University Hospitals Bristol NHS
NHS Foundation Trust

Agenda for a Public Meeting of the Trust Board of Directors to be held on 30 January 2014 at 10:30 in the Conference Room, Trust Headquarters, Marlborough Street, Bristol, BS1 3NU

Item	*Sponsor*	*Page*
1. Chairman's Introduction and Apologies To **note** apologies for absence received.	Chairman	
2. Declarations of Interest In accordance with Trust Standing Orders, all members present are required to declare any conflicts of interest with items on the Meeting Agenda.	Chairman	
3. Minutes and Actions from Previous Meetings To consider the Minutes of a Public Meeting of the Trust Board of Directors dated 28 November 2013 for **approval,** and to **note** the status of Actions agreed.	Chairman	4
4. Chief Executive's Report To receive this verbal report to **note**.	Chief Executive	18
Delivering Best Care		
5. Quality and Performance Report To receive the Quality and Performance Report for **review**. a. Quality & Outcomes Committee Chair's Report b. Patient Experience – Chief Nurse c. Performance Overview – Director of Strategic Development d. Board Review	Director of Strategic Development and Deputy Chief Executive	24
6. Infection Control Quarterly Report To receive this report by Chief Nurse for **review**.	Chief Nurse	111
7. Transforming Care Report To receive this report by the Chief Executive to **note**.	Chief Executive	143
8. Research and Innovation Strategy Update Report To receive this report by the Medical Director for **review**.	Medical Director	149
9. Report Withdrawn		
10. National Maternity Survey To receive this report by the Chief Nurse to **review.**	Chief Nurse	154
11. Report on actions arising from Care Quality Commission inspection of Theatres at Bristol Royal Hospital for Children To receive this report from the Chief Executive to **note**.	Chief Executive	188

Item	*Sponsor*	*Page*
Delivering Best Value		
12. Finance Report To receive this report by the Director of Finance and Information for **review**.	Director of Finance and Information	194
13. Finance Committee Chair's Report To receive this verbal report by the Chair of the Finance Committee for **review**.	Director of Finance and Information	
Leading in Partnership		
14. Partnership Programme Board Report To receive the Partnership Programme Board report to **note**.	Chief Executive	213
Renewing our Hospitals		
15. Quarterly Capital Projects Status Report To receive this report by the Director of Strategic Development and Deputy Chief Executive to **note**.	Director of Strategic Development and Deputy Chief Executive	216
16. Refresh to the BRI Redevelopment Full Business Case To consider this refresh presented the Chief Operating Officer for **approval**.	Chief Operating Officer	223
Quality, Performance & Compliance		
17. Response to Report of Handling Complaints by NHS Hospitals in England by Ann Clwyd MP and Professor Tricia Hart To receive this report by the Chief Nurse for **approval.**	Chief Nurse	235
Corporate Governance		
18. Audit Committee Chair's Report To receive this verbal report by the Chief Executive for **review**.	Chief Executive	
19. Corporate Risk Register To receive this report by the Chief Executive for **review**.	Chief Executive	246
20. Board Assurance Framework Report To receive this report from the Chief Executive for **review**.	Chief Executive	256
21. Report Results of Q2 Compliance Framework Monitoring	Chief	268

Item	*Sponsor*	*Page*
Exercise To receive this report by the Chief Executive to **note**.	Executive	
22. Q3 Compliance Framework Monitoring and Declaration Report (including quarterly financials) To receive this report by the Chief Executive to **approve**.	Chief Executive	270
23. Register of Seals To receive this report by the Chief Executive to **note**.	Chief Executive	284
Information and Other		
24. Any Other Business To note any other relevant matters (not for decision).	Chairman	
25. Date of Next Meeting **Public Trust Board meeting**, 27 February 2014 at 10:30 in the Conference Room, Trust Headquarters, Marlborough Street, Bristol, BS1 3NU.	Chairman	

Minutes of a Public Meeting of the Trust Board of Directors held on 28 November 2013 at 10:30 in The Conference Room, Trust Head Quarters, Marlborough Street, Bristol, BS1 3NU

<table>
<tr><th colspan="2">Board Members Present</th></tr>
<tr><td>

- John Savage – Chair
- Robert Woolley – Chief Executive
- Paul Mapson – Director of Finance & Information
- James Rimmer – Chief Operating Officer
- Sue Donaldson – Director of Workforce & Organisational Development
- Deborah Lee – Director of Strategic Development and Deputy Chief Executive

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- Helen Morgan – Acting Chief Nurse
- Sean O'Kelly – Medical Director
- Lisa Gardner – Non-executive Director
- Guy Orpen – Non-executive Director
- Emma Woollett – Non-executive Director
- Julian Dennis – Non-executive Observer
- Jill Youds – Non-executive Observer
- David Armstrong – Non-executive Director

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<tr><th colspan="2">Others in Attendance</th></tr>
<tr><td>

- Charlie Helps – Trust Secretary
- Fiona Reid – Head of Communications
- Sue Milestone – Governor - Carers of Adults
- Florene Jordan – Staff governor
- Peter Bayliss – Rapid Response Nurse
- Tony Tanner – Public governor
- Brenda Rowe – Public governor
- Anne Skinner – Patient governor
- Marc Griffiths – Appointed governor
- Ruth Hendy – Cancer Specialist Lead Nurse

</td><td>

- John Steeds – Patient governor
- Mo Schiller – Public governor
- Wendy Gregory – Governor - Patient Carers
- Neil Havercroft – Foundation Trust Member
- Jeanette Jones – Appointed governor
- Clive Hamilton – Public governor
- Debbie Corrigan – Health Research Authority (Public)
- Susan Ahlquist – User Representative Cancer Board
- Bob Skinner – Foundation Trust Member
- Pauline Holt (Management Assistant to the Trust Secretary)

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<tr><th>Item</th><th>Action</th></tr>
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1. Chairman's Introduction and Apologies

The Chairman welcomed those present including new Non-executive Directors and Observers, and noted apologies from Iain Fairbairn, John Moore, Alison Ryan and Kelvin Blake.

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2. Declarations of Interest

In accordance with Trust Standing Orders, all members present were required to declare any conflicts of interest with items on the Meeting Agenda.

There were no declarations of interest.

3. Minutes and Actions from Previous Meeting

The Board considered the Minutes of the Public Trust Board of Directors meeting dated 31 October 2013 and **approved** them as an accurate record.

Actions:
There were no Action responses to note.

Matters Arising:
There were no matters arising.

4. Chief Executive's Report

The Chief Executive advised the Board on a number of key appointments and awards:

- UH Bristol was to host the Local Clinical Research Network for the West of England from 1st April, on behalf of the National Institute for Health Research. Consequently the Chief Executive was pleased to announce that Dr Stephen Falk, Consultant Clinical Oncologist and Honorary Senior Lecturer at the Bristol Haematology/Oncology Centre, had been appointed as Clinical Director for the West of England Clinical Research Network.
- The successful Forget-me-not event on Dementia was attended by 130 staff, governors and members of the public. Natalie Godfrey, Dementia Nurse had won the national award for 'Best Dementia Nurse Specialist' and dementia lead for 2013 at the National Dementia Care Awards.
- The staff award event, Recognising Success, had been a great evening with many staff groups represented. On the same evening the South West Leadership Academy had awarded Dr Emma Redfern the 'Emerging Leader of the Year'. He declared this to be "great for the profile of the Trust".
- Chaplain Veronica Lee had won the 'Spiritual Care Award' in the Butterfly Awards, a charity supporting people overcoming infant loss.
- Finally the Board noted a Gold Level Audit Report from the National Security Inspectorate for the Security Team in the Trust. He said that UH Bristol was

the only Trust to have achieved gold status. John Steeds, who was in attendance, asked James Rimmer at what stage the Wayfinding and Signage project had reached. He was advised that staff and patient feedback had been received and the basic principles had been decided with further work yet to take place with design consultants to define the zoning of the core campus. It was the intention to have new signage in place from May 2014 onwards to coincide with the opening of the new Bristol Royal Infirmary ward block. James Rimmer said he was happy to share further information with interested governors. Lisa Gardner asked when the Welcome Centre was due to open and Deborah Lee advised 16 December with a formal opening ceremony after Christmas 2013. She concluded that there was a programme of formal orientation and would ensure that Non-executives Directors and governors had the opportunity to attend. *There being no further questions the Chief Executive concluded his report.*	Action 215 Action 216
Delivering Best Care	
5. Quality and Performance Report *The Board received the Quality and Performance report for review.* **Patient Experience** Helen Morgan presented the report and described it as a "salutary lesson on how not to discharge a patient from care". She explained that the incident reported had occurred during a period of black escalation and much had been learnt, particularly surrounding the importance of good communication on handover. Progress included the opening of the new Discharge Lounge facility which was receiving positive feedback from patients. Wider organisational changes such as those involving Lloyds Pharmacy and a review of the whole mobile phlebotomy service were taking place. Lisa Gardner asked which checks had taken place regarding the dispensing of drugs by Lloyds Pharmacy to match the Bristol Royal Infirmary Pharmacy prescribing policy. Helen Morgan to report following further consultation with the Head of Pharmacy. Emma Woollett asked if safeguards were in place for those patients who were not discharged via the Discharge Lounge. Helen Morgan advised that checks were routinely in place. However, the patient referred to in the report had been discharged	Action 217

during a period of black escalation which had affected the quality of care.

Anne Skinner, who was in attendance, asked if patients were routinely moved at night. Helen Morgan said there was a clear policy not to do so under normal circumstances.

Performance Overview

The monthly Quality & Performance Report detailed the Trust's current performance on national frameworks, and a range of associated Quality, Workforce and Access standards. Exception reports were provided to highlight areas for further attention and actions that were being taken to restore performance.

Deborah Lee advised the Board that:

- There had been a small improvement in the overall "health of the organisation" with six months of stability or improved positions. Significant improvement had been shown in the area of recruitment to research trials and hospital cancelled appointments. An area where insufficient progress had been made was staff sickness absence but with an improved focus on disseminating the learning received from well performing divisions.
- Patient Experience had retained a green rating across all measures and the Trust had maintained a GREEN position in relation to efficiency.
- The Emergency Department (4-hour waiting time) standard had been achieved for the third month in a row at a time when emergency admissions were at a high and when ambulance arrivals were higher than was typical for the period. This indicated that work around patient flow was being embedded and delivering sustained improvements.
- Finance was reported for the first time under the new risk assessment framework issued by Monitor. It described a relatively positive position except in the area of Cash Reducing Efficiency Savings. With an expectation of Quarter 4 being delivered successfully, the team's focus remained on not commencing the year 2014/5 with any "carry forward", underlying deficit.
- In regard to the Trust overall assessment, October had heralded a new approach to Monitor's assessment of Trusts with either a GREEN, RED or 'under investigation' status. UH Bristol had achieved a GREEN rating, despite the C difficile target having breached the trajectory standard set by Monitor. This breach represented the third quarter failed resulting in the expectation that Monitor would investigate. Preliminary discussions with Monitor appeared to indicate that they had a level of assurance based on previous Trust examinations over recent times in relation to infection control. The Trust had provided Monitor with significant evidence regarding infection control

practice and Deborah Lee described the current position as a reflection of many other Trusts. Expectations were that a GREEN rating would be restored in Quarter 4 should no further deterioration take place in other areas.

Quality and Outcomes Committee Chair's Report

John Savage, as acting Chair of the Quality and Outcomes Committee explained that the purpose of the Committee was to thoroughly examine, question and assess the performance of the Trust on behalf of the Board. He advised that particular note had been made of the position on C difficile, 62 day screening and referral to treatment times and that good steady progress had been made. The inclusion of the monthly Serious Incident Report allowed the Committee, on behalf of the Board, to take an early detailed look at incidents whilst awaiting root cause analysis of each case to conclude.

The Chair invited Sue Donaldson to expand on sickness absence. She advised that the assessments being undertaken centred around both the causes and the consequences of sickness absence. The Human Resources team was working closely with line managers and Occupational Health on this work.
She highlighted the importance of health prevention promotion amongst staff noting particularly the 'flu vaccination programme to combat one of the highest reasons for staff absence'. Also of note was stress/anxiety related absences and much effort had been put into workshops to inform and raise awareness of the need for early provision of support to staff under these circumstances.

Jill Youds asked Sue Donaldson if there was a correlation between sickness absence and morale/engagement at UH Bristol. She was advised that a wider analysis featuring a better understanding of how the metrics were related was to be undertaken, not looking at sickness absence in isolation but viewing it "in the round". Sue concluded that she had been encouraged by her first impressions of the general level of staff enthusiasm and morale.

The Chief Executive asked Dr Richard Brindle, who was in attendance, for an overview of the Trust's position regarding C difficile compared to national and regional benchmarks. Dr Brindle replied that UH Bristol target figures were very low thereby allowing one or two cases to change the Trust's rating from green to a red. Nationally, C difficile showed a smooth curve with a slightly "bumpier" curve for the region. Much was being done with pharmacy colleagues checking antibiotic prescribing. His overall conclusion was that the C difficile figures for UH Bristol were a reflection of (perhaps) a wider than average prevalence for C difficile in the local community than that for the rest of the country.

Deborah Lee informed the Board that constructive discussions with Commissioners regarding 62 day cancer pathways had led to an agreement for a piece of work to develop incentives and possible penalties, within the contract framework for next year. The intention being that providers would be incentivised to examine their processes contributing to the delay to tertiary services at UH Bristol. She welcomed this as a new sense of engagement and commitment from Commissioners to solve the pre-hospital aspect of the pathway.

Emma Woollett noted the first AMBER in high risk cannula antibiotic compliance. Helen Morgan explained that there was a very clear action plan surrounding cannulas and there was a pilot of a new monitoring machine to detect if there was any biological material in areas being cleaned.

Lisa Gardner expressed concern regarding turnover figures in the Trust and asked Sue Donaldson if comprehensive exit reviews were undertaken. She advised that these were done but the value received as a result was being examined. A new piece of work was being commissioned which would focus on viewing figures departmentally to compare recurring patterns between the turnover and sickness absence rates.

The Chairman asked for questions from the governors present.

Wendy Gregory, who was in attendance, asked for clarification as to where delays came concerning the 62 day cancer target. Deborah Lee explained that delays occurred in the phase where a patient was undergoing investigation for a possible diagnosis of a cancer and was referred by another hospital to a tertiary provider. On a different subject, Wendy Gregory pointed out that members of staff may be carers and asked if the Trust recognised that as a factor in sickness absence figures. Sue Donaldson said there was a need to better understand the performance matrix and how the figures "came together". For staff engagement it was clear that there was a need to have clear objectives and to be part of an effective team. To conclude she advised that in the light of the Francis Report a piece of work was being undertaken with data as it evolved to further understand the drivers.

Clive Hamilton, who was in attendance, asked if the Trust was "deflecting effort disproportionately" to the achievement of quality benefits as opposed to cash reducing efficiency savings. Deborah Lee explained that those were the quality priorities that the Board had set for itself as important for the benefit of patients.

Clive Hamilton, referring to the report (p66) asked how ward transfers affected the risk of "patient misdosing". Sean O'Kelly explained that although one ward had

been performing poorly against the standard much work had been undertaken to improve performance. He informed the audience that electronic prescribing would improve the situation and was a move that was expected within the next year.

There being no further questions the Chairman drew this item to a close.

6. National Cancer Survey and Action Plan

The Board received the National Cancer Survey and Action Plan for review.

Helen Morgan presented the report advising that it summarised the key findings for UH Bristol from the 2012 National Cancer Patient Experience Survey.

Of the 60 overall questions relating to hospital care:
- 45 UH Bristol scores were in the mid-60% of Trust scores nationally
- 15 UH Bristol scores were classed as being among the lowest 20% nationally
- No UH Bristol scores were classed as being among the highest (best) 20% of scores nationally

The two UH Bristol scores that were "firmly" within the worst 20% were among the most important drivers of a good patient experience for people with cancer:
- Whether the patient found it easy to contact their Cancer Nurse Specialist (66%)
- Whether the patient was given written information about their cancer (60%)

The quantitative results of the survey were disappointing (despite methodological concerns) and the Trust was committed to improving these results.

The action plan was focused on:
- Improving accessibility to Clinical Nurse Specialists
- Information provision.

Ruth Hendy, Cancer Specialist Lead Nurse, spoke of a focus on identifying good practice and a sharing of this across teams. Links were being made across divisions and a review of cancer specialists generally. This review had enabled a "pulling out" of gaps in service provision and enabled these to be addressed. There was, she said clinical and divisional buy-in and although the review was annual there would be localised repeats within teams to enable early warning of changes in performance.

Wendy Gregory interjected, stressing the importance of Cancer Nurse Specialists, and asked for reassurance that the lack of a nurse specialist for Melanoma would be addressed. Ruth Hendy advised that a strategy was being discussed by divisions for cross-working as people progressed on their pathways and would form part of

divisional operating plans. Mo Schiller, who was in attendance, stressed the need for specialist nurses across the Trust. Paul Mapson advised that this was a decision for Commissioners. The Chief Executive clarified that both the risk and the priority were fully understood by the Trust. Emma Woollett suggested an update on Cancer Nurse Specialists be provided to the Board after six months. *There being no further questions the Chairman drew this item to a close.*	Action 218
7. Francis Report Trust Response *The Board received the Francis Report Trust Response for approval.* Sean O'Kelly presented the report, explaining that the paper set out the actions UH Bristol NHS Foundation Trust Board of Directors had taken to accelerate improvements for patients and support for staff in the context of the second Francis Report, the Keogh Reviews and the Berwick Report. The paper described the challenges generated by these reports and the actions the Trust had taken to assess itself against and meet those recommendations. The outcome of this process was the emergence of a number of themes where the Trust might expect some benefit from further developmental work. These included addressing perceived variation in attitudes to openness and sharing across the Trust, listening and learning more effectively throughout the Trust and making the process of change easier and more "usual" within the Trust. It showed the Trust's commitment to continue to improve care for patients and enhance the openness and transparency of its performance by undertaking the work identified through the Transforming Care Programme and by continuing to critically self-evaluate through enhanced staff engagement, so that any further opportunities for learning could be identified. Emma Woollett considered it to be a good report and welcomed the recommendation of constant vigilance with no room for complacency. She asked if timings were available on the specific action plan. Sean O'Kelly advised that timings had been set and would be tracked with some actions already completed such as putting the duty of candour into contracts and other policies. The Chairman requested an update at appropriate future Board meetings.	Action 219

Clive Hamilton expressed a view that the Council of Governors "had not been involved in" the Board's response to the Francis Report. Helen Morgan advised that she had received confirmation that governors were invited to provide their insights and ideas through the programme of listening events and at other opportunities.The Chief Executive advised that governors' views had been reflected in the final report which would be published in the public domain. *After due consideration the Board approved the Francis Report Trust Response for publication. There being no further questions the Chairman drew this item to a close.*	
8. Quarterly Patient Experience Report *The Board received the Quarterly Patient Experience Report for review.* The report provided an overview of UH Bristol's services from the perspective of patients and carers. It brought together feedback from a number of sources, including surveys, praise, complaints and on-line ratings. Helen Morgan reported that significant progress had been made in maternity services which were in line with the national average. She wished to give the Board assurance that methodologies had changed in the way post- and ante-natal wards worked and that initial feedback was very positive. Lisa Gardner observed disappointing results for Specialised Services, Women's and Children's and Surgery, Head and Neck, in regard to patient experience objectives. Helen Morgan explained that a different approach was to be taken for the next year, on specifically targeted areas which were likely to show some improvement as a result. Julian Dennis asked if patient questionnaires contained weighted questions. Helen Morgan said that there were a number of quantified core questions utilised but would check with the Patient Experience Lead if questions were weighted. Deborah Lee informed the Board that a forthcoming 'Simple Guide' for staff would focus on patient experience and be a valuable resource for both new Executive Directors and for governors. *There being no further questions the Chairman drew this item to a close.*	Action 220
Delivering Best Value	
9. Finance Report	

The Board received the Finance Report for review.

The summary income and expenditure statement showed a surplus of £2.342m (before technical items) for the seven months ending 31st October 2013. The cumulative position represented an adverse variance of £0.201m against the planned surplus for the period of £2.543m.

In Month 7, whilst the year end Trust forecast was still deliverable, the hoped for improvement in run rate had not yet been evident. Of particular concern was the £0.9m in month deterioration in the Surgery, Head and Neck Division which was undergoing investigation.

The results to 31st October were reflected in the Trust's Risk Assessment Framework - Continuity of Services Risk Rating of 4 (actual 3.5).

Report from the Chair of the Finance Committee

Lisa Gardner, Chair of the Finance Committee, advised that they had looked ahead to 2015/16 which would be a challenging year nationally and had examined ways in which to maximise efficiencies. Savings targets and managing demand activity and capacity planning had been considered and a report had been requested for the January 2014 meeting. The full business case update for specialist paediatrics had been examined by the Finance Committee which recommended a refresh to the Board for its approval.

Julian Dennis asked if there were unexpected profiling issues. Paul Mapson replied that there were no profiling issues but there were actions that needed to be implemented in the second half of the year that were made more difficult to achieve by winter pressures.

There being no further questions the Chairman drew this item to a close.

Leading in Partnership

10. Partnership Programme Board Report

The Board received the Partnership Programme Board Report to note.

The Partnership Programme Board had met with the aim of promoting effective joint working between the partner trusts for the benefit of patients and staff within the two organisations.

The Chief Executive advised that in addition to service transfers where the Board had an oversight role, the Partnership Programme Board looked at how to take the Bristol Acute Services Review forward, the position on pathology and the options

for the future of histopathology services at UH Bristol, given the recommendations in the Mishcon enquiry of 2010. He explained that agreement had been reached for additional formal working between the two Trusts' Executive Directors to support this aim. Emma Woollett asked for some assurance regarding the actions being undertaken to meet the pathology/histopathology requirements. The Chief Executive stated that both Boards of Directors had formally signed up to the recommendation that histopathology should be integrated. This integrated service was to come under the leadership of one trust but remain on separate sites for the time being. The feasibility of options for further integration, location and phasing timescales for physical integration were being discussed. Further information to be provided to the Board meeting in January 2014. *There being no further questions the Chairman drew this item to a close.*	Action 221
Corporate Governance	
11. Foundation Trust Constitution Revisions *The Board received the Foundation Trust Constitution Revisions for approval.* At the meeting of the Council of Governors on 31 October 2013, a motion from the floor was carried to make the following revisions to the Foundation Trust Constitution: a) To immediately change the Foundation Trust Constitution to allow for more representation from young people on the Council of Governors giving two extra places, and to invite the Youth Council to nominate two people to those positions. b) To immediately change the Foundation Trust Constitution to permit public members from territories outside the Trust's current locality – a tertiary group in a similar form to the patient tertiary group, or an amalgamation of the two into a public and patient tertiary constituency. The report set out the drafting of these revisions for approval by the Trust Board of Directors. The Board considered the proposal, having due regard to the views of governors, and took into account various other factors currently at play in the local health economy, as well as potential future Constitutional changes related to the Health and Social Care Act 2012 and the Trust's strategic direction. The Board approved the revised Foundation Trust Constitution for adoption with immediate effect.	

There being no questions the Chairman drew this item to a close.

Renewing our Hospitals

12. Centralisation of Specialised Paediatrics Business Case Refresh

The Board received the Centralisation of Specialised Paediatrics Business Case Refresh for approval.

The purpose of the paper was to present the income and expenditure refresh of the Full Business Case for specialist paediatrics following significant revisions to the income planning assumptions originally incorporated and approved by the Board in February 2011.

The Board considered the refreshed full business case noting the revised planning parameters, consequent reassessment of required capacity and associated expenditure and noted its scrutiny by the Finance Committee who have confirmed their support of the approach and outcomes and approved the proposal.

There being no questions the Chairman drew this item to a close.

Information and Other

13. Any Other Business

The Chief Executive briefed the Board on the 'black escalation' status at the Bristol Royal Hospital for Children due to the pressures from winter respiratory disease. He advised that a number of children had been sent to neighbouring hospitals as a result.

John Steeds, who was in attendance asked for the opinion of the Board on the implications of planned cuts to the Social Services budget. The Chief Executive advised that the Trust was working closely to support new community capacity and to make existing processes as effective and efficient as possible. Additionally, the government was making £2.8 billion available in 2015/16 to support closer integration of the services.

Clive Hamilton asked for further information regarding the visit of the Care Quality Commission (CQC) to the Bristol Royal Hospital for Children. The Chief Executive explained that a complaint had been received by the CQC relating to cleanliness and tidiness at the hospital. The CQC had been unaware of the building work under way in the hospital, but would provide their inspection report and any recommendations in due course.

There being no further business the meeting closed at 13:00 **14. Next Meeting** 30 January 2014 at 10:30 in the Conference Room, Trust Headquarters, Marlborough Street, Bristol BS1 3NU.	

Action by	ID	Meeting Date	Public / Private	Minute number & title	Description (minute)	Action to be Taken	Date to Report Back
Chief Executive	221	28/11/2013	Public	10. Partnership Programme Board	The feasibility of options for further integrationof histopathology services, including, location and phasing timescales for physical integration were being discussed. Further information to be provided to the Board meeting in January 2014.	Further information to be provided to the Board meeting in January 2014.	30/01/2014
Chief Nurse	217	28/11/2013	Public	5. Quality & Performance Report	Lisa Gardner asked what checks had taken place regarding the dispensing of drugs by Lloyds pharmacy to match the Bristol Royal Pharmacy prescribing policy. Helen Morgan to ascertain from Steve Brown Head of Pharmacy.	Helen Morgan to ascertain from Steve Brown Head of Pharmacy.	30/01/2014
Chief Nurse	218	28/11/2013	Public	6. National Cancer Survey & Action Plan	Wendy Gregory stressed the importance of Cancer Nurse Specialists and asked for reassurance that the lack of a nurse specialist for Melanoma would be addressed. Ruth Hendy advised that a strategy was being discussed by divisions for cross-working as people progressed on their pathways and would form part of divisional operating plan.	Emma Woollett suggested an update to the Board be provided after six months.	30/05/2014
Chief Nurse	220	28/11/2013	Public	8.0Quarterly Patient Experience Report	Julian Dennis asked if patient questionnaires contained weighted questions. Helen Morgan said that there were a number of quantified core questions but would check with Paul Lewis, Patient Experience Lead (Surveys and Evaluation), if questions were weighted.	Helen Morgan to ascertain. 23/01/14 The scoring approach used for the UH Bristol monthly survey, models the approach taken by the Care Quality Commission in their national patient survey programme. To calculate the score for a survey question, a weighting is taken across all of the response options. For example, where a three-point scale is used, weightings of 1, 0.5, and 0 will be applied from the "best" to "worst" response options respectively. There is no weighting between questions (e.g. to assign more importance to some questions than to others).	30/01/2014
Chief Operating Officer	215	28/11/2013	Public	4. Chief Executive's Report	John Steeds, who was in attendance, asked James Rimmer at what stage the Wayfaring Signage project was. He was advised that staff and patient feedback had been received and the basic principles had been decided with further work yet to take place with the design consultants to define the zoning of the core campus. It was the intention to have the new signage in place from May 2014 onwards to coincide with the opening of the new ward block. James Rimmer said he was happy to share with Governors information on where the project had got to.	James Rimmer to share with Governors information on where the project had got to.	30/01/2014
Director of Strategic Development	200	26/09/2013	Public	10. Research & Innovation Strategy Report	Concerns were expressed that the Research & Innovation metrics in the dashboard were inconsistent with the metrics in the first more detailed report. DL advised that relative performance was different for absolute patients recruited versus the weighted recruitment but she agreed to review and ensure all reports were aligned.	All research metrics in Board performance reports to be reviewed to ensure they are aligned. 31/10/13 XW advised work in train to bring RND matrix in line. Nationally reported position against 70 day recruitment to be investigated. Fully monitored report to next meeting.	28/11/2013
Director of Strategic Development	216	28/11/2013	Public	4. Chief Executive's Report	Lisa Gardner asked when the Welcome Centre was due to open and Deborah Lee advised 16 December with a formal opening ceremony after Christmas. She concluded that there was a programme of formal orientation and would make sure the Non-executives and Governors had the opportunity to attend.	Include Governors and Non-executives into programme of formal orientation	30/01/2014
Director of Workforce and Organisational Development	158	27/06/2013	Public	3 - Actions from Previous Meetings	Emma Woollett referred to Item 7 of the minutes of 31 May 2013 (National Staff Survey Results: Page 12 of the Board pack), regarding the Trust's performance in relation to previous years and engagement with nursing staff. She requested that the Board was kept informed about this work.	To keep the Board informed about the Trust's work on engagement with nursing staff. Update 26/9 H Morgan advised paper being worked on currently and will be available at the end of the year 15/1/14 Meeting to be held 15/1/14 with Sue Donaldson regarding engagement. Future Board date to follow.	27/02/2014
Director of Workforce and Organisational Development	161	27/06/2013	Public	5d - Quality and Performance Report - Board Review	John Moore referred to the Workforce report, requesting a greater understanding of the process by which the Trust planned its staff numbers. He particularly wanted to know how the Trust reconciled its increase in Bank and Agency spend with the focus on providing cost savings and high quality care. Claire Buchanan confirmed that she would provide a detailed summary of workforce planning as part of a future Board Seminar on the topic.	Detailed summary of workforce planning to be provided at May 2014 Board Seminar.	30/05/2014
Director of Workforce and Organisational Development	202	26/09/2013	Public	9. Teaching & Learning Strategy Update Review	5 year strategy - review and refresh strategy to ensure it is still in line and up to date.	To be brought back to the board in December 14/1/14 To be brought to the Board in April 2014 to align to the ten strategic priorities within the existing strategy and aligning this to the work with David Relph on the Clinical strategy	30/04/2014
Medical Director	219	28/11/2013	Public	7.0Francis Report Trust Response	The outcome of this process was the emergence of a number of themes where the Trust might expect some benefit from further developmental work. These included addressing perceived variation in attitudes to openness and sharing across the Trust, listening and learning more effectively throughout the Trust and making the process of change easier and more usual within the Trust.	The Chairman requested an update at future Board meetings.	28/02/2014

University Hospitals Bristol NHS
NHS Foundation Trust

Cover Sheet for a Report for the Public Trust Board Meeting to be held on 30 January 2014 at 10:30 in the Conference Room, Trust Headquarters, Marlborough Street, Bristol, BS1 3NU

Item 04 – Chief Executive's Report
Purpose
To report to the Board on matters of topical importance to the Trust, including a report of the activities of the Senior Leadership Team.
Abstract
The Board will receive a verbal report of matters of topical importance to the Trust, in addition to the attached report summarising the key business issues considered by the Senior Leadership Team in the month.
Recommendations
The Trust Board is recommended to note the key issues addressed by the Senior Leadership Team in the month and to seek further information and assurance as appropriate about those items not covered elsewhere on the Board agenda.
Report Sponsor
Robert Woolley, Chief Executive
Appendices
List your appendices, including your Report in the following format: • Appendix A –Senior Leadership Team Report

APPENDIX A

TRUST MANAGEMENT EXECUTIVE

REPORT TO TRUST BOARD – JANUARY 2014

1. INTRODUCTION

This report summarises the key business issues addressed by the Senior Leadership Team in December 2013 and January 2014.

The group **agreed** outcomes and actions from the Trust Management Away Day held on 27 November 2013 about its purpose, deliverables, desired behaviours and support requirements. The group **agreed** it be renamed to the Senior Leadership Team with immediate effect.

2. COMMUNICATIONS

The Senior Leadership Team **noted** the monthly reports on the activities of the Communications Department.

3. QUALITY, PERFORMANCE AND COMPLIANCE

The group noted the draft Quarter 3 2013/2014 position in respect of performance against Monitor's Compliance Framework. The Clostridium Difficile trajectory, 4-hour emergency target and Referral to Treatment Non-Admitted standard had not been achieved. The 62-day GP/Screening cancer standard was still to be reported but it was hoped to be achieved with appropriate breach re-allocations. The Quarter 3 end position for the 4-hour emergency target had been 93.7%. It had been a challenging period, in particular the Women's and Children's emergency department which had experienced a number of episodes in black escalation. Detailed reports in respect of the referral to treatment non-admitted waiting times and recovery plans to address the position had been received.

The group received the Monitor Quarter 3 Declaration of Governance Compliance 2013/2014 and **approved** the recommendation to the Trust Board to declare the standards failed to be clostridium difficile, the Referral to Treatment Non-Admitted standard and the Accident and Emergency 4-hour standard. In addition, the likely Quarter 4 failure of clostridium difficile and Referral to Treatment Non-Admitted standards for a further quarter are to be flagged to Monitor as part of the narrative that accompanied the declaration, along with the ongoing risks to achievement of the 4-hour standard and 62-day GP cancer standard.

The group received a compliance report on essential training and **approved** recommended actions to address the position.

The group received and **approved** a report detailing UH Bristol's response to the recommendations about NHS complaints management contained in the Francis Report, the Clwyd Report and the Parliamentary and Health Service Ombudsman's Report and recommended actions, for onward submission to the Trust Board.

The group received and **approved** a report summarising key findings for UH Bristol from the 2013 National Survey Maternity results and an action plan, for onward submission to the Trust Board.

4. STRATEGY AND BUSINESS PLANNING

The group received and **supported,** in principle, a proposal to stop all non-specialised, elective activity for Welsh Local Health Boards (with whom the Trust does not have a contract) for implementation from 1 April 2014, in the light of continuing payment issues.

The group **noted** updates on the business planning round 2014-2016 and development of Divisional and Trust Operating Plans for that period. The main focus of the updates had been around the business planning milestones and the recently issued Monitor Guidance for the Annual Planning Review 2014/2015.

The group received and **approved** the Full Business Case refresh for the Bristol Royal Infirmary Redevelopment and confirmed its commitment to the Board to deliver a safe and viable scheme within the parameters set.

The group received and **approved** recommendations outlining the national changes to Agenda for Change terms and conditions in relation to pay progression and options for implementation.

In the light of a detailed review of its future prospects, the group received and **approved** a proposal to cease to run the Trust Playscheme and signpost local playscheme providers, who could provide equal, if not better, services at comparable rates.

The group **approved,** in principle, the recommendation that the Trust support the transfer of the Homoeopathy service to social enterprise status, subject to the conclusion of necessary due diligence and other formal requirements.

5. RISK, FINANCE AND GOVERNANCE

The group received and **approved** revised policies for Single Sex Accommodation, Information Governance and Confidential Data Sharing.

The group received and **approved** terms of reference for Divisional Risk Management Groups.

The group received and **approved** the Board Assurance Framework Quarter 3 update report, for onward submission to the Trust Board.

The group received and approved the Corporate Risk Register, for onward submission to the Trust Board.

The group received and **supported** the recommendations from two Internal Audit reports around sickness and annual leave reporting and emergency planning and business continuity.

Reports from subsidiary management groups were **noted**, which included the following:

- an update on the wayfinding and signage project

- an update on work to revise the Major Incident Plan and **support** for the request for a one year extension so that the plan could be updated in line with the changes coming into place over the next 12 months
- an update on the centralisation of specialist paediatrics and Bristol Royal Infirmary projects
- an update on the work of the Transforming Care programme

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

6. RECOMMENDATIONS

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

Robert Woolley
Chief Executive
January 2014

University Hospitals Bristol NHS
NHS Foundation Trust

Patient story for November Patient Experience Group

Division of Medicine

Mrs A's story

This story relates to the experience of a patient, Mrs A, who died whilst in our care earlier this year. The Trust received a complaint from Miss A, the patient's daughter.

Mrs A was known to have ovarian cancer following diagnosis in 2009 and had previously experienced excellent care under the gynae-oncology team at St Michael's Hospital: Miss A was very complimentary about the care and professionalism her mother had received at that time. In 2013, Mrs A was admitted to the Bristol Royal Infirmary Emergency Department by ambulance following a collapse at home which had required the Emergency Services to break into her home to rescue her. She arrived in the Emergency Department during an intensely busy period and was nursed in the queue for a period of time. Miss A was upset to see her distressed frail, elderly mother, clearly in the end stages of her life, being cared for on a trolley in the corridor outside of the Emergency Department. A trainee paramedic had attempted to take blood in the corridor: Miss A had asked the paramedic to stop as it was adding to her mother's pain and distress. Mrs A was in the queue for approximately 30 minutes until a cubicle became available for her.

Miss A was complimentary about the attentiveness of Emergency Department staff: she realised that her mother was deteriorating, but could see that she was being kept comfortable. Later the same evening, Mrs A was admitted directly to a ward bed in the Old Building of the Bristol Royal Infirmary. This bed was in the middle of the ward. Miss A expressed her concerns that no cubicle was available: the nurses pulled the curtains around her mother's bed but Miss A was distressed at the lack of privacy and dignity this afforded. Miss A felt that the nursing staff were polite but 'distant'. Following a discussion with the doctor, Miss A was encouraged to go home and rest, but she found this difficult as she was worried about the care that her mother would receive.

Miss A was contacted by the ward the next morning at 6.30am to say her mother had passed away. She came into the ward to find her mother's bed still in the middle of the ward, with the curtains closed. Miss A is an NHS employee and understood the pressures the hospital was facing, but she was angry because end of life care had been given a low priority: she felt that there had been a systematic failure to provide dignity to a dying patient and her family.

Context

- The Trust was in red escalation on the morning of the day when Mrs A was admitted. The Trust moved to black escalation at 5pm due to predicted bed requirements far exceeding availability.
- Up to six trolleys were queuing outside the Emergency Department at any one time.
- Additional capacity beds were already opened and in use.

Good practice

- Mrs A's care was not delayed once she was in an Emergency Department cubicle; and when an inpatient bed became available, it was utilised for a direct admission rather than via the Medical Assessment Unit. This prevented an additional bed move for Mrs A.

Concerns

- Mrs A's story highlights the need to ensure that end of life care is a priority for all staff regardless of capacity issues. Nursing staff need to act with compassion in all circumstances.
- It was unclear whether staff had spent any time with the family to welcome them and provide the personal touches that may have given the family the assurances they needed before they left, or have supported them if they wanted to remain in the hospital overnight.

Actions and shared learning

- This patient story has been shared at the End of Life Steering Group, the divisional band 7 meeting, the divisional governance meeting and with the Clinical Site Management Team.
- The Head of Midwifery has also agreed to present it at the Trust Privacy and Dignity Group to share learning.
- The contact details of the Palliative Care Team will be recirculated to staff to ensure they are aware that the team can be accessed for advice and that this is available 24 hours a day
- Staff on the ward will attend additional end of life training by the palliative care team.
- The Clinical Site Team is currently engaged in a project to support and develop awareness of its role in patient safety and patient flow issues. This work will be extended to ensure the team is fully conversant with the divisional quality agenda. The Division of Medicine will also work with the Clinical Site Team to ensure that the needs of any patients under the care of the Division of Medicine who may also receive care from other divisions are recognised and that adjustments to the delivery of the service are made as appropriate.
- The new expanded Elderly Assessment Unit will be opened on 20th January 2014. The team managing the Unit will be asked to consider how end of life care is modelled in it specifically to prevent inappropriate transfers during a patients care pathway.

Carole Tookey
Head of Nursing Division of Medicine

University Hospitals Bristol NHS
NHS Foundation Trust

Report for a Public Meeting of the Trust Board of Directors to be held on 30 January 2014 at 10.30 in the Conference Room, Trust Headquarters, Marlborough Street, Bristol, BS1 3NU

Item 5 – Quality and Performance Report

To **review** the Trust's performance on Quality, Workforce and Access standards.

Abstract

The monthly Quality & Performance Report details the Trust's current performance on national frameworks, and a range of associated Quality, Workforce and Access standards. Exception reports are provided to highlight areas for further attention and actions that are being taken to restore performance.

The report has previously been considered by the Board's Quality and Outcomes Committee.

Recommendations

The Board is recommended to **review** the current performance of the Trust and to ratify the actions being taken to improve performance.

Executive Report Sponsor or Other Author

'Health of the Organisation' – Deborah Lee (Director of Strategic Development)

'**Quality**' – Carolyn Mills (Chief Nurse) & Sean O'Kelly (Medical Director)

'**Workforce**' – Sue Donaldson (Director of Workforce & Organisational Development)

'**Access**' – James Rimmer (Chief Operating Officer)

Authors:

Xanthe Whittaker (Head of Performance Assurance / Deputy Director of Strategic Development)

Anne Reader (Head of Quality (Patient Safety))

Heather Toyne (Assistant Director of Workforce Planning)

Previous Meetings

Date the paper was presented to the relevant Group or Committee:

Executive Team	Trust Management Executive	Quality and Outcomes Committee	Finance Committee	Audit Committee	Other
		20 December 2013			

University Hospitals Bristol NHS
NHS Foundation Trust

SUMMARY QUALITY & PERFORMANCE REPORT

January 2014

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CONTENTS

SECTION A – Performance Overview

Summary

There has been a deterioration in the overall 'health' of the organisation, with an increase in RED rated indicators by three and a decrease in GREEN rated indicators by one. This follows five consecutive months of prior improvement. The net changes in indicators include the A&E 4-hour standard moving from a GREEN to a RED rating in the month. Despite achievement of the national standard in both October and November, the failure to achieve the 95% standard in December resulted in this indicator being failed for the quarter as a whole. This was primarily due to exceptional levels of emergency admissions into the Bristol Children's Hospitals (39% above the same period last year) following a local peak in respiratory illness that mirrored the national picture. However, this is in the context of strong performance against patient experience, clinical effectiveness and quality of care indicators, with all seven measures now being GREEN rated, with no grade 3 or 4 pressure score being reported in the month and the remaining indicators retaining their GREEN rating from last month.

The three measures of the Trust's efficiency are currently RED rated. However, the Length of Stay of patients discharged in the month actually decreased by 0.19 days relative to the previous month, but was RED rated due to Length of Stay being above the target for quarter-end. The Outpatient Appointment Hospital Cancellation Rate increased in the period, although this was expected due to the actions being taken to bring-forward patients' appointments to support achievement of the Referral to Treatment Time (RTT) Non-Admitted standard. The reasons behind the deterioration in Theatre Efficiency are not well understood and are thought to reflect a recording issue in December, which is being investigated. Both indicators of the Trust's Research activities have retained their GREEN rating for a further month. Improvements have also been seen in Appraisal compliance rates, with the other Workforce indicator, sickness rates, remaining within the AMBER tolerance.

Three of the four measures of financial performance have retained their GREEN rating, with the remaining indicator, Cash Releasing Efficiency Savings (CRES), moving to a RED rating for the month, but with a forecast for the year of 80.7% (AMBER). The forecast for CQUINS and Contract Penalties continues to be GREEN rated; further refinements to these forecasts will be made on an ongoing basis.

The Trust has a draft score of 3.0 for quarter 3 against Monitor's Risk Assessment Framework which was introduced on the October 1st 2013. This score reflects the failure to achieve the Referral to Treatment Time (RTT) Non-admitted standard, as forecast following the Head & Neck service transfer from North Bristol Trust, the failure to recover the *Clostridium difficile* (C. diff) cumulative trajectory for the year to date, and the failure of the A&E 4-hour standard following the recent deterioration in performance. Although performance against the 62-day GP cancer standard is just below target for the quarter as a whole, breach reallocation for late referral by other providers is being pursued. Subject to these reallocations being agreed the Trust will be able to declare compliance with these standards under the rules set-out by Monitor in its Risk Assessment Framework. The failure to recover the C. diff trajectory during quarter 3 constitutes the third consecutive quarter failed, and for this reason it is expected Monitor will request further information in order to investigate the failure of this standard as a potential governance concern. However, Monitor has already

reflected their recognition of the challenge such a low number of cases now represents for this and other trusts in the same position. It is also expected Monitor will request further information on the reasons for the failure of the 95% 4-hour standard. With a score of 3.0 the Trust would otherwise be GREEN rated against this new framework.

SECTION B – Organisational Health Barometer

Providing a Good Patient Experience

ID	Indicator	Previous	Current	YTD	Thresholds	Change from previous	Notes
A01	Patient survey - Local Patient Experience Score	88	89	N/A	Green: >= 90 Red: < 88	↑	Current month is November 2013
A02	Patient Complaints as a Proportion of Activity	0.185%	0.199%	0.203%	Green: <0.21% Red: >0.25%	↑	
A03	Same Sex Accommodation Breaches (Number of Patients Affected)	0	0	0	Green: 0 Red> >0	→	

Delivering High Quality Care

ID	Indicator	Previous	Current	YTD	Thresholds	Change from previous	Notes
B01	Incidence of Hospital Acquired Pressure Sores (Grades 3 or 4)	1	0	11	Green: 0 Red: > 1	↓	No RAG rating for YTD.
B02	Number of Inpatient Falls Per 1,000 Beddays	5.42	5.59	5.66	Green < 5.6 Red: >= 5.6	↑	

Keeping People Safe

ID	Indicator	Previous	Current	YTD	Thresholds	Change from previous	Notes
C01	Number of Serious Incidents (SIs)	5	6	53		↑	
C02	Cumulative Number of C.Diff cases	30	34	34	Below Trajectory		

Being Accessible

ID	Indicator	Previous	Current	YTD	Thresholds	Change from previous	Notes
D01	18 Weeks Admitted Pathways	91.6%	92.1%	92.9%	Green: >=90% Red: <85%	↑	
D02	Number of Cancer Standards Failed	1	1	2	Green: 0 Red: >=2	→	Previous is Q1, Current and YTD are confirmed Q2.
D03	A&E 4 Hour Standard	95.4%	90.8%	94.4%	Green: >=95% Red: <95%	↓	

PERFORMANCE OVERVIEW

Being Effective

ID	Indicator	Previous	Current	YTD	Thresholds	Change from previous	Notes
E01	Summary Hospital Mortality Indicator (SHMI) - In Hospital Deaths	70.1	62.2	67.7	Green: <80 Red: >=90	↓	Previous is September 2013 and Current is October 2013.
E02	30 Day Emergency Readmissions	315	293	2295	Below 12/13 Readmission Rate	↓	Previous is October's discharges where there was an emergency Readmission within 30 days. Current is November's discharges.

Being Efficient

ID	Indicator	Previous	Current	YTD	Thresholds	Change from previous	Notes
F01	Overall Length of Stay (Spell)	4.32	4.13	4.31	Green: <= Quarterly target 3.9 Red: >= Quartrely target 3.9	↓	The target for 2013/14 for this overall indicator of Length of Stay has been derived from the Trust's bed model.
F03	Theatre Productivity - Percentage of Sessions Used	92.4%	86.9%	92.3%	Green: >= 90% Red: < 90%	↓	The theatre productivity data-set has been revised, to enable a more accurate capture of the number of expected theatre sessions run during the period.
F04	Outpatient appointment hopsital cancellation rate	10.8%	11.5%	10.9%	Green: <=6.0% Red: >=10.7%	↑	

Valuing Our Staff

ID	Indicator	Previous	Current	YTD	Thresholds	Change from previous	Notes
G01	Appraisal Compliance	87.3%	88.8%	N/A	Green: 85% and above Red: below 85%	↑	
G02	Staff Sickness	4.1%	4.3%	3.9%	Green: up to 0.2 % pts above target Red: >=0.5% pts above target	↑	

Promoting Research

ID	Indicator	Previous	Current	YTD	Thresholds	Change from previous	Notes
H02	Cumulative Weighted Recruitment	25,589	29,437	29,437	Green: Above 2012 Red: Below 2012		Current (and YTD) is rolling Calendar YTD position. Previous is Jan-Sep 2013 and Current is Jan-Oct 2013.
H03	Percentage of Studies Meeting the 70 Day Standard (Submission to Recruitment)	39.4%	42.9%	42.9%	Green: >=30% (Upper Quartile) Red: <27.7% (Median)	↑	Current is Q3 2012/13 – Q2 2013-14. Previous is Q2 2012/13 – Q1 2013/14. Updated Quarterly, so data is same as last month.

PERFORMANCE OVERVIEW

Governing Well

ID	Indicator	Previous	Current	YTD	Thresholds	Change from previous	Notes
J01	Monitor Governance Risk Rating	2	3	N/A	Green: < 1 Red: > = 4	↑	Previous shows the confirmed Q2 position. Current shows the forecast Q3 position.

Delivering Our Contracts

The Previous column represents Month 8 2013/14. Current (and YTD) represents Month 9 2013/14

ID	Indicator	Previous	Current	YTD	Thresholds	Change from previous	Notes
K01	Financial Performance Against CQUINs (£millions)	£8.42	£8.26	£8.26	> 50% Green < 50% Red	↓	YTD and Current is Potential year-end rewards based on best assessment of likely year end performance. Further refinements of this forecast continue to be made.
K02	Contract Penalties Incurred - Variance From Plan (£millions)	£0.03	-£0.39	-£0.39	Green: Below Plan Red: Above Plan	↑	Data is variance above (+) or below (-) plan, with a higher negative value representing better performance. YTD and Current is variance reported for December based on best known data where available taking funding provision into account. This includes Readmissions and Emergency Marginal Tariff Adjustment.

Managing Our Finance

ID	Indicator	Previous	Current	YTD	Thresholds	Change from previous	Notes
L01	Monitor Continuity of Service	3.5	3.5	3.5	Green: >=3.0 Red: <2.5	→	For financial measures except CRES, Current and YTD is Current Year To Date. For CRES there is a separate total for latest month and YTD. Previous is previous month's reported data.
L02	Liquidity	3.0	3.0	3.0	Green: >=3.0 Red: <2.5	→	
L03	Capital Service Capacity	4.0	4.0	4.0	Green: >=3.0 Red: <2.5	→	
L04	CRES Achievement	78%	74%	78%	Green: >=90% Red: < 75%	↓	

Notes

Unless otherwise stated, Previous is November 2013 and Current is December 2013

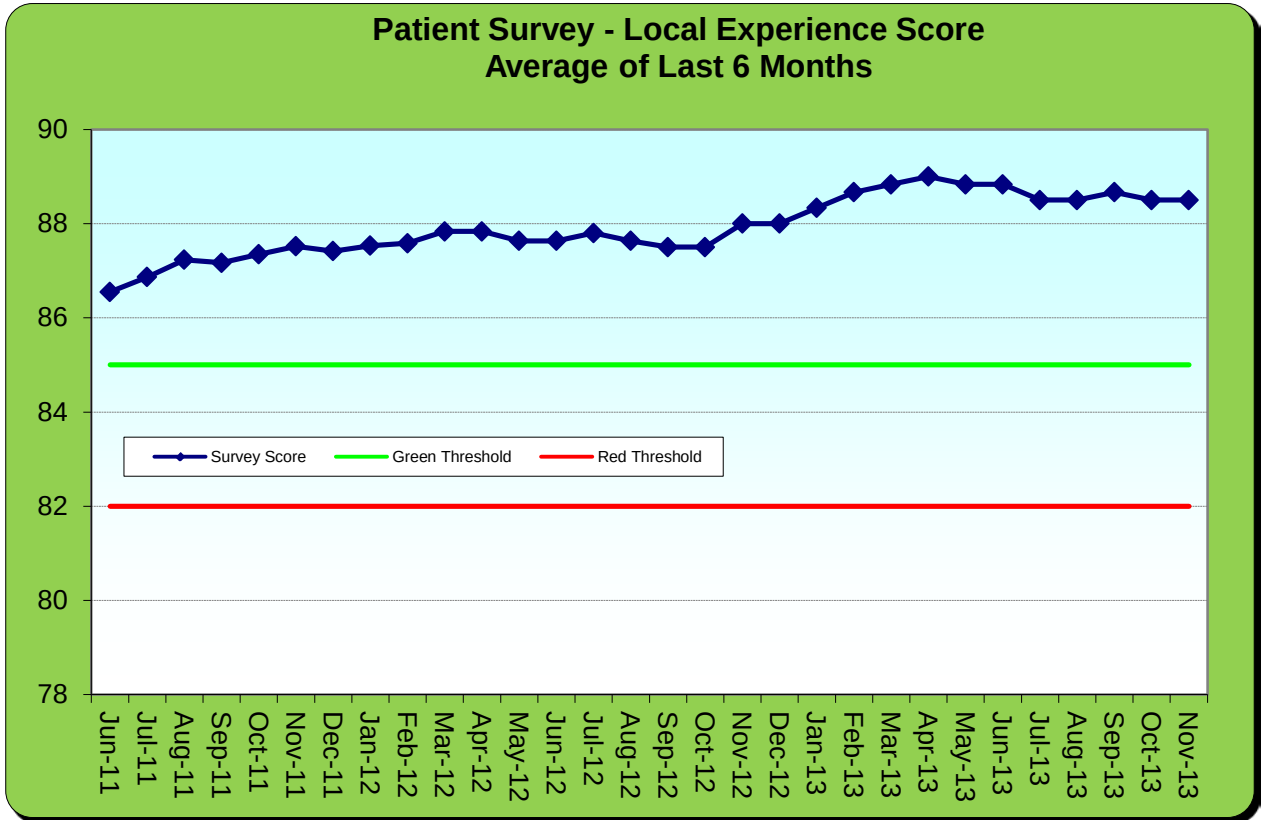
YTD (Year To Date) is the total cases/cumulative score for the year so far, from April 2012 up to and including the current month

RAG (Red/Amber/Green) rating only applied to YTD where an agreed target number of cases/score exists .

PERFORMANCE OVERVIEW

Organisational Health Barometer – exceptions summary table

Indicator in exception	Exception Report	Additional information
Cumulative number of C. diff cases	In the *Quality* section of this report	
A&E 4hour standard	In the *Access* section of this report	
Length of Stay	See *Additional Information*	There was a decrease in the Length of Stay of patients discharged in the month, from 4.32 in November to 4.13 in December. However, length of stay remains above plan. Analysis shows the reduction in length of stay was partly due to a lower proportion of long stay patients being discharged in the month, which is consistent with the observed increases in the number of long-stay patients being in hospital at month-end.
Theatre Productivity	See *Additional Information*	Further analysis of the reasons for the deterioration in utilisation rates are underway and will be reported on next month.
Outpatient appointment hospital cancellation rate	See *Additional Information*	As part of the recovery plan for the Referral To Treatment Time (RTT) Non-Admitted standard, patients' appointments are being cancelled and brought forward. The deterioration in performance against this indicator was therefore forecast.
Cash Releasing Efficiency Savings (CRES) achievement	See separate *Finance Report*	


Patient Survey - Local Experience Score
Average of Last 6 Months
90
88
86
84
82
80
78
Survey Score
Green Threshold
Red Threshold
Jun-11
Jul-11
Aug-11
Sep-11
Oct-11
Nov-11
Dec-11
Jan-12
Feb-12
Mar-12
Apr-12
May-12
Jun-12
Jul-12
Aug-12
Sep-12
Oct-12
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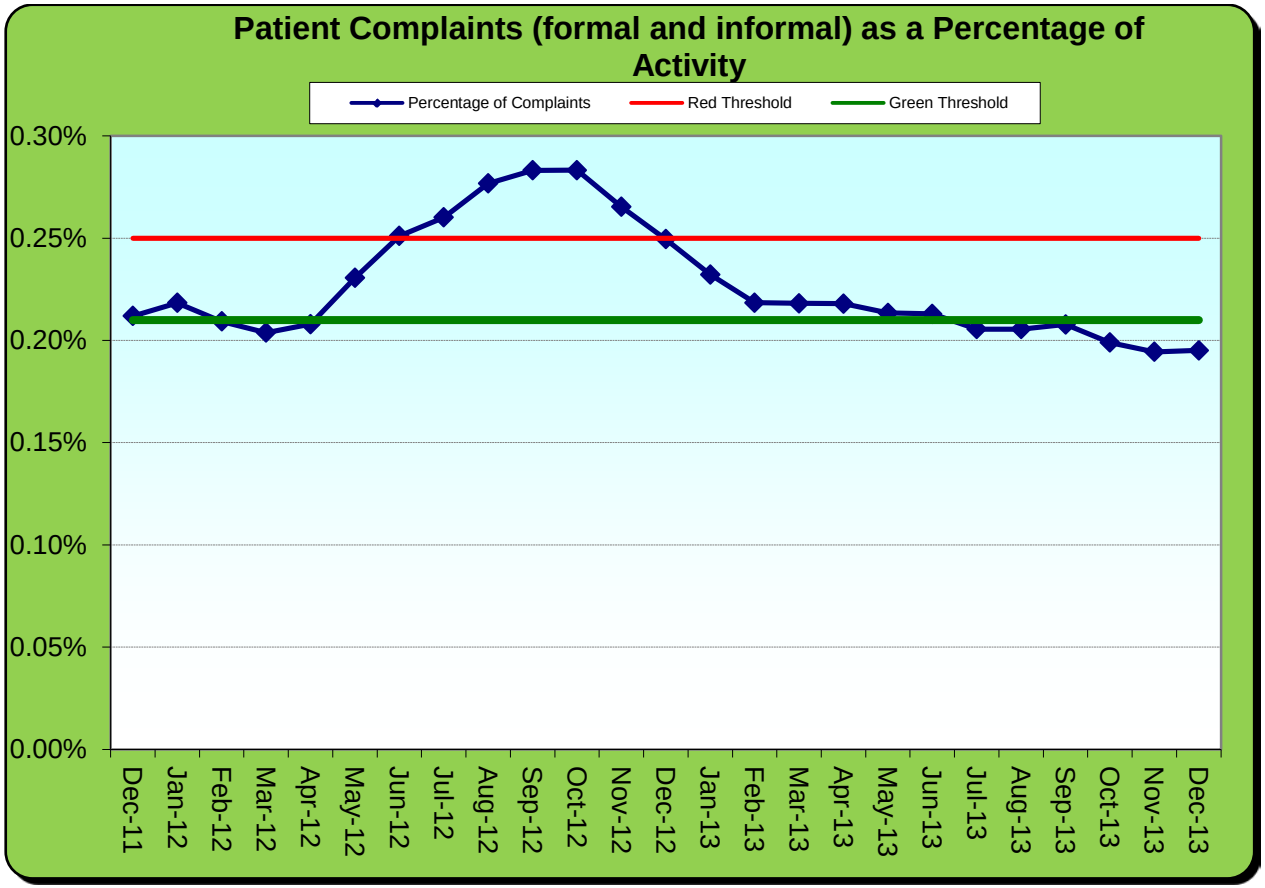
Oct-13
Nov-13


Patient Complaints (formal and informal) as a Percentage of Activity
Percentage of Complaints
Red Threshold
Green Threshold
0.30%
0.25%
0.20%
0.15%
0.10%
0.05%
0.00%
Dec-11
Jan-12
Feb-12
Mar-12
Apr-12
May-12
Jun-12
Jul-12
Aug-12
Sep-12
Oct-12
Nov-12
Dec-12
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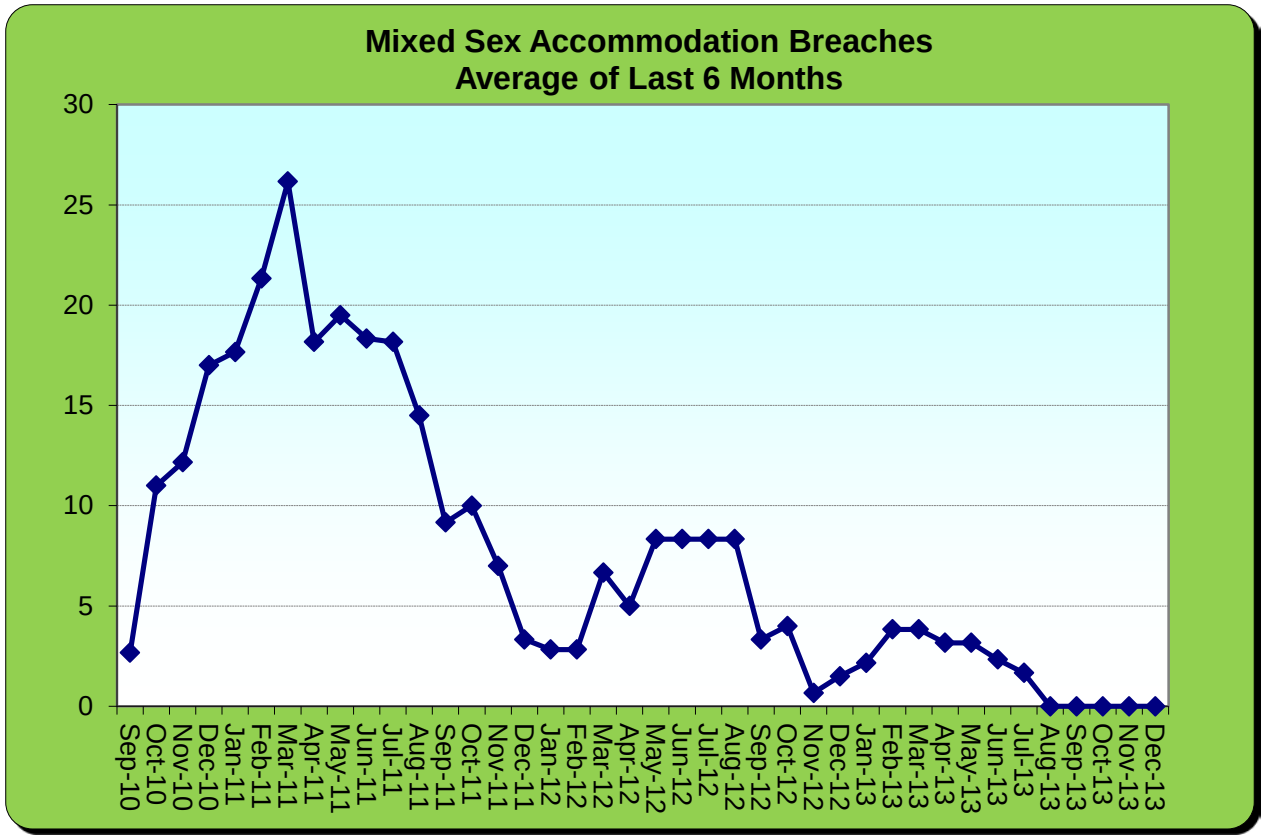
Oct-13
Nov-13
Dec-13


Mixed Sex Accommodation Breaches
Average of Last 6 Months
30
25
20
15
10
5
0
Sep-10
Oct-10
Nov-10
Dec-10
Jan-11
Feb-11
Mar-11
Apr-11
May-11
Jun-11
Jul-11
Aug-11
Sep-11
Oct-11
Nov-11
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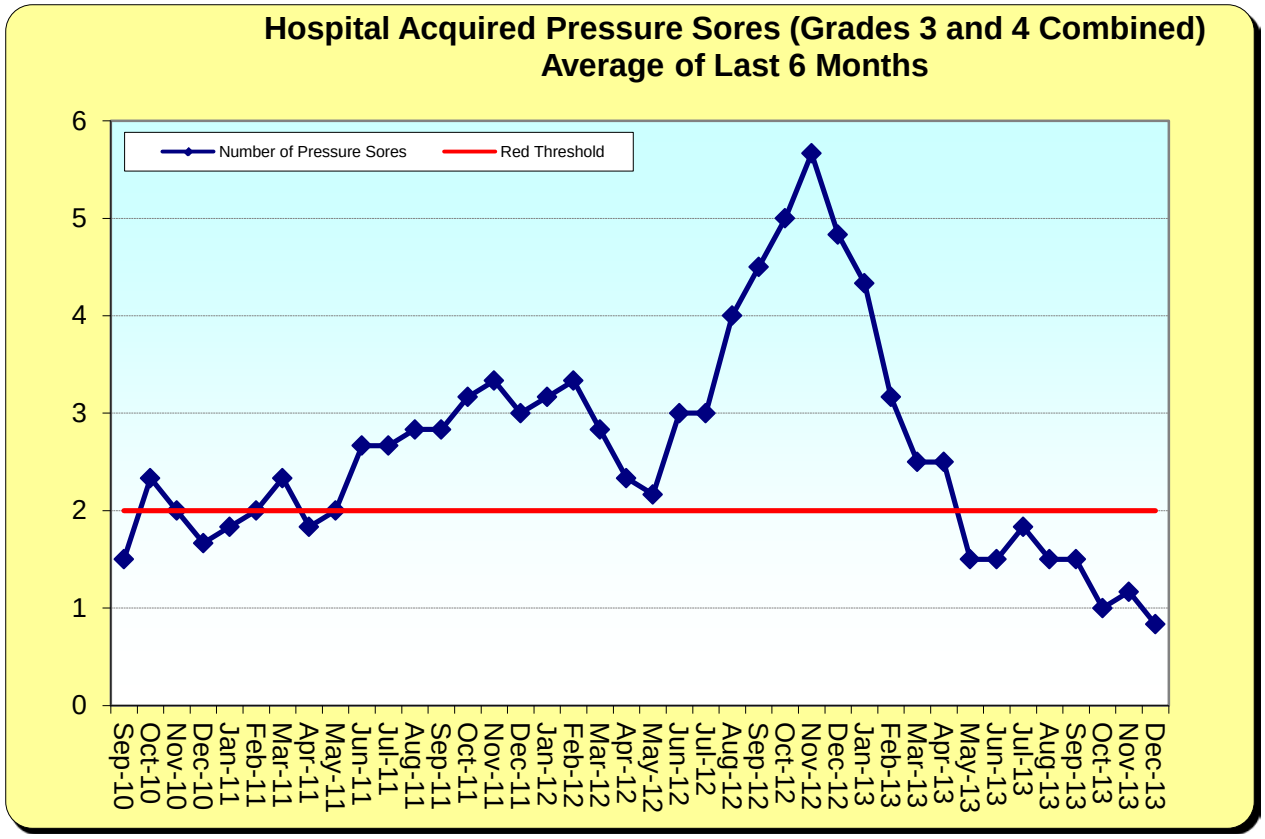
Hospital Acquired Pressure Sores (Grades 3 and 4 Combined)
Average of Last 6 Months
Number of Pressure Sores
Red Threshold
6
5
4
3
2
1
0
Sep-10
Oct-10
Nov-10
Dec-10
Jan-11
Feb-11
Mar-11
Apr-11
May-11
Jun-11
Jul-11
Aug-11
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Oct-11
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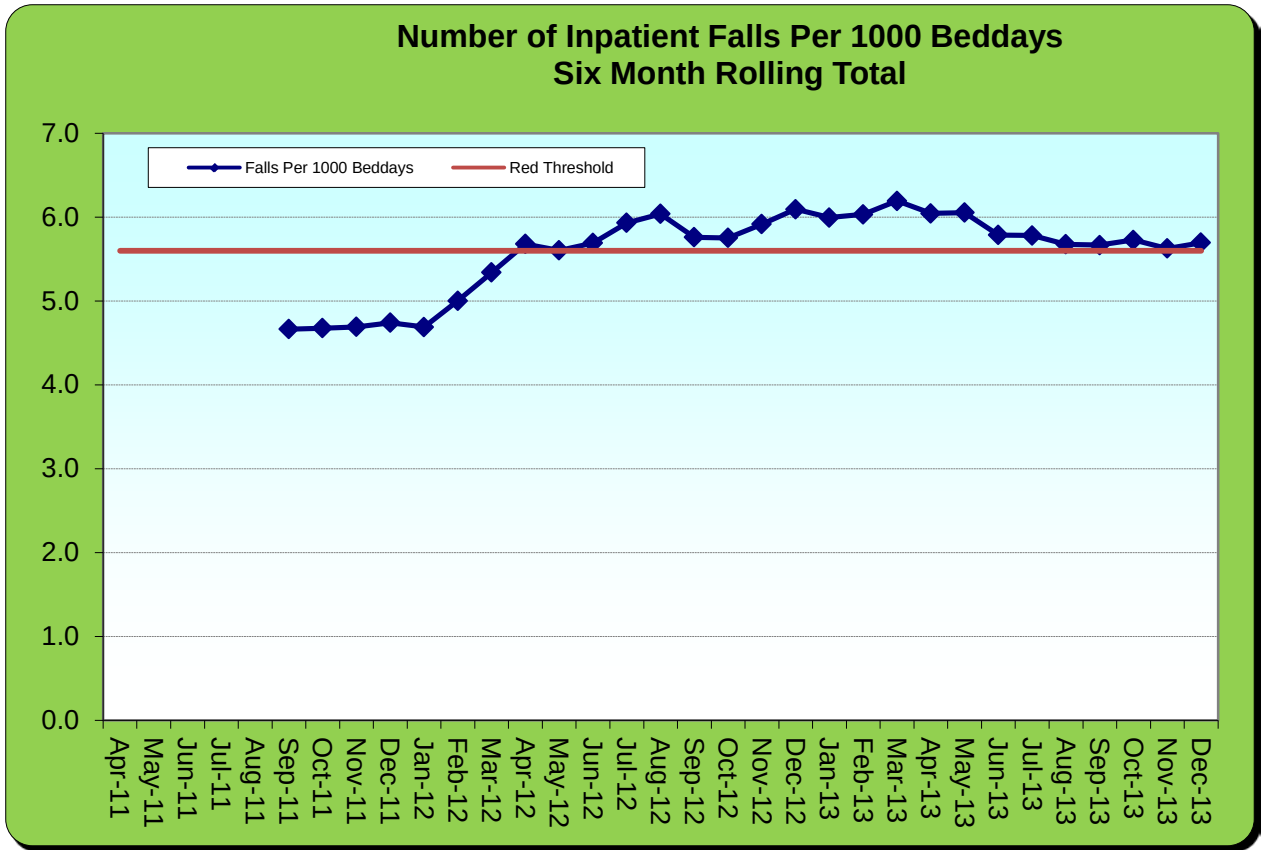
Number of Inpatient Falls Per 1000 Beddays
Six Month Rolling Total
Falls Per 1000 Beddays
Red Threshold
7.0
6.0
5.0
4.0
3.0
2.0
1.0
0.0
Apr-11
May-11
Jun-11
Jul-11
Aug-11
Sep-11
Oct-11
Nov-11
Dec-11
Jan-12
Feb-12
Mar-12
Apr-12
May-12
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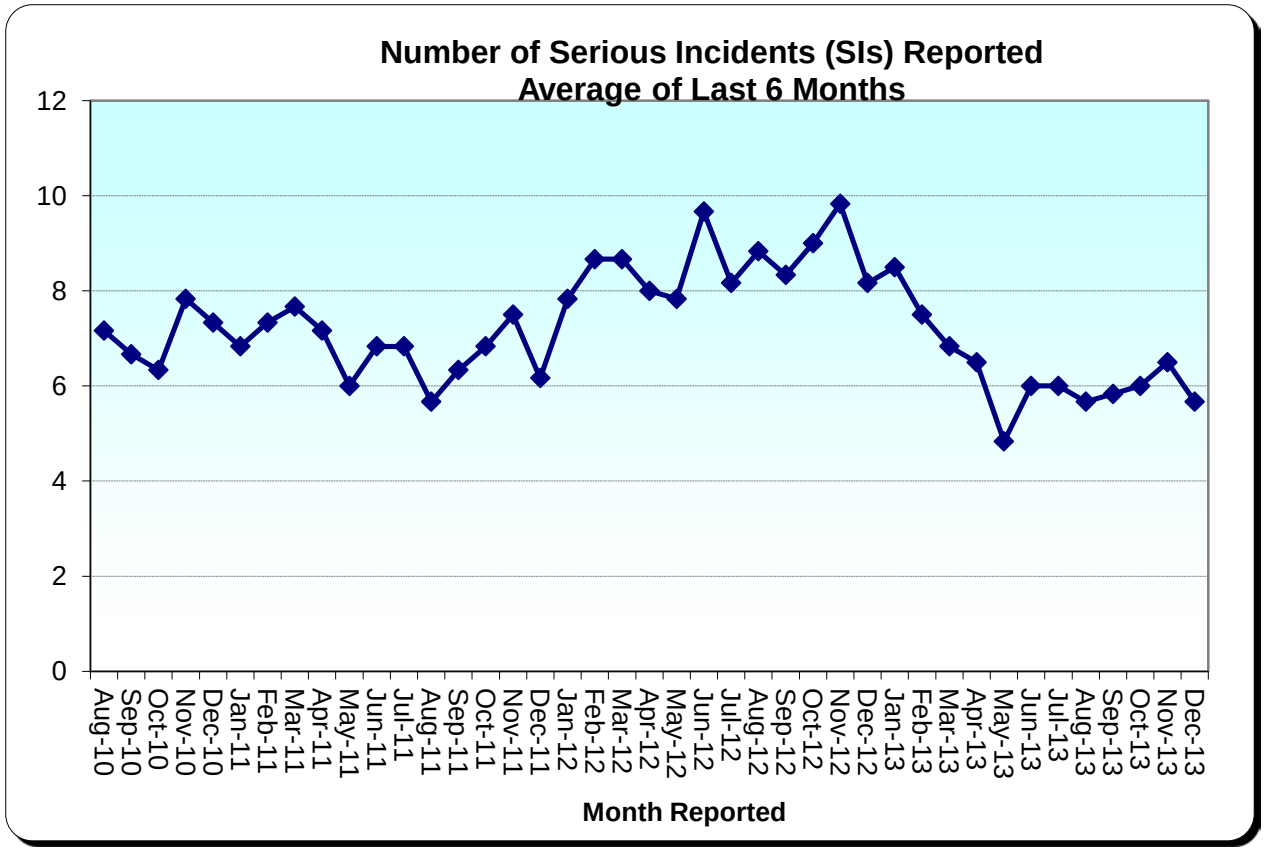
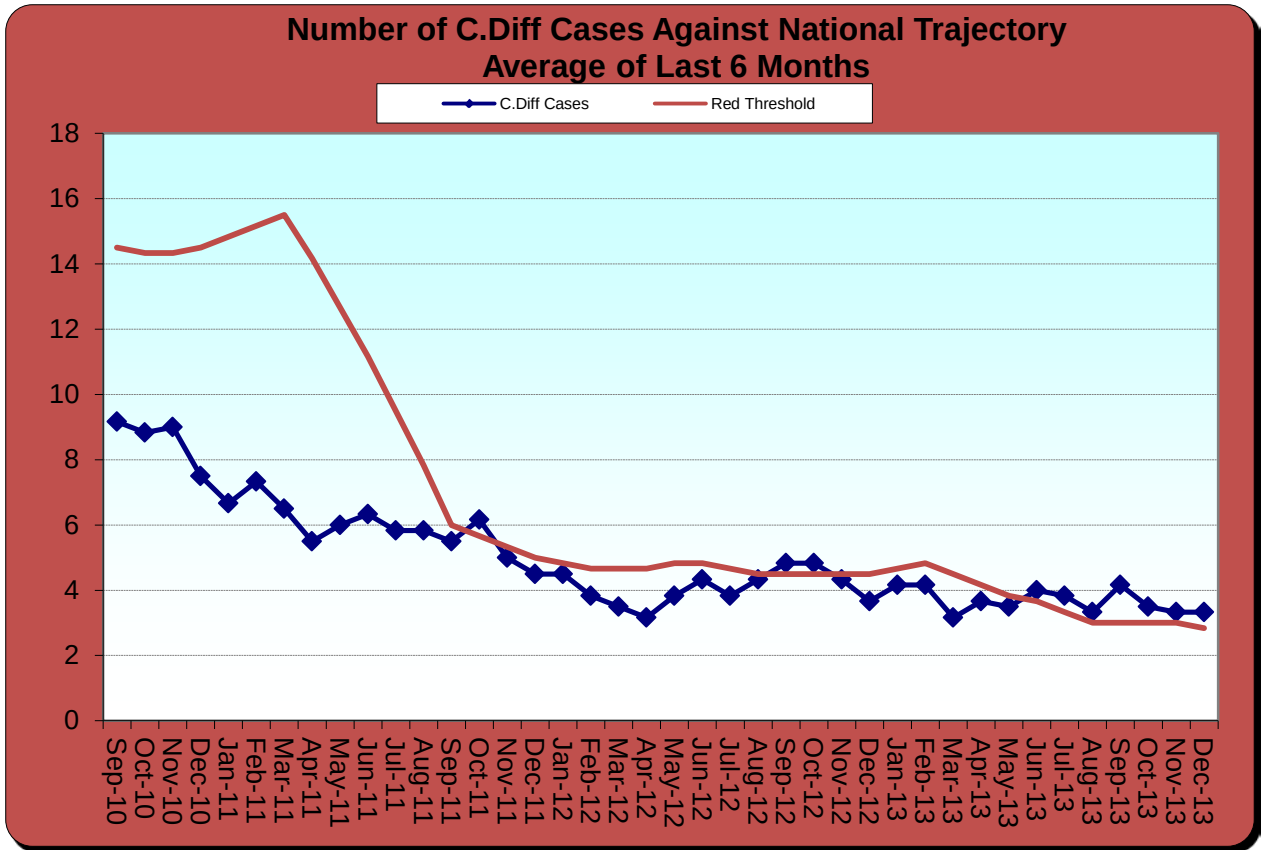
Dec-13

