an apparently recently refurbished side room/toilet. Disabled toilet had a defective door which I got stuck in for quite a few nervous moments!*	We are sorry to hear of the difficulties this patient had on our ward. As a result of this the Matron is checking that all of the handrails / doors are now in working order, and will raise a request to the Estates Department if necessary.
	A604	*The nurses and staff were very friendly. However, very, very noisy - hard to sleep and would be nice to have clean sheets and toilets. I should stress the staff were very friendly though.*	The Matron has addressed the issue around cleaning: a nursing action plan is now in place and a meeting has taken place with the Facilities Manager. The Ward Manager has raised awareness of the noise at night and cleanliness with the Ward Staff via their Safety Brief. The Matron will also carry out a night visit as part of the Trust's noise at night reduction campaign.

Division	Area	Comment	Response from ward / department
Women's and Children's *(Bristol Royal Hospital for Children)*	E500	*The night staff made me feel very uncomfortable, not offering help and sitting on phones and just ignoring me instead. My son was very upset and I wanted help to get his medicines in but was told just not to give him it. Also could hear staff laughing behind your back.*	We are very sorry to hear that this family had a poor experience on ward E500. This experience is against the Trust values of respecting everyone and these are not behaviours that we expect from our staff. Unfortunately without specific dates of when this occurred we cannot investigate further. As a result of this feedback however, the Ward Sisters will be reminding all staff of acceptable professional behaviour and will ensure all staff are trained in good customer service behaviours
	E406	*Nursing and medical staff could not be faulted for their care and attention. During a 3 night/4 day stay, we did not have our bay area cleaned or swept at all. There was a plaster stuck to the floor the entire time from the previous patient.*	Thank you for this feedback. The Head of Nursing has raised this concern with the manager of Hotel Services, to ensure that high standards of cleanliness are maintained at all times
	Emergency Department (Bristol Royal Hospital for Children)	*Mental health crisis - there was no service available. We needed a mental health crisis assessment, not forthcoming after a 4 hour wait. Follow up was a telephone call recommending an app. We are alone.*	We are very concerned to hear this feedback. Patients that arrive in our Emergency Department are assessed by our staff. If the initial assessments raise a serious level of concern about the patient's mental health, the emergency Child and Adolescent Mental Health Service team ("CAMHS") attend the hospital to assess the patient themselves. Alternatively, if the initial assessment indicates a follow-up is required but not immediately then the patient is referred to the community CAMHS service. CAMHS is an external organisation to UH Bristol and we will make them aware of this feedback.
	E602	*All of the staff were exceptional. The only thing that wasn't great was that everyone just walked in when the curtains were closed despite the yellow signs stitched on saying "ask before entry". As I was expressing and was walked in on a few times, I felt a little embarrassed.*	We are grateful that this issue has been brought to our attention. The Head of Nursing has discussed these observations with the Matron for Penguin ward. This has also been discussed with the ward staff to remind them of the importance of ensuring privacy and dignity is maintained at all times.

Division	Area	Comment	Response from ward / department
Women's and Children's *(Bristol Royal Hospital for Children)*	E512	*All staff lovely and helpful. They couldn't do enough for us. However our daughter has been very bored stuck in her room and we hoped to use the playroom to find it's now shut. Our daughter would have really benefited by having access to the playroom so it's such a shame for her and many other children that they no longer have anywhere to play.*	Thank you for your feedback. Each ward in the Children's Hospital has a play room, and there is also a central play room on level 5. Unfortunately, due to the availability of play staff, it is not possible to keep all of the play rooms open at all times. However, as a result of this feedback the Matron for Daisy ward is reviewing the play provision on the ward.
	E510	*Facilities for parents are horrendous: little kitchen, unclean and nowhere for parents to chill out.*	We do recognise that the parent facilities on the ward are not ideal. We are very sorry that this is the case; we are currently constrained by space limitations across the Children's Hospital. The Head of Nursing has asked the ward Sister on Caterpillar ward to explore the possibility of updating the facilities. The kitchen should nevertheless be kept clean and tidy clean and we have raised this with the ward's cleaning team.
Women's and Children's *(Maternity Services)*	Community Midwifery	*Note*: The Trust received three comments about difficulties in contacting community midwifery bases by telephone.	We apologise for the issues our service-users experienced during Quarter 4 in trying to contact some community midwifery bases. Another local NHS provider owns the bases and has been in the process of re-installing telephone land lines in to the bases. Whilst this work is being carried out, our service-users are being advised that the community midwives are contactable either via the Community Office or the Central Delivery Suite at St. Michael's Hospital.

Division	Area	Comment	Response from ward / department
Medicine	BRI ED	*I was admitted overnight due to a mental health crisis and was forgotten about. I was put in a small room and was told I would be given a sleeping tablet and anti-sickness tablet but neither of this happened. No member of staff updated me at all during the time I was there, and no one even popped their head around to see if I was alright or even still there. It was only when my mother queried what was going on that the staff admitted they had not been informed I was even there and that they would start following things up. I was actively suicidal but was left all alone with no one monitoring me.*	We are very sorry to hear about the poor experience that this patient had in our Emergency Department. We would very much like to offer our apologies directly to this patient, and investigate their experience further so that we can address the issues of concern. Unfortunately, this feedback is provided anonymously and so we do not have an opportunity to do this. However, there are very important points of learning within the feedback that we have asked our Liaison Psychiatry Team to identify and share with the ED team. We have also asked the Patient Experience and Involvement Team to carry out a wider review of feedback received about from patients who have mental health issues, so that this can be discussed at the Trust's Mental Health Steering Group.
	BRI ED	*The shabby waiting area, no quiet place for people with severe mental health problems. Notice screen never updates and information is useless as it's out of context.*	We appreciate that the ED can be a challenging environment for patients with mental health problems, particularly when it is very busy. Our staff do try to accommodate peoples' needs when we can and are very sorry that this didn't happen for this patient. The management team are also progressing plans for an upgrade of the Emergency Department facilities / environment. As a result of this feedback we have reviewed the process of updating the notice board to ensure this is kept up to date.
	BRI ED	*No food available in hospital as after shops & cafes closed.*	We appreciate that the shopping facilities in the BRI are not available 24-hours and are sorry that this respondent was hungry during their visit. There are some limited food choices available in the Emergency Department via vending machines. Our staff can provide some food when patients have a protracted stay and this feedback will be shared with the team to remind them to proactively offer this where appropriate.
	A400	*Excellent nursing staff. The thing that lets the ward down are the showers. They flood and there is so much pressure it could knock you off your feet or damage fragile skin. They are dangerous!*	We are sorry that this patient had problems with the showers. As a result of this feedback we have asked the maintenance team review the shower pressure and drainage.

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

This section of the report provides examples of some of the corporate Patient and Public Involvement (PPI) activities being carried out at the Trust. Each quarter a comprehensive summary of PPI is reviewed by the Trust's Patient Experience Group.

My Journey – mystery shopping

In Quarter 4 the Patient Experience and Involvement Team launched "My Journey" – which adopts mystery shopping methodologies used in the private sector and applies these to an NHS acute Trust setting. The mystery shoppers are trained volunteers. The first "My Journey" focussed on the patient journey to the Dermatology Department in the Bristol Royal Infirmary and the Cardiac Outpatient Department in the Bristol Heart Institute. Feedback from the exercise was shared with service leads and other relevant members of staff. The findings are also reviewed at the Trust's Outpatient Services Steering Group. A programme of activity for 2019/20 is currently being finalised. Updates will be provided in the next Quarterly Patient Experience and Involvement Report.

More effective support for lay representatives on Trust groups

The Trust has adopted a corporate quality improvement objective for 2019/20, to identify and better support "lay representatives" who give their time to work on UH Bristol groups and committees. This will include providing our staff with better guidance on recruiting and induct lay members, mapping which groups / committees currently have lay members, and providing better training / support to lay members.

Maternity services "patient experience at heart" work shops

The Trust's Patient and Public Involvement Lead led a series of eight "Patient Experience at Heart" workshop discussions for UH Bristol maternity service staff. This provided an opportunity to discuss patient experience and how this can be improved – with a particular focus on how each individual member of staff has a role to play in delivering the best possible experience for service-users. In total over 60 maternity staff attended from a range of job roles. The outcomes report is currently being prepared and will be reported to the service during Quarter 1 2019/20.

The Sight Loss Council

In April 2019, colleagues from the Bristol Eye Hospital met with representatives from the newly formed Bristol Sight Loss Council, which brings together a range of organisations including Action for Blind and the Macular Degeneration Society. Building a positive relationship with the Bristol Sight Loss Council will enable us to understand and improve the experience of patients who have visual impairments.

Bristol Healthwatch

In March 2019, the Trust's Patient and Public Involvement Lead participated in the annual Healthwatch Bristol conference, and co-facilitated a workshop on Transgender Care in Health with The Diversity Trust.

Dementia Care

In April the Trust held a "Health Matters" event focussing on the care offered to patients with a dementia and their carers. The event included a workshop with participants to review relevant patient information / leaflets that we currently provide in respect of these issues.

Cardiac Services

In March 2019, the Patient Experience and Involvement Team ran two focus groups to explore the impact of "less invasive heart procedures" on patients. This is part of a series of focus groups that will inform how the cardiac service can support cardiac patient's emotional and psychological needs.

Living with and Beyond Cancer

In March 2019, around 20 participants attended a group discussion which explored aspects of how the Trust's cancer services are currently delivered and the impact this has on the lives of the patients. This was organised jointly with MacMillan.

Quality Counts event

In January 2019 members of the UH Bristol Involvement Network joined Trust Members and representatives of the Trusts Young Person's Involvement Group in our annual Quality Counts event. The outcomes of the event helped to inform the Trust's quality objectives for the coming year, the trust's 2025 vision and the work-plan for the Trust's Patient Inclusion and Diversity Group 2019/20.

7. Update on the Trust's "Here to help" project, including the new rapid-time electronic feedback system

The "Here to help" project is being carried out by the Trust's Transformation Team and the Patient Experience and Involvement Team. It comprises a number of patient experience improvement projects, including:

- Learning from customer service concepts and methods that are used in the private sector
- Improving the way that we promote feedback opportunities to our patients and visitors
- Implementing a rapid-time patient / visitor feedback and reporting system at the Trust

7.1 Customer service project

The Trust's two-year "customer service mind set" corporate quality improvement objective came to a close in March 2019. There have been a number of achievements during this period, including:

- Developing a set of customer service principles for UH Bristol
- Embedding these principles in to:
    - Nursing assistant assessment centres
    - Volunteer assessment centres, induction and competencies
    - Corporate induction
    - Customer service training
    - Preceptorship programme
    - Administration update days
    - Relevant apprenticeship programmes
    - Trust standard competency-based interview template (to commence during Quarter 1 2019)
    - Outpatient standard operating procedures, audit templates and new competencies for administrative staff
- Implementing a new mystery shopping programme

- Improving telephone pick up rates in a number of “hot spots” around the Trust via the *#takephonership* project
- Designing and piloting a new advanced customer service training course for staff in “front of house” roles

The customer service project itself will continue in to a third year in 2019/20, with a focus on securing funding for a roll-out of the advanced customer service training and developing a customer service toolkit for UH Bristol managers and teams.

7.2 Here to help posters and comment cards

The Patient Experience and Involvement Team worked with a professional marketing agency to improve the way the Trust encourages our patients / visitors to raise issues with us and to give feedback about their experience. The resulting “Here to help” design is now being used in a range of ways across the Trust. For example, the new “Here to help” posters were put up in all of our wards and departments during Quarter 4. New patient / visitor comment cards, with a similar design to the posters, are being distributed to our wards and departments. The signage for our new touchscreen feedback points (see below) also has this same design. In this way we can convey a consistent message that UH Bristol is a listening and responsive organisation.

7.3 *Rapid-time feedback and reporting system*

The Trust’s new electronic patient / visitor feedback and reporting system, Optimum Contact, is now live after the following milestones were reached:

- Late December 2019: feedback system went live on the UH Bristol external website. This allows people to access the feedback channels via their own devices (the website link is promoted on the new “Here to help” posters – see 7.2 above).
- In late March 2019, six touchscreen feedback points were installed in the Bristol Royal Infirmary (BRI). These feedback points are located to ensure that people pass at least one on their way in or out of the hospital.

Regular feedback is being received through these new channels and forwarded on to Divisions for information or further action as appropriate.

We are currently carrying out an evaluation of this “Phase 1” of the project to inform a wider roll out of the touchscreens to all of our hospital sites. The next phase of the project is currently being planned. The aim is to install touchscreen feedback points across all of our hospital sites by the end of the 2019 calendar year. The third phase of the project, which we aim to complete by the end of the 2019/20 financial year, will involve using the Optimum Contact system to generate automated service-level reports of patient survey and feedback data.

Appendix A – UH Bristol corporate patient experience programme

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

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

Appendix B: survey scoring

Postal surveys

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

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

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

Friends and Family Test Score

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

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

University Hospitals Bristol
NHS Foundation Trust

Meeting of the Board of Directors in Public on Tuesday 30 July 2019 in the Conference Room, Trust Headquarters

Report Title	**Patient Complaints Q4 Report**
Report Author	**Tanya Tofts, Patient Support and Complaints Manager; Chris Swonnell, Head of Quality, Patient Experience and Clinical Effectiveness**
Executive Lead	**Carolyn Mills, Chief Nurse**

1. Report Summary

Summary of performance in Quarter 4

	Q4	
Total complaints received	493	↑
Complaints acknowledged within set timescale	99.6%	=
Complaints responded to within agreed timescale – formal investigation	88.2%	↑
Complaints responded to within agreed timescale – informal investigation	84.0%	↑
Proportion of complainants dissatisfied with our response (formal investigation)	7.0%	↓

2. Key points to note

(Including decisions taken)

Improvements:

- The proportion of complainants expressing dissatisfaction with the outcome of the investigation of their concerns has fallen for the second consecutive quarter.
- Complaints about Dermatology fell in Quarter 4 following actions taken in response to increasing demand for the service.
- Complaints about patient parking at South Bristol Community Hospital also fell in Quarter 4 following the introduction of new pay machines and signage.

However:

- Complaints about the Emergency Department, Trauma and Orthopaedics, and outpatient services at the Bristol Heart Institute increased in Quarter 4. Complaints about 'attitude and communication' also increased across the Divisions of Surgery, Specialised Services and Women & Children.
- Data suggests a long-term rising trend in complaints about Bristol Eye Hospital – a more detailed analysis of this trend is being undertaken during the second quarter of 2019/20.

3. Risks

If this risk is on a formal risk register, please provide the risk ID/number.

N/A

4. Advice and Recommendations

(Support and Board/Committee decisions requested):

• This report is for **INFORMATION.** • The Board is asked to **NOTE** the report.

5. History of the paper **Please include details of where paper has previously been received.**	
Patient Experience Group	23/5/19
Senior Leadership Team	19/6/19
Quality and Outcomes Committee	25/6/19

University Hospitals Bristol
NHS Foundation Trust

Complaints Report

Quarter 4, 2018/2019

(1 January 2019 to 31 March 2019)

Author: Tanya Tofts, Patient Support and Complaints Manager

Quarter 4 Executive summary and overview

	Q4	
Total complaints received	493	↑
Complaints acknowledged within set timescale	99.6%	=
Complaints responded to within agreed timescale – formal investigation	88.2%	↑
Complaints responded to within agreed timescale – informal investigation	84.0%	↑
Proportion of complainants dissatisfied with our response (formal investigation)	7.0%	↓

Successes	Priorities
• The proportion of complainants expressing dissatisfaction with the outcome of the investigation of their concerns has fallen for the second consecutive quarter. • Complaints about Dermatology fell in Quarter 4 following actions taken in response to increasing demand for the service. • Complaints about patient parking at South Bristol Community Hospital also fell following the introduction of new pay machines and signage. • Examples of specific service improvements made in response to complaints in Q4 can be found in section 4 of this report.	• Responding to complaints within the timescale agreed with the complainant remains a priority across all Divisions. Due to the majority of complaints now being responded to via the informal complaints process, breaches of timescales for informal complaints are now being reported to the Trust Board, in addition to breached formal responses. The target for both formal and informal responses is for 95% to be sent out by the deadline agreed with the complainant.
Opportunities	**Risks & Threats**
• The Patient Support and Complaints Team is in the process of refreshing training materials in response to feedback from previous attendees at training sessions. The training is designed to provide staff with the confidence to handle complaints raised directly with them and to assist senior managers in investigating and responding to formal complaints. • UH Bristol complaints training and procedures are to be shared with Weston General Hospital as a closer working relationship between the two Trusts develops during 2019/20.	• Complaints about the Emergency Department, Trauma and Orthopaedics, and outpatient services at the Bristol Heart Institute increased in Quarter 4. Complaints about 'attitude and communication' also increased across the Divisions of Surgery, Specialised Services and Women & Children. • Data suggests a long-term rising trend in complaints about Bristol Eye Hospital – a more detailed analysis of this trend is being undertaken during the second quarter of 2019/20.

1. Complaints performance – Trust overview

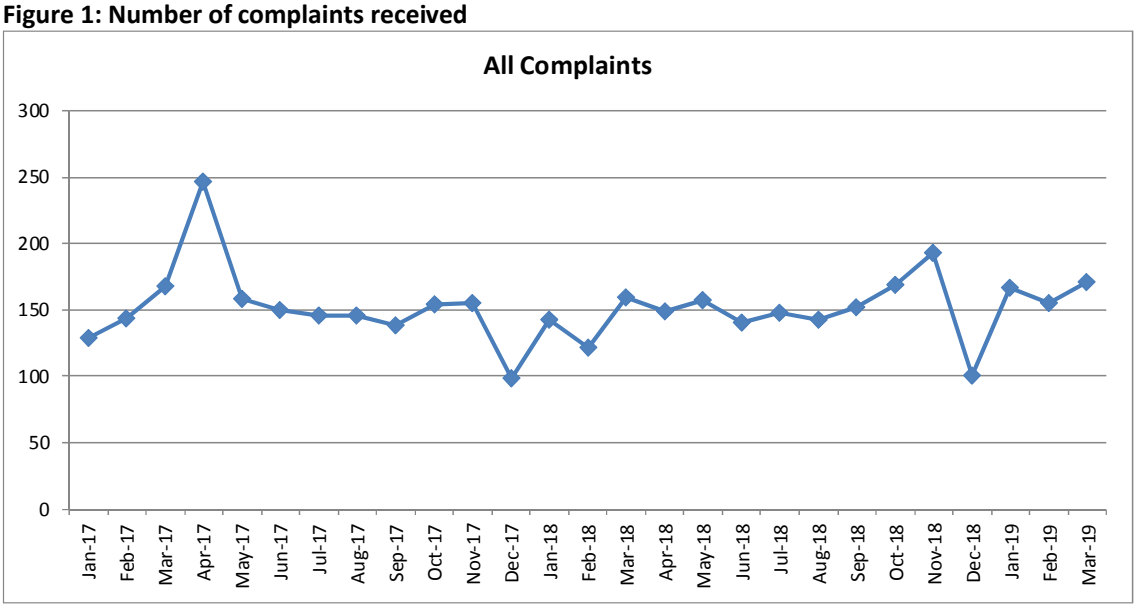
The Trust is committed to supporting patients, relatives and carers in resolving their concerns. Our service is visible, accessible and impartial, with every issue taken seriously. Our aim is to provide honest and open responses in a way that can be easily understood by the recipient.

1.1 Total complaints received

The Trust received 493 complaints in quarter 4 (Q4) of 2018/19. This total includes complaints received and managed via either formal or informal resolution (whichever has been agreed with the complainant)[1] but does not include concerns which may have been raised by patients and dealt with immediately by front line staff.

Figure 1 provides a long-term view of complaints received per month. This shows that the Trust typically receives around 150 complaints per month. In months where more complaints have been received, this has been attributable to a specific one-off issue (e.g. a high number of complaints about car parking at South Bristol Community Hospital were received in Q3).

Figure 1: Number of complaints received



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

Figure 2: Numbers of formal v informal complaints

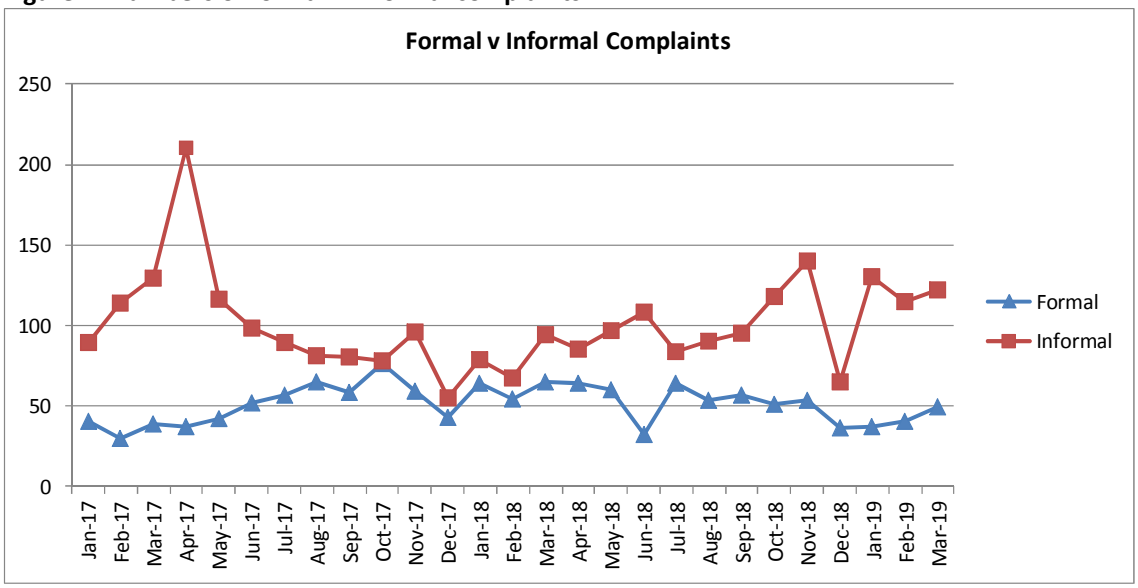


Figure 2 (above) shows complaints dealt with via the formal investigation process compared with those dealt with via the informal investigation process, over the same period. It is encouraging to see that we are consistently dealing with a higher proportion of complaints via the informal process, as this means that these issues are being dealt with as quickly as possible and by the specialty managers responsible for the service involved.

1.2 Complaints responses within agreed timescale

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

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

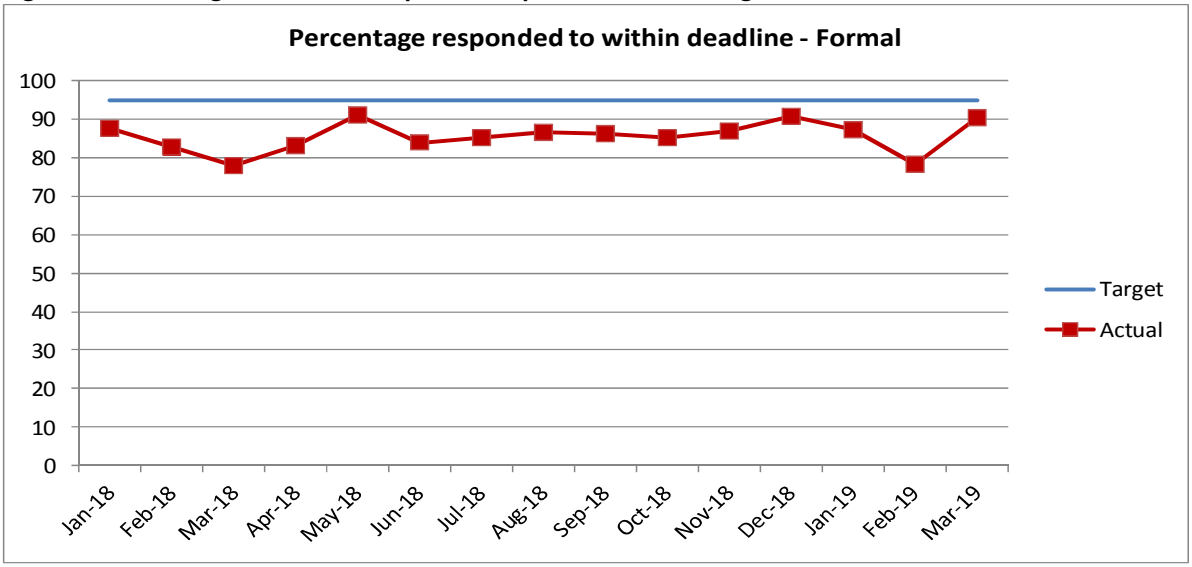
1.2.1 Formal Investigations

The Trust's target is to respond to at least 95% of complaints within the agreed timescale. The end point is measured as the date when the Trust's response is posted to the complainant. Figure 3 shows the percentage of formal complaints responded to within the agreed timescale since January 2018.

In Q4 2018/19, 88.2% of responses were posted within the agreed timescale. This represents 25 breaches out of the 169 formal complaints which received a response during the quarter[2]. This unfortunately does not reflect an improvement on the 88.1% reported in Q3 and remains below the Trust's target of 95%. Figure 3 shows the Trust's performance in responding to complaints since October 2016.

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

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

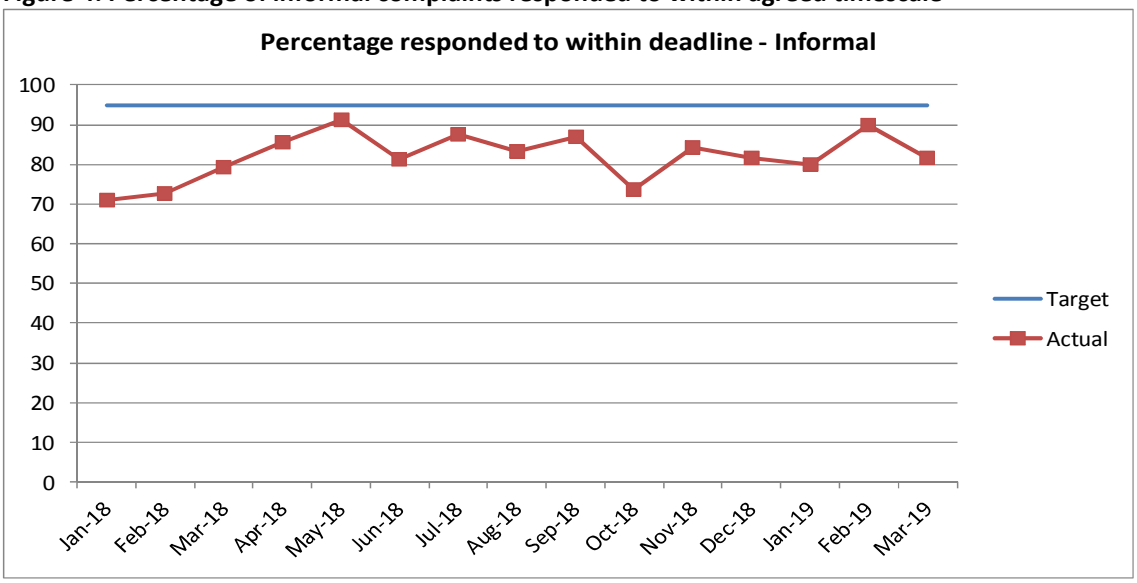


1.2.2 Informal Investigations

In Q4 2018/19, the Trust received 367 complaints that were investigated via the informal process. During this period, the Trust responded to 231 complaints via the informal complaints route and 84.0% of these were responded to by the agreed deadline.

Figure 4 (below) shows performance since January 2018, for comparison with formal complaints, although it should be noted that the 95% target was only formally introduced in Q4.

Figure 4: Percentage of informal complaints responded to within agreed timescale



1.3 Dissatisfied complainants

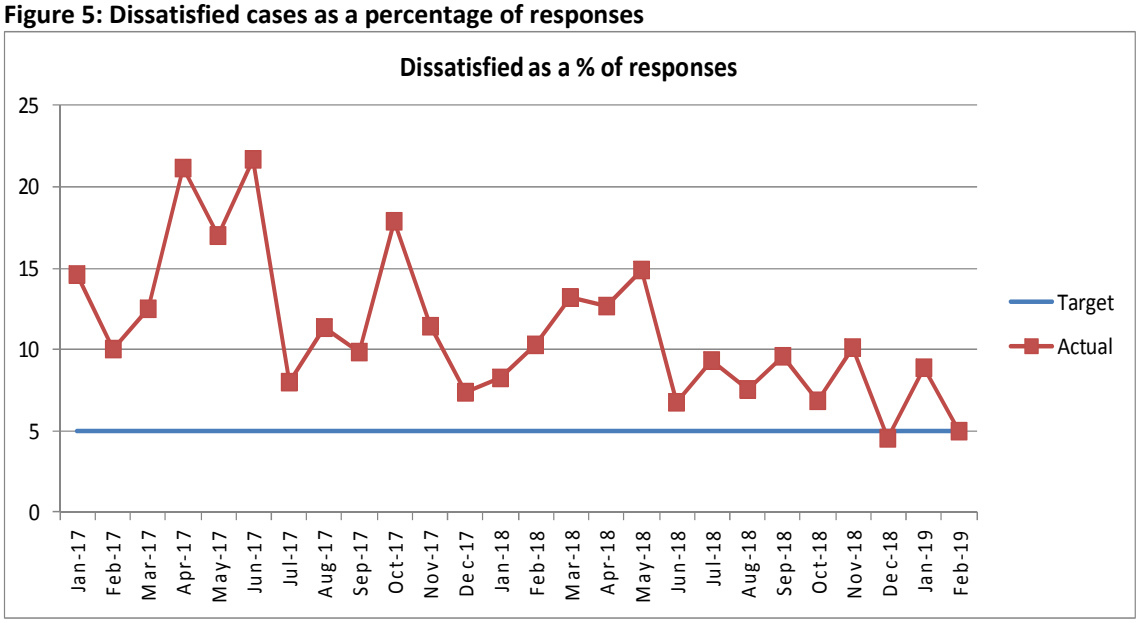
Since we commenced reporting on this metric, our target has been for less than 5% of complainants to be dissatisfied with our [formal] response to their complaint. However, as detailed in the Q3 complaints report, a detailed review of all dissatisfied cases revealed that the best possible score the Trust could have achieved would have been between 6% and 8%. It has subsequently been agreed that the current target of 5% would be re-based to 8% for 2019/20, i.e. with effect from Q1 2019/20.

This data is reported **two months in arrears** in order to capture the majority of cases where, having considered the findings of our investigations, complainants tell us they are not happy with our response.

In Q4 2018/19, by the cut-off point of mid-April 2019 (the point at which dissatisfied data for Q4 was confirmed for board reporting), eight complainants who received a first response from the Trust in January and February 2019, had contacted us to say they were dissatisfied. This represents 7.0% of the 114 first responses sent out during that period.

Figure 5 shows the monthly percentage of complainants who were dissatisfied with aspects of our complaints responses since January 2017.

Figure 5: Dissatisfied cases as a percentage of responses



2. Complaints themes – Trust overview

Every complaint received by the Trust is allocated to one of eight major categories, or themes. Table 1 provides a breakdown of complaints received in Q4 2018/19 compared with Q3 2018/19.

Complaints regarding 'appointments and admissions' remained high, accounting for almost a third of all complaints received, with 25 of these being for Bristol Heart Institute, 20 for Bristol Eye Hospital and 16 for Bristol Dental Hospital,

There was also an overall increase in complaints about 'attitude and communication'. Half of these complaints (57) were in respect of the attitude of staff. Failure to answer the telephone or failure to

respond accounted for 21 complaints. Bristol Eye Hospital received 17 of complaints in this category, whilst Bristol Royal Hospital for Children received 16, although there were no departmental trends identified at either site.

Table 1: Complaints by category/theme

Category/Theme	Number of complaints received in Q4 (2018/19)	Number of complaints received in Q3 (2018/19)
Appointments & Admissions	154 (31.2% of all complaints) ↑	135 (29.2% of all complaints) ↑
Clinical Care	124 (25.2%) ↑	123 (26.6%) ↓
Attitude & Communication	114 (23.1%) ↑	90 (19.4%) ↑
Facilities & Environment	56 (11.4%) ↓	62 (13.4%) ↑
Information & Support	21 (4.3%) ↓	32 (6.9%) ↑
Documentation	14 (2.8%) ↑	13 (2.8%) ↑
Discharge/Transfer/Transport	7 (1.4%) ↓	8 (1.7%) ↓
Access	3 (0.6%) ↑	0 (0%) ↓
Total	**493**	**463**

Each complaint is also assigned to a more specific sub-category, of which there are over 100. Table 2 lists the ten most consistently reported sub-categories, which together accounted for just under 70% of the complaints received in Q4 (343/493).

Table 2: Complaints by sub-category

Sub-category	Number of complaints received in Q4 (2018/19)	Q3 (2018/19)	Q2 (2018/19)	Q1 (2018/19)
Cancelled/delayed appointments and operations	87 (6.1% increase compared to Q3) ↑	82	69	96
Clinical care (Medical/Surgical)	67 (28.7% decrease) ↓	94	87	53
Appointment administration issues	42 =	42	48	37
Attitude of medical staff	28 (55.5% increase) ↑	18	15	20
Car Parking	25 (45.7% decrease) ↓	46	16	7
Failure to answer telephones/failure to respond	21 (50% increase) ↑	14	10	9
Communication with patient/relative	19 (58.3% increase) ↑	12	24	29
Lost/Misplaced/Delayed test results	18 (350% increase) ↑	4	4	9
Attitude of nursing/midwifery staff	13 (62.5% increase) ↑	8	13	8
Attitude of administrative/clerical staff	13 (18.8% decrease) ↓	16	10	12
Clinical care (Nursing/Midwifery)	10 (23.1% decrease) ↓	13	37	24

In Q4, the number of complaints categorised as 'facilities and environment' decreased and, whilst almost half of these (25) were still in respect of car parking, there were just three in March 2019, suggesting that actions taken to resolve the parking issues at South Bristol Community Hospital have had the desired effect. There was also a significant decrease in complaints about 'clinical care (medical/surgical)'. A sub-category appearing in this table for the first time in Q4 is

'Lost/Misplaced/Delayed test results'. Whilst the total number of complaints in this sub-category is not high, it is a substantial increase on previous quarters. However, there are not any identifiable trends – the complaints are spread across a variety of sites and departments. This will be monitored closely to identify whether the Q4 figure was a 'one off'.

Figures 6-9 (below) show the longer term pattern of complaints received since January 2017 for a number of the complaints sub-categories reported in Table 2. Figure 6 shows a reduction in complaints about clinical care (medical/surgical) compared to the previous two quarters, whilst Figure 8 shows a downward trend in complaints about car parking since a peak in November 2018. Trends in sub-categories of complaints are explored in more detail in the individual divisional details from section 3.1.1 onwards.

Figure 6: Clinical care – Medical/Surgical

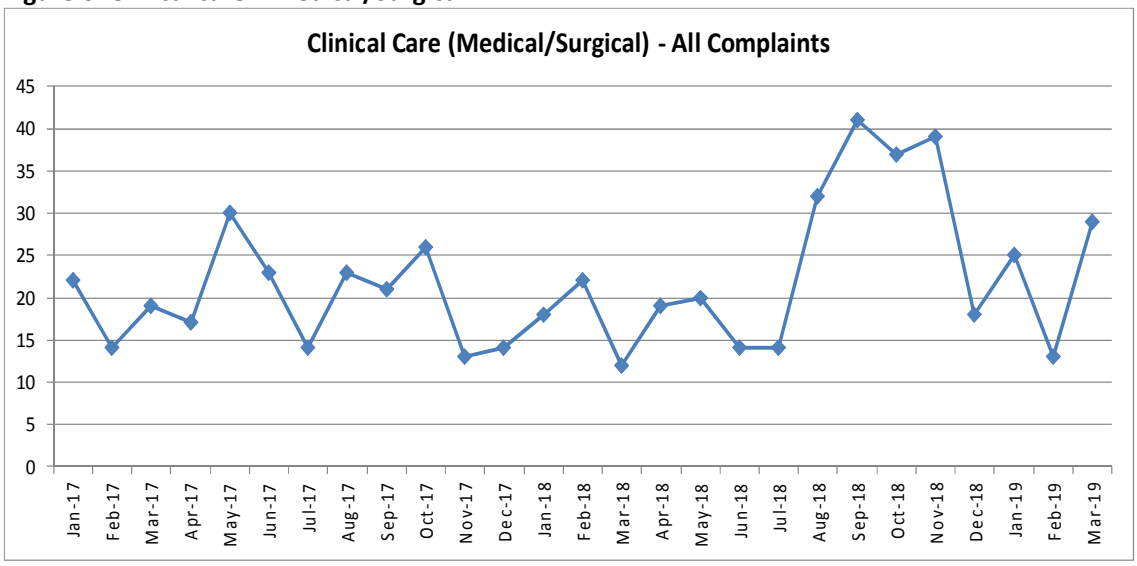


Figure 7: Cancelled or delayed appointments and operations

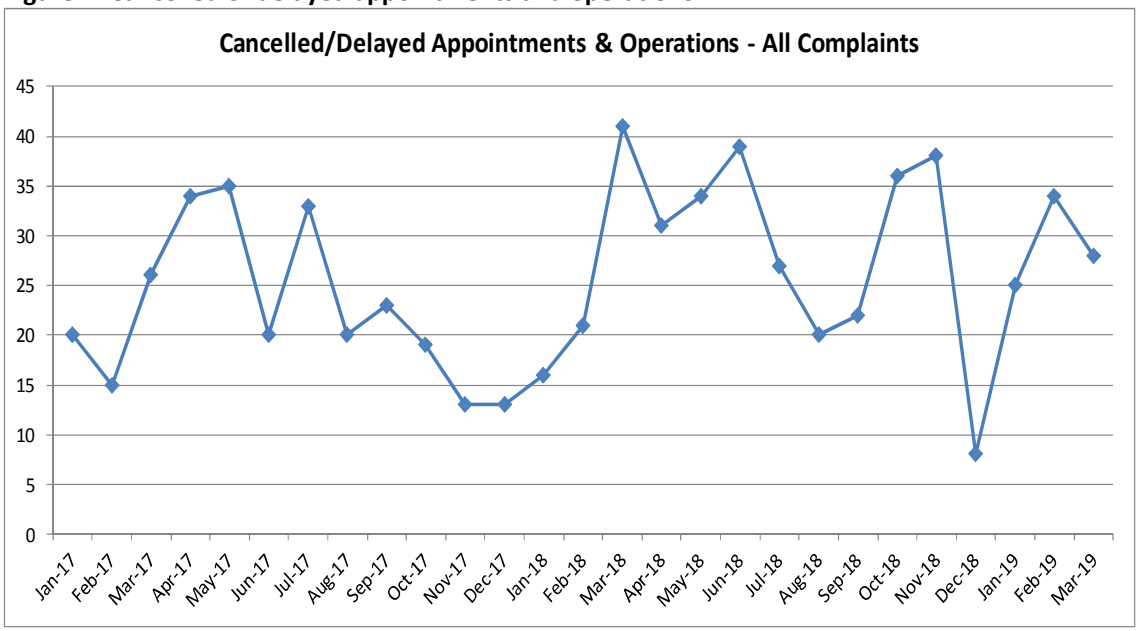


Figure 8: Car Parking

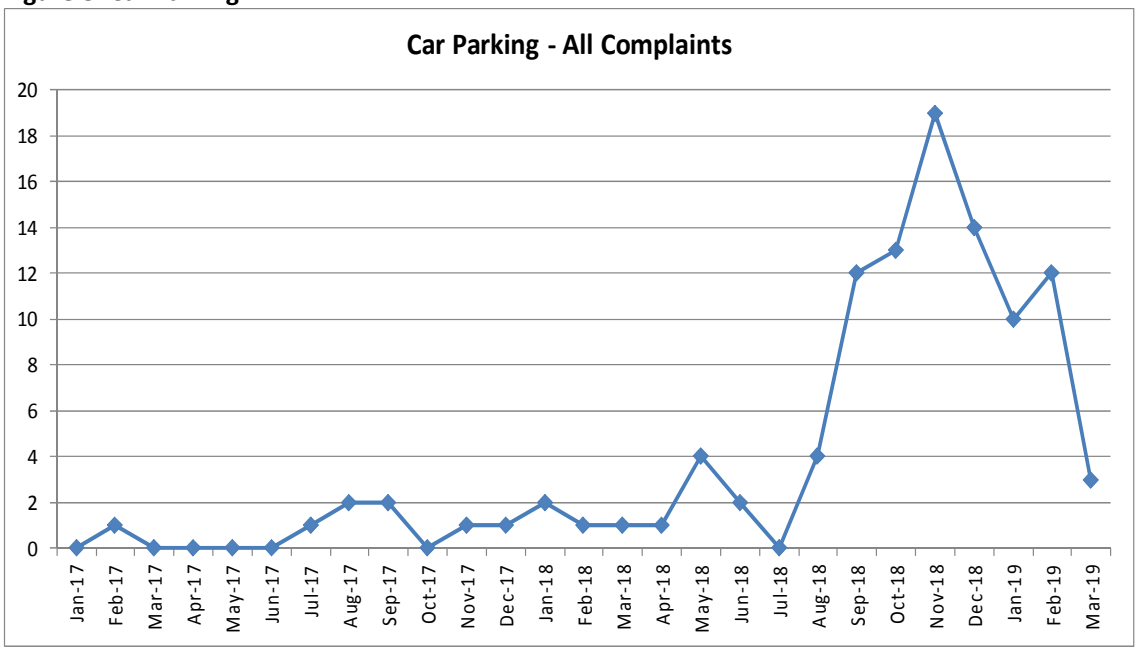
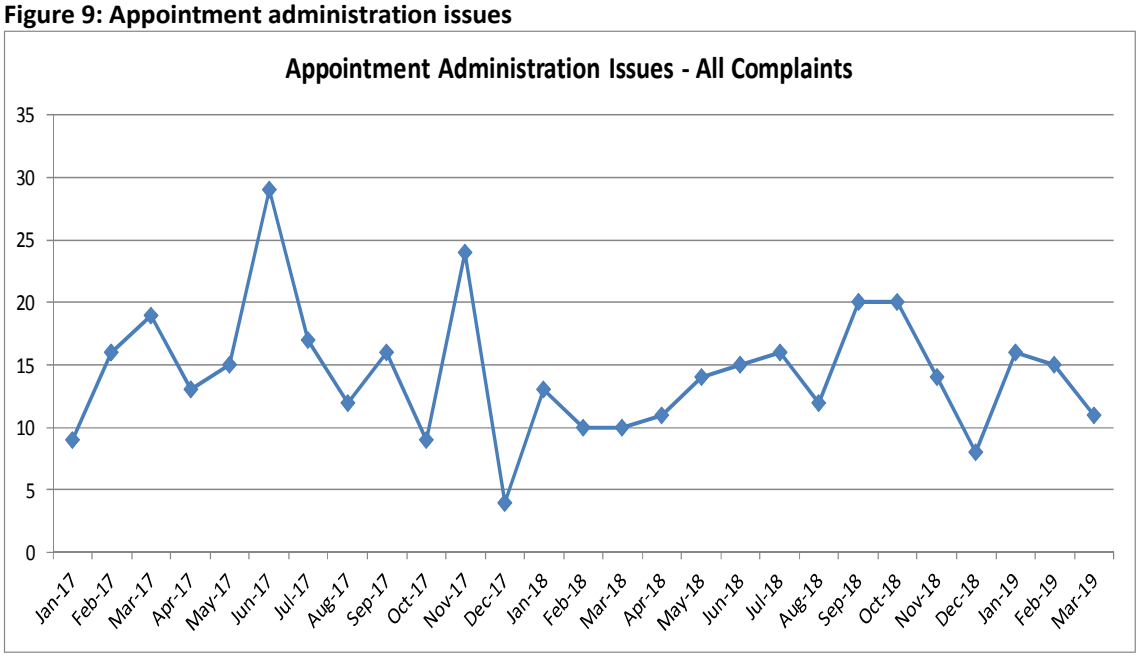


Figure 9: Appointment administration issues



3. Divisional Performance

3.1 Divisional analysis of complaints received

Table 3 provides an analysis of Q4 complaints performance by Division. In addition to providing an overall view, the table includes data for the three most common reasons why people complain: concerns about appointments and admissions; and concerns about staff attitude and communication. Data for the Division of Trust Services is not included in this table but is summarised in section 3.1.6 of the report.

Table 3	**Surgery**	**Medicine**	**Specialised Services**	**Women & Children**	**Diagnostics & Therapies**
Total number of complaints received	176 (138) ↑	98 (92) ↑	65 (59) ↑	70 (74) ↓	25 (19) ↑
Number of complaints about appointments and admissions	66 (66) =	25 (21) ↑	34 (23) ↑	20 (18) ↑	8 (4) ↑
Number of complaints about staff attitude and communication	43 (24) ↑	26 (30) ↓	13 (9) ↑	21 (11) ↑	6 (6) =
Number of complaints about clinical care	52 (34) ↑	28 (27) ↑	12 (21) ↓	24 (35) ↓	5 (6) ↓
Area where the most complaints have been received in Q4	Bristol Dental Hospital (BDH) – 34 (30) Adult Restorative Dentistry (BDH) – 8 (9) Bristol Eye Hospital (BEH) – 57 (41) BEH Administration Dept – 11 (14) Trauma & Orthopaedics – 18 (8) ENT – 8 (10) Upper GI – 11 (8) QDU Endoscopy – 7 (6)	Emergency Department (BRI) – 23 (17) Dermatology – 15 (22) Unity Sexual Health – 6 (10)	BHI (all) – 44 (38) BHOC (all) – 18 (17) BHI Outpatients – 24 (12) BHI & BHOC Appt Depts – 13 (7) Chemo Day Unit / Outpatients (BHOC) – 10 (7) Ward C708 – 3 (9) Ward C705 – 4 (8)	**BRHC (all) – 46 (53)** Paediatric Neurology & Neurosurgical – 5 (7) Children's ED (E308) – 3 (6) Paediatric Orthopaedics – 3 (5) ENT (BRHC) – 1 (4) **StMH (all) – 24 (20)** Gynaecology Outpatients (StMH) – 6 (6)	Radiology – 9 (7) Audiology – 2 (5) Physiotherapy – 3 (1)
Notable deteriorations compared with Q3	Bristol Eye Hospital (BEH) – 57 (41) Trauma & Orthopaedics – 18 (8)	Emergency Department (BRI) – 23 (17)	BHI Outpatients – 24 (12) BHI & BHOC Appt Depts – 13 (7)	No notable deteriorations	No notable deteriorations
Notable improvements compared with Q3	No notable improvements	Dermatology – 15 (22)	Ward C708 – 3 (9) Ward C705 – 4 (8)	ENT (BRHC) – 1 (4) Children's ED (E308) – 3 (6)	Audiology – 2 (5)

3.1.1 Division of Surgery

There was an increase of 27.5% in the total number of complaints received by the Division of Surgery in Q4, compared with Q3. However, it should be noted that Q3 figures are generally lower across the Trust, due to the historically lower number of complaints received in December. Complaints received by Bristol Dental Hospital, Bristol Eye Hospital and Trauma & Orthopaedics increased in Q4 following decreases in Q3.

Complaints about 'clinical care' increased significantly, as did those categorised under 'attitude and communication'. Complaints regarding 'appointments and admissions', which includes cancelled and delayed appointments and surgery, remained at the same level as reported in Q3.

Table 4: Complaints by category type

Category Type	Number and % of complaints received – Q4 2018/19	Number and % of complaints received – Q3 2018/19
Appointments & Admissions	66 (37.5% of total complaints) =	66 (47.8% of total complaints) ↑
Clinical Care	52 (29.5%) ↑	34 (24.6%) ↓
Attitude & Communication	43 (24.3%) ↑	24 (17.4%) ↑
Information & Support	7 (3.9%) ↑	4 (2.9%) ↑
Documentation	2 (1.2%) ↓	3 (2.2%) ↓
Discharge/Transfer/ Transport	2 (1.2%) ↓	3 (2.2%) ↑
Access	2 (1.2%) ↓	3 (2.2%) ↓
Facilities & Environment	2 (1.2%) ↑	1 (0.7%) =
Total	**176**	**138**

Table 5: Top sub-categories

Category	Number of complaints received – Q4 2018/19	Number of complaints received – Q3 2018/19
Cancelled or delayed appointments and operations	37 ↓	42 ↑
Clinical care (medical/surgical)	26 ↑	25 =
Appointment administration issues	17 ↓	22 ↓
Failure to answer telephones/ failure to respond	13 ↑	4 ↓
Attitude of Medical Staff	10 ↑	6 ↑
Attitude of Dentist	9 ↑	1 =
Communication with patient/relative	8 ↑	2 ↓
Lost/Misplaced/Delayed test results	6 ↑	1 ↑

Table 6: Divisional response to concerns highlighted by Q4 data

Concern	Explanation	Action
Complaints received by Bristol Eye Hospital increased from 41 in Q3 to 57 in Q4. Almost half of the complaints (27) related to outpatient services, 11 were about inpatient services, four were for the Emergency Department and 14 came under 'other' for the type of service (these include administrative functions, reception, waiting areas, etc.) 11 complaints were received in respect of the Administration Department and the majority were about appointment issues.	We note that the overall number of complaints in the BEH is rising as an overall trajectory from May 2017 (see Figure 12). The majority of formal complaints for the BEH refer to the quality of information provided to patients about their future care pathway following appointments, treatment and admission. Analysis reveals that most of these complaints were about the availability of appointments or about delays/cancelled appointments and waiting time in clinic	During Q2 2019/20 we will undertake a detailed analysis of the rising trend in complaints since 2017. Work is ongoing to maximise utilisation of available appointments, and two new posts have been approved in the Operating Plan for 2019/20, which will reduce the need for doctors to cover the BEH ED, which will in turn provide additional capacity and support waiting time reduction.
Complaints about the Trauma & Orthopaedics (T&O) service increased from eight in Q3 to 18 in Q4. Appointments and admissions accounted for half of these complaints, with the others being about clinical care (5), attitude and communication (2) and one was in relation to a patient's discharge arrangements.	Access to and cancelled appointments were the main problems. Formal complaints referred to queries about clinical care and how this is communicated /interpreted at the time of consultations. No trends were identified with regard to staff attitude.	There are significant challenges within this service relating to medical staffing. The hand service remains closed and patients are being redirected to other providers by the ERS service.
Complaints received by Bristol Dental Hospital increased slightly from 30 in Q3 to 34 in Q4. Eight of these complaints were about Adult Restorative Dentistry and seven each were received in respect of the Administration Department and Oral Medicine.	The overall trajectory of complaints about the BDH has continued to reduce overall since June 2017 (see Figure 11). There was a slight increase in Q4 but not at concerning levels Following a review there were no specific trends identified regarding complaints in BDH in Q4.	We will continue to monitor for trends in the overall trajectory at the BDH and for any specific themes.

Current divisional priorities for improving how complaints are handled and resolved

- Complaint handling performance remains consistently high and this needs to be maintained
- We continue to see an increase in informal complaints that are successfully resolved
- Through further complaints training we will continue to encourage the timely resolution of complaints locally where possible.
- The division is continuing to build a culture of learning from complaints by ensuring feedback is shared with staff.

Priority issues we are seeking to address based on learning from complaints

- Analysis of Q4 data shows a notable increase in complaints about 'failure to answer telephones/failure to respond'. We will highlight this as an increasing trend at governance meetings and through Divisional communication.
- Analysis will be undertaken in Q2 to understand the why we are seeing an overall increase in the number of complaints at the Bristol Eye Hospital.

Figure 10: Surgery, Head & Neck – formal and informal complaints received

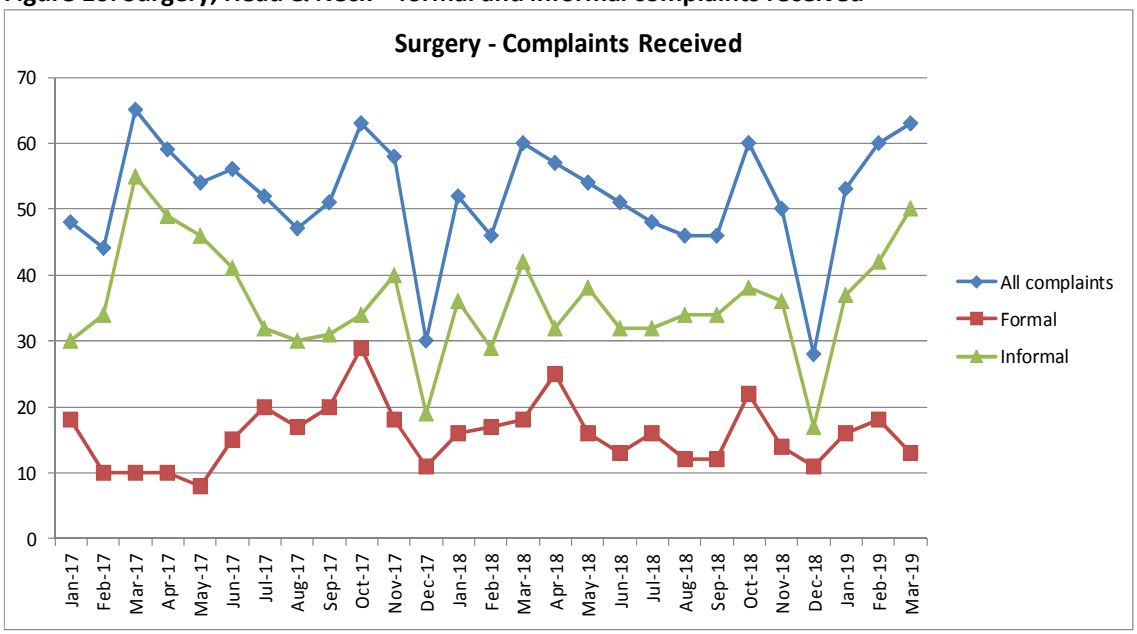


Figure 11: Complaints received by Bristol Dental Hospital

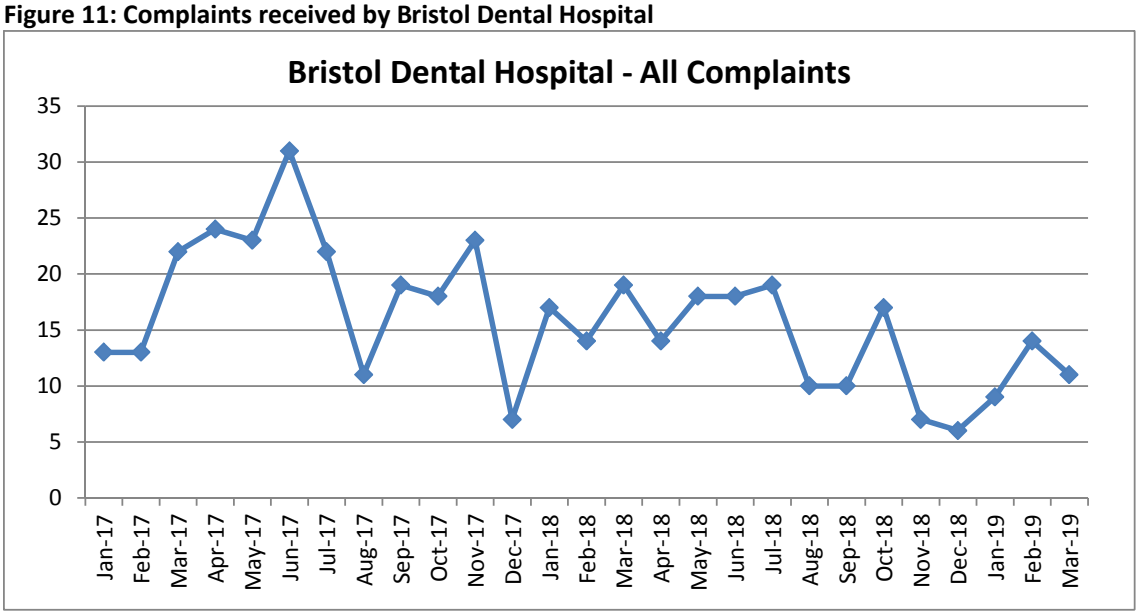


Figure 12: Complaints received by Bristol Eye Hospital

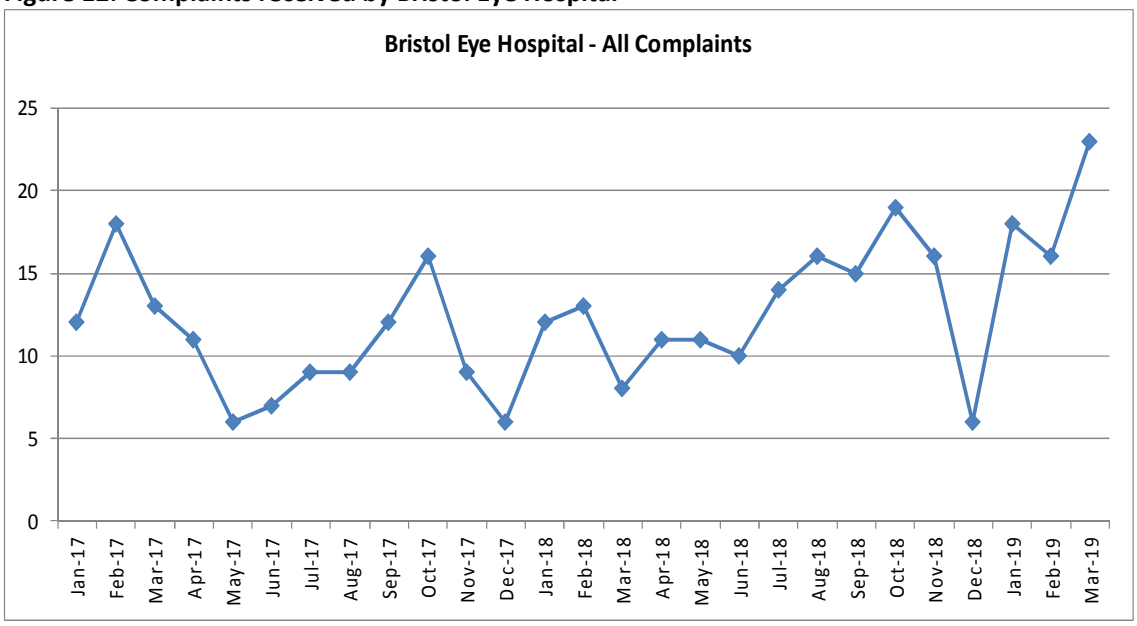
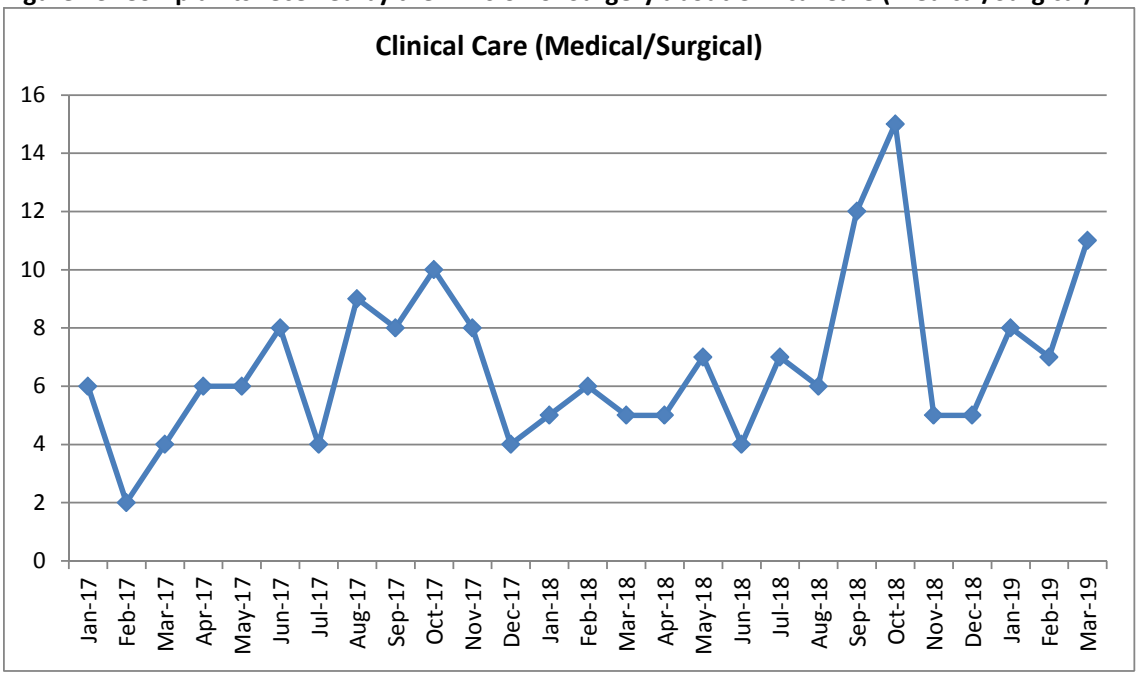


Figure 13: Complaints received by the Division of Surgery about Clinical Care (Medical/Surgical)



3.1.2 Division of Medicine

In Q4, the Division of Medicine received a slightly higher number of complaints compared with Q3 (98 compared with 92 in Q3). Complaints received by Dermatology decreased, following a concerted effort by the Division to address the capacity problems being experienced within the department. There was an increase in the number of complaints received for the Emergency Department (23 in Q4, compared with 17 in Q3).

There were increases in the number of complaints received in respect of 'appointments and admissions' and 'facilities and environment', although complaints fell in the category of 'attitude and communication' following the significant increase reported in Q3. Whilst the numbers are small, the Division continues to have the highest number of complaints relating to lost personal property.

Table 7: Complaints by category type

Category Type	Number and % of complaints received – Q4 2018/19	Number and % of complaints received – Q3 2018/19
Clinical Care	28 (28.6% of total complaints) ↑	27 (29.4% of total complaints) ↓
Attitude & Communication	26 (26.5%) ↓	30 (32.6%) ↑
Appointments & Admissions	25 (25.5%) ↑	21 (22.8%) ↓
Facilities & Environment	9 (9.2%) ↑	5 (5.4%) =
Documentation	5 (5.1%) ↑	4 (4.3%) ↑
Discharge/Transfer/ Transport	4 (4.1%) ↑	2 (2.2%) ↓
Information & Support	1 (1.0%) ↓	3 (3.3%) ↓
Access	0 (0%) =	0 (0%) ↓
Total	**98**	**92**

Table 8: Top sub-categories

Category	Number of complaints received – Q4 2018/19	Number of complaints received – Q3 2018/19
Cancelled or delayed appointments and operations	17 ↑	14 ↑
Clinical care (medical/surgical)	18 ↓	22 ↓
Attitude of medical staff	10 ↑	8 ↑
Attitude of nursing staff	6 ↑	4 =
Appointment administration issues	5 ↑	4 ↓
Personal (lost) property	5 ↑	4 ↑
Attitude of A&C staff	3 ↓	5 ↑
Communication with patient/relative	3 =	3 ↓
Lost/Misplaced/Delayed test results	3 ↑	2 ↑

Table 9: Divisional response to concerns highlighted by Q4 data

Concern	Explanation	Action
Complaints received for the Emergency Department increased from 17 in Q3 to 23 in Q4. Eight of the 23 complaints received were about attitude and communication, seven related to clinical care and three complaints were made under the category of facilities and environment (including lost personal property and cleanliness of the department).	The increase in complaints is a seasonal effect and has a direct correlation to operational pressures, crowding and increased waiting to be seen times. These operational pressures have resulted in an increase in stress related sickness amongst staff, further compounding the pressure on remaining staff. Whilst not intentional, this impacts negatively on the ED staff's communication with patients, compromising how they are kept informed in a kind and compassionate way, which is always the team's intention.	Complaint themes are reviewed at the ED multidisciplinary meeting and relevant action planning occurs, including discussion at Board rounds, teaching sessions and the departmental mortality and morbidity meetings where appropriate. Messages regarding a focus on kindness and compassion are being included in daily safety briefings and messages of the week. As part of their monitoring, the ED Matrons escalate any concerns about departmental cleanliness and where the cleaning specification does not appear to be being delivered. Additional security is in place in the reception area to deal with incidents of antisocial or violent/ aggressive behavior, to improve the patients' experience in the waiting area. Specific training is being undertaken with unregistered nursing staff regarding the management of patient property, specifically patients' lost property.

Current divisional priorities for improving how complaints are handled and resolved:

To encourage staff to manage complaints at the first point of contact at the time the issue occurred – this will improve the patient experience and will not delay patients and/or relatives receiving a timely response to their concerns, leading to a more positive outcome.

Priority issues we are seeking to address based on learning from complaints:

Communication issues – reinforcing the Trust Values and how they are used to avoid complaints regarding attitude of staff.

Figure 14: Medicine – formal and informal complaints received

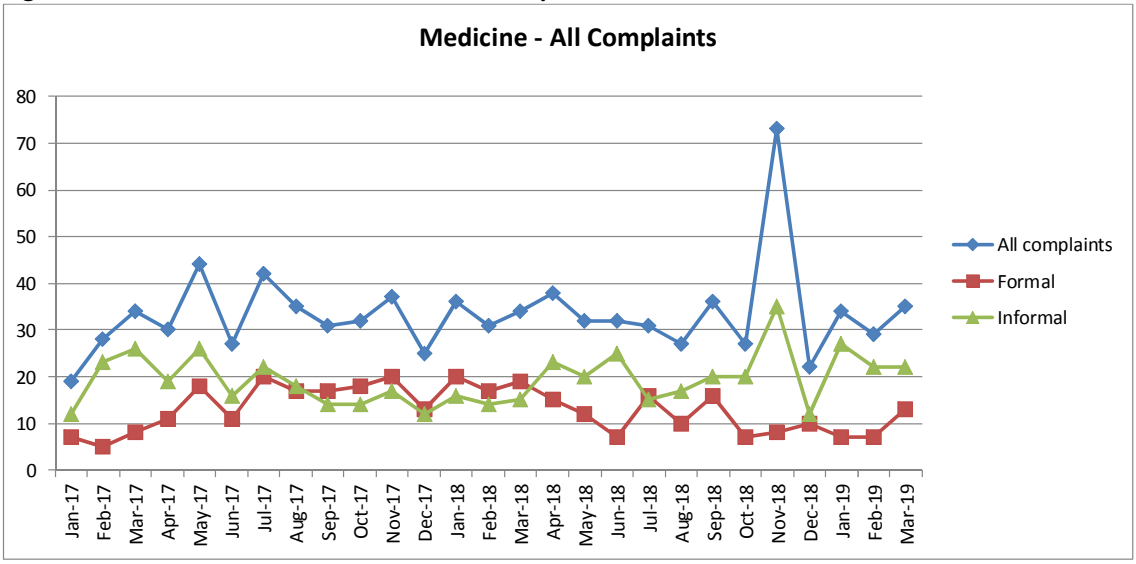


Figure 15: Complaints received by Dermatology

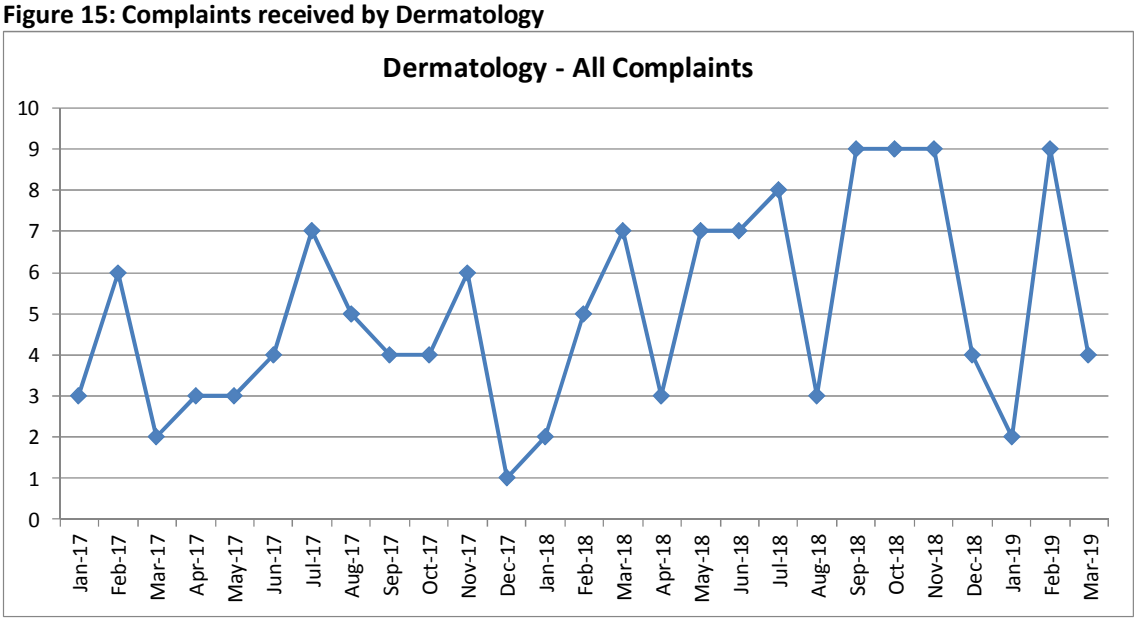
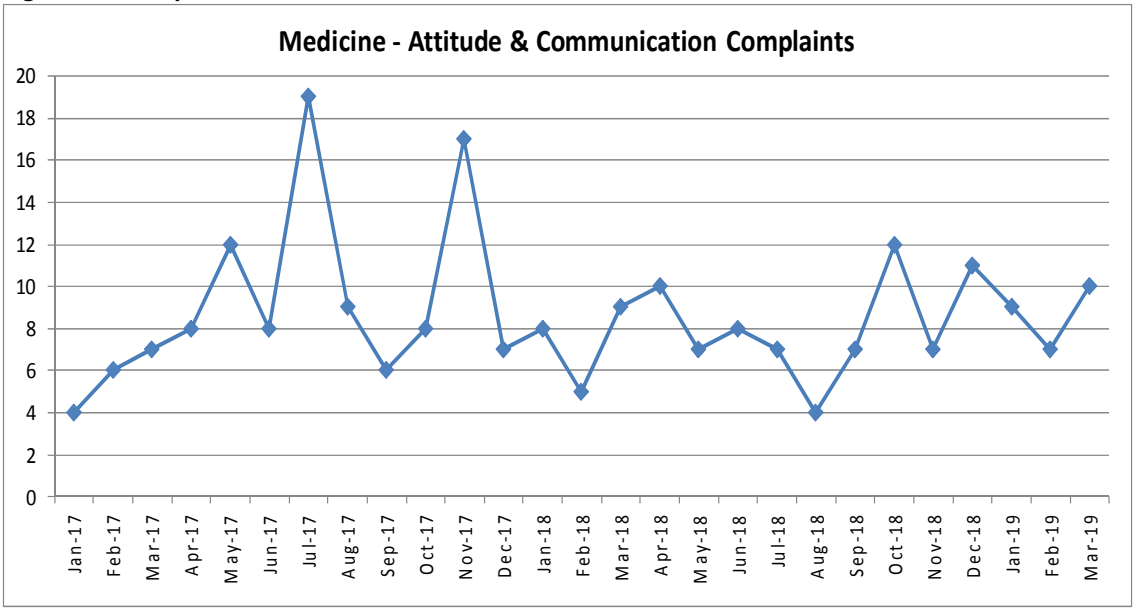


Figure 16: Complaints about attitude and communication



3.1.3 Division of Specialised Services

The Division of Specialised Services received 65 new complaints in Q4; an increase on the 59 received in Q3. Of these 65 complaints, 44 were for the Bristol Heart Institute (BHI), compared with 38 in Q3, and 18 were for the Bristol Haematology & Oncology Centre (BHOC), compared with 17 in Q3. The remaining three complaints were for the Clinical Genetics service based at St Michael's Hospital.

Over half of all complaints received by the Division in Q4 (52.4%) came under the category of 'appointments and admissions', which includes complaints about cancelled and delayed appointments and surgery. There was also an increase in the number of complaints received in the category of 'attitude and communication' with 13 complaints received, compared with nine in Q3.

Complaints in all sub-categories increased in Q4, compared with Q3, with the exception of 'clinical care (medical/surgical)' which decreased significantly, from 18 in Q3 to six in Q4. This was in line with a decrease overall in complaints about 'clinical care', from 21 in Q3 to 12 in Q4.

Table 10: Complaints by category type

Category Type	Number and % of complaints received – Q4 2018/19	Number and % of complaints received – Q3 2018/19
Appointments & Admissions	34 (52.4% of total complaints) ↑	23 (39% of total complaints) ↑
Attitude & Communication	13 (20%) ↑	9 (15.3%) ↓
Clinical Care	12 (18.5%) ↓	21 (35.6%) ↓
Documentation	3 (4.6%) ↑	2 (3.4%) ↑
Information & Support	1 (1.5%) ↓	3 (5.1%) ↓
Discharge/Transfer/Transport	1 (1.5%) =	1 (1.7%) ↓
Facilities & Environment	1 (1.5%) ↑	0 ↓
Access	0 (0%) =	0 (0%) =
Total	**65**	**59**

Table 11: Top sub-categories

Category	Number of complaints received – Q4 2018/19	Number of complaints received – Q3 2018/19
Cancelled or delayed appointments and operations	19 ↑	15 ↓
Appointment administration issues	12 ↑	6 ↑
Clinical care (medical/surgical)	6 ↓	18 ↓
Lost/Misplaced/Delayed test results	4 ↑	1 ↓
Failure to answer phone/ Failure to respond	4 ↑	2 ↑
Attitude of medical staff	3 ↑	1 ↓
Attitude of A&C staff	2 ↑	0 ↓

Table 12: Divisional response to concerns highlighted by Q4 data

Concern	Explanation	Action
Complaints received for Bristol Heart Institute Outpatients doubled from 12 in Q3 to 24 in Q4. Eleven of the 24 complaints were made in respect of appointments and admissions, which includes cancelled and delayed appointments or operations. Eight of the complaints were about attitude and communication. The three complaints about clinical care for BHI Outpatients were all in respect of lost/misplaced/delayed test results.	Four of the eleven complaints about appointments and admission were from patients chasing Pacing/Heart monitor appointments. Three complaints were due to cancelled appointments which was either an admin error or due to consultants' leave. Two of the complaints were about not being able to contact the relevant Department. The majority of these eight complaints were about departments not answering the phone. Two complaints related to poor consultant communication with patients. All three clinical care complaints were about chasing test results: one MRI, one gated CT and one stress test.	With regard to Pacing/Heart monitor appointments – there had been a substantial backlog of patients (400+) but this has now been resolved with use of Agency Staff. Consultants have been reminded that they must give six weeks' notice of annual leave. The Division will not cancel appointments unless something has happened beyond its control, e.g. emergency in Cath Lab or emergency leave needed. Awareness of Customer Care training and Breaking Bad News communication skills is being raised through the Division's Safety Brief and Newsletter.
The appointments departments for Bristol Heart Institute and Bristol Haematology & Oncology Centre received a total of 13 complaints in Q4, compared with seven in Q3.	Three complaints related to long waits to be seen in the Haematology Clinic, four related to booking blood tests/line care appointment and oncology appointments, whilst another two were requests to bring	An additional clinic session has been organised for Haematology run by a Consultant and Registrar, alleviating some of the pressure on the Tuesday afternoon clinic and reducing waiting times.

The majority of these (10) were about cancelled or delayed appointments and appointment administration issues).	forward Radiotherapy appointments (which was done).	A new team member is now working on reception to assist with booking blood tests and line care appointments.

Current divisional priorities for improving how complaints are handled and resolved:

Having more verbal conversations to provide a more personal approach to a complaint, by ringing the complainant to discuss their complaint and ensure have all the issues.

The Division is piloting having more face-to-face meetings with complainants in an effort to provide more effective resolution of their concerns and to reduce dissatisfied responses. Meetings will in future be recorded and complainants will be sent a copy (with appropriate Information Governance arrangements in place); a cover letter will still be provided with the agreed actions and updates included.

Priority issues we are seeking to address based on learning from complaints.

Raising awareness of Customer Care and Breaking Bad News /Dealing with difficult conversations training.

Figure 17: Specialised Services – formal and informal complaints received

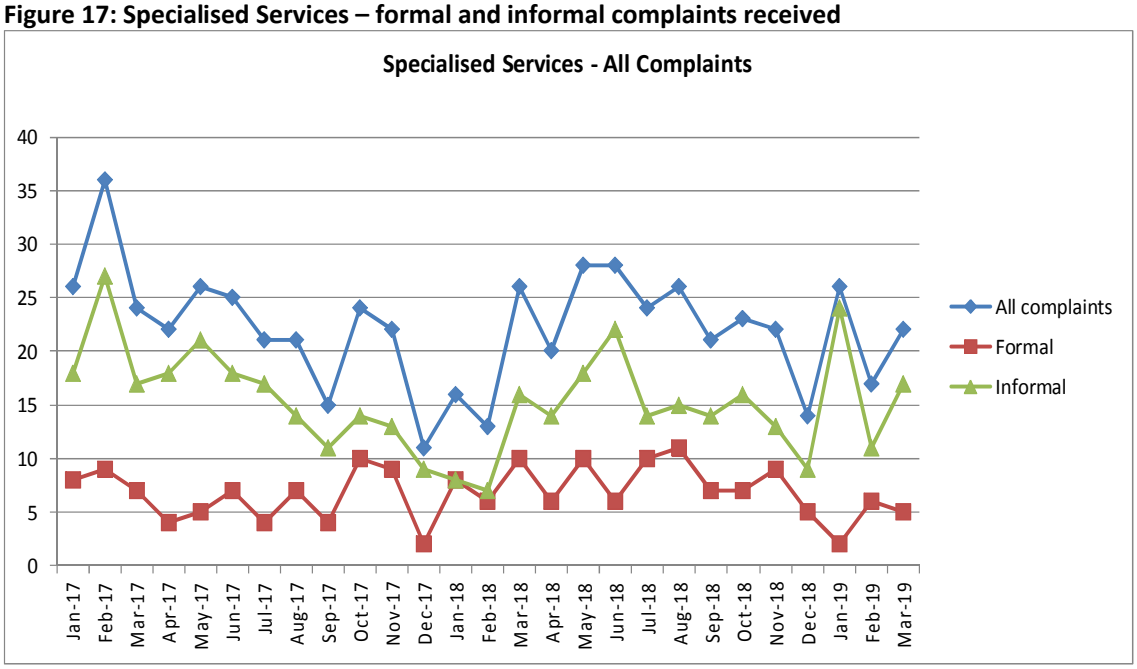


Figure 18: Complaints received by Bristol Heart Institute

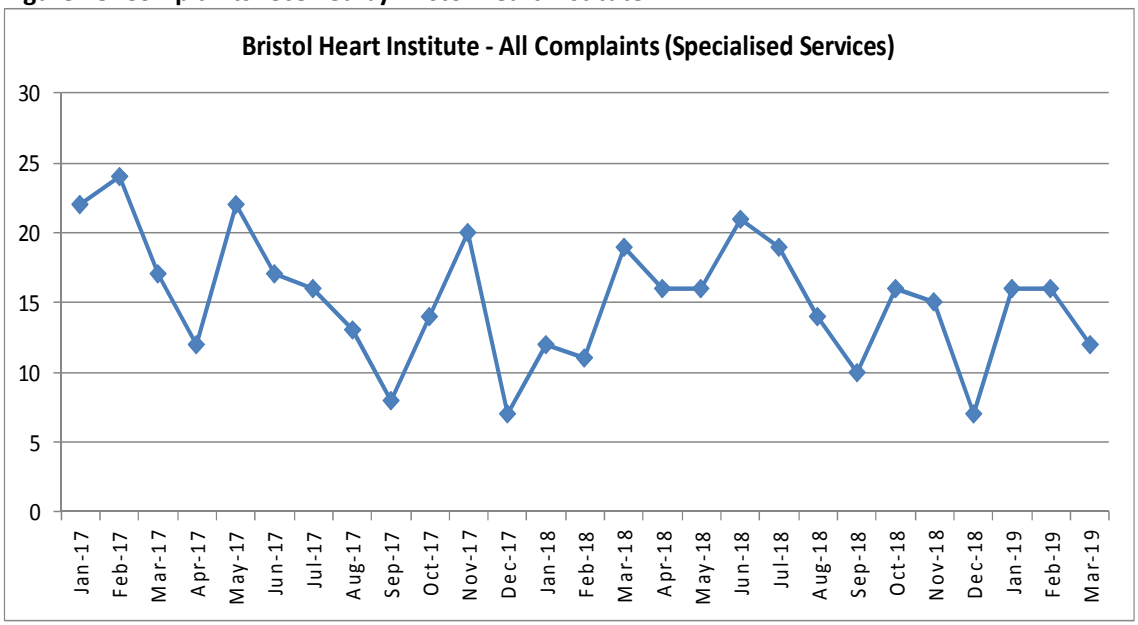


Figure 19: Complaints received by Bristol Haematology & Oncology Centre

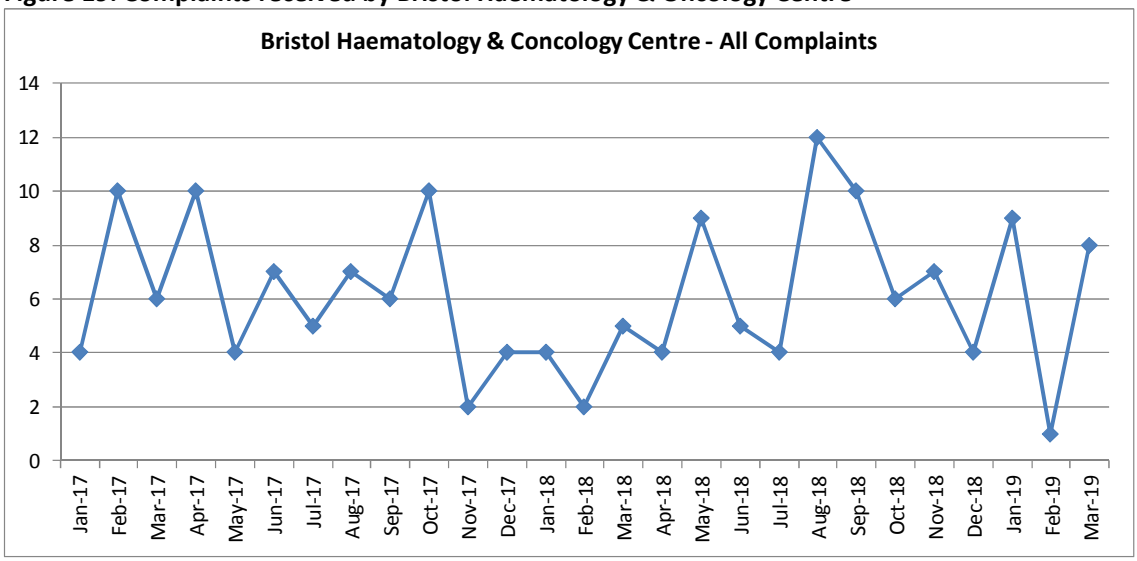
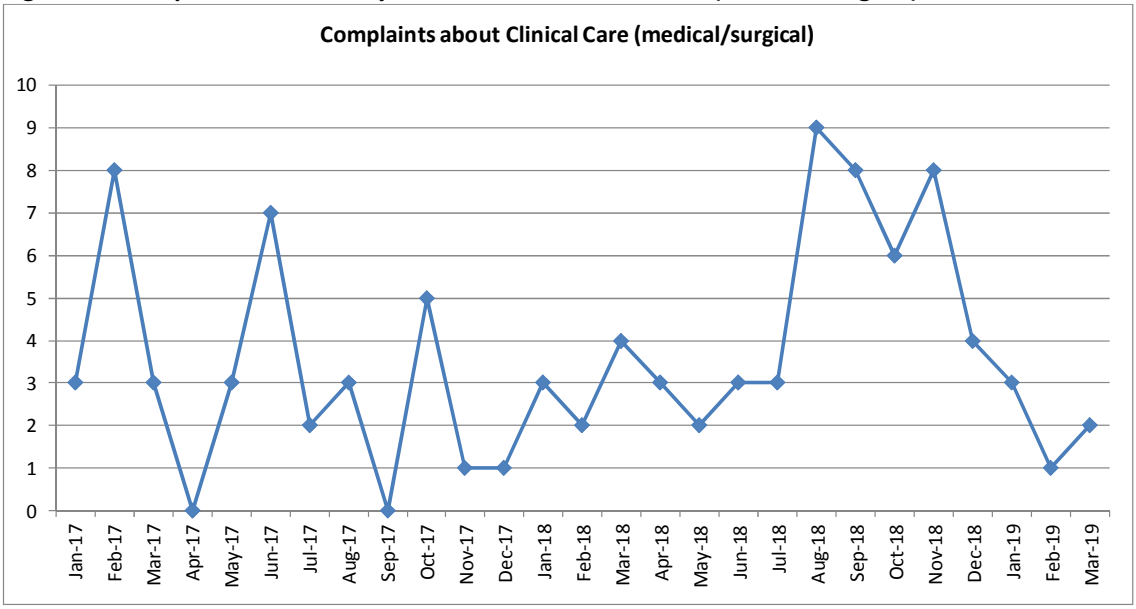


Figure 20: Complaints received by Division about Clinical Care (medical/surgical)



3.1.4 Division of Women's and Children's Services

The total number of complaints received by the Division decreased slightly from 74 in Q3 to 70 in Q4. Complaints for Bristol Royal Hospital for Children (BRHC) accounted for 46 of the 71 complaints, a decrease on the 53 received in Q3. 24 of the complaints received were for St Michael's Hospital (StMH), a slight increase on the 20 received in Q3.

There was a notable decrease in the number of complaints received by the Division in respect of 'clinical care' (24 compared with 35 in Q3). This is reflected in the reduced number of complaints in the sub-categories of 'clinical care (medical/surgical)' and 'clinical care (nursing midwifery)' as shown in Table 14 below. However, there was an increase in complaints related to 'attitude and communications', from 11 in Q3 to 21 in Q4.

Table 13: Complaints by category type

Category Type	Number and % of complaints received – Q4 2018/19	Number and % of complaints received – Q3 2018/19
Clinical Care	24 (34.3% of total complaints) ↓	35 (47.3% of total complaints) ↓
Attitude & Communication	21 (30.0%) ↑	11 (14.8%) ↓
Appointments & Admissions	20 (28.5%) ↑	18 (24.3%) ↑
Information & Support	2 (2.9%) ↓	6 (8.1%) ↓
Facilities & Environment	2 (2.9%) ↑	1 (1.4%) ↓
Documentation	1 (1.4%) ↓	2 (2.7%) ↑
Discharge/Transfer/Transport	0 (0%) ↓	1 (1.4%) ↑
Access	0 (0%) =	0 (0%) =
Total	**70**	**74**

Table 14: Top sub-categories

Category	Number of complaints received – Q4 2018/19	Number of complaints received – Q3 2018/19
Clinical care (medical/surgical)	14 ↓	24 ↑
Cancelled or delayed appointments and	12 ↑	10 ↑
Clinical care (nursing/midwifery)	5 ↓	7 ↓
Communication with patient/relative	5 ↑	4 =
Attitude of nursing/midwifery	5 ↑	2 ↓
Attitude of medical staff	5 ↑	2 ↓
Lost/Misplaced/Delayed test results	4 ↑	2 ↑

Table 15: Divisional response to concerns highlighted by Q4 data

Concern	Explanation	Action
BRHC 15 of the 46 complaints received by BRHC (32.6%) related to 'attitude and communication'. The number of complaints in this category was particularly high at the end of the quarter (11 of the 15 complaints were received in March 2019). Nine of the complaints were in relation to inpatient services and six were about outpatient services.	**BRHC** Analysis of complaints about attitude and communication shows that these are clustered around specific areas and staff within Children's Services.	**BRHC** The areas and individuals identified have been sent on customer service training and spoken to by line managers to aid learning and development as appropriate.

Current divisional priorities for improving how complaints are handled and resolved:

StMH
StMH Complaints Coordinator attends weekly management meetings to provide an update on complaints and where they are in the process; thus escalating any cases that could potentially breach their response date. The Division is about to advertise for a new Complaints Coordinator, whose remit will include writing complaint responses.

BRHC
In the Q3 Complaints Report, it was reported that a new spreadsheet was being developed to identify key themes from complaints. The content of this spreadsheet will be ready for analysis in Q1 2019/20, having gathered several months' worth of data. We will then develop improvement plans to address these themes.

Priority issues we are seeking to address based on learning from complaints.

StMH

- The Head of Midwifery will meet with the manager of the Trust's Overseas Visitors Team, to discuss the wording of the letter sent to overseas visitors; specifically, a process needs to be put in place so that the Finance Department and the Overseas Visitors Team are alerted to where a patient they are involved with has a bereavement.
- Delivery Suite midwives are being encouraged to explain the two call bells in the delivery rooms and, whilst not encouraging patients and visitors to pull the emergency bell, making them aware that it exists.
- Sonographers are now stating clearly on scan reports when an anomaly is suspected and referring to the Fetal Medicine Team.
- Likely timescales (1 to 3 working days) for being contacted by the Fetal Medicine Unit with an appointment are now being given to patients and an appointment will be given within 3 to 5 working days.
- Further" Patient Experience at the Heart" Workshops have been held at St Michaels for all staff.

BRHC

Communication and attitude has been a common theme this quarter; staff and areas have received training on customer service interactions and also leadership development. We are now focussing on developing staff to deal more proactively with concerns and to stop these progressing to complaints where possible.

Figure 21: Women & Children – formal and informal complaints received

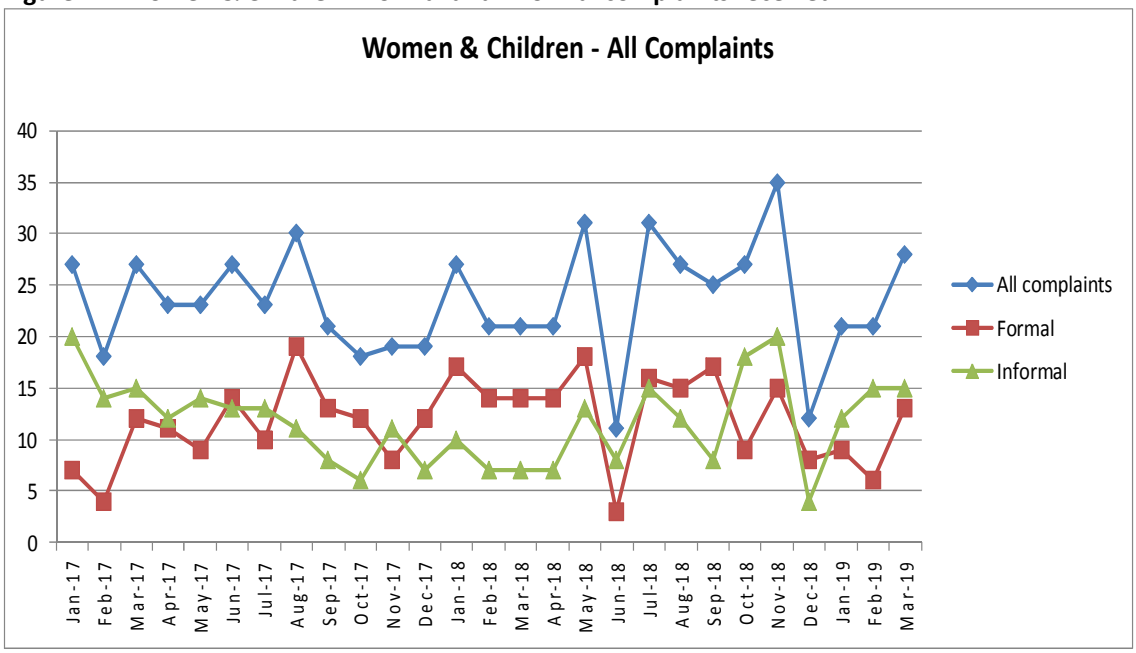


Figure 22: Complaints received by Bristol Royal Hospital for Children

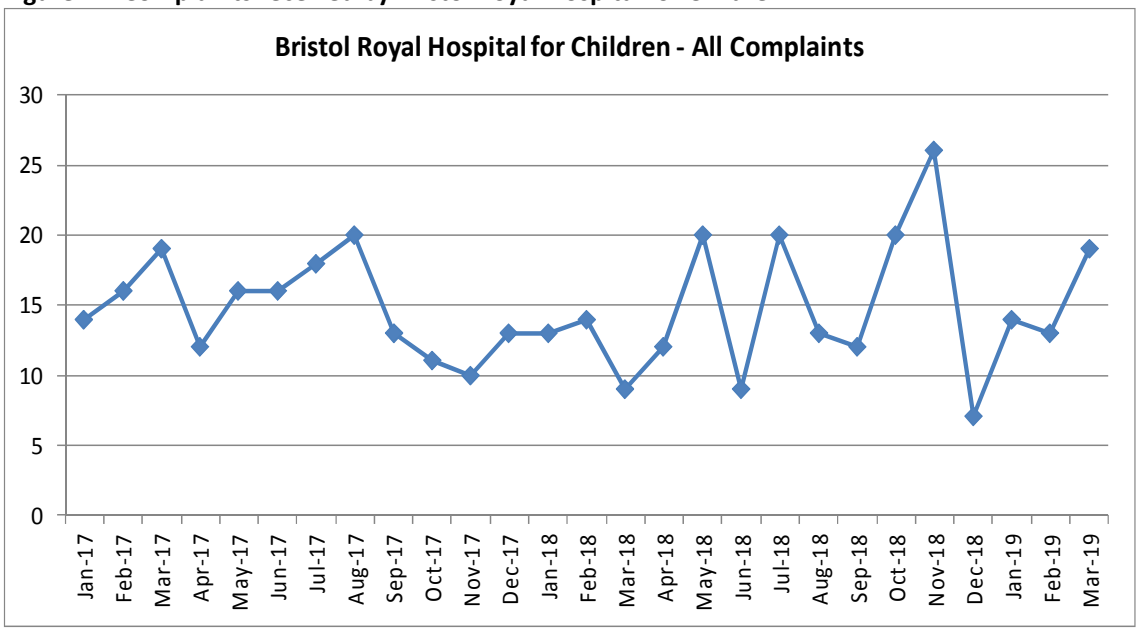


Figure 23: Complaints received by St Michael's Hospital

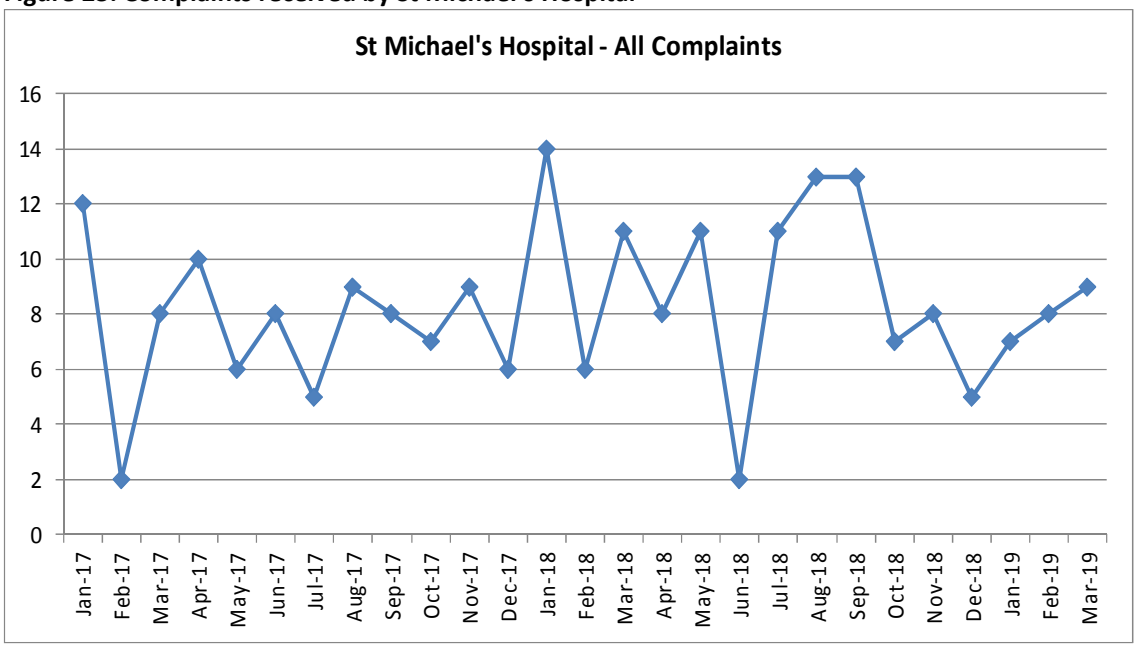
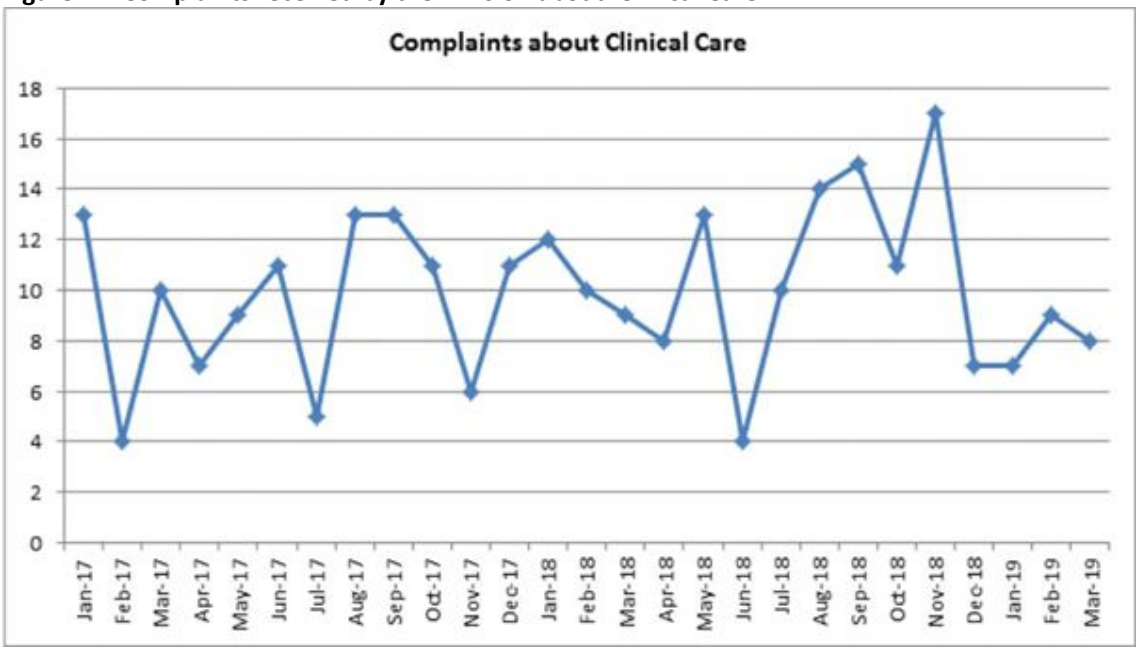


Figure 24: Complaints received by the Division about 'Clinical Care'



3.1.5 Division of Diagnostics & Therapies

Complaints received by the Division of Diagnostics and Therapies increased from 19 in Q3 to 25 in Q4.

