North Bristol NHS Trust
Board Meeting
Thursday 26 April 2012
Board Room, Trust Headquarters, Frenchay Hospital

AGENDA FOR PUBLIC SESSION

1. APOLOGIES

2. TO RECEIVE QUESTIONS FROM MEMBERS OF THE PUBLIC

3. TO RECEIVE QUESTIONS FROM LINKS REPRESENTATIVES

4. MINUTES

	Minutes of the Trust Board meeting held on 29 March 2012	**Enc**

5. MATTERS ARISING

6. GOVERNANCE, QUALITY AND SAFETY

6.1	Cerner Implementation Update	**MB/RB/Verbal**
6.2	Quality Report	**MNO/Enc**
6.3	Quality Account Priorities for 2012/13	**MNO/Enc**
6.4	Updated Action Plan on Bristol Histopathology Services	**CB/Enc**

7. STRATEGY

7.1	Redevelopment Project Highlight Report	**DP/Enc**
7.2	Major Trauma Final Report	**HH/Enc**
7.3	Foundation Trust Update	**RB/Verbal**
7.4	Research & Innovation Strategy Report 2011-12 Qtr 4	**HH/Enc**

8. SERVICE DELIVERY AND PERFORMANCE

8.1	Management Information Reports	
	8.1.1 Activity and Performance Report	**SWa/Enc**
	8.1.2 Workforce Strategy & Organisation Development	**HH/Enc**
	8.1.3 Infection Control Report	**CB/Enc**
	8.1.4 Provisional Month 12 Finance Report and 2011/12 Final Accounts Summary	**SWe/Enc**
	8.1.5 Building Our Future Tracker	**HH/Enc**
8.2	Equality & Diversity – 2011/12 Report and Objectives	**HH/Enc**

9. COMMUNICATIONS

9.1	Chairman's Report	**PR/Verbal**
9.2	Chief Executive's Report	**RB/Verbal**

P.T.O.

10. INFORMATION

11. ANY OTHER BUSINESS

12. NEXT MEETING

The next meeting will be held on Thursday 31 May 2012 in the Board Room, Trust Headquarters, Frenchay Hospital.

13. RESOLUTION

That representatives of the press and other members of the public be excluded from the remainder of this meeting having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest (section (2) Public Bodies (Admission to Meetings) Act 1960)

North Bristol NHS Trust
Minutes of the North Bristol NHS Trust meeting held on 29 March 2012

Present:	**Mr P Rilett (Chair)**	
	Mr M Bell	**Professor A Waterman-Pearson**
	Mrs R Brunt	**Ms M-N Orzel**
	Dr C Burton	**Mr N Patel**
	Mr K Guy	**Mr D Powell**
	Mr H Hayer	**Mrs S Watkinson**
	Mr S Hughes	**Mr S Webster**
	Mr R Mould	**Mr S Wood**
	Mr A Nield	
Observers:	**Mr S Bolton, LINkS**	**Mrs D Havercroft**
	Mr J Britton	**Ms V Mathias, BEP**
	Mr D Chandler	
	Mr M Charters, Cap Gemini	
	Ms S Constancon, Cap Gemini	
In Attendance:	**Mr T Bartlett**	
	Ms S Lewis	

ACTION

46/12 QUESTIONS FROM THE PUBLIC

Mr Chandler referred to a recent experience in A&E at Frenchay which he had described in an e-mail to Mrs Brunt. He stated that he had not meant to offend Mrs Brunt, Miss Orzel or Dr Burton. He had felt there was a patient safety issue as there were no chairs available between 4.30 p.m. and 11.00 p.m. and there was no security presence in the department. He suggested that the Trust needs to work with the local commissioning group and with UHB. He was happy to leave this with Mrs Brunt, Miss Orzel and Dr Burton to look into. The Chairman thanked Mr Chandler for attending the meeting, assured him that his comments were taken seriously and that he would be responded to. **RB/MNO/ CB**

Mrs Havercroft requested a response from the Non-Executive Directors to her letter regarding the issue of the histopathology services. The Chairman assured her that she would receive one. **PR**

Mrs Havercroft asked that public involvement in relation to the integration of pathology services be publicised more widely. A meeting on 8 March had been advertised in a newsletter issued on 13 March. Dr Burton confirmed that the need for effective public involvement was acknowledged and stated he would be happy to meet with Mrs Havercroft to discuss her concerns.

47/12 QUESTIONS FROM LINKS

There were no questions from LINkS.

48/12 MINUTES

The minutes of the meeting held on 23 February 2012 were agreed as a correct record.

49/12 MATTERS ARISING

(i) Cerner Implementation (Minute 30/12 refers)

Mrs Brunt reported that the independent investigation was currently in its second week of work and was reporting directly to her. An interim update would come to the Board in April. **RB**

Mr Bell stated that 100% of outpatients clinics were now using the system and the backlog was being cleared. Background training for staff was taking place, together with streamlining to ensure the system was used in the most efficient way.

(ii) Major Trauma (Minute 34/12 refers)

The launch of the Major Trauma Centre had taken place on 2 April. Contingency arrangements were in place for all shifts to be covered before extra consultants were appointed. Interviews were to be held the following week for 3 positions. The SHA had approved the Severn Network and a final project report would come to Board in April, followed by a 3 month project evaluation report to the Building Our Future programme Board. **HH**

The TARN system would be used to collect performance data and patients would also be tracked through the system. A 'hot' ICU bed was currently being trialled. It was noted that the introduction of a separate major trauma team could relieve the pressure on ED. Also there was now a more formal arrangement for repatriation of patients which was already working well.

50/12 QUALITY REPORT

The report was noted. The 2 directorates who were struggling to meet nutritional assessment standards were being targeted and were already improving. Mr Powell queried whether the 5.5% target for pressure ulcers was realistic. Ms Orzel explained that this was a stretch target and although it was ambitious, hospitals in Wales had already achieved zero. Dr Burton noted that there had been no change in the number of falls since the reduction in Autumn 2010. It was agreed that, although they were on an overall downward trajectory, regular review was required.

Ms Orzel reported that the level of achievement to obtain a gold NQAT was being raised, as this needed to be a continual improvement process. Intentional rounding brought a lot of these issues together and would be launched for all patients from April. Information on compliance would be brought to the Board. **MNO**

It was agreed that the new style Quality Report was effective.

51/12 NATIONAL STAFF ATTITUDE SURVEY 2011

Mr Hayer reported that the Trust was following up the lowest scoring areas through an internal survey of all staff. To date 1000 staff had responded. Results would be reviewed by the Staff Engagement Group which was chaired by Mrs Brunt and Mr Guy was also a member. The Workforce & Governance Committee would ensure that a summary of actions were brought to the Board in May. **HH**

Mr Puckett asked how the paper questionnaire was being made available and requested that the results were circulated in hard copy as well as electronically. This applied to other items as well, e.g. staff expense claims. This matter would be discussed at the Staff Engagement Group. **RB/HH**

52/12 SINGLE SEX ACCOMMODATION DECLARATION OF COMPLIANCE

The full compliance statement had been published in May 2011, which had now been reviewed and would be issued on the NBT public website. The Board was pleased to note that there had been no breaches during 2011/12.

53/12 LEARNING DISABILITIES ANNUAL REPORT

Professor Waterman-Pearson expressed her confidence that the amount of work undertaken represented sufficient assurance for the Board. It was noted that positive feedback had been received from a patient experience group.

54/12 NBT REDEVELOPMENT PROJECT HIGHLIGHT REPORT

Mr Powell reported that the commissioning process for the new hospital was under way, the scheme was on programme and there had been no variations. Most of the design was complete and the health and safety on the site remained at a very high standard. The ‘topping out’ event earlier in the month had gone well and involved 20 staff. Mock-ups would be available for staff to visit in approximately a month, and site visits could take place in about a year.

55/12 FOUNDATION TRUST UPDATE

Mrs Brunt reported that the timeline was still being adhered to. There had been a successful Executive to Executive meeting with the SHA the previous week, with a full Board to Board assessment scheduled for 16 April. Following this there would be a submission to the Department of Health, who would be likely to take 2 months to decide on referral to Monitor. A Company Secretary with a legal background, and currently working in a local authority, had been appointed and would commence in 3 months' time.

NBT was ahead of its recruitment trajectory for members, which indicated strong public interest in the organisation. It was noted that members were already participating in areas where there was an immediate need for public involvement. 180 people had expressed an interest in being a governor and elections would take place in the summer. "Your Hospital" would now include a section for members and each one would receive a welcome pack.
(Mr Wood left the meeting at this point.)

56/12 PATHOLOGY INTEGRATION

Dr Burton reported that there would be decisions for the Board to consider in May/June, before the next Advisory Panel. Mr Hughes indicated that he would like to be involved and it was noted that there was a large KPI requirement. It was noted that NBT ultimately do not have to agree to the integrated service, but could continue with a Trust specific service, working in partnership with other organisations.

Following the Pathology review LEAN ways of working would be further explored.

57/12 ACTIVITY AND PERFORMANCE

Mrs Watkinson reported that a recent meeting with GWAS had been very positive. The results of the ambulance handovers audit would be brought to Trust Board when ready. Length of Stay (LOS) had improved although more work was being undertaken. The figures for February indicated unlikely achievement of the 2 week cancer wait despite validation to be completed. **SWa**

An assessment of why ED performance has not improved since September, identified a range of issues, not all of which were in NBT's control. The Healthy Futures Programme Board was undertaking a piece of work on patient flows across the BNSSG area.

58/12 WORKFORCE STRATEGY & ORGANISATION DEVELOPMENT

The number of staff compliant with mandatory training would be

improved by better communication with staff and the introduction of auto reminders.

36 recommendations for MARS had been forwarded to the SHA, of which 26 had been approved (giving a Trust saving of approx £1m p.a.) and 4 were pending.

Sickness absence was being targeted case by case.

59/12 INFECTION CONTROL REPORT

It was noted that a double test was currently needed for C Diff, but the pilot had not shown that the new methods would affect the totals. Norovirus was also in the community, which was an additional pressure.

60/12 FINANCE REPORT

It was noted that the Trust may get to a FT risk rating of 4 at year end instead of the planned 3. There was confidence that the £9m surplus would be reached.

61/12 BUILDING OUR FUTURE TRACKER

How the projects align with the Operating Plan would need discussion in July/September. Breast and Urology transfers would not now take place until the autumn so that the necessary period of staff consultation could take place.

62/12 2012/13 PROPOSED BUDGET

It was noted that the financial risk ratings table indicated a plan to move to a financial risk rating of 4 for 2012/13. The budgeted recurring surplus of £11.0m was better than the £8.8m planned in the IBP.

63/12 RIVERSIDE REDEVELOPMENT OPTION

Approval was given by the Board. **SWe**

64/12 CHAIRMAN'S REPORT

The Chairman and Chief Exec had attended a South Glos Cabinet meeting that week with the PCT & AWP. The Local Authority were supportive of our work on the Frenchay site. It was noted that South Glos would be moving from a cabinet to a committee structure and the increase in population would be in their new core strategy.

65/12 CHIEF EXECUTIVE'S REPORT

The Health & Social Care Bill had gone through Parliament and had Royal Assent. Changes in education and training delivery by Health Education England would see the formation of Local Education and Training Boards who would have some discretionary spend to address local needs. More information would be brought to Board as it emerged.

The 2012/13 Operating Plan sign off meeting with the SHA had been attended by Mrs Brunt and Mr Webster, and the contract had been previously agreed.

The recent topping out ceremony at Southmead had been a good opportunity to show a group of staff around the site.

NBT had hosted a national specialised commissioning conference that week in the Learning and Research building.

There had been 3 consultant panels since the last meeting. A Respiratory Consultant with an interest in interstitial lung disease, and a Cleft Palate Surgeon had been appointed, with no appointment to the Paediatric Neurology post.

ANNUAL GRMC REPORT

It was agreed this was a useful report .

ANY OTHER BUSINESS

There was no other business.

NEXT MEETING

The next meeting would be held on Thursday 26 April 2012 in the Board Room, Frenchay Hospital.

RESOLUTION

That representatives of the press and other members of the public be excluded from the remainder of this meeting having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to other public interest (section (2) Public Bodies (Admission to Meetings) Act 1960.

North Bristol NHS Trust CQUINs Performance Overview 2011/12

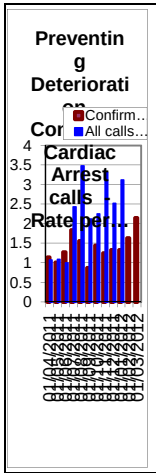
APPENDIX 3

CQUIN	YE Target	To be measured	Max reward	MONTHLY PERFORMANCE Apr-11	May-11	Jun-11	Jul-11	Aug-11	Sep-11	Oct-11	Nov-11	Dec-11	Jan-12	Feb-12	Mar-12	YEARLY PERF YTD	QUARTERLY PERFORMANCE 10/11	Q1	Q2	Q3	Q4	Target currentlv
VTE Risk Assessment	90%	Monthly	£600,000	94.8%	94.2%	94.4%	94.4%	94.7%	95.0%	94.2%	93.3%	84.1%	86.6%	84.9%		92.6%	93.3%	92.9%	94.5%	91.3%		Fail
National Patient Survey	71.9	Survey	£300,000													68.5						Fail
NQAT Patient Experience	90%	End Q3	£300,000	100.0%	90.9%	96.3%	96.9%	97.2%	100.0%	97.3%	97.4%	97.5%	100.0%	100.0%	97.6%	97.6%		94.6%	96.2%	97.4%	99.2%	Achieve
Cancer Efficiency Pathway	80%	Q3 & Q4	£340,000	80.0%	87.0%	89.7%	91.3%	73.3%	85.7%	78.6%	84.8%	86.2%	80.6%	87.0%	69.6%	82.9%	80.5%	86.3%	83.1%	83.5%	79.2%	Achieve
Dementia Diagnosis Recording for Inpatients	25% Imp	End Q4	£68,000	9.7%	2.2%	10.5%	-10.2%	-6.1%	10.5%	-18.6%	33.0%	18.8%	28.8%	28.8%	8.0%	9.6%		7.5%	-1.9%	11.1%	21.9%	Fail
SHA Dementia Plan - Ward Moves	95%	End Q4	£102,000						94.3%	91.7%	95.4%	98.8%	98.7%	98.6%	99.0%	99.0%			94.3%	95.6%	98.8%	Achieve
SHA Dementia Plan - Mandatory Training		End Q4	£170,000																			
Discharge Letter Summaries Issued Within 24 Hrs - Pilot Data	90%	Nov 11 & Jan 12	£170,000	89.7%	88.2%	97.1%	91.6%	94.9%	94.7%	92.7%	92.2%	96.3%				93.0%		93.1%	94.8%	93.0%		Achieve
% Discharge summaries complete - Pilot Data	80%	Nov 11 & Jan 12	£170,000	10.5%	17.7%	22.6%	51.3%	64.6%	67.1%	68.3%	68.3%	83.2%				70.0%				70.0%		Fail
Falls - Assessment on admission	90%	From Q3	£170,000							95.6%	96.3%	90.9%	91.9%	96.4%	94.6%	94.5%				94.6%	94.4%	Achieve
Falls - Reduction in number	< 152 /mth	Q4	£170,000							178	164	182	233	207	230	2236				524	670	Fail
Learning Disability - availability of materials		Q2 & Q4	£170,000																			Achieve
Learning Disability - assessment within 48 hrs	90%	Q4	£170,000	100.0%	55.6%	75.0%	62.5%	87.5%	100.0%	80.0%	100.0%	100.0%	100.0%	80.0%		86.2%		86.2%	83.3%	93.3%		Achieve
Long Term Conditions - EOL online learning tool		End Q4	£340,000																			Achieve
Maternity - % Spont vaginal births of all births	61.0%	11/12	£170,000	57.8%	57.5%	60.7%	59.5%	59.6%	59.2%	54.6%	55.1%	53.8%	61.4%	56.0%	63.7%	58.3%	60.0%	58.7%	59.4%	54.5%	60.5%	Fail
Maternity - % Spont births of all vaginal births	83.0%	11/12	£170,000	81.0%	78.8%	82.5%	81.4%	81.6%	81.7%	79.1%	77.7%	79.7%	84.2%	79.8%	87.0%	81.3%	81.7%	80.0%	80.6%	78.8%	83.9%	Fail
Medication Errors - reduction in 'harmful' errors	1.83%	11/12	£68,000	1.9%	0.0%	1.6%	0.0%	0.0%	2.1%	0.0%	1.3%	0.0%	1.3%	2.5%	1.9%	1.0%		1.1%	0.6%	0.4%	1.7%	Achieve
Medication Errors - drugs omitted because unavailable	1.95%	Q4	£272,000	2.03%	1.61%	2.27%	2.51%	1.92%	2.07%	1.92%	2.37%	2.28%	1.88%	1.47%	1.05%	1.94%		1.99%	2.14%	2.19%	1.46%	Achieve
NQAT Survey - Nutritional Care	90%	End Q4	£340,000	100.0%	72.7%	70.4%	62.5%	63.9%	67.6%	70.3%	73.7%	67.5%	73.2%	80.5%	90.2%	90.2%		70.4%	67.6%	67.5%	90.2%	Achieve
Patient Transport Service - %hosp aborted journeys	3.8%	Mthly from Aug	£170,000				7.6%	9.8%	10.0%	9.8%	9.1%	9.2%	9.5%	8.5%	8.7%	9.4%			10.2%	9.4%	8.9%	Fail
Patient Transport Service - %bookings for non-med escort	9%	Monthly	£170,000			20.4%	18.7%	17.0%	18.1%	15.6%	16.3%	15.4%	13.1%	12.8%	12.7%	16.1%		20.4%	17.9%	15.7%	12.9%	Fail

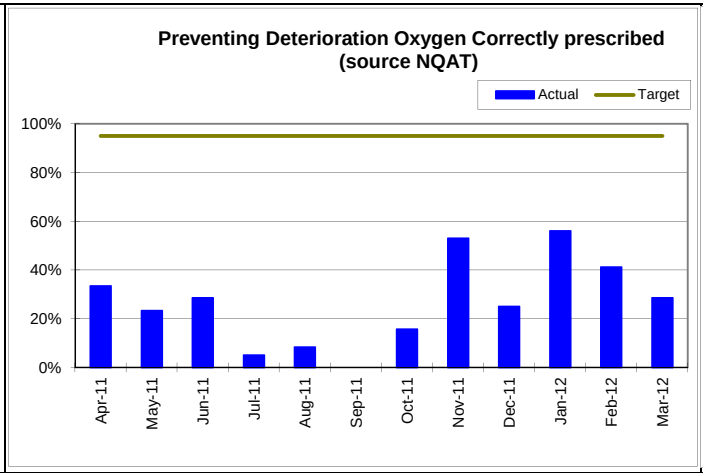
North Bristol NHS Trust CQUINs Performance Overview 2011/12

CQUIN	YE Target	To be measured	Max reward	MONTHLY PERFORMANCE Apr-11	May-11	Jun-11	Jul-11	Aug-11	Sep-11	Oct-11	Nov-11	Dec-11	Jan-12	Feb-12	Mar-12	YEARLY PERFORMANCE YTD	10/11	QUARTERLY PERFORMANCE Q1	Q2	Q3	Q4	Target currently
Smoking Cessation – Referrals	500	11/12	£340,000	74	96	157	130	135	136	105	90	78	71	69		1141		327	401	273		Achieve
Hospital Acquired Pressure Ulcers - Grades 2+/ 10,000 bed days	5.5	11/12	£340,000	9.6	9.9	10.9	9.8	11.5	10.5	14.0	17.6	19.2	15.0	12.8	14.3	12.9	7.4	9.5	10.7	16.9	14.1	Fail
Reduction in Neonatal CONS Infections - 24-26wks gestation	48.6%	11/12	£170,000	20.0%	33.3%	No babies	66.7%	66.7%	75.0%	33.3%	62.5%	20.0%	75.0%	71.4%	22.2%	50.8%		25.0%	69.2%	50.0%	54.2%	Fail
Reduction in Neonatal CONS Infections - 27-29wks gestation	24.7%	11/12	£170,000	20.0%	25.0%	80.0%	40.0%	50.0%	0.0%	0.0%	0.0%	40.0%	66.7%	60.0%	33.3%	37.0%		42.9%	30.8%	18.2%	57.1%	Fail
HIV Service - % receiving home delivery drugs	25% Inc	31-Mar-12	£340,000	4.1%	7.4%	20.4%	18.1%	20.7%	25.9%	26.3%	28.5%	16.3%	33.0%	27.0%	26.7%	26.7%		20.4%	25.9%	16.3%	26.7%	Achieve
Contract																						
Service User Experience	19	Monthly	£36,900	0	0	0	1	0	0	0	5	2	7	5		20		0	1	7		Achieve
Care Planning	85%	Monthly	£36,900	98.0%	98.0%	98.3%	96.3%	94.0%	97.4%	96.2%	96.0%	100.0%	100.0%	100.0%		98.0%		98.0%	95.9%	97.4%		Achieve
End of Life	220	Monthly	£49,200	40	40	31	5	19	20	28	31	16	26	4		220		111	44	75		Achieve
Ambulatory Care Sensitive Conditions	100	Monthly	£73,800	17	17	8	44	59	58	104	89	76	54	67		576		69	186	269.00		Achieve
Discharge Planning	80%	Monthly	£49,200	95.0%	95.0%	96.0%	95.0%	98.0%	96.0%	97.0%	98.0%	97.0%	97.0%	99.0%		97.0%		95.3%	96.3%	97.3%		Achieve
Health Partnership																						
24/7 Cover	100%	Monthly	£28,167	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%		100.0%	100.0%	100.0%	100.0%	Achieve
Statementing	95%	Monthly	£28,167	100.0%	100.0%	100.0%	100.0%	100.0%	95.0%	90.0%	100.0%	100.0%	100.0%	100.0%	100.0%	99.0%		100.0%	100.0%	100.0%	100.0%	Achieve
Serious Case Reviews	100%	Monthly	£28,167	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%		100.0%	100.0%	100.0%	100.0%	Achieve
CAMHS Health Outcomes (CORC)	35%	Monthly	£28,167				36.8%	33.3%	35.5%	43.9%	42.2%	26.5%				36.6%			35.3%	38.3%		Achieve
DNA Rates	5.5%	Monthly	£28,167	5.1%	4.9%	5.1%	5.5%	6.2%	5.0%	5.4%	4.9%	6.1%	4.4%	4.5%		5.2%		5.0%	5.5%	5.4%		Fail
Breast feeding rates in 8 lowest wards at 6-8 weeks (Bristol)	32.9%	Apr-12	£14,083			32.8%			34.4%			37.0%				34.8%		32.8%	34.4%	37.0%		
Breast feeding rates in 8 lowest wards at 6-8 weeks (S Glos)	37.2%	Apr-12	£14,083			38.6%			31.8%			36.7%				35.7%		38.6%	31.8%	36.7%		

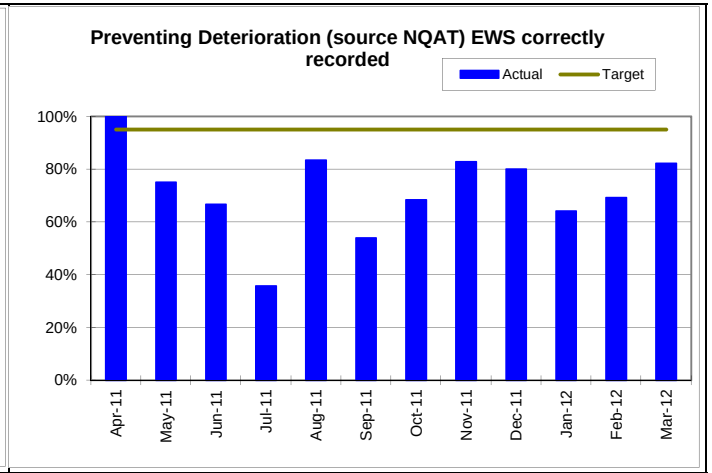
North Bristol NHS Trust - Quality Indicators



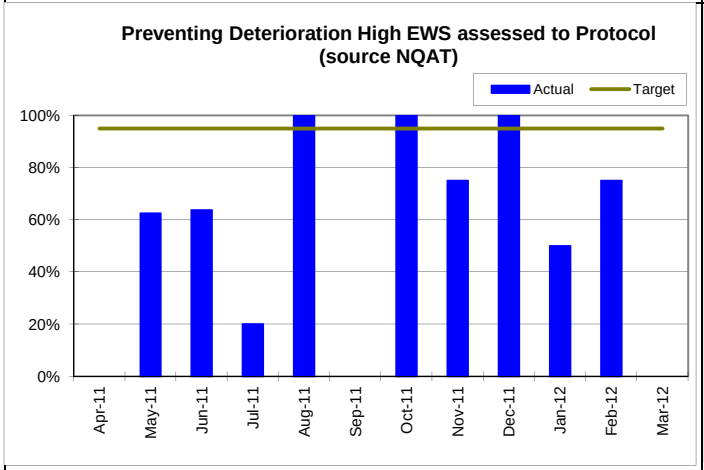
The light bar shows the confirmed cardiac arrests. A slight increase in March of 29 Calls (22 in Feb). The rolling mean is 1.4 against the national average of 2.5



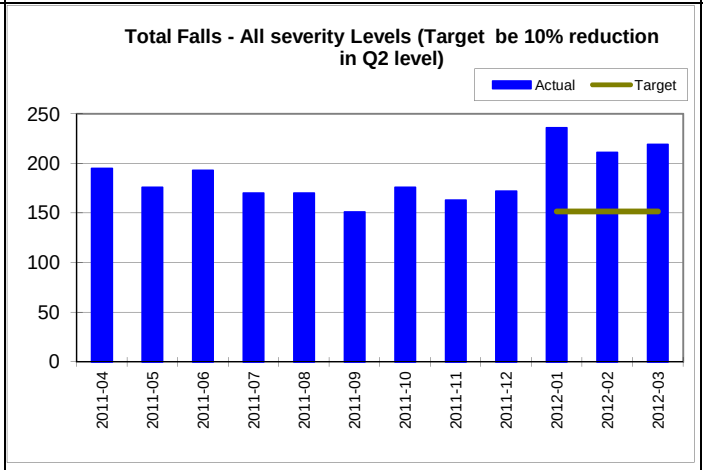
In March 6 out of 21 cases were correctly completed according to the oxygen prescribing policy. Over the year there has been some improvement but more work will be done to raise awareness with junior doctors.