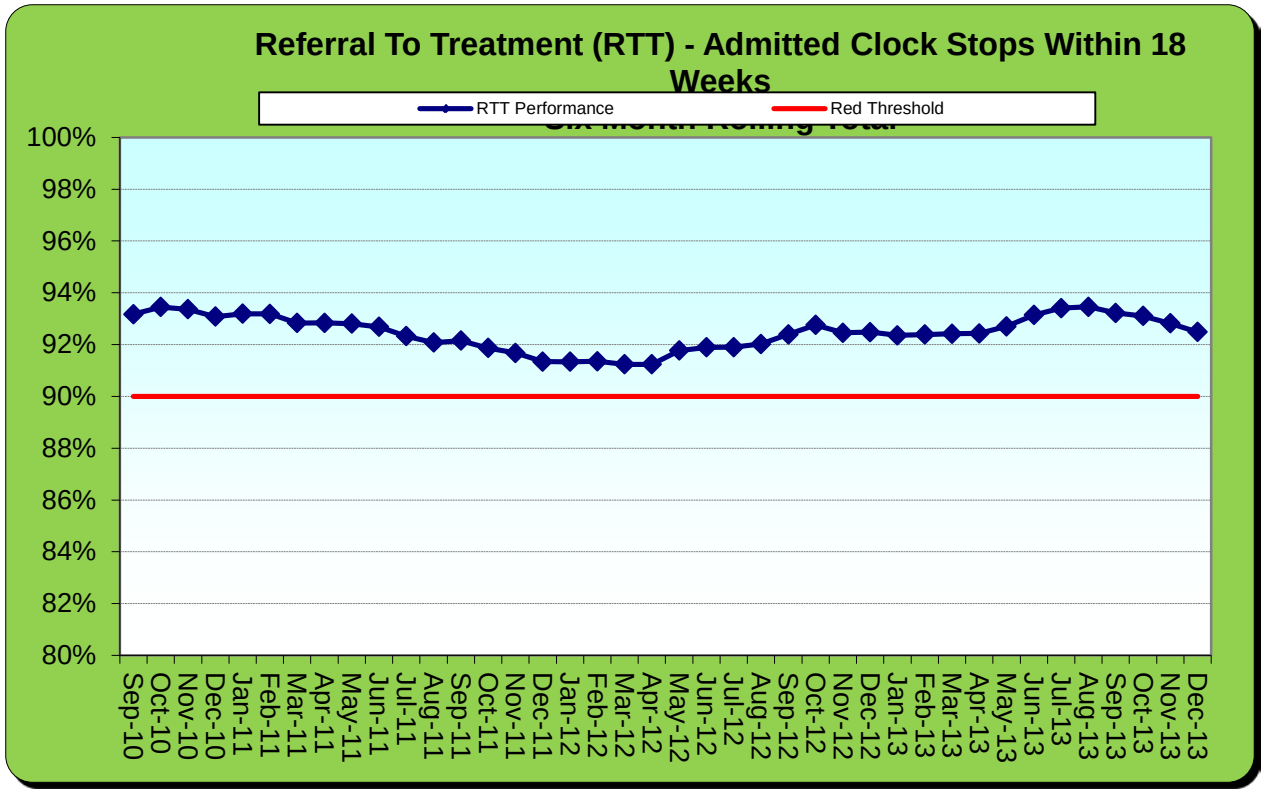
PERFORMANCE OVERVIEW



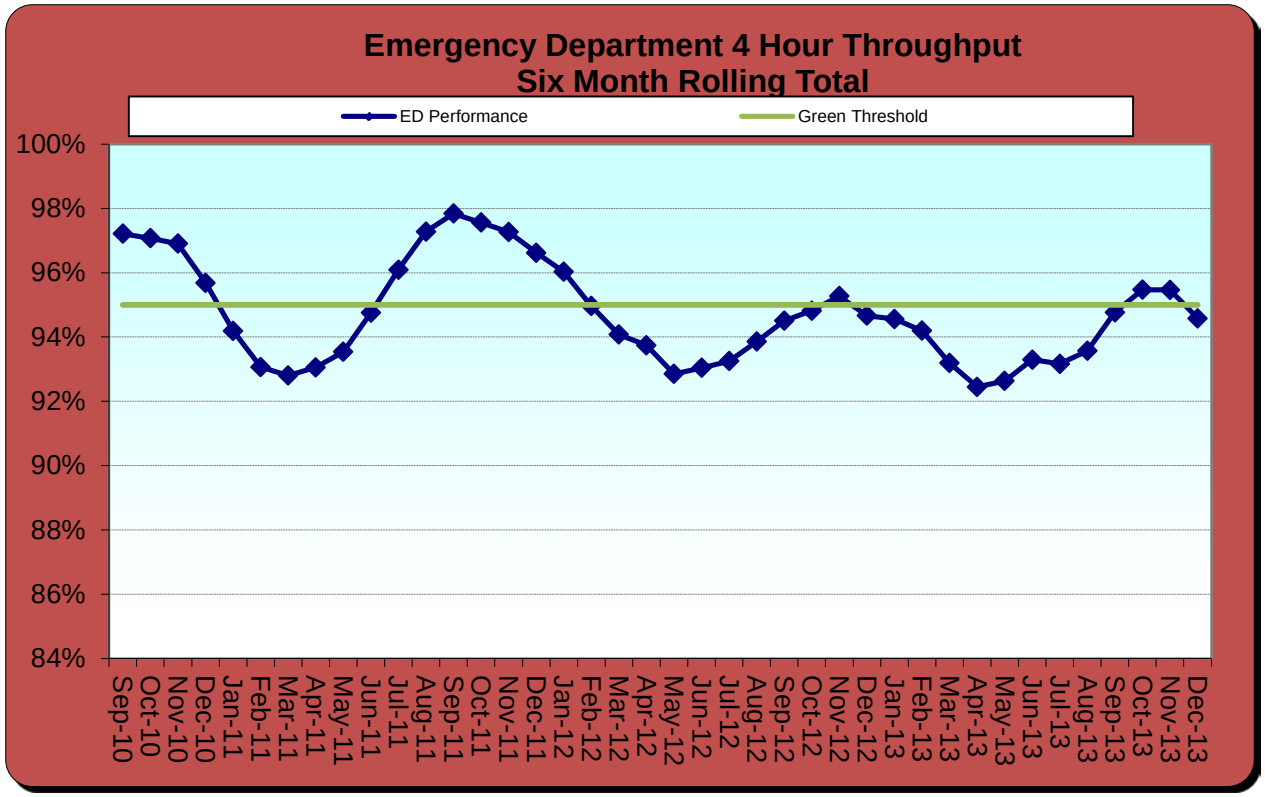
PERFORMANCE OVERVIEW

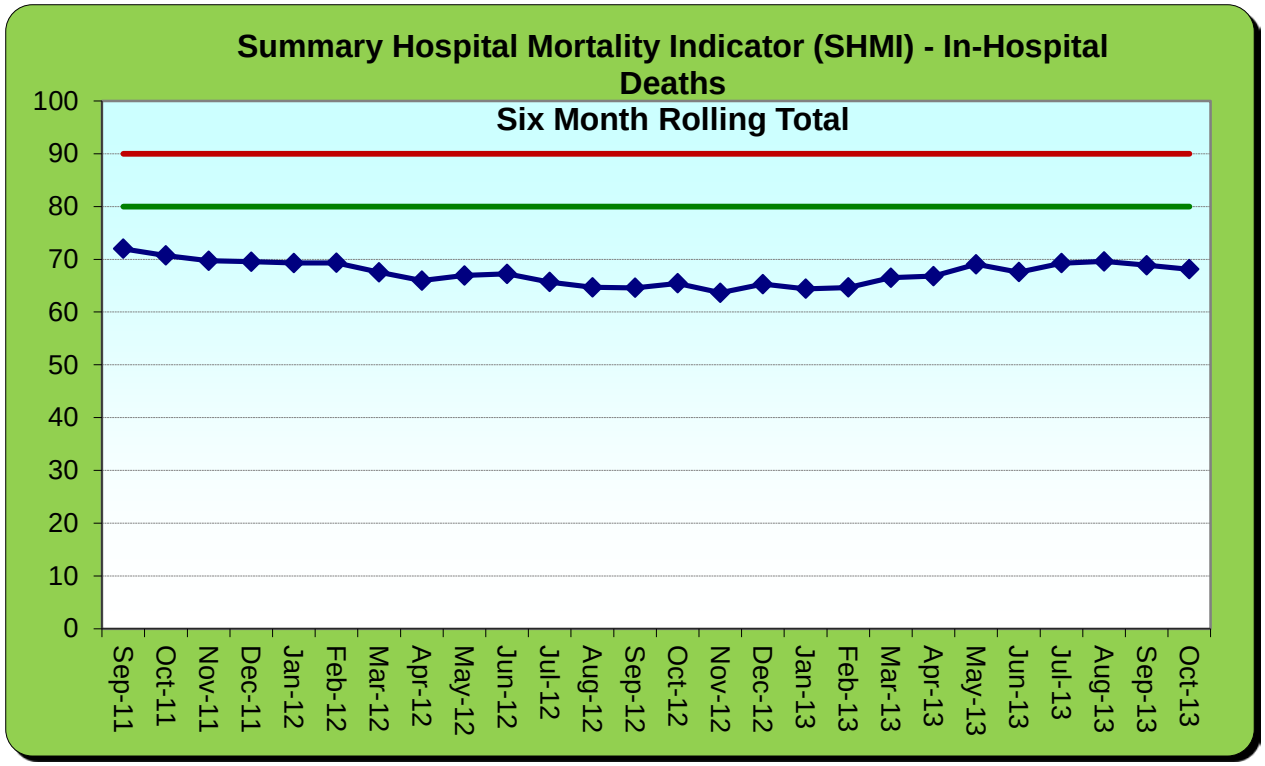


PERFORMANCE OVERVIEW



PERFORMANCE OVERVIEW




Summary Hospital Mortality Indicator (SHMI) - In-Hospital Deaths
Six Month Rolling Total
100
90
80
70
60
50
40
30
20
10
0
Sep-11
Oct-11
Nov-11
Dec-11
Jan-12
Feb-12
Mar-12
Apr-12
May-12
Jun-12
Jul-12
Aug-12
Sep-12
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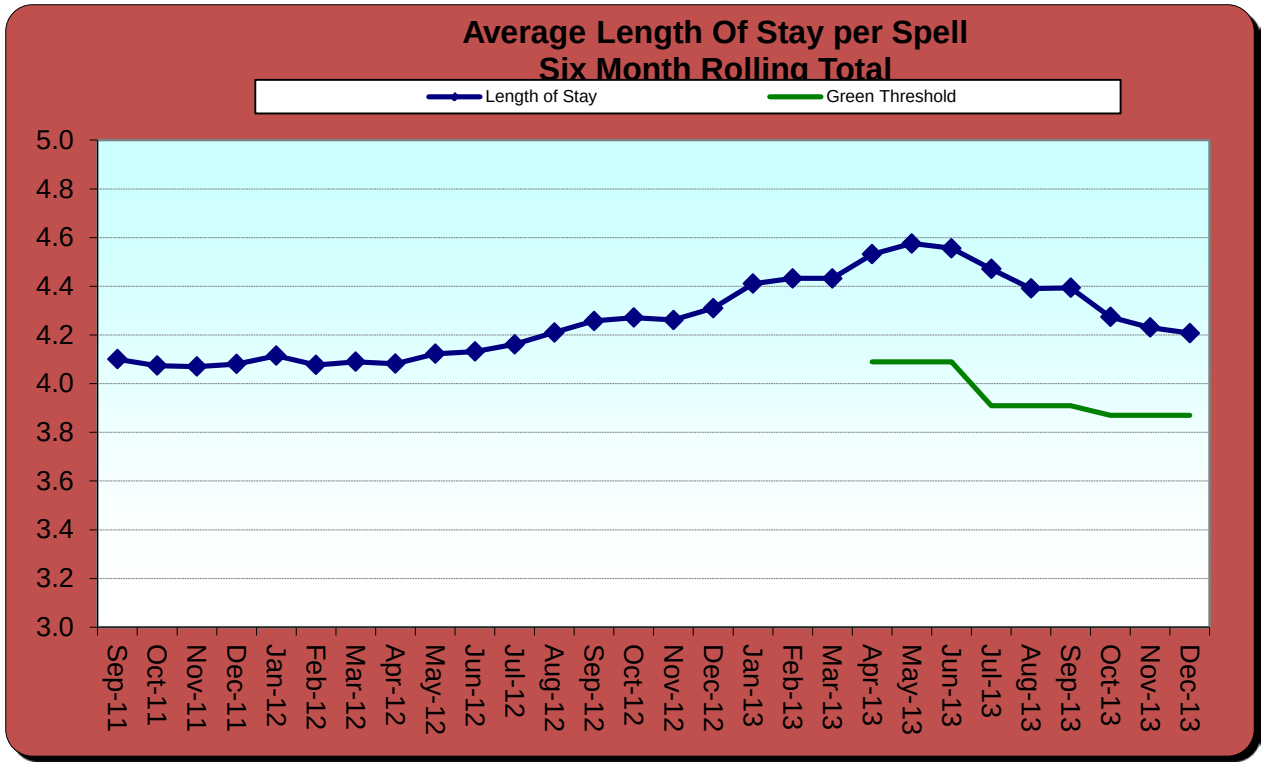
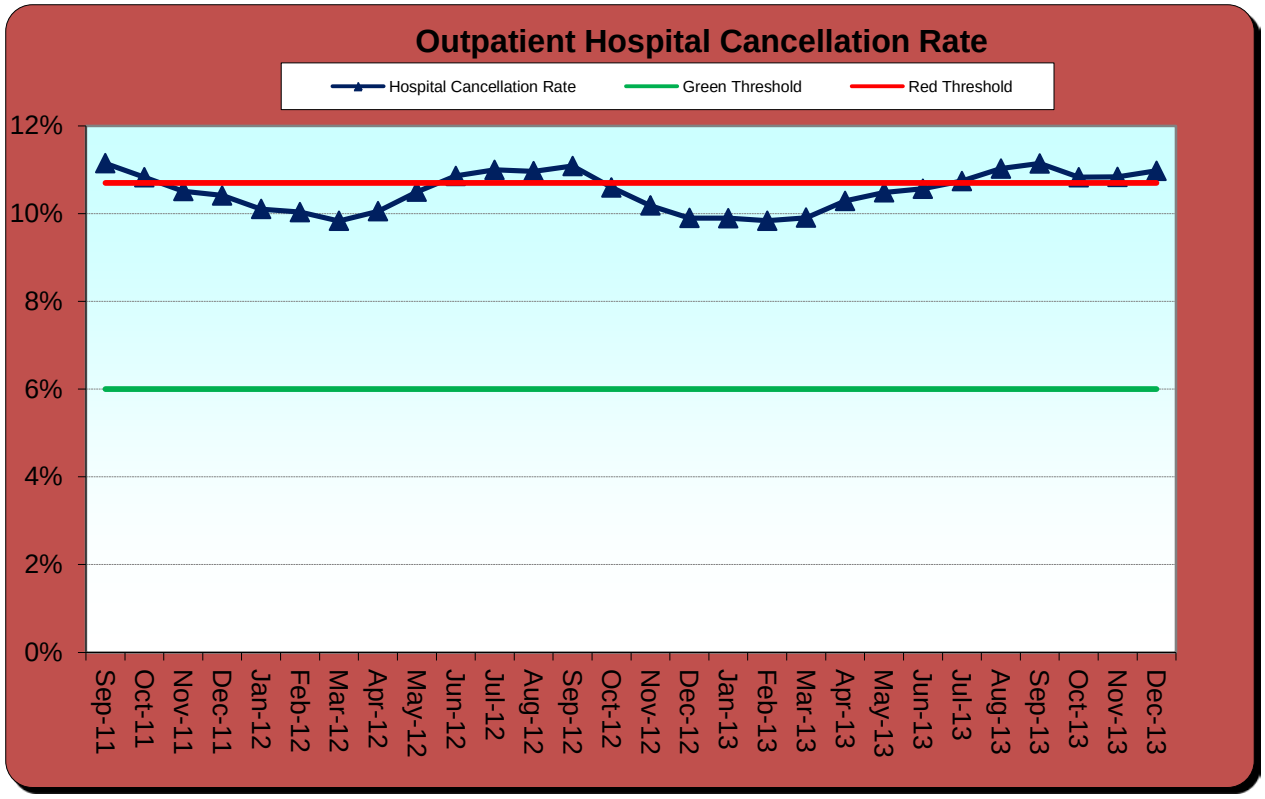
Sep-13
Oct-13

PERFORMANCE OVERVIEW



PERFORMANCE OVERVIEW



SECTION C – Monitor's Compliance Framework

At the end of December the Trust had achieved all of the targets in Monitor's 2013/14 Risk Assessment Framework for the quarter, with the exception of the A&E 4-hour maximum wait, the cumulative *Clostridium difficile* (C. diff) trajectory and the RTT (Referral to Treatment Time) Non-admitted standard.

The following Exception Reports are provided for the three of the standards not achieved for the quarter:

- A&E 4-hour maximum wait (1.0) – *Access section*
- *Clostridium difficile* cumulative trajectory (1.0) – *Quality section*
- RTT Non-admitted standard (1.0) - *Access section*

An exception report is also provided for the 62-day GP standard, which was achieved for quarter 3 as a whole following breach reallocation to late referring providers, but is considered to be at risk of being failed in quarter 4.

Overall the Trust scored 3.0 against the new Risk Assessment Framework in Quarter 3, reflecting the standards failed. This would equate to a GREEN risk rating in terms of the score alone. Because the Trust has exceeded the quarter-end target of 26 cases of *Clostridium difficile,* and has therefore failed the standard for three consecutive quarters, it is expected Monitor will request further information in order to investigate the failure of this standard as a potential governance concern. However, Monitor has already reflected their recognition of the challenge such a low number of cases now represents for this and other trusts in the same position. Monitor may also consider escalating the Trust for the failure of the A&E 4-hour standard.

Please see the Monitor dashboard on the following page, for details of reported position for quarter 3 2013/14.

PERFORMANCE OVERVIEW

Monitor's Risk Assessment Framework - dashboard

	Number	Target	Weighting	Target threshold	Reported Year To Date	Compliance Framework Q3 12/13	Compliance Framework Q4 12/13	Compliance Framework Q1 13/14	Compliance Framework Q2 13/14	Risk Assessment Framework Q3 13/14 to date*	Risk Assessment Framework Q3 Actual quarter-end*	Notes	Q3 Actual Risk rating
Monitor Risk Assessment Framework	1	Infection Control - C.Diff Infections Against Trajectory	1.0	< or = trajectory	34	✓	✓	×	×	34	×	Cumulative trajectory: Q1 9; Q2 18; Q3 26; Q4 35	Not achieved
	2a	Cancer - 31 Day Diagnosis To Treatment (Subsequent - Drug)	1.0	98%	99.9%	✓	✓	✓	✓	99.7%	✓		Achieved
	2b	Cancer - 31 Day Diagnosis To Treatment (Subsequent - Surgery)		94%	95.1%	✓	✓	✓	✓	96.8%	✓		
	2c	Cancer - 31 Day Diagnosis To Treatment (Subsequent - Radiotherapy)		94%	98.0%	✓	✓	✓	✓	97.9%	✓		
	3a	Cancer 62 Day Referral To Treatment (Urgent GP Referral)	1.0	85%	81.0%	✓	×	✓	×	85.1%	✓	62 day GP standard achieved subject to breach reallocation	Achieved
	3b	Cancer 62 Day Referral To Treatment (Screenings)		90%	92.3%	×	✓	✓	✓	90.3%	✓		
	4	Referral to treatment time for admitted patients < 18 weeks	1.0	90%	92.9%	Achieved each month	Achieved each month	Achieved each month	✓	92.3%	✓		Achieved
	5	Referral to treatment time for non-admitted patients < 18 weeks	1.0	95%	93.2%	Achieved each month	Achieved each month	Achieved each month	×	92.5%	×	Standard failed each month in the quarter.	Not achieved
	6	Referral to treatment time for incomplete pathways < 18 weeks	1.0	92%	92.5%	Achieved each month	Achieved each month	Achieved each month	✓	92.7%	✓		Achieved
	7	Cancer - 31 Day Diagnosis To Treatment (First Treatments)	1.0	96%	97.5%	✓	✓	✓	✓	98.0%	✓		Achieved
	8a	Cancer - Urgent Referrals Seen In Under 2 Weeks	1.0	93%	96.4%	✓	✓	✓	✓	96.4%	✓		Achieved
	8b	Cancer - Symptomatic Breast In Under 2 Weeks		93%	Not applicable	✓	✓	Not applicable	Not applicable	Not applicable	Not applicable		
	9	A&E Total time in A&E 4 hours (95th percentile)	1.0	95%	94.4%	×	×	×	✓	93.7%	×		Not achieved
	10	Self certification against healthcare for patients with learning disabilities (year-end compliance)	1.0	Agreed standards met	Standards met	✓	Standards met	Standards met	Standards met	Standards met	Standards met		Achieved
		CQC standards or over-rides applied	Varies	Agreed standards met	None in effect	RED	Not applicable	Not applicable	Not applicable	Not applicable	Not applicable		Achieved
					rating	AMBER-RED	AMBER-RED	AMBER-RED	AMBER-RED	Requiring escalation	Requiring escalation		

Please note: If the same indicator is failed in three consecutive quarters, a trust will be put into escalation and Monitor will investigate the issue to identify whether there are any governance concerns. For A&E 4-hours, escalation will occur if the target is failed in two quarters in a twelve-month period and is then failed in the subsequent nine-month period or for the year as a whole. Quarterly figures quoted for the **62-day CANCER STANDARDS** include the impact of breach reallocations for late referrals, which are allowable under Monitor's Compliance Framework. For this reason, the quarterly figures may differ from those quoted in the Access Tracker. For the period shown only Q1 and Q3 2013/14 have had corrections applied for breach reallocations.

***Q3 Cancer figures based upon confirmed figures for October and November and draft figures for December. The 62-day GP cancer figures include assumed breach reallocations, which are still subject to confirmation. The C diff and MRSA figures are shown as the cumulative positions against the quarter-end target.**

3.0
Escalation for further investigation of issues

QUALITY

1.1 QUALITY TRACKER

Topic	ID	Title	Green	Red	12/13	13/14 YTD	Jan-13	Feb-13	Mar-13	Apr-13	May-13	Jun-13	Jul-13	Aug-13	Sep-13	Oct-13	Nov-13	Dec-13	12/13 Q4	13/14 Q1	13/14 Q2	13/14 Q3
Patient Safety																						
Infection Rates	DA01a	Infection Control - Cumulative MRSA Cases	0	0	10	1	8	9	10	0	1	1	1	1	1	1	1	1	10	1	1	1
	DA03a	Infection Control - Cumulative C.Diff Cases	35	35	48	34	42	48	48	6	10	14	17	20	25	27	30	34	48	14	25	34
	DA02	Infection Control - MSSA Cases	29	29	34	22	0	5	2	1	3	1	2	1	5	3	3	3	7	5	8	9
	DA05	Number of GRE Bacteraemias	2	3	16	10	1	1	1	0	1	2	2	1	1	1	2	-	3	3	4	3
	DA06	E. Coli Bloodstream Infections	-	-	236	156	17	19	17	15	18	12	21	17	17	18	17	21	53	45	55	56
MRSA Screenings	DD01	MRSA Pre-Op Elective Screenings	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
	DD02	MRSA Emergency Screenings	95%	80%	94.3%	94.7%	95.4%	95.9%	95.7%	95.8%	94.8%	95.7%	92.3%	93.9%	94.8%	95.2%	94.9%	95.2%	95.7%	95.5%	93.6%	95.1%
Infection Checklists	DB01	Hand Hygiene Audit	95%	80%	96.3%	96.5%	97.1%	94.9%	96.7%	97.8%	96.2%	97.6%	98.1%	92.4%	97.8%	96.4%	96.1%	96%	96.3%	97.2%	96%	96.2%
	DB02	Antibiotic Compliance	90%	80%	84.8%	87.4%	86.1%	89.3%	87%	89.2%	89.3%	89%	88.3%	85%	86.5%	85.9%	86.5%	86.5%	87.4%	89.2%	86.7%	86.2%
Cleanliness	DC01	Cleanliness Monitoring - Overall Score	95%	70%	-	-	95%	96%	96%	96%	93%	95%	95%	96%	94%	95%	95%	94%	-	-	-	-
	DC02	Cleanliness Monitoring - Very High Risk Areas	95%	95%	-	-	96%	96%	96%	97%	96%	97%	96%	98%	96%	95%	96%	96%	-	-	-	-
	DC03	Cleanliness Monitoring - High Risk Areas	95%	70%	-	-	95%	96%	95%	95%	93%	95%	96%	95%	95%	94%	96%	95%	-	-	-	-
Serious Incidents	S02	Number of Serious Incidents (SIs) Reported	-	-	91	53	9	4	3	6	2	11	9	3	4	7	5	6	16	19	16	18
	S02a	Number of Confirmed Serious Incidents (SIs)	-	-	86	28	7	4	3	6	2	9	5	1	4	1	-	-	14	17	10	1
	S02b	Number of Serious Incidents (SIs) Still Open	-	-	1	23	1	0	0	0	0	1	3	2	0	6	5	6	1	1	5	17
	S03	Serious Incidents Reported Within 48 Hours	80%	80%	84.6%	79.2%	66.7%	100%	33.3%	83.3%	100%	81.8%	66.7%	100%	25%	85.7%	100%	83.3%	68.8%	84.2%	62.5%	88.9%
	S04	Percentage of Serious Incident (SI) Investigations Completed Within Timescale	80%	80%	89.8%	93.5%	90.9%	100%	100%	50%	100%	100%	100%	100%	100%	85.7%	100%	100%	95.8%	86.7%	100%	93.3%
	S01	Total Never Events	0	0	1	2	0	0	0	0	0	1	0	0	0	0	0	1	0	1	0	1
Patient Safety Incidents	S06	Number of Patient Safety Incidents Reported	-	-	11128	8121	997	933	1029	1083	998	965	1134	914	922	1062	1043	-	2959	3046	2970	2105
	S06a	Patient Safety Incidents Per 100 Admissions	-	-	8.55	9.22	9.17	9.15	9.36	10.22	8.87	9.22	10.05	8.38	8.45	9.07	9.49	-	9.23	9.43	8.97	9.27
	S06b	Patient Safety Incidents Per 100 Beddays	-	-	3.61	4.05	3.7	3.89	3.88	4.25	3.87	3.98	4.47	3.63	3.82	4.17	4.22	-	3.82	4.03	3.98	4.19
	S07	Number of Patient Safety Incidents - Severe Harm	-	-	83	28	8	6	6	2	3	3	3	1	3	9	4	-	20	8	7	13
Falls	AB01	Falls Per 1,000 Beddays	5.6	5.6	5.98	5.66	5.68	6.43	5.84	5.61	6.01	5.16	5.64	5.76	5.8	5.96	5.42	5.59	5.97	5.6	5.73	5.66
	AB03	Repeat Inpatient Fallers	24%	24%	23.9%	24.8%	25%	24.4%	25.8%	29.9%	21.5%	23.5%	26.7%	24.7%	25.9%	19.4%	25.3%	25%	25.1%	25%	25.7%	23.4%
	AB02	Falls Patients Aged 65+	1408	1408	1408	966	112	117	121	116	119	80	99	115	102	121	93	121	350	315	316	335
Pressure Ulcers Developed in the Trust	DE01	Pressure Ulcers Per 1,000 Beddays	0.651	0.651	1.264	0.705	0.965	1.336	0.829	0.745	0.543	0.66	0.788	0.755	1.078	0.706	0.526	0.555	1.033	0.649	0.871	0.596
	DE02	Pressure Ulcers - Grade 2	84	120	348	148	26	29	22	15	14	14	18	18	26	17	12	14	77	43	62	43
	DE03	Pressure Ulcers - Grade 3	0	1	39	10	0	3	0	3	0	2	2	1	0	1	1	0	3	5	3	2
	DE04	Pressure Ulcers - Grade 4	0	1	3	1	0	0	0	1	0	0	0	0	0	0	0	0	0	1	0	0
Pressure Ulcers Present on Admission	DE07	Pressure Ulcers On Admission - Grade 2	-	-	797	655	82	76	94	78	81	81	73	83	70	54	62	73	252	240	226	189
	DE08	Pressure Ulcers On Admission - Grade 3	-	-	173	95	18	10	10	9	15	12	8	11	12	14	5	9	38	36	31	28
	DE09	Pressure Ulcers On Admission - Grade 4	-	-	54	29	6	3	6	2	6	3	6	4	1	3	2	2	15	11	11	7
Venous Thrombo-embolism (VTE)	N01	Adult Inpatients who Received a VTE Risk Assessment	96%	95%	96.4%	97.7%	93.2%	96.5%	95.5%	97.9%	97.1%	97%	96.6%	98.1%	97.9%	98%	98.5%	98.2%	94.9%	97.1%	97.5%	98.2%
	N02	Percentage of Adult Inpatients who Received Thrombo-prophylaxis	93%	90%	93.6%	92.8%	79.1%	85.4%	88.8%	86.1%	89.2%	93.2%	91.6%	92.5%	95.6%	94.6%	95.1%	97.1%	84.5%	89.4%	93.2%	95.6%
Nutrition	WB04	Dietetics: Nutritional Assessments	85%	85%	-	84.1%	-	-	-	85.7%	79.9%	79.4%	77.4%	78.5%	83.5%	88.2%	89.8%	93.3%	-	81.6%	79.7%	90.4%
	WB03	Food Chart Review	90%	85%	-	80.4%	-	-	-	-	75.1%	77.4%	72.3%	92.4%	80.9%	83.8%	76.9%	84.1%	-	76.2%	81.8%	82.1%
Safety	Y01	WHO Surgical Checklist Compliance	100%	99.5%	99.2%	99.6%	99.6%	99.5%	99.9%	99.6%	99.7%	99.6%	99.7%	99.5%	99.5%	99.6%	99.5%	99.7%	99.7%	99.6%	99.6%	99.6%
Medicines	WA01	Medication Errors Resulting in Harm	1.61%	2.84%	1.08%	0.85%	0%	0.96%	2.36%	0.69%	2.84%	0.66%	0.74%	0%	0.7%	0.61%	0.56%	-	1.12%	1.37%	0.49%	0.59%
	WA10a	Medication Reconciliation Within 1 Day (Assessment and BHI Wards)	95%	95%	92%	97.4%	92.9%	98%	95.5%	97%	89.1%	95.7%	99.1%	98.3%	99%	99.1%	100%	100%	95.1%	93.8%	98.8%	99.7%
	WA10b	Medication Reconciliation Within 1 Day (BHOC and Gynae Wards)	85%	75%	-	90.8%	-	-	-	-	-	-	93.3%	97.5%	89.1%	89.5%	90.8%	83.3%	-	-	93.6%	88.1%
	WA03	Non-Purposeful Omitted Doses of the Listed Critical Medication	2.25%	2.5%	2.99%	2.17%	2.91%	1.52%	2.53%	2.66%	2.05%	1.7%	1.91%	2.1%	1.19%	2.75%	2.32%	2.6%	2.35%	2.19%	1.74%	2.56%
NHS Safety Thermometer	AK01	Safety Thermometer - Coverage	100%	99%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
	AK03	Safety Thermometer - Harm Free Care	94.9%	91.3%	91.3%	93.6%	90.9%	91.1%	92%	91.1%	93.1%	92%	91.9%	95.2%	94.5%	93.5%	95.8%	95%	91.3%	92.1%	93.9%	94.7%
	AK04	Safety Thermometer - No New Harms	97.7%	95.9%	95.7%	97%	94.9%	95.3%	96.3%	96.4%	96.4%	96.6%	95.9%	97.3%	98.3%	96.7%	97.4%	97.9%	95.5%	96.5%	97.2%	97.3%
	DE05	Pressure Ulcers Reduction (Safety Thermometer)	300	348	390	159	26	32	22	19	14	16	20	19	26	18	13	14	80	49	65	45
	AR02	Early Warning Scores (EWS) Completed Correctly	95%	90%	95%	99%	98%	100%	-	-	99%	98%	99%	99%	99%	99%	98%	99%	98%	98%	99%	99%
	AR04	Deteriorating Patient: SBAR	80%	70%	-	79%	-	-	-	-	76.9%	91.7%	40%	80%	66.7%	93.3%	75%	75%	-	84%	66.7%	82.9%

QUALITY

Topic	ID	Title	Annual Target Green	Annual Target Red	Annual 12/13	Annual 13/14 YTD	Monthly Totals Jan-13	Feb-13	Mar-13	Apr-13	May-13	Jun-13	Jul-13	Aug-13	Sep-13	Oct-13	Nov-13	Dec-13	Quarterly Totals 12/13 Q4	13/14 Q1	13/14 Q2	13/14 Q3
Clinical Effectiveness																						
Mortality	X02	Hospital Standardised Mortality Ratio (HSMR) - 2009/10 Baseline	73.8	90	-	-	64.4	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
	X03	Summary Hospital Mortality Indicator (SHMI) - In Hospital Deaths	80	90	65.6	67.7	58.3	64.5	74.1	65.4	73	69.8	67.2	66.5	70.1	62.2	-	-	65.6	69.6	67.9	62.2
	X04	Summary Hospital Mortality Indicator (SHMI)	-	-	92.2	-	-	-	92.3	-	-	-	-	-	-	-	-	-	92.3	-	-	-
Learning Disability	AA01	Learning Disability (Adults) - Risk Assessment Completed	85%	85%	82.8%	84.2%	80%	80%	91.3%	100%	93.8%	93.8%	37.5%	80%	88.2%	100%	85%	88.9%	85.4%	95.7%	65.8%	88.9%
	AA03	Learning Disability (Adults) - Percentage Adjustments Made	58%	48%	-	80%	-	-	-	50%	81.3%	93.8%	50%	100%	88.2%	100%	95%	77.8%	-	76.1%	73.7%	91.7%
	AA02	Learning Disability (Paediatrics) - Percentage Risk Assessed	90%	85%	77.9%	87.4%	86.7%	98.3%	95.6%	97.4%	98.2%	70.2%	100%	100%	61.1%	83.8%	90.7%	96.4%	93.9%	88.7%	83.8%	89.9%
Readmissions	C01	Emergency Readmissions Percentage	3%	3%	3%	2.6%	3.1%	2.7%	3%	2.9%	2.5%	2.4%	2.6%	2.5%	2.8%	2.7%	2.7%	-	2.9%	2.6%	2.6%	2.7%
Maternity	G09	Number of Births in Midwife-Led Unit	100	70	-	454	-	-	-	-	-	-	72	67	81	80	83	71	-	-	220	234
Fracture Neck of Femur	U02	Fracture Neck of Femur Patients Treated Within 36 Hours	95%	90%	57%	77.7%	59%	44.8%	48.3%	60%	51.5%	73.5%	75.9%	77.1%	96.6%	90.5%	95.5%	87.8%	51.5%	61.9%	82.8%	90.5%
	U03	Fracture Neck of Femur Patients Seeing Orthogeriatrician within 72hours	95%	90%	63.5%	72.3%	56.4%	51.7%	62.1%	70%	36.4%	64.7%	62.1%	68.6%	75.9%	81%	95.5%	100%	56.7%	56.7%	68.8%	94%
	U04	Fracture Neck of Femur Patients Achieving Best Practice Tariff	90%	80%	36.5%	57.3%	28.2%	31%	34.5%	43.3%	15.2%	47.1%	44.8%	54.3%	69%	71.4%	90.9%	87.8%	30.9%	35.1%	55.9%	84.5%
Stroke Care	O01	Stroke Care: Brain Imaging Within 1 Hour	50%	50%	50%	51.4%	51.1%	55.6%	45.7%	45.2%	44.2%	48.7%	60%	53.7%	62.2%	58%	36.1%	-	50.9%	46%	58.5%	48.8%
	O02	Stroke Care: 90%+ Time On Stroke Unit	90%	80%	79.3%	83.8%	82.6%	80.6%	83.3%	69%	83.7%	84.6%	91.1%	82.9%	89.2%	86%	83.3%	-	82.2%	79%	87.8%	84.9%
	O03	High Risk TIA : Starting Treatment in 24 Hours	60%	60%	58.8%	57.9%	58.8%	44.4%	71.4%	40%	81.3%	50%	35.3%	62.5%	71.4%	73.3%	40%	61.1%	60%	56.4%	55.3%	63.2%
Dementia	AC01	Dementia Admissions - Case Finding Applied	90%	80%	-	77.8%	-	-	-	50%	85.7%	96.3%	80.1%	86.2%	86.6%	83.4%	74.9%	49.7%	-	90.3%	84.5%	68.7%
	AC02	Dementia Admissions - Assessment Completed	90%	80%	-	56.5%	-	-	-	64.3%	87.5%	61.5%	40.4%	52.9%	53.4%	59%	57.7%	66.7%	-	65.6%	49.2%	60.7%
	AC03	Dementia Admissions - Referred Onto Specialist Services	90%	80%	-	71.8%	-	-	-	100%	100%	85.7%	66.7%	62.5%	62.5%	75%	75.9%	61.5%	-	90.9%	63.6%	70.7%
Patient Experience																						
Mixed Sex Accom.	M01	Same Sex Accommodation Breaches - Number of Patients	0	1	42	0	4	9	0	0	0	0	0	0	0	0	0	0	13	0	0	0
Monthly Patient Surveys	P01d	Patient Survey - Local Patient Experience Score	85	82	-	-	90	89	88	89	89	88	88	89	89	88	89	-	89	89	89	89
	P01e	Patient Survey - Explaining Medication Side Effects	64	61	-	-	61	61	59	59	62	63	63	59	63	58	64	-	60	61	60	61
	P01f	Patient Survey - Maternity Services	85	83	-	-	83	88	-	85	92	88	89	85	84	79	81	-	86	88	85	80
	P01g	Patient Survey - Kindness and Understanding	90	88	-	-	93	93	93	93	94	92	94	93	94	93	93	-	93	93	93	93
Friends and Family Test	P03	Friends and Family Test Coverage	20%	15%	-	15.5%	-	-	-	6.4%	8.2%	10.7%	12.4%	14.5%	22.1%	24.7%	25.2%	18.1%	-	8.4%	16.2%	22.7%
	P04	Friends and Family Test Score	63	43	-	73	-	-	-	75.1	72.3	70.2	74.7	73.5	73.8	73.6	73	70.5	-	72.1	74	72.6
Patient Complaints	T01a	Patient Complaints as a Proportion of Activity	0.21%	0.25%	0.25%	0.202%	0.215%	0.222%	0.189%	0.245%	0.212%	0.195%	0.173%	0.223%	0.202%	0.192%	0.185%	0.199%	0.208%	0.218%	0.198%	0.192%
	T03	Formal Complaints Responded To Within Timeframe	98%	90%	54.8%	73.7%	50%	68.3%	50.7%	47.4%	54.7%	66.7%	80.3%	77.2%	87.8%	84.9%	82.2%	88.1%	54.8%	56.5%	81.4%	85%
	T04a	Complainants Disatisfied With Response	48	48	20	48	5	3	0	1	8	6	6	11	1	7	2	6	8	15	18	15

1.2 SUMMARY

It is once again encouraging to see both falls and pressure ulcer incidence per 1,000 bed days remaining below the green threshold for the second consecutive month and that the number of actual falls which occurred in the month remains below the number of expected falls based on the age profile of our inpatient population. However, it is disappointing there were two serious incidents involving patients who fell and sustained major fractures. The investigations from these two incidents will identify if there is any further learning which can be implemented to prevent patients from falling.

Unfortunately an unprecedented number of patients were admitted with a fractured neck of femur in December which meant that, despite the increase in theatre capacity, an insufficient number of these patients were treated within the best practice target of 36 hours. However, the Board will note 100% of these patients were seen by an Ortho-geriatrician within 72 hours.

The number of complaints received expressed as a proportion of activity has remained below the green threshold for the past four consecutive months, and is supported by the continued Friends and Family Test score above the national average. We do remain focused on improving the timeliness of complaints and the quality of responses as described in the relevant exception reports.

The section of this report showing the summary of performance against Commissioning for Quality and Innovation (CQUIN) metrics shows that we are on track to achieve some or all of the reward for the majority of this subset of the CQUINs for 2013/14, although we remain challenged by a minority, for example the national dementia CQUIN, as mentioned in previous reports. The exception reports provided in section 1.4 give further details of actions being taken to improve our performance.

Achieving set threshold (35)	**Thresholds not met or no change on previous month (9)**
- GRE (Glycopeptide Resistant Enterococci) Bacteraemias - MRSA (Meticillin Resistant Staphylococcus aureus) screening – elective - MRSA (Meticillin Resistant Staphylococcus aureus) screening – emergency - Hand Hygiene Audit - Cleanliness monitoring very high risk areas - Cleanliness monitoring high risk areas - Serious Incidents reported with 48 hours - Serious incident investigations completed within required timescales - Inpatient falls incidence per 1,000 bed days - Total pressure ulcer incidence per 1,000 bed days - Number of grade 3 hospital acquired pressure ulcers	- Antibiotic prescribing compliance - Cleanliness monitoring overall Trust score - WHO surgical checklist compliance - Medicines reconciliation performed within one day of admission (Oncology and Gynaecology wards) - Escalation of the deteriorating patient using a structured communication tool (improvement target being discussed with commissioners) - Number of births in midwifery led unit - Stroke care: percentage spending 90% + time on a stroke unit - Fractured neck of femur patients achieving best practice tariff - Friends and Family Test-coverage

QUALITY

- Number of grade 4 hospital acquired pressure ulcers - Percentage of adult in-patients who had a Venous Thrombo-Embolism (VTE) risk assessment - Percentage adult in-patients who received thrombo-prophylaxis - Patients seen by dietician with 'MUST' (Malnutrition Universal Screening Tool) score of 2 or more - Medicines reconciliation performed within one day of admission (Assessment and cardiac wards) - Reduction in medication errors resulting in moderate or severe harm - NHS Safety Thermometer-coverage - NHS Safety thermometer-harm free care - NHS Safety thermometer-no new harms - Pressure Ulcer reduction (Safety Thermometer CQUIN) - Deteriorating patient: Early Warning Scores - Summary Hospital Mortality Indicator in-hospital deaths (SHMI) - Risk assessment of adult patients with known learning disability within 48 hours - Learning disability (adults)-percentage adjustments made - Risk assessment of paediatric patients with known learning disability within 48 hours - 30 day emergency re-admissions - High risk TIA (Transient Ischaemic Attack) patients starting treatment with 24 hours - Fractured neck of femur patients seeing an ortho-geriatrician within 72 hours - Number of breaches of the same sex accommodation standard - Patient experience local patient experience score - Monthly patient survey: kindness and understanding - Monthly patient survey: explaining medication side effects - Friends and Family Test Score - Patient complaints as a proportion of all activity	
Quality metrics not achieved or requiring attention (17)	**Quality metrics not rated (12)**

QUALITY

- MRSA (Meticillin Resistant Staphylococcus aureus) bloodstream cases against trajectory - Clostridium difficile cases against national trajectory - MSSA (Meticillin Sensitive Staphylococcus aureus) cases against trajectory - Never Events - Repeat inpatient falls - Falls in inpatients over 65 - 72 hour Food Chart review - Number of grade 2 hospital acquired pressure ulcers - Non-purposeful omitted doses of listed critical medication - Stroke care: percentage receiving brain imaging within 1 hour - Fractured neck of femur patients treated with 36 hours - Dementia admissions-case finding applied - Dementia admissions-assessment completed - Dementia admissions-referred on to specialist services - Monthly patient survey: maternity services kindness and understanding - Percentage of complaints resolved within agreed timescale - Number of complainants dissatisfied with our response (not responded in full)	**Metrics for information** - E coli *(Escherichia coli*) blood stream infections (surveillance only) - Number of serious incidents - Confirmed number of serious incidents - Total number of patient safety incidents reported - Total number of patient safety incidents per 100 admissions - Total number of patient safety incidents per 100 bed days - Number of patient safety incidents severe harm - Number of Grade 2 pressure ulcers present on admission - Number of Grade 3 pressure ulcers present on admission - Number of Grade 4 pressure ulcers present on admission - Hospital Standardised Mortality Ratio (HSMR) - Summary Hospital Mortality Indicator including out of hospital-deaths within 30 days of discharge (SHMI)

QUALITY

Summary of Performance against Commissioning for Quality and Innovation (CQUIN) Quality Dashboard Metrics

The Board is asked to note the current position against 2013/14 CQUIN targets reported in the Quality Dashboard:

- Venous Thrombo-Embolism (VTE) risk assessment to be achieved each quarter - percentage for December was 98.2% against a target of 95%. In order to achieve the CQUIN for Quarters 2-4 we need to sustain the 95% risk assessment target and investigate all hospital associated VTE.
- Percentage of patients with a Malnutrition Universal Screening Tool (MUST) score of 2 or more seen by dietician - performance in December was 93.3% against a target of 85% to be achieved in Quarter 4.
- Review of food chart within 72 hours for patients requiring their nutritional intake to be monitored - performance in December 84.1% against a target of 90% to be achieved in Quarter 4.
- Medicines Reconciliation for oncology and gynaecology wards - performance in December is 83.3% against a target of 85%
- Non-purposeful omitted doses of listed critical medication - performance in December 2.6% against a target of 2.25% to be achieved for the year as a whole. Performance year to date is 2.17%
- National Safety Thermometer CQUIN - we have agreed with commissioners to reduce hospital acquired grade 2-4 pressure ulcers by 15% for the first six months of 2013/14 and sustain this for the second six months. Performance in December was 14 pressure ulcers against target of no more than 25 a month on average over the six month period.
- Detection of the deteriorating patient: Early Warning Scores completed correctly as measured by monthly ward audits to be achieved in Q4 2013/14 - performance for December is 99% against at target of 95% to be achieved Quarter 4.
- Deteriorating patient: escalation of patients with an early warning score of 4 or more using a structured communication tool SBAR (Situation, Background, Assessment, and Recommendation) - Performance for December was 75% against a proposed target of 70% for Q3 rising to 80% in Q4. Performance for Q3 as a whole is 82.9%; we have therefore achieved the proportion of CQUIN reward for Q3.
- Risk assessment of adult patients with a known learning disability within 48 hours - performance in December was 88.9% against a target of 85%. Sustaining 85% of patients being risk assessed is a pre-requisite to achieving the new “reasonable adjustments” CQUIN target for 2013/14.
- Learning disability - reasonable adjustments put in place for identified adult patients - performance in December was 77.8% against a target of 58%.
- Risk assessment of paediatric patients with a known learning disability within 48 hours - performance in December was 96.4% against a target of 90% for 2013/14.
- Patients admitted with dementia:

1. Percentage of patients aged over 75 years identified with a clinical diagnosis of delirium or who have been asked the dementia case finding question - performance in December was 49.7% against a target of 90%
2. Percentage of patients positively identified in 1) who had a diagnostic assessment - performance in December was 66.7% against a target of 90%
3. Percentage of patients positively identified in 2) who were referred for further diagnostic advice - performance in December was 61.5% against a target of 90%

The target is 90% for three consecutive months for all three stages

- Friends and Family Test coverage - the response rate in December was 18.1%, against a target of 20% by Quarter 4 for the remaining 50% of the CQUIN.

1.3 CHANGES IN THE PERIOD

Performance against the following indicators changed significantly compared with the last reported month:

- Dietetics: percentage of patients with a malnutrition risk score of 2 or more receiving a nutritional assessment by a dietician up ↑ from 89.8% in November to 93.3% in December.
- Non-purposeful omitted doses of listed critical medication up ↑ from 2.32% in November to 2.6% in December.
- High risk TIA patient starting treatment with 24 hours up ↑ from 40% in November to 61.1% in December;
- Dementia case finding applied down ↓ from 74.9% in November to 49.7% in December.

1.4 EXCEPTION REPORTS

Exception reports are provided for fifteen RED rated indicators and a further two indicators* which are AMBER rated or have been of interest to the Board, seventeen indicators in total.

Please note: an exception report is **not** provided for MRSA cases although it is red on the dashboard. This is because the measure has been changed to a cumulative measure throughout 2013/14 rather than number of cases each month. The red threshold of one case was triggered in May 2013 and therefore this measure will automatically remain red for the rest of 2013/14. **There were no new cases in December 2013.** An exception report has also **not** been provided for the number of hospital acquired grade 2 pressure ulcers. This is because this number is below an internally set target of no more than 15 per month, but this remains red rated because the green threshold in the dashboard was set based on a period of under-reporting of grade 2 hospital acquired pressure ulcers in 2010/11 and has not been rebased in subsequent years. The Board has been regularly informed via exception reports of a range of robust actions to reduce the incidence of all pressure ulcers, in response to the overall pressure ulcer incidence.

1. Clostridium difficile cases against national trajectory
2. MSSA (Meticillin Sensitive Staphylococcus aureus) cases against trajectory
3. Antibiotic prescribing compliance*
4. Never Events
5. Repeat inpatient falls
6. Falls in inpatients over 65
7. 72 hour Food Chart review
8. Non-purposeful omitted doses of listed critical medication
9. Number of births on midwife led unit*
10. Stroke care: percentage receiving brain imaging within 1 hour
11. Fractured neck of femur patients treated with 36 hours
12. Dementia admissions-case finding applied
13. Dementia admissions-assessment completed

QUALITY

14. Dementia admissions-referred on to specialist services
15. Monthly patient survey: maternity services kindness and understanding
16. Percentage of complaints resolved within agreed timescale
17. Number of complainants dissatisfied with our response (not responded in full)

QUALITY

Q1. EXCEPTION REPORT: *Clostridium difficile*	**RESPONSIBLE DIRECTOR: Chief Nurse**

Description of how the standard is measured:

This applies to patients in hospital for more than 3 days, who have unexplained reasons for diarrhoea whose test positive for *Clostridium difficile.* The national reduction objective set centrally is 35 cases in the year. Financial penalties are linked to the national target and occur if a ceiling of 35 cases is breached in 2013/14

Monitor measurement period: Cumulative year-to-date trajectory, reported quarterly.

Performance in the period, including reasons for the exception:

Total number of cases at the end of December was 34 against a target of 26. There were four Trust apportioned cases of *Clostridium difficile* in the month against a target of two. The Trust has had 4 fewer cases, year-to-date, than for the same period last year (2012/13).

Division	Target	Number of cases
Medicine	1	1
Surgery, Head & Neck	1	2
Women's & Children's	0	0
Specialised Services	0	1

The Divisions of Specialised Services and Surgery, Head & Neck exceeded their monthly target in December. All cases of *Clostridium difficile* infection are investigated by the Infection Control team using a modified root cause analysis process.

Recovery plan, including expected date performance will be restored:

The action plan is ongoing and is monitored on a fortnightly basis by the Medical Director and the Chief Nurse in collaboration with the Director of Infection Prevention and Control (DIPC) and the Senior Infection Control Nurse/Deputy DIPC. The actions are also monitored through the Infection Control monthly operational meeting and the quarterly Infection Control Group.

New and existing cases are reviewed and implementation of prevention measures monitored. The management of *Clostridium difficile* positive patients continues on the cohort ward with daily monitoring of patients by the Infection Control Team. An update of actions within the recovery plan are below:

QUALITY

- Seventeen General Practitioners attended the study afternoon in the Education centre on 5th December. This was well received by the GPs and they are keen for more sessions to be arranged. More sessions are planned throughout the year. These sessions will add to their Continuing Professional Development (CPD) points;
- A new antibiotic called Temocillin has been added to the formulary. There is evidence that there is less risk of patients developing *Clostridium difficile* when being treated with this antibiotic;
- Procalcitonin testing continues in the Elderly Admissions Unit and the Medical Assessment Unit. Since this test has been implemented there have been some preliminary results showing 58% of antibiotics have been stopped or not given as a result of a low procalcitonin;
- The implementation of an antibiotic guideline smartphone application (App) is underway. Training has commenced and the uploading of data is now complete. Data now being proof read. It is planned for the App to be available from April 2014;
- Screening of Bone Marrow Transplant (BMT) *Clostridium difficile* positive patients on admission has commenced;
- Partnership working with colleagues in the Clinical Commissioning Group (CCG) continues. The CCG is planning to appoint an Infection Control Nurse, who once in post will liaise closely with the Trust team.

QUALITY

Q2. EXCEPTION REPORT: Meticillin Sensitive Staphylococcus Aureus (MSSA) cases against trajectory	**RESPONSIBLE DIRECTOR: Chief Nurse**

Description of how the standard is measured:

The number of MSSA cases of patients in hospital for more than 2 days. This equates to no more than 29 cases in year. This target has no financial penalties and does not contribute to the Monitor Compliance Framework.

Performance in the period, including reasons for the exception:

There were three Trust apportioned cases of MSSA in December 2013. This is one over the Trust's target trajectory for December of two cases.

Actions to prevent MSSA are similar to those for MRSA, although at present widespread screening for MSSA is not recommended nationally. The number of people who harmlessly carry MSSA (approximately one third) is far greater than MRSA. The overall trajectory for quarter three is nine cases against a target of seven. The total number of on target cases year to date as at the end of December is 22 against a target of 22.

Recovery plan, including expected date performance will be restored.

All cases relating to patients that have been in hospital for a minimum of 2 days prior to becoming symptomatic and being tested, are investigated by the clinical team with learning shared at the Infection Control Operational meeting chaired by the Deputy Chief Nurse.

- Monthly Infection Control safety audits include insertion and management of Intravenous cannula;
- All elective and emergency in patients undergoing invasive procedures are given sachets of Chlorhexadine body and hair wash, with instructions to use on the morning of their procedure;
- The IV access coordinator instigates investigation of patients who have line related infections; this is reported back monthly to the infection control operational meeting;
- MSSA screening continues in Cardiac and Renal services.

Delivery of the plan is being monitored and managed through the monthly Infection Control Operational meeting.

QUALITY

Q3. EXCEPTION REPORT: Antibiotic Prescribing Compliance	RESPONSIBLE DIRECTOR: Medical Director

Description of how the standard is measured:

Antibiotic prescribing compliance measures the compliance with three elements of the antibiotic prescribing policy in line with national antimicrobial stewardship initiatives. These are:

1. Antibiotic choice is according to guideline/ microbiology results or microbiologist recommendation
2. The indication is stated on the prescription
3. A stop or review date is included on the prescription.

In order to be deemed compliant, a prescription for an antibiotic must meet all three criteria.

Performance in the period, including reasons for the exception:

The overall percentage remained the same in December at 86.5%. There was a rise in compliance in two divisions:

- Specialised Services (94.6%, a rise from 86.6%)
- Women's & Children's (87.6%, a rise from 78.4%)

There was a fall in compliance in two divisions:

- Medicine (85.1%, a fall from 87.9%)
- Surgery, Head & Neck (84.3% a fall from 91.3%)

Reasons for the exception:

- 524 reviews were undertaken in December, 71 were non-compliant. Of these 50 (9.5%) did not include a valid stop or review date. This percentage has risen this month;
- Unfortunately there was a dip in compliance in Surgery this month, mainly due to no stop or review dates;
- The compliance in Neonatal Intensive Care Unit has increased significantly to 86% therefore Women's and Children's has seen an overall rise in compliance. Specialised Surgery achieved their second highest compliance figure since the start of reporting.

Recovery plan, including expected date performance will be restored:

QUALITY

- Continue to monitor through Divisional Boards;
- A teaching session on antibiotic prescribing for F2s doctors is occurring in January and will highlight the antibiotic prescribing bundle;
- The antibiotic prescribing smartphone application is now under production with a planned release in February;
- A teaching session with the surgical infection control link nurses has already taken place in January

QUALITY

Q4. EXCEPTION REPORT: Never Event	RESPONSIBLE DIRECTOR: Medical Director/Chief Nurse

Description of how the standard is measured:

Never events are very serious, largely preventable patient safety incidents that should not occur if the relevant preventative measures have been put in place. There are currently 25 different categories of Never Events listed by NHS England for 2013/14.

Performance in the period, including reasons for the exception:

The Never Event which occurred In December was a " Retained foreign object post-operation". This involved a guard from a disposable Poole sucker becoming detached during a procedure and inadvertently left inside the patient. This item is not subject to the usual swab and instrument counts. The WHO Surgical Safety Checklist was complied with in this case, but would not have prevented the incident. The patient required further minor surgery to remove the item.

The patient was informed of the error as soon as it was identified. A full Root Cause Analysis investigation is underway, and a Serious Incident Panel Review is being commissioned to consider the broader organisational issues of what happened.

Recovery plan, including expected date performance will be restored:

The incident investigation process will need to reach its conclusion before the full extent of the learning is known. Recommendations from both the Root Cause Analysis investigation and the Panel Review will be considered and actions implemented to reduce the risk of a recurrence.

However, an action has already been implemented following the initial review of the incident which is that disposable instruments will be included in swab and instrument counts in UH Bristol's operating theatres.

QUALITY

Q5-Q6. EXCEPTION REPORT:	**RESPONSIBLE DIRECTOR: Chief Nurse**
• **Repeat inpatient falls** • **Falls in patients aged over 65 years**	

Description of how the standard is measured:

The number of hospital episodes which ended in the month during which a patient fell more than once expressed as a percentage of the number of hospital episodes which ended in the month.

Performance in the period, including reasons for the exception:

Performance in the month for falls incidence was 5.59 per 1,000 bed days against the national benchmark of 5.6. There were 141 inpatient falls in December. This means that overall performance was below the green threshold.

However, the number of patients experiencing repeat falls was under performing at 25% and the number of patients over 65 who fell was 121 compared to 93 in November. The degree of harm, based on National Patient Safety Agency guidance, arising from the falls in December was:

Degree of Harm	Feb 13	Mar 13	Apr 13	May 13	Jun 13	Jul 13	Aug 13	Sep 13	Oct 13	Nov 13	Dec 13
Near Miss	4	0	0	4	0	0	0	0	0	0	0
Negligible	68	75	65	71	89	87	109	84	88	93	109
Minor	65	63	54	67	26	54	35	53	63	37	30
Moderate	2	3	1	1	1	1	0	2	0	1	0
Major	2	2	1	1	0	1	1	1	1	3	2
Unavoidable death	0	0	1	0	0	0	0	0	0	0	0
Total	**141**	**143**	**122**	**144**	**116**	**143**	**145**	**140**	**152**	**134**	**141**

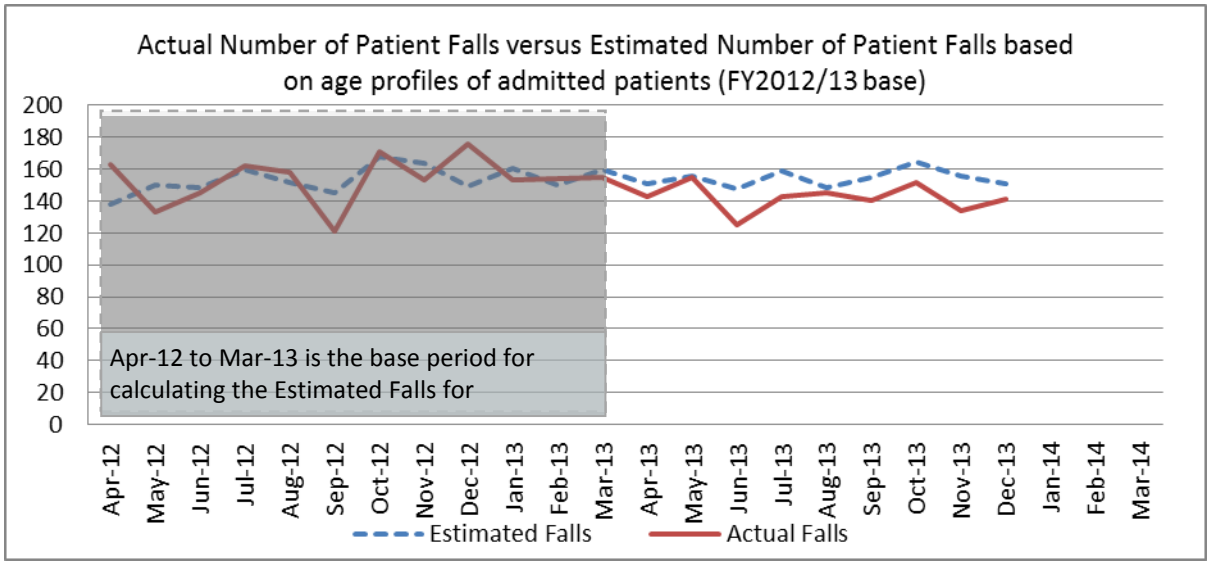
It is disappointing to see there were two falls resulting in major harm to patients in December. Root Cause Analysis investigations are underway for these and learning will be shared at the Falls Steering Group.

As the numbers of elderly patients we admit is rising steeply, we have developed an approach to estimating the impact the age of our patients has on the incidence of inpatient falls. The graph below shows that, based on the age profile of patients admitted in December, we would estimate there would be 151 falls but in fact 141 occurred. Year to date there have been 110 fewer falls than 'expected'.

QUALITY

Divisional Data	Feb 13	Mar 13	Apr 13	May 13	Jun 13	Jul 13	Aug 13	Sep 13	Oct 13	Nov 13	Dec 13
Diagnostics & Therapies	0	1	2	0	1	0	2	1	3	3	1
Medicine	88	74	78	91	85	94	88	90	109	87	101
Specialised Services	22	18	12	21	14	19	23	18	8	13	16
Surgery Head & Neck	28	33	24	24	24	19	28	23	29	24	20
Women's & Children's	3	7	6	7	2	11	3	9	3	7	3
Total	**141**	**133**	**122**	**143**	**126**	**142**	**145**	**140**	**152**	**134**	**141**

	Apr-13	May-13	Jun-13	Jul-13	Aug-13	Sep-13	Oct-13	Nov-13	Dec-13	Jan-14	Feb-14	Mar-14
Estimated Falls	151	156	147	159	148	155	164	156	151			
Actual Falls	143	155	125	143	145	140	152	134	141			



Recovery plan, including expected date performance will be restored:

A modified version of the FallSafe programme is in the planning stages for outpatients. The FallSafe programme is continuing to be reviewed on a monthly basis at the Falls Steering Group with all relevant actions taken:

- Areas that have high numbers of falls with harm are providing information through the monthly falls report with a clear narrative on actions that

are required to ensure a reduction of harm;

- The Safety Thermometer data for falls is now included in the monthly falls report for divisions to add narrative and context for their figures; this will then be discussed at the meeting where all the divisions are represented;
- A plan has been developed for the Falls Co-ordinator, so that her time is spent in high risk areas, to support the staff to reduce harm for patients;
- The FallSafe programme includes actions which focus on reducing the number of times a patient falls;
- High risk areas, such as South Bristol Community Hospital, are trialling a patient sensor pad, to alert the nurse that the patient has moved so that they can go and check that the patient is safe and give assistance as required;
- Early recognition for staff of patients that have fallen who are transferred from one ward to another is being discussed at the next Falls Steering Group. This was identified as a root cause from one of the recent Root Cause Analyses; the use of a red background falling star magnet on the patient status at a glance boards, and a sticker for the nursing documentation, is going to be discussed.
- The introduction of 15 minute micro teaching to be discussed and planned at the January Falls Group.

QUALITY

Q7. EXCEPTION REPORT: 72 hour food chart nutrition review	RESPONSIBLE DIRECTOR: Chief Nurse

Description of how the standard is measured:

Completion of 72-hour food chart review for all adult patients with a Malnutrition Universal Screening Tool (MUST) score of 2 or higher. Data comes from the monthly audit using the same sample as the Safety Thermometer.

Performance in the period, including reasons for the exception:

Performance in December was 84.1%, an improvement from 76.9% in November but below the target of 90% to be achieved in Quarter 4. The breakdown by division is shown in the table below:

Division	Percentage	Numbers compliant
Medicine	87.6% ⇧	92/105
Surgery, Head & Neck	77.6% ⇧	27/38
Specialised Services	85% ⇩	22/26
Women's & Children's	50% (0 patients last month)	1/2
Trust	**84.1%**	**142/171**

Recovery plan, including expected date performance will be restored:

- Each ward in each Division since November have been asked to complete and return an action plan for the any aspects of the monthly Safety Thermometer audits where their compliance was not 100%. This revealed areas where compliance with the food chart review was not completed for all patients and confirmed their actions to address it. A number of wards have submitted action plans detailing increasing awareness at Safety Briefings and informal ward audits by the Supervisory Band 7s. This is seen as a positive step towards them acknowledging the actions required to deliver this target and has resulted in an improvement, but not yet to the required 90%;
- Each Head of Nursing is working with their wards where there was anything less than 100% compliance to support changing practice to improve this important patient care measure;
- The Nutrition Steering Group is looking at the timing of the 72-hour review to see if it can be more closely aligned with lunchtimes around 72 hours, rather than 72 hours after the food chart was commenced.

QUALITY

Q8. EXCEPTION REPORT: Omitted doses of critical medication	RESPONSIBLE DIRECTOR: Medical Director

Description of how the standard is measured:

Drug charts for a sample of over 500 patients each month are reviewed. The previous three days of treatment are observed and the numbers of non-purposeful omitted doses of critical medicine are recorded. The CQUIN target is to achieve less than 2.25% in the cumulative average for the year 2013/2014.

Critical medicines are defined as the following:

- Any anticoagulant
- Any insulin
- Any short-acting bronchodilator
- Intravenous anti-infective
- Any thrombolytic
- Any 'Stat' drug (a "one off" prescription)
- Any anticonvulsant
- Intravenous aminophylline
- Any drug used to treat Parkinson's Disease
- Any drug used in resuscitation or anaphylaxis management
- Any anti-transplant immunosuppressant

(Please note: this list is based upon that defined by the National Patient Safety Agency with local review to include additional areas of importance). An omitted does is recorded if the administration box is blank or has code 9 inserted 'Drug not available'.

Performance in the period, including reasons for the exception:

As shown in the table below, performance in December was 2.6% against a target of 2.25%. Although the current cumulative average is within the less than 2.25% target, Q3 average is above this. If the current levels continue then we are likely to achieve 2.27% for the year (which equates to 50% of the CQUIN target). To achieve the full CQUIN target there can be no more than 23 patients per month with missed doses of critical drugs (assuming a sample size of 950 patients) for the next 3 months.

Notwithstanding the CQUIN target, our focus is to reduce risks to patients from non-purposeful omitted doses of critical medication.

QUALITY

Quarter	Period	Total Number of Patients With Meds Missed	Total Number of Patients Reviewed	%
13/14 Q1	April	24	903	2.66%
	May	16	779	2.05%
	June	11	647	1.69%
Total		**51**	**2329**	**2.19%**
13/14 Q2	July	13	681	1.91%
	August	23	1097	2.10%
	September	11	921	2.10%
Total		**47**	**2699**	**1.74%**
13/14 Q3	October	25	909	2.75%
	November	22	948	2.32%
	December	26	999	2.60%
Total		**73**	**2856**	**2.56%**
Grand Total		**171**	**7889**	**2.17%**

The majority of omitted doses each month are anti-coagulants, with intravenous anti-infectives being the second most frequent.

Recovery plan, including expected date performance will be restored:

There is a comprehensive omitted doses action plan which is monitored by the Trust Medicines Governance Group. Examples of actions contained therein include:

- On discovery, Ward Pharmacists follow up all omissions of critical medicines with the Ward Sister;
- Ward Sisters reminder to staff to check all sections of the new drug chart;
- Ward Pharmacists and Ward Sister to conduct retrospective review of omissions in November/December to better understand the causes;
- Trust-wide Safety Bulletin "Critical Missed Doses" sent out identifying actions for prescribers and nursing staff;
- Review of labelling of dispensed critical medicines underway, to highlight this to staff receiving the medicine;
- Revisit of "no-interruption" drug rounds e.g. pilots of red tabards for the nurses administering medicines;
- Consideration of medicines administration competency assessment for new staff;
- Sharing learning from omitted dose incidents.

QUALITY

Q9. EXCEPTION REPORT: Number of Births on the Midwife Led Unit	RESPONSIBLE DIRECTOR: Chief Nurse

Description of how the standard is measured:

The Trust measures Midwifery Led Unit standards using two methods to check the accuracy of our figures. An initial paper trawl of birth registers, incident forms and transfer forms is collated. Then subsequently a report is run from Medway Maternity using exclusions to accurately report our figures and capture any missed data.

Performance in the period, including reasons for the exception:

	July 13	Aug 13	Sep 13	Oct 13	Nov 13	Dec 13
Number of Births per month Red <70, Amber 71-99, Green 100 or more	72	67	81	80	83	71

There were slightly fewer births in the Midwife Led Unit in December, but as a whole activity was quieter in December 2013 and so as a consequence there were fewer women suitable for delivery in the Midwife Led Unit (MLU).

Recovery plan, including expected date performance will be restored:

- The midwives are actively encouraging women to give birth in the MLU across the community of BNSSG. (Bristol North Somerset and South Gloucester). Leaflets promoting the unit have been sent to all bases across BNSSG to actively encourage the women to give birth here;
- The Volunteer Tours of the Unit have been re-written and now feature the MLU as part of their remit to show parents to be, the facilities;
- Feedback form local organisations, independent midwives and the local National Childbirth Trust has all been very positive;
- By the end of the financial year we will have a baseline against which to set more accurate thresholds for births in the MLU for 2014/15;
- The website for the MLU has been updated to include better pictures, statistics of births and progress so far. A press release is being planned to celebrate the few months since the unit was opened.

QUALITY

Q10. EXCEPTION REPORT: Stroke care: percentage receiving brain imaging within an hour	**RESPONSIBLE DIRECTOR: Medical Director**

Description of how the standard is measured:

The percentage of patients suspected as suffering from a stroke that are scanned within 1 hour of arrival in the hospital. The national standard is for at least 50% of suspected strokes to be scanned within 1 hour. Scanning helps to ensure patients requiring thrombolysis are appropriately identified. This is based upon the finding that around 50% of suspected strokes have clinical indications that warrant a scan.

Performance in the period, including reasons for the exception:

In November 36.1% (13/36) of patients received imaging within 1 hour against a target of 50%. This follows four consecutive months during which the national standard was achieved. The national standard is based upon the assumption that 50% of stroke patients have symptoms that suggest brain imaging is required to assess their condition. The standard is based upon a diagnosis at discharge of stroke. However, many patients present with confusion and collapse, where the possibility of a stroke is not immediately obvious.

The aim is for all identified stroke patients to have brain imaging within an hour. A protocol has been established to support this, which includes ambulances team ringing through to the Emergency Department and going straight to the imaging department to have a CT scan. Overall the protocol is working well in-hours, but is less consistent out of hours.

Recovery plan, including expected date performance will be restored:

- The Division of Medicine continues to focus on what improvements can be made to the brain imaging pathway out of hours, as this is the period during which performance against the standard is less consistent

Performance for the quarter as a whole was 48.8%, and therefore marginally below the 50% standard. Performance for the year to date is 51.4% and above the national standard.

QUALITY

Q11. EXCEPTION REPORT: Fractured neck of femur patients treated with 36 hours	**RESPONSIBLE DIRECTOR: Medical Director**

Description of how the standard is measured:

Best Practice Tariff (BPT) for patients with an identified hip fracture requires all of the following standards to be achieved:

1. Surgery within 36 hours from admission to hospital
2. Ortho-geriatric review within 72 hours of admission to hospital
3. Joint care of patients under a Trauma & Orthopaedics Consultant & Ortho-geriatrician Consultant
4. Completion of a Joint Assessment Proforma
5. Multi-Disciplinary Team (MDT) rehabilitation led by an Ortho-geriatrician
6. Falls Assessment
7. Bone Health Assessment
8. Abbreviated Mental Test done on admission and pre-discharge

Performance in the period, including reasons for the exception:

In December 2013, 41 patients aged over 60 years were discharged following treatment for a fractured neck of femur and, of these, 36 patients received surgery with 36 hours (87.8%). In previous months an average of 30 patients aged over 60 years were discharged following treatment for hip fractures, therefore high volumes of trauma in December had a detrimental impact on time to theatre performance.

Recovery plan, including expected date performance will be restored:

- Continued daily monitoring of trauma waiting times and escalation within Division to identify additional theatre capacity when required;
- Ortho-geriatrcian Consultant input now expected to consistently achieve >90% for review within 72 hours;
- Anticipating high levels of trauma continuing in January 2014 and resultant poorer performance for time to theatre;
- Further problems are anticipated in January due to unplanned absence of two consultants;
- Expect performance to improve >90% by February 2014.

QUALITY

Q12-Q14. EXCEPTION REPORT: Dementia Stage 1 - Find Stage 2 – Assess & Investigate Stage 3 – Referral on to GP	RESPONSIBLE DIRECTOR: Chief Nurse

Description of how the standard is measured:

The National Dementia CQUIN, "Find, Assess and investigate, Refer (FAIR)" occurs in three parts:

1. **Find**
   The case finding of at least 90% of all patients aged 75 years and over following emergency admission to hospital, using the dementia case finding question and identification of all those with delirium and dementia. This has to be completed within 72 hours of admission. Compliance is measured by auditing records on the electronic discharge system;
2. **Assess and Investigate**
   The diagnostic assessment and investigation of at least 90% of those patients who have been assessed as at-risk of dementia from the case finding question and/or presence of delirium;
3. **Refer**
   The referral of at least 90% of clinically appropriate cases to General Practitioner to alert that an assessment has raised the possibility of the presence of dementia.

The CQUIN payment is triggered by meeting the threshold of at least 90% in each of the three stages (divided equally) in any three consecutive months in the year.

Targets: Green rating 90% or above, Amber rating 80% - 89%, Red rating below 80%

Performance in the period, including reasons for the exception:

Over the last 12 months we have admitted 5509 patients across the Trust who are aged 75 years or over as emergency admissions and who have remained inpatients for more than 72 hours. This is an average of 460 patients per month to which this CQUIN applies. To achieve the 90% threshold an average of 414 of these patients must be screened, assessed and investigated and referred on to the GP for 3 consecutive months. Although we have yet to achieve compliance we aim to see a steady overall improvement in scores for all three stages by the implementation of our recovery (detailed below).

Stage 1- Find – status RED

Performance in December for Stage 1 was 49.4%, a significant deterioration from November which was 74.9%. The dementia case finding question has now been added to all clerking proforma although for patients admitted to the Division of Medicine this only occurred in October 2013. As the Division

of Medicine accommodates the majority of patient aged 75 years or more in its inpatient emergency population, the change to the clerking proforma was expected to improve compliance, however disappointingly this has not been the case.

Stage 2 – Assessment and Investigation –status RED

Performance in December for Stage 2 was 66.7% against a target 90%. This is an improvement from November (57.7%).

Data for compliance is extracted from the specific electronic discharge summary for the 75 years and over patients (introduced in May 2013). There continues to be a number of patients who are aged 75 years and over who do not have the right electronic discharge summary used; however this number is reducing (105 in September compared with 215 in June, reduced to 100 in October, 95 in November and 94 in December).

The fields on the specific electronic discharge summary for the 75 year old and over patients can be, and are in some cases, still being bypassed. This results in patients who may have had the required assessments and investigations being counted as a "no".

Stage 3 – Referral on to GP – status RED

Performance in December for Stage 3 was 61.5% compared with 75.9% in November, demonstrating deterioration over the last month.

The number of patients audited is growing each month as the use of the specific electronic discharge summary increases. In December the number of patients admitted as emergencies who were aged 75 years and over minus exclusions stood at 302, the highest number to date.

For stage 2 and 3 of the CQUIN several fields on the specific electronic discharge summary are required in combination to ascertain whether the standards have been met. As fields are being bypassed, appropriate patients may have been assessed and investigated and referred, but this is not being reflected in the data.

There is also a significant number of patients aged 75 years and over where the specific electronic discharge summary has not been used at the point of discharge as mentioned above. If the specific electronic discharge summary is not used then none of the data on the care that may have been given in relation to the CQUIN is available for those patients so they have to be excluded.

Recovery plan, including expected date performance will be restored:

The focus of recovery will be:

- Ensure all patients who are aged 65 years and over have an abbreviated mental test score completed within the first 72 hours of admission;
- All patients who are aged 75 years and over are screened for delirium and are asked the dementia case finding question within 72 hours of admission;
- All appropriate patients following screening are assessed and investigated and referred on to the General Practitioner;
- Ensure that for all patients who are aged 75 years and over the correct specific electronic discharge summary is used;
- Improve the quality of the completion of the electronic discharge summaries to reduce the number of bypassed fields so that the data better reflects practice.

QUALITY

Steps to achieve this are:

- Improvement measures will be driven by the Trust's Dementia Operational Steering Group;
- The electronic discharge summary has been reviewed and revised to make completion more straightforward to improve compliance. Changes were implemented late November 2013;
- CQUIN requirements will be clarified on Connect (Intranet) pages, including publishing monthly figures. The information will be updated monthly with links distributed using Newsbeat (January 2014);
- A quarterly article regarding the requirements and progress of the CQUIN will be published in Newsbeat going forward;
- Continued reiteration of the requirements in Dementia Awareness Training (for all staff on induction);
- NHS England has published the outcome of their dementia education scoping exercise. This is being used to inform induction/ training requirements in the future for 'Basic Dementia Awareness'. An application has been made to reinstate the allocation of an hour time slot on induction for Dementia Training with revised and enhanced content to ensure all staff receive "Basic plus" competency level on induction. This will be considered at next Essential Training Steering Group meeting on 30th January 2014;
- The process to extract data regarding non-compliance by division and ward is in place form December 2013. This information will be used to facilitate divisional assistance and focused work (from January 2014 reflective of December's compliance). This has been distributed to Medical Director / Clinical Chairs and Heads of Nursing to support improvement in compliance and this will continue on a monthly basis;
- An additional clerking sheet has been developed in liaison with the elderly medicine consultant team which includes CQUIN requirements (FAIR process) as a prompt. This will be implemented on 20th January when the larger Elderly Admissions Unit (EAU) opens. This will enable focused work in key admission areas EAU and the Medical Admissions Unit (MAU);
- The case finding question (Stage 1) has been incorporated into the revised Trust wide adult admission document for nurses and allied health professions. A Trust-wide project group has been established to implement this in April 2014;
- A Dementia Specialist Nurse post will be submitted as part of the Division of Medicine's Operating Plan January 2014 supported by a business case to assist with improving care for patients with dementia.

QUALITY

Q15. EXCEPTION REPORT: Patient Experience-Kindness and understanding on postnatal wards	**RESPONSIBLE DIRECTOR: Chief Nurse**

Description of how the standard is measured:

As part of the Trust's monthly maternity survey, women are asked whether they were treated with kindness and understanding on the postnatal wards at St Michael's Hospital. This survey is carried out by post and so there is a time delay in receiving the results: this exception report relates to women who were cared for during November 2013.

The question wording and scoring methodology are taken from the Care Quality Commission's national survey programme. This example, derived from the November 2013 data, shows how the result is calculated as a weighting across all of the response options to the question:

Thinking about the care you received in hospital after the birth of your baby, were you treated with kindness and understanding?

Yes, definitely – 68%
Yes, to some extent – 26%
No – 6%
Score = 68 + (26 x 0.5) = 81

Performance in the period, including reasons for the exception:

Improvement of this survey score to at least 85/100 is one of the Trust's Quality ambitions for 2013/14. The score for November was 81, representing minimal or no change from baseline. This score has been red-rated for the last two survey months (October and November 2013). There is a time-delay in receiving the survey data and so there was insufficient opportunity to influence the November results by the time it was apparent that there was a red-rating for October.

There are three significant changes to postnatal care that could be a contributing factor to the recent results:

- Reconfiguration of the postnatal wards: whilst this was based on service-user feedback, and carried out to improve patient experience, there has been a period of adjustment for ward staff;
- A relatively large number of new midwives recruited into post;
- Midwifery assistant vacancies on the postnatal wards.

It should be noted that this score has seen sustained improvement since 2010. This was reflected in the 2013 National Maternity Survey (relating to women who gave birth in March 2013), where UH Bristol was classed as being better than the national average for kindness and understanding on postnatal wards. It should also be noted that the October and November scores are still in line with the national average, and that there has been no corresponding rise in complaints relating to maternity services.

QUALITY

Recovery plan, including expected date performance will be restored:

A number of actions are planned or have been undertaken in relation to these issues:

- The results have been discussed at the Women's Executive Committee. Further discussions will take place at the January matron's meeting;
- A review of the monthly survey data has been carried out to provide greater insight into the results;
- A staff survey has been carried out to obtain feedback about the new ward configuration. Women on the wards are also being asked for their views about the changes. This feedback is currently being reviewed and an action plan will be put in place by the end of January 2014;
- The Trust's Patient Experience Lead (engagement and involvement) will run a workshop with newly recruited midwives, focussing on how their role impacts on patient experience. This will replicate a number of earlier staff workshops in maternity services, which correlated with a positive increase in the survey scores;
- A consultant-level Patient Experience Lead for postnatal care has been identified and will become a champion for this element of quality;
- Recruitment to the midwifery assistant vacancies is now complete.

QUALITY

Q16. EXCEPTION REPORT: Number and percentage of complaints resolved within Local Resolution Plan timescale	**RESPONSIBLE DIRECTOR: Chief Nurse**

Description of how the standard is measured:

The number of complaints which are resolved within the timescale originally agreed (or subsequently renegotiated) with the complainant. The target for the percentage to be resolved within the formal timescale is 98% each month.

Performance in the period, including reasons for the exception:

In December 2013, 37 responses out of the 42 which had been due in that month were posted to the complainant by the date agreed (88.1%). This represents an improvement on the 81.2% reported for November 2013.

Five breaches were recorded in total for November:

- Surgery, Head & Neck – one case breached, due to a delay within the Division in providing the response for sign off.
- Medicine – one case breached due to a delay within the Division in providing the response for sign off.
- Facilities & Estates – one case breached due to a delay within the Division in providing the response for sign off.

There were no breaches at all for the Divisions of Specialised Services, Diagnostics & Therapies and Women & Children.

In total therefore, three of the five breaches were therefore attributable to Divisions; the remaining breaches were attributable to a delay during the sign-off process.

57.1% of the total responses due in November were returned to the Patient Support and Complaints Team at least four working days before the response was due with the complainant, a decrease on the 66.7% recorded in November.