Almost half of the complaints received (12) were for Radiology services, with five being received for Audiology and two for Physiotherapy.

Table 16: Complaints by category type

Category Type	Number and % of complaints received – Q4 2018/19	Number and % of complaints received – Q3 2018/19
Appointments & Admissions	8 ↑	4 (21.1%) =
Attitude & Communication	6 =	6 (31.6% of total complaints) ↓
Clinical Care	5 ↓	6 (31.6%) ↑
Facilities & Environment	2 =	2 (10.5%) ↑
Information & Support	2 ↑	1 (5.2%) ↓
Documentation	1 ↑	0 (0%) =
Access	1 ↑	0 (0%) =
Discharge/Transfer/Transport	0 =	0 (0%) =
Total	**25**	**19**

Table 17: Top sub-categories

Category	Number of complaints received – Q4 2018/19	Number of complaints received – Q3 2018/19
Appointment administration issues	5 ↑	3 ↑
Clinical care (medical/AHPs)	4 ↓	6 ↑
Communication with patient/relative	2 ↑	-
Attitude of medical staff/AHPs	0	3 ↑

Table 18: Divisional response to concerns highlighted by Q4 data

Concern	Explanation	Action
Numbers of complaints regarding appointments and admissions remain small in absolute terms but in Q4 they increased to their highest level since Q3 of 2016/17.	The eight complaints received are a mixture of delayed appointment referrals, difficulties in contacting departments, short notice of an appointment, and long delays at Boots Pharmacy.	These complaints are across several services; there is not a particular theme. In each case, the complainant was responded to with an explanation for the delay or apology for the lack of response from the departments and appointments booked or timeline given. Two complaints were not taken forward by the complainants so did not require a response.
Five of the eight complaints in this category are in respect of appointment administration issues.	These complaints were across three different services so there is no particular department of concern. Two of the complaints are in respect of difficulties contacting the department by telephone and three were delayed referrals.	All patients have been contacted, given appointments and received apologies for the difficulties/delays. All referrals were within the required timeframes, with the exception of physiotherapy which was experiencing staffing shortages. We are undertaking a review of our telephone management systems to see if we can improve communications with the departments.

Current divisional priorities for improving how complaints are handled and resolved:

Complaints are a high priority for the division to ensure timescales are consistently met, and we rarely request extensions to complaint deadlines. There is a robust divisional process in place:

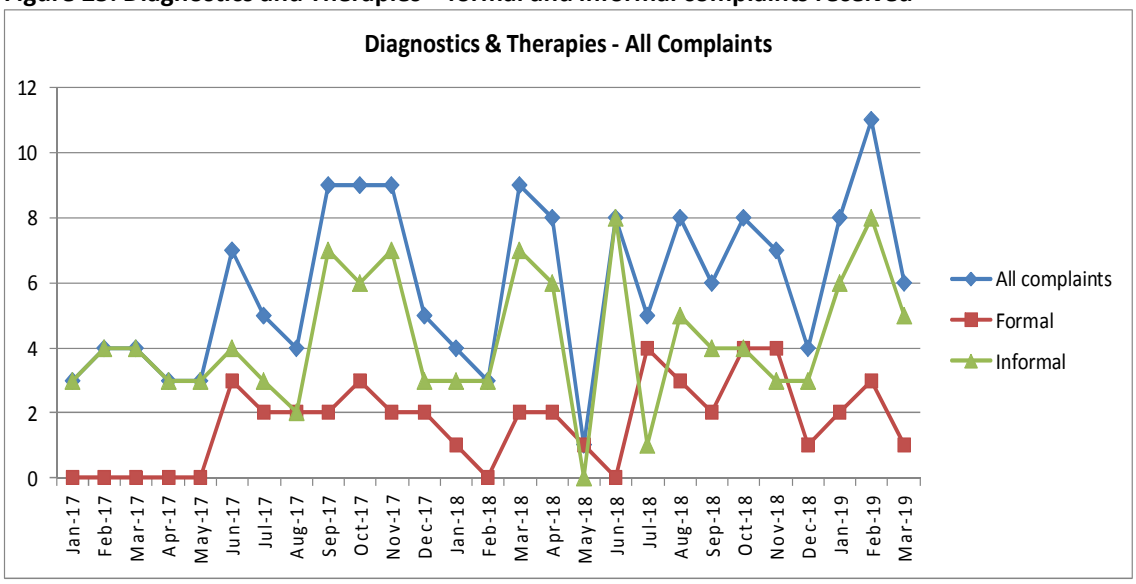
- A complaints coordinator who receives and disseminates the complaints to relevant individuals;
- Input from all services involved;
- Clearly assigned leads within the divisional management team for each complaint;
- Tracking log with timescales for all complaints to ensure deadlines are met;
- Final sign off and review of all formal complaints are undertaken by the Divisional Director;

- Bi-monthly internal analysis and report on complaints presented at the Divisional Clinical Quality Committee.

Priority issues we are seeking to address based on learning from complaints.

The division undertakes regular internal analysis on complaint responses it both leads for, and contributes to.

Figure 25: Diagnostics and Therapies – formal and informal complaints received



3.1.6 Division of Trust Services

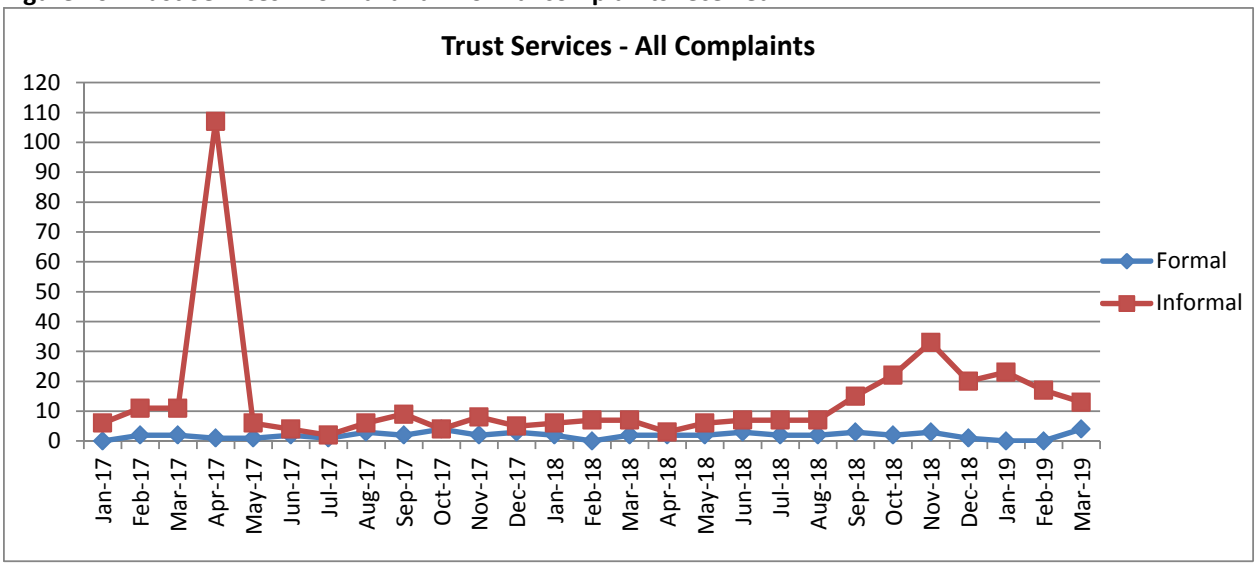
The Division of Trust Services, which includes Facilities & Estates, received 57 complaints in Q4, compared with 81 in Q3 and 36 In Q2.

The high number of complaints received in Q3 has been explained in a previous report, with the majority being in respect of parking issues at South Bristol Community Hospital (SBCH).

Of the 57 complaints received in Q4, 26 were about car parking across various Trust sites. Complaints about the problems at SBCH reduced notably towards the end of the quarter following the implementation of new pay machines and signage.

The remainder of the complaints received were spread across various departments/areas, including Medical Records, Cashiers, the hospital free bus service and Boots Pharmacy (retail).

Figure 26: Trust Services – formal and informal complaints received



3.2 Complaints by hospital site

Complaints increased across all hospital sites, with the exception of Bristol Royal Hospital for Children, South Bristol Community Hospital and Central Health Clinic, which all saw reductions in the number of complaints received. The most notable increase by percentage was Bristol Eye Hospital, which saw a 39% increase compared with Q3.

Table 19: Breakdown of complaints by hospital site[3]

Hospital/Site	Number and % of complaints received in Q4 2018/19	Number and % of complaints received in Q3 2018/19
Bristol Royal Infirmary	193 (39.1% of total complaints) ↑	171 (36.9% of total complaints) ↑
Bristol Eye Hospital	57 (11.7%) ↑	41 (8.9%) ↓
Bristol Royal Hospital for Children	48 (9.7%) ↓	56 (12.2%) ↑
Bristol Heart Institute	48 (9.7%) ↑	40 (8.6%) ↓
St Michael's Hospital	42 (8.5%) ↑	40 (8.6%) ↓
Bristol Dental Hospital	34 (6.9%) ↑	30 (6.5%) ↓
South Bristol Community Hospital	30 (6.1%) ↓	52 (11.2%) ↑
Bristol Haematology & Oncology Centre	22 (4.5%) ↑	18 (3.9%) ↓
Central Health Clinic	8 (1.6%) ↓	12 (2.6%) ↑
Community Dental Sites	3 (0.6%) ↑	0 (0%) =
Southmead and Weston Hospitals (UH Bristol services)	3 (0.6%) ↑	0 (0%) ↓
Estates & Facilities Building	2 (0.4%) ↑	1 (0.2%) =
Trust Headquarters	1 (0.2%) =	1 (0.2%) ↓
IM&T (Southwell Street)	1 (0.2%) ↑	0 (0%) =
Off Trust Premises	1 (0.2%) ↑	0 (0%) =
TOTAL	**493**	**463**

[3] It should be noted that these figures will not all match complaints by Division as some divisional services take place at other sites. For example, ENT comes under the remit of the Division of Surgery but the clinic is based at St Michael's Hospital and some services that come under Diagnostics & Therapies are undertaken at the Children's Hospital.

3.2.1 Breakdown of complaints by inpatient/outpatient/ED status

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

In Q4, 44.8% (*38.9%) of complaints received were about outpatient services, 30.6% (34.1%) related to inpatient care, 5.5% (4.1%) were about emergency patients; and 19.1% (22.9%) were in the category of 'other' (as explained above).

** Q3 percentages are shown in brackets for comparison.*

Figure 27: All patient activity

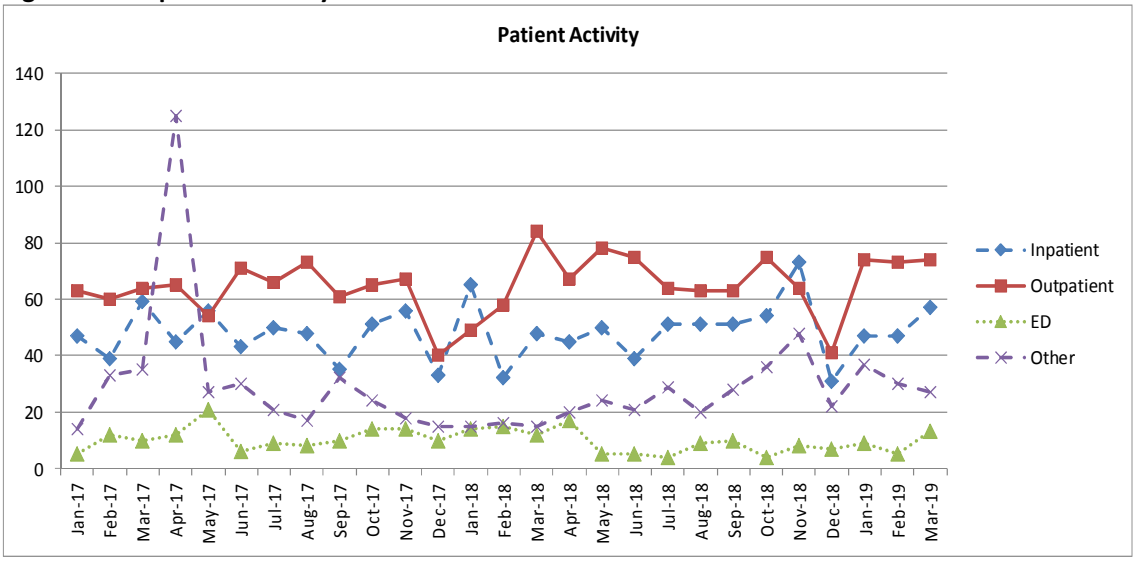


Table 20: Breakdown of Area Type

Complaints	Area Type				
Month	**ED**	**Inpatient**	**Outpatient**	**Other**	**Grand Total**
Oct-17	14	51	65	24	154
Nov-17	14	56	67	18	155
Dec-17	10	33	40	15	98
Jan-18	14	65	49	15	143
Feb-18	15	32	58	16	121
Mar-18	12	48	84	15	159
Apr-18	17	45	67	20	149
May-18	5	50	78	24	157
Jun-18	5	39	75	21	140
Jul-18	4	51	64	29	148
Aug-18	9	51	63	20	143
Sep-18	10	51	63	28	152
Oct-18	4	54	75	36	169

Nov-18	8	73	64	48	193
Dec-18	7	31	41	22	101
Jan-19	9	47	74	37	167
Feb-19	5	47	73	30	155
Mar-19	13	57	74	27	171
Grand Total	**175**	**881**	**1174**	**445**	**2675**

3.3 Complaints responded to within agreed timescale (for formal resolution process)

All Divisions reported breaches in Q4, totalling 25 breaches, which is similar to the number of breaches reported in the previous three quarters, as shown in Table 21 below. In Q4, the Trust responded to 169 complaints via the formal complaints route and 85.2% of these were responded to by the agreed deadline.

Table 21: Breakdown of breached deadlines - Formal

Division	Q4 (2018/19)	Q3 (2018/19)	Q2 (2018/19)	Q1 (2018/19)
Surgery	3 (5.6%)	6 (9.5%)	4 (6.7%)	4 (5%)
Women & Children	15 (31.3%)	13 (25%)	13 (27.7%)	10 (22.2%)
Trust Services	2 (40%)	3 (27.3%)	1 (20%)	3 (33.3%)
Medicine	1 (3.3%)	3 (6.8%)	2 (6.7%)	4 (7.4%)
Specialised Services	3 (12.5%)	0 (0%)	5 (14.3%)	4 (20%)
Diagnostics & Therapies	1 (11.1%)	1 (8.3%)	0 (0%)	0 (0%)
All	**25 breaches**	**26 breaches**	**25 breaches**	**25 breaches**

(So, as an example, there were three breaches of timescale in the Division of Surgery in Q4, which constituted 5.6% of the complaint responses which were sent out by that division in Q4.)

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

Table 22 shows a breakdown of where the delays occurred in Q4. Nineteen breaches were attributable to Divisions, four were caused by delays in the Patient Support & Complaints Team and two breaches were attributable to delays during Executive sign-off.

Table 22: Reason for delay

Breach attributable to	Surgery	Medicine	Specialised Services	Women & Children	Diagnostics & Therapies	Trust Services	All
Division	0	1	1	14	1	2	**19**
Patient Support & Complaints Team	1	0	2	1	0	0	**4**
Executives/sign-off	2	0	0	0	0	0	**2**
All	**3**	**1**	**3**	**15**	**1**	**2**	**25**

3.3.1 Complaints responded to within agreed timescale (for informal resolution process)

For the first time, in Q4, we are reporting the number of informal complaints that breached the deadline agreed with the complainant, i.e. this is a new Board-reported target, reflecting the fact that the majority of complaints received by the Trust are now handled via the informal process. Breaches of informal complaint timescales are, by definition, attributable to Divisions because the Patient Support & Complaints Team and Executive Directors do not contribute to the sign-off process. In Q4, the Trust responded to 231 complaints via the informal complaints route and 84.0% of these were responded to by the agreed deadline.

Table 23: Breakdown of breached deadlines - Informal

Division	Q4 (2018/19)	Q3 (2018/19)	Q2 (2018/19)	Q1 (2018/19)
Surgery	10 (14.5%)			
Women & Children	8 (33.3%)			
Trust Services	10 (22.2%)			
Medicine	3 (7.1%)			
Specialised Services	5 (12.2%)			
Diagnostics & Therapies	1 (10%)			
All	**37**			

3.4 Outcome of formal complaints

In Q4, the Trust responded to 169 formal complaints[4]. Tables 24 and 25 below show a breakdown, by Division, of how many of these cases were upheld, partly upheld or not upheld in Q4 and Q3 of 2018/19 respectively. A total of 87.0% of complaints were either upheld or partly upheld in Q4, compared with 82.9% in Q3.

Table 24: Outcome of formal complaints – Q4 2018/19

	Upheld	Partly Upheld	Not Upheld
Surgery	19 (35.8%) ↓	25 (47.2%) ↑	9 (17%) ↓
Medicine	8 (26.7%) ↓	19 (63.3%) ↑	3 (10%) ↓
Specialised Services	12 (50%) ↓	10 (41.7%) ↓	2 (8.3%) ↓
Women & Children	18 (37.5%) ↓	24 (50%) ↓	6 (12.5%) ↑
Diagnostics & Therapies	1 (11.1%) ↓	7 (77.8%) ↑	1 (11.1%) ↓
Trust Services	4 (80%) ↑	0 (0%) ↓	1 (20%) ↓
Total	**62 (36.7%)** ↓	**85 (50.3%)** ↓	**22 (13%)** ↓

Table 25: Outcome of formal complaints – Q3 2018/19

	Upheld	Partly Upheld	Not Upheld
Surgery	28 (44.4%) ↑	22 (34.9%) ↓	13 (20.7%) ↑
Medicine	17 (38.6%) ↑	15 (34.1%) ↑	12 (27.3%) ↑
Specialised Services	15 (42.8%) ↑	17 (48.6%) ↑	3 (8.6%) ↓
Women & Children	24 (46.2%) ↑	25 (48.1%) ↑	3 (5.7%) ↓
Diagnostics & Therapies	4 (33.3%) ↑	6 (50%) ↑	2 (16.7%) ↑
Trust Services	3 (27.2%) ↑	4 (36.4%) ↑	4 (36.4%) ↑
Total	**91 (41.9%)** ↑	**89 (41.0%)** ↑	**37 (17.1%)** ↑

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

4. Learning from complaints

All feedback is welcome, as it creates an opportunity for us to better understand, and to improve, the care and treatment we provide to our service users. All complaints are investigated, learning is identified and any necessary changes to practice are made. Actions resulting from complaints are monitored and reviewed by our Divisions; the Patient Support and Complaints Team also monitors progress.

Below are some examples of actions which have been completed during Q4 2018/19.

- Following receipt of a complaint about how difficult and painful it had been for a patient to have a naso-gastric (NG) tube inserted, the Division updated teaching sessions (including the clinical skills refresher update) to incorporate consideration of individual patient circumstances which may require more input from the medical team and an amended plan which still supports the NG policy (Surgery).

- Following an increased number of complaints about cancelled and/or delayed appointments and procedures in the Queen's Day Unit Endoscopy service, a new Operations Manager has been recruited into the Endoscopy booking team (Surgery).

- A complaint was received from a patient who was still receiving reminders about an overdue ultrasound scan, despite having suffered a miscarriage. Training was provided to the appropriate radiology staff, to remind them of the correct process for cancelling appointments when they are advised that a patient has miscarried (Diagnostics & Therapies).

- As a result of a complaint regarding Trust staff being unable to produce appointment letters in a larger font for patients with sight impairment, a standard operating procedure has been written explaining to staff how they can select different sized fonts when printing letters from the Medway system (Medicine – Trust-wide action).

- A complaint was received by St Michael's Hospital about the way in which information was shared with a patient and her partner regarding abnormalities identified in their baby and the need to terminate the pregnancy. The investigation showed that a lot of the information needed by the parents had been provided but they had been too upset to take a lot of it on board. As a result of this complaint, an information leaflet has been produced, containing all of the information that parents need in these circumstances, so that this can be handed to them to take home and read in their own time (Women & Children).

5. Information, advice and support

In addition to dealing with complaints, the Patient Support and Complaints Team is also responsible for providing patients, relatives and carers with help and support. Two hundred enquiries were received in Q4, a decrease of 9.0% on the number received in Q3 following a consistent increase in the numbers received each quarter over the previous year. Table 26 below shows a breakdown of the 'Top 10' requests for advice, information and support dealt with by the team in Q4.

Table 26: Enquiries by category

Category	Enquiries in Q4 2018/19
Information about patient	45
Hospital information request	45
Medical records requested	21
Appointment queries	31
Communication	14
Clinical care	13
Clinical information request	10
Travel/transfer arrangements and transport	4
Accommodation enquiry	4
Bereavement/emotional support	4

Most enquiries are assigned to a particular Division within the Trust; however some fall outside of these divisions. Table 27 below shows where each of the 200 enquiries is assigned.

Table 27: Enquiries by Division

Division/Area	Number of enquiries in Q4 2018/19	Number of enquiries in Q3 2018/19
Surgery	46	39
Non-Divisional	36	48
Trust Services	32	51
Specialised Services	31	25
Women & Children	21	17
Medicine	16	21
Other NHS Organisation	10	15
Diagnostics & Therapies	5	4
Non NHS	3	0
Total	**200**	**220**

In addition to the enquiries detailed above, in Q4 the Patient Support and Complaints team recorded 166 enquiries that did not proceed. This is where someone contacts the department to make a complaint or enquiry but does not leave enough information to enable the team to carry out an investigation (and the team is subsequently unable to obtain this information), or they subsequently decide that they no longer wish to proceed with the complaint.

Including complaints, requests for information or advice, requests for support, compliments and cases that did not proceed, the Patient Support and Complaints Team is dealing with a steadily increasing volume of activity, with a total of 903 separate enquiries in Q4 2018/19, compared with 865 in Q3, 841 in Q2, 819 in Q1 and 741 in Q4 2017/18. This equates to a 22% increase in enquiries compared with the corresponding period one year ago.

The team also recorded and acknowledged 44 compliments received during Q4 and shared these with the staff involved and their Divisional teams.

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

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

that complaints made orally (via the telephone or in person) will be acknowledged within two working days.

In Q4, 313 complaints were received in writing (275 by email and 38 letters/complaint forms) and 178 were received verbally (12 in person via drop-in service and 166 by telephone). Two complaints were also received in Q4 via the Trust's new 'real-time feedback' service. Of the 463 complaints received in Q4, 99.6% (491 out of the 493 received) met the Trust's standard of being acknowledged within two working days (verbal) and three working days (written). This is the same as that reported in Q3.

The Patient Support & Complaints Manager closely monitors cases that are not acknowledged within timescale and reports to the Head of Quality (Patient Experience & Clinical Effectiveness) if there are any concerns and/or patterns.

7. PHSO cases

During Q4, the Trust was advised of Parliamentary and Health Service Ombudsman (PHSO) interest in 10 new complaints. During the same period, four existing cases remained ongoing. A total of 14 cases were closed during Q4: none were upheld, one was partly upheld and all recommendations have been complied with; four were not upheld and the remaining nine were closed with the PHSO taking no further action.

Table 28: Complaints opened by the PHSO during Q4

Case Number	Complainant (patient unless stated)	On behalf of (patient)	Date complaint received by Trust [and date notified by PHSO]	Site	Department	Division
16724	GS	HS	01/10/2018 [10/01/2019]	BRHC	PICU	Women & Children
Patient tragically died in BRHC in 2015 at age of 14yrs. Long standing complaint which parents have now sent to the PHSO for investigation. Medical records and copy of complaint file sent to PHSO on 27/03/2019 – currently awaiting an update on progress from the PHSO.						
16122	RR		23/08/2018 [19/02/2019]	StMH	Ward 76	Women & Children
PHSO made contact in February 2019 stating that they had been asked to look at this complaint. Despite UH Bristol returning the PHSO's calls and leaving messages, nothing further has been heard from the PHSO and no records have been requested.						
15271	DL		02/07/2018 [23/01/2019]	BRI	Endocrinology	Medicine
Copy of complaint file and relevant policies sent to PHSO on 29/01/2019. Medical records were sent to PHSO on 26/02/2019. PHSO confirmed that they have partly upheld the complaint and asked the Trust to send the patient a letter of apology, which was sent on 15/05/2019, with a copy to the PHSO. This case therefore also appears in the list of closed PHSO cases in Table 30 below.						
15161	DH		25/06/2018 [04/03/2019]	BHI	Outpatients (BHI)	Specialised Services
Call received from PHSO on 04/03/2019 asking if a complaint had been made to the Trust by this patient and whether we had sent our final response. Despite calls back to the PHSO and messages being left, no further contact has been received and no records have been requested.						
13567	IR		27/03/2018 [05/03/2019]	BHI	Ward C604 - CICU	Specialised Services

Medical records and copy of complaint file sent to PHSO on 12/03/2019. Currently awaiting a further update on progress from the PHSO.						
11887	JD		18/12/2017 [21/01/2019]	BRI	Accident & Emergency (BRI)	Medicine
PHSO contacted Trust on 21/01/2019 to ask for a copy of the Trust's response letter dated 22/05/2018. Discussed case with PHSO and sent copy of letter requested on 23/01/2019. No further contact has been received from the PHSO at the time of writing this report (May 2019).						
10412	MR	JR	29/09/2017 [19/03/2019]	StMH	Ward 76	Women & Children
PHSO requested further information about this case, which was sent to them by email on 27/03/2019. The PHSO advised on 30/04/2019 that they would not be taking any further action and were closing their file. This case was therefore newly notified by the PHSO in Q4 and will be detailed as a closed case in Q1 2019/20.						
9698	LD		22/08/2017 [24/01/2019]	StMH	Central Delivery Suite	Women & Children
PHSO contacted Trust to advise that whilst they were not planning to investigate this complaint, they wished to know if the Trust would be prepared to add a note from the patient to her medical records to indicate that she disagreed with an entry. This was subsequently done and a form provided by Medical Records and completed by the patient was added to her and her baby's records on 18/03/2019. This case therefore also appears in the list of closed PHSO cases in Table 30 below.						
4904	PM	OM	28/11/2016 [15/02/2019]	BRHC	Paediatric Neurology	Women & Children
Copies of medical records and complaint file sent to PHSO on 22/02/2019. On 26/02/2019 the Trust received a letter from the PHSO advising of the scope of their investigation. Further information has subsequently been requested by the PHSO and all requests have been complied with to date.						
6723	LM	OM	17/03/2017 [13/02/2019]	BHI	Ward C808 - Medicine	Medicine
PHSO called to discuss case with PSCT Manager on 19/02/2019. PHSO subsequently advised that they were not going to take any further action and were closing their file. This case therefore also appears in the list of closed PHSO cases in Table 30 below.						

Table 29: Complaints ongoing with the PHSO during Q4

Case Number	Complainant (patient unless stated)	On behalf of (patient)	Date complaint received by Trust [and date notified by PHSO]	Site	Department	Division
11619	SQ		01/12/2017 [05/10/2018]	StMH	Ward 78 (Gynaecology)	Women & Children
PHSO contacted us on 05/10/2018 to request a copy of the patient's medical records and a copy of the referral letter from their GP. These records were sent to the PHSO on 07/11/2018 and we have not heard anything further from the PHSO at the time of writing this report.						
13256	MR	WR	07/03/2018	BRI	Ward A400 - OPAU	Medicine
The PHSO advised the Trust on 11/04/2019 that they felt we should have the opportunity to respond to a complaint directly from the patient's family (previous complaint raised by patient's care home). A formal investigation is currently underway, with a response due by 07/06/2019.						
9403	LD	DM	03/08/2017 [07/09/2018]	BHOC	Ward D703 - Haematology	Specialised Services
We were contacted by the PHSO on 23/01/2019, requesting a copy of the complaint file. This was sent to them on 01/02/2019 and they have subsequently come back to request further information, which was sent to them on 07/05/2019.						

8853	KK		10/07/2017 [24/08/2018]	BRI	Trauma & Orthopaedics	Surgery
Advised by PHSO on 09/05/2019 that they need to seek further clinical advice in respect of this case and they anticipate that this will take approximately 6-8 weeks.						

Table 30: Complaints closed by the PHSO during Q4

Case Number	Complainant (patient unless stated)	On behalf of (patient)	Date complaint received by Trust [and date notified by PHSO]	Site	Department	Division
15570	JT	JT	19/07/2018 [24/12/2018]	SBCH	Day Surgery/Endoscopy (SBCH)	Surgery
Nothing further heard from complainant or PHSO since January 2019, when the Trust confirmed to the PHSO that we would be happy to investigate the complainant's outstanding concerns if they wished to contact us. Case therefore closed.						
13910	DR	VH	13/04/2018 [04/12/2018]	StMH	Fetal Medicine Unit	Women & Children
PHSO confirmed on 07/05/2019 that they do not intend to investigate further and are closing their file.						
13638	SC	LC	28/03/2018 [12/11/2018]	StMH	Central Delivery Suite	Women & Children
PHSO advised on 27/02/2019 that they do not intend to carry out a full investigation or take any further action and are closing their file.						
11659	JH	AH	06/12/2017 [14/11/2018]	BRI	Upper GI	Surgery
PHSO decided that the Trust had not been given ample opportunity to respond to this complaint. We therefore ascertained the full details of the complainant's outstanding concerns and sent a formal written response on 12/04/2019.						
11557	LG	BG	29/11/2017 [31/10/2018]	BRI	Ward A400 - OPAU	Medicine
PHSO advised on 21/03/2019 that they were not taking any further action in respect of this complaint and were closing their file.						
11011	KS		02/11/2017 [14/11/2018]	StMH	Gynaecology Outpatients	Women & Children
PHSO advised on 01/05/2019 that they were not going to uphold this complaint as they had found no failings in respect of the Trust's care and treatment of the patient.						
4256	MM	JM	28/10/2016 [04/10/2018]	BRI	Thoracic Surgery	Surgery
PHSO advised on 03/04/2019 that they were not upholding this complaint. They subsequently forwarded a letter from the complainant which they had requested be shared with the Division as feedback.						
5774	JB	JB	24/01/2017 [05/07/2018]	BRI	Dermatology	Medicine
Complaint led by Weston Area Health Authority. PHSO requested copy of patient's medical records from UH Bristol; these were sent on 19/07/2018. Further records were then requested and sent to the PHSO on 06/09/2018. PHSO confirmed on 08/04/2019 that they had concluded their investigation and had not upheld the complaint.						
3937	TR	PP	10/10/2016	BRI	Upper GI	Surgery

			[14/09/2018]			
The PHSO advised us on 18/01/2019 that they had completed their assessment and would be taking no further action in respect of this complaint. Case ongoing during Q3 and closed in Q4.						
1161	AB		07/04/2016 [06/09/2018]	BHI	Ward C708 – Cardiac Surgery	Specialised Services
The PHSO advised us on 17/01/2019 that they had closed this case and would be taking no further action in respect of this complaint. Case ongoing during Q3 and closed in Q4.						
10267	SL		20/09/2017 [02/07/2018]	SBCH	Radiology (SBCH)	D&T
Advised by PHSO on 21/03/2019 that they have completed their investigation and have not upheld this complaint.						
15271	DL		02/07/2018 [23/01/2019]	BRI	Endocrinology	Medicine
Copy of complaint file and relevant policies sent to PHSO on 29/01/2019. Medical Records sent to PHSO on 26/02/2019. PHSO confirmed that they have partly upheld the complaint and asked the Trust to send the patient a letter of apology, which was sent on 15/05/2019, with a copy to the PHSO.						
9698	LD		22/08/2017 [24/01/2019]	StMH	Central Delivery Suite	Women & Children
PHSO contacted Trust to advise that whilst they were not planning to investigate this complaint, they wished to know if the Trust would be prepared to add a note from the patient to her medical records to indicate that she disagreed with an entry. This was subsequently done and a form provided by Medical Records and completed by the patient was added to her and her baby's records on 18/03/2019.						
6723	LM	OM	17/03/2017 [13/02/2019]	BHI	Ward C808 - Medicine	Medicine
PHSO called to discuss case with PSCT Manager on 19/02/2019. PHSO subsequently advised that they were not going to take any further action and were closing their file.						

8. Complaint Survey

Since February 2017, the Patient Support & Complaints team has been sending out complaint surveys to all complainants six weeks after their complaint was resolved and closed. The survey responses are now monitored on a regular basis in order that improvements can be made to the way that the Patient Support & Complaints team work as a direct result of the responses received.

Table 31 below shows data from the 37 responses received during Q4, compared with those received in previous quarters. Feedback improved in a number of areas in Q4, particularly in respect of respondents who confirmed that a timescale for dealing with their complaint had been agreed with them (94.1%) and respondents who recalled being given details of independent complaints advocacy services (54.3%). There was also a reduction in the number of respondents who said they did not receive their response within the agreed timescale and those who did not feel that they received sufficient updates on the progress of their complaint.
None of the respondents to the survey said they had taken up the option of a complaint resolution meeting in Q4 (our records show that nine complainants requested a meeting as their preferred method of feedback in Q4).

Table 31: Complaints Survey Data

Survey Measure/Question	Q4 2018/19	Q3 2018/19	Q2 2018/19	Q1 2018/19
Respondents who confirmed that a timescale had been agreed with them by which we would respond to their complaint.	94.1% ↑	67.5%	78.8%	68.2%
Respondents who felt that the Trust would do things differently as a result of their complaint.	14.3% ↓	15.8%	22.4%	11.1%
Respondents who found out how to make a complaint from one of our leaflets or posters.	8.6% ↓	15.8%	9%	7.5%
Respondents who confirmed we had told them about independent advocacy services.	54.3% ↑	46.2%	32.8%	33.3%
Respondents who confirmed that our complaints process made it easy for them to make a complaint.	62.9% ↓	65%	69.6%	66.7%
Respondents who felt satisfied or very satisfied with how their complaint was handled by the Patient Support & Complaints Team.	65.7% ↑	63.4%	69.1%	64.5%
Respondents who said they did not receive their response within the agreed timescale.	14.3% ↓	17.5%	16.4%	18.6%
Respondents who felt that they were treated with dignity and respect by the Patient Support & Complaints Team.	97.1% ↓	97.5%	81.8%	95.5%
Respondents who felt that their complaint was taken seriously when they first raised their concerns.	80.5% =	80.5%	81.4%	84.5%
Respondents who did not feel that the Patient Support & Complaints Team kept them updated on progress often enough about the progress of their complaint.	17.1% ↓	20%	29.9%	31.8%
Respondents who received the outcome of our investigation into their complaint by way of a face-to-face meeting.	0% ↓	2.9%	1.6%	2.3%
Respondents who said that our response addressed all of the issues that they had raised.	58.3% ↑	57.9%	57.1%	60%

University Hospitals Bristol
NHS Foundation Trust

Meeting of the Board of Directors in Public on Tuesday 30 July 2019 in the Conference Room, Trust Headquarters

Report Title	**Patient Complaints Annual Report**
Report Author	**Tanya Tofts, Patient Support and Complaints Manager; Chris Swonnell, Head of Quality, Patient Experience and Clinical Effectiveness**
Executive Lead	**Carolyn Mills, Chief Nurse**

1. Report Summary

In accordance with NHS Complaints Regulations (2009), this report sets out a detailed analysis of the number and nature of complaints received by University Hospitals Bristol NHS Foundation Trust (UH Bristol) in 2018/19.

2. Key points to note

(Including decisions taken)

In summary:

- 1,845 complaints were received by the Trust in the year 2018/19, averaging 154 per month. This compares with a total of 1,817 complaints received in 2017/18, an increase of 1.5%.
- In addition, the Patient Support and Complaints Team dealt with 965 other enquiries, including compliments, requests for support and requests for information and advice; this represents a 37.7% increase on the 701 enquiries dealt with in 2017/18. The team also received and recorded an additional 618 enquiries which did not proceed after being recorded. In total, the team received 3,428 separate enquiries into the service in 2018/19; an increase of 9.8% on the previous year.
- In 2018/19, the Trust had 31 complaints referred to the Parliamentary and Health Service Ombudsman (PHSO). During the same period, a total of 22 cases were closed by the PHSO. Of these 22 cases, one was upheld, two were partly upheld, four were not upheld and 15 fell into a new category designated by the PHSO whereby they carried out an initial review but then decided not to investigate and closed their file, citing ‘no further action’. At the end of the year 2018/19, four cases were still under investigation by the PHSO, in addition to the 31 new cases reported above.
- 779 complaints were responded to via the formal complaints process in 2018/19 and 87.0% of these (678) were responded to within the agreed timescale. This is an improvement on the 83.0% achieved in 2017/18, although performance remains below the Trust target of 95%. A total of 974 complaints were responded to in 2018/19 via the informal complaints process and 83.5% of these (813) were responded to within the agreed timescale.
- At the end of the reporting year, 9.5% of complainants had expressed dissatisfaction with the formal response they had received. This compares with 9.7% in 2017/18 and 11.8% in 2016/17.

3. Risks **If this risk is on a formal risk register, please provide the risk ID/number.**	
N/A	
4. Advice and Recommendations *(Support and Board/Committee decisions requested)*:	
• This report is for **INFORMATION.** • The Board is asked to **NOTE** the report.	
5. History of the paper **Please include details of where paper has previously been received.**	
Patient Experience Group	23/5/19
Senior Leadership Team	19/6/19
Quality and Outcomes Committee	25/6/19

University Hospitals Bristol
NHS Foundation Trust

ANNUAL COMPLAINTS REPORT 2018/2019

Author: Tanya Tofts, Patient Support and Complaints Manager - May 2019

Contents

Executive Summary

In accordance with NHS Complaints Regulations (2009), this report sets out a detailed analysis of the number and nature of complaints received by University Hospitals Bristol NHS Foundation Trust (UH Bristol) in 2018/19. The report also records other support provided by the Trust's Patient Support and Complaints Team[1] during the year.

In summary:

- 1,845 complaints were received by the Trust in the year 2018/19, averaging 154 per month. Of these, 702 were managed via the formal investigation process and 1,143 through the informal investigation process. This compares with a total of 1,817 complaints received in 2017/18; however, the small increase of 1.5% also needs to be read in the context of an increasing annual volume of patient activity in our hospitals.

- In addition, the Patient Support and Complaints Team dealt with 965 other enquiries, including compliments, requests for support and requests for information and advice; this represents a 37.7% increase on the 701 enquiries dealt with in 2017/18. The team also received and recorded an additional 618 enquiries which did not proceed after being recorded. In total, the team received 3,428 separate enquiries into the service in 2018/19; an increase of 9.8% on the previous year.

- In 2018/19, the Trust had 31 complaints referred to the Parliamentary and Health Service Ombudsman (PHSO), representing a significant 182% increase on the number of cases referred the previous year. During the same period, a total of 22 cases were closed by the PHSO. Of these 22 cases, one was upheld, two were partly upheld, four were not upheld and 15 fell into a new category designated by the PHSO whereby they carried out an initial review but then decided not to investigate and closed their file, citing 'no further action'. At the end of the year 2018/19, four cases were still under investigation by the PHSO, in addition to the 31 new cases reported above.

- 779 complaints were responded to via the formal complaints process in 2018/19 and 87.0% of these (678) were responded to within the agreed timescale. This is an improvement on the 83.0% achieved in 2017/18, although performance remains below the Trust target of 95%. A total of 974 complaints were responded to in 2018/19 via the informal complaints process and 83.5% of these (813) were responded to within the agreed timescale.

- At the end of the reporting year, 9.5% of complainants had expressed dissatisfaction with the formal response they had received. This compares with 9.7% in 2017/18 and 11.8% in 2016/17. A concerted effort to reduced numbers of dissatisfied responses, through delivery of training and review of the dissatisfied cases received, resulted in improvement performance against this metric, particularly towards the end of the financial year.

[1] i.e. UH Bristol's integrated 'PALS' and complaints team

1. Accountability for complaints management

The Board of Directors has corporate responsibility for the quality of care and the management and monitoring of complaints. The Chief Executive delegates responsibility for the management of complaints to the Chief Nurse.

The Trust's Patient Support and Complaints Manager is responsible for ensuring that:

- All complaints are fully investigated in a manner appropriate to the seriousness and complexity of the complaint, in line with the complainant's wishes;
- All formal complaints receive a comprehensive written response from the Chief Executive or his nominated deputy, or a local resolution meeting with a senior clinician and senior member of the divisional management team;
- Complaints are resolved within the timescale agreed with each complainant at a local level wherever possible;
- Where a timescale cannot be met, an explanation is provided and an extension agreed with the complainant; and
- When a complainant requests a review by the Parliamentary and Health Service Ombudsman, all enquiries received from the Ombudsman's office are responded to in a prompt, co-operative and open manner.

The Patient Support and Complaints Manager line manages a team which consists of one full time Deputy Manager, five part-time complaints officers/caseworkers and three part-time administrators. The total team resource, including the manager, is currently 7.46 WTE.

2. Complaints reporting

Each month, the Patient Support and Complaints Manager reports the following information to the Trust Board:

- Total number of complaints received
- Percentage of complaints responded to within the agreed timescale
- Percentage of cases where the complainant is dissatisfied with the original response

In addition, the following information is reported to the Patient Experience Group, which meets every three months:

- Validated complaints data for the Trust as a whole and also for each Division
- Quarterly Complaints Report, identifying themes and trends
- Annual Complaints Report (which is also received by the Board).

The Quarterly Complaints Report provides an overview of the numbers and types of complaints received, including any trends or themes that may have arisen, including analysis by Division and information about how the Trust is responding. The Quarterly Complaints Report is also reported to the Trust Board and published on the Trust's web site.

3. Total complaints received in 2018/2019

The total number of complaints received during the year was 1,845, and increase of 1.5% on the 1,817 complaints received the previous year. Of these, 702 (38%) were managed through the formal investigation process and 1,143 (62%) through the informal investigation process; this compares with 674 (37%) complaints managed formally in 2017/18 and 1,388 (63%) managed informally.

A formal complaint is classed as one where an investigation by the Division is required in order to respond to the complaint. A senior manager is appointed to carry out the investigation and gather statements from the appropriate staff. These statements are then used as the basis for either a written response to, or a meeting with, the complainant (or sometimes a telephone call from the manager). The method of feedback is agreed with the complainant and is their choice. The Trust's target is that this process should take no more than 30 working days in total.

An informal complaint is one where the issues raised can usually be addressed quickly by means of an investigation by the divisional management team and a telephone call to the complainant. The Trust's target is that this process should take no more than 10 working days in total.

Figure 1 provides a long-term view of complaints received per month that were dealt with via the formal investigation process compared to those dealt with via the informal investigation process, over the same period. The figures below do not include informal concerns which are dealt with directly by staff in our Divisions.

Figure 1 – Numbers of formal v informal complaints

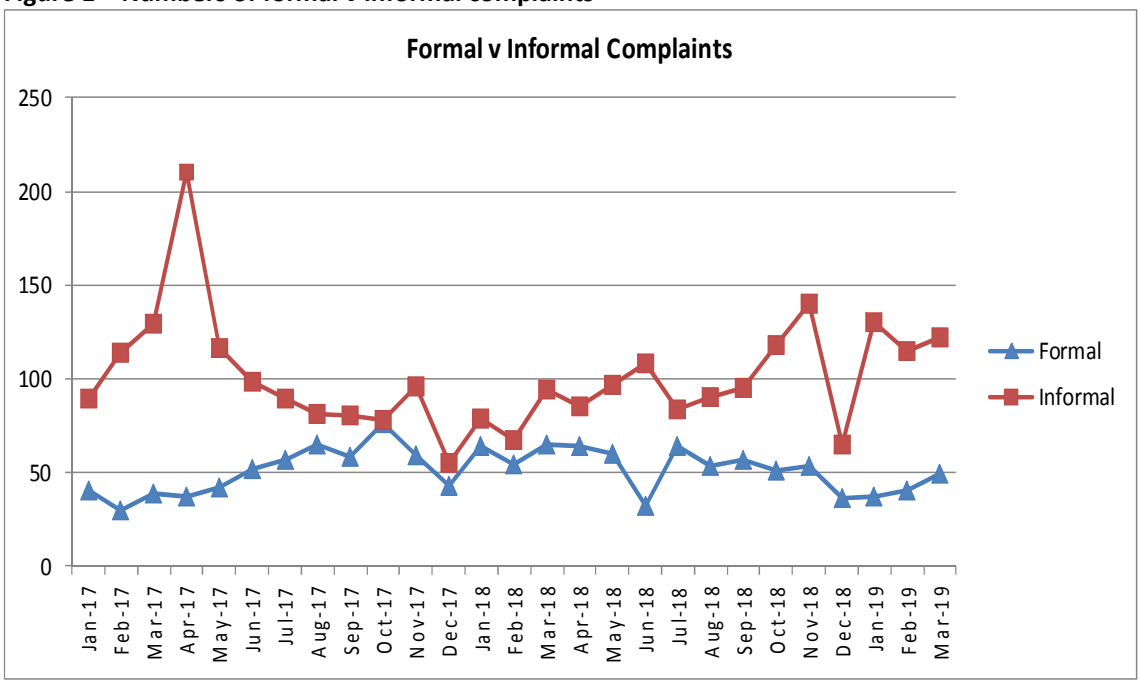


Table 1 below shows the number of complaints received by each of the Trust's divisions compared with the previous year. Directional arrows indicate change compared to the previous financial year.

Table 1 - Breakdown of complaints by Division

Division	Informal complaints 2018/19	Informal complaints 2017/2018	Formal complaints 2018/19	Formal complaints 2017/2018	Divisional total 2018/19	Divisional total 2017/18
Surgery	428 ↓	429 ↓	188 ↓	199 ↑	616 ↓	628 ↓
Medicine	258 ↑	203 ↓	128 ↓	202 ↑	386 ↓	405 ↓
Specialised Services	187 ↑	166 ↓	84 ↑	77 ↓	271 ↑	243 ↓
Women and Children	148 ↑	119 ↓	143	154 ↑	291 ↑	273 ↓
Diagnostics and Therapies	53 ↓	59 ↑	28 ↑	19 ↑	81 ↑	78 ↑
Trust Services (including Facilities & Estates)	175 ↑	167 ↑	25 ↑	23 ↑	200 ↑	190 ↑
TOTAL	**1249 ↑**	**1143 ↓**	**596 ↓**	**674 ↑**	**1845 ↑**	**1817 ↓**

Table 1 shows an increase in complaints received by four of the Trust's six Divisions. The overall number of complaints managed via the formal complaint process decreased by 11.6% in 2018/19, whilst the number managed informally increased by 9.3%.

4. Complaint themes

The Trust records all complaints under one or more of eight high-level reporting themes, depending upon the nature and complexity of the complaint. This data helps us to identify whether any trends or themes are developing when matched against hospital sites, departments, clinics and wards.

Table 2 and Figure 2 show complaints received in 2018/19 by theme, compared with 2017/18 and 2016/17.

Table 2 - Complaint themes – Trust totals

Complaint Theme	Total Complaints 2018/19	Total Complaints 2017/18	Total Complaints 2016/17
Access	11 ↓	12 ↓	16 ↓
Appointments and Admissions	571 ↑	519 ↓	589 ↓
Attitude and Communication	384 ↓	492 ↑	454 ↓
Clinical Care	519 ↑	491 ↑	490
Facilities and Environment	176 ↑	82 ↓	89 ↓
Discharge/Transfer/Transport	36 ↓	73 ↓	89 ↑
Documentation	41 ↑	31 ↑	12 ↑
Information and Support	107 ↓	116 ↓	136
TOTAL	**1845 ↑**	**1817 ↓**	**1875 ↓**

In 2018/19, there were increases in five of the eight categories when compared with the previous year. The largest increase was in complaints categorised as 'facilities and environment'. The majority of complaints in this category were about parking problems at South Bristol Community Hospital. Action was taken to rectify these problems and complaints about this reduced significantly towards the end of the year.

There were notable reductions in the numbers of complaints received about 'attitude and communication' (a 22% reduction) and 'discharge/transfer/transport' (a 50% reduction).

5. Performance in responding to complaints

In addition to monitoring the volume of complaints received, the Trust also measures its performance in responding to complainants within agreed timescales, and the number of complainants who are dissatisfied with responses.

5.1 Percentage of complaints responded to within timescale

The Trust's expectation is that all complaints will be acknowledged within two working days for telephone enquiries and within three working days for written enquiries. The complainant's concerns are confirmed and the most appropriate way in which to address their complaint is agreed. A realistic timescale in which the complaint is to be resolved is agreed, based on the complexity of the complaint whilst responding in a timely manner. In 2018/19, 98.1% of complaints (1,810 of 1,845) were acknowledged within the agreed timescale.

The Local Authority Social Services and National Health Service Complaints (England) Regulations 2009, together with guidance from the Parliamentary and Health Service Ombudsman, indicate that the Trust must investigate a complaint 'in a manner appropriate to resolve it speedily and efficiently and keep the complainant informed.' When a response is not possible within the agreed timescale, the Trust must inform the complainant of the reason for the delay and agree a new date by which the response will be sent.

The Trust captures data about the numbers of complaints responded to within the agreed timescale. The Trust's performance target continues to be 95% compliance. Over the course of the year 2018/19, 87.0% of formal responses were responded to within the agreed timescale, an improvement on the 83.0% achieved in 2017/18 and 86.1% 2016/17. Of the 974 complaints responded to via the informal complaint process, 83.5% were responded to within the agreed timescale.

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

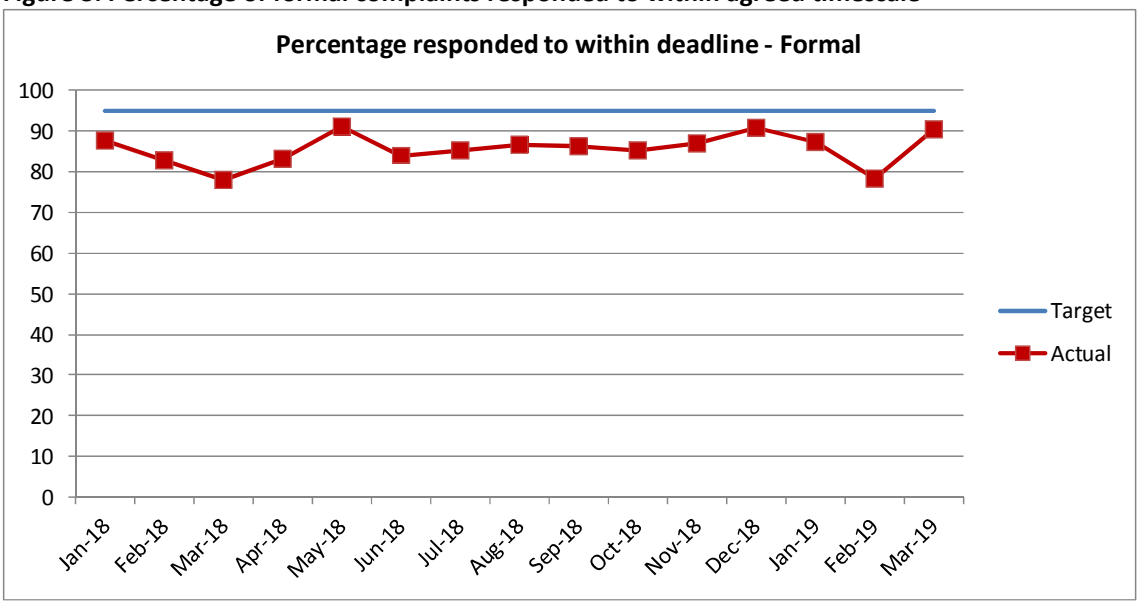
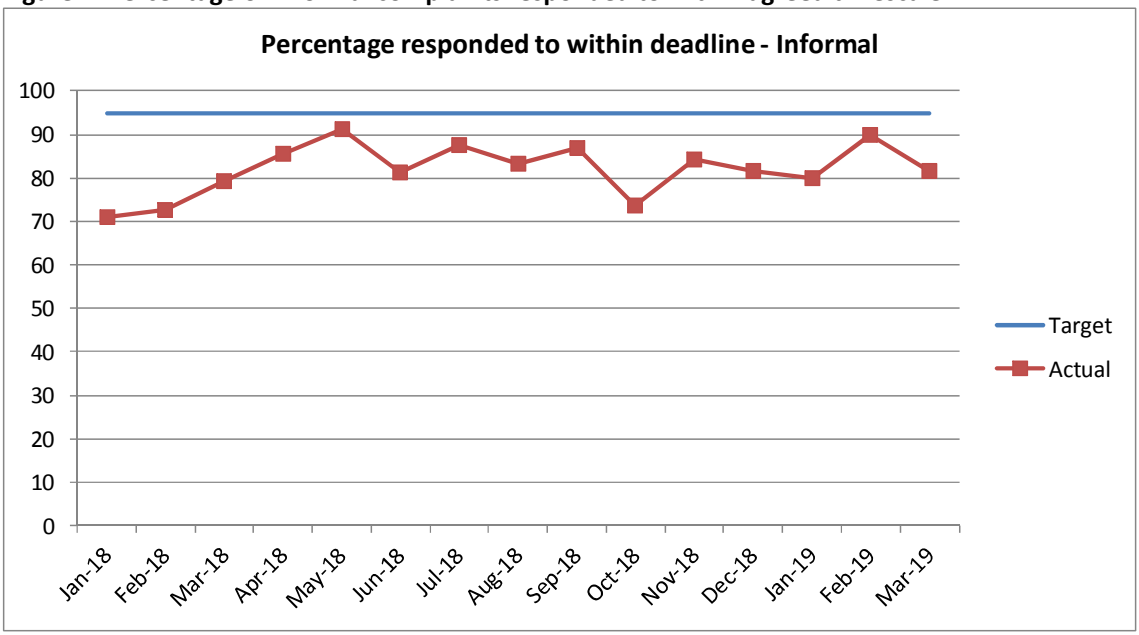


Figure 4. Percentage of informal complaints responded to within agreed timescale



5.2 Numbers of complainants who are dissatisfied with our response

The Trust also measures performance in respect of the number of complainants who are dissatisfied with the response provided to their complaint due to the original investigation being incomplete or inaccurate (which we differentiate from follow-up enquiries where a complainant raises additional questions).

At the time of writing, 9.5% of complainants have expressed dissatisfaction with complaints responses sent out during 2018/19. This compares with 9.7% measured at the corresponding point in 2017/18 and 11.5% for 2016/17.

6. Parliamentary and Health Service Ombudsman (PHSO)

If a complainant is unhappy with the way in which their complaint has been dealt with by the Trust and feels that local resolution of their complaint has not been satisfactory, they have the option of asking the PHSO to carry out an independent review of their complaint.

In 2018/19, the Trust had 31 complaints referred to the Parliamentary and Health Service Ombudsman (PHSO), compared with 11 in 2017/18. During the same period, a total of 22 cases were closed by the PHSO. Of these 22 cases, one was upheld, two were partly upheld, four were not upheld and 15 fell into a new category designated by the PHSO whereby they carried out an initial review but then decided not to investigate and closed their file, citing 'no further action'. At the end of the year 2018/19, four cases were still under investigation by the PHSO, in addition to the 31 new cases reported above.

7. Information, advice and support

In addition to managing complaints, the Patient Support and Complaints Team also deals with information, advice and support requests. The total number of enquiries received during 2018/19 is shown below, together with figures from 2017/18 and 2016/17 for comparative purposes:

Table 3:

Type of enquiry	**Total Number 2017/18**	**Total Number 2017/18**	**Total Number 2016/17**
Request for advice / information/support	780	576	524
Compliments	185	125	290
Total	**965**	**701**	**814**

8. Looking back and ahead

UH Bristol continues to be proactive in its management of complaints and enquiries, recognising that the way we respond to concerns and complaints is part of our commitment to excellence in customer service and acknowledging that all complaints are a valuable source of learning.

In 2018/19, for example:

- Actions implemented as a result of complaints are now reported in the quarterly complaints reports under the heading of 'learning from complaints' for review Trustwide.
- Monthly reviews of dissatisfied complaints were carried out for each Division, by the Head of Quality (Patient Experience & Clinical Effectiveness) and Heads of Nursing in order to identify learning in respect of how formal written responses can be improved.
- Significant work was completed in the drafting of a Complaints Toolkit, jointly developed with the Patients Association. A version of the toolkit for use at UH Bristol will be finalised and implemented in 2019/20.
- A system for rapid response to complaints raised through the Trust's 'real time feedback' system has been implemented successfully with all enquiries received so far being either resolved or taken forward to the enquirer's satisfaction on the day of receipt.
- The PSCT Manager and three PSCT Complaints Officers attended pilot sessions of Medical Mediation Foundation training with the Division of Children's Services.
- Complaints training has been provided to a large number of staff across all Divisions in respect of handling complaints with confidence and investigating and responding to formal complaints.
- Standard Operating Procedures (SOPs) have been updated in respect of extensions to complaint response deadlines and 'high risk' complaints that may require escalation to Executives.

Looking ahead to 2019/20, our focus will be on ensuring that we make further improvements in performance in respect of responding to complaints within the timescale agreed with complainants, reducing the number of complainants who are dissatisfied with our response to their concerns and sharing learning from complaints with staff Trustwide. We will also ensure that this learning is shared with the complainant who raises the issue, in order to reassure them that changes have been made as a result of their complaint.

Our detailed complaints work plan for 2019/20 is available upon request.

Meeting of the Board of Directors in Public on Tuesday 30 July 2019 in the Conference Room, Trust Headquarters

Report Title	**Infection Prevention Control Annual Report**
Report Author	**Martin Williams, Consultant Microbiologist**
Executive Lead	**Carolyn Mills, Chief Nurse**

1. Report Summary

The purpose of the report is to inform patients, public, staff, Trust board members and the Clinical Commissioning Group of the Infection Prevention and Control activities undertaken in 2018/19 within University Hospitals Bristol NHS Foundation Trust, and to demonstrate progress against performance targets.

2. Key points to note
(Including decisions taken)

- Infection Prevention and Control is part of University Hospital Bristol NHS Trusts overall risk management strategy.
- The report provides assurance to the Board that the Trust has discharged its responsibilities as per the Health and Social Care Act.
- During 2018/19 there were no formal outbreaks declared.
- The limit set for Clostridium Difficile infections for 2018/19 was 44. The Trust performed well in this area with 31 Trust apportioned C..Diff infections. Of those, 9 were determined to be due to a “lapse in care”
- New guidance was issued for 2018/19 (NHSI 2018), which included a zero tolerance to avoidable MRSA bacteraemia, and a removal of the third party designation.

3. Risks
If this risk is on a formal risk register, please provide the risk ID/number.

The risks associated with this report include:
There is one risk on the corporate risk register.

4. Advice and Recommendations
(Support and Board/Committee decisions requested):

- This report is for **ASSURANCE**.
- The Board is asked to **NOTE** the report.

5. History of the paper
Please include details of where paper has previously been received.

Quality and Outcomes Committee	Circulated via email

Infection Prevention and Control Annual Report 2018/19

1. Introduction

The purpose of the report is to inform patients, public, staff, Trust board members and the Clinical Commissioning Group of the Infection Prevention and Control activities undertaken in 2018/19 within University Hospitals Bristol NHS Foundation Trust, and to demonstrate progress against performance targets. All NHS organisations must have effective systems in place to control healthcare associated infections as set out in the Health and Social Care Act (2008). Infection Prevention and Control is part of University Hospital Bristol NHS Trusts overall risk management strategy. This report provides assurance to the Board that the Trust has discharged its responsibilities as per the Health and Social Care Act.

The authors would like to acknowledge the contribution of other colleagues to this report, in particular, the sections on decontamination, cleanliness, antimicrobial prescribing and vascular access.

2. Infection Prevention and Control Structure

Infection Prevention & Control Team

Specialist advice is provided to clinicians throughout the hospital by the Infection Prevention and Control team. The Director Infection Prevention & Control (DIPC) is the designated Infection Prevention and Control Doctor (IPCD.)
Additional support to the team is provided by on-call cross cover arrangements which are in place for Microbiologists from University Hospitals Bristol, North Bristol Trust, Royal United Hospital and Weston hospital. Specialist advice in virology is provided by the North Bristol Trust Consultant Virologists.

The specialist infection, prevention and control nursing team provide education, support and advice to all Divisions, Trust staff and patients and relatives. The key responsibilities of the IPC team are to:

- Ensure there are policies, procedures and guidelines in place for the prevention, management and control of infection across the organisation.
- Communicate information relating to communicable disease to all relevant parties within the Trust.
- To provide and oversee the provision of education and training in the principles of infection prevention and control to the relevant staff groups.
- Work with clinicians to improve surveillance and to strengthen prevention and control of infection in the Trust.
- Provide appropriate expert infection control advice in the Trust, taking into account national guidance,
- Share information between relevant parties within the NHS when transferring the care of patients to other healthcare institutions or community settings.

2.1 Corporate Responsibility

The Chief Nurse is the responsible Executive Director within the Trust for Infection Prevention and Control and reports to the Chief Executive and the Board of Directors. The Director for Infection Prevention and Control (DIPC) is a Consultant Microbiologist in the Trust.

2.2 Infection Prevention & Control Governance

The Infection Control Group (ICG) is responsible for ensuring that there is internal overview of compliance with national standards and limits, local policies, guidelines and external assessments e.g. decontamination standards, Care Quality Commission standards and the Patient-led assessments of the Care Environment (PLACE). ICG is chaired by the Chief Nurse who is the executive lead for Infection prevention & Control or the DIPC. The group meet bi-monthly. Reports are received at each meeting from the sub groups which are; Decontamination Board, Antimicrobial Stewardship Group, Facilities and Estates, Occupational Health and each clinical Division. ICG reports to the Clinical Quality Group, and Quality and Outcomes Committee.

2.3 DIPC Reports to Board of Directors

The DIPC reports to Quality and Outcomes Committee quarterly, key Infection Prevention & Control (IP&C) performance metrics are reported monthly as part of the Board quality and performance report. The IP&C annual report is submitted to the Board of Directors.

2.4 Compliance with the Health and Social Care Act 2008 Code of Practice on the Prevention and Control of Infections and Related Guidance

Compliance criterion 1.
Systems to manage and monitor the prevention and control of infection. These systems use risk assessments and consider the susceptibility of service users and any risks that their environment and other users may pose to them.
• The Infection Prevention and Control Team (IPCT) has, Infection Control Nurses (ICN's) and includes, the deputy Director of Infection Prevention & Control), an Intravenous Access Co-ordinator, an antimicrobial pharmacist, an analyst and administrative support. • The Director of Infection Prevention and Control (DIPC) who is also a consultant microbiologist leads the team and reports directly to the Chief Nurse. • The Chief Nurse chairs the Infection Control Group (ICG) which meets bi-monthly. • The Trust Board receives monthly infection control exception reports within the quality report for key performance indicators related to infection. • The Quality Outcomes Committee (Board sub-committee) receives quarterly infection control reports. • The IP&CT has an annual work plan which is monitored by the ICG. All infection control incidents are managed through the Trust's incident reporting process and any risks that relate to infection control are managed via the Trust's risk management process. ICG reviews and monitors all IP&C corporate and divisional risks. Divisional reports to the group include updates on risks and their management. • There is a programme of cleanliness audits with audits conducted in high and very high risk areas monthly. The reports from these audits are presented through ICG and disseminated across the Divisions for local action and re-audit accordingly. • Infections are reported via the Datix incident management system and are also reported externally via the Public Health England data capture system. • All infection control training is mapped against the UK Core Skills Training Framework Statutory/Mandatory Subject Guide, Version 1.4 (2017). This includes measures to prevent risks of infection. • The IPCT are responsible for the development and updating of Trust wide infection control policies which are ratified through the ICG. • Audits to monitor compliance against key policies are undertaken as per the annual audit plan this includes monthly hand hygiene audits and audits relating to Aseptic Non-Touch Technique (ANTT)

practice.

- The Trust water safety group work oversees the work to deliver the requirements set out in the HTM 04 revision. This multi-disciplinary group ensures that there are systems and processes in place to manage the complex water systems and a water safety plan is in place. The estates currently share information / assurance around maintenance activities undertaken, share sample results taken and identify where risks might be in line with guidance documentation. The group shares knowledge, learning from past experiences and ensures that the governance structures are in place. Background levels of pseudomonas in the augmented care areas are monitored and microbiology flag areas of concern. Investigations take place as required and exception reports go through ICG.

Compliance criterion 2.

Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infections.

- The Trust has designated leads for environmental cleaning and decontamination of equipment.
- Annual audits relating to Decontamination are conducted by external auditors to monitor compliance.
- The Trust employs an external expert advisor in Decontamination who completed audits within Decontamination areas annually.
- An external auditing body conducts annual audits CSSD to ISO 13485:2016 standard.
- There is a system in place to ensure decontamination before equipment is maintained/serviced/repaired whether within the area or transferred from the area via a DC1 form. Staff completes this form when returning items to MEMO for repair.
- MEMO is audited by the British Standard Institute twice a year as part of the ISO 13485:2016 quality management standard.
- Monthly cleanliness audits are carried out within clinical area, areas for improvement are identified and follow up audits are undertaken to ensure improvements in standards have been made.
- Cleaning schedules are available for public view within each clinical area.
- There are suitable handwashing facilities in all appropriate areas and hand gels with signage on entry to each ward area.
- The Trust has policies in place to manage the clinical environment and ensure appropriate cleaning mechanisms are used at all times including cleaning an environment after a patient with an infection is cared for within it.
- When an enhanced, deep clean is undertaken due to an infection, the standards of cleaning are signed off by a senior person within the clinical area to confirm they meet the requirements.
- All clinical staff receive training on infection prevention and control which includes decontamination and cleaning of equipment. Compliance with infection control training at the end of 2018/19 was 90%. The reduction in training compliance was due to the training requirement went from three yearly to once a year. However the training compliance is increasing month on month.
- Within the current linen policy it clearly states the Trust will ensure that throughout the collection and distribution functions Used Linen is segregated from Clean Linen. Monthly service user meetings are held with the clinical teams, where the laundry quality and satisfaction are discussed and documented. Quarterly contract performance review meetings are held with the supplier, where it is evidenced the compliance with the agreed KPIs.
- Within the current linen policy it clearly states the colour coding of bags to be used for dirty and infected linen.
- The overriding regulatory documentation for the provision of linen is the Health Technical Memorandum HTM 01-04 – Decontamination of Linen for Health and Social Care. HTM 01-04

supersedes earlier versions of laundry guidance including HSG (95)18

Compliance criterion 3.
Ensure appropriate antimicrobial use to optimise patient outcomes and to reduce the risk of adverse events and antimicrobial resistance.
• Joint specialist pharmacist/microbiologist ward rounds undertaken to all relevant areas weekly. These include auditing antimicrobial prescriptions for compliance with the anti-infective guidelines, providing advice on the management of all infections where appropriate and applying the Start Smart Then Focus (SSTF) principle to all prescriptions. Application of the Sepsis Six toolkit ensures patients with sepsis are treated promptly and the review team follow them up to ensure therapy is narrowed where possible. (we don't do the specific Sepsis reviews – that was the sepsis CQUIN team). • Antimicrobial Steering (AS) Group meet quarterly, and discuss, compliance with guidelines, expenditure, anti-infective incidents, guidelines, Anti-Microbial Resistance (AMR) CQUIN targets & and other items relating to antimicrobial use. Membership includes the medical director, DIPC, consultant microbiologists, paediatric ID, senior clinicians representing the divisions, representation from the NMPs, representation from Infection Control, director of pharmacy and the anti-infective specialist pharmacists. AS prescribing compliance is reported monthly to the trust board, divisional leads and consultants throughout the trust. • The Trust has an Anti-infective prescribing Policy and guidelines covering all the points below. These are available on the trust intranet (dedicated anti-infective pages) and the Microguide app for all users. Compliance is monitored weekly as detailed above. Regional and national benchmarking is undertaken; the Trust has participated in an annual Point Prevalence Audit within the South West Region, and the South West Regional Antimicrobial Group that meet quarterly. National benchmarking is available on the NHSE Fingertips website, UHB submit data for inclusion. • Microbiology systems provide readily accessible computer data and telephone advice both in and out-of-hours on microbiological data and susceptibility results. • Trust induction covers expectations and sign-posting to guidelines etc. for those prescribing antimicrobials. FY1s are provided with a teaching session that covers antimicrobial resistance, common infections and the rationale for stewardship practices. Anti-infective pharmacists provide ad-hoc teaching to FY1s on any other related topics as required.

Compliance criterion 4.
Provide suitable accurate information on infections to service users, their visitors and any person concerned with providing further support or nursing/ medical care in a timely fashion.
• National information is utilised for patient and public information on infection control where appropriate. • Where local information is produced this is submitted to the patient experience lead and the Trust communications team for appropriate approvals. • Posters, leaflets and signage is used to promote good hand hygiene practices, inform patients and visitors if there are particular requirements for infection control and also to provide public health information and advice. • Information is also available on the Trust website and relevant information is sent out using social media. • Patient confidentiality is maintained at all times and information is only shared with other organisations in accordance with Data Protection principles.

Compliance criterion 5.
Ensure prompt identification of people who have or are at risk of developing an infection so that they receive timely and appropriate treatment to reduce the risk of transmitting infection to other people.
• The Trust infection control team work closely with partnering organisations including Public Health England, the CCG and other healthcare providers to ensure and information regarding infection within the local area is known and action is taken accordingly. • Public Health England is informed of any notifiable infection and any outbreaks or serious incidents are notified to Public Health England and the CCG. • The responsibility for infection prevention and control is devolved to all groups in the organisation and Trust wide representation at the alternate monthly infection control group ensure timely and effective cascading of information to all areas.

Compliance criterion 6.
Systems to ensure that all care workers (including contractors and volunteers) are aware of and discharge their responsibilities in the process of preventing and controlling infection.
• All staff receives infection control training on induction to the Trust and this includes volunteers. • In addition, the Trust adheres to the UK Core Skills Training Framework on all training including updates. • Infection control is core within all job descriptions for staff employed within the Trust. • Additional training and competencies are in place for skills such as Aseptic Non Touch Technique and urinary catheterisation. • Leaflets are available for all contractors.

Compliance criterion 7.
Provide or secure adequate isolation facilities.
• The Trust has policies in place for the appropriate isolation of patients as required. • There is a ward that can be converted into a cohort ward should this be required in the situation of an outbreak. • The Trust's estates strategy has seen an investment in facilities for isolating patients. The Trust has a number of standard side rooms plus specialist ventilation rooms. Specialist ventilation rooms are required for patients with certain infections such as those that are airborne, diseases of high consequence or for patients who are highly immunocompromised (Department of Health, 2013). • The table below shows the breakdown of the isolation facilities across the Trust by Division/location:

Division/location	Specialist ventilation	Ensuite side room	Room only (no ensuite)
Medicine	2	83	5
South Bristol Community Hospital		14	
Surgery	5	50	8
Women's		6	17
Specialised services	6	49	3
Children's	4	62	43

Compliance criterion 8.
Secure adequate access to laboratory support as appropriate.
• Microbiology is accredited to UKAS ISO:15189 standards. • Appropriate policies and procedures are in place.

Compliance criterion 9.
Have and adhere to policies, designed for the individual's care and provider organisations that will help to prevent and control infections.
• The Trust has policies within each of the areas specified within this criterion and audits are undertaken where appropriate to identify compliance. • All policies are available to staff on the internal website and are updated in accordance with their requirements. • All new or amended Trust wide Infection Prevention & Control policies are approved through ICG and assured through Clinical quality Group prior to being published.

Compliance criterion 10.
Providers have a system in place to manage the occupational health needs and obligations of staff in relation to infection.
• All staff can access occupational health services or access appropriate occupational health advice between 08:00 – 17:00 with advice line being open 08:30 – 15:30 5 days per week. • Occupational health policies on the prevention and management of communicable infections in care workers are in place • Occupational Health have in place risk assessment categories that are applied at time of commencing work via the Health and Wellbeing process. • In keeping with Occupational Health recommendations, an independent confidential recording system is in place. • All risks are assessed pre-employment and clearance is based on the Department of Health Guidance. • Those staff at constant risk due to non-conversion (protection against Hepatitis B) is recalled automatically annually. New staff are seen pre-employment and recommendations made. In employment they are recalled for blood testing as required. • Occupational Health liaised with the UK Advisory Panel for Healthcare Workers Infected with Blood-borne Viruses (BBV) when advice is needed on procedures that may be carried out by BBV-infected care workers, or when advice on patient tracing, notification and offer of BBV testing may be needed; Clinicians see each affected staff member and monitor as needed • A risk assessment and appropriate referral after accidental occupational exposure to blood and body fluids is undertaken. • There is a 24 hour service for the management of occupational exposure to infection, which may include provision for emergency and out-of-hours treatment, possibly in conjunction with accident and emergency services, the clinical site management team and on-call infection prevention and control specialists. • Arrangements are in place for the provision of influenza vaccination for healthcare workers where appropriate

Feb-19

Staff Groups	Total Staff per Group	Total Vaccinated per Group	Percentage
Doctors	1271	1067	83.95%
Nurses	2795	2097	75.03%
Prof. Qual	1255	974	77.61%
Support to Clinical	2,097	1986	94.71%
N/A Other (Non-Frontline)	2491	639	25.65%
Total All Staff	**9909**	**6763**	68.3%

Total Frontline Staff	**7418**
Total Frontline Vaccinated	**6124**
Percentage Frontline Vaccinated	**82.6 %**

3. Health Care Associated Infections

3.1 Overview

University Hospitals Bristol NHS Foundation Trust continues to take part in mandatory surveillance of Methicillin-resistant Staphylococcus aureus (MRSA) bacteraemias, Methicillin-Sensitive Staphylococcus aureus (MSSA) bacteraemias, *E. coli* and Clostridium difficile cases.

To support the ambition to reduce the number of healthcare-associated Gram-negative bloodstream infections (GNBSI) by March 2021, in September 2017, NHS Improvement extended mandatory reporting to include *Klebsiella* species and *Pseudomonas aeruginosa*. Together with *Escherichia coli (E. coli)* these organisms account for more than 70% of all healthcare-associated GNBSI. GNBSI continue to increase in England and cause significant morbidity and mortality in our patients. University Hospitals Bristol reported on *Klebsiella* species and *Pseudomonas aeruginosa* GNBSIs retrospectively from 1 April 2017 to Public Health England's (PHE) data capture system (DCS).

MRSA bacteraemias and laboratory detected *C. diff* toxin results are reported monthly via the Public Health England healthcare associated infections Data Capture System (HCAI DCS) website and signed off on behalf of the Chief Executive.

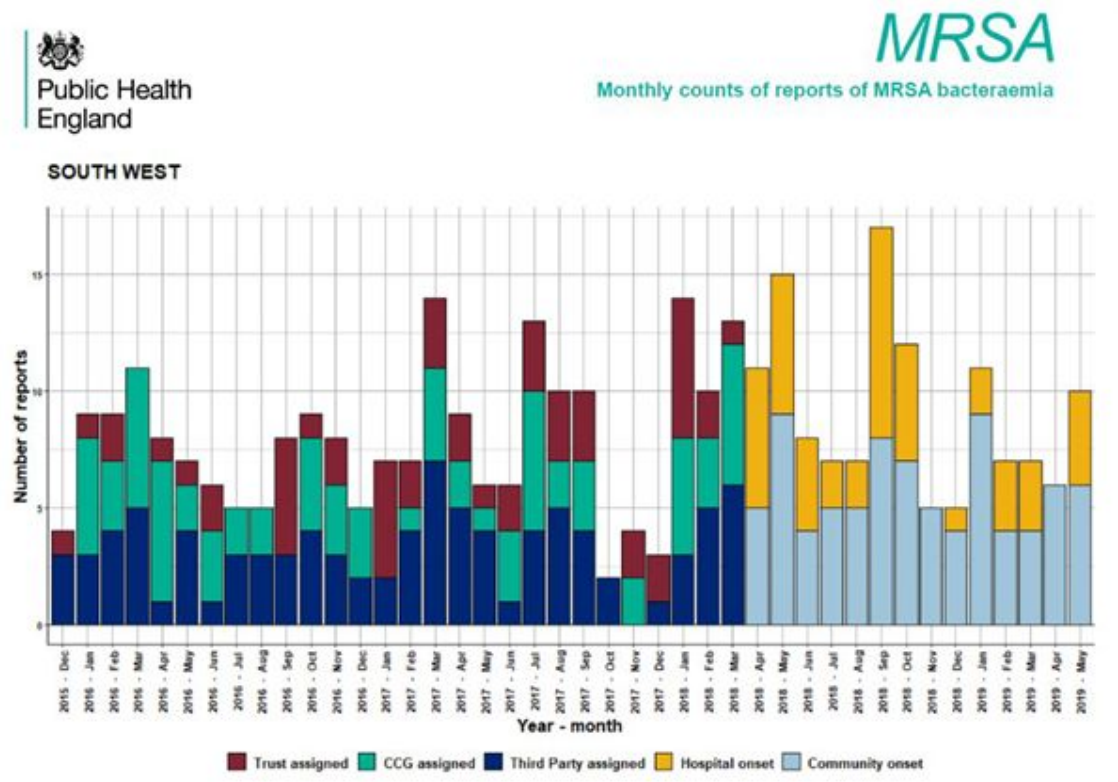
3.2 National Limits

MRSA

Staphylococcus aureus is a gram positive bacterium carried harmlessly in the nose of approximately a third of the population. In healthcare settings, where patients are often undergoing invasive procedures it can cause serious illness including wound, respiratory and blood stream infections. Meticillin resistant *S.aureus* (MRSA) is a strain of *S.aureus* that has acquired a number of resistance mechanisms and is resistant to

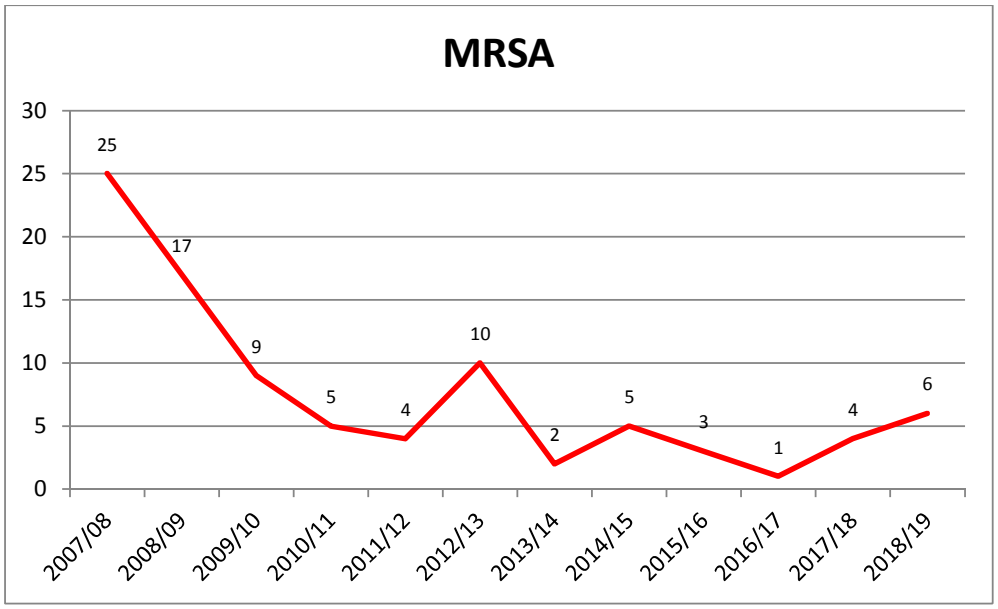
many antibiotics (including flucloxacillin and meticillin) and therefore is potentially a greater risk to patients as infections may be harder to treat.

Public Health England (PHE) has carried out mandatory enhanced surveillance of MRSA bacteraemias since October 2005 for NHS acute Trusts. Patient-level data of any MRSA bacteraemias are reported monthly to PHE. Independent sector (IS) healthcare organisations providing regulated activities also undertake surveillance of MRSA bacteraemia.

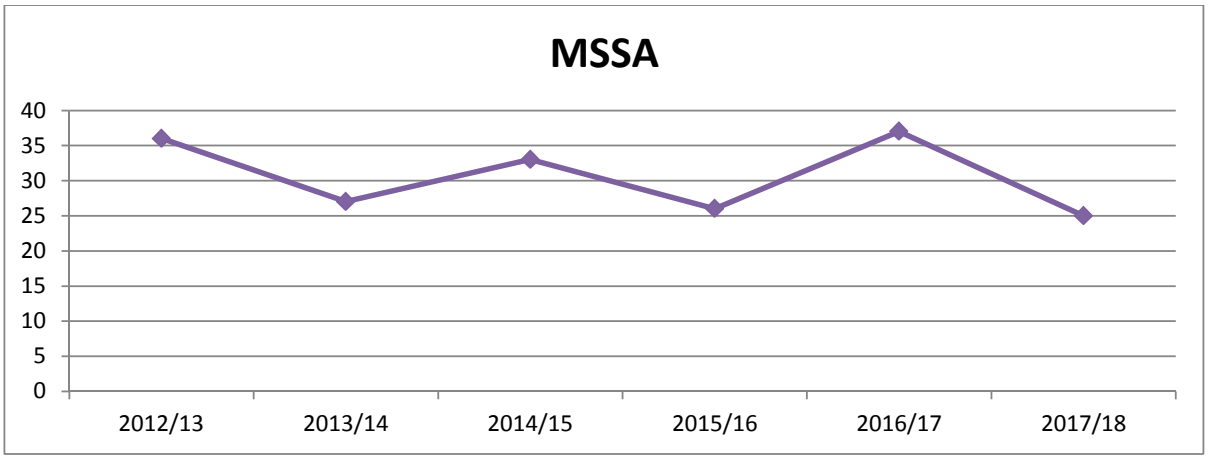


The standard for acute Trusts attributable cases in 2017/18 measure is applied to patients admitted to hospital for more than 2 days. Previously, any case that was deemed as being "unavoidable" was requested for third party assignment and, if agreed, did not count against the Trust. New guidance was issued for 2018/19 (NHSI 2018), which included a zero tolerance to avoidable MRSA bacteraemia, and a removal of the third party designation. It is now recommended that bacteraemia identified less than 48 hours of admission to the Trust is attributed to the community (CCG), whereas bacteraemia occurring more than 2 days after admission are attributed to the acute Trust. The limit has no financial penalties.

Numbers of Trust attributed Meticillin resistant S.aureus *blood stream infections since 2007.*



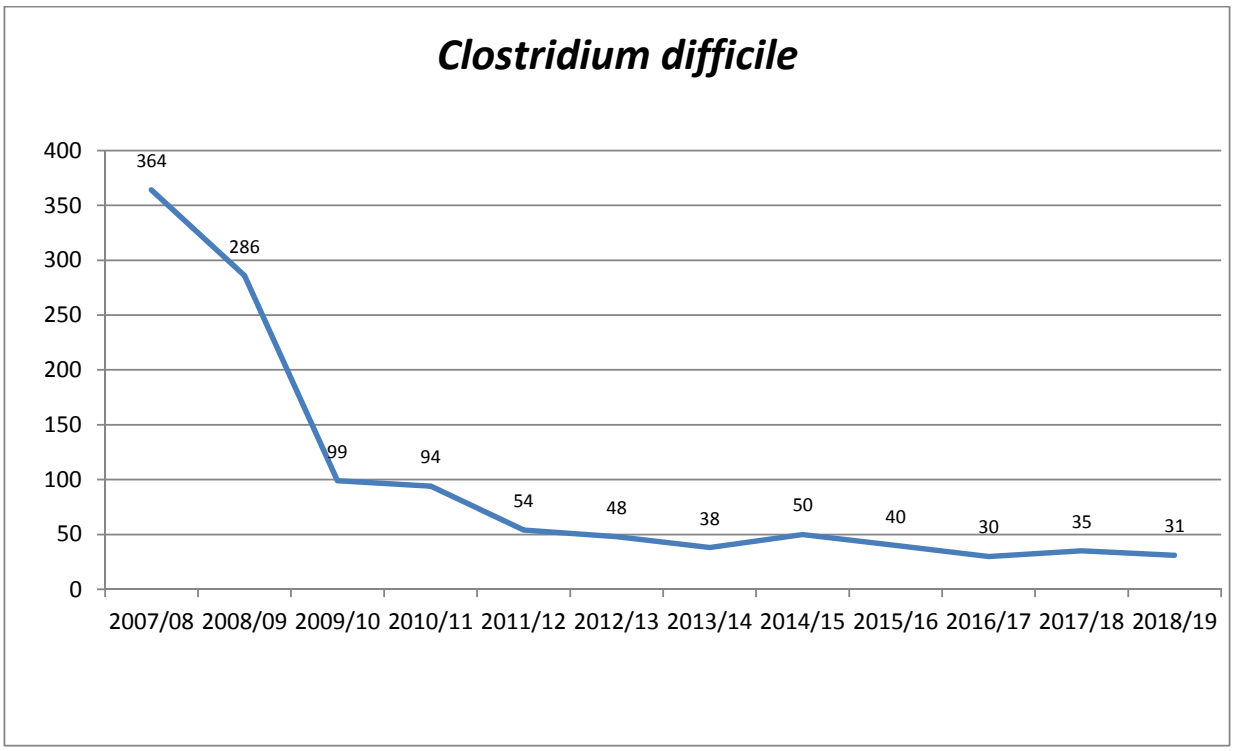
University Hospital Bristol has experienced a higher number of MRSA bacteraemia cases attributed to the Trust during 2018/19. A reassessment of the cases has shown some lapses in care that have been addressed at ward level and Trust wide. However the reassessment has shown that the lapses in care for the cases did not attribute to the patients infection in all cases, except one. Although under the present guidance a full post infection review is not required. The Trust reintroduced this to ensure that any lapses in care would be highlighted and addressed. Infection Prevention & Control continue to work with all staff to ensure patients receive a high standard of care.



MSSA
The standard for Trust attributable cases is measured by patients in hospital for more than 2 days. The Trust limit was no more than 25 cases in the year. This limit has no financial penalties. The Trust reported 28 cases, which is a higher number of cases than expected. A review of all the cases was undertaken and the largest proportion of MSSA bacteraemia was in cardiac services. Targeted interventions were put in place to address any areas of improvement.

All Trust attributed MSSA infections are reviewed by the IPCT, a bacteraemia infection review is completed and an action plan is generated and is detailed within the Datix system for each infection.

There has been an increase in patients nationally with MSSA bacteraemia



C.Diff

The limit set for *Clostridium Difficile* infections for 2018/19 was 44. The Trust performed well in this area with 31 Trust apportioned C.Diff infections. Of those, 9 were determined to be due to a "lapse in care". The graph below shows there has been a reduction in C.Diff at UHBristol over the last few years.

There were clear themes for improvement in where "lapses in care" were identified. These were as follows:

- Incomplete documentation
- Delays in sending stool samples
- Inappropriate antibiotics prescribed

Action taken:

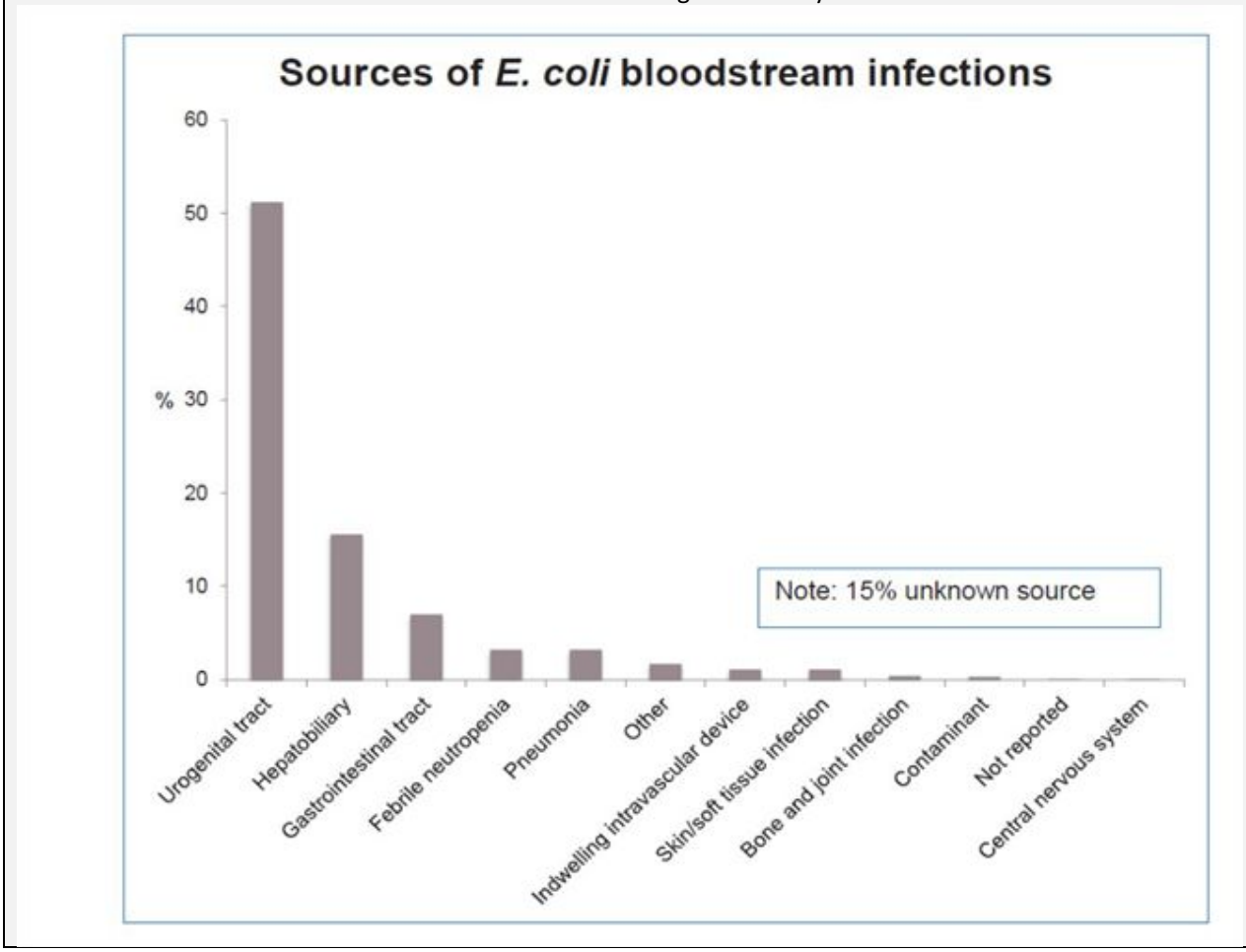
- Documentation reviewed and updated
- Bespoke ward based training on infection control delivered incorporating learning
- Updated Trust wide training programmes
- Amended review paperwork to improve investigating and reporting
- Hand hygiene audit tool reviewed with improved reporting mechanisms
- Joint specialist pharmacist/microbiologist ward rounds to most wards at least weekly, auditing antimicrobial prescriptions for compliance with the Anti-infective Guidelines

Gram Negative Infections

In 2017 Public Health England introduced mandatory surveillance of E.coli, Pseudomonas and Klebsiella. In 2017/18 there was a healthcare community wide ambition for a 10% reduction in E.coli infections introduced. There are no limits at present for Pseudomonas and Klebsiella.
The IP&CT complete the mandatory paperwork on the National data capture system for the above.