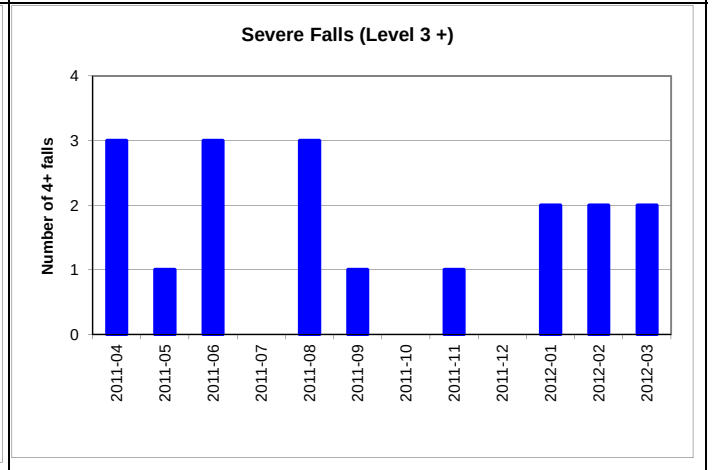
In March the number of cases with EWS scored correctly was 82% to the previous score of 69% in February



Of the 28 sets of notes reviewed in March only one set was a high EWS scoring. This one set however was not assessed correctly therefore the March figure is 0%



There were 219 falls in March an increase of 8 from the 204 fals in February.

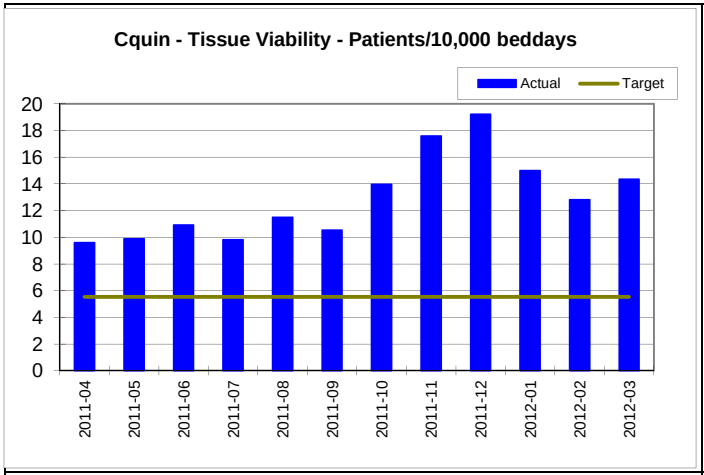


Further validation of falls incidents reduced the serious falls in February from 3 falls to 2. There were 2 serious falls in March. *Data source: validated incidents on Safeguard*

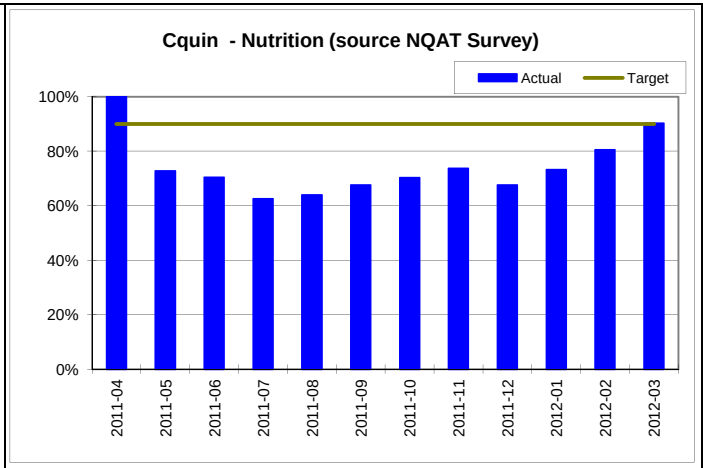
Due to initial data quality issues related to the Cerner implementation accurate bed day information for December is not currently available therefore the following indicators have estimated denominator activity:-

Cardiac Arrest Calls
Pressure Ulcers

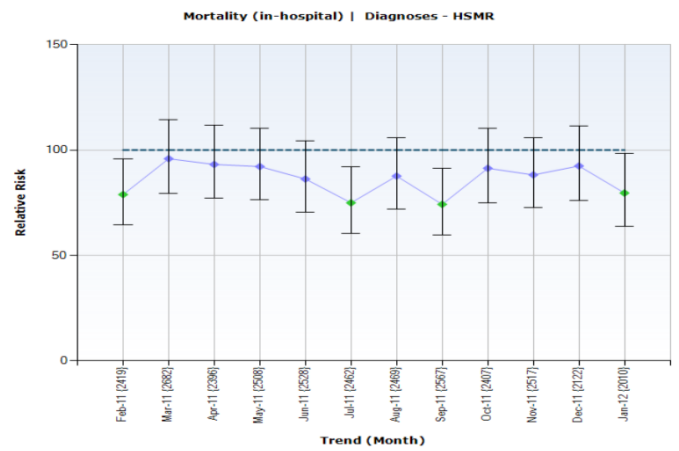
North Bristol NHS Trust - Quality Indicators



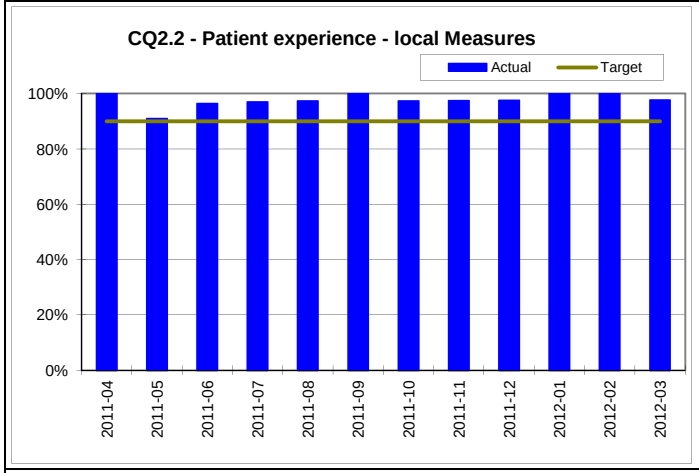
There has been a slight increase to 14.3 patients per 10,000 beddays. There was one complex case grade 2 PU which deteriorated to a grade 3. There were no grade 4 ulcers in March.



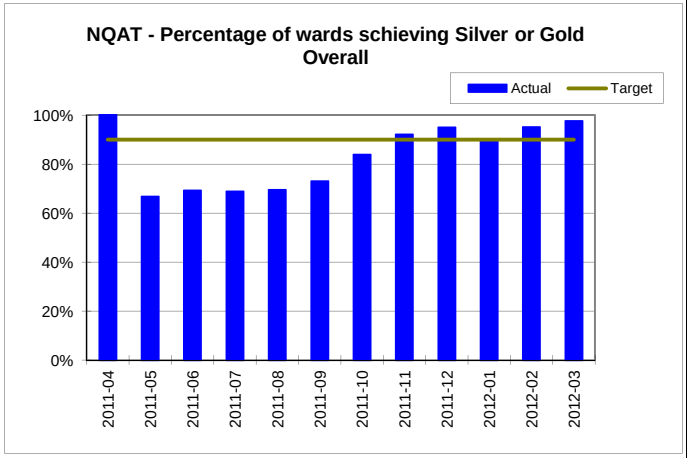
The position at the end of March is 90% of wards are achieving silver or gold on the nutrition element.



Rolling year cumulative relative risk = 86.3 with a further reduction showing at 91.2 in the upper confidence interval



Wards audited are achieving either silver or with patients rating their experience with a score at 90% or above consistently throughout the year.



This shows a full audit of all wards with 98% of wards achieving silver of gold.

North Bristol NHS
NHS Trust

Report to Trust Board – April 2012

Title:	**Quality Report to Board**
Purpose of paper:	To inform the Board on progress with measures of the quality of clinical services provided by the Trust and progress with priorities set out in the Trust's Quality Account.

For Discussion

Executive Summary:

NBT mortality rate is lower than the national average	**HSMR –** rate continues to be below the national expected mortality rate of 100 with a rolling mean of 86.3 using the Dr Fosters age adjusted casemix.
The rolling mean rate of cardiac arrest calls is 1.4 per 1000 discharges.	**Preventing Deterioration** – Cardiac arrest rates remain well below national average of 2.5 per 1000 discharges.
Serious falls are reducing **The CQUIN for 10% reduction in Qtr 4 measured against Qtr 2 will not be achieved**	**Falls** – There were two grade 4 falls in March. Further validation has reduced the February figure from three to two The final figure for the number of overall falls this year is 2232 compared to 2339 last year, so there is a reduction of 107.
Pressure ulcer (PU) incidence has increased 14 patients per 10,000 bed days in March. **The CQUIN target of 5.5 patients per 10,000 bed days has not been achieved.**	**Pressure Ulcers:** 42 patients were reported with grade 2 pressure ulcers in March. One patients' grade 2 ulcer deteriorated to a grade 3. There were no grade 4 pressure ulcers.
100% of wards are rated by patients as good	**NQAT ward audits;** The patient experience measure for this financial year has been met.
The CQUIN target for 90% of wards rated as silver or gold for nutrition, has been achieved	**Nutrition** - The number of wards rated silver or gold increased from 78% in February to 90% in March.
The Trust has achieved over 3 million pounds in incentive payments.	The CQUINs year end achievement table is set out in Appendix 3

Action Required

The Trust Board is asked to note the contents of this report.

Key Risks:	Non-achievement of CQUIN targets would prevent the Trust from accessing incentive payments and result in the Trust receiving financial penalties

Impact on Patients:	All measures relate to the delivery of patient care, achievement of gateways/CQUIN targets helps to build confidence in Trust service provision and assure the public/other key stakeholders that the organisation is meeting quality and safety standards		
CQC Outcome:	O16 – assessing & monitoring quality of services	**Responsible Committee:**	GRMC Quality Committee
Financial Issues considered:	As indicated in regard to incentive payments/penalties.	**Equality Impact Assessment:**	Considered throughout
Legal Issues	Legal issues are considered throughout.	**Sustainability Assessment Completed:**	No

Presented by: Marie-Noelle Orzel – Director of Nursing
Prepared by: Lesley Le-Pine – Head of Clinical Governance
Phil Martin – Information Analyst

North Bristol NHS
NHS Trust

Report to the Trust Board – April 2012

Title: **Quality Priorities for Quality Account**

Purpose of paper: To present to Board the recommended list of Trust quality priorities for the year ahead following discussion with clinical directorates and patient & public consultation.

For Agreement and Decision

Executive Summary:

- Clinical Directors and Executives drew up a 'long list' of possible topics at the Quality Committee in January 12. This list was then discussed with the Trust Patient Panel to obtain their views.
- These topics were then compiled into a survey for patient and public consultation which was available on line via the website and distributed to in-patients on wards. It was also distributed to Local Councillors and community groups.
- Presentations including the shortlist were also made to the two Local Authority Health Scrutiny Committees to seek their views.
- 158 patients completed the survey during their stay in hospital. 106 members of the public completed the survey by either receiving an email via a community group, via social media or seeing it on the NBT website home page.
- The results of the survey were analysed and ranked according to importance as rated by patients and the public. These were discussed by Executives and the final shortlist of six topics was presented to Trust Management Team to agree the final priorities as recommended to the Board below;

Recommendations
Further reducing infection with a focus on reducing urinary infections for those with Catheters
Ensuring patients are eating and drinking well
Always involving and informing you of the treatment you will have and keeping you informed of your anticipated discharge date
Increased observations for most unwell patients

- The priority topics chosen will only be part of the Trusts overall quality improvement work. Work will be ongoing with all infection control reduction targets against MRSA, CDiff, MSSA and Ecoli. Dementia work is ongoing and is part of the Operating Framework. Falls, pressure ulcers and VTE will continue to be monitored via the safety thermometer.
- The final draft for the Quality Account will be presented to the Trust Board in May, prior to distributing for comment to Health Scrutiny Committees, Commissioners and LINks. The final document is required to be published by 30th June

Action Required: The Board is asked to agree the recommended quality priorities in the year ahead, for inclusion in the Trust Quality Account

This document could be made public under the Freedom of Information Act 2000.
Any person identifiable, corporate sensitive information will be exempt and must be discussed under a 'closed section' of any meeting.

Key Risks: Non compliance with safety standards and the ability to measure & show improvement could result in poor patient outcomes, result in poor performance and impact on Trust reputation with external bodies such as Monitor and the CQC.

Impact on Patients: These priorities contribute to the delivery of high quality safe patient care and compliance with required standards. This helps to build confidence in Trust service provision and assure the public/other key stakeholders that the organisation is meeting quality and safety standards.

CQC Outcome:	Outcomes 2, 4, 5, 8, 9 and 16
Responsible Committee:	Quality Committee, GRMC
Financial Issues considered:	No
Equality Impact Assessment Completed:	Considered throughout
Legal Issues Considered:	Considered throughout
Sustainability Assessment Completed:	No

Presented by:	Marie-Noelle Orzel, Director of Nursing
Prepared by:	Lesley Le-Pine, Head of Clinical Governance

INDEPENDENT INQUIRY INTO HISTOPATHOLOGY SERVICES

AT UNIVERSITY HOSPITALS BRISTOL NHS FOUNDATION TRUST

Report to the Bristol Health and Adult Social Care Scrutiny Commission and the South Gloucestershire Health Scrutiny Select Committee about progress in implementation of the Histopathology Action Plan

Introduction

This paper is provided to support a specially convened meeting of the Bristol Health and Adult Social Care Scrutiny Commission and the South Gloucestershire Health Scrutiny Select Committee on 23 April 2012.

Context

UH Bristol commissioned an Independent Inquiry in 2009 to review allegations about its Histopathology services and to consider whether appropriate action was taken by the Trust to address these concerns. The Independent Inquiry, conducted by a panel of experts and chaired by Jane Mishcon, a leading barrister, published its report and recommendations in December 2010.

The panel obtained further independent, professional review of the diagnostic competence of the Consultant Histopathologists at UH Bristol from the Royal College of Pathologists, whose findings are given in the report.

The Independent Inquiry found no evidence to suggest that the Histopathology department at UH Bristol provides anything other than a safe service. However, the panel had specific concerns about the culture, attitude and working practices in the department and made criticisms of the way that the Trust had managed clinical concerns when they were raised.

UH Bristol issued a public apology for the fact that a small number of patients had been harmed and that concerns about its services were not promptly and thoroughly investigated at the time that they arose.

The Care Quality Commission (CQC), the national regulator for health and social care, undertook its own review of histopathology services at UH Bristol in May 2011, following a misdiagnosis which occurred in December 2010. The CQC found that UH Bristol was compliant with all six of the essential standards of quality and safety which it reviewed. In order to maintain this compliance, the CQC suggested that some improvements should be made in three of the six areas, which the Trust has committed to address.

Monitor, the Foundation Trust regulator, undertook a separate review of governance at UH Bristol in response to the Independent Inquiry findings and expressed itself satisfied with the governance of the Trust.

Action plan

Following publication of the report of an Independent Inquiry into Histopathology services at University Hospitals Bristol NHS Foundation Trust (UH Bristol) in December 2010, a joint action plan was produced by UH Bristol and North Bristol NHS Trust in response to the Inquiry recommendations.

A joint Trust management group has met monthly to monitor progress against the action plan and quarterly progress meetings have taken place with NHS Bristol, commissioner for both Trusts. Inside UH Bristol, progress is formally reported on a quarterly basis to the Clinical Quality Group, the Trust Management Executive, the non-executive-led Quality and Outcomes Committee, the Board of Directors and the Membership Council of elected and appointed Governors of the Trust.

External updates have been provided quarterly to Bristol Health and Adult Social Care Scrutiny Commission and on request to the South Gloucestershire Health Scrutiny Select Committee, Care Quality Commission and Monitor, the Foundation Trust Regulator. A joint Trust response to questions raised at the South Gloucestershire Health Scrutiny Select Committee in January 2012 is attached for information.

Version 26 of the Trust's action plan, dated 11 April 2012, is also provided for the purpose of updating Councillors about progress to date. All actions bar one are shown as completed since the Committee received its last report in November 2011. Councillors are particularly asked to note the joint agreement across UH Bristol and North Bristol Trust to invest in two new Consultant posts, following a detailed capacity review and business case.

The outstanding action relates to the recommended integration of the two Histopathology departments, which has been agreed in principle but which is now located inside a wider PCT-led review of pathology services across Bristol, North Somerset and South Gloucestershire. While this this has affected the pace at which the Trusts could address this specific recommendation, it has given greater confidence to the eventual achievement of an appropriate and sustainable outcome, which will have fully involved clinical staff across both Trusts in its design.

Independent Inquiry Panel review

In line with the final recommendation in the Inquiry report, in December the Trust invited the Panel to return to review the steps taken to address their recommendations, which they did in late February and early March this year. The object of the review was to consider the sufficiency, progress and effectiveness of actions taken or planned by UH Bristol to address the formal recommendations contained in the Inquiry report and to provide a short written statement of the panel's conclusions to the Trust.

The Panel reviewed documentary evidence supporting the claims of progress against the action plan, interviewed a number of service users as well as clinical and managerial stakeholders from both Trusts and visited the laboratory facilities at UH Bristol. Their findings were received on 19 March and contain a number of recommendations for continuing focus by the two Trusts. The Trusts have prepared a further action plan to address these issues which is in the process of formal ratification by both Trusts.

Attachments

Councillors are provided with the following documents:

. joint letter from University Hospitals Bristol NHS Foundation Trust and North Bristol Trust to the South Gloucestershire Health Scrutiny Commission
. report from Independent Inquiry Panel following their review in February/March 2012 of progress against the Histopathology action plan
. latest version of the Histopathology action plan.

Conclusion

Councillors are invited to:

. seek further information and assurance about the progress of the action plan and the documentation provided in response to previous questions
. consider what style and frequency of reporting by the Trusts will most effectively meet the committees' future needs.

Robert Woolley

Chief Executive

12 April 2012

South Gloucestershire Council

By Email

Robert Woolley
Chief Executive
University Hospitals Bristol NHS Foundation Trust

Ruth Brunt
Chief Executive
North Bristol NHS Trust

Date: 8th February 2012
Your ref:
Our ref:
Enquiries to: Claire Rees, Democratic Services
Tel: 01454 864116
Fax: 01454 864661
E-mail: claire.rees@southglos.gov.uk

Dear Robert and Ruth

Thank you to you and your colleagues for attending the Health Scrutiny Select Committee meeting on 4th January 2012 to present your report on the Histopathology Inquiry, and respond to issues raised by the South West Whistleblowers Health Action Group. As you are aware the Committee resolved to agree recommendations at its next meeting, which I am pleased to say took place this morning, and the Committee agreed a final set of recommendations for your Trust's consideration, details of which are set out below:

1 The Committee would like to receive quarterly reports from UHB and NBT on how the Trusts are implementing the Histopathology Action Plan. To include, what actions are being taken, the outcomes of these actions and the next steps. The Committee appreciates that the Trusts already report to the Bristol Health and Adult Social Care Scrutiny Commission and in the interests of efficiency the Committee is in favour of receiving the reports jointly with the Commission (subject to its agreement), by way of a joint scrutiny arrangement.

2 The Committee would like a commitment from UHB and NBT that the latest Quality Accounts include details of how the Trusts are meeting the Histopathology Action Plan, which incidentally, the Committee is due to receive presentations on in April 2012, prior to submitting a commentary for the final Quality Accounts in May/June 2012.

3 At the meeting there was quite a lengthy discussion on the use of double reporting and the Committee would like written clarification on the following:
- What is the rationale for double reporting in some histopathology specialities but not others;
- How does UHB and NBT compare with other trusts in England with regard to when and how the you decide to undertake double reporting;
- What information and guidance is provided by the Royal College of Pathologists – is there any benchmarking data;
- Are there any NICE guidelines around double reporting in histopathology?

4 That in order to be reassured that double reporting in histopathology is being undertaken when it is appropriate and necessary, the Trusts are asked to consider conducting statistically significant (the appropriate percentage being

5 That the Trusts ensure that specialist histopathologists are used in their specialist areas.

6 That there are separate Paediatric and Adult Histopathology Departments, however, they maintain close links and share good working practices.

7 That as part of the update reports on the implementation of the Histopathology Action Plan, the Trusts provide information which demonstrates how the organisations are specifically undergoing a cultural change in order to ensure that similar problems do not arise again in the future.

8 There is a need for significant work to be undertaken in order to rebuild public confidence in the Trusts' Histopathology services, not only in terms of assuring patients and the public that the Trusts' provide a safe and accurate service, but also in relation to attracting more high quality staff to the service in the future. We ask that the Trusts provide the Committee with information on the strategies in place to address this going forward.

You will note that the first recommendation is the Committee's intention to work with the Bristol Health and Adult Social Care Scrutiny Commission in taking this forward by way of a joint scrutiny arrangement. I understand that the Bristol Commission is going to consider this matter at its next meeting on 19th March. On the assumption that the Commission is in support of a joint scrutiny arrangement, it would seem sensible that your responses to all the recommendations are reported back via that mechanism rather than directly back to the South Gloucestershire Select Committee.

I will get in touch with you again once it is clear how any joint scrutiny arrangements will be constituted. In the meantime, however, should you have any comments in relation to the recommendations that you wish to bring to the Committee's attention please let me know.