Continued divisional focus will be required in order to achieve the Trust's 98% compliance target.

(It should be noted that if a response breaches a deadline because significant amendments are necessary, this is attributed as a divisional breach, even if the Division met the initial response deadline.)

Recovery plan, including expected date performance will be restored:

- Three cases out of five breached their deadlines due to delays within divisions. A 'validation report' has been completed for each case by the relevant Divisional Complaints Co-ordinator: as well as being a validation of the breach (data quality check), the report also describes how the delay could have been avoided and therefore how the Division will learn from this for the future;

QUALITY

- Performance is discussed and monitored at the Patient Experience Group, chaired by the Chief Nurse;
- All written responses must be received by the Patient Support & Complaints Team four working days before the response is due with the complainant: this is to allow time for the response to be checked prior to Executive sign-off.

QUALITY

Q17. EXCEPTION REPORT: Number of complainants dissatisfied with response	**RESPONSIBLE DIRECTOR: Chief Nurse**

Description of how the standard is measured:

The number of complainants who are dissatisfied with the response provided to their complaint due to the original investigation being incomplete or inaccurate. The target set for this indicator is nil.

Performance in the period, including reasons for the exception:

In December 2013, six complainants told us that they were dissatisfied with our response to their complaint; an increase on the three cases reported in November 2013. The six cases related to complaints in the following Divisions:

- Division of Medicine – two cases
- Division of Surgery, Head & Neck – four cases

The Patient Support and Complaints Team has reviewed these complaints and returned them to the relevant Divisions for further investigation and response to the outstanding concerns.

In the cases from Surgery Head & Neck, two complainants were dissatisfied because they did not feel their concerns had been fully addressed, one felt the Trust had not understood the impact the issues raised had had on them and one disagreed with a funding decision that is outside of the Trust's control.

In the Medicine cases, one complainant wished to attend a meeting to discuss their outstanding concerns and one disputed the information provided in the response.

Recovery plan, including expected date performance will be restored:

- A system has now been implemented to formally verify details of all dissatisfied cases with the Division. This ensures data accuracy and requires the Division to consider whether anything could have been done differently when the initial response was written – for purposes of future learning;
- The corporate Patient Support & Complaints Team continues to monitor response letters to ensure that all aspects of a complaint have been fully addressed; amendments are requested from Divisions if necessary;
- There is also rigorous checking of response letters by the Acting Chief Nurse, to ensure responses are complete and adequate before being sent to the complainant.

1.5 SUPPORTING INFORMATION

1.5.1 QUALITY ACHIEVEMENTS

This month's quality achievements are from the Division of Specialised Services.

Improved Quality Metrics - Falls and Pressure Ulcers reduction

The Division has seen a significant and sustained reduction in the incidence of falls which has been achieved through the divisional Falls Lead and the Ward Sisters working hard with staff to really understand the reasons for patients falling.

For the month of December the Division has seen no hospital acquired grade 2, 3 or 4 Pressure Ulcers, this is an exceptional achievement given that in December 2012 there were 9 pressure ulcers within the Division. Staff have been commended on this achievement and recognise the importance of ensuring that this is sustained.

Health and Safety

The Division have maintained its Blue Excellent rating in 2013's external Health and Safety Audit. The Divisional Leads for Health & Safety have ensured that all areas are aware of their responsibilities with regards to health and safety and have been commended with maintaining this result.

Gamma Knife

The official opening of the new Gamma Knife service was held on 22nd October in the Bristol Haematology & Oncology Centre (BHOC). This will provide patients across the South and South West of the UK with the best radio-surgical treatment available. Gamma Knife Radiosurgery is a day case radiotherapy (x-ray) treatment that uses 192 tiny beams of radiotherapy. These beams all focus on the tumour or lesion in the brain that needs treating and give a very high dose of radiotherapy in that spot, whist giving a very low dose of radiotherapy to the surrounding brain. The whole treatment occurs on one day and almost all patients can go home within one hour of completing the treatment.

High Dose Brachytherapy

The high dose rate brachytherapy service at BHOC has been extended to offer treatment to men with low and intermediate risk prostate cancer. This offers an alternative treatment to prostatectomy or a long course of radiotherapy for men in these risk groups. It is a type of radiation treatment given as a single procedure with one overnight stay on Ward 61. It is expected that the side effects will be less than with external radiotherapy as the high dose rate brachytherapy is focused on the prostate gland alone.

Recognising Success Staff Awards

The Division was delighted to have done so well at the Recognising Success Staff Awards in November 2013.

QUALITY

- Kate Love, Superintendent Radiographer was awarded the Inspirational Leader Award and Sarah Dodds, Head of Nursing was awarded Highly Commended in this Category
- Sarah Furniss, Matron was part of the team who won the Patient Safety award for their work in implementing the SBAR (Situation, Background, Assessment, Recommendation) structured communication tool for escalating deteriorating patients for urgent senior clinical review.
- The Cardiac Catheter Multi-Disciplinary Team was awarded Highly Commended in the Clinical Team of the Year.
- The Bristol Haematology and Oncology Centre Voluntary Drivers and Patricia Murphy, The Teenage and Young Adults with Cancer Volunteer were both awarded Highly Commended in the Volunteer of the year award.

Staff Engagement and Well Being

- Over the past quarter the Division has implemented a Divisional Newsletter which is emailed to all staff every month, this has received widespread positive feedback. Focus groups for staff run by the Divisional Human Resources team on wards and departments have also commenced in order to listen and hear from staff about what it is like to work here and how we can improve communication at all levels.
- An exciting initiative has commenced for our staff who are working whilst pregnant. The Divisional Human Resources Business Partner has set up monthly workshops which offer a range of information and tips on pregnancy, maternity and childcare. These are provided by our own healthcare professionals and have been well attended from across the Trust with some positive feedback received.

Staff Achievements

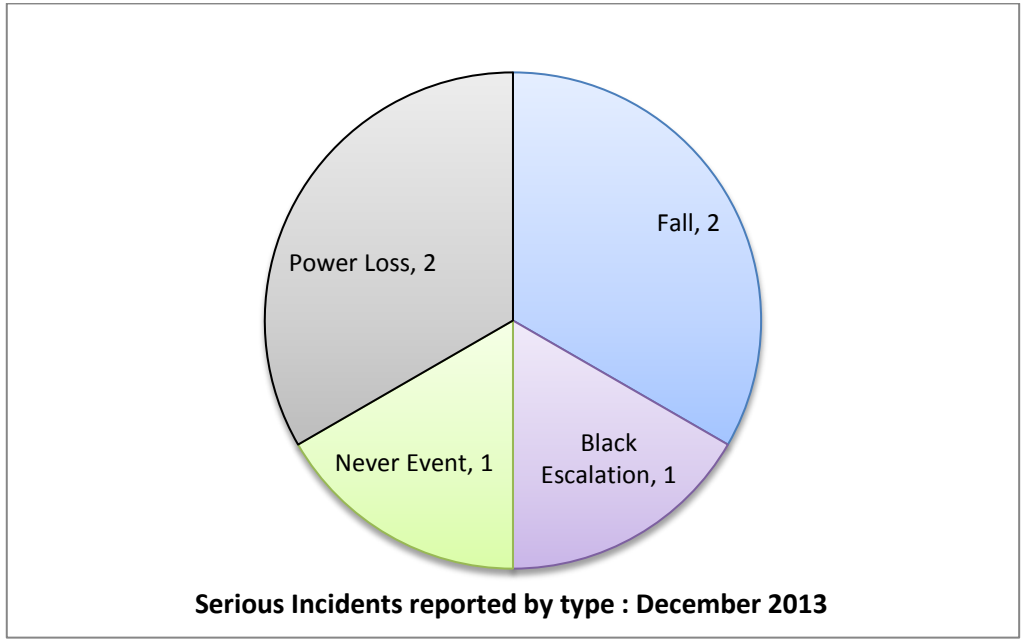
- National recognition for Consultant Cardiac Surgeon: Mr Jon Hutter was awarded the Severn Deanery Postgraduate School of Surgery Surgical Trainer of the Year in 2013 for his surgical skills and excellence in training
- PhD for Nurse Consultant: Jenny Tagney, Cardiology Nurse Consultant has obtained her PhD for the work she undertook entitled : ‘A randomised, clinical trial of a psycho-educational nursing intervention in people with Implantable Cardioverter Defibrillators’
- Valentino Oriolo, Lead Practitioner for Acute Coronary Syndrome and Cardiac Rehabilitation, has successfully secured a National Institute for Health Research (NIHR) clinical fellowship which will lead to his PhD. Valentino’s research project will be exploring how quality of life is measured in people who have survived Out-of-Hospital Cardiac Arrest.

1.5.2 SERIOUS INCIDENT THEMES

The quality dashboard shows that six serious incidents were reported in December 2013, one more than in the previous month. Five of the six incidents were reported within the 48 hour timescale.

The incident which breached the 48 hour timescale was reported in a timely manner as a health and safety incident and automatically notified to the Health & Safety Department, but the potential patient safety risk was not recognised and the Patient Safety Team was not notified. The Head of Health & Safety Services has asked her team to consider the patient safety impact of reported health and safety incidents and to contact the Patient Safety Team for advice if unsure.

The themes of serious incidents reported in December are shown below.



Serious Incidents reported by type : December 2013

QUALITY

Date of Incident	SI Number	Division	Reported within 48 hours	Status	Incident Type	Initial assessment of harm	Investigation
05/12/2013	2013 36060	Women's & Children's	Yes	Open	Black Escalation	None	Root Cause Analysis (RCA) underway
18/11/2013	2013 35962	Women's & Children's	No	Open	Power outage	Moderate	RCA underway
09/12/2013	2013 36314	Medicine	Yes	Open	Fall	Major	RCA underway
18/12/2013	2013 37656	Trust Services	Yes	Open	Power outage	None	RCA underway
30/12/2013	2013 38345	Medicine	Yes	Open	Fall	Major	RCA underway
22/12/2013	2013 38507	Surgery Head & Neck	Yes	Open	Never Event. Retained foreign object post-surgery.	Minor	RCA underway

WORKFORCE

2.1 SUMMARY

The Trust has selected a range of key workforce indicators. The indicator below target this month is bank and agency usage.

 **Achieving (1)**	 **Underachieving (2)**
- Appraisal compliance - compared with target	- Workforce numbers– compared with budget - Sickness absence - compared with target
 **Failing (1)**	 **Not reported/scored (1)**
- Bank and agency usage - compared with target	- Turnover (no target)

2.2 EXCEPTION REPORTS

An exception report is provided for the RED-rated indicator, which in December 2013 was as follows:

- Bank and agency usage – red rated against target

WORKFORCE

W2. EXCEPTION REPORT: Bank and Agency compliance	RESPONSIBLE DIRECTOR: Director of Workforce and Organisational Development

Description of how the standard is measured:

Bank and agency usage in Full Time Equivalents (FTE) compared with targets set by Divisions for 2013/14.

Performance in the period:

- Overall variance from target reduced from 41.9% to 38.8% during the last month. The reduction in variance against target during the last quarter was 21% and is shown in the last graph in the Supporting Information, section 2.3.1.
- Use of bank and agency staff reduced from 376 FTE in November to 346 FTE in December. Agency reduced by 16% (13.2 FTE) and bank reduced by 16% (16.5 FTE) in December compared with the previous month.
- Nursing agency reduced by 23% (11.3 FTE), and nursing bank reduced by 5% (10.3 FTE). 15.8 FTE was worked by nursing staff to fill bank shifts but paid as overtime, a reduction of 16% compared with last month.

Bank and Agency (FTE)	UH Bristol	Diagnostics & Therapies	Medicine	Specialised Services	Surgery Head & Neck	Women's & Children's	Trust Services (excluding Facilities & Estates)	Facilities & Estates
Actual December 2012	381.3	13.2	129.2	39.3	87.3	63.1	25.3	23.9
Actual December 2013	346.3	10.9	114.8	49.6	57.8	52.5	25.8	35.1
Target December 2013	212.1	18.5	49.8	24.3	45.1	46.9	12.3	15.1
	38.8%	-70.7%	56.6%	51.1%	22.0%	10.6%	52.2%	56.9%

Reasons for the exception:

- Usage of bank and agency for every reason reduced compared with last month, with the exception of nursing assistant one-to-one care, where usage was slightly higher than last month, accounting for 10% of all nursing and midwifery bank and agency usage.
- Trust-wide, approximately 31% of bank and agency usage was for increased patient acuity, extra capacity and increased administrative workload.
- 23% of bank and agency was booked to cover vacancies, compared with over 27% last month. The percentage of usage to cover vacancies was highest in Facilities & Estates, at 29%.
- Nearly 11% of usage was due to sickness absence compared with 14% last month.

WORKFORCE

Recovery plan, including progress and expected date performance will be restored:

One-to-One Care

- The Division of Medicine has progressed with the work to develop more effective staffing models for one-to-one care and Registered Mental Nurse Agency requirements, and will be producing a draft strategy by the end of February. The strategy will include Assessment Criteria and Training, and will also cover optimal staffing models to ensure the best care for these patients.

Workforce Planning

- The workforce planning process for both the annual operating plan and the Bristol Royal Infirmary (BRI) Redevelopment is now underway, with a focus on strengthening workforce planning to better align with capacity plans, including reviewing flexible staffing models.
- Staff rostering is being reviewed to reduce peaks in demand for bank staff. There have been visits to learn from other trusts and proposals are being developed to build on best practice and provide support and further training where necessary.

Recruitment and Retention

- Divisions continue to reduce reliance on bank and agency by recruiting to a higher percentage of the nursing and midwifery budgeted staffing, and each division is working with the Recruitment Team to ensure that new starters commence as soon as possible. Usage should continue to reduce as vacancies are filled by the end of the fourth quarter of the year.
- The recovery plan to reduce nursing vacancies has been slower during December, and vacancies still stand at 5.5%, largely due to the Christmas period resulting in delays in start dates, with 54 FTE with start dates during the first week of January. There were also 54 nursing and midwifery recruits who started during the month of December, 38 FTE of which were registered nurses.
- Plans are underway to improve the recruitment of newly qualified nursing staff through an assessment centre approach on a cohort basis. This will enable the Trust to plan the new graduate intake each year and provide a more rigorous process to ensure the quality and calibre of graduates appointed. The Recruitment Team is also working with Nursing colleagues to attract more experienced nurses. Part of this approach includes an Open Day, which is being planned for March 2014.
- 10 new cleaning staff commenced this month; 6 in Facilities & Estates and 4 in the Trust Bank office. Recruitment continues for Domestic Assistant posts during the final quarter of the year, with close partnership working between the Facilities Managers and the Recruitment team, to further streamline the processes and increase the speed of conversion from application to appointment. A dedicated campaign for recruitment to the Children's Hospital expansion goes live in January 2014, with two Open Days, which should also attract applications for vacancies across the rest of the Trust.
- Turnover amongst registered nurses has been steadily increasing over the last two years, and now stands at 11.4% compared with 6.7% in December 2011. Recruiting to keep pace with turnover has become increasingly challenging, so divisions and corporate Human Resources are working together to develop an action plan to improve retention, including more detailed and accessible exit questionnaires, and gathering feedback from new starters within their first year with a view to addressing any specific issues. This action plan will be developed and

implemented over the next six months.

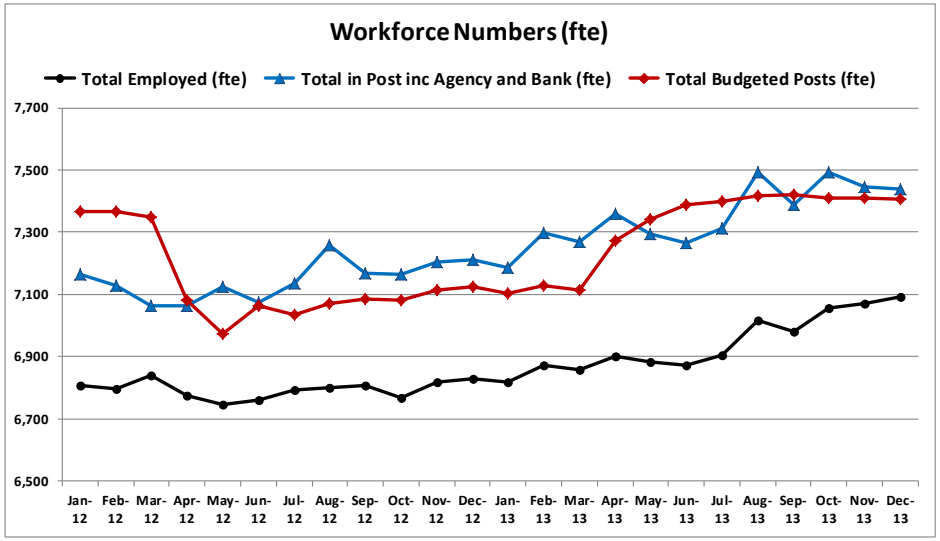
Management of Sickness Absence

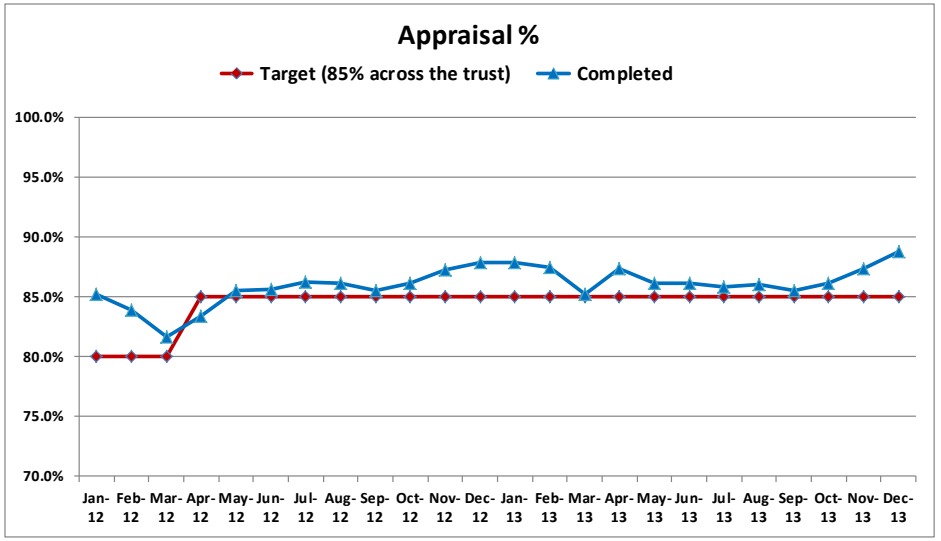
- The Trust-wide Health and Well-Being plan continues to be implemented, including the pilot group for pregnant staff in Specialised Services Division, the February launch of the "Lighten-up" campaign to target stress, and the Health and Wellbeing website revisions, due by the end of January.
- The recommendations in the internal audit on Sickness and Annual Leave will continue to be implemented over the next six months, including addressing untimely submission of sickness returns, the need to remind staff about Trust policies and procedures and more guidance on the use of the Percentage Absence Calculator. The Supporting Attendance Policy is being reviewed which will support the implementation of these recommendations.
- Divisions with high sickness have continued to implement local recovery plans.

2.3 SUPPORTING INFORMATION

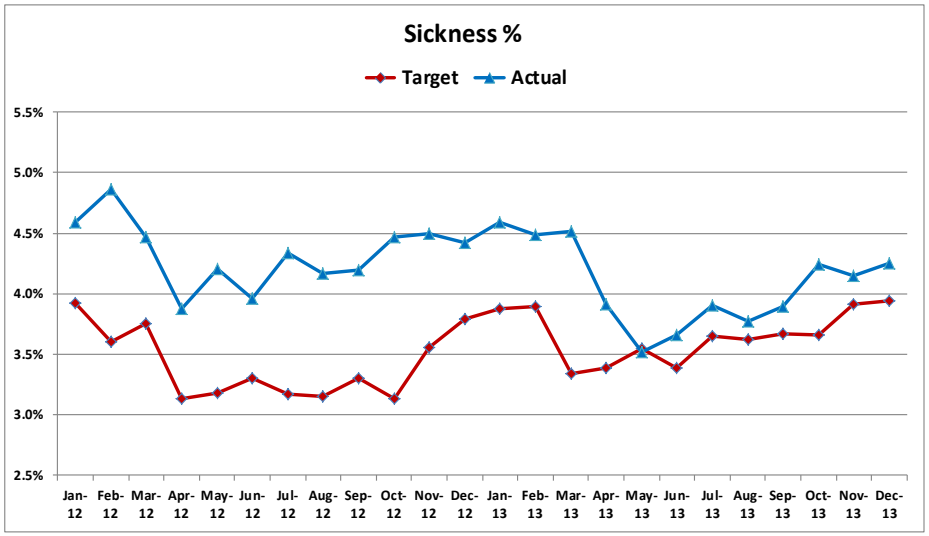
2.3.1 Performance against key workforce standards

This section provides an outline of the Trust's performance against workforce indicators for workforce numbers, appraisal rates, sickness rates, top five causes of sickness absence and bank and agency usage. The last two charts are for nursing and midwifery, showing agency rates and vacancy rates.





WORKFORCE


Sickness %
Target
Actual
5.5%
5.0%
4.5%
4.0%
3.5%
3.0%
2.5%
Jan-12
Feb-12
Mar-12
Apr-12
May-12
Jun-12
Jul-12
Aug-12
Sep-12
Oct-12
Nov-12
Dec-12
Jan-13
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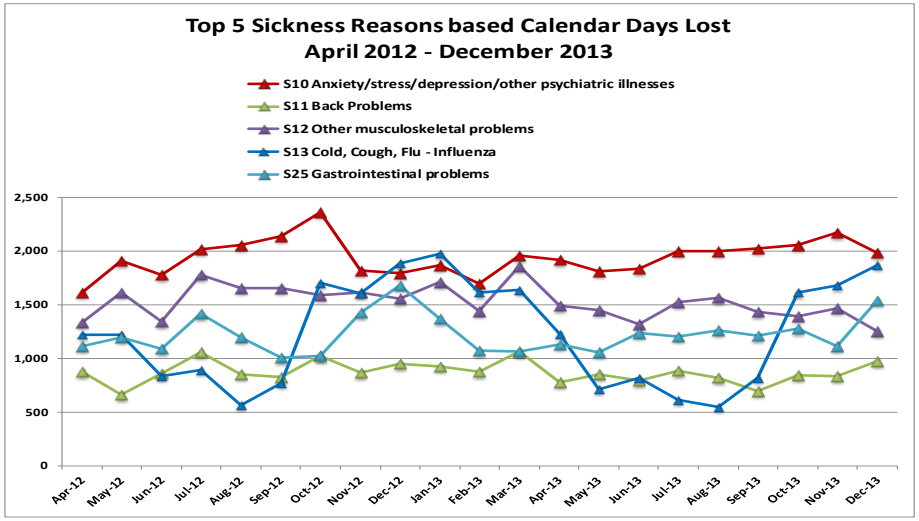
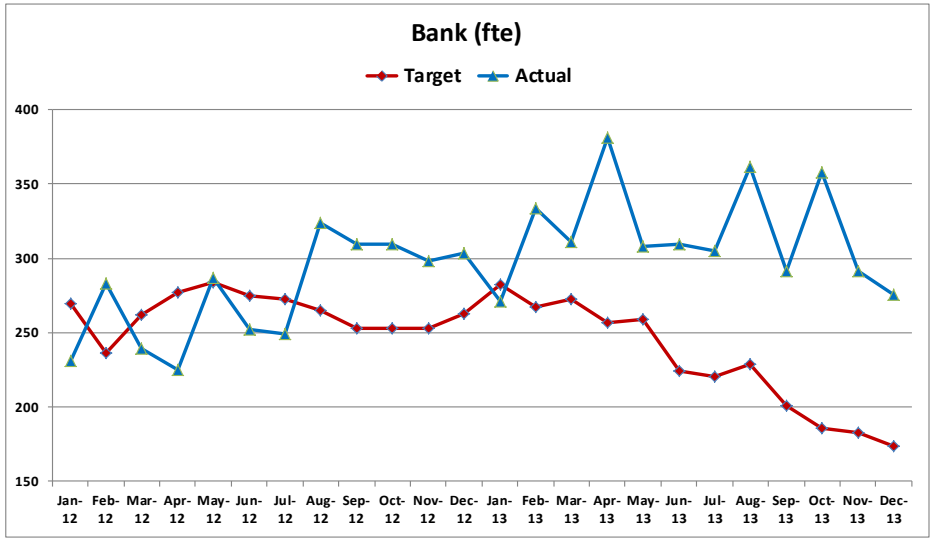
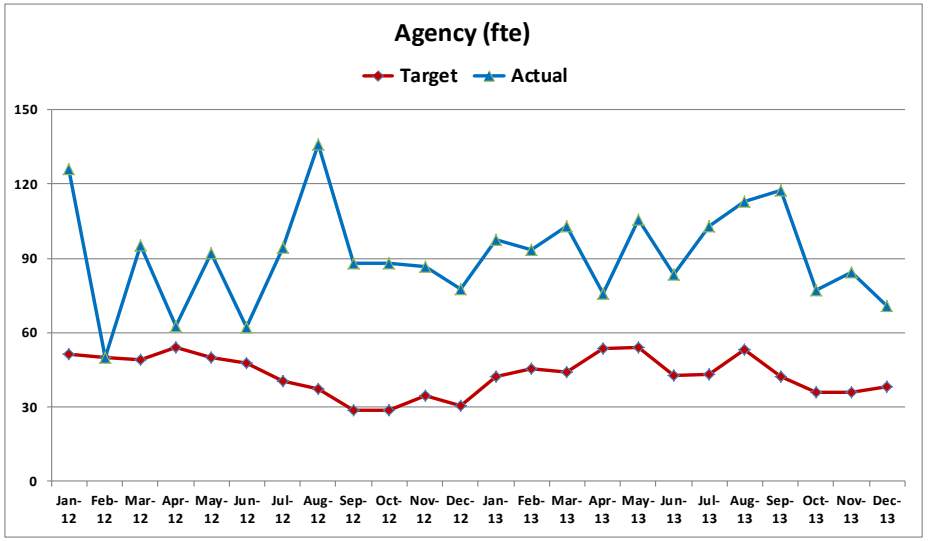
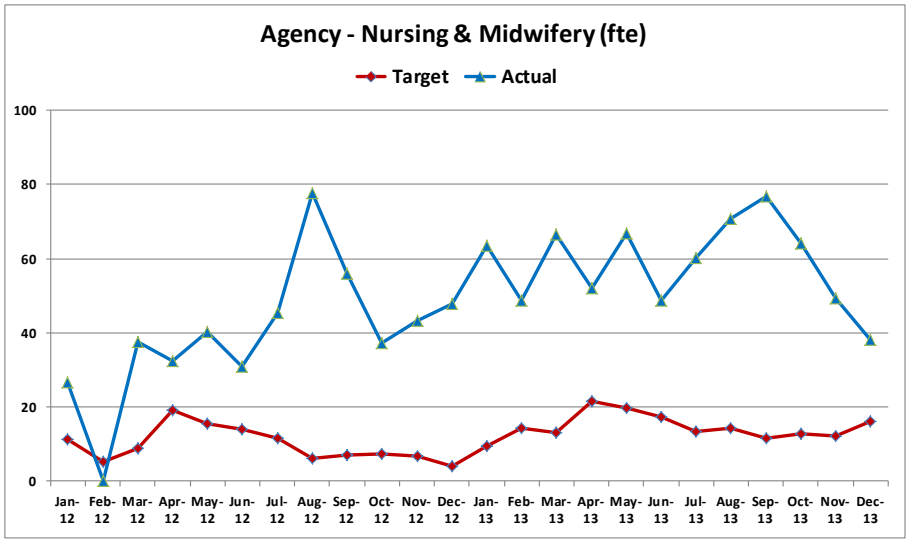
Nov-13
Dec-13

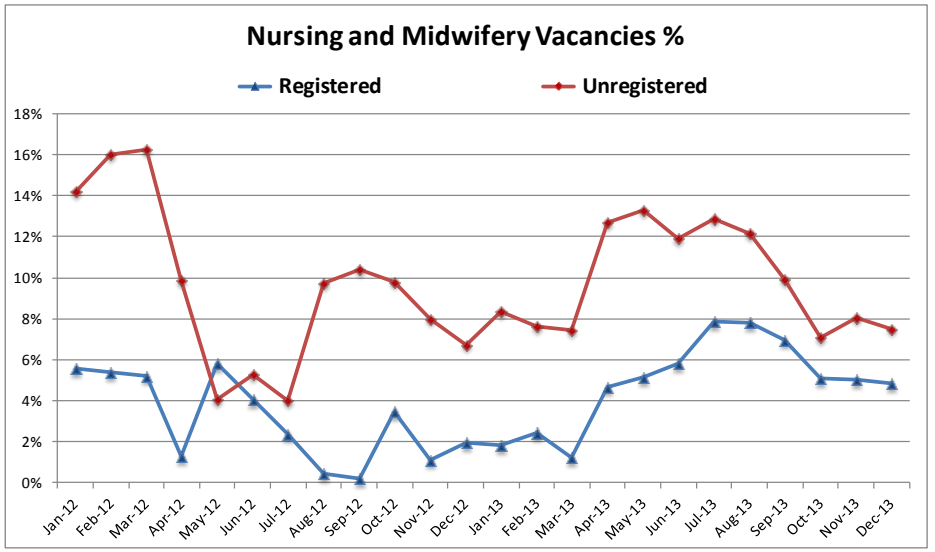

Top 5 Sickness Reasons based Calendar Days Lost
April 2012 - December 2013
S10 Anxiety/stress/depression/other psychiatric illnesses
S11 Back Problems
S12 Other musculoskeletal problems
S13 Cold, Cough, Flu - Influenza
S25 Gastrointestinal problems
2,500
2,000
1,500
1,000
500
0
Apr-12
May-12
Jun-12
Jul-12
Aug-12
Sep-12
Oct-12
Nov-12
Dec-12
Jan-13
Feb-13
Mar-13
Apr-13
May-13
Jun-13
Jul-13
Aug-13
Sep-13
Oct-13
Nov-13
Dec-13

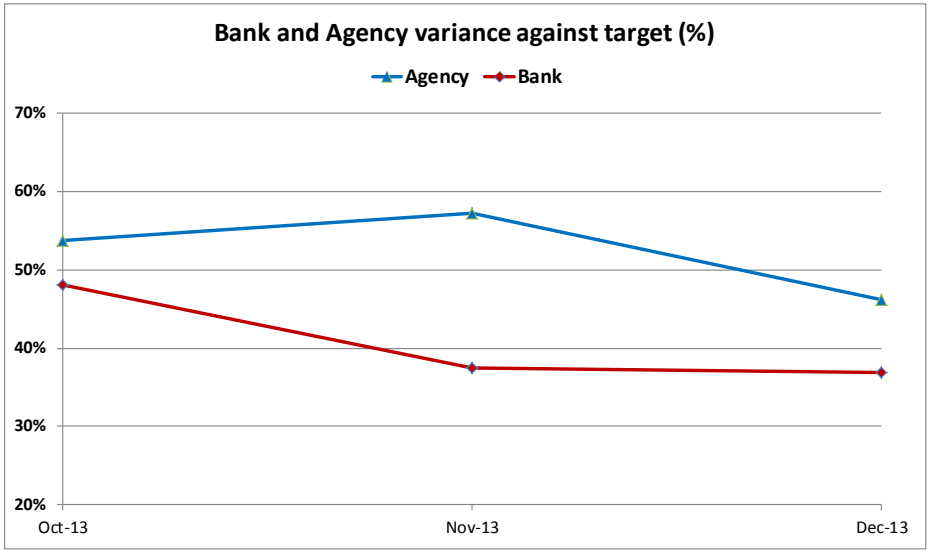

Bank (fte)
Target
Actual
400
350
300
250
200
150
Jan-12
Feb-12
Mar-12
Apr-12
May-12
Jun-12
Jul-12
Aug-12
Sep-12
Oct-12
Nov-12
Dec-12
Jan-13
Feb-13
Mar-13
Apr-13
May-13
Jun-13
Jul-13
Aug-13
Sep-13
Oct-13
Nov-13
Dec-13


Agency (fte)
Target
Actual
150
120
90
60
30
0
Jan-12
Feb-12
Mar-12
Apr-12
May-12
Jun-12
Jul-12
Aug-12
Sep-12
Oct-12
Nov-12
Dec-12
Jan-13
Feb-13
Mar-13
Apr-13
May-13
Jun-13
Jul-13
Aug-13
Sep-13
Oct-13
Nov-13
Dec-13

WORKFORCE


Agency - Nursing & Midwifery (fte)
Target
Actual
100
80
60
40
20
0
Jan-12
Feb-12
Mar-12
Apr-12
May-12
Jun-12
Jul-12
Aug-12
Sep-12
Oct-12
Nov-12
Dec-12
Jan-13
Feb-13
Mar-13
Apr-13
May-13
Jun-13
Jul-13
Aug-13
Sep-13
Oct-13
Nov-13
Dec-13


Nursing and Midwifery Vacancies %
Registered
Unregistered
18%
16%
14%
12%
10%
8%
6%
4%
2%
0%
Jan-12
Feb-12
Mar-12
Apr-12
May-12
Jun-12
Jul-12
Aug-12
Sep-12
Oct-12
Nov-12
Dec-12
Jan-13
Feb-13
Mar-13
Apr-13
May-13
Jun-13
Jul-13
Aug-13
Sep-13
Oct-13
Nov-13
Dec-13


Bank and Agency variance against target (%)
Agency
Bank
70%
60%
50%
40%
30%
20%
Oct-13
Nov-13
Dec-13

2.3.2 Sickness absence

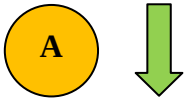
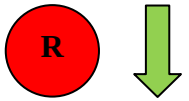
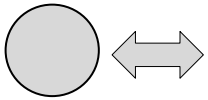
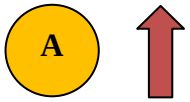
Sickness absence this month is within the tolerance zone of the target and is therefore rated amber, and does not therefore require an exception template. The following data is included for information, showing sickness absence rate against target for each division.

	UH Bristol	Diagnostics & Therapies	Medicine	Specialised Services	Surgery Head & Neck	Women's & Children's	Trust Services (excluding Facilities & Estates)	Facilities & Estates
Absence December 2012	4.4%	2.4%	4.8%	4.8%	4.1%	4.6%	3.3%	7.6%
Target December 2013	3.9%	2.8%	3.9%	4.0%	3.6%	4.4%	2.9%	6.4%
Absence December 2013	**4.3%**	**2.8%**	**4.1%**	**5.1%**	**3.5%**	**4.5%**	**4.0%**	**7.2%**
Cumulative absence December 2013	3.9%	2.7%	4.5%	4.4%	3.6%	3.8%	3.1%	5.8%
	0.4%	0.0%	0.2%	1.1%	-0.1%	0.1%	1.1%	0.8%

2.3.3 Changes in the period

Performance is monitored for workforce costs, workforce numbers, bank and agency usage, turnover, sickness and appraisal percentage. Essential Training in January 2014 and New Deal Regulations compliance will be reported in February 2014.

The following dashboard shows key workforce information indicators RAG (Red, Amber, Green) rated for the month of December. Red rated indicators are outside tolerance limits and exception reports are provided for these.

Indicator	RAG Rating[1]	Commentary	Notes
Workforce Numbers		Workforce numbers reduced by 0.1% compared with November 2013. This month, workforce numbers were 0.4% above budgeted FTE. This compares with November 2013, which was 0.5% above budgeted establishment.	See summary and supporting information
Bank/ Agency		Agency reduced by 16% (13.2 FTE) and bank reduced by 16% (16.5 FTE) in December compared with the previous month.	See summary, supporting information and exception report.
Turnover		Rolling turnover (with exclusions) remained static at 11.5%.	See summary
Sickness		Sickness increased by 0.2% to 4.3%, 0.4 percentage points above the monthly target across the Trust. This compares with November 2013, which was 0.2 percentage points above the monthly target.	See summary and supporting information
Appraisal		Trust-wide appraisal rates for all staff were 88.8%. All Divisions achieved the stretch target of 85% which was introduced in April 2012. Divisional rates were: Diagnostics & Therapies 89.7%, Medicine 90.5%, Specialised Services 88.5%, Surgery Head & Neck 89.2%, Women's & Children's 85.4%, Trust Services 93.4%, and Facilities & Estates 87.6%.	See summary and supporting information

Note: RAG (Red, Amber, Green) rating reflects whether the indicator has achieved the target, or is within defined tolerance limits. The direction of the arrow shows the change from last month. The colour of the arrow reflects whether actual this month is better in relation to the target (green) or further from the target than last month (red). Please note that sickness and bank and agency targets are set by Divisions.

2.3.4 Monthly forecast and overview

Measure	Dec-12	Jan-13	Feb-13	Mar-13	Apr-13	May-13	Jun-13	Jul-13	Aug-13	Sep-13	Oct-13	Nov-13	Dec-13	December 13 Planned
Budgeted Posts (FTE)	7126.2	7102.7	7127.7	7114.5	7272.5	7340.6	7387.6	7399.9	7415.6	7420.3	7408.3	7411.1	7406.4	7344.6
Total Employed (FTE)	6831.1	6818.7	6871.8	6856.9	6902.7	6882.4	6872.9	6905.5	7017.4	6979.7	7056.7	7071.7	7093.7	7120.1
Bank (FTE) Admin & Clerical	76.9	63.2	77.7	71.2	83.3	65.8	71.7	75.1	95.3	67.1	80.0	63.9	58.4	37.3
Bank (FTE) Ancillary Staff	16.1	14.5	17.5	19.4	25.3	21.6	27.3	29.8	37.6	27.4	36.7	27.0	25.6	9.9
Bank (FTE) Nursing & Midwifery	210.6	181.7	224.6	205.4	257.6	209.0	200.2	189.6	217.1	188.6	232.2	194.5	184.2	121.5
Agency (FTE) Admin & Clerical	10.9	13.1	12.5	11.7	9.8	17.8	11.3	18.2	19.9	27.3	12.2	14.8	17.4	7.4
Agency (FTE) Ancillary Staff	12.9	15.9	19.0	17.8	7.6	17.2	13.7	12.2	10.5	-0.5	-10.0	10.7	10.5	5.6
Agency (FTE) Nursing & Midwifery	47.9	63.6	48.7	66.4	52.1	66.8	48.7	60.3	70.9	76.9	64.1	49.4	38.1	16.1
Overtime	61.1	66.5	61.9	86.1	79.5	57.0	59.3	62.1	71.1	96.1	81.9	66.9	64.0	
Sickness absence[1] Rate (%)	4.4%	4.6%	4.5%	4.5%	3.9%	3.5%	3.7%	3.9%	3.8%	3.9%	4.2%	4.1%	4.3%	3.9%
Appraisal (%)	87.8%	87.9%	87.4%	85.2%	87.3%	86.1%	86.1%	85.9%	86.1%	85.5%	86.1%	87.3%	88.8%	85.0%
Rolling Average Turnover[2] (all reasons) (%)	18.2%	17.7%	18.2%	18.3%	18.5%	18.5%	18.7%	15.9%	18.7%	18.5%	18.4%	18.3%	18.2%	
Rolling Average Turnover[3] (with exclusions) (%)	11.2%	11.4%	11.4%	11.4%	11.5%	11.4%	11.6%	11.6%	11.7%	11.6%	11.5%	11.5%	11.5%	
Vacancy[4] Rate (%)	4.1%	4.0%	3.6%	3.6%	5.1%	6.2%	7.0%	6.7%	5.4%	5.9%	4.7%	4.6%	4.2%	

- Sickness absence is expressed as a percentage of total whole time equivalent staff in post.
- Turnover measures the number of leavers expressed as a percentage of the average number of staff in post in the period. Turnover (all reasons) excludes bank, locum and honorary staff.
- Turnover (with exclusions) excludes bank, locum, honorary and fixed term staff together with junior doctors.
- Vacancy measures the number of vacant posts as a percentage of the budgeted establishment.

ACCESS STANDARDS

3.1 SUMMARY

The following section provides a summary of the Trust's performance against key national access standards at the **end of December 2013**. It shows those standards not being achieved either in the current ***quarter (i.e. quarter 3)***, and/or the ***month***. The standards include those used in Monitor's Compliance Framework, as well as key standards included within the NHS operating framework and NHS Constitution.

Achieving (18)	**Underachieved (1)**
- 31-day diagnosis to treatment cancer standard - *subsequent drug + radiotherapy* - 31-day diagnosis to treatment cancer standard - *subsequent surgery* - 31-day diagnosis to treatment cancer standard - *first treatment* - 62-day referral to treatment cancer standard – *screening referred* - 62-day referral to treatment cancer standard – *GP referred* - 2-week wait urgent GP referral cancer standard - Referral to Treatment Time for admitted patients - Referral to Treatment Time for incomplete pathways - Genito-Urinary Medicine (GUM) 48-hour access - A&E Time to Initial Assessment - A&E Left without being seen rate - A&E Time to Treatment - A&E Unplanned re-attendance - Reperfusion times (door to balloon time of 90 minutes) - Infant health – breastfeeding rate	- Reperfusion times (call to balloon time of 150 minutes) – *local target not achieved* - 6-week wait for key diagnostic tests
Failed (4)	**Not reported/scored (0)**
- Referral to Treatment Time for non-admitted patients - A&E Maximum waiting time (4-hours) - Last-minute cancelled (LMC) operations - 28-day readmission following a last-minute cancellation	

*Please note: Performance for the cancer standards is reported by all trusts in the country two months in arrears. The current cancer performance figures shown include the draft figures for December. Indicators are shown as being **failed** where the required standard is not achieved for the quarter to date. Indicators are shown as being **underachieved** if there has been a failure to achieve the national target in the current month, but the quarter is currently being achieved, or where a local standard is not being met.*

3.2 ACCESS DASHBOARD

Access Standards - dashboard

		Thresholds		Previous YTD	Year to date (YTD)	Month												Quarter			
	Target	Green	Red			Jan-13	Feb-13	Mar-13	Apr-13	May-13	Jun-13	Jul-13	Aug-13	Sep-13	Oct-13	Nov-13	Dec-13	Q4 12/13	Q1 13/14	Q2 13/14	Q3 13/14
Cancer	Cancer - Urgent Referrals Seen In Under 2 Weeks	93%	93%	94.8%	96.4%	96.2%	95.8%	96.9%	97.6%	96.1%	97.1%	96.6%	95.7%	97.2%	95.0%	96.2%	Cancer standards report two months in arrears	96.3%	96.9%	96.5%	95.6%
	Cancer - 31 Day Diagnosis To Treatment (First Treatments)	96%	96%	97.1%	97.5%	96.4%	95.4%	97.1%	98.1%	98.2%	97.6%	99.4%	96.5%	94.3%	96.8%	99.5%		96.3%	98.0%	96.7%	98.2%
	Cancer - 31 Day Diagnosis To Treatment (Subsequent - Drug)	98%	98%	100.0%	99.9%	100.0%	98.3%	100.0%	100.0%	100.0%	99.0%	100.0%	100.0%	100.0%	100.0%	100.0%		99.4%	99.7%	100.0%	100.0%
	Cancer - 31 Day Diagnosis To Treatment (Subsequent - Surgery)	94%	94%	94.3%	95.1%	95.6%	97.7%	93.8%	83.8%	100.0%	97.2%	96.1%	95.2%	89.3%	100.0%	92.6%		95.6%	94.2%	94.2%	97.6%
	Cancer - 31 Day Diagnosis To Treatment (Subsequent - Radiotherapy)	94%	94%	98.8%	98.0%	95.5%	100.0%	100.0%	98.9%	98.9%	98.2%	97.8%	98.1%	97.1%	97.1%	97.6%		98.3%	98.7%	97.7%	97.3%
	Cancer 62 Day Referral To Treatment (Urgent GP Referral)	85%	85%	87.4%	81.0%	76.2%	72.9%	82.0%	83.1%	78.5%	85.7%	76.6%	77.9%	82.7%	83.5%	82.7%		77.0%	81.7%	78.9%	83.1%
	Cancer 62 Day Referral To Treatment (Screenings)	90%	90%	90.5%	92.3%	86.7%	87.5%	97.8%	96.3%	89.3%	91.2%	95.3%	100.0%	93.9%	91.7%	84.5%		90.5%	92.1%	96.6%	87.7%
	Cancer 62 Day Referral To Treatment (Upgrades)	Not published	Not published	94.7%	93.8%	72.4%	90.6%	70.8%	100.0%	100.0%	100.0%	94.3%	88.2%	100.0%	86.7%	84.2%		78.8%	100.0%	94.2%	85.3%
Referral to Treatment	Referral To Treatment Admitted Under 18 Weeks	90%	90%	92.4%	92.9%	91.1%	92.3%	93.6%	93.5%	93.2%	94.4%	93.0%	92.8%	92.2%	92.9%	91.6%	92.1%	92.3%	93.7%	92.7%	92.3%
	Referral To Treatment Non Admitted Under 18 Weeks	95%	95%	95.7%	93.2%	95.1%	96.4%	96.2%	95.8%	95.7%	95.7%	92.5%	91.5%	91.3%	92.4%	91.3%	94.0%	95.9%	95.7%	91.8%	92.5%
	Referral To Treatment Incomplete pathways Under 18 Weeks	92%	92%	92.1%	92.5%	92.1%	92.4%	92.1%	92.3%	92.2%	92.8%	92.2%	92.3%	92.6%	92.9%	93.1%	92.2%	92.2%	92.5%	92.4%	92.7%
A&E Clinical Quality Indicators	A&E Total time in A&E 4 hours - without Walk in Centre attendances	95%	95%	94.3%	94.4%	94.6%	93.0%	90.0%	91.1%	95.4%	96.0%	93.8%	95.6%	97.1%	95.1%	95.4%	90.8%	92.5%	94.1%	95.4%	93.7%
	A&E Time to initial assessment (95th percentile) - in minutes	15	15	77	15	12	14	21	53	39	14	14	13	12	13	13	14	15	38	13	13
	A&E Time to treatment decision (median) - in minutes	60	60	54	52	45	47	58	57	51	51	54	47	49	53	53	53	51	53	50	53
	A&E Unplanned reattendance rate (within 7 days)	5%	5%	2.5%	1.3%	2.8%	2.8%	2.9%	0.7%	0.7%	0.7%	0.6%	0.7%	0.6%	2.3%	2.2%	3.0%	2.8%	0.7%	0.6%	2.5%
	A&E Left without being seen	5%	5%	2.0%	1.8%	1.1%	1.2%	1.7%	1.8%	1.4%	1.4%	1.8%	1.7%	1.8%	2.2%	2.1%	2.1%	1.4%	1.5%	1.7%	2.1%
Other key access standards	Last Minute Cancelled Operations	0.80%	1.50%	1.02%	0.97%	1.61%	1.59%	1.18%	1.65%	0.96%	0.82%	1.15%	0.85%	0.72%	0.65%	0.96%	1.02%	1.46%	1.14%	0.91%	0.85%
	28 Day Readmissions	95%	85%	91.0%	89.4%	93.9%	90.2%	90.6%	89.6%	81.3%	89.5%	88.9%	88.4%	93.6%	95.0%	95.0%	92.6%	91.2%	86.0%	90.1%	94.0%
	6-week wait for key diagnostics	99%	99%		98.5%	85.9%	92.0%	95.5%	97.9%	98.0%	98.4%	97.7%	98.2%	98.5%	98.9%	99.5%	98.8%	91.1%	98.1%	98.1%	99.1%
	Primary PCI - 150 Minutes Call To Balloon Time (direct admissions only)	90%	70%	82.6%	83.3%	86.0%	83.3%	72.4%	87.9%	66.7%	87.8%	89.7%	84.4%	65.0%	86.2%	91.2%		81.6%	81.3%	81.5%	88.9%
	Primary PCI - 90 Minutes Door To Balloon Time (direct admissions only)	90%	90%	91.7%	94.0%	93.0%	90.5%	82.8%	93.9%	87.9%	95.1%	96.6%	90.6%	95.0%	96.6%	97.1%		89.5%	92.5%	93.8%	96.8%
	Infant Health - Mothers Initiating Breastfeeding	76.3%	74.5%	80.4%	81.4%	79.2%	82.7%	81.4%	81.6%	80.8%	85.0%	82.4%	81.5%	78.9%	81.6%	79.1%	82.3%	81.0%	82.4%	80.9%	81.0%

Please note:
Where the threshold for achieving the standard has changed between years, the latest threshold for 2013/14 has been applied in the Red, Amber, Green ratings.
Infant Health breast feeding rates have a GREEN threshold of being above 2011/12 performance, and a RED threshold of the national average that year.
The standard for Primary PCI 150 Call to Balloon Time only applies to direct admissions - the local target is shown as the GREEN threshold and the national target as the RED.
All **CANCER STANDARDS** are reported nationally two months in arrears. Monthly figures are indicative, until they are finalised at the end of the quarter. The figures shown are those reported as part of the National Cancer Waiting Times data-set. They do not reflect any breach reallocation for late referrals, which is only allowable under Monitor's Compliance Framework.

3.3 CHANGES IN THE PERIOD

Performance against the following national standards changed significantly compared with the last reported period:

- A&E 4-hour maximum wait ↓(down from 95.4% in November to 90.8% in December)
- 6-week wait for key diagnostic test ↓ (down from 99.5% in November to 98.8% in December)
- 28-day readmission following a last-minute cancellation ↓ (down from 95.0% in November to 92.6% in December)
- 62-day referral to treatment cancer standard - *screening referred* ↓ (down from 91.7% in October to 84.5% in November) – but forecast to achieve for the quarter as a whole
- Reperfusion times (call to balloon time of 150 minutes) ↑ (up from 86.2% in October to 91.2% in November)

Please note the above performance figures only show the final reported position and do not show the draft December performance against the cancer standards, although additional information is noted where the draft figures have been validated.

3.4 EXCEPTION REPORTS

Exception reports are provided for the four RED rated performance indicators, and two indicators* reported as at risk for quarter 4.

1) Last-minute cancellations
2) 28-day readmission following a last-minute cancellation
3) 62-day referral to treatment cancer standard – *GP referred**
4) Referral to Treatment Time (RTT) Non-admitted pathways standard
5) A&E 4-hour maximum wait
6) 6-week wait for key diagnostic tests*

ACCESS STANDARDS

A1–A2. EXCEPTION REPORT: Last-minute cancellation + 28-day readmission following a last-minute cancellation	RESPONSIBLE DIRECTOR: Chief Operating Officer

Description of how the target is measured:

1) The number of patients whose operation was cancelled at last minute for non clinical reasons, as a percentage of all admissions.

This standard remains part of the NHS Constitution.

Monitor measurement period: Not applicable

Performance during the period, including reasons for exception:

There were 47 last-minute cancellations (LMCs) of surgery in December (1.02% of operations) which is above the national standard of 0.8%. The main reasons for cancellations in December were as follows:

- 36% (17 cancellations) were due to an emergency patient being prioritised on the day
- 23% (11 cancellations) were due to no ITU/HDU beds to admit a patient to
- 11% (5 cancellations) were due to a surgeon being taken ill/not being available due to having to cover another session
- 9% (4 cancellations) were due to no ward bed being available to admit a patient to
- 9% (4 cancellations) were due to theatre sessions running over because of clinically complex patients taking longer than expected

Of the 47 cancellations, 18 were day-cases and 29 were inpatients (38% day-cases). On average, seventy percent of the Trust's admissions in a month are day-cases. The higher rate of inpatient cancellations reflects the high cancellation rate due to emergency patients needing to take priority, and no critical care beds being available, which is more likely to impact inpatient than day-case procedures.

Only 4 of the 47 cancellations were due to a ward bed not being available. This reflects the improvement in patient flow seen during the period. During the same period last year there were 12 bed-related cancellations.

In December, 92.6% of patients cancelled in the previous month were readmitted within 28 days of the cancellation, which is just below the 95% national standard. There were 4 breaches of standard in the month. The reason for these patients not being readmitted within the target 28 days was more urgent patients needing to take priority and bed pressures in the Bristol Children's Hospital.

Recovery plan, including expected date performance will be restored:

The following actions continue to be taken to reduce last-minute cancellations and support achievement of the 0.8% standard (*please note: actions completed in previous months have been removed from the following list*):

- Ongoing implementation of 4-hour plans, the actions from which should reduce cancellations related to bed availability (see A&E 4-hour

Exception Report – A5);

- Escalation of all LMCs not re-booked within 7 days of cancellation (ongoing); patient list now also being reviewed at the weekly or fortnightly Referral to Treatment Time (RTT) meetings with Divisions;
- Monthly validation of all potential LMCs re-established, to ensure we are not inappropriately reporting last-minute cancelled operations, or failures to re-admit within 28 days, and that we understand the reasons for cancellations (ongoing);
- Outputs of the weekly scheduling meeting are reviewed by Surgery, Head & Neck team, to be clear on the accountability for making sure theatre lists are appropriately booked (i.e. will not over-run), and the necessary equipment/staffing are available (ongoing);
- Weekly reviews of future week's operating lists continue, to ensure the demand for critical care beds is spread as evenly as possible across the week; daily reviews of current demand for critical care beds, and flexible critical care bed-usage across Divisions to minimise cancellations (ongoing);
- Daily e-mails circulated of all on-the-day cancellations within the Bristol Royal Infirmary by the nominated Patient Flow Co-ordinator, to help ensure patients are re-booked within target (ongoing);
- The Division of Surgery, Head & Neck will be opening an additional ITU bed, taking the total adult general High Dependency Unit (HDU)/Intensive Therapy Unit (ITU) beds to 20 – the twentieth ITU bed will open on the mid February (it was planned for the 20th January, but unfortunately this date had to be moved);
- Actions have been identified to front-load the elective critical care requests towards the start of the week to smooth the flow through ITU. Thoracic team to re-model team timetable to support moving HDU requests to Mondays by 1st October 2013 (**Action complete**) – there is now a weekly review of all critical care requests to smooth flow;
- The Division of Surgery, Head & Neck has reviewed the cancellations due to scheduling errors – patient flow managers have undertaken work to review avoidable reasons for last minute cancellations due to scheduling issues. A working group was set-up to review scheduling. A Standard Operating Procedure has been written to assist discharges through ITU/HDU (**Action complete**)
- Review of thoracic emergency capacity to be undertaken in Quarter 3 to reassess theatre capacity to avoid routine cancellations of electives for emergency inpatients (ongoing).

Progress against the recovery plan:

The 0.8% national last-minute cancelled operations standard was not achieved in December. However, performance for Q3 as a whole at 0.85% was significantly better than the same period last year at 1.04%. The 28-day readmission standard was also narrowly missed for the quarter at 94% against the 95% standard. Current pressures on ward and ITU bed availability, due to high levels of emergency admissions, puts achievement of the standard in quarter 4 at risk. However, the opening of the additional critical care bed, in particular, is expected to bring further improvements in performance

against these standards, along with Phase 2 of the patient flow programme.

ACCESS STANDARDS

A3. EXCEPTION REPORT: 62-day referral to treatment for GP referred patients	RESPONSIBLE DIRECTOR: Chief Operating Officer

Description of how the target is measured:

The number of patients with confirmed cancers treated within 62 days of referral, as a percentage all cancer patients treated during the period under that standard. There are separate targets for GP and screening referred patients.

Monitor measurement period: Quarterly, as part of a combined 62-day cancer standards (weighted 1.0)

Performance during the period, including reasons for exceptions:

62-day GP referred

Performance in November was 82.7%. However, following further validation of October's performance, that improved from the previously reported 83.5% to 85.5%. This will be reflected when the quarter's data is submitted in full at the beginning of February.

Breach analysis for the November showed the following:

- Late tertiary referral – 19.2% – *unavoidable*
- Medical deferral/clinical complexity – 19.2% – *unavoidable*
- Clinical trial – 15.3% - *unavoidable*
- Admitted diagnostic procedure delay – 15.3% - *avoidable*
- Delayed outpatient appointment – 11.5% - *avoidable*
- Patient choice delay – 11.5% - *unavoidable*
- Elective cancellation (due to critical/high care bed availability) – 3.8% of breaches – *avoidable*
- Pathway delay other provider – *3.8% - unavoidable*

The total proportion of breaches that were considered to be *potentially* avoidable in November was 31%. The 85% standard could have been achieved without any breach reallocation for late referral if the Trust had been able to prevent 50% (2 of the 4) of these potentially avoidable breaches from occurring. This, however, would have been very challenging, as breaches are usually multi-factorial and involve an element of both avoidable and unavoidable causes.

Lung pathways accounted for 31% of the breaches of standard in the period. The reasons for the breaches were mainly due to late referral, but also, clinical complexity, outpatient appointment delay and no critical care bed being available. Head & Neck accounted for a further 31% of breaches, with admitted diagnostic procedure delays representing half of all breach reasons.

The transfer of breast and urology services to North Bristol Trust has left the Trust with a challenging group of pathways to meet the 62-day GP standard. This is because breast cancers are relatively easy to treat within 62-day of referral because the diagnostic pathways are simple and patients

are usually fit enough to proceed to treatment without further intervention. To illustrate this, the table below shows the latest (quarter 2 2013/14) national average performance against the 85% standard for each tumour site. In quarter 2 2013/14 the 85% standard was only achieved for breast and skin cancers. The national cancer waiting times guidance acknowledges that the targets applied to the cancer standards will not be achievable for every tumour site. The Trust is now the only trust in the country that provides neither breast nor urology cancer services.

Tumour site	National average performance against 85% standard in Q2 2013/14
Breast	97.4
Gynaecological	82.7
Haematological	83.1
Head & Neck	74.5
Lower Gastrointestinal	78.8
Lung	79.0
Other	74.3
Sarcoma	76.2
Skin	97.3
Upper Gastrointestinal	78.9
Urological	83.4
All Cancers	**86.7**

To achieve the 85% standard in future quarters the Trust has to therefore perform better than it has historically performed for each of the remaining tumour sites. A programme of work on the high volume tumour sites is ongoing, focusing on how we can make cancer pathway management more proactive, such as shadowing booking the likely next step in the pathway and developing more pre-planned pathways for patients. This should minimise the unavoidable delays and improve the experience for patients.

Recovery plan, including expected date performance will be restored:

The following actions are being taken to reduce the risks to achievement of the 62-day standard for GP referred patients in Quarter 4 2013/14. *Please note: actions completed in previous months have been removed from the following list*:

- An initial review has been carried-out of pathway redesign opportunities for patients referred-in on the 62-day GP pathway. This has identified a number of areas which have been scoped and project plans developed. These include:
    - Review of Head & Neck cancer pathways, to include ways of reducing identified delays during the diagnostic phase; current and future state mapping now completed; high impact/quick wins action plan drawn-up and are now being implemented;
    - Reducing the maximum wait for the first outpatient appointment from 14 days to 10 days; initial analysis undertaken which

highlighted four pathways which could benefit from a shorter wait: lung, head & neck, colorectal and haematology; colorectal capacity to be reviewed as a priority and additional activity to be included in the Division's 2014/15 Operating Plan, both to deliver a shorter first wait, but also to support shorter waiting times for other outpatient steps in the pathway;

- An electronic solution for adding of cancer patients to the elective waiting list (ongoing);
- A fast-track pathway for patients identified as having cardiac problems which need to be assessed or treated, prior to treatment of their cancer, has been established and is being trialled;
- Ensuring there is enough capacity to see cancer patients in the pre-operative assessment clinic one-stop service; ensuring demand for key diagnostic tests (e.g. CPET) that are required following pre-operative assessment can be met, so that these patients can be fast-tracked (Ongoing); one additional fast-track slot for CPET testing has been established per week, alongside the pre-operative assessment clinic that thoracic patients attend; the slots will be increased to three in March; capacity and demand for pre-operative assessment slots has been assessed, which showed there should be sufficient capacity to see all patients, so attendance rates are now being monitored;
- Work to speed-up the transfer of internal referrals between respiratory and thoracic surgery, including reducing typing delays;
- Work with late referring providers for lung cancer treatments; several improvements have been made following discussions with Taunton; referral times will now be monitored to understand the impact; improvements to pathways will be rolled-out to other providers;
- Shadow-booking of the follow-up outpatient appointment that needs to takes place after the Multi-Disciplinary Team (MDT) meeting;
- A year's worth of benchmarking data has been produced to enable visits to high performing trusts for Lung and Colorectal cancer pathways to be identified (**Action complete**); visit planned to Sheffield Teaching Hospitals NHS Trust;
- ICE (Order Communications) diagnostic test requesting to be reviewed to reduce the risk of requests being made as routine rather than fast-track.

- Changes to the thoracic clinic timetable, which should significantly reduce the waits for outpatient appointments (**in place from beginning of October**); the thoracic pathway as a whole has been process mapped and further work is being undertaken to implement improvements to the pathway including timely referral from Respiratory Physicians;
- Additional thoracic and upper gastro-intestinal operating lists have been established, to help to reduce the delays to patients cancelled as a consequence of current emergency pressures (Ongoing);
- Additional Intensive Therapy Unit (ITU) bed to be opened mid February;
- Benchmarking of our cancer performance against an agreed peer group of trusts that have similar workload and complexity of cases (Action complete); next quarterly report produced for the March Cancer Board

ACCESS STANDARDS

- Letters continue to be sent to referring trusts when a referral is received after day 46 in the pathway (Ongoing); breach reallocation agreed with late referring provider as appropriate;
- Please also see the actions detailed in the A&E 4-hour plans update (see Exception report - A5).

Progress against the recovery plan:

December's performance against the 62-day GP standard is 82.7% before final validation. Breach reallocations for late referrals are currently being agreed and should take performance for the quarter to above 85%. The 62-day screening standard was achieved without breach reallocation.

The full impact of the early changes to the lung cancer pathway should be seen during quarter 4. The impact of further pathway redesign work in other areas should also be seen in quarter 4. However, early indications are that the expected number of breaches for the quarter is high, due to late tertiary referrals, patient choice to delay pathways over the Christmas period, medical deferrals and cancellations due to no critical care beds being available. Achievement of the 62-day GP standards in quarter 4 is therefore considered to be at risk.

ACCESS STANDARDS

A4. EXCEPTION REPORT: Referral to Treatment Time (RTT) non-admitted pathways standard	RESPONSIBLE DIRECTOR: Chief Operating Officer

Description of how the target is measured:

The number of patients treated or discharged within 18 weeks of referral, as a percentage of all patients treated or discharged in the month. The Non-admitted target of 95% relates to those patients not requiring an admission as part of their treatment.

Performance is assessed by Monitor at an aggregated Trust level.

Monitor measurement period: Monthly achievement required but quarterly monitoring

Performance during the period, including reasons for exceptions:

Performance in December was 94.0%, which is a significant improvement on the November position of 91.3%, but still 1.0% below the 95% national standard. The failure to achieve the RTT non-admitted standard was forecast following the Head & Neck service transfer from North Bristol Trust, due to the number of patients already waiting over 18-week for their first outpatient appointment, at the point of transfer. The forecast failure was flagged to Monitor in the Annual Plan, and re-stated as part of the quarter 2 declaration of compliance.

The analysis of the breaches confirms that the main reasons for the failure to achieve the 95% standard in December were:

- Additional patients that had waited over 18 weeks from referral being seen for first outpatient appointments within the adult Ear, Nose & Throat and Oral Surgery services following transfer of the waiting list from North Bristol Trust; this is partly due to the volume and length of waits at the time of transfer, but also increases in referral volumes beyond that expected as part of the transfer
- Additional patients being seen for their first outpatient appointment to reduce the waiting times in other dental specialties where waiting times have increased

The backlog of non-admitted over 18 week RTT waiters in Adult Ear, Nose & Throat (ENT) increased from 100 in November to 119 in December, mainly due to a reduction in service capacity. Similarly, the number of non-admitted over 18 week RTT waiters in the other key Head & Neck specialties increased from 276 in November to 296 in December. However, there was a decrease in the number of long waiters in Oral Surgery, from 112 in November to 95 in December.

Although the RTT Non-admitted standard would have been achieved if Adult ENT and Dental specialties had performed at 95% or above, there has also been a failure to achieve the 95% standard in a number of other specialties, including Rheumatology, Trauma & Orthopaedics, Dermatology and Paediatric specialties, which is being addressed as part of the recovery plan.

The current assessment of RTT backlogs and plans to bring forward outpatient appointments forecasts delivery of the 95% standard in quarter 2 2014/15. Plans are therefore going back for further review by Divisions, to try to establish what additional actions and capacity can be put in place to

restore performance more quickly. A RTT Steering Group has been established to review and oversee the implementation of the plans. Plans will come back to the Senior Leadership Team in February for sign-off.

Recovery plan, including expected date performance will be restored:

- A RTT steering group has been established to review and progress action plans to restore performance as quickly as possible; this will meet weekly in quarter 4, but will then run monthly; the agreed plans and trajectory will be reported to the Board next month;
- Options to increase service capacity within adult ENT continue to be explored and progressed; a new process for offering patients the opportunity of attending an earlier appointment at UK Specialist Hospitals – UKSH - Emersons Green Treatment Centre has been established, some of whom would otherwise have breached the 18-week RTT standard with current waiting times; a locum is being appointed and additional ad hoc clinic sessions both in and out-of-hours are being put in place, although outpatient nurse staffing remains a constraint
- Additional capacity continues to be established to reduce waiting times for patients waiting their first outpatient appointment in dental specialties (Ongoing); a further recovery trajectory is being developed which in combination with the Adult ENT plan will provide a forecast for how quickly performance can be restored for Head & Neck services
- Each of the remaining specialties that is currently not achieving the 95% standard is reviewing its recovery plan with the aim of bringing forward achievement of the 95% standard in quarter 4

Progress against the recovery plan:

Although there's been a significant reduction in the number of patients waiting over 18 weeks on non-admitted pathways, monthly performance continues to be below 95% for patients treated in the period. The key risk to achievement of the RTT Non-admitted standard in quarter 4 is long waits for first outpatient appointments, which is the focus of the recovery plans. The aim is to restore achievement of the 95% standard in non Head & Neck specialties as soon as possible in Quarter 4. The work currently being undertaken will inform the recovery trajectory for Head & Neck services and therefore determine the forecast for achievement of the standard again, at a Trust level.

ACCESS STANDARDS

A5. EXCEPTION REPORT: A&E maximum wait 4 hours	RESPONSIBLE DIRECTOR: Chief Operating Officer

Description of how the target is measured:

A&E maximum wait 4 hours

The number of patients admitted, discharged or transferred within 4 hours of arrival in the Trust's Bristol Royal Infirmary (BRI), Bristol Children's Hospital and Bristol Eye Hospitals, as a percentage of all patients seen. The local Walk in Centre attendances are no longer included in the performance figures.

Monitor measurement period: Quarterly

Performance during the period, including reasons for exceptions:

Whilst the 95% standard was achieved at a Trust level in October and November there was a deterioration in performance in December which resulted in the standard being failed for the quarter as a whole.

The main dip in performance in performance was at the Bristol Children's Hospital, with performance in December being significantly below the 95% standard at 89.8%. This decline in performance has been associated with a significant increase in ambulance arrival and emergency admissions, with a 19% and 34% increase over the same month last year, respectively. There were 767 emergency admissions in December, which is the highest level recorded (see Table 1), the next highest being in November. The very high levels of emergency admissions are due to exceptional levels of paediatric respiratory illness within the community, which mirrors the national picture. Levels peaked before Christmas, as predicted by national public health teams, and then declined. Performance for January to date in the Children's Hospital is above 97%.

Table 1. The number of emergency admission into the Bristol Children's Hospital (via the Emergency Department) each month during the last four years

Year	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2010/11	628	570	488	478	400	509	587	570	639	637	522	575
2011/12	498	384	340	337	283	388	393	453	448	414	387	469
2012/13	398	568	546	621	401	492	516	514	574	479	460	578
2013/14	583	533	517	523	507	588	637	743	767			

Performance at the BRI is below the 95% standard in January. This appears to mainly be due to several wards being closed due to norovirus, which has resulted in empty ward beds not being able to be used and also numbers of patients staying over 14 days rising.

ACCESS STANDARDS

Recovery plan, including expected date performance will be restored: Work continues on Phase II of patient flow project, which is now fully operational. Six projects have been prioritised. Updates on progress are detailed below:

- ***Ambulatory Care*** – maximise the use of ambulatory care pathways for ambulatory care conditions to reduce emergency admissions.

  First additional pathway developed for Anaemia (**completed**). Development of additional pathways for Ambulatory Care (in progress).

- ***Ward Processes*** – this will include continued work on reverse triage, criteria-led discharge, electronic handover (eHandover) and discharge medication (To Take Away - TTA) and aims to develop a proactive approach to discharge planning, support the continued increase of patients discharged before midday, increase TTAs and discharge summaries prepared the day before discharge and increase discharges at weekends.

  Pilot Upper Gastrointestinal and Bristol Heart Institute TTA process (In progress). Specification for IT system to be agreed (Completed). New IT system to support ward processes to be fully operational by end of February 2014.

- ***Critical Care Pathways*** – aims to improve timeliness of transfers to and from Intensive Therapy Unit (ITU), reduce the number of elective cancellations due to ITU availability and improve the timeliness of repatriation of tertiary referrals.

  Executive sign off of repatriation policy for ITU to ITU transfers (**completed**). Secure sign-up from neighbouring trusts (January 2014). Review scheduling of complex cases requiring ITU throughout the week (January 2014).

- ***Care Homes Project*** – develop processes to support transfers to care homes 7 days per week and the timeliness from referral to transfer to care homes.

  New referral / transfer form signed off (**completed**). Secure sign-up to transfer standards at the Care Home Group (January 2014).

- ***Improved working with partners & Out of hospital care*** – these projects have been combined due to the significant overlap. The joint project aims to improve information sharing and joint working to smooth pathways for patients across partner organisations, reduce the amount of time patients are delayed in an acute hospital setting, better utilisation of community beds available for rehabilitation and to clarify the care needs of patient and community services required to support patients discharged from hospital into community beds.

  Community rehabilitation pilot to commence (In progress - review February 2014). Additional community case managers to be in post (January 2014). Weekly review of delays with partner organisations to reduce delays in acute setting (In progress)

- ***Medical Assessment Unit (MAU)*** – to ensure ownership of management of patients within MAU and early supported discharge from MAU either via outpatients or Ambulatory Care.

  Agree operational policy and specialty bed allocation for unit (**completed**). Pilot new ways of working (January 2013).

- ***Elderly Assessment Unit (EAU)*** – EAU is now part of the 'business as usual' work programme following the work undertaken in Phase I. However, based on the successes of the project in reducing the length of stay for over 75 year olds, a larger EAU opened on the 20th January 2014. This was achieved through a reconfiguration of the current wards and increased the size of the EAU from 18 to 30 beds, to support

additional focus on the elderly care pathways (January 2014).

Progress against the recovery plan:

The 95% national standard was achieved in October and November. However, due to the recent deterioration in performance at the Bristol Children's Hospital (BCH) and the Bristol Royal Infirmary (BRI), the 95% standard was not met in December or for the quarter as a whole. Performance has now recovered to well above the 95% standard in the BCH, but remains below standard at the BRI. Phase II of the Patient Flow Programme is now operational and will help to support ongoing improvements in patient flow through the BRI. Performance is expected to reach the 95% standard again once the wards affected by norovirus are re-opened. The 95% standard is still forecast to be achieved in quarter 4, although achievement is considered to be at risk given January's performance and the expected higher level of emergency pressures in quarter 4.

ACCESS STANDARDS

A6. EXCEPTION REPORT: 6-week wait for key diagnostic tests	RESPONSIBLE DIRECTOR: Chief Operating Officer

Description of how the target is measured:

The number of patients waiting over 6 weeks for one of the top 15 key diagnostic tests at each month-end, shown as a percentage of all patients waiting for these tests. The figures include patients that are more than 6 weeks overdue a planned diagnostic follow-up test, such as a surveillance scan or scoping procedures. The national standard is 99%.

Monitor measurement period: Not applicable; the monitoring period nationally is monthly.

Performance during the period, including reasons for exceptions:

Performance in December was 98.8% against the 99% national standard for 6-week diagnostic waits. This is a deterioration on November's performance, when the 99% national standard was achieved. There were 70 breaches of the 6-week standard at month-end, 13 of which were for paediatric endoscopies, and 32 for cardiac stress echos.

An improvement plan was implemented in November 2012, following which there were month on month improvements in performance against the 6-week wait standard through to the end of June.

Improvement trajectory	Mar 2013	Apr 2013	May 2013	Jun 2013	Jul 2013	Aug 2013	Sep 2013	Oct 2013	Nov 2013	Dec 2013
Waiting list size (estimate)	4324	4304	4284	4274						
Forecast number of > 6 weeks non endoscopy cases	80	60	40	30						
Forecast number of > 6 weeks endoscopy cases	282	188	94	0						
Forecast total > 6 weeks	**362**	**248**	**134**	**30**						
Performance trajectory	91.6%	94.2%	96.9%	99.3%	99.0%	99.0%	99.0%	99.0%	99.0%	99.0%
Actual number of > 6 weeks other	67	50	107	37	50	82	65	65	22	54
Actual number of > 6 weeks adult audiology	0	0	0	46	83	23	21	2	2	1
Actual number of > 6 weeks endoscopy	130	43	19	11	11	8	4	6	7	15
Actual total > 6 weeks	197	93	126	94	144	113	90	73	31	70
Actual performance	**95.5%**	**97.9%**	**98.0%**	**98.4%**	**97.7%**	**98.2%**	**98.5%**	**98.9%**	**99.5%**	**98.8%**

The original dip in performance resulted from demand for the gastrointestinal endoscopies outstripping available service capacity. This was due to a significant rise in demand for the procedures, which is a pattern that has been seen both regionally and nationally. The rise in demand could not be responded to quickly due to delays in the opening of additional facilities at South Bristol Community Hospital. However, a remedial action plan was

developed which addressed this and the backlog of adult endoscopy cases was cleared at the end of May. There were two breaches of the 6-week wait standard for adult endoscopies in December. These were not due to capacity reasons but clinical complexity. There were a further thirteen breaches for paediatric gastrointestinal endoscopies, which resulted from cancellations due to emergency pressures in the period, and also more urgent cases needing to be scoped.

Demand for Cardiac Stress Echocardiograms is rising due to recent chances in NICE guidance for patients with cardiac problems. Capacity is also restricted due to the limited number of staff able to undertake these diagnostic tests. There were thirty-two month-end breaches for Stress Echocardiograms, which is an increase of sixteen relative to last month. A recovery plan has been developed for Cardiac Stress Echocardiograms, with a planned date for addressing the backlog of the end of February. However, the plan is being revised in light of a known drop in capacity due to a planned consultant absence of several weeks.

Recovery plan, including expected date performance will be restored:

The following actions are being taken to support achievement of the 6-week wait standard in quarter 3. *Please note: actions completed in previous months have been removed from the following list*:

- Additional capacity is being identified to minimise the number of patients waiting over 6 weeks for a Stress Echocardiograms; a capacity plan has been developed but is now being revised due to a planned absence by one of the lead consultants;
- Additional capacity to be put in place to reduce the small backlog of paediatric endoscopy procedures following the loss of capacity in December due to emergency admissions
- Due to the high level of patient cancellations and resultant bulge in demand for diagnostic tests in January, the Division of Diagnostics & Therapies is reviewing the need for extra capacity to be established in quarter 4, in order to clear any backlogs

Progress against the recovery plan:

Although the 99% standard was achieved in November, the number of long waiters has increased in a number of areas including Stress Echocardiograms and Paediatric endoscopies. There were a high number of patient cancellations in December, which have resulted in a bulge in demand for diagnostic tests in January. For this reason it is not expected performance will be restored until March at the earliest, although plans continue to be developed to bring forward achievement.

University Hospitals Bristol NHS
NHS Foundation Trust

Cover Sheet for a Report for a Public Trust Board Meeting, to be held on 30 January 2014 at 10:30 in the Conference Room, Trust Headquarters, Marlborough Street, Bristol, BS1 3NU

6. Infection Control Quarterly Report

Purpose

An update of Infection Prevention and Control activities during, October, November and December 2013.

Abstract

The Trust continues to reduce the number of *Clostridium difficile* cases, although the number of cases is above the third quarter trajectory. The action plan continues and is monitored by the Medical Director and Chief Nurse. The Infection Control Group and SDG.

There have been no MRSA bacteraemia since May 2013. The IV access coordinator is in post and has set up a vascular access group with member of the multidisciplinary team.

All decontamination equipment within the Trust remains compliant in terms of annual and quarterly validation – this service is provided by a third party provider – Audere. Validation for community dental decontamination equipment is also provided by a third part contractor – Eschmann.

With an increase in *Clostridium difficile* cases over the past few months Matrons in all Divisions have taken a proactive approach and met with their infection control teams to review all cases. As a result matron's have actioned some concentrated training for new starters and infection control have supported wards very well. Cannula spot checks continue to be a focus by matrons with an emphasis on removing pre admission cannula within 24 hours of admission.

The monitoring of antibiotic prescribing compliance continues. The inclusion of a stop or review date continues to be the main barrier to the achievement of the 90% target.

The scores have improved over the last 3 months, achieving a Trust wide score of 96% in November.

Due to black escalation in January, this report has not yet gone to the Infection Control Group – it is hoped that the Infection Control Group can be rearranged for early February.

Recommendations

The Trust Board is recommended to receive this report by the Chief Nurse for review.

Report Sponsor

Chief Nurse Carolyn Mills

Appendices

- Linen Audit Report.
- Preliminary report for the use of Procalcitonin testing.

INFECTION PREVENTION AND CONTROL QUARTERLY REPORT (OCTOBER-DECEMBER 2013) TO THE TRUST BOARD

REPORT PRODUCED BY DIRECTOR INFECTION PREVENTION AND CONTROL AND THE SENIOR INFECTION CONTROL NURSE/DEPUTY DIPC

Clostridium difficile:

- The national target ceiling for 2013/14 has been set at 35 cases. There are financial penalties aligned to this target.