E.coli

The UK has seen a steady increase in the number of E.coli blood stream infections (BSI) in the past few years. This is despite the reduction in the number *of Meticillin Resistant Staphylococcus Aureus* BSI and *Clostridium difficile* cases.
In 2017 the Secretary of State for Health launched an ambition to reduce the Healthcare-associated Gram-negative BSI by 50 % by 2021. Gram-negative BSI is thought to have contributed to approximately 5,500 deaths in the UK NHS in 2015. The most common source of infection is the urogenital tract at 51.2% of all E.coli BSI infections.
A look back exercise was undertaken at UHBristol. From the 30 cases reviewed, our findings concur with the national theme that the common source of E. coli BSI is the genitourinary tract.



Based on Abernathy, J et al (2017) Epidemiology of *Escherichia coli* bacteraemia in England, results of enhanced sentinel surveillance programme. *Journal of Hospital infection* 95 (4): 365-375.

3.3 Surgical Site Surveillance

The methodology from Public Health England is used and data is entered onto the National database which then produces reports and figures on a quarterly basis. The surveillance team follow up all patients at 30 days post discharge. This process captures the whole patient journey and gives data on post discharge infections and readmissions to the trust, or other trusts, with infections of the surgical site. The specialities included in data collection were:

- Adult orthopaedic (mandatory)
- Adult CABG and non CABG
- Paediatric non CABG
- Hysterectomy (including laparoscopic procedures)
- General GI surgery (non-laparoscopic)

The programme has been reduced throughout the year due to recruitment; however, data has been collected for adult and paediatric cardiac surgery, orthopaedics and GI. Post discharge surveillance has also continued. A permanent post has been funded and the recruitment process is underway.

4 .Incidents, Risks and Outbreaks

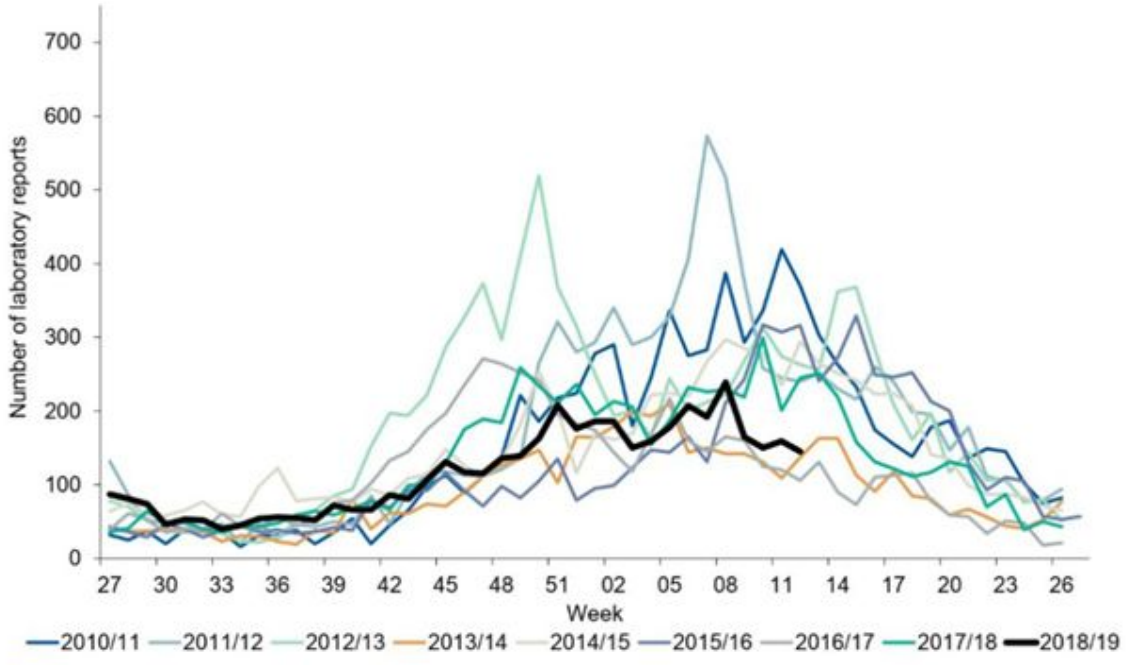
During 2018/19 there were no formal outbreaks declared. The Trust has had some bay and ward closures due to infections. All infection control incidents of outbreaks are reported via the Datix incident management system. Noro virus is reported via Public Health England national norovirus system.

The Trust Board review the corporate risk register quarterly. There is one risk on the corporate risk register. There are 19 risks on the divisional risk register. These are reviewed bi monthly at the Infection Control group.

4.1 Norovirus Activity

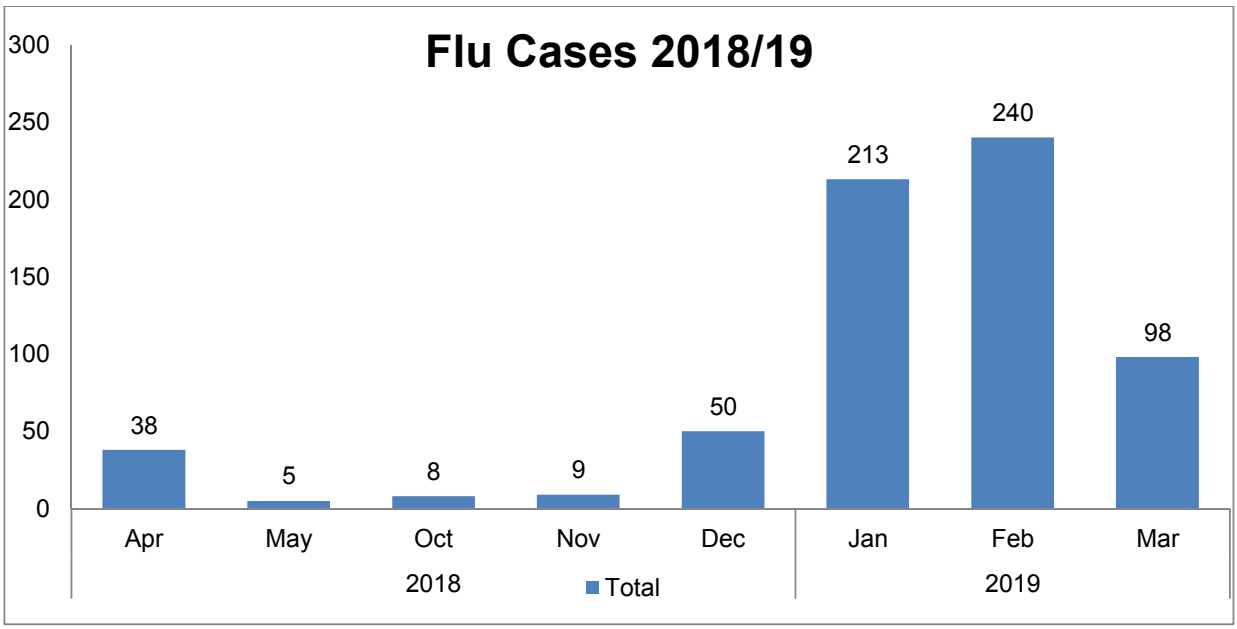
Norovirus cases are proactively managed with involvement from the infection control team. Patients are managed and tested in accordance with local and national policy, reporting cases through the Public Health England norovirus reporting system. The infection control team support the re-opening of areas as appropriate.

Figure 1: Seasonal comparison of laboratory reports of norovirus 2010/11-2018/19 (England and Wales)



4.2 Influenza

The Trust introduced repaid flu testing, for critical care areas and the emergency departments during the winter period. The results were reported back to the clinical areas within two hours.



4.3 Measles

There was an outbreak of measles nationally during 2018/19. A number of patients entered our Emergency department, and needed to be informed due to possible exposure.

- 178 patient contacts that had potentially been exposed in the Emergency Department (ED) were informed by letter.
- Information Posters were displayed in both Emergency Departments.
- Communications department sent out messages via social media to ask patients with symptoms not to come to ED but to phone their GP or NHS 111, if they did not require emergency treatment. If they did present to ED, to ensure staff are immediately aware.
- Information on Connect for staff, including clinical guidelines. Staff were required to ensure they were up to date with MMRs/immune.
- CCG asked to cascade information to GPs not to send patients to ED unless necessary and to phone ahead.
- Posters displayed at Saint Michaels Hospital. Information leaflets available.

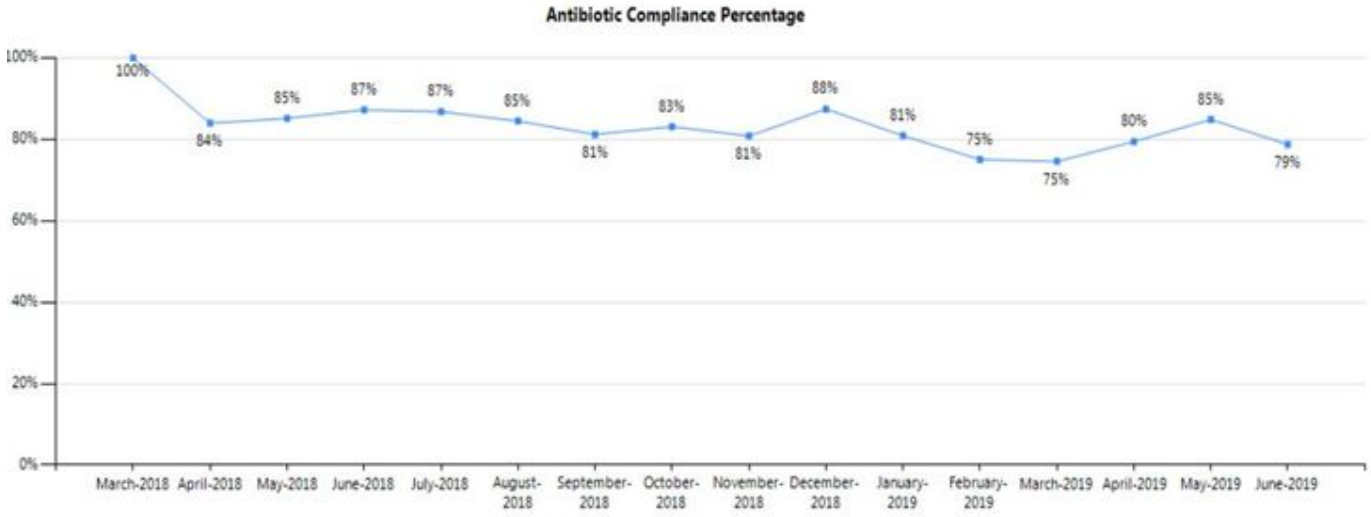
5. Antimicrobial Stewardship

The term 'antimicrobial stewardship' is defined as 'an organisational or healthcare-system-wide approach to promoting and monitoring judicious use of antimicrobials to preserve their future effectiveness' (NICE, NG15, August 2015). Antimicrobial Stewardship operates across all clinical areas of UHBristol as part of the Trusts antimicrobial stewardship programme.

The activity of the antimicrobial stewardship team is monitored through the anti-infective steering group, chaired by the medical director. The group have continued to meet quarterly throughout 2018/2019 regularly reviewing compliance, expenditure, CQUIN delivery, incident trends, up-dating and producing new guidelines, audit and education and training policy, in line with the recommendations from the DoH on the delivery of a robust antimicrobial stewardship programme.

5.1 Prescribing Compliance

The Anti-infective Pharmacy team have continued to work with the microbiologists and paediatric infectious diseases team reviewing antimicrobial prescribing across the Trust. Compliance continues to vary. The increase in stewardship rounds on AMU has led to a reduction in compliance due to the vast amount of data captured. We now feedback AMU data at the board round on a daily basis; the support from the AMU team has been exemplary and compliance has improved.



Stewardship reviews continue to be entered on to Medway; the details are visible as a clinical note attached to each patient. This allows clinicians to see the results of prescription reviews, any recommendations made and which member of the team carried out the review. As we move toward electronic prescribing, we are reviewing data collection and thus the stewardship rounds themselves will inevitably change although we will maintain our presence on the wards.

5.2 Antimicrobial CQUIN 2018/2019

In this financial year we achieved two of the three CQUIN targets for Antimicrobial Resistance.
The final figures were:

- Reduction in total antibiotic consumption –4.37% reduction (target 1%)
- Target - maintain previous year's consumption or demonstrate appropriate use, we provided evidence to show that every carbapenem prescription was either as per guidelines or on the advice of microbiology
- Target – increase proportionate use of Access antibiotics (narrow spectrum) by 3% – we did not achieve this target

5.3 Antimicrobial CQUIN 2019/2020

The targets for the coming year are:

- Lower UTI diagnosis & treatment in patients 65 and older – the diagnosis should not be based on a urinary dipstick result, treatment should follow NICE (Trust) guidelines and an MSU should be sent when starting treatment – the threshold for successful achievement is between 60-90%
- Single dose antibiotic prophylaxis for elective colorectal surgery -– the threshold for successful achievement is between 60-90%
- Antifungal stewardship – we need to formulate a dedicated antifungal stewardship team, guidelines (have been reviewed), undertake diagnostic gap analysis and audit our prescribing practice

The reduction in total antibiotic consumption (1% reduction) and the aim to increase our use of narrow spectrum agents is now part of our standard contract.

5.4 Guidelines

We have 72 antimicrobial guidelines. Guidelines are reviewed on a 2 yearly basis (or sooner if new evidence or national guidance is available). 29 guidelines underwent a review in 2018/19, 3 guidelines are currently being reviewed.
We have had access to the Microguide app since 2014, the license for this was renewed in 2017/18 and we now have the desktop version available via a link on the intranet.

5.5 Audit and Quality Improvement

Completed in 2018/19:
Prepack of co-amoxiclav: QI project of audit of use, 5-day pack size sourced, stock replaced
Adult Urinary tract infection QI project – provided evidence to support the CQUIN target for 2019/20
Audit of the Adult vancomycin prescribing chart
New guideline introduced in dermatology to align antibiotic prophylaxis prescribing
Paediatric whiteboard now includes information as to whether patient is on antibiotics (IV or PO)

Ongoing:
Paediatric AE audit
Paediatric vancomycin QI project
Adult teicoplanin audit
Adult azithromycin audit (on hold)

5.6 Education and Training

Delivery of educational sessions was provided on the following occasions:

F1 teaching	Sep 2018
F1 teaching	April 2019 – UTI in 65+
Regional preregistration pharmacists	Sep 2018
Pharmacists/technicians – Appendicitis	July 2018
Pharmacists/technicians – UTIs	July 2018
Pharmacists/technicians – Tonsillitis/Quinsy	Jan 2019
Pharmacists/technicians - UTI	February 2019
BNSSG IC Conference	May 2019

5.7 Expenditure

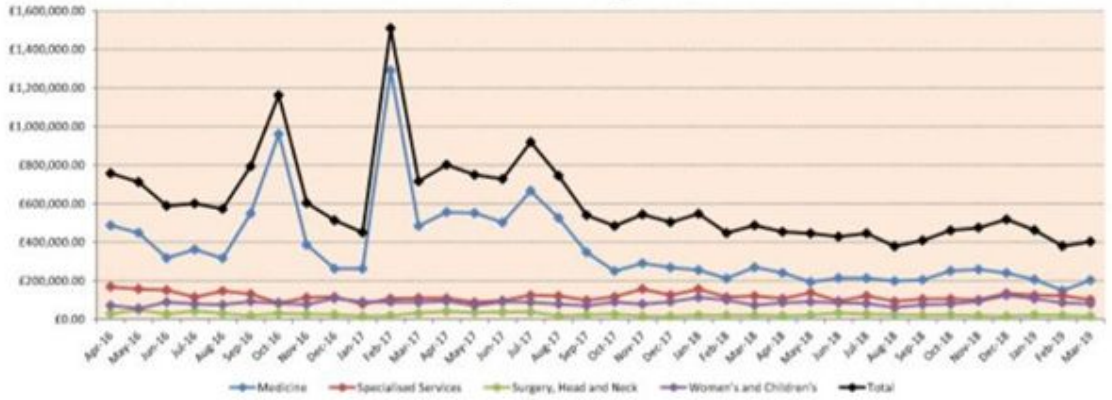
Again, there was a slight increase in both antibiotic and anti-viral expenditure over winter months due to influenza cases. Overall, anti-infective expenditure remained on a downward trajectory throughout 2018/2019 financial year.

Anti-Infective Expenditure Report, Q4 2018/19

Spend by division and PbR exclusion status

	Division	Q1 2016/2017	Q2 2016/2017	Q3 2016/2017	Q4 2016/2017	Q1 2017/2018	Q2 2017/2018	Q3 2017/2018	Q4 2017/2018	Q1 2018/2019	Q2 2018/2019	Q3 2018/2019	Q4 2018/2019
PbR	Medicine	£108,705	£120,881	£132,399	£132,872	£150,395	£151,921	£145,323	£166,683	£150,056	£158,340	£196,419	£169,435
	Specialised Services	£45,961	£43,343	£68,524	£52,130	£95,101	£87,054	£76,972	£73,752	£51,854	£57,575	£64,260	£60,963
	Surgery, Head & Neck	£77,832	£47,656	£52,312	£43,815	£79,211	£64,501	£46,226	£50,635	£44,264	£54,306	£54,913	£51,978
	Women's & Children's	£67,769	£84,001	£81,688	£83,105	£105,504	£95,633	£88,538	£101,353	£95,328	£96,364	£104,464	£126,520
	Total	**£300,267**	**£295,881**	**£334,922**	**£311,922**	**£430,210**	**£399,109**	**£357,061**	**£392,424**	**£341,501**	**£366,584**	**£420,055**	**£408,896**
Non-PbR	Medicine	£1,146,678	£1,108,734	£1,479,241	£1,906,418	£1,459,117	£1,388,596	£865,328	£570,919	£498,618	£459,573	£554,600	£390,985
	Specialised Services	£432,005	£350,705	£245,885	£246,098	£201,609	£258,209	£324,172	£320,065	£288,970	£263,041	£279,128	£289,921
	Surgery, Head & Neck	£28,734	£46,966	£30,963	£26,006	£35,469	£14,512	£14,271	£13,676	£30,060	£20,654	£6,561	£9,065
	Women's & Children's	£150,471	£165,325	£189,012	£187,209	£153,345	£144,160	£171,701	£187,125	£169,631	£124,590	£195,468	£147,043
	Total	**£1,757,889**	**£1,671,730**	**£1,945,101**	**£2,365,731**	**£1,849,540**	**£1,805,477**	**£1,175,472**	**£1,091,785**	**£987,279**	**£867,857**	**£1,035,755**	**£837,015**
Total	Medicine	£1,255,383	£1,229,615	£1,611,640	£2,039,290	£1,609,512	£1,540,517	£810,651	£737,602	£648,674	£617,913	£751,018	£560,420
	Specialised Services	£477,966	£394,048	£314,409	£298,228	£296,710	£345,263	£401,144	£393,817	£340,824	£320,615	£343,388	£350,884
	Surgery, Head & Neck	£106,566	£94,622	£83,275	£69,820	£114,679	£79,013	£60,499	£64,312	£74,323	£74,959	£61,474	£61,043
	Women's & Children's	£218,241	£249,326	£270,700	£270,314	£258,849	£239,793	£260,238	£288,479	£264,959	£220,954	£299,932	£273,563
	Total	**£2,058,156**	**£1,967,611**	**£2,280,023**	**£2,677,652**	**£2,279,750**	**£2,204,586**	**£1,532,533**	**£1,484,209**	**£1,328,780**	**£1,234,442**	**£1,455,810**	**£1,245,911**

Total Anti-Infective Expenditure by Division and Month



6. Decontamination Risks

51 on the register for decontamination: 5 requiring action, 26 accepted, 19 closed, 1 rejected

Risks requiring action:

- Risk 1343 - Risk of service interruption due to poor level of decontamination provision in Hey Groves Theatres – recently been agreed that HGT will look to fund a band 3 Decon lead who can then formalise links with QDU. A number of measures are being in place to reduce the decontamination of workload in hours to HGT and divert to QDU.
- Risk 1531 - Jet AER Failures – capital monies have been made available and procurement process has commenced
- 2458 - Risk of service stoppage due to steam supply to CSSD being interrupted due to interruptions to CSSD steam supply
- 2739 - RISK OF NOT BEING ABLE TO PERFORM AUTOMATED DECONTAMINATION PROCESSES IN ENT OPD – SMH
- 2740 – Risk that staff will come to harm working in an environment that is not fit for purpose in terms of the decontamination tasks

6.1 Successes for Year 18 - 19

- Refurbishment of CSSD – completed
- CSSD Kingsdown maintained accreditation to ISO 13485:2016
- Continued improvements in departments that undertake local decontamination during the annual audit undertaken by the AED
- Decontamination training delivered to staff undertaking local decontamination
- Installation of high low sinks and new work surfaces in CSSD decontamination room
- Drawing up of and implementation of action plan following AED annual trust-wide decontamination audit.
- Installation of the Spend to Save initiative to move the UV decontamination machine for BHI cath labs for the decontamination of TOE scopes from Radiology level 2
- Purchase of 1 new AER for BCH theatres
- Purchase of 1 new AER for HGT theatres
- Commencement of residual protein testing of surgical instruments in CSSD

6.2 Project of Works for 19 – 20

- Commencement of use of Process Control Devices in CSSD and Endoscopy.
- Reduction in decontamination processing costs in line with Divisional Cost Improvement Plans
- Relocation of Dental Decontamination Service to CSSD Kingsdown
- Drawing up and implementation of action plan following AED annual trust-wide decontamination audit.
- Installation of new AER's for HGT and BCH
- Continue to monitor decontamination risks and work through actions in order to close risks where possible or convert to accepted
- Installation and commissioning of 8th washer disinfector in CSSD Kingsdown

The term 'antimicrobial stewardship' is defined as 'an organisational or healthcare-system-wide approach.

7. Facilities

7.1 Current Year (2018/19)

The Facilities department has made continual improvements to performance and working strategy to ensure the best patient environment experience. Actions and initiatives during 2018/19 included:

7.2 Facilities Cleaning

a) The Cleaning Policy and Cleaning Reasonability Framework have been reviewed and signed off.

b) The current Linen contract has been extended until March 2020, to enable the procurement process to take place. It has been agreed that the tender process will not combined with NBT.

c) No additional funding for winter pressure deep cleans was approved and this proved to have a significant impact on the current deep cleans resource.

d) The cleanliness audits results are presented at the Estates and Facilities Divisional Management Board. Dashboard for assurance compliance.

7.3 Quality Assurance for Cleanliness

a) Cleanliness Auditing

- The Trust receives assurance by monitoring cleanliness on a daily basis in line with the National Specifications for Cleanliness and internal SOP. This audit team is independent from the Facilities Hotel Services, Estates and Clinical teams.

- Each area is assigned a risk category (very high, high, significant or low risk) and a RAG rating (red, amber or green). High risk areas such as intensive care units and theatres (where patients are more vulnerable to infection) are very high risk and audited on a monthly basis.

- The tables below show the Facilities audit scores by hospital.

Facilities VERY HIGH

	2018								2019			
	Apr	May	June	July	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
BRI	98	98	99	98	98	99	98	99	98	98	99	98
BHI	98	98	98	98	97	98	97	98	97	97	99	99
BRCH	97	97	98	98	98	98	98	98	97	98	98	98
SMH	96	96	97	96	95	95	97	98	97	96	97	98
BHOC	97	98	97	98	98	97	98	97	97	97	98	98
BDH												
BEH	99	97	98	98	98	98	98	98	98	97	98	98
SBCH	97	97	97	97	99	98	98	99	99	99	98	99
CHIC												

Facilities HIGH

	2018								2019			
	Apr	May	June	July	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
BRI	95	96	96	95	96	94	95	95	96	95	95	96
BHI	96	95	95	95	94	93	94	95	93	95	95	95
BRCH	96	96	98	97	96	96	95	96	97	96	97	97
SMH	95	95	95	93	92	92	92	96	95	92	96	98
BHOC	96	96	97	96	97	97	96	97	98	97	97	98
BDH	94	89	96	96	94	95	94	94	96	95	95	96
BEH	98	95	96	97	97	96	96	96	96	97	97	98
SBCH	97	97	96	98	97	97	98	98	97	97	96	97
CHC	95	97	97	94	94	97	96	98	98	98	99	99

Facilities Significant

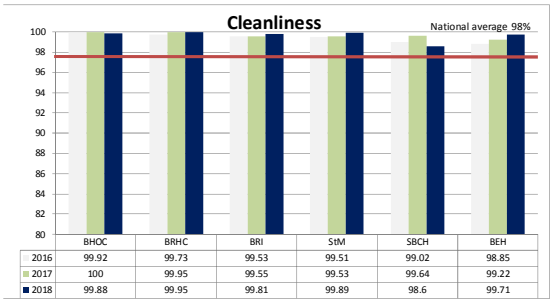
	2018								2019			
	Apr	May	June	July	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
BRI	87	96	90	88	95	87	88	94	90	86	90	86
BHI	91	91	87	91	84	82	85	90	86	89		89
BRCH	93	97	95	92	78	89	89	92	80	96	90	97
SMH	89	93	87	89	94	88	91	91	97	91	96	98
BHOC	88		99	93	98	96	88	86	94	95	93	89
BDH	91		84	82		80	84		83	94		81
BEH	92	92	95	91	94	94	94	96	91	94	97	98
SBCH	96	97	89	98	91	95	98	98	98	96	95	95
CHC	93	95	96	94	100	96	95	96		96	98	

b) PLACE

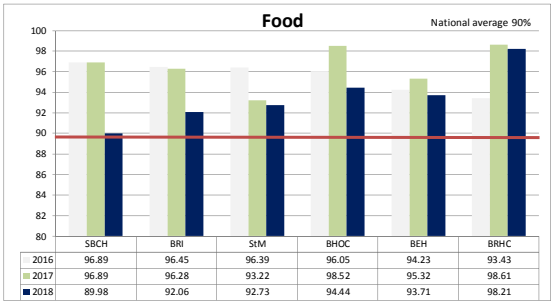
Successful completion of the Patient Led Assessment of the Care Environment (PLACE) assessments in 2018 at six hospitals. The elements assessed included cleanliness, privacy & dignity, disability, dementia, food and condition & appearance. The assessments included representatives from clinical, facilities and estates whilst being led by patient representatives including governors, volunteers, patients and HealthWatch.

The results are shown below. They were presented to management groups including: E&F Divisional Board, Infection Control Group, Privacy & Dignity Group, Dementia Group, Governors.

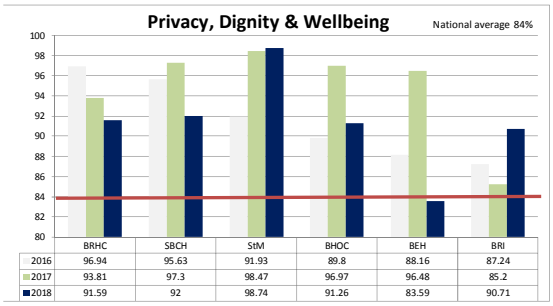
PLACE 2016 to 2018



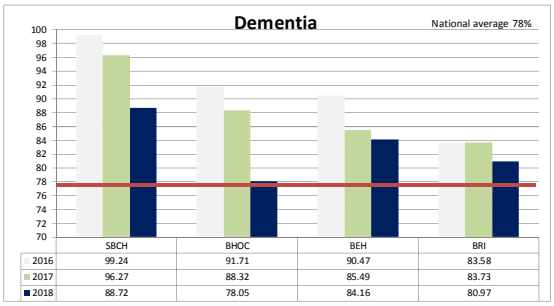
	BHOC	BRHC	BRI	StM	SBCH	BEH
2016	99.92	99.73	99.53	99.51	99.02	98.85
2017	100	99.95	99.55	99.53	99.64	99.22
2018	99.88	99.95	99.81	99.89	98.6	99.71



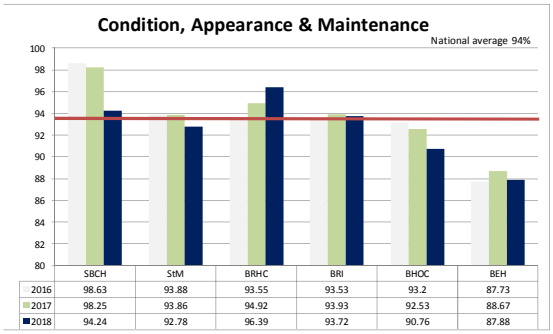
	SBCH	BRI	StM	BHOC	BEH	BRHC
2016	96.89	96.45	96.39	96.05	94.23	93.43
2017	96.89	96.28	93.22	98.52	95.32	98.61
2018	89.98	92.06	92.73	94.44	93.71	98.21



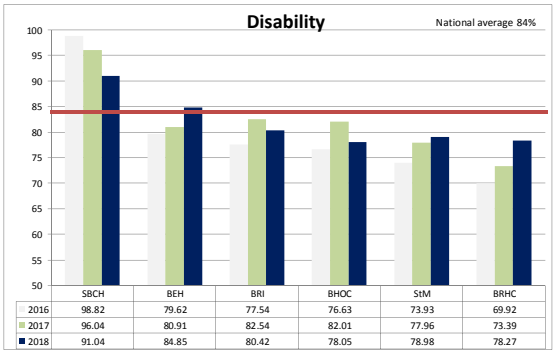
	BRHC	SBCH	StM	BHOC	BEH	BRI
2016	96.94	95.63	91.93	89.8	88.16	87.24
2017	93.81	97.3	98.47	96.97	96.48	85.2
2018	91.59	92	98.74	91.26	83.59	90.71



	SBCH	BHOC	BEH	BRI
2016	99.24	91.71	90.47	83.58
2017	96.27	88.32	85.49	83.73
2018	88.72	78.05	84.16	80.97



	SBCH	StM	BRHC	BRI	BHOC	BEH
2016	98.63	93.88	93.55	93.53	93.2	87.73
2017	98.25	93.86	94.92	93.93	92.53	88.67
2018	94.24	92.78	96.39	93.72	90.76	87.88



	SBCH	BEH	BRI	BHOC	StM	BRHC
2016	98.82	79.62	77.54	76.63	73.93	69.92
2017	96.04	80.91	82.54	82.01	77.96	73.39
2018	91.04	84.85	80.42	78.05	78.98	78.27

7.4 Training

a) Manual handling for non-clinical staff is now included in Skills Training for new Hotel Service Assistants and update training is provided for Estates and Facilities staff provided by Estates and Facilities trainers.

b) Waste management training across the Trust is being provided for teams locally by the Facilities Waste Management team. Information on waste streams and correct segregation is now available on

Connect.

c) With the introduction of the new Hotel Service Assistant (H.S.A) B2 Role, the new starter skills training course has been update to include 4 of the 5 key elements. These elements include;
    - Deep Clean
    - Changing Curtains
    - Descaling/Hazardous Chemicals
    - Additional Cleaning Machinery (Including use of fogging machines)

d) The local Facilities Induction programme is under review and may include the 5th element of IT system skills

7.5 Next Financial Year (2019/20)

Facilities cleaning:

a) Funding for additional deep cleaning during the winter months, requires approval early to ensure this is in place for the forthcoming winter.

b) The current Linen contract has been extended until March 2020, to enable the procurement process to take place. It has been agreed that the tender process will not combined with NBT

7.6 PLACE

The H&SCIC are reviewing the PLACE process. The assessments will be held in September 2019.

7.7 The National Specifications for Cleanliness

These are being reviewed by the H&SCIC and changes are anticipated in the second half of 2019.

7.8 Business and Compliance Team

A team has been set up within Estate and Facilities to manage the Divisions performance and compliance and includes: cleanliness auditing, PLACE, Health and Safety, Training, PAM.

8. References

Department of Health (2013) Health Building Note 00-09: Infection control in the built environment.
Health and Social Care Act (2008), Available at: https://www.legislation.gov.uk/ukpga/2008/14/contents (Accessed 5 June 2018)

National Institute for Health and Care Excellence (NICE) Quality Standard 113 (2016) Healthcare-associated infections, NICE

National Institute for Health and Care Excellence (NICE) Guidance NG15 (2015) Antimicrobial stewardship: systems and processes for effective antimicrobial medicine use, NICE

Public Health England (2018) Official Statistics - Norovirus and rotavirus: summary of surveillance 2017 to 2018, Available at: https://www.gov.uk/government/statistics/norovirus-national-update_ (Accessed 11 June 2019)

Meeting of the Board of Directors in Public on Tuesday 30 July 2019 in the Conference Room, Trust Headquarters

Report Title	**People Strategy**
Report Author	**Matt Joint, Director of People**
Executive Lead	**Matt Joint, Director of People**

1. Report Summary

At UH Bristol we want to create a positive, inclusive culture that attracts, develops and retains exceptional people. Our aim is that by 2025 we will have realised this vision but in order to achieve this we need a people strategy that engages our people, gives them a firm belief in a positive future and enables them to manage the workforce challenges that we face.

Our new people strategy must help us to adapt to our changing local context and the exceptional and unprecedented current challenges facing the health service as a whole. It must enable us to support and develop a workforce that can deliver new models of care and work collaboratively with our healthcare partners

It has become harder to recruit too many key roles, which places greater emphasis on retention and on our ability to develop skills and capability. This will require greater focus on staff development, career paths, flexible working arrangements, wellbeing and work-life balance. We will also need to demonstrate that we truly understand and support the development of a more inclusive culture in our Trust.

We will need to be more agile and more actively engaged in finding solutions to our workforce challenges than we have been. UH Bristol is well positioned to actively participate and take a lead role in implementing a modern workforce strategy for the NHS. The Trust's leadership now has a collective responsibility to take the People Strategy forward and to ensure that UH Bristol continues to build a workforce able to make an outstanding contribution to the Trust, our local system and the communities that we serve.

2. Key points to note

(Including decisions taken)

The People Strategy was presented at Strategic SLT and the June Business SLT and updates made as a result of the feedback. The People Strategy is one of the enabling strategies of the Trust's Embracing Change, Proud To Care, and 2025 Strategy and is supported by strategies relating to Education, Recruitment & Retention, Organisational Development, Diversity & Inclusion and the Strategic Workforce Plan. These supporting documents are available on request.

3. Risks

If this risk is on a formal risk register, please provide the risk ID/number.

The risks associated with this report include:

N/A

4. Advice and Recommendations

(Support and Board/Committee decisions requested):

- This report is for **APPROVAL**.

• The Board is asked to **APPROVE** the report.

5. History of the paper Please include details of where paper has previously been received.	
Senior Leadership Team - Business	05 June 2019
People Management Group	13 June 2019
Trust Partnership Forum	18 June 2019
Senior Leadership Team - Strategic	19 June 2019
Senior Leadership Team - Business	17 July 2019
People Committee	25 July 2019

2025 STRATEGY

University Hospitals Bristol People Strategy 2020-2025

1. INTRODUCTION

Foreward from Director of People

At UH Bristol we want to create a positive, inclusive culture that attracts, develops and retains exceptional people. Our aim is that by 2025 we will have realised this vision but in order to achieve this we need a people strategy that engages our people, gives them a firm belief in a positive future and enables them to manage the workforce challenges that we face.

There are concerns about the sustainability of the current NHS workforce model and a growing recognition that the existing approaches to healthcare, workforce education, recruitment and training need to change. We are in a good position and can demonstrate a track record in delivering previous strategies. However, we know our new people strategy must help us to adapt to our changing local context and the exceptional and unprecedented current challenges facing the health service as a whole. Demand for care is increasing as the population grows and ages and patient needs become more chronic and complex. There are significant national shortages in the health and social care workforce, which call into question our ability to continue providing services in the way we always have, and is a lever for finding new ways to deliver our services, treatment and care. The People Strategy must enable us to support and develop a workforce that can deliver new models of care and work collaboratively with our healthcare partners

It has become harder to recruit to many key roles, which places greater emphasis on our ability to develop skills and capability. Even with focused investment it will take years to see the benefits in our clinical workforce. We will need to ensure that retention is central to our workforce strategy. This will require greater focus on staff development, career paths, flexible working arrangements, wellbeing and work-life balance. We also need to demonstrate that we truly understand and support the development of a more inclusive culture in our Trust.

The more we can remain close to the changes in healthcare and, indeed, influence the changes in healthcare the more confident the Trust can be about its focus and workforce investments. We will need to be more agile and more actively engaged in finding solutions to our workforce challenges than we have been. Working and leading in partnership with Healthier Together and the way that we integrate with Weston Area Health NHS Trust provide early opportunities to produce new workforce solutions. UH Bristol is well positioned to actively participate and take a lead role in implementing a modern workforce strategy for the NHS – to test assumptions, develop initiatives, adopt best practice, to collaborate and lead across the local system regionally and nationally to build and deliver effective workforce plans.

UH Bristol has a workforce of which it is justly proud and our achievements as a Trust are largely due to the quality of our staff. We have put in place a good foundation for our people agenda over recent years but it is time for a more ambitious strategy. The Trust's leadership now has a collective responsibility to take the People Strategy forward and to ensure that UH Bristol continues to build a workforce able to make an outstanding contribution to the Trust, our local system and the communities that we serve.

2. MISSION AND VISION

Our Mission and Vision – Link to Core/Enabling Strategy

Our Mission *To enable our people to be the best they can be, so they can deliver the best patient care.*

Our Vision is**: To create a positive and inclusive culture that attracts, engages, develops and retains exceptional people.**

The delivery of our Mission and Vision is underpinned by our values, which provide the principles of how we behave as individual members of staff and as an organisation.

Our Values are

- Respecting everyone
- Embracing change
- Recognising success
- Working together

3. BACKGROUND and CHANGING ENVIRONMENT

Background and what we have achieved in area over last five years in this area

Building and delivering a successful People Strategy requires the Trust to manage and support its staff exceptionally well. We need to recruit, induct, develop, manage talent, ensure that people enjoy what they do, feel appreciated and included, part of a team and supported to be the best they can be. Our people need to be well led and the senior leaders of the Trust must strive to visibly live the values and demonstrate leadership behaviours. The People Strategy is supported by strategies relating to Education, Recruitment & Retention, Organisational Development, Diversity & Inclusion and the Strategic Workforce Plan and is aligned to the NHS People Plan.

Organisational Development

The Trust's organisational development programme of work is driven by the key findings from the staff survey and is fully aligned to the People Strategy. The work programme is influenced by the annual staff engagement score, which is measured through the NHS staff survey. This score has increased for five consecutive years and is reported at 7.2 (out of 10). Our ambition is to achieve a score of 8.0 by 2025.

Our Organisational Development focus continues to be the development of a positive culture in which we provide conditions to improve experience at work and enhance patient care. Our priority is to set the agenda for inclusive accountable and adaptable leadership. We will continue to support this goal with key interventions such as our Executive Leadership Programme and mandatory leadership and management training. We will also continue to support the wellbeing of our staff through our network of wellbeing advocates and our wellbeing framework and associated tools and training.

We will focus on improving the diversity and inclusion of our workforce and our services, providing a safe environment and a great place to build a career. The Trust has been focusing on diversity and inclusion as an integral part of the People Strategy and we have launched our Diversity and Inclusion Strategy to support us to deliver our vision of being committed to inclusion in everything we do.

Organisational efficiency requires close alignment between what the organisation is trying to achieve and the things that individual employees prioritise. We will develop a strong culture of performance management, linking individual goals to the Trust's strategic objectives. We will ensure that individual performance is judged fairly in terms of not only *what* is achieved but *how* people achieve their goals by measuring against the Trust's values and leadership behaviours.

We will continue our efforts to build a positive workplace culture where people feel valued, listened to and involved in decision making processes and where collective leadership is the norm. Many of the building blocks for this work are already in place through promoting flexibility, wellbeing, career development, and tackling discrimination, bullying and harassment but it is important that we demonstrate that our commitments are bringing rapid and positive change to our staff.

Recruitment and retention strategy

We have a strong marketing brand that we will continue to use across all national and local campaigns, establishing the Trust as an attractive employer of choice. Creative and innovative recruitment campaigns will continue to be a priority activity for all of the Trust's hard to recruit staff. A new recruitment website has been developed for all staff groups, which will create a one stop platform for all applicant and candidate information and will promote the Trust as the outstanding organisation it is.

In a context where external recruitment will only become more challenging it is essential that we optimise the retention of talented and high potential people by developing talent pipelines and clear development paths for individuals, enabling the creation of diverse talent pools to grow the organisation in the future

We need to implement significant workforce changes. This includes the introduction of new and specialist roles such as advanced clinical practitioners and nursing associates, role redesign, skill changes and innovative terms and conditions, particularly in areas where there are ongoing national supply shortages.

We will give greater focus to international recruitment as a solution to recruiting the depletion of skills available in the UK market across specific hard to fill specialties, along with the development of a wider range of apprentice job roles and progression pathways.
.
We will also implement methods and tools that enable a more efficient deployment of staff through e-rostering. Supporting rota compliance and e-rostering for medical staff will also provide greater visibility of critical staffing shortages.

Inflexible and unpredictable working patterns make it harder for people to balance their work and personal life obligations. We want UH Bristol to be a consistently great place to work, but this means that we need to modernise some of our working practices. Offering flexibility will encourage our staff to stay longer, feel fulfilled in their role and allow them the freedom to balance their commitments and activities outside of work. We will champion the benefits of flexible working.

Working collectively across the healthcare system, we will continue to focus on reducing reliance on agency demand and supply and establishing strong staff bank pools across all disciplines, to cover last minute gaps whilst maintaining safe patient care. We are increasingly sharing best practice in recruitment with our system partners and creating a collective approach to recruitment. Retaining our staff and focussing efforts on reducing staff turnover is critical to our developing workforce. Specific initiatives include flexible working options, retire and return, career development pathways and internal mobility schemes.

Education Strategy

The Education Strategy presents a new vision and framework for education across the Trust where learning is embraced as a vibrant and integral part of our workplace. As a large university teaching hospital, education of our staff is one of our core responsibilities and essential for supporting and driving forward ambitions to provide outstanding, safe, clinically effective patient care. Access to education has an ever-increasing influence in attracting, and retaining, a highly skilled workforce. There is a correlation between high quality patient care and highly motivated staff that feel valued. The people that work in our Trust are our most valuable asset; creating a learning organisation culture that embeds learning for all our

staff and trainees recognises this and directly reflects Trust's values.

The education core strategy complements the People Strategy and the Trust's overall strategy and an implementation plan details how the vision and key priorities for education will be fully realised. Health and social care systems are experiencing ever increasing complexity and challenges both in terms of the workforce and its clinical services. Education must be prioritised as a part of our investment in people. Indeed, access to high quality education is known to lead to improved staff retention and engagement. These are vital priorities at a time when NHS staff are reporting feeling undervalued and with low morale.

In the future workforce supply and retention will become ever more challenging and a highly visible, innovative, quality provision of education will become a factor in where people choose to work and stay. Education needs to be part of an overall ambition for the Trust to become a learning organisation, where learning is an integral activity given the same standing as that of clinical services and research. In this model learning is relevant to the person, the teams that work together and of direct benefit to patient care and wellbeing. Learning can then be situated as part of the workplace environment that can be facilitated through both formal and informal learning opportunities.

To effectively lead, and respond, to the future health and social care priorities our staff will need to be motivated and highly adaptable to changing workplace environments. This will require us as a Trust to change and embrace learning as part of who we are, and what we do. If we embrace this vision, we have every opportunity to become nationally and internationally known as a place where exceptional careers are created.

Strategic Workforce Plan

The Trust has developed a strategic workforce plan to support the transformation of the Trust's workforce. The strategic workforce plan was developed using evidence from six months of data collection, analysis and benchmarking. The plan includes Trust-wide workforce initiatives for roles such as Healthcare Scientists, Nursing and Nursing Associates, Advanced Clinical Practitioners, Advanced Healthcare Practitioners, Doctors in Training, Speciality Doctors and Associate Specialists. The relevance and inter-dependence of the supporting strategies, relating to Education, Recruitment and Retention, and Organisational Development and Leadership, are evident throughout the Strategic Workforce Plan.

4. Process for the development of the strategy

Outline of process to develop strategy and engagement undertaken

- **Engagement Development**

This strategy has been informed by a multi methods approach to engagement that are outlined below:

- External Benchmarking
- Input from Board and People Committee
- Policy review
- Literature Search / critical appraisal of related evidence
- Engagement with Healthier Together for a health and social care system perspective
- External provider networks

5. Strategic priorities and guiding principles for the People Strategy

The Key Strategic Priorities and Objectives

TRUST PEOPLE PRIORITIES
• We will attract recruit and retain exceptional people
• We will become a beacon of outstanding education, providing education that nurtures motivation and aspirational career development.
• We will build a culture of Engagement and Diversity that truly drives the best behaviours in our people and supports their health and wellbeing.
• We will provide people systems that support self-service and enable managers to provide efficient, timely management of their people.

Strategic People Initiatives

Development – foster excellence in all areas of teaching and learning to become a beacon of outstanding education	**Culture – investing in our people to create a culture that fulfils the Trust's potential at every level**
1. Consistently achieve high compliance and staff engagement in education. 2. Invest in and develop education for new roles and future focused transformational models of care. 3. Promote lifelong learning where education stimulates, motivates and constructively challenges 4. Create a learning culture and become known as a national and global leader of NHS education. 5. Promote health careers through networks with local communities, universities, schools and colleges 6. Secure an apprenticeship model that becomes known as a national centre of excellence	1. Deliver against the commitments of the Diversity and Inclusion strategy. 2. Achieve a staff engagement score of 8.0 by 2025 by focusing on improving staff experience and increasing retention. 3. Deliver the strategic plan for leadership and management development. 4. Develop a culture of performance management; linking this to personal development and increased organisational efficiency 5. Achieve a significant improvement in Bullying and Harassment by focusing on the three key areas of leadership, communications and staff support. 6. Ensure staff are supported with both their physical and psychological wellbeing
Resourcing – recruit, retain and identify talent	**Develop an integrated customer centred approach to People Systems**
1. Continue to develop and maximise the Trust's Employer Brand through creative and innovative marketing and attraction solutions 2. Become a national & International Employer of Choice 3. Establish new & advanced Roles 4. Optimize the retention of talented people by developing clear development paths, enabling the creation of diverse talent pools to grow the organisation in the future. 5. Implement the strategic workforce plan 6. By better supporting and developing staff improve staff retention, while they acquire the skills, expertise and care their patients need.	1. People Web - implement a customer friendly self-service HR advice and information platform. 2. Implement e-job planning and e-rostering for medical staff 3. Improve the user experience of e-appraisal 4. Implement robust sickness reporting for all staff groups 5. Maximise the potential of the HR Case Management System to provide improved oversight of employee relations risks and issues .

Governance, Assurance and Accountability

How we will assure ourselves of the effectiveness and success of this strategy

The governance process to monitor delivery and provide assurance and oversight including management of any risks to the delivery of the new strategic priorities.

This strategy and its associated workplan will be monitored through the People Management Group with Quality Assurance from the Peoples Committee. It will also provide regular reporting to the Senior Leadership Team. The assurance will be supported by the people data and analytics that are produced by the workforce planning and analytics team and by information derived from regular surveys and assessments, such as the annual staff survey.

We will recruit and attract exceptional people

Utilising our Employer Brand			
Action	Responsibility	Measures	Timeline
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.	Associate Director of HR Operations	-Increase in quality applicants -Strong employer identity -Reduced agency and bank reliance -Reduced turnover -Increased staff morale -Reduction in vacancies -Organisation and service	Ongoing

National & International Employer of Choice			
Action	Responsibility	Measures	Timeline
Use our reputation for excellence in clinical services, research, education and teaching to lever worldwide recruitment opportunities and position the Trust as an employer of choice on a national and international platform	Associate Director of HR Operations	-Appointments to hard to fill areas/posts. -Rota gaps filled. -Reduced locum spend. -Safe working hours for DiT	Ongoing – linked to needs identified in the divisional workforce plans

New & Advanced Roles			
Action	Responsibility	Measures	Timeline
Develop a clear plan for new role design and new ways of working particularly in areas which remain hard to fill, in order to transform and optimise workforce efficiency.	Head of Strategic Workforce Planning	Clear defined strategy for new roles across UHB	Targets in line with national strategy for ACP's, NA's and PA's pending release in Autumn 2019

Talent Management			
Action	Responsibility	Measures	Timeline
Optimize the retention of talented people by developing clear development paths, enabling the creation of diverse talent pools to grow the organisation in the future.	Divisional Leadership teams Head of OD	Launch the National High performing scheme across the STP	Nov 2019
Develop talent management framework	Divisional Leadership teams Head of OD	Task and finish group to develop talent management framework (to include succession planning)	Nov 2019

Strategic Workforce Planning			
Action	Responsibility	Measures	Timeline
Implementation of divisional strategic workforce plans to support the transformation of the workforce	Divisional Leadership teams Head of Strategic Workforce	Implementation tracked against plan through the monthly performance reviews.	From June 2019

Develop an integrated customer centred approach to People Systems

People Web - implement a customer friendly self-service HR advice and information platform.			
Action	Responsibility	Measures	Timeline
Develop a customer friendly People Web, providing an intuitive, self-service IT platform which offers up to date resources and advice/guidance for all staff across a wide ranging suite of workforce matters.	Associate Director of HR Operations	Benchmarking against other services provided by other HR intranets	Linked to IM&T Microsoft 365 initiative due in 2019.

Implement e-job planning and e-rostering for medical staff			
Action	Responsibility	Measures	Timeline
Implement e-job planning and e-rostering for medical staff, creating transformational efficiencies, and sustainable workforce solutions to the management of safe working.	Head of Workforce Productivity	Increased visibility of vacancies, reduction in locum spend, increase in sickness reporting	Feb 2019 through to July 2020

Improving the user experience of e-appraisal			
Action	Responsibility	Measures	Timeline
We will develop the e-appraisal system to make clearer links between individual goals and the Trust's strategic objectives and enabling individuals to identify and access training and development to support the achievement of their goals and career aspirations.	Associate Director of HR Operations	Clear cascade of objectives down to front line staff. Individual training requests more closely linked to organisational goals	Ongoing

Absence Management			
Action	Responsibility	Measures	Timeline
Implement robust absence reporting for all staff groups	Associate Director of HR Operations	Line manages have clear visibility if absence. Significant reduction in absence.	From Oct 2019

HR Case Management System			
Action	Responsibility	Measures	Timeline
Maximise the potential of the HR Case Management System to provide improved oversight of employee relations risks and issues	Associate Director of HR Operations	More timely identification and better management of risks.	Ongoing

A Beacon of outstanding education with a culture of organisational learning

Consistently achieve high compliance and staff engagement in education.			
Action	Responsibility	Measures	Timeline
Review the data reporting schedule and the content of essential training for all staff and trainees.	Associate Director of Education Head of Education Corporate Lead	Compliance data CQC	August 2019
Implement a new governance process for the oversight and agile decision making of essential training.	Associate Director of Education Head of Education	TORs Governance structure	June 2019
Instigate and evaluate the BNSSG essential training passporting project.	Head of Education Corporate education leads	Evaluations Compliance data Reduced training repetition	August 2019
Review, and innovate, digital learning for essential training.	Education Leads Simulation Digital services	Evaluations Compliance	Starts Oct 2019
Explore on-line learning platforms to enhance the accessibility and streamlining of information for individual learning plans.	Associate Director of Education	Education Survey Training Needs Analysis	Starts Dec 2019
Introduce new methods of essential to role education such as action learning sets and coaching.	Education Leads	Training Needs Analysis Appraisals	January 2020

Invest in and develop education of new roles, skills and competencies for future focused transformational models of care			
Action	Responsibility	Measures	Timeline
Develop a consistent, central business planning process of the education required for new roles and levels of practice.	Associate Director of Education	SLT minutes Financial Business Plans	June 2019
Introduce a training needs analysis process focused on the skills and competencies necessary for achieving transformational workforce priorities.	Associate Director of Education HRBPs	OPPs Corporate Objectives TNAs	Dec 2019
Secure, implement and evaluate education necessary to promote new roles such as ACPs, Nursing Associates and Physician Associates.	Associate Director of Education Head of Workforce Planning	Business Plans Procurement process	April 2019
Identify, and build, a sustainable model of relevant post graduate education.	Associate Director of Education HONs DME	CPD funding CPD database	Jan 2020

Promote lifelong learning where education stimulates, motivates and constructively challenges.			
Action	Responsibility	Measures	Timeline
Create a modern future focused library/knowledge management service.	Head of Library	LQAF Education Survey Library Survey	March 2020
Increase the visibility of motivational learning activities such as journal clubs and evidence-based ward rounds.	Associate Director of Education Education Leads	Staff survey Happy App	Dec 2019
Embrace new technologies for education.	Digital Services Head of Library	LQAF Digital	March 2020

Create a learning culture and become known as a national and global leader of NHS education.			
Action	Responsibility	Measures	Timeline
Participate and lead related city wide and regional learning and skills programmes.	Associate Director of Education	Community Engagement LEP	Aug 2020
Support the dissemination of high-quality education i.e. publications and conferences.	Education Leads Line managers	Publications National and global awards	Dec 2020
Raise the overall profile of education equitable to clinical services and research and innovation.	Associate Director of Education	CQC Staff Survey	Dec 2020

Promote health careers through networks with our local communities, universities, schools and colleges.			
Action	Responsibility	Measures	Timeline
Identify key schools and colleges for long-term mutually conducive partnerships.	Associate Director of Education Head of Education Careers Leads	Work experience data Outreach data	Oct 2019
Expand the materials and information depicting the full range of health care careers.	Associate Director of Education Head of Education Careers Leads	Work experience data Outreach data	Dec 2019

Promote health careers through networks with our local communities, universities, schools and colleges.			
Support BNSSG school and colleges collaborative initiatives.	Associate Director of Education Head of Education Careers Leads	Work experience data Outreach data	Feb 2020
Develop a strategic plan for work experience.	Associate Director of Education Head of Education Careers Leads	Work experience data Outreach data	Oct 2019

Secure an apprenticeship model that becomes known as a national centre of excellence.			
Action	Responsibility	Measures	Timeline
Create a learning infrastructure enabling the high attainment of the Ofsted Common Inspection Framework.	Associate Director of Education Head of Education	Ofsted Internal Audit	Sep 2019
Implement an engagement and communication apprenticeship strategy.	Associate Director of Education Head of Education	Ofsted Internal Audit	April 2019
Introduce a preparation programme for managers supporting apprentices.	Head of Education Apprenticeship team	Ofsted Internal Audit	May 2019
Secure business planning as part of the apprenticeship approval process.	Associate Director of Education Head of Education	Ofsted Internal Audit Education Dashboard	April 2019
Develop an apprenticeship model able to host and lead provision across BNSSG /region.	Associate Director of Education Head of Education	Ofsted Internal Audit Education Dashboard	Dec 2020

We will build a culture of Engagement and Diversity that truly drives the best behaviours in our people and supports their wellbeing

Diversity & Inclusion			
Action	Responsibility	Measures	Timeline
Deliver against the commitments within the Diversity and Inclusion 5 year framework; as detailed in the action plan against the four strategic priorities of: • Leadership & Cultural transformation • Positive action & practical support • Accountability & assurance • Monitoring progress & benchmarking	Senior Leadership Team Head of OD	As detailed in the action plan contained within the strategy	Year 1 plan in place

Staff Engagement and Recognition			
Action	Responsibility	Measures	Timeline
To continue to see a year on year improvement with engagement rising to 8.0 by 2025 by continuing to develop innovative solutions in partnership with divisions to build robust engagement plans focusing on improving staff experience and increasing retention	Divisional Leadership teams Head of OD	Increased Staff Engagement scores as measured through the staff survey Review of engagement plans in performance reviews People Committee governance	Annually Quarterly

Leadership & Management			
Action	Responsibility	Measures	Timeline
To deliver against the strategic plan for leadership and management development. Develop a greater sense of managers' accountability for supporting and developing staff – improving staff performance, growing their confidence and realising individual and team potential.	Head of OD	Increased compliance with attendance at training for newly appointed and promoted managers Programmes aligned to the leadership management apprentice offer. A robust plan in place for the Board, Exec Directors and Senior Leadership team. Leadership and management Staff survey measures increase year on year	Ongoing

Performance Management			
Action	Responsibility	Measures	Timeline
To develop a culture of performance management; linking this to personal development and increased organisational efficiency through alignment to talent management and succession planning	Head of OD	Communications campaign to increase compliance and focus on quality	June 2019
Ensure close alignment between what the organisation is trying to achieve and the things that individual employees prioritise. Align performance to pay where appropriate	Head of Reward Head of OD	Evidence that Individual goals linked to the Trust's strategic objectives. Developing the framework for performance management to align to the pay review requirements. .	March 2020
Fully review training, ensuring that individual performance is judged fairly in terms of not only *what* is achieved but *how* people achieve their goals by measuring against the Trust's values and leadership behaviours.	Head of OD	Ensure the training is fully reviewed Further develop bitesize videos to support staff and managers	July 2019 onwards

Tackling Bullying & Harassment			
Action	Responsibility	Measures	Timeline
To realise a year on year improvement in the staff survey by focusing on the three key areas of leadership, communications and staff support within the delivery plan	Senior Leadership Team Head of OD/ Director of Comms	Review all supporting documentation for staff Implement communications plan for tackling bullying and harassment Commence team development work with leadership teams	June 2019 October 2019

Workplace Wellbeing			
Action	Responsibility	Measures	Timeline
To deliver against the wellbeing framework ensuring staff are supported with both their physical and psychological wellbeing.	Head of OD Wellbeing leads	Commence phase 1- psychological wellbeing plan- training and supporting guides	June 2019
Develop phase 2 - psychological wellbeing plan Launch wellbeing framework for physical and psychological wellbeing	Head of OD Wellbeing leads	Commence phase 2 - psychological wellbeing plan.	October 2019

Meeting of the Board of Directors in Public on Tuesday 30 July 2019 in the Conference Room, Trust Headquarters

Report Title	**Arts and Culture Strategy**
Report Author	**Anna Farthing, Arts Programme Director**
Executive Lead	**Matt Joint, Director of People**

1. Report Summary

The paper sets out the Arts and Culture Strategy for University Hospitals Bristol NHS Foundation Trust for approval by the Trust Board.

2. Key points to note
(Including decisions taken)

The Board should note that the Arts and Culture Strategy has been reviewed by the Image Design Environment and Arts Group (IDEAS), presented at a Board Seminar, Senior Leadership Team meeting, and to the People Committee.

The paper:

- makes the case for the continuation and development of the central programme piloted in 2018/19;
- describes the national and local context for the arts in hospital;
- outlines the aims and priority areas for the establishment of the programme and the approach to funding.

The Arts and Culture strategy is identified within the overarching strategy, 'Embracing Change, Proud to Care - our 20205 Vision' and will contribute to the Trust's strategic goals of 'delivering the highest quality, affordable care', 'providing a healthy and healing environment in our hospitals' and 'getting the best value from every pound of public money we spend'.

3. Risks
If this risk is on a formal risk register, please provide the risk ID/number.

The risks associated with this report include:
N/A

4. Advice and Recommendations
(Support and Board/Committee decisions requested):

- This report is for **APPROVAL**.
- The Board is asked to **APPROVE** the report.

5. History of the paper
Please include details of where paper has previously been received.

Board Seminar	28 June 2019
Senior Leadership Team	18 July 2019
People Committee	25 July 2019

1. PROVOCATION:

Imagine someone took away…
All of your books and all of your music.
Your radio and your television, your Netflix and your Spotify.
Your freedom to go to the cinema, the theatre, a museum, a concert.
Your freedom to gather with family or friends over a meal or a drink.
Imagine someone said …. 'You cannot visit your own kitchen, open your fridge, eat what you choose, whenever you fancy it. Nor can you take a long leisurely candle lit bath.'

Imagine being unable to get fresh air.
No garden, no glancing at a bird in a tree, or going for a stroll on the street.
No ball games, running in the rain, dancing to a beat, or paddling your feet.
Imagine having no daylight or night sky and not really knowing what time it is.
Imagine that anything you begin can be disrupted by anyone, at any time.
Imagine being in a place that is never really still or ever quiet.

Would you know who you are?

Our identity is defined by the cultural choices we make.

Being deprived of culture strips us of the means of expressing our identity.
Being deprived of culture is detrimental to our psycho-social wellbeing and negatively impacts our physical health.

Culture enables individuals to express themselves in ways of their choosing.
Culture supports the development of changing identities through the life course.
Culture benefits wellbeing,
…. even when co-existent with poor health,
…. even at the end of life.

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2. INTRODUCTION

This paper sets out the arts and culture strategy for University Hospitals Bristol NHS Foundation Trust.

It makes the case for continuation and development of the central programme piloted in 2018/19, describes the national and local context for the arts in hospital, and outlines the aims and priority areas for the establishment of the programme and the approach to funding.

This iteration is written for readers among the Trust's internal governance committees. It will subsequently be revised and published, with appropriate graphic

design and imagery, for those external partners, stakeholders and funders with whom we wish to collaborate in order to make the vision a practical reality.

The Arts and Culture strategy is identified within the overarching strategy, 'Embracing Change, Proud to Care - our 20205 Vision' as a part of the Enabling Strategy for Estates, 'to ensure that we create a healthy and healing environment through our culture and arts programme and fully embed into future design considerations across the Trust estate.' Elements more closely linked to staff and patient activity can also be integrated into the Enabling Strategies for Communications, Education, and People. Activity undertaken with academic partners can be integrated with the Trust's strategy for Research.

3. VISION

- In 2025 for engagement with #UHBristolArts activity to be accepted and expected as a normal part of the experience of visiting, working or being cared for in UHB NHS FT.
- For #UHBristol Arts to be recognised as a leader in local, regional and national debates on Arts and Health.
- For UHBristol NHS FT to be fully engaged in research and higher education concerning Arts and Health with academic and cultural partners.

4. AIMS AND OBJECTIVES

The aims and objectives of the Arts and Culture Programme at University Hospitals Bristol NHS Foundation Trust (#UHBristolArts) are to enrich our organisation and benefit the health and wellbeing of all patients, staff, students, volunteers and visitors who engage with our sites and services.

#UHBristolArts will benefit staff, students, volunteers, patients and visitors by improving the *aesthetic experience* of engaging with the Trust.

- *Aesthetic experience*: 'feeling alive' and 'fully conscious' through activation of the senses, sight, sound, smell, touch, taste, as well as memory and emotion.
- Anaesthetic: numbing of sensation, unconsciousness.

#UHBristolArts will contribute to brand creation and recognition, by ensuring that spaces are well designed and by providing well considered creative activities.

#UHBristolArts will encompass a wide range of cultural forms, including architecture and design, visual art and photography, music and performance, movement and digital media, food and horticulture, creative writing, reading and discussion.

#UHBristolArts will be outward facing and provide a platform for mutually beneficial civic and national partnerships with organisations that are expert in health, education and research, as well as art, design and cultural heritage.

#UHBristolArts will adopt a 'design thinking' approach, informed by research evidence and evaluated by benchmarking best practice.

- Design of Built Environment - to support the development of design based on research and best practice and support creative consultation and engagement with end users
- Design of Landscape and Public Realm – working with neighbours to develop our physical estate and outdoor realm for wellbeing and sustainability, including Air Quality and Biodiversity/Biophilia
- Design of Creative and Cultural activity – to support patient recovery and the wellbeing of staff, students and carers and to ensure all activity is based on research and professional practice in Arts and Health
- Design of Brand and User Experience – to support cohesive and integrated design goals in everyday actions, eg. use of temporary signage.
- Design of Medical Education curricular – to support the efforts and intentions of Medical Educators to adopt creative and cultural approaches for the better understanding of Compassionate Human Factors of Healthcare
- Design Thinking to support innovation, improvement, and problem solving.

5. STRATEGIC ALIGNMENT

The Arts and Culture Strategy will contribute to the Trust's strategic goals of 'delivering the highest quality, affordable care', 'providing a healthy and healing environment in our hospitals' and 'getting the best value from every pound of public money we spend'. It will do this by working in partnership with specialist organisations in civic society and the culture sector and by applying evidence from research about the beneficial impact of well-considered arts, design and heritage activities to relevant decisions.

The Arts and Culture Strategy will contribute to the Trust's overall Mission and Vision in the following ways:

- By applying the results of research into the impact of participation and engagement with the Arts on patient recovery and on the health and wellbeing of staff, students, volunteers and carers. Taking a population approach, this to include activities that take place onsite, offsite and in the digital realm.
- By applying the results of research into the impact of good design in the natural landscape and built environment on patient recovery and the health and wellbeing of staff, students, volunteers and carers. This to include the improvement of existing Estate and ensuring Capital projects are supported with research and evidence based design advice. [1]
- By recognising our role as a civic 'anchor institution' and forming new kinds of mutually beneficial partnerships with cultural and academic insitutions as well as arts and health professionals and developing new ways of engaging with the Trust, including new forms of volunteering.
- By taking a leading role in social prescribing for Arts and Health within the Integrated Care System, including the provision of signposts to community

[1] Innovation Health and Wealth report (2011) challenged the NHS to improve the implementation of proven good practice and innovation, to become better at generating research, enrolling patients and putting research into practice, and to work more effectively with industry to benefit patients and the economy. This can include research into Arts and Health and collaboration with the Creative and Cultural Industries.

based resources for inpatients, outpatients and those being discharged. This to include working with the BNSSG CCG and STP, Healthier Together and Healthy Weston.

- By supporting innovation through the development of key skills from Medical Humanities such as reflective practice, deep listening, creative thinking, visual literacy and manual dexterity and working with those areas of the Trust's activity that need to embrace change in cost effective and sustainable ways.

The Arts and Culture strategy also aligns with those of external stakeholders, such as Arts Council England's 'Shaping the Next Ten Years' (Summer 2019) and Bristol City Council's 'One City Plan' (January 2019)

The strategy has been informed by research published by the All Party Parliamentary Group Inquiry into Arts, Health and Wellbeing, 'Creative Health: The Arts for Health and Wellbeing (July 2017). It has also been benchmarked against the Arts and Culture strategies of other NHS Foundation Trusts.

6. BACKGROUND

The rationale for a Trust-wide arts programme was formally accepted by the Trust Board in April 2017, which agreed that it could bring significant benefits in terms of:

1. supporting the psychological and social needs of our patients and potentially improving their outcomes and relations with healthcare professionals
2. fostering a stronger relationship with staff, with patients and with the civic community.

The hospital's charity, Above and Beyond, generously approved a grant to allow recruitment of an Arts Programme Director for a period of 18 months to pilot an initial programme of arts activities and produce this strategic plan.

Dr Anna Farthing was duly appointed in May 2018 and established a programme under the handle #UHBristolArts. Her brief was to audit the current resource, research the current context, and scope a potential infrastructure that could support a programme of activity. She spent six months in the People Team, six months in the Estates team and 12 months testing programme themes with staff, patients and external partners in the context of the local, regional and national agenda. This strategy is informed by that period of 'action research'.

The signing of Memoranda of Understanding with UWE (complete), City of Bristol College (in progress) and University of Bristol (pending) added to the resources available to the programme. To date, the project has been supported by a Poet In Residence supported by Above and Beyond (one day per month), an MA Curating Intern from UWE (one day per week) whose primary role has been to catalogue existing visual artworks, and a BA Performing Arts intern (20 days) who supported the development of bedside activities for patients. In September 2019, Arts Therapies Students from City of Bristol College will begin placements at South Bristol Community Hospital.

The Arts Programme Director is currently contracted to the end of October 2019. This strategy provides for the role and the work to continue and for resources to be allocated so that it may become more effectively embedded.

7. APPROACH TO STRATEGY

The development of this strategy has been overseen by the IDEA (Image, Design, Environment and Arts) Reference Group, a sub-group of the Senior Leadership Team, chaired by the Chief Executive and including Non-Executive Director and Governor representatives.

The UHB Arts Programme Director has collaborated with those in similar roles at UCLH, GOSH, York, Derby and Oxford to initiate a NHS National Performance Advisory Group for Arts, Heritage and Design in Healthcare. The NPAG group has surveyed more than 40 acute hospital Trusts to collate strategic plans, ascertain the levels of resource and investment, and share best practice.

The approach to developing this strategy has consisted of contextual research, action research and reflective practice, conducted around a number of pilots:

- Thematic: 12 months of test programming linked to exploring core themes (Partnership, Place, Bodies, Words, Images, Sound, Creativity, Nourish, Moving, Boredom, BHI 10, Arts and Health, Eyes, Breath, Learning)
- Events: A monthly ‘Second Wednesday’ event at which patients, carers, staff, researchers, students and members of the public discuss their interests, priorities and issues of concern. Panels comprise a health professional, an academic and a culture professional speaking from personal and professional perspectives.
- Design: Pilot projects on environmental design with staff participation (working without windows, medical records) staff rooms and kitchens (supported by Interior Design students from UWE) and an initial review of Emergency Department.
- Reflection: Pilot projects on using arts as reflective tools for staff development and behaviour change (Dental Summit, Positiviteeth, Noise@Night, Wellbeing Days for Medicine, Surgery, Womens and Children’s)
- Patient Activity: Pilot projects on arts participation with patients: Poet in Residence at SBCH, Choir visits to wards, contributions to Dementia Café, ‘Boredom Buster’ ward based activities.

Throughout, there has been regular engagement with Board members, Governors, patient representatives and Above and Beyond, with the Trust medical education function and with Medical School and Medical Humanities colleagues in the Universities.

In addition, consultation has taken place with a range of external parties:

- All Party Parliamentary Group on Arts, Health and Wellbeing
- Culture Health and Wellbeing Alliance
- NHS National Performance Advisory Group for Arts, Heritage and Design

- Arts and Health South West
- Bristol City Council Culture Team
- Bristol Public Health
- Bristol Arts on Referral
- University of Bristol
- University of West of England
- City of Bristol College
- Arts Council England
- North Somerset Council
- Fresh Arts (NBT Southmead)
- Art at the Heart (RUH Bath)
- Willis Newson (Arts Consultancy)
- Stretto Architects
- Stride Treglown Architecture Practice
- Hospital Arts teams at GOSH, UCLH, Oxford, York and Derby

8. NATIONAL CONTEXT

…the Government's own analysis of its data on arts participation rates in England estimates that the total annual NHS cost savings due to reductions in GP visits is £168.8 million.

The NHS Long Term Plan, published in January 2019, highlights the value of Arts and Culture in addressing population health. This finding was informed and influenced by earlier work to collate the research and evidence base.

In 2014 Lord Howarth convened the All Party Parliamentary Group for Arts and Health (APPG) to initiate an inquiry into how the Arts can support Health and Social Care. The group looked at decades of work in diverse settings from Florence Nightingale's 'Notes on Nursing' (1859), Paintings in Hospitals (founded 1959) to the use importance of role-play in medical training.

The publication in 2017 of the APPG's 'Creative Health Report' has had a significant impact on the national picture and the pace of change. Some of the key findings relevant to this strategy are:

- The arts can help keep us well, aid our recovery and support longer lives better lived.
- The arts can help meet major challenges facing health and social care: ageing, long- term conditions, loneliness and mental health.
- Across art forms, creative activity improves quality of life for people with dementia and their carers.
- During terminal illness, arts participation provides an antidote to physical and psychological pain.
- The arts and culture – including architecture, design and heritage – enrich environments, making them beneficial to our health and wellbeing.
- The arts have a contribution to make to the committed, compassionate and caring health service envisaged in the Francis Inquiry, making them central to training and development.

- Within the NHS, around £1 in every £40 is spent on sick leave, including anxiety, depression and stress. Arts engagement has a part to play in the self-care of health and social care professionals.
- The Public Services (Social Value) Act requires commissioners of public services to think about how they can secure not only economic but also social and environmental benefits.
- The arts can help save money in the health service and social care.

The position of the Trust in relation to key APPG recommendations can be found in Appendix 1.

The Culture, Health and Wellbeing Alliance (CHAWA) was founded in 2018. As founding members of the NHS National Performance Advisory Group (NPAG) for Arts, Heritage and Design in Hospitals, #UHBristolArts has been actively engaged in developing the remit and programme of CHAWA.

8.1 RESEARCH CONTEXT

#UHBristolArts anticipates being closely involved with the newly formed Repository for Arts and Health Resources, an online database and research hub of 'grey literature' for this discipline as part of ongoing collaboration with the NPAG, CHAWA and the APPG.

In the past 18 months, the programme has engaged with a number of externally funded research projects including Heart of the Matter (partners in London and Newcastle) The Impossible Garden (Luke Jerram and the Bristol Vision Institute) Life of Breath (Durham and Bristol Universities) and the recently formed research networks for Landscape and Environment and for Sensory Landscape. Funded by organisations such as Wellcome Trust, Arts and Humanities Research Council, British Heart Institute and others, these connections add significant value and resource to the programme.

There are significant opportunities for the #UHBristolArts programme to initiate, as well as engage with, interdisciplinary research in the fields of Medical Humanities, Arts and Health, Sci-Arts and Environmental Design through our position as a University Hospitals Trust and our outward facing strategic position.

8.2 LOCAL CONTEXT

As the NHS shifts its focus to a Population Health model, the Trust has an opportunity to take a leading role in developing the pending Arts and Culture Strategy for the BNSSG STP and creating an appropriate infrastructure that enables efficiencies and quality control to be at the forefront of joined up working.

Regionally, Arts and Health South West continues to provide a network with access to advice and guidance. Having led the formation of the National Culture, Health and Wellbeing Alliance, the organisation is currently developing a strategic plan for the South West region.

Locally, Bristol City Council is now working to the One City Plan. Launched in January 2019, it describes how city partners will work together to deliver a fair,

healthy and sustainable city by 2050. The One City Plan incorporates elements of Bristol's Cultural Strategy and is informed by the Cultural Cities Enquiry from Core Cities.

The UHB Arts and Culture Programme is creating strategic alliances with the long established Arts Programmes at Royal United Hospitals Bath and North Bristol Trust. A brief description of arts programmes in these neighbouring Trusts can be found in Appendix 2.

8.3 TRUST CONTEXT

The Trust has recognised the importance of incorporating art into its physical environment, most obviously in the internal design of the new Bristol Royal Hospital for Children in 2001 but also as an integral part of major capital schemes over the last 8 years, often supported by Above and Beyond.

This implicit strategy of exploiting individual construction or refurbishment projects has resulted in a patchwork of arts interventions and a visible mismatch between old and new environments across the Trust. It has not supported holistic management of the external appearance of the Trust's estate nor a consistent approach to public arts, such that special steps have had to be taken in the past to ensure corporate sign-off of proposed public artworks and, even then, major exterior design decisions have had limited corporate oversight.

Following review with staff and contractors, it has emerged that at the conclusion of such projects there can also be confusion over responsibility for care and maintenance of artworks. Across the Trust, many large scale pieces are now in need of cleaning and many of those that require electrical power are in need of repair.

This implicit strategy has also encompassed the physical environment, to the exclusion of the other beneficial arts activities identified by the British Medical Association (although staff have adopted best practice interventions to good effect in limited clinical areas, such older people's health).

9. NEEDS AND OPPORTUNITIES

This strategy takes account of a range internal and external needs and opportunities across the domains of the Image, Design, Environment and Arts (IDEA) group for staff, students, volunteers, visitors and patients and supports a number of cross cutting challenges.

Based on existing research, the following benefits can be anticipated from implementing the opportunities presented by this Arts and Culture strategy:

- Arts engagement increasing wellbeing, whatever the state of an individual's health or cognitive capacity, even at the end of life.
- Facilitated creative activity building community, reducing isolation and alleviating symptoms of depression among patients, staff and carers.
- Creative and imaginative activity that induces a state of cognitive 'flow' reducing the need for pain relief and some other forms of medication.

- Interdisciplinary thinking and co-design processes that embrace both artistic and scientific paradigms supporting the development of innovative solutions to challenging problems.
- Well-designed spaces, as part of Phase 5 Capital developments and planned refurbishment, decreasing stress and anxiety among patients and visitors, and contributing towards the recruitment and retention of staff and students

Consequences of not having an integrated approach to Image, Design, Environment and Arts.
Historically, individual arts practitioners and art therapists have been engaged by charities to work with specific patient groups on short contracts (for example Teenage Cancer Trust funded creative writing, Grand Appeal funded Music Therapists,). These arts and health experts have had a positive impact but have not been able to develop longer term relationships with colleagues. Where longer term activity has been undertaken, it has been led by individual members of staff working from their own initiative and independently, often with limited resources and without adequate support. Examples include the creative projects undertaken as part of medical education, interventions by nursing staff to support long stay patients and those with dementia, and chaplaincy staff leading activity days for older people.

Staff have sometimes been supported by volunteers or small charitable funds, but they have not had any structures through which to reflect, share their knowledge and experiences, or to access the evidence base or the many physical and human resources that exist within the professional Arts and Health or wider cultural sectors. They have had neither access to research, nor the capacity to build a body of knowledge that can be shared. They deserve more support.

Owing to a lack of understanding regarding the negative health impacts of poorly designed environments, areas of the Trust estate appear unkempt, cluttered with posters, vinyls, pop up banners. The lack of design leads to objects being stored inappropriately, patients getting lost and frustrated, and subsequent inefficiencies.

Example: the recent engagement of the London based design company TILT to re-design the Children's Emergency Department, funded by The Grand Appeal, is a welcome intervention to an area that needs repurposing and refurbishment, but there is currently no engagement with either the IDEAS group or the Arts and Culture Programme to share consultation with patients and staff, to harvest lessons learned or to share design expertise more widely.

Staff recruitment, retention and wellbeing:
Workspace: Currently, many staff work in poorly designed work spaces, in windowless environments, with extremely limited facilities for meals, rest or team building. When money becomes available for refurbishment, unless a charity employs an external design company, the changes made are currently not based on evidence. We currently have no research base with which to establish design protocols for workspaces. Through collaboration with our civic partners such as UWE Interior Design, the Architecture Centre and University research networks such as 'Sensory Environments' we will be able to access knowledge and support so that when investment is made in refurbishment, it delivers maximum benefit.

Representation: Although there has been excellent branding developed by external agencies, such as the Love Bristol nurse recruitment campaign, there is much more that can be done to improve integration and better represent the cultural diversity of the whole workforce. This is a stated objective of the People strategy. The culture programme can provide opportunities to reflect and celebrate the diversity of our workforce for example through exhibitions, music, food and festivals.

Sickness: The Arts and Culture programme supports the Wellbeing aims of the People Strategy and provides evidence based creative releases for workplace stresses. Staff 'culture clubs' in other Trusts are showing wellbeing benefits. Cultural activities ranging from singing and dance to creative writing and skill shares can support staff through the 'five ways to wellbeing' (connection, physical activity, learning, giving, mindfulness).

Medical Education:
As a teaching hospital, we are closely involved with innovations in medical education and training. The Arts and Culture Programme will develop resources to support curriculum change, building on Robin Phillip's pioneering work on 'Compassionate Human Factors in Healthcare', the Clod Ensemble's 'Circle of Care' and Professor Trevor Thompson 'Medical Humanities and Whole Person Care'. It will also support relevant student societies such as 'Arts in Medical Education', and creative forms of reflective practice for clinicians as part of CPD. Through non clinical partnerships with UWE, UoB and CoB College, there are also opportunities to highlight a greater range of NHS careers and contribute towards widening participation.

Patient recovery and discharge rates.
Activity: As cognitive science develops, the health benefits of sensory and cultural engagement activities are becoming more widely understood. It is accepted that Children need to have activities provided while in hospital. There is a growing body of evidence that such activities benefit everyone.

Discharge: Our pilot at SBCH has revealed that older patients are more likely to be discharged to care homes if they are seen to be active, communicative and cognitively engaged in cultural activities such as craft, movement to music, creative writing, reminiscence and discussion over shared meals.

Environmental Design: The NHS 15 Steps Programme states that visitors make judgements on the quality of the treatment they expect based on their perception of the visual and physical environment. Poor design, often the default effect of a lack of design thinking, impacts on brand recognition, on communication, on calming, on efficiencies and on sustainability. It causes frustration, wastes time and money, and causes ill health. Currently, each of our buildings is littered with temporary signage, pop up banners, things that ought to be stored elsewhere and temporary fixes, even to our entrance doors. Those responsible for patient care and estates maintenance have neither the time nor the expertise to address design challenges. The Arts and Culture Programme can broker relationships with designers at all levels from UWE students to the very best professionals to provide expert support and ensure an evidence base and good practice is made available to all staff.

An Anchor Institution:

Taking a PLACE based approach builds on the opportunities presented by the greater emphasis on Population Health across the CCG and our position as an 'anchor institution' in Bristol and in the South West.

Civic connections: Our main campus is uniquely situated at the centre of Bristol's cultural quarter. There are public gardens, museums, concert halls, art galleries, libraries and music shops within 5 minutes walk which have resources to support the wellbeing our staff, patients and visitors. South Bristol Community Hospital is co-located with City of Bristol College, Bottleyard Film Studios and a sports centre. Many of our neighbouring organisations want to partner with us but have been hitherto unsure who to approach. The Arts Programme has brokered non-clinical relationships with neighbouring organisations and currently represents the Trust on the Bristol City Centre Business Improvement District (BID) to ensure that our Levy Payment shows return on investment. In the past twelve months this has supported a Staff Welcome Pack, Air Quality Audit, sharing of resources and knowledge about the Night-time Economy and planters from Incredible Edible. Our relationship with Bristol City Council, both the Public Health and Culture Team, has been strengthened by joint projects such as 'This Girl Can' exhibition. Our relationship with the University is strengthened through interdisciplinary projects such as the Wellcome funded, 'Life of Breath'. In the longer term, being 'good neighbours' through such networks can help address shared issues such as emergency planning, climate change, flooding, transport and green infrastructure.

Population Health: As the NHS shifts its focus to a Population Health model, the Trust has an opportunity to take a leading role in developing the pending Arts and Culture Strategy for the BNSSG STP and creating an appropriate infrastructure that enables efficiencies and quality control to be at the forefront of joined up working. There is already extensive work being undertaken at North Bristol Trust to explore the potential of arts based 'social prescribing' for chronic conditions. We are also following developments with Bristol's primary care 'link workers' who came into post at the beginning of July.

Weston Super Mare: There are significant opportunities to test a new model for Population Health with an Arts and Health focus in Weston Super Mare through Healthy Weston and Healthier Together owing to the particular demographic (older people and young families) and the willingness of stakeholders such as the Local Authority, Weston College, Arts Council England, the cultural sector and those engaged in the tourism economy to engage in developing a destination and centre of excellence. This includes new forms of mutually beneficial volunteering such as Green Volunteers and Creative Companions that add value, capacity and resource to the Trust while also offering wellbeing opportunities to those at risk of social isolation. A focussed community project, such as a festival of Arts and Health, could in part ameliorate some of the fears and concerns of local people regarding the merger and provide opportunities for making connections with local stakeholding organisations.

10. PRIORITY FOCUS

- Partnership and Collaboration:
- Advice and Advocacy:

- Project work and Programming:

Partnership and Collaboration: To add capacity to the #UHBristolArts programme, to establish Bristol as the foremost city for Arts and Health research and practice, and to ensure continuity of provision for patients and staff both within and without the hospital environment, the programme and its officers will be outward facing and engaged with stakeholders in relevant networks.

#UHBristolArts will develop beneficial partnerships with civic organisations such as Bristol City Council, Bristol Culture, Business Improvement District, University of Bristol, University of West of England, City of Bristol College, BBC Bristol, Avon Wildlife Trust, Green Capital Partnership, and individual arts and cultural organisations as well as Arts and Health programmes in NHS Trusts within the Bristol, North Somerset and South Gloucestershire Clinical Commissioning Group.

#UHBristolArts will form and maintain strategic partnerships with the Arts and Health sector through the NHS National Performance Advisory Group for Arts, Heritage and Design in Healthcare (as founding members), the All Party Parliamentary Group for Arts, Health and Wellbeing (as contributors) Arts and Health South West, Bristol Arts on Referral and the Culture Health and Wellbeing Alliance.

Advice and Advocacy: Art and Design is an important way of championing brand quality and promoting high quality outcomes within the Estates strategy. The Arts are an effective communication tool for diverse internal audiences and can also provide positive stories and visually compelling media content for external audiences, supporting both the Communications and People strategies.

The #UHBristolArts team can add value by supporting working colleagues with design thinking processes. Capital projects, both refurbishment and commissioning of spaces, are a priority over the next five years. A creatively accessible and engaging design development process can ensure that every penny spent on capital contributes positively to the aesthetic environment, and therefore positively impacts workplace environment, recruitment and retention as well as patient experience, recovery and readiness for discharge.

Projects and Programming: The purpose of the participatory programme will be to test approaches, and to establish protocols with colleagues to ensure sustainability. This will include:

- establish a regular review of art and design, revisiting existing spaces and assessing ‘value’ using criteria such as pleasure, purpose, position, and programmes of maintenance. Empower engagement, encourage flexibility and provide opportunities for change.
- hosting artists and writers ‘in residence’ over extended periods so that they can build meaningful relationships with staff and develop best practice through thorough evaluation.
- a rolling programme of exhibitions in key public spaces, some related to significant anniversaries or teams, others showing work from medical

students, staff, civic partners or by artists for sale. The dynamism of the changing programme is intended to help develop visual literacy and 'noticing'
- supporting nursing campaigns to improve patient experience by creating resources for in-patients that address specific concerns. Eg. Boredom Busters, Armchair Museums, activities to #endPJparalysis or quieten Noise@Night.
- establishing a programme of live music, song and performance on wards and in public spaces
- developing continuity for patients by establishing 'creative companion' volunteering for long stay patients connected to 'link workers' in General Practice who are able to signpost creative activity through social prescribing networks.
- establishing creative activities that relate to Medical Humanities such as reflective writing, reading and discussion groups for staff and students
- promoting creative expression from diverse perspectives in order to support representation, equality and diversity objectives
- identifying and improving provision for gathering spaces for social and cultural whether indoors, outside or nearby.

11. RESOURCES AND FUNDING

There are many opportunities to fund Arts and Health work from external sources and through strategic partnership working. Research among NPAG colleages has revealed that most Hospital Arts and Culture programmes are funded by a combination of core costs for staff, additional hospital charity funding for projects, academic and civic partnerships and match funding, where the Trust contributes a portion to gain leverage with Arts funders.

In the first twelve months, the Arts Programme Director has secured over £40K of value for the programme from partners in the academic, cultural and charitable sectors. However, most of the relevant funding organisations, as well as smaller Trusts and Foundations, want to see a strategic plan with an overview of ambition before committing major project funds. This strategy document will provide some of the required accompanying material necessary in order to make future bids.

Arts Council England has adopted 'relevance' as a funding criteria and have made a commitment to supporting work that benefits health and wellbeing. ACE are also revising their funding models away from grants to single organisations, towards more flexible and sustainable forms of investment to strategic partnerships and specialist networks that can share best practice. Before investing, ACE will want to see the Trust making secure and long term financial commitments to developing the programme. Potential funders who will also expect the Trust to commit to the future of the programme, not just to individual projects, include Heritage Lottery Fund, Wellcome Trust, Clore, Paul Hamlyn, Esmee Fairburn and others.

This strategy calls for a level of core funding support from the Trust, so that the programme can be embedded and sustained in the long-term. Under this strategy, the Arts and Culture Programme is not an optional add-on to the Trust's service

portfolio but an integral part of its offer to patients, visitors and staff and is therefore due a minimum level of recurring revenue investment.

Recognising the perennial challenge to the Trust's overall revenue, however, it is recommended that in order to implement the strategy, the Trust adopts the principle of 'One Percent For Art' between 2020 and 2025 linked to the Phase 5 Capital Programme, providing resource for staff and infrastructure to support Arts, Design and Heritage activity connected to the upgrading of our core infrastructure (estate and landscape) and compassionate human factors.

Percent for Art is a policy that has been adopted in Ireland, Finland, Norway, the USA and in the UK by Local Authorities such as Bolton. It has also been adopted, together with the strategic us of Section 106 and Community Infrastructure Levies, in the construction of new healthcare settings. Locally this has included funding the Arts team at North Bristol Trust and the installation of artwork in the Bristol Heart Institute.

The Arts and Culture Programme would also seek project funding support from grants, gifts and donations through charities such as Above and Beyond and The Grand Appeal, stakeholders such as Arts Council England, and through partnership with academic and cultural organisations.

This will contribute to funding a team of 3 staff, augmented by a team of visiting arts and health professionals, supported by student interns and volunteers. (This model is based on an audit of the situation in other Trusts of a similar scale)

It is proposed that the Arts Programme Director will continue to build partnerships in relevant sectors and with stakeholders and funders, oversee strategic developments, and work closely with Estates and Facilities teams to improve the overall look and feel of the Trust's landscape and environment through contributing to both maintenance regimes and capital projects. The Arts Programme Director would also be responsible for managing visiting professionals, students, volunteers and liaising with staff groups. The department will be supported by an Administrator, who will be desk based, a primary point of contact, and responsible for managing the budgets, procurement, contracts, data and evaluation necessary for reporting to the communications team as well as partners and funders. A Programme and Exhibitions Manager will work across the Trust ensuring that artworks and infrastructure elements (pianos, artcarts, AV screens etc) across the Estate are programmed, monitored and maintained and that good documentation for evaluation is gathered.

12. GOVERNANCE

[Review IDEA group membership]

13. APPENDICES

Appendix 1:

APPG recommendations

We recommend that, at board or strategic level, in NHS England, Public Health England and each clinical commissioning group, NHS trust, local authority and health and wellbeing board, an individual is designated to take responsibility for the pursuitof institutional policy for arts, health and wellbeing.

At UHBristol that individual is Chief Executive, Robert Wooley. He and the current Arts Programme Director, Dr Anna Farthing, have both contributed to the APPG inquiry. Other 'champions' represented on the Arts Programme steering group for Image, Design, Environment and Arts Strategy (IDEAS) include the Director of People, the Director of Estates, two non-executive directors, one representing the University of Bristol, the other a former architect, and the Head of Engagment for Bristol City Council Culture team.

We recommend that those responsible for NHS New Models of Care and Sustainability and Transformation Partnerships ensure that arts and cultural organisations are involved in the delivery of health and wellbeing at regional and local level.

#UHBristolArts has an opportunity to play a leading role in building the necessary partnerships to make this inter-disciplinary collaborative working a reality within the BNSSG CCG and STP, particularly through the Arts and Health and social prescribing strands of Healthier Together and Healthy Weston.

We recommend that the education of clinicians, public health specialists and other health and care professionals includes accredited modules on the evidence base and practical use of the arts for health and wellbeing outcomes. We also recommend that arts education institutions initiate undergraduate and postgraduate courses and professional development modules dedicated to the contribution of the arts to health and wellbeing.

Our position as a Teaching Hospital, and our partnerships with Bristol University, UWE and City of Bristol College, puts us in an excellent position to co-develop relevant courses and to ensure that emerging professionals are trained to standards that suit our Trusts's needs. In cultural education, we are currently developing modules for placement for Fd Arts Therapies students from City of Bristol College, hosting an MA Curating intern from UWE and undergraduate interns from Bristol University's School of Arts.

We recommend that Research Councils UK and individual research councils consider an interdisciplinary, cross-council research funding initiative in the area of participatory arts, health and wellbeing, and that other research-funding bodies express willingness to contribute resources to advancement of the arts, health and wellbeing evidence base. We recommend that commissioners of large-scale, long-term health surveys include questions about the impacts of arts engagement on health and wellbeing.

Our position as a Research Hospital means that we already have the expertise to lead in this area, and could develop projects to attract funds to undertake relevant

research. We are currently collaborating with the following Wellcome funded research projects: “Heart of the Matter’, ‘Life of Breathe’, Bristol University Centre for Health Humanities and Science and other research groups such as Landscapes, Gardens and Health Network,

Appendix 2

Neighbouring Hospital Arts programmes

At North Bristol Trust: Fresh Arts provides regular art exhibitions and creative activities like knitting, music and dance for patients, staff and visitors at Southmead and Cossham Hospitals. Established in 2007 Fresh Arts is funded by both NHS revenue and Southmead Hospital Charity, the charity which manages donations to the hospitals. Project funding comes from other sources including Southmead League of Friends and the National Lottery’s Awards for All scheme. Key activities: exhibitions, FA Music, Knit With Me, Momentum, a Dance Group for Parkinson’s, Make Your Mark painting activities for patients with artists, Play It Again -music and storytelling project for older patients and patients living with dementia, Art festivals, staff celebrations and events. The team consists of two experienced Arts Programmers, supported by freelance staff and a volunteer squad of ‘Creative Companions’ supervised by a qualified Art therapist.

In Bath: Art at the Heart supports the Royal United Hospital Bath with an award winning art and design programme that stimulates healing and well-being and creates an uplifting environment for patients, visitors and staff. It reaches on average 200,000 people per year through exhibitions, workshops, performances and design. There are three full time staff, two artists in residence and a number of freelance artists.

Main key goals:
• To increase the number of workshops offered to patients, visitors and staff.
• To build upon the permanent and loan art collection for public areas.
• To offer a number of artist and musician residencies across the Trust.
• To strengthen research and evaluation work.
• To continue working with local schools and universities, as well as arts and cultural organisations.
• To protect and curate the RUH’s medical history.
• To manage major arts commissions for the RUH North Development and other capital projects.

Meeting of the Public Board on Tuesday 30 July 2019 in the Conference Room, Trust Headquarters

Report Title	**Risk Management Strategy**
Report Author	**Sarah Wright, Head of Risk Management**
Executive Lead	**Robert Woolley, Chief Executive**

1. Report Summary

On an annual basis the Trust Board should review their risk appetite and tolerance statements.

This purpose of paper is to review the refreshed statements as part of the annual review of the Risk Management Strategy.

The Risk Appetite Statement has been developed following consultation at Board Seminar.

2. Key points to note *(Including decisions taken)*

The following amendments to the previous strategy document have been agreed at Risk Management Group and Senior Leadership Team:

Section 4 - Risk Management Priorities
Reference to annual priorities removed as these are key functions of the Trust Risk Management arrangements and are ongoing.

Section 6 - Risk Appetite Statement
The Board of Directors have determined the Trusts risk appetite as an 'open' one. In practice this means that a level of risk taking is encouraged in order for the Trust to maintain a progressive approach to the delivery of services, where assurance can be sought that any associated risks can be mitigated to a tolerable level.

Section 7 - Risk Tolerance
This section is new and was previously undefined.

Section 8 - Duties, Roles and Responsibilities
The governance structure has been updated.
The roles and responsibilities of the sub-committees of the Board have been defined.

3. Risks
If this risk is on a formal risk register, please provide the risk ID/number.

The risks associated with this report include: None

4. Advice and Recommendations
*(Support and Board/Committee decisions requested)***:**

- This strategy is for **APPROVAL**.
- The Board of Directors is asked to **APPROVE** the report.

5. History of the paper
Please include details of where paper has previously been received.

Risk Management Group	9 July 2019
Senior Leadership Team	17 July 2019
Audit Committee	26 July 2019

Risk Management Strategy

Document Data			
Subject:	Risk Management		
Document Type:	Strategy		
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Introduction

University Hospitals Bristol NHS Foundation Trust ('the Trust') is faced with a number of factors that may impact upon its ability to meet its objectives. The effect of uncertainty on those objectives is known as risk.

Risk Management can be defined as the identification, assessment, and prioritisation of risks followed by a coordinated and economical application of resources to minimise, monitor and control the probability and/or impact of unfortunate events. Risks should also be reviewed at regular intervals to ensure they continue to be appropriately mitigated.

