Due to the impact of Coronavirus COVID-19, the Trust Board will meet virtually but is unable to invite people to attend the public session. Trust Board papers will be published on the website, and interested members of the public are invited to submit questions to trust.secretary@nbt.nhs.uk in line with the Trust's normal processes. A recording of the meeting will be made available on the Trust's website.

# Trust Board Meeting – Public

**Thursday 30 July 2020**
**10.00 – 11.30**
**Virtual Meeting**

**A G E N D A**

| No. | Item | Purpose | Lead | Paper | Time |
|---|---|---|---|---|---|
| **OPENING BUSINESS** | | | | | |
| 1. | Welcome and Apologies for Absence: | Information | Chair | Verbal | 10:00 |
| 2. | Declarations of Interest | Information | Chair | Verbal | 10:02 |
| 3. | Minutes of the Public Trust Board Meeting Held on 28 May 2020 | Approval | Chair | Enc. | 10:05 |
| 4. | Action Chart from Previous Meetings | Discussion | Trust Secretary | Enc. | 10:08 |
| 5. | Matters Arising from Previous Meeting | Information | Chair | Verbal | 10:12 |
| 6. | Chair's Business | Information | Chair | Verbal | 10:15 |
| 7. | Chief Executive's Report | Information | Chief Executive | Verbal | 10:20 |
| **PERFORMANCE AND FINANCE** | | | | | |
| 8. | Integrated Performance Report | Discussion | Chief Executive | Enc. | 10:30 |
| **QUALITY** | | | | | |
| 9. | Quality Account | Approval | Director of Nursing & Quality | Enc. | 10.40 |
| 10. | Quality Strategy | Approval | Medical Director / Director of Nursing & Quality | Enc. | 10.50 |
| **Governance & Assurance** | | | | | |
| 11. | Quality & Risk Management Committee Upward Report | Information | NED Chair | Enc. | 11.00 |
| 12. | Fit & Proper Person Requirements Report | Information | Trust Secretary | Enc. | 11.15 |
| **CLOSING BUSINESS** | | | | | |
| 13. | Any Other Business | Information | Chair | Verbal | 11.15 |
| 14. | Questions from the Public in Relation to Agenda Items | Information | Chair | Verbal | 11.20 |
| 22. | Date of Next Meeting: Thursday 24 September 2020, 10.00 a.m. Venue TBC | | | | 11:30 |
| | *Resolution: Exclusion of the Press and Public. It is recommended that, pursuant to the Public Bodies (Admission to Meetings) Act 1960, Section 1(2), the press and members of the public be excluded from further items of business, having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest.* | | | | |

NHS North Bristol NHS Trust

**TRUST BOARD DECLARATIONS OF INTEREST**

| Name | Role | Interest Declared |
|---|---|---|
| Ms Michele Romaine | Chair | • Nothing to declare. |
| Mr Kelvin Blake | Non-Executive Director | • Non-Executive Director of BRISDOC who provide GP services to North Bristol NHS Trust.<br>• Trustee, Second Step. Provide mental health services for the Bristol North Somerset and South Gloucestershire area.<br>• Trustee, West of England Centre for Integrated Living. Provide a range of services to disabled people living in the Bristol, North Somerset and South Gloucestershire area.<br>• Lay Member of the Avon & Somerset Advisory Committee. The Committee is responsible for forming interview panels for the appointment of magistrates.<br>• Director, Bristol Chamber of Commerce and Initiative.<br>• Member of the Labour Party. |
| Ms Jaki Davis | Non-Executive Director | • Trustee of the Cheltenham Trust.<br>• Trustees of the Friends of the Wilson Museum and Art Gallery in Cheltenham. |
| Mr John Everitt | Non-Executive Director | • Councillor, Newton St Loe Parish Council.<br>• Member of Bath Abbey Appeal Committee.<br>• Daughter works for NBT.<br>• Trustee, Wellsway Multi Academy Trust – an education trust that manages approx. 20 schools. |
| Professor John Iredale | Non-Executive Director | • Pro-Vice Chancellor of University of Bristol.<br>• Member of Medical Research Council.<br>• Trustee of:<br>  ○ British Heart Foundation<br>  ○ Children's Liver Disease Foundation<br>  ○ Foundation for Liver Research<br>• Chair of the governing board, CRUK Beatson Institute. |

| Name | Role | Interest Declared |
|---|---|---|
| Mr Tim Gregory | Non-Executive Director | • Son-in-law works for NBT. |
| Mr Richard Gaunt | Non-Executive Director | • Non-Executive/Governor of City of Bristol College.<br>• Local Board Governor of Colston's Girls' School.<br>• Non-Executive Director of Alliance Homes, social housing and domiciliary care provider |
| Ms Kelly Macfarlane | Non-Executive Director | • Managing Director of Thames Water Utilities Ltd.<br>• Vice President of The Institute of Customer Service.<br>• Sister is Centre Leader of Genesiscare Bristol – Private Oncology.<br>• Sister works for Pioneer Medical Group, Bristol. |
| Mr Ade Williams | Associate Non-Executive Director | • Superintendent Pharmacist and Director of M J Williams Pharmacy Group – NHS community pharmacy contractor and private vaccination services provider.<br>• Practice Pharmacist, Broadmead Medical Centre<br>• Pharmacy Ambassador and Clinical Advisor, Pancreatic Cancer Action Charity. |
| Ms Andrea Young | Chief Executive | • Hospitality received from Royal College of Anaesthetists – dinner to the value of £40 on 26 February 2020. Invitation from Vice President of RCOA, who is employed by NBT as an anaesthetist. |
| Ms Evelyn Barker | Chief Operating Officer & Deputy Chief Executive | • Nothing to declare. |

| Name | Role | Interest Declared |
|---|---|---|
| Ms Helen Blanchard | Interim Director of Nursing and Quality (from 2 July 2018 to 7 November 2019) Director of Nursing and Quality (from 8 November 2019) | • Nothing to declare. |
| Dr Chris Burton | Medical Director | • Wife works for NBT.<br>• Hospitality received from Royal College of Anaesthetists – dinner to the value of £40 on 26 February 2020. Invitation from Vice President of RCOA, who is employed by NBT as an anaesthetist. |
| Mr Neil Darvill | Director of Information Management and Technology (non-voting position) | • Wife works as a senior manager for Avon and Wiltshire Partnership Mental Health Trust. |
| Ms Jacqui Marshall | Director of People and Transformation (non-voting position) | • Nothing to declare. |
| Mrs Catherine Phillips | Director of Finance | • Hospitality received to the value of £735.68 for Patient Hotel Study tour of Denmark/Sweden hosted by St Monica's Trust. Hospitality included local transport and transfers, meals and tour guide/interpreter. NBT paid for flights and accommodation (February 2020). |
| Mr Simon Wood | Director of Estates, Facilities and Capital Planning (non-voting position) | • Member of Bristol City Council's Bristol One City Environmental Sustainability Board. |

# DRAFT Minutes of the Public Trust Board Meeting held on Thursday 28 May 2020 at 10.00am Virtual via Microsoft Teams

**Present:**

| | | | |
|---|---|---|---|
| Michele Romaine | Chair | Andrea Young | Chief Executive |
| Kelvin Blake | Non-Executive Director | Evelyn Barker | Chief Operating Officer |
| John Everitt | Non-Executive Director | Helen Blanchard | Director of Nursing & Quality |
| Jaki Meekings-Davis | Non-Executive Director | Chris Burton | Medical Director |
| | | Neil Darvill | Director of Informatics |
| Tim Gregory | Non-Executive Director | Catherine Phillips | Director of Finance |
| Kelly MacFarlane | Non-Executive Director | Jacqui Marshall | Director of People & Transformation |
| Richard Gaunt | Non-Executive Director | | |
| Ade Williams | Associate Non-Executive Director | Simon Wood | Director of Estates, Facilities & Capital Planning |

**In Attendance:**

| | | | |
|---|---|---|---|
| Xavier Bell | Director of Corporate Governance & Trust Secretary | Pete Bramwell | Head of Communications |
| | | Isobel Clements | Corporate Governance Officer |

**Observers:** Due to the impact of Coronavirus Covid-19, the Trust Chair took the decision to suspend non-urgent and non-essential meetings until further notice. The Trust Board met virtually but was unable to invite people to attend the public session. Trust Board papers were published on the website, and interested members of the public were invited to submit questions in line with the Trust's normal processes.

**Action**

**TB/20/05/01 Welcome**

The Chair welcomed everyone to the public meeting of the Board. Non-Executive Directors Jaki Meekings-Davis, Kelvin Blake, John Everitt, and Richard Gaunt, Associate Non-Executive Director Ade Williams, and Pete Bramwell, Head of Communications, joined by teleconference.

**TB/20/05/02 Apologies For Absence and Welcome**

The Board noted that apologies for absence had been received from John Iredale, Non-Executive Director.

**TB/20/05/03 Declarations of Interest**

There were no new declarations of interest but an update to the Trust Board register of interests as currently published on the NBT website and annexed to the Board papers was required as follows:

- Kelvin Blake, NED, was no longer a Board member for UHBW **IC**

**TB/20/05/04 Minutes of the previous Public Trust Board Meeting**

**RESOLVED that the minutes of the public meeting held on 26 March 2020 be approved as a true and correct record subject to the addition of Tim Gregory as an attendee.**

**TB/20/05/05 Action Log and Matters Arising from the Previous Meeting**

The following updates to the Trust Board action log were provided:

- Actions 24, 28 and 29 were closed. The caesarean deep-dive would

be included in the Annual Quality Governance Account due at QRMC in September and the lead for the allotment was to stay with the facilities team and transferred to the well-being team when fully established;

- Action 19 was amended to July as discussions to enable effective patient stories were to take place with Helen Blanchard, Director of Nursing & Quality, Kelly Macfarlane, NED, and NBT's patient experience lead. Michele Romaine, Trust Chair, requested that virtual options for re-instating Trust Board patient stories be investigated;
- Action 21 was ongoing, so the due date was extended;
- Action 22 was delayed pending Covid-19 restoration phase 2 and 3 and discussion concerning how NED walk-arounds would work with social distancing requirements etc.

**RESOLVED that the Action Log and amendments as above was noted. No matters arising were raised.**

**TB/20/05/06 Chair's Business**

*{Healthier Together slideshow to be shared with the Board}* **MR**

Michele Romaine, Chair of the Trust, provided the following updates:

- Kelly MacFarlane, new NED, was to replace Rob Mould as Freedom To Speak Up Board representative;
- Andrea Young, Chief Executive, and Michele Romaine had attended the STP Healthier Together Board in the previous week. A commitment to learning from changes during the Covid-19 response was perceived across system partners with a set of goals and principles shared. It was reported that the shared principles aligned with pre-Covid-19 system aims;
- Andrea Young confirmed that NBT would have a role in three areas of Healthier Together transformation priorities: Urgent care (NBT's Kieran Flanagan was leading); Outpatients (specifically end-to-end digital pathway transformation); and development of acute provider's role as part of the STP alongside Sirona (community care), the three Local Authorities (LAs) and BNSSG Clinical Commissioning Group (CCG), particularly regarding collaboration around care homes;
- One Healthier Together goal was to recognise inequalities impact of Covid-19 and to develop community-based healthcare management.

**RESOLVED that the Chair's Briefing be noted.**

**TB/20/05/07 Chief Executive's Report**

Andrea Young, Chief Executive, provided the following updates:

- The Trust was gradually re-instating urgent and important activity

whilst ensuring re-configuration of the hospital recognised and streamed patients into Covid-19, untested and non-Covid-19 streams to prioritise safety for staff and incoming patients;

- A range of Health & Well-Being was available for staff and the Trust had begun a pulse survey, results of which would be discussed at a future meeting;
- Weston hospital had temporarily closed to new admissions due to increasing Covid-19 cases. All staff were being tested but a re-open date remained unknown. It was confirmed that NBT was a part of the system response to manage North Somerset patients;
- The latest CQC report for Avon & Wiltshire Partnership (the mental healthcare provider in the region) detailed that two areas – child and adolescent mental health and patients with learning difficulties – had improved in rating from 'requires improvement' to 'good';
- Bristol was one of only two centres to be awarded Academic Health Science status. This recognised the strong link between health partners, Local Authorities and academia, and was something to be proud of.

**RESOLVED that the Chief Executive's Report be noted.**

**TB/20/05/08 Integrated Performance Report**

Andrea Young introduced the Integrated Performance Report (IPR) for April data. NBT had suspended all non-urgent activity on 17 March 2020 hence some items on the IPR such as capacity looked improved. However, the IPR was clarified as a snap-shot in time for which full conclusions could not be drawn. The Trust continued to monitor the situation in terms of impact on patients not being treated. As mentioned, NBT was re-introducing some elective activity. This was managed by the Service Restoration Board chaired by Evelyn Barker, Chief Operating Officer and Deputy Chief Executive.

<u>Operational</u>
Evelyn Barker presented the operational section of the IPR. Key elements to note were as follows:

- The IPR was green on many key targets. This was likely due to a 50% reduction in ED attendances though ED attendance in the previous week (to be evidenced in June's IPR) had risen dramatically to an average of 200 per day. Increased attendances presented a challenge to ensure appropriate social distancing was maintained;
- NBT was the best performing major trauma centre in the country (96% performance) which provided a moral boost in difficult circumstances;
- Despite the focus on discharging patients at the outbreak of the pandemic, NBT had the highest number of patients with greater than 21 day stays in the South West. This would remain a focus for the Trust;

- Concern regarding the diagnostic performance was raised (61% six week wait performance and 402 greater than 13 week wait breaches). The Board were assured that these figures were similar to other Trust's figures and NBT was reinstating diagnostic tests;
- Waiting list sizes had reduced due to a reduction in referrals. During April, NBT treated many patients prior to the cessation of referral and elective operations;
- Cancer performance was reported as in upturn and ahead of trajectory though it was reported some patients had refused to attend two week wait appointments due to nervousness around Covid-19.

<u>Questions and comments on operational section of IPR:</u>

- John Everitt, NED, requested clarity on how the Trust was prioritising patients waiting for elective care.
- Tim Gregory, NED, raised concern that NBT had been struggling with diagnostics performance prior to Covid-19 and this had worsened during the pandemic. He requested assurance on how patients were being triaged and how harm analysis due to waits were being carried out;
- Richard Gaunt, NED, raised the issue that from a governance perspective, the standard KPIs included in the IPR may need to be re-visited to ensure the progress of NBT's Covid-19 recovery;
- In response to the above points, Evelyn Barker confirmed that the Quality & Risk Management Committee (QRMC) had received a paper on the process of harm reviews from treatment delays due to Covid-19 the previous week;
- Kelvin Blake, NED, requested clarification of why stroke figures had reduced and why pressure injuries had increased per 1000 bed days despite reduced occupancy:
    - Regarding stroke figures, Chris Burton, Medical Director, clarified that the stroke team had informed him that the IPR data was not correct as NBT's performance had actually significantly improved. This would be corrected for June's IPR; **CB**
    - Regarding pressure injuries, Helen Blanchard explained analysis had taken place to understand cause and effect and Heads of Nursing had led an audit of patient-facing care and peer reviews to further understand ongoing incidents;
    - In addition, a prospective piece of work to look at the profile of patients who develop pressure injuries had been commissioned. This would analyse the nutritional status, characteristics and length of stay to extract commonalities that may be pertinent to the development of PIs and understanding those at high-risk;
    - It was acknowledged that despite the vast amount of work happening within the Trust regarding PIs, NBT had not seen **HB**

the reduction anticipated. A report on PI work was requested for review at a future Board meeting;

- Jaki Meekings-Davis, NED, queried if data on PIs could be broken-down into departments - such as ICU – for audit purposes. It was noted that patients in ICU had developed PIs in relation to medical devices used to treat Covid-19 but the number of incidents did not account for the increase in PIs overall;
- Following a comment from Michele Romaine that the increase in ED attendance over the past week should be understood, Evelyn Barker confirmed that the majority of attendances were majors as opposed to minors. This included increased trauma cases and stroke likely due to the warm weather and increased movement of people.

People

Jacqui Marshall, Director of People & Transformation, presented the staff section of the IPR. It was noted that vacancy and turnover rates had improved. Where appropriate, interviews had been carried out virtually and this was planned to continue.

More broadly, the importance of job security has been emphasized during the pandemic which provided an opportunity for the system to promote careers in health and jobs available in BNSSG. Helen Blanchard also noted that NBT was attempting to convert regular bank staff into annualised staff within the nursing workforce.

Questions and comments on People section:

- Richard Gaunt commended the reduction in vacancies but queried the maintenance of agency spend. Jacqui Marshall responded that agency had been used at the beginning of the pandemic to fill a staff gap and winter agency spend was historically higher;
- It was acknowledged that further understanding of staff on long-term sick leave and management of shielding staff was required. Xavier Bell, Director of Corporate Governance & Trust Secretary, noted that long-term staff sickness was an ongoing focus of People & Digital Committee which would be resumed in June;
- It was confirmed that an internal Occupational Health management system was used.

Finance

Catherine Phillips, Director of Finance, presented the finance section of the IPR. Key points were as follows:

- During Covid-19, NBT had worked in financial regimes different to the norm which was reflected in the IPR;
- NBT was now funded in block payments for costs rather than activity from a CCG and NHS specialist consortium. This would continue to the end of July but may be extended;
- In April, two times £45m was received to ensure cash issues were not experienced during Covid-19 and to allow for fast payment to

suppliers;

- NBT had spent £45m on pay, products and non-pay and received £2.5m for specific Covid-19 costs mainly related to covering staff sickness, shielding and isolation and additional mega-team costs;
- NBT received £52m income in April and spent the same amount, leading to a break even position;
- When compared with the quarter four winter period, NBT received less income and spent less money. The pay bill remained static, non-pay considerably reduced due to the reduction in activity and non-elective work.

Questions and comments on Finance section:

- After a query from John Everitt, NED, Catherine Phillips assured the Board that the Trust was confident in recovering the full £16m of the operational and set-up plan for Covid-19 spend as signed-off by the Department of Health;
- Following a query regarding capital 2020/21 plans from Jaki-Meekings Davis, NED, Catherine Phillips clarified that NBT had suspended all non-urgent activities during Covid-19 but some capital work had been accelerated and completed under Covid-19 reimbursement (£6m claimed to date). The capital team would begin to re-prioritise the capital plan in light of the situation;
- Neil Darvill, Head of IM&T, further stated that formal IM&T governance would ratify the re-prioritised 2020/21 plan but he was optimistic NBT would be able to go ahead with most of the programme. Simon Wood, Director of estates, facilities and capital planning, confirmed the team were internally taking stock and re-prioritisation would depend on review of the transformation priorities. It was noted however, that some projects required for Health and Safety would be progressed as soon as possible though some specialist contractors may not return due to Covid-19 pressures;
- Tim Gregory, NED, queried the status of the 70-bed additional rehabilitation unit discussed pre-Covid-19. Andrea Young confirmed discussions with Sirona and CCG who currently commission the building had paused but would need to be re-started. **SW**

Infection Control

Chris Burton, Medical Director, presented the infection control section of the IPR. NHSE had introduced categorisation of patients that had potentially developed Covid-19 while in hospital as follows:

1. Day of admission = not hospital acquired
2. 1-7 days in hospital development = possible hospital acquired
3. 8-14 days in hospital = probable acquired in hospital
4. Post-14 days in hospital = definitely hospital acquired

The Trust processed all those who developed Covid-19 symptoms after eight days in NBT. According to this, four patients fell into this category in May and would be the focus of learning by the Trust. Chris Burton reassured the Board that the Trust was focussed on this issue and was

taking all actions it could to reduce the risks of outbreaks.

Questions and comments on the infection control section of the IPR:

- Michele Romaine noted that the infection control section of the IPR and NHSE categories did not allow for understanding of where staff had contracted Covid-19 at work. It was acknowledged that this was an important question but one which was unlikely to be known unequivocally;
- Kelly MacFarlane, NED, suggested that the Trust should understand numbers of staff who have had Covid-19 and further investigate the impact on BAME staff;
- It was confirmed that 1200 staff had been tested with 194 receiving a positive Covid-19 result. It was noted that only staff with symptoms were currently tested and the testing capability had been expanded after the peak was experienced. However, antibody testing would help with understanding numbers of staff who have had Covid-19;
- It was confirmed that the IPR included elective activity and outcomes for NBT patients treated in the Independent Sector (IS). However, Chris Burton confirmed that other responsibilities such as quality were included in the precise national contract;
- Tim Gregory, NED, requested assurance that infection control in the IS mirrored NBT's standards. It was confirmed that contracts stipulated each IS hospital needed to have its own infection control system, doctors and nurses. NBT patients were also pre-screened and swabbed prior to IS admission and NBT's infection control team had completed IS walk-throughs for further assurance.

**RESOLVED:**

- **The Integrated Performance Report was noted;**
- **The Board confirmed the compliance statements;**
- **July's Trust Board would be a seminar on NBT's strategy including re-prioritisation and sequencing of the transformation plan, financial possibilities and reducing activity back-log.**

**TB/20/05/09 Freedom to Speak-Up Report**

Xavier Bell, Director of Corporate Governance & Trust Secretary presented the bi-annual Freedom to Speak-Up Report. Key points to note were as follows:

- The Trust was below national average for FTSU reports. This was discussed at April's Guardians meeting where it was suggested this may be due to NBT's reactive rather than proactive structure;
- Kelly Macfarlane, NED, had attended the April Guardians meeting which was reasonably attended overall;
- Concerns raised did not increase during Covid-19 even though rapid changes to staff structures had taken place. It was suggested that

this may have been due to daily NBT-wide communications and team huddles which allowed concerns to be raised divisionally;

- A number of Covid-19 specific concerns were raised specifically regarding (a lack of) social distancing within the Trust. Concerns raised fed into work such as changing the set-up of Vu café;
- It was positively reported that no staff who raised concerns had experienced detriment but the increase in anonymous concerns raised compared to national average was potentially concerning and was to be investigated;
- The Trust was commissioning a Guardian with designated time to lead the FTSU Guardians, attend patient safety groups and increase proactivity. Positively, all current Guardians wanted to continue to be ambassadors alongside the lead guardian;
- Kelly MacFarlane noted a full-time FTSU guardian was required to further embed the process and to target certain groups such as Healthcare Assistants and midwifes whose FTSU report numbers were low;
- In addition, FTSU reports relating to bullying would need to be investigated as it may be that manager training could help if concerns were raised due to a badly handled performance management conversation. Jacqui Marshall highlighted that NBT was carrying out line manager awareness and training as a step towards a Just culture of learning rather than punishment.

<u>Questions and comments on the FTSU report were as follows:</u>

- Andrea Young raised concern that the layout of the data detailed in the report was not conductive for encouraging divisional improvements. For example, it was suggested that instead of divisional red and green ratings, data could be presented as per 1000 head rate;
- The difficulty in ensuring reporters remained anonymous and ensuring concerns produced learning was acknowledged. Thematic analysis, reports to and meetings with Divisional Management Teams would be possible once the lead Guardian was in post;
- Triangulation of data (for example with Staff Survey results) would be carried out to provide a Trust-wide picture and learning;
- Kelvin Blake, NED, raised concern that anonymous reports do not allow for analysis of trends and commonalities between reporters;
- Michele Romaine suggested that reports organised by job types would allow assessment of empowerment compared to divisionally-organised FTSU reports.

**RESOLVED that:**

- **FTSU data presentation be reconsidered before being presented to divisions;**
- **Agreed to aim to reduce the number of anonymous reports;**
- **Approved of the commissioning of an FTSU lead guardian.**

**TB/20/05/10 Committee Upward Report: Quality & Risk Management (QRMC)**

Kelvin Blake, NED, presented the QRMC upward report. It was noted that QRMC received comprehensive reports regarding Nightingale Hospital Bristol (NHB), Trust-Level risks and a deep-dive into Serious Incidents (SIs). The deep-dive into SIs reported 152 actions stemming from 52 SIs. Positively, no surprises were elicited from the deep-dive. Falls were analysed for commonalities separately due to contributing to two-thirds of SIs.

It was confirmed that QRMC was responsible for analysis into the impact on patients from delays in treatment. This had been discussed at May's QRMC but was not detailed in the upward report.

Discussion was had regarding the benefits and negatives to continuing monthly QRMC meetings. QRMC had taken the view that it would be in a position to revert back to bi-monthly meetings after July.

**RESOLVED:**

- **QRMC upward report to be retrospectively amended to include details on the discussion re harm risks new approach to analysis of patient harm due to delays during Covid-19;** **XB**
- **QRMC's ongoing frequency to be decided at July's QRMC.**

**TB/20/05/11 Any Other Business**

- It was noted that antibody tests were available for all staff including NEDs;
- The Chair requested that July's public Trust Board be made virtually available to members of the public. **XB/IC**

**TB/20/05/12 No questions from the Public were received**

**TB/20/05/13 Date of Next Meeting**

The next public meeting of the Board is scheduled to take place on Thursday 30 July 2020, 10.00 a.m. The Board will meet virtually. Trust Board papers will be published on the website, and interested members of the public are invited to submit questions in line with the Trust's normal processes.

The meeting concluded at 11.30am

**North Bristol NHS Trust** **Trust Board - Public Committee Action Log**

## Trust Board - Public ACTION LOG


| Meeting Date | Agenda Item | Minute Ref | Action No. | Agreed Action | Owner | Deadline for completion of action | Item for Future Board Meeting? | Status/ RAG | Info/ Update | Date action was closed/ updated |
|---|---|---|---|---|---|---|---|---|---|---|
| 30/01/2020 | Patient Story / Staff Story | TBC/20/01/04 | 19 | Patient story advance six month plan to be created for patient and staff stories with sufficient secondary options to ensure a staff/patient story is brought to the Board | **Helen Blanchard Director of Nursing & Quality** | Jul-20 | No | Open | Discussions with HB, KM and patient leads to re-design effective patient stories to restart. Date amended from March to July | 28/05/2020 |
| 30/01/2020 | Chief Executive's Report | TBC/20/01/08 | 21 | Chief Executive to explore the Trust's approach to commercialisation of data with David Wynick | **Andrea Young, Chief Exec** | Jul-20 | Yes- matters arising | Open | Conversations ongoing, not resolved. Amended due date from May to July | 28/05/2020 |
| 30/01/2020 | Board member's walk-arounds | TBC/20/01/09 | 22 | A Board workshop/ seminar to reach a shared decision on NED and Exec walk-arounds, including staff perspectives, to be organised | **Xavier Bell, Director of Corporate Governance** | TBD | Yes | Delayed | Delayed until hospital restoration plan phase 2 & 3 complete | 28/05/2020 |
| 30/01/2020 | Quality & Risk Management Committee upward report | TBC/20/01/10 | 23 | NHS patient safety strategy overview discussion to be scheduled for a Board work away-day in 2020 (May or October dates available), including Just Culture. | **Helen Blanchard Director of Nursing & Quality** | May-20 | Yes, work away-day | Closed | Just Culture seminar topic scheduled for August | 18/03/2020 |
| 30/01/2020 | North Bristol Trust Five Year Strategy 2019-2024 | TBC/20/01/12 | 26 | Board discussion on prioritisations of strategic goals to be planned (May or October dates available). | **Xavier Bell, Director of Corporate Governance** | Oct-20 | Yes, seminar | Closed | Strategy Workshop at July private meeting. | 28/05/2020 |
| 28/05/2020 | Integrated performance report | TB/20/05/08 | 30 | Data regarding stroke figures included in the IPR to be corrected/ confirmed | **Chris Burton, Medical Director** | June-20 (private) | Yes, IPR at private | Closed | | 24/07/2020 |
| 28/05/2020 | Integrated performance report | TB/20/05/08 | 32 | Confirmation of timelines for re-starting 70 bed additional unit plans to be achieved via liaison with CCG and South Glos Council | **Simon Wood Director of Facilities** | Jul-20 | Matters arising in July | Open | On forward workplan for July TB | 09/06/2020 |

## Trust Board - Public ACTION LOG

| | | | |
|---|---|---|---|
| Closed | Action completed and can be filtered out | Amber | Status not updated/completed and/or the deadline passed |
| Blue | Completed and will be removed from chart for next iteration. A = On current meeting agenda | Red | Status not updated/completed and/or deadline passed by more than one month |
| Green | Status updated and on track within timescale | | |

| Meeting Date | Agenda Item | Minute Ref | Action No. | Agreed Action | Owner | Deadline for completion of action | Item for Future Board Meeting? | Status/ RAG | Info/ Update | Date action was closed/ updated |
|---|---|---|---|---|---|---|---|---|---|---|
| 28/05/2020 | Freedom to Speak-Up Report | TB/20/05/09 | 33 | FTSU data presentation be reconsidered before being presented to divisions | **Xavier Bell, Director of Corporate Governance/ Kelly Macfarlane, NED** | Jul-20 | No | Closed | Data presentation has been reviewed. The numbers of concerns are so low, that presenting the data in more granular detail at Divisional level risks identifying the individuals. | 24/07/2020 |
| 28/05/2020 | Committee upward report: QRMC | TB/20/05/10 | 34 | QRMC upward report to be retrospectively amended to include details on the discussion re proposals of greatest risks/ new approach to analysis of patient harm due to delays during Covid-19 | **Xavier Bell, Director of Corporate Governance** | Jul-20 | No | Closed | The report has been updated as requested. | 24/07/2020 |
| 28/05/2020 | Any Other Business | TB/20/05/11 | 38 | July's public Trust Board be made virtually available to members of the public | **Isobel Clements** | Jul-20 | No | Closed | July Trust Board meeting to be recorded for publication on the website | 08/06/2020 |

NHS North Bristol NHS Trust

| | | | |
|---|---|---|---|
| **Report To:** | Trust Board | | |
| **Date of Meeting:** | 30 July 2020 | | |
| **Report Title:** | Integrated Performance Report | | |
| **Report Author & Job Title** | Lisa Whitlow, Associate Director of Performance | | |
| **Executive/Non-executive Sponsor (presenting)** | Executive Team | | |
| **Purpose:** | **Approval** | **Discussion** | **To Receive for Information** |
| | | **X** | |
| **Recommendation:** | The Trust Board is asked to note the contents of the Integrated Performance Report. | | |
| **Report History:** | The report is a standing item to the Trust Board Meeting. | | |
| **Next Steps:** | This report is received at the Joint Consultancy and Negotiation Committee, Operational Management Board, Trust Management Team meeting, shared with Commissioners and the Quality section will be shared with the Quality and Risk Management Committee. | | |

8

| **Executive Summary** | |
|---|---|
| Details of the Trust's performance against the domains of Urgent Care, Elective Care and Diagnostics, Cancer Wait Time Standards, Quality, Workforce and Finance are provided on page six of the Integrated Performance Report. | |
| **Strategic Theme/Corporate Objective Links** | **1. Provider of high quality patient care**<br>a. Experts in complex urgent & emergency care<br>b. Work in partnership to deliver great local health services<br>c. A Centre of Excellence for specialist healthcare<br>d. A powerhouse for pathology & imaging<br>**2. Developing Healthcare for the future**<br>a. Training, educating and developing our workforce<br>b. Increase our capability to deliver research<br>c. Support development & adoption of innovations<br>d. Invest in digital technology<br>**3. Employer of choice**<br>a. A great place to work that is diverse & inclusive<br>b. Empowered clinically led teams<br>c. Support our staff to continuously develop<br>d. Support staff health & wellbeing |

| | |
|---|---|
| **Board Assurance Framework/Trust Risk Register Links** | The report links to the BAF risks relating to internal flow, staff retention, staff engagement, productivity and clinical complexity. |
| **Other Standard Reference** | CQC Standards. |
| **Financial implications** | Whilst there is a section referring to the Trust's financial position, there are no financial implications within this paper. |
| **Other Resource Implications** | Not applicable. |
| **Legal Implications including Equality, Diversity and Inclusion Assessment** | Not applicable. |
| **Appendices:** | Not applicable. |

NHS North Bristol NHS Trust

## North Bristol NHS Trust

# INTEGRATED PERFORMANCE REPORT

## July 2020 (presenting June 2020 data)

# CONTENTS

# North Bristol Trust Integrated Performance Report Scorecard

| Domain | Description | National Standard | Current Month Trajectory (RAG) | Jun-19 | Jul-19 | Aug-19 | Sep-19 | Oct-19 | Nov-19 | Dec-19 | Jan-20 | Feb-20 | Mar-20 | Apr-20 | May-20 | Jun-20 | Trend | Benchmarking (in arrears except A&E & Cancer as per reporting month) | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | | | | | | | | | | | | | | National Performance | Rank | Quartile |
| Responsive | A&E 4 Hour - Type 1 Performance | 95.00% | 82.38% | 72.53% | 72.49% | 87.89% | 85.14% | 80.04% | 80.18% | 74.64% | 78.33% | 72.43% | 80.16% | 96.00% | 95.47% | 94.74% | | 87.98% | 22/114 | |
| | A&E 12 Hour Trolley Breaches | 0 | 0 | 1 | 0 | 0 | 0 | 4 | 9 | 2 | 38 | 48 | 2 | 0 | 0 | 0 | | 0 - 28 | 1/10 | |
| | Ambulance Handover < 15 mins (%) | 100% | 94.83% | 93.75% | 94.02% | 97.18% | 97.29% | 94.09% | 94.34% | 92.65% | 92.71% | 91.06% | 95.41% | 94.72% | 97.38% | 98.50% | | | | |
| | Ambulance Handover < 30 mins (%) | 100% | 99.04% | 98.91% | 98.93% | 99.78% | 99.81% | 99.19% | 99.14% | 99.22% | 98.72% | 98.15% | 99.37% | 99.53% | 99.56% | 99.96% | | | | |
| | Ambulance Handover > 60 mins | 0 | 0 | 4 | 0 | 0 | 0 | 0 | 1 | 0 | 2 | 2 | 1 | 0 | 0 | 0 | | | | |
| | Delayed Transfers of Care | 3.50% | 3.50% | 6.06% | 5.40% | 7.75% | 8.90% | 7.28% | 7.19% | 6.88% | 8.29% | 7.96% | 9.23% | 7.02% | 4.69% | 4.23% | | | | |
| | Stranded Patients (>21 days) - month end | | | 133 | 137 | 280 | 160 | 139 | 129 | 129 | 162 | 158 | 123 | 63 | 60 | 75 | | | | |
| | Bed Occupancy Rate | | 85.00% | 95.19% | 95.51% | 94.81% | 95.18% | 96.51% | 96.29% | 96.91% | 98.95% | 98.87% | 82.25% | 50.84% | 58.18% | 75.59% | | | | |
| | Diagnostic 6 Week Wait Performance | 1.00% | 1.19% | 6.84% | 8.16% | 9.39% | 8.69% | 9.09% | 8.87% | 12.56% | 11.00% | 5.60% | 10.25% | 61.24% | 65.94% | 46.56% | | 55.74% | 144/227 | |
| | Diagnostic 13+ Week Breaches | 0 | 0 | 84 | 130 | 205 | 225 | 239 | 63 | 147 | 258 | 113 | 114 | 402 | 2292 | 3161 | | | 153/226 | |
| | Diagnostic Backlog Clearance Time (in weeks) | | | 0.2 | 0.2 | 0.2 | 0.2 | 0.2 | 0.2 | 0.3 | 0.3 | 0.1 | 0.2 | 1.2 | 2.7 | 2.0 | | | | |
| | RTT Incomplete 18 Week Performance | 92.00% | 83.68% | 85.03% | 85.21% | 83.39% | 83.20% | 83.28% | 82.58% | 82.43% | 83.62% | 82.95% | 80.02% | 71.82% | 64.51% | 58.20% | | 62.21% | 212/382 | |
| | RTT 52+ Week Breaches | 0 | 29 | 17 | 14 | 14 | 16 | 13 | 14 | 14 | 9 | 17 | 43 | 130 | 275 | 454 | | 0 - 1466 | 127/157 | |
| | Total Waiting List | | 30908 | 28590 | 28740 | 28587 | 29313 | 29118 | 28351 | 28078 | 29672 | 29552 | 28516 | 25877 | 25518 | 25265 | | | | |
| | RTT Backlog Clearance Time (in weeks) | | | 2.8 | 3.0 | 3.0 | 3.3 | 3.1 | 3.0 | 3.0 | 3.2 | 3.0 | 3.2 | 4.4 | 6.9 | 10.3 | | | | |
| | Cancer 2 Week Wait | 93.00% | 87.51% | 78.40% | 71.87% | 66.06% | 69.93% | 87.23% | 90.21% | 81.94% | 78.21% | 89.94% | 91.25% | 76.35% | 93.17% | - | | 94.19% | 106/137 | |
| | Cancer 2 Week Wait - Breast Symptoms | 93.00% | 88.44% | 76.83% | 96.75% | 94.64% | 96.08% | 98.61% | 92.00% | 81.08% | 70.27% | 89.63% | 81.82% | 76.47% | 98.28% | - | | 93.74% | 10/65 | |
| | Cancer 31 Day First Treatment | 96.00% | 90.00% | 88.03% | 90.87% | 89.67% | 90.20% | 85.76% | 93.24% | 96.80% | 92.74% | 95.36% | 97.71% | 93.66% | 85.23% | - | | 93.94% | 102/108 | |
| | Cancer 31 Day Subsequent - Drug | 98.00% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | - | 100% | 100% | 100% | 100% | - | | 98.98% | 1/29 | |
| | Cancer 31 Day Subsequent - Surgery | 94.00% | 77.08% | 77.88% | 83.33% | 82.56% | 75.23% | 69.09% | 79.80% | 81.54% | 72.00% | 70.89% | 85.09% | 75.76% | 79.73% | - | | 88.46% | 51/67 | |
| | Cancer 62 Day Standard | 85.00% | 80.92% | 76.99% | 74.35% | 88.59% | 72.58% | 66.98% | 71.62% | 75.53% | 68.18% | 61.31% | 74.15% | 74.34% | 69.52% | - | | 69.86% | 71/133 | |
| | Cancer 62 Day Screening | 90.00% | 95.83% | 84.31% | 85.00% | 92.59% | 90.00% | 77.50% | 81.43% | 81.13% | 64.38% | 67.27% | 83.95% | 85.92% | 46.67% | - | | 47.91% | 33/66 | |
| | Mixed Sex Accomodation | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | | | | |
| | Electronic Discharge Summaries within 24 Hours | 100% | | 83.53% | 84.37% | 83.03% | 84.35% | 84.18% | 83.21% | 83.19% | 83.81% | 82.97% | 83.48% | 83.08% | 83.98% | 85.74% | | | | |

# North Bristol Trust Integrated Performance Report Scorecard

| Domain | Description | National Standard | Current Month Trajectory (RAG) | Jun-19 | Jul-19 | Aug-19 | Sep-19 | Oct-19 | Nov-19 | Dec-19 | Jan-20 | Feb-20 | Mar-20 | Apr-20 | May-20 | Jun-20 | Trend |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Quality Patient Safety & Effectiveness | 5 minute apgar 7 rate at term | | | 0.7% | 0.2% | 0.4% | 1.7% | 0.9% | 0.6% | 0.5% | 0.5% | 0.7% | 0.7% | 1.3% | 1.6% | 1.0% | |
| | Caesarean Section Rate | | | 30.4% | 31.6% | 34.0% | 32.3% | 32.8% | 35.3% | 33.9% | 38.4% | 34.0% | 33.4% | 31.5% | 33.9% | 36.7% | |
| | Still Birth rate | | | 0.4% | 0.2% | 0.4% | 0.7% | 0.8% | 0.2% | 0.7% | 0.2% | 0.0% | 0.4% | 0.2% | 0.0% | 0.0% | |
| | Induction of Labour Rate | | | 43.0% | 36.5% | 38.2% | 36.5% | 38.5% | 35.3% | 40.2% | 41.4% | 41.4% | 40.8% | 40.6% | 38.9% | 34.9% | |
| | PPH 1000 ml rate | | | 13.2% | 15.3% | 10.9% | 14.9% | 13.3% | 13.3% | 12.2% | 10.7% | 9.2% | 9.7% | 8.7% | 12.9% | 11.5% | |
| | Never Event Occurance by month | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 1 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | |
| | Serious Incidents | | | 7 | 10 | 5 | 5 | 3 | 3 | 6 | 3 | 5 | 7 | 3 | 1 | 4 | |
| | Total Incidents | | | 1094 | 1066 | 1108 | 952 | 1131 | 1120 | 1096 | 1149 | 1116 | 847 | 596 | 656 | 736 | |
| | Total Incidents (Rate per 1000 Bed Days) | | | 44 | 42 | 44 | 38 | 44 | 45 | 42 | 43 | 45 | 38 | 45 | 42 | 41 | |
| | WHO | | 95% | 95.84% | 95.80% | 97.32% | 97.56% | 97.65% | 97.78% | 98.98% | 99.72% | 99.30% | 99.30% | 99.50% | 99.50% | 99.50% | |
| | Pressure Injuries Grade 2 | | | 31 | 24 | 34 | 46 | 43 | 43 | 32 | 34 | 17 | 29 | 24 | 16 | 13 | |
| | Pressure Injuries Grade 3 | | | 0 | 1 | 0 | 0 | 0 | 0 | 1 | 0 | 1 | 1 | 0 | 0 | 0 | |
| | Pressure Injuries Grade 4 | | | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | |
| | Falls per 1,000 bed days | | | 30 | 31 | 31 | 30 | 31 | 30 | 31 | 32 | 30 | 27 | 16 | 18 | 21 | |
| | Stroke - Patients Admitted | | | 88 | 77 | 89 | 76 | 89 | 83 | 82 | 79 | 72 | 97 | 71 | 72 | 79 | |
| | Stroke - 90% Stay on Stroke Ward | | 90% | 75.00% | 89.55% | 89.06% | 79.37% | 93.15% | 91.18% | 70.97% | 81.54% | 87.10% | 86.67% | 87.10% | 81.13% | - | |
| | Stroke - Thrombolysed <1 Hour | | 60% | 62.50% | 60.00% | 77.78% | 75.00% | 50.00% | 37.50% | 41.67% | 62.50% | 66.67% | 66.67% | 50.00% | Nil | - | |
| | Stroke - Directly Admitted to Stroke Unit <4 Hours | | 60% | 49.35% | 64.29% | 72.86% | 50.00% | 51.95% | 62.16% | 59.68% | 42.65% | 54.84% | 58.44% | 74.19% | 64.15% | - | |
| | Stroke - Seen by Stroke Consultant within 14 Hours | | 90% | 70.00% | 80.82% | 74.07% | 76.12% | 84.34% | 81.58% | 73.53% | 90.28% | 80.60% | 80.00% | 79.41% | 94.34% | - | |
| | MRSA | 0 | 0 | 0 | 0 | 0 | 1 | 0 | 1 | 1 | 1 | 0 | 0 | 0 | 0 | 0 | |
| | E. Coli | | 4 | 5 | 2 | 6 | 4 | 7 | 7 | 7 | 7 | 4 | 6 | 2 | 3 | 2 | |
| | C. Difficile | | 5 | 6 | 8 | 3 | 6 | 5 | 2 | 3 | 5 | 4 | 4 | 1 | 4 | 3 | |
| | MSSA | | 2 | 1 | 5 | 3 | 5 | 2 | 3 | 1 | 1 | 2 | 3 | 1 | 2 | 1 | |
| Quality Caring & Experience | PALS - Count of concerns | | | 93 | 126 | 118 | 81 | 119 | 104 | 90 | 107 | 108 | 104 | 45 | 105 | 49 | |
| | Complaints - % Overall Response Compliance | | 90% | 71.00% | 89.00% | 91.00% | 92.00% | 87.00% | 90.00% | 81.00% | 82.61% | 88.57% | 88.89% | 88.46% | 100% | 98.30% | |
| | Complaints - Overdue | | | 20 | 9 | 1 | 4 | 1 | 2 | 3 | 0 | 2 | 0 | 2 | 1 | 0 | |
| | Complaints - Written complaints | | | 52 | 55 | 51 | 53 | 47 | 41 | 36 | 57 | 51 | 26 | 24 | 27 | 40 | |
| Well Led | Agency Expenditure ('000s) | | | 1305 | 1179 | 1329 | 968 | 836 | 990 | 868 | 1081 | 869 | 1112 | 613 | 386 | 364 | |
| | Month End Vacancy Factor | | | 10.79% | 11.55% | 11.58% | 9.39% | 8.75% | 8.77% | 9.21% | 8.80% | 7.56% | 6.76% | 4.91% | 4.93% | 5.39% | |
| | Turnover (Rolling 12 Months) | | 14.00% | 15.47% | 15.10% | 14.82% | 14.75% | 14.46% | 14.44% | 14.47% | 14.08% | 13.68% | 13.25% | 12.80% | 12.50% | 12.30% | |
| | Sickness Absence (Rolling 12 month -In arrears) | | 4,4% | 4.30% | 4.31% | 4.35% | 4.36% | 4.38% | 4.43% | 4.44% | 4.45% | 4.46% | 4.46% | 4.53% | 4.56% | - | |
| | Trust Mandatory Training Compliance | | | 90.00% | 88.30% | 90.01% | 88.95% | 88.89% | 88.80% | 88.97% | 87.99% | 87.95% | 87.95% | 87.42% | 87.23% | 87.07% | |

# EXECUTIVE SUMMARY
# June 2020

**Urgent Care**

The Trust achieved the four-hour performance trajectory of 82.38% with performance of 94.74% and reported nil 12-hour trolley breaches for the third month in a row. ED attendances stabilised in June, remaining below pre-COVID-19 levels (-16.23%). The reduced attendance level continues to favourably impact four-hour performance. Nationally, Trust performance maintained the ranking of 1st out of 10 Adult Major Trauma Centres and ranks 22nd out of 114 reported positions for Type 1, four hour performance.