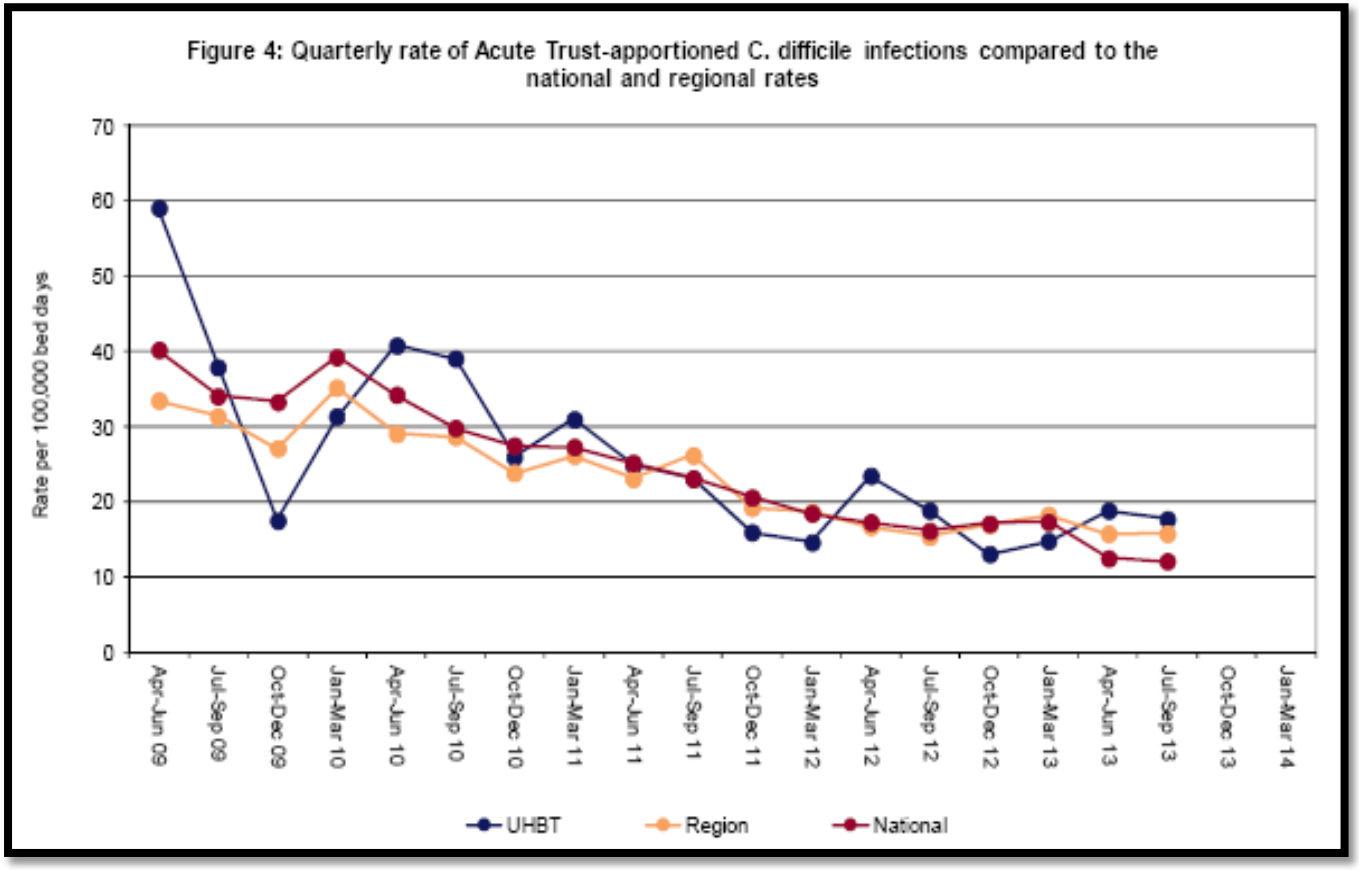
	OCTOBER	NOVEMBER	DECEMBER
Target	3	3	2
Actual	2	3	4

- The third quarter total was 9 cases of *Clostridium difficile.* This was against a target of 8. Although exceeding the Trust target at this time for 2013/14, the Trust are 4 cases below the total for the first 3 quarters of 2012/13, so there is still a year on year reduction.
- Timelines are undertaken for each case to investigate if there were any common themes or if further actions need to be implemented.
- The action plan continues to ensure the Trust is delivering safe and best practice to patients who acquire *Clostridium Difficile*. Updated actions include:
- Patients who are colonised with *Clostridium difficile* and who have active disease continue to be nursed and managed on the cohort ward.
- Procalcitonin testing continues in MAU and EAU. Preliminary results show that 58% of antibiotics have been stopped or not given due to low Procalcitonin levels. Dr Isobel Baker has included a report for ICG.
- Seventeen General Practitioners attended the study afternoon in the Education centre on 5th December. This was well received by the GP's and they are keen for more sessions to be arranged. More sessions are planned throughout the year. These sessions can be added to their Continuing Professional Development (CPD) points.
- A study morning was held in November for senior staff and managers of nursing homes. This included management of patients with *Clostridium difficile*, antibiotic treatment and environmental cleaning. More session are planned throughout the year.
- A new antibiotic called Temocillin has been added to the formulary. There is less risk of patients developing *Clostridium difficile* when being treated with this antibiotic.
- The antibiotic guideline smartphone application (App). Training has commenced and uploading of data is complete. Data now being proof read. It is planned for the App to be available from April 2014.
- Screening of BMT *Clostridium difficile* positive patients on admission has commenced.

- A trial commenced in December using an Adenosine Triphosphate (ATP) machine. This will enable the Trust to ensure the standards of cleaning are being met. Results will be available at the next ICG meeting in April.
- Partnership working with colleagues in the Clinical Commissioning Group (CCG) continues. The CCG are planning to appoint an Infection Control Nurse, who once in post will liaise closely with the Trust team.

Comparative data:

Figure 1 – Rate of *Clostridium difficile* infection per 1,000 bed days



The graph shows that the Trust is above the National and Regional rate for the first quarter. The data is published one quarter in arrears.

- No deaths caused by *Clostridium difficile* on part one of the death certificates for this quarter.

MRSA BACTERAEMIA

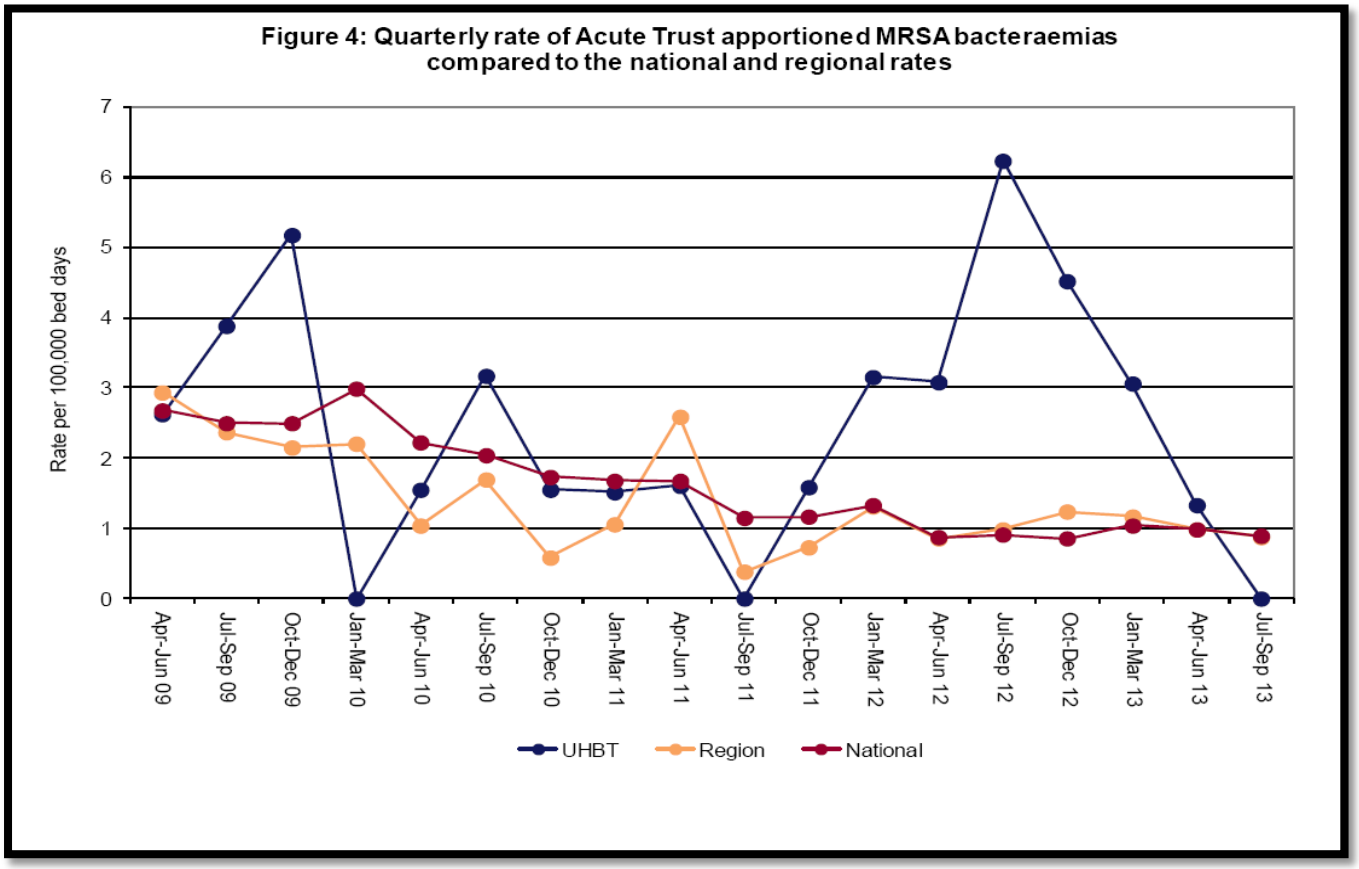
October	November	December.
0	0	0

There have been no MRSA bacteraemia attributed to the Trust since May 2013. The IV access coordinator has been in post since August 2013. The following actions have been commenced:

- A vascular access group has been set up. This is a multidisciplinary group meeting on a monthly basis. The group will facilitate a multidisciplinary approach to improvements in vascular access and provide a forum for collaboration across neighbouring Trusts and specialities. The group will monitor quality indicators, facilitate the development of guidelines using evidence based practice and adhere to national standards. The group will organise and facilitate Trust wide education.
- An audit is to be undertaken to ascertain the level of understanding staff have with regards to ANTT and to look at practice. This will initially be within the admitting units as they undertake the largest volume of peripheral cannula insertion and IV therapies.
- All adult central line insertions are being capture on four different databases in the Trust. Work is being undertaken to develop the databases so that staff can record any line removals or any incidences that occur whilst the line is insitu.
- All cases of line infections are investigated. Timelines are completed by the clinical staff and reported to the infection control operational meeting.
- A detailed action plan is being developed and will be included in the next ICG for monitoring.

Comparative data

Figure 3 – Rate of MRSA bacteraemia per 10,000 bed days



- There were no deaths attributed to MRSA during this quarter.
- Figure 1 provides comparative regional and national data for Trust-apportioned cases by quarter as published by the Public Health England. These data are published one quarter in arrears. For the reported quarter, the Trust rate was above the regional and national rate.

MSSA

The Trust target has been set at 29 cases for the year. There have been 22 cases The actions for MSSA are the same as MRSA.

	October	November	December
Target	2	3	2
Actual	3	3	3

- The total for this quarter is 9 against a target of 7. There are no financial penalties associated with this target.

Ecoli

	October	November	December
Post 48hrs	11	6	6
Pre 48hrs	7	11	15

- There are no national or Trust targets for E coli bacteraemias. Numbers are recorded on the Public Health England data base.

GRE/VRE

October	November	December
1	2	Data not available.

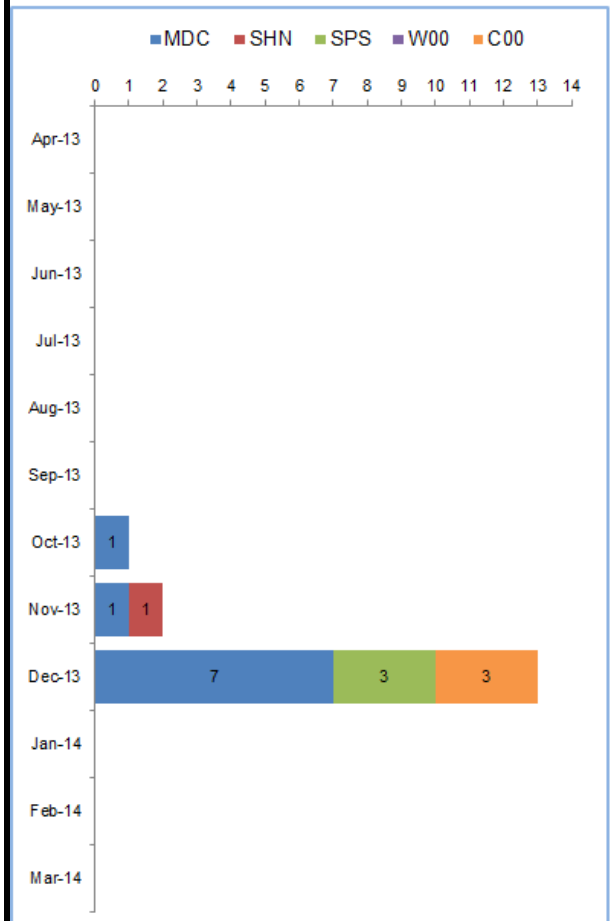
- There are no national or Trust targets for GRE/VRE bacteraemias. Numbers are recorded on the Public Health England data base.

Outbreaks and untoward incidents: Norovirus

University Hospitals Bristol NHS
NHS Foundation Trust

NOROVIRUS

Quarter 3: October - December 2013



Graph 1. No. Wards/Areas Closed and Part Closed by Division

TRUST	MDC	SHN	SPS	W00	C00
3	3	0	0	0	0

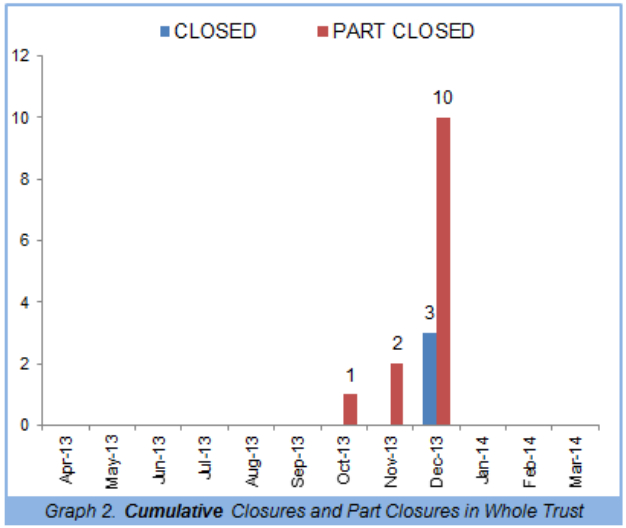
Table 1. No. Whole Wards Closed in Period

TRUST	MDC	SHN	SPS	W00	C00
13	6	1	3	0	3

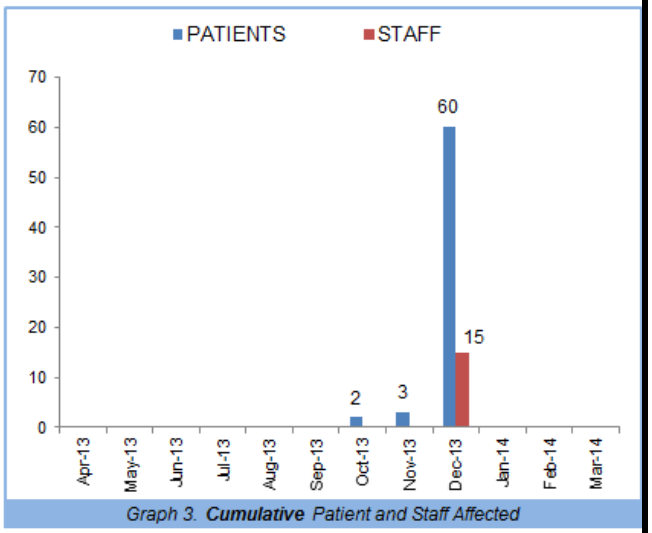
Table 2. No. Ward Bays Part Closed in Period

TRUST	MDC	SHN	SPS	W00	C00
171	156	0	8	0	7

Table 4. No. Beddays Lost in Period



Graph 2. ***Cumulative*** *Closures and Part Closures in Whole Trust*



Graph 3. ***Cumulative*** *Patient and Staff Affected*

TRUST	MDC	SHN	SPS	W00	C00
83	71	1	5	0	6

Table 3. Total Affected in Period

TRUST	MDC	SHN	SPS	W00	C00
12	7	1	1	0	3

Table 5. No. Areas Deep Cleaned in Period?

TRUST	MDC	SHN	SPS	W00	C00
21	18	0	2	0	1

Table 6. No. Positive Cases in Period

Outbreaks and untoward incidents: RSV

During the last two weeks of November first two weeks of December the Children's Hospital suffered an unusually precipitous start to the RSV Season, leading to acute pressures on in- patient services and Black Escalation. These pressures were felt by all neighbouring Trusts with in - patient paediatric facilities leading to complete lack of beds to transfer children to. For several days no PICU beds could be identified in England or Wales. Working with the Division and Public Health England Virologists, the Infection Prevention and Control Team worked to revise our previously accepted isolation procedures. The Standard Operating Policy for co–horting children with respiratory viruses was revised, extra capacity beds were opened. Containment was successfully achieved.

Incident investigation themes

MDR TB. All appropriate patients have been contacted and screened as required. Final meeting to close down incident will be in February 2014. Update of this incident will be presented at April Infection Control Group.

During December, a large number of staff and a small number of children were affected with diarrhoea and vomiting on the Paediatric Intensive Care Unit (PICU). This affected elective admissions to the unit. On investigation, it was noted staff had come to work and were symptomatic. An RCA has been requested, this will be reported back at the April Infection Control Group.

Training compliance:

The training compliance data not available in time for the meeting.

Innovation/activity linked to patient improvement

Introduction of Procalcitonin testing in MAU and EAU, a reduction in antibiotic prescribing, report included in papers.

Infection prevention and control sessions for community colleagues

The Team have hosted two successful sessions in the last quarter with the aim of building on a joint hospital/community approach to patient care. The first was aimed at Care Home managers and senior staff and focused on 'Managing the person with *Clostridium difficile*'. Presentations from medical microbiology, infection control and facilities generated a lively discussion and a number of good ideas to help improve patient care. The second session aimed at GPs focused on 'Current topics in microbiology & virology' and included presentations from UH Bristol Consultant Microbiologists and a Public Health England Consultant Virologist. The intention is to run further sessions over the coming year on topical infection prevention and control subjects.

Surgical Site Infection Surveillance (SSIS)

Currently the Trust participates in the Public Health England SSIS for orthopaedic surgery (categories: repair of neck of femur and hip replacement). Participation in the reporting of orthopaedic procedures is mandatory for all hospitals in England.

The surveillance is targeted at surgical procedures that are relatively common, are associated with a relatively high risk of infection or have far-reaching consequences for the patient when infections occur. SSIs account for approximately 16% of all healthcare-associated infections.

A key aim of this surveillance service is to enable participating hospitals to compare their rates of SSI in a specific group of surgical procedures against a benchmark – the pooled mean rate for participating hospitals.

There are ten categories where UH Bristol could participate and the Infection Prevention & Control Team are working with relevant personnel to roll out the programme.

Audit

Linen audit report included.

Saving Lives – Trustwide Compliance

Saving Lives has now been incorporated into a new format, which is called Infection Control Safety Thermometer. This is undertaken on a monthly basis alongside the patient thermometer. Heads of Nursing, Matrons and Ward Managers receive their results on a monthly basis in order for them to put actions in place as required. If it is felt that old format (Saving Lives) is required as extra quality assurance, by the Ward Manager, then these are undertaken as and when the Ward Manager feels appropriate.

Hygiene code and Care Quality Commission outcome 8 compliance:

The Infection Control Group received evidence against the compliance standards at its meeting November 2013. The Group confirmed the continued declaration of compliance. Confirmation of compliance will be confirmed at the Next Infection Control Group.

Compliant	Minor concerns	Moderate concerns
50	2	3

Infection Control Programme 2013/14 Action Progress (RAG rated)

Green	Amber	Red
37	5	0

Infection Prevention and Control related risks:

The Infection Control Group need to review all risk register entries related to infection prevention and control at the next ICG.

Low	Moderate
6	1

New Documents/Publications

- Infection Prevention Society and Royal College of Nursing. **Infection Prevention and Control within Health and Social Care: Commissioning, Performance Management and Regulation Arrangements (England).** November 2013

DECONTAMINATION REPORT

Sterile Services: Annual Accreditation Audit – 2014 visit
Dates of 10th – 14th March 2014 are booked for this year's annual accreditation audit.

CSSD air handling unit and ventilation compliance
7 new pressure stabilisers have now been fitted, resulting in a significant improvement in air flow across the department. Next step is to for the "dampeners" to be connected to the fire alarm system – estates are organising

CSSD refurbishment plans and CSP
1st stage of washroom works completed December 13 – this also included an upgrade to the departments RO plant. 7 new washers to be installed from middle of February to mid-April. Condense line needs to be replaced due to age profile – works will occur before end of February.

CSSD Dashboard
CSSD dashboard continues to be updated on a monthly basis and is to be found on the decontamination workspace.

Tray wrap breach have significantly reduced in the last 3 months and the department is now reporting this a green – only 1 reported tray wrap breach for December. Moving sets to containers continues.

Appraisal compliance for the department: Oct 13 – 98%, Nov – 100%, Dec – 96%
CSSD has had approval from Trust for 3 additional staff to join the team to support the additional work it will be doing due to CSP. Recruitment has commenced. Sickness levels continue to fluctuate in the department, but staff do undertake Over Time to fill gaps and assist in maintaining service.

CSSD Kingsdown: Clean Steam Installation
Part of the CSSD refurbishment programme but due to the phasing of capital expenditure will now not occur until the third year which will be 15-16.
Automatic Endoscopic Reprocessors at SBCH – poor water results. Unfortunately SBCH has had two episodes of experiencing mycobacteria in the final rinse water of the AER's. High level chlorination of the machines has been undertaken. CFPP guidance states that if mycobacteria is found in the rinse water the machines should be taken out of use. UHB convened a meeting of key personnel to discuss the situation and following discussion with the Trust microbiologists, manufacturers of the equipment, and completion of a risk assessment it was agreed that UGI and LGI endoscopy would continue to be delivered at SBCH. Urology also continues to be delivered by NBT but the use of sterile sheaths was implemented. We are waiting on water results following high level sanitisation on 6/1/14. Issue to be further discussed at Decontamination Board 24/1/14. The microbiologists have made it clear that though there has been mycobacteria in the rinse water the risk of harm to patients is negligible.

Annual and quarterly testing and validation of Trust wide decontamination equipment
All decontamination equipment within the Trust remains compliant in terms of annual and quarterly validation – this service is provided by a third party provider – Audere. Validation for community dental decontamination equipment is also provided by a third part contractor – Eschmann.

Decontamination Equipment: Capital Monies
BRCH theatres decontamination room is now complete.
Due to the value of RO plant upgrade for QDU it is necessary to go to tender – this is being progressed by procurement.
Expressions of interest have been submitted for capital monies in the following areas:

- RO plant replacement BDH
- RO plant replacement BEH
- RO plant replacement level 3 BRCH
- AER replacement QDU
- Additional AER ENT OPD
- 3 x Endoscope HEPA filtered drying cabinets QDU

Decontamination equipment: AER in the new children's theatres in the new build.
Following receipt of tender responses it was agreed that site visits were required to view different manufactures products in use as well as speak with end users – visits currently being arranged.

Decontamination Facility – level C, SMH.
Unfortunately the standard of work initially undertaken in this facility did not meet Trust standards – following a meeting on site with estates and contractors, areas to be rectifies were identified and additional works are being undertaken – this has included replacing the sink and drainer. It is now expected that this facility will be ready for use in February.

BRCH level 8 RO water plant
Although there was no interruption to the renal dialysis service the decontamination engineers have been concerned about the quality of the water being provided by the level 8 plant. Purite attended site on numerous occasions, often working through the night – eventually a delivery pump was changed and the system has run satisfactorily for the last 3 weeks. The plant continues to be monitored.

BDH RO plant
A number of breakdowns have occurred with the RO plant in the BDH for the past 12 months which has impacted upon the decontamination department's ability to provide service. Environmental Water Systems have attended site on many occasions and they have now identified the issue to be the water softener. 16/1/14 – EWS carried out emergency repairs to the softener – it is hoped that this cures the problem. Capital bid has been submitted for the replacement of the machine – it is 11 years old.

High Water Results – BHI and HGT
New pipe work and new mini-therm RO water plant has been installed in HGT - with success. Water counts are now regularly within acceptable limits.
BHI – has undergone several deep disinfections and membrane changes – last 2 results have been satisfactory. Plan is to move back to normal sensitisation routine – we will monitor situation. If we lose control of the system once more, then the manufacturer will be tackled with a view to changing the unit.

Automatic reprocessors for radiology ultrasound probes
At October Board it was recommended by the Trust AED that in the first instance a decontamination room was required in radiology, BRI before the purchase of automatic reprocessors. D&T have identified a space that could be converted into a decontamination room. Costs for room conversion have been received and it is deemed to be financially possible to make the room changes and purchase two decontamination machines. D&T are progressing this work along with support from Estates, Infection Control and Decontamination Manager.

Power outage – decontamination consequences
Power outages in both November and December 2013 have impacted upon the decontamination equipment Trust wide. Engineers attended relevant sites to reboot machinery that does not automatically restart once power is restored.
Greatest impact was upon CSSD, as the server power pack was destroyed during December outage. Electronic track and trace system went down and all processing steps had to be recorded manually. Power restored 36 hours later following installation of new power pack – all manual data then entered onto system in order that full track and trace is in place.

MATRON REPORT

Matrons checklist/quality in care tool
With an increase in c diff cases over the past few months Matrons in all Divisions have taken a proactive approach and met with their infection control teams to review all cases. As a result matron's have actioned some concentrated training for new starters and infection control have supported wards very well. Cannula checked continue to be a focus of spot checks by matrons with an emphasis on removing pre admission cannula within 24 hours of admission.

Facilities issues
Matrons have worked with facilities to ensure that bird control is dealt with promptly and that preventative measures are now in place to prevent their return. Linen reviews continue to show a high quality of service.

Estates issues
No Major issues to report this quarter

Patient Environment Operational Group
New cleaning frameworks now approved and a change to national cleanliness scores will be brought in in April. Facilities teams are currently working with the Matrons to ensure all ward staff are aware of the changes. This is being undertaken through the Sister's meetings.

Ward refurbishment activity
Work progresses and Matrons continued to be involved at every stage.

ANTIBIOTIC PRESCRIBING COMPLIANCE

The monitoring of antibiotic prescribing compliance continues. The inclusion of a stop or review date continues to be the main barrier to the achievement of the 90% target. The results for quarter 3 are as follows:

Division	Number of reviews	Percentage compliant	Number compliant	No. Not Compliant	No. not to guideline	No. with no stop or review date	No. with no Indication
Medicine	916	87%	798	118	27	80	16
Specialised Services	317	88%	278	39	10	23	8
Surgery, Head & Neck	446	89%	397	49	14	26	13
Women's & Children's	432	80%	348	84	1	69	40
Trustwide Total	**2111**	**86%**	**1821**	**290**	**52**	**198**	**77**

There was a drop in compliance in quarter 2 throughout the trust.

FACILITIES AND ESTATES REPORT

Radiator Cleaning
Radiator cleaning continues whenever there is an operational window of opportunity. Ward 7 was completed on 8 January. No other radiators have been cleaned since the previous report, pending the go ahead for areas from the Divisions (Managed through the Estates Forum).

South Bristol Community Hospital (outsourced Hard & Soft Facilities Management)
Cleaning
The quarterly average cleaning score across all areas has been 96.3% against a Trust target of 95%, increasing 1% over the previous quarter scores.

Hydrogen Peroxide Gas decontamination activity
HPG has been utilised on the wards or side rooms on one occasion during the quarter.

Cleanliness Monitoring Results
The scores have improved over the last 3 months, achieving a Trustwide score of 96% in November.

A report is going to SDG in February which recommends revised target audit scores and a greater coverage of the audit system.

Audit score sheets have been updated to include columns which identify the failure reasons. The audits from areas whose score is rated amber or red are now being notified to Infection Control.

For weekly monitoring of the Very High risk categories see Appendix C (b).

Trust staff have been observed wearing raspberry scrubs outside the Theatre environment – both outside the BRI and more recently sitting in the Costa Coffee public seating area, in the Bistro and in M&S Food. This colour was specifically procured to identify theatre staff outside of theatres. Clarity is sought as to whether this protocol is in place.

UH Bristol Cleaning Audit Scores

RESULTS		2012		2013										
Risk Category	Area	Nov	Dec	Jan	Feb	Mar	Apr	May	June	July	Aug	Sep	Oct	Nov
VERY HIGH														
Areas include:- Theatres, Intensive Care Units (Adult & Children), Emergency Departments, Oncology Wards etc.	B.R.I	97	96	97	97	96	94	95	96	95	94	96	96	96
	B.R.C.H	97	96	96	96	96	94	96	96	95	95	95	95	96
	S.M.H	95	93	93	96	96	97	96	95	96	93	96	95	96
	B.H.O.C	96	97	97	97	96	97	98	97	97	97	98	98	97
	B.E.H	97	97	98	97	96	97	96	96	98	98	98	97	96
	S.B.C.H	98	98	96	97	97	97	96	97	96	98	98	97	98
	Total Average	97	96	96	96	96	96	96	96	96	96	97	96	96
HIGH														
Areas include:- All ward areas not covered above, Clinics X-ray Depts, etc. Sterile Services, Pharmacy etc	B.R.I	94	94	94	94	93	94	94	95	94	94	93	93	93
	B.R.C.H	94	96	93	96	93	95	97	96	96	95	94	95	96
	S.M.H	94	93	94	96	96	97	94	95	95	95	94	93	97
	B.H.O.C	96	97	96	97	96	97	97	96	97	97	98	99	98
	B.D.H	96	96	95	97	95	95	96	95	95	95	94	93	95
	B.E.H	97	98	97	98	96	96	96	95	97	98	98	98	97
	C.H.C	95	95	95	94	96	96	96	97	97	97	94	95	97
	S.B.C.H	96	96	95	97	95	95	93	95	96	95	94	96	96
	Total Average	95	95	95	96	95	95	95	96	96	96	95	95	96
SIGNIFICANT														
Areas include:- All Hospital Entrances, Levels and Stairwells, Public Toilets, Receptions Physiotherapy Departments,	B.R.I	90	92	95	91	88	90	90	91	93	90	89	93	90
	B.R.C.H	88	93	88	89	83	88	91	84	93	93	85	92	96
	S.M.H	96	97	93	98	98	91	92	97	90	96	91	88	97
	B.H.O.C	90		95		84	92	90	84	98	91	94	97	98
	B.D.H	95		95	96	92	89	88	90	92	95	95	89	95
	B.E.H	97	96	95	96	96	94	96	95	97	96	92	95	95
	C.H.C		87	96	100	91	96	94	89	96	100	88	97	97
	S.B.C.H		97	99	94	96	99	92	95	98	99	95	98	96
	Total Average	93	94	94	95	91	92	91	91	95	95	90	94	95
LOW														
Areas include:- Offices, Medical Records, Stores areas etc.	B.R.I	96												
	B.R.C.H													
	S.M.H													
	B.H.O.C													
	B.D.H													
	B.E.H													
	C.H.C													
	S.B.C.H		100	93		96				93		96		
	Total Average	96	100	93		96				93		96		
	TRUST SCORE	95	95	95	96	95	94	94	94	95	96	94	95	96

KEY	
	From 95% to 100%
	From 80% to 94%
	Under 80%

Very High Risk Detail

VERY HIGH RISK Weekly Results			Sep-13						Oct-13						Nov-13					
	Week Beginning	Number audits required in month	2nd	9th	16th	23rd	30th	Average Total	1st	7th	14th	21st	28th	Average Total	1st	4th	11th	18th	25th	Average Total
Site	Area																			
B.R.I	Theatre 10	1		97				97				98		98					98	98
	Cardiac Cath Suite	1				97		97				95		95					98	98
	CICU (Red Floor)	1				95		95					98	98					96	96
	Coronary Care Unit	1			97			97				98		98					99	99
	Ward 3 -ITU/HDU	1				100		100				98		98					99	99
	Ward 99	1				95		95				97		97					97	97
	Heygroves Theatres	4	80	97	91	95	96	92	85		97	92		91		92		91		92
	HGT - Outer Areas	4	83	92	88	92	92	89	88		95	92		92		93		93		93
	Emergency Department	1		95				95				95		95				96		96
	Queens Day Unit	4		94		95		95		94	93			94	93			94	92	93
	Radiology Intervention	4	97	94	97	97		96	97		100	94	94	96		81	97		94	91
	Ward 23 a	1				96		96					96	96			96			96
	Ward 26a Cohort ward	1	94	93	97	98		96	97	97				97					97	97
B.R.H.C	B.M.T.	1				95		95					97	97				97		97
	WARD 35 - New	1				96		96				97		97			96			96
	Oncology Day Beds (Blue Floor)	1			96			96		95				95			95			95
	WARD 34 - Oncology	1	91	Moving		95		93	96					96				97		97
	Operating Theatres	1				96		96				94	99	97			97			97
	Theatres Outer Areas	4	85	82	92	96		89	99	77	78	84	87	85			92	91	86	90
	P.I.C.U.	1				96		96				96		96			Emergency			
	WARD 37 - Renal	1	96	96	98			97			97			97				95		95
	Emergency Department	1	92	95	95	95		94	95					95				97		97
S.M.H	Central Delivery Suite	4	85	91	95	95		92	93	88	90	85		89	94		94	97	96	95
	Theatres	1	96					96				98		98				95		95
	Theatres Outer Areas	1	98					98				95		95				97		97
	SCBU/NICU	1				97		97				98		98					93	93
	MLU	1				98		98		97				97	98					98

Very High Risk Detail

VERY HIGH RISK Weekly Results			Sep-13						Oct-13						Nov-13					
	Week Beginning	Number audits required in month	2nd	9th	16th	23rd	30th	Average Total	1st	7th	14th	21st	28th	Average Total	1st	4th	11th	18th	25th	Average Total
B.H.O.C	Brachytherapy Theatres	1			99			**99**					99	**99**				98		98
	Ward 61	1	93	98	98	98		**97**	99					**99**			96			96
	Ward 62	1				98		**98**		98				**98**			99			99
	Chemotherapy Day Unit	1	96					**96**	95					**95**			96			96
B.E.H	Theatres	1		96			100	**98**			95	100	100	**98**				95		95
	Theatres Outer Areas	1		99			100	**100**			91	98	96	**95**			100	95	95	97
	Emergency Department	1		95				**95**			97			**97**					97	97
SBCH	Day Surgery & Endoscopy	1				95		**95**					95	**95**					95	95
	BHOC Treatment Suite	1		100				**100**				98		**98**					100	100
	Number of audits per week		13	16	12	23	4		10	7	10	19	10		3	3	11	15	15	
	Number of audits for the month - against total audits required	54				65		68				58		56				54		47
	Percentage Achieved							**105%**						**97%**						**87%**
KEY	>95%<100%																			
	>80%<94%																			
	<80%																			

Outer areas for Theatres - Areas used by staff not open to patients

Dr Richard Brindle – *Consultant Microbiologist. Director of Infection Prevention and Control*

Joanna Hamilton-Davies – *Senior Infection Control Nurse, Deputy DIPC*

January 21st 2014

University Hospitals Bristol NHS
NHS Foundation Trust

Division of Diagnostics & Therapies

Laboratory Medicine

Infection Control

Clinical Audit Report

Linen handling and management
At ward level 2013

Audit ID 3495

Audit Lead: Karen Fletcher
Supervisor: Joanna Hamilton Davies

December 2013

Audit of linen handling and management at ward level 2013

Background

During December 2011, the University Hospitals Bristol engaged Royal Devon and Exeter NHS Foundation Trust laundry to manage their linen contract as opposed to sunlight, due to numerous complaints of the condition and supply of the laundry. Following the changes, an audit of the handling and management of the linen at ward level was undertaken as part of the annual audit programme. Evidence was gained using the Infection Control Nurses Association (2004) Audit tool for monitoring infection control Section 4.3 Handling and disposal of linen. www.icna.co.uk. The data was collected using onsite inspection and observation as well as discussion with staff. Forty two areas within University Hospitals Bristol were examined in the study, including Bristol Royal Infirmary, Bristol Children's Hospital, St Michaels Hospital, Bristol Oncology Centre and Bristol heart Institute. South Bristol Community Hospital were not included in the audit as Sunlight are their current suppliers.

The general aim of the audit was to ascertain that the general principles intended for linen handling are being adhered to and managed appropriately to prevent cross infection. It was also to ensure the changes within the laundry contract reflected improvement both in the supply and quality of the linen.

Aim

To ascertain whether the general principles for linen handling are being adhered to.

Objectives

To ensure linen is managed and handled appropriately to prevent cross infection.

Criteria	Target (%)	Exceptions	Source & Strength* of Evidence	
Linen is managed and handled appropriately as detailed in audit tools for monitoring infection control.	100	none	Infection Control Nurses Association (2004) Audit tools for monitoring infection control Section 4.3 Handling and disposal of linen. www.Icna.co.uk	C

***Strength of Evidence**

A At least one randomised controlled trial as part of a body of literature of overall good quality and consistency addressing the specific recommendation

B Availability of well-conducted clinical studies but no randomised clinical trials on the topic of the recommendation

C Expert committee reports or opinions and/or clinical experience of respected authorities. Absence of directly applicable clinical studies of good quality

D Recommended good practice based on clinical experience (local consensus)

Methodology

This audit was carried out from 1 July to 30 September 2013. Data were collected by Infection Prevention and Control Nurses who will observe how linen are handled and managed during their routine visits to wards. 42 wards were randomly selected and included in this audit. Data collection form see appendix 1.

Results

Staff within the ward areas commented on the high quality and regular supplies of the linen since the new contract commenced. All forty two wards checked for cleanliness during the audit was found to be nicely laundered and presented. Linen was also stored in a clean and dust free designated areas although eight of the areas also used the linen cupboard to store inappropriate items such as pressure cushions, Christmas decorations and electric cables. These items were stored on a different shelf and were away from used linen and other inappropriate items. The inappropriate items housed in the linen stores were of a clean nature in wards with very few storage areas. All forty two areas had a designated linen storage area, which when examined, one of the storage areas were found to be dusty and the remaining forty one were clean, tidy and dust free.

All linen must be stored in appropriate colour coded bags (supplied by Devon and Exeter) according to policy and less than 2/3 full, thus enabling them to be fastened securely. The bags should then be stored correctly in designated areas. Forty one of the areas observed during the audit were segregating their linen in the appropriate colour bags, one ward however was marked not applicable as they were not observed carrying out this process. Forty one areas were found to be filling the bags so they were less than two thirds full with one ward over filling them, making it difficult to close the bag securely. All linen however was stored correctly in appropriate segregated areas. All wards had sufficient laundry bags as a shortage of supplies had been a major problem in the past as was reflected in the 2010 audit.

Obtaining the data as to the appropriate use of linen skips, ensuring linen was not left on floors or being carried to skips by staff was difficult to assess as the timing of the visits to the areas did not always coincide with the task. This also applied to observing the use of PPE during the handling of contaminated linen. As a result of this, a high level of non applicable answers are displayed with one member of staff not following the correct policy when using the linen skips and one member of staff not using PPE appropriately.

Ward based washing machines must be industrial and used in conjunction with a tumble dryer. The items must be situated in a designated area and be on a pre-planned maintenance programme. Written guidance and evidence that the guidelines are being adhered to should be available. Five of the areas examined were found to be using a washing machine with a tumble dryer available for use in three of them. Two of the

wards were on a pre planned maintenance programme and there was written evidence that guidelines were being adhered to in two of the areas.

Posters should be available in the wards to inform staff which colour linen bags should be used for the various linen types. Unfortunately, these were not available on twenty six of the wards. The reason for this may be due to the high level of ward moves to accommodate the building work in the trust as they had not been replaced.

Summary of results

	Audit standards	**Compliance %**
1.	Clean linen is stored in a clean designated area separate from used linen (not in the sluice or bathroom).	100 (42/42)
2.	Clean linen is free from stains (randomly check linen).	100 (42/42)
3.	Clean linen store is clean and free from dust.	98 (41/42)
4.	Clean linen store is free from inappropriate items.	81 (34/42)
5.	The top and floor of the linen cupboard/trolley are free of stored items.	64 (27/42)
6.	Linen is segregated in appropriate colour coded bags according to policy.	100 (41/41) 1 not applicable
7.	Bags are less than 2/3 full and are capable of being secured.	98 (41/42)
8.	Bags are stored correctly prior to disposal.	100 (42/42)
9.	Linen skips and the appropriate bags are taken to the area required. (Staff are not carrying soiled linen or leaving it on the floor).	96 (23/24) 18 unable to observe
10.	Gloves and apron are worn when handling contaminated linen.	96 (22/23) 19 unable to observe
11.	Ward based washing machines are only used with the agreement of Infection Control.	40 (2/5) 37 not applicable
12.	A washing machine if used is situated in an appropriate designated area.	40 (2/5) 37 not applicable
13.	There is written guidance regarding the use of the washing machine.	40 (2/5) 37 not applicable
14.	There is evidence that the guidelines are being adhered to (question staff and observe use)	40 (2/5) 37 not applicable
15.	If a washing machine is in use a tumble dryer is also available which is externally exhausted.	100 (3/3) 39 not applicable
16.	There is evidence that the washing machine and tumble dryer are on a pre-planned maintenance programme.	40 (2/5) 37 not applicable
17.	Hand washing facilities are available in the laundry room.	50 (1/2) 40 not applicable
18.	A poster is available on the ward trolley/cupboard to show designated coloured bags to be used.	38 (16/42)

Conclusions

The general principles for linen handling are generally followed in most wards. However, the ward based washing machines in three of the five wards were not used with the agreement of Infection Control. The handling of soiled linen and skips and the use of PPE could not be observed due to the timing of the visits by the assessor.

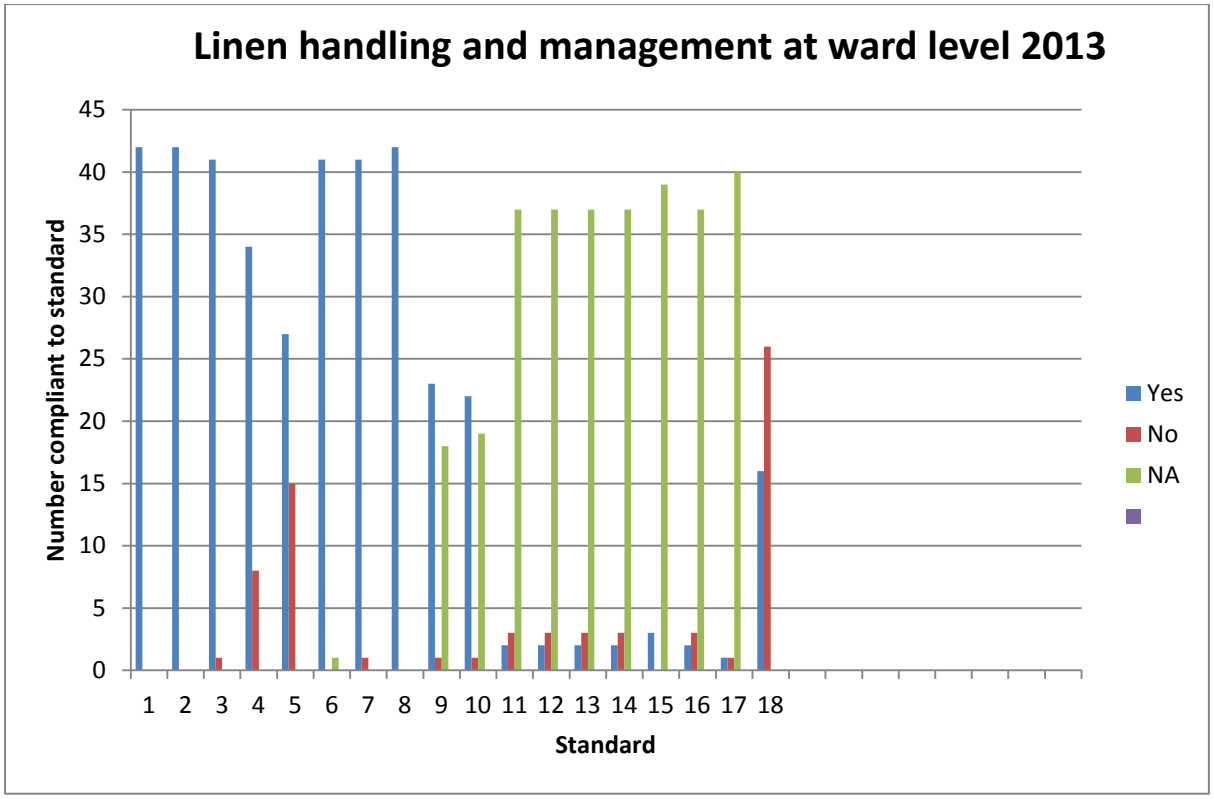
Recommendations

Washing machines may remain in the ward areas identified within the audit until they are no longer in working order. Industrial machines will then replace them, used in conjunction with industrial tumble dryers, all of which must be on a pre planned maintenance programme. During the rebuild and refurbishment of the trust, the remainder of old washing machines will be removed. Any remaining machines should have written evidence that the guidelines are being adhered to.

On completion of this audit a member of the laundry company was contacted to ensure all wards had the relevant signs to indicate the colour of bag to use with the relevant linen. Infection control will continue to audit the linen to ensure the standard of cleanliness and availability of the linen continues. Appropriate colour coded linen bags were found to be plentiful on the wards which is a vast improvement when compared to previous audits, this should be maintained by the linen company.

A PPE audit will be carried out by the infection control team, which will identify poor practice issues when handling soiled linen and also increase awareness within the ward areas.

Linen stores will be inspected during regular walk arounds, attended by Infection control, Matrons, Estates and Facilities and improved if and when required.


Linen handling and management at ward level 2013
Number compliant to standard
45
40
35
30
25
20
15
10
5
0
1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18
Standard
Yes
No
NA

ACTION PLAN

Suggested Action	Implementation Date	Any additional notes*	Staff member responsible	Change Stage	***Change Stage Key***
Washing machines may remain in the ward areas identified within the audit until they are no longer in working order.	December 2013		Karen Fletcher	4	*1. Agreed but not yet actioned*
Educate staff that the washing machine must be situated in an appropriate designated area, there must be a written guidance regarding the use of the washing machine.	December 2013		Karen Fletcher	4	*2. Action in progress*
To provide written evidence that the washing machine and tumble dryer are on a pre-planned maintenance programme.	February 2014	*Can add the name of responsible person for the three wards here*	Karen Fletcher	1	*3. Made – partial implementation*
A poster is available on the ward trolley/cupboard to show designated coloured bags to be used.	February 2014	Poster to be provided by Royal Devon and Exeter NHS Foundation Trust laundry.	Karen Fletcher	1	*4. Full implementation completed*

* Where agreement or progress of the action plan has been discussed/recorded

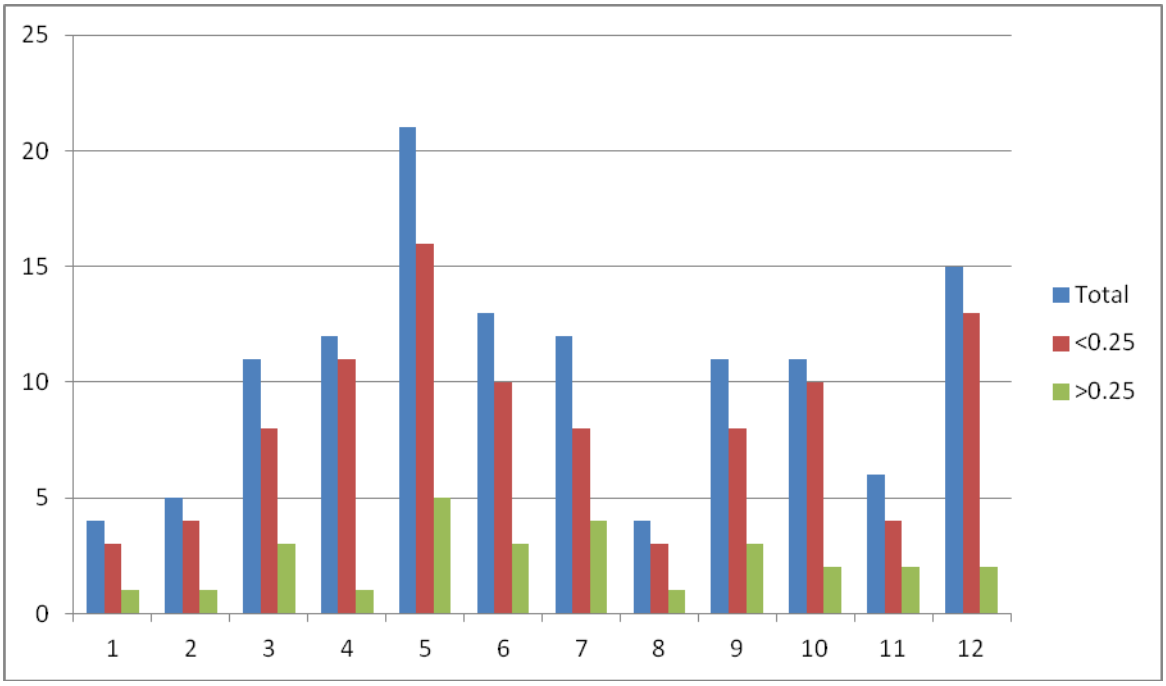
Appendix 1: Data collection form

Standard: Linen is managed and handled appropriately to prevent cross infection Ward:

	Ward Management of Linen	Yes	No	N/A	Comments
1.	Clean linen is stored in a clean designated area separate from used linen (not in the sluice or bathroom)				
2.	Clean linen is free from stains (randomly check linen)				
3.	Clean linen store is clean and free from dust				
4.	Clean linen store is free from inappropriate items				
5.	The top and floor of the linen cupboard/trolley are free of stored items.				
6.	Linen is segregated in appropriate colour coded bags according to policy				
7.	Bags are less than 2/3 full and are capable of being secured				
8.	Bags are stored correctly prior to disposal				
9.	Linen skips and the appropriate bags are taken to the area required. (Staff are not carrying soiled linen or leaving it on the floor)				
10.	Gloves and apron are worn when handling contaminated linen				
11.	Ward based washing machines are only used with the agreement of Infection Control				
12.	A washing machine if used is situated in an appropriate designated area.				
13.	There is written guidance regarding the use of the washing machine				
14.	There is evidence that the guidelines are being adhered to (question staff and observe use)				
15.	If a washing machine is in use a tumble dryer is also available which is externally exhausted				
16.	There is evidence that the washing machine and tumble dryer are on a pre planned maintenance programme				
17.	Hand washing facilities are available in the laundry room				
18.	A poster is available on the ward trolley/cupboard to show designated coloured bags to be used.				

Procalcitonin (PCT) on MAU patients

Levels were done for 125 patients during the course of 12 weeks (October to December 2014).



Out of the 125 patients, 14 were not done as per protocol (mostly they had a different diagnosis), and were excluded from the analysis, which leaves 111 patients to be evaluated.

23 patients had a high PCT level (≥ 0.25 µg/L), 88 patients a low PCT level (< 0.25 µg/L).

Presumptive diagnosis in the 23 patients with high levels was community acquired pneumonia in 12 (53%) patients, infective exacerbation of COPD in 3 (13%) patients, urinary tract infection in 7 (30%), and ?UTI/CAP in 1 (4%) patients. The age range in this group was 24-92 years, with an average age of 73.3 years.

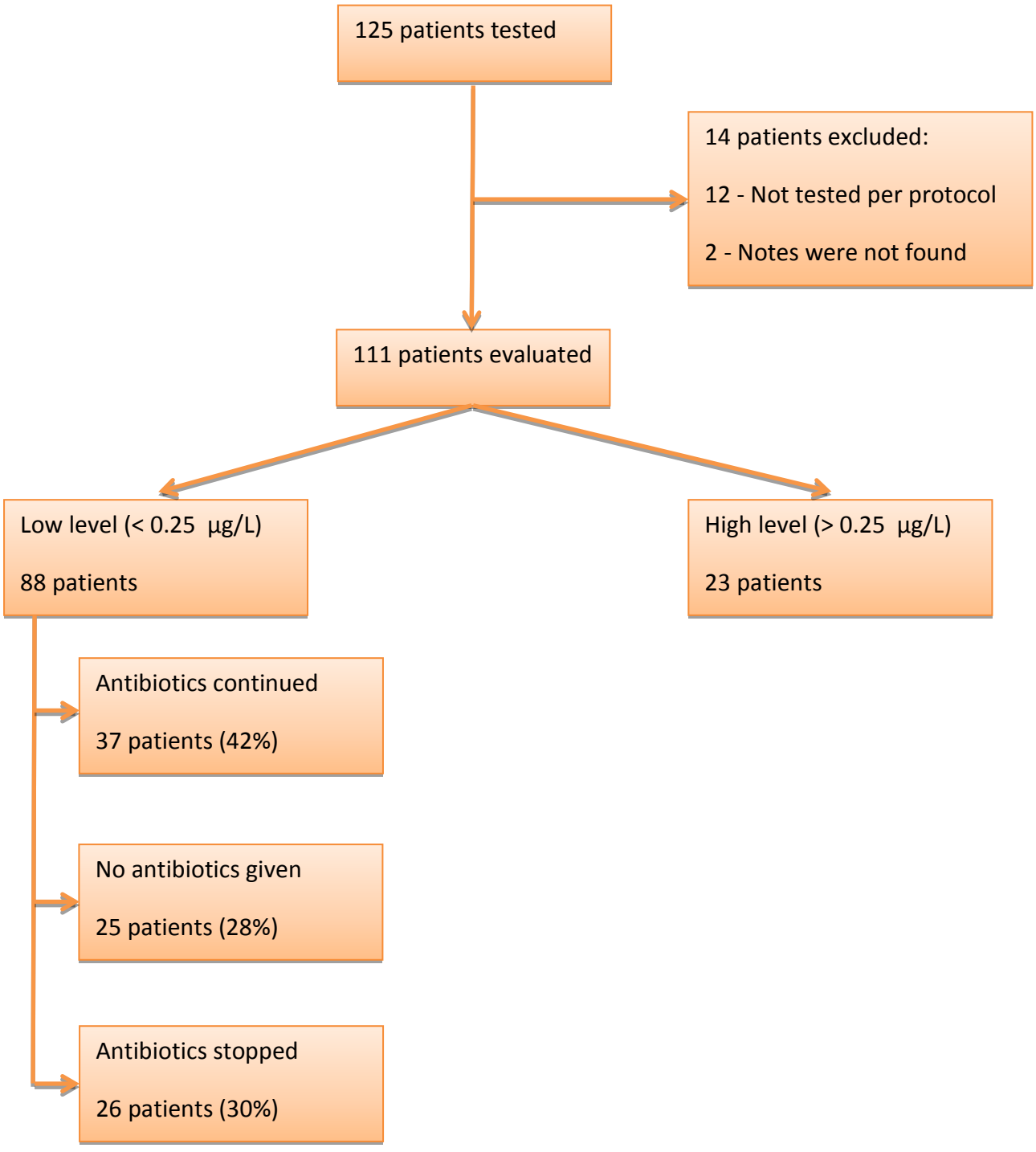
Presumptive diagnosis in the 88 patients with low levels was community acquired pneumonia in 37 (42%) patients, infective exacerbation of COPD in 15 (17%) patients, urinary tract infection in 29 (33%), and ?UTI/CAP in 7 (8%) patients. The age range in this group was 20-99 years, with an average age of 72.7 years.

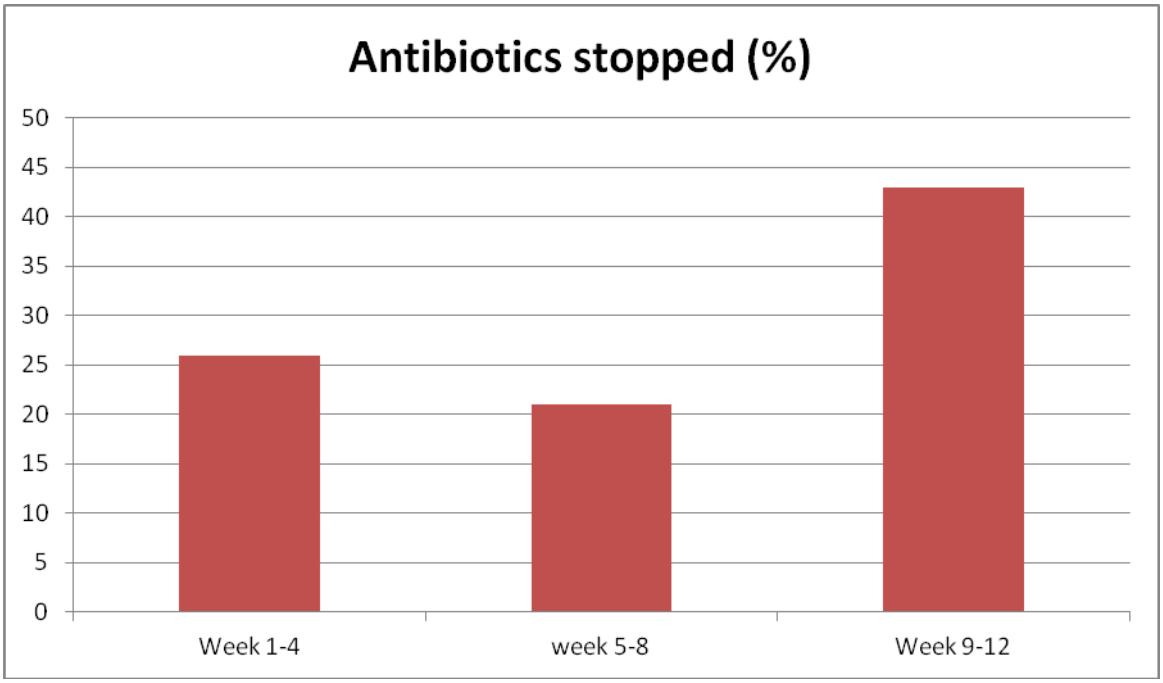
Was antibiotic use reduced by measuring procalcitonin levels?

All 23 patients with high levels were given antibiotics.

In 37 (42%) out of the 88 patients with low levels antibiotics were continued, no antibiotics were given in 25 (28%), and antibiotics were stopped in 26 (30%) patients.

In 7 (28%) out of the 25 patients in whom no antibiotics were given, antibiotics were held awaiting the PCT result.





The percentage of patients with low PCT levels in whom antibiotics were stopped was highest in the last month. In the first month there was a lot of involvement from microbiologists to encourage stopping antibiotics, in the second month this was reduced, first the rate dropped a bit, then it increased. This might reflect increased acceptance of the test and confidence in the test result.

What are the characteristics of the patients with low PCT levels when antibiotic were continued?

In the group of patients in whom antibiotics were continued, the average PCT level was 0.11 µg/L, 68% of the patients had a level > 0.1 µg/L. In the group where no antibiotics were given or the antibiotics were stopped, the average was slightly lower (0.09 µg/L), and only 35% had a level > 0.1 µg/L.

In the 37 patients in whom antibiotics were continued:

- 9 had raised CRP (≥ 20) and neutrophils (> 7.5)
- 15 had raised CRP, but normal neutrophils
- 6 had raised neutrophils but CRP <20
- 7 had normal neutrophils and CRP <20.

Does stopping antibiotics in patients with low PCT levels affect mortality?

7-day mortality was 0 out of 23 in the group with high levels, 1 out of 37 (2.7%) in the patients with low levels in whom antibiotics were continued, and 1 out of 51 (1.9%) in patients with low levels where no antibiotics were given, or antibiotics were stopped (0 out of 26 where antibiotics were stopped).

Data for 30-day mortality and re-admission within 30 days is not yet complete.

Simple EXCEL statistics showed no correlation between:

- PCT levels and CRP (0.1805)
- PCT levels and WCC (-0.1171)
- PCT levels and neutrophils (-0.0594)
- PCT levels and neutrophil/lymphocyte quotient (-0.1701)

University Hospitals Bristol NHS
NHS Foundation Trust

Cover Sheet for a Report for a Public Trust Board Meeting, to be held on 30 January 2014 at 10:30 in the Conference Room, Trust Headquarters, Marlborough Street, Bristol, BS1 3NU

7. Transforming Care Report
Purpose
To update the Board on progress made in developing Transforming Care
Abstract
• Detail on key activities that are complete or underway to develop the transformation agenda including: The purpose and content of Transforming Care, actions being taken to support the organisation to change, aligning transformation with savings delivery and changes to the programme's governance.
Recommendations
The Trust Board is recommended to receive this report by the Chief Executive to note.
Report Sponsor
Chief Executive
Appendices

Transforming Care: Update to Trust Board

January 2014

The purpose of this report is to update Trust Board on progress made in developing Transforming Care since the last update in October 2013. This report sets out progress on:

- The purpose and content of the Transforming Care Programme
- How we support the organisation to change
- Aligning transformation and savings delivery
- Governance of our transformation work

1. The purpose and content of Transforming Care.

As stated previously a simple and clear narrative was agreed by the Senior Leadership Team to better explain what Transforming Care is and why we prioritise it.

1.1 The purpose of Transforming Care is twofold:

- To drive us towards our vision for the trust, and
- To enable all our staff to improve the services which our patients receive

In support of its purpose, Transforming Care is both a set of projects and a structured approach that supports the organisation in making change happen.

1.2 The 6 pillars of Transforming Care continue to provide focus on the areas we need to address in order to achieve our vision. The executive leads for each pillar have developed aims and measures of success to give clarity of the intent of each pillar with a means of measuring progress towards these aims. Additionally, they have defined the key Trust wide programmes which support the delivery of the pillar aims, along with the benefits and outcomes these programmes will deliver. The aims and measures of success have been combined to produce a Transforming Care "dashboard", which includes a Red/Amber/Green assessment of the health of the projects and progress towards the pillar measures of success.

1.3 The dashboard is reviewed monthly by the Transformation Board allowing it to assess whether we have the right portfolio of projects and we are confident in the health of those projects. A summarised version of the dashboard is attached at appendix 1. Additionally, a programme wide milestone plan is being developed to give the Transformation Board greater clarity of the high level plans of trust wide projects. This will incorporate a communications plan to raise awareness and engagement with key programmes of work.

1.4 Following review of the dashboard in December, Transformation Board has initiated work to scope the potential for 3 further trust wide projects:

- 7 day working: Input is being taken from Divisions to understand the scope of changes required and determine the need for a Trust wide programme.
- Electronic Data Management (EDM): Work is ongoing with IM&T to assess the case for a transformation programme to run alongside this IT implementation and realise the change opportunities enabled by EDM.
- Enhanced Surgical Recovery Programme: The potential benefits of extending the scope of this work are being assessed.

1.5 The types of project we need to deliver to transform patient care ranges from the large and complex Trust wide programmes to the small and simple projects, and includes end to end pathway work and service changes. All of this work contributes towards Transforming Care and our programme is being developed to support and enable all of this.

1.6 Previously we identified the need to do more on patient pathway improvement. A standardised approach has been developed by the Transformation Team, and pilot projects using this structure are underway to address the Cancer Surgical 62 day pathway and the Paediatric Cardiac surgery pathway. The 62 day pathway work is well advanced, with a “quick win” action list underway and a “future state” pathway design approaching completion. The common feature of these projects to date has been strong engagement with the clinical and non-clinical team members who support the pathway to understand the issues and develop responses.

1.7 The majority of projects to improve patient care will continue to be identified and delivered within service teams in the Divisions. Business planning has sought to better align operational plans for 2014/15 with Transforming Care, with Divisions identifying their transformational change projects which align to the pillars.

2. Supporting the organisation to change

The second part of the purpose of Transforming Care is to support the organisation to plan, mobilise and deliver change projects to achieve its goals.

2.1 The Transformation Team is providing greater support to Divisions in delivering change through the introduction of Division representatives. These roles provides a point of contact with regular face to face involvement, help to access support for scoping, prioritising and planning of projects, plus input and support to the Divisional management team.

2.2 To encourage and support staff at all levels across the Trust to drive change a simple guide, ’How to Transform Care’ has been made available on Connect. It offers a consistent approach for planning and implementing change projects through the use of a structured method and use of basic service improvement tools, with a clear focus on benefits delivery. The guide also promotes the use of a common suite of project documents to encourage more rigour and discipline for delivering projects. The aim is for the method and tools to be used at all levels across the Trust, and the Transformation team will provide training and support in using the tools to deliver change projects successfully,

through the role of the Divisional reps. In addition, the Transforming Care content on Connect has also been updated and hosts the 'How to Transform Care' guide.

2.3 Work is progressing between the Transformation and Organisation Development teams to develop an approach for broad scale staff engagement on transformation. This will take place in the context of a wider piece of work on staff experience referencing principles described by Professor Michael West of Lancaster University Management School, and align with existing work across the Trust along with the work identified in our response to the Francis report. A proposal will be presented to the Transformation Board in February.

3. Transformation and savings delivery.

3.1 Many of the areas of work which contribute towards our savings targets are transformational in nature. The Transformation and Finance teams continue to work together closely to support teams in developing and delivering savings plans, with a strong focus on identifying the 2014/15 savings requirement.

3.2 Specifically we have worked to support the development of the Trust wide workstreams in developing transformational programmes which support the divisions in their savings identification. These programmes are at various stages of development and a key area of focus is to strengthen the rigour of the analysis and planning underpinning their work.

3.3 A key element of the revised governance is the Transformation Programme Board (chaired by the Chief Executive) playing a stronger role in the oversight of the savings programme. To supplement this approach, the Chief Executive will attend the next Programme Steering Group in early February in order to review workstream plans for 2014/15 with executive sponsors and workstream leads.

3.4 At present there is a gap between the likely savings target and the value of the financial opportunities identified through divisional plans, as detailed in the Director of Finance's reporting to the Board. A full update will follow submission of Divisions' operating plans on 31st January.

4. Transformation Governance.

4.1 Revisions to the Terms of Reference for the Transformation Programme Board have aimed to enhance governance of Transforming Care, by giving stronger leadership of the transformation agenda and to provide improved oversight of the Trust's savings work.

4.2 As a result, Transformation Programme Board meetings now focus more strongly on:

- The effectiveness of delivery of our existing scope of programmes
- Challenge to the scope of work
- The progress of development of Transforming Care
- Progress in developing the Trust's savings programme.

This agenda is providing the Transformation Programme Board with the opportunity to challenge the work being undertaken, and to strengthen the linkage between savings and transformation.

4.3 Transforming Care is now a substantive agenda item on the Senior Leadership Team (SLT) agenda, reflecting the importance of the Transformation agenda to the delivery of the Trust's aims.

4.4 A 'Reference Group' of people who are leading and promoting change is being established, to provide a forum where people can share learnings and identify priorities for support. It is anticipated that 1 or 2 key players from this group will join the Transformation Programme Board.

5. Moving forward:

Key next steps:

- Continue to develop and use the Transforming Care dashboard to measure and challenge progress toward pillar aims and the health of Trust wide projects
- Develop the approach for broad engagement on transformation within a wider staff experience programme
- Ensure all of the savings workstreams are effectively established
- Further support the Divisions in developing transformational change programmes aligned to the aims of Transforming Care
- Further expand our use of pathway improvement to deliver better care and improved patient flow

Simon Chamberlain

20th January 2014

Transforming Care Dashboard - Month 9

University Hospitals Bristol NHS Foundation Trust

	Delivering best care	Improving patient flow	Delivering best value	Renewing our hospitals	Building capability	Leading in partnership
Pillar Leads:	Sean O'Kelly/Helen Morgan	James Rimmer/ Sean O'Kelly	Paul Mapson/James Rimmer	Deb Lee/James Rimmer	Sue Donaldson/Helen Morgan	Deb Lee/Sean O'Kelly
Pillar Aims	To deliver high quality care: Patients are safe from harm; Staff are friendly, helpful, compassionate and sensitive to individual needs; Clinical effectiveness is top class; Services are constantly improved to enhance patient experience.	To deliver better, timelier and safer care for patients (in-patients, outpatients and day patients) by improving flow through our patients' journeys.	To deliver increasing value for the public money we spend by becoming more efficient, by prudent investment and by managing within our budgets.	To support the delivery of best care, by making best use of resources available to us to provide our staff and our patients, with the best possible environment and technologies.	To create an environment where everyone's contribution is valued. Build and develop an agile workforce with the right skills, who are confident in themselves and actively seek opportunities to do things better and deliver expert services with compassion.	To continue to build positive relationships with key partners for the benefit of our patients and people in the communities we serve.
Outcomes & Benefits	• Maintain our position of the lowest risk rating of patient care, as assessed by CQC. Continually increase clinical effectiveness in order enhance patient safety and patient experience. • Deliver leading edge clinical services by ensuring evidence based national guidance is incorporated into practice. • Deliver sustainable improvements in our standards of patient safety to achieve targets set by the Safer Care South West programme. • Drive forward improved standards of care as measured by the NHS Safety Thermometer to achieve and sustain performance in the top quartile of trusts, nationally. • Continually strive to improve the services our patients experience and sustain top quartile performance in the national 'Friends and family' test score.	• Drive forward sustainable improvements in patient experience and flow through key pathways, reduced length of stay and delayed discharges, to deliver consistent achievement of the Emergency Department 4 hour standard and Referal to treatment and Cancer waiting times. • Maximise the efficiency of our theatre suites to achieve consistent reductions and delays in theatres, with lists starting on time. • Embed standard and consistent process enhancements that increase our utilisation of outpatient clinics by reducing delays and overbooking of clinics, minimising 'Do not attends' and cancellations. • Patients are discharged when clinically appropriate to a setting where they continue to receive the care and support they need. • Transform patient pathways to improve efficiency by standardising a multi disciplinary approach that enhances levels ofcare and uses leading edge clinical techniques (ie Enhanced Recovery).	• Deliver the planned savings required to operate within our financial plans, aligned to the delivery of our transformational change programme. • Deliver greater operation efficiency, avoiding unplanned and premium payments and operating in line with agreed budgets. • Strengthen internal procedures to critically review the need for maximise control over all operational expenditure.	• Services in the new BRI facilities are delivered through new transformed models of care, team structures and ways of working to support best care supporting earlier diagnosis, improved flow and reduced length of stay • All children's services are delivered from a single site with the resulting improvment in access to specialist children's provision and ensuirng compliance with national service standards • New IM&T systems provide information where and when needed to support care, and enable more efficient ways of working for individuals and teams. • Way finding changes provide clear and simple information to guide patients, staff and visitors around our hospitals.	• Clarity amongst all staff as to the Trusts key objectives, how they will be achieved and the right skills and behaviours to deliver high quality care. • Improved staff engagement and continuous contribution resulting in a transformational culture with patient experience and flow at it's heart. • Develop a reputation as an 'employer of choice' and in turn enable the recruitment and development of 'best fit' employees in order to achieve the outcomes and benefits set out against each pillar. • Improvement culture 'as standard.'	• Pathway improvement across the health and social care system, to improve flow and access to care for people in our communities. • Increased research activities resulting income and enhanced access to trials for patients • Improved whole system urgent care, notably out of hospital care provision. • Increased trust and alignment of strategies, plans and patient pathways between UH Bristol and North Bristol Trust. • Further development of the parthership between Trust and Weston • Successful support to fund raising, in particular to large appeals.
Measures	Impact on performance/outcomes Health of programmes	Impact on performance/outcomes Health of programmes	Impact on performance/outcomes Health of programmes	Impact on performance/outcomes Health of programmes	Impact on performance/outcomes Health of programmes	Impact on performance/outcomes Health of programmes
Highlights	• Clinical Quality as at 31st Dec: - 227 days since last MRSA (19/5/13) - 256 days since last Grade 4 pressure ulcer (19/4/13). • Internal review of the Safer Care South West measures reveals that sustained improvements have been achieved in 50 of the 64 improvements, so far. • Summary Hospital - Level Mortality Indicator (SHMI) performance is significantly better reflecting the focus on clinical effectiveness. • Ongoing reduction in the number of pressure ulcers - currently achieving target for 1000 bed days. On track to achieve Pressure Ulcer CQUIN (Commissioning for Quality and Innovation) payment for full year. • Patient falls are within the 'per 1000 days' target for the second month running. • Reviewing the outputs of a pilot in BCH to use a new patient safety culture learning tool. The aim is to roll out with Multi disciplinary teams, in line with divisional requirements, from April 2014.	• Outpatient 'Do not attend' performance has improved to it's lowest level, following implementation of the text reminder system. The new call reminder service is scheduled to go live in February. • Outpatient Productivity assessment for each specialty has been developed to aid better demand v capacity planning. Will be issued to divisions in January to support identification of savings opportunities. • Theatres improvement programme re-established - with 5 specific projects commenced. • Positive progress is being made in engaging social care and community care partners to drive foreward the out of hospital care projects. • Good progress being made by the clinically led project teams within the other Patient flow phase 2 work programmes.	• Savings for 2014/15 to be updated through Operating plans - with 1st draft due on 31st January. • Review of workstream progress with the Chief Executive to be held on 7th February. • New Head of Service Line Reporting is promoting greater use of the system across the divisions, whilst also using Reference costing tool and Albatross software,to help focus on profitability of individual services. • A Guide for Budget Managers has been issued to drive better management and control of budget. A mandatory training programme will be launched in early 2014.	• Welcome centre opened • Draft BRI Re-development plan being prepared for move of services into new builds. • BRI business case refresh approved. • Centralisation of specialist paediatrics (CSP) business case re-fresh approved. • Planning application submitted for upgrade to Queens building facade. • Transformation of neuro-sciences model of care underway. • Dedicated additional resource to be deployed into Simulation Centre for 4 months prior to move to allow testing of new service models and care pathways. • New MRI scanner delivered to BRHC - will be operational in February. • CSP Change Day, facilitated by Transformation Director. • Estates strategy refresh business case to board on 30th January.	• Transformational Leadership development activity is on track. Programme for wider leadership co-hort commenced in January with further milestones re finance and e-learning on plan. • Post 'Recognising Success' evaluation under way. • Performance Management approach agreed for roll-out. • Retention strategy being developed and co-ordinated • Recruitment to non-nursing vacancies underway but continue to be a challenge; nursing vacancies reduced by 19% in November	• Academic Health Science Network (AHSN) project established re Neonatal monitoring. • Board to board with Bristol Community Health being established. • Health & Well Being Board reconsidering provider membership - event in Jan 2014.

University Hospitals Bristol NHS
NHS Foundation Trust

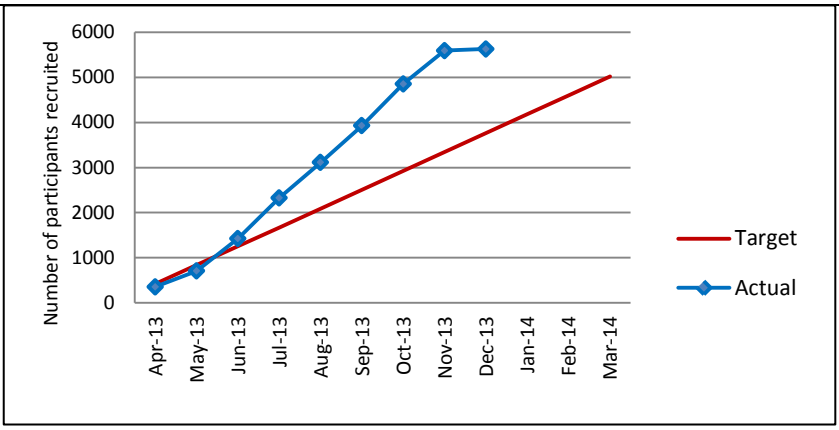
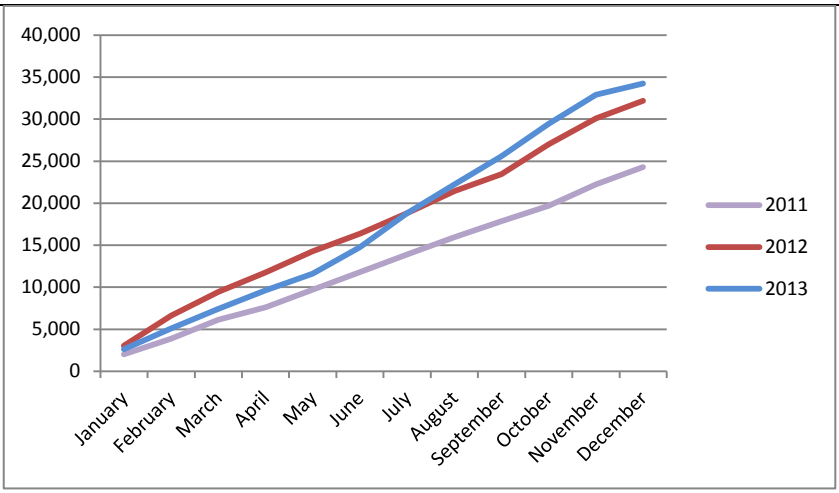
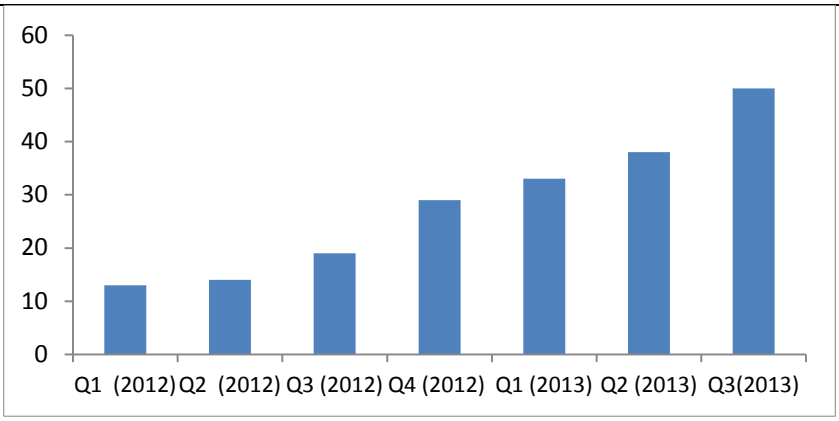
Cover Sheet for a Report for a Public Trust Board Meeting, to be held on 30 January 2014 at 10:30 in the Conference Room, Trust Headquarters, Marlborough Street, Bristol, BS1 3NU

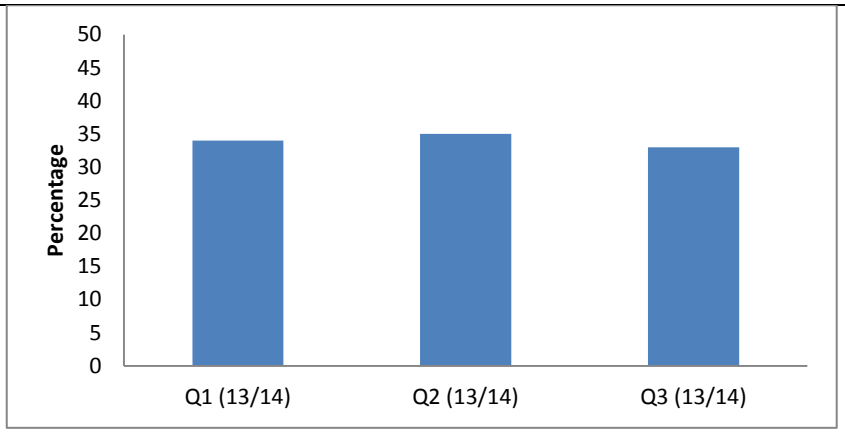
8. Research and Innovation Update Report
Purpose
The Director of Research will give an oral report to update the Board on research activity within the Trust. Data will be presented on recruitment activity into NIHR portfolio trials, which determines future funding, and performance against the Department of Health benchmark relating to the time to setup and open trials. Regional activity, developments and forward planning with respect to aligning our research and clinical service strengths with our regional partners (principally Bristol Health Partners, CLAHRC*West*, the West of England AHSN and West of England CRN) will be discussed.
Abstract
Recommendations
The Trust Board is recommended to receive this report by the Medical Director for review.
Report Sponsor
Medical Director
Appendices
Research & Innovation Q3(2013/2014) performance report

UH Bristol update: Recruitment into NIHR portfolio trials continues to exceed the expected target. Weighted recruitment has surpassed the figures for 2012 (calendar year) which will serve to secure at least the same amount of funding received in 2013. The precise funding amount will be decided by the new West of England Clinical Research Network (previously WCLRN) in May 2014. Performance in initiating research at UH Bristol continues to improve whilst performance in delivery of commercial trials is still showing variation. Work is underway to address this.