It is widely recognised that an effectively planned, organised and controlled approach to risk management is a cornerstone of sound management practice and is key to ensuring the achievement of objectives. A comprehensive management approach to risk reduces adverse outcomes, and can result in benefit from what is often referred to as the 'upside of risk'.
Risk Management is an integral part of good governance and the Trust has adopted an integrated approach to the overall management of risk irrespective of whether the risks are clinical, organisational or financial.

This **strategy** is the high level document within the Trust and does not set out to cover in detail the management of specific risks. This more detailed information is set out in related policies, in particular the **Risk Management Policy**.

Document Change Control				
Date of Version	**Version Number**	**Lead for Revisions**	**Type of Revision**	**Description of Revision**
20/08/2009	1.0	Assistant Director of Governance	Major	Supersedes United Bristol Healthcare Trust Risk Management Strategy.
12/08/2010	2.0	Assistant Director of Governance	Major	Updated following NHLSA Level 1 assessment
09/02/2012	2.1	Chief Executive	Major	Rewrite to reflect NHS NHSLA Level 2
27/02/2012	3.0	Chief Executive	Major	Approved by Trust Board of Directors
29/03/2013	4.0	Trust Risk Manager	Major	Approved by Trust Board of Directors
22/04/2015	5.0	Trust Secretary	Major	Complete restructuring
30/06/2016	5.1	Trust Secretary	Minor	Additions to include Risk Management Objectives and greater clarity in terms of the risk appetite
31/07/2017	6	Trust Secretary	Major	Roles & responsibilities updated. Objectives for 2017/18 identified.
31/07/2018	6.1	Head of Risk Management	Minor	Extended in line with development of Trust Strategy.
30/01/2019	7	Head of Risk Management	Major	Updates to include Risk Management Objectives and greater clarity in terms of the risk tolerance.
26/06/2019	7.1	Head of Risk Management	Minor	Inclusion of updated statement of risk appetite.

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1. Introduction

1.1 An understanding of the risks that face NHS Trusts is crucial to the delivery of healthcare services moving forward. The business of healthcare is by its nature, a high-risk activity and the process of risk management is an essential control mechanism. Effective risk management processes are central to providing University Hospitals Bristol NHS Foundation Trust (UHB) Board with assurance on the framework for clinical quality and corporate governance.

1.2 Our mission is to improve the health of the people we serve by delivering exceptional care, teaching and research every day. Our vision is for Bristol and our hospitals, to be among the best and safest places in the country to receive care. To ensure that the care provided at UHB is safe, effective, caring and responsive for patients, the board must be founded on and supported by a strong governance structure.

1.3 UH Bristol is committed to developing and implementing a risk management strategy that will identify, analyse, evaluate and control the risks that threaten the delivery of its objectives. The strategic risk reports will be used by the Trust Board and assuring committees to identify, monitor and evaluate risks to the achievement of the strategic priorities. It will be used alongside other key management tools, such as quarterly corporate objectives updates, performance and quality dashboards, and financial reports, to give the Board a comprehensive picture of the organisational risk profile.

1.4 The management of risk underpins the achievement of the Trust's objectives. UH Bristol believes that effective risk management is imperative to not only provide a safe environment and improved quality of care for service users and staff, it is also significant in the financial and business planning process. This illustrates that risk management is the responsibility of all staff.

1.5 The risk management process involves the identification; evaluation and treatment of risk as part of a continuous process aimed at helping the Trust reduce the incidence and impacts of risks that they face. Risk management is therefore a fundamental part of both the operational and strategic thinking of every part of the service delivery within the organisation. This includes clinical, non-clinical, corporate, business and financial risks.

1.6 The Trust is committed to working in partnership with staff to make risk management a core organisational process and to ensure that it becomes an integral part of the Trust philosophy and activities. This risk management strategy represents a developing and improving approach to risk management which will be achieved by building and sustaining an organisational culture, which encourages appropriate risk taking, effective performance management and accountability for organisational learning in order to continuously improve the quality of services.

1.7 The Trust recognises that complete risk control and/or avoidance is impossible, but that risks can be minimised by making sound judgments from a range of fully identified options and having a common understanding at Board level of risk appetite and tolerance.

1.8 As part of the Annual Governance Statement, UH Bristol will make a public declaration of compliance against meeting risk management standards. The Trust currently has good systems and process for risk management in place as evidenced by internal and external review.

2. Purpose

2.1 The purpose of the Risk Management Strategy is to detail the Trust's framework within which the Trust leads, directs and controls the risks to its key functions in order to comply with Health and Safety legislation, NHS Improvement (NHSI) compliance requirements, key regulatory requirements such as Care Quality Commission, and its strategic objectives and to communicate the Trusts statement of risk appetite and tolerance levels. The risk management strategy underpins the Trust's performance and reputation, and is fully endorsed by the Trust Board.

3. Risk Management Objectives

The strategic objectives in relation to risk management will be achieved by:

1. Ensuring that all staff are adequately trained and competent to execute their duties in respect of risk management.
2. Including risk management issues when writing reports and considering decisions.
3. Continuing to demonstrate the application of risk management principles in line with the Risk Management Policy.
4. Reinforcing the importance of effective risk management as part of the everyday work of all staff employed or engaged by the Trust.
5. Maintaining a comprehensive register of risks (clinical and non-clinical) and reviewing these on a periodic basis.
6. Ensuring controls are in place to effectively mitigate the risk and are understood by those expected to apply them.
7. Ensuring gaps in controls are rectified and assurances are reviewed and acted upon in a timely manner.
8. Maintaining documented procedures of the control of risk and provision of suitable information, training and supervision.
9. Ensuring adequate monitoring arrangements are in place and continually seeking improvement.

4. Risk Management Priorities

The following priorities have been identified:

1. Ensure alignment between risk management activities with business cycles of the sub-committees of the Trust Board.
2. Work with divisions to ensure the implementation of risk treatment is sufficient to effectively mitigate the risks identified.
3. Ensure availability of educational risk material.

4. Improve the transparency of risk by adopting a standardised method of risk description, focussing on cause and effect of risks.

5. Ensure that risk registers maintained at a departmental level are of an acceptable standard and subject to regular review.

6. Embed the practice of risk reviews being in alignment with quarterly reporting cycles.

7. Ensure the processes for approval of risks are clearly defined and assuring that there is a consistent approach across divisions.

8. Monitor reports to Risk Management Group to ensure that all areas of known risk are identified and formalised onto a risk register.

5. Risk Appetite

5.1 Risk appetite can be defined as 'the amount and type of risk that an organisation is willing to take in order to meet their strategic objectives. Organisations will have different risk appetites depending on their sector, culture and objectives. A range of appetites exist for different risks and these may change over time.

We need to know about risk appetite because:

5.2 If we do not know what our organisation's collective appetite for risk is and the reasons for it, then this may lead to erratic or inopportune risk taking, exposing the organisation to a risk it cannot tolerate; or an overly cautious approach which may stifle growth and development

5.3 If our leaders do not know the levels of risk that are legitimate for them to take, or do not take important opportunities when they arise, then service improvements may be compromised and patient and user outcomes affected.

5.4 The Board of Directors have determined the Trusts risk appetite as an 'open' one. In practice this means that a level of risk taking is encouraged in order for the Trust to maintain a progressive approach to the delivery of services, where assurance can be sought that any associated risks can be mitigated to a tolerable level.

6. UH Bristol Risk Appetite Statement

6.1 The UH Bristol Board of Directors is willing to consider all potential delivery options in pursuit of the achievement of organisational objectives, provided that a satisfactory level of reward or value for money can be demonstrated, proportionate to the risk being taken.

Specifically;

6.2 With regard to finance, the Board is prepared to invest but will always seek to minimise the possibility of financial loss by ensuring all associated risks are mitigated to a tolerable level. During decision making, service improvements, benefits and patient outcomes will be considered alongside value for money. Where appropriate the Board will ensure resources are allocated in order to capitalise on potential opportunities.

6.3 With regard to compliance with statue and regulations, the Board will seek assurance that the organisation has high levels of compliance in all areas other than where it has been specifically

determined that the efforts required to achieve compliance would outweigh the potential adverse consequences.

6.4 Research and innovation is encouraged at all levels within the organisation, where a commensurate level of improvement can be evidenced and an acceptable level of management control is demonstrated. As a Global Digital Exemplar Organisation the Board of Directors will seek to implement digital systems and support technological developments to optimise operational delivery.

6.5 The Board of Directors accepts that some decisions made in the interest of change may have the potential to expose the organisation to additional public scrutiny or media interest. Proactive management of Trust communications may be considered to protect the organisation's reputation and maintain public confidence.

7. Risk Tolerance

7.1 Whilst risk appetite is about the pursuit of risk to achieve objectives, risk tolerance is about what an organisation can actually cope with and thresholds at which it is willing to 'accept' a specific risk. The following tables define the risk scores, above which risks may not be 'accepted' and must be actively mitigated.

7.2 The Tolerance level applies to the 'Target' score of 'Action Required' risks and the 'Current' (and Target) score of 'Accepted' risks.

Risk Domain	Definition	Accepted Risk Score	Risk Level
Safety	Impact on the safety of patients, staff or public	1-6	Moderate
Quality	Impact on the quality of our services and patient experience.	1-6	Moderate
Workforce	Impact upon our human resources (not safety), organisational development, staffing levels, competence and training.	1-8	High
Statutory	Impact upon on our statutory obligations, regulatory compliance, assessments and inspections.	1-8	High
Reputation	Impact upon our reputation through adverse publicity.	1-9	High
Business	Impact upon our business and project objectives. Service and business interruption.	1-9	High
Finance	Impact upon our finances.	1-9	High
Environmental	Impact upon our environment, including chemical spills, building on green field sites, our carbon footprint.	1-8	High

7.3 Tolerance levels of Safety & Quality risks 1-6 (Below the black line)

Impact	Likelihood				
	1 Negligible	2 Minor	3 Moderate	4 Major	5 Catastrophic
5 Very Likely	5	10	15	20	25
4 Likely	4	8	12	15	20
3 Possible	3	6	9	12	15
2 Unlikely	2	4	6	8	10
1 Rare	1	2	3	4	5

7.4 Tolerance levels of Workforce, Statutory and Environmental 1-8 (Below the black line)

Impact	Likelihood				
	1 Negligible	2 Minor	3 Moderate	4 Major	5 Catastrophic
5 Very Likely	5	10	15	20	25
4 Likely	4	8	12	15	20
3 Possible	3	6	9	12	15
2 Unlikely	2	4	6	8	10
1 Rare	1	2	3	4	5

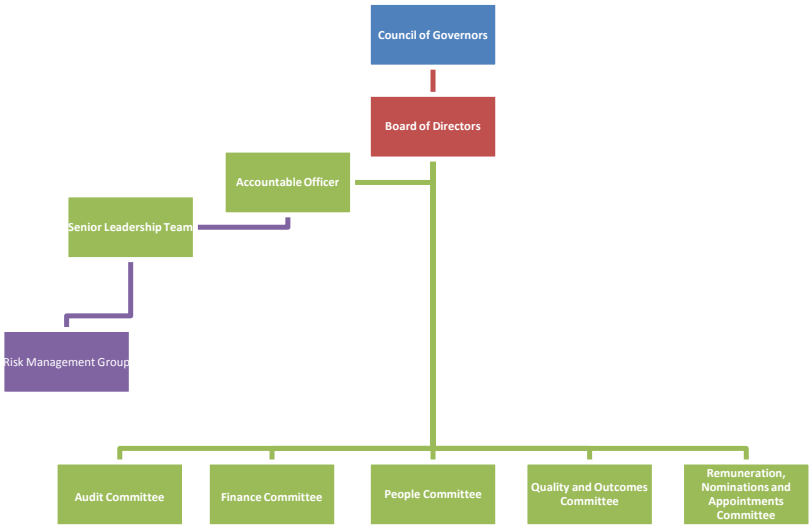
7.5 Tolerance levels of Reputation, Business & Finance Risks 1-9 (Below the black line)

	Likelihood				
	1 Negligible	2 Minor	3 Moderate	4 Major	5 Catastrophic
5 Very Likely	5	10	15	20	25
4 Likely	4	8	12	15	20
3 Possible	3	6	9	12	15
2 Unlikely	2	4	6	8	10
1 Rare	1	2	3	4	5

8. Roles and Responsibilities

The success of the risk management programme is dependent on the defined and demonstrated support and leadership offered by the Senior Leadership Team and Trust Board as a whole. However, the day-to-day management of risk is the responsibility of all staff, and the identification and management of risks requires the active engagement and involvement of staff at all levels. Staff are best placed to understand the risks relevant to their areas of work and must be enabled to manage these risks, within a structured risk management framework. The specific roles and responsibilities in relation to risk management are laid out in detail in the Risk Management Policy.

8.1 Governance Structure



8.2 Reporting Structure to Trust Board

Divisional Governance Groups and Risk Forums report into divisional boards who in turn provide monthly exception reports to the SLT. SLT also receive a report of any divisional risks, of 12 or above that have been recommended by SLT to remain at a divisional level. Risk Management Group meets on a quarterly basis and receives speciality risk report and divisional risk registers on a rolling annual cycle. Audit Committee receives the Corporate Risk Registers (Operational and Strategic) for assurance that the Trust has robust systems and processes in place for the management of risk. Other sub-committees of the Trust Board, People Committee, Quality & Outcomes Committee and Finance Committee receive quarterly risk reports relevant to their business.

8.3 Trust Board of Directors

In relation to the delivery of this strategy, the Executive and Non-Executive Directors have a collective responsibility as a Trust Board to ensure that the Risk Management processes are providing them with adequate and appropriate information and assurances relating to risks against the Trust's objectives. The Executive and Non-Executive Directors are responsible for ensuring that they are adequately equipped with the knowledge and skills to fulfil this role.

The Board is also responsible for reviewing the effectiveness of its internal control systems and is required to ensure that the Trust's risk management arrangements are sound and protects patients, staff, the public, and other stakeholders against risks of all kinds.

The Annual Governance Statement made by the Trust's Chief Executive in the annual report and accounts must demonstrate that the Trust Board has been informed on all risks and has arrived at its conclusions on the totality of risk based on all the evidence presented to it through the responsibilities delegated to the committees within the organisation.

8.4 Audit Committee

The Audit Committee shall review the establishment and maintenance of an effective system of governance, risk management and internal control across the whole of the organisation's activities.

8.5 Quality and Outcomes Committee, Finance Committee and People Committee

The sub-committees of the Trust Board shall receive updates to Corporate Strategic and Operational Risk Registers on a quarterly basis and review the suitability and implementation of risk mitigation plans with regard to their potential impact on the organisation. They are also responsible for seeking assurance that there is alignment between the core business of the committees and oversight of the risk mitigation activities.

8.6 Senior Leadership Team & Risk Management Group

As a Management Group established and chaired by the Chief Executive, the Risk Management Group (RMG) is responsible for discharging the responsibility of the Senior Leadership Team for the management of organisational risk. This includes receiving the Corporate Risk Register and divisional risk registers in full on a rotational basis and monitoring the achievement of the risk management objectives.

8.7 Divisional Management Boards

Divisional Management Boards are responsible for having a planned risk assessment programme in place, comprised of quarterly Divisional Management Board meetings and monthly Divisional Governance meetings, at which, the implementation of recommendations from risk assessments and action plans with realistic timescales for mitigating risks are reviewed.

Divisional Management Boards shall adopt a standardised approach to the management of risk in accordance with the duties defined in the Risk Management Policy and the Terms of Reference of the Risk Management Group. They are also responsible for reviewing the divisional risk register and considering risks escalated to the management board from their departments for adding to the Divisional Risk Register.

Divisional Directors are accountable to the Chief Operating Officer for the implementation of the Risk Management Strategy and Policy locally.

8.8 The Chief Executive

The Chief Executive is accountable to the Chairman and the Board and, as the Accountable Officer, has overall responsibility for ensuring that the Trust operates effective risk management processes in order to protect all persons who may be affected by the Trust's business. The Chief Executive is required to sign annually, on behalf of the Board, an Annual Governance Statement, in which the

Board acknowledges and accepts its responsibility for maintaining and reviewing the effectiveness of a sound system of internal control, including risk management.

8.9 Executive Directors

Executive Directors are responsible for managing risk as delegated by the Chief Executive and set out in the Risk Management Policy and the Terms of Reference of the Risk Management Group. Executive Directors are also responsible for risks allocated to them on the Corporate Risk Registers and Trust Services Divisional Risk Register.

8.10 Trust Secretary

The Trust Secretary is responsible for ensuring that the Trust Board of Directors is cognisant of its duties towards risk governance and management and for coordinating the annual cycle of Board business to ensure these duties are incorporated on the Board's agenda. The Trust Secretary is also responsible for the coordination of the Trust's Board Assurance Framework to ensure that the Board remains sighted on the key risks facing the Trust.

8.11 Head of Risk Management

The Head of Risk Management develops implements and monitors compliance with the risk management policy and is responsible for maintaining the overall structure for risk management within the Trust. The post-holder facilitates the development of a risk aware culture within the Trust, compiles risk information and prepares reports for the Senior Leadership Team, Risk Management Group, Trust Board of Directors and the sub-committees of the Board on risk information and the achievement of the risk management objectives.

9. Responsibility for Monitoring Compliance

9.1 The Head of Risk Management shall monitor the processes for managing risk locally to ensure they are being complied with as per this Strategy and the Risk Management Policy and Procedure.

9.2 The Risk Management Group shall monitor the implementation of the risk management objectives

9.3 The overall implementation of this strategy shall be monitored through the annual internal audit review.

10. Compliance & Assurance

10.1 The NHSI 'Single Oversight Framework' enables Trusts to demonstrate that they are performing within their agreed provider licence. It is therefore imperative that the Trust is aware of any risks (e.g. associated with new business or service changes) which may impact on its ability to adhere to this framework.

10.2 The Board Assurance Framework is made up of two parts, the first is the monitoring of the achievement of the Trust Strategic Priorities and Corporate Objectives, and the second is the compilation of a strategic risk register, identifying the significant risks to the achievement of the priorities. These reports provide the Trust Board with a means of satisfying itself that its responsibilities are being discharged effectively. It identifies through assurance where aspects of service delivery are being met to satisfy internal and external requirements. In turn it will inform the Board where the delivery of objectives is at risk due to a gap in control and/or assurance.

10.3 All NHS bodies are required to sign a full Annual Governance Statement (AGS) and must have the evidence to support this Statement. The Annual Report brings together this evidence.

10.4 The designated Assurance Committees of the Trust Board are the Quality & Outcomes Committee (Clinical Risk), the Finance Committee (Financial Risk), and People Committee (Workforce Risk).

10.5 It is the responsibility of the Assurance Committees to report to the Trust Board, on a quarterly basis any new risks identified, gaps in assurance/control, as well as positive assurance on an exception basis.

10.6 The Head of Risk Management will work closely with the Executive Leads, Governance to ensure that the document remains dynamic and is integral to the Business Planning cycle.

10.7 If at any time performance reporting and risk management processes indicate that the Trust will not meet a current or future regulatory requirement/target then the Board must notify NHSI via an Exception Report.

11. Associated Documentation

This strategy should also be read in conjunction with the following Risk Management Policies which are all available on the intranet:

Risk Management Policy and Procedure

Incident Management Policy

Meeting of the Board of Directors in Public on Tuesday 30 July 2019 in the Conference Room, Trust Headquarters

Report Title	**WAHT Partnership and Merger Update**
Report Author	**Paula Clarke, Director of Strategy and Transformation**
Executive Lead	**Paula Clarke, Director of Strategy and Transformation**

1. Report Summary

This paper updates the Trust Board on the partnership with Weston Area Health NHS Trust (WAHT) and progress with the merger plan.

2. Key points to note
(Including decisions taken)

The Merger Programme is proceeding, working to the twin milestones of Full Business Case (FBC) by November 2019 Trust-Board, and merger to take place on 1st April 2020. This remains a challenging timetable, with complex interdependencies requiring detailed management.

Alongside the merger planning, collaborative working is progressing through the joint Partnership Management Board with significant developments including maternity services moving to a single service covering both Trusts and a formal launch of the clinical practice group (CPG) model of collaborative working.

3. Risks
If this risk is on a formal risk register, please provide the risk ID/number.

The merger programme board holds the transaction risk register and reviews and manages these risks at its fortnightly programme board meeting.

The risk to business as usual performance at UH Bristol potentially resulting from the merger process is currently being assessed for the corporate risk register.

4. Advice and Recommendations
*(Support and Board/Committee decisions requested)***:**

- This report is for **ASSURANCE**
- The Board is asked to **NOTE** the report

5. History of the paper
Please include details of where paper has previously been received.

Merger Programme Board	25th July 2019

University Hospitals Bristol NHS
NHS Foundation Trust

Trust Board

Agenda Item:

Date: 30th July 2019

Title of report

University Hospitals Bristol NHS Foundation Trust (UHBristol) and Weston Area Health NHS Trust (WAHT) Partnership and Merger Update

Report Update

1. Introduction

The Boards of University Hospitals Bristol NHS Foundation Trust (UHBristol) and Weston Area Health NHS Trust (WAHT) have announced an 'intent to merge the two organisations'. We believe that this is in the best interests of patients, staff and the communities we jointly serve. A partnership management board meets monthly to identify opportunities for collaboration and oversees the process towards merger. The next step is the development of a detailed business case, which will set out the costs and the benefits of merger in considerable detail. Work on this has commenced with the UHBristol Trust Board scheduled to take a decision on the case in November later this year, so that subject to satisfactory completion of the approvals process, the legal merger (via acquisition) can formally take place on 1st April 2020.

To support the process, a programme team has been established to manage the development of the full business case, and detailed plans for merger. UHBristol is currently undertaking a due diligence exercise to enable a full understanding of the costs and benefits of merger.

Alongside the merger planning, since May 2017, our organisations have been working more closely together through a formal partnership, seeking to secure benefits for the patients, populations and staff of both Trusts'. Maternity services have moved to a single service covering both Trusts and, as a result, they have been able to develop the service and recruit into vacancies. Colleagues from WAHT maternity service formally joined UHBristol workforce on 1 June 2019. Further collaborative work is supported through a number of clinical practice groups (CPGs). Involving a wide range of our clinical and non-clinical colleagues, the aim of CPGs is to shape clinical services to ensure the whole patient journey provides access to the best care and most innovative treatments possible. A launch event took place on 27 June with radiology teams from both organisations presenting how they have embraced this way of working and already host a regular monthly CPG to look at staff development opportunities and making the best use of capacity across sites to benefit patients and staff. The work coming out of the CPGs, will feed into the merger planning.

2. Context

Both Trusts face rising demand for NHS services from a growing population. Becoming part of a larger Trust is expected to help solve some of the longstanding issues that WAHT have struggled with for many years and to support Bristol's potential and capacity to develop its specialised services. The merger will also support delivery of the ambitions of the NHS Long-Term Plan and the Bristol North Somerset and South Gloucestershire's (BNSSG) System Plan, by enhancing acute care collaboration.

There are three main focus areas for both patients and staff:

1. Operational: clinically and financially viable organisation for future services

2. Clinical: strengthened workforce, more resilient, quality services
3. Financial: achieving economies of scale.

These translate into the following benefits:

- Providing a clinically sustainable and viable foundation for future services
- Increasing the resilience of the wider health economy by merging WAHT into a larger organisation.
- Providing a strengthened workforce with improved flexibility, recruitment and retention through maximising the opportunity of UHBristol's reputation and brand.
- Improving patient outcomes through reduction in clinical variation
- Securing local access to appropriately delivered district general acute services in North Somerset
- Creating the conditions for future financial sustainability and effective use of resources
- Releasing the efficiencies of shared corporate services to achieve value for money
- Improving operational performance through improved and standardised processes and common performance frameworks
- Better use of shared estates and facilities to enable future service developments across a larger campus
- Ability to test new ways of working, clinical models and pathways of care - across hospital, primary and community care interfaces
- Supporting the delivery of the wider regional Healthier Together system plan

Both Trusts are partners in the Bristol, North Somerset and South Gloucestershire Clinical Commissioning Group (CCG) led Healthy Weston process. The outcomes from the consultation will be considered by the CCG on 1st October 2019 and will inform the UHBristol merger business case.

3. Merger Planning

The Merger programme oversees nine workstreams, covering the key areas of work as follows:

	Workstream name
1	Full Business case
2	Corporate Governance
3	Corporate Services Integration
4	Finance
5	Clinical Governance and Quality
6	Communications and Engagement
7	Clinical Services Operation
8	Workforce and Organisational Development
9	Information Management and Technology

These are each led by a UHBristol executive and are made up of representatives from both the WAHT and UHBristol teams. The initial focus will be on progressing the following:

- Development of the Business Case (FBC)

- Undertaking the Due Diligence exercise
- Development of the Post Transfer Implementation Plan (PTIP)
- Benefits planning and realisation

The Full Business Case and associated documents will be subject to extensive review and scrutiny before Trust Board decision at the end of November. The following table sets out the key governance meetings that provide the board (in public) with assurance on the robustness of the process.

Meeting	**Date**
Council of Governors briefing	30th July 2019
UHBristol Stategic Senior Leadership Team (SLT) (reviews preliminary due diligence findings)	7th August 2019
Quality and Outcomes Committee (reviews the clinical case)	30th August 2019
UHBristol Finance Committee (reviews the financial case)	30th August 2019
Draft Full Business case (FBC) subject to external review	26th September 2019
CCG considers their decision making business case for Healthy Weston	1st October 2019
People Committee (UHBistol approves the TUPE transfer process)	29th October 2019
UHBristol Trust Board (reviews the full due diligence report and approves the Heads of Terms)	31st October 2019
Board to Board session (UHBristol and WAHT to jointly review the case for change)	Date to be confirmed
UHBristol Trust Board (Decision on FBC)	28th November 2019
WAHT Board (Notes decision on FBC)	28th November 2019
Council of Governors (Notes decision on FBC)	28th November 2019

As part of the programme a communications and engagement strategy has been developed with the intent to keep staff and stakeholders informed as we move through the process. We have started these communications, but will be stepping them up with dedicated partnership sections on the intranet, staff newsletters and bulletins and through direct and cascade staff briefings.

We also recognise that there are distinct similarities and differences between both organisations and therefore the importance of engaging staff in the journey of cultural integration as we move from two to one organisation. We will be undertaking a 'cultural diagnostic' exercise so that we better understand the prevailing cultures and attitudes at both Weston and UHBristol. This will inform a process to create the mission and values for the new organisation as we progress towards merger implementation. Our cultural integration programme will be commencing in the autumn and continue through year 1 post-merger.

Future reports will update the Trust Board on progress of the business case and the approvals process through to merger.

Meeting of the Board of Directors in Public on Tuesday 30 July 2019 in the Conference Room, Trust Headquarters

Report Title	**Healthier Together Update**
Report Author	**Robert Woolley, Chief Executive**
Executive Lead	**Robert Woolley, Chief Executive**

1. Report Summary
This report is to provide an update to the Boards of the Healthier Together partners on work that has done within the Healthier Together Network.
2. Key points to note *(Including decisions taken)*
A variety of work has been completed since the previous update and is contained in the report.
3. Risks **If this risk is on a formal risk register, please provide the risk ID/number.**
The risks associated with this report include: None
4. Advice and Recommendations *(Support and Board/Committee decisions requested)*:
• This report is for **INFORMATION**. • The Board is asked to **NOTE** the report.
5. History of the paper **Please include details of where paper has previously been received.**
N/A

Healthier Together

Improving health and care in Bristol, North Somerset and South Gloucestershire

Healthier Together

Update report for Partner Boards

23

June 2019

Robert Woolley **Joint STP Lead Executive**
Julia Ross **Joint STP Lead Executive**
Gemma Self **Head of Transformation, Healthier Together**

For further details please contact Healthier Together Office

Email: **bnssg.healthier.together@nhs.net**

Website bnssghealthiertogether.org.uk
Twitter @HTBNSSG

1. INTRODUCTION

The purpose of this report is to provide an update to the Boards of the Healthier Together partners to provide a formal update on system work that has taken place over the previous months and looking forward to the coming months.

2. SYSTEM DEVELOPMENT

2.1 CITIZENS PANEL

Our Healthier Together Panel now has more than 1,000 people representing the views from a cross-section of our Bristol, North Somerset and South Gloucestershire population.

Survey two focused on topics including people's smoking habits, experiences of planned care, thoughts on sharing health records and urgent care. About two thirds of the panellists replied to the survey. Some of the key findings include:

- 11% of BNSSG residents report that they have had an outpatient or clinic appointment that they considered to be a waste of their time.
- 13% of BNSSG residents report that they have had surgery or treatment that they later regretted (or know someone who has).
- 81% BNSSG residents are comfortable with their health and social care records being shared with NHS professionals.
- Between one half and two thirds of BNSSG residents would travel (up to 3 hours on average) to receive specialist care with better results, rather than stay close to home.
- 74% of BNSSG residents currently feel happy – a slightly higher % than we saw in the winter months.
- 19% of our panellists smoke cigarettes and this is most prevalent in the 16-24 age group. Those least happy, healthy and in control are statistically significantly more likely to be smokers.
- Most people would like to book follow up appointments using an online booking system.

The results are currently being shared across the partnership and we will be discuss the findings in detail with relevant programme areas to understand how insights can be used and if we need to take further steps to explore some of the issues in greater detail. Findings from all surveys will be used to inform the development of our five year system plan. Full results from the survey can be accessed by emailing the Healthier Together Office.

Survey three has recently gone live and covers topics including keeping well, eating habits, use of alternatives to A&E and shared decision making. The results will be available in late July.

2.2 ICS DEVELOPMENT

Our system completed the nationally sponsored Aspirant ICS programme at the end of 2018. This Programme enabled us to accelerate our system work particularly on solutions to reduce the demand for and redesign Urgent Care and the implementation of Population Health Management (see 2.4 below).

Our time on the programme has been documented in a case study by NHS England and this can be found in Appendix One. An additional wave of systems were nominated to be formally recognised as ICS in May 2019, however BNSSG was not agreed to be put forward by the regional NHS E/I office as the system plan and supporting contracts has not been agreed.

2.3 SYSTEM LEADERSHIP DEVELOPMENT

The Healthier Together office is currently undergoing a tender exercise to identify an external partner to work on System Leadership Development programme to commence later in 2019. This programme will be for individuals working across organisations on system-wide programmes of work and particularly provide the opportunity to develop leadership and influencing skills in a complex system.

In the week of the 8th July, bidders will be presenting their approach to delivering a system leadership development programme to a panel of individuals from across partner organisations. The successful partner will be announced in early August with the intention to start delivering the programme in the Autumn.

2.4 POPULATION HEALTH MANAGEMENT

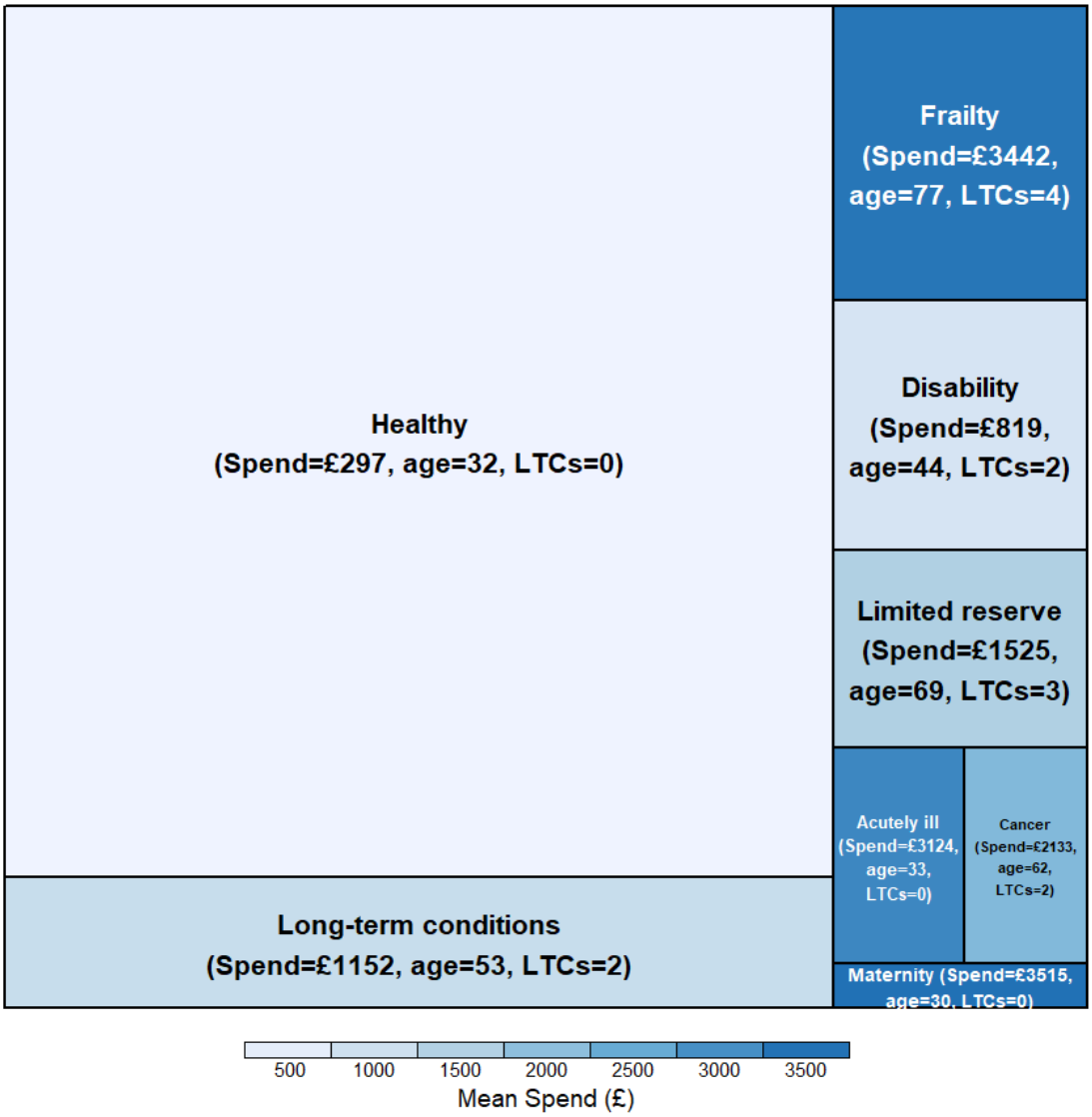
Following on from work started with the Aspirant ICS programme, we have continued to work with Optum to build and develop our approach to Population Health Management. This will support us both strategically to understand the needs of our whole population, but also provide evidence of opportunities for localities to proactively manage the health of their population. A fundamental requirement for Population Health Management (PHM) is a large data pool, linking data between primary care and all other providers of health and care. This data will enable us to understand our population both strategically (for example trends in social and clinical activities prior to the use of an urgent care service) and within communities (for example targeted appointments for men ages 40-60 with pre-diabetes and hypertension).

Definition
Population Health Management improves population health by data driven planning and delivery of proactive care to achieve maximum impact.

It includes segmentation, stratification and impactabilty modelling to identify local 'at risk' cohorts - and, in turn, designing and targeting interventions to prevent ill-health and to improve care and support for people with ongoing health conditions and reducing unwarranted variations in outcomes.

Currently our linked dataset covers a population size of 50,000 people. A data sharing agreement is currently being signed by general practices across the area to increase the scale of the dataset and increase the accuracy of the insight available.

An initial segmentation based on the currently available data demonstrates a population level understanding of the different segments and their underlying characteristics.



Furthermore, combining data from all settings of care enables an improved understanding of the patterns of service use enabling improved proactive management in a primary care setting and the start of predictive analysis of trends in risk factors.

Over the next few months as more general practices enable their data to be linked, reports for both the 5 year plan and localities will be developed to enable prioritisation of which population could be best supported to stay healthy and well.

2.5 SYSTEM FINANCIAL RECOVERY PLAN – 2019/20

Since 2016, Healthier Together partners have been working together to improve health and care services, financial sustainability and the wellbeing of the population. Through collaboration over recent years the system has greatly improved its financial position, from a £92.8m deficit in 2016/17 to a deficit of £59.5m in 2018/19.

In 2019/20, the Healthier Together partnership has for the first time developed a single, NHS system-wide financial and operational plan for 2019/20 by combining individual organisational plans. This resulting financial plan initially proposed a deficit of £58.7m, which was £15m adrift from the target set nationally for us by NHS England/Improvement.

Following further detailed financial planning and discussions with NHS England /Improvement, the Healthier Together Partnership has agreed to a further £9.9m in NHS savings this financial year to help bring our planned deficit in line with the target set. There are a number of ways of reducing costs within our system, including reducing waste and duplication, disinvesting in services which are not demonstrating a positive impact or delaying planned investments.

The plan to deliver the £9.9m in 2019/20 is now described as the System Financial Recovery Plan (SFRP).

This is a real opportunity for BNSSG to work together to jointly deliver a savings plan for the system. It is important to note that lead NHS organisations have been identified by the Chief Executives to ensure the acceleration of each of these new or existing projects; BNSSG partner organisations will need to collaborate and hold each other to account for delivery of the agreed recovery actions. Partnership Board is

2.6 5 YEAR SYSTEM PLAN

The BNSSG Sponsoring Board has previously noted the national NHS Long Term Plan, published in January 2019, and the likely expectation on local health systems to produce local five-year plans for implementing the commitments set out nationally. What exactly will be expected of local systems is not yet known as the implementation guidance has been delayed although we know the direction of travel and can begin our planning because we know what is needed for our population.

The local plan is likely going to have to:

- Involve local communities in its development
- Use evidence of population need to inform priorities and targeted action
- Build on existing plans and strategies
- Define how outcomes will be achieved and initiatives will be adopted
- Outline how financial stability will be achieved

We have agreed that an important foundation of achieving these expectations in BNSSG is through our work on population health and population health management. This will see an increasingly linked dataset, combining acute, mental health, community and primary care data which will add to other data profiles at ward and cluster level alongside JSNAs for the 3 localities and the BNSSG-wide STP case for change. Using this data will enable our system to understand for the first time:

- Our population: How groups of the population use the wider health system upstream before an individual has an unplanned episode, enabling identification of opportunities for prevention and maximising value.
- Our service redesign: Patterns in service use by cohorts of people with similar needs or demographics enabling design of targeted services
- Impact of redesign initiatives: Use of both retrospective and prospective data already collected by partner organisations to assess the multiple variables influencing the impact of a redesign initiative

Collectively, this data will enable an understanding of the specific needs of the local population, the impact of wider determinants and the gaps in care and unwarranted variation. Using modelling to determine high and emerging risk groups most amenable to interventions will enable design of interventions to target the relevant population segments.

3. PROGRAMME DELIVERY

3.1 GENERAL PRACTICE

The General Practice Resilience and Transformation Programme is leading on the refresh of a system-wide Primary Care Strategy.

There is a proposed two part approach to the strategy:

Part 1: For September 2019: Refresh the old strategy to a living document that adapts to the changing environment. It will support and connect with Primary Care Networks (PCNs), Integrated Care System (ICS), Urgent Care and other strategies. Engagement through an initial workshop to be clear on:

- Commitment for an ongoing piece of work
- Identifying key groups to provide the information we need
- Agree how we work together as part of the wider system
- Develop clinical leadership and the future model of care
- Specific engagement with patients and service users to be clear on population needs in order to write the strategy from a patient's perspective

Part 2: 5 years: Describe a transformational change plan of where we want to be in the future; articulating what the clinical model will look like

This is planned to come to the STP Executive Group in October 2019.

3.2 HEALTHY WESTON

Public consultation concluded on 14th June 2019. The consultation was extended following the extension of purdah due to the European elections. The consultation is on track to meet engagement targets.

Clinical Services Design and Delivery Group evaluated alternative a proposal from a group of Weston General Hospital consultants. The evaluation of the model scored less favourably than the model proposed in the consultation but a number of ideas have been put forward that would enhance the proposals.

Drafting of the decision making business case is underway. First full draft scheduled to go to Steering Group in August with the final decision expected in October at the CCG Governing Body meeting.

3.3 MENTAL HEALTH

To date, the programme team have engaged more than 1,300 people in seminars, events and focus groups about mental health, including people with lived experience, all our GP practices and the general public. The process of engagement has been complex and has highlighted many different views it has highlighted the pervasive nature of mental health and wellbeing as part of every service. Through this process we have identified the following key areas of focus:

- Prevention & Self-care
- Access
- Integration
- Sustainability

The draft strategy is scheduled to be completed by the end of June. Project groups to be established to take forward work against the four strategy themes beyond this

4. HEALTHIER TOGETHER OFFICE RESOURCE PLAN

In February 2019, STP Executive Group agreed ongoing funding for the Healthier Together Office including a structure with the team in permanent contracts. The functions of the Healthier Together Office have been aligned to three areas:

- Leadership and Management of the Partnership
- System Development
- Programme Management and Delivery

A reconfiguration of the team, managed through a consultation process, has enabled new roles to be put into place, including Project Managers and Analyst and Head of System Development. These will enable us to accelerate both our programmes of work and the wider system development required for us to become an ICS.

A full structure will be shared once the consultation process has progressed. Over the course of June / July, existing members of staff will be recruited into roles and any unfilled roles will be openly recruited. We would look to attract individuals who work within system partner organisations into these roles to provide an opportunity for them and to build shared working further.

Sebastian Habibi has been appointed into the role of Programme Director and will start in post in late August.

5. RECOMMENDATIONS

The Board is asked to:

- Note the information in this report
- Confirm that this report can be shared with Partner Boards for their consideration

Robert Woolley, Joint STP Lead Executive
Julia Ross, Joint STP Lead Executive
Gemma Self, Healthier Together Head of Transformation

Appendix One:

Bristol, North Somerset and South Gloucestershire – Urgent and Emergency Care redesign

System context	BNSSG STP, better known as the Healthier Together Partnership, serves a population of nearly 1 million people, and consists of 13 organisations including one CCG, three local authorities and three hospital trusts. The system has several strengths including effective leadership relationships, a clear purpose and good interconnectivity between the different system tiers (region, STP, Place and neighbourhood). A key challenge has been redesigning urgent and emergency care for 2019/20, which requires system-wide decisions and agreement. BNSSG emergency admissions have risen by 25% since 2013/14, compared to population growth of 4%. There are more than 15 entry points into the UEC system for patients to navigate, and demand from an ageing and increasingly complex population is predicted to rise.
How the Aspirants programme approached the challenge	The system focused the majority of their programme on a large scale two day intensive UEC 'incubator event' consisting of several smaller transformational sessions, for an audience of more than 100 including local authorities, GPs, consultants. The purpose of the event was to build a solution to the UEC challenge, test it through different perspectives and agree next steps to implement changes captured in single document (UEC roadmap). To achieve this, in advance of the event, a core team of key individuals across the system, NHSEI, and the lead external facilitator met weekly to discuss scope, inputs, outcomes and outputs for the event to meet the jointly collaborated and owned end result. This was resource intensive for STP staff including senior leaders as well as programme SMEs.
Impact of the programme on the system and system leaders	The system leadership (both the executive and leaders at the different tiers of system working) saw the immediate impact of working collaboratively to find solutions. By the end of the programme, system leaders had agreed a new UEC care model as well as high level governance arrangements, governance principles to inform an Memorandum of Understanding and draft principles to feed into a financial risk framework. The system leadership also identified and agreed other key areas to successfully implement the UEC delivery model including Triage & Routing, Digital & Data and Social Marketing & Communications. The Medical Director in the system felt the programme had helped accelerate their progress "It would have otherwise taken us many months to design and agree this and so we are now able to deliver change for winter 2019."
Expected impact of the programme on service delivery, patients and/or the wider population	The system aims to stabilise UEC ED activity and to increase the number of people accessing urgent care services delivered in primary and community settings. The programme will also deliver an increased focus on proactive health management of high impact users as integrated services in the community mature. It is expected that we will see an increase in individuals accessing advice digital first in primary care.

Meeting of the Board of Directors in Public on Tuesday 30 July 2019 in the Conference Room, Trust Headquarters

Report Title	**Transforming Care Programme Board Report**
Report Author	**Cathy Caple, Associate Director of Improvement and Innovation**
Executive Lead	**Paula Clarke, Director of Strategy and Transformation**

1. Report Summary

This Transforming Care update describes the highlights for the period April to June 2019 (quarter 1) 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.

2. Key points to note
(Including decisions taken)

- A summary of two key developments around improvement and innovation: QI Gold programme and the Bright Ideas competition;
- Continued delivery of the Transforming Care programme in 2019/ 20, delivering significant benefits across the Trust (appendix 1).

3. Risks
If this risk is on a formal risk register, please provide the risk ID/number.

The risks associated with this report include:
None

4. Advice and Recommendations
(Support and Board/Committee decisions requested):

- This report is for **INFORMATION**.
- The Board is asked to **NOTE** the report.

5. History of the paper
Please include details of where paper has previously been received.

Transformation Board	Wednesday 10th July 2019
Senior Leadership Team	Wednesday 17th July 2019

This Transforming Care update describes the highlights over quarter 1 2019/20(April-June 2019) against the three priority areas agreed for the Transformation Board: digital transformation, working smarter and quality improvement.
A summary of the highlights of progress during quarter 1 is given below, and the priorities for the following quarter are outlined. A more detailed description of latest progress against key projects is attached at Appendix 1.

Two key developments around improvement and innovation to note are:

QI Gold Programme

Whilst running the quality improvement (QI) silver programme cohorts in 2018/19 it was apparent that there were a number of larger-scale projects coming through that were more complex than could be supported by the silver programme. There was also an emerging requirement to align the QI programme outputs with divisional priorities. The gold programme has been designed to address this gap whilst maintaining the local ownership and benefits of the bronze and silver programme.

The aims of this programme are:

1) To provide more in depth knowledge and coaching of QI methodologies
2) To align the outputs of QI to divisional objectives and transformation priorities
3) To provide support for larger programmes of work aligned to divisional or corporate objectives but which currently sit outside of the transformation work stream

Clinical divisions, Estates & Facilities and Trust services have been asked to submit applications for the QI Gold programme. Projects should be of duration of up to a year to plan and deliver, and be supported by the divisional or corporate teams. Suitable projects for the QI gold programme are those that the Division already wants to deliver and for which teams would benefit from teaching and support to support delivery.

The programme will run over six days from September 2019 to July 2020, with monthly drop-in support sessions. The programme will be run by the UH Bristol QI Faculty, with some guest speakers. Opportunities are being explored to work collaboratively with the University of Bristol to deliver a year-long QI module as part of the new masters for healthcare leadership and improvement, due to be launched in 2020.

Projects will be overseen through the divisions with updates provided through the Improvement and Innovation steering group. Completed projects will be presented to Transformation Board in July 2020.

Bright Ideas competition

The bi-annual Bright Ideas competition will be re-launched at the QI Forum in July 2019. Bright Ideas aims to encourage innovation, stimulate safety and quality improvement, and provide help to get the best ideas off the ground. The competition will promote innovations which have the potential to improve patient care, and to reward innovative individuals and teams within University Hospitals Bristol. The competition is being supported by Above & Beyond and the West of England Academic Health Sciences Network.

For entrants with the best ideas, support will be provided by the QI Faculty to get an idea implemented, and could on occasions help with access to funding. A Bright Ideas winner will receive expert advice and guidance, have the opportunity to showcase their skills and talent, and be able to develop their CV and gain new skills.

Bright Ideas entries may come from any area of Trust activity. Entries will be judged against the following criteria:

- An innovative idea that addresses an identified problem
- Feasibility – an idea that can be practically delivered
- A good understanding of the views of other people who may be affected
- Potential to re-apply the idea across our hospitals
- Originality

The closing date for entries is 6th September 2019, and the judging panel will be held in October 2019.

Transforming Care – Progress Summary Q1 2019-20

Successes	Priorities
• Endoscopy improvement: increased percentage of incoming patient and staff calls answered, and backlog responded to. Developed plans to improve staff experience and processes. • Real-time outpatients: continued roll out in Medicine and Specialised Services, and planning for roll out to Surgery in July. • Transforming outpatients: following the Healthier Together BNSSG outpatient transformation workshop, agreed partners will work together on solutions, with support from NHSE Elective Care Transformation Programme team. • Improving handover using Careflow digital system: 40% medical teams using Careflow, 60% in planning or piloting phase; roll out continues across services. • Rolling out emailing of patient appointment letters across the Trust.	• Real-time outpatients: launch to staff a video to showcase the benefits of real-time outpatients. • Transforming outpatients: pilot for non-face to face lung nodule clinic to commence August 2019. • Identify which clinical pathways to pilot; learn best practice from Royal Free through the clinical practice group approach. • Scoping of the real time bed management digital options. • QI Gold programme to be launched, first cohort to run September 2019 to July 2020 for up to seven project teams across the Trust. • Annual QI Forum to be held on Friday 12th July in BHI atrium (74 posters displayed and 14 projects shortlisted.) • Bright Ideas Competition to support innovation to be launched at QI Forum.
Opportunities	**Risks and Threats**
• Collaboration with the University of Bristol to deliver a QI module as part of the new masters for healthcare leadership and improvement. • Support from Above & Beyond and WEAHSN will enable the Trust to support small funding requests for developing and implementing innovative ideas.	• Capacity of transformation team to support all the transforming care priorities where support requested – the work programme for delivering the Transforming Care priorities has been phased in line with resource availability. • Capacity of clinical support for digital transformation implementation. • The implementation of People Web is dependent on the Trust deciding to implement Office 365.

Pillars: Working Smarter | Digital | Quality Improvement

Transforming Care Report

Status: 10th July 2019

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

Project, Aim & Project Sponsor (PS)	Key Dates		Progress Last Month	Aims for Next 3 Months	When	Benefits delivered or expected	Key Messages (Challenges, Awareness, Discussion)
Escalation of deteriorating patient **PS: Carolyn Mills/Bill Oldfield** Implement automatic escalation of NEWS triggers to the appropriate level of care to enable a proactive and rapid response/treatment	**Project start** **Delivery phase starts** **Project close**	Oct 2019	• Project not yet commenced, planned start Autumn 2019	• Project scope, plan and team established	Oct	• Improved patient outcomes • Early recognition and proactive management of deterioration • Reduction of unplanned admissions to ITU related to failure to recognise/act upon signs of deterioration • Sustain low level of cardiac arrests on inpatient wards	**Potential risks identified**: • Delays to the completion of e-obs embedding work • Delays to roll out of Careflow to clinical teams through the Improving Handover project
EPMA and Discharge Summary **PS: Bill Oldfield** Implement an Electronic Safe Effective Patient Centred Prescribing and Medication Administration System	**Project start** **Delivery phase starts** **Project close**	TBC TBA TBA	• Run through of proposed business continuity plan to refine standard procedures by SBCH working group • User testing of the latest version of EPMA Commencement of change meetings with Division of Surgery • All support and training for EPMA to go through IT Service desk, moving to a sustainable model for support to clinical users in future	• Division of surgery next area for Medway discharge summary roll out • Sustainable business continuity plan approved • BNSSG standardised discharge summary template implemented in Medway • Roll out of Medway discharge summary to Maternity wards	tbc July Aug Sept	• EPMA ensure timely administration of medication • Streamline discharge medication processes • Reporting and Dashboard mechanisms will support action prioritization and efficiency • Improve quality of discharge summary	**Challenges** • Further improvement to the business continuity/resilience arrangements needed • Can only prescribe for patients on a current inpatient spell, not in advance or once discharged – affects workflow for elective surgical admissions **For awareness:** • Planning for return to use of EPMA continues anticipating a Big bang approach where all adult inpatient ward go live in single phase, rapid roll out –supernumerary staff will be needed to support this process, which will need to be funded
Improving Handover Careflow **PS: Carolyn Mills/Bill Oldfield** To have effective communication systems across teams to deliver timely, safe and effective care Trust Wide	**Project start** **Delivery phase starts** **Project close**	Nov 2018 Jan 2019 Jan 2020	• Rollout continuing across services (**1688** users and **237** groups set up) • Agreed trial in General Paeds/Caterpillar of tasks and referrals functionality • Medical teams progress: Currently 40% complete; 60% planning or piloting	• Careflow training videos produced • BRHC Medical teams handover rollout complete • Process agreed for BRHC out of hours teams • Roll out plans for all Divisions using Careflow for Medical Handover agreed	May Jun Aug Jul	• Reduction of communication incidents due to team communication and inadequate handover: 19/20 to date **118 incidents** • Reduction of dropped handover sheets: 19/20 to date - **6** dropped handover sheets • Secure real-time communication & remote clinical decision making based on patient information • Reduction in bleeps releasing time for other tasks	**Challenges** • Embedding Careflow in some services as use of the system is currently optional **For awareness:** • Options for achieving Trust roll out by November 2019 discussed at Transformation Board 10th July 2019, agreed to present proposal to MIOs for Careflow champions to support rollout in all divisions to speed up process.
Real time Bed Management **PS: Mark Smith** Accurate information about admission, transfer and discharge is digitally recorded in real time and used to facilitate bed management decisions	**Project start** **Delivery phase starts** **Project close**	Feb 2019 TBC TBC	• Current practice continues to be explored with a sample of stakeholders in all divisions • Additional observations have been arranged during July	• Technical capability of Medway is explored for recording real time information • Summary of current process written for all stakeholders	Aug	• Trust wide bed status is 100% accurate at all times • Improved bed management decision-making • Improved staff experience by reducing duplication e.g. bed management meetings/phone calls/ visits Support the achievement of RTT, 4 hr target, cancer pathways and reducing LMCs	None
People Web (Self Service) **PS: Matt Joint** Replacement for HR web enabling staff and managers to easily find information	**Project start** **Delivery phase starts** **Project close**	Oct/ Nov 18 On hold TBC	• No progress possible until decision made regarding Trust implementation of Microsoft 365	• Trust decision regarding implementation of Microsoft 365 made • Dependent on decision -Trust roll of Microsoft 365 completed • Communication campaign to promote new	TBC TBC TBC	• Easy access to HR guidance for line managers and employees • Reduction in phone calls/emails to employee services	**For Awareness** • This project is dependent on the Trust deciding to implement Office 365
Personal Health Record **PS: Project on hold** Patients to have direct electronic access to their health records. Enabling patients to engage with their care and treatment	**Project start** **Delivery phase starts** **Project close**	Nov 2018 On hold On Hold	• Project on hold	• Meet with System C to agree future roadmap for project	TBC	• Patients to have better visibility and transparency of their patient information • Patients will have access to general information about UHB and lifestyle advice	**For Awareness** • Digital services Director and Chief Clinical Information officers overseeing decisions regarding next steps for project
Transforming Outpatients **PS: Mark Smith** To transform the way outpatient services are delivered in BNSSG- providing timely and appropriate access to specialist expertise.	**Project start** **Delivery phase starts** **Project close**	June 2019 Provisional Sept 2019 March 2020	• Agreement from partners across BNSSG to work together on solutions • Trust wide comms to gather ideas and current 'non-traditional' clinics • BNSSG workshop to gather and spark ideas- a lot of UHB attendees	• Status of all current non face to face services provided defined • Defined pricing and cost assumptions for non face to face services • Pilot commenced for lung nodules non face to face clinic	Jul Aug Aug	• Patients, GPs and other referring organisations will experience timely and clinically appropriate access to specialist knowledge • Technology will be used to empower patients with the knowledge to manage their condition and to simplify how expertise is accessed	**Challenges** • CCG expectations around what is achievable within the year. • Resource to evaluate advice and guidance for commissioners to continue funding tariff.
Clinical Pathways **PS: In discussion** To be identified as part of project mobilisation	**Project start** **Delivery phase starts** **Project close**	July 2019 TBA TBA	• Clinical Practice Group launch held on 26th June • Working with in conjunction with lead for clinical practice groups for the Acute Care Collaboration to develop model	• Develop clinical practice group methodology for pilot pathways • Pathways agreed: 2 Weston, 2 Internal, 2 NBT	July July	• To be identified as part of project scope	None

Project, Aim & Project Sponsor (PS)	Key Dates		Progress Last Month	Aims for Next 3 Months	When	Benefits delivered or expected	Key Messages (Challenges, Awareness, Discussion)
Real-time Outpatients **PS: Mark Smith** To deliver a high quality service through a friendly, accessible, consistent and timely service	**Project start** **Delivery phase starts** **Project close**	Aug 2018 Oct 2018 March 2021	• Timeline agreed for sleep server transfer (to resolve IT issues in Respiratory and Sleep) • Rheumatology and 3 areas in BRHC went live on 1st July • Clinical Genetics focusing on reducing the typing backlog and improving admin processes. • Dental agreed as first area within Surgery, followed by BEH and ENT • Film promoting the benefits of RTOP edited and finalised.	• Implementation of CRIS booking module to allow appointments to be made without vetting first • RTOP in BHI relaunch/reinvigoration • Initial scoping meetings take place with Dental, ENT, Dermatology, Gastro, Hepatology • BRHC evaluation and next areas decided • Respiratory, Sleep, and CF launch RTOP • Communications and film promoting the benefits of RTOP developed and released	Sep Jul Jul Sep Sep Jul	• Better cross-cover and improved business continuity due to standardisation of admin roles • Enable greater throughput of patients within clinic • Reduce lost income due to missing outcomes; BHI have a **76% reduction in missing outcomes** from baseline of 511 • Improved clinic letter turnaround, and less chance of fines: **BHI 53% 7 day turnaround May 2019** (decreased due to staff sickness) • Reduced DNA rate as patients understand what is happening: **Reduced from 5.3% to 3.9%** between October 2018 and May 2019	**Challenges** • Resistance to change of practice by consultants and medical secretaries • Med sec vacancies, sickness, and typing backlogs compound to increase resistance to change • Various IT issues (incl. slow PC speed) **For Awareness** Corporate risk 3115 added: As part of 'Real time outpatients project' it has been raised there is also a related issue with the amount of loose scanning, and backlogs of scanning that are piling up within some specialities.
Dermatology Admin Project **PS: Toria Hastings** To more efficiently meet the growing demand of dermatology services and improve the patient and staff experience	**Project start** **Delivery phase starts** **Project close**	Nov 2018 June 2019 Dec 2019	• High risk fast track patients regularly being straight booked for their FU. • Straight booking of high risk patients requiring a biopsy or surgery being piloted. • Allocate App for A/L signed off and staff job plans are being uploaded • Text reminders live for all routine clinics	• Processes documented for high risk pts being straight booked for FUs and surgery • Confirmed plan for standardised clinic templates • Staff boards updated in service to help aid staff understanding and interaction	Aug Aug Aug	• Reduction in hospital and patient cancellations • FU patients are seen on time • Fast track patients seen at the BRI will be booked for surgery on the day • Staff have the knowledge and confidence to meet expectations of their role • Patients receive an effective response	**Challenges** • Staff capacity to attend meetings and complete actions • IM+T capacity to support with solutions
Optimising Diagnostics **PS:** Alison Lowndes To ensure that patient diagnostic pathways are necessary, timely and lean by April 2019	**Project start** **Delivery phase starts** **Project close**	Oct 2018 Nov 2018 March 2020	• Radiographer led hot-reporting of ED plain films continued2-5pm • Principles of Optimising Diagnostics and plan of work drafted • Further opportunities explored, as raised as the Strategic Oversight Group Urine test guidelines and urine dipstick CQUIN comms	• Principles and plan taken to savings board • UHB to host SW CT reduction group • 'Wee week' to promote urine testing and the CQUIN to take place • Radiographer led reporting hours increased, and scope extended to reporting GP plain films. • Implement first PDSA in PICU and BHI	Jul Jul Jul Aug April	• Support diagnostics productivity improvement, as required by the organisation to include: • Minimize unnecessary testing • Better utilisation of staff and equipment • Improving pathways and timeliness, as identified by the organisation	**Challenges** • Staff capacity to deliver PDSA cycles in ward areas, access data, gain consensus, write guidelines, and complete clinical audits • Different clinical judgements are becoming evident around what tests are 'unnecessary' **For Awareness** • The Strategic Oversight Group defined the areas of focus as; Practice, Protocol, and Process
BEH Cataract Project **PS: Mark Smith** To improve patient flow through the Cataracts Service	**Project start** **Delivery phase starts** **Project close**	June 2018 Aug 2018 TBA	• Trial commenced for surgery with Mydrane® intracameral anaesthesia • Motivation for additionality of A&B pre-op bid revised and re-submitted • Comments from surgeons integrated in new Medisoft handbook	• Funding for pre-operative equipment and refurbishment is agreed • Medisoft handbook is trialled in cataract clinics • Bluespier functionality is explored with IM&T • Business case is submitted for List Builder (artificial intelligence for scheduling)	Aug Jul Jul Jul	• Reduce avoidable last minute cancellations by 50% to 2.5% of total procedures (**3%** in May 2019) • Increase number of cataract procedures to **380 per month** by the end of 2019/20 (**currently 319**) • Reduced average length of patient pathway (**starting average = 35 weeks**) • Reduce time in pre-op clinic by 50% • Reduced number of attendances per pathway	**Challenges** • Pre-admission one-stop clinic transformation is delayed until decision regarding funding is made Agreeing future clinical leadership for the cataract service
Endoscopy Improvement **PS: Philip Kiely** To improve efficiency and wellbeing in the endoscopy booking team	**Project start** **Delivery phase starts** **Project close**	TBC TBC TBC	• Caught up with responding to voicemail messages • Increased percentage of incoming patient and staff calls answered	• Move booking team to purpose built office space • Fully recruit and train all booking staff • Pursue purchasing HICCS scheduling tool from UHS • Go live with Synertec letter and leaflet printing	Aug Aug Jul Jul	• Increased utilisation of lists • Better patient experience with bookings • Increased efficiency of bookings team • Improved staff wellbeing and reduced turnover	**Challenges** • Estates team still to decide which team the building work will be led by (capital or small works) • EMIS have decided to retire the HICCS platform and UHS are acquiring it which will delay our purchase and implementation • Further turnover affecting staff training and reducing efficiency
Innovation & Quality Improvement (QI) **PS: Paula Clarke** To build an innovation culture at UH Bristol - increasing staff capability and opportunity to practice innovation and QI	**Project start** **Delivery phase starts** **Project close**	Jan 2017 April 2017 TBA	• 71 posters accepted to be displayed for the **QI Forum on 12th July** • Development plan for the QI Gold programme agreed	• Business as usual' admin operation plan for QI Hub and QI Forum agreed and in place • QI Forum event held • First QI Gold programme held	Jul Jul Sep	• Increased number of staff who have knowledge and confidence to conduct QI projects in their area: • **715 staff** attended Bronze training • **71 staff** completed or undertaking Silver training • Development of an Innovation culture in the Trust • **92** QI project ideas submitted to the QI Hub	**Challenges** • Fast expansion could result in increased variation of delivery – structured training and presenter guidance will mitigate • Not enough capacity of faculty to meet with growing demand of QI sessions and QI Hub submissions
Customer Service **PS: Carolyn Mills** To develop a consistent customer service mind-set in all our interactions with patients and their families	**Project start** **Delivery phase starts** **Project close**	May 2017 TBC Dec 2019	• Trust-wide SOP for telecoms shared with stakeholders for sign off via OSG • #TakePhonership drop-in session held at BDH • Endoscopy tripled telephone pick-up rate during June • New customer service recruitment questions went live in question bank	• Charitable funds approved for advanced training • Telecoms automated report is refined and finalised • Finalise design of customer service toolkit • Telecoms governance process is launched • Hold a final workshop with staff	Jul Jul Aug Sept Sept	• Monthly telecoms complaints in 19/20 are above mean for 18/19 but sustaining within control limits • Telephone complaints reduced by **53%** in thirteen worst performing departments in 2018/19 • Trust-wide telephone complaints reduced by **32%** in 18/19 compared to 2017/18 • Areas recognised for good practice through improved pick-up rate and complaints reduction	• Sustaining improvements is difficult due to absence/vacancies in admin teams • Shortage of resources in clinical services (e.g. nursing staff for chemotherapy) increases administrative pressure • Telecoms improvement work competes for priority with other processes
Improvement and Innovation enabling strategy **PS: Paula Clarke**	**Project start** **Delivery phase starts** **Project close**	April 2019 Oct 2019 Sept 2019	Draft IT&I strategy developed	• Present draft outline of IT&I strategy to Trust Board Seminar and Transformation Board for discussion • Present draft IT&I strategy to SLT and Trust Board for discussion and approval • Communicate IT&I strategy to Trust and partners	Jul Sep Oct	• Trust staff and partners clearly understand the strategy around how Improvement and Innovation will be taken forward by UHB	Capacity of staff to improve and innovate may impact on the delivery of the strategy

Meeting of the Board in Public on Tuesday 30 July 2019 in the Conference Room, Trust Headquarters

Report Title	**Phase 5 Strategic Capital Update**
Report Author	**Carly Palmer, Assistant Director of Estates**
Executive Lead	**Paula Clarke, Director of Strategy and Transformation**

1. Report Summary

Delivering consistent high quality, patient-centred care and valuing our people, are core to the mission of the Trust. Providing a modern, fit for purpose environment is an essential part of achieving these priorities.

In September 2018, Trust Board approved a Strategic Capital Investment Programme and Medium term Financial Plan totalling £237m to 2022/23 to support the Trust in renewing and upgrading what is an aged estate, as well as supporting expansion of very specialist acute care that can only be delivered in a hospital environment and avoids patients travelling outside Bristol where possible.

This paper provides Trust Board with a summary update on progress against the Phase 5 strategic capital investment programme, highlighting the status of individual schemes and the ongoing process to re-assess and review the programme in the context of our 2025 Strategy renewal and the emergence of additional strategic investment proposals.

The report also advises that a Procure22 principle supply chain partner has been appointed (BAM Construction).

2. Key points to note
(Including decisions taken)

- 10 schemes have reached Outline Business Case approval status, 2 of which are at Full Business Case stage and are currently at construction stage.
- The remaining 8 approved schemes are progressing to further design stages. Planning approval has been received for Cardiology Stage 1and is imminent for Cardiovascular Research Unit.
- 13 schemes are at Strategic Outline Case stage.
- An approach to re-prioritisation is currently in development stage and will be informed by the approach to the updated Estates Strategy.

3. Risks
If this risk is on a formal risk register, please provide the risk ID/number.

The risks associated with this report include:

- 2642 strategic risk register - Risk that the Trust is unable to invest in maintaining and modernising the Trust estate.

4. Advice and Recommendations
*(Support and Board/Committee decisions requested)***:**

- This report is for **INFORMATION.**
- The Board is asked to **NOTE** the report.

5. History of the paper – *N/A*

STRATEGIC CAPITAL UPDATE - Phase 5 Programme
Quarter 1 2019/20

1. Background

Delivering consistent high quality, patient-centred care and valuing our people, are core to the mission of the Trust. Providing a modern, fit for purpose environment is an essential part of achieving these priorities.

In September 2018, Trust Board approved a Strategic Capital Investment Programme and Medium term Financial Plan totalling £237m to 2022/23. Indicative allocations for the Programme were agreed into the proposed categories below, recognising that there is a need to keep the priorities within and between allocations under review in the context of emergent issues and the Trust strategic renewal process;

- Major clinical services strategic schemes (phase 5)
- Estates Replacement
- Estates Infrastructure and Compliance
- Medical Equipment and Operational Capital
- Information Technology

The proposed Programme is essential to support the Trust in renewing and upgrading what is an aged estate as well as supporting expansion of very specialist acute care that can only be delivered in a hospital environment and avoids patients travelling outside Bristol where possible. Over 50% of the proposed investment is into replacement and upgrade of existing estate and equipment to ensure our environment remains modern, fit for purpose and capable of managing appropriate increasing demand.

A component element of the programme was an investment of £120.3m for Major Strategic Schemes known as Phase 5. A list of prioritised schemes for Phase 5 was set out in the investment programme focussed on developments that either:

- Developed the physical estate to support the implementation of our clinical strategy and our focus on the delivery of specialist services locally and regionally.
- Provide a required update to poor clinical and staff environments in areas not covered by phases 1-4 of the Trust prior capital investment programme.

This paper provides Trust Board with a summary update on progress against this programme and the ongoing process to re-assess and review the programme for assurance that the Trust is providing the right environment to be able to deliver our strategic objectives.

2. Progress to date

An original list of priority schemes was set out in the investment programme and indicatively approved by the Trust Board in Sept 2018 (attached as Appendix 1). A number of schemes have progressed to approved Outline Business Cases (OBC) or Strategic Outline Cases (SOC). The table below outlines the case types and status of each scheme.

Phase 5 Schemes	Status
Myrtle Road	FBC approved
BHOC Stage 1 2019/20 additional capacity	OBC approved
BHOC Stage 2 expansion	SOC approved
D603 refurbishment	OBC approved
Cardiology Stages 1 and 2	OBCs approved (x 2)
BEH redesign	OBC approved
StMH Level E refurbishment	OBC approved
Cardiovascular Research Unit	OBC approved
NICU expansion	OBC approved
Dermatology	SOC approved
BRHC expansion	SOC approved
Holistic wellbeing centre	SOC approved - Maggie's Charity agreement to fully fund
Endoscopy JAG	SOC pending
Queens level 7 ward	SOC pending
ICU / CICU integrated critical care	SOC pending
Medical education facilities improvements	SOC pending

The need to adapt and consider emerging requirements from the Trust 2025 strategy renewal process and the external environment was accepted by the Board in 2018. This assessment has identified a number of further requirements for capital investment into the estate as follows:

BEH 5th Theatre to enable theatre refurbishment/maintenance programme and longer-term additional capacity	SOC approved
Trust wide theatre review to undertake required refurbishment and upgrade and provide additional capacity for strategic clinical service plans	SOC pending
Infrastructure upgrades (5th generator) to ensure resilience and support the strategic capital investment programme	FBC approved
Adult Emergency "Front Door" capacity for ED and medical admissions	SOC pending
Radiology development and clinical adjacency alignment	SOC pending
Pharmacy aseptic production unit	SOC pending
ICU/CICU Stage 1 shorter term capacity increase	SOC pending

A process to review the Phase 5 programme is currently in development. Schemes at SOC stage (unless fully funded by an external source) have been "paused" until this is completed however design continues for some schemes to appropriately inform an assessment of the capital requirement. The review process will also be informed by the completed Site

Development Plan 2018- 2023, the approach underway to develop a 2025 Estates Strategy and a review of the Medium Term Financial Plan. Updates will be provided to Trust Board in the next quarterly report.

3. Procurement update

The March 2019 Update Report confirmed the decision to proceed with a mixed procurement strategy to deliver the capital programme. The approved procurement route for the majority of complex and high value schemes is ProCure 22 which is pre-approved by Department of Health and is fully OJEU compliant.

A Principal Supply Chain Partner (PSCP), BAM Construction were appointed in July following a selection process between 3 bidders from the P22 framework. This selection was in line with protocol and complies fully with Trust Standing Financial Instructions.

4. Recommendations to Trust Board

- **Note the overall content of this report**

Appendix 1: Phase 5 Clinical Services Programme Summary (Initial Priority List September 2018)

Scheme	Brief summary of schemes
Myrtle Road Acquisition and refurbishment	Purchase of the Myrtle Road property at top of St Michael's Hill to provide additional non-clinical space to enable the transfer of non-clinical functions out of core clinical areas to support the other schemes in the programme. Strategically, this will also support an improved and modern environment for non-clinical staff.
Cardiology Expansion	Cardiology services are part of our core specialist and regional provision and the service has demonstrated year on year growth. Increased contracts for additional activity have been agreed with local and specialised commissioners and additional physical space for catheter laboratories and in-patient beds is required to ensure we can continue to realise our strategic priority to develop our specialist offer.
Cardiac Research Unit	Cardiac research is central to our research and innovation agenda and to ensuring patients can continue to access leading edge interventions. This scheme proposes to co-locate the Cardiac Research Unit currently provided on Queen's building L7 with the BHI and also vacates core clinical space on L7 of the Queens Building to enable re-provision of medical ward capacity in support of the expansion of cardiac and cardiac inpatient facilities.
D603 (BHOC inpatient ward refurbishment)	Refurbishment of Bristol Haematology and Oncology Centre (BHOC) inpatient ward. Providing an improved and modernised environment for staff and patients.
Integrated critical care	The provision of critical care facilities is core to the development of our specialist surgical cancer and cardiac work, which are central to the strategic development of our specialist and regional services portfolio. The proposed scheme will assess the opportunities to integrate general and cardiac ICU provision, along with expansion in the bed base to address the current constraints in capacity and account for future growth.
BHOC expansion	Cancer services are core to providing high quality services to the local population and to continue to develop and innovate in our specialist and regional services. Sustained growth has been experienced in haematology and oncology services over the last 5 years, supported by increased contracts with our commissioners and income growth in these areas. Additional physical capacity and modernisation of the environment is required in BHOC to respond to this growth and maintain an appropriate environment for staff and patients alongside expanding oncology service access in more local units.
Holistic Well-being Centre/Maggies Centre	Patient feedback has continued to reflect the need for an appropriate environment aligned to, but separate from, the hospital environment for patients with cancer or other long term conditions. Work is underway to progress a Maggie's Centre for our patients including a collaboration between the Trust, Maggie's and Penny Brohn charities. This programme is strategically aligned to our quality objectives, as well as our development of general and specialist cancer services.

St Michaels Hospital level E (maternity) refurbishment	Upgrade of outdated environment at St Michael's Hospital (STMH) for maternity services. Strategically aligned to providing a modern and up to date environment for our staff and patients and to achieving high quality care in our general services for the local population we serve.
Bristol Eye Hospital ground floor design	We have seen ongoing growth in Ophthalmology services over the past 5 years, resulting in contract growth with commissioners. The environment within the Bristol Eye Hospital (BEH), and particularly on the ground floor is outdated and suboptimal in layout to maximise efficient working for staff and timely throughput for patients. This scheme proposes to change the layout of areas of the BEH identified as suboptimal to enable new ways of working and models of care to improve the productivity of outpatient services, expand capacity to match increased demand and provide a modern environment for staff and patients. There is clear alignment of this programme to our current and future strategic objectives, both in relation to environment and driving productivity and efficiency and to the development of our local and specialist service offer.
Bristol Royal Hospital for Children Expansion	The delivery of local, regional and super-regional services for children is a core strand of our clinical, teaching and research agenda, both currently and for the future. Since the centralisation of specialist paediatric services, we have continued to experience growth across a number of our paediatric services. This has led to the requirement for additional space in the children's hospital and this proposal is to expand facilities in the Emergency Department, outpatients, inpatient beds and paediatric intensive care services. This will result in high quality modern environment for staff and patients, as well as enabling the future strategic development of our paediatric services.
Expansion of the Neonatal Intensive Care Unit	The provision of high quality neonatal intensive care facilities is central to the strategic development of our maternity and paediatric services portfolio. Work is currently underway with North Bristol NHS Trust (NBT) and commissioners to progress plans to collaborate to deliver safe, sustainable services for the local and regional population into the future.
Dermatology upgrade and expansion	The environment within the current dermatology department requires significant refurbishment in order to provide an adequate clinical and non-clinical environment for staff and patients. Its current location is also suboptimal, with patients experiencing difficulty in accessing the department. In addition, dermatology activity has grown significantly over the last 5 years, supported by increased commissioner contracts. This has included the transfer of activity from Weston and more recently, from Taunton. Dermatology services are core to our clinical services strategy, both in relation to general services we provide to our local population and the development of specialist work for the wider region. The proposal is to build a new and modern unit to provide the required space for the expanding service, as well as a modern environment for staff and patients.

Queen's Level 7 Ward	An additional medical ward is required on the Bristol Royal Infirmary (BRI) site to support the development of cardiology services as part of the scheme outlined (i.e. provide space within the Bristol Heart Institute (BHI) to increase cardiology ward capacity) and support resilience of patient flow in the context of increasing medical admissions. The development of medical and cardiology inpatient services is core to our provision of urgent and planned care services for our local and regional populations.
Theatre and Endoscopy facilities	Proposed review and potential redesign of the current theatre and endoscopy facilities, with a focus on Queen's Day Unit (Level 4 BRI) to support the development of endoscopy and theatre facilities.
Transport Hub	*Currently on hold pending appeal for planning permission*

Meeting of the Board of Directors in Public on Tuesday 30 July 2019 in the Conference Room, Trust Headquarters

Report Title	**Corporate Objectives Update – Q1**
Report Author	**Paula Clarke, Director of Strategy & Transformation**
Executive Lead	**Paula Clarke, Director of Strategy & Transformation**

1. Report Summary

The purpose of this paper is to provide an update to the Board on the delivery of the Trust's Corporate Objectives for Quarter 1.

2. Key points to note
(Including decisions taken)

The organisational Corporate Objectives for 2019/20 were approved in May 2019. These were written to align with the strategic priorities set out in our new Trust strategy, Embracing Change, Proud To Care – Our 2025 Vision. Our strategic priorities are:

- **Our Patients**: We will excel in consistent delivery of high quality, patient centred care, delivered with compassion.
- **Our People**: We will invest in our staff and their wellbeing, supporting them to care with pride and skill, educating and developing the workforce for the future.
- **Our Portfolio**: We will consolidate and grow our specialist clinical services and improve how we manage demand for our general acute services, focussing on core areas of excellence and pursuing appropriate, effective out of hospital solutions.
- **Our Partners**: We will lead, collaborate and co-create sustainable integrated models of care with our partners to improve the health of the communities we serve.
- **Our Potential**: We will be at the leading edge of research and transformation that is translated rapidly into exceptional clinical care and embrace innovation.
- **Our Performance**: We will deliver financial sustainability for the Trust and contribute to the financial recovery of our health system to safeguard the quality of our services for the future.

This report should be read in conjunction with the Q1 Board Assurance Framework (BAF) update, which provides assurance on the management of risks to the delivery of the Trust strategic priorities.

3. Risks
If this risk is on a formal risk register, please provide the risk ID/number.

The risks associated with this report include:
None

4. Advice and Recommendations
(Support and Board/Committee decisions requested):

- This report is for **INFORMATION**.
- The Board is asked to **NOTE** the report.

5. History of the paper
Please include details of where paper has previously been received.

Senior Leadership Team	17 July 2019

CORPORATE PLAN 2019/20

Plan Owner: Paula Clarke

Version Number/Date: V1.0 22 July 2019

Our Vision:
Anchor our future as a major specialist service and teaching centre with a reputation for excellence;
Work in partnership and where appropriate, lead, within an Integrated Care System, to extend the scope of service delivery outside our hospitals, locally, regionally and beyond;
Excel in world-class health services research and our culture of innovation

Ref	NEW Strategic Priorities	NEW Corporate Objectives 2019/20	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	**Our Patients**: We will excel in consistent delivery of high quality, patient centred care, delivered with compassion.	Deliver outstanding care evidenced through our CQC rating.	• Improve consistency of care for services rated as "requiring improvement". • Deliver on any actions arising from planned CQC review - April / May 2019.	CQC core services inspection took place 30th April - 3rd May 2019, with Well-led review following on 21-23 May. Draft report due 12th July 2019, with formal publication mid-August.			CN
		Ensure our services are responsive and achieve all constitutional access standards.	• **RTT:** The Performance team delivered trajectory compliance for 12 consecutive months in the 18/19 financial year. Whilst the 19/20 trajectory is challenging, we continue to maintain the high standards through robust monitoring at the weekly Performance meeting. • **Cancer:** With changes in the recording of cancer metrics and the delivery of the flag ship standard for 62 days cancer compliance in 18/19, across 8 of the 12 months, we have set our trajectory for 19/20 to maintain delivery of this standard on a monthly basis. The real risk to the organisation in terms of compliance is predominantly around access to HDU and ITU capacity for significant surgical interventions. Whilst late referrals from other organisations will always create some concern under the revised national standards (introduced April 2019), the performance impact of these on UH Bristol is significantly reduced. • **Diagnostics:** Diagnostic trajectories are closely monitored at the weekly Performance meeting this continues to be the more challenging standard to deliver. However the risk form August onwards will sit in a single modality which is unlikely to deliver compliance in Q3. • **ED:** As a Trust this remains our most challenged environment in which to deliver compliance due to the continued growth in 18/19 across all three ED departments. A three-stage plan has been developed that delivers a long-term investment in staff recruitment, a short term plan to bridge key pressure points during the day and a long-term view to redevelop the existing estate is currently underway.	**RTT:** April achieved 89.0% and May achieved 88.1%, which are both above the recovery trajectory of 87.9%/ June is on-track to achieve the 88% recovery trajectory. **Cancer:** April achieved 86.8% which is above the 85% target. May performance 84.4% with 2 outstanding queries. Potential to still comply but at risk. Quarter at low-moderate risk depending on how much June position improves with proper validation.		Continue to deliver RTT recovery trajectory of 87.9% at each month-end and cancer 62 day national standard of 85%. Aim for all diagnostics, excluding CT Cardiac to be delivering the 99% standard by end of Q2. CT Cardiac recovery trajectory being worked through with D&T division with the need for a robust plan to deliver the standard. ED recovery trajectory of 90.5% (Jul, Aug) and 85.6% (Sep). Urgent Care plan reviewed through UCOG and Urgent Care Steering Group	COO
				Diagnostics: April finished at 95.3% and May at 93.4%, this did not achieve the 99% standard or the recovery trajectory (96%). June is forecast to finish below standard at around 95%			COO
		Ensure that patients have access to the right hospital care when they need it and that we create effective interfaces with out-of-hospital services to discharge patients as soon as they are medically fit.	• Work with the wider system to identify and optimise the available resources of the appropriate and safe places for on going care to enable discharges to be prioritised where and when possible. • Identify challenges to patient flow and themes to be address through established weekly ED performance and flow meetings. • Increase our attendance at WSOG to ensure we have expert knowledge provided by the acute Trust to identify appropriate destination for patient discharge. • Review Delayed Transfers of Care (DToCs) with senior system partners and develop improvement targets for numbers of DToCs and bed days lost for 2019/20.	ED:April was 78.3%, May 78.0% and June 81.5%. This was below the NHSI recovery trajectory of 84.5% (Apr) and 90.5% (May,Jun). Focused work on the stranded patient reviews continued in Q1 with an increase in the number of whole system operational groups convened. The delayed patient tracking list (DPTL) was launched across the site to inform a uniformed collection of delay data across BNSSG The green to go list remained high with (on average) c.30 beds being occupied with DTOC patients Work into trusted assessment for nursing homes and a new BNSSG launch of managing expectations has been planned.		Launch of full DPTL roll out (August) Launch of the trusted assessor pilot (September) Launch of the BNSSG managing expectation policy (August)	COO
		Deliver the quality objectives outlined in our quality strategy (ensuring timely access to services; improving patient and staff experience; improving outcomes and reducing mortality; delivering safe and reliable care) supported by our Digital Hospital Programme.	• Deliver year 1 objectives of the Trust's Patient Safety Improvement Programme (2019 - 2021). • Deliver the Trust's Annual Quality Objectives and agreed 2019/20 CQUIN indicator specifications. • Develop a new Quality Strategy 2020 - 2023. • Build on current Infection Prevention & Control work, focusing on e-coli infections and achieving targets for anti-biotic use.	Patient Safety Programme 2019/20: There has been slippage in the leadership and culture and interruptions and distractions workstreams at this early stage of the programme. Others on track. Corporate quality objectives agreed and signed off by Trust Board in May 2019 as part of annual Quality Report (Account). Objectives include use of digital technology to improve patient safety. Majority of objectives are on-plan at end of Q1, as reported to CQG/SLT/QOC. Work on development of new Quality Strategy (2020-2025?) to commence in autumn 2019. 2019/20 CQUINs are not yet signed off with commissioners. Q1 baseline audits for CCG CQUINs and NHS England CQUIN triggers are underway and on track for submission date end July 2019. There is a risk of not meeting year end targets due to the delay in finalising schemes, however initial forecast remains set to achieving 80% of available CQUINs in 2019/20.			CN / MD
		Continue to develop our estate and provide a modern, nurturing environment for staff and patients.	• Develop a Culture and Arts Strategy to support patient recovery, staff and student well-being and connections with our local communities • Develop and approve business cases for the service developments in the strategic capital programme • Develop an Estates Strategy building on the Site Development Plan • Progress infrastructure investment plans	• The Trust Arts & Culture Strategy is in the final stages of development, work has been coordinated by the IDEAS group chaired by Robert Woolley. • Business cases for NICU, BEH Theatres and the Holistic cancer/Maggie's Centre were approved in Q1. alignment with 2025 Strategy Development completed with additional proposals identified for adult ED redesign, theatre refurbishment, radiology, pharmacy. • Recruitment is underway for additional resourcing for the Phase 5 Programme to undertake prioritisation and programme management of schemes. • The Estates strategy is in development and external resource has been appointed to support this. • Infrastructure investments for 2019/20 have been approved and the delivery of these is being monitored via the Trust Capital Group, reporting to the Capital Programme Steering Group.		• Arts & Culture Strategy approval - July • Phase 5 review and reprioritisation to be included in the estates strategy • Estates Strategy approval - October	DofS&T
		Place patient, staff and public engagement at the heart of everything we do.	**To be in the upper quartile performance for all national patient surveys.** **Patients:** • Continue to improve our patient experience across all services. • Complete implementation of rapid time feedback system across all sites.	As of 1/7/19, the Trust has achieved top 20% scores for the national inpatient survey (2017) and the national surveys of children and parents (both 2016). The Trust is also on the threshold of the top 20% in the national A&E survey (2016) and achieved above national average scores in the national maternity survey (2018) and national cancer survey (2017). Results from the 2018 national inpatient survey have recently been received and appear to show a continuing positive trend; results from the 2018 A&E survey are anticipate during Q2/3. Rapid time feedback screens were introduced into the BRI at the end of 2018/19 - a roll-out plan is in place to introduce feedback screens to our other hospitals during 2019/20.			CN / DoP
2	**Our People**: We will invest in our staff and their wellbeing, supporting them to care with pride and skill, educating and developing the workforce for the future.	The Strategic Workforce Plan is successfully translated into Divisional Plans against which recruitment, Education and OD deliver an improved pipeline of resource.	• Organisational development initiatives e.g. D&I strategy, leadership development demonstrably improve UHB's ability to recruit and retain valued staff. • Talent management is implemented to at least 8A and above in all Divisions, establishing clear talent pipelines and clear succession plans for the Divisional Boards.	Divisional action plans drafted and in progress		Ongoing monitoring against plans	DoP
		Difficult to fill medical roles are successfully recruited for UHB, Weston and potentially for the ICS.	• Overall vacancy rates are maintained at or below the level for 2018/19. • Appointment of Trust-wide recruitment lead for medical workforce. • Establish an international recruitment pipeline, with particular focus on hard to recruit medical/specialist roles. • Evidence that revised recruitment and selection approach has delivered a more diverse and inclusive group of new hires.	The Trust vacancy position remained below target (4.5% May 2019 against a target of 5%) during Q1. Robust recruitment plans are in place for all hard to recruit to areas and these plans include the use of international head hunters for medical and nursing posts to generate a pipeline of suitable candidates. During Q1 the Trust has managed to secure GMC sponsorship status for the Obs & Gynae department making us more attractive to international candidates. A further application is being submitted for Paediatric BMT in Q2 with other specialist areas being considered. A Clinical Talent Acquisition Manager has now been appointed and will be joining the Trust in September to help target medical & dental, nursing, AHP and scientific recruitment challenges. D&I task and finish project initiated as part of the new Trust strategy to target the resourcing elements of the strategy such as shortlisting, Job Description and advert wording to make us as an employer more attractive to a more diverse workforce.			DoP
		Unified approach to the commissioning and mobilisation of new and extended roles and the requirement for the Trust to take an organisational view and response to how new and advanced roles are supported and deployed now and in the future. The three roles are : Advanced Clinical Practitioners, Physician Associates and Nursing Associates.	SLT agreement to the roles and workforce model and the required investment.	Business case and funding for TNA's agreed . Funding approach for PA's agreed. No agreement for ACP funding.		Internal recruitment to trainee NA's over the summer with start date on course 14th October. Participate in HEE ACP survey.	DoP
		• We will excel in the provision and procurement of high-quality education that creates a highly skilled, adaptable and competent workforce for safe, compassionate care. • We will become a beacon of outstanding education with a culture of organisational learning. • We will provide education that nurtures motivation and aspirational career development. • We will champion outstanding education and support of our trainees	• Implement model for the oversight, coordination and delivery of education and a governance framework for the monitoring, visibility and quality assurance of education. Develop shared governance processes with external education providers. • Demonstrate improvement in inclusive opportunities for career development • Consistently achieve 90% plus compliance in essential training. • Ensure funding for education is equitable and transparent Evidence that trainees receive a good or excellent and supportive clinical placement experience. • Introduce motivating Induction and welcome to the Trust and provide outstanding teaching for all our trainees – average satisfaction rates of x% • Establish an apprenticeship model and delivery that meets with Ofsted standards. • Create a learning community and show evidence of national leadership of NHS education.	Governance structure now developed and part of monitoring process. External partners UoB, UWE and Weston College part of governance process. Essential training above 90% compliance with the exception of resuscitation. Impact assessment completed of resuscitation with recommendations being taken forward.		Audit of Apprenticeship delivery inclusive of off the job training. Full Business case for education to SLT. Development of an estates education strategy/project as part of phase 5. Evaluation of essential training . Ongoing implementation of education strategy .	DoP
		• Identify Talented people, manage talent pipelines and ensure robust succession plans are in place. • Lead and guide the ICS in the implementation of the national senior high potential scheme. • Implement management and leadership development for all levels of Trust management.	• Validate draft divisional succession plans using the divisional talent review data. • Pilot talent assessments and talent pipelines at senior management level (8A and above) and middle management level.	Divisions have completed succession plans which need to be validated. The Trust was successful in its bid to be part of the national pilot for talent management which commences in July		The Trust commences work with the National Leadership Academy in July to conduct a three month diagnostic phase for Talent Management. This diagnostic will be used to inform the Trust approach to Talent Management alongside the learning from the High Potential scheme which commences in October	DoP
		• Through improvements to people systems, enable manager self-service. • Continued focus on our values, leadership behaviours and staff recognition, as well as how we engage with staff, support their wellbeing and, management are listening and responding to staff concerns and suggestions. • Implement strategic workforce plan, including Trust-wide workforce initiatives for roles such as Healthcare Scientists, Nursing and Nursing Associates, Advanced Clinical Practitioners and Doctors in Training. • Implementation of Education, Recruitment and Retention, and Organisational Development and Leadership strategy to meet the in-year workforce requirements and prepare for the longer-term requirements.	• Test and prove the benefits of new roles and new workforce models, with evidence of the associated efficiencies. • Reduction in manager reliance on Employee Services and Medical HR. • Significant improvement in key HappyApp metrics. • Manager Self Service - functionality of Allocate and ESR Self Service for sickness (and other absence) recording to be reviewed by end Oct '19(?) and recommendations made • Further review based on outcome (of above) to inform whether a move to full Self Service (and ceasing of e-forms) is recommended by end March '20(?). Implementation of Microsoft 365 to enable full functionality of the revised HR Web.	Business case and funding for TNA's agreed . Funding approach for PA's agreed. No agreement for ACP funding. ESR regional lead invited to Trust end July to run through functionality of ESR Self Service		Internal recruitment to trainee NA's over the summer with start date on course 14th October. Participate in HEE ACP survey. Review to be completed, recommendations paper to be written for HR Systems Group > People group > People Committee	DoP DoP
		Deliver the ICS Healthier Together people agenda through leadership of LWAB and associated people committees to deliver the LWAB and HRDs strategic goals. Oversee successful integration of People strategy (and HR integration) with Weston.	Deliver the strategic objectives of the STP for Training, Education & Talent. Support the delivering of the STP HR Directors' goals for 2019/20.				DoP
		To drive staff engagement through positive experience of the Happy App by rolling this out to all teams, including clinical teams, by 2020.	• Introduce an 'Insights' text analysis tool to search keywords within any data range. A pre-set word cloud will feature within 5 separate categories; Emotion lens; Employers Branding; System Themes; Benchmarking and Improvement. • Supplement current dashboard report with longitudinal data analysis to help identify and deliver appropriate local engagement and improvement activities within each Division. • Develop additional report functionality over time with provider. • Deliver systematic communication and action plan to uphold high level awareness and user experience amid all occupational groups. • Target promotion to recruit hard-to-reach teams. • Consult with stakeholders to exploit opportunities to promote the Happy App and to resolve staff engagement issues raised.			Continue to increase usage by targeting 'hard to reach' areas. Working with 'insight t	DoP
		You Said, We Did	To continue to see year on year increase with staff engagement as measured by the staff survey to 7.6. To strive to be in the upper quartile for the ten themes within the staff survey. These are as follows: • Equality Diversity and Inclusion; Staff Engagement; Health and Wellbeing; Immediate Managers; Morale; Quality of Appraisal; Quality of Care; Safe Environment : Bullying and Harassment; Safe Environment : Violence; Safety Culture			Commence pilot of Talent Management, Conduct targeted FFT for Q2, Continue to run training for staff and managers on wellbeing, Deliver the key milestones in the D&I strategy for Q2	