Yours sincerely

Claire Rees
Democratic Services Officer
On behalf of the Health Scrutiny Select Committee

CC
Dr Chris Burton, Medical Director, North Bristol NHS Trust
Members of the Health Scrutiny Select Committee
Kathryn Hudson, Associate Director, NHS South Gloucestershire
Louise Winn, Head of Patient & Public Involvement, NHS South Gloucestershire
Romayne de Fonseka, Scrutiny Officer, Bristol City Council

North Bristol NHS
NHS Trust

University Hospitals Bristol NHS
NHS Foundation Trust

Trust Headquarters
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Tel: 0117 342 3720
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RW/RB/yq

11 April 2012

Claire Rees
Democratic Services Officer
South Gloucestershire Council Council Offices
Castle Street
Thornbury
Bristol BS35 1HF

Dear Claire,

Thank you for your letter of February 8th which sets out a number of recommendations the Health Scrutiny Select Committee would like North Bristol NHS Trust and University Hospitals Bristol NHS Foundation Trust to consider in relation to the Independent Inquiry into Histopathology Services which reported in 2010. We will respond to each of these recommendations in turn.

1. Quarterly reports on progress with implementation of the Histopathology Action Plan to the Committee and the Bristol Health and Adult Social Care Scrutiny Commission

   The Trusts are grateful for the recent clarification of the working arrangements which will apply to the proposed joint meetings at which progress reports will be requested and confirm that they are content to report in this way. The Trusts would like to point out that the nature of their reporting may warrant adjusting, following the judgement of the Independent Inquiry Panel, who reviewed progress with the implementation of their recommendations in February/March.

2. Quality Accounts

   Both Trusts can confirm that they are content to include details of progress with the implementation of the Histopathology Action Plan in their Quality Accounts.

3. Double Reporting

   Double reporting refers to a process whereby the initial diagnosis following histopathological examination is confirmed by a second cellular pathologist. There is no national requirement for or guidance on double reporting, other than in a small number of specific disease areas discussed below. We are aware that the Royal College of Pathologists is currently aiming to prepare guidance on this matter.

- What is the rationale for double reporting in some histopathology specialities but not others?

There is limited evidence to suggest that double reporting has the potential to improve the quality of histopathology diagnoses, though this evidence is stronger in some clinical areas than others.

The conditions where double reporting is nationally recommended are those where there is the best evidence. Double reporting is highly resource intensive and focussing the process on areas where there is most benefit is appropriate. There are other means by which quality is assured and any potential misdiagnosis prevented from causing harm to a patient. These include the practice of reviewing histopathology diagnoses through the Cancer Multi-disciplinary Team (MDT) structure, where a histopathologist is in attendance.

The approach to double reporting at UH Bristol and NBT is documented through a formal protocol. This protocol emphasises that it is good professional practice to discuss cases where there is diagnostic uncertainty with colleagues and also identifies those areas where the Trusts themselves have mandated double reporting. The rationale for the areas identified is a combination of external guidance and local decision. Separate decisions have previously been made by the Trusts about where to focus double reporting resource. The Trusts are now working together to ensure that the guidance is consistently applied in both services.

- How do UHB and NBT compare with other trusts in England with regard to when and how you decide to undertake double reporting?

  Information regarding double reporting practice at other Trusts is not published and is therefore not readily available. There is no standard approach nationally. Our inquiries indicate that there are a range of different practices in Trusts with respect to the extent of double reporting and the conditions on which it is focussed. It is believed that our practice is in line with comparable Trusts. In view of the concerns that have been raised locally, however, the Trusts will continue to review practice in this area.

- What information and guidance is provided by the Royal College of Pathologists – is there any benchmarking data?

  We understand that the Royal College of Pathologists is currently preparing guidance on double reporting which we will consider fully when published. We are not aware of any benchmarking data on this issue.

- Are there any NICE guidelines around double reporting in histopathology?

  There is no general NICE guidance about double reporting in histopathology. There is specific guidance in the 2006 ‘Improving Outcomes for People with Skin Tumours including Melanoma’ which now falls under NICE as follows: -

  ‘All Malignant Melanomas and severely atypical naevi should be double-reported, if resources allow the report to be generated within 2 weeks’.

  There is also some specific guidance from professional bodies in gastrointestinal pathology where double reporting is suggested for High-grade dysplasia in Barrett's oesophagus and high-grade dysplasia for chronic inflammatory bowel disease.

4. Clinical Audit Programme

We are asked to consider conducting a statistically significant sampling of cases to demonstrate

whether the original pathologists' conclusion was correct and whether the decision to double report or not was correct.

The Trusts already plan to undertake audits to confirm that in those areas where it is the policy to double report that it does take place. The Quality Assurance processes described below ensure that any identified discrepancies in pathology reporting will be investigated to allow consideration of whether double reporting should have taken place.

An exercise in case sampling at UHBristol has already taken place and is reported in the Independent Inquiry report. More than 3500 cases were reviewed and the President of the Royal College of Pathologists commented on the results. Interpretation of the information is problematic in the absence of benchmark data from other sites for comparison. Because the level of errors is very low the number of samples that need to be reviewed to produce a statistically significant conclusion is very large and such an exercise is therefore costly. The Trusts take the view that quality of reporting should be assured through ongoing Quality Assurance processes rather than a one-off large scale sampling exercise. This is in accordance with the view of the Royal College of Pathologists, as shown in the accompanying document, and fits more appropriately with the nature of pathology interpretation as part of a process contributing to patient diagnosis, rather than a test that can be objectively demonstrated to be right or wrong.

Quality assurance processes continue to be developed by both Trusts:

a) Audits to compare the reporting of the original biopsy sample with reporting of the resection specimen post surgery will reveal any discrepancies.
b) In areas where double reporting takes place there is a process for resolving any differences in reports which will include reference to external experts where required. Audit information will be kept for review at individual professionals' appraisal when an expert report has differed from an original report.
c) Changes to interpretation of histopathology report following Multi-Disciplinary Team discussion will be recorded and subject to audit.
d) Any events resulting in harm are reported as serious incidents and subjected to root cause analysis.
e) Discrepancies attributed to individual pathologists will be managed through the appraisal process and any significant concerns will be managed more formally. This will also be the format for discussion with individual pathologists about performance within external quality assurance (EQA) schemes.

5. Specialist histopathologists

Both Trusts have ensured that specimens requiring specialist reporting are reported by histopathologists who specialise in the appropriate specific area of cellular pathology. This is now a matter of policy in both Trusts and is monitored through the governance function of Multidisciplinary Teams.

6. Paediatric and Adult histopathology Departments

The Trusts believe that the optimum approach to ensuring the quality of paediatric cellular pathology is to maintain the paediatric specialist team within the wider cellular pathology group, whilst at the same time respecting the particular requirements of a paediatric service. The future

model is under active consideration through the PCT-led pathology services review, which is consulting widely with appropriate professional staff.

7. Cultural change

   Both Trusts believe that significant progress has been made in the achievement of demonstrable cultural change within the Bristol Cellular Pathology service. Material changes such as the successful initiation of joint staff meetings, the appointment and acceptance of a single Clinical Lead for the service and the development of specialist histopathology teams which span both organisations have generated a genuine atmosphere of renewal. Additionally, external consultants skilled in organisational development continue to work with members of staff. Both Trusts strongly believe that further progress will be achieved and are happy to report on this as requested.

8. Public confidence

   The Trusts believe that any adverse impact on levels of public confidence in the histopathology service in Bristol has been limited. The Trusts believe that through the substantial work associated with the successful implementation of the Histopathology Action Plan, together with the explicit public reporting of progress, wider public confidence in histopathology services can be maintained. Confidence should be enhanced through the current work to develop an integrated pathology service for Bristol which incorporates significant public and patient involvement.

We hope you will find these comments helpful to the work of the Committee and look forward to reporting further progress in due course.

Alongside this response to the specific queries from South Gloucestershire Health Scrutiny Select Committee , we are making available to the first joint meeting with the Bristol Health and Adult Social Care Scrutiny Commission, the findings of the Independent Inquiry Panel following its recent review and the regular quarterly report of progress against the Trusts' joint action plan.

Yours sincerely,

Robert Woolley
Chief Executive
University Hospitals Bristol NHS Foundation Trust

Ruth Brunt
Chief Executive
North Bristol NHS Trust

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020 7643 5000 (Fax: 020 7353 5778)
www.hailshamchambers.com

Dear Robert,

Inquiry into Histopathology Services in Bristol

Thank you for inviting the Panel to review the steps taken to address the recommendations made in the Inquiry Report we submitted in December 2010.

We conducted interviews in Bristol on 29 February and 1 March 2012. We are very grateful to everyone who came to see us and for the arrangements made for us to revisit the Histopathology Department. We were very pleased to have been able to talk to patients and relatives as well as members of staff from both Trusts.

We have come to three broad conclusions.

1) Both Trusts (UHBT and NBT) are to be congratulated on all that has been achieved so far. We have seen evidence of a genuine commitment to implement our recommendations and evidence of real progress.

   We are greatly encouraged by:

   a) The appointment of Dr Rob Pitcher as the Clinical Lead for Cellular Pathology. We are impressed by his experience, ability and commitment. Dr Pitcher has worked extremely hard and effectively to bring about necessary changes and a great deal has been done in a short time, but we are reassured to see that he is also sensitive to the fact that it takes time to adjust to new work cultures and environments. We were very pleased to learn that Dr Pitcher has also been appointed to be the Clinical Lead for the Bristol Pathology Review.

   b) The appointment of six new consultants, four of whom we met. It is particularly favourable that three of the appointments are in the specialty areas of respiratory and paediatric histopathology, given that these were the two specialties about which the original concerns were raised.

   c) The establishment of two new consultant posts. Given the very challenging financial outlook, the funding of these posts is evidence of the commitment of the Trust Boards to strengthen and improve the histopathology service in Bristol.

   d) The steps that have been taken towards the integration of the service across the two trusts.

   e) The partial upgrading of the BRI histopathology department.

   f) The introduction of process redesign and the Lean methodology.

2) Although much has been done, there is still much to do. We recommend a focus on the following issues:

a) Keep up the momentum of change and improvement. Culture and attitudes cannot be transformed quickly and it is transformation that is required.

b) Resolve the staffing issues in breast histopathology as soon as possible and repatriate to NBT the work currently being done by Source Bioscience. This is of vital importance.

c) Make the decision about the future of pathology services in Bristol as soon as possible. The Panel has no view on its location(s) other than, as we recommended, histopathology should operate as a unified service with diagnostic reliability and clinical effectiveness as dominant criteria.

d) Fully implement the introduction of sub-specialty teams so that single teams of specialist pathologists are providing histopathology services across Bristol

e) Continue the review of MDTs to ensure that the teams are functioning reliably and effectively across the city.

f) Implement and audit the agreed procedure for double reporting.

g) Keep consultant staffing under review. We anticipate that further consultant posts will be required to ensure a timely diagnostic service in which the histopathologists confine their practice to areas of specialist competence proven by quality assurance and audit.

h) Continue to develop the network for paediatric and perinatal pathology with Oxford and Southampton.

i) Fund further upgrading of the BRI Department. We recognise that it is important to keep in mind the longer term schemes likely to be required following the Bristol Pathology Review.

3) It is imperative that the Trust communicates to the public and to patients the progress which is being made and provides as much detailed supporting evidence of progress as possible. Because of some adversarial relationships that have developed, it may have been difficult to share information as openly as is desirable. However, it is vital that a way is found to overcome this problem. It is not enough to make progress — progress must be seen and felt – particularly by service users.

We again wish to congratulate both Trusts on all that has been achieved. We hope that good progress will continue to be made and that this will be demonstrated to and acknowledged by everyone.

Finally, unless the Trust wishes to consider inviting us to return for a further review of progress, we suggest that the Inquiry Panel is formally disbanded.

Yours sincerely,

Jane Mishcon

Professor Sir James Underwood

Ken Jarrold CBE

Margaret Spittle OBE

Michael Summers

North Bristol NHS Trust

Report to the Trust Board – April 2012

Title: Updated action plan on Bristol histopathology services

Purpose of paper: To provide the Trust Board with an update

Executive Summary:

- Since last discussion of the action plan the inquiry panel have returned to Bristol to review the progress made since their report in December 2010. A letter to UHBristol from the chair of the panel, following the review, is attached to the papers.

- Following this letter the histopathology action plan which is owned by UHBristol but contributed to by NBT is in the process of being revised

- UHBristol accompanied by NBT and NHS Bristol reported to the South Gloucesteshire Health Overview and Scrutiny commission in January on progress with histopathology services.

- A further joint meeting of Bristol and South Gloucestershire HOSCs to look at histopathology services will be held on 23rd April.

- Attached papers:
  - letter from SGlos HOSC following meeting in January,
  - response to SGlos from CEOs NBT and UHBristol,
  - letter from chair of review panel,
  - report from UHBristol to meeting of 23rd April. The action plan has not been included as it is under revision. Outstanding actions from the previous plan are referred to in this report.

Action Required: The Trust Board is asked to note the update

Impact on Patients: Pathology services are crucial to the work of many other specialties and patients need assurance that the service is of high quality.

CQC outcomes: 1, 2, 4, 6, 12, 13, 14, 16, 17, 20

Presented by: Dr Chris Burton, Medical Director

Prepared by: Dr Chris Burton, Medical Director

Southmead Hospital Redevelopment Project

Highlight Report	Date: 13/04/12	Period: 15/03- 13/04	SRO: David Powell
	Report Number:	94	Author: Martin Warren

Decisions Required: None

Key Issues: **Construction work is on programme and the remaining design is progressing steadily**

Programme 2011/12	A S O N D J F M A M J J A S O N	On programme and three tower cranes have completed their tasks and been removed
Ward block envelopes	G G G G G G G G G	Window installation to Block 6 is under way and substantially complete to most other areas
Clinical block envelopes	G G G G G G G G G	Louvre installation to the Energy Centre has continued and terracotta installation is complete on blocks 1-7
Ward block fit outs	G G G G G G G G G	Pod deliveries to blocks 5 & 6 will complete during April
Clinical block fit outs	G G G G G G G G G	Pre fit out works are complete to blocks 1-7 and fit out has started and continued to plan
Clinical (C-sheets)	G G	Only Theatres and Burns C sheets are still awaited from Carillion
Equipping	G G G G G G G G G	Evaluation of supplier tenders for digital X-Ray, gamma camera, fluoroscopy and interventional radiology units are on programme
Concourse Roof	G G G G G	Good progress on roof glazing, with Sector 1 complete and sector 2 in progress.
Commissioning	G G G G G	The Move Project Team has been formed and regular meetings arranged. Extensive stakeholder list has been developed.

Risk/Cost impacts				RAG
Summary:	**IM&T resources being reviewed to deliver the procurement and commissioning phase.**			**A**
Type	**No.**	**Risk**	**Mitigation**	**Score**
Operational	F12	Schedule of Trust supply IM&T equipment is found to be incomplete and Capital Plan could be inadequate to fund all Trust supply IM&T equipment	A detailed reconciliation against the agreed C sheets is under way in order to populate the IM&T database and ensure the correct budget is in place to procure and deliver the PFI	15
Commissioning	P10	Staff unable to allocate sufficient time to engage with commissioning new building and delay the opening	The Trust is actively planning the immediate priority projects including Cerner, BoF, Operational Planning and FT application. It is essential that there is sufficient resource and engagement from 2012 on what is needed to transform the services and to commission the new building.	15
Operational	A6	Service transfers out from NBT do not proceed as planned	Generic space planning allows for temporary mix changes and closure programme around Frenchay could be managed to allow time to resolve service transfer issues. Maintain close liaison with UHB and other organisations to ensure early warning signs are picked up and seek share of risk of delay with new host organisation.	12

Quality		RAG
Summary:	**The quality of design submissions and samples generally continue to meet the Trust requirements and expectations**	**G**
Design	Internal wayfinding is progressing well with the help of the Trustwide Reference group, following decisions at March Programme Board	G
Clinical/functionality	Useful visit by NBT staff to Forth Valley Hospital to identify teething problems during 1st year of AGV. Lessons learnt will assist Carillion avoid same issues.	G
Technical	IM&T Strategic Partner Tenders being evaluated and clarification meetings arranged. Plan is to appoint in July 2012	G
Arts	Water feature proposals ready to be signed off by Programme Board	G
Sustainability	Carillion have consistently diverted over 95% of their construction waste from landfill to recycling for the last 12 months	G
Comms/involvement	The Comms & PPI Core Group has merged with the steering group and the first combined meeting held. Forward planning now includes all redevelopment schemes	G

Asbestos/Ground Conditions	Number	Cost £000	RAG
Unexpected ground conditions	0	0	**G**
Unidentified asbestos	1 (Phase 1 demolitions)	200 (anticipated and allowed for in budget)	**G**
Variations	**Number**	**Cost £000**	**RAG**
Error Corrections:	0	0	**G**
Strategic Decisions:	1	0	**G**

North Bristol NHS Trust

Report to the NBT Trust Board
26 April 2012

Title:	**Southmead Hospital Redevelopment Update**
Purpose of paper:	To provide an overview of issues and risks associated with the Southmead Hospital Redevelopment project.

To note

Executive Summary:

- Construction work is on programme. The Topping Out Ceremony on 21 March received good press coverage. The 17 staff from across the Trust who attended were enthused about the future following the tour of parts of the building.
- The bulk of the design process has been completed.
- Three NBT staff visited Forth Valley Hospital to identify teething problems during their 1st year of AGV operation. The very useful lessons learnt will assist Carillion avoid similar issues and help NBT in formulating operational policies.
- Rectification works to the staff MSCP are progressing
- Carillion's claim for unidentified asbestos, which is a standard contractual requirement, has been agreed but not yet formally documented.
- No claims have been received by the Trust.

Action Required: The Trust Board is asked to **Note** the issues identified.

Key Risks:
The key risks identified for the period include:

- Schedule of Trust supply IM&T equipment is found to be incomplete and Capital Plan could be inadequate to fund all Trust supply IM&T equipment. A detailed reconciliation against the agreed C sheets is under way in order to populate the IM&T database and ensure the correct budget is in place to procure and deliver the PFI
- Service transfers between Trusts not proceeding to agreed timescales. Contingency plans are being developed in the event that services are unable to transfer.
- Staff not having sufficient time to engage with the service redesigns and workforce planning for development of the commissioning plan for the new hospital. The forthcoming major projects which could compete with resources are planned to peak prior to the new hospital commissioning process.

Impact on Patients:

Emerging costs that have not been allowed for could reduce available funding for patient care or could result in additional savings being required. A successfully delivered design should bring significant benefits to patients, visitors and staff in terms of environment and functionality.

CQC Outcome:	**10 and 26**
Responsible Committee:	**North Bristol Trust Redevelopment PB**
Financial Issues considered:	**Yes**
Equality Impact Assess't Completed:	**Yes**
Legal Issues Considered:	**Yes**
Sustainability Assess't Completed:	**No**
Presented by:	**David Powell, Director of Projects**
Prepared by:	**Martin Warren, Project Manager**

North Bristol NHS Trust

Trust Board - April 2012

Title: # Major Trauma - Project Closure Report

Purpose of paper: To brief the Trust Board on the closure of the Major Trauma (Building our Future) project with a review of achievements against objectives, a review of the benefits case and arrangements for the on-going management of Major Trauma. This paper was considered in full by the Trust Management Team on 17 April 2012. Major trauma moved into 'business as usual' on 2 April 2012.

Action Required: The Trust Board is asked to **NOTE** the project closure and on-going arrangements for the management of major trauma at NBT and the Severn Major Trauma Network.

Impact on Patients: **The Major Trauma project is intended to reduce mortality for patients suffering major trauma injuries**

CQC Outcome: **4,6,13**

Responsible Committee: **Building our Future Programme Board**

Financial Issues considered: **Yes**

Equality Impact Assessment Completed: Yes where applicable

Presented by: Harry Hayer, Senior Responsible Officer, Major Trauma

Prepared by: Simon Sethi, Senior Programme Manager, Major Trauma
Victoria Cooney, Network Manager, Severn Major Trauma Network

This document could be made public under the Freedom of Information Act 2000.
Any person identifiable, corporate sensitive information will be exempt and must be discussed under a 'closed section' of any meeting.

Major Trauma Project Summary

1. Purpose of paper

This paper will evaluate the Major Trauma project's achievements against set objectives and will give a review of the benefits case following the recent project closure and launch of the Major Trauma Centre on the 2nd April 2012. It will then outline arrangements for the on-going management of Major Trauma highlighting outstanding risks and mitigating actions.

The Trust Management Team, at its meeting on 17 April 2012, was asked to note project closure, arrangements for on-going management, risks and mitigating actions. Where deemed insufficient, TMT was asked to suggest alternative mitigating actions.

2. Overview

The Major Trauma Project was split into two phases. The first was a viability assessment of whether NBT wished to pursue MTC status on the basis of financial and organisational considerations. The second launch phase aimed to achieve MTC designation, recruit to infrastructure, designate the Severn Major Trauma Network and ensure sufficient capacity was available for the likely demand.

The Major Trauma Project met its objectives within date, budget and scope. The Trust is now in a strong position to meet the standards required to obtain best practice tariff, thereby supporting the Trust's overall financial position. Key determinants in this project's success have been excellent clinical leadership from both the Network Director (Professor David Lockey) and MTC Clinical Lead (Dr Benjamin Walton), a highly motivated and selected project team (led by Simon Sethi), and the Senior Responsible Officer (Harry Hayer). In addition, the project has benefited from being fundamentally aimed at developing an area in which many staff are already expert and enthusiastic.

3. Review of achievement against objectives

The Major Trauma Project had five key objectives, which are reviewed below.

3.1. Designation of NBT as a Major Trauma Centre. NBT achieved successful designation by NHS South of England as a Major Trauma Centre following a process of evidence submission and an assessment day.

3.2. Implement infrastructure to meet Major Trauma Specification. Funding has been secured for all infrastructure at the MTC required to meet the designation requirements which includes but is not limited to: Network Clinical Director, Clinical Lead for the MTC, Nurse Practitioners, Rehabilitation Facilitators, a comprehensive training programme and 24/7 Trauma Team Leader Consultant cover.

3.3. Creation of a Severn Major Trauma Network. All acute trusts in the Severn region have achieved Trauma Unit designation with the exception of WAHTr. A stakeholder day informed the construction of a Network Operational Plan outlining how the network will function. A Network Assurance day took place in March after which formal designation for the Severn Network was given by NHS South of England.

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3.4. Capacity. To inform capacity plans, a detailed review was undertaken of the demand increases at other Major Trauma Centres alongside a review of the major trauma patients currently being treated at NBT. This informed a demand projection which, alongside a draft MTC Operational Plan, were for the focus for discussion at an MTC Stakeholder event in January 2012. Following this event, capacity plans were drafted by directorates and signed off by TMT. Due to concerns around the sufficiency of capacity and the difficulty in projecting demand, the operational plan includes clear contingency plans drawn up by Directorates in the event of more demand than expected occurring.

3.5. Paediatrics. The project was required to confirm the current paediatric major trauma pathway and appoint a Regional Paediatric Major Trauma Clinical Lead to provide clinical leadership for the pathway changes over the next two years whilst Paediatric Major Trauma transfers to the Bristol Children's Hospital. The current pathway has now been agreed and a joint Paediatric Major Trauma Lead post across the South West has been advertised with 4 applicants.

4. On-going risk management

There are three key risks identified for NBT as a Major Trauma Centre, these are outlined below with their mitigation plans.

4.1 Capacity. There is a recognised lack of robust information on which to base demand projections. The Major Trauma Network Manager will report monthly on major trauma activity to trigger a capacity escalation scenario if required, as defined in the operational plan. The Major Trauma Service as documented above will report into the Director of Operations as a pilot microsystem and as such will be able to immediately escalate higher than expected transfer. It should be noted that capacity plans have been drawn up by, and will be implemented and funded by, Directorates and not the Major Trauma team.