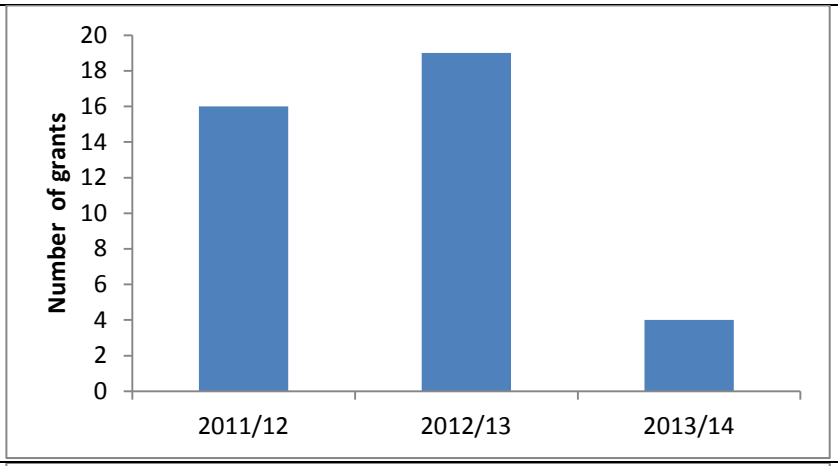
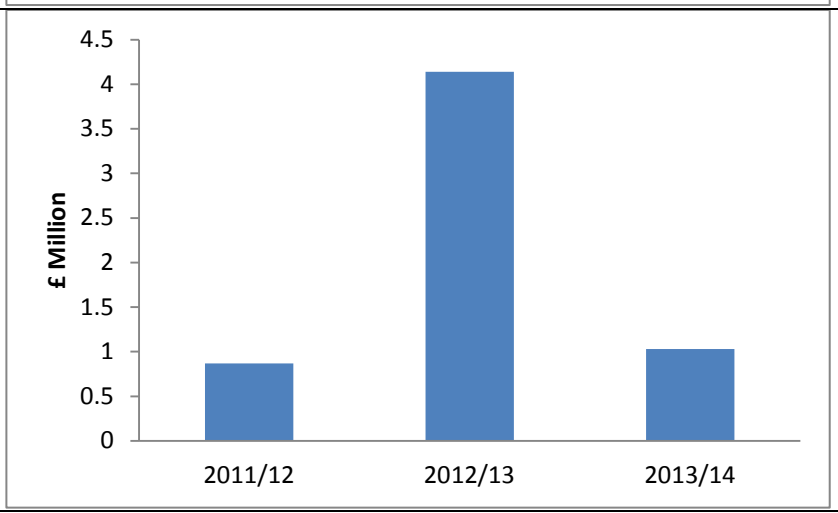
Regional update: Setup of the new West of England Clinical Research Network (WECRN) and CLAHRCwest, both of which are hosted by UHBristol, is on track with senior positions appointed for both organisations. The WECRN and CLAHRCwest will be co-located in Whitefriars.

Recruitment Indicators:

	Target for 13/14	Performance	Progress against target
Cumulative number of patients recruited into NIHR portfolio studies NB. There is a 4 week lag of data from the portfolio.	5014		
Cumulative weighted recruitment into NIHR portfolio studies (exception: calendar year)	Increase on previous year		
Percentage of studies meeting 70 day first-patient first-visit benchmark	Increase each quarter		

Our performance of meeting the 70 day first patient first visit benchmark *in comparison to other Trusts* (reported to Barometer)	Green: >=30% (Upper Quartile) Red: <27.7% (Median)	NIHR PID report- Quarter 2 2013/2014 In Upper quartile	
Percentage of commercial studies which recruited to time and target in the reporting period	Increase on previous quarter		

Grants Indicators:

	Target		
Number of Grants submitted	No target		N/A
Total value of Grants awarded in year	No target		N/A

UH Bristol R&I Q3 2013-14

Key:

NIHR	National Institute of Health Research - created by DoH in 2006 to implement the R&D strategy: 'Best Research for Best Health'
Portfolio	The NIHR's list of adopted studies. Studies that are funded through major funders (NIHR, Research Councils, Charities etc) via peer reviewed open national competition are eligible for inclusion on the NIHR Portfolio. Other studies are also adopted on a case by case basis. Funding from CLRNs is provided to support NIHR portfolio adopted studies. Some Commercial research is also adopted but no funding is provided via the CLRNs. UH Bristol falls under the WCLRN who provides funding for delivery of our portfolio studies.
Weighted recruitment	There are 3 different bands of study within the NIHR portfolio- Band 1, 2 and 3. This banding represents the complexities of a study. Patients recruited into a band 1 study are weighted lower than those recruited into a band 2 (observational) study which in turn is weighted lower than those recruited into a band 3 study (interventional). The ratio for the weighting is 1:3:14. The weighted recruitment provides an indicator of the monetary value of our research portfolio and influences the delivery funding supplied by the WCLRN at the end of the year.
70 day benchmark	This benchmark has been set by the NIHR and is 70 days from receipt of a valid research application into Research and Innovation to first patient recruited (consented) by the research team. Our target for approval of each study is 30 days thus allowing 40 days for the research teams to recruit.
Internal delay	Where the 70 day benchmark is not met we are required to supply reasons for this. Some factors influencing whether this benchmark is met is out of our control for example; external sponsors causing delays. However some reasons for not meeting this benchmark is a delay caused by UH Bristol and is thus an 'internal delay'.
Time to target	When an approval application is received into Research & Innovation a target number of patients to be recruited is provided as well as duration of the study. The NIHR requires us to submit quarterly data on whether our commercial studies are meeting their recruitment target and within the timescales of the research study.
Commercial studies	Commercial studies - Research funded AND sponsored (i.e. contracted) by commercial companies e.g. pharmaceutical company; medical device company
Non-commercial studies	Non-commercial - All other research. Funded by a non-commercial organisation such as the NIHR, a research council or charity or local funding. Also includes studies funded by a grant from a commercial company but sponsored by a non-commercial organisation.
R&D approval	Any project that is to be delivered within an NHS trust must be approved by that trusts R&D department before it can start recruiting patients. R&D approval is a process to confirm that a study can be delivered safely and successfully at UH Bristol
RCF	Research capability funding - funding provided by the NIHR for use in developing new grant applications and/or plugging the gaps of NIHR Investigators' salaries in-between grants
WCLRN	WCLRN - One of 25 Comprehensive Local Research Networks (CLRNs) as part of a national research network infrastructure. All NHS organisations in Avon, Gloucester, Wiltshire, Dorset and Somerset are members of the Western CLRN.

University Hospitals Bristol NHS
NHS Foundation Trust

Cover Sheet for a Report for a Public Trust Board Meeting, to be held on 30 January 2014 at 10:30 in the Conference Room, Trust Headquarters, Marlborough Street, Bristol, BS1 3NU

9. Report Withdrawn
Purpose
Abstract
Recommendations
Report Sponsor
Appendices

University Hospitals Bristol NHS
NHS Foundation Trust

Cover Sheet for a Report for a Public Meeting of the Trust Board of Directors, to be held on 30 January 2014 at 10.30 in the Conference Room, Trust Headquarters, Marlborough Street, Bristol, BS1 3NU

Item 10 – National Maternity Survey

Purpose

This item provides a summary of the Trust's performance in the Care Quality Commission's national maternity survey

Abstract

As part of this national survey, 177 women who gave birth at UH Bristol during March 2013 completed a postal questionnaire about their experience of the Trust's maternity services.

The Care Quality Commission has benchmarked UH Bristol's performance against the 136 other trusts that participated in the survey. The key results of this comparative analysis are as follows:

- Of the seven scores relating to UH Bristol's community antenatal care, five were in line with the national average and two were better than the national average

- Of the seventeen UH Bristol scores relating to experiences of care during labour/birth and on postnatal wards, fourteen were in line with the national average and three were better

The Care Quality Commission Benchmark reports are provided for information. In conjunction with the Head of Midwifery, the UH Bristol Patient Experience and Involvement Team has also produced a local analysis report. This report summarises the key findings, identifies a number of improvement themes, and provides an action plan in response to the survey results.

Recommendations

The Board is recommended to **receive** this report from the Chief Nurse to review.

Report Sponsor

Chief Nurse.

Report Author

Paul Lewis, Patient Experience Lead (Surveys and Evaluation)

Sarah Windfeld (Head of Midwifery)

Appendices

1. National maternity survey local analysis report and action plan
2. Care Quality Commission benchmark report for antenatal care
3. Care Quality Commission Benchmark report for care during and after birth

Title:	**2013 National Maternity Survey Results: Local Analysis Report**
Paper to:	Trust Board
Purpose:	To provide an analysis of the Trust's survey results and to outline service improvement activity in relation to the key issues identified.
Authors:	Analysis: Paul Lewis, Patient Experience Lead (surveys and evaluation) Action plan: Sarah Windfeld, Head of Midwifery
Date:	9th January 2014

1. Maternity services at UH Bristol

UH Bristol provides community midwifery services from thirteen bases located across south and central Bristol. Most women are under the care of a community midwife during pregnancy and in the first few weeks following the birth of their baby. Women who have more complex needs will be under the direct care of a hospital consultant. UH Bristol has a central delivery suite, midwifery-led delivery suite, antenatal and postnatal wards located at St Michael's Hospital. Around 400 babies per month are born at the Trust.

2. National Maternity Survey methodology

Women were sent a questionnaire by post if they were aged 16 or over, had a live birth during March 2013[1], and gave birth in a hospital, maternity unit or at home. As part of the survey, 360 women were sent a questionnaire about their experience of UH Bristol's maternity services, with 177 responding. This is a response rate of 50%[2] - slightly above the overall national response rate of 46%. In total, 137 NHS acute trusts in England participated in the survey. The national maternity survey takes place approximately every three years and is a useful tool for benchmarking against other trusts. To ensure that more timely data is available for quality assurance and improvement purposes, UH Bristol carries out a monthly maternity survey. This largely replicates the national survey methodology and is sent to around 250 women per month. In addition, "real-time" feedback is captured across the Trust's community and hospital maternity services via the Friends and Family Test survey, which went live nationally on 1 October 2013[3].

[1] The UH Bristol sample comprised women who had given birth in March 2013. Other trusts took their sample from January or February 2013, but this was not possible for UH Bristol as that cohort of women had already participated in the Trust's monthly maternity survey.
[2] The response rate calculation excludes questionnaires that could not be delivered.
[3] It is anticipated that NHS England will publish maternity Friends and Family Test results from all trusts, monthly from February 2014 onwards.

3. Headline Results: Care Quality Commission Benchmark Reports

The Care Quality Commission (CQC) has produced two "benchmark" reports for UH Bristol, covering experiences of antenatal and hospital care. The reports show UH Bristol's scores[4] on a range of survey questions, against a comparison with other maternity services in England.

3.1 Antenatal care

Of the seven scores relating to the antenatal care provided by UH Bristol's community midwives, five were classed as being "the same as other trusts" (in lay terms: in line with the national average[5]). Two scores were classed as being "better than other Trusts", which means that they were better than the national average by a statistically significant degree:

- Thinking about your antenatal care, were you spoken to in a way you could understand[6]?
- Thinking about your antenatal care, were you involved enough in decisions about your care?

3.2 Hospital care

Of the seventeen UH Bristol scores relating to care in hospital during labour/birth[7] and on postnatal wards, fourteen were in line with the national average, and three were better:

- During labour and birth, did the staff introduce themselves?
- During labour and birth, were you spoken to in a way you could understand?
- On the postnatal wards, were you treated with kindness and understanding?

3.3 Changes from the 2010 national maternity survey

Ten of the questions in the 2013 survey are directly comparable to the previous national maternity survey carried out in 2010. For UH Bristol, three of these ten scores improved to a statistically significant degree:

- During labour, could you move around and choose the most comfortable position?
- During labour and birth, were you spoken to in a way you could understand?
- On the postnatal wards, were you treated with kindness and understanding?

These improvements are against a background of national improvement in the maternity survey results, particularly around themes relating to communication and involvement in care decisions.

[4] Scores range from zero to ten (with ten being the best), and are derived from all of the response options to a survey question - see Appendix C for further details. Please note that the CQC no longer provide a report that directly compares UH Bristol with the national average in percentage terms.

[5] Technically: no statistically significant difference to the mean score across all trusts.

[6] No other trust in England achieved a higher score than UH Bristol on this question

[7] Only four UH Bristol respondents gave birth at home.

3.4 Comparison with selected other trusts

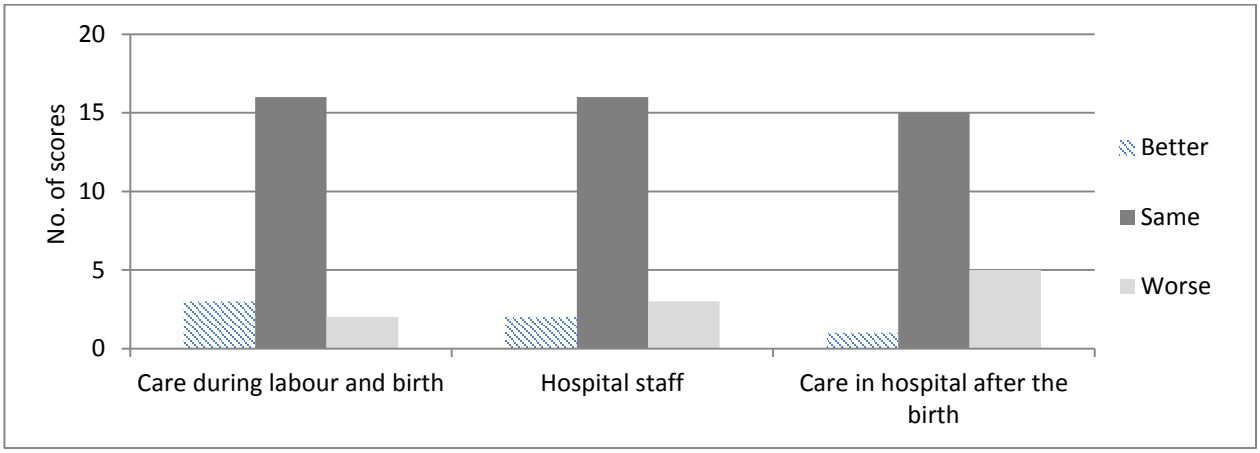
A simplified version of the benchmark report relating to hospital care is available to the public via the CQC website[8]. This aggregates the data into three elements of hospital care: labour and birth, hospital staff, and care in hospital after the birth. Again, the scores are rated on the basis of whether they are better, the same, or worse than the national average. UH Bristol scored in line with the national average in all three sections (Table 1). It can also be seen that five of the seven trusts compared in Table 1 achieved at least one "better than average" rating.

Table 1: national survey ratings, compared to the national average, for selected maternity hospitals in the South West region (note: data has not been published for Weston Area Health NHS Trust).

	Care during Labour and birth	**Hospital staff**	**Care in hospital after the birth**
Salisbury NHS FT	Better	Better	Better
Gloucestershire Hospitals NHS FT	Same	Better	Better
Taunton & Somerset NHS FT	Same	Same	Better
Royal Devon & Exeter NHS FT	Better	Same	Same
Yeovil District Hospital NHS FT	Better	Same	Same
Great Western Hospitals NHS FT	Same	Same	Same
University Hospitals Bristol NHS FT	Same	Same	Same
North Bristol NHS Trust	Same	Same	Worse

A wider analysis has been carried out to compare UH Bristol's performance to twenty similar large acute teaching trusts in England[9]. Chart 1 shows that most scores among this cohort are in line with the national average. In other words: UH Bristol's performance is largely in line with its peer trusts. Four of these twenty-one peer trusts achieved one or more rating that was better than the national average, with nine trusts receiving one or more "worse than the average" rating.

Chart 1: distribution of maternity survey ratings, compared to the national average, for twenty-one similar trusts in England (including UH Bristol)

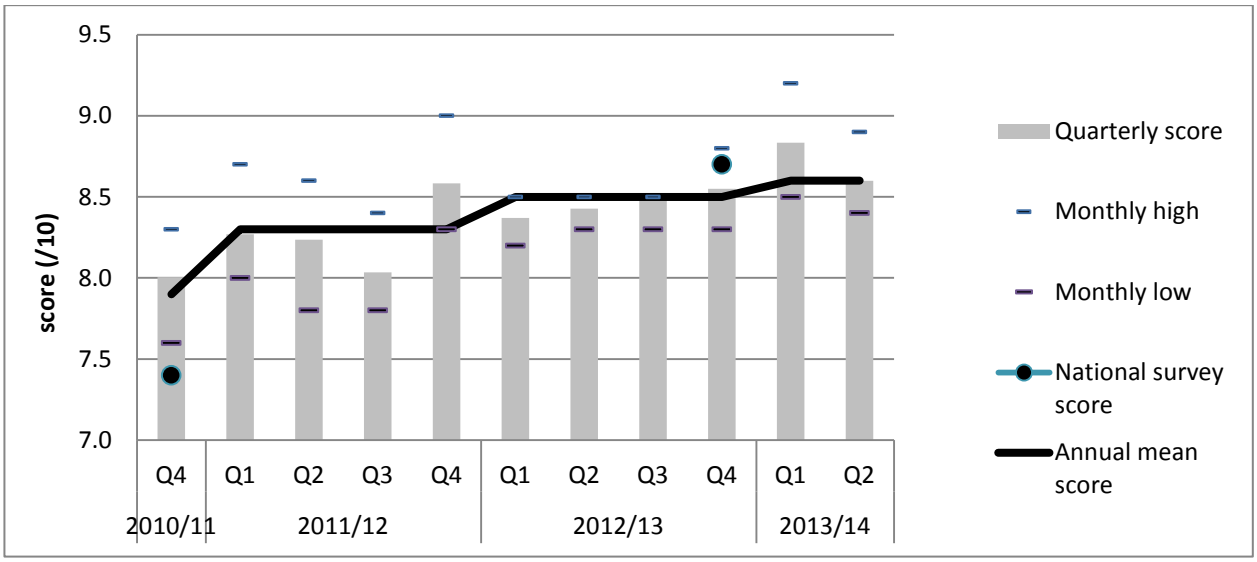


[8] http://www.cqc.org.uk/surveys/maternity
[9] As identified by the Department of Health (2007/8). See Appendix B for the full table of comparison results.

4. Recognising success: kindness and understanding on postnatal wards

In the 2013 national maternity survey, UH Bristol's score on treating women with kindness and understanding on postnatal wards was better than the national average. This represents a significant achievement, particularly as in the 2010 national maternity survey the Trust was on the borderline of being among the worst 20% of trusts nationally on this measure. Using the UH Bristol monthly maternity survey, we can demonstrate the progress that was made between the two surveys (Chart 1)[10]. This was achieved primarily through a clear focus by hospital-based maternity staff on improving this score, including participation in a number of workshops which allowed staff to reflect on how their behaviours can affect patient experience (known as the "Patient Experience at Heart" workshops). The learning from this approach will be incorporated into UH Bristol's plans for improving patient experience during the 2014/15 financial year.

Chart 1: St Michael's Hospital scores for kindness and understanding on postnatal wards (2010-2013)



Source: UH Bristol monthly maternity survey; CQC national maternity survey

5. How good are the national maternity survey results?

The analysis so far has shown that UH Bristol maternity services perform at least as well as the national average and have improved in several key areas. However, this doesn't in itself tell us whether women think that they receive high quality maternity care. The CQC chief inspector of hospitals, Professor Sir Mike Richards, said in response to the results at a national-level:

"I'm encouraged there are improvements, but in too many cases the quality of care delivered is just not good enough."

[10] UH Bristol carries out a monthly survey of maternity service users, which is sent to around 250 women per month and is closely modelled on the national maternity survey methodology.

To determine how good the national maternity survey results are, it is useful to look at the percentage of women who ticked the best possible response option to each question (as opposed to the CQC scoring approach, which also gives some credit for "*fairly satisfied*" type responses)[11]. For some aspects of care, a majority or relatively large minority of women did not give UH Bristol top marks. These results largely reflect themes that emerge nationally, around continuity of care for antenatal appointments, responsiveness to women during labour/birth, and care on postnatal wards. Each of the points raised in this analysis is addressed in Section 6 of this report.

Antenatal care

- **94%** of women were given a choice of where they could give birth, but only **58%** said that they were given enough information to make this choice
- **17%** of women were given a choice of where to have their antenatal appointments
- **11%** of women saw the same midwife for each appointment; **47%** of women would have liked to have seen the same midwife at each antenatal appointment
- **97%** of women were always spoken to in an understandable way during their antenatal appointment, but **24%** said that they didn't always have enough time with the midwife

Care during labour and birth

- **17%** of women felt that they did not get appropriate advice when they first contacted the hospital or a midwife after going into labour
- **15%** felt that concerns they raised to staff during labour were not taken seriously
- **16%** had to wait more than five minutes for assistance after pressing the call button
- **18%** were left alone by midwives or doctors at a time when they were worried

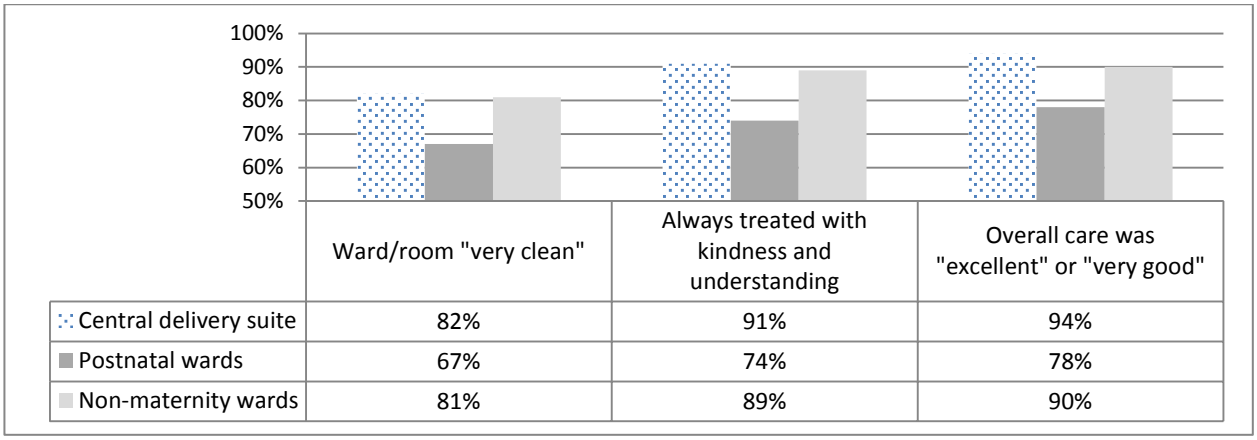
Postnatal wards

- **58%** were given the information or explanations they needed on the postnatal ward
- **22%** of women said that they were not always treated with kindness and understanding on the postnatal wards at St Michael's Hospital
- **40%** said their ward or room wasn't "very clean"
- **19%** said that their decisions on how to feed their baby were not always respected by midwives
- **26%** felt that they were kept in hospital too long (13%) or sent home too early (13%) after the birth

[11] There are pros and cons to each approach - for a review see http://www.pickereurope.org/assets/content/pdf/Survey_data_analyses/Generalizability%20of%20survey%20results%20v2%20(2).pdf

Chart 2 below uses UH Bristol's own survey data to demonstrate a further issue – the disparity between care experiences on postnatal wards and other areas of the Trust. As an example, even with the significant improvement in UH Bristol's score around kindness and understanding on postnatal wards, this still lags behind the equivalent results for care during labour/birth and the Trust's general inpatient wards. One of the main explanations that women provide for this difference in their written feedback, is that wards seem to have relatively few midwives compared to the delivery suites (where one-to-one care is the norm). The differences in perceptions of cleanliness are more difficult to explain, as this is not supported by other quality assurance data the Trust holds. Nevertheless actions are being undertaken to improve this issue (see Section 6).

Chart 2: comparison of UH Bristol patient experience ratings



	Ward/room "very clean"	Always treated with kindness and understanding	Overall care was "excellent" or "very good"
Central delivery suite	82%	91%	94%
Postnatal wards	67%	74%	78%
Non-maternity wards	81%	89%	90%

Source: UH Bristol monthly maternity and inpatient surveys, July-September 2013.

6. Improving women's experiences of maternity services at UH Bristol

A number of themes emerge from UH Bristol's survey results, which in most cases reflect the trends at a national-level. At UH Bristol, most of these issues have are already been identified via the regular feedback collected from maternity service-users and other data sources (e.g. audits, service evaluations). The maternity services team at UH Bristol continually strive to improve the service they provide, as the following initiatives that took place during 2013/14 demonstrate:

- The creation of 11.6 new midwifery posts at St Michael's Hospital
- Participation of hospital-based maternity staff in the "Patient Experience at Heart" workshops, to reflect on how they can influence service-user experience
- Opening four new midwifery-led birthing suites at St Michael's Hospital
- As a result of service-user feedback: an expansion of menu choices and food availability, and a new inspection system to ensure that food is of a consistently high quality
- Reconfiguration of the wards at St Michael's Hospital to separate antenatal and postnatal women (again, based on service-user feedback)
- The nomination of a consultant-level lead for service-user experience

UH Bristol's response to the specific issues raised in the national maternity survey (see previous section) is provided in Table 2 - over.

Table 2: UH Bristol's response to the national maternity survey findings

	Theme	Comment	Response/ action(s)	Lead/date
1. Antenatal	1.1. Continuity of care (i.e. seeing the same midwife for each antenatal appointment)	A recent audit of UH Bristol, North Bristol NHS Trust, and Weston Area Health NHS Trust, found that on average women see three to four midwives over the course of nine antenatal appointments (with no significant differences between the trusts). The main challenge here is around the large number of service-users relative to midwives (particularly factoring-in part time working, maternity/sick leave, and staff turnover)	It is unlikely that women will be able to see the same midwife for each appointment (although efforts are made to do so for women with complex needs). However, the Trust is committed to continued working with the Bristol Clinical Commissioning Group and our neighbouring trusts to explore ways to minimise the number of midwives women see, and to ensure that there is seamless care between midwives.	Sarah Windfeld, via the BNSSG Maternity Services Liaison Committee, quarterly meetings
	1.2 Choice of where to have antenatal appointments	This presents similar challenges to those described in 1.1, with the additional difficulty of needing to find suitable locations. Most appointments are currently at a clinic in the community, although efforts are made to have appointments available at Children's Centres (formerly Sure Start Centres) as well.	No additional actions planned specifically in response to the survey.	
	1.3 Information to assist women in making the choice of where to give birth	Women already receive an information leaflet outlining these choices, and have the opportunity to discuss this decision with their midwife.	Community midwives will be asked to draw women's attention to this leaflet, as it may be being "lost" among the other information that they are given.	Sara-Jane Sheldon/ January 2014
			The leaflet is currently being reviewed and an updated version will be available by March 2014.	Sara Jane Sheldon/ Belinda Cox / March 2014.
	1.4 The amount of time spent with a midwife during antenatal appointments.	Given the large number of antenatal appointments, this presents similar resource challenges to those described in 1.1. All women are given the telephone number of their midwife team, who they can speak to outside of the appointments if they need to.	No additional actions planned specifically in response to the survey.	

	Theme	Comment	Response/ action(s)	Lead/date
2. Labour and birth	2.1 Advice received when first contacting the hospital after going into labour	This is usually a telephone-based assessment to ascertain how far a woman's labour has progressed. This is carried out by an experienced midwife, but clearly every woman's labour is different, and in some situations women are in more advanced labour than is evident from this assessment.	The results will be shared with hospital based midwives as a general learning point. The telephone triage system will however need to remain in place, as it would not be feasible for a midwife to check every woman in person, or to invite all women in at the very start of their labour. Records are kept of the telephone assessments and regular clinical audits carried out to ensure they are of a high standard.	Sarah Windfeld/ January 2014
	2.2 Ensuring women's concerns are taken seriously during labour	This may be related to the way that staff sometimes respond to women's concerns, as clinical assessments will be the primary means through which women are assessed.	The "Patient Experience at Heart" workshops will now have a section where staff can reflect on ways to demonstrate in practice that they take all concerns seriously.	Sarah Windfeld/ Tony Watkin (from February 2014)
	2.3 Responding to call bells	Women in advanced labour or with complex needs have one-to-one care. The expansion of midwifery posts at St. Michael's Hospital should ensure a generally more "responsive" service to all women.	No additional actions planned specifically in response to the survey.	
	2.4 Ensuring that women aren't left alone at a time that worries them	As per 2.3	No additional actions planned specifically in response to the survey.	
3. postnatal wards	3.1 Ensuring women have the explanations/ information that they need on the postnatal wards	This is related to a wider theme, as in the written survey comments a number of women have said that they did not get sufficient support on the postnatal wards. This is in part reflective of the difference in staff ratios between the delivery suites and wards. However, it is also recognised by the Trust that more midwives would improve care and recruitment is underway to increase numbers by 11.6 full time equivalent posts.	The next Face-to-Face survey will interview women on postnatal wards about their information needs. Further actions will be developed from this feedback.	Tony Watkin/ February 2014
			Healthcare Assistants provide information verbally to women. This process will be reviewed with the aim of ensuring it is carried out in a timely/structured way, and meets the needs of service-users.	Sarah Windfeld/ February 2014

	Theme	Comment	Response/ action(s)	Lead/date
3. postnatal wards (continued)	3.2 Ensuring women are treated with kindness and understanding on the postnatal wards	Although the Trust is now rated as being better than the national average on this element of care, the aim is to increase the score so that it is at least in line with other inpatient areas of UH Bristol. There will be continued focus on this issue by the maternity services team at St Michael's Hospital.	Reconfiguration of postnatal wards in response to feedback from women	Complete
			All new midwives will attend the Patient Experience at Heart staff workshops	Sarah Windfeld/Tony Watkin (ongoing)
			Existing staff will receive a Patient Experience at Heart "refresher" every two years as part of the patient safety day	Sarah Windfeld/ ongoing
			Appointment of a consultant-level lead for Patient Experience	Complete
	3.3 Cleanliness of postnatal wards	This theme also emerged from the Trust's monthly maternity survey and is already the focus of improvement activity by the Facilities Department. The results will continue to be monitored and further actions undertaken if necessary.	The Facilities Department have carried out a number of actions to improve cleanliness, including increasing bin collections and amending cleaning rotas. These results will continue to be monitored via the Trust's monthly maternity survey.	Colin Waldron/ ongoing
	3.4 Supporting womens' decisions about feeding their baby	Women are encouraged to breast-feed. However, there can be a fine-line between active promotion and ensuring women are supported in the choices they make.	This is related to staff behaviour and so will be incorporated as a learning-theme in the Patient Experience at Heart workshops and refresher sessions.	Sarah Windfeld/Tony Watkin (ongoing)
	3.5 Length of stay in hospital after giving birth	Women are discharged on the basis of clinical readiness. However, it is recognised that expectations of length of stay can differ between women. Given the need for bed-space discharge may also sometimes appear to be rushed. In addition, better/ongoing communication with women about their discharge plans may help this issue.	Although the length of stay will continue to be determined by clinical need, the increase in midwife numbers should provide an opportunity for more effective discharge planning and ongoing-dialogue with service-users. These results will be shared as a learning point for maternity staff.	Sarah Windfeld/ January 2014

Appendix A: table of UH Bristol scores and national comparison

	UH Bristol	Best score nationally	Better/same/ worse than national average
Thinking about your antenatal care, were you spoken to in a way you could understand?	9.8	9.8	Better
Thinking about your antenatal care, were you involved enough in decisions about your care?	9.2	9.3	Better
Did the staff treating and examining you introduce themselves?	9.3	9.5	Better
Did you have confidence and trust in the staff caring for you during your labour and birth?	9.1	9.3	Same
Thinking about your care during labour and birth, were you spoken to in a way you could understand?	9.6	9.8	Better
If your partner or someone else close to you was involved in your care during labour and birth, were they able to be involved as much as they wanted?	9.7	9.9	Same
Thinking about the care you received in hospital after the birth of your baby, were you treated with kindness and understanding?	8.7	9	Better
If you contacted a midwife, were you given the help you needed?	8.8	9.2	Same
During your labour, were you able to move around and choose the position that made you most comfortable?	8.8	9.2	Same
Thinking about your care during labour and birth, were you treated with respect and dignity?	9.3	9.7	Same
Did you have skin to skin contact (baby naked, directly on your chest or tummy) with your baby shortly after the birth?	9.4	9.8	Same
During your pregnancy, did you have a telephone number for a midwife or midwifery team that you could contact?	9.5	10	Same
Thinking about your care during labour and birth, were you involved enough in decisions about your care?	8.5	9.1	Same
Were you (and/or your partner or a companion) left alone by midwives or doctors at a time when it worried you?	7.9	8.6	Same
Were you offered any of the following choices about where to have your baby?	4.6	5.3	Same
If you raised a concern during labour and birth, did you feel that it was taken seriously?	8.4	9.2	Same
Did you get enough information from either a midwife or doctor to help you decide where to have your baby?	7.6	8.4	Same
If you used the call button how long did it usually take before you got the help you needed?	8	8.8	Same
During your antenatal check-ups, were you given enough time to ask questions or discuss your pregnancy?	8.5	9.4	Same
During your antenatal check-ups, did the midwives listen to you?	8.6	9.5	Same
How clean was the hospital room or ward you were in?	8.6	9.5	Same
Do you feel that the length of your stay in hospital after the birth was…	7.4	8.6	Same
Thinking about the care you received in hospital after the birth of your baby, were you given the information or explanations you needed?	7.5	8.8	Same
At the very start of your labour, did you feel that you were given appropriate advice and support when you contacted a midwife or the hospital?	8.1	9.5	Same
Thinking about your stay in hospital, how clean were the toilets and bathrooms you used?	8	9.6	Same
During your pregnancy were you given a choice about where your antenatal check-ups would take place?	1.8	6	Same

Appendix B: Comparison of results from twenty-one large acute teaching trusts

	Labour and birth	Staff	Care in hospital after the birth
Cambridge University Hospitals NHS Foundation Trust	Better	Better	About the same
Oxford University Hospitals NHS Trust	Better	About the same	Better
University Hospital Southampton NHS Foundation Trust	About the same	Better	About the same
Central Manchester University Hospitals NHS Foundation Trust	About the same	About the same	About the same
The Newcastle Upon Tyne Hospitals NHS Foundation Trust	About the same	About the same	About the same
University Hospitals Bristol NHS FT	About the same	About the same	About the same
University Hospitals Of Leicester NHS Trust	About the same	About the same	About the same
Guy's and St Thomas' NHS Foundation Trust	About the same	Worse	About the same
Imperial College Healthcare NHS Trust	About the same	Worse	About the same
Leeds Teaching Hospitals NHS Trust	About the same	About the same	Worse
Nottingham University Hospitals NHS Trust	About the same	About the same	Worse
Sheffield Teaching Hospitals NHS Foundation Trust	About the same	About the same	Worse
University College London Hospitals NHS Foundation Trust	About the same	About the same	Worse
University Hospital of South Manchester NHS Foundation Trust	About the same	About the same	About the same
Birmingham Women's NHS Foundation Trust	Worse	About the same	About the same
Liverpool Women's NHS Foundation Trust	About the same	About the same	About the same
Barts Health NHS Trust	Worse	Worse	About the same
King's College Hospital NHS Foundation Trust	About the same	About the same	About the same
Chelsea and Westminster Hospital NHS Foundation Trust	Better	About the same	About the same
Royal Free London NHS Foundation Trust	About the same	About the same	Worse

Appendix C: Explanation of the Care Quality Commission's survey scoring methodology

For 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 national survey questions have three or more response options. In the CQC benchmark report, each one of these response options contributes to the calculation of the score.

As an example: Were you treated with kindness and understanding on the postnatal wards?

	Weighting	**Responses**	**Score**
Yes, definitely	1	78%	77*1 = 77
Yes, probably	0.5	19%	19*0.5 = 9.5
No	0	5%	5*0 = 0

The result is then calculated as (77+9.5)/10 = 8.7

As the survey score is using a relatively small sample to draw conclusions about the wider population, it is an estimate and has a quantifiable margin of error around it. In this case the margin of error is +/-0.6, meaning that we can be 95% certain that the true score is somewhere between 8.1 and 9.3.

Conceptually, this is how the CQC classify Trust scores against the national average for each question:

1. Take the mean score across all trusts nationally (i.e. add up all of the Trust scores for this question, and divide this by the number of Trusts). The mean Trust score on the kindness and understanding question is 8.0
2. For each trust, use the margin of error in their data to give the expected range of scores for that trust. So, given UH Bristol's margin of error for this question is +/-0.6, the CQC would expect our score to be between 7.4 and 8.6
3. UH Bristol's score, at 8.7, falls outside the top-end of this range, and is therefore classified as being better than most other Trusts.

Appendix D: schedule of CQC data publication/UH Bristol committee reports

National maternity survey benchmark data released to Trusts under embargo	5th December
Results summarised by email to UH Bristol Executives and Senior Managers for Maternity Services	6th December
Results made public	12th December
Results reviewed at the UH Bristol Patient Experience Group	19th December
Results and draft local analysis report reviewed at Women's Executive Committee Meeting	9th January
Results and local analysis report reviewed at the Senior Leadership Team Committee	15th January
Results and local analysis report reviewed at the Quality and Outcomes Committee of the Trust Board	28th January
Results and local analysis report reviewed at the Quality and Outcomes Committee of the Trust Board	30th January

Maternity care pathway reports: antenatal care

Survey of women's experiences of maternity services 2013

University Hospitals Bristol NHS Foundation Trust

The national survey of women's experiences of maternity services 2013 was designed, developed and co-ordinated by the Co-ordination Centre for the NHS Patient Survey Programme at Picker Institute Europe.

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National NHS patient survey programme

Survey of women's experiences of maternity services 2013

CQC Maternity care pathway reports: antenatal care

The Care Quality Commission is the independent regulator of health and adult social care in England.

Our purpose:
We make sure health and social care services provide people with safe, effective, compassionate, high-quality care and we encourage care services to improve.

Our role:
We monitor, inspect and regulate services to make sure they meet fundamental standards of quality and safety and we publish what we find, including performance ratings to help people choose care.

Survey of women's experiences of maternity services 2013

To improve the quality of services that the NHS delivers, it is important to understand what service users think about their care and treatment. One way of doing this is by asking people who have recently used their local health services to tell us about their experiences.

Information drawn from the questions in the maternity survey will be considered by the Care Quality Commission (CQC) as part of its new Hospital Intelligent Monitoring. NHS England will use the results to check progress and improvement against the objectives set out in the NHS mandate, and the Department of Health will hold them to account for the outcomes they achieve. The Trust Development Authority will use the results to inform the quality and governance assessment as part of their Oversight Model for NHS Trusts.

The 2013 survey of women's experiences of maternity services involved 137 NHS acute trusts in England. We received responses from more than 23,000 service users, a response rate of 46%. Women were eligible for the survey if they had a live birth during February 2013[1], were aged 16 years or older, gave birth in a hospital, birth centre, maternity unit, or who had a home birth. NHS Trusts in England took part in the survey if they had a sufficient number of eligible women that give birth at their NHS trust during the sampling time frame.

Similar surveys of maternity services were carried out in 2010 and 2007. They are part of a wider programme of NHS patient surveys which covers a range of topics including acute inpatient, outpatient, and A&E services, ambulances, and community mental health services. To find out more about our programme and the results from previous surveys, please see the links in the further information section.

This report contains the benchmarked results for this and 92 other trusts for the antenatal care section of the questionnaire. When answering questions in the survey about labour and birth, we can be confident that in all cases women were referring to the acute trust from which they were sampled from. Hence it is possible to compare the results for labour and birth across all 137 NHS trusts that took part in the survey. The survey also asked women about their experiences of antenatal and postnatal care, to cover the entire pregnancy and birth for completeness. However, some women who gave birth at an acute trust may not have received their antenatal and postnatal care from that same trust. This could be due to one of several reasons, such as: having moved home, having to travel for more specialist care, or due to variation in the provision of services across the country.

For this survey, we asked trusts to complete an additional piece of work to identify which of the

[1]Some trusts with a small number of women delivering in February would have also included women who gave birth in January 2013, one NHS trust included women who gave birth in March.For further details on women excluded from the survey, please see the survey guidance manual at: http://www.nhssurveys.org/survey/1250

women in their sample were likely to have also received their antenatal care from the same trust at which they gave birth, and 93 trusts that took part in the survey were able to do this. The aim was to help trusts to gain the insight to improve services, by improving the accuracy when attributing survey responses to the care provider.

The trusts that completed the exercise used location information of respondents to identify which women were resident within their boundaries, and responses from those women were used to calculate scores for the antenatal and postnatal survey data for each trust. The scores for antenatal care relating to the 93 trusts have been provided in this report and in a separate postnatal care report report (86 trusts were able to provide information for postnatal care). The data cannot be considered as statistically robust as the data for labour and birth, for several reasons:

1. Although the value of the data is improved when looking at individual trust performance, due to the more accurate attribution of responses to provider, the lack of complete coverage across all trusts means that we cannot fairly say that one trust is 'better' or 'worse' than all others. Hence trusts are only identified as being 'better' or 'worse' within the subset of trusts that completed the attribution exercise. We cannot say that the subset of trusts is representative of all trusts, and so it is not a true benchmark for performance across England.
2. The attribution was based on the location of respondents. There was no means available to identify women who had received care from a different provider for other reasons, such as due to requiring specialist care, or having moved house during pregnancy. So although the attribution exercise improved the data to a considerable degree, it may remain that some respondents are included in the data despite having received care from another trust.
3. The NHS trusts completed the attribution themselves, and due to the limitations of the process the co-ordination centre were unable to verify the accuracy of the exercise. This means we cannot be certain about the reliability of the attribution of the data.

The antenatal and postnatal survey data from the trusts that completed the attribution exercise will be shared with those trusts. The data will be considered by the Care Quality Commission (CQC) to inform its Intelligent Monitoring and will be shared with CQC inspectors. The reports will be published on the NHS Surveys website, but should be viewed with caution for the reasons described above.

Interpreting the report

This report shows how a trust scored for each question in the antenatal care section of the survey, compared with the range of results from 92 other trusts. It is designed to help understand the performance of individual trusts and to identify areas for improvement.

A 'section' score is also provided, labelled S1 and S2 in the 'section scores' on page 5. The scores for each question are grouped according to the relevant sections of the questionnaire, which are 'The start of care in pregnancy' and 'Antenatal check-ups'.

Standardisation

Trusts have differing profiles of maternity service users; for example, one trust may have more 'first time' mothers than another. This is significant because whether a woman has given birth previously (parity) could influence their experiences and could potentially lead to a trust's results appearing better or worse than if they had a slightly different profile of maternity service users. To account for this, we 'standardise' the data. Results have been standardised by parity and age of respondent, to ensure that no trust will appear better or worse than another because of its respondent profile. This helps to ensure that each trusts age-parity profile reflects the national age-parity distribution (based on all of the respondents to the survey). It therefore enables a more fair comparison of results from trusts with different profiles of maternity service users.

Scoring

For each question in the survey, the individual responses were converted into scores on a scale of 0 to 10. A score of 10 represents the best possible response. Therefore, the higher the score for each question, the better the trust is performing.

It is not appropriate to score all questions within the questionnaire; this is because not all of the questions assess the trusts in any way.

Graphs

The graphs in this report display the range of scores achieved by the subset of trusts that completed the attribution exercise, from the lowest score achieved (left hand side) to the highest score achieved (right hand side).

The black diamond shows the score for your trust. The black diamond (score) is not shown for questions answered by fewer than 30 people because the uncertainty around the result would be too great. The trust will also not have a section score for the corresponding section; this is because the section data is not comparable with other trusts, as it is made up of fewer questions.

The graph is divided into three sections:

- If your trust score lies in the orange section of the graph, your trust result is 'about the same' as most other trusts in the survey.
- If your trust score lies in the red section of the graph, your trust result is 'worse' compared with most other trusts in the survey.
- If your trust score lies in the green section of the graph, your trust result is 'better' compared with most other trusts in the survey.

The text to the right of the graph clearly states whether the score for your trust is 'better' or 'worse' compared with most other trusts included in this analysis. If there is no text here then your trust is 'about the same'.

You may find that there is no red area, and/or no green area in the charts shown for some questions. This can occur in the analysis of the data and is an acceptable consequence of the statistical technique that is used. The size of the orange area is constructed by considering how different all trust scores are across the range, as well as the confidence we can have in that particular trust's score (by looking at the number of respondents to that question). In some cases, this will lead to such a wide margin of error that the 'expected range' (the orange section) will be very wide, and therefore will also cover the highest or lowest scoring trusts for that question.

Methodology

The categories described above are based on a statistic called the 'expected range' which is uniquely calculated for each trust for each question. This is the range within which we would expect a particular trust to score if it performed 'about the same' as most other trusts in the survey. The range takes into account the number of respondents from each trust as well as the scores for all other trusts. This means that where a trust is performing 'better' or 'worse' than the majority of other trusts, this is likely to be a true reflection of all service users that have visited the trust, rather than being unique to those who responded to the survey.

A technical document providing more detail about the methodology and the scoring applied to each question is available on our website (see further information section below).

Tables

At the end of the report you will find tables containing the data used to create the graphs.

Please note that comparative data is not shown because it is not possible to tell from the 2010 survey data which women received their antenatal care from the same trust at which they gave birth.

Further information

The full national results for the 2013 survey are on the CQC website, including the reports for all NHS trusts for the 'labour and birth' section of the questionnaire, and the technical document outlining the methodology and the scoring applied to each question:
www.cqc.org.uk/PatientSurveyMaternity2013

This report and the equivalent reports for postnatal care are available on the NHS surveys website, along with more detail on the attribution exercise:
www.nhssurveys.org

The results for the 2007 and 2010 surveys can be found on the NHS surveys website at:
www.nhssurveys.org/surveys/299

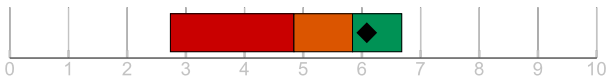
Full details of the methodology for the survey can be found at:
www.nhssurveys.org/survey/1250

More information on the programme of NHS patient surveys is available at:
www.cqc.org.uk/public/reports-surveys-and-reviews/surveys

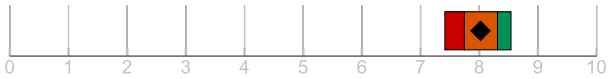
Survey of women's experiences of maternity services 2013
University Hospitals Bristol NHS Foundation Trust

Section scores

S1. The start of your care in pregnancy (Antenatal Care)



S2. Antenatal check-ups



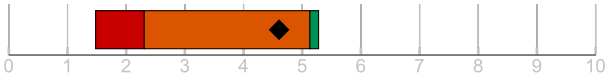
Better

Best performing trusts	'Better/Worse'	Only displayed when this trust is better/worse than most other trusts
About the same	◆	This trust's score (NB: Not shown where there are fewer than 30 respondents)
Worst performing trusts		

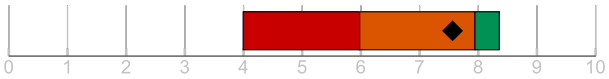
Survey of women's experiences of maternity services 2013
University Hospitals Bristol NHS Foundation Trust

The start of your care in pregnancy (Antenatal Care)

B4. Were you offered any of the following choices about where to have your baby?

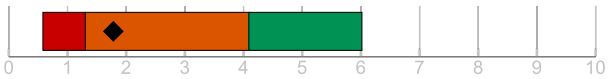


B6. Did you get enough information from either a midwife or doctor to help you decide where to have your baby?

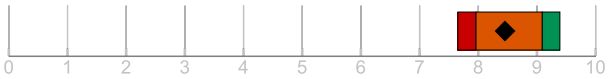


Antenatal check-ups

B7. During your pregnancy were you given a choice about where your antenatal check-ups would take place?

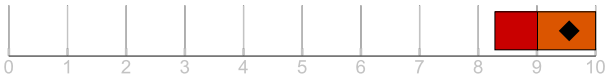


B10. During your antenatal check-ups, were you given enough time to ask questions or discuss your pregnancy?



B11. During your antenatal check-ups, did the midwives listen to you?

B12. During your pregnancy, did you have a telephone number for a midwife or midwifery team that you could contact?



B13. If you contacted a midwife, were you given the help you needed?

B14. Thinking about your antenatal care, were you spoken to in a way you could understand?

Better

B15. Thinking about your antenatal care, were you involved enough in decisions about your care?

Better

Best performing trusts	'Better/Worse'	Only displayed when this trust is better/worse than most other trusts
About the same	◆	This trust's score (NB: Not shown where there are fewer than 30 respondents)
Worst performing trusts		

Survey of women's experiences of maternity services 2013
University Hospitals Bristol NHS Foundation Trust

		Scores for this NHS trust	Lowest trust score achieved	Highest trust score achieved	Number of respondents (this trust)
The start of your care in pregnancy (Antenatal Care)					
S1	Section score	6.1	2.7	6.7	
B4	Were you offered any of the following choices about where to have your baby?	4.6	1.5	5.3	91
B6	Did you get enough information from either a midwife or doctor to help you decide where to have your baby?	7.6	4.0	8.4	78
Antenatal check-ups					
S2	Section score	8.0	7.4	8.5	
B7	During your pregnancy were you given a choice about where your antenatal check-ups would take place?	1.8	0.6	6.0	93
B10	During your antenatal check-ups, were you given enough time to ask questions or discuss your pregnancy?	8.5	7.7	9.4	96
B11	During your antenatal check-ups, did the midwives listen to you?	8.6	8.2	9.5	97
B12	During your pregnancy, did you have a telephone number for a midwife or midwifery team that you could contact?	9.5	8.3	10.0	97
B13	If you contacted a midwife, were you given the help you needed?	8.8	5.9	9.2	82
B14	Thinking about your antenatal care, were you spoken to in a way you could understand?	9.8	8.6	9.8	97
B15	Thinking about your antenatal care, were you involved enough in decisions about your care?	9.2	7.3	9.3	96

Patient survey report 2013

Survey of women's experiences of maternity services 2013

University Hospitals Bristol NHS Foundation Trust

The national survey of women's experiences of maternity services 2013 was designed, developed and co-ordinated by the Co-ordination Centre for the NHS Patient Survey Programme at Picker Institute Europe.

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Survey of women's experiences of maternity services 2013

CQC Maternity care pathway reports: labour and birth

The Care Quality Commission is the independent regulator of health and adult social care in England.

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Survey of women's experiences of maternity services 2013

To improve the quality of services that the NHS delivers, it is important to understand what service users think about their care and treatment. One way of doing this is by asking people who have recently used their local health services to tell us about their experiences.

Information drawn from the questions in the maternity survey will be considered by the Care Quality Commission (CQC) as part of its new Hospital Intelligent Monitoring. NHS England will use the results to check progress and improvement against the objectives set out in the NHS mandate, and the Department of Health will hold them to account for the outcomes they achieve. The Trust Development Authority will use the results to inform the quality and governance assessment as part of their Oversight Model for NHS Trusts.

The 2013 survey of women's experiences of maternity services involved 137 NHS acute trusts in England. We received responses from more than 23,000 service users, a response rate of 46%. Women were eligible for the survey if they had a live birth during February 2013[1], were aged 16 years or older, gave birth in a hospital, birth centre, maternity unit, or who had a home birth. NHS Trusts in England took part in the survey if they had a sufficient number of eligible women that give birth at their NHS trust during the sampling time frame.

Similar surveys of maternity services were carried out in 2010 and 2007. They are part of a wider programme of NHS patient surveys which covers a range of topics including acute inpatient, outpatient, and A&E services, ambulances, and community mental health services. To find out more about our programme and the results from previous surveys, please see the links in the further information section.

This report contains the benchmarked results for this trust for the labour and birth section of the questionnaire. When answering questions in the survey about labour and birth, we can be confident that in all cases women were referring to the acute trust from which they were sampled from. Hence it is possible to compare the results for labour and birth across all 137 NHS trusts that took part in the survey.

The survey also asked women about their experiences of antenatal and postnatal care, to cover the entire pregnancy and birth for completeness. However, some women who gave birth at an acute trust may not have received their antenatal and postnatal care from that same trust. This could be due to one of several reasons, such as: having moved home, having to travel for more specialist care, or due to variation in the provision of services across the country.

[1]Some trusts with a small number of women delivering in February would have also included women who gave birth in January 2013, one NHS trust included women who gave birth in March.For further details on women excluded from the survey, please see the survey guidance manual at: http://www.nhssurveys.org/survey/1250

For this survey, we asked trusts to complete an additional piece of work to identify which of the women in their sample were likely to have also received their antenatal and postnatal care from the same trust at which they gave birth, and 93 trusts that took part in the survey were able to do this for antenatal care and 86 trusts for postnatal care. The aim was to assist trusts to gain the insight to improve services, by improving the accuracy when attributing survey responses to the care provider.

The antenatal and postnatal survey reports will be published on the NHS Surveys website, but should be viewed with caution for the reasons contained within those documents.

Interpreting the report

This report shows how a trust scored for each question in the labour and birth section of the survey, compared with the range of results from all other trusts that took part. It is designed to help understand the performance of individual trusts and to identify areas for improvement.

A 'section' score is also provided, labelled S3-S5 in the 'section scores' on page 5. The scores for each question are grouped according to the relevant sections of the questionnaire, which are 'labour and birth', 'staff' and 'care in hospital after the birth'.

This report shows the same data as published on the CQC website: (http://www.cqc.org.uk/public/reports-surveys-and-reviews/surveys). The CQC website displays the data in a more simplified way, identifying whether a trust performed 'better,' 'worse' or 'about the same' as the majority of other trusts for each question and section.

Standardisation

Trusts have differing profiles of maternity service users; for example, one trust may have more 'first time' mothers than another. This is significant because whether a woman has given birth previously (parity) could influence their experiences and could potentially lead to a trust's results appearing better or worse than if they had a slightly different profile of maternity service users. To account for this, we 'standardise' the data. Results have been standardised by parity and age of respondent, to ensure that no trust will appear better or worse than another because of its respondent profile. This helps to ensure that each trust's age-parity profile reflects the national age-parity distribution (based on all of the respondents to the survey). It therefore enables a more fair comparison of results from trusts with different profiles of maternity service users.

Scoring

For each question in the survey, the individual responses were converted into scores on a scale of 0 to 10. A score of 10 represents the best possible response. Therefore, the higher the score for each question, the better the trust is performing.

It is not appropriate to score all questions within the questionnaire; this is because not all of the questions assess the trusts in any way, or they may be 'filter questions' designed to filter out respondents to whom following questions do not apply. An example of a filter question would be C4: 'Did the pain relief you used change from what you had originally planned?'

Graphs

The graphs in this report display the range of scores achieved by all trusts taking part in the survey, from the lowest score achieved (left hand side) to the highest score achieved (right hand side).

The black diamond shows the score for your trust. The black diamond (score) is not shown for questions answered by fewer than 30 people because the uncertainty around the result would be too great. The trust will also not have a section score for the corresponding section; this is because the section data is not comparable with other trusts, as it is made up of fewer questions.

The graph is divided into three sections:

- If your trust score lies in the orange section of the graph, your trust result is 'about the same' as most other trusts in the survey.
- If your trust score lies in the red section of the graph, your trust result is 'worse' compared with most other trusts in the survey.

- If your trust score lies in the green section of the graph, your trust result is 'better' compared with most other trusts in the survey.

The text to the right of the graph clearly states whether the score for your trust is 'better' or 'worse' compared with most other trusts in the survey. If there is no text here then your trust is 'about the same'.

You may find that there is no red area, and/or no green area in the charts shown for some questions. This can occur in the analysis of the data and is an acceptable consequence of the statistical technique that is used. The size of the orange area is constructed by considering how different all trust scores are across the range, as well as the confidence we can have in that particular trust's score (by looking at the number of respondents to that question). In some cases, this will lead to such a wide margin of error that the 'expected range' (the orange section) will be very wide, and therefore will also cover the highest or lowest scoring trusts for that question.

Methodology

The categories described above are based on a statistic called the 'expected range' which is uniquely calculated for each trust for each question. This is the range within which we would expect a particular trust to score if it performed 'about the same' as most other trusts in the survey. The range takes into account the number of respondents from each trust as well as the scores for all other trusts. This means that where a trust is performing 'better' or 'worse' than the majority of other trusts, this is likely to be a true reflection of all service users that have visited the trust, rather than being unique to those who responded to the survey.

A technical document providing more detail about the methodology and the scoring applied to each question is available on our website (see further information section below).

Tables

At the end of the report you will find tables containing the data used to create the graphs and background information about the service users that responded.

Scores from the 2010 survey where comparable are also displayed. A statistically significant difference means that the change in the results is very unlikely to have occurred by chance. The column called 'change from 2010' uses arrows to indicate whether the score for this year shows a statistically significant increase (up arrow), a statistically significant decrease (down arrow) or has shown no statistically significant change (no arrow) compared with 2010. Significance is tested using a two-sample t-test.

Where a result for 2010 is not shown, this is because the question was either new this year, or the question wording and/or the response categories have been changed. It is therefore not possible to compare the results as we do not know if any change is caused by alterations in the survey instrument, or variation in a trust's performance.

Comparisons are not shown if your trust has merged with other trusts since the 2010 survey. Please note that comparative data is not shown for the sections as the questions contained in each section can change year on year.

Notes on specific questions

The following questions were not answered by women who had a planned caesarean: **C1, C2, C3, C4** and **C5**.

Question C8 and C9 were not answered by women who had a planned or emergency caesarean.

Question C13: The question is compared with 2010 based only on the 'not at all' response, as the other response options were altered during the survey development.

The following questions were not answered by women who had a home birth and did not go to hospital: **D1, D2, D3, D4, D5** and **D6**.

Further information

The full national results for the 2013 survey are on the CQC website, together with an A to Z list to view the results for each trusts labour and birth questions, and the technical document outlining the methodology and the scoring applied to each question:
www.cqc.org.uk/PatientSurveyMaternity2013

For the trusts that were able to carry out the attribution exercise, the reports for antenatal and postnatal care are available on the NHS surveys website, along with more detail on the attribution:
www.nhssurveys.org

The results for the 2007 and 2010 surveys can be found on the NHS surveys website at:
www.nhssurveys.org/surveys/299

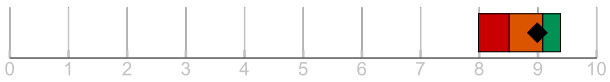
Full details of the methodology for the survey can be found at:
www.nhssurveys.org/survey/1250

More information on the programme of NHS patient surveys is available at:
www.cqc.org.uk/public/reports-surveys-and-reviews/surveys

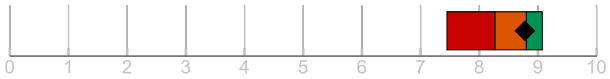
Survey of women's experiences of maternity services 2013
University Hospitals Bristol NHS Foundation Trust

Section scores

S3. Labour and birth



S4. Staff



S5. Care in hospital after the birth

Best performing trusts	'Better/Worse'	Only displayed when this trust is better/worse than most other trusts
About the same	◆	This trust's score (NB: Not shown where there are fewer than 30 respondents)
Worst performing trusts		

Survey of women's experiences of maternity services 2013
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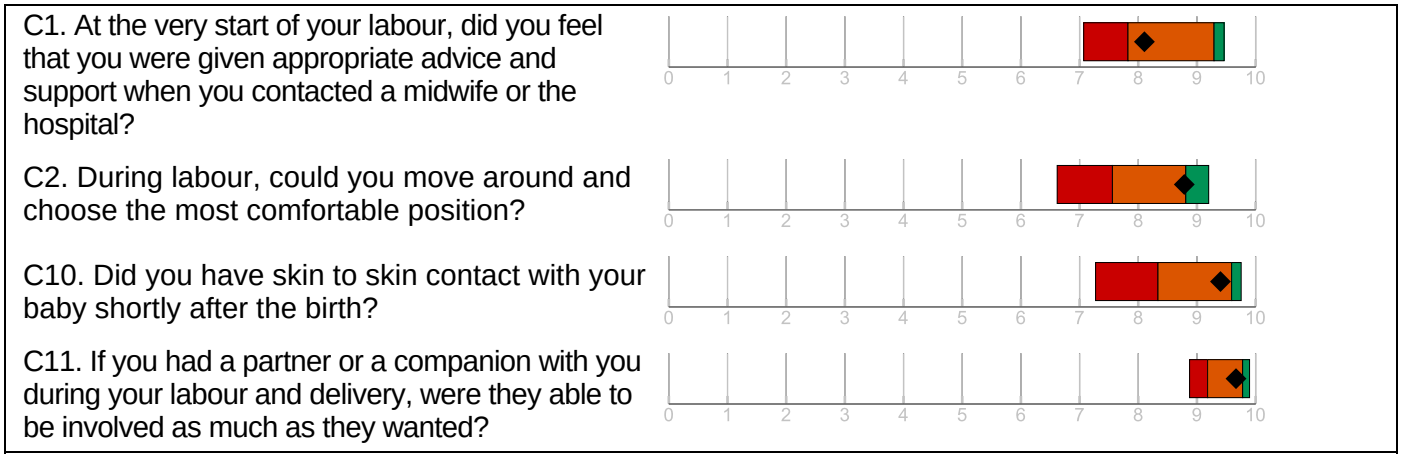
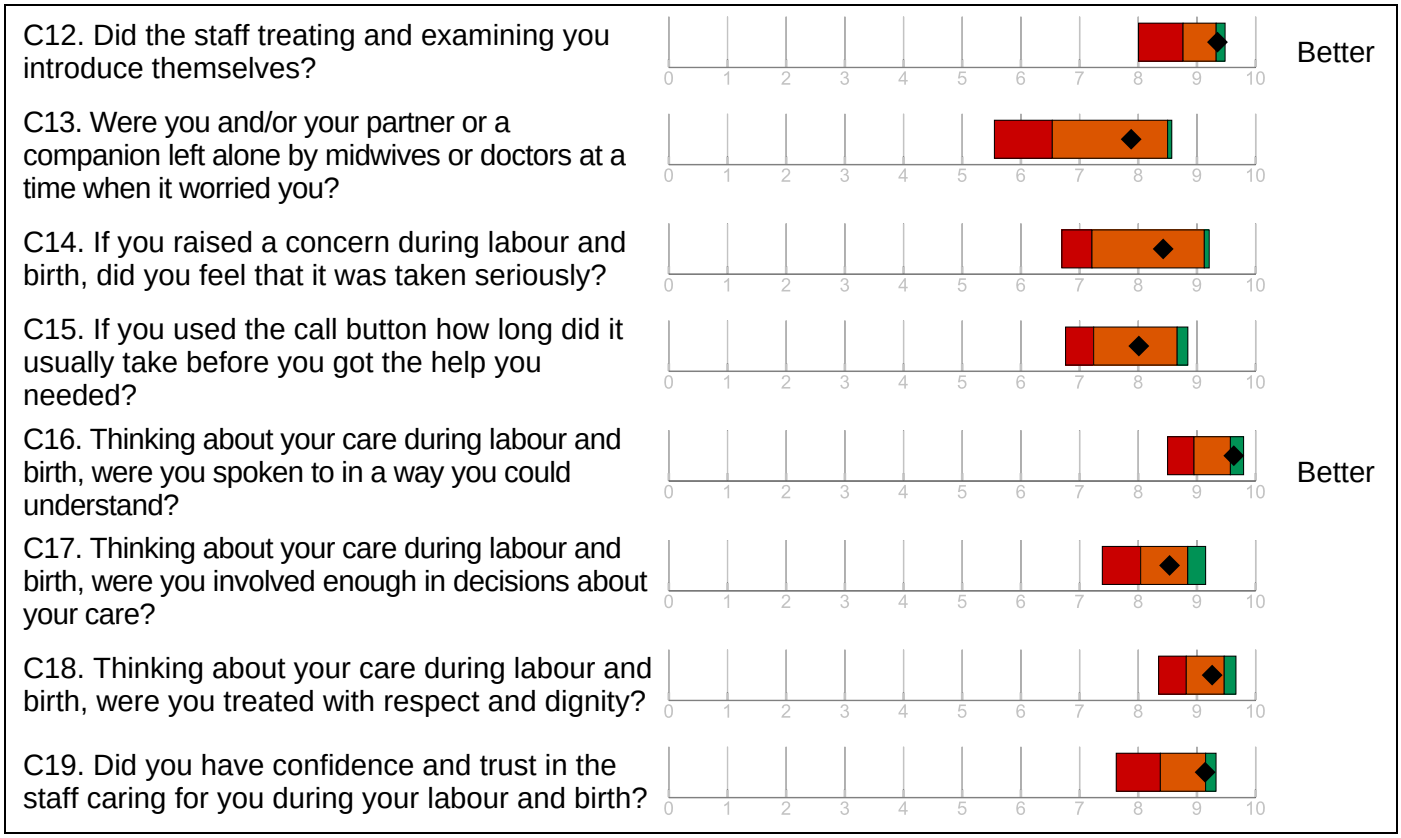
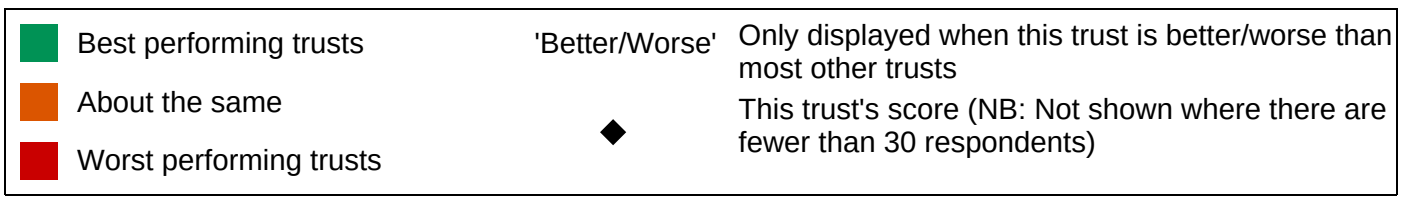
Labour and birth



Staff





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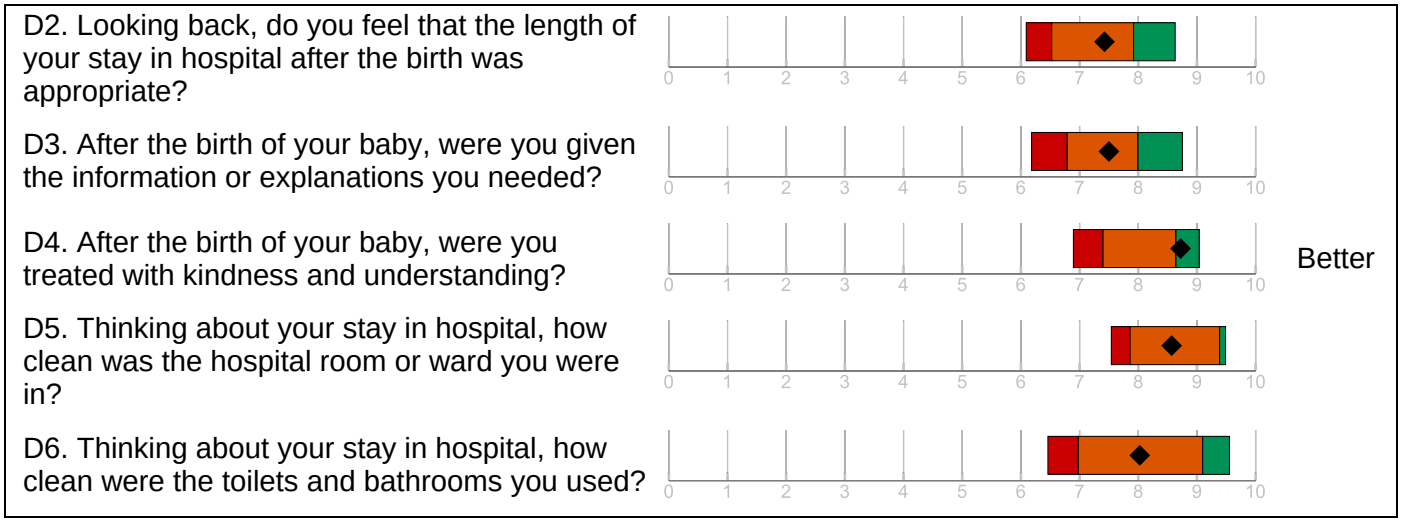
Care in hospital after the birth



Best performing trusts	'Better/Worse'	Only displayed when this trust is better/worse than most other trusts
About the same	◆	This trust's score (NB: Not shown where there are fewer than 30 respondents)
Worst performing trusts		

Survey of women's experiences of maternity services 2013

University Hospitals Bristol NHS Foundation Trust

		Scores for this NHS trust	Lowest trust score achieved	Highest trust score achieved	Number of respondents (this trust)	2010 scores for this NHS trust	Change from 2010
Labour and birth							
S3	Section score	9.0	8.0	9.4			
C1	At the very start of your labour, did you feel that you were given appropriate advice and support when you contacted a midwife or the hospital?	8.1	7.1	9.5	126		
C2	During labour, could you move around and choose the most comfortable position?	8.8	6.6	9.2	131	8.0	↑
C10	Did you have skin to skin contact with your baby shortly after the birth?	9.4	7.3	9.8	159		
C11	If you had a partner or a companion with you during your labour and delivery, were they able to be involved as much as they wanted?	9.7	8.9	9.9	172		
Staff							
S4	Section score	8.8	7.4	9.1			
C12	Did the staff treating and examining you introduce themselves?	9.3	8.0	9.5	171		
C13	Were you and/or your partner or a companion left alone by midwives or doctors at a time when it worried you?	7.9	5.5	8.6	171	8.2	
C14	If you raised a concern during labour and birth, did you feel that it was taken seriously?	8.4	6.7	9.2	101		
C15	If you used the call button how long did it usually take before you got the help you needed?	8.0	6.8	8.8	86		
C16	Thinking about your care during labour and birth, were you spoken to in a way you could understand?	9.6	8.5	9.8	171	9.2	↑
C17	Thinking about your care during labour and birth, were you involved enough in decisions about your care?	8.5	7.4	9.1	169	8.7	
C18	Thinking about your care during labour and birth, were you treated with respect and dignity?	9.3	8.3	9.7	170		
C19	Did you have confidence and trust in the staff caring for you during your labour and birth?	9.1	7.6	9.3	171	9.1	

↑ or ↓	Indicates where 2013 score is significantly higher or lower than 2010 score (NB: No arrow reflects no statistically significant change) Where no score is displayed, no 2010 data is available.

Survey of women's experiences of maternity services 2013

University Hospitals Bristol NHS Foundation Trust

		Scores for this NHS trust	Lowest trust score achieved	Highest trust score achieved	Number of respondents (this trust)	2010 scores for this NHS trust	Change from 2010
Care in hospital after the birth							
S5	Section score	8.0	7.0	8.9			
D2	Looking back, do you feel that the length of your stay in hospital after the birth was appropriate?	7.4	6.1	8.6	162	7.5	
D3	After the birth of your baby, were you given the information or explanations you needed?	7.5	6.2	8.8	170	6.9	
D4	After the birth of your baby, were you treated with kindness and understanding?	8.7	6.9	9.0	171	7.4	↑
D5	Thinking about your stay in hospital, how clean was the hospital room or ward you were in?	8.6	7.5	9.5	170		
D6	Thinking about your stay in hospital, how clean were the toilets and bathrooms you used?	8.0	6.5	9.6	171		

↑ or ↓	Indicates where 2013 score is significantly higher or lower than 2010 score (NB: No arrow reflects no statistically significant change) Where no score is displayed, no 2010 data is available.

Survey of women's experiences of maternity services 2013
University Hospitals Bristol NHS Foundation Trust

Background information

The sample	This trust	All trusts
Number of respondents	177	23077
Response Rate (percentage)	50	46

Demographic characteristics	This trust	All trusts
Percentage of mothers	(%)	(%)
First-time	50	48
Who have previously given birth	50	52
Age group (percentage)	(%)	(%)
Aged 16-18	1	1
Aged 19-24	9	10
Aged 25-29	16	23
Aged 30-34	36	35
Aged 35 and over	39	31
Ethnic group (percentage)	(%)	(%)
White	84	83
Multiple ethnic group	2	2
Asian or Asian British	6	8
Black or Black British	6	4
Arab or other ethnic group	0	1
Not known	2	3
Religion (percentage)	(%)	(%)
No religion	42	33
Buddhist	1	1
Christian	48	55
Hindu	0	2
Jewish	0	1
Muslim	6	6
Sikh	0	1
Other religion	1	1
Prefer not to say	2	1
Sexual orientation (percentage)	(%)	(%)
Heterosexual/straight	96	96
Gay/lesbian	0	0
Bisexual	1	1
Other	1	0
Prefer not to say	3	3

University Hospitals Bristol NHS
NHS Foundation Trust

Cover Sheet for a Report for a Public Trust Board Meeting, to be held on 30 January 2014 at 10:30 in the Conference Room, Trust Headquarters, Marlborough Street, Bristol, BS1 3NU

11. Report on actions arising from Care Quality Commission inspection of Theatres at Bristol Royal Hospital for Children

Purpose

To enable the Board to receive the action plan submitted by the Trust to the Care Quality Commission in response to concerns identified during a responsive review in November 2013.

Abstract

The Care Quality Commission undertook a response review (inspection) of Theatres at Bristol Royal Hospital for Children on 19 November 2013. The Bristol Royal Hospital for Children forms part of the Trust's 'Main Site' registration with the CQC. The CQC found the Trust to be non-compliant with Outcome 8 (cleanliness and infection control) and Outcome 16 (assessing and monitoring quality of service provision). The CQC's concerns related primarily to issues regarding cleanliness and clutter in corridor areas adjacent to theatres, during a time when building works were taking place. The attached action plan was submitted to the CQC on 30 December 2013.

Recommendations

The Trust Board is recommended to receive this report by the Chief Executive to note.

Report Sponsor

Chief Executive

Appendices

Report on actions

Report on actions you plan to take to meet CQC essential standards

Please see the covering letter for the date by which you must send your report to us and where to send it. **Failure to send a report may lead to enforcement action.**

Account number	RA7
Our reference	INS1-1061272669
Location name	University Hospitals Bristol Main Site
Provider name	University Hospitals Bristol NHS Foundation Trust

Regulated activities	**Regulation**
Surgical procedures Treatment of disease, disorder or injury	Regulation 12 HSCA 2008 (Regulated Activities) Regulations 2010 Cleanliness and infection control
	How the regulation was not being met:
	Suitable standards in relation to cleanliness and infection control were not being consistently maintained. Regulation 12.

Please describe clearly the action you are going to take to meet the regulation and what you intend to achieve

We will ensure that the outer theatre department areas meet all environmental cleanliness and hygiene standards. We will also ensure effective monitoring of cleanliness audit outcomes and take action if required to ensure that the highest standards are maintained.

- We will move existing storage areas (bay in theatre corridor, two bays in recovery) to the temporary storage area in the new build; we will undertake a risk assessment of this change for patients and staff.
- We will ensure that all nursing staff participate in the infection control micro teaching programme.
- Jo Davies (JD), the Trust's Deputy Director of Infection Prevention and Control, met with the Theatre Matron and Hotel Services Manager on 18th December 2013 to review outer theatre area cleanliness audit results and standards. Existing facilities and infection control audits will be combined into a single audit and will be carried out on a weekly basis. The weekly audit will include all of the agreed areas consolidated to one list.
- We will replace any damaged equipment e.g. operating table attachments, tourniquets, operating table mattresses, trolley mattresses and trolley cot sides.
- We will ensure that all equipment areas can be easily accessed for cleaning.

- Clean linen will be stored in a covered container/cupboard to ensure it is kept in a hygienic condition for use with patients. We will ensure clear separation between clean and dirty laundry.

- We will ensure that used intravenous drip bags are disposed of in a timely and appropriate manner in a covered sharps container kept in the sluice areas, as per Trust policy.

- We will ensure that there is a robust and effective tracking system for all equipment that demonstrates it has been cleaned, e.g. a coloured tape indicator system when equipment is clean and ready for use.

- We will ensure that any notices displayed either on equipment, notice boards or walls are laminated and are attached correctly so they can be cleaned effectively.

- No hot drinks are to be permitted in the anaesthetic room.

Who is responsible for the action?	Charlotte Jones, Matron

How are you going to ensure that improvements have been made and are sustainable? What measures are you going to put in place to check this?

- Existing facilities and infection control audits will be combined into a single audit and will be carried out on a weekly basis. Prompt action will be taken in response to audit results where this is indicated.

- We will ensure that all risk assessments are up-to-date.

- Staff training records will provide documentary evidence that staff have participated in infection control micro-teaching.

Who is responsible?	Charlotte Jones, Matron

What resources (if any) are needed to implement the change(s) and are these resources available?

- Trust-wide Infection Control Team and Facilities weekly input to carry out the audit – resources have been identified and agreed.

Date actions will be completed:	31st January 2014

How will people who use the service(s) be affected by you not meeting this regulation until this date?

We have already begun to implement all of the actions detailed above and these requirements have been clearly communicated to staff. The actions will be completed by 31st January 2014 at the latest. We do not anticipate any detrimental effect upon people who use our services whilst these actions are being implemented.

Completed by: (please print name(s) in full)	Charlotte Jones
Position(s):	Matron

Date:	20th December 2013

Regulated activities	Regulation
Surgical procedures Treatment of disease, disorder or injury	Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010 Assessing and monitoring the quality of service provision
	How the regulation was not being met:
	Risks to the safety of patients and staff within the operating department were not being effectively identified and managed in all areas. Regulation 10 (1).

Please describe clearly the action you are going to take to meet the regulation and what you intend to achieve

We will ensure that risks relating to the health, welfare and safety of patients and staff in theatres are effectively identified, assessed and managed.

- Specialists will be engaged to review our storage systems with a view to developing bespoke solutions to maximise available storage in the outer storage areas.
- We will ensure the corridor between the Paediatric Intensive Care Unit and Theatres is kept clear at all times. Following a risk assessment undertaken, it has been agreed that the best option in achieving this is to decant stores from delivery cages to smaller trollies on level 3 prior to making smaller deliveries to the level 4 Theatre suite (this arrangement will need to be in place until April 2014 when the current storage area can be moved to the new storage area which is currently being built).
- We will ensure that the corridor between PICU and Theatres is kept clear at all times by decanting supplies delivered in larger crates that could obstruct the corridor, to smaller trollies on level 3.
- A daily review of this corridor area will be undertaken by the Theatre Coordinator.
- A reminder will be issued to staff that all fire doors, including those to the utility rooms, must not be restricted and need to be kept shut at all times. Laminated notices will be attached to the utility room doors: ‘Fire Door – do not obstruct the door and keep shut at all times’.
- The content of the corridor utility rooms will be reviewed and re-organised appropriately to allow immediate accessibility.
- The department’s operating registers will be moved to a more secure office area within the department.
- We will undertake a review of all outstanding estates repairs, produce a ‘snag list’ and ensure that these works are carried out with immediate effect, e.g. damaged fire door.
- On an ongoing basis, any estates works which are required will be reported on the ‘Agility’ system. This will provide a weekly estates maintenance plan and a robust reporting mechanism to demonstrate compliance that works reported are completed.
- We will ensure that appropriate action is being taken to reduce risks associated with the

environment including any building works and changes to the environment. All current risk assessments relating to the current capital build programme will be reviewed with immediate effect.

