Public Trust Board Meeting Papers

Date: Thursday 30 January 2020

Time: 11.00 – 13.00

Venue: Conference Room, Trust Headquarters

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

Board of Directors (in Public)

Meeting of the Board of Directors to be held in Public on
Thursday 30 January 2020, 11.00 – 13.00
Conference Room, Trust HQ, Marlborough St, Bristol, BS1 3NU
AGENDA

NO.	AGENDA ITEM	PURPOSE	SPONSOR	TIMINGS
Preliminary Business				
1.	Apologies for Absence – *Verbal update*	Information	Chair	
2.	Declarations of Interest – *Verbal update*	Information	Chair	
3.	What Matters to Me – a Patient Story	Information	Chief Executive	11.00
4.	Minutes of the Last Meeting • **28 November 2019**	Approval	Chair	11.15
5.	Matters Arising and Action Log	Approval	Chair	11.17
6.	Chief Executive's Report	Information	Chief Executive	11.25
Strategic				
7.	WRES Data Review	Assurance	Director of People	11.35
8.	Board Assurance Framework a) Strategic Risk Register - Q3 Update b) Corporate Objectives – Q3 Update	Assurance	Chief Executive	11.45
9.	WAHT Partnership Update	Assurance	Chief Executive	11.55
10.	Strategic Capital Update	Assurance	Director of Strategy and Transformation	12.10
11.	Strategic Outline Case for the West of England Pathology Network	Approval	Medical Director	12.15
12.	Transforming Care Programme– Q3 Update	Assurance	Director of Strategy and Transformation	12.20
13.	Healthier Together Sustainability and Transformation Partnership	Information	Chief Executive	
Quality and Performance				
14.	Committee Chair's Reports	Assurance	Chairs of the Committees	12.25

NO.	AGENDA ITEM	PURPOSE	SPONSOR	TIMINGS
	• Quality and Outcomes • People • Finance • Audit			*To follow*
15.	Quality and Performance Report	Assurance	Deputy Chief Executive and Chief Operating Officer, Chief Nurse, Medical Director, Director of People	12.35
16.	Finance Report	Assurance	Director of Finance and Information	12.40
17.	Learning from Deaths Report – Q3 Update	Assurance	Medical Director	12.45
18.	Safe Working Hours Guardian Report	Assurance	Medical Director	12.50
19.	Patient Experience Report – Q2 Update	Information	Chief Nurse	
20.	Patient Complaints Reports – Q2 Update	Information	Chief Nurse	
Governance				
21.	Accounting Policies Update	Approval	Director of Finance and Information	13.00
22.	Remunerations, Nominations and Appointments Committee Terms of Reference	Approval	Director of Corporate Governance	13.05
23.	Register of Seals – Q3 Update	Information	Director of Corporate Governance	
24.	Governors' Log of Communications	Information	Chair	
Concluding Business				
25.	Any Other Urgent Business – *Verbal Update*	Information	Chair	
26.	Date and time of next meeting • **30 March 2020**	Information	Chair	

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3

Meeting of the Board of Directors in Public on Thursday 30 January 2020

Report Title	**What Matters to Me – a 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.

2. Key points to note
(Including decisions taken)

Mr Bhadresa will be attending Trust Board. By request, no further details are available.

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.**

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

N/A

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

Thursday 28 November 2019 at 11:00 – 13:00, Conference Room, Trust Headquarters, Marlborough Street, Bristol, BS1 3NU

Present (Members of the Board):

Name	Job Title/Position
Jeff Farrar	Chair of the Board
Robert Woolley	Chief Executive
David Armstrong	Non-Executive Director
Sue Balcombe	Non-Executive Director (Designate)
Madhu Bhabuta	Non-Executive Director (Designate)
Paula Clarke	Director of Strategy and Transformation
Julian Dennis	Non-Executive Director
Bernard Galton	Non-Executive Director
Matt Joint	Director of People
Neil Kemsley	Director of Finance and Information
Jayne Mee	Non-Executive Director
Carolyn Mills	Chief Nurse
John Moore	Non-Executive Director
William Oldfield	Medical Director
Guy Orpen	Non-Executive Director
Mark Smith	Deputy Chief Executive and Chief Operating Officer
Martin Sykes	Non-Executive Director

In Attendance:

Name	Job Title/Position
Eric Sanders	Director of Corporate Governance
Mark Pender	Head of Corporate Governance
John Kirk	Communications Manager
Alun	Patient (for Item 3 – Patient Story)
Tony Watkin	Patient and Public Involvement Lead (for Item 3)
Mark Stevens	Assistant General Manager, Bristol Eye Hospital (for Item 3)
Samantha Burgess	Matron, Bristol Eye Hospital
Paul Kearney	Chief Executive, Above and Beyond
Sarah Walter	Regional Lead, NHS Confederation
Dave Tyas	NHS Professionals
John Sibley	Public Governor
John Rose	Public Governor
Kathy Baxter	Public Governor
Ray Phipps	Public Governor
Rhona Thomas	Member of staff (Joint Union Committee Chair)
Benjamin La Fevre	Member of staff (Higher Specialist Scientist Training student)

Elliott Warren	Member of staff (Higher Specialist Scientist Training student)
Tasmin Sharley	Member of staff (Higher Specialist Scientist Training student)
Ying Li	Member of the public (Higher Specialist Scientist Training student)
Helen Leveret	Member of the public (Patients Not Passports)
Jamie Leveret	Member of the public (Patients Not Passports)
Barbara Needham	Member of the public (Patients Not Passports)
Clive Hamilton	Member of the public
Seamus Daley-Dee	Member of the public
Barbara Bradbury	Member of the public

4

Minutes: Sarah Murch: Membership and Governance Administrator

The Chair opened the Meeting at 11:05

Minute Ref	Item Number	Action
Preliminary Business		
01/11/2019	**1. Welcome and Introductions/Apologies for Absence**	
	The Chair, Jeff Farrar, welcomed everyone to the meeting. Apologies were received from Steve West, Non-Executive Director.	
02/11/2019	**2. Declarations of Interest**	
	Members of the Board noted the following interests: • Since 1 September, Jeff Farrar and Robert Woolley also held the respective roles of Chair and Chief Executive at Weston Area Health NHS Trust (WAHT) as well as UH Bristol. • Sue Balcombe, Non-Executive Director (Designate) at UH Bristol, was also a Non-Executive Director at WAHT. • Guy Orpen Non-Executive Director, held a senior position at the University of Bristol. • Madhu Bhabuta, Non-Executive Director (Designate), was a lay trustee at the University of Bristol.	
03/11/2019	**3. What Matters To Me – A Patient Story**	
	The meeting began with a patient story, introduced by Carolyn Mills, Chief Nurse, and Tony Watkin, Patient and Public Involvement Lead. This month's patient story came from Alun. Alun had been a user of services at UH Bristol for over 15 years both as a patient at the Bristol Eye Hospital and as a parent of a child who attended the Bristol Royal Hospital for Children. He had been invited to talk about his experiences of accessing health care as a blind person. He invited members of the Board to wear visual simulation spectacles simulating different types of visual impairment for the duration of his talk to give them a sense of how it felt. He described his patient journey and his needs at each stage of the	

Minute Ref	Item Number	Action
	process. Sometimes his expectations had been met, but more often than not they were not. Consequences had included missing his appointments because he had been sent an appointment letter by post and had no-one to read it to him, problems getting into the hospital because the taxi could not find a suitable place to drop him off, and difficulties checking in and finding someone who could help him because he could not see signage or read directions. On the ward, he often found that patient information leaflets, menus, and other vital sources of information were not in a format that he could access. He reflected on the progress that the Trust had made over the years in understanding the experience of people with visual impairments. He was particularly pleased that the Eye Hospital was now engaging with people with visual impairments in its refurbishment plans. He stressed that there were many more measures that the Trust could put in place that would not cost a lot of money, particularly in terms of increasing awareness. He wished to emphasise that people with different visual impairments all had very different requirements, and requested that staff ask about the needs of individual patients rather than making assumptions. Members of the Board reflected on their experience of wearing the visual simulation spectacles and discussed with Alun the ways in which his story had illustrated the difficulties faced by patients with a visual impairment. They recognised the fear and isolation that visually-impaired patients experienced and noted the need to utilise the expertise of patients in this area, for example incorporating patient experience into staff training. They acknowledged the contribution of Kathy Baxter, Public Governor, to the Trust's increased focus on supporting people with visual impairments and noted that she had recently received a national award for her work raising awareness and training staff. In response to a question about how his experiences of Bristol Eye Hospital differed from those in the Trust's other hospitals, Alun responded that while in general there was a greater level of awareness and service user engagement in the Eye Hospital, he had noticed different elements of good practice in other hospitals as well. The Chair thanked Alun for attending*. Alun, Tony Watkin and Mark Stevens left the meeting.*	
03a/11/2019	**Public Question – Patients Not Passports** Before embarking on the business of the meeting, the Chair, Jeff Farrar, noted that several members of the public were in attendance from the Patients Not Passports group and he invited them to put their question to the Board. Helen Leveret spoke on behalf of Bristol Patients Not Passports, a campaign group which opposed the changes to the law introduced by the	

Minute Ref	Item Number	Action
	government in 2014 to expand charging regulations for overseas visitors. The changes placed a duty on NHS trusts to check the eligibility of patients before providing treatment. The group had raised concerns about the financial, ethical, safety and healthcare aspects of these ID checks and upfront charges with the UH Bristol Board in May 2019. However, they had felt that the Trust's response had only partially addressed their concerns. They now wished to find out how Trust intended to monitor harm caused to patients as a result of this policy, how the costs and income that it generated were evaluated, and at what point the Trust would suspend ID checks and upfront charging if the consequential harms could not justify the financial income. She drew the Board's attention to the Bristol Patients Not Passports petition, which had gained 35,577 signatures, and which called for Robert Woolley as Chief Executive to suspend ID checks at UH Bristol, suspend upfront charging in the Trust and to call on the government to suspend charging in the NHS. Jeff Farrar, Trust Chair, thanked the group's representatives for attending and for bringing the matter to the Board's attention. He underlined the Trust's expectation that all patients would be treated with respect and dignity. He explained that the Board was committed to leading the Trust in a fair and ethical way; however, it needed to comply with legal constraints and requirements. He agreed to provide a more comprehensive written response to the group's questions and asked that they continue a dialogue with the Board on this important issue. In response to a further question from Helen Leveret, he explained that the Board was unable to discuss the issue further at the present meeting due to time constraints but agreed to give it due consideration at another time. **Actions:** **- Written response to be provided to Patients not Passports.** **- Board members to consider the issues raised by Patients not Passports at a future meeting.**	Chair
04/11/2019	**4. Minutes of the last meeting**	
	Board members reviewed the minutes of the meeting held on 27 September 2019. An amendment was noted to the attendance list with respect to the job titles of Guy Orpen and William Oldfield. There were no further amendments. **Members RESOLVED to:** • **Receive** the minutes of the Board of Directors meeting held in public on 27 September 2019 as a true and accurate record subject to the above amendment.	

4

Minute Ref	Item Number	Action
05/11/2019	**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: **94/09/2019 Improvement, Transformation and Innovation Strategy** **Clarification of Quality Improvement methodology and Board Committee oversight to be included in the strategy.** Paula Clarke confirmed that this would be scheduled in on the work programme for the People Committee. **99/09/2019 Any Other Urgent Business/Patient Story** **i. Consideration to be given as to whether members of the Board or governors could attend staff training sessions on transgender awareness.** **ii. Guide for healthcare workers in relation to transgender issues to be circulated to the Board once finalised** **iii. Board to write to national commissioners to seek assurance on the availability of transition services and demand and supply issues in this area.** An update would be provided on these actions at the meeting in January 2020. **61/07/2019 People Strategy** **People Strategy to be amended to demonstrate staff engagement in its development.** This had been completed and the action could be closed. **62/07/2019 Arts and Culture Strategy** **People Committee to receive detailed report on Arts Strategy including budget and success criteria.** This would be received at the next People Committee meeting. Julian Dennis further added that the Trust's organ donation committee had agreed to support an art installation celebrating organ and tissue donation to mark the change in the law regarding organ donation consent which would come into effect in 2020. He felt that this would be beneficial for the Trust and asked that it be progressed through the Trust's arts strategy. **74/07/2019 Self-Assessment of Board Cycle** **David Armstrong and Eric Sanders to discuss improvements to the Annual Business Cycle.** This action remained open. **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.** This action remained open. **Members RESOLVED to:** • **Note** the updates against the action log.	

4

Minute Ref	Item Number	Action
06/11/2019	**6. Chief Executive's Report**	
	The Board received a summary report of the key business issues considered by the Senior Leadership Team in October and November 2019. Robert Woolley, Chief Executive, provided updates on the following matters: • There remained considerable uncertainty as to the outcome of the General Election on 12 December 2019 and the implications for the NHS. This would form the context for the long-term plan that health organisations in Bristol, North Somerset and South Gloucestershire region had been developing collaboratively through the regional Sustainability and Transformation Partnership. • There had been very significant pressure on Emergency Department services across the region particularly in the Bristol Royal Infirmary and the Bristol Royal Hospital for Children. The unprecedented level of demand meant that the Trust needed to urgently revisit its plans for winter and consider whether they would be sufficient. The Board would receive a formal update through its Quality and Outcomes Committee. • The Trust's partnership with Weston Area Health NHS Trust (WAHT) continued to make positive progress towards the formal planned merger date of 1 April 2020. The Board had today approved the transaction business case for the merger to proceed to the next stage, i.e. review and assessment by regulators. This meant that the TUPE (Transfer of Undertakings - Protection of Employment) consultation for staff currently employed by WAHT could now begin so that at the point of merger their employment would transfer to the newly-merged organisation. • In October, UH Bristol had made a declaration of climate emergency jointly with North Bristol NHS Trust. This followed the Board's approval of the Trust's new sustainable development strategy which included an ambition to be carbon neutral by 2030. The Trust was also discussing with Bristol City Council their proposals for a Clean Air Zone in the city centre and how this would affect the hospitals. • Finally, as part of its arts and culture programme, the Trust had acquired 10 pianos which would be situated around the hospitals for the month of December for anyone to play, to highlight the positive effect of music on the health and wellbeing of patients and staff. Clive Hamilton, member of the public, observed that the Trust had lodged an appeal against Bristol City Council's refusal of planning permission for its proposed new transport hub. He asked how this was consistent with the Trust's intention to be carbon neutral in 2030. Robert Woolley explained that the case for the transport hub had been developed in the context of the Trust's sustainable development plans and so included measures to make it easier to use more sustainable forms of transport as well as helping to solve the current parking problems experienced by people using our hospitals. **Members RESOLVED to:** • **Receive** the Chief Executive's Report for information.	

<table>
<tr><th>Minute Ref</th><th>Item Number</th><th>Action</th></tr>
<tr><td colspan="3">Patient Care and Clinical Outcomes</td></tr>
<tr><td>07/11/2019</td><td>7. Quality and Performance Report</td><td></td></tr>
<tr><td></td><td>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 in relation to Quality, Workforce and Access standards during the past month.

Access Standards:
• Emergency Department: The measure for percentage of Emergency Department patients seen in less than 4 hours was 82.4% for October. Mark Smith highlighted that the Trust was not alone in struggling to meet the national standard of 95%. This morning the regional STP (Sustainability and Transformation Partnership) had declared a critical incident as a system as all partner organisations were under enormous and sustained pressure. They would now look collectively for a solution. The Trust's winter planning was now being reviewed and the Board would receive a report at its next Quality and Outcomes Committee meeting.
• Referral-to-Treatment: The percentage of Referral To Treatment (RTT) patients waiting under 18 weeks was 83.0% at the end of October against the national 92% standard. While this had deteriorated, the Trust now had a better understanding of why. He publicly thanked the clinical staff who had come in to do additional sessions at weekends in their own time to try to reduce the backlog in this area.
• 62-day Cancer Standard: The 62 Day Cancer standard for GP referrals achieved 85.4% for Quarter 2 (July-September), making the Trust one of very few in the country meeting the national standard of 85%.
• Diagnostic Patients: The percentage of Diagnostic patients waiting under 6 weeks at end of October was 95.9%, lower than the national 99% standard. This had stabilised with a slow trajectory of improvement.

Quality Standards:
• Venous thromboembolism (VTE) risk assessments remained at 78% against the national 95% requirement. William Oldfield, Medical Director, explained that the Trust had begun implementing an electronic system for these in August and while there was gradual overall improvement across the Trust, some areas still remained challenged.
• The Trust was working on changes to the way patients were coded in relation to its mortality indicators, which may affect performance.
• New appointments had been made to support the Trust's developing 'silver trauma' service.
• Carolyn Mills, Chief Nurse, further provided reassurance that the Trust was sighted on the need to maintain a quality service for</td><td></td></tr>
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Minute Ref	Item Number	Action
	patients and make sure they were safe even in the Emergency Department queues. In response to a question from Martin Sykes, Non-Executive Director, Mark Smith confirmed that the length of stay had reduced in relation to emergency patients, but that this did not compensate for the number of patients coming in and the lack of community provision which gave rise to challenges in discharging patients in a timely way. **Workforce Standards**: • Matt Joint, Director of People, highlighted that the Trust had launched a recruitment campaign for areas that were hard to recruit to, for example, middle-grade doctors in the Emergency Department. The vacancy rate at 4.3% was better than target, turnover was steady at 13%, and sickness absence was slightly above target at 4.2% Numbers of staff completing the annual national staff survey so far were better than last year. • The Trust was about to start the TUPE transfer process for staff currently employed by Weston Area Health NHS Trust and a significant amount of preparation was taking place. **Members RESOLVED to:** • **Receive** the Quality and Performance Report for assurance.	
08/11/2019	**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 meeting on 25 November. • The Committee had received a presentation from Emma Redfern on improvements made by the Trust in the diagnosis of aortic dissection. One of her patients had attended the meeting to tell his story, having received treatment at our hospitals that saved his life. Her work would now be disseminated around the country. • The Committee had raised a question around the figures for resuscitation training for junior doctors which looked surprisingly low but was likely to be due to a recording error. • The Committee had discussed the Emergency Department pressures and looked forward to receiving in December a further report about the additional work required to revise the Trust's winter plans. • The Committee had continued to express concerns about the rate of staff annual appraisals, which was below expectations. • The Committee had commended the cancer teams for continuing to meet the 62-day cancer standard. **Members RESOLVED to:** • **Receive** the Quality and Outcomes Committee Chair's report for assurance.	

Minute Ref	Item Number	Action
09/11/2019	**9. Report from the Chair of the People Committee**	
	Bernard Galton, Non-Executive Director, and Chair of the People Committee reported the following key issues from the Committee's meeting on 25 November: • The Committee had discussed key workforce indicators and had received an update on workforce issues from a national, regional and organisational perspective. This had included information about the implications of the regional long-term plan and the tax changes affecting the pensions of consultants and higher paid staff. The progress of the Trust's flu vaccination programme was discussed. • The Committee had provided scrutiny into medical workforce issues across the divisions • The Committee had discussed with the Trust's new Clinical Talent Acquisition Manager how the Trust could improve its recruitment to specialist roles. They had noted that more work was required in the area of talent management and staff development and requested a further update on progress in six months' time. • The Committee had received assurance as to the WAHT merger and the TUPE transfer process for staff. • The Committee had received a report about the measures that the Trust was taking to minimise physical and verbal aggression from patients towards staff. Board members discussed talent acquisition and talent management. Guy Orpen, Non-Executive Director, asked that the Trust's plans in this area include sufficient emphasis on diversity and inclusion. Matt Joint responded that the Trust was reviewing its recruitment practices specifically to strengthen the emphasis on diversity and inclusion. He added that UH Bristol was one of six Trusts chosen by the national Workforce Race Equality Standard body to receive intensive support in this area. David Armstrong, Non-Executive Director, further emphasised the relationship between talent management and effective staff appraisals, and asked for greater attention on this area. **Members RESOLVED to:** • **Receive** the People Committee Chair's report for assurance.	
Workforce		
10/11/2019	**10. Flu Vaccination Trust Self-assessment**	
	Matt Joint, Director of People, presented a report providing assurance to the Board on the progress of the seasonal influenza vaccination programme for Trust staff. The Trust had been given a CQUIN (incentivised target) to ensure that 80% of front-line staff had been vaccinated by the end of February 2020. There had been a well-structured campaign this year across the regional Sustainability and Transformation Partnership. At this point (week 8 of the campaign), 71.2% of front-line staff had been vaccinated,	

Minute Ref	Item Number	Action
	which was a significant improvement on this time last year. Board members were asked to have their flu vaccination if they had not already done so. Ray Phipps, Public Governor, referred to the Emergency Department pressures and suggested that a small increase in incidences of influenza could be a tipping point. This was noted. **Members RESOLVED to:** **Receive** the Flu Vaccination Trust Self-Assessment report for assurance.	
Strategic Performance and Oversight		
11/11/2019	**11. Transforming Care Programme Board Report – Q2 update**	
	Paula Clarke, Director of Strategy and Transformation, presented an update for Quarter 2 on the work of the Trust's Transformation Board and Transformation Team in the areas of quality improvement, working smarter, and digital transformation. The report gave a brief overview of individual projects and actions. Among highlights for the quarter was the establishment of more clinical practice groups: groups of clinicians in different organisations meeting to discuss common issues, share best practice and align ways of working. Board members discussed the report. Jayne Mee, Non-Executive Director, noted that one of the divisional transformational projects had focussed on Emergency Department ambulance handover and expressed interest in finding out the outcome of this. Mark Smith advised that the ambulance handover was now a focus for NHSIE within the urgent care metrics and suggested that the Board received regular updates on the project via the Quality and Outcomes Committee. **Action – Establish effect of ED Ambulance Handover transformation project on ambulance handover times and review Board reporting of ambulance handovers.** Jayne Mee further noted a number of potential risks highlighted in the report around resource issues and asked to what extent these would affect the output of the projects. Paula Clarke responded that the Trust was already working to minimise these but would keep under review how it deployed its capacity particularly given current operational pressures. In response to several questions from Non-Executive Directors about the delays to the re-implementation of Electronic Prescribing and Medicines Administration (EPMA), William Oldfield reminded the Board that EPMA was on hold due to issues that the Trust's system suppliers needed to overcome and the Trust was continuing to evaluate the return to manual prescribing. In response to a question from Madhu Bhabuta, Non-Executive Director, about how the Transforming Care programme dealt with requests for extra work, Paula Clarke responded that the priorities were annually agreed	Deputy CE/COO

4

Minute Ref	Item Number	Action
	through the Trust's divisional operating plans. During the year, if divisions wished to add extra projects, these would be considered by the Transforming Care Programme Board to find out whether they could be accommodated. **Members RESOLVED to:** • **Receive** the Transforming Care Programme Board Report for assurance.	
Financial Performance		
12/11/2019	**12. Finance Report**	
	Neil Kemsley, Director of Finance and Information, introduced the Finance Report which informed the Board of the financial position of the Trust in October. Key points included: • The Trust was reporting a core surplus of around £5.060m to date against a planned surplus of £6.086m. • The Trust continued to forecast the expected achievement of the year-end delivery of the control total. • The key challenges were consistent with previous reports and reflected the operational pressures that the Trust was currently experiencing. The two key financial issues remained income from activities underperformance and increased nursing and midwifery pay costs. The position had however improved from the previous months of this year, with performance improving in three out of the five clinical divisions. • At an aggregate level for the Trust the total risk forecasting for year-end stood at £11m, which included additional plans to manage winter pressures. To set against that, £8.5m reserves had been identified and mitigations included divisional recovery plans, negotiations with commissioners, and continuing to look at technical financial opportunities. • The Trust's cash position remained strong at £135.3m, with the Trust's capital programme £3m behind plan for the year to date. • The divisions would provide their first draft operating plans for 2020/21 on 18 December for consideration by the Finance Committee on 20 December. **Members RESOLVED to:** • **Receive** the Finance Report for assurance.	
13/11/2019	**13. Finance Committee Chair's report**	
	Martin Sykes, Chair of the Finance Committee, reported back from the Committee's meeting on 25 November including the following key points: • The Committee had discussed the current year's position in relation to next year and the process for setting next year's plan. • The Committee had considered the IT business case for Weston Area Health NHS Trust (WAHT), the funding for which was coming	

Minute Ref	Item Number	Action
	through UH Bristol, and had supported it for onward submission to the Board • The Committee had considered the finance section of the WAHT merger transaction business case and were fully assured as to the level of detail which would now form part of the Trust's negotiations with national bodies over levels of funding for the transaction. • The Committee had agreed to receive a report at its next meeting on the savings plan in the Estates and Facilities Department. **Members RESOLVED to:** • **Receive** the Finance Committee Chair's report for assurance.	
Governance		
14/11/2019	**14. Register of Seals – Q2 Update**	
	This report informed the Board of all new applications of the Trust Seal since the previous report in July 2019. **Members RESOLVED to:** • **Receive** the Register of Seals – Q2 update for information**.**	
15/11/2019	**15. 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.	
Concluding Business		
16/11/2019	**16. Any Other Urgent Business**	
	• The Chair, Jeff Farrar, announced that he had chaired the Trust's Bright Ideas group – an initiative modelled on 'Dragon's Den' in which staff were invited to pitch their ideas for improvements. He had found this particularly inspiring and invited more Non-Executive Directors to get involved. • Jeff Farrar thanked the organisers of the Trust's Recognising Success Staff Awards Ceremony on 22 November, and also expressed gratitude on behalf of the Trust to the Above and Beyond charity for funding it. Finally, Jeff noted that it was the final Board meeting for John Moore, who had served as a Non-Executive Director at the Trust for the last nine years. He thanked John Moore for the support and advice that he had given to Board members and commented that his input had always been greatly valued, particularly as he had always been prepared to ask the difficult	

4

Minute Ref	Item Number	Action
	questions for the benefit of patients. John Moore spoke warmly about his experience of the role of Non-Executive Director over the last nine years. For him, the Trust's journey of improvement in that time had been characterised by two key things: firstly its patient-centred culture, and secondly its governance structure of Executive Directors, Non-Executive Directors and Governors, which had matured over time into a relationship of mutual respect and appropriate challenge. He asked that the Board continue to maintain its sense of responsibility about the thoroughness of its decision-making, keep improving relations with other organisations as system leaders, and maintain its focus on staff wellbeing and patient experience. Kathy Baxter, Public Governor, added her thanks to John Moore on behalf of the Trust's governors. The Chair closed the meeting at 12:45.	
17/11/2019	**17. Date and time of Next Meeting**	
	The date of the next meeting was confirmed as 11.00 – 13.00, Thursday 30 January 2020, Conference Room, Trust HQ, Marlborough Street, Bristol, BS1 3NU.	

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

Public Trust Board of Directors Meeting
30 January 2020
Action Tracker

Outstanding actions from the meeting held on 28 November 2019					
No.	**Minute reference**	**Detail of action required**	**Responsible officer**	**Completion date**	**Additional comments**
1.	03a/11/2019	**Public Question – Patients Not Passports** i. Written response to be provided to Patients not Passports. ii. Board members to consider the issues raised by Patients not Passports at a future meeting.	Chair	January 2020	**Completed since last meeting** A written response was provided to Patients not Passports in December 2019.
2.	11/11/2019	**Transforming Care Programme Board Report** Establish effect of ED Ambulance Handover transformation project on ambulance handover times and review Board reporting of ambulance handovers.	Deputy CE/COO	January 2020	**Completed since last meeting** This action would be addressed at the Quality and Outcomes Committee under the Quality and Performance Report in January 2020.
3.	84/09/2019	**Chief Executive's Report** Report to be brought back to the Board on opportunities and risks facing South Bristol Community Hospital. Report due to come back in 4-6 months on the strategy for SBCH. Board oversight of SBCH on an ongoing basis to be considered as part of the Board cycle.	Director of Strategy and Transformation/ Director of Corporate Governance	January 2020	**Work in Progress** A working group is being established with Sirona partners to progress the strategy for services and support any contractual or service model changes for 2021/2022. This will inform the longer term strategy for SBCH as will the business case in development through Healthier Together for stroke services.
4.	88/09/2019	**Report from the Chair of the People Committee** Leaders of all six Trust divisions to be invited to Board Seminars/People Committee meetings to report their	Director of People	January 2020	**Work in Progress** Update to be provided at January

		actions to tackle bullying and harassment and the resulting impact.			2020 meeting.
5.	99/09/2019	**Any Other Urgent Business** i. Consideration to be given as to whether members of the Board or governors could attend staff training sessions on transgender awareness. ii. Guide for healthcare workers in relation to transgender issues to be circulated to the Board once finalised iii. Board to write to national commissioners to seek assurance on the availability of transition services and demand and supply issues in this area.	Chief Nurse Chief Nurse Chair	January 2020	**Work in Progress** Update to be provided at January 2020 meeting.
6.	74/07/2019	**Self-Assessment of Board Cycle** David Armstrong and Eric Sanders to discuss improvements to the Annual Business Cycle.	Director of Corporate Governance	March 2020	**Work in Progress** Business cycle updated for reviews to take place in March 2020.
7.	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.	Director of Corporate Governance / Committee Chairs	January 2020	**Work in Progress** This was in progress and the revised Terms of Reference would be reviewed by each Committee and the Board - update to be provided at the January 2020 meeting.
Closed actions from the meeting held on 28 November 2019					
No.	**Minute reference**	**Detail of action required**	**Responsible officer**	**Completion date**	**Additional comments**
1.	94/09/2019	**Improvement, Transformation and Innovation Strategy** Clarification of Quality Improvement methodology and Board Committee oversight to be included in the strategy.	Director of Strategy and Transformation	November 2019	**Completed** The People Committee would track the effectiveness and success of this strategy which had been included within the document.

2.	62/07/2019	**Arts and Culture Strategy** People Committee to receive detailed report on Arts Strategy including budget and success criteria	Director of People	November 2019	**Completed** This item had been included on the agenda in November 2019 for the People Committee.
3.	61/07/2019	**People Strategy** People Strategy to be amended to demonstrate staff engagement in its development.	Director of People	November 2019	**Completed** Verbal update provided at November 2019 meeting.

APPENDIX A

SENIOR LEADERSHIP TEAM

REPORT TO TRUST BOARD – JANUARY 2020

1. INTRODUCTION

This report summarises the key business issues addressed by the Senior Leadership Team in December 2019 and January 2020.

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

6

The group **approved** the Strategic Outline Case for the refurbishment of the Emergency Department and Radiology, noting, further discussions are required.

The group **approved** the Strategic Outline Case and Memorandum of Understanding for the future model of the West of England Pathology Network.

The group **approved** the proposal to implement the new job planning policy.

The group **noted** the mandate in respect of the changes to rules regarding pay progression as set by Agenda for Change.

The group **approved** the implementation of a balance scorecard for staff 8c and above.

The group **approved** the proposal to move to the 2017 terms and conditions in respect of Clinical Fellows.

The group **noted** the milestones and timelines in respect of the Weston Merger for the next quarter.

The group **approved** the recommendations and proposed amendments for the NHS Standard Contract for 2020/21.

The group **approved** the proposal to re-tender for a new outsourced pharmacy service.

The group **approved the scale and scope** of the proposed investment for the business case to deliver the transformation, improvement and innovation strategy, noting this would need to be considered and discussed in the wider operating planning round discussions and priorities.

The group **approved the scale and scope** of the proposed investment for the Communication Strategy, noting this would need to be considered and discussed in the wider operating planning round discussions and priorities.

The group **approved** the proposal to move to phase 2 of the low energy lighting refurbishment.

The group **approved in principle** the next steps in relation to creating out of hospital capacity.

4. RISK, FINANCE AND GOVERNANCE

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

The group **noted** the update on the development of the business case for Clinical Decant via Out of Hospital Capacity.

The group **approved in principle** the requests for funding allocation for winter planning.

The group **approved** the Terms of Reference for the Digital Hospital Programme Board.

The group **noted** the next steps following the internal audit on Conflicts of Interest.

The group **noted** the update in respect of the Dental Action Plan.

The group **noted** the update from the Estates and Facilities Fit for Future Review report.

The group **approved** the development of a Sustainability Board, and **supported in principle,** the proposal for future investment for an expanded Sustainability team, noting this would need to be considered and discussed in the wider operating planning round discussions and priorities.

The group **noted** the updated from the Patient Safety Programme Board.

The group **received** the risk exception reports from Divisions.

The group **approved** the Corporate and Strategic Risk Registers prior to presentation to Trust Board.

The group **approved** the report for Guardian of Safe Working.

The group **approved** the Quarter 3 Corporate Objectives update.

The group **approved** the Quarter 3 Corporate Quality Objectives update.

The group **approved** the Quarter 3 Transforming Care Report.

The group **approved** the Quarter 3 Strategic Capital Update.

The group **approved** the Quarter 3 Serious Incident Report.

The group **noted** the Quarter 3 Freedom to Speak up update.

The group **received** an Internal Audit reports for Clinical Audit (Satisfactory Rating), Business Planning and Capital Prioritisation (Significant Rating) and, Children's Safeguarding Supervision: Position Statement (limited rating).

The group **received** the Quarter 2 Complaints and Quarter 2 Patient Experience Reports.

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

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

5. RECOMMENDATIONS

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

Mark Smith
Deputy Chief Executive/Chief Operating Officer
January 2020

Meeting of the Board of Directors in Public on Thursday 30 January 2020

Report Title	**Diversity & Inclusion Strategy Plan Update: including Workforce Race Equality Standard (WRES) and the Workforce Disability Equality Standard (WDES)**
Report Author	**Samantha Chapman, Head of Organisation Development**
Executive Lead	**Matt Joint, Director of People**

1. Report Summary

The purpose of this paper is to:

- Provide Board members with a summary of the purpose and reporting format of the WRES & WDES
- Summarise the WRES & WDES indicators
- Present the WRES and WDES indicators and actions aligned with the Diversity & Inclusion Strategy Plan.

The full WRES and WDES Reports are also attached to this paper for information.

2. Key points to note
(Including decisions taken)

Board members are asked to receive the report for assurance and note the progress update.

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

The risks associated with this report include:

- **Risk 285:** (Risk of non-compliance with the Public Sector Equality Duties and equalities legislation resulting in reputational damage.)

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

- This report is for **Assurance.**

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

People Committee	27th January 2020

Respecting everyone
Embracing change
Recognising success
Working together
Our hospitals.

7

Diversity & Inclusion Strategy Plan Update: including Workforce Race Equality Standard (WRES) and the Workforce Disability Equality Standard (WDES)

1.0 Purpose

The purpose of this paper is to:

- Provide the People Committee with a summary of the purpose and reporting format of the WRES & WDES
- Summarise the WRES & WDES indicators
- Present the WRES and WDES indicators and actions aligned with the Diversity & Inclusion Strategy Plan for discussion

2.0 Background

The Trust is required to report on the Workforce Race Equality Standard and the Workforce Disability Equality Standard each year. This section sets out those standard requirements and the indicators that underpin these standards.

2.1 The NHS Workforce Race Equality Standard (WRES)

The WRES is designed to be a tool and an enabler of change. It was implemented in response to the NHS Equality & Diversity Council's announcement in July 2014 that it had agreed action to ensure employees from black and minority ethnic (BME) backgrounds have equal access to career opportunities and receive fair treatment in the workplace.

7

There are nine WRES indicators. Four of the indicators focus on workforce data; four are based on data from the national NHS Staff Survey questions, and one indicator focuses upon black and minority ethnic (BME) representation on Boards. The WRES highlights any differences between the experience and treatment of white staff and BME staff in the NHS with a view to closing those gaps through the development and implementation of action plans focused upon continuous improvement over time.

Implementing the WRES is a requirement for NHS commissioners and NHS healthcare providers including independent organisations, through the NHS standard contract.

A reporting template, including the data submitted to NHS England, and actions taken and planned, is used to present an overview of the Trust's latest WRES implementation. Once completed, the report template is published on the Trust's website.

The nine Workforce Race Equality Standard (WRES) Indicators are:

Four Workforce Indicators – for each of the four workforce indicators, compare the data for white and BME staff.

- WRES Indicator 1 - Percentage of staff in each of the AfC Bands 1-9 or Medical and Dental subgroups and VSM (including executive Board members) compared with the percentage of staff in the overall workforce disaggregated by Non-clinical staff; Clinical staff – of which Non-Medical staff; Medical & Dental staff
- WRES Indicator 2 - Relative likelihood of BME staff being appointed from shortlisting compared to that of White staff being appointed from shortlisting across all posts
- WRES Indicator 3 - Relative likelihood of BME staff entering the formal disciplinary process, compared to that of white staff entering the formal disciplinary process, as measured by entry into a formal disciplinary investigation.
- WRES Indicator 4 - Relative likelihood of BME staff accessing non-mandatory training and CPD as compared to white staff.

Four National NHS Staff Survey indicators - for each of the four staff survey indicators, compare the outcomes of the responses for White and BME Staff.

- WRES Indicator 5 - Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in the last 12 months.
- WRES Indicator 6 - Percentage of staff saying they have experienced harassment, bullying or abuse from staff in the last 12 months
- WRES Indicator 7 - Percentage of staff believing that the organisation provides equal opportunities for career progression or promotion
- WRES Indicator 8 - Percentage of staff personally experiencing discrimination at work from their manager/team leader or another colleague in the last 12 months

Board Representation Indicator - for this indicator, compare the difference for White and BME staff.

- WRES Indicator 9 - Percentage difference between the organisation's Board voting membership and its overall workforce, and the Board's Executive membership and its overall workforce

2.2 The NHS Workforce Disability Equality Standard (WDES)

The WDES is designed to improve workplace experience and career opportunities for Disabled people working, or seeking employment, in the National Health Service (NHS). The WDES follows the NHS Workforce Race Equality Standard (WRES) as a tool and an enabler of change.

7

The WDES is a series of evidence-based Metrics that provides NHS organisations with a snapshot of the experiences of their Disabled staff in key areas. By providing comparative data between Disabled and non-disabled staff, the information can be used to understand where key differences lie; and provide the basis for the development of action plans, enabling organisations to track progress on a year by year basis.

The WDES is mandated through the NHS Standard Contract and is restricted to NHS Trusts and Foundation Trusts for the first two years of implementation (2019 and 2020).

An online reporting form and data was completed and submitted to NHS England. This information formed the basis of the Trust's Metrics Report and Action Plan, published on the Trust's website.

The ten Workforce Disability Equality Standard (WDES) Metrics are:

Three Workforce Metrics – for each of the three workforce metrics, compare the data for both Disabled and non-disabled staff.

- WDES Metric 1 – Percentage of staff in AfC pay band or medical and dental subgroups and very senior managers (including executive Board members) compared with the percentage of staff in the overall workforce. (The calculation is undertaken separately for non-clinical and for clinical staff.)
- WDES Metric 2 – Relative likelihood of Disabled staff compared to non-disabled staff being appointed from shortlisting across all posts
- WDES Metric 3 – Relative likelihood of Disabled staff compared to non-disabled staff entering the formal capability process, as measured by entry into the formal capability procedure

Four National NHS Staff Survey Metrics – for each of the following four Staff Survey metrics, compare the responses for both Disabled and non-disabled staff.

- WDES Metric 4 – Staff Survey Q13
  Percentage of Disabled staff compared to non-disabled staff experiencing harassment, bullying or abuse from patients/service users, their relatives or other members of the public; managers; other colleagues

Percentage of Disabled staff compared to non-disabled staff saying that the last time they experienced harassment, bullying or abuse at work, they or a colleague reported it

- WDES Metric 5 – Staff Survey Q14
Percentage of Disabled staff compared to non-disabled staff believing that the Trust provides equal opportunities for career progression or promotion

- WDES Metric 6 – Staff Survey Q11
Percentage of Disabled staff compared to non-disabled staff saying that they have felt pressure from their manager to come to work, despite not feeling well enough to perform their duties

- WDES Metric 7 Staff Survey Q5
Percentage of Disabled staff compared to non-disabled staff saying that they are satisfied with the extent to which their organisation values their work

- WDES Metric 8 – Staff Survey Q28b *(only includes the responses of Disabled staff)*
Percentage of Disabled staff saying that their employer has made adequate adjustment(s) to enable them to carry out their work

NHS Staff Survey and the engagement of Disabled staff – For Metric 9 a), compare the staff engagement scores for Disabled, non-disabled staff and the overall Trust score

- WDES Metric 9 (a) – The staff engagement score for Disabled staff, compared to non-disabled staff and the overall engagement score for the organisation
- WDES Metric 9 (b) – Has your trust taken action to facilitate the voices of Disabled staff in your organisation to be heard? (Yes) or (No). If yes, please provide at least one practical example of current action being taken.

Board Representation Metric – For this metric, compare the difference for Disabled and non-disabled staff

- WDES Metric 10 – Percentage difference between the organisation's Board voting membership and its organisation's overall workforce, disaggregated by voting membership of the Board and by Executive membership of the Board

Appendix A sets out how the Workforce Diversity & Inclusion Strategy Action Plan supports improvements in the experience of our BME staff aligned with the WRES measures, and our how the Workforce Diversity & Inclusion Strategy Action Plan supports improvements in the experience of our Disabled staff, aligned with the WDES measures.

Appendix B shows the progress against these actions during Q3.

The Half-Year progress update and the full WRES and WDES Reports are attached to this paper for information.

3.0 Next Steps

People Committee are invited to receive this summary and aligned plan for comment and assurance.

The next annual WRES & WDES reporting to NHS England will be in Quarter 2 2020. There will be further development of the plan in light of the Trust's participation in the national WRES pilot launched on 22nd January 2020.

The People Committee will receive a quarterly update on ongoing progress against the aligned plan in accordance with the agreed governance for Diversity & Inclusion reporting.

These tables set out the WRES and WDES measures and how the actions align with the Workforce Diversity & Inclusion Strategy

WRES Measure	D&I Strategy Objective	D&I Strategy and WRES Actions
WRES Indicator 1 – Percentage of staff in each of the AfC Bands 1-9 or Medical and Dental subgroups and VSM (including executive Board members) compared with the percentage of staff in the overall workforce disaggregated by Non-clinical staff; Clinical staff – of which Non-Medical staff; Medical & Dental staff	**We will be recognised as an inclusive employer committed to ensuring our workforce reflects the community it serves.**	• Review of shortlisting process to provide assurance that the anonymised process removes opportunities for bias • Review interview template and interview question bank with a view to including D&I section / specific question • Research/commission/develop refresher training for recruiting managers – Inclusivity in Recruitment – to be delivered as one hour, back to back sessions over two days. • Refresh panel composition with a view to including an extra, independent, person as part of the selection process to challenge on aspects of inclusivity. (For interviews of B7 or B8a and above roles initially) • Review recruitment processes for Board appointments, including executive search agencies. *Action to be included in Year 2 Strategy Action Plan:* *We will aim to increase ESR declaration rates and reduce the number in the 'Not known/not declared' categories*
	We are committed to inclusion in everything we do including Recruitment, Induction, Training, Appraisal and Talent Management	• Agree our approach to inclusive Talent Management ensuring this complements the career pathway work in the education strategy. • We will ensure our appraisal framework includes a Diversity and Inclusion objective so every leader is able to demonstrate their commitment to diversity, inclusion and fairness.
WRES Indicator 2 - Relative likelihood of BME staff being appointed from shortlisting compared to that of White staff being appointed	**We will be recognised as an inclusive employer committed to ensuring our workforce reflects the community it serves.**	Actions described for Indicator 1 (above) should also influence the outcomes for this indicator.

from shortlisting across all posts		
WRES Indicator 3 – Relative likelihood of BME staff entering the formal disciplinary process, compared to that of white staff entering the formal disciplinary process, as measured by entry into a formal disciplinary investigation.	**Inclusion is integral in our people policies encouraging positive conversation and introducing informal processes where possible**	• Review of our people policies (as they fall due for review) to ensure a consistent message and approach to inclusion • Ensure we continue to offer to Investigating Officers training to all managers undertaking HR related investigations *Action to be included in Year 2 Strategy Action Plan:* *We will use the NHS WRES strategy document 'A fair experience for all: closing the ethnicity gap in rates of disciplinary action across the NHS' to test a model of good practice to reduce the disproportionate gap in BME and white staff entering the formal process.*
WRES Indicator 4 – Relative likelihood of BME staff accessing non-mandatory training and CPD as compared to white staff.	**Our Education Strategy focuses on inclusion and is a key enabler to delivering the vision supported by our Trust Values**	• Diversity and Inclusion attendance figures to be reported as part of data sets being developed • Working with University of Bristol to develop unconscious bias training for student intakes • Development of Cultural Awareness training which will launch in February 2020
WRES Indicator 5 – Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in the last 12 months.	**As leaders we role model the Values and Leadership behaviours creating an environment that encourages feedback and where staff feel safe to challenge**	*Actions to be included in Year 2 Strategy Action Plan:* *We will implement a framework designed to drive down levels of bullying and harassment at work.* *We will provide a clear support framework so that staff can feel safe and confident to challenge and report harassment or abuse from patients or service users.*
WRES Indicator 6 - Percentage of staff saying they have experienced harassment, bullying or abuse from staff in the last 12 months	**As leaders we role model the Values and Leadership behaviours creating an environment that encourages feedback and where staff feel safe to challenge**	*Actions to be included in Year 2 Strategy Action Plan:* *We will implement a framework designed to drive down levels of bullying and harassment at work.* *We will provide a clear support framework so that staff can feel safe and confident to challenge and report harassment or abuse from patients or service users.*
WRES Indicator 7 - Percentage of	**We will be recognised as an inclusive employer committed to**	• Review of shortlisting process to provide assurance that the

staff believing that the organisation provides equal opportunities for career progression or promotion	**ensuring our workforce reflects the community it serves.** **We are committed to inclusion in everything we do including Recruitment, Induction, Training, Appraisal and Talent Management** **Our Education Strategy focuses on inclusion and is a key enabler to delivering the vision supported by our Trust values**	anonymised process removes opportunities for bias • Review interview template and interview question bank with a view to including D&I section / specific question • Research/commission/develop refresher training for recruiting managers – Inclusivity in Recruitment – to be delivered as one hour, back to back sessions over two days. • Refresh panel composition with a view to including an extra, independent, person as part of the selection process to challenge on aspects of inclusivity. (For interviews of B7 or B8a and above roles initially) • Review recruitment processes for Board appointments, including executive search agencies. • Agree our approach to inclusive Talent Management ensuring this complements the career pathway work in the education strategy. • We will ensure our appraisal framework includes a Diversity and Inclusion objective so every leader is able to demonstrate their commitment to diversity, inclusion and fairness. • Provide inclusive education that nurtures staff motivation and aspirational career development and values the individual and the teams that work together
WRES Indicator 8 - Percentage of staff personally experiencing discrimination at work from their manager/team leader or another colleague in the last 12 months	**As leaders we role model the Values and Leadership behaviours creating an environment that encourages feedback and where staff feel safe to challenge** **We are committed to inclusion in everything we do including Recruitment, Induction, Training, Appraisal and Talent**	Actions to deliver all objectives from the Workforce Diversity & Inclusion Plan Year 1 are intended to lead to increased cultural competence and therefore a decrease in incidents of discrimination in the workplace.

	Management **We celebrate and value the contribution all of our staff make at all levels of the organization** **We encourage shared learning by openly sharing our diversity data in a meaningful way** **Inclusion is integral in our people policies encouraging positive conversation and introducing informal processes where possible** **We will be recognised as an inclusive employer committed to ensuring our workforce reflects the community it serves**	
WRES Indicator 9 - Percentage difference between the organisation's Board voting membership and its overall workforce, and the Board's Executive membership and its overall workforce	**We will be recognised as an inclusive employer committed to ensuring our workforce reflects the community it serves**	• Review recruitment processes for Board appointments, including executive search agencies

WDES Measure	D&I Strategy Objective	D&I Strategy and WDES Actions
WDES Metric 1 – Percentage of staff in AfC pay band or medical and dental subgroups and very senior managers (including executive Board members) compared with the percentage of staff in the overall workforce. (The calculation is undertaken separately for non-clinical and for clinical staff.)	**We are committed to inclusion in everything we do including Recruitment, Induction, Training, Appraisal and Talent Management** **We will be recognised as an inclusive employer committed to**	• Agree our approach to inclusive Talent Management ensuring this complements the career pathway work in the education strategy. • We will ensure our appraisal framework includes a Diversity and Inclusion objective so every leader is able to demonstrate their commitment to diversity, inclusion and fairness. • Ensure all recruitment processes are reviewed to ensure an inclusive approach from application to appointment.

	ensuring our workforce reflects the community it serves	*Action to be included in Year 2 Strategy Action Plan:* *We will aim to increase ESR declaration rates and reduce the number in the 'Not known/not declared' categories*
WDES Metric 2 - Relative likelihood of Disabled staff compared to non-disabled staff being appointed from shortlisting across all posts	**We will be recognised as an inclusive employer committed to ensuring our workforce reflects the community it serves**	• Review of shortlisting process to provide assurance that the anonymised process removes opportunities for bias • Review interview template and interview question bank with a view to including D&I section / specific question • Research/commission/develop refresher training for recruiting managers – Inclusivity in Recruitment – to be delivered as one hour, back to back sessions over two days. • Refresh panel composition with a view to including an extra, independent, person as part of the selection process to challenge on aspects of inclusivity. (For interviews of B7 or B8a and above roles initially) • Review recruitment processes for Board appointments, including executive search agencies.
WDES Metric 3 - Relative likelihood of Disabled staff compared to non-disabled staff entering the formal capability process, as measured by entry into the formal capability procedure	**Inclusion is integral in our people policies encouraging positive conversation and introducing informal processes where possible**	• Review of our people policies (as they fall due for review) to ensure a consistent message and approach to inclusion • Ensure we continue to offer to Investigating Officers training to all managers undertaking HR related investigations
WDES Metric 4 **(a)Percentage of Disabled staff compared to non-disabled staff experiencing harassment, bullying or abuse from patients/service users, their relatives or other members of the public; managers; other colleagues** **(b)Percentage of Disabled staff compared to non-disabled staff**	**As leaders we role model the Values and Leadership behaviours creating an environment that encourages feedback and where staff feel safe to challenge**	*Actions to be included in Year 2 Strategy Action Plan:* *We will implement a framework designed to drive down levels of bullying and harassment at work.* *We will provide a clear support framework so that staff can feel safe and confident to challenge and report harassment or abuse from patients or service users.*

saying that the last time they experienced harassment, bullying or abuse at work, they or a colleague reported it		
WDES Metric 5 **Percentage of Disabled staff compared to non-disabled staff believing that the Trust provides equal opportunities for career progression or promotion**	**We will be recognised as an inclusive employer committed to ensuring our workforce reflects the community it serves.** **We are committed to inclusion in everything we do including Recruitment, Induction, Training, Appraisal and Talent Management** **Our Education Strategy focuses on inclusion and is a key enabler to delivering the vision supported by our Trust values**	• Review of shortlisting process to provide assurance that the anonymised process removes opportunities for bias • Review interview template and interview question bank with a view to including D&I section / specific question • Research/commission/develop refresher training for recruiting managers – Inclusivity in Recruitment – to be delivered as one hour, back to back sessions over two days. • Refresh panel composition with a view to including an extra, independent, person as part of the selection process to challenge on aspects of inclusivity. (For interviews of B7 or B8a and above roles initially) • Review recruitment processes for Board appointments, including executive search agencies • Agree our approach to inclusive Talent Management ensuring this complements the career pathway work in the education strategy. • We will ensure our appraisal framework includes a Diversity and Inclusion objective so every leader is able to demonstrate their commitment to diversity, inclusion and fairness. • Provide inclusive education that nurtures staff motivation and aspirational career development and values the individual and the teams that work together
WDES Metric 6 **Percentage of Disabled staff compared to non-disabled staff saying that they have felt pressure from their manager to come to work,**	**As leaders we role model the Values and Leadership behaviours creating an environment that encourages feedback and where staff feel**	• Develop a cultural awareness programme for staff in partnership with University of the West of England and University of Bristol

despite not feeling well enough to perform their duties	**safe to challenge** **Inclusion is integral in our people policies encouraging positive conversation and introducing informal processes where possible**	• Review of our people policies (as they fall due for review) to ensure a consistent message and approach to inclusion • Ensure we continue to offer to Investigating Officers training to all managers undertaking HR related investigations
WDES Metric 7 Percentage of Disabled staff compared to non-disabled staff saying that they are satisfied with the extent to which their organisation values their work	**We celebrate and value the contribution all of our staff make at all levels of the organisation**	• We will continue to share staff stories at Board and work to develop a series of staff story videos to promote the experiences of our diverse workforce • Review existing recognition schemes to ensure there is an inclusive approach from the nominations process to the panel
WDES Metric 8 Percentage of Disabled staff saying that their employer has made adequate adjustment(s) to enable them to carry out their work	**Inclusion is integral in our people policies encouraging positive conversation and introducing informal processes where possible**	• Review of our people policies (as they fall due for review) to ensure a consistent message and approach to inclusion • Ensure we continue to offer to Investigating Officers training to all managers undertaking HR related investigations
WDES Metric 9 (a) The staff engagement score for Disabled staff, compared to non-disabled staff and the overall engagement score for the organisation		The Trust has an Improving Staff Experience plan linked to its People Strategy. This is not specifically targeted, but for all staff.
WDES Metric 9 (b) Has your trust taken action to facilitate the voices of Disabled staff in your organisation to be heard? (Yes) or (No) If yes, please provide at least one practical example of current action being taken.	**Staff Forums grow to become an increased staff voice who represent our workforce and the community we serve**	• Ensure Staff Forums have a programme of work that can be celebrated at the annual staff network event and engages further recruitment to the group *Please note that the response to Metric 9(b) was YES. The Trust has an active forum for staff with seen and unseen disabilities – ABLE+.*
WDES Metric 10 Percentage	**We will be recognised as an**	• Review recruitment processes for Board appointments,

difference between the organisation's Board voting membership and its organisation's overall workforce, disaggregated by voting membership of the Board and by Executive membership of the Board	**inclusive employer committed to ensuring our workforce reflects the community it serves**	including executive search agencies

Diversity & Inclusion Strategy Plan Update Q3 (October to December 2019)

APPENDIX B

Strategic Priorities		Objective	Action Required	Timeline	Progress Update	RAG
Leadership and Cultural Transformation	**1**	**As leaders we role model the Values and Leadership behaviours creating an environment that encourages feedback and where staff feel safe to challenge**	Leadership & Management programmes to increase focus on inclusivity as a core theme	End of July 2019	The workforce diversity & inclusion plan is being incorporated into training discussions to increase the focus on inclusivity as a core theme. Learning from best practice and feedback from course participants informs regular reviews of the content.	Complete
			Develop a cultural awareness programme for staff in partnership with University of the West of England and University of Bristol	End of December 2019 Revised to end March 2020	Work to scope the content and potential methods of delivery of a cultural awareness programme supported by Psychological Wellbeing Lead to review resources available to staff and to inform direction of travel. Collaboration with other Trusts and bodies (NHSI) to help inform a new training package in development December 2019 for delivery January/February 2020. Executive sponsorship to develop and implement a UH Bristol Transgender Care Policy has been agreed. The policy will anchor the principles by which the trust will support trans people and transgender questioning children and young persons who access clinical services across the Trust. The policy will support UH Bristol transgender staff, including those who are non-binary, in the workplace. It will be supplemented by staff guidance on, “How to improve the experience of the transgender community who use our services and to support transgender colleagues.” To ensure appropriate and consistent understanding and practice one policy covering both patients and staff will be developed as a collaborative venture between the Workforce Diversity and Inclusion Group and the Patient Inclusion and Diversity Group.	On Track

Key to RAG: = On Track = Complete = Risks slippage = Behind plan/not achieved

WRES link WDES link

	All actions for this Objective link to: **WRES Indicator 5 – Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in the last 12 months.** **WRES Indicator 6 - Percentage of staff saying they have experienced harassment, bullying or abuse from staff in the last 12 months** **WRES Indicator 8 - Percentage of staff personally experiencing discrimination at work from their manager/team leader or another colleague in the last 12 months** **WDES Metric 4 (a) - Percentage of Disabled staff compared to non-disabled staff experiencing harassment, bullying or abuse from patients/service users, their relatives or other members of the public; managers; other colleagues (b)Percentage of Disabled staff compared to non-disabled staff saying that the last time they experienced harassment, bullying or abuse at work, they or a colleague reported it** **WDES Metric 6 - Percentage of Disabled staff compared to non-disabled staff saying that they have felt pressure from their manager to come to work, despite not feeling well enough to perform their duties**				
2	**We are committed to inclusion in everything we do including Recruitment, Induction, Training, Appraisal and Talent Management**	Agree our approach to inclusive Talent Management ensuring this complements the career pathway work in the education strategy.	End of July 2019 (Revised to end May 2020)	People Committee approved the development of a Talent Management Framework to be implemented by May 2020. This framework will pull together the learnings from the diagnostic tool which has been undertaken and the 'High Potential Scheme' across the STP which focuses on Talent at Band 8A and above to support the pipeline for the existing Aspiring Director programmes already in place. A project lead has been appointed to deliver this programme of work and a progress report will go to People Committee in January 2020 which will detail the outline plan from the diagnostic and what actions are required to take forward this agenda.	On Track
	We are committed to inclusion in everything we do including Recruitment, Induction, Training,	We will ensure our appraisal framework includes a Diversity and Inclusion objective so every leader is able to demonstrate their commitment to diversity, inclusion and	End of October 2019 (Revised to end March 2020)	The Trust's pay progression plan includes commitments to the Diversity & Inclusion Strategy and influence on the Appraisal recovery plan. The focus for improvement will be led and supported by the programme of work outlined to the NHS Pay Progression plan 2021. Stage 1 of the programme will be implemented March 2020 and the focus for action will include: • Review of E-Appraisal Documentation	On Track

Key to RAG: = On Track = Complete = Risks slippage = Behind plan/not achieved

WRES link WDES link

	#	Objective	Action	Timescale	Progress	RAG
		Appraisal and Talent Management	fairness.		• Cultural implementation plan including development of pilot group of Executive and Divisional Teams to introduce a balanced score-card and cascades of objectives with a rollout across the organization from April 2021	On Track
		All actions for this Objective link to: **WRES Indicator 1 – Percentage of staff in each of the AfC Bands 1-9 or Medical and Dental subgroups and VSM (including executive Board members) compared with the percentage of staff in the overall workforce disaggregated by Non-clinical staff; Clinical staff – of which Non-Medical staff; Medical & Dental staff** **WRES Indicator 7 - Percentage of staff believing that the organisation provides equal opportunities for career progression or promotion** **WRES Indicator 8 - Percentage of staff personally experiencing discrimination at work from their manager/team leader or another colleague in the last 12 months** **WDES Metric 1 - Comparative data for Disabled and non-Disabled staff -** **Percentage of staff in AfC pay band or medical and dental subgroups and very senior managers (including executive Board members) compared with the percentage of staff in the overall workforce.** **WDES Metric 5 - Percentage of Disabled staff compared to non-disabled staff believing that the Trust provides equal opportunities for career progression or promotion**				
	3	**We celebrate and value the contribution all of our staff make at all levels of the organisation**	Review existing recognition schemes to ensure there is an inclusive approach from the nominations process to the panel	End of June 2019 (Phase 1)	Phase one of the full review of existing schemes included a refreshed nominations and panel process for the Recognising Success Awards in November. A record 400+ nominations were received and assessed by a panel including representation from the Trust's Staff Forums.	Complete
				End Dec 19 (Phase 2)	An audit of Divisional recognition schemes has identified variation across the Trust in terms of leadership, frequency, reward and linkage to the annual Recognising Success awards. A checklist of recommendations has been provided to Divisions to conduct self-assessments to ensure alignment to the Trust People Strategy, Diversity and Inclusion Strategy and national best practice. A progress update will be presented to HR SLT in January 2020. The 2019 Recognising Success event took place on 22nd	Complete

Key to RAG: [light blue] = On Track [green] = Complete [orange] = Risks slippage [red] = Behind plan/not achieved

WRES link WDES link

				End March 2020 (Phase 3)	November to celebrate and share colleagues' work and to thank them via nomination. A full review of the Recognising Success processes and delivery has commenced to ensure equity of approach as directed by staff feedback and in alliance to our merged Trust values. This is in preparation for 2020 with the potential inclusion of existing Weston Area Health employees. The Trust Recognition Framework is a practical aid to support recognition schemes and will be reviewed in light of the outcomes of these two reviews. The review of UH Bristol Recognising Success Awards is affiliated with the Weston Celebrating Success Awards. Work is underway to determine whether a joint event will be planned from 2020 and how this should be delivered to fulfil strategic priorities and effectively meet the needs of the merged workforce	Complete / On Track
			We continue to share staff stories at Board and work to develop a series of staff story videos to promote the experiences of our diverse workforce	End of October 2019 *(Revised to end Jan 2020)*	Divisions and members of the Workforce Diversity & Inclusion Group are supporting promotion of the opportunity for staff to share their stories with the Board. It is anticipated that the inclusion of Staff Stories to Divisional Boards in many Divisional D&I Plans will increase the confidence of staff to share their stories with the Trust Board and help to ensure a full programme of contributors to March 2020. The potential to develop a series of staff stories videos is being explored with the Communications Team.	Risks slippage
			Increase the reverse mentoring scheme and extend this to over 20 leaders	End of December 2019	The Executive Team are now either participating in or preparing to participate in the Reverse Mentoring Scheme, or mentoring through other schemes. The drive to recruit BAME staff to act as Mentors is being supported by Divisional HR Business Partners and Diversity &	Behind plan/not achieved

Key to RAG: = On Track = Complete = Risks slippage = Behind plan/not achieved

WRES link WDES link

Public Board Meeting - January 2020-30/01/20 - Page 39

					Inclusion Leads. The focus during Q2 was on recruiting BAME staff to act as mentors, before extending the opportunity to be mentored to senior leadership teams in Divisions during Q3. The target for BAME mentors has not been reached and therefore the opportunity to be mentored has not yet been extended to senior leadership teams.	Behind plan/not achieved (red)
			Introduce a 'Lift to Climb' scheme for senior diverse staff to mentor more junior staff	End of March 2020	An invitation was extended to senior leaders at Band 8a and above to participate in development of the Trust's scheme to help staff who aspire to progress through the organisation. Two focus groups have been held as part of the development of the scheme which is on track for launch by the end of March 2020.	On Track (blue)
		Actions for this objective link to: **WRES Indicator 8 - Percentage of staff personally experiencing discrimination at work from their manager/team leader or another colleague in the last 12 months** **WDES Metric 7 - Percentage of Disabled staff compared to non-disabled staff saying that they are satisfied with the extent to which their organisation values their work**				
Accountability and Assurance	**4**	**We encourage shared learning by openly sharing our diversity data in a meaningful way**	Build on existing Diversity and Inclusion data to develop a data set that increases awareness of activity and progress from both the workforce data and patient activity.	End of October 2019	The Trust publishes certain sets of diversity data annually in line with regulatory requirements. This includes; equality data relating to workforce and service users, Workforce Race Equality Standard data, and Gender Pay Gap data. Workforce data sets were shared with Divisions as part of the Strategy Half-year update in October, together with one-page summaries of progress and future actions for the Workforce Race Equality Standard and Workforce Disability Equality Standard.	Complete (green)

Key to RAG: [blue] = On Track [green] = Complete [orange] = Risks slippage [red] = Behind plan/not achieved

WRES link WDES link

			We will review our governance for Diversity and Inclusion to ensure appropriate cross division and professional representation is in place	End of September 2019	To align with the objectives of the Diversity & Inclusion Strategy and to better support delivery of the actions, the terms of reference for the Workforce Diversity & Inclusion Group (previously the Equality & Diversity Group) were reviewed and updated, and approved by the People Management Group in May 2019. Local (Divisional) Diversity & Inclusion plans are in place and progress will be reported into Divisional reviews and Workforce D&I Group from December 2019.	
			Actions for this objective support awareness of WRES and WDES reporting and progress.			
	5	**Our Strategy is communicated at all levels reflecting our commitment to change**	Develop a robust communications plan for 2019/20 for Diversity and Inclusion ensuring this is embedded in all of our practices and interactions with staff, public and patients	End of June 2019	The Diversity & Inclusion communications plan ensures that diversity and inclusion feature more prominently in both internal and external communications, and will form an integral part of the overall Trust Communications Strategy currently in development.	
Positive Action and Practical Support	6	**Our Education Strategy focuses on inclusion and is a key enabler to delivering the vision supported by our Trust values**	Provide inclusive education that nurtures staff motivation and aspirational career development and values the individual and the teams that work together	As detailed in the education strategy	Data has been extrapolated from the Learning and Development team for staff /trainee access to the line management system that has identified D and I data. This will be part of education development and related to CQC regulation related to training and staff development. Memorandum of Understanding with Bristol City College to be approved at December Education Group. UWE have HEE funded study for implementing unconscious bias training related to supporting students in clinical practice. Intends to offer training in the first to senior nursing leads and then draw implications for impact of learning environment.	

Key to RAG: = On Track = Complete = Risks slippage = Behind plan/not achieved

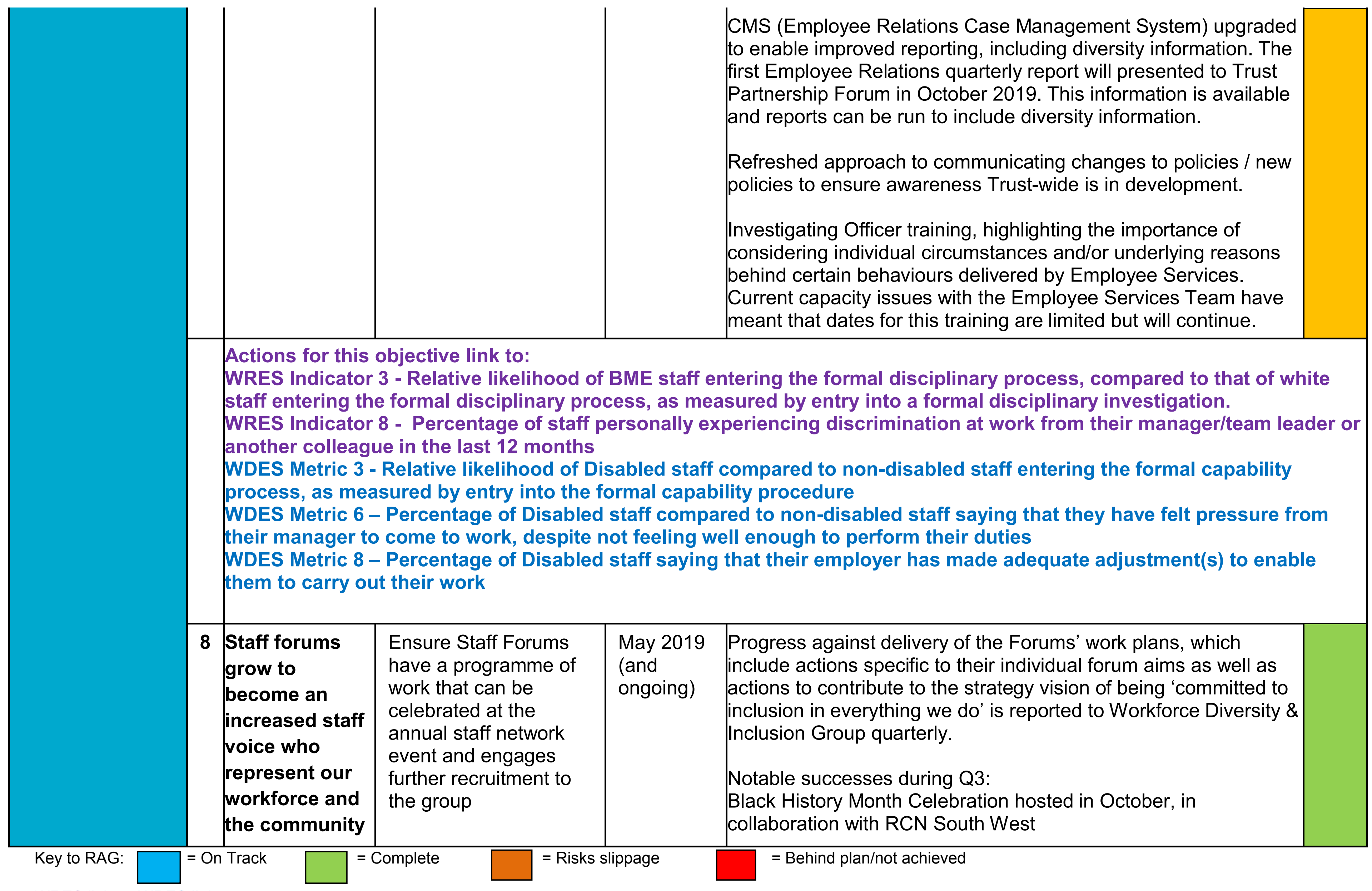
WRES link WDES link

Public Board Meeting - January 2020-30/01/20 - Page 41

					Developments also in place with under-graduate medical students – principles of how to further support D and I as part of Academy being taken to Education Group in December. Traineeships and work experience beginning to become increasingly aligned to Diversity & Inclusion principles.	
		Actions for this objective link to: **WRES Indicator 4 - Relative likelihood of BME staff accessing non-mandatory training and CPD as compared to white staff.** **WRES Indicator 7 - Percentage of staff believing that the organization provides equal opportunities for career progression or promotion** **WDES Metric 5:** **Percentage of Disabled staff compared to non-disabled staff believing that the Trust provides equal opportunities for career progression or promotion**				
	7	**Inclusion is integral in our people policies encouraging positive conversation and introducing informal processes where possible**	We will conduct a full review of our people policies and align these to the communication framework to ensure a consistent message and approach to inclusion. Ensure we continue to offer to Investigating Officers training to all managers using our HR related policies	End of March 2020	All policies continue to be reviewed in line with the Trust's equality impact assessment to ensure inclusion and consideration of the impact upon the whole workforce. All policies due for review are considered for inclusive language. A schedule of review for policies is in place to support this and as each is due for review this will be a specific focus. However, not all policies will have been reviewed by March 2020. A diversity and inclusion statement has been agreed through HR Policy Group and HR SLT and will be included in all new policies as they are reviewed. Exit Questionnaire now includes diversity questions in line with the staff survey to enable further analysis of reasons for leaving for specific categories such as age, gender, ethnicity, sexual orientation.	

Key to RAG: = On Track = Complete = Risks slippage = Behind plan/not achieved

WRES link WDES link



					CMS (Employee Relations Case Management System) upgraded to enable improved reporting, including diversity information. The first Employee Relations quarterly report will presented to Trust Partnership Forum in October 2019. This information is available and reports can be run to include diversity information. Refreshed approach to communicating changes to policies / new policies to ensure awareness Trust-wide is in development. Investigating Officer training, highlighting the importance of considering individual circumstances and/or underlying reasons behind certain behaviours delivered by Employee Services. Current capacity issues with the Employee Services Team have meant that dates for this training are limited but will continue.	
		Actions for this objective link to: **WRES Indicator 3 - Relative likelihood of BME staff entering the formal disciplinary process, compared to that of white staff entering the formal disciplinary process, as measured by entry into a formal disciplinary investigation.** **WRES Indicator 8 - Percentage of staff personally experiencing discrimination at work from their manager/team leader or another colleague in the last 12 months** **WDES Metric 3 - Relative likelihood of Disabled staff compared to non-disabled staff entering the formal capability process, as measured by entry into the formal capability procedure** **WDES Metric 6 – Percentage of Disabled staff compared to non-disabled staff saying that they have felt pressure from their manager to come to work, despite not feeling well enough to perform their duties** **WDES Metric 8 – Percentage of Disabled staff saying that their employer has made adequate adjustment(s) to enable them to carry out their work**				
	8	**Staff forums grow to become an increased staff voice who represent our workforce and the community**	Ensure Staff Forums have a programme of work that can be celebrated at the annual staff network event and engages further recruitment to the group	May 2019 (and ongoing)	Progress against delivery of the Forums' work plans, which include actions specific to their individual forum aims as well as actions to contribute to the strategy vision of being 'committed to inclusion in everything we do' is reported to Workforce Diversity & Inclusion Group quarterly. Notable successes during Q3: Black History Month Celebration hosted in October, in collaboration with RCN South West	

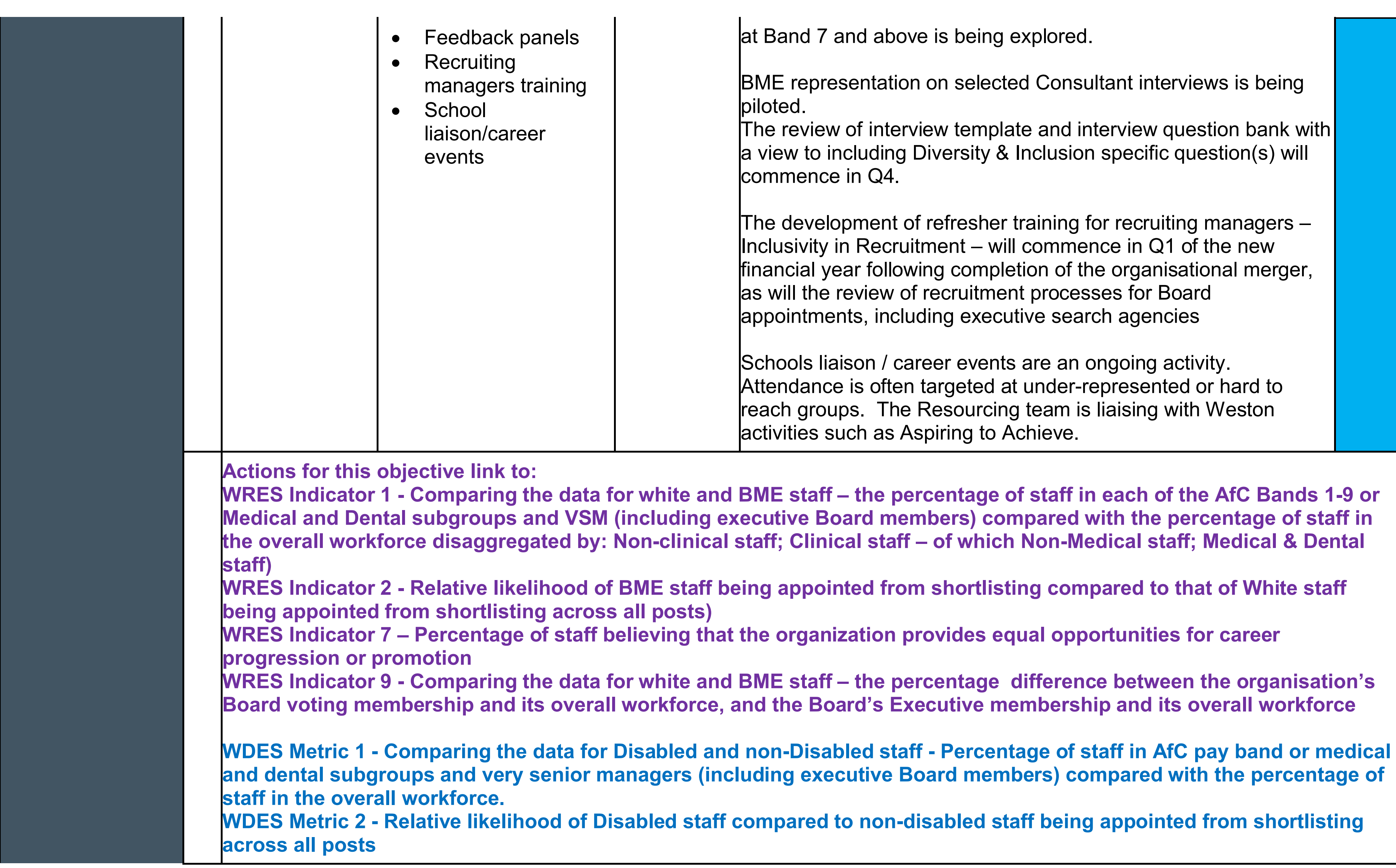
Key to RAG: = On Track = Complete = Risks slippage = Behind plan/not achieved

WRES link WDES link

		we serve			Sign-up to the NHS Rainbow Badges Scheme, launched in September, reached 2,500 by the end of December BME Forum Chair is part of the WRES Experts programme LGBT Forum Chair is taking part in Radius Employee Led Networks Programme to further develop knowledge and skills to share with all Trust staff forums to enable further growth and influence.	
		Actions for this objective link to: **WDES Indicator 9(b) - Has your trust taken action to facilitate the voices of Disabled staff in your organisation to be heard? (Yes) or (No)** **If yes, please provide at least one practical example of current action being taken.**				
Monitoring Progress and Benchmarking	9	**We will be recognised as an inclusive employer committed to ensuring our workforce reflects the community it serves**	Ensure all recruitment processes are reviewed to ensure an inclusive approach from application to appointment. This will include reviewing: • Job description and person specifications • Advertising • Shortlisting processes • Recruitment processes for Board appointments • Panel composition • Interview questions	December 2019 Revised to end March 2020	Projects to review and recommend updates to job descriptions, person specifications and 'House Standard' job advertising to ensure inclusive and gender neutral language completed during Q3. Revised job description and person specification templates will be used for recruitment to the merged organisation from 1st April 2020. Revised Advertising toolkit to be launched by end March 2020. Review of shortlisting process to provide assurance that the anonymised process removes opportunities for bias has been completed. Nine masterclasses have been delivered on the shortlisting process to provide assurance that the anonymised process removes opportunities for bias. Responses from the UK University Hospitals Network to enable benchmarking of best practice in balanced shortlisting indicate that only one member of the network uses a system of balanced shortlisting, which is carried out outside the standard recruitment process. The potential to trial a similar, manual, system for posts	

Key to RAG: = On Track = Complete = Risks slippage = Behind plan/not achieved

WRES link WDES link



			• Feedback panels • Recruiting managers training • School liaison/career events		at Band 7 and above is being explored. BME representation on selected Consultant interviews is being piloted. The review of interview template and interview question bank with a view to including Diversity & Inclusion specific question(s) will commence in Q4. The development of refresher training for recruiting managers – Inclusivity in Recruitment – will commence in Q1 of the new financial year following completion of the organisational merger, as will the review of recruitment processes for Board appointments, including executive search agencies Schools liaison / career events are an ongoing activity. Attendance is often targeted at under-represented or hard to reach groups. The Resourcing team is liaising with Weston activities such as Aspiring to Achieve.	On Track
		Actions for this objective link to: **WRES Indicator 1 - Comparing the data for white and BME staff – the percentage of staff in each of the AfC Bands 1-9 or Medical and Dental subgroups and VSM (including executive Board members) compared with the percentage of staff in the overall workforce disaggregated by: Non-clinical staff; Clinical staff – of which Non-Medical staff; Medical & Dental staff)** **WRES Indicator 2 - Relative likelihood of BME staff being appointed from shortlisting compared to that of White staff being appointed from shortlisting across all posts)** **WRES Indicator 7 – Percentage of staff believing that the organization provides equal opportunities for career progression or promotion** **WRES Indicator 9 - Comparing the data for white and BME staff – the percentage difference between the organisation's Board voting membership and its overall workforce, and the Board's Executive membership and its overall workforce** **WDES Metric 1 - Comparing the data for Disabled and non-Disabled staff - Percentage of staff in AfC pay band or medical and dental subgroups and very senior managers (including executive Board members) compared with the percentage of staff in the overall workforce.** **WDES Metric 2 - Relative likelihood of Disabled staff compared to non-disabled staff being appointed from shortlisting across all posts**				

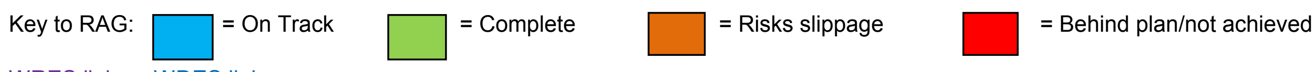
Key to RAG: [blue] = On Track [green] = Complete [orange] = Risks slippage [red] = Behind plan/not achieved

WRES link WDES link

Public Board Meeting - January 2020-30/01/20 - Page 45

Public Board Meeting - January 2020-30/01/20 - Page 46

		WDES Metric 5 - Percentage of Disabled staff compared to non-disabled staff believing that the Trust provides equal opportunities for career progression or promotion **WDES Metric 10 - Comparing the data for Disabled and non-disabled staff - the percentage difference between the organisation's Board voting membership and its organisation's overall workforce, disaggregated by voting membership of the Board and by Executive membership of the Board**				
	10	**We will seek opportunities to learn from others, developing our partnerships at a regional and national level**	We will work in partnership with the Bristol Manifesto and other partners across the city to share learning and best practice	Bi-monthly meetings	During Q1 the Trust submitted workforce data to contribute to the city-wide report on workforce race equality. This is an award-winning set of race diversity statistics developed by the Bristol Manifesto for Race Equality. The Race Equality Strategic Leaders Group has agreed an action plan in response to the outcomes of this data set, to which the Trust will contribute as a partner member. Update reports are due from June 2020. There is ongoing attendance at Bristol Manifesto for Race Equality Strategic Leads and HR Leads meetings, making full use of our external partners to share learning and best practice.	
			Actively work with external education providers to establish shared governance and enhanced partnership working	As detailed in the education strategy	Implementation of new, agile co-created models of working being developed across the STP with enhanced process around governance. Data for Diversity and Inclusion on apprenticeships being captured and aligned to outcomes and retention performance indicators. Collaboration across the STP with this data.	



WRES link WDES link

Workforce Disability Equality Standard Metrics Report & Action Plan
July 2019

Workforce Disability Equality Standard (WDES) - Overview[1]

As set out in the NHS Long Term Plan, respect, equality and diversity are central to changing culture and will be at the heart of our workforce implementation plan. The NHS draws on a remarkably rich diversity of people to provide care to our patients. But we fall short in valuing their contributions and ensuring fair treatment and respect. NHS England, with its partners, is committed to tackling discrimination and creating an NHS where the talents of all staff are valued and developed – not least for the sake of our patients and the delivery of high quality healthcare.

The NHS Workforce Disability Equality Standard (WDES) is designed to improve workplace experience and career opportunities for Disabled people working, or seeking employment, in the National Health Service (NHS). The WDES follows the NHS Workforce Race Equality Standard (WRES) as a tool and an enabler of change.

The WDES is a series of evidence-based Metrics that will provide NHS organisations with a snapshot of the experiences of their Disabled staff in key areas. By providing comparative data between Disabled and non-disabled staff, this information can be used to understand where key differences lie; and will provide the basis for the development of action plans, enabling organisations to track progress on a year by year basis. The WDES provides a mirror for the organisation to hold up to itself, to see whether or not it sees a reflection of the communities that it serves.

Organisations will be encouraged to introduce new measures and practices which positively support disability equality in the workplace and further the involvement and engagement of Disabled communities more widely in the work and aims of the NHS.

Purpose

This report provides the information which will be included in the Trust's published WDES report this year. It includes the data for the ten metrics which was submitted to NHS England via the Strategic Data Collection Service by 1st August 2019. This data forms the basis of NHS England's report into the WDES which is due in late 2019. It also includes actions to support disability equality in the workplace, linking them to the Year 1 actions to deliver the Trust's Workforce Diversity & Inclusion Strategy Plan.

The Trust's forum for disabled staff (ABLE+) is engaged in development of this plan.

[1] The Overview is taken from the NHS England NHS Workforce Disability Equality Standard Technical Guidance

Workforce Disability Equality Standard (WDES) – 2019 Report

The data which has been submitted to NHS England and planned actions to deliver improvements are shown below.

Workforce Metrics – for each of the three workforce metrics, compare the data for both Disabled and non-disabled staff.

Metric 1	Percentage of staff in AfC payband or medical and dental subgroups and very senior managers (including executive Board members) compared with the percentage of staff in the overall workforce. (The calculation is undertaken separately for non-clinical and for clinical staff.)

Data for reporting year (snapshot as at 31st March 2019)

Overall workforce = 3% Disabled, 93% not disabled and 4% not declared/unknown/null

Non-clinical staff	Disabled % (of cluster)	Not disabled % (of cluster)	Disability unknown or null % (of cluster)
Cluster 1 (Bands 1 - 4)	4%	92%	4%
Cluster 2 (Band 5 - 7)	5%	94%	2%
Cluster 3 (Bands 8a - 8b)	1%	95%	4%
Cluster 4 (Bands 8c - 9 & VSM)	2%	89%	9%

Clinical Staff	Disabled % (of cluster)	Not disabled % (of cluster)	Disability unknown or null % (of cluster)
Cluster 1 (Bands 1 - 4)	3%	94%	3%
Cluster 2 (Band 5 - 7)	2%	96%	2%
Cluster 3 (Bands 8a - 8b)	1%	97%	2%
Cluster 4 (Bands 8c - 9 & VSM)	2%	90%	8%

Notes:

Data is derived from the ESR.

Clusters of pay bands/groups are used to allow a better understanding of Disabled staff across the workforce because of the low percentages of Disabled staff recorded in ESR.

The total number of staff recorded in ESR as disabled is 265.

The number of staff who responded to the 2018 NHS Staff Survey and said they had a physical or mental health condition, disability of illness lasting more than 12 months was 715 (16%).

Nationally, there is significant under-reporting of the numbers of staff who declare themselves to be disabled. (On average, 3% of people state that they are disabled on ESR, on average 18% declare that they have a disability on the NHS Staff survey- a 15% difference in the disability declaration rate.)

The NHS (and the Trust) can only know whether significant improvements are being made to the

Public Board Meeting - January 2020-30/01/20 - Page 48

Cluster 5 (Medical & Dental Staff, Consultants)	1%	89%	10%
Cluster 6 (Medical & Dental Staff, Non-Consultants career grade)	1%	89%	10%
Cluster 7 (Medical & Dental Staff, Medical and dental trainee grades)	3%	81%	16%

number of Disabled people working in the NHS if the disability declaration rate improves year on year.

Planned action(s) from the Workforce Diversity & Inclusion Strategy Plan April 2019 – March 2020:

- Agree our approach to inclusive Talent Management ensuring this complements the career pathway work in the education strategy.
- We will ensure our appraisal framework includes a Diversity and Inclusion objective so every leader is able to demonstrate their commitment to diversity, inclusion and fairness.
- Ensure all recruitment processes are reviewed to ensure an inclusive approach from application to appointment.

The above are included in the Workforce D&I Strategy plan as actions to support delivery of the following objectives:

We are committed to inclusion in everything we do including Recruitment, Induction, Training, Appraisal and Talent Management
We will be recognized as an inclusive employer committed to ensuring our workforce reflects the community it serves

Additional planned action(s) for 2019/2020

- Increase ESR disability declaration rates and reduce the number in the 'Not known/not declared' categories by:
- Increased focus on using the Health Appraisal section of Appraisals as an opportunity to discuss any change in health status (and update via ESR self-service)
- Promotion of ESR self-service to add or amend disability information
- Reinforcing the importance of transferring/collecting/recording diversity data for ALL starters

Measures of success: Year on year decrease in 'Not known/not declared' status on ESR, and year on year increase in disability declaration rates

Metric 2	Relative likelihood of Disabled staff compared to non-disabled staff being appointed from shortlisting across all posts

Data for reporting year (1st April 2018 – 31st March 2019)	***Notes***
Disabled people are 1.76 times less likely to be appointed from shortlisting that non-disabled people. This is calculated from the following figures for all recruitment episodes recorded on TRAC: (see table below)	The data is taken from the TRAC system used for all recruitment episodes. More detailed data is published on the Trust's website at Equality Performance & Objectives The number of shortlisted applicants who either did not state or did not wish to disclose whether or not they have a disability was 171. The number appointed from shortlisting was 52 (outnumbering the number of Disabled people appointed from shortlisting.) The Trust operates a Guaranteed Interview Scheme which ensures those applicants declaring a disability are interviewed provided they meet all of the essential criteria of the role. The scheme provides positive action for Disabled staff, and NHS England supports and encourages all NHS Organisations to use the Guaranteed Interview Scheme in their recruitment processes.

	Disabled	Non-disabled
Number of shortlisted applicants (headcount)	390	5,863
Number appointed from shortlisting (headcount)	51	1,346

Planned action(s) from the Workforce Diversity & Inclusion Strategy Plan April 2019 – March 2020:

- Review of shortlisting process to provide assurance that the anonymised process removes opportunities for bias
- Review interview template and interview question bank with a view to including D&I section / specific question (eg: "What have you done in your previous role(s) to promote diversity and inclusion?")
- Research/commission/develop refresher training for recruiting managers – Inclusivity in Recruitment – to be delivered as one hour, back to back sessions over two days. (Will include launch of refreshed JDs, advertising and interview Qs)

Refresh panel composition with a view to including an extra, independent, person as part of the selection process to challenge on aspects of inclusivity. (For interviews of B7 or B8a and above roles initially)

Review recruitment processes for Board appointments, including executive search agencies.

The above are included in the Workforce D&I Strategy plan as actions to support delivery of the following objective:

We will be recognized as an inclusive employer committed to ensuring our workforce reflects the community it serves.

Metric 3	Relative likelihood of Disabled staff compared to non-disabled staff entering the formal capability process, as measured by entry into the formal capability procedure

Data for the reporting period (1st April 2017 – 31st March 2019)	*Notes*
Disabled staff are 3.44 times more likely than non-disabled staff to enter the formal capability process. This is measured by the number of Disabled and non-disabled staff entering the formal part of the process in the Performance Management Policy as recorded on the Case Management System.	For the purpose of this year's reporting, capability is defined as capability on the grounds of performance, not ill health. Data is for all cases live on the Case Management System between 1st April 2017 and 31st March 2019. The diversity information about staff on our case management system is pulled through from ESR. Disability status is not always declared or up to date, which has an impact on the accuracy of the data on the case management system.

Planned action(s) from the Workforce Diversity & Inclusion Strategy Plan April 2019 – March 2020:

- Review of our people policies (as they fall due for review) to ensure a consistent message and approach to inclusion
- Ensure we continue to offer to Investigating Officers training to all managers undertaking HR related investigations

The above are included in the Workforce D&I Strategy plan as actions to support delivery of the following objective:

Inclusion is integral in our people policies encouraging positive conversation and introducing informal processes where possible

National NHS Staff Survey Metrics – for each of the following four Staff Survey metrics, compare the responses for both Disabled and non-disabled staff.

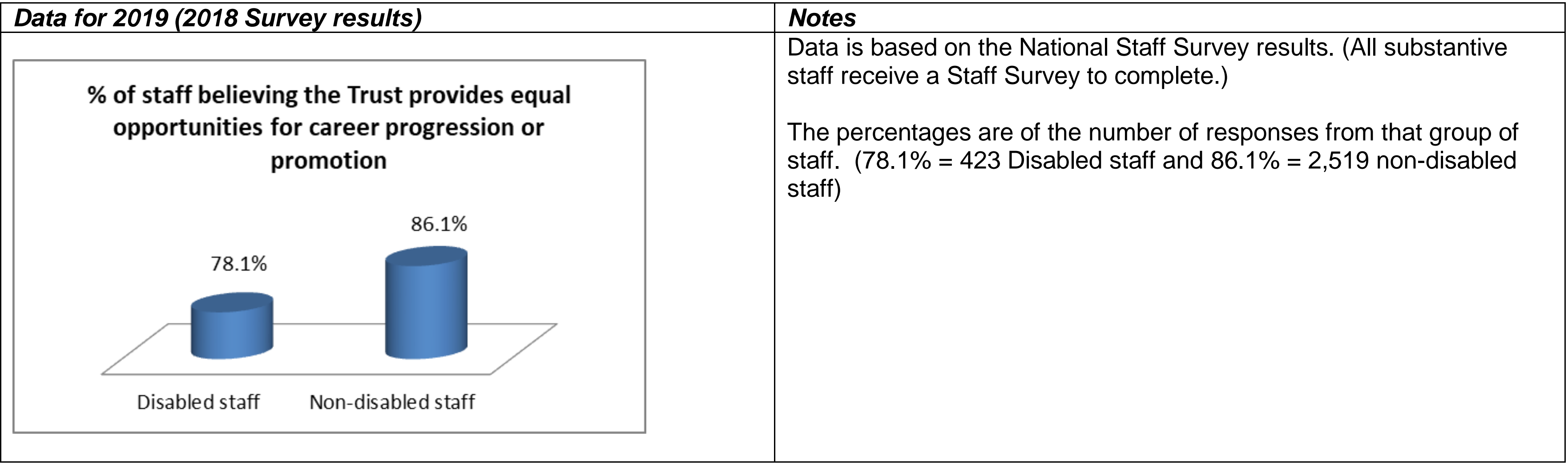
Metric 4 Staff Survey Q13	(a) Percentage of Disabled staff compared to non-disabled staff experiencing harassment, bullying or abuse from patients/service users, their relatives or other members of the public; managers; other colleagues (b) Percentage of Disabled staff compared to non-disabled staff saying that the last time they experienced harassment, bullying or abuse at work, they or a colleague reported it

Data for 2019 (2018 Survey results)		***Notes***
% of staff who experienced at least one eipsode of harassment, bullying or abuse in the last 12 months Disabled staff / Non-disabled staff Patients, service users, relatives, other members of the public: 30.2% / 23.0% Managers: 18.2% / 9.9% Other colleagues: 28.3% / 16.0%	% of staff who reported, or had a colleague report, their last experience of harassment, bullying or abuse Disabled staff: 47.5% Non-disabled staff: 45.6%	Data is based on the National Staff Survey results. (All substantive staff receive a Staff Survey to complete.) The percentages are of the number of responses from that group of staff. (For example, 30.2% = 723 Disabled staff) Of the bullying and harassment cases reported to the Employee Services team and recorded on the Case Management System, only one was reported by a Disabled person. The diversity information about staff on our case management system is pulled through from ESR. Disability status is not always declared or up to date, which has an impact on the accuracy of the data on the case management system.

Planned action(s) 2019/2020:

- A Senior Leadership Plan to develop different ways to reduce bulling and harassment and to support staff to feel they have a voice – to be agreed September 2019
- Divisions to identify service actions and interventions to improve this result as part of Divisional Improving Staff Experience Plans – measured by Staff Survey results in 2020

Metric 5 Staff Survey Q14	Percentage of Disabled staff compared to non-disabled staff believing that the Trust provides equal opportunities for career progression or promotion

Data for 2019 (2018 Survey results)	***Notes***
	Data is based on the National Staff Survey results. (All substantive staff receive a Staff Survey to complete.) The percentages are of the number of responses from that group of staff. (78.1% = 423 Disabled staff and 86.1% = 2,519 non-disabled staff)

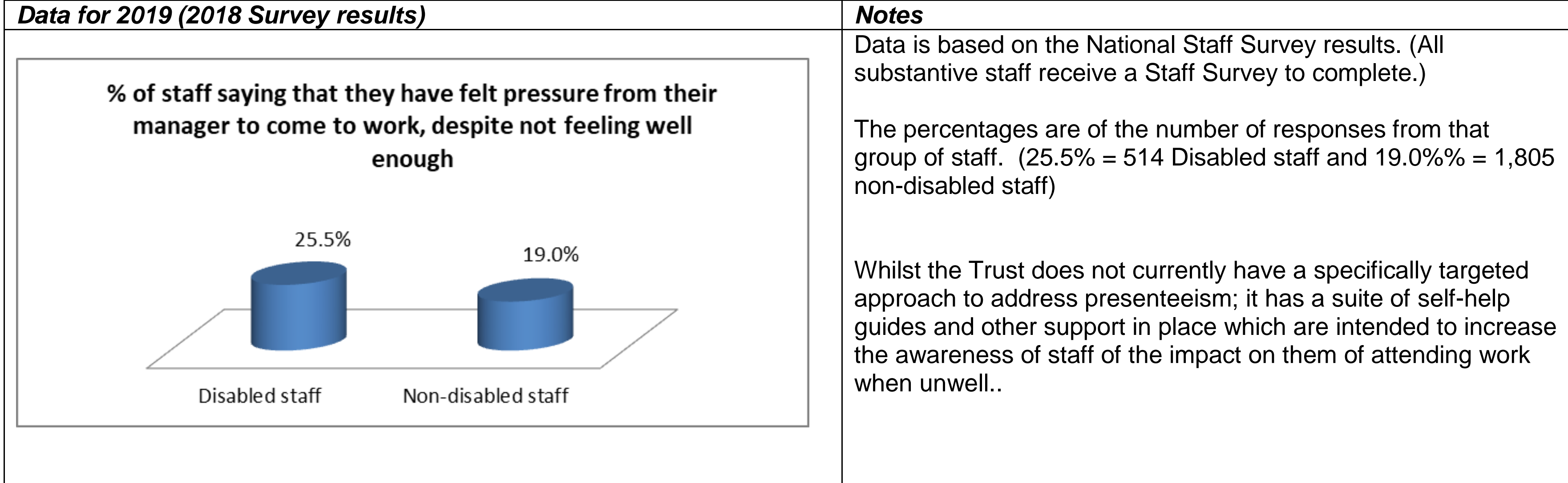
Planned action(s) from the Workforce Diversity & Inclusion Strategy Plan April 2019 – March 2020:

- Review of shortlisting process to provide assurance that the anonymised process removes opportunities for bias
- Review interview template and interview question bank with a view to including D&I section / specific question (eg: "What have you done in your previous role(s) to promote diversity and inclusion?")
- Research/commission/develop refresher training for recruiting managers – Inclusivity in Recruitment – to be delivered as one hour, back to back sessions over two days. (Will include launch of refreshed JDs, advertising and interview Qs)
- Refresh panel composition with a view to including an extra, independent, person as part of the selection process to challenge on aspects of inclusivity. (For interviews of B7 or B8a and above roles initially)
- Review recruitment processes for Board appointments, including executive search agencies

The above are included in the Workforce D&I Strategy plan to deliver the following objective:

We will be recognized as an inclusive employer committed to ensuring our workforce reflects the community it serves.

Metric 6 Staff Survey Q11	Percentage of Disabled staff compared to non-disabled staff saying that they have felt pressure from their manager to come to work, despite not feeling well enough to perform their duties

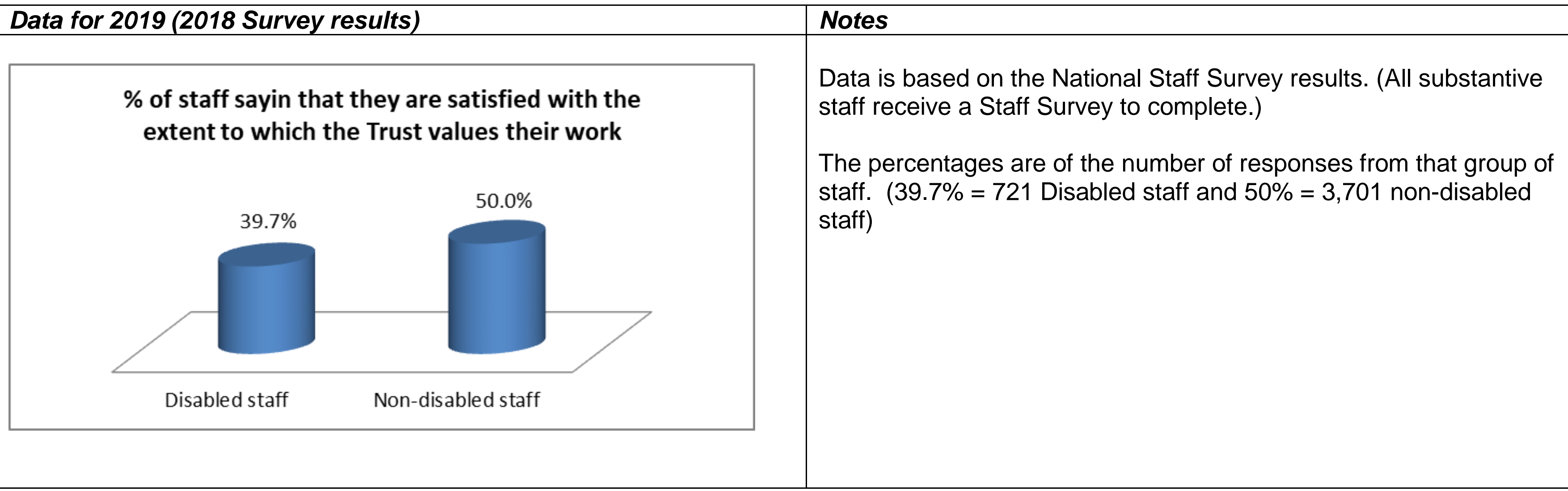
Data for 2019 (2018 Survey results)	*Notes*
	Data is based on the National Staff Survey results. (All substantive staff receive a Staff Survey to complete.) The percentages are of the number of responses from that group of staff. (25.5% = 514 Disabled staff and 19.0%% = 1,805 non-disabled staff) Whilst the Trust does not currently have a specifically targeted approach to address presenteeism; it has a suite of self-help guides and other support in place which are intended to increase the awareness of staff of the impact on them of attending work when unwell..