4.2 Over or under-triage. There is a risk that either not enough patients will be redirected to the MTC (causing financial risk) or too many (causing a capacity risk). Therefore a rigorous process of designation has been undertaken with GWAS including a training programme in using the triage tool. The efficacy of these tools will be monitored on an on-going basis by GWAS and the Network Manager to ensure they are effective.

4.3 Delivery of Best Practice requirements. The best practice tariff for Major Trauma will fund the new infrastructure. There is a risk that key requirements – particularly acceptance within 2 calendar days – may not be met. To mitigate this risk, the Trust Management Team has signed off an automatic acceptance policy which confirms major trauma cannot be delayed or declined from coming to NBT. To minimise capacity risks as a result, an Automatic Repatriation Policy for major trauma has also been agreed across the Network.

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5. Review of the Benefits Case

The table below reviews the project's delivery against the benefits outlined in the PID.

Group	Benefit	Evaluation
Patients	Patients will receive a service that delivers the highest possible care for patients 24 hours a day, seven days a week	With effect from April 2nd 2012 patients are now receiving a 24 hour consultant-led Major Trauma service
	Reduction of 20% in preventable deaths in the Severn area as measured by TARN submissions	Aim to deliver benefit over first two years of MTC launch. Since the MTC project has launched, the Trust saves 3.4 lives per 100 more than expected compared to other centres.
	Performance against quality metrics including head injury, grade of doctor assessing, time to CT scan and time to theatre.	These measures are now being tracked and will be reported on at least quarterly.
Staff	Reputational benefit of NBT being recognised as a centre for tertiary trauma and associated specialties	A media strategy was successfully implemented by the press office which fit with SHA and national press releases.
	Increasing the skills of the workforce will result in increased job satisfaction for staff	Plans are in place for comprehensive delivery of training across a number of key staff groups to ensure buy-in to the process.
Organisation	Major Trauma designation ensures the longer term financial viability of the Trust through securing this aspect of the health market and its related specialties	The Major Trauma Project will deliver surpluses over the following four years as outlined in the IBP.
	Enhance the Trust's ability to be the provider of choice (i.e. a reputation for excellent clinical services)	Press coverage and clinical networking are already showing signs of increased recognition of NBT as a centre of excellence.
	Contribution to enhance clinical reputation with Commissioners and potential employees	In recent recruitment in both trauma and ED, there has been stated interest from applicants for applying to NBT due to its specialist Major Trauma status.
	Contribution to enhance clinical engagement and leadership with service transformation.	Stakeholder workshops have shown widespread enthusiasm and engagement with service change and improvement around major trauma.

6. On-going management arrangements

In the February meeting of Execs, it was agreed that Major Trauma would function as a clinical microsystem housed within the Musculoskeletal directorate but with the clinical lead reporting directly to the Director of Operations with effect from 2 April 2012.

7. Conclusion

The Major Trauma Project has delivered all required objectives in order to launch both the Centre and the Severn Major Trauma Network and will contribute significantly to both quality and safety of care and the Trust's financial bottom line.

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Sheet 1 - R&I Strategy Status Report

North Bristol NHS Trust

Research & Innovation Strategy Status Report 2011-12 -Quarter 4

Summary of Progress in Quarter 4:

R&I KPI metrics indicate targets are being met or exceeded in terms of study numbers and raw patient recruitment.

NIHR Research Capability Funding allocations for 2012/13 from Department of Health are expected imminently.

Learning and Research Phase 2 planning application was submitted in Feb 2012

The NBT Intellectual Property policy has been updated.

Strategic Aim 1:	***Support our leading clinical researchers and develop new talent***
Objectives:	*1.1 Provide Protected Time for Research*
	1.2 Develop Research Capacity
	1.3 Develop Engagement with Clinical Research Networks

A call for NBT Research Capability Funding applications will be opened once the 2012/2013 allocation has been notified to NBT by the Department of Health. Awards will be made to provide protected time for NBT researchers to develop NIHR grant applications.

Strategic Aim 2:	***Increase high quality research and innovation activity by improving and developing new opportunities for engagement***
Objectives:	*2.1 Support and Increase National Institute for Health Research (NIHR) Portfolio Research*
	2.2 Develop and Lead New Research
	2.3 Increase Patient and Public Involvement (PPI)
	2.4 Develop Innovation Activities

Two intentions to award have been received by NBT from the NIHR (Programme Grant - £2M/Efficiency & Mechanism Evaluation grant - £). Comments from the NIHR awarding panels need to be adequatley addressed before funding awards are confirmed/announced.

A campaign targeted at Pharmaceutical/Device commercial companies will take place in April 2012, aimed as encouraging companies to see NBT as the organisation of choice for conducting commercial research.

A new NBT Innovation Strategy is being developed.

Strategic Aim 3:	***Increase income arising from research and innovation and use that income in support of our strategic aims***
Objectives:	*3.1 Maximise External Income*
	3.2 Develop the Internal Funding Scheme
	3.3 Develop Best Practice in Financial Management

NBT Research Committee approved changes to the Intellectual Property Policy so that profits are shared from commercialised patents, design rights and books such that inventors receive 20% and their Directorates receive 80% to put to CRES.

Strategic Aim 4:	***Strategic aim 4: Develop research and innovation infrastructure, providing access to protected space and facilities***
Objectives:	*4.1 Establish a Clinical Trials Unit (CTU)*
	4.2 Scope the Potential for establishing Clinical Research Facilities
	4.3 Scope the potential for a BioTechnology Incubator

Learning and Research Phase 2 planning continues, a planning application was submitted in Feb 2012.

An outputs, outcomes and Impact survey to being developed to capture the impact of the research being undertaken at NBT. A paper will be presented to the Research Committee in April outlining the process and content.

Strategic Aim 5:	***Work with partners to deliver the NBT strategic aims and develop a pan-Bristol research and innovation strategy***
Objectives:	*5.1 Tackle priorities for research through partnership*
	5.2 Develop a pan-Bristol Research and Innovation Strategy
	5.3 Support the development of Regional Research and Enterprise

Bristol Health Partners have appointed Prof Peter Mathieson as Director and agreed/shared partner priorities.

Other Research & Innovation Highlights

An outputs, outcomes and Impact survey to being developed to capture the impact of the research being undertaken at NBT. A paper will be presented to the Research Committee in April outlining the process and content.

Arrows

Target Currently met, AND..	Target NOT met this quarter although on target overall, AND..	Target NOT met this quarter and NOT on target overall, AND..
This quarter IMPROVED on preceding quarter	This quarter IMPROVED on preceding quarter	This quarter IMPROVED on preceding quarter
This quarter SAME as preceding quarter	This quarter SAME as preceding quarter	This quarter SAME as preceding quarter
This quarter DOWN on preceding quarter	This quarter DOWN on preceding quarter	This quarter DOWN on preceding quarter

Sheet 2 - Key Performance Indicators

North Bristol NHS Trust

Key Performance Indicators

Q3 2011-12

Indicator	TOTAL 2009-10	TOTAL 2010-11	Q1	Q2	Q3	Q4	Target (where appropriate)	Progress
Non-commerical studies active - ALL (No.)	342	473	385	430	482	491	N/A	
Non-commerical studies active - NIHR Portfolio only (No.)	84	204	172	196	221	228	N/A	
NIHR Programme Grants for Applied Research led by NBT active (No.)	2	3	3	3	3	3	3	
Other NIHR grants led by NBT active (No.)	3	7	7	8	9	9	6	
Commercial studies active - ALL (No.)	51	74	51	52	52	59	N/A	
Commercial studies active - NIHR Portfolio only (No.)	8	21	15	19	19	23	N/A	
Patients Recruited - NIHR Portfolio only (No.)	5467	6519	2204	3481	3807	4764	4388	
Income - NIHR Delivery funding	£1,065,204	£2,674,942	£700,000	£1,337,631.00	£2,166,752	£2,879,003	£2.9million	
Total grant income administered by NBT - NIHR Grants only (£)	£4,565,580	£6,478,650	£6,487,064	£6,719,412	£6,912,635	£6,912,635	N/A	
Net contribution to NBT's existing embedded research costs	£1,000,000	£1.456million	£1,360,000	£1,495,000	£1,495,000	£1,495,000	£1.49million	
Commercialised products (No.)	3	3	0	0	2	5	N/A	
Product innovation projects active (No.)	45	34	15	7	28	27	N/A	
Royalties from licensed products before royalty sharing	£109,784	£65,250.51	£18,863.40	£37,418.00	£37,418.00	£37,418.00	TBC	

Sheet 3

Description of the metrics used

Please note: All figures are cumulative totals

KPI	***Definition/Relevance***	***Target***
Non-commercial studies active	The number of studies active and number of patients recruited into those studies (sometimes referred to as 'accruals') is a useful high level indicator of the overall size of NBT research portfolio. These KPIs are routinely used in regional and national comparisons between organisations (particularly NIHR Portfolio studies) and are also used in any activity/formula based funding allocations made by Department of Health or research networks. Commercial research also generates a) profit for NBT (in that commercial direct costs are changed) and b) capacity building income (20% of direct costs) which is directed to the Innovation Seed Fund (see below).	The Research Committee will agree a local target
Commercial studies active		The Research Committee will agree a local target
Patients recruited		The target for the number of patients recruited has been determined by the R&I finance plan.
NIHR Research for Patient Benefit (RfPB)	Attracting NIHR Grants (where NBT is the lead NHS Organisation) is of particular importance as additional Department of Health income (Flexibility & Sustainability Funding (FSF)) is paid in direct proportion to NIHR Grant Income to NBT in the previous calendar year. FSF is used to fund the development of future NIHR Grants and therefore a virtuous cycle can be maintained. The main NIHR grants are included in the KPIs and will be reported annually due to the varying timescales throughout the year at which these grants are awarded. The 'other NIHR Grants' refer to funding streams such as Health Technology Assessment (HTA), Invention for Innovation (I4I) and Service Delivery & Organisation (SDO).	The target for the number of successful NIHR grants has been determined by the R&I finance plan.
NIHR Programme Grants for Applied Research (PGAR)		
Other NIHR grants		
Income - NIHR Delivery Funding	NIHR Delivery funding is allocated to NHS Trusts based on the number of patients the Trust recruits into NIHR Portfolio studies each year. The Western Comprehensive Local Research Network (WCLRN) determinesand provides the NHS Trusts' allocations in the South West region.	Based on 2009-10 activity, the WCLRN has provisionaly allocated £2.679million to NBT to support the delivery of NIHR portfolio studies.
Total grant income administered by NBT	This represents the total value of all NIHR grants held by NBT for this financial year.	There is no target agreed for this KPI.

Commercialised products	The number of different products invented by NBT staff that have been commercialised.	Local target – yet to be agreed.
Product Innovation projects active	The number of product innovation projects that are currently active provides a high level indicator of the NBT innovation activity	Local target – yet to be agreed.
Royalties from licensed products before royalty sharing	This is royalties from licensed intellectual property rights before royalty sharing accrording to our IP Policy takes place between the inventor, their department and the trust. This does **not** include income from sales of products developed and produced in-house.	Local target defined within the business case drafted in 2007 to support NBT continuing with the Trust Innovation Lead role. This target will be reviewed and amended after local discussions have taken place.

Glossary of terms

NIHR	'Best Research for Best Health'
FSF	Flexibility and Sustainability 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
Embedded FSF	Research development time which already exists within individuals' job plans
Accruals	Number of patients recruited to a study
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
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.
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.

North Bristol NHS Trust

Report to the Trust Board – 26th April 2012

Title: **Activity and Performance Report**

Purpose of paper: To present the current Trust position against new and existing performance targets/indicators to the Board.

For Information

Executive Summary:

Emergency Access – continues to be the highest priority for improvement. An exception report has been prepared as part of this Board Report.

18 Week Referral to Treatment Time – You will note from the Board Report that for the 2nd month running, the incomplete pathway medium has not achieved. This is purely due to a validation issue within the Cerner information system. A working group has been set up with appropriate operational staff to review the actions which should result in the number of incomplete pathways reducing. This will not however, be fully completed for approximately 3 to 4 months, due to the complexity of the work needed to be undertaken.

Cancer – Having reviewed the cancer data for March 2012 all indications are that cancer has achieved comfortably for year end, .and in most instances has improved.

Cancelled Operations – A validation is still being undertaken for February's cancelled operations position.

Re-admission Rates – The readmission rates within 30 days following emergency admission have risen significantly and further work is being done to understand the rationale behind this.

Choose and Book – As predicted now that all the outpatient clinics have been rebuilt on the Cerner system our slot availability has increased and is now within target.

Stroke Management – Due to problems with access to neurosurgical beds, this target has not achieved for the past 3 months and this is being closely monitored.

Action Required:

No action required.

The Trust Board is asked to:

Note the content of the report.

Key Risks:

None delivery of operational performance may invoke financial penalty and reputational damage.

Impact on Patients:

Timely access to services is very important to patients.

CQC Outcome:	**Performance indicators.**
Responsible Committee:	**PPFC**
Financial Issues considered:	**Yes**
Equality Impact Assessment Completed:	**No**
Legal Issues Considered:	**Yes**
Sustainability Assessment Completed:	**No**

Presented by: **Sue Watkinson, Director of Operations**

Prepared by: **Dan Bates, Information Analyst**

			TARGET	MONTHLY PERFORMANCE												YEARLY PERF		QUARTERLY PERFORMANCE			
				Apr-11	May-11	Jun-11	Jul-11	Aug-11	Sep-11	Oct-11	Nov-11	Dec-11	Jan-12	Feb-12	Mar-12	YTD	10/11	Q1	Q2	Q3	Q4
Referral to Treatment 18 Weeks	NATIONAL MEASURE	Admitted 18 weeks	90%	92.0%	93.1%	92.8%	91.3%	90.0%	93.1%	92.6%	91.8%	90.1%	90.2%	90.1%		91.6%	92.2%	92.6%	91.5%	91.1%	
		Admitted median	< 11.1	6.6	7.7	7.7	8.0	7.3	7.4	7.4	6.7	7.0	6.4	5.1		7.0	7.3	7.3	7.6	7.0	
		Admitted 95th percentile	< 23	20.3	20.7	20.1	20.4	21.7	20.0	20.0	20.9	21.3	22.0	22.4		21.0	19.9	20.3	20.7	20.7	
		Non Admitted 18 weeks	95%	98.5%	98.1%	98.0%	98.1%	98.4%	98.5%	98.3%	96.9%	96.8%	95.4%	97.8%		97.7%	98.0%	98.2%	98.3%	97.2%	
		Non-admitted median	< 6.6	4.4	5.0	4.1	4.1	4.3	4.4	3.9	4.0	3.4	6.1	4.7		4.4	4.6	4.6	4.3	3.9	
		Non-admitted 95th percentile	< 18.3	12.6	13.1	13.4	13.0	13.0	13.6	13.3	14.7	15.3	17.6	14.7		14.0	13.4	13.0	13.1	14.3	
		Incomplete pathway 95th percentile	< 28	24.6	24.4	23.7	23.6	24.6	23.7	23.9	24.7	24.3	24.7	25.1		24.3		23.7	23.7	24.3	
		Incomplete pathway median	< 7.2	6.6	6.6	6.0	5.9	6.6	6.4	5.9	6.4	6.1	8.0	8.7		6.7		6.0	6.4	6.1	
Cancer	NATIONAL MEASURE	TWW GP Referrals	> 93%	93.6%	93.2%	93.5%	93.2%	96.0%	93.2%	93.7%	95.9%	94.1%	90.0%	93.0%		93.8%	93.6%	93.4%	94.0%	94.6%	
		TWW Breast Symptoms	> 93%	96.3%	98.0%	100.0%	96.2%	96.3%	96.8%	98.2%	98.2%	100.0%	96.0%	97.0%		97.8%	97.1%	97.1%	95.5%	98.7%	
		62 Day First Treatment from GP Referral	> 85%	93.7%	92.0%	87.7%	92.8%	84.5%	88.7%	86.8%	89.6%	88.2%	86.3%	86.4%		88.2%	87.9%	89.2%	88.0%	88.7%	
		62 Day First Treatment from Consultant Screening	> 90%	83.3%	100.0%	100.0%	100.0%	100.0%	100.0%	91.7%	100.0%	100.0%	90.0%	100.0%		95.8%	94.5%	94.4%	100.0%	97.7%	
		62 Day First Treatment from Consultant Upgrade	> 90%	100.0%	90.9%	92.3%	100.0%	100.0%	100.0%	100.0%	100.0%	94.7%	93.8%	100.0%		95.8%	94.1%	93.2%	100.0%	94.7%	
		31 Day First Treatment from Diagnosis	> 96%	99.4%	99.0%	98.6%	96.9%	97.3%	97.2%	98.6%	96.7%	96.5%	97.8%	98.1%		97.2%	97.7%	98.9%	96.8%	97.1%	
		31 Day Secondary AntiCancer Drug Treatment	> 98%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%		100.0%	100.0%	100.0%	100.0%	100.0%	
		31 Day Secondary Surgery Treatment	> 94%	98.1%	98.6%	100.0%	97.7%	98.9%	97.5%	98.4%	97.7%	97.0%	96.3%	94.4%		97.4%	96.3%	98.9%	97.1%	97.6%	
		31 Day Secondary Radiotherapy Treatment	> 94%	No cases	No Cases	100.0%	No Cases	No Cases	No Cases	No Cases	No Cases	No Cases	No Cases	No Cases		100.0%	100.0%	100.0%	No Cases	No Cases	
	LOCAL	31 Day Secondary Palliative Care	> 94%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	No Cases	100.0%	100.0%		100.0%	100.0%	100.0%	100.0%	100.0%	
		31 Day Secondary Active Monitoring	> 94%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	No Cases	No Cases	100.0%		100.0%	100.0%	100.0%	100.0%	100.0%	
Cancelled Ops	NATIONAL	Cancelled Ops for non-clinical reasons	< 0.8%	0.4%	0.4%	0.6%	0.6%	0.8%	1.0%	0.7%	0.8%	0.9%	0.7%			0.8%	1.0%	0.4%	0.8%	0.8%	
		Cancelled Ops rebooking within 28 days	> 95%	78.9%	100.0%	100.0%	96.4%	87.2%	100.0%	87.9%	90.0%	77.1%	80.0%			94.7%	88.0%	94.2%	94.9%	85.2%	

		TARGET		MONTHLY PERFORMANCE												YEARLY PERF		QUARTERLY PERFORMANCE			
				Apr-11	May-11	Jun-11	Jul-11	Aug-11	Sep-11	Oct-11	Nov-11	Dec-11	Jan-12	Feb-12	Mar-12	YTD	10/11	Q1	Q2	Q3	Q4
Emergency	NATIONAL MEASURE	A&E Total time 95th percentile (4 hours) **TOTAL**	< 4.00	3.97	3.95	3.97	3.98	3.97	4.55	5.23	5.17		6.00	5.90	Note: Jan 12 includes data from 9th to 31st Jan only	5.12	2.47	3.97	4.21	5.95	
		A&E Total time 95th percentile (4 hours) **SMD**	< 4.00	2.57	2.50	2.88	2.32	2.57	2.48	2.50	2.47		2.67	2.85		2.60	2.47	2.65	2.46	2.76	
		A&E Total time 95th percentile (4 hours) **FRE**	< 4.00	3.98	3.97	3.98	4.05	3.98	5.02	6.00	5.62		6.45	6.33		5.60	3.98	3.98	4.35	6.39	
		A&E 4 hour wait (**SMD, FRE & YATE**)	> 95%	97.6%	97.9%	97.2%	97.6%	96.4%	97.6%	93.9%	93.9%		85.1%	89.8%		95.8%	97.1%	97.6%	96.3%	93.9%	
		A&E 4 hour wait **SMD**	> 95%	100.0%	100.0%	100.0%	99.9%	100.0%	99.8%	99.9%	99.9%		100.0%	99.9%		100.0%	99.9%	100.0%	99.9%	99.9%	
		A&E 4 hour wait **FRE**	> 95%	96.7%	97.0%	96.0%	95.0%	96.5%	92.7%	91.1%	91.2%		77.4%	85.5%		94.0%	96.4%	96.6%	94.7%	91.2%	
		A&E Unplanned reattendance rate **TOTAL**	< 5%	4.2%	4.4%	3.7%	4.8%	4.6%	4.4%	4.4%	4.1%	3.6%	3.1%	3.4%		4.0%	4.6%	4.0%	4.6%	4.0%	
		A&E Unplanned reattendance rate **SMD**	< 5%	4.2%	3.6%	3.0%	4.6%	5.7%	5.2%	5.6%	5.0%	4.6%	3.6%	3.9%		4.4%	6.1%	3.5%	5.1%	5.2%	
		A&E Unplanned reattendance rate **FRE**	< 5%	4.2%	4.6%	3.9%	4.9%	4.3%	4.2%	4.0%	3.8%	3.4%	3.0%	3.3%		3.9%	4.1%	4.2%	4.4%	3.7%	
		A&E Left dept without being seen **TOTAL**	< 5%	2.7%	2.2%	2.4%	2.7%	2.3%	3.0%	2.3%	2.7%	3.4%	3.3%	4.0%		2.9%	2.4%	2.4%	2.7%	2.8%	
		A&E Left dept without being seen **SMD**	< 5%	2.0%	1.0%	1.9%	1.6%	1.4%	0.8%	1.2%	1.4%	0.7%	1.2%	1.3%		1.4%	1.4%	1.6%	1.2%	1.1%	
		A&E Left dept without being seen **FRE**	< 5%	3.0%	2.5%	2.6%	3.0%	2.6%	3.6%	2.6%	3.1%	4.0%	3.8%	4.7%		3.3%	2.7%	2.7%	3.1%	3.2%	
		A&E Initial assessment 95th percentile (15 mins) **TOTAL**	< 15	76	76	53	90	79	81	80	60		162	168		110		69	82	70	
		A&E Initial assessment 95th percentile (15 mins) **SMD**	< 15	46	37	0	22	53	0	10	0		0	68		101		28	25	5	
		A&E Initial assessment 95th percentile (15 mins) **FRE**	< 15	76	75	53	90	77	81	80	60		162	168		110		68	79	70	
		A&E Time to treatment median (60 mins) **TOTAL**	< 60	60	54	54	53	49	65	54	58		98	103		66		56	56	56	
		A&E Time to treatment median (60 mins) **SMD**	< 60	33	30	30	28	29	32	28	24		47	53		35		31	30	26	
		A&E Time to treatment median (60 mins) **FRE**	< 60	69	61	61	61	56	78	65	71		117	121		78		64	65	68	
		A&E Ambulance Handover times > 2hrs	0	0	4	5	1	1	33	41	34	35	26	42		234	19	9	35	110	
		A&E Ambulance Handover times > 45 mins	0	92	48	36	26	56	243	307	251	174	118	170		1657	678	176	325	732	
Length of Stay	LOCAL MEASURE	Overall Elective LOS	< 3.90	4.20	3.98	3.59	3.97	4.16	4.36	3.46	3.86	3.21	2.95	4.13		3.75	3.99	3.92	4.16	3.77	
		Elective Pre-op LOS	< 0.3	0.26	0.28	0.21	0.28	0.27	0.59	0.18	0.21	0.19	0.11	0.09		0.23	0.28	0.25	0.38	0.21	
		Overall Emergency LOS	< 5.26	5.06	5.56	5.50	5.20	5.43	5.43	5.27	5.68	5.53	5.53	5.53		5.43	5.43	5.39	5.33	5.48	
		Acute Emergency LOS	< 4.6	4.36	4.69	4.79	4.56	4.82	4.79	4.54	5.00	5.30	4.98	4.98		4.80	4.66	4.64	4.69	4.93	