- Where a risk assessment highlights risks that cannot be resolved locally, these will be escalated to the General Manager.

Who is responsible for the action?	Charlotte Jones, Matron

How are you going to ensure that improvements have been made and are sustainable? What measures are you going to put in place to check this?

- We will introduce a checklist of Health and Safety compliance which will be completed monthly with the Division's Health and Safety Lead.
- Risk Assessments held locally will be confirmed as current and reviewed as part of the above mentioned checklist.
- Outstanding estates works recorded on the Agility system will be monitored by the Theatre Matron and any concerns will be escalated to the General Manager.

Who is responsible?	Julie Vass, General Manager

What resources (if any) are needed to implement the change(s) and are these resources available?

- Funding for storage solutions will be identified if required following the review by storage specialists.
- All senior theatre staff (Band 6 and above) will have received training in the Safeguard Risk Web system for reporting and reviewing web-based risk assessments – no additional resource is required as training is being implemented Trust-wide.

Date actions will be completed:	31st January 2014

How will people who use the service(s) be affected by you not meeting this regulation until this date?

- Many of the actions have already commenced.
- The Theatre Co-ordinator is undertaking a daily 'walk-through' of theatres in order to identify and resolve as much as possible, any risks during the action plan period.
- All identified risks will continue to be captured on a paper based system while staff training on the web based system is completed. Thereafter all assessments will be web based in their recording and management.

Completed by: (please print name(s) in full)	Julie Vass
Position(s):	General Manager
Date:	23rd December 2013

University Hospitals Bristol NHS
NHS Foundation Trust

Cover Sheet for a Report for a Public Trust Board Meeting, to be held on 30 January 2014 at 10:30am in the Conference Room, Trust Headquarters, Marlborough Street, Bristol, BS1 3NU

12. Finance Report

Purpose

To report to the Board on the Trust's financial position and related financial matters which require the Board's **review.**

Abstract

The summary income and expenditure statement shows a surplus of £3.749m (before technical items) for the nine months ending 31st December 2013. The cumulative position represents a favourable variance of £0.117m against the planned surplus for the period of £3.632m.

Service Level Agreement income over-performance continues to grow with a further £2m increase in December. The concern is that despite this the net Divisional position is still deteriorating and commissioners are now raising real formal issues arising from the implications of this over-performance.

The results to 31st December are reflected in the Trust's Risk Assessment Framework - Continuity of Services Risk Rating of 4 (actual 3.5).

Recommendations

The Trust Board is recommended to receive this report by the Director of Finance and Information for review.

Executive Report Sponsor or Other Author

- Sponsor – Director of Finance and Information
- Other Author – Head of Finance

Appendices

- Appendix 1 – Summary Income and Expenditure Statement
- Appendix 2 – Divisional Income and Expenditure Statement
- Appendix 3 – Monthly Analysis of Pay Expenditure
- Appendix 4 – Executive Summary
- Appendix 5 – Financial Risk Matrix
- Appendix 6 – Financial Risk Ratings

Previous Meetings

Executive Team	Trust Management Executive	Quality and Outcomes Committee	Finance Committee	Audit Committee	Other
			24 January 2014		

REPORT OF THE FINANCE DIRECTOR

1. Overview

The summary income and expenditure statement shows a surplus of £3.749m (before technical items) for the nine months ending 31 December 2013. The cumulative position represents a favourable variance of £0.117m against the planned surplus to date of £3.632m.

The favourable movement in the month has been achieved by the continuing use of Trust Reserves (including the balance of Incremental Draft moneys) to cover the net overspend in the month on Divisional Services. The position is summarised in the table below.

	£'000	£'000
Income and Expenditure Surplus to 30th November (before Technical Items)		**3,217**
Annual Plan Surplus £5.922m x 1/12th		494
Overspending in December by Divisions	(668)	
Incremental Drift Reserve – (£0.873m x 1/12th)	73	
Trust Reserves (£7m x 1/12th)	583	
Financing changes and other minor	50	38
Income and Expenditure Surplus to 31st December – before Technical Items		**3,749**
Technical Items		
- Asset Impairment		(412)
- Depreciation on Donated Assets		(637)
Income and Expenditure Surplus to 31st December – after Technical Items		**2,700**

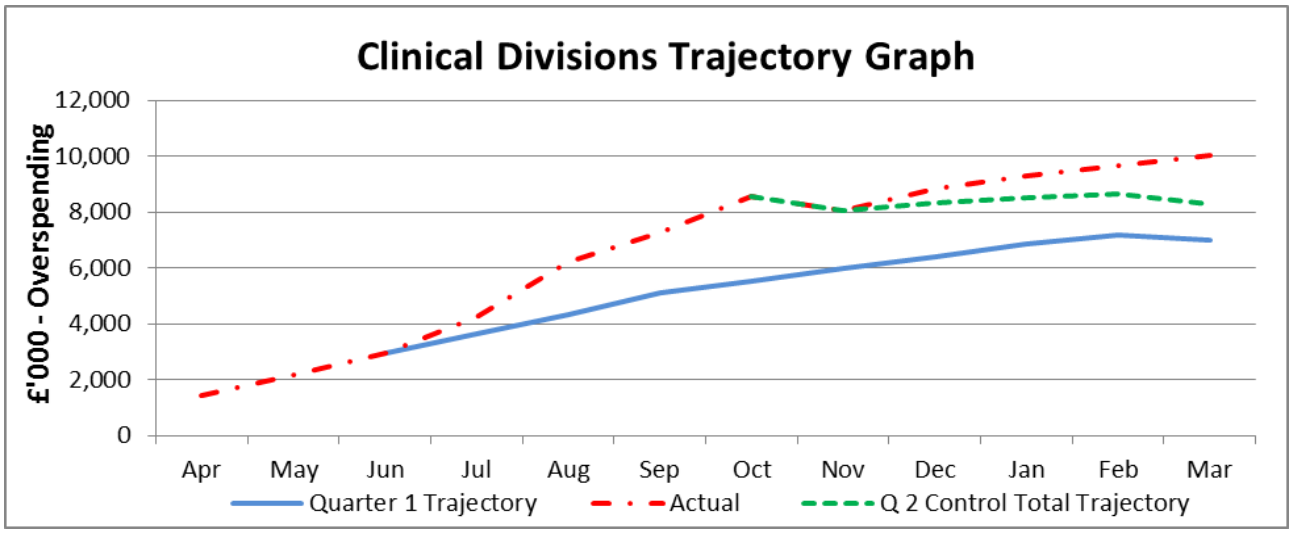
Service Level Agreement income over-performance continues to grow with a further £2m increase in December. The concern is that despite this the net Divisional position is still deteriorating and commissioners are now raising real formal issues arising from the implications of this over-performance.

The results to 31st December are reflected in the Trust's Risk Assessment Framework - Continuity of Services Risk Rating of 4 (actual 3.5). Further information on the financial risk rating is given in section 7 below and appendix 6.

The table below shows the Trust's income and expenditure position setting out the variances on the four main income and expenditure headings. This generates an overspending against divisional budgets of £8.541m. Detailed information and commentary for each Division is to be considered by the Finance Committee (agenda item 5.3 refers).

Divisional Variances	Variance to 30th November	December Variances	Variance to 31st December
	Fav/(Adv) £'000	Fav/(Adv) £'000	Fav/(Adv) £'000
Pay	(3,208)	(56)	(3,264)
Non Pay	(4,730)	(476)	(5,206)
Operating Income	615	(129)	486
Income from Activities	2,326	498	2,824
Sub Totals	(4,997)	(163)	(5,160)
Savings Programme	(2,876)	(505)	(3,381)
Totals	**(7,873)**	**(668)**	**(8,541)**

The trajectories from Clinical Divisions for delivery of the out-turn within the control total of £8.16m is shown below.



Pay budgets have a cumulative overspending of £3.264m – an overspending of £56k in the month. The principal area of concern is the overspending of £0.150m in December for the Surgery, Head and Neck Division (overspending to date of £1.544m). For the Trust as a whole bank, agency, overtime and waiting list initiative and other payments totalled £1.56m in December and £17.0m to date.

Non-pay budgets show an adverse variance of £5.206m to December, an overspending of £0.476m in the month. There were significant overspendings recorded in a number of Divisions. The overspending for Diagnostic and Therapies of £0.154m includes additional costs associated with higher activity levels particularly for laboratory medicine and radiology. For the Medicine Division the overspending of £0.193m is in respect of costs incurred to support unfunded capacity for example, hotel services and drugs. For Surgery, Head and Neck the overspending of £103k in the month relates mainly to activity related clinical and other supplies expenditure. The overspending recorded against Facilities and Estates (£81k) includes higher than planned expenditure on cleaning materials, disposable linen, security and car parking.

Operating Income budgets show an adverse variance of £0.129m for the month with a cumulative favourable position of £0.486m. The overspending in December for the Specialised Services Division relates to a review of savings achieved and a reduction in research income.

Income from Activities shows an over-performance of £2.824m to date, an improvement of £0.498m in the month. Clinical activity performance (which includes an element of 'pass through' payments) has been strong with higher than planned income in Diagnostic and Therapies (£85k), Medicine (£0.125m), Specialised Services (£0.318m) and Surgery, Head and Neck (£0.125m).

The table below summarises the changes in financial performance in December for each of the Trust's management divisions.

	Cumulative Variance to 30th November Fav / (Adv)	Variance for December Fav / (Adv)	Cumulative Variance to 31st December Fav / (Adv)	Quarter 2 Control Totals Fav / (Adv)
	£'000	£'000	£'000	£'000
Diagnostic and Therapies	257	2	259	150
Medicine	(1,845)	(231)	(2,076)	(1,750)
Specialised Services	(850)	146	(704)	(1,000)
Surgery, Head and Neck	(4,256)	(564)	(4,820)	(4,750)
Women's and Children's	(1,378)	(113)	(1,491)	(1,000)
Estates and Facilities	117	9	126	150
Trust HQ	179	30	209	260
Trust Services	(97)	52	(44)	(220)
Totals	**(7,873)**	**(668)**	**(8,541)**	**(8,160)**

2. Forecast Outturn

The financial plan for the year is an income and expenditure surplus of £6.168m. The forecast has been generated using divisional assessments at Month 9 (Quarter 3) as follows:

	Quarter 2 Forecast Variance from Plan	Quarter 3 Projected Variance from Plan
	£'000	£'000
Clinical Divisions		
– Diagnostics & Therapies	-	150
– Medicine	(2,250)	(2,000)
– Specialised Services	(1,600)	(700)
– Surgery, Head & Neck	(5,750)	(5,500)
– Women's & Children's	(1,800)	(1,500)
Sub Total	**(11,400)**	**(9,550)**
Corporate Divisions		
– Facilities & Estates	50	150
– Miscellaneous Support Services	(370)	(300)
– Research & Innovation	100	100
– Other Corporate Divisions	120	350
– Corporate share of activity over performance	500	750
Sub Total	**400**	**1,050**

Reserves		
– Contingency	1,000	1,000
– Inflation Reserve	900	1,100
– Capital Charges Reserve	1,600	1,600
– Strategic Reserve	800	800
– Corporate Savings Programme	(800)	(800)
– Non-recurring reserves / provisions	2,000	1,600
– Loan interest reserve	900	900
– Transfers to Capital	600	500
Sub Total	**7,000**	**6,700**
Other		
– CQUINs	1,500	-
– Incremental Drift	1,500	800
Sub Total	**3,000**	**800**
Financing Items		
– Depreciation on Owned Assets	500	500
– Interest Payable	500	500
Sub Total	**1,000**	**1,000**
Planned Operating Surplus for the Year	**5,922**	**5,922**
Forecast Operating Surplus for the Year	**5,922**	**5,922**
Technical Items		
- Donations & Grants	-	-
- Reversal of Impairments	-	-
- Depreciation on Donated Assets	-	-
Sub Total	**-**	**-**
Planned Technical Items Surplus for the year	**246**	**246**
Forecast Technical Items Surplus for the Year	**246**	**246**
Total Forecast Surplus for the Year	**6,168**	**6,168**

It can be seen that the Trust is still forecasting to deliver its planned surplus of £5.9m in a manner broadly similar to the Quarter 2 forecast, albeit with funding for CQUINs and incremental drift now being allocated to Divisions.

What is however clear, is that the Divisional positions have not improved as hoped leaving the concern that the run rate going into 2014/15 will increase significantly the scale of challenge in what is already a very challenging year.

Each Division reports its delivery against its control total trajectory in the main body of the Finance report so the issues arising are described therein.

The preliminary report which provides the 5-yearly re-valuation of the Trust's land and buildings has recently been received from the District Valuer. This is under review and will shortly be discussed with the External Auditor. An update will be given in next month's report.

3. The main Divisional Budget changes in December include the following:-

	£'000
Mutually Agreed Resignation Schemes	292
Medical and Dental Education Levy	208
Energy inflation	116
European Working Time Directive	107
Legal Expenses	78

4. Savings Programme

The Trust's Savings Programme for 2013/14 is £20.989m. The forecast savings for the year has been revised from £16.783m to £16.930m, an increase of £147k. Savings of £12.360m have been achieved to date. The significant areas of concern are in the non-achievement in the Specialised Services and Surgery, Head and Neck Divisions which report significant under performance after nine months. The risk assessed forecast outturn is £16.93m i.e. some £4.06m less than Plan. The Finance Committee will receive a more detailed report on the Savings Programme under item 5.4 on this month's agenda.

	Savings Programme Performance to 31 December			1/12ths Phasing Adj	Total Variance Fav / (Adv)
	Plan	Actual	Variance Fav / (Adv)		
	£'000	£'000	£'000	£'000	£'000
Diagnostics and Therapies	1,034	1,530	496	28	524
Medicine	2,300	2,150	(150)	81	(69)
Specialised Services	2,378	1,598	(780)	(68)	(848)
Surgery, Head and Neck	5,213	1,781	(3,432)	43	(3,389)
Women's and Children's	2,012	1,966	(46)	30	(16)
Estates and Facilities	850	850	-	39	39
Trust HQ	800	856	56	26	82
Other Services	1,247	1,629	382	(86)	296
Totals	**15,834**	**12,360**	**(3,474)**	**93**	**(3,381)**

5. Income

Contract income was £2.01m higher than plan in December. Activity based contract performance at £280.44m for the nine months to 31st December is £3.25m greater than plan. Contract rewards / penalties at a net income of £4.77m are £1.62m better than plan. Income of £49.59m for 'Pass through' payments is £4.38m higher than Plan.

Clinical Income by Worktype	**Plan**	**Actual**	**Variance**
	£'m	£'m	£'m
Activity Based			
Accident & Emergency	10.00	9.78	(0.22)
Emergency Inpatients	50.65	50.61	(0.04)
Day Cases	22.65	25.67	3.02
Elective Inpatients	36.85	36.06	(0.79)
Non-Elective Inpatients	20.54	20.13	(0.41)
Excess Bed days	6.17	5.92	(0.25)
Outpatients	43.39	45.63	2.24
Bone Marrow Transplants	5.97	5.11	(0.86)
Critical Care Bed days	29.78	29.04	(0.74)
Other	51.19	52.49	1.30
Sub Totals	**277.19**	**280.44**	**3.25**
Contract Rewards / Penalties	3.15	4.77	1.62
Pass through payments	45.21	49.59	4.38
Totals	**325.55**	**334.80**	**9.25**

6. Expenditure

In total, Divisions are shown as overspent by £8.541m. The table given in section 1 (page 3) summarises the financial performance for each of the Trust's management divisions. Further analysis of the variances by pay, non-pay and income categories is given at Appendix 2.

This position is after additional recurring support of £5.8m for the year has been issued from Reserves as follows:

	2013/14	Year to Date
	£'000	£'000
Diagnostics and Therapies	537	403
Medicine	953	715
Specialised Services	1,053	789
Surgery, Head & Neck	1,966	1,475
Women's and Children's	1,291	968
Totals	**5,800**	**4,350**

Four divisions are red rated[1] for their financial performance to date.

The **Division of Medicine** reports a cumulative adverse variance of £2.076m for the nine months to 31st December, an overspending of £0.231m in the month.

The Division has a significant overspending on pay headings, £47k in December and a cumulative overspending of £2.136m. The Division reports progress on the impact of tighter controls on agency costs. Nursing staff costs reduced when comparing quarter 2 with quarter 1 and there has been a further reduction in quarter 3. The additional capacity provided however means that nursing costs remain significantly above planned levels. Expenditure of £4.659m has been incurred in the nine month period on bank, agency, overtime, waiting list and other payments.

Non-pay budgets have overspent by £0.951m to date, an overspending of £0.193m in the month. The excess unfunded capacity continues to result in further cost pressures against catering, portering, cleaning and other internal recharges. Drugs expenditure was also higher (activity related) together with patients transferring from the Cheltenham and Gloucester Adult Cystic Fibrosis service.

The Division reports an adverse variance of £18k in the month on its Operating Income budgets thereby reducing the year to date surplus to £85k. The in-month overspend is due primarily to reduced dermatology recharges.

Income from Activities has an over achievement of £0.125m in the month thereby increasing the cumulative over performance to date to £0.995m.

The **Division of Specialised Services** reports an adverse variance on its income and expenditure position of £0.704m for the nine months to 31st December, an improvement in the month of £146k.

Pay budgets show an overspending of £0.366m to date, an increase in the month of £35k. The December overspending is for the continued use of premium rate staffing in the CICU.

Non pay budgets show an overspending to date of £76k, an underspending of £32k in the month. Drugs budgets underspent by £69k in the month after funding received for retrospective costs from the Women's and Children's Division.

[1] Division has an annualised cumulative overspending greater than 1% of approved budget.

Operating Income budgets show a cumulative adverse variance of £17k, an overspending of £115k in December. Income from Activities shows a cumulative underspending of £0.602m, an improvement in December of £0.318m. Favourable income variances are recorded against Cardiac Critical Care (£0.248m), Cardiology (£0.440m) and Oncology (£0.476m). Cardiac Surgery under performance to date is £0.458m. Radiotherapy reports a positive in month performance of £102k to bring their year to date position to £9k favourable.

The Surgery, Head and Neck Division reports an adverse variance on its income and expenditure position of £4.820m for the nine months to 31st December, an overspending in the month of £0.564m.

Pay budgets have overspent by £0.150m in the month, to give a cumulative overspending of £1.694m. The overspending in December relates mainly to historical budget shortfalls and higher than planned expenditure on medical staff. The Division has incurred costs of £3.707m after nine months on bank, agency and waiting list initiative payments in order to deliver contracted activity.

Non pay budgets are underspent by £19k in the month to give a cumulative overspending of £1.789m. The favourable impact of a budget adjustment (£122k) for pass through costs is slightly greater than the overspending on other managed budgets (clinical supplies and drugs).

Income from Activities shows a favourable variance of £1.882m to date. The improvement in the month is a combination of higher than planned activity (£125k) offset by the pass through adjustment (contra to non-pay budget).

Operating Income budgets show a cumulative favourable variance of £170k to December, an improvement of £44k in the month.

The Division of Women's and Children's Services reports a cumulative adverse variance on its income and expenditure position of £1.491m to December an overspending of £0.113m in the month.

Pay budgets are overspent by £36k for the period and cumulatively overspent by £91k. Non-pay budgets show an overspending of £54k in the month, cumulatively £0.295m.

Income from Activities shows an adverse variance of £1.093m for the April – December period. The improvement in December of £2k includes a share (£0.125m) of the receipt of £0.250m received from NHS England for Winter Pressures. Income for paediatric medical specialities was £197k above plan whilst under-performance was recorded against paediatric surgical specialties, cardiac surgery and 'Welsh PICU'.

The remaining three divisions are green rated.

The **Diagnostic and Therapies Division** reports an underspending for the month of £2k to give a cumulative underspending to 31st December of £0.259m.

The Facilities and Estates Division - the Division reports an underspending to December of £126k, an improvement of £9k in the month.

Trust Headquarters Services report a cumulative underspending of £0.209m for the nine months to 31st December, an improvement of £30k in the month.

7. Financial Risk Rating

The Trust's overall financial risk rating, based on results for the nine months ending 31st December is 4. The actual financial risk rating is 3.50 (November 3.50) which rounds to 4. The actual value for each of the metrics is given in the table below together with the bandings for each metric. Further information showing performance to date is given at Appendix 6.

	June	September	October	November	December
Liquidity					
Metric Performance	(11.06)	(3.88)	(5.16)	(3.95)	(4.15)
Rating	2	3	3	3	3
Capital Service Capacity					
Metric Performance	2.63	2.71	2.74	2.86	2.87
Rating	4	4	4	4	4
Overall Rating	**3**	**4**	**4**	**4**	**4**

8. Capital Programme

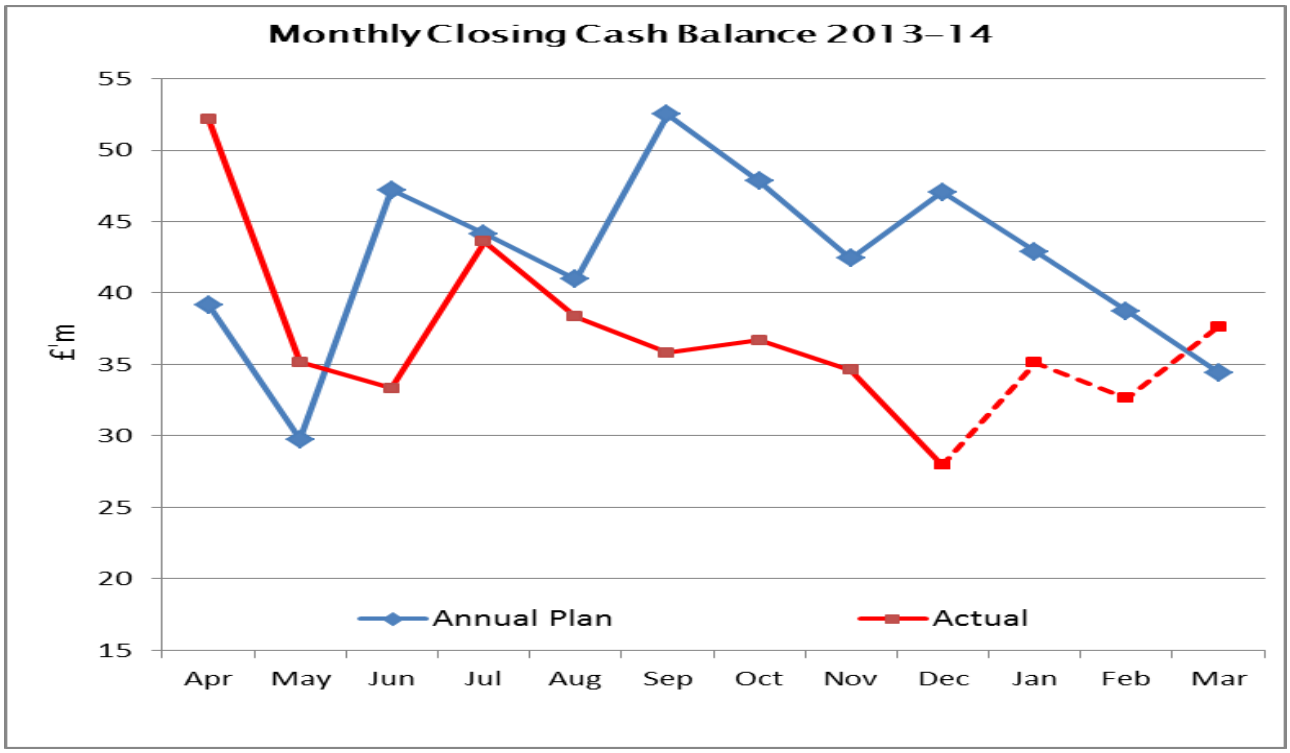
A summary of income and expenditure for the nine months ending 31st December is given in the table below. Expenditure for the period of £47.364m is £1.242m less than the current Plan.

		Nine Months Ending 31st December		
Plan for Year		**Plan**	**Actual**	**Variance Favourable / (Adverse)**
£'000	**Sources of Funding**	£'000	£'000	£'000
230	Public Dividend Capital	-	-	-
1,132	Donations	532	532	-
17,959	Retained Depreciation	13,212	13,069	(143)
50,000	Prudential Borrowing	50,000	30,000	(20,000)
700	Sale of Property	-	-	-
30	Grants / Contributions	30	30	-
4,855	Cash balances	(15,168)	3,733	18,901
74,906	**Total Funding**	**48,606**	**47,364**	**(1,242)**
	Expenditure			
(55,387)	Strategic Schemes	(37,673)	(37,451)	222
(10,216)	Medical Equipment	(4,366)	(4,223)	143
(3,964)	Information Technology	(1,777)	(1,646)	131
(2,341)	Roll Over Schemes	(1,109)	(1,137)	(28)
(10,436)	Operational / Other	(3,681)	(2,907)	774
7,438	Anticipated Slippage	-	-	-
(74,906)	**Total Expenditure**	**(48,606)**	**(47,364)**	**1,242**

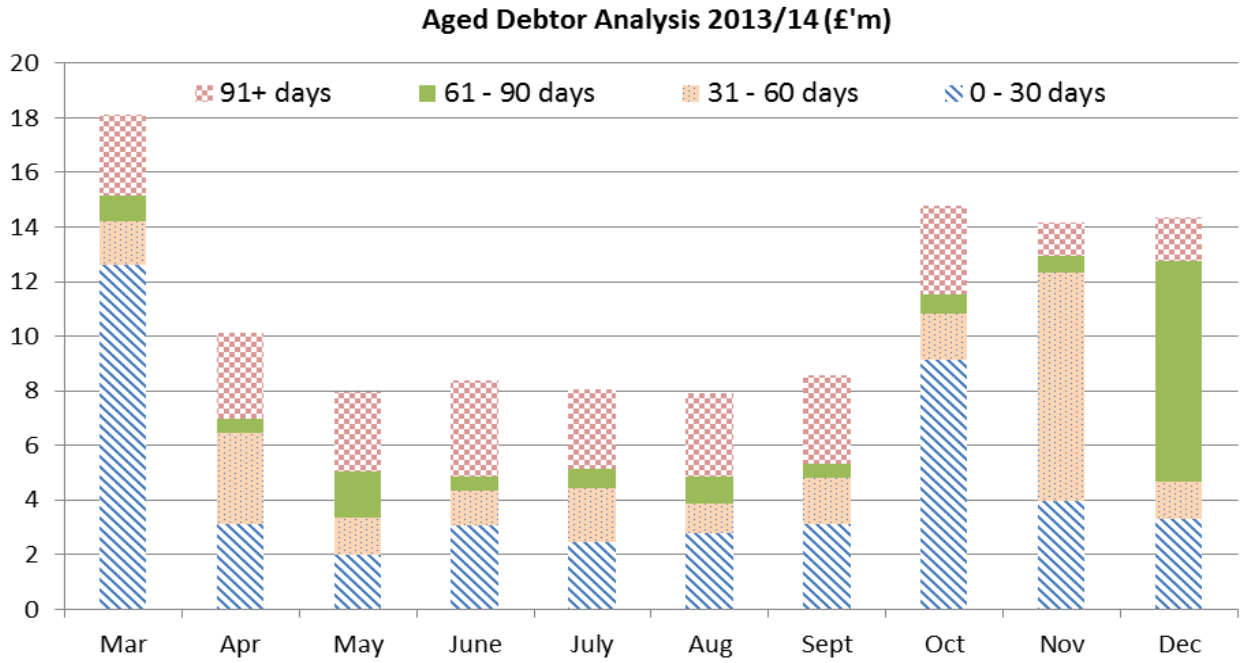
The Finance Committee is provided with further information on this under agenda item 6.

9. Statement of Financial Position (Balance Sheet) and Cashflow

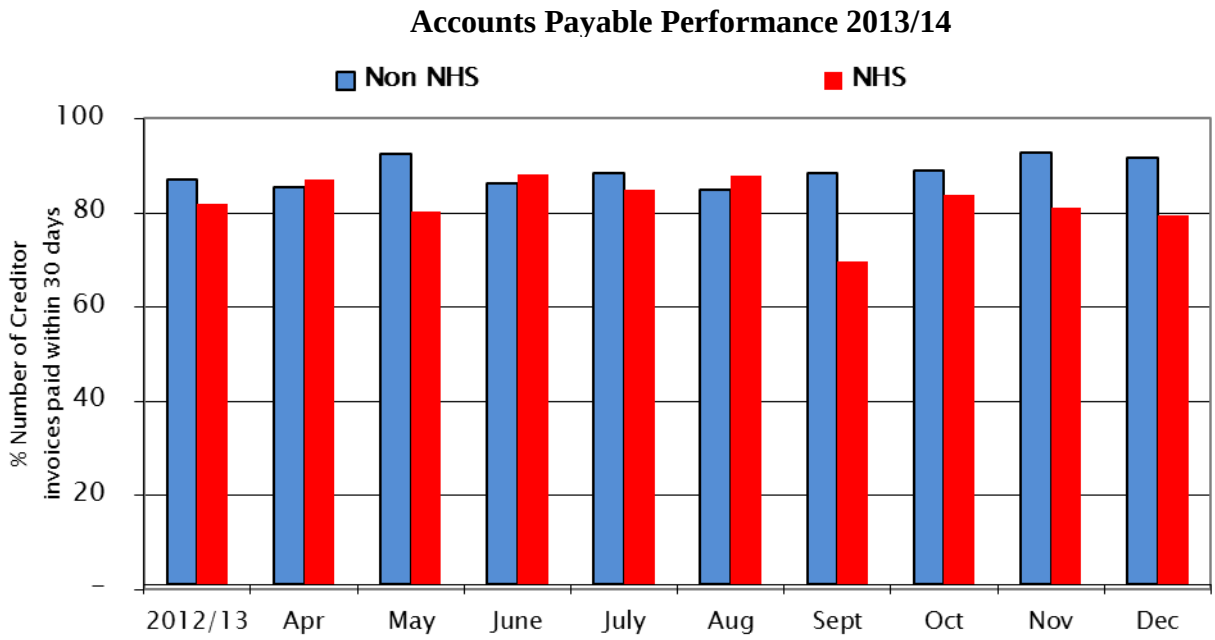
Cash - The Trust held a cash balance of £28m as at 31st December. The Trust drew down a seventh tranche (£3m) of the long term loan agreement with the Foundation Trust Financing Facility in December with the balance of £19m to be drawn down later in 2013/14. The projected year end cash balance is £37.6m.



Debtors - The total value of invoiced debtors has increased by £0.178m during December to a closing balance of £14.343m. The total amount owing is equivalent to 9.9 debtor days.



Accounts Payable Payments - The Trust aims to pay at least 90% of undisputed invoices within 30 days. In December the Trust achieved 80% and 92% compliance against the Better Payment Practice Code for NHS and Non NHS creditors.



Attachments

Appendix 1 – Summary Income and Expenditure Statement
Appendix 2 – Divisional Income and Expenditure Statement
Appendix 3 – Monthly Analysis of Pay Expenditure 2013/14
Appendix 4 – Executive Summary
Appendix 5 – Financial Risk Matrix
Appendix 6 – Financial Risk Rating

UNIVERSITY HOSPITALS BRISTOL NHS FOUNDATION TRUST
Finance Report December 2013- Summary Income & Expenditure Statement

Approved Budget / Plan 2013/14	Heading	Position as at 31st December			Actual to 30th November	Forecast Outturn
		Plan	Actual	Variance Fav / (Adv)		
£'000		£'000	£'000	£'000	£'000	£'000
	Income (as per Table I and E 2)					
442,786	From Activities	334,306	338,854	4,548	301,601	453,102
92,546	Other Operating Income	69,548	69,964	416	62,073	93,132
535,332	**Sub totals income**	**403,854**	**408,818**	**4,964**	**363,674**	**546,234**
	Expenditure					
(311,000)	Staffing	(233,542)	(238,218)	(4,676)	(210,794)	(316,423)
(178,434)	Supplies and Services	(138,131)	(145,230)	(7,099)	(130,558)	(193,259)
(489,434)	**Sub totals expenditure**	**(371,673)**	**(383,448)**	**(11,775)**	**(341,352)**	**(509,682)**
(8,305)	Reserves	(5,250)	-	5,250	-	-
(873)	Reserves - Incremental Drift	(655)	-	655	-	-
-	Profiling Adjustment	594	-	(594)	-	-
36,720	**EBITDA**	**26,870**	**25,370**	**(1,500)**	**22,322**	**36,552**
6.86	**EBITDA Margin - %**		**6.21**		**6.14**	**6.69**
	Financing					
66	Reserves/Profiling	(647)	-	647	-	-
(85)	Profit/(Loss) on Sale of Asset	(85)	(85)	-	(38)	(38)
(18,710)	Depreciation & Amortisation - Owned	(13,631)	(13,069)	562	(11,595)	(17,959)
50	Interest Receivable	38	111	73	100	139
(363)	Interest Payable on Leases	(272)	(277)	(5)	(246)	(367)
(1,954)	Interest Payable on Loans	(1,289)	(949)	340	(791)	(1,488)
(9,803)	PDC Dividend	(7,352)	(7,352)	-	(6,535)	(9,809)
5,922	**NET SURPLUS / (DEFICIT) before Technical Items**	**3,632**	**3,749**	**117**	**3,217**	**7,030**
	Technical Items					
2,250	Donations & Grants (PPE/Intangible Assets)	-	-	-	-	1,132
(3,030)	Impairments	(412)	(412)	-	(412)	(3,030)
1,886	Reversal of Impairments	-	-	-	-	1,886
(860)	Depreciation & Amortisation - Donated	(645)	(637)	8	(566)	(850)
-	Profiling Adjustment	1,057	-	(1,057)	-	-
6,168	**SURPLUS / (DEFICIT) after Technical Items**	**3,632**	**2,700**	**(932)**	**2,239**	**6,168**

UNIVERSITY HOSPITALS BRISTOL NHS FOUNDATION TRUST
Finance Report December 2013- Divisional Income & Expenditure Statement

Approved Budget / Plan 2013/14	Division	Total Net Expenditure / Income to Date	Variance [Favourable / (Adverse)]					Total Variance to date	Total Variance to 30th November	Control Totals
			Pay	Non Pay	Operating Income	Income from Activities	CRES			
£'000		£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
	Service Agreements									
434,672	Service Agreements	325,551	-	-	(93)	93	-	-	-	-
-	CQUINs		-	-	-	-	-	-	-	-
-	Overheads	1,803	-	-	-	1,803	-	1,803	713	-
40,516	NHSE Income	30,105	-	-	-	-	-	-	-	-
475,188	**Sub Total Service Agreements**	**357,459**	**-**	**-**	**(93)**	**1,896**	**-**	**1,803**	**713**	**-**
	Clinical Divisions									
(47,790)	Diagnostic & Therapies	(35,457)	70	(777)	(8)	450	524	259	257	150
(62,672)	Medicine	(49,077)	(2,136)	(951)	85	995	(69)	(2,076)	(1,845)	(1,750)
(72,067)	Specialised Services	(54,239)	(366)	(76)	(17)	602	(847)	(704)	(850)	(1,000)
(88,540)	Surgery Head & Neck	(71,326)	(1,694)	(1,789)	170	1,882	(3,389)	(4,820)	(4,256)	(4,750)
(93,623)	Women's & Children's	(71,558)	(91)	(295)	3	(1,093)	(15)	(1,491)	(1,378)	(1,000)
(364,692)	**Sub Total - Clinical Divisions**	**(281,657)**	**(4,217)**	**(3,888)**	**233**	**2,836**	**(3,796)**	**(8,832)**	**(8,072)**	**(8,350)**
	Corporate Services									
(32,533)	Facilities And Estates	(24,681)	219	(360)	93	135	39	126	117	150
(23,744)	Trust Services	(17,832)	589	(479)	(115)	61	80	136	112	260
(8,321)	Other	(7,919)	145	(479)	202	(208)	296	(44)	(98)	(220)
(64,598)	**Sub Totals - Corporate Services**	**(50,432)**	**953**	**(1,318)**	**180**	**(12)**	**415**	**218**	**132**	**190**
(429,290)	**Sub Total (Clinical Divisions & Corporate Services)**	**(332,089)**	**(3,264)**	**(5,206)**	**413**	**2,824**	**(3,381)**	**(8,614)**	**(7,940)**	**(8,160)**
(8,305)	Reserves	-	-	5,250	-	-	-	5,250	4,667	6,287
(873)	Reserves - Incremental Drift	-	655	-	-	-	-	655	582	873
(9,178)	**Sub Total Reserves**	**-**	**655**	**5,250**	**-**	**-**	**-**	**5,905**	**5,249**	**7,160**
36,720	**Trust Totals Unprofiled**	**25,370**	**(2,609)**	**44**	**320**	**4,720**	**(3,381)**	**(906)**	**(1,978)**	**(1,000)**
	Financing									
66	Reserves/Profiling	-	-	53	-	-	-	53	1,237	-
(85)	(Profit)/Loss on Sale of Asset	(85)	-	-	-	-	-	-	-	-
(18,710)	Depreciation & Amortisation - Owned	(13,069)	-	562	-	-	-	562	500	500
50	Interest Receivable	111	-	73	-	-	-	73	67	-
(363)	Interest Payable on Leases	(277)	-	(5)	-	-	-	(5)	(4)	-
(1,954)	Interest Payable on Loans	(949)	-	340	-	-	-	340	307	500
(9,803)	PDC Dividend	(7,352)	-	-	-	-	-	-	-	-
(30,865)	**Sub Total Financing**	**(21,621)**	**-**	**1,023**	**-**	**-**	**-**	**1,023**	**2,107**	**1,000**
5,922	**NET SURPLUS / (DEFICIT) before Technical Items**	**3,749**	**(2,609)**	**1,067**	**320**	**4,720**	**(3,381)**	**117**	**129**	**0**
	Technical Items									
2,250	Donations & Grants (PPE/Intangible Assets)	-	-	-	-	-	-	-	-	-
(3,030)	Impairments	(412)	-	-	-	-	-	-	-	-
1,886	Reversal of Impairments	-	-	-	-	-	-	-	-	-
(860)	Depreciation & Amortisation - Donated	(637)	-	8	-	-	-	8	7	-
-	Profiling Adjustment	-	-	(1,057)	-	-	-	(1,057)	(985)	-
246	**Sub Total Technical Items**	**(1,049)**	**-**	**(1,049)**	**-**	**-**	**-**	**(1,049)**	**(978)**	**-**
6,168	**SURPLUS / (DEFICIT) after Technical Items Unprofiled**	**2,700**	**(2,609)**	**18**	**320**	**4,720**	**(3,381)**	**(932)**	**(849)**	**0**

Analysis of pay spend 2012/13 and 2013/14

Division		2012/13	2013/14													2012/13
		Total	Apr	May	Jun	Q1	Jul	Aug	Sep	Q2	Oct	Nov	Dec	Q3	Total	Mthly Average	Mthly Average
		£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Women's and Children's	Pay budget	70,755	6,062	5,854	6,088	18,004	5,935	6,246	6,073	18,254	6,243	6,101	6,112	18,456	54,714	6,079	5,896
	Bank	2,042	189	125	133	446	148	199	167	514	197	122	129	448	1,408	156	170
	Agency	1,480	91	115	118	323	180	156	198	534	83	63	108	254	1,111	123	123
	Waiting List initiative	164	8	15	30	53	61	22	26	109	42	49	31	122	284	32	14
	Overtime	57	8	7	4	18	6	9	32	47	24	26	22	73	138	15	5
	Other pay	67,615	5,815	5,577	5,700	17,093	5,628	5,819	5,762	17,209	5,902	5,893	5,896	17,690	51,992	5,777	5,635
	Total Pay expenditure	71,359	6,111	5,838	5,984	17,933	6,023	6,205	6,185	18,413	6,248	6,153	6,186	18,587	54,933	6,104	5,947
	Variance Fav / (Adverse)	(604)	(49)	16	104	71	(88)	41	(112)	(159)	(5)	(52)	(74)	(131)	(219)	(24)	(50)
Medicine	Pay budget	44,264	3,736	3,707	3,620	11,063	3,693	3,695	3,656	11,044	3,767	3,648	3,651	11,066	33,173	3,686	3,689
	Bank	3,430	397	282	259	938	256	302	259	817	310	230	231	771	2,526	281	286
	Agency	1,374	224	311	223	758	252	205	225	681	179	125	120	424	1,863	207	115
	Waiting List initiative	148	12	48	8	68	13	18	14	45	4	9	8	21	134	15	12
	Overtime	72	9	7	7	22	6	5	45	57	18	26	14	57	136	15	6
	Other pay	41,085	3,434	3,353	3,409	10,195	3,399	3,515	3,387	10,301	3,598	3,486	3,532	10,616	31,112	3,457	3,424
	Total Pay expenditure	46,110	4,076	4,001	3,906	11,982	3,926	4,044	3,930	11,901	4,109	3,876	3,904	11,889	35,772	3,975	3,842
	Variance Fav / (Adverse)	(1,846)	(340)	(294)	(285)	(919)	(233)	(349)	(274)	(856)	(342)	(228)	(253)	(823)	(2,598)	(289)	(154)
Surgery Head and Neck	Pay budget	69,283	5,870	5,867	5,945	17,682	5,864	5,962	5,924	17,750	5,957	5,886	5,924	17,767	53,199	5,911	5,774
	Bank	2,247	230	159	173	562	174	201	145	520	203	128	116	447	1,529	170	187
	Agency	981	49	48	88	186	106	136	127	369	64	49	43	156	711	79	82
	Waiting List initiative	1,097	60	50	113	223	215	221	114	550	135	128	109	372	1,145	127	91
	Overtime	149	14	7	8	29	16	37	54	108	110	52	24	186	322	36	12
	Other pay	67,476	5,698	5,702	5,669	17,068	5,583	5,779	5,914	17,276	5,738	5,816	5,845	17,399	51,744	5,749	5,623
	Total Pay expenditure	71,950	6,051	5,965	6,051	18,068	6,094	6,375	6,354	18,823	6,250	6,173	6,137	18,560	55,451	6,161	5,996
	Variance Fav / (Adverse)	(2,667)	(181)	(99)	(106)	(386)	(230)	(413)	(431)	(1,074)	(293)	(287)	(213)	(793)	(2,252)	(250)	(222)
Specialised Services	Pay budget	35,888	2,967	2,958	3,166	9,091	3,073	3,061	3,072	9,206	3,054	3,061	3,071	9,186	27,483	3,054	2,991
	Bank	1,071	105	75	83	263	91	132	91	314	129	97	85	311	888	99	89
	Agency	1,194	82	113	147	342	166	161	152	479	200	180	162	542	1,363	151	99
	Waiting List initiative	288	42	27	29	98	18	9	26	53	49	50	34	133	284	32	24
	Overtime	70	12	7	6	25	8	8	22	39	28	18	14	60	123	14	6
	Other pay	34,439	2,798	2,797	2,844	8,440	2,919	2,710	2,881	8,509	2,811	2,817	2,864	8,492	25,441	2,827	2,870
	Total Pay expenditure	37,063	3,039	3,018	3,110	9,167	3,202	3,021	3,172	9,394	3,217	3,162	3,159	9,538	28,099	3,122	3,089
	Variance Fav / (Adverse)	(1,175)	(72)	(60)	56	(76)	(129)	40	(100)	(189)	(163)	(101)	(88)	(352)	(616)	(68)	(98)

Analysis of pay spend 2012/13 and 2013/14

Division		2012/13	2013/14													2012/13
		Total £'000	Apr £'000	May £'000	Jun £'000	Q1 £'000	Jul £'000	Aug £'000	Sep £'000	Q2 £'000	Oct £'000	Nov £'000	Dec £'000	Q3 £'000	Total £'000	Mthly Average £'000	Mthly Average £'000
Diagnostic & Therapies	Pay budget	38,231	3,265	3,330	3,299	9,894	3,295	3,355	3,343	9,992	3,313	3,285	3,283	9,881	29,767	3,307	3,186
	Bank	398	38	27	30	96	35	32	24	91	28	17	20	65	252	28	33
	Agency	362	(17)	(1)	23	5	26	34	41	101	32	35	35	102	209	23	30
	Waiting List initiative	176	15	10	16	41	16	9	27	52	10	21	21	52	145	16	15
	Overtime	279	34	25	27	86	25	25	27	77	27	25	30	83	245	27	23
	Other pay	37,491	3,143	3,244	3,177	9,564	3,194	3,169	3,219	9,582	3,249	3,220	3,190	9,660	28,806	3,201	3,124
	Total Pay expenditure	38,706	3,213	3,306	3,273	9,792	3,295	3,270	3,339	9,904	3,347	3,317	3,297	9,961	29,657	3,295	3,225
	Variance Fav / (Adverse)	(475)	52	24	26	102	(0)	85	4	89	(34)	(33)	(14)	(80)	110	12	(40)
Facilities & Estates	Pay budget	18,638	1,566	1,556	1,585	4,706	1,465	1,552	1,514	4,531	1,566	1,509	1,536	4,611	13,850	1,539	1,553
	Bank	285	39	30	36	105	39	62	39	140	64	37	43	144	390	43	24
	Agency	1,174	43	28	38	109	24	29	22	75	35	21	19	74	258	29	98
	Waiting List initiative	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	Overtime	1,131	86	73	94	253	92	89	73	254	97	52	57	205	713	79	94
	Other pay	15,952	1,408	1,400	1,353	4,161	1,394	1,403	1,339	4,137	1,373	1,339	1,366	4,079	12,376	1,375	1,329
	Total Pay expenditure	18,542	1,576	1,532	1,520	4,628	1,550	1,583	1,473	4,606	1,568	1,449	1,485	4,503	13,737	1,526	1,545
	Variance Fav / (Adverse)	97	(10)	24	65	78	(85)	(31)	41	(75)	(2)	60	51	108	113	13	8
Trust Services (Including R&I and Support Services)	Pay budget	26,447	2,114	2,117	2,249	6,480	2,166	2,343	2,207	6,717	2,286	2,461	3,414	8,160	21,357	2,373	2,204
	Bank	527	75	51	45	170	60	63	56	179	65	47	44	156	505	56	44
	Agency	133	10	22	48	80	28	26	32	86	35	38	35	108	273	30	11
	Waiting List initiative	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	Overtime	185	13	10	7	30	8	6	5	19	7	6	8	20	69	8	15
	Other pay	24,361	2,011	1,947	2,071	6,029	2,048	2,157	2,016	6,221	2,073	2,231	3,168	7,472	19,722	2,191	2,030
	Total Pay expenditure	25,206	2,108	2,031	2,171	6,309	2,144	2,251	2,109	6,504	2,180	2,322	3,255	7,756	20,569	2,285	2,101
	Variance Fav / (Adverse)	1,241	6	87	78	171	23	92	98	213	106	139	159	404	788	88	103
Trust Total	Pay budget	303,506	25,580	25,388	25,952	76,920	25,492	26,213	25,788	77,494	26,186	25,951	26,990	79,127	233,542	25,949	25,292
	Bank	10,001	1,073	748	758	2,580	803	992	781	2,575	996	678	669	2,343	7,497	833	833
	Agency	6,699	482	640	683	1,803	781	747	798	2,325	628	511	521	1,660	5,789	643	558
	Waiting List initiative	1,873	137	150	196	483	323	279	207	809	240	257	203	700	1,992	221	156
	Overtime	1,943	174	136	153	463	162	179	259	600	311	204	169	684	1,747	194	162
	Other pay	288,419	24,308	24,017	24,224	72,551	24,165	24,552	24,518	73,236	24,744	24,802	25,863	75,409	221,194	24,577	24,035
	Total Pay expenditure	308,935	26,174	25,691	26,014	77,879	26,233	26,749	26,563	79,545	26,919	26,452	27,424	80,796	238,218	26,469	25,745
	Variance Fav / (Adverse)	(5,429)	(594)	(303)	(62)	(959)	(741)	(535)	(774)	(2,051)	(733)	(501)	(434)	(1,668)	(4,676)	(520)	(452)

NOTE: Other Pay includes all employer's oncosts.

University Hospitals Bristol NHS
NHS Foundation Trust

Appendix 4

Key Issue	RAG	Executive Summary	Table
Service Level Agreement Income and Activity	G	Contract income was £2.01m higher than plan in the December and is now £9.25m higher than Plan for the year to date. Activity based contract performance at £280.44m for the first nine months is £3.25m greater than plan. Contract rewards / penalties at a net income of £4.77m are £1.62m favourable to plan. 'Pass through' payments to date total £49.59m and are £4.38m higher than Plan. A&E Attendances at 86,218 are 1,120 **higher** than planned. The average number of daily attendances is 314. Emergency activity at 26,622 is 0.6% or 151 spells **higher** than planned. Non Elective activity at 2,053 is 5.2% or 113 spells **lower** than planned. Elective activity at 10,731 is 6.7% or 777 spells **lower** than per planned. Day case activity at 38,805 is 11.3% or 3,947 spells **higher** than planned. Outpatient Procedure activity at 38,301 is 22.7% or 7,082 attendances **higher** than planned. New Outpatients activity at 115,510 is 13.1% or 13,383 attendances **higher** than planned. Follow up Outpatient activity at 224,922 is 6.5% or 13,808 attendances **higher** than planned. An income analysis by commissioner is shown at Table INC 2. Information on clinical activity by Division, specialty and patient type is provided in table INC 3.	Agenda Item 5.2 INC 1
Income and Expenditure	G	The surplus before technical items for the first nine months of 2013/14 is £3.749m. This represents an over performance of £0.117m when compared with the planned surplus to date of £3.632m. Total income to date of £408.818m is £4.964m higher than Plan. Expenditure at £383.448m is greater than Plan by £6.464m. Financing costs are £1.617m lower than Plan.	Agenda Item 5.3 I&E 1 I&E 2 I&E 3a I&E 3b

Key Issue	RAG	Executive Summary	Table
Savings Programme	R	The 2013/14 Savings Programme totals £20.989m. Actual savings achieved for the 9 months to 31st December total £12,360m, a shortfall of £3.381m against divisional plans. The risk assessed forecast outturn is for savings of £16.930m to be achieved for the year.	Agenda Item 5.4
Statement of Financial Position and Treasury Management	G	The cash balance at the end of December is £28.0m. The year-end cash balance is forecast to be £37.6m. The balance on Invoiced Debtors has increased by £0.178m in the month to £14.343m. The invoiced debtor balance equates to 9.9 debtor days. Creditors and accrual account balances total £69.099m with £2.799m relating to deferred income. Invoiced Creditors - payment performance for the year to date for Non NHS invoices and NHS invoices within 30 days was 89% and 82% respectively.	Agenda Item 7 SFP 1 SFP 2 SFP 3
Capital	G	Expenditure for the nine months to 31st December of £47.364m is £1.242m less than planned.	Agenda Item 6
Financial Risk Rating	G	The Trust's overall financial risk rating under the new Risk Assessment Framework for the nine months to 31st December has been calculated to be 4 (actual score 3.5), (November 3.5).	Agenda Item 5.1 App 6

Appendix 5

UNIVERSITY HOSPITALS BRISTOL NHS FOUNDATION TRUST

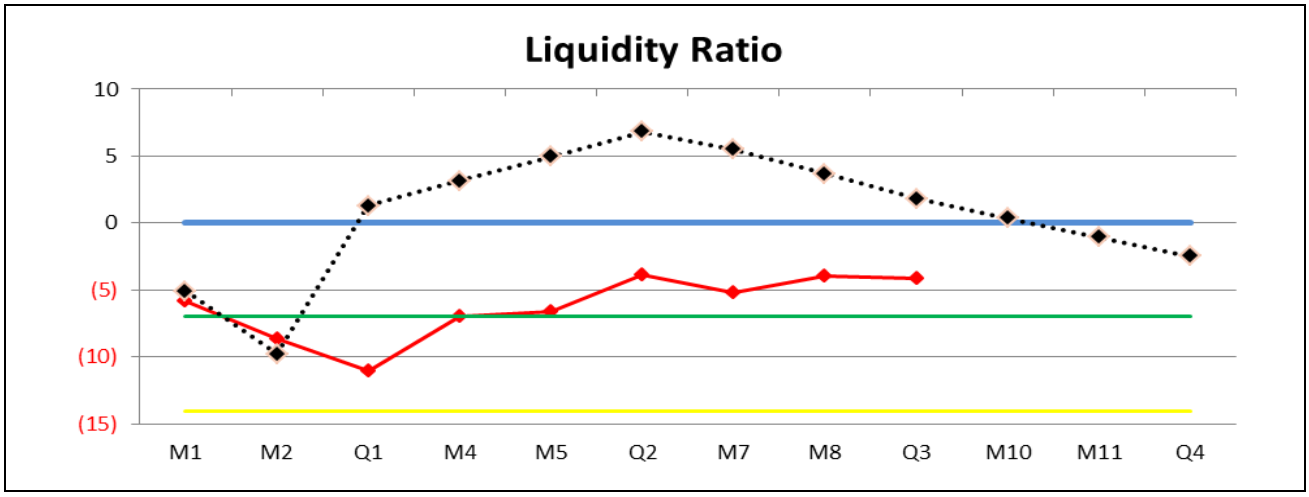
Finance Report December 2013 - Risk Matrix

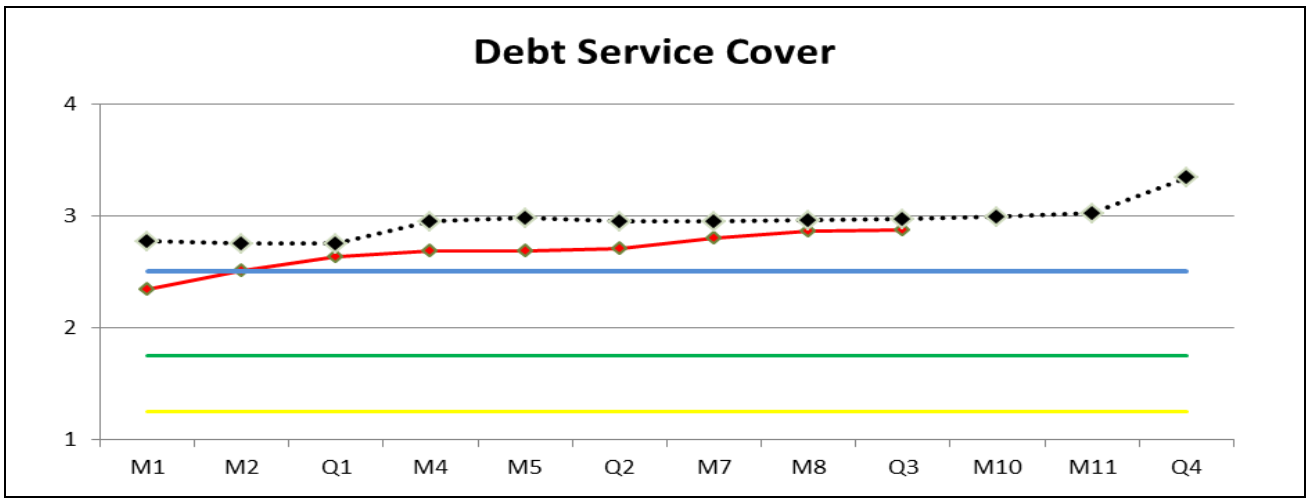
Corporate Risk Register Ref.	Description of Risk	Risk if no action taken		Action to be taken to mitigate risk	Lead	Residual Risk		Progress / Completion
		Risk Score	Financial Value			Risk Score	Financial Value	
			£'m				£'m	
741	Savings Programme	High	10.0	Programme Steering Group established. Monthly Divisional reviews to ensure targets are met. Benefits tracked and all schemes risk assessed.	JR	High	5.0	Savings achieved = 78% of Plan to 31st December. Forecast outturn savings is projected to be £16.930m ie £4.059m less than Plan.
962	Delivery of Trust's Financial Strategy in changing national economic climate.	High	-	Long term financial model and in year monitoring of financial performance by Finance Committee and Trust Board.	PM	High	-	2014/15 Plans are very challenging
2116	Non delivery of contracted activity	Medium	5.0		JR	Medium	4.0	Pressures in Children's Hospital plus other Divisions due to Winter and capaicty.
1858	Non receipt of pledges of charitable moneys to partly finance capital expenditure	Medium	3.0	Monitoring of capital expenditure. Maintain dialogue with respective trustees.	PM	Medium	2.0	Firm pledges not yet available.
1240	SLA Performance Fines	Medium	2.0	Infection Control plan implemented. Regular review of performance.	DL	Low	1.0	
	Commissioner Income challenges	Medium	2.0	Maintain reviews of data, minmise risk of bad debts	PM	High	1.0	
1623	Risk to UH Bristol of fraudulent activity.	Low	-	Local Counter Fraud Service in place. Pro active counter fraud work. Reports to Audit Committee.	PM	Low	-	

Continuity of Service Risk Rating – December 2013 Performance

The following graphs show performance against the 2 Financial Risk Rating metrics which came into use from 1st October under the new Risk Assessment Framework. The 2013/14 Annual Plan is shown as the black line against which actual performance will be plotted in red. The metric ratings are shown for **FRR 4 (blue line)**; **FRR 3 (green line)** and **FRR 2 (yellow line)**.

	June	September	October	November	December
Liquidity					
Metric Performance	(11.06)	(3.88)	(5.16)	(3.95)	(4.15)
Rating	2	3	3	3	3
Capital Service Capacity					
Metric Performance	2.63	2.71	2.74	2.86	2.87
Rating	4	4	4	4	4
Overall Rating	**3**	**4**	**4**	**4**	**4**





University Hospitals Bristol NHS
NHS Foundation Trust

Cover Sheet for a Report for a Public Trust Board Meeting, to be held on 30 January 2014 at 10:30 in the Conference Room, Trust Headquarters, Marlborough Street, Bristol, BS1 3NU

14. Partnership Programme Board Report

Purpose

To provide the Board with an update on matters considered at the December 2013 meeting of the University Hospitals Bristol and North Bristol NHS Trust Partnership Programme Board.

Abstract

The Partnership Programme Board meets on a bi-monthly basis and considers matters of relevance to the partnership agenda between University Hospitals Bristol and North Bristol NHS Trust with the aim of promoting highly effective joint working between the partner trusts for the benefit of patients and staff within the two organisations.

A summary of the key issues discussed is provided to the Board, for information.

Recommendations

The Board is recommended to **note** the highlight report of the recent Partnership Programme Board.

Report Sponsor

- Sponsor – Chief Executive
- Author – Director of Strategic Development

Appendices

- Appendix A – Partnership Programme Board Highlight Report December 2013.

North Bristol NHS Trust
University Hospitals Bristol NHS Foundation Trust

The Partnership Programme Board

Held on Wednesday 16th December 2013

Key Points Summary

STRATEGIC

Executive to Executive Meeting

The first meeting of the Executive to Executive had taken place. It was noted that this was a useful means to take executive action on items discussed by the Partnership Programme Board. It was agreed that the two Trusts would support each other to ensure the series of service moves and developments were adequately supported and aligned. A commitment was also agreed to build and promote the 'Bristol' brand.

South Gloucestershire and Bristol Overview and Scrutiny Commission

It was noted that both commissions would be receiving an update on the Acute Services Review. A formal response would be prepared by David in response to questions posed through Public Forum Statements.

Lessons Learned from Head and Neck / ENT Transfer

Both Trusts have plans in place to ensure that all of the learning from recent services moves is captured for the benefit of any future moves. A "checklist" of good practice will be developed and be used to inform the approach to the vascular transfer.

Histopathology

Rob Pitcher to conclude work for the Executive to Executive meeting in January and produce a report from this to the next Partnership Programme Board describing the options open to the two Trust's in relation to further integration of the two cellular pathology services.

Severn Pathology

A joint response to the Scrutiny Commission was agreed by Robert Woolley and Andrea Young, prior to the next meeting on 28th January. It was noted that UH Bristol would need to explain their decisions around Severn Pathology and the way forward for their pathology services. Chris Burton and Deborah Lee were asked to prepare a paper for the Commission.

Learning for Future Ventures

The Executive Team meeting had considered a paper jointly developed by Deborah Lee and Chris Burton which set out the perspectives, from both organisations, on the issues that had impacted upon the success of the pathology initiative. This had been developed to capture the key lessons learnt from this reflection which would positively shape future joint working.

Recruitment and Retention Premium (RRP)

NBT advised that they had reached a RRP withdrawal agreement with staff side organisations at the end of the formal consultation process.

Board to Board

The next Board to Board is scheduled for 14th March 2014. Robert Woolley and Andrea Young to agree an agenda for discussion at the February meeting.

OPERATIONAL

Vascular Services

The Board had received an update from the Executive Leads regarding progress. The position of RUH was now becoming clearer, with verbal assurance having been received by NHS England that agreement had been reached with the Trust to comply with the national service specification. Further work was needed to present the benefits of an arterial centre and vascular network to Wiltshire CCG

and OSC and this is in hand.

Harry Hayer had alerted the Board to a potential extension in timescale beyond 30 June 2014 to enact changes due to risks outside of the Trust's control. Deborah Lee advised that UH Bristol were reliant on the service transfer in order to undertake a serious of internal moves and any revised timeline would need to be considered in the context of a full impact assessment of the implications for UH Bristol.

Centralisation of Specialist Paediatrics
Deborah Lee provided an overview of the project noting its status was AMBER reflecting a small number of risks the most significant relating to the medical workforce model which had not yet been agreed and had the potential to jeopardise the transfer timeline. This risk had been escalated and the two Executive Leads for NBT and UH Bristol were working through options for its resolution.

NBT Update
Andrea Young outlined the new hospital project, the appointment process for a new Director of Nursing and interim Director of Operations, performance challenges, the appointment of a new Non-Executive Director (Sue Sundstrom), and pending appointments of Chief Information Officer and Director of Operational Finance.

UH Bristol Update
Deborah Lee reported the appointments of Sue Donaldson as Director of Workforce and OD and four new Non-Executive Directors, highlights regarding the UH Bristol redevelopment programme, including the creation of a new Welcome Centre.

Laboratory Information Management System
Chris Burton advised of delays in approving the business case but work was in hand to resolve.

Dr Foster's 'Good Hospital Guide'
Harry Hayer reported strong results for both Trusts' in the guide. This information should be used to further strengthen the 'Bristol' brand.

Bristol Health Partners
Andrea Young has been appointed Chair of Bristol Health Partners. The position of Director of Bristol Health Partners is now vacant anda recruitment process would be underway in the new year.

Date of Next Meeting
17th February 2014

Attendees
NBT
Harry Hayer, Robert Mould, Andrea Young, Chris Burton and Avril Waterman-Pearson.
UH Bristol
Emma Woollett, Deborah Lee, Paul Mapson and John Savage.

Apologies
UH Bristol
Iain Fairbairn, Sean O'Kelly and Robert Woolley
NBT
Catherine Phillips

University Hospitals Bristol NHS
NHS Foundation Trust

Cover Sheet for a Report for a Public Trust Board Meeting, to be held on 30 January 2014 at 10:30 in the Conference Room, Trust Headquarters, Marlborough Street, Bristol, BS1 3NU

15. Quarterly Capital Projects Status Report

Purpose

The purpose of this paper is to update the Board on the current status of the Trust's major capital development schemes.

Abstract

The attached report describes progress, issues and risks arising from the Trust's three major capital developments which are governed through the Strategic Development Department and associated programme infrastructure.

The Welcome Centre is now complete and fully operational and thus excluded from this update. The remainder of the programme remains largely on track in respect of both budget and timelines, based on the revised programme reported previously, with the notable exception of a further revised handover date for the Bristol Haematology and Oncology Centre (BHOC) scheme arising from a range of issues relating to the existing building. The impact of this delay has been fully assessed and is manageable in the context of both service and other related transfers.

The report notes a number of programme risks that are being actively managed and mitigated where possible. One risk, within the Centralisation of Specialist Paediatrics (CSP) transfer, pertaining to medical workforce has been escalated to Chief Executives and discussions to resolve this issue remain ongoing.

Finally, the Trust has invited the Office for Government and Commerce (OGC) Gateway Review Team to undertake a Gateway 4 Review of both the CSP and BRI schemes; the first of these reviews will commence in mid-February and be reported to the Board in due course.

Recommendations

The Trust Board is recommended to note this report by the Director of Strategic Development.

Report Sponsor

Director of Strategic Development and Deputy Chief Executive

Appendices

Appendix A – Quarterly Status Report.

STRATEGIC DEVELOPMENT QUARTERLY STATUS REPORT
Item 16 – 30th January Trust Board

1. Introduction

This status report provides a summary update for Quarter 3 on the Trust's strategic capital schemes, all of which are managed through their respective project boards, which in turn report to the Senior Leadership Team.

2. Project Updates

CENTRALISATION OF SPECIALIST PAEDIATRICS		
1	**Decisions required**	None.
2	**Progress**	Majority of build is complete with remaining departments progressing well: • Level 03 CT scanner delivery scheduled for 4th Feb • Level 04 Hybrid and Theatres complete, MRI completion on programme for 2nd Feb • Level 04 Extension of Recovery and changing facilities commenced • Level 05 New school facility commenced • Level 05 Ward block fit out continuing. Models of care and operational policies have progressed well and are moving into the detailed job planning stage. Staff retention at NBT remains a risk which is being monitored through the Project Board and work is in hand to consider how best UH Bristol can support the service ahead of transfer. Previous risks relating to Junior doctor rotas and medical records have been resolved in period
3	**Budget**	A capital allocation of £31.3m is in the capital programme including charitable funding support of £5.83m. The scheme remains within budget and the 2013/14 cash flow has been re-projected and incorporated within the Trusts capital programme. Work continues with the Grand Appeal to identify other areas of support to maximise the benefit of their support. A full refresh of the Full Business Case has now been approved in the reporting period.
4	**Programme**	The final 2 phases of work internal to the Children's hospital are in progress. The knock effect of the delay to the Hybrid Catheter lab area reported previously has resulted in some time pressure to complete the recovery and changing facilities, but this is being closely monitored and the necessary remedial actions undertaken.

5	**Risks**	**Risk**	**Mitigation Actions**
		Models of Care (MoC) and Operational Policy's for transferring services are not agreed in project timelines.	Jan 2014 update from Project Board; Project Board received an update to outline the approach to resolve the outstanding MoC issues and planning. The Project Board was assured the outstanding issues were resolvable in a short timescale but have requested a more detailed risk assessment be presented to the February Board following evaluation of the risks by the January Operational Delivery Group.
		Concerns that planning assumptions relating to level of paediatric emergency department (ED) activity transfer are understated.	Children's ED urgent care activity planning incorporated into wider urgent care capacity planning exercise and original assumptions reviewed and revised if appropriate. Nov 2013; NBT review carried out. Dec 2013; Project Board noted Royal College Report expected 13th Dec 2013. Operational mitigations for higher than expected activity being developed alongside communications plan to support presentation of children to "right place, first time".
		Agreement on medical staff transferring, or to be contracted, from NBT still not agreed.	Nov 2013; risk to be extended to include challenges with regards to recruitment to project timeframes. Escalated to CEOs and work in hand to resolve.
		Fail to retain staffing required at NBT to maintain transferring services.	Robust communications and engagement activity with NBT staff including regular CSP Newsletter issued to all staff on TUPE list. Regular face to face road-shows now programmed in through to transfer, delivered at Frenchay and targeted at all staff that will be transferring. TUPE consultation ensuring that all staff have adequate opportunity to discuss any concerns regarding their transfer.
		Agreement on Out of Hours Theatre Model cannot be achieved in context of available resources.	Task and finish group convened to work through options, reporting to Operational Delivery Group. Range of options identified and being evaluated.

BRISTOL ROYAL INFIRMARY PROJECT INCLUDING AIR AMBULANCE ACCESS, GENERATORS AND QUEEN'S FAÇADE		
1	**Decisions required**	To note; the scheme incorporates the helipad, the site wide generators and the Queen's Façade.
2	**Progress**	**BRI Phase 3** – Revised programme dates for all levels now agreed and on programme. The final ambulance diversion will finish on 7th Feb following completion of the external works in the ambulance bay. **BRI Phase 4** – Space allocation plan for Phase 4 agreed, very small number of residual issues to resolve regarding use of Central Health Clinic and final location for EEG service. Process to confirm office accommodation commenced, with leadership from Divisional Director. Ward refurbishment work scope defined and agreed, final costs being assessed but expected to be managed within £3m budget. Ward closure and move programme version 17 approved by Project Board. **Air Ambulance Access/Helipad –** Final commissioning in hand and on programme for test flights to take place from 31st March 2014 and pad to be fully operational by April 2014. **Queens Façade** – Final designer was selected, Nieto Sobejano from Madrid and meetings are on-going to finalise the design. Planning application submitted December 13 with successful pre-application meetings having taken place. Tender process to appoint contractors commenced.
3	**Budget**	A total capital allocation of £92.3m is in the capital programme including assumed charitable funding support of £2m. Allocation of £86.6m for the phase 3 works includes funding for the Helipad and site wide generators, which is now part of the target price agreement. Allocation also includes funding for facade. The scheme remains within its capital budget. A re-fresh of revenue has been concluded and is presented to the January 2014 Board.
4	**Programme**	Delay to overall completion due to agreed changes level 9 which introduced a six month delay for final scheme completion. However the majority of levels will be handed over to the original programme and all levels with the exception of level 9 will be handed over by August 2013 and level 9 in December 2013. Commissioning timelines, post-handover, are now being developed with a view to minimising the commissioning period as far as possible.

5	**Risks**	**Risk**	**Mitigation Actions**
		Activity and capacity assumptions do not materialise as planned, following recent re-fresh, due to changes in demand or LOS assumptions. Concern raised about Vascular Transfer and non-elective flows being different to projected in original model.	More detailed working required as to how projected activity and bed model plans are expressed within divisional Operating Plans for next year. FBC Re-fresh now concluded and feeding into Divisional Operating Plans. Operational contingency plans for higher than expected in-flows, or delayed out-flows, being developed.
		Medical staffing Model moves from acute physicians to speciality take model. The risk is that the current model can't be operational from service transfer, within the agreed costs for additional medical staffing.	Business case taken for additional staff/solution by Divisional Director - outside of this project scope, but project is dependent on its outcome. BRI Redevelopment Implementation Manager supporting the Division to work on costing model.
		Current ward move sequencing plans suggests a 5-6 month period of 5 site working for Medicine.	Options paper developed by Medicine to support the earlier closure of inpatient wards within the Old Building, which requires support from SHN for temporary access to cohort area on ward 800. SHN considering impact on service.

BRISTOL HAEMATOLOGY & ONCOLOGY CENTRE (BHOC)			
1	**Decisions required**	None.	
2	**Progress**	BHOC Redevelopment external structure complete and bunker construction running to programme. Internal fit-out now on-going. Remedial works almost complete to existing drainage system. Clinical Trials Unit now complete. Internal works progressing, commissioning to commence end January 2014.	
3	**Budget**	Allocation of £16.5m (incl. £2m for Linac replacement) supported by £6.5m of charitable funding pledged by Above and Beyond, Teenage Cancer Trust and the Friends of BHOC. The scheme is now within budget though note below re an emerging risk arising from bunker works.	
4	**Programme**	A revised programme has been issued by Laing's confirming completion and handover of Level 3 BHOC on 24th February 2014. Haematology and BMT services will transfer to the new accommodation on 7th March 2014. The contract completion date is 24th February 2014 (excluding the Linac E bunker refurbishment).	
5	**Risks**	**Risk**	**Mitigation Actions**
		Delay to Level 3 completion. Revised handover date of 24th February 2014.	Progress on site is monitored weekly.
		Actual costs of Linac E refurbishment exceeds budget figure of £135k.	Laing O'Rourke working with design team and supply chain to keep the costs within the initial quote.

3. Conclusion

The Trust Board is requested to receive this report for information, noting the risks that have been identified and the mitigation/contingency plans that have been developed.

Author: Andy Headdon, Strategic Development Programme Director
Date updated: 20.01.2014

University Hospitals Bristol NHS
NHS Foundation Trust

Cover Sheet for a Report for a Public Trust Board Meeting, to be held on 30 January 2014 at 10:30 in the Conference Room, Trust Headquarters, Marlborough Street, Bristol, BS1 3NU

16. Refresh of the BRI Redevelopment Full Business Case

Purpose

The purpose of this paper is to provide the Board with an updated position in respect of the business case for the BRI Redevelopment.

Abstract

The FBC for the BRI Redevelopment was originally signed off in April 2011. In July 2013 the Trust Board signed off amendments to the FBC due to changes in the activity levels projected with a subsequent revision to the bed base and models of care.

This Refresh is put forward following more detailed work on;

- Revised Models of Care
- Capacity Planning
- Revised workforce requirements and the process for addressing any further revenue impact on Divisions
- The financial revenue position of the project

The refreshed Full Business Case was received by the Finance Committee in December 2013 and recommended by the Committee for approval by the Trust Board.

Recommendations

The Trust Board is asked to approve the revised Full Business Case for BRI Redevelopment.

Report Sponsor

Chief Operating Officer

Appendices

BRI Redevelopment Refresh Final

BRI Redevelopment Full Business Case Refresh
December 2013

1. Introduction

This document updates specific sections of the full business case (FBC) for the BRI Redevelopment originally submitted in April 2011. Due to changes in planned activity levels and the associated bed base, non-delivery of QIPP schemes and a revision to the previously described Models of Care an updated FBC was approved at the Trust Board on 30th July 2013.

This refresh has been prepared to ensure full consideration has been given to those impacts at an operational level with the key steps and governance for this process agreed through the BRI Redevelopment Project Board and Operational Delivery Group. The refresh was discussed at the Trust Management Executive on 13th November 2013.

Therefore this paper is put forward to approve:

- The revised Models of Care;
- The Capacity Planning;
- The revised workforce requirements and the process for addressing any further revenue impact on Divisions; and
- The financial revenue position of the project.

2. Model of Care

2.1 Overview

At the time of the approval of the Full Business Case in April 2011, a detailed model of care (MOC) for the Divisions of Medicine and Surgery, Head & Neck was described that centred the patient flow through an Integrated Assessment Unit (IAU). Wards and bed numbers in the redevelopment were also allocated to the Divisions, in line with future bed demand modelling.

A review of the feasibility of this integrated model was instigated for two main reasons:

- The medical staffing model for the IAU was reliant on acute physicians. Recruitment to this role was not proving successful in the trust, and was confirmed as a national problem. Whilst there is confidence that this role is being developed, and can be recruited to in future years, this will not be in place for the opening of the new facilities; and
- The bed model was refreshed in early 2013, and the revised demand predictions indicated the need for greater assessment unit capacity for medicine, and an overall increase in bed numbers of 55 (41 beds + 14 flex beds to meet Q4 demand increases) for the Divisions. The bed model also highlighted the reductions in length of stay across a number of HRGs, that the modelling was predicated on.

A multidisciplinary cross-divisional group re-designed the high level MOC, patient flow and ward allocations which were presented to the Trust Management Executive in March 2013.

Subsequent development of the revised MOC has since focussed on clarifying the detail of specific pathways both within and across divisions, developing the options for clinical support services that could enhance the effectiveness of the revised MOC and re-assessing the workforce requirements.

2.2 Model of Care for Division of Medicine;

All admissions requiring assessment (excluding acute oncology, acute cardiology and stroke) will enter the hospital through an acute medical assessment unit (AMU). The AMU consists of 3 distinct areas:

- Ambulatory Care Unit;
- Medical Assessment Unit; and
- Elderly Assessment Unit.

The reconfiguration of medical wards reflects changes in the bed base and supports the development of specialty specific pathways.

The planned changes in services support the re-provision of the existing high care medical beds on ward 10 and 11 with a view to future expansion of the high care bed base through the 2014-15 Operational Planning Process (OPP). This will enable ward 3 to be fully utilised as step up and step down beds for patients in Gastroenterology, Hepatology and Respiratory pathways in the future.

2.3 Model of Care for Division of Surgery, Head & Neck

The revised model of care improves the patient pathway for elective and emergency patients. There will be clearer differentiation of the pathways with physical layout supporting separate flows of patients through a protected bed base. The development of these clearly defined pathways will ensure both flows of patients are managed and prioritised appropriately to maximise the benefits of the Enhanced Recovery Programme.

The reconfiguration of wards provides co-location of the surgical bed base with theatres, critical care and the SAS facility. 32 bed wards support a different combination of mixed specialties and the development of new ways of working.

2.4 Changes in Assessment Unit provision between the original FBC, Current Practice and the Revised MOC.

FBC Position	Current Practice	Revised MOC
Integrated Assessment Unit (IAU), comprising: **-Assessment Unit, Level 3** - 40 spaces for a combination of beds (20), trollies (10) and chairs (10) - 21 beds allocated to Medicine, 11 to Surgery and 8 to non-med/surg specialities. -Beds and trollies to be open 24/7, chairs 8am-9pm **-Short Stay Ward, Level 4** -30 bed area – allowing 18 beds for Medicine and 12 for Surgery.	**Separate Assessments Units:** • **Medicine – MAU** Ward 17 – 25 beds Open 24/7 • **Surgery – STAU** Ward 2 – 28 bed/chair spaces. Open 24/7	**Separate Assessment Units** (24hrs) with greater integration within each Division. -**Acute Medical Assessment Unit** (AMU) comprising: **1)** Ambulatory Care Unit (ACU) **2)** Medical Assessment Unit (MAU) - 32beds **3)** Elderly Assessment Unit (EAU) – 32 beds -**Surgical & Trauma Assessment Unit** (STAU) – 30 bed/chair spaces. Also benefitting from: 1) Acute trauma direct admission 2) H&N direct access treatment room

2.5 Diagnostic and Therapy Service to support the revised Models of Care

The meetings to agree the model of care held with the Divisions during May 2013 highlighted the need to consider the options for enhanced service provision from Division of Diagnostics and Therapies (D&T), as detailed in the FBC. The assumption for therapy services in the FBC was that there would be step-changes in the workforce in the preceding years prior to the opening of the new ward block and that this would be funded via the Divisional OPP. Adult therapy services put forward a proposal to move to more comprehensive 6-day working in the 2013/14 D&T OPP, but there were no internal funds available to support this.

This was a key stage in developing the workforce model in readiness for 2014/15 and has been added to the divisional risk register. As a 6 or 7 day working model will not be in place in time for the reconfiguration of services, agreement needed to be reached with the Divisions. D&T put forward a menu of options, which allowed the Divisions to develop the service areas that they believe offer the greatest impact on admission avoidance and reduced length of stay.

Further work has now been completed to confirm the requirements to support the revised models of care. For the Division of Medicine it was identified that the following developments would provide the most effective and affordable solution in support of their model of care:

- 6-day assessment and rehab model developed in support of EAU for both Occupational Therapy and Physiotherapy;
- Routine Bank Holiday cover on EAU for both Occupational Therapy and Physiotherapy; and
- 6-day cover model developed in support of South Bristol Community Hospital.

In addition MAU will continue to be supported with 24 hour respiratory physiotherapy cover which forms the majority of workload for therapy services, but will also be able to support the new Saturday service based on EAU if there are relevant patients.

To support the Division of Surgery, Head & Neck the following developments were identified to provide the most effective and affordable solution in support of their model of care:

- 6-day cover developed in T&O for both Occupational Therapy and Physiotherapy;
- Routine Bank Holiday cover on T&O for both Occupational Therapy and Physiotherapy;
- Dietetic Saturday morning service in support of upper GI Enhanced Recovery Pathway; and
- Provide two hours of ultrasonography input into STAU on Saturdays, Sundays and Bank Holidays (split between am and pm).