Planned action(s) for 2019/2020:

Actions to improve declaration rates on ESR, as for Metric 1, and especially:

- Increased focus on using the Health Appraisal section of Appraisals as an opportunity to discuss any change in health status (and update via ESR self-service)

Metric 7 Staff Survey Q5	Percentage of Disabled staff compared to non-disabled staff saying that they are satisfied with the extent to which their organisation values their work

Data for 2019 (2018 Survey results)	*Notes*
	Data is based on the National Staff Survey results. (All substantive staff receive a Staff Survey to complete.) The percentages are of the number of responses from that group of staff. (39.7% = 721 Disabled staff and 50% = 3,701 non-disabled staff)

Planned action(s) from the Workforce Diversity & Inclusion Strategy Plan April 2019 – March 2020:

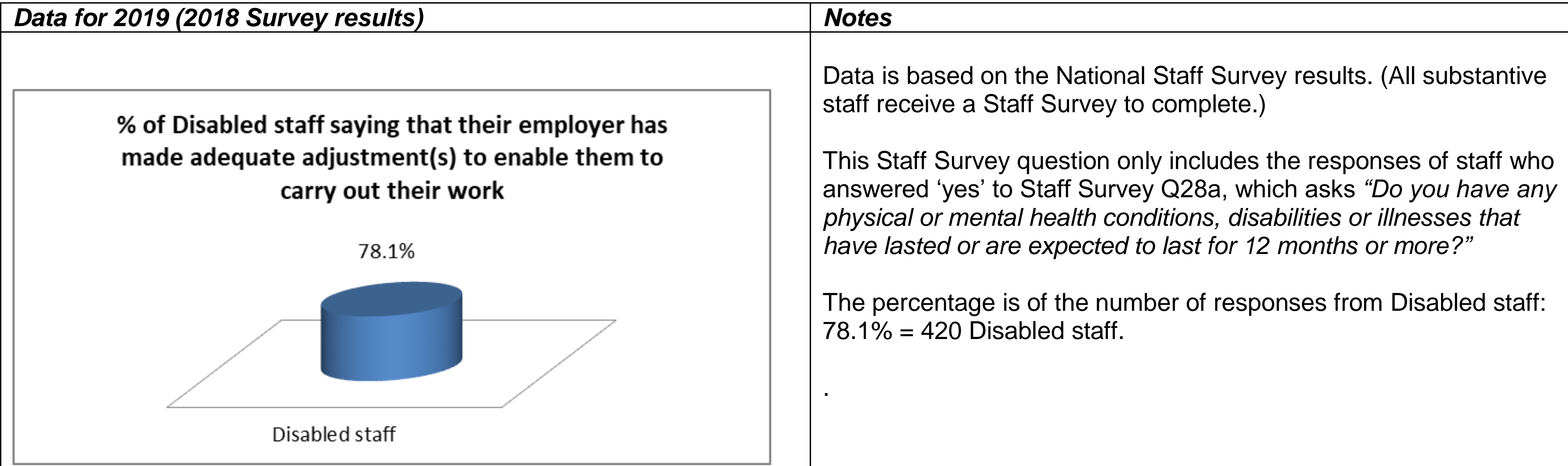
- We will continue to share staff stories at Board and work to develop a series of staff story videos to promote the experiences of our diverse workforce
- Review existing recognition schemes to ensure there is an inclusive approach from the nominations process to the panel

The above are included in the Workforce D&I Strategy plan to deliver the following objective:

We celebrate and value the contribution all of our staff make at all levels of the organisation

The following NHS Staff Survey Metric only includes the responses of Disabled staff

Metric 8 Staff Survey Q28b	Percentage of Disabled staff saying that their employer has made adequate adjustment(s) to enable them to carry out their work

Data for 2019 (2018 Survey results)	*Notes*
	Data is based on the National Staff Survey results. (All substantive staff receive a Staff Survey to complete.) This Staff Survey question only includes the responses of staff who answered 'yes' to Staff Survey Q28a, which asks *"Do you have any physical or mental health conditions, disabilities or illnesses that have lasted or are expected to last for 12 months or more?"* The percentage is of the number of responses from Disabled staff: 78.1% = 420 Disabled staff. .

Planned action(s) for 2019/2020:

Launch and promote the process developed by Able+ to support managers and staff with advice and guidance about reasonable adjustments

Planned action(s) from the Workforce Diversity & Inclusion Strategy Plan April 2019 – March 2020:

- Review of our people policies (as they fall due for review) to ensure a consistent message and approach to inclusion
- Ensure we continue to offer to Investigating Officers training to all managers undertaking HR related investigations

The above are included in the Workforce D&I Strategy plan to deliver the following objective:

Inclusion is integral in our people policies encouraging positive conversation and introducing informal processes where possible

Public Board Meeting - January 2020-30/01/20 - Page 56

NHS Staff Survey and the engagement of Disabled staff

For Metric 9 a), compare the staff engagement scores for Disabled, non-disabled staff and the overall Trust score

Metric 9 (a)	**The staff engagement score for Disabled staff, compared to non-disabled staff and the overall engagement score for the organisation**

Data for 2019 (2018 Survey results)	***Notes***
Staff engagement score for Disabled staff, non-disabled staff and the overall engagement score for the Trust Disabled staff: 6.9 Non-disabled staff: 7.3 Organisation average: 7.2	Data is based on the National Staff Survey results. (All substantive staff receive a Staff Survey to complete.) The staff engagement score is a composite score made up of the responses to nine individual questions in the staff survey. (It is a score out of 10) 6.9 = responses from 730 Disabled staff 7.3 = responses from 3,721 non-disabled staff 7.2 = organisation average for 4,771 staff

Planned action(s) for 2019/2020:

The Trust has an Improving Staff Experience plan linked to its People Strategy. This is not specifically targeted, but for all staff.

Metric 9 (b)	Has your trust taken action to facilitate the voices of Disabled staff in your organisation to be heard? (Yes) or (No) If yes, please provide at least one practical example of current action being taken.

Response for 2019
The Trust facilitates the voices of Disabled staff through the Disabled staff forum – ABLE+. The Forum has been active for three years, and is represented on and supported by the Trust's Workforce Diversity & Inclusion Group, contributing to the work of that group in supporting delivery of the Trust's Workforce Diversity & Inclusion Strategy. Members of the Forum were involved in development of the Strategy, which includes as a year 1 objective: **Staff Forums grow to become an increased staff voice who represent our workforce and the community we serve** ABLE+ (and the Trust's other staff forums – the BAMEW Forum and LGBT Forum) promoted their presence and work to colleagues in the Trust at a Staff Forums Event in May, opened by the Trust Chairman. The Forum has been involved in partnership working on the WDES from the beginning, including attendance at one of the early workshops held by NHS England. When members of ABLE+ were asked the question "Has your Trust taken action to facilitate the voices of Disabled staff in your organisation to be heard?" they suggested a third possible answer: 'to a certain extent'. The majority of them chose this option. They were also asked "What other actions do you think the Trust could/should take to enable the voices of Disabled staff to be heard?" The responses to this question form the basis for the planned actions, below.

Planned action(s) for 2019/2020:

- Hold a 'Disability Awareness Day' on 24th September 2019 in which Executives have been invited to participate
- Provide more guidance for managers to ensure that they understand their obligations in regard to providing reasonable adjustments
- Continue to raise the profile of ABLE+ and the awareness of support available for staff (including through the Reasonable Adjustments guidance paper)
- Increased focus on using the Health Appraisal section of Appraisals as an opportunity to discuss any change in health status (and update via ESR self-service)

Links to actions to deliver the following objectives from the Workforce Diversity & Inclusion Plan Year 1 (April 2019 – March 2020):

Staff Forums grow to become an increased staff voice who represent our workforce and the community we serve

Board Representation Metric

For this metric, compare the difference for Disabled and non-disabled staff

Metric 10	**Percentage difference between the organisation's Board voting membership and its organisation's overall workforce, disaggregated by voting membership of the Board and by Executive membership of the Board**

Data for 2019 (2018 Survey results)	***Notes***
The Trust has a 3% Disabled workforce and 6% of the voting members of the Board has a declared disability. The percentage difference between the Trust's Board voting membership and the overall workforce is +3%. The Trust has a 3% Disabled workforce and 0% of the Executive members of the Board has a declared disability. The percentage difference between the Trust's Executive Board membership and the overall workforce is - 3%.	The voting membership of the Board is the whole membership – made up of Executives and non-Executives. The Executive membership of the Board are the direct employees of the Trust.

Planned action(s) from the Workforce Diversity & Inclusion Strategy Plan April 2019 – March 2020:

- Review recruitment processes for Board appointments, including executive search agencies

The above is included in the Workforce D&I Strategy plan to deliver the following objective:

We will be recognized as an inclusive employer committed to ensuring our workforce reflects the community it serves

Conclusion

The relatively low self-declaration rates of Disabled staff at the Trust on the ESR reflects the national picture, and we hope that the publication of national statistics in the Workforce Disability Standard will add urgency to the need to resolve this locally and nationally.   Until the declaration rate improves it is difficult to identify where work needs to focus to remove barriers to progression.

We've made a practice of examining the Staff Survey responses from both BAME staff and Disabled staff over the past few years, and recognise that the workplace experience of both groups needs to improve.

The organisation's response has been to develop a Workforce Diversity & Inclusion Strategy for the next five years which sets out our vision of being 'committed to inclusion in everything we do', and how we aim to deliver this over the next five years.

Accountability for improving the experience of Disabled staff sits with the Trust Board. Progress is reported into the Board on a quarterly basis through the People Committee, who will be the approving body for this Report and Action Plan.

Workforce Race Equality Standard Metrics Report &Action Plan August 2019

Workforce Race Equality Standard (WRES) - Background

In response to the NHS Equality & Diversity Council announcement in July 2014 that it had agreed action to ensure employees from black and minority ethnic (BME) backgrounds have equal access to career opportunities and receive fair treatment in the workplace, the Workforce Race Equality Standard (WRES) was implemented.

There are nine WRES indicators. Four of the indicators focus on workforce data, four are based on data from the national NHS Staff Survey questions, and one indicator focuses upon black and minority ethnic (BME) representation on Boards. The WRES highlights any differences between the experience and treatment of white staff and BME staff in the NHS with a view to closing those gaps through the development and implementation of action plans focused upon continuous improvement over time.

NHS organisations published and or submitted WRES data for the first time in August 2015. This data presented each organisation's response to each of the nine WRES indicators and constitutes the WRES baseline. Alongside the WRES baseline data, organisations also developed Action Plans that outline the practical approach needed to continuously improve organisational performance with regard to workforce race equality.

From 2016/17, WRES reporting has been included in the NHS standard contract for NHS provider organisations and it also featured in the new 2016/17 CCG Assessment and Improvement Framework.

Planned actions in previous reports have been linked to the 2016 – 2019 Equality & Diversity Strategic Objectives for the Trust, and updates included in annual Equality & Diversity Reports. In order to further develop the existing programme of work into an inclusive strategy, the Trust has worked with internal stakeholders (including members of the Trust's BAME Workers Forum) and the National WRES Team, and launched its Workforce Diversity & Inclusion Strategy in May 2019.

Purpose

This report provides the information which will be included in the Trust's published WRES report this year. It includes the data for the nine metrics (with the exception of Indicator 4) which was submitted to NHS England via the Strategic Data Collection Service by 30th August 2019. This data forms the basis of NHS England's report into the WRES which is due in late 2019/early 2020. It also includes a comparison with last year's data, actions taken so far and further planned actions to support workforce race equality, linking them to the Year 1 actions to deliver the Trust's Workforce Diversity & Inclusion Strategy Plan.

Feedback from the Trust's BAME Workers Forum is included in the conclusion to this report.

Public Board Meeting - January 2020-30/01/20 - Page 61

Workforce Race Equality Standard (WRES) – 2019 Report & Action Plan

The data which has been submitted to NHS England, comparisons with previous years' data and actions taken and planned, is shown below.

Workforce Indicators – for each of the four workforce indicators, compare the data for white and BME staff.

1	Percentage of staff in each of the AfC Bands 1-9 or Medical and Dental subgroups and VSM (including executive Board members) compared with the percentage of staff in the overall workforce disaggregated by: Non-clinical staff; Clinical staff – of which Non-Medical staff; Medical & Dental staff

Data for previous year (2018)

Overall workforce = 83.1% White and 14.9% BME (2% unknown/not given)

Non-Clinical Staff

	White	BME	Unknown
Band 1	45.8%	52.6%	1.6%
Band 2	86.9%	12.0%	1.0%
Band 3	89.4%	10.0%	0.6%
Band 4	94.1%	5.0%	0.9%
Band 5	92.0%	7.6%	0.4%
Band 6	92.4%	6.9%	0.7%
Band 7	95.0%	4.3%	0.7%
Band 8A	94.8%	5.2%	0.0%
Band 8B	97.9%	2.1%	0.0%
Band 8C	95.7%	4.3%	0.0%
Band 8D	100.0%	0.0%	0.0%
Band 9	100.0%	0.0%	0.0%
VSM	100.0%	0.0%	0.0%

Data for reporting year (2019)

Overall workforce = 83% White and 14.4% BME (2.5% unknown/not given)

Non-Clinical Staff

	White	BME	Unknown
Band 1	48.2%	45.9%	5.9%
Band 2	83.1%	11.1%	5.7%
Band 3	87.0%	9.9%	3.1%
Band 4	92.8%	5.6%	1.6%
Band 5	91.6%	7.2%	1.2%
Band 6	91.9%	6.8%	1.4%
Band 7	93.1%	4.6%	2.3%
Band 8A	96.0%	4.0%	0.0%
Band 8B	94.0%	4.0%	2.0%
Band 8C	95.7%	4.3%	0.0%
Band 8D	100.0%	0.0%	0.0%
Band 9	100.0%	0.0%	0.0%
VSM	100.0%	0.0%	0.0%

Narrative

Data is taken from the ESR as at 31st March 2018 and 31st March 2019. These are the figures submitted via SDCS.

The percentage shown is for each pay band. The percentage of BME staff in the lowest band (Band 1) is much higher than that in the overall workforce, and BME staff are under-represented in other Agenda for Change pay bands, especially at senior levels.

The exception is Band 5 non-medical clinical staff – typically from the Nursing & Midwifery staff group.

Non-clinical staff on Band 1 would typically be from the Estates & Ancillary staff group.

Clinical Staff on Medical & Dental pay grades more closely align with the ethnic make-up of the overall workforce.

It is disappointing to see no real increase in the numbers of BME staff in senior grades, in spite of actions taken.

Public Board Meeting - January 2020-30/01/20 - Page 62

Clinical Staff - *Non-Medical 2018*

	White	BME	Unknown
Band 1	65.1%	33.9%	1.0%
Band 2	80.4%	19.4%	0.3%
Band 3	87.0%	13.0%	0.0%
Band 4	92.5%	7.5%	0.0%
Band 5	79.4%	19.9%	0.7%
Band 6	90.0%	9.6%	0.4%
Band 7	94.8%	4.7%	0.5%
Band 8A	93.0%	6.1%	0.9%
Band 8B	96.5%	3.5%	0.0%
Band 8C	95.1%	2.4%	2.4%
Band 8D	87.5%	0.0%	12.5%
Band 9	100.0%	0.0%	0.0%
VSM	100.0%	0.0%	0.0%

Clinical Staff – *Medical & Dental 2018*

	White	BME	Unknown
Consultants (including Senior Medical Staff)	81.8%	15.3%	2.9%
Non-consultant career grades	63.1%	26.3%	10.6%
Trainee grades	72.9%	12.6%	14.5%
Other	47.6%	4.8%	47.6%

Clinical Staff - *Non-Medical*

	White	BME	Unknown
Band 1	65.0%	32.4%	2.6%
Band 2	80.1%	18.5%	1.4%
Band 3	85.8%	12.9%	1.3%
Band 4	92.9%	6.7%	0.4%
Band 5	79.6%	18.8%	1.6%
Band 6	89.1%	10.1%	0.8%
Band 7	94.5%	5.0%	0.5%
Band 8A	92.6%	6.5%	0.9%
Band 8B	96.6%	3.4%	0.0%
Band 8C	95.2%	2.4%	2.4%
Band 8D	85.7%	0.0%	14.3%
Band 9	100.0%	0.0%	0.0%
VSM	100.0%	0.0%	0.0%

Clinical Staff – *Medical & Dental 2019*

	White	BME	Unknown
Consultants (including Senior Medical Staff)	80.0%	14.9%	5.0%
Non-consultant career grades	66.4%	26.7%	6.9%
Trainee grades	75.1%	16.1%	8.8%
Other	56.5%	8.7%	34.8%

More disappointing is the increase in the number of staff whose ethnicity is not recorded on the ESR.

Links to the Equality & Diversity Strategic Objective for 2016 – 2019:
To improve the opportunities for members of our diverse communities to gain employment with and progress within the Trust.

Links to the Workforce Diversity & Inclusion Strategy 2020 – 2025 as described below.

Public Board Meeting - January 2020-30/01/20 - Page 63

Actions taken:

- Training to raise awareness of unconscious bias/stereotyping included in Recruiting the Best training for recruiting managers, and in Corporate Induction section on Equality & Diversity, and Equality, Diversity & Human Rights training.
- Anonymising of application forms as presented for shortlisting.
- More applicants from BME backgrounds encouraged through promoting career opportunities (including apprenticeships and traineeships) in appropriate local schools & colleges
- Apprentice recruitment data (including gender, ethnicity, age etc) reported to the Education Skills Funding Agency
- Review of advertising and selection process for internal opportunities to ensure transparency and equality of opportunity
- Work with Bristol Manifesto for Race Equality HR Leads on city-wide recruitment initiatives
- Introduction of Reverse Mentoring Scheme involving staff from BAME backgrounds and senior managers from October 2018
- Promotion of Leadership & Management development training to staff from protected groups, through delivery of presentation to E&D Group, BAME Forum and other appropriate groups.
- Open forum discussions during October 2018 with the BAMEW Forum and Trust Equality & Diversity Group about barriers to progression and how best to remove them.

Planned action(s) from the Workforce Diversity & Inclusion Strategy Plan April 2019 – March 2020:

- Review of shortlisting process to provide assurance that the anonymised process removes opportunities for bias
- Review interview template and interview question bank with a view to including D&I section / specific question (eg: "What have you done in your previous role(s) to promote diversity and inclusion?")
- Research/commission/develop refresher training for recruiting managers – Inclusivity in Recruitment – to be delivered as one hour, back to back sessions over two days. (Will include launch of refreshed JDs, advertising and interview Qs)
- Refresh panel composition with a view to including an extra, independent, person as part of the selection process to challenge on aspects of inclusivity. (For interviews of B7 or B8a and above roles initially)
- Review recruitment processes for Board appointments, including executive search agencies.

The above are included in the Workforce D&I Strategy plan to support delivery of the following objective:

We will be recognized as an inclusive employer committed to ensuring our workforce reflects the community it serves.

In addition, we will aim to increase ESR declaration rates and reduce the number in the 'Not known/not declared' categories

2. Relative likelihood of BME staff being appointed from shortlisting compared to that of White staff being appointed from shortlisting across all posts

Data for previous year (2018)	*Data for reporting year (2019)*	*Narrative*
White staff are 2.23 times more likely to be appointed from shortlisting than BME staff.	White staff are 1.6 times more likely to be appointed from shortlisting than BME staff.	Data is for April 2017 to March 2018 and for April 2018 to March 2019, as submitted via SDCS. The data is taken from the TRAC system used for all recruitment episodes. More detailed data is published on the Trust's website at Equality Performance & Objectives There is an encouraging increase in the likelihood of BME staff being appointed from shortlisting. As the data is for appointments made up to 31st March 2019, it is not reflected in the data for Indicator 1, above. Links to the Equality & Diversity Strategic Objective for 2016 – 2019: **To improve the opportunities for members of our diverse communities to gain employment with and progress within the Trust** Links to the Workforce Diversity & Inclusion Strategy 2020 – 2025 as described below.

Actions taken:

As for Indicator 1, above, relating to Recruitment

Planned action(s) from the Workforce Diversity & Inclusion Strategy Plan April 2019 – March 2020:

Additional actions described for Indicator 1 should also influence the outcomes for this indicator.

3. Relative likelihood of BME staff entering the formal disciplinary process, compared to that of white staff entering the formal disciplinary process, as measured by entry into a formal disciplinary investigation.

Data for previous year (2018)	*Data for reporting year (2019)*	*Narrative*
Relative likelihood of BME staff entering the formal disciplinary process is **3.16** times greater than white staff	Relative likelihood of BME staff entering the formal disciplinary process is **2.06** times greater than white staff.	This is measured by the number of BME and white staff entering a formal disciplinary investigation as recorded on the Case Management System. Data is for cases live between 1st April 2017 and 31st March 2018, and 1st April 2018 and 31st March 2019. For both years the number of cases exclude ongoing cases live during the previous period. It is encouraging to see a decrease in the relative likelihood of BME staff entering the formal disciplinary process. *Links to the Equality & Diversity Strategic Objective for 2016 – 2019:* **To work towards a more inclusive and supportive working environment for all of our staff.** Links to the Workforce Diversity & Inclusion Strategy 2020 – 2025 as described below.

Actions taken:

- Further analysis of the data for 2015/2016 and 2016/2017, comparing entry into the disciplinary process by pay band shows that the majority of cases involve staff from lower pay bands.
- Actions in Divisional Improving Staff Experience plans to reduce the number of formal disciplinary cases – especially involving BME staff – where appropriate

Planned action(s) from the Workforce Diversity & Inclusion Strategy Plan April 2019 – March 2020:

- Review of our people policies (as they fall due for review) to ensure a consistent message and approach to inclusion
- Ensure we continue to offer to Investigating Officers training to all managers undertaking HR related investigations

The above are included in the Workforce D&I Strategy plan to support delivery of the following objective:

Inclusion is integral in our people policies encouraging positive conversation and introducing informal processes where possible

In addition, we will use the NHS WRES strategy document 'A fair experience for all: closing the ethnicity gap in rates of disciplinary action across the NHS' to test a model of good practice to reduce the disproportionate gap in BME and white staff entering the formal process.

4. Relative likelihood of BME staff accessing non-mandatory training and CPD as compared to white staff.

Data for previous year (2018)	*Data for reporting year (2019)*	*Narrative*
Relative likelihood of white staff accessing non-mandatory training is **1.32** times greater.	Relative likelihood of white staff accessing non-mandatory training is **1.24** times greater	Diversity data is recorded for all training undertaken through the Learning Management System. However, not all non-mandatory training uses this system. As the data required for the SDCS submission calculates the relative likelihood based on a comparison with the overall workforce, this has again not been included as the numbers will not be statistically relevant. As an alternative, the responses to Q20 as reported this year for the 2017 and 2018 National Staff Surveys have been used.

Descriptor	***BME 2017***	***White 2017***	***BME 2018***	***White 2018***
Number of staff in workforce	1,398	7,826	1,401	8,067
Number of staff who stated they had received training, learning or development in the last 12 months (not including mandatory training)	420	3,111	538	3,836
Likelihood of receiving such training	0.300	0.397	0.384	0.475

Relative likelihood of White staff accessing non-mandatory training compared to BME staff (0.397/0.300) = 1.32 times greater (2018)

Relative likelihood of White staff accessing non-mandatory training compared to BME staff (0.475/0.384) = 1.24 times greater (2019)

Links to the Equality & Diversity Strategic Objectives for 2016 – 2019:
To improve the opportunities for members of our diverse communities to gain employment with and progress within the Trust.

To work towards a more inclusive and supportive working environment for all of our staff.
Links to the Workforce Diversity & Inclusion Strategy 2020 – 2025 as described below.

Public Board Meeting - January 2020-30/01/20 - Page 67

Actions taken:

The recording and reporting of non-Mandatory training data was included in the WRES action plans for 2015 and 2016.

- Divisional E&D reps to work with Divisional training leads – with support from the BAMEW Forum - to promote non-mandatory training and Continuing Professional Development to BME staff
- The Trust has implemented a support programme of basic and functional skills, for all employees, designed to improve literacy and numeracy standards and to facilitate progression onto an apprenticeship programme
- Promotion of Leadership & Management development training to staff from protected groups, through delivery of presentation to E&D Group, BAME Forum and other appropriate groups
- Open forum discussions during October 2018 with the BAMEW Forum and Trust Equality & Diversity Group about barriers to progression and how best to remove them
- First stage of Leadership & Management Training is added to the training plan for all new managers and supervisors

Planned action(s) from the Workforce Diversity & Inclusion Strategy Plan April 2019 – March 2020:

- Diversity and Inclusion attendance figures to be reported as part of data sets being developed

The above is included in the Workforce D&I Strategy plan to support delivery of the following objective:

Our Education Strategy focuses on inclusion and is a key enabler to delivering the vision supported by our Trust Values

National NHS Staff Survey indicators. For each of the four staff survey indicators, compare the outcomes of the responses for White and BME Staff

5. Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in the last 12 months.

Data for previous year (2018) (2017 Staff Survey Results)	***Data for reporting year (2019) (2018 Staff Survey Results)***	***Narrative***
White 26.2% BME 25.0%	White 24.3% BME 24.3%	Data is taken from the National Staff Survey results for 2017 and 2018. (All substantive staff receive a Staff Survey questionnaire to complete.) It is positive to see a continued reduction in the percentage of BME staff experiencing harassment, bullying or abuse from patients, relatives or the public as reported in the Staff Survey. *Links to the Equality & Diversity Strategic Objective for 2016 – 2019:* **To work towards a more inclusive and supportive working environment for all of our staff.**

Actions taken:

- Raise staff awareness that clinical incident reporting can be used to report incidents of harassment, bullying, abuse or discrimination by patients, relatives and the general public
- Through the Equality & Diversity Group, explore how best to communicate our expectations of the behaviours associated with the Trust Value of Respecting Everyone to both staff and patients and service users.
- Targeted interventions at Divisional level where Staff Survey results have indicated there is a need (Divisional Improving Staff Experience plans will include details)
- Work on guidance and support for staff experiencing racial abuse from patients with cognitive impairments (for example, dementia), and how to communicate expectations of behaviours to these patients. (Working with Dementia team and BAMEW Forum members.)

Planned additional action(s) for 2019/2020:

- Finalise and publish support for staff who are verbally or physically abused by patients

6. Percentage of staff saying they have experienced harassment, bullying or abuse from staff in the last 12 months

Data for previous year (2018) (2017 Staff Survey Results)	***Data for reporting year (2019) (2018 Staff Survey Results)***	***Narrative***
White 22.6% BME 28.3%	White 23.1% BME 26.5%	Data is taken from the National Staff Survey results for 2017 and 2018. (All substantive staff receive a Staff Survey questionnaire to complete.) Although there has been an encouraging reduction in incidents of harassment, bullying or abuse from colleagues, these are still unacceptably high scores. *Links to the Equality & Diversity Strategic Objective for 2016 – 2019:* **To work towards a more inclusive and supportive working environment for all of our staff.**

Actions taken:

- Equality, Diversity & Human Rights training included as part of Essential Training 3-yearly updates for all staff from October 2017 includes a section on tackling bullying & harassment at work. Available as an e-learning package or face to face sessions.
- Launch of new Dignity at Work Policy used to promote positive behaviours across the Trust. Rollout during October/November 2017 included discussions and presentations across the Trust.
- Targeted interventions at Divisional level where Staff Survey results have indicated there is a need as part of Divisional Improving Staff Experience plans
- Launch of Leadership Behaviours at UH Bristol during August 2017 – workshops promoting positive leadership behaviours cascaded during Autumn 2017.
- Promotion of Freedom to Speak Up Guardian and Advocates as additional sources of support
- Senior Leader workshop in September 2018 to discuss different approaches to tackling bullying and harassment.
- Dedicated helpline continues to provide support through a confidential helpline and email address

Planned additional action(s) for 2019/2020:

Public Board Meeting - January 2020-30/01/20 - Page 70

- The Trust's Dignity at Work Policy is undergoing a scheduled revision and will include a focus on early interventions to resolve incidents of unacceptable behaviour.
- The outcomes of the SLT discussions have been developed locally as part of the improving staff experience plans in the divisions
- A targeted 'team development' programme for the Senior Leadership Team is being planned

Links to the Workforce D&I Strategy plan objective:

As leaders we role model the Values and Leadership behaviours, creating an environment that encourages feedback and where staff feel safe to challenge

7. Percentage of staff believing that the organisation provides equal opportunities for career progression or promotion

Data for previous year (2018) (2017 Staff Survey Results)	***Data for reporting year (2019) (2018 Staff Survey Results)***	***Narrative***
White 90.6% BME 69.3%	White 87.0% BME 67.5%	Data is taken from the National Staff Survey results for 2017 and 2018. (All substantive staff receive a Staff Survey questionnaire to complete.) This is an area which has been highlighted for priority action because of the large disparity between the reported experience of BME and white staff. *Links to the Equality & Diversity Strategic Objectives for 2016 – 2019:* **To improve the opportunities for members of our diverse communities to gain employment with and progress within the Trust.** **To work towards a more inclusive and supportive working environment for all of our staff**. Links to the Workforce Diversity & Inclusion Strategy 2020 – 2025 as described below.

Actions taken:

- Training to raise awareness of unconscious bias/stereotyping included in Recruiting the Best training for recruiting managers, and in Corporate Induction section on Equality & Diversity, and Equality, Diversity & Human Rights training.

- Review the advertising and selection process for internal opportunities to ensure transparency and equality of opportunity
- The Trust is developing progression and learning pathways for existing staff, through the apprenticeship structure, to develop within their career and into leadership and management opportunities
- Divisional E&D reps to work with Divisional training leads – with support from the BAMEW Forum - to promote non-mandatory training and Continuing Professional Development to BME staff
- Introduction of Reverse Mentoring Scheme involving staff from BAME backgrounds and senior managers in October 2018
- Promotion of Leadership & Management development training to staff from protected groups, through delivery of presentation to E&D Group, BAME Forum and other appropriate groups.
- Divisions to identify service actions and interventions to improve this result as part of Divisional Improving Staff Experience Plans
- Open forum discussions during October 2018 with the BAMEW Forum and Trust Equality & Diversity Group about barriers to progression and how best to remove them.

Planned action(s) from the Workforce Diversity & Inclusion Strategy Plan April 2019 – March 2020:

- Review of shortlisting process to provide assurance that the anonymised process removes opportunities for bias
- Review interview template and interview question bank with a view to including D&I section / specific question (eg: "What have you done in your previous role(s) to promote diversity and inclusion?")
- Research/commission/develop refresher training for recruiting managers – Inclusivity in Recruitment – to be delivered as one hour, back to back sessions over two days. (Will include launch of refreshed JDs, advertising and interview Qs)
- Refresh panel composition with a view to including an extra, independent, person as part of the selection process to challenge on aspects of inclusivity. (For interviews of B7 or B8a and above roles initially)
- Review recruitment processes for Board appointments, including executive search agencies.

The above are included in the Workforce D&I Strategy plan to support delivery of the following objective:

We will be recognized as an inclusive employer committed to ensuring our workforce reflects the community it serves.

8. Percentage of staff personally experiencing discrimination at work from their manager/team leader or another colleague in the last 12 months

Data for previous year (2018) (2017 Staff Survey Results)	*Data for reporting year (2019) (2018 Staff Survey Results)*	*Narrative*
White 7.0% BME 16.0%	White 6.2% BME 14.1%	Data is taken from the National Staff Survey results for 2017 and 2018. (All substantive staff receive a Staff Survey questionnaire to complete.) Although there is a decrease in the number of BME staff reporting experiences of discrimination from colleagues through the staff survey, the large difference compared to the experience of white staff is a great cause for concern. *Links to the Equality & Diversity Strategic Objective for 2016 – 2019:* **To work towards a more inclusive and supportive working environment for all of our staff.** Links to the Workforce Diversity & Inclusion Strategy 2020 – 2025 as described below.

Actions taken:

- Equality, Diversity & Human Rights training included as part of Essential Training 3-yearly updates for all staff from October 2017. Available as an e-learning package or face to face sessions.
- Launch of new Dignity at Work Policy used to promote positive behaviours across the Trust. Rollout during October/November 2017 included discussions and presentations across the Trust.
- Targeted interventions at Divisional level where Staff Survey results have indicated there is a need as part of Divisional Improving Staff Experience plans
- Launch of Leadership Behaviours at UH Bristol during August 2017 – workshops promoting positive leadership behaviours cascaded during Autumn 2017.
- Promotion of Freedom to Speak Up Guardian and Advocates as additional sources of support

- Senior Leader workshop in September 2018 to discuss different approaches to tackling bullying and harassment. A detailed plan will be presented to the Senior Leadership Team in November 2018.

Planned additional action(s) for 2019/2020:

The Trust's Workforce Diversity & Inclusion Strategy & Plan, launched in May 2019, has as its core vision an aim to be 'committed to inclusion in everything we do'. Actions to deliver the following objectives from the Workforce Diversity & Inclusion Plan Year 1 are intended to lead to increased cultural competence and therefore a decrease in incidents of discrimination in the workplace.

Links to actions to deliver the following objectives from the Workforce Diversity & Inclusion Strategy Plan Year 1 (April 2019 – March 2020):

- We are committed to inclusion in everything we do including Recruitment, Induction, Training, Appraisal and Talent Management
- We celebrate and value the contribution all of our staff make at all levels of the organization
- We encourage shared learning by openly sharing our diversity data in a meaningful way
- Inclusion is integral in our people policies encouraging positive conversation and introducing informal processes where possible
- We will be recognized as an inclusive employer committed to ensuring our workforce reflects the community it serves

In addition, the Trust's Dignity at Work Policy is undergoing a scheduled revision and will include a focus on early interventions to resolve incidents of unacceptable behaviour.

Board Representation Indicator. For this indicator, compare the difference for White and BME staff.

9. Percentage difference between the organisation's Board voting membership and its overall workforce, and the Board's Executive membership and its overall workforce

Data for previous year (2018)	***Data for reporting year (2019)***	***Narrative***
93.8% of Voting Board Members are White 0% of Voting Board Members are BME 6.3% of Voting Board Members are of unknown/not stated ethnicity 14.9% of the overall workforce are BME Percentage difference between Voting Board Membership & overall workforce is –14.9% Exec Board membership = 100% White	88.2% of Voting Board Members are White 0% of Voting Board Members are BME 11.8% of Voting Board Members are of unknown/not stated ethnicity 14.4% of the overall workforce are BME Percentage difference between Voting Board Membership & overall workforce is –14.4% Exec Board membership = 100% White	Data is taken from the ESR as at 31st March 2018 and 31st March 2019. These are the figures submitted via SDCS. *Links to the Equality & Diversity Strategic Objectives for 2016 – 2019:* **To improve the opportunities for members of our diverse communities to gain employment with and progress within the Trust.** **To work towards a more inclusive and supportive working environment for all of our staff.** Links to the Workforce Diversity & Inclusion Strategy 2020 – 2025 as described below.

Planned action(s) from the Workforce Diversity & Inclusion Strategy Plan April 2019 – March 2020:

- Review recruitment processes for Board appointments, including executive search agencies

The above is included in the Workforce D&I Strategy plan to support delivery of the following objective:

We will be recognized as an inclusive employer committed to ensuring our workforce reflects the community it serves

Conclusion

The Trust is committed to improving the working experience of all of its staff and acknowledges that it has further to travel for our BME staff. We were inspected in May of this year and rated Outstanding by the CQC, including in the Well-led domain. However, their report highlighted the following:

"Poor representation from the black and minority ethnic (BME) group in the higher levels of management was seen to represent limitations to development opportunities for this group of staff. Whilst the group spoke highly of the behaviours and attitudes of senior leaders with regards to staff of a BME background, it was also felt that a lack of movement to better represent the diversity of the workforce at a more senior level was a cultural issue borne out of a lack of action in this regard for many years."

This echoes the outcomes of our WRES reports, and the WRES and the Trust's previous WRES outcomes have been key drivers in the development of our Workforce Diversity & Inclusion Strategy, as we recognise that as an organisation we have not been making the progress we would wish towards improving the working experience of many of our BME staff.

The Strategy and accompanying action plan sets out our vision of being 'committed to inclusion in everything we do', and how we aim to deliver this over the next five years.

Vital to the continuous improvement in the experience of our BME staff is the work of our BAMEW Forum. They are actively engaged in conversations and have their own workplan, and are also contributing to the national WRES Frontline Staff Discussion Forum. Their input and participation is crucial to the delivery of the planned actions, and we are delighted that one of the Forum members will be part of cohort 3 of the WRES Expert programme.

Members of the Forum have highlighted the data for Metric 4 (relative likelihood of BME staff accessing non-mandatory training and CPD) and the necessity of ensuring that those who allocate time and money for continuing professional development (CPD) are aware of their responsibility to provide support to BME staff to progress along with their peers of the same banding. Without access to CPD, BME staff will continue to be under-represented at senior management level, as shown by the data in Metric 1.

Accountability for improving the experience of BME staff sits with the Trust Board. Progress is reported into the Board on a quarterly basis through the People Committee, who will be the approving body for this Report and Action Plan.

University Hospitals Bristol
NHS Foundation Trust

Meeting of the Board of Directors in Public on Thursday 30 January 2020

Report Title	**Q3 Strategic Risk Register**
Report Author	**Sarah Wright, Head of Risk Management**
Executive Lead	**Robert Woolley, Chief Executive**

1. Report Summary

The Trust's Board Assurance Framework is formed of two elements:

- Part A - Assurance around the achievement of the Trusts strategic objectives
- Part B - Assurance that any risks to the achievement of the strategic objectives are being adequately mitigated or controlled.

This report forms part B of the Trust's risk Board Assurance Framework and is the mechanism for reporting on the management and treatment of strategic risks (*risks to the achievement of the Trusts strategic objectives)*.

2. Key points to note

There are **15** risks on the Strategic Risk Register; this is summary of the action taken to manage the risks during the last financial quarter :

Points to note:

- 1 new risk - 3472 Risk that the Trust fails to deliver the Sustainable Development Strategy
- 1 risk has increased - 2633 (IM&T Systems) from 4 to 8
- 2 risks have reduced - 2640 (Commissioning) from 12 to 8 and 2954 (Brexit) from 15 to 9
- No risks closed

Good practice suggests that Board committees should use the BAF as a tool for delivering their responsibilities.
Considering the following prompts when reviewing strategic risks could be beneficial:

- Are there any identified gaps in assurance?
- Are mitigating plans in place?
- Is there good evidence that risks are being effectively managed?
- What specific action is the committee to commission for review at its next meeting?

3. Risks

See attached appendix.

4. Advice and Recommendations:

- This report is for **Assurance.**

5. History of the paper

Top Team Meeting	30/12/2019

8.1

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Risk Management Group	14/01/2020
Senior Leadership Team	22/01/2020
People, Finance and QOC (relevant risks)	27/01/2020
Audit Committee	28/01/2020
Trust Board	30/01/2020

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Alignment with Strategic Priorities

The Trust has identified 6 strategic priorities to support delivery of its vision.

The annual corporate objectives have been formulated to support the delivery of the strategic priorities. The RAG ratings against the achievement of the 2019/20 corporate objectives is shown in the second column.

The strategic risks identified that may have an impact of the achievement of the strategic priorities, are noted in the third column.

STRATEGIC PRIORITIES	Corporate Objective RAG*	STRATEGIC RISKS
1 - **Our Patients**: We will excel in consistent delivery of high quality, patient centred care, delivered with compassion.		2644
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.		737, 2646, 2694
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.		2642
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.		2640, 2643, 3472.
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.		2633, 2741, 2992
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.		416, 869, 2695, 2954

Taken from Document - Corporate Objectives 2019.20 Q3 update v1.0 16Jan2020

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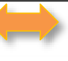
New Strategic Risks		
3472	**Risk that the Trust fails to deliver the Sustainable Development Strategy**	**10**
	The Trust has publically declared a climate emergency recognising the impact climate change is having on the world. This shows a clear and positive commitment to tackle climate change and the effects on the health of our population. The commitments are set out in the Trust's Sustainable Development Strategy. If the Trust is unable to meet its commitments under the Sustainable Development Strategy it may be held publically to account. This is a significant reputational risk through not achieving the expectations of our staff, the public and our civic partners (under the One City Plan). This reputational risk would be increased through any failure to meet the significant national constitutional, contractual and regulatory sustainability requirements (see below). This reputational risk reflects the wider risk of failing to achieve Trust Strategic objectives that contribute to meeting our sustainability commitments. Mitigation of this risk is dependent on successful and timely delivery of the Sustainable Development Strategy. This requires financial and staff resources to be made available for delivery. It also requires Trust wide engagement with the strategy through effective leadership and communication. Clear governance processes will need to be established to ensure delivery of the strategy is supported, monitored and reported internally and publicly.	

8.1

Quarterly update on existing Risks		
416	**Risk that the Trust may not be able to deliver the financial strategy**	**9**
	The strategic plan requires an underlying position of circa. £4m surplus and the control total to be delivered to receive PSF required for the capital programme. Based on Corporate Risk 959 (Operational Plan) and Corporate Risk 1843 (Core control total) the current assessment of the risk likelihood remains 'possible'.	
737	**Risk that continuity and effectiveness of services may suffer through inability to recruit**	**12**
	In the past quarter the Trust's vacancy position reduced to 5.2% and is now only marginally above the Trust target of 5%. The Divisional with the largest overall reduction in headcount was Surgery that deteriorated from 127 FTE to 103 FTE. There largest staff group with increases was within Nursing and Midwifery where the vacancy rate rose from 239 FTE to 248 FTE. The largest group with reductions was within Medical and Dental, where the recruitment rate improved from 34 FTE to 38 FTE. There is a strong pipeline of newly qualified nurses with bi-monthly nurse recruitment days taking place. Recruitment and marketing plans are in place for all hard to recruit to areas with a specific focus on medical and dental vacancies post the August and September rotation. The Trusts new Clinical Talent Acquisition Manager is now in post and meeting clinical areas to develop bespoke recruitment plans to target all clinical hot spots.	
869	**Risk that the Trusts reputation may be negatively affected**	**9**
	A high profile inquest took place during December which may result in adverse media coverage. A media handling plan was put in place to mitigate reputational impact.	

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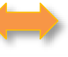
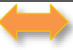
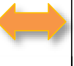
2633	**Risk that Trusts IM&T Systems fail to deliver the required levels of efficiencies**	**8**
	Achievement of efficiencies generated by the Digital Hospitals Programme is continuing to be directed and monitored by the IT Management Group, the Digital Hospitals Programme Committee and the Transformation Board. The Digital Hospitals Programme Committee has been raised up to Management Group level to ensure better clinical oversight and management of the programmes achievement of clinical improvements. The amended terms of reference for the group were approved by the Senior Leadership Team in December 2019. Work continues in partnership between digital services and transformation to improve maturity in targeting benefit realisation, and monitoring performance. The current assessment has increased in likelihood because from a strategic long term viewpoint, an inadequate infrastructure (i.e. computer room 2) puts at risk the Trust's strategic aims for efficiencies reliant on effective IT.	
2640	**Risk that services are not commissioned at levels of forecasted demand**	**8**
	All contracts are now signed for 2019/20. There are challenges to the delivery of the anticipated levels due to the underperforming elective plan caused by emergency admission pressure on beds. The elective under performance this year could be carried forward into 2020/21, which transfers the risk to a later period (if this non recurring activity is not purchased by commissioners).	
2642	**Risk that the Trust is unable to invest in maintaining and modernising the Trust estate**	**6**
	A review process has been undertaken and all identified schemes are being worked up to Strategic Outline Case status as a minimum. Medium Term Financial Plan is due to be reviewed in February 2020, this will re profile capital investment, once the final investment priorities and potential solution are agreed.	
2643	**Risk that the STP fails to deliver a system strategy**	**8**
	System planning through STP is feeding into the BNSSG long term plan, this will inform the basis of the Trusts Divisional Operating Plans for 2020/21.	
2644	**Risk that a local or regional provider fails to maintain viability of services**	**8**
	The Trust is awaiting confirmation that the transfer of services from local community providers to Sirona for 2020/21 is complete and avoids any risk of unforeseen demand or gaps in service. Resilience risks at Weston Area Healthcare Trust remain high.	
2646	**Risk that the Trust has insufficient management and leadership capacity and capability**	**12**
	Over 250 delegates have attended the leadership and management development programmes in quarter 3. The annual review of programmes within the Leadership and management development offer have taken place this continues to be in collaboration with the apprenticeship team and agenda .The focus of review included the sessions on wellbeing and diversity and inclusion. An update of Leadership and Management Development offer on HR web and Connect has been implemented improving access and understanding for all and connecting the Apprenticeship programme of work.	

8.1

2694	Risk that the Trust's workforce is insufficiently motivated and engaged	12
	National Staff Survey 2019 closed on 29th November 2019 with a provisional response rate of 53%. The confirmed response rate will be delivered early January 2020. The focus of improving response rates in the Estates and Facilities team has seen an provisional increase in response rates of 11% Staff survey outcomes and engagement scores will be reported in March 2020. The review of reporting on staff experience planning has led to the introduction of Cultural and People plan in 2020. Programmes of work across the organisation continue to take place including our annual 2019 Staff Recognising Success event in November. Divisions continue to drive local activities in line with their ambitions to improve Staff Experience at work.	
2695	Risk that the Trust fails to establish and maintain robust governance processes	9
	Good progress has been made to finalise and approve the enabling strategies, although the quality strategy timeline has been moved back into 2020/21 and the Digital Strategy requires completion. Work has progressed in relation to compliance with OFSTED and fire safety requirements.	
2741	Risk that Research and Innovation is not adequately supported	9
	There is an ongoing programme of work to minimise this risk. However, it is not possible to say when the mitigation will be effective from. All areas of work are focussed on maintaining or increasing our research activity and mitigating this risk. The associated action remains on track for delivery by the end of Q4 19/20.	
2954	Risk that Brexit causes disruption to delivery of NHS goods and services	9
	The government has now stood down all EU Exit plans. In terms of our internal plans we have stood down our EU Exit Planning Group. Having planned for three different no deal EU Exit deadlines we have been able to undertake a comprehensive review of our supply chain and highlighted and mitigated specific risks. Prior to planning being stood down the group where assured we were at a position as a Trust where risks were mitigated and plans were robust if there was to be a no deal EU Exit. One of the big focuses, both nationally and as a Trust, was pharmacy supply routes. This work included a robust contingency model for the supply of short shelf life radio isotopes. If required the group will be stood up again and will undertake a review of all previously completed work in conjunction with the Bristol and Weston Purchasing Consortium as well as other workstreams including workforce, data access, all supply routes (including clinical and non-clinical supplies as well as medical devices) and reciprocal healthcare agreements. The assessment of the likelihood of a negative impact has therefore reduced going into Q4 2019/20.	
2992	Risk that benefits of transformation, improvement and innovation are not realised	9
	The business case for investment in QI training capacity was approved at SLT January 2020. The next step is to confirm the level of investment.	

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The current and target assessments of risks are shown below:

Risk ID	Q4 17/18	Q1 18/19	Q2 18/19	Q3 18/19	Q4 18/19	Q1 19/20	Q2 19/20	Q3 19/20	Q4 19/20		Target
416	6	6	6	6	6	9	9	9			4
737	12	12	12	12	12	12	12	12			6
869	9	9	9	9	9	Accepted					9
2633				4	4	4	4	8			4
2640				12	12	12	12	8			8
2642	12	12	12	6	6	Accepted					6
2643				12	8	8	8	8			8
2644				12	8	Accepted					8
2646				12	12	12	12	12			6
2694				12	12	12	12	12			4
2695	9	9	9	9	9	9	9	9			6
2741	9	9	9	9	9	9	9	9			6
2954				12	8	8	15	9			3
2992					9	9	9	9			6
3472								10			

8.1

The current scores are summarised in the following heat map:

Impact	Likelihood				
	1 Negligible	2 Minor	3 Moderate	4 Major	5 Catastrophic
5 Very Likely					
4 Likely			737, 2646		
3 Possible			416, 869, 2695, 2741, 2954, 2992	2694	
2 Unlikely			2642	2640, 2633, 2643, 2644	3472
1 Rare					

Strategic Risk Register								Inherent				Controls			Assurance			Current Assessment						Target				Review	
ID	Domain	Origin	Proximity	Strategy	Assurance	Executive	Principal Risk Description	C	L	S	Risk level	Key Controls	Adequacy	Gaps in Controls	Form of Assurance	Level	Gaps in Assurance	C	L	S	Risk level	Action Details	Due date	C	L	S	Risk level	Next Review	Status
416	Financial	External	In the next 3-5 Financial Years	Financial Strategy	Finance Committee	Director of Finance & Information	If the income and expenditure surplus is not delivered or can't be achieved then less cash is available to fund the capital programme. If the cost of capital schemes increase beyond that provided for. for, then the strategy will need revising through reducing content, deletion or deferral or additional funding needs to be found. If additional schemes are required not provided for in the programme. then additional funding sources are needed or the programme reprioritised. If external regulation is imposed regarding the use of Trust resources (this may include the requirement to share resources within an STP or restrictions on the use of cash surpluses) then the strategy may be compromised. All of these would risk delivery of the Trust's financial strategy.	Catastrophic	Likely	20	Very High Risk	Effective reporting, monitoring and review of operational plan to identify issues requiring a financial recovery plan. Established contract monitoring and commissioner dialogue to minimise external factors arising from contracting issues. Established working relationship with Charitable partners to manage donations Fully worked up schemes in advance with experienced staff input, control of tenders and costs and effective monitoring and reporting of costs. A managed contingency reserve. Engagement at a national level regarding any proposed external regulation A comprehensive, committed capital programme proceeding at pace.	Inadequate	Whilst risks 2 and 3 above are effectively controlled, at month 5, the delivery of the 2019/20 planned control total and resulting PSF is uncertain particularly with a Divisional adverse variance of £5.5m against operating plans at month five. Additional significant concern is the potential risk of external regulation on the use of Trust cash resource and capital investment.	Detailed monthly submission of financial performance submitted to the Regulator, NHS Improvement. Strong statement of financial position. Liquidity metric of 1 (highest) and Use of Resources Rating of 1 (highest rating) Regular Reporting to the Finance Committee and Trust Board. Monthly Pay Controls Group, Non Pay Controls Group and Nursing Controls Group scrutiny of Divisions performance. Rolling 5 year Medium Term Capital Programme (source and applications of funds) approved annually by the Finance Committee and Board. Monthly management scrutiny of capital expenditure at the Capital Programme Steering Group. Delivery of the capital programme, including the prioritisation and allocation of strategic capital.	Second Line Assurance - Risk and Compliance	None noted.	Moderate	Possible	9	High Risk	Divisional recovery plans required for 4 clinical divisions - surgery, medicine, specialised services and women's and children's. Recovery plans to be signed off and then pro-actively delivered/monitored. Run rates need to be reduced to be able to achieve core control total and secure PSF for investment as per the strategy. Continued review at Divisional finance and activity reviews and quarterly reviews to identify and implement necessary recovery actions to deliver operating plans Deliver the action plan out lined in the 2020/21 business planning paper approved at Finance Committee to improve the underlying position.	31/03/2020 31/03/2020 31/03/2021	Moderate	Unlikely	6	Moderate Risk	02/03/2020	Action Required Risks
737	Workforce	External	Is Currently an Issue	People Strategy	People Committee	Director of People	If the Trust is be unable to recruit and retain sufficient numbers of substantive staff and to fill specific staff groups/occupations where there is a limited supply, Then continuity and effectiveness of services may suffer, Resulting in increased waiting times, inefficiencies, harm and poor patient experience.	Moderate	Very Likely	15	Very High Risk	Recruitment sub-group being reinstated from October 2019 as a sub group of People Management Committee. Robust recruitment plans in place for all hard to recruit to areas. New Clinical Talent Acquisition Manager developing clinical recruitment strategy and action plan Divisional position reviewed through monthly exec scrutiny.	Inadequate	The nursing vacancy position remains a challenge in some hard to fill areas such as Care of the Elderly, T&O, Oncology & Haematology. Turnover in nursing remains high. Ongoing challenges exist with Radiographers, Sonographers, Neurophysiology and Audiology, where there is a national and international shortage. Each of these roles remain on the national shortage occupation list. A dedicated D&T recruitment manager is in post to give key recruitment input to these hard to recruit to roles. The Trust is dependent upon Health Education England to allocate sufficient numbers of doctors in training. The number of doctors the Trust is allocated does not correlate with optimum staffing levels. This results in ongoing vacancy rates. Ongoing gaps in consultant posts such as Dermatology, Stroke Services and Acute Medicine continue to challenge service delivery.	Monitoring achievement of Strategic Workforce Plan objectives though People Committee. Divisional performance is monitored monthly at Performance and Operational Reviews. Monitoring of controls by People Committee.	Second Line Assurance - Risk and Compliance	None noted.	Moderate	Likely	12	High Risk	TRAC functionality now fully rolled out across medical recruitment and a full suite of medical KPI's introduced. Work ongoing to ensure that consultants more fully use the functionality available through TRAC. Introduce new roles and innovative T&C's to attract new junior doctors in training. Marketing & attraction – ongoing marketing plan for innovative campaigns using recruitment videos, targeted email shots, social media and recruitment microsites, all underpinned with a strong marketing brand. Develop the scope of the apprenticeship provision, to include a wider number of job roles, levels and progression pathways. Ongoing Undertake robust workforce planning, to ensure there is sufficient staff with the right skills, and clear opportunities for career progression. Plan being developed New approach to the recruitment of newly qualified nurses adopted from March 2019 with auto offer being provided to all final year UWE students. UWE student welcome letter now moved to first year students. Success to be evaluated on a quarterly basis. European head hunters now being used to target hard to recruit to nursing and medical vacancies. Success being reviewed on a quarterly basis. Brexit – Package of support measures going live 1st April 2019 which includes drop in support sessions to help EU staff with the application process for EU settled status and personalised letters being issued to all EU staff. Impact on EU staff numbers being monitored on a weekly basis and reported to NHS Commissioners.	31/03/2020 31/03/2020 31/03/2020 31/03/2020 31/03/2020 31/03/2020 31/03/2020 31/03/2020	Moderate	Unlikely	6	Moderate Risk	02/03/2020	Action Required Risks
869	Reputational	External	Is Currently an Issue	Trust Strategy	Audit Committee	Deputy Chief Executive	If the Trust is subject to adverse media coverage due to provision of inadequate care, Then public perception of Trust activities may be affected, Resulting in reputational damage.	Moderate	Likely	12	High Risk	Pro-active monitoring of forthcoming publications, inquests and other milestones. Detailed communications strategies and plans developed as appropriate. Robust inquest preparation for these including pro-active & reactive communication. Media and stakeholder management and monitoring of social media as considered appropriate. Transparent implementation of external review recommendations. Active placement of positive news about Trust services.	Adequate	None noted.	Reporting of Electronic media analytics to SLT from Website, Facebook, Twitter, Instagram and Patient Information Service. Complaint reports. Inquest reports. Clinical outcome monitors.	First Line Assurance - Operational	None noted.	Moderate	Possible	9	High Risk			Moderate	Possible	9	High Risk	02/03/2020	Accepted Risks
2633	Quality	External	In the next 3-5 Financial Years	Digital Strategy	Finance Committee	Director of Finance & Information	If the Trusts clinical Systems fail to operate at the required levels of reliability, Then planned efficiencies may not be realised, Resulting in inability to deliver effective care, poor patient outcomes and staff disengagement in the digital strategy.	Major	Very Likely	20	Very High Risk	Disaster Recovery Plan. Business Continuity arrangements (Trust and local plans). Engagement in local and regional Emergency Preparedness, Resilience and Response Framework (EPRR). Regular testing on individual parts of the Trust's IT infrastructure. Harnessing the CCIO team and their clinical networks to engage and collaborate widely across clinical users. This is now further supported by establishing Digital Hospital Programme Committee Applying best practice management and operational disciplines and controls to IT operations	Adequate	None noted.	Testing of disaster recovery arrangements to SLT. Routine departmental assurance by programme management office for all digital and IM&T projects and activities reported to IM&T Management Group. EPRR Annual Report to the Board.	Third Line Assurance - Independent	Digital Services do undertake a range of testing on individual parts of the Trusts IT infrastructure, but a full disaster recovery test has not taken place for a number of years. It has been agreed that it would not be worthwhile undertaking a full live failure/outage test. The reason discussed was that this would cause major inconvenience to clinical services over many hours no matter what time of the day or night it took place (it would require to separate outages of approximately 6 hours each).	Major	Unlikely	8	High Risk	RMG directed Neil Kemsley to amend this risk to account for affect poor infrastructure (such as CR2) could have upon strategic aims. Therefore, Infrastructure should be included in the Strategy.	30/06/2020	Major	Rare	4	Moderate Risk	02/03/2020	Action Required Risks

Strategic Risk Register								Inherent				Controls			Assurance			Current Assessment						Target				Review	
ID	**Domain**	**Origin**	**Proximity**	**Strategy**	**Assurance**	**Executive**	**Principal Risk Description**	**C**	**L**	**S**	**Risk level**	**Key Controls**	**Adequacy**	**Gaps in Controls**	**Form of Assurance**	**Level**	**Gaps in Assurance**	**C**	**L**	**S**	**Risk level**	**Action Details**	**Due date**	**C**	**L**	**S**	**Risk level**	**Next Review**	**Status**
2640	Quality	External	In the next 3-5 Financial Years	Trust Strategy	Quality & Outcomes Committee	Director of Strategy & Transformation	If services are not commissioned at levels of forecasted demand, Then the Trust could have insufficient capacity to manage patients, Resulting in increased waiting times and poor patient experience.	Major	Likely	16	Very High Risk	Trust Strategy sets context for capacity required. Operating Plan (annual with review and change) and established contract negotiation processes. Engagement with the STP and 2019/20 system plan submitted Executive membership of System Delivery Oversight Group Operating Plan processes (annual with review and change). Integrated Contract & Quality Performance Management monthly meetings with commissioners and monthly internal Commissioning and Planning forum. Strategic capital programme agreed to 2023 and Site Development Plan completed Q4 2018/19.	Adequate	None noted.	Reports to Quality & Outcomes Committee include: Integrated Performance Report. Reporting of Improvement trajectories - RTT, Cancer etc. Reports to Trust Board include: - Annual Operating Plan. - Strategic Capital Programme. - Integrated Performance Report. - Financial Report - Reporting of Improvement Trajectories - RTT, Cancer etc. - Quality Impact Assessments for service developments / capacity not commissioned.	Second Line Assurance - Risk and Compliance	Lack of agreement of the urgent care blended tariff contract.	Major	Unlikely	8	High Risk	Commence process to negotiate 2020/21 activity, reflecting the BNSSG long term plan and demand management.	31/03/2020	Major	Unlikely	8	High Risk	02/03/2020	Action Required Risks
2642	Business	Internal	In the next 3-5 Financial Years	Estates Strategy	Audit Committee	Chief Operating Officer	If the Trust is unable to invest in maintaining and modernising the Trust estate, Then there could be a deterioration of the patient and staff work environment, and facilities that may not support patient care pathways, Resulting in inefficiencies, deterioration in staff engagement and a poor patient experience.	Major	Very Likely	20	Very High Risk	Medium Term Financial Plan. Strategic Capital Plan and Operational Plan. Planned preventative maintenance budget. Trust Capital Group Chaired by Deputy COO, receives monthly status reports on Capital Projects from Divisions and Assistant Director of Estates. SCCS Programme Board to oversee all SCCS schemes, chaired by Director of Strategy and Transformation. Financial Control Procedures, including the scheme of delegation and Standing Financial Instructions in place. Approved Five year Medium Term Capital Programme. Delivery of the 2019/20 capital programme, including the prioritisation and allocation of strategic capital. Delivery of the 2019/20 Operational plan without significant deterioration in the underlying run rate to ensure availability of strategic capital is available for future investment.	Adequate	None noted.	Monthly KPI report through Divisional Board on Reactive maintenance. Prioritisation of backlog maintenance through Capital Programme Steering Group Reports from Trust Capital Group to Capital Programme Steering Group. Reports from Phase 5 Programme Board to Capital Programme Steering Group. Chairs reports from Capital Programme Steering Group to Finance Committee. Rolling 5 year Medium Term Capital Programme (source and applications of funds) approved annually by the Finance Committee and Board. Monthly management scrutiny of capital expenditure at the Capital Programme Steering Group. Regular Reporting to the Finance Committee and Trust Board.	Second Line Assurance - Risk and Compliance	Lack of assurance that capital expenditure controls for delegated Divisional Capital are fully effective.	Moderate	Unlikely	6	Moderate Risk			Moderate	Unlikely	6	Moderate Risk	02/03/2020	Accepted Risks
2643	Business	External	In the next 3-5 Financial Years	Trust Strategy	Audit Committee	Director of Strategy & Transformation	If the STP fails to deliver a system strategy, Then system partners will be unable to align service delivery strategies, delivering incremental changes rather than transformation, that supports delivery of the NHS Long Term Plan objectives. Resulting in poorer outcomes and experience for patients and reputational damage for the Trust.	Major	Possible	12	High Risk	Engagement with STP - Chief Executive joint lead for Healthier Together STP with other Executives playing lead roles. System Delivery Oversight Group meetings (SDOG) in place which bring BNSSG planning and strategy leads together. System Planners Group as a subgroup of SDOG has been revised in April 2019 and brings together strategy and planning leads below Exec level. Healthier Together reports into Trust Board SLT updates/standing item on strategic or business meetings as appropriate. A BNSSG System Plan for 2019/20 was submitted in April 2019 The 5 year plan was submitted in December 2019. Measures to increase and improve current partnership working with WAHT and significant involvement in Healthy Weston programme. Establishment of Clinical Sponsorship Board with NBT. Process in place to co-ordinate Trust approach into, and secure communication output from, key system groups.	Adequate	None noted.	STP Reports to the Board and SLT.	Second Line Assurance - Risk and Compliance	Need for further development of relationships and networks with emerging Primary Care locality hubs. System approach to demand and capacity modelling not yet agreed.	Major	Unlikely	8	High Risk	Participate in process to inform demand and capacity modelling. Test role of associate medical director for primary care to support development of relationships between primary, community and secondary care Hold workshops 2-3 times per year with primary care and Sirona to support development of locality hubs for agreed conditions	31/03/2020 31/12/2020	Major	Unlikely	8	High Risk	02/03/2020	Action Required Risks
2644	Quality	External	In the next 3-5 Financial Years	Trust Strategy	Audit Committee	Director of Strategy & Transformation	If a local or regional provider fails to maintain viability of services, Then this could lead to significant, unplanned increases in demand for a UHB service or services, Resulting in increased waiting times, increased cancellations, harm and poor patient experience.	Major	Possible	12	High Risk	Stakeholder Engagement - CCG, WAHT, NBT, NHSI/E, Community Providers Healthier Together System Delivery and Oversight Group (SDOG) provides a forum for system level planning and risk management. Membership of Clinical Networks. Operating Plans. Horizon scanning including review of local CQC and Deanery reports and monthly commissioning & planning group. Contract meetings with commissioners. Partnership Boards - NBT, WAHT Clinical Strategy Group horizon scanning. System contingency planning approach applied throughout clinical operational groups	Adequate		CEO and Executive reports to Board. Board briefings and reports form Partnership Boards, and Board to Board meetings. Integrated Performance Report and Finance Report - tracking of activity changes.	Second Line Assurance - Risk and Compliance	None.	Major	Unlikely	8	High Risk	Review of contracts held with NSCP / BCH and agreement of transfer arrangements with Sirona Attendance at Integrated Care Programme Board / Community Services mobilisation group to understand impact of Sirona Year 1 plans on likely activity shifts from the Trust. In turn information should be used to ensure Trust provided services are planned for in accordance with system interventions that are being planned	30/04/2020 30/04/2021	Major	Unlikely	8	High Risk	02/03/2020	Accepted Risks

Strategic Risk Register								Inherent				Controls			Assurance			Current Assessment						Target				Review	
ID	**Domain**	**Origin**	**Proximity**	**Strategy**	**Assurance**	**Executive**	**Principal Risk Description**	**C**	**L**	**S**	**Risk level**	**Key Controls**	**Adequacy**	**Gaps in Controls**	**Form of Assurance**	**Level**	**Gaps in Assurance**	**C**	**L**	**S**	**Risk level**	**Action Details**	**Due date**	**C**	**L**	**S**	**Risk level**	**Next Review**	**Status**
2646	Workforce	Internal	In the next 3-5 Financial Years	People Strategy	People Committee	Director of People	If the Trust has insufficient management and leadership capacity and capability, Then the Trusts ability to deliver its strategy may be negatively affected, Resulting in decreased capacity to maintain financial and operational sustainability.	Major	Very Likely	20	Very High Risk	Identified VSM's have dedicated deputy roles to support them creating a succession planning approach in the future Succession planning has identified routes of succession for all Executive level VSM's. leadership and management development programmes have been mandated for all newly appointed and promoted managers as of August 1st 2018. These programmes support the newly developed apprenticeship for managers and leaders Access to external NHS leadership development programmes is made avaialble and advertised through the central team and accessed by all staff groups Personal development plans for individuals in place as part of the E-Appraisal process Talent management has commenced across the organisation.	Inadequate	Further development of the Talent Management Framework is required.	Assurance reports to the Remuneration, Nominations and Appointments Committee and SLT. Divisional Performance reviews and the People Committee will provide the governance for this risk.	Second Line Assurance - Risk and Compliance	Divisional level analysis of succession plan not in place at present, therefore there is an 'unknown' risk. The risk of not funding the executive leadership programme will impact on the ability to provide leadership capacity at the senior level of the organisation.	Moderate	Likely	12	High Risk	Development of Talent Management Framework to ensure a robust framework to Talent Management. There are three key areas of focus for Talent Management which will culminate in a framework being developed in April 2020 based on the learning from these three key areas. 1) The Trust is leading the 'High Potential Scheme' across the STP which focuses on Talent at Band 8A and above to support the pipeline for the existing Aspiring Director programmes already in place. In order to support this significant systems leadership project recruitment to a part-time project lead to be hosted at UH Bristol. The post holder will commence at the end of October with the programme development phase commencing in January 2020. 2) The Trust has secured its position as a pilot site for the diagnostic tool for Talent working with the National Leadership Academy. The tool will enable us as early adopters to understand the baseline position for talent in the organisation and the actions required to develop a sustained approach alongside informing the aforementioned organisational framework. The TM diagnostic tool is designed to enable organisations to review themselves against robust and evidence based indicators of effective TM and will be completed by the end of October 3)Regional Talent Board- developing aspiring	20/04/2020	Moderate	Unlikely	6	Moderate Risk	02/03/2020	Action Required Risks
2694	Workforce	Internal	In the next Financial Year	People Strategy	People Committee	Director of People	If the factors that contribute to a decrease in the staff annual engagement score are not improved, Then the workforce may be disengaged and demotivated, Resulting in increased turnover, absence and other workforce KPI's.	Moderate	Likely	12	High Risk	Focus on staff well-being, engagement and personal development through robust improving staff experience plans. Development of apprenticeship strategy to support development of staff at all levels. People Strategy, focus on improving key cultural elements of Staff Engagement, Bullying and Harassment, reward and recognition, Performance Management, Equality and Diversity, wellbeing and leadership and management development. All workstreams have detailed action plans focusing on improving motivation and engagement.	Adequate	None noted.	Monthly HR/OD partnership meetings in place to review all plans which are then presented to the people management group and the supporting sub groups of wellbeing and Diversity and Inclusion. Each division has a workforce committee to provide assurance on this agenda Divisional Performance reviews monitoring progress against these KPI's Quarterly update to the the people committee and the Trust Board	Second Line Assurance - Risk and Compliance	Not achieving a score in the upper quartile nationally among peer Trusts.	Major	Possible	12	High Risk	The recognition framework will be refreshed and re-launched at the end of February following an audit of recognition schemes across the organisation which as been completed	28/02/2020	Major	Rare	4	Moderate Risk	02/03/2020	Action Required Risks
2695	Business	Internal	In the next 3-5 Financial Years	Trust Strategy	Audit Committee	Deputy Chief Executive	If the Trust fails to establish and maintain robust governance processes, Then Operational, financial and quality performance could be negatively impacted, Resulting in additional regulatory scrutiny and reputational damage.	Moderate	Very Likely	15	Very High Risk	Internal Audit reports. External audit plan and reports. Risk Management Strategy. Governance Structure. Performance Management Framework. Estates & Facilities Compliance report produced and reported monthly to E&F DMB and quarterly into Audit Committee. Annual assessment against the Foundation Trust Code of Governance Annual Provider Licence self certifications	Adequate	Updates required to the enabling strategies to support the delivery of the revised Trust Strategy (includes the Education Strategy) Compliance with OFSTED requirements specifically relating to apprenticeships. Governance around estates compliance including fire safety.	External well-led reviews. CQC Inspections. Internal quarterly reviews of CQC regulation 17. Annual Report, Annual Governance Statement, and Annual Quality Report and Annual Accounts submitted to Trust Board. Regular reporting to NHS Improvement following Board approval. NHS Improvement returns signed off by the Trust Board. Internal Audit Reports on Governance, risk management and financial accounts reported to Audit Committee. Monthly Board Reports. Performance and Finance Reports at each Board Meeting. Committee Reports at each Board Meeting. Independent reports from CQC on Inspection Visits.	Third Line Assurance - Independent	Partial assurance of effectiveness of controls, in light of on-going failure of some standards.	Moderate	Possible	9	High Risk	Completion of Premises Assurance Model (PAM)compliance report. Board to review and approve all enabling strategies Produce action plan to improve compliance with OFSTED requirements relating to apprenticeships.	30/03/2021 30/06/2020 29/02/2020	Moderate	Unlikely	6	Moderate Risk	02/03/2020	Action Required Risks

Strategic Risk Register								Inherent				Controls			Assurance			Current Assessment						Target				Review	
ID	**Domain**	**Origin**	**Proximity**	**Strategy**	**Assurance**	**Executive**	**Principal Risk Description**	**C**	**L**	**S**	**Risk level**	**Key Controls**	**Adequacy**	**Gaps in Controls**	**Form of Assurance**	**Level**	**Gaps in Assurance**	**C**	**L**	**S**	**Risk level**	**Action Details**	**Due date**	**C**	**L**	**S**	**Risk level**	**Next Review**	**Status**
2741	Quality	Internal	In the next 3-5 Financial Years	Research Strategy	Quality & Outcomes Committee	Medical Director	If financial pressures, service pressures or failure to recognise the value of research cause it to be deprioritised, Then the Trust will be unable to sustain research activity, Resulting in loss of reputation, income and ability to attract and retain highly skilled and motivated staff. limitation of patient choice, loss of potential to offer novel and/or cutting edge treatments and inability to contribute to the evidence to improve patient care.	Moderate	Likely	12	High Risk	Memorandum of agreement with University of Bristol. Joint Posts and Clinical Networks. Research Standing Operating Procedures. Process in place for corrective and preventative actions where breaches of GCP/protocol are identified to support learning by PI/CI and research team. Regular review of research recruitment on a trust-wide level. Key Performance Indicators at divisional level (bed holding only) finalised for regular divisional review. Appropriate study selection to maximise fit with patient pathways and minimise high resource use at times of clinical pressure. Research grants, Research Capability Funding, commercial and delivery income maintained. SPAs recognised in consultant job plans. Experienced and dedicated research teams to support delivery of clinical research. NIHR award £21m over 5 years for Biomedical Research Centre to Trust and UoB partnership. New Clinical Director and substantive Chief Operating Officer to Local Clinical Research Network. Review of impacts of research and engagement with SLT, board	Adequate	None noted.	Reporting structures for divisional research committees/groups to Trust Research Group. Regular reports to divisions and the Board on KPI reviews (Trust-wide & divisional). Internal and External Audits and inspections. Process in place to identify and address poor performance within R&I Dept.	Second Line Assurance - Risk and Compliance	No clear mechanism for protecting time for non-medical PIs who do not hold funded research role recruiting to National Institute of Health Research portfolio trials not in place.	Moderate	Possible	9	High Risk	Continue to work with our researchers, with the RDS and with trials units to encourage them to submit high quality applications to NIHR funding streams. NIHR project grants draw in Research Capability Funding. Therefore increasing the number and value of NIHR project grants will lead to an increase over time of RCF. Drawing in successful grants also increases the research activity of the trust.	31/03/2020	Moderate	Unlikely	6	Moderate Risk	02/03/2020	Action Required Risks
2954	Business	External	In the next Financial Year	Trust Strategy	Audit Committee, Finance Committee, People Committee, Quality & Outcomes Committee	Chief Operating Officer	If the Government fail to negotiate a robust withdrawal agreement and framework for a future trading relationship with the EU, Then the plans could result in disruption to delivery of goods and services to NHS providers, Resulting in potential delays in importing medicines, exclusion from the European Rare Diseases Network, the ending of reciprocal healthcare agreements and new immigration rules that could affect the ability of the NHS to recruit doctors,other medical staff and nursing staff from the rest of the EU, and the subsequent changes to current rules around the mutual recognition of medical qualifications.	Moderate	Very Likely	15	Very High Risk	Organisations to follow guidance from the Secretary of State for Health and Social Care on the government's on-going preparations to protect patients and health and social care services in the event of a March 2019 no-deal scenario, should this occur. The Department for Health and Social Care has also written to pharmaceutical companies and suppliers of medical devices asking for their contingency plans and pinpointing where their concerns lie (e.g. short-life products, warehousing, distribution) in order to focus national-level support where necessary. The Trust is planning to support employment settlements costs for permanent staff who have classed themselves as from countries within the European Union.	Inadequate	The Trust is unable to address the cause of the risk.	Findings of preparatory work, table top exercise and updates to operating plans report into SLT.	Second Line Assurance - Risk and Compliance	None noted.	Moderate	Possible	9	High Risk	Whilst there is a risk no future relationship is agreed with the EU by the end of the transition relationship all Trust internal planning is stood down. Action is to review if internal planning needs to be be re-established utilising the same structures	31/10/2020	Moderate	Rare	3	Low Risk	02/03/2020	Action Required Risks
2992	Business	Internal	In the next 3-5 Financial Years	Quality Strategy	Quality & Outcomes Committee	Director of Strategy & Transformation	If sufficient priority is not given to developing the capacity and capability of staff for delivering transformation, improvement and innovation; Then staff in the organisation may not be able to support the scale and pace of change necessary to work in new ways and deliver the organisation's and system's strategies; Resulting in a partial or non-realisation of benefits, loss of reputation as an innovative organisation, poor performance, demotivation of staff, associated impact on recruitment and retention, and a reduced influence as a leader in our Local system.	Moderate	Possible	9	High Risk	Transformation Programme Board membership at Executive and Divisional Director / Clinical Chair level. Transformation and improvement priorities embedded into annual Trust and Divisional operating plans. Approved Innovation & Improvement Strategic Framework in place. Staff engagement embedded in planning service improvement and transformation work. Transformation and other service improvement leads networked across the divisions. Working in partnership with the Academic Health Science Network to train a cohort of improvement coaches. Quality Improvement Academy established 2017 and "dosing plan" for training developed. Digital Hospital programme a priority within the Transformation programme with Digital Hospital Committee aligning actions into clinical safety and operational decisions. Transformation, Improvement and Innovation strategy approved by Trust Board 27.9.19. Six monthly updates to be provided through governance structure to People Committee	Adequate	None noted.	Reporting to Transformation Board & Senior Leadership Team. Evidence of wide range of innovation and improvement programmes completed/underway including good response to programmes such as Bright Ideas, Trust Recognising Success awards , Quality Improvement Hub, QI annual forum and achievement of local / national awards. Audit and inspections. Quarterly Transformation reports to the Trust Board and annual Trust Board Seminar focus on Innovation & Improvement and QI Hub. Digital Strategy presented to Trust Board, Including updated objectives and additional functional scope. Benefits realisation plans in place for all Transformation projects. Routine departmental assurance by programme management office for all digital and IM&T projects and activities reported to IM&T Management Group.	First Line Assurance - Operational	Lack of an Improvement and Innovation strategy. Scale of QI Programme for larger transformation projects. Securing sufficient capacity to deliver 'Dosing' strategy.	Moderate	Possible	9	High Risk	Grow the scope of the QI Academy offer with development of a QI Gold programme and Leading QI for Senior Leaders In order to achieve the necessary culture change, we propose expanding on the Quality Improvement (QI) training and support currently available, in line with a strategic Dosing Model. This will double the number of training sessions and coaches, as well as provide a presence at the Weston site of a merged organisation. In addition, offering online training and general awareness will ensure that all staff know that improvement is part of everybody's job and that improvement support is available.	31/03/2020 30/04/2020	Moderate	Unlikely	6	Moderate Risk	02/03/2020	Action Required Risks
3472	Reputational	External	In the next 3-5 Financial Years	Sustainability Strategy	Audit Committee	Chief Operating Officer	If the Trust fails to educate and drive changes in behaviour and ways of working of staff, contractors and in the supply chain, Then it will be unable to contribute to making a positive impact on combatting climate change, Resulting in failure to deliver on the priorities and objectives in the Trust Sustainability Strategy and reputational damage.	Catastrophic	Possible	15	Very High Risk	Sustainability Strategy approved at Trust Board in September 2019. A Sustainable Development Board with supporting governance structure and work streams to oversee delivery of the Sustainable Strategy has been approved by SLT. Sustainability Plan in place to support delivery of strategy objectives. Energy & Sustainability Manager in Post. Big Green Scheme responsible for supporting the Trust's work to become more sustainable; socially, environmentally and economically, across all areas.	Inadequate	None noted.	None noted.	First Line Assurance - Operational	None noted.	Catastrophic	Unlikely	10	High Risk	Develop proactive stakeholder engagement and communication plan Develop a detailed action plan with costings to ensure that business cases are produced and funding secured though Capital Programme Steering Group. Produce targets for divisions to include in divisional operating plans to support target achievement.	31/03/2020 31/03/2020 31/03/2020	Catastrophic	Rare	5	Moderate Risk	13/03/2020	Action Required Risks

Meeting of the Board of Directors in Public on Thursday 30 January 2020

Report Title	**Corporate Objectives Update – Q3 Update**
Report Author	**Executive Team members**
Executive Lead	**Paula Clarke, Executive 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 3.

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.

The Q3 report now uses a five-point scale to indicate progress against each of the objectives:

		Current ratings
Grey	Not due to start yet	0
Red	Not started and behind schedule / not achieved	3
Amber	Commenced but behind schedule / risk of not achieving	18
Blue	Commenced and on-plan	8
Green	Complete	12

This report should be read in conjunction with the Q3 Board Assurance Framework (BAF) update, which provides assurance on the management of risks to the delivery of the Trust strategic priorities.

8.2

Respecting everyone
Embracing change
Recognising success
Working together
Our hospitals.

3. Risks If this risk is on a formal risk register, please provide the risk ID/number.	
The risks associated with this report include: As aligned in BAF	
4. Advice and Recommendations *(Support and Board/Committee decisions requested)*:	
• This report is for **Assurance.**	
5. History of the paper **Please include details of where paper has previously been received.**	
Senior Leadership Team	22 January 2020

8.2

Respecting everyone
Embracing change
Recognising success
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Our hospitals.

CORPORATE PLAN 2019/20

Plan Owner:	
Paula Clarke	***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.***
Version Number/Date:	
V1.0 16Jan2020	

Grey	Not due to start yet
Red	Not started and behind schedule / not achieved
Amber	Commenced but behind schedule / risk of not achieving
Blue	Commenced and on-plan
Green	Complete

Ref	Strategic Priorities	Corporate Objectives 2019/20	Goals for the Organisation (ideally these should be measurable goals)	Q3 Update	RAG	Q4 Milestones	Exec 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.	The Trust finalised its action plan in response to the CQC's 'should do' recommendations and submitted this plan to the CQC		Close the 'must do' action plan and confirm a timetable for closure of the Trust's 'should do' action plan.	CN
		Ensure our services are responsive and achieve all constitutional access standards.	• **RTT**: Deliver the recovery trajectories of 87.9% (Apr-Nov, Mar) and 86.9% (Dec-Feb) at each month-end during 2019/20. This is the percentage of patients waiting under 18 weeks. Also deliver zero 52+ week breaches from September • **Cancer:** Maintain the national standard of 85% for cancer 62 day GP referrals • **Diagnostics**: Return to the 99% standard by quarter 4. Deliver improvement during quarters 1-3 • **ED**: Deliver the trust-level recovery trajectory each month in 2019/20. The trajectory was set at 2018/19 levels plus 0.5%.	**RTT:** October and November achieved 83.0% and December is likely to achieve 83% (validation is still ongoing). These are below the recovery trajectory. Reduction in elective activity is driving the performance reduction with a significant increase in backlog volumes for Dental services (8852 at Nov-19, up from 5578 at end of Jan-19). There were five 52 Week breaches at end of November. The overall RTT List Size has increased from 29207 in Mar-18 to 34739 at end of Nov-19. Focus is shifting to the delivery of a reduced overall waiting list size and current NHSI trajectories required Trusts to maintain Mar-18 levels by Mar-20 **Cancer:** Quarter 2 was compliant at 85.4%. October was compliant and November is expected to be compliant. There is a reasonable chance of compliance in quarter 3 however surgical cancellations due to winter pressures are an ongoing risk. **Diagnostics:** October finished at 95.9% and November at 96.7%, this did not achieve the 99% standard. December is likely to achieve around 96.5-97%, validation still ongoing. **ED:** October was 82.5%, November 80.3%, December 76.1%. This was below the NHSI recovery trajectories of 89.7% (Oct), 84.7% (Nov) and 83.5% (Dec).		**RTT:** Recover RTT recovery trajectory of 87.9% (Oct, Nov) and 86.9% (Dec) at each month-end. As part of OPP planning rounds, plans to reduce overall list size during 2020/21 need developing. **Cancer:** Maintain cancer 62 day national standard of 85%. **Diagnostics:** Deliver 99% in Quarter 4. Winter pressures resulting in Endoscopy capacity being used for escalation capacity is a significant risk. Impact being reviewed with the division. **ED:** trajectories for Q4 are 85.0% (Jan), 81.6% (Feb) and 81.7% (Mar)	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.	Securing sufficient out of hospital discharge capacity remains an objective of the out of hospital delivery group, and unfortunately the position is challenged, with very high numbers of delayed patients (c110-120) and associated bed days. Bristol City Council have proposed a new model of homecare and reablement, approved by UCOB, which is being worked up in terms of how likely securing staffing an funding for the model is. In the meantime we have asked for an interim bed based model to be commissioned to bridge the gap whilst homecare services build to the level of capacity required. To support UHB processes we continue to work with a continuous improvement methodology via our Whole System Operational Group with UHB system partners. A recent addition to the WSOG plan stems from a "Raid" event run in partnership with GP and community health colleagues who came on to our wards to spend time on board rounds and with the MDTs to break down barriers to discharge. We have several new projects we are now working with partners on, including setting up better communication opportunities between ward, general practice and community teams to support discharge planning. We are also reviewing our approach to long length of stay reduction and are refreshing the format of the "Stranded Patients Review Meeting", to include therapy and senior nursing colleagues, as well as partner organisations.		• New Stranded Patients process in place, monitored through WSOG • Refresh of Out of Hospital Delivery Group workplan to refocus on delivery of capacity • Complete actions on Raid plan	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.	• After the Q2 update was written, the monthly meetings planned to take the project forward were stood down following agreement that work on a new Quality Strategy would be deferred until later in 2020 and undertaken as a merger organisation. Therefore there has been no further progress against this element of the objective during Q3. • At the end of Q3, all corporate Quality objectives were on plan with the following exceptions: - Limited progress with implementation of electronic monitoring of IV cannulas - Slippage in timeline for implementation of on-line disability access guide to 2020/21, but funding secured. - Slippage in interruptions and distractions workstream in respect of Never Events. • Leadership and culture, interruptions and distractions patient safety programme workstreams remain behind plan due to capacity in the team to take forward. This slippage has been accepted and there will be changes and re-prioritisation of workstream objectives to run on a slower track and to enable closer working with Weston colleagues on aligning improvements in these areas. National steer on focus of medicines safety improvement work received Q3. Daily feeds from digital observations to wards are imminent, which will support timely recognition and response to deteriorating patient. • Falls and alcohol/tobacco CQUINS likely to underachieve due to the need for significant groundwork in aligning and rationalising clinical paperwork before improvements can be made.		• Work to deliver 2019/20 quality objectives to be concluded. • Reset timescales for Leadership and culture, interruptions and distractions patient safety programme workstreams. Meeting with WEAHSN and ARC February re monitoring and academic evaluation of interruptions and distractions workstream. Vitals upgrade due February 2020 will support improvements in timely recognition and response of deteriorating patient. West of England Patient Safety Collaborative focus on medicines safety Q4.	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	• Arts strategy approved in July 2019. Delivery action plan managed through IDEAS group. Current approved programme on track for delivery this year. Approval given to make key appointments to increase capacity. Future funding agreed in principle • 16 approved strategic capital business cases at either SOC or OBC level; 4 further cases to achieve SOC approval status. • Estates Strategy development expertise commissioned and initial phase commenced. An external review of site infrastructure has been commissioned and the initial findings reported. This will be used to inform the finalisation of the estate master plan options and be incorporated into the final estate strategy update. Two primary options have been identified which comprise either a new outpatients or Adult Emergency department on the Marlborough Hill site. The remainder of the programme is dependent on this decision being made.		• Develop implementation plan for delivery of Arts Strategy for 20/21. • Strategic capital programme business cases review to be completed which will inform the next stage of the Estates Strategy development. • Number of planning scenarios to be developed to inform the full Estates Strategy. • Conclude initial high level assessment of site-wide infrastructure and consider next steps, based on recommendations.	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.	• The Trust achieved the top score for any general acute Trust in the 2018 national inpatient survey (the second time in three years). In Q3 the latest results from the national cancer and A&E annual surveys became available; A&E scores were upper quartile and cancer scores were on the threshold. • In Qs1-3 2019/20, 98-99% of UHB patients rated their overall experience of care as "good" or better; our overall patient experience scores demonstrate steady and consistent improvements. • In Q3, four new feedback screens were installed in St Michael's Hospital, plus one in the BHI.		• In Q4, five screens are planned for installation in the Children's Hospital.	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.	• Work continues to deliver against the OD plans for D&I, wellbeing and staff engagement with a quarterly progress report going to people committee. In terms of Talent Management a stakeholder meeting has taken place to understand the challenges and share best practice to Talent Management in order to develop an agile organisational framework that reflects the business requirements • The Trust has secured its position as a pilot site for the diagnostic tool for Talent working with the National Leadership Academy. This will be a national NHS tool in 2019 however; the tool will enable us as early adopters to understand the baseline position for talent in the organisation and the actions required to develop a sustained approach alongside informing the aforementioned organisational framework • The Trust is also leading the 'High Potential Scheme' across the STP which focuses on Talent at Band 8A and above to support the pipeline for the existing Aspiring Director programmes already in place. In order to support this significant systems leadership project recruitment to a part-time project lead to be hosted at UH Bristol within OD has commenced.		• Delivery of the strategic action plan for D&I is on target with Q3 performance being presented to people committee in January,. The Trust will also commence its national WRES programme pilot on January 22nd • Development of a culture and people plan is underway in each division to bring together all OD plans and ensure increased governance, these will be in place by the end of February 2020 • The corporate OD plan which includes wellbeing; engagement, and performance management remains on track with performance against the plan being reported to the people committee in January • An update against progress with the Talent management framework will go to People Committee in January reporting against the diagnostic that has been completed and the early learning from the high potential scheme which has commenced in terms of its progress against project plan.	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.	• Trust vacancy rate continues to reduce and stood at 4.2% across all staff groups in November 2019. Work continues on the creation of a fuller Talent Acquisition team to support the Trust's Clinical Talent Acquisition Manager. Key focuses during Q3 have been around agreeing an approach for medical recruitment. Within the Medicine Division and specifically ED, a Middle Grade medical recruitment campaign was created and set live with a bespoke campaign site http://uhbristolcareers.co.uk/ed which included personal experiences and more details of the interests on offer, publicised using a media plan which included BMJ and EMJ. • Examples of other specific interventions include: -Occupational Health Consultant advertised using brand new advert 'best of both worlds', PAs were negotiable and provided candidates with the opportunity to still pursue private practice interests. Research showed the lack of time to follow private interests was putting candidates off. Supported with proactive media plan and Talent team used LinkedIn to contact key industry contacts in Occupational Health sector to test the advert and spread the word further. This activity has resulted in two strong candidates who saw the advert or were recommended and have since visited the Trust and will be formally interviewed in January. - Paediatric Radiation Oncologist: Interviewed, needs CESR but department feedback is positive and due to the hard-to-fill nature of the role, the extra support and time needed to get the candidate ready has been justified. '- Acute Medicine Consultant: Efforts to advertise role so far have not been fruitful. Meeting scheduled in January to regroup and establish new strategy to fill vacancy, potentially going out for General Internal Medicine Consultant with interest in Acute, which is considered to be easier to recruit to in comparison and will take the pressure off other Acute Consultants so that they can develop the service. '- ED and Medicine Recruitment Films planned to help position and sell Trust as an employer of choice to the world - progress has slowed due to critical incidents and availability (ED film shoot cancelled and needs to be rescheduled) but will be picked up in Q4.		• Realisation of the medical recruitment approach within ED. • ED Middle Grade campaign to close and evaluate. • Developing a medical recruitment strategy for Weston. • New Talent Acquisition Specialist to start, to support talent acquisition implementation. • Appointment of hard-to-fill OH Consultant and Paediatric Radiation Oncologist post. Acute Medicine campaign Live Talent Acquisition Manager to work with HR BPs to update 'hard-to-fill list' Talent Pool List to be piloted from January - gathering names of doctors, to be used as mailing list in future recruitment efforts.	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.	Further recruitment of TNA numbers from existing unregistered workforce has been completed that will enable a further 12 to commence their apprenticeship training at UWE in February 2020. This will account for the agreed 20 TNA for medicine and surgery. The next steps require closer working with Heads of Nursing to embed the role as part of the nursing workforce strategy. The work has also identified the need to offer enhanced upskilling development opportunities for nursing assistants so that they are able to meet the necessary entry requirements of the programme. This will form part of the developing nursing assistant academy objectives. Physician Associates have now been recruited to medicine with an aligned evaluation. An under graduate clinical placement circuit, to commence from May 2020, is being developed to create a workforce supply route for the role. ACP business case process agreed with SLT and awaiting divisions to submit their business cases for oversight from SLT.		During Q4, will review experience of recruited TNAs and agree workforce strategy such as competency framework and long term workforce for encompassing Nursing Associates.	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 model implemented and shared with divisions with a request for enhanced divisional representation . During January and February 2020 proposed consultation on the education structure for effective utilisation of investment and necessary to cement the foundations for becoming a beacon of outstanding education. Shared working group established with both Weston college and UoB. Review of essential training as part of CQC should do action plan that will be overseen as part of the newly formed corporate education group. This is also aligned to the STP skills pass porting project that is seeking enhanced sharing of essential training across BNSSG. Proposal from the Education Group for new study leave policy to support equitable funding of essential and essential to role training , plan to be discussed at February SLT. Medical induction review working group in place with a streamlined proposal being developed with a plan for SLT sign off during Feb/March 2020. In view of Weston merger planned review of corporate induction for all staff and trainees delayed until post April 2020. In the meantime scoping of inductions being undertaken. Ofsted full inspection took place in December 2019 that highlighted core necessary actions for 2020. Next steps to be discussed at People Committee.		Consultation on education structure and associated investment to be completed during Q4. Implement the CQC should do action plan for essential training. Discuss and develop a new apprenticeship quality improvement plan following December 2019 Ofsted full inspection.	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.	• A stakeholder meeting has taken place to understand the challenges and share best practice to Talent Management in order to develop an agile organisational framework that reflects the business requirements. • The Trust has secured its position as a pilot site for the diagnostic tool for Talent working with the National Leadership Academy. This will be a national NHS tool in 2019 however; the tool will enable us as early adopters to understand the baseline position for talent in the organisation and the actions required to develop a sustained approach alongside informing the aforementioned organisational framework. • The Trust is also leading the 'High Potential Scheme' across the STP which focuses on Talent at Band 8A and above to support the pipeline for the existing Aspiring Director programmes already in place. In order to support this, significant systems leadership project recruitment to a part-time project lead to be hosted at UH Bristol within OD has commenced.		An update against progress with the Talent management framework will go to People Committee in January reporting against the diagnostic that has been completed and the early learning from the high potential scheme which has commenced in terms of its progress against project plan. It is anticipated an outline framework will be in place Q1 2020	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.	• 7 PAs now recruited in medicine. Overseeing working group in place and scoping possible undergraduate PA clinical placement circuit across the Trust aiming to commence from May 2020. • Recruitment and selection process for first cohort of TNAs. This identified the challenge of internal NAs having the necessary admission criteria of a level 3 profile and functional skills. Additional functional skills opportunity for TNA applicants facilitated through Weston College that will enable a further cohort for February 2020. Long term solution for increased access to stand alone functional skills being scoped with Weston College and across the STP. •ACP cross Trust working group to be re established during January 2020 that will oversee the implementation of the ACP business cases across the Trust. Funded HEE places for ACPs working in Emergency Department agreed as part of national work. STP undertaking scoping of ACP roles across the STP over next 3-4 months.		• PA clinical placement circuit and evaluation plan to be completed during Q4. • Clear development pathway for NAs wanting to progress to TNAs. • Q4 oversee divisional ACP business cases as part of a trust wide working group.	DoP
	• 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.	•Following a review of the different functionalities and costs, it has been determined that ESR self service will be implemented for absence management, which links in with its impending roll out for pay progression. •It is intended that ESR self service will replace eforms but due to the pending Weston merger, work is currently focusing on extending eforms into Weston to achieve consistent management of pay and employee terms & conditions. •There is currently no update from IT on Microsoft Office 365.		Continue work to ascertain the feasibility on introducing eforms into Weston, concluding with either the introduction of eforms or expansion of Weston's current usage of ESR self service.	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.	•Supporting the goal of making the BNSSG Health an Care the Best Place to Work, the HRDs have commenced a programme of work on Flexible/Agile working and health and well being. To support our goal of improving the Leadership Culture we have launched the Peloton system leadership programme for 60 senior people within the STP. Our goal of Releasing Time to Care has been progressed through the continued focus on Agency savings, particularly the focus on reducing high-cost agency use. We have implement the 'Capital Nurse' style registered nursing supply project, supporting the goal of Addressing Urgent Workforce Shortages. The goal of optimising skills has moved forward with the appointment of a full-time project manager to the Learning Academy. In supporting the goal of delivering a new operating model for workforce, the McKinsey workforce planning tool is now being used to drive appropriate areas of focus and workforce development. •The Healthier Together HRD Group, chaired by Matthew Joint, established strategic priorities around the core areas of improved retention and participation, hiring/supply pipeline, temporary staffing, improved retention and participation in Q2. Each priority area now has a delivery programme, sponsored by an HRD. The HRDs have agreed to lead the Organisational Development agenda for the STP and have agreed a work plan to support collaborative delivery of programmes supporting talent development, Diversity and Inclusion, Wellbeing and cultural development.		•Launch of Aspire, an STP wide talent management system •Conclusion of the Peloton programme and agree plan for next steps	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.	Quality Objective 4: Driving positive staff engagement through expanded use of the Happy App - the Trust has exceeded its target to increase the number of teams registered for the Happy App by 10%. In Q2, an increase of 35% was achieved		• The Trust has exceeded its target to increase the number of teams registered for the Happy App by 10%. In Q2, 215 teams and 340 moderators were listed onto the system. This remains the same in Q3. • Communication and engagement activities outlined in the annual stakeholder plan continue to sustain awareness and widespread usage within clinical and non-clinical environments. The Happy App usage and themes, as appropriate, is reported on a quality basis to the people committee for assurance	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	You Said.. We did took place w/c 16th September ahead of the staff survey launch on 23rd September. The Survey is supported by a robust communications plan alongside being supported by ongoing OD interventions and a strategy plan for D&I and wellbeing.		The survey closed in November; results are embargoed until March 2020. A subsequent plan will be put in place to respond to the results from the survey	DoP
		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	A year one strategy plan is in place and progress against this is reported to the People Committee on a quarterly basis. All actions in the plan are on target.		A year one strategy plan is in place and progress against this is reported to the People Committee on a quarterly basis. All actions in the plan are on target. Under the four strategic headings of: Leadership and cultural transformation, Monitoring progress and benchmarking, positive action and practical support, Accountability and assurance. The Trust has been chosen as one of the pilot sites for WRES with a launch event on January 22nd, this will help to inform the year 2 strategy plan which will launch Q1 2020	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 contract variation agreement signed with NHS England on 12th August 2019. • Operational Delivery Network (ODN) hosting arrangement SLA completed with NHS England for Paediatric critical care and surgery in children. This SLA is pending inclusion with NHS England contract; contract variation drafted and issued to commissioners. • Genomic Medicine Centre contract extension achieved until March 2020, but awaiting confirmation of intentions for 2020/21. • NICU single service management model options reviewed and business case updated. • Cardiovascular Research Unit (CRU) capital scheme with UoB expected to commence in Q2 2020/21.		• Complete 2020/21 contract plan including agreement of CAR-T invoicing arrangements to bring into the main UH Bristol contract. • Complete contract variation for inclusion of ODN Hosting arrangement with NHS England • Confirm commissioning intentions for Genomics Medicine Centre for 2020/2021 • Finalise NICU full business case	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.	• Cardiovascular and MSK system Clinical Practice Groups established.		• 100 day improvement project to be completed for Respiratory Services.	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.	Medical outliers have increased this year as a result of pressures on the medical bed base related to the very high numbers of medically fit for discharge patients who are awaiting community and social care services. In order to address this we are responding to the situation by putting in place additional medical and nursing review teams across the week and at weekends to discharge appropriate patients in a timely way, and have refocussed teams on using the discharge lounge. In the longer term we will work with A&E Delivery Board partners on out of hospital care planning and delivery as current delivery plans are insufficient to meet demand. The DPTL methodology is embedded, further refined by used of CUR, and in the longer term we are working to streamline processes. We are using the data in our work with partners and to improve internal processes. New projects include a review of the single referral form process and enabling work to ensure the Integrated Care Bureau are able to make immediate decisions regarding discharge destinations using robust information.		Revised Out of Hospital Delivery Group workplan, focussing on delivery of capacity to match demand. Launch of Proactive Hospital Board to focus on internal efficiency processes at ward level, and at the backdoor.	COO
		• Implementation of Electronic Prescribing System to reduce medication errors.	• Phased re-implementation of EPMA following upgrade to System C.	• Software requirements for re-introduction of EPMA have been confirmed and System C has notified the Trust that development has been scheduled for completion in product release 'PI17', which is expected to be released by System C in late March. Date for introduction to UHBristol for commencement of testing cycles is anticipated in Q1 20/21. Date for go-live will be agreed following initial testing cycle in Q1.		• No EPMA milestones will occur during Q4.	CN / MD / CCIO
		• Standardisation of Handover Processes between Clinical Teams to optimise communication and information flows between teams.	• Implementation of Careflow Handover Module.	• Project activity by the Transformation team to standardize handover process and introduce Careflow handover into BRHC has continued through this period and will complete in Q4, followed by introduction into other hospitals on a schedule to be agreed.		• Completion of BRHC phase and agreement of schedule for further roll-out of Careflow-based Handover processes across the Trust anticipated in March 2020.	
		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.	• Further strategy meeting held with Sirona in December with agreement of plans to present into Strategic SLT, sharing of demand and capacity modelling assumptions and Exec to Exec meeting in February 2020. • Roll out of Advice and Guidance services continues and evaluation expected in Quarter 4. • Ongoing attendance at Primary Care Integrated Locality Boards and established Primary / Secondary Interface Group with CCG and the three Acute Trusts. • Overall RAG assessed as Amber, primarily due to an expected delay in Advice and Guidance evaluation which could impact on contract negotiating position for 2020/21. Recovery activity underway with CCG to streamline evaluation requirements focusing on changes made to GP referral to 1st outpatient appointment conversion rates. • AMD for Primary Care appointed 2 x sessions per week in collaboration with OneCare as a 6 month pilot.		• Advice and Guidance evaluation reviewed and approach for inclusion in Outpatients blended tariff agreed with commissioners. • BEH GP engagement event held • Project initiation meetings for BNSSG Eye Hospital Strategy • Primary / Secondary Care Interface Strategy and immediate priorities to be confirmed following internal scoping by Associate Medical Director for Primary Care. • SBCH specific group to be established with a project plan developed to guide key actions to agree future MOC, estates issues, TUPE plans etc. • Further GP engagement event scheduled with the BEH on 21 January 2020 and further UH Bristol-wide event being planned for April 2020.	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 .	Long Term Plan response submitted in November and internal communication / development of Operating Plans underway.		• Agreement of 2020/21 contract plan and updates to Long Term Plan submission as required. • Wider communication on LTP following national implementation update on LTP (post purdah)	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	1. Sector-wide reviews of specialities e.g. Cardiovascular Disease commenced with good engagement. 2. Review of Clinical Cabinet underway to redefine role within BNSSG. 3. BHP confirmed as desired model for next three years. 4. The CPG approach has been refined into a 4 stage development cycle. Initiation meetings have taken place in Dermatology with NBT and in Pre-habilitation with NBT, WAHT, UHB and Primary Care. The STP Cardiovascular Disease programme initiation meeting has agreed to progress work within the heart failure and AF pathways.		Confirmation of individual pathways and setting up of pathway-specific working parties.	MD / DofS&T
		• Implement the ReSPECT Process within UH Bristol and work with our partners to implement across the sector.	• Implementation of ReSPECT documentation.	ReSPECT documentation implemented across sector in October 2019.		Monitoring of consequences / adverse events.	CN / MD
		• Develop a sector-wide Medical Examiner model that is responsive and consistent.	• Development of Medical Examiner model and recruitment to posts by March 2020.	Sector-wide approach confirmed and Project Manager recruited and in post. Medical staff undergoing M.E. Training.		Preparation and approval of Business Case for M.E. Model	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	• The Clinical Sponsorship Board with NBT is established and meetings take place quarterly. The introduction of CPG's is being tested at specialty level and work is underway in Rheumatology and Dermatology. • Weston Partnership Management Board continues to meet monthly. The agenda has been amended to ensure key focus on progress for merger and merger on track for 1 April 2020. • Clinical Practice Groups continue to be established at specialty level and additional Clinical Integration meetings have been set up for clinical leads from both organisations to discuss clinical services integration and CPG development each fortnight. • Corporate services integration plans and future team structures have been developed at service level and are being shared with senior leads in WAHT		• Successful merger completed • Clinical and corporate integration plans in place • Dates for Clinical Sponsorship Board confirmed for 2020/21 with NBT	DofS&T
		Recruit to Well Being Programme	Establish Programme and confirm on-going funding if successful. Monitor via staff survey	• Sector-wide reviews of specialities e.g. Cardiovascular Disease commenced with good engagement. • Review of Clinical Cabinet underway to redefine role within BNSSG. • BHP confirmed as desired model for next three years.		Confirmation of individual pathways and setting up of pathway-specific working parties.	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	• Development of charitable partners policy commenced. • Above & Beyond and Grand Appeal engaged in draft capital bids for 2020/21. • A model of scaled-down, sustainable ongoing support for young people's volunteering has been agreed, but is dependent upon funding being identified in the Operating Planning process for a part-time young people's volunteer mentor in 2020/21 and beyond.		• Complete development of charitable partners policy. • Develop Terms of Reference for the new Charities Forum • Outcome awaited of the ICP bid to enable a sustainable legacy to the project.	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.	• Work closely with our academic and university partners to 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 BRC and the new ARC.	• Number of new clinical academic appointments in our priority research areas. • Percentage of appropriate new appointments who are contacted by R&D within 3 months of appointment. • Work closely with our partners to deliver strong BRC, CRF and AHSC bids in the next two years.	• Sector-wide approach confirmed and Project Manager recruited and in post. Medical staff undergoing M.E. Training. • Onboarding process designed to identify new joiners and inform of research opportunities. • Routine discussion of new clinical academic appointments and opportunities at the joint partnership group meeting held between the University of Bristol and UH Bristol. • AHSC bid submitted; awaiting outcome. • BRC and CRF calls expected Q1 2021.		• Preparation and approval of Business Case for M.E. Model • AHSC outcome expected Q4 2019/20. Other actions ongoing	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.	• Improving Handover using Careflow Connect: Implementation of Careflow for medical handover commenced in BHOC and BHI. Use of internal referrals and task management processes developed and trialled across BRHC departments, such as Emergency and Radiology. • Embedding phase of VTE digital risk assessment established to improve compliance. • Digital real time bed management gap analysis of current processes and available digital functionality completed for BRI and BRHC. Development requirements of digital functions identified and work commenced with supplier. • Digital hospital benefits: ongoing monitoring and identification of actions required to realise benefits. Reporting to NHS Digital and internal governance groups structure developed. Update provided for the organisation via the Transformation Notice Board presentation in December 2019, which is available on Connect and communicated via Newsbeat.		Ongoing delivery of digital hospital transformation including: • Improving Handover using Careflow Connect: Implementation of multidisciplinary handover in BRHC, BHI and BHOC •VTE Risk Assessment-work with clinical areas to understand compliance challenges, and implement of reports for Executives and Divisional clinical chairs to monitor performance •Real-time bed management: Complete gap analysis in remaining areas. Trial new process in one adult pathway. Testing of hardware of by Clinical Site Teams for mobile working. • Transfer of Customer Care programme into business as usual	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	Highlights of transforming care programme: • Draft business case for investment in the Transformation, Improvement and Innovation strategy, discussed and approved by Transformation Board. • Transforming Outpatients workshop held for key staff across the Trust to identify opportunities for implementing advice and guidance, non face to face appointments and reduce follow ups. • Clinical Practice Groups (CPG): Oncology workshop held, and workstreams to prioritise agreed. Initial meetings held for Dermatology and Prehabilitation. Ongoing development of methodology. • Successful bid to Above and Beyond to support the final phases of the Customer Care programme: 24 Advanced Customer care training sessions, which will train approximately 700 staff over 2 years.		• Business case for investment in the Transformation, Improvement and Innovation strategy approved by SLT. • Transforming Outpatients: development of Trust strategy aligning with STP approach, trial of video conferencing, development of toolkit to support divisional teams •Clinical Practice Groups: Progress Oncology CPG outputs, commence next phase of prehabilitation hold initial meetings with further clinical services - Paediatrics, Gynaecology	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	• QI Gold Days 4 & 5 held in December 2019 focusing on change management. Ongoing mentoring provided by QI Faculty members to teams to support delivery of projects. • Bright Ideas competition panel held 21st October 2019, 51 ideas submitted, 9 shortlisted. 8 schemes were supported either with small amounts of funding or senior support to test and implement the idea. • Ongoing delivery of bronze, preceptorship and silver QI programmes.		• Ongoing delivery of bronze, preceptorship and silver QI programmes • Bright Ideas competition round 2 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.	Central repository in place. Governance structures in place. Action plan monitoring as part of Working Smarter programme and Finance and Ops Reviews		Ongoing monitoring	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	• Regular Executive Level reviews in place. Recruitment levels improved. Annual Report presented to SLT and Trust Board for noting. • number of research active staff identified remains steady over the past five years. • Ongoing active engagement by R&I team with new consultants identified through medical staffing to establish interest in research and advise of research infrastructure. • Work with LCRN to clarify support available in the Trust and across the region for early career researchers so mechanisms for support can be publicised and implemented well.		• Ongoing monitoring. • Baseline work with LCRN ongoing and will continue into new financial year as part of the LCRN business planning process.	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).	•Planned savings to 30 November 2019 (Q3 not complete yet) are £3,791k, Actual Savings £2,262k, Adverse variance £1,528k; 60% achievement. •All Divisions below plan for the year to date; the forecast outturn is £4,114k against a plan of £5,619k, a shortfall of £1,505k (73% achievement).		Performance against plan is reviewed each month at Finance and Operations Reviews, Cost Savings Delivery Board and Finance Committee. Corrective action, where required, is supported by senior leadership.	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 Quarter 1 Quadrant Reports published by Division, Day Case rate, Length of Stay and Outpatients on 3rd September 2019. Quarter 2 will be published by 31 December 2019 following usual validation process.		Data output reviewed and discussed at Trustwide Working Smarter Forum, Finance and Operations meetings and Cost Savings Delivery Board. Length of stay opportunities, in particular, will inform the 2020/21 Operating Plan process commencing in October 2019.	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.	• Specialty review papers covering 5 services have been presented to Savings Board and the Finance Committee.		• Output of specialty reviews to be incorporated in the 20/21 cost improvement plan	DoF
		Secure contracts with commissioners which reflect demand and work with partners to reduce costs across the system through pathway redesign	• Finalise 2019 / 20 contract. • Focus on 2020 / 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.	• 1st Draft Indicative Activity Plans completed in alignment with Long Term Planning principles. • All contracts have been signed for 19/20. Planning has commenced for 20/21 with papers presented to SLT and the Finance Committee. The STP submitted its 5 year plan in November 2019.		• Implementation of technical planning guidance and completion of operating plans including NHSI/E submission. • Ongoing engagement with STP planning function to ensure system objectives are met by the Trust. • Year 1 of Long Term Plan will form basis of the STP's Operating Plan for 20/21.	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.	• Report received from Southampton on potential for advertising income. To be taken forward Q1 2020/21. • Pharmacy team finalising tender specification.		• Pharmacy tender specification to be finalised and issued	DofS&T

Meeting of the Board of Directors in Public on Thursday 30 January 2020

Report Title	WAHT Partnership Update
Report Author	Paula Clarke, Director of Strategy and Transformation
Executive Lead	Paula Clarke, Director of Strategy and Transformation

1. Report Summary

The Boards of University Hospitals Bristol NHS Foundation Trust (UH Bristol) and Weston Area Health NHS Trust (WAHT) are proposing to merge to form a single organisation called University Hospitals Bristol and Weston NHS Foundation Trust on 1 April 2020. Significant progress continues in planning for a successful merger which will deliver exceptional local services for local people and specialist services across the South West and beyond.