			TARGET	MONTHLY PERFORMANCE												YEARLY PERF		QUARTERLY PERFORMANCE			
				Apr-11	May-11	Jun-11	Jul-11	Aug-11	Sep-11	Oct-11	Nov-11	Dec-11	Jan-12	Feb-12	Mar-12	YTD	10/11	Q1	Q2	Q3	Q4
Readmissions	LOCAL MEASURE	Readmissions within 30 days - Emerg Readmissions following Elect Admission	<115/ month	107	104	107	97	88	89	98	115	94	73	89		1158	1384	317	275	306	
		Readmissions within 30 days - Emerg Readm following Emergency Adm - 2% reduction	-2%	-1.6%	-5.4%	-0.6%	1.5%	-2.0%	1.2%	-12.0%	-7.5%	-15.4%	-3.7%	41.9%		3.0%		-2.6%	0.3%	-11.7%	
Other	NATIONAL MEASURE	6 Week Diagnostic Waits	> 99.5%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	99.6%	99.6%		100%	100%	100%	100%	100%	
		Revascularisation - 11 weeks	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%		100%	100%	100%	100%	100%	
		C&B Sufficient appointment slots	> 96%	97%	97%	98%	99%	99%	95%	99%	98%	94%	96%	97%		97%	98%	98%	98%	97%	
		18 Week Direct Access Audiology	> 95%	99%	100%	99%	99%	100%	100%	100%	100%	100%	100%	100%		100%	99%	99%	100%	100%	
		High Risk TIA	> 60%	90%	57%	65%	57%	79%	64%	74%	86%	83%	76%	82%		74%	26%	68%	67%	81%	
		Stroke Management 90% on Stroke Unit	> 80%	80%	89%	83%	86%	86%	85%	89%	85%	67%	71%	76%		82%	79%	85%	84%	81%	
	LOCAL MEASURE	DNA rates	< 5%	9%	10%	10%	10%	10%	11%	10%	10%	14%	16%	16%		12%	10%	10%	11%	12%	
		Stage of Treatment - 26 week Inpatient breaches	100%	100%	100%	100%	100%	100%	100%	100%	100%					100%	100%	100%	100%		
		Stage of Treatment - 13 week Outpatient breaches	100%	100%	100%	100%	100%	100%	100%	100%	100%					100%	100%	100%	100%		
		Delayed Transfers	1.42%	2.04%	2.47%	2.25%	1.72%	1.86%	1.66%	1.76%	2.33%	2.85%	1.50%	2.13%		2.06%		2.25%	1.72%	2.30%	
		Daycase Rates	> 72.7%	72.8%	73.3%	74.3%	73.0%	74.6%	74.1%	74.6%	73.1%	61.9%	67.4%	74.6%		72.6%	71.5%	73.3%	74.0%	70.4%	

Explanation of operational performance targets and associated financial penalties

Target	Target Description	Contract measure	Financial penalty per target	Total possible financial penalty per 12 months
Admitted 18 weeks	90% of all admitted patients for an elective operation/ procedure (pathway) should be treated within 18 weeks from referral.	Contract penalty	**Up to £3,000,000**	**Up to £3,000,000**
Admitted median	The middle patient out of all admitted 18 week pathways should wait no longer than 11.1 weeks	Contract penalty	**Up to £3,000,000**	**Up to £3,000,000**
Admitted 95th percentile	The patient at 95% out of all admitted 18 week pathways should not be waiting longer than 23 weeks	Contract penalty	**Up to £3,000,000**	**Up to £3,000,000**
Non-admitted 18 weeks	95% of all non-admitted patients should wait no longer than 18 weeks.	Contract penalty	**Up to £3,000,000**	**Up to £3,000,000**
Non-admitted median	The middle patient out of all the non-admitted 18 week pathways should wait no longer than 6.6 weeks	Contract penalty	**Up to £3,000,000**	**Up to £3,000,000**
Non-admitted 95th percentile	The patient at 95% out of all the non-admitted pathways should not wait longer than 18.3 weeks.	Contract penalty	**Up to £3,000,000**	**Up to £3,000,000**
Incomplete pathway 95th percentile	The patient at 95% of all incomplete pathways should not wait longer than 28 weeks	Contract penalty	**Up to £3,000,000**	**Up to £3,000,000**
Incomplete pathway median	The middle patient out of all the incomplete pathways should wait no longer than 7.2 weeks	Contract penalty	**Up to £3,000,000**	**Up to £3,000,000**
TWW GP referrals	93% of all patients with suspected cancer will be see from date of referral within 2 weeks	Contract penalty	**2% of the value of all activity associated with this patient group**	**2% of the value of all activity associated with this patient group**

TWW Breast symptoms	93% of all patients with suspected cancer will be see from date of referral within 2 weeks	Contract penalty	**2% of the value of all activity associated with this patient group**	**2% of the value of all activity associated with this patient group**
62 day First treatment from GP referral	85% of all patients with a cancer diagnosis will receive their first treatment within 62 days from being referred by their GP	Contract penalty	**2% of the value of all activity associated with this patient group**	**2% of the value of all activity associated with this patient group**
62 day First treatment from Consultant screening	90% of all patients with a cancer diagnosis following routine screening will have their first treatment within 62 days of referral	Contract penalty	**2% of the value of all activity associated with this patient group**	**2% of the value of all activity associated with this patient group**
62 day First treatment from Consultant Upgrade	90% of all patients with a cancer diagnosis following a routine consultant referral will have their first treatment within 62 days	Contract penalty	**2% of the value of all activity associated with this patient group**	**2% of the value of all activity associated with this patient group**
31 day First treatment from diagnosis	96% of all patients following a cancer diagnosis will be have their first treatment within 31 days	Contract penalty	**2% of the value of all activity associated with this patient group**	**2% of the value of all activity associated with this patient group**
31 day Secondary AntiCancer Drug Treatment	98% of patients will have cancer drug treatments within days for second or subsequent treatments	Contract penalty	**2% of the value of all activity associated with this patient group**	**2% of the value of all activity associated with this patient group**
31 day Secondary Surgery Treatment	94% of patients wait no more than 31 days for second or subsequent surgical cancer treatment	Contract penalty	**2% of the value of all activity associated with this patient group**	**2% of the value of all activity associated with this patient group**
31 day Secondary	94% of patients wait no more than 31 days for	Contract penalty	**2% of the value**	**2% of the value**

Radiotherapy Treatment	second or subsequent radiotherapy cancer treatment		**of all activity associated with this patient group**	**of all activity associated with this patient group**
31 day Secondary Palliative Care	94% of patients wait no more than 31 days for second or subsequent palliative care	Internal target	**No financial penalty**	**No financial penalty**
31 Day Secondary Active Monitoring	94% of patients wait no more than 31 days for second or subsequent active monitoring	Internal target		**No financial penalty**
Cancelled Operations for non-clinical reasons	Provider cancellation of Elective Care operation for non-clinical reasons either before or after Patient admission – 0.8% of all elective admissions	Contract penalty	**£15k per quarter breached**	**£60k**
Cancelled Operations re-booking within 28 days	95% of same-day cancellation to be re-booked within 28 days	Contract penalty	**Provider must pay for the relevant Patient's treatment by another provider of the Patient's choice**	**Provider must pay for the relevant Patient's treatment by another provider of the Patient's choice**
A&E total time 95th percentile (4 hours)	95% of patients to spend no longer than 4 hours in department	Contract penalty	**2% of value of A&E activity for period**	**2% of value of A&E activity for period**
A&E unplanned re-attendance rate	Less than 5% of patients to re-attend unless planned	Contract penalty	**Penalty to be decided**	**Penalty to be decided**
A&E left department without being seen	Less than 5% of patients leave department without being seen	Contract penalty	**Penalty to be decided**	**Penalty to be decided**
A&E Initial assessment 95th percentile (15 mins)	95% of patients have initial assessment within 15 minutes	Contract penalty	**Penalty to be decided**	**Penalty to be decided**
A&E time to treatment median (60 mins)	The middle patient of all patients waiting treated within 60 minutes	Contract penalty	**Penalty to be decided**	**Penalty to be decided**

A&E Ambulance Handover times >2 hours	No ambulance handovers taking longer than 2 hours	Contract penalty	**Penalty to be decided**	**Penalty to be decided**
A&E ambulance handover times >45 mins	No ambulance handovers taking longer than 45 minutes	Contract penalty	**£95 per breach**	**£95 for each breach**
Length of stay measures	Local targets set for improved productivity	Internal target	**No financial penalty**	**No financial penalty**
Readmissions within 30 days – emergency re-admissions following elective admission	With the exception of specific patient groups, emergency re-admission following an elective admission within 30 days is not paid for	Contract limiter	**No re-admission activity is paid for**	**No re-admission activity is paid for**
Readmissions within 30 days – emergency re-admissions following emergency admission	2% reduction on 2010/11 levels of emergency re-admissions following emergency admissions	Contract limiter	**Activity not paid for if reduction is less than 2%**	**Activity not paid for if reduction is less than 2%**
DNA rates	“Did not attend” rates to be less than 5%	Internal target	**No financial penalty**	**No financial penalty**
6 week diagnostic waits	99.5% of diagnostic waits to be less than 6 weeks	Contract penalty	**£10k / month breached**	**£120k**
Revascularisation – 11 weeks	100% of revascularisation within 11 weeks	National target	**No financial penalty**	**No financial penalty**
Choose & Book sufficient appointment slots	Failure to ensure that “sufficient appointment slots” are made available on the Choose and Book system – 96% availability	Contract penalty	**£10k / month breached**	**£120k**
18 week direct access audiology	95% of Patients seen within 18 weeks for direct access audiology treatment	Contract penalty	**£10k per month breached**	**£120k**
Stroke management 90% on stroke unit	80% of stroke patents who spend at least 90% of their time on a stroke unit.	Contract penalty	**£30,000 per quarter**	**£120,000**
Stage of Treatment – 26 week inpatient	No patient waiting longer than 26 weeks from referral to admitted treatment	National target	**No specific financial**	**No specific financial**

breaches			**penalty**	**penalty**
Stage of Treatment – 13 week outpatient breaches	No patient waiting longer than 13 weeks for an outpatient appointment from referral	National target	**No specific financial penalty**	**No specific financial penalty**
Delayed Transfers	Delayed transfers of care to be maintained at a minimal level. Target set at 20% reduction on 2010/11 levels	Contract penalty	**No financial penalty**	**No financial penalty**
Daycase Rates	72.7% of specific procedures to be carried out as a daycase	Internal target	**No financial penalty**	**No financial penalty**

Performance against SLA

Performance against SLA

North Bristol NHS Trust

EXCEPTION REPORT FOR EMERGENCY ACCESS TARGETS

1. Background

1.1 Since September 2011, there have been significant problems in achieving the Emergency Access Targets within Frenchay Emergency Department.

1.2. None achievement of the emergency access targets can result in patients waiting longer than necessary to be seen, treated and discharged/admitted.

1.3 Whilst we are confident, no harm has come to patients as a result of extended length of time in the Emergency Department, we strive to ensure that all our patients are seen in a timely manner.

1.4 Following significant diagnostics a number of issues have been identified.

2. Diagnostics

2.1 In additional to the internal diagnostics, the Emergency Care Intensive Support Team (ECIST) were invited in to the Trust to review our internal processes and were also invited to look at the wider patient flow across BNSSG.

2.2 The combination of the internal diagnostic and the ECIST report found the following issues may be impacting on Emergency Access

- Fewer than expected patients transferred from Frenchay to Southmead
- Fewer direct admissions than expected to the Southmead site. These patients are being admitted directly to Frenchay instead
- An increased length of stay for medical patients
- Bed managers are now managed centrally rather than in directorates
- There has been a shift in peak activity times
- Implementation of the full clinical management system (CMS) which is an electronic ambulance system to manage patient flow across BNSSG
- Increase in delayed discharges days – in Health Categories
- The South Gloucestershire Common Approach
- High acuity of Patients
- Variability in actual ambulance handover times compared to reported ambulance handover times.

3. Action Plan

3.1 A revised action plan is being drawn up Trust-wide as the existing action plan has not delivered the improvement expected at this time.

3.2. A Turnaround Director has been appointed to the Medical Directorate and is working Trust-wide to ensure that the new action plan is delivered. Access to bed's has significantly improved over the past month

3.3. Work has been commissioned through the Healthy Futures Board across BNSSG with the ECIST. The work will focus on full system wide patient flow for emergency activity.

3.4. A further piece of work has been commissioned across Bristol to review delayed discharges. The number of health delays in NBT are higher than the national average and NBT experiences high levels of waits for continuing healthcare assessment funding decision and placements. This piece of work will be able to review the patient pathway and make some changes which will improve timely access to community based services.

3.5. The ECIST have arranged for a clinically led improvement workshop within NBT in May to ensure that clinical engagement is fully embedded within the emergency department and admission wards / departments.

3.6. A trajectory of ED improvement has been agreed with the PCT and SHA.

3.7. Recruitment has taken place of 5 Initial Assessment Nurses for the Emergency Department at Frenchay who are all due to start within the next 2 months.

3.8. A high level meeting between NBT and GWAS has taken place recently which provided some constructive suggestions and ideas to take forward to improve ambulance handover times. The 2 week ambulance audit has been completed and we are awaiting the report, which will be shared with the Board.

3.9. Two task and finish groups have been set up internally within NBT. A Length of Stay Group chaired by Marie-Noelle Orzel, and an Emergency Access Group chaired by Sue Watkinson.

4. Recommendations

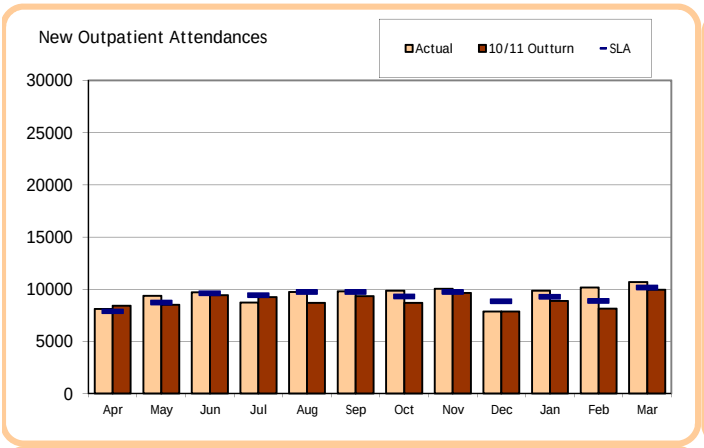
4.1 That the Trust Board reviews the approach outlined in this paper for consideration.

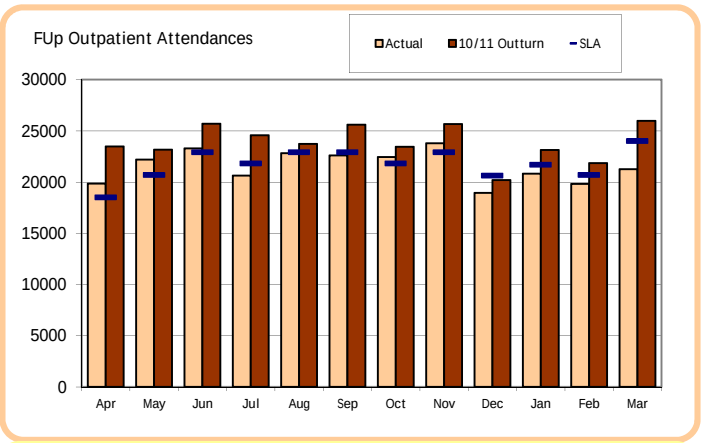
4.2 That the Trust Board approves the continuing support of the ECIST.

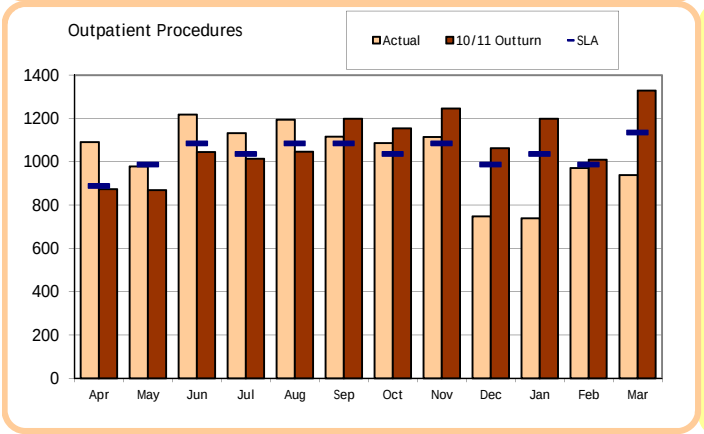
Sue Watkinson
Director of Operations

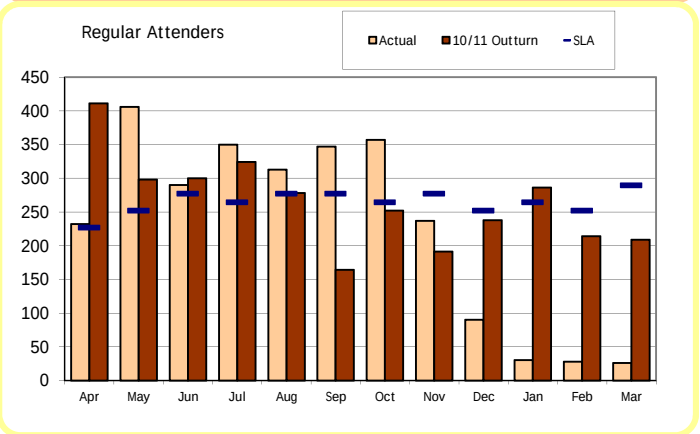
Performance against SLA 2011/12 : DATA SOURCE = WAREHOUSE

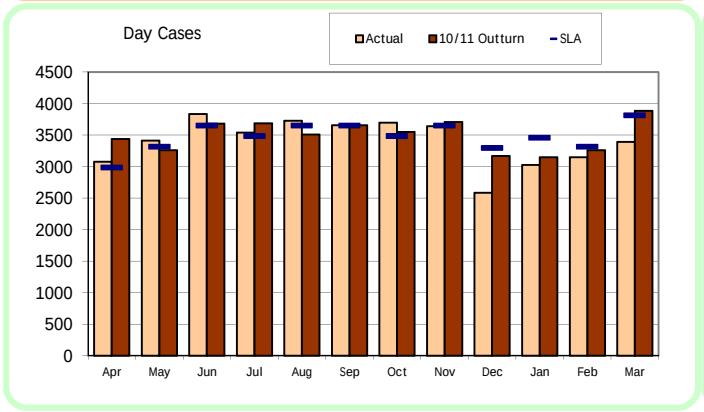
Directorate / Specialty = ALL

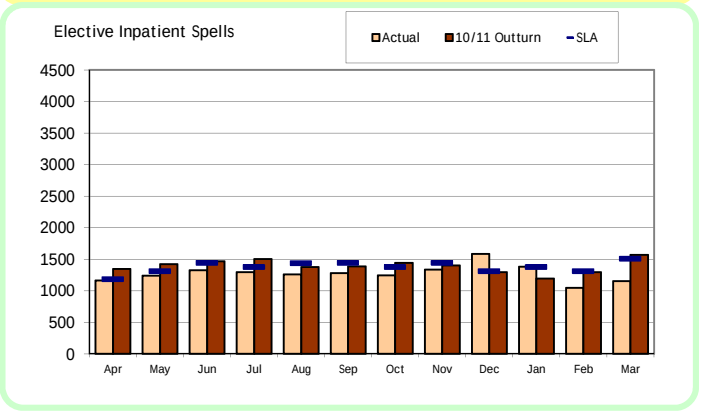


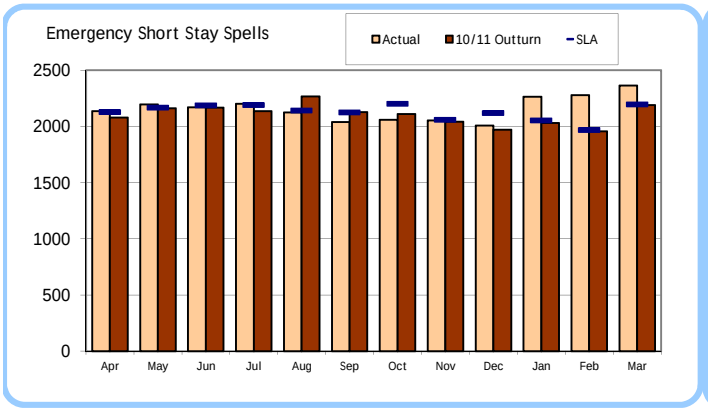


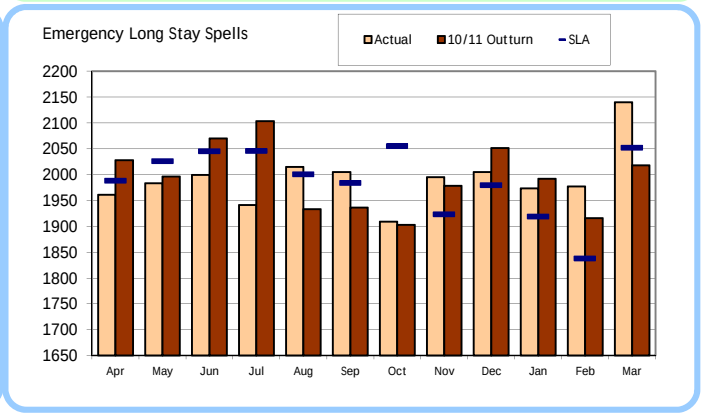












Performance against SLA 2011/12 : DATA SOURCE = WAREHOUSE

Directorate / Specialty = ALL

Workforce & OD Strategy Delivery Tracker 2012/13

Quarterly Tracker	**18/04/2012**	**Period: Reporting Quarterly**
	Report Number: 1	
Decisions Required:	**None**	
Workforce & OD Strategy	**> Workforce & OD Strategy and Delivery Plan - approved by Workforce Committee and Trust Board.** **> Milestones and actions supporting the Core Workstreams established will be reported on a quarterly basis (starting with this report) with update on Q1 performance in the next report.** **> New Workforce & OD report created for April to enable Trust to track Workforce & OD strategic achievements.** **> OD: maintaining progress on existing work streams i.e. Staff Engagement Strategy, Personal Maps of Change - Ready for Change, and Values & Behaviours.** **> Staff Engagement Strategy closed as a BOF workstream and transferred to OD. Needed to reschedule Values work by one month in line with risk management plan.** **> Completed preparations for the implementation of the OD Strategy workplan for 2012 -13.**	

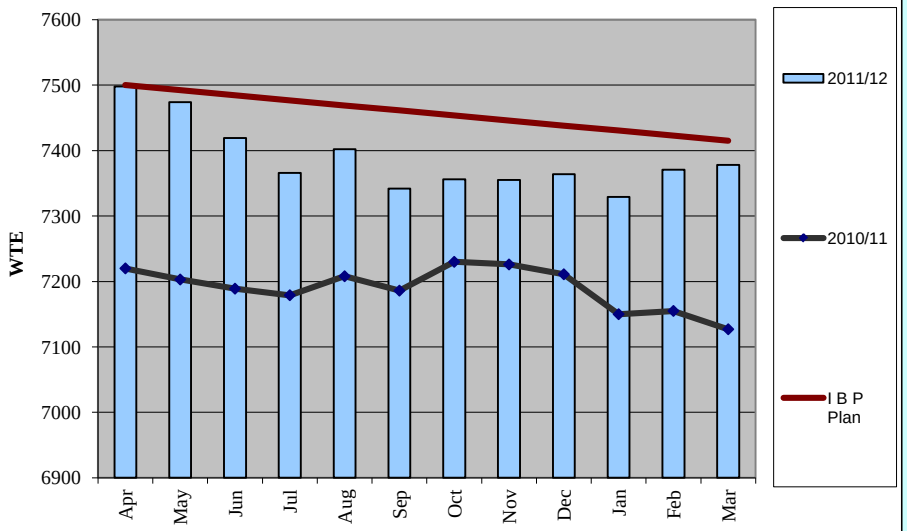
Delivery Plan 2012							**Key Issues and Actions (to move Workstreams to Green rating)**
Core Workstreams	**Q1**	**Q2**	**Q3**	**Q4**	**Q1**	**Q2**	White = Design Red = Project plan being scheduled Amber = Project plan missed some deadlines Green = Project plan on track
OD Strategy							Design meeting held April, with 2012-13 workplans drawn-up. Will be updated and reviewed quarterly. Currently focusing on resource requirements, establishing partnerships and initial actions
Staff Engagement Strategy							Moved from BoF Programme to be included within Workforce and OD Strategy
Local Staff Engagement plans							Staff Engagement Group considering results and actions on behalf of Workforce & OD Committee. Report to Trust Board in May
Personal Maps of Change							Documentation agreed and included in appraisal paperwork. NBT story drafted which includes 2012 Milestones' to be drafted and signed off in Q1 by the Staff Engagement Group. Further full version to be launched in Autumn, which includes updates from the operating plan
Values							The results of the focus groups have been communicated to TMT and JCNC. Draft values currently being refined and will be reported to Trust Board in July
Leadership Development							Evaluation of 'LEAD' currently underway. Future direction/focus of leadership development currently under review
Health & Wellbeing							Health and Well Being Strategy development under way. Revised sickness policy in place
Pay & Reward							Recommendations to be presented at July's Trust Board outlining NBT's position on Pay & Reward. Awaiting funding of approval to take forward. NBT part of South West Pay Consortium
Spans & Layers (Org Design)							Awaiting approval on funding
High Performing Teams							Initial scoping meeting has taken place to establish aims and objectives
Workforce Planning							86% of plans submitted, now reviewing to ensure alignment with financial & performance plans

Top Workforce Risks			
Subject	**Risk**	**Score**	**Mitigation**
Staff Engagement	Size and complexity of change agenda leads to drop in morale, quality, safety and performance	16	Comprehensive staff engagement and communications strategy in place. Leadership development programmes being developed.
Mandatory Training	Staff not up to date with training could affect quality and safety of service provision	12	e-learning packages developed and promoted. Electronic alerts to staff and managers to remind when training accreditation expires. Communication of Directorate league tables to Senior Managers. Bank workers who have not kept their training accreditation up to date will not be placed on shifts.
Workforce Planning	Low/high levels of staff could affect quality, safety and Trust finances	9	86% of workforce plans submitted, now embedded in the PPFC monitoring & CRES plans for 3 years. Arrangements are in place to provide a detailed workforce plan ready for Monitor by the end of June 2012.