The required input from D&T presents a cost pressure which is identified within Section 5; Finance. Costs have been mitigated to a large extent by accommodating the changes above through some redesign of existing capacity requirements and through service transformation.

2.6 Comparisons in the support from Diagnostics and Therapies between FBC, current practice and the FBC Refresh

Service	FBC Position	Current Practice	FBC Refresh
Radiology	Ultrasound, CT and MRI provided 7 days, extended hours and with early reporting. 24/7 access to IAU for X-ray and CT scanning and ultrasound via mobile facilities. More in-depth scanning provided by the diagnostics dept 8.30am – 20.30. Access to a consultant radiologist 7 days a week.	Imaging currently provided Mon-Fri 8.30am – 5pm, excluding bank holidays. Set times for STAU U/S only, am. Urgent/EM plain film, CT & MRI available out-of-hours, with U/S prioritised through the on-call radiology registrar.	**Medicine** No enhancements to current service required **Surgery, Head & Neck** Ultrasound to support STAU
Therapies	Senior occupational therapist and physiotherapist cover for 7 days of the week, providing early discharge support to the IAU/SS.	5 day service, with some week-end cover largely to target post-op, respiratory patients and those being discharged early in the following week.	**Medicine** Extend 5 day service to 6 day **Surgery, Head & Neck** No enhancements to current service required
Pharmacy	7 day senior pharmacist cover, 8am – 10pm for IAU	Currently providing Mon-Fri service to MAU 5.5hrs daily, STAU 2hrs.	**Medicine/Surgery, Head & Neck** No enhancements to current service required

3. Capacity Requirements

3.1 Capacity Planning

The required bed base in the original FBC detailed a requirement of 336 inpatient beds at the BRI in 2015/16, making a number of assumptions around population, performance improvement and service transfers.

As the assumptions made in the original FBC were no longer deemed to be accurate a further reconciliation exercise was undertaken which demonstrated a requirement for 376 beds in 2016/17. This change to the future bed requirement was agreed by the Trust Board in July 2013. Further work through various patient flow and efficiency initiatives agreed to a reduced timescale to achieve the projected bed base. This brings forward the realisation of the projected bed base of 376 +14 flex into the 2014-15 year.

Table 3.1 – Overview of changes between original FBC and revised bed provision agreed in July 2013

Service Area	FBC Position	Current Practice	FBC Refresh	Variance	
				Original FBC vs refresh	Current vs FBC refresh
Assessment (includes 8 ED OBS)	27	60	70	+43	+10
Short Stay (includes EAU)	27	20	48	+21	+28
Speciality Wards	282	326	258	-24	-68
Totals	**335**	**406 (+ 9 flex)**	**376 (+ 14 flex)**	**+ 41 (+ 14 flex)**	**-30 (+ 5 flex)**
SHN Total		**154**	**152**		
Medicine Total		**252**	**224**		

In summary, the key changes between FBC and refresh shown in table 3.1 that have been factored into the revised bed modelling are:

- Less population growth than originally anticipated at FBC;
- Change to the methodology for calculating LOS improvements;
- Emergency flow bed reductions are less than originally assumed;
- Vascular services transferring out of BRI;
- CF services transferring into BRI;
- Non-delivery of primary care QIPP schemes to reduce the numbers of admissions;
- Patient flow and efficiency work programmes that bring forward the realisation of the projected bed base into the 2014-15 year.

Cleft services are planned to transfer to the BRI, however any bed impact is yet to be confirmed and is therefore not included within the current bed model.

3.2 Ward Allocation and Bed Numbers

The revised ward allocations were agreed after the revision of the model of care which was submitted to Trust Management Executive in March 2013 and were allocated on the following principles:

- The patient flow must support the ethos of right patient, in the right place, at the right time;
- Starting at the front door, there must be sufficient assessment capacity for both medicine and surgery;

- Enhanced diagnostics are required in the assessment units, e.g. ultrasound, to prevent admission and support discharge;
- Colocation of Divisional wards will allow for effective and efficient patient care;
- Specialties that have complementary requirements to be located together e.g. upper and lower GI;
- The number of patients outlying in wards designated to other specialities must be limited;
- Flexibility in the bed base must be available to accommodate patients in the right place during admission peaks;
- Key enhancements to patient pathways must be allowed for, e.g. the development of short stay elderly care, as part of medical emergency care pathway and the development of an integrated orthogeriatric model within the surgical division on control facilities need to be provided;
- A discharge lounge area situated close to patient transport would enhance the patient flow; and
- Permanent beds are placed in the best quality environment.

Appendix One shows the ward allocations and bed numbers by Division.

4. Workforce Requirements

4.1 Overview

As the MOC and bed requirements have been revised from the original FBC assumptions further workforce planning has been necessary to ensure that the revised services can be fully supported. The changes described in the revised MOC and capacity planning impact on the required bed base and the way in which emergency/non-elective admissions are managed. The review of workforce has therefore focused on ward nursing, ward support staff and medical staff. A review of Facilities Management workforce is currently underway.

4.2 Nursing Workforce

Considerable work has been undertaken by both divisions to agree nurse staffing levels within the context of recent RCN Guidance, the Francis report, changing patient acuity and the new physical environment of the wards. Detailed analysis down to ward level has been completed for the newly configured wards and sign off for the nursing workforce requirements has been received by the Acting Chief Nurse.

The Nurse per Occupied Bed day (NPOB) ratios and the Nurse Budget per bed both demonstrate a small increase from current levels in this refresh.

4.3 Overview of changes in NPOB from original FBC to FBC Refresh

Division	FBC Position	Current practice	FBC refresh	Variance FBC vs refresh	Variance current vs refresh
SHN	1.42	1.39	1.43	+0.01	+0.04
Medicine	1.62	1.59	1.57	-0.05	-0.02
TOTAL		**1.51**	**1.52**		**+0.02**

4.4 Overview of changes in Nurse Budget per Bed original FBC to FBC Refresh

Division	Current practice	FBC refresh	Variance (current to refresh)
SHN	46.18	47.65	+1.47
Medicine	53.02	52.81	-0.21
TOTAL	**50.22**	**50.72**	**+0.50**

4.5 Medical Workforce

There are no material changes to medical workforce for Division of Surgery, Head & Neck.

The medical staffing requirements for Division of Medicine are identified to support the front loading of clinical consultant time to support the unplanned care model, and reflect the step change required from current practice. The Division has defined a workable model for delivering this using existing general and specialty teams and moving to a model of 'specialty take' as an evolutionary step towards an acute physician model in the future. Against a cost range of between £0k-£363k, Trust Management Executive recognise the need to support additional work on this in partnership with the Division as part of their 2014-15 OPP.

4.6 Comparison in workforce between FBC, current practice and the FBC Refresh

Service Area	FBC Position (2011)	Current Practice	FBC Refresh (2013)	Variance	
				Original FBC vs FBC Refresh	Current vs FBC Refresh
Division of Surgery, Head and Neck (all current practice workforce assumptions are based on future bed base and are expressed pro rata)					
Nursing – wte	170.28 (57%RN) for 120 beds	214.27 (60.5% RN) for 152 beds	217.96 (59.1% RN) for 152 beds	+47.68	+3.69
NPOB ratio	1.42	1.39	1.43	+0.01	+0.04
Additional nursing costs					£130,900
Housekeepers and Ward Clerks – wte	12	17.5	17.5	+5.73	+0.03
Additional other ward staff costs					£-23,740
Medical Staffing	N/A	N/A	N/A		
Total SHN additional workforce costs					**£107,160**
Division of Medicine (all current practice workforce assumptions are based on future bed base and are expressed pro rata)					
Nursing – wte	232 (53%RN) for 153 beds	352.16 (60.9% RN) for 224 beds	352.32 (59.9% RN) for 224 beds	+120.32	+0.16
NPOB ratio	1.62	1.59	1.57	-0.05	-0.02
Additional nursing costs					**£59,350**
Housekeepers, Ward Clerks and porters – wte	18	23.71	23.55	+5.55	-0.16
Additional other ward staff costs					£8,820
Sub-total additional nursing and ward staff costs					£68,170
Total additional nursing and ward staff costs (mitigated by band 2 and 3 rostering)					**£34,000**
Division of Diagnostics and Therapies					
Therapies and Radiology cost	N/A	N/A	N/A		£85,000
Total Diagnostics and Therapies additional costs					**£85,000**

The Trust Management Executive recognised the costs of Diagnostics and Therapies (£85k) and nursing (£107k SHN and £34k Medicine) up to £226k, as being necessary and as such have approved them in principle within the absolute scheme maximum of £4.9m, but that the Business Case remains subject to Operating Plan review and approval.

5. Financial Position

5.1 Revenue

The FBC was approved by the Trust Board in April 2011. At 2013/14 prices, the approved net recurring revenue cost is £5.1m on completion of Phase 3 in 2014/15, reducing to £3.6m from 2015/16 onwards on the completion of Phase 4 and the subsequent closure of the BRI Old Building.

The approved FBC's recurring revenue assessment covered the costs of provision of the new Terrell Street building's infrastructure in terms of capital charges, equipment maintenance and facilities management costs. It also included the income and expenditure consequences of the anticipated emergency activity flows from Frenchay Hospital when it closes in 2014. The FBC revenue assessment did not allow for additional workforce costs associated with extended hours of operation nor did the FBC include an assessment of the nursing savings arising from the planned reduction in beds. Both elements were considered separately from the FBC; any proposal to extend operating hours would be subject to the Trust's annual Operating Plan process and nursing workforce savings due to bed reductions were included in Division's prospective savings plans.

The refresh of the forecast net recurring revenue cost and capital requirement of the BRI Redevelopment scheme was reported to the Trust Board in July 2013 as part of the Trust's medium term liquidity review. The financial refresh is summarised in Table 5.1 below:

Table 5.1 Revenue – July 2013 update

	2014/15 Recurring revenue cost £M	2015/16 Recurring revenue cost £M	2016/17 Recurring revenue cost £M	
Net recurring cost	**(5.1)**	**(3.6)**	**(3.6)**	**FBC restated at 2013/14 prices.**
Income	(2.8)	(2.8)	(2.7)	Income reduction driven by forecast non-elective activity volumes falling by two thirds from 1,666 spells to 504 spells.
Pay and non-pay	1.2	1.2	1.2	Impact of reduced non elective activity volumes requiring 11 fewer beds; pay cost reduction of £0.8m mainly nursing. Non pay reduction of £0.4m.
FM	(0.7)	(1.7)	(0.5)	New ward £0.4m, use of CHC and TPCC £0.1m.
Capital charges	0.5	0.0	0.7	£0.5m reduction due to reduced cost of capital from 4.81% to 3.71%.
Total	(1.8)	(3.3)	(1.3)	
Net recurring cost	**(6.9)**	**(6.9)**	**(4.9)**	**FBC refresh (July 2013)**

The Trust Board approved a net recurring increase of £1.3m in the context of the Trust's Long Term Financial Plan. The approval by the Trust Board effectively caps the recurring revenue at a cost of £4.9m for the scheme.

Any further revenue costs arising must be afforded within the Trust's 2014/15 Operating Plan which is framed within the Long Term Financial Plan.

5.2 Capital

Overall, since the approval of the FBC, the additional capital costs arising from cost transfers and scheme parameter changes totals £32.1m compared with the approved FBC of £80.7m. The position is summarised in table 5.2 below:

Table 5.2 Capital

	Capital £m	
FBC	**80.7**	**Approved sum for Phase 3 and Phase 4.**
Cost transfer	5.6	Cost of Helipad £3.4m and HV generators.
Cost transfer	5.7	TSB Level 5 cost for Paediatric services.
Cost transfer	2.7	Updated assessment of Rheumatology relocation £2.2m and cost of Restaurant provision £0.5m.
Parameter	4.3	Cost of 24 bedded ward in TSB and Level 3 changes
Parameter	13.5	Additional work packages.
Other	0.3	Costs associated with the provision of a Well Room.
Total	**32.1**	**Increase compared with FBC.**
Revised FBC	**112.8**	

The capital requirement of the BRI Redevelopment scheme is fully funded in the Trust's Medium Term Capital Programme (MTCP) and capital expenditure for the period to March 2018 remains unchanged at £290.9m in line with the approved MTCP.

5.3 Affordability

The 2014/15 financial outlook is extremely challenging for the Trust. The Trust is currently facing a financial gap of £11.7m for 2014/15. This is primarily due to the National efficiency savings requirement of £15.7m against which the Trust has yet to identify any savings. The affordability of the major strategic schemes has always been predicated upon the Trust delivering its National saving requirement. Given the Trust's current savings programme position, the affordability of each of the Trust's major strategic schemes is now subject to further critical examination with the objective of minimising revenue costs prior to the implementation of each scheme.

In line with the FBC approved in April 2011, the July 2013 revenue forecast included the cost of provision of the new infrastructure and the impact of emergency flows only. Any costs and savings associated with changing the models of care, reducing the bed establishment and workforce requirements are external to the FBC and are part of Division's 2014/15 Operating Plans. Additional workforce costs have been identified through the refresh process and some apportionment of income associated with non-elective activity transfer will offset this in part. Any residual costs will need to be offset either by delivering additional savings or more realistically by proceeding with planned investments in a reduced manner.

Cost pressures are considered in the following ranges: Diagnostics & Therapies (£0k to £85k); nursing (£0k to £141k); and Medical staff (£0k to £363k).

A critical review of the new Terrell Street building infrastructure costs of £8.3m has established opportunities for cost reduction in facilities management and equipment maintenance. Based on this review, the Director of Facilities & Estates has been set a savings challenge of £0.5m but are not as yet agreed.

The recurring cost of capital charges is dependent upon the District Valuer's (DV) assessment of the Trust's estate which is due in January 2014 coupled with a further DV assessment of the new Terrell Street building in 2014 shortly after opening.

5.4 Financial Risk Analysis

The FBC revenue assessment makes a number of assumptions each of which bring a degree of risk. A summary of the key risks, mitigation and risk rating are described in the table below:

Risk	Mitigation	Rating
The revaluation of the Trust's estate by the District Valuer does not impair the capital investment in line with the capital charges assumption.	Detailed discussions are taking place with the District Valuer to ensure the assessment of the TSB value accurately reflects the level of refurbishment and new build works.	Medium
The Trust's assessment of the Emergency Flow from Frenchay Hospital is overstated at 504 spells.	A detailed re-assessment has been undertaken by the Business Planning Team. The FBC approved in April 2011 originally assessed the emergency flows at 1,666 spells, a reduction of 1,162 spells.	Medium

6. Summary

The BRI Redevelopment FBC refresh has ensured that a robust approach has been taken to reviewing the models of care and ensuring workforce plans are in place. The scheme is capped at a forecast revenue cost of £4.6m in 2014/15 and £4.9m recurringly in 2016/17.

Whilst a number of risks to the income and expenditure assumptions have been noted, none of these is assessed as high risk at this time. The risks will be kept under review at the BRI Redevelopment Operational Delivery Group and Project Board.

Appendix One; Ward Allocation and Bed Numbers

FBC Position Speciality	Beds 10/11	Ward	Beds 14/15	Revised Solution Speciality
GI + Hepatology	26	2	20	GI + Hepatology
		3	14	High Care & Step Down
Respiratory	24	4	20	Respiratory
Care of the Elderly	27	10	27	Care of the Elderly
Stroke + Care of the Elderly	20	17	25	Acute Stroke Unit
Respiratory and CF	24	54	24	Care of the Elderly
	8	ED Obs	8	Observation Ward in ED
Care of the Elderly & Endocrinology + cohort	32	N2		
		N3	24	GI + CF + Cohort
IAU	21	AU - L3	32	MAU
Short Stay	18	SS - L4	30	Elderly Admission and Short Stay
Discharge Lounge		W 18	14	Flex
UGI & Colorectal	40	5a	22	T & O
		5b	18	T & O
Thoracic	18	6	18	GS - non-elective SS
T&O	30	14	30	STAU
Head & Neck	32	N1	32	Thoracic/H+N
	0	N2	32	UGI/LGI
IAU	11	AU - L3	0	
Short Stay	12	SS - L4	0	
Cardiology split	-8			
	335	Total Bed Base	376	
		Difference in bed base - revised solution compared to FBC	41	
		Total Beds in Q1	390	
		Difference revised solution compared to FBC in Q1	55	

Current Position Speciality	Beds Jul-13	Ward	Beds 15/16	Revised Solution Speciality
Flex	14	20		
Flex	16	21		
Care of the Elderly	21	23		
GI + cohort	21	26		
GM	19	7		
Hepatology	22	11		
Short Stay	19	15		
Stroke + Care of the Elderly	19	12		
Respiratory	27	10	27	Care of the Elderly
Acute Care of the Elderly	17	4	20	Respiratory
MAU	25	17	25	Acute Stroke Unit
		2	20	GI + Hepatology
		3	14	High care & Step Down
Respiratory and CF	24	54	24	Care of the Elderly
	8	ED Obs	8	Observation Ward in the ED
Total Medicine	**252**	IMAU -L 3	32	MAU
		Short Stay - L4	30	Elderly Admissions and Short Stay
		N3	24	Gi + CF + Cohort
		W 18	14	Flex
Vascular	21	9		
STAU	28	2		
UGI	22	5a	22	T & O
Head and Neck	18	5b	18	T & O
Thoracic	18	6	18	GS - non-elective SS
Colorectal	17	18		
T&O	30	14	30	STAU
		N1	32	Head & Neck and Thoracic
Total SH&N	**154**	N2	32	UGI and LGI
	406	Total Bed Base	376	
		Difference - Revised Solution compared to Current Position	-30	
(Includes 9 flex)	415	Total Beds in Q1	390	(Includes 14 flex)
		Difference revised solution compared to Current Position in Q1	-25	

University Hospitals Bristol NHS
NHS Foundation Trust

Cover Sheet for a Report for a Public Trust Board Meeting, to be held on 30 January 2014 at 10:30 in the Conference Room, Trust Headquarters, Marlborough Street, Bristol, BS1 3NU

17. Response to Report of Handling Complaints by NHS Hospitals in England by Ann Clwyd MP and Professor Tricia Hart

Purpose

The purpose of this report is to enable the Board to review the findings of Ann Clwyd and Tricia Hart's report, *Putting patients back in the picture* (a review of the NHS complaints system commissioned by the Prime Minister and Secretary of State for Health in response to the Francis Report into failings at Mid Staffordshire NHS Foundation Trust) and to consider the Trust's response to these findings.

Abstract

The recommendations of the Clwyd-Hart review are presented here alongside recommendations about complaints management contained in the Francis Report itself and recommendations published separately by the Parliamentary and Health Service Ombudsman (in *Designing good together*) arising from research which contributed to the Clwyd-Hart review. These recommendations overlap in many areas and have therefore been presented in summary form.

The Trust's responses to the various recommendations have been categorised as follows:

- Things we are confident that we already do;
- Things we are already planning to do;
- Things we need to add to our plans; and
- Things which would be challenging and/or impractical to implement

Following the Board's review, Trust's complaints work plan will be updated to reflect any agreed actions. Implementation of these actions will be monitored via the Patient Experience Group.

This report has previously been discussed by the following groups:

- Patient Experience Group (21/11/13)
- Governors' Quality Project Focus Group (07/1/14)
- Senior Leadership Team (15/1/14)
- Quality and Outcomes Committee (28/1/14)

Recommendations

The Trust Board is recommended to receive this report by the Chief Nurse for review.

Report Sponsor

Chief Nurse

Appendices

Trust response to the Clwyd-Hart Report

Subject: **Trust response to the Clwyd-Hart Report**

Report to: **Quality and Outcomes Committee / Trust Board**

Author: **Chris Swonnell, Head of Quality (Patient Experience and Clinical Effectiveness)**

Date: **17th January 2014**

1. Introduction

This report provides a draft response to recommendations about NHS complaints management contained in:

- The Francis Report
- The Clwyd-Hart Report (which was commissioned by the Government in response to the Francis recommendations)
- The Parliamentary and Health Service Ombudsman's report *Designing good together* (which contains recommendations from research which contributed to the Clwyd-Hart report)

The report includes a number of proposed actions which, once agreed, will be incorporated into the Trust's existing complaints work plan.

2. The Clwyd-Hart Report

On 28th October 2013, the Government published *Putting patients back in the picture*, containing the conclusions of a review of the NHS complaints system, commissioned by the Prime Minister and Secretary of State for Health, and co-chaired by the Rt. Hon Ann Clwyd MP for the Cynon Valley and Professor Tricia Hart, Chief Executive, South Tees Hospitals NHS Foundation Trust. This report ('the Clwyd-Hart Report') looks at how complaints about care in NHS hospitals made by patients, their carers and representatives are listened to and acted on by hospitals.

It should be noted that whilst most of the review's recommendations focus on improving the complaints system, some also relate to the delivery of care and to whistleblowing. This response document, prepared initially for the Patient Experience Group, concentrates on implications for complaints management, however the wider recommendations may merit discussions in other forums – these recommendations are highlighted at the end of this report.

The Clwyd-Hart review was commissioned in the wake of widely-publicised failings at Mid Staffordshire NHS Foundation Trust. As the authors points out, most of their recommendations cover very familiar territory: the report cites a series of other reviews dating back as far as the Wilson Report, *Being Heard* (1994), which have highlighted the shortcomings of complaints management in the NHS. The conclusion is clear: the NHS has not learned sufficiently from the past.

The principles of effective NHS complaints management have long been understood:

- make sure that people know how to make a complaint
- welcome complaints as opportunities to learn and improve
- give people confidence that they won't be discriminated against them if they complain
- ensure that people who want to complain get the support they need
- take time to understand what the issue is and what the complainant wants
- respond honestly, openly, empathetically, fully and in a timely manner
- implement changes and share learning so that mistakes are not repeated

It should be noted that whilst the Clwyd-Hart Report is focussed squarely on NHS complaints management, its recommendations also go beyond this to address some of the reasons why people feel the need to complain. It is imperative that staff are trained, approachable and show respect and empathy to patients; and that patients are helped to understand their care and have access to an appropriate range of information and support on the ward. The Trust actively monitors these aspects of patient care, and many others, through its robust patient survey programme.

3. Summary of recommendations for management of complaints in the Clwyd-Hart Report, the Francis Report and *Designing good together* (Parliamentary and Health Service Ombudsman)

In September 2013, the Trust Board received and approved the Trust's Annual Complaints Report for 2012/13, which included a work plan for improving our complaints management: this work plan incorporated learning from a series of previous publications from the Parliamentary and Health Service Ombudsman and the Patients Association.

Since then, in August 2013, the Parliamentary and Health Service Ombudsman has published *Designing good together: transforming hospital complaint handling.* On 28th October 2013, the Government published the Clwyd-Hart Report, which incorporates learning from the Parliamentary and Health Service Ombudsman's research. And our own Trust Board agreed a formal response to the detailed Francis recommendations in November 2013.

The recommendations from Francis, Clwyd-Hart and the Parliamentary and Health Service Ombudsman duplicate and overlap in many areas. Section 2 of this report therefore attempts to bring all of the relevant recommendations together in one place. These recommendations have been categorised as follows:

- Things we already do, and do well
- Things which are already part of our work plan
- Things which need to be added to the work plan
- Things which would be challenging and/or impractical to implement within available resources

Recommendations from Francis are coded 'F';
Parliamentary and Health Service Ombudsman recommendations are coded 'PHSO';
Clwyd-Hart recommendations are coded 'CH'.
In some instances, recommendations have been paraphrased for sake of brevity.

a) Recommendations which we are confident that we currently meet:

Recommendation	Comment
1. All complainants should receive a personalised acknowledgement of their complaint (PHSO).	This happens.
2. Complainants should be assigned a single point of contact who takes time to understand what the complainant wants to achieve through the complaint (PHSO).	This happens – a caseworker is assigned to each formal complaint.
3. Everyone who makes a formal complaint should be offered a face-to-meeting (PHSO).	This happens.
4. Informal concerns should be investigated with the same rigour as formal complaints (F).	This happens.
5. Comments or complaints which describe events amounting to an adverse or serious incident should trigger an investigation (F).	All complaints are risk assessed by the Patient Support and Complaints Team, who will liaise with the Patient Safety Team if complaints indicate an incident.
6. Where complaints span more than one organisation, they need to co-operate (CH).	This happens.
7. Complainants should receive a personalised apology, delivered in a manner of their choosing (PHSO).	This happens.
8. The final response should include what lessons have been learnt and what steps will be taken by the trust (PHSO).	This happens[1].
9. Narrative from complaints is just as important as numbers (F).	Our Board receives a detailed patient story each month, which is usually based on learning from a complaint. Narrative comments from our monthly patient surveys are coded to highlight suggestions and concerns, and are reviewed by Divisions.
10. Information about complaints should be shared with commissioners (F).	Our Clinical Commissioning Group receives full details of six complaints each quarter (complaints letters, responses, action plans).
11. CEO should personally sign off complaints letters (CH).	All complaints response letters carry the signature of the Chief Executive. Draft complaints responses are reviewed and approved by a rota of Executive Directors which includes the Chief Executive.

[1] Although we recognise that there is always scope to improve the quality of our complaints responses

b) Recommendations which are addressed in our existing complaints work plan:

Recommendation	Comment
12. Advocacy and advice should be available to people who want to complaint (F); Patients and carers should know who to go to with their questions or concerns (PHSO); Patients and carers should have an intermediate contact with whom they can discuss a concern before making a formal complaint (PHSO).	Advice and support are provided by the Patient Support and Complaints Team; external advocacy is provided by 'SEAP'[2] (formerly the Independent Complaints Advocacy Service). Since the abolition of the Independent Complaints Advocacy Service, access to independent advocacy is now potentially confusing for members of the public: each local authority makes its own arrangements for how advocacy will be provided (we are currently trying to gather information about provision within BNSSG). However, we recognise that we need to improve how we sign people to the Patient Support and Complaints Team and this is part of our existing work plan. The Patient Support and Complaints Team's move to the Bristol Royal Infirmary Welcome Centre (December 2013) forms part of this.
13. Providers should "constantly promote" to the public their desire to receive and learn from complaints; and "constant encouragement" should be given to people to share their views (F); Trusts should provide simple ways for people to give feedback in hospital, including pen and paper at bedside (CH); Trusts should encourage positive and negative feedback (CH); Patients and carers should be made to feel confident about providing feedback, and hospitals should actively seek this (PHSO).	There are many ways that we encourage people to give us feedback, including the use of comments cards and Friends and Family Test cards. Actions in our existing work plan relating to reviews of signage, patient information and web-based information about complaints all support this recommendation. Separate to the complaints work plan, we are conscious that comments cards have been withdrawn from some wards (e.g. Division of Medicine) in order to focus on the Friends and Family Test: all Divisions have been asked to reintroduce comments cards in January 2014.
14. There should be "multiple gateways" for people to make complaints, and we should develop a greater willingness to communicate with relatives via email (F); Patients and carers need to be told how to access the formal complaints process (PHSO); PALS/Complaints needs to be clearly sign-posted (CH).	We encourage people to try to resolve concerns face-to-face with staff. If people need/want to contact the Patient Support and Complaints Team, they can do this in person, by phone and by email. We will also be introducing a new complaints form as a tear-off within the 'How to make a complaint' leaflet, as a further way of contacting us (part of existing work plan).
15. Staff should receive complaints system training, including how to log issues raised (PHSO); Staff need complaints training (CH).	A review of complaints training forms part of our existing work plan. In addition, we are developing a new form on the Ulysses Safeguard system to enable divisional staff to quickly log informal complaints. Terms of reference have been agreed for a joint project with the Patients Association, focussing on the quality of our complaints responses, commencing in Q4 2013/14. Work with Director of Medical Education to develop and enhance complaints training within junior doctors' education programme.

[2] SEAP stands for "Support, Empower, Advocate, Promote"

Recommendation	Comment
16. Complainants should be able to agree the nature of their complaint and desired outcomes with complaints staff (PHSO); The precise questions to be answered should be agreed by the complainant (PHSO); The response should address the initial complaint directly and accurately (PHSO); We need to record complaints and how we are responding – and make sure that this meets the complainant's expectations (CH).	We have an existing plan to introduce a system where we ask complainants to state three things that they want to achieve by making a complaint. This is based on learning from Cambridge University Hospitals (Addenbrooke's): we hope this will help us to tailor our responses to the complainant's needs and reduce the number of complainants who say that they are unhappy with our response.
17. PALS should be adequately resourced (CH).	We have recently benchmarked our Patient Support and Complaints Team staffing against PALS and complaints staffing in other trusts. As a result of this review an additional full-time Band 5 caseworker has been appointed (commencing March 2014), returning the team to its full staffing complement[3]. The Trust's PALS/complaints resources is nonetheless small compared to benchmarked peers: the resilience of our team is therefore critical.

c) Recommendations which require further consideration or action:

Recommendation	Comment	Proposed action
18. Litigation should not be a barrier to complaining (F).	The Trust's Complaints Policy currently states that complaints can be processed up until the point when legal action is commenced.	Following discussion at Senior Leadership Team and based upon advice from the Trust's legal team, this wording will be amended to make it clear that the complaints process does not need to stop when a request for copy medical records is received. NHS Litigation Authority guidance states clearly that "saying sorry is not an admission of legal liability; it is the right thing to do" and that "it is important not to delay giving a meaningful apology for any reason, including where there is a claim".[4]

[3] The effect of a series of changes within the Patient Support and Complaints Team is that a previously vacant Band 6 post (held vacant during 2013) will now be replaced with equivalent Band 5 caseworker support, generating a net increase in total hours.

[4] NHSLA – *Saying Sorry*, 2013

Recommendation	Comment	Proposed action
19. If a complaint amounts to a serious incident, an arms-length investigation of the complaint is warranted. Similarly, if a complaint highlights professional misconduct or issues about the performance of senior managers (F); We should offer independent (external) investigation if a complaint relates to a serious incident (CH).	This happens only occasionally, usually relying on the good will of another trust. There are no pre-set trigger points.	Review current practice within context of overall serious incident process. Heads of Quality to review.
20. Complainants should be involved in the changes that take place as a result of their complaint (PHSO).	We do not routinely ask complainants whether they want to be kept informed about any action being taken as a result of their complaint. This needs to be introduced.	Introduce as standard practice with effect from February 2014.
21. Best practice is shared across trusts (PHSO).	A local network of complaints managers could help to facilitate this.	For consideration by Patient Support and Complaints Manager as a longer-term developmental activity.
22. Trained volunteers may have a role to support people who want to make a complaint (CH).	There is a degree of ambiguity in the wording of the Clwyd-Hart Report (p33) about the kind of support the authors envisage from volunteers. The Trust does not currently have any plans to recruit volunteers to roles which focus exclusively on complaints support, however we agree that volunteers should be trained so that they are aware of the different ways that patients are able to give feedback or raise concerns, so that they can support patients, where appropriate, in the course of their core volunteer duties (e.g. befriending, meal-time support, etc).	Include in volunteer recruitment and induction from February 2014.

Recommendation	Comment	Proposed action
23. Board-led scrutiny of complaints should include "action taken" in response to complaints (CH); Board-level scrutiny of complaints should "regularly involve lay representatives" (CH).	The Board receives a monthly story about action taken in response to a particular complaint, however this story is not currently presented by the complainant. Actions are also summarised in the Annual Complaints Report. It would not be practical for the Board to receive details of actions in response to every complaint we receive, however we need to find a suitable way of providing the Board with more information about complaints themes and actions, in addition to the current data about complaints volumes and performance.	Chief Nurse and Head of Quality (Patient Experience and Clinical Effectiveness) to conduct initial review of current complaints reporting to Board, and produce recommendations for consideration by Executive Directors and the Quality and Outcomes Committee. In response to the best practice examples cited in the Clwyd-Hart Report: rather than create a dedicated Board sub-group to review complaints, there may be scope to incorporate this scrutiny within the role of the Quality and Outcomes Committee (note: detailed quarterly complaints reports are currently reviewed by the Patient Experience Group and Senior Leadership Team, but not by the Quality and Outcomes Committee or Board). Chief Nurse to discuss with the chair of the Quality and Outcomes Committee.
24. We have a duty to offer complainants a conversation at the start of the complaints process (CH).	Patient Support and Complaints Team capacity issues mean that this has not always been possible. It should be noted that it is not always possible to contact complainants by telephone; our acknowledgement letters also make it clear to complainants that they can contact us if they would like to have a conversation prior to the investigation of their concerns.	Patient Support and Complaints Team staffing capacity will be strengthened by the appointment of a new caseworker, commencing March 2014.
25. Publish annual complaints report in plain English (CH).	We produce an Annual Complaints Report, however this is not necessarily geared to a public audience.	For 2013/14, we will seek input from local Healthwatch to ensure readability and relevance to a public audience.

Recommendation	Comment	Proposed action
26. Patients, patient representatives and local communities and local Healthwatch should be "fully involved" in the development and monitoring of complaints systems in all hospitals (CH).	Local Healthwatch is represented at the Trust's Patient Experience Group.	A first step will be to engage with local Healthwatch (via the Patient Experience Group) about their views and understanding regarding this recommendation. Also see recommendation 25, above.

d) Recommendations which would be challenging to implement and/or may not be practical

Recommendation	Comment	Proposed action (if indicated)
27. A summary of each upheld complaint should be published on the Trust's web site (F).	This recommendation would require an unrealistic level of investment to support the task of anonymising and publishing approximately 100 complaints every month. We are, however, committed to being more transparent about the complaints we received. The Board receives a monthly patient story (see comments above), and we publish monthly complaints performance data in the public domain. We also publish an Annual Complaints Report which describes themes and learning.	We will publish our quarterly complaints reports in the public domain – implement by end of February 2014. See also recommendation 23 regarding review of Board-level reporting. Explore potential for publishing details of randomly selected complaints which are already shared with our Clinical Commissioning Group as part of their monitoring function. Seek advice from Patients Association as part of project described in recommendation 15.
28. "Facilities" should be made available to independent advocates and their clients (F).	We will always work with SEAP to try to meet whatever requirements they may have, however we are not in a position to offer a dedicated on-site facility.	No additional action planned.
29. PALS should operate 24 hours a day, 7 days week (PHSO).	This recommendation would require an unrealistic level of investment. However, people are able to email or leave phone messages with our Patient Support and Complaints Team at any time of the day or night. The Trust's Clinical Site Management Team is also available out-of-hours as a point of contact for urgent concerns.	Patient Support and Complaints Team Manager to confirm with Clinical Site Management Team.

Recommendation	Comment	Proposed action (if indicated)
30. Complainants should be kept up to date with their case – with clarity on what is happening and why at every stage (PHSO).	This should be by exception only, in circumstances where there has been a delay in the complaints process. At the start of the complaints process, we will always agree with the complainant what their concerns are, what they want to achieve, whether they would like a face-to-face meeting, how long we will take to complete an investigation, and how we will contact them with our findings. If this has been agreed and both parties are clear about expectations, it is difficult to envisage the benefit of an interim conversation – this would add an additional stage to the complaints process and would, like-as-not, frustrate the complainant.	No additional action planned.
31. All staff should receive training on writing statements and responding to formal complaints (PHSO).	Staff who are regularly involved in complaints resolution should receive training (see recommendation 16). It would not be realistic or desirable for training to be given to "all" staff (if this recommendation is read literally). However, all new staff receive key messages about handling complaints as part of staff induction.	No additional action planned.
32. Face-to-face meetings should be offered, at a place of the complainant's choosing, and with plenty of time to talk through the response in detail (PHSO).	Unfortunately, it is not always practicable to offer to meet at a place of the complainant's own choosing. However, we will always seek to make reasonable adjustments.	No additional action planned.
33. Complaints functions should remain separate from "patient services" (implicitly, PALS), so that patients do not feel they have to go through PALS first before they make a complaint (CH).	Like many trusts, we now operate an integrated service covering PALS and complaints functions (the Patient Support and Complaints Team), positioned appropriately at 'arms-length' from clinical services, albeit part of the same organisation (the Clwyd-Hart Report expresses concerns about potential conflicts of interest). Patients have direct access to the formal complaints process if this is the way they would like us to deal with their concerns; PALS is not a hurdle to negotiate.	No additional action planned.

4. Concluding remarks

Earlier drafts of this report have been discussed by the Patient Experience Group and the Governors' Quality Project Focus Group. The Senior Leadership Team's support is now sought in respect of the management response to the various recommendations listed in this report, and the proposed actions which will, if agreed, be incorporated into the Trust's complaints work plan.

Staff throughout the organisation give considerable time and energy to investigating and addressing the cause of complaints; and we are getting better at responding to complainants openly, transparently and with empathy. However, there is always scope to do things better – and we know we must. The recommendations described in this report provide a strong platform to improve the way we manage the complaints process, but if we focus only on the functional aspects of complaints management, we will at least partly miss what Robert Francis, Ann Clwyd, Tricia Hart and the PHSO are telling us: which is that effective complaints management is borne out of an organisational culture that puts patients first and receives complaints and concerns not as threats or unwanted distractions, but as opportunities to put things right and to learn for the future.

University Hospitals Bristol NHS
NHS Foundation Trust

Cover Sheet for a Report for a Public Trust Board Meeting, to be held on 30 January 2014 at 10:30 in the Conference Room, Trust Headquarters, Marlborough Street, Bristol, BS1 3NU

19. Corporate Risk Register

Purpose

The Corporate Risk Register contains risks identified as having a potential impact on corporate objectives, including risks identified in and escalated from divisions.

Escalated risks from divisions may be reassessed against corporate objectives.

Risks are formally approved for inclusion on and removal from the Corporate Risk Register by the Senior Leadership Team

Abstract

The Corporate Risk Register is provided in a new layout to aid readability.

New Corporate Risks:

- 08/01/2014 Risk Number 2344 – Achievement of Strategic Objectives

Risks De-escalated to Divisions

- Risk Number 766 (Medicine) - Delays in transfer of patients to Community Services
- Risk Number 1705 (Trust Services) - Risk of Harm to Patients from Falling.
- Risk Number 2228 (Trust Services) - Patients on Hold

Risks Closed

- None

Recommendations

The Trust Board is recommended to receive this report by the Chief Executive for review

Report Sponsor

Chief Executive

Appendices

Corporate Risk Register

Corporate Risk Register 23/01/2014

Number	Risk Title	Executive Lead	Risk Rating
741	Cash Releasing Efficiency Savings (CRES) Schemes	Chief Operating Officer - James Rimmer	Very High (Red)
1383	Failure to Reduce the Incidence of Health-Care Acquired Infection	Chief Nurse - Helen Morgan	Very High (Red)
1412	Failure to meet Cancer Targets	Chief Operating Officer - James Rimmer	Very High (Red)
1422	Compliance of the ED with Monitor's 4-hour Wait Clinical Indicator.	Chief Operating Officer - James Rimmer	Very High (Red)
1704	Corridor Queue Outside The Emergency Department	Chief Operating Officer - James Rimmer	Very High (Red)
1977	Lack of Capacity on NICU	Chief Operating Officer - James Rimmer	Very High (Red)
2344	Achievement of Strategic Objectives	Director Of Strategic Development - Deborah Lee	Very High (Red)

Corporate Risk Register Report

Risk Number: 741 **Status:** Action Required **Risk Title:** Cash Releasing Efficiency Savings (CRES) Schemes

Domain	Monitoring Group	Risk Assessor	Risk Owner	Executive Lead	Assessment Date	Next Review Due:	Current Risk Rating	Target Risk Rating
Financial	Programme Steering Group	Dean Bodill	James Rimmer	Chief Operating Officer - James Rimmer	25/06/2012	10/04/2014	16 Very High (Red)	0

BAF Reference and details of strategic objective:

10.3 - Deliver the annual Cash Releasing Efficiency Savings (CRES) programme in line with the LTFP requirements

Risk Description	Details of Control or Assurance	Effectiveness
Risk of Plans under achieving and impacting on trust annual and planned outturn. Savings are not identified, are duplicated or double counted, slippage in delivery, activity growth consumes benefit, in year costs pressure or competing priorities eliminate gains.	Monthly Divisional CRES reviews, Monthly Divisional Performance reviews , Quarterly reviews, Monthly review by CRES Programme Steering Group, monthly updated at a glance reports	High
	Benefits tracking systems - all schemes are tracked based on actual savings to specific budget line and this is monthly reviewed and end of year forecast risk assessed	High
This risk is also reflected in divisional risks 1912, 1420 and 1021 .	Divisional control of vacancies and procurement monitored at monthly performance meetings. Those Divisions who have challenges meeting the target are given additional external and internal support to assist in managing the recovery.	Medium
	Regular Reporting to the Finance Committee and Trust Board	High

Risk Number: 1383 **Status:** Action Required **Risk Title:** Failure to Reduce the Incidence of Health-Care Acquired Infection

Domain	Monitoring Group	Risk Assessor	Risk Owner	Executive Lead	Assessment Date	Next Review Due:	Current Risk Rating	Target Risk Rating
Patient Safety	Clinical Quality Group	Joanna M Davies	Helen Morgan	Chief Nurse - Helen Morgan	03/01/2013	23/12/2013	15 Very High (Red)	2 Low (Green)

BAF Reference and details of strategic objective:

11.4 - Maintain a "Green" Monitor Governance Risk Rating and meet all mandated and contractual performance targets.

Risk Description	Details of Control or Assurance	Effectiveness
Specifically Clostridium Difficile and MRSA.	Weekly meetings to review actions against outturn. Guidance on priortisation for isolation.	High
	Increase in single rooms across the Trust as part of the BRI redevelopment from 11% to 33%	High
MRSA exceeded 2012/13 target by 5 cases at the end of November 2012 and the Monitor deminmus target of 6 cases for the year is now irrecoverable. This will impact adversely on the Trust's governance risk rating under Monitor's Compliance Framework.	Matron and ward monitoring for C diff dashboard monthly	High
	Saving lives/High Impact Intervention programme to reduce bacteraemias with audit of practice monthly	High
	Admission risk assessment form	High
Trust over achieved Clostridium Difficile target. MRSA target not achieved. ten cases attributed to Trust. MRSA recovery plan insitu and on going.	Policies in place for MRSA and C diff prevention and management and antibiotic prescribing	Medium

Corporate Risk Register Report

Risk Number: 1383 **Status:** Action Required **Risk Title:** Failure to Reduce the Incidence of Health-Care Acquired Infection

Domain	Monitoring Group	Risk Assessor	Risk Owner	Executive Lead	Assessment Date	Next Review Due:	Current Risk Rating	Target Risk Rating
Patient Safety	Clinical Quality Group	Joanna M Davies	Helen Morgan	Chief Nurse - Helen Morgan	03/01/2013	23/12/2013	15 Very High (Red)	2 Low (Green)

BAF Reference and details of strategic objective:

11.4 - Maintain a "Green" Monitor Governance Risk Rating and meet all mandated and contractual performance targets.

Risk Description

Specifically Clostridium Difficile and MRSA.

MRSA exceeded 2012/13 target by 5 cases at the end of November 2012 and the Monitor deminmus target of 6 cases for the year is now irrecoverable. This will impact adversely on the Trust's governance risk rating under Monitor's Compliance Framework.

Trust over achieved Clostridium Difficile target. MRSA target not achieved. ten cases attributed to Trust. MRSA recovery plan insitu and on going.
C diff action plan in place to reduce c diff, antibiotic protocols for c diff being reviewed.

Cleaning standards to be monitored using ATP machine for assurance.

Details of Control or Assurance	Effectiveness
Weekly meetings to review actions against outturn. Guidance on priortisation for isolation.	High
Increase in single rooms across the Trust as part of the BRI redevelopment from 11% to 33%	High
Matron and ward monitoring for C diff dashboard monthly	High
Saving lives/High Impact Intervention programme to reduce bacteraemias with audit of practice monthly	High
Admission risk assessment form	High
Policies in place for MRSA and C diff prevention and management and antibiotic prescribing	Medium
Infection Control Group monitor progress quarterly	High
Trust Board monitor C diff and MRSA performance monthly	High
Infection control induction and update training with compliance over 90%	High
Use of identification by alert on clinical information systems	Medium
Infection Control delivery programme developed and implemented annually	Medium
Infection control team in place together with DIPC and deputy DIPC.	Medium
Daily review of clostridium difficile numbers and movement of patients.	High
Review of performance against plan at Service Delivery Group.	High
Action plan delivery monitored and developed at the Trust Infection Control Group.	High
MRSA elective screening in place to meet national expectations.	High
MRSA emergency screening implemented.	High
Trust reporting and specimen testing to National guidance for c diff.	High

Action Plan for Risk: 1383 **Action Number:** 3 **Responsibility Of:** Joanna M Davies **Target date:** 31/03/2014

C. Difficile recovery plan developed.

Corporate Risk Register Report

Risk Number: 1412 **Status:** Action Required **Risk Title:** Failure to meet Cancer Targets

Domain	Monitoring Group	Risk Assessor	Risk Owner	Executive Lead	Assessment Date	Next Review Due:	Current Risk Rating	Target Risk Rating
Quality	Cancer Board	Hannah Marder	James Rimmer	Chief Operating Officer - James Rimmer	15/04/2013	10/02/2014	16 Very High (Red)	4 Moderate (Yellow)

BAF Reference and details of strategic objective:

11.4 - Maintain a "Green" Monitor Governance Risk Rating and meet all mandated and contractual performance targets.

Risk Description	Details of Control or Assurance	Effectiveness
Failure to meet Cancer Targets, specifically 2-week, 31-day and 62-day target.	Weekly meetings held with all Divisions to review cancer patient tracking. Performance reviewed every two weeks at the Service Delivery Group and at the Trust Management Executive via SDG. Performance reported to Cancer Board at every meeting.	High
	Choose and book - implemeted for 14 day breast and seen performance improve to 98%. needs to be sustained at this level or better	Medium
	Additional ITU capacity - identified as cause of several key 62 day cancellations and addressed through additional capital investment in 2010 on interim basis and 2011 on semi permanent basis	Medium

Action Plan for Risk: 1412 **Action Number:** 3 **Responsibility Of:** Various **Target date:** 31/03/2014

Use of ongoing cancer performance target action plan to manage specific actions to improve performance e.g. pathway redesign. Actions identified via monthly breach reviews and weekly PTLs. Action plan updated fortnightly and reviewed by Service Delivery Group.

Action Plan for Risk: 1412 **Action Number:** 4 **Responsibility Of:** Xanthe **Target date:** 31/03/2014

Ongoing close patient level management of cancer PTL, including a weekly cross-divisional review meeting

Risk Number: 1422 ***Status:*** Action Required ***Risk Title:*** Compliance of the ED with Monitor's 4-hour Wait Clinical Indicator.

Domain	*Monitoring Group*	*Risk Assessor*	*Risk Owner*	*Executive Lead*	*Assessment Date*	*Next Review Due:*	*Current Risk Rating*	*Target Risk Rating*
Statutory	Service Delivery Group	Christopher Davies	James Rimmer	Chief Operating Officer - James Rimmer	22/06/2012	02/04/2014	16 Very High (Red)	8 High (Amber)

BAF Reference and details of strategic objective:

11.4 - Maintain a "Green" Monitor Governance Risk Rating and meet all mandated and contractual performance targets.

Risk Description	*Details of Control or Assurance*	*Effectiveness*
Failure to meet the 5 core ED clinical indicators results in non-compliance with Monitor and this will incur significant financial penalty to the Trust. 95th Percentile achievement of the 4 hour arrival to disposal standard. Initial assessment to be completed within 15 minutes of arrival for ambulance patients. Time to treatment - 60 minute median for all ED patients arrival to start of treatment. Number of patients who did not wait to be seen. Number of patients who return to the ED for the same complaint. Suboptimal patient experience and non-compliance with Monitor requirements if patients wait longer than 4 hours in the Emergency Department. Failure of clinical indicator incurring financial penalty. Trustwide non-compliance.	Clinical Site Management Team ED electronic tracking board located in ED, MAU, CSM team offices, STAU and on Connect. ED staffing structure to support compliance with the standard, validation processes for all 4 hour breaches, additional portering staff to assist with transfers and admissions, 2 daily patient flow meetings, data analysis and bank holiday planning.	Medium
	Daily validation process and review of performance	Complete
	Feedback to clinical staff each time a breach occurs	Complete
	Review of performance on a weekly basis. There was a short term dip in performance due to validation issues in response to the new IT Medway system. This has now been rectified.	Complete
	Review of resources and equipment in order to achieve this indicator (medical and nursing).	Complete
	Emergency Access Steering Group in place	Medium
	Daily Leadership in Flow meetings in place	High
	Additional discharge coordinators in place	Medium
	Closer working with social services.	Medium
	Attendance and daily ward rounds being monitored.	Medium
	The trust has plans to move more patients in to extra capacity being provided in the community. Both the trust and division are working on plans to reduce LOS which will improve flow and occupancy.	High

Action Plan for Risk: 1422 ***Action Number:*** 9 ***Responsibility Of:*** ***Target date:*** 13/05/2014

Continuation of the flow project work with exsisting and new projects

Action Plan for Risk: 1422 ***Action Number:*** 10 ***Responsibility Of:*** ***Target date:*** 31/03/2014

Out of Hospital capacity being provided by community.

Corporate Risk Register Report

Risk Number: 1704 **Status:** Action Required **Risk Title:** Corridor Queue Outside The Emergency Department

Domain	Monitoring Group	Risk Assessor	Risk Owner	Executive Lead	Assessment Date	Next Review Due:	Current Risk Rating	Target Risk Rating
Patient Safety	Trust Management Executive	Bernadette Greenan	Peter Collins	Chief Operating Officer - James Rimmer	10/01/2012	02/04/2014	20 Very High (Red)	9 High (Amber)

BAF Reference and details of strategic objective:

3.3 - To be recognised by our patients and their families for the consistently high quality of the care they receive whilst in our care

Risk Description	*Details of Control or Assurance*	*Effectiveness*
At regular intervals patients on ambulance trolleys are queuing in the corridor outside of the E.D due to department at full capacity. Condition of these patients is not known and there is a risk of patient deterioration and/or collapse. Patients can wait up to two hours without assessment, treatment or care. The frequency of ambulance conveyances is variable and not always within the receiving Trusts control. There is a lack of availability of oxygen, suction, of privacy and dignity Patient experience is also compromised from being unwell in public area, and having to discuss confidential information in a public thoroughfare. Patient may not have basic needs met and may be at an increased risk of developing pressure damage. Breeches, late bed requests, inadequate prioritising, Longer treatment period required, Additional treatment required, Patient suffers for longer than is necessary. Delay to ambulance crew.	Allocation of emergency department (ED) nurse to corridor patients to triage and priortise admission to ED as space becomes available. Assistant nurse who completes vital signs and a pain score within 15 minutes of all ambulance arrivals	Medium
	Formal escalation policy for ED when pressure rises. Try to restrict number of patients queuing to 3 by triggering internal escalation plans. Automatic 999 rerouting, using Great Western Ambulance Service and capacity management system (CMS) is intended to mitigate this risk over time. Go live was 6th December 2011 and effectiveness of this remains uncertain.	Medium
	Supplementary oxygen from portable cylinders	Medium
	Portable suction from ambulances or from ED resuscitation room	
	If possible keep cubicle space free in Ed to use as rolling cubicle for toileting, undressing of patients etc.	Medium
	Ambulance crews to monitor patients vital sign and pain control as per own protocol or if needed on a more regular basis as guided by the ED shift coordinator. All vital signs need to be reported to the ED shift coordinator Prioritise patients and off load when ED capacity available	Medium
	20-06-2012 GWAS and UH Bristol expect advice from EUST to allow shared care of any queuing patients with a 'rapid assessment and treatment' approach. Joint GWAS - acute trust meeting to discuss and agree approach 12/07/2012.	
	Pressure area care by ambulance crews, if this is part of their remit. Can advise patients to change position in some instances	Low
	ED notes of these patients kept with the ED shift coordinator. Patients in corridor identified in this way on the tracking system. Put queuing patient id no on shift coordinators sheet. Ensure the CSMs are aware of patients queuing	Medium

When capacity becomes available it will be used for the patient of highest priority	Medium
New RCA process in discussion with James Rimmer 1. All 4 hour Ambulance waits will be designated a SI, reported within 48hours and a full RCA carried out as per usual. It has been argued that such an event may not specifically adhere to the NPSA SI criteria. This point was acknowledged, but in the light of several serious related events occurring recently and the fact that such a delay indicates that the system as a whole is under severe strain, it was felt that using the SI approach was appropriate. 2. All 2 hour waits would continue to be reported to the SHA by Chris 3. Multiple 2 hour waits was the issue that was required further discussion with the Clinical team, with regards to what this term actually meant (relating to circumstances such as static queues or moving queues) and how / if it should be responded to with an SI. This will be discussed at the Emergency Access Steering Group and the conclusions reported via the Patient Safety Group	No Effect
RATTing protocol in place	Medium

Action Plan for Risk: 1704	***Action Number:*** 7	***Responsibility Of:*** James Rimmer	***Target date:*** 28/02/2014

Develop SOP for Immediate Handover

Action Plan for Risk: 1704	***Action Number:*** 8	***Responsibility Of:*** James Rimmer	***Target date:*** 31/01/2014

Review of Trust escalation procedure

Action Plan for Risk: 1704	***Action Number:*** 9	***Responsibility Of:*** James Rimmer	***Target date:*** 31/03/2014

Patient Flow projects will support this - see risk 1422

Corporate Risk Register Report

Risk Number: 1977 **Status:** Action Required **Risk Title:** Lack of Capacity on NICU

Domain	Monitoring Group	Risk Assessor	Risk Owner	Executive Lead	Assessment Date	Next Review Due:	Current Risk Rating	Target Risk Rating
Patient Safety	Divisional Management Meeting W&C	Caralin Donavans	James Rimmer	Chief Operating Officer - James Rimmer	29/10/2012	02/03/2014	15 Very High (Red)	4 Low (Green)

BAF Reference and details of strategic objective:

3.3 - To be recognised by our patients and their families for the consistently high quality of the care they receive whilst in our care

Risk Description	Details of Control or Assurance	Effectiveness
NICU at St Michael's Hospital does not have adequate capacity to meet the local, network and regional requirements.	Cot Policy agreed by Trust and Network Board to prioritise last 2 intensive cots for infants requiring sub specialist care, transferring out less ill babies if necessary and possible. Consultant and senior nurse review of all possible discharge/transfer of infants 2/3 times per day minimum. Consultant advice to referring hospital when we are unable to take patients. Transfer any appropriate infant to PICU or BRCH if capacity permits. Transfer of mothers in-utero as preferable to ex-utero transfer. Any mother in who transfer presents a risk will be delivered at St Michael's and the baby stabilised and transferred out if possible. If that baby is too ill to transfer another will be transferred out in his/her place where the situation and condition allows. Good communication with parents around the need to transfer and arrangements for return should capacity allow.	Medium

Action Plan for Risk: 1977 **Action Number:** 1 **Responsibility Of:** Caralin Donavans **Target date:** 01/04/2014

Develop plans to increase number of cots, in keeping with national standards.

Corporate Risk Register Report

Risk Number: 2344 ***Status:*** Action Required ***Risk Title:*** Achievement of Strategic Objectives

Domain	*Monitoring Group*	*Risk Assessor*	*Risk Owner*	*Executive Lead*	*Assessment Date*	*Next Review Due:*	*Current Risk Rating*	*Target Risk Rating*
Business	Trust Management Executive	Deborah Lee	Deborah Lee	Director Of Strategic Development - Deborah Lee	08/01/2014	16/04/2014	15 Very High (Red)	2 Low (Green)

BAF Reference and details of strategic objective:

Achieve Full Compliance with Health & Safety Requirements / Achievement of CRES / Compliance with EUWTD / Compliance with CQC Standards / Maintain GREEN Monitor Risk Rating

Risk Description	*Details of Control or Assurance*	*Effectiveness*
Risk of failure to achieve one or more strategic objectives within the Board Assurance Framework	Executive Director ownership and accountability for each stratgeic objective with responsibility for ensuring delivery and devloping remedial action plans where necessary	Medium

Action Plan for Risk: 2344 ***Action Number:*** 1 ***Responsibility Of:*** Deborah Lee ***Target date:*** 31/03/2014

Recovery plans for each high risk objectve to be developed alongside risk assessment of impact of non-achievement with approriate risk management and mitigation plans developed.

University Hospitals Bristol NHS
NHS Foundation Trust

Cover Sheet for Report of the Public Meeting of the Trust Board of Directors to be held on 30 January 2014 at 09.30 in the Conference Room, Trust Headquarters, Marlborough Street, Bristol, BS1 3NU

Item 20 – Board Assurance Framework

Purpose

To provide the Board with the quarterly update of progress against the Trust's objectives at the end of Quarter 3 and to provide assurance of the control of any associated risks to delivery.

Abstract

Context

This reporting format brings together the former Board Assurance Framework and the report on Corporate Objectives into a single monitoring and assurance framework.

The purpose of the Framework is to track progress against the Trust's stated medium term objectives and specifically tracks progress against the 2013/14 milestones which were derived as part of the 2013/14 Annual Planning programme. Importantly, the framework also describes any risks to delivery that have been identified to date and describes the actions being taken to control such risks so as to ensure delivery is not compromised.

Any inherent risk rating that is high or extreme (RED rated) is also captured within the Trust's Corporate Risk Register through the reporting of the risk to achievement of any corporate objectives within the BAF.

Quarter 3 Position

There has been a deterioration in Trust wide performance against the Trust's Corporate Objectives in quarter three. Four objectives are now at high risk of not being achieved for the year and are therefore RED rated, these are:

- Achievement of Cash Releasing Efficiency Savings (CRES)
- Compliance with *New Deal* for affected staff
- Compliance with all Care Quality Commission (CQC) Essential Standards
- Maintain a GREEN Monitor Governance Risk Rating (GRR)

This deterioration has been driven by the recent CQC inspection of the Bristol Children's Hospital resulting in non-compliance with standards 8 and 16.

Finally, there are 41 (42) objectives where delivery is forecast therefore with a residual rating of GREEN and 7 (8) AMBER rated objectives.

The Board is asked to note that objective 11.3 has been rephrased to reflect the correct terminology against which medical workforce compliance is assessed.

NB: Figures in brackets reflect Q2 position.
Recommendations
The Board is asked to **Note** the report and associated actions to ensure all corporate objectives are met.
Executive Report Sponsor and Author
• Sponsor – Chief Executive • Author – Director of Strategic Development
Appendices
• Appendix A – Board Assurance Framework

Executive Team	Senior Leadership Team	Quality and Outcomes Committee	Finance Committee	Audit Committee	Other
	15 January 2014				Risk Management Group – 8 January 2014

Executive Team	Trust Management Executive	Quality and Outcomes Committee	Finance Committee	Audit Committee	Other

Objective	Driving Strategy	Serial Number	Strategic Objectives (3 – 5 years)	Outcome	Key Priorities for Action 2013-2014	Progress Towards Achievement of Actions %	Progress Towards Achievement Narrative	What are current risks to achieving our objectives	Risk rating (Red, Amber, Green)	How are the risks to achievement being mitigated? (controls)	Source of Assurance that Risks are Actively Managed	Residual Risk To Achieving Objective	Risk Register Reference (if applicable)	Executive Owner	Executive Management Group
1	T&L	1.1	We will develop and implement a teaching and learning Strategy that is fully integrated with all other strategies in order to support the Trust's mission.	Improved Teaching and Learning provision within the Trust. Improved recognition externally of UH Bristol as a Teaching Hospital	Strategy implemented in line with plan. Strategy reviewed and updated to reflect changes in Teaching and Learning requirement. Essential training requirements refocused and new recording system purchased and implemented. LETB implication	50% to 75% 50% to 75%	On target, working with Head of Strategic Development to refresh strategy. 8 week implementation plan complete. Testing reporting with user group.	Reduced training compliance due to staff not being released for essential training.	Green	New training matrix reduced times spent on essential training.	Essential Training Steering Group and HR Board.	Green		Dir W&OD	Teaching and Learning Group
1	R&I	1.2	We will focus on and foster our priority areas of high quality translational and applied health services research and innovation where we are, or have the potential to be world leading	Developmental research groups established and productive.	Support for NIHR grant applications in place with researchers aware of process and appropriate and agile triage system in place for support for new applications. New researchers identified when they join the trust. Researchers supported by divisional management teams to submit and deliver grants.	50% to 75%	Mechanisms in place for identifying new researchers. Support systems in place; new website in development to support researchers. Awareness of research raised in the clinical divisions; research strategy in place in D&T.	Clinical pressures prioritised, putting development and delivery of research at risk.	Green	Regular communications with divisional management teams, researchers and research delivery teams. Systems for setting up research simplified and underpinned proactively by R&I. Escalation of issues as required.	Regular review of KPIs relating to recruitment and grant submissions (monthly). Weekly review of recruitment levels. Regular oversight of performance against plan for small grants and grant development/ submission.	Green		Dir Med	Research Group
1	R&I	1.3	We will develop a culture in which research and innovation are embedded in routine clinical services leading to improvements in clinical care	Transparency within Divisions of research funding achieved. Divisional governance structures for research in place.	Implementation in line with agreed Divisional plans. All divisions report research performance against KPIs at divisional boards. All Divisional Research Units have clear reporting lines through divisional boards.	50% to 75%	Terms of reference for divisional boards agreed, with R&I elements included. Development of R&I strategy under way in conjunction with clinical strategies. Meetings with 4/5 CCs and DDs arranged to discuss research agenda.	No significant risks identified to date.	Green	Not applicable	Not applicable	Green		Dir Med	Research Group
1	R&I	1.4	We will demonstrate our undertaking to improve patient health through our excellence in world-class translational and applied health services research and our culture of innovation by increasing participation in NIHR trials	Increase in the number of patients entering NIHR trials	Increase in weighted recruitment by 5% over previous year.	50% to 75%	Weighted recruitment levels have recovered and are in line with expected levels for this year.	Recruitment levels and complexity of trials will not secure delivery funding at the required level.	Green	Recruitment work stream projects to maximise recruitment; engagement with research delivery staff and principal investigators; regular communications about performance to researchers.	Regular review of recruitment work stream projects (bi-weekly); KPI review monthly. Weekly review of recruitment levels.	Green		Dir Med	Research Group
1	CSS	1.5	We will consolidate and expand our specialist services portfolio through designation of target services and repatriation of work from outside the South West	An increase in income from specialised services and a greater proportion of Trust income coming from the specialist portfolio.	Ensure CSP scheme is on track to maintain designation for Paediatric Burns and secure Neurosciences designations as they are undertaken. To prepare for the commencement of the revised Paediatric Cardiac Surgery Networks from April 2014. Continue implementation plans for adult BMT and Cardiac Surgery repatriation in response to 2012/13 achievements. Successfully transfer Exeter thoracic and Basingstoke liver work. Scope and identify further opportunities for service repatriation and develops plans to secure transfers Undertake gap analysis to understand compliance of all "prescribed services" with national specialist service specifications and secure derogation as required to ensure continued commissioning of specialist services.	50% to 75%	CSP building programme on track - no impact from recently agreed changes to BRI scheme. Level 5 handed over on time to allow Ward 62 decent and BHOC scheme to proceed as required. Equipment to support neuro-surgical designation included in procurement plan. Limited progress on Paediatric Safe & Sustainable due to national delays. Trust response to Adult Congenital Heart Disease Designation Consultation made and gap analysis against draft standards concluded. Successful pilot of repatriation of cardiac surgery work from Cornwall established - 12 cases transferred in first 6 weeks of pilot. National service specifications now not operational until October 2013. Initial gap analysis undertaken with all major areas of non-compliance recorded on risk registers as appropriate. Proposals for commissioner investment to address areas of non-compliance now submitted as part of 2014/15 planning round.	Building programme falls behind plan or service transfer preparations are not concluded as required. Key designation standards cannot be met. Service offer is not sufficiently attractive to secure work from other areas or bed / theatre capacity is insufficient to enable transfer of new work. Trust does not secure derogation for areas where it is not compliant with specification resulting in requirement to invest to achieve compliance or risk losing service or full funding.	Green	Robust programme management and governance structure & processes around all four capital schemes. CSP Operational Delivery Group retaining oversight of compliance with designation standards through Model Of Care work streams. Work is in train to create sufficient protected capacity to support repatriation of elective surgical work. All gaps in compliance identified and plans in place to address or seek derogation.	Project Board minutes. External gateway reviews and internal audit findings. Project and corporate Risk Registers.	Green	759	Dir SD	Clinical Strategy Group and Strategic Development Scheme Project Boards.
1	CSS	1.6	We will work with our partners to ensure the optimal configuration for acute services across the City	Single strategy for acute services developed and agreed between NBT and UH Bristol and endorsed by commissioners. Reduction in the number of specialities duplicated across the City, fewer opportunities for competition between acute Trusts.	Ensure the successful implementation of the Head & Neck / ENT service transfer from NBT. Work effectively with appointed External Advisers to develop Acute Service Plan Successfully conclude Vascular Services Review and determine any further priorities for service rationalisation. Deliver all BRI and CSP annual milestones to support successful service transfer in May 2014	50% to 75%	Service transfer concluded. Work with Cooperation and Competition Directorate (CCD) concluded. BASR reports now received - insights informing Trust Strategy Re-fresh and discussions with NBT on-going regarding next steps. Vascular Services Review on track for service consolidation by end of June 2014 and derogation against national service specification from October provisionally agreed with commissioners. Recent risk to deadline identified in light of possible OFT involvement. Revised building programme, following Level 9 changes, on track with exception of BHOC which is now delayed by 6 weeks to handover in late February 2014. Welcome Centre opened on plan and very well received.	Monitor find Trust in breach of its license as a result of transfer and impose remedial actions upon Trust. Risk that work doesn't identify sufficient opportunities to contribute to a significant closure of anticipated financial gap and/or next steps not able to be agreed between partners. Agreement of model for vascular consolidation cannot be reached and/or is delayed for one or more reasons including CCD and public consultation processes. Building programme falls behind plan or service transfer preparations are not concluded as required. Key designation standards cannot be met.	Green	Robust response to CCD Stage 2 Review of transfer. Involvement of Partnership Programme Board and Healthy Futures Board in agreeing and driving next steps and subsequent progress. Effective steering group leading work and engaging wider stakeholders as required. Strong emphasis on patient benefits arising from proposed consolidation. Robust programme management and governance structure & processes around all four capital schemes.	CCD submission. Integration Project Board minutes and papers. Vascular Review Steering Group minutes and papers. Commissioner assessment of compliance with service specification. Project Board minutes. External gateway reviews and internal audit findings.	Green	759	Dir SD	Clinical Strategy Group / BRI & CSP Project Boards

Objective	Driving Strategy	Serial Number	Strategic Objectives (3 – 5 years)	Outcome	Key Priorities for Action 2013-2014	Progress Towards Achievement of Actions %	Progress Towards Achievement Narrative	What are current risks to achieving our objectives	Risk rating (Red, Amber, Green)	How are the risks to achievement being mitigated? (controls)	Source of Assurance that Risks are Actively Managed	Residual Risk To Achieving Objective	Risk Register Reference (if applicable)	Executive Owner	Executive Management Group
1	CSS	1.7	We will undertake a feasibility study of the opportunities and models for increasing Private Patient Services and Income	Options for private patient services scoped and model for UH Bristol agreed and progressed	Implement plan to re-establish improved private patient service at UH Bristol, with a particular focus on both patients and consultants improving the offer to them.	50% to 75%	Project plan for 2013-14 signed off by TME. Phase I - Getting the Basics Right of project completed August 2013. Phase 2 - Building on Foundations - project planning is underway. PMI Contracts in place with BUPA, Aviva and Pru-Health. Service Evaluations with Divisions underway.	Capacity constraints on beds and support functions limits opportunities to develop private practice Frustration on speed of progress results in disengagement of clinical and managerial staff	Amber	Patient Flow project to reduce LOS and occupancy rates. Identification of mixture of private market opportunities, some of which are not reliant on bed capacity. Communication Strategy to be overseen by Steering Group.	Private Patients Steering Group responsible for monitoring and ensuring the delivery of the private services project plan 2013/14. Reports to TME on quarterly basis.	Green		COO	Senior Leadership Team
1	CSS	1.8	Grow the non-clinical income base through exploiting greater commercial opportunities for income generation	Increase in the number of third party providers to whom UH Bristol provides its services. Increase in non-clinical income	Open Welcome Centre and commence all retail operations. Support development of emergency alliances with pharmacy industry. Develop case of need for 'Commercial Director' or similar. Identify further opportunities for commercial developments / partnerships	75% to 100%	Welcome Centre on track for handover to Trust November 2013 and all five retailer leases signed. Partnership Agreement with Novartis finalised to support work of Bristol Eye Hospital including capital grant. Partner to develop options for Old Building site including exploration of commercial opportunities for income generation. retained and work in hand.	Programme delays occur that cannot be recovered elsewhere in programme. Fifth lease is not secured. No further commercially viable opportunities are identified.	Green	Robust programme management and governance structure in place. External partner secured to bring additional commercial expertise to Executive Team.	BRI Project Board minutes and Welcome Centre Steering Group minutes	Green		Dir SD	BRI Redevelopment Board
1	CES	1.9	Fully embed the Trust's values in everything we do and say and establish them as the behaviours that drive the way we do things around here.	Improvements in staff survey questions which pertain to morale and positive work place. Reduction in number of staff experiencing bullying and harassment. Achieve place in top 20% of Trusts for UH Bristol being a "good place to work".	Staff Survey remains in top 20% of Trusts - Improvements in the annual staff survey and Multi Professional Education and Training (MPET), especially relating to bullying and harassment. KPI show consistently improved staff inpatient and outpatient outcomes. Staff sickness below 3.5% for the year Loud and Clear survey results implemented with clear action plan.	50% to 75%	Over 5,000 staff now received values based training. Staff sickness in November is currently 4.2%. Trust in top 20% for engagement.	Values training now not essential therefore less staff may attend. Sickness levels could increase.	Green	Still encouraging staff to attend values training through communications. Values training is included in induction.	Regular reporting to TME and Teaching and Learning Steering Group.	Green		Dir W&OD	Senior Leadership Team
2	CSS	2.1	We will further refine our strategic intentions and operational role in community service provision	Clear position statement on the provision of community services by UH Bristol. Direction of travel agreed for community services currently provided by UH Bristol.	Support the application of Bristol Homeopathic Hospital to become a social enterprise. Identify further opportunities for the full utilisation of SBCH. Evaluate impact of the GP Care test and learn pilot "Consultant Link".	50% to 75%	Advanced discussions with an existing Community Interest Company (CIC) now in train with view to transfer of service. Work in train to secure novation of UH Bristol contracts to new CIC. BHH now transferred to SBCH. Work on-gong to improve theatre and outpatient utilisation. TME Strategy Session occurred in December and work on-going to scope further uses. Consultant Link evaluation very successful on non-financial parameters. Continuation of pilot in cardiology agreed to year end though no further roll out until tariff issues resolved.	IBP not viable and transfer to social enterprise cannot be established. Acceptable Advice & Guidance tariff for consultant link cannot be established.	Green	Divisional and Executive Director support to IBP development. Contract novation being pursued to enhance chance of agreement to transfer. Realistic and reasonable approach to tariff setting.	CSG and TME minutes and papers.	Green		Dir SD	Clinical Strategy Group
2	CSS	2.2	We will confirm our intentions with regard to major strategic opportunities that are likely to arise in the medium term including our role on the provision of services to the Weston community, our role in the running of SBCH and the organisational model through which we will work with North Bristol Trust.	Clarity regarding organisational model for acute services in Bristol. UH Bristol position in relation to SBCH and Weston formulated and agreed by Board.	Progress integration work to agreed timeline to include development of Service Plan, OBC and FBC during 2013/14 Evaluate the options for the Trusts involvement in the delivery of services to North Somerset population in response to future plans for Weston Area Healthcare Trust (WAHT) If appropriate, mobilise bid in response to any proposals relating to WAHT	50% to 75%	Trust integration not progressed. Acute Services Review concluded. Next steps now being formulated though delay incurred due to capacity constraints at NBT linked to hospital move. WHAT procurement delayed from original timeline. Discussions with potential future partners have taken place. On-going discussions with WAHT and other partners to support on-going sustainability of vulnerable services at WAHT. Additional to support to new service areas currently being agreed.	Risk that work doesn't identify sufficient opportunities to contribute to a significant closure of anticipated financial gap. WHAT business case is not supported by Treasury and procurement does not proceed as planned.	Green	Involvement of Partnership Programme Board and Healthy Futures Board in agreeing and driving next steps and subsequent progress No mitigations in control of Trust around business case risk. Trust continues to develop working relationships with WHAT and support delivery of viable clinical services pending clarity over future of WAHT.	Integration Project Board , PPB and HFPB minutes and papers. CSG minutes and papers.	Green		Dir SD	Clinical Strategy Group
2	R&I	2.3	Partnership Working – we will work with our partners in Bristol Health Partners and our regional partners to align our research and clinical strengths leading to the formation of collaborative Health Integration Teams	Academic Health Sciences Collaborations operating across health partners with demonstrable increase in research and teaching activity as a result.	Establish and start to deliver successful HIT programmes of work through Bristol Health Partners. Actively engage with AHSN structure.	50% to 75%	CLAHRC has been awarded; HITs will be supported through CLAHRC infrastructure. Key appointments are being made. Communication and reporting links established.	No significant risks identified to date.	Green	Not applicable	Not applicable	Green		Dir Med	Bristol Health Partners Board
3	T&L	3.1	Learning and Development Centre of Excellence - We will create an Academy recognised both within and outside the Trust, that delivers high quality learning and development which is aligned with trust strategies and culture.	The trust will have a Training Academy that delivers quality assured solutions to its staff and the wider community	All training across the Trust and to external bodies is academy delivered or accredited. / Income generation and activity levels delivered in line with the business plan.	50% to 75%	Strategy refresh 2013	No significant risks identified to date.	Green	Not applicable	Not applicable	Green		Dir W&OD	Teaching and Learning Group
3	T&L	3.2	Skilled and flexible workforce - We will ensure that learning and career pathways are developed based on Trust priorities, are flexible and responsive to changes in service and are supported by effective development solutions	All training is based on Trust requirements, linked to required competencies and provides career development for individuals.	Career Pathways in place for all key roles, linked to the strategic workforce requirements of the Trust Pathways reviewed based on updated Trust requirements Flexible workforce linked to business priorities and operating plan.	75% to 100%	Performance management work stream is on track for delivery, along with the leadership framework.	No significant risks identified to date.	Green	Not applicable	Not applicable	Green		Dir W&OD	Teaching and Learning Group

Objective	Driving Strategy	Serial Number	Strategic Objectives (3 – 5 years)	Outcome	Key Priorities for Action 2013-2014	Progress Towards Achievement of Actions %	Progress Towards Achievement Narrative	What are current risks to achieving our objectives	Risk rating (Red, Amber, Green)	How are the risks to achievement being mitigated? (controls)	Source of Assurance that Risks are Actively Managed	Residual Risk To Achieving Objective	Risk Register Reference (if applicable)	Executive Owner	Executive Management Group
3	CSS	3.3	To be recognised by our patients and their families for the consistently high quality of the care they receive whilst in our care	For each of the next three years, we will seek year on year improvements in patient reported experience of care as measured by our own robust patient surveys and national patient surveys. We will carry out robust patient surveys during 2012/13 to measure progress on these goals. Baseline data will be derived from previous surveys and the targets will be based, as a minimum, on the best Trust score nationally (as determined by the national outpatient survey). We will also seek to improve our scores for 50% of indicators in each successive National Patient Survey.	1. We will implement the second year of our Patient Experience and Involvement Strategy for 2012-2015, focussing in particular on improving the experience of care amongst maternity patients (Quality Strategy goal: to improve our scores for at least 50% of measures in the 2013 National Maternity Survey, when compared to the previous survey in 2010) 2. We will implement the NHS Friends and Family Test 3. We will seek to increase the proportion of patients who receive an explanation of medication side effects when they are discharged. 4. We will ensure patients are treated with kindness and understanding	50% to 75%	1. Strong performance in 2013 National Maternity Survey - detailed report to be presented at SLT and Board in January (60% of comparable indicators have improved compared to 2010). Current improvement activities focussing on induction of labour and women with diabetes. Reduction in reported complaints. Recent tail-off in 'kindness and understanding' scores following previous significant improvement - Head of Midwifery is reviewing and monitoring. 2. FFT implemented - very good scores (73 to date in 2013/14 is close to upper 20% threshold) and response rates (25.2% in November - target is 20% in Q4) on wards and in EDs. FFT also implemented according to schedule in maternity services. 3. Piloting of an electronic tool developed by Pharmacy has been extended from Ward 14 to 5a, 6 and 18 (the tool provides a list of standard drugs which can be ticked according to which are being administered to the patient - the tool then provides the patient with information about common side-effects). 4. Latest survey data (November 2013) shows score of 93.0 (green-rated)	Initial FFT implementation goal (15% minimum response rate in Q1) was not achieved - currently subject to discussion with commissioners in view of excellent progress since Q1.	Green	Corporate PPI team actively supporting Divisions with: ongoing FFT implementation and focus; improving patient experience in maternity services.	Monitoring by corporate PPI team, Patient Experience Group, Divisional Boards. FFT is also monitored by Trust Board.	Green		Chief Nurse	Patient Experience Group, reporting to the Clinical Quality Group
3	CSS	3.4	We will strive to eliminate all incidents of unintended harm to patients and be recognised nationally for the safety of the services we offer.	To reduce adverse events by 30% and mortality by 15% from the 2009 baseline by the end of 2014.	1. The spread of all key changes relating to the NHS South West Quality and Patient Safety Improvement Programme will have been achieved in all (breadth) work streams with at least 50% penetration (depth) into other applicable patient populations and areas 2. We will reduce medication errors. 3. We will continue to embed the use of medicines reconciliation. 4. We will improve the escalation of deteriorating patients (timely intervention, reducing cardiac arrest calls). 5. We will increase the level of harm free care (reducing pressure ulcers, falls, VTEs, catheter associated UTIs) using the new harms measure in the NHS Safety Thermometer. 6. We will reduce hospital-acquired healthcare infections 7. We will improve levels of nutritional screening and specifically 72 hour nutritional review of patients	75% to 100%	1. Achieved 15% HSMR reduction. Achieved 30% reduction in adverse event rate in 3 consecutive months but normal variation in small numbers and LOS reduction will continue to produce some points above the target. Improved overall score of 4.5 achieved in patient safety programme by November 2013 now back on trajectory. 2. Reduction in non-purposeful omitted doses of critical medication improved but not sustained (2.3% against a target of 2.25%) in November, reduction in medication errors resulting in moderate or severe harm achieved. 3. Sustained improvement in medicines reconciliation in all areas where implemented. 4. Deteriorating patient: November 2013 compliance-Early Warning Score (EWS) correctly recorded 98.4%, EWS acted upon 82.4%, use of SBAR structured communication 75%. 5. Thresholds set for harm free care and no new harms using upper and lower quartile benchmarked acute teaching Trusts. Harm free care at 95.8% in November achieved the upper quartile benchmark. No new harms at 97.4% in November remains just below the upper quartile benchmark. 6. There were 30 cases of *C Diff* up to November (12 month target is 35). One case of MRSA in May means we will not achieve the zero target for the year. Recovery plans / exception reports to Trust Board. 7. In November 76.9% of inpatients received a documented 72 hour nutritional review (target 90%). Recovery plans / exception reports to Trust Board.	Risk that patients will not attain optimal nutritional status to support recovery due to insufficient compliance with the 72 hour nutrition(food chart) review and associated actions Risk of not achieving infection control targets.	Amber	Heads of Nursing focus on 72 hour food chart review with requirement for exception reporting/implementation of action plans by ward sisters Detailed recovery plans / exception reports presented to Board in respect of infection control targets.	Programme monitoring. Board quality metrics and exception reports.	Green		Chief Nurse	Patient Safety Group reporting in to the Clinical Quality Group
3	CSS	3.5	To be recognised for the excellent clinical outcomes we achieve for our patients across all areas of service.	For each of the next three years, we will seek to maintain our 'lower than expected' headline mortality ratings (HSMR and SHMI).	1. We will ensure that patients with an identified special need, including those with a Learning Disability have a risk assessment and patient-centred care plan in place. 2. We will continue to implement our Dementia action plan. 3. We ensure that 90% of patients who suffer a stroke spend at least 90% of their time on a dedicated stroke ward 4. We will achieve the best practice tariff for hip fractures 5. We will ensure that patients with diabetes have improved access to specialist diabetic support 6. We will commence a baseline review of available clinical outcomes data	50% to 75%	1. Green-rated risk assessment performance since September 2013. 2. Good progress with implementation of dementia plan; but red-rated CQUIN performance in Q3 to date. Exception reports to Trust Board - recovery actions in place. 3. Amber-rated performance in Q3 to date (86%). 4. Green-rated performance (for the first time) in November (91%). 5. CQUIN thresholds have now been agreed - overall red-rated performance to date (green in SH&N Division only). 6. Initial scoping meeting with Medical Director; pilot to commence Q4.	Risk of failing to achieve targets. Detailed Q3 report to Clinical Quality Group in January 2014.	Green	Exception reports have been received by Trust Board detailing recovery plans in months when targets for learning disabilities, dementia, stroke and hip fractures have not been achieved.	Board quality metrics and exception reports.	Green		Dir Med	Variously: Quality Intelligence Group, Clinical Effectiveness Group, Clinical Quality Group