		Deliver the Trust's vision of being 'committed to inclusion in everything we do' through implement a programme of change initiatives that realise: • Increased staff engagement resulting in improved patient care • Ensuring talent is maximised in the organisation • Our Leadership teams represent the community we serve • An inclusive approach to development; education and promotion • Greater innovation; as research shows that diverse teams are more likely increase organisational effectiveness	• Year on year improvement with data measures (to be defined). This will include: WRES, WDES and Gender Pay Gap . • Effective delivery of the strategic plan by ensuring robust governance is in place for the review and compliance with EDS2. • Increased staff forum members and increased year on year attendance on National Leadership Academy programmes including 'stepping up' • Year on year reduction in the disproportionate number of BAME staff involved in: Disciplinary & Grievance and Bullying & Harassment. • Evidence of progress towards the delivery of the National targets for recruitment in 2020. • Staff Survey year on year increase in: Percentage of staff believing that the Trust provides equal opportunity for career progression and promotion			In order to improve accountability and assurance as one of the key strategic priorities in the D&I strategy the focus for Q2 is to work with provider teams, develop a meaningful Diversity & Inclusion data set for Divisions and the wider workforce to increase awareness of activity and progress; reporting to People Committee in October.	DoP
3	**Our Portfolio**: We will consolidate and grow our specialist clinical services and improve how we manage demand for our general acute services, focussing on core areas of excellence and pursuing appropriate, effective out of hospital solutions.	Build, support and participate in networks of specialist services in south-west England, Wales and beyond with clinical academic centres of excellence for cancer, children's, cardiovascular and other services .	• Continue development of chimeric antigen receptor T-cell (CAR-T) treatment • Improve formalisation of clinical networks in children's services e.g. renal, respiratory and palliative care • Develop the Genomics Medicines Centre working with the NBT Genetic Laboratory Centre • Develop a business case for NICU services across Bristol working with NBT, the ODN and commissioners • Approve a business case for a Cardiovascular Research Unit at the BHI with UoB and BHF	• CAR-T treatment has been commissioned and is being delivered to patients at UH Bristol. • Work is underway to complete a business case to go to commissioners for approval to expand the UH Bristol critical care bed base in two phases, related to the capital works planned under the Phase 5 Capital Programme. • The Outline Business Case for NICU services has been approved by NBT and UHB Boards • The Outline Business Case for the Cardiovascular Research Unit has been approved.		• Dialogue seeking approval from commissioners for the Phase 1 expansion of critical care beds Childrens' regional network approach in development with NHSE specialised commissioners	DofS&T
		Use learning from best practice and benchmarking to inform ongoing assessment of service strategies.	Work within the Healthier Together Acute Care Collaboration to assess priorities for collaborative working based on quality, workforce, service outcome and financial measures and targeting services with resilience risks or significant variation	• Prioritisation exercise undertaken to establish the top priority clinical areas for collaborative work between the acute Trusts in BNSSG.		• ACC Strategy approved by Healthier Together - September • Clinical Practice Groups to begin to be established across all 3 acute providers	DofS&T
		Resolve internal problems that slow down patient flow which impact on the effective delivery of general and specialist care.	• Achieve further reductions in outliers for 2019/20. 15% reduction achieved 16/17 to 17/18. 2019/20 targets to be agreed. • Long Length of Stay/Stranded Patients: NHSE have a requirement on Trusts to have plans in place for a 40% reduction in the number of patients with a length of stay of 21+ days. The Trust's Discharge Team, with divisional input, have submitted initial plans to NHS England. • Length of Stay reductions to be reviewed as part of the Productivity work, as per "Achieve upper quartile productivity benchmarks across all measures" in section 6 below.	The roll out of CUR action plans across the Divisions has been completed To ensure strong outlier performance during winter 2019 an additional consultant has been secured to replicate the 2018 methodology A review of the medical take has been launched with a two phase implementation , the first is a rapid review prior to winter 2019 with a second phase of total redesign to meet patient needs through the QI Gold Programme		Undertake Phase one of the medical take Complete the divisional actions from the CUR plan Finalise the DPTL submission in full	COO
		• Implementation of Electronic Prescribing System to reduce medication errors. • Standardisation of Handover Processes between Clinical Teams to optimise communication and information flows between teams.	• Phased re-implementation of EPMA following upgrade to System C. • Implementation of Careflow Handover Module.	Reimplementation of EPMA has been delayed due to issues with System C upgrades and resilience of infrastructure. System infrastructure resilience has been upgraded and tested and in now ready. Further System C upgrades are anticipated in Q2 / Q3 which will allow re-introduction of EPMA as a rapid roll-out across the Trust. A re-implementation plan for rollout is under development to incorporate learning from previous pilots and will be presented to SLT for approval.		Delivery of System C Upgrades	CN / MD / COO
		Develop our provider to provider relationships with primary and community care, with an expectation that our teams will actively seek new ways of working together for the benefit of patients and our default as a system will become to care for people out of hospital first	• Work with new adult community services provider for BNSSG to develop the model of care for South Bristol Community Hospital rehabilitation services and opportunities to increase collaborative delivery of out of hospital care. • Establish bi-annual engagement and continuous professional development events with GP Localities. • Deliver advice and guidance services for GPs in 9 specialities, and evaluate in 2019/20 and progress plans to launch additional specialties via the STP Outpatient Programme Board. • Develop Eye Care Strategy for BNSSG working with commissioners and community optometrists • Contribute to the development of Healthier Together Integrated Care localities and Primary Care strategies	• Confirmed with CCG maintenance of current services at SBCH for minimum 2020/21 and actions to inform development of future models • Agreement with OneCare GP organisation to co-fund a pilot Associate Medical Director for Primary Care • Input into the early stages of Healthier Together Primary Care strategy • Successful UH Bristol tender awarded for Optometrist input into referral management triage pilot with BNSSG CCG as part of 19/20 Eye Care Strategy • Scoping of pilot for Eye Hospital Urgent Care Advice and Guidance telephone line undertaken as part of the 19/20 Eye Care Strategy • Development of evaluation framework for Advice and Guidance services currently in delivery		• New community service provider to be confirmed mid July - meeting to be arranged by September to confirm sub contracting arrangements and develop relationships • Third Primary care engagement workshop July including all acute providers and focussed on frailty models of care • AMD primary care post recruited • Mobilisation of optometrist referral management pilot • Business case for Eye Hospital Urgent Care Advice and Guidance line developed with CCG and recommendation made for invest to save pilot. • Development of standardised responses across providers (haematology, cardiology, rheumatology, dermatology) • Development of protocols, guidance and education to be uploaded to REMEDY for top A&G requests	DofS&T
4	**Our Partners:** We will lead, collaborate and co-create sustainable integrated models of care with our partners to improve the health of the communities we serve.	Continue to lead and support the BNSSG Healthier Together Partnership to progress towards an integrated care system by 2021, with the aim of making BNSSG "Outstanding".	• Provide a lead role in developing the Healthier Together 5 year Plan by autumn 2019 • Contribute to delivery of a single system plan for 2019/20 to address the three key challenges that the system has agreed to focus on: urgent care, workforce sustainability and financial recovery	• Early in Q1 the BNSSG System agreed and submitted its first whole system plan for 2019/20. This was amended and resubmitted in May following feedback from NHSE and NHSI and associated Financial Recovery Plan developed • Full UHB engagement in system-level planning and design groups. • The System Delivery Oversight Group (SDOG) and System Planners Group have revised their terms of reference and refocussed to deliver the 5 year plan		• Agree the detailed plan for development of the 5 year plan and submit first draft by September Strategic planning approach to modelling a 3 year breakeven system plan to be agreed • Agree an improved approach to system planning for the 2020/21 planning round	DofS&T
		Develop the Clinical Practice Group Programme and links with Bristol Health Partners and the BNSSG Clinical Cabinet to review existing pathways and design and implement optimal pathways with minimal unwarranted variation across the sector.	• Formation of further CPGs. • Design and implementation of new pathways. • Engage and support the BNSSG Clinical Cabinet to agree how we improve value from our combined resources and target unwarranted variation in outcomes for our populations	Introduction of CPG Programme continues to progress. Successful engagement event held with WHAT with agreement to jointly progress programme and potential clinical / managerial leaders identified. Joint Clinical Sponsorship Board established with NBT which is identifying and supporting further opportunities for the CPG Programme to optimise care pathways and reduce variation across the two Trusts. BNSSG Clinical Cabinet aware of Programme although Primary Care involvement still minimal.		Creation of new CPGs across sector.	MD
		• Implement the ReSPECT Process within UH Bristol and work with our partners to implement across the sector. • Develop a sector-wide Medical Examiner model that is responsive and consistent.	• Implementation of ReSPECT documentation. • Development of Medical Examiner model and recruitment to posts by March 2020.	Sector-wide commitment to implement RESPECT Process in Q3 reached. Communication Package agreed for Trust staff. Electronic training module and funding source identified and in process of being placed on Kallidus. Medical Staff Induction Day being modified to incorporate necessary training. Joint sector-wide approach to implementation of Medical Examiner Model agreed with Coroner, NBT and WAHT. Job Description and Funding for Project Manager agreed with advertisement in process. Initial cohort of potential Medical Examiners identified.		Implementation of RESPECT Process.	CN / MD
		Commit to the vision and principles of the BNSSG Acute Care Collaboration Strategy, further developing our partnerships with Weston Area Health NHS Trust and North Bristol NHS Trust to support improved outcomes for our populations and our collective clinical and financial sustainability	• Lead the development of an Acute Care Collaboration Strategy for BNSSG • Implement a Clinical Sponsorship Board with NBT to align clinical strategies that ensure high quality and consistent clinical services offer for local and regional populations • Successfully progress our formal partnership with Weston Area Health Trust and actions to complete the planned merger by April 2020 with a focus on clinical practice group development and corporate support integration	Programme office set up to progress the merger case with WAHT with the Partnership Management Board continuing in advance of merger. Formal Clinical Practice Group launch event held on 27th June. Progress being made with Weston at specialty level and accreditation process to support specialties in development. Formal Clinical Sponsorship Board with NBT now in place. Quarterly meetings have been established with agreed ToR. The first 2 meetings have taken place.		• ACC Strategy approved by Healthier Together - September • Significant work will be undertaken in Q2 to develop the Full Business Case for the merger with WHAT for approval in Q3	DofS&T
		Recruit to Well Being Programme	Establish Programme and confirm on-going funding if successful. Monitor via staff survey				CN / MD
		Actively pursue opportunities to work more effectively and creatively with our voluntary sector and charitable partners	• Work with charitable partners to support delivery of our corporate objectives and specifically our strategic and operational capital plans and providing opportunities for our staff to improve the care they deliver. • Develop a sustainable model for continuing to work with young volunteers/deliver the volunteering strategy objectives	• As more business cases are approved for the Phase 5 Capital Programme, formal work has continued with Above & Beyond and the Grand Appeal to confirm charitable contributions and fundraising timetables for the capital programme. • Following completion of the 2019/20 business planning round, processes are being revised for the 2020/21 round and the plan is to include specific processes to apply for charitable funding.		• Establish monthly meetings with charities re Phase 5 Programme • Confirm charitable funding for Phase 5 programme	DofS&T
5	**Our Potential:** We will be at the leading edge of research and transformation that is translated rapidly into exceptional clinical care and embrace innovation.	• Encourage clinical appointments that mirror and complement our current research programmes. • Ensure all new substantive appointments are contacted within three months and advised of research opportunities and seed funding. • Actively participate in the new ARC.	• Number of new appointments who are contacted by R&D within 3 months of appointment. • Number of clinicians actively engaged in research.	New process for identifying new appointments confirmed. Discussions with University underway to review joint clinical academic appointments as appropriate. Joint Appraisal mechanism for Clinical Academics under development. Ongoing Trust involvement with LCRN and BHP - outcome of ARC application still awaited.			MD
		Use technology and our digital capabilities to transform where and how we deliver care, education and research and maximise the opportunity provided by our successful appointment as a Global Digital Exemplar site	• Deliver the 2019/20 Transforming Care priorities related to digital hospital transformation • Embed the digital hospital benefits strategy across the Trust • Communicate the benefits delivery widely to the organisation, ensuring lessons learned are logged and shared.	• Continued delivery of key digital transformation projects: Improving Handover with Careflow being rolled out across BRHC and medical teams; scoping stage for designing real time bed management system • Digital hospital benefits strategy approved • Continued working with NHS Digital to implement the digital hospital benefits strategy • BHOC benefits published in Voices magazine		• Ongoing delivery of digital hospital transformation • Communication of benefits delivery for key projects to staff	DofS&T
		Continue to develop and deliver our Transforming Care programme to support achievement of our strategic ambitions	• Transforming Care priorities and actions agreed for 2019/20 with a continued focus on working smarter, digital transformation and building quality improvement capacity and capability • Develop an Innovation and Improvement Strategy	• Transforming Care priorities and actions for 2019/20 agreed by SLT, project plans being developed for new projects (outpatients transformation and clinical pathways development) by Transformation Team leads. • Improvement, Transformation & Innovation Strategy - drafting commenced		• Improvement, Transformation & Innovation Strategy first draft being presented to Transformation Board and Board Seminar July 19 • Improvement, Transformation & Innovation Strategy approved by Board of Directors September 19	DofS&T
		Provide our staff with improvement skills and capabilities through our QI Academy and create an environment that makes it easy to innovate within organisation through our QI Hub	• Develop the QI Gold programme and commence training aligning projects to organisational objectives • Celebrate achievements and share learning through an annual QI Forum • Create an innovation fund to support staff to develop good ideas, supported by our charitable partners in Above & Beyond	• Curriculum for QI Gold programme and governance developed, and approved by Transformation Board • Funding to support innovative ideas secured from Above & Beyond and West of England Academic Health Science Network, to support Bright Ideas competition		• QI Gold programme launched, with call for 6-7 projects from across divisions • QI forum held 12th July 2019, showcasing 73 improvement projects across the Trust • Bright Ideas competition launched	DofS&T
		• Develop a central repository for all external GIRFT reviews. • Ensure each review results in a deliverable action plan. • Monitor compliance with action plans on a 6 monthly basis.	• Development of database. • Development of action plan monitoring process.	Meeting held with GIRFT Team to review processes going forward. Central repository for GIRFT outputs under construction. Governance of GIRFT Programme within Trust under Review.		Creation of central GIRFT repository	MD
		• Act as the host organisation for the LCRN and continue to improve our working relationship and reporting structure. • Ensure all new substantive appointments are contacted within three months and advised of research opportunities and seed funding	• Continued improvement in LCRN performance metrics. • Number of clinicians actively engaged in research	Relationship with LCRN re-established with reporting mechanisms into SLT and Trust Board confirmed. LCRN Strategy under development. Demonstrable improvement in LCRN metrics in Q4 of 2018/19.		Improved LCRN Metrics	MD
6	**Our Performance:** We will deliver financial sustainability for the Trust and contribute to the financial recovery of our health system to safeguard the quality of our services for the future.	Work smarter not harder, by eliminating waste and ensuring we add value from every action we take, however small, to maintain our financial health in the context of severe local and national financial pressures	• The Trust has a productivity programme using GIRFT, Model Hospital, CUR, SLR and other benchmarking data embedded within the Divisional Savings Plan; the target for the year is £5.536m. • Target is split by Division as follows: Diagnostics and Therapies (£368k), Medicine (£544k), Specialised Services (£685k), Surgery (£2050k), Women's and Children's (£1,768k), Trust Services (£91k), Estates and Facilities (£31k).	Quarter 1 planned savings are £1533k, actual savings £1163k, adverse variance £370k. 76% achievement. Productivity projects within the Division of Surgery, under-achieving year to date.		Performance is discussed at the Divisional monthly finance and operations reviews and cost savings delivery board. Performance against plan is scrutinised with plans sought to ensure variance against plan is corrected.	COO
		Achieve upper quartile productivity benchmarks across all measures utilising the benchmarking and productivity information available to us through Getting It Right First Time (GIRFT), the Model Hospital and other programmes	• Embed the Working Smarter programme into Divisional "business-as-usual", making improvement everyone's business • Continue programme of service line reporting reviews.	2019/2020 Q1 not published yet.		Performance is discussed at the Divisional monthly finance and operations reviews and cost savings delivery board. Performance against plan is scrutinised with plans sought to ensure variance against plan is corrected.	COO
		Evaluate the financial sustainability of all clinical services with the aim of moving Reference Cost Index to below 100 for all	• Clear comprehensive costing information available in timely manner accessible and understood by divisional leads • Prioritised reports / deep dives for outlying services • Work with other Trusts on selected specialities				DoF
		Secure contracts with commissioners which reflect demand and work with partners to reduce costs across the system through pathway redesign	• Finalise 19 / 20 contract • Focus on 20 / 21 contractual arrangements as part of system including CCGs and Specialist Commissioning. • Align £, people and service delivery within contract planning • Work STP partners to agree financial principles to support the 5 year plan	• NHS Long term plan implementation framework published informing 5 year planning assumptions and development of system goals / priorities • 19/20 contracts finalised to confirm in year delivery plan		• 1st draft BNSSG system plan submitted by 15th September 2019	DoF / DofS&T
		Increase our income through innovative commercial approaches	• Explore opportunities to expand our income using learning from the NHS Commercial Directors Forum and benchmarking	Further scoping of commercial opportunities using learning from SW Commercial Directors' network, focusing on pharmacy manufacturing unit, advertising opportunities and hosting fire training		• Consultancy appointed to scope options for Pharmacy Manufacturing Unit • Proposal for income generation developed and presented to SLT	DofS&T

Meeting of the Board of Directors in Public on Tuesday 30 July 2019 in the Conference Room, Trust Headquarters

Report Title	**Finance Report**
Report Author	**Neil Kemsley, Director of Finance and Information and Dean Bodill, Senior Assistant Director of Finance**
Executive Lead	**Neil Kemsley, Director of Finance and Information**

1. Report Summary

This report will inform the Finance Committee of the financial position of the Trust for June and provide assurance on the delivery of the Core Control total.

2. Key points to note
(Including decisions taken)

- The plan for June required a Core (i.e. excluding Provider Sustainability Funding (PSF) and MRET) deficit of £0.389m, and a total surplus (including PSF and MRET) of £1.209m before technical items.
- The Trust is reporting a deficit of £0.377m to date excluding technical items, which is £0.012m favourable to plan. The main areas of concern are
    - Activity under-performance of £1.269m year to date
    - Nursing overspending of £1.579m year to date.
- PSF funding is shown as achieved for the quarter. It is expected that the year-end control total will be achieved as mitigating actions to improve activity delivery and reduce pay overspending are taken.
- The reported favourable variance of £0.012m is due to:
    - Divisional and Corporate overspends of £2.063m,
    - Corporate share of income under performance £0.045m, offset by
    - Financing underspends of £0.087m
    - Release of Corporate Reserves of £2.033m
- The Divisional and Corporate Services deficit in June is £2.063m, compared to £1.293m last month, a deterioration of £0.770m.

3. Risks
If this risk is on a formal risk register, please provide the risk ID/number.

None

4. Advice and Recommendations
(Support and Board/Committee decisions requested):

- This report is for **INFORMATION**.
- The Board is asked to **NOTE** the report.

5. History of the paper
Please include details of where paper has previously been received.

Finance Committee	25 July 2019

Section 1 – Executive Summary

	2019/20 Annual Plan	Income / (Expenditure)		Variance
		Plan to date	Actual to date	Favourable /(Adverse)
	£m	£m	£m	£m
Corporate Income	656.563	161.491	161.446	(0.045)
Divisions & Corporate Services	(603.234)	(150.875)	(152.938)	(2.063)
Financing	(36.161)	(8.972)	(8.885)	0.087
Reserves	(14.575)	(2.033)	-	2.033
Surplus/(deficit) excl PSF	**2.593**	**(0.389)**	**(0.377)**	**0.012**
PSF Core Funding	9.576	1.436	1.436	-
MRET Funding	0.646	0.162	0.162	-
Prior Year PSF Post Accounts Allocation			0.710	0.710
Surplus/(deficit) incl PSF	**12.815**	**1.209**	**1.931**	**0.722**

- The annual plan is to deliver a core control total surplus of £2.593m, receive Provider Sustainability Funding (PSF) and MRET funding of £10.222m, with a total surplus of £12.815m.
- The annual plan reflects the resubmission to NHS Improvement on 23rd May, updated to reflect further contractual changes with commissioners. As the contracts have not yet been signed, there remains risk to this plan. In particular the urgent care income does not reflect the blended tariff approach which has not been finalised. A normal Payment by Results contract has been assumed instead (which is the default arrangement).
- In June the Trust moved to latest contract proposals which include a local price review, which is neutral at the bottom line for both commissioners and Trust.
- The plan for June required a core i.e. excluding Provider Sustainability Funding (PSF) and MRET deficit of £0.389m, and a total surplus (including PSF and MRET) of £1.209m.
- The Trust is reporting a deficit of £0.377m to date excluding technical items, which is £0.012m favourable to plan.
- PSF funding for quarter 1 is shown as achieved. Based on the current forecast it is expected that the year-end control total will also be achieved.
- The Trust has received a prior year allocation of PSF of £0.710m. This residual 2018/19 bonus has a cash benefit but will not be taken into consideration in measuring performance against 2019/20 control totals.
- The Divisional and Corporate Services deficit of £2.063m follows an in month deterioration of the clinical divisions of £0.770m. This deficit has been supported by the release of non-recurrent reserves linked to prior year income.
- The adverse variances in Diagnostics and Therapies and Women's and Children's are expected to improve if activity can be increased.
- Medicine and Surgery remain of concern in terms of ability to deliver the Operating Plan. Surgery's in month deterioration of £0.509m takes the year to date adverse variance against budget to £1.168m. The ability to deliver activity going forward is of great concern partly due to capacity pressures. Medicine's deterioration against budget of £0.182m in month is due to income underperformance and continued pay overspending. Within Medicine concern remains in particular around the run rate of overspend on Junior Doctor's pay.
- A range of key actions that will contribute to towards improved financial control and performance are summarised in the body of this report.

Section 2 – Division and Corporate Services Performance

Performance by Division and Corporate Service Area:

The table below shows the movement in cumulative variance in the last month and the variance against Operating Plan trajectory.

	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	(0.039)	(0.017)	(0.056)	0.139	(0.195)
Medicine	(0.320)	(0.182)	(0.502)	(0.160)	(0.342)
Specialised Services	0.013	0.188	0.201	0.096	0.105
Surgery	(0.659)	(0.509)	(1.168)	(0.183)	(0.985)
Women's & Children's	(0.311)	(0.096)	(0.407)	0.140	(0.547)
Estates & Facilities	(0.009)	(0.004)	(0.013)	0.009	(0.022)
Trust Services	0.003	(0.036)	(0.033)	(0.011)	(0.022)

- In June the aggregate position deteriorated by £0.770m to give a year to date adverse variance to budget of £2.063m.

- The average deficit for the last six months of 2018/19 was circa £0.550m per month. In 2019/20 the monthly adverse variances have been higher at £0.574m for April, £0.719m for May and £0.770m for June.

- Medicine is £0.502m adverse to budget. Income from Activities is £0.063m adverse, pay is £0.948m adverse of which £0.747m is in nursing and £0.389m medical staff. This is offset in non-pay mainly through the release of funding following contract transfer.

- Surgery is £1.168m adverse to budget. Pay is £0.647m adverse of which £0.254m is medical and dental and £0.321m is nursing. Income from Activities is £0.943m adverse with £0.284m within Dental and £0.380m Trauma and Orthopaedic.

- Women's and Children's is £0.407m adverse to budget. Pay is £0.578m adverse of which £0.306m relates to nursing and midwifery. Income from Activities is £0.267m adverse, an improvement from May. Neurosurgery activity which is low volume, high value, is below plan accounting for £0.209m, though it was above plan in June.

  Action: Meetings have been arranged for Medicine and Surgery Divisions between the Divisional Directors, Divisional Finance Managers, Director of Finance, Head of Financial Management and Chief Operating Officer to review the current risks and consider further mitigations that will support delivery of the Operating Plan.

Diagnostic and Therapies

Diagnostics and Therapies reports a year to date adverse variance of £0.056m which is £0.195m adverse to the Operating Plan trajectory. The key reason for the position is an adverse variance on Income from Activities of £0.087m which includes the Division's share of adverse variances in other Divisions £0.178m. For services hosted by the Division, Audiology services are reporting an adverse variance on of £0.109 to date offset by other over performances within the Division including Radiology which is £0.116m favourable year to date. Within the year to date position adverse variances on non-pay of £0.221m are offset by a favourable variance on pay £0.243m which is largely accounted for by vacancies.

- **Key Action:** The Division is securing locum staff to address the underperformance in Audiology. The Division confirms this will claw back most of the shortfall to date and enable achievement of contracted activity going forward.

Medicine

An adverse variance in month of £0.182m resulting in a cumulative adverse variance of £0.502m. Pay was £0.327m adverse in month, of which £0.219m relates to nursing and £0.122m to medical pay. Income from Activities under performed this month by £0.132m, of which £0.153m related to emergency inpatients, resulting in a cumulative under performance of £0.063m.

The Division is £0.342m adverse to its Operating Plan trajectory. Income is £0.066m adverse to planned trajectory following an adverse performance in June. Nursing pay is £0.240m adverse to trajectory, due to higher than budgeted enhanced care costs, increased capacity, increased agency usage in ED and higher than planned levels of vacancies and sickness requiring higher than planned agency costs. Medical pay is £0.148m adverse to the Operating Plan trajectory, £0.003m on consultants and £0.145m on other medical staff, driven by high levels of sickness and maternity leave and pressures in ED. Non-pay in total contributes a favourable variance of £0.130m, with a favourable variance of £0.093m on drugs.

Key Actions:

- Nursing – Ongoing review of implementation of ECO policy, Focus on recruitment. Review of alternative staffing options for additional capacity.
- Medical Staff – The Division has established a medical staff controls group to focus on and address areas of adverse variance and address rota gaps. Recruitment of physician associates in order to reduce high cost locum spend.
- SLA Performance – Additional clinic capacity has been established and is due to come on line in August to support recovery of elective performance for example in Dermatology.
- Divisional Working Smarter/ Productivity – working group established and focussing on identifying and implementing additional productivity/savings schemes.

Surgery

An adverse variance to budget in month of £0.509m resulting in a cumulative adverse variance of £1.168m. Pay deteriorated by £0.207m in June (and is £0.647m adverse to date). Medical pay has an adverse in month variance to budget of £0.097m taking the cumulative total to £0.254m. These levels of adverse variance are lower than in 2018/19 due to reduced levels of premium payments to date. Nursing was £0.112m adverse in month resulting in a £0.321m adverse variance year to date, pressures in Adult CICU are the main driver for this.

Non-pay improved by £0.124m and is £0.463m favourable to date. Key drivers for the favourable position are the allocation of contract transfer funding to non-pay in order to rebase adverse variances from 2018/19 and lower activity levels so far this year.

Income from Activities reported an adverse variance in month of £0.420m resulting in a cumulative under performance at £0.943m. There has been significant underperformance against contract in Oral/Dental services £0.284m, Ophthalmology £0.187m and Trauma and Orthopaedics £0.380m.

The Division is £0.985m adverse to its Operating Plan trajectory. Income is £0.996m adverse as a consequence of significantly lower than planned activity partly due to a high number of elective cancellations in the BRI and Ophthalmology. Outpatient work in the Dental Hospital has been lost due to medical staff vacancies which are now being recruited to. Nursing pay is £0.189m adverse due to pressures in ITU as well as higher than planned agency and bank in theatres and some wards. Non-pay is favourable to the Operating Plan by £0.263m, clinical supplies being £0.261m favourable. The non-pay position is different to the previous year partly due to additional funding being allocated to non-pay as part of the utilisation of the

increased funding through contract for 2019/20 and partly due to the low levels of activity in the first three months of the financial year.
Key Actions:

- Nursing – Appointment of additional nursing recruitment resource to help with filling vacant posts and avoiding high cost agency staff particularly in GICU the area of most significant adverse variance.
- Medical Staff – Ensuring timely recruitment to vacant posts to recover and improve activity delivery i.e. Dental and Ophthalmology.
- SLA Performance – Exploring ways of increasing capacity to avoid cancelled operations. Reviewing adverse position in Dental and Ophthalmology and introducing actions plans to address these shortfalls.
- Divisional Working Smarter/ Productivity – working group established and focussing on identifying and implementing additional productivity/savings schemes.
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Specialised Services

A favourable variance in month of £0.188m resulting in a cumulative favourable variance of £0.201m. Income from Activities is £0.199m favourable to plan which includes an adverse variance in Cardiology of £0.289m offset by favourable variances in other specialties. Pay is £0.376m adverse to plan year to date with adverse variances in medical staff of £0.210m and nursing £0.113m.

The Division is £0.105m favourable to its Operating Plan trajectory. This includes favourable variances on income £0.156m and non-pay £0.236m being offset by an adverse variance on pay £0.287m.

Women's and Children's

An adverse variance of £0.096m in month resulting in a cumulative adverse variance of £0.407m. In month an improved performance on Income from Activities of £0.087m takes the cumulative performance to £0.267m adverse to plan. The key areas of underperformance to date being Neurosurgery £0.209m adverse, Accident and Emergency £0.223m adverse and Oncology and Haematology £0.115m adverse. This is offset by favourable variances in other areas including BMT £0.240m favourable. Pay deteriorated by £0.267m in June, of which £0.092m related to nursing and £0.129m to medical staff. Pay is £0.578m adverse to date.

The Division is £0.547m adverse to its Operating Plan trajectory. Income is £0.349 adverse to the Operating Plan, medical pay is £0.104m favourable to the Operating Plan, nursing pay is adverse to plan by £0.219m. Non-pay is adverse to the Operating Plan trajectory by £0.043m with a favourable variance on clinical supplies £0.120m offsetting small adverse variances on drugs and other expenditure.

Key Actions:

- SLA Performance – The Division is focussed on delivery of contracted volumes after a slow start to the year – particularly in April. June showed and improvement in run rate and the Division expects delivery of contract volumes to improve over the coming months.
- Nursing – The Division has held a successful recruitment campaign for nurses and this is expected to have a positive impact in reducing the nursing adverse variance run rate in the next few months, particularly by reducing high cost agency usage.

Section 3 – Division and Corporate Services Performance continued

Performance by subjective heading

Subjective	Monthly Average 2018/19 £m	2018/19 Outturn £m	April 2019 £m	May 2019 £m	June 2019 £m	2019/20 To date £m
Nursing & midwifery pay	(0.504)	(6.052)	(0.604)	(0.491)	(0.484)	(1.579)
Medical & dental pay	(0.405)	(4.863)	(0.360)	(0.187)	(0.445)	(0.992)
Other pay	0.101	1.208	0.242	0.197	0.109	0.549
Non-pay	(0.489)	(5.865)	0.954	0.189	0.356	1.499
Income from Operations	0.007	0.085	(0.173)	(0.094)	(0.002)	(0.269)
Income from Activities	0.713	8.555	(0.632)	(0.336)	(0.301)	(1.269)
Total	**(0.577)**	**(6.932)**	**(0.573)**	**(0.722)**	**(0.767)**	**(2.062)**

- Nursing pay continues to overspend in the early months of 2019/20 as it did throughout 2018/19, with the average overspend being similar to that seen in the previous financial year. June reported a very similar variance to that seen in May.
- Medical and dental pay has also overspent in the first months of 2019/20 but to a lesser extent than the run rate for 2018/19 following additional funding linked to anticipated activity delivery. Of the £0.992m overspend year to date, £0.389m is within Medicine Division, £0.254m is in Surgery with £0.210m in Specialised and £0.179m in Women's and Children's. These are offset by an underspend in Diagnostics and Therapies.
- Other pay areas continue to underspend notably in Diagnostics and Therapies.
- Non-pay variance is favourable year to date, although it must be recognised that activity has been lower than plan reducing clinical supplies expenditure and non-recurrent support funding sits mainly within these subjectives.
- Income from Operations has an adverse variance, primarily in Research which has been offset by reduction in expenditure.
- Income from Activities is behind plan due to reduced activity, particularly in Surgery, where cancellations of elective inpatient activity and reduced outpatient activity caused an £0.542m adverse variance, with the year to date Surgery income from activities being £0.719m adverse.

Section 4 – Subjective Analysis Detail

a) Nursing (including ODP) and Midwifery Pay

Favourable/ (Adverse)	Monthly Average 2018/19	18/19 Outturn £m	April 2019 £m	May 2019 £m	June 2019 £m	2019/20 To date £m
Substantive	0.891	10.713	0.742	0.818	0.956	2.516
Bank	(0.814)	(9.788)	(0.740)	(0.770)	(0.871)	(2.381)
Agency	(0.581)	(6.978)	(0.606)	(0.539)	(0.569)	(1.714)
Total	**(0.504)**	**(6.053)**	**(0.604)**	**(0.491)**	**(0.484)**	**(1.579)**

- Nursing pay variance (including ODP's) was £0.484m adverse in the month. The largest in month overspend was in the Medicine Division at £0.219m in June compared to £0.257m in May and an average run rate of £0.141m in 2018/19. The position in June did reflect the fourth consecutive month where total costs of nursing staff reduced but continued pressures in ED, Ward A512 remaining open and the cost of the enhanced supervision pool remain a risk to delivering the planned position. Medicine's June overspend was driven by; the Trust-wide Enhanced Supervision Pool, £0.052m, sickness cover, £70k, and vacancy cover £0.116m. Surgery's £0.155m overspend (inclusive of ODP's) in June takes the annual position to £0.457m. The main drivers being extra capacity remaining in QDU (still open), patient acuity in ITU, and additional working. Specialised Services and Women's and Children's overspent by £0.043m and £0.096m respectively.

- Nursing budgets on wards are set with a 20% allowance for unavoidable time lost as a result of training (2%), sickness (3%) and annual leave (15%). However, it is possible to be within the 20% allowance in terms of hours worked and still be over budget if the staff used to cover the shifts are at a premium cost.

- In June the nursing lost time percentage for inpatient staff numbers (i.e. wte/hours worked) was 124%, which is 4% over the 120% allowance. Medicine was the highest at 126%, Women's and Children's services were both at 124%, closely followed by Surgery at 123%. Only Specialised Services remained within the wte budget allowance at 119%. This accounts for £1.167m of the year to date adverse variance.

- Sickness for registered staff remained similar to levels in April and May though there was an increase in Women's services taking it above planned levels. Medicine were the only Division with lower than plan sickness for this staff group. Unregistered staff sickness was again above plan in all areas, with the exception of Children's services. Specialised showed a slight decrease but all other areas worsened compared to May.

- Vacancy levels remain significantly higher than plan for registered nurses for all but Women's and Children's. Women's and Children's remain below vacancy targets for registered nurses. Unregistered staff vacancies remain significantly above plan in Surgery and Specialised, though Surgery reduced from 15.1% in May to 11.0% in June. The other areas are either within plan or just slightly (less than 1%) above.

- Total enhanced observation costs for June were £0.231m an improvement of £0.043m compared to May. Pressure is predominately seen in Medicine although there was a cost reduction in month compared to April and May. The run rate remains significantly above plan at £0.129m average per month.

Action: An established Nursing controls group meets monthly to review and challenge any adverse nursing variances. Each Divisional Head of Nursing produces a monthly report explaining adverse variances and actions being taken to address these including adverse lost time variances.

Specific actions include; full review of the ECO policy and its application across the Trust, action to coordinate across BNSSG to avoid high cost agency, appointment of additional recruitment resource, ongoing review of variation on lost time and price volume variances and actions.

Section 4 – Subjective Analysis Detail continued

b) Medical and Dental Pay

Favourable/ (Adverse)	Monthly Average 2018/19 £m	2018/19 Total £m	April 2019 £m	May 2019 £m	June 2019 £m	2019/20 To date £m
Consultant						
− substantive	0.093	1.117	0.131	0.169	0.074	0.374
− add. hours	(0.198)	(2.378)	(0.147)	(0.146)	(0.157)	(0.450)
− locum	(0.065)	(0.778)	(0.036)	(0.020)	(0.040)	(0.096)
− agency	(0.032)	(0.389)	(0.059)	(0.066)	(0.077)	(0.202)
Other						
− substantive	0.115	1.381	0.078	0.165	0.150	0.393
− add. hours	(0.143)	(1.720)	(0.127)	(0.125)	(0.159)	(0.411)
− penalty exception	(0.001)	(0.013)	0.000	(0.001)	0.000	(0.001)
− locum	(0.148)	(1.772)	(0.144)	(0.143)	(0.151)	(0.438)
− agency	(0.026)	(0.311)	(0.056)	(0.020)	(0.085)	(0.161)
Total	**(0.405)**	**(4.863)**	**(0.360)**	**(0.187)**	**(0.445)**	**(0.992)**

- The adverse medical pay variance in year to date is £0.992m which is slowing of the run rate from 2018/19.
- The in month position was an adverse variance of £0.445m, the worst to date in 2019/20 financial year returning to levels seen through the latter part of 2018/19. This reflected an uplift in actual expenditure for a number of Division.
- The largest in month overspend was within Women's and Children's for the first time in the year reflecting increased expenditure which included some arrears payments for Consultants recharged from other Trusts.
- Medicine's adverse variance was £0.122m in June (£0.389m year to date), this is mostly on 'other medical staffing' which was £0.096m adverse in the month. This reflects an increase in actual costs for agency cover on rota gaps and locum costs in particular in Emergency Department and also high costs for less than full time trainees.
- Surgery's adverse variance was £0.097m in June, £0.075m of which was on 'other' medical staff posts. This reflects premium costs to cover rota gaps in general and trauma services as well as covering more general vacancies. Additional funding was targeted to the Consultant budgets following the contract transfer reducing the overspend to date. Alongside this, lower activity has reduced the cost of premium payments.
- Specialised Service's adverse variance worsened in month reporting £0.109m mainly on other medical staff lines where the premium cost of locum cover on vacancies is the significant driver.
- **Action**: The Medical and Dental Steering Group has been re-established and will bring much clearer focus and attention to dealing with adverse medical staffing variances. The initial focus will be on clearer controls for job planning, rostering and leave management.

Section 4 – Subjective Analysis Detailed continued

c) Non-Pay

Favourable /	Monthly Average 2018/19 £m	2018/19 Outturn £m	April 2019 £m	May 2019 £m	June 2019 £m	2019/20 To date £m
Blood	(0.021)	(0.249)	(0.028)	(0.011)	(0.007)	(0.046)
Clinical supplies & services	(0.248)	(2.977)	0.236	0.171	0.039	0.446
Drugs	(0.063)	(0.753)	(0.066)	0.012	0.068	0.014
Establishment	(0.014)	(0.173)	0.031	(0.018)	(0.018)	(0.005)
General supplies & services	0.001	0.014	0.030	(0.007)	0.037	0.060
Outsourcing	(0.041)	(0.488)	(0.036)	(0.038)	(0.097)	(0.171)
Premises	(0.029)	(0.348)	(0.026)	0.015	(0.085)	(0.096)
Services from other	(0.100)	(1.204)	0.057	(0.064)	(0.012)	(0.019)
Research	(0.009)	(0.106)	0.083	0.032	(0.008)	0.107
Other non-pay	0.035	0.419	0.673	0.097	0.440	1.210
Total	**(0.489)**	**(5.865)**	**0.954**	**0.189**	**0.357**	**1.499**

- The favourable position of £1.499m year to date continues to reflect underspends on most clinical Divisions following money allocated into non-pay reserves after the contract transfer for the year and lower activity levels than planned.
- The underspend on Clinical Supplies & Services is mainly in Specialised Services and Surgery year to date, but with a slowing run rate of underspend in June. For Specialised this reflects increasing activity.
- Adult Cardiology continues to over-perform against cost improvement schemes.
- Outsourcing was lower in April and May than at the end of 2018/19, but has risen slightly in June to £0.097m adverse with increased activity for Specialised Services.
- Other expenditure includes a £0.180m favourable variance relating to the Bowel Cancer Screening Service but the majority of the favourable variance seen is driven by non-pay budgets held on reserve lines awaiting allocation or being used to support the financial position on a non recurrent basis.

Section 5 – 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	(0.028)	5.868	5.811	(0.057)
Bone Marrow Transplants	(0.062)	2.050	2.210	0.160
Critical Care Beddays	0.340	13.967	14.497	0.529
Day Cases	(0.143)	10.103	10.053	(0.051)
Elective Inpatients	(0.263)	14.966	14.096	(0.869)
Emergency Inpatients	(0.478)	27.795	27.244	(0.552)
Excess Beddays	(0.119)	1.588	1.320	(0.268)
Non-Elective Inpatients	0.265	8.308	8.419	0.112
Other	(0.025)	17.772	17.442	(0.330)
Outpatients	0.252	20.081	19.926	(0.155)
Total Activity Based	**(0.261)**	**122.498**	**121.018**	**(1.481)**
Contract Penalties	0.003	(0.342)	(0.411)	(0.069)
Contract Rewards	0.000	1.377	1.377	0.000
Pass through payments	0.713	20.925	21.914	0.989
Prior Year Income	0.000	0.616	0.616	0.000
Other	(0.136)	7.580	7.926	0.347
PSF Funding	0.000	1.436	1.436	0.000
Prior Year PSF Allocation	0.710	0.000	0.710	0.710
2019/20 Total	**1.029**	**154.090**	**154.586**	**0.496**

- Activity based income was £0.261m adverse in June, resulting in a £1.481m adverse position year to date.
- Elective inpatients are £0.869m below plan to date, of which £0.392m is within Surgery and £0.273m in Specialised Services.
- Emergency Inpatients have an adverse variance in year to date of £0.552m. Surgery is adverse to plan by £0.319m and Women's and Children's by £0.323m, these are offset by a favourable variance for Specialised Services.
- Critical Care Beddays are favourable to plan by £0.529m year to date most notably in Adult Cardiac ITU and NICU.
- Bone Marrow Transplants are ahead of the year to date plan in June by £0.160m, being £0.186m ahead in paediatrics and £0.026m behind plan in Specialised Services.
- Outpatients is £0.155m below plan to date. Specialised Services is £0.192m below plan, primarily Cardiology, and Surgery is £0.364m below plan, primarily Dental. This is offset by the other Divisions being ahead of plan, in particular Women's and Children's Division £0.235m.
- The Trust has received penalties of £0.411m year to date, £0.069m greater than planned. This is predominantly RTT 52 week waits.
- CQUIN performance is shown on plan (80% achievement) whilst the CQUIN schemes are being agreed.
- Income relating to pass through payments was £0.713m above plan in June, with a £0.989m favourable cumulative variance.
- The reasons for the underperformance on activity are being reviewed to ensure activity can be delivered.
- A bonus payment of £0.710 was received in June for prior year sustainability funding, this does not impact the control total
- The level of un-coded spells has increased slightly from last month (86% from 90% coded) and the valuation of this is now just £2.5m from £11.7m five months ago.

Section 6 – Savings Programme

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

	2019/20 Annual Plan £m	Year to date		
		Plan £m	Actual £m	Variance fav/(adv)£m
Allied Healthcare Professionals	0.025	0.006	0.006	-
Blood	0.133	0.039	0.039	-
Diagnostic Testing	0.181	0.000	0.000	-
Estates & Facilities	0.420	0.136	0.138	0.002
Healthcare Scientists Productivity	0.139	0.035	0.026	(0.009)
HR Pay and Productivity	0.058	0.015	0.015	-
Income, Fines and External	0.630	0.157	0.128	(0.029)
Medical Pay	0.286	0.074	0.057	(0.017)
Medicines	1.070	0.380	0.510	0.130
Non-Pay	4.149	1.281	1.132	(0.149)
Nursing Pay	0.369	0.063	0.050	(0.013)
Other / Corporate	1.361	0.340	0.340	-
Productivity	5.619	1.533	1.163	(0.370)
Trust Services	0.490	0.120	0.119	(0.001)
Unidentified	1.945	0.486	0.000	(0.486)
Total	**16.876**	**4.665**	**3.723**	**(0.942)**

Analysis by Division:

	2019/20 Annual Plan££m	Year to date		
		Plan £m	Actual £m	Variance fav/(adv) £m
Diagnostics &	1.625	0.428	0.438	0.010
Estates & Facilities	0.512	0.153	0.183	0.030
Finance	0.158	0.040	0.040	-
Human Resources	0.101	0.027	0.025	(0.002)
IM&T	0.164	0.035	0.037	0.002
Medicine	2.832	0.652	0.324	(0.328)
Specialised Services	1.992	0.598	0.554	(0.044)
Surgery	4.577	1.375	0.787	(0.588)
Trust Headquarters	0.188	0.047	0.047	-
Women's & Children's	3.366	0.970	0.941	(0.029)
Corporate/Capital	1.145	0.286	0.293	0.007
Miscellaneous Support	0.216	0.054	0.054	-
Total	**16.876**	**4.665**	**3.723**	**(0.942)**

- The savings requirement for 2019/20 is £16.876m. The Trust has achieved savings of £3.723m against a plan of £4.665m. The underachievement to date of £0.942m includes unidentified savings of £0.486m.
- Medicine is £0.328m behind plan to date. £0.301m is savings yet to be identified.
- Surgery is £0.588m behind plan of which £0.254m is within productivity and £0.250m is savings yet to be identified.
- The Trust is forecasting to make savings of £15.131m by year end, 89% of plan. This is an improvement of £0.009m from the forecast in May, however forecast delivery for productivity schemes has deteriorated by £0.283m. This is offset by improved forecast outturns of £0.140m on drugs and £0.210 on procurement savings. The balance is due to minor changes in other workstreams.

- **Key Actions:**
  - The in year performance and forecast outturn are reviewed and challenged in detail at the monthly Divisional Savings Programme reviews and at the Cost Savings Delivery Group as well as Divisional Finance and Ops reviews.
  - Divisions have also established Working Smarter/Productivity Groups to generate and action new schemes.

Section 7 - Use of Resources Rating

The Trust's Use of Resources Ratings is summarised below:

		Year to date	
	Weighting	Plan	Actual
Liquidity			
Metric Result – days		39.4	39.7
Metric Rating	20%	1	1
Capital servicing capacity			
Metric Result – times		1.7	1.8
Metric Rating	20%	1	1
Income & expenditure margin			
Metric Result		0.7%	0.7%
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		(24%)	(5%)
Metric Rating	20%	1	1
Overall URR (unrounded)		**1**	**1.4**
Overall URR (rounded)		**1**	**1**
Overall URR (subject to override)		**1**	**1**

- The Trust's Use of Resources Rating for the period to 30th June 2019 is 1 against a plan of 1.
- The Trust is reporting a deficit of £0.377m to date which is £0.011m favourable to plan.
- The Trust is forecasting to deliver its core financial control total of £2.593m and therefore PSF money of £1.436m is assumed year to date.

Section 8 – Capital Programme

Chart 1 – Capital Programme

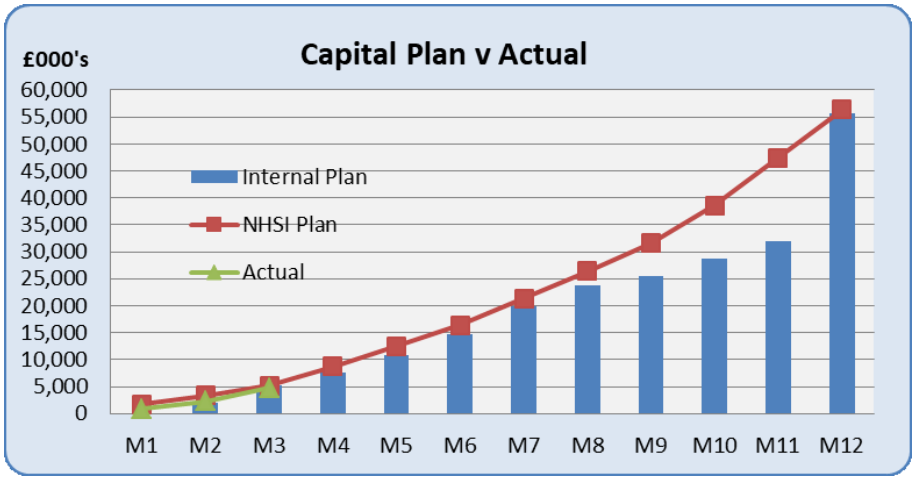
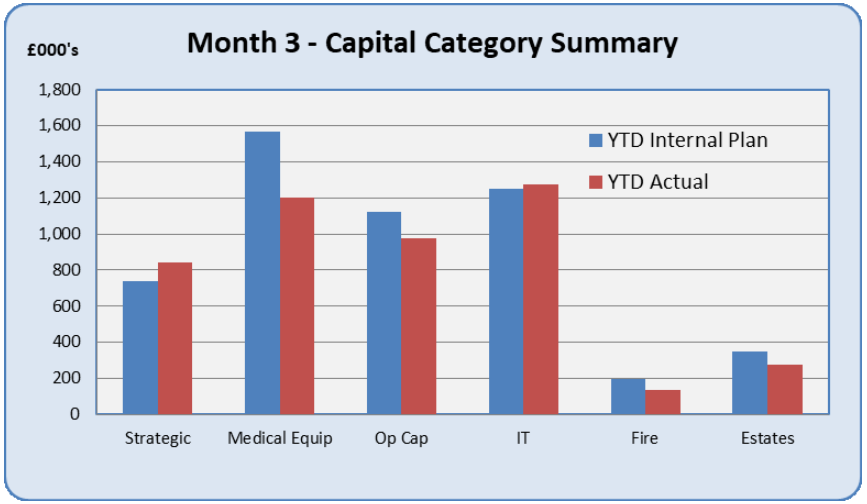


Chart 2 – Subjective Analysis



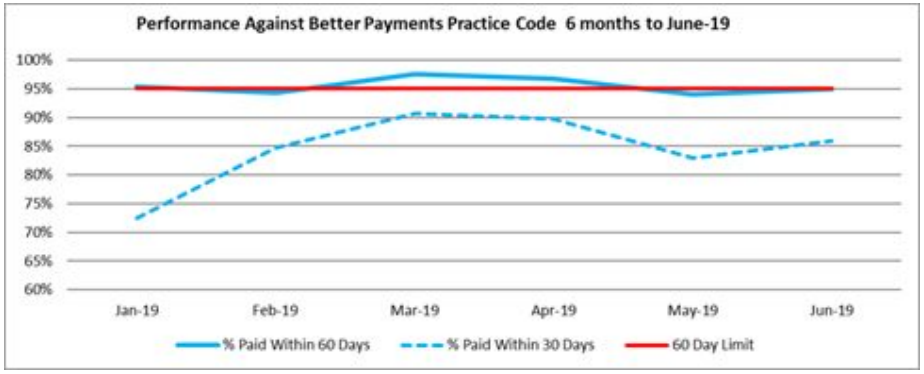
- The NHS Improvement (NHSI) Operational Plan for 2019/20 resubmitted in May included a capital programme of £56.435m, with £5.183m to be spent by the end of June.
- Following the approval of the 2019/20 prioritised schemes an internal plan has been developed which reflects schemes delivery as advised by budget holders, procurement and estates.
- Divisional profiles have been received and reviewed by Trust Capital Group. IM&T and phase 5 profiles will be updated in July and will reduce the expenditure currently profiled into month 12.
- Capital expenditure to 30th June is £4.704m against an internal plan of £5.219m, £0.515m behind plan.
- The key variances are within medical equipment and operational capital which are behind plan by £0.362m and £0.150m respectively, offset by strategic schemes which are ahead of plan by £0.101m.
- Additional resources have been agreed for Bristol and Weston Purchasing Consortium (BWPC) estates and finance to support the delivery of the current year programme.
- NHSI/E have requested a national review of all capital programmes, at STP level, to identify slippage in 2019/20 plans of 20% which will provide headroom on the national capital limits. The Medium Term Capital programme (MTCP) has been updated for approval.

Section 9 – Statement of Financial Position and Cashflow

Prior year closing 31 March 2019 £000's		Current month plan 30 June 2019 £000's	Current month actual 30 June 2019 £000's	Variance 30 June 2019 £000's
	Current assets			
11,406	Inventories	11,406	11,243	(163)
68,610	Trade and other receivables	57,944	65,365	7,421
99,855	Cash	104,546	100,954	(3,592)
179,871	**Total current assets**	**173,896**	**177,562**	**3,666**
	Current liabilities			
(83,159)	Trade and other payables	(81,310)	(82,902)	(1,592)
(6,925)	Borrowings	(6,215)	(6,191)	24
(184)	Provisions	(184)	(189)	(5)
(5,311)	Other liabilities	(2,442)	(3,602)	(1,160)
(95,579)	**Total current liabilities**	**(90,151)**	**(92,884)**	**(2,733)**
84,292	**Net current assets / liabilities**	**83,745**	**84,678**	**933**

- The net current assets at 30 June 2019 were £84.678m, £0.933m higher than the Annual Plan; current assets are higher by £3.666m and current liabilities higher by £2.733m.
- The Trust's cash and cash equivalents balance was £100.954m, £3.592m lower than plan. The lower cash balance primarily relates to the outstanding payment from NHS England for the final Provider Sustainability Funds for 2019/20 which is expected to be paid in July.
- The total value of debtors was £43.733m an increase in the month of £1.819m. Debts over 90 days old increased by £1.722m with the significant debtor balances actively reviewed by the service agreements team, Finance Project Manager and Head of Transaction Services

Payment Performance



- In June, 95% of invoices were paid within the 60 day target set by the Prompt Payments Code and 86% were paid within the 30 day target set by the Better Payment Practice Code.

Appendix 1

UNIVERSITY HOSPITALS BRISTOL NHS FOUNDATION TRUST

Finance Report June 2019– Summary Income & Expenditure Statement

Approved Budget / Plan 2019/20	Heading	Position as at 30th June			Actual to 31st May
		Plan	Actual	Variance Fav / (Adv)	
£'000		£'000	£'000	£'000	£'000
	Income				
623,861	From Activities	154,225	152,928	(1,297)	102,430
93,601	Other Operating Income (excluding PSF & MRET)	24,377	24,109	(268)	15,959
717,462	**Sub totals income**	**178,602**	**177,037**	**(1,565)**	**118,389**
	Expenditure				
(413,199)	Staffing	(105,302)	(107,323)	(2,021)	(71,613)
(250,934)	Supplies and Services	(62,684)	(61,206)	1,478	(41,241)
(664,133)	**Sub totals expenditure**	**(167,986)**	**(168,529)**	**(543)**	**(112,854)**
(14,575)	Reserves	(2,033)	–	2,033	–
–			–	–	–
38,754	Earnings before Interest,Tax,Depreciation and Amortisation	**8,583**	**8,508**	**(75)**	**5,535**
5.40	**EBITDA Margin – %**		**4.81**		**4.68**
	Financing				
(23,939)	Depreciation & Amortisation – Owned	(5,898)	(5,951)	(53)	(3,982)
244	Interest Receivable	61	201	140	132
(216)	Interest Payable on Leases	(54)	(54)	–	(36)
(2,300)	Interest Payable on Loans	(594)	(594)	–	(401)
(9,950)	PDC Dividend	(2,487)	(2,487)	–	(1,658)
(36,161)	**Sub totals financing**	**(8,972)**	**(8,885)**	**87**	**(5,945)**
2,593	NET SURPLUS / (DEFICIT) before Technical Items excluding PSF & MRET	**(389)**	**(377)**	**12**	**(410)**
9,576	Provider Sustainability Funding (PSF) – Core	1,436	1,436	–	958
646	Marginal Rate Emergency Tariff (MRET)	162	162	–	108
–	Prior year PSF post accounts reallocation	–	710	710	–
12,815	SURPLUS / (DEFICIT) before Technical Items including PSF & MRET	**1,209**	**1,931**	**722**	**656**
	Technical Items				
3,800	Donations & Grants (PPE/Intangible Assets)	250	77	(173)	51
(888)	Impairments	–	–	–	–
–	Reversal of Impairments	–	–	–	–
(1,590)	Depreciation & Amortisation – Donated	(393)	(405)	(12)	(270)
14,137	SURPLUS / (DEFICIT) after Technical Items including PSF & MRET	**1,066**	**1,603**	**537**	**437**

Approved Budget / Plan 2019/20	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 PSF & MRET)											
620,568	Contract Income	152,492	152,492	-	-	-	-	-	-			
-	Penalties	-	-	-	-	-	(8)	(8)	-			
-	Contract Rewards	-	-	-	-	-	-	-	-			
-	Overhead share of income variance	-	(45)	-	(19)	-	(18)	(37)	(73)			
35,995	NHSE Income	8,999	8,999	-	-	-	-	-	-			
656,563	**Sub Total Corporate Income**	**161,491**	**161,446**	-	**(19)**	-	**(26)**	**(45)**	**(73)**			
	Clinical Divisions											
(58,696)	Diagnostic & Therapies	(14,859)	(14,915)	243	(221)	9	(87)	(56)	(39)	139	(195)	32
(84,793)	Medicine	(21,523)	(22,025)	(948)	513	(4)	(63)	(502)	(320)	(160)	(342)	(384)
(118,188)	Specialised Services	(28,583)	(28,382)	(376)	355	23	199	201	13	96	105	56
(117,141)	Surgery	(29,643)	(30,811)	(647)	463	(41)	(943)	(1,168)	(659)	(183)	(985)	(357)
(136,721)	Women's & Children's	(34,595)	(35,002)	(578)	441	(3)	(267)	(407)	(311)	140	(547)	100
(515,539)	**Sub Total - Clinical Divisions**	**(129,203)**	**(131,135)**	**(2,306)**	**1,551**	**(16)**	**(1,161)**	**(1,932)**	**(1,316)**	**32**	**(1,964)**	**(553)**
	Corporate Services											
(40,113)	Estates and Facilities	(9,916)	(9,929)	22	(10)	(1)	(24)	(13)	(9)	9	(22)	55
(32,150)	Trust Services	(7,728)	(7,761)	92	(113)	(12)	-	(33)	3	(11)	(22)	(4)
(15,432)	Other	(4,028)	(4,113)	172	68	(240)	(85)	(85)	29	25	(110)	5
(87,695)	**Sub Totals - Corporate Services**	**(21,672)**	**(21,803)**	**286**	**(55)**	**(253)**	**(109)**	**(131)**	**23**	**23**	**(154)**	**56**
(603,234)	**Sub Total (Clinical Divisions & Corporate Services)**	**(150,875)**	**(152,938)**	**(2,020)**	**1,496**	**(269)**	**(1,270)**	**(2,063)**	**(1,293)**	**55**	**(2,118)**	**(497)**
(14,575)	Reserves	(2,033)	-	-	2,033	-	-	2,033	600			
(14,575)	**Sub Total Reserves**	**(2,033)**	-	-	**2,033**	-	-	**2,033**	**600**			
38,754	**Earnings before Interest,Tax,Depreciation and Amortisation**	**8,583**	**8,508**	**(2,020)**	**3,510**	**(269)**	**(1,296)**	**(75)**	**(766)**			
	Financing											
(23,939)	Depreciation & Amortisation - Owned	(5,898)	(5,951)	-	(53)	-	-	(53)	(50)			
244	Interest Receivable	61	201	-	140	-	-	140	91			
(216)	Interest Payable on Leases	(54)	(54)	-	-	-	-	-	4			
(2,300)	Interest Payable on Loans	(594)	(594)	-	-	-	-	-	9			
(9,950)	PDC Dividend	(2,487)	(2,487)	-	-	-	-	-	-			
(36,161)	**Sub Total Financing**	**(8,972)**	**(8,885)**	-	**87**	-	-	**87**	**54**			
2,593	**NET SURPLUS / (DEFICIT) before Technical Items excluding PSF & MRET**	**(389)**	**(377)**	**(2,020)**	**3,597**	**(269)**	**(1,296)**	**12**	**(712)**			
9,576	Provider Sustainability Funding (PSF) - Core	1,436	1,436	-	-	-	-	-	-			
646	Marginal Rate Emergency Tariff (MRET)	162	162	-	-	-	-	-	-			
-	Prior year PSF post accounts reallocation	-	710	-	-	710	-	710	-			
10,222	**Sub Total PSF & MRET**	**1,598**	**2,308**	-	-	**710**	-	**710**	-			
12,815	**SURPLUS / (DEFICIT) before Technical Items including PSF & MRET**	**1,209**	**1,931**	**(2,020)**	**3,597**	**441**	**(1,296)**	**722**	**(712)**			
	Technical Items											
3,800	Donations & Grants (PPE/Intangible Assets)	250	77	-	-	(173)	-	(173)	51			
(888)	Impairments	-	-	-	-	-	-	-	-			
-	Reversal of Impairments	-	-	-	-	-	-	-	-			
(1,590)	Depreciation & Amortisation - Donated	(393)	(405)	-	(12)	-	-	(12)	(8)			
1,322	**Sub Total Technical Items**	**(143)**	**(328)**	-	**(12)**	**(173)**	-	**(185)**	**43**			
14,137	**SURPLUS / (DEFICIT) after Technical Items including PSF & MRET**	**1,066**	**1,603**	**(2,020)**	**3,585**	**268**	**(1,296)**	**537**	**(669)**			

REGISTERED NURSING - NURSING CONTROL GROUP AND HR KPIs

Graph 1 **RN Sickness**

Division	Target/ Actual	M1	M2	M3	M4	M5	M6	M7	M8	M9	M10	M11	M12
Medicine	*Target*	*3.0%*	*3.0%*	*3.0%*	*3.8%*	*3.8%*	*3.8%*	*3.9%*	*3.9%*	*3.9%*	*3.6%*	*3.6%*	*3.6%*
Medicine	Actual	3.3%	3.0%	2.7%									
Specialised Services	*Target*	*3.2%*	*3.2%*	*3.2%*	*3.4%*	*3.4%*	*3.4%*	*3.8%*	*3.8%*	*3.8%*	*3.6%*	*3.6%*	*3.6%*
Specialised Services	Actual	4.3%	4.4%	4.3%									
Surgery	*Target*	*3.8%*	*3.8%*	*3.8%*	*3.8%*	*3.8%*	*3.8%*	*3.7%*	*3.7%*	*3.7%*	*3.7%*	*3.7%*	*3.7%*
Surgery	Actual	4.2%	4.1%	4.2%									
Women's	*Target*	*3.6%*	*3.6%*	*3.6%*	*3.7%*	*3.7%*	*3.7%*	*4.1%*	*4.1%*	*4.1%*	*3.8%*	*3.8%*	*3.8%*
Women's	Actual	4.1%	3.3%	4.5%									
Children's	*Target*	*3.6%*	*3.6%*	*3.6%*	*3.7%*	*3.7%*	*3.7%*	*4.1%*	*4.1%*	*4.1%*	*3.8%*	*3.8%*	*3.8%*
Children's	Actual	3.9%	3.5%	3.9%									

Source: HR info available after a weekend. Note: Prior month will get updated retrospectively so figures can change from one month to another.

Graph 2 **RN 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	9.6%	9.3%	9.8%									
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	7.8%	8.8%	9.8%									
Surgery	*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	Actual	9.1%	8.9%	9.1%									
Women'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	Actual	1.2%	2.7%	3.9%									
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%*
Children's	Actual	-2.6%	0.4%	1.6%									

Source: HR

Graph 3 **RN Turnover**

Division	Target/ Actual	M1	M2	M3	M4	M5	M6	M7	M8	M9	M10	M11	M12
Medicine	*Target*	*15.9%*	*15.7%*	*15.5%*	*15.3%*	*15.2%*	*15.0%*	*14.8%*	*14.7%*	*14.5%*	*14.3%*	*14.2%*	*14.0%*
Medicine	Actual	16.1%	15.3%	16.5%									
Specialised Services	*Target*	*15.3%*	*15.2%*	*15.0%*	*14.8%*	*14.7%*	*14.5%*	*14.3%*	*14.2%*	*14.0%*	*13.8%*	*13.7%*	*13.5%*
Specialised Services	Actual	16.8%	17.1%	16.9%									
Surgery	*Target*	*15.6%*	*15.2%*	*14.9%*	*14.5%*	*14.2%*	*13.9%*	*13.5%*	*13.2%*	*12.8%*	*12.5%*	*12.2%*	*11.8%*
Surgery	Actual	14.8%	15.1%	14.3%									
Women's	*Target*	*12.2%*	*12.0%*	*11.8%*	*11.6%*	*11.4%*	*11.3%*	*11.1%*	*10.9%*	*10.7%*	*10.5%*	*10.3%*	*10.1%*
Women's	Actual	10.9%	10.5%	11.5%									
Children's	*Target*	*12.2%*	*12.0%*	*11.8%*	*11.6%*	*11.4%*	*11.3%*	*11.1%*	*10.9%*	*10.7%*	*10.5%*	*10.3%*	*10.1%*
Children's	Actual	12.0%	12.3%	12.5%									

Source: HR - Registered. Note: Prior month will get updated retrospectively so figures can change from one month to another.

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*	*147.4*	*148.4*	*133.9*	*133.4*	*133.8*	*133.4*	*151.1*	*165.1*	*170.6*	*195.6*	*194.6*	*192.8*
Medicine	Actual	274.3	250.5	211.3									
Specialised Services	*Target*	*50.2*	*50.2*	*50.2*	*75.1*	*75.1*	*75.1*	*62.7*	*50.2*	*50.2*	*50.2*	*50.2*	*50.2*
Specialised Services	Actual	54.7	81.6	102.0									
Surgery	*Target*	*85.3*	*85.3*	*78.0*	*78.0*	*70.7*	*34.2*	*34.2*	*34.2*	*34.2*	*34.2*	*34.2*	*34.2*
Surgery	Actual	168.1	144.6	125.2									
Women's	*Target*	*35.2*	*34.9*	*34.9*	*35.2*	*35.2*	*35.2*	*35.2*	*35.2*	*52.7*	*52.7*	*52.7*	*54.0*
Women's	Actual	1.7	0.9	2.2									
Children's	*Target*	*123.2*	*104.8*	*104.8*	*87.9*	*87.9*	*87.9*	*87.9*	*87.9*	*70.3*	*70.3*	*70.3*	*32.4*
Children's	Actual	164.4	121.7	148.8									
Trust Total	*Target*	441.3	423.7	401.9	409.6	402.7	365.8	371.1	372.6	378.1	403.1	402.1	363.7
Trust Total	Actual	663.2	599.3	589.5	-	-	-	-	-	-	-	-	-

Source: Finance GL (excludes NA 1:1)

Graph 5 **Operating plan for nursing agency wte**

Division	Target/ Actual	M1	M2	M3	M4	M5	M6	M7	M8	M9	M10	M11	M12
Medicine	*Target*	*20.0*	*20.0*	*18.0*	*18.0*	*18.0*	*18.0*	*19.0*	*21.0*	*23.0*	*25.0*	*25.0*	*26.0*
Medicine	Actual	36.8	36.5	27.6									
Specialised Services	*Target*	*6.0*	*6.0*	*6.0*	*9.0*	*9.0*	*9.0*	*7.5*	*6.0*	*6.0*	*6.0*	*6.0*	*6.0*
Specialised Services	Actual	6.6	10.3	13.8									
Surgery	*Target*	*11.0*	*11.0*	*10.0*	*10.0*	*9.0*	*4.0*	*4.0*	*4.0*	*4.0*	*4.0*	*4.0*	*4.0*
Surgery	Actual	19.4	17.4	16.5									
Women's	*Target*	*2.0*	*2.0*	*2.0*	*2.0*	*2.0*	*2.0*	*2.0*	*2.0*	*3.0*	*3.0*	*3.0*	*3.0*
Women's	Actual	0.2	0.1	0.3									
Children's	*Target*	*7.0*	*6.0*	*6.0*	*5.0*	*5.0*	*5.0*	*5.0*	*5.0*	*4.0*	*4.0*	*4.0*	*1.8*
Children's	Actual	16.6	14.6	17.1									
Trust Total	*Target*	46.0	45.0	42.0	44.0	43.0	38.0	37.5	38.0	40.0	42.0	42.0	40.8
Trust Total	Actual	79.7	78.9	75.4	-	-	-	-	-	-	-	-	-

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*	*3.9%*	*3.9%*	*3.5%*	*3.5%*	*3.5%*	*3.5%*	*3.6%*	*4.1%*	*4.5%*	*4.8%*	*4.8%*	*5.0%*
Medicine	Actual	12.9%	12.3%	10.6%									
Specialised Services	*Target*	*1.4%*	*1.4%*	*1.4%*	*2.1%*	*2.1%*	*2.1%*	*1.7%*	*1.4%*	*1.4%*	*1.4%*	*1.4%*	*1.4%*
Specialised Services	Actual	3.2%	5.0%	6.2%									
Surgery	*Target*	*2.1%*	*2.0%*	*1.8%*	*1.8%*	*1.7%*	*0.7%*	*0.7%*	*0.7%*	*0.7%*	*0.7%*	*0.7%*	*0.7%*
Surgery	Actual	7.9%	7.2%	6.3%									
Women's	*Target*	*0.6%*	*0.6%*	*0.6%*	*0.6%*	*0.6%*	*0.6%*	*0.6%*	*0.6%*	*0.9%*	*0.9%*	*0.9%*	*0.9%*
Women's	Actual	0.0%	0.0%	0.1%									
Children's	*Target*	*1.0%*	*0.8%*	*0.8%*	*0.7%*	*0.7%*	*0.7%*	*0.7%*	*0.7%*	*0.5%*	*0.6%*	*0.6%*	*0.3%*
Children's	Actual	3.9%	3.1%	3.6%									
Trust Total	Target	5.0%	4.8%	5.6%	6.0%	6.3%	7.4%	6.6%	6.1%	5.5%	7.1%	7.7%	8.0%
Trust Total	Actual	6.5%	6.2%	6.1%									

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	9,646	9,748	9,295									
Specialised Services	Actual	4,608	4,825	4,655									
Surgery	Actual	4,431	4,699	4,392									
Children's	Actual	3,926	3,899	3,883									
Women's	Actual	2,586	2,776	2,711									
Trust Total	Actual	25,197	25,947	24,936	-	-	-	-	-	-	-	-	-

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*	*46*	*46*	*46*	*46*	*45*	*46*	*45*	*45*	*45*	*46*	*46*	*45*	**548**
Medicine	Actual	155	133	98										**386**
Specialised Services	*Target*	*21*	*21*	*21*	*21*	*21*	*21*	*21*	*21*	*21*	*21*	*21*	*21*	**257**
Specialised Services	Actual	24	29	41										**95**
Surgery	*Target*	*47*	*46*	*46*	*46*	*46*	*46*	*46*	*46*	*46*	*46*	*46*	*46*	**554**
Surgery	Actual	44	62	48										**154**
Women's	*Target*	-	-	-	-	-	-	-	-	-	-	-	-	**-**
Women's	Actual													**-**
Children's	*Target*	*36*	*50*	*44*	*12*	*12*	*12*	*12*	*12*	*12*	*12*	*12*	- *81*	**145**
Children's	Actual	36	50	44										**130**
Trust Total	*Target*	149.8	163.1	157.5	125.3	125.0	125.5	125.1	125.0	125.0	125.9	125.3	31.6	**1,504**
Trust Total	Actual	259.2	273.6	231.2	-	-	-	-	-	-	-	-	-	**764**

Source: Service Improvement Team - Nikki

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

Division	Target/ Actual	M1	M2	M3	M4	M5	M6	M7	M8	M9	M10	M11	M12	
Trust Total	*Target*	21	21	21	23	23	23	40	40	39	40	40	40	**369**
Trust Total	Actual	21	21	7										**50**

Source: Service Improvement Team - Russell/Nikki - Master Combined CIP schedule

NURSING ASSISTANTS (UNREGISTERED) - NURSING CONTROL GROUP AND HR KPIs

Graph 1 **NA Sickness**

Division	Target/ Actual	M1	M2	M3	M4	M5	M6	M7	M8	M9	M10	M11	M12
Medicine	*Target*	*6.8%*	*6.8%*	*6.8%*	*7.2%*	*7.2%*	*7.2%*	*7.0%*	*7.0%*	*7.0%*	*6.4%*	*6.4%*	*6.4%*
Medicine	Actual	6.9%	7.1%	8.1%									
Specialised Services	*Target*	*5.9%*	*5.9%*	*5.9%*	*7.0%*	*7.0%*	*7.0%*	*6.5%*	*6.5%*	*6.5%*	*5.4%*	*5.4%*	*5.4%*
Specialised Services	Actual	8.1%	8.7%	8.0%									
Surgery	*Target*	*4.6%*	*4.6%*	*4.6%*	*4.6%*	*4.6%*	*4.6%*	*4.5%*	*4.5%*	*4.5%*	*4.5%*	*4.5%*	*4.5%*
Surgery	Actual	10.0%	5.6%	8.3%									
Women's	*Target*	*8.1%*	*8.1%*	*8.1%*	*7.7%*	*7.7%*	*7.7%*	*7.0%*	*7.0%*	*7.0%*	*6.0%*	*6.0%*	*6.0%*
Women's	Actual	12.7%	12.6%	15.1%									
Children's	*Target*	*8.1%*	*8.1%*	*8.1%*	*7.7%*	*7.7%*	*7.7%*	*7.0%*	*7.0%*	*7.0%*	*6.0%*	*6.0%*	*6.0%*
Children's	Actual	6.7%	7.0%	6.7%									

Source: HR info available after a weekend. Note: Prior month will get updated retrospectively so figures can change from one month to another.

Graph 2 **NA 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	2.6%	5.0%	5.9%									
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	12.8%	14.9%	12.1%									
Surgery	*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	Actual	13.8%	15.1%	11.0%									
Women'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	Actual	9.1%	6.9%	5.6%									
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%*
Children's	Actual	5.1%	4.4%	1.5%									

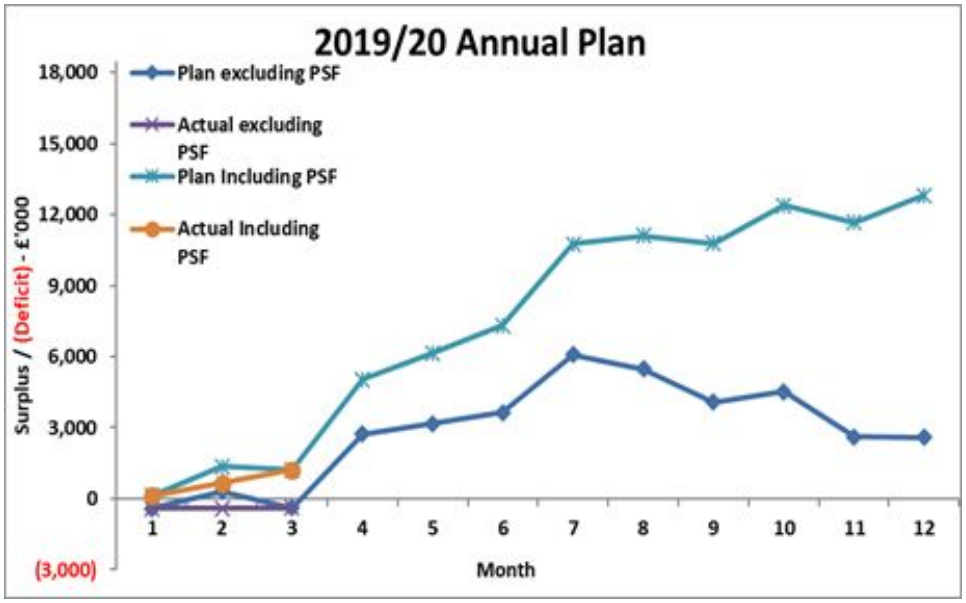
Source: HR

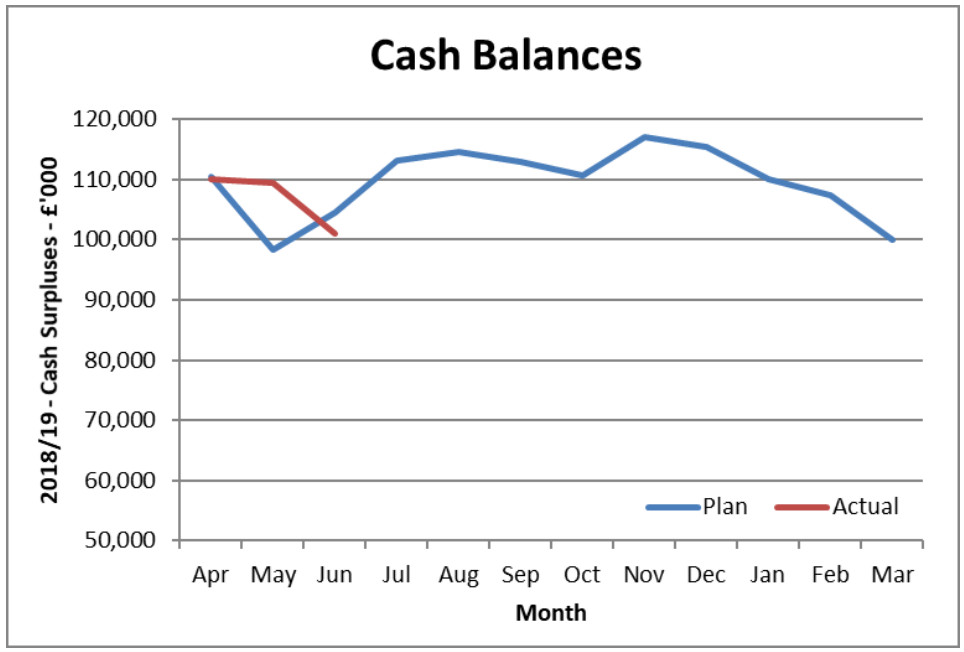
Graph 3 **NA Turnover**

Division	Target/ Actual	M1	M2	M3	M4	M5	M6	M7	M8	M9	M10	M11	M12
Medicine	*Target*	*22.7%*	*22.3%*	*21.9%*	*21.5%*	*21.1%*	*20.8%*	*20.4%*	*20.0%*	*19.6%*	*19.3%*	*18.9%*	*18.5%*
Medicine	Actual	24.5%	25.8%	25.9%									
Specialised Services	*Target*	*13.5%*	*13.8%*	*14.1%*	*14.4%*	*14.7%*	*15.1%*	*15.4%*	*15.7%*	*16.0%*	*16.4%*	*16.7%*	*17.0%*
Specialised Services	Actual	16.6%	17.3%	19.8%									
Surgery	*Target*	*18.9%*	*18.7%*	*18.5%*	*18.3%*	*18.1%*	*18.0%*	*17.8%*	*17.6%*	*17.4%*	*17.3%*	*17.1%*	*16.9%*
Surgery	Actual	20.0%	20.2%	20.5%									
Women's	*Target*	*15.3%*	*15.0%*	*14.7%*	*14.4%*	*14.1%*	*13.8%*	*13.5%*	*13.3%*	*13.0%*	*12.7%*	*12.4%*	*12.1%*
Women's	Actual	13.4%	13.1%	13.6%									
Children's	*Target*	*15.3%*	*15.0%*	*14.7%*	*14.4%*	*14.1%*	*13.8%*	*13.5%*	*13.3%*	*13.0%*	*12.7%*	*12.4%*	*12.1%*
Children's	Actual	18.4%	17.5%	18.9%									

Source: HR. Note: Prior month will get updated retrospectively so figures can change from one month to another.

Performance – Finance



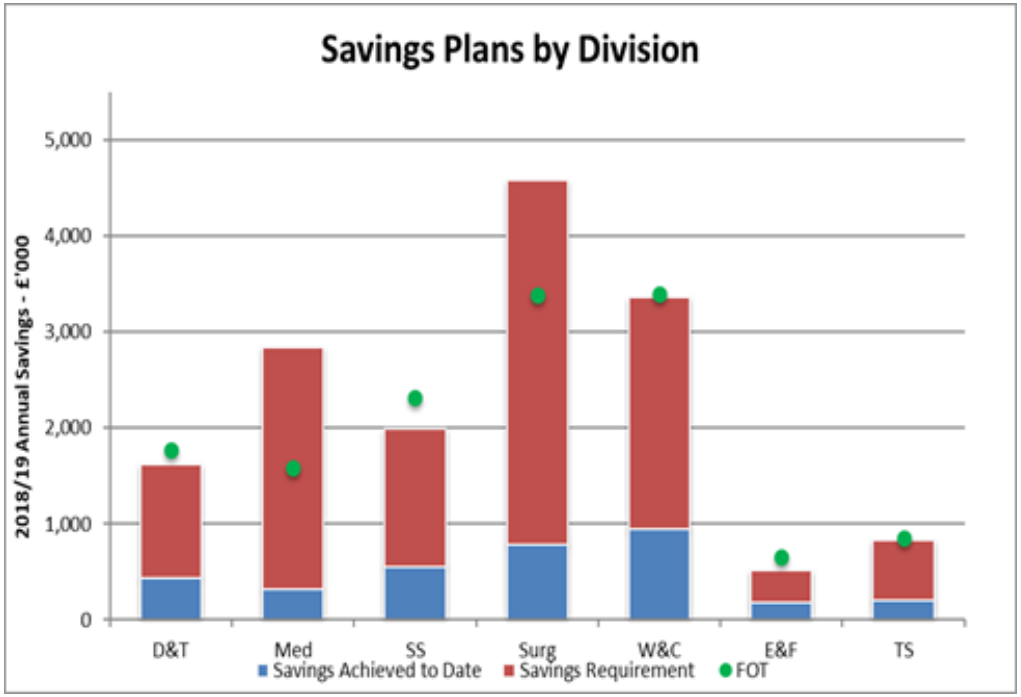


Divisional Actual Spend - £'000					
	In Month			Plan for Year	FOT Outturn
Divisional Agency	Apr	May	Jun		
Nursing & Midwifery	684	660	648	**6,499**	**8,064**
Medical					**0**
Consultants	72	82	92	**644**	**924**
Other Medical	56	20	85	**212**	**456**
Other	140	144	131	**1,384**	**1,704**
Total	**952**	**906**	**956**	**8,739**	**11,148**

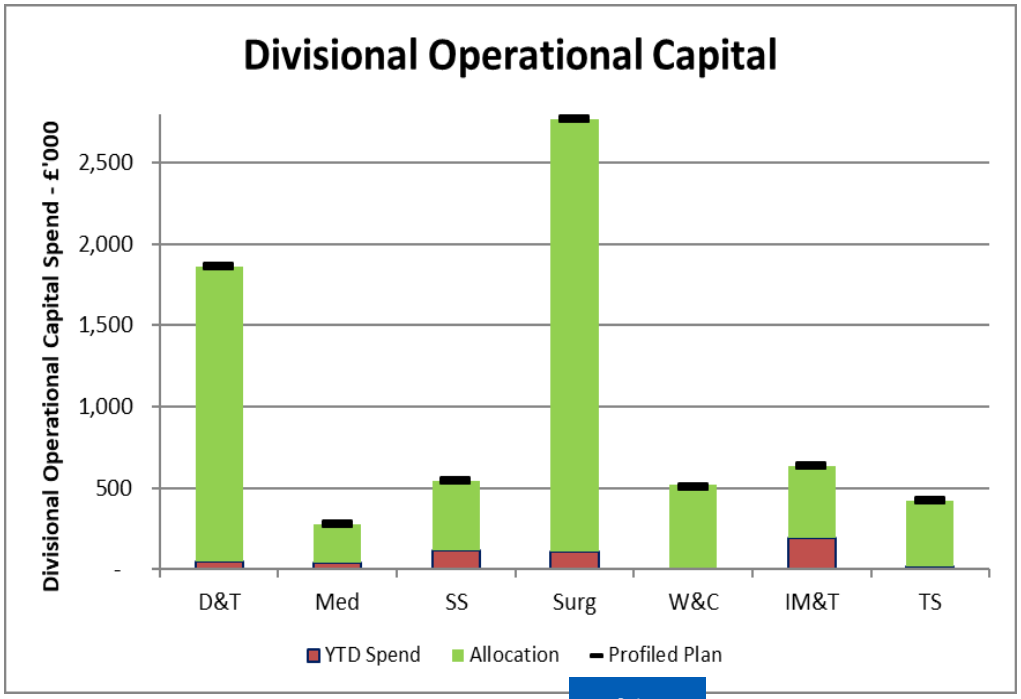
YTD Variance to Budget Surplus/(Deficit) - £'000			
Division	Apr	May	Jun
Diagnostics & Therapies	(4)	(39)	(56)
Medicine	(167)	(320)	(502)
Specialised Services	(54)	13	201
Surgery	(175)	(659)	(1,168)
Women's & Children's	(215)	(311)	(407)
Estates & facilities	(5)	(9)	(13)
Trust Services	4	3	(33)
Other Corporate Services	42	29	(85)
Total	**(574)**	**(1,293)**	**(2,063)**

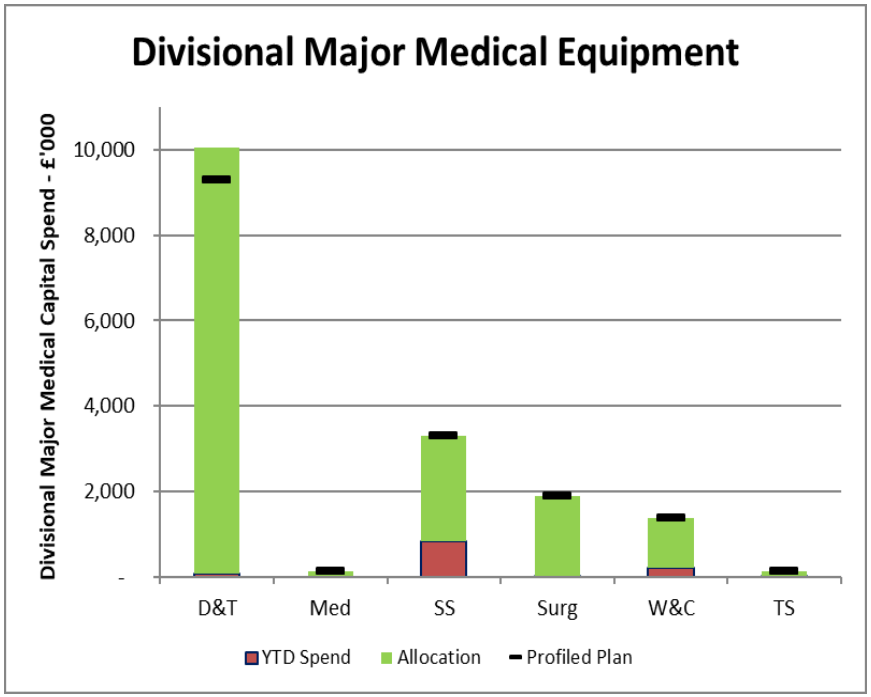
In Month Variance to Budget Surplus/(Deficit) - £'000			
Subjective Heading	Apr	May	Jun
Nursing & Midwifery Pay	(604)	(491)	(484)
Medical & Dental Pay	(360)	(187)	(445)
Other Pay	243	197	109
Non Pay	954	189	356
Income from Operations	(173)	(94)	(2)
Income from Activities	(632)	(336)	(301)
Total	**(572)**	**(722)**	**(767)**

Performance – Finance



2019/20 Capital Programme			Year to date		
Internal Plan	Subjective Heading	Profiled Plan / FOT	Profiled Plan	Actual spend	Variance
£m		£m	£m	£m	£m
	Sources of Funding				
8.60	PDC	8.60	-	-	-
3.80	Donations - Cash	3.79	0.12	0.07	0.05
-	Donations - Direct	0.01	0.01	0.01	-
	Cash:				
25.53	Depreciation	25.53	5.90	5.95	(0.050)
0.68	Insurance Claim	0.68	0.29	0.29	-
18.16	Cash balances	17.07	(1.09)	(1.61)	0.52
56.78	**Total Funding**	**55.69**	**5.22**	**4.70**	**0.52**
	Application/Expenditure				
(24.60)	Strategic Schemes	(24.59)	(0.74)	(0.84)	0
(18.62)	Medical Equipment	(17.84)	(1.56)	(1.20)	(0.36)
(14.52)	Operational Capital	(14.46)	(1.12)	(0.97)	(0.15)
(2.42)	Fire Improvement Programme	(2.17)	(0.20)	(0.14)	(0.06)
(14.75)	Information Technology	(14.75)	(1.25)	(1.28)	0
(4.59)	Estates Replacement	(4.59)	(0.35)	(0.28)	(0.07)
(79.49)	**Gross Expenditure**	**(78.40)**	**(5.22)**	**(4.70)**	**(0.52)**
22.71	In-year Slippage	22.71	-	-	-
(56.78)	**Net Expenditure**	**(55.69)**	**(5.22)**	**(4.70)**	**(0.52)**





Meeting of the Finance Committee on 25 July 2019 in the Conference Room, Trust Headquarters

Reporting Committee	**Finance Committee**
Chaired By	**Jeff Farrar, Non-Executive Director and Chair**
Executive Lead	**Neil Kemsley, Director of Finance and Information**

For Information

The Committee received the Finance Update for June 2019 from the Director of Finance and Information. Key points highlighted included the following.

The plan for June required a core deficit of £0.389m (excluding PSF and MRET), and a total surplus of £1.209m (including the same) before technical items.
The Trust was reporting a deficit of £0.377m to date excluding technical items, which was £0.012m favourable against the plan. Particular areas of concern included activity under-performance of £1.269m to date and nursing overspending of £1.579m year to date. The Divisional and Corporate Services deficit in June 2019 was £2.063m, compared to £1.293m in May, a deterioration of £0.770m.

The Committee noted that whilst the figures were positive, the issue of medical and nursing overspend, and the covering of that with reserves, remained a matter of concern and the Committee would be keen for further updates on mitigation activity around this. The Committee noted that overspend in some divisions had been a problem for some time. It was suggested that this issue, and how to mitigate it, should be discussed in further detail at the 1 August 2019 Executive Team Away Day.

The Committee received an update on contract income for 2019/20, which was £1.03m higher than plan in June 2019. Activity-based services were lower than plan, whilst 'pass through' payments were higher than plan. Contract rewards and penalties were on plan. The trust has received an additional £0.71m in bonus sustainability funding for 2018/19, which is included in this report.

The Committee received an update on Divisional finances. Overall, the in-month deterioration in divisional positions for June 2019 totalled £770k, taking the divisional deficit to date to £2.063m. The Director of Finance and Information, and the Deputy Chief Executive and Chief Operating Officer were working with Medical and Surgical Divisions to assess current operational and financial pressures, risks and potential mitigations. These would be reported back to next meeting of the Finance Committee. A similar process would be followed with rest of Divisions ahead of the September 2019 Committee meeting.

The Committee received update on the Trust's progress regarding the 'Working Smarter' Programme, outlining the approach and methodology employed to deliver productivity, how it was embedded in divisions, as well as governance and assurance. The paper also covered sources of benchmarking, and actual and planned productivity for 2018/19 and 2019/20. The Committee noted this was very positive, detailed and showed good progress.

For Board Awareness, Action or Response

The Committee approved the process for developing the National Costs Submission. The Submission would be approved by the Director of Finance and Information once complete.

The Committee received a tabled update on the preliminary findings of the financial due diligence for the merger via acquisition of Weston Area Health NHS Trust (WAHT) by the Trust. This gave the Committee an overarching understanding of the financial position at WAHT, and the potential implications in the event of a merger, and it was noted this would feed into the dedicated discussion of Due Diligence by the Board on 30 July.

Key Decisions and Actions

The Committee approved the process for developing the National Costs Submission. The Submission would be approved by the Director of Finance and Information once complete.

The Committee agreed to approve the revised Medium Term Capital Programme, subject to further iterations for the phase 5 programme and five year planning.

The Committee asked to receive an update on the progress of the 'Working Smarter' programme in a few months' time.

Additional Chair Comments

There were no additional comments.

Date of next meeting:	**30 August 2019**

Meeting of the Board of Directors in Public on Tuesday 30 July 2019 in the Conference Room, Trust Headquarters

Report Title	**West of England AHSN Board Report**
Report Author	**Robert Woolley, Chief Executive**
Executive Lead	**Robert Woolley, Chief Executive**

1. Report Summary
This report is to provide an update on work undertaken by the West of England Academic Health Science Network (AHSN).
2. Key points to note *(Including decisions taken)*
A variety of work has been completed since the previous update and is contained in the report.
3. Risks **If this risk is on a formal risk register, please provide the risk ID/number.**
The risks associated with this report include: None
4. Advice and Recommendations *(Support and Board/Committee decisions requested)*:
• This report is for **INFORMATION**. • The Board is asked to **NOTE** the report.
5. History of the paper **Please include details of where paper has previously been received.**
N/A

Report from West of England Academic Health Science Network Board

June 2019

1. Purpose

This is the quarterly report for the Boards of the member organisations of the West of England Academic Health Science Network (AHSN). Further information about the items summarised below together with the Board papers are posted on our website for information.

2. Highlights of our work in Quarter 4 of 2018/19

National Programmes

All of the national programmes we are adopting during the current two year cycle ending in March 2020 are on track for delivery with targets generally met or exceeded in 2018/19. Of note:

2.1 PReCePT, this programme is now adopted by all 14 other AHSNs across England. The 2018/19 outturn data received in May 2019 showed the West of England average performance at 70% of eligible mothers receiving magnesium sulphate against a national target of 85%. The West of England AHSN PReCePT Programme team have re-engaged with all the maternity units and while all units are confident that their clinical pathways for MgSO4 administration are well embedded but suspect a disconnect in the information exchange between teams administering the $MgSO_4$ and the neonatal team who enter the successful administration in BadgerNet (the data source of NNAP).

Table: 2018/19 $MgSO_4$ activity for West of England maternity units:

Maternity unit	**Eligible mothers**	**$MgSO_4$ given** *number*	**$MgSO_4$ given** *percentage*
Gloucestershire	31	19	61%
Swindon	11	9	82%
Southmead	49	30	61%
St Michael's	30	27	90%
Bath	14	9	64%
West of England Total	**135**	**94**	**70%**

2.2 Polypharmacy Programme, national targets for this new national programme are still to be defined and are expected in quarter 3 of 2019/20, but in the meantime NHS England requires AHSNs to work towards the development of an "offer". The West of England AHSN hosted a workshop in December 2018 with a follow up workshop planned for June 2019 to develop a system wide approach to identify priorities for this programme.

2.3 Innovation Technology Payment (ITP) tariff products, the next set of ITP products have now been announced by NHS England. The West of England AHSN role is to

make them known to our member organisations and to support their uptake where appropriate.

The next set of ITP products have now been announced by NHS England. The West of England AHSN role is to make them known to our member organisations and to support their uptake where appropriate. Along with continued NHS England financial support for many of the previous ITP products, the new products to the tariff are:

- Space-Oar: an Implantable spacer gel to minimise rectal damage during prostate radiotherapy
- gammaCore: a product which delivers electrical Vagal nerve stimulation for the prevention and treatment of cluster headache
- High Sensitivity Troponin testing for early rule out of acute myocardial infarction in the emergency department setting
- Placenta Growth factor testing to assess early diagnosis of pre-eclampsia in pregnant women
- Faecal Microbiotica Transplant for the treatment of recurrent clostridium difficile.

If you would like to know more about any of the above, please contact Clare Evans clare.evans@weahsn.net.

2.4 Patient Safety Collaborative Medicines Safety Programme The AHSN network is scoping a programme of work with NHS Improvement that is likely to focus on the reduction of errors in the administration of medicines in care homes.

3. Challenge Calls

The innovations identified through our three recent calls - *Evidence into Practice*, *Futures Challenges* and *Create Open Health* - are intended to deliver both immediate useful solutions for our local member organisations and stakeholders and subject to implementation and evaluation, can then form part of a pipeline of programmes that the West of England AHSN can offer for adoption and spread across the wider AHSN Network.

3.1 Evidence into Practice and Futures Challenges Calls

The Evidence into Practice Call was launched in March and closed on 26 April 2019 and received 20 applications. This call is looking for innovations or improvements supported by specific research or evidence that will improve the quality of patient care. We have shortlisted seven applications for review at a selection panel on 4 July 2019.

3.2 The Futures Challenges

This call is looking for innovative solutions (technology solutions or digital) and products from companies that are already on the market and will ultimately be capable of supplying their product or service on a commercial basis. We have selected four companies and products.

Young People and Mental Health Resilience

- An avatar- based digital technology, augmented reality platform that transports users into realistic environment
- A tailored digital support tool for gamifying physical activities and supporting mental wellbeing

Keeping People Healthy at Home

- A digital behaviour platform for people with type 2 diabetes and prediabetes
- Telehealth services

We will shortly be inviting member organisations to submit expressions of interest in hosting the successful projects and there will be a formal matching process.

3.3 Create Open Health Initiative

This was a national call where the AHSN partnered with the Welcome Trust and Creative England and for innovative early stage digital or technology based ideas to support the health and wellbeing of young people aged 12-18. A total of 150 applications were received, 12 of which were selected for the next stage business development "boot-camp" sessions. One of the projects now receiving additional support from tech developers and the AHSN is from University Hospitals Bristol NHS Foundation Trust, focusing on developing a solution supporting young people attending the emergency department for mental health support.