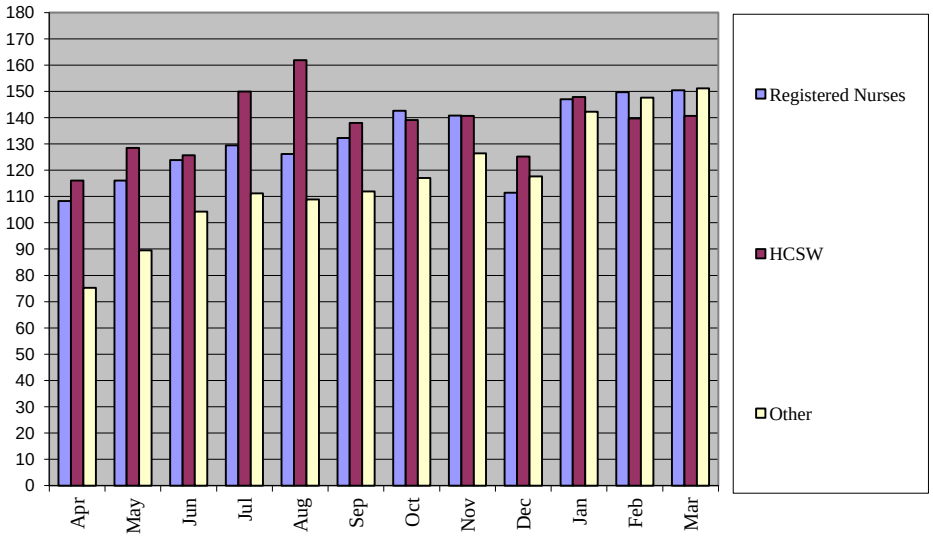
Key National Developments		
Subject	**Issue**	**NBT Impact**
Age discrimination in Service Provision	The implementation of the final part of the Equality Act 2010 has been delayed from April 2012 to October 2012	This part of the Act has been subject to significant discussion on implementation and the concept of 'objective justification'. Important for NBT/NHS due to the significance of age, particularly older age, in healthcare, and is intended to accommodate the many clinical judgements about older, frail patients where age is a key factor in determining their treatment. The basic principle in the Act is that no-one should receive 'less favourable treatment' because of a protected characteristic such as age.

HR & D Workforce Information - March 2012

Staff in Post



Bank and Agency Usage



Workforce Issues

Staff in Post - figures for 11/12 exceeded those of the previous year, due to transfer of South Gloucester Community Health staff.

MARS - the Trust's second MARS scheme has led to 29 applications submitted to the SHA. All have been approved, although one member of staff has subsequently withdrawn from the scheme. This will lead to a recurring saving in excess of £950,000.

Medical Revalidation - All doctors who wish to practise medicine in the UK must be both registered and licensed with the GMC. This applies whether they practise full-time, part-time, as a locum, privately or in the NHS. The purpose of revalidation is to assure patients and the public, employers and other healthcare professionals that licensed doctors are up to date and are practising to the appropriate professional standards. When revalidation is introduced, doctors who wish to keep their licence to practise will need to demonstrate to the GMC every five years that they are up to date and fit to practise.

The evidence to support revalidation will be collected during “enhanced” annual appraisals. Revalidation will not involve a point-in-time assessment of a doctor’s knowledge and skills, but will be based on a continuing evaluation of a doctor’s practise in the place in which the doctor works. It will be based on local systems of appraisal and clinical governance. Doctors who fail to revalidate will have their licence to practice withdrawn. NBT is a 'designated body' which means that the organisation is responsible under legislation for the revalidation of all clinicians who have a 'prescribed connection' to the Trust (those whose main NHS contract is with NBT). The standards of internal systems will be subject to external review. Ultimate responsibility for revalidation in the Trust is held by the Responsible Officer which in this case is the Medical Director.

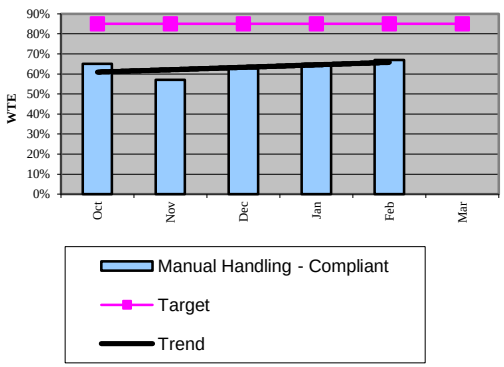
NBT eXtra - During 2011/12, **NBT eXtra** filled a record number of nursing shifts, equating to 92,134 for the year. In March, NBT eXtra managed to fill 9,929 nursing shifts compared with 6,877 at the same point last year, an increase of nearly a third. High levels of requests are attributed to lack of careful rostering of annual leave, higher levels of sick leave in some areas, and a growing use of bank staff to cover substantive vacancies.

HR & D Statutory and Mandatory Training Compliance - February 2012

Health & Safety Compliance

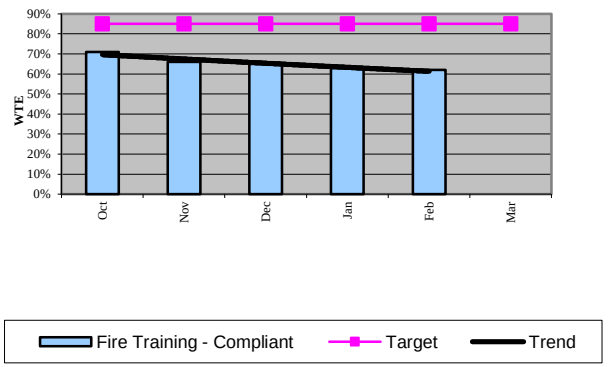
General trend upwards, but 9% short of target

Manual Handling Compliance



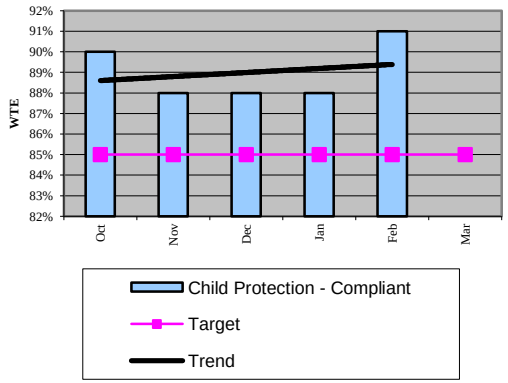
General trend upwards, but 18% short of target

Fire Training Compliance



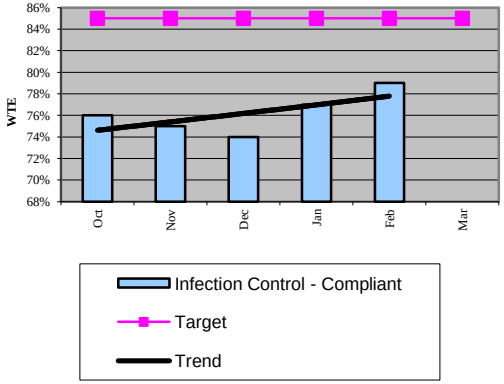
After increases in the summer, general trend on compliance with fire training is down, and 23% short of target

Child Protection Compliance



Compliance is good

Infection Control Compliance



From being compliant in June 2011, figures fell significantly to Dec 11, but now show sign of improving. Short of target by 6%.

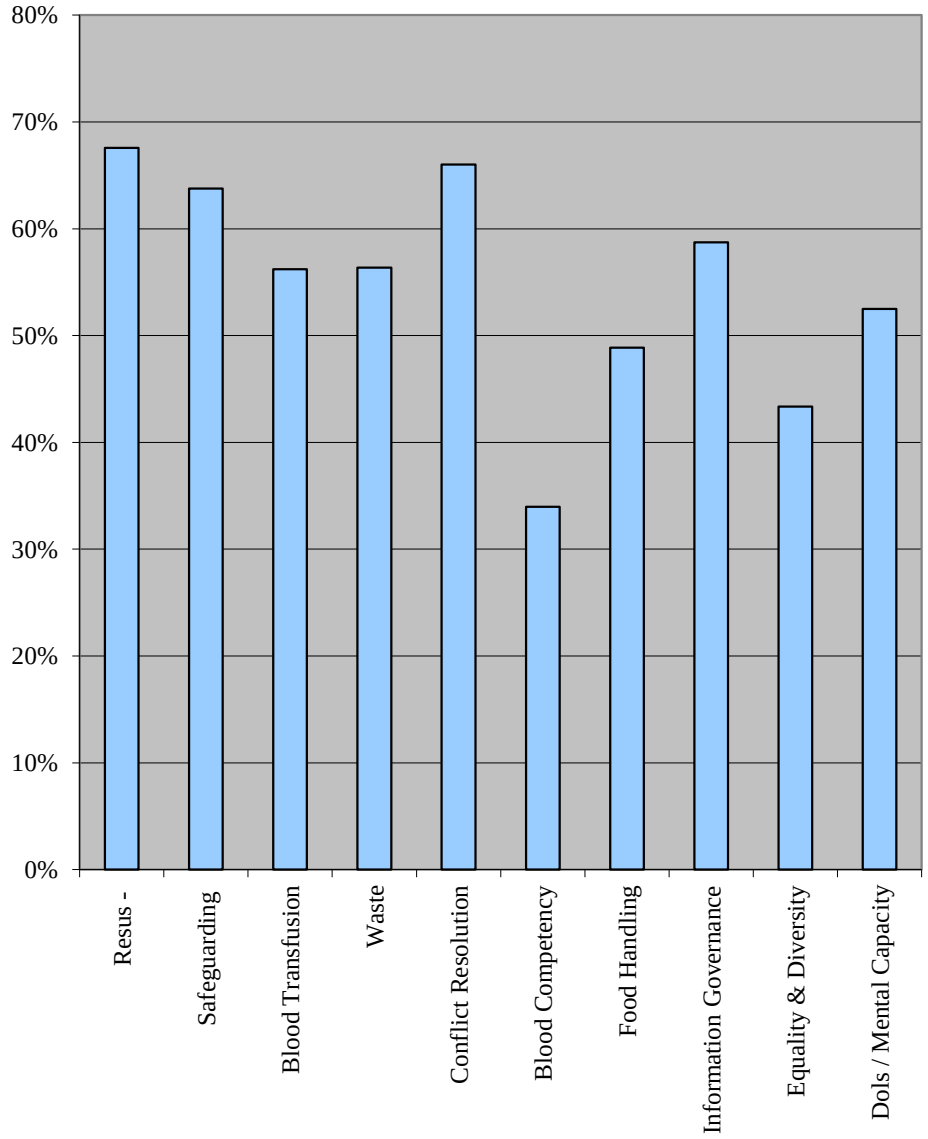
Comment:

> Work undertaken in BNSSG to rationalise the identity of e-learning modules, with the aim of being able to auto-generate, from MLE, an email reminder to staff when their previous courses expire. This will be rolled out throughout the Trust in April 2012. An initial email will be sent to the individual followed by an email to both individual and manager, in time to book on training, 12 weeks before they fall into non compliance

> Directorate league tables are now being produced for use by Senior Managers

> Bank workers who have not kept their training accreditation up to date will not be placed on shifts.

HR & D - Other Statutory & Mandatory Training Compliance - February 2012



Resus April 2012: New TNA in place with increase target group - has affected and dropped overall % - primarily clinical staff, other covered by first aiders

Safeguarding adults 3rd year of 3 year training plan - anniversary in December '12 - primarily clinical staff

*Blood Transfusion competencies training requirements have changed from 3 yearly update to two yearly update requirements causing a drop in compliance. Staff involved with the collection and administration of blood and blood products. Level and competence by role.

*Waste 3rd year of 3 year training plan - anniversary in December '12 – all staff

Conflict Resolution 3rd year of 3 year training plan - anniversary in December '12 – all staff

*Food applies to food handlers in patient areas and catering department only

*Information Governance new training programme started on induction Autumn 2011 – all staff

*Equality & Diversity currently once only requirement / on induction – all staff. Frequency under review,

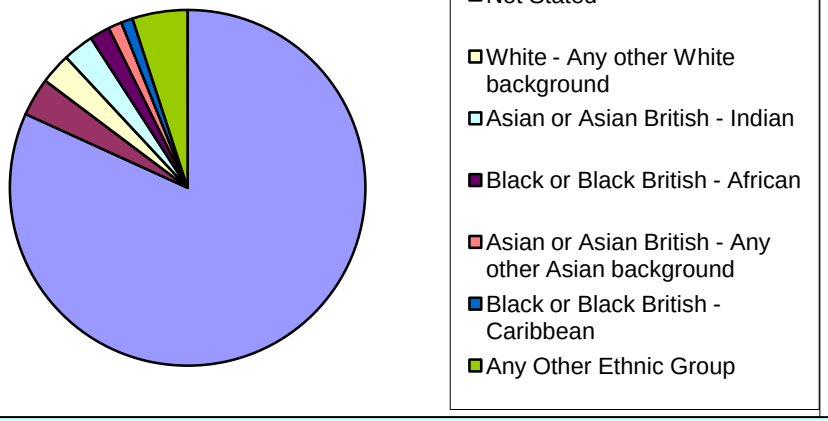
Deprivation of Liberty/Mental Capacity 3rd year of 3 year training plan - anniversary in December '12 - primarily clinical staff

*Elearning available for this module on NBT MLE and SW Learning4Health

Dementia training to start in April 2012 with an organisational baseline of 16% compliance for all staff

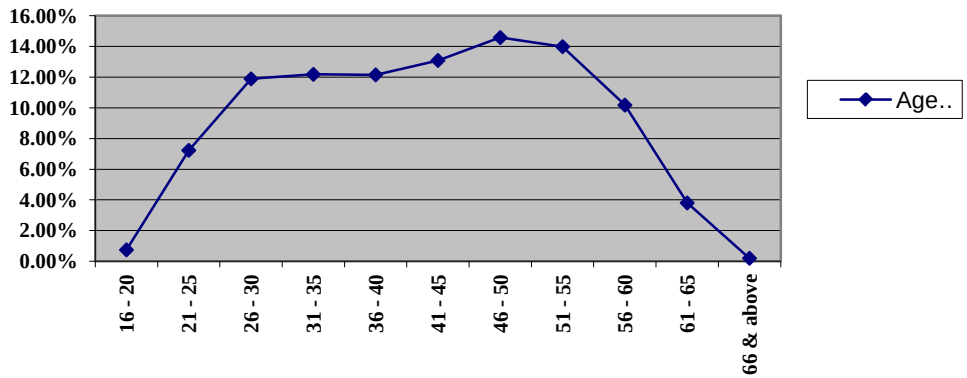
HR & D Equality and Diversity - March 2012

Ethnic Origin



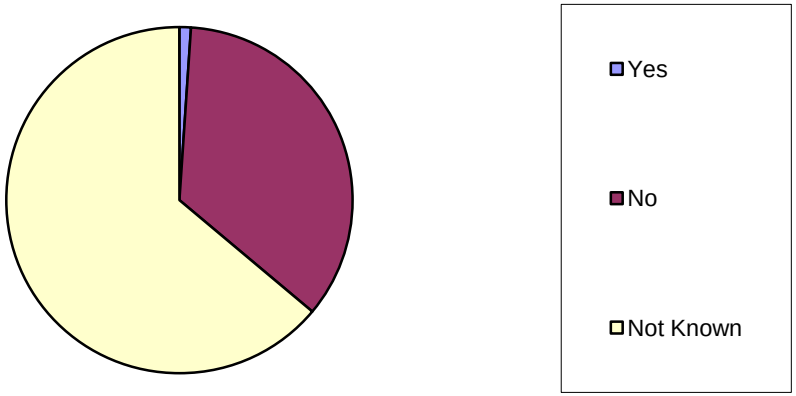
With 84% white, 3% not known, and 13% BME, this compares favourably to the 2001 census data which showed Bristol as 8.2% BME and South Gloucester as 3.2% BME,

Age Profile



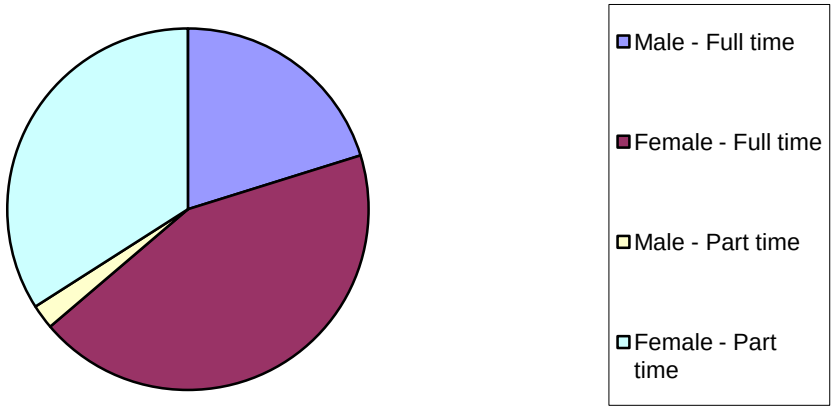
The Trust's age profile will start to move to the right, due to the removal of the retirement age, and future increase in state pension age. This changes previous workforce planning assumptions of staff movements for the next 3 years.

Disabled



Whilst less than 2% of staff have declared themselves disabled, this compares to 16% who declare disability in the staff attitude survey.

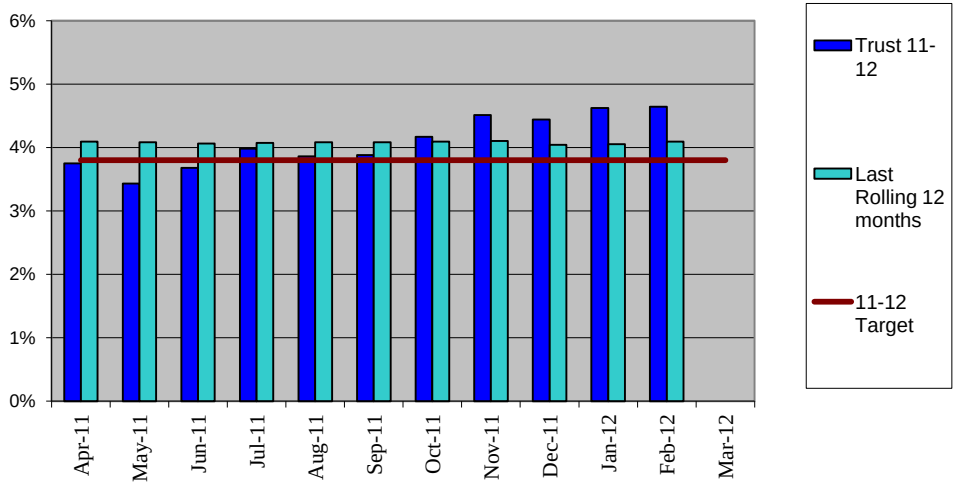
Gender



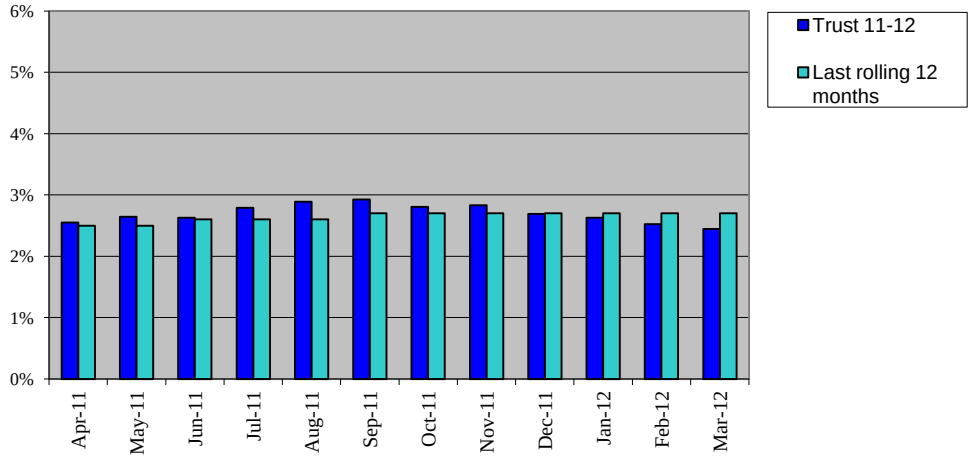
Based on wte, 77% of the Trust's workforce are female, and 36% are employed part time. (this excludes bank staff).

HR & D Absence and Labour Turnover - Feb/March 2012

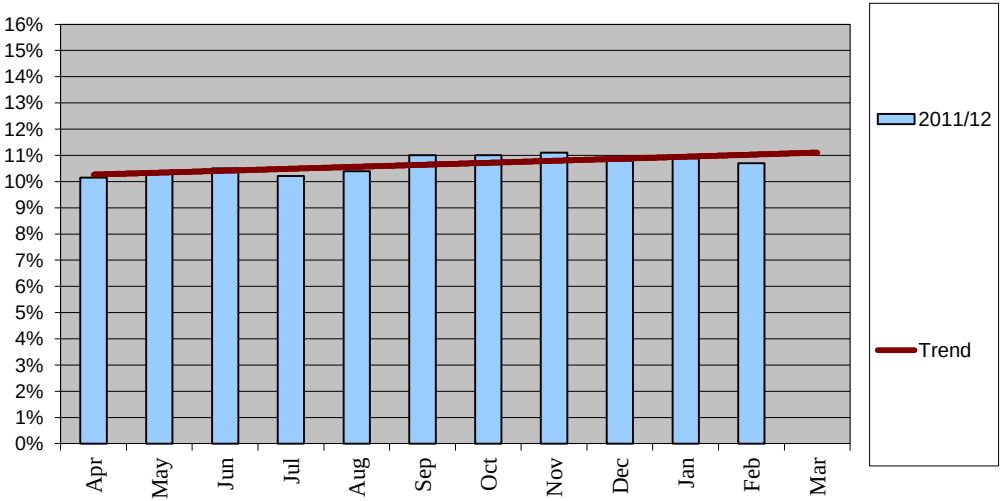
Sickness Absence



Maternity Absence



Labour Turnover



Sickness absence
Rolling 12 month remains over target with higher than usual absence during February. Half of individual staff groups are over target with Estates and Ancillary at over 8%. 6 directorates however reduced sickness between January and February.