There are a number of benefits in building on the many years of partnership working between the two Trusts and taking the step to become one organisation. These include:

- A better experience for our patients – ensuring people from North Somerset and surrounding areas will be able to be seen and treated in their local hospital, and improving access to specialist services in both Bristol and Weston through better use of an expanded workforce, estates and facilities.
- A 13,000+ strong workforce increases our diversity, capacity and resilience. Allowing for greater development opportunities for our staff across a much wider portfolio of services, strengthening the knowledge base, peer support and skills and experience of all our employees.
- The opportunity to share expertise and best practice – particularly in the delivery of exemplar models of frailty, ambulatory and out-of-hospital care. Using the opportunity to develop and learn from each other to create truly joined up care which enables people to stay in their own home, or return home as soon as they no longer need our care.
- Accelerating the roll out of digital technology to enhance and improve the quality and delivery of services across the new organisation, further cementing our Digital Exemplar status.
- Releasing untapped potential in our services – particularly medical and surgical ambulatory care, nurturing innovation, and research and empowering our teams to design services and pathways at the forefront of care.

Both organisations are committed to the merger and delivery of these benefits. Following Board approval at the end of November 2019 of the plans to bring the two Trusts together, the transaction business case for the merger has now progressed to the next stage which requires review and assessment from our regulators.

9

2. Key points to note
(Including decisions taken)

New name for the combined Trust

At the point of merger the newly formed organisation will be named University Hospitals Bristol and Weston NHS Foundation Trust. There will be no change to any of the names of hospital sites e.g. Weston General Hospital, Bristol Royal Infirmary will remain.

TUPE transfer consultation

WAHT are currently leading on the Transfer of Undertakings (Protection of Employment) (TUPE) consultation with their staff. This commenced on Monday 2 December and will end 31 January, and there have been a number of communication and engagement activities undertaken to support staff through this process. Following review of feedback obtained during the TUPE consultation process, Weston staff will receive a letter at the beginning of March confirming the outcome of the consultation and the transfer of their employment to the new Trust.

Service integration

Plans to integrate clinical and corporate services continue to be developed by clinical and non-clinical teams from both organisations, with a core focus on delivering a safe transfer of staff and services from day 1. Integration of corporate services will take place in a phased way from April 2020 with a view to fully integrating these services by the autumn. WAHT's clinical services will initially operate as a separate clinical division of University Hospitals Bristol and Weston NHS Foundation Trust with a view to fully integrating these services by March 2022.

Cultural integration

An organisational and cultural integration programme is underway to create the conditions pre, during and post-merger to ensure we have an engaged and committed workforce for the future and to develop an inclusive culture, that attracts, develops and retains exceptional people. A cultural diagnostic has been undertaken in WAHT following 5 cultural themes:

- Vision & Values
- Goals & Performance
- Support & Compassion
- Learning & Innovation
- Teamwork

9

This work is being brought together with a cultural assessment undertaken in UH Bristol relatively recently. In addition, a number of Hopes and Fears workshops have been carried out on both sites with more sessions planned in February.

The findings from these activities will be brought together and used to help to shape an organisational and cultural integration programme for the merger, which will outline how we plan to bring the cultures together, and how we start to build shared values and a vision for the merged organisation.

Managing risk and realising benefits process

The PTIP (Post-Transaction Integration Plan) sets out the process being followed by the Merger Programme Board (MPB) to manage risk and realise benefits. An update report has been provided to the January Audit Committee. To ensure sufficient focus, a Risk and Benefits Management Group (sub-group of MPB) has been established, chaired by the Director of Corporate Governance to:

- Track the progress of the delivery of benefits against the agreed measurement criteria within the four themes identified in the Post-transaction Integration Plan (PTIP): Quality, Finance, Operational and Workforce
- Receive risks to delivery of benefits that are escalated from individual workstreams and agree mitigations
- Review current and emerging programme, transaction and integration risks, ensuring that they are appropriately assessed and risks managed and mitigated by risk owners, through the Trusts risk management system (DATIX).
- Confirming risks and mitigating actions at the Merger Programme Board (MPB) on an exception reporting basis.

Key milestones

In addition to the key dates outlined above, a thorough approvals process of the merger is underway. Key milestones are outlined below:

January

- Regulatory and Department of Health and Social Care scrutiny of plans and the process to bring our organisations together.

February

- Regulatory scrutiny continues and final documents and plans for the merger approved, including the post-merger integration plan (PTIP) by relevant Trust Committees.
- Extraordinary Trust Board to consider and approve the Board Certification Pack
- Board to Board Meeting with NHSEI to review the reporting accountants opinion on the transaction and information supporting the risk rating process

9

March

- NHSEI issue a transaction risk rating to UH Bristol
- Both Trust Boards meet separately to approve the transaction, subject to satisfactory completion of the regulatory process.
- UH Bristol Council of Governors meets to approve the process.
- Final submission and application to merge sent to Department of Health and Social Care for consideration.
- Late March - Letter of support from the Secretary of State
- Late March - NHS Improvement grants formal application for statutory transaction
- Late March – WAHT Trust Board – completes all activities required to confirm dissolution and transfer of responsibilities
- 30th March UHBristol Trust Board confirm receipt of the grant of acquisition and assure itself about the implementation plan

April

- Subject to regulatory and Secretary of State approval (as outlined above) UH Bristol NHS Foundation Trust and Weston Area Health NHS Trust will merge on 1 April to become University Hospitals Bristol and Weston NHS Foundation Trust.
- WAHT will TUPE transfer their employment to the new organisation.

3. Risks

The risk to business as usual performance at UH Bristol, as a result of pursuing a merger is on the corporate risk register (Risk 3269).

The Merger Programme Board holds the transaction risk register and reviews and manages these risks at its fortnightly Board meeting.

4. Advice and Recommendations

- This report is for **Assurance**

5. History of the paper

Please include details of where paper has previously been received.

N/A

9

Meeting of the Board in Public on Thursday 30 January 2020

Report Title	**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.

This paper provides Trust Board with a summary update on progress against the Strategic capital investment programme, highlighting the overall status of the programme and the ongoing process to re-assess and review in the context of our 2025 Strategy renewal and the emergence of additional strategic investment proposals.

2. Key points to note

(Including decisions taken)

- 10 schemes continuing to be actively progressed.
- First Procure22 scheme, Cardiology Stage 1, to commence on site in March 2020.
- Process has progressed for reviewing wider list of schemes and completing an Estates Master Plan that includes outputs from an independent review of the Estates infrastructure.
- Planning approval is expected for the Cardiovascular Research Unit by the end of January 2020.

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 **Assurance.**

5. History of the paper

Please include details of where paper has previously been received.

Senior Leadership Team	22 January 2020

10

Respecting everyone
Embracing change
Recognising success
Working together
Our hospitals.

STRATEGIC CAPITAL PROGRAMME UPDATE
Quarter 3 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 investment of £120.3m into Major clinical services strategic schemes, part of the overall of Investment Programme and Medium Term Financial Plan totalling £237m to 2022/23.

A list of prioritised schemes 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. Current position

The previous report to Trust Board for Q2 set out the need to review and refresh the programme schemes in response to emerging requirements from the Trust 2025 strategy renewal and described the process and timetable that was being adopted. In summary, this was a 2 stage process of "Check & Challenge" and Estates Master planning, the former having already been undertaken in September 2019. The timeline reported in Q2 is shown below with relevant updates.

- Step 2 - Master planning exercise – This was completed by the end of November 2019 as planned and findings were reported back to Senior Leadership Team on 4th December.
- The Estates Infrastructure review was expected to be complete by mid-November. This has proven to be more complex than originally anticipated resulting in a delay. The report is now due at the end of January 2020.
- The Long term Financial Plan (LTFP) will be considered by the Board in March 2020.
- Workforce requirements continue to be addressed through the strategic workforce plan processes.

Through the Step 2 process, it was agreed that the starting point for the Master Planning exercise, and the most time critical schemes are adult ED / Radiology and Paediatric ED expansion and a Trust-wide Theatre expansion scheme.

A small number of high level scenarios for developing the physical estate, commencing with these 2 priority projects, has been completed. A process is underway to secure wider clinical engagement into assessing the options for these developments and the critical success factors that will determine the preferred option. A Strategic Outline Case (SOC) has been completed for the ED expansion and a refreshed SOC is being finalised for the Theatre expansion.

10

Further details on the ED and Theatre cases and the master planning recommendation will be presented to the Board Seminar in March 2020. Discussions are continuing internally through Strategic Capital Clinical Services (SCCS) Programme Board and through SLT regarding the development of Marlborough Hill site to optimise the use of the Estate to not only address the requirements for service developments but also to ensure flexibility of use for the future.

3. Update on Specific Schemes

In recognition of the requirement to maintain momentum around the strategic capital programme, a number of schemes are continuing to be progressed in parallel to the Master Planning process. A brief update is provided below:

- Myrtle Road: construction due to be completed by January 2020.
- Cardiovascular Research Unit: planning determination not yet achieved, this is expected in January 2020 with an approximate construction start date of June 2020 and completion in July 2021.
- Cardiology Stages 1 & 2: Stage 1 has received planning approval. Final construction costs are due on 20th January 2020, with the Full Business Case (FBC) expected to be progressed through to approval via the Trust governance process during February 2020.
- ICU / CICU Stage 1: Business case approved (construction forms part of Cardiology Stage 1 above, to be incorporated into combined FBC).
- Level 7 Ward: This is planned to commence following the construction of the Cardiovascular Research Unit in approx. July 2021.
- BHOC stages 1 & 2: Stage 1 (expansion of outpatient and chemo day chair capacity on levels 4 & 5) works planned to commence March 2020. Stage 2 project team established, scope of works to be defined before programme can be developed.
- Medical education facilities improvements : Initial improvement works identified within Dolphin House, design brief in development. Additional investment into other education facilities to be undertaken although scope not yet defined.
- NICU expansion (system approved OBC) : Project team established and contractor instructed to commence design planning.
- D603 (100% charitably funded) : Design being finalised and contractor formally instructed. Work planned to commence in summer 2020, subject to the identified decant solution being supported.
- Holistic Centre (100% charitably funded) : SOC approved by Trust and Charity boards. Scheme to be managed ad delivered by Maggie's.

A brief summary of all schemes in the Strategic Capital Programme is included in Appendix 1.

4 Recommendations to Trust Board

- **Note the overall content of this report**

10

Appendix 1: Strategic Capital 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 Stages 1 and 2	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.
Cardiovascular Research Unit	Cardiac research is central to our research and innovation agenda and to ensure 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 wards, providing an improved and modernised environment for staff and patients.
Integrated critical care stage 1 and 2	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 on a phased basis to address the current constraints in capacity and account for future growth.
BHOC expansion stage 1 and 2	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/Maggie's 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 supra-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.
BEH 5thTheatre	Surgicube theatre development to facilitate the essential maintenance of existing theatres, also providing potential future capacity for expansion.
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. The development of additional theatres will facilitate the essential refurbishment of existing theatres to maintain resilience and provide potential future expansion capacity.

ED / Radiology	Expansion of ED facilities to meet increasing levels of demand. Combined business case with Radiology in order to create a single integrated department to deliver significant improvements in Emergency Department (ED) reporting turnaround times. Options being explored to either expand services within current location (Level 3 Queens) or a new build development elsewhere in the main hospital site.
Pharmacy – aseptic services	Appointment of external specialist approved to review aseptic services and provide a recommendation for future service provision. Review to include potential relocation of services into a single development and will also explore commercial opportunities.
Medical Education Facilities	Capital investment into education facilities to modernise and improve both environment and increase teaching and training capacity.
Transport Hub	*Currently on hold pending appeal for planning permission*

Meeting of the Board of Directors in Public on Thursday 30 January 2020

Report Title	West of England Pathology Network Memorandum of Understanding and Strategic Outline Case
Report Author	West of England Pathology Network
Executive Lead	Dr William Oldfield, Medical Director

1. Report Summary

Attached four documents;

- West of England Pathology Network Strategic Outline Case and two appendices not included in the main document
- West of England Pathology Network Memorandum of Understanding

In response to NHS Improvement setting out the requirement that Pathology Networks are consolidated across the country our Laboratory Medicine service led by Dr Andrew Day, Clinical Lead, has played an active part in the formation and development of the West of England Network. Following input from all partners the Network has progressed the potential options for the future and developed a Strategic Outline Case setting out the proposed direction. Approval is now sought to move forward to develop an Outline Business Case.

To support the work the Network has developed a Memorandum of Understanding to bring clarity about the roles and responsibilities of each party.

The papers were considered at the Divisional Board of Diagnostics and Therapies in December and supported. The Board felt it was important to consider any lessons learned from the previous Cellular Pathology transfer as this work progresses. The papers were considered at the Senior Leadership Team in December and supported.

Weston Area Health NHS Trust is a member of the network and will approve these documents through its own governance route at this time.

2. Key points to note
(Including decisions taken)

The commitment to development of an Outline Business case includes the requirement for the Trust to contribute a proportionate share of the costs of the project as outlined in the document. This was supported through SLT and is included in the OPP financial plans for 2020-21.

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.**

11

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5. History of the paper **Please include details of where paper has previously been received.**	
Divisional Board – Diagnostics and Therapies	4th December 2019
Senior Leadership Team	18th December 2019

11

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WEST OF ENGLAND PATHOLOGY NETWORK
STRATEGIC OUTLINE CASE

11

Senior Responsible Officer: Deborah Lee, Chief Executive Officer, Gloucestershire Hospitals NHS Foundation Trust
Sponsoring Body: West of England Pathology Network
Date: 24th October 2019

EXECUTIVE SUMMARY

The purpose of this Strategic Outline Case (SOC) is to secure organisational Board support for the next steps in considering the rationalisation of pathology services across the West of England Pathology Network. It has been developed with the full support and input of the member organisations (and their stakeholders) and is the Network's response to the NHS Improvement expectation that further consolidation of pathology services, as heralded in the Carter Review of 2006, would take place across the NHS. NHSI's expectations were communicated to NHS providers of pathology services in September 2017 (Appendix 1) including the view that for the West of England Network, full consolidation of services to a single hub located at North Bristol NHS Trust was their preferred model. The NHSI financial modelling indicated that the Network could release £8.2m through the single hub model being proposed (Appendix 2).

Following extensive discussions, which resulted in the generation of six additional options, in addition to that advocated by NHSI, it is now proposed that three options - alongside a do nothing scenario - are taken forward for further development and appraisal culminating in the production of an Outline Business Case (OBC). Of note, the three shortlisted options do not include the model advocated by NHS Improvement on the basis that this model evaluated less positively than the "do nothing" scenario.

Organisational Boards are asked to approve the SOC and confirm their support for development of the three shortlisted options, including the modest investment set out in section 9 of the SOC, and to approve the appended Memorandum of Understanding which sets out the basis on which the Network member organisations will work together to develop the Outline Business Case.

1. INTRODUCTION

The purpose of this strategic outline case is to describe the background, current context and proposals in respect of pathology services across the member Organisations of the West of England Pathology Network and, importantly, to seek Boards' approval for the development of an Outline Business Case.

The Case aims to set out the drivers for change, including a summary of the challenges and opportunities that face the services in scope. Having been at the forefront of thinking and development of pathology services nationally, the Network has now fallen behind many others in having not yet gained the support of Boards to develop a business case for the wholescale rationalisation of pathology services across the Network is more challenging. The reasons for this are multifactorial and considered as part of this Strategic Outline Case but can be summarised as uncertainty about the financial and quality benefits to be derived through such an approach, recent investment in facilities outside of the proposed hub and the challenges presented by the Network's geography. A further consideration germane to this case has been a lack of resource to develop a strategic case; a commitment from Boards to develop an Outline Business Case will also require a commitment to resource such a step and this is addressed through this proposal.

Oversight of the SOC development has been the West of England Pathology Network Board, Chaired by Deborah Lee, Chief Executive of Gloucestershire Hospitals NHS Foundation Trust who is the Senior Responsible Officer (SRO) for the Strategic Outline Case. The SOC was considered by the Network Board at its October meeting and supported by all members.

2. PROJECT RATIONALE AND CONTEXT

In September 2017 NHS Improvement (NHSI) wrote to all Trusts in England to propose a consolidation of Pathology nationally in to 29 networks in a new hub and spoke arrangement with a view to supporting the realisation of efficiencies following on from the Carter review and Model Hospital tool developments.

Locally the proposal was for North Bristol NHS Trust (NBT), University Hospital Bristol NHS Foundation Trust (UHBFT), Royal United Hospitals NHS Foundation Trust (RUHFT), Weston Area Health Trust (WAHT) and Gloucestershire Hospitals NHS Foundation Trust (GHFT) to form a network and in doing so cross the boundaries of three STP regions.

The context of pressures, challenges, opportunities and previous history of pathology partnership working for each of the organisations identified for the network is different and has been considered within the development of the wider objectives of this Strategic Outline Case. In early 2018 the identified organisations, with the addition of Public Health England's SW Regional Laboratory (PHE) – provider of Microbiology services to UHBristol and the RUH, agreed to form a Network Board with the remit to:

- identify any configurational changes that would be financially beneficial, improve quality or increase efficiency
- co-ordinate and oversee the implementation of any mutually agreed changes

Within this scope, the network agreed to include consideration of the specific NHSI proposals which identified NBT as the host for the hub laboratory with the other Trusts acting as spokes or Essential Services Laboratories (ESLs) within the new Network proposal. The stated estimated benefit from this consolidation was identified by NHSI as £8.4m. This figure has not yet been validated by the West of England Network and confirming the scale of the opportunity would be a key feature of the Outline Business Case.

Appendix 3 summarises the current configuration of Pathology Services within the West of England Pathology Network.

3. STRATEGIC CASE FOR CHANGE

Pathology is an essential clinical service for all acute and primary care healthcare providers with 70-80% of clinical decisions requiring input from pathology and 95% of chronic disease pathways reliant upon pathology. As such it is critical to delivering a high quality clinical service, patient flow in acute settings, reduced bed occupancy, avoided admissions and fewer secondary complications that meet the needs of patients and clinicians.

Pathology Modernisation has been in sharp focus nationally and locally within Bristol, North Somerset and South Gloucestershire (BNSSG) and Gloucestershire since the publication of the second Lord Carter of Coles report in 2008. The key recommendations of this report in relation to service configuration, logistics, information technology and the opportunity to deliver 20% efficiency savings in pathology has underpinned the national and local pathology strategy over the last 10 years. This in turn has led to a number of major developments within BNSSG and Gloucestershire, as follows:

1. The implementation of a pan Bristol, WAHT and RUH Managed Equipment service in 2009
2. Refurbishment and enhancement of Blood Science Laboratory facilities at BRI
3. PCT Pathology Review process from 2010-2013, which resulted in Severn Pathology and the PHE Collaboration with NBT. Proposed consolidation of UH Bristol and WAHT into a single site did not take place.
4. Outsourcing of local logistics solutions across BNSSG
5. Development of New Laboratory Facilities at RUH
6. The development of the Phase 2 Pathology building at NBT and the integrated Pathology model for Severn Pathology
7. Implementation of a single Clinisys LIMS system for NBT, UHB, WAHT and PHE in 2016
8. NBT awarded contracts as the Genomics Laboratory Hub for the South West and the HPV cervical screening provider for the South West
9. Gloucester and Cheltenham consolidation of Microbiology on the Gloucester site and Histology, and Cytology at Cheltenham, and partial consolidation of blood sciences on the Gloucester site (out of hours Clinical Biochemistry).
10. Consolidation of Cell Path services from Frenchay, Weston and UHBristol on the North Bristol site
11. Consolidation of Infection Sciences from Frenchay, RUH, Myrtle Rd and UHBristol on the North Bristol site and subsequent release of Estate.
12. Refurbishment of the Clinical Biochemistry Lab at GHFT under their current Roche Managed Service arrangement
13. Rationalisation of GHFT LIMS onto one system and current development of a new LIMS compliant with SnoMed CT
14. West of England Pathology Network jointly procuring a new Managed Service Contract commencing in June 2021
15. Bristol Haematology Oncology Diagnostic Service (BIHODs) is used by the RUH for integrated haematological diagnostic reporting
16. Genetic monitoring of CML with PCR for BCR/ABL - RUH will be moving genetic testing from another provider to NBT
17. RUH Haematology and Histopathology departments use NBT for Histopathology second opinions on bone marrow trephines and lymph node cases LIMS governance board has been set up between the hospital sites

NHSI wrote to Trusts in September 2017 with proposals for a new hub and spoke configuration of 29 pathology networks and have provided support in the form of a number of events focused on the pathology efficiency expectations, where and how these might be delivered and the requirements for developing business cases that are aligned to the 'Model Hospital' opportunities.

Trusts within the West of England responded to these proposals at the end of September 2017, formed the West of England Pathology Network Board and have been working with NHSI ever since leading to the development of this Strategic Outline Case.

A number of quick wins from this process have already been realised from the savings opportunity originally identified within national proposals:

- A Network wide retendering of the Managed Service Contracts (MSC) which supports the national agenda and development of the network by delivering enhanced savings. It will also act as an enabler for any further changes within the network in line with whatever service configuration proposals emerge through the Network Business Case process. Standardisation of technology as within the current MSC is a key enabler for reconfiguration whereas a lack of standardisation is a blocker when it comes to delivering service redesign. One of the benefits already realised from the network approach is that of scale. GHFT have now been included in this tender to tie in with the end of their current Managed Equipment Service. The contract has also been expanded to include new technologies. It should be noted that the West of England Pathology Network is currently in the dialogue stage of procurement for the West of England Pathology MSC, which would cover the vast majority of Pathology Services across the 5 local Trusts and PHE. This procurement is expected to conclude with contracts being signed in June 2021. This £300m procurement represents a significant opportunity for the network to standardise, reduce unnecessary duplication and deliver a broad range of quality and financial benefits, whilst maximising the benefits of innovation in technology with an appropriate transfer of risk to a Primary MSC Provider.

- The expansion of the Pathology Network has also facilitated closer working between the laboratories. There are currently projects under way for IT links between RUH and NBT using the National Pathology Exchange software (NPEx). This system will provide the facility to electronically request tests from one laboratory to another and receive electronic reports straight into the LIMS from the other laboratory.

- The operational network group has also reviewed the "send-away" test volumes throughout the network and procured a joint "send-away" test contract with a London provider. NBT, UHBFT and GHFT laboratories are all benefiting from efficiencies in logistics and reporting as well as better prices based on the total contract volumes.

Further work for the operational group includes a review of pathology test nomenclature, panel and test activity and costings across the network.

Current challenges and opportunities for pathology include:

- Continual drive to improve efficiency
- Recruiting and retaining high quality biomedical scientist and consultant staff – particularly with the challenge of local demographics
- Elimination of inappropriate variation
- Ensuring the right test is performed on the right patient at the right time and in the right place – e.g. appropriate repertoire with appropriate turnaround times to optimise the efficiency and safety of patient pathways e.g. prevent admissions or facilitate earlier discharges or manage patients closer to home

- Providing a comprehensive 24/7 service where required reflecting the evolving pattern of care and service provision e.g. evening outpatient clinics, weekend theatre lists and weekend discharges
- Ever increasing workload – numbers and complexity
- Demand optimisation
- Effective use of IT to support requesting and clinical decision making e.g. Order Comms, NPEx and to improve efficiency
- Impact of UKAS accreditation – placing additional demands on Pathology departments
- Governance and accountability
- Challenges of GIRFT initiative
- Quality improvement/drive towards excellence of service
- Digital pathology requirement for histopathology departments
- Developing and co-ordinating an effective POCT programme, not just within the local Healthcare environment, that delivers safe, efficient and cost effective care that is fully integrated within our Pathology services

4. PATHOLOGY BENCHMARKING

Pathology features within the 'Model Hospital', as an area of opportunity for removal of unwarranted variation. The model hospital is the key output of Lord Carter's broader review of hospital efficiency and productivity, which identifies a potential for pathology to save £200m nationally. The delivery of the recommendations from Lord Carter's Report alongside realisation of the opportunities within the 'Model Hospital' is being led by NHSI and there is growing expectation that the West of England Pathology Network makes progress on this agenda.

The table below compares the cost per test for each site:

	Microbiology	Cellular Pathology	Blood Sciences
NBT	£ 9.96	£20.58	£1.50
GHFT	£ 4.66	£19.32	£0.88
RUHFT	£ 9.29	£13.86	£0.89
UHBFT	-	-	£0.55
WAH	£ 2.54	-	£1.97
PHE	£10.13	-	-
Group Median	£ 7.32	£17.92	£1.16
National Median	£ 4.36	£21.11	£0.92

Table 1 Cost By Test By Discipline for Each Trust *(Model Hospital; latest published period 2017/18)*

The quality and comparability of the benchmarking data is variable and accounts for some of the differences above; a key component of the Outline Business Case will be to develop reliable benchmarking to inform both the Network opportunity and individual organisation opportunity.

The methodology used in each individual Trust organisations is different and needs to be taken into consideration when interpreting the benchmarking

5. CURRENT POSITION

Reflecting the nature and location of pathology services in the Network area, members agreed that wholesale adoption of the NHSI recommended model was unlikely to meet the needs and aspirations of local providers and as such work was undertaken to scope and evaluate the options open to the Network which had the potential to realise the quality and financial benefits described in the Model Hospital.

Network member organisations held a workshop in December 2018 with the primary aim of identifying a long list of options for pathology networking across the defined geography. This culminated in each organisation evaluating (and scoring) each of the options based on their own local service requirements. This evaluation has been collated and used to draw up a short list of options to compare against a "do nothing" further option and a full NHSI model consolidation of pathology services in a hub and spoke.

To assist with this step, the Network's Operational Group have sought information from other pathology networks. Representatives from the Operational Group visited Frimley Park Hospital, one of the hub sites of the Berkshire and Surrey Pathology Service; it was very clear from the visit that the network had taken many years to achieve its current structure. They had a strong vision based on technology, procurement and workforce. There were also major drivers to the setting up of the network due to the age of the facilities and equipment at a couple of the sites. The model was based on a contractual joint venture between the Trusts. A single hub had been discounted due to the lack of contingency.

The Operational Group also approached Kent and Medway pathology network to gain an understanding of the development of their network. They are at a much earlier stage than Berkshire and Surrey Pathology Service. A full time project team have been employed to work on the pathology network development, with the outline business case in development covering MSC, LIMS and a number of site configurations.

The factors considered in the workshop for developing the long list evaluation criteria were:

- Delivering high quality pathology services that are recognised as responsive, innovative and able to deliver long term sustainable benefits meeting the needs of the pathology market
- Increased efficiency benefits through economies of scale and removal of unnecessary duplication
- Improvements in quality linked to a common governance structure, minimising potential risks to patient safety and embedding of continuous improvement methodologies
- Delivering appropriate capacity and new technology to respond effectively and consistently to the needs of an aging population demographic with increasing incidence of long term conditions and embedding of continuous improvement methodologies
- Service resilience through the 'whole system' approach minimising waste and redundancy
- An ability to compensate for skill shortages in the Pathology workforce through the benefits of shared training and recruitment initiatives, new technology and enhanced opportunities for skill mixing
- Standardised Reporting across the network with significant patient flows avoiding the need for repeat testing
- Driving efficiency in patient pathways aligned to access to new technology.
- Developing a network model for Pathology that supports a clinically and financially sustainable service.
- Advocating equality for patients throughout the geographical area based on access to common testing platforms, results interpretation and specialist testing irrespective of where the patient comes from or is referred to
- Increasing the alignment between Public Health England (PHE) a fully integrated collaborating partner in pathology at NBT and its customers across the network through standardisation of molecular technologies, sharing of expertise and the opportunity to integrate serology testing with biochemistry automation
- Introduction of connected IT LIMS systems linking all sites and enabling the efficient movement of specimens between sites.

6. CONSIDERATION OF OPTIONS

Reflecting the issues and considerations above, the following criteria and associated weighting were agreed by the Network Board.

The options were scored from 1-5 by each organisation for each critical success factor (1- meets none of the requirements to 5 meets all of the requirements). The total split for the success factors 35% for general, finance and governance and 65% patients and clinical quality.

The scores were multiplied by the overall weighting for each critical success factor and the total scores from each organisation (NBT, GHFT, WHAT, UHBFT and RUHFT) per option were averaged to give the combined scores.

Critical Success Factor	Link to SMART Objective	Proposed Sub - Weighting	Proposed overall weighting	Rationale for Weighting
Standardisation		15	9.8	The model facilitates the reduction of unwarranted variation, removal of unnecessary duplication and allows us to standardise to maximise resilience, quality and value. It allows for the introduction of common standard operating procedures, common ranges, KPIs and clinical reporting across sites.
Patient Safety and Experience		25	16.3	The option minimises any potential risk to patient safety, e.g. the need to have some services within a certain proximity to the patient, with any necessary links between staff, consultants (MDTs) and the patient are preserved or established.
Clinical Quality		20	13	The option provides the right level of clinical oversight to create a consultant led service with a common clinical governance structure across all sites
Clinical Responsiveness		20	13	The option delivers clinical responsiveness to acute trust requirements, local clinical specialisms and evolution of clinical services
Achievability		8	4.9	The service addresses the emerging needs of the pathology market and would face the lowest level of resistance by stakeholders
Achievability		8	4.9	Evidence that other organisations have successfully implemented the model without affecting quality
Workforce Sustainability		5	3.3	Does this option allow for higher levels of recruitment and retention. Does it present opportunities to manage the predicted/actual workforce shortage. Does it allow for sharing of skills and the broader benefits of driving staff and service development
Strategic fit, innovation and clinical sustainability		15	5.3	The option would provide the greatest chance for WoE Pathology Network to demonstrate alignment with national policy, become a clinically & financially sustainable service, supporting the retention of current & future revenues in the face of emerging

				commissioning intentions and supporting the development of the service to meet the future needs of the new models of care / value based population health propositions.
Potential Affordability		25	8.8	The option would provide the best opportunity to access funding and is likely to provide a high return on investment. Capital requirements are low and therefore achievable.
Potential Value for Money		30	10.5	The option would provide the greatest level of savings over the long term through economies of scale, synergy and removal of unnecessary duplication / unwarranted variation
Facilities, IT and Equip Systems		15	5.3	The options allows the introduction of a common of connected IT LIMS that would link all sites and common equipment platforms across all sites. Availability of estates for development of pathology
Control and Governance		15	5.3	The option would allow WoE Pathology Network to operate with an autonomous governance structure allowing it to operate in the market and effectively respond to market forces

Table 2: Critical Success Factors and Weightings

Against the SMART objectives and Critical Success Factors three possible configurations exceeded the status quo model and it is proposed that these are taken forward for detailed evaluation through an Outline Business Case, against the "do nothing" scenario. Of note however, the prescribed NHSI model did not evaluate above the current configuration and it is not proposed that this be developed further.

Options	Main Features	Combined Score
Status Quo	No change in overall service ownership but continue to co-operate for mutual benefit on procurement etc. Board process to continue for mutual benefit.	3.45
Virtual Hub	Manage services as a network to minimise duplication and maximise efficiency whilst maintaining scale at each site. Further centralisation of specialist testing. Make best use of available technology to facilitate Network working e.g. digital pathology. Centralise some functions – including potentially Quality Management, training, IT. Operate to a single set of quality standards – with common SOPs etc. Laboratories remain on current sites with joint pathology Network Board and memorandum of understanding:	4.08
Distributed Hub	Consolidation by test/technology/sub-specialism at different sites. Sub specialisms delivered locally to clinical sub specialisms and ensuring local ESL requirements (to be defined) are provided at all sites as a minimum. Centralise some functions - including, potentially, Quality Management, training, IT. Operate to a single set of quality standards - with common SOPs, etc. Laboratories remain on current sites with Network Board and memorandum of understanding	3.69

Multi Hub	Full consolidation by discipline across the available sites with ESLs (to be defined) at all other sites. Centralise some functions - including, potentially, Quality Management, training, IT. Operate to a single set of quality standards - with common SOPs, etc.	3.44
Dual/Twin Hub	Full consolidation into two mirrored or complimentary laboratories with ESLs (to be defined) at each other site. Centralise some functions - including, potentially, Quality Management, training, IT. Operate to a single set of quality standards - with common SOPs, etc. Two large hub laboratories and ESLs on other three sites.	3.50
NHSI Model	Full consolidation into single hub at NBT with NHSI defined ESLs at all other sites	3.26
Outsource	Partnership with private provider to deliver pathology services for all providers on the same terms following a procurement process	2.64

Table 3: Combined Scores For Each Configuration

7. FUTURE NETWORK MANAGEMENT MODEL

The purpose of any reconfiguration of activity will be to sustain quality over the long term whilst ensuring the best use of resources. The Network recognises that change to delivery model may result in differential impact between organisational members. This is likely to require the network to describe partnership and governance arrangements that ensure an appropriate distribution of the resulting risks and benefits. The options for such arrangements will be explored at OBC phase for final conclusion in the FBC.

8. TIMETABLE AND NEXT STEPS

Subject to support of member Boards, it is proposed that the three shortlisted options, alongside the required “do nothing” option are developed further and evaluated through the production of an Outline Business Case, through which a preferred option will be identified for Final Business Case (FBC) development.

Through the presentation of the SOC, member organisations will be asked to confirm that none of the short-listed options are unacceptable, in principle, sign up to a Memorandum of Understanding as the governance framework for the next phase of this programme and commit to the investment proposed in a team to develop the OBC.

Key Milestones	Timing
SOC Approval	November 2019
Agreement of OBC project resources Agreement of Memorandum of Understanding for development of OBC	November 2019 November 2019
Further development of shortlisted options to enable detailed financial and quality impact evaluation	December 2019 to March 2020
OBC Approval *	June 2020

Table 4 Key deliverables and outline timeframe

*This timeline will be confirmed with alignment to the MSC.

9. PROJECT STRUCTURE AND RESOURCING

This Strategic Outline Case has been developed through the contribution of staff from Network member organisations. However, the development of the OBC will require additional dedicated to capacity and capability and the table below describes the estimated costs.

Description	WTE	Time Period	Cost £
Programme Director	0.2 WTE	6 months	£8,490
Programme Manager	1 WTE	6 months	£35,699
Finance support	0.5 WTE	6 months	£17,850
Legal support	As required and approved by the programme director	6 months	
Administration support	0.5 WTE	6 months	£6,891
Subject Matter Expertise			£10,000
Stage 1 - Pay Total			**£78,930**
Other Costs			
Non-pay			£7,900
Stage 1 - Other Total			
Contingency 15%			£13,024
Projected OBC Costs			**£99,855**

Organisation	Pathology Budget	% Share	Total Requested Cost £
GHFT	£21.68m	19.9	19,871
NBT	£39.93m	36.6	36,547
PHE	£11.20m	10.3	10,285
RUH	£15.65m	14.3	14,279
UHB	£14.52m	13.3	13,281
WAHT	£6.10m	5.6	5,592
Total		**100%**	**£99,855**

Should the OBC proceed to Full Business Case, the future resources required will be reviewed and may change.

10. KEY RISKS

The primary risks to the OBC development and proposed mitigation measures are described below

Risk	Mitigation Measures
Insufficient capacity and expertise to develop OBC to required standard	Secure commitment to resource through OBC Identify additional capacity and capability from member organisations and/or external sources
Failure to meet proposed timeline	Establish robust programme management and oversight arrangements including sufficient capacity and capability in programme team

NHSI approval	SOC approval and early agreement of NHSI support for OBC approach and content. Involvement of key NHSI personnel in Network Board and related activities.
Failure to secure support of member organisation Boards	Senior representation from member organisations on Network Board to enable identification of concerns and barriers to approval . Involvement of member organisations lead staff in development of the Outline Business Case to reduce likelihood of challenge to OBC content
Failure to align with the managed service contract (MSC) with resulting impact on OBC development and final option.	Risk identified as part of MSC procurement approach and approach and timings now aligned in so far as legally sound to do so.

11. RECOMMENDATIONS

Trust Boards are asked to approve this Strategic Outline Case (SOC) and in doing so agree to:

1) The detailed development of the three shortlisted options to OBC level:
   - Virtual hub
   - Distributed hub
   - Dual/twin hub
2) Agreement to enter into a Memorandum of Understanding to govern the development of the Outline Business Case
3) Commitment to the proposed share of programme costs

11

Appendix 3

Current configuration of Pathology Services within the West of England Pathology Network

Organisation	Pathology Services Provided	Referral Centre (Yes/No)	If Yes for which Services
North Bristol NHS Trust	Clinical Biochemistry (Routine & Specialist) Clinical Haematology Clinical Immunology Tissue Typing Blood Transfusion Cellular Pathology • Histopathology* • Cytology (Designated SW Regional HPV Screening Centre) Infection Sciences (Routine and Antimicrobial Assay Lab) South West Genomics Hub Laboratory	Yes	HPV Testing Genomics Testing SIHMDs Newborn Screening Antibiotic Reference Immunology
University Hospital Bristol NHS Foundation Trust	Clinical Biochemistry (Routine & Specialist) Clinical Haematology Clinical Immunology	Yes	Metabolic Testing Specialist Coagulation
Royal United Hospital Bath NHS Foundation Trust	Clinical Biochemistry (Routine?) Clinical Haematology Clinical Immunology Blood Transfusion Cellular Pathology • Histopathology • Non Gynae Cytology • Andrology	No	
Gloucestershire Hospitals NHS Foundation Trust	Clinical Biochemistry (Routine) Clinical Haematology Clinical Immunology Blood Transfusion Cellular Pathology • Histopathology • Non Gynae Cytology Infection Sciences (Microbiology) • Bacteriology • Mycology • Molecular Virology • Manual and Automated Virology (Serology) • Andrology	No	
Weston Area Healthcare NHS Trust	Clinical Biochemistry (Routine) Clinical Haematology Blood Transfusion Microbiology - Bacteriology	No	
Public Health England SW Regional Laboratory	Infection Sciences (Microbiology) • Bacteriology (provider for UH Bristol & RUH) • Mycology • Molecular Virology • Manual and Automated Virology (Serology)	Yes	

*NBT provides Histopathology Services for Bristol and Weston

7th September 2017,
Gloucestershire Hospitals NHS Foundation Trust

ESTABLISHING AND IMPLEMENTING 29 PATHOLOGY NETWORKS ACROSS ENGLAND

Dear Deborah Lee, Sean Elyan & Stuart Diggles,

Since the end of last year, we have been working with your teams to validate your 2015-16 pathology data and we have since collected the majority of the required information for 2016-17. This last enabled us to construct a comprehensive picture of NHS pathology services across the country, through which it is possible to compare overall, regional and local performance year-on-year. This builds upon Lord Carter's pathology service reviews of 2006 and 2008 and work looking into operational performance and productivity in acute trusts published in 2016. The exercise has revealed continued unwarranted variations across England in how rapidly and efficiently services are delivered to patients and how productively laboratories are run. We must now take urgent action to implement Lord Carter's recommendations in order to provide high-quality, rapid and comprehensive diagnostic services for patients which are delivered in the most efficient manner. This will facilitate the introduction of, and widest access to, new investigations and diagnostic systems, and improve training and career development for our scientific and technical staff.

Using the national data from acute non-specialist providers we have identified 29 potential pathology networks to be run as a Hub and Spoke model – preserving essential laboratory services relevant to each hospital on site, whilst centralising within each the performance of both high volume and more complex tests. The most advanced investigations utilising, for example, genetic and molecular techniques, may need to be restricted to fewer sites, necessitating 'cross network arrangements'. Such a structure will support a high quality service to patients and facilitate the introduction of a new generation of investigations; enhance the career opportunities for clinical scientific and technical staff working within the service; and be more efficient, delivering recurrent projected annual savings to the NHS of at least £200m.

The 29 networks have been shared with our Pathology Optimisation Delivery Board, which is chaired by Professor Adrian Newland, and attended by representatives of the professional organisations of the Pathology Alliance. The Board has reviewed the configuration of the proposed networks, and recognises that adjustments may be needed to accommodate progress already made in some regions, and to reflect established patient pathways. A major task for the Board will be to work within NHS Improvement to ensure a smooth implementation of the proposed plans over the next three years.

We now need your Trust to review your proposed network and confirm your commitment to move towards this Hub and Spoke model. After seeking approval from your Board, please can each Chief Executive and Medical Director across the proposed network sign and a return a letter to nhsi.pathservices@nhs.net which states their agreement to establish the proposed network by 30 September 2017.

About your proposed network

We have attached a data pack about your proposed network which explains how the Hub and Spoke model can best serve your patients whilst ensuring that any services critical to your health population remain in place and available for patients. Within your pack, you will see this network capitalises on the recent investment at North Bristol NHS Trust and models a future state where it becomes the Hub for surrounding trusts. The model shows a potential saving opportunity of £8.20 million. We recognise that this proposed network crosses STP boundaries however, the proposed configuration is understood to be aligned with clinical flows of specialist referrals.

If you have any questions regarding your proposed network and the data, please contact the team on nhsi.pathservices@nhs.net or call 0203 747 0604.

What your Trust needs to do by the end of September 2017:

- Send a formal written response returned to NHS Improvement confirming that your trust Chief Executive, Medical Director and Chair agree with the composition of the proposed pathology network;

- If you disagree with your proposed network and would like to be considered as part of a different cluster, please contact NHS Improvement urgently, setting out your evidence-base for this alternative. We will help work towards your proposed network as long as there is a strong rationale that services to patients will thereby be improved including improved quality and enhanced value as compared with the suggested configuration. We will also seek confirmation that the model would pass inspection/certification by relevant national bodies.

- Provide reassurance that commitment to any agreement relating to, for example initiation or renewal of a managed service contract, will be postponed pending review and agreement with NHS Improvement.

What your agreed network needs to do by the end of October 2017:

- Ensure Executive level attendance at the relevant NHS Improvement facilitated workshop for your proposed network. The expectation is that this workshop will deliver agreement between network partners concerning:

    - A commitment from all network partners to a timetable for achieving formal board agreement on a partnership or outsourcing model with the aim of rationalising pathology services;

    - The formation of a project team and the necessary commitment to resources to progress rapidly to deliver:

        - A strategic outline business case, approved by all partnership boards, for provision of pathology across a network;

        - A governance structure, timetable and deliverables for an inter trust Steering Group to oversee these processes;

        - A local engagement plan on how you will keep patients and wider public, and the clinical and scientific communities responsible for delivering the service informed and engaged as you start to implement your network.

An NHS Improvement representative will contact the CEO of each Trust with further details regarding the timing of these workshops within the next two weeks.

What your agreed network needs to do by the end of January 2018:

- Provide written confirmation to NHS Improvement that your Trust Board has formally agreed on a partnership or outsourcing model with the aim of rationalising pathology services.

- Provide NHS Improvement with a written update on progress made to establish where services will be delivered, the anticipated savings, and implementation timeline.

Learning from established networks

There are a number of networks which are already up and running .Some are wholly based upon NHS providers, and some are partnerships between the NHS and private sector. These have provided insight into the national pathology programme through the National Pathology Implementation Optimisation Delivery Board, and we would be pleased to arrange introductions to interested parties so that experiences can be shared.

Our support offer to your network

We recognise that a programme of this scale delivered at pace requires guidance and support, and we aim to ensure you are helped at every phase. There will be a series of activities over the coming three months to ensure your network is learning from our pathfinders as well as being supported with the latest evidence and a template toolkit so you do not have to start this process with a blank page. We also recognise that the availability of resources, including capital and change management capacity, are potentially important enablers for the implementation of Pathology networks. Trusts should prioritise resources already available to them to support delivery of network formation and service consolidation as an investment in recurrent benefits for patients and the NHS's finances. NHS Improvement will ensure that “Carter compliant” business cases are prioritised for approval where NHS Improvement sign-off is necessary.

We will be hosting facilitated workshops for each proposed network during September and October so please send us the contact details of anyone trust who should be invited to attend. In order to continuously support you throughout the implementation phase, we have recruited a Regional Diagnostic Implementation Lead with subject-matter expertise in Pathology network formation and service consolidation.

We also recognise there are risks in delivering this programme, but will work with all our networks to regularly review risks and support them to find solutions, which we will share. We will also support and encourage all networks to be open and transparent with their workforce and the patients they serve about what the new Hub and Spoke model will mean to them. Finally, we will be working closely with partners at NHSE who refer in the ‘Five Year Forward View Next Steps’ document to the work of NHS Improvement and to facilitate engagement with Commissioners, thereby ensuring a ‘joined up’ approach throughout this vital exercise.

We are grateful for your ongoing commitment in making the 29 pathology networks a reality for the NHS and its patients.

Dr Jeremy Marlow
Executive Director of Operational Productivity

Professor Tim Evans
National Director of Clinical Productivity

Cc: Professor Adrian Newland, Chair, National Pathology Optimisation Delivery Board
NHS Improvement Regional Executive Managing Directors

11

NHSI NETWORK CONSOLIDATION MODEL
METHOD STATEMENT FOR PATHOLOGY NETWORKS IDENTIFICATION AND SAVINGS CALCULATION

All analysis and modelling for your proposed network was based on the 15/16 data submitted in October 2016. Feedback was received from 133 of 136 of the non-specialist acute trusts which included submissions from pathology networks that already deliver services for a number of trusts and trusts that outsource their pathology to NHS, private or public/private joint venture partners.

1. Network Identification

Identifying target pathology networks was the result of a number of analysis, modelling and review processes. Below is a summary of the key steps that led to your current network configuration.

Step 1: Future Hub Shortlist

Analysis of 15/16 data showed that 25 providers (out of the 112 trusts that submitted data) currently account for half the volume and cost of pathology provided by the NHS. Please refer to figure 1 below. These top 25 providers were set as likely hubs for modelling future consolidation options and value.

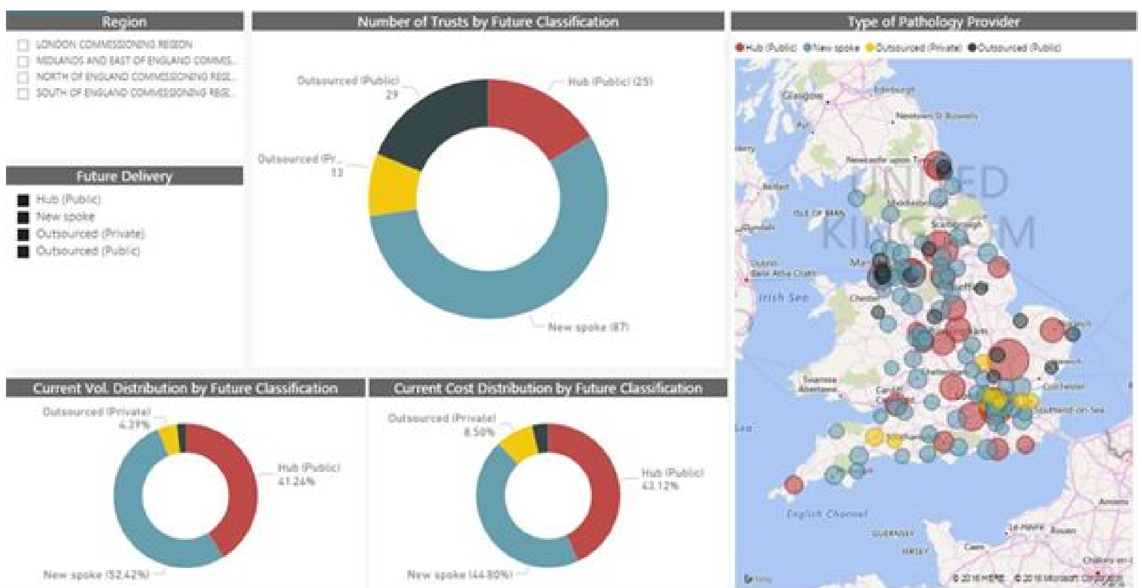


Figure 1: Workload and cost distribution analysis

All other provider trusts were classed as future spokes for analysis and modelling purposes.

Step 2: STP & Population Alignment

Once the potential hub sites were identified, alignment between these sites and STP boundaries were analysed. This identified areas where services were already provided by a single supplier across multiple STPs, isolated STPs that did not include a possible hub site from the analysis as well as regions where STPs were being provided services by a single provider that could potentially work within a larger regional network. We also considered trust location and driving distances to identify areas where smaller services should operate as a hub to ensure that all routine services could be delivered regionally.

The outcome of this analysis was an initial identification of 29 possible pathology networks that were analysed based on population size. The aim was to create networks that would deliver services to populations of between 1.5 million and 2.5 million. Exceptions to this were areas such as Greater Manchester that went beyond this but were already collaborating or isolated areas where there were no obvious partnership options, such as Norfolk.

Step 3: Network Refinement

Once the initial network options were defined, each network was reviewed with the project's clinical advisory team to identify those natural clusters of trusts where STP boundaries did not align with existing clinical networks and patient flows. Existing pathology relationships and networks were also considered. Finally, the list of networks was shared with all the regional NHSI DIDs who were asked to highlight any areas where proposed networks did not align with changes in trust relationships, for example, merging trusts or trusts with a shared executive team.

The resulting target network model is the 29 networks that will be presented to trust CEOs.

Step 4: Model Hub Selection

As a rule, each network was modelled with a single hub and multiple spokes. The hub was selected as the provider with the highest reported volume. However, where there was a query about the volume data submitted by any one trust, the number of FTEs and trust pathology budget were used as additional indicators to identify the largest pathology operation within the network. Further adjustments to the volume rule include existing networks, partnerships and projects where a hub, or even multiple hubs, have already been identified.

Other Consideration

It is accepted that there are several alternative configurations that can also deliver the target savings and service improvements associated with pathology consolidation. There are also associations such as the already well-established cancer networks and the genetics networks that influence the forming of pathology networks. It is proposed that, as part of the network review, these alternatives be considered.

2. **Savings Calculation**

   2.1. **Cost of current operations:** All staff costs except those associated with consultants and consultant clinical scientists plus the costs of consumables, reagents and equipment & maintenance.

   2.2. **Cost of Hub Future:** The cost of current operations with a factor included for expected staffing efficiency gains. These expected staffing efficiency gains are calculated through benchmarking of similar laboratories.

   2.3. **Cost of referrals to hub:** This is the sum of all costs for work that is currently being done onsite that will be transferred to the hub. This is achieved by adding up the costs involved in processing cellular sciences/anatomical pathology and microbiology combined with an added efficiency factor (13%) for economies of scale at the hub. The cost of non-urgent blood sciences that will be transferred to the hub is then calculated by estimating the percentage of blood sciences work that will remain onsite (60%). These blood sciences costs also have an efficiency factor applied to reflect economies of scale benefits (32%).

   The non-pay costs for this metric refer to consumables, reagents, equipment & maintenance. The pay costs refer to operational staff and the cost of management and band 8 staff are not transferred across to the hub.

   2.4. **Cost of spoke labs:** The staff costs are calculated by ascertaining the existing cost per test for blood sciences and then applying that to the new volume that will be kept onsite calculated earlier. A minimum value of £1042870 is placed on this calculation as a spoke lab will carry costs associated with shift work and have minimum staff cost despite volume.

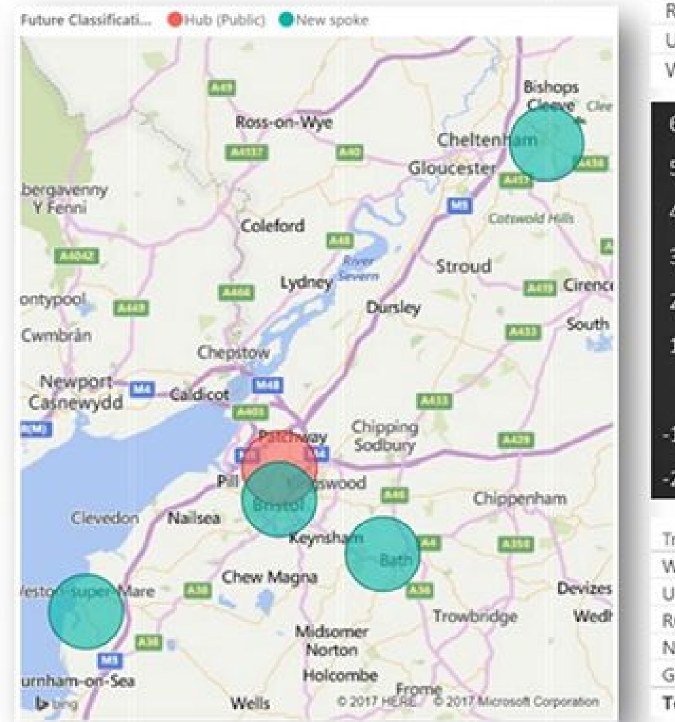
   The staff costs are then added to the spoke's future non-pay costs which are calculated by totalling the consumable, reagent and equipment and maintenance costs associated with blood sciences and adjusting for the factor that will remain onsite (60%).

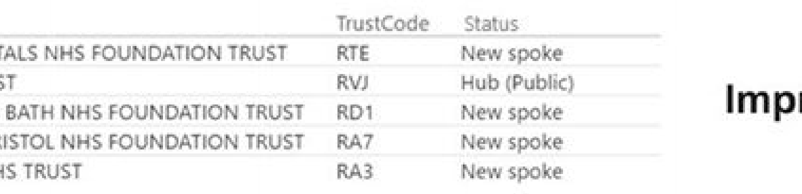
2.5. Cost of consolidated service: This is calculated by adding the future cost of the hub as calculated above to the cost of each spoke lab also as calculated above. The cost of the calculated work that is transferring from the spoke to the hub, also calculated above, is then added to the total. This figure is the predicted cost of the new network.

2.6. Consolidated savings: Savings are calculated by subtracting the new cost of the network as a consolidated service from the original cost of current operations.

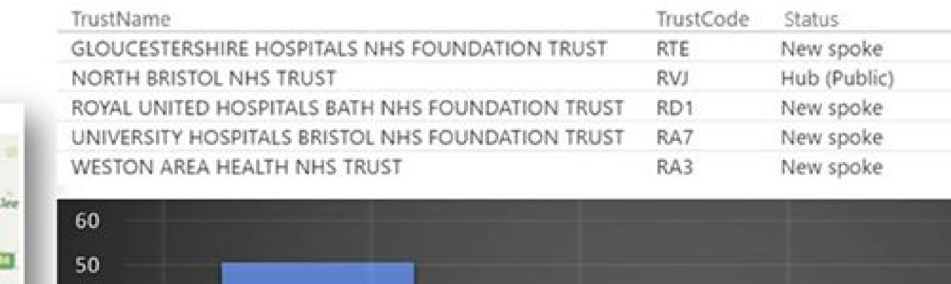
11

South 3





TrustName	TrustCode	Status
GLOUCESTERSHIRE HOSPITALS NHS FOUNDATION TRUST	RTE	New spoke
NORTH BRISTOL NHS TRUST	RVJ	Hub (Public)
ROYAL UNITED HOSPITALS BATH NHS FOUNDATION TRUST	RD1	New spoke
UNIVERSITY HOSPITALS BRISTOL NHS FOUNDATION TRUST	RA7	New spoke
WESTON AREA HEALTH NHS TRUST	RA3	New spoke



TrustName	Future Cla...	Sites 24/7	Total Cost	Total FTE	Total Tests
WESTON AREA HEALTH NHS TRUST	New spoke	1.00	£4,073,764.00	46	749,955.00
UNIVERSITY HOSPITALS BRISTOL NHS FOUNDATION TRUST	New spoke	1.00	£14,214,145.62	111	6,265,534.00
ROYAL UNITED HOSPITALS BATH NHS FOUNDATION TRUST	New spoke	1.00	£12,682,431.00	132	7,573,666.00
NORTH BRISTOL NHS TRUST	Hub (Public)	1.00	£31,545,637.00	444	8,832,126.00
GLOUCESTERSHIRE HOSPITALS NHS FOUNDATION TRUST	New spoke	1.00	£21,076,603.00	287	9,150,547.00
Total		**5.00**	**£83,592,580.62**	**1021**	**32,571,828.00**

TrustName	Cost of Current Ops	Cost of Hub Future	Cost of Referrals to Hub	Cost of Spoke Labs	Cost of Consolidated Service	Consolidation Saving
NORTH BRISTOL NHS TRUST	21,519,019.00	18,454,610.00			18,454,610.00	3,064,409.00
GLOUCESTERSHIRE HOSPITALS NHS FOUNDATION TRUST	13,987,498.00		8,747,038.75	1,723,707.30	10,470,746.04	3,516,751.96
ROYAL UNITED HOSPITALS BATH NHS FOUNDATION TRUST	6,467,754.00		2,803,270.58	2,588,476.80	5,391,747.38	1,076,006.62
UNIVERSITY HOSPITALS BRISTOL NHS FOUNDATION TRUST	6,271,027.62		2,852,953.48	2,367,054.08	5,220,007.57	1,051,020.06
WESTON AREA HEALTH NHS TRUST	2,359,581.00		2,093,225.66	776,132.11	2,869,357.77	-509,776.77
Total	**50,604,879.62**	**18,454,610.00**	**16,496,488.46**	**7,455,370.29**	**42,406,468.75**	**8,198,410.87**

Summer 2017: NHS Improvement proposed pathology networks

South 3

NHS Improvement

TrustName	TrustCode	Status
GLOUCESTERSHIRE HOSPITALS NHS FOUNDATION TRUST	RTE	New spoke
NORTH BRISTOL NHS TRUST	RVJ	Hub (Public)
ROYAL UNITED HOSPITALS BATH NHS FOUNDATION TRUST	RD1	New spoke
UNIVERSITY HOSPITALS BRISTOL NHS FOUNDATION TRUST	RA7	New spoke
WESTON AREA HEALTH NHS TRUST	RA3	New spoke

TrustName	Future Cla...	Sites 24/7	Total Cost	Total FTE	Total Tests
WESTON AREA HEALTH NHS TRUST	New spoke	1.00	£4,073,764.00	46	749,955.00
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Summer 2017: NHS Improvement proposed pathology networks

West of England Pathology Network

Memorandum of Understanding

Between:

(1) Gloucestershire Hospitals NHS Foundation Trust ("**GHFT**") and

(2) North Bristol NHS Trust ("**NBT**"); and

(3) Public Health England Southwest ("**PHE**") and

(4) Royal United Hospitals Bath NHS Foundation Trust ("**RUH**") and

(5) University Hospitals Bristol NHS Foundation Trust ("**UHBristol**") and

(6) Weston Area Health NHS Trust ("**WAHT**")

Referred to as the "**Parties**".

1. Background

1.1 In response to NHS Improvement's ("**NHSI**") requirement for the formation of 29 pathology networks in England, the Parties have formed a Partnership to oversee the agreement to form of a pathology network, subject to approval of the associated business cases. This Partnership is called the "West of England Pathology Network" ("**WoEPN**").

2. Commitments Underpinning the Memorandum of Understanding

2.1 This MOU outlines the principles on which the Parties have agreed that the Partnership will:

2.1.1 collaborate for the benefit of patients and staff impacted by the work of the member organisations with respect to the scope of service covered by the Network.

2.1.2 assist the WoEPN in developing and submitting a successful Outline Business Case (OBC) and Full Business Case (FBC) to the respective organisations Boards and NHSI

2.1.3 subject to the approval of the Full Business Case from NHS Boards and NHSI, implement the preferred option across the Network

2.2 In this MOU (unless the context otherwise requires), defined words or expressions will have the meanings set out within this MOU. References to Paragraphs are references to this MOU.

11

3. Development of Business Cases

3.1 The parties will work together to prepare a strong, deliverable and successful business case at each stage by:

3.1.1 co-operating in the preparation of the business cases at each stage;

3.1.2 promptly providing any information reasonably requested in connection with the preparation of the business cases including costing and activity data;

3.1.3 Alerting the Network Board to any proposed developments within their own STP or adjacent STP that have the potential to impact upon the development of this Network's business case.

3.1.4 ensuring due diligence and appropriate organisational sign off and governance relating to key data sets such as workforce, activity and finance information and the final Business Case

3.1.5 providing a named lead contact, who will liaise with and correspond with the team working on the preparation of the business cases.

4. Execution of the Partnership

4.1 The Parties agree to act in accordance with the following principles to support the Partnership:

- Be focused on improving service quality, patient outcomes and staff experience
- Collaborate, co-operate and be responsive
- Be open and transparent
- Learn, develop and seek to achieve the Partnership's full potential
- Adopt a positive outlook
- Adhere to statutory requirements and best practice
- Act in a manner that reflects and respects the importance of the relationship of the Members under the Partnership
- Deploy appropriate resources

4.2 The Parties will each appoint a representative as a voting member of the West of England Pathology Board. The role of such member will be determined in accordance with the Terms of Reference for the West of England Pathology Board, and is expected to be of sufficient seniority to enable the execution of all business items.

4.3 The parties will agree and jointly fund (net of securing external funding) the resources agreed as required for the delivery of the process to complete the business cases to their conclusion. These will be clearly set out within each Business Case.

5. Costs

5.1 Each Party will bear any individual costs for entering into this Memorandum of understanding. Costs in relation to developments and changes within the network will be set out and agreed within relevant business cases and reviewed in line with agreed timeframes by the WoE Network Board

6. Third Parties

6.1 This MOU and the documents referred to in it are made for the benefit of the Parties and their successors and permitted assigns, and are not intended to benefit, or be enforceable by, anyone else.

6.2 In particular this MOU is not intended (and shall not be deemed) to create any direct contractual relationship between the Parties.

7. Confidentiality

7.1 Subject to Paragraph 7.2, the Parties agree that they will keep confidential any and all information so disclosed exclusively for the purposes of the Partnership, and that the Parties will not directly or indirectly use or disclose any of the information in whole or in part save for the purpose of the Parnership in accordance with this MOU.

7.2 Paragraph 7.1 will not apply to:

7.2.1 any matter which a Party can demonstrate is already or becomes generally available and in the public domain

7.2.2 any disclosure which is required pursuant to any law placed upon the Party making the disclosure;

7.2.3 any disclosure of information which is already lawfully in the possession of the receiving Party prior to its disclosure by the disclosing Party;

7.2.4 any disclosure in compliance with the Freedom of Information Act 2000, as amended from time to time; or

7.2.5 any information which the Parties agree in writing is not confidential.

DRAFT

7.3 The Parties will agree the full particulars and timing of any announcements or other publicity relating to the business governed by the Network Board, which any of the Parties plans to make

8. **Miscellaneous**

8.1 No variation or waiver of this MOU (or any part of this MOU) will be effective unless made in writing, signed by or on behalf of the Parties and expressed to be such a variation.

8.2 This MOU shall not be taken to create any legal partnership or other similar arrangement. No Party shall hold itself out to any third party as being the agent of the other or have the authority to bind any other Party without the prior written approval of said Party in each and every case.

DRAFT

For and on behalf of GHFT

Signed:

Print name:

Title:

Date:

For and on behalf of NBT

Signed:

Print name:

Title:

Date:

For and on behalf of PHE

Signed:

Print name:

Title:

Date:

For and on behalf of RUH

Signed:

Print name:

Title:

Date:

For and on behalf of UHBristol

Signed:

Print name:

Title:

Date:

For and on behalf of WAHT

Signed:

Print name:

Title:

Date:

DRAFT

University Hospitals Bristol
NHS Foundation Trust

Meeting of the Board of Directors in Public on Thursday 30 January 2020

Report Title	**Transforming Care Programme Board Report**
Report Author	**Melanie Jeffries, Transformation Programme Manager**
Executive Lead	**Paula Clarke, Director of Strategy and Transformation**

1. Report Summary

This Transforming Care update provides highlights for quarter 3 2019/20 (Oct –Dec 2019) of the priorities agreed for Transformation Board and the Transformation Team: quality improvement, working smarter (productivity) and digital transformation.

2. Key points to note
(Including decisions taken)

- Continued delivery of the Transforming Care programme in 2019/ 20, across the Trust (appendix 1)
- Bright Ideas relaunched as a biannual competition, progress report on October 2019 attached (appendix 2)

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 **Assurance.**

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

Senior Leadership Team	22 January 2020

12

Respecting everyone
Embracing change
Recognising success
Working together
Our hospitals.

This Transforming Care update provides highlights for quarter 3 2019/20 (October – December 2019) of the priorities agreed for Transformation Board and the Transformation Team: quality improvement, working smarter (productivity) and digital transformation.

Bright Ideas
The panel for the Bright Ideas biannual competition was held on 21 October 2019. Of the 51 submissions, nine were shortlisted across a variety of topics. The applicants presented their ideas for improvement and innovation to the panel and answered questions from the panel members.

Most ideas were well-developed with presenters asking for small amounts of funding or senior support to implement or test their idea. A small number of ideas were improvement opportunities observed within the Trust, which the finalists felt they would struggle to take forward without the support of the panel.

The panel was very impressed with the quality of ideas, and passion of all involved. The panel agreed to support eight of the Bright Ideas:

- Implementation of a penicillin allergy testing and 'de-labelling' service
- Introduction of a visual reminder for patients receiving prescribed dietician products, which can be placed by the bedside
- Replace plastic cups with paper or reusable cups at water fountains
- Development of patient symptom advice videos to send to parent/carers following discharge from Children's Emergency Department
- Investigate how a patient salon service for personalised care could work at UH Bristol
- Implement a service where charities can collect food waste from hospitals and donate it to homeless people
- To introduce Makaton signs to level 5 of Bristol Royal Hospital for Children, and investigate how a training programme could work
- To create and distribute a patient diary to engage children age 6 to 12 years in their care

These winners are now receiving project or financial support to implement their Bright Idea. The competition will run twice a year, with submissions reopening 27th January – 20th March. The next panel is scheduled for 29th April. Further details included at Appendix 2.

Clinical Practice Groups
The clinical practice group approach is a new concept being piloted for single specialty teams based in different organisations to work together. The concept has been developed from the Royal Free Hospital methodology.

The ambition of a clinical practice group (CPG) is:

- ensure the delivery of evidence based best care
- reduce unwarranted variation in clinical practice and processes,
- offer patients care in the most appropriate setting
- ensure the same pathway and standard of care across all organisations

The first clinical practice group workshops have been held between Oncology services across UH Bristol and Weston Area Health Trust (WAHT), and with services providing Pre-habilitation before surgery across UH Bristol, WAHT, NBT and Primary Care. Once the model is established the plan is to extend CPGs across all appropriate services within BNSSG and potentially beyond.

Transformation Care SPORT report

A summary of the highlights of progress during quarter 3 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.

12

Transforming Care – Progress Summary Q3 2019-20	
Successes	**Priorities**
• Bright Ideas competition relaunched as a biannual competition, with 8 successful applicants in October 2019. • Development of Clinical Practice Group methodology with Oncology and Pre-habilitation service workshops, and initial meetings with Adult Dermatology and Rheumatology • Delivery of QI Gold Days 4-5 and coaching/ mentoring provided to project teams from an allocated QI Faculty member • Emailing of appointment letters project transferred to business as usual • Clinical Utilisation Review supported the development of business as usual processes through the implementation of standardised delay code guidance, and roles and responsibilities. • Trauma and Orthopaedics Junior Doctor Training project to resolve issues completed • Uro-gynae pathway to ensure patients sees the right clinician first time completed • Facilitation of workshops, and where required the development of action plans for operational teams in the following areas: – Paediatric Eating Disorder Inpatient pathway – Union Partnerships – UH Bristol and Weston – Internal Medicine Forum – redesign of medicine model – Estates Team Leader away day – NICU – Equitable Access across UH Bristol and North Bristol workshop	• Transforming Outpatients – development and implementation of a toolkit for implementing Advice and Guidance, Telephone clinics and reducing follow ups. • Transforming Outpatients – trial of video conferencing clinic appointments • Development of the Improving Inpatient Handover project to include utilisation of all Careflow functions, which can support an improvement in multi- disciplinary team communication. • Further development of Clinical Practice Group methodology, and establishment of pilots for: – Paediatrics in Weston and UH Bristol – Gynaecology in Weston and UH Bristol • Bright Ideas competition spring 2020 launch in January 2020 • Digital VTE Risk Assessment launch for 16-18 year olds in Bristol Royal Hospital for Children, and Bristol Eye Hospital Inpatients • Provide support to the operational team to deliver the Waste Management project, focusing on compliance with waste segregation • Implementation of Green to Go patient management on Medway, and discontinuation of current database • Trial and develop digital real time bed management functions, outputs and processes. • Securing funding to deliver the Transformation, Improvement and Innovation strategy • Support to the urgent care recovery programme.
Opportunities	**Risks and Threats**
• Development of Continuous Improvement Huddles, working with Children's Emergency Department • Partnership working with transformation teams in other organisations as part of Clinical Practice Groups and Transforming Outpatients programme • Business case for Transformation, Improvement and Innovation strategy submitted to SLT	• Ability to deliver Transformation, Improvement and Innovation strategy if business case is not approved • Impact of the Weston merger on the capacity of clinical and corporate services that are also required to support the delivery of transformation projects.

Pillars: Working Smarter | Digital | Quality Improvement

Appendix 1: Transforming Care Report

Status: 10th January 2020

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
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**	Oct 2019	• Available baseline data for current processes assessed and gaps identified. • Working with Patient Safety Team to review audits and manual data collections. • Two potential wards identified for the pilot. To be confirmed after process mapping completed on both wards.	• Process mapping methodology developed and tested for current, future day & night processes	Feb	• 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
	Delivery phase starts	March 2020		• Identify early adopter ward for implementing ideal process using automatic escalation.	Jan	
	Project close	TBC		• Baseline data for current processes established and measures in place	Jan	
Transfer of Care Communication **PS: Steve Gray** To standardise clinical documents within Professional Record Standards Body (PRSB) standards including Outpatient letters	**Project start**	July 2019	• Training plan completed for other priority areas such as Paediatrics with an amended training package to support • Notification of Death, Cancellation of Procedures, Poor Prognosis, Cardiology Treat and Return Summary template built , ready to support the Trust move from ICE to Medway	• Discharge Summaries go live in BEH, QDU Medical Day Case, SBCH, Rheumatology, Dermatology and ACU Day case.	Feb	• Improve quality and clarity of discharge summaries • Work towards a one usage IT system • Achieve 100% compliance within PRSB standards • Improve targeted turnaround time for clinical correspondence
	Delivery phase starts	Nov 2019		• Clinical Correspondence rollout plan in draft and meeting to discuss and agree timelines planned	Dec	
	Project close	Dec 2020		• Meeting with Paediatrics 20th Jan to discuss training and roll out plan. Full project team established to support	Jan	
Improving Handover (CareFlow Connect) **PS: Carolyn Mills/Bill Oldfield** To have effective communication systems across teams to deliver timely, safe and effective care Trust Wide	**Project start**	Nov 2018	• Rollout continuing across services (**2190** users and **279** groups set up)	• CareFlow training videos produced	Nov	• Reduction of communication incidents due to team communication and inadequate handover: 19/20 to date **340 incidents** • Reduction of dropped handover sheets: 19/20 to date - **19** dropped handover sheets • Secure real-time communication & remote clinical decision making based on patient information • Reduction in bleeps releasing time for other tasks
	Delivery phase starts	Jan 2019	• CareFlow handover rollout underway for BHI & Therapies	• Referrals functionality trialled in BRHC in PICU	Dec	
	Project close	Mar 2020	• Careflow SOP approved by Digital Hospital Programme Committee Tasks functionality trialled in BRHC CED and radiography – training underway to trial in General Paeds and Caterpillar Ward	• BRHC out of hours process trialled • CareFlow handover rollout in Medicine, Surgery and Gynae underway	Jan Feb	
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**	Feb 2019	• Joint session held with digital services, clinical site management team and A300 matrons to explore new process for allocating beds and indicating bed is ready • Process map created to explain proposed new procedure for allocating beds Processes in BHI shadowed	• Data sources for digital boards are explored	Feb	• 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
	Delivery phase starts	TBC		• Technical capability of Medway is explored for recording real time information	Mar	
	Project close	TBA		• Gap analysis of current process and Medway functionality written for all stakeholders • Trial process planned for one adult pathway (TBA)	Mar Feb	
People Web (Self Service) **PS: Matt Joint** Replacement for HR web enabling staff and managers to easily find information	**Project start**	Oct 18	• None		**On Hold**	• Easy access to HR guidance for line managers and employees • Reduction in phone calls/emails to employee services
	Delivery phase starts	On hold				
	Project close	TBC				
Personal Health Record **PS: End Stage** Patients to have direct electronic access to their health records. Enabling patients to engage with their care and treatment	**Project start**	Nov 2018	• Decision taken to End stage - report prepared with successes to date for handover when Project resumes		**On Hold**	• Patients to have better visibility and transparency of their patient information • Patients will have access to general information about UHB and lifestyle advice
	Delivery phase starts	On Hold				
	Project close	On Hold				
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**	June 2019	• Programme lead- Outpatient manager left the Trust. Await replacement starting Feb 2020 • Dental biopsy telephone clinic launched • Advice and Guidance implemented in Lipids • Meetings with Divisional teams held to plan opportunities in their areas	• Virtual appointment pilot commenced in Children's oncology	Mar	• 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
	Delivery phase starts	Sept 2019		• Transforming outpatient toolkit designed	Mar	
	Project close	March 2020		• A&G evaluation completed	Feb	
Clinical Practice Groups **PS: Paula Clarke /Andy Hollowood** To be identified as part of project mobilisation	**Project start**	July 2019	• Initial Pre initial CPG (BNSSG) meeting held on 20th December	• Rheumatology CPG workshop held	TBC	• In development
	Delivery phase starts	Nov 2019	• Initial Dermatology CPG (NBT/UHB) meeting held on 12th December	• Initial meetings held with clinical services – Paediatrics, Care of the Elderly, Gynae • 2nd Oncology workshop held	Mar Jan	
	Project close	March 2021	• Ongoing refinement of model as initial CPGs are commenced	• CPG governance structure signed off	Jan	

Project, Aim & Project Sponsor (PS)	Key Dates		Progress Last Month	Aims for Next 3 Months	When	Benefits delivered or expected
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	• Engagement with paeds T&O Med Secs and planning Real Time launch in speciality in January • Continued engagement with gynaecology and BDH re launch in February • Stocktake of progress with incoming Outpatients manager	• Implementation of CRIS booking module to allow appointments to be made without vetting • RTOP in BHI relaunch/reinvigoration • Meeting with Rheumatology to discuss sustainability of Real Time. • Dental launch • Divisional performance and ops reviews to include real time measures.	TBC TBC Jan Feb TBC	• Better cross-cover and improved business continuity due to standardisation of admin roles • Enable greater throughput of patients within clinic • Reduce missing outcomes • Improved clinic letter turnaround, and less chance of fines • Reduced DNA rate as patients understand what is happening
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	• Refocus/restart on key workshops that will make some quick wins in improving staff and patient experience. • Milestone dates to be re-planned	• Confirm RTOP booking system for biopsies • Confirmed standardised clinic templates plan and clinic rules. Increase the use of POD style clinics for skin cancer and general clinics • Review all patient appointment letters and schedules to ensure patients are getting the right letter for the correct appointment • Relaunch surgery workshop, the aim to relook at surgery booking form • Launch electronic outcomes for Weston UHB clinics	Dec Dec Dec Dec Dec	• 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
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	• Work planned for January, when Transformation lead has capacity	• Optimising Diagnostics training in development • Toolkit in development • Final principles circulated	Jan Jan Jan	• 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
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 Dec 2019	• Initial floor plan produced for H301 pre-op one-stop clinics • Drop-in held for staff to view plans for new pre-operative clinics • Equipment specification shared with consultants for comment	• Detailed specifications for refurbishment agreed • Job planning is commenced for consultants in one-stop clinics • Pre-operative nursing assessment tool is developed to support streamlined clinics	Jan Feb Mar	• Reduce avoidable last minute cancellations (LMCs) by 50% to 2.5% of total procedures (5% in Nov, 7% in Dec – note this is raised comparted to average for Q1 and Q2) • Increase number of cataract procedures to 380 per month by the end of 2019/20 (353 in November and 262 in December) • Reduced average length of patient pathway (starting average = 35 weeks) • Reduce time in pre-op clinic by 50%
Endoscopy Improvement **PS: Philip Kiely** To improve efficiency and wellbeing in the endoscopy booking team	**Project start** **Delivery phase starts** **Project close**	Sep 2018 Jan 2019 TBC	• Continuing to run Glanso weekend lists at South Bristol Community Hospital. • Training competencies written and being used to train new staff members.	• All booking staff to start and to be trained. • New Assistant Performance and Operations Manager to start 20/1/20. • Commence tender for reporting system including an electronic scheduling tool • Weekly Scheduling meeting to include Nurse Endoscopist and QDU Nurse Manager.	Jan Jan Dec TBA	• Increased utilisation of lists • Better patient experience with bookings • Increased efficiency of bookings team • Improved staff wellbeing and reduced turnover

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
		Apr 2017
		TBA
			• QI Silver Cohort 6 commencing Mar 2020 fully booked
			• 7 out of 8 Bright ideas projects have commenced, and have allocated support
			• Days 4 & 5 of the QI Gold programme developed and delivered
				• Bright Ideas competition winner letter of engagement signed to release funding
				• Business case for additional training capacity submitted to SLT
				• Two additional QI Bronze sessions in Weston delivered prior to merger
				• Bright Ideas Spring 2020 competition launched
					Feb
					Dec
					Mar
					Jan
						• Increased number of staff who have knowledge and confidence to conduct QI projects in their area:
						  • **997 staff** attended Bronze training
						  • **87 staff** completed or undertaking Silver training
						• Development of an Innovation culture in the Trust
						• **124** QI project ideas submitted to the QI Hub

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 March 2018 March 2020	• Session held with Patient Complaints and Support team re: lessons learned from #TakePhonership initiative • #TakePhonership post project review paper shared for comment before distributing to stakeholders • Handover meeting held with Central Outpatients and Telecoms in IM&T	• Rollout plan for customer service training is developed • Finalise design of customer service toolkit • Programme update shared with staff to promote engagement with training rollout • Content of advanced customer service training is finalised with external trainer	Jan Feb Jan Jan	• Telephone complaints **for Q3 19/20 (n= 41) are higher than complaints for Q3 in 18/19 (n= 17) but reduced compared to Q2 19/20 (n=48).** • Areas recognised for good practice through improved pick-up rate and complaints reduction
Improvement and Innovation enabling strategy **PS: Paula Clarke**	**Project start** **Delivery phase starts** **Project close**	Apr 2019 Oct 2019 Sept 2019	• Implementation of strategy underway		Oct 2019	• Trust staff and partners clearly understand the strategy around how improvement, transformation and innovation will be taken forward by UHB

Bright Ideas Report

November 2019

Project, Aim & Project lead	Key Dates		Progress Last Month	Aims for Next 3 Months	When	Benefits expected
Anti-biotic de-labelling service **Sue Wade and Emily Marshall** Implement a penicillin allergy testing and 'de-labelling' service	**Project start** **Project close**	Oct 2019 TBC	• Case Study written and in Newsbeat • Service promoted in Anti-Microbial Resistance week • Patient information leaflet drafted	• Medway clinical note edited to include de-labelling and testing consent • Patient information leaflet signed off • Briefing pre-op assessment staff • Service rolled out within pre-op	Dec Nov Jan Feb	• De-labelled patients can be given cheaper antibiotics (10x reduction in price) • De-labelled patients can be given more effective penicillin • Decreased risk of anti-microbial resistance
A cupcake magnet **Lenka Nekvasilova** Introduce a visual reminder of patients received prescribed dietician products, which can be placed by the bedside	**Project start** **Project close**	Oct 2019 Mar 2020	• Discussions with senior nurse and Matron • Copyright free image found • Agreed numbers of magnets required per ward, and numbers of wards • Case study included in Newsbeat	• Find quotes for magnet production, and get magnets produced • Link in with Dietetics service • Roll out to medicine wards, including staff briefings • Poster drafted and disseminated	Dec Dec Jan Jan	• Patients are given their prescribed dietetics products on time • Improved quality of care • Less food wasted
Reduce the use of plastic cups **Rachel Savage and Lynn Glossop** Replacing plastic cups at drinking machines with paper or reusable cups	**Project start** **Project close**	Nov 2018 Mar 2020	• Sustainability manager has booked meeting with winners	• Sustainability manager to meet with Lynn and Rachel • Jeff Farrar to ask the Sustainability team about the project when the strategy comes to the board	Nov Nov	• Less plastic used/wasted • Cost saving as less plastic cups are purchased • Cost saving as less cups are disposed of
Video safety netting **Nick Sargant** Development of patient symptom advice videos to send to parent/carers following discharge from CED	**Project start** **Project close**	Oct 2019 Mar 2020	• Contacted in-house videographer • National opportunities explored further • Information governance contacted regarding consent	• Process mapping to understand specification • Specification document developed • Confirmation of Information Governance agreement for the project • IT requirements understood • Three quotes requested from suppliers	Dec Dec Dec Dec Nov	• Parent/carers are clearer about when they need to bring the child back to hospital
Personalised Care **Nicole Brinson-Kroon** Investigate how a patient salon service could work at UH Bristol	**Project start** **Project close**	Nov 19 TBC	• Senior manager identified to support project	• Senior Manager to meet with Nicole to develop/scope the idea further • Infection control engaged in idea	Dec TBC	• To be scoped, but expected to be: ○ Improved patient wellbeing ○ Improved patient hygiene

Project. Aim & Project lead	Key Dates		Progress Last Month	Aims for Next 3 Months	When	Benefits expected
Reducing food waste **Terri Clements** Implement a service where charities can collect food waste from the hospitals and donate it to homeless people	**Project start**	Nov 2018	• Jeff Farrar challenged current policy • Idea/policy being checked with Legal • Charities that could take the food waste researched	• New food waste policy drafted	TBC	• Less food wasted: ○ Less wasted money ○ Reduced carbon footprint • More food
				• Food waste collection process developed	TBC	
	Project close	End Stage Sept 19		• Charities to collect the food agreed	TBC	
Bringing Makaton to the Children's Hospital **Chloe Hammond** To introduce Makaton signs to Level 5 of the BRHC, and investigate how a training programme could work.	**Project start**	Oct 2019	• Unsure of progress as both Chloe and the Transformation support are off sick	• Procure signage and badges	TBC	• Greater accessibility and inclusion at BRHC • Greater skilled workforce
	Project close	TBC		• Get signage put up on Level 5, and distribute the badges	TBC	
				• Write business case for Makaton training	TBC	
Patient diaries for children **Katie Francis** To be identified as part of project mobilisation	**Project start**	Oct 2019	• Katie has identified support for her diaries • 'Diary champions' identified on each ward	• Production of diaries	TBC	• Improved patient engagement in their own care • Improved patient experience
	Project close	Mar 2020		• Launch and distribution of diaries	TBC	

Meeting of the Board of Directors in Public on Thursday 30 January 2020

Report Title	Healthier Together Sustainability and Transformation Partnership including Long Term Plan
Report Author	Seb Habibi, Programme Director, Healthier Together
Executive Lead	Robert Woolley, Chief Executive

1. Report Summary
This report is to update the Board on the Healthier Together Five Year Plan 2019-2024 and other significant programmes within the Healthier Together STP.
2. Key points to note *(Including decisions taken)*
The local Five Year Plan was resubmitted to NHSE/I on 10 January 2020, following a revision of financial plans for the NHS statutory bodies within Bristol, North Somerset, and South Gloucestershire (BNSSG). This revision commits us to reducing the deficit against our NHS system control total for 2020/21 and to maintaining our financial recovery trajectory going forward to 2023/24. Publication of the local Five Year Plan is expected following release of the NHSE/I national LTP Implementation Plan. This is likely in March this year. Other ambitious plans include allowing patients to access more care digitally and making BNSSG the best place to work with updates on both these topics in the attached paper. Further details from becci.green@nhs.net Business Manager, Healthier Together.
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.**
5. History of the paper **Please include details of where paper has previously been received.**
N/a

13

Respecting everyone
Embracing change
Recognising success
Working together
Our hospitals.

Meeting of the Board of Directors in Public

Healthier Together STP Update

Thursday 30 January 2019

13

Five Year Plan

Over the next five years, we will make major changes to health and care services to better serve people in Bristol, North Somerset and South Gloucestershire (BNSSG). We are building a model of care based on prevention, proactive care, integration and personalisation to create a service fit for the challenges of the 21st century.

Our plan was resubmitted to NHS England / Improvement on Friday 10 January, along with 44 other STP system plans from across the country.

Our revised financial plans will reflect assumptions that NHSE/I will provide additional revenue support which will enable us to deliver financial sustainability for Weston Area Healthcare Trust (WAHT) through the merger with University Hospitals Bristol (UHB).

In addition NHSE/I expect our revised plans to commit us to reducing the remaining deficit against our NHS system control total for 2020/21.

The additional savings required would be on top of system transformation savings, other CCG savings provider efficiencies for the NHS Trusts in BNSSG that were already built into our LTP.

Our Healthier Together Partners have agreed to work with us to develop strategies for improving outcomes and value as set out in our LTP and this approach reflects a shared commitment to delivering a financially sustainable system for the benefit of our population, patients and staff across BNSSG.

We expect a national LTP Implementation Plan to be published in March and following this we will publish our local Five Year Plan, being mindful of local elections and announcements around this time.

Our plan to engage with people across BNSSG is well advanced and this will include briefings for elected representatives and local media. Details will also be posted online to the Healthier Together website and on social media.

Integrated Care

Localities development

A seminar is taking place on Thursday 12 March in Bristol for members of the Partnership Board, Clinical Cabinet, Integrated Care Steering Group, and local councillors with a health and wellbeing remit. The objective is to create a shared sense of ambition as integrated localities are critical to the future success of our system. The concept, governance, co-design, and practicalities will be explored.

13

Acute Care Collaboration

Outpatients transformation

We have agreed an ambitious plan that will ensure patients can access more care digitally (1) removing the need for a third of patient journeys (2) joining up services between the GP, community and hospitals (3) enabling patients to get faster access to the care they need in the most appropriate location (4) allowing us to measure patient outcomes – using information to design services that truly meet patients' future needs.

We are currently developing the specification for a single patient app for all of BNSSG that will enable patients to schedule appointments, have telephone and video consultations and capture outcomes that are meaningful to them. Next month we will be piloting advice and guidance as the default option for general neurology referrals. This will increase communication and learning between GPs and specialists, enabling patients to get quicker access to advice and care and potentially avoiding a hospital attendance.

Urgent Care

A challenging operational environment (winter pressures on the system) but excellent working between organisations is reported along with the commitment to support staff and patients/public. Of note, winter funding has allowed us to increase capacity especially in community and home settings to support discharge from hospital. We are currently identifying system changes that will support more sustainable services and care and help for people closer to home, such as extra primary care slots for urgent care, and use of the NHS app.

Mental Health

Mental Health Strategy

This was discussed at Partnership Board in December. Significant feedback has been received from partners on key issues including a needs assessment and BAME community involvement. Work is ongoing to incorporate this feedback within the final Mental Health Strategy for approval by Partnership Board in March.

Learning Disability and Autism 'All Age' Workshop

During the first programme board the group agreed a stakeholder workshop proposal which took place on Wednesday 22 January. The workshop agenda included an introduction to Five Year Plan priorities, place-based service mapping and co-production.

Children & Families

The first Children and Families programme board took place on Monday 25 November and the group agreed to an extended workshop on Tuesday 14 January. The board have been working to produce a service mapping document and during the workshop four task and finish groups were agreed for (1) an autistic spectrum disorder hub (2) digital information sharing/database (3) team around school model and (4) out of hours rapid response around children services and CAMHS.

Workforce

Progress is underway on each of our strategic priority areas. Highlights include:

Making BNSSG the best place to work

Our year-long social care workforce project finishes in March. Deliverables include:

- ✓ Faster DBS checks: pilot launching in North Somerset
- ✓ 'I Care' ambassadors scheme promoting careers in social care
- ✓ Student and rural support schemes piloting as alternative social care provision
- ✓ Improved collaboration across our local authorities

Learning Academy to optimise skills

This is to provide consistent and standardised training at scale, improving quality and reducing overheads as well as reducing the cost of BNSSG health and social care staff moving between employers. Most recently we have agreed to introduce a standard 'passport' system for basic competencies across the whole system to ensure consistent training and speed up induction. An apprentice strategy is also being developed with agreement expected in April.

New Operating Model for Workforce

A 'staff bank' project manager is being recruited to develop an operating model for a collaborative staff bank across community, primary care and social care as an alternative to unfilled staffing gaps or costly agency solutions.

Estates and Corporate Services

The physical locations of new 'Locality Hubs' are currently being scoped and agreed. Primary care improvement works are also underway at Weston Villages, Gloucester Road, Little Stoke and Tyntesfield. These are due for completion by March 2020.

Sebastian Habibi

Programme Director, Healthier Together STP for Bristol, North Somerset and South Gloucestershire

Meeting of the Quality and Outcomes Committee on 27th January 2020

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

Information

- In respect of the Trust's zero tolerance policy towards violent and anti-social behaviour, it was requested that the publicity material used by the Trust to promote this policy be circulated to members of the Committee.

- The Quality & Performance Report was considered, and the continuing high level of pressure on the hospital, and the impact this was having on the elective programme, was noted by the Committee. Key points highlighted to the Committee included the following:

  - Both Children's and Adult Emergency Departments had seen high levels of admissions over the past month;
  - 'Green to go' numbers had seen an increase in new patients;
  - Ambulance handover data showed a spike in handover times, which was felt to be due to the reporting data being unvalidated. The Committee queried the requirement to continue using South West Ambulance Foundation Trust's (SWASFT) unvalidated data.
  - The Referral-to-Treatment (RTT) had stabilised and the Divisions had robust plans for clearing the backlog. The Trust had also made a successful bid for national funding which would be used primarily to support the RTT and diagnostics backlog.
  - The Trust had achieved compliance with its Quarter 3 cancer performance targets in Quarter 3.
  - The diagnostic waiting times had continued to improve in Quarter 3.

- The Committee received a progress report against the Trust's quality objectives for 2019/20. It was reported that one objective had been completed and three were on plan to be achieved, with the remaining four behind schedule. During the ensuing discussion it was requested that the reasons why electronic monitoring had not been implement in ED, theatres and the Queen's Day Unit be clarified for the next meeting.

- The Committee received the following reports for information and assurance:

  - Serious Incident Report – Q3 Update
  - Root Cause Analysis Reports
  - Monthly Nurse Safe Staffing Report
  - Review of Clinical Quality Risks – Quarter 3
  - Learning from Deaths Report – Quarters 1 & 2 Update
  - Infection Control Report - Q3 Update

14.1

- Quarterly Inquest Report – Q3 Update

For Board Awareness, Action or Response	
The Committee received a report which detailed the approach to the approval of the Weston Area Heath NHS Trust (WAHT) 2019/20 Financial Accounts, Annual Report and Quality Account. It was noted that a similar report would go the corresponding committees at WAHT. Discussion centred on the Quality Account, and it was noted that both the WAHT and UHBristol Quality Accounts would come to the Audit Committee and the Quality and Outcomes Committee in May prior to being signed off by the Trust Board. The Committee was assured that the objectives for 2020/2021 would be planned for the whole merged organisation, although the new Weston Division might have some specific objectives added to its operational plan in the short term.	
Key Decisions and Actions	
N/A	
Date of next meeting:	**25th February 2020**

14.1

Meeting of the People Committee on 27th January 2020

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

For Information
• The Director of People provided a strategic update to the Committee. An update was provided on the STP HR Development Strategy, and a discussion took place on the resources available within the Trust to address Equality & Diversity issues in this context. It was suggested that E&D resources could be shared across the STP, but the need for the Trust to adequately resource this area of work was also recognised. An update was also provided on the TUPE process at Weston Area Heath NHS Trust, and the processes in place to recruit to the new leadership team there. It was noted that the integration of Corporate Services across the two Trusts was in train, and a new integrated HR function would be in place from 1st February 2020. The Committee requested that it be provided with the new HR Structure at its next meeting, and it was stated that the Committee would need to be assured that there was sufficient capacity and capability to meet the strategic people priorities. • The Committee received an update on the pension tax issue. • The Committee considered the Workforce Performance report. It was reported that the Trust remained under pressure and as a result the use of agency staff had risen. It was however confirmed that overall the Trust had remained within its agency cap. The level of stress related sickness absence was also noted with concern. Recruitment and retention was also discussed, and it was agreed that a deep dive into the reasons given by staff for leaving the Trust should be considered at the February meeting of the Committee. A detailed look at recruitment and retention in light of the forthcoming merger would also be considered at that meeting. The Committee discussed the disappointing figures in respect of the completion of appraisals, and it was suggested that further consideration needed to be given to possible sanction if line managers did not complete appraisals in a timely manner. • The People Committee received reports on the following for information and assurance: o Talent management update o Organisational Development update o Freedom to Speak Up six monthly update
For Board Awareness, Action or Response
The Committee devoted most of its time to consideration of the Trust's Workforce Race Equality Standard (WRES) Action Plan, prior to its consideration at the Trust Board. The report provided a six monthly update on progress, and the Head of Organisation Development and Trust Chair also provided details of the national WRES pilot project which six NHS Trusts, including UHBristol, were involved in. The

14.2

aim of this was to make WRES 'business as usual', and the national WRES team would spend a week at the Trust as part of this project. The Trust's participation in the pilot project was welcomed as positive evidence of its commitment to this issue, and it was requested that this be highlighted to the Trust Board during its consideration of the WRES Action Plan.

Key Decisions and Actions	
In addition to the actions agreed above, the Committee also agreed that its annual work plan should come to each meeting for review, and that an update report on reshaping the medical workforce should also be presented to the February meeting.	
Date of next meeting:	**25th February 2020**

14.2

Meeting of the Finance Committee – 27th January 2020

Reporting Committee	Finance Committee
Chaired By	Martin Sykes, Non-Executive Director
Executive Lead	Neil Kemsley, Director of Finance and Information

Information

The Committee received the Finance Director's Report. In respect of the national and regional context, it was reported that the expectation was that the NHS nationally would achieve its revenue plan for 2019/20. In respect of the STP, the financial position for a number of organisations within the BNSSG region had negatively shifted, and this had already been recognised in the planning process for the 2020/21 financial year.

The Director of Finance reported that NHS Trusts across the country were being challenged to plan their capital spending better, and all Trusts had been asked to double check their capital programme forecasts for Quarter 3. It was also noted that the requirements of providing additional urgent care, and the disruption this was causing to the delivery of elective programmes, was a common issue being seen across the country.

In respect of the Trust's own financial performance, it was reporting a core surplus of £4.107m to date, which was £0.024m favourable to plan. Divisions and Corporate Services were £8.180m adverse to Operating Plans. The key issues highlighted included the following:

- Income from activities underperformance of £5.014m, with an underperformance of £0.145m in month;
- Increased nursing and midwifery pay costs of £1.952m year to date
- Divisions were £1.3m adverse to their expected trajectories at December.

The Committee reviewed the Quarter 3 Corporate and Strategic Risk Registers. It was noted that the risk relating the Brexit had been reduced as the risk of a 'no deal' scenario had been eliminated following the recent general election.

The Committee received the following for assurance:

- Statement of Financial Position
- Quarterly Treasury Management Report
- WAHT Annual Report and Accounts Approval Process

For Board Awareness, Action or Response

The Committee devoted most of its time to considering an update on Digital Services provided by Steve Gray, Chief Information Officer. It was reported that finding a balance between the maintaining the services provided by the department, whilst at the same time developing new and innovative solutions, was an ongoing challenge, particularly in light of the increased demand from users with a capacity within the department which had not grown at a corresponding rate. It was reported that a

14.3

strong foundation of systems, skills, processes and know-how had been established to build what was recognised by NHS Digital's Provider Digitization programme as a good level of digital maturity that will be embedded across the Trust more rapidly over the coming period.

During the ensuing discussion it was noted that the developing Digital Strategy was one of the Trust's critical enablers for its future development, and that this would be considered by the Trust Board in March. The Non-Executive Directors welcomed the clarity provided in the report in respect of the Trust's current position and the roadmap for the future. Details of the newly established Digital Hospital Programme Board were provided to the Committee, and it was requested that the an update on the development of this Board, its terms of reference and reporting lines be reviewed at the next meeting of the Finance Committee.

Key Decisions and Actions	
N/A	
Date of next meeting:	**25th February 2020**

14.3

Meeting of the Audit Committee – 28th January 2020

Reporting Committee	Audit Committee
Chaired By	David Armstrong, Non-Executive Director
Executive Lead	Neil Kemsley, Director of Finance and Information

Information
• The Audit Committee considered the Strategic and Corporate Risk Registers and was satisfied that the Trust's risk management processes remained under very good control. It was reported that the risk around Brexit had been reduced due to a no deal Brexit being averted following the recent general election. • The Committee received the Counter Fraud Update report, and noted the progress in respect of investigations into conflicts of interest and gifts and hospitality, which had been the main focus of work over recent months, was reported. The importance of continued vigilance and action in respect of staff declaring conflicts of interests was highlighted by the Committee. • The Committee considered six Internal Audit Reviews and was satisfied with the recommendations and outcomes from these. • The six monthly update on the Data Security and Protection Toolkit was received and noted. • The Committee received the regular reports on Losses and Special Payments and Single Tender Actions. The Chair requested that in future both reports provide a risk analysis to highlight any new risks that had emerged since the last report.

For Board Awareness, Action or Response
• The Audit Committee considered the following documents relating to the proposed merger with Weston Areas Heath NHS Trust (WAHT) for assurance: a) Due Diligence Risk Management Update; b) Transfer Approach and Checklist; c) Approach and Governance for the WAHT 19/20 Financial Accounts, Annual Report and Quality Account; d) Update on the Approach to Policy Alignment. The Committee was satisfied that the appropriate processes were in place in respect of the above. The Committee particularly welcomed the establishment of the Risks and Benefits Management Group (a sub-group of Merger Programme Board) which would look at the risks and benefits arising from the merger. The Committee also discussed its responsibilities in respect of signing off the WAHT 19/20 Financial Accounts, Annual Report and Quality Account. • The Committee undertook a review of Estates risks. Concern was expressed regarding the ongoing difficulty being experienced in getting staff released to undertake essential fire safety training, and it was suggested a cultural shift was

14.4

required in order the resolve this so that attendance at training was driven by need, not an individual's ability to attend. During the ensuing discussion it was agreed that the Divisions were responsible for ensuring members of staff undertook the appropriate training, and the Chief Executive undertook to hold the divisional management teams to account in respect of their responsibilities in this area. In respect of the SPORT analysis contained in the report, it was requested that this takes account all estate risks and not just those relating to fire. • In respect of the BHOC serious incident recommendations, it was noted that the action relating to low energy lighting would not be closed until January 2021, and Chief Executive was asked to confirm with the Senior Leadership Team that this was acceptable and appropriate.
Key Decisions and Actions
• The Committee approved the Trust's revised Accounting Policies for 2019/20. • The Committee made a recommendation to the Council of Governors in respect of the extension of the External Auditor's contract.

Date of next meeting:	**28th April 2020**

14.4

Meeting of the Board of Directors in Public on Thursday 30 January 2020

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.

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

- This report is for **Assurance.**

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

Quality and Outcomes Committee	27/01/2020
People Committee	27/01/2020

15

Respecting everyone
Embracing change
Recognising success
Working together
Our hospitals.

Quality and Performance Report

January 2019

1.1 OVERVIEW – Executive Summary

Oversight Framework

- The 62 Day Cancer standard for GP referrals achieved 87.0% for November. This achieved the national standard of 85%. Quarter 1 and Quarter 2 also delivered the 85% standard. Quarter 3 is currently at 86.2% and is on track to achieve for the quarter.
- The measure for percentage of Emergency Department (ED) patients seen in less than 4 hours was 76.1% in December. This did not achieve the 95% national standard or the improvement trajectory target of 83.5%. Attendance levels have risen, especially in the Paediatric Department.
    - If local Walk-In Centre activity was assigned, as per 2018/19 apportionment rules, then overall performance would be around 80% (an uplift of approximately 4%).
- The percentage of Referral To Treatment (RTT) patients waiting under 18 weeks was 82.5% as at end of December. This did not achieve the national 92% standard or the improvement trajectory target of 86.9%.
- The percentage of Diagnostic patients waiting under 6 weeks at end of December was 96.1%, with 309 patients waiting 6+ weeks. This is lower than the national 99% standard. The recovery trajectory, in agreement with commissioners, was re-based at the start of Quarter 3 and the Trust narrowly missed the December recovery target of 96.5%.

Headline Indicators

There were four Clostridium Difficile cases in December but this still keeps the Trust below the maximum allowed for the financial year of 57 cases. In addition, there were no MRSA cases in December. Pressure ulcer incidence remained below target in December, with two grade 2 pressure ulcers and none at grade 3 or 4. The Falls incidence was slightly above the target of 4.8 falls per 1,000 bedays; at 4.82. There were 131 patient falls with two resulting in moderate harm or above.

The headline measures from the monthly patient surveys and the Friends and Family Test remain above their minimum target levels in December 2019. In Complaints, 84% of formal complaints were responded to within deadline which is slightly below the Trust standard of 85%. 5.7% of October's complaint responses (4 cases) were re-opened due to complainant being dissatisfied with the original response.

Last Minute Cancelled Operations (LMCs) were at 2.5% of elective activity and equated to 153 cases. This is is the highest number in the last three years. In December, seven patients were not re-admitted within 28 days following an LMC.

Workforce

December 2019 compliance for Core Skills (mandatory/statutory) training remained at 90% overall across the eleven programs.

Bank and Agency Usage (4.8% and 1.2% respectively) remains above the Trust's GREEN threshold, however all divisions reduced bank usage this month. Turnover reduced to 13.2% from 13.4% last month, 1 division saw an increase in turnover whilst 5 divisions saw a reduction in turnover. The reasons for leaving continue to be reviewed through the Exit Questionnaire. Response rates have slowed during December and January and so further promotion is planned.

Sickness absence remained static at 4.7% compared with the previous month, with increases in three divisions.

Overall appraisal compliance remained static at 70.8%. The appraisal recovery plan remains in place. The focus of action includes: a) areas of low compliance including direct interventions at manager and service level, b) attendance at local meetings across the organisation, c) review of attendance at the Trust Appraisal training to enable, particularly where there is a link to low compliance

1.2 OVERVIEW –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 –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%	81.9%	84.8%	81.4%	82.4%	80.3%	76.1%			
	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%	84.0%	86.8%	85.8%	83.6%	85.4%	87.0%				
	Actual (Quarterly)	85.7%			85.4%								
	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%	86.5%	84.3%	83.6%	83.0%	83.0%	82.5%			
	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%	96.2%	95.1%	96.2%	95.9%	96.7%	96.1%			
	Trajectory							96.0%	96.5%	96.5%	97.0%	98.0%	98.0%

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

OVERVIEW – Key Performance Indicators Summary

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

Safe

- Infection Control (C. diff and MRSA)
- Patient Falls
- Pressure Ulcers
- Medicines Management
- Essential Training
- Nurse staffing levels

Caring

- Monthly Patient Surveys
- Friends and Family Test Score
- Complaints Response Time
- Dissatisfied Complainants

Responsive

- A&E 4-hours
- Delayed Transfers of Care
- Referral to Treatment Times
- Last Minute Cancellations
- Diagnostic Waits
- Outpatient Hospital Cancellations
- Cancer 2 Week Wait
- Outpatient DNAs (Did Not Attend)
- Cancer 62 Day
- Outpatient Overdue Follow-Up Reduction

Effective

- Mortality
- Hip Fracture - 36 and 72 Hour Standards
- Hip fracture - Best Practice Tariff
- Outliers
- 30 Day Emergency Readmissions

Efficient

- Bank Usage
- Agency Usage
- Turnover
- Vacancies
- Staff Sickness
- Appraisal Compliance
- Length of Stay

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

	Successes	Priorities
ACCESS	• Delivered the cancer 62 day GP and 31 day first definitive treatment national standards in November • Compliance with the 2 week wait first appointment cancer standard has been sustained throughout quarter 3 • CT Cardiac services are on track to clear the majority of the 6 week diagnostic backlog by February 2019 • Following submission of an option paper to Speciality commissioning, we have successful averted any 52-week breach finds in Clinical Genetics service. We have also agreed a process of some referrals to be re-directed to other providers to help us recover our backlog position • The Acute Medical Unit (AMU, A300) queue was developed and launched, which sees ED admissions to AMU queued within the AMU environment rather than within ED.	• Sustain compliance with the cancer standards as far as possible within the limitations of winter pressures. Continue close management of cancer patients to ensure patients are clinically prioritised correctly so no harm results from any unavoidable delays • Decembers Referral To Treatment performance was 82.5% against the 86.9% standard. For the end of March 2020 the focus is to recover the waiting list size to March 2018 (29,200). Due to pressures in emergency services and the priority for Cancer patients, recovery of the waiting list size by March 2020 is at risk. Additional meetings with Divisions have been arranged by Deputy COO to develop a recovery plan • Recover diagnostic 6 week standard in quarter 4 (99% waiting under 6 weeks). • Additional capacity for Paediatric MRI and adult Endoscopy diagnostics needs to be identified to allow services to deliver the 99% standard. • Continue with in/out –sourcing options in adult endoscopy while additional clinical fellow post is filled.
	Opportunities	**Risks and Threats**
ACCESS	• Current implementation plan of Medway PAS at Weston continues. The RTT Performance Lead is working closely with the Weston Clinical Systems team and the validation teams to support this and to agree which new functionality Weston will implement for testing. It is key that RTT Status codes that are implemented at Weston match those that are currently in place at UHB. On this basis, 5 days of Medway System C team have been secured at UHB to support implementation of any new functionality • NHSEngland/ImprovementI have invited UHB to partake in the 26 Week South West Regional Programme Launch. The first meeting is planned for January and will be attended by the RTT Performance Lead • Planning round for 2020/21 is underway where discussions around capacity planning, demand management and efficiency improvements (e.g. Length of Stay) will be undertaken • Action plans to ensure that core components of flow (such as use of discharge lounge, timely declaration of beds and criteria led discharge) are being developed in each bed holding Division with clear KPIs and monitoring framework.	• Winter pressures remain a significant risk to sustaining compliance with cancer standards throughout winter. The pressures result in cancellations due to lack of beds (critical care and ward beds), reduced capacity for cancer surgery due to elective pacing (limitation on the number of surgeries performed per day), and reduced capacity for diagnostic or minor treatment procedures due to relevant areas being used for escalation capacity • November saw the increase in ED attendances sustained. When comparing Quarter 3 (Oct-Nov) with Quarter 2, the Bristol Royal Infirmary is seeing a 4.6% increase in activity. The Children's Hospital is seeing a 25% increase in attendances. In addition, the adult services saw its highest number of attendances on 3rd and 4th November, when 256 and 257 patients attended • The Trust continues to report 52 week breaches in Division of Surgery due to a number of last minute cancellations, patient choice and some revalidation of pathways. At the end of December there were ten 52 week breaches • The recovery of RTT waiting list size and Zero 52 week breaches by end of March 2020 is at high risk of non-delivery, not only due to the emergency pressures and cancer patient priorities but also additional issues relating to consultant pension tax and the agenda for change reduction for nursing/ward staff resulting in those staff groups no longer willing to cover additional sessions or drop lists • The use of Endoscopy capacity over Christmas (to provide additional capacity for emergency admissions) has caused a deterioration in the 6 week standard for routine and elective endoscopy work.

Public Board Meeting - January 2020-30/01/20 - Page 158

OVERVIEW – Successes, Priorities, Opportunities, Risk & Threats

	Successes	Priorities
QUALITY	• 100% compliance with all timescales in the national Serious Incident Framework in Quarter 3 2019/20. • Two hospital acquired grade 2 pressure ulcers in December 2019, out of 27,195 patient beddays, in the context of operational challenges and extra capacity beds open.	• Antibiotic prescribing compliance has continued to deteriorate slightly over Quarter 3 2019/20. In December 2019 it was 71.8% (334 prescriptions out of 465 were compliant with all elements of antibiotic prescribing requirements.) Monitoring indicates some prescriptions have been written in haste in the context of operational pressures, with the review date having been inadvertently omitted. Monitoring for January 2020 suggests 75%+ compliance thus far. The anti-microbial pharmacy team plan to review slightly fewer prescriptions in the monitoring audits to allow them to spend more time in wards supporting anti-microbial use, focussing on wards with lower compliance but also recognising good practice. • Compliance with the new system for electronic recording of VTE risk assessments continues to be around 77-78%. The VTE Prevention Group has worked to fix any issues that have been raised (e.g. availability of risk assessment form in outpatient areas such as ED). We are sure that reduced compliance is not due to lack of knowledge to complete the form or lack of education that it needs to be done. It seems to partly be an issue getting around to it when there are so many other things to do in the context of operational pressures. Support to improve compliance continues from the Transformation Team. There is no suggestion that appropriate thrombo-prophylaxsis isn't being prescribed from the reviews undertaken of cases of hospital associated VTE. A new thematic approach to the review of hospital associated VTEs for 2020/21 is under consideration, with first reviews of cases being undertaken by a pharmacist and a sub-set of cases going forward as requiring further medical input. Assurance monitoring of thrombo-prophylaxsis prescribing will recommence in February 2020.
	Opportunities	**Risks and Threats**
QUALITY	• To improve the time to theatre performance for patients requiring surgery for fractured neck of femur following the recruitment of new Trauma and Orthopaedic consultants as detailed later on in this report (and thus the achievement of best practice tariff).	• No new risks or threats identified to quality and safety within UH Bristol.

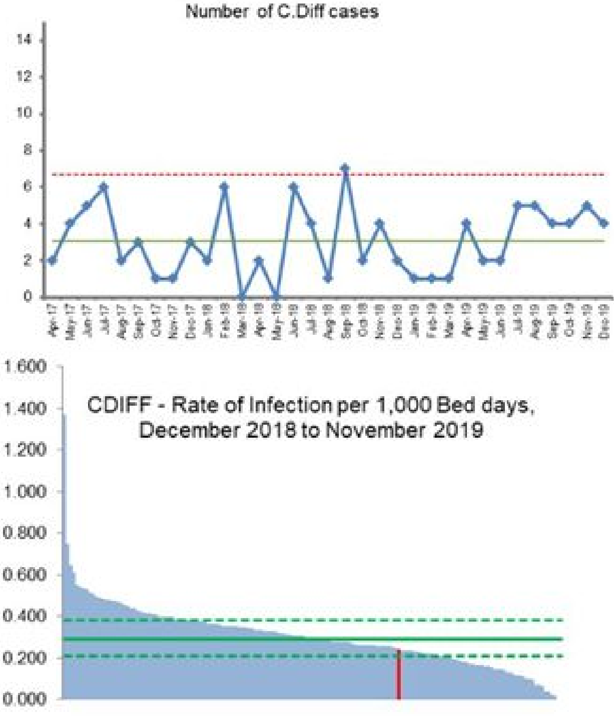
OVERVIEW – Successes, Priorities, Opportunities, Risk & Threats

	Successes	Priorities
WORKFORCE	▪ NHSE/I commended the Trust's holistic workplace wellbeing offer and requested a case study for inclusion in the 'Best Place to Work' chapter of the pending NHS People Plan (due for launch early 2020), to showcase interventions and to demonstrate the impact of the programme at the Trust ▪ Two new support guides added to existing library of wellbeing resources these are *Coping with Trauma* and *Coping with the Death of a Patient* ▪ The national addendum to contract for senior clinical staff has been issued; this confirms the government will ensure there is no financial detriment arising from their pension accrual ▪ Finalisation of a new eLearning programme for a Generic Risk Assessor update as an alternative method of training. ▪ Invitation to be part of the NHSE/I regional summit recognising the significant work undertaken and continuing on the system wide collaboration for nurse agency controls	▪ Aligning 5 programmes under the Healthier Together Learning Academy Skills 'Pass-Porting' arrangements following a number of challenges with the aspirations for pass-porting training records of staff between all BNSSG employers ▪ Focus remains on driving the seasonal influenza vaccination programme with a CQUIN target of 80% frontline staff vaccinated by February 2020. Compliance at end of Q3 is 78.8% ▪ Commencing focus on a timeframed and measurable Medical HR service improvement review programme to create a sustained and robust model, fit for purpose for the organisation ▪ Implementation of a new Agenda for Change Job Matching System to enable remote matching, which will support business as usual demand, but also the anticipated increase in activity with the intergration of services with the Weston merger. This will be supported by the launch of an eLearning programme for Agenda for Change Job Matching • Following the completion of a review of the Occupational Health business model the service is awaiting decision on investment in order for service recovery to be realised as quickly as possible
	Opportunities	**Risks and Threats**
WORKFORCE	▪ Supporting Essential Training Programme Leads in building compliance improvement plans, in response to a post-CQC inspection recommendation ▪ Collaboration with Bristol Council, private sector and other care providers to support the 'International Year of the Nurse & Midwife', with the aim of getting more people/children to pursue healthcare as a profession ▪ Participation in the national workforce race equality cultural change pilot which is being launched in January 2020 and will the development of our year 2 diversity and inclusion strategy action plan ▪ Due to changes in the operational management team in Weston's Staff Bank service, UHBristol have taken over the operational responsibility of the service from 1 January 2020. A focused review of processes and systems is underway to ensure alignment with UHBristol's service offering	▪ The risks and issues being faced with vacant posts within Employee Services and Medical HR at UHBristol are compounded by the challenges being faced with high volumes of employee relations cases. This demand is further increased by the support being offered to Weston's day to day HR service ▪ Operational pressure will slow progress with the BNSSG&B agency controls programme for nursing with an increased demand for high cost nurse agency use ▪ Appraisal compliance remains well below target at 70.8%. All divisions are non-compliant ▪ Following a successful marketing campaign, the Occupational Health Consultant candidates withdrew their applications, resulting in a continued risk to the availability of consultant led clinics and impact on recovery of performance

Public Board Meeting - January 2020-30/01/20 - Page 160

PERFORMANCE – Safe Domain

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 four trust apportioned C.Diff cases in December 2019, giving 35 cases year-to-date. This is still below the maximum allowable year-to-date cases of 28.
Commentary/ Actions:	The four C.Diff cases require a review by our commissioners before determining if the cases will be Trust apportioned due to lapse in care. These cases are attributed to the Trust after patients have been admitted for two days (day 3 of admission). This is a new criterion from NHSI, which commenced in April 2019. There was one case of Community Onset Healthcare Associated (COHA) C. Difficile in December. Patients assigned to the COHA category are those with C. Difficile who are admitted to one our hospitals overnight and had a previous admission in the previous four weeks. The patients within this criteria count towards the Trust numbers. The Infection Control Team investigates these cases to ensure there have been no in lapses in care. There was one case of Community Onset/Community Acquired (COCA) attributed to the community in December.
Ownership:	Chief Nurse



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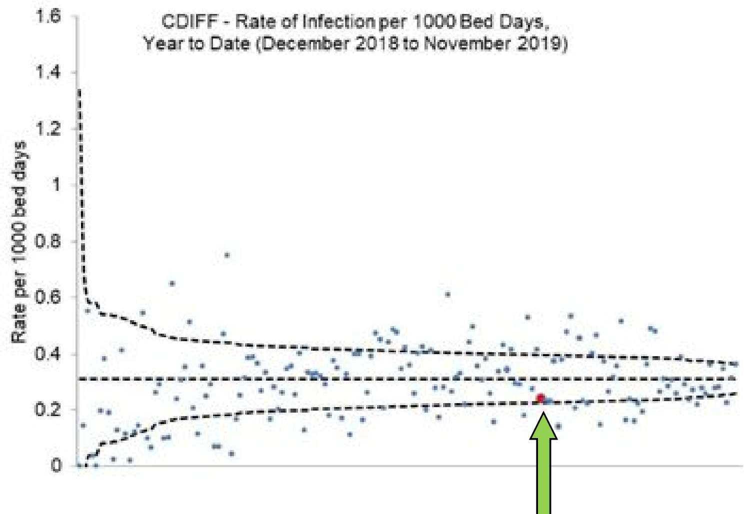
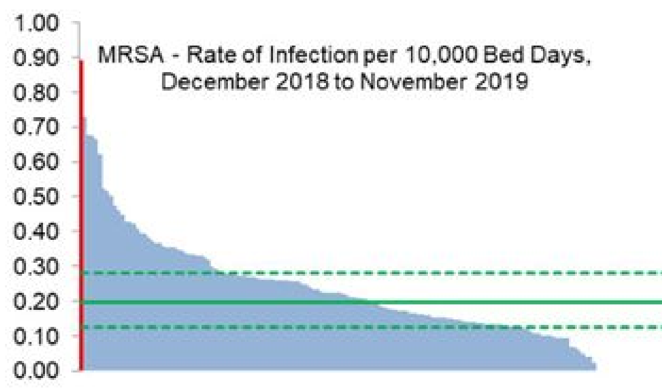


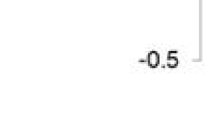
CDIFF Cases	Dec-19	2019/2020
Medicine	1	4
Not Known	0	2
Specialised Services	0	4
Surgery	1	6
Women's and Children's	2	19
Grand Total	0	35

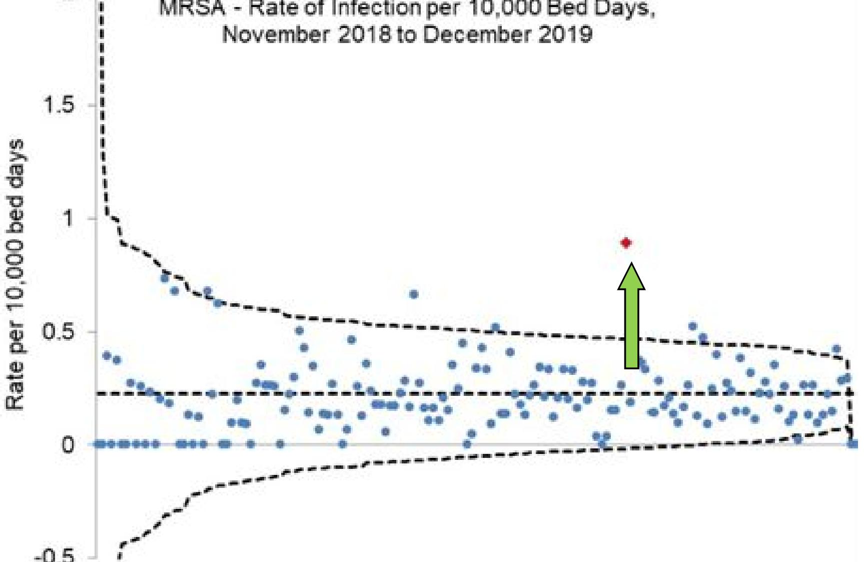
PERFORMANCE – Safe Domain

Infections – Methicillin-Resistant Staphylococcus Aureus (MRSA)	
Standards:	No Trust Apportioned MRSA cases.
Performance:	There were zero Trust apportioned MRSA cases in December 2019 and so one case year to date.
Commentary/ Actions:	-
Ownership:	Chief Nurse

MRSA	Dec-19	2019/2020
Medicine	0	0
Specialised Services	0	1
Surgery	0	0
Women's and Children's	0	0
Grand Total	0	1



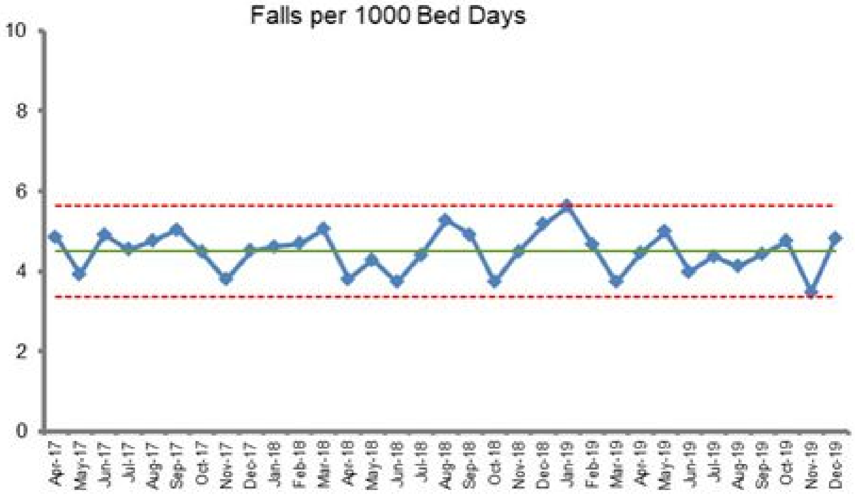




Unbroken horizontal line is England median; dotted lines are upper & lower quartiles

PERFORMANCE – Safe Domain

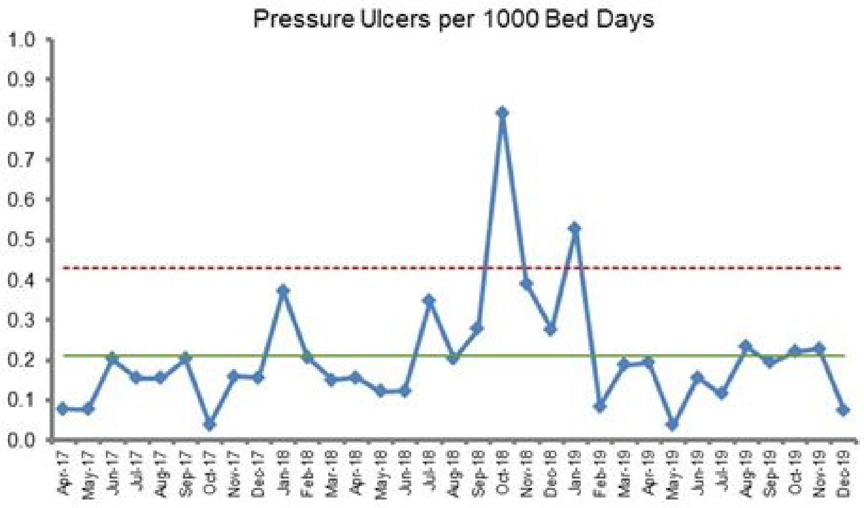
Patient Falls	
Standards:	Inpatient Falls per 1,000 beddays to be less than 4.8. Less than 2 per month resulting in Harm (Moderate or above)
Performance:	Falls rate for December was 4.82 per 1,000 beddays. This was 131 falls with two resulting in moderate or higher level of harm.
Commentary/ Actions:	The overall number of falls increased to 131 with increases seen in both Surgery and Medicine. The month of December was operationally challenging with a number of extra capacity beds opened. There were two falls resulting in harm occurring within the Division of Medicine, neither occurred in an escalation area. Immediate actions have been taken and shared with other Divisions at the January Falls Group meeting to ensure Trust wide learning. Outcomes of investigations will be discussed in the Falls Group in due course and any further mitigating actions implemented. Implementing actions required to achieve new 2019/20 Falls CQUIN has commenced, which include: 1. Measuring lying and standing blood pressure measurement for all patients 65 years and over (7% compliance against an NHSI CQUIN target of 80%). A new Falls Care Plan has recently being introduced to support improvement. 2. Ensuring no anti-psychotic, anxiolytics or hypnotics, are given during hospital stay or if required there should be documentation of rationale (60% compliance against an NHSI CQUIN target of 80%). 3. Ensuring patient mobility assessment is documented within 24hrs or mobility aid provided within 24hrs (99% compliance against an NHSI CQUIN target of 80%). The following were also approved at the January 2020 meeting: • The Falls Champion Role Description, competencies and method for sign off to provide development for the champions and to ensure good practice within their areas. • The Falls Patient Information Leaflet to support and involve patients and relatives in their help to prevent falls both in the community and in hospital • An updated Falls E-Learning package to increase staff knowledge in falls prevention and management. The 2020 National Audit of Inpatient Falls has commenced, with interim results to be reviewed in 6 months' time to capture any themes or actions that need to be taken in year. The 2020/21 Falls Group work and audit plans are out to consultation across Divisions and will be approved at the March 2020 meeting.
Ownership:	Chief Nurse



Public Board Meeting - January 2020-30/01/20 - Page 163

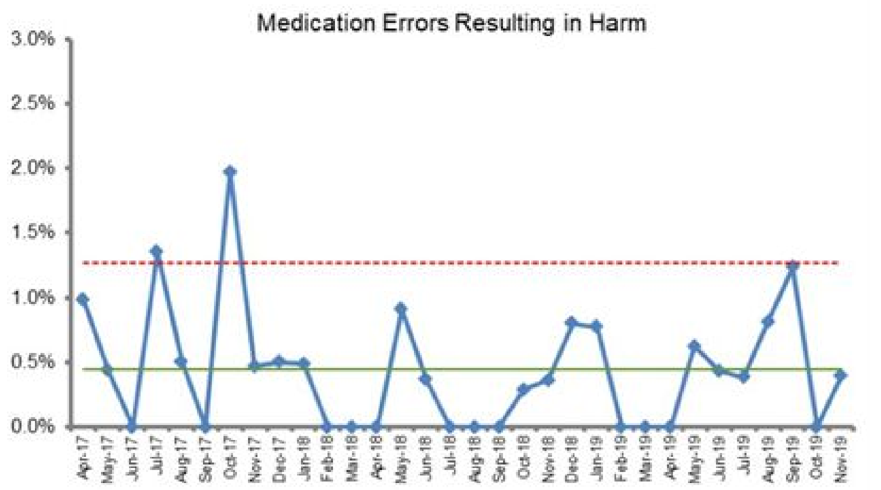
PERFORMANCE – Safe Domain

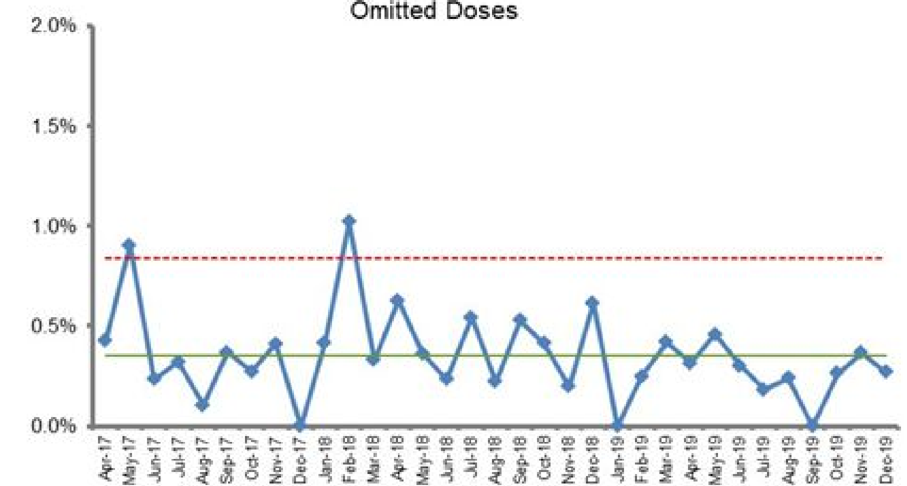
Pressure Ulcers	
Standards:	Hospital acquired Pressure Ulcers to be below 0.4. No Grade 3 or 4 Pressure Ulcers
Performance:	Pressure Ulcers rate for December was 0.074 per 1,000 beddays. There were two category 2 pressure ulcers (heel and sacrum) and zero category 3 or 4 pressure ulcers.
Commentary/ Actions:	There was one unstageable pressure ulcer incident for an end of life patient. The patient had a complex injury with mixed aetiology. The injury had deteriorated and the true depth of the wound /category has not been determined as yet. It is likely to deteriorate to at least a category 3 pressure ulcer. An investigation is underway and initial actions in place. The 2019/20 Tissue Viability Group work plan continues to focus on reducing the number of pressure ulcers developed on wards. • The Tissue Viability Team continues to deliver monthly targeted training to wards following an incident or on request from the Ward Manager • The role of the Tissue Viability Champions is to be relaunched January 2020 • Develop a poster to raise awareness of the need to reposition the patient as part of the pressure relieving measures • To review and update the pressure ulcer risk assessment tool and then move it to a digital format. All actions are monitored through the tissue viability steering group.
Ownership:	Chief Nurse



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:	One moderate harm medication incidents were reported in November 2019, out of 252 cases audited (0.4%) Omitted doses were at 0.27% in December (1 case out of 370 reviewed in areas using paper drug charts).
Commentary/ Actions:	The medication incident concerned a paediatric patient who suffered an extravasation of a cannula in their hand, which resulted in the development of compartment syndrome and required an operation under general anaesthetic to treat. An investigation is underway to determine whether this could have been prevented despite the cannula site inspection indicating a healthy site. The non-purposeful omitted critical medicines audit in areas using paper drug charts identified one unintentional omission of a critical medicine. The cumulative year to date figure is 0.27%, (13 cases out of 4771 patients reviewed.) The unintentional omission related to an omission of an oral anticoagulant that was not available on the ward at the time the dose was due. There is a system in place to ensure that wards are able to source the required medication from other wards, but this did not happen.
Ownership:	Medical Director





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 December 2020 Essential Training overall compliance remained static at 90% compared to the previous month (excluding Child Protection Level 3).
Commentary/ Actions:	January 2020 (December 2019 data) compliance for Core Skills (mandatory/statutory) training remained at 90% overall across the eleven programs. Overall compliance for 'Remaining Essential Training' also remained at 94%, same as the previous month. ▪ Compliance for ReSPECT Awareness eLearning improved in the last month to 25%, toward a target of 90%. Doctors continue to be given regular 'countdown' reminders to complete their ReSPECT Awareness eLearning by 1 April 2020, when it will be added to the list of other Essential Training in monthly reporting, and will also be factored into overall compliance. ▪ The Healthier Together Learning Academy Skills 'Pass-Porting' Group presented its recommendations and incremental proposal on 7 January, aiming to resolve difficulties in pass-porting training records of staff between all BNSSG employers. Five programmes are being aligned in January.
Ownership:	Director of People

Essential Training	Dec-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	87%	90%
Information Governance	86%	95%
Moving and Handling (formerly Manual Handling)	89%	90%
NHS Conflict Resolution Training	93%	90%
Preventing Radicalisation	95%	90%
Resuscitation	80%	90%
Safeguarding Adults	92%	90%
Safeguarding Children	93%	90%

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

PERFORMANCE – Safe Domain

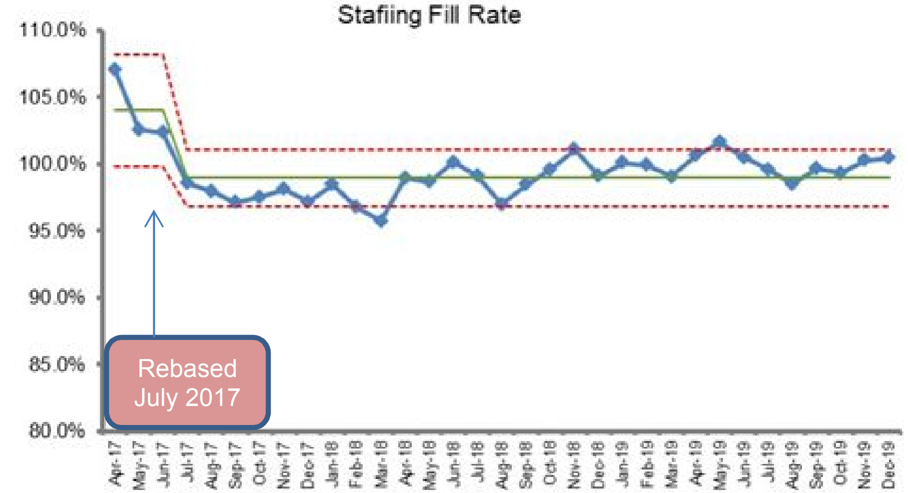
<table>
<tr><th colspan="2">Nursing Staffing Levels</th></tr>
<tr><td>Standards:</td><td>Staffing Fill Rate is the total hours worked divided by total hours planned. A figure over 100% indicates more hours worked than planned. No target agreed</td></tr>
<tr><td>Performance:</td><td>December's overall staffing level was at 100.5% (243,355 hours worked against 242,238 planned).
Registered Nursing (RN) level was at 96.7% and Nursing Assistant (NA) level was at 110.3%</td></tr>
<tr><td>Commentary/ Actions:</td><td>Overall for the month of December 2019, the trust had 97% cover for RN's on days and 97% RN cover for nights. The unregistered level of 103% for days and 120% for nights reflects the activity seen in December 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.
• Assurance: Monitored through agency controls action plan</td></tr>
<tr><td>Ownership:</td><td>Chief Nurse</td></tr>
</table>

DECEMBER 2019 DATA

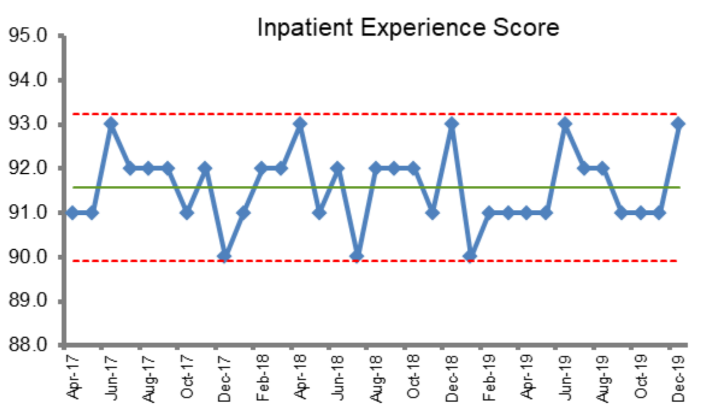
	Day	Night	TOTAL
Registered Nurses	96.9%	96.5%	96.7%
Nursing Assistants	103.3%	120.2%	110.3%
TOTAL	**98.8%**	**102.5%**	**100.5%**

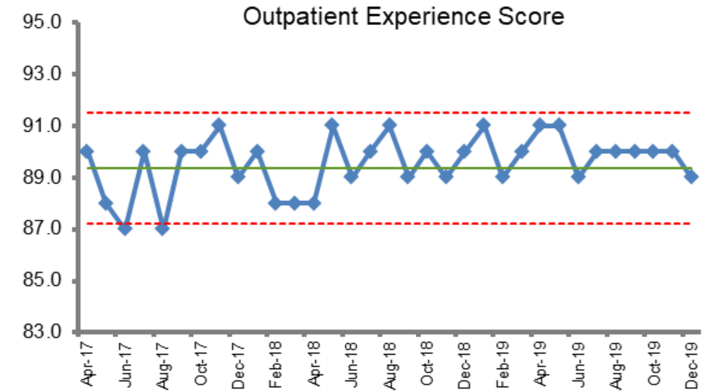
Medicine	109.9%
Specialised Services	100.4%
Surgery	104.3%
Women's and Children's	93.3%
TOTAL	**100.5%**

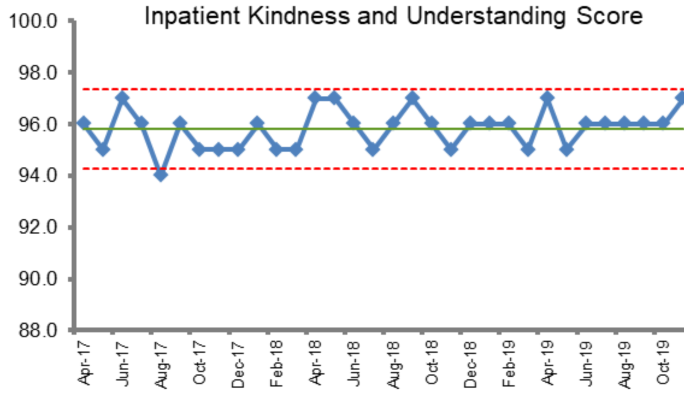


PERFORMANCE – Caring Domain

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 December 2019, the inpatient score was 93/100, for outpatients it was 89. For the kindness and understanding question it was 97.
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







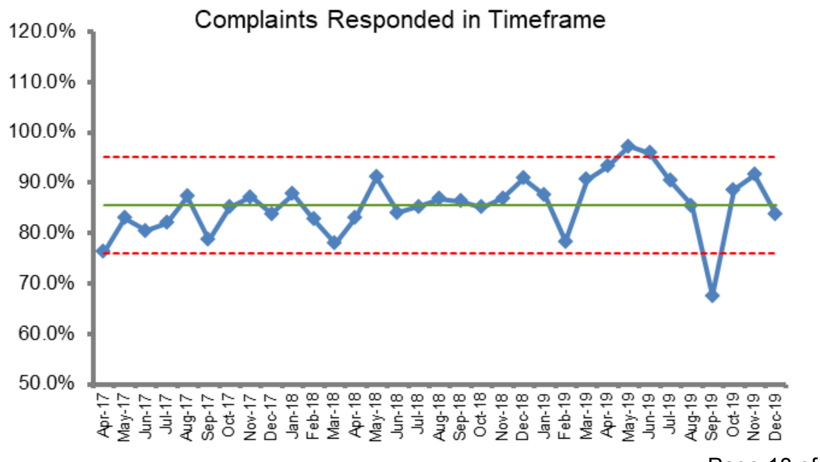
PERFORMANCE – Caring Domain

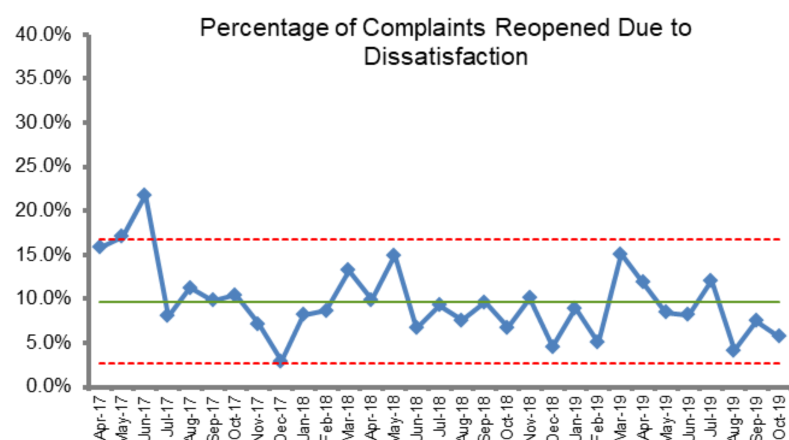
Friends and Family Test (FFT) Score	
Standards:	The FFT score is the number of respondents who were likely or very likely to recommend the Trust, as a percentage of all respondents. Standard is that the score for inpatients should be above 90%. The Emergency Department minimum target is 70%.
Performance:	December's FFT score for Inpatient services was 98.6% (1984 out of 2013 surveyed). The ED score was 84.6% (1314 out of 1553 surveyed). The maternity score was 99.1% (348 out of 351 surveyed).
Commentary/ Actions:	The Trust's scores on the Friends and Family Test were above their target levels.
Ownership:	Chief Nurse

	Response Rate		Score	
	Dec-19	2019/2020	Dec-19	2019/2020
Inpatients				
Medicine	36.1%	40.7%	97.2%	98.0%
Surgery	33.7%	35.7%	99.0%	98.9%
Specialised Services	25.6%	38.1%	99.5%	98.9%
Women's and Children's	42.1%	31.3%	98.8%	98.7%
TOTAL	**35.3%**	**36.1%**	**98.6%**	**98.6%**
Emergency Department				
Bristol Royal Infirmary	11.0%	11.4%	69.1%	68.2%
Children's Hospital	15.2%	16.8%	82.4%	83.1%
Eye Hospital	30.7%	26.6%	98.0%	95.6%
TOTAL	**16.6%**	**16.7%**	**84.6%**	**83.3%**
Maternity				
TOTAL	**26.8%**	**26.7%**	**99.1%**	**97.6%**

PERFORMANCE – Caring Domain

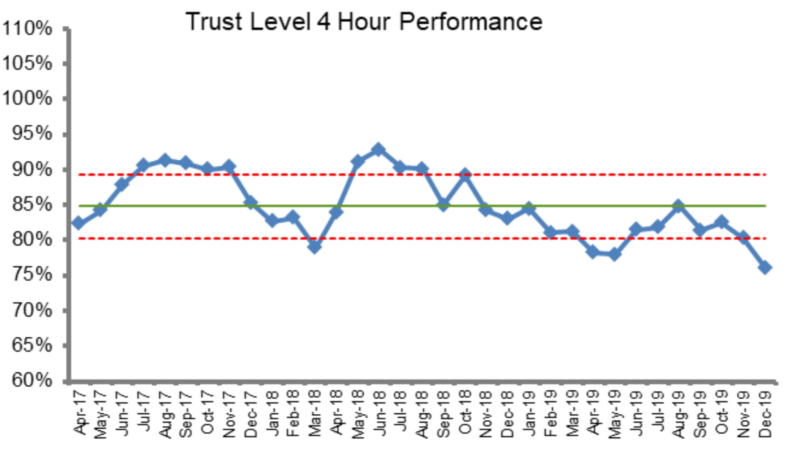
Patient Complaints	
Standards:	For all formal complaints, 95% of them should have the response posted/sent to the complainant within the agreed timeframe, with a lower tolerance (Red) of 85%. Of all formal complaints responded to, less than 8% should be re-opened because complainant is dissatisfied, with an upper tolerance (Red) of 12%.
Performance:	In December, 46 out of 55 formal complaints were responded to with timeframe (83.6%) Of the 70 formal complaints responded to in October, 4 resulted in the complainant being dissatisfied with the response (5.7%)
Commentary/ Actions:	December's response rate saw a deterioration on the 92% reported in November 2019 and the 89% reported in October 2019. There were nine breaches from the 55 formal responses sent out in December, with eight of those breaches attributable to the Divisions and one due to a delay during the Executive sign-off process. Of those breaches attributable to the Divisions, these were all breaches for the Division of Medicine. The Division have experienced further challenges due to a combination of long term sickness and vacancies in key areas associated with complaints. They now have a robust plan in place to improve performance and this has been shared with the Chief Nurse. The breach attributable to a delay during sign-off was for the Division of Specialised Services. These breaches have been validated by the Divisions. The Divisions of Diagnostics & Therapies, Surgery and Women & Children all achieved 100% for formal responses in December, with all formal responses being sent out by the deadline agreed with the complainant. There were no formal responses for Trust Services in December. The Trust's performance in responding to complaints via informal resolution within a timescale agreed with the complainant was 91%, an improvement on the 83% reported in November but slightly down on the 93% reported in October 2019. This equates to six breaches from the 68 responses in December. Of the six breaches recorded, there were four breaches from the Division of medicine and two from the Division of Surgery. The rate of dis-satisfied complaints in October (this measure is reported two months in arrears) was 5.7%. This represents four cases from the 70 first responses sent out during that month, compared with 7.5% reported for September 2019 and 4.2% reported for August 2019.
Ownership:	Chief Nurse

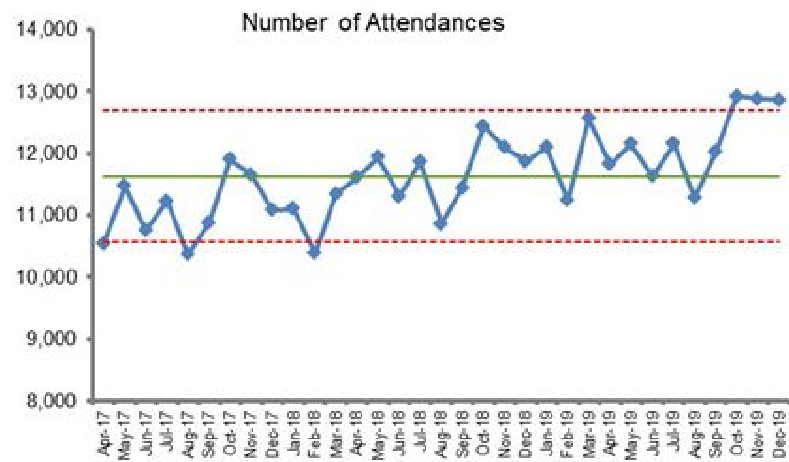


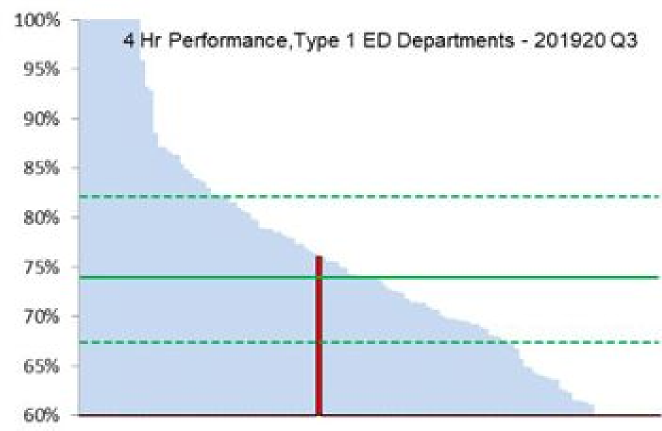


2.3 PERFORMANCE – Responsive Domain

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 83.5% for December.
Performance:	Trust level performance for December was 76.12% (12858 attendances and 3071 patients waiting over 4 hours).
Commentary/ Actions:	When comparing Quarter 3 (Oct-Nov) 2019 with Quarter 3 2018, the Bristol Royal Infirmary is seeing a 7.9% increase in activity. The Children's Hospital is seeing 28 patients per day more on average, which is a 25% increase in attendances. Actions: • Flow week undertaken across the Adult bed holding Divisions supported by Diagnostic and Therapies. • New escalation capacity identified and risk assessed to be included in the new escalation policy which is currently being drafted • A third medical outlier consultant ward round was arranged to support quality and flow • New transfer team piloted • GP sessions were trialled (when shifts could fill) were piloted within the ED • Action plans to ensure that core components of flow (such as use of discharge lounge, timely declaration of beds and criteria led discharge) are being developed in each bed holding Division with clear KPIs and monitoring framework. • The Acute Medical Unit (AMU, A300) queue was developed and launched, which sees ED admissions to AMU queued within the AMU environment rather than within ED.
Ownership:	Chief Operating Officer



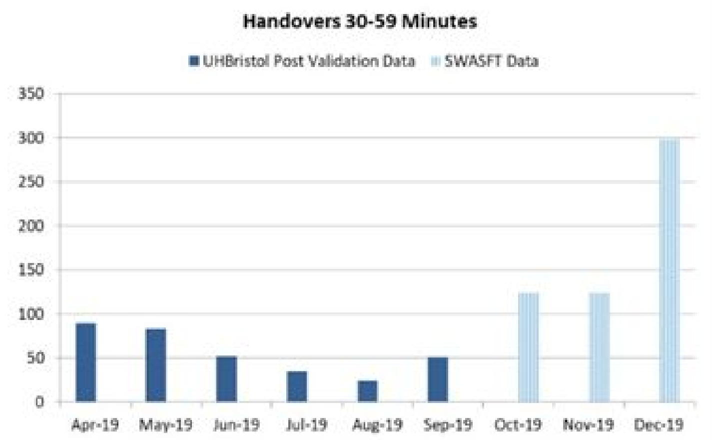


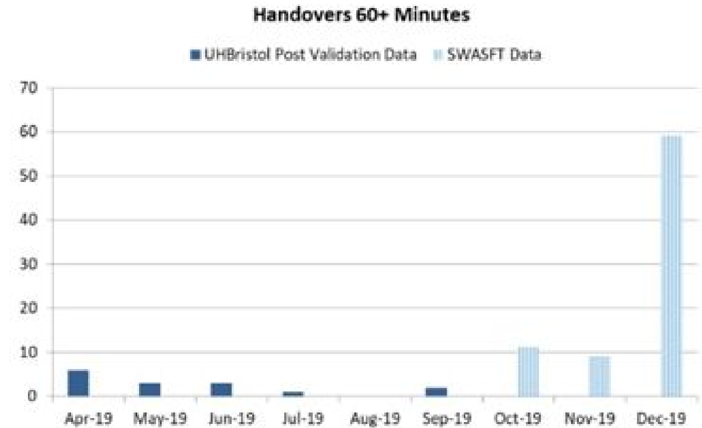


Unbroken horizontal line is England median; dotted lines are upper & lower quartiles

AMBULANCE HANDOVERS

Prior to October 2019, the Trust validated the data from the South West Ambulance Service Foundation Trust (SWASFT) and it was this post-validation data that was reported within UHBristol. This did not tally with the data the Ambulance Service was reporting within their organisation. From October 2019, UHBristol discontinued the validation process and agreed to use the SWASFT data.





Note that there is no national monthly performance return for this data; it is up to the organisations across the system to agree on the correct data source for these measures. This is on the Bristol, North Somerset and South Gloucestershire (BNSSG) A&E Delivery Board agenda. Although data is submitted each day (11am) on the NHSI Daily Situation Report (SitRep), this is only data as at 11am for the previous day, it is for operational purposes and is not necessarily a complete, validated or approved performance dats set.

PERFORMANCE – Responsive Domain

	Attendances		Under 4 Hours		Performance	
	Dec-19	2019/2020	Dec-19	2019/2020	Dec-19	2019/2020
BRI	6385	56295	4049	38610	63.41%	68.59%
Trust	12858	109709	9787	88274	76.12%	80.46%

Emergency Department Attendances

15,000 14,000 13,000 12,000 11,000 10,000 9,000 8,000 7,000 6,000

Apr May Jun Jul Aug Sep Oct Nov Dec Jan Feb Mar

2017/2018 2018/2019 2019/2020

Percentage of Emergency BRI Spells - Patients Aged 75yrs and Over

40% 35% 30% 25% 20% 15% 10% 5% 0%

Apr May Jun Jul Aug Sep Oct Nov Dec Jan Feb Mar

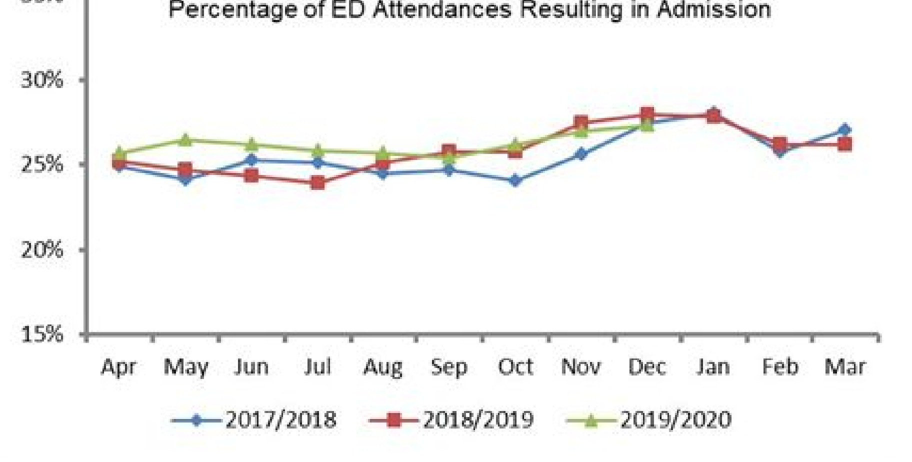
2017/2018 2018/2019 2019/2020

Emergency Inpatient Activity (BRI Discharges)

4,000 3,500 3,000 2,500 2,000 1,500 1,000

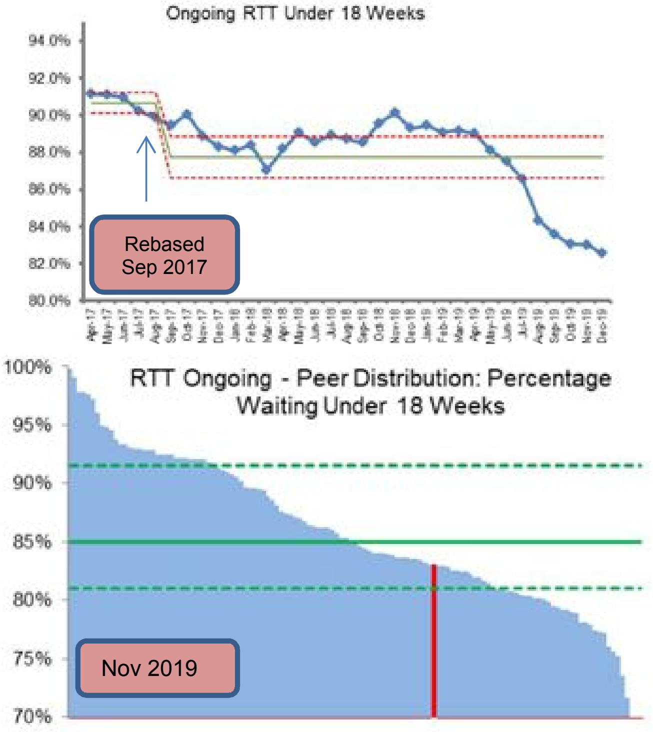
Apr May Jun Jul Aug Sep Oct Nov Dec Jan Feb Mar

2017/2018 2018/2019 2019/2020



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 86.9% for end of December. In addition, no-one should be waiting 52 weeks or over from September 2019.
Performance:	At end of December, 82.5% of patients were waiting under 18 week (28,511 out of 34,539 patients). Ten patients were waiting 52+ weeks
Commentary/ Actions:	The 92% national standard was not met at the end of December and the improvement trajectory of 86.9% was missed. The overall waiting list size has been increasing: from 29,207 at March 2018 to 34,739 as at end of November 2019.December saw the total list size reduce by 200, down to 34539. However there is still an increase of around 6,000 patients that need to be cleared to return the Trust to March 2019 levels. National guidance on the planning assumptions for 2020/21 are still to be published from NHSE/I but local system assumptions are to plan to reduce the total wait list to March 2019 levels during 2020/21. These plans are being worked through as part of the 2020/21 Operational Performance and Planning (OPP) process. At the end of November 2019, the Trust reported ten 52 week waiters: five in Trauma & Orthopaedics, three in Oral Surgery, one in Maxillo Facial Surgery and one in Cardiac Surgery.
Ownership:	Chief Operating Officer



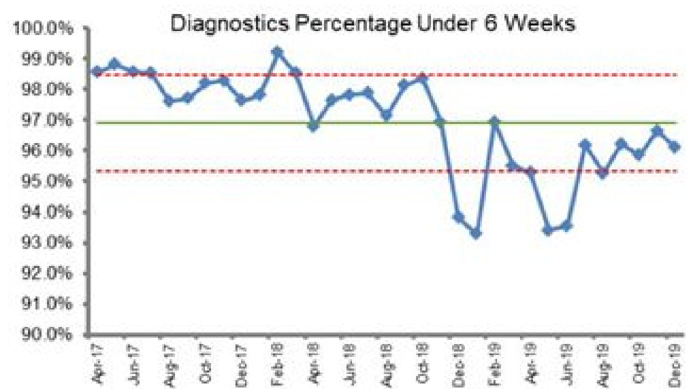
Unbroken horizontal line is England median; dotted lines are upper & lower quartiles

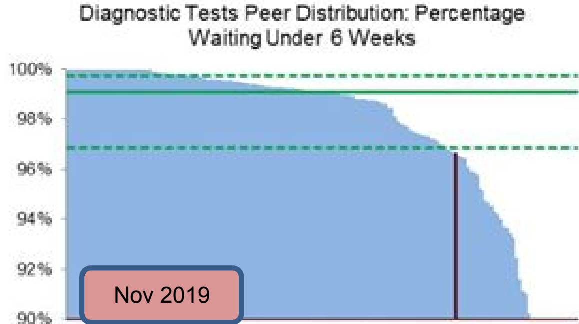
Ongoing Pathways at Dec-19

	Ongoing Pathways	Ongoing Over 18 Weeks	Ongoing Performance
Cardiology	2,692	605	77.5%
Cardiothoracic Surgery	367	94	74.4%
Dermatology	2,327	231	90.1%
ENT	2,131	135	93.7%
Gastroenterology	1,401	91	93.5%
General Medicine	9	0	100.0%
Geriatric Medicine	101	7	93.1%
Gynaecology	1,383	269	80.5%
Neurology	242	14	94.2%
Ophthalmology	4,212	504	88.0%
Oral Surgery	3,536	913	74.2%
Other (Clinical Genetics)	1,135	208	81.7%
Other (Dental)	3,155	789	75.0%
Other (General Surgery)	1,806	455	74.8%
Other (Haem/Onc)	228	23	89.9%
Other (Medicine)	602	25	95.8%
Other (Other)	442	10	97.7%
Other (Paediatric)	6,805	1,348	80.2%
Other (Pain Relief)	87	0	100.0%
Other (Thoracic Surgery)	147	24	83.7%
Plastic Surgery	1	0	100.0%
Rheumatology	575	110	80.9%
Thoracic Medicine	550	61	88.9%
Trauma & Orthopaedics	604	112	81.5%
TOTAL	34,539	6,028	82.5%

PERFORMANCE – Responsive Domain

Diagnostic Waits	
Standards:	Diagnostic tests should be undertaken within a maximum 6 weeks of the request being made. The national standard is for 99% of patients referred for one of the 15 high volume tests to be carried-out within 6 weeks, as measured by waiting times at month-end. The Trust has committed to recovery by Quarter 4 2019/20
Performance:	At end of December, 96.10 % of patients were waiting under 6 weeks (7,613 out of 7,922 patients). There were 309 breaches of the 6-week standard and a maximum of 80 were needed to achieve 99%.
Commentary/ Actions:	The Trust did not achieve the 99% national standard at end of November. • MRI breach volumes are in Paediatrics (75), which is run by the Diagnostics and Therapies division. Two key risks have transpired: firstly that Waiting List Initiatives would not provide the required additional capacity and secondly that an additional list to be provided from November, with Paediatrics, would not be substantive and only runs on an ad-hoc basis. The division are pursuing insourcing options • Adult Endoscopy (145 breaches) only had 1 of the 2 new Clinical Fellow posts commenced. December also saw significant use of the Endoscopy area for escalation capacity for emergency patients, thereby reducing elective capacity for Endoscopy work. Insourcing and Outsourcing capacity will need to be increased to cover this shortfall.
Ownership:	Chief Operating Officer





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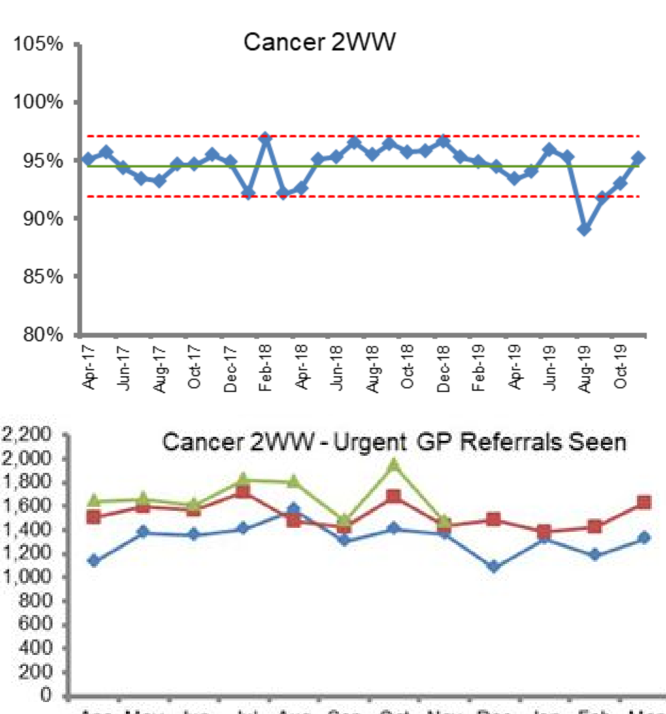
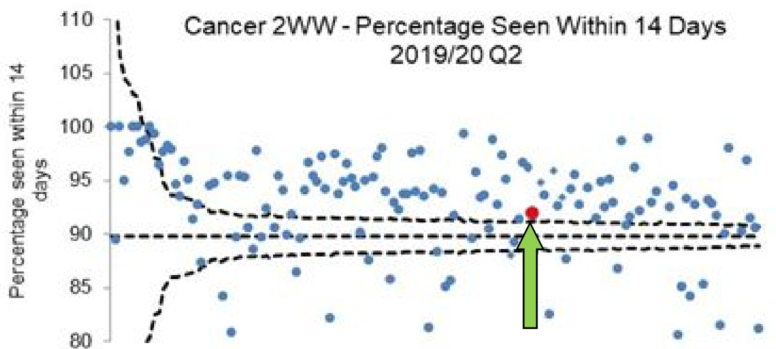
Diagnostic Tests Waiting List at Dec-19	Under 6 Weeks	6+ Weeks	Total Waiting	Percentage Under 6 Weeks
Audiology	353	0	353	100.0%
Colonoscopy	218	70	288	75.7%
CT	1,476	25	1,501	98.3%
Cystoscopy	1	0	1	100.0%
DEXA Scan	222	9	231	96.1%
Echocardiography	943	2	945	99.8%
Flexi Sigmoidoscopy	81	28	109	74.3%
Gastroscopy	219	73	292	75.0%
MRI	1,702	92	1,794	94.9%
Neurophysiology	184	0	184	100.0%
Sleep Studies	141	8	149	94.6%
Ultrasound	2,073	2	2,075	99.9%
Grand Total	**7,613**	**309**	**7,922**	**96.1%**

2.3 PERFORMANCE – Responsive Domain

Cancer Waiting Times – 2WW	
Standards:	Urgent GP-referred suspected cancer patients should be seen within 2 weeks of referral. The national standard is that each Trust should achieve at least 93%
Performance:	For November, 95.2% of patients were seen within 2 weeks (1398 out of 1469 patients). Quarter 1 2019/20 achieved 94.4%. Quarter 2 achieved 92.0%. Quarter 3 (Oct-Nov) is at 93.9%.
Commentary/ Actions:	The standard has been achieved in each quarter since 2018/19 Q1 but was not achieved in 2019/20 Quarter 2, due to unprecedented demand for dermatology (33% increase from the same period last year, also seen at other providers). The standard recovered compliance (93%) in October and compliance has been sustained since.
Ownership:	Chief Operating Officer



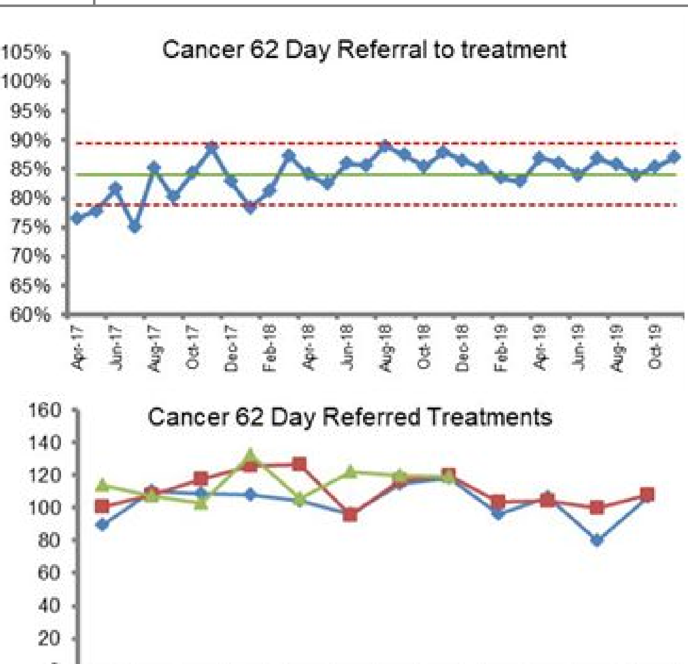


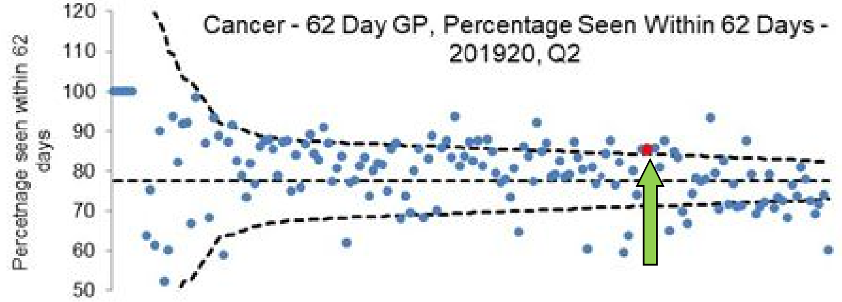
Cancer 2WW - Nov-19

	Under 2 Weeks	Total Pathways	Performance
Suspected children's cancer	16	17	94.1%
Suspected gynaecological cancers	96	101	95.0%
Suspected haematological malignancies e	13	13	100.0%
Suspected head and neck cancers	333	349	95.4%
Suspected lower gastrointestinal cancers	161	183	88.0%
Suspected lung cancer	29	29	100.0%
Suspected sarcomas	1	1	100.0%
Suspected skin cancers	671	683	98.2%
Suspected upper gastrointestinal cancers	78	93	83.9%
Grand Total	**1,398**	**1,469**	**95.2%**

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 November, 87.0% of patients were seen within 62 days (103.5 out of 119 patients). Quarter 1 2019/20 achieved 85.7%. Quarter 2 achieved 85.6%. Quarter 3 (Oct-Nov) is at 86.2%.
Commentary/ Actions:	The Trust achieved compliance in October and November 2019. Winter pressures remain a significant risk to sustaining compliance throughout winter. High levels of cancellations, for both ward and critical care beds, were incurred in December and early January. In addition, the use of day-case procedure areas as escalation capacity has impacted on timescales for some cancer diagnostics and day case treatments. Winter pacing, whereby the number of elective surgeries per day is restricted to mitigate the risks around emergency patient flow, has also impacted performance against the standard by reducing capacity for cancer procedures. Operational teams continue to work proactively to manage optimally within these restrictions, to minimise delays.
Ownership:	Chief Operating Officer



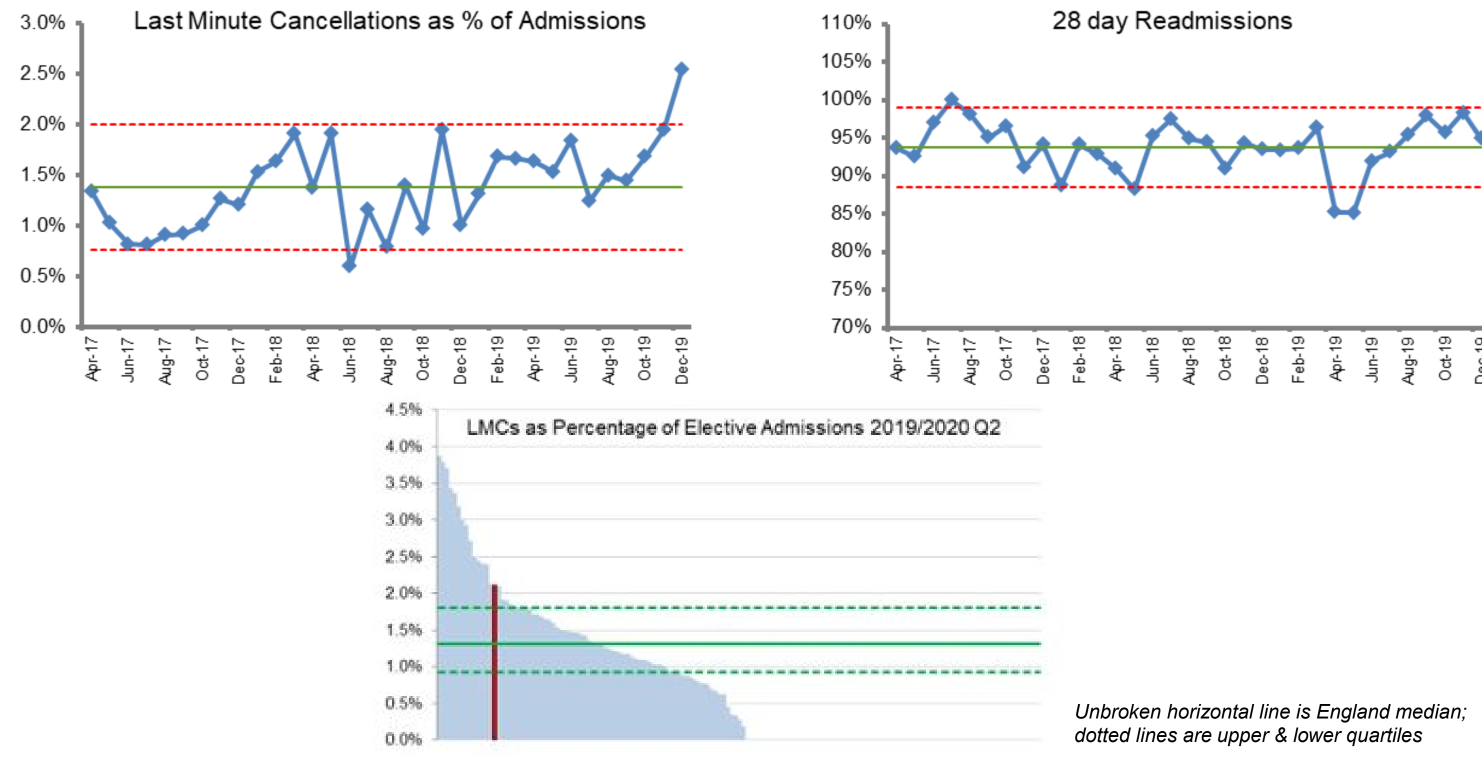


Cancer 62 Day - Nov-19

	Within Target	Total Pathways	Performance
Breast	3.5	3.5	100.0%
Gynaecological	1.0	2.0	50.0%
Haematological	6.0	8.0	75.0%
Head and Neck	7.0	12.0	58.3%
Lower Gastrointestinal	9.5	11.5	82.6%
Lung	9.0	9.5	94.7%
Other	1.0	2.0	50.0%
Sarcoma	2.5	3.5	71.4%
Skin	50.5	51.5	98.1%
Upper Gastrointestinal	9.5	11.5	82.6%
Urological	4.0	4.0	100.0%
Grand Total	**103.5**	**119.0**	**87.0%**

PERFORMANCE – Responsive Domain

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 December there were 153 last minute cancellations, which was 2.54% of elective admissions. Of the 137 cancelled in November, 130 (94.9%) had been re-admitted within 28 days. This means seven patients breached the 28 day readmission standard.
Commentary/ Actions:	The most common reason for cancellation was “No Beds Available” (54 cancellations). Overall there were 8 in Medicine, 29 in Cardiac Services, 12 in ENT & Thoracics, 27 in Gastrointestinal Surgery, 36 in Ophthalmology, 4 in Trauma & Orthopaedics, 12 in Dental Services, 9 in Gynaecology and 16 in Paediatrics. The 28 day breaches were in Trauma & Orthopaedics (2), Gastrointestinal Surgery (2), Paediatrics (2) and Gynaecology (1),
Ownership:	Chief Operating Officer



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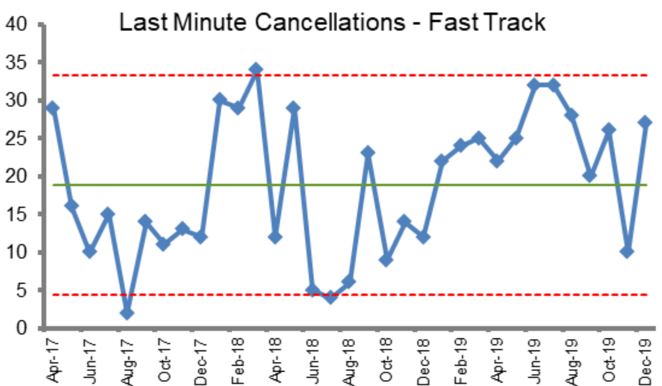
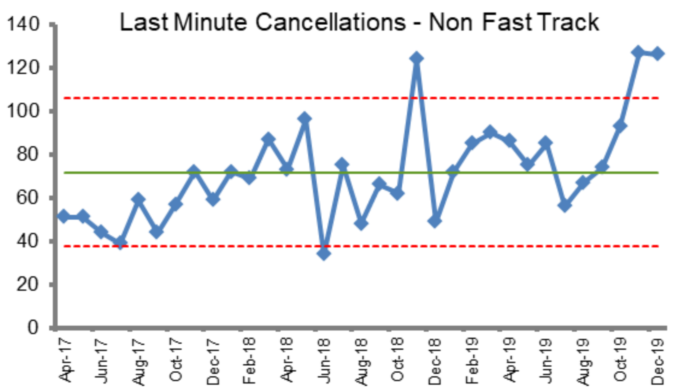
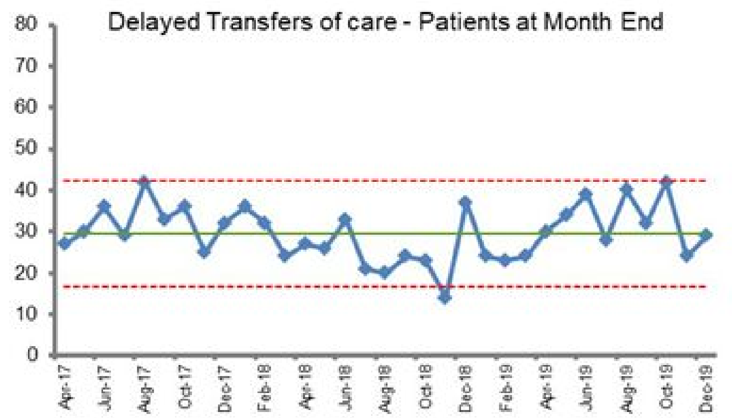


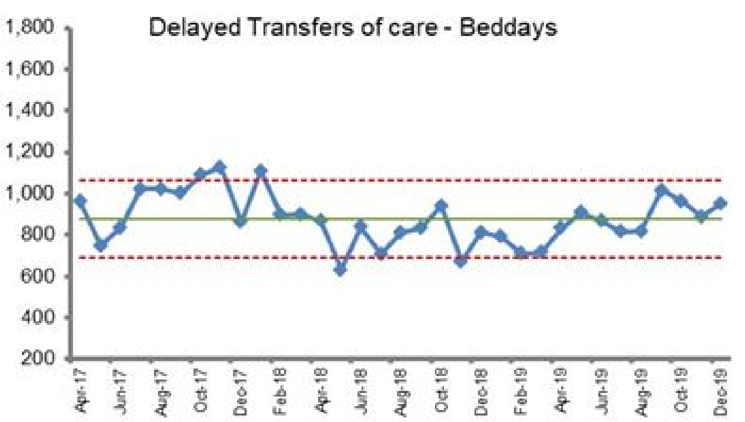


Cancellation Reason	Fast Track	Routine	Urgent	TOTAL
No Beds Available	16	18	20	54
Other Emergency Patient Prioritised	0	7	11	18
No Theatre Staff	0	13	2	15
Surgeon Taken Ill	1	10	4	15
Booking Error	1	6	3	10
Surgeon Unavailable	0	7	1	8
AM list over-ran	1	3	4	8
No HDU Beds	4	1	1	6
Equipment Unavailable	0	3	0	3
No Recovery Staff	1	2	0	3
Other clinically complicated Patient in theatre	2	1	0	3
No ITU Beds	1	2	0	3
Equipment Failure	0	2	0	2
Theatre Repairs required	0	2	0	2
Nurse Prac Unavailable	0	1	0	1
PAS-only Error	0	1	0	1
List did not start on time	0	1	0	1
TOTAL	**27**	**80**	**46**	**153**

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 December there were 29 Delayed Transfer of Care patients as at month-end (including 8 at South Bristol), and 951 beddays consumed by DToC patients.
Commentary/ Actions:	The Integrated Care Bureau (ICB) handled 294 SRF’s (Single Referral Forms) in December. 72 patients were referred to Homefirst, 33 for Pathway 2 and 6 for Pathway 3. The ICB also manages SRF’s for North Somerset, South Gloucestershire and Weston equating to 61 patients in December 2019. Care Home Selection has managed 11 self-funding patients in December 2019, with a turnaround time ranging from 24 hours to 12 days. This is helping reduce delays for patients awaiting long term care (either home or an intermediate care setting). North Somerset delays continue as a result of increased admissions from Weston’s Emergency Department.
Ownership:	Chief Operating Officer

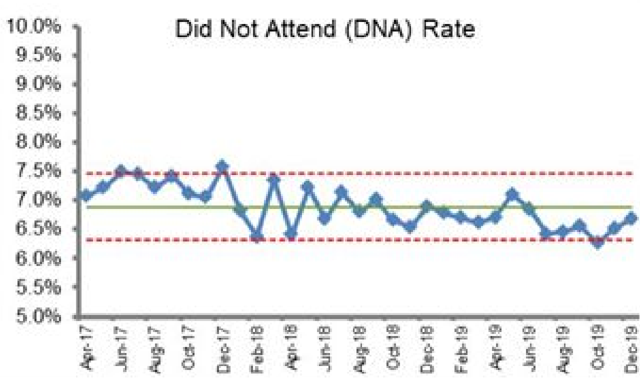


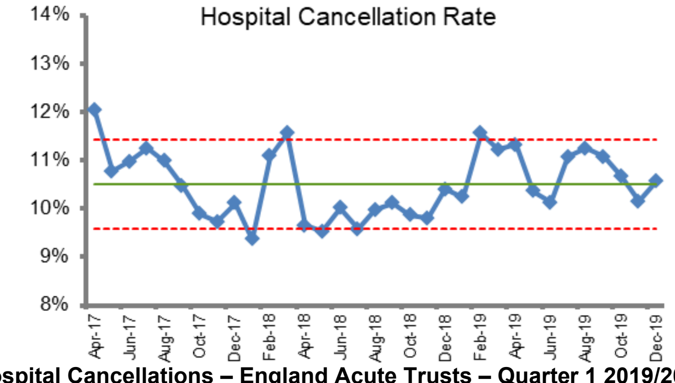


Code	Reason	Accountable	Dec-19 Patients (Acute)	Beddays (Acute)	Patients (Non-Acute)	Beddays (Non-Acute)
A	Completion of assessment	Both	3	115	2	43
		NHS	1	56	1	29
		Social Care	4	166	0	1
C	Further non acute NHS care	NHS	1	14	0	0
Di	Care Home Placement	NHS	0	9	0	5
		Social Care	1	29	0	9
Dii	Care Home Placement	NHS	1	51	0	0
		Social Care	3	53	1	20
E	Care package in own home	NHS	1	46	0	0
		Social Care	6	191	4	113
F	Community equipment / adaptions	Both	0	1	0	0
TOTAL			21	731	8	220

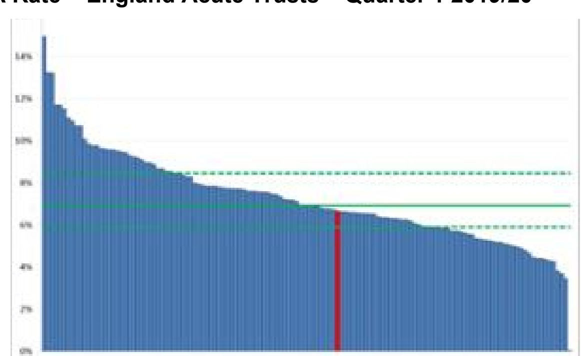
2.3 PERFORMANCE – Responsive Domain

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 December there were 8,952 hospital-cancelled appointments, which was 10.6% of all appointments made. There were 4,003 appointments that were DNA'ed, which was 6.7% of all planned attendances.
Commentary/ Actions:	No update this month. A new Outpatient Services Manager starts with the Trust from the beginning of February. Last month's commentary is included below: 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. In May 2019, the text message sent to patients as a reminder was standardised and the cost of a DNA and patient initials for paediatric patients were included. This has reduced the DNA rated further. There is ongoing work to include the location code for the clinic so that patients can see which clinic they need to attend without the need of the original appointment letter. 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.
Ownership:	Chief Operating Officer

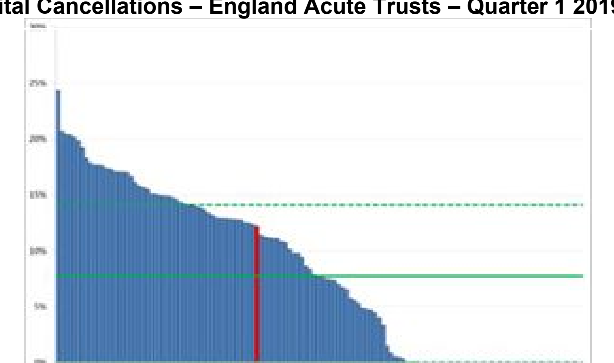




DNA Rate – England Acute Trusts – Quarter 1 2019/20



Hospital Cancellations – England Acute Trusts – Quarter 1 2019/20

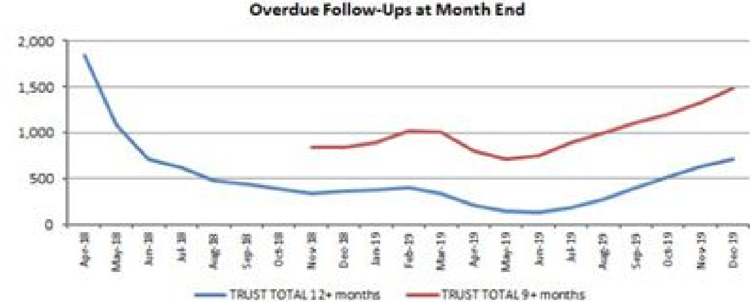


Unbroken horizontal line is England median; dotted lines are upper & lower quartiles

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 December, number overdue by 12+ months is 713 and overdue by 9+ months is 1485.
Commentary/ Actions:	The focus remains on two specialties: Trauma & Orthopaedics and Clinical Genetics. All other areas have cleared the 9+ month backlog and are focussed on the 6-8 month cohort. Plans are being worked through, via the weekly performance meetings, for the two specialties to achieve clearance of the backlogs during Quarter 4. Please note that although there is an increase in these volumes it is confined to two specialties with known capacity issues. The Trust overall has made significant improvements since 2017 when the numbers overdue by 6+ months stood at 9,000.
Ownership:	Chief Operating Officer

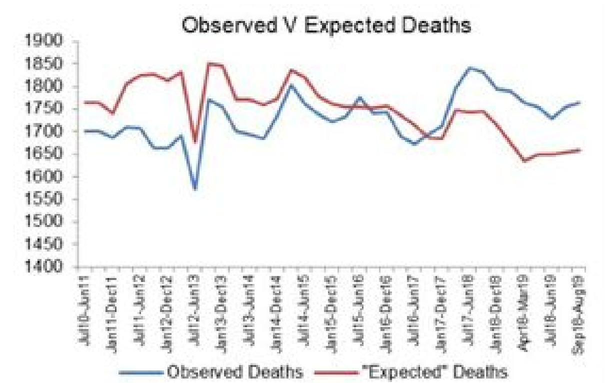
		Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19
Outpatients Overdue by 12+ Months	Diagnostics and Therapies	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	Medicine	461	133	23	5	7	3	3	2	3	4	3	3	3	3	3	3	3	3	1	1	1
	Specialised Services	188	206	214	208	95	58	67	7	5	8	12	0	0	34	62	90	136	183	274	321	348
	Surgery	444	221	92	17	3	0	0	0	0	11	23	49	61	62	66	91	135	214	243	309	362
	Women's and Children's	756	526	387	387	371	375	322	323	350	351	360	282	150	46	3	0	2	2	5	2	2
	TRUST TOTAL 12+ months	**1,849**	**1,086**	**716**	**617**	**476**	**436**	**392**	**332**	**358**	**374**	**398**	**334**	**214**	**145**	**134**	**184**	**276**	**402**	**523**	**633**	**713**
Outpatients Overdue by 9+ Months	Diagnostics and Therapies								3	2	0	0	0	0	0	2	0	0	0	0	0	0
	Medicine								20	4	4	3	4	4	3	3	4	4	5	5	6	7
	Specialised Services								125	95	142	247	253	181	261	278	323	392	450	503	536	569
	Surgery								125	124	108	146	216	264	272	333	450	499	586	630	724	858
	Women's and Children's								565	620	640	629	530	349	174	128	111	101	66	62	61	51
	TRUST TOTAL 9+ months								**838**	**845**	**894**	**1025**	**1003**	**798**	**710**	**744**	**888**	**996**	**1107**	**1200**	**1327**	**1485**

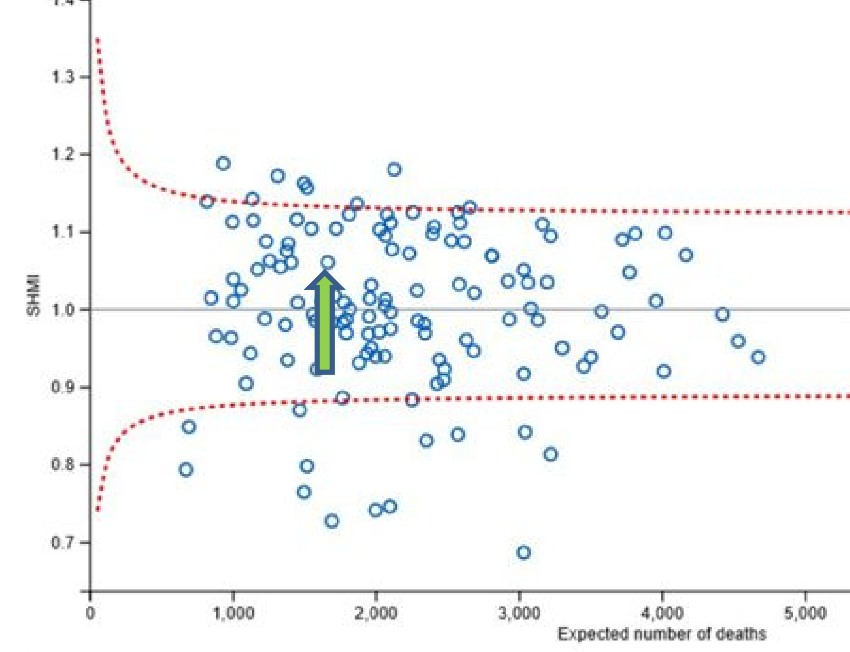


PERFORMANCE – Effective Domain

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 now published monthly and covers a rolling 12 –month period. Data is published 6 months in arrears.
Performance:	Latest SHMI data is for 12 month period September 2018 to August 2019. The SHMI was 106.1 (1765 deaths and 1660 “expected”). The Trust is in NHS Digital’s “As Expected” category.
Commentary/ Actions:	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

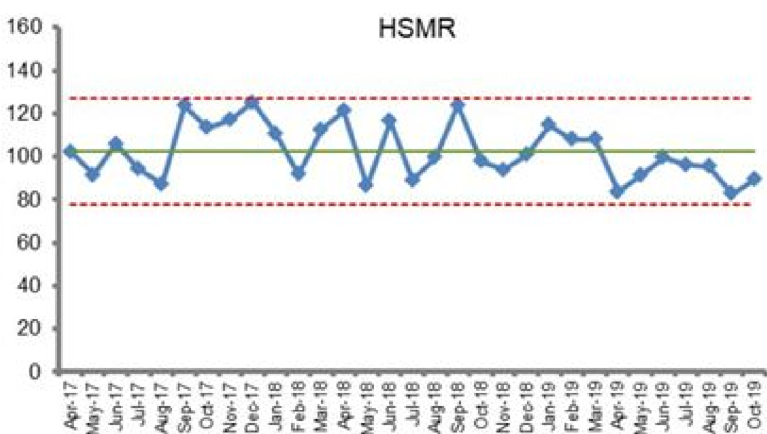
Timeframe	Observed Deaths	"Expected" Deaths
Oct15-Sep16	1,741	1,752
Jan16-Dec16	1,743	1,758
Apr16-Mar17	1,690	1,737
Jul16-Jun17	1,674	1,714
Oct16-Sep17	1,693	1,686
Jan17-Dec17	1,712	1,684
Apr17-Mar18	1,796	1,748
Jul17-Jun18	1,841	1,744
Oct17-Sep18	1,833	1,745
Jan18-Dec18	1,795	1,715
Mar18-Feb19	1,790	1,675
Apr18-Mar19	1,765	1,635
Jun18-May19	1,755	1,650
Jul18-Jun19	1,730	1,650
Aug18-Jul19	1,755	1,655
Sep18-Aug19	1,765	1,660

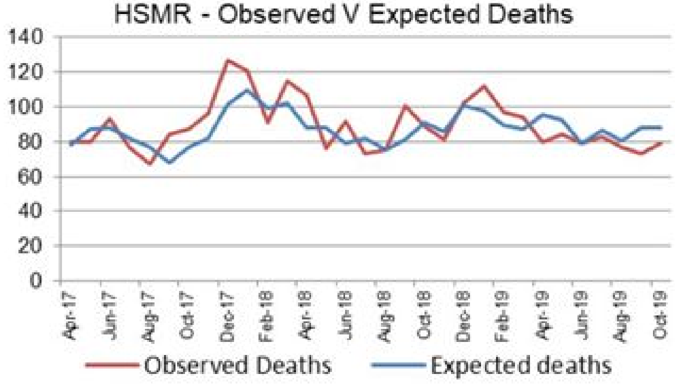




2.4 PERFORMANCE – Effective Domain

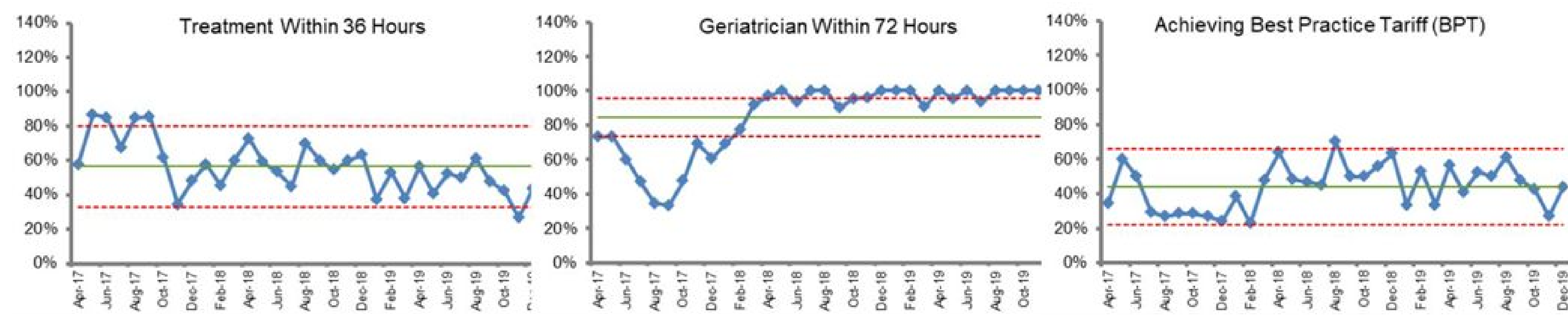
Mortality – Hospital Standardised Mortality Ratio (HSMR)	
Standards:	This is the national measure published by Dr Foster .It is the number of actual deaths divided by "expected" deaths, multiplied by 100. The Hospital Standardised Mortality Ratio (HSMR) is in-hospital deaths for conditions that account for 80% of hospital deaths
Performance:	Latest HSMR data is for October 2019. The HSMR was 89.5 (79 deaths and 88 "expected")
Commentary/ Actions:	Reported HSMR is from CHKS (Capita Health Knowledge System) and is subject to annual rebasing. 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





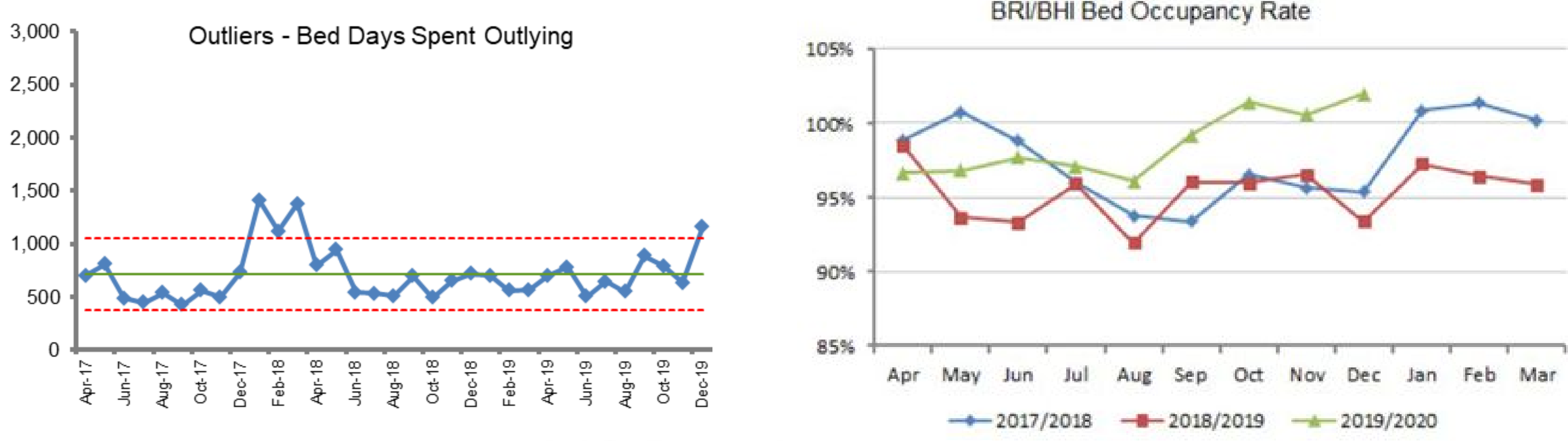
2.4 PERFORMANCE – Effective Domain

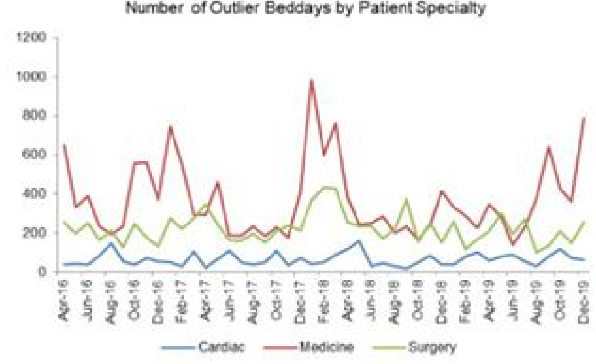
Fracture Neck of Femur	
Standards:	Best Practice Tariff (BPT), is a basket of indicators covering eight elements of what is considered to be best practice in the care of patients that have fractured their hip. 90% of patients should achieve Best Practice Tariff. Two key measures are being treated within 36 hours and seeing an orthogeriatrician within 72 hours. Both these measures should achieve 90%.
Performance:	In December, there were 26 patients discharged following an admission for fractured neck of femur. Of these, 23 were eligible for Best Practice Tariff (BPT). For the 36 hour target, 44% (10 patients) were seen with target. For the 72 hour target, all 23 patients (100%) were seen within target. Therefore 10 patients (44%) achieved all elements of the Best Practice Tariff.
Commentary/ Actions:	Ongoing Actions: • Recruitment to two additional Trauma & Orthopaedic consultants is currently underway. One consultant is now in post with the second consultant due to start 27th January 2020. This will release trauma list cover and enable on-call cover to move from 1:10 to 1:12 with further plans for PAs to be released to create 1:14 rota. However, due to the resignation of another consultant, the rota will only be 1:11 until the posts are all fully recruited to. Interviews to replace this consultant who has recently resigned are set for 12th March 2020. • Both of the newly appointed surgeons will have a sub-specialism in hips, whereas at the moment we only have one. Having more consultants available who specialise in hip surgery will mean there will be more flexibility in terms of staffing theatres with the appropriate operating skills and enabling hip surgery to happen more flexibly. • A job planning meeting has been held with the orthopaedic consultant body and there are plans for the job plans to be amended to provide more consistent trauma consultant cover. This will be enacted in early 2020 in line with the start date of the newly appointed consultant. We have appointed a deputy clinical director who has been asked to focus on job plans which will give the dedicated time to ensure this is enacted as soon as possible. • The change to the on-call rotas (that will happen upon the implementation of the new job plans) will mean a team based approach to on call, providing more sub- speciality availability on any given day/week for trauma cover. Therefore, hip fracture patients are more likely to be operated on in a more timely manner, rather than having to wait for a consultant with the appropriate sub-specialty interest to be available. • The appointment of additional consultants, along with the re job planning of the remaining consultants, will enable all day operating lists to be organised for trauma, which will increase efficiency and enable more cases to be carried out on a given day. There will also be flexibility to split the lists on a given day, if it were to be more productive to provide two sub-specialist consultants on the same day, depending on the patient casemix. • A third ortho-geriatric consultant has been appointed to support silver trauma and is now in post. This is supporting the silver trauma wards with patient care and flow and is already evident in our performance regarding the 100% achievement of being reviewed by ortho geriatrician.
Ownership:	Medical Director



PERFORMANCE – Effective Domain

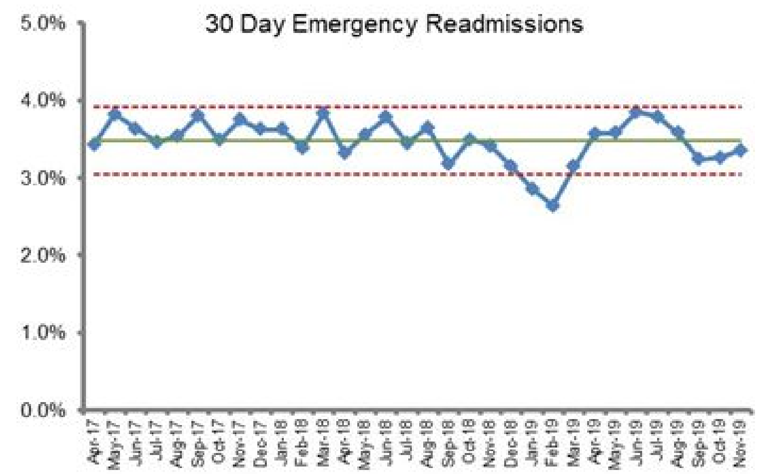
Outliers	
Standards:	This is a measure of how many bed-days patients spend on a ward that is different from their broad treatment speciality: medicine, surgery, cardiac and oncology. Our target is a 15% reduction which equates to a 9029 bed-days for the year with seasonally adjusted quarterly targets.
Performance:	In December there were 1164 outlying beddays (1 bedday = 1 patient in a bed at 12 midnight).
Commentary/ Actions:	The December target of no more than 705 beddays was not achieved. Of all the outlying beddays 787 were Medicine patients, 114 were Specialised Services patients and 254 were Surgery patients. 251 beddays were patients outlying overnight in Escalation capacity in Queens' Day Unit (A414). This was an average of 8 beds per day.
Ownership:	Chief Operating Officer





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 November, there were 13,542 discharges, of which 454 (3.35%) had an emergency re-admission within 30 days.
Commentary/ Actions:	7.9% of Medicine division discharges were re-admitted within 30 days as an emergency, 3.5% from Surgery and 1.6% from Specialised Services. Data is monitored on a regular basis through divisional performance reviews and is included on the speciality performance reports.
Ownership:	Chief Operating Officer

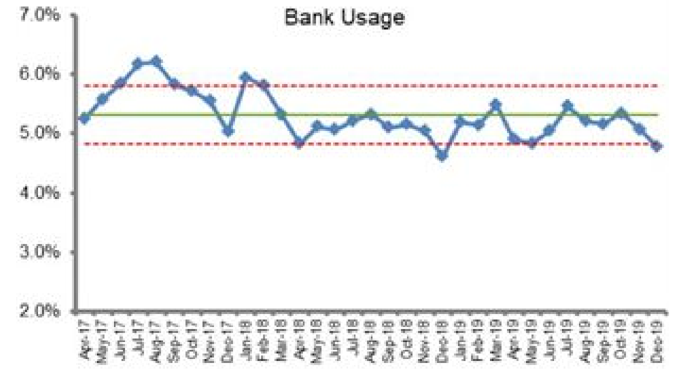


Discharges in November 2019

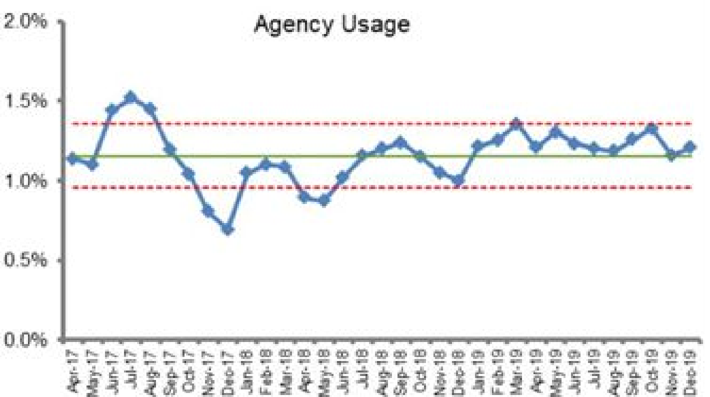
Division	Emergency Readmits (All)	Total Discharges	% Emergency Readmits (All)
Diagnostics and Therapies	1	33	3.03%
Medicine	219	2,788	7.86%
Specialised Services	46	2,893	1.59%
Surgery	121	3,512	3.45%
Women's and Children's	67	4,316	1.55%
Grand Total	**454**	**13,542**	**3.35%**

2.5 PERFORMANCE – Efficient Domain

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 December 2019, total staffing was at 9148 FTE. Of this, 4.8% was Bank (436 FTE) and 1.2% was Agency (110 FTE).
Commentary/ Actions:	**Agency usage** increased by 4.0 FTE. The largest reduction was seen in the division of Women's and Children's, decreasing to 12.9 FTE from 12.8 FTE the previous month. The largest increase was seen in the division of Medicine, increasing to 55.4 FTE compared to 49.7 FTE in the previous month. The largest staff group reduction was within Nursing and Midwifery staff reducing to 91.4 FTE compared to 94.8 FTE in the previous month. The largest staff group increase was within Medical staff increasing to 8.0 FTE compared to 3.3 FTE in the previous month. **Bank usage** reduced by 29.4 FTE. All divisions reduced bank usage. The largest reduction was seen in the division of Surgery, decreasing to 96.2 FTE from 105.7 FTE the previous month. All staff groups reduced bank usage, the largest reduction was within Nursing and Midwifery staff reducing to 289.9 FTE compared to 304.0 FTE in the previous month. ▪ Significant pressures across the healthcare system have seen an increased demand for temporary staff. ▪ Work is ongoing with BNSSG&B partners to drive down the cost of nurse agency supply which has been challenged with the operational pressures being experienced. As a result, an increase in high cost nurse agency supply has been seen in the last month, but still within the approved exclusion areas. Focus remains on improving supply from lower cost Tier 1 agency suppliers. ▪ The Autumn/Winter Staff Bank recruitment campaign continues to increase the available Bank pool across all staff groups. The last month has seen 16 new NA's, 4 RN's, 4 AHP's, 12 A&C & 4 HSA's appointed to the Bank. ▪ The Out of Hours Staff Bank service in Weston has been provided by UHBristol Temporary Staffing Bureau since August 2019. A smooth and successful operational transition has been seen. UHBristol with effect from January 2020 will take on Weston's Nurse Bank service. The creation of a non-clinical Bank for Weston is underway with a planned implementation date of 1 April 2020.
Ownership:	Director of People



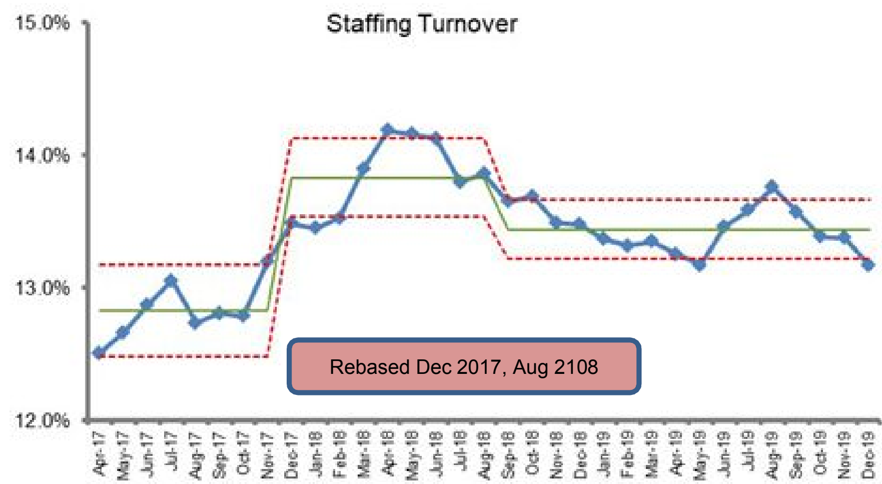
Bank	Dec FTE	Dec Actual %	KPI
UH Bristol NHS Foundation Trust	**436.3**	4.8%	**4.4%**
Diagnostics & Therapies	12.8	1.2%	1.5%
Medicine	125.6	9.1%	9.4%
Specialised Services	59.1	5.5%	5.9%
Surgery	96.2	5.2%	4.6%
Women's & Children's	66.1	3.1%	1.4%
Trust Services	31.7	3.7%	3.5%
Facilities & Estates	44.9	6.0%	6.4%



Agency	Dec FTE	Dec Actual %	KPI
UH Bristol NHS Foundation Trust	**110.4**	**1.2%**	**0.7%**
Diagnostics & Therapies	8.5	0.8%	0.9%
Medicine	55.4	4.0%	1.6%
Specialised Services	11.2	1.0%	1.2%
Surgery	22.1	1.2%	0.3%
Women's & Children's	12.9	0.6%	0.3%
Trust Services	0.0	0.0%	0.8%
Facilities & Estates	0.3	0.0%	0.5%

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 December 2019, there had been 955 leavers over the previous 12 months with 7252 FTE staff in post on average over that period; giving a Turnover of 955 / 7252 = 13.2%.
Commentary/ Actions:	Turnover reduced to 13.2% from 13.4% last month, 1 division saw an increase in turnover whilst 5 divisions saw a reduction in turnover. The largest divisional increase was seen within Specialised Services increasing to 15.4% from 15.1% the previous month. The largest divisional reduction was seen within Facilities and Estates reducing to 12.4% from 13.0% the previous month. The biggest reduction in staff group was seen within Nursing and Midwifery Unregistered (1.3 percentage points). The largest increase in staff group was seen within Healthcare Scientists (0.7 percentage points). ▪ Reasons for leaving continue to be reviewed through the Exit Questionnaire. Response rates have slowed during December and January and so further promotion is planned. ▪ The 2019 National Staff Survey closed on 29 November 2019 with a provisional response rate of 55%; a 3% increase on 2018 Staff Survey, with 5123 staff taking time to complete the survey. Staff survey results are embargoed until 6 March at which point heat-maps will also be released for the development of future culture and staff engagement plans at both corporate and local levels. ▪ The launch of the NHSI Retention Programme commences in January with revised policies and guides on Flexible Working, Retirement Options, Internal Transfers and Career Development (initially focussing on NAs) . These will be supported by staff stories where individuals have been supported through various flexible options, allowing them to successfully remain with the organisation.
Ownership:	Director of People



Turnover	Dec-19	KPI
UH Bristol NHS Foundation Trust	13.2%	**13.1%**
Diagnostics & Therapies	12.2%	11.0%
Medicine	15.9%	14.2%
Specialised Services	15.4%	13.9%
Surgery	13.0%	12.7%
Women's & Children's	11.5%	11.6%
Trust Services	13.1%	15.0%
Facilities & Estates	12.4%	15.7%

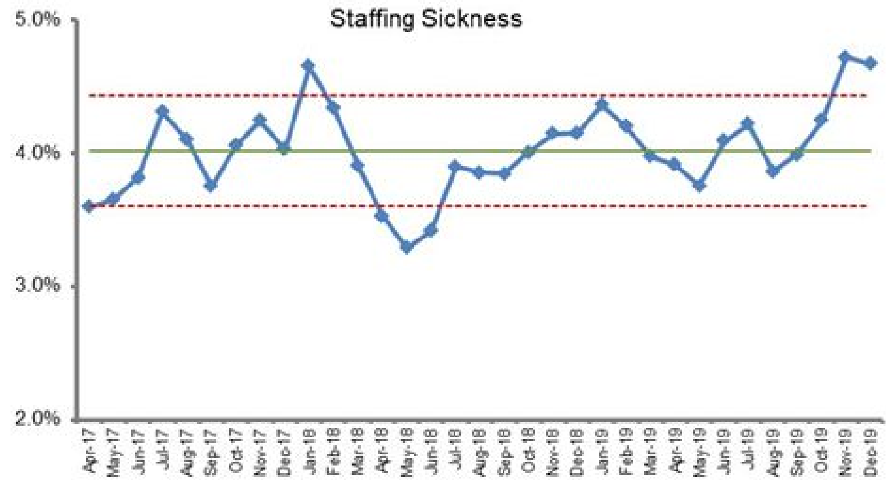
2.5 PERFORMANCE – Efficient Domain

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 December 2019, funded establishment was 8982 FTE, with 381 FTE as vacancies (4.2%).
Commentary/ Actions:	Overall vacancies increased to 4.2% compared to 4.1% in the previous month. The largest staff group increase was seen within Nursing staff increasing to 199.5 FTE from 187.0 FTE the previous month. There were two staff groups with reductions; the largest was in Ancillary staffing, which reduced to 78.1 FTE from 81.4 FTE the previous month. Trust Services had the largest Divisional reduction to 45.3 FTE from 47.8 FTE the previous month. ▪ Focus remains across all staff groups to ensure there are proactive approaches and responses to the supply pipeline needs. ▪ Specically in the last month: o 3 Return to Practice candidates were appointed, starting the programme in January. o TNA assessment centre held with a cohort of 12 TNAs set to join the Trust in February. o ED Middle Grade recruitment campaign went live with a bespoke campaign site. o ED Nurse specific advert went live to fill 22 vacancies. Interviews set for the end of January. ▪ Collaboration with NBT is focused on shared recruitment initiatives, marketing through social media and the nurse pipeline. ▪ UHB are participating in a key expert group including all of the large London trusts to help shape the development of a new candidate portal to improve the candidate on-boarding experience and better streamline processes through the TRAC recruitment system. Anticipated go live is planned for the end of 2020. • Scoping to introduce a Skype booth within the Resourcing Service to support an increased digital approach to interviews
Ownership:	Director of People

Vacancy	Dec-19	KPI
UH Bristol	4.2%	5.0%
Diagnostics & Therapies	4.5%	5.0%
Medicine	4.7%	5.0%
Specialised Services	4.2%	5.0%
Surgery	5.3%	5.0%
Women's & Children's	0.7%	5.0%
Trust Services	5.1%	5.0%
Facilities & Estates	9.1%	5.0%

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 December, total available FTE days were 266,955 of which 12,445 (4.7%) were lost to staff sickness.
Commentary/ Actions:	Sickness absence remained static at 4.7% compared with the previous month, with increases in three divisions. The division of Specialised Services saw the greatest increase, rising from 3.7% last month to 4.5%. Diagnostic and Therapies and Surgery saw the Largest divisional reductions, both reducing 0.5% compared to previous month. The largest staff group increase was seen in Additional Clinical Services, where sickness increased to 6.7% compared with 6.4% the previous month. The largest staff group reduction was seen within Allied Healthcare Professionals, reducing to 2.5% from 3.2% the previous month. ▪ The delivery of targeted wellbeing support was seen through ten workshops held in December. ▪ Development of an e-learning session on ‘stress awareness & self-care’ continues which will be available from March 2020. ▪ eLearning for Supporting Attendance approved and ready for launch. Promotion of this is to commence at the end of January. Programme of face to face training sessions to be confirmed in February. This will replace most ad hoc sessions, but these will still be available where necessary.
Ownership:	Director of People



Sickness	Dec-19	KPI
UH Bristol	4.7%	**4.0%**
Diagnostics & Therapies	3.4%	3.2%
Medicine	5.7%	4.6%
Specialised Services	4.6%	3.6%
Surgery	4.5%	3.6%
Women's & Children's	4.2%	4.1%
Trust Services	3.6%	2.8%
Facilities & Estates	7.9%	6.4%

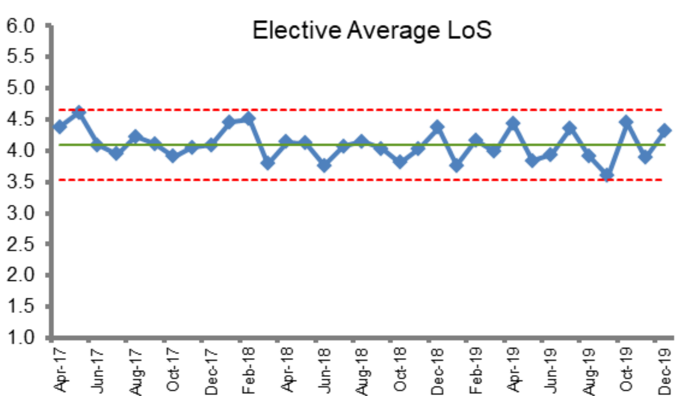
PERFORMANCE – Efficient Domain

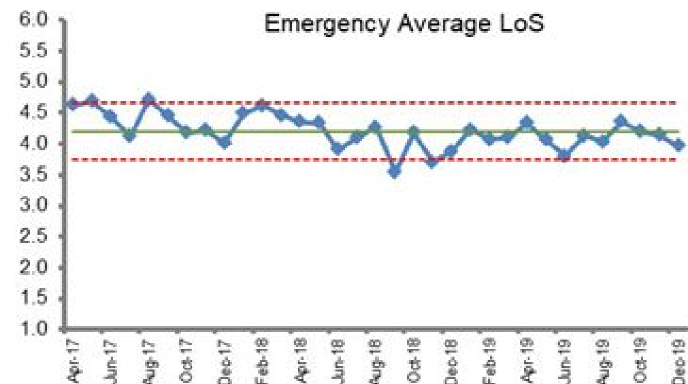
<table>
<tr><th colspan="2">Staff Appraisal</th></tr>
<tr><td>Standards:</td><td>Staff Appraisal in measured as a percentage of staff excluding consultants who have had their appraisal signed-off.
The target is 85% Trust-wide.</td></tr>
<tr><td>Performance:</td><td>In December 2019, 5,925 members of staff were compliant out of 8,370 (70.8%).</td></tr>
<tr><td>Commentary/ Actions:</td><td>Overall appraisal compliance remained static at 70.8%. There were increases in two of the divisions.
The largest divisional reductions were seen within Diagnostics and Therapies, reducing to 72.9% from 74.2% the previous month.
The largest divisional increases were seen within Specialised Services, increasing to 79.5% from 75.9% the previous month.
All divisions are non-compliant.
The appraisal recovery plan remains in place. The focus of action includes:
• Areas of low compliance including direct interventions at manager and service level
• Attendance at local meetings across the organisation
• Review of attendance at the Trust Appraisal training to enable, particularly where there is a link to low compliance
• Ongoing development of supporting tools for managers; including how to write SMART objectives
• A dedicated appraisal inbox where real time feedback can be responded to and actioned upon
• The programme of work overseeing the new nationally mandated rules for Pay Progression continues, with immediate focus commencing on the small number of staff for whom this effects in 2020. Toolkits, guides and associated policies are being developed/refined and will form part of the Trust wide communication plan for these changes.</td></tr>
<tr><td>Ownership:</td><td>Director of People</td></tr>
</table>

Appraisal (Non-Consultant)	Dec-19	Nov-19	KPI
UH Bristol NHS Foundation Trust	70.8%	70.8%	**85.0%**
Diagnostics & Therapies	72.9%	74.2%	85.0%
Medicine	67.6%	68.8%	85.0%
Specialised Services	79.5%	75.9%	85.0%
Surgery	64.3%	64.4%	85.0%
Women's & Children's	71.7%	72.9%	85.0%
Trust Services	67.6%	67.9%	85.0%
Facilities & Estates	75.0%	72.7%	85.0%

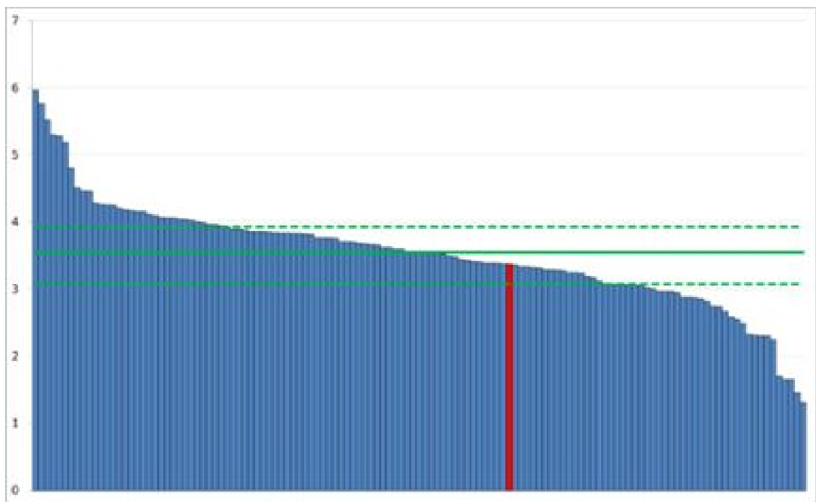
PERFORMANCE – Efficient Domain

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 December there were 6,828 discharges that consumed 25,571 beddays, giving an overall average length of stay of 3.75 days.
Commentary/ Actions:	The Operational Planning process is underway for 2020/21. As part of that, divisions will be reviewing contract plans for next year and what the impact is likely to be on bed requirements. Any bed gaps will then need to be closed by additional capacity, demand management or improved length of stay. This process is ongoing
Ownership:	Chief Operating Officer





Average Length of Stay – England Trusts - 2019/20 Quarter 1



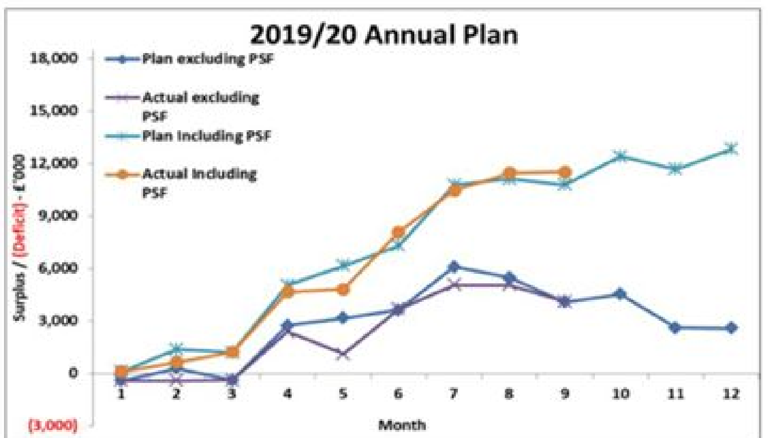
Unbroken horizontal line is England median; dotted lines are upper & lower quartiles

Length of Stay of Inpatients at month-end

Sep-19	7+ Days	14+ Days	21+ Days	28+ Days
Bristol Children's Hospital	62	45	35	31
Bristol Haematology & Oncology Centre	20	11	6	6
Bristol Royal Infirmary	219	126	90	65
South Bristol Hospital	58	51	43	35
St Michael's Hospital	23	15	13	12
TRUST TOTAL	383	248	187	149

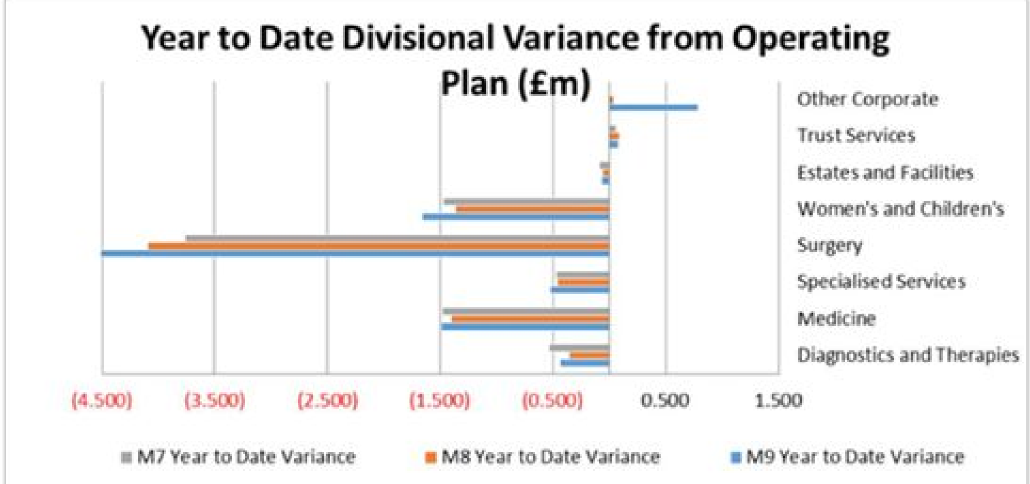
Bristol Royal Infirmary Divisional Breakdown:

Medicine	129	81	65	48
Specialised Services	38	22	13	8
Surgery, Head & Neck	52	23	12	9

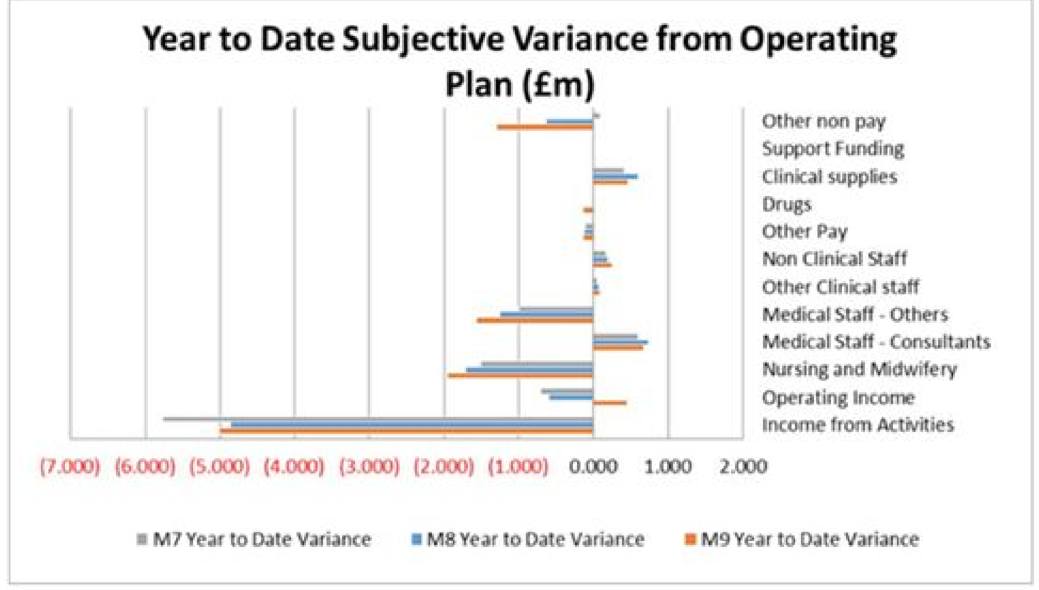


Public Board Meeting - January 2020-30/01/20 - Page 196

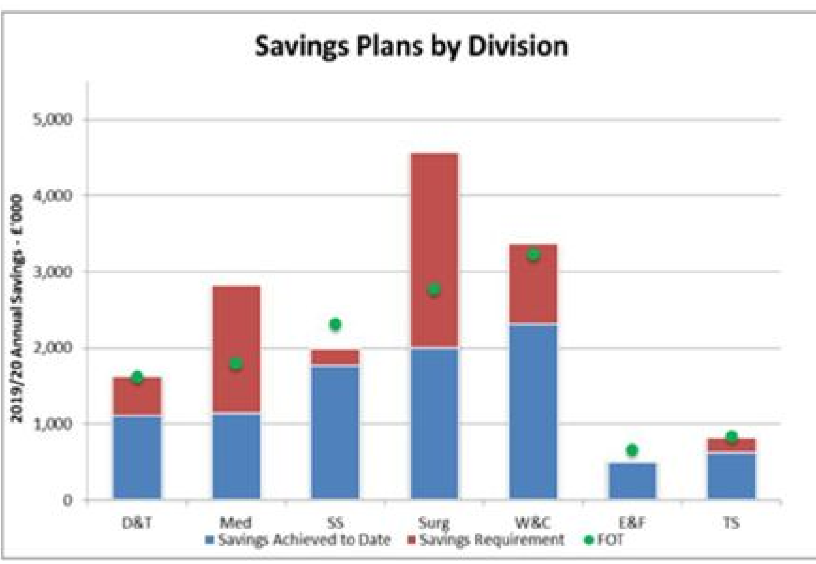
2.6 FINANCIAL PERFORMANCE

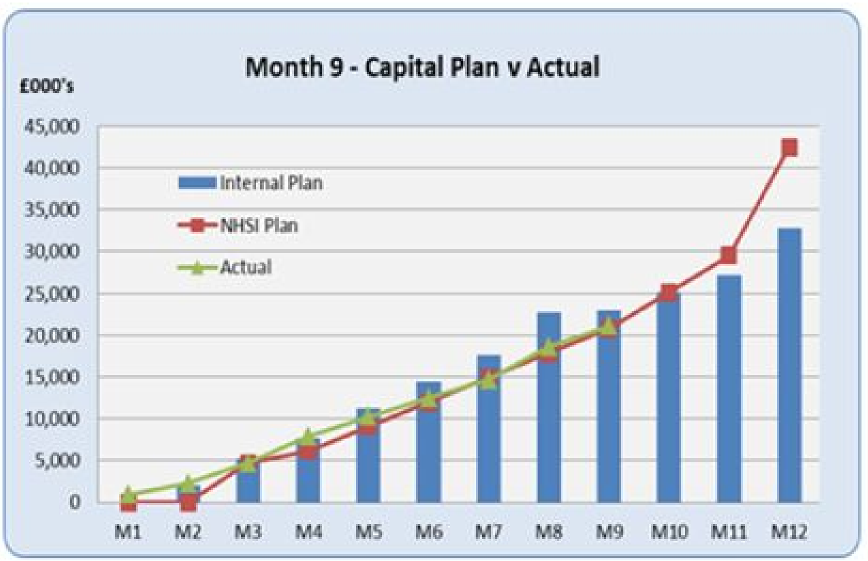


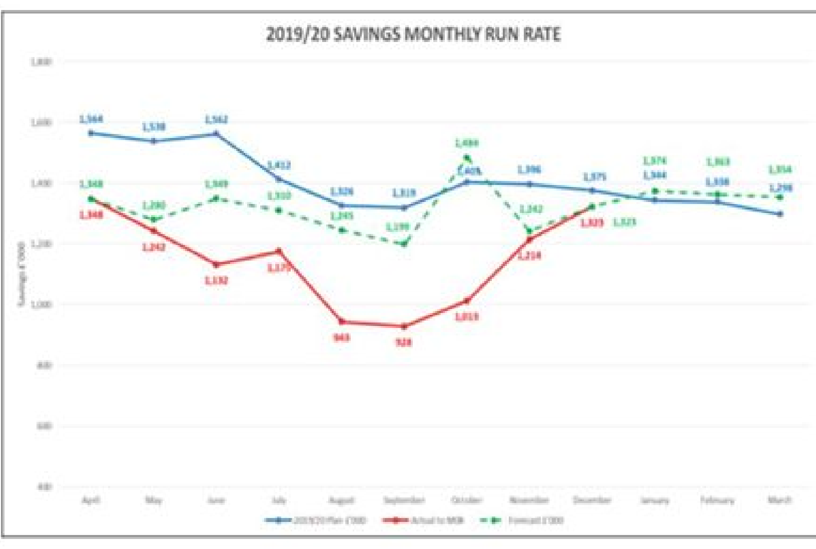
RAG Rating to Operating Plan	In Month	Year to Date
D & T	R	R
Medicine	R	R
Specialised	R	R
Surgery	R	R
W & C	R	R
E & F	A	A
Trust Services	A	G

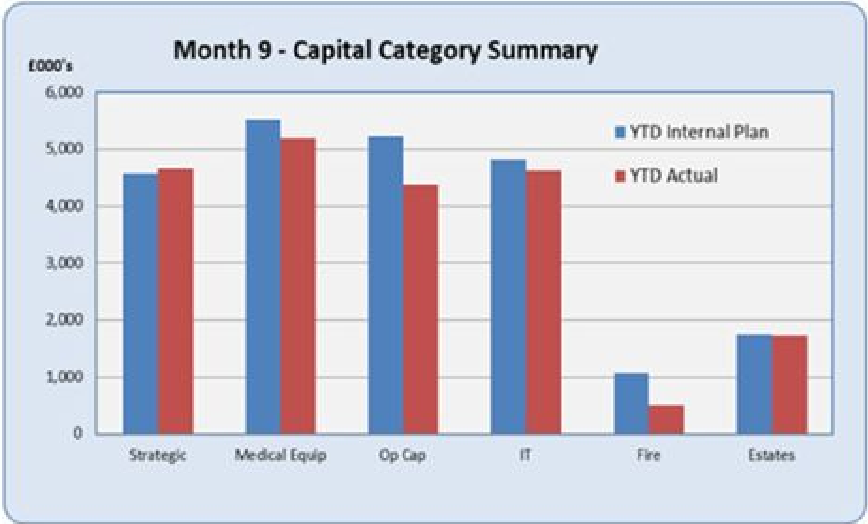


2.6 FINANCIAL PERFORMANCE





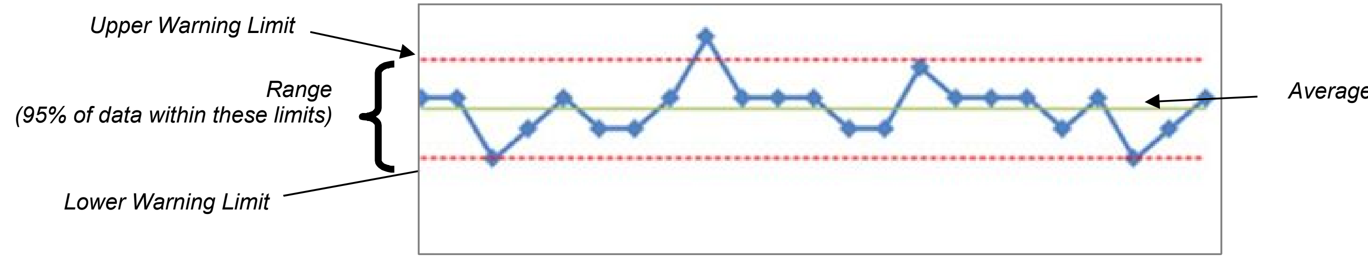




APPENDIX 1 – Explanation of SPC Charts

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 Care Quality Commission Rating

The Care Quality Commission (CQC) published their latest inspection report on 16th August 2019. Full details can be found here: https://www.cqc.org.uk/provider/RA7

The overall rating was OUTSTANDING, and the breakdown by domain and category is shown below.

Rating for acute services/acute trust

	Safe	Effective	Caring	Responsive	Well-led	Overall
Urgent and Emergency Care	Requires improvement ↓ May 2019	Good ↓ May 2019	Outstanding ↑ May 2019	Requires improvement →← May 2019	Good ↓ May 2019	Requires improvement ↓ May 2019
Medical Care (including older people's care)	Good Mar 2017	Good Mar 2017	Good Mar 2017	Good Mar 2017	Good Mar 2017	Good Mar 2017
Surgery	Good →← May 2019	Good →← May 2019	Outstanding →← May 2019	Outstanding ↑ May 2019	Outstanding →← May 2019	Outstanding →← May 2019
Critical care	Good Dec 2014	Good Dec 2014	Good Dec 2014	Requires improvement Dec 2014	Good Dec 2014	Good Dec 2014
Services for children and young people	Good →← May 2019	Outstanding →← May 2019	Good →← May 2019	Good →← May 2017	Outstanding ↑ May 2019	Outstanding ↑ May 2019
End of life care	Good Dec 2014	Good Dec 2014	Good Dec 2014	Good Dec 2014	Good Dec 2014	Good Dec 2014
Maternity	Requires improvement May 2019	Good May 2019	Good May 2019	Good May 2019	Good May 2019	Good May 2019
Outpatients and diagnostics	Good Mar 2017	Not rated	Good Mar 2017	Good Mar 2017	Good Mar 2017	Good Mar 2017
Overall trust	Requires improvement ↓ May 2019	Good ↓ May 2019	Outstanding ↑ May 2019	Good ↑ May 2019	Outstanding →← May 2019	Outstanding →← May 2019

APPENDIX 3 – Trust Scorecards

SAFE, CARING & EFFECTIVE

Topic	ID	Title	Annual 18/19	Annual 19/20 YTD	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	18/19 Q4	19/20 Q1	19/20 Q2	19/20 Q3
Patient Safety																				
Infections	DA01	MRSA Trust Apportioned Cases	6	1	0	1	0	0	0	0	0	1	0	0	0	0	1	0	1	0
	DA02	MSSA Trust Apportioned Cases	34	40	3	2	4	5	6	4	6	5	4	4	3	3	9	15	15	10
	DA03	CDiff Trust Apportioned Cases	31	35	1	1	1	4	2	2	5	5	4	4	5	4	3	8	14	13
	DA06	EColi Trust Apportioned Cases	83	69	5	5	8	6	8	9	14	4	5	8	6	9	18	23	23	23
Infection Checklists	DB01	Hand Hygiene Audit Compliance	97%	97.1%	96.3%	96.6%	96.7%	95.6%	95.7%	96.6%	96.9%	98%	97.9%	97.7%	97.7%	97.8%	96.6%	95.9%	97.6%	97.7%
	DB02	Antibiotic Compliance	78.9%	77.4%	79.1%	66.3%	68%	76.1%	84.2%	80.2%	88.6%	85.6%	82.1%	75.1%	73.8%	71.8%	72.2%	79.1%	84.5%	73.5%
Cleanliness Monitoring	DC01	Cleanliness Monitoring - Overall Score	-	-	96%	96%	95%	96%	96%	95%	96%	96%	96%	96%	95%	98%	-	-	-	-
	DC02	Cleanliness Monitoring - Very High Risk Areas	-	-	97%	98%	98%	98%	98%	98%	97%	98%	98%	98%	97%	99%	-	-	-	-
	DC03	Cleanliness Monitoring - High Risk Areas	-	-	96%	97%	97%	97%	96%	96%	96%	96%	96%	96%	96%	98%	-	-	-	-
Serious Incidents	S02	Number of Serious Incidents Reported	70	58	3	7	5	7	3	8	10	8	5	4	7	6	15	18	23	17
	S02a	Number of Confirmed Serious Incidents	63	40	2	6	5	7	3	7	9	8	5	1	-	-	13	17	22	1
	S02b	Number of Serious Incidents Still Open	5	18	1	1	0	0	0	1	1	0	0	3	7	6	2	1	1	16
	S03	Serious Incidents Reported Within 48 Hours	98.6%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
	S03a	Serious Incidents - 72 Hour Report Completed Within Timescale	94.3%	94.8%	100%	100%	100%	85.7%	100%	100%	100%	100%	60%	100%	100%	100%	100%	94.4%	91.3%	100%
	S04	Serious Incident Investigations Completed Within Timescale	96.8%	100%	100%	80%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	93.8%	100%	100%	100%
	S04a	Overdue Exec Commissioned Non-SI Investigations	10	13	1	0	0	1	1	1	1	2	4	2	0	1	1	3	7	3
Never Events	S01	Total Never Events	5	3	0	0	1	0	0	1	1	1	0	0	0	0	1	1	2	0
Patient Safety Incidents	S06	Number of Patient Safety Incidents Reported	17839	11200	1520	1551	1570	1373	1027	1765	1710	1650	1734	1941	-	-	4641	4165	5094	1941
	S06b	Patient Safety Incidents Per 1000 Beddays	58.56	47.33	57.27	64.61	58.94	53.22	38.47	68.73	65.54	63.96	66.82	71.47	-	-	60.13	53.28	65.44	24.07
	S07	Number of Patient Safety Incidents - Severe Harm	88	60	7	4	10	7	1	6	10	16	11	9	-	-	21	14	37	9
Patient Falls	AB01	Falls Per 1,000 Beddays	4.48	4.38	5.61	4.67	3.72	4.46	4.98	3.97	4.37	4.11	4.43	4.75	3.46	4.82	4.66	4.48	4.3	4.35
	AB06a	Total Number of Patient Falls Resulting in Harm	27	14	3	1	3	3	0	0	2	1	1	4	1	2	7	3	4	7
Pressure Ulcers Developed in the Trust	DE01	Pressure Ulcers Per 1,000 Beddays	0.295	0.161	0.527	0.083	0.188	0.194	0.037	0.156	0.115	0.233	0.193	0.221	0.228	0.074	0.272	0.128	0.18	0.174
	DE02	Pressure Ulcers - Grade 2	80	31	13	2	5	4	1	4	2	4	3	5	6	2	20	9	9	13
	DE04A	Pressure Ulcers - Grade 3 or 4	10	7	1	0	0	1	0	0	1	2	2	1	0	0	1	1	5	1
Venous Thrombo-embolism (VTE)	N01	Adult Inpatients who Received a VTE Risk Assessment	98.3%	87.2%	98.2%	98%	98.7%	98.5%	98.2%	98.2%	98.2%	77%	78.9%	78%	78.7%	77%	98.3%	98.3%	85.3%	77.9%
	N02	Percentage of Adult Inpatients who Received Thrombo-prophylaxis	92.6%	93.4%	91.4%	88.6%	94.5%	93.4%	93.2%	94.2%	93.1%	-	-	-	-	-	91.9%	93.5%	93.1%	-
	N04	Number of Hospital Associated VTEs	47	29	4	8	3	4	5	0	9	10	1	-	-	-	15	9	20	-
	N04A	Number of Potentially Avoidable Hospital Associated VTEs	5	3	0	1	2	1	0	0	1	1	0	-	-	-	3	1	2	-
	N04B	Number of Hospital Associated VTEs - Report Not Received To Date	2	13	0	0	0	1	1	0	4	6	1	-	-	-	0	2	11	-
Nutrition Audit	WB10	Fully and Accurately Completed Screening within 24 Hours	91.1%	86.4%	-	-	89.9%	-	-	84.4%	-	-	86.9%	-	-	87.9%	89.9%	84.4%	86.9%	87.9%
Safety	Y01	WHO Surgical Checklist Compliance	99.8%	99.9%	99.8%	99.8%	99.9%	99.9%	99.6%	99.9%	99.9%	100%	100%	99.9%	99.9%	99.9%	99.8%	99.8%	100%	99.9%
Medicines	WA01	Medication Incidents Resulting in Harm	0.29%	0.49%	0.77%	0%	0%	0%	0.62%	0.43%	0.38%	0.81%	1.23%	0%	0.4%	-	0.28%	0.37%	0.8%	0.2%
	WA03	Non-Purposeful Omitted Doses of the Listed Critical Medication	0.37%	0.27%	0%	0.25%	0.42%	0.31%	0.46%	0.3%	0.18%	0.24%	0%	0.26%	0.37%	0.27%	0.24%	0.37%	0.14%	0.3%

APPENDIX 3 – Trust Scorecards

			Annual		Monthly Totals												Quarterly Totals			
Topic	ID	Title	18/19	19/20 YTD	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	18/19 Q4	19/20 Q1	19/20 Q2	19/20 Q3
Deteriorating Patient	AR03	National Early Warning Scores (NEWS) Acted Upon	88%	-	83%	91%	85%	-	-	-	-	-	-	-	-	-	86%	-	-	-
Out of Hours	TD05	Out of Hours Discharges (8pm-7am)	8.7%	7.6%	7.9%	6.4%	7%	8.3%	8.3%	8.3%	6.5%	7.8%	7.6%	6.1%	7%	9.2%	7.1%	8.3%	7.3%	7.4%
Timely Discharges	TD03	Percentage of Patients With Timely Discharge (7am-12Noon)	23.9%	22.7%	23%	23.1%	22.8%	22.5%	23.5%	22.1%	23.3%	21.7%	21.4%	24%	23.3%	22.4%	23%	22.7%	22.2%	23.2%
	TD03D	Number of Patients With Timely Discharge (7am-12Noon)	9815	7019	821	718	839	749	805	705	815	708	713	870	873	781	2378	2259	2236	2524
Staffing Levels	RP03	Staffing Fill Rate - NA Shifts	108.9%	109.7%	110.3%	109.5%	106.9%	108.8%	110.1%	109.4%	110.5%	108.8%	110.9%	108.9%	109.5%	110.3%	108.9%	109.5%	110.1%	109.6%
Clinical Effectiveness																				
Mortality	X04	Summary Hospital Mortality Indicator (SHMI) - National Quarterly Data	105.1	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
	X04A	Summary Hospital Mortality Indicator (SHMI) - National Monthly Data	107.2	106	106.8	106.9	108	106.4	106.4	104.8	106	106.3	-	-	-	-	107.2	105.9	106.2	-
	X02	Hospital Standardised Mortality Ratio (HSMR)	105	90.9	114.7	108	108.1	83.7	91.1	99.7	96.3	95.5	82.7	89.5	-	-	110.4	91	91.3	89.5
Readmissions	C01	Emergency Readmissions Percentage	3.3%	3.53%	2.85%	2.64%	3.15%	3.57%	3.58%	3.85%	3.79%	3.58%	3.24%	3.26%	3.35%	-	2.89%	3.67%	3.54%	3.31%
Fracture Neck of Femur	U02	Fracture Neck of Femur Patients Treated Within 36 Hours	56.3%	45.5%	37.5%	52.9%	38.1%	56.3%	40.9%	52.4%	50%	61.1%	47.8%	42.3%	26.7%	43.5%	41.9%	49.2%	52.1%	36.7%
	U03	Fracture Neck of Femur Patients Seeing Orthogeriatrician within 72 Hours	97%	98.6%	100%	100%	90.5%	100%	95.5%	100%	93.3%	100%	100%	100%	100%	100%	96.8%	98.3%	97.2%	100%
	U04	Fracture Neck of Femur Patients Achieving Best Practice Tariff	51.3%	45.5%	33.3%	52.9%	33.3%	56.3%	40.9%	52.4%	50%	61.1%	47.8%	42.3%	26.7%	43.5%	38.7%	49.2%	52.1%	36.7%
Stroke Care	O01	Stroke Care: Percentage Receiving Brain Imaging Within 1 Hour	51.1%	50.8%	51.1%	48.3%	69.2%	52.8%	44.4%	41%	51.1%	45.7%	54.3%	59.6%	52.6%	-	56.6%	46.1%	50.8%	56.5%
	O02	Stroke Care: Percentage Spending 90%+ Time On Stroke Unit	84.2%	74.1%	80%	100%	82.1%	72.2%	85.2%	74.4%	84.4%	71.4%	69.6%	70.2%	68.4%	-	85.8%	76.5%	75.4%	69.4%
	O03	High Risk TIA Patients Starting Treatment Within 24 Hours	58.6%	65.6%	50%	84.6%	90%	69.2%	43.8%	28.6%	92.9%	50%	81.8%	88.9%	55.6%	71.4%	75.5%	50%	77.1%	72%
Dementia	AC01	Dementia - FAIR Question 1 - Case Finding Applied	83%	85.8%	88.2%	86.4%	81.5%	84.2%	87.6%	85.8%	85.8%	88.3%	91%	85.9%	84.8%	79.6%	85.4%	85.8%	88.5%	83.3%
	AC02	Dementia - FAIR Question 2 - Appropriately Assessed	94.3%	89.2%	98%	95.9%	100%	94.1%	95.8%	85.2%	94.6%	76.9%	83.8%	89.7%	88.1%	86.5%	97.9%	92.9%	86%	88.1%
	AC03	Dementia - FAIR Question 3 - Referred for Follow Up	85.7%	82.6%	100%	50%	71.4%	83.3%	66.7%	100%	100%	100%	100%	60%	100%	100%	75%	81.8%	100%	71.4%
Outliers	J05	Ward Outliers - Beddays Spent Outlying.	7708	6659	702	559	567	704	782	503	645	547	887	794	633	1164	1828	1989	2079	2591
Patient Experience																				
Monthly Patient Surveys	P01d	Patient Survey - Patient Experience Tracker Score	-	-	90	91	91	91	91	93	92	92	91	91	91	93	91	91	92	92
	P01g	Patient Survey - Kindness and Understanding	-	-	96	96	95	97	95	96	96	96	96	96	96	97	96	96	96	96
	P01h	Patient Survey - Outpatient Tracker Score	-	-	91	89	90	91	91	89	90	90	90	90	90	89	90	90	90	90
Friends and Family Test Coverage	P03a	Friends and Family Test Inpatient Coverage	35.1%	36.1%	32.2%	40.5%	34.6%	36.3%	42.4%	34.4%	39.4%	36.2%	34.2%	36.2%	31%	35.3%	35.5%	37.7%	36.7%	34.1%
	P03b	Friends and Family Test ED Coverage	16%	16.7%	16%	15.2%	11.6%	13.8%	18.1%	18.7%	17.4%	18.2%	15.2%	16.9%	15.8%	16.6%	14.2%	16.8%	16.9%	16.4%
	P03c	Friends and Family Test MAT Coverage	18.3%	26.7%	20.2%	23%	20.6%	28.5%	30.4%	24.1%	30.1%	31.6%	16.5%	17.7%	36.1%	26.8%	21.2%	27.7%	25.9%	26.6%
Friends and Family Test Score	P04a	Friends and Family Test Score - Inpatients	98.2%	98.6%	98.7%	98.4%	98.4%	98.4%	98.3%	98.3%	98.9%	98.8%	99%	98.4%	98.7%	98.6%	98.5%	98.4%	98.9%	98.5%
	P04b	Friends and Family Test Score - ED	82.1%	83.3%	81.1%	80.4%	75.4%	76.7%	83.8%	84.2%	82.9%	85.2%	81.5%	85.2%	83.8%	84.6%	79.2%	82%	83.3%	84.6%
	P04c	Friends and Family Test Score - Maternity	97.3%	97.6%	98.5%	98.7%	97.5%	96.7%	97.7%	97.6%	96.9%	97.2%	98.7%	98.1%	97.1%	99.1%	98.3%	97.4%	97.4%	98%
Patient Complaints	T01	Number of Patient Complaints	1845	1406	167	155	171	184	161	166	168	125	149	178	150	125	493	511	442	453
	T03a	Formal Complaints Responded To Within Trust Timeframe	86.1%	89.2%	87.5%	78.3%	90.6%	93.2%	97.2%	95.9%	90.4%	85.4%	67.5%	88.6%	91.5%	83.6%	85.2%	95.5%	83.6%	88.3%
	T03b	Formal Complaints Responded To Within Divisional Timeframe	85.5%	91.8%	87.5%	85%	92.5%	93.2%	98.6%	98%	91.6%	93.8%	75%	90%	95.8%	83.6%	88.2%	96.6%	88.3%	90.3%
	T05A	Informal Complaints Responded To Within Trust Timeframe	83.7%	88.8%	80%	89.9%	81.7%	90.6%	86.9%	89.8%	85.7%	87.9%	90.3%	93.4%	83.3%	91.2%	84%	89%	87.5%	90.1%
	T04c	Percentage of Responses where Complainant is Dissatisfied	9.11%	8.57%	8.93%	5%	15.09%	11.86%	8.45%	8.16%	12.05%	4.17%	7.5%	5.71%	-	-	9.47%	9.5%	8.77%	5.71%

APPENDIX 3 – Trust Scorecards

RESPONSIVE

Topic	ID	Title	Annual 18/19	Annual 19/20 YTD	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	18/19 Q4	19/20 Q1	19/20 Q2	19/20 Q3
Referral to Treatment (RTT) Performance	A03	Referral To Treatment Ongoing Pathways Under 18 Weeks	-	-	89.4%	89.1%	89.2%	89%	88.1%	87.5%	86.5%	84.3%	83.6%	83%	83%	82.5%	-	-	-	-
	A03a	Referral To Treatment Number of Ongoing Pathways Over 18 Weeks	-	-	2915	3100	3081	3161	3578	3874	4436	5216	5574	5866	5903	6028	-	-	-	-
Referral to Treatment (RTT) Wait Times	A06	Referral To Treatment Ongoing Pathways Over 52 Weeks	144	78	16	21	13	14	11	11	9	9	5	4	5	10	50	36	23	19
	A07	Referral To Treatment Ongoing Pathways 40+ Weeks	-	-	147	161	119	115	136	128	152	211	219	202	219	282	-	-	-	-
Cancer (2 Week Wait)	E01a	Cancer - Urgent Referrals Seen In Under 2 Weeks	95.3%	93.4%	95.2%	94.9%	94.4%	93.4%	94%	95.9%	95.2%	89%	91.7%	93%	95.2%	-	94.8%	94.4%	92%	93.9%
	E01c	Cancer - Urgent Referrals Stretch Target	56.5%	39.6%	63.7%	46.5%	49%	43.8%	45.6%	54.7%	35.2%	27.5%	33.7%	38.6%	37.8%	-	52.7%	47.9%	31.9%	38.2%
Cancer (31 Day)	E02a	Cancer - 31 Day Diagnosis To Treatment (First Treatments)	97.2%	95.8%	97%	96.5%	98.3%	95.4%	94.1%	95.1%	97.1%	96.3%	94.4%	96.6%	97%	-	97.2%	94.9%	95.9%	96.8%
	E02b	Cancer - 31 Day Diagnosis To Treatment (Subsequent - Drug)	98.4%	98.4%	99.2%	99.1%	100%	98.4%	97.9%	99.1%	99%	99%	97.1%	97.7%	99.2%	-	99.5%	98.5%	98.4%	98.4%
	E02c	Cancer - 31 Day Diagnosis To Treatment (Subsequent - Surgery)	96.1%	92.3%	95%	96.3%	97.6%	95.9%	90.9%	89.7%	90.4%	94.2%	91.7%	93.3%	92.3%	-	96.2%	92.1%	92.1%	92.9%
	E02d	Cancer - 31 Day Diagnosis To Treatment (Subsequent - Radiotherapy)	95.8%	94.7%	95.7%	98%	94.1%	96.4%	89.6%	91.8%	94.4%	95.2%	96.2%	96.5%	96.8%	-	96%	92.7%	95.2%	96.6%
Cancer (62 Day)	E03a	Cancer 62 Day Referral To Treatment (Urgent GP Referral)	85.6%	85.8%	85.1%	83.5%	82.9%	86.8%	86%	84%	86.8%	85.8%	84%	85.4%	87%	-	83.8%	85.7%	85.6%	86.2%
	E03b	Cancer 62 Day Referral To Treatment (Screenings)	66.7%	75.3%	35.7%	75%	66.7%	71.4%	100%	83.3%	66.7%	100%	85.7%	55.6%	53.8%	-	47.6%	82.6%	83.3%	54.5%
	E03c	Cancer 62 Day Referral To Treatment (Upgrades)	83.7%	86.3%	86.8%	74.7%	91.8%	95%	89.6%	83.5%	85.7%	87.1%	80.8%	82.9%	84%	-	84.6%	89.7%	84.4%	83.6%
	E03f	Cancer Urgent GP Referrals - Numbers Treated after Day 103	54	32	4	3	7	3.5	3.5	3	4.5	6.5	3.5	3	4.5	-	14	10	14.5	7.5
Cancelled Operations	F01	Last Minute Cancelled Operations - Percentage of Admissions	1.31%	1.69%	1.31%	1.68%	1.66%	1.63%	1.53%	1.84%	1.25%	1.49%	1.44%	1.68%	1.94%	2.54%	1.54%	1.67%	1.39%	2.03%
	F01a	Number of Last Minute Cancelled Operations	1059	1011	94	109	115	108	100	117	88	95	94	119	137	153	318	325	277	409
	F02	Cancelled Operations Re-admitted Within 28 Days	93.4%	93%	93.4%	93.6%	96.3%	85.2%	85.2%	92%	93.2%	95.5%	97.9%	95.7%	98.3%	94.9%	94.7%	87.3%	95.3%	96.3%
Admissions Cancelled Day Before	F07	Percentage of Admissions Cancelled Day Before	1.67%	1.89%	1.75%	2.17%	0.85%	1.65%	2.39%	1.62%	1.81%	1.54%	1.93%	2.59%	1.95%	1.43%	1.58%	1.89%	1.76%	2.02%
	F07a	Number of Admissions Cancelled Day Before	1348	1127	126	141	59	109	156	103	128	98	126	183	138	86	326	368	352	407
Primary PCI	H02	Primary PCI - 150 Minutes Call to Balloon Time	73.2%	65.1%	71.4%	76.7%	65.2%	83.9%	61.8%	68.6%	54.3%	64.7%	60.5%	-	-	-	70.3%	71%	59.8%	-
	H03a	Primary PCI - 90 Minutes Door to Balloon Time	91.9%	86.8%	88.6%	93.3%	87%	96.8%	88.2%	85.7%	80%	88.2%	83.7%	-	-	-	89.2%	90%	83.9%	-
Diagnostic Waits	A05	Diagnostics 6 Week Wait (15 Key Tests)	-	-	93.28%	96.93%	95.5%	95.27%	93.41%	93.54%	96.19%	95.26%	96.21%	95.85%	96.65%	96.1%	-	-	-	-
Outpatients	R03	Outpatient Hospital Cancellation Rate	10.1%	10.7%	10.2%	11.6%	11.2%	11.3%	10.4%	10.1%	11.1%	11.2%	11.1%	10.7%	10.2%	10.6%	11%	10.6%	11.1%	10.5%
	R05	Outpatient DNA Rate	6.8%	6.6%	6.8%	6.7%	6.6%	6.7%	7.1%	6.8%	6.4%	6.5%	6.6%	6.3%	6.5%	6.7%	6.7%	6.9%	6.5%	6.5%
Outpatient Ratio	R01	Follow-Up To New Ratio	2.12	2.14	2.2	2.25	2.13	2.09	2.1	2.21	2.12	2.25	2.15	2.07	2.15	2.11	2.19	2.13	2.17	2.11
ERS	BC01	ERS - Available Slot Issues Percentage	16.5%	16.7%	12.5%	16.8%	17.3%	13.9%	16.9%	15.8%	17.9%	16.9%	14.6%	17%	20.6%	-	15.5%	15.5%	16.5%	18.6%

APPENDIX 3 – Trust Scorecards

Topic	ID	Title	Annual 18/19	Annual 19/20 YTD	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	18/19 Q4	19/20 Q1	19/20 Q2	19/20 Q3
Delayed Discharges	Q01A	Acute Delayed Transfers of Care - Patients	216	212	20	13	20	22	23	27	19	32	19	30	19	21	53	72	70	70
	Q02A	Non-Acute Delayed Transfers of Care - Patients	80	86	4	10	4	8	11	12	9	8	13	12	5	8	18	31	30	25
	Q01B	Acute Delayed Transfers of Care - Beddays	6744	5839	653	550	519	609	607	625	532	654	783	708	590	731	1722	1841	1969	2029
	Q02B	Non-Acute Delayed Transfers of Care - Beddays	2590	2224	138	161	198	223	302	243	283	165	233	257	298	220	497	768	681	775
Green To Go List	AQ06A	Green To Go List - Number of Patients (Acute)	-	-	48	65	62	53	56	61	48	75	58	83	69	75	-	-	-	-
	AQ06B	Green To Go List - Number of Patients (Non Acute)	-	-	7	30	19	26	25	27	31	23	26	31	20	27	-	-	-	-
	AQ07A	Green To Go List - Beddays (Acute)	-	-	1814	1894	1962	1882	2435	1916	1986	2402	2393	2480	2388	2398	-	-	-	-
	AQ07B	Green To Go List - Beddays (Non-Acute)	-	-	463	631	819	759	842	830	877	659	840	948	812	784	-	-	-	-
Length of Stay	J03	Average Length of Stay (Spell)	3.79	3.84	3.83	3.74	3.78	4.05	3.73	3.61	3.83	3.82	4.02	3.91	3.83	3.75	3.79	3.8	3.89	3.83
	J04D	Percentage Length of Stay 14+ Days	6.3%	6.5%	6.6%	6.4%	6.4%	7.2%	6.5%	6%	6.6%	6.6%	6.8%	6.6%	6.2%	6.3%	6.5%	6.6%	6.6%	6.4%
14 Day LOS Patients	C07	Number of 14+ Day Length of Stay Patients at Month End	-	-	221	234	222	247	256	262	238	274	248	249	227	254	-	-	-	-
AMU	J35	Percentage of Cardiac AMU Wardstays	3.6%	4.9%	4%	6.3%	5.6%	3.6%	3.7%	6.9%	4.4%	5.3%	4.2%	7.4%	5.2%	3.9%	5.2%	4.7%	4.6%	5.5%
	J35A	Percentage of Cardiac AMU Wardstays Under 24 Hours	36.1%	34.5%	55.6%	24.5%	24%	39.3%	18.8%	21.6%	40%	45.2%	41.9%	38.6%	33.3%	33.3%	32.6%	25.2%	42.6%	35.7%

Emergency Department Indicators

Topic	ID	Title	Annual 18/19	Annual 19/20 YTD	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	18/19 Q4	19/20 Q1	19/20 Q2	19/20 Q3
ED - Time In Department	B01	ED Total Time in Department - Under 4 Hours	86.34%	80.46%	84.5%	81.05%	81.23%	78.25%	77.95%	81.48%	81.86%	84.78%	81.42%	82.47%	80.28%	76.12%	82.27%	79.2%	82.64%	79.63%

This is measured against the national standard of 95%

Topic	ID	Title	Annual 18/19	Annual 19/20 YTD	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	18/19 Q4	19/20 Q1	19/20 Q2	19/20 Q3
ED - Time In Department (Differentials)	BB14	ED Total Time in Department - Under 4 Hours (STP)	86.34%	80.46%	84.5%	81.05%	81.23%	78.25%	77.95%	81.48%	81.86%	84.78%	81.42%	82.47%	80.28%	76.12%	82.27%	79.2%	82.64%	79.63%
	BB07	BRI ED - Percentage Within 4 Hours	78.39%	68.58%	74.67%	69.23%	70.33%	63.57%	63.86%	68.78%	68.95%	74.81%	70.93%	72.03%	70.87%	63.41%	71.46%	65.38%	71.53%	68.8%
	BB03	BCH ED - Percentage Within 4 Hours	93.05%	90.29%	92.92%	90.46%	89.39%	91.96%	90.38%	93.61%	94.82%	95.3%	89.51%	90.31%	85.94%	84.42%	90.9%	91.96%	93.02%	86.78%
	BB04	BEH ED - Percentage Within 4 Hours	97.38%	97.79%	97.7%	98.02%	97.07%	96.1%	98.39%	97.55%	98.16%	98.37%	97.4%	98.8%	96.84%	98.55%	97.58%	97.32%	97.98%	98.08%

This is measured against the trajectories created to deliver the Sustainability and Transformation Fund targets

Topic	ID	Title	Annual 18/19	Annual 19/20 YTD	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	18/19 Q4	19/20 Q1	19/20 Q2	19/20 Q3
Trolley Waits	B06	ED 12 Hour Trolley Waits	1	8	0	0	0	0	0	0	0	0	0	0	0	8	0	0	0	8
Time to Initial Assessment	B02	ED Time to Initial Assessment - Under 15 Minutes	95.6%	97.3%	97.7%	97.9%	96.5%	96.8%	97%	98.3%	98%	98.4%	96.2%	98.8%	97.8%	94.6%	97.3%	97.4%	97.5%	97%
	B02b	ED Time to Initial Assessment - Data Completness	97.2%	97.2%	96.5%	97.4%	99%	97.6%	98.4%	98%	98.3%	96.1%	98.2%	96.6%	98.3%	93.7%	97.6%	98%	97.5%	96.1%
Time to Start of Treatment	B03	ED Time to Start of Treatment - Under 60 Minutes	49.3%	49.6%	48.9%	45.2%	43.9%	46.1%	47.6%	49.9%	50.1%	55.6%	50.9%	50.1%	48.4%	47.9%	46%	47.9%	52.2%	48.8%
	B03b	ED Time to Start of Treatment - Data Completeness	96.9%	96.8%	97.5%	96.7%	96.4%	96.6%	96%	96.1%	96.8%	97.2%	96.7%	97.4%	97.2%	97.2%	96.9%	96.2%	96.9%	97.3%
Others	B04	ED Unplanned Re-attendance Rate	3.3%	3.6%	3.2%	3.3%	3.6%	3.5%	3.2%	3.1%	3.4%	3.3%	3.5%	3.9%	4.2%	4.2%	3.3%	3.3%	3.4%	4.1%
	B05	ED Left Without Being Seen Rate	1.7%	1.6%	1.3%	1.6%	2.1%	1.6%	1.8%	1.6%	1.7%	1.5%	1.9%	1.4%	1.4%	1.9%	1.7%	1.7%	1.7%	1.5%
Ambulance Handovers	BA09	Ambulance Handovers - Over 30 Minutes	698	352	42	57	50	96	87	55	36	25	53	-	-	-	149	238	114	-
Acute Medical Unit (AMU)	J35	Percentage of Cardiac AMU Wardstays	3.6%	4.9%	4%	6.3%	5.6%	3.6%	3.7%	6.9%	4.4%	5.3%	4.2%	7.4%	5.2%	3.9%	5.2%	4.7%	4.6%	5.5%
	J35a	Percentage of Cardiac AMU Wardstays Under 24 Hours	36.1%	34.5%	55.6%	24.5%	24%	39.3%	18.8%	21.6%	40%	45.2%	41.9%	38.6%	33.3%	33.3%	32.6%	25.2%	42.6%	35.7%

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)	2,382	1,116	3,698	5,060	5,054	4,107	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	4,672	4,808	8,083	10,457	11,463	11,527	0	0	0
Year to Date Variance Divisional Position Favourable / (Adverse) £'000	Diagnostics & Therapies	(4)	(39)	(56)	(66)	(328)	(366)	(343)	(178)	(273)			
	Medicine	(167)	(320)	(502)	(701)	(1,222)	(1,687)	(2,023)	(2,045)	(2,245)			
	Specialised Services	(54)	13	201	82	(173)	(265)	(335)	(322)	(397)			
	Surgery	(175)	(659)	(1,168)	(1,867)	(2,760)	(3,422)	(4,188)	(4,576)	(5,428)			
	Women's & Children's	(215)	(311)	(407)	(534)	(1,029)	(1,377)	(1,474)	(1,465)	(1,814)			
	Estates & facilities	(5)	(9)	(13)	(24)	(66)	(76)	(80)	(57)	(72)			
	Trust Services	4	3	(33)	17	25	39	51	78	74			
	Other Corporate Services	42	29	(85)	(37)	(89)	49	55	108	867			
	Total	**(574)**	**(1,293)**	**(2,063)**	**(3,130)**	**(5,642)**	**(7,105)**	**(8,337)**	**(8,457)**	**(9,288)**	**0**	**0**	**0**
Year To Date Savings Actuals £'000	Diagnostics & Therapies		299	438	543	591	700	823	964	1,108			
	Medicine		231	324	426	532	627	746	941	1,141			
	Specialised Services		381	555	811	1,060	1,190	1,311	1,530	1,774			
	Surgery		572	788	1,063	1,249	1,485	1,630	1,783	1,999			
	Women's & Children's		660	941	1,171	1,310	1,451	1,738	2,006	2,308			
	Estates & facilities		120	183	232	281	331	382	455	506			
	Trust Services		134	202	270	341	412	483	553	624			
	Other Corporate Services		195	292	382	477	573	668	763	859			
	Total	**0**	**2,591**	**3,723**	**4,898**	**5,841**	**6,769**	**7,781**	**8,995**	**10,318**	**0**	**0**	**0**
In Month Variance Subjective Analysis Favourable / (Adverse) £'000	Nursing & Midwifery Pay	(542)	(449)	(438)	(475)	(274)	(603)	(530)	(554)	(535)			
	Medical & Dental Pay	(360)	(187)	(445)	(433)	(381)	(139)	(307)	(390)	(619)			
	Other Pay	180	155	64	263	202	203	119	159	190			
	Non Pay	954	189	356	(101)	475	518	(388)	(439)	(831)			
	Income from Operations	(172)	(94)	(2)	(18)	(116)	(205)	(5)	123	1,053			
	Income from Activities	(632)	(336)	(301)	(303)	(2,419)	(1,238)	(122)	981	(89)			
	Total	**(572)**	**(722)**	**(766)**	**(1,067)**	**(2,513)**	**(1,464)**	**(1,233)**	**(120)**	**(831)**	**0**	**0**	**0**
In Month Agency Expenditure Actuals £'000	Nursing & Midwifery	684	644	627	615	648	720	726	642	608			
	Medical												
	Consultants	72	82	92	94	72	61	84	52	120			
	Other Medical	56	20	85	108	54	35	68	49	46			
	Other	140	144	131	154	185	72	169	117	76			
	Total	**952**	**890**	**935**	**971**	**959**	**888**	**1,047**	**860**	**850**	**0**	**0**	**0**
Cash £'000	Actual Cash	**110,000**	**109,402**	**100,954**	**119,042**	**127,950**	**126,226**	**135,301**	**121,697**	**117,727**	**0**	**0**	**0**
Capital Spend £'000	Actual Capital Expenditure	**916**	**2,300**	**4,704**	**7,868**	**10,229**	**12,449**	**14,672**	**18,632**	**21,084**			
		(722)	(481)	(819)	(645)	(453)	(539)	(718)	(785)	(964)			

Meeting of the Board of Directors in Public on Thursday 30 January 2020

Report Title	**Finance Report**
Report Author	**Neil Kemsley, Director of Finance & IT; Kate Parraman, Deputy Director of Finance**
Executive Lead	**Neil Kemsley, Director of Finance & IT**

1. Report Summary

The purpose of this report is to:

- inform the Finance Committee of the financial position of the Trust for December
- provide assurance on the delivery of the Core Control total, including risks and mitigations

2. Key points to note
(Including decisions taken)

Attached is a summary dashboard and performance report.

The plan for December required a core (i.e. excluding Provider Sustainability Funding (PSF) and MRET) surplus of £4.083m. The Trust is reporting a core surplus of £4.107m to date, which is £0.024m favourable to plan.

Division and Corporate Services are £8.180m adverse to Operating Plans.
The key issues are:

- Income from activities underperformance of £5.014m, with an underperformance of £0.145m in month
- Increased nursing and midwifery pay costs of £1.952m year to date

Divisions are £1.3m adverse to their expected trajectories at December.

The full value of the recurring and non-recurring reserves is within the position. The expectation being that the recovery actions being taken by Divisions will improve the run rate in the latter part of the year.

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

Risk 959 – Risk that the Trust fails to deliver the Operational Plan
Risk 1843 – Risk of failure to achieve Trust's Core Control Total

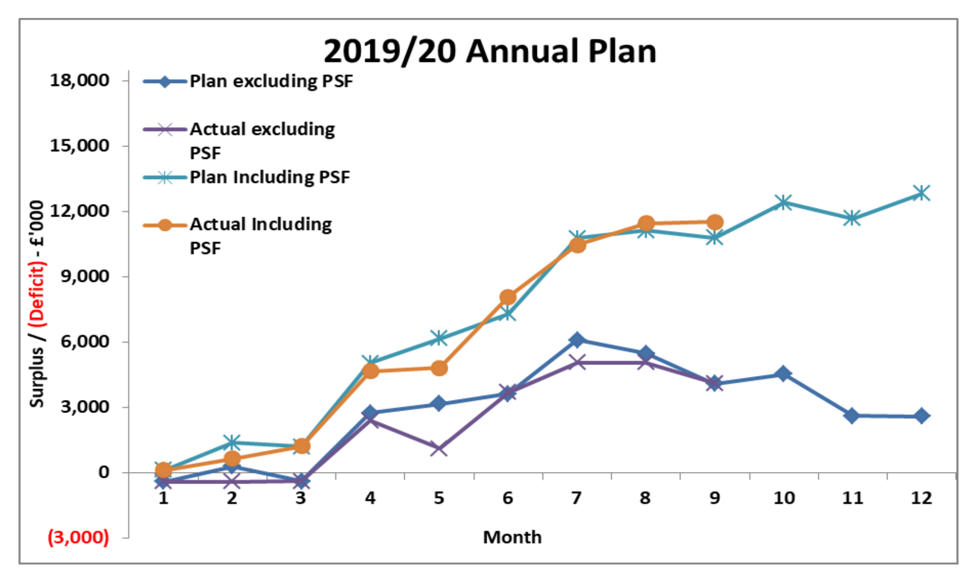
4. Advice and Recommendations
*(Support and Board/Committee decisions requested)***:**

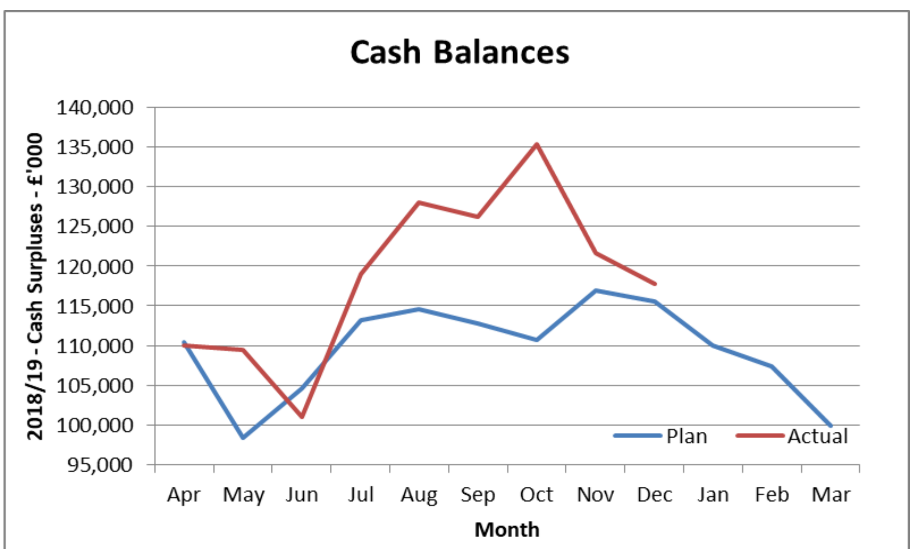
- This report is for **Assurance.**

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

Finance Committee	27 January 2020

Performance – Finance (plan, income and cash)





Activity Based Contract Income 2018-19 and 2019-20

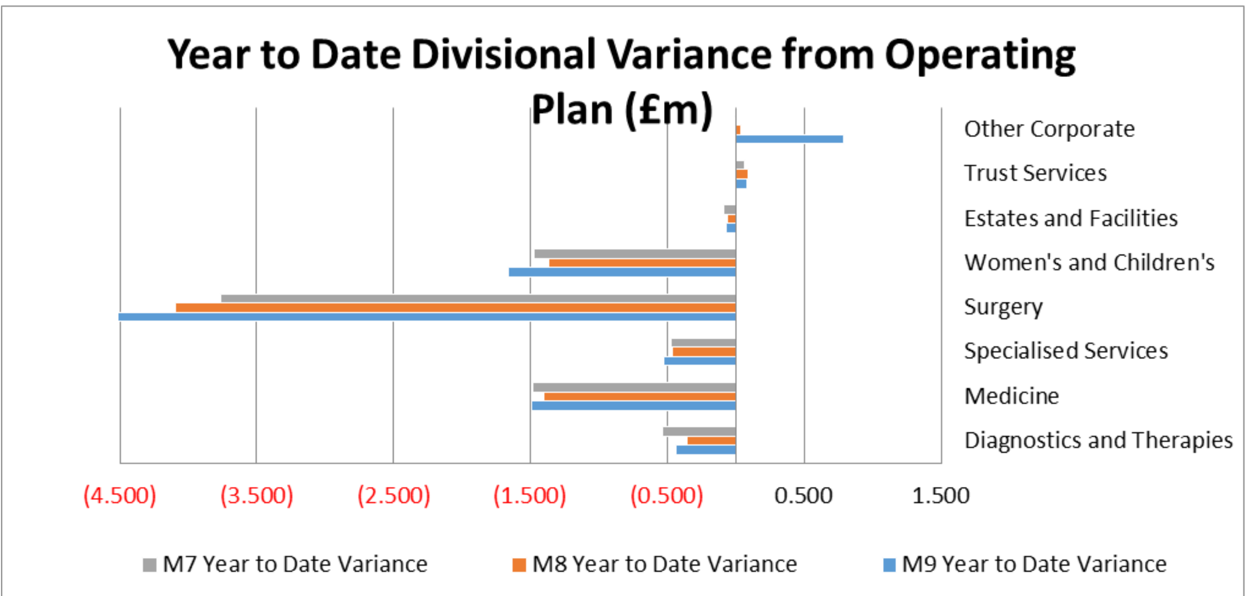
£'m

46
44
42
40
38
36
34
32
30

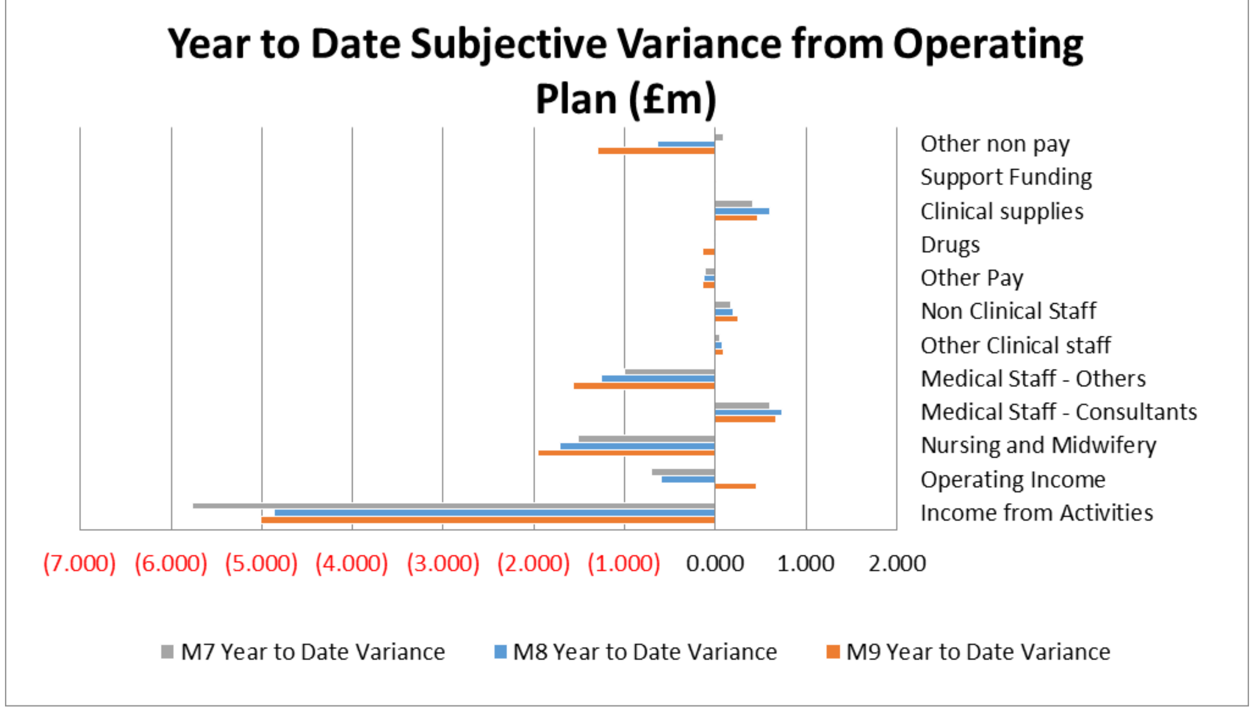
Apr-18 May-18 Jun-18 Jul-18 Aug-18 Sep-18 Oct-18 Nov-18 Dec-18 Jan-19 Feb-19 Mar-19 Apr-19 May-19 Jun-19 Jul-19 Aug-19 Sep-19 Oct-19 Nov-19 Dec-19 Jan-20 Feb-20 Mar-20

Planned Income
Actual Income

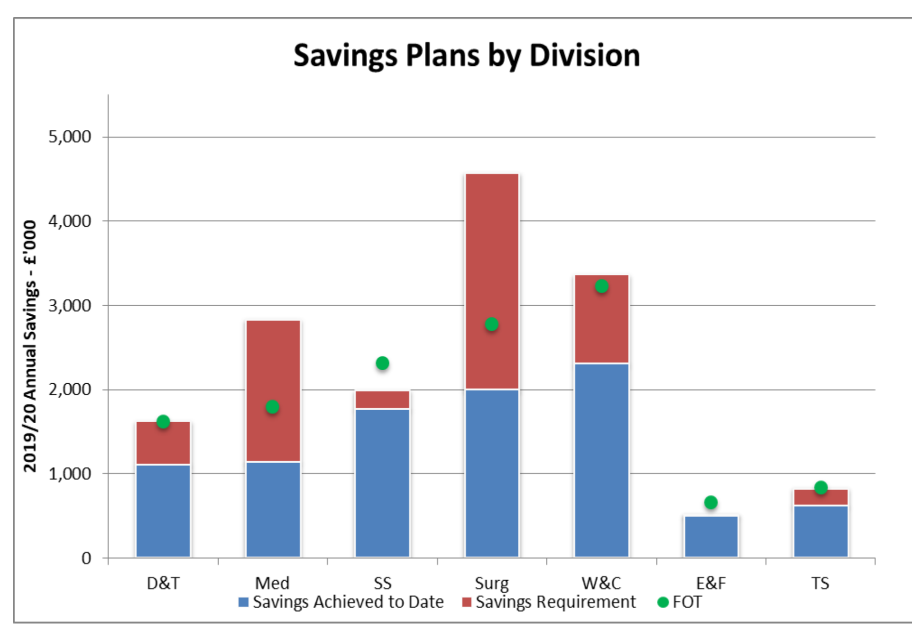
Performance – Finance (Divisional Operating Plans)

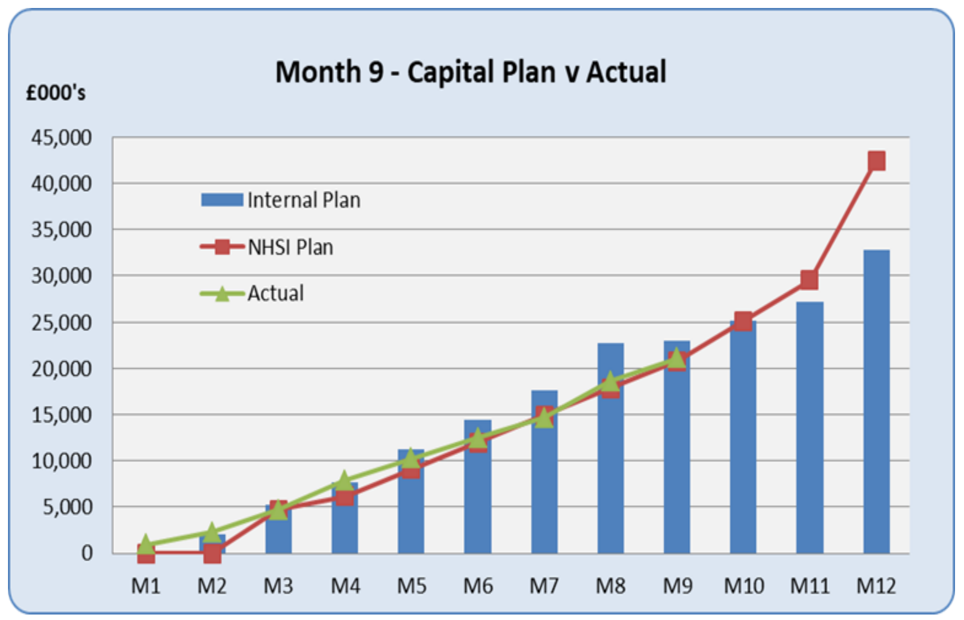


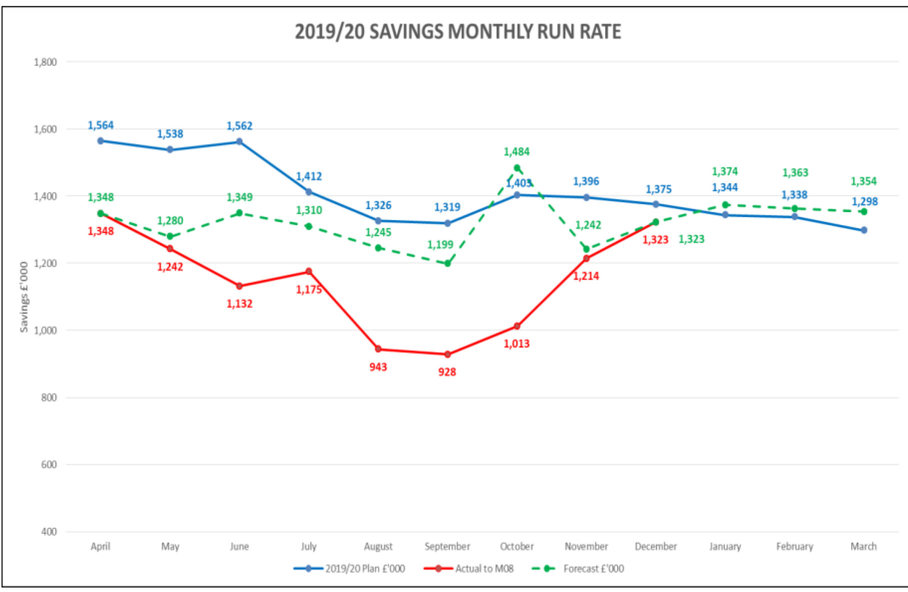
RAG Rating to Operating Plan	In Month	Year to Date
D & T	R	R
Medicine	R	R
Specialised	R	R
Surgery	R	R
W & C	R	R
E & F	A	A
Trust Services	A	G

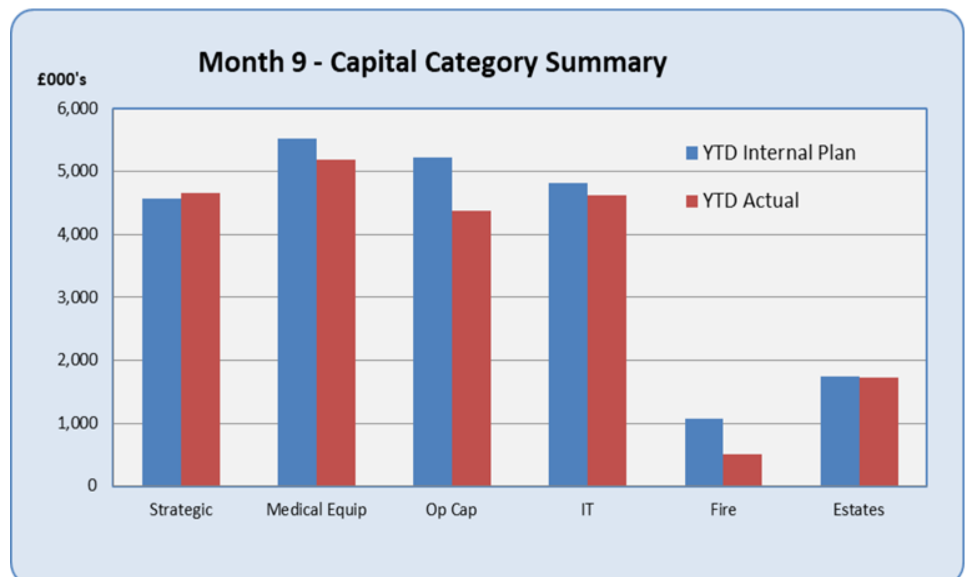


Performance – Finance (savings and capital)





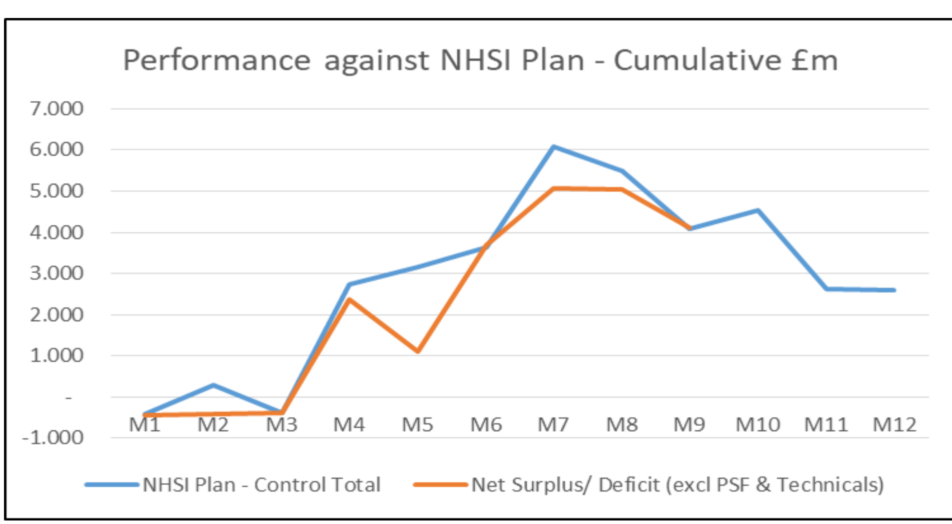




Report of the Finance Director

Section 1 – Executive Summary

Performance to NHSI Plan	2019/20 NHSI Plan £m	Income / (Expenditure) Plan to date £m	Income / (Expenditure) Actual to date £m	Variance Favourable /(Adverse) £m
Income from Activities	620.546	465.181	466.045	0.864
Income from Operations	92.222	69.165	72.767	3.602
Expenses – Pay	(428.393)	(319.862)	(323.132)	(3.270)
Expenses – Non Pay	(245.904)	(183.601)	(185.150)	(1.549)
Financing	(35.878)	(26.800)	(26.423)	0.377
Surplus/(deficit) excl PSF	**2.593**	**4.083**	**4.107**	**0.024**
PSF Core Funding	9.576	6.224	6.224	-
MRET Funding	0.646	0.486	0.486	-
Prior Year PSF Post Accounts Allocation	-	-	0.710	0.710
Surplus/(deficit) incl PSF	**12.815**	**10.793**	**11.527**	**0.734**



- The Trust is £0.024m favourable to the NHSI control total year to date, compared with £0.435m adverse last month, representing an improvement of £0.5m in month against plan.
- As can be seen by the graph, the profiled plan is to increase the surplus next month before reducing to the year-end core control surplus of £2.6m.
- The Trust continues to forecast achievement of the year-end core control total. This is in line with the Month 9 submission and forecast required by NHSE/I.
- Income from activities is £0.9m favourable to plan compared to £0.1m adverse last month and £1.4m adverse the month before. Activity based income was £0.3m adverse to plan in December (£1.4m favourable in November and £0.5m adverse in October) and is £6.3m adverse year to date.
- Income from operations is £3.6m favourable to plan and represents additional income received during the year primarily through income for hosting arrangements, offset by increases in pay and non pay expenditure as well as insurance income.
- Operational expenditure (pay and non-pay) is £4.8m adverse to plan. In part this offsets the costs associated with additional income from operations but also reflects the Divisional position described in the next section.

Performance to Budget	2019/20 Annual Budget	Income / (Expenditure)		Variance
		Budget to date	Actual to date	favourable /(adverse)
	£m	£m	£m	£m
Corporate Income	658.386	493.581	491.470	(2.111)
Divisions & Corporate Services	(606.748)	(451.652)	(460.940)	(9.288)
Financing	(36.161)	(27.024)	(26.423)	0.601
Reserves	(12.884)	(8.419)	-	8.419
Profiling adjustment		(2.403)	-	2.403
Surplus/(deficit) excl PSF	2.593	4.083	4.107	0.024
PSF Core Funding	9.576	6.224	6.224	-
MRET Funding	0.646	0.486	0.486	-
Prior Year PSF Post Accounts Allocation	-	-	0.710	0.710
Surplus/(deficit) incl PSF	12.815	10.793	11.527	0.734

Note:

The corporate income annual budget comprises contract income (£621.8m) and education levy funding (£36.1m). Contract income differs from the NHSI plan for income from activities due to changes in the contract after the NHSI plan was submitted (£2.4m increase) and the allocation of some income from activities budgets to Divisions (£1.8m).

The income underperformance is shown in the Division's variances and the corporate income variance, which is the corporate share of contract under performance and penalties, as shown on appendix 2.

- Delivery of the NHSI plan is managed through Divisional Operating Plans and budgets set at cost centre level, assigned to budget managers.
- The corporate income adverse variance of £2.1m represents the corporate share of under performance on contract income.
- Division and Corporate Services budgets are £9.3m adverse to budget, of which £6.1m is pay and £4.5m is income from activities, offset by £0.7m favourable on non pay and £0.6m favourable on income from operations. Surgery is £5.4m adverse, Medicine £2.2m and Women's and Children's £1.8m.
- The deterioration in Clinical Divisions is £1.6m in the month, of which £0.9m is Surgery, £0.3m Women's and Children's and £0.2m Medicine.
- To mitigate the Divisional adverse position, non-recurring support is being used, held in reserves. The level of support used of £8.4m represents the full assessment of the reserve that is available.
- The additional £2.403m represents a profiling adjustment to bring the Trust's budget to date into line with the NHSI plan. This is a presentational issue only and relates to a difference in profiling which has been shown through reserves rather than adjusting a number of predominantly income budgets.

Public Board Meeting - January 2020-30/01/20 - Page 211

Section 2 – Division and Corporate Services Performance against Operating Plan

	Diagnostics & Therapies		Medicine		Specialised Services		Surgery		Women's and Children's		Non Clinical Divisions*		Total	
	M9 £m	YTD £m	M9 £m	YTD £m	M9 £m	YTD £m	M9 £m	YTD £m	M9 £m	YTD £m	M9 £m	YTD £m	M9 £m	YTD £m
Income from Activities	(0.047)	(0.654)	0.273	0.180	(0.036)	(0.644)	(0.359)	(3.081)	0.042	(0.811)	(0.018)	(0.004)	(0.145)	(5.014)
Income from Operations	(0.005)	(0.001)	(0.003)	(0.015)	0.020	(0.004)	(0.017)	(0.146)	0.008	(0.029)	1.034	0.643	1.037	0.448
Nursing & Midwifery	0.004	0.001	(0.112)	(1.142)	(0.012)	(0.082)	(0.146)	(0.658)	0.013	(0.181)	0.018	0.110	(0.235)	(1.952)
Medical & Dental Pay	(0.001)	0.155	(0.093)	(0.358)	(0.077)	(0.424)	(0.034)	(0.138)	(0.111)	(0.062)	(0.054)	(0.070)	(0.370)	(0.897)
Other Pay	0.029	0.043	(0.018)	(0.036)	(0.004)	(0.101)	(0.011)	(0.025)	0.021	0.009	0.046	0.310	0.059	0.200
Non Pay	(0.052)	0.024	(0.137)	(0.120)	0.053	0.732	(0.199)	(0.816)	(0.276)	(0.592)	(0.298)	(0.193)	(0.909)	(0.965)
Total	**(0.072)**	**(0.432)**	**(0.090)**	**(1.491)**	**(0.056)**	**(0.523)**	**(0.766)**	**(4.864)**	**(0.303)**	**(1.666)**	**0.728**	**0.796**	**(0.563)**	**(8.180)**

*Includes Estates & Facilities, Trust Services and Corporate Services

Divisions and Corporate Services are £8.2m adverse to their Operating Plans. The areas of key concern are highlighted.

Diagnostic and Therapies

An adverse variance in month of £0.072m increasing the cumulative adverse variance to £0.432m.

Key variances:

Income from Activities

- An adverse variance of £0.047m in month increasing the year to date adverse variance to £0.654m. The Division's share of income shortfalls in other Divisions is £0.509m adverse year to date. For services hosted by Diagnostics and Therapies, income from activities is £0.046m favourable year to date. The hosted services variance year to date is mainly due to an adverse variance in audiology of £0.158m offset by a favourable variance for diagnostic imaging of £0.249m.

Key action:
Implement plans to improve audiology activity.

Medicine

An adverse variance in month of £0.090m resulting in a cumulative adverse variance of £1.491m.

Key variances:
Income from Activities

- In month a favourable variance of £0.273m. Whilst positive this is less than assumed in the Divisional forecast trajectory and includes favourable variances on emergency in patients £0.208m, day cases £0.016m and ED attendances £0.030m.

Nursing pay

- An adverse variance of £0.112m in month taking the year to date variance to £1.142m. This is explained by escalation capacity in ward 512 that is not included in the operating plan £0.412m year to date, ECO and RMN expenditure £0.147m year to date, pressure to staff ED queue £0.371m year to date, cost of using premium rate staffing to cover sickness and vacancies £0.212 year to date.

Medical pay

- Within the adverse in month variance of £0.093m, Junior Doctors has an adverse variance of £0.081m taking the year to date variance to £0.346m.

Reasons for the adverse variance to date include additional posts previously covering rota gaps within ED earlier in the year, cover for sickness and maternity leave, costs of covering ward 512 and two additional posts continuing to cover Rheumatology 'follow up' backlogs.

Key actions:

Income from activities

- Pursue coding opportunities identified through Dermatology GIRFT review (but may require coding & counting agreement).
- Continue to monitor elective activity recovery plans through monthly specialty reviews.
- Dedicated 'Direct Access' day in Rheumatology to increase throughput of outpatient activity (triaged on arrival).
- Agree bed model and pursue proposal for out of hospital capacity.
- Consider offer of SDEC service in 2020/21.

Nursing pay

- Division will continue to attempt to engage with commissioners and/or AWP in respect of the increasing cost of ECO nurses.
- Division continues to actively pursue overseas recruitment for another 15 Registered Nurses (for each WTE agency replaced by a substantive nurse, the saving is estimated at around £35k per year. net of recruitment fees.
- Anticipated reduction in Tier 4 ECO usage.
- Division to continue working on substantive, Trust employed RMN (front door) model.
- Division to consider initiatives that improve retention rates for specific posts (ACPs and ENPs in ED for example).
- Carefully monitor the "allocate on arrival" initiative to ensure that fill rate is not increased to the point of reduced productivity.

Medical pay

- Fortnightly rota management group now created to identify opportunities to review staffing across the division in real time.
- Continue at pace to implement recruitment process changes identified through the Medical Workforce Task and Finish Group, to reduce any delays in advertising for clinical fellows to fill deanery gaps.
- Consider how to manage the impending shortfall in ED middle grade posts.

- Physicians Associates have now started and will have, in part reduced the need for additional locums.
- Consider how to approach the impending issue of moving to 1:3 rotas.
- Consider opportunity to create joint acute and Endoscopy/Stroke Consultant posts to enhance prospect of recruitment.
- Consider opportunity for joint Acute/Respiratory post
- Consider how SDEC 'offer' may look for 2020/21.

Surgery

An adverse variance in month of £0.766m resulting in a cumulative adverse variance of £4.864m.

Key variances:

Income from activities

- An adverse variance of £0.359m in month taking the year to date variance to £3.081m
- Underperformance in Oral/Dental services £1.004m due to vacancies and sickness in the medical team with pension tax issue reducing availability of additional sessions. The in month adverse variance of £0.059m represents a deterioration in run rate.
- Underperformance in Ophthalmology £0.618m partly due to vacancies and delays in delivering planned productivity gains.
- Underperformance in Trauma and Orthopaedics £0.784m following cancelled elective activity to accommodate cancer recovery work.
- Underperformance in ENT £0.155m due to vacancies and cancellations to support cancer work during a period of bed pressures.

Nursing Pay

- An adverse variance of £0.146m in month taking the year to date variance to £0.658m. QDU £0.190m adverse year to date due to supporting escalation activity. Adult ITU £0.248m adverse linked to acuity in the ward and vacancy cover. BRI Wards combined are £0.215m adverse due to agency costs covering vacancies and sickness.
- Non Pay – To month six non pay reported a favourable variance of £0.036m however a significant deterioration in the last three months has taken the year to date variance to £0.816m adverse. The in month adverse variance was £0.199m being caused by high levels of outsourcing and higher than planned levels of spend on clinical supplies including blood.

Key actions:

- Income – Exploring ways of increasing capacity to avoid cancelled operations, this includes potential increased use of outsourcing and insourcing. Recruitment to vacancies and mobilising weekend sessions to recover Oral/ Dental income. Project manager in the Eye Hospital focussing on delivering income recovery. Improve theatre scheduling processes including more forward planning and avoidance of short notice changes. The Division is working to generate lists of "standby" patients so that a list can continue with day cases of non HDU patients not proceed.
- Nursing – Division is pursuing recruitment of overseas nurses, 10 recruited to date.
- Divisional Working Smarter/ Productivity – working group focussing on identifying and implementing additional productivity/savings schemes. Focus on improving scheduling and reducing length of stay. Recruitment of an 'extended role practitioner' is underway to support the surgical ambulatory pathways.
- More detailed information on actions being taken regarding recovery actions are included as part of the Divisional report.
- Revised non pay controls have been implemented on the back of the implementation of the Managed Inventory System.

Specialised Services

An adverse variance in month of £0.056m resulting in a cumulative adverse variance of £0.523m.

Key variances:

Income from Activities

- An adverse variance of £0.036m in month taking the year to date variance to £0.644m. Cardiology is favourable in month £0.145m taking the year to date variance to £0.033m adverse. Cardiac surgery, £0.464m adverse through vacancies and difficulty in filling sessions. In month deterioration £0.053m. BMT income is adverse to plan by £0.372m an in month improvement of £0.027m. Oncology £0.218m adverse due to capacity constraints in advance of the planned BHOC expansion and staffing vacancies. Private patients are favourable to plan by £0.196m.

Medical pay

- An adverse variance of £0.077m in month taking the year to date variance to £0.424m. Consultants are £0.129m adverse to plan, predominately due to difficulty in covering vacancies in Oncology requiring the use of high cost agency and additional sessions required to deliver activity in

Haematology. Other Medical staff are £0.295m adverse year to date overspends are reported across specialties of Haematology, Cardiac Surgery and Oncology.

Nursing Pay

- Nursing pay is reporting an adverse variance to date of £0.082m, £0.012m adverse in month. The year to date adverse variance is due to ECO costs £0.080m, specialist nursing costs and pressures across the majority of wards.

Key actions:

- Cardiac Surgery income - Continue attempts to fill vacant posts.
- Cardiology income - Going back out to consultants to request additional session cover for vacant slots. Recruit a locum to cover vacant slots. Reviewing annual leave policies. Continue agreeing temporary staffing for Physiology and nursing staff to cover vacancies in these areas. Review utilisation performance of sessions.
- Oncology income - Identification of additional clinic space.
- Medical pay - Continued drives to attract and recruit oncology staff . Consider opportunities to recruit non-medical posts to cover difficult to recruit to roles. Review demand and capacity in haematology. Continue attempts to attract staff into vacancies. Review locum spend in Cardiac surgery and Cardiology.
- Nursing pay – Review ECO practices and improve application. Improve recruitment into Ward D603. Continue new CICU Friday staffing meeting. Continual development of recruitment and retention plans. Review sickness issues in C705.

<u>Women's and Children's</u>

An adverse variance of £0.303m in month resulting in a cumulative adverse variance of £1.666m. The In month variance is caused by a deterioration in non pay of £0.276m mainly in theatres, a deterioration in medical staff £0.111m these being offset by smaller favourable variances on income from activities £0.042, other pay £0.021m. Other smaller variances make up the balance.

Key variances:

Income from activities

- A favourable variance of £0.042m in month taking the year to date adverse variance to £0.811m.
- Neurosurgery is £0.967k adverse, activity is below plan for this low volume high cost service.
- ED is £0.388m adverse with the levels of planned growth not being delivered. However activity has increased since September after lower levels earlier in the year.
- An adverse variance to date in cardiac activity of £0.620m.
- Paediatric surgery is £0.374m adverse through reduced emergency and non-elective activity. However December activity was above planned levels by £0.100m.
- Additional Bone Marrow Transplant activity (28 cases performed this year) has provided £0.562m additional income.
- Both Gynaecology £0.249m and Maternity services £0.192m at St Michaels are reporting significantly favourable variances.

Nursing Pay

- A favourable variance of £0.013m in month taking the year to date variance to £0.181m adverse.
- Costs associated with caring for patients with higher acuity have been particularly high in Caterpillar Ward resulting in additional bed capacity over the first half of the year this coupled with high agency usage has resulted in an adverse variance of £0.037m adverse year to date.
- Neurosciences ward costs are £0.058m adverse year to date due to high agency spend.
- PICU's nursing is £0.401m adverse to plan, due to recruitment to posts that was not factored into the original plan.

Clinical supplies

- Clinical supplies report an adverse variance of £0.197m year to date a deterioration of £0.100m in month, there are adverse variances to date Cardiology and Cardiac Surgery on equipment and supplies.

Key actions:

- Income – The Division is focussed on delivery of contracted volumes and is undertaking a detailed review to determine the forecast going forward and understand opportunities and threats to delivering the contract.
- Nursing – The Division is focussing on ensuring as far as possible that establishments are fully covered for the rest of the year in order to avoid agency costs.

Divisional progress against expected (FOT) trajectories

	Expected Trajectory to Month 09	Actual Variance at month 09	Variance	Control Total FOT
	£m	£m	£m	£m
Diagnostics & Therapies	(0.258)	(0.273)	(0.015)	0
Medicine	(2.225)	(2.245)	(0.020)	(2.400)
Specialised Services	(0.071)	(0.397)	(0.326)	0
Surgery	(4.817)	(5.428)	(0.611)	(6.000)
Women's and Children's	(1.451)	(1.814)	(0.363)	(1.500)
Estates and Facilities	(0.093)	(0.072)	0.021	0
Trust Services	0.055	0.074	0.019	0
Total	**(8.860)**	**(10.155)**	**(1.295)**	**(9.900)**

The table shows, for each division, the expected trajectories at month nine, the actual variance against budget at month nine and where relevant the control total established in October.

Variance to control total trajectories

- **Diagnostics and Therapies –** is currently on track to achieve the control total of breakeven being adverse to trajectory by only £0.015m at month nine. There is a more favourable than expected variance on income from activities mainly due to improvements in other divisions performance of £0.174m offset by adverse variances on pay £0.041m and non pay £0.148m.

- **Medicine –** is off trajectory by £0.020m with a worse than expected variance of £0.215m on nursing pay a favourable variance of £0.041m on other pay a favourable variance of £0.565m on income and an adverse variance of £0.411m on non pay.

- **Specialised Services –** is off trajectory by £0.326m. There is a worse than planned variance on income of £0.204m. Nursing and medical staffing variances are favourable to trajectory by £0.070m, this is offset by an adverse variance on non pay of £0.161m.

- **Surgery –** is adverse to its control trajectory by £0.611m. This is due an adverse variance on income £0.068m and an adverse variance on non pay of £0.536m. Pay remains on trajectory.

- **Women's and Children's –** is adverse to its trajectory by £0.363m with a favourable variance on income of £0.038m offset by an adverse variance on pay £0.205m of which £0.192m relates to medical staff. Non pay reports an adverse variance of £0.195m

- **Estates and Facilities** – The Division remains on trajectory to deliver a breakeven year end position.

- **Trust Services –** The Division remains on trajectory to deliver a breakeven year end position.

Further detail regarding divisional performance against control total trajectories is provided in the individual divisional finance committee reports.

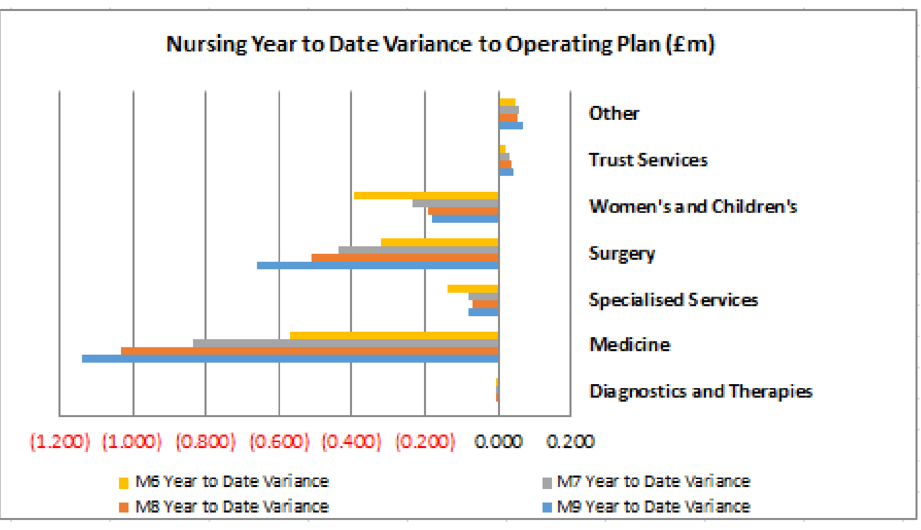
The corporate assessment of aggregate risks and key mitigations is provided in section 8.

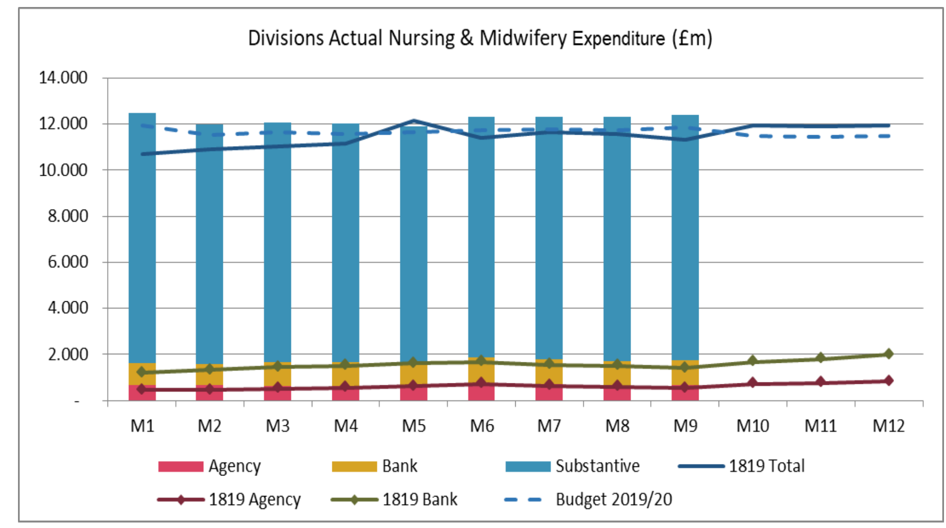
Section 3 – Division and Corporate Services Performance against Subjective Headings

Performance against Operating Plan by subjective heading:

Subjective	Year to Date (Month 9)		
	Op. Plan Var £m	Actual Var. £m	Var. From Plan £m
Income from Activities	0.555	(4.459)	(5.014)
Operating Income	0.115	0.561	0.446
Nursing and Midwifery	(2.449)	(4.401)	(1.952)
Medical Staff - Consultants	(1.544)	(0.876)	0.668
Medical Staff - Others	(0.820)	(2.383)	(1.563)
Other Clinical staff	0.354	0.442	0.088
Non Clinical Staff	0.445	0.702	0.257
Other Pay	0.533	0.388	(0.145)
Drugs	(0.175)	(0.310)	(0.135)
Clinical supplies	(0.592)	(0.120)	0.472
Support Funding	1.510	1.511	0.001
Other non pay	0.957	(0.345)	(1.302)
Total	(1.110)	(9.290)	(8.180)

a) Nursing and Midwifery Pay





Nursing and midwifery spend continues to be significantly adverse to plan for Medicine and Surgery Divisions. Women's and Children's remains adverse but for the third month in a row has reduced that deficit.

Divisional expenditure on Nursing and Midwifery in December was £12.401m, £0.099m higher than November (£12.302m). The increase was across all categories of staffing both temporary and substantive, but mainly in Surgery and Medicine divisions

The nursing lost time percentage for inpatient staff numbers (i.e. wte/hours worked) improved to 124% compared with 126% last month, which is now 4% over the 120% allowance. This accounts for £3.448m of the year to date adverse variance. Medicine remained the highest although they improved by 1% to 129% in month. All other divisions also improved with Surgery (120%) and Specialised Services (119%) getting within the 120% allowance. Women's and Children's improved by 5% and 2% moving to 123% and 126% respectively.

Sickness levels for registered nurses (RN) have seen further increases in most divisions in December. All divisions are now reporting sickness levels above target rates, with Medicine, Specialised Services and Children's at their highest levels of the year. The most significant movement in month was for Specialised Services which increased by 1.6% to 5.0%, against a target of 3.8%. Surgery reported a considerable decrease of 1.2% however is still 0.7% over target. Following a similar trend, the sickness levels for nursing assistants (NA) saw the most significant increase from Specialised Services of 1.0% and the most significant decrease from Surgery of 2.4%. All divisions are reporting sickness levels above the target rates for nursing assistants, with the exception of Children's.

Vacancies for registered nurses (RN) have remained broadly static with the exception of Medicine where vacancies have increased by 1.8% compared to November. All remain above target (5%) except for Women's and Children's. The only significant changes in nursing assistant (NA) vacancies were in Medicine and Children's. Medicine decreased from 3.1% to 0.1%, while Children's increased from 1.0% to 4.5%. Surgery remains the highest level of NA vacancies at 12.5%.

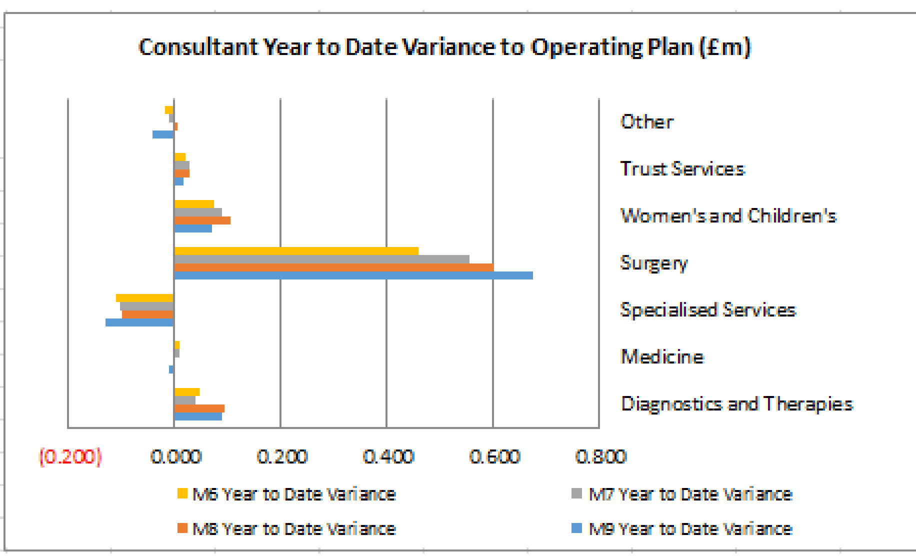
The cost of ECOs saw a substantial increase compared to November. This was mostly driven by a particularly high month for Medicine at £0.145m and Surgery at £0.052m. Women's and Children's continue to have particularly low costs for the third time in a row, reporting £0.002m, the lowest figure to date.

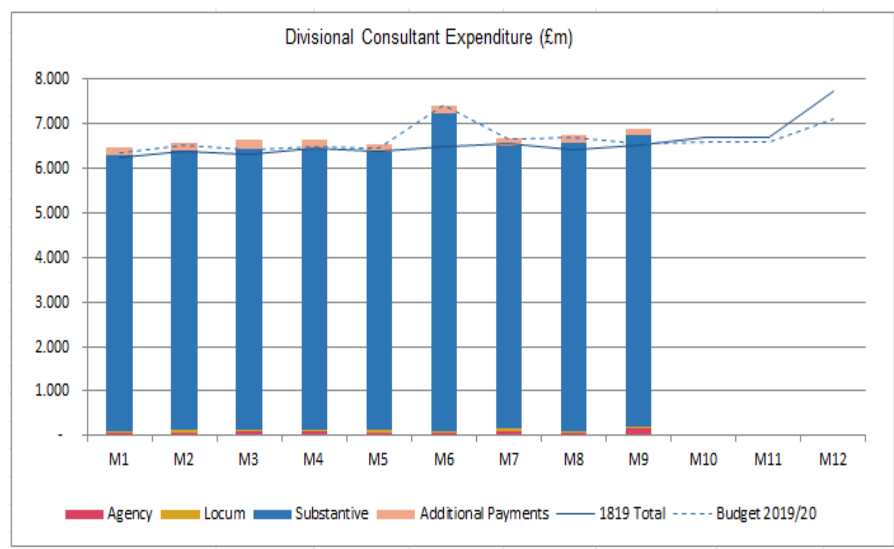
Medicine continues to have the highest variance to Operating Plan for nursing staff at £1.142m adverse year to date, this is a slight improvement on run rate in the month. Actual expenditure increased in month by £0.070m reflecting an increase in agency expenditure of £0.054m of which most was due to RMNs. The largest contributing factors for the adverse position to plan are the escalation ward (A512) remaining open (£0.412m year to date), staffing the ED queue (£0.371m) and the cost of ECO's and RMN's (£0.147m).

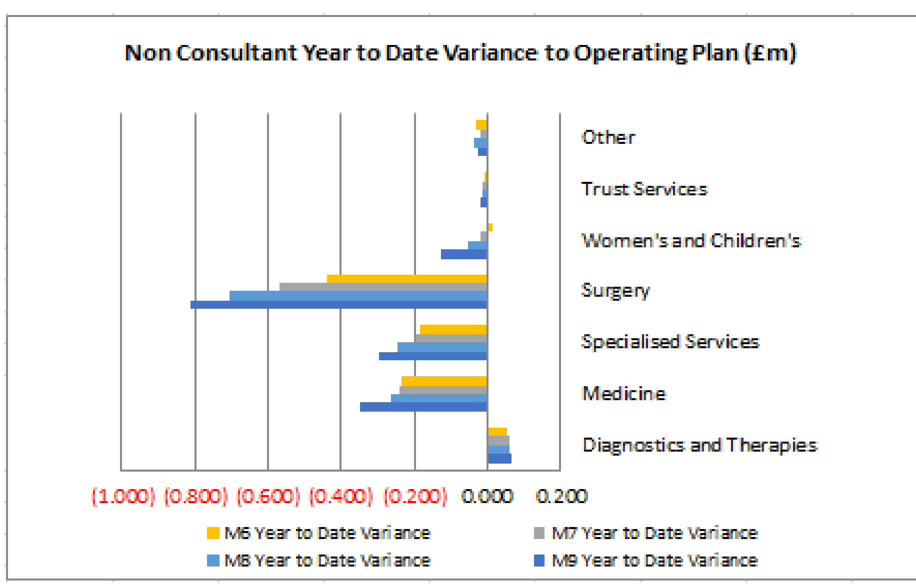
Surgery continued to worsen with an in month adverse position of £0.146m and are the second most adverse to plan at £0.658m year to date. The in month position was significantly worse than November due to additional capacity in QDU and the ongoing sickness issues. Acuity continues to be a challenge for the division and actual expenditure on nursing increased by £0.124m of which £0.056m was related to agency staff use.

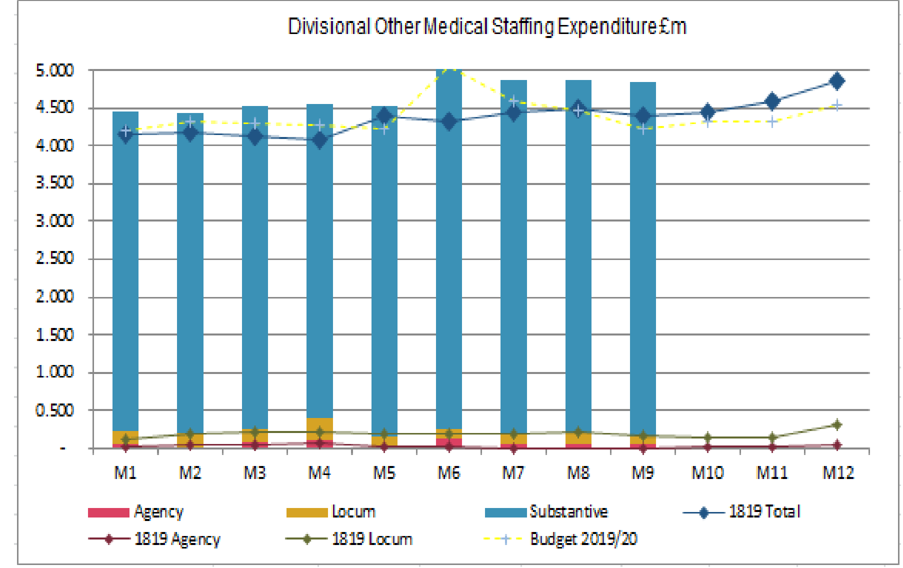
Women's and Children's continue an improving in month run rate with December's position improving by £0.013m to a year to date adverse position of £0.181m compared to £0.194m in November. The year to date position reflects in part additional capacity planned in ED alongside higher staffing numbers in PICU following better than anticipated recruitment to vacancies. The improvement in month reflects continued efforts to manage sickness and vacancies which has resulted in reduced agency costs in month.

b) Medical and Dental Pay









Medical and Dental pay in total has a year to date adverse variance to Operating Plan of £0.895m (£0.527m in November). Consultant expenditure is favourable to plan (£0.668m) with non consultant expenditure being £1.563m adverse to plan.

Absolute expenditure on Medical and Dental staff in Divisions was £11.719m which is slightly higher than November's figure of £11.581m reflecting increased in agency and substantive staff costs but a decrease in locum costs.

Additional payments remained broadly static for Consultants compared to November and reduced slightly for other grades.

Specialised Services is adverse to plan for both Consultant and other medical staffing – totalling £0.424m adverse year to date both were an in month worsening. The year to date position for Consultants is due to overspends in Oncology and Haematology, due to the premium of cost of vacancy cover and a shortage of available staff to recruit substantively. Other medical staff is £0.295m adverse year to date, £0.048m in month. Overspends reflect cover for vacancies in the year to date and the cost of additional sessions and maternity cover. Whilst maternity cover will continue as a pressure work continues to review locum cover arrangements and to increase recruitment into vacancies.

Medicine has a total medical staffing position of £0.358m year to date which is entirely due to other medical staff, with December being a particularly high month. Ward A512 is still requiring cover either through additional sessions or locums, there has been additional staffing for the ED queue.

Surgery has a large favourable year to date variance to plan for consultants of £0.675m but an adverse variance for other medical staff at £0.813m. The consultant variance is driven by vacancies in Dental and Trauma & Orthopaedics as well as lower spend in Ophthalmology due to both vacancies and lower uptake of additional sessions. The adverse variance on 'other medical staff' is caused by additional session costs over and above the level of vacancies in particular in Anaesthetics and the Eye Hospital. The run rate has remained reasonably steady over the last three months, though it did improve slightly in December.

Section 4 – Clinical and Contract Income

Contract income by work type:

	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	0.035	17.734	17.770	0.036
Bone Marrow Transplants	0.082	6.351	6.538	0.187
Critical Care Beddays	0.032	41.307	42.573	1.266
Day Cases	(0.261)	31.305	30.747	(0.558)
Elective Inpatients	(0.481)	46.557	42.213	(4.343)
Emergency Inpatients	0.615	83.997	82.772	(1.225)
Excess Beddays	0.017	4.830	4.602	(0.228)
Non-Elective Inpatients	0.003	25.105	25.740	0.635
Other	(0.242)	53.969	53.583	(0.385)
Outpatients	(0.116)	62.659	60.945	(1.714)
Total Activity Based	(0.317)	373.813	367.483	(6.330)
Contract Penalties	(0.228)	(1.026)	(1.663)	(0.637)
Contract Rewards	(0.177)	4.160	3.780	(0.381)
Pass through payments	0.801	63.241	67.201	3.960
Prior Year Income	(0.000)	1.849	1.849	0.000
Other	0.276	24.833	25.833	1.001
PSF Funding	0.000	6.224	6.224	(0.000)
Prior Year PSF Allocation			0.710	0.710
2019/20 Total	0.354	473.093	471.417	(1.677)

The level of coded spells for December is 82.4%

- Activity based income was £0.3m adverse in December, (compared to £1.4m favourable in November), resulting in a £6.3m adverse position year to date. Emergency inpatients and outpatient attendances continue to show improvement compared to previous months.

- Elective inpatients (including day cases) was £0.5m below plan in December worsening the position to £4.4m adverse to plan for the year. The movement in month is predominantly £0.1m within Specialised Services and £0.2m in Women's and Children's with Trust overheads share being £0.1m.

- Emergency inpatients are £0.6m above plan in the month reducing the year to date adverse position to £1.2m of which £0.6m is within Surgery, £0.3m in Medicine, £0.3m in Women's and Children's with Trust overheads share being £0.3m. This is offset by Specialised Services being £0.3m favourable.

- Other income is £0.2m below plan in month. In includes CAR-T for which there were no treatments in December contributing £0.15m underperformance in month.

- Outpatients is £1.7m below plan to date. Surgery is £1.0m below plan and Specialised Services is £0.4m below plan, with Trust overheads share being £0.4m.

- The Trust has received penalties of £1.7m year to date, £0.6m greater than planned. This is predominantly due to RTT 52 week waits, cancelled operations and the expectation that the emergency care risk share framework will result in marginal rate payment above the agreed plan for 2019/20.

- CQUIN performance is now shown as £0.4m adverse to plan, recognising the Commissioner's strict adherence to national rules for calculation. Forecast outturn is now 77%.

- Income relating to pass through payments was £4m above plan to date. Excluded drugs are £3.6m above plan which includes CAR-T cell therapy products.

Section 5 – 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	0.019	0.019	-
Blood	0.133	0.102	0.102	-
Diagnostic Testing	0.181	0.104	-	(0.104)
Estates & Facilities	0.420	0.327	0.328	0.001
Healthcare Scientists Productivity	0.139	0.104	0.028	(0.076)
HR Pay and Productivity	0.058	0.046	0.054	0.008
Income, Fines and External	0.579	0.442	0.448	0.006
Medical Pay	0.286	0.215	0.206	(0.009)
Medicines	1.070	0.955	1.382	0.427
Non-Pay	4.200	3.235	3.475	0.240
Nursing Pay	0.369	0.251	0.202	(0.049)
Other / Corporate	1.361	1.021	1.021	-
Productivity	5.619	4.246	2.686	(1.560)
Trust Services	0.490	0.371	0.368	(0.003)
Plans in development	1.945	1.459	-	(1.459)
Total	**16.876**	**12.896**	**10.318**	**(2.578)**

Analysis by Division:

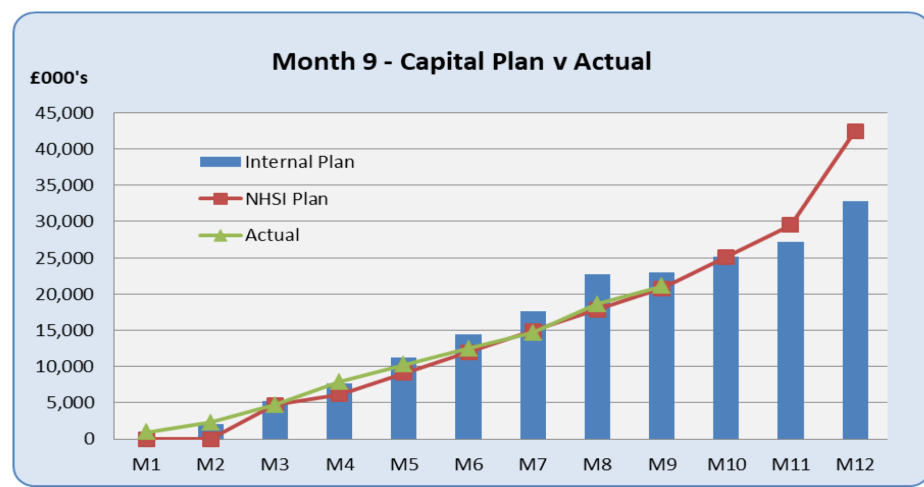
	2019/20 Annual Plan £m	Year to date		
		Plan £m	Actual £m	Variance fav/(adv) £m
Diagnostics & Therapies	1.625	1.230	1.108	(0.122)
Medicine	2.832	2.107	1.141	(0.966)
Specialised Services	1.992	1.578	1.774	0.195
Surgery	4.577	3.579	1.999	(1.580)
Women's & Children's	3.366	2.526	2.308	(0.219)
Estates & Facilities	0.512	0.394	0.506	0.111
Finance	0.158	0.119	0.118	(0.001)
Human Resources	0.101	0.081	0.077	(0.005)
IM&T	0.164	0.121	0.126	0.005
Trust Headquarters	0.188	0.141	0.142	0.001
Miscellaneous Support	0.216	0.162	0.162	-
Corporate/Capital Charges	1.145	0.859	0.859	-
Total	**16.876**	**12.896**	**10.318**	**(2.578)**

- The savings requirement for 2019/20 is £16.876m. To date, the Trust has achieved savings of £10.318m against a plan of £12.896m leaving a shortfall to date of £2.578m.
- Surgery is £1.580m behind plan of which £0.700m relates to underachievement on productivity plans, the balance is represented by minor slippage on existing plans and a remaining gap which will have to be found through maturing schemes currently in the Divisional pipeline but which are as yet insufficiently developed.
- Medicine is £0.966m behind plan to date. The currently worked up plans are on track to deliver, however the balance will need to be delivered by maturing schemes currently in the Divisional pipeline.
- The Trust is forecasting to make savings of £14.408m by year end, 85% of plan; a deterioration of £0.126m from the forecast in November. Forecast delivery for Productivity has deteriorated by £0.069m and Diagnostic Testing by £0.052m, the balance is due to minor changes in other workstreams.

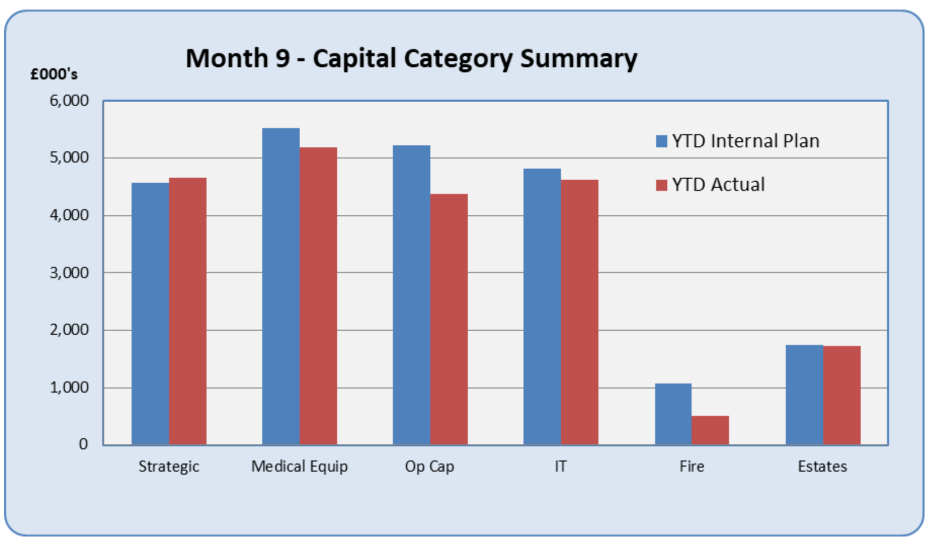
Key Actions:

- 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.

Section 6 – Capital Programme



Programme Analysis



Key Points

- The forecast outturn has been updated at quarter end to £32.767m, a £3.385m reduction on the quarter two forecast. The decrease primarily relates to the current month variance, the Strategic Capital Clinical Services (SCCS) schemes, the fire improvement programme and a high level slippage review.

- The reassessment of the SCCS programme is dependent on the estates master planning exercise and infrastructure review, which are due to be reported in February, with schemes being taken forward in 2020/21.

- At 31st December capital expenditure was £21.084m against a profiled internal plan of £22.954m, £1.870m behind plan. The variance can be seen in the programme analysis chart.

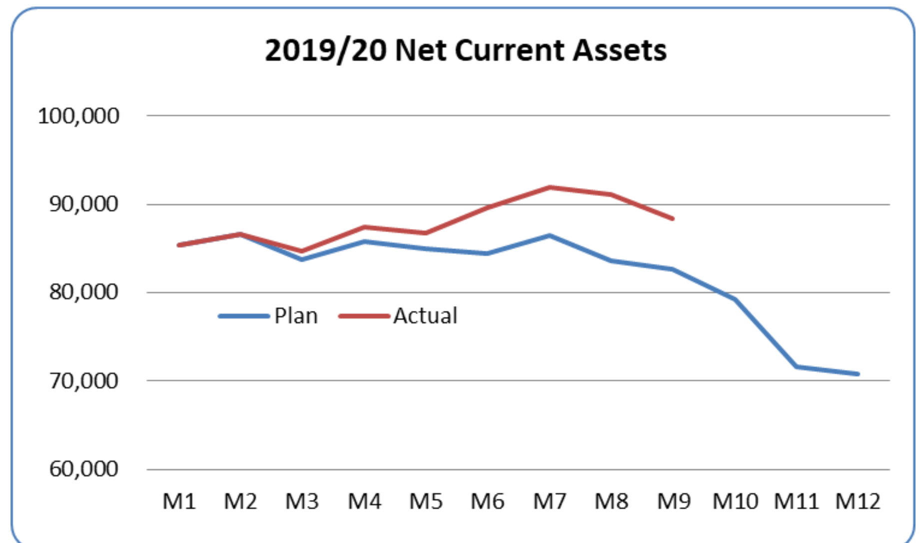
- The key variances were medical equipment, operational capital and fire improvement which were behind plan by £0.340m £0.844m and £0.570m respectively. The variances in medical equipment and operational capital principally relate to timing differences as a result of capacity constraints with a risk of further slippage into 2020/21. The fire improvement variance is explained below.

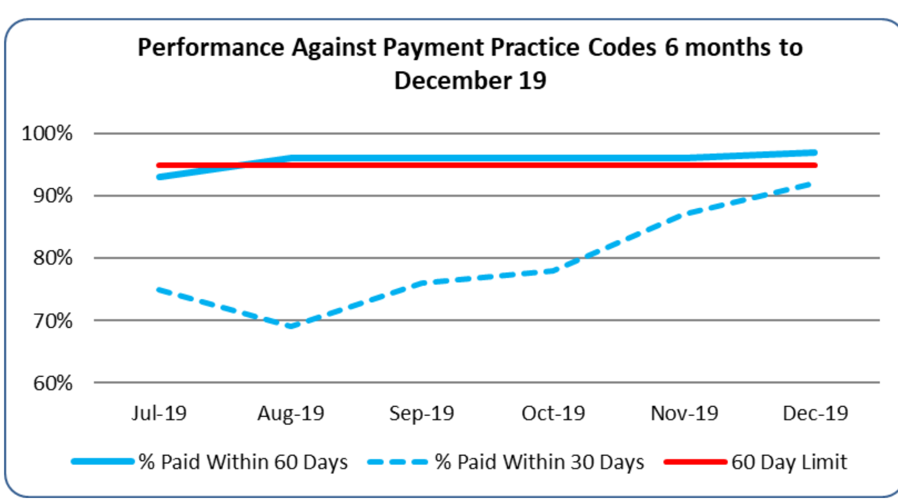
- Expenditure in the final quarter of the year is expected to be £11.683m, significantly higher than previous quarters. This increase in spend is in line with expectations as Combined Heat and Power scheme has commenced and high value medical equipment procurements will complete in year.

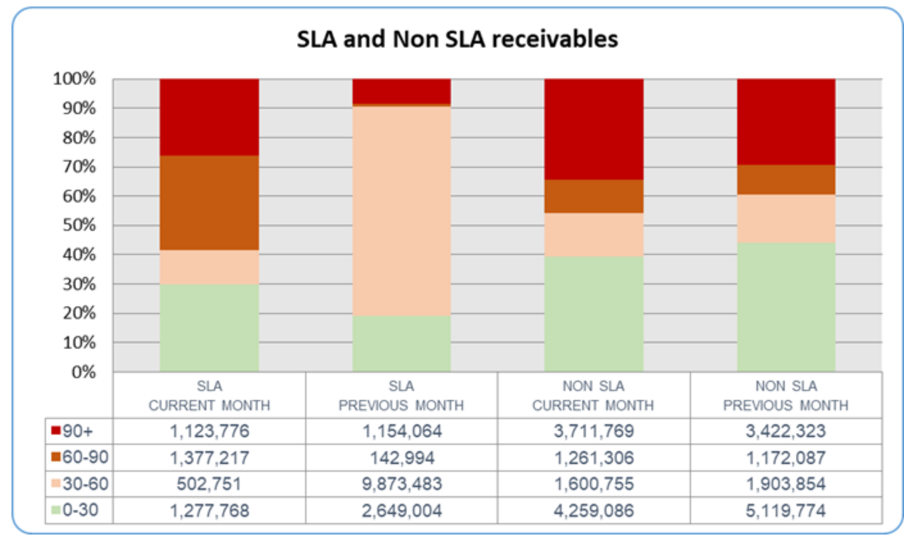
- The fire improvement programme is behind plan, by £0.570m. The programme is split into two phases; phase 1 is due to complete in January with phase 2 originally planned to commence in January. There is currently a delay on phase 2 as tender evaluations are undertaken and the Estates department will report back to Capital Programme Steering Group (CPSG) in February 2020.

- The fire improvement monitoring format was agreed at CPSG and will be used to report the financial and operational progress of the programme on a monthly basis.

Section 7 – Statement of Financial Position and Cashflow







	SLA CURRENT MONTH	SLA PREVIOUS MONTH	NON SLA CURRENT MONTH	NON SLA PREVIOUS MONTH
90+	1,123,776	1,154,064	3,711,769	3,422,323
60-90	1,377,217	142,994	1,261,306	1,172,087
30-60	502,751	9,873,483	1,600,755	1,903,854
0-30	1,277,768	2,649,004	4,259,086	5,119,774

Key Points

- The net current assets at 31 December were £88.440m, £5.814m higher than the NHSI plan.
- The Trust's cash and cash equivalents balance was £117.727m, £2.239m higher than the NHSI plan. The cash balance variance primarily relates to slippage on the capital programme and a delay in the receipt of public dividend capital funding.
- The receivables positon of £15.114m decreased in month by £10.324m however receivables over 90 days old increased by £0.259m to £4.836m. Furthermore, the Trust received £1.124m in January for invoices outstanding at 31 December.
- In December, 97% of invoices were paid within the 60 day target set by the Prompt Payments Code and 92% were paid within the 30 day target set by the Better Payment Practice Code (BPPC).

Section 8 - Corporate Assessment of Aggregate Risks and Key Mitigations

The financial position reported in month 8 and in particular the improved income position, led to an increased confidence in the Trust' ability to deliver the year-end control total. Although this remains the case at Month 9, it is evident that there is a significant level of volatility in terms of monthly financial performance, even after taking into account the fact the Trust planned to make a deficit in December.

The previous corporate assessment suggested the need to mitigate divisional financial risks of up to £11m against which we could allocate £8.5m of corporate reserves. So a potential problem of £2.5m.

Such is the variability in financial performance in the last two months we have now undertaken a number of assessments in order to establish a range of potential positions at year end. These include corporate income projections, revised detailed forecasts at divisional level and comprehensive reviews of reserves and other balance sheet flexibilities. Although these indicate a wide range of potential out-turns, from a surplus of £1m to £5m, the most-likely position still delivers the control total.

Given the main financial pressure this year relates to our under-performance in terms of activity, this will also create a compounding pressure in 2020/21, in terms of the reduced income baseline. Given this context, it is clearly vital for the Trust to get to a position of greater confidence in terms of delivering this year, as soon as possible, in order to order to increase the focus on the development and implementation of the Operating Plan for next year.

Appendix 1

UNIVERSITY HOSPITALS BRISTOL NHS FOUNDATION TRUST

Finance Report December 2019– Summary Income & Expenditure Statement

Approved Budget / Plan 2019/20	Heading	Position as at 30th November			Actual to 30th November
		Plan	Actual	Variance Fav / (Adv)	
£'000		£'000	£'000	£'000	£'000
	Income				
628,579	From Activities	472,888	466,045	(6,843)	415,054
96,819	Other Operating Income (excluding PSF & MRET)	72,201	72,767	566	63,593
725,398	**Sub totals income**	545,089	538,812	(6,277)	478,647
	Expenditure				
(423,790)	Staffing	(317,006)	(323,132)	(6,126)	(286,464)
(249,970)	Supplies and Services	(186,154)	(185,150)	1,004	(163,653)
(673,760)	**Sub totals expenditure**	(503,160)	(508,282)	(5,122)	(450,117)
(12,884)	Reserves	(8,419)	–	8,419	–
–	NHS Improvement plan profile	(2,403)	–	2,403	–
38,754	Earnings before Interest,Tax,Depreciation and Amortisation	31,107	30,530	(577)	28,530
5.34	**EBITDA Margin – %**		5.67		5.96
	Financing				
(23,939)	Depreciation & Amortisation – Owned	(17,835)	(18,061)	(226)	(16,022)
244	Interest Receivable	183	658	475	584
(216)	Interest Payable on Leases	(162)	(163)	(1)	(145)
(2,300)	Interest Payable on Loans	(1,748)	(1,748)	–	(1,558)
(9,950)	PDC Dividend	(7,462)	(7,109)	353	(6,335)
(36,161)	**Sub totals financing**	(27,024)	(26,423)	601	(23,476)
2,593	NET SURPLUS / (DEFICIT) before Technical Items excluding PSF & MRET	4,083	4,107	24	5,054
9,576	Provider Sustainability Funding (PSF) – Core	6,224	6,224	–	5,267
646	Marginal Rate Emergency Tariff (MRET)	486	486	–	432
	Prior year PSF post accounts reallocation		710	710	710
12,815	SURPLUS / (DEFICIT) before Technical Items including PSF & MRET	10,793	11,527	734	11,463
	Technical Items				
3,800	Donations & Grants (PPE/Intangible Assets)	2,250	1,149	(1,101)	1,039
(1,393)	Impairments	–	–	–	–
505	Reversal of Impairments	–	–	–	–
(1,590)	Depreciation & Amortisation – Donated	(1,188)	(1,222)	(34)	(1,085)
14,137	SURPLUS / (DEFICIT) after Technical Items including PSF & MRET	11,855	11,454	(401)	11,417

UNIVERSITY HOSPITALS BRISTOL NHS FOUNDATION TRUST

Finance Report December 2019 – Divisional Income & Expenditure Statement

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 30th November	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)											
621,847	Contract Income	466,384	466,384	–	–	–	–	–	–			
–	Penalties	–	(229)	–	–	–	(229)	(229)	(83)			
–	Contract Rewards	–	(379)	–	–	–	(379)	(379)	(203)			
–	Overhead share of income variance	–	(1,503)	–	272	–	(1,775)	(1,503)	(1,377)			
36,539	NHSE Income	27,197	27,197	–	–	–	–	–	–			
658,386	**Sub Total Corporate Income**	**493,581**	**491,470**	**–**	**272**	**–**	**(2,383)**	**(2,111)**	**(1,663)**			
	Clinical Divisions											
(60,685)	Diagnostic & Therapies	(45,365)	(45,638)	685	(570)	63	(451)	(273)	(178)	159	(432)	(110)
(86,955)	Medicine	(65,204)	(67,449)	(3,014)	604	(15)	180	(2,245)	(2,045)	(754)	(1,491)	(984)
(119,235)	Specialised Services	(89,127)	(89,524)	(871)	973	71	(570)	(397)	(322)	126	(523)	280
(119,077)	Surgery	(89,326)	(94,754)	(1,990)	(269)	(146)	(3,023)	(5,428)	(4,576)	(564)	(4,864)	(1,434)
(139,293)	Women's & Children's	(104,114)	(105,928)	(1,687)	477	31	(635)	(1,814)	(1,465)	(148)	(1,666)	(217)
(525,245)	**Sub Total – Clinical Divisions**	**(393,136)**	**(403,293)**	**(6,877)**	**1,215**	**4**	**(4,499)**	**(10,157)**	**(8,586)**	**(1,181)**	**(8,976)**	**(2,465)**
	Corporate Services											
(40,831)	Estates and Facilities	(29,929)	(30,001)	109	(114)	3	(70)	(72)	(57)	2	(74)	122
(33,851)	Trust Services	(24,739)	(24,665)	440	(300)	(66)	–	74	78	(5)	79	4
(6,821)	Other	(3,848)	(2,981)	203	(68)	622	110	867	108	76	791	–
(81,503)	**Sub Totals – Corporate Services**	**(58,516)**	**(57,647)**	**752**	**(482)**	**559**	**40**	**869**	**129**	**73**	**796**	**126**
(606,748)	**Sub Total (Clinical Divisions & Corporate Services)**	**(451,652)**	**(460,940)**	**(6,125)**	**733**	**563**	**(4,459)**	**(9,288)**	**(8,457)**	**(1,108)**	**(8,180)**	**(2,339)**
(12,884)	Reserves	(8,419)	–	–	8,419	–	–	8,419	8,419			
–	NHS Improvement plan profile	(2,403)	–	–	2,403	–	–	2,403	738			
(12,884)	**Sub Total Reserves**	**(10,822)**	**–**	**–**	**10,822**	**–**	**–**	**10,822**	**9,157**			
38,754	**Earnings before Interest,Tax,Depreciation and Amortisation**	**31,107**	**30,530**	**(6,125)**	**11,827**	**563**	**(6,842)**	**(577)**	**(963)**			
	Financing											
(23,939)	Depreciation & Amortisation – Owned	(17,835)	(18,061)	–	(226)	–	–	(226)	(188)			
244	Interest Receivable	183	658	–	475	–	–	475	421			
(216)	Interest Payable on Leases	(162)	(163)	–	(1)	–	–	(1)	(1)			
(2,300)	Interest Payable on Loans	(1,748)	(1,748)	–	–	–	–	–	(1)			
(9,950)	PDC Dividend	(7,462)	(7,109)	–	353	–	–	353	297			
(36,161)	**Sub Total Financing**	**(27,024)**	**(26,423)**	**–**	**601**	**–**	**–**	**601**	**528**			
2,593	**NET SURPLUS / (DEFICIT) before Technical Items excluding PSF & MRET**	**4,083**	**4,107**	**(6,125)**	**12,428**	**563**	**(6,842)**	**24**	**(435)**			
9,576	Provider Sustainability Funding (PSF) – Core	6,224	6,224	–	–	–	–	–	–			
646	Marginal Rate Emergency Tariff (MRET)	486	486	–	–	–	–	–	–			
–	Prior year PSF post accounts reallocation	–	710	–	–	710	–	710	710			
10,222	**Sub Total PSF & MRET**	**6,710**	**7,420**	**–**	**–**	**710**	**–**	**710**	**710**			
12,815	**SURPLUS / (DEFICIT) before Technical Items including PSF & MRET**	**10,793**	**11,527**	**(6,125)**	**12,428**	**1,273**	**(6,842)**	**734**	**275**			
	Technical Items											
3800	Donations & Grants (PPE/Intangible Assets)	2,250	1,149	–	–	(1,101)	–	(1,101)	(961)			
(1,393)	Impairments	–	–	–	–	–	–	–	–			
505	Reversal of Impairments	–	–	–	–	–	–	–	–			
(1,590)	Depreciation & Amortisation – Donated	(1,188)	(1,222)	–	(34)	–	–	(34)	(31)			
1,322	**Sub Total Technical Items**	**1,062**	**(73)**	**–**	**(34)**	**(1,101)**	**–**	**(1,135)**	**(992)**			
14,137	**SURPLUS / (DEFICIT) after Technical Items including PSF & MRET**	**11,855**	**11,454**	**(6,125)**	**12,394**	**172**	**(6,842)**	**(401)**	**(717)**			

Meeting of the Board of Directors in Public on Thursday 30 January 2020

Report Title	**Learning from Deaths Report – Q1 & Q2 Update**
Report Author	**Mark Callaway, Deputy Medical Director**
Executive Lead	**William Oldfield, Medical Director**

1. Report Summary

This report summarises the learning from deaths process for quarter 1 and quarter 2 of 2019/2020.

2. Key points to note
(Including decisions taken)

- The report demonstrates a similar number of adult deaths within the organisation as to the 2 previous years.
- There was no avoidable death in the first 2 quarters of 2019/2020.
- The process of Learning from Deaths in patients with learning difficulties has been refined and embedded.

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

The risks associated with this report include:

- Consistent engagement with the Consultant body is required to ensure timely reviews.

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

- This report is for **Assurance.**

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

Quality and Outcomes Committee	27th January 2020

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Learning from Deaths

Report for Quarter 1 and 2

for 2019/2020

MP Callaway

20th January 2020

Introduction

The learning from deaths process has been established within the organisation and all adult deaths excluding out of hospital cardiac arrests continue to be screened by the lead Mortality Nurse. This process allows the Mortality Nurse to assess the quality of patient care and where the patient notes trigger the Structured Case Note Review these are then are distributed to the relevant Division for further assessment and further reviews are undertaken.

This report summarises the activity in quarters 1 and 2 2019/2020.

Report

The figures for quarter 1 2019/2020 are very similar to the figures reported for the same quarters last year. There were 555 adult deaths in the first 2 quarters of 2018/2019 compared to 566 for the first two quarters of this year. These are all deaths that are not out of hospital cardiac arrest. Again these numbers are very similar 73 in 2018/19 compared to 64 in the first 2 quarters of this year.

All adult in patient deaths were screened by the lead Nurse in Mortality and 22% were identified as needing a further Structured Case Note Review (SCNR).

One death in quarter one required a further secondary screen and but no death within this quarter was identified as potentially avoidable.

The standard of care across the domains of care remained good, with little identified change when compared to the recent Annual report.

The learning from deaths process was reviewed as a part of the Trusts CQC visit in Quarter 1 and 2 and was noted to be an area of outstanding practice.

'The approach to learning from deaths was exemplary with a clear focus on areas other than clinical needs such as dignity, end of life care and the experiences of those close to patients. The team had discovered the extra benefits the bereavement team could offer given their proximity to those close to patients who had died. The importance of the soft intelligence they could gain was clearly understood and used to make improvements to the care of patients who were dying and those close to them.'

There was one death in these two quarters that triggered a second review from the MD team office, this was in a patient in whom there was a potential delay in the diagnosis of chest pain in a patient who developed a Non ST elevation myocardial infarction, the patient underwent Coronary angiography the following morning but there was a delayed, and as such this death falls into the category of potentially avoidable. The details of this case were shared with the appropriate clinical teams.

	Quarter 1 (Apr – Jun 19)	Quarter 2 (July – Sept 19)	Quarter 3 (Oct – Dec 19)	Quarter 4 (Jan – Mar 20)	Totals
Total deaths (in Patients)	325	294			**619**
OOHCA	36	28			**64**
Total excluding OOHCA	299	266		-	**566**
Total SCNR identified	70 (23%)	48 (18%)			**118 (21%)**
Medicine	40 (13%)	20 (7%)			**60**
complete	9	0			**9**
pending	31	20			**51**
Surgery	18 (6%)	10 (4%)			**28**
complete	5	1			**6**
pending	13	9			**22**
Specialised Services	12 (4%)	17 (6%)			**29**
complete	6	7			**13**
pending	6	10			**16**
Number triggering MDO Review	1	0			**1**
Number of SI reports in the last episode of care related to patient death	5	6			
Number of avoidable deaths	**0**	0			
Number of Deaths in patients with Learning Difficulties	**0**	2			

3

Proposals going forward for 2019/2020

Changes To the review system

1. Medical Examiners

A new system overseeing the method of certification of death is being rolled out in England. This system is dependent on the appointment of Medical Examiners who will review all adult deaths within acute providers and discuss each case with both the clinical team and next of kin prior to the issuing of a death certificate. Currently 3 UK Trusts have adopted this method, which is likely to be statuary by the end of this year. A regional Medical Examiner has been appointed and a project team has been recruited to co-ordinate and lead this work which is being undertaken as collaboration between NBT, UHBristol and Weston. This work is being led in UHBristol by Dr Emma Redfern and Dr Mark Callaway.

A project plan has been constructed to provide 7 day cover overall all organisations and work with both internal and external stakeholders. The job Description for both Lead Medical Examiner and the lead Medical Examiners officer are currently going through each organisations governance system with a view to recruitment in March and a role out of the new system in August 2020.

It is likely that the provision of the Medical Examiner service will replace much of the work undertaken by the lead nurse for Mortality and although the Medical Examiners will not be undertaken Structured Case Note Review (SCNR), any concerns raised by their initial review will be entered into the appropriate Trusts governance system.

2. The loss of the Adult Mortality Screening Nurse

Tina Whiting who was an inaugural member of the Learning from Deaths Team and has been the lead Mortality Nurse responsible for screening and developing the system of recording data since that time. Tina is leaving the team at the end of quarter 2. One of the largest pieces of work Tina undertook was to review all the additional groups of patients, other the statutory triggers, and who had triggered a SCNR. This piece of work was undertaken by Tina and the Clinical Fellows and indicated that no patient safety concerns were identified despite screening these additional patients with a SCNR.

A decision was then made to reduce the number of categories of patient to be reviewed to the five statutory categories, where SCNR will be undertaken. This was proposed as a practical solution during this period of transition which brings this system more in line with the two other Trusts as we move to adopt the medical examiner system.

We have the reassurance of the work completed over the last two years by the Lead mortality nurse to support and inform this decision. This will mean, consequently that there are a lower number of SCNRs completed.

Reviews and Involvement of the Consultant Body

The Senior Leadership team supported the proposal to include a structured Case Note review into the Professional Supportive activity of all consultants caring for Adults. The philosophy supporting this decision was that it allowed all Doctors to review the care being provided within the organisation.

There are several outstanding reviews that have spent a long time allocate to reviewers and we are currently in transitional year working with all the Clinical Divisions to ensure all consultants deliver on their professional responsibilities with regard to the Learning from Deaths process.

This work is being co-ordinated via the MD office.

The involvement of LEDER team

The LEDER process for co-ordinating for reviewing and assessing deaths in patients with learning Difficulties has been refined and embedded into the process for learning from deaths. The LEDER nurse will liaise and request a mortality review, SCNR, which is completed promptly and signed off within the Division.

Conclusion.

The Learning form deaths process demonstrates that although there is consistency between the number of deaths and the number of these deaths triggering review that the majority of cases demonstrate good care, with only a small amount of cases being referred for a second review to assess avoid ability.

There were no avoidable deaths in the first two quarters of 2019/2020.

Dr MP Callaway

20th January 2020

Meeting of the Board of Directors in Public on Thursday 30 January 2020

Report Title	Report On Safe Working Hours: Doctors And Dentists In Training January 2020
Report Author	Dr Alistair Johnstone, Guardian Of Safe Working
Executive Lead	Dr William Oldfield, Medical Director

1. Report Summary

The 2016 Junior Doctor contract has been introduced for all doctors in training employed at the Trust. This report summarises the exception reports raised over the past 12 months and the use of additional internal and external locum / agency staff to cover additional workload and rota gaps. In addition there have been a number of changes agreed to the 2016 TCS which are gradually being introduced in the 12 months from August 2019. Many of these changes increase the number of staff required to provide a safe rota – the degree of readiness for each rota in the Trust is also described.

2. Key points to note
(Including decisions taken)

- Summary of 2019 exception reports
- Ongoing reliance on internal locums to cover additional work of 4,000 – 5,000 additional hours / month
- Summary of immediate safety concerns
- Delay in roll out of eRostering
- Update on readiness of individual rotas against the changes to the 2016 contract being phased in from Aug 19

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

The risks associated with this report include:
Describes areas of the Trust where workload or staffing numbers have the potential to impact the ability to ensure safe levels of medical staffing and the ability of junior medical staff to access educational opportunities. Excessive workload has a negative effect on staff morale.

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

- This report is for **Assurance.**

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

SLT	22 January 2020

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QUARTERLY REPORT ON SAFE WORKING HOURS: DOCTORS AND DENTISTS IN TRAINING January 2020

Executive summary

The 2016 Junior Doctor contract has been introduced for all doctors in training employed at the Trust. This report summarises the exception reports raised over the past 12 months and the use of additional internal and external locum / agency staff to cover additional workload and rota gaps. In addition there have been a series of changes agreed to the 2016 TCS which are gradually being introduced in the 12 months from August 2019. Many of these changes increase the number of staff required to provide a safe rota – the degree of readiness for each rota in the Trust is also described.

This paper will be presented to the public board in January and is published on the Trusts external website. It may also form part of future CQC inspections.

Introduction

The 2016 contract (amended in July 2019 following negotiations between NHS employers), and a locally adapted version of it, is now used for all training grade doctors and local equivalents employed by the Trust from August 2019. There continues to be a small number of doctors employed on the 2002 TCS but it expected that this number will decline with rotations to new posts over the coming 12 months. It is unlikely that we will have anyone employed on the old TCS beyond August 2020.

High level data

Number of doctors / dentists in training (total):	638
No of locally employed doctors on 2018 TCS	150
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 and less than Weston General)

a) Exception reports

One of the key changes of the new contract is the introduction of a system called exception reports. This system allows doctors to submit a report when their actual hours of work vary from their rota, they fail to get adequate rest breaks or they are unable to attend agreed educational activities due to service commitments. This system replaces a previous system of rota monitoring which was widely viewed as no longer being fit for purpose.

The new system requires the junior doctors supervisor to meet with the doctor and discuss the reasons for each report being submitted. In the case of additional hours being worked a decision is then made to either allow the doctor compensatory time off in lieu or payment for the additional hours. The reports are subsequently reviewed by the Medical HR department and the Guardian of Safe Working to ensure safe working limits are not exceeded. Where these limits are breached there may be a "fine" levied against the division involved.

The contract refresh has placed increased emphasis on an educational supervisor reviewing and discussing any exception reports in a timely manner – the target is to have a review within 7 days of submission. This target is particularly challenging as delays can be caused by both junior doctor and supervisor workload and work pattern. However, considerable work by the Medical HR team and the Divisional teams has seen a consistent reduction in the average time taken to sign off reports:

Month	August	September	October	November	December
Average time to review / sign off reports (days)	28.8	25.2	31.8	24.4	14.4

There were 674 exception reports submitted across the Trust in 2019.

Year: 2019

Sum of No. episodes Row Labels	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Grand Total
Medicine	13	13	11	11	5	11	10	39	37	31	28	17	226
Specialised Services	24	11	23	10	8	13	4	6	17	21	8	6	151
Surgery	30	11	13	25	14	10	17	15	25	14	17	4	195
Women's and Children's	4	1	3	6	4	29	5	11	7	10	7	15	102
Grand Total	**71**	**36**	**50**	**52**	**31**	**63**	**36**	**71**	**86**	**76**	**60**	**42**	**674**

As would be expected busy specialities with larger numbers of trainees saw more exception reports being submitted. Specialities with an established history of shift working (such as Emergency medicine) seem to see comparatively few exception reports despite the considerable workload pressure they are under.

Year	2019												
Sum of No. episodes	**Column Labels**												
Row Labels	**Jan**	**Feb**	**Mar**	**Apr**	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**	**Grand Total**
⊟Medicine	**13**	**13**	**11**	**11**	**5**	**11**	**10**	**39**	**37**	**31**	**28**	**17**	**226**
Accident and emergency											1		1
General medicine	13	13	11	10	5	11	10	33	34	31	23	16	210
Geriatric medicine								1					1
Intensive therapy				1								1	2
Respiratory Medicine								5	3				8
Dermatology											4		4
⊟Specialised Services	**24**	**11**	**23**	**10**	**8**	**13**	**4**	**6**	**17**	**21**	**8**	**6**	**151**
Cardiology			5	1					10	13	3		32
Clinical Oncology			2	1	2	6		4	3	5	2	1	26
Haematology	22	10	16	8	6	6	4	2	4	3	3	5	89
Medical oncology		1				1							2
Palliative medicine	2												2
⊟Surgery	**30**	**11**	**13**	**25**	**14**	**10**	**17**	**15**	**25**	**14**	**17**	**4**	**195**
Anaesthetics	2	7	3	5	10	7	8	5	2		2		51
General surgery	28	4	10	19	4	2	7	10	23	13	9	1	130
Ophthalmology				1		1	2						4
Oral & maxillo-facial surgery											4		4
Trauma & Orthopaedic Surgery										1	2	3	6
⊟Women's and Children's	**4**	**1**	**3**	**6**	**4**	**29**	**5**	**11**	**7**	**10**	**7**	**15**	**102**
Neonatology	1	1			1	11	1		5	2			22
Obstetrics and gynaecology	1			3		3			1	7		8	23
Paediatric cardiology						1							1
Paediatrics	2		3	3	3	14	4	11	1	1	6	7	55
Paediatric surgery											1		1
Grand Total	**71**	**36**	**50**	**52**	**31**	**63**	**36**	**71**	**86**	**76**	**60**	**42**	**674**

There is a growing acceptance across more senior grades of doctors that exception reporting is an important process to highlight problem areas within the Trust. In the first year there was significant reluctance from these grades to report problems due to a culture of "not causing a fuss". However, this pattern has noticeably changed over the past year with a much more even spread of reports across the various grades of doctor.

	No of reports
2016	46
Foundation 1	46
Senior trainee	1
2017	**528**
Foundation 1	337
Junior trainee	129
Senior trainee	62
2018	**764**

Foundation 1	227
Junior trainee	307
Senior trainee	165
2019	**674**
Foundation 1	254
Junior trainee	203
Senior trainee	217

The system is designed to allow doctors in training to report both the requirement to work additional hours and when they are unable to achieve agreed educational activities (such as teaching) due to excessive workload. The vast majority of reports are for additional hours worked and ongoing encouragement of trainees to use the system to highlight missed education is required.

Sum of No. episodes		Month												
Division	**Type**	**Jan**	**Feb**	**Mar**	**Apr**	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**	**Grand Total**
Medicine	Educational		3	1			3	3			1			11
	Hours	8	7	7	11	4	8	5	36	36	28	21	15	186
	Pattern	5	3	3		1		2	3	1	2	7	2	29
Medicine Total		**13**	**13**	**11**	**11**	**5**	**11**	**10**	**39**	**37**	**31**	**28**	**17**	**226**
Specialised Services	Educational	1	2	5	1	1	1			1	1	2		15
	Hours	23	9	18	9	7	12	4	6	16	20	6	6	136
Specialised Services Total		**24**	**11**	**23**	**10**	**8**	**13**	**4**	**6**	**17**	**21**	**8**	**6**	**151**
Surgery	Educational	2	2	1	1	1	2	1	2					12
	Hours	28	9	12	24	12	8	16	13	21	13	14	4	174
	Pattern					1				4		3		8
	Service Support										1			1
Surgery Total		**30**	**11**	**13**	**25**	**14**	**10**	**17**	**15**	**25**	**14**	**17**	**4**	**195**
Women's and Children's	Educational				2	1	1	1	2	1	3	1	1	13
	Hours	4	1	3	4	3	24	4	9	6	5	4	13	80
	Pattern						3				2	2	1	8
	Service Support						1							1
Women's and Children's Total		**4**	**1**	**3**	**6**	**4**	**29**	**5**	**11**	**7**	**10**	**7**	**15**	**102**
Grand Total		**71**	**36**	**50**	**52**	**31**	**63**	**36**	**71**	**86**	**76**	**60**	**42**	**674**

b) Work schedule reviews

The contract has introduced a system of work schedule reviews for rotas where the template rota does not seem to accurately reflect the actual rota worked by the doctor. Traditionally a "template rota" has been designed by the Medical HR department to be compliant with the various rota rules and then individual departments have adapted this to fit leave and varying numbers of staff. This means that actual work rotas can vary significantly from the template rota (which now determines the pay of the junior doctor)

It remains extremely challenging to manually write and review rotas. The Trust has purchased an eRostering solution (Allocate) however roll out has been slower than expected. This remains a significant concern.

c) Locum bookings

The Trust has traditionally been very reliant on using locum doctors (both from external staff and using its own internal staff) to fill gaps on rotas and respond to fluctuations in workload. The new contract introduces much stricter safe working limits and all locum work carried out by internal staff needs to be taken into account when calculating total work hours. Trainees are allowed to "opt out" of the maximum 48 hour working week average to work up to 56 hours.

Until an eRostering system is fully established there is no effective way of monitoring the additional work below against the safe working limits described in the contract.

Whilst many junior doctors welcome the ability to carry out additional work the effect that these additional hours have on fatigue and morale is of concern. This recurring internal locum usage suggests that additional staff may be required in certain areas to make rotas more resilient to fluctuation in staff numbers and workload.

2019	April	May	June	July	Aug	Sept	Oct	Nov	Dec
Total No of hours additional work undertaken by junior doctors	4033	4874	3593	5575	7200	4166	4175	3133	3243

Locum bookings

Additional doctors are also occasionally contracted through external locum agencies

Division	Number of shifts worked.	Number of hours.	Accumulative number of shifts 2019.	Accumulative number of hours 2019
W&C	12	115	98	971
Med	122	983	849	5261
SH&N	15	163	359	3762
SpS	98	861	458	4366
D&T				
TOTAL	**247**	**2122**	**1764**	**14360**

d) Vacancies

Vacancies were reported in the annual “rota gap report” in July 2019. Rota gaps are being reported by Medical HR to divisional teams on a more frequent basis. The highly specialist nature of the work carried out by the Trust in several areas makes it particularly challenging to fill certain vacancies and rota gaps.

e) Medical Sickness – Junior Doctors

Rates of sickness remain at around 1% across junior doctor grades, well below most other staff groups in the Trust.

Qualitative information

Issues arising – Immediate Safety Concerns

The exception reporting process allows junior doctors to flag up incidents where they believe that their work pattern puts their safety, or that of their patients, at risk. A total of 12 exception reports have been flagged with safety concerns over the past year and these are closely reviewed to see if there is any learning for the wider organisation.

The vast majority of the time these reports are submitted after a junior doctor experiences an exceptional increase in workload either due to an increase in patient numbers or unexpected absences on a rota.

Sum of No. episodes	Month								
Division	Mar	May	Jun	Jul	Aug	Oct	Nov	Dec	Grand Total
Medicine				2					2
Specialised Services	1	1				2			4
Surgery						1			1
Women's and Children's			1		1		2	1	5
Grand Total	**1**	**1**	**1**	**2**	**1**	**3**	**2**	**1**	**12**

Rota	Doctors description of safety concern	Actions taken to prevent recurrence
Cardiology	Case load of 13 outliers on top of CCU work with acutely unwell patients. Despite senior support for a few of the patients, had to review some patients who had already been seen as ATSP by nursing staff due to low BP etc, duplicating workload. High load of scans to book/chase, many complex patients and some challenging communication. A list of VTE assessments requiring completion at around 3pm while I still had 5 patients to see on the ward round. Medway running slowly. Limited support in chasing scans, procedure reports etc	Ongoing workload issue in cardiology
General Surgery F2	Volume of work was far too much for the number of surgical doctors on call. Due to having many surgical cases in theatres, and a huge	Raised with divisional management and

	number of ward and take patients this mean that patients had to wait long lengths of time to be seen or re-reviewer after investigations. Senior reviews were difficult to obtain as the registrar was in theatre. This put huge pressure on the registrar when they had finished a long case in theatre (and should be having a short break) to see the surgical take patients. All members of the team including from registrar to FY1 had no break in 13 hours, due to sheer volume of tasks and people to see. Food was eaten whilst going through the list with the consultant. I personally also left 30 minutes late as we were late starting handover due to a case overrunning in theatre. Although not avoidable this makes an already long day even longer. A culmination of these things meant that patients were left waiting to be reviewed by a senior and to have their initial clerking, which obviously is not the ideal level of care. It also left the doctors fatigued and with low morale.	rota coordinators – felt to be an due to an unpredictable surge in patient numbers which was managed very well by the team on the day
Paeds Surgery F2 & CT1-2	Night shift for general surgery. Arrive to work to find out that due to sickness I am required to also carry the medical SHO bleep for the night. Therefore held both bleeps for the night, doing the work for both roles over night. As a surgical trainee I do not have adequate paediatric life support for the role on the crash team. Given an alternative role on the crash team (scribe). Accepted the medical SHO bleep for the night as no other option.	Changes made to the induction to ensure all trainees at the Childrens Hospital have suitable resus training
General Paeds	3 endocrine patients admitted from the previous night were not reviewed till late afternoon as endocrine clinic in the morning. Patients and nursing staff dissatisfaction was apparent. Attending consultant helped out with seeing some of the patients but on expense of his own clinical work.	Raised with divisional management and rota coordinators

Issues arising – Other areas of concern

2018 Junior Doctor Contract Refresh (agreed from July 2019)

Several of the changes to the rota rules have the effect of increasing the number of junior doctors required to safely cover a rota and maintain adequate levels of medical cover. This is particularly challenging for rotas with small numbers of doctors or significant weekend / out of hours working (such as Emergency Medicine).

A RAG risk chart showing compliance against the new rota rules and actions taken to address problems is attached as appendix A.

eRostering

The roll out of eRostering across the Trust for junior doctor staffing is progressing slower than planned. This means that several of the key functions of the contract – such as work service reviews and managing additional locum work within the safety rules – are extremely difficult to implement.

Following previous concerns about this there is a renewed focus from the corporate HR team on encouraging and supporting the rollout across the Trust.

Areas of particularly high workload / with training concerns

Trainee workload in some areas of the Trust is extremely high – a situation that has worsened as winter pressures have increased. In some areas this workload is impacting on the ability to attend agreed training and education opportunities and negatively affects trainee morale.

Despite these significant challenges I'm really encouraged to see an increasing focus on wellbeing that is happening across the Trust. There have been several significant projects over the past few months including wellbeing week and the appointment of a wellbeing lead which have had a very positive effect.

Summary

Across the NHS junior doctors continue to provide remarkable care under very difficult circumstances. UH Bristol is far from alone in having the challenges described in this report and, in fact, is lucky to have senior clinicians and managers who are engaged and interested in making improvements where needed.

Whilst the exact effect of the new contract rules remain unclear I will continue to monitor and report on these to the Board.

Dr Alistair Johnstone

Guardian of Safe Working

January 2020

Appendix B – Rota rule changes 2019

Junior doctors
2018 contract refresh

Factsheet: Safety limits and rest

The below table highlights the changes to the safety limits and rest provisions between the 2016 terms and conditions and the 2018 contract refresh. For full details please refer to schedule 3 of the terms and conditions of service (TCS).

2016 terms and conditions	2018 contract refresh
Maximum of 72 hours work in any 7 consecutive day period.	Maximum of 72 hours work in any 168-hour consecutive period.
46-hours rest required after 3-4 consecutive night shifts.	46-hours rest required after any number of rostered nights.
Doctors paid at nodal point 2 are exempt from the requirements that no doctor shall be rostered for work at the weekends greater than 1 week in 2 for one placement during their foundation year.	No doctor shall be rostered for work at the weekend at a frequency of more than 1 week in 2.
No doctor shall be rostered for work at the weekend at a frequency of greater than 1 week in 2.	All reasonable steps should be taken to avoid rostering trainees at a frequency of greater than 1 in 3 weekends.
Where 8 shifts of any length are rostered or worked on 8 consecutive days, there must be a minimum 48-hours rest rostered immediately following the conclusion of the eighth and final shift.	Maximum of 7 shifts of any length can be rostered or worked on 7 consecutive days. Where a shift contains hours of work across more than one day, the work on each day will be counted independently toward the total number of consecutive days*.
No more than 5 long shifts shall be rostered or worked on consecutive days. Where 5 long shifts are rostered on consecutive days, there must be a minimum 48-hour rest period rostered immediately following the conclusion of the fifth long shift.	No more than 4 long shifts shall be rostered or worked on consecutive days. There must be a minimum 48-hour rest period rostered immediately following the conclusion of the final long shift*.
A doctor must receive: • at least one 30 minute paid break for a shift rostered to last more than 5 hours, and • a second 30 minute paid break for a shift rostered to last more than 9 hours.	A doctor must receive: • at least one 30 minute paid break for a shift rostered to last more than 5 hours • a second 30 minute paid break for a shift rostered to last more than 9 hours • A third 30-minute paid break for a night shift as described in paragraph 15 of Schedule 2, rostered to last 12 hours or more.

*As soon as reasonably practicable from August 2019, and in any event as soon as possible before 5 August 2020, the employer will consult with doctors and agree to alter existing rotas.

Appendix B – State of readiness for new contract changes

Division	ROTA	WEEKEND FREQUENCY	Breaches	From October 2019 (no later than December 2019)	From October 2019 (no later than February 2020)		Maximum consecutive shifts by no later than August 2020	
				Maximum 72 hours work in any consecutive 168 hour period	Weekend frequency no greater than 1:3 if possible. 1:2 rotas to be signed off. No doctor should work more than 1:2	46 hours rest after 3-4 or any night shift	Consecutive shifts reduced from 8 to 7	Consecutive long day shifts rostered worked reduced from 5 to 4.Must be 48 hour rest period after last shift
W&C	Paeds ED ST1-8	1 in 2.2	Weekend frequency 1:2.2, min period off after consecutive days week 2, max consecutive shifts, min period off after consecutive shifts weeks 3-4, max consecutive shifts week 5, max consecutive shifts		1:2.2.	✓	✓	✓

			weeks 6-7, min period off after consecutive shifts week 11.					
W&C	Paeds ED ST1-3	1 in 2.2	Weekend frequency 1:2.2, min period off after consecutive days week 2, max consecutive shifts, min period off after consecutive shifts weeks 3-4, max consecutive shifts week 5, max consecutive shifts weeks 6-7, min period off after consecutive shifts week 11.		1:2.2.	✓	✓	✓
W&C	Paeds ED FY2 & GPVTS	1 in 2	Weekend frequency 1:2		1:2.0.			
W&C	Paeds ED GPVTS Community	1 in 3	No breaches					
W&C	Paediatric Anaesthetics	1 in 3.5	No breaches					
W&C	PICU ST3+	1:2 - 1:3	Weekend frequency 1:2 - 1:3 (varies - no fixed rota pattern). Impossible to state breaches with new rules due to lack of pattern.		1:2 - 1:3			
W&C	Paediatric Surgery F2 & CT/ST1-2	1 in 4.5	One shift moved to make current pattern compliant. New versions being drafted. (Min Period off after long shifts week 3)					✓

W&C	**Paeds Surgery ST3+ Oct 19**	1 in 4	**Max consecutive shifts & max weekly hours weeks 1-2, min period off after consecutive days weeks 2-3, max consecutive shifts week 3**	✓		✓	✓	✓
W&C	**Paeds Surgery Ed Fellows**	1 in 4.5	**No breaches**					
W&C	**Paeds T&O Surgery ST3+**	1 in 4.33	**No breaches (week 9 NWD moved from Monday to Tuesday)**					
W&C	**Clinical Ed Fellows Paed Orthopaedics**	n/a	**No breaches**					
W&C	**Paeds Neurosurgery**	1 in 6	**No breaches**					
W&C	**Paeds Cardiac Surgery**	1 in 2	**Weekend frequency 1:2**		**1:2.0.**		✓	✓
W&C	**Paeds Cardiology ST3+**	1 in 4	**Max consecutive shifts and min period off after consecutive days weeks 1-2 & 4-5**				✓	✓
W&C	**Paeds Oncology ST6-8**	1 in 6	**No breaches**					
W&C	**NICU ST1-3**	1 in 3	**New rota built and compliant. To be used from March. (Min Period off after long shifts week 4)**			✓		✓

W&C	NICU ST4+	1 in 3	New rota built and compliant. To be used from March. (Max consecutive shifts weeks 8-9, Min Period off after consecutive days week 9)			✓		✓
W&C	NEST Sep 19	1 in 3.5	No breaches					
W&C	F2 Paediatric Academic trainee	n/a	No breaches					
W&C	Gen Paeds FY2 & GPVTS	1 in 3	Max consecutive shifts and min period off after consecutive days weeks 6-1			✓		✓
W&C	Gen Paeds (ED) FY2	1 in 2.6	Weekend frequency 1:2.6, min period off after consecutive days weeks 7 & 11		1:2.6.	✓		
W&C	Gen Paeds ST1-3 w/specialities	1 in 2.6	Weekend frequency 1:2.6, min period off after consecutive days week 7 & week 11		1:2.6. Amended to 1:3.25	✓		
W&C	Gen Paeds ST4+ w/specialities	1 in 3.86	No breaches					
W&C	Gen Paeds ST4+ w/TW	1 in 3.86	No breaches					
W&C	Gen Paeds ST4+ w/specialities 50% OOH	1 in 6.75	No breaches					

Public Board Meeting - January 2020-30/01/20 - Page 247

W&C	**Gen Paeds ST4+ w/TW 50% OOH**	1 in 6.75	**No breaches**					
W&C	**O&G FY2 & ST1-2**	1 in 3.7	**No breaches**					
W&C	**O&G ST3-5**	1 in 4.5	**No breaches**					
W&C	**O&G ST6+**	1 in 4	**No breaches**					
D&T	**Clinical Pathology**	1 in 6	**No breaches**					
D&T	**Radiology ST1**	n/a	**No breaches**					
D&T	**Radiology ST2**	1 in 4	**Fail - min period off after consecutive days. Easy to fix by moving an 'off day' to a different day of the week**			✓		
D&T	**Radiology ST2-5**	1 in 4.5	**Failed for multiple reasons (max weekly hours, max consecutive shifts and min period off). No Easy fix, rota might need rewriting and including ST2 doctors.**	✓		✓		
D&T	**Microbiology (doctors employed by NBT)**	n/a	**Failed for multiple reasons (max consecutive shifts and min period off). No Easy fix, rota will need rewriting**	✓		✓		
Surgery	**General Anaes 1st/2nd**	1 in 4	**No breaches**					
Surgery	**Obstetrics**	1 in 4	**No breaches**					

Surgery	**Cardiac**	1 in 4	**No breaches**					
Surgery	**ITU Intermediate Registrars**	1 in 2.4	**Week 1, 3, 4, 6, 8, 9, 11 fail due to too many consecutive long shifts (5 shifts in a row)**					✓
Surgery	**ITU Intermediate ACCS**	1 in 2.4	**Week 1, 3, 4, 6, 8, 9, 11 fail due to too many consecutive long shifts (5 shifts in a row)**					✓
Surgery	**ITU Intermediate Fellows**	1 in 2.4	**Week 1, 3, 4, 11 fail due to too many consecutive long shifts (5 shifts in a row), week 8/9 fails too many consecutive shifts (8 in a row)**				✓	✓
Surgery	**ITU Advanced**	1 in 4	**No breaches**					
Surgery	**GICU F1/2**	1 in 2.83	**Week 1, 8, 10/11, 12, 16/17 fail due to too many consecutive long shifts (5 in a row)**					✓
Surgery	**GICU ACF2**	1 in 2.83	**Week 10/11 fail due to too many consecutive long shifts (5 in a row)**					✓

Surgery	**General Surgery F1**	1 in 5	**Week 5/6 fails due to too many consecutive shifts (8 in a row)**				✓	
Surgery	**General Surgery F2/CT1-2**	1 in 4	**Week 2/3 fails due to too many consecutive shifts (8 in a row), week 7 Friday fails due to no break following 4 long shifts.**				✓	✓
Surgery	**General Surgery ST3+**	1 in 6	**Week 5 Friday fails due to no break following 4 long shifts.**					✓
Surgery	**Cardiothoracic Surgery CT1-2**	1 in 3	**No breaches**					
Surgery	**Thoracic Surgery**	1 in 3	**No breaches**					
Surgery	**T&O F2/CT1-2**	1 in 3.33	**No breaches**					
Surgery	**T&O ST3+**	1 in 4.33	**No breaches**					
Surgery	**ENT ST1-2/GPVTS**	1 in 5	**No breaches**					
Surgery	**ENT ST1-2 CEF**	1 in 10	**No breaches**					
Surgery	**ENT ST3-8**	1 in 9	**No breaches**					

Public Board Meeting - January 2020-30/01/20 - Page 250

Surgery	**Ophth 1st On-Call**	1 in 6	**Week 1 fails due to too many consecutive shifts (8 in a row)**				✓	
Surgery	**Ophth 2nd On-Call**	1 in 6	**No breaches**					
Surgery	**OMFS DCT1-2**	1 in 4	**Week 1 fails due to too many consecutive long shifts (5 in a row), week 3 fails due to not enough rest following night shift need Wednesday off)**			✓		✓
Surgery	**OMFS ST3+**	1 in 6	**No breaches**					
SPS	Oncology Clinical Fellows	NA	**No breaches**					
SPS	Oncology Education Fellows	NA	**No breaches**					
SPS	Oncology ST3+	1 in 3.7	**Yes – Maximum Consecutive Shifts (8) - Changes have been made to be implemented from Feb 2020 and therefore compliant with new rules.**				✓	
SPS	Haematology Clinical Fellows	NA	**No breaches**					
SPS	Haematology Education Fellows	NA	**No breaches**					
SPS	Haematology ST3+	1 in 4	**Yes – But breached on 2016 ts+cs - Local agreement of consecutive on-call shifts agreed by Clinical Chair and Trainees. Now also breaching**				✓	

			max consecutive shifts (8)					
SPS	Haematology/Oncology F2/CMT	1 in 4	**Yes – Maximum Consecutive Shifts (8) - Changes have been made to be implemented from April 2020 and therefore compliant with new rules**				✓	
SPS	Cardiothoracic Surgery CST	1 in 3	**No breaches**					
SPS	Cardiothoracic Surgery ST3+ / CF	1 in 2	**Yes – Max Weekend Frequency, Min period off after long days, Min period off after consecutive days.**		**1:2.0.**		✓	✓
SPS	Cardiology ACHD Clinical Fellows	NA	**No breaches**					
SPS	Cardiology Education Fellows	NA	**No breaches**					
SPS	Cardiology ST3+	1 in 5	**No breaches**					
Trust	Occupational Health	n/a	**No breaches**					
Medicine	ED SHO	1 in 2	**Weekend frequency 1:2.**		**1:2.0.**		✓	✓
Medicine	ED Middle Grade	1 in 2	**Weekend frequency 1:2.**		**1:2.0.**		✓	
Medicine	General Medicine SHO	1 in 3.4	**Fails on 7 consecutive days**				✓	
Medicine	General Medicine ST3+	1 in 4.5	**Fails on 7 consecutive days**				✓	
Medicine	General Medicine F1	1 in 5.67	**Fails on 7 consecutive days**				✓	

Medicine	Cardio/Med fellows RFB	1 in 3	**Fails on 7 consecutive days**				✓	
Medicine	ST1/2 Cardio/Med fellows RFB	1 in 3	**Fails on 7 consecutive days**				✓	
Medicine	Dermatology	n/a	**No breaches**					

Public Board Meeting - January 2020-30/01/20 - Page 253

Meeting of the Board of Directors in Public on Thursday 30 January 2020

19

Report Title	Patient Experience Report – Quarter 2
Report Author	Paul Lewis, Patient Experience and Involvement Team Manager
Executive Lead	Carolyn Mills, Chief Nurse

1. Report Summary

This report analyses patient survey data received up to Quarter 2 2019/20 and summarises some of the recent Patient and Public Involvement activity taking place 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 2 2019/20.
- South Bristol Community Hospital survey scores continued their positive improvement trend and were all above the target levels.
- The Trust continued to see an improved performance in the National Cancer Patient Experience Survey.
- UH Bristol received positive results in the National Accident & Emergency Survey. In particular, the care provided by our doctors and nurses was rated as being better than the national average.
- The Trust's postnatal wards (73 and 76) had below target scores on the "kindness and understanding" survey measure in Quarter 1 and 2. In the last Quarterly report this was attributed to a high demand for the service and it was anticipated that the scores would improve due to actions taken by the management team to alleviate service pressures. This does appear to have happened, with the scores showing an improvement trend and hitting their target levels in both August and September (the July score was below target, which dragged down the overall score for Quarter 2).
- Ward C808 (care of the elderly) received a below-target "inpatient tracker" score in Quarter 2 (83 against a minimum target of 85). The ward has been below target for three consecutive quarters. It is important to emphasise that the majority of feedback for the ward is still positive, and slightly lower than average survey scores for care of the elderly services are something that is also reflected at a national-level. However, there is scope to improve patient experience in these services. In June 2019 a new job role commenced in the Division of Medicine that will see the roll out of an education programme for staff working on care of the elderly wards. This will include a focus on improving communication with patients, visitors and carers.

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

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Embracing change
Recognising success
Working together
Our hospitals.

The risks associated with this report include: Not applicable.	
4. Advice and Recommendations *(Support and Board/Committee decisions requested)*:	
• This report is for **Information.**	
5. History of the paper **Please include details of where paper has previously been received.**	
Patient Experience Group	19 November 2019
Senior Leadership Team	18 December 2019
Quality and Outcomes Committee	20 December 2019

Respecting everyone
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Quarterly Patient Experience and Involvement Report

Incorporating current Patient and Public Involvement activity and patient survey data received up to Quarter 2 2019/20

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

Patient Experience and Involvement Team

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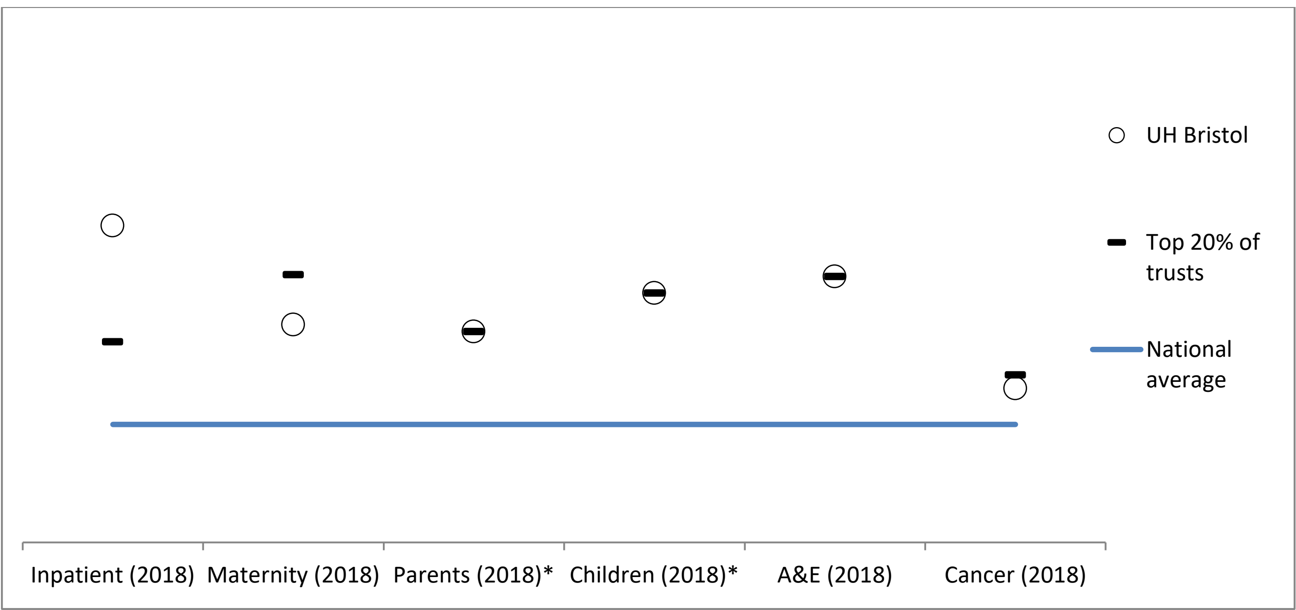
1. Overview of patient-reported experience at UH Bristol

Successes	Priorities
• All of UH Bristol's headline Trust-level patient satisfaction survey measures were above their target levels in Quarter 2. • South Bristol Community Hospital survey scores continued their positive improvement trend and were all above the target levels. • The Trust continued to see an improved performance in the National Cancer Patient Experience Survey. • UH Bristol received positive results in the National Accident & Emergency Survey. In particular, the care provided by our doctors and nurses was rated as being better than the national average.	During November 2019 patient feedback points were installed at St Michael's Hospital. This is part of the Trust's rapid-time feedback system and will enable patients and visitors to give feedback via touchscreens located at the hospital, including the ability to request a call back from the Trust if they are having any issues or concerns about their experience. The next phase of the implementation of the Trust's rapid-time feedback system will see feedback points installed in the Bristol Royal Hospital for Children (currently scheduled for implementation in Quarter 4 19/20).
Opportunities	**Risks & Threats**
An analysis is being carried out by the Patient Experience and Involvement Team, to look at the hospital experience of patients who have a mental health issue. This piece of work is the result of several negative Friends and Family Test comments about this theme over the last year. The analysis will look at the experience of this patient group in more detail, using robust data from the Trust's national inpatient survey. The results will be presented to the Patient Experience Group in Quarter 4 19/20 and a summary will be provided in the Quarterly Patient Experience and Involvement Report.	The Trust's postnatal wards (73 and 76) had below target scores on the "kindness and understanding" survey measure in Quarter 1 and 2. In the last Quarterly report this was attributed to a high demand for the service and it was anticipated that the scores would improve due to actions taken by the management team to alleviate service pressures. This does appear to have happened, with the scores showing an improvement trend and hitting their target levels in both August and September (the July score was below target, which dragged down the overall score for Quarter 2). Ward C808 (care of the elderly) received a below-target "inpatient tracker" score in Quarter 2 (83 against a minimum target of 85). The ward has been below target for three consecutive quarters. It is important to emphasise that the majority of feedback for the ward is still positive, and slightly lower than average survey scores for care of the elderly services are something that is also reflected at a national-level. However, there is scope to improve patient experience in these services. In June 2019 a new job role commenced in the Division of Medicine that will see the roll out of an education programme for staff working on care of the elderly wards. This will include a focus on improving communication with patients, visitors and carers.

2. National benchmarks

The Care Quality Commission's national patient survey programme provides a comparison of patient-reported experience across NHS trusts in England. UH Bristol tends to perform better than the national average in these surveys (Chart 1). The results of each national survey, along with improvement actions / learning, 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[1]



**The full national data for the national children / parent survey has not yet been released and so the national average / top 20% thresholds for these two data points in the chart are currently an estimate.*

In Quarter 2 the results of the 2018 national Accident & Emergency survey were published. For UH Bristol, the results relate to care provided at the Bristol Royal Infirmary Emergency Department. The Department achieved a positive set of results in this survey:

- Four of their scores were classed as being better than the national average to a statistically significant degree:
    - While you were in A&E, did a doctor or nurse explain your condition and treatment in a way you could understand?
    - If you had any anxieties or fears about your condition or treatment, did a doctor or nurse discuss them with you?
    - Did you have confidence and trust in the doctors and nurses examining and treating you?
    - Sometimes, a member of staff will say one thing and another will say something quite different. Did this happen to you?

- The Emergency Department was classed as being better than the national average in the section of the survey relating to care provided by doctors and nurses.

[1] This is based on the survey question that asks patients to rate their overall experience. This question is not included in the national maternity survey, and so we have constructed this score based on a mean score across all of the survey questions.

- The remaining 31 scores were in line with the national average, meaning that none of the Trusts' scores were classed as being below this benchmark to a statistically significant degree.

The Bristol Royal Infirmary Emergency Department is currently preparing a formal response to the learning points identified in the survey – primarily around waiting times, the environment of the Department, and availability of food / drink in the department. This report will be reviewed by the Patient Experience Group and the Quality and Outcomes Committee of the Trust Board in Quarter 3 2019/20.

In Quarter 2 we also received the latest results from the 2018 National Cancer Patient Experience Survey (NCPES). In the 2018 NCPES, UH Bristol was classed as being better than the national average to a statistically significant degree on five out of the forty-nine survey questions (Table 1). No scores were classed as being below this benchmark. UH Bristol's results in 2018 are part of a continued improvement trend for the Trust in this survey, which has outpaced the rate of improvement nationally and is moving closer to putting UH Bristol amongst the top performing Trusts in this survey (see Chart 1). The focus will be on continuing to deliver the Trust's NCPES action plan. This plan has wide-ranging actions that have driven the improvement in the experience of UH Bristol patients with cancer. The results of this survey were reviewed by the Trust's Cancer Steering Group and the Quality and Outcomes Committee in Quarter 3.

3. Survey results

3.1 Survey results overview

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

Table 1: summary of headline survey metrics

	Current Quarter (Quarter 2)	Previous Quarter (Quarter 1)
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	Green	Green
Emergency Department Friends and Family Test response rate	Green	Green

3.2 Quarter 2 Exception Reports

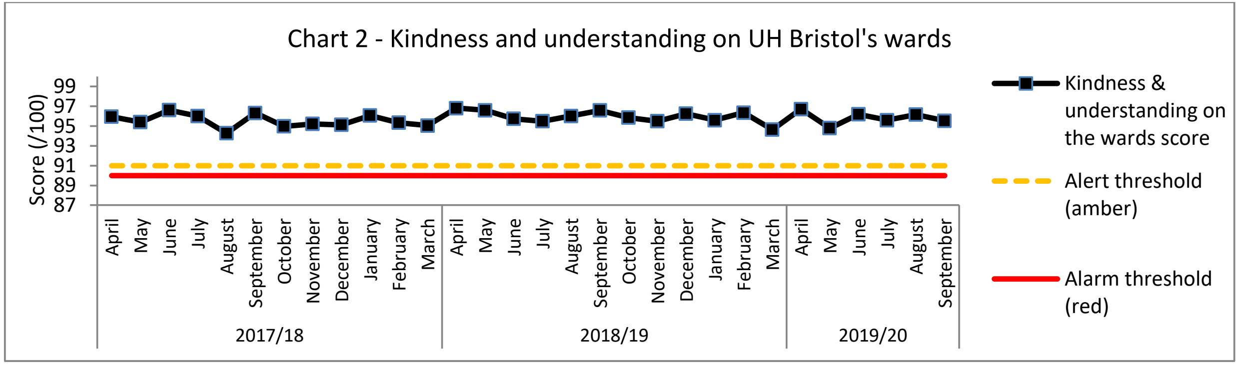
Issue	Description	Response
1. Kindness and understanding on postnatal wards	The postnatal wards (73 and 76) had a slightly below target score on the "kindness and understanding" measure in Quarter 2 (89/100 against a target of 90).	We reported in Quarter 1 that the maternity service had a below target score on this measure, which was attributed to heightened demand on the service during that period. It was anticipated that, following actions taken by the management team to alleviate the service pressures, the survey scores would improve. This appears to have been the case, with the August and September scores returning to the target levels (the July score was below target, which pulled down the overall score in Quarter 2). It should also be noted that the Trust's maternity service is in line with national norms on this survey measure.
2. Ward C808 inpatient tracker score	Ward C808 (care of the elderly) received a below-target "inpatient tracker" score in Quarter 2 (83 against a minimum target of 85). The ward has been below target for three consecutive quarters (though Quarter 2 represented an improvement on the previous scores). The "communication" elements of the tracker were particularly low. It should be noted that the majority of feedback for the ward remains very positive.	The relatively low survey scores for care of the elderly services are something that is reflected at a national-level. Analysis by the Patient Experience and Involvement Team (presented in a previous Quarterly Patient Experience and Involvement Report) demonstrated that UH Bristol performs significantly better than the national average in this respect. However, there is scope to improve patient experience in these services. In June 2019 a new job role commenced in the Division of Medicine that will see the roll out of an education programme for staff working on care of the elderly wards. This will include a focus on improving communication with patients, visitors and carers. It is anticipated that this role will have a positive impact on the survey scores (although, given the challenges of caring for patients in this setting, this likely to be an effect that is seen over the medium-term rather than immediately). The Division will also convene a short-life working group in Quarter 3 to review the patient experience feedback / data for care of the elderly services and identify improvement opportunities.
3. Communication at discharge in the Division of Medicine	Three postal survey scores relating to communication at discharge were relatively low for the Division of Medicine in Quarter 2.	A key challenge is that patients in this Division often have complex / long-term clinical needs, and so often leave with a large amount of information / medication. The "discharge checklist" used by the Division was amended last year to further ensure that key information is brought to patients' attention at discharge. The senior management team is confident that the checklist is being followed. A short-life working group is being planned for Quarter 3 (see above), to review the patient experience feedback / data for care of the elderly services and identify improvement opportunities. Conveying information at discharge will be a key focus of this work.

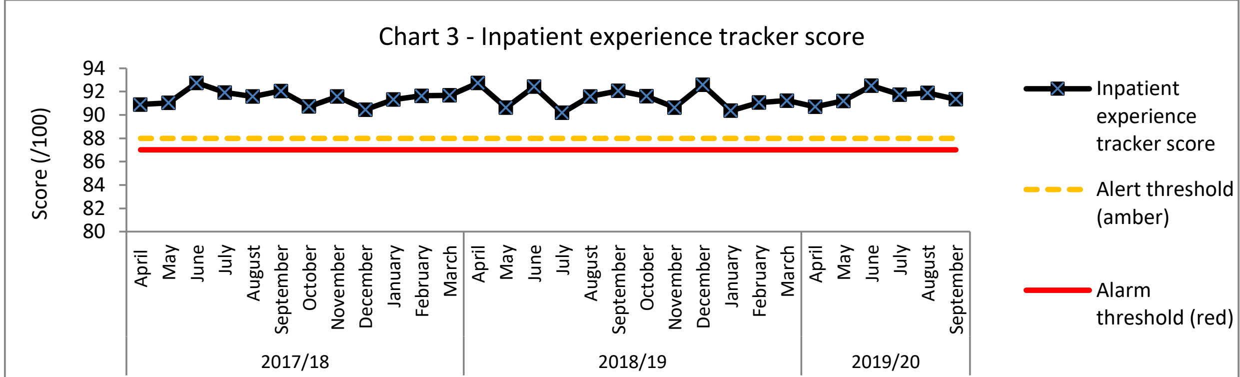
Issue	Description	Response
4. Ward A512 inpatient tracker score	The inpatient tracker score for ward A512 was below target in Quarter 2 (83 against a target of 85).	A512 is an additional capacity ward that is used primarily when the Trust's inpatient services are extremely busy and at present it does not have permanent team members or leadership – all of which may be affecting the quality of patient experience. The Division of Medicine is converting A512 in to a permanent ward and has recruited permanent staff, including two Band 6 leadership posts, to achieve this. We anticipate that this continuity should improve the patient experience on the ward going forwards.

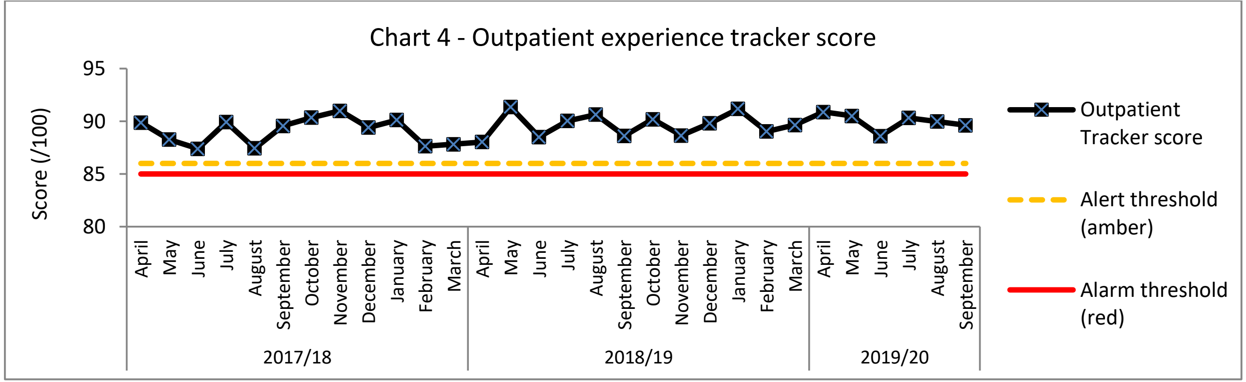
4. Full survey data

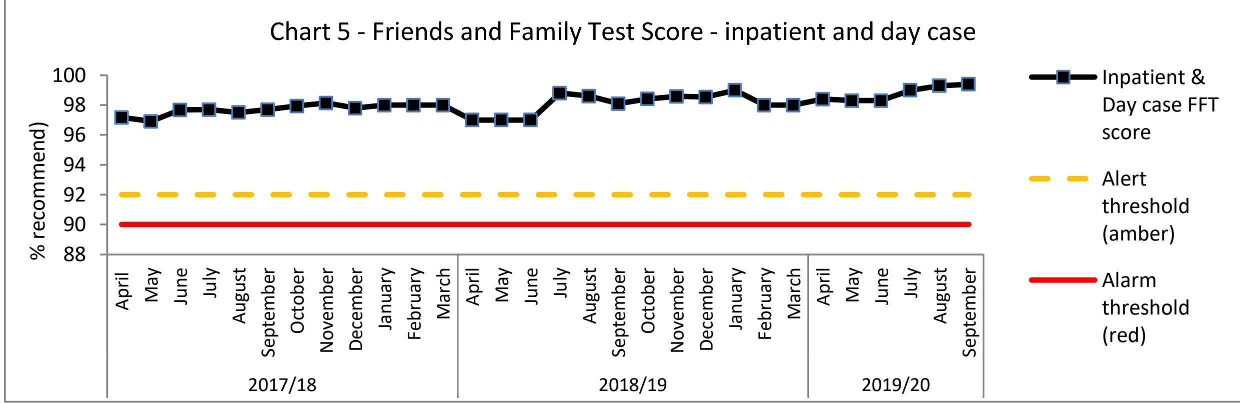
This section of the report provides a full breakdown of the headline survey data to ward level. Caution is needed below Divisional level, as the margin of error becomes larger. At ward level in particular it is important to look for trends across more than one of the survey measures presented.

19









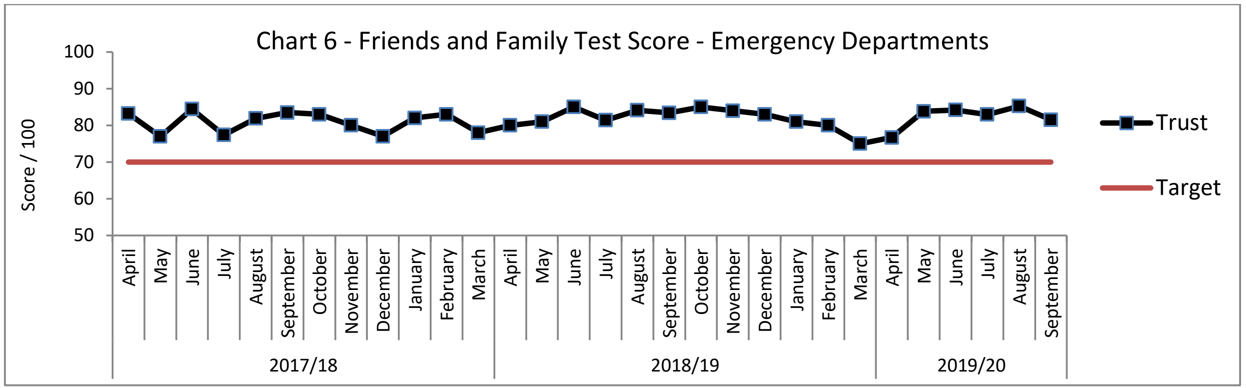


Chart 6 - Friends and Family Test Score - Emergency Departments
Score / 100
100
90
80
70
60
50
April
May
June
July
August
September
October
November
December
January
February
March
2017/18
2018/19
2019/20
Trust
Target

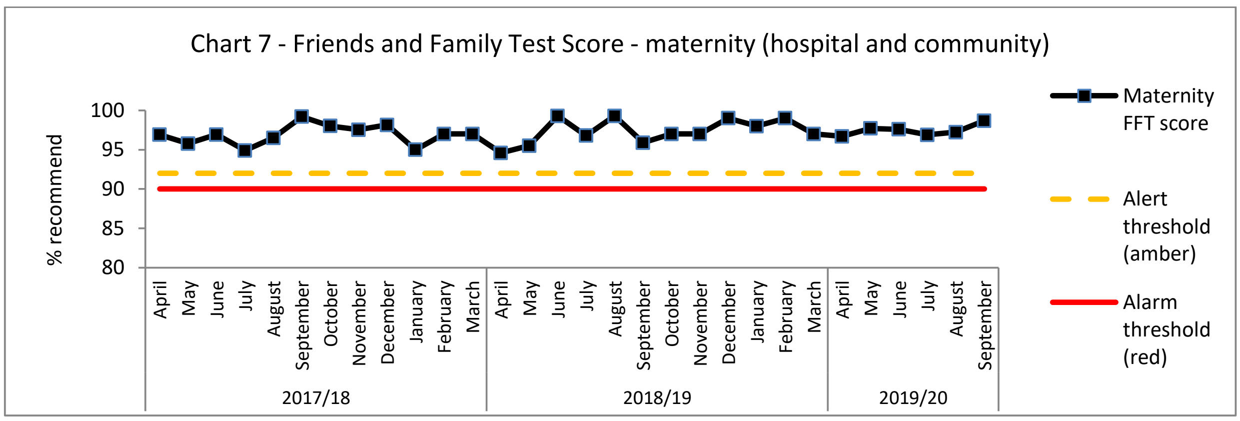


Chart 7 - Friends and Family Test Score - maternity (hospital and community)
% recommend
100
95
90
85
80
2017/18
2018/19
2019/20
Maternity FFT score
Alert threshold (amber)
Alarm threshold (red)

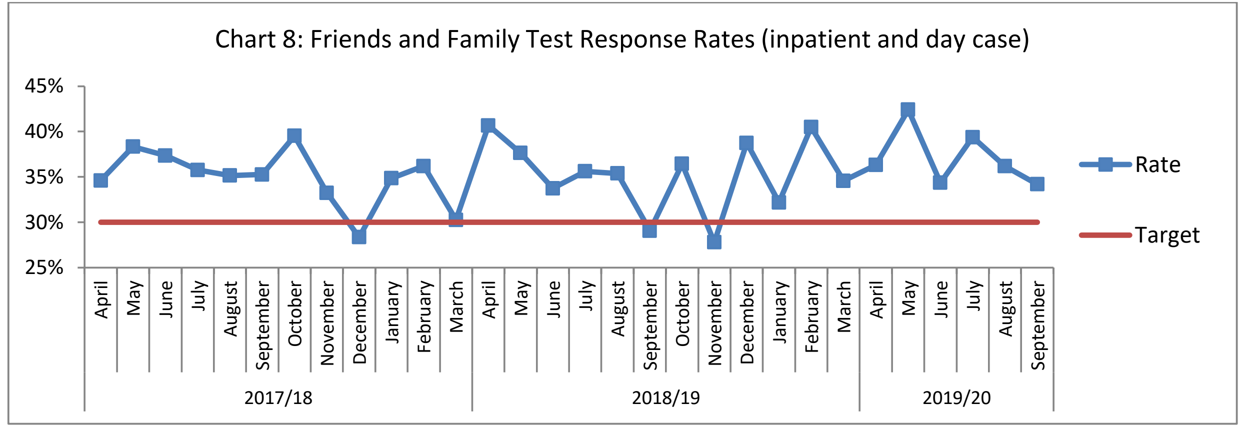


Chart 8: Friends and Family Test Response Rates (inpatient and day case)
45%
40%
35%
30%
25%
2017/18
2018/19
2019/20
Rate
Target

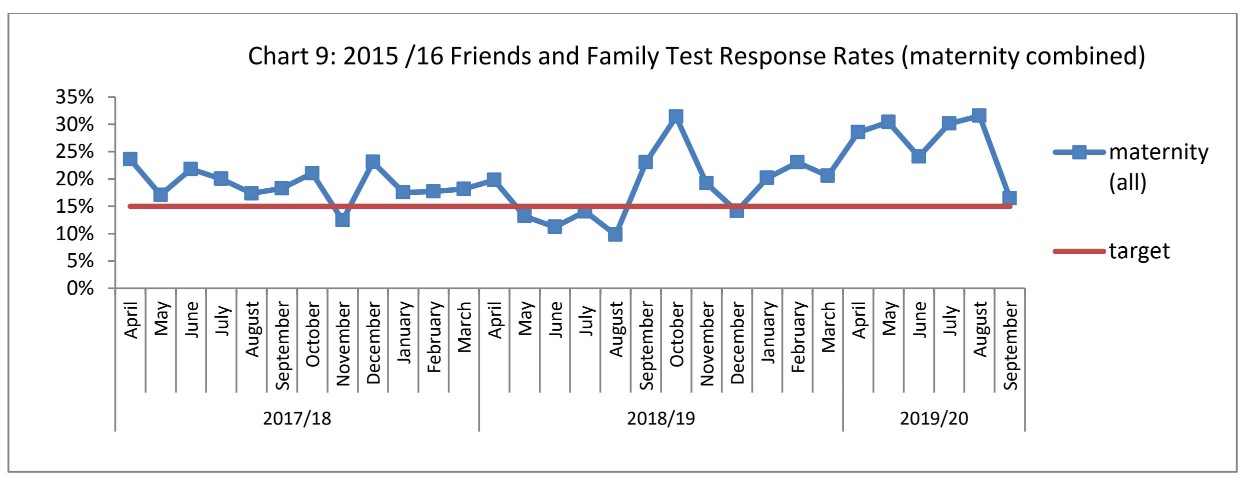
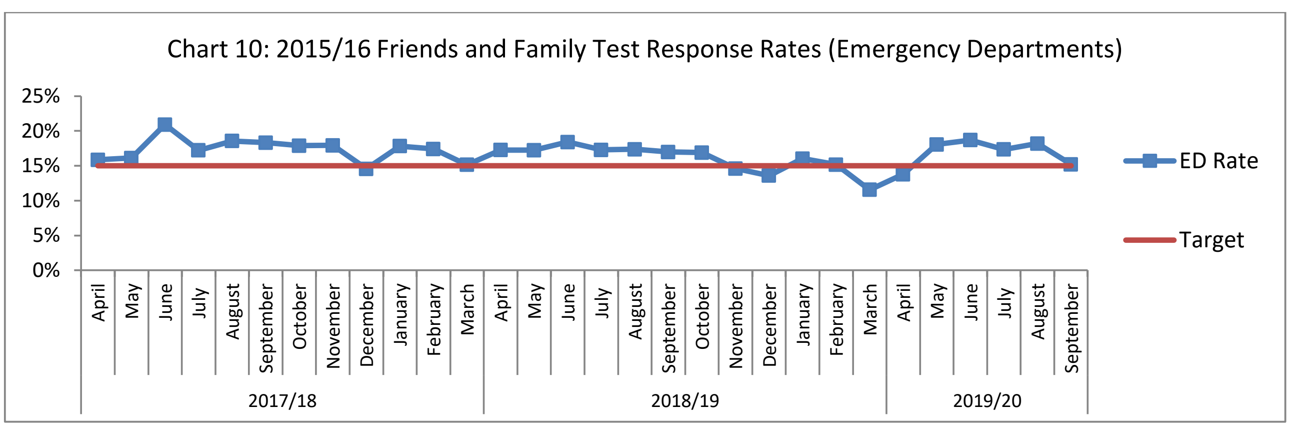
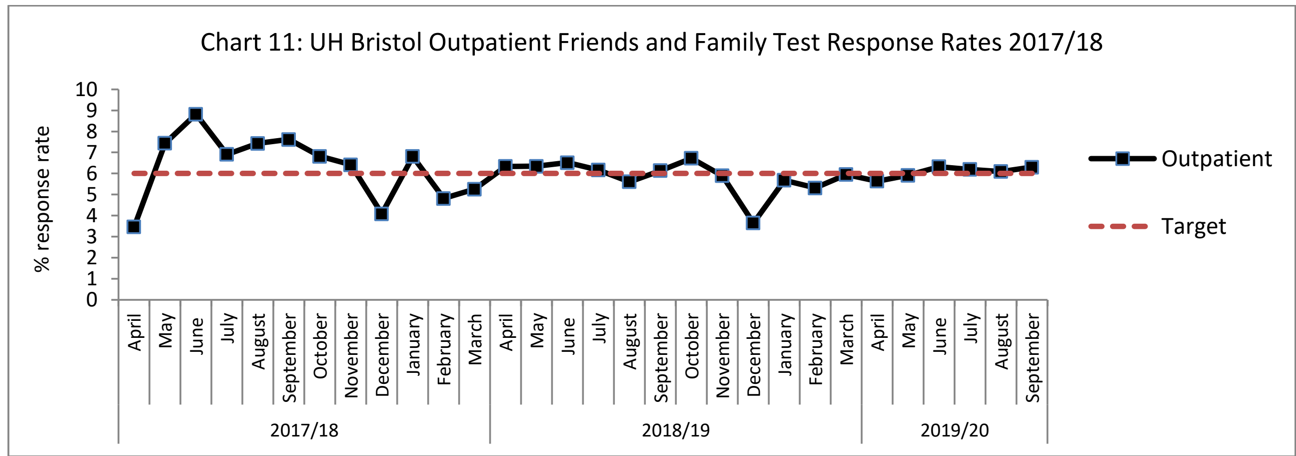


Chart 9: 2015 /16 Friends and Family Test Response Rates (maternity combined)
35%
30%
25%
20%
15%
10%
5%
0%
2017/18
2018/19
2019/20
maternity (all)
target





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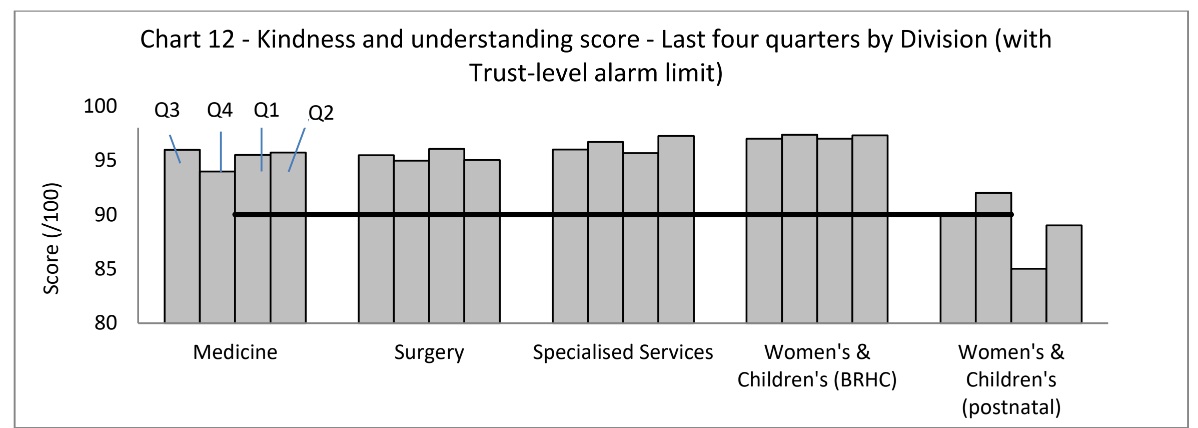
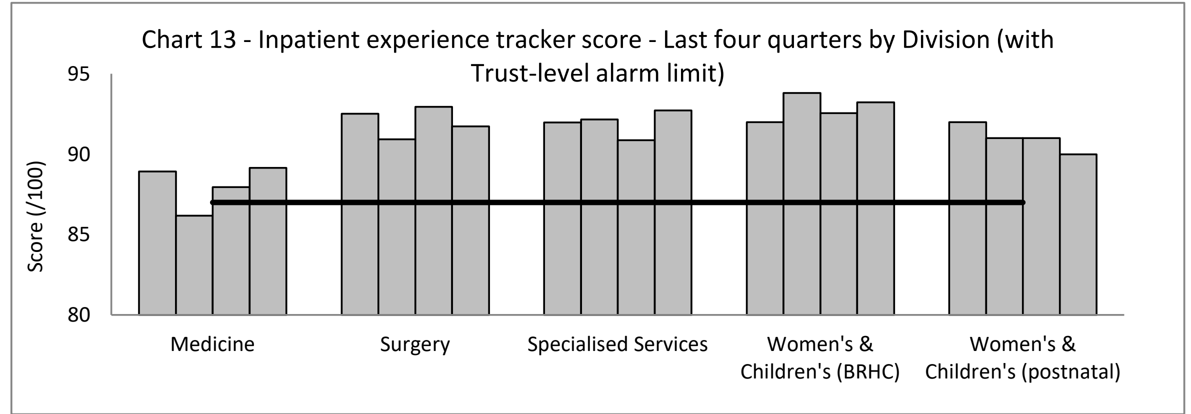
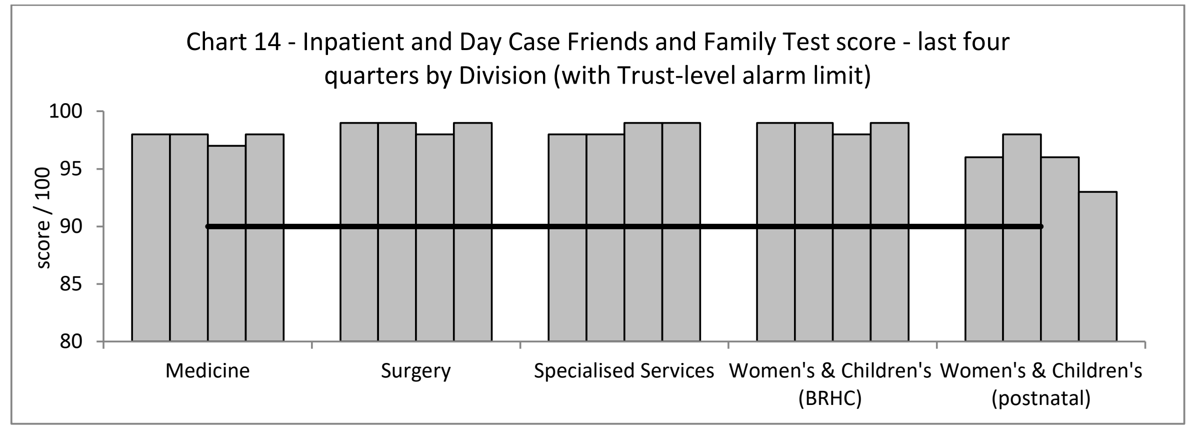
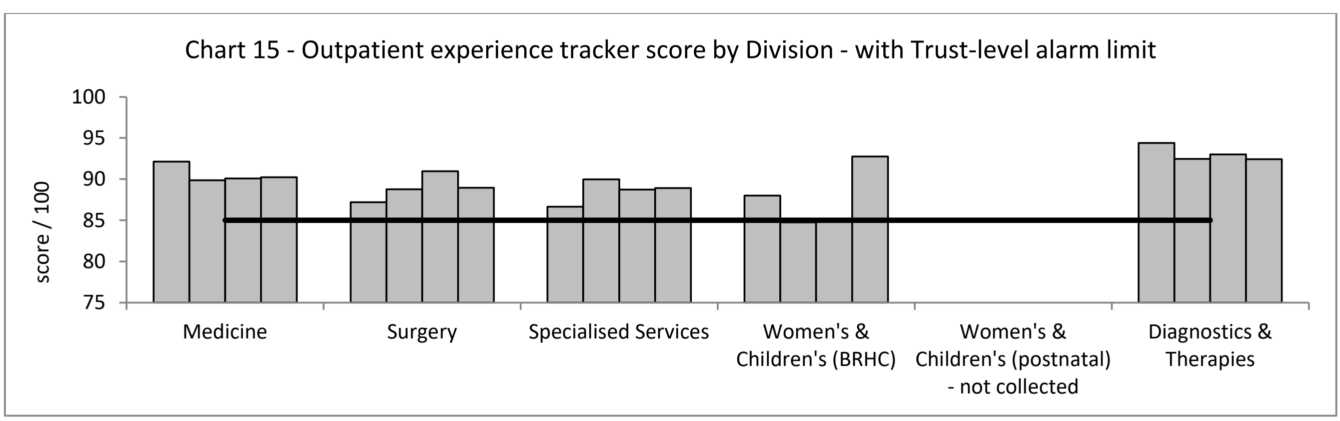
4.1 Divisional level survey results



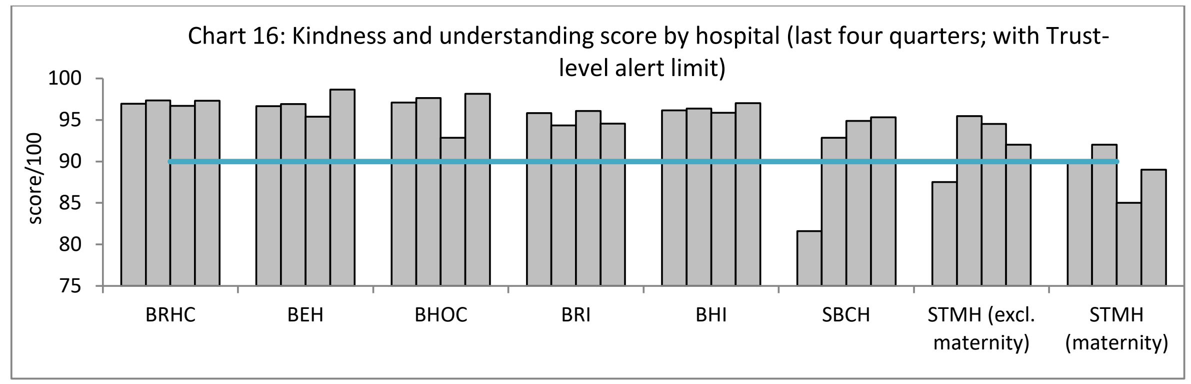


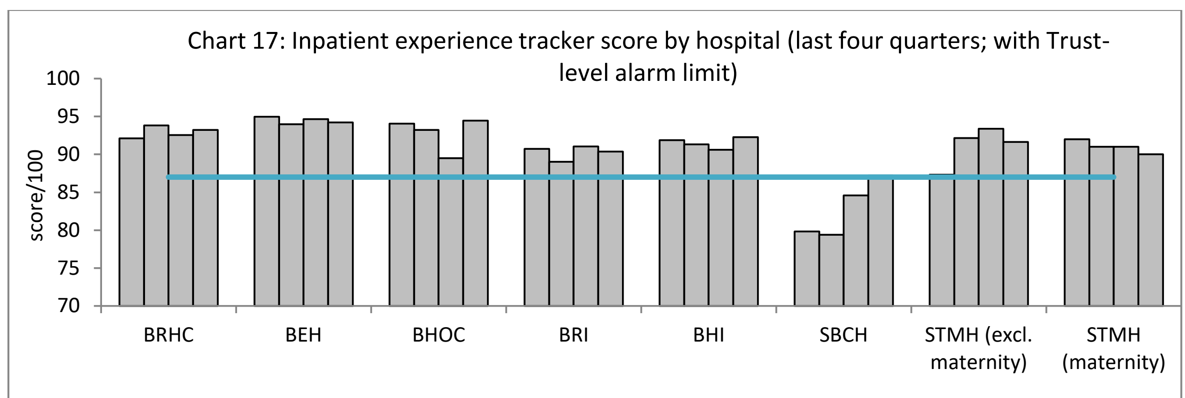


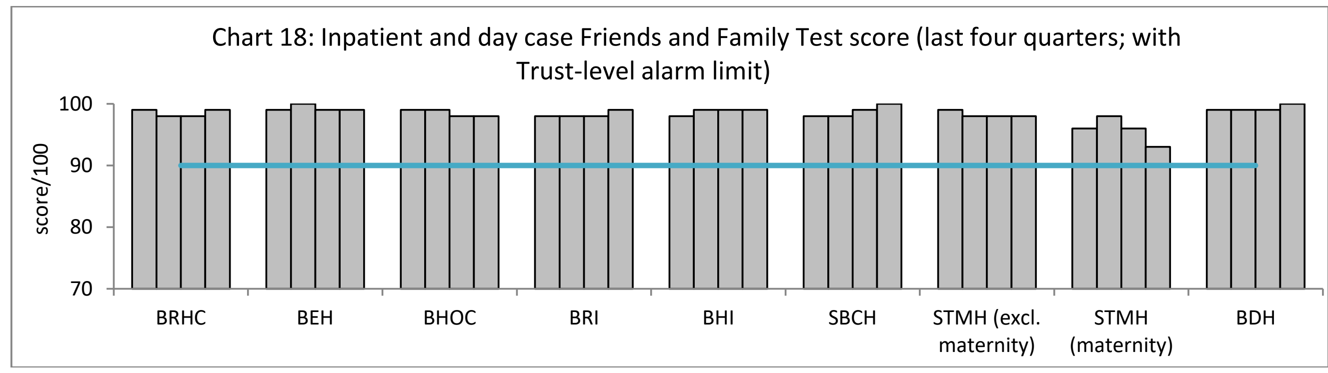


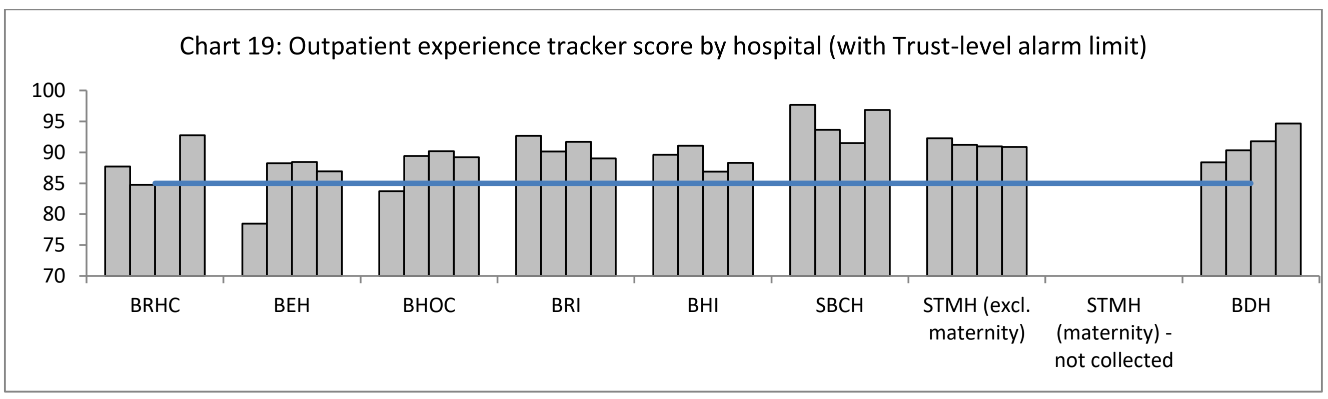
4.2 Hospital level headline survey results

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)

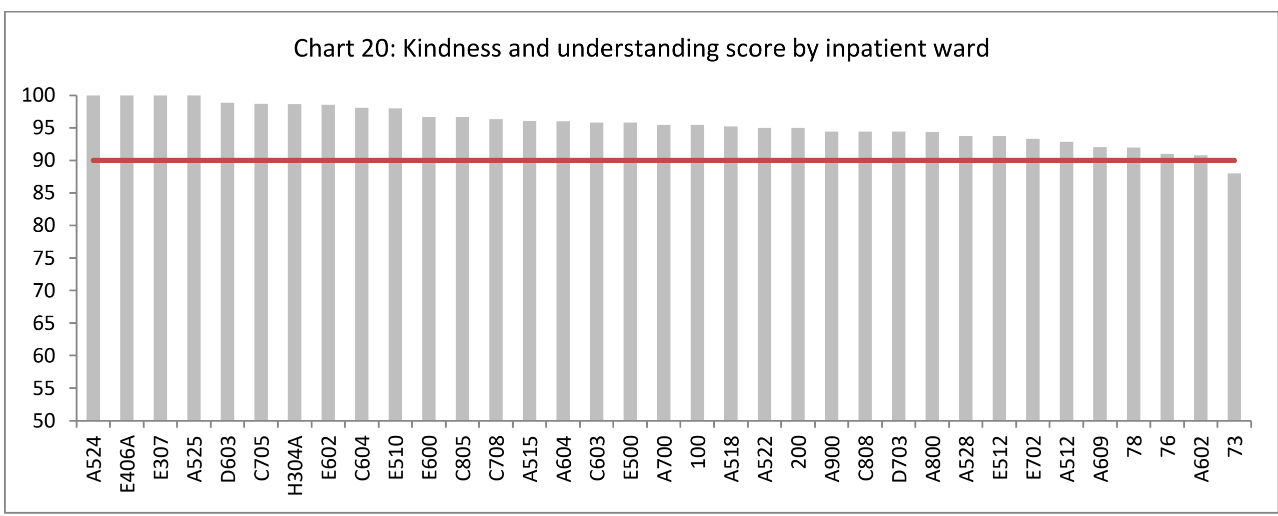


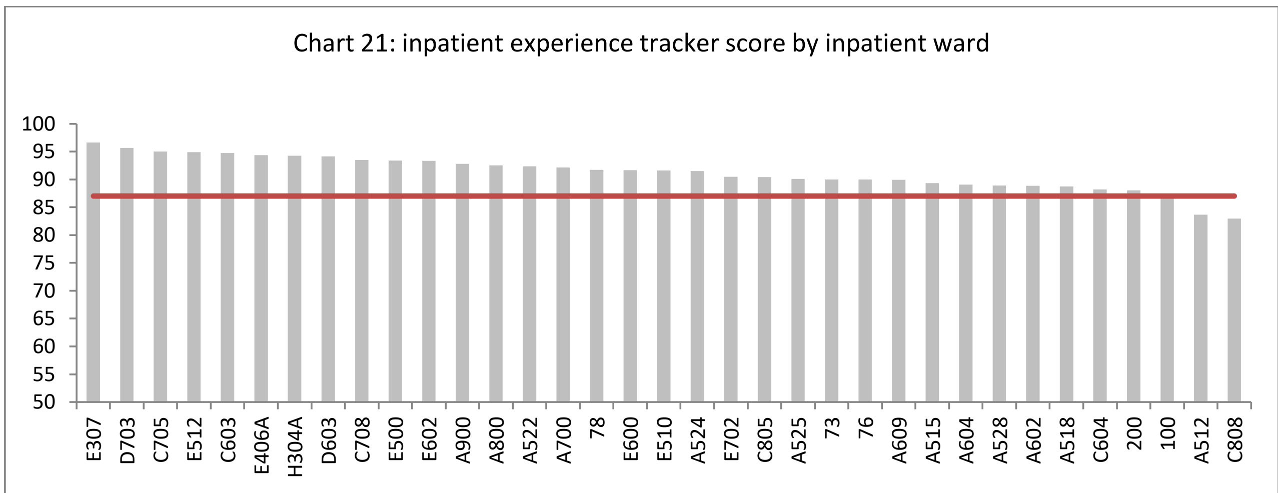


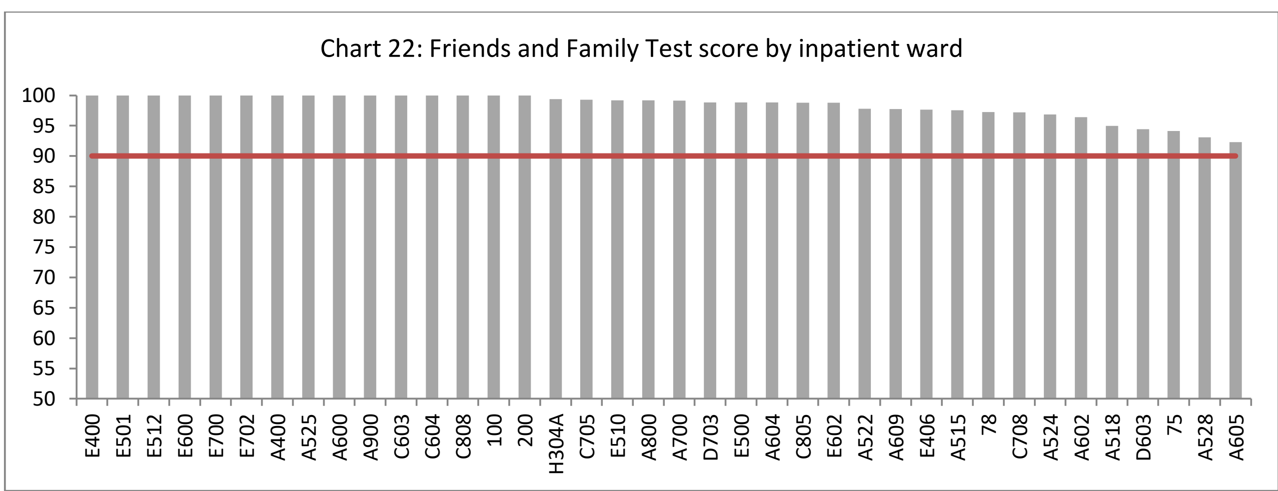




4.3 Ward level headline inpatient survey results







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 2 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?	94	95	91	92		93
How would you rate the hospital food?	62	63	60	61	58	62
Did you get enough help from staff to eat your meals?	85	91	91	88		88
In your opinion, how clean was the hospital room or ward that you were in?	94	96	95	96	90	96
How clean were the toilets and bathrooms that you used on the ward?	89	92	91	92	81	92
Were you ever bothered by noise at night from hospital staff?	83	88	84	87		86
Do you feel you were treated with respect and dignity by the staff on the ward?	96	98	96	97	93	97
Were you treated with kindness and understanding on the ward?	96	97	96	95	89	96
Overall, how would you rate the care you received on the ward?	89	91	92	90	90	91
When you had important questions to ask a doctor, did you get answers that you could understand?	86	92	92	90	87	90
When you had important questions to ask a nurse, did you get answers that you could understand?	88	93	91	90	90	90
If your family, or somebody close to you wanted to talk to a doctor, did they have enough opportunity to do so?	75	75	81	79	79	77
If your family, or somebody close to you wanted to talk to a nurse, did they have enough opportunity to do so?	85	89	91	88	87	88
Were you involved as much as you wanted to be in decisions about your care and treatment?	82	85	90	86	87	86
Do you feel that the medical staff had all of the information that they needed in order to care for you?	88	91	91	90		90

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

	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?	71	80	84	77	81	**78**
Did a member of staff explain why you needed these test(s) in a way you could understand?	88	89	90	87		**89**
Did hospital staff keep you informed about what would happen next in your care during your stay?	80	87	89	86		**86**
Were you told when this would happen?	79	80	83	83		**81**
Beforehand, did a member of staff explain the risks/benefits in a way you could understand?	87	93	96	94		**93**
Beforehand, did a member of staff explain how you could expect to feel afterwards?	75	79	85	84		**81**
Were staff respectful of any decisions you made about your care and treatment?	91	95	95	94		**94**
During your hospital stay, were you ever asked to give your views on the quality of your care?	26	32	33	27	33	**29**
Do you feel you were kept well informed about your expected date of discharge from hospital?	77	84	85	88		**84**
On the day you left hospital, was your discharge delayed for any reason?	59	54	61	66	72	**60**
Did a member of staff tell you about medication side effects to watch for when you went home?	54	62	59	70		**63**
Did hospital staff tell you who to contact if you were worried about your condition or treatment after you left hospital?	71	88	92	87		**85**

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.

19

Table 4: 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
Medicine	A522	*Staff were very helpful and attentive. Room environment was clean and spacious. Tea and meal staff were very helpful. Food was good (choice selection was good). Only downside was noise at night - made sleeping very difficult (sometimes impossible).*	Thank you for your feedback. We are pleased that you found the staff so helpful and attentive, but are sorry to hear that it was difficult to sleep. We are planning to undertake night visits during Quarter 3 and will ensure A522 is visited to check on noise levels. We'll also make it a focus in the daily Safety Brief for the ward team.
	A300	*Lovely ward, lovely staff, good food. I was in bed 10 and it was a bit chilly and the lights outside very bright so quite hard to sleep. But everything else fine.*	Thank you for your positive comments about the ward. We are sorry to hear about the bright lights: each bay and side room should have the doors closed at nights to help prevent disturbances. We are very sorry that you were cold at night and additional blankets should have been provided for you. We will share your comment with the ward team as a point of learning.
	A300	*Staff very approachable, helpful and competent. Process managed very well. Only minor criticism would be: a bit more update on what's happening when. Also due to admittance time, going x-rays etc and queuing for bed in corridor, missed out on food in evening. Something to consider.*	Thank you for your feedback. We will provide your feedback to the team on A300 and share your comment as part of the daily Safety Brief. A300 has access to snack boxes and so it is not acceptable that you weren't offered any food – again we will raise this in the daily Safety Brief as a point of learning. Thank you again for your feedback and are pleased that, overall, you had a positive experience.
	A518	*The staff are excellent. The space is dire. As a wheelchair user it's far too small. Privacy is impossible, there is barely any natural light. It's depressing and I think it would slow recovery in some patients. The staff save it - 10/10 for them!*	Thank you for your feedback. We do recognise that the environment on A518 needs improving. A refurbishment is planned and we are currently working on the details of this, including finding a suitable space to care for patients whilst the work is taking place.

Division	Area	Comment	Response from ward / department
Surgery	Bristol Eye Hospital Day Case	*Excellent service but I have been here 8 hours when letter said maximum 4. Staff need to inform patients of what's happening and why there are delays.*	We are very sorry to hear about the long wait that this patient faced. It is extremely unusual for patients to be here that long, but clearly when it does occur then patients must be kept fully informed about what is happening. We have used this comment as a point of learning for the staff on the day case ward.
	Ward H304	*Please fix faulty windows in Bay 2 (H304). The catch is faulty so they bang open/close.*	Thank you for your feedback. The windows in the ward have recently been fully refurbished and so this problem has been fixed.
Women's & Children's (Maternity)	Ward 78	*Nursing and medical care second to none. All staff on ward helpful. Only thing to change is disabled access in bathroom - not enough grab handles and difficult to manoeuvre wheelchair.*	Thank you for bringing this to our attention. The Gynaecology Matron will assess the bathroom and ask the Estates Department to put in more grab handles as required.
	Ward 78	*Good care. Communication very good. No mixed messages. Negative - very noisy at night, nurses talking etc. I was in a bed next to their station.*	There are ear plugs available on the ward and we are sorry that these were not made available to the patient. The ward staff will be reminded to offer these. The Trust is re-running the Noise at Night awareness campaign in November, which will also help to highlight the importance of this issue.
	Ward 73	*Very good care provided by the midwives. However, what lets this ward down is the catering staff - all of them, and I mean all of them are extremely rude. Have been spoken to in an unacceptable manner all because I was one minute late for lunch or asked for a banana instead of an orange! They have made me feel upset on a number of occasions when I am already upset enough for being in here.*	Thank you for your feedback. We are very concerned to hear that members of the catering staff were rude to you: this is completely unacceptable and we sincerely apologise for this. The Head of Midwifery has spoken to the Hotel services manager about this issue and he is dealing with the staff responsible through the appropriate Trust processes.

Division	Area	Comment	Response from ward / department
Women's & Children's (Maternity continued)	Emergency Department	*Staff are good, but the waiting room is horrid and inadequate. No windows, the area is far too small, seats ripped, no easy access to outside.* Not enough cubicles, not enough toys. *When doors lock at 10pm, it's crazy trying to get out the place*	Thank you for your feedback. We recognise that the Department requires a refurbishment and we are due to carry this out in Spring 2020. In the meantime, we have secured funding to re-upholster the seats and we have placed an order for this (we are awaiting timescales for the work to be carried out). In relation to the signposting out of hours, the Department Sister has requested additional support/signage to be put in place. Our play assistant works tirelessly to update and replace the toys, but it is difficult to keep on top of this issue as unfortunately the toys regularly go missing. We are going to design posters to ask politely that people do not to take the toys away with them when they leave. Thank you again for your feedback.
Women's & Children's (Bristol Royal Hospital for Children)	E600	*The nurses were all friendly especially our allocated day nurses, they made my son feel at ease and happy when he was upset. My only complaint would be how loud the nurses spoke to each other through the night adding to the noise which was unavoidable i.e. machines.*	Thank you for your positive feedback about our team. We are sorry that the noise at night made your stay difficult: as a team and ward we are having a real drive on reducing noise at night. We have some new posters up and have sent out a reminder to the nursing team regarding conversation levels at night, with the nurse in charge of the shift monitoring the noise level. Where possible, parents/carers who are sleeping on the ward are nursed in a cubicle to reduce the general impact of noise at night. We also have ear plugs and eye masks available for parents to use at night.

6. Update on the Trust's rapid-time patient feedback system

The Trust has procured an electronic feedback system that enables patients and visitors to give feedback about their experience at UH Bristol via the UH Bristol website, their own mobile devices, and via touchscreen feedback points located around the Trust. In Quarter 2 the installation of feedback points was completed at St Michael's Hospital, complementing the eight devices already installed in the Bristol Royal Infirmary.

In November 2019 the Patient Experience Group received an update on the feedback being received via the system since it went live in April 2019. The Trust received around 500 pieces of feedback through the system during the 6 month period analysed. The majority of responses contained positive feedback about the Trust's services (see Table 5). The feedback being received is very much "in the moment", in that it is often submitted whilst people are in our care and / or in hospital and is available in near-real time. In this way, as intended, the system compliments the Trust's survey feedback channels, which are more retrospective in nature and are designed to generate accurate measurements of patient-reported experience.

Table 5: feedback themes from the rapid-time system

Theme	*% of comments*
Staff - positive	53%
Environment - negative	16%
Delays - negative	6%
Staff - negative	4%
Environment - positive	3%

Of the responses received during this period, 242 contained specific feedback that we were able to send on to Divisions either for information or action (the remainder were either not usable or were too generic to identify a specific service area). The Trust received 20 requests for a call-back from people using the system - around one per week over the six month period analysed. These requests related to a wide range of resolvable issues, for example raising a concern about the hospital care being received or reporting an issue with the hospital estate. We expect the number of call back requests to increase as the touchscreen feedback points are rolled out more widely across the Trust.

The Patient Experience and Involvement Team is currently working with the Bristol Royal Hospital for Children to install seven feedback points there. Locations have been identified and we anticipate the enabling works / installation taking place during Quarter 4 2019/20. We are currently working with the Divisions of Surgery and Specialised Services to identify appropriate locations in the Bristol Haematology and Oncology Centre, Bristol Eye Hospital, and Bristol Dental Hospital.

7. 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.

Supporting UH Bristol lay representatives

The Trust has a corporate quality objective during 2019/20 to improve the support we provide to patients and members of the public who act as "lay members" on UH Bristol groups and committees. During Quarter 2 the

Trust's Patient and Public Involvement Lead mapped out which Trust groups / committees currently have lay representation on them. A draft of the training programme has also been developed and will be reviewed at the Patient Experience Group in November 2019. A pilot training session will take place in December 2019.

My Journey mystery shopping programme

In Quarter 4 2018/19 the Patient Experience and Involvement Team launched "My Journey" as an additional patient experience evaluation tool which combines elements of mystery shopping techniques and the NHS 15 Steps Challenge. The "My Journey" team are trained Trust and staff Volunteers. The "My Journey" in Quarter 1 focussed on a patient journey to the Dermatology Department in the Bristol Royal Infirmary and the Cardiac Outpatient Department in the Bristol Heart Institute. In doing so feedback was gathered on four consecutive steps of the patient journey:

- Pre-visit: check for relevant information on the Trust's external website and contact the department by telephone
- Arrival at the hospital: first impressions, environment, helpfulness of staff
- Onward journey to the clinic/department: signage, way-finding
- Arrival at the clinic/department: first impressions, environment, helpfulness of staff

Feedback from the exercise was shared with service leads and reviewed at the Trust's Outpatient Services Steering Group. The feedback was generally very positive, in particular about the UH Bristol staff that the mystery shoppers had interactions with. It was noted that some staff, and in particular the Meet and Greet Volunteers in the Welcome Centre of the BRI, went out of their way to offer a personalised service by way of escorting "patients" to their destination. Participants reported mixed experiences of navigating the trust website and the quality of information held on it – this has been shared with the Communications Team.

Learning Disabilities Steering Group

UH Bristol has started a process to recruit carers of young adults with a learning disability to be lay members on the Trust's Learning Disabilities Steering Group. We anticipate that they will start in their new roles during Quarter 4 2019/20.

The Bristol Physical Access Chain

During Quarter 2, representatives of the Bristol Physical Access Chain met with the Trust's Operations Transport and Green Travel Manager to discuss and influence proposals to improve the arrangements for disabled parking, drop off points, bus and taxi services to the entrance of the BRI.

South Bristol Community Hospital "touch point mapping"

Based on our ongoing work to understand why our inpatient survey scores tend to be lower at South Bristol Community Hospital (SBCH), in September 2019 we applied learning from the Trust's work around improving customer service (the Here to help project) and used "touchpoint mapping" to gain insight in to our patients' "emotional journey" at this hospital. Emotional touchpoints are the moments where the person recalls being touched emotionally or cognitively (deep and lasting memories). They can be 'big moments' in a patient's contact with a service or 'small acts' that have a huge impact on an individual whilst maybe not seeming significant to others. In the context of SBCH, the inpatient journey is often complex - usually starting at the BRI (e.g. following a stroke) before moving to SBCH for an extensive period of rehabilitation.

Conversations were held with patients and carers to explore the in-patient transfer process from the BRI to arrival on the ward at SBCH, communication with staff, mealtimes and the discharge process. The key findings include:

- The value patients and carers place on the quality of a clear and unambiguous explanation of the transfer of care from the BRI to SBCH, both in terms of the logistics of the transfer and discussing the expectations of care at SBCH
- A recognition that for some patients and carers, the process of change from one location to another can be uncomfortable, emotionally charged and disorientating
- The quality of the departure from the BRI and the arrival at SBCH, including the orientation process for both patients and carers, is a key part of the journey and can have an immediate and lasting impact on how a patient or carer feels about SBCH. It is a formative moment. Feedback indicates this aspect of care is generally handled well and with sensitivity at SBCH, but that there sometimes may be an assumption made that patients and carers have inherent knowledge about SBCH, its location and the care provided

In addition:

- The quality of the carer support provided at SBCH particularly in respect of supporting individuals with complex needs and carers who are themselves traumatised by circumstances was noted as excellent.
- There was some suggestion of an underlying anxiety amongst some patients (and their carers) about the discharge process from SBCH to home, and what that might entail in terms of a perceived loss of relationships, the familiarity of the ward and isolation.

Overall, the report was very complimentary about the care provided by SBCH, but there are clear pointers here about areas that are key emotional touchpoints that may be able to be further strengthened. The full summary report for this work is currently being finalised by the Patient and Public Involvement Lead and will be provided to the Division of Medicine and Diagnostics and Therapies Division during Quarter 3.

Appendix A – UH Bristol corporate patient experience programme

The Patient Experience and Involvement Team at UH Bristol manages 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.

Meeting of the Board of Directors in Public on Thursday 30 January 2020

Report Title	Quarter 2 Complaints Report
Report Author	Tanya Tofts, Patient Support and Complaints Manager
Executive Lead	Carolyn Mills, Chief Nurse

20

1. Report Summary

Summary of performance in Quarter 2

	Q2	
Total complaints received	442	↓
Complaints acknowledged within set timescale	99.8%	↑
Complaints responded to within agreed timescale – formal investigation	83.6%	↓
Complaints responded to within agreed timescale – informal investigation	87.5%	↓
Proportion of complainants dissatisfied with our response (formal investigation)	9.9%	↓

2. Key points to note
(Including decisions taken)

Improvements:

- 442 complaints were received in Q2 compared with 511 in Q1.
- 99.8% of complaints were acknowledged in a timely manner.
- The percentage of complainants advising us they were dissatisfied with our response improved from 13.4% in Quarter 1 to 9.9% in Quarter 2.
- There were notable reductions in numbers of complaints received for the Bristol Dental Hospital, Queen's Day Unit (Endoscopy), Dermatology and the Chemotherapy Day Unit/Outpatients.

However:

- In Q2 the percentage of formal responses sent out by the agreed deadline was the lowest since Quarter 4 of 2017/18. Performance in the Division of Medicine was affected by a key gap in post in their Quality & Patient Safety Team.
- The number of complaints received by Audiology, Boots Pharmacy (BRI), Paediatric Neurology/Neurosurgery, Paediatric Orthopaedics and the BRI Emergency Department increased in Quarter 2.

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

N/A

Respecting everyone
Embracing change
Recognising success
Working together
Our hospitals.

4. **Advice and Recommendations** *(Support and Board/Committee decisions requested)*:	
• This report is for **Information.**	
5. **History of the paper** **Please include details of where paper has previously been received.**	
Patient Experience Group	21/11/19
Senior Leadership Team	18/12/19
Quality and Outcomes Committee	20/12/19

Respecting everyone
Embracing change
Recognising success
Working together
Our hospitals.

20

Complaints Report

Quarter 2, 2019/2020

(1 July 2019 to 30 September 2019)

Author: Tanya Tofts, Patient Support and Complaints Manager

Quarter 2 Executive summary and overview

	Q2	
Total complaints received	442	↓
Complaints acknowledged within set timescale	99.8%	↑
Complaints responded to within agreed timescale – formal investigation	83.6%	↓
Complaints responded to within agreed timescale – informal investigation	87.5%	↓
Proportion of complainants dissatisfied with our response (formal investigation)	9.9%	↓

Successes

- 99.8% of complaints were acknowledged in a timely manner.
- The percentage of complainants advising us they were dissatisfied with our response improved from 13.4% in Quarter 1 to 9.9% in Quarter 2.
- There were notable reductions in numbers of complaints received for the Bristol Dental Hospital, Queen's Day Unit (Endoscopy), Dermatology and the Chemotherapy Day Unit/Outpatients.
- 442 complaints were received in Quarter 2 compared with 511 in Q1.

Priorities

- 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.
- The Trust's 2019 CQC inspection highlighted the need to develop an overall measure of the lifetime of a complaint from the point of receipt (the measurement used in board reports – and documented above – is calculated using a starting point when the content of a complaint is agreed with a Trust caseworker, which may be sometime after the complaints was first received). This measure will be developed and introduced by April 2020.

Opportunities

- Reporting of severity rating of complaints has commenced in this report (see section 9).
- Opportunities to exchange knowledge and learning with the complaints service at Weston General Hospital (UH Bristol's Deputy Patient Support and Complaints Manager is currently supporting the process of aligning complaints processes across the two organisations ahead of next year's planned merger).

Risks & Threats

- In Quarter 2 the percentage of formal responses sent out by the agreed deadline was the lowest since Quarter 4 of 2017/18. Performance in the Division of Medicine was affected by a key gap in post in their Quality & Patient Safety Team.
- The number of complaints received by Audiology, Boots Pharmacy (BRI), Paediatric Neurology/Neurosurgery, Paediatric Orthopaedics and the BRI Emergency Department increased in Quarter 2.

1. Complaints performance – Trust overview

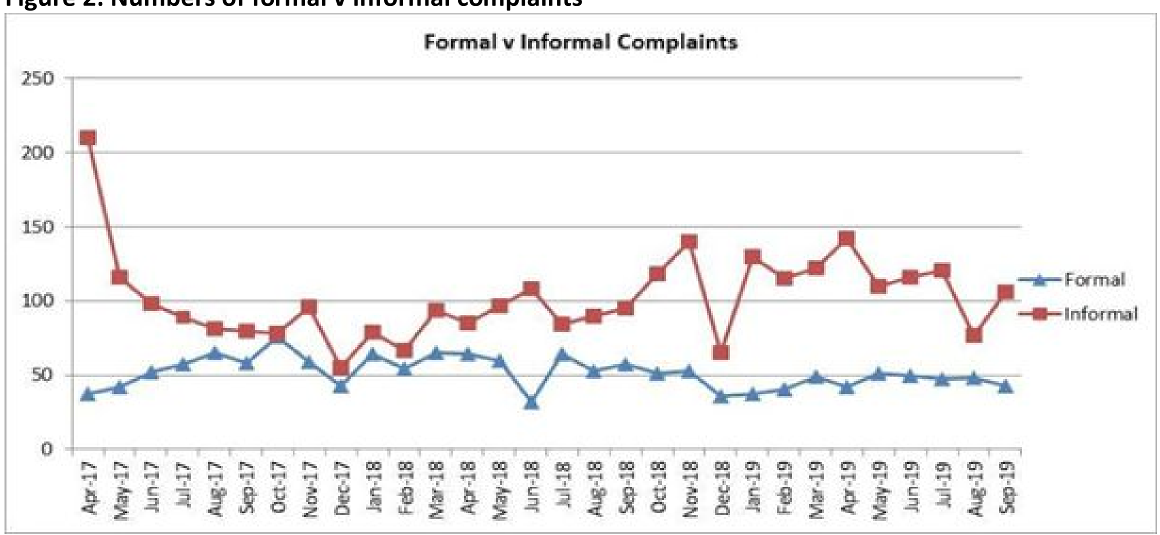
The Trust is committed to supporting patients, relatives and carers in resolving their concerns. Our service is visible, accessible and impartial, with every issue taken seriously. Our aim is to provide honest and open responses in a way that can be easily understood by the recipient.

1.1 Total complaints received

The Trust received 442 complaints in quarter 2 (Q2) of 2019/20. 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. This had increased to an average of 170 per month over the last three quarters; however, Q2 saw a return to the average of 150 per month.

Figure 1: Number of complaints received

Figure 2: Numbers of formal v informal complaints



[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 (above) shows complaints dealt with via the formal investigation process compared with those dealt with via the informal investigation process, over the same period. We continue to deal with a higher proportion of complaints via the informal process, which 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.

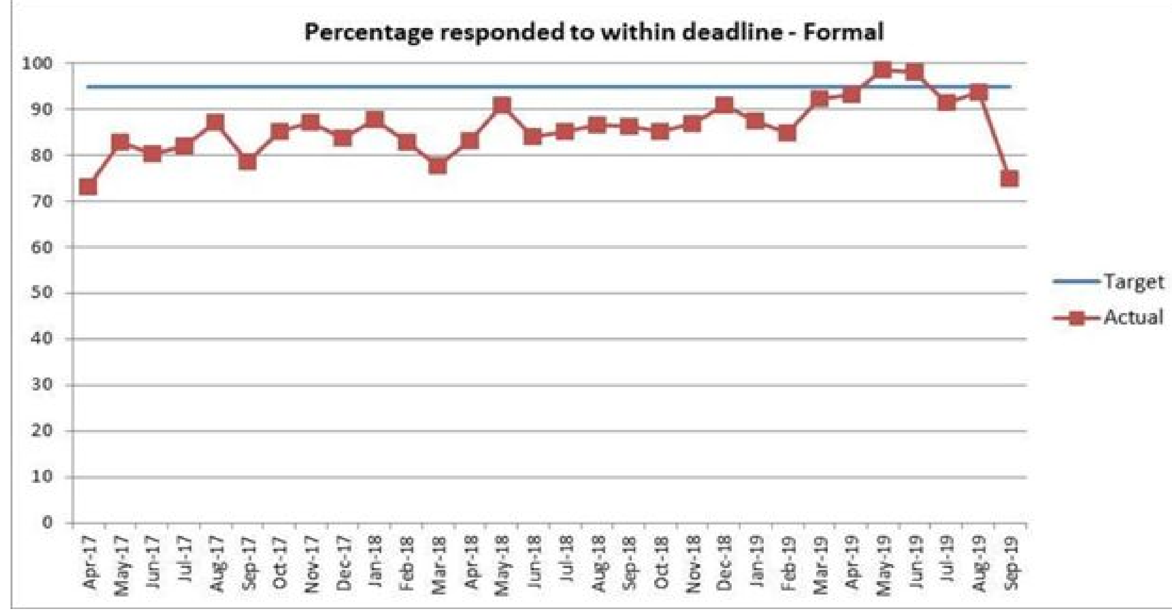
When a complaint is managed through the informal resolution process, the Trust and complainant also agree a timescale and this is usually 10 working days.

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.

In Q2 2019/20, 83.6% of responses were posted within the agreed timescale. This represents 28 breaches out of the 171 formal complaint responses which were sent out during the quarter[2]. This is a deterioration of the 96.6% reported in Q1 and the lowest percentage reported since the 82.3% reported in Q4 of 2017/18. Figure 3 shows the Trust's performance in responding to complaints since April 2017. Please see section 3.3 of this report for details of where these breaches occurred and at which part of the process they were delayed.

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



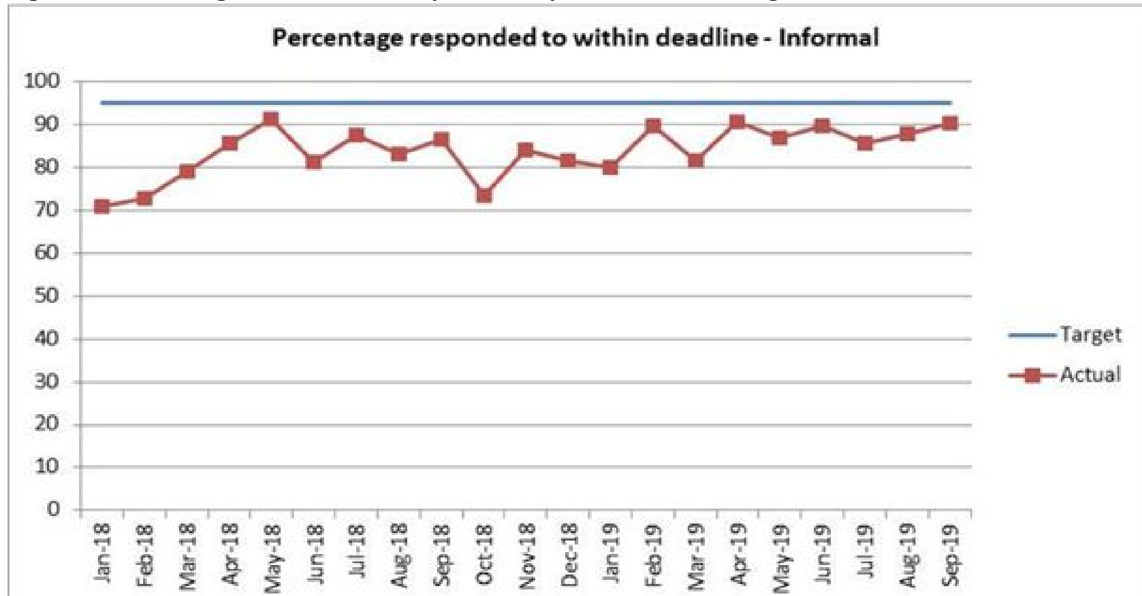
[2] Note that this will be a different figure to the number of complainants who *made* a complaint in that quarter.

1.2.2 Informal Investigations

In Q2 2019/20, the Trust received 304 complaints that were investigated via the informal process. During this period, the Trust responded to 232 complaints via the informal complaints route and 87.5% (203) of these were responded to by the agreed deadline, a small decrease compared to the 89% reported in Q1.

The percentage of informal complaints resolved within the agreed deadline has been formally reported to the Board since Q4 2018/19, given that so many complaints are now resolved informally. Figure 4 (below) shows performance since April 2018, for comparison with formal complaints, although it should be noted that the 95% target was only formally set with effect from Q4 2018/19.

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



1.3 Dissatisfied complainants

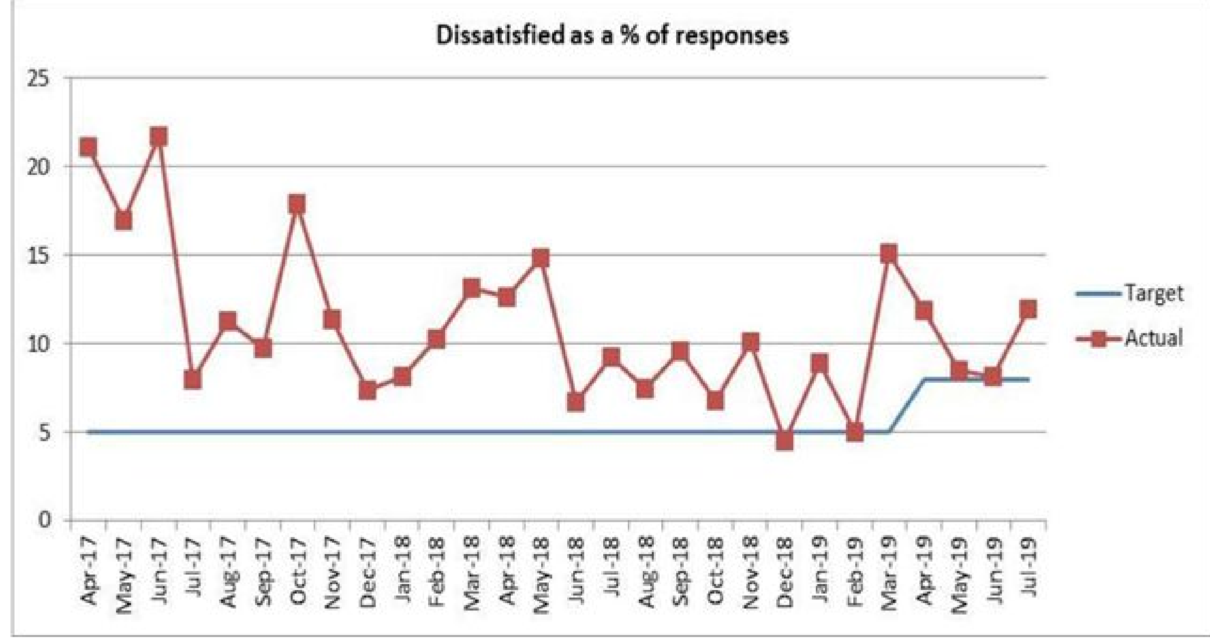
Our revised target for 2019/20 is that no more than 8% of complaints responses should lead to a dissatisfied response.

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 Q2 2019/20, we are able to report dissatisfied data for May, June and July 2019. 20 complainants who received a first response from the Trust during those months have since contacted us to say they were dissatisfied. This represents 9.9% of the 203 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 April 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 Q2 2019/20 compared with Q1.

Complaints in all categories either decreased or remained the same compared with Q1.

Complaints in respect of 'appointments and admissions' and 'clinical care' accounted for 65.8% of all complaints received (291 of 442).

Table 1: Complaints by category/theme

Category/Theme	**Number of complaints received in Q2 (2019/20)**	**Number of complaints received in Q1 (2019/20)**
Appointments & Admissions	155 (35.1% of all complaints) ↓	190 (37.2% of all complaints) ↑
Clinical Care	136 (30.8%) ↓	141 (27.6%) ↑
Attitude & Communication	78 (17.6%) ↓	100 (19.6%) ↓
Facilities & Environment	36 (8.2%) =	36 (7.0%) ↓
Information & Support	17 (3.8%) ↓	21 (4.1%) =
Discharge/Transfer/Transport	13 (2.9%) =	13 (2.5%) ↑
Documentation	7 (1.6%) ↓	9 (1.8%) ↓
Access	0 (0%) ↓	1 (0.2%) ↓
Total	**442**	**511**

Each complaint is also assigned to a more specific sub-category, of which there are over 100. Table 2 lists the most consistently reported sub-categories, which together accounted for 73% of the complaints received in Q2 (322/442).

Table 2: Complaints by sub-category

Sub-category	Number of complaints received in Q2 (2019/20)	Q1 (2019/20)	Q4 (2018/19)	Q3 (2018/19)
Cancelled/delayed appointments and operations	92 (13.2% decrease compared to Q1) ↓	106	87	82
Clinical care (Medical/Surgical)	84 (1.2% decrease) ↓	85	67	94
Appointment administration issues	40 (38.5% decrease) ↓	65	42	42
Attitude of medical staff	19 (9.5% decrease) ↓	21	28	18
Failure to answer telephones/failure to respond	22 (4.8% increase) ↑	21	21	14
Car Parking	12 (25% decrease) ↓	16	25	46
Clinical care (Nursing/Midwifery)	11 (31.3% decrease) ↓	16	10	13
Diagnosis issues	11 (10% increase) ↑	10	4	5
Referral errors	11 (22.2% increase) ↑	9	11	1
Communication with patient/relative	10 (44.4% decrease) ↓	18	19	12
Medication incorrect/ not received	10 (233.3% increase) ↑	3	4	0

In Q2, the sub-categories of ‘diagnosis issues’, ‘referral errors’ and ‘medication incorrect/not received’ appeared in Table 2 for the first time. Of particular note is the large increase in complaints received in relation to medication.

The most significant decreases were in the numbers of complaints received about ‘appointment administration issues’ and ‘car parking’.

Figures 6-9 (below) show the longer term pattern of complaints received since April 2017 for a number of the complaints sub-categories reported in Table 2. Figure 6 shows an increase towards the end of Q2 in complaints about clinical care (medical/surgical) and Figure 7 shows an upward turn in complaints about cancelled appointments and operations towards the end of the quarter. Figure 8 shows the continued downward trend in complaints about car parking since its 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

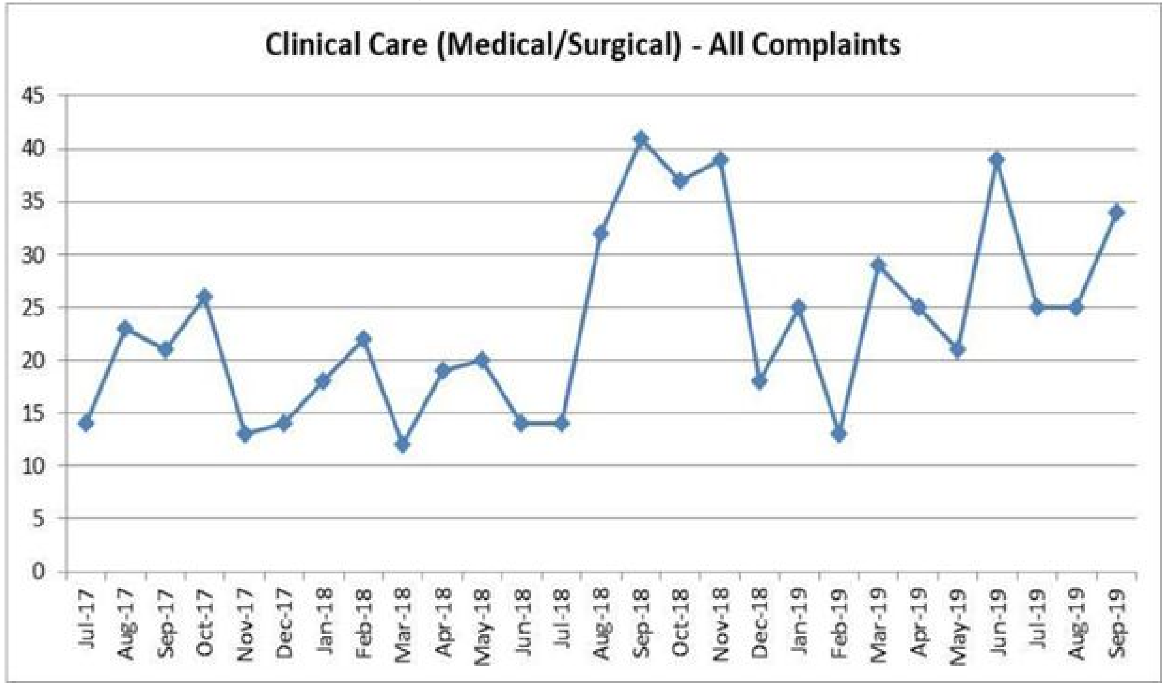
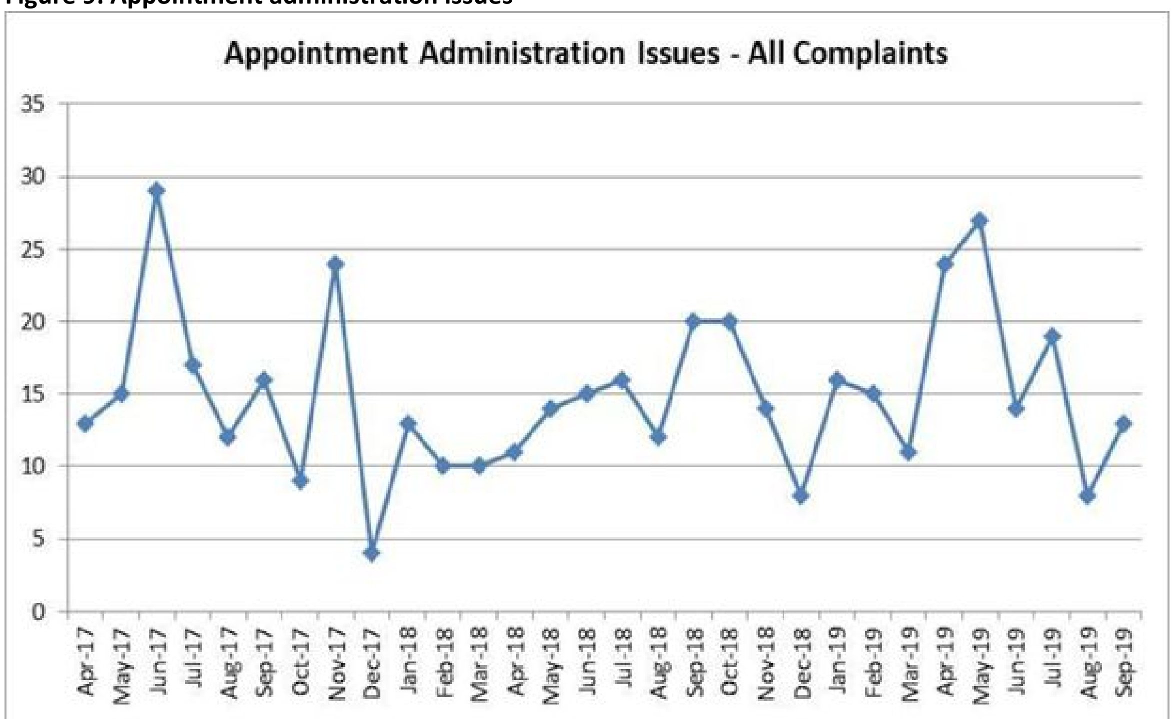


Figure 7: Cancelled or delayed appointments and operations

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 Q2 complaints performance by Division. In addition to providing an overall view, the table includes data for the three most common reasons why people complain: concerns about appointments and admissions; 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	155 (187) ↓	97 (116) ↓	70 (82) ↓	70 (73) ↓	22 (17) ↑
Number of complaints about appointments and admissions	72 (97) ↓	22 (30) ↓	27 (35) ↓	23 (16) ↑	9 (10) ↓
Number of complaints about staff attitude and communication	25 (31) ↓	18 (26) ↓	13 (18) ↓	12 (15) ↓	5 (4) ↑
Number of complaints about clinical care	44 (46) ↓	35 (40) ↓	23 (19) ↑	27 (34) ↓	6 (2) ↑
Area where the most complaints have been received in Q2	Bristol Dental Hospital (BDH) – 33 (44) (inc. Admin Dept below) Administration Department (BDH) – 10 (12) Bristol Eye Hospital (BEH) – 42 (43) (inc. Outpatients below) BEH Outpatients – 14 (17) Trauma & Orthopaedics – 19 (22) ENT – 16 (19) Upper GI – 8 (11) QDU Endoscopy – 7 (13)	Emergency Department (BRI) – 31 (25) Dermatology – 17 (27) Rheumatology – 5 (3) Clinic A410 – 5 (3)	**BHI (all) – 45 (53)** **BHOC (all) – 21 (25)** BHI Outpatients – 23 (28) BHI & BHOC Appt Depts – 16 (15) Clinical Genetics – 4 (4)	**BRHC (all) – 44 (48)** Carousel Outpatients (E301) – 8 (7) Paediatric Neurology & Neurosurgical – 8 (5) Children's ED (E308) – 6 (6) Paediatric Orthopaedics – 6 (2) **StMH (all) – 25 (22)** Gynaecology Outpatients (StMH) – 10 (9) Ward 78 (Gynaecology) – 4 (2)	Radiology – 9 (10) Audiology – 6 (3) Boots Pharmacy – 4 (1)
Notable deteriorations compared with Q1	No notable deteriorations	Emergency Department (BRI) – 31 (25)	No notable deteriorations	Paediatric Neurology & Neurosurgical – 8 (5) Paediatric Orthopaedics – 6 (2)	Audiology – 6 (3) Boots Pharmacy – 4 (1)
Notable improvements compared with Q1	Bristol Dental Hospital (BDH) – 33 (44) QDU Endoscopy – 7 (13)	Dermatology – 17 (27)	Ward C708 – 3 (6) Chemo Day Unit / Outpatients (BHOC) – 1 (6)	Carousel Outpatients (E301) – 2 (8)	Physiotherapy – 0 (2)

3.1.1 Division of Surgery

There was a reduction in the total number of complaints received by the Division of Surgery in Q2; 155 compared with 187 in Q1 and 176 in Q4. Complaints received by Bristol Dental Hospital (BDH) decreased by 25% in Q2 and those received by QDU (Endoscopy) almost halved. There were no notable increases in complaints received by any departments within the Division.

Complaints about 'appointments and admissions' decreased by just over 25% following a significant increase in Q1. There were also reductions in complaints about 'attitude and communication' and 'clinical care'.

The Division achieved 94.1% against its target for responding to formal complaints within the agreed timescale in Q2 and 90% for informal complaints. Please see section 3.3 Table 21 for details of where in the process any delays occurred.

Table 4: Complaints by category type

Category Type	**Number and % of complaints received – Q2 2019/20**	**Number and % of complaints received – Q1 2019/20**
Appointments & Admissions	72 (46.5% of total complaints) ↓	97 (51.9% of total complaints) ↑
Clinical Care	44 (28.4%) ↓	46 (24.6%) ↓
Attitude & Communication	25 (16.1%) ↓	31 (16.6%) ↓
Information & Support	6 (3.9%) ↑	5 (2.6%) ↓
Discharge/Transfer/ Transport	3 (1.9%) =	3 (1.6%) ↑
Documentation	3 (1.9%) ↑	2 (1.1%) =
Facilities & Environment	2 (1.3%) ↓	3 (1.6%) ↑
Access	0 (0%) =	0 (0%) ↓
Total	**155**	**187**

Table 5: Top sub-categories

Category	**Number of complaints received – Q2 2019/20**	**Number of complaints received – Q1 2019/20**
Cancelled or delayed appointments and operations	46 ↓	57 ↑
Clinical care (medical/surgical)	28 ↓	30 ↑
Appointment administration issues	18 ↓	34 ↑
Attitude of Medical Staff	9 ↑	4 ↓
Referral errors	7 ↑	2 ↓
Diagnosis delayed / incorrect / missed	6 ↑	2 ↑
Communication with patient/relative	4 =	4 ↓
Failure to answer telephones/ failure to respond	4 ↓	6 ↓

Table 6: Divisional response to concerns highlighted by Q2 data

Concern	Explanation	Action
The number of complaints received by the ENT service remained higher than expected in Q2, on a par with Q1, when the clinical team was affected by vacancies and annual leave, resulting in the cancellation of routine patients to meet demand for fast track patients. In Q2, seven of the 16 complaints related to cancellations and appointment administration issues, with the remainder consisting of five complaints about 'clinical care' and three in respect of 'attitude and communication'.	Bed pressures during Q2 saw an increase in the cancellation of surgery. Appointments have been changed/cancelled to accommodate more urgent patients. 'Clinical care' and 'attitude and communication' refer to formal complaints where patients have come away from hospital and realised that they do not have a clear understanding about the next steps on their treatment pathway.	During this period it should be noted that the ENT consultant team has responded promptly and effectively to the complaints received; the Division remains confident that this will continue. The clinical team is now established and working to reduce cancellations. The Division and Trust continue to try to minimise the cancellation of surgery, but it is often inevitable due to overall operational pressures. The booking team continues to book patients according to clinical priority and ensures communication with patients is effective when changing appointments.
The number of complaints received for the Bristol Eye Hospital (BEH) rose in September following reductions in the previous two months. Of the 42 complaints received in Q2, 19 were about 'appointments and admissions'; 10 related to 'clinical care'; and seven were in respect of 'attitude and communication'. Complaints about outpatient services accounted for 14 complaints in Q2, with the remainder spread across different departments in the BEH.	Complaints about 'appointments and admissions' were a result of increased demand on the service.	There is a new administrative structure in place, which will strengthen the processes in place with regards to managing the booking process and appointments and will improve patients experience. The Division will continue to maximise the utilisation of available appointments.

Current divisional priorities for improving how complaints are handled and resolved

The Division continues to encourage and monitor informal complaints using a tracker system. This in reviewed on a daily basis to promote the timely response of informal complaints within the 10 day time frame

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

The Divisional Complaints Coordinator will be providing additional training to new Assistant General Managers to ensure consistent quality of written complaints responses.

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

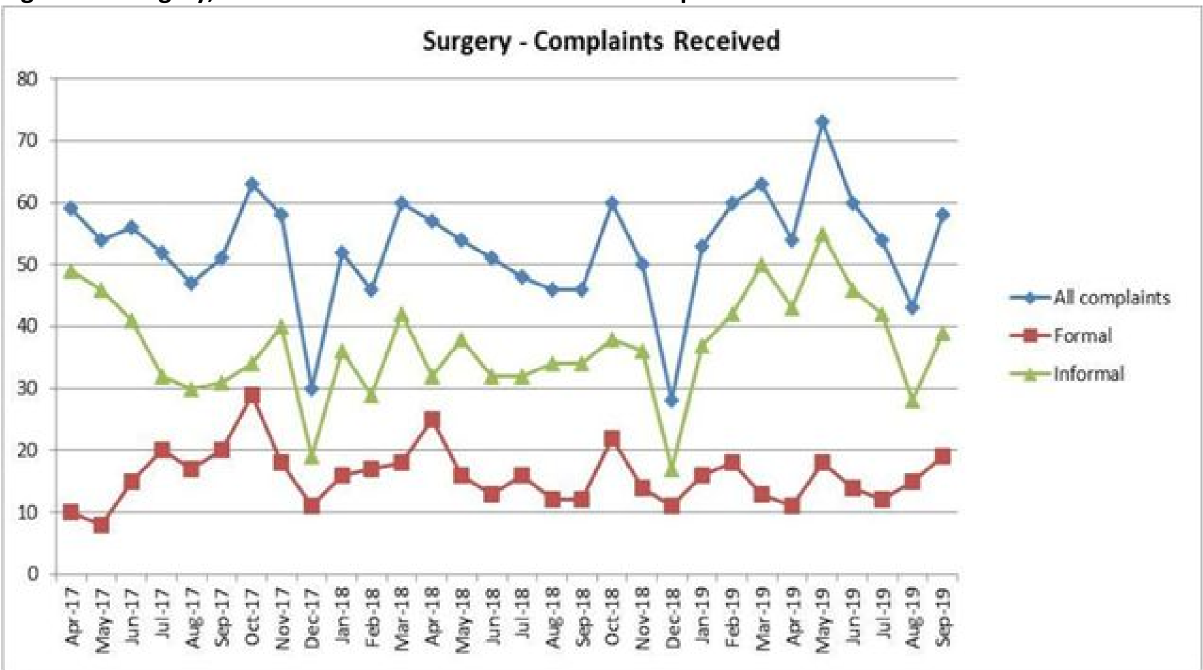


Figure 11: Complaints received by Bristol Dental Hospital

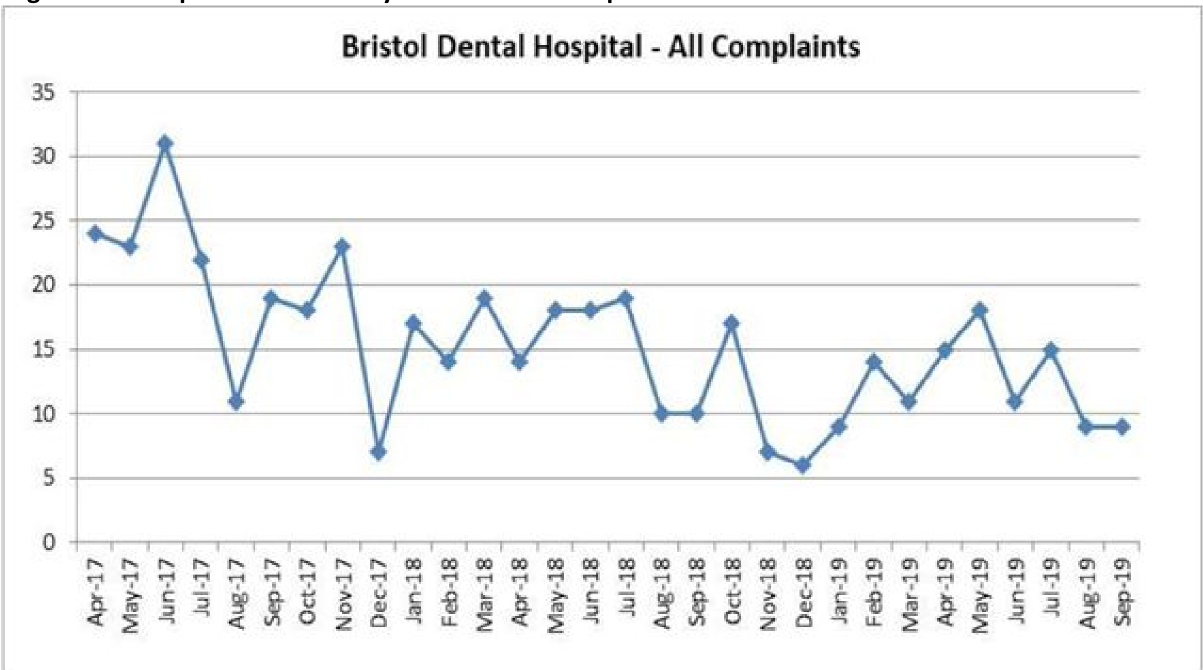


Figure 12: Complaints received by Bristol Eye Hospital

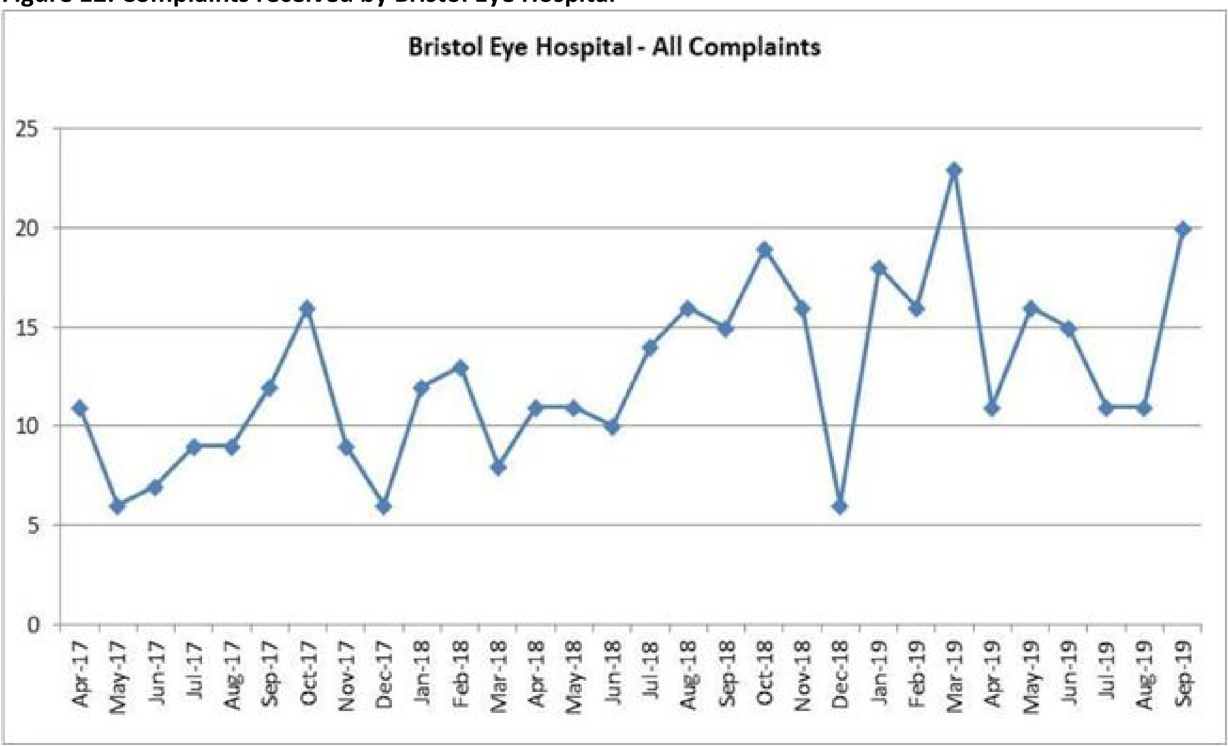
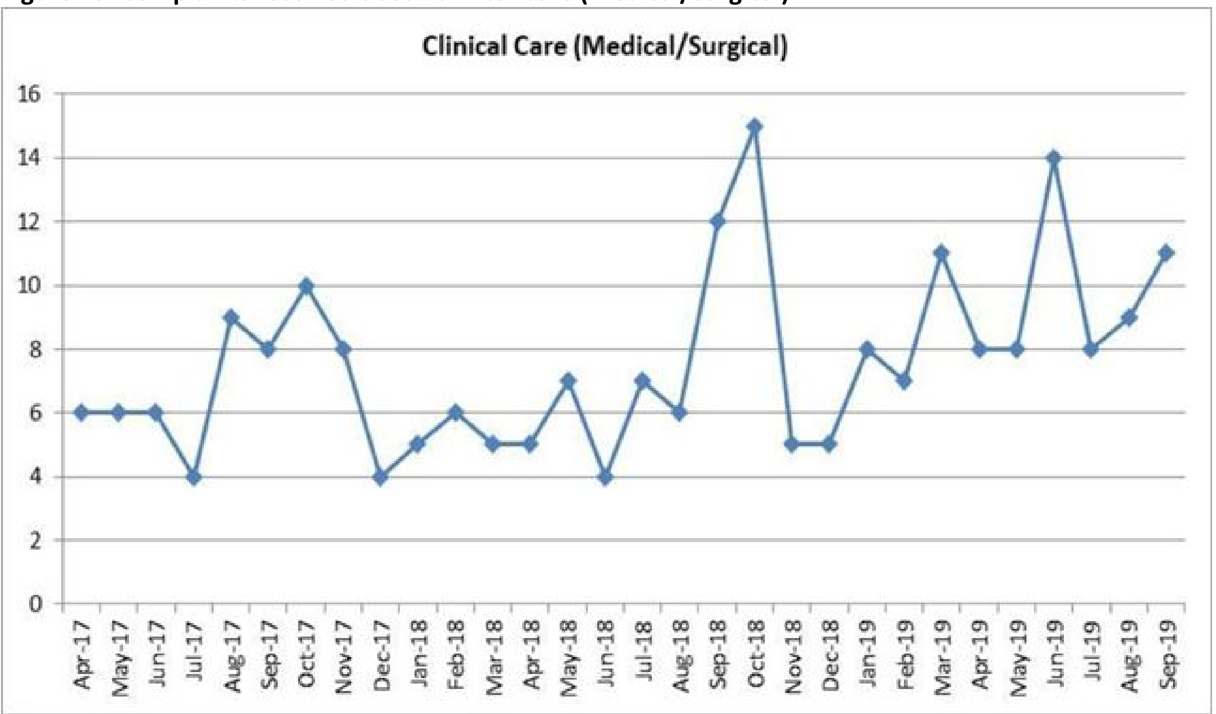


Figure 13: Complaints received about Clinical Care (Medical/Surgical)



3.1.2 Division of Medicine

In Q2, there was a reduction of 16.4% in the overall number of complaints received by the Division of Medicine compared with Q1. There was a notable reduction in the number of complaints received by the Dermatology service (down by 37%). There was an increase in complaints for the Emergency Department, which increased from 25 in Q1 to 31 in Q2.

The highest number of complaints received by the Division was in respect of 'clinical care (medical/surgical)', which remained similar to the number received in Q1. The last two quarters have seen the highest number of complaints reported under this sub-category since Q1 2017/18.

The Division achieved 76.7% against its target for responding to formal complaints within the agreed timescale in Q2 and 75.8% for informal complaints. Please see section 3.3 Table 21 for details of where in the process any delays occurred.

Table 7: Complaints by category type

Category Type	Number and % of complaints received – Q2 2019/20	Number and % of complaints received – Q1 2019/20
Clinical Care	35 (36.1% of total complaints) ↓	40 (34.5% of total complaints) ↑
Appointments & Admissions	22 (22.7%) ↓	30 (25.9%) ↑
Attitude & Communication	18 (18.5%) ↓	26 (22.4%) =
Facilities & Environment	9 (9.3%) ↑	7 (6.1%) ↓
Discharge/Transfer/ Transport	9 (9.3%) ↑	5 (4.3%) ↑
Information & Support	4 (4.1%) =	4 (3.4%) ↑
Documentation	0 (0%) ↓	4 (3.4%) ↓
Access	0 (0%) =	0 (0%) =
Total	**97**	**116**

Table 8: Top sub-categories

Category	Number of complaints received – Q2 2019/20	Number of complaints received – Q1 2019/20
Clinical care (medical/surgical)	27 ↑	26 ↑
Cancelled or delayed appointments and operations	15 ↓	18 ↑
Failure to answer phone/ failure to respond	7 ↑	5 ↑
Discharge arrangements	5 ↑	4 ↑
Personal (lost) property	5 ↑	4 ↓
Transfer/Transport	4 ↑	1 ↓
Waiting time in clinic	4 ↑	0 ↓
Diagnosis delayed / missed / incorrect	3 ↓	5 ↑
Attitude of A&C staff	3 ↓	5 ↑
Attitude of medical staff	3 ↓	8 ↓

Table 9: Divisional response to concerns highlighted by Q2 data

Concern	Explanation	Action
There was an increase in the number of complaints received by the Emergency Department (ED) in Q1. Of the 31 complaints received, 12 were recorded under the sub-category of 'clinical care (medical/surgical)'; four were specifically in respect of waiting times and the remainder was spread across a variety of sub-categories.	Q2 has seen an unprecedented rise in people attending the ED.	Addressed through existing plans enacted by the Division to address capacity challenges in ED.
The Division of Medicine responded to 76.3% of all complaints (formal and informal) within the agreed timescales in Q1, compared with 92.4% in Q1 and 94.4% in Q4 2018/19.	The resignation of the Divisional Complaints Coordinator has negatively impacted on performance due to limited capacity within the Divisional Quality and Patient Safety team.	The vacant post has been recruited to, however the post-holder has been on extended sick leave, so the capacity challenge remains.

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

Re-establishing the Divisional Quality and Patient Safety team.

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

Care and experience of patients in the ED queue.

Figure 14: Medicine – formal and informal complaints received

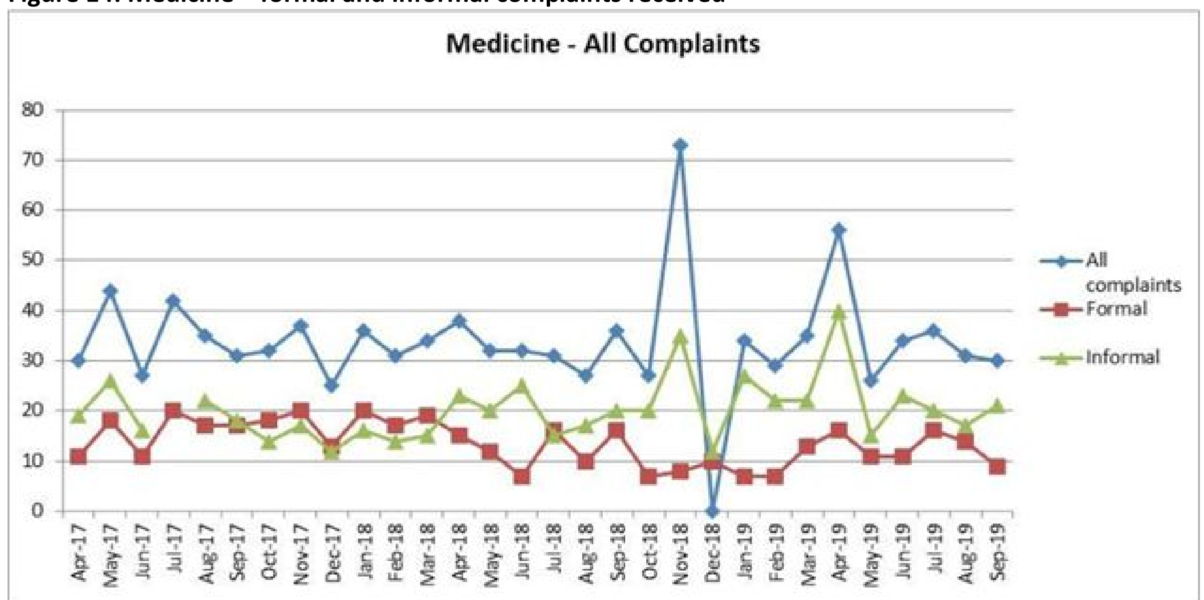


Figure 15: Complaints received by Dermatology

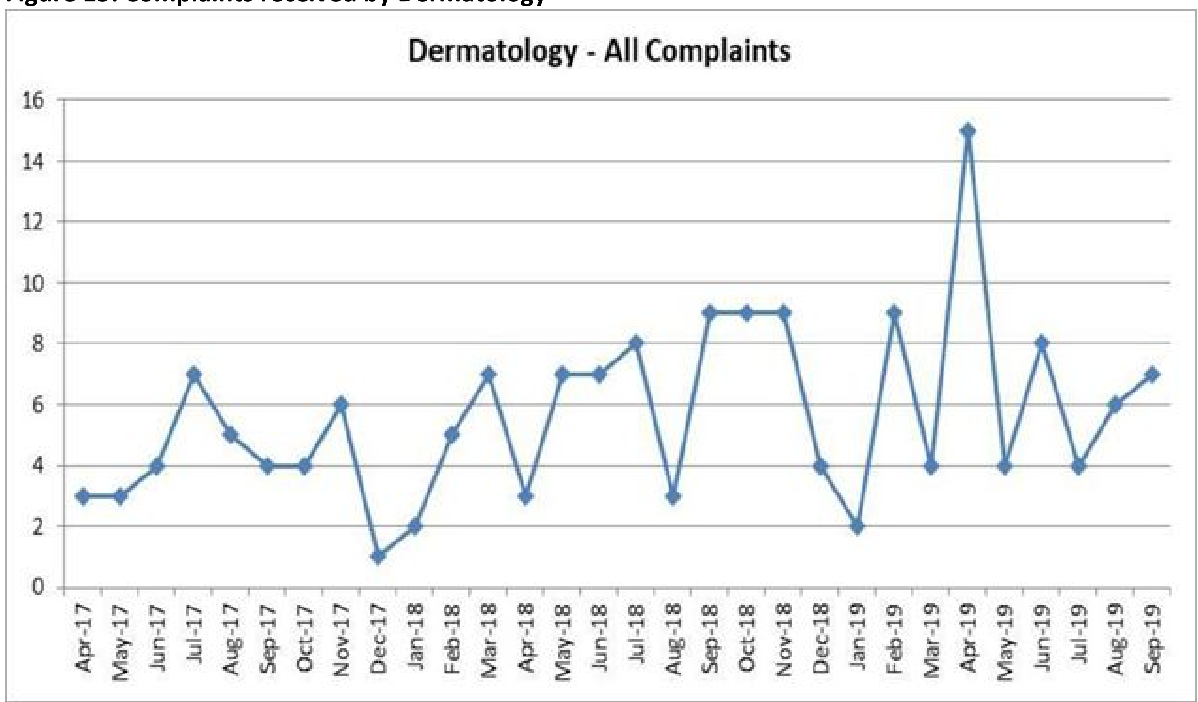


Figure 16: Complaints about attitude and communication

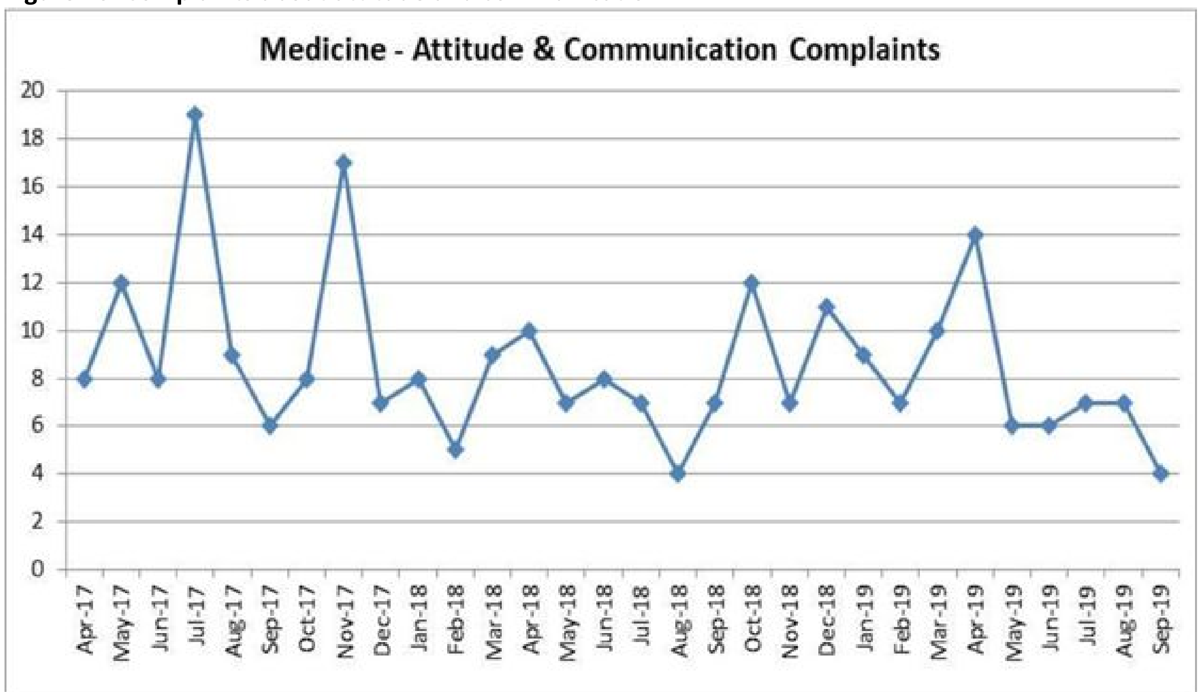
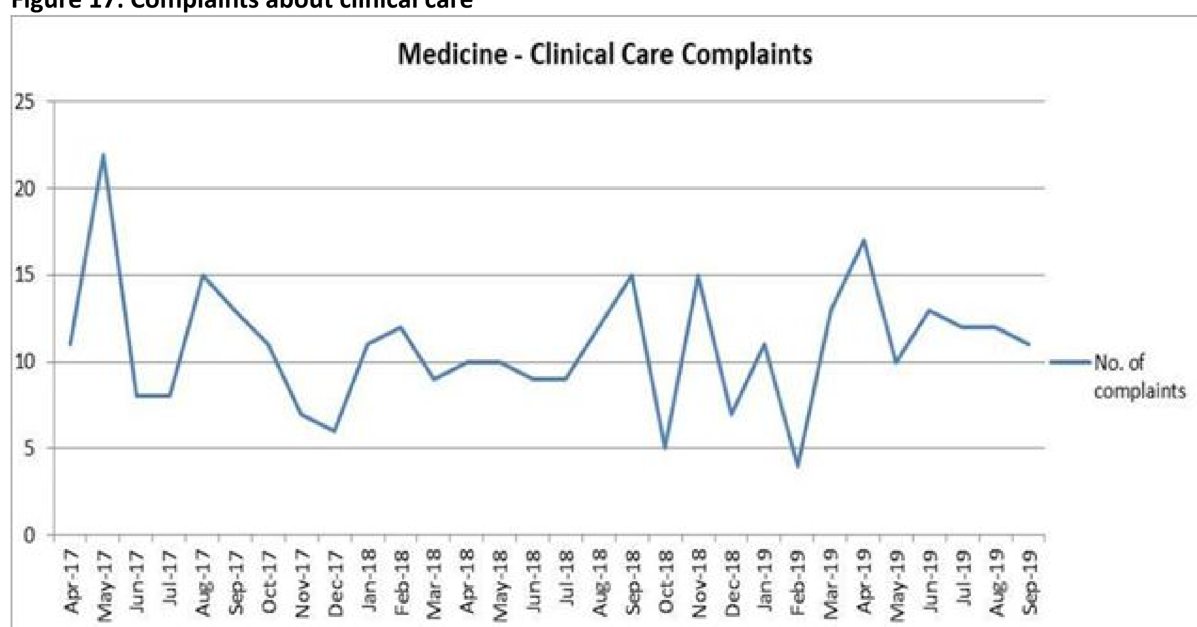


Figure 17: Complaints about clinical care



3.1.3 Division of Specialised Services

The Division of Specialised Services received 70 new complaints in Q2; a reduction of 14.6% compared with Q1. Of these 82 complaints, 45 were for the Bristol Heart Institute (BHI), compared with 53 in Q1; and 21 were for the Bristol Haematology & Oncology Centre (BHOC), compared with 25 in Q1. The remaining four complaints were for the Clinical Genetics service based at St Michael's Hospital.

The largest number of complaints received by the Division was recorded under the category of 'appointments and admissions' (38.6%), which includes complaints about cancelled and delayed appointments and surgery. There were small increases in the numbers of complaints relating to 'clinical care', 'documentation' and 'facilities and environment'. However, complaints received in respect of five of the eight categories decreased compared with Q1.

The Division achieved 70.8% against its target for responding to formal complaints within the agreed timescale in Q2 and 94.9% for informal complaints. Please see section 3.3 Table 21 for details of where in the process any delays occurred.

Table 10: Complaints by category type

Category Type	**Number and % of complaints received – Q2 2019/20**	**Number and % of complaints received – Q1 2019/20**
Appointments & Admissions	27 (38.6% of total complaints) ↓	35 (42.7% of total complaints) ↑
Clinical Care	23 (32.8%) ↑	19 (23.2%) ↑
Attitude & Communication	13 (18.6%) ↓	18 (21.9%) ↑
Documentation	3 (4.3%) ↑	2 (2.4%) ↓
Facilities & Environment	3 (4.3%) ↑	1 (1.2%) =
Information & Support	1 (1.4%) ↓	4 (4.9%) ↑
Discharge/Transfer/ Transport	0 (0%) ↓	3 (3.7%) ↑
Access	0 (0%) =	0 (0%) =
Total	**70**	**82**

Table 11: Top sub-categories

Category	Number of complaints received – Q2 2019/20	Number of complaints received – Q1 2019/20
Cancelled or delayed appointments and operations	13 ↓	21 ↑
Appointment administration issues	11 ↓	12 =
Clinical care (medical/surgical)	12 ↑	7 ↑
Failure to answer phone/ Failure to respond	7 =	7 ↑
Lost / misplaced / delayed test results	7 ↑	2 ↓
Attitude of medical staff	3 =	3 =
Medication incorrect / not received	2 ↑	1 =

Table 12: Divisional response to concerns highlighted by Q2 data

Concern	Explanation	Action
The number of complaints received by the Appointment Departments at Bristol Heart Institute (BHI) and Bristol Haematology & Oncology Centre (BHOC) increased in Q2; the fourth consecutive quarterly increase. 11 of the 16 complaints received were for the BHI.	**BHI** There was one formal complaint and 10 informal complaints for the BHI. The formal complaint related to a patient not being aware of how long the waiting list was. The informal complaints were about patients being booked into the wrong clinics, waiting times, patients being unable to book appointments and patients being sent DNA letters incorrectly.	**BHI** Action has been taken to reduce waiting list times, including additional work being undertaken at a private hospital in Bristol. A new Cath Lab is being built in 2020 which will improve capacity. Referral letters are being copied to patients and GPs now have more detailed information about the correct process for referrals. Clinic Coordinators have been reminded to liaise with both the patient and their GP when incorrect referrals are received. The Echocardiogram Coordinator has been reminded to contact every patient who DNAs to establish the reason for this before discharging the patient back to their GP.

Complaints about 'clinical care' increased in Q2. Of the 23 complaints recorded under this category six each were for BHI Outpatients and BHOC Outpatients, with the remainder spread across Clinical Genetics and various wards.	**BHI** The over-arching theme of these complaints is communication, with different terminology used by different teams, which is confusing for patients and miscommunication around medication and listening to patients' families and carers. **BHOC** One complaint was about a patient not receiving adequate pain relief and another was in respect of a respiratory outlier who felt neglected as it took several days for tests to be carried out.	**BHI** Clinicians have been reminded to be conscious of the terminology used by other teams, to give clear explanations and rationale for treatment and to listen to their patients and to their relatives/carers. **BHOC** Apologies were given where appropriate and the Matron spoke to the respiratory patient concerned and followed up with the respiratory registrar.

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

A proposal and business case has been entered into the Operating Plan for additional administrative support to the team to assist with cover for the Divisional Complaints and Governance Coordinator, and with administration for the team.

Priority issues we are seeking to address based on learning from complaints.
Courses are currently available for staff via the online training portal Kallidus. Regular briefings are given at meetings, reminding staff of the importance of clear, compassionate communication and about the training currently available. The Division is also considering having this training made essential for senior medical staff through their annual appraisal and they will be carrying out a scoping exercise to ascertain what is available and whether this training would need to be outsourced or could be provided in house.

Figure 18: Specialised Services – formal and informal complaints received

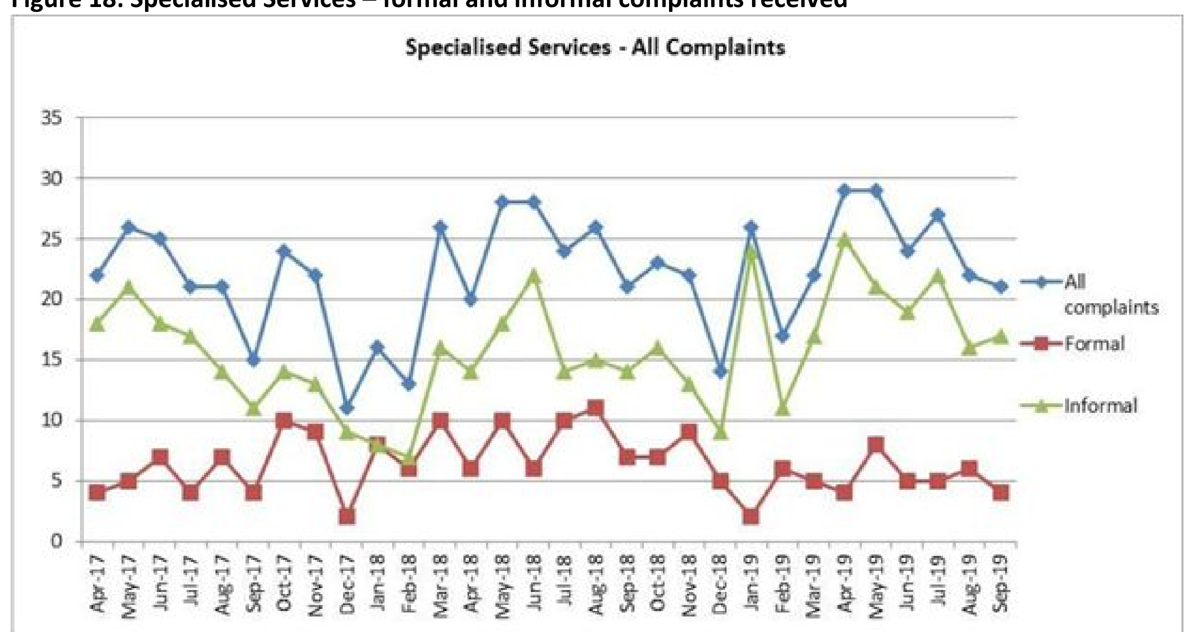


Figure 19: Complaints received by Bristol Heart Institute

Bristol Heart Institute - All Complaints (Specialised Services)

25
20
15
10
5
0

Apr-17 May-17 Jun-17 Jul-17 Aug-17 Sep-17 Oct-17 Nov-17 Dec-17 Jan-18 Feb-18 Mar-18 Apr-18 May-18 Jun-18 Jul-18 Aug-18 Sep-18 Oct-18 Nov-18 Dec-18 Jan-19 Feb-19 Mar-19 Apr-19 May-19 Jun-19 Jul-19 Aug-19 Sep-19

Figure 20: Complaints received by Bristol Haematology & Oncology Centre

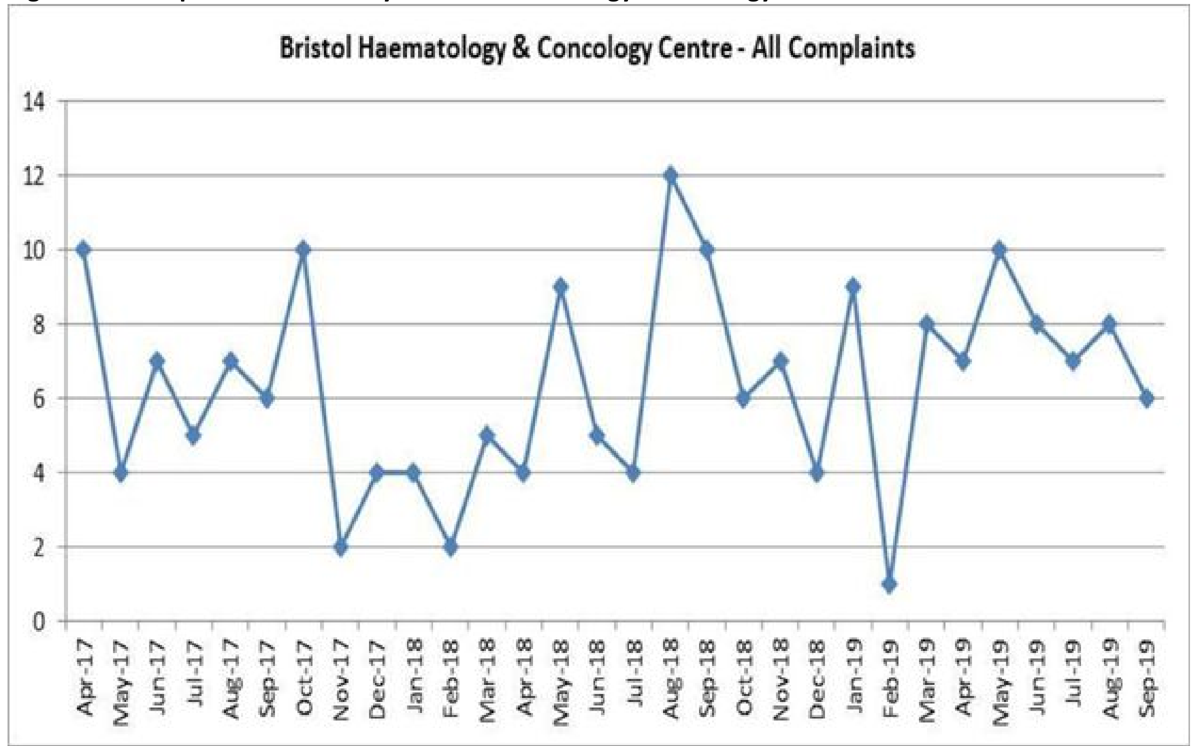
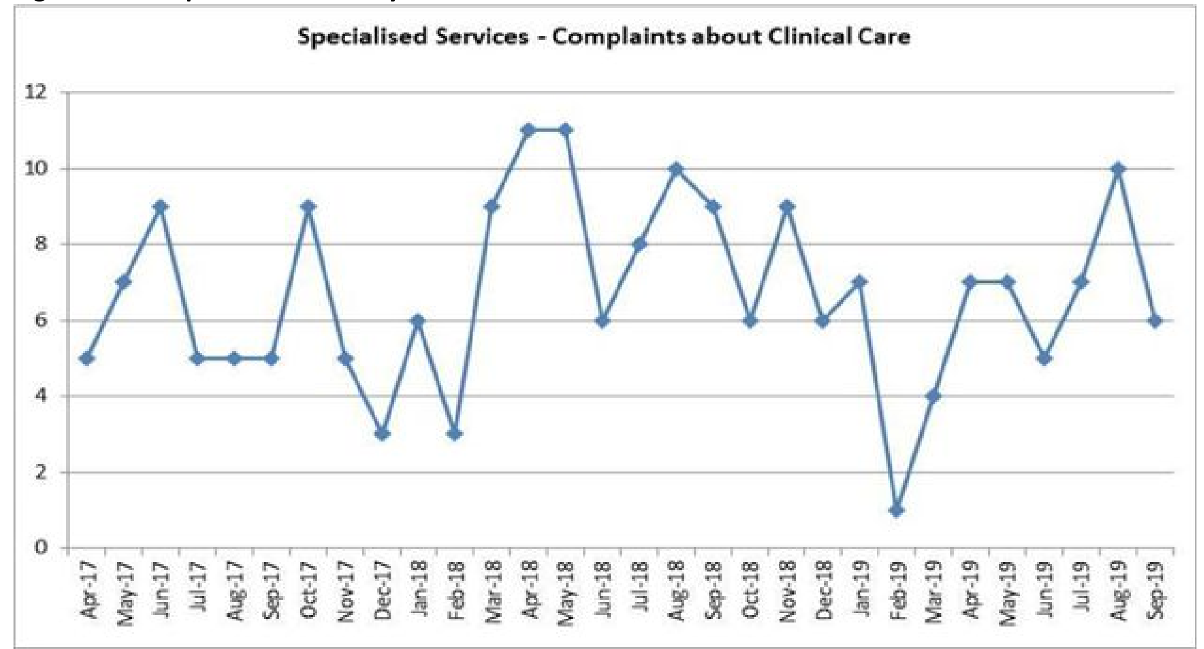


Figure 21: Complaints received by Division about Clinical Care



3.1.4 Division of Women's and Children's Services

The total number of complaints received by the Division in Q2 was 70. Numbers of complaints received by the Division have remained consistent for the last three quarters. Complaints for Bristol Royal Hospital for Children (BRHC) accounted for 44 of the 73 complaints, compared with 48 in Q1. There were 25 complaints for St Michael's Hospital (StMH); a slight increase on the 22 received in Q1. There was also one complaint for the Paediatric Outpatients service at South Bristol Community Hospital.

In Q1, this was the only clinical division to see a reduction in the number of complaints about 'appointments and admissions'; however, in Q2, they were the only clinical division to record an increase in this category.

The Division achieved 94.4% against its target for responding to formal complaints within the agreed timescale in Q2 and 88.5% for informal complaints. Please see section 3.3 Table 21 for details of where in the process any delays occurred.

Table 13: Complaints by category type

Category Type	**Number and % of complaints received – Q2 2019/20**	**Number and % of complaints received – Q1 2019/20**
Clinical Care	27 (38.6% of total complaints) ↓	34 (46.6% of total complaints) ↑
Appointments & Admissions	23 (32.9%) ↑	16 (21.9%) ↓
Attitude & Communication	12 (17.1%) ↓	15 (20.5%) ↓
Facilities & Environment	4 (5.7%) ↑	2 (2.7%) =
Information & Support	2 (2.9%) ↓	4 (5.5%) ↑
Discharge/Transfer/Transport	1 (1.4%) =	1 (1.4%) ↑
Documentation	1 (1.4%) ↑	0 (0%) ↓
Access	0 (0%) ↓	1 (1.4%) ↑
Total	**70**	**73**

Table 14: Top sub-categories

Category	Number of complaints received – Q2 2019/20	Number of complaints received – Q1 2019/20
Clinical care (medical/surgical)	17 ↓	22 ↑
Cancelled or delayed appointments and operations	15 ↑	8 ↓
Clinical care (nursing/midwifery)	5 ↓	6 ↑
Appointment administration issues	5 =	5 ↑
Communication between staff and with patient/relative	4 =	4 ↓
Attitude of medical staff	4 ↑	3 ↓
Referral errors	3 ↑	2 ↓

Table 15: Divisional response to concerns highlighted by Q2 data

Concern	Explanation	Action
In Q2, the division saw an increase in the number of complaints received in respect of 'appointments and admissions', which includes complaints about cancelled and delayed appointments and operations. Of the 23 complaints received in this category, 15 were for Children's Services (including the one from SBCH).	**BRHC** The complaints received spanned a number of departments, with no common themes within this broad category. Due to the changing clinical priority of patients requiring surgery and unforeseen clinical emergencies arising, there are times when the cancellation of appointments is unavoidable and an immediate alternative cannot always be given, especially when the procedure is complex.	**BRHC** The Divisional Complaints Coordinator will monitor complaints about cancelled appointments by department to identify any emerging themes at an early stage. This will allow early actions to be taken to try and prevent a further increase of complaints in this category.
The eight complaints in this category for StMH were all for Gynaecology Outpatients.	**StMH** Delays for patients waiting to receive outpatient appointments have been an issue due to clinician absence.	**StMH** The Division has commenced a Gold QI transformation project for antenatal clinic outpatients; learning will be transferred to the gynaecology service and waiting times will be monitored.

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

StMH
We will continue to report weekly complaint status and escalate any concerns to the Divisional Director to avoid breaches of deadlines.

BRHC
A new Divisional Complaints Coordinator is in post and will be closely monitoring complaints for the early identification of themes and trends. The post holder will also be auditing actions taken as a result of a complaint to ensure their effectiveness in improving patient experience.

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

StMH
The gynaecology services is reviewing its policy for gynaecology patients who have diagnostic test results outstanding and our protocol for recall of patients if issues are identified from outstanding results. We are also developing robust rules for escalation to consultants for junior doctors for patients who are not improving as expected.

BRHC
The Divisional Complaints Coordinator will consider how best to increase staff understanding of the complaints process, including the options available to a patient or their family when they are unhappy with any element of care received. This will prevent overuse of the formal complaints process, particularly when a more immediate outcome is required.

Figure 22: Women & Children – formal and informal complaints received

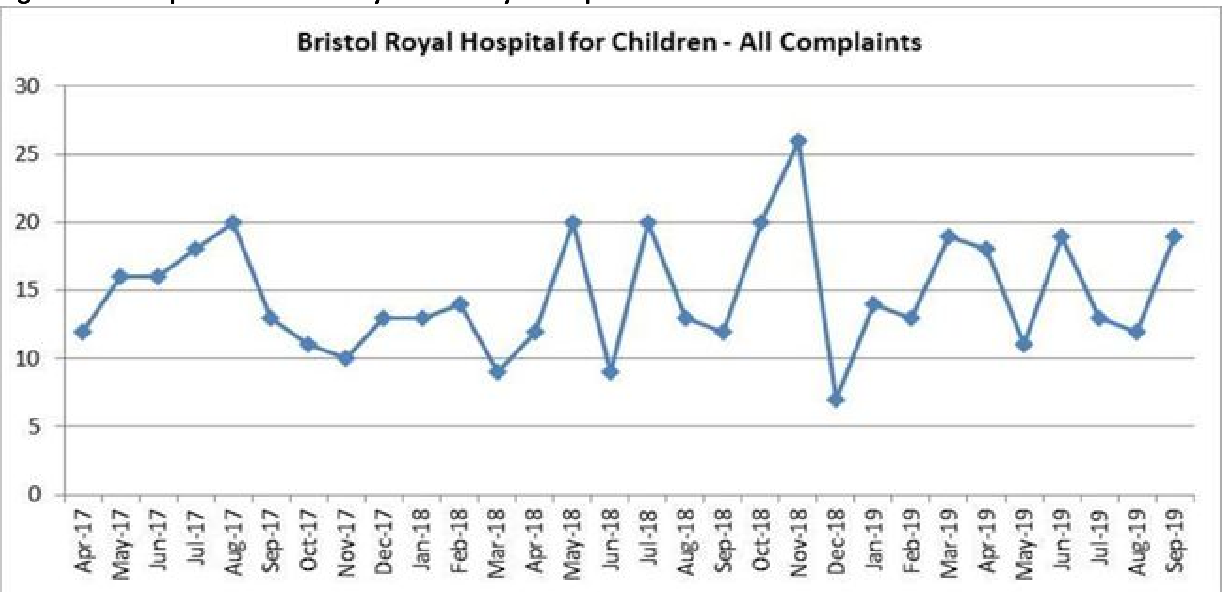
Women & Children - All Complaints

40
35
30
25
20
15
10
5
0

Apr-17 May-17 Jun-17 Jul-17 Aug-17 Sep-17 Oct-17 Nov-17 Dec-17 Jan-18 Feb-18 Mar-18 Apr-18 May-18 Jun-18 Jul-18 Aug-18 Sep-18 Oct-18 Nov-18 Dec-18 Jan-19 Feb-19 Mar-19 Apr-19 May-19 Jun-19 Jul-19 Aug-19 Sep-19

All complaints
Formal
Informal

Figure 23: Complaints received by Bristol Royal Hospital for Children



20

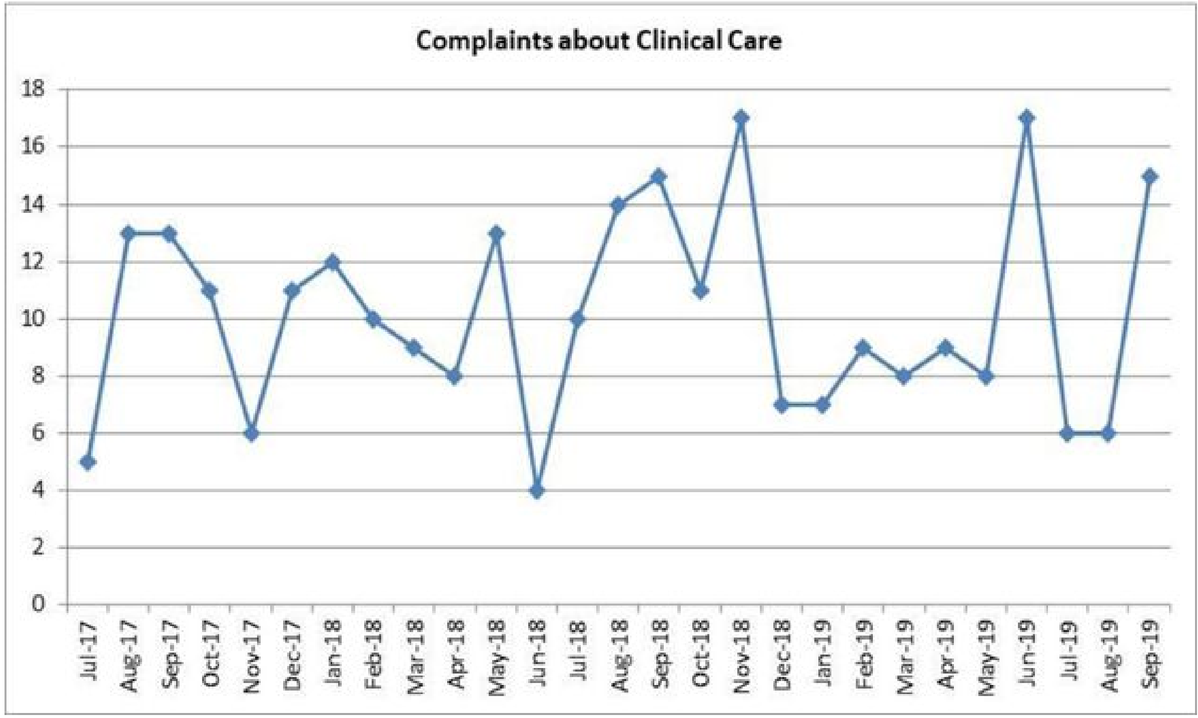
Figure 24: Complaints received by St Michael's Hospital

St Michael's Hospital - All Complaints

0 2 4 6 8 10 12 14 16

Apr-17 May-17 Jun-17 Jul-17 Aug-17 Sep-17 Oct-17 Nov-17 Dec-17 Jan-18 Feb-18 Mar-18 Apr-18 May-18 Jun-18 Jul-18 Aug-18 Sep-18 Oct-18 Nov-18 Dec-18 Jan-19 Feb-19 Mar-19 Apr-19 May-19 Jun-19 Jul-19 Aug-19 Sep-19

Figure 25: 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 17 in Q1 to 22 in Q2 of 2019/20. The most notable increase was in complaints categorised under 'clinical care'. Of the 22 complaints received by the Division in Q2, 86% were for Radiology (9), Audiology (6) and Boots Pharmacy (4). There were no notable deteriorations or improvements in numbers of complaints received overall in Q1. For this reason, there is no table below for the division to comment on concerns highlighted by Q2 data.

The Division achieved 87.5% against its target for responding to formal complaints within the agreed timescale in Q2 and 100% for informal complaints. Please see section 3.3 Table 21 for details of where in the process any delays occurred.

Table 16: Complaints by category type

Category Type	**Number and % of complaints received – Q2 2019/20**	**Number and % of complaints received – Q1 2019/20**
Appointments & Admissions	9 ↓	10 ↑
Clinical Care	6 ↑	2 ↓
Attitude & Communication	5 ↑	4 ↓
Information & Support	1 ↓	4 ↓
Facilities & Environment	1 ↑	0 ↓
Documentation	0 =	0 ↓
Access	0 =	0 ↓
Discharge/Transfer/Transport	0 =	0 =
Total	**22**	**17**

Table 17: Top sub-categories

Category	**Number of complaints received – Q2 2019/20**	**Number of complaints received – Q1 2019/20**
Appointment administration issues	4 =	4 ↓
Failure to answer phone / failure to respond	3 ↑	0 ↓
Medication not received	3 ↑	1 ↑
Waiting time in clinic / pharmacy	3 ↑	0 ↓

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

It is a high priority for the division to ensure complaints timescales are consistently met, and extensions to deadlines are rarely requested. There is a robust divisional process in place:

- 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. No concerns were highlighted from the Q2 data and therefore no current priority issues have been identified.

Figure 26: 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 26 complaints in Q2, compared with 36 in Q1 and 57 in Q4. Of the 26 complaints received in Q2, 11 were about car parking across various Trust sites, there were for the Private & Overseas Patients Team and three were about the Welcome Centre Reception. The remainder of the complaints received was spread across various departments/areas, including issues about transport, retail outlets in the BRI and the cashiers' office.

The Division achieved % against its target for responding to formal complaints within the agreed timescale in Q2 and % for informal complaints. Please see section 3.3 Table 21 for details of where in the process any delays occurred.

Figure 27: Trust Services –all complaints received

3.2 Complaints by hospital site

Complaints reduced across all hospital sites, with the exception of St Michael's Hospital and UH Bristol services hosted at Southmead. It should be noted however that the complaints for St Michael's Hospital include the Division of Surgery (ENT) as well as Women's & Children's services.

Whilst the number of complaints received for some hospital sites reduced, the percentage share of all complaints received by the each site actually increased, as was the case for complaints about Bristol Royal Infirmary (BRI) and Bristol Heart Institute (BHI) amongst others.

Table 18: Breakdown of complaints by hospital site[3]

Hospital/Site	Number and % of complaints received in Q2 2019/20	Number and % of complaints received in Q1 2019/20
Bristol Royal Infirmary	182 (41.2%) ↓	207 (40.5% of total complaints) ↑
St Michael's Hospital	50 (11.3%) ↑	48 (9.4%) ↑
Bristol Heart Institute	47 (10.6%) ↓	54 (10.5%) ↑
Bristol Royal Hospital for Children	46 (10.4%) ↓	48 (9.4%) =
Bristol Eye Hospital	42 (9.5%) ↓	43 (8.4%) ↓
Bristol Dental Hospital	33 (7.5%) ↓	44 (8.6%) ↑
Bristol Haematology & Oncology Centre	21 (4.8%) ↓	27 (5.3%) ↑
South Bristol Community Hospital	13 (2.9%) ↓	27 (5.3%) ↓
Southmead and Weston Hospitals (UH Bristol services)	4 (0.9%) ↑	3 (0.6%) =
Central Health Clinic and Unity Community Clinics	3 (0.7%) ↓	7 (1.4%) ↓
Community Dental Sites	1 (0.2%) =	1 (0.2%) ↑
TOTAL	**442**	**511**

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 28 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 Q2, 45.2% (*45.6%) of complaints received were about outpatient services, 29.9% (33.3%) related to inpatient care, 9.5% (6.5%) were about emergency patients; and 15.4% (14.6%) were in the category of 'other' (as explained above).

** Q1 percentages are shown in brackets for comparison.*

[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.

Figure 28: All patient activity

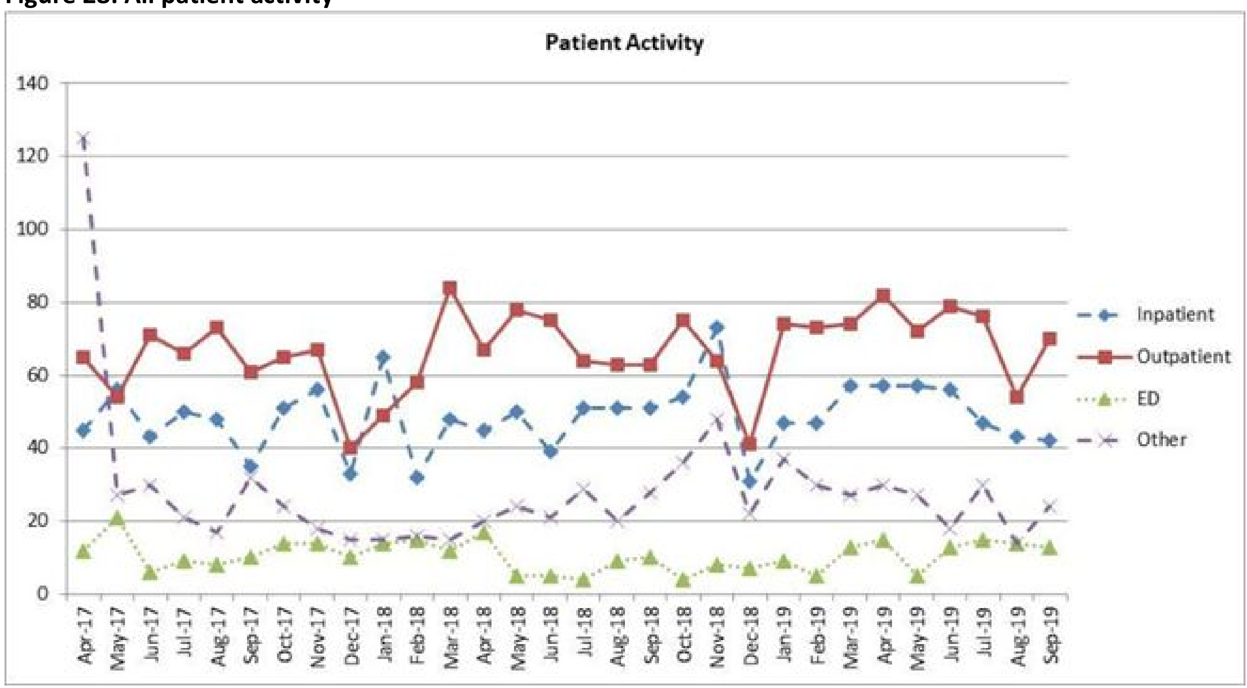


Table 19: Breakdown of Area Type

Complaints	Area Type				
Month	**ED**	**Inpatient**	**Outpatient**	**Other**	**Grand Total**
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
Apr-19	15	57	82	30	184
May-19	5	57	72	27	161
Jun-19	13	56	79	18	166
Jul -19	15	47	76	30	168
Aug-19	14	43	54	14	125
Sep-19	13	42	70	24	149
Grand Total	**212**	**1043**	**1435**	**531**	**3221**

3.3 Complaints responded to within agreed timescale for formal resolution process

All divisions reported breaches of formal complaint deadlines in Q2, with a total of 28 breaches of deadlines reported Trustwide.

The Division of Medicine reported 10 breaches of deadline, Specialised Services reported seven, Trust Services had five, Surgery had three, Women & Children reported two and Diagnostics & Therapies had one. It should however be noted that none of the breaches for Surgery or Diagnostics & Therapies were attributable to the Divisions (see Table 21 below).

20

This is a significant deterioration on the 8 breaches reported in Q1.

In Q2, the Trust responded to 171 complaints via the formal complaints route and 83.6% of these were responded to by the agreed deadline, against a target of 95%.

Table 20: Breakdown of breached deadlines - Formal

Division	Q2 (2019/20)	Q1 (2019/20)	Q4 (2018/19)	Q3 (2018/19)
Surgery	3 (5.9%) ↑	0 (0%)	3 (5.6%)	6 (9.5%)
Women & Children	2 (5.5%) =	2 (5.3%)	15 (31.3%)	13 (25%)
Trust Services	5 (55.6%) ↑	0 (0%)	2 (40%)	3 (27.3%)
Medicine	10 (23.3%) ↑	1 (2.2%)	1 (3.3%)	3 (6.8%)
Specialised Services	7 (29.2%) ↑	5 (23.8%)	3 (12.5%)	0 (0%)
Diagnostics & Therapies	1 (12.5%) ↑	0 (0%)	1 (11.1%)	1 (8.3%)
All	**28 breaches**	**8 breaches**	**25 breaches**	**26 breaches**

(So, as an example, there were three breaches of timescale in the Division of Surgery in Q2, which constituted 5.9% of the complaint responses which were sent out by that division in Q2.)

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 21 shows a breakdown of where the delays occurred in Q2. Four of the breaches were caused by delays within the Patient Support & Complaints Team, four were attributable to delays during the Executive sign-off process and20 were attributable to the Divisions.

Table 21: Source of delay

Breach attributable to	Surgery	Medicine	Specialised Services	Women & Children	Diagnostics & Therapies	Trust Services	All
Division	0	10	5	1	0	4	**20**
Patient Support & Complaints Team	1	0	1	1	0	1	**4**
Executives/sign-off	2	0	1	0	1	0	**4**
All	**3**	**10**	**7**	**2**	**1**	**5**	**28**

3.3.1 Complaints responded to within agreed timescale for informal resolution process

In Q4 of 2018/19, we commenced reporting of the number of informal complaints that breached the deadline agreed with the complainant. Performance against this measure is now reported to the Trust Board. All breaches of informal complaint timescales are attributable to the Divisions as the Patient Support & Complaints Team and Executives do not contribute to the time taken to resolve these complaints. In Q2, the Trust responded to 232 complaints via the informal complaints route (compared with 335 in Q1) and 87.5% of these were responded to by the agreed deadline; a slight deterioration on the 89% reported in Q1.

Table 22: Breakdown of breached deadlines - Informal

Division	Q2 (2019/20)	Q1 (2019/20)	Q4 (2018/19)	Q3 (2018/19)
Surgery	9 (10.0%) ↓	16 (11.0%)	10 (14.5%)	
Women & Children	3 (11.5%) ↓	4 (12.9%)	8 (33.3%)	
Trust Services	7 (24.1%) ↑	6 (20.0%)	10 (22.2%)	
Medicine	8 (24.2%) ↑	7 (11.7%)	3 (7.1%)	
Specialised Services	2 (5.1%) ↑	0 (0%)	5 (12.2%)	
Diagnostics & Therapies	0 (0%) ↓	2 (18.2%)	1 (10.0%)	
All	**29**	**35**	**37**	

3.4 Outcome of formal complaints

In Q2, the Trust responded to 171 formal complaints[4]. Tables 23 and 24 below show a breakdown, by Division, of how many of these cases were upheld, partly upheld or not upheld in Q2 of 2019/20 and Q1 of 2019/20 respectively. A total of 85.4% of complaints were either upheld or partly upheld in Q2, compared with 74.3% in Q1.

Table 23: Outcome of formal complaints – Q2 2019/20

	Upheld	Partly Upheld	Not Upheld
Surgery	16 (31.4%) ↓	26 (51.0%) ↑	9 (17.6%) ↓
Medicine	14 (32.6%) ↑	25 (58.1%) ↑	4 (9.3%) ↓
Specialised Services	11 (45.8%) =	9 (37.5%) ↑	4 (16.7%) =
Women & Children	8 (22.2%) ↓	20 (55.6%) ↑	8 (22.2%) ↓
Diagnostics & Therapies	4 (50.0%) ↑	4 (50.0%) ↑	0 (0%) ↓
Trust Services	5 (55.6%) ↑	4 (44.4%) ↑	0 (0%) ↓
Total	**58** ↓	**88** ↑	**25** ↓

Table 24: Outcome of formal complaints – Q1 2019/20

	Upheld	Partly Upheld	Not Upheld
Surgery	24 (38.1%) ↑	25 (39.7%) =	14 (22.2%) ↑
Medicine	12 (26.7%) ↑	18 (40.0%) ↓	15 (33.3%) ↑
Specialised Services	11 (52.4%) ↑	6 (28.6%) ↓	4 (19.0%) ↑
Women & Children	18 (47.3%) =	11 (29.0%) ↓	9 (23.7%) ↑
Diagnostics & Therapies	2 (40.0%) ↑	2 (40.0%) ↓	1 (20.0%) =
Trust Services	2 (28.6%) ↓	2 (28.6%) ↑	3 (42.8%) ↑
Total	**69** ↑	**64** ↓	**46** ↑

[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 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 monitor progress.

Below are some examples of actions which have been completed during Q2 2019/20.

- Following a complaint from a patient who underwent an angioplasty at Bristol Heart Institute (BHI), filming of a new Cardiac Rehabilitation Phase 1 film has been completed, specifically for the BHI. This is in addition to the existing film for patients who needed rehabilitation following a cardiac arrest, which caused confusion for the complainant as it did not apply to him (Specialised Services).

- A complaint about the lack of analgesia available during a gynaecology examination was discussed at the Gynaecology Governance meeting. As a result of this complaint, it was agreed that patients would be offered paracetamol during clinics and Entonox would be made available in the department so it could be prescribed if needed (Women & Children).

- The Division of Surgery received a complaint from the family of a patient who had sadly passed away in hospital and they were upset that, upon arrival at the funeral home, the patient still had lines in situ which had not been removed in hospital. As a result, the Division has ensured that all mortuary assistants receive the appropriate training so that this situation does not happen again (Surgery).

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. A total of 228 enquiries were received in Q2, a 12% increase on the 203 received in Q1. The team also recorded and acknowledged 32 compliments received during Q2 and shared these with the staff involved and their Divisional teams. This is compared with 45 compliments reported in Q1.

Table 26 below shows a breakdown of the 'Top 10' requests for advice, information and support dealt with by the team in Q2.

Table 25: Enquiries by category

Category	**Enquiries in Q2 2019/20**
Information about patient	92
Hospital information request	32
Medical records	22
Appointment queries	22
Referral queries	7
Patient choice information	7
Support with access/disability support	5
Clinical care	4
Admissions/Discharge enquiries	4
Signposting	4

In addition to the enquiries detailed above, in Q2 the Patient Support and Complaints team recorded 160 enquiries that did not proceed, compared with 148 in Q1. This is where someone contacts the department to make a complaint or enquiry but does not leave enough information to enable the

team to carry out an investigation (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 continues to deal with a high volume of activity, with a total of 862 separate enquiries in Q2 2019/20, compared with 906 in Q1, 903 in Q4 of 2018/19, 865 in Q3 and 841 in Q2.

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 Q2, 253 complaints were received in writing (216 by email and 37 letters) and 180 were received verbally (17 in person via drop-in service and 163 by telephone). Nine complaints were also received in Q2 via the Trust's 'real-time feedback' service. Of the 442 complaints received in Q2, 99.8% (441 out of the 442 received) met the Trust's standard of being acknowledged within two working days (verbal) and three working days (written).

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 Q2, the Trust was advised of Parliamentary and Health Service Ombudsman (PHSO) interest in three new complaints. During the same period, five existing cases remain ongoing. A total of four cases were closed during Q2: all four were closed with the PHSO taking no further action.

Table 26: Complaints opened by the PHSO during Q2

Case Number	Complainant (patient unless stated)	On behalf of (patient)	Date complaint received by Trust and [date notified by PHSO]	Site	Department	Division
19622	NC	MC	11/03/2019 [23/07/2019]	BHI	Ward C808	Medicine
The PHSO advised the trust in July 2019 that the complaint is actually out of time so they are considering whether or not to investigate it – we are currently awaiting their decision.						
17825	CJ	DJ	03/12/2018 [16/09/2019]	BHOC	Ward D603	Specialised Services
The PHSO advised the trust in September 2019 that the complaint is actually out of time so they are considering whether or not to investigate it – we are currently awaiting their decision.						
15045	LP		19/06/2018 [05/07/2019]	BRI	Endocrinology	Medicine
The PHSO requested a copy of the Trust's complaint file in July 2019 and we are currently awaiting further contact from them.						

Table 27: Complaints ongoing with the PHSO during Q2

Case Number	Complainant (patient unless stated)	On behalf of (patient)	Date complaint received by Trust [and date notified by PHSO]	Site	Department	Division
8853	KK		10/07/2017 [24/08/2018]	BRI	Trauma & Orthopaedics	Surgery
On 29/05/2019, the PHSO confirmed that they planned to partly uphold this complaint. We subsequently complied with their recommendations and we are just keeping the case open as the PHSO would like to see a copy of the Trust's action plan following a Trauma & Orthopaedics Governance meeting, which is scheduled for 3 December 2019.						
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. Update from PHSO received on 30/107/2019 advising that they are hoping to carry out interviews with Trust staff in December 2019/January 2020, with the aim of providing their final report by February 2020. The Trust has asked the PHSO to explain the purpose of interviewing staff given that so much time has passed (four years) and the detrimental effect of this on the staff involved.						
15161	DH		25/06/2018 [04/03/2019]	BHI	Outpatients (BHI)	Specialised Services
The PHSO advised us on 13/11/2019 that they have requested further advice from one of their clinical advisers, who needs a CD or DVD copy of the procedure in order to comment on the treatment and care provided. We are currently checking whether this is available to send to the PHSO.						
4904	PM	OM	28/11/2016 [15/02/2019]	BRHC	Paediatric Neurology	Women & Children
The PHSO contacted us in October 2019 to advise that they are still reviewing the clinical advice, following which they will be in a position to share with the Trust what the evidence is showing them.						
18996 Ulysses	AC	BC	08/06/2015 [01/02/2018]	BRHC	PICU	Women & Children
The PHSO asked the Trust to review its clinical experts' reports and comment on these. The trust's comments were sent to the PHSO on 08/11/2019 and we are currently waiting to hear further from them.						

Table 28: Complaints closed by the PHSO during Q2

Case Number	Complainant (patient unless stated)	On behalf of (patient)	Date complaint received by Trust [and date notified by PHSO]	Site	Department	Division
17286	AS		05/11/2018 [02/04/2019]	StMH	ENT	Surgery
Advised by PHSO in September 2019 that they would not be investigating this case and had closed it at the assessment stage. **No Further Action**.						
16661	LE	JH	26/09/2018 [16/04/2019]	BRHC	Paediatric Neurosurgery	Women & Children
Advised by PHSO in September 2019 that they would not be investigating this case and had closed it at the assessment stage. **No Further Action**						

13256	MR	WR	07/03/2018 [29/08/2018]	BRI	Ward A400 - OPAU	Medicine
PHSO suggested to complainant that he come back to the Trust for a full investigation into his concerns. He did this and we have provided a detailed written response and a meeting. Complainant has now decided to seek compensation via a legal claim. Case closed by PHSO. **No Further Action**						
9403	LD	DM	03/08/2017 [07/09/2018]	BHOC	Ward D603	Specialised Services
We last heard from the PHSO on 28/06/2019, when they advised that they were still considering whether they need to investigate this matter further and would either write to us with the scope of their investigation or email us if they decide to take no further action. We have now closed the case as we have heard nothing from the PHSO for five months. **No Further Action**						

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 response rate to this survey is consistently low, so the results need to be interpreted with caution.**

Table 31 below shows data from the 14 responses received during Q2, compared with those received in previous quarters. Feedback in Q2 indicated that 100% of complainants felt they were treated with dignity and respect by the Patient Support & Complaints Team. Feedback also improved in respect of the number of respondents who confirmed they were told about independent advocacy services.

Table 29: Complaints Survey Data

Survey Measure/Question	Q2 2019/20	Q1 2019/20	Q4 2018/19	Q3 2018/19
Respondents who confirmed that a timescale had been agreed with them by which we would respond to their complaint.	53.9% ↓	80.0% ↓	94.1% ↑	67.5%
Respondents who felt that the Trust would do things differently as a result of their complaint.	7.1% ↓	14.3% =	14.3% ↓	15.8%
Respondents who found out how to make a complaint from one of our leaflets or posters.	0% ↓	12.5% ↑	8.6% ↓	15.8%
Respondents who confirmed we had told them about independent advocacy services.	57.2% ↑	48.0% ↓	54.3% ↑	46.2%
Respondents who confirmed that our complaints process made it easy for them to make a complaint.	57.1% ↓	66.7% ↑	62.9% ↓	65%
Respondents who felt satisfied or very satisfied with how their complaint was handled by the Patient Support & Complaints Team.	50% ↓	70.8% ↑	65.7% ↑	63.4%
Respondents who said they did not receive their response within the agreed timescale.	21.4% ↑	13.6% ↓	14.3% ↓	17.5%
Respondents who felt that they were treated with dignity and respect by the Patient Support & Complaints Team.	100% ↑	91.7% ↓	97.1% ↓	97.5%
Respondents who felt that their complaint	92.9% ↑	84% ↑	80.5% =	80.5%

was taken seriously when they first raised their concerns.				
Respondents who did not feel that the Patient Support & Complaints Team kept them updated on progress often enough about the progress of their complaint.	61.5% ↑	12.5% ↓	17.1% ↓	20%
Respondents who received the outcome of our investigation into their complaint by way of a face-to-face meeting.	0% =	0% =	0% ↓	2.9%
Respondents who said that our response addressed all of the issues that they had raised.	28.6% ↓	50.0% ↓	58.3% ↑	57.9%

In Q2, the survey included two new questions. One asked complainants if there was anything that was particularly good about our complaints process/service. One respondent noted how a senior manager at St Michael's Hospital and an ENT consultant had taken the time to contact them personally, and that this had made a difference to their experience.

We also asked complainants how we could improve the service. Comments received included:

- "I did not feel that so many different staff needed to be involved in responding to complaint."
- "It's really simple, if you tell somebody you will do something, you should do it."
- "No problem with complaints process but I didn't get the outcome I felt was necessary."
- "It felt like a tick box exercise had been completed and that no one genuinely understood and apologised for the inconvenience of two wasted trips to the Eye Hospital."

9. Severity of Complaints

Since April 2019, the Patient Support & Complaints Team has been recording the severity of complaints received by the Trust using a system of categorisation proposed by researchers at the London School of Economics. This severity rating is based on the nature of the complaint as first described to the Trust by or on behalf of the patient; not after the issues have been investigated. This ensures that the rating is reliable and independent of the outcome of the investigation.

We know from NHS data that Trusts with high levels of incident reporting have fewer instances of severe harm to patients, i.e. organisations with cultures that encourage reporting when things go wrong, learn and provide safer care. The LSE research suggests a similar pattern of data associated with patient complaints, i.e. Trusts who receive high levels of low level severity complaints receive lower levels of high severity complaints, again indicating that a culture of openness to receiving and learning from complaints is associated with safer and higher quality care. Put another way, receiving complaints should not be viewed as a bad thing *per se*; it depends what the complaint is about.

Staff in the Patient Support & Complaints Team have all received training on rating the severity of complaints, taking into account the clinical, management and relationship problems experienced by the complainant and apportioning the overall complaint as either "low", "medium" or "high" severity. A practical example of each of these categories is shown in Table 30 below.

During the next year, as we build our dataset, we hope that this will enable us to begin to differentiate between higher and lower performing areas within the Trust (in terms of the severity of

complaints reported) and to use the information to explore opportunities for quality improvement.

Table 30: Examples of severity rating of complaints

	Low severity	Medium severity	High severity
Clinical problem	Isolated lack of food or water	Patient dressed in dirty clothes	Patient left in own waste in bed
Clinical problem	Slight delay administering medication	Staff forgot to administer medication	Incorrect medication administered
Management problems	Patient bed not ready on arrival	Patient was cold and uncomfortable	Patient relocated due to bed shortage
Management problems	Appointment cancelled and rescheduled	Chasing departments for an appointment	Refusal to give appointment
Relationship problems	Staff ignored question from patient	Staff ignored mild patient pain	Staff ignored severe distress
Relationship problems	Staff spoke in condescending manner	Rude behaviour	Humiliation in relation to incontinence

Since April 2019, the Trust has received 953 complaints (511 in Q1 and 442 in Q2), all of which have been severity rated by the Patient Support & Complaints Team. Of these 953 complaints, 598 were rated as being low severity, 311 as medium and 44 as high. Figure 29 below shows a breakdown of these severity ratings by month since April 2019.

Figure 29: Severity rating of complaints

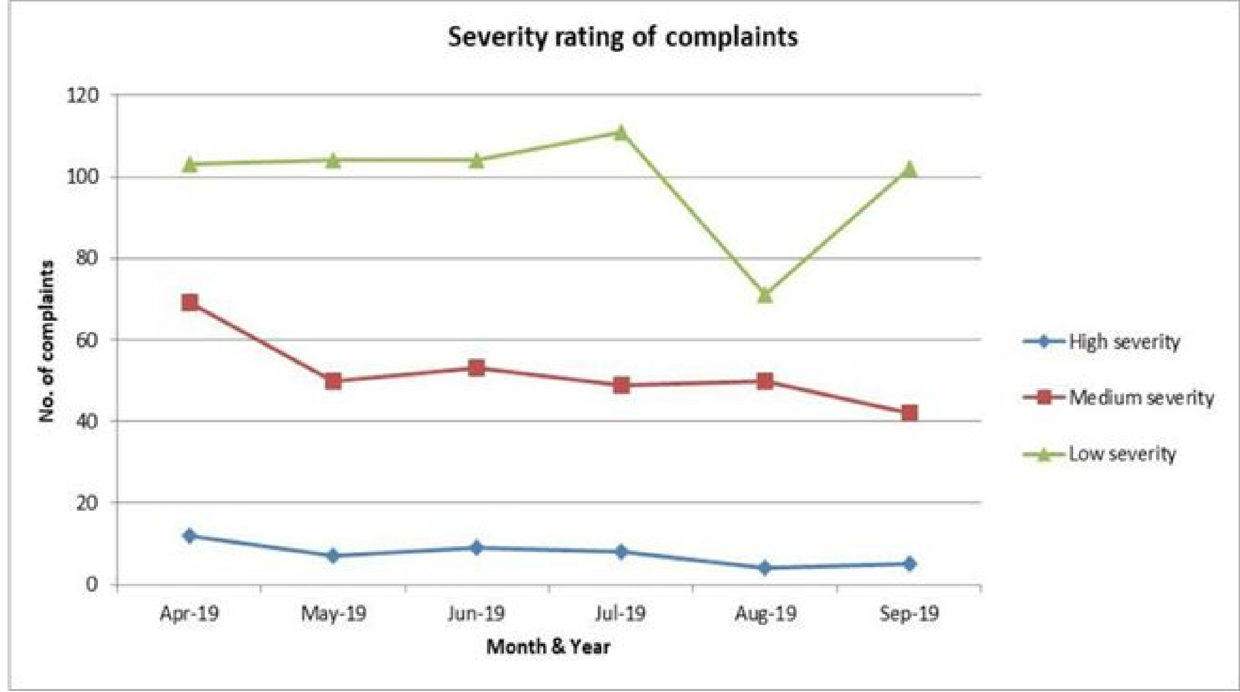


Table 31: Severity rating of complaints by Division (all complaints received in Q1 and Q2 2019/20)

Division	**High Severity**	**Medium Severity**	**Low Severity**	**Totals**
Women & Children	12 **(8.4%*)**	61	69	**142**
Specialised Services	11 **(7.1%)**	40	105	**156**
Medicine	10 **(4.8%)**	77	120	**207**
Surgery	10 **(2.9%)**	116	215	**341**
Trust Services	1 **(1.6%)**	8	55	**64**
Diagnostics & Therapies	0 **(0%)**	9	34	**43**
Totals	**44 (4.6%)**	**311**	**598**	**953**

*i.e. 8.4% of complaints received by Women's & Children's Services in the first half of 2019/20 were rated as high severity – this compares, for example, with 2.9% of complaints about Surgery.

Meeting of the Board of Directors in Public on Thursday 30 January 2020

Report Title	**Review Of Accounting Policies**
Report Author	**Kate Parraman, Deputy Director of Finance**
Executive Lead	**Neil Kemsley, Director of Finance and Technology**

1. Report Summary

To approve the Trust's revised Accounting Policies for 2019/20.

2. Key points to note
(Including decisions taken)

The Accounting Policies are required to be approved for inclusion in the Annual Accounts. The Trust is required to review its accounting policies whenever changes are required by an accounting standard, following advice from NHS Improvement including revisions to the Department of Health and Social Care Group Accounting (DHSC GAM) or where it would improve the understanding of the Trust's statutory accounts. The Trust maintains a full set of approved accounting policies but only includes those relevant to the Trust's Annual Report and Accounts in the published document.

The policies have been amended to reflect date and referencing changes, updates to the example accounting policies, information which will be confirmed at year end and deletions.

The changes reflecting the example accounting policies published in the DHSC GAM and for reference purposes only, there will be no accounting, reporting or disclosure changes.

The Trust is required to disclose the forecast impact of accounting standards issued but not yet adopted within the accounting policies. The accounting standard IFRS 16 (leases) is effective from 01 April 2020 and will result in operating lease expenditure currently reported in the Statement of Comprehensive Income being included in the Statement of Financial Position. The Trust has undertaken a preliminary assessment of the impact of the standard and is working with the lease counterparts for South Bristol Community Hospital and University of Bristol to assess the full impact. A further paper will be presented to the April Audit Committee regarding the full impact of the lease accounting standard.

Further changes may be required if additional guidance is issued before year end or following External Audit advice during their statutory audit of the 2019/20 annual accounts. Any further changes will be reported to the Audit Committee for their approval.

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 **Approval.**

5. History of the paper
Please include details of where paper has previously been received – *N/A*

21

Respecting everyone
Embracing change
Recognising success
Working together
Our hospitals.

ACCOUNTING POLICIES

1. Introduction

This report asks the Audit Committee to **approve** the revised Accounting Policies which will be incorporated in the Statutory Accounts for the Year Ended 31st March 2020.

The Trust is required to review its accounting policies whenever changes are required by an accounting standard, following advice from NHS England/Improvement including revisions to the Department of Health and Social Care Group Accounting Manuel (DHSC GAM) or where it would improve the understanding of the Trust's statutory accounts. The accounting policies are included as part of the Trust's statutory accounts. The Audit Committee is required to consider and approve changes in the accounting policies. This report informs the Audit Committee of the recommended changes for its approval.

The recommended changes in this report follow the publication of the 2019/20 DHSC GAM. There may be additional changes required during the final accounts audit. Any further changes will be notified to the Audit Committee in May. The changes made are detailed below with reference to how the changes can be identified on the copy of the Accounting Policies in Appendix 1.

2. Proposed Accounting Policy Changes

The policies have been amended as follows:

a) Date and number referencing changes are highlighted in yellow

b) Updates to reflect the example accounting policies in the DHSC GAM are highlighted in green with the main changes relating to;

   a. the application of IFRS 15 (*Revenue from Contracts with Customers*) in section 1.4 and IFRS 9 (*Financial Instruments*) in section 1.12 following the implementation of the standards in 2018/19. The amendment does not change the accounting, reporting or disclosures arrangement it clarifies the application arrangements.

   b. the apprenticeship levy policy moving from section 1.9 *(Government Grants)* to 1.4 *(Income)* to establish a complete income position within section 1.4. There will be no accounting, reporting or disclosure changes.

c) Information which will be confirmed at year end is highlighted blue and primarily relate to:

   a. The impact of accounting standards issued but not yet adopted – see section 3 below.

   b. Critical estimates and judgements - revaluation assumptions used in the District Valuer's year end desktop review of Land and Buildings

   c. Critical estimates and judgements - month 12 income, partially completed spells and maternity pathways. There have been no significant changes to the Trust's approach in these areas (section 1.21 d, e and f).

d) Deletions are highlighted in red with a strikethrough.

3. IFRS 16 *(leases)* - impact of accounting standards issued but not yet adopted

The DHSC GAM contains a section on accounting standards that have been issued but not yet adopted which are required to be included in the policies (section 1.20). The accounting standard IFRS 16 (leases), as adapted and interpreted by the HMT Financial Reporting Manual, is effective from 01 April 2020.

The new standard will see operating leases currently included within note 5.2, operating lease expenses, being included in the statement of financial position. The Trust has undertaken a preliminary assessment of the impact for the NHSE&I information request submitted on the 15th January 2020 however is continuing to assess the full impact in conjunction with lease counterparts for South Bristol Community Hospital and the University of Bristol.

The full impact of the implementation of the standard will be reported to the Audit Committee in April and included in the draft submission of the annual accounts in April.

4. Further Changes Required

It is anticipated that further changes will be required as additional guidance and information becomes available including during the course of the statutory year-end audit. A further paper will be presented as part of the approval of the annual accounts in May.

5. Recommendation

The Audit Committee is asked to

- note the proposed changes to the Trust's accounting policies for 2019/20 and **approve** the Trust's revised Accounting Policies;

- **note** that there may be further changes required before the approval of the 2019/20 year end accounts.

1. Accounting policies

NHS Improvement, in exercising the statutory functions conferred on Monitor, has directed that the financial statements of NHS foundation trusts shall meet the accounting requirements of the Department of Health Group Accounting Manual (GAM) which shall be agreed with HM Treasury. Consequently, the following financial statements have been prepared in accordance with the DH Group Accounting Manual 2019/20 issued by the Department of Health and Social Care. The accounting policies contained in the GAM follow International Financial Reporting Standards (IFRS) to the extent that they are meaningful and appropriate to NHS foundation trusts, as determined by HM Treasury, which is advised by the Financial Reporting Advisory Board. Where the DHSC Group Accounting Manual permits a choice of accounting policy, the accounting policy that is judged to be most appropriate to the circumstances of the Trust for the purpose of giving a true and fair view has been selected. The particular policies adopted are described below. The accounting policies have been applied consistently in dealing with items considered material in relation to the accounts.

1.1 Going Concern

The annual report and accounts have been prepared on a going concern basis. After making enquiries, the directors have a reasonable expectation that University Hospitals Bristol NHS Foundation Trust has adequate resources to continue in operational existence for the foreseeable future.

1.2 Accounting convention

These accounts have been prepared under the historical cost convention modified to account for the revaluation of property, plant and equipment, intangible assets, inventories and certain financial assets and financial liabilities.

1.3 Operating Segments

Income and expenditure are analysed in the Operating Segments note (Note 2) and are reported in line with management information used within the Trust.

1.4 Income

~~***Revenue from Contracts with customers***~~

~~Where income is derived from contracts with customers, it is accounted for under IFRS 15. The GAM expands the definition of a contract to include legislation and regulations which enables an entity to receive cash or another financial asset that is not classified as a tax by the Office of National Statistics (ONS). As directed by the GAM, the transition to IFRS 15 in 2018/19 has been completed in accordance with paragraph C3 (b) of the Standard.~~

In the ~~adoption~~ application of IFRS 15 a number of practical expedients offered in the Standard have been employed. These are as follows;

- ~~As per paragraph 121 of the Standard~~ The Trust ~~will~~ does not disclose information regarding performance obligations part of a contract that has an original expected duration of one year or less,
- The Trust is to similarly not disclose information where revenue is recognised in line with the practical expedient offered in ~~paragraph B16 of~~ the Standard where the right to consideration corresponds directly with value of the performance completed to date.
- The FReM has mandated the exercise of the practical expedient offered in ~~C7(a) of~~ the Standard that requires the Trust to reflect the aggregate effect of all contracts modified before the date of initial application.

Revenue from Contracts with customers

Revenue in respect of goods/services provided is recognised when (or as) performance obligations are satisfied by transferring promised goods/services to the customer and is measured at the amount of the transaction price allocated to those performance obligations. ~~At the year end, the Trust accrues income relating to performance obligations satisfied in that year. Where the Trust's entitlement to consideration for those goods or services is unconditional a contract receivable will be recognised. Where entitlement to consideration is conditional on a further factor other than the passage of time, a contract asset will be recognised~~. Where consideration received or receivable relates to a performance obligation that is to be satisfied in a future period, the income is deferred and recognised as a contract liability.

Revenue from NHS Contracts

The main source of income for the Trust is contracts with commissioners for health care services. Revenue in respect of services provided is recognised when (or as) performance obligations are satisfied by transferring promised services to the customer, and is measured at the amount of the transaction price allocated to that performance obligation. At the year end, the Trust accrues income relating to performance obligations satisfied in that year. Where a patient care spell is incomplete at the year end, revenue relating to the partially complete spell is accrued in the same manner as other revenue

~~A performance obligation relating to delivery of a spell of health care is generally satisfied over time as healthcare is received and consumed simultaneously by the customer as the Trust performs it. The customer in such a contract is the commissioner, but the customer benefits as services are provided to their patient. Even where a contract could be broken down into separate performance obligations, healthcare generally aligns with paragraph 22(b) of the Standard entailing a delivery of a series of goods or services that are substantially the same and have a similar pattern of transfer. At the year end, the Trust accrues income relating to activity delivered in that year, where a patient care spell is incomplete.~~

Where income is received for a specific performance obligation which is to be satisfied in the following financial year, that income is deferred.

Where the Trust is aware of a penalty based on contractual performance, the Trust reflects this in the transaction price for its recognition of revenue. Revenue is reduced by the value of the penalty.

The Trust does not receive income where a patient is readmitted within 30 days of discharge from a previous planned stay. This is considered an additional performance obligation to be satisfied under the original transaction price.

The Trust receives income from commissioners under Commissioning for Quality and Innovation (CQUIN) schemes. The Trust agrees schemes with its commissioner but they affect how care is provided to patients. That is, the CQUIN payments are not considered distinct performance obligations in their own right; instead they form part of the transaction price for performance obligations under the contract.

Revenue from research contracts

Where research contracts fall under IFRS 15, revenue is recognised as and when performance obligations are satisfied. For some contracts, it is assessed that the revenue project constitutes one performance obligation over the course of the multi-year contract. In these cases it is assessed that the Trust's interim performance does not create an asset with alternative use for the Trust, and the Trust has an enforceable right to payment for the performance completed to date. It is therefore considered that the performance obligation is satisfied over time, and the Trust recognises revenue each year over the course of the contract.

Provider Sustainability Funding (PSF)

Income recognised in the accounts relating to the Provider Sustainability Funding for quarter 4 core funding ~~and the incentive and bonus payments~~ is based on the values notified by NHS England/Improvement ~~following the Trust exceeding its surplus control total~~. This ~~These~~ value~~s~~ ~~are~~ is indicative and the final amount receivable by the Trust will be notified by NHS England/Improvement following submission of the final accounts.

NHS Injury cost recovery scheme

The Trust receives income under the NHS Injury Cost Recovery Scheme, designed to reclaim the cost of treating injured individuals to whom personal injury compensation has subsequently been paid, for instance by an insurer. The Trust recognises the income when it receives notification from the Department of Work and Pension's Compensation Recovery Unit has completed the NHS2 form and confirmed there are no discrepancies with the treatment. The income is measured at the agreed tariff for the treatments provided to the injured individual, less a provision for unsuccessful compensation claims and doubtful debts in line with IFRS 9 requirements of measuring expected credit losses over the lifetime of the asset.

Apprenticeship Levy

The value of the benefit received when the Trust accesses funds from the Government's apprenticeship service are recognised as income in accordance with IAS 20, Accounting for Government Grants. Where these funds are paid directly to an accredited training provider, non-cash income and a corresponding non-cash training expense are recognised, both equal to the cost of the training funded.

Income from the sale of non-current assets is recognised only when all material conditions of sale have been met, and is measured as the sums due under the sale contract.

1.5 Expenditure on employee benefits

Employee benefits - short term

Salaries, wages and employment-related costs, including payments arising from the apprenticeship levy, are recognised in the year in which the service is received from employees. The cost of annual leave entitlement earned but not taken by employees at the end of the year is recognised in the financial statements.

An assessment of annual leave owing to staff at 31st March 2020 has been calculated using a sample of staff across all staff groups of a size sufficient to ensure above 95% confidence in the value of the liability. The average annual leave owed to staff groups in the sample has been used to calculate the total number of hours owed to all staff in post in March 2020. An average hourly cost has been applied to each staff group to calculate the cost of annual leave owed.

Pension costs

NHS Pension Scheme

Past and present employees are covered by the provisions of the two NHS Pension Schemes. Details of the benefits payable and rules of the schemes can be found on the NHS Pensions website at www.nhsbsa.nhs.uk/pensions. The schemes are unfunded defined benefit schemes that cover NHS employers, GP practices and other bodies, allowed under the direction of the Secretary of State in England and Wales. They are not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities. Therefore, each scheme is accounted for as if it were a defined contribution scheme: the cost to the Trust of participating in each scheme is taken as equal to the contributions payable to that scheme for the accounting period.

For early retirements other than those due to ill health the additional pension liabilities are not funded by the scheme. The full amount of the liability for the additional costs is charged to

expenditure at the time the Trust commits itself to the retirement, regardless of the method of payment.

The schemes are subject to a full actuarial valuation every four years and an accounting valuation every year.

1.6 Expenditure on other goods and services

Other operating expenses are recognised when, and to the extent that they have been received, and is measured at the fair value of the consideration payable ~~those goods and services~~. Expenditure is recognised in operating expenses except where it results in the creation of a non-current asset such as property, plant and equipment.

1.7 Property, Plant and Equipment

Recognition

Property, Plant and Equipment is capitalised where:

- individually its cost is in excess of £5,000; or
- it forms a group of similar assets with an aggregate cost in excess of £5,000 (where the assets have an individual cost in excess of £250, are functionally interdependent, have broadly similar purchase dates, are expected to have similar lives and are under single management control); or
- it forms part of the initial setting-up cost of a new building or refurbishment of a ward or unit, irrespective of individual or collective cost;
  and
- it is held for use in delivering services or for administrative purposes;
- it is probable that future economic benefits will flow to, or service potential will be provided to the Trust;
- it is expected to be used for more than one financial year;
- the cost of the item can be measured reliably.

Where a significant asset includes a number of components with different economic lives, then these components are treated as separate assets within the asset's classification and depreciated over their individual useful economic lives.

Measurement (Valuation)

All property, plant and equipment assets are measured initially at cost, representing the costs directly attributable to acquiring or constructing the asset and bringing it to the location and condition necessary for it to be capable of operating in the manner intended by management.

Assets that are held for their service potential and are in use are measured subsequently at their current value in existing use. Assets that were most recently held for their service potential but are surplus are measured at fair value where there are no restrictions preventing access to the market at the reporting date.

Land and buildings

Revaluations of property, plant and equipment are performed with sufficient regularity to ensure that carrying amounts are not materially different from those that would be determined at the end of the reporting period.

Current values in existing use are determined as follows:

- Land and non-specialised buildings – market value for existing use
- Specialised buildings – depreciated replacement cost, modern equivalent asset basis.

Assets in the course of construction are initially recorded at cost. Costs include professional fees and, where capitalised in accordance with IAS 23, borrowing costs. Assets are revalued by professional valuers every year end through a desktop exercise, as part of the five year review, or, for significant properties, when they are brought into use and then depreciation commences.

Other assets

Other assets including plant, machinery, IT and equipment that are held for operational use are valued at depreciated historic cost where these assets have short useful economic lives or low values or both, as this is not considered to be materially different from current value in existing use.

Subsequent expenditure

Where subsequent expenditure enhances an asset beyond its original specification, the directly attributable cost is capitalised. Where subsequent expenditure restores the asset to its original specification, the expenditure is capitalised and any existing carrying value of the item replaced is written-out and charged to operating expenses.

Depreciation

Freehold land and assets under construction are not depreciated. Freehold land is considered to have an infinite life, and assets in the course of construction are not depreciated until the asset is brought into use.

Otherwise, depreciation is charged to write off the costs or valuation of property, plant and equipment, less any residual value, on a straight-line basis over their estimated useful lives. The estimated useful life of an asset is the period over which the Trust expects to obtain economic benefits or service potential from the asset. This is specific to the Trust and may be shorter than the physical life of the asset itself. Estimated useful lives and residual values are reviewed each year end, with the effect of any changes recognised on a prospective basis as a change in estimate under IAS 8. The Trust's valuers, the Valuation Office, assess the estimated remaining useful life of buildings, installations and fittings.

Assets held under finance leases are depreciated over the shorter of the lease term and the estimated useful life, unless the Trust expects to acquire the asset at the end of the lease term, in which case the asset is depreciated in the same manner as for owned assets.

The remaining maximum and minimum economic lives of property, plant and equipment assets held by the Trust are as follows:

Asset Type	Minimum Life	Maximum Life
Buildings excl. dwellings	14 years	49 years
Dwellings	18 years	26 years
Plant and machinery (incl. medical equipment)	1 year	20 years
Transport equipment	1 year	7 years
Information technology	1 year	7 years
Furniture and fittings	1 year	9 years

When assets are revalued, the accumulated depreciation at the date of revaluation is eliminated against the gross carrying amount of the asset, and the net amount is restated to the revalued amount of the asset.

Revaluation gains and losses

Increases in asset values arising from revaluations are recognised in the revaluation reserve, except where, and to the extent that, they reverse an impairment previously recognised in operating

expenses, in which case it is credited to expenditure to the extent of the decrease previously charged there. A revaluation decrease that does not result from a loss of economic value or service potential is recognised as a charge to the revaluation reserve to the extent that there is an available balance for the asset concerned, and thereafter charged to operating expenses.

Gains and losses recognised in the revaluation reserve are reported in the Statement of Comprehensive Income as an item of 'other comprehensive income'.

The Trust transfers the difference between depreciation based on the historical amounts and revalued amounts from the revaluation reserve to retained earnings.

Impairments

At each financial year end, the Trust checks whether there is any indication that its property, plant and equipment have suffered an impairment loss. If there is indication of such an impairment, the recoverable amount of the asset is estimated to determine whether there has been a loss and, if so, its amount.

Impairment losses that arise from a clear consumption of economic benefit are taken to expenditure. A compensating transfer is made from the revaluation reserve to the income and expenditure reserve of an amount equal to the lower of (i) the impairment charged to operating expenses; and (ii) the balance in the revaluation reserve attributable to that asset before the impairment.

An impairment that arises from a clear consumption of economic benefit or service potential is reversed when, and to the extent that, the circumstances that gave rise to the loss are reversed. Reversals are netted against any impairment charges within Operating Expenses to the extent that the asset is restored to the carrying amount it would have had if the impairment had never been recognised. Any remaining reversal is recognised in the revaluation reserve.

Other impairments are treated as revaluation losses. Reversals of 'other impairments' are treated as revaluation gains.

Donated, government grant and other grant funded assets

Donated and grant funded non-current assets are capitalised at their current value in existing use, if they will be held for their service potential, or otherwise at fair value on receipt, with a matching credit to income receipt.

Deferred income is recognised only where conditions attached to the donation preclude immediate recognition of the gain.

The donated and grant funded assets are subsequently accounted for in the same manner as other items of property, plant and equipment.

1.8 Intangible assets

Recognition

Intangible assets are non-monetary assets without physical substance which are capable of being sold separately from the rest of the Trust's business or which arise from contractual or other legal rights. They are recognised where they have a cost in excess of £5,000, where it is probable that future economic benefits will flow to, or service potential be provided to, the Trust and where the cost of the asset can be measured reliably.

Software

Software which is integral to the operation of hardware e.g. an operating system is capitalised as part of the relevant item of property, plant and equipment. Software which is not integral to the operation of hardware e.g. application software, is capitalised as an intangible asset.

Measurement

Intangible assets acquired separately are recognised initially at cost, comprising all directly attributable costs needed to create, produce and prepare the asset to the point that it is capable of operating in the manner intended by management. Subsequently intangible assets are measured at current value in existing use by reference to an active market, or, where no active market exists, the lower of amortised replacement cost and the value in use where the asset is income generating.

Intangible assets are held at amortised historical cost which is considered to be an appropriate proxy for fair value. Revaluations gains and losses and impairments are treated in the same manner as for Property, Plant and Equipment.

Amortisation

Intangible assets are amortised over their expected useful economic lives in a manner consistent with the consumption of economic or service delivery benefits.

The remaining maximum and minimum economic lives of intangible assets held by the Trust are as follows:

Asset type	Minimum life	Maximum life
Software (purchased)	1 year	9 years

Purchased computer software licences are amortised over the shorter of the term of the licence and their estimated economic lives.

1.9 Government grants

Government grants are grants from Government bodies other than income from commissioners or NHS trusts for the provision of services. Grants from the Department of Health and Social Care are accounted for as Government grants. Where the Government grant is used to fund revenue expenditure, it is taken to the Statement of Comprehensive Income to match that expenditure.

~~The value of the benefit received when accessing funds from the Government's apprenticeship service is recognised as income at the point of receipt of the training service. Where these funds are paid directly to an accredited training provider, the corresponding notional expense is also recognised at the point of recognition for the benefit.~~ (Disclosed at 1.4)

1.10 Inventories

Inventories are valued at the lower of cost and net realisable value. This is considered to be a reasonable approximation to current cost due to the high turnover of inventories.

1.11 Cash

Cash is cash in hand and deposits with any financial institution repayable without penalty on notice of not more than 24 hours. Cash and bank balances are recorded at current values.

1.12 Financial Assets and Financial Liabilities

Financial assets and financial liabilities are recognised when the Trust becomes party to the contractual provision, or in the case of trade payable and receivables, when the goods or services have been received and delivered. ~~and as a result has a legal right to receive or a legal obligation to pay cash or another financial instrument. The GAM expands the definition of a contract to include legislation and regulations which give rise to arrangements that in all other respects would be a financial instrument and do not give rise to transactions classified as a tax by ONS~~. Financial assets are derecognised when the contractual rights have expired or when the asset has been transferred and the Trust has transferred substantially all of the risks and rewards of ownership or has not retained control of the asset. Financial liabilities are de-recognised when the obligation is discharged, cancelled or expires.

Financial assets and financial liabilities are initially recognised at fair value plus or minus directly attributable transaction costs for financial assets not measured at fair value through profit or loss. Fair value is taken as the transaction price, or otherwise determined by reference to quoted market prices, where possible, or by valuation techniques. Financial assets are classified into the following categories: financial assets at amortised cost, financial assets at fair value through other comprehensive income, and financial assets at fair value through profit and loss. The classification is determined by the cash flow and business model characteristics of the financial assets, as set out in IFRS 9, and is determined at the time of initial recognition.

~~Financial assets are classified as subsequently measured at amortised cost.~~

Financial assets at amortised cost

Financial assets and financial liabilities measured at amortised cost are those held with the objective of collecting contractual cash flows and where cash flows are solely payments of principal and interest. This includes cash equivalents, contract and other receivables, trade and other payables, rights and obligations under lease arrangements and loans receivable and payable.

After initial recognition, these financial assets and financial liabilities are measured at amortised cost using the effective interest method, less any impairment. The effective interest rate is the rate that exactly discounts estimated future cash receipts through the life of the financial asset or financial liability to the gross carrying amount of the financial asset or amortised cost of a financial liability.

Interest revenue or expense is calculated by applying the effective interest rate to the gross carrying amount of a financial asset or amortised cost of a financial liability and recognised in the Statement of Comprehensive Income and a financing income or expense. In the case of loans held from the Department of Health and Social Care, the effective interest rate is the nominal rate of interest charged on the loan.

Impairment of financial assets

For all financial assets measured at amortised cost lease receivables and contract assets, the Trust recognises a loss allowance representing expected credit losses on the financial instrument.

The Trust adopts the simplified approach to impairment, in accordance with IFRS 9, and measures the loss allowance for trade receivables, contract assets and lease receivables at an amount equal to lifetime expected credit losses.

For other financial assets, the loss allowance is measured at an amount equal to lifetime expected credit losses if the credit risk on the financial instrument has increased significantly since initial recognition (stage 2), and otherwise at an amount equal to 12-month expected credit losses (stage 1). HM Treasury has ruled that central government bodies may not recognise stage 1 or stage 2 impairments against other government departments, their executive agencies, the Bank of England, Exchequer Funds, and Exchequer Funds' assets where repayment is ensured by primary legislation. The Trust therefore does not recognise loss allowances for stage 1 or stage 2 impairments against these bodies. Additionally, the Department of Health and Social Care provides a guarantee of last resort against the debts of its arm's length bodies and NHS bodies (excluding NHS charities), and the Trusts does not recognise loss allowances for stage 1 or stage 2 impairments against these bodies. For other financial assets that have become credit impaired since initial recognition (stage 3), expected credit losses at the reporting date are measured as the difference between the asset's gross carrying amount and the present value of the estimated future cash flows discounted at the financial asset's original effective interest rate. Any adjustment is recognised in profit or loss as an impairment gain or loss.

Expected losses are charged to operating expenditure within the Statement of Comprehensive Income and reduce the net carrying value of the financial asset in the Statement of Financial Position.

~~Financial assets are de-recognised when the contractual rights to receive cash flows from the assets have expired or the Trust has transferred substantially all the risks and rewards of ownership~~. (Duplication)

~~Financial liabilities are de-recognised when the obligation is discharged, cancelled or expires.~~ (moved above)

1.13 Leases

Leases are classified as finance leases when substantially all the risks and rewards of ownership are transferred to the lessee. All other leases are classified as operating leases.

Lessee accounting:

Finance leases

Where substantially all risks and rewards of ownership of a leased asset are borne by the Trust, the asset is recorded as Property, Plant and Equipment and a corresponding liability is recorded. The value at which both are recognised is the lower of the fair value of the asset or the present value of the minimum lease payments, discounted using the interest rate implicit in the lease. Lease payments are apportioned between finance charges and reduction of the lease obligation to achieve a constant rate of interest on the remaining balance of the liability. Finance charges are recognised in the Statement of Comprehensive Income.

Operating leases

Other leases are regarded as operating leases and the rentals are charged to operating expenses on a straight-line basis over the term of the lease. Operating lease incentives received are added to the lease rentals and charged to operating expenses on a straight-line basis over the life of the lease.

Leases of land and buildings

Where a lease is for land and buildings, the land component is separated from the building component and the classification for each is assessed separately.

Lessor accounting:

Operating leases

Rental income from operating leases is recognised on a straight-line basis over the term of the lease. Initial direct costs incurred in negotiating and arranging an operating lease are added to the carrying amount of the leased asset and recognised as an expense on a straight-line basis over the lease term.

1.14 Provisions

Provisions are recognised when the Trust has a present legal or constructive obligation as a result of a past event, it is probable that the Trust will be required to settle the obligation, and a reliable estimate can be made of the amount of the obligation. The amount recognised as a provision is the best estimate of the expenditure required to settle the obligation at the end of the reporting period, taking into account the risks and uncertainties. Where a provision is measured using the cash flows estimated to settle the obligation, its carrying amount is the present value of those cash flows using HM Treasury's discount rates.

Early retirement provisions are discounted using HM Treasury's pension discount rate of -0.50% (0.29% 2019/20) in real terms. All general provisions are subject to separate discount rates according to the expected timing of cashflows from the Statement of Financial Position date:

Expected cash outflows	Years	HMT real rate (%)	
		2019/20	2018/19
Short term	1-5	0.51	0.76
Medium term	6-10	0.55	1.14
Long term	10 or more	1.99	1.99

Clinical negligence costs

The NHS Resolution operates a risk pooling scheme under which the Trust pays an annual contribution to NHS Resolution which, in return, settles all clinical negligence claims. The contribution is charged to the Statement of Comprehensive Income. Although the NHS Resolution is administratively responsible for all clinical negligence cases, the legal liability remains with the Trust. The total value of clinical negligence provisions carried by the NHS Resolution on behalf of the Trust is disclosed at note 17.2.

Non-clinical risk pooling

The Trust participates in the Property Expenses Scheme and the Liabilities to Third Parties Scheme. Both are risk pooling schemes under which the Trust pays an annual contribution to the NHS Resolution and in return receives assistance with the costs of claims arising. The annual membership contributions, and any excesses payable in respect of particular claims are charged to operating expenses when the liability arises.

1.15 Contingencies

Contingent assets (from past events whose existence will only be confirmed by one or more future events not wholly within the Trust's control) are not recognised as assets, but disclosed in note 21.1 where an inflow of economic benefits is probable.

Contingent liabilities are not recognised, but disclosed in note 21.2, unless the probability of a transfer of economic benefits is remote. Contingent liabilities are defined as:

- possible obligations arising from past events whose existence will be confirmed only by the occurrence of one or more uncertain future events not wholly within the entity's control; or
- present obligations arising from past events but for which it is not probable that a transfer of economic benefits will arise or for which the amount of the obligation cannot be measured with sufficient reliability.

1.16 Public Dividend Capital

Public Dividend Capital (PDC) is a type of public sector equity finance which represents the Department of Health and Social Care's investment in the Trust. HM Treasury has determined that PDC is not a financial instrument within the meaning of IAS 32. At any time, the Secretary of State can issue new PDC to, and require repayments of PDC from, the trust. PDC is recorded at the value received.

An annual charge, reflecting the cost of capital utilised by the Trust, is payable as public dividend capital dividend. The charge is calculated at the rate set by the Secretary of State with the consent of HM Treasury (currently 3.5%) on the average relevant net assets of the Trust during the financial year. Relevant net assets are calculated as the value of all assets less all liabilities, except for:

- donated assets
- average daily cash balances held with the Government Banking Services (GBS) and National Loans Fund deposits, excluding cash balances held in GBS accounts that relate to a short term working capital facility
- Any PDC dividend balance receivable or payable and

- the final incentive elements of the Provider Sustainability Funding.

The average relevant net assets are calculated as a simple average of opening and closing relevant net assets.

In accordance with the requirements laid down by the Department of Health and Social Care the dividend for the year is calculated on the actual average relevant net assets as set out in the 'pre-audit' version of the annual accounts. The dividend thus calculated is not revised should any adjustment to net assets occur as a result of the audit of the annual accounts.

1.17 Value Added Tax (VAT)

Most of the activities of the Trust are outside the scope of VAT. Irrecoverable VAT is charged to the relevant expenditure category or included in the capitalised purchase cost of fixed assets. Where output tax is charged or input VAT is recoverable, the amounts are stated net of VAT.

1.18 Third party assets

Assets belonging to third parties (such as money held on behalf of patients) are not recognised in the accounts since the Trust has no beneficial interest in them. However, they are disclosed in note 25 to the accounts.

1.19 Losses and special payments

Losses and special payments are items that Parliament would not have contemplated when it agreed funds for the health service or passed legislation. By their nature they are items that ideally should not arise. They are therefore subject to special control procedures compared with the generality of payments. They are divided into different categories, which govern the way that individual cases are handled. Losses and special payments are charged to the relevant functional headings in expenditure on an accruals basis, including losses which would have been made good through insurance cover had the Trust not been bearing its own risks (with insurance premiums then being included as normal revenue expenditure).

However, the losses and special payments note 26 is compiled directly from the losses and compensations register which reports on a cash basis with the exception of provisions for future losses.

1.20 Accounting standards that have been issued but not yet been adopted

The DHSC GAM does not require the following Standards and Interpretations to be applied in 2019/20. These standards are still subject to HM Treasury FReM adoption, with IFRS 16 being for implementation in 2020-21, and the government implementation date of IFRS17 still subject to HM Treasury consideration.

Standards and Interpretations	Financial year for which the change first applies
IFRS 16 *Leases*	Effective 1 April 2020 as adapted and interpreted by the FReM ~~Application required for accounting periods beginning on or after 1 January 2020, but not yet adopted by the FReM: early adoption is not therefore permitted.~~
IFRS 17 *Insurance Contracts*	Application required for accounting periods beginning on or after 1 January 2021, but not yet adopted by the FReM: early adoption is not therefore

	permitted.
~~IFRIC 23 *Uncertainty over Income Tax Treatments*~~	~~Application required for accounting periods beginning on or after 1 January 2019.~~

The Trust has not adopted any new accounting standards, amendments or interpretations early. The new leases standard IFRS 16 will see a number of operating leases currently included within note 5.2 operating lease expenses being included in the statement of financial position. ~~As this change is expected from 2020/21 detailed work has not yet been undertaken to quantify the impact.~~ The Trust has undertaken an assessment of the standard with the expected impact being…..**(The impact is being assessed in January 2020 and therefore this paragraph will be updated for the Annual Accounts submissions in April and May 2020)**

There will be no significant impact from the other standards.

1.21 Critical accounting estimates and judgements

Estimates and judgments are continually evaluated and are based on historical experience and other factors, including expectations of future events that are believed to be reasonable under the circumstances.

Critical judgements in applying the entity's accounting policies

The Trust has made no judgements in applying the accounting policies other than those involving accounting estimates.

Critical accounting estimates and assumptions

The Trust makes estimates and assumptions concerning the future. The resulting accounting estimates will, by definition, seldom equal the related actual results. The estimates and assumptions that have a significant risk of causing a material adjustment to the carrying amounts of assets and liabilities within the next financial year are addressed below.

a) Depreciation
   Depreciation is based on automatic calculations within the Trust's Fixed Asset Register and is calculated on a monthly basis throughout the year. When an asset is added to the Fixed Asset Register, it is given a useful economic life by the capital accountant, depending on the class of asset (i.e. vehicle, IT equipment etc). Buildings can be assigned a useful economic life of up to 49 years by the District Valuer as part of their valuations, depending on their state of repair and intended use. Useful economic life can be adjusted on the Fixed Asset Register if required, for example following an external valuation by the District Valuer. This judgement will take into account past experience. Typically more expensive items have a longer lifespan which reduces the degree of sensitivity of charges.

b) Revaluation
   The Trust's assets are subject to the quinquennial revaluation by the Trust's approved valuers. In the interim years the Trust's assets are revalued using desktop revaluations undertaken by the Valuation Office. The Valuation Office is an expert therefore there is a high degree of reliance on the valuer's expertise.

   For 2019/20 the Building Cost Information Service (BCIS) publications for Quarter 1 2020, adopted for 31st March 2020 valuations, had a marked variation in the BCIS location factors applicable to the South West region of England compared to the 31st March 2018 asset valuations. The District Valuer's professional expertise was this reflected a short term fluctuation, reducing the impact of the published indices through adopting a smoothing approach to the location factor, providing greater consistency in the valuations of the Trust's specialised

assets. **To be updated for the April and May submissions based on the final index and the District Valuers adaptation**

c) Impairment

Impairments are based on the Valuation Office's revaluation, on application of indices or on revaluation of individual assets e.g. when brought into operational use, or identified for disposal. Assumptions and judgments are that valuations and the assumptions used are applicable to the Trust's circumstances. Additionally, management reviews would identify circumstances which may indicate where an impairment has occurred.

d) Month 12 income from activities

As the NHS Annual Accounts and invoicing deadlines fall before actual month 12 activity data is available, it is necessary to make an estimate for the accounts.

Forecast outturn activity and value is calculated throughout the year using established profiles in combination with year to date activity as the basis for estimating the full year activity. Profiles are set up at the beginning of the year to reflect the anticipated spread of activity throughout the year and are used to spread the annual plan as well as to forecast the activity. The main profiles used are:

- Twelfths – used for block contracts.
- Actual days – (calendar days in month) used for non-elective and emergency work.
- Working days – (excludes weekends and bank holidays plus an additional day at Christmas) used for elective work and outpatients.
- Specific profiles – more detailed profiles are set up for example where it is known that particular activity is not planned to start until part way through the year, e.g. date of service transfer, commencement of new development.

The Trust's approach to this estimate for month 12 incorporates reviewing actual contract monitoring data from month 7 onwards for estimating the final months of the year.

Where Month 12 interim activity data is available prior to closing the month 12 position this will be reviewed to assess whether changes are required. If the assessment is deemed significant the estimates will be replaced with the actual data and the commissioners will be notified of the changes.
The value of uncoded activity is estimated using an average tariff basis.

e) Partially completed spells

This is an estimate of income due in relation to patients admitted before the year end, but not discharged. It is calculated at spell level and is based on a realistic estimate of the number of unfinished days at the end of the financial year, calculated using data available from previous month ends. This is necessary due to the timing of the final accounts, which means that the actual figure will not be available. The day of admission counts as an unfinished day.

The valuation of unfinished activity will use specialty bed day rates. The rates are weighted to ensure they are consistent with the proportion of actual income that is received, using information gleaned from previous months incomplete spells. In calculating the proportion of actual income, the first two days of each spell will attract a disproportionate amount of the income in recognition that some costs are heavily weighted towards the beginning of the spell. For 17/18 and 18/19 surgical specialties 45% of the income is allocated to the first 2 days with the remaining 55% apportioned equally over the total length of stay. For medical specialties the figures are 25% and 75% respectively.

In making this estimate the volume of unfinished activity is calculated using an average of the first 11 months of the year. The rates used are calculated at specialty level, the greatest level of

detail that can be determined for unfinished activity, and reflect the distribution of costs through the spell in recognition of the early days of the spell generally being the most expensive.

The income is accrued and agreed with local Clinical Commissioning Groups and with NHS England.

f) Maternity pathway (incomplete antenatal spells)
This is an estimate of income received in advance in relation to patients who commenced their antenatal pathway in one financial year but who will not finish it until after the end of the financial year. It is calculated on the following basis:

- Assume the length of an ante natal pathway is 182 days (c 6 months).
- Estimate the proportion of pathways that will be incomplete at the end of the financial year. The position at 29th February 2020 has been used as a proxy, as the month 12 activity was not available.
- Using the ante natal booking date, calculate how many days of the ante natal period are likely to occur after 29th February 2020.
- Value these days as a proportion of the pathway tariff.

1.22 Changes in accounting policy

Foundation Trusts may change an accounting policy only where it is required by a new standard or interpretation (including any revisions to the GAM) or voluntarily only if it results in the Trust's financial statements providing reliable and more relevant information about transactions, events, conditions, or the financial position, financial performance or cash flows.

The changes arising from the introduction of a new standard or interpretation will be implemented in accordance with the specific transitional provisions, if any, of that standard or interpretation. Where no such specific transitional provisions exist, or where the Trust changes an accounting policy voluntarily, the changes will be applied retrospectively i.e. through a prior period adjustment. In accordance with IAS 8 any prior period adjustments will be effected by restating each element of equity (reserves) at the start of the prior year as if the accounting policy had always applied.

Meeting of the Trust Board in Public on 30 January 2020

Report Title	**Remuneration, Nominations and Appointments Committee Terms of Reference**
Report Author	**Eric Sanders, Director of Corporate Governance**
Executive Lead	**Eric Sanders, Director of Corporate Governance**

1. Report Summary

To present the revised Terms of Reference of the **Remuneration, Nominations and Appointments Committee** for approval by the Board.

2. Key points to note
(Including decisions taken)

- The Terms of Reference (ToR) for the Remuneration, Nominations and Appointments Committee require that, at least once a year, the Committee shall review its own performance, constitution and Terms of Reference to ensure it is operating at maximum effectiveness, and recommend any changes it considers necessary to the Board of Directors for approval.
- The ToR now include a stakeholder analysis to identify the internal and external stakeholders which influence the work of the Committee, These stakeholders and the requirements on the Committee are set out in Section 2, with the format mirroring that of the changes recently implemented for the Audit Committee.
- The requirements from stakeholders are then cross referenced to the specific paragraphs in the ToR.
- Through this process it was identified that the ToR for the Committee did not explicitly state that the HM Treasury Guidance relating to off payroll appointments should be considered where this type of arrangement is being proposed. This is now included in para 8.1.9 (and highlighted in yellow).
- The Remuneration, Nominations and Appointments Committee considered the above proposed amendments to its Terms of Reference at its November meeting, and recommended them to the Trust Board for 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:
N/A

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

- This report is for **Approval.**

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

N/A

22

Page **1** of **1**

Terms of Reference - Remuneration, Nominations and Appointments Committee

Version Tracking				
Version	Date	Revision Description	Editor	Approval Status
1.0	March 2009	Existing version	N/A	N/A
1.1	28/02/2012	Major review for consideration by the Trust Board of Directors	TSec	Draft
2.0	27/03/2012	Minor revisions to the purpose of the Committee following direction of the Trust Board of Directors	TSec	Approved
3.0	14/11/14	Revisions in line with FTN Good Governance compendium and best practice. With a view to combining Remuneration Committee and Nomination and Appointments Committee	Director of Workforce & OD /Trust Sec	TBC
4.0	28/04/16	Annual review for consideration by the Trust Board of Directors	Trust Secretary	Approved
5.0	12/05/2017	Annual review for consideration by the Trust Board of Directors. Minor amendment to section 3.3 ensuring clarity of the reporting on the annual statement on remuneration.	Trust Secretary	Approved
6.0	18/04/2018	Annual review for consideration by the Committee and the Board of Directors. Minor amendments for clarity/consistency and to: a) Change the Chair of the Committee from the Vice-Chair of the Board of Directors to the Chair of the Board of Directors b) Clarify that the Trust Secretary or their nominated deputy may minute meetings of the committee.	Deputy Trust Secretary	Approved
7.0	25/11/2019	Annual review for consideration by the Committee and the Board of Directors. Amended to include stakeholder information and analysis (paragraph 2).	Director of Corporate Governance	

Table of Contents

1	**Purpose**	**3**
2	**Context**	**3**
2	**Authority**	**4**
3	**Reporting**	**5**
4	**Membership**	**5**
5	**Quorum**	**5**
6	**Secretary**	**5**
7	**Duties**	**6**
	Appointment	**6**
	Remuneration	**6**
8	**Notice and Conduct of Meetings**	**7**
9	**Minutes of Meetings**	**7**
10	**Frequency**	**8**
11	**Review Terms of Reference**	**8**

22

1. Purpose

1.1. To be responsible for identifying and appointing candidates to fill all the Executive Director positions on the Board and for determining their remuneration and other conditions of service.

1.2. When appointing the Chief Executive, the committee shall be the committee described in Schedule 7, 17(3) of the National Health Service Act 2006 (the Act). When appointing the other Executive Directors the committee shall be the committee described in Schedule 7, 17(4) of the Act.

2. Context

Stakeholder Community

2.1. The Remuneration, Nominations and Appointments Committee's primary responsibility is to the Board of Directors, as detailed above. However, in order to discharge these responsibilities appropriately the Committee must work in close partnership with a number of internal and external Stakeholders. These Stakeholders influence the work of the Committee by:

- establishing external benchmark standards and requirements
- providing / receiving assurance on the suitability and efficacy of the Trust's approach.

2.2. The Stakeholders of the Remuneration, Nominations and Appointments Committee are identified below:

Internal (accountable to)

- Board of Directors
- Council of Governors

External

- NHS Improvement
- HM Treasury
- NHS Business Authority.

Stakeholder Analysis

2.3. The Terms of Reference and the responsibilities of the Remuneration, Nominations and Appointments are dependent on an accurate understanding of the Stakeholder community and their associated requirements, especially any deliverables that are required, either from or by the Committee.

2.4. The following table provides an analysis of the requirements and dependencies associated with the Remuneration, Nominations and Appointments Stakeholder Community.

2.5. **Requirements from Remuneration, Nominations and Appointments Committee** - Explains what the Committee is required to do based on the requirements of the stakeholder.

2.6. **Inputs into Remuneration, Nominations and Appointments Committee** - Explains what needs to be provided into the Committee to allow it to fulfil the requirements of the stakeholder.

22

Stakeholder	Requirements from RN&AC		Inputs to RN&AC	
	General	Formal Deliverables	General	Formal Deliverables
Board of Directors and Council of Governors	Identifying and appointing candidates to fill all the Executive Director positions on the Board and for determining their remuneration and other conditions of service.			Job descriptions for roles Proposed salary for roles Description of the recruitment process Advice on the appointment of executive recruitment support (All section 8.1)

Stakeholder	Requirements from RN&AC		Inputs to RN&AC	
	General	Deliverables	General	Deliverables
NHS Improvement	Guidance on pay for Very Senior Managers in NHS Trusts and Foundation Trusts	Review of salaries on appointment and annually thereafter		Annual salary review with benchmarking information (8.2)
NHS Improvement	Best practice principles and processes to help Board of Directors to maintain good quality corporate governance. (NHS Foundation Trust Code of Governance)			Annual review of Board skills and knowledge mix. (8.1.1)
HM Treasury	Guidance about the appointment of 'office holders'			Report on proposed off-payroll appointments at VSM (8.1.9)
NHS Business Authority	Guidance on the administration of the NHS Pension Scheme			NHS pensions and disclosure of Senior Managers' Remuneration (Greenbury) (9.2)

3. Authority

3.1. The Remuneration, Nominations and Appointments Committee (the Committee) is constituted as a standing committee of the Trust's Board of Directors (the Board). Its constitution and terms of reference shall be as set out below, subject to amendment at future Board meetings.

3.2. The committee is authorised by the Board to act within its terms of reference. All members of staff are directed to co-operate with any request made by the committee.

3.3. The committee is authorised by the Board to instruct professional advisors and request the attendance of individuals and authorities from outside the t=Trust with

relevant experience and expertise if it considers this necessary for or expedient to the exercise of its functions.

3.4. The committee is authorised to obtain such internal information as is necessary and expedient to the fulfilment of its functions

4. Reporting

4.1. The committee Chair shall report to the Trust Board of Directors on all proceedings undertaken within its duties and responsibilities.

4.2. The committee shall make whatever recommendations to the Trust Board of Directors it deems appropriate on any area within its remit where action or improvement is needed.

4.3. The Committee Chair (on behalf of the Remuneration, Nominations and Appointments Committee) shall make a statement in the annual report about its activities and the process used to decide remuneration.

4.4. The Committee shall make information available regarding the attendance of all members at Committee meetings.

5. Membership

5.1. The membership of the committee shall consist of:

- The Trust Chair
- The other Non-Executive Directors of the Board

5.2. And in addition, when appointing Executive Directors other than the Chief Executive:

- The Chief Executive

5.3. The Trust Chair shall Chair the Committee.

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

5.5. At the invitation of the Committee, meetings shall normally be attended by the:

- Chief Executive Officer
- Director of People

5.6. Other persons may be invited by the Committee to attend a meeting so as to assist in deliberations, at the discretion of the Chair.

5.7. Any non-member, including the secretary to the Committee, will be asked to leave the meeting should their own conditions of employment be the subject of discussion.

6. Quorum

6.1. The quorum necessary for the transaction of business shall be the Chair of the Committee and three independent Non-Executive Directors.

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

7. Secretary

7.1. The Trust Secretary shall be secretary to the Committee.

8. Duties

8.1. Appointments

The Committee will:

8.1.1. Regularly review the structure, size and composition (including the skills, knowledge, experience and diversity) of the Board, making use of the output of the board evaluation process as appropriate, and make recommendations to the Board, and Nomination Committee of the Council of Governors, as applicable, with regard to any changes.

8.1.2. Give full consideration to and make plans for succession planning for the Chief Executive and other Executive Directors taking into account the challenges and opportunities facing the trust and the skills and expertise needed on the Board in the future.

8.1.3. Keep the leadership needs of the Trust under review at executive level to ensure the continued ability of the trust to operate effectively in the health economy.

8.1.4. Be responsible for identifying and appointing candidates to fill posts within its remit as and when they arise.

8.1.5. When a vacancy is identified, evaluate the balance of skills, knowledge and experience on the Board, and its diversity, and in the light of this evaluation, prepare a description of the role and capabilities required for the particular appointment. In identifying suitable candidates the Committee shall use open advertising or the services of external advisers to facilitate the search; consider candidates from a wide range of backgrounds; and consider candidates on merit against objective criteria.

8.1.6. Ensure that a proposed Executive Director's other significant commitments (if applicable) are disclosed before appointment and that any changes to their commitments are reported to the Board as they arise.

8.1.7. Ensure that proposed appointees disclose any business interests that may result in a conflict of interest prior to appointment and that any future business interests that could result in a conflict of interest are reported.

8.1.8. Consider any matter relating to the continuation in office of any Board Executive Director including the suspension or termination of service of an individual as an employee of the trust, subject to the provisions of the law and their service contract.

8.1.9. Ensure that guidance from HM Treasury is considered where any off payroll appointments are proposed.

8.2. Remuneration

The Committee will:

8.2.1. Establish and keep under review a remuneration policy in respect of Executive Board Directors.

8.2.2. Consult the Chief Executive about proposals relating to the remuneration of the other Executive Directors.

8.2.3. In accordance with all relevant laws, regulations and trust policies, decide and keep under review the terms and conditions of office of the trust's Executive Directors, including:

- Salary, including any performance-related pay or bonus;
- Provisions for other benefits, including pensions and cars;
- Allowances;
- Payable expenses;
- Compensation payments.

8.2.4. In adhering to all relevant laws, regulations and trust policies establish levels of remuneration which are sufficient to attract, retain and motivate Executive Directors of the quality and with the skills and experience required to lead the trust successfully, without paying more than is necessary for this purpose, and at a level which is affordable for the Trust;

8.2.5. Use national guidance and market benchmarking analysis in the annual determination of remuneration of Executive Directors, while ensuring that increases are not made where trust or individual performance do not justify them;

8.2.6. Be sensitive to pay and employment conditions elsewhere in the Trust.

8.2.7. Monitor and assess the output of the evaluation of the performance of individual Executive Directors, and consider this output when reviewing changes to remuneration levels.

8.2.8. Advise upon and oversee contractual arrangements for executive directors, including but not limited to termination payments to avoid rewarding poor performance.

9. Notice and Conduct of Meetings

9.1. The Secretary shall call meetings of the Committee at the request of the Chair not less than ten clear days prior to the date of the meeting.

9.2. Unless otherwise agreed, notice of each meeting confirming the venue, time and date, together with an agenda of items to be discussed, shall be available to each member of the Committee and where appropriate, other persons required to attend, no later than three working days before the date of the meeting,

9.3. Supporting materials shall be provided to Committee members and to other attendees as appropriate, at the same time.

10. Minutes of Meetings

10.1. The Trust Secretary, or their nominated deputy, shall minute the proceedings and resolutions of the Committee, including the names of members present and others in attendance. Draft minutes shall be distributed to Committee members for approval after each meeting.

10.2. The Committee shall receive and agree a description of the work of the Committee, its policies and all executive director emoluments in order that these are accurately reported in the required format in the trust's annual report and accounts.

11. Frequency of Meetings

11.1. The Committee shall meet at least three times per annum and at such other times as the Chair of the Committee shall require.

12. Review of Terms of Reference

12.1. At least once a year, the Committee shall review its own performance, constitution and Terms of Reference to ensure it is operating at maximum effectiveness and recommend any changes it considers necessary to the Board of Directors for approval.

Meeting of the Board of Directors in Public on Thursday 30 January 2020

Report Title	Register of Seals Report – Q3 Update
Report Author	Mark Pender, Head of Corporate Governance
Executive Lead	Eric Sanders, Director of Corporate Governance

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 **November 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**.
5. History of the paper **Please include details of where paper has previously been received.**
N/A

23

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Recognising success
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Public Board Meeting - January 2020-30/01/20 - Page 345

Register of Seals

November 2019 – January 2020

Reference Number	Date Signed	Document	Authorised Signatory 1	Authorised Signatory 2	Witness	Additional Comments
828	11 Dec 19	P22 Agreement for Strategic Capital Programme (phase 5) BHOC Stage 1 Levels 4 and 5	Robert Woolley	Neil Kemsley	Mark Pender	This agreement was for DH approved framework documentation.

Meeting of the Board of Directors in Public on Thursday 30 January 2020

Report Title	Governors' Log of Communications
Report Author	Kate Hanlon, Membership Engagement Manager
Executive Lead	Jeff Farrar, Chair

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 one question has been raised and answered.

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.**

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

N/A

24

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Governors' Log of Communications

23 January 2020

ID **Governor Name**

230 **Martin Rose** ***Theme:*** Hospital televisions ***Source:*** From Constituency/ Members

Query **29/11/2019**

At a recent Trust event, I heard from a member of the public who was concerned about the televisions provided at patient beds for patients to use during their stay on our wards.

Unfortunately, it appears that a significant number of them do not function and patients are left with no television, which is particularly hard for those who don't receive many visitors or other stimulation.

I understand that the company who was maintaining the television sets has since gone into administration and this may have left us with no maintenance contract and a number of faulty televisions. Is this the case, and if so, what is being done about it?

Division: Trust-wide ***Executive Lead:*** *Director of Finance* ***Response requested:*** 13/12/2019

Response **09/12/2019**

Currently the Trust's adult inpatient beds are served by two separate patient entertainment systems. The Trust owns, operates and maintains the system in the Bristol Heart Institute, Bristol Haematology and Oncology Centre, the Bristol Eye Hospital and within the new ward block at the Bristol Royal Infirmary. This system is fully operational.

The company supplying the patient entertainment systems within the Bristol Royal Infirmary's Queens Building and at St Michael's Hospital has told the Trust it can no longer fulfil its contract to operate and maintain the system. UH Bristol is currently working to seek to resolve this situation.

Status: *Closed*