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3		3.6	We will achieve compliance as far as is reasonably practicable with all Health & Safety regulations	We will achieve 5 - 10% improvement year on year with audit compliance across the Trust	Each Division/ area drafts and completes resultant action plan to achieve 5% increase in compliance year on year. Priority to reduce work related stress incidents.	50% to 75%	The 5 clinical divisions were subjected to annual audit in October 2013 as well as Trust services which is split into 3 specific areas, Facilities & Estates, IM&T and the remainder of Trust Services. This equates to 8 days of auditing and 8 reports, in 2013 we sustained 'blue rating' in the two Divisions/ services of Facilities & Estates and Specialised Services while 4 Divisions/ services achieved the 5% increase required. 2 of which achieved 'blue rating' namely Diagnostic & therapies and IM&T . The most recent Willis Audit shows a year on year improvement of 6%.	2 areas Medicine and Women's & Children's did not achieve the 5% increase in 2012. All areas should reach the 85% mark by 2014 but this is subject to commitment to deliver the requirements in already challenging times. Trust Services and Women's & Children's services are areas that are a cause for concern due to their departmental audit returns and the responses within them regarding completion of risk assessment for the second year running.	Amber	Health and Safety features in the Divisional Operating plans including the top five priorities identified by the Willis audit. These are part of the quarterly divisional performance review and also monitored at the quarterly Trust Health & Safety'/ Fire Safety Committee with an exception report from each Divisional Health & Safety lead. Specific issues in each area audited will be developed into a action plan which is both Trust wide issues/ themes and Divisional issues/ themes.	Minutes of performance reviews and quarterly exception reports from Health and Safety leads. Departmental audit question sets have been transferred onto a summary sheet for each Division to highlight gaps in information required by September 20th 2013	Amber	2012 and 2147	Dir W&OD	Risk Management Group
4	CSS / CES	4.1	We will play a greater role in shaping the health system in Bristol and the Southwest through our early and constructive engagement with future influencers. We will improve our reputation with our commissioners by understanding their needs better and rapidly responding to the issues they raise.	Established and productive relationships with PCT Clusters, GP Consortia and National Commissioning Board with evidence of UH Bristol leading, not reacting to, change. GPs will report improved levels of satisfaction with UH Bristol's response to their commissioning intentions and ad hoc issues (evidenced through formal market surveying)	Develop and undertake a 360 assessment of the strength of key partnerships and track our on-going reputation and profile. Develop effective working model with CCG and Local Area Team. Identify top 3 commissioners priorities for UH Bristol and develop plan to address (within any associated resource constraints)	50% to 75%	Methodology for gathering external stakeholder views being developed with aim of concluding by end of Q4. Terms of Reference for Clinical Leaders forum reviewed and revised and approach to in year contracting monitoring with CCG and Area team commissioners agreed and commenced June 2013. Initial commissioning priorities agreed (patient communications) and two workshops held in June and July - both fully subscribed to by primary care to progress joint work. Action plan arising from workshops now formulated. and further workshops planned for Q4.	Key risk to delivery is capacity within planning team to conclude work on time. No risks identified to actions agreed - risk remains that agreed ways of working do not yield benefits anticipated. Insufficient progress on agreed priorities is achieved.	Green	Clarity regarding priorities within team.	Strategic Development Team meeting work programme and minutes. Clinical Leaders forum ToRs, minutes and papers. Contract monitoring meeting agenda, papers and actions / issues tracker.	Green		Dir SD	Clinical Strategy Group and Commissioning & Planning Group.
4	CSS	4.2	We will strengthen our approach to marketing our services to both GPs and consultant referrers with a view to maintaining or growing market share in our target areas	No service losing market share except where as a response to a Trust business decision.	Continue to Issue refreshed monthly newsletter to primary care and evaluate success in year. Develop service specific marketing plans for target growth areas e.g. cardiac surgery.	75% to 100%	On-going and positive feedback secured re GP Newsletter and workshop with primary care staff on communications and service priorities took place in June and July. Pilot of external edition of *Voices* publication commencing with the January/February 2014 edition. Plans for targeting growth, through repatriation, of cardiac activity developed and yielding positive results.. Service branding and marketing approach agreed, starting with marketing of Gamma Knife Service.	Risk that plans do not result in retention or growth in activity.	Green	Robust approach to developing and maintaining high quality communications supported by pro-active engagement with primary and secondary care referrers.	Communication materials. Activity monitoring to confirm success of plans for growth.	Green		Dir SD	Senior Leadership Team
4	CES	4.3	Agree the nature and form of our future relationships with our major fundraising partners. Agree our priorities for charitable funding and develop cases for support in partnership with charitable leads	Fundraising target for major appeals achieved. Positive working relationships in place with all major charitable partners.	Commence public phase of major fund raising campaigns. Agree on-going governance model for Above & Beyond in light of proposed changes to NHS charity regulation Work closely with partners to develop cases of support for major donors, Trusts and foundations. Confirm specific fundraising priorities with The Grand Appeal.	50% to 75%	Teenage Cancer Trust appeal launched May 2013, Above and Beyond successfully launched (Golden Gift Appeal) in June and The Grand Appeal (Gromit Unleashed) launched with public auction of Gromit statues planned for October 3rd.. Cases of support developed for all major equipment / schemes and multiple applications for funds submitted to trusts and foundations with some significant one of donations secured as a result. List of additional fundraising priorities provided to TGA - response anticipated following January 2014 Trustee meeting.	Insufficient funds are raised to support pledges made by charitable partners with consequent impact on Trust's own capital programme and priorities.	Green	Pro-active and effective working with all charitable partners to support their own activities.	Project Board minutes and risk registers.	Green		Dir SD	BRI / CSP / BHOC Project Boards and Trust Management Executive
4	T&L	4.4	Leaders of the future - We will create leadership and talent pools who are equipped with the skills, knowledge and behaviours required to lead the Trust both now and in the future.	We will have leaders who are fully effective and are able to embrace and deliver change is a safe and sustainable way	Talent Matrix fully developed and linked to movements around the Trust - Succession planning at the heart of selection decisions Management and Leadership development solutions fully implemented to support the development of senior staff across the Trust in line with business requirements. Management and Leadership Training externally recognised as best in class.	50% to 75%	Leadership framework on track for delivery and we will be using the talent matrix for leadership solutions. Leadership and management framework will be launched on the 24 September along with Connect site to support implementation.	No significant risks identified to date.	Green	Not applicable	Not applicable	Green		Dir W&OD	Teaching and Learning Group

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4	CES	4.5	We will continue to work with our media partners locally, regionally and nationally to ensure UH Bristol positions itself as a trustworthy and notable commentator on health issues and is recognised as a successful organisation, through case studies of our staff and patients in relation to Research & Innovation, Teaching & Learning and patient care.	Positive to negative media about UH Bristol increases. All proactive media about UH Bristol is balanced; the Trust is consistently featured aligned to its core values and brand through media coverage. The Trust is known for its commentators	Establish regular liaison meetings with local and regional media including BBC Promote UH Bristol regionally and nationally through nomination of best practice initiatives for regional and national awards Proactively position "good news" stories and activities in media	75% to 100%	Regular meetings established with Editor of Bristol Evening Post and Health Correspondent though personnel changes are planned for New Year and new relationships will need to be established.. Good ongoing relationships and contact with news organisations. Four initiatives entered for HSJ Awards - shortlisted for HSJ Energy Efficiency Award and Cystic Fibrosis service shortlisted for Service Redesign Award from 1100 entries Multiple examples of UH Bristol's pioneering work in local media. Communications team works proactively with all Bristol-based newsrooms and with other organisations to ensure coverage in a wide variety of media and management of ongoing relationships where possible. One example is coverage of the Trust's obesity service on ITV's Tonight programme early in September which has led to an ongoing relationship with the reporter and the likelihood of another positive piece.	Adverse publicity arising from unpredicted events	Green	Positive working with local health correspondents and proactive communications management in event of adverse incidents likely to attract media attention.	Monthly communications progress to TME	Green		Dir SD	Senior Leadership Team
4	CES	4.6	The Trust embraces all appropriate methods of communication, with staff, patients, members and the wider public to involve them in the strategic developments of the Trust.	Staff survey shows improvements in staff perception of communication with respect to capital developments All KPIs being achieved to required standards. Minimal patient complaints about negative impact of construction works	Restructure communications team to reflect forward priorities and workforce requirements. Communication Strategy approved by TME and work streams for all key objectives established and effective. Pilot external issue of Voices for distribution through GP, dental and optician practices Establish staff newsletters for all major redevelopment projects and launch Simple Guide Series Launch staff listening events, and review wider engagement activities in support of reinvigoration of Transforming Care and strategy refresh.	75% to 100%	Restructure of communications team is now complete. Four new appointments made and a fifth being advertised currently. TME approved strategy in May 2013 and work stream objectives agreed and monitored monthly via TME. Simple Guide To Finance published June 2013, Simple Guide to Savings published in September and Simple Guide to Patient Experience in December. CSP Newsletter launched and very well received. Listening events took place in the summer and staff actively engaged used the Bulletin Board to air their views and respond to others. TME's views have been sought on the use of social media for the Trust and this will be developed in Q4.	Capacity constraints in team due to delayed recruitment.	Green	Pro-active recruitment campaign, effective succession planning for key roles.	Monthly communications progress to TME	Green		Dir SD	Capital Programme Steering Group
5	ES	5.1	An Estates Strategy exists which is agreed by the Board, covering the period up to 2020. Approved Site Development Control Plan exits	Develop a 10 year Estates Strategy and secure Board approval Develop a three year rolling capital planning programme to support Estates Strategy. Develop a Site Development Control Plan	Develop plans for the implementation and funding of BRI Redevelopment Phase 4 and align these with the 3 year rolling capital programme. Approve an Operational Capital programme for the year which delivers service-driven operational requirements whilst integrating with the medium term Strategic Capital Programme and the Strategic Developments. Review year 3 of the 3 year rolling capital programme to reflect progress made and changing operational requirements. Complete development studies for the two remaining areas of the precinct for which there is no long term plan. Consider the outcome of Trust Integration review and align Estate Strategy to that outcome.	50% to 75%	Trust Board Seminars Nov & Dec 2013 undertake discussions to shape direction. Jan 2014 report to Full Trust Board to agree approach and approve preparation of a SOC or FBC. March/April 2014 completion of SOC/FBC to CPSG/TME/Trust Board. Consultants appointed to undertake options appraisal for Old Building site and area east of Marlborough Hill. Programme of work agreed to progress towards Board Seminar on 15 November where options will be presented for discussion before work stream is completed. Options for Phase 4 being prepared for summer decision. Procurement method to be agreed. The three year operational and strategic capital programme is being reviewed following the decision to add a 24 bed ward to the Terrell Street building and to accelerate the provision of the Discharge Lounge and part of the CSSD department upgrade which will deliver the additional capacity required to support paediatric neuro and burns services transferring to the Trust in early 2014. Projects within the programme will be adjusted in terms of delivery dates to match the overall availability of capital year on year. Consultants for Estate Strategy work in connection with the two areas of the precinct will be appointed at end of June (Q1) to complete exercise by end of Q2.	All stakeholders views not taken into account. A programme of enabling projects and departmental moves has been completed and approved by both SESG and CPSG. Handover dates for the Terrell Street building are now confirmed by LoR and a ward closures programme is being developed jointly between Medicine and Surgery. Work continues with the two Divisions to define the extent of both major and minor works to wards as different specialties move to new locations. A £3m budget is agreed within the overall programme and it is a low risk that this would not be sufficient.	Green	Presentation of work and options to Board Seminar 15 November. Programme approval by SESG and CPSG has defined project scope, project-by-project budgets and an overall programme. A strict change control mechanism has been implemented. Risk registers are prepared on a project by project basis by the project group, all accountable to the BRI Redevelopment Project Board. CPSG also review spend against plan on a monthly basis.	Agreed base programme, space plan and budget with robust change control mechanism in place. BRI Redevelopment Programme Board has overall control and oversight with sub-groups with specific terms of reference.	Green		COO	Senior Leadership Team

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5	ES	5.2	Ensure on-going compliance with all annual fire and safety audits.	Avon Fire & Rescue Service issue no Improvement Notices. Health & Safety Executive issue no improvement notices. Care Quality Commission Outcome 10 (Safety and Suitability of Premises) remains compliant. Willis Risk Management Audit shows no major unmitigated risks.	Milestones within year four of the 4 - Year Fire safety Improvement Plan implemented - 2013/14 will the programme of fire compartmentation in the Queens building implemented. Review outcomes by Division, of the 2012 Annual Willis Risk Assessment and develop and deliver action and improvement plans. Continually review evidence with regard to Outcome 10 and update as capital and backlog programmes are delivered.	50% to 75%	Project to upgrade fire compartmentation in the Queens building has been tendered and is about to start in Q2. Issues around obtaining access to clinical areas may prolong the implementation. Annual Willis Risk Action Plan being implemented. Last year obtained blue rating Capital programme projects continue to contribute to positive action towards Outcome 10 assessment. Departmental Fire Risk Assessment compliance has increased from 54% to 80%	Potential for construction project delays relating to access to clinical areas may elongate the delivery of the overall programme.	Green	Regular review meetings with users re access. Fortnightly monitoring by Estates Forum Close monitoring of Departmental and building risk assessments. Close liaison with Avon Fire and Rescue Service so they understand our issues and what we doing about them.	Executive Management Group minutes Health and Safety Group minutes F&E Divisional Risk Management Sub-Group minutes Estates Forum Action Notes.	Green	1603	COO	Service Delivery Group
5	ES	5.3	To strengthen our approach to business continuity with the aim of ensuring patient safety and minimising operational disruption during times of incident.	UH Bristol viewed as a beacon Trust in the Avon Health Emergency Response Group area. Outcome of test exercises identifies no major shortcomings in Trust arrangements	Integration of the BS25999 standard into Business Continuity Management Strategy Continual review of all Divisional and Trust Business Continuity Plans. Consolidation of learning outcomes following Business Continuity Events into future planning (Medway, Generators). Alignment with the BS25999 Business Continuity Standard ,	50% to 75%	BS25999 will be superseded by ISO 22301. A current internal audit of all trust business continuity plans is being conducted. An internal and external audit have been completed and areas for BCM improvement identified. An improvement plan has been developed and will feature in 2013/14 work plan A structured debrief process is implemented following BCP incidents allowing for identification of learning outcomes and integration into future planning	Limited staff resource to enable full commitment to the process	Green	Current plans remain fit for purpose. 0.2 wte seconded to the team to provide assistance to Resilience Manager. Assessing future needs of team to improve resilience of the service.	Business continuity planning group provides progress updates to the Civil contingencies Committee	Green		COO	Civil Contingencies Committee
5	ES	5.4	Improvement trust wide satisfaction with the services provided by the Estates Function Development of KPIs and systems of feedback from Divisions to ensure improvements in responsiveness	User surveys indicate an 80% level of compliance with Service Level Agreement Key Performance Indicators User surveys show 80% return being good or excellent	Implement outcome of year end review against SLA Monthly review of patient feedback as provided through the Trusts continuous patient experience monitoring	75% to 100%	Estates SLA implemented from April 2013. First quarter reported to SDG . Second quarter report will expand the number of KPIs reported User survey being readied currently.	IT issues with hand held devices for reporting progress in real time delayed the full implementation from Q1 to Q2. Issues now resolved. Estates now require wifi coverage in the estates workshops to embed the technology. Implementation in Q3 .	Green	Estates users satisfaction survey completed Dec 2013, results to CPSG Jan 2014. Improvement in all categories. Escalated to Exec Team and priority given by IM&T to this work stream.	Divisional Board Minutes SDG minutes	Green		COO	Service Delivery Group
5	ES	5.5	Ensure estates practice contributes fully to infection control objectives	Internal and external Assurances / Audits indicate no major shortcomings in key safety related areas. All improvements to process identified through assurances and audits are fully implemented. Compliance with HTMs 1 -7 Assured regularly (at least once every 2 years) Increased percentage of single rooms available year on year.	Implement Operational Capital Programme with regard to estates projects. Implementation of the Agility web-based reporting system for maintenance reporting and tracking across all the Trust hospitals. Gain approval to and implement Service Level Agreement for Estates Services.	75% to 100%	Regular review meetings with I/C team re capital projects. Reviews of projects against four milestones are recorded in the Estates Forum notes. Compliance with ventilation HTM 03 generating additional costs in capital projects - which is being managed within budgets. Single rooms improvement will NOT be achieved in the year but will be delivered as and when the Terrell Street building is handed over in phases.	The key risk is changes in personnel where interpretation of requirements can change. Resource in I/C team to review works proposals is a risk at times of high activity.	Green	Monitored fortnightly by Estates Forum 1:1 liaison with I/C team project by project. 4-stage signoff process agreed with I/C and implemented	Executive Management Groups minutes	Green	1383	COO	Service Delivery Group
5	ES	5.6	Reduce further our carbon footprint	Carbon footprint is reduced by 5% per annum over next 3 years	Achieve annual reduction in energy consumption of 5% per annum over next three years. Implement annual milestones of three year energy strategy and Big Green Scheme. Sustainability aspect of Operating Plans to receive the same degree of review and scrutiny as other aspects of the plans.	50% to 75%	New Energy Report now produced monthly showing both volume by hospital and cost. Big Green Scheme revitalised September with a four-prong approach. Specific KPIs and targets are being finalised. Sustainability considerations a requirement of Divisional Operational Plans for this year. A programme of spend to save (both Trust funded and Department of Health funded) energy reduction schemes being implemented.	Users inadvertently increase demand for energy resource without being consciously aware of it e.g. installation of additional electrical equipment, IT equipment etc.	Green	Improved energy reporting methodology, shared with users	F&E Divisional Board minutes Monthly / quarterly finance and performance reviews SDG minutes	Green		COO	Service Delivery Group
6	T&L	6.1	Implement revised performance management processes to better align individual performance with trust goals	Performance management will fully support the achievement of Trust goals	Performance management framework implemented. Underperforming staff appropriately supported to improve. Reward and recognition scheme worked up.	50% to 75%	Corporate HR have designed performance management framework; Draft going to staff side for comments; all appraisal documentation being reviewed and updated; performance management documentation to be reviewed. Teaching and Learning to confirm additional training sessions for managers. Payroll and HR IS to advise on recording process. Link also to Regional ER Sub group.	Managers not appropriately managing poor performing staff.	Green	Good relations with staff side. Additional support for managers in how to performance manage staff including refresher training.	Regular staff side communication. Numbers of managers completing appraisal and performance management training.	Green		Dir W&OD	Teaching and Learning Group

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6	LTFP	6.2	Develop and embed a Trust wide transformation programme to ensure that the Trust maintains and wherever possible improves the quality of its services whilst reducing the cost base of those services in line with funding requirements.	The Trust achieves a balanced plan for the next three years	Re-invigorate the Transforming Care Programme through the recruitment of a new Transformation Director and the delivery of a renewed implementation group. Lead the creation and sign off of CRES plans to ensure a Trust wide balanced Operational Plan Drive the delivery of Year 3 and Transformation Plans and lead the development of any additional Transformation work streams.	50% to 75%	The Transforming Care dashboard has been developed defining clear scope, aims and success measures for trust wide projects, and giving Transformation Board renewed focus on the scope and effectiveness of the projects. Mobilised Transformation contacts for each Division and pathway improvement projects to increase engagement on Division Transformation priorities. Revised Transformation Board provides greater focus on savings programme issues and strengthened leadership of savings work streams.	Current schemes identified are not sufficient or robust enough to achieve the Trust wide savings requirement. Balance of transformation to savings not maintained Inability to identify further schemes for future years	Green	Close management of scheme development through accountability meetings, Programme Steering Group and Transformation Board. Senior Leadership Team is addressing our approach to productivity improvement linked to development of the work streams SLT approach balances actions which will deliver over at least 2 year period	Monthly and Quarterly Performance and Finance Meetings KPMG Review Programme Steering Group	Green		COO	Programme Steering Group
6	CSS	6.3	Delivery of significant improvement in outpatients by 2014.	The Outpatients function is transformed and is upper quartile nationally on a range of indicators including new to follow-up appointments, Do Not Attends and Cancelled appointments. Clinical Administration is streamlined by using technology, the new Patient Administration System is used to best effect and saved Consultant PAs have been redistributed/eliminated.	Continue to develop the central booking office. Maintain improvements in booking processes identified by the post-Medway implementation review. Achieve greater patient satisfaction as measured by reduced complaints. Deliver cost savings through improved outpatient efficiency. Increase throughput via improved productivity.	50% to 75%	Digital dictation system in implementation phase. Standards for Outpatients developed and implemented across the Trust. Review for compliance planned in Jan & Feb. Increased productivity of clinics by doing more through the same enabling FOT outpatients savings plan of £500K Appointment reminder system being implemented Q3&4 to reduce DNAs. Productivity sheets by speciality detailing slot utilisation, DNA rates, demand and capacity information completed for divisional to enable outpatients savings targets for 2014/15 to be agreed. Appointments centre in operation in Bristol Eye Hospital and Bristol Dental Hospital. Plan to move to Welcome centre Jan 2014 which will have face to face element. Changing Clinic structure to improve flow and reduce patient complaints in BEH.	Willingness of operational teams including clinicians to adopt best practice and comply with standards. Risk to cost saving as achievement may require reducing PAs & Nursing staff time. Risk that we are unable to accurately identify opportunities due to lack of slot utilisation figures from Medway	Amber	Rolling programme of specialty assessments focusing on priority areas first. Escalation to Clinical Chair & Divisional Director of required Escalation to Programme Steering Group if required Manual slot utilisation analysis while Medway development is progressed	Productive Outpatients Programme Steering Group Monthly and Quarterly Performance and Finance Meetings Programme Steering Group.	Amber	741	COO	Transformation Programme Board
6	CSS	6.4	Delivery of significant improvement in theatre productivity by 2014.	Theatre processes have been fully re-engineered and have released significant savings.	Review the productive theatre plans in light of re-worked theatre timetable.	50% to 75%	New theatre transformation programme mobilised. 5 work streams identified addressing prompt starts, scheduling, data capture and quality, non-pay (supplies) and theatre performance management. Away day held with senior staff to secure engagement and support for the approach.	Cancellations of elective surgery due to bed capacity constraints Maintaining momentum and securing the resource needed	Amber	Patient flow project looking at reducing LOS, improving flow and bed occupancy to improve access to acute beds and flow through ICU Senior Division leadership focus on success of the theatre project	Theatres Transformation Group Divisional Board	Amber	741	COO	Transformation Programme Board
6	CSS	6.5	Delivery of improvement to upper quartile for Average Length of Stay (ALOS) and associated bed productivity by 2014.	The Trust's Average Length of Stay (ALOS) is Upper quartile for the majority of HRGs.	Deliver reduced length of stay in line with revised capacity plan (tba) to ensure Trust is in line with 2014 bed plans. Programme to look at both internal and external factors.	50% to 75%	Joint Patient flow project with KPMG commenced in February - 7 projects in phase I - key deliverables include Discharge lounge opened September 2013, Elderly admissions unit operational, routine improved use of Medway to share bed status, reverse triage in place, and discharge logger for all adult wards. Phase II of patient flow project, now fully operational. Six projects have been prioritised - Ambulatory care, Ward Processes, Critical Care Pathways, Care homes project, Improved working with Partners / Out of Hospital Care, Medical Assessment unit.	Growth in activity and demand has a negative impact on planned bed reductions Reliance on external agencies to support admission avoidance and discharges to community. Winter pressures across the health community.	Amber	Phase II projects operational using the same governance structure as per Phase I. Regular monitoring of emergency demand across the patch to identify changes in volume and case mix Strong partnership working with external agencies including joint membership of Out of Hospital Care project group. Winter pressures funding identified to support additional pressures during January 2014.	R3 Programme Steering Group and weekly Project meetings Monthly and Quarterly Performance and Finance Meetings System Wide Operational Group	Amber	741 1422 1704	COO	Transformation Programme Board
7	CSS	7.1	Develop and implement an engagement programme that ensures staff are fully involved in the work and development of the trust, are able to contribute to its further development and go the extra mile to ensure its success.	Fully engaged workforce evidenced by their participation in and awareness of transformation programme, reflected in staff survey results	implementation continues in line with Trust priorities. Multiple significant programmes and events take place across the Trust promoting and seeking involvement in Transforming Care Evaluation commences through staff survey.	50% to 75%	Engagement paper taken to Strategic TME, outlining proposed objectives and actions. Agreement secured to carry out baseline measurement exercise across the Trust. This has been scoped and costed and is the subject of a further paper. Recommendation and action is to carry out Divisional specific surveys in addition to national survey. Working group set up with Divisional HR Business Partners and AD HR (OD) to plan and execute divisional specific engagement activities, support retention, and share best practice. Each division has an engagement plan, linked to division-specific issues. Reward/recognition framework developed, to ensure strong, positive performance management. Evaluation carried out via National Staff Survey. Local surveys/focus groups being established to strengthen and deepen evaluation tools and to inform future engagement plans.	Lack of staff and manager engagement in the process.	Amber	Engagement programme underway. Listening evens undertaken. Divisional engagement plans developed for each Division and discussed/challenged at quarterly reviews. Back to the Floor exercises planned for autumn/winter.	Staff are actively attending and contributing to engagement events.	Amber		Dir W&OD	Trust Management Executive

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7	R&I	7.2	We will train, mentor and support research-active staff to deliver high quality translational and applied health services research of direct patient benefit in our priority areas of research	Increased number of staff participating in research activities with associated increase in number of approved research Pas, patients in trials and grant income.	Continue research workforce work plan to develop a skilled, high performing workforce. Develop and make available tools to allow all staff to understand and interact with the research agenda, as appropriate for their roles, leading to greater understanding within the trust of the purpose and benefits of research.	50% to 75%	Workforce work plan continuing according to plan. Research Matron has developed key links with peers and with band 7 research nurses, an important new line of communication into the divisions. Work has commenced with OD to develop tools for UH Bristol staff in leadership roles to support their research understanding and skills.	No significant risks identified to date.	Green	Not applicable	Not applicable	Green		Dir Med	Research Group
7	CSS	7.3	Ensure continuing GMC licensing of all Medical Staff, and compliance with Responsible Officer legislation, through the development and operation of an effective and efficient Revalidation process	An effective and efficient system of Revalidation supporting the continued licencing of Medical Staff by the GMC	Operate the Trust's Revalidation system and provide Revalidation recommendations to the GMC	50% to 75%	Revalidation system working well. 74 doctors revalidated since April 2013. 2 deferrals and one non-engagement. Smooth rollout of e-portfolio system to support revalidation. Good uptake of use of this system. All appraisals will be on this system by April 2014 with the exception of a few clinical fellows using the appropriate College based system. Contract for 360 patient and colleague feedback system has been signed.	Difficulty in identifying relatively short term clinical fellow posts.	Green	1: Have developed share drive spread sheet with Medical HR to ensure list of Clinical fellows is kept up to date. Working reasonably well.	Monitored at monthly Revalidation Group meeting	Green		Dir Med	Senior Leadership Team
7	T&L	7.4	We become an acknowledged regional leader in equality and diversity outcomes both for our patients and staff	All Trust staff (new and existing) undertake basic E&D training dealing with communication and behaviours Selected Trust staff undertake specialist training and updates Patient satisfaction levels are broadly similar across all protected characteristics Patient complaints centred on E&D issues are minimised Staff satisfaction levels are broadly similar for all protected characteristics	Year on year increase in % accessing training. Target 80% by 2014 Year on year development of trained and supported staff, competent in new legislation, new clinical issues such as dementia care etc. Rising patient satisfaction levels and reducing differentials between groups Reduction by 15% - remove Rising staff satisfaction levels and reducing differentials between groups as measured through patient and staff satisfaction surveys.	25% to 50%	Values training now include E&D aspects and needs to be accounted in % coverage returns. Difficulty in accessing complaints by protected characteristics in order to measure satisfaction levels; E&D/EDS leaflet to launch in Autumn.	Limited time on corporate induction for satisfactory Equality and Diversity Training. Trust does not monitor all its patients for protected characteristics.	Amber	HWB/ED group to discuss and acknowledge issues relating to E&D.	Regular reporting on E&D issues and workforce issues.	Amber		Dir W&OD	Equality and Diversity Steering Group ; Patient Experience Group
7	T&L	7.5	We become a national exemplar for the NHS Equality Delivery System	Implementation of the NHS Equality Delivery System	Implementation enables the Trust to make year on year improvements in reported health outcomes for those in protected groups	25% to 50%	UH Bristol working with BNSSG E&D leads to refresh EDS across the locality (EDL relaunched in November 2013).	Lack of implementation of the EDL.	Amber	HWB/E&D group to discuss and acknowledge issues relating to E&D. Need to review the Trust's EDL in light of the revised changes. Patient Experience group also being involved.	Regular reporting on equality diversity to the E&D/HWB Steering group with appropriate action as required.	Amber		Dir W&OD	Equality and Diversity Steering Group Trust Board
8	IT	8.1	Implement modern clinical information systems in the Trust	Modern clinical information systems are in use in the Trust	Phase 2 Implementation Phase 3 Design	50% to 75%		Continuing monitoring of system operation	Green	Regular monitoring in place	IM&T Committee and CSIP Committee	Green		DoF	Information Management and Technology Board
8	IT	8.2	Review and deliver fit for purpose clinical admin support processes	Fit for purpose clinical admin process in place	Agree and implement action plan arising from review	75% to 100%	Now converted into other work steams. Completed - to be reviewed 2014/15.	No significant risks identified to date.	Green	Not applicable	Not applicable	Green		DoF	Transformation Programme Board
8	IT	8.3	Improve our ability to manage our business through the production of robust and timely business intelligence to both head quarters and divisional staff	20% reduction in analyst time spent on routine report preparation. Improved Divisional satisfaction with information format and flow	Review staff use of QlikView Workforce, Ward Key Performance Indicators and other reports that were piloted in 2012/13, to inform changes in reporting requirements and access to reports. Develop a full suite of QlikView reports to support the Transformation agenda. Using the Divisional Analyst time freed-up by QlikView, along with the identified Corporate and Divisional information needs, develop reports that provide additional business intelligence (e.g. benchmarking data, predictive modelling/forecasting). Conduct an annual review of business intelligence and reporting needs and update QlikView reporting in line with this.	75% to 100%	Evaluation of the QlikView Workforce reports completed and presented to the Service Delivery Group (SDG) on the 2nd July. Consideration will be given to the inclusion of Essential Training compliance information once the Learning Management System has been successfully implemented. The use of QlikView to provide budgetary analysis also being scoped. QlikView now contains all Trust Key Performance Indicators. This includes transformation metrics used to monitor and provide decision support for the R3 work-stream. Monthly data briefings now provided for R3 using QlikView reports. These have informed Phase II of the Patient Flow Programme. QlikView is also being used to develop Clinical Dashboards, which will be piloted in Q4 in Surgery, Head & Neck. Benchmarking reports produced for both TME and the Cancer Board on a quarterly basis. Benchmarking data-sets now made available to Divisional teams to support the development of the 14/15 Operating Plans.	No significant risks identified to date.	Green	Not applicable	Not applicable	Green		Dir SD	Senior Leadership Team
8	LTFP	8.4	Develop better understanding of service profitability using Service Line Reporting	Better resource allocation in the Trust	SLR development. Use of results in informing Business Planning.	0% to 25%	2012/13 results published.	Staff turnover with two costing specialists having recently secured promotion elsewhere.	Green	Replacement commences November 2013.	Not applicable	Green		DoF	Finance Committee

Objective	Driving Strategy	Serial Number	Strategic Objectives (3 – 5 years)	Outcome	Key Priorities for Action 2013-2014	Progress Towards Achievement of Actions %	Progress Towards Achievement Narrative	What are current risks to achieving our objectives	Risk rating (Red, Amber, Green)	How are the risks to achievement being mitigated? (controls)	Source of Assurance that Risks are Actively Managed	Residual Risk To Achieving Objective	Risk Register Reference (if applicable)	Executive Owner	Executive Management Group
9	T&L	9.1	Deliver a full Trust review of structures using the "spans and layers" approach	Structures will have appropriate spans of control and the number of layers between senior leaders and patients will be minimised	Spans and layers programme completes. Full assessment of outcomes reported and maintenance targets achieved. Further review of structures with new programme of potential changes identified	75% to 100%	Spans and layers no longer currently active as a programme.	No significant risks identified to date.	Green	Not applicable	Not applicable	Green		Dir W&OD	Senior Leadership Team
10	LTFP	10.1	Deliver minimum normalised surplus	Deliver minimum normalised surplus	Achieve full delivery of annual CRES programme (detail provided below) and positive contract settlement with CCG and NHSE commissioners.	50% to 75%	SLA signed in line with Heads of Terms. CRES Delivery (see 10.3)	LA sign off and Somerset CCG re re-admissions	Green	On-going discussions.	Oversight by operational planning core group.	Green		DoF	Finance Committee
10	LTFP	10.2	Deliver minimum cash balance	Deliver minimum cash balance	Maintain ratio of at least 15 days and cash balance of no less than £15m.	75% to 100%	Trust remains on target to meet objective this year.	Satisfactory income and expenditure outturn.	Green	Monthly cash flow projections and liquidity performance reported monthly to Finance Committee.	Monthly reports to Finance Committee and Trust Board. Quarterly Reporting to Monitor via Finance Committee and Trust Board.	Green		DoF	Finance Committee
10	LTFP	10.3	Deliver the annual Cash Releasing Efficiency Savings (CRES) programme in line with the LTFP requirements	Cost reductions commensurate with CRES target achieved	Ensure robust in year oversight of Divisional CRES plans through monthly Finance & Operations Reviews Develop recurrent CRES plans to ensure all non-recurrent CRES is secured recurrently by Q3 2012. Deliver 13/14 CRES requirement on a normalised basis.	75% to 100%	As at month 07 80% target identified ion a risk assessed basis The Trust has a savings target for 2013/14 of £20.989m the forecast outturn delivery is £16.871m as at month 07 or 80.0% This forecast outturn has remained at roughly this figure for some time . It is imperative that new savings schemes are implemented urgently in order to improve this figure. As the present time there is little assurance that the Trust will achieve the target set for this financial year. hence the red RAG rating. Within the forecast outturn of £16.871m there remains non recurring savings identified of £3,845m.	The most significant risk to the existing plans is the risk of not being able to close beds within the Medicine Division this is valued at £635k in the savings plan and built into the current forecast outturn . Other savings plans have been robustly risk assessed however there still remains a forecast shortfall this year of £4.1m overall. The Non recurring savings within the overall forecast outturn of £16.871m is currently £3.845m.	Red	Savings Programme plans are regularly reviewed each month at Divisional and Work stream accountability meetings . This helps to ensure that the current forecast delivery is robust. Workstreams have been refreshed and are identifying additional savings through productivity in Theatres and Outpatients although it is not anticipated that this will generate additional savings in 201314 all underachieved savings will be carried forward to the next financial year.	Divisions are held to account for this both at Monthly Divisional Savings Programme Reviews and more importantly the monthly Operational and Financial reviews chaired by the COO and attended by the DOF and other Directors. Monthly reports on progress are presented to the Finance Committee Internal Audit Report.	Red	741	COO	Finance Committee
11	LTFP	11.1	Maintain Monitor Financial Risk Rating of 3 or above	Maintain Monitor Financial Risk Rating of 3 or above	Achieve EBITDA, Return on Assets, Net Surplus Margin and Liquidity ratio in line with plan	50% to 75%	Financial Risk Rating of 3 to Month 2 May 2013.	Delivery of CRES plans and reduction of premium cost services. Increase in volume of clinical activity to secure income from activities income in line with SLA and Trust Plan.	Green	Monthly Operational and Financial Reviews chaired by COO with Exec Director support.	Monthly reports to Finance Committee and Trust Board. Quarterly Reporting to Monitor via Finance Committee and Trust Board.	Green		DoF	Finance Committee
11	T&L	11.2	Achieve Compliance with New Deal contractual requirements for junior medical and dental staff	All staff will be working appropriate hours, and taking appropriate rest breaks.	Remain compliant in audit through regular monitoring and review of shift patterns and hours worked.	75% to 100%	Monitoring of rotas continues, in close conjunction with Lead Doctors, Divisional Directors and HR Business Partners. Concerted efforts are being made to reduce the number of non-compliant rotas.	There are a small number of areas where achieving compliant rotas is challenging.	Red	Regular monitoring exercises planned in all areas. Re-monitoring exercises are undertaken where required. Communication maintained with job holders concerning hours worked. Regular meetings taking place between Lead Doctors, Divisional Directors and HR Business Partners Progress reviewed by Executive Lead at monthly Divisional finance and operational review meetings.	Monitoring of Junior Doctors hours.	Red		Dir W&OD	Senior Leadership Team
11	CSS	11.3	Maintain registration with CQC including compliance with essential standards of quality and safety	Continued compliance with all relevant CQC standards	Ensure on-going compliance with all CQC registration Outcomes	50% to 75%	Following CQC re-inspection of Ward 32 (BRHC) and Maternity Services on 26/4/13, the Trust became formally compliant with all CQC Outcomes. The CQC carried out a responsive review of BRHC theatres on 19/11/13 - the CQC's judgement is that the Trust is non-compliant with Outcome 8 (cleanliness and infection control - primarily due to inconsistent cleaning and infection control practices in areas adjacent to paediatric theatres, i.e. corridors and storage areas) and Outcome 16 (assessing and monitoring quality of service provision - primarily because of an ineffective system for assessing risks).	By definition, the Trust has not achieved its goal of maintaining compliance with all CQC standards throughout 2013/14. At the time of writing, an action plan is being drafted by Women's and Children's Division to address concerns identified in the 19/11/13 inspection - this plan is due to be submitted to the CQC by 3/1/14.	Red	Operational and Executive Leads for all Outcomes. Monitoring by CQC group, Risk Management Group. Actions in relation to 19/11/13 inspection are owned by Women's and Children's Divisional Board.	Operational and Executive Leads for all Outcomes. Monitoring by CQC group, Risk Management Group.	Red		Chief Nurse	Risk Management Group

Objective	Driving Strategy	Serial Number	Strategic Objectives (3 – 5 years)	Outcome	Key Priorities for Action 2013-2014	Progress Towards Achievement of Actions %	Progress Towards Achievement Narrative	What are current risks to achieving our objectives	Risk rating (Red, Amber, Green)	How are the risks to achievement being mitigated? (controls)	Source of Assurance that Risks are Actively Managed	Residual Risk To Achieving Objective	Risk Register Reference (if applicable)	Executive Owner	Executive Management Group
11	CSS	11.4	Maintain a "Green" Monitor Governance Risk Rating and meet all mandated and contractual performance targets.	Continued compliance with all relevant performance standards set as part of Monitor's performance framework (and contractual negotiations), with special reference to those three priorities set out below,	Build sustainable performance in all areas with aim of moving ambition for delivery beyond national standards where possible	50% to 75%	Delivery against 4 hour standard at a Trust level in October and November but there has been a deterioration in performance in December both at the BRI and Children's hospitals. Elderly admissions unit opened in 19th June 2013. Discharge lounge opened on 16th September 2013. Improved performance for diagnostic endoscopy waiting times (99% target achieved in November)	1. Sustaining 4 hour performance during winter months 2. Backlog of ENT / OMF / Clinical Genetics non-admitted waits impacting on RTT performance 3. Cdiff performance exceeding target 4. Cancer 62 day performance at risk for Q4	Red	1. Patient Flow project phase II in progress which includes both internal and external partnership working. Regular monitoring of demand to identify trends. 2. Recovery plan for ENT and Clinical genetics RTT performance being monitored on a weekly basis to ensure improvements in performance 3. Regular monitoring of progress against action plan. 4. Cancer Rapid Improvement Group focussing on pathway improvements for 62 day cancer waits. Escalation process for cancellations of elective activity to ensure appropriate actions taken to prevent cancellations. On-going discussions regarding breach reallocation for late referrals. Business case for 20th ITU bed approved. Profiling of complex cases throughout the week being reviewed.	R3 Programme Steering Group Monthly and Quarterly Performance and Finance Meetings Service Delivery Group System Wide Operational Group	Red	1422 1967 1412 1383	COO	Senior Leadership Team

University Hospitals Bristol NHS
NHS Foundation Trust

Report for a Public Trust Board Meeting, to be held on 30 January 2014 at 10:30 in the Conference Room, Trust Headquarters, Marlborough Street, Bristol, BS1 3NU

21. Results of Q2 Compliance Framework Monitoring

Purpose

To brief the Board on the results of the Quarter 2 Compliance Framework Monitoring Exercise.

Abstract

Monitor's analysis of Q2 is now complete. Based on this work, the Trust's current ratings are:

- Financial risk rating - 3
- Shadow continuity of services risk rating - 4
- Governance risk rating – GREEN

The Trust has been assigned a Green governance risk rating but has failed to meet the C.difficile, RTT (non-admitted) and Cancer 62-day wait (from urgent GP referral) targets.

Recommendations

The Board is recommended to note the report.

Report Sponsor

- Chief Executive

Appendices

- Appendix A – Q2, 2013-14 Reporting Executive Summary

University Hospitals Bristol NHS Foundation Trust
Q2 2013 - 14 Reporting Executive Summary

Monitor

Risk ratings

Financial Risk Rating:			Shadow Continuity of Service Risk Rating	
13/14:	YTD Plan	YTD Actual	13/14:	YTD Actual
	3	3		4
Governance Risk Rating:				
Declared risks at APR:	• Cdiff, RTTnona, AETime		YTD Actual:	Green
Breaches for Current Period:	• Cdiff, C62dGP, RTTnona			

- The Trust achieved a FRR 3 in line with plan at Q2 2013/14. EBITDA is behind plan by £1.3m (£15.7m v £17.1m) largely due to overspends on agency costs, spend on additional capacity to meet activity levels ahead of plan and cost savings behind plan.
- The Trust has breached the C.difficile, RTT (non-admitted) and 62-day cancer performance targets at Q2 2013/14 and is rated GRR Green.

Summary Income & Cash Flow vs Plan

£m	2013/14 Q2			2013/14 YTD		
	Plan	Actual	Variance	Plan	Actual	Variance
Op. Rev for EBITDA	135.7	137.5	1.7	268.2	269.3	1.1
Employee Expenses	(79.5)	(79.5)	(0.1)	(158.9)	(157.4)	1.5
PFI Op. expense	0.0	0.0	0.0	0.0	0.0	0.0
All other Op. costs	(47.0)	(49.5)	(2.5)	(92.2)	(96.1)	(3.9)
EBITDA	9.3	8.4	(0.9)	17.1	15.7	(1.3)
Surplus/(Deficit) pre exceptionals	4.4	3.8	(0.6)	7.7	6.7	(1.0)
Net Surplus/(Deficit)	1.5	0.5	(1.0)	2.0	0.7	(1.3)
EBITDA %	6.8%	6.1%	(0.7%)	6.4%	5.8%	(0.5%)
CapEx (Accruals Basis)	(18.4)	(16.2)	2.3	(37.1)	(31.6)	5.5
Net cash flow	5.3	2.4	(2.8)	17.6	0.8	(16.8)
Cash & Equiv	52.7	35.9	(16.8)	52.7	35.9	(16.8)
FRR Liquidity days	33.7	22.7	(10.9)	33.7	22.7	(10.9)
CIP % OpEx less PFI	4.3%	3.1%	(1.1%)	4.1%	2.9%	(1.3%)
Net current assets	19.1	4.5	(14.6)	19.1	4.5	(14.6)
Borrowing (excluding PFI)	64.8	45.8	(19.0)	64.8	45.8	(19.0)

Key risks	Action taken / committed	Gaps and residual concerns
Performance target breaches • **C.diff:** The Trust breached the Q1 and Q2 target and has breached the Q3 target at November 2013 reporting 28 cases against a Q3 target of 26. • **RTT(nona):** The Trust breached the target in each month of the quarter, resulting in a breach at Q2 (91.8% v 95%). • **Cancer62d:** The Trust breached the Q2 target (78.8% v 85%) largely due to a change in its portfolio of services. • **A&E**: The Trust met the A&E target at Q2, however A&E performance remains a risk over the winter period.	• The Trust's review of each C.difficile case has confirmed that there is no evidence of cross-infection. The Trust continues to work with its partners to address appropriate antibiotic prescribing in the community. • The Trust has capacity in place across the year to reduce the number of long waiters and address the RTT backlog. The Trust is in discussion with commissioners to agree a cap on fines, which is currently agreed at £250k. • The Trust has established a programme of cancer improvement pathway work. The impact is expected to be realised from the end of Q3 2013/14. • The Trust's winter plan has been approved by the Board. The Bristol Royal Infirmary (BRI) redevelopment will further support improvement of A&E patient pathways.	• The Trust has breached the C.difficile target in three consecutive quarters, up to and including Q3, which will trigger consideration of further regulatory action in line with the *Risk Assessment Framework* at Q3 2013/14. • The Trust has declared a risk to achievement of the RTT (non-admitted) target and 62 day cancer target at Q3. The Trust is forecasting a return to compliance from Q4 2013/14. • There is a risk to A&E performance over winter 2013/14 given the Trust failed to meet the target during winter 2012/13. A&E pressures may adversely impact Q4 RTT and cancer performance.
Operational improvements • The Trust has on-going concerns around length of stay, poor discharge and excess demand on emergency which is resulting in high agency costs and overspends. • Length of stay reduction is required for successful delivery of the Bristol Royal Infirmary (BRI) redevelopment.	• The Trust has completed Phase I of its patient flow programme which resulted in the opening of a new discharge lounge and elderly assessment unit. The Trust has commenced work on Phase II and III which includes working with Bristol CCG to increase bed capacity across the out of hospital care pathway.	• Additional costs to meet emergency demand will continue to erode EBITDA. • Where length of stay reduction is not achieved this may impact delivery of both the winter plan and cost savings plan.
CIP planning and delivery • The Trust has delivered 79% of its cost saving and revenue generation target at Q2 and is anticipating an in-year cost savings shortfall. • The CIP gap in future years remains substantial.	• Governance arrangements for identification and delivery of cost savings are being led by the Director of Transformation and are embedded in the Trust's processes. • The Trust is working with other trusts in the area to identify further cost savings opportunities for the medium term.	• Reliance on additional funding for activity above the base contract raises the risk of contract disputes and increases financial pressure in future periods. • Use of reserves to mitigate overspend and CIP slippage may put pressure on delivery of the plan.
Next steps	• **Continue quarterly monitoring.**	

University Hospitals Bristol NHS
NHS Foundation Trust

Cover Sheet for a Report for a Public Trust Board Meeting, to be held on 30 January 2014 at 10:30 in the Conference Room, Trust Headquarters, Marlborough Street, Bristol, BS1 3NU

22. Q3 Risk Assessment Framework Monitoring and Declaration

Purpose

The Trust is required to make its quarter 3 declaration of compliance with the 2013/14 Monitor Risk Assessment Framework by 31 January 2014. The purpose of this report is to set out the Senior Leadership Team's recommendations to the Board in support of this declaration.

Abstract

Since 1 April 2013 all NHS foundation trusts require a licence from Monitor stipulating specific conditions that they must meet to operate. Key among these are financial sustainability and governance requirements. The 'Risk Assessment Framework' constitutes Monitor's approach to overseeing the sector under the new rules. It explains how Monitor will use the framework to assess individual NHS foundation trusts' compliance with two specific aspects of their work: the continuity of services and governance conditions in their provider licences.

The Risk Assessment Framework replaced the Compliance Framework from 01 October 2013.

The aim of a Monitor assessment under the Risk assessment framework is to show when there is:

- a significant risk to the financial sustainability of a provider of key NHS services which endangers the continuity of those services; and/or
- poor governance at a NHS foundation trust.

These will be assessed separately using new types of risk categories set out in the Framework; each NHS foundation trust will be assigned two ratings. The role of ratings is to indicate when there is a cause for concern at a provider. It is important to note that concerns do not automatically indicate a breach of the licence or trigger regulatory action. Rather, they will prompt Monitor to consider where a more detailed investigation may be necessary to establish the scale and scope of any risk.

This report sets out the Trust's risk rating for finance and governance, as calculated using the criteria set out in the Risk Assessment Framework.

The Director of Strategic Development and Deputy Chief Executive has provided an analysis of governance risk (Appendix A).

The Director of Finance and Information has provided commentary on financial risk to the Finance Committee.

The Trust Executive confirms that it is not aware of any matters arising in the quarter requiring an exception report to Monitor which have not already been reported.

Recommendations

The Trust Board of Directors is recommended to approve a declaration as follows:

- A submission against the 'Governance Rating' reflecting the three standards failed in quarter 3, and,
- A 'Continuity of Service Risk' of 4 (3.5 rounded up).

Report Sponsor
Chief Executive
Appendices
Appendix A – Monitor Quarter 3 declaration against the 2013/14 Risk Assessment Framework for Governance

Monitor Quarter 3 declaration against the 2013/14 Risk Assessment Framework for Governance

1. Context

The Trust is required to make its quarter 3 declaration of compliance with the 2013/14 Monitor Risk Assessment Framework by 31st January 2014.

The Trust's scores against the Risk Assessment Framework are used to derive a Governance Rating for quarter 3, by counting the number of 'Governance Concerns' that have been triggered in the period. These Governance Triggers at present include the following:

- Service Performance Score of 4 or greater (i.e. four or more standards failed in the period)
- A single target being failed for three consecutive quarters
- The A&E 4-hour standard being failed for two quarters in any four-quarter period *and* in any additional quarter over the subsequent three-quarter period
- Breaching the annual *Clostridium difficile* objective by failing three consecutive year-to-date quarters *or* failing the full-year objective at any point in the year
- CQC warning notices

In the future Monitor intends to include in its list of Governance Concerns patient and staff metrics including changes in satisfaction rates, turn-over rates, levels of temporary staffing and cost reduction plans in excess of 5%.

The resultant Governance Rating that Monitor publishes will depend on further investigations it conducts following Governance Concerns being triggered. The following shows the rationale for the application or either a GREEN or a RED rating:

Table 1 Monitor's process for determining the Governance 'status' of a Foundation Trust

Governance 'status' of the Foundation Trust		Governance rating: What Monitor will publish
No evident concerns	→	Green
Issue identification **Prioritisation** **Consideration of breach**	Emerging concerns (e.g. persistently failing access targets; major third party concerns, financial issues) Further information requested Concerns serious enough to trigger formal investigation Breach or likely breach identified; formal/informal action pending	**Current status and a description of:** • Factors driving concerns • Actions Monitor is taking/considering • Next steps
Action Formal regulatory action under sections 105 (Enforcement undertakings), 106 (Discretionary requirements), and/or 111 (Licence condition and Powers of removal, suspension and disqualification of directors and governors)	→	Red

Each quarterly declaration to Monitor must take account of performance in the quarter, and also note expected performance risks in the coming quarter. The forecast risks will be declared to Monitor as part of the narrative that accompanies the submission.

Monitor compares the quarterly declarations a trust makes with its Annual Plan risk assessment. If a trust declares a standard as not met as part of its quarterly declaration, which it did not declare at risk in the annual plan risk assessment, the trust may be required to commission an independent

review of its self-certification and associated processes. In the 2013/14 Monitor Annual Plan the Trust declared three standards to be at risk of failure in the year:

- A&E 4-hour maximum wait
- *Clostridium difficile* (C. diff) annual objective
- 18-week Referral to Treatment Time (RTT) non-admitted standard

2. Performance in the period

Table 2 shows the performance in quarter 3 against each of the standards in Monitor's Risk Assessment Framework. The following standards were not achieved in the quarter:

- *Clostridium difficile* (C. diff) (scores 1.0) – failed for the third consecutive quarter (Governance Concern triggered)
- RTT Non-admitted pathways standard (1.0)
- A&E 4-hour standard (1.0) – failed during a three-quarter period following failure during the preceding four-quarter period (Governance Concern triggered)

Under the rules set-out within the Risk Assessment Framework both the C. diff and the A&E 4-hour standard would trigger Governance Concerns.

In addition, if either the 62-day GP or 62-day Screening standards are confirmed as having been failed in quarter 3, this would add an additional 1.0 to the Service Performance Score, giving an overall score of 4.0 and triggering a further Governance Concern. Please note that performance against the cancer standards is still subject to final national reporting at the beginning of February and therefore the position shown in Table 2 is draft only.

3. Quarter 3 risk assessment

The risk assessment detailed in Table 2 sets-out the performance against each standard in Monitor's 2013/14 Risk Assessment Framework in quarter 3, along with the key risks to target achievement for quarter 4. The mitigating actions that are being taken are also provided, along with the residual risk.

The C. diff objective is assessed to have a high residual risk of not being achieved in quarter 4, due to the flat seasonal profiling of the trajectory by Monitor, and the cumulative position year-to-date at the end of quarter 3. To achieve the quarter 4 target (which is the annual objective of 35 cases) the Trust would need to have no more than one further case in quarter 4, which is considered to highly unlikely. A failure against the *C. diff* objective in quarter 4 would again trigger a Governance Concern against the new Risk Assessment Framework. However, Monitor has already reflected its recognition of the challenge such a low number of cases now represents for this and other trusts in the same position.

The failure of the A&E 4-hour 95% standard in quarter 4 would also result in a Governance Concern being triggered. Monitor's response to this is likely to be dependent upon its review of the quarter 3 failure and the resultant actions and improvement trajectory the Trust commits to.

It was originally forecast that the transfer of Head & Neck services from North Bristol Trust (NBT) at the end of March would result in a potential failure of the RTT non-admitted standard for the first two quarters of 2013/14, due to the longer than expected waiting times at the point of transfer and partial validation of pathways. Whilst the RTT Non-admitted standard was achieved in quarter 1 this year, the standard was failed each month in quarter 2 and quarter 3. Although good progress has been made in addressing the Head & Neck backlogs the risk of a further quarter's failure has increased as a result of the long waiting times for first outpatient appointments in quarter 4 for Adult ENT and a number of dental specialties. More recently performance against the non-admitted standard has declined in a number of other RTT specialties including Rheumatology and

Trauma & Orthopaedics. Referrals have increased across a range of specialties, putting additional pressure on services to maintain shorter waiting times for first outpatient appointments in the face of this additional demand. A failure to achieve the RTT Non-admitted in quarter 4 would be the third consecutive this standard has been failed. This would also trigger a Governance Concern. Plans have been developed to improve performance in all specialties that are currently not achieving the 95% standard.

The Trust is currently expected to confirm achievement of the 62-day GP and screening cancer standard in quarter 3, following the reallocation of breaches to late referring providers. This, however, is subject to final reporting and breach reallocation agreement. The portfolio of cancer services that the Trust now provides, following the transfer out of Breast and Urology and the transfer in of all Head & Neck cancers, makes the 62-day GP standard significantly more challenging to achieve, as evidenced by national performance for each tumour site. Although there is an active programme of improvement work the 62-day GP standard is flagged as high risk in quarter 4 specifically due to the additional impact high levels of patient choice and late referrals have on breach volumes in quarter 4. However, in achieving the standard in quarter 3 the Trust will have, critically, avoid a pattern of consecutive failures of this standard.

A further three standards have a moderate residual risk of being failed in quarter 4. These are the RTT Ongoing pathways standard, the 62-day Screening cancer standard and the 31-day subsequent surgery cancer standard. Risks to achievement of these standards remain under close scrutiny through the Service Delivery Group (SDG) and the Senior Leadership Team (SLT).

4. Recommendation

The Trust will be declaring the standards failed in quarter 3 to be, the *C. diff* objective, the RTT Non-Admitted standard, and the A&E 4-hour standard. In addition it is recommended that the likely failure of the *C. diff* and RTT non-admitted standards for a further quarter are flagged to Monitor as part of the narrative that accompanies the declaration, along with the ongoing risks to achievement of the A&E 4-hour standard and the 62-day GP cancer standard.

Table 2 Summary of 2013/14 quarter 3 performance and the risks to quarter 4 compliance

Indicator[1]	Q3 Score	Achieved in Q3 2013/14?	New risks to Q4 2013/14?	Risks/Issues	Steps being taken to mitigate risks	Current risk rating	Residual risk rating[2]
18-weeks Referral to Treatment for admitted pathways (aggregate)	1.0	Yes – achieved each month	No – continued risks from Q3	- Long waits for first outpatient appointments in Adult ENT, Dermatology, Dental and some paediatric specialties. - Increasing backlogs in some admitted specialties, such as Ophthalmology and some paediatric specialties.	- Additional capacity being established to reduce the > 18 week backlog wherever possible - Cross Divisional approach to "breach quota" to support whole Trust achievement. - Robust monitoring and escalation to optimise the number of long waiters booked each month.	Moderate	Low
18-weeks Referral to Treatment for non-admitted pathways (aggregate)	1.0	No – not achieved Oct to Dec	No – continued risks from Q3	- Head & Neck non-admitted backlogs reducing, but still being addressed - Long waits for first outpatient appointments in Adult ENT, Dental and some paediatric specialties - Non admitted RTT performance cannot be planned/managed in the same way as admitted pathways, because attendance at an outpatient appointment may, or may not, stop a patient's RTT clock	- Additional capacity being established to see as many ENT and Dental patients as possible before 18 weeks - A revised process for offering ENT patients a choice of being referred to the local Independent Sector Treatment Centre is being established - Plans have been developed to support achievement of the RTT Non-admitted standard in all other RTT specialties.	High	High
18-weeks Referral to Treatment for	1.0	Yes – achieved	Yes – not fully	- Same as for RTT admitted, plus; - Waiting times for future new	- See RTT admitted and non-admitted plans	High	Moderate

[1] The highlighted indicators are those flagged as at risk in the 2013/14 Annual Plan.

[2] The 'Residual' Risk Rating represents the most likely risk level that will remain once the impact of mitigating actions have been applied to the 'Original' risk. The 'Original' risk is the risk rating before any mitigating actions have been taken. For this reason the terms are different from the 'Current' and Target' risk categories used on the Trust's Risk Register for the management of risk.

incomplete pathways (aggregate)		each month	mitigated	outpatient appointments have increased which is likely to impact on the number of over 18 week ongoing pathways in Q4	- Small team of temporary staff to be appointed to validate 'On hold' patients on Medway in Q4, which is likely to improve RTT Ongoing performance		
A&E Maximum waiting time 4 hours	1.0	No – achieved 95% standard in Oct and Nov but failed in Dec and Q3 as a whole	Yes – Q4 historically worst performing quarter	- Ambulance arrivals remain significantly higher than in previous years - Length of stay generally decreasing but still above plan - Delayed discharges have reduced but over 14-day stays remain higher than optimal - Norovirus outbreaks common in Q4 - A further spike in paediatric respiratory illness whilst unlikely cannot be ruled-out - Increased levels of trauma and weather related illnesses more likely in Q4	- Phase 2 of the Patient Flow has been planned and is now in the implementation phase - BRI Discharge Lounge open, which has been associated with improved timeliness of discharge and improvements in flow in Q3 (even at higher occupancy rates) - Additional actions continue to be taken to support performance at the Bristol Children's Hospital	High	High
Cancer: 62-day wait for first treatment – GP Referred	1.0	Yes – with late referral breach reallocation (**SUBJECT TO FINAL REPORTING**)	Yes – Q4 historically a poor performing quarter due to patient choice to delay over Christmas period	- High levels of patient choice - Late tertiary referrals - Increasing volumes of patients for tumour sites that nationally perform well below the 85% standard - Intensive Therapy Unit (ITU) bed related cancellations - Cancellations of surgery due to emergency pressures	- Weekly Cancer Rapid Improvement Group established in Q3, focusing on pathway redesign for high volume ,lower performing, tumour sites and improving steps in the pathway for high volume causes of breaches - Monthly and quarterly breach reviews, along with benchmarking against an equivalent peer group, being used to inform further improvement work	High	High

					- Patients on the cancer patient tracking list continue to be actively managed and any delays escalated - Full effect of improvements made in the thoracic pathway in quarter 2 and 3 - Additional ITU bed to come on line on a permanent basis in January - Breach reallocations to be agreed with late referring providers as necessary - See also A&E 4-hour plans		
Cancer: 62-day wait for first treatment – Screening Referred		Yes – with breach reallocation for breach following timely referral (**SUBJECT TO FINAL REPORTING**)	No	- Breast pathways now shared due to service transfer - Patient choice in bowel screening pathway - Age extension to the bowel screening programme - Colorectal elective capacity not always sufficient to meet demand - Please note future risk to target achievement when we lose the majority of Breast Screening pathways, following the transfer of the Avon Breast Screening Service in 2014/15	- All patients on shared pathways actively tracked via our Cancer Register until treated at other providers - Specialist practitioner and colonoscopy waiting times remain short and continue to be closely monitored - Need for additional elective capacity for colorectal surgery continuously reviewed	High	Moderate
Cancer: 31-day wait for subsequent treatment - subsequent surgery	1.0	Yes	No	- Cancellations of surgery due to emergency pressures (ITU and ward beds) - Having enough surgical capacity to meet peaks in demand, especially for the hepatobiliary	- As many patients as possible offered dates well before the breach to enable surgery to be re-booked if cancelled - Implementation of the Patient Flow Programme should reduce	High	Moderate

				service	the risk of bed-related cancellations - New schedule of theatre sessions/planned ITU usage commenced at the start of Q3, which should smooth ITU bed demand across the week - Additional ITU bed to come on line on a permanent basis in January		
Cancer: 31-day wait for subsequent treatment - subsequent drug therapy		Yes	No	- No significant risks	- Continue to pro-actively manage patients on the Cancer patient tracking list	Low	Low
Cancer: 31-day wait for subsequent treatment - subsequent radiotherapy		Yes	No	- No significant risks	- Continue to pro-actively manage patients on the Cancer patient tracking list	Low	Low
Cancer: 31-day wait for first treatment	0.5	Yes	No	- No significant risks	- Continue to pro-actively manage patients on the Cancer patient tracking list	Low	Low
Cancer: Two-week wait - urgent GP referral seen within 2 weeks	0.5	Yes	No	- No significant risks	- Continue to pro-actively manage patients on the Cancer patient tracking list	Low	Low
Symptomatic breast seen within 2 weeks		Yes	No	- Not applicable (service has transferred)	- Not applicable	N/A	N/A
Clostridium difficile	1.0	No – 9 cases in Q3 against a target of 8;	No – ongoing risks to	- Target for the year as a whole is 35 cases; to achieve in Q4 we can have no more than one	- Procalcitonin testing of high risk patients in the Elderly Assessment Unit (EAU) and	High	High

		34 cases year-to-date against a target of 26	cumulative trajectory from Q1, Q2 and Q3	further case - Flat profiling of annual target over the quarters imposed by Monitor - Bristol community is an outlier for antibiotic prescribing	Medical Assessment Unit (MAU) continues, to reduce the use of un-necessary antibiotics - An antibiotic prescribing phone application is being implemented - Use of Fidaxomicin to treat patients at high risk of C. diff recurrence or relapse - Awareness sessions for GPs and Nursing Home Managers		
Certification against compliance with requirements regarding access to healthcare for patients with a learning disability	0.5	Yes	No	- No significant risks	See the standard set-out in Appendix 1, which the Trust is declaring compliance with.	Low	Low

Appendix 1 – Learning Disability Access Criteria

Criteria	Trust evidence
1. Does the NHS foundation trust have a mechanism in place to identify and flag patients with learning disabilities and protocols that ensure that pathways of care are reasonably adjusted to meet the health needs of these patients?	• The Trust has a clinical alert system which has approximately 3,000 patients registered and is managed by the learning disabilities Nurse/team. This system has proven to be an effective way of identifying known patients with learning disabilities when accessing both inpatient and outpatient services • The Trust has an informative learning disabilities internal web page which includes referral pathways and documentation tools to support assessments, implementation and reasonable adjustments. The learning disabilities risk assessment gives opportunity for staff teams to record all reasonable adjustments made against the identified needs • When individuals with learning disabilities are referred to the learning disabilities team from carers or external providers (local authority), the team is able to support pre-planned admissions and make reasonable adjustments according to identified needs. As a Trust we are able to provide multiple procedures under one general anaesthetic, bringing diverse teams together as required for treatment and/or investigations
2. Does the NHS foundation trust provide readily available and comprehensive information to patients with learning disabilities about the following criteria: - Treatment options - Complaints and procedures and - Appointments?	• The Trust has a series of `Easy Read' leaflets. Easy Read uses pictures to support the meaning of text. It can be used by a carer/staff teams in support of the decision making process regarding treatment and care • The Trust 'Easy Read' range includes: ➢ Healthcare and treatment options ➢ Consent ➢ How to contact patient support and complaints team ➢ Going into hospital and what happens ➢ Learning disabilities liaison nurse ➢ Being discharged from hospital • The Trust has various appointment letters to support individuals individual needs
3. Does the NHS foundation trust have protocols in place to provide suitable support for family carers who support patients with learning disabilities?	• The trust has a `Welcome pack' which profiles the Trust providing a range of information around admission and orientation when visiting • The learning disabilities risk assessment has a section to identify the needs of family and carers to ensure reasonable adjustments are made for them as well

	as the individual receiving direct care • The learning disabilities team provide support to all carers identified for individuals accessing both inpatient and outpatient services and continues from preadmission through to discharge planning. • The Trust has a Carers' Strategy and Carer support worker to support the needs of carers
4. Does the NHS foundation trust have protocols in place to routinely include training on providing health care to patients with learning disabilities for all staff?	• The Trust `essential training' programme including at Trust induction learning disabilities awareness training for non-clinical and clinical staff and includes medical staff • The LD nurse delivers custom made training to meet the needs of existing staff groups as required • Annual training events are hosted for link nurses to support their knowledge and skills in caring for patients with learning disabilities
5. Does the NHS foundation trust have protocols in place to encourage representation of people with learning disabilities and their family carers?	• The Trust consults with Learning Disability user groups when strategies and Easy Read materials are in draft format for comments • The Trust provides annual training events whereby users groups attend and receive training around health needs, procedures and support systems available when accessing acute services
6. Does the NHS foundation trust have protocols in place to regularly audit its practices for patients with learning disabilities and to demonstrate the findings in routine public reports?	• The Trust has a Learning Disabilities Strategy that informs the work plan for the Steering Group and sets the standards • Service delivery and outcomes are captured by the learning disabilities team and are incorporated into Trust and divisional objectives • The learning disabilities team monitor monthly the risk assessment and reasonable adjustment compliance to deliver the CQUIN and ensure best care • The Learning Disability Steering Group reports to the Patient Experience Group

Appendix 2 – Draft declaration

Declaration of risks against healthcare targets and indicators for 2013-14 by University Hospitals Bristol

These targets and indicators are set out in the Risk Assessment Framework

Definitions can be found in Appendix A of the Risk Assessment Framework

NOTE: If a particular indicator does not apply to your FT then please enter "Not relevant" for those lines.

Target or Indicator (per Risk Assessment Framework)	Quarter 3 Actual Performance	Achieved/Not Met	Any comments or explanations
Referral to treatment time, 18 weeks in aggregate, admitted patients	92.3%	Achieved	
Referral to treatment time, 18 weeks in aggregate, non-admitted patients	91.3%	Not met	*Further information provided with Governance statement*
Referral to treatment time, 18 weeks in aggregate, incomplete pathways	92.7%	Achieved	
A&E Clinical Quality- Total Time in A&E under 4 hours	90.8%	Not met	*Achieved 95% standard in Oct & Nov. Average for Q3 = 93.7%.*
Cancer 62 Day Waits for first treatment (from urgent GP referral)	85.1%	Achieved	*Subject to breach reallocation agreement with other providers*
Cancer 62 Day Waits for first treatment (from NHS Cancer Screening Service referral)	90.3%	Achieved	*Subject to breach reallocation agreement with other providers*
Cancer 31 day wait for second or subsequent treatment - surgery	96.8%	Achieved	*Subject to final national reporting*
Cancer 31 day wait for second or subsequent treatment - drug treatments	99.7%	Achieved	*Subject to final national reporting*
Cancer 31 day wait for second or subsequent treatment - radiotherapy	97.9%	Achieved	*Subject to final national reporting*
Cancer 31 day wait from diagnosis to first treatment	98.0%	Achieved	*Subject to final national reporting*
Cancer 2 week (all cancers)	96.4%	Achieved	*Subject to final national reporting*
Cancer 2 week (breast symptoms)	0.0%	Not relevant	
Clostridium Difficile -meeting the C.Diff objective	34	Not met	*Target for the end of Q3 = 26.*
MRSA - meeting the MRSA objective	N/A	Not relevant	No longer applicable under RAF
Compliance with requirements regarding access to healthcare for people with a learning disability	N/A	Achieved	

Risk of, or actual, failure to deliver Commissioner Requested Services	No	
CQC compliance action outstanding (as at 31 Dec 2013)	No	
CQC enforcement action within last 12 months (as at 31 Dec 2013)	No	
CQC enforcement action (including notices) currently in effect (as at 31 Dec 2013)	No	
Moderate CQC concerns or impacts regarding the safety of healthcare provision (as at 31 Dec 2013)	No	
Major CQC concerns or impacts regarding the safety of healthcare provision (as at 31 Dec 2013)	No	
Trust unable to declare ongoing compliance with minimum standards of CQC registration	No	

Appendix 3 – Narrative to accompany the declaration

The board is unable to make one of more of the confirmations in the section above on this page and accordingly responds:

A There are three targets in Monitor's Compliance Framework for which the Board is unable to declare compliance with in quarter 3. These are: the Clostridium difficile (C. diff) cumulative trajectory, the A&E 4-hour standard and the RTT Non-admitted pathways standard.
In 2012/13 the Trust achieved its annual C. diff objective (48 cases vs. a target of 54), but failed the cumulative quarterly trajectory in the first two quarters of the year. This was due to the strong seasonal pattern of cases which has been evidenced over a number of years. The Trust has reported 34 cases year-to-date against the target of 26 for the end of quarter 3. Whilst further improvements are required to realise the target reductions the Trust has reported 4 fewer cases year to date than the same period last year. Additional measures continue to be taken to reduce the incidence of C. diff infections. This includes, the introduction of a Procalcitonin test, to reduce the need for antibiotics in some high risk patients, Temocillin to reduce the risk of patients developing C. diff and a mobile phone application for facilitating correct antibiotic prescribing practice. The Trust conducted a telephone questionnaire in Q2 with ten of the top performing trusts on C. diff in the country to identify any further measures high performing trusts were taking. There were no further interventions identified that could be adopted. The Trust has held Study Days for Nursing Home Managers and GPs on Infection Control & Prevention, to try to reduce the number of C. diff cases emerging from the community. However, due to the current position year to date against the annual objective of 35 cases, the C. diff cumulative trajectory is forecast to be failed in quarter 4.

B The Trust achieved the 95% 4-hour standard for four consecutive months (August through to November inclusive), following improvements made through the Trust's Patient Flow Programme. This included the opening of new Discharge Lounge, and the implementation of an Elderly Assessment Unit. However, system pressures continue to impact on the Trust's ability to deliver sustained A&E 4-hour performance, including significant increases in paediatric A&E attendances relating to respiratory illness, which resulted in a 39% increases in emergency admissions during November and December relative to the same period last year. During this period the BRI also had to close wards due to norovirus and whilst contingency plans exist for this occurrence, these have not fully mitigated the impact on flow due to the prolonged nature of the outbreak.
Ambulance arrivals continue to be significantly above last year's levels (up 10%), and at any point in time around 50 delayed discharge patients un-necessarily occupying acute beds. Work is ongoing and has been escalated with system partners in health and social care to improve this position, but improvements have yet to impact. For this reason the Trust is declaring achievement of the 4-hour standard to be subject to ongoing risk. The projects that comprise the second phase of the Patient Flow Programme have commenced. These include the expansion of the Elderly Assessment Unit in association with a new model of care in medicine, further focus on complex discharge (Care Homes and Continuing HealthCare assessments), out of hospital care and enhancements to the Medical Assessment Unit pathways.

C Following the transfer of Head & Neck services from North Bristol NHS Trust and the associated transfer of a large number of patients with extended waits, the Trust declared in its Annual Plan significant risks to the Trust's ongoing achievement of the non-admitted RTT pathways standard, with the potential risk of failure in two quarters. The 95% non-admitted standard was achieved each month in quarter 1, but was failed in quarter 2 and quarter 3. Additional service capacity was established to address the backlogs. However, the impact of the backlogs is now forecast to extend into quarter 4 due to higher than expected levels of GP referrals across a range of specialties. The Trust Board is therefore declaring a potential risk of failure of the RTT Non-admitted standard in quarter 4. Whilst the 62-day GP standard is expected to be confirmed as achieved in quarter 3, following breach reallocation to other providers, the Board is also declaring a risk against the standard in quarter 4, due to ongoing system pressures. The Trust has recently experienced higher than usual levels of late referrals from a range of other providers. This, in combination with the high levels of patient choice over the Christmas period, the impact of cancellations resulting from significant emergency pressures in Q3, and the composition of the Trust's new cancer portfolio following the transfer out of breast and urology cancer services at the end of Q4 2012/13 (two high performing tumour-sites), achievement of the 62-day GP standard is considered at risk. The Trust embarked on a programme of cancer pathway improvement work at the end of Q2. This work has strong support from the clinical teams. The programme includes work to reduce delays to pathways that are within the control of the Trust, but also work with referring providers to support more timely referral.

University Hospitals Bristol NHS
NHS Foundation Trust

Report for a Public Meeting of the Trust Board of Directors to be held on 30 January 2014 at 10:30 in the Conference Room, Trust Headquarters, Marlborough Street, Bristol, BS1 3NU

Item 23 – Register of Seals

Purpose

To report applications of the Trust Seal as required by the Foundation Trust Constitution.

Abstract

Standing Orders for the Trust Board of Directors stipulates that an entry of every 'sealing' shall be made and numbered consecutively in a book provided for that purpose and shall be signed by the persons who shall have approved and authorised the document and those who attested the seal. A report of all applications of the Trust seal shall be made to the Board containing details of the seal number, a description of the document and the date of sealing.

The attached report includes all new applications of the Trust Seal to 08 January 2014 since the previous report to 20 September 2013.

Recommendations

The Board is recommended to receive this report to note

Executive Report Sponsor and Author

- Sponsor – Chief Executive
- Author – Trust Secretary

Appendices

- Appendix A – Trust Seal Register to 2014-01-30

Reference Number	Date Signed	Description of Document Sealed	Signatory 1	Signatory 2	Witness	Date Received	Presented for Signature By	Returned To	Date Returned
719	14/11/2013	Lease to EE Ltd & Orange for installation of telecomms equipment at THQ, Marlborough Street, Bristol	R Woolley	P Mapson	C Helps	12/11/2013 10:00	Pepper, Bob	Bryan, Mary	15/11/2013
720	14/11/2013	Lease between Brislington Junior FC & this Trust. Lease of property at the playing fields utilised by the football club at Brislington House Playing Fields	R Woolley	P Mapson	C Helps	12/11/2013 10:00	Pepper, Bob	Bryan, Mary	15/11/2013
721	10/12/2013	Lease between UHBristol and The Stock Shop Ltd. Unit 2b BRI Welcome Centre.	R Woolley	P Mapson	C Helps	10/12/2013 09:00	Headdon, Andy	Headdon, Andy	11/12/2013
722	11/12/2013	Lease between UHBristol and WH Smith Hospitals Ltd. Unit 3 BRI Welcome Centre	R Woolley	P Mapson	C Helps	10/12/2013 09:00	Headdon, Andy	Headdon, Andy	11/12/2013
723	11/12/2013	Lease between UH Bristol and Boots UK Ltd. Unit 4 BRI Welcome Centre	R Woolley	P Mapson	C Helps	10/12/2013 09:00	Headdon, Andy	Headdon, Andy	11/12/2013
724	11/12/2013	Licence between UH Bristol and WH Smith Hospitals Ltd. Unit 3 BRI Welcome Centre.	R Woolley	P Mapson	C Helps	10/12/2013 09:00	Headdon, Andy	Headdon, Andy	11/12/2013
725	11/12/2013	Licence between UH Bristol and WH Smith Hospitals Ltd. Unit 1, BRI Welcome Centre.	R Woolley	P Mapson	C Helps	10/12/2013 09:00	Headdon, Andy	Headdon, Andy	11/12/2013
726	11/12/2013	Lease between UH Bristol and WH Smith Hospitals Ltd. Unit 1 BRI Welcome Centre	R Woolley	P Mapson	C Helps	10/12/2013 09:00	Headdon, Andy	Headdon, Andy	11/12/2013
727	11/12/2013	Lease between UH Bristol and Compass Contract Services (UK) Ltd. and Compass Group UK & Ireland Ltd. Unit 2a BRI, Welcome Centre.	R Woolley	P Mapson	C Helps	10/12/2013 09:00	Headdon, Andy	Headdon, Andy	11/12/2013
728	11/12/2013	Licence between UH Bristol and Compass Contract Services UK Ltd and Compass Group UK & Ireland Ltd. Unit 2a BRI Welcome Centre	R Woolley	P Mapson	C Helps	10/12/2013 09:00	Headdon, Andy	Headdon, Andy	11/12/2013
729	11/12/2013	Licence between UH Bristol and Boots UK Ltd. Unit 4, BRI, Welcome Centre.	R Woolley	P Mapson	C Helps	10/12/2013 09:00	Headdon, Andy	Headdon, Andy	11/12/2013
730	07/01/2014	Bristol General Hospital s106 Supplemental Agreement	R Woolley	C Helps	P Mapson	22/12/2013 09:00	Pepper, Bob	Pepper, Bob	08/01/2014
731	07/01/2014	Intermediate Building Contract Capital Expenditure Approval Ward 78&72, Squash Court Queens Building L5.	R Woolley	P Mapson	C Helps	22/12/2013 09:00	Horton, Sandra	Horton, Sandra	08/01/2014