4. Future Facing Events

We are planning a series of West of England wide events focussing on future facing opportunities and themes that have the potential to have significant impact on and benefit to the NHS in the next 5-10 years. These events will include national thought leaders and futurists and will use practical examples of the technology in use to facilitate discussion about the opportunities for the West of England. The events will be aimed at senior leaders and we intend to cover:

- Population health management and Big Data
- Genomics and precision medicines
- Diagnostics, Digital and AI
- Robotics and autonomous Systems

5. Changes to the West of England AHSN Board membership

We were pleased to welcome the following new Board members:

- Paul Roberts, Chief Executive Officer for 2gether NHS Foundation Trust and Gloucestershire Care Services NHS Trust representing the mental health sector
- John MacLeod, Applied Research Collaborative (ARC) Director Designate
- Tracey Cox, Chief Executive Officer for BaNES, Swindon and Wiltshire CCGs and STP

Natasha Swinscoe

Chief Executive Officer

June 2019

Meeting of the Board of Directors in Public on Tuesday 30 July 2019 in the Conference Room, Trust Headquarters

Report Title	**Register of Seals Report**
Report Author	**Sophie Melton Bradley, Head of Corporate Governance**
Executive Lead	**Eric Sanders, Trust Secretary**

1. Report Summary

This report will show applications of the Trust Seal as required by the Foundation Trust Constitution.

The attached report includes all new applications of the Trust Seal since the previous report in **January 2019**.

2. Key points to note
(Including decisions taken)

Standing Orders for the Trust Board of Directors stipulate 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.

3. Risks
If this risk is on a formal risk register, please provide the risk ID/number.

The risks associated with this report include:
N/A

4. Advice and Recommendations
(Support and Board/Committee decisions requested):

- This report is for **INFORMATION**.
- The Board is asked to **NOTE** the report.

5. History of the paper
Please include details of where paper has previously been received.

N/A

Register of Seals – February 2019 – July 2019

Reference Number	Date Signed	Document	Authorised Signatory 1	Authorised Signatory 2	Witness	Additional Comments
817	26/02/19	BHOC Fire Incident Recover Works	Robert Woolley (Chief Executive)	Mark Smith (Deputy Chief Executive & Chief Operating Officer)	Sophie Melton Bradley (Head of Corporate Governance)	Contract for BHOC Fire Incident Recovery Works as approved by CPSG/BHOC Recovery Board.
818	12/06/19	JCT Intermediate Building Contract with contractors designed 2016	Robert Woolley (Chief Executive)	Paul Mapson (Director of Finance and Information)	Sophie Melton Bradley (Head of Corporate Governance)	Standard form of contract for planned building work. Signed under seal to extend the defects liability period for the works from 6-12 years.

Meeting of the Board of Directors in Public on Tuesday 30 July 2019 in the Conference Room, Trust Headquarters

Report Title	**NIHR CRN Annual Report 2018/19 (hosted body report)**
Report Author	**Dr Kyla Thomas and Dr Sue Taylor**
Executive Lead	**Dr William Oldfield, Medical Director**

1. Report Summary

The Clinical Research Network (CRN) West of England is submitting the Annual Report 2018/19 for Host Trust Board approval. The CRN West Of England secured a network budget increase of 1.6% for 2018/19 based on a number of variables, one of them being a continued increase in the percentage of commercial and non-commercial studies closed having recruited to time and target. For 2017/18 this was 76% for commercial studies, which is above the national average, and 74% for non-commercial studies. The Annual Report 2018/19 submitted to the Board for approval reports on achievements during 18/19 and builds on the successes of 2017/18.

2. Key points to note
(Including decisions taken)

The CRNCC Executive Team held a performance meeting with the Clinical Research Network West of England on the 17th July 2019 in London. Dr Kyla Thomas and Dr Sue Taylor were present in person; Dr William Oldfield attended via teleconference. CRNCC feedback for the NIHR CRN Annual Report 2018/19 was that it was a good report and approved in principle. CRNCC commended the LCRN's collaboration with non-NHS partners, Public Health and the establishment of the NIHR Bristol Managers Group. CRNCC also noted excellent performance enabling 37,380 participants to take part in research compared with the local target of 28,883. Recruitment to Dementias and Neurodegeneration was also above target and the CRN was the top recruiter of the 15 LCRNs. The LCRN was also commended on recruitment to the First Global patient in Cancer. The plan was approved in principle dependent on Host Trust Board approval.

3. Risks
If this risk is on a formal risk register, please provide the risk ID/number.

The risks associated with this report include:
The LCRN must continue to monitor the performance and delivery of the national target for recruitment to time and target with primary and secondary care partners for commercial and non-commercial studies. The CRNCC national target is 80%. The LCRN achieved 60% for commercial studies and 74% for non-commercial studies at year end 2018/19.

4. Advice and Recommendations
(Support and Board/Committee decisions requested):

- This report is for **APPROVAL**.
- The Board is asked to **APPROVE** the report.

5. History of the paper
Please include details of where paper has previously been received.

Senior Leadership Meeting	19 July 2019

NIHR | National Institute for Health Research

Clinical Research Network West of England

Integrated Annual Plan and Report 2018/19

Date of Mid Year Progress Report submission: 12/12/18
Date of End of Year Report submission: 16/05/2018

Section 1. Host Organisation Approval	
Confirmation that this Annual Plan has been reviewed and agreed by the LCRN Partnership Group:	**Yes**
Date of the LCRN Partnership Group meeting at which this Annual Plan was agreed:	**06/06/18**
Confirmation that this Annual Plan has been reviewed and approved by the LCRN Host Organisation Board:	**Yes**
Date of the LCRN Host Organisation Board meeting at which this Annual Plan was (or will be) approved:	**29/06/18**
Confirmation that this Annual Report has been reviewed and agreed by the LCRN Partnership Group:	**No**
Date of the LCRN Partnership Group meeting at which this Annual Report was agreed:	05/06/19
Confirmation that this Annual Report has been reviewed and approved by the LCRN Host Organisation Board	**No**
Date of the LCRN Host Organisation Board meeting at which this Annual Report was (or will be) approved:	30/07/19
If this Report has not been approved by the LCRN Host Organisation Board at the time of submission to CRNCC, then the LCRN Host Organisation Nominated Executive Director should provide that confirmation by email to the CRNCC once the Board has approved the Report	

Section 2. Compliance with the Performance and Operating Framework

Please indicate whether the Host Organisation and LCRN Partners are delivering the LCRN in full compliance with the specific areas/clauses of the Performance and Operating Framework 2018/19 listed below. Please provide a brief explanation of the reasons for partial / non-compliance in the commentary section.

POF area		Annual Plan Compliance	Commentary	Mid Year Compliance	Commentary	Annual Report Compliance	Commentary
Part A: Context							
3.	Working Principles	Yes		**Yes**		Fully Compliant	All aspects of the annual plan are fully compliant other than 5 of the specialty objectives which are outlined in the sections below.
Part B: Performance Framework							
2.	LCRN Performance Indicators						
	2.1 High Level Objectives	Yes	HLO 2A, 2B, 4, 5A and 5B for key deliverables to meet the target. See Key Projects section 2.	**Yes**		Fully Compliant	Where the LCRN has been underperforming for these HLOs there have been mitigating action taken to improve the targets.
	2.2 Specialty Objectives	No	We believe the following specialty objectives are not achievable due to factors out of partners and the networks influence. 1. Children. Target 90%. Baseline 6 of 9 Trusts (67%). Two of the other three trusts provide CAMHS services and not general medical care therefore any children recruited through CAMHS are likely to go into MH badged studies. GCS not currently recruiting into children's studies (previously non-recruiting PO). Baseline 86% if CAMHS population excluded from metric Also multiple studies recruiting children in primary care setting. 2. Dermatology-The LCRN have identified staff who are interested in being a nurse PI but this is dependent on suitable studies on the Portfolio. Essentially small number of trusts effects means each trust not recruiting has high impact on percentage. 3. ENT-The Portfolio is very small and is dependent on suitable studies for trainee involvement. 4. Mental Health - Lack of studies which are opening new sites recruiting children and young people 5. Stroke - The 8% target for RCTs is ambitious given the CRN recruitment as a % of SSNAP-recorded admissions in 2016-17 was 3% nationally and for 2017-18 YTD in the West of England it is 2%.	**No**	The following specialty objectives are not achievable due to factors out of partners and network influence.	Not Compliant	We have met 24/30 specialty objectives, further detail is provided in section 6.
	2.3 LCRN Operating Framework Indicators	Yes	3.1 No identified lead for Metabolic & Endocrine		Unable to appoint to this post despite repeated advertisement.	Not Compliant	We continue to be unable to appoint to the Metabolic and Endocrine CRSL post; the Musculoskeletal CRSL post has been vacant since September and the Oral & Dental CRSL role was covered by the National Oral & Dental Lead.
	2.4 Initiating and Delivering Clinical Research Indicators	Yes				Fully Compliant	
	2.5 LCRN Partner Satisfaction Survey Indicators	Yes				Fully Compliant	
	2.6 LCRN Customer Satisfaction Indicators	Yes				Fully Compliant	
	2.7 LCRN Patient Experience Indicators	Yes				Fully Compliant	
3.	Performance Management Processes	Yes				Fully Compliant	
Part C: Operating Framework							
2.	Governance and Management	Yes				Fully Compliant	
3.	Financial Management	Yes				Fully Compliant	See Appendix 10.4 & 10.5 Commercial Income Policy.
4.	CRN Specialties	Yes				Partially Compliar	See 2.3 above
5.	Research Delivery	Yes	The existing Study Support Service process will be optimised during the next financial year to ensure maximum value is being delivered to the research community. See Key Projects section 5.			Fully Compliant	
6.	Information and Knowledge	Yes				Fully Compliant	
7.	Stakeholder Engagement and Communications	Yes	Further investment within the communication team will be undertaken in 2018-19 to ensure the LCRN can align its local strategy with CRN CC national communication strategy. (please see key projects)			Fully Compliant	
8.	Organisational Development	Yes	Supra Regional Working, (please see key projects)			Fully Compliant	
9.	Business Development and Marketing	Yes				Fully Compliant	

Section 3. Executive Summary

Please complete the Table below, entering key performance highlights, successes and challenges from 2018/19

Please specify up to five areas where the LCRN has performed very well / significantly surpassed targets. This section is an opportunity for LCRNs to highlight excellent performance and successes. The intention is to enable opportunities to showcase these examples as case studies, opportunities for regional or national roll-out and sharing of best practice.	**1**	1. Increased collaboration with the LCRN's non-NHS partners and Public Health leading to an increase in growth surpassing the LCRN's target for HLO1. Collaborations include the University of Bristol's Avon Longitudinal Study of Parents and Children (ALSPAC), University of Bristol School of Public Health (PH), local hospitals and community providers, PH division of Local Authorities. We have established a relationship with Community Pharmacists and developed the Peripatetic Research Delivery Team who are supporting large vaccine studies within schools.
	2	The LCRN has the highest number of volunteers registered on Join Dementia Research and the highest percentage of people with a dementia diagnosis registered on Join Dementia Research (1.21%).
	3	Established the NIHR Bristol Managers and Directors Group where the focus has been to work collaboratively with NIHR Bristol Biomedical Centre, NIHR CLAHRC West, NIHR School for Primary Care Research, NIHR School for Public Health Research, NIHR School for Social Care Research, NIHR BRTC/CTEU, NIHR Health Protection Research Unit, and NIHR Clinical Research Network WE. All the managers/COOs across the NIHR infrastructure have shared and collated the key areas of group's work programmes to enhance joint working (e.g key research areas, training and capacity).
	4	Detailed review of the study support service in 2018/19 resulted in moving from a devolved network to a centralised service. All elements of the study suport service for lead network studies now undertaken by LCRN to ensure consistency in the standard of the service provided and complete oversight. This was undertaken on consultation with our partner organisations.
	5	Increased engagement in non NHS and public health settings has been a strength for the LCRN. The Peripatetic Research Delivery Team worked on 12 studies in 7 types of non-NHS setting in 2018-19. These settings have included the RICE Memory Clinic, the Bristol Well-being and Dementia Service, a womens' shelter, care homes, Bristol schools (7 in total), Sue Ryder (a hospice) and a private Community Provider (Virgin Health Care). Research Site Initiative (RSI) funding has provided infrastructure to a Community Provider (Bristol Community Health) and a Hospice (Dorothy House) who have recruited into NIHR studies in 2018-19 and supported JDR. An adult dental health study recruited into 14 new dental sites in the West of England in 2018-19, supported by CRN Service Support Costs. Engagement work with Public Health has led to the planned opening of more public health studies in the West of England which will be supported by the Peripatetic Research Delivery Team in 2019-20 (FRANK Friends and the SaFE study).

High Level Objectives	The LCRN recruited 37,380 participants to NIHR CRN Portfolio studies in financial year 2018/19, exceeding the LCRN target by 29%. The LCRN recruited 8,418 participants to NIHR CRN Portfolio studies managed by the Dementias and Neurodegeneration specialty in financial year 2018/19, exceeding the LCRN target by 1430%
Specialty Objectives	24 specialty objectives were completed/on target. Detail is provided in Section 6.
LCRN Operating Framework Indicators	The LCRN has met the operating framework indicators with the exception of being able to appoint to all the CRSL posts, with one (Metabolic & Endocrine) outstanding throughout the year and one (Musculoskeletal) unfilled since September. The Oral & Dental CRSL post was covered by the National Specialty lead.
LCRN Partner Satisfaction Survey Indicators	6/9 partner organisations completed the partner satisfaction survey, 67% (Data from 08/04/19; survey closed 15/04/19).
LCRN Customer Satisfaction Indicators	Customer Satisfaction Survey response rate of 6.68% (Data from Bulletin, dated 29/03/19).
LCRN Patient Experience Indicators	There were 442 (269 Adults PRES/173 Young Persons PRES) respondents across all POs, an increase from 330 resonpondents in 2017-18.

Host Organisation	The Host Organisation has continued to fulfill its responsibilities as an LCRN Host in line with the DHSC/LCRN Host agreement. University Hospitals Bristol NHS Foundation Trust has met all requirement in the Performance and Operating Framework in terms of LCRN structure, management roles and governance arrangements. The LCRN Executive Group continue to meet on a monthly basis with support from the Host organisation Medical Director, Dr William Oldfield, and attendance from Trust Finance (Assistant Finance Director Kirtsy Cepek). The LCRN Annual Plan and Annual Report 2018/19 are considered for approval at full public Host Board meeting with the Clinical Director (CD) and/or the Chief Operating Officer in attendance.
Governance and Management	Improved Partnership Group engagement and senior attendance.
Financial Management	Delivered financial break-even for 2018/19. Internal audit completed by Audit South West September 2018 and report submitted to the CRNCC October 2018. 3 year funding model developed and agreed by LCRN Partnership Group with an introduction of a performance and growth element to incentivise and improve performance. Finance tool training established for secondary care partners.

CRN Specialties	Advertisement of all Divisional Leads and Clinical Specialty Lead posts, which were due for a three year renewal, commenced in January 2018. The LCRN recruited into 29 of the 30 specialties in 2018/19 (there was no recruitment to the Ear, Nose and Throat specialty). The LCRN met 24 of the 30 specialty objectives in 2018/19. The LCRN was the highest recruiter to Dementias and Neurodegeneration studies and the second highest recruiter to Public Health studies in 2018/19. In terms of recruitment per million population, the LCRN ranked: 1st in Injuries and Emergencies, 3rd in Anaesthesia, Perioperative Medine and Pain Management, 4th in Children, and 5th in Oral and Dental. Royal United Hospitals Bath NHS Foundation Trust achieved a first European patient recruited in a metastatic breast cancer study (CPMS ID 36952) in the Cancer specialty.
Research Delivery	Performance of recrutiment to time and target had reduced slightly in Q2 2018/19, 60% for 2A and 73% for 2B (target 80%) therefore an escalation process was introduced for partners not achieving metrics supported with greater resources made available for through the LCRN core team. A workforce review of the core LCRN team evidenced the need to provide more support for partners through the secondary partner locality lead role. As a result of this recommendations were made to increase the core management team to the LCRN Partnership Group in Q4 2018, which was approved, with the aim of improving these metrics for 2019/20. A review of the Study Support Service in 2018 resulted in centralising the service within the LCRN to ensure a streamlined service that is delivered in accordance with NIHR CRNCC SOPs and guidance documents. There has been a sustained investment of expansion of CRN Support into non-NHS settings resulting in a considerable improvement in HLO1.
Information and Knowledge	EDGE LPMS fully implemented in all nine partner organisations and 47 general practices; monitoring of data quality and adherence to minimum data set is ongoing. System established to collect recruitment data from low activity general practices/non-NHS sites not managing their own instance of EDGE. The LCRN Business Intelligence Unit team have been trained to develop and design QlikView applications for ODP. The LCRN Business Intelligence Community of Practice has been re-established to support the implementation, development and use of NIHR and local information systems. All LCRN information systems have been reviewed and are compliant with GDPR.
Stakeholder Engagement and Communications	Increased visibility of the LCRN within the local research community and wider audiences using a range of on-line and off-line communications channels (including local and national print, TV, radio and websites (e.g. https://www.nihr.ac.uk/nihr-in-your-area/news.htm?custom_in_LCRN=3909). Developed a 'real time' news blog to collate and disseminate timely, appropriate news and significantly increased 'users' numbers and time spent reading news, the impact of which will become apparent in 2019/20. Continued to deliver our strong programme of patient involvement and engagement through People in Health West of England PPIE network (http://www.phwe.org.uk/). Seven Patient Research Ambassadors by the end of 2018/19. CRN Patient Research Amabassdors regularly attend partnership group meeting. Action plan developed arising from responses to patient research experience survey for implementation in 2019/20.
Workforce Learning and Organisational Development	Promoted culture of modern workplace learning, including awareness of NIHR National Learning Directory e-learning Programmes, Resources and Communities. The LCRN has trained 302 people on 24 courses (including Introduction to GCP, GCP Refresher, Valid Informed Consent, Next Steps in Clinical Research, Let's Talk Trials, Paediatric Communication and Consent, and Dry Ice training). Delivered 13 events with a total of 335 attendees to bring together and support non--medical research delivery staff and medical staff across the region. Promoted a culture of improvement and innovation through events and quarterly supra network knowledge exchanges covering all workstreams.
Business Development and Marketing	LCRN Business Development Profile refreshed as part of 2019/20 Annual Plan for marketing purposes by the national Business Development team. Worked with Contract Research Organisations (CROs) and Life Sciences Industry to support partnership working with the LCRN and Partner Organisations. Developed collaborative working with the West of England AHSN, supporting their ongoing work regarding the the Innovation Exchange model for the Accelerated Access Review of SMEs. IOM worked with AHSN and NOCRI to locally deliver the NIHR Roadshow for MedTech SMEs and presented at the event. The network has promoted the continued importance of the industry agenda to LCRN Partner Organisations and investigators through specialty leads, R&D Management and study teams. The network has supported the national Biosimilars campaign although scoping of local portfolio revealed no open biosimilar studies to build case studies.
National Contributions	The network has contributed to all national Communications campaigns. Regular Research Delivery Manager contribution to Divisional meetings and national initiatives, e.g PPIE Equality and Diversity event, IOM contributed to the Industry Improvement Plan, COO is National Wellbeing lead, NC is a Learning Group Advisor on the ALP and a member of the National Learning Directory Steering Group, and Senior RDM contributed to the High Level Objective review. Continuous Improvement Lead working with national team on Accelerating Digital and and improvement plan for study support. LPMS Lead has contirbuted to the CPMS-LPMS integration project, including regular attendance on teleconferences and face-to-face meetings, review of project documentation and testing of new functionality.

Section 4. Key Projects

Section 4 of the template should be used to detail the key projects to be delivered by the network in 2018/19. Please include local network projects and activities, projects to be delivered in collaboration with other LCRNs (as part of regional LCRN-Cluster collaborative activities or other LCRN collaborations), and projects to be delivered nationally/CRN-wide led locally by the LCRN. Projects to be delivered in collaboration with other parts of the NIHR and/ or other external organisations should also be included. Please add additional rows as required.

Columns A-F should be completed as part of the 2018/19 Annual Plan.
Columns G-H should be completed as part of the 2018/19 Mid Year Progress Report.
Columns I-J should be completed as part of the 2018/19 Year End Report.

RAG Information:

The RAG ratings are automated. Please select Complete, Green, Amber or Red from the drop-down menu in column I and the colour will update automatically.

Complete (C)	Milestone complete.
Red (R)	The specified deliverable was not delivered by the Milestone Date. Commentary is mandatory.
Amber (A)	There is a risk that the specified deliverable will not be delivered by the Milestone Date. Commentary is mandatory.
Green (G)	On target to deliver the specified deliverable by the Milestone Date.
N/A	The Key Project and/or Outcome is no longer required and therefore this Milestone is no longer applicable. Commentary is mandatory.

		To complete at Annual Plan stage				To complete at Mid Year Progress Report stage		To complete at Year End Report stage	
Ref	**Key project**	**Outcome**	**Lead**	**Milestone**	**Milestone date**	**RAG**	**Commentary**	**RAG**	**Commentary**
1. Governance and Management									
2.1.1	**Rotational Induction for Clinical Director Designate to National CRN Coordinating centre LCRN Liaison meetings**	As part of the Clinical Director Designate induction plan, in preparation for April 2019 handover, the CD Designate will attend the National CRN Coordinating Centre LCRN Liaison meetings on a rotational basis with the current Clincal Director	Dr Kyla Thomas	1. The CDD to have attended 40% attendance for National CRN Coordinating Centre/LCRN Liaison meetings in keeping with current PA allocation (2 PAs)	Q4	Amber	1. Dr Kyla Thomas took on the Clinical Director role as of the 1st November 2018. Dr Steve Falk working in an advisory capacity from 1st November until 31 March 2019 1.0 PA.	Complete	
2.1.2	**Named Deputy Chief Operating Officer identified**	Nurse Consultant (seconded) will formally deputise on behalf of the Chief Operating Officer	Paula Tacchi	N/A	Q1	Complete	1. Nurse Consultant/Deputy COO continues in seconded role. Interview for permanent post to take place 17/12/18.	Complete	Appointed to permanent post in Dec 2018
2.1.3	**Category B LCRN Partner flow down contract templates used to contract with all Category B LCRN Partners**	Supraregional approach to partner B contracts, with an external legal practice being approached to provide assurance of the contracts to partner B organisations	Supra Regional Approach	1. To have identified an external legal firm and agreed a standardised approach supra regionally, with CRN Wessex, CRN Thames Valley & South Midlands and CRN South West Peninsula	Q1	Green	1. All partner B organisations were approached via the LCRN without the requirement of external legal practice.	Complete	
2.1.4	**Name and contact details for the individual within the LCRN Host Organisation with specialist knowledge of information governance who is available to respond to queries raised relating to LCRN-funded activities:**	Joe Ellis Information Governance Officer Joe.Ellis@UHBristol.nhs.uk 0117 342 3701				Green		Complete	
2. Financial Management									
2.2.1	Section 5					Green			
3. High Level Objectives									
2.3.1	**Extend support for health and social care research taking place in non-NHS settings.** Following the recent change to the portfolio inclusion criteria the Clinical Director Designate (a Consultant in Public Health) is leading plans to: • Scope open eligible studies which may benefit from the network support • Engage with local relevant academic departments / Chief Investigators to ensure CRN support is considered during study set up • Coordinate support for governance and applications in non-NHS settings (via the primary care embedded study support service) • Explore how to best to resource new areas e. g.upskilling existing Research Support Team and submission of a development bid to support a role which promotes further engagement with Local Authorities and Public Health England	Improve HLO1	Clinical Director Designate, Chief Operating Officer, Research Delivery Managers, Study Support Lead and Nurse Consultant	1. Scoping and engagement work is continuing from Q4 17-18. 2. Support for governance and applications in non-NHS settings will continue as currently and will be reconfigured as new national guidance is issued and in the service review (Ref 2.5.1 below) 3. Workforce training needs will be assessed on a per-study basis	Q1 Q3-4 Q1-4	Green	1. Meetings with University of Bristol's Avon Longitudinal Study of Parents and Children (ALSPAC) leadership to establish support for current and future studies. -Pending portfolio adoption of 4400+ recruit study. 2. Meetings between CRN WE SMT and University Public Health (PH) researchers. -University of Bristol, University of the West of England Bristol (UWE), University of Bath. -Collaboration between CRN WE and CLAHRC West. -Preparation of ARC bid (Strong PH theme throughout). -Increased engagement with CLAHRC West staff. -Coordination between CRN WE and local hospices and community providers to grow and attract research. 3. Support for infrastructure and Delivery team support in Sue Ryder, Dorothy House, Bristol Community Health and Virgin Care. -Engagement with PH Division of Local Authorities. -South Gloucestershire, Bristol, BANES, North Somerset. -Consistent attendance at PH National Specialty Group meetings. -Meetings with local Community Pharmacists to develop a portfolio of research ready pharmacy sites. -Peripatetic Research Delivery Team supporting large vaccines studies run in local schools.	Complete	1. The Peripatetic Research Delivery Team worked on 12 studies in 7 types of non-NHS setting in 2018-19. These settings have included the RICE Memory Clinic, the Bristol Well-being and Dementia Service, a womans' shelter, care homes, Bristol schools (7 in total), Sue Ryder (a hospice) and a private Community Provider (Virgin Health Care). 2. RSI funding has provided infrastructure to a Community Provider (Bristol Community Health) and a Hospice (Dorothy House) who have recruited into NIHR studies in 2018-19 and supported JDR. 3. An Adult Dental Health Study recruited into 14 new dental sites in the West of England in 2018-19, supported by CRN Service Support Costs. 4. Engagement work with Public Health has led to the planned opening of more public health studies in the West of England which will be supported by the Peripatetic Research Delivery Team in 2019-20 (FRANK Friends and the SaFE study).

Section 4. Key Projects

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Amber (A)	There is a risk that the specified deliverable will not be delivered by the Milestone Date. Commentary is mandatory.
Green (G)	On target to deliver the specified deliverable by the Milestone Date.

2.3.2	**Expand use of Research Support Teams (Primary Care and Mental Health / Dementia) In order to better support research delivery across organisational boundaries and manage peaks in activity there will be a focus on expanding the use of the Research Support Teams. Skill sharing between the previously independent teams will also be explored.**	Improve HLO1	Nurse Consultant and Division 4 RDM	1. Map opportunities throughout year where teams can support peaks in activity (i.e. meet capacity demands for short duration / high recruitment studies e.g. vaccine studies) 2. Identify areas / studies where teams can more efficiently work together. 3. Develop areas where 'Research Practitioner' roles can support activity in Primary Care	Q1 Q1-2 Q1-4	Green	1. Members of both teams have provided support for vaccine studies during times of peak activity. 2. Support has been provided from both PC and MHD teams to deliver studies across organisational boundaries including non-NHS settings. 3. Research Practitioner role has been effectively introduced to deliver studies which had originally been deemed as requiring a research nurse.	Complete	1. The Primary Care and Mental Health Teams now effectively cross-cover each other to now work as the Peripatetic Research Delivery Team. They share one organisational study allocation and capacity tool to manage a combined caseload and share performance targets. 2. The Clinical Research Practitioner role has worked safely and effectively on many studies in the Peripatetic Research Delivery Team 2018-19 and allowed a more efficient targeting of nurse resource. The numbers of CRPs within the team has increased. 3. The Peripatetic Research Delivery Team has worked across specialties (Primary Care, Mental Health and Childrens) and in community, Primary Care and hospital settings in 2018-19. 4. The Peripatetic Research Delivery Team has supported a large children's vaccine study which was run in seven Bristol schools and Sixth Form Colleges. They supported 29 clinics in the first two waves of the study, providing 4-5 team members to staff the clinics. This assisted in the recruitment of 1064 participants for the Network and supported the delivery of research into non-NHS settings and across specialties.
2.3.3	**Staff skill mix / structure reviews Lead staff reviews in 2 Partner Organisations identified as being outliers regarding cost per ABF (to run in parallel with LCRN-wide staff review- Ref 8.2)**	Improve HLO1 (via increased return on investment within specified POs)	Nurse Consultant	1. Initial scoping 2. Consultation (where necessary) and implementation	Q1 Q2-4	Green	1. Scoping of potential skill mix undertaken with both partner organisations. 2. Consultation process underway.	Complete	See Case Study 1 Weston Area Health Trust Skill Mix Review
2.3.4	**Implementation of recommended actions from LCRN Review Project In Q3 17-18 a Project was commissioned to investigate why the West of England CRN was falling behind on recruitment in comparison to other LCRNs. The report from the project is due at the end of Q4. Recommended actions from the report are expected to be implemented throughout 2018-19.**	Improve HLO1	All core team members where appropriate	1. Decision by Senior Leadership team as to which recommended actions to take forward (i. e. based on feasibility, available resource and potential impact etc.) 2. Planning and implementation of relevant future projects which will facilitate increased delivery.	Q1 Q2-4	Complete		Complete	
2.3.5	**Root cause analysis of all commercial studies which do not achieve RTT To provide insight into future potential areas of improvement all commercial studies closing within secondary sites failing to meet RTT will be categorised and narrative recorded to explain why RTT was missed.**	Improve HLO2a in secondary care	IOM	1. Finalise categories and build drop-down / text field within EDGE to record reasons for not achieving RTT. 2. Monitor collection of data within POs 3. Analyse results and provide recommendations for Annual Plan 19/20	Q1 Q1-Q4 Q4	Amber	1. Categories drafted and process discussed with POs. 2. LPMS fields under discussion to ensure data is recorded consistently.	Amber	This project to prospectively collect intelligence on reasons for failing to meet RTT was not delivered within 18/19. However, a retrospective review of all studies failing to meet RTT within 18/19 (when compared with performance in 17/18) was carried out (see section 2.11.1). Following a managerial re-structure in Q1 19/20, the intention is to continue with this project as originally envisaged. As of 01/04/2019, the LCRN have all agreed to record Root Cause Analysis, using the newly created entities at site and study level on Edge for all studies where an open study BRAG rating turns from amber to red on the monthly RTT report or once a study has closed red.

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2.3.6	**Commercial Community of Practice Primary Care: To improve engagement with primary care commercial research delivery. A Primary Care Community of Practice group was established in Q4 2017-18. The group provides an opportunity for PCOs to share best practice on recruitment / feasibilities for commercial studies. 14 PCOs were represented at the first meeting and feedback indicated an interest to continue the group (i. e. teleconferences and face to face meetings).** **Secondary Care: Monthly teleconferences with PO R&Ds to facilitate flow of information from CRN CC to PO, share best practice, and identify areas for collaborative working across the network. For 2018-19, the group will explore the concept of network-wide feasibility.** **For both primary and secondary care, the LCRN is able to facilitate conversations and relationship building between POs/PCOs and sponsors through these community of practice meetings/events.**	Improve HLO2a in primary care	IOM	1. A development bid will be submitted to the LCRN Executive Group to fund a session of Primary Care Research Nurse time to continue to lead the project. 2. Teleconferences and face to face meetings will be facilitated by the IOM / Senior Portfolio Facilitator	Q1 Q1-4	Green	1. Successful development bid for protected time for two Primary Care Research Nurses to contribute to the project. Training has taken place as part of their induction. 2. During 2018-19 to date, there has been a teleconference and face-to-face meeting attended by Primary Care staff and representatives from industry, both of which received good feedback. The third face-to-face meeting is planned for 20/12/18.	Complete	1. Primary Care Commenrial Community of Practice (PC CCOP) Research Nurses are key members of the PC CCOP committee. Both attended the National Primary Care Industry Meeting in February and shared learning with the wider group. Also PC CCOP Research Nurses presented at the CRN WE Primary Care RSI Event in March and promoted the work of the group. Development funding application submitted for 2019/20 to continue project. 2. Two face-to-face meetings held within 2018/19, both with good representation from Primary Care Organisations and speakers from industry (Novo Nordisk and Sanofi). Two teleconferences held within year with a focus on sharing best practice for studies open at multiple sites within the region. Key outcomes include a screening rota for secondary care studies suitable for Primary Care. A total of 41 studies were reviewed, resulting in an additional 7 recruiting and 4 PIC studies offered to Primary Care, and the planned creation of standardised site contract templates for collaboration between sites.
2.3.7	**RTT Incentive Scheme** **Mirroring the national finance model, a local incentive scheme will be set up to reward achievement of RTT (including PCO and POs).**	Improve HLO2	IOM	1. Finalise structure for scheme (engaging with R&D Management Group and gaining approval from Executive Group) 2. A development bid will be submitted to the LCRN Executive Group to ring fence funding for RTT awards in primary and secondary care 3. Promote scheme with partner organisations and primary care organisations.	Q1-2 Q2-Q4	N/A	1-3. Development bid unsuccessful. RTT performance to be included in financial model for FY 2019-20. Propose Primary Care RTT incentive scheme as part of new RSI scheme.	Complete	RTT incentive scheme fully embedded into PO annual funding allocation model for 2019/20. POs made aware of intention to reward RTT throughout 2018/19 in order to increase focus on RTT improvement activities. For Primary Care Organisations the RTT award payments remain a separate scheme with payments made in Q4.
2.3.8	**Locally celebrate achievement of RTT Congratulatory letters, from the CD / COO, will be sent to PIs / Research Teams achieving RTT in commercial studies.**	Improve HLO2	IOM and Communications Lead	1. Letters will produced quarterly and articles throughout year	Q1-Q4	Green	1. Letters sent quarterly. Business as usual.	Complete	Now business as usual.
2.3.9	**Scoping best practice to achieve HLO4 and HLO5** To better understand how to improve HLO4 and HLO5 the Study Support Service Lead will contact locally and nationally high performing centres to learn of practices/ processes which may be applicable to sites within region.	Improve HLO4 and HLO5	Study Support Service Lead	1. Investigate local practices in locally high performing sites/teams along with practices in the 3 top performing LCRNs 2. Disseminate findings via R&D Management Group Meeting and monthly Study Support Service teleconference 3. Action plan any activities requiring implementation on a regional level	Q1 Q2 Q2-4	Amber	1. Activities undertaken on all LCRNs reviewed and themed. 2-3. Findings disseminated to RDMs and Portfolio Facilitators for feedback.	Complete	All actions from LCRN Annual Delivery Plans 2017-18 relating to HLO 4 and 5 were collated into one document to identify additional activities that the LCRN can implement locally. Now business as usual.

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2.3.10	**Improving HLO6** The proportion of general practices recruiting to NIHR studies in 2017-18 was 96 out of 286. However, many practices are merging to cover larger population groups which will reduce the proportion of practices recruiting to NIHR studies. The availability of studies on the portfolio for primary care has also reduced substantially. The focus for 2018-19 will be to ensure that GPs are offered and supported to deliver any studies available to the region to ensure maximum engagement and to ensure that research is embeded into the new landscape.	Improving HLO6 for primary care	Nurse Consultant, Senior Research Officer for Primary Care and GP Champions	1. Shortage of Studies - advertising campaign/clearer systematic links with researchers 2. Future proofing the RSI scheme - to encourage research at scale and variation in research sites based on the successful North West Thames Model 3 Flexible Team development - cross-covering with MHT to eventual merge	Q1-4	Green	1. Engagement with PC researcher within LCRN in place. 2. RSI scheme currently being revised 3. Flexible team are cross covering studies. New posts now advertised to work across all areas.	Complete	1. The RSI Scheme has been re-engineered to allow more collaborations to apply for funding to support research at scale and maximise the potential of the Primary Care Networks to engage with research. 101 applications were received for the new RSI Scheme 2019-20; an improvement from the previous year (89 applications). Applications were received from 26 new Primary Care Organisations and 4 non-NHS sites (including a pharmacy). RSI funding now supports 9 collaborations, including two thirds of GP practices in Swindon, as Swindon sites have formed large federations and submitted collaborative applications. See Case Study 2 RSI Proposal 2019-20. 2. LCRN have employed a Research Nurse to work across nine practices in a locality in Bristol to promote Hub and Spoke and integrated research practices. 3. The Peripatetic Research Delivery Team have worked on 13 Primary Care studies in 2018-19, undertaking screening, consenting and follow-ups to support GPs and practice teams' engagement with research. 4. Engagement and communication with Primary Care stakeholders was supported by a large RSI Event attended by 120 members of the Primary Care research community, including academics and study teams. The event showcased new studies and how sites were working innovatively to enable greater research engagement from patients. 5. The LCRN also held a Primary Care Research Nurse Professional Development Event, attended by 15 Primary Care Delivery Research Nurses from across the region. The event showcased the training available from the LCRN and NIHR, including PI training. Also it supported networking and the use of Twitter/WhatsApp/Facebook to communicate across wide geographical regions.
4. LCRN Specialty Activities									
2.4.1	Specialty Lead Vacancy Intentional vacancy in Metabolic & Endocrine will continue in 2018-19. Role has been previously advertised without any applications. RDM will attend the National Specialty meetings.	Connection between LCRN and National Specialty group / cluster offices will be maintained by RDMs in the abscence of appointed CRSLs in Metabolic & Endocrine.	RDMs	1. Meetings will be attended throughout the year	Q1-4	Amber	1. RDM has not been able to attend specialty meetings to date. Workforce review underway to establish capacity for RDM to attend in the future.	Red	Workforce review is complete, new posts required to increase RDM capacity. See Case Study 3 CRN West of England Workforce Review. Intention for all meetings to be attended in 2019/20 by RDM or newly appointed CRSL.
2.4.2	**Induction for new Division 2 Lead** Plan to induct new Divisional 2 Lead in CRN business.	To equip the new Divisional Lead with the necessery knowledge and information to perform the role	Division 2 RDM	1. Focussed sessions (CPMS, national / local funding models, local structure etc.) 2. Ongoing support provided by Division 2 RDM and relevant portfolio facilitator	Q1 Q1-4	Green	1. Induction/training sessions held in April 2018. 2. Regular monthly contact with CRSL.	Complete	1-2. CDL well inducted in role with ongoing support from Division 2 RDM and Portfolio Facilitator. Following the CDL/CRSL recruitment process for 2019-2022, the existing Division 2 CDL has been reappointed.
2.4.3	**CRSL Review** All CRSLs are being asked to complete a survey at the end of Q4 17/18. The survey has a number of objectives: - To understand their training needs. - To assess their contribution to CRN business. - To re-affirm their responsibilities as a CRSL. CRSLs will also attend a mid-year progress meeting with their DL	- All CRSLs need the necessary knowledge and skills to perform their role both on a local and national level. - The CRSL role requires that individuals are committed to improving local participation in their specialty (where possible), and meeting their local and national responsibilities. - The survey is expected to highlight any areas requiring refreshing for 18/19.	CD, CDD and DLs	1. Surveys reviewed and feedback provided (including any areas requiring attention). 2. Action plans drawn up for any training needs identified. 3. Progress assessed at mid-year meetings. 4. Where needed, CRSL posts will be re-advertised	Q1 Q1 Q2 Q4	Amber	1-3. The newly appointed Clinical Director will advertise all CRSL positions in Q4 as the majority of the CRSLs appointments are due for renewal.	Complete	
5. Research Delivery									

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2.5.1	The core LCRN Study Support Service will continue to work closely with NHS Partners to deliver an efficient service. The aim for 2018-19 is to increase the numbers of core staff within the LCRN who are able to support the service by developing the portfolio facilitators through in house training to support local and practical application of the service. A review of the SSS will also take place with our Partners to ensure we are providing value for money, with a move to a centralised approach for oversight of service support costs.	To consistently deliver the local elements of the CRN's Study Support Service within West of England	Study Support Service Lead	Key Deliverables: 1.Review the primary and community research management and support and make recommendations for future provision of the service. 2. Continue with the early contact and engagement. 3. Provide study recommendations and risk assessments to other LCRNs. 4. Focus efforts on local community. 5. Review the matrix of responsibilities for the study support service for commercial, non-commercial and multi centred studies with all stakeholders with a mid-year evaluation to ensure it is effective service and make recommendations for future provision of the service. 6. Workshop with partner organisations and core team to identify and develop tools and materials to support them to deliver the service. 7. Work with the supra regional group to ensure continuous improvement of the service.	Q3-4 Q1-4 Q1-4 Q1-4 Q2-4 Q2-4 Q1-4	Green	1. Primary and community research management activities agreed by way of matrices to define roles and responsibilities and reduce duplication. 2. Early contact and engagement continues. 3. The SSS was reviewed which included: a scoping exercise in July 2018, a visit to LCRN July 2018, agreeing matrices, and a workshop on 04/07/2018. The Study Support Service workshop was held with Partner Organisations to: -Identify things that work well so we can build in them. -Identify areas for improvement and challenges so we can find solutions. -Identify how we measure quality and success in the Study Support Service. -Identify how we improve oversight and assurance. -Identify how we collaboratively address gaps in service? -Identify how we know we are delivering a good service? Outputs from the workshop were used to redefine the LCRNS SSS provision. 4. The SSS have spent time this year meeting with non-NHS organisations and attending events to promote the NIHR CRN and bring in new business. 5. The matrices for use in primary care have been agreed to define roles and responsibilities and reduce duplication. When discussed with secondary POs, it was agreed that this information is better captured in a checklist on the LPMS of choice (EDGE). 6. Workshops have been held with RDMs and PFs and materials such as aide-memoirs and process maps have been developed. 7. The SRLCRN SSS group have met three times this year and have found value in meeting to discuss challenges and identify solutions.	Complete	1. The matrices for use in primary care have been agreed to define roles and responsibilities and reduce duplication although some of this work was superseded by the SSS review. When discussed with secondary POs, it was agreed that this information is better captured in a checklist on the LPMS of choice (EDGE). 2 and 3. The bulk of work for SSS in 2018-19 involved a review of SSS. The LCRN undertook a review of the SSS with a view to implementing changes to improve assurance, oversight and delivery of the service locally. The review (see Case Study 17 SSS review V1.0) included: -Scoping exercise July 2018 Three LCRNs (CRN Eastern, CRN North West London and CRN Wessex) were interviewed about their SSS provision. The LCRN found that most LCRNs operated a centralised or mixed model. -Visit to LCRN July 2018 The COO and RDM work stream lead for SSS visited CRN South London on 18/07/2018 to see how their Study Support Service operated as part of a local SSS review. -Agree matrices See point 1 above. -Workshop with POs on 04/07/2018 The Study Support Service workshop was held with Partner Organisations to: -Identify things that work well so we can build in them. -Identify areas for improvement and challenges so we can find solutions. -Identify how we measure quality and success in the Study Support Service. -Identify how we improve oversight and assurance. -Identify how we collaboratively address gaps in service. -Identify how we know we are delivering a good service. -Identify and develop tools and materials to support delivery of the service. Six questions were presented for discussion and feedback: 1. What works well in your organisation? 2. What are the areas for improvement or challenges? 3. How do we measure quality and success in the Study Support Service? 4. How do we collaboratively address gaps in service? 5. How do we improve oversight on Lead LCRN grant applications? 6. How do we improve oversight on costing and attribution (AcoRD)? Outputs from the workshop were used to redefine the LCRNS SSS provision and, following this scoping work, the LCRN proposed a change to the current Study Support Service provision from 1 October 2018. It was decided to integrate the SSS into the core LCRN team. The Lead LCRN would perform the SSS responsibilities in house across the team: RDMs, PFs, CRSLs and SSS team. A second workshop with POs on 20/09/2018 to share findings from the SSS review and launch of a change to the current Study Support Service provision from 1 October 2018 whereby: -All elements of the SSS for Lead Network studies are undertaken by the LCRN.

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2.5.2	**Coordinated working between Study Support Service and Industry**	To ensure consistent delivery of the Study Support Service for commercial research	IOM and Industry SPo	1. Work closely with Industry Single Point of Contact, RDMs and Portfolio Facilitators to support commercial research and promote Study Support Service to customers. 2. Activities as described in 2.5.1.	Q1-4 Q1-4	Green		Green	Following core team staff review in Q3, decision made to combine Study Support Service and Industry under a common manager (the Senior Research Delivery Manager). Some planning work undertaken in Q4 for full implementation in Q1 19/20.
2.5.3	**Accurate Minimum Data Set data Monthly reports are distributed to highlight missing data (and discrepancies between LPMS and CPMS within POs). The Portfolio Facilitators meet monthly with POs to understand and correct data. Sponsors are chased if recruitment isn't uploaded onto CPMS with an escalation pathway for non-compliance. Recently rolled out primary care report (where PCOs can check their performance data) to continue in 2018-19.**	Provision of near time Minimum Data Set data items	RDMs and BI Manage	1. Monthly reports from LPMS (EDGE) will continue to be shared with Partner Organisations R&D to identify missing data points and data quality issues within EDGE . 2. Ongoing data quality checks on Capacity and Capability data 3. HLO performance tabled at monthly R&D Management meeting. 4. Provide support to Partner Organisations who are not meeting the HLO requirements. 5. LCRN BIU to deliver CPMS/LPMS training to sites on request.	Q1-4 Q1-4 Q1-4 Q1-4 Q1-4	Green	1-5. All activities continue to be delivered in line with milestones detailed in CRN Business Plan 2018/19. The introduction of the EDGE Local Portfolio Management System into GP Practices in 2018/19 will mean that existing reporting and data quality management of the minimum data set will need to extend into primary care; the BI team plans to extend reports and systems into primary care in Q4 2018/19.	Complete	Project delivered within Q1-2. Focus in Q3-4 was on LPMS/CPMS implementation, see section 2.6.3 for further details for Primary Care.
2.5.4	Prioritisation of dementia research Development of the newly formed 'Mental Health and Dementia Research Support Team' (a regional team managed directly by the core team and therefore better able to work across boundaries) will continue in 18/19. Work will focus on: -Better connecting primary care sites (i.e. acting as PICs) with established research units. -Developing rater skills with the team and other delivery teams within region (including the Primary Care Research Support Team who can provide reciprocal cover). -Expanding research (along with the Primary Care Research Support Team) into local non-NHS settings (i.e. care homes).	Increase recruitment into dementia studies, particularly by working across traditional boundaries	Division 4 RDM	1. Formal 'launch' of the 'Mental Health and Dementia Research Support Team', and generation of promotional material to explain how the team can support studies. 2. Increase with 2 new organisations within region and demonstrate work linking multiple organsiations 3. Develop a programme to increase provision of rater training opportunties across LCRN 4. Collaborate with neighbouring LCRNs on projects	Q1 Q4 Q2 Q4	Green	1-4. Decision made to merge 'Mental Health and Dementia Research Support Team' and 'Primary Care Research Support Team' and re-brand as 'Multi-professional Research Support Team'. The team is supporting non-NHS settings research (for instance in a domestic abuse charity, schools-based vaccination study and a Public Health Cohort study) and this will be key role for this team going forward.	Green	Further to the mid-year commentary, the team is now functioning as a merged team (Peripatetic Research Delivery Team) with a common application to access support. A barrier to collaboration with trusts has been the 'funding following consent' finance model. Locally this has been overcome by negotiating and agreeing a split of ABF (regardless of where consent takes place) between the regional team and trusts. Following local scoping, increasing the provision of rater training was not felt to be a priority and was not continued.
2.5.5	**Promotion of the use of Join Dementia Research (JDR) CRN West of England is engaging with an NIHR exemplar initiative 'Embedding Research In Care (ERICA)' which aims to sustainably embed / promote JDR within the wider NHS. Plan to test and evaluate projects before national launch.**	Increase number of people registering with JDR	Division 4 RDM	1. Establish Project Plan Board consisting of members interested in dementia (trusts, CCGs, AHSNs, Universities) 2. Formulate early project programme (determine scope of work and plan programme of work i.e. initiating 'quick win' projects and longer term objectives). 3. Deliver on project plan	Q1 Q1 Q2-4	Green	1. Board formed with good levels of commitment. Group decided on particular focus of increasing number of BME people registering and improving knowledge of dementia service staff of JDR. 2-3. Plans drawn up and are being implemented. Projects have included promoting JDR on local radio and sending letters to all recently diagnosed patients within a memory (which had not previously engaged with JDR).	Complete	The JDR board met 3 times in 2018/19 to decide which JDR projects to locally implement. This is now business as usual. The LCRN had the highest number of volunteers registered on Join Dementia Research in 2018/19 and the highest percentage of the population with a dementia diagnosis registered on Join Dementia Research (1.21%).
2.5.6	**To facilitate collaborative working across primary and secondary care** To increase recruitment via PIC activity, open communication and collaborative ways of working across primary and secondary care will be developed. Lessons learnt from diabetes and dementia projects will be rolled out to other areas.	-Increase in PIC activity across primary and secondary care -Commercial research delivered across diverse healthcare settings	IOM and Primary Care Team	1. Inviting PO R&Ds to meet with PCOs within each locality will strengthen links between these organisations. Speciality focused events such as the Diabetes Regional Events held in April and September 2017 and the Dementia Outreach Project managed by the RICE centre will continue into 2018-19 and include representation from the LCRN to promote this joined up way of working. 2. Explore how we can utilise primary care and mental health peripatetic teams to expand industry offer into non-NHS settings such as community providers/care homes (linked to projects 2.3.1 and 2.3.2)	Q1-4 Q2-4	Green	1. Industry Managers from PO R&Ds meeting with commercially active Primary Care sites as part of the Primary Care Commercial Community of Practice (section 2.3.6) to discuss the next steps for collaborating. Diabetes Regional Event held in November 2018 and Dementia Outreach Project Event held in June 2018. 2. Discussions about support for commercial research at NBT and AWP have been had.	Amber	1. Two PC CCOP meetings were dedicated to improving collaboration between primary and secondary care. Diabetes Research Nurse from NBT presented at one session and highlighted opportunities for collaboration. Case studies from secondary care working between sites was presented at the second PC CCOP face-to-face meeting. Planned work to create an open access directory for primary and secondary sites to contact relevant person(s). 2. Utilising the Peripatetic Research Dleivery Team to support commercial studies was considered for a number of studies within 2018/19 but none progressed. Careful consideration of the finances is needed in any agreement to support. 3. The LCRN had the second highest proportion of GP Practices recruiting into commercial studies in 2018/19 (6%).

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2.6.1	**Greater utilisation of ODP** Due to delays in research activity being uploaded to CPMS, performance reporting in West of England has typically represented LPMS research activity. Performance report generation has therefore focussed on the use of Excel / Access. With the advent of research activity being exchanged between LPMS / CPMS, there is a need to update the skillset with the core team to better manipulate charts etc. within ODP.	Make better use of ODP program to represent research activity, leading to greater insights into local performance/areas requiring attention. A particular focus will be increasing the use of Statistical Process Control charts.	BI Workstream Lead and BI Manager	1. All staff members who routinely generate reports to undergo ODP training 2. Link with teams within Supra Network who edit ODP for peer support and to develop joint projects. 3. Continue to provide ODP user courses for delivery teams (target to re-visit all major trusts and expand training to primary care teams). 4. Explore potential for digitalising ODP training materials e.g. through webinar system.	Q1 Q1-2	Amber	Focus on implementing CPMS-LPMS integration has delayed elements of this project. 1, 3 and 4. Advanced ODP training planned for Q4. Following the roll out of EDGE training for PC sites and second round of training (Q1-2 19/20) is planned. 2. Discussion held on ODP skill sharing within BI supraregional group. Plan to share ODP SPC charts.	Green	1. BI Manager, Senior Portfolio Facilitator and 3 Portfolio Facilitators completed training based upon the QlikView Developer and Designer courses in Q4. 2. ODP development is a regular item at the supra-network BI meeting. All BI teams have agreed to support each other in ODP development. 3. Focus on training 47 sites in primary care reduced capacity within team to proactively target all trusts for ODP training, however training has been provided throughout the year on an ad-hoc basis. 4. Digitalising ODP training not achieved in 2018/19, this project will roll into 2019/20.
2.6.2	**Development of staff management tool** Due to plans to remove staff names from the to the CRN Finance Tool, a new process will need to be developed to provide adequate oversight of resource deployment with Partner Organisations.	Continuation of ability of Partner Organisations to provide assurance that CRN funding is being appropriately spent.	COO and BI Manager	1. A solution on a Supra regional level will be explored initially. 2. Work with local Data Protection Lead to assure PO's that the LCRN is compliant with GDPR.	Q1 Q1-2	Green	1. Q1 and Q2 Host Finance provided training to secondary partner organisations on how to upload returns on to CRN Finance Tool. Meeting January with Finance leads within POs to evaluate progress and facilitate improvements with returns. 2. Meeting held between COO and GDPR lead within host to review compliance with current systems used within CRN.	Amber	1. The local workaround for re-adding names to PO finance returns continues to be cumbersome and time-consuming. The project to simplify the oversight of Partner Organisation returns will roll into 2019/20 and will be picked up by the newly created CRN Finance Officer post. 2. Review of LCRN systems by the Host organisation GDPR lead resulted in all systems being declared compliant.
2.6.3	**Extend use of LPMS in Primary Care setting** While the roll out of EDGE into CRN West of England Partner organisations has been completed, there has been limited implementation of the system in the primary care setting. CRN West of England will scope how LPMSs are being implemented in primary care by other LCRNs, exploring GP Practices' reception and engagement with their LPMS and evaluating the training and support needs of the practices. A project plan will be written to deliver an initial EDGE rollout phase to volunteer GP Practices in financial year 2019-20.	To plan for rollout of EDGE to General Practice in 2019-20.	BI Workstream Lead and BI Manager	1. Explore LPMS implementation in primary care with counterparts in other LCRNs and establish whether GP Practices are managing their own instances of their LPMS 2. Establish the feasibility of EDGE being implemented at the GP Practice level within CRN West of England 3. If feasibility is confirmed, identify GP Practices who will be early adopters of EDGE for initial rollout phase in 2019-20 4. Produce project plan for rollout phase in 2019-20	Q1-2 Q2-3 Q2-3 Q3-4	Amber	1-4. Decision made to roll out LPMS in PC via 2 methodologies: individual LPMS accounts for high activity sites and central uploading for low activity sites. Rollout phase has been pushed forward to Q3-4 2018/19 due to anticipated go-live of CPMS-LPMS Research Activity interface by the end of FY 18/19. Early focus has been on training sites with high activity to use/enter recruitment activity on EDGE (57 of 86 sites trained so far). Uploading of recruitment activity is being monitored as 'go-live' date approaches.	Green	1-4. Initial training for 47 sites with individual instances of the LPMS has been completed, with the LCRN now moving into monitoring of uploading and ad-hoc support phase. A system to collect site level recruitment (via a Google Form for central uploading to LPMS) for sites with lower levels of activity has been finalised and will go live in Q1 2019/20.
2.6.4	**To contribute to the planning and delivery of national BI initiatives** **BI Manager or nominated deputy will attend all meetings of national working groups including but not limited to the INSIGHT group, Virtual Business Intelligence Unit and ODP Developers. BI Manager or nominated deputy will also attend and contribute to national teleconferences including but not limited to CRN EDGE LPMS group, and vBIU ODP Developers group.**	To forward the national Information and Knowledge agenda whilst developing local skillset.	BI Workstream Lead, BI Manager and Portfolio Facilitators	1. Aim to have representation at all national meetings related to Information and Knowledge	Q1-4	Amber	1. CRN West of England has been represented at the national CPMS-LPMS research activity interface meetings, however due to staff absence the LCRN has been unable to send a representative to national ODP meetings (the LCRN was unable to identify a deputy with the appropriate knowledge to make a meaningful contribution to the meeting), although a representative has dialled in to most CRN EDGE CPMS teleconferences. The LCRN has had several teleconferences with CRN Wessex Business Intelligence Manager after the national meetings to be given a summary of discussions. CRN West of England plans to send a representative to all remaining national Business Intelligence meetings in 2018/19.	Complete	
2.6.5	**Community of Practice for BI** **BI Manager will lead the re-establishment of a community of 'EDGE Champions' in each PO and meet quarterly with an expanded remit to cover the use of all our business intelligence platforms (i.e. the Open Data Platform (ODP) and LCRN produced reports) and surrounding procedures (e.g. Study Change Log). The group will input into procedures, share best practice and ensure new developments are cascaded to POs.**	Better understanding and use of all features of BI tools (ODP, EDGE,local processes) leading to more efficient working.	BI Manager	Root cause analysis of all commercial studies which do not achieve RTT To provide insight into future potential areas of improvement all commercial studies closing within secondary sites failing to meet RTT will be categorised and narrative recorded to explain why RTT was missed.	Q1 Q2-4	Green	1. The CRN West of England BI Community of Practice (incorporating the EDGE champions group) was revived and met on 25 July 2018 to discuss business intelligence systems and activities in partner organisations across CRN West of England. The group will be key to disseminating CPMS-LPMS business changes. 2. A planned meeting in Autumn 2018 was postponed due to staff absence, however a meeting will be held in Q4 18/19 focusing on preparedness for the launch of the CPMS-LPMS research activity interface.	Complete	Second meeting of PO BI leads held in Q4. Plan to continue meeting as business as usual with an intention to hold them more regularly with the roll out of LPMS/CPMS integration work.
7. Stakeholder Engagement and Communications										

Section 4. Key Projects

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2.7.1	**Delivery of LCRN PPIE Inititives** CRN West of England will collaborate with POs and People in Health in the West of England (PHWE), to coordinate the delivery of PPIE activity across the LCRN.	Deliver CRN PPIE initiatives locally	PPIE Workstream Lead	1. The LCRN will appoint a communications assistant in Q1, the post holder will assist in delivering the LCRN PPIE strategy. 2. The LCRN will continue to fund P/T administration post in PHWE, to facilitate the delivery of the Patient Research Experience Survey and Patient Research Ambassador Inititive across the PHWE PPIE network .	Q1 Q1-4	Complete	1. Two half-role Communications Assistants have been appointed and have assisted with the PPIE strategy. 2. A restructuring of the PHWE Network means that the P/T administration post has not been renewed this year. Instead the Patient Research Experience Survey and the Patient Research Ambassador Initiative will be administered and co-ordinated via the CRN, working with partner organisations.	Complete	1- 2 Posts are now filled and supporting PPIE inititives locally.
2.7.2	**Patient Research Experience Survey (PRES)** In partnership with POs and delivery teams across the network, the LCRN will coordinate the design,delivery and reporting of the 2018-19 Patient Research Experience Survey.	2018-19 PRES designed delivered across all partner organisations	PPIE Workstream Lead	1. PRES working group, which includes representatives from all POs, LCRN public contributors, LCRN PPIE lead and communications manager, will meet in Q1. 2. the group will review results and report on 2017-18 survey. The report will be shared with all POs, recommendations will inform opportunities for learning and improvement for the LCRN and POs, to improve patient experiences. 3. The working group will design and plan delivery of the 2018-19 survey.There will be a focus on the delivery strategy for 2018-19 PRES, with the aim of increasing the number of respondents across the network. CRN LCRN had 307 respondents in 2016-17, this increased to 332 in 2017-18 using a similar delivery startegy. In 2018-19 new startegies to increase uptake will be explored, this will include a digitalised approach and utilising PRAs embededed in POs. 4. This work will be carried out in collaboration with all POs; the working group will explore a digital strategy in an attempt to increase the response rate. Local Patient Research Ambassadors will be included in the delivery strategy of the PRES 2018-19, utilising PRAs within POs to promote and raise awareness of the PRES and the importance of recording research participants experience in research	Q1-4	Green	1. The PRES working group met on numerous occasions. 2. The group reviewed the results of the 2017-2018 survey and presented a report on the results. 3. The working group designed, planned and delivered the 2018-19 PRES. The decision was made by the group to produce four PRES versions: three for young people (ages 4-7, 8-13 and 14-17) and a main adult PRES. Digital means to respond were also provided via the Survey Monkey program. 4. The PRES 2018-19 has been shared with collaborators in POs, with research teams delivering Primary Care studies (e.g. BE on the Team) and local PRAs.	Complete	1-4. 2018-19 PRES went live from mid November 2018, it was distributed by all POs across all specialities until Febuary 2019. For examples of PRES questionnaires distributed see Case study 14 PRES questionnaires, 2018. There were 442 (269 Adults PRES/173 Young Persons PRES) respondents across all POs, an increase from 330 resonpondents in 2017-18. A summary report was created and individual reports shared with all POs. (See Case Study 18 Summary of PRES responses) Recommendations from the report will be discussed at the 2019 working group meeting planned Q2. A key finding from the adult PRES was that 93% of research participants identified as White British.
2.7.3	**Young Persons Patient Research Experience Survey (PRES)** •In partnership with a local young persons advisory group, the LCRN will coordinate the design, planning, delivery and reporting of a young persons survey in 2018-19. •The LCRN PPIE Lead will facilitate contact with YPAG groups across the supra network, in an effort to create one collaborative YPAG group across the supra network region, with an aim to work on a young persons PRES which could be utilised across the the Supra network.	2018-19 Young persons PRES designed delivered in the region Two young people from each network in the Supra regional network will be identified to create a working group for a Supra regional young persons PRES	PPIE Workstream Lead	1. Local Young Person Advisory Group (YPAG) will design a PRES for their age groups in 2018-19. 2. Two members of the YPAG group will lead this project in 2018-19.	Q1	Complete	1. Three versions of the young persons PRES were produced as per the discussion and direction of the Young Persons Advisory Group. 2. These were distributed to research teams working with children and Children's Hospitals.	Complete	See Case Study 19 Children's PRES summary report.
2.7.4	**Patient Research Ambassador Initiative (PRAI)** **In 2017-18 the LCRN in collaboration with PHWE launched the PRAI throught its extensive PPIE network. At present there are a small number of PRAs locally. In 2018-19 the LCRN in collaboration with current PRAs and PPIE leads across the network will undertake a project to define the role locally and embed PRAI leads into POs**	Definition of PRA role locally, PRAI strategy for 2018-19	PPIE Workstream Lead	1. LCRN PPIE lead will facilitate a workshop in Q1-2 to define the role of the PRA locally. PPIE leads from POs, local Universities, partner organisations from PHWE, public contributors will be invited to the workshop. 2. An outcome will be a PRAI strategy for the LCRN, which will include the identification of a PRAI lead from POs and other stakeholders across the network. 3. This work will be undertaken while communicating with PPIE leads across the Supra Network, in an attempt to standardise the PRAI across the four networks.This will build on discussions and communication platforms which arose from the Supra Network event in Sept. 2017	Q1-2	Amber	1. An EOI for a project lead to deliver this project was sent out across the network on 30/7/2018, unable to appoint to this post. 2. PPIE lead and LCRN Comms manager will begin to undertake this project in Q4, given the increase in communications admin support within the LCRN. 3. PPIE lead continues to work closely with PPIE leads across the Supra Network, sharing best practice and resources.	Green	1-3 Work was undertaken with supra-network colleagues to gain insight into experience and best practice for implementing a PRA scheme. The LCRN is planning to appoint a Business and Operations Manager in 2019; a priority project for this post holder will be to expand the PRA scheme locally, with oversight from the PPIE Lead. PPIE lead and Comms manager have developed a project plan for the PRA scheme.

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2.7.5	**Evidencing inclusion and diversity** In line with the Patient and Public Reach Framework . The LCRN and PPIE partner across the network will pilot a system to record and share the range of PPIE activities that is happening locally (Register of LCRN PPIE Activities).	A report recording the reach and contact with patient and public groups across the LCRN.	PPIE Workstream Lead	1. The LCRN PPIE lead and LCRN communications manager will coordinate a scoping exercise across PHWE organisations and their PPIE registers, which include 700+ patients and members of the public. The aim will be to better understand and map inclusion and diversity across the PPIE network in the LCRN.	Q2-3	Green	1. PHWE restructure carried out during 2018, coordinator role is hoped to be advertised in 2019, decision made that the PHWE coordinator would be best placed to carry out this piece of work. Other pieces of work were undertaken to explore inclusion and diversity both locally and nationally: Participants age and ethnicity were included in 2018/19 PRES, to get a snapshot of who is participating in research across the network. A collaborative bid (CRN, UWE, Division 2 CRSL) submitted to the innovation small grants scheme. To carry out a scoping exercise, looking at inclusion and diversity in stroke research across the network. This bid was unsuccessful, the project will be revisited in 2019. PPIE lead worked with the CRN CC PPIE team, to help run a national event on equality and diversity "A Conversation About Equality, Diversity & Equity". This event was held in Leeds on 29/11/2018, there is a follow on event planned in 2019.	Complete	1. This piece of work will be carried out in collaboration with PHWE partners in 2019/20. PHWE coordinator is now in post which will provide the resource to carry out this piece of work. Age and ethnicty were collected in 2018/19 PRES. 93% of respondents identified as being white British. This will be highlighted to the PRES working group and the group will explore ways to increase the diversity of research participants in the LCRN.
2.7.6	**Pilot of National Standards for Public Involvement** PHWE (PPIE Leads from all organisation and public contributors) held a workshop in 2017, to discuss the draft National Standards for Public Involvement document. The outcome was a collaborative written response to the standards consultation. PHWE have submitted an expression of interest to be a test bed site for piloting of the national standards in 2018	LCRN and PPIE partners will be successful in their bid to be involved in the national pilot of the public involvement standards	PPIE Workstream Lead	1. PHWE will submit an expression of interest to be involved in the national pilot of the standards,putting the standards to practical use in their own working environment and sharing what they learn.	Q1-4	Complete	1. PHWE submitted an expression of interest be a test bed pilot site. The PHWE collaboration was not chosen to be a test site, however has been selected to be a freestyle test bed for PPIE standards.	Complete	As part of PHWE, LCRN will pilot two Standards (Standard 3: SUPPORT & LEARNING and Standard 6: GOVERNANCE). This is being carried out in partnership with Bristol BRC, CLAHRC and HPRU.

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2.7.8	**Stakeholder Engagement and Communications** **A review of the operational aspect of the communications plan will take place in 2018 in order to renew and refresh communication goals and objectives in order to ensure value for money.** **This will coincide with an increased investment in the communication team**	To deliver the items as set out in the Communications Contract Support Document	Communications Manager	1. An RDM has been assigned as Communications Lead to oversee the communications strategy and line manage the Communications Manager. There will be further investment, manifest as additional communications support, in order to meet the requirements of the POF, NIHR strategies and the LCRN Communications Plan 2018-19. 2. A working group, led by the Communications Manager and PPIE Lead will be set up and operational in Q1 to create a Communication Plan that will asssist delivery of the LCRN Annual Plan 2018-19. 3. In accordance with the POF, a ring-fenced budget of c.£5k will be provided for planned communications and JDR activities, with monthly updates provided to the Finance Team. 4. The communications Manager will work in partnership with PPIE Lead to deliver Stakeholder Engagement and Communications function. 5. The Communication function will be developed to : -Contribute to and support national CRN and NIHR campaigns and initiatives such as Join Dementia Research (JDR) and the UK Clinical Trials Gateway (UKCTG). -Maintain microsite with up-to-date and relevant information. -Further communications activities supporting LCRN research delivery such as specialty specific promotional materials and support of speciality specific engagement events. -Work with supra-regional partners on areas of common activity -Build on existing links with other NIHR infrastructure via the local networks Communications group which includes representation from WEAHSN, CLAHRC West, Bristol Health Partners and local HEI's. 6. Build on existing links with the NIHR funded research infrastructure group for NIHR Managers West of England, Clinical Trials Units, CLAHRC, Biomedical Research Centre and Schools for Public Health and Primary Care Research to increase our cross working and collaboration.	Q1-4 Q1-4 Q1-4 Q1-4 Q1-4 Q1-4 Q1-4	Green	1. The appointment of the RDM as Communications Lead and the expansion of the team has been put into place. 2. Staff absence meant that a working group was not possible during Q1. Instead, the Communication Manager created the Communications Plan from the proposed Annual Plan 2018-19, suggesting Communications outputs for each promised project. 3. A ring-fenced budget has been provided and used to fund Adobe Suite software (for typesetting), print costs for collateral and the PRES's. Further plans include subscriptions to Survey Monkey and Hootsuite. 4. Ongoing 5. These Communications functions are being developed and completed and further information about work to date has been included in a separate document for information (including social media measurement, local news stories etc.) The Join Dementia Research function continues to be supported, as does work with supra network partners, with a number of activities planned for the end of Q4. 6. Plans are in place to collaborate further with NIHR funded research groups in the region in Q4. The recent appointment of a regional Communications Lead will influence these plans, as part of their role is to collaborate across NIHR groups.	Green	1. A workforce review in Q4 identified the need for a Business Comms/Admin Manager to ensure senior oversight of the communications strategy and a more cohesive support for communication within the LCRN. The initial investment of additional communications support has proven sound, with a subsequent increase in media output, events management, training administration and internal communications. 2. Further work has been undertaken to strengthen relationships with Communications Department staff in POs, something to further build upon in 2019/20. 3. Ring-fenced budget was also used for professional print for events and displays. 4. Further work was undertaken with supra-network colleagues to gain insight into experience and best practice for implementing a PRA scheme, that will be undertaken in Q1 2019-20. 5. The Join Dementia Research function has now been absorbed into the Communications team, working with a Portfolio Facilitator. Regular national and local JDR and Dementia meetings are attended. Work has continued with supra-network partners, with a joint document produced for researchers on the best uses of social media and further investigation into promoting equity of access, a project for 2019/20. 6. The role of regional NIHR Communications Lead has now become firmly embedded and regular meetings have been arranged, along with Twitter forums and sharing of contacts and best practice. 7. Further information can be seen in Case Study 5 Communications Report May 2019.
2.7.9	**NHS Engagement Strategy**	Development and implementation of a plan to deliver the NHS Engagement Strategy	Communications Lead	RDM assigned as Communication Lead to: Develop further a high quality and responsive relationships with key stakeholders and partners. To ensure stakeholders have easy access to the information they need in a way they would choose to access it and ensure the LCRN develops and communicates its broad engagement across the health and social care system nationally, regionally and locally. -Improve awareness and understanding of the work and impact of the LCRN. -Measures of success are shared and understood.	Q1 Q1-4	Green	1. RDMs and PF's have regular meetings with their localities to ensure regular updates. 2. Two R&D managers sit on the OMG group to a) represent and feed up from R&D managers and b) feedback to R&D managers. 3. There has been further engagement and development of relationships with the relevant Comms manager with R&D remit within Partner Organisations. 4. RDMs and PF's feedback any "news" of interest to the comms team who then follow up with the relevant PO as appropriate. 5. News and updates are distributed through a variety of communication and media channels.	Green	1. A workforce review in Q4 identified the need for a Business Comms/Admin Manager to ensure senior oversight of the communications strategy and a more cohesive support for communication within the LCRN. The initial investment of additional communications support has proven sound, with a subsequent increase in media output, events management, training administration and internal communications. 2. Stakeholder relationship management continues, with analysis of current relationships and regular communications journeys planned for 2019/2020. 3. These relationships will be further enhanced by adoption of a Customer Relationship Management system, to streamline communications and data records with regular contacts and greater utilise intelligence across teams.

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2.7.10	**Improving Access to Digital Technology. There are currently barriers in place which prevent full and effective use of NIHR communication tools and technology. There will be a focus on identifying and working to resolve them to enable the LCRN to increase effectiveness in delivery of core business**	Removal of barriers currently in place to enable increased effectiveness of use of NIHR and other digital communication tools	CI Workstream Lead and Communications Manager	1. Identification of ability of LCRN funded staff to access NIHR Hub, digital and social media and barriers currently in place a) within the core LCRN and b) within Partner Organisations. 2. Scoping work to identify other LCRN's who have encountered these barriers and how they overcame them. 3. Make recommendations on how to overcome these barriers. 4. Aim to implement recommendations.	Q1-4	Green	1. The main barriers have been identified as: (a) limited awareness of LCRN funded staff of the digital opportunities that are available and (b) IT teams in Trusts who distrust Google due to security issues and have blocked Chrome. 2-4. The SUPRA Network has identified the need for a role that work across networks, dedicated to working with IT in Trusts and developing the possibilities for CRN members. The CRN WE will be able to utilise the learning and recommendations made by the person in post.	Green	Discussions are continuing between the COO and Host IT to continue to facilitate the infrastructure required to deliver network business within Google Chrome.
2.7.11	**Improving effectiveness of EOI Process. A process exists to ensure relevant PO's and health professionals are kept informed of relevant opportunities to get involved in portfolio studies, however some issues have been identified and it is suspected the conversion rate of EOI's to actual studies in the LCRN is not as high as it could be. The process will be reviewed in 2018-19 to identify and implement recommendations for improvement/**	Improve communication and transparency throughout the entire process. Improve stakeholder engagement and satisfaction. Improve conversation rate from EOI to new studies in the LCRN.	CI Workstream Lead	1. Assess baseline stakeholder satisfaction, request suggestions for improvement, request feedback on potential items to mechanisms to improve process. 2. Process map the entire process with relevant internal and external stakeholders. 3. Identify barriers and areas of duplication. 4. Remove areas of duplication and make recommendations to overcome barriers. Implement new streamlined process 5. Assess stakeholder satisfaction post new process.	Q1-4	Green	Work started as part of a QI silver award scheme. 1. Stakeholder mapping carried out. 2. PDSA cycle underway around amended new study tracker. 3. Speciality specific infographics under development.	Complete	
8. Organisational Development										
2.8.1	Workforce - PI Development PI training materials are available for trusts to use as appropriate. We will refine these to provide specific resources to enable the (1) development of (Nurse, Midwife, Allied Health Professional) NMAHP PIs in both Primary and Secondary Care and (2) provision of Industry focussed resources for use in Primary Care.	Implementation of (1) PI training program for NMAHP PIs in Primary and Secondary Care; (2) Industry focussed PI training for Primary Care practices and an increase in the number of commercial PIs	Nurse Consultant	1. PI training materials distributed across the partner organisations for their adaption and delivery to meet local needs. 2. Adapted for specific audiences to include: Development of the NMAHP PI workforce in Primary and Secondary Care; Focus on Industry active practices in Primary Care. 3. Implementation of these training materials with a minimum of one session per audience. 4. Include commercial focus for specialty specific PI training.	Q1-Q4	Green	1. PI training materials have been distributed to all POs. 2. PI training materials have been revised and formed to include resources to be used as a programme. Currently being reviewed by experienced PIs. 3. Pilot session of revised materials planned for early 2019.	Complete	See Case Study 6 PI Training Powerpoint and Case Study 7 PI Training Groupwork Resources.

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2.8.2	**Workforce review** Using new template to map the workforce, needs and development within the LCRN and across the partner organisations.	Completion of workforce review which will enable the development of a long term workforce development plan which is responsive to local needs	Nurse Consultant	1. Research Infrastructure Workforce Committee utilised to support gathering the information needed to complete the review.	Q1 - Q2	Complete	1. Workforce review document submitted to CC. Workforce Development Lead in post. (Complete). -Commence skill mix review for two partner organisations, WAHT and AWP. (Complete). -Commence information gathering for Workforce Plan. (Complete). Q2 -Establish funding for WAHT and AWP to determine team profile. (Complete). -Continue to gather information for workforce plan. (Complete). -Develop LCRN induction materials for Induction and Training website for all LCRN staff. (Complete). -Identify projects to improve training resources and materials.(Complete). -Plan Induction Open Day for new LCRN staff working in POs. (In progress). -Finalise and submit workforce plan. (Complete). Q3 -Support consultation process in WAHT and AWP, as required. (In progress; dates to interview in WAHT January 2019). -Launch Induction and Training website for all LCRN staff. (In progress; materials being finalised). -Commence developing PI training package. (In progress; materials to be reviewed by experienced PIs December 2018). -Launch Induction Open Days - held quarterly (Dates set for 2019). -Commence workforce review of LCRN team to determine appropriate skill mix and team structure. (In progress; data gathering to be completed mid December).	Complete	See Case Study 3 CRN West of England Workforce Review
2.8.3	**Wellbeing Plan** For 2018-19 there will be a focus on Wellbeing activities within the LCRN core team. These will be overseen by the wellbeing lead and expect to be supported by volunteer 'wellbeing warriors'.	Development and implementation of a Wellbeing program of activities for staff within the LCRN core team	Nurse Consultant	1. Identification of 'wellbeing warriors' from within the LCRN core team. 2. Wellbeing activities will be prioritised and agreed. 3. Monthly wellbeing focus sessions included in the staff meeting schedule. 4. Quarterly focus on specific trust policies which support both managers and individual staff to enable wellbeing at work.	Q1-Q4	Green	1. Concept of 'wellbeing warriors' revised to have specific individuals lead on five wellbeing projects that have arisen from well being focussed workshops with core LCRN team. 2. Wellbeing activities agreed and implemented. 3. Wellbeing focussed sessions are integrated to the staff meeting schedule, but not needed on a monthly basis. 4. Focus has been to meet wellbeing needs identified by the staff in the wellbeing workshops rather than looking at the specific trust policies.	Complete	Wellbeing activities integrated into everyday working. See Case Study 8 Wellbeing workshop - the return.
2.8.4	**Improving skills and confidence in use of digital tools and technology**	LCRN core and funded staff have improved skills and confidence in the use of digital tools and technology.	CI Workstream Lead, Nurse Consultant and Communications Manager	1. Assess baseline confidence and skill level of staff in using digital tools and technology. 2. Identify areas where increased skills and confidence and required. 3. Identify best intervention mechanisms to improve each skill 4. Implement interventions. 5. Assess confidence and skill level after intervention.	Q1-4	Green	1-4. Work ongoing, this will also form part of the supra-regional learning technologist remit.	Complete	First round of interviews unsuccessful in 2018/19. Supra- regional learning technologist post renamed to Digital Learning Designer, appointed Q1 2019/20
2.8.5	**Improving awareness, knowledge & continuous improvement skills of LCRN staff**	LCRN core and funded staff have access to materials to increase their continuous improvement skills, knowledge and awareness.	CI Workstream Lead	1. Work with the NC to review what current awareness, skills and knowledge is present and review training and development needs. 2. Identify what other organisations (PO's, AHSN, BHP, CLAHRC West, HEIs) are offering in terms of CI skills and development. 3. Work with Communications Manager to ensure that all relevant staff have knowledge about how to access appropriate materials to improve their skills, knowledge and awareness as appropriate.	Q1-4	Green	1-3. Work continues. Information to be gathered systematically as part of the PO business planning cycle.	Green	

Section 4. Key Projects

Section 4 of the template should be used to detail the key projects to be delivered by the network in 2018/19. Please include local network projects and activities, projects to be delivered in collaboration with other LCRNs (as part of regional LCRN-Cluster collaborative activities or other LCRN collaborations), and projects to be delivered nationally/CRN-wide led locally by the LCRN. Projects to be delivered in collaboration with other parts of the NIHR and/ or other external organisations should also be included. Please add additional rows as required.

Columns A-F should be completed as part of the 2018/19 Annual Plan.
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2.8.6	**Exploring scope for digitalising development materials and processes. The aim for 2018-19 will be to streamline and automate some processes involved with the learning and development programme. The LCRN will also explore whether there is potential for development of some digital based services such a local induction webinar for LCRN funded staff.**	Recommendations are made to digitalise materials and processes in learning and development where appropriate	CI Workstream Lead and Nurse Consultant	1. Review current learning and development materials format and processes. 2. Scope other LCRN's to identify which have become more digitalised. 3. Assess which materials and processes within CRN West of England have potential to adopt these processes. Make recommendations for implementation within the LCRN e.g. webinar for local induction of LCRN funded staff.	Q1-4	Green	1. LCRN Training website designed and developed to enable induction and training materials to be available. 2. Co-funding a supra-regional Learning Technologist role with the 3 other LCRNs in the supra-region. 3. NIHR learn guidance materials under development.	Complete	1-3. Supra-regional learning technologist role advertised and interviewed but not appointed in 2018/19. Successfully appointed as Digital Learning Designer in Q1 2019/20. Training resources now collated onto training website with ease of access for all LCRN funded staff. See Case Study 9 WE training website.
2.8.7	**To implement the Improvement and Innovation review proposals**	Implementation of the Innovation and Improvement Framework via key projects which support the CI workstream via other workstreams.	COO and RDMs	The LCRN has a culture of Continuous Performance Improvement therefore all key projects also support the CI workstream.	Q1-4	Green	1. As described in column 63E - covered elsewhere within plan.	Green	
2.8.8	**Increase supra-regional working**	To increase collaboration across neighbouring LCRNs, share best practice and reduce duplication.	COO and each Workstream Lead	1. All work streams will participate in supra regional meetings. 2. The meetings will have a common structure and framework and will identify shared work stream priorities. They will also: 2.1 Meet face to face twice a year. 2.2 Report outcomes of meetings to quarterly COO meeting. 2.3 Work to a common Terms of Reference.	Q1-4	Green	1-2.3. All work-streams are holding supra-regional meetings.	Complete	
9. Business Development and Marketing										
2.9.1	**Support locally led commercial research Meet with the local AHSN and SMEs to supplement the flow of national commercial research by promoting home-grown industry research**	LCRN/SME partnership	IOM	1. Meet with WEAHSN and local SMEs to increase proportion of locally lead NIHR commercial studies on the local portfolio. 2. Collaborative working with the local AHSN and CLARHC on the Innovation Exchange model for the Accelerated Access Review.	Q3-4 Q1-4	Green	1. Learning from supra-regional work regarding SME engagement. This includes exploring the additional capacity needed for Business Development activities to engage with SMEs and work collaboratively with WEAHSN. 2. Established links with WEAHSN and a meeting is planned to discuss the Innovation Exchange model for the Accelerated Access Review.	Amber	1. Held two meetings with WEAHSN to map our service and offerings, and establish ways to work more closely to support local SMEs. Joint CRN/AHSN post not taken forward. 2. Ongoing work with WEAHSN regarding the the Innovation Exchange model for the Accelerated Access Review.
2.9.2	**Support national business development initiatives Work with local Investigators to develop a strategic plan to support the national interests of Biosimilars studies. The challenge to delivering on this priority will be the availability of studies on the Portfolio.**	Increase in Biosimilar research activity	IOM and Communications Lead	1. Work with the Communication Lead to raise awareness of Biosimilars in order to increase the LCRN support for biosimilars in 2018-19. 2. Success measured through an increase in the number of patients with greater clinical experience with biosimilar compounds.	Q2-4	Amber	1-2. Difficulties around the identification of Biosimilar trials with current data has been identified; communications on hold until this is developed further. Plan to provide communication team in Q3 with open Biosimilar study open in the region.	Red	1-2. Scoping of local portfolio revealed no open biosimilar studies to build case studies. Work has therefore been paused.
2.9.3	**To promote the LCRN industry agenda** Develop our external-facing industry processes so the network is seen as an attractive place to bring new studies and ensuring our offer delivers to and beyond expectations of the life sciences industry	Increase the number of commercial studies delivered within LCRN	IOM	1. Industry workstream lead to meet with sponsors on a strategic level regarding coordinated work with performance and pipeline throughout year, initially focussing on those with the largest number of trials within the LCRN. 2. Collaboration with Communications Lead for communication materials to promote LCRN industry offer to POs/PCOs. Industry Workstream Lead to attend specialty specific regional events to promote the Life Sciences Industry Strategy. 3. Industry Workstream Lead to conduct a scoping exercise with three high performing LCRNs for industry to understand best practice and identify industry processes to be considered for adaptation and adoption in the West of England.	Q1-2 Q1-4 Q3-4	Green	1. IOM and IPL met with 3 representatives from industry to discuss the research pipeline, current performance and LCRN processes to support future research. 2. Plan to include disease specific infographic to promote the LCRN with SIF. 3. IPL met with 3 LCRNs to explore current and planned projects and processes. Created a report document to summarise key themes. Initiated work to map out roles and responsibilities for performance monitoring in line with Study Support Service, which was agreed by PO R&Ds and has lead to the implementation of Study of Concern ratings for BRAG rated black/red/amber commercial studies in decline.	Complete	1. IOM/IPL met with a total of 6 representatives from industry within year to discuss research pipeline and LCRN opportunities. IOM and IPL attended SCRS conference in March with representatives and speakers from a wide range of industry sponsors/CROs. 2. Specialty specific infographics developed for 17 specialties with plan to include in SONS emails sent from the Portfolio Facilitator team. 3. Work completed by mid-year (see cell H71).
2.9.4	**Ensure the provision of NIHR CRN Study Support Service offer for Industry Costing Template validation process**	Ensure Industry Costing Template validation within 3 working days	IOM and Industry SPoC	1. Industry Workstream Lead and Industry SPoC (managed by Senior PF) to provide an efficient and standardised Industry Costing Template Validation service to life science companies to reduce queries and duplication from participating POs	Q1-4	Green	1. Business as usual. Costing templates validated within 3 days.	Green	1. Business as usual. Costing templates validated within 3 days. Ongoing work to prepare for online costing template and new process.
11. New Projects										

Section 4. Key Projects

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2.11.1	**HLO2a analysis**	Improve HLO2a	Industry Performance Lead	New project developed within year				N/A	A piece of work was undertaken to examine the reasons for the local decline in HLO2a. This was a retrospective review of all studies failing to meet RTT within 2018-19 (when compared with performance in 2017-18). See Case Study 10 HLO2a Analysis. The report was published containing a number of recommendations which were implemented within year to improve RTT. For example: a) continuation of the PC CCOP (see section 2.3.6), b) routine use of Study of Concern ratings (see section 2.11.2), c) proactive review of studies due to close within year and highlight studies which could close early due to achieving study target in UK, d) track studies that have been withdrawn.
2.11.2	**Study of Concern (C1/C2)**	Improve HLO2a	IOM and Industry Performance Lead	New project developed within year				N/A	See Case Study 11 Improving HLO2a: A Guide to Study of Concern Ratings. The Study of Concern (C1/C2) system was implemented to improve performance monitoring for commercial studies by prioritising the studies with the greatest need (i.e. BRAG red/amber/black studies continuing to decline). The Study of Concern 1 (C1) label is given to BRAG rated red/amber/black studies which are downtrending (identified on the RTT report) for at least two months. Site action planning and implementation is needed for C1 studies. The Study of Concern 2 (C2) label is given to BRAG rated red/amber/black studies which are downtrending for at least 3 months and not improving despite improvement planning. C2 studies are managed at site level with support from the LCRN to include escalation CRSL/CDL, sharing of best practice with other sites, regionally and nationally, and use of PIC sites if applicable. C1/C2 studies are now reviewed at PO R&D locality visits, CRSL meetings with RDMs, and at specialty specific COPs.

Section 5. High Level Objectives Targets			
HLO	**LCRN Target**	**Mid Year Commentary**	**Year End Commentary**
1	28,883		The LCRN recruited 37,380 participants to NIHR CRN Portfolio studies in financial year 2018/19, exceeding the LCRN target by 29%. Two studies were responsible for over 30% of the total recruitment activity in 2018/19, CPMS ID 39692 "The second Bristol online survey of dementia attitudes" and CPMS ID 40692 "YP 26+ 2018 Questionnaire".
7	550		The LCRN recruited 8,418 participants to NIHR CRN Portfolio studies managed by the Dementias and Neurodegeneration specialty in financial year 2018/19, exceeding the LCRN target by 1430%. CPMS ID 39692 "The second Bristol online survey of dementia attitudes" accounted for 89% of the total recruitment activity to the Dementias and Neurodegeneration specialty in 2018/19.

Section 6. Specialty Objectives

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				Mid Year Progress Report		Year End Report	
Ref	**Specialty**	**Local activities to achieve the national objective** **The local planned activities described below will be implemented to support achievement of the national specialty objectives and result in the following outcomes:** **1.1 Sharing of best practice, skills and knowledge.** **1.2 Creation of communities of practice (COP).** **1.3 Skilled and equipped workforce to grow and promote research.** **1.4 Increased collaboration and involvement.** **1.5 Development of a more balanced portfolio.**	**Timescale**	**RAG**	**Commentary**	**RAG**	**Commentary**
1	**Ageing [1]**	-CRSL due to return from maternity leave in May, initial focus will be on induction to CRN, role and local portfolio of ageing studies (currently 1 study) -All ageing studies open to new sites will be assessed for suitability at local sites and approaches made to potential PIs, including those early in their career. -Explore potential for recruiting across geriatrics as ageing is one of RUH's priority research areas. -Explore potential for increasing collaborations with RICE and Designability to enable further activity within this area.	Q1-2			Green	This specialty objective has been met. All clinicians in geriatrics (including but not limited to early career researchers (ECR)) in the region were contacted to generate interest in ageing research. It was established there was interest and a number of individuals who were not previously research active agreed to receive Expressions of Interest for new studies. Due to the very low number of ageing studies which have gone out to 'Expression of Interest' (only 1 study this year) all ageing study teams were contacted to enquire if they were looking for new sites and whether they would they consider opening a site in the West of England. 22 Study teams were contacted, 20 teams replied and none were opening new sites. An event for all trainees in geriatric medicine within the region was held to stimulate interest in future clinical research. The agenda included: a) General introduction to research including the personal research journey of an academic geriatrician b) National infrastructure to support clinical research and how to access it and c) a shortened GCP course so the trainees could contribute to current / active research within the trusts they are working in. In Q4 efforts have concentrated on building on the significant enthusiasm to build infrastructure and expertise in ageing and neurodegeneration research at the Research Institute for Care of Older People (RICE) in Bath. This work will continue in 2019/20.

Section 6. Specialty Objectives

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2	**Anaesthesia, Perioperative Medicine and Pain Management [2]**	The LCRN has an actively recruiting Trainee Network (Severn Trainee Anaesthesia Research-STAR). -CRSL to continue to meet with STAR Committee a minimum of three times a year and monthly with the STAR trainee lead to review portfolio and share best practice. -Encourage participation in and support recruitment to trainee-led studies such as SWeAT (CPMD ID: 32193), DALES and ATOMIC (CPMS IDs: TBC) to deliver RTT. -Encourage trainee involvement in consultant-led studies such as FLO-ELA (CPMS ID: 33869) and PQIP (CPMS ID: 34612) to increase training and research experience of trainees and deliver RTT. -CRSL to support and supervise trainee led funding applications to at least one national grant e.g. VASGBI trainee development grants and NIAA grants. -CRSL and RDM to work on supporting studies to open at all five eligible POs (GRH, GWH, NBT, RUH and UHB) to maintain and increase research opportunities	Q1-4 Q1-4 Q1-4 Q1-4 Q1-4			Complete	The specialty objective has been achieved. The SWeAT study led by Alex Loosely as CI recruited 397 participants and consisted of two phases. The survey/quantitative phase completed in 2017 followed immediately by the second qualitative phase completed in 2018. This was all part of an initial protocol as funded by NIAA/AAGBI. Data analysis was completed at the end of 2018 and two papers from SWeAT study been accepted by Anaesthesia journal in March 2019. It has been nominated for a national award and the CRN can be very proud of this exemplar trainee-led study developed from scratch by our trainee network, STAR. The LCRN has an actively recruiting Trainee Network (Severn Trainee Anaesthesia Research - STAR). -CRSL met with STAR Committee a minimum of three times a year and monthly with the STAR trainee lead to review portfolio and share best practice. -CRSL encouraged participation in and supported recruitment to the following trainee-led studies: 1. SWeAT (CPMD ID: 32193) 2. DALES (CPMS ID: 37360) -CRSL encouraged trainee involvement in the following consultant-led studies: 1. FLO-ELA (CPMS ID: 33869) 2. PQIP (CPMS ID: 34612) -CRSL supported and supervised trainee led funding applications and VASGBI trainee development grant was awarded to Bristol trainee, Richard Armstrong, in July 2018. Two trainees were co-applicants on successful NIAA/AAGBI award for the GALORE study in July 2018. -The first STAR research study day delivered in 2018 with new CRSL, Chris Newell, presenting. -CRSL and RDM supported the following studies to at all five eligible POs (GRH, GWH, NBT, RUH and UHB): 1. FLOELA (CPMS ID: 33869) 2. PQIP (CPMS ID: 34612) 3. DALES (CPMS ID: 37360) 4. GALORE (CPMS ID: 36436) Other activities: -CRSLs for APOMP and Critical Care and agreed to review portfolio as a whole because there is so much overlap, with a view to holding joint events in the future. The LCRN now consider this one large portfolio. -A joint event 'Developing anaesthesia and critical care research together' to raise the profile of research in both these specialties will be held on 26 April 2019. -Supported CRSL in succession planning to identify suitable candidates for CRSL role in 2019-20. Source: ODP 07/05/2019 This specialty is ranked 10/15 for total recruitment, an increase from 2017-18.

Section 6. Specialty Objectives

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3	**Cancer [3]**	-RDM will build on collaboration with a well-established network through South West Cancer Alliance providing a forum for the Somerset, Wiltshire, Avon and Gloucestershire (SWAG) network, using the SWAG network to raise awareness of new portfolio studies. - RDM will attend Speciality group meetings, with a standing research agenda item to report SSG performance across the network, launch new studies across the network, encourage network wide target setting and intra network referrals into trials. - Subspecialty leads (SSL) are the SWAG research leads, all SSGs meetings (Biannual) will be used as an opportunity for RDM and SSLs to review the subspecialty performance and identify suitable studies from the national portfolio to open at sites in the LCRN. - LCRN will continue engagement with 100,000 Genomes project, staff from inception have been integrated into the relevant research teams recruiting in cancer pathways. There will be trust steering group meetings to explore further areas of growth across different specialities. RDM will engage with the steering group, to support increased recruitment of cancer patients to the project across the region. - GWH cancer research delivery team has undergone restructure, this has affected recruitment to cancer trials at GWH, recruitment to a number of studies suspended, no new studies opened 2017-18. CRSL, RDM and PF will support GWH to reopen suspended studies and explore areas where there is capacity to open new studies in 2018-19. - LCRN workforce development lead and RDM will work with R&D, research delivery team and cancer PI's at GWH , to review skill mix and capacity within the team, a measure of success will be new cancer studies opened and recruiting in 2018-19. - GWH is within CRN LCRN, however the cancer clinical referral pathway is towards CRN Thames Valley & South Midlands, this presents some challenges in the delivery of cancer research at GWH. RDM will meet with CRN Thames Valley cancer RDM, to explore collaboration between both networks, in relation to supporting and growing the cancer portfolio at GWH. - Building on the success of last years collaboration with CRN South West Peninsula, running a colorectal research study day. RDM and CRSL will explore running another study day in collaboration with CRN South West Peninsula, in a chosen subspecialty, to engage with clinicians, trainees and research delivery teams across both networks, raising awareness of current studies and highlighting opportunities for new studies, or collaboration opportunities in the chosen area. We will encourage members to join and contribute to CSG. Specific Area for focus 2018-19: - Palliative Care and Supportive Services, RDM, CRSL, LCRN Primary care lead will meet , to explore opportunities for growth in the this areas. Links will be developed with local hospices, to identify training needs and capacity to delivery Palliative Care and Supportive Services research across the network. - RDM will liaise with Sue Ryder Hospice in Gloucestershire ,learn from their success in this area. Best practice can be shared to other hospices in the region. Liaise with CRN Kent, Surrey and Sussex and CRN Yorkshire and Humber, to share intelligence in this area of research, both networks have a strong portfolio in this area.	Q1-4 Q1-4 Q1-4 Q1 Q1-4 Q1-2 Q1 Q1-2	Green	-LCRN report embedded as a standard agenda item on all SSGs, agenda slots is used to highlight new studies opening in the network. This is also used as an opportunity to communicate any CRN issues, e.g. proposed changes to HLOs, speciality objectives and performance. -Currently meeting 8/13 subspecialty performance objectives, forcasted to meet 12/13. WoE is currently 10/15 LCRNs recruitment per million population. -RDM worked closely with 100,000 Genomes project team during the period of portfolio adoption. This project is now complete, West of England will continue to host a GMC. -At GWH there was a successful development bid submitted with support from division 1 RDM and locality lead RDM, to resource a research nurse to support the growth of the cancer portfolio. This resource is now in post and the cancer portfolio is growing again. There have been a number of cancer studies opened in GWH in 2018/19 -LCRN RDM and Thames Valley LCRN RDM met with GWH delivery team lead 28/03/2018. The aim was to discuss collaboration in regard to the cancer portfolio, given the referral pathway between both LCRNs. This will be revisited in 2019, to explore further opportunities to collaborate. -LCRN RDM and SWP RDM have collaborative working relationship and have collaborated in a number of areas, such as TYA and subspecialty events. There is another subspeciality event planned for 2019, with the creation of a South West lung Community of Practice. -Key hospices in the region have now been identified. National RDM lead for PCSS has now provided a list of studies which could be run in hospices. LCRN Primary Care lead and RDM will share these with local teams, to identify possible studies that local teams could run. LCRN Primary Care Lead and RDM plan to hold a PCSS in 2019, this will aim to get key stakeholders in the region together to discuss the opportunities for growth in this subspecialty.	Complete	-Speciality objectives have been met for 2018/19 and LCRN recruited into 12/13 cancer subspecialties; an increase from 11/13 in 2017/18. The LCRN were 11/15 nationally for recruitment per million population in 18/19. This is an improvement from 15/15 in 2017/18. -LCRN has an established relationship with the SWAG network; this is used as a platform for engagement with oncology clinicians across the region. Through the SWAG SSGs the LCRN identified and have now appointed two CRSLs for Cancer, a Medical Oncologist and a Surgical Oncologist, to lead on the new harmonised objectives. -LCRN recruited 1631 participants to the 100,000 Genomes project, a proportion of which were into the cancer arm of the project. -GWH now have nine studies open to recruitment, of which three were opened in 2018. 6/9 BRAG rated green, 2/9 BRAG rated amber, 1/9 BRAG rated red. The RDM is planning a further meeting with Thames Valley RDM, GWH R&D and cancer clinicians at GWH to continue to explore areas of growth. -In collaboration with SWP RDM and lung cancer clinicians from both LCRNs, there was an inaugural South West Lung Oncology Group meeting held in February 2019. The aim of the event was to discuss how our regions can work together to access more research opportunities for lung cancer patients. -RDM and Primary Care Research Officer have met with the educational lead and deputy CEO of Dorothy House Hospice. The team at Dorothy House are very enthusiastic about becoming research active. The LCRN will support them in this; GCP and PI training have been offered. The team at Dorothy House will also be put in contact with the team at Sue Ryder Hospice in Gloucester in order to share best practice.

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4	**Cardiovascular Disease [4]**	-CRSL and RDM to gather information from R&Ds and launch survey to identify cardiac surgery staff within POs and non-NHS organisations. -In collaboration with Workforce Lead, arrange PI Masterclass training sessions with the aim to increase research activity within CVD surgery teams. A key challenge will be establishing new links and increasing engagement from cardiovascular surgery staff in NIHR Portfolio research in addition to research from BRC. -Establish a process for regional referrals for cardiac surgery studies to increase recruitment and develop collaborative ways of working.	Q1 Q2-4 Q1-4	Green	Questionnaire sent to cardiac surgeons and wider research team at Bristol Heart Institute and discussions with BRC to understand the quantity of research in the pipeline. A PI Training course is being developed through Workforce Development which will be offered to the cardiac surgery team. Individuals planning on acting as PI in the coming year will be encouraged to attend, as well as current new PIs. Launched the CVD Community of Practice with 4 POs which includes monthly teleconferences to discuss new and existing studies, performance and sharing best practice. OMACS (CPMS 35331) which was previously a single site study at BHI is now open at NBT also, and the sites are working together to deliver this study. Highlighting studies open, or with the possibility of opening at multiple sites for COP discussions.	Complete	The specialty objective has been achieved. See Appendix 10.6 Cardiovascular Workforce Plan. A cardiac surgery workforce plan was created following consultation with cardiac surgeon PIs at the Bristol Heart Institute (University Hospitals Bristol) through conversations and a questionnaire sent to all known cardiac surgeons. The local Cardiovascular Speciality Objective Workforce Plan was agreed by Cluster A in April 2019 with the following key objectives: 1) Hold an awareness raising educational event in Bristol for cardiac surgery staff by Q4 2019/20. 2) Hold PI training at BHI for cardiac surgery staff by Q4 2019/20. 3) Invite cardiac surgery staff to cardiovascular Community of Practice by Q1 2019/20. 4) Identify and invite a cardiac surgeon at BHI to work more closely with RDM and CRSL by Q1 2019/20. 5) Raise issues regarding cardiac surgery trainee pathways nationally and discuss with other LCRNs to understand the full scale of the problem by Q3 2019/20.
5	**Children [5]**	Target 90%. Baseline 6 of 9 Trusts (67%). Two of the other three trusts provide CAMHS services and not general medical care therefore any children recruited through CAMHS are likely to go into MH badged studies. GCS not currently recruiting into children's studies (previously non-recruiting PO). Baseline 86% if CAMHS population excluded from metric. Also multiple studies recruiting children in primary care setting. -Continue to routinely examine and review the portfolio for suitable studies to open in sites not currently recruiting children. -Explore the potential for developing collaboration with primary care and community settings to recruit children to studies -GCS and 2gether will be one organisation by the end of 2018-2019. Continue to engage with both organisations around studies that recruit children, assessing feasibility for local delivery. -Continue to review studies allocated to other specialities that recruit children to assess feasibility for opening in CRN West of England sites.	Q1-4 Q1-4 Q1-4 Q1-4	Green	89% (8/9) trusts recruiting children to studies. Other work ongoing.	Amber	The specialty objective has not been achieved. -Number of participants recruited to children studies increased by 15% in 2018/19 compared with 2017/18. -78% (7/9) of NHS Trusts recruited to children NIHR Portfolio studies (managing specialty), and 89% (8/9) of NHS Trusts recruited children to NIHR Portfolio studies (supporting and managing specialty) in 2018-19. There were 34 studies open at 8 local NHS Trusts with children as the supporting specialty. The one non-recruiting NHS Trust (Gloucestershire Care Services) is merging with 2Gether NHS Foundation Trust in 2019/20. -The merger of GCS and 2Gether has not yet been completed. Continued to work with both organisations regarding studies that recruit children. -Network-wide children vaccines Research Nurse appointed through development funding which led to successful set up and delivery of the TOP: Transmission of Pneumococcus within Family Units (CPMS 35674) study in Bath and Gloucestershire (outside the usual centre of Bristol) and involved cross collaboration with child health records and working in the community. -Work has started on collaboration between Primary Care and UHB for commercial and non-commercial children vaccine studies. Joint working between CRSLs and RDMs to facilitate this and to design a mutually beneficial arrangement.

Section 6. Specialty Objectives

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6	**Critical Care [6]**	-Maintain current level of five ICUs (100%) recruiting into studies on the NIHR CRN Portfolio (GRH, GWH, NBT, RUH and UHB) to maintain research opportunities. -Build on success of Critical Care meetings in 2017-18 and hold another event in Q3/4 to promote and generate research. -Explore possibility of opening up invitation to anaesthesia and injuries and emergency specialty colleagues to share best practice and increase collaborative working. -Use Critical Care event and newly formed 'Critical Care Research Group' as a platform to encourage and develop at least one successful grant submission from the South West to NIHR by March 2020. -Liaise with relevant R&D about potential applications. -Develop promotional materials to showcase specialty.	Q1-4 Q3-4 Q2-4 Q1-4 Q2-4 Q1-4			Complete	The specialty objective has been achieved. 5 ICUs (83%) recruited into studies on the NIHR CRN Portfolio in 2018/19. - CRSL and RDM maintained five ICUs (100%) recruiting into studies on the NIHR CRN Portfolio (GRH, GWH, NBT, RUH and UHB). - 'Critical Care Research Group' held one event in 2018-19: 1. 'Developing critical care research together' event held on 09/11/2018. Sixteen people attended with presentations from NIHR RDS and Nurse Consultant. The audience was made up of nurses, ICU Consultants, RDS staff and an ICU Research Sister from UHB led a meeting specifically for research nurses after the event to share best practice. - CRSL for APOMP and Critical Care agreed to review portfolio as a whole because there is so much overlap, with a view to holding joint events in the future. The LCRN now consider this one large portfolio. - CRSL for Critical Care presented about perioperative cardiac arrest at VASGBI Conference on 20/09/19. - A joint Critical Care/Anaesthesia event 'Developing anaesthesia and critical care research together' to raise the profile of research in both these specialties will be held on 26/04/2019. - Approached RUH to further develop NIHR portfolio in 2019/20. - Draft outline of promotional materials discussed at event on 09/11/2018. Source: ODP 07/05/2019 This specialty is ranked 13/15 for total recruitment, a decrease from 2017-18. This specialty is ranked 12/15 for recruitment per million population, a decrease from 2017-18. This specialty is ranked 9/15 for complexity weighted recruitment, an increase from 2017-18.

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7	**Dementias and Neurodegeneration [7]**	-Scoping work to identify local early career researchers though a local health integration team (HIT) initiative. This will be carried out via the new local Dementia Researcher website as part of the HIT workplan. -Identified individuals will be invited to join a local community of early career researchers using platforms such as the Dementia Researcher Website or g+. -Plan to hold an event for community to provide an opportunity to: raise profile of dementia & neurodegeneration research / network with peers / share best practice and learn from more experienced PIs within the region (using the PI masterclass materials) -Build on existing centres with successful research portfolios e.g. RICE.	Q1 Q2-3 Q3-4			Green	Engagement work with the Bristol Health Integration Team (HIT) identified a portfolio eligible study and support was given to the Chief Investigator to adopt it onto the portfolio. The study was promoted in regional trusts, GPs and JDR along with non-traditional locations such as local universities. The local success of this study led it to be the highest recruiting dementia study nationally in 2018/19. Targeted PI training for Early Career Researchers for disease specialties in Division 4 was provided in Q4. The event was loosely based on the generic CRN PI training course which was stripped back in order to provide more time for Division 4 specific case studies and networking. Alongside our Training Facilitator the training was also delivered by our Division 4 Co-Leads, both of whom are current experienced PIs who described their journey into clinical research and used case studies as part of the training. All attendees agreed to share contact details to facilitate future peer-to-peer contact. The course was over-subscribed with 15 people attending. In the feedback, 14 of 15 attendees anticipated a change in their practice as a result of the course and all 15 would recommend the training to others.
8	**Dermatology [8]**	-Currently no nurse PIs in post. However reconfiguration to a regionally based service offers significant opportunities for 2018-19. -CRSL and RDM to identify suitable studies on the NIHR CRN Portfolio to involve nurse PIs. -Signpost two volunteers identified at dermatology meeting to suitable training to support Nurse PI role. -Build on success of dermatology meeting in 2017-18 and hold another event in Q2-3 to share best practice and develop research c new service configuration.	Q1-4 Q1-4 Q2-3			Complete	The specialty objective has been achieved. There is one Nurse PI in post in Primary Care. - The LCRN has signposted two volunteers identified at dermatology meeting on 16/11/2017 to suitable training to support the Nurse PI role. - Dermatology event held on 27/09/2018 at the University of Bath to share best practice and develop a research community. The event had 20 attendees. The audience consisted of researchers from both Bath and Bristol. - Supported CRSL in succession planning to identify suitable candidates for CRSL role in 2019/20. Source: ODP 07/05/2019 This specialty is ranked 13/15 for total recruitment, an increase from 2017-18. This specialty is ranked 10/15 for recruitment per million population, an increase from 2017-18. This specialty is ranked 12/15 for complexity weighted recruitment, an increase from 2017-18.

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9	**Diabetes [9]**	Continue to improve and develop primary-secondary care collaboration in the delivery of Diabetes research through the role of the Diabetes Project lead by: -Continuing to develop the regional meetings bringing together all stakeholders. -Building COPs across primary and secondary care through improved communication. -Sharing best practice across research sites, by leading COPs. -Feedback and involvement of the PPI group to shape the development of the project. -Support for sites when completing expressions of interest. -Engaging industry with research teams, raising the profile of diabetes research within the region, through the development of promotional material of research conducted in our region.	Q1-4			Green	The specialty objective of increasing the recruitment to Diabetes research studies by 5% has not been achieved. The Diabetes project lead has successfully engaged with stakeholders in Primary and Secondary care to improve collaboration in the delivery of diabetes research.
10	**Ear, Nose and Throat [10]**	-Advertise, identify and appoint a local NIHR specialty trainee lead for ENT, hearing and balance research. -CRSL and RDM provide support to trainee lead to equip them with knowledge to grow research in the LCRN. -Establish a trainee COP to share knowledge and best practice.	Q1-4 Q1-4 Q1-4			Complete	The specialty objective has been achieved. ENT Specialty Trainee lead post advertised in August 2018. Two applicants applied for the post and both were appointed in September 2018 to maximise opportunities in this area. - CRSL and RDM have provided support to trainee leads to equip them with knowledge to grow research in the LCRN. - ENT Specialty Trainee leads have established a workplan (See Case Study 12 ENT trainee work plan V1.0). - Part of this workplan includes establishing a trainee COP to share knowledge and best practice. This is already in place, informally through other avenues. - ENT CRSL and ENT Specialty Trainee attended NIHR CRN ENT Specialty event on 25/10/2018. - Inaugural LCRN ENT event held on 11/09/2018. Fifteen people attended with presentations from CRSL and Pete Blair, Professor of Epidemiology and Statistics and researcher on the Oasis study (CPMS ID: 30694). - Joint regional audiology event held with CRN SWP on 04/03/2019. Source: ODP 07/05/2019 This specialty is not ranked for total recruitment, as there is no recruitment data to report against. This specialty is not ranked for recruitment per million population, as there is no recruitment data to report against. This specialty is not ranked for complexity weighted recruitment, as there is no recruitment data to report against.

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11	**Gastroenterology [11]**	-Identify and appoint a new CRSL for the specialty. -Identify studies on the portfolio where patients could be referred from primary care. -Identify and collaborate with two primary care practices in Gloucestershire to increase referrals from primary care.	Q2-3 Q1-4 Q2-4			Green	The specialty objective has been achieved. Dr Andrew Claridge was appointed in March 2019. - New CRSL in post for 2019/20. - The CapaCITY study (CPMS ID: 17784), Enterosgel in the treatment of Irritable Bowel Syndrome with Diarrhoea study (CPMS ID: 34032), and NAXOS study (CPMS ID: 32770) were supported by Primary Care. - Flexible workforce not yet recruited in Gloucestershire to work with Primary Care to increase referrals. Plan to take this forward into 2019/20. Source: ODP 07/05/2019 This specialty is ranked 15/15 for total recruitment, a decrease from 2017-18. This specialty is ranked 15/15 for recruitment per million population, a decrease from 2017-18. This specialty is ranked 15/15 for complexity weighted recruitment, a decrease from 2017-18.
12	**Genetics [12]**	-Continue to ensure all early career researchers have exposure to NIHR portfolio research via existing mechanisms, assessing baseline in April 2018 and progress at March 2019 -Work with relevant 100K Genome project staff to identify ways to support this project appropriately in LCRN recruiting sites	Q1-4 Q1-3			Green	The specialty objective has been achieved. - Encouraged ECRs to undertake GCP training, attend Genetics Research Matters NIHR study day, and take on PI role with assistance for identifying patients on the counsellor checklist for some conditions e.g. Breast Cancer. - Dissemination of study information/research opportunities in monthly meetings to include 'Study of the Month' presentations. - Since April 2018 there has been an increase in ECRs from eight to 12, and an increase in those taking on a PI role from two to three. - 100,000 Genome Project (CPMS 37319) successfully recruited from 5 Partner Organisations within LCRN totalling >1,600 participants.
13	**Haematology [13]**	-Continue to ensure involvement of all trainees in NIHR portfolio research via existing mechanisms. -Continue to pursue formalisation of agreement with Severn Deanery to include research as part of training programme.	Q1-4 Q2-4			Green	The specialty objective has been achieved. - Haematology registrar from UHB involved in pilot of trainee engagement programme, who was a national exemplar in the HaemSTAR programme and recognised with an award. Now in post at RUH, and led the Flight study (CPMS 34919). A new trainee at UHB will take over the role, thereby propagating and sustaining this trainee activity. - UHB host a trainee post 'Clinical Fellow in haemostasis and non-malignant haematology' which has a specific remit for engagement in haematology research. - Clinical research training and GCP remains a component of induction for all of the haematology trainees.

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14	**Health Services Research [14]**	-The LCRN has 6 secondary care sites and all have taken part in HSDR portfolio research in the last 2 years. In addition there were 40 GP sites who engaged in HSDR as well as 2gether (community mental health). -The aim is to recruit new non-secondary care sites, where appropriate, as this will depend on the specific study by more active engagement with the primary care team at the CRN or other portfolio facilitators.	Q1-4			Complete	The specialty objective has been achieved. There is an increase in sites for studies funded by HSDR.
15	**Hepatology [15]**	Currently recruiting to the portfolio in the disease areas of Cirrhosis and NASH. -Continue to work on engaging with relevant individuals and teams throughout the region. -Organise and host an event "Raising the profile of hepatology research" to bring involved and interested individuals together to increase collaboration within the region.	Q1-4 Q3-4			Green	The specialty objective has been achieved. -Currently recruiting to the portfolio in the disease areas of Cirrhosis and NASH with a growing portfolio and commercial reputation within Gloucestershire. -Ongoing engagement especially with trainees in Gloucestershire. -Raising the profile of hepatology research event not held due to capacity issues. Source: ODP 07/05/2019 This specialty is ranked 15/15 for total recruitment, a decrease from 2017-18. This specialty is ranked 15/15 for recruitment per million population, a decrease from 2017-18. This specialty is ranked 13/15 for complexity weighted recruitment, an increase from 2017-18.

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16	**Infection [16]**	-No current named champion in post. -Agree remit of role of champion for sexually transmitted infection. -Advertise, identify and appoint suitable candidate. CRSL has already identified a suitable candidate to approach but advert will go out across the LCRN. -CRSL and RDM to orientate and provide support to champion to equip them with knowledge to grow research in the LCRN. -CRSL and champion to develop plan for growing research in the LCRN. -CRSL and RDM to work on developing the portfolio to increase research opportunities. -Consider holding a stakeholder engagement event locally or adding LCRN to agenda of a pre-existing meeting/event.	Q1 Q1-4 Q1-4 Q1-4 Q1-4 Q3-4			Complete	The specialty objective has been achieved. Dr Paddy Horner was appointed as the new champion for sexually transmitted infection in September 2018. - CRSL and RDM orientated and provided support to champion to equip them with knowledge to grow research in the LCRN and held a meeting with Paddy Horner on 26/09/2018 to discuss remit of the role. - CRSL and Champion to develop plan for growing research in the LCRN. - CRSL and RDM have worked on developing the portfolio to increase research opportunities. - CRSL and RDM attended and presented at the 'Preparing sexual health for antimicrobial resistant bacteria' held by the 'Sexual Health Improvement Programme (SHIP)' on 21/09/2018. - RDM attended and presented at the British Association for Sexual Health and HIV (SWBASHH) Study Day 27/11/2018. - Developed a business case to support regional investment in sexual health in 2019/20. Source: ODP 07/05/2019 This specialty is ranked 12/15 for total recruitment, a decrease from 2017-18. This specialty is ranked 9/15 for recruitment per million population, no change from 2017-18. This specialty is ranked 13/15 for complexity weighted recruitment, no change from 2017-18.

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17	**Injuries and Emergencies [17]**	-LCRN actively involved in pre-hospital studies. National emergencies lead has a particular research interest in this area and is based in our network -CRSL and RDM meeting at least once and build links with both CRN South West Peninsula and the Ambulance Trust (based in CRN South West Peninsula and responsible for services in CRN West of England) to agree future collaboration. -Supporting the three POs outside of Bristol (GRH, GWH and RUH) to develop their research portfolio to increase research opportunities and encourage participation as appropriate new studies come online.	Q1-2 Q1-4			Complete	The specialty objective has been achieved. The LCRN is actively involved in pre-hospital studies. National emergencies lead has a particular research interest in this area and is based in our region. Future opportunities for participation in portfolio studies with pre-hospital component identified through NSG. -CRSL and RDM met with South Western Ambulance Service NHS Foundation Trust (based in CRN South West Peninsula and responsible for services in CRN West of England) and agreed potential for future collaboration, allocation of resource, lack of research capability funding (and future directions for allocation), what research they would like to be involved in and understanding issues around capacity. -Supported the three POs outside of Bristol (GRH, GWH and RUH) to develop their research portfolio to increase research opportunities and encourage participation as appropriate new studies come online. This has been achieved through disseminating potential studies through network contacts and by direct contact from the CRSL with potential PIs at these sites. Source: ODP 07/05/2019 This specialty is ranked 3/15 for total recruitment, an increase from 2017-18. This specialty is ranked 1/15 for recruitment per million population, an increase from 2017-18. This specialty is ranked 3/15 for complexity weighted recruitment, an increase from 2017-18.
18	**Mental Health [18]**	-RDM and CRSL to continue work with the 2 CAMHS Champions to site new studies within region. -Where appropriate, the Regional Mental Health and Dementia Team will assist with set up and delivery. New reinvigorated academic unit in Bristol should start to develop and recruit to home grown studies. Move to regionally based team should exploit strong recruitment growth in Gloucestershire.				Amber	The specialty objective has been met. Maintaining engagement with the 2 CAMHS Champions has been difficult given the dearth of available CAMHS studies. The Regional Mental Health and Dementia Team is supporting a study in Treatment Resistant Depression by recruiting through primary and bringing participants into mental health services for the study. Two interventional studies of treatment resistant depression are in set up and we propose to use this successful model.
19	**Metabolic and Endocrine Disorders [19]**	This objective will be met through the diabetes workforce due to an inability to recruit to this post	Q1-4	Green	Spreadsheet containing information of the staff undertaking metabolic and endocrine disorder studies completed on a quarterly basis, as requested.	Complete	The specialty objective has been achieved. The required spreadsheet has been completed.
20	**Musculoskeletal Disorders [20]**	-Advertise, identify, appoint and support Orthopaedic Champion role. There is a strong academic department in this area. -In 2017-18 Q4, PIs for Musculoskeletal Disorder NIHR Portfolio studies within the region were invited to apply for the Co-Lead role of Clinical Research Specialty Lead in Musculoskeletal Disorders. Once appointed, we will be inducting and supporting this person in their role	Q1-2 Q1-4	Red	Vacant MSK CRSL. No Orthopaedic Champions yet identified. CRSL job description being refreshed for 2019-20 and post will be readvertised.	Red	The specialty objective has not been achieved. - Musculoskeletal Disorders CRSL post advertised as part of CRSL recruitment process for 2019-22 and via a targeted approach to local CIs/PIs. However, the LCRN was unable to appoint to this post and has also been unable to appoint to the Orthopaedic Champion role.

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21	**Neurological Disorders [21]**	-CRSL role currently out to advert and expectation is that post will be filled in Q1 2018-19. Remit of successful applicant will be mentoring junior researchers -Initial focus will be on induction to CRN, role and local portfolio of ageing studies (currently 7 studies) -All neurological disorder studies open to new sites will be assessed for suitability at local sites and approaches made to potential PIs, including those early in their career -Scoping work will be carried out with higher recruiting regions (in terms of both number of studies and recruitment) to understand best practice to improve performance in West of England	Q1 Q1-2 Q1-4 Q2-4			Amber	- In 18/19, with a new Neurology CRSL in post (Prof Neil Scolding) efforts have concentrated on a) Induction for the CRSL in CRN business and b) Generating interest in the region for Neurologists (including Early Career Researchers, but not limited to them) to take on portfolio studies. - New contact has been established with Neurologists in a number of POs who have agreed to receive Neurology Expression of Interests. - In 18/19, 12 Neurological Disorders Expression of Interest were sent out to sites (4 commercial and 8 non-commercial). So far none of these have converted into new studies.
22	**Ophthalmology [22]**	-Continue to build Ophthalmology community of practice to encourage and support increased participation in NIHR Portfolio studies. To develop this community, we will identify and invite other interested researchers within the region in order to improve access of research to patients of organisations providing eye services. -Tracking patients across organisations as services move (i.e UHB to WAHT) to help to build stronger links for research within the region.	Q1-4 Q1-4	Green	First face-to-face event with Ophthalmology community and plans to extend invite to the wider teams for the next event in Spring 2019.	Green	The specialty objective has been achieved. - 75% (3/4) of NHS Trusts providing eye services recruited to NIHR Portfolio studies in 2018/19. - Largest recruiting study of 2016-17 and 2017-18, The CVI Project: Prevalence Study (CPMS 33759) which totaled 1,743 participants, closed in August 2017, hence the lower recruitment in 2018/19 compared with 2017/18. - RDM and PF host monthly COP teleconferences with the delivery teams. LCRN held a successful face-to-face event in December 2018 where teams presented their ways of working, shared successes and challenges, and highlighted priorities and plans for ophthalmology. As part of the development of this community, we are involving a wide range of professions such as imaging staff and optometrists. - Work relating to the tracking of patients across organisations has been absorbed by the planned merger between UHB and WAHT.
23	**Oral and dental health [23]**	Updated plan (as of 19.04.18 confirmed by S.Taylor 26.04.18): -Continue to increase awareness of the Oral and Dental Specialty and Network -To support oral and dental research awareness of the incoming West of England CRN primary care research team -Disseminate national survey of dentists' research readiness across West of England CRN -Review uptake of GCP Training across the oral and dental workforce -Maximise recruitment to portfolio from Bristol CTU -Support Adult Dental Health Survey of Adults attending General Dental Practices -Monitor NIHR portfolio to identify studies that can be opened in LCRN -Make most of local strengths and identify opportunities presented by the JLA PSP -To consider identifying practices that could support the recruitment of healthy volunteers or participants for public health studies to support research readiness -To consider building a network of research-interested dentists and dental care professionals (Original plan submitted: -To work with the NIHR CRN CC National Dental lead based within region with the aim of developing a plan to engage the dental workforce community in research following clarity around the JLA priority setting partnership.)	Q1-4		One new Oral and Dental study opened.	Red	The specialty objective has not been achieved. -Due to capacity issues within the core team, the requirements to survey local dentists and dental care professionals has not been undertaken and will be rolled into the next financial year. -There has been an increase in the delivery of Oral and Dental studies this year.
24	**Primary Care [24]**	-Severn Deanery have agreed to support the research champion posts -GP ST3 research champion scholarship programme 2 posts will be advertised on the deanery website	Q1-4	Complete	Two research scholars appointed.	Complete	Two GP Scholars were appointed.

Section 6. Specialty Objectives

RAG Information:

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Complete (C)	Milestone(s) complete.
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Amber (A)	There is a risk that one or more specified deliverable will not be delivered by the Milestone Date.
Green (G)	On target to deliver all specified deliverables by the Milestone Date.

				Mid Year Progress Report		Year End Report	
Ref	**Specialty**	**Local activities to achieve the national objective** **The local planned activities described below will be implemented to support achievement of the national specialty objectives and result in the following outcomes:** **1.1 Sharing of best practice, skills and knowledge.** **1.2 Creation of communities of practice (COP).** **1.3 Skilled and equipped workforce to grow and promote research.** **1.4 Increased collaboration and involvement.** **1.5 Development of a more balanced portfolio.**	**Timescale**	**RAG**	**Commentary**	**RAG**	**Commentary**
25	**Public Health [25]**	-Production of a LCRN England Public Health Partnership Research work plan. -At least two LA PH departments in LCRN with a clinical academic appointment/number of appointees. -Number of LA PH departments in LCRN with an internal research function/ formal relationship with the university. -Develop existing relationships with local SPHR to encourage enrolment of PH studies on to the LCRN portfolio.	Q1-4 Q1-4 Q1-4 Q1-4			Complete	The specialty objective has been achieved. -There are three studies managed by the Public Health specialty and 11 studies supported by the specialty. In meeting our local plans: -The West of England Public Health Partnership (WE PHP), a framework for joint working relationships and Public Health service delivery, has been developed and agreed between Bath and North East Somerset Council, Bristol City Council, North Somerset Council and South Gloucestershire Council; it includes a research workstream. The workstream's major areas of work are establishing a co-ordinated Public Health research and evaluation programme across the West of England, promoting collaborative working, and developing a research aware and research ready Public Health workforce. These areas of work include specified activities, outputs, and outcomes led by a specified lead (Dr Michael Dalili). -Local authorities in our LCRN with clinical academic appointments are South Gloucestershire Council (Dr Gemma Morgan, Dr Kyla Thomas) and Bristol City Council (Dr Jo Williams). -Local authorities in our LCRN with an internal research function/ formal relationship with a university are Bristol City Council, South Gloucestershire Council, Bath and North East Somerset (BANES) Council, and Gloucester City Council. -LCRN has developed a strong relationship with our local School for Public Health Research led by Professor Rona Campbell and continue to engage with them in supporting research and growing the public health speciality.
26	**Renal Disorders [26]**	Currently six open commercial studies with 5 different PIs, (growth of two over last year). -Identify current PIs with no commercial activity in the last three years from the NIHR CRN Portfolio to identify additional potential new commercial PIs. -There is potential to continue growth and development of renal portfolio in GHFT, including commercial studies. Assess all commercial studies requesting expressions of interest within Gloucestershire for feasibility. -Organise and host an event "Raising the profile of renal research" to bring involved and interested individuals together to increase collaboration within the region and develop our regional profile for renal commercial research.	Q1-2 Q1-4 Q2-4			Complete	The specialty objective has been achieved. -Three new commercial PIs in 2018/19. -Work still ongoing with regard to current PIs with no commercial activity to identify additional potential new commercial PIs. -11 commercial renal studies sent to sites for EOIs during 2018/19, all of which were considered by GHFT. -"Raising the Profile of Renal Research" event was planned for July 2018 in Gloucestershire, but did not happen due to competing commitments.

Section 6. Specialty Objectives

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				Mid Year Progress Report		Year End Report	
Ref	**Specialty**	**Local activities to achieve the national objective** **The local planned activities described below will be implemented to support achievement of the national specialty objectives and result in the following outcomes:** **1.1 Sharing of best practice, skills and knowledge.** **1.2 Creation of communities of practice (COP).** **1.3 Skilled and equipped workforce to grow and promote research.** **1.4 Increased collaboration and involvement.** **1.5 Development of a more balanced portfolio.**	**Timescale**	**RAG**	**Commentary**	**RAG**	**Commentary**
27	**Reproductive Health and Childbirth [27]**	Objective A: 83% (5/6) acute NHS Trusts providing maternity services are currently recruiting into RH&C studies. The non-recruiting site essentially now has only a small midwife led unit therefore aim to maintain this at 83%. -Continue to support COP of senior midwives who collaborate effectively to ensure all sites are informed of pipeline studies, assess feasibility of potential new studies and troubleshoot difficulties with open studies. -Identify all potential studies allocated to specialities outside RH&C to assess feasibility for delivery by RH&C teams. -Explore potential for increasing activity in other sub-specialities including neonatal, gynaecology & fertility. -Continue to grow links with regions outside CRN West of England via the RH&C champions & co-speciality lead to try and attract more studies to the region at an earlier stage of development -Explore potential to increase links with commercial companies on both RH&C portfolio and and cross-speciality studies e.g. gestational diabetes. Objective B (Recruitment within the LCRN geography as a proportion of infant mortality data for that region) Awaiting clarification from Coordinating Centre	Q1-4 Q1-4 Q1-4 Q2-4 Q1-4 Q3-4 TBC			Complete	The specialty objective has been achieved. - 100% (6/6) of NHS Trusts providing maternity services recruited into NIHR Portfolio RH&CB studies in 2018/19 (increased from 83%). - Ongoing successful COP attended by Midwives from across the region. The monthly meetings chaired by the CRSL provide a forum to share best practice, discuss current and planned studies, disseminate important information from the RH&CB Champions, and provide peer support for new members of staff. ->4,200 patients recruited into studies with RH&CB as supporting specialty which has required RH&CB involvement e.g. YP 26+ 2018 Questionnaire (CPMS 40692). - Some reproductive teams now taking on multiple studies in different specialties where they recruit pregnant women (e.g RUH). This has enabled the research midwife team to grow and become stable. - Focus on developing into gynaecology studies at NBT (to include participation in MifeMiso (CPMS 33415), and RUH has a Paediatric Research Nurse working on neonatal studies. There is a higher than national average number of gynaecology studies within West of England, and a Nurse Consultant PI. - RH&CB Champions attend quarterly national meetings and feedback to the COP, including information about new studies which could be suitable for the region. Strong links with the LCRN Core Team mean the RDMs/Portfolio Facilitators are able to follow up leads on these studies. - NBT and RUH have strong collaborations between RH&BC and diabetes research teams to deliver commercial studies.

Section 6. Specialty Objectives

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28	**Respiratory Disorders [28]**	-Encourage participation in and support recruitment to rare diseases studies such as TILT (CPMS ID: 34338), ASSESS-meso (CPMS ID: 33514), RAMPP (CMS ID: 19214) and Hi-SPEC (CPMS ID: 31533). -Establish a respiratory nurse community of practice to share knowledge and best practice. -CRSL and RDM to work on developing the portfolio outside of NBT to increase research opportunities especially RUH which has a research active specialist Pulmonary Hypertension service (one of only 5 outside London) and will be involved in a number of collaborative projects in 2018-19.	Q1-4 Q2-3 Q1-4			Complete	The specialty objective has been achieved. - Supported recruitment to the following rare disease studies: 1. TILT (CPMS ID: 34338) 2. ASSESS-meso (CPMS ID: 33514) 3. RAMPP (CMS ID: 19214) 4. Hi-SPEC (CPMS ID: 31533) - CRSL and RDM worked on developing the portfolio outside of NBT to increase research opportunities, especially at RUH which has a research active specialist Pulmonary Hypertension service (one of only five outside London) and will be involved in a number of collaborative projects in 2018/19. - Plan to establish a respiratory nurse COP to share knowledge and best practice. Inaugural event planned for Q2 2019/20. - The LCRN agreed a commitment to fund a respiratory project at NBT in 2019/20. (See Case Study 13 Respiratory bid V1.0). Source: ODP 07/05/2019 This specialty is ranked 13/15 for total recruitment, no change from 2017/18. This specialty is ranked 10/15 for recruitment per million population, an increase from 2017/18. This specialty is ranked 12/15 for complexity weighted recruitment, no change from 2017/18.
29	**Stroke [29]**	-CRSL and RDM to launch survey to identify greater details about local plans for stroke research and some of the barriers/facilitators for conducting RCTs. -Continue our cross-regional working by identifying key projects/models from other LCRNs which could be adopted and adapted for the West of England. -Hold a stroke research event with speakers from RCT study teams to promote and educate local PIs and stroke research teams about why and how to offer their patients RCTs. The main challenge will be the availability of stroke RCTs on the Portfolio. Also a focus on RCT recruitment will need to be balanced against recruitment to higher recruiting studies for contribution to HLO1.	Q1 Q1-4 Q4	Red	Launched RCT survey. Disseminated and discussed results with the stroke COP group. Close working with CRN SWP for stroke, to include joint hosting the Stroke Research Event in June 2018. The planned focus for the 2019 event is recruitment into RCTs. Attended the launch of the Stroke HIT in November 2018 with the view of supporting research originating from the HIT.	Red	The specialty objective has not been achieved. - RCT recruitment as a % of SNNAP-recorded admissions was 2%. - Recruitment to all stroke studies as a % of SNNAP-recorded admissions was 16%. See cell F38 for activities.

Section 6. Specialty Objectives

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30	**Surgery [30]**	-The success of Bristol BRC bid including a surgical innovation theme, presents significant opportunities for the LCRN. At least one large local NIHR trial will open across the network in 2018 . -RDM will attend BRC surgical team monthly meetings, to ensure a close working relationship with the group and the LCRN. The LCRN will offer network support where possible, to facilitate BRC trials opening in other sites across the network, increasing recruitment into surgical trials across the LCRN. -CRSL, RDM and PF will meet face to face every quarter, to review local and national surgical portfolios. With focus on local performance, horizon scanning the national portfolio for opportunities across all 15 surgical sub-specialties. Local opportunities and barriers will be discussed and an action plans put in place to address these opportunities and barriers locally. -2017/18 no surgical trials were open in GWH or WAHT. CRSL and RDM will develop surgical team engagement across these POs, through face to face meetings with potential PIs and delivery teams. -CRSL identified a colorectal trial, PPAC2 (CPMS 35187). CRSL and RDM will engage with colorectal surgical teams at GWH, WAHT and GRH to identify potential PIs,teams across the network will be encouraged to open this trial where possible. -CRSL and RDM will support current PIs across the network.Opportunities for non medic PIs will be explored across the surgical teams in the LCRN. Potential non-medic PI's will be identified across the network, PF will identify appropriate studies for identified non-medic PIs. -CRSL is an active PI, currently developing an NIHR proposal. The LCRN will actively support this development by linking the CRSL with a successful CI in the region, this collaboration will work on the proposal in 2018. The planned outcome is the development of the CRSL into an active CI in the region. -PF will raise awareness of future and current research opportunities across all 15 subspecialties, via email contact with the sub specialty champions and surgical delivery teams across the network. The model currently in place across the SWAG SSG network, will be replicated across the surgical research community. Specific Areas of focus 2018-19: -Plastic and Hand surgery, little or no activity in this area currently, RDM and CRSL will engage with plastic surgeons across the network, to appoint a SSL in this area. The SSL, CRSL and RDM will review the national portfolio with the aim to opening at least one study in this area 2018-19. -The appointment of a new clinical Professor of Vascular Surgery in the region presents an opportunity to establish a community of practise for this subspecialty.CRSL, RDM, will meet with the Professor of Vascular Surgery, to look at network wide approach to building the portfolio and mapping links locally and nationally. This community of practice could then be the model of best practice across other sub specialties in the region.	Q1-4 Q1-4 Q1-4 Q2-3 Q1-4	Green	-LCRN has now increased engagement with local BRC and the surgical theme lead. -RDM presented to BRC surgical team at monthly meeting. COO, CD and RDM presented to BRC Senior management teams.The aim of these presentations were to discuss future areas of collaboration. LCRN has now increased engagement with the BRC and the surgical theme lead. -A development bid was submitted by two POs to increase resources in surgical delivery teams, which will facilitate opening BRC studies outside host organisation. -BRC Surgical theme lead and Bristol Clinical Trials Evaluation Unit are key collaborators in the Sunflower study (CPMS 38686). This trial is in set up in 5 POs across the region, including GWH and WAHT where previously there were no surgical trials open. -RDM and CRSL have met each quarter to review the portfolio and explore areas for growth in the region. -PPAC 2 (CPMS 35187) is now open in two POs and in set up in a third. -CRSL has developed a NIHR grant proposal to be submitted in January 2019. LCRN division one lead is a collaborator on the proposal.	Complete	The speciality objectives have been achieved for 2018/19. The LCRN has recruited into 14/15 subspecialties and nine of the subspecialties have recruited >=2 recruits per 100,000 population. The LCRN is ranked 10/15 nationally for recruitment per million population; this is an improvement from 15/15 in 2017/18. - Surgery CRSL and RDM engage with clinicians across the Bristol Surgical Trials Centre and two UKCRN registered clinical trials units in Bristol: the Musculoskeletal Research Unit and the MRC ConDuCT-II Trials for Methodology Research Hub, which includes the Surgical Innovation theme of the NIHR Bristol Biomedical Research Centre. There are surgical trials from these areas opened across in sites across the network e.g. CPMS 39344, CPMS 11911 and CPMS 38107. - 16 surgical studies opened in the LCRN in 2018/19, including PPAC2 (CPMS 35187) which opened in multiple sites. - The NIHR grant application submitted by the CRSL in collaboration with the Division 1 lead was unsuccessful, however this will be revisited in 2019/20. - The CRSL for surgery and the newly appointed cancer CRSL (Oncology surgeon) will work closely together to address the cancer surgery harmonised objective.

Section 7. LCRN Operating Framework Indicators

Section 7 of the template should be used to provide commentary on adherence to the LCRN Operating Framework Indicators.

ID		Guidance	Year End Commentary
1.1	**Domain**: Governance and Management **Indicator**: LCRN provides an Annual Plan, Annual Report and other documents as requested by the National CRN Coordinating Centre **Assessment Approach**: Monitoring of provision of key documents requested by the National CRN Coordinating Centre	No further information required.	
1.2	**Domain**: Governance and Management **Indicator**: LCRN Clinical Director and/or LCRN Chief Operating Officer attend all National CRN Coordinating Centre/LCRN Liaison meetings **Assessment Approach**: Attendance registers for National CRN Coordinating Centre/LCRN Liaison meetings	Please comment on attendance at national meetings, if wished. The CRNCC maintain a central record.	CD and/or the Chief Operating Officer attended all CRNCC Liaison meetings and strategic summits.
1.3	**Domain**: Governance and Management **Indicator**: LCRN Host Organisation and LCRN Category A Partners submit an NHS Information Governance Toolkit annual assessment to NHS Digital and attain Level 2 or Level 3 **Assessment Approach:** Analysis of information on the NHS Digital Information Governance Toolkit website which provides open access to attainment levels for all submitting organisations	Please confirm that the Host Organisation have completed the NHS Digital Data Security and Protection Toolkit submission and that they have met all standards. If the Host Organisation completed the Information Governance Toolkit assessment prior to the launch of the NHS Digital Data Security and Protection Toolkit and within the financial year, please confirm the score and attainment level.	The Host Organisation has achieved 90 out of the 100 mandatory evidence items for the Data Security and Protection Toolkit and has submitted an Improvement Plan to NHS Digital which they have reviewed and approved. The Host Organisation completed v14.1 of the Information Governance Toolkit for the year 2017/18, and achieved a satisfactory submission of 67%.
1.4	**Domain**: Governance and Management **Indicator**: Category A LCRN Partner flow down contract templates used to contract with all Category A LCRN Partners **Assessment Approach**: LCRN Annual Report	Please comment on Category A Partner organisation recorded in AR Appendix 3, if wished.	Please see appendices.
1.5	**Domain**: Governance and Management **Indicator**: Category B LCRN Partner flow down contract templates used to contract with all Category B LCRN Partners **Assessment Approach**: LCRN Annual Report	Please comment on Category B Partner organisation contracting as recorded in AR Appendix 1, if wished.	Please see appendices.
2.1	**Domain**: Financial Management **Indicator**: Internal audit in respect of LCRN funding managed by the LCRN Host Organisation, undertaken at least once every three years and which meets the minimum scope requirements specified by the National CRN Coordinating Centre **Assessment Approach:** Monitoring of audit reports provided by the LCRN Host Organisation to the National CRN Coordinating Centre	Please indicate any outstanding recommendations from the last internal audit performed that may not have been implemented fully by the Host Organisation. Please also provide the “opinion” provided by the auditor for the Host audit.	No outstanding recommendations remain from the Internal Audit completed in September 2018.
2.2	**Domain**: Financial Management **Indicator**: Deliver robust financial management using appropriate tools and guidance **Assessment Approach:** ● Monitoring by the National CRN Coordinating Centre of percentage variance (allocation vs expenditure) quarterly and year-end (target is 0%) ● Monitoring by the National CRN Coordinating Centre of proportion of financial returns completed to the required standard and on time (target is 100%) ● Monitoring of financial management via LCRN financial health check process	No further information required.	
2.3	**Domain**: Financial Management **Indicator**: Distribute LCRN funding equitably on the basis of NHS support requirements **Assessment Approach:** Comparison by the National CRN Coordinating Centre of annual LCRN Partner funding allocations and NHS Support requirements	Please comment on whether the LCRN adopted a bidding process for LCRN Partners to apply for additional LCRN funding to meet NHS support requirements. If applicable, please confirm the percentage of funding requests approved / rejected.	A competitive bidding process was advertised to POs in Q1 and Q3 2018/19. In total, 43 of 71 bids received (61%) were funded.

3.1	**Domain**: CRN Specialties **Indicator**: LCRN has an identified Lead for each NIHR CRN Specialty **Assessment Approach:** The LCRN Host Organisation shall: ● Provide the National CRN Coordinating Centre with access to a list of LCRN Clinical Research Specialty Leads, which includes each individual's start/end dates and contact information ● Notify the National CRN Coordinating Centre if there are changes within the financial year ● Provide a narrative to justify intentional vacancies or the expected timeframe to fill vacancies	Please provide commentary on intentional vacancies or the expected timeframe to fill Local Specialty Lead vacancies as referenced in the LCRN Fact Sheet.	We have been unable to appoint to one CRSL role for the whole year: Metabolic and Endocrine Disorders, and have been unable to recruit to the Musculoskeletal Disorders CRSL role since September when the previous post holder stepped down.
3.2	**Domain**: CRN Specialties **Indicator**: Each LCRN Clinical Research Specialty Lead attends at least 2/3 of National Specialty Group meetings **Assessment Approach:** Attendance registers for National Specialty Group meetings	We are in the process of creating and sharing a central record. In the meantime, please provide locally held information in respect of this indicator.	All CRSL roles were re-advertised in Q4 and will be appointed to by Q1 of 2019. There has been no formal record set up internally to monitor attendance at national meetings of CRSLs. Any concerns regarding attendance are escalated through the divisions. Attendance registers are checked ad hoc.
3.3	**Domain**: CRN Specialties **Indicator**: Each LCRN provides evidence of support provided to their LCRN Clinical Research Specialty Leads to enable them to undertake their role in contributing to the NIHR CRN's nation-wide study support activities, specifically in respect of commercial early feedback and non-commercial expert review for the eligibility decision and including where applicable, local feasibility activities, delivery assessments and performance reviews **Assessment Approach:** Review by the National CRN Coordinating Centre of evidence of support provided in LCRN Annual Plan and Report	Please provide evidence of the impact and outcomes from activities delivered to enable your Local Speciality Leads to undertake national activities in respect of commercial early feedback and non-commercial adoption.	RDMs meet regularly with their CRSLs to provide support in performing CRN activities. Early Feedback training materials have been localised and distributed to all CRSLs. When aware of an Early Feedback request, a local follow up email has been sent.

4.1	**Domain**: Research Delivery **Indicator:** Each LCRN consistently delivers the local elements of the CRN's nation-wide Study Support Service as specified in the latest version of the Standard Operating Procedures produced by the National CRN Coordinating Centre and available as part of the LCRN Contract Support Documents **Assessment Approach:** Monitoring by the National CRN Coordinating Centre of provision of the individual components of the Service via the study progress tracker application on Open Data Platform where the LCRN is assigned as the Lead LCRN and/or Performance Lead	Please ensure your commentary references and provides context for the Study Support Progress Tracker app information available on Open Data Platform for studies led by the LCRN in 2018/19 as this provides a mechanism for visualising the local CRN provided service outputs at a study level. For example the number of study delivery assessments completed and the number of study start up documents uploaded into CPMS as a percentage of the number of studies for which the LCRN is assigned as the Lead LCRN.	Please see section 4: 2.5.1 for details of the review of the SSS in 2018/19. SSS study progress tracker 2018/19: Total number of Lead studies: 82 The number of Lead studies that have received support from SSS at any stage: 81 (98.78%) 1. Early contact and engagement: There are 35 studies which have received Early Contact and Engagement which is derived from the number of studies with an Early Contact and Engagement Document attached to the study record or studies with Early Contact and Engagement Notes. A further breakdown of studies which have had Early Contact and Engagement is detailed below: Industry Costing Template Document: 2.86% Industry Costing Template Validation Checklist: 0% Attribution Review and Monitoring Document: 0% Early Contact and Engagement Note: 97.14% AcoRD Attribution Note: 0% 2. Early feedback (commercial studies only) There are no studies that have received Early Feedback which is derived from the number of studies with a commercial submission request for the Early Feedback Service. 3. Site identification (commercial studies only) One commercial study received Site Identification which is derived from the number of studies with a commercial submission request for the Site Identification Service. 4. Optimising delivery There are 80 studies which have received Optimising Delivery which is derived from the number of studies with a submission request for the Site Intelligence Service, that have an Original Research Delivery Assessment on the study record or with a National Study Delivery Assessment Form document attached A further breakdown of studies which have had Optimising Delivery support is detailed below: Site Intelligence Service Submission: 15% Original Research Delivery Assessment: 97.5% National Study Delivery Assessment Form: 35% 5. Study set-up There are 60 studies which have received Effective Study Set-up which is derived from the number of studies which have an Effective Start Up - Study Recommendations or an Effective Start Up - Study Milestone Schedule Document attached to the study record. A further breakdown of the number of studies which have had Effective Study Set-up support is detailed below: Study Recommendations Document: 36.67% Study Milestone Schedule Document: 0% Set-up Recommendations Note: 86.67% 6. Performance monitoring There are 21 studies which have received Performance Monitoring which is derived from the number of studies which have a Performance Monitoring Outcome note on the

4.2	**Domain**: Research Delivery **Indicator:** Each LCRN provides near time Minimum Data Set data items as specified by the National CRN Coordinating Centre, which have been quality assured to accurately reflect research activity measures and enable collaborative delivery of studies across the NHS **Assessment Approach:** ● Monitored via Open Data Platform reports, the single research intelligence system and the Research Delivery Assurance Framework ● Analysis of percentage of missing and inaccurate data points from each LCRN	Please provide an analysis of percentage of missing and inaccurate data points.	All POs in the region have an assigned 'locality link' RDM and PF to work with sites to correct inaccurate data points. The RDMs also work on data quality for Lead studies within their divisional specialties.
5.1	**Domain**: Information and Knowledge **Indicator**: LCRN provides an LPMS to capture for their region the required Minimum Data Set data items as specified by the National CRN Coordinating Centre, and enables timely sharing of information as one element of the single research intelligence system **Assessment Approach:** Monitoring by the National CRN Coordinating Centre of system integration, usage and data transfer as part of the single research intelligence system	No further information required.	
5.2	**Domain**: Information and Knowledge **Indicator**: LCRN provides support for ongoing provision of an LPMS solution **Assessment Approach:** Review of budget line for provision of an LPMS in LCRN Annual Financial Plan	No further information required.	
5.3	**Domain**: Information and Knowledge **Indicator**: Each LCRN has a nominated representative in attendance at all national NIHR CRN Virtual Business Intelligence meetings **Assessment Approach:** Attendance registers for national NIHR CRN Virtual Business Intelligence meetings	Please comment on attendance at national meetings. The CRNCC maintain a central record.	All meetings attended where possible by Business Intelligence Lead or Business Intelligence Manager.
5.4	**Domain**: Information and Knowledge **Indicator**: Each LCRN has a nominated representative in attendance at all national CPMS-LPMS meetings where either a) strategic sign off is required or b) an operational working perspective is required **Assessment Approach:** Attendance registers for national CPMS-LPMS meetings	Please comment on attendance at national meetings. The CRNCC maintain a central record.	All meetings attended where possible by Business Intelligence Lead or Business Intelligence Manager.
6.1	**Domain**: Stakeholder Engagement and Communications **Indicator**: LCRN has an experienced and dedicated communications function **Assessment Approach:** ● Individual's name and contact details provided to the National CRN Coordinating Centre ● Non-pay budget line for communications identified in LCRN Annual Plan	Please provide any additional commentary on vacancies and the expected timeframe to fill these. Please comment on non-pay communications spend. The CRNCC maintains a central contacts list.	Please see 2.7.8.
6.2	**Domain**: Stakeholder Engagement and Communications **Indicator**: Each LCRN has a defined approach to communications and action plan aligned with both the NIHR CRN and NIHR strategies **Assessment Approach:** ● Review and monitoring of LCRN Annual Plan ● Review of outcomes as reported within LCRN Annual Report ● Evidence of joint work with local NIHR infrastructure reviewed	Please cross-reference from Section 4.7 and add any additional commentary as required.	As above.

6.3	**Domain**: Stakeholder Engagement and Communications **Indicator**: The LCRN has in place a senior leader with experience and identified responsibility for PPIE **Assessment Approach:** Individual's name and contact details provided to the National CRN Coordinating Centre	Please provide any additional commentary on vacancies and the expected timeframe to fill these. The CRNCC maintains a central contacts list.	RDM assigned the PPIE workstream attending national PPIE leads meetings. The PPIE lead attends PHWE Steering group meeting and chairs their operational group meeting. The lead has responsibility and oversight of the PRES and PRA projects locally.
6.4	Domain: Stakeholder Engagement and Communications Indicator: The LCRN records metrics of research opportunities offered to patients Assessment Approach: ● The LCRN will hold information on its reach with patients and the public (metrics may include local website usage, leaflet distribution, social media reach etc) ● Evidence of local patient evaluation system ● Progress discussed at national PPIE meetings and reported in LCRN Annual Report	Please cross-reference from Section 4.7 and add any additional commentary as required.	Please see 2.7.8 and Case Study 14 PRES questionnaires, 2018.
6.5	**Domain**: Stakeholder Engagement and Communications **Indicator**: The LCRN has collaborative PPIE workplans across CRN and partners with measurable outcomes for delivery of learning resources **Assessment Approach:** ● LCRN Annual Plan includes PPIE workplan with clear outcomes, milestones and measurable targets ● Non-pay budget line for PPIE and WTE for PPIE role(s) identified in LCRN Annual Plan ● Progress reported in LCRN Annual Report	Please cross-reference from Section 4.7 and add any additional commentary as required.	Please see section 4: 2.7.1 - 2.7.6 The LCRN in collaboration with PHWE partners has an annual workplan, with SMART objectives and deliverables; the workplan is developed by PPIE leads in PHWE partner organisation in collaboration with public contributors working with each of the partner. All POs have submitted their annual business plan which includes a section on PPIE, outlinng their support of PPIE initiatives.
6.6	Please refer to section 2.5.5 for details of local promotion of JDR.	Please comment on how the LCRN has supported the awareness of, engagement with and delivery of National CRN Coordinating Centre-managed services, such as Join Dementia Research (JDR) and Be Part of Research (formerly known as the UK Clinical Trials Gateway (UKCTG)), cross-referencing from Section 4.7 as required.	The LCRN has helped to promote JDR with a number of initiatives, such as mailout collaborations with Bristol Dementia Wellbeing and radio shows on local radio aimed primarily at under-represented communtities (see Case Study15, JDR Takeover Ujima Radio) including a two hour Ujima Radio show featuring carers and Dementia experts. A cake and coffee event was also delivered in a Bristol community centre, along with local Dementia POs. The UK Clinical Trials Gateway continues to be promoted although anticipation of the newly branded Be Part of Research site is the focus.
6.7	**Domain**: Stakeholder Engagement and Communications **Indicator**: Each LCRN delivers the Patient Research Ambassadors (PRAs) project **Assessment Approach:** ● Review and monitoring of LCRN Annual Plan ● Review of outcomes as reported within LCRN Annual Report	Please cross-reference from Section 4.7 and add any additional commentary as required.	Expanding the PRA project across the LCRN is a priority for 2019/20 (Ref. Secton 4- 2.7.4).

6.8	**Domain**: Stakeholder Engagement and Communications **Indicator**: Each LCRN delivers the patient experience survey, as specified by the National CRN Coordinating Centre **Assessment Approach:** ● Review and monitoring of LCRN Annual Plan ● Review of outcomes as reported within LCRN Annual Report	Please comment on the Patient Research Experience Survey findings, impacts, and plans for continuous improvement.	The Patient Research Experience Survey (PRES) was delivered in a different format this year. It included a full questionnaire based upon the PRES working group feedback along with the mandatory questions. The main PRES included a keepable strip that clearly stated 'thank you' to everyone in the region who has taken part in research, while the main part of the leaflet was folded and gummed to create a postage paid encapsulated form. Separate designs were also created for three age groups: 4-7, 8-13 and 14-17. (See Case Study 14 PRES questionnaires, 2018) There were 442 PRES questionnaires returned (269 adult and 173 children). Reports for each Trust were created using Google Data Suite and sent to Trusts with summaries and sharable social media content detailing their best results. Greater engagament with Trusts who recorded poor returns will be undertaken in 2019/20 to ensure meeting of HLO. There are also discussions around having year-round digital version for POs and Research Teams to email to participants.
6.9	**Domain**: Stakeholder Engagement and Communications **Indicator**: Each LCRN develops and implements a plan to deliver the CRN NHS Engagement Strategy **Assessment Approach:** ● Review and monitoring of LCRN Annual Plan ● Review of outcomes as reported within LCRN Annual Report	Please comment on the plan, outcomes and impacts resulting from delivery to date of the CRN NHS Engagement Strategy.	Please see 2.7.8.
7.1	**Domain**: Workforce, Learning and Organisational Development **Indicator**: The LCRN has in place a senior leader with identified responsibility for the wellbeing of all LCRN-funded staff **Assessment Approach:** ● Individual's name and contact details provided to the National CRN Coordinating Centre ● Implementation of the local action plan to support the wellbeing framework and action plan	Please advise if there has been any change in the name or contact details of the senior leader with identified responsibility for the wellbeing of all LCRN-funded staff. The CRNCC maintains the central contacts list.	The local action plan for wellbeing activities within the LCRN core team has been implemented. Wellbeing activities now form part of normal working practice within the team. The COO chairs the Wellbeing meetings on behalf of CRNCC. The Deputy COO is the wellbeing lead for the LCRN.
7.2	**Domain**: Workforce, Learning and Organisational Development **Indicator**: Each LCRN has an active programme of activities that engage the wider workforce to promote clinical research as an integral part of healthcare for all **Assessment Approach:** ● Evidence of programme of learning opportunities provided in LCRN Annual Plan and Report ● Increased engagement of local partners in promoting the work of the NIHR	Please cross-reference from Section 4.8 and add any additional commentary as required.	The local programme of learning has been supported by facilitators from all the partner organisations. See Case Study 9 WE Training website and Case Study 16 LCRN NIHR Learn Annual Update 2019 CRN WE.
7.3	**Domain**: Workforce, Learning and Organisational Development **Indicator**: The LCRN has in place a senior leader with identified responsibility for driving a culture of Continuous Improvement (Innovation and Improvement) supported by an action plan aligned to local and national initiatives and performance metrics **Assessment Approach:** ● Evidence of programme of activities provided in LCRN Annual Plan and Report ● Effective approaches shared by Continuous Improvement Leads at national meetings	Please cross-reference from across the Annual Report and add any additional commentary as required, including details of impacts, benefits, lessons learned, and how these have been shared with the wider CRN.	Please see 2.7.10, 2.7.11, 2.8.5, 2.8.6.

8.1	**Domain**: Business Development and Marketing **Indicator**: Each LCRN has an up to date business development and marketing Profile using the template provided by the National CRN Coordinating Centre **Assessment Approach:** ● Profile template submitted as part of LCRN Annual Plan ● Contact details provided for assigned LCRN Profile lead in LCRN Annual Plan	No further LCRN information required	
8.2	**Domain**: Business Development and Marketing **Indicator**: The LCRN has an action plan for promoting the industry agenda aligned with the national business development strategy **Assessment Approach:** ● Review and monitoring of LCRN Annual Plan ● Review of outcomes as reported within LCRN Annual Report	Please cross-reference from Section 4.9 and add any additional commentary as required.	Planning has taken place in Q3/4 2018/19 to restructure Industry (and SSS) into all RDM / PF roles within the core team. This will raise the visibility of the CRN industry agenda with all internal (within the CRN) and external local interactions.
8.3	**Domain**: Business Development and Marketing **Indicator**: The LCRN actively contributes to the intelligence gathering process from NIHR CRN Customers using the template provided by the National CRN Coordinating Centre **Assessment Approach:** LCRN reports interactions with NIHR CRN Customers at the Life Sciences Industry Forum meetings	Please report on interactions with NIHR CRN Customers at the Life Sciences Industry Forum meetings.	Local Life Sciences interactions discussed at national meetings where appropriate. The creation of a national meeting to discuss Business Development has made learning about national updates and sharing best practice amongst IOMs much easier.

Section 8. Financial Management (for information only at Annual Report)

8.1	Please provide details of the plans that you anticipate impacting on the allocation of LCRN funding for 2018-19. (For example particular studies that require large investment, concentration on a particular specialty)	
8.2	In respect of the LCRN 2018-19 local funding model, please complete the following table* by entering the proportion of LCRN funding (%) within the funding elements detailed. If there are any other elements to the model please describe what this is for and the proportion of funding allocated to this.	

Funding Element	**Examples**	**Description of model**	**% of Total CRN Funding Budget 2018-19 Budget**
Host Top sliced element	Core Leadership team, Host Support costs, LCRN Centralised Research Delivery team	Includes Core CRN and Host Support	12.40%
Block Allocations	Primary care, Clinical support services (i.e. pharmacy)	Includes Primary Care & Mental Health, but excludes Clinical Support Services as included	10.80%
Activity Based	Recruitment HLO 1, number of studies	Reflects allocations to POs which is predominantly calculated by ABF	73.70%
Historic allocations	PO funding previously agreed		0.00%
Performance Based	HLO performance, Green Shoots funding	Includes dementia, diabetes & training	0.70%
Population Based	Adjustments for NHS population needs		0.00%
Project Based	Study start up		%
Contingency / Strategic funds	Funds held centrally to meet emerging priorities during the year	Includes development & contingency fund and 18-19 transition fund	2.40%
Cap and Collar	Please provide your upper and lower limits if applicable		10% CAP
		With two POs being treated as an exception and receiving a 22% and 34% reduction in 201	10% COLLAR
Other funding allocations			%
Comments			

*Notes	1. It is assumed that the Local Funding Model is net of any National Top Slice as these are pass through costs 2. If the funding element category is not applicable to your Local Funding Model, please enter 0% 3. The percentages (%) entered in the table should equate to 100%

8.3	If the 2018-19 local funding model methodology has changed since 2017-18 please give a brief description of the changes	The cap and collar has been increased from 5% to 10%, with two exceptions detailed above.	
8.4	Please confirm whether monitoring visits will be taking place over the course of 2018-19. If yes, please provide details of which Partner organisations will be covered and the rationale behind this decision. Please also indicate what proportion of your Partner organisations are being monitored (Category A Partners).	None required	
8.5	What are the key financial risks and mitigations for 2018-19?	Filling & retaining all CRN Core posts during 2018-19. The mitigation would be to monitor and allocate any CRN Core underspend at the end of each quarter	
8.6	Please provide details of any planned audit of the LCRN Host Organisation in 2018-19	Meeting with Host Audit to discuss planned Audit for 2018-19	

Section 9. Non-Supported Non-Commercial Studies

Please provide a list of any studies that your LCRN has decided not to support, or has been unable to support, in the 2018/19 financial year, where the study had no feasibility concerns but the study was not supported for other reasons, e.g. funding constraints or study not meeting value for money metric. See Eligibility Criteria for NIHR Clinical Research Network Support; https://www.nihr.ac.uk/funding-and-support/documents/study-support-service/Eligibility/Eligibility-Criteria-for-NIHR-Clinical-Research-Network-Support.pdf

CPMS Study ID	Study Title	Priority Category	Name of the LCRN Partner(s) that did not support the study	Primary reason for non-support	Comments
We have no reported incidents of studies deemed as 'ur					

Section 10. Appendices

Ref no	Title	Link
Provided by CRNCC (please update and return as part of the 2018/19 Annual Report)		
10.AR Appendix 1	Category B Partner organisations	https://docs.google.com/spreadsheets/d/1b7tJHVR4LiLJQNLWOmyVQnhooX2yhEl4LCKZpa3HBRk/edit?usp=sharing
10.AR Appendix 2	Category C Partner organisations	https://docs.google.com/spreadsheets/d/1FT98SxiVyslEQ-U8g_hlhq6AEXqQUU2gGUyrrrLBsPw/edit?usp=sharing
10.AR Appendix 3	LCRN Fact Sheet	https://docs.google.com/document/d/1DgIqbbR5_8Fk26-8hZPm387DlVoi5m4NXrG0OrfDhqQ/edit?usp=sharing
10.AR Appendix 4	Finance Section for the LCRN Fact Sheet	https://drive.google.com/file/d/1WVG-3j8iLeBY23KqApv6JlVTArc8c2fe/view?usp=sharing
Provided by LCRN as part of Annual Plan and/or Mid-Year Performance Report (please amend or remove as appropriate for the 2018/19 Annual Report)		
10.1	Business Development and Marketing Profile	https://drive.google.com/open?id=1g4n8zOh7fF1sNIdoKltURZZY_gwsie7DHPbLP7KVXmo
10.2	Risk and Issues Log	https://drive.google.com/open?id=1guPN9xJYILh-2nvloeLXFvLbr_5fLHx6LzFMkaAYo7I
10.3	Workforce Plan	https://docs.google.com/spreadsheets/d/1BlickkZQCCPEIMj5xPzv274-TVtXkUk-Qs3wbzF_kHw/edit?usp=sharing
10.4	Commerical Income Policy SOP	https://drive.google.com/open?id=18WYQry8CvpxycKkQ2ZfMtpvthUYtAeA9
10.5	Primary Care Commercial Income Policy SOP	https://drive.google.com/open?id=19GjQNniyq5NqW3cJDKDwDGHasV94mY0Q
10.6	Cardiovascular Workforce Plan	https://drive.google.com/open?id=14t_ixcht5P13VOMlAIo0VmVtJpQ4FW_O
10.7	Category B Contract not received - reasons	https://drive.google.com/drive/folders/1NeoAtgldSQwdsXM8OpjrJNU94hoJaFIJ
Case Study 1	Weston Area Health Trust Skill Mix Review	https://drive.google.com/drive/folders/1NeoAtgldSQwdsXM8OpjrJNU94hoJaFIJ
Case study 2	RSI Proposal 2019-20	https://drive.google.com/drive/folders/1NeoAtgldSQwdsXM8OpjrJNU94hoJaFIJ
Case Study 3	CRN West of England Workforce Review	https://drive.google.com/drive/folders/1NeoAtgldSQwdsXM8OpjrJNU94hoJaFIJ
Case study 4	Portfolio Facilitator interview V1.0	https://www.nihr.ac.uk/news/clinical-research-network-supports-staff-at-royal-united-hospitals-bath-research-and-delivery-c
Case Study 5	Communications Report May 2019	https://docs.google.com/document/d/1CuGvv3hXlFYZ5WpvGCdP9c6EUIocjXwhoS6n9bPJwQ8/edit?usp=sharing
Case study 6	PI Training Powerpoint	https://drive.google.com/file/d/1nlmlaRrrLNVtMI4cA7DE1A5lQc9YLn-9/view
Case Study 7	PI Training Groupwork Resources	https://drive.google.com/drive/folders/1NeoAtgldSQwdsXM8OpjrJNU94hoJaFIJ
Case Study 8	Wellbeing Workshop - the return	https://drive.google.com/drive/folders/1NeoAtgldSQwdsXM8OpjrJNU94hoJaFIJ
Case Study 9	WE Training website	https://wetraining.nihr.ac.uk/
Case Study 10	HLO2a Analysis	https://drive.google.com/open?id=1b9yRilQ13r3tpK8HFRLcJU3ZLl5MxYl-
Case Study 11	Improving HLO2a: A Guide to Study of Concern Ra	https://drive.google.com/open?id=1Rg59WETLpdx9GHFVWknXzUdAwAEtJyyh
Case study 12	ENT trainee work plan V1.0	https://drive.google.com/drive/folders/1NeoAtgldSQwdsXM8OpjrJNU94hoJaFIJ
Case study 13	Respiratory bid V1.0	https://drive.google.com/drive/folders/1NeoAtgldSQwdsXM8OpjrJNU94hoJaFIJ
Case Study 14	PRES questionnaires, 2018	https://drive.google.com/file/d/1TM2wmTwDfNIrH0vMk2dF2xpbLpJIu7fG/view?usp=sharing
Case Study 15	JDR takeover Radio Ujima	https://nihrcrnwe.blogspot.com/search/label/JOIN%20DEMENTIA%20RESEARCH
Case Study 16	LCRN NIHR Learn Annual Update 2019 CRN WE	https://drive.google.com/drive/folders/1NeoAtgldSQwdsXM8OpjrJNU94hoJaFIJ
Case study 17	SSS review V1.0	https://drive.google.com/drive/folders/1NeoAtgldSQwdsXM8OpjrJNU94hoJaFIJ
Case Study 18	Summary of PRES responses	https://drive.google.com/drive/folders/1NeoAtgldSQwdsXM8OpjrJNU94hoJaFIJ
Case Study 19	Children's PRES summary report	https://drive.google.com/drive/folders/1NeoAtgldSQwdsXM8OpjrJNU94hoJaFIJ

Section 11. Glossary

Abbreviation	Definition
2gether	2gether NHS Foundation Trust
ABF	Activity based funding
AHSN	Academic Health Science Network
APOMP	Anaesthesia, Perioperative Medicine and Pain Management
BHP	Bristol Health Partners
BI	Business Intelligence
BIU	Business Intelligence Unit
BRC	Biomedical Research Centre
CAMHS	Child and Adolescent Mental Health Services
CCG	Clinical Commissioning Group(s)
CD	Clinical Director
CDD	Clinical Director Designate
CI	Chief Investigator
CI	Continuous Improvement
CLAHRC West	Collaboration for Leadership in Applied Health Research and Care West
COP	Community of Practice
CPMS	Central Portfolio Management System
CRN	Clinical Research Network
CRSL	Clinical Research Specialty Lead(s)
CSG	Clinical Studies Group
CVD	Cardiovascular disease
DH	Department of Health
DL	Divisional Lead(s)
EOI	Expressions of interest
GCS	Gloucestershire Care Services
GDPR	General Data Protection Regulation
GHFT	Gloucestershire Hospitals NHS Foundation Trust
GRH	Gloucestershire Royal Hospital

GWH	Great Western Hospitals NHS Foundation Trust
HEI	Health Education Institute
HLO	High Level Objective(s)
HSDR	Health Services Delivery Research
IOM	Industry Operations Manager
JDR	Join Dementia Research
JLA	James Lind Alliance
LA PH	Local Authority Public Health
LCRN	Local Clinical Research Network
LPMS	Local Portfolio Management System
MH	Mental Health
MHT	Mental Health team
NASH	Non-alcoholic steatohepatitis
NBT	North Bristol NHS Trust
NC	Nurse Consultant
NIHR	National Institute for Health Research
NIHR CRN	National Institute for Health Research Clinical Research Network
NMAHP	Nurse, Midwife, Allied Health Professional
ODP	Open Data Platform
PC CCOP	Primary Care Commercial Community of Practice
PCO	Primary Care Organisation
PF	Portfolio Facilitator(s)
PHWE	People in Health West of England
PI	Principal Investigator
PIC	Patient Identification Centre
PO	Partner Organisation(s)
POF	Performance and Operating Framework
PRA	Patient Research Ambassador
PRAI	Patient Research Ambassador Initiative
PRES	Patient Research Experience Survey

PPIE	Patient, Public Involvement and Engagement
R&D	Research and Development
RCTs	Randomised Controlled Trial
RDM	Research Delivery Manager(s)
RICE	Research Institute for the Care of Older People
RH&CB	Reproductive Health and Childbirth
RSI	Research Site Initiative
RTT	Recruitment to Time and Target
RUH	Royal United Hospitals Bath NHS Foundation Trust
SPoC	Single Point of Contact
SONS	Studies Open to New Sites
SSG	Site Specific Groups
SSL	Subspecialty Lead(s)
SSS	Study Support Service
STAR	Severn Trainee Anaesthesia Research Group
SWAG	Somerset, Wiltshire, Avon and Gloucestershire
UHB	University Hospitals Bristol NHS Foundation Trust
WAHT	Weston Area Health NHS Trust
WEAHSN	West of England Academic Health Science Network
YPAG	Young Persons' Advisory Group

(For reference only) Section 12. Example CRN XXXX Annual Report Executive Summary		
Please complete the Table below, entering key performance highlights, successes and challenges from 2018/19		
Please specify up to five areas where the LCRN has performed very well / significantly surpassed targets. This section is an opportunity for LCRNs to highlight excellent performance and successes. The intention is to enable opportunities to showcase these examples as case studies, opportunities for regional or national roll-out and sharing of best practice.	**1**	
	2	
	3	
	4	
	5	
High Level Objectives		
Specialty Objectives		
LCRN Operating Framework Indicators		
LCRN Partner Satisfaction Survey Indicators		
LCRN Customer Satisfaction Indicators		
LCRN Patient Experience Indicators		
Host Organisation	• The Host Organisation has continued to fulfil its responsibilities as an LCRN Host in line with the DHSC/LCRN Host Organisation Agreement. XXXX Trust fully met all requirements in the Performance and Operating Framework in terms of LCRN structure, management roles, and governance arrangements. • Executive Group refreshed to quarterly meetings with support from Host Organisation Medical Director (CRN XXXX's Executive Lead), and attendance from Senior Human Resources Lead, XXXX. • Quarterly Board report reviewed at Host Organisation Executive Performance Board Meeting, and then considered at full public Host Board meeting with Clinical Director (CD) and Chief Operating Officer (COO) in attendance. • Strong relationship between CRN XXXX and the Host Organisation. Regular meetings, the ability to escalate where needed, and Host support, has been key to successful performance. • Stable management infrastructure enabling constructive challenge and effective decision- making.	
Governance and Management	• Improved Partnership Group engagement and senior attendance.	
Financial Management	• Delivered financial break-even for 2018/19. • Internal audit in respect of LCRN funding managed by the LCRN Host Organisation completed by Host Organisation in MMM YYYY and report submitted to the CRNCC on MMM YYYY.	
CRN Specialties	• Recruited to all 30 CRN specialties. • Local Clinical Research Specialty Leads appointed for X/30 CRN specialties • nn% of specialty objectives met. • In the top 5 LCRNs for mental health recruitment. • XXXX achieved a first global patient in an XXXX study (Study ID: XXXX) in the Respiratory Disorders Specialty.	
Research Delivery	• Recruitment to Time and Target performance (>80%) sustained for both commercial and non--commercial activity (HLO 2). • XXXX Trust is the X highest recruiting Trust in the country with nn,nnn recruits. • XXXX Trust is the highest recruiting Mental Health Trust in the country with n,nnn recruits. • Delivered the NIHR CRN Study Support Service in accordance with NIHR CRNCC SOPs and guidance documents. Research and Development community actively engaged in the development of local Standard Operating Procedures to support Study Support Service. nn SOPs now live. • Met the target of recruiting 10% of participants to Dementia studies on the NIHR CRN Portfolio from "Join Dementia Research".	
Information and Knowledge	• LPMS operational and good engagement in all Partner organisations. • All LPMS data points provided to the CRNCC's timelines. Data quality assurance and data validation systems in place. • Pro-active LPMS user group to support ongoing LPMS development and functionality. • Developed analysis and benchmarking of activities from ODP and financial data to improve operational delivery and Value for Money. • Responsive 'Helpdesk' service provided by BI Team to support all users in relation to systems provided for NIHR CRN (Hub/ODP/LPMS), supported by face to face and webinar training as appropriate.	

Stakeholder Engagement and Communications	• Increased visibility of the LCRN within the local research community and wider audiences using a range of on-line and off-line communications channels (including local and national print, TV, radio and websites (e.g. XXXX). • Developed a 'real time' news room to collate and disseminate timely, appropriate news and significantly increased 'users' numbers and time spent reading news, the impact of which will become apparent in 2019/20. • Continued to deliver our strong programme of patient involvement and engagement through initiatives such as XXXX. • nn Patient Research Ambassadors by the end of 2018/19. Patient Research Ambassador activities have led to XXXX, YYYY, ZZZZ. • Action plan developed arising from responses to patient research experience survey for implementation in 2019/20.
Workforce Learning and Organisational Development	• Promoted culture of modern workplace learning, including awareness of NIHR National Learning Directory e-learning Programmes, Resources and Communities. • Trained nnn people on courses (including Introduction to GCP, GCP Refresher, Valid Informed Consent, Fundamentals of Clinical Research). • Delivered two well attended Research Forum events to bring together and support non--medical research delivery staff across the region. • Promoted a culture of Improvement and innovation through x activity or n events including celebration events and supra network knowledge exchanges. • Delivered various projects on Accelerating Digital including n small grant scheme applications.
Business Development and Marketing	• LCRN Business Development Profile refreshed as part of 2019/20 Annual Plan for marketing purposes by the national Business Development team. • Worked with Contract Research Organisations (CROs) and Life Sciences Industry to support partnership working with the LCRN and Partner organisations. • Developed 'Collaborative' framework within the XXXX region and into other LCRN regions to enable greater engagement with companies and development of potential new ways of working. • The network has promoted the continued importance of the industry agenda to LCRN Partner organisations and investigators through XXX, YYY, ZZZ. • The network has supported the national Biosimilars campaign through XXX, YYY, ZZZ which has resulted in AAA, BBB, CCC.
National Contributions	• The network has contributed to all national Communications campaigns. • Regular Research Delivery Manager contribution to Divisional meetings, and attendance at Specialty meetings on a rotational basis. • Clinical Director member of XXXX Board and contributed to XXXX Working Group. • Continuous Improvement Lead working with national team on Accelerating Digital. • Local work on LPMS has been actively shared through the LPMS Lead, along with contributions to the Business Intelligence community.

[1] Increase early career researcher involvement in NIHR CRN Portfolio research

[2] Increase the number of NIHR CRN Portfolio studies led by trainees as Chief Investigator or co-Chief Investigator

[3] Increase patient access to Cancer research studies across the breadth of the Cancer subspecialties (Brain, Breast, Colorectal, Children and Young People, Gynae, Head & Neck, Haematology, Lung, Sarcoma, Skin, Supportive & Palliative Care and Psychosocial Oncology, Upper GI, and Urology)

[4] Develop the research workforce in cardiovascular surgery

[5] Increase NHS participation in Children's studies on the NIHR CRN Portfolio

[6] Increase intensive care units' participation in NIHR CRN Portfolio studies

[7] Increase early career researcher involvement in NIHR CRN Portfolio research

[8] Develop the Dermatology Principal Investigator (PI) workforce

[9] Improve primary-secondary care collaboration in the delivery of Diabetes research

[10] Increase trainee involvement in NIHR CRN Portfolio research

[11] Improve recruitment to NIHR CRN Gastroenterology studies

[12] Increase early career researcher involvement in NIHR CRN Portfolio research

[13] Establish links with the relevant professional organisations to encourage and support trainee involvement in NIHR CRN Portfolio studies

[14] Increase the number of recruitment sites for NIHR CRN Portfolio studies funded by the Health Services and Delivery Research programme

[15] Increase access for patients to Hepatology studies on the NIHR CRN Portfolio

[16] Develop research infrastructure (including staff capacity) in the NHS to support clinical research

[17] Increase participation in pre-hospital studies via Ambulance Trusts

[18] Increase participation in Mental Health studies involving children and young people

[19] Understand and develop the research workforce that work in Metabolic and Endocrine-led studies

[20] Increase engagement of orthopaedic champions to support the delivery of Musculoskeletal Disorders studies on the NIHR CRN Portfolio

[21] Increase early career researcher involvement in NIHR CRN Portfolio research

[22] Increase NHS participation in Ophthalmology studies on the NIHR CRN Portfolio

[23] To develop the Oral and Dental research workforce in order to meet the demands of the expected growth in the portfolio following the JLA Priority Setting Partnership

[24] Increase engagement of GP registrars and First Five GPs with NIHR CRN Portfolio research

[25] Develop research infrastructure (including staff capacity and working with local authorities) to support research in Public Health

[26] Increase the number of 'new' Principal Investigators (PIs) engaged in commercial Renal Disorders studies on the NIHR CRN Portfolio

[27] Increase the proportion of NHS Trusts recruiting into Reproductive Health and Childbirth studies on the NIHR CRN Portfolio

[28] Increase access for patients to Respiratory Disorders studies on the NIHR CRN Portfolio

[29] CRN recruitment to Stroke RCTs should be at least 8% of the 2017/18 Sentinel Stroke National Audit Programme (SSNAP)-recorded hospital admissions

[30] Increase patient access to Surgery research studies on the NIHR CRN Portfolio across the breadth of the surgical subspecialties

Meeting of the Board of Directors in Public on Tuesday 30 July 2019 in the Conference Room, Trust Headquarters

Report Title	**NIHR CRN Annual Plan (hosted body report)**
Report Author	**Dr Kyla Thomas and Dr Sue Taylor**
Executive Lead	**Dr William Oldfield, Medical Director**

1. Report Summary

The Clinical Research Network (CRN) West of England is submitting the Annual Plan 2019/20 for Host Trust Board approval. The National Clinical Research Network Co-ordinating Centre (CRNCC) and the Department of Health and Social Care (DHSC), Research and Evidence Directorate agree a set of national priorities, high level objectives and harmonised specialty objectives for the CRN on an annual basis which are outlined within the performance and operating framework 2019/20. These priorities are set in pursuance of the visions, goals and aims of the network and are reflected in the Annual Plan 2019/20. The priority for the local LCRN is to meet and possibly exceed the target set on an annual basis by DHSC by focusing on three key areas of growth, performance and collaboration.

The Annual Plan 2019/20 reflects the LCRN's local response to delivering the performance objectives set by CRNCC and has been approved in principle by the LCRN Partnership Group on the 5th June 2019 (please see Annual Plan attached) and the CRNCC Executive Team (in Principle). Approval and sign off by the Host Trust Board is required.

2. Key points to note

(Including decisions taken)

The CRNCC Executive Team held a performance meeting with the Clinical Research Network West of England on the 17th July 2019 in London. Dr Kyla Thomas and Dr Sue Taylor were present in person. Dr William Oldfield teleconferenced in to the meeting. CRNCC feedback for the NIHR CRN Annual Plan was that it was a good plan overall with clear milestones with strong plans detailed for projects supporting a broad range of areas. The plan was approved in principle dependent on Host Trust Board approval.

3. Risks

If this risk is on a formal risk register, please provide the risk ID/number.

The risks associated with this report include:

More detail regarding specialty objectives was noted in the feedback. This was discussed during the CRNCC Executive Team performance meeting where assurance was provided by the CRN regarding difficult to recruit to specific Clinical Research Specialty Lead posts (Oral and Dental Lead, Musculoskeletal Lead and Metabolic and Endocrine Lead). Since submitting the report these posts have now been filled (Musculoskeletal) or are in the process of being appointed to.

4. Advice and Recommendations *(Support and Board/Committee decisions requested)*:	
• This report is for **APPROVAL**. • The Board is asked to **APPROVE** the report.	
5. History of the paper **Please include details of where paper has previously been received.**	
Senior Leadership Meeting	19 July 2019

NIHR | National Institute for Health Research

Clinical Research Network
CRN West of England

2019/20 Annual Plan, Mid Year Progress Report and Annual Report

Date of Annual Plan submission: 23/04/2019

Date of Mid Year Progress Report submission: XX

Date of Annual Report submission: XX

Section 1. Host Organisation Approval	
1A. Annual Plan	
Confirmation that this Annual Plan has been reviewed and agreed by the LCRN Partnership Group:	No
Date of the LCRN Partnership Group meeting at which this Annual Plan was agreed:	05/06/19
Confirmation that this Annual Plan has been reviewed and approved by the LCRN Host Organisation Board:	No
Date of the LCRN Host Organisation Board meeting at which this Annual Plan was (or will be) approved:	30 July 2019
1B. Mid Year Progress Report	
Host Organisational approval and LCRN Partnership Group agreement is not required for the Mid Year Progress Report.	
1C. Annual Report	
Confirmation that this Annual Report has been reviewed and agreed by the LCRN Partnership Group:	
Date of the LCRN Partnership Group meeting at which this Annual Report was agreed:	05/06/19
Confirmation that this Annual Report has been reviewed and approved by the LCRN Host Organisation Board	No
Date of the LCRN Host Organisation Board meeting at which this Annual Report was (or will be) approved:	30 July 2019

Section 2: Compliance with the Performance and Operating Framework

Please indicate whether the Host Organisation and LCRN Partners are delivering the LCRN in full compliance with the specific areas/clauses of the Performance and Operating Framework 2019/20 listed below.
Please provide a brief explanation of the reasons for partial / non-compliance in the commentary section.
Any areas of partial / non-compliance must be mitigated by the inclusion of a Key Project in Section 4 in order to achieve compliance. Please include a cross-reference to the Key Project ID.

POF area	Annual Plan Compliance	Commentary	Mid Year Progress Report Compliance	Commentary	Annual Report Compliance	Commentary
Part A: Context						
A.3. Working Principles						
Part B: Performance Framework						
B.2. LCRN Performance Indicators						
Set 1. High Level Objectives	Fully Compliant					
Set 2. Specialty Objectives						
Set 3. LCRN Operating Framework Indicators	Fully Compliant					
Set 4. Initiating and Delivering Clinical Research Indicators	Fully Compliant					
Set 5. LCRN Partner Satisfaction Survey Indicators	Fully Compliant					
Set 6. LCRN Customer Satisfaction Indicators	Fully Compliant					
Set 7. LCRN Patient Experience Indicators	Fully Compliant					
B.3. Performance Management Processes	Fully Compliant					
Part C: Operating Framework						
C.2. Governance and Management	Fully Compliant					
C.3. Financial Management	Fully Compliant					
C.4. CRN Specialties	Partially Compliant	**Currently recruiting to CRSLs. To be confirmed pending interviews. MSK, Metabolic and Endocrine, Oral and Dental, Neurodegeneration.**				
C.5. Research Delivery	Fully Compliant					
C.6. Information and Knowledge	Fully Compliant					
C.7. Stakeholder Engagement and Communications	Fully Compliant					
C.8. Organisational Development	Fully Compliant					
C.9. Business Development and Marketing	Fully Compliant					

Section 3. Executive Summary (Annual Report only)		
Section 3. Executive Summary should only be completed as part of the Annual Report submission. For the Annual Report, please complete the Table below, entering key performance highlights, successes and challenges from 2019/20		
Please specify up to five areas where the LCRN has performed very well / significantly surpassed targets. This section is an opportunity for LCRNs to highlight excellent performance and successes. The intention is to enable opportunities to showcase these examples as case studies, opportunities for regional or national roll-out and sharing of best practice.	**1**	
	2	
	3	
	4	
	5	
High Level Objectives		
Specialty Objectives		
LCRN Operating Framework Indicators		
LCRN Partner Satisfaction Survey Indicators		
LCRN Customer Satisfaction Indicators		
LCRN Patient Experience Indicators		
Host Organisation		
Governance and Management		
Financial Management		
CRN Specialties		
Research Delivery		
Information and Knowledge		
Stakeholder Engagement and Communications		
Workforce Learning and Organisational Development		
Business Development and Marketing		
National Contributions		

Section 4: Key Projects

Section 4 of the template should be used to detail the key projects to be delivered by the network in 2019/20. Please include local network projects and activities, projects to be delivered in collaboration with other LCRNs (as part of regional LCRN-Cluster collaborative activities or other LCRN collaborations), and projects to be delivered nationally/CRN-wide led locally by the LCRN. Projects to be delivered in collaboration with other parts of the NIHR and/ or other external organisations should also be included.

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	Milestone complete.
Red (R)	The specified deliverable was not delivered by the Milestone Date. Commentary is mandatory.
Amber (A)	There is a risk that the specified deliverable will not be delivered by the Milestone Date. Commentary is mandatory.
Green (G)	On target to deliver the specified deliverable by the Milestone Date.
Complete (C)	The Key Project and/or Outcome is no longer required and therefore this Milestone is no longer applicable. Commentary is mandatory.

To complete at Annual Plan stage						To complete at Mid Year Progress Report stage		To complete at Annual Report stage	
Ref	Key project	Outcome	Lead	Milestone	Milestone	RAG	Commentary	RAG	Commentary
1. Governance and Management									
4.1.1	GDPR Compliant.	All SOPs and business processes are compliant with GDPR.	COO	1. Continue to map all CRN processes which are introduced in year to ensure they are compliant with GDPR. 2. Representation by an SMT LCRN member on the IG lead operational group within the Host. 3. IG named lead Trust Host David Smith.	Q1-4				
4.1.2	Host Organisation and LCRN Category A partner submits a baseline level for NHS Data security and protection.	Host and Partner A organisations compliant.	COO	1. Review Host annual assessment. 2. Review Partner A host annual business plans to confirm assessment rating. 3. Escalate to CRNCC should mandatory requirements not met.	Q1-4				
2. Financial Management									
4.2.1	Ensure all LCRN Category A partner allocations are distributed based on the Financial Principles Paper 2019/18.	Distribute LCRN funding based on agreed principles to ensure funding is distributed equitably on the basis of NHS support requirements.	COO	1. Review Partner A performance as part of the business planning process. 2. Apply financial principles. 3. Agree allocations through the LCRN Executive Group and LCRN Partnership Group.	Q1				
4.2.2	Establish structure for robust financial monitoring of partners.	Reassurance that all partners are meeting the minimum financial control standards, including the recently launched commercial income policy.	COO	1. Development of a monitoring visit plan in collaboration with supranetwork finance group. 2. Supranetwork finance group to share good practice from monitoring visits with COOs. 2. Introduction of annual financial monitoring visits. 3. BI Annual meeting with finance leads by host finance.	Q1 Q2 Q2 Q2-4 Q2-4				
3. High Level Objectives									
4.3.1	HLO 1	Agree targets across the region for 2019/20.	CD/COO	1. Review site data provided by the LCRN BI team from the LPMS. 2. Review and agree recruitment figures in secondary care partners business plan. 3. Analyse primary care predicted recruitment data with the primary care SMT. 4. Analyse recruitment within other regional settings.	Q1 Q1 Q1 Q1 Q1				
4.3.2.	HLO 6d	Increase the number of health and social care research studies that recruit the required number of people in a timely way.	CD/COO	1. Continue to develop to the four key workstreams as follows of the Public Health project 2.Expanding the local public health NIHR portfolio 3.Developing pathways of support for research outside of the NHS 4.Creation and set-up of a new West of England regional hub of engagement in collaboration with Public Health England. The hub will build on existing networks to foster communication and collaborations between public health researchers and practitioners across organisations outside of the NHS and integrate public health research and health and social care delivery 5. Developing a research aware and research ready public health workforce	Q1-4				

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4.3.3	HLO 2a/b Identify and prioritise studies in greatest need and those which could benefit from LCRN intervention such as sharing best practice locally and/or nationally, and escalation to the CRSL to improve performance.	Improve HLO 2a	IOM/RDMs/CRS	1. Continue providing trending data via RTT report and the use of Study of Concern ratings (C1/C2) for commercial studies downtrending for >1 and 3 months respectively. Following pilot, embed this as business as usual. 2. Incorporate Study of Concern data in Commercial Performance Report showing the trend of C1/C2 studies by PO and specialty to identify areas for particular focus. Present Commercial Performance Report data at R&D Management and CDL meetings alongside HLO dashboard report. 3. Following pilot, consider extending C1/C2 categories and Study of Concern process to non-commercial studies. 4. Following pilot, consider extending C1/C2 categories and Study of Concern process to primary care (see section 4.3.4).	Q1 Q1 Q2-3 Q2-3				
4.3.4	HLO 2a/b Primary Care	Improve HLO 2a	IOM/SPF/SRO	1. Continue quarterly teleconferences/face-to-face meetings facilitated by the IOM/Senior Portfolio Facilitator/Primary Care Team. Focus on sharing best practice to improve RTT for current studies. 2. Secure funding to continue Primary Care Research Nurse time to work as part of the Primary Care Commercial Community of Practice (PC CCOP) group. 3. Develop the group to generate key projects to improve primary care commercial research. 4. Following the roll out of EDGE in primary care, create Primary Care Performance Report to show BRAG ratings for open and closed studies by Primary Care Organisation. Primary Care Team to initiate performance monitoring conversations with sites during practice visits and as part of the PC CCOP. 5. Consider introduction of Study of Concern ratings (see section 4.3.3) for primary care.	Q1-4 Q1 Q1-4 Q2 Q2-3				
4.3.5	HLO 2a/b Lead LCRN studies performance monitoring	Improve HLO 2b	SSS/BI	1. Coordinate performance monitoring of LCRN led studies with regional sponsors. 2. Embed study performance monitoring for lead LCRN commercial and non-commercial studies into RDM role with support from PFs. 3. Develop ODP app to produce 'task list' of lead LCRN studies for performance monitoring based on NSDA ratings.	Q1 Q1 Q2-4				
4.3.6	HLO 6a:Proportion of NHS Trusts recruiting each year into NIHR CRN Portfolio studies	Improve HLO 6a	RDMs/POs	All NHS trusts within West of England are expected to recruit into NIHR CRN portfolio studies in 2019/18. Our smallest trust (a community services trust) which in the past has had inactive years is merging with a mental health trust.	Q2				
4.3.7	HLO 6b: Proportion of NHS Trusts recruiting each year into NIHR CRN Portfolio commercial contract studies	Improve HLO 6b	IOM	NHS trusts within West of England will be supported to open and recruit into commercial contract studies.					
4.3.8	HLO 6c: Redesign aspects of the RSI Scheme to support Research at Scale to model evolving landscape in PC	Improve HLO 6c	SRO	1. Coordinate and communicate new model to all stakeholders 2. Facilitate experienced sites to share expertise/buddy less experienced/new sites in collaborative bids 3. Supervision and monitor the outputs of a dedicated RN to work across a locality in Bristol (2yr project). 4. Analyse data on practice population to demonstrate on year improvement as practices merge. 5. Flexible Research Team to support new/inexperienced sites	Q1-4				

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4.3.9	HLO 6d: To increase the number of non-NHS sites accessing support to build infrastructure and training via the RSI Scheme 2019-20	Improve HLO 6d	SRO	1. Ongoing developmental work to engage community sites to include a) community providers b) hospices c) pharmacists d) dentists e) care homes 2. Create active research site contacts lists for each community site specialism. 3. Share best governance practice across non-NHS settings 4. Flexible Research Team to prioritise support for Non-NHS sites where appropriate	Q1-4 Q2 Q2 Q1-4				
4.3.10	HLO 3: Supporting delivery of commercial research	Within the context of a devolved model, LCRN to work more closely with Partner Organisation R&Ds to support delivery of commercial research	IOM / RDMs	1. Through the RDM locality responsibilities and as part of the monthly industry teleconference between PO Industry Managers and LCRN, the process of conducting feasibility for commercial studies will be collaborative and supported by the LCRN to include using national data and intelligence to inform target setting.	Q1-4				
4. LCRN Specialty Activities									
4.4.1	Induction programme for CRSLs	Support CRSLs to fulfil their roles	CD/RDMs lead for their specialties	1. Develop a training and induction programme for CRSLs to include knowledge about the CRN and the SSS offering. 2. Establish effective ways of working for CRSLs to collaborate with RDMs with support from CDLs to ensure the timely and effective delivery of studies on the local portfolio and continued development of the specialty in line with strategic priorities and local strengths.	Q1 Q1-4				
5. Research Delivery									
4.5.1	Overhaul of Industry and SSS workstreams to integrate working.	1. Integrate SSS and industry workstream. 2. Clearer processes. 3. Efficient working. 4. Reduced duplication. 5. Consistency in tone and messaging from both services.	SRDM and IOM	1. Combine workstreams under a single RDM. 2. Workshop with Industry and SSS staff to scope project and identify gaps and areas of duplication. 3. Agreed processes, escalation points and ways of working. 4. Production of templates and other materials with consistent messaging. 5. Agreed business rules for discrepancy checks and data cleaning.	Q1 Q1 Q1-2 Q3 Q3-4				
4.5.2	Enhancing LCRN core team's SSS knowledge.	1. Shared learning across the LCRN core team. 2. Increase in research knowledge and understanding, improving service to researchers. 3. Increased opportunities to promote SSS and develop new business.	SSS Lead	1. Workshop with LCRN core team to promote understanding. 2. LCRN core team shadowing Industry and SSS staff to understand processes.	Q3 Q3-4				
4.5.3	Support awareness of, engagement with and delivery of National CRN Coordinating Centre managed services, such as Join Dementia Research (JDR) and Be Part of Research within the West of England	Increase the number of registrants (specifically those with dementia) on JDR in the West of England. Locally promote Be Part of Research within West England.		1. Embed the project management of JDR and Be Part of Research into the Comms/PPIE core team function (as opposed to the previous model of a 'stand-alone' JDR officer role). 2. Continue to host quarterly 'JDR Board meetings' (as previously required by the JDR ERICA project). The Board members consist of local dementia service leads, dementia academics and individuals with links to dementia services / commissioning and research. The board will continue to feed into local JDR strategy, and assist with delivery of projects. Ongoing projects include; a project to increase participation of people who are Black and Minority ethnic, a project to increase knowledge of JDR with local healthcare workers and increase the number of local JDR champions	Q1-4				

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4.5.4	Expand the use of the LCRN Peripatetic Research Team	Increased engagement with and recruitment in inexperienced, new and non-NHS sites	SRO	1. Expand culture of cross-covering and support across specialties, prioritising inexperienced, new and non-NHS sites 2. Creation of greater team cohesion and sharing of targets. 3. For Team to support portfolio adopted Public Health Studies 4. For Team to continue to support vaccine studies run in schools 5. For roll out of PI training to Band 6 to support research delivery in non-NHS sites 6. To champion the role of the Clinical Research Practitioner	Q1-4				
4.4.5	Early Feedback service	Improve compliance with national service offering	RDMs lead for their specialties	1. RDMs and PFs to support CRSLs with Early Feedback reviews for commercial studies. Develop new process to track requests and escalate issues.	Q1-4				
4.4.6	Engagement with non-NHS sites	Expand research in non-NHS settings (hospices and schools)	PC	Hospices 1. Work with the charity, Dorothy House Hospice, to enable the organisation to become research active 2. Appoint a Research Fellow, funded by Dorothy House, to be hosted by our partner HEI, the University of Bath, to initiate new research grants in palliative care research 3. Prepare communications about the new collaboration and the aims, to spearhead new and relevant research in end of life care 4. Plan a forthcoming launch and conference on palliative care 5. Set up a steering group of supporters 6. Establish a strategy for becoming an emerging centre of excellence in this field Schools 1. Work with partners (including the University of Bristol and the NIHR SPHR) to develop a School Health Research Network in the West of England region.	Q1-4				
4.4.7	Engagement with Public Health research	Expand public health research	SRA/CRSL	1. Continue to work with the ALSPAC cohort study to offer support and portfolio adoption to substudies and prepare for the launch of their next clinic in 2020/2021 2. Continue to establish relationships with local public health research centres and groups, including the NIHR RDS and SPHR to promote CRN visibility and engagement 3. Engage with early career researchers and attend local events and conferences to ensure CRN representation and signposting 4. Work with CIs and PIs to identify the needs of and types of tailored support that can be offered for their studies on the portfolio 5. Reach out to partner organisations to identify new opportunities for engagement	Q1-4				
4.4.8	Continued engagement with NIHR Infrastructure Managers and Directors across the region	To enhance collaborative working across the NIHR infrastructures. explore shared resources, and explore cross-cutting activities.	NIHR Directors, Managers, COO	1. Quarterly meetings to develop further a set of focused theme enhanced collaboration and joint working. 2. Identify clear opportunities around training and capacity build	Q1-4				
4.4.9	Supra- network Primary Care Meeting	Develop supra-regional working across	RDMs, NMAPS	Date to be confirmed for inaugural meeting	Q1-4				
6. Information and Knowledge									
4.6.1	Implement recommendations of the LCRN Internal workforce restructure	To ensure the Senior Research Delivery Manager has the capacity to coordinate business Intelligence activities within the LCRN and have the capacity to participate in nationally agreed business intelligence initiatives	SRDM	1. Internal workstream and divisional restructure to facilitate the process	Q1				

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4.6.2	Development of ODP apps in order to present more sophisticated analysis of performance management data.	Improve use of ODP to present recruitment activity and performance management data, leading to greater insights into local performance/areas requiring attention.	BIM	1. Redesign LCRN ODP app to incorporate both CPMS and EDGE data 2. Design sheets to replace as much static reporting with live data as possible 3. Launch redesigned ODP app 4. Work collaboratively with supra-regional LCRNs to develop joint projects and provide peer support. 5. Investigate the use of QlikView for forecasting; explore the potential of developing sheets for predictive analytics 6. Continue to offer ODP training to partner organisations on an ongoing basis.	Q1 Q1 Q1-2 Q1-4 Q3-4 Q1-4				
4.6.3	LPMS in Primary Care Use of EDGE by GP Practices to become business as usual activity in 2019/20.	1. Ensure all research active GP Practices reporting research activity either via their own instance of EDGE or via a centrally managed instance of EDGE so that recruitment activity contributes to HLO 1 2. Primary care research activity reported to CPMS via the Research Activity API 3. Use of EDGE by RSI-supported practices becomes business as usual	SRO /BIU	1. All GP Practice consortia, RSI sessional and level 2 practices have received training and are reporting recruitment activity on EDGE 2. All RSI introductory and level 1 practices have received training and are reporting recruitment activity using Google Form to populate central Google sheet for core team upload to centrally managed instance of EDGE 3. Active monitoring of GP Practice engagement through regular reports on most recent recruitment activity recorded on EDGE. 4. Active monitoring of "Confirmed - Not accurate" messages from the Recruitment Activity API for GP Practices and provide support to correct data errors 5. Offer ongoing training programme to GP Practices in the use of EDGE, including advanced functionality, e.g. reporting, delegation log, finance templates, etc. 6. Provision of LCRN EDGE helpdesk function for primary care	April/May 2019 April/May 2019 Q1-4 Q1-4 Q1-4 Q1-4				
4.6.4	Advanced uses of EDGE EDGE offers a great deal more functionality than simply recording recruitment activity, however some POs are not taking advantage of this additional functionality. Training will be developed in order to introduce these POs to some of the more advanced features of EDGE in order to allow them to exploit the system to the fullest.	Increased use of EDGE functionality in order to support delivery and performance management of studies by POs.	BIM	1. Survey partner organisations who are the most advanced users of EDGE to determine key functionality to aid successful delivery of studies, e.g. attributes, work flows, reporting, financial templates, etc. 2. Survey supra-regional network LCRNs to identify what they consider the key functionality to aid successful delivery of studies. 3. Identify existing training materials that can be adapted for use in an Advanced uses of EDGE training programme. 4. Develop training programme for Advanced uses of EDGE. 5. Deliver training on site to LCRN Partner organisations.	Q1 Q1 Q2 Q2 Q2-4				
4.6.5	Lead LCRN performance management of studies using EDGE EDGE will be used as a tool for the performance management of NIHR CRN Portfolio non-commercial studies	Improved performance management of LCRN led NIHR CRN Portfolio non-commercial studies	BIM	1. Create project level EDGE attribute for each LCRN led NIHR CRN Portfolio non-commercial open study and record performance management data, including information received from CI and sponsor relevant to study delivery 2. Where non-commercial study closes having not achieved recruitment to time or target, a root cause analysis is completed by either the study sponsor or RDM and recorded on EDGE record	Q1-4 Q1-4				

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4.6.6	Support new processes involving the Research Activity API The Research Activity API will transfer recruitment data from EDGE to CPMS on a nightly basis for non-exception studies when it goes live in spring 2019. The LCRN must ensure that all sites are ready for this event and will put in place systems to monitor error messages generated by the API and systems to monitor non-compliance with the new reporting process. The LCRN must ensure that data is captured at all sites, including non-NHS sites, for non-exception studies.	1. Ensure LCRN recruitment activity contributes to HLO 1 2. Improve partner organisations' use of EDGE for reporting recruitment activity 3. Capture of recruitment activity at non-NHS sites to ensure reporting completeness for NIHR CRN Portfolio non-exception studies	BIM	1. Develop systems for monitoring the transfer of recruitment activity data from EDGE to CPMS using the Research Activity API, including active monitoring of "Confirmed - Not accurate" messages from the Recruitment Activity API and providing support to partner organisations to correct data errors 2. Develop systems to identify unexpected lulls in recruitment activity and report to partner organisations for further investigation 3. Develop systems to capture recruitment activity data from non-NHS sites in order to ensure complete coverage of recruitment activity in the LCRN	Q1-2 Q1-2 Q1				
4.6.7	Contacts database The LCRN's centralised contacts database is no longer being maintained and contacts data is currently collected in a number of disparate applications and locations, meaning that it can be difficult to identify the most current information. A centrally managed contacts database will provide a single system where the LCRN can easily maintain data quality and users are guaranteed to have the most up-to-date information.	Improved accuracy and completeness of the LCRN's contacts data	BIM	1. Shortlist cloud-based contacts management software for testing 2. Select cloud-based contacts management software based on short list. 3. Determine categories to use to classify contacts, e.g. membership of the LCRN's groups, contacts' research interest specialties and subspecialties 4. LCRN staff to systematically review all contacts and add them to the contacts database 5. Regular review of data quality, with additions and deletions of contacts as appropriate, becomes business as usual	Q1 Q1 Q1 Q1-2 Q2-4				
4.6.8	Large scale interventional studies Large scale interventional studies are often (but not always) simpler to deliver than other interventional studies, requiring fewer resources. A robust process needs to be developed to assess the resource implications of these studies in order to support successful delivery by POs	POs will be properly resourced to support delivery of large scale interventional studies	BIM	1. Identify all large scale interventional studies open to recruitment in the LCRN 2. PFs collate relevant study documentation (IRAS form, protocol, SoECAT) to assess resources required for delivery of the study 3. RDM reviews documentation and calculates a per patient cost for the study 4. Decision on per patient costs are share with participating partner organisations and feeds into the LCRN's financial modelling 5. Becomes business as usual.	Q1 Q1 Q1-2 Q1-2 Q2-4				
4.6.9	Access to NIHR Hub G-Suite applications Partner Organisations continue to encounter varying levels of difficulty when access NIHR Hub G-Suite applications, mainly due to access restrictions placed on "social media" sites by firewall software. The LCRN aims to resolve any remaining access issues in 2019/20 so as to enable all partner organisations to make use of the tools provided for collaborative working in shared workspaces.	Increased use of NIHR Hub by POs in order to facilitate shared working on a common technological platform	BIM	1. Survey all POs to determine current access restrictions imposed by their IM&T departments 2. Identify whether access restrictions are targeted at particular apps or the G-Suite ecosystem as whole 3. Identify G-Suite champions within partner organisations to liaise with their IM&T departments to remove access restrictions 4. Escalate to the Partnership Group/ NIHR servicedesk if issues remain unresolved	Q1 Q1 Q2-4 Q2-4				

Section 4: Key Projects

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4.6.10	BI COP Although a meeting of the revived BI COP (previously EDGE Champions) was held in July 2018, staff absence meant that the only other meeting of the year took place at the end of March 2019. Quarterly meetings will be established in 2019/20, and the group's remit will include all business intelligence platforms (i.e. ODP, EDGE and locally managed databases) and surrounding procedures (e.g. Study Change Log). The group will input into procedures, share best practice and ensure new developments are cascaded to PO. Representation will be sought from primary care and non-traditional research settings.	To improve understanding and use of all features of BI resources (e.g. ODP, EDGE, etc.) and processes leading to more efficient working.	BIM	1. Liaise with primary care team and staff working in non-traditional research settings to identify potential individuals who may have an interest in the BI COP and invite them to the group. 2. Arrange quarterly meetings of the COP at the LCRN Offices 3. Meetings become Business as Usual	Q1 Q1 Q2-4				
4.6.11	Develop learning resources for BI Work supra-regionally with the newly appointed Learning Technologist to develop learning resources for BI	Support local staff to develop BI skills to allow them to generate standard reports and manipulate data independently of the BI team Coordinated approach to digitally enabled learning resources.	BIM	Appointment to be shared, supra regional digital learning designer post. Identify a number of projects in collaboration with the supra-regional network to work with the Learning technologist to deliver, including (but not limited to): 1. Explore the use of "Filtered" as a platform for the delivery of training resources (https://nihr.gf.filtered.com/#/) 2. ODP training aimed at research nurses and other partner organisation delivery staff, focused initially on the basic CRN/LCRN sheets and expanding to include the LCRN developed app once launched 3. EDGE training: adding new Users, searching for sites, adding patients, etc. (see also Advanced uses of EDGE above) 4. NIHR Hub training: Gmail / Calendar / Drive / Kanbanchi 5. Requesting an Eduroam account and accessing the service 6. Data manipulation in Excel for reporting purposes: Pivot tables / vlookup / advanced charts 7. Implications of GDPR for research	Q2-4				
7. Stakeholder Engagement and Communications									
4.7.1	LCRN is one of the main organisational partners in PHWE, a regional network supporting public involvement and engagement in health research and service improvement. The main organisational partners are: NIHR Clinical Research Network West of England (LCRN) Bristol Health Partners (BHP) National Institute for Health Research Bristol Biomedical Research Centre (BRC) NIHR Collaboration for Leadership in Applied Health Research and Care West (CLAHRC West) West of England Academic Health Science Network (West of England AHSN)	Deliver PPIE initiatives across the region:	PPIE Lead/PHWE	1.Working with a Steering Group and Operational Group to develop a coordinated approach to delivering agreed PPIE activities (PHWE work plan). 2.Working with public contributors linked to partner organisations, including Healthwatch and the NIHR RDS. 3.Provision of advice and guidance on PPIE 4.Delivery of support to staff undertaking PPIE in the partner organisations 5.Increasing PPIE capability via delivery of a learning and development programme e.g. running Building Research Partnerships workshops across the PHWE region.	Q1-4				

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4.7.2	PRES In partnership with POs and delivery teams across the network, the LCRN will coordinate the design, delivery and reporting of the 2019-20 Patient Research Experience Survey.	2019-20 PRES designed and delivered across all partner organisations	RDMs, Deputy COO, Comms team	1. A now well established PRES working group, which includes representatives from all POs, LCRN public contributors, LCRN PPIE lead and CM, will meet in Q1-2. 2. 2018/19 PRES results will be analysed, report written and shared with POs, recommendations from the report presented to working group. 3.Increase response rates to PRES, in line with HLO4 targets. LCRN has year on year increased PRES response rates 2016/17 - 307 respondents, 2017/18 - 332 respondents and 2018/19- 430.					
4.7.3	Patient Research Ambassador (PRA) In 2017/18 the LCRN in collaboration with PHWE launched the PRA through its extensive PPIE network. Due lack of resource in the core team and a restructure of PHWE we have been unable to develop the role or grow our PRA numbers. At present there are a small number of PRAs locally. This is a priority for 2019-20, the LCRN in collaboration with current PRAs, PPIE leads across the network and partners People in Health West of England will undertake a project to embed PRAs throughout the network.	Relaunch PRA initiative within the LCRN PRAs embedded in all partner organisations	PPIE Lead	1.Identify key stakeholders in the region, PPIE lead will facilitate a meeting with the aim of agreeing a PRA strategy for the region. 2.Utilise shared resources from the PPIE and Comms supra network group to develop a LCRN PRA induction resource pack 3. Engage with voluntary sector in POs, offer PRA role to current trust volunteers. 4. PRA initiative included in the PHWE annual work plan 5. A re-launch event will be held in 2019	Q1-2 Q1-4 Q1 Q1 Q3				
4.7.4	Free style pilot National Standards for Public Involvement. PHWE has been selected as a test bed site for the freestyle pilot of the National Standards	As part of PHWE, LCRN will pilot two Standards (Standard 3: SUPPORT & LEARNING and Standard 6: GOVERNANCE)	PPIE Lead	1. This will be carried out in partnership with Bristol BRC, CLAHRC and HPRU 2. Develop and implement a plan for each of the standards	Q1-4				
4.7.5	Restructure of PPIE to support national and local initiatives	Implement the findings of the LCRN core team workforce review	NC/RDM	1. Transition period for strategic support for PPIE. 2. Formal proposals of changes. 3. Final agreement and changes and notify CRNCC. 4.Develop a PPIE workplan with communication team.	Q1-2				
4.7.6	To undertake a series of stakeholder engagement activities in Primary Care and across non-NHS sites	To promote a COP across stakeholders in PC and in non-NHS sites	SRO	1. Host an RSI Event for PC and extend to non-NHS sites 2. Support Hospice Networking Event 3. Community Research Nurse Development/Networking Event 4. Supporting BI with Commercial COPP 5. Supranetwork Event. 6. Supporting at Swindon Event - promoting Research at Scale	Q1-4				
4.7.7	Local public and patients have raised awareness of Be Part of Research Portal and JDR register	Be Part of Research will be the main call to action in all patient-facing communications, with National messaging around the service supported and amplified.	CM	1. Promote portal through events with POs and stakeholders where public will attend. 2.JDR activities will be supported alongside the JDR Specialty board, comprising local partners from service delivery and charities and agreed projects will be delivered and effectiveness measured where possible.	Q1-Q4				
4.7.8	Improved attendance at quarterly Network Communication Group meetings.	To proactively support new and emerging NIHR strategies relevant to stakeholder engagement and communication goals	CM	1. Complete stakeholder mapping exercise, working with NIHR Regional Communications Lead to improve relationships with Communications teams with key stakeholders	Q1-Q4				

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4.7.9	Defined approach to communication and action plan aligned with NIHR strategies.	A robust Communications Strategy that will meet POF requirements, support local and national plans and greatly improve PO and patient engagement.	CM	1. A working group will be formed of internal stakeholders to influence the targets for the Communications Strategy and agreed measurements of success for LCRN projects (that can be supported by campaigns or other Communications) 2. These will be submitted to local media and local Trusts, where appropriate, and published on the LCRN Blog and NIHR LCRN Microsite. Local campaigns will be designed and delivered to further enhance the LCRN's profile and reputation with internal and external stakeholders. 3. A dedicated non-pay budget line will be ring-fenced to achieve the communication plan to incorporate communications activity across numerous channels such as radio advertising, social media promotion, print and other promotional activities as appropriate for research projects, PPIE and JDR. 4. Earlier input from specialty research leaders regarding the awareness and promotion of local research opportunities and the importance of research overall will be sought and recorded, with agreed outcomes and milestones. 5. Regular reports on all planned and completed activity will be produced and submitted to the LCRN Executive; and mid-year and end of year reports submitted to the coordinating centre. 6. A new suite of documentation will be created targeted towards specific audiences, to aid CRN team engagement and, where ethics allows, study promotion.	Q1-Q4				
4.7.10	Implement NIHR Brand Guidelines	To ensure LCRN and partners adopt and adhere to the new guidelines	CM	The new NIHR Brand Guidelines will be distributed and the effects of the new branding delivered as workshops to R&D managers and specialty teams, working with RDMs and PFs to coordinate, and CM and team will act as Brand Guardians to ensure adherence	Q1-Q2				
4.7.11	Increase visibility within research workforce in LCRN region	An improved set of communications for the customer journey	CM	Project to investigate LCRN initial contact communications with new study contacts will be undertaken, looking to improve engagement and offer links to a wider range of local offers, such as Training website, blog and relevant NIHR acknowledgement requirements in publications. Work with Study Support Team to investigate communications around the end of study team collaboration process.	Q1-Q2				
4.7.12	Communications and PPIE supra network	Equity of access - Analyse the findings of the 2017 NIHR & HRA report and other relevant information on attitudes to research. Work to establish a baseline data set to better understand the populations served within the supra network region and their health and social care needs. Marketing materials & branding - Work together to ensure the successful implementation of the NIHR's new visual identity. Collaborate on the development of marketing materials in accordance with local needs. Shared learning - Regular meetings and use of the Google community to share resources, ideas and best practice.	CM, PHWE, RDM	1. Produce evidence of research undertaken into attitudes to research. 2. See above for ensuring that new brand guidelines are adopted and adhered to. Share best practice with SUPRA group as appropriate. 3. Continue to share resources with supra network colleagues and use data to inform and develop communications that ensure people are aware of the opportunity to participate in and benefit from high quality health and social care research studies. Marketing materials and branding Successful implementation of the NIHR's visual identity across the supraregion. Marketing materials addressing local audiences and needs.	Q1-Q4 Dec 2019				

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4.7.13	CI is embedded within all aspects of LCRN business.	The LCRN will be informed of PO CI activities. The LCRN will continue to promote the quality improvement programmes to POs and core staff, encouraging them to plan QI programme "projects" within their annual plans.	RDMs,	1.LCRN POs will share their CI activities as part of their annual planning process 2. Review CI at business planning stage with POs. 3. Mid-year review stage. 4. Year end	Q1-4				
4.7.14	Building communities of practice locally and nationally to ensure a consistent approach to CI	To enable the LCRN to be responsive to new ways of working. To enable shared learning from groups to enable innovative, streamlined, efficient services To measure Impact and benefit.	Deputy COO, CM	The LCRN will seek via COP, National CI group, National Divisional groups and Locality links to share appropriate approaches from elsewhere and highlight local innovative practices.	Q1-4				
8. Workforce, Learning and Organisational Development									
4.8.1	Implementation of a local action plan to support the CRNCC wellbeing framework.	To ensure wellbeing is embedded in the LCRN culture	Deputy COO Locally COO Nationally	1. COO to continue in the CRNCC national role as wellbeing lead. Wellbeing group to present to COO away day 6th June. 2. Deputy COO to continue in role as wellbeing lead locally 3. Implementation and evaluation of 12 wellbeing themes developed nationally through the LCRN Wellbeing Leaders group.	Q1-4				
4.8.2	Implementation of the findings of the LCRN skill mix review and workforce planning review by the LCRN Workforce Lead	To ensure the core team is sufficiently resourced in relation to capacity and capability to deliver the performance and operating framework.	Deputy COO	Recommendations and evaluation of the skill mix review to be presented to LCRN Executive Group and ratified by the LCRN Partnership Group					
4.8.3	Supra-network WFD Leads	To develop standardised induction and resource to be shared across the supra-region To develop standardised training resource to be shared across the supra-region To inform and help drive workforce development strategies, policies and procedures and share best practice throughout the supra-regional area.	WFD Leads	There are four supra-regional WFD forum meetings annually, including two face to face meetings, which feed bi-annually into the SR-LCRN COO meeting .	Q2-4				
4.8.4	National support for the 70@70 initiative	To support a new community of senior clinical nurses and midwives who will champion the promotion of an embedded research active culture, encourage and support innovation, and inform research priorities in their organisations.	COO	Active member of the Steering Committee for the 70@70 initiative	Q2-4				
9. Business Development and Marketing									
4.9.1	Promote industry agenda	Increase in commercial activity in the region	IOM/IPL	1. Work with RDMs to promote commercial research and the implementation of the Working with the Life Sciences Industry Strategy at locality and specialty level 2. Hold a workshop as part of the annual Primary Care RSI event to encourage and support uptake of commercial research within primary care. Mentorship provided by PC CCOP (see section 4.3.4).	Q1-4 Q1				
4.9.2	Develop our external facing industry processes	Ensure our offer delivers to and beyond expectations of the Life Sciences Industry	IOM	Conduct a scoping exercise with other LCRNs to understand how best to undertake local Business Development activities to be considered for adaptation and adoption in the West of England.	Q2-4				

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10. Life Sciences										
4.10.1	MedTech/SMEs	Support locally led commercial research in line with the Industrial Strategy Life Sciences Sector Deal 2	IOM/IPL	1. Further develop relationships with the local AHSN / RDS to clarify signposting and support for SMEs to supplement the flow of national commercial research by promoting home-grown industry research, linking in with their Innovation Exchange. 2. Increase proportion of locally led commercial studies from local SMEs on the portfolio.	Q1-2 Q1-4					
4.10.2	National Improvement Plan	Improve study support service offering to the Life Sciences in line with National Improvement Plan	IOM/RDMs	1. WP1 Stakeholder Engagement: Support the Champion Programme locally (if applicable) and encourage local AHSN and SMEs to use Interactive Route Map. 2. WP6 - Effective Study Start Up: Optimise support for sponsors during the set-up stage of study delivery by embedding phone calls by RDMs to discuss known/expected challenges and sharing of knowledge amongst LCRNs. 3. WP7 - Performance Monitoring: Embed performance monitoring of single site lead LCRN commercial studies into RDM roles.	Q1-4 Q1-4 Q1-4					
4.10.3	Single review process	Support nationally coordinated contract value negotiation process as per NHS England National Directive on Commercial Contract Research Studies	IOM	Support local reviewers (if applicable) with adoption and delivery of Interactive Costing Template (iCT) to support collaborative review approach.	Q1-4					
4.10.4	Supra-network working	To increase collaboration across neighbouring LCRNs, share best practice and reduce duplication. Consistent commercial study support service offering across supra network	IOM/IPL	1.Continue collaborating on key industry topics as a supra-regional group with CRN Wessex, Thames Valley and South West Peninsula by meeting quarterly via teleconference/face-to-face meetings. Topics include SSS changes (Early feedback, Performance Monitoring and Effective Study Set Up), Single review process, and training for newly commercially active PIs. 2. Report into COO supra-network group.	Q1-4					
4.10.5	Community of Practice	Increase collaborations between primary and secondary care	IOM/RDMs/Primary Care	1. Hold a joint event/meeting for PC CCOP (see section 4.3.4) and Industry Management community to follow on from initial work to bring together primary and secondary care for commercial studies. 2. Create standardised SLA template for use by sites working in partnership with other sites for commercial research.	Q2-3 Q1					
4.10.6	Industrial Strategy Life Sciences Sector Deal 2	Support the local implementation of the Industrial Strategy Life Sciences Sector Deal 2	IOM/RDMs	1. Support local applications to become a centre for 'late phase commercial research'. 2. Through the PC CCOP, identify barriers for local Trusts and GP practices to act as participant identification centres (PICs). Create a system to better reward PIC activity to encourage more collaborations between primary and secondary care. 3. Continue to monitor commercial set-up times to ensure the region is competitive nationally. 4. Continue to encourage uptake of the Clinical Practice Research Datalink in GP practices in the region through the PC CCOP, RSI event and practice visits.	Q1-4 Q1-2 Q1-4 Q2-4					
11. New Projects (to be completed at Mid Year /Annual Report if appropriate)										
4.11.1										
4.11.2										

Section 5: High Level Objectives

Columns F-G should be completed as part of the 2019/20 Annual Plan. Annual Plan for HLOs 1 and 7 only i.e. the greyed out rows do not require completion at this time.
Column H should be completed as part of the 2019/20 Mid Year Progress Report.
Column I should be completed as part of the 2019/20 Year End Report.

HLO	Objective		Measure	National Target	LCRN Target	Annual Plan Commentary (How target has been determined and supporting rationale)	Mid Year Commentary	Year End Commentary
1	Deliver significant levels of participation in NIHR CRN Portfolio studies	A	Number of participants recruited to NIHR CRN Portfolio studies	TBC (A)	28883	The LCRN recruitment target for 2019/20 remains unchanged from 2018/19. With no increase in the LCRN's financial allocation for 2019/20, it will be challenging for Partner Organisations to increase their levels of recruitment activity. The recruitment goal for 2018/19 has been achieved due to two high recruiting studies (CPMS ID 39692 The second Bristol online survey of dementia attitudes and CPMS ID 40962 YP26+ 2018 Questionnaire). The LCRN will concentrate on expanding research activity into non-traditional settings such as care homes, community healthcare and Public Health settings and work with General Practice to reverse the downward trend in recruitment activity in primary care, although this depends on the availability of primary care studies on the NIHR CRN Portfolio. The LCRN is also working across all the NIHR structures within the region through the NIHR Clinical Directors and Managers group to maximise recruitment opportunities.		
		B	Number of participants recruited to commercial contract NIHR CRN Portfolio studies	TBC (A)	1000	Commercial participants are included in the target above		
2	Deliver NIHR CRN Portfolio studies to recruitment target within the planned recruitment period	A	Proportion of commercial contract studies achieving or surpassing their recruitment target during their planned recruitment period, at confirmed CRN sites	80%				
		B	Proportion of noncommercial studies achieving or surpassing their recruitment target during their planned recruitment period	80%				
3	Increase the number of studies delivered for the commercial sector with support from the NIHR Clinical Research Network	A	Number of new commercial contract studies entering the NIHR CRN Portfolio	TBC (B)				
		B	Number of new commercial contract studies entering the NIHR CRN Portfolio as a percentage of the total commercial MHRA CTA approvals for Phase II–IV studies	75%				
4			This objective is no longer included in 2019/20 High Level Objectives. Replaced by new HLO 9.					
5			This objective is no longer included in 2019/20 High Level Objectives. Replaced by new HLO 9.					
6	Widen participation in research by enabling the involvement of a range of health and social care providers	A	Proportion of NHS Trusts recruiting into NIHR CRN Portfolio studies	99%				
		B	Proportion of NHS Trusts recruiting into NIHR CRN Portfolio commercial contract studies	70%				
		C	Proportion of General Medical Practices recruiting into NIHR CRN Portfolio studies	45% (C)				
		D	Number of non-NHS sites recruiting into NIHR CRN Portfolio studies	TBC (D)				
7	Deliver significant levels of participation in NIHR CRN Portfolio Dementias and Neurodegeneration (DeNDRoN) studies		Number of participants recruited into Dementias and Neurodegeneration (DeNDRoN) studies on the NIHR CRN Portfolio, each year	25,000	550	The high numbers of recruits to DeNDRoN studies in 2018/19 was due to a single study, CPMS ID 39692- The second Bristol online survey of dementia attitudes, which closed at year end. This study was an outlier and performance will not reach similar levels in 2019/20		
8	Demonstrate to people taking part in health and social care research studies that their contribution is valued		Number of NIHR CRN Portfolio study participants responding to the Patient Research Experience Survey, each year	10,000 (E)				
9	Reduce study site set-up times for NIHR CRN Portfolio studies by 5%	A	Average study site set-up time for commercial contract studies, at confirmed Network sites (days)	TBC (F)				
		B	Average study site set-up time for non-commercial studies (days)	TBC (F)				

HLO TABLE NOTES

1 Site set up time defined as “Date Site Selected” to “Date First Participant Recruited”
2 Average site set-up time defined as the median average of all individual site set-up times for all studies in a reporting year

(A)	HLO 1A / 1B	The Ambition values will be the mean of the annual values for the 5-year period 2014/15 to 2018/19
(B)	HLO 3A	The Ambition value will be an increase in the 2018/19 annual value
(C)	HLO 6C	Reverted to current value of 45%. Note 2017/18 outturn was 32%, and 2018/19 to Q3 is 33%
(D)	HLO 6D	The Ambition value will be the 2018/19 annual value plus 5%
(E)	HLO 8	The Ambition value of 10,000 respondents represents an increase of 14% on the 2018/19 outturn of 8,779 respondents
(F)	HLO 9A / 9B	The Ambition value will be the 2018/19 annual value less 5%

Section 6: Specialty Objectives

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Annual Plan						Mid Year Report		Year End Report	
Ref	**Objective**	**Specialties Included**	**Measure**	**Target**	**Local activities to achieve the national objective**	**RAG**	**Commentary**	**RAG**	**Commentary**
1	To develop local LCRN schemes/programmes for promoting and improving early career researcher (ECR) involvement in NIHR research	All	A. LCRNs to have at least one named individual who acts as an ECR/Training Lead AND B. LCRNs to demonstrate year on year increases in ECR involvement in at least 50% of specialties (e.g. new PIs or CIs, links with Royal College or other professional organisations, record of ECR staff per specialty and the trials to which they are recruiting – they may not necessarily be LCRN funded)	A. 1 ECR/Training Lead per LCRN AND B. 5% Increase in ECR involvement in 50% of all specialties	Part A: ECR lead: Clinical Director: Kyla Thomas. Delegated responsibilities to CDLs and CRSLs. Support by LCRN workforce development lead/Deputy COO:Paula Tacchi Part B: Establish baseline using quantitative and qualitative methods to populate CRNCC template once available. Work with Divisional Leads and CRSLs to explore strategic options and hold network-wide awareness raising events suitable for those wishing to become involved in research. Link these events with ongoing specialty specific PI training to increase number of PIs, and encourage ECRs and new PIs to shadow CRSLs and join specialty group meetings. Develop relationships with established networks for some specialties such as STAR and SPARCS, also develop networks in other relevant specialties (e.g. Primary Care). Implement findings of the Improving Recruitment paper 2018 Build on the success of the 'tailored' Mental Health PI course 2018/19 (i.e. delivered by existing Mental PIs rather than facilitator-led) and roll out to other specialties. Surgical speciality will appoint an ECR champion, who will be responsible for introducing Associate PI scheme.Plan to track Associate PIs to see if they remain research active in consultant roles. Explore the potential for non-NHS PI training				

2	To increase opportunities for people to participate in health research in less established specialties (<70 open studies on the NIHR CRN Portfolio in April 2018)	Ageing Anaesthesia, Perioperative Medicine and Pain Management Critical Care Dermatology Ear, Nose and Throat Haematology Injuries and Emergencies Oral and Dental Health Public Health	Each LCRN to increase recruitment in studies or the number of studies open to recruitment within all of these nominated specialties	LCRN demonstrates either 5% increase in recruitment or 5% increase in open studies in ALL nominated specialties	The local planned activities described below will be implemented to support achievement of the national specialty objectives: 1.1 Sharing of best practice, skills and knowledge. 1.2 Creation of COP. 1.3 Developing a skilled and equipped workforce to grow and promote research. 1.4 Increase collaboration and involvement. 1.5 Development towards a more balanced portfolio. 1.6 Continue to perform weekly searches of CPMS for studies which are 'open to new sites' and distribute / stimulate interest amongst local clinicians. Ageing Provide LCRN support to support the growth of research developed at the Research Institute for Care of Older People in Bath. There is significant enthusiasm to build infrastructure and expertise to expand the ageing and neurodegeneration portfolio however there is some structural issues regarding LCRN funding which need resolving. -Promote the local uptake of locally-led Ageing studies, utilising the Regional Flexible Team where appropriate (i.e. when recruiting patients from non-NHS environments). Anaesthesia, Perioperative Medicine and Pain Management. Hold at least one engagement event. Explore potential for signposting to NIHR from other organisations e.g. POMCTN. Improve ease of access for potential site PIs to see actively recruiting NIHR CRN studies in West of England (via web / social media.) CRSL to attend at least two of the quarterly STAR committee meetings and meet monthly with STAR Trainee Lead to share best practice in NIHR CRN Portfolio study recruitment. Hold quarterly formal meetings between CRSLs for anaesthesia and critical care to improve collaborative working between the two specialties and share recruitment strategies. Critical Care Hold at least two engagement events, one of which is aimed at early career researchers. Develop 'research capability' profile for each ICU in the LCRN to maximise potential for recruitment across all relevant POs. Meet with STAR trainee lead (as per APMP) quarterly. Continue work to support development of a collaborative network NIHR application (part of three year strategy). Dermatology Hold at least one engagement event. Support the collaboration of departments of dermatology and the collaboration of dermatology with other specialities and research groups Support dermatology trainees in taking part in clinical research. Ear, Nose and Throat Hold at least one engagement event. Use intelligence from specialty trainee for ENT posts to inform approach and share best practice. Haematology Through HaemSTAR trainee programme, develop PIs and embed GCP training for trainees to work on NIHR Portfolio studies. Injuries and Emergencies. Explore appetite for engagement events or adding research to an existing agenda/event. Oral and Dental Health Hold at least one engagement event Promote the online GCP training specific for Dental practices Public Health Engage with the PHE SW: R&E Hub, West of England Public Health Partnership (which includes Local Authority Departments of Public Health) and the NIHR SPHR Support and attend PHE SW: R&E Hub events using this as an opportunity to facilitate cross working and participation in Portfolio studies				

3	To broaden participation within well-established specialties, particularly in areas or groups who have historically been underrepresented on the NIHR CRN Portfolio	Cancer -Cancer Surgery -Radiotherapy -Rare Cancers -Teenage and Young Adults Diabetes -Diabetes managed, Primary Care supporting PLUS Primary Care managed, Diabetes supporting PLUS any specialty managed, if both Diabetes AND Primary Care are supporting Hepatology -Nonalcoholic fatty liver disease -Nonalcoholic steatohepatitis Gastroenterology -Endoscopy Injuries and Emergencies -Pre-hospital care and Trauma Infection -Antimicrobial Resistance Mental Health -Children and Young People Metabolic and Endocrine Disorders -Obesity Respiratory Disorders -Rare Diseases Stroke -Hyperacute AND Acute Care Studies (sum of both) Cardiovascular Disease	A. Increase recruitment by 5% into at least 50% of the nominated sub-specialties B. 2nd year of a two-year objective begun in 2018/19: LCRNs to enact the cardiothoracic surgery workforce plan made as part of the 2018/19 objective	A. 5% increase in recruitment for 50% of the nominated subspecialties B. Cardiothoracic surgery workforce plans implemented	Continue to perform weekly searches of CPMS for all specialties for studies which are 'open to new sites'. When suitable studies are found, these will be distributed amongst the relevant clinicians and teams to promote uptake. Cancer Surgery - Appoint two new CRSLs for Cancer, a medical oncologist and a surgical oncologist. One of the key objectives for the surgical appointment will be to work closely with the CRSL for surgery to broaden participation in cancer surgery trials. - RDM, surgical and cancer surgery CRSL will plan an engagement event aimed at surgical oncologists across the region. The event will be the first step in creating a community of practice for surgical oncologists.LCRN will use existing links with Somerset, Wiltshire Avon & Gloucestershire Cancer Alliance (SWAG) to engage with clinicians across the region. - Cluster F will provide baseline metrics and will measure improvement in this sub speciality, once the LCRN has a baseline metric provided, key areas can be focused on to increase recruitment across the region. Radiotherapy - Division one lead is currently covering the LCRN radiotherapy lead role. - RDM and CDL will build further collaborations with radiotherapy units across the region. - Identify key clinicians in GRH, BHOC, RUH and GWH, CDL and CRSL to arrange a network wide meeting to discuss growth areas across the region.This can be carried out via existing links with SWAG network - Cluster F will provide baseline metrics and will measure improvement in this sub speciality, once the LCRN has a baseline metric provided, key areas can be focused on to increase recruitment across the region. Rare Cancers - LCRN is currently recruiting into trials across all sub-specialties, including rare cancers. RDM CDL and CRSL will identify relevant subspecialties and explore strategies for broadening participation across the region e.g Sarcoma. - Within the LCRN, BHOC and Bristol Royal Hospital For Children have the largest portfolio of rare cancer trials, through the SWAG network meetings, referrals into rare cancer trials at BHOC and Bristol Royal Hospital For Children will be encouraged. PIs for rare cancer trials will be invited to present trails to clinicians from across the region at the meetings, to raise awareness and encourage referrals. - Cluster F will provide baseline metrics and will measure improvement in this sub speciality, once the LCRN has a baseline metric provided, key areas can be focused on to increase recruitment across the region. Teenagers and Young Adults - TYA research nurse post is being rolled out across all LCRNs 2018/19. RDM to meet with Jamie Cargill, Teenage Cancer Trust Nurse Consultant and the TYA research lead, to agree a strategy for the LCRN, to broaden participation in this area. - UHB is the Principal Treatment Centre for TYA with Cancer for the South West of England, RDM will explore further collaborations with South West Peninsula CRN, to broaden participation in this area. Diabetes Use ODP function to scope Primary Care diabetes studies. Build on the work of the 2016-2018 Diabetes project which set up processes to deliver diabetes studies across Primary and Secondary Care. Metabolic & Endocrine Disorders Diabetes research team is liaising with the bariatric service to identify which obesity studies they can support. -Women's Health research team are horizon scanning to deliver relevant obesity studies that also relate to reproductive health Hepatology Work with CRSL to establish a list of all hepatology researchers across the region. Horizon scanning of portfolio for nonalcoholic fatty liver disease and nonalcoholic steatohepatitis				

4	To ensure specialty or sub-specialty representation and leadership is embedded in all LCRNs	-ENT - Audiology Champion -Infection - STI Champion -Health Services Research Champions -Oral and Dental Health - Primary Care Dental Champion -Public Health Champion -Renal Disorders - Urology Champions	All nominated specialties to have a local named Champion	15 LCRNs	Work with CDLs and CRSLs to identify and appoint Champion who will be supported by CRSL. 1. Health Services Research Champion CRSL for Health Services Research to act as research champion 2. Oral & Dental Health Seek Primary Care Dental Champion 3. Public Health Senior Research Associate in Public Health (recently appointed as CRSL) to act as Public Health Research Champion 4. Renal Use list of attendees at NSG meetings provided by CRNCC to identify urology champion. 5. Infection STI Champion Existing- STI Champion recruited in 2018/19. 6. ENT Existing- Two ENT Champions recruited in 2018/19. 7. PC Three existing GP Champions in post. Two Primary Care Commercial RN champions.				
5	To record the age (or year of birth) of participants recruited into NIHR CRN Portfolio studies in order to assess the extent to which recruitment age profiles match the age demographics of the incidence/prevalence of diseases	-Ageing -Cancer -Children -Dementias and Neurodegeneration -Mental Health -Neurological Disorders	For the six nominated specialties, 80% of Trusts/Research organisations within each LCRN either to: A. Record age (or year of birth) for NIHR CRN Portfolio study participants from April 2019 so that anonymised data can be extracted from LPMSs directly OR B. Provide the LCRN with a quarterly report of anonymised age data, relating to participants in NIHR CRN Portfolio studies OR C. If neither (A) or (B) above are currently possible within an LCRN, to develop a plan/solution for implementation in 2020/21 that will allow age data to be obtained for participants in NIHR CRN Portfolio studies from 80% of Trusts/Research organisations	For all studies within the six nominated specialties, 80% of Trusts/Research organisations within an LCRN either: A. To record age (or year of birth) in the LPMS OR B. To provide anonymised age data on participants OR C. The LCRN to develop a plan that will allow age data to be collected for NIHR CRN Portfolio studies from 80% of Trusts/Research organisations by 2020/21	-In Q1 a survey will be distributed to all POs investigating what patient level information they are currently recording in the LPMS. They will also be asked what would potentially be acceptable to record. -Given the current experience of collecting date of birth for cancer study participants, it is known that some POs have internal issues with their Information Governance departments about what level of patient identifiable information is allowed to be recorded on LPMS. -An approach to record age (date of birth or year of birth) in LPMS across all disease areas will initially be sought. Where this is not possible, recording date of birth/year of birth for the six nominated areas will be encouraged. Where there is no agreement to do this, alternative routes to collecting this information will be explored.				

Section 7. LCRN Operating Framework Indicators (not required at Annual Plan Stage)

At Annual Plan stage the expectation is that any plans required to support delivery of LCRN Operating Framework Indicators are listed in Section 4: Key Projects or as appendices
Column C should be completed as part of the 2019/20 Mid Year Progress Report.
Column D should be completed as part of the 2019/20 Year End Report.

ID		Mid-Year Commentary (if required)	Year End Commentary (if required)
1.1	**Domain:** Governance and Management **Indicator:** Each LCRN provides an Annual Plan, Annual Report and other documents as requested by the National CRN Coordinating Centre **Assessment Approach:** Monitoring of provision of key documents requested by the National CRN Coordinating Centre		
1.2	**Domain:** Governance and Management **Indicator:** Each LCRN Clinical Director and/or LCRN Chief Operating Officer attends all National CRN Coordinating Centre/LCRN Liaison meetings **Assessment Approach:** Attendance registers for National CRN Coordinating Centre/LCRN Liaison meetings		
1.3	**Domain:** Governance and Management **Indicator:** Each LCRN Host Organisation and LCRN Category A Partner submits an NHS Data Security and Protection Toolkit annual assessment to NHS Digital. All NHS Trusts were asked to provide an initial baseline assessment in October 2018. LCRN Host Organisations and LCRN Category A Partners should aim to achieve "Standards Met" (i.e. completed all mandatory evidence items and assertions). If "Standards Not Met" remains after completion or publication, the Host Organisation will be required to assess whether this impacts business delivered on behalf of the NIHR CRN. If this is the case, the Host Organisation is required to submit a report to the National CRN Coordinating Centre outlining the failure and mitigating actions to ensure improvement and achievement of the mandatory data security and protection standards. **Assessment Approach:** Review of submitted Host Organisation Report outlining failures and mitigating actions		
1.4	**Domain:** Governance and Management **Indicator:** Category A LCRN Partner flow down contract templates used to contract with all Category A LCRN Partners **Assessment Approach**: LCRN Annual Report		
1.5	**Domain:** Governance and Management **Indicator:** Category B LCRN Partner flow down contract templates used to contract with all Category B LCRN Partners **Assessment Approach:** LCRN Annual Report		
1.6	**Domain:** Governance and Management **Indicator:** Category C LCRN Partner flow down contract templates used to contract with all Category C LCRN Partners **Assessment Approach:** LCRN Annual Report		
2.1	**Domain:** Financial Management **Indicator:** Internal audit in respect of LCRN funding managed by the LCRN Host Organisation, undertaken at least once every three years and which meets the requirements of the LCRN Minimum Financial Controls Contract Support Document specified by the National CRN Coordinating Centre **Assessment Approach:** Monitoring of audit reports provided by the LCRN Host Organisation to the National CRN Coordinating Centre		

2.2	**Domain:** Financial Management **Indicator:** Deliver robust financial management using appropriate tools and guidance **Assessment Approach:** ● Monitoring by the National CRN Coordinating Centre of percentage variance (allocation vs expenditure) quarterly and year-end (target is 0%) ● Monitoring by the National CRN Coordinating Centre of proportion of financial returns completed to the required standard and on time (target is 100%) ● Monitoring of financial management via LCRN financial health check process		
2.3	**Domain:** Financial Management **Indicator:** Distribute LCRN funding equitably on the basis of NHS support requirements **Assessment Approach:** Comparison by the National CRN Coordinating Centre of annual LCRN Partner funding allocations and NHS Support requirements		
3.1	**Domain:** CRN Specialties **Indicator:** LCRN has an identified Lead for each NIHR CRN Specialty **Assessment Approach:** Each LCRN Host Organisation shall: ● Provide the National CRN Coordinating Centre with access to a list of LCRN Clinical Research Specialty Leads, which includes each individual's start/end dates and contact information ● Notify the National CRN Coordinating Centre if there are changes within the financial year ● Provide a narrative to justify intentional vacancies or the expected timeframe to fill vacancies		
3.2	**Domain:** CRN Specialties **Indicator:** Each LCRN Clinical Research Specialty Lead attends at least 2/3 of National Specialty Group meetings **Assessment Approach:** Attendance registers for National Specialty Group meetings		
3.3	**Domain: CRN Specialties** **Indicator: Each LCRN provides evidence of support provided to their LCRN Clinical Research Specialty Leads to enable them to undertake their role in contributing to the NIHR CRN's nationwide study support activities, specifically in respect of commercial early feedback and non-commercial expert review for the eligibility decision and including where applicable, local feasibility activities, delivery assessments and performance reviews** **Assessment Approach:** **Review by the National CRN Coordinating Centre of evidence of support provided in LCRN Annual Plan and Report**		
4.1	**Domain:** Research Delivery **Indicator:** Each LCRN consistently delivers the local elements of the CRN's nation-wide Study Support Service as specified in the latest version of the Standard Operating Procedures produced by the National CRN Coordinating Centre and available as part of the LCRN Contract Support Documents **Assessment Approach:** Monitoring by the National CRN Coordinating Centre of provision of the individual components of the Service via the study progress tracker application on Open Data Platform where the LCRN is assigned as the Lead LCRN and/or Performance Lead		

4.2	**Domain:** Research Delivery **Indicator:** Each LCRN provides near time Minimum Data Set data items as specified by the National CRN Coordinating Centre, which have been quality assured to accurately reflect research activity measures and enable collaborative delivery of studies across the NHS **Assessment Approach:** ● Monitored via Open Data Platform reports, the single research intelligence system and the Research Delivery Assurance Framework elements of the LCRN Contract Compliance Assurance Framework ● Analysis of percentage of missing and inaccurate data points from each LCRN		
5.1	**Domain:** Information and Knowledge **Indicator:** Each LCRN provides an LPMS to capture for their region the required Minimum Data Set data items as specified by the National CRN Coordinating Centre, and enables timely sharing of information as one element of the single research intelligence system **Assessment Approach:** Monitoring by the National CRN Coordinating Centre of system integration, usage and data transfer as part of the single research intelligence system		
5.2	**Domain:** Information and Knowledge **Indicator:** Each LCRN provides support for ongoing provision of an LPMS solution **Assessment Approach:** Review of budget line for provision of an LPMS in LCRN Annual Financial Plan		
5.3	**Domain:** Information and Knowledge **Indicator:** Each LCRN has in place a senior manager to coordinate business intelligence activities within the LCRN. The identified lead will participate in nationally agreed business intelligence improvement initiatives and attend national NIHR CRN business intelligence meetings **Assessment Approach:** ● Attendance registers for national NIHR CRN business intelligence meetings ● Individual's name and contact details provided to the National CRN Coordinating Centre		
5.4	**Domain:** Information and Knowledge **Indicator:** Each LCRN has a nominated representative in attendance at all national CPMS-LPMS meetings where either a) strategic sign off is required or b) an operational working perspective is required **Assessment Approach:** Attendance registers for national CPMS-LPMS meetings		
5.5	**Domain:** Information and Knowledge **Indicator:** Each LCRN has a plan to ensure that the best researchers, wherever they are based, undertake clinical, and public health and social care research in the areas of England with the greatest health needs **Assessment Approach:** ● Review and monitoring of LCRN Annual Plan ● Review of outcomes as reported within LCRN Annual Report ● Monitoring of national metrics relating to the priority disease areas specified by the Department of Health and Social Care		

6.1	**Domain:** Stakeholder Engagement and Communications **Indicator:** Each LCRN has an experienced and dedicated communications function to support national CRN, NIHR and local CRN objectives **Assessment Approach:** ● Individual's name and contact details provided to the National CRN Coordinating Centre ● Non-pay budget line for communications identified in LCRN Annual Plan		
6.2	**Domain:** Stakeholder Engagement and Communications **Indicator:** Each LCRN has a defined approach to communications and action plan aligned with both the NIHR CRN and NIHR strategies **Assessment Approach:** ● Review and monitoring of LCRN Annual Plan ● Review of outcomes as reported within LCRN Annual Report ● Evidence of joint work with local NIHR infrastructure reviewed		
6.3	**Domain:** Stakeholder Engagement and Communications **Indicator:** Each LCRN has in place a senior leader experienced in PPIE to support national CRN, NIHR and local CRN objectives **Assessment Approach:** ● Individual's name and contact details provided to the National CRN Coordinating Centre ● Evidence of LCRN PPIE activity and continuous improvement based on recorded participant experience and reported in the LCRN Annual Plan and Report ● Non-pay budget line sufficient for PPIE plan delivery ● WTE role(s) identified in LCRN Annual Plan		
6.4	**Domain:** Stakeholder Engagement and Communications **Indicator:** Each LCRN records metrics of research opportunities offered to patients and users of wider health and care services **Assessment Approach:** ● Each LCRN will hold information on its reach with patients and the public (metrics may include local website usage, leaflet distribution, social media reach etc.) ● Evidence of local participant evaluation system ● Progress discussed at national PPIE meetings and reported in LCRN Annual Report		
6.5	**Domain:** Stakeholder Engagement and Communications **Indicator:** Each LCRN has in place an active programme of learning activities supporting patient and public involvement in research **Assessment Approach:** ● LCRN Annual Plan includes PPIE workplan with clear outcomes, milestones and measurable targets ● Non-pay budget line for PPIE and WTE for PPIE role (s) identified in LCRN Annual Plan ● Programme of work and continuous improvement in participant involvement, engagement, learning activities and participant experience reported in LCRN Annual Report		

6.6	**Domain:** Stakeholder Engagement and Communications **Indicator:** Each LCRN supports awareness of, engagement with and delivery of National CRN Coordinating Centre-managed services, such as Join Dementia Research (JDR) and Be Part of Research (formerly known as the UK Clinical Trials Gateway (UKCTG)) **Assessment Approach:** ● Review of outcomes as reported within LCRN Annual Report ● Review of performance on JDR		
6.7	**Domain:** Stakeholder Engagement and Communications **Indicator:** Each LCRN delivers the Patient Research Ambassadors (PRAs) project as specified by the National CRN Coordinating Centre **Assessment Approach:** Evidence of PRA activity, continuous improvement of project delivery and reporting of impacts in LCRN Annual Plan and Report		
6.8	**Domain:** Stakeholder Engagement and Communications **Indicator:** Each LCRN delivers and reports on the Patient Research Experience Survey, as specified by the National CRN Coordinating Centre **Assessment Approach:** ● Monitoring of the responses to the Patient Research Experience Survey as required by the Patient Research Experience Framework ● Patient experience survey findings and impacts reported to CRN Coordinating Centre with an accompanying plan for continuous improvement presented in LCRN Annual Plan and Report		
6.9	**Domain:** Stakeholder Engagement and Communications **Indicator:** Each LCRN develops and implements a plan to increase and continuously improve the quality of local healthcare engagement, capitalising on opportunities presented by national strategic initiatives such as new CQC research markers **Assessment Approach:** ● Review of plans for continuously improving engagement in LCRN Annual Plan ● Review of improvement plan outcomes and impacts as reported within LCRN Annual Report ● Evidence of piloting utilisation of new data on being asked about research from CQC Inpatient Experience Survey ● Evidence of corporate positioning as a helpful partner in supporting Partnership Organisations with new CQC requirements		

7.1	**Domain:** Workforce, Learning and Organisational Development **Indicator:** Each LCRN has a senior leader in place to coordinate workforce planning, recruitment, development and retention. The identified lead will participate in nationally agreed workforce development initiatives, drive a culture of modern workplace learning, and support the delivery of an integrated approach to workforce development across the NIHR CRN **Assessment Approach:** ● Individual's name and contact details provided to the National CRN Coordinating Centre ● Implementation of the local action plan to support the LCRN Workforce ● Review and monitoring of NIHR Learn metrics		
7.2	**Domain:** Workforce, Learning and Organisational Development **Indicator:** Each LCRN has in place a senior leader with identified responsibility for the wellbeing of all LCRN-funded staff **Assessment Approach:** ● Individual's name and contact details provided to the National CRN Coordinating Centre ● Implementation of a local action plan to support the CRN wide wellbeing framework		
7.3	**Domain:** Workforce, Learning and Organisational Development **Indicator:** Each LCRN has an active programme of activities that engage the wider workforce to promote health and social care research as an integral part of healthcare for all **Assessment Approach:** ● Evidence of a programme of learning opportunities provided in the LCRN Annual Plan and Report ● Increased engagement of local partners in promoting the work of the NIHR		
7.4	**Domain:** Workforce, Learning and Organisational Development **Indicator:** Each LCRN has in place a senior leader with identified responsibility for driving a culture of Continuous Improvement (Innovation and Improvement) supported by an action plan aligned to local and national initiatives and performance metrics **Assessment Approach:** ● Evidence of a programme of activities provided in the LCRN Annual Plan and Report ● Effective approaches shared by Continuous Improvement Leads at national meetings		

7.5	**Domain:** Workforce, Learning and Organisational Development **Indicator:** Each LCRN has in place a GCP Programme Lead, a suitably qualified individual responsible for strategic oversight of GCP education across their LCRN **Assessment Approach:** ● Individual's name and contact details provided to the National CRN Coordinating Centre ● Annual plan of appropriate face-to-face GCP training, suitably resourced using approved GCP Facilitators ● Review and monitoring of NIHR Learn metrics		
8.1	**Domain:** Business Development and Marketing **Indicator:** Each LCRN has an up to date business development and marketing Profile using the template provided by the National CRN Coordinating Centre **Assessment Approach:** ● Profile template submitted as part of LCRN Annual Plan ● Individual's name and contact details provided for assigned LCRN Profile lead in LCRN Annual Plan		
8.2	**Domain:** Business Development and Marketing **Indicator:** Each LCRN has an action plan for promoting the industry agenda aligned with the national business development strategy **Assessment Approach:** ● Review and monitoring of LCRN Annual Plan ● Review of outcomes as reported within LCRN Annual Report		
8.3	**Domain:** Business Development and Marketing **Indicator:** Each LCRN actively contributes to the intelligence gathering process from NIHR CRN Customers by actively engaging with the Business Development and Marketing team **Assessment Approach:** LCRN reports interactions with NIHR CRN Customers at the Life Sciences Industry Forum meetings		

Section 8: Financial Management

8.1	Please provide details of the plans that you anticipate impacting on the allocation of LCRN funding for 2019/20. (For example particular studies that require large investment, concentration on a particular Specialty)	There are currently no known studies or programmes of research that will have a significant impact on the LCRN allocation for 2019/20.
8.2	In respect of the LCRN 2019/20 **local** funding model, please complete the following table* by entering the proportion of LCRN funding (%) within the funding elements detailed. If there are any other elements to the model please describe what this is for and the proportion of funding allocated to this	
*Notes	1. It is assumed that the Local Funding Model is net of any National Top Slice as these are pass through costs	
	2. If the funding element category is not applicable to your Local Funding Model, please enter 0%	
	3. The percentages (%) entered in the table should equate to 100%	

Funding Element	**Examples**	**Description of model**	**% of Total CRN Funding Budget 2019/20 Budget (Please note that these should total 100%)**
Host Top sliced element	Core Leadership team, Host Support costs, LCRN Centralised Research Delivery team	Core Leadership team, Host Support costs, LCRN Centralised Research Delivery team	14.70%
Block Allocations	Primary care, Clinical support services (i.e. pharmacy)	Primary care, Clinical support services (i.e. pharmacy)	10.10%
Activity Based	Recruitment HLO 1, number of studies	Recruitment HLO 1, number of studies	58.00%
Historic allocations	PO funding previously agreed	PO funding previously agreed	0.80%
Performance Based	HLO performance, Green Shoots funding	HLO performance, Green Shoots funding	14.50%
Population Based	Adjustments for NHS population needs	Adjustments for NHS population needs	0.00%
Project Based	Study start up	Study start up	0.00%
Contingency / Strategic funds	Funds held centrally to meet emerging priorities during the year	Funds held centrally to meet emerging priorities during the year	1.80%
Other funding allocations			0.10%
Total			100.00%
Cap and Collar	Please provide your upper and lower limits if applicable	Please provide your upper and lower limits if applicable	6% CAP
			6% COLLAR
Comments			

8.3	If the 2019/20 local funding model methodology has changed since 2018/19, please give a brief description of the changes	The local funding model has been changed to include a performance incentivisation element. 70% allocated of the prior year's funding based on weighted recruitment in the period 1st January 2017 to 31st December 2018. 10% allocated of the in-year allocation based on performance against HLO1 5% allocated of the in-year allocation based on performance against HLO2A 5% allocated of the in year allocation based on performance against HLO2B The allocation of the remaining will be calculated using POs predicted recruitment values agreed and documented in 2019/20 business plans
8.4	Please confirm whether monitoring visits will be taking place over the course of 2019/20. If yes, please provide details of which Partner organisations will be covered and the rationale behind this decision. Please also indicate what proportion (by spend) of your Category A Partner organisations are being monitored	Please see 4.2.2 of key projects.
8.5	Please confirm how much is being spent on addressing disease prevalence; a minimum of 2% of budget is required. This should be highlighted as 'strategic funding' in the CRN Finance Tool	For 2019/20 a growth and development section has been added to partners business plans to identify the funding required to address local health priorities. These will considered under a competitive review via OMG and divisional leaders and ratified at the LCRN Executive Group.
8.6	What are the key financial risks and mitigations for 2019/20?	Filling & retaining all CRN Core posts during 2019-20. To mitigate this there will be monthly monitoring and allocate any CRN Core underspend at the end of each quarter.
8.7	In which financial year did your previous internal audit take place? Have all of the auditor's recommendations been implemented and, if not, when will they be implemented?	Internal Audit took place in 2018/19. All of the recommendations have now been implemented.
8.8	If the next internal audit is due in 2019/20, please give the estimated date of the audit	

Section 9: Appendices

Ref no	Title	Link
Annual Plan Appendices		
AP Appendix 1	Business Development and Marketing Profile **(Please update using Google Suggesting mode / Track-changes)**	https://docs.google.com/document/d/17eOEeAhIw8GBFz7tpBWOo2hAM3my2pAgBw22LwTVwyY/edit?usp=sharing
AP Appendix 2	Workforce Plan	https://docs.google.com/spreadsheets/d/1IJeHYOyAc3FA8Fu74NiIE4y5-zG_JrAhIBZb3DIHfB0/edit#gid=1081893024
AP Appendix 3	Risk and Issues Log	https://docs.google.com/spreadsheets/d/16bEgLs-ufYmrltQqPMBhuQptSuxsISpeBQ22KLedYHk/edit#gid=1070235198
AP Appendix 4	Cardiovascular Workforce Plan	https://docs.google.com/document/d/1xDsC0-BmgZNBHRqRCPNJfFZYSQCDTpW7Q3UNhTzP4fQ/edit
Please add additional appendices as needed		
Mid Year Progress Report Appendices		
MYPR Appendix 1	LCRN Fact Sheet	
MYPR Appendix 2	Risk and Issues Log	
Please add additional appendices as needed		
Annual Report Appendices		
AR Appendix 1	LCRN Fact Sheet	
AR Appendix 2	Finance section for the LCRN Fact Sheet	
AR Appendix 3	LCRN Category B Providers	
AR Appendix 4	Non-Supported Non-Commercial Studies	
Please add additional appendices as needed		

Section 10. Glossary

Abbreviation	Definition
AHSN	Academic Health Science Network
ALSPAC	Avon Longitudinal Study of Parents and Children
API	Application Programming Interface
APMP	Anaesthesia, Pain Management and Perioperative Medicine
BHOC	Bristol Haematology and Oncology Centre
BHP	Bristol Health Partners
BI	Business Intelligence
BIM	Business Intelligence Manager
BIU	Business Intelligence Unit
BRC	Biomedical Research Centre
CAMHS	Children and Adolescent Mental Health Services
CD	Clinical Director
CDL	Clinical Divisional Lead
CI	Chief Investigator
CLAHRC	Collaboration for Leadership in Applied Health Research and Care
CM	Communications Manager
COO	Chief Operating Officer
CCOP	Commercial Communities of Practice
COP	Communities of Practice
CPMS	Central Portfolio Management System
CRN	Clinical Research Network
CRNCC	Clinical Research Network Co-ordinating Centre
CRSL	Clinical Research Specialty Lead
DeNDRoN	Dementias and Neurodegeneration
ECR	Early Career Researcher
ENT	Ear, Nose and Throat
GCP	Good Clinical Practice
GDPR	General Data Protection Regulation
GRH	Gloucestershire Hospitals NHS Foundation Trust
GWH	Great Western Hospitals NHS Foundation Trust
HEI	Healthcare Environment Inspectorate
HLO	High Level Objective
HPRU	Health Protection Research Units
HRA	Health Research Authority
iCT	Interactive Costing Template
ICU	Intensive Care Unit
IG	Information Governance
IM&T	Information Management and Technology
IOM	Industry Operations Manager
IPL	Industry Performance Lead
JDR	Join Dementia Research
LCRN	Local Clinical Research Network
LPMS	Local Portfolio Management System
NC	Nurse Consultant

NIHR	National Institute of Health Research
NIHR CRN	National Institute of Health Research Clinical Research Network
NMAPS	Nurses Midwives and Allied Health Professionals
NSDA	National Study Delivery Assessment
NSG	National Specialty Group
ODP	Open Data Platform
PC	Primary Care
PC CCOP	Primary Care Commercial Communities of Practice
PC COP	Primary Care Communities of Practice
PF	Portfolio Facilitator
PHE	Public Health England
PHE SW: R&E	Public Health England South West: Research and Enterprise
PHWE	People in Health West of England
PI	Principle Investigator
PIC	Participant Identification Centre
PO	Partner Organisation
POF	Performance and Operating Framework
POMCTN	UK Perioperative Medicine Clinical Trials Network
PPIE	Patient, Public Involvement and Engagement
PRA	Patient Research Ambassadors
PRES	Patient Research Experience Survey
QI	Quality Improvement
R&D	Research and Development
RDM	Research Delivery Manager
RDS	Research Design Service
RN	Research Nurse
RSI	Research Site Initiatives
RTT	Recruitment to Time and Target
RUH	Royal United Hospital Bath NHS Foundation Trust
SLA	Service Level Agreement
SME	Small Medium Enterprise
SMT	Senior Management Team
SoECAT	Schedule of Events Cost Attribution Tool
SOP	Standard Operating Procedure
SPARCS	The Severn and Peninsula Audit and Research Collaborative for Surgeons, a trainee-led collaborative in the South West of En
SPF	Senior Portfolio Facilitator
SPHR	School for Public Health Research
SR-LCRN	Supra-Regional Local Clinical Research Network
SRA	Senior Research Assistant
SRDM	Senior Research Delivery Manager
SRO	Senior Research Officer
SSS	Study Support Service
STAR	Severn Trainee Anaesthetic Research
STI	Sexually Transmitted Infection
SWAG	Somerset, Wiltshire Avon & Gloucestershire Cancer Alliance
SWASFT	South Western Ambulance Service NHS Foundation Trust (SWASFT)

TYA	Teenagers and Young Adults
WFD	Workforce Development

Meeting of the Private Board on 30 July 2019 in the Conference Room, Trust Headquarters

Report Title	**Self-Assessment of Board Cycle**
Report Author	**Sophie Melton Bradley, Head of Corporate Governance**
Executive Lead	**Eric Sanders, Trust Secretary**

1. Report Summary

As part of its governance processes, the Board of Directors has the opportunity to review its own Annual Business Cycle on a regular basis (at least annually).

The draft Annual Business Cycle for the upcoming year (September 2019 – August 2020) is therefore provided for comment and approval by the Board of Directors.

2. Key points to note
(Including decisions taken)

In reviewing the Annual Business Cycle 2019-20, the Board may wish to reflect on the following:

- Will the identified business items help provide assurance to the Board? Are there any critical 'gaps' from the Board's point of view?
- Will these business items provide the Board with assurance as to (1) the effective management of the organisation, and (2) the implementation of the strategic plan?
- Do the identified business items effectively cover the identified strategic risks to the organisation's management and implementation of the strategic plan?

3. Risks

There is risk to the effective governance if the Board's business cycle is not robust, relevant and enables the Board to fulfil its governance function effectively.

4. Advice and Recommendations
(Support and Board/Committee decisions requested):

- This report is for **APPROVAL**.
- The Board is asked to **DISCUSS AND APPROVE** the Annual Board Business Cycle 2019/19.

5. History of the paper
Please include details of where paper has previously been received.

Executive Directors Meeting	26 June 2019

BOARD OF DIRECTORS
ANNUAL BUSINESS CYCLE - PUBLIC BOARD - 2019/20

	Sponsor	Author	September	October - Private Only	November	(December - No meetings)	Jan	February - Private Only	March	April - Private Only	May	June- Private Only	July	(August - No meetings)
Board Administration														
Preliminary Business														
Apologies for absence	Verbal						Verbal							
Declarations of interest	Verbal						Verbal							
Patient Story	Chief Nurse	Head of Quality (Patient Experience)												
Staff Story	Director of People	Var.												
Minutes of the last meeting	Chair	Trust Secretary												
Matters arising and action log	Chair	Trust Secretary												
Chief Executive's Report	Chief Executive	Chief Executive												
Corporate Risk Register	Chief Executive	Head of Risk Management			Q2		Q3				Q4		Q1	
Board Assurance Framework - Strategic Risk Register - Corporate Objectives Update	Chief Executive Director of Strategy and Transformation	Head of Risk Management Director of Strategy and Transformation			Q2		Q3				Q4		Q1	
Operational Performance and Oversight														
Patient Care and Clinical Outcomes														
Quality and Performance Report	Deputy Chief Executive and Chief Operating Officer; Chief Nurse; Director of People; Medical Director													
Quality and Outcomes Committee - Chair's Report	Chair of the Quality and Outcomes Committee	Trust Secretary												
Quarterly Patient Experience Report (& Annual)	Chief Nurse FOR INFORMATION Only	Head of Quality (Clinical Effectiveness & Patient Experience)	Q1				Q2		Q3				Q4	
Quarterly Patient Complaints Reports	Chief Nurse FOR INFORMATION Only	Head of Quality (Clinical Effectiveness & Patient Experience)	Q1				Q2		Q3				Q4/Annual Report	
Six-Monthly Nurse Staffing Report	Chief Nurse	Chief Nurse												
Learning from Deaths Report	Medical Director	Deputy Medical Director	Q1				Q2		Q3				Q4	
Safeguarding Annual Report	Chief Nurse	Nurse Consultant Safeguarding											Annual Report	
Safe Working Hours Guardian Report	Medical Director	Safe Working Hours Guardian									6-monthly-update		Annual Report	
Seven Day Services Self- Assessment	Medical Director	Clinical Audit and Effectiveness Manager						6-monthly update				Update		
Annual Quality Report and External Auditors Assurance	Chief Nurse	Head of Quality (Clinical Effectiveness & Patient Experience)												
Workforce														
Equality and Diversity Annual Report	Director of People	Deputy Director of People												
National Staff Survey Results	Director of People	Deputy Director of People												
Medical Revalidation	Medical Director	Consultant Anaesthetist												
Diversity and Inclusion Report	Director of People	Head of organisational Development												
Freedom to Speak Up Annual Report	Trust Secretary	Trust Secretary									**Annual Report**			
Education Performance Report	Director of People	Head of Education											Annual Report	
Research, Innovation and Education (inc. Learning and Development)														
Research and Innovation Report	Medical Director	Director of R&D			Six monthly						Six monthly			
Strategic Performance and Oversight														
Strategy and Transformation														
Healthier Together Sustainability and Transformation Partnership	Chief Executive	Chief Executive												
WAHT Partnership	Chief Executive	Director of Projects to Chief Executive Office												
Transforming Care Programme Board Report	Director of Strategy and Transformation	Transformation Programme Director	Q2				Q3				Q4		Q1	
Sustainability Strategy	Director of Strategy and Transformation	Director of Strategy and Transformation												
Operational Plan: - Approval of 19/20 Plan (with sub-item on Going Concern)	Director of Strategy and Transformation	Associate Director of Strategy & Business Planning							Approval - 19/20				Q1	
Strategic Capital Update	Director of Strategy and Transformation and Director of Finance and Information	Director of Strategy and Transformation and Director of Finance and Information												
Financial Performance														
Approval of the 19/20 Budget	Director of Finance and Information	Deputy Director of Finance							Approval - 19/20					
Finance Report	Director of Finance and Information	Deputy Director of Finance												
Finance Committee Chair's Report	Chair of Finance Committee	Trust Secretary												
Annual Report and Accounts	Chief Executive and Director of Finance and Information	Deputy Director of Finance												
Capital Investment Policy	Director of Strategy and Transformation	Associate Director of Finance												
Treasury Management Policy	Director of Finance and Information	Associate Director of Finance												
Accounting Policies Update	Director of Finance and Information	Deputy Director of Finance												
Standing Financial Instructions – Review	Director of Finance and Information	Deputy Director of Finance					Approval							
Financial Resources Book	Director of Finance and Information	Deputy Director of Finance												
Board Administration														
Governance														
Annual Review Codes of Conduct for the Board and Council of Governors (including Fit and Proper Persons Test)	Trust Secretary	Deputy Trust Secretary												
Annual Review of Directors Interests	Trust Secretary	Deputy Trust Secretary												
Review of Finance Committee Terms of Reference	Trust Secretary	Trust Secretary												
Review of Audit Committee Terms of Reference	Trust Secretary	Deputy Trust Secretary												
Review of Quality and Outcomes Committee Terms of Reference	Trust Secretary	Deputy Trust Secretary												
Review of Remuneration and Nomination Committee Terms of Reference	Trust Secretary	Deputy Trust Secretary												
Annual Review of the Constitution	Chief Executive	Trust Secretary												
Annual Review of Risk Management Strategy and Policy	Chief Executive	Trust Secretary												
Emergency Preparedness Annual Report	Deputy Chief Executive and Chief Operating Officer	Deputy Chief Operating Officer												
Register of Seals	Trust Secretary	Deputy Trust Secretary			Q2		Q3				Q4		Q1	
Corporate Governance Statement Self Assessment Certification	Chief Executive	Trust Secretary												
NHS I Self-Certification (against G6)	Chief Executive	Trust Secretary												
Audit Committee Chair's Report	Chair Audit Committee	Trust Secretary												
Annual Review of SFIs	Director of Finance and Information	Deputy Director of Finance												
BRCH annual report	Chief Nurse	Divisional Director W&C												
NIHR CRN Annual Plan and Annual Report (hosted body report)	Medical Director	Network Manager												
CHD Network Annual Report (hosted body report)	Medical Director	Network Manager												
Governors' Log of Communications	Chair	Trust Secretary												
Self Assessment of Board Cycle	Trust Secretary	Trust Secretary												
Concluding business														
Any other urgent business	Chair						Verbal			Verbal				
Date of next meeting	n/a						Verbal			Verbal				

	Private Meeting
	Public Meeting
	Both

University Hospitals Bristol NHS Foundation Trust

Meeting of the Board of Directors in Public on Tuesday 30 July 2019 in the Conference Room, Trust Headquarters

Report Title	**Reimbursement of Expenses for the Council of Governors Policy**
Report Author	**Kate Hanlon, Membership and Engagement Manager**
Executive Lead	**Eric Sanders, Trust Secretary**

1. Report Summary

The Governors' Expenses Policy, which outlines the criteria for the submission of governor expenses and the process for claiming and repayment, was reviewed and approved in September 2018.

Following an HMRC PAYE inspection in May 2019, the Trust has reviewed a number of areas. The Trust mileage rate paid to governors (£0.56p per mile) is above the tax threshold (£0.45p per mile). Employed staff claims are paid through the payroll and the excess value subject to tax is automatically deducted as the taxable rate of pay can be identified. This facility is not available for governors who are not employees of the Trust and not subject to PAYE. Therefore the standard mileage rate has been reduced to the HMRC maximum tax exempt level of £0.45 per mile.

The policy has been changed to reflect the revised standard mileage rate, all other rates offered by the Trust do not exceed HMRC values and remain the same.

2. Key points to note
(Including decisions taken)

The standard mileage rate governors can claim through expenses has been reduced to the HMRC maximum tax exempt level of £0.45 per mile.

3. Risks
If this risk is on a formal risk register, please provide the risk ID/number.

None

4. Advice and Recommendations
(Support and Board/Committee decisions requested):

- This report is for **APPROVAL**.
- The Board is asked to **APPROVE** the report.

5. History of the paper
Please include details of where paper has previously been received.

N/A

Respecting everyone
Embracing change
Recognising success
Working together
Our hospitals.

University Hospitals Bristol NHS Foundation Trust

Reimbursement of Expenses for the Council of Governors Policy

Document Data			
Document Type:	Policy		
Document Reference	22188		
Document Status:	Draft		
Document Owner:	Trust Secretary		
Executive Lead:	Chief Operating Officer		
Approval Authority:	Trust Board of Directors		
Review Cycle:	36		
Date Version Effective From:	30 July 2019	**Date Version Effective To:**	29 July 2022

What is in this policy?
This policy sets out the circumstances under which governors of University Hospitals Bristol NHS Foundation Trust (the Trust) may be reimbursed for travel and other expenses as a result of carrying out pre-agreed governor duties.

Document Change Control				
Date of Version	**Version Number**	**Lead for Revisions (Job title only)**	**Type of Revision**	**Description of Revision**
Aug 2015	1.0	Trust Secretary	Major	First draft
Aug 2018	2.0	Trust Secretary	Minor	Review of policy, amendment of expenses rate, input into updated template
July 2019	3.0	Trust Secretary	Minor	Change to standard mileage rate in line with HMRC guidance

Table of Contents

1. Introduction

As a Foundation Trust, University Hospitals Bristol is accountable to the public, patients and staff members through the elected and appointed governors on the Council of Governors. The roles and responsibilities of a governor require the governors to communicate with their constituencies and attend meetings (as agreed through the Membership Office). This ensures that the public, patient and staff members are engaged in planning, delivering and improving NHS services.

2. Purpose

The post of governor of a Foundation Trust is voluntary, and it is a fundamental principle that no governor shall receive any form of salary or remuneration for being a governor, however reasonable expenses should be covered to ensure governors are not out of pocket.

The Trust's Constitution makes the provision for reimbursement of expenses to members of the Council of Governors.[1]

In line with principles of transparency for good governance, the Trust, along with other NHS Foundation Trusts, is required to publish expenses paid to governors in its Annual Report.

3. Scope

This document applies to all governors. The Trust will reimburse governors for reasonable travel and other expenses incurred through participation in pre-agreed governor activities.

4. Duties, Roles and Responsibilities

4.1 Governors

(a) It is the responsibility of each individual governor to ensure value for money when incurring expenses, taking into account both cost and convenience. If there is any doubt then governors must seek prior approval from the Trust Secretary before committing expenditure. Governors should agree with the Trust Secretary the general nature and level of expenditure to be incurred prior to the expenses being incurred. Failure to do so may result in reimbursement being withheld.

(b) It is the responsibility of governors to ensure that correct claims are made.

(c) If a governor is receiving State Benefits, it is their responsibility to check with their local government agency whether the receipt of any expenses might affect their entitlements.

(d) Governors should make their claim for reimbursement of expenses promptly; ideally within four weeks of incurring, and this should be done within three months of the expense being incurred.

(e) All governors should complete a BACs form so that reimbursements can be paid electronically directly into a governor's bank account.

[1] The Trust Constitution is available at the following link: http://www.uhbristol.nhs.uk/about-us/key-publications/

4.2 Membership Office

(a) It is the responsibility of the Membership Office to circulate the policy to all governors, including the claim form and BACS form, and to process expense claims promptly.

4.3 Trust Secretary

(a) It is the responsibility of the Trust Secretary to approve travelling and subsistence expenses incurred by a governor while attending any *external* meetings, seminars and events on behalf of the Trust in his/her capacity as a governor. Any expenses relating to caring should be discussed and agreed with the Trust Secretary before any commitments are made.

5. Policy Statement and Provisions

5.1 Reimbursement of expenses

Expenses will be reimbursed for the following activities:

a) Travelling expenses incurred by a governor while attending meetings, seminars and events organised by the Trust;

b) Travelling and subsistence expenses incurred by a governor while attending external meetings, seminars and events at the request of or on behalf of the Trust in his/her capacity as a Governor. Expenses of this type must be approved in advance by the Trust Secretary and, if necessary, can be arranged by the Membership Office through current Trust travel booking/accommodation mechanisms.

Any expenses other than vehicle mileage must be supported by valid receipts. Failure to produce such receipts may result in reimbursement being withheld. Any expenses outside of the above must be agreed with the Trust Secretary.

In line with Bristol City Council and the Trust's commitment to encouraging greener travel, the general expectation is that governors will use public transport to carry out their duties e.g. standard class rail return, bus and coach. However, if it is necessary to use a vehicle, mileage may be claimed as set out in Appendix E. Please note that where vehicle use applies, the Trust will pay mileage and reasonable parking costs only.

In extreme circumstances (for example, due to physical disability/medical reasons/late evening meetings in circumstances when personal safety may be compromised), reimbursement may be considered for reasonable taxi fares and agreed in advance by the Trust. Where this is the case the claimant may be required to provide documentary evidence to support such a request, for example a doctor's letter to confirm they are unable to use public transport or walk the required distance.

If a governor meeting or event takes place over a lunchtime appropriate provision of food and drink will be made.

Subsistence allowance, where the governor is away from their home for longer than five hours for the purpose of attending a designated meeting and where no refreshment is provided at the Trust's expense, or provided at the venue, will be paid up to a maximum of £5 per person per meeting.

The Trust will also reimburse governors for any reasonable carer costs incurred during the course of carrying out their role. Any cost relating to caring should be discussed and agreed with the Trust Secretary before any commitments are made.

The Trust will aim to provide the governors with hard copies of meeting papers where required, however, on occasions where this does not happen, the Trust will reimburse governors for "out of pocket expenses" for personal office equipment disposables and stationery up to a maximum of £50.00 per year.

5.2 Reimbursement process

Any persons claiming for travel costs must do so using the appropriate expenses claim form (see Appendix F). All governors are encouraged to submit the form electronically to the Membership Office. Receipts must be provided for any travel, carer and other expenses (with the exception of vehicle mileage).

If vehicle mileage is being claimed, the return mileage will be calculated for the actual journey undertaken but will not exceed that from the post code of the governors home address to the venue. This ensures that the Trust does not pay inappropriate mileage, for example in the event that a claimant travels from outside of the local area to a Trust event as a result of commitments unrelated to the Trust.

Reimbursed expenses should be for the exact amount claimed; not for a rounded-up or average amount.

Reimbursement will normally be paid electronically directly into a governor's bank account. This is the quickest and most secure form of payment. All governors should complete a BACs form, see Appendix G, and submit the completed form to the Membership Office. If any governor seeks an alternative payment method then they should speak to the Membership Office.

6. Appendix A – Monitoring Table for this Policy

The following table sets out the monitoring provisions associated with this Policy.

Objective	Evidence	Method	Frequency	Responsible	Committee
All governors receive a copy of this policy, claims form and BACS form	Email or hard copy of policy to all governors		On induction, and after any approved changes to the policy	Membership Office	Council of Governors
Expenses forms are processed by the Membership Office	Expenses recorded on governor database	Expense claims checked and signed off by Membership Manager before being sent on to Finance Department	As received	Membership Office	Council of Governors
Finance Department reimburses expenses	Claims recorded on monthly membership budget		As received	Finance Department	Council of Governors

7. Appendix B – 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:	Trust Secretary
Is this document: A – replacing an expired policy, B – replacing an alternative policy, C – a new policy:	A
Alternative documentation this policy will replace (if applicable):	[DITP - Existing documents to be replaced by]
This document is to be disseminated to:	Council of Governors
Method of dissemination:	By email, and hard copy where required
Is Training required:	No
The Training Lead is:	[DITP - Training Lead Title]

Additional Comments
[DITP - Additional Comments]

8. Appendix C – Document Checklist

Checklist Subject	Checklist Requirement	Document Owner's Confirmation
Title	The title is clear and unambiguous:	Yes
	The document type is correct	Yes
Content	The document uses the approved template:	Yes
	The document contains data protected by any legislation	No
	All terms used are explained in the 'Definitions' section:	Yes
	Acronyms are kept to the minimum possible:	Yes
	The 'target group' is clear and unambiguous:	Yes
	The 'purpose and scope' of the document is clear:	Yes
Document Owner	The 'Document Owner' is identified:	Yes
Consultation	Consultation with stakeholders (including Staff-side) can be evidenced where appropriate:	Not Applicable
	The following were consulted	Not Applicable
	Suitable 'expert advice' has been sought where necessary:	Not Applicable
Evidence Base	References are cited:	Yes
Trust Objectives	The document relates to the following Strategic or Corporate Objectives:	[DCL - Trust Objectives]
Equality	The appropriate 'Equality Impact Assessment' or 'Equality Impact Screen' has been conducted for this document:	[DCL - Equality Impact Assessment completed]
Monitoring	Monitoring provisions are defined:	Yes
	There is an audit plan to assess compliance with the provisions set out in this procedural document:	Yes
	The frequency of reviews, and the next review date are appropriate for this procedural document:	Yes
Approval	The correct 'Approval Authority' has been selected for this procedural document:	Yes

9. Appendix D - Equality Impact Assessment (EIA) Screening Tool

Query	Response
What is the main purpose of the document?	This policy sets out the circumstances under which governors of University Hospitals Bristol NHS Foundation Trust (the Trust) may be reimbursed for travel and other expenses as a result of carrying out pre-agreed governor duties.
Who is the target audience of the document (which staff groups)? Who is it likely to impact on? (Please tick all that apply.)	Add ☑ or ☒ Staff Patients Visitors Carers Others ☑ Governors

Could the document have a significant **negative** impact on equality in relation to each of these characteristics?		NO	Please explain why, and what evidence supports this assessment.
Age (including younger and older people)		X	
Disability (including physical and sensory impairments, learning disabilities, mental health)		X	
Gender reassignment		X	
Pregnancy and maternity		X	
Race (includes ethnicity as well as gypsy travelers)		X	
Religion and belief (includes non-belief)		X	
Sex (male and female)		X	
Sexual Orientation (lesbian, gay, bisexual, other)		X	
Groups at risk of stigma or social exclusion (e.g. offenders, homeless people)		X	
Human Rights (particularly rights to privacy, dignity, liberty and non-degrading treatment)		X	

Will the document create any problems or barriers to any community or group? NO

Will any group be excluded because of this document? NO

Will the document result in discrimination against any group? NO

If the answer to any of these questions is YES, you must complete a full Equality Impact Assessment.

Could the document have a significant **positive** impact on inclusion by reducing inequalities?	YES		If yes, please explain why, and what evidence supports this assessment.
Will it promote equal opportunities for	X		

people from all groups?			
Will it help to get rid of discrimination?	X		
Will it help to get rid of harassment?	X		
Will it promote good relations between people from all groups?	X		
Will it promote and protect human rights?	X		

On the basis of the information / evidence so far, do you believe that the document will have a positive or negative impact on equality? (Please rate by circling the level of impact, below.)

Positive impact				Negative Impact		
Significant	Some	Very Little	NONE	Very Little	Some	Significant

Is a full equality impact assessment required? NO

Date assessment completed: 15 July 2019

Person completing the assessment: Kate Hanlon, Membership Manager

10. Appendix E - Governor Mileage Allowances

These mileage allowances are consistent with the HMRC maximum tax exempt level.

Type of vehicle/allowance	Mileage allowance
Car (all types of fuel) up to 10,000 miles	45p per mile
Motor cycle	24p per mile
Pedal cycle	20p per mile
Passenger allowance	5p per mile (tax-free)

11. Appendix F – Governor Expenses

University Hospitals Bristol NHS Foundation Trust

Please note: Receipts must be provided for public transport fares (bus, coach, train, taxi, etc.) and should be attached to this form. If you are unable to obtain a car parking receipt, please note details i.e. where you parked.

Name: _____ **Mileage allowance (see back for allowance)**: _____

Date	Description *(what was the title of the meeting etc. you attended? Or include other items i.e. stationery)*	Location *(where was meeting held)*	Travel details *(how did you travel i.e. car, bus, cycle, taxi etc. Include other i.e. car parking)*	Number of car miles *(if applicable)*	Costs £	p
				TOTAL		

PTO

Type of vehicle/allowance	Annual mileage up to 10,000 miles (standard rate)	All eligible miles travelled
Car (all types of fuel)	45 pence per mile	
Motor cycle		24 pence per mile
Pedal cycle		20 pence per mile
Passenger allowance		5 pence per mile

I declare that:

a) The travelling expenses and allowances are in accordance with the appropriate regulations and are in connection with official visits to places indicated on the date(s) shown.
b) The details shown match the vehicle used in respect of this claim.
c) Where a claim for mileage is made:
   - A valid third party insurance policy (including cover against risk of injury to, or death of passengers and damage to property in respect of the vehicle) was held for the period of the claim.
   - This policy will continue to be maintained while the vehicle is used by me on official duties and will cover the use of the vehicle in official business.
d) No other claim has been made or will be made by me on any public body for expenses or allowances in connection with the business stated.

Signature of claimant: _____ Date: _____

Address of claimant including post code: _____

_____

Authorised by Membership Manager: _____ Cost centre: 150227 Acct code: 30216

This form to be emailed, posted or handed to the Membership Office for reimbursement.

12. Appendix G – BACS Form

Expenses for Governors

BACS FORM

Finance Department
Creditor Payments
Trust Headquarters
Marlborough Street
PO Box 1053
Bristol BS99 1YF
Email: Ann.Clark@uhbristol.nhs.uk

Full Name :	
Payee Name if Different to Above :	
Postal Address :	
Tel number :	
Email address :	

Bank Name :	
Bank Branch :	
Bank Address :	
Bank Sort Code	
Bank Account Number :	
Building Society Number :	

Meeting of the Board of Directors in Public on Tuesday 30 July 2019 in the Conference Room, Trust Headquarters

Report Title	**Governors Log of Communications**
Report Author	**Kate Hanlon, Membership Engagement Manager**
Executive Lead	**Eric Sanders, Trust Secretary**

1. Report Summary

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.

2. Key points to note
(Including decisions taken)

- Since the last Board meeting three new questions have been added to the log. Two have been answered and closed, one is waiting for a response from the Executive Lead.
- Two questions which were awaiting a response in May have been answered and closed.

3. Risks
If this risk is on a formal risk register, please provide the risk ID/number.

None

4. Advice and Recommendations
(Support and Board/Committee decisions requested):

- This report is for **INFORMATION**.
- The Board is asked to **NOTE** the report.

Governors' Log of Communications

22 July 2019

ID	Governor Name		
226	Garry Williams	***Theme:*** Plastic waste	***Source:*** From Constituency/ Members

Query **16/07/2019**

What is the Trust doing about plastic pollution – is it proactively reducing and reusing, or recycling? Is the Trust prudent in its use of natural resources to lessen its impact on our environment?

Division: Trust-wide ***Executive Lead:*** *Director of Strategy and Transformation* ***Response requested:*** 30/07/2019

Response

Status: *Assigned to Executive Lead*

ID	Governor Name		
225	John Rose	***Theme:*** Follow up appointments	***Source:*** Project Focus Group

Query **17/06/2019**

What techniques will the Trust apply to achieve its intention to reduce the number of follow up appointments across the local health system as stated in the May 2019 Quality and Performance Report (Access Opportunities)?

Division: Trust Services ***Executive Lead:*** *Chief Operating Officer* ***Response requested:*** 01/07/2019

Response **28/06/2019**

Through the Outpatient Steering Group the Trust will be working within the Divisions and with North Bristol and Weston Area Health Trusts to reduce the number of follow-ups across the system in the following ways:

- Non face to face - work has commenced to run proof of concept trials during quarters 3 and 4 of 19/20 looking at non face to face alternatives for follow-ups, this will include virtual clinics or telemedicine (where the patients results are reviewed and a decision made by a consultant/Nurse/AHP if the patient requires a face to face appointment and if not what if any treatment is required), virtual clinics (where the patient sees the clinician via a video link, this could either be with the patient at an outlying clinic or at home) and telephone clinics. We are also exploring the increased use of nurse led group clinics, education days for patients and use of electronic systems to enable share care between the GP and the consultant.
- Follow-up reduction – the Trust is working with North Bristol Trust, Weston Area Health Trust and BNSSG CCG to review new to follow-up ratios and identify services where there may be opportunity to benchmark against other Trusts whose performance may be better. The three largest areas of opportunity identified so far are Ophthalmology, Haematology and Trauma and Orthopaedics. It is hoped to review patient pathways across all three Trusts and community providers to reduce the overall number of follow-ups required by utilising innovative alternatives as well as improving efficiency and giving patients greater access to healthcare as and when they need it, through the use of patient initiated follow-up.
- Real time outpatients – the Trust launched the real time outpatients project in October 2018, the aim of the project is to allow all of the administrative tasks relating to a patient's clinic appointment to take place on the day of the visit. This means that patients will leave the clinic knowing what the next step in their treatment is, and when that will take place. It will reduce significantly waste within the system by shortening the turnaround time for clinic letter production, enabling diagnostics, follow- up and 'to come in' (TCI) dates to be booked in a more timely manner. Finally, it will enable the appointment outcome, next steps on the patient pathway, and discharge (if applicable) to be confirmed as correct, known as validation in real time. It is hoped that this will reduce the number of follow-ups that were felt to be unhelpful due to results not being available etc.

Status: *Closed*

ID	Governor Name		
224	Carole Dacombe	***Theme:*** Parking at South Bristol Community Hospital	***Source:*** From Constituency/ Members

Query **21/05/2019**

We understand that members of the public have been experiencing some significant and distressing problems related to car parking charges at South Bristol Community Hospital.

Due to difficulties with non-functioning payment machines (operated by ParkingEye) people have been forced to leave the car park without paying and have then received letters demanding excess charge payments with no opportunity to simply pay the expected original fee.

We wish to seek assurance that this matter is being dealt with urgently by the Trust in order to offer both short-term advice for people attending the hospital site AND a sustainable system for payment of car parking charges moving forward

Division: Trust Services ***Executive Lead:*** *Chief Operating Officer* ***Response requested:*** 04/06/2019

Response **22/05/2019**

The parking meters at South Bristol Community Hospital were all changed on 15 April 2019 to ANPR (Automatic Number Plate Recognition) machines that charge for the time used – and the machines indicate the exact amount to be paid on exit. We are monitoring for any new complaints since they were installed and have none to date. We have worked with ParkingEye to rescind all Parking Charge Notices issued prior to the change of payment machines.

Status: *Closed*

ID	Governor Name		
223	Mo Phillips	***Theme:*** Employment Conditions for Bank staff	***Source:*** From Constituency/ Members

Query **03/05/2019**

A Foundation Trust member has raised a question in the light of a recent visit to hospital. The member was told that a nursing assistant didn't receive holiday pay or sick pay even though they had worked full time on the bank for some years. Given the central role played by bank staff in caring for our patients, we would welcome clarification of the terms of employment of bank staff and their entitlement to any benefits.

Division: Trust-wide ***Executive Lead:*** *Director of People* ***Response requested:*** 17/05/2019

Response **22/05/2019**

Given the nature of a zero hours contracts bank only staff do not get paid when they are off sick. However, they have holiday pay through an additional 12.07% in their basic salary, which is standard industry practice for the management of zero hour workers. Should bank staff want the full benefits of a substantive member of staff then they can of course apply for a substantive role. Although our vacancy rate is significantly lower than most Trusts we still have significant turnover and it is usually a matter of preference whether the individual works as bank staff or substantively. Some zero hours contracts in other industries have unfortunately developed a negative reputation because of the way a minority of organisation have favoured them over substantive contracts in a way that disadvantages staff but, when deployed properly alongside a choice of substantive employment, they offer a desirable flexible working option for many people.

Status: *Closed*

ID	Governor Name		
222	Jane Sansom	***Theme:*** Rota Gaps	***Source:*** Governor Direct

Query **03/05/2019**

The consultant physicians are very concerned about rota gaps amongst junior and middle grade staff as a result of current staffing levels, which may worsen in August. How is the Trust Executive supporting the Division of Medicine to resolve these issues to minimise the impact on patient safety and flow as well as staff morale and wellbeing?

Division: Medicine ***Executive Lead:*** *Director of People* ***Response requested:*** 17/05/2019

Response **11/07/2019**

This is a major area of focus for the Trust. While UH Bristol actually has one of the best fill rates for junior doctors in the region we do not receive sufficient numbers of junior doctors to fill the rotas. This situation has become steadily worse and is not likely to get better for some years. Unfortunately, the supply of junior doctors is not within our control. However, we have been exploring alternative workforce models and new and advanced roles, which can reduce the dependency on junior doctors. We have recently approved the recruitment of six Physicians Associates for Medicine. If this initiative is successful, we plan to increase the number of Physicians Associates further. We already have a number of Advanced Clinical Practitioners (ACPs) in the Trust. This role requires considerable investment in terms of developing the ACPs but the evidence indicates significant long-term benefits and we are developing a case for potential investment in ACPs. We are also believe there are opportunities to increase the efficiency within our rotas and we are currently implementing e-rostering to support this. It is worth noting that we have recently agreed with the consultant body that we will set up a programme of activity where we work closely with consultant representatives to explore other avenues for resolving the issues.

Status: *Closed*