Maternity Leave
Rolling 12 month maternity leave level is 2.7%

Turnover
General trend for the year is a slight increase in turnover, but figures have actually reduced since November.

North Bristol NHS
NHS Trust

Report to Trust Board – April 2012

Title: **Workforce & Organisation Development Report**

Purpose of paper: To provide Trust Board with an update and assurance on ongoing workforce and organisation development delivery against strategic objectives.

For Information

Action Required:	Trust Board is asked to **NOTE** the attached paper.
Key Risks:	Financial and performance-related risks
Impact on Patients:	The Trust's workforce and organisation development strategy and associated matters directly affect the provision of patient care and treatment
CQC Outcome:	CQC Outcomes 12,13,14
Responsible Committee:	Workforce Strategy & Governance Committee
Financial Issues considered	Yes
Equality Impact Assessment Completed:	Yes where applicable
Legal Issues Considered:	Yes
Sustainability Assessment Completed:	Not Applicable

Presented by: **Harry Hayer, Director of Organisation, People & Performance**

Prepared by: **Robert Baker, Associate Director, Human Resources & Development**
Cathy Meredith, Head of Organisation Development

This document could be made public under the Freedom of Information Act 2000.
Any person identifiable, corporate sensitive information will be exempt and must be discussed under a 'closed section' of any meeting.

North Bristol NHS Trust

Report to Trust Board – April 2012

Title: Monthly Infection Control Report

Purpose of paper: To update Trust Board on Infection Control performance.

For discussion

Executive Summary:

MRSA

- There were no MRSA bacteraemia attributable to the Trust in March 2012.
- In 2011/12 11 MRSA bacteraemia were recorded against the target of 8.
- Target for 2012/13 has been set at 6 cases.
- Elective MRSA screening compliance for March 2012 is 97%.
- Emergency MRSA screening compliance for March 2012 is 89.5% with 87.5% of patients being screened with 24 hours of admission. A Directorate level summary is attached.
- Emergency screening compliance has been incorporated into our local commissioning contract for 2012/13.

MSSA

- There were 7 MSSA bacteraemia in March 2012, 1 attributable to NBT.
- Total cases within NBT for 2011/12 were 34 against a target 37.
- A further 25% reduction has been set for 2012/13 giving a target of 26.

Clostridium *difficile*

- There were 5 *C.difficile* cases in inpatients during March 2012, of these 4 were attributable to the Trust.
- Total C.*diff* cases for 2011/12 was 79. Performance has achieved both the SHA target of 113 and has improved upon last year's outturn position of 91.
- Target for 2012/13 has been set at 61 cases.

E-Coli

- There were 21 cases of E-coli bacteraemia during March 2012 of which 7 were attributable to the Trust.
- No trajectory for E-Coli bacteraemia had been set for 2011/12 with the Trust outturn position being 70 cases. A reduction of 20% based on 2011/12 outturn has been set for 2012/13 giving a target of 56 cases.

Norovirus

- In March there were 3 reported ward closures due to confirmed Norovirus.

Outbreaks

- There were no reported outbreaks in March 2012.

Hand Hygiene

- In March 2012, Trust wide compliance was 95% (target 95%) with all Directorates apart from Musculoskeletal and Neurosciences being above the Trust target. Hand hygiene compliance has been incorporated into our local commissioning contract for 2012/13.

Mandatory Training

- Infection Control mandatory training is at 77 % (target 85 %).
- Continued action is required from Directorates to ensure improvement continues.
- Targeted educational support is being provided by the IPCT.

Action Required: Trust Board are asked to note the report

Key Risks:

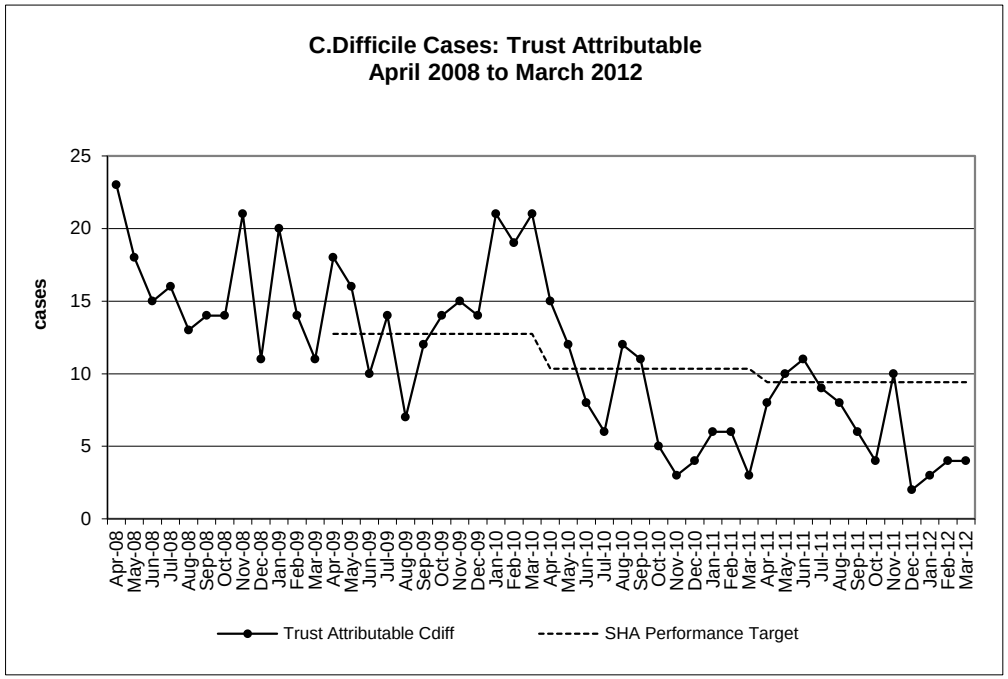
- Non achievement of DH MRSA bacteraemia trajectory in 2012/13 target 6
- Non achievement of MRSA emergency screening target which is set at 95%
- Non achievement of 2012/13 reduction in C.*diff* target 61 cases
- Infection control mandatory training compliance

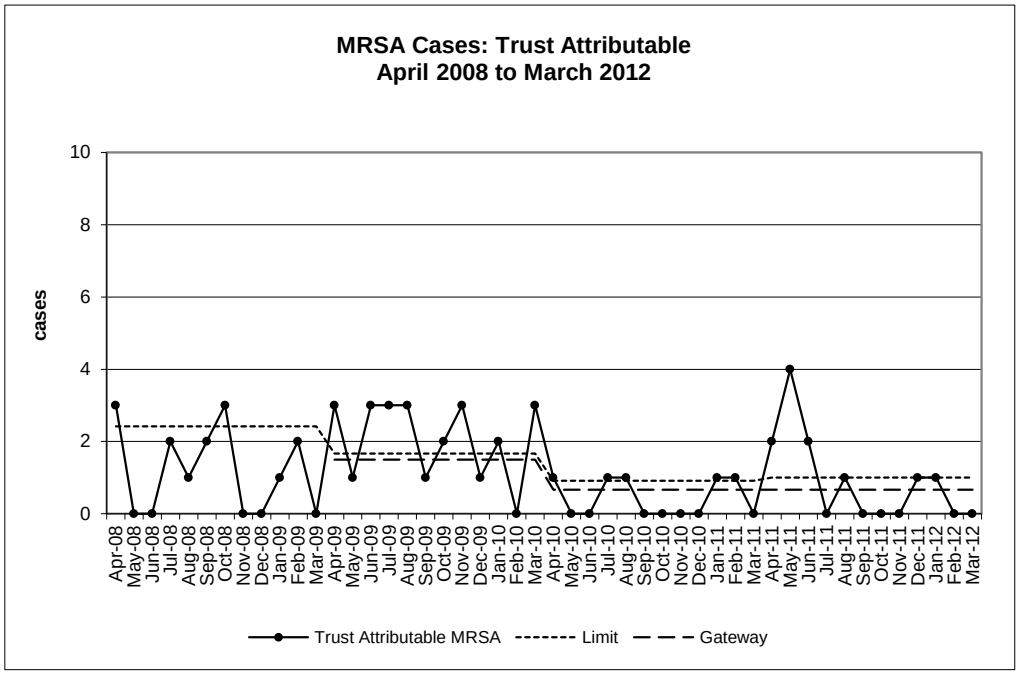
Impact on Patients: Patients deserve the highest level of professional standards.

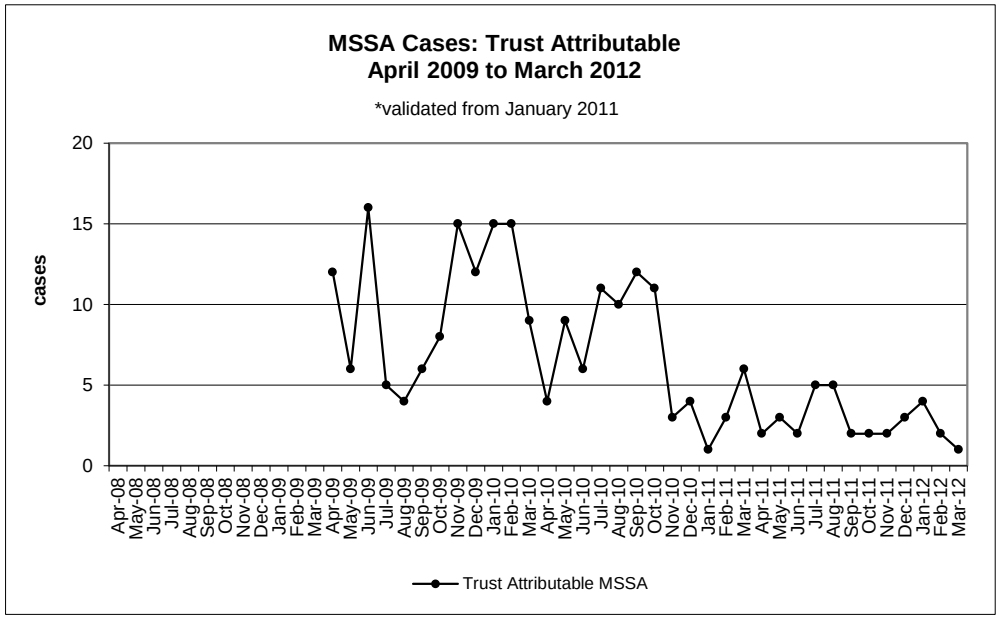
CQC Outcome:	Outcome 8 (regulation 12)
Responsible Committee:	Control of Infection Committee
Financial Issues considered:	Yes
Equality Impact Assessment Completed:	No
Legal Issues Considered:	Yes
Sustainability Assessment Completed:	Yes

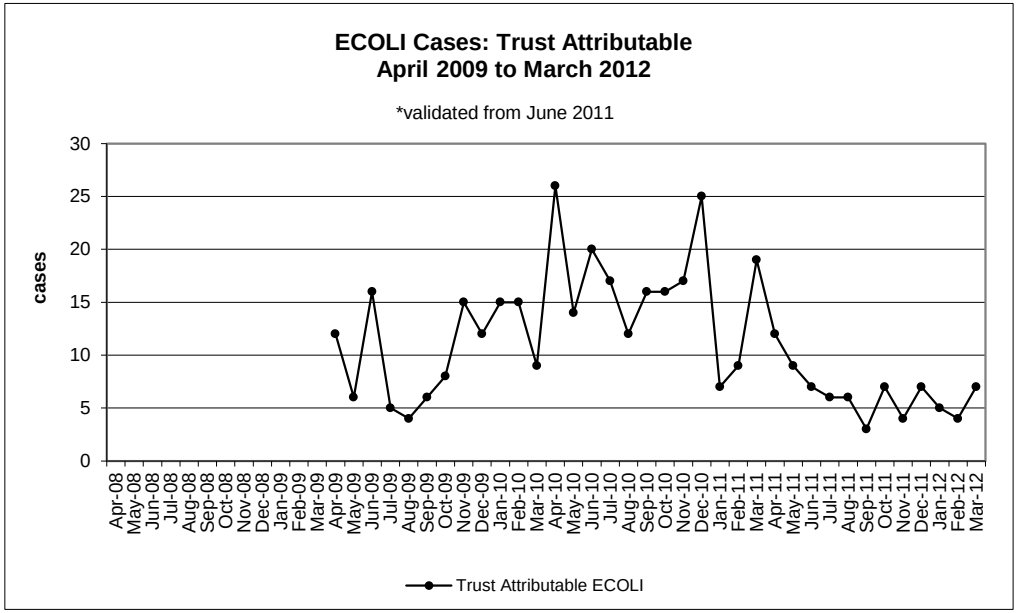
Presented by: Chris Burton Medical Director /DIPC
Prepared by: Helen Richardson Assistant Director of Nursing

Trust Board Infection Report March 2012

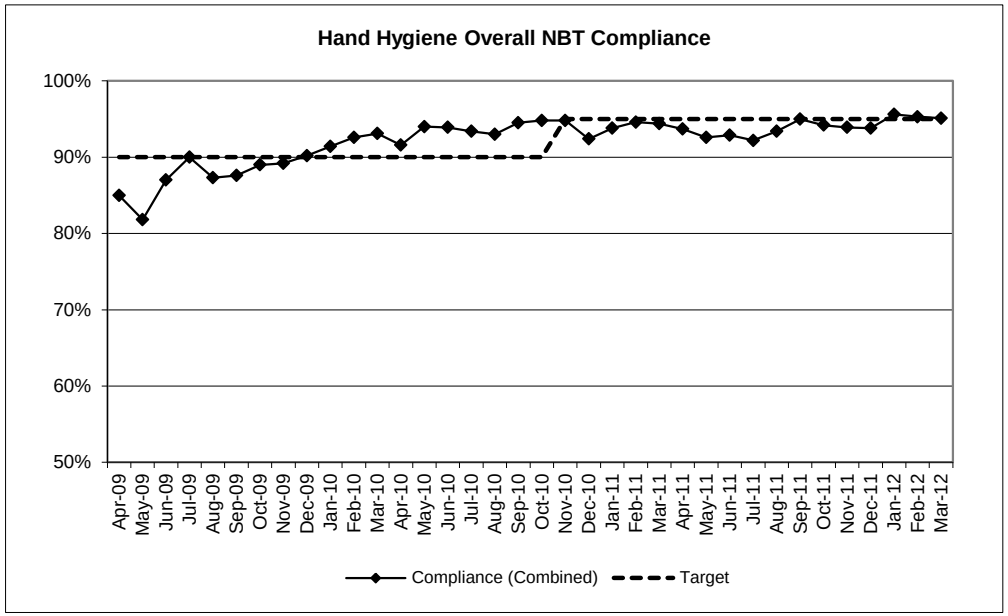


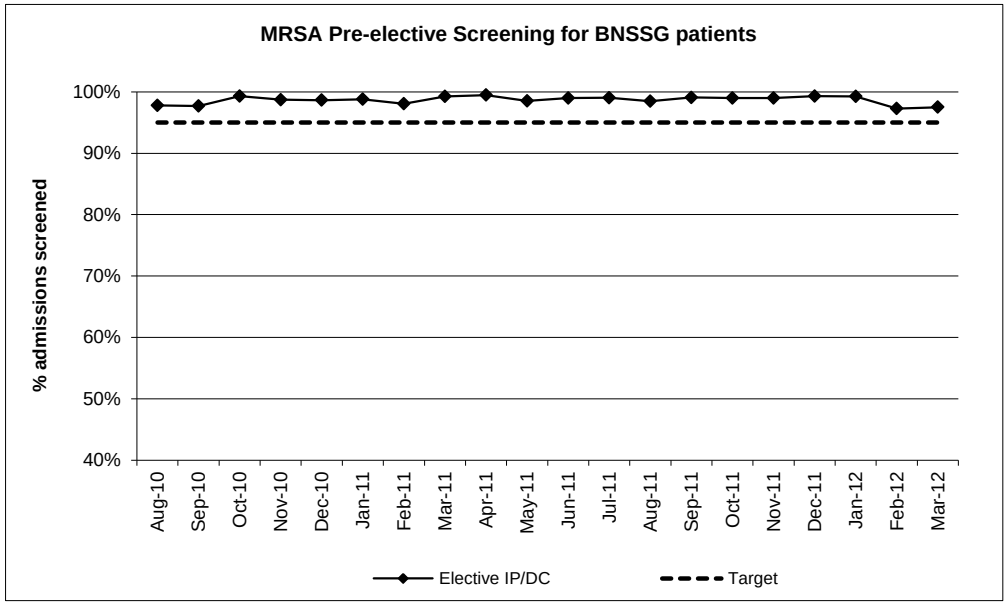


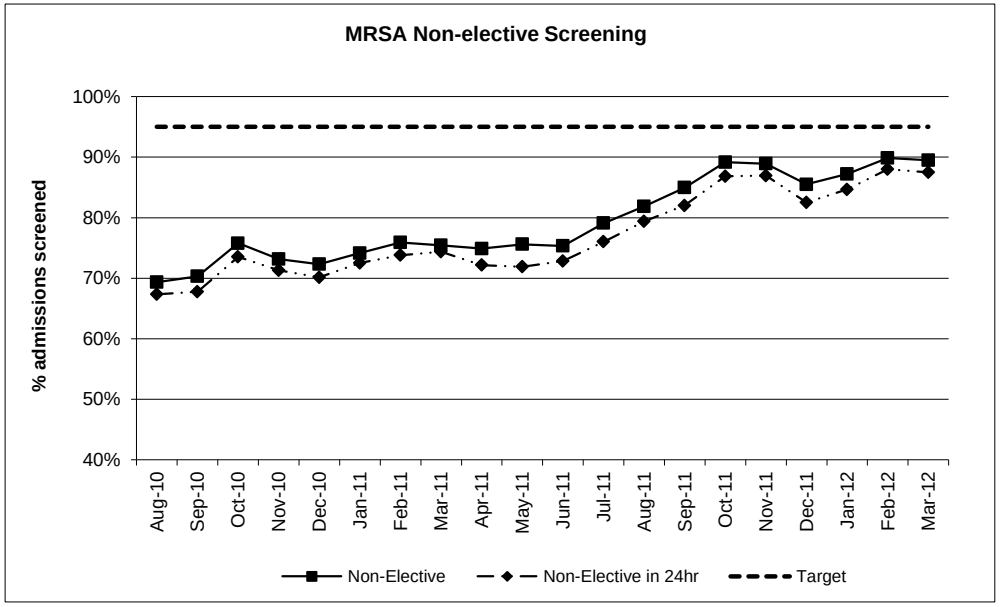




Trust Board Infection Report March 2012







Report to the Trust Board – 26th April 2012

Title: Provisional Month 12 and 2011/12 Final Accounts Summary.

Purpose of paper: To inform the Board of the key elements of the outturn position in advance of accounts submission to the Department of Health (DH) on Monday 23rd April 2012.

For Information

Executive Summary:

- The draft accounts are currently in the process of being prepared for submission on Monday 23rd April. The detail is therefore not available at the time of writing this report but performance against the key financial performance targets and forecast outturn is shown.
- The Trust is measured on four key financial performance targets and these have all been achieved.
- The target of a surplus excluding impairments of £8.98m was achieved.
- More detail on the accounts will be reported to the Trust Board in May.

.

Action Required: **The Trust Board is asked to note the contents of this report.**

Key Risks: **The draft accounts are subject to audit.**

Impact on Patients: **None**

Presented by: **Steve Webster, Director of Finance and Information**

Prepared by: **Mark Ross, Financial Controller**

NORTH BRISTOL NHS TRUST

Report to Trust Board 26th April 2012

Provisional Month 12 and 2011/12 Final Accounts Summary

1. Overall performance against financial targets

Draft accounts are being prepared for submission on the 23rd April and so a detailed income and expenditure account, cash flow and balance sheet analysis isn't yet available.

The Trust has four key financial targets and performance against each target is as follows:

Description	Target	Achieved	Notes
Breakeven	£8.98m surplus (excluding impairments)	£9.002m surplus	Achieved
Capital cost absorption rate	3.5%	3.5%	Achieved
External financing limit	(£16.9m)	(£27.1m)	Achieved – underspend is permitted
Capital Resource Limit	£14.9m	£12.9m	Achieved – underspend is permitted

The Trust achieved all its targets within thresholds set by the Department of Health.

The breakeven performance excludes impairments, accounting for donated assets and the effect of accounting for PFI assets. The following table shows the reconciliation between the deficit in the accounts and the surplus recorded against our statutory breakeven target.

	£m
Retained deficit	-72.6
Add back:	
Impairments	79.4
Donated assets	1.5
PFI accounting	0.7
Surplus recorded for break even	9.0
Target surplus	9.0

.
Notes:

1. Impairments largely relate to the reduction in the value of the Frenchay site reflecting the remaining operational life to the Trust.

2. Donated assets. A change to the accounting for donated assets in 2011-12 has meant that the net effect of depreciation and donations received is now shown as an adjustment to the breakeven target rather than income from the donated asset reserve.
3. PFI accounting. This relates to the Beaufort car park – the effects of which (largely the cost of accrued interest) are excluded from the breakeven target.

2. Performance against Forecast on income and expenditure

The table below shows the forecast position reported at month 11 against draft month 12 accounts.

	Year end forecast variance at m11 (Fav) / adv £000's	**Year end m12 outturn variance** (Fav) / adv £000's	**Movement** (Fav) / adv £000's
Income			
PCT income for activity done	(3,231)	(2,823)	408
Other Income	28	(128)	(156)
Total Income	**(3,203)**	**(2,951)**	**252**
Expenditure			
Directorate Pay	1,480	1,951	472
Directorate Non Pay	4,444	4,568	125
Capacity reductions not achieved	4,035	4,035	0
Reserves released	(4,000)	(4,000)	0
CRES	(324)	(910)	(586)
Total Expenditure	**5,635**	**5,645**	**10**
EBITDA	2,432	2,694	262
Capital charges and financing costs	(2,476)	(2,717)	(241)
Variance to planned surplus	**(44)**	**(22)**	**22**

The table above shows that the Trust was very close to the forecast overall with an adverse swing on EBITDA offset by a lower dividend charge. Table 1 shows the overall position and highlights the in-month variances. The key elements are:

2.1 Income

Due to the continuing problems with reporting PCT income fully to commissioners since the Cerner implementation, as previously reported, year end outturn positions have been agreed with the main commissioners. This is based on forecasts assessed from the months 1 to 8 data (the last complete snapshot pre-Cerner). The main commissioners account for 92% of total PCT income.

Non-PCT income was favourable to forecast.

2.2 Pay expenditure

This was higher than forecast with high bank and agency usage in the month. Neurosciences and Medicine make up £0.6m of the in-month overspend on pay of £0.8m, with very high specialling costs reported in Neurosciences and Medicine being a continuation of the trend of recent months.

2.3 Non pay expenditure

This is close to forecast overall although there are a number of adverse swings on some Directorates which need further analysis.

3. Balance Sheet

3.1 Capital.

The Trust ended the year £2m underspent against the Capital Resource Limit which was lower than forecast in month 11.

3.2 Cash

The year end cash balance was £28.3m - £1.7m less than forecast. This is primarily because £1.7m of payments expected from Bristol PCT were not received until April.

The performance against the payment code was 93%.

3.3 Financial Risk Ratings.

Provisional risk ratings in the table below show a level 4 in line with forecast.