**Elective Care and Diagnostics**

The Trust has reported a continued reduction in overall wait list size in June due to a reduced level of referrals, resulting from the COVID-19 pandemic. There were 454 patients waiting greater than 52 weeks for their treatment in June against a trajectory of 29. The continued increase in breaches is due predominately to cancelled operations as part of the initial COVID-19 response and the impact of the application of the Royal College of Surgeons Clinical Prioritisation guidance. Diagnostic performance improved to 46.56% in June resulting from a further increase in activity as part of the second phase of the COVID-19 response. A high level review is completed by modality for all patients waiting over 13 weeks for their diagnostic test to ensure no harm has come to the patient as a result of the extended wait times. Despite the significant impact the pandemic has had on planned care performance, nationally the Trust positioning has improved for Diagnostic six week performance, proportion of 13 week waits (Diagnostics) and RTT 18 week performance.

**Cancer wait time standards**

The TWW standard improved significantly to 93.17% in May (achieving the 93% target), positively impacted by the roll out of virtual clinics. The Trust did not achieve the trajectory for treatment within 31 days of diagnosis. The standard was adversely impacted by an activity reduction, with patients being triaged for treatment as part of safety netting. The 62 day waiting time standard deteriorated in May resulting from a reduction in treatments due to the implementation of Infection Prevention Control measures lengthening the pathway. Any delays to treatment have been in line with national guidance to ensure safety for patients and staff.

**Quality**

There has been a significant increase in complaints regarding Access to Services in June-20. These complaints are predominately a result of cancelled operations and delays to appointments. The Trust is currently focussed on minimising COVID-19 transmission and supporting new design of the hospital for restoration. Full investigations are being carried out for any probable or definite hospital acquired infections. The Trust is at lower levels than trajectory for C-Difficile, MSSA and eColi, with no MRSA cases for the year to date.

**Workforce**

Staff turnover continues to improve in 2020/21 with May's position at 12.30%, compared to 12.50% last month and 15.60% at the same time last year. Vacancy factor is reported as 5.4% in June compared with 10.8% at the same time last year, The vacancy factor has increased in June as the impact of staff employed through the pandemic period (aspirant nurses and future F1s) has been removed. Temporary staffing demand increased by 20% in June predominantly in registered and unregistered nursing due to RMN use, enhanced care needs and increased occupancy.

**Finance**

NHSI/E has suspended the usual operational planning process and financial framework due to COVID-19 response preparations. The revised financial framework will now apply until the end of August (and potentially the end of September), an update on the funding process for quarters 3 and 4 is due imminently. The position for the end of June shows the Trust meeting the NHSI/E calculated income level and achieving a breakeven position.

# RESPONSIVENESS
## SRO: Chief Operating Officer
## Overview

**Urgent Care**

The Trust achieved the four-hour performance trajectory of 82.38% with performance of 94.74% and reported nil 12-hour trolley breaches for the third month in a row. Nationally, Trust performance maintained the ranking of 1st out of 10 Adult Major Trauma Centres and ranks 22nd out of 114 reported positions for Type 1, four-hour performance.

Bed occupancy averaged at 75.59% with reduced variation in June, resulting from the overall stabilisation of attendances and resulting admissions. A reduced level of walk-in attendances and bed occupancy has favourably impacted four-hour performance in month. However, ambulance attendances are back to pre-COVID-19 levels, which has resulted in a slight performance deterioration from May. Lower levels of DToC patients (4.23% vs. 3.5% target) continued in June, however would have released 5 additional beds to the Trust had the 3.5% target been achieved. Stranded patient levels increased slightly, caused by a lengthening in the pathway due to a requirement for a negative COVID-19 test result before discharge to a care setting. The impact is being partially mitigated by a reduction in test turnaround times.

**Planned Care**

**Referral to Treatment (RTT) –** The Trust has not achieved the pre-COVID-19 RTT trajectory of 83.68%, with a performance of 58.20%. The total RTT wait list size in month has declined further resulting from a reduced level of referrals due to the COVID-19 pandemic. The number of patients exceeding 52 week waits in June was 454 against a trajectory of 29; the majority of breaches (282; 62.11%) being in Trauma and Orthopaedics. Reduced elective activity as a result of the initial COVID-19 response and the application of the Royal College of Surgeons Clinical Prioritisation guidance, leading to some of the longest waiting patients having further extended waits has been a significant factor in the deterioration in the 52 week wait position and the 18 week RTT performance.

**Diagnostic Waiting Times –** Trust performance for diagnostic waiting times improved in June as a result of increased elective activity as part of the second phase of the NHS Response to COVID-19. As of June, 46.56% of patients have waited more than 6 weeks for a diagnostic test compared to a pre-COVID-19 trajectory of 1.19%. Nationally, the Trust position continued to improve moving into the upper third quartile. The Trust had been on track to deliver significantly improved performance following a period of increased capacity in CT and Endoscopy up until early March. The Trust is reviewing the harm review process for patients waiting greater than 13 weeks for their diagnostic test in light of the increasing volumes of patients with extended wait times. High level reviews are mandated by the Trust at modality level for all patients waiting over 13 weeks.

**Cancer**

The Trust achieved three of the seven Cancer Wait Times standards in May and achieved trajectory for four of the standards. Achievement of the TWW and TWW Breast Symptoms standards was a result of the successful roll out of virtual clinics which improved patient confidence in attending appointments. As expected, the 31 Day standard deteriorated in May. The operational effect of COVID-19 saw patients being triaged for treatment as part of safety netting. This was in line with the national prioritisation framework. The deterioration in the 62 Day standard is reflective of the introduction of the pre-surgery 14 day shielding requirement that has lengthened the pathway.

**Areas of Concern**

The main risks identified to the delivery of national Responsiveness standards are as follows:

- Lack of community capacity and/or pathway delays fail to support bed occupancy requirements as per the Trust's response to the COVID-19 pandemic.
- The ongoing impact of COVID-19 Infection Prevention and Control guidance and Clinical Prioritisation guidance on the Trust's capacity and productivity and therefore, ability to deliver national wait times standards.

# QUALITY PATIENT SAFETY AND EFFECTIVENESS
# SRO: Medical Director and Director of Nursing & Quality
# Overview

## Improvements

**Infection control** – Current effort is focussed on minimising COVID-19 transmission and supporting new design of the hospital for restoration. Quality and Risk Management Committee (QRMC) has reviewed the board level assurance of infection control practice and this was also positively discussed in a one hour call with the CQC (as part of their routine reviews with all providers) on 21st July.

The Trust is at lower levels than trajectory for C-Difficile, MSSA and eColi, with no MRSA cases for the year to date.

**COVID-19 pathways:** The hospital restoration programme is near completion with COVID-19 and non COVID-19 pathways in place.

**Mortality Reviews (COVID pandemic)** –The results of the 'pandemic mortality review' on a random selection of 30 cases between 20th March and 20th April were reported to the July QRMC meeting. Overall care delivery in each case was evaluated as being 'Adequate' or better. The review did generate some important learning and recommendations, which will be overseen by the Clinical Effectiveness and Audit Committee

**Pressure Injuries –** There has been a continued reduction in the overall incidence of pressure injuries in June, with no device related pressure injuries for the first time in 15 months.

## Areas of Concern

**Caesarean Section rate:** During June the service has seen an increase in caesarean section rates.

# WELL LED
# SRO: Director of People and Transformation and Medical Director
# Overview

**Corporate Objective 4: Build effective teams empowered to lead**

**Expand leadership development programme for staff**

The Trust's leadership and management development programmes has now restarted, with new methods of delivery designed and implemented to ensure the safety of staff through social distancing.

**Prioritise the wellbeing of our staff**

Sickness rose in May to 4.6% with the impact of COVID-19 related sickness with COVID-19 being the 3rd greatest sickness absence reason by time list in April and May. Psychological support to all staff increased during pandemic period from 2 WTE to approx. 10 WTE by seconding clinical psychologists whose patient caseload had dropped due to reduction in normal activity. Pulse surveys rated question: "I feel cared for by the Trust, in terms of my health and wellbeing" during pandemic period averaged 3.4 out of 5. A new full time clinical psychologist started in July to provide bespoke support to Consultants who were identified as not accessing traditional wellbeing support.

**Continue to reduce reliance on agency and temporary staffing**

Demand for temporary staff increased by ~20% in June compared wit May with bank, agency and unfilled shifts all increasing. This is still 36% lower than the same period in 19/20 due to reduced activity and occupancy. The predominant increase was in registered nursing and midwifery for both bank and agency (largest growth for reason 'Vacancy') with largest increase in agency in critical care and theatres anaesthetics nursing, and; in unregistered nursing and midwifery for bank (largest growth for reason 'Enhanced Care') and largest increases in NMSK and gastroenterology.

**Vacancies**

The Trust vacancy factor was 5.4% in June compared with 10.8% at this time last year, this excludes additional staff employed during the pandemic on COVID-19 budgets. The position for April and May has also now been updated showing a position of 4.9% in both months. The small increase in June equates to a 33 wte increase predominantly in Administrative and Clerical staff , Medical and Dental and Pharmacy. It should be noted that ahead of finalised budgets the vacancy position is not yet stable.

**Turnover**

The Trust turnover continues to improve with June's position at 12.3% compared to 12.5% last month and 15.6% at the same time last year. Recruitment and Turnover is now a workforce planning programme within the NBT Transformation Programme with an ongoing organisation wide focus on retention to continue the Trust significant improvement.

# FINANCE
# SRO: Director of Finance
# Overview

On 17 March 2020, the Trust received a letter from Simon Stevens and Amanda Pritchard which suspended the operational planning process for 2020/21 and gave details of an alternative financial framework that covers from April 2020 to July 2020.

During this four month period, instead of being monitored in terms of delivering an agreed financial trajectory, the Trust; excluding any impacts of COVID-19, is being given income in line with historical expenditure adjusted for inflation and is required to manage its spend in line with this to effectively breakeven.

In addition, the Trust is able to recover any reasonable costs incurred responding to the COVID-19 pandemic while this is in line with national guidance and is approved by the regional team during their assurance work on the Trust after submission of month end returns.

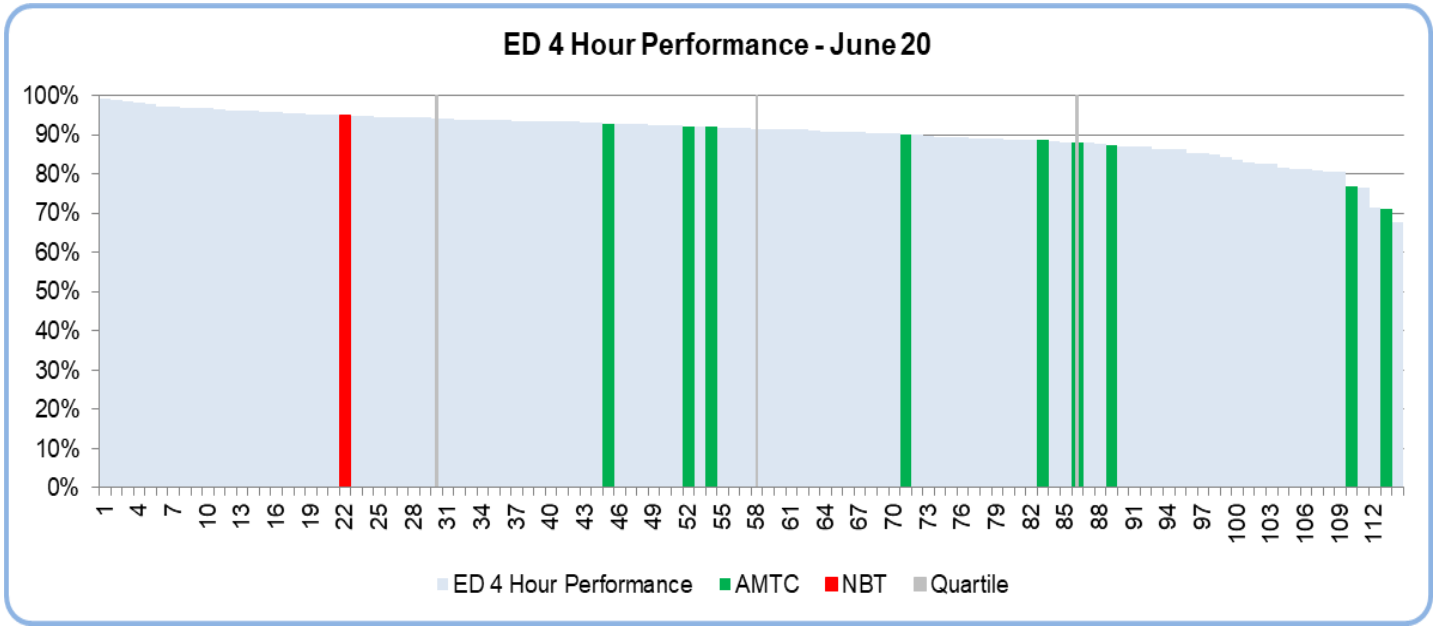
The revised financial framework will now apply until the end of August (and potentially the end of September), an update on the funding process for quarters 3 and 4 is due imminently.

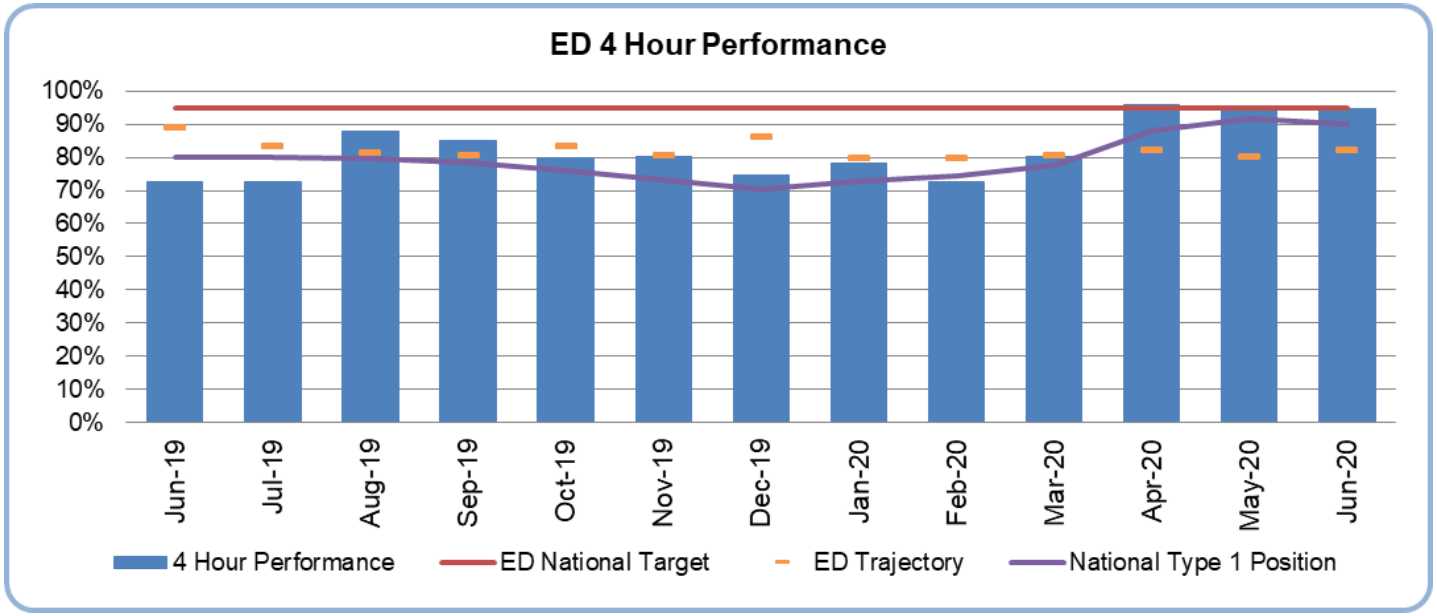
The new framework requires the Trust to breakeven against an NHSI/E calculated income level and to recover any additional costs incurred in dealing with the COVID-19 pandemic (net of any savings from reduced or cancelled elective activity) in line with national guidance.  The position for the end of June shows the Trust meeting this requirement and achieving a breakeven position.

NHS North Bristol NHS Trust

# RESPONSIVENESS

## Board Sponsor: Chief Operating Officer
## Evelyn Barker




## Urgent Care

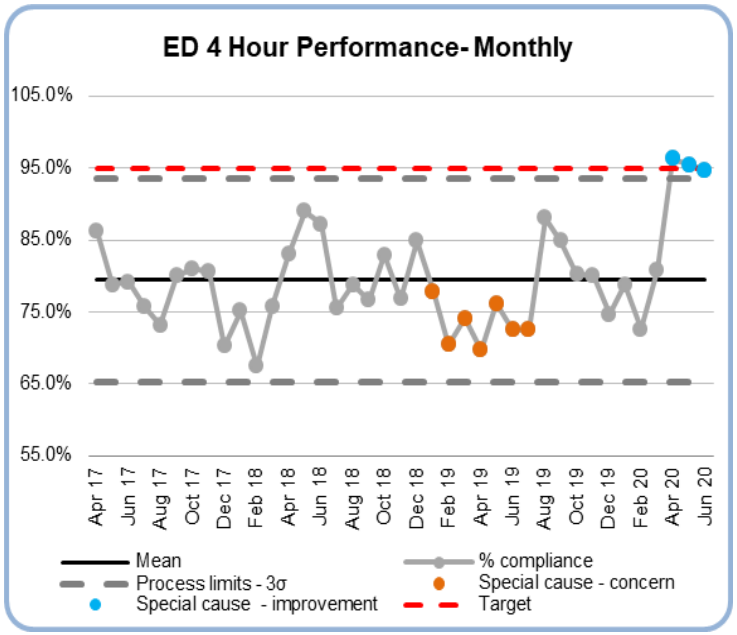
The Trust continued to exceed the four-hour performance trajectory in June and was close to achieving the national standard of 95% with performance of 94.74%. The national standard was achieved for Quarter 1 2020 with a total performance of 95.31%.

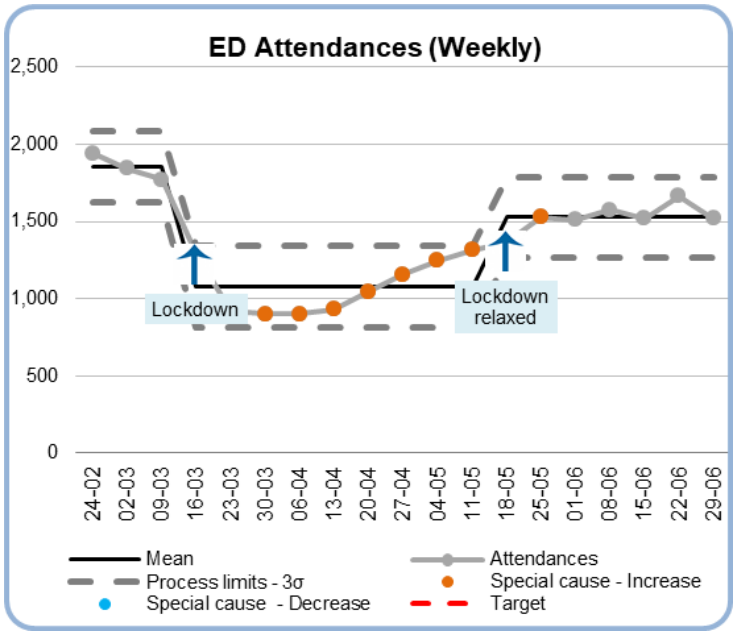
The performance position continues to be positively impacted by a 16.23% reduction in overall attendances, resulting from the COVID-19 pandemic.

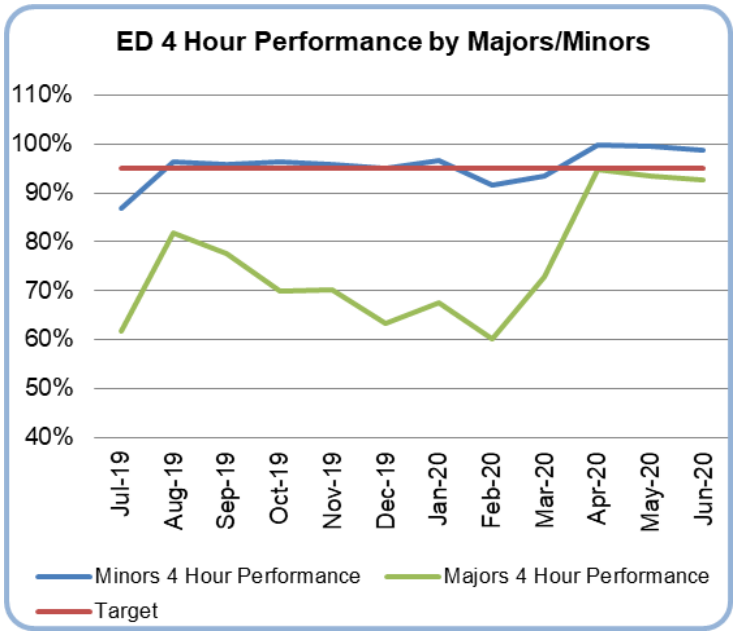
Current trajectories were set before the pandemic and will be reset for September 2020 – March 2021 to more accurately reflect the anticipated delivery for the rest of the year. The Trust continues to perform well for Type 1 performance when compared nationally.

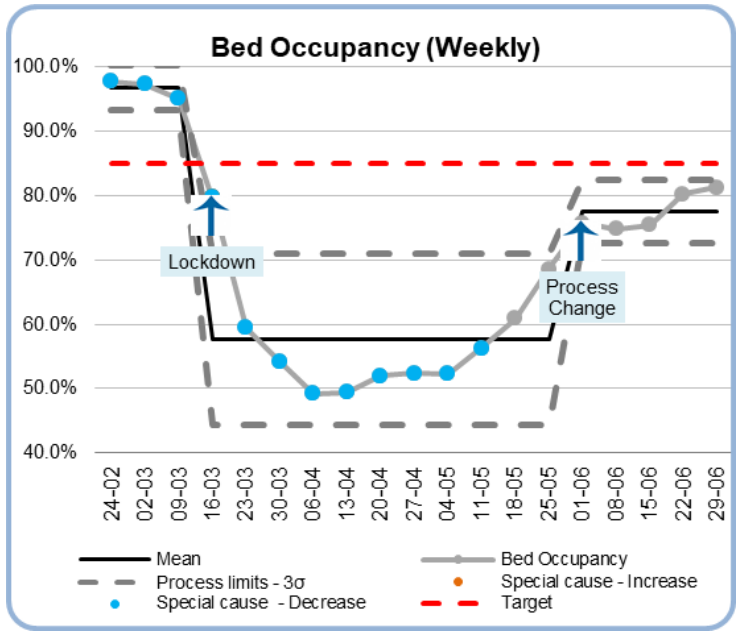
At 6725, there were 15.83% less attendances than planned as per the Phase 2 plan. Non-Elective admissions were down against plan for long-stay admissions (-13.57%) and short-stay admissions (-4.48%).

ED performance for the NBT Footprint stands at 95.95% and the total STP performance was 92.88% for June.



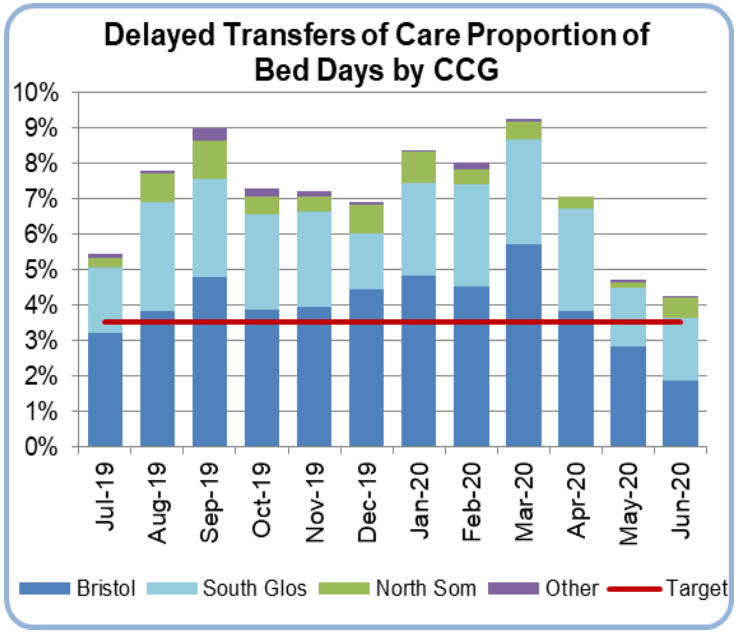



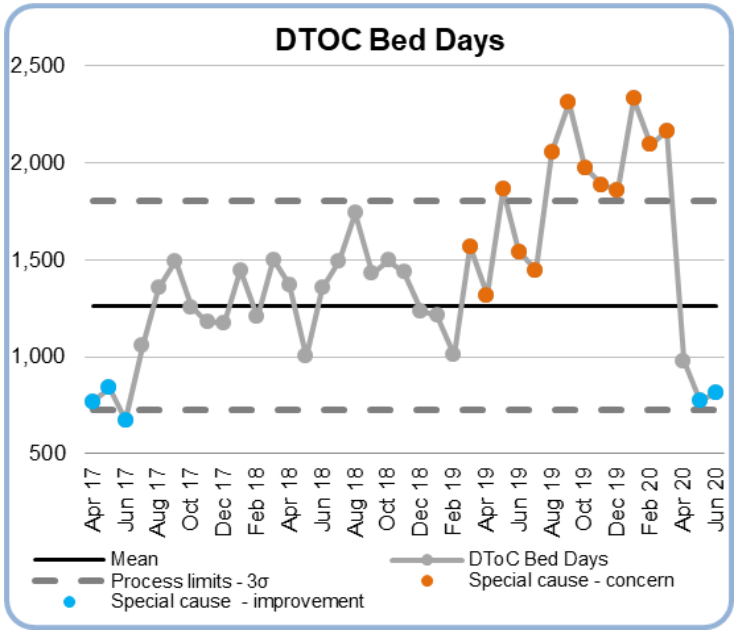

## 4 Hour Performance

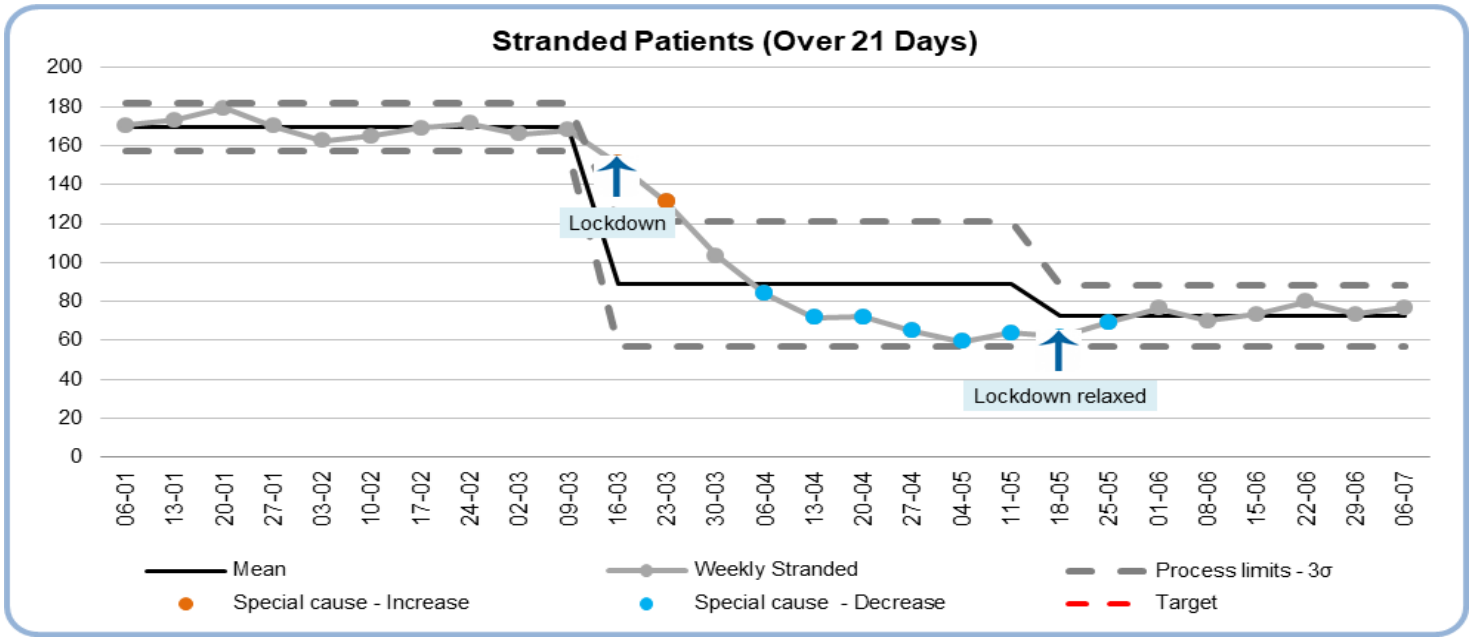
Of the breaches in ED in June, 33.33% were a result of awaiting or undergoing treatment in ED and 24.58% were a result of ED delays, primarily waits for assessments and late referrals to specialties. This represents a static position from May and a significant shift from wait for beds pre-COVID-19 (9.89%) resulting from the improved bed position.

The increasing trend in ED attendances stabilised throughout June, remaining below pre-COVID-19 levels. A reduction in walk-in attendances when compared to pre-COVID-19 levels is driving the overall decrease and is as per Phase 2 plans. Ambulance arrivals began to rise following the easing of lockdown rules on the 13 May and as of June are back to pre-COVID-19 levels.

There was less variation in bed occupancy during June 2020, impacted by the stabilisation of attendances. Bed occupancy varied between 70.59% and 86.11%, breaching 85% once in month. The method for calculating bed occupancy changed in June due to a reduction in the overall bed base resulting from the implementation of Infection Prevention Control measures. This has increased the overall bed occupancy position, but remains below pre-COVID-19 levels.



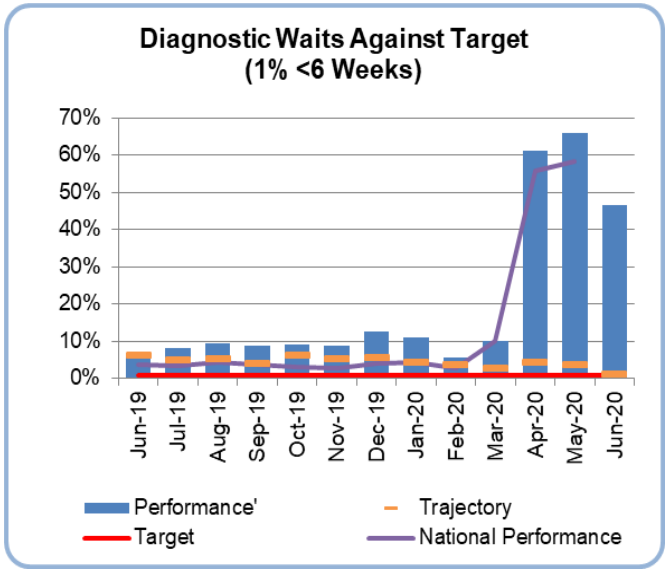

## DToCs and Stranded Patients

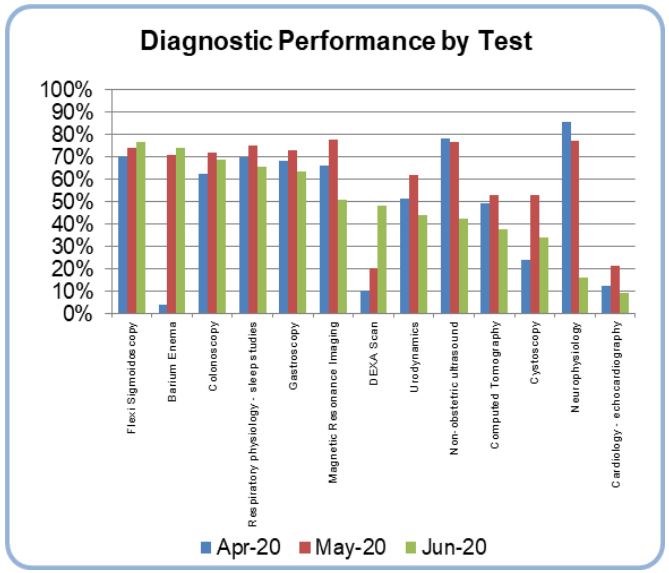
Whilst DToCs formal reporting has been ceased following the implementation of the services response to COVID-19, the review process has been maintained in NBT. The average level of DToC has reduced to 4.23%. However, the average bed days accumulated by delayed patients is 186.75 weekly equivalent to 6 beds. Had the Trust achieved the national 3.5% target 5 beds would have been released.

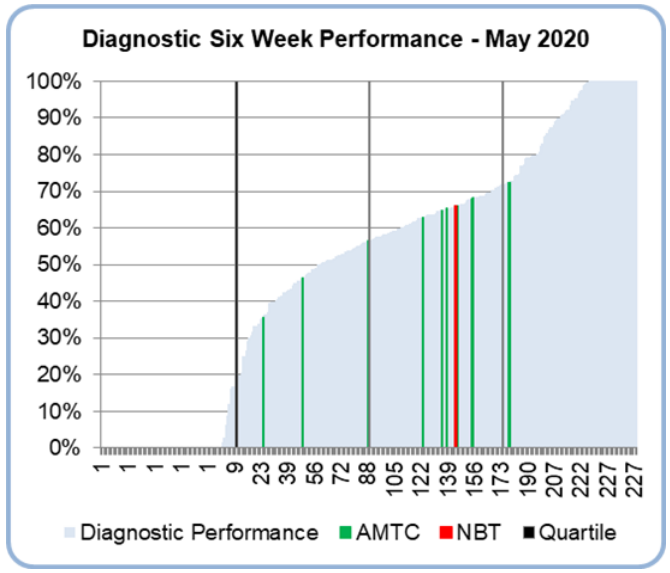
The main reasons for delay this month are linked to provision of more complex care requirements on pathway 1 that require additional capacity, access to residential dementia beds and fast track pathways.

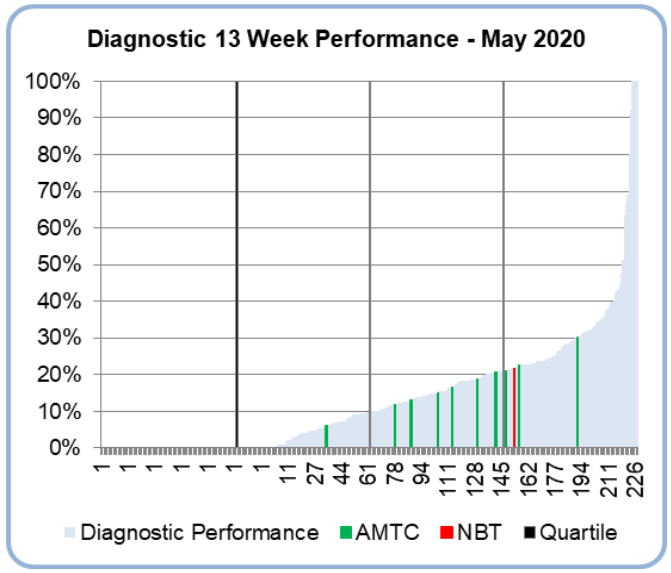
Stranded patient levels have increased and the trajectory remains on an upward trajectory. The process is under review with partners to ensure time is used to escalate both specific patients and themes that impact on the timely discharge of patients. The requirement for swabs for all patients discharged to a care setting did initially impact on length of stay, but this is being resolved as testing time reduces.

There are significant delays associated with patients who swab positively multiple times without symptoms, or those who refuse a swab for transfer.




## Diagnostic Waiting Times

Diagnostic performance has improved to 46.56% in June versus a trajectory of 1.19%. The improved position is a result of increased activity.

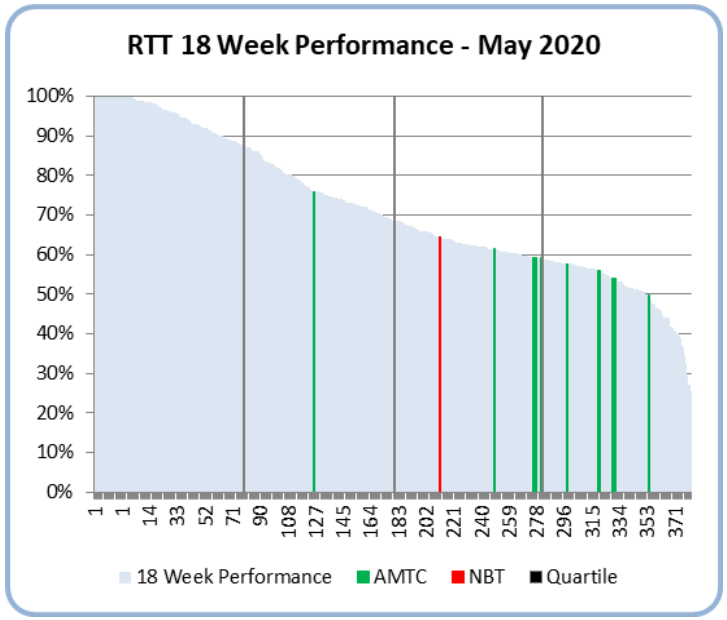
At the end of April, the Trust entered the second phase of the NHS Response to COVID-19 where providers were asked to step up non-COVID-19 urgent services and some routine, non-urgent elective care. As a result, diagnostic waiting list activity increased by a further 63.65% in June (27.68% in May).

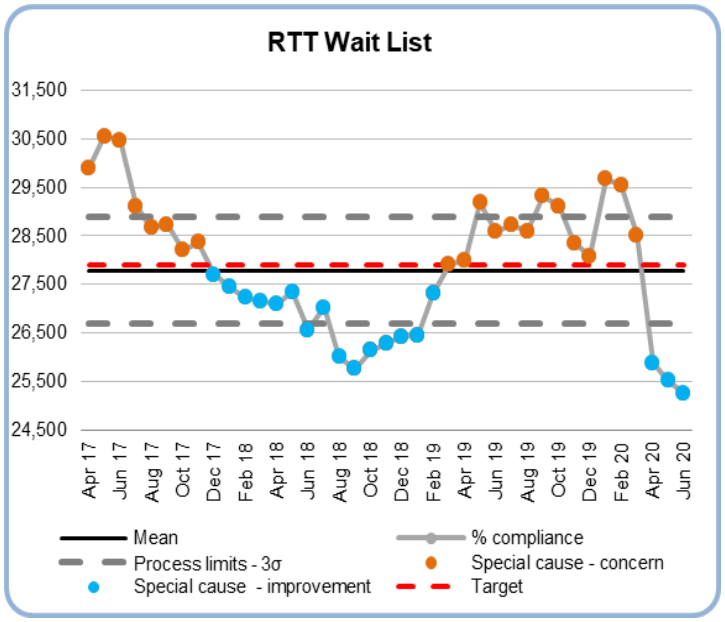
Percentage performance has been impacted by a reduction in the backlog and the overall wait list. 13+ week waits continue to increase (37.91%), resulting from capacity constraints and patient choice.

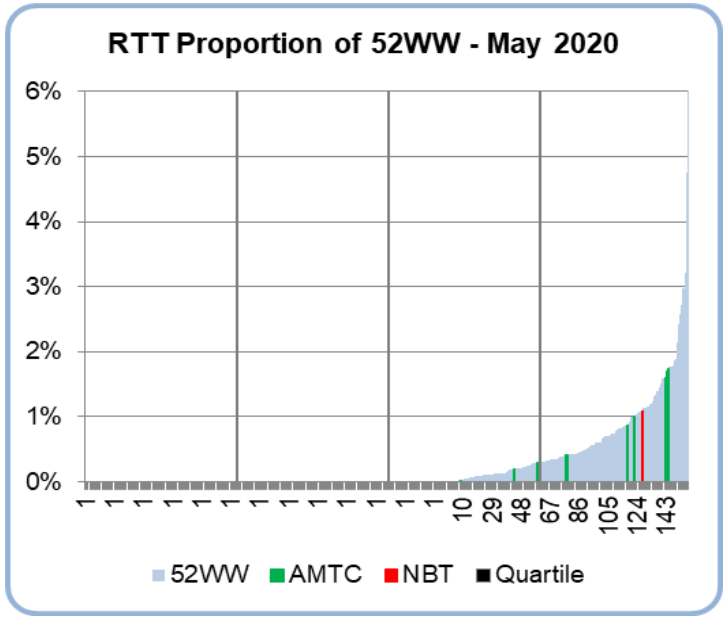
All 13 test types continue to report in month underperformance. Nationally, the Trust positioning has improved month on month throughout the pandemic for both six week and 13 week performance.

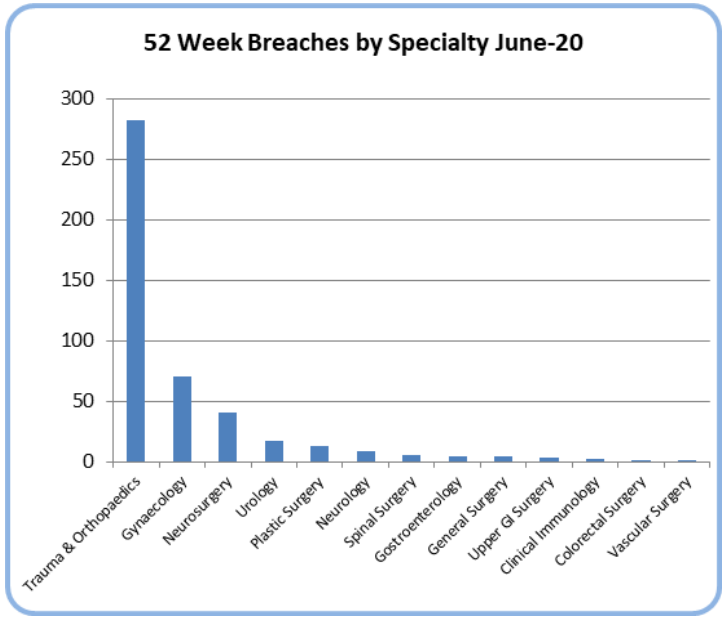
The Trust is reviewing the harm review process for patients waiting greater than 13 weeks for their diagnostic test in light of the increasing volumes of patients with extended wait times. The expectation is that high level reviews are still completed by modality type for all patients waiting over 13 weeks.

Prior to the pandemic there had been a successful bid for Elective Care funds to support delivery of the national diagnostics target. The Trust had been on track to deliver performance, following a period of increased capacity. All Endoscopy delays can now be primarily attributed to COVID-19. Additional capacity has been secured through the independent sector where patients will be seen in order of clinical urgency.




## Referral to Treatment (RTT)

The Trust has not achieved the RTT trajectory in month with performance of 58.20% against trajectory of 83.68%.

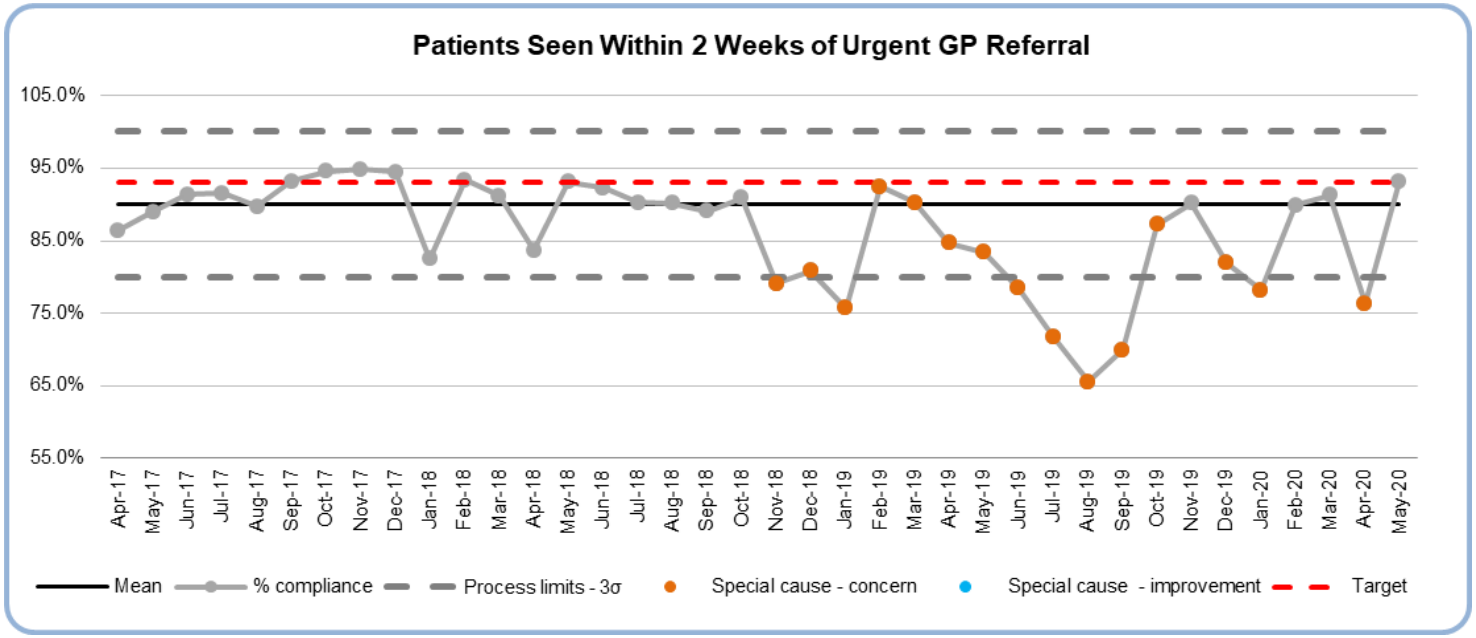
In response to COVID-19, all elective surgery was cancelled apart from 'P1' urgent/life and limb surgery from Thursday 19 March. The Trust also postponed routine outpatient appointments from the end of March until 30 June. This affected the Trust performance and backlog position. On the 13 March the Trust had been predicting performance of 81.50% and a backlog of 5050 (actual backlog was 5697).

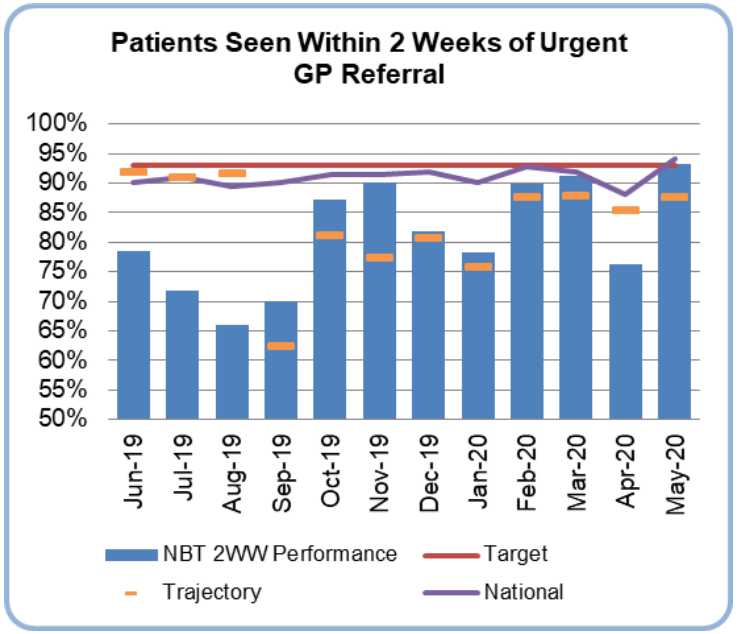
The continued reduction in wait list size has been predominantly due to an ongoing referral reduction in June as a result of COVID-19.

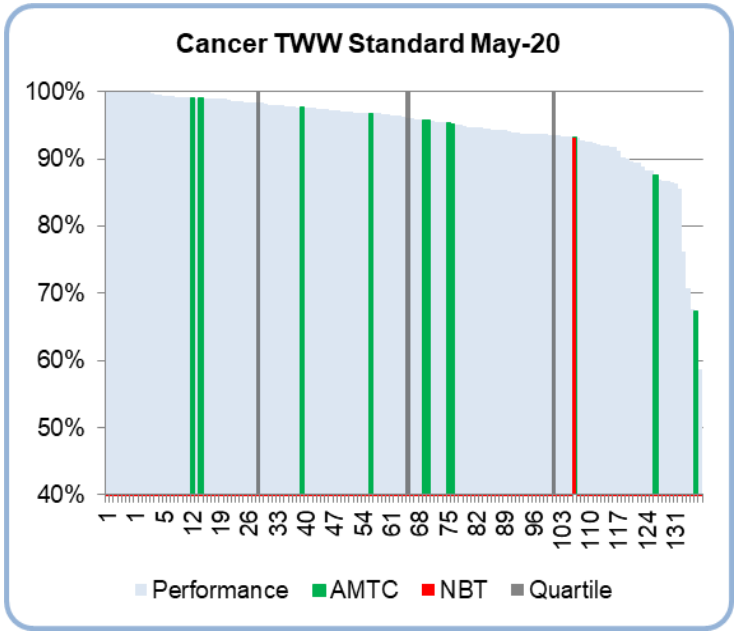
The Trust has reported 454 patients waiting more than 52 weeks from referral to treatment in June, against a pre-COVID trajectory of 29.

Remedial actions to reduce the number of breaches were hampered by winter pressures during January and February and the COVID-19 pandemic for March-June 2020. Service restoration is currently underway which will support the recovery of RTT performance going forwards.

Nationally, the Trust's 18 week performance positioning improved in May, moving from the lower third quartile to the upper third quartile. The positioning of 52WW has remained static since February 2020.




## Cancer
## Two Week Wait (TWW)

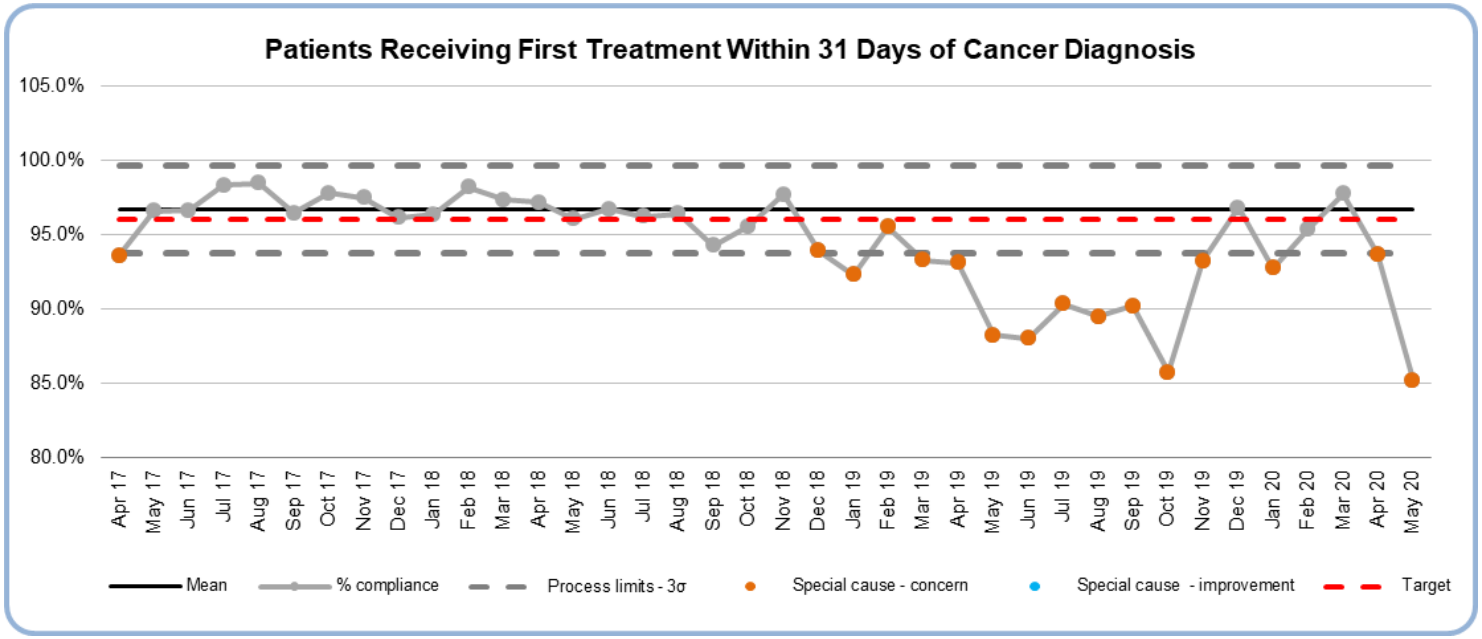
The Trust achieved both the recovery trajectory and the national standard with a performance of 93.17% for the TWW standard in May.

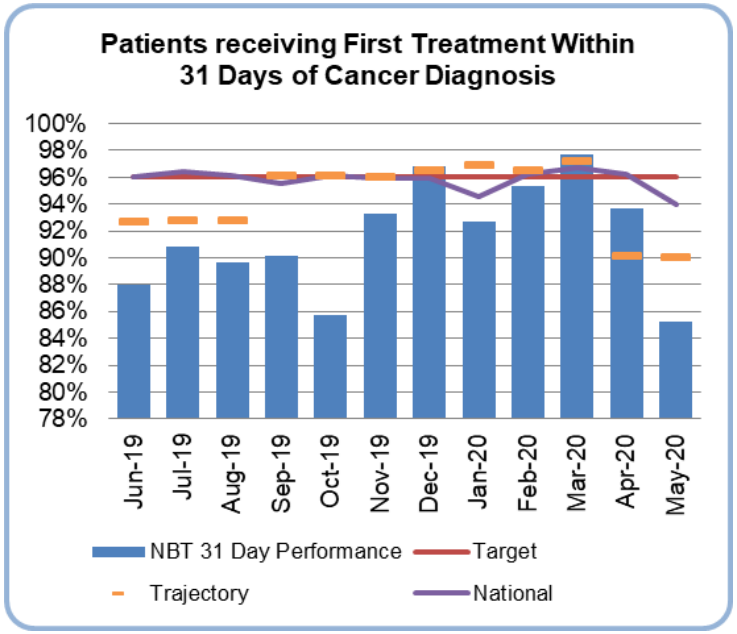
Out of the 1303 patients seen in May 89 breached, 58 (65.17%) related to Upper GI and Colorectal pathways.

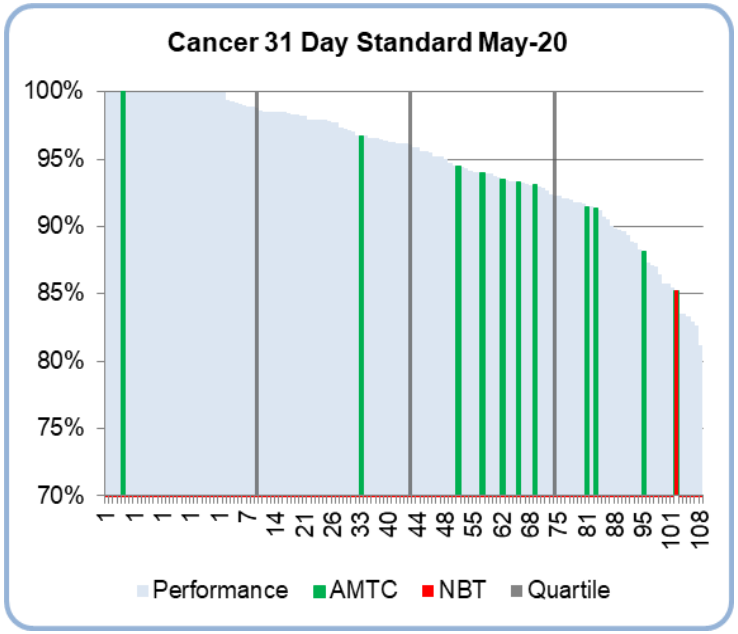
Virtual clinics were successfully delivered in May with the majority of cancer patients receiving a phone call with the clinician prior to any face to face consultation or diagnostic appointment. In reviewing the patient breach reasons, patient confidence in attending appointments increased in May compared to April and this is reflected in the breach position with 52 patient choice breaches in April and only 22 in May.

The Trust experienced a 34.78% drop in TWW referrals in May compared to May 2019 across all specialties as a result of COVID-19.

All patients who declined initial referral, face-to-face consultation or diagnostic test have been contacted as part of the safety netting procedures put in place during the pandemic.




## Cancer
## 31-Day Standard

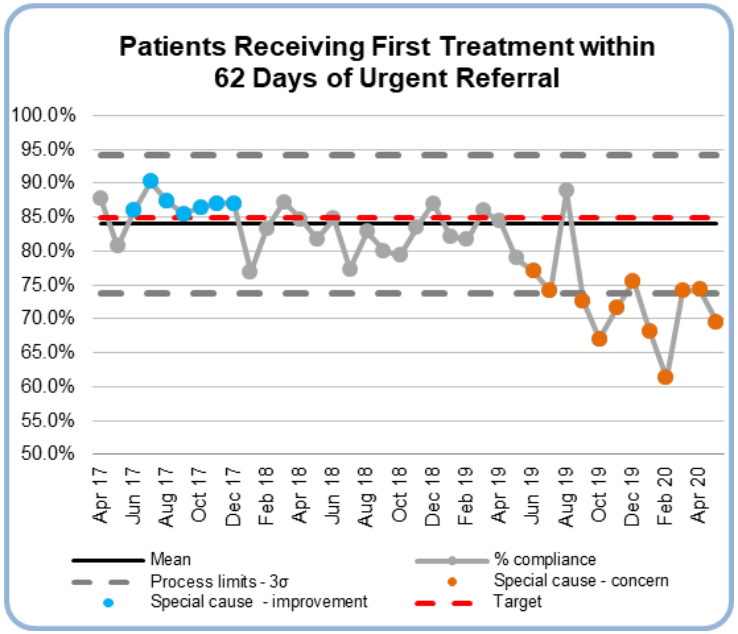
The Trust did not achieve the 31 day first treatment national standard of 96% with performance of 85.23% and failed Trajectory of 90.00%.

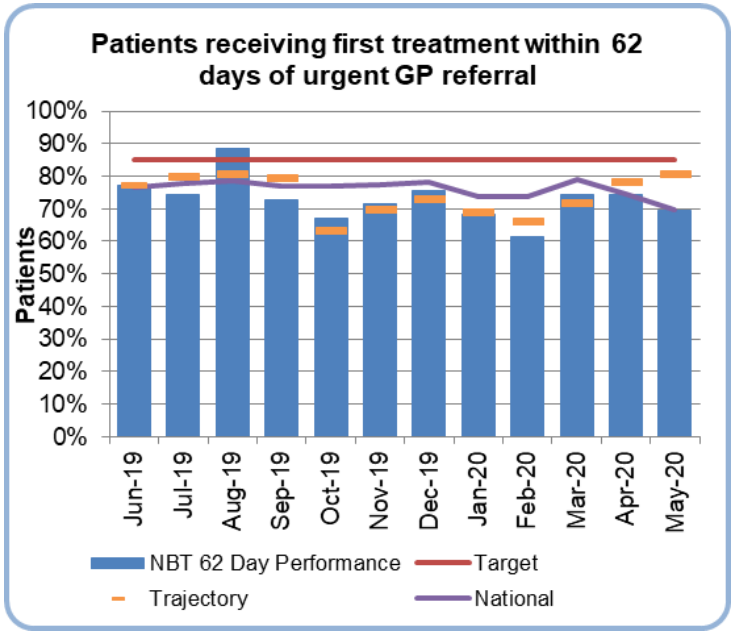
We were able to treat 176 patients in total, 26 of which breached the 96% target. The operational effect of COVID-19 saw patients being clinically triaged and remains on clinical review with the surgical team for treatment as part of safety netting. This was in line with the national prioritisation framework.

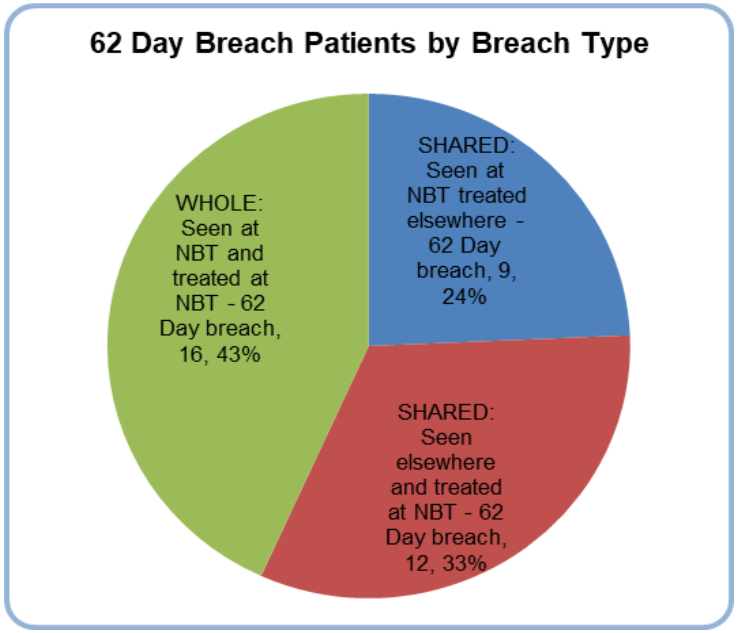
The Trust achieved the 31 day subsequent surgery treatment trajectory, but failed the standard. Skin passed subsequent surgery with a 100% achievement due to temporarily pausing the Sentinal-Node Biopsy (SNB) service in May. Wide local excisions continued.

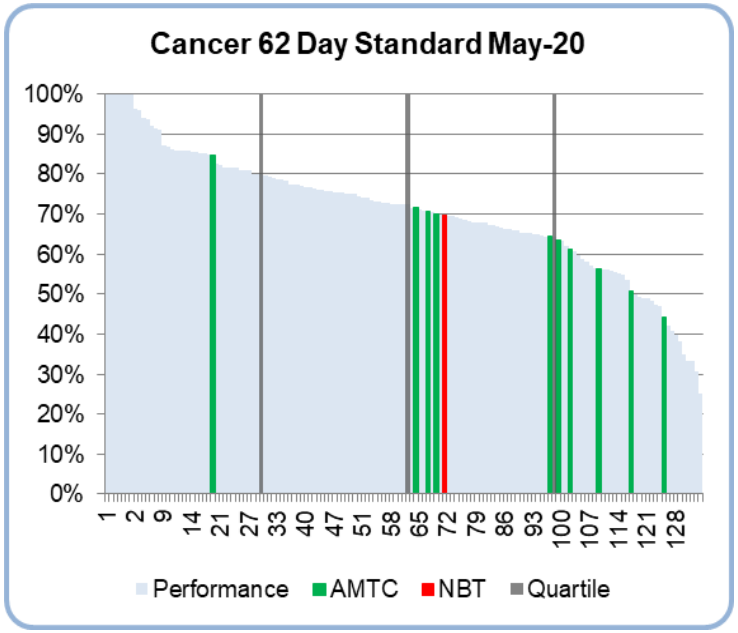
There were 14 104 day breaches in May; 10 within Urology (5 did not require harm reviews due to active surveillance or treated elsewhere); 3 in Colorectal (all requiring harm reviews) and one in Gynaecology (does not require a harm review as treated elsewhere).

Out of the 8 Datix reviews 6 were related to COVID-19 impact delays on the diagnostic and treatment pathways. These have yet to be clinically reviewed.




## Cancer
## 62-Day Standard

The Trust did not achieve the 62 day trajectory in May 2020, reporting a position of 69.52% against a trajectory of 80.92%.

The Trust treated 101 patients in May. This was lower than the number treated in March and April.

In May Urology, Breast and Colorectal continued to provide treatment via the Independent Sector. Overall treatment numbers are lower this month due to the introduction of the pre-surgery 14 day shielding requirement that lengthened the pathway. For example in May Urology treated 33 patients compared to 49 in April.

There were 26 breaches of which 17 were in Urology. The majority were caused by delays in the diagnostic pathway.

43% of the breaches were NBT delays, 33% were shared with referring organisations and 24% were NBT patients treated elsewhere.

NB: The breach types and breach **reasons** come from the internal reporting system and therefore, may not exactly match the overall numbers reported nationally.

NHS North Bristol NHS Trust

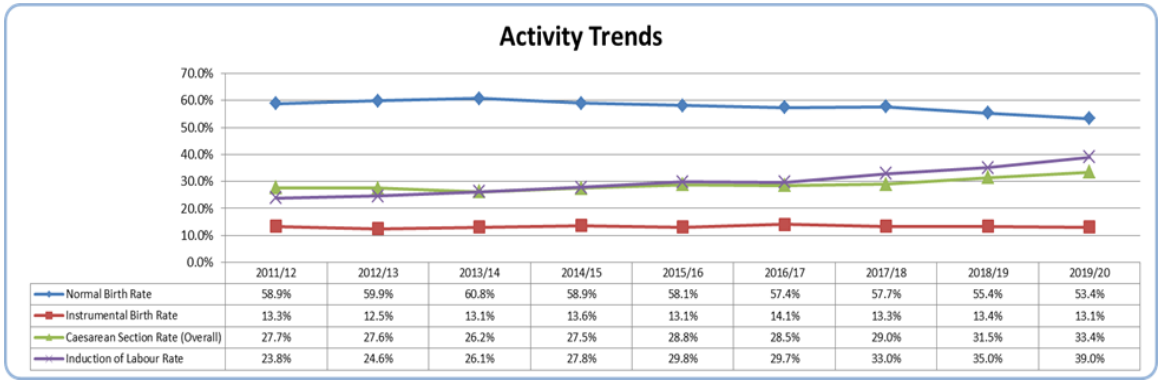
# Safety and Effectiveness

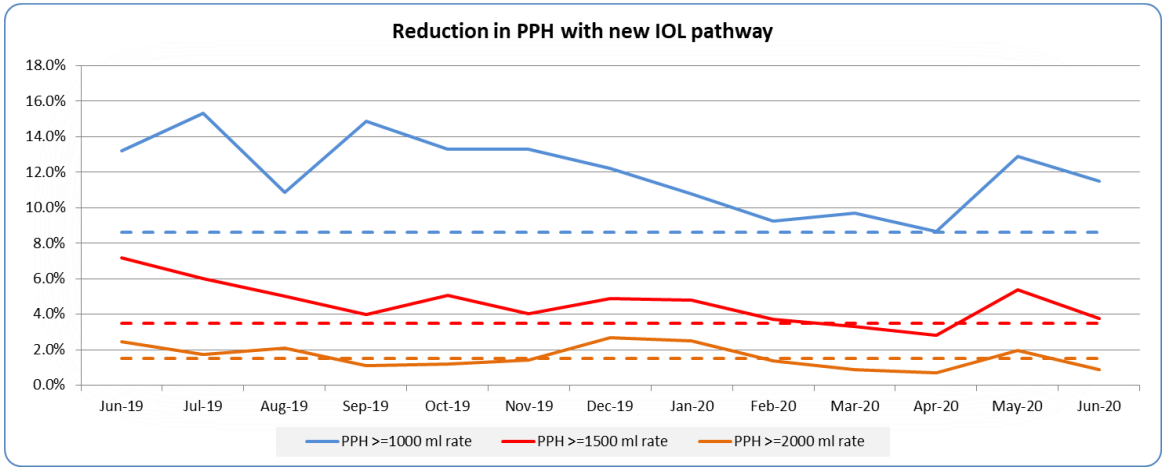
## Board Sponsors: Medical Director and Director of Nursing and Quality
## Chris Burton and Helen Blanchard

## NBT Maternity Dashboard

| | Target | Jun-19 | Jul-19 | Aug-19 | Sep-19 | Oct-19 | Nov-19 | Dec-19 | Jan-20 | Feb-20 | Mar-20 | Apr-20 | May-20 | Jun-20 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Caesarean section rate (overall) | 28.0% | 30.4% | 31.6% | 34.0% | 32.3% | 32.8% | 35.3% | 33.9% | 38.3% | 34.0% | 33.4% | 31.5% | 33.9% | 36.7% |
| Elective CS rate (as % of all birth episodes) | | 9.2% | 15.6% | 14.0% | 14.3% | 16.6% | 19.2% | 13.7% | 16.5% | 14.4% | 15.6% | 12.0% | 14.0% | 15.4% |
| Emergency CS rate (as % of all birth episodes) | | 21.2% | 16.0% | 19.9% | 18.0% | 16.2% | 16.1% | 20.2% | 21.8% | 19.7% | 17.8% | 19.5% | 19.9% | 21.3% |
| Induction of labour rate | 32.1% | 43.0% | 36.5% | 38.2% | 36.5% | 38.5% | 35.3% | 40.2% | 41.5% | 41.4% | 40.8% | 40.6% | 38.9% | 34.9% |
| PPH >=1000 ml rate | 8.6% | 13.2% | 15.3% | 10.9% | 14.9% | 13.3% | 13.3% | 12.2% | 10.8% | 9.2% | 9.7% | 8.7% | 12.9% | 11.5% |
| PPH >=1500 ml rate | 3.5% | 7.2% | 6.0% | 5.0% | 4.0% | 5.0% | 4.0% | 4.9% | 4.8% | 3.7% | 3.3% | 2.8% | 5.4% | 3.8% |
| PPH >=2000 ml rate | 1.5% | 2.5% | 1.7% | 2.1% | 1.1% | 1.2% | 1.4% | 2.7% | 2.5% | 1.4% | 0.9% | 0.7% | 1.9% | 0.9% |
| 5 minute apgar <7 rate at term | 0.9% | 0.7% | 0.2% | 0.4% | 1.7% | 0.9% | 0.6% | 0.5% | 0.5% | 0.7% | 0.7% | 1.3% | 1.6% | 1.0% |
| Stillbirth rate | 0.4% | 0.4% | 0.2% | 0.4% | 0.7% | 0.8% | 0.2% | 0.7% | 0.2% | 0.0% | 0.4% | 0.2% | 0.0% | 0.0% |
| Stillbirth rate at term | | 0.0% | 0.0% | 0.0% | 0.5% | 0.2% | 0.0% | 0.0% | 0.0% | 0.0% | 0.0% | 0.3% | 0.0% | 0.0% |
| Stillbirth rate <37 weeks | | 5.3% | 2.3% | 5.4% | 2.7% | 8.3% | 3.2% | 8.3% | 2.9% | 0.0% | 4.8% | 0.0% | 0.0% | 0.0% |

**RAG is determined by a tolerance level set by the number of standard deviations away from the target a performance is.*




## COVID-19 Maternity

Capacity in CDS remains reduced related to changes required to manage Covid .The Division has been focused on patient flow and reducing any unnecessary delays in the Induction of Labour pathways.

The impact of reduced beds and neonatal cots across the system has created additional challenges for NBT but has been managed through

- Creation of extra space on Neonatal unit with 32 cots now available.
- Extra Induction of Labour beds are planned to open in July.
- Revision of escalation policy
- Direct discharge from CDS now fully implemented

Partners attendance at 1st and 2nd trimester scans was restricted during June and visiting on postnatal wards was changed in line with Trust and national guidance.

## Clinical quality outcomes

PPH rates were reduced from May in month and are being monitored.

Caesarean section rate in June increase noted at 36.7%, the division is reviewing the possible cause of this increase.

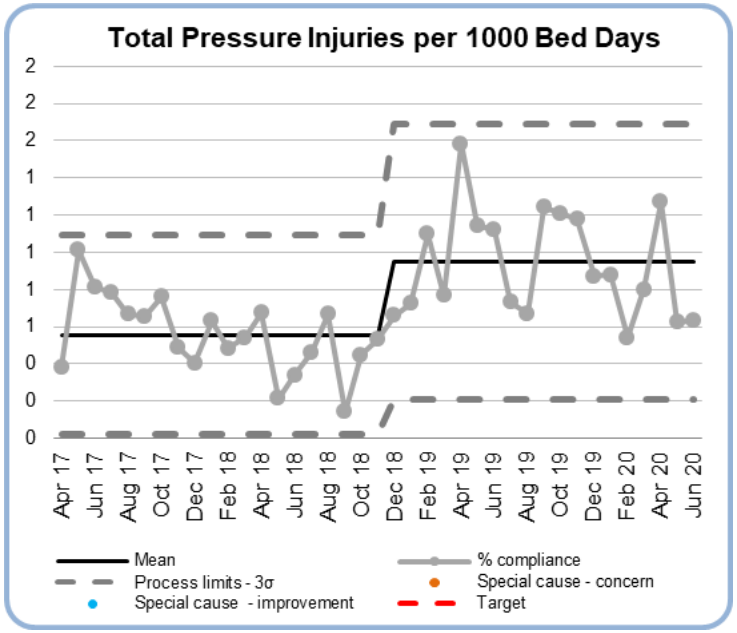
HDU care review is in progress and will incorporate the review of the theatre complex to include HDU/recovery areas.

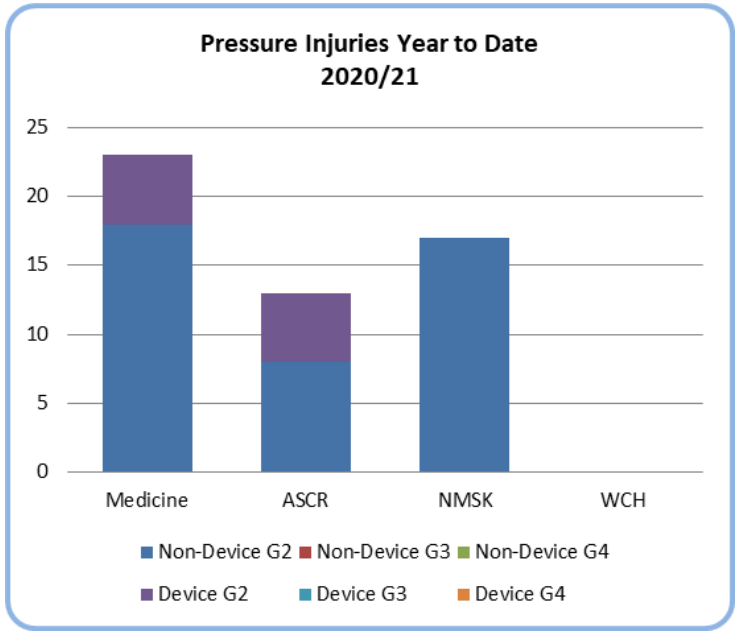
## Safe staffing

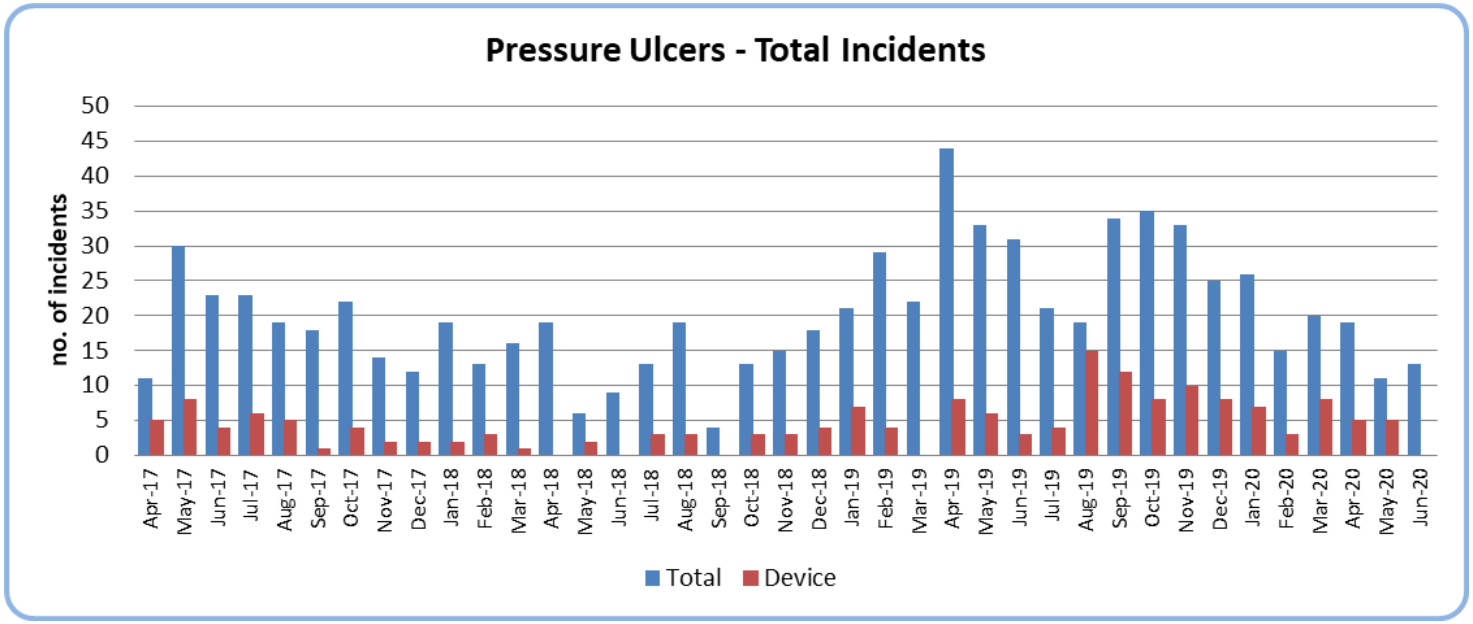
Maternity Theatre scrub nurse cover has been implemented based on a revised business plan and is being monitored by the division.

Midwifery staffing levels are being managed through daily monitoring and re-deployment whilst a revision of safe staffing (BR+) is updated in line with implementation of a new team working plan for midwifery (continuity of carer).

## QP2




**Pressure Injuries (PIs)**

The Trust ambition for 2020/21 is:

- Zero for both Grade 4 and 3 pressure injuries.
- 30% reduction of Grade 2 pressure injuries.
- 30% reduction of device related pressure injuries,

In the first quarter of the year there have been no reported Grade 3 or 4 pressure injuries.

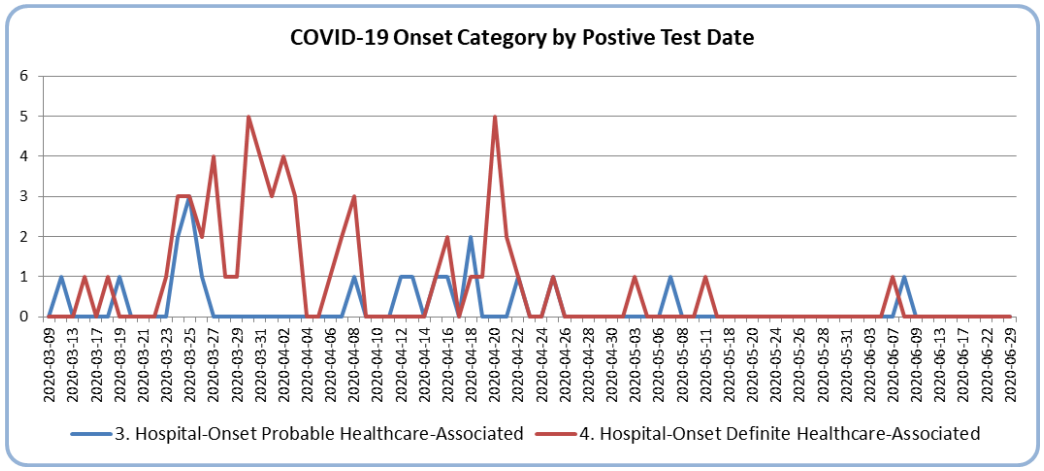
In June, 13 Grade 2 pressure injuries were reported, on 12 patients.
There have been no device related injuries this month with Heels reported as the highest incidence with the summary as follows:
Heel: 54%
Coccyx/ Sacrum: 23%
Buttock: 15%
Ankle: 8%

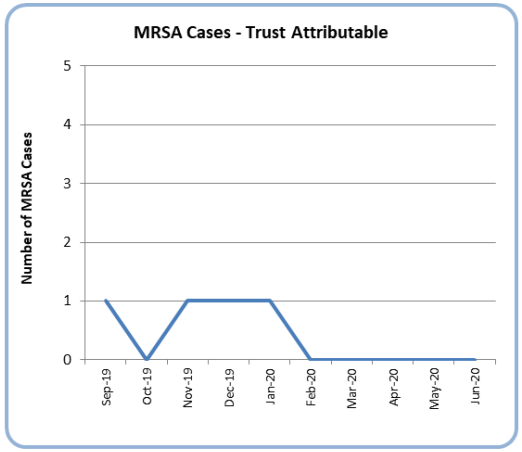
June observed a continued reduction in Grade 2 pressure injuries, this may correlate to the improved focus on pressure area care by clinical divisions who continue:

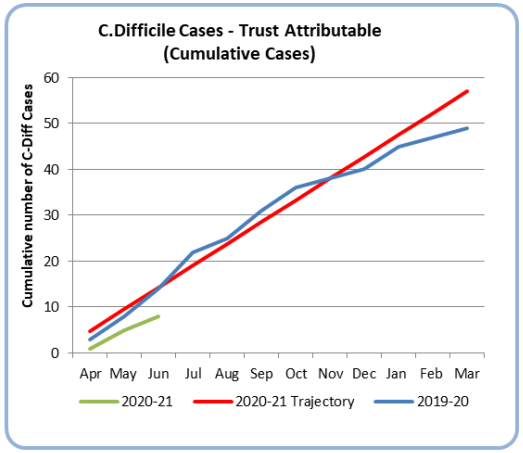
- undertaking patient facing audits with senior nurses during May/June.
- conducting peer reviews of care across the organisation.
- Trust's pressure injury incident meeting and safety huddles which have paused during COVID-19.

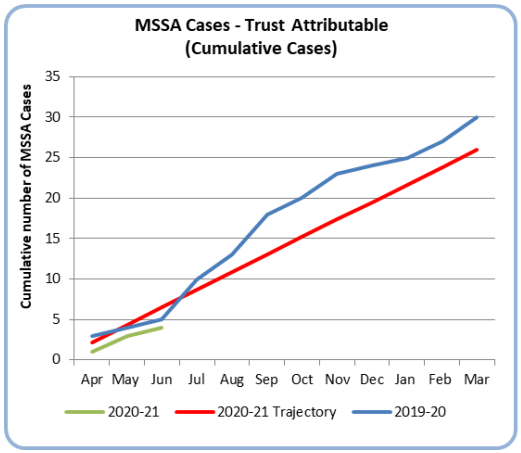
A focused thematic review is underway to review the outcomes of 2019/20 and actions around learning to facilitate this year's reduction strategy. The planned completion for this is September 2020.

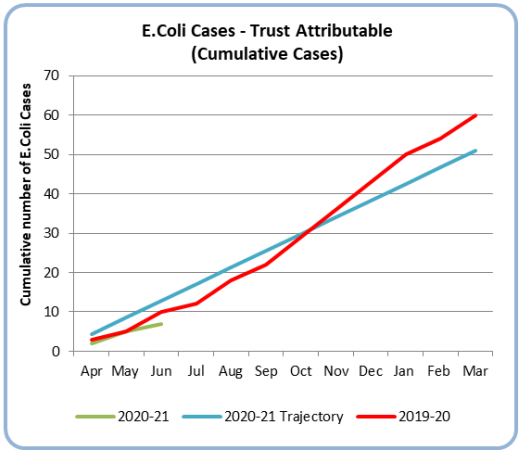
**QP4**




**COVID- 19 (Coronavirus)**

The Trusts infection control effort and resources are focussed on managing the COVID-19 epidemic and its impact on the Trust. Actions are in place to ensure compliance with national guidance as it develops. Quality and Risk Management Committee has reviewed the board level assurance of infection control practice and this was also covered in a one hour call with the CQC (as part of their routine reviews with all providers) on 21st July.

There has been national concern about the risk of transmission of COVID-19 infection in hospital. Reporting now categorises all cases of COVID-19 and whether attributable to hospital (probable or definite), as illustrated in the graph. Each case developing beyond 7 days in hospital is immediately flagged to IPC and investigated using the established IPC incident management systems.

Fluid resistant surgical masks are now being worn by all staff as required by national guidance

The hospital restoration programme is near completion with COVID-19 and non COVID-19 pathways in place. Staff testing regimes are being established as are processes for managing work contacts of staff who may test positive.

**MRSA**

There were no reported cases of MRSA bacteraemia in the first quarter of the year (April- June).

**C. Difficile**

In June, there were three Trust attributable case reported. A total of 8 cases for quarter one, which is an improved position from the same point last year.

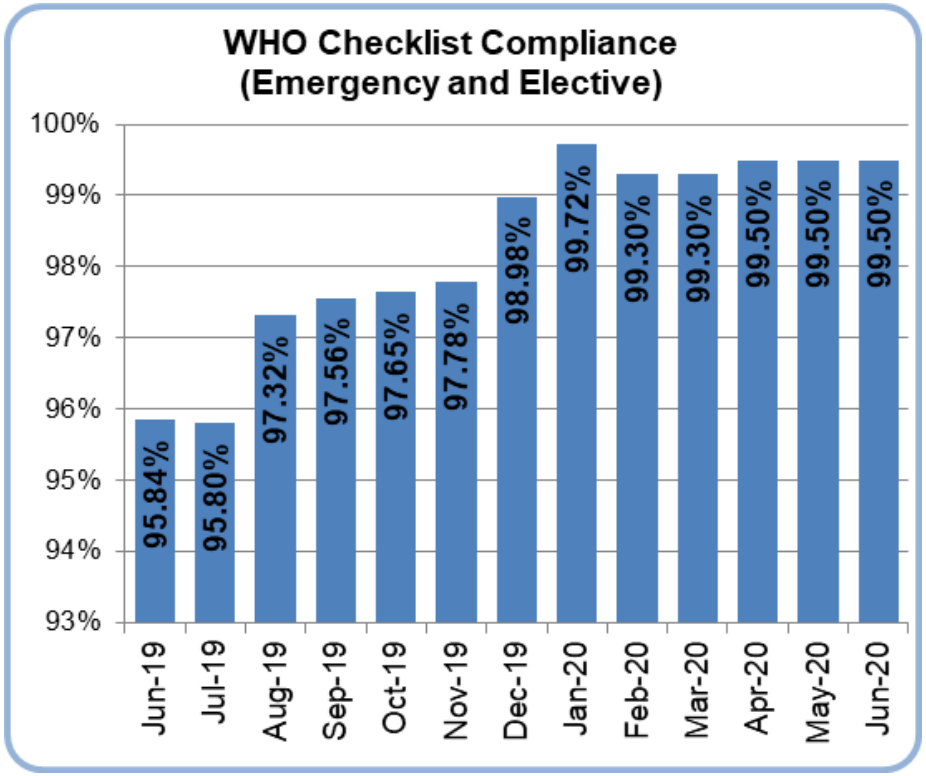
**MSSA**

There was one case of MSSA bacteraemia in June. A total of 4 cases for quarter one, which is an improved position from the same point last year

**E. Coli.**

Further community wide work to reduce these infections is planned for 2020/21.

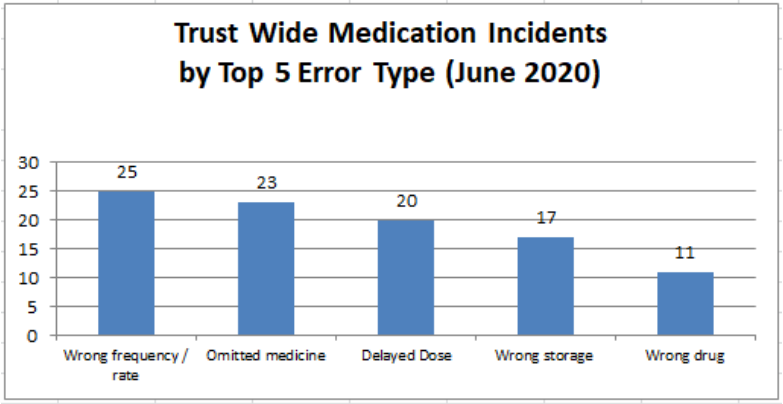
## QP2

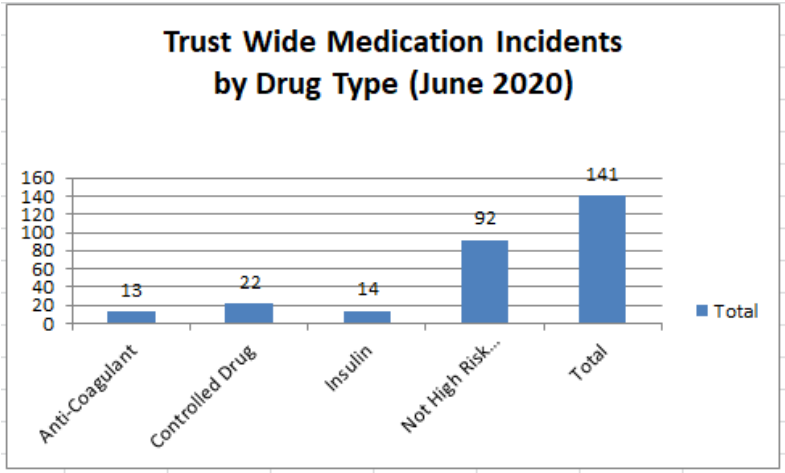


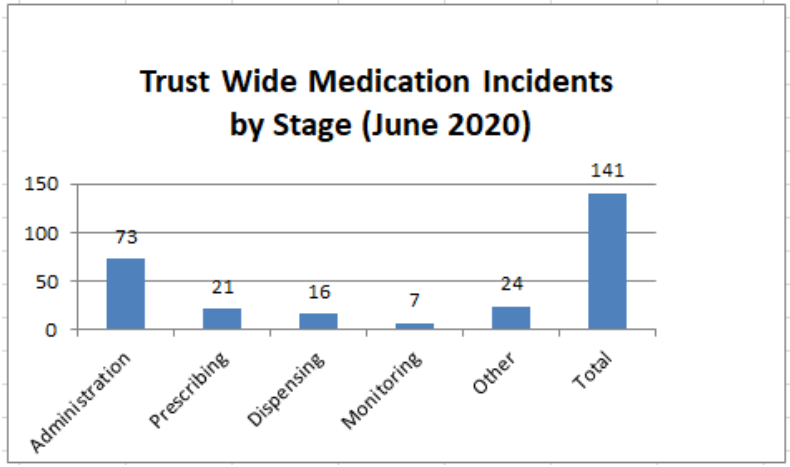

### WHO Checklist Compliance

The Board expects that a WHO surgical safety checklist will be completed and documented prior to each operation in theatres.

The IPR report of less than 100% is due to issues with data capture. All cases where WHO was not recorded electronically are reviewed to ensure that checklist compliance was recorded in the paper medical records.




## Medicines Management

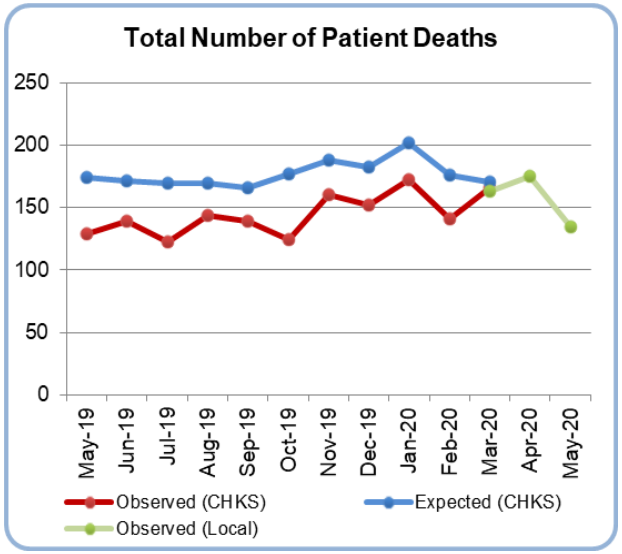
**Severity of Incidents:** No Harm incidents formed c.92% of all incidents reported during June 20; demonstrating a strong culture of incident reporting across the Trust. Low Harm incidents formed c.7% of all incidents reported in June 20 and the trends/themes are highlighted below. The Moderate incidents are being investigated to clarify the classification of harm and identify the learning.

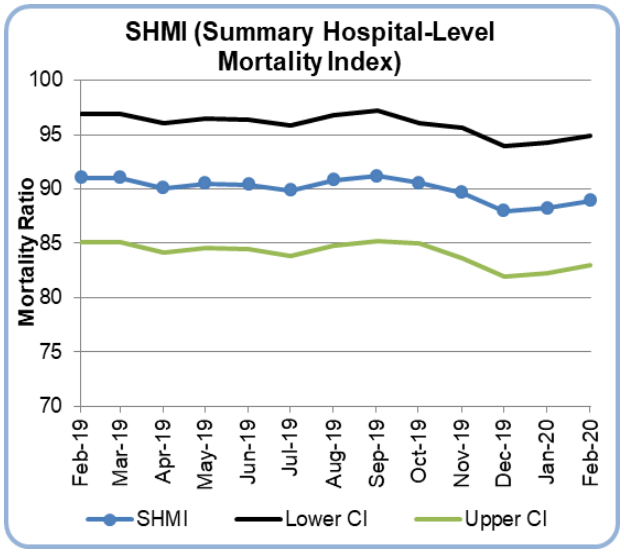
**Incidents by Type of Medication:** During June 20, approximately c.65% of all Medication incidents involved a High Risk Medicine. A collaborative working group have now been establish as part of the STP Medicines Optimisation Quality & Safety Committee to focus on a system wide approach to Insulin and Anticoagulant incidents.

**Top Type of Errors:** Omitted & Delayed Doses accounted for c.34% of all incidents reported during June 20. This type of error constantly appears as the most common error type across the Trust.
Omitted / delayed doses were associated with main cause of LOW HARM incidents in June 20 (c.34%) and May 20 (c.31%).

**Incidents by Stage:** Incidents occurring at the Administration stage accounted for c.52% of all incidents; with prescribing (c.15%) and dispensing (c.11%) and being the next two most common stages at which medication errors occur within the Trust. The challenge of increasing the visibility and themes within “other Medication Incidents” remains a priority for the Medication Safety Team.

## Mortality Outcome Data




### Overall Mortality

Mortality outcome data has remained within the expected statistical range.

### Mortality Review Completion

The current data captures completed reviews from 01 May 19 to 30 Apr 20. In this time period (this is now reported as a 12 month rolling time frame), 88.3% of all deaths had a completed review. Of all "High Priority" cases, 83% completed Mortality Case Reviews (MCR), including twenty-two of the twenty-two deceased patients with Learning Disability and twenty-seven of the twenty-eight patients with Serious Mental Illness.

### Mortality Review Outcomes

The number of cases reviewed by MCR with an Overall Care score of adequate, good or excellent is 97.0% (score 3-5). There have been thirteen mortality reviews with a score of 1 or 2 indicating potentially poor, or very poor care which are reviewed through Divisional governance processes.

All of these cases will be reviewed through the Clinical Risk Operational Group.

### Backlog of Cases

Due to the suspension of the Mortality Review process during the peak of the COVID-19 Pandemic there was a back-log of reviews for March and April. A Pandemic Mortality Review was undertaken in lieu of screenings on a random selection of 30 cases between 20th March and 20th April which assessed overall care delivery as being 'Adequate' or better in each case.

This review generated some important learning and recommendations, which will be reviewed by QRMC on 17th July. The ongoing oversight of agreed actions will be via the Clinical Effectiveness and Audit Committee.

High priority reviews for this time period are still being requested and undertaken.

## Mortality Review Completion

| May 19 – Apr 20 | Completed | Required | % Complete |
|---|---|---|---|
| Screened and excluded | 1103* | | |
| High priority cases | 205 | | |
| Other cases reviewed | 327 | | |
| Total reviewed cases | 1635 | 1846 | 88.6% |

| Overall Score | 1=very poor | 2 | 3 | 4 | 5= Excellent |
|---|---|---|---|---|---|
| Care received | 0.0% | 3.0% | 18.4% | 50.7% | 27.9% |

The overall score percentages are derived from the score post review and does not include screened and excluded.

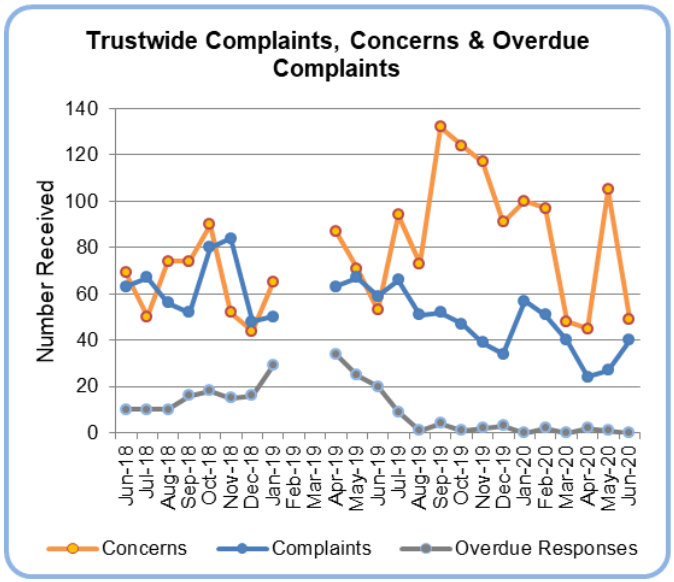
| Date of Death | May 19 – Apr 20 |
|---|---|
| In progress | 3 |
| Reviewed not SIRI | 10 |
| Reported as SIRI | 0 |
| Total score 1 or 2 | 13 |

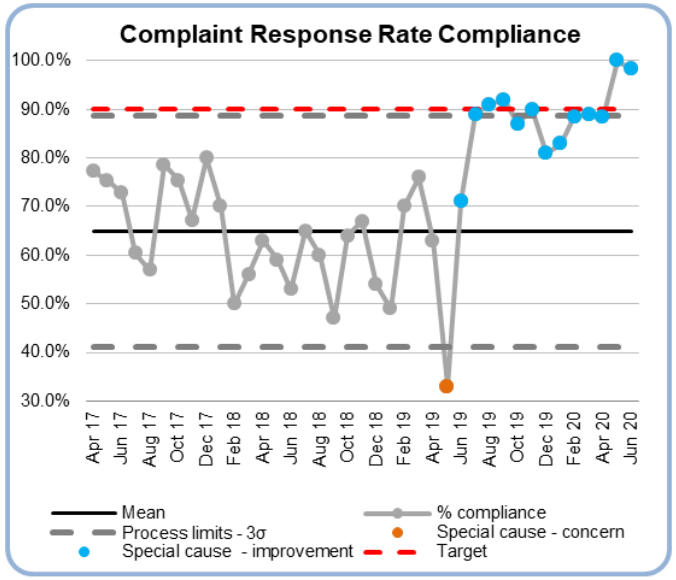
*171 (non high priority) cases were excluded from any form of review between January and April 2020 to aid with clearing a backlog of cases worsened by the COVID-19 pandemic mortality review suspension.

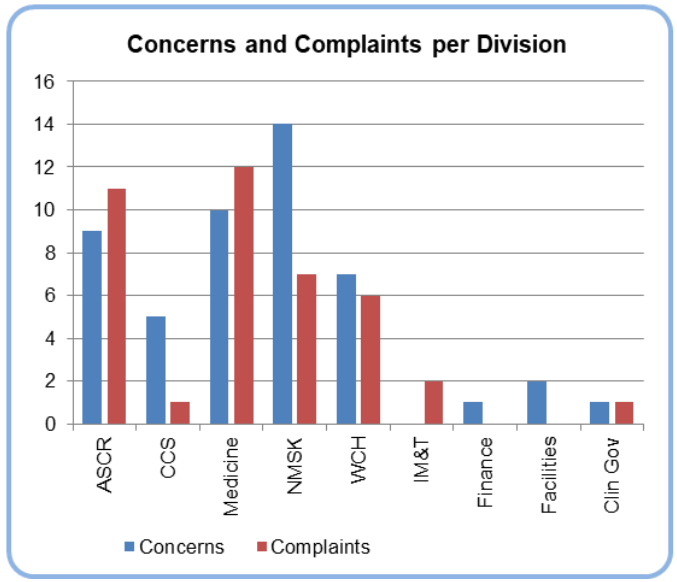
All high priority cases are still being reviewed.

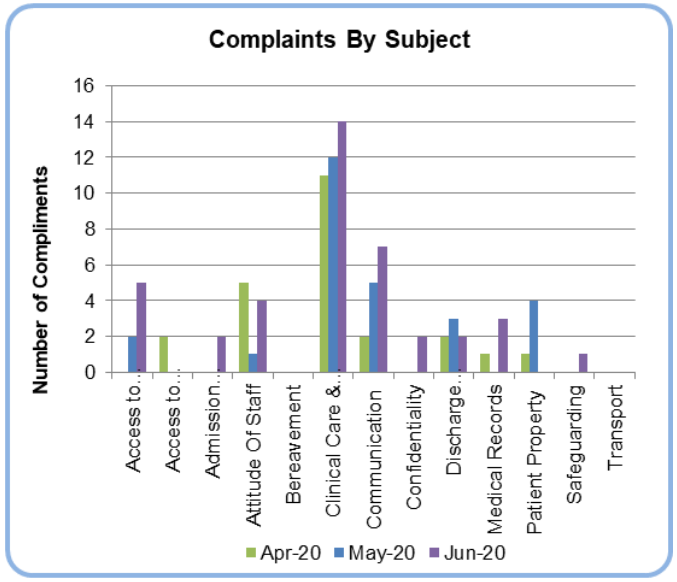
# Patient Experience

## Board Sponsor: Director of Nursing and Quality
## Helen Blanchard




N.B. Feb-19 and Mar-19 data has been removed for complaints, concerns and overdue complaints owing to data quality issues. From June-19 Enquiries have **not** been included in the 'concerns' data.

## Complaints and Concerns

In June 2020, the Trust received 40 formal complaints. This is an increase on the previous month but reflects the gradual increase in Trust activity.

Review of the complaint subjects shows a significant increase in complaints regarding Access to Services. These complaints are mostly about cancelled operations and delays to appointments. This is perhaps an expected consequence of COVID-19.

The 40 formal complaints can be broken down by division: (the previous month total is shown in brackets)

| | | | |
|---|---|---|---|
| ASCR | 11 (6) | CCS | 1 (0) |
| Medicine | 12 (14) | NMSK | 7 (4) |
| WCH | 6 (3) | IM&T | 2 (0) |
| Clinical Gov | 1 (0) | | |

The Policy and Processes for managing cases have recently been updated. Enquiries are no longer included in the number of PALS concerns reported. These are recorded and reported separately. This enables a more realistic picture of the level of actual concerns and complaints being received. In June 2020, a total of 55 enquiries were received by the Patient Experience Team.

**Compliance Response Rate Compliance**

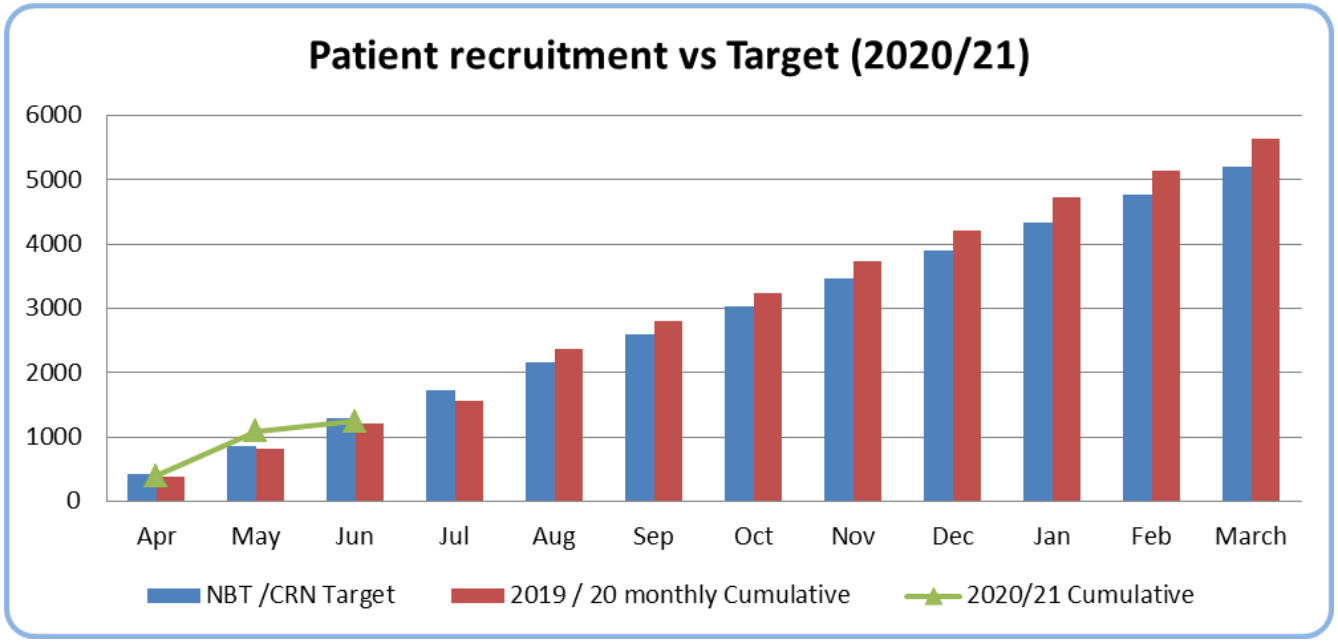
The chart demonstrates the sustained improvement in responding to complaints within agreed timescales. In June, 98% of complaints were closed on time. That is; of the 60 complaints due to be closed in June, 59 were responded to on or before the due date.

**Overdue complaints**

There are no overdue complaints.

# Research and Innovation

## Board Sponsor: Medical Director




| R&I Covid response | | | | |
|---|---|---|---|---|
| **Highlights** | •Opened 18 COVID studies recruiting 1201 participants | •Provided opportunity to 1222 participants (16 more than Q1 last year) | •Ranked 3rd in the country for recruitment to COV002 vaccine trial (541 participants) | 46 research nurses, AHPs and administrators clinically deployed |

The NBT recruitment target was set before the Covid outbreak. However despite and because of the Covid outbreak recruitment in 20/21 has been strong. Please note that with studies suspended due to Covid, recruitment through Q2-3 is anticipated to slow.

R&I is working with all regional partners to open further vaccine Covid studies and position the region as a centre of excellence for adult vaccine studies for the long term.

R&I is working with research teams, clinical services and Core clinical services to identify studies that can open to recruitment without impacting the capacity of the Trust to delivery basic clinical services.

NBT has been awarded three prestigious NIHR research grants; Dr Katie Whale, £250,000, for the REST trial (sleep interventions for Total Knee Replacement); Dr Sarah Drew, £146,000, (patient experiences of diagnosis for vertebral fracture); Professor Nick Maskell, £432,000 for the AERATOR study (Aerosolisation And Transmission Of SARS-CoV-2 in Healthcare Settings)

NBT currently leads 54 research grants (NIHR, charity, industry and other) to a total value of £22.3m, and is a partner on 44 grants to a total value of £8.9m.

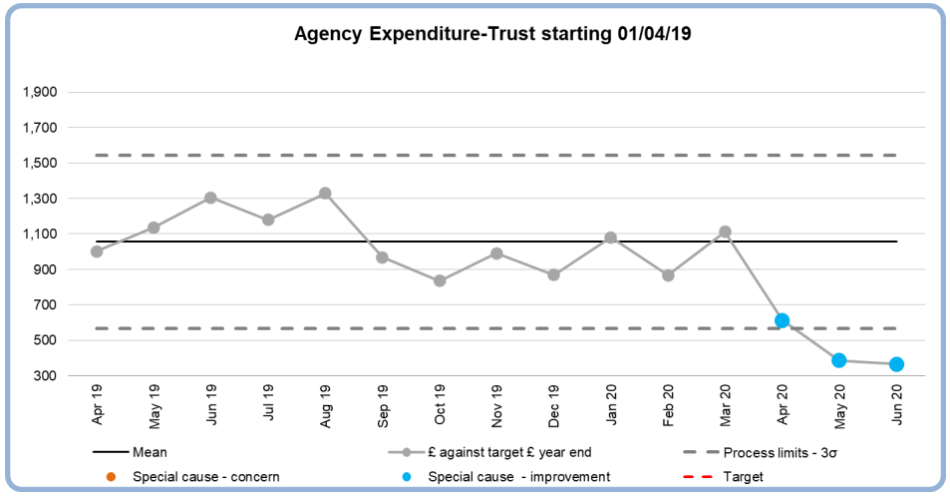
To help drive forward the COVID-19 research effort, NBT has developed 21 COVID-19 related research grant ideas (as lead (9) or as a major partner, (11)).

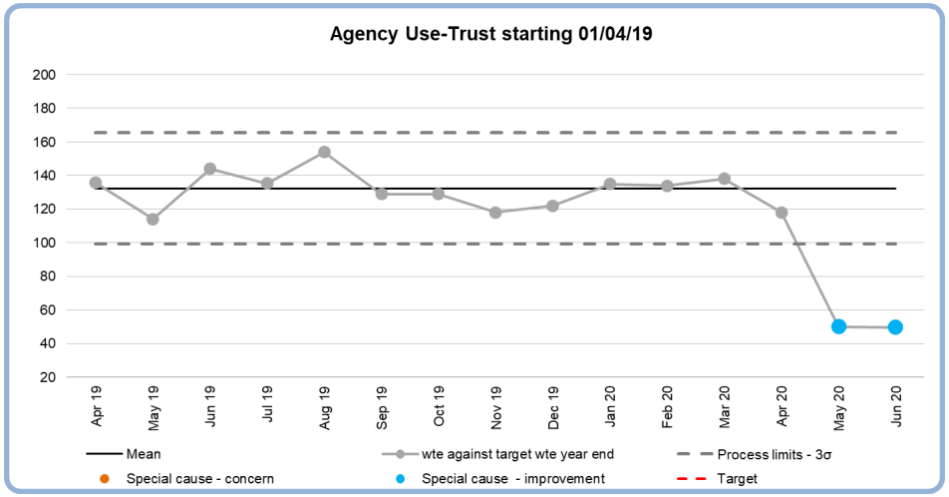
NHS North Bristol NHS Trust

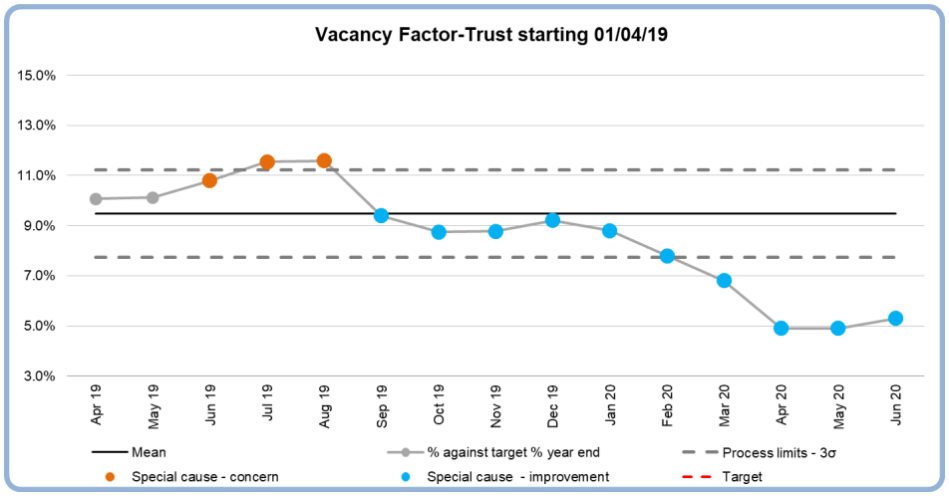
# Well Led

## Board Sponsors: Medical Director, Director of People and Transformation
## Chris Burton and Jacqui Marshall

# Workforce



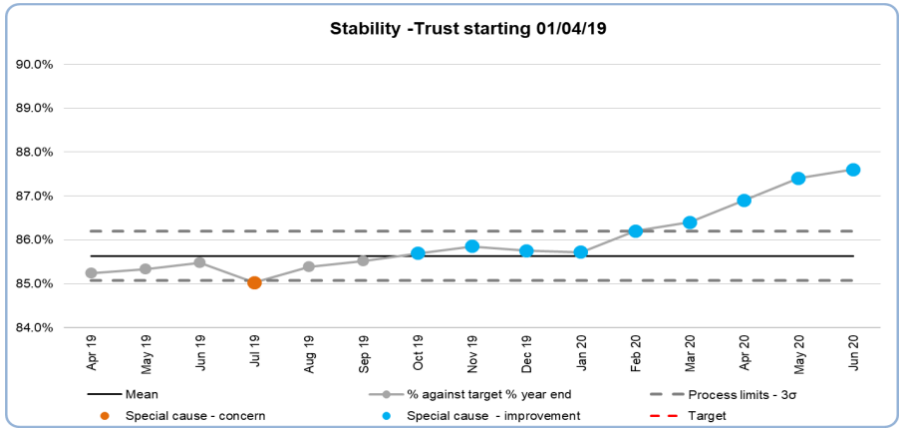

## Resourcing

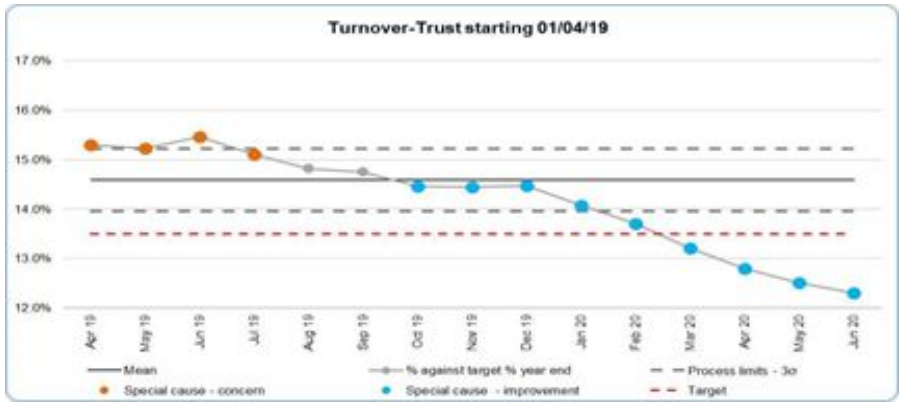
Band 5 nurse recruitment continues domestically through online engagement activities and interviews. The September intake of band 5 nurses is at approximately the same level as last year with 112 wte in September 2020 intake assuming an average conversion from offers of 78%, last year 108 wte nurse band 5s started in September.

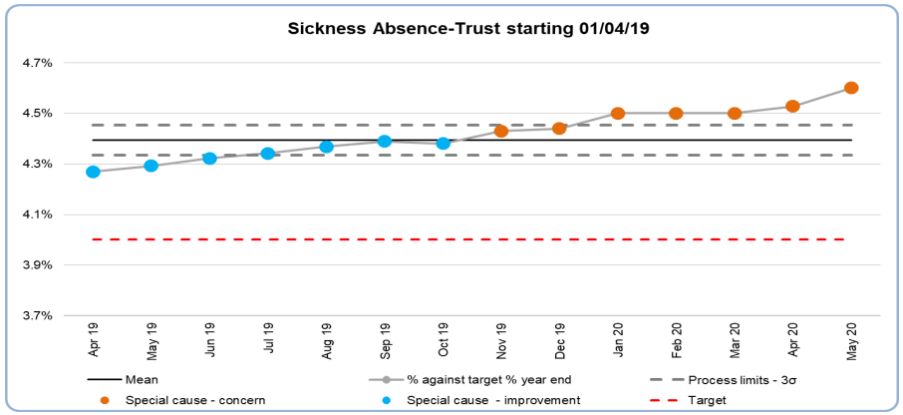
International recruitment for nurse band 5s continues with 10 nurses per month between August 2020 and March 2021 (except December and January). The intention is to deliver 60 starters in 20/21 via our partnership with Yeovil. The 45 anticipated starters through the Valencia pipeline will not deliver in 20/21 and the impact of this will be determined when budget setting is finalised for 20/21.

There is ongoing work to convert bank staff to substantive but with low take up of numbers to date. Specific bank recruitment campaigns are in progress targeting areas with ongoing agency nursing use.

# Engagement and Wellbeing




## Turnover and Stability

All staff groups , other than unregistered nurses ,saw an improvement in turnover,. The unregistered nurse position was due to 23 wte aspirant nurses leaving who were employed during the pandemic period.

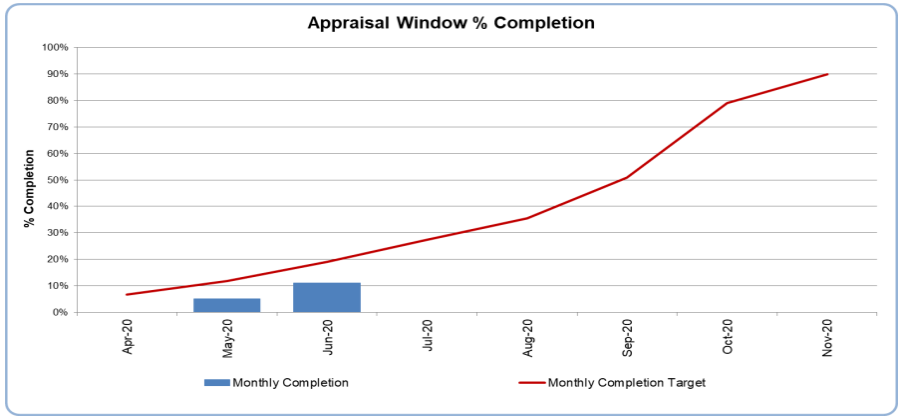
The NHSI/NBT nursing retention action plan paused during the COVID-19 period has now been refreshed with a focus on retaining new starters who have joined during the COVID-19 period due to the unusual circumstances at the time. This is being incorporated into the overall workforce transformation programme.

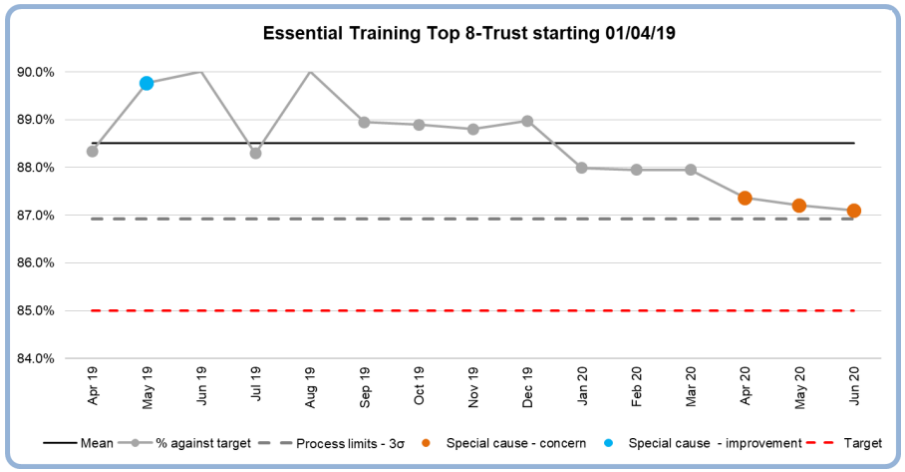
## Sickness

The People Team are finalising actions from the 'stress at work' project undertaken pre-COVID-19 and are currently developing a 'Talking Toolkit' for managers linked to this. This is due for launch early next month.

Other People Team work undertaken to help improve sickness absence includes:

- Supporting the return of Shielding staff through the development and provision of tools and advice and guidance for staff and managers.
- Completing the final implementation phase of the ER Case Tracker with the remaining line managers which will mean all formal sickness cases being logged and managed via the new system.
- Sickness Absence management training has now re-commenced and Manager Advice Sessions attendance is increasing.
- The Just Culture project has been initiated within Facilities, which should help managers develop a different approach to managing people issues both formally and informally and support improved attendance.
- Transfer of all sickness absence resources and toolkits onto LINK.




| Training Topic | Variance | May-20 | Jun-20 |
|---|---|---|---|
| Child Protection | 0.9% | 86.4% | 87.4% |
| Adult Protection | 1.2% | 87.9% | 89.0% |
| Equality & Diversity | 0.3% | 91.2% | 91.5% |
| Fire Safety | 0.0% | 86.2% | 86.1% |
| Health &Safety | 0.6% | 90.8% | 91.4% |
| Infection Control | -3.3% | 92.1% | 88.8% |
| Information Governance | -0.3% | 83.4% | 83.1% |
| Manual Handling | -1.0% | 79.1% | 78.1% |
| Waste | 0.1% | 88.0% | 88.1% |
| **Total** | **-0.2%** | **87.2%** | **87.1%** |

## Appraisal

### Leadership & Management Development

Due to COVID-19 all leadership & management programmes were paused until the end of June. All programmes have now restarted in July and delivery has been reviewed to support the trust guidance on social distancing.

### OneNBT Leadership Programme

The 2020 application has remained open despite COVID-19 and has been extended to the end of September. There were 42 deferred applicants and there has been 60 applications received, which gives 102 participants for 2020 so far.

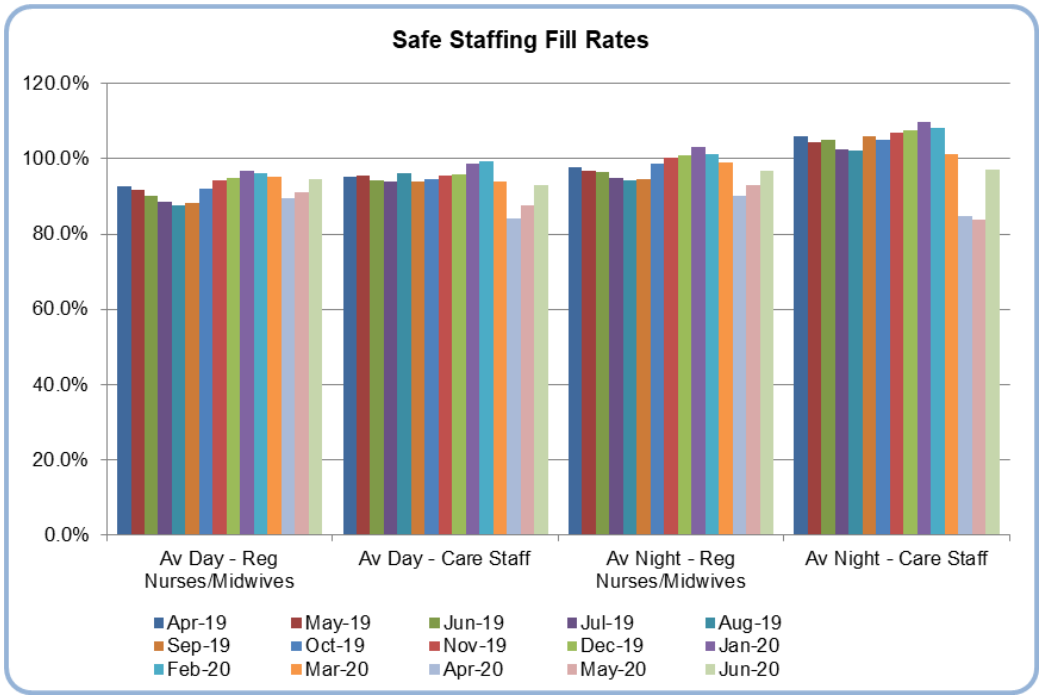
The core leadership day will also be delivered online and split into two parts to give participants an introduction to the programme.

### OneNBT L&M Apprenticeships

The corporate apprenticeships were paused during the pandemic, however all cohorts have now restarted. We have had 2 managers successfully complete their apprenticeship and both achieving a distinction which is fantastic news for the programme.

10 managers are still due to complete their end-point assessment in the next few months. There are still 15 managers enrolled in the Level 3 Leadership & Management Apprenticeship (qualification), 9 of which have been promoted since joining the programme.

The Oct-20 cohort has 15 applicants and we have seen a significant increase in demand through word of mouth and department nominations as a result of the impact they have seen from previous learners on the programme.




| Jun-20 | Day shift | | Night Shift | |
|---|---|---|---|---|
| | RN/RM Fill rate | CA Fill rate | RN/RM Fill rate | CA Fill rate |
| Southmead | 94.6% | 93.1% | 97.0% | 97.2% |

The numbers of hours Registered Nurses (RN) / Registered Midwives (RM) and Care Assistants (CA), planned and actual, on both day and night shifts are collated. CHPPD for Southmead Hospital includes ICU, NICU and the Birth Suite where 1:1 care is required. This data is uploaded on UNIFY for NHS Choices and also on our Website showing overall Trust position and each individual gate level. The breakdown for each of the ward areas is available on the external webpage.

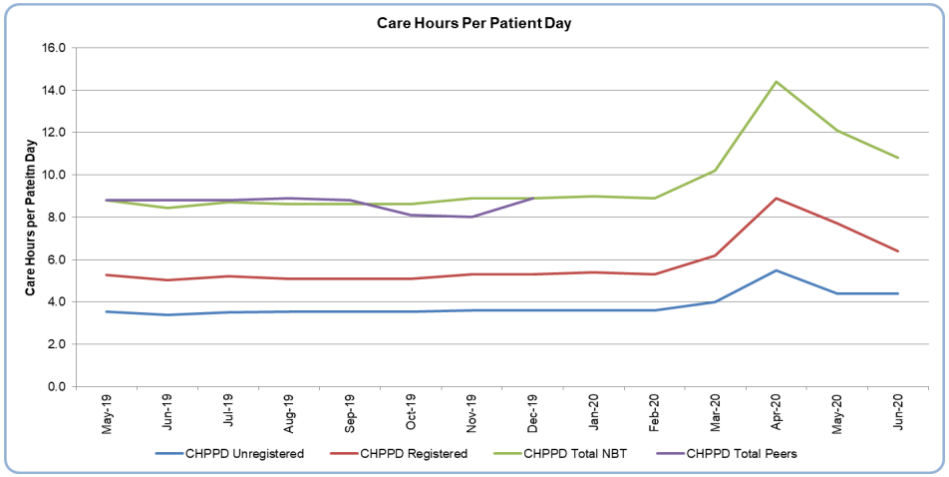
The safe staffing report now requires the wards to identify Nursing Associates including Trainees and AHP staff employed in an inpatient area. The current version of the roster system is unable to break this down, however changes are anticipated and will be back reported as soon as it is possible.

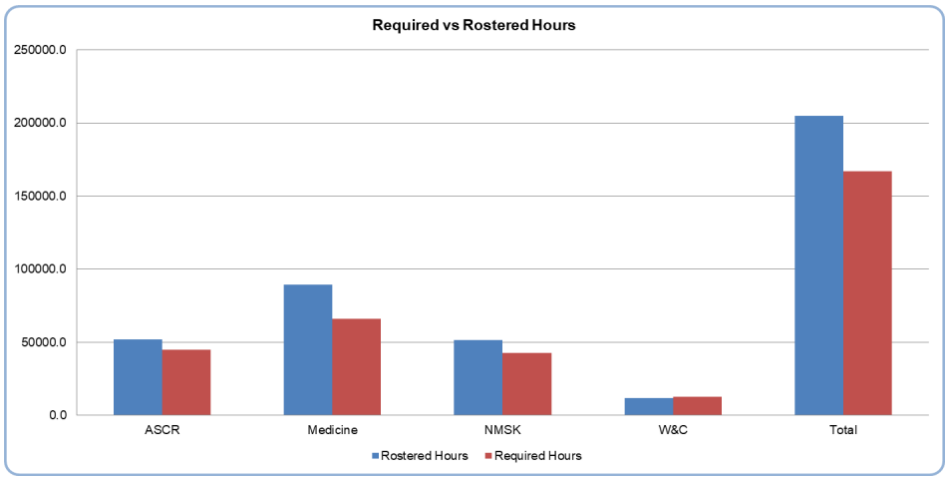
In March the organisation, in preparedness for COVID-19 phase, reduced the elective activity and capacity was released for care pandemic response. During May 2020, in responding to the COVID-19 pandemic, the organisation reconfigured the inpatient services. 10 wards were reconfigured and there are now two elective care wards (7a, 7b) and one inpatient wards remaining closed (Elgar). Of particular note is the change to staffing levels in Cotswold with the temporary release of planned Non registered care hours due to low patient numbers.

The organisation's overall occupancy has been reduced and elective activity programme is in restoration phase with reduced elective care beds available in the reconfiguration. Where shifts have been unfilled, an acuity assessment was carried out and staff will have been moved from areas of lower activity if and when needed and the overall CHPPD can be seen in the following slides showing a continued increase in June due to the current situation.

Wards below 80% fill rate for Registered Staff
Cotswold (73% Day)
Gate 7a ( 70% Day: 62% Night)

Wards below 80% fill rate for Care Staff
Gate 37 ICU (32% Day : 37% Night)
Gate 26a (65% Day)
Cotswold (4% day : 0% Night)
NICU (69% Day : 64% Night)
Gate 7a (38% Day : 51% Night)
Gate 7b ( 71% day : 68% Night)
)




## Care Hours per Patient Day (CHPPD)

The chart shows care hours per patient day for NBT total and is split by registered and unregistered nursing. The chart shows CHPPD for the Model Hospital peers (all data from Model Hospital. Peer values are only available to Feb 2019).

During June 2020 the organisation was prepared and staff available to respond to a pandemic surge as is shown with CHPPD and rostered versus required hours. Staffing levels were maintained at levels to respond to short notice changes in demand and to support service restoration of the pandemic response.

## Safe Care Live (Electronic Acuity Tool)

The acuity of patients is measured three times daily at ward level.

The Safe Care data is triangulated with numbers of staff on shift and professional judgement to determine whether the required hours available for safe care in a ward/unit aligns with the rostered hours available.

Staff will be redeployed between clinical areas and Divisions following daily staffing meetings involving all Divisions, to ensure safety is maintained in wards/areas where a significant shortfall in required hours is identified, to maintain patient safety.

NHS North Bristol NHS Trust

# Finance

## Board Sponsor: Director of Finance
## Catherine Phillips

| Position as at 30 June 2020 | | | | |
|---|---|---|---|---|
| | Apr | May | Jun | YTD |
| | £m | £m | £m | £m |
| Contract Income | 45.1 | 44.9 | 46.1 | **136.1** |
| Other Income | 25.8 | 9.6 | 10.7 | **46.1** |
| **Total Income** | **70.9** | **54.4** | **56.9** | **182.2** |
| Pay | (34.3) | (34.5) | (34.1) | **(102.9)** |
| Non-Pay | (30.7) | (14.0) | (16.8) | **(61.4)** |
| Financing | (5.9) | (6.0) | (6.0) | **(17.9)** |
| **Total Expenditure** | **(70.9)** | **(54.4)** | **(56.9)** | **(182.2)** |
| **Surplus/ (Deficit)** | **0.0** | **0.0** | **0.0** | **0.0** |

## Statement of Comprehensive Income

### Assurances

The financial position at the end of June shows a breakeven position consistent with the new cost recovery regime that has been implemented to support service delivery under COVID-19.

Income includes additional true-up funding of £3.4m which includes the £2.1m funding for Covid-19 costs, Nightingale costs incurred in month of £1.0m and the underlying core Trust deficit of £0.3m

Financial reviews and variance analyses have been performed on the June result reported above in comparison with both the Quarter 4 run rate for 2019/20 and also the Trust level budget/plan (now suspended) that was agreed in March.

The resulting table and comments are included on the following page for assurance.

There are no key issues to report.

| 31 March 2020 £m | | Position as at 30th June 2020 Actual £m |
|---|---|---|
| | **Non Current Assets** | |
| 560.0 | Property, Plant and Equipment | 561.5 |
| 12.0 | Intangible Assets | 11.4 |
| 4.0 | Non-current receivables | 4.0 |
| **576.0** | **Total non-current assets** | **576.8** |
| | **Current Assets** | |
| 13.1 | Inventories | 12.9 |
| 50.5 | Trade and other receivables NHS | 27.2 |
| 22.2 | Trade and other receivables Non-NHS | 34.0 |
| 10.7 | Cash and Cash equivalents | 91.1 |
| **96.4** | **Total current assets** | **165.2** |
| **672.4** | **Total assets** | **742.0** |
| | **Current Liabilities (< 1 Year)** | |
| 11.1 | Trade and Other payables - NHS | 6.8 |
| 57.6 | Trade and Other payables - Non-NHS | 87.5 |
| 3.7 | Deferred income | 50.3 |
| 13.0 | PFI liability | 13.6 |
| 173.6 | DHSC loans | 173.7 |
| 2.4 | Finance lease liabilities | 2.4 |
| **261.4** | **Total current liabilities** | **334.3** |
| **(165.0)** | **Net current assets/(liabilities)** | **(169.1)** |
| **411.0** | **Total assets less current liabilites** | **407.7** |
| 7.2 | Trade payables and deferred income | 6.5 |
| 377.8 | PFI liability | 375.1 |
| 5.4 | DHSC loans | 5.4 |
| 5.3 | Finance lease liabilities | 5.6 |
| **15.3** | **Total Net Assets** | **15.1** |
| | **Capital and Reserves** | |
| 248.5 | Public Dividend Capital | 248.5 |
| (382.3) | Income and expenditure reserve | (383.4) |
| 0.0 | Income and expenditure account - current year | (0.2) |
| 149.1 | Revaluation reserve | 150.2 |
| **15.3** | **Total Capital and Reserves** | **15.1** |

## Statement of Financial Position

### Assurances

Total borrowing from DOH remain at the end of 2019/20 level of £178.5m. The Trust ended the month with a cash balance of £91.1m, compared with the March figure of £10.7m. The improved cash position is a result of the new financial regime with which paid over expected income for both April and May in the first month of the year.

### Key Issues

The level of payables is reflected in the Better Payment Practice Code (BPPC) performance for the month was 89.6% by value compared to an average of 85.6% for 2019/20.

## Statement of Comprehensive Income, Further Assurance

NHSI/E calculated the expected cost base of the Trust using two methods to generate a monthly block contract amount and a monthly top-up amount. Any spend over/under this is adjusted in future months and so the Trust has effectively had its operational costs funded through a retrospective true-up process, though any significant variation from the NHSI/E calculated sums will be subject to review.

For the month of May the Trust has had to request additional true-up funding of £2.6m which includes the £3.2m funding for Covid-19 costs and reduction of £0.5m for Nightingale's estimated setup costs. Due to the lower levels of elective activity there are significant underspends that offset the majority of the £2.6m under-funding off the Trust block and top up payments.

The Trust has communicated to NHSI/E that while spend directly related to COVID-19 may reduce in coming months the underspends experienced in April and May are mow falling away as service restoration work increases activity.

The table below shows the June spend for the Core Trust compared to the Quarter 4 spend run rate and also compared to the Board approved annual plan.

| | Core Trust Position as at 30 June 2020 | | | | | | |
|---|---|---|---|---|---|---|---|
| | Actual | Q4 Avg (*) | Act. V Q4 Avg. | | Budget | Act. V Budget | |
| | £m | £m | £m (Adv)/Fav | % | £m | £m (Adv)/Fav | % |
| Contract Income | 46.1 | 44.4 | 1.7 | 3.9% | 48.3 | (2.1) | (4.4%) |
| Other Income | 7.6 | 10.4 | (2.8) | (26.7%) | 12.9 | (5.3) | (40.9%) |
| **Total Income** | **53.8** | **54.8** | **(1.0)** | **(1.9%)** | **61.2** | **(7.4)** | **(12.1%)** |
| Pay | (32.7) | (33.0) | 0.3 | (1.0%) | (33.8) | 1.1 | (3.2%) |
| Non-pay | (15.1) | (16.5) | 1.4 | (8.6%) | (16.9) | 1.8 | (10.7%) |
| Financing | (6.0) | (6.1) | 0.1 | (1.4%) | (6.1) | 0.1 | (1.4%) |
| **Total Expenditure** | **(53.8)** | **(55.6)** | **1.8** | **(3.3%)** | **(56.7)** | **3.0** | **(5.3%)** |
| **Surplus / (deficit)** | **(0.0)** | **(0.8)** | **0.8** | **(100.0%)** | **4.4** | **(4.4)** | **(100.0%)** |

*(*) Quarter 4 average has been adjusted for large one-off elements recognised in March as part of the year-end process which would skew the average*

**Financial Risk Ratings , Capital Expenditure and Cash Forecast (4 months).**

The capital expenditure for Quarter 1 is £7.2 m which compares to a year to date plan of £5.9m.

**Financial Risk Rating**

The new financial framework means that a Financial risk rating is no longer calculated or reported to NHSI.

**Rolling Cash forecast**

A high level cashflow forecast has been developed which shows that the Trust is able to manage its affairs without any external support. The forecast covering the four months of the new financial regime is shown below.

| Cash £m | Opening balance | Apr-20 (actual) | May-20 (actual) | Jun-20 (actual) | Jul-20 (forecast) |
|---|---|---|---|---|---|
| Receipts | | 115.5 | 71.8 | 70.2 | 10.7 |
| Outgoings | | (60.8) | (58.2) | (58.1) | (59.9) |
| Net cashflow | | 54.7 | 13.6 | 12.1 | (49.3) |
| Cum cashflow | 10.7 | 65.4 | 79.0 | 91.1 | 41.8 |

NHS North Bristol NHS Trust

# Regulatory

## Board Sponsor: Chief Executive
## Andrea Young

# Monitor Provider Licence Compliance Statements at June 2020
## Self-assessed, for submission to NHSI

| Ref | Criteria | Comp (Y/N) | Comments where non compliant or at risk of non-compliance |
|---|---|---|---|
| G4 | Fit and proper persons as Governors and Directors (also applicable to those performing equivalent or similar functions) | Yes | A Fit and Proper Person Policy is in place. All Executive and Non-Executive Directors have completed a self assessment and no issues have been identified. Further external assurance checks have been completed on all Executive Directors and no issues have been identified. |
| G5 | Having regard to monitor Guidance | Yes | The Trust Board has regard to NHS Improvement guidance where this is applicable. |
| G7 | Registration with the Care Quality Commission | Yes | CQC registration in place. The Trust received a rating of Good from its inspection reported in September 2019. A number of mandatory actions were identified which are being addressed through an action plan. The Trust will receive updates on these actions via its Quality and Risk Management Committee. |
| G8 | Patient eligibility and selection criteria | Yes | Trust Board has considered the assurances in place and considers them sufficient. |
| P1 | Recording of information | Yes | A range of measures and controls are in place to provide internal assurance on data quality. Further developments to pull this together into an overall assurance framework are planned through strengthened Information Governance Assurance Group. |
| P2 | Provision of information | Yes | The trust submits information to NHS Improvement as required. |
| P3 | Assurance report on submissions to Monitor | Yes | Scrutiny and oversight of assurance reports to regulators is provided by Trust's Audit Committee and other Committee structures. |
| P4 | Compliance with the National Tariff | Yes | NBT complies with national tariff prices. Scrutiny by CCGs, NHS England and NHS Improvement provides external assurance that tariff is being applied correctly. It should be noted that NBT is currently receiving income via a block arrangement in line with national COVID-19 financial arrangements. |
| P5 | Constructive engagement concerning local tariff modifications | Yes | Trust Board has considered the assurances in place and considers them sufficient. It should be noted that NBT is currently receiving income via a block arrangement in line with national COVID-19 financial arrangements. |
| C1 | The right of patients to make choices | Yes | Trust Board has considered the assurances in place and considers them sufficient. It should be noted that the Trust is currently complying with national COVID-19 guidance which involves the standing down of significant elective and outpatient activity. |
| C2 | Competition oversight | Yes | Trust Board has considered the assurances in place and considers them sufficient. |
| IC1 | Provision of integrated care | Yes | Range of engagement internally and externally. No indication of any actions being taken detrimental to care integration for the delivery of Licence objectives. |

# Appendix 1: Glossary of Terms

Unless noted on each graph, all data shown is for period up to, and including, 31 May 2020.

All data included is correct at the time of publication.
Please note that subsequent validation by clinical teams can alter scores retrospectively.

**Target lines**
**Improvement trajectories**
**National Performance**

**Upper Quartile**

**Lower Quartile**

## NBT Quality Priorities 2020/21

**QP1** Enhance the experience of patients with Learning Disabilities and / or Autism by making reasonable adjustments which are personal to the individual

**QP2** Being outstanding for safety – at the forefront nationally of implementing the NHS Patient Safety Strategy within a 'just' safety culture.

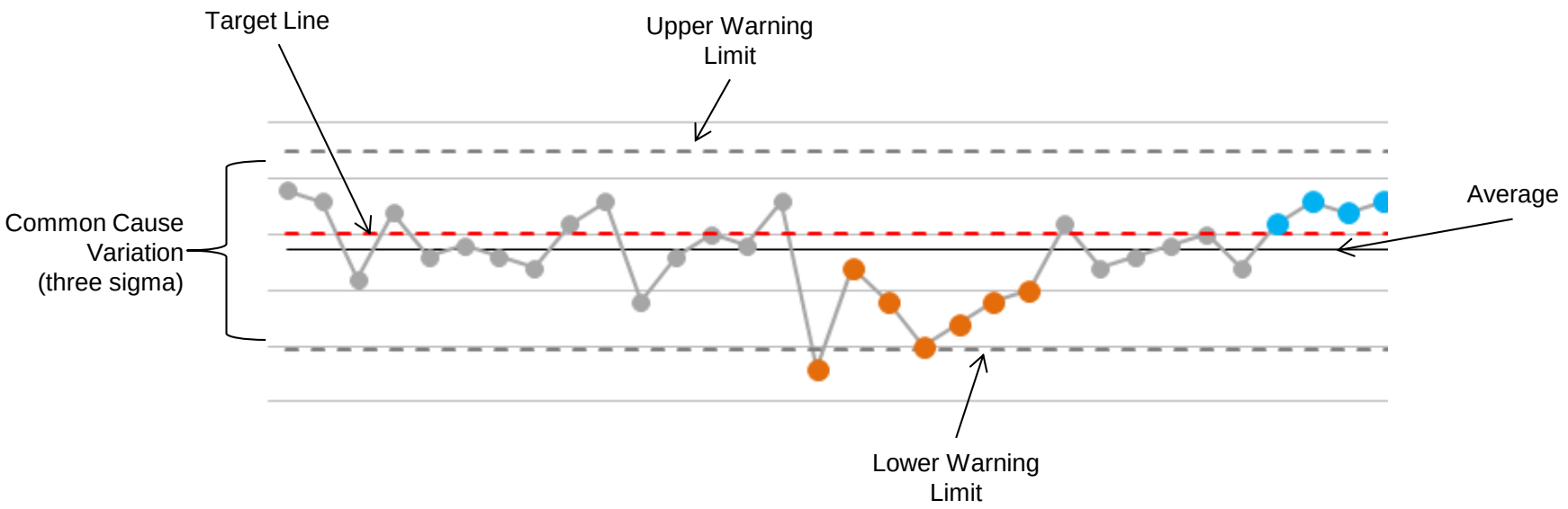
**QP3** Ensuring excellence in our maternity services, delivering safer maternity care.

**QP4** Ensuring excellence in Infection Prevention and Control to support delivery of safe care across all clinical services

## Abbreviation Glossary

| | |
|---|---|
| **AMTC** | Adult Major Trauma Centre |
| **ASCR** | Anaesthetics, Surgery, Critical Care and Renal |
| **ASI** | Appointment Slot Issue |
| **CCS** | Core Clinical Services |
| **CEO** | Chief Executive |
| **Clin Gov** | Clinical Governance |
| **CT** | Computerised Tomography |
| **DDoN** | Deputy Director of Nursing |
| **DTOC** | Delayed Transfer of Care |
| **ERS** | E-Referral System |
| **GRR** | Governance Risk Rating |
| **HoN** | Head of Nursing |
| **IMandT** | Information Management |
| **LoS** | Length of Stay |
| **MDT** | Multi-disciplinary Team |
| **Med** | Medicine |
| **MRI** | Magnetic Resonance Imaging |
| **NMSK** | Neurosciences and Musculoskeletal |
| **Non-Cons** | Non-Consultant |
| **Ops** | Operations |
| **P&T** | People and Transformation |
| **PTL** | Patient Tracking List |
| **RAP** | Remedial Action Plan |
| **RAS** | Referral Assessment Service |
| **RCA** | Root Cause Analysis |
| **SI** | Serious Incident |
| **TWW** | Two Week Wait |
| **WCH** | Women and Children's Health |
| **WTE** | Whole Time Equivalent |

# Appendix 2: Statistical Process Charts (SPC) Guidance




**Orange dots signify a statistical cause for concern.** A data point will highlight orange if it:
A) Breaches the lower warning limit (special cause variation) when low reflects underperformance or breaches the upper control limit when high reflects underperformance.
B) Runs for 7 consecutive points below the average when low reflects underperformance or runs for 7 consecutive points above the average when high reflects underperformance.
C) Runs in a descending or ascending pattern for 7 consecutive points depending on what direction reflects a deteriorating trend.

**Blue dots signify a statistical improvement.** A data point will highlight blue if it:
A) Breaches the upper warning limit (special cause variation) when high reflects good performance or breaches the lower warning limit when low reflects good performance.
B) Runs for 7 consecutive points above the average when high reflects good performance or runs for 7 consecutive points below the average when low reflects good performance.
C) Runs in an ascending or descending pattern for 7 consecutive points depending on what direction reflects an improving trend.

**Special cause variation** is unlikely to have happened by chance and is usually the result of a process change. If a process change has happened, after a period, warning limits can be recalculated and a step change will be observed. A process change can be identified by a consistent and consecutive pattern of orange or blue dots.

**Further reading:**
SPC Guidance: https://improvement.nhs.uk/documents/2171/statistical-process-control.pdf
Managing Variation: https://improvement.nhs.uk/documents/2179/managing-variation.pdf
Making Data Count: https://improvement.nhs.uk/documents/5478/MAKING_DATA_COUNT_PART_2_-_FINAL_1.pdf

| | | | |
|---|---|---|---|
| **Report To:** | Trust Board | | |
| **Date of Meeting:** | 30 July 2020 | | |
| **Report Title:** | Quality Account (2019/20) Final Draft for approval | | |
| **Report Author & Job Title** | Paul Cresswell, Associate Director of Quality Governance | | |
| **Executive Sponsor (presenting)** | Helen Blanchard, Director of Nursing & Quality | | |
| **Purpose:** | **Approval** | **Discussion** | **To Receive for Information** |
| | X | | |
| **Recommendation:** | The Trust Board is requested to:<br>• **Review & approve** the final draft of the Quality Account. | | |
| **Report History:** | The first draft of the 2019/20 Quality Account was provided for comments at the June Board.<br>A number of subsequent changes have been made following that meeting and the version presented was reviewed and supported for approval at the July 2020 QRMC meeting. | | |
| **Next Steps:** | • Publication on Trust and NHS Choices websites by 31st July 2020. | | |

**Executive Summary**

Quality Account 2019/20

In line with national guidance, a delay in the production and publication of the Trust's annual Quality Account was agreed. This guidance also recognised that its coverage would be minimised to meet statutory requirements (in line with the Quality Account regulations) but with a greatly reduced requirement for information or narrative sourced from clinical teams. The requirement for an external audit of the Quality Account was also waived.

In the meantime, the compilation of the Quality Account has continued within the Clinical Governance team, taking information already obtained during the year and data available from Trust information systems and reporting, such as the Board Integrated Performance Report (IPR).

With this in mind and taking account of the requirements for external stakeholder consultation (which remain necessary under the regulations) the timeline for production has been followed/ planned as below (shaded areas have been completed);

| Date | Activity |
|---|---|
| 5/6/20 | Content first draft to Lead Execs (HB & CB) – comments/updates for 9/6/20 (QRMC papers) |
| 9/6/20 | Circulated to TMT members (for comments prior to 18/6/20) & to QRMC members |
| 16/6/20 | First draft - review at QRMC |
| 17/6/20 | Changes made for any QRMC feedback |
| 18/6/20 | Issue for external consultation (30 days) |
| 25/6/20 | Second draft – reviewed at Trust Board and subsequent updates made from feedback |
| 17/7/20 | QRMC review / approval |
| 20/7/20 | Finalise with external consultation comments added in |
| 30/7/20 | Board approval |
| 31/7/20 | Publish on website and with NHS Choices. |

The final draft Quality Account is attached as **Appendix A.**

QRMC is requested to review and approve this version for publication on the NHS Choices and NBT external website.

| | |
|---|---|
| **Strategic Theme/Corporate Objective Links** | **1. Provider of high quality patient care**<br>a. Experts in complex urgent & emergency care<br>b. Work in partnership to deliver great local health services<br>c. A Centre of Excellence for specialist healthcare<br>d. A powerhouse for pathology & imaging<br>**2. Developing Healthcare for the future**<br>a. Training, educating and developing out workforce<br>b. Increase our capability to deliver research<br>c. Support development & adoption of innovations<br>d. Invest in digital technology |
| **Board Assurance Framework/Trust Risk Register Links** | **BAF ref.SIR14** - Sustained demand and increased acuity of patients in hospital will impact on patient safety and outcomes, leading to harm in patients and poorer patient experience.<br>(Current risk rating = 12) |
| **Other Standard Reference** | Care Quality Commission Regulations |
| **Financial implications** | Quality Account external audit – not required this year, therefore no cost. |
| **Other Resource Implications** | As above |
| **Legal Implications including Equality, Diversity and Inclusion Assessment** | Providers of NHS healthcare are required to publish a quality account each year. These are required by the Health Act 2009, and in the terms set out in the National Health Service (Quality Accounts) Regulations 2010 as amended1 ('the quality accounts regulations').<br>The Department of Health and Social Care published the NHS (Quality Accounts) Amendment Regulations 2017 in July 2017. |
| **Appendices:** | 9A – Quality Account 2019/20 Final Draft |

North Bristol NHS Trust

# Account of the Quality of Clinical Services


9

## 2019/20

Exceptional healthcare, personally delivered

# Contents 2019/20







# Part 1

## A statement on quality from the Chief Executive

Part 1

# Statement on quality from the Chief Executive

The end of 2019/20 will forever be remembered as the time the NHS faced its biggest challenge due to the COVID-19 pandemic. At the time of writing we are still unsure what the future holds in regards to the future but we do know COVID-19 will be with us for some time. In all my time as Chief Executive of North Bristol NHS Trust I have felt nothing but pride for our staff and what they do each and every day. But during the past few months I have not only had that pride reinforced but have been humbled by the way our staff at NBT have risen to the this challenge and ensured we can continue to provide safe care to our patients.

As with many aspects of our hospital, this year's Quality Account has been shaped by the pandemic response. However this response is one which comes from our culture at NBT of committed staff, empowered through our award winning Perform programme to take ownership of decisions and working well in their teams. As a result every one of our 8000 staff are focussed on patients and improving services.

## CQC rating

In September 2019, this approach to working collectively for the benefit of our patients was rewarded when we achieved our first Care Quality Commission (CQC) 'Good' rating since moving into the Brunel Building in 2014. This was an incredible achievement and could not have happened were it not for everyone connected to NBT working with a single focus.

I was thrilled that the final report recognised this and our continual commitment to improving services when it stated "quality and improvement was everybody's business." The emergency department, medicine and surgery divisions received special recognition of quality improvement projects that were celebrated nationally. It was particularly pleasing to see the CQC recognise the efforts our staff go to in providing emotional support to patients, families and carers and in our dedication to challenging poor practice when things go wrong. These are just two examples of how providing the very best care to patients matters to everyone at NBT.

The CQC rating marked a significant step in our journey and one where quality improvement was a key theme in helping us achieve 'Outstanding' in both caring and leadership. Our End of Life service was also rated as 'Outstanding', highlighting the support we offer for patients and their families at the most testing of times.

The CQC commented we were "fizzing with enthusiasm" and we will take confidence and energy from this feedback to not only carry on doing what we are doing but to strive day in day out to continue to improve and deliver high quality services for our patients as One NBT.

## Patient experience

A key area of focus at the start of the year was to improve the experience of patients with learning disabilities (LD) and autism and we have made good progress with this important work.

We have expanded our team of Learning Disability and autism nurses, which now operates seven days a week. We have also recruited over 80 learning disabilities and autism champions who work at ward level and provide additional support for staff. When the pandemic started we recognised the need to quickly develop a Covid-19 passport for LD and autistic patients to support them through their time in our care.

I am also pleased to announce that in Kelvin Blake, one of our Non- Executive Directors, we have a Board champion for this work.

Ensuring that all of our staff respond appropriately and sensitively to the needs of people with learning disabilities or autism will again be one of our quality priorities in 2020/21 as we want to go further and embed outstanding care every time.

# Statement on quality from the Chief Executive



In April 2019 we also launched our Patient Advice and Liaison Service (PALS) to try and address patient feedback and concerns more responsively. We have opened a dedicated drop in space in the Atrium that has enabled us to resolve concerns more effectively and at the time patients or their families raise them. This again is part of our commitment at NBT to respond to concerns and queries from both staff and patients as they happen.

We will continue to listen to feedback from patients, their families and carers to keep improving patient experience. I want to assure anyone reading this that we do listen to what our staff and patients tell us. Feedback over the past year from patients has led to several improvements including better signage across the hospital, improved waiting areas and changes to ensure that staff now inform patients of any appointment delays upon arrival. This feedback will be even more crucial as we look to establish new ways of working due to COVID-19 in a way that patients and visitors can still feel safe when they come to our hospital.

**Looking ahead**

As we move into 2020/21 we will all have to adapt to the way we run and receive services due to COVID-19, especially in the short term. However there are already numerous examples of how staff have responded to the challenges posed to us in recent months with agility and compassion.

I also know that restrictions to our visitors' policy has caused particular challenges to the wellbeing of patients and families, however staff have responded to this resourcefully by launching several family communication initiatives. For example, patients can now nominate a family member or friend who can be contacted by the medical team to inform and discuss their condition. Similarly frontline staff have also introduced 'virtual visits' for patients, arranging for iPads to be used to connect them with family and friends providing a valuable morale boost.



We accelerated our digital programmes during the COVID-19 period with the rapid implementation of clinical IT systems such as eObservations, Care Flow Connect and Attend Anywhere eObservations. This enables ward staff to enter routine observation recordings onto an iPad, allows all ward staff to see where the sickest patients on the ward are, and supports clinical staff to take a view of the acuity of all our patients across the hospital. It improves reliability and safety as observation recordings are no longer carried about on pieces of paper. Attend anywhere has enabled us to provide advice, guidance and on line consultations through the pandemic and during lockdown when patients were unable to come into the hospital.

I am incredibly proud of our role leading the development of the NHS Nightingale Hospital Bristol at the University of the West of England (UWE) site. The Nightingale will continue to be important in ensuring we can safely deliver care for patients across the region should we experience further Covid-19 surges. It can provide up to 300 intensive care beds for coronavirus patients if needed and is a truly successful piece of collaboration with partners across the Severn Critical Care Network, including the MOD, the Army, UWE and all NHS bodies in the West of England. The hospital was built in 21 days and has now trained over 1000 staff to work in the facility if and when local hospitals fill up their beds.

Finally, we are also working with other Trusts and research partners on a number of crucial coronavirus research studies to further understand how the disease affects people differently and to find an effective treatment or vaccine. Patients at NBT were entered in the RECOVERY trial which has recently reported success in reducing mortality from COVID-19.

**Andrea Young**
**Chief Executive North Bristol NHS Trust**



# Part 2

## Priorities for improvement and statements of assurance from the Board

# 2.1 Priorities for Improvement

Part 2

**Every year the Trust sets priorities for improvement which are consulted upon internally and externally and represent areas where we would like to see significant improvement over the course of the year.**

## Our priorities for 2019/20 were:

1 Supporting Patients to Get Better Faster and More Safely

2 Meeting the Identified Needs of Patients with Learning Disabilities/ Autism

3 Improving Our Response to Deteriorating Patients

4 Learning and Improving from Patient and Carer Feedback

5 Learning and Improving from Clinical Governance Systems



Part 2

# 2.1 Priorities for Improvement

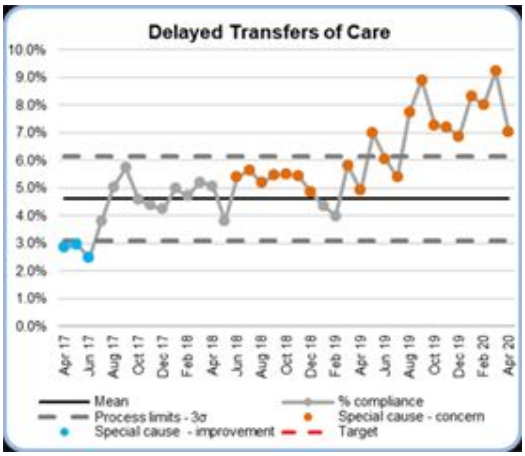
## Supporting Patients to Get Better Faster and More Safely

**Our commitment:** We will continue to improve the identification and assessment of frail patients so that we can tailor our services to their individual needs and reduce the number of 'stranded' patients within our hospital. We will also continue developing our hospital at home service for elective patients, reducing length of stay and ensuring a positive patient experience.

### Delayed Transfer of Care

A 'delayed transfer of care' occurs when a patient is medically fit to leave the hospital but is still occupying a bed.

Main reasons for delay are linked to waiting for a complex assessment bed, waiting for rehab bed availability and fast track placements.




The average level of DToC has remained at c.6.5%, above the target level. The impact of this is continued pressure on Trust bed occupancy levels, which are higher than the national goal of 92%.

The impact of COVID-19 has significantly altered the landscape. Since mid-March 2020, there has been a significantly different pattern of hospital activity and the pandemic has also affected the transition of patients into out of hospital locations. In effect the previous 'normal' clinical model has changed completely and consequently new plans and actions are being developed to manage this in the short and medium term in line with emerging national requirements and local intelligence.

### Frailty Assessments

The establishment of the Frailty Scores and use of CGA are key tools that have been implemented to support this work and are being embedded into clinical practice.

### Hospital at Home

The Hospital at Home service, went from strength to strength during 2019/20 and is widely utilised throughout the Trust. The service prides itself in being a patient centred service; continuously growing, developing and adapting itself for the needs of individual patients, from a variety of different clinical backgrounds.

During 2019/20, 751 patients benefited from the service, enabling them to transfer home to continue their hospital treatments, whilst saving over 6000 bed days for the trust.

| 751 | 6,000 |
|---|---|
| H@H patients | Bed days saved |

The service has always received excellent patient feedback. In 2019 69% of patients who provided feedback had a very good experience, where 87% of patients were extremely likely to recommend the service to others.

In November 2019, the service established its first formal referral pathway for the Plastic Trauma Clinic which has enabled patients to commence hospital treatment immediately from clinic and avoid an inpatient stay. The Hospital at Home service also became one of the first areas to solely utilise the Careflow Connect handover that has enhanced the level of communication between our community patients and the hospital.

# 2.1 Priorities for Improvement



## Meeting the Identified Needs of Patients with Learning Disabilities & Autism

**Our commitment:** We will deliver the three NHS Improvement priority standards to improve care delivery to patients and through the new Learning Disability and Autism Steering Group drive work at ward level to train staff and deliver tangible improvements in care quality.

Over a million people in England have a learning disability and we know they often experience poorer access to healthcare than the general population. The NHS Long Term Plan (January 2019) commits the NHS to ensuring all people with a learning disability, autism or both can live happier, healthier, longer lives.

In June 2018, NHS Improvement launched the national learning disability improvement standards for NHS trusts. These were designed with people with a learning disability, carers, family members and healthcare professionals to drive rapid improvement of patient experience and equity of care. The three standards which apply to all NHS trusts cover:

- respecting and protecting rights;
- inclusion and engagement;
- workforce.

North Bristol Trust completed an initial self-assessment exercise against these 3 standards and our feedback is incorporated in our improvement plan and strategy. During 2019/20 a second benchmarking exercise in the form of a patient and staff survey has been completed and submitted to NHS Improvement, the report is yet to be released.

**2019/20 achievements:**

- We held an Experience Based Design Focus Group with Carers of patients with Learning Disabilities from Bristol & South Gloucestershire.
- We have set up a learning disability and autism steering group which meets bi-monthly.
- Our 3 year plan for improvement has been agreed through the steering group.
- The learning disability liaison team was expanded to a seven day service, supporting patients with autism with a Lead Nurse now successfully appointed and in post.
- We have improved triage / assessment of soft signs and supported wards with Mental Capacity Act and best interest decision making.
- We have over 80 Learning Disability and Autism champions at ward level and a Non Executive Director, Kelvin Blake, nominated as a Board level champion.
- Developed and implemented a COVID-19 passport to add to the hospital passport and guidance notes for clinical staff assessing and treating patients with a Learning Disability or Autism during the COVID-19 pandemic.

Part 2

# 2.1 Priorities for Improvement

## Improving Our Response to Deteriorating Patients

**Our commitment:** We will build upon the successful implementation of the National Early Warning Score (NEWS2) to ensure that patients exhibiting signs of deterioration in their condition are quickly identified and appropriately treated.

**Key achievements during 2019/20:**

Management of Sepsis remains good with sepsis screening at 100% and antibiotics administered within 60 minutes at 91%

We have hosted focus groups with staff representation and combined this with a large snapshot audit to identify themes for improvement:

**Top 3 Focus Group themes:**

Communication

Clinical Experience

Care Planning (and Handover)

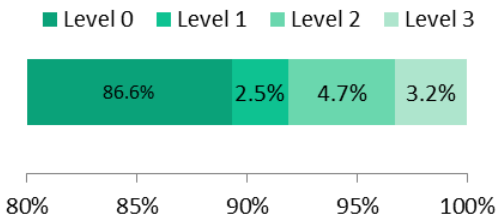
**Top 3 Audit themes:**

Escalation

Observation

Documentation

**Escalation Profile from e-Obs**




Electronic observations (e-Obs), including a sepsis and separate bespoke NeuroNews2 modules were launched in March 2020, at the start of the COVID-19 pandemic.

Early data helps to identify the proportion of critically unwell patients outside of the Intensive Care Unit.

**Further planned actions:**

1. A Deteriorating Patient Steering Group with links to divisional governance and executive sponsorship is planned although implementation has been paused to manage the impact of COVID-19.

2. Reviewing what has worked well during the COVID-19 pandemic in terms of ward-based doctors and enhanced 7 day cover, to consider how we develop escalation processes.

3.Using SIM and QI training to support work on psychological safety and improved communication within teams

4. Develop e-Obs assurance reports and data dashboard on QlikSense for accessibility

5. Working with the digital team to explore the connection between e-Obs and Careflow Connect to encourage the safest use of this function for our clinical teams.

# 2.1 Priorities for Improvement

Part 2

## Learning & Improving from Patient & Carer Feedback

**Our commitment:** We will demonstrate a much stronger and more responsive approach to seeking, understanding and acting upon different forms of patient feedback. This work will be supported and driven by a new Board sub committee for Patient Experience.

### Patient feedback is an important source of information that should help staff implement changes that will improve care quality and patient safety.

In April 2019, we successfully launched the Patient Advice and Liaison Service (PALS) which has reduced the number of overdue complaint responses. The PALS service has an office in the hospital where patients, carers or family members can walk in and speak to someone about their experience. PALS continues to grow and improve, looking ahead to 2020/21 this means further embedding PALS within the Trust.

The service will move into a new larger office space which will improve the visibility and accessibility of the service.

PALS will increase their profile by educating ward staff, improving the availability of information across the hospital and online and by undertaking engagement events or out-reach events in groups across the community.

PALS will also asses its reporting and monitoring to ensure it can support Divisions to manage, respond to and learn from their concerns.

**Further achievements in 2019/20 include:**

- A Trust Board committee has been established giving a higher profile to patient and carer experience.
- Engagement with those using our services has increased and is influencing Outpatient improvement.
- The comparison of feedback from the Friends and Family Test and complaints is enabling focused action for improvement.
- Positive engagement with carers' forums is growing and influencing our work to support carers.

**Actions taken in response to learning from complaints**

We have improved the signage throughout the hospital to help patients and carers.

Improvements to the waiting area for Gynaecology Emergency Clinic

Refreshing manual handling training for ward staff with a focus on ensuring staff are compassionate and kind when moving and handling patients.

Improved staff training on taking consent for clinical procedures, in particular where the nature of the procedure changes from that which was originally discussed or agreed by the patient.

Reception staff to inform patients of any delays when they are checked in for appointments.

The Palliative Care team have reviewed the education they provide focusing on improving communication with patients and their relatives when patients have a poor prognosis.

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Part 2

# 2.1 Priorities for Improvement

## Learning and Improving through Clinical Governance Systems

**Our commitment:** We will embed the new quality governance structures for which investment was agreed in March 2019. The identification, investigation and learning from various forms of clinical incidents or events will be applied into tangible actions that drive improvements in quality of care.

**A key component of embedding strong quality assurance and improvement as close to the patient as possible has been the strengthening of Quality Governance in clinical divisions.**

A change programme with strong executive leadership, lay membership and Non-Executive Director oversight was delivered between September 2018 and June 2019. This delivered a range of significant improvements that underpinned the CQC inspection success, in September 2019, when the Trust achieved a 'Good' rating overall. The Trust was awarded an Outstanding rating in the Well Led domain which includes assessment of governance.

In addition a further review of the Improvement Programme by the Trust's internal auditors, KPMG, provided 'Significant Assurance' that it had demonstrably achieved its goals.

Key improvements included;

- Investment in quality governance resources within clinical divisions and appointment into those posts during 2019 to improve the timeliness and quality of work undertaken.
- The establishment of trustwide quality governance learning events, within which clinical and corporate teams share approaches and learning to improve quality of care.
- The creation of a robust Patient Advice & Liaison Service (PALS) and increasing number of concerns managed through this route rather than requiring a formal complaints process.
- Significant improvements in risk management and patient safety incident governance, supported by tailored staff training.
- Improvements in quality governance structures supporting the Trust Board.
- New trust wide policies for mortality and morbidity reviews, patient consent and completion of multidisciplinary team meetings (MDTs).
- The establishment of a project to deliver the new medical examiner service for NBT, jointly with University Hospitals Bristol Foundation Trust and Weston Area Health Trust.
- Agreement to implement a new ward accreditation model taking the learning from a site visit to University College London Hospitals (UCLH) Foundation Trust to review their approach.

A phase 2 programme designed to maximise the learning and benefits from the work already completed commenced in early 2020. This programme is now being adapted in light of the COVID-19 pandemic and will evolve in the coming months.

# 2.1 Priorities for Improvement

Part 2

Every year the Trust sets priorities for improvement. These have been developed through engagement with the Patient Safety & Clinical Risk Committee, Clinical Effectiveness & Audit Committee, Trust Management Team and with patient and wider representation at the Patient Experience Group, Patient Participation Group and the BNSSG CCG.

They were developed in conjunction with a new Trust Quality Strategy, which will be finalised for approval at Trust Board in July 2020.

In line with the principles set out within the new strategy, improvement priorities are monitored by a Trust-wide Committee or Group which is responsible for agreeing and overseeing delivery against specific improvement actions. These will typically be a mixture of both quantitative and qualitative measures.

The development work on these is in progress, having been disrupted by the COVID-19 pandemic response. This work will be overseen as set out below.

## The Quality Account priorities for 2020/21 and their related governance arrangements are:

| Objective | Trust wide Oversight |
|---|---|
| 1. **Meeting the identified needs of patients with Learning Disabilities, Autism or both.** | **Learning Disability & Autism Steering Group**<br>Chair: Director of Nursing & Quality |
| 2. **Being outstanding for safety – a national leader in implementing the NHS Patient Safety Strategy, within a 'just' safety culture.** | **Patient Safety & Clinical Risk Committee**<br>Chair: Director of Nursing & Quality |
| 3. **Ensuring excellence in our maternity services, delivering safe and supportive maternity care.** | **Patient Safety & Clinical Risk Committee**<br>Chair: Director of Nursing & Quality |
| 4. **Excellence in Infection Prevention and Control to support delivery of safe care across all clinical services** | **Infection Prevention & Control Committee**<br>Chair: Medical Director |

*In addition, quarterly updates against the improvement goals will be provided from the end of Quarter 2 (September 2020), with formal reporting to the Trust Management Team, chaired by the Chief Executive and the Quality & Risk Management Committee, chaired by one of the Trust Non-Executive Directors.*

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Part 2

# 2.1 Priorities for Improvement

# 2.2 Statements from the Board Review of Services

Part 2

**The trust has reviewed all the data available to them on the quality of care in all of the NHS services listed below.**

## Medicine

Emergency Medicine
Acute Medicine
Mental Health Liaison
Immunology / Infectious Diseases / HIV
Haematology
Acute Oncology
Medical Day Care
Palliative Care
Cardiology
Care of the Elderly
Clinical Psychology
Diabetes / Endocrinology
Gastroenterology
Respiratory
Endoscopy

## Anaesthesia, Surgery, Critical care and Renal

Critical Care
General surgery
Vascular Network
Breast Services
Plastics, Burns and Dermatology
Anaesthetics
Renal & Transplant
Elective Care
Urology
Emergency Care

## Women's and Children's Health

Maternity Services
Gynaecology
Fertility Services
Neonatal Intensive Care Unit (NICU)

## Core Clinical Services

Pharmacy Services
Outpatients
Clinical Equipment Services
Therapy Services:
Nutrition & Dietetics
Speech and Language Therapy
Occupational Therapy
Physiotherapy
Severn Pathology:
Pathology Services
Blood Sciences
Cellular Pathology
Infection Sciences
Genetics
Imaging Services:
Medical Photography & Illustration
Interventional Radiology

## Neurosciences and Musculoskeletal

Elective orthopaedics
Trauma
Major trauma
Bristol Centre for Enablement
Rheumatology
Neurosurgery
Spinal Service
Neurology
Stroke Service
Neurophysiology
Neuropsychiatry
Neuropsychology
Neuropathology
Chronic pain

9

Part 2

# 2.2 Statements from the Board Review of Services

The Trust reviews data and information related to the quality of these services through regular reports to the Trust Board and the Trust's governance committees. To provide data quality assurance there is a Data Quality Tracker, which is updated daily and made available to all staff. The Data Quality Tracker is one of the leading quality management products used by the Data Quality Marshalls within IM&T. This team triages both internal and external data quality queries, ensuring that any item raised is logged, assigned, tracked, and ultimately resolved, engaging wider resources as required.

There is a monthly North Bristol Trust Data Quality Meeting, focusing on all internal and external quality issues. The outcome from this Board is then visible internally to higher level quality forums and to the IM&T Committee, and externally to our commissioners via our Data Quality and Improvement Plan Meeting and Finance Information Group meetings, all of which are held monthly. Throughout 2019/20, this governance structure has continued to report Data Quality as green and an area of increasing assurance.

In line with the principles of Service Line Management embedded during 2018/19 the leadership teams of our five clinical divisions are responsible for their own internal assurance systems. Clinical divisions are then subject to regular executive reviews during which performance against standards of quality and safety are assessed. Through these mechanisms the Trust reviews all of the data available on the quality of care across its services.

The income generated by the NHS services reviewed in 2019/20 represents 100% of the total income generated from the provision of NHS services by North Bristol NHS Trust for 2019/20.



# 2.2 Statements from the Board
# Care Quality Commission

Part 2

## NBT rated Outstanding for care and Good overall by CQC

Since the Trust's last inspection two years ago NBT has improved on every assessment bar one. Crucially, the Trust's approach to caring for patients has been rated as Outstanding, as has the way the organisation is led. The Trust's end of life service has also been rated as Outstanding.


Care Quality Commission

North Bristol NHS Trust is required to register with the Care Quality Commission under section 10 of the Health and Social Care Act 2008. NHS trusts are registered for each of the regulated activities they provide, at each location they provide them from. As at 31/03/2020, the Trust's registration status is that it is registered for all of its regulated activities, without any negative conditions, such as enforcement actions during the reporting period.

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## July 2019 Inspection

A team of inspectors from the CQC visited the trust during June and July 2019 to check the quality of five core services: urgent and emergency services, medical care (including older people's care), surgery, maternity and end of life care. The CQC also looked specifically at management and leadership to answer the key question: Is the Trust well led?

**37 domains were inspected and 84% were either rated as either Good or Outstanding**

Inspectors found:

- Staff treated patients with compassion and kindness, respected their privacy and dignity, took account of their individual needs, and helped them understand their conditions.
- Staff provided emotional support to patients, families and carers.
- Services are well planned and managed by staff with the right skills, knowledge and experience.
- The Trust has a strong culture, with good morale and a clear set of patient-centred values.
- The Trust has a proactive approach to preventing harm, with staff willing to challenge poor practice, but when things do go wrong lessons are learned.
- The Trust has a culture of learning, innovation and continuous improvement.
- The CQC found us "fizzing with energy".

Part 2

# 2.2 Statements from the Board Care Quality Commission

## Overall Trust Rating

| Overall Rating | Safe | Effective | Caring | Responsive | Well-Led |
|---|---|---|---|---|---|
| Good | Good | Good | Outstanding | Requires Improvement | Outstanding |

## Southmead Hospital Rating

| | Safe | Effective | Caring | Responsive | Well-Led | Overall Rating |
|---|---|---|---|---|---|---|
| Urgent & Emergency Services | Good | Good | Outstanding | Requires Improvement | Outstanding | Good |
| Medical Care | Good | Good | Good | Requires Improvement | Good | Good |
| Surgery | Good | Good | Good | Good | Good | Good |
| Critical Care | Good | Good | Good | Requires Improvement | Good | Good |
| Maternity & Gynaecology | Requires Improvement | Good | Good | Good | Good | Good |
| Children & Young People Services | Good | Good | Good | Good | Good | Good |
| End of Life Care | Good | Outstanding | Outstanding | Outstanding | Outstanding | Outstanding |
| Outpatients | N/A | Good | Good | Good | Good | Good |
| **Overall Location** | Good | Good | Outstanding | Requires Improvement | Outstanding | Good |

## Cossham Hospital Rating

| | Safe | Effective | Caring | Responsive | Well-Led | Overall Rating |
|---|---|---|---|---|---|---|
| Maternity & Gynaecology | Good | Good | Outstanding | Outstanding | Good | Outstanding |
| Outpatients | Good | N/A | Good | Good | Good | Good |
| **Overall Location** | Good | Good | Good | Good | Good | Good |

# 2.2 Statements from the board Research and Innovation

Part 2

**This year more patients than ever had the opportunity to take part in research.**

**101** new research studies

**5584** The number of patients receiving relevant health services provided by North Bristol NHS Trust in 2019/20 that were recruited to participate in research approved by a research ethics committee.

INVESTORS IN PEOPLE™

Our research and innovation team was recognised nationally with an Investors in People Silver Accreditation award. We were also shortlisted as finalists in the employer of the year category for our work to support our research staff.

## Recognition

NBT had huge success, being awarded 6 National Institute for Health Research (NIHR) grants designed and led by NBT staff supported by our patient advisers. We now have a total portfolio of research grants worth £32 million. NBT led a regional project to help understand barriers to engaging staff in research across the NHS. This will help Research and Innovation design better engagement packages for both staff and patients; increasing opportunities for all.

## Collaboration

NBT are leading a collaborative project across the West of England to ensure all patients have equal access to research. We set up a joint research team with Sirona to enable respiratory patients in the community access to greater research opportunities. Through this project 3 new studies were opened enabling more than 113 patients to participate.

## Public contribution

We ran 40 sessions for patients to contribute to research design and help us make sure we are delivering the research that is important to our community. Patients and the public helped us decide which research to support with the Southmead Hospital Charity Research Fund and we recently awarded £166,082 supporting projects across NBT.

## What next?

Next year we will focus more research towards priorities identified with our regional partners, focusing on improving the health and wellbeing of our community. We also aim to increase research in areas of new technology focused on transforming healthcare for the future.

## COVID-19

Research is one of the Governments three key strategies for dealing with the pandemic. Currently there is no known treatment for this disease but NBT is working alongside other research organisations and NHS Trusts across the country to ensure that we can get the best answers and treatment to our patients. We have created a dedicated COVID-19 Research Team, together with Pathology and Pharmacy and we are seeking to give as many patients as possible the opportunity to join in this research.

We are running a number of trials looking at different treatments for COVID-19, as the disease infects so many different people from different patient populations and we are investigating the use of different treatments for different patients so we can ensure everyone receives the very best care. In addition to this, we are looking at the impact during pregnancy for both mother and infant and how we can improve diagnostics.

Part 2

# 2.2 Statements from the board CQUIN Achievement 2019/20

A proportion of our income in 2019/20 was conditional upon achieving quality improvement and innovation goals agreed between North Bristol NHS Trust and local Clinical Commissioning Groups or NHS England for the provision of NHS services, through the Commissioning for Quality and Innovation (CQUIN) payment framework. Further details of the agreed goals for 2019/20 are available electronically at;

https://www.england.nhs.uk/wp-content/uploads/2019/03/ccg-cquin-1920-indicator-secifications-feb-2020.pdf

https://www.england.nhs.uk/nhs-standard-contract/cquin/cquin-19-20/

| Title | National & Local CQUINs (CCG contracted) | Outcome |
|---|---|---|
| **1. Antimicrobial Prescribing** | Achieving 90% of antibiotics treatment for lower UTI in 65+ IP<br>Achieving 90% of antibiotics surgical prophylaxis treatment for elective colorectal surgery | |
| **2. Staff Flu Vaccinations** | Uptake of flu vaccinations by frontline clinical staff of 80% | |
| **3. Risky Behaviours** | Achieving 80% Timely Screening (Alcohol & Tobacco)<br>Achieving 90% of identified smokers given brief advice<br>90% of patients identified as drinking above low risk levels, given brief advice or offered a specialist referral | |
| **7. Falls Prevention** | Achieving 80% of 65+ inpatients receiving key falls prevention actions | |
| **11. Same Day Emergency Care** | 75% of patients with confirmed pulmonary embolus being managed in a same day setting<br>75% of patients with confirmed atrial fibrillation managed in a same day setting<br>Patients with or confirmed Community Acquired Pneumonia should be managed in a same day setting | |

| Title | Specialised CQUINs (NHS England contracted) | Outcome |
|---|---|---|
| **PSS1 Medicines Optimisation** | 1. Improving efficiency in the IV chemotherapy pathway from pharmacy to patient<br>2. Supporting national treatment criteria (Blueteq)<br>3. Faster adoption of prioritised best value medicines and treatment<br>4. Anti-Fungal Stewardship | |
| **PSS8 Severe Asthma** | 1. Appropriate initiation prescribing and annual review of biologics by a severe asthma centre<br>2. Virtual network MDTs<br>3. Network spokes prescribe repeat medication<br>4. Completion of data to the UK Severe Asthma Registry and NHS England Quality Dashboard | |
| **PSS10 Spinal Surgery Network** | 1. Spinal Network MDT Oversight<br>2. Data entry on BSR<br>3. Concentration of Specialised Surgery<br>4. Avoidance of unnecessary interventions | |
| **PSS11 Promoting Transplantation** | 1. Establish a Network<br>2. Organ utilisation<br>3. Donor and recipient experience in networked providers<br>4. Promoting donation | |

| | |
|---|---|
| Good Achievement - 80%+ | |
| Partial achievement - 40%-79% | |
| Poor achievement- <40% | |

# 2.2 Statements from the Board Operational Performance

Part 2

## Cancer Performance

Performance against the 62 day cancer standard improved in 2019/20 with the Trust achieving against its planned trajectory for 50% of the year. The standard achieved the national target of 85% in August. The majority of treatment delays have been the result of capacity issues in Urology with backlog clearance plans ongoing and performance improving as a result, after some issues with patient choice over the winter months.

The Trust carried out the highest amount of treatments year to date in March without having a major impact on breach totals.

The 31-day first treatment target was achieved once, in December 2019, with 96.8%. Performance fell below 90% in four months but has improved to above 90% since November 2019. The decline in performance is attributable to delays in robotic surgery within Urology and complex pathways and capacity issues in other Specialties.

The two-week waiting (TWW) time for urgent cancer referrals has delivered against trajectory for the 6 months since September 2019, with the highest performance reported in November 2019 at 90.21%. Performance against national standard has been challenged by workforce issues, demand outstripping capacity in dermatology during the summer months and patients choosing not to accept the appointments offered or cancelling those booked within the two-week target. Development and implementation of longer-term plans to close the demand and capacity gap should see an overall return to TWW standards by the end of 2020/21.

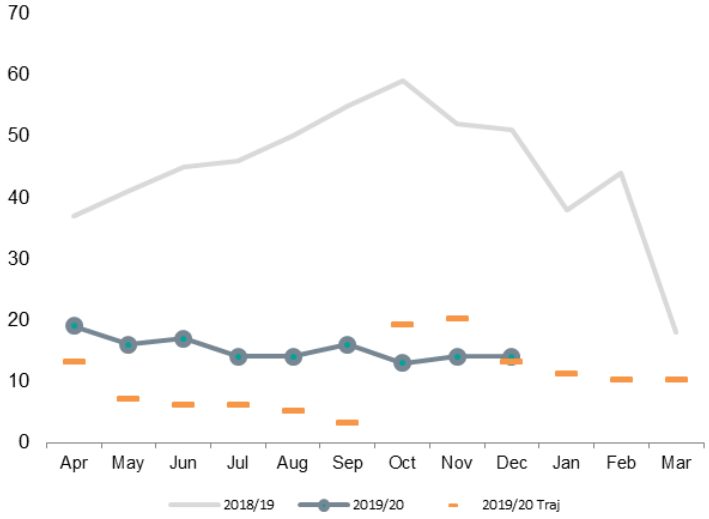
| Cancer Multidisciplinary Team (MDT) Performance | Target | Q1 19/20 | Q2 19/20 | Q3 19/20 | Q4 19/20 |
|---|---|---|---|---|---|
| Patient seen within 2 weeks of urgent GP referral | 93% | 82% | 69% | 86% | 86% |
| Patients with breast symptoms seen by specialist within 2 weeks | 93% | 85% | 96% | 91% | 81% |
| Patients receiving first treatment within 31 days of cancer diagnosis | 96% | 90% | 90% | 92% | 95% |
| Patients waiting less than 31 days for subsequent drug treatment | 98% | 100% | 100% | 100% | 100% |
| Patients waiting less than 31 days for subsequent surgery | 94% | 80% | 80% | 77% | 76% |
| Patients receiving first treatment within 62 days of urgent GP referral | 85% | 80% | 79% | 71% | 68% |
| Patients treated within 62 days of screening | 90% | 90% | 89% | 80% | 72% |

## 52 Week Waits

Throughout 2019/20, 52 Week waits have remained the lowest they have been for the last three years. Cancellations in the elective plan hindered the Trust's ability to continue releasing these patients and have therefore reported an increased number of long waiters in March 2020. Actions are being taken to support the clearance of breaches in 2020/21.

We are continuing to work with system partners to ensure that the number of patients waiting more than 52 weeks for elective surgery is minimized in 2020/21; however this is likely to be further impacted by the coronavirus Covid-19 outbreak in the UK.

**Trust Total 52 Week Wait 2018/19 vs 2019/20 and 2019/20 trajectory**




The Trust has historically experienced patients waiting in excess of 52 weeks on Referral to Treatment (RTT) pathways in a number of specialties. Exceptional actions have been taken to reduce the number of long waiting patients, including demand management through restrictions to access of services, outsourcing to the independent sector, waiting list initiatives and locum appointments to clear the backlog. The Trust's ambition to achieve zero patients waiting more than 52 weeks in 2019/20 has been held back by a number of factors, including:

- Complexities with accessing independent sector capacity;
- The impact of pension changes on staff capacity;
- Commissioner affordability; and
- The pressure of delayed transfers of care impacting the Trust's elective activity.

## Referral to Treatment

The Trust had set a trajectory predicting a performance position of 88.13% by the end of 2019/20. However, postponing the routine elective plan in response to COVID-19 negatively affected the March RTT position. Had the elective programme been delivered as planned, an end of year position of 83.50% was expected.

Actual performance for 2019/20 is 80.02% with a backlog of 5697 patients waiting over 18 weeks. The overall wait list size was 28,516 patients at the end of March 2020 against a trajectory of 27,754, which was set excluding patients on the e-Referral service (eRS). Therefore, the Trust would have met its trajectory for wait list size excluding patients on eRS, with a reported position of 26,588.

In January 2020 the Trust included all patients with an active RTT clock reporting in eRS in the national RTT submission. The inclusion of these patients improved the position and brought the Trust in line nationally. Following the inclusion of eRS patients the Trust's position is more closely aligned to the national picture. The Trust moved from position 304/373 to 297/375 and is now ranking second out of 11 Adult Major Trauma Centres.

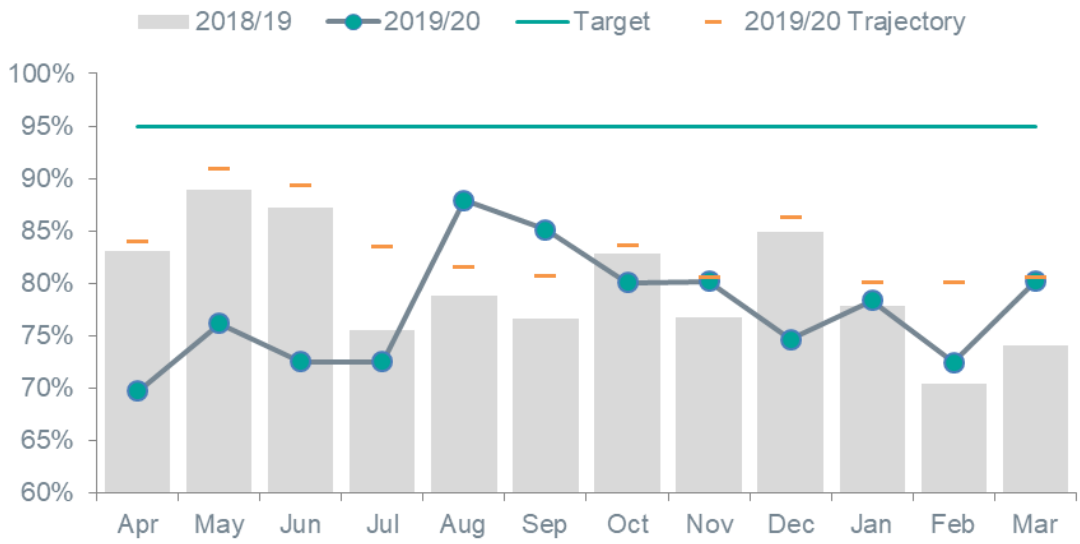
# 2.2 Statements from the Board Operational Performance

Part 2

## Accident & Emergency Maximum Waiting Time

The four-hour ED waiting time standard remained challenged in 2019/20 with a full year performance of 77.49% against a trajectory of 86.09%. However, waiting times significantly improved in August 2019, resulting from improved staffing. Since August 2019 the Trust has performed well nationally for Type 1, four-hour performance.

Frequently reporting in the upper or second quartile, the Trust regularly reports the highest performance amongst Adult Major Trauma Centres.




## Bed Occupancy

The flow of patients through hospitals is recognised nationally to be affected when bed occupancy rises above 92%. The Trust has reported monthly bed occupancy positions in 2019/20 varying from 94.81% in August 2019 and 95.19% and 95.18% in June and September 2019 respectively. The highest reported bed occupancy has been in January (98.95%) and February 2020 (98.86%). This was against the Trust's ambition of not exceeding 95% bed occupancy in any period. This demonstrates an improvement in 5 months when compared to 2018/19. Improved bed occupancy reduced the need to use escalation capacity and numbers of patient outliers, supporting the ethos of 'right place, first time'. Bed occupancy fell sharply in March due to the COVID-19 pandemic and the suspension of elective hospital admissions.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Part 2

# 2.2 Statements from the Board Hospital Episode Statistics and DQIPs

## Hospital Episode Statistics

The Trust submits a wealth of information and monitoring data centrally to our commissioners and the Department of Health. The accuracy of this data is of vital importance to the Trust and the NHS to ensure high-quality clinical care and accurate financial reimbursement. Our data quality reporting, controls and feedback mechanisms are routinely audited and help us monitor and maintain high-quality data. We submit to the Secondary Users' Service for inclusion in the Hospital Episode Statistics (HES) which are included in the latest published data. Within this data we are expected to include a valid NHS number and the General Medical Practice (GMP) Code and report this within each year's quality account. The summary of our data quality on these items is detailed below.

| M9 | 2018/19 | | 2019/20 | | 2019/20 National average | |
|---|---|---|---|---|---|---|
| | NHS No. | GMP code | NHS No. | GMP code | NHS No. | GMP code |
| Admitted Patient Care | 99.8% | 100.0% | 99.8% | 100.0% | 99.5% | 99.7% |
| Out Patients | 99.7% | 100.0% | 99.8% | 100.0% | 99.7% | 99.6% |
| A&E | 98.4% | 99.9% | 98.5% | 99.9% | 97.7% | 97.9% |

**We have exceeded national averages for all measurement criteria in 2019/20.**

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## Commissioner Data Quality Improvement Plans (DQIPs)

As part of contractual reporting requirements, the Trust is required to agree and undertake Data Quality Improvement Plans (DQIP's) for both NHSE and CCG. The Trust had the largest DQIP in the Commissioning region at the start of 2018/19, and demonstrated unprecedented improvement in data quality which led to no DQIP from BNSSG CCG in 2019/20. The Trust's response to our Commissioner DQIP in 2019/20 is summarised as follows:

| Commissioner DQIP Performance | DQIP Items | Items Delivered | % Complete | DQIP Status |
|---|---|---|---|---|
| NHS England | 18 | 12 | 66.7% | On Track* |
| BNSSG CCG | N/A | N/A | N/A | N/A |

* *The monitoring of DQIP was paused from Month 11 in 2019/20 as part of the overall COVID-19 pandemic response. The 6 remaining items on the 2019 DQIP have a full delivery plan in place, and will be completed within Q1 2020/21.*

There are no plans for a DQIP to be issued in 2020/21 from either NHSE or BNSSG CCG. Processes for raising ad hoc data quality queries have been in place since 2018/19, and will be utilised on an ongoing basis to support the existing governance structures around quality and performance. Both Commissioners and key Trust stakeholders will be advised of data quality performance via established governance structures, and DQIP's may be instigated in future should the need arise and with the agreement of all parties.

The performance against our DQIP has been a recurring item for assurance to key governance forums, and has received praise from Commissioners.

# 2.2 Statements from the board
# Clinical Coding Performance

Part 2

## CLINICAL CODING PERFORMANCE

Clinical Coding is the process whereby information written in the patient notes is translated into coded data and entered onto hospital information systems for statistical analysis and financial reimbursement from Commissioners via the National Tariff Payment System.

Coding provides an essential service to the Trust, benefitting quality of care, patient safety, income from activity, and supports research and best practice initiatives. Accurate coding is widely recognised by the NHS as an essential element for benchmarking performance against peers.

As part of the annual Data Security & Protection Toolkit submission (formerly known as the IG Toolkit), we are required to demonstrate the accuracy of our clinical coding. Our year-on-year performance is detailed below:

| Clinical coding performance | DSP Toolkit Met | 2018/19 | 2019/20 | ↑↓ |
|---|---|---|---|---|
| Primary Diagnosis | 90% | 94.50% | 90.25% | -4.25% |
| Secondary Diagnosis | 80% | 96.40% | 91.69% | -4.71% |
| Primary Procedure | 90% | 95.90% | 93.36% | -2.54% |
| Secondary Procedure | 80% | 85.70% | 84.21% | -1.49% |

The 2019/20 performance has shown a decline on the performance of 2018/19, with the following factors influencing the results obtained this year:

- **Expanded audit regime:** There has been a material increase in the frequency and scope of audit activity throughout 2019/20 which has led to ten times the volume of spells audited.
- **Engagement of external coding auditors:** NBT have engaged highly specialised external clinical coding auditors to ensure a fully impartial and transparent level of scrutiny and assurance, complete with recommendations for further improvement.
- **Integration into Coding Improvement strategy:** Full incorporation of audit work into the Clinical Coding Improvement Strategy – areas of improvement and opportunity are being actively sought out and aligned with recommendations from GIRFT and benchmarking sources.

The service has continued to perform to high standards against the backdrop of increasing volume and complexity in activity, while embracing additional scrutiny and an expanded audit regime. The overall 2019/20 performance is indicative of Standards Met assurance rating within the DSP Toolkit.

Part 2

# 2.2 Statements from the board
# Improvement Strategy and Data Security & Protection Toolkit

## CLINICAL CODING IMPROVEMENT STRATEGY

The Trust's Clinical Coding team has consistently developed and matured its offering to the Trust since receiving an internal audit rating of Significant Assurance with Minor Improvement in November 2017. The development of the Clinical Coding Improvement Strategy in 2019 has led to the following material advancements in 2019/20:

- ✓ **Annual Improvement Plan**: A full Clinical Coding Improvement strategy and 18 month plan of improvement works has been ratified via Finance and IM&T Committee. This ensures a long-term and measurable programme of continual improvement across clinical divisions, with evidence to be obtained via improvement in average tariff, and enhanced Depth of Coding benchmark performance.
- ✓ **New Technology**: Implementation of Medical History Assurance (MHA) coding quality software which delivered an additional £1.98m of assured income from planned inpatient activity during 2018/19, with a further £819k in 2019/20.
- ✓ **Data Analytics:** Deployment of Clinical Coding QlikSense data analytics app, which is revolutionising clinicians' engagement with the inpatient coding process, and senior management awareness of Coding's operational throughput. Further analytics development on Depth of Coding benchmarking is planned for 2020/21
- ✓ **Engagement:** Attendance at Divisional Management Team and Specialty Team meetings, supported by 1-2-1's with Consultants, bespoke specialised clinical coding audits, group workshops, new online learning packages, and reviews of processes and pro-forma.
- ✓ **Partnerships & External Communications:** Our commitment to continual improvement has drawn attention from professional networks and technology providers in 2019/20. Our Coding function worked with 3M and to produce an online webinar hosted by HFMA detailing our strategic improvement agenda.

Our progress has drawn national attention and recognition, starting with the Future NHS Award Nomination in 2018/19, and continuing in 2019/20 with our engagement by HFMA to share the ongoing success surrounding our transformation work.

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## DATA SECURITY & PROTECTION TOOLKIT

The Information Governance Toolkit was replaced in 2018/19 with the Data Security & Protection Toolkit. It is an online self-assessment tool that allows us to measure our performance against the National Data Guardian's data security standards. The toolkit provides us with assurance that we are practising good data security and that personal information is handled correctly.

In 2018/19 the Trust achieved Standards Met across the toolkit submission. In 2019/20, the toolkit assessment has expanded to incorporate further criteria relating to cyber assurance and related compliance measures. While NBT remains on-track to maintain compliance, the deadline for submission has been moved to September 2020 to enable Trusts to focus on the COVID-19 pandemic response. The table below therefore reflects the prior period's performance, the expansion of the Toolkit criteria in 2019/20, and that overall performance is to be confirmed during 2020/21.

| | 2018/19 | 2019/20 |
|---|---|---|
| Mandatory evidence items provided | 100 | 116* |
| Assertions confirmed | 40 | 44* |
| Assessment status | Standards Met | TBC September 2020* |



# Part 3

## our quality indicators

- Patient Safety
- Clinical Effectiveness
- Patient Experience

# 3.1 Patient Safety
# Patient Safety Incidents

Part 3

The safety of our patients is at the core of our approach and culture and we aim to be outstanding for safety and at the forefront nationally in implementing the NHS Patient Safety Strategy.

Patient safety incidents that are reported by our staff provide us with key insights into the safety of our patients.

In 2019/20 we have built on work done previously by focussing on embedding our systems and processes that facilitate learning. We have a strong approach to reporting and learning from incidents, regularly reviewing and analysing trends and themes of incidents and learning.

We continued to be heavily engaged in the national developments led through the Healthcare Safety Investigation Branch (HSIB), with Trust staff seconded to lead the support programme for Maternity Safety training. We have already adopted good practice identified in the HSIB approach and are engaging with national patient safety leads across a range of areas set out in the NHS Patient Safety Strategy.

We are driving our improvement work within the two foundations of the Patient Safety System and Patient Safety Culture. Our response to the NHS Patient Safety Strategy to date has involved a wide range of presentations and discussions at various forums across the Trust to engage our staff and prepare the ground for implementation of specific plans. These will be developed alongside the detail released within forthcoming national guidelines that support the strategy implementation.

During 2020-21 our focus will include developing and implementing an annual patient safety plan to underpin our Quality Strategy, enhancing how we turn learning into improvement and focusing on our Patient Safety Culture and systems that provide us with insights into the safety of our patients.

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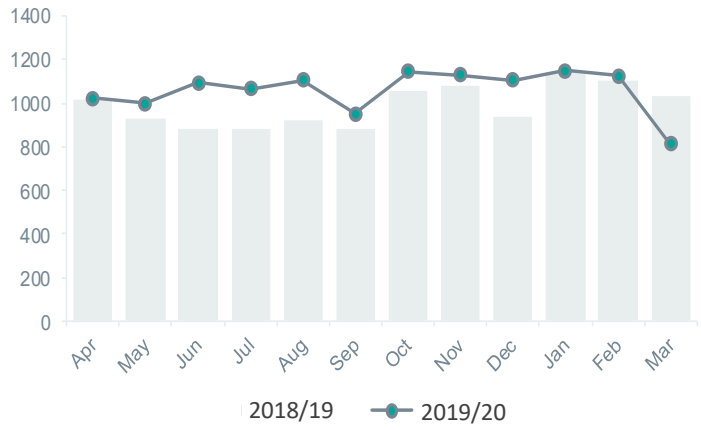
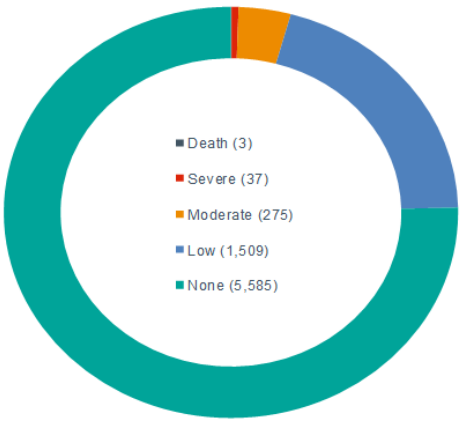



In our most recent patient safety incident upload to the national system we have shown an increased incident reporting rate, often considered as an indication of a good safety and learning culture.

The reduction in March 2020 is accounted for by the reduced activity levels due to COVID-19 impact on services.

This is the latest available validated level of harm data for the period Apr-Sep 2018 uploaded to the National Reporting and Learning System.



# 3.1 Patient Safety Freedom to Speak Up

Part 3

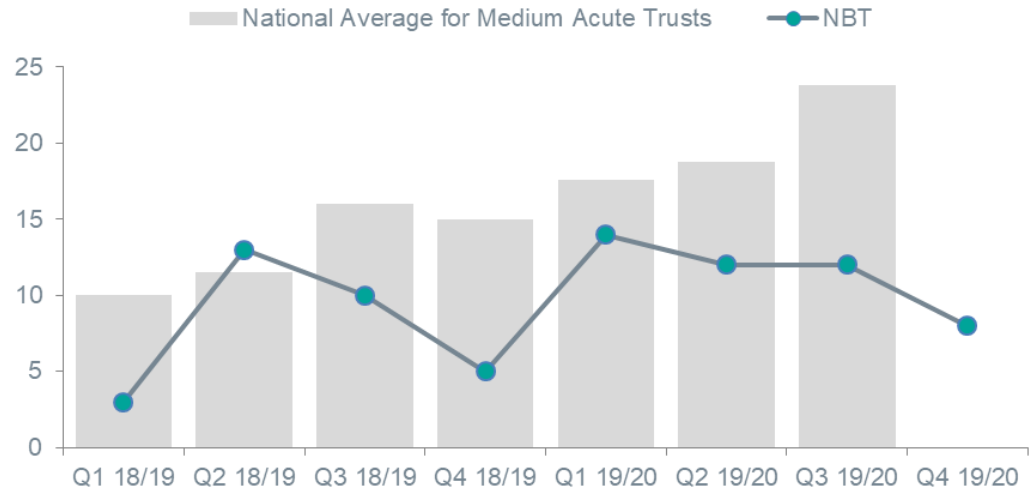
Freedom to Speak Up (FTSU) is an arrangement arising from the recommendations in the Francis report (the Mid Staffordshire NHS Foundation Trust public enquiry). Effective speaking up arrangements help to protect patients and improve the experience of NHS workers.

FTSU Guardians have been in place at NBT since 2017 and are now well established. Guardians have been identified and recruited across different areas and groups within the Trust (including junior doctors, nursing, support and corporate staff), giving staff an additional route to raise issues and concerns, and enabling the Trust to respond and deal with concerns more effectively.

The number and type of concerns raised in 2019/20 are broadly in line with national expectations, covering patient safety and quality and staff behaviours, but are slightly below the national average for medium sized acute Trusts.

The numbers of staff who report suffering a detriment as a result of speaking up has reduced compared to 2018/19, although the number of staff raising concerns anonymously is higher than the national average. The Board reviews this information several times a year, alongside other incident and feedback information, to ensure that themes are identified and appropriate action taken. A FTSU vision, strategy and action plan are in place with progress being monitored by the FTSU Guardian group and the Board.

**NBT FTSU Cases vs National Average Medium Acute Trusts**




***National average data for Q4 2019/20 not available at time of reporting***

**What next?**

**The following key areas of focus have been agreed for 2020/21, as follows:**

1. The recruitment of a Lead FTSU Guardian with ring-fenced time allocated to the role. This individual will lead the existing NBT Guardian network.

2. The FTSU vision and strategy to be updated as part of the Trust's overall people strategy and focus on creating a "just culture"

3. Continue to ensure a range of FTSU Guardians/champions from diverse groups e.g. BAME and different levels and professions within the Trust.

4. Refreshing the Trust Board's FTSU self-evaluation, with results to feed into the refreshed strategy and vision.

5. Ongoing communication to the Trust as a whole about Freedom to Speak Up

Part 3

# 3.1 Patient Safety Guardian for Safe Working Hours

## Exception Reports for Review 26/02/2020 – 26/05/2020

| | | | |
|---|---|---|---|
| 110 Live | 1424 Exceptions in total | 1 Exceptions last 30 days | 0 Exceptions last 7 days |
| 0 ISCs last 30 days | 0 ISC's last 7 days | 110 Overdue | 1 Action required |

**Type of report**

| Hours | Service Support | Safety |
|---|---|---|
| **36** reports | **2** reports | **0** reports |

**New Contract Rules**
The British Medical Association and NHSEmployers are in discussion regarding enhanced payment rates for weekend work frequency greater than 1:2, an issue which is becoming more common. As well as guidelines for payment of annual leave not taken due to Megateam working during Coronavirus pandemic.

**Exception Reports**
Guardian now able to action and close overdue Exception Reports if a supervisor has not done so within 7 days.

**Networking**
The Guardian has attended a national meeting held in London, and is a member of the Regional Forum of Safer Working Guardians. Now in contact by WhatsApp with national and regional groups as well as having email contact with a number of other Guardians in the region to share updates.

**Payroll**
Process in place for payment of excess hours worked which will include new trainees who leave in August 2020 but have outstanding monies.

**Junior Doctor Contract Meetings**
Initiated by the Deputy Medical Director, these meetings are held every 6 weeks between the Guardian for Safe Working Hours, the Deputy Medical Director, Medical HR Lead and the Director of Medical Education.

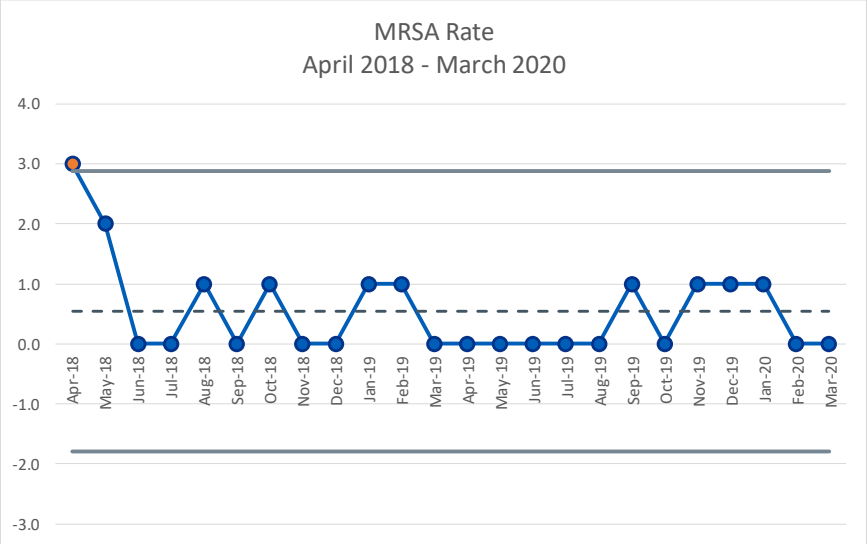
**Local Negotiating Committee**
Guardian attends or submits progress reports to each meeting to increase awareness of current issues and interfaces with British Medical Association.

# 3.1 Patient Safety Quality Indicators

Part 3

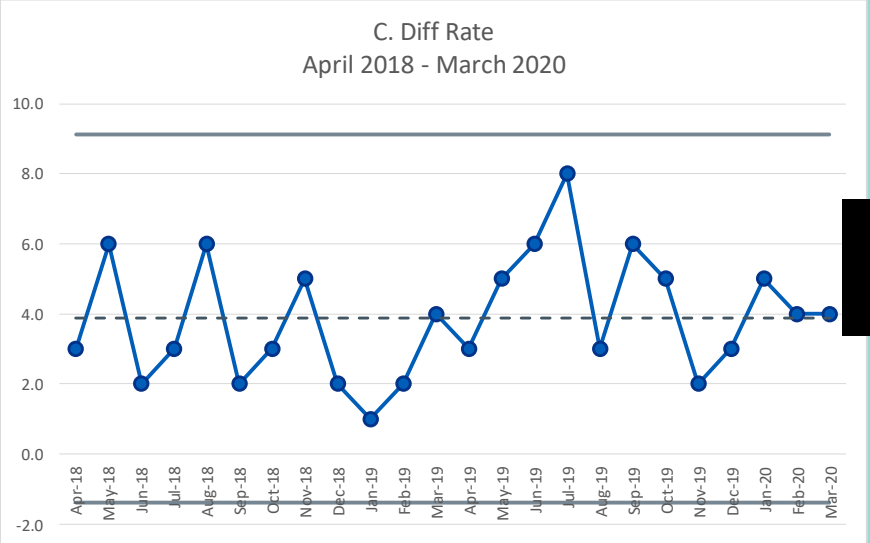
## MRSA

In 2018/19 the Trust identified MRSA Bacteraemia as a significant internal control issue. The Trust has reported four cases of MRSA Bacteraemia in 2019/20, a significant reduction in the nine cases reported in 2018/19, and a clear indication that the Trust's quality improvement initiative to reduce these infections has had effect. This is no longer considered to be a significant internal control issue.




## C-Difficile

The Trust reported 51 cases cumulatively in 2019/20 against the target of fewer than 57 cases and therefore successfully delivered the overall reduction of cases across the year.

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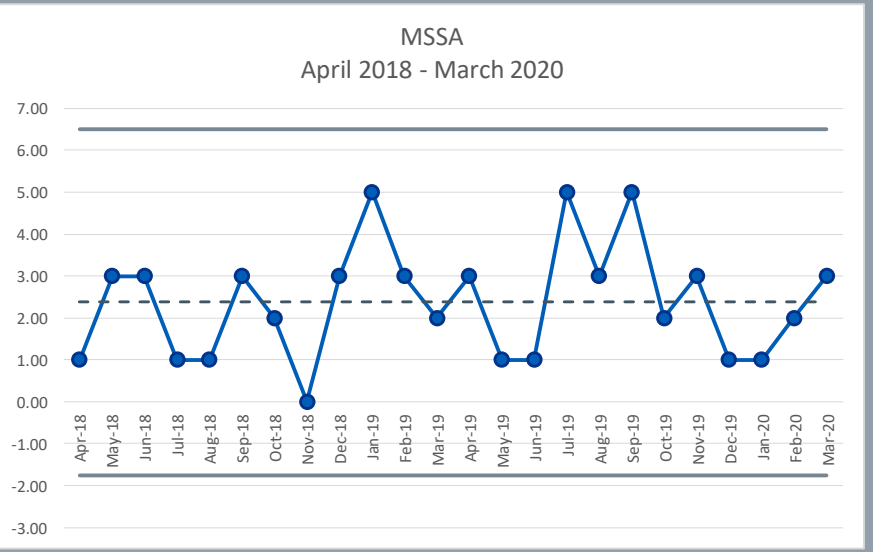
## MSSA

There were 30 reported cases of MSSA bacteraemia during 2019/20. This rate is comparable to the regional and national benchmark and is continually monitored and reviewed at the Trust's Staphylococcus Steering Group.

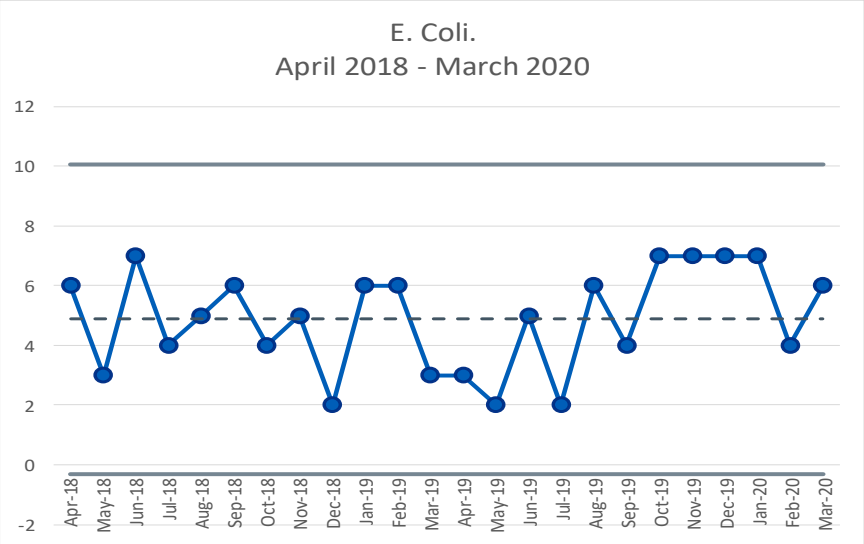


Part 3

# 3.1 Patient Safety Quality Indicators

## E. Coli.

Unfortunately, the Trust did not meet its target of a 10% reduction in E.Coli. infections and further community wide work to reduce these infections is planned for 20/21.

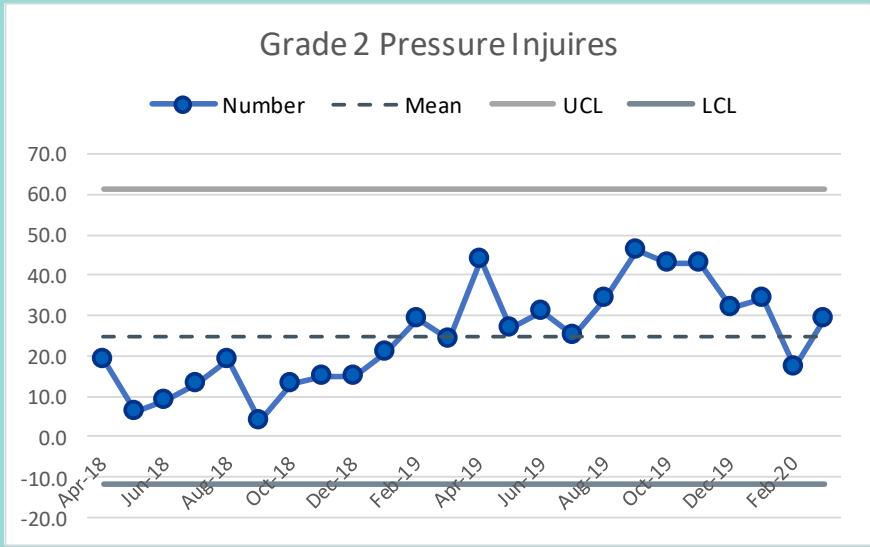



## Pressure Injuries

The trust achieved 0 grade 4 pressure injuries during 2019/20.

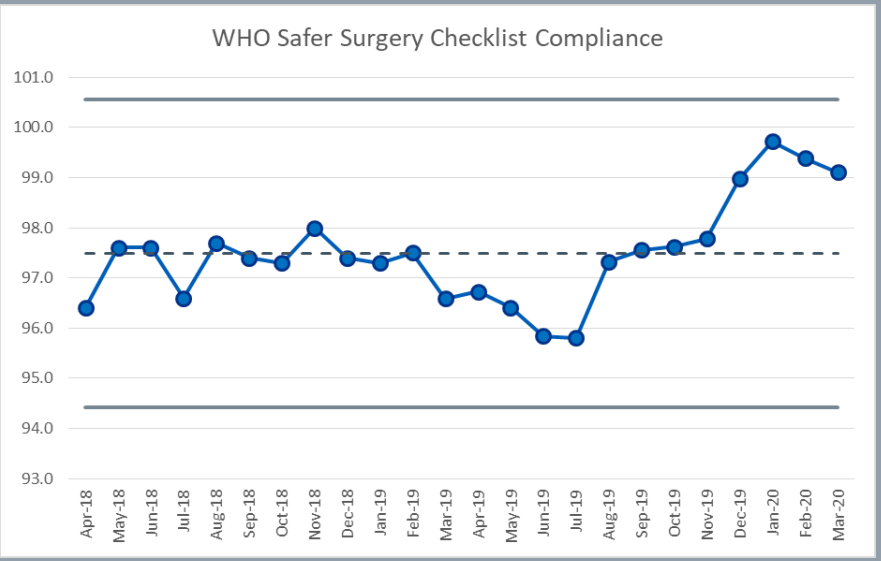
The trust saw a reduction in the number of grade 3 pressure injuries during 2019/20.

5 grade 3 were reported 2019/20 compared with 6 reported in 2018/19




## WHO Safer Surgery Checklist

The Board expects that a WHO surgical safety checklist will be completed and documented prior to each operation in theatres. NBT theatres have consistently remained above the 95% target for completing the WHO Safer Surgery Checklist for the totality of 2019/20.



# 3.1 Patient Safety Safeguarding Adults

Part 3

## What we did in 2019/20

We continued to embed good practice in Mental Capacity Act (MCA) and we introduced new capacity assessment documentation that is simpler to use and meets NBT's legal obligations. The form has also been adopted by the CCG for use in Primary Care.

We supported staff with 1,962 concerns providing significant training, telephone advice, case discussions, support with best interests meetings and signposting / diversion to alternative services.

We contributed to multiagency forums and sub groups of the Safeguarding Adults and Joint Boards (SABs).

We developed the content of the level 3 training for adult safeguarding alongside colleagues at University Hospitals Bristol and Weston General Hospital and the Clinical Commission Group (CCG) to ensure uniformity across Bristol, North Somerset and South Gloucestershire (BNSSG). We also reviewed all training and policies in line with legislation and guidance.

We engaged in NBT audits and multiagency audits to better understand the experiences of adults at risk and their carers who present to our services.

We amended the Deprivation of Liberty Safeguards (DoLS) application to include a capacity assessment; this ensures legal process for detaining a patient is evidenced with practitioners being supported in their practice.

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## What difference did it make?

We improved staff understanding and compliance of the MCA & DoLS, as recognised by the CQC in their 2019 inspection, and have continued to complete and submit an increased number of DoLS applications which support the safeguarding of our patients who cannot consent to be in hospital for their treatment.

The learning and recommendations for NBT, from Domestic Homicide Reviews (DHR) and Serious Adult Reviews (SAR), have been embedded into safeguarding training and incorporated into clinical practice where appropriate and possible.

Our staff have acted appropriately and increased the concerns and disclosures from adults at risk, as part of their core practice and alerted these to the safeguarding team for additional support, guidance and onward referral.

Safeguarding team has continued to improve the governance with the electronic incident system for the safeguarding platform to understand the types of concerns our staff are managing most frequently and target training and support to these areas. This has also ensured better reporting and data collection.

## Objectives 2020/21

We will continue the MCA project plan with to embed and sustain ongoing improvements, including work on the Best Interests process with new forms to support clinical staff and protect our patients' human rights.

We will develop Liberty Protection Safeguards LPS strategy, policy and practice guidance when regulations and Code of practice are published to ensure NBT is ready to meet the legal requirements when the MCA Amendment Act comes into force.

We will complete Audits to demonstrate compliance with MCA/ DoLS and safeguarding requirements.

We will review the DoLS process to ensure lawful detention of patients is carried out in a uniform and auditable way, review information governance across the different external DoLS teams and improve internal quality assurance processes.

We will review practice guidance, policy and training when the Domestic Violence Bill is published

Part 3

# 3.1 Patient Safety Safeguarding Children

Safeguarding children is about protecting children from maltreatment, prevention of impairment of their health and development which includes taking actions to enable all children to have the best outcomes. As a health provider organisation we have opportunities to engage with children and their families as they use our services and can offer help for families and children that may prevent harm and contribute to better outcomes. We do this in partnership with families through assessment, care planning, and sharing of information with partner agencies and referral to appropriate services.

**Key achievements during 2019/20:**

We embedded the use of the Child Protection - Information Sharing (CP-IS) system in line with NHS England and NHS Digital that supports professionals to help identify children who are most vulnerable and may need additional support whilst accessing the Emergency Department, maternity care and direct admissions to wards through GP referral. This system now enables us to receive alerts for children using our services that are not local to our area. This enables staff to liaise with local authorities across England to share information and act to protect children in our care.

In 2020/21, we plan to roll the CP - IS system out Trust wide.

We focused on quality improvement of referrals to Children's Social Care with particular emphasis on the voice of the child where the adult parent was our patient. Sharing clear information and concerns and advocating the child's voice when we raise concerns is a core skill for all staff and is integral to good safeguarding children practice. The local authority needs clear information that explains the needs of the child and how the current concerns are impacting on them.

In 2020/21, we will continuing working with teams to provide specialist safeguarding training enabling staff to gain a clearer understanding of the voice of the child allowing them to be better advocates for children who may have emerging need for early help.

We established links with the 'Safer Options' team Bristol in partnership with University Hospitals Bristol and Weston (UHBW) for the health contribution to reducing the impact of knife crime on children and communities. This is a newly established Local Authority team designed to combat criminal exploitation of young people and serious youth violence.

By working with our partners and taking action together health services can contribute to protecting the most vulnerable in our communities from becoming victims, we can help stop young people from being exploited and we can find solutions to support those at risk of being drawn into a life of violence.

We incorporated learning from local and national reviews into our training and supervision and have used feedback from staff to redesign our level 3 safeguarding children training to be more practice focused building confidence in having challenging conversations with families and quality information sharing with partner organisations. Building confidence and capacity in our workforce contributes to better outcomes and experiences for patients.

In 2020/21, we will be expanding group supervision to level 3 safeguarding children trained staff in the Medicine Division and working with clinical leaders to ensure they have the confidence and skills to support their staff.

# 3.2 Clinical Effectiveness Provision of Seven Day Services

Part 3

We fully recognise the importance of providing safe care seven days a week. In December 2013 Professor Bruce Keogh, Medical Director of NHS England, launched a project to improve patient care across seven days of the week in response to a perception that care was less good on a Saturday and Sunday than care on the other five days of the week. As a result of this work a national NHS England audit was mandated across all acute hospitals in England, which we have fully embraced to support our ongoing improvement work.

It is a requirement, reflected in the Government's mandate and NHS planning guidance for North Bristol Trust to ensure that our services achieve four priority standards which are in place to check that patients have access to consultant-directed assessment (Clinical Standard 2), diagnostics (Clinical Standard 5), interventions (Clinical Standard 6) and on-going review (Clinical Standard 8) every day of the week.

## Clinical Standard 2

Clinical standard 2 requires all emergency admissions to be seen and have a thorough clinical assessment by a suitable consultant as soon as possible and within 14 hours from the time of admission to hospital.

The clinical audit shows that we achieved 89% during weekdays and 92% during weekends which means we meet the standard during weekend periods but not during the week. However against a 90% standard we underperform by only 1% during week days and our average overall compliance is 90% across seven days.

We are assured that we provide sufficient daily consultation presence to support the delivery of this standard.

## Clinical Standard 5

Our provision of consultant directed diagnostic tests has remained the same.

| | Weekend | Weekday |
|---|---|---|
| CT | ✓ | ✓ |
| Echocardiograph | ✓ | ✓ |
| Microbiology | ✓ | ✓ |
| MRI | ✓ | ✓ |
| Ultrasound | ✓ | ✓ |
| Upper GI Endoscopy | ✓ | ✓ |

## Clinical Standard 6

Our provision of consultant directed interventions has also remained the same.

| | Weekend | Weekday |
|---|---|---|
| Critical Care | ✓ | ✓ |
| Primary PCI | ✓ | ✓ |
| Cardiac Pacing | ✓ | ✓ |
| Thrombolysis for Stroke | ✓ | ✓ |
| Emergency General Surgery | ✓ | ✓ |
| Interventional Endoscopy | ✓ | ✓ |
| Interventional Radiology | ✓ | ✓ |
| Renal Replacement | ✓ | ✓ |
| Urgent Radiotherapy | ✓ | ✓ |

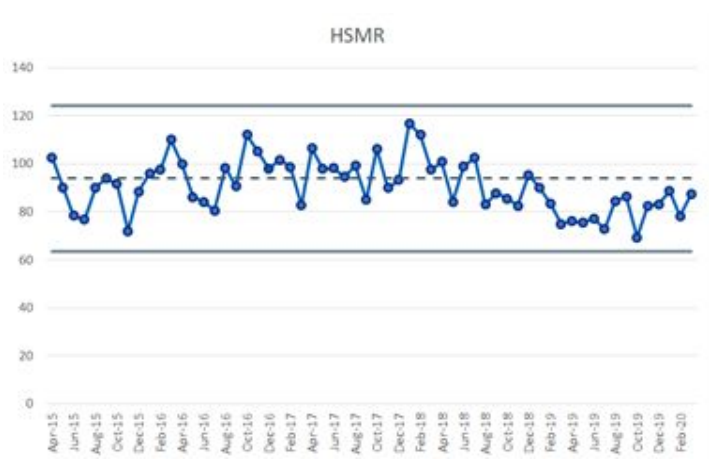
## Clinical Standard 8

This standard requires all patients with high dependency needs to be seen and reviewed by a consultant twice daily unless a clear pathway requires a different frequency. At NBT that standard is met for over 90% patients on weekdays but the standard was not met during weekends where 79% patients received twice daily reviews and 85% once daily reviews. However it should be noted that these figures represent a total of 11 daily reviews which were not documented and therefore assumed not to have taken place.

Part 3

# 3.2 Clinical Effectiveness
# Mortality and Learning from Deaths

North Bristol NHS Trust has a policy of reviewing every patient death. We also monitor our mortality rates using the Summary Hospital Mortality Index (SHMI) and the Hospital Standardised Mortality Ratio (HSMR). These determine the ratio between the number of deaths within the hospital and the number of expected deaths.


Both SHMI and HSMR data presents a good picture for mortality rates at NBT, with the local ratio remaining at or below 100 for the past 12 months. HSMR also displays a shift in the data below the mean since December 2018 indicating a sustained drop in the mortality rate.

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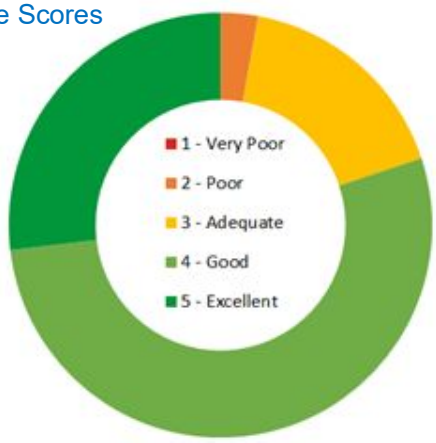
## Care Scores




## Activity


NBT has reviewed 83.2% of all deaths occurring between 01/04/2019 and 31/03/2020 as of 01/06/2020. This includes via structured judgement reviews (SJR), serious incident investigations and coroner's inquests. Reviewers undertaking an SJR are given a window of 2 months since date of death to review a case.

Care scores for 2019/20 show 0% very poor care with 2.8% of reviews rating overall care as poor. 97.2% of care scores were adequate, good, or excellent (80.1% good or excellent).

Throughout 2020/2021 we will be looking at how we can extract more meaningful learning from mortality reviews and, how we can turn that learning into action to improve care for our patients. This will involve deeper analysis of the review data looking at extracting themes, and undertaking roundtables led by clinical staff.

### COVID-19 Response

During the peak of the COVID-19 outbreak staff were under increasing clinical pressures and we had to amend our working practices to ensure the safety of our patients and staff whilst protecting our capacity to cope with a surge of COVID-19 patients.

We are undertaking an Initial Pandemic Mortality Review on 30 cases from the initial pandemic period to ensure that the quality of care remained high for both COVID and non-COVID patients.

# 3.2 Clinical Effectiveness National Clinical Audit

Part 3

## Participation in National Clinical Audits

During 2018/19 North Bristol NHS Trust participated in 47 out of 48 National Clinical Audits the Trust was eligible for. (For full details please see Annex 4).

## Outcomes and Learning

**North Bristol NHS Trust reported good outcomes for the majority of national clinical audits during 2019/20.** The responsibility to ensure national clinical audits are reviewed and actions are taken forward lies within individual specialties and divisions. Where there is a national audit 'outlier' (meaning it is of potential concern to the Trust) the investigation, response and improvement actions are escalated to the Clinical Effectiveness and Audit Committee (CEAC), chaired by the Trust Medical Director. This ensures we respond in a timely and thorough manner, and improvement actions are approved and undertaken.

The Trust was notified that NBT was presenting as an outlier on certain measures within 4 of 47 national clinical audits during 2019/20 (8.5%). The Trust undertook reviews of all outcomes that were outside the expected levels and used the learning from these reviews to implement improvement work to better our outcomes in these areas. Details of the learning and reviews are outlined below.

### National Bowel Cancer Audit (September 2019)

***30 day unplanned readmission rate***

The investigation showed that the following contributed to a higher than expected 30 day unplanned readmission rate:

- NBT includes Surgical Hot Clinic day attendances, same day stoma therapy attendances and all ward day attendances for catheter removal as readmissions—these cases should not be classed as readmissions, when the readmission rate is adjusted for these cases it is within the expected range

The following action was put in place to address the issue:

- Review coding practices for outpatient attendances

### National Early Inflammatory Arthritis Audit (October 2019)

***Proportion of patients with their first review within 3 weeks of referral***

The investigation showed that the following contributed to delayed reviews:

- NBT has seen an exponential rise in urgent and suspected referrals to the EIA service over the last 4 years
- There has been a shortage of staff and a lack of applicants to fill locum posts
- NBT is the preferred centre for patients who live closer to UHB or Weston

The following actions were approved to address these issues:

- Business cases have been approved for additional staff members
- The EIA referral form and pathway criteria was reviewed and updated to prioritise patients most likely to have EIA (this was a collaborative piece of work with UHB, Weston, and primary care)
- Implemented RAS on the Electronic Referral System resulting in more stringent triaging
- Linking with high performing trusts in the region to share learning

# 3.2 Clinical Effectiveness National Clinical Audit

## National Neonatal Audit Programme (October 2019)

***Documented consultation with parents by a senior member of the neonatal team within 24hrs of a baby's first admission***

The investigation showed that the following issue was identified:

- Consultation was not logged in the electronic system which uploads to the NNAP data set, yet ward records indicated that 95% of episodes had parental consultations within 24 hours

The following actions were undertaken to address the issue:

- Business case has been agreed for data management support within the division
- New NICU admission documents are being developed to capture the summary of parental communications more comprehensively
- An awareness campaign is being implemented to highlight the importance of documentation

## National Maternal and Perinatal Audit (October 2019)

***% of term, singleton births with an obstetric haemorrhage more than or equal to 1500ml***

***% of term, singleton, cephalic, vaginal births with a 3rd or 4th degree perineal tear***

The investigation highlighted the following practices which led to a reported higher rate of haemorrhage ≥1500ml and 3rd or 4th degree perineal tears:

- NBT has a higher than average rate of instrumental births and there is an increased use of forceps over vacuum. Although forceps are safer for the baby, they do carry a higher risk of 3rd or 4th degree tear
- The service measures blood loss as opposed to estimating blood loss after births which many other units do, this could lead to under-reporting at other units

The following actions have been undertaken in order to lower the rates of ≥1500ml haemorrhage and 3rd or 4th degree perineal tears:

- Both metrics are monitored on the local dashboard and reductions have been seen across both measures
- Action plans have been put in place to increase staff education for our local processes as well as best practice guidance
- NBT is the founder of Practical Obstetric Multi-Professional Training (PROMPT) for PPH management and drill stations training is undertaken regularly
- We are also working with the Maternal Neonatal Health Safety Collaborative (MNHSC) on a project to reduce PPH ≥1500ml by 30% by May 2020
- There has been significant change to practice and training on prevention and recognition of Obstetric Anal Sphincter Injury (OASI) which is likely to lead to a further reduction in rates over the coming years

# 3.3 Patient Experience
# Learning from Patient Feedback

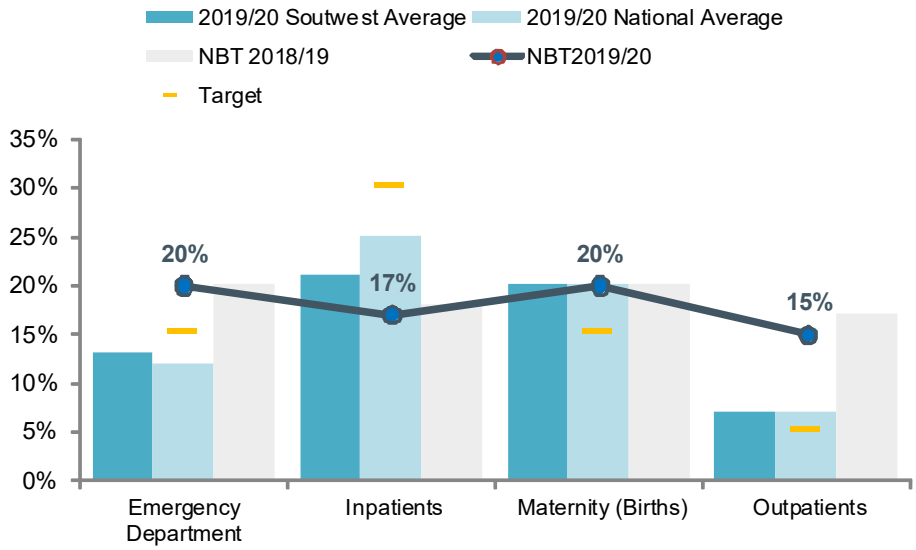
Part 3

## The Friends and Family Test (FFT) is an important feedback tool that enables people using our services to give real-time feedback about their experiences.

It asks people if they would recommend the service they have used to their family and friends, should they ever need to use it and why. The commentary given is critical in helping us to make improvements to the care we provide and to recognise what we are doing well. The survey is completely anonymous and provides patients with a choice to opt out.

We report monthly Trust Board and NHS England on the percentage of patients who have completed a survey and percentage of those respondents who would recommend the service to their family and friends.

**NBT average response rate 2019/20 compared to national average, south west average and NBT average response rate 2018/19**




**Required response rate targets set by the NHS:**

ED (15%)
Inpatients (30%)
Maternity Births (15%)
Outpatients (6%)

***Due to the Coronavirus Pandemic, 2019/20 data is from April 2019 to the end of February 2019. March 2020 data is not included as FFT was paused, in line with NHS England guidance.***

**What % of our patients would recommend us to their friends and family?**

| 93% | 95% | 90% | 96% |
|---|---|---|---|
| **of our inpatients would recommend us to friends and family.** | **of our outpatients would recommend us to friends and family.** | **of our emergency department attendees would recommend us to friends and family.** | **of our maternity patients would recommend us to friends and family.** |
| This is compared to 95% in the region, and 96% nationally. | This is compared to 95% in the region, and 94% nationally. | This is compared to 87% in the region, and 85% nationally. | This is compared to 97% in the region, and 97% nationally. |

Part 3

# 3.3 Patient Experience Learning from Patient Feedback

## Friends and Family Test Results Overview

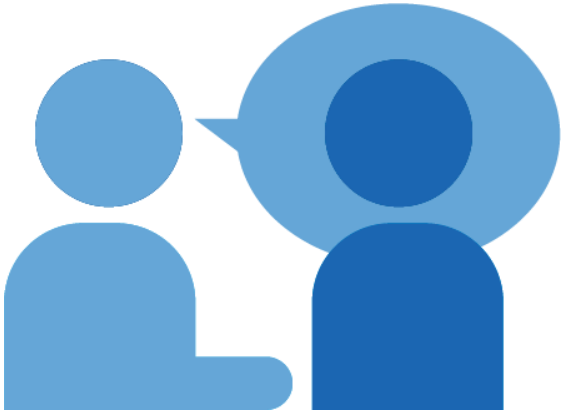
**Inpatients:** In 2019/20 there has been a slight decrease again in the annual average response rate for inpatients, but within this an overall increase from day-case patients. There was no overall change in the average percentage of patients recommending the inpatient services. The majority of feedback is very positive and relates to staff attitude: staff being professional, caring, helpful and friendly. The negative experiences, which are in the minority, relate to poor communication.

In the **Emergency Department** the response rate remained well above the required rate and also above the national and regional average. The percentage of patients recommending the service has varied across the months but overall there has been an upward trend. The positive feedback relates to positive staff attitude and behaviour and the negative about the lack of information on their waiting experience.

**Outpatient services** continue to have overall excellent response rates between 12 -19% and well above the national and regional average levels. The percentage of patients recommending the services is also above these benchmarked averages at national and regional level. The positive feedback relates to positive staff attitude, behaviour and care and the small amount of negative feedback relates to lack of communication about waiting.

**Maternity Services (Birth):** The number of responses received from mothers following their birth experience has shown a decreasing trend. The percentage of those recommending the service has varied but an overall increase in the number of mothers recommending the service has been identified. The vast majority of feedback is very positive, relating to positive staff attitude and behaviour, staff really listening and respecting the mother's views, being caring and professional.

The wealth of feedback is available in near time to all wards, department and many specialities through the Envoy data platform. The appointment of patient experience leads in the Divisions has enabled an increased use of the data to maintain and celebrate good practice that is giving a positive experience to patients and also addressing areas of improvement. A national change in FFT will occur in 2020/21 with an explicit change in the questions being asked and a clear requirement to demonstrate and report on the use of the feedback from our patients.



# 3.3 Patient Experience
# Learning from Patient Feedback

Part 3

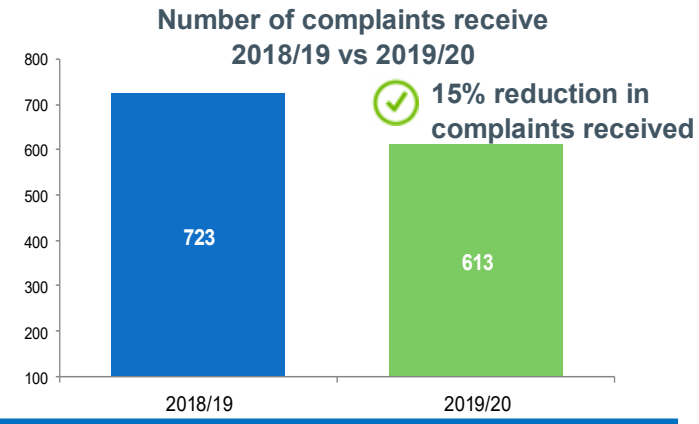
The overall number of formal complaints received in 2019/20 was 613 this is 15% decrease compared with the previous year, 2018/19 where the number of formal complaints received was 723

**100%**

compliance rate in acknowledging complaints within three working days

(NHS Complaint Regulations)

We have seen a significant reduction in the average number of complaints received per month and our average monthly completion rate has improved. This highlights the impact of divisional recovery plans which continue to be implemented.




| | 2018/19 | 2019/20 |
|---|---|---|
| Average number of complaints received per month | 62 | 53 |
| Average monthly completion rate | 60.5% | 78.5% |

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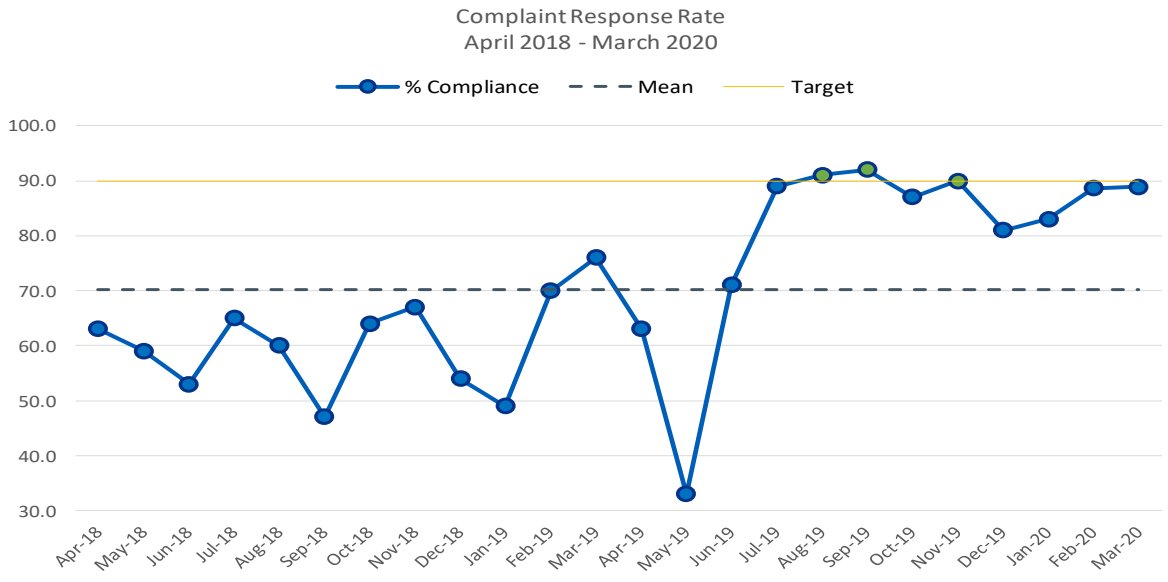
In 2019/20 we have worked very hard to reduce the number of overdue responses. Since April 2019 we have consistently reduced the number of overdue responses every month. In January 2020, for the first time we had no overdue responses.

We aim to continue this work into 2020/21.



Part 3

# 3.3 Patient Experience
# Learning from Patient Feedback

## In April 2019, we successfully launched the Patient Advice and Liaison Service (PALS) which has reduced the number of overdue complaint responses.

Throughout 2019/20, the service has continued to grow and has staff to support people with resolving their concerns and issues quickly. PALS has improved the accessibility of raising concerns in the hospital with a 'drop in' office where patients, carers or family members can walk in and speak to someone about their experience.

## Patient Perspective

PALS were contacted by a patient's daughter (PD) regarding her mother's (M) treatment. M was brought into Southmead via ambulance with suspected heart attack. M was assessed and informed it wasn't a heart attack but she had probable liver metastasis, and needed an urgent CT scan to discover where the primary cancer was located. PD said M was sent home with no information or pain management plan, and told to wait for a phone call.

Time passed and the PD called to chase a date for M's CT scan. She was told there was an IT problem which meant the request had not been received and M was not on the list. M was added to the list and given an appointment for 10 days later. PD felt that whilst staff had been trying their best, communication was very poor and they were not given sufficient information.

PD asked PALS to help her and M navigate the hospital system to understand what was happening and the best way forward to get a speedy diagnosis for M and the pain relief she needed.

The PALS officer arranged for the speciality team to contact PD the same day. The PALS officer also contacted radiology and asked if M's scan could be expedited. After the PALS officer was able to clarify M's availability, they were able to rebook the appointment for the next day. The PALS officer agreed that M would be contacted with the CT results to discuss how her treatment would be taken forward.

PD was grateful for the help from PALS who provided clarity, reassurance and positive action to support PD and M.



## Looking ahead to 2020/21

- ✓ The service will move into a new larger office space which will improve the visibility and accessibility of the service.
- ✓ PALS will increase their profile by educating ward staff, improving the availability of information across the hospital and online and by undertaking engagement events or out-reach events in groups across the community.
- ✓ PALS will also asses its reporting and monitoring to ensure it can support Divisions to manage, respond to and learn from their concerns.

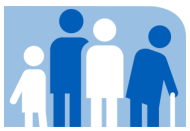
# 3.3 Patient Experience Patient Surveys

Part 3

The Trust participated in the Care Quality Commissions National Patient Survey programme in 2019, and received the results from a number of 2018 and 2019 surveys. All results are reviewed alongside data from FFT, complaints and concerns, to identify areas for improvement and celebrate good patient reported experience. The results and actions are reported and monitored through the Patient Experience Group and the Patient and Carer Experience.

| | |
|---|---|
| Inpatient survey 2019 ( to be published in May / June 2020) | National Cancer Patient Experience Survey 2018, published in 2019 |
| Urgent and Emergency Care Survey 2018, published in 2019 | Maternity Survey 2019, published January 2020 |

## Inpatient survey 2019 (published 2020)



We surveyed, **1,250** randomly chosen patients who were admitted in July 2019


The **response rate** remained high at **47%** The average response rate for similar trusts is 44%.

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## Most improved areas:

- ✓ Planned admission: admission date not changed by hospital (focus for improvement from last year).
- ✓ Right amount of information about treatment or condition in the Emergency Department.
- ✓ Staff completely explained reasons for changing wards at night (focus for improvement from last year).
- ✓ Not bothered by noise at night from other patients.
- ✓ Food was very good or good.

## The following areas were identified for improvement and shared with each Division:

- Patients asked to give views on the quality of care.
- Patients received information explaining how to complain.

Discharge:

- Family and friends given enough information on how to help care.
- Patients told what to look out for and who to contact if worried.
- Family and home situation considered in planning.
- Enough notice is provided about when discharge will be.

Part 3

# 3.3 Patient Experience Patient Surveys

## National Cancer Patient Experience Survey 2018 (published in 2019)

### Overall care score


This survey is undertaken every year. NBT was rated **8.8/10** for overall care, an improvement on last year.

We scored above or within the expected range in 51 (96%) questions out of 53 reported.

✓ Staff, patient care and treatment and the NHS in general

✗ Appointment delays, diagnostics and results and waiting times

**Improvements since the last survey in April 2017:**

Funding from NHS England and Macmillan Cancer Support has been used to improve patient experience. The Cancer Support Worker role for inpatients and outpatients was enhanced and dedicated physiotherapists, dieticians and psychologists support was put in place to address patients' holistic needs. All patients are offered a holistic needs assessment, personalised care plan and are encouraged to attend a health and wellbeing event.

NBT's Macmillan Wellbeing Centre continues to be a flagship service providing a vast range of information and support. Over 16,000 people affected by cancer and their families used the Centre in 2018.

## Urgent and Emergency Care Survey 2018 (published in 2019)

The **response rate** was **30%,** which is in-line with similar Trusts..

**Most improved from last survey**

- ✓ Told when could resume normal activities
- ✓ Understood why tests were needed
- ✓ A&E department was very or fairly clean
- ✓ Staff did not contradict each other
- ✓ Family or home situation considered

**Least improved from last survey**

- Told side-effects of medications
- Waited under two hours to be examined by a doctor/nurse
- Able to get suitable food or drink
- Staff helped control pain
- Waited under an hour in A&E to speak to a doctor/nurse

**Areas of focus for improvement:**

- Medication - Told side-effects of medications
- Communication of results - Told how would receive the results of tests
- Patient/Carer Refreshment - Able to get suitable food or drink
- Waited under two hours to be examined by a doctor/nurse – action relates to ensuring the patient understands the role of the person (nurse or doctor) and the review was classed as an examination.

# 3.3 Patient Experience Patient Surveys

Part 3

## Maternity Survey 2019 (published January 2020)

This survey is undertaken every year. The response rate was **41%**, 5% higher than the average response rate of similar organisations (36%).

### Feedback

**Most improved areas:**

- ✓ Discharged without delay.
- ✓ Partner / companion involved.
- ✓ Found decisions as to how to feed their baby were respected by midwives.
- ✓ Involved enough in decisions about their care (antenatal).
- ✓ Offered a choice of where to have baby.

**Least improved areas:**

- Had a telephone number for midwives (antenatal)
- Provided with relevant information about feeding their baby
- Felt concerns were taken seriously
- Saw the midwife as much as they wanted (this was already a top scoring area)
- Not left alone when worried

### Areas for improvement

- Provision of a telephone number for Midwives (antenatal care)
- Provision of relevant information about feeding their baby
- Provision of appropriate advice and support at the start of labour
- Not left alone when worried (Labour)
- Felt concerns were taken seriously ( Labour)
- Able to ask questions afterwards about labour and birth
- Discharged without delay (Postnatal care)
- Partner was able to stay with them as long as they wanted



Part 3

# 3.3 Patient Experience Volunteers

**Volunteers continue to play a crucial role in enhancing the experience of our patients and their carers for which we remain extremely thankful.**

Our volunteers supported Southmead Hospital Charity to facilitate events such as; The Great Bristol Buskathon, Abseil Adventure, Run Row Ride and our Christmas market and raffle. Two members of the volunteer team, were awarded with the 'Southmead Hospital Charity Supporter of the Year Award'.

Our Move Maker Team continues to welcome and support the thousands of patients who enter the hospital. They were awarded with the Queens Award for Voluntary Service and were visited by HRH the Duke of Gloucester to present the award. The ED Volunteer Team increase to 30 volunteers and are making a huge difference to improving the patient experience within ED and AMU.

The Patient Partners continue to influence the work of the Trust, being active participants on core committees and working groups, including the Quality Governance Improvement Programme, Risk and Safety Groups, Patient Experience Group and others. Their involvement in the appointment of staff at all levels continues and is greatly valued. Key contributions this year have included giving a patient perspective on the process and approach on the use of the ReSPECT document, improvements in the patient check in kiosk and patient involvement in research

Our Creative Companions, trained and supported by our Fresh Arts Team, continue their work with patients who are frail or have cognitive impairment to introduce activities such as knitting, painting and collage.

Our Fresh Arts Music Team has conducted over 500 hours of live music including pianists playing for patients and staff. They have participated in hospital events throughout the year and successfully auditioned 21 new volunteers.

A volunteer Response Team have been recruited and trained to provide valuable practical help and emotional support and advice for patients during the discharge process.

During the COVID-19 Crisis the Response Team adapted their role to suit the needs of the hospital at a critical time. The team have delivered an average of 169 medications to wards, freeing up ward staff to concentrate on other important tasks, as well as supporting the distribution of donated items, delivering patient belongings to wards and improving patient and staff wellbeing by continuing the volunteer pianist program.

Our ward volunteers continue to make a very positive difference in a variety of roles including befriending, supporting meal time staff and providing administrative support. An NHS Heroes award was presented to one of our volunteers this year after a nomination from his ward manager for exceptional service The year also marked the 90th birthday of one of our volunteers who has been volunteering on our wards for over 24 years.

Our Macmillan Wellbeing Centre Volunteers supported 16,000 people by welcoming and signposting visitors, providing complementary therapies and running craft workshops. They have also attended cancer forums, and supported the running of Health and Wellbeing events.

Our Spiritual and Pastoral Care volunteers have continued to provide valuable support to patients and their families. A new team called Purple Butterfly Volunteers were recruited and specially trained to support compassionate end of life care. The volunteers offer one-to-one support, compassionate listening, comfort and companionship particularly for those patients with few or no visitors.

**Over 450** Volunteers, including Movemakers, Chaplaincy, Fresh Arts, Southmead Hospital Charity and ward based volunteers.

# Annex 1: A statement of directors' responsibilities for the quality report.

Annex 1

**The directors are required under the Health Act 2009, National Health Service (Quality Accounts) Regulations 2010 and National Health Service (Quality Account) Amendment Regulation 2011 to prepare Quality Accounts for each financial year. The Department of Health has issued guidance on the form and content of annual Quality Accounts (which incorporate the above legal requirements).**

In preparing the Quality Account, directors are required to take steps to satisfy themselves that:

- the Quality Account presents a balanced picture of the Trust's performance over the period covered;
- the performance information reported in the Quality Account is reliable and accurate;
- there are proper internal controls over the collection and reporting of the measures of performance included in the Quality Account, and these controls are subject to review to confirm that they are working effectively in practice;
- the data underpinning the measures of performance reported in the Quality Account is robust and reliable, conforms to specified data quality standards and prescribed definitions, is subject to appropriate scrutiny and review; and
- the Quality Account has been prepared in accordance with Department of Health guidance.

The directors confirm to the best of their knowledge and belief they have complied with the above requirements in preparing the Quality Account.

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By order of the Board

Signed Date 30/07/2020

**Michele Romaine**
**Chairman**

Signed Date 30/07/2020

**Andrea Young**
**Chief Executive**

# Annex 2: COVID-19 Governance and Controls



From 16 March 2020 NBT implemented formal central command and control arrangements in response to the COVID-19 crisis:

- Silver Command: Meeting twice daily and overseeing the organisational response to the emerging pandemic. Silver Command is supported by a series of Bronze-level cells focusing on specific areas including workforce, communications, facilities, out-patients, divisional management teams, personal protective equipment, and finance and logistics.
- Clinical Reference Group: Bringing together senior clinical leaders from across the Trust, this group provides advice to both Silver and Gold Commands, and is responsible for determining clinical thresholds and guidelines.
- Gold Command: Chaired by the Chief Operating Officer with the Medical Director and Director of Nursing & Quality, Gold Command provides strategic direction and coordination and acts as a point of escalation for Silver Command. It is the key liaison with BNSSG Health and Care Silver Command and connects with regulators and other external bodies as appropriate. Gold Command is responsible for reporting to Trust Management Team and Trust Board on all COVID-19 related matters.

Trust Board ratified the command and control arrangements at its meeting on 27 March 2020, and agreed a series of amendments to the Trust's Standing Orders and Standing Financial Instructions, creating a streamlined process for financial decision making related to the COVID-19 response, while still maintaining appropriate risk-based controls. These amendments were also reviewed by the Trust's Audit Committee on 7 April 2020 to ensure they were robust and appropriate in the circumstances.

On 30 March 2020 NBT was identified as the host organisation for the NHS Nightingale Hospital Bristol, accountable for the setting up and operation of the new unit. This has involved the creation of a new Nightingale division within the NBT governance structure, and will be described in detail in the 2020/21 annual governance statement.

# Annex 3: Consultation with External Organisations



**External Comments on the Quality Account**

The draft Quality Account was circulated for comment in the period 23/05/2019—19/06/2019. A list of the organisations that were sent the document as part of the consultation is shown below:

- North Bristol Patient Partnership Group
- Bristol— People Scrutiny Committee
- Healthwatch Bristol , North Somerset and South Gloucestershire (combined response)
- North Somerset Health Overview and Scrutiny Panel
- NHS Specialised Commissioning (no response)
- Bristol, North Somerset and South Gloucestershire CCG (no response)
- South Gloucestershire—Public Health Scrutiny Committee (no response)

# Annex 3: Consultation with External Organisations



**Bristol—People Scrutiny Committee**

The Health Scrutiny Committee (Sub-Committee of the People Scrutiny Commission) holds the statutory health scrutiny function for Bristol City Council. The Committee received a copy of the North Bristol NHS Trust Quality Account 2019-20 draft report on the 18 June 2020.

Due to changes in working practice as a result of Covid-19 response and recovery planning, it was agreed that the Health Scrutiny Committee would not request a formal briefing, and that it would not meet to discuss the report. Instead, the report would be circulated to all Members of the Committee, who would provide comments to the Chair, Cllr Massey. This would form the Committee's comments to North Bristol NHS Trust, which are detailed in this letter.

- The Committee commented that it was good to see the Trust had developed the hospital improvement for patients with learning disabilities.
- It was noted that is was important to learn from patient and family feedback and so the emphasis on progress with PALS was positive news.
- The ongoing work on Freedom To Speak Up (FTSU) through encouraging staff to raise concerns and issues was welcomed.
- The Committee noted that it appeared that more work needed to be done to reduce the number of eColi infections, although other infection rates had generally improved.
- It was very positive to see the links with the Safer Options team in the local authority and other examples of work on safeguarding children.
-

Overall, the Committee would like to extend its congratulations to the Trust for achieving the CQC rating of Outstanding for Care, and Good overall, which was a considerable improvement on previous inspections. The Chair noted that it was particularly positive to see the recognition for end of life care, as this was an aspect that impressed Members on an earlier visit to the Hospital.

Yours sincerely,

Dan Berlin

Scrutiny Advisor

# Annex 3: Consultation with External Organisations



**North Bristol Trust Patient Partnership Group**

It would be remiss of me if I failed to start my Patient Partnership Group Comments without mentioning the exceptional time the Trust has undergone in 2020 due to COVID-19. As with all other Trusts across the country, NBT rose to the challenge and dedicated themselves wholeheartedly to this, at times, an overwhelming task. Speaking from personal experience, and on behalf of the rest of the Partnership Members, I would like to express my deepest gratitude to ALL the staff who have given their all in working above and beyond what can humanly be expected of them. I continue to be proud and honoured to be a Patient Representative for this Trust and its heroic staff. THANK YOU.

Since the last Quality Account NBT has continued to strive towards improving the services and care it provides for its patients. Their continued commitment to provide safe and effective care for all is a constant source of tremendous positivity. An enormous amount of work has been undertaken in the last year on Patient Safety and this shines through in this Quality Account. The introduction of Electronic Observations is another great initiative project which will replace the paperwork involved in recording these observations making life easier for nurses and doctors alike. There remains a gap in ward based doctors and 7 day coverage. I know that work continues on this and I am confident this will be reflected in next year's Quality Account. Obviously, as most outpatient departments, scans etc. were reduced to those most at need, the reduction will have been tremendous therefore this is going to take some time to get back on track and to catch up. This, of course, is true across the country.

We, as partners have been involved in the recruitment of some wonderful new Consultants and senior members of staff, ensuring that the continuance of the great work the Trust has achieved continues and will also continue to improve.

Christine Fowler

Chair, NBT Patient Partnership Group

# Annex 3: Consultation with External Organisations



**Healthwatch Bristol, North Somerset and South Gloucestershire**

We welcome the opportunity to comment on the Quality Account for North Bristol Hospitals NHS Trust. This account shows good involvement with patients and groups, and in particular the representation of people with Autism and Learning Disabilities aligning well with the goal of the NHS Long Term Plan. We suggest your Steering Group establishes a working group from the main organisations who support LD groups with users, to look at issues. This would fit well with your 2020/21 priority Meeting the identified needs of patients with Autism and Learning Disabilities.

Your emphasis on learning from patient feedback in 2019/20 and establishment of the PALS service has helped to further understanding of your patient community. We continue to be impressed with your engagement with organisations that amplify patient experiences and the Trust has established systematic ways to collect, discuss and inform the planning and delivery of care. Your chosen themes for your focus groups on clinical experience, communication and care-planning & handover, match issues from patient feedback we have collected.

We commend the focus for 2020/21 on safe and supportive maternity care, prevention and infection control and a 'just' safety culture. This will support your workforce and embed a culture of continuous learning, transparency and accountability.

Vicky Marriott

Area Manager, Healthwatch Bristol, North Somerset and South Gloucestershire



**North Somerset Health Overview and Scrutiny Panel**

It was felt that the NSC Health Overview and Scrutiny Panel had had insufficient contact with NBT over 2019/20 – partly due the Panel's overriding focus during that period on the Healthy Weston proposals – to be in a position to comment on the Quality Account. Furthermore, due to recent Covid-19 challenges, the Panel has not had an opportunity on this occasion to meet with the Trust prior to its QA response to discuss performance specifically in respect of North Somerset residents.

# Annex 4: National Clinical Audit Case Ascertainment

Annex 4

During 2019/20 106 local clinical audits were completed and reviewed. Actions from these audits are put onto the Trust audit action log.

During 2019/20 44 national clinical audits and 3 national confidential enquiries covered NHS services that NBT provides. During that period NBT participated in 98% national clinical audits and 100% national confidential enquiries of the national clinical audits and national confidential enquiries which it was eligible to participate in.

The national clinical audits and national confidential enquiries that NBT was eligible to participate in during 2019/20, and the national clinical audits and national confidential enquiries that NBT participated in, and for which data collection was completed during 2019/20, are listed below alongside the number of cases submitted to each audit or enquiry as a percentage of the number of registered cases required by the terms of that audit or enquiry.

| | National Clinical Audit and Clinical Outcome Review Programmes | Host Organisation | NBT Eligible | NBT Participating | Case Ascertainment | Data Year |
|---|---|---|---|---|---|---|
| 1 | Assessing Cognitive Impairment in Older People/Care in Emergency Departments | Royal College of Emergency Medicine (RCEM) | Y | Y | +100% (71/50) | 2019 |
| 2 | BAUS Urology Audit – Cystectomy | British Association of Urological Surgeons (BAUS) | Y | Y | +100% (221/217) | 2016-2018 |
| 3 | BAUS Urology Audit – Female Stress Urinary Incontinence | British Association of Urological Surgeons (BAUS) | Y | Y | 96 | 2016-2018 |
| 4 | BAUS Urology Audit – Nephrectomy | British Association of Urological Surgeons (BAUS) | Y | Y | +100% (614/469) | 2016-2018 |
| 5 | BAUS Urology Audit – Percutaneous Nephrolithotomy | British Association of Urological Surgeons (BAUS) | Y | Y | 206 | 2016-2018 |
| 6 | BAUS Urology Audit – Radical Prostatectomy | British Association of Urological Surgeons (BAUS) | Y | Y | +100% (913/904) | 2016-2018 |
| 7 | Care of Children in Emergency Departments | Royal College of Emergency Medicine (RCEM) | Y | Y | +100% (137/50) | 2019 |
| 8 | Case Mix Programme (CMP) | Intensive Care National Audit and Research Centre (ICNARC) | Y | Y | 100% (2617/2617) | 2019/20 |
| 9 | Child Health Clinical Outcome Review Programme | National Confidential Enquiry into Patient Outcome and Death (NCEPOD) | N | N/A | N/A | N/A |
| 10 | Elective Surgery – National PROMs Programme | NHS Digital | Y | Y | Participation Rate: 31.1% (441/1,418) Response Rate: 70.5% (320/441) | 2017/18 |
| 11 | Endocrine and Thyroid National Audit | British Association of Endocrine and Thyroid Surgeons (BAETS) | Y | Y | 103 | 2013-2017 |

# Annex 4: National Clinical Audit Case Ascertainment

Annex 4

| | National Clinical Audit and Clinical Outcome Review Programmes | Host Organisation | NBT Eligible | NBT Participating | Case Ascertainment | Data Year |
|---|---|---|---|---|---|---|
| 12 | Falls and Fragility Fractures Audit Programme (FFFAP) | Royal College of Physicians (RCP) | Y | Y | | |
| | Fracture Liaison Service Database | | Y | Y | 2093 | 2018 |
| | National Audit of Inpatient Falls | | Y | Y | 100% | 2019 |
| | National Hip Fracture Database | | Y | Y | 96.8% (575/594) | 2019 |
| 13 | Inflammatory Bowel Disease (BD) Registry, Biological Therapies Audit | IBD Registry Ltd | Y | Y | 0% (0/0) | 2019 |
| 14 | Major Trauma Audit | Trauma Audit Research Network (TARN) | Y | Y | 100% | |
| 15 | Mandatory Surveillance of Bloodstream Infections and Clostridium Difficile Infection | Public Health England (PHE) | Y | Y | 100% | |
| 16 | Maternal, Newborn and Infant Clinical outcome Review Programme | Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK (MBRRACE-UK) | Y | Y | 100% | |
| 17 | Medical and Surgical Clinical Outcome Review Programme | National Confidential Enquiry into Patient Outcome and Death (NCEPOD) | Y | Y | | |
| | In Hospital Management of Out of Hospital Cardiac Arrests | | Y | Y | 100% (2/2) | 2019 |
| | Dysphagia in Parkinson's Disease | | Y | Y | 0% (0/1) | 2019 |
| | Acute Bowel Obstruction | | Y | Y | 50% (4/8) | 2019 |
| 18 | Mental Health – Care in Emergency Departments | Royal College of Emergency Medicine (RCEM) | Y | Y | +100% (135/50) | 2019 |
| 19 | Mental Health Care Pathway – CYP Urgent & Emergency Mental Health Care and Intensive Community Support | National Collaborating Centre for Mental Health (NCCMH) | N | N/A | N/A | N/A |
| 20 | Mental Health Clinical Outcome Review Programme | National Confidential Inquiry into Suicide and Homicide in Mental Health (NCISH) | N | N/A | N/A | N/A |
| 21 | National Asthma and Chronic Obstructive Pulmonary Disease (COPD) Audit Programme (NACAP) | Royal College of Physicians (RCP) | Y | Y | | |
| | Paediatric Asthma Secondary Care | | N | N | N/A | |
| | Asthma (Adult and Paediatric) and COPD Primary Care – Wales only | | N | N | N/A | |
| | Adult Asthma Secondary Care | | Y | Y | 100% (320/320) | 2019/20 |
| | Chronic Obstructive Pulmonary Disease (COPD) Secondary Care | | Y | Y | 100% (800/800) | 2019/20 |

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# Annex 4: National Clinical Audit Case Ascertainment

Annex 4

| | National Clinical Audit and Clinical Outcome Review Programmes | Host Organisation | NBT Eligible | NBT Participating | Case Ascertainment | Data Year |
|---|---|---|---|---|---|---|
| 22 | National Audit of Breast Cancer in Older People (NABCOP) | Royal College of Surgeons | Y | Y | 100% (770/770) | 2019 |
| 23 | National Audit of Cardiac Rehabilitation | University of York | Y | Y | 100% | 2019 |
| 24 | National Audit of Care at the End of Life (NACEL) | NHS Benchmarking Network | Y | Y | 100% (40/40) | 2019/20 |
| 25 | National Audit of Dementia (Care in General Hospitals) | NHS Digital | Y | Y | 100% (50/50) | 2018 |
| 26 | National Audit of Pulmonary Hypertension | Royal College of Paediatrics and Child Health (RCPCH) | N | N/A | N/A | N/A |
| 27 | National Audit of Seizure Management in Hospitals (NASH3) | University of Liverpool | Y | Y | N/A | Not yet published |
| 28 | National Bariatric Surgery Registry (NBSR) | British Obesity and Metabolic Surgery Society (BOMSS) | Y | Y | 100% (303/303) | Apr 14—Mar 17 |
| 29 | National Cardiac Arrest Audit (NCAA) | Intensive Care National Audit and Research Centre (ICNARC)/ Resuscitation Council UK | Y | Y | 100% | 2019 |
| 30 | National Cardiac Audit Programme (NCAP) – National Audit of Cardiac Rhythm Management | Barts Health NHS Trust | Y | Y | 100% (141/141) | 2015-2018 |
| 31 | National Clinical Audit of Anxiety and Depression | Royal College of Psyciatrists (RCPsych) | N | N/A | N/A | N/A |
| 32 | National Clinical Audit of Psychosis | Royal College of Psyciatrists (RCPsych) | N | N/A | N/A | N/A |
| 33 | National Diabetes Audit – Adults<br>National Diabetes Foot Care Audit<br>National Diabetes Inpatient Audit (NaDIA)<br>NaDIA – Harms<br>National Core Diabetes Audit<br>National Pregnancy in Diabetes Audit | NHS Digital | Y<br>Y<br>Y<br>Y<br>Y<br>Y | Y<br>Y<br>Y<br>Y<br>Y<br>Y | 195/195 (100%)<br>142/142 (100%)<br>N/A<br>79/79 (100%)<br>75/75 (100%) | 2015-2018<br>2018<br>Trust level data not available<br>2019<br>2016-2018 |
| 34 | National Early Inflammatory Arthritis Audit (NEIAA) | British Society for Rheumatology (BSR) | Y | Y | 15% (320/2144) | |
| 35 | National Emergency Laparotomy Audit (NELA) | Royal College of Anaesthetists (RCOA) | Y | Y | 83% (179/228) | |
| 36 | National Gastro-intestinal Cancer Audit Programme (GICAP)<br>National Oesophago-gastric Cancer (NOGCA)<br>National Bowel Cancer Audit | NHS Digital | Y<br>Y<br>Y | Y<br>Y<br>Y | 100% (93/93)<br>+100% (251/218) | 2014-2018<br>2019 |

# Annex 4: National Clinical Audit Case Ascertainment

Annex 4

| | National Clinical Audit and Clinical Outcome Review Programmes | Host Organisation | NBT Eligible | NBT Participating | Case Ascertainment | Data Year |
|---|---|---|---|---|---|---|
| 37 | National Joint Registry (NJR) | Healthcare Quality Improvement Partnership (HQIP) | Y | Y | 100% (1523/1523) | 2019 |
| 38 | National Lung Cancer Audit | Royal College of Physicians (RCP) | Y | Y | 235/235 (100%) | 2017 |
| 39 | National Maternity and Perinatal Audit (NMPA) | Royal College of Paediatrics and Child Health (RCPCH) | Y | Y | 100% | 2016/17 |
| 40 | National Neonatal Audit Programme – Neonatal Intensive and Special Care (NNAP) | Royal College of Paediatrics and Child Health (RCPCH) | Y | Y | 100% (624/624) | 2019 |
| 41 | National Ophthalmology Audit (NOD) | Royal College of Ophthalmologists (RCOphth) | N | N/A | N/A | N/A |
| 42 | National Paediatric Diabetes Audit (NPDA) | Royal College of Paediatrics and Child Health (RCPCH) | N | N/A | N/A | N/A |
| 43 | National Prostate Cancer Audit | Royal College of Surgeons (RCS) | Y | Y | 100% (595/595) | 2019 |
| 44 | National Smoking Cessation Audit | British Thoracic Society (BTS) | Y | Y | 100% (1/1) | 2019 |
| 45 | National Vascular Registry | Royal College of Surgeons (RCS) | Y | Y | | |
| | AAA | | Y | Y | 100% (60/60) | 2019 |
| | CEA | | Y | Y | 100% (88/88) | 2019 |
| | Bypass | | Y | Y | 100% (654/654) | 2019 |
| | Angioplasty | | Y | Y | 100% (186/186) | 2019 |
| | Amputation | | Y | Y | 100% (208/208) | 2019 |
| 46 | Neurosurgical National Audit Programme | Society of British Neurological Surgeons | Y | Y | N/A | Trust level data not available |
| 47 | Paediatric Intensive Care Audit Network (PICANet) | University of Leeds/ University of Leicester | N | N/A | N/A | N/A |
| 48 | Perioperative Quality Improvement Programme (PQIP) | Royal College of Anaesthetists | Y | Y | N/A | N/A |
| 49 | Prescribing Observatory for Mental Health (POMH-UK) | Royal College of Psychiatrists (RCPsych) | N | N/A | N/A | N/A |
| 50 | Reducing the Impact of Serious Infections (Antimicrobial Resistance and Sepsis) | Public Health England (PHE) | Y | Y | 100% (174/174) | 2018/19 |
| 51 | Sentinel Stroke National Audit Programme (SSNAP) | King's College London | Y | Y | 90%+ | 2019 |
| 52 | Serious Hazards of Transfusion: UK National Haemovigilance Scheme | Serious Hazards of Transfusion (SHOT) | Y | Y | 100% | 2019 |
| 53 | Society for Acute Medicine's Benchmarking Audit (SAMBA) | Society for Acute Medicine (SAM) | Y | Y | 100% | 2019 |

# Annex 4: National Clinical Audit Case Ascertainment

Annex 4

| | National Clinical Audit and Clinical Outcome Review Programmes | Host Organisation | NBT Eligible | NBT Participating | Case Ascertainment | Data Year |
|---|---|---|---|---|---|---|
| 54 | Surgical Site Infection Surveillance Service | Public Health England (PHE) | Y | Y | | 2018/19 |
| | Hip replacement | | Y | Y | 100% (811/811) | |
| | Knee replacement | | Y | Y | 100% (678/678) | |
| 55 | UK Cystic Fibrosis Registry | Cystic Fibrosis Trust | N | N/A | N/A | N/A |
| 56 | UK Parkinson's Audit | Parkinson's UK | Y | Y | | 2019 |
| | Elderly Care | | Y | Y | 100% (20/20) | |
| | Neurology | | Y | Y | +100% (40/20) | |
| | Physiotherapy | | Y | Y | +100% (36/10) | |
| | Speech and Language Therapy | | Y | N | N/A | |
| | Occupational Therapy | | Y | N | N/A | |

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# Annex 5: Learning from Deaths



27.1 During 2019/20 1,520 of NBT's patients died. This comprised the following number of deaths which occurred in each quarter of that reporting period:

423 in the first quarter
420 in the second quarter
455 in the third quarter
222 in the fourth quarter

27.2 By 03/06/2020, 1,200 case record reviews and 64 investigations have been carried out in relations to 1,520 of the deaths included in item 27.1. In 0 cases a death was subjected to both a case record review and an investigation.[1]

The number of deaths in each quarter for which a case record review or an investigation was carried out was:

381 in the first quarter
346 in the second quarter
362 in the third quarter
175 in the fourth quarter

27.3 0 representing 0% of the patient deaths during the reporting period is judged to be more likely than not to have been due to problems in the care provided to the patient. In relation to each quarter this consisted of:

0 representing 0% for the first quarter
0 representing 0% for the second quarter
0 representing 0% for the third quarter
0 representing 0% for the fourth quarter

27.4 Recent learning from the death identified in item 27.3:

Not applicable

27.5 Recent actions undertaken as a result of the learning outlined in item 27.4:

Not applicable

27.6 The impact of the actions undertaken in section 27.5

Not applicable

27.7 276 case record reviews and 6 investigations completed after 13/05/2019 which related to deaths which took place before the start of the reporting period.

27.8 0 representing 0% of the patient deaths before the reporting period, are judged to be more likely than not to have been due to problems in the care provided to the patient. This number has been estimated by counting those deaths that were subject to an investigation as a result of it being more likely than not that the death was due to problems in care.

27.9 1 representing 0.05% of the patient deaths during 2018/19 are judged to be more likely than not to have been due to problems in the care provided to the patient.

[1] This is because where a death is covered by another investigation the mortality review request is withdrawn from the system

# Annex 6: Mandatory Indicators



| | Mandatory indicator | NBT Most Recent | National average | National best | National worst | NBT Previous |
|---|---|---|---|---|---|---|
| | **Venous thromboembolism (VTE) risk assessment** | **95.81%**<br>**Mar19-Dec19** | **95.48%**<br>**Mar19-Dec19** | **100%**<br>**Mar19-Dec19** | **69.76%**<br>**Mar19-Dec19** | **96.05%**<br>**2018/19** |
| 23 | The Trust considers that this data is as described as there is a continued close focus on VTE risk assessment performance given that it is a board reported quality metric within the Integrated Performance Report.<br>It is also regularly scrutinised through the Thrombosis Committee as part of the wider reviews undertaken of Hospital Acquired Thrombosis and related Root Cause Analyses (mini RCAs). In 2017 the effectiveness of this work was recognised by the awarding of VTE Exemplar Status to the Trust. | | | | | |
| | **Clostridium difficile rate per 100,000 bed days (patients aged 2 or over) - Trust apportioned cases only** | **9.8**<br>**2018/19*** | **13.2** | **0.0** | **91.0** | **9.9**<br>**2017/18** |
| 24 | The Trust considers that this data is as described as it is directly extracted from Public Health England National Statistics and the trend variation from previous year is consistent with internal data intended to inform ongoing improvement actions.<br>*Latest national data published on https://www.gov.uk/government/statistics/clostridium-difficile-infection-annual-data is 2018/19. 2019/20 data will be published in July 2020 after the Quality Account has been published. | | | | | |
| | **Rate of patient safety incidents reported per 1,000 bed days** | **47.0**<br>**Apr19-Sep19** | **49.8** | **103.8** | **26.3** | **35.2**<br>**Apr18-Sep18** |
| 25 | **Percentage of patient safety incidents resulting in severe harm or death** | **0.5%**<br>**Apr19-Sep19** | **0.3%** | **1.6%** | **0.0%** | **0.4%**<br>**Apr18-Sep18** |
| | The Trust considers that this data is as described as it is supplied by the National Reporting and Learning System (NRLS) and is consistent with internal data reviewed on a monthly basis during the year and reported to the Board.<br>The Trust will continue to act to increase the overall rate of reporting, which is a sign of a positive safety culture, whilst also acting upon lessons learned to identify improvements to practice. This has already shown a reduction in the proportion of severe harm or death related incidents in the period stated above. | | | | | |
| | **Responsiveness to inpatients' personal needs** | **69.2**<br>**2018/19** | **67.2** | **85.0** | **58.5** | **71.2**<br>**2017/18** |
| 20 | The Trust considers that this data is as described as it is directly extracted from National Survey data and the trend variation from previous year is consistent with internal surveys intended to inform ongoing improvement actions. | | | | | |
| | **Percentage of staff who would be happy with standard of care provided if a friend or relative needed treatment** | **80%**<br>**2019** | **71%** | **88%** | **41%** | **74%**<br>**2018** |
| 21 | The Trust considers that this data is as described as it is directly extracted from National Survey data and the trend variation from previous year is consistent with internal surveys intended to inform ongoing improvement actions. | | | | | |
| | **Summary Hospital-level Mortality Indicator (SHMI) value and banding** | **October 2018—September 2019 NBT Score 90.37 (Peer average 99.08)**<br>**October 2017—September 2018 NBT Score 93.64** | | | | |
| 12 | The Trust considers that this data is as described as it is directly extracted from the CHKS system and analysed through the Trust's Mortality Group, the medical Director and within specialties. The rate is also consistent with historic trends and the Trust's understanding of the increased acuity of patients being seen within different specialties. | | | | | |

# Annex 6: Mandatory Indicators