		Actual	Actual	Actual
		Mar-11	Feb-12	Mar-12
Financial Metrics - Indicators used to derive financial risk rating				
EBITDA margin	%	7.9	7.4	7.2
EBITDA % achieved	%	94.0	94.1	94.2
Return on Capital Employed	%	6.5	6.7	6.1
I&E Surplus margin (net of dividend)	%	1.6	1.6	1.4
Liquidity Ratio	Days	3.0	13.3	23.5
Weighted Average		**3.0**	**3.3**	**3.5**
Overall FRR		**2**	**3**	**4**

North Bristol NHS Trust

Table 1

Finance Report March 2012 - Summary Income & Expenditure Statement

Plan £'000	Description	Position as at 31st March: Budget £'000	Actual £'000	Variation from budget: Adverse / (Favourable) £'000	In-month: Adverse / (Favourable) £'000
	Income				
429,551	PCT Income	432,376	435,199	(2,823)	22
76,050	Other Operating Income	83,778	83,906	(128)	(135)
505,601	Total Income	516,154	519,105	(2,951)	(113)
	Expenditure				
322,425	Pay	329,623	331,574	1,951	806
142,568	Non Pay	145,776	150,345	4,568	682
	Variance to planned savings	910		(910)	(831)
	Capacity reductions not achieved	(4,035)		4,035	335
	Reserves released	4,000		(4,000)	(333)
464,993		476,274	481,919	5,645	658
40,608	Earnings before Interest & Depreciation	39,880	37,186	2,694	545
22,073	Depreciation & Amortisation on Purchased Assets	21,345	20,535	(810)	24
	Profit on disposal	0	(99)	(99)	(29)
(25)	Interest receivable	(25)	(48)	(23)	(3)
1,311	Interest payable on loans	1,311	1,294	(17)	(17)
8,269	PDC Dividend	8,269	6,501	(1,768)	(498)
8,980	Net Surplus / (Deficit)	8,980	9,002	(22)	23
4,552	Fixed asset impairments	4,552	79,362	74,810	74,810
429	Below the line effect of IFRIC 12	429	717	288	288
	Donated Assets	0	1,494	1,494	1,494
3,999	Surplus /(Deficit) after impairments	3,999	(72,571)	76,570	76,615

Building our Future Tracker

Monthly Tracker	Date: 13-Apr-12	Period: 16 March to 13 April 2012
	Report Number: 4	
Decisions Required:	None raised	

Programme 2012 ▶ J F M A M J J A D O N D J F					Key Issues and Actions (to move projects to Green rating)
Core Projects					
Theatre and Surgical Pathways	R	A	A	A	Project is Amber due to delay in the recruitment of Productive Operating Theatre (TPOT) facilitators.
Bed Reconfiguration	G	G			Project transferred to Business as Usual. Stroke End of Project review submitted to March Programme Board.
Nursing & Direct Patient Care	R	R	R	R	The project is rated 'red' due to not achieving agreed project benefits. The project team are working with Finance to ensure clear alignment with CRES plans for 2012. From April benefits will be reported month on month.
Non-Pay	G	G	G	G	On Target. PID for Phase 2 approved by April Programme Board.
Outpatients	A	A	A	A	The project is rated 'amber' due to not achieving agreed project benefits in 2011/12. Independent analysis has verified the benefit opportunity identified by the project. The Future Outpatient Option Appraisal patient feedback has been collated and analysed.
Medical Staffing	R	A	A	A	The project is rated 'amber' due to quality and financial benefits delay in 2011/12.
Rehabilitation Redesign	R	G	G	A	Project is rated as 'amber'. Actions to progress the project are decisions awaitied from the Commisioners about the Frenchay Health and Social Care development and the process by which we achieve the required model of care.
Acute Assessment	G	G	G	G	On Target. Financial opportunity complete on Best Practice Tariffs and other ambulatory pathways. GP identified to move forward with primary care element of two ambulatory pathways
Managing Change	G	G	G	G	On Target. Work progressing on Staff engagement and values. Now interlinked more strongly with staff development.
Radiology Redesign	A	R	R	R	The project is rated 'red' due to not achieving the timeline for an approved Project Initiation Document. Decision about the scope of the project has been delayed.
Long Term Conditions	G	G	A	G	Project on target. Test of change pilot: multi-agency planning on AAU has commenced with OT atending daily post take ward round.
Operating Plan	G	G	A	A	The project is rated 'amber'. Corporate capacity delaying milestones for development of enabling systems. Additional supporting resource providing additional resource for simulation events / desk top exercises and the planned conferences.
IM&T					
Cerner	R	R	A	A	The project is rated 'amber'.
PCA Phase 1	A	A	G	G	The project is rated 'green'.
Service Centralisations					

Programme 2012 ▶ J F M A M J J A D O N D J F	Key Issues and Actions (to move projects to Green rating)
Pathology Redesign — A G G A	The project is rated 'amber' as delivery is currently dependant on the successful recruitment of an IT project manager and their ability to work with others to design and cost IT solutions required to consolidate the service.
Major Trauma — A A A	This project went 'live' on 2nd April and has now transferred to 'Business as Usual'. End of Project review will be submitted to July Programme Board.
Specialist Paediatrics — NA R R R	The project is rated 'red' due to not achieving the timeline for the workforce plans by specialty.
Breast Service Centralisation — NA A A A	The project is rated 'amber' due to the review of the project scope.
Urology Service Centralisation — NA A R A	The project is rated 'amber' due to uncertainty of timelines for delivery. A rescheduling excercise to be undertaken for Autum 12 transfer date.
ENT & OMF Centralisation — NA A R A	The project is rated 'amber' due to uncertainty of timelines for delivery. A rescheduling excercise to be undertaken for Autum 12 transfer date.

Risk impacts			RAG
Top Programme Risks			**R**
No.	**Risk**	**Mitigation**	**Score**
1	Directorates lacking the combination of organisational capacity/skills/ownership to make the changes happen	Further work alongside Directorates to ensure that plans are translated into action BoF scope to be expanded to move further into working with Directorates to deliver productivity and efficiency and transformation objectives Discussions at Exec team underway on the best way of moving this forward	**20**
2	Lack of clarity on dependencies between changes made in individual Directorates (i.e. non-BoF) being delivered across the Organisation. Risk that without an aggregate picture across the organisation being monitored the delivery could fall short in the areas of quality, patient experience and financial health	Consideration being given to expand BoF Programme Management Office (PMO) from summer 2012.	**20**
Top Programme Issues			**R**
No.	**Issue**	**Mitigation**	**Score**
1	Bottom up financial benefits are much lower than the expected mid case scenario modelled.	Review of financial benefits at Benefits case to ensure all opportunity has been identified. Delivery of 4 key workstreams - CRES stock-take, Service Line Strategies, CRES Delivery Plans and Mobilisation of Strategic Themes	**20**

North Bristol NHS
NHS Trust

Report to Trust Board – April 2012

Title: **Equality and Diversity Objectives 2012 - 2016**

Purpose of paper:

The Trust is legally required to meet the duties of the Equality Act 2010, and Public Sector Equality Duty (PSED), The general duty requires the Trust to have due regard to the need to:

- eliminate discrimination, harassment, victimisation and any other conduct that is prohibited by or under the Act
- advance equality of opportunity between people who share a relevant protected characteristic and people who do not share it
- foster good relations between people who share a relevant protected characteristic and people who do not share it

This includes Trusts having to promote better performance of the equality duty, including by publishing:

- equality objectives, at least every four years
- the first equality objectives by April 2012

This paper presents draft Equality and Diversity Objectives for the four years 2012 – 2016 for agreement. They will however be subject to annual review and report to the Board

For Action

Action Required:	Trust Board is asked to **APPROVE** the attached paper
Key Risks:	Financial and performance-related risks
Impact on Patients:	The Trust's workforce and organisation development strategy and associated matters directly affect the provision of patient care and treatment
CQC Outcome:	CQC Outcomes 12,13,14
Responsible Committee:	Workforce Strategy & Governance Committee
Financial Issues considered	Yes
Equality Impact Assessment Completed:	Yes where applicable

This document could be made public under the Freedom of Information Act 2000.
Any person identifiable, corporate sensitive information will be exempt and must be discussed under a 'closed section' of any meeting.

Legal Issues Considered: Yes

Sustainability Assessment Completed: Not Applicable

Presented by: **Harry Hayer, Director of Organisation, People & Performance**

Prepared by: **Robert Baker, Associate Director, Human Resources & Development**
Lesley Mansell, Equality and Diversity Manager

NBT Equality Objectives 2012 - 2016

Delivering the Equality Agenda

The NHS Equality Delivery System (EDS) is a framework designed to help NHS organisations improve equality performance and embed equality into mainstream NHS business so that we can provide a better service that meets the requirements of people from diverse communities. NBT has worked through the framework to provide evidence to support our grading.

The Trust works closely with the regional NHS cluster to deliver the EDS and has worked in partnership to gather feedback from communities on the evidence produced to support our grading. We also consulted with the public, staff and Trades Unions for their opinion on our service delivery which impacted on our assessment, and this has been supported by the Equality & Diversity Committee.

The evidence report used to set the equality objectives may be viewed on the NBT Internet.

NBT Equality Objectives 2012 – 2016

Description	Equality Delivery System Standard
1) We will mainstream the EDS into the business planning process regarding service delivery for patients	Better health outcomes for all (section 1) Improved patient access and experience (section 2)
2) We will increase equality monitoring data and recording of the impact of EDS objectives (patients)	Better health outcomes for all (section 1) Improved patient access and experience (section 2)
3) We will mainstream the EDS into the business planning process regarding service delivery for staff	Empowered, engaged and well-supported staff (section 3)
4) We will increase equality monitoring data and recording of the impact of EDS objectives (staff)	Empowered, engaged and well-supported staff (section 3)
5) We will implement the Equality and Diversity Competency Framework	Inclusive leadership at all levels (section 4)

Below are further details for each objective setting out why they've been chosen, what we want to achieve and how they will be monitored/measured.

NBT Equality Objective 1
We will mainstream the EDS into the business planning process regarding service delivery for patients

Why we have chosen this objective

- EDS is a national tool designed for the NHS and supported by the Chief Executive of the NHS which will help us to benchmark outcomes
- The Seldom Heard Groups research report (2010) showed that certain groups feel they do not have equal access to services
- It will help bring about systematic change including inter-agency collaborative working
- It will help to address areas of under performance, risks and inefficiency
- The EDS will support managers to plan and deliver on equality

What we want to achieve

- Improve service delivery across protected characteristics especially for BME, Disabled, LGBT, (Lesbian, Gay, Bisexual and Trans) and Gypsy/Roma/Traveller patients
- To eliminate discrimination through consultation with people from different equality groups and find out what they think of our services
- Implementation of Patient Engagement plan
- Review how the Trust engages patients across the nine protected groups to identify gaps
- Improve patient safety and achieve EDS green rating from amber
- Improve procurement and commissioning procedures to ensure that these meet the PSED
- Demonstrate how we meet patient requirements
- Demonstrate how we meet the Public Sector Equality Duty (PSED)
- Bring about a systematic change to embed equality, diversity and Human Rights into the business planning process
- Ensure that public involvement in our Foundation Trust Status is diverse
- Maintain and improve patient satisfaction

How it will be Measured

- Audit the existing system for capturing the protected characteristics
- Gathering qualitative information through QIPP, Patients Surveys and engagement with patients
- Performance data and reports reflecting the protected characteristics across the Trust will be analysed and presented to the Equality & Diversity Committee
- Trust Board to receive an annual equality update
- Patient safety outcomes measured across all equality target groups, with the active participation of staff and managers engaging with patient groups and involving local communities
- A range of measures to be identified by the Patient Experience Group will be used as a benchmark to assess progress. The Group will report progress to the Equality & Diversity Committee
- Outcomes from the new patient experience reporting tool to be monitored and reviewed by the Patient Experience Group and action plans formulated from this. This will be reported to the Equality & Diversity Committee

NBT Equality Objective 2
Increase equality monitoring data and recording of the impact of EDS objectives - patients

Why we have chosen this objective

- Low levels of collection of equality data across protected characteristics especially for Disabled, LGBT, (Lesbian, Gay, Bisexual and Trans) and Gypsy/Roma/Traveller patients
- The Seldom Heard Groups research report (2010) showed that certain groups feel they do not have equal access to services. The monitoring data starts to demonstrate how we meet their requirements and the Public Sector Equality Duty
- Patients and public comments and feedback

What we want to achieve

- Improve collection of equality monitoring data by 50% across protected characteristics particularly for Disabled, LGBT, (Lesbian, Gay, Bisexual and Trans) and Gypsy/Roma/Traveller patients
- Gather and publish patient data to inform our priorities
- Improve targeting of resources for patients with protected characteristics Gather and publish patient data to inform our priorities
- Collaboration with GPs to gather equality information so NBT can better meet requirements of in patients and out patients

How it will be Measured

- Audit the existing system for capturing the protected characteristics
- Gather information through QIPP, CQC Patients Surveys and engagement with patients to determine impact and outcomes
- Performance data and reports, including action plans reflecting the protected characteristics across the Trust collected from Cerner will be analysed and periodic statistical reports presented to the Equality & Diversity Committee
- Trust Board to receive an annual equality update
- Patient safety outcomes measured across all equality target groups, with the active participation of staff and managers engaging with patient groups and involving local communities using the new reporting tool which is outcome focussed
- Patient Experience Group to monitor and review information gathered from the reporting tool and action plans formulated from this
- A template to be devised for DMT use to report half yearly on progress on outcomes to the Equality & Diversity Committee
- Outcomes of consultation and engagement with community groups and HealthWatch including the South Gloucestershire Community Forum and the Bristol Health Equality Partnership will be analysed and presented to the Governance Risk Management Committee and the Equality & Diversity Committee

NBT Equality Objective 3
We will mainstream the EDS into the business planning process regarding service delivery for staff

Why we have chosen this objective

- Low levels of collection of equality data across protected characteristics os staff especially for Disabled, LGBT, (Lesbian, Gay, Bisexual and Trans) Gypsy/Roma/Traveller and on Religion or Belief

- Evidence of less than average satisfaction rates shown in staff attitude survey reports in particular regarding disabled staff
- To support our on-going leadership commitments and corporate objectives
- Staff Attitude survey shows that disabled staff feel less empowered and low take up of equality training
- Staff comments and feedback

What we want to achieve

- Eliminate discrimination of staff with protected characteristics
- Demonstrate how the Trust meets the requirements of the Public Sector Equality Duty
- Improve equality performance
- Bring about a systemic change to embed equality, diversity and Human Rights into the business planning process
- Implementation of Staff Engagement plan, with overall improved satisfaction rate
- Revision of the online equality training package and increase take up of equality training by 50%
- Improve satisfaction of disabled staff by 50%
- Better representation of workforce from protected groups (e.g. BME, Disabled, LGBT)
- Revision of our equality impact assessment process and ensure that all new/revised policies and service plans take equality into consideration

How it will be Measured

- Equality & Diversity Committee to consider the findings of the annual Staff Attitude Survey and make recommendations for future engagement action planning
- The Equality & Diversity Committee to develop and oversee an action plan which underpins the equality objectives
- A template to be devised for DMT members to report half yearly on progress on outcomes to the Equality & Diversity Committee
- Outcomes of Staff Engagement initiative will be reviewed by the Staff Engagement Group and provide a report with recommendations to the Equality & Diversity Committee annually
- Implement a revised Equality Impact Assessment process

NBT Equality Objective 4
Increase equality monitoring data and recording of impact of EDS objectives - staff

Why we have chosen this objective

- Low levels of collection of equality data across protected characteristics especially for Disabled, LGBT, (Lesbian, Gay, Bisexual and Trans) and Gypsy/Roma/Traveller patients
- Less than average satisfaction rates shown in staff attitude survey reports in particular regarding disabled staff
- Staff comments and feedback

What we want to achieve

- Better collection of equality monitoring data across protected characteristics especially for Disabled, LGBT, (Lesbian, Gay, Bisexual and Trans) and Gypsy/Roma/Traveller patients
- Improve targeting of resources for patients with protected characteristics
- Gather and publish staff data to inform our priorities
- Implementation of Staff Engagement plan
- Improved rates of satisfaction in Staff Attitude Survey

- Better representation of workforce from protected groups (e.g. BME and Disabled)

How it will be Measured

- Conduct a further personal data cleansing exercise to enable all members of staff to submit accurate information. This will include a communication strategy to educate and encourage staff with different protected characteristics to report personal information accurately
- Using ESR, prepare performance data and reports with action plans to reflect the protected staff characteristics across the Trust. Periodic statistical reports will be presented to the Equality & Diversity Committee for scrutiny
- Trust Board to receive an annual equality update
- A template to be devised for DMT use to report half yearly on progress on outcomes to the Equality & Diversity Committee
- This equality objective will be taken forward, and reported as part of the Trust Workforce Planning initiatives
- Progress on outcomes of increased diverse workforce will be reported to the Equality & Diversity Committee annually with recommendations for actions on how these can be improved
- Annual Equality statistics report will be compiled and presented to the Equality & Diversity Committee
- Outcomes of consultation and engagement with community groups and HealthWatch including the South Gloucestershire Community Forum and the Bristol Health Equality Partnership will be analysed and presented to the Governance Risk Management Committee and the Equality & Diversity Committee

NBT Equality Objective 5
We will implement the Equality and Diversity Competency Framework

Why we have chosen this objective

- This is a national tool designed for the NHS that will help us bring about systemic change.
- It will ensure that equality is everyone's business, and everyone is expected to take an active part, supported by the work of specialist equality leaders and champions
- It will help to address areas of under performance, risks and inefficiency

What we want to achieve

- Compliance with the Equality Act 2010
- Advance equality and foster good relations within NBT and beyond
- Improve equality performance work to ensure that staff work in culturally competent ways within a work environment free from discrimination
- Stronger partnerships with community groups
- Develop leadership skills to bring about a systemic change to embed equality, diversity and Human Rights in the business planning process

How it will be Measured

- 70% of top 180 Senior NBT leaders will complete a self assessment on their personal and team understanding and application of the Trust's Equality objectives
- Outcomes of consultation with staff and patients will be reported annually to the Equality & Diversity Committee
- The Equality & Diversity Committee will consider the findings of the annual Staff Attitude Survey and make recommendations for future actions

- Reports will be presented annually to the Equality & Diversity Committee on performance of managers and outcomes for patients and staff including action plans
- The Trust Board will receive an annual equality update from the L&D on the Trust's Leadership Development Programmes
- The Trust will adopt and embed the Competency Framework for Equality and Diversity Leadership in it's leadership development programmes. Outcomes from this will be provided annually to the Equality & Diversity Committee

Lesley Mansell
Equality and Diversity Manager
Human Resources & Development

April 2012

North Bristol NHS Trust

Report to Trust Board – April 2012

Title:	**Equality & Diversity Performance Against Objectives 2011/12**
Purpose of paper:	The aim of this paper is to present the performance outcomes for the Trust's 2011/12 Equality and Diversity objectives. The work programme and annual report 2011/12 are based on these objectives.

To Note

Executive Summary:	To meet the legislative requirements the Executive Team, General Managers and HR & D were asked to provide information about actions they had carried out in relation to the protected characteristics and the Equality Scheme and the Trust Board's Equality & Diversity Objectives 2011/12. The responses have been included in the **Annual Equality Report 2011** and provide a snapshot of activity on equality and diversity at the Trust. This was approved by the Equality and Diversity Committee, and is available on the Trust Internet site. The outcomes of the specific Equality & Diversity Objectives 2011/12 are included in this report.
Action Required:	The Trust Board is asked to **NOTE** the outcomes from the Equality & Diversity Objectives 2011/12.
Impact on Patients:	Better health outcomes for all; improved patient access and experience
Risk Issues:	NBT must ensure that it meets the requirements of the statutory public sector equality duty (Equality Act 2010) and the statutory duty to consult and involve patients and empower, engage and include staff (NHS Act 2006) by showing evidence of achievements.
Healthcare Standards:	Governance
Equality & Diversity:	Improve performance by embedding equality into our mainstream business
Legal Issues:	Maintain legal compliance (an essential condition for the CQC registration process)

Prepared by: Lesley Mansell Equality and Diversity Manager

Presented by: Harry Hayer, Director of Organisation, People & Performance

NORTH BRISTOL NHS TRUST

Equality and Diversity Objectives 2011/12

The NBT Equality & Diversity Objectives 2011/12 were presented to the Board in November 2011.

The work has been captured in the Annual Equality Diversity Report 2011, published on the Internet. However outcomes for each objective are summarised in the table below.

	Equality and Diversity Objectives 2011/12	Outcomes 2011 – 2012
Deliver a transition between previous and current legislative requirements	Ensure that the Trust's Equality Policy is updated in line with new legislation, including all protected characteristics	The Trusts' Equality Policy has been updated in line with the Equality Act 2010 and covers all the protected characteristics.
	Update the Equality Report for 2010 with actions taken under the existing Equality Schemes into a concluding Equality Report for 2011	The Equality Report for 2011 has been compiled and approved by the Equality and Diversity Committee it sets out actions contained within the Equality Scheme, and has been published on the Trust's Internet.
	Publish monitoring information currently held by the Trust before December 2011 on Recruitment, Workforce and the application of processes to staff	The Annual Equality Monitoring Report for 2010 was published on the NBT web site in summer 2011, and data for 2011/12 is currently being collated.
Support Big 5 Objectives to ensure staff : ***'Feel engaged and involved in decisions affecting their service and their employment'***	Confirm Equality Champions for protected characteristics, to give leadership and support to E&D deliverables	The Board has appointed two Equality Champions on director and one non-executive director. Two further Champions have been appointed for Mental Health and Disability respectively.
	Promote and publicise regularly E&D throughout the Trust, in particular on disability, recognising previous SAS results	Message of the day, the electronic notice board, weekly bulletin, the equality web page are all used to promote equality events and matters. Items have appeared in the Trust magazine "Insite." For disability matters the following have been publicised: computer aids for staff, Two Ticks Scheme and Access to Work, Mindful Employer. The equality web page on the HR&D Portal has been updated to include more information for staff on disability.
	Commence BME mentoring scheme to help support career progression	Training was carried out and very well received. The first pair have been matched to undertake mentoring sessions.
	Continue to press for E&D to be at the heart of all management policy and strategic decisions, ensuring that Equality Impact Assessments are undertaken to	Equality Impact Assessments continue to be submitted and approved by the Equality & Diversity Committee. Ensuring E&D is at the heart of business planning is included as an Equality Objective for 2012-2016.

	evidence consideration Agree Equality Standards for relevant protected characteristics, in line with LGBT (sexual orientation group) standards previously adopted	 Equality Standard agreed by E&D Committee for disability.
Ensure Trust complies with new requirements arising from the Equalities Act 2010	Undertake a public, patient and staff consultation on strategic Equality Objectives for the Trust for publication next year Within Equality Delivery System (EDS) cluster to lead and support the interpretation of the EDS and undertake formal assessment process of the Trust's current position Use the EDS to inform the on-going consultation on Equality Objectives Ensure that the EDS delivers proposals for including general public within work of Trust & equalities, as well as patients and staff Through the EDS to review Equality Impact Assessment guidance to deliver a system fit for the future	Two engagement events were held in South Glos and Bristol in conjunction with the Equality Delivery System cluster group. A presentation was given to the Patient Experience Group who were invited to comment. Staff were invited to attend a feedback meeting and to comment via email. The draft Equality Objectives have been formulated from this. Work continued in 2011 to develop the new process. The Formal assessment of the Trust's position has been completed and agreed by the E&D Committee, and EDS cluster group Information gathered from consultation events and the outcomes form the Equality Delivery System shaped the new Equality Objectives, being presented to the Board. The general public as well as patients and suppliers and others are included in the Equality Objectives. The EDS cluster group is considering a document produced by the NBT as part of the review of the Equality Impact Assessment process prior to drawing up a new system

Summary

The delivery of these objectives ensures that equality issues have been operationalised, at the core of business planning and strategy/policy development and can be evidenced. This work has shaped the Equality Objectives for 2012-2016 which the Trust is required by law which gives a clear direction for our equality agenda over the next 4 years, but with annual review.

Lesley Mansell
Equality & Diversity Manager
Human Resources & Development

April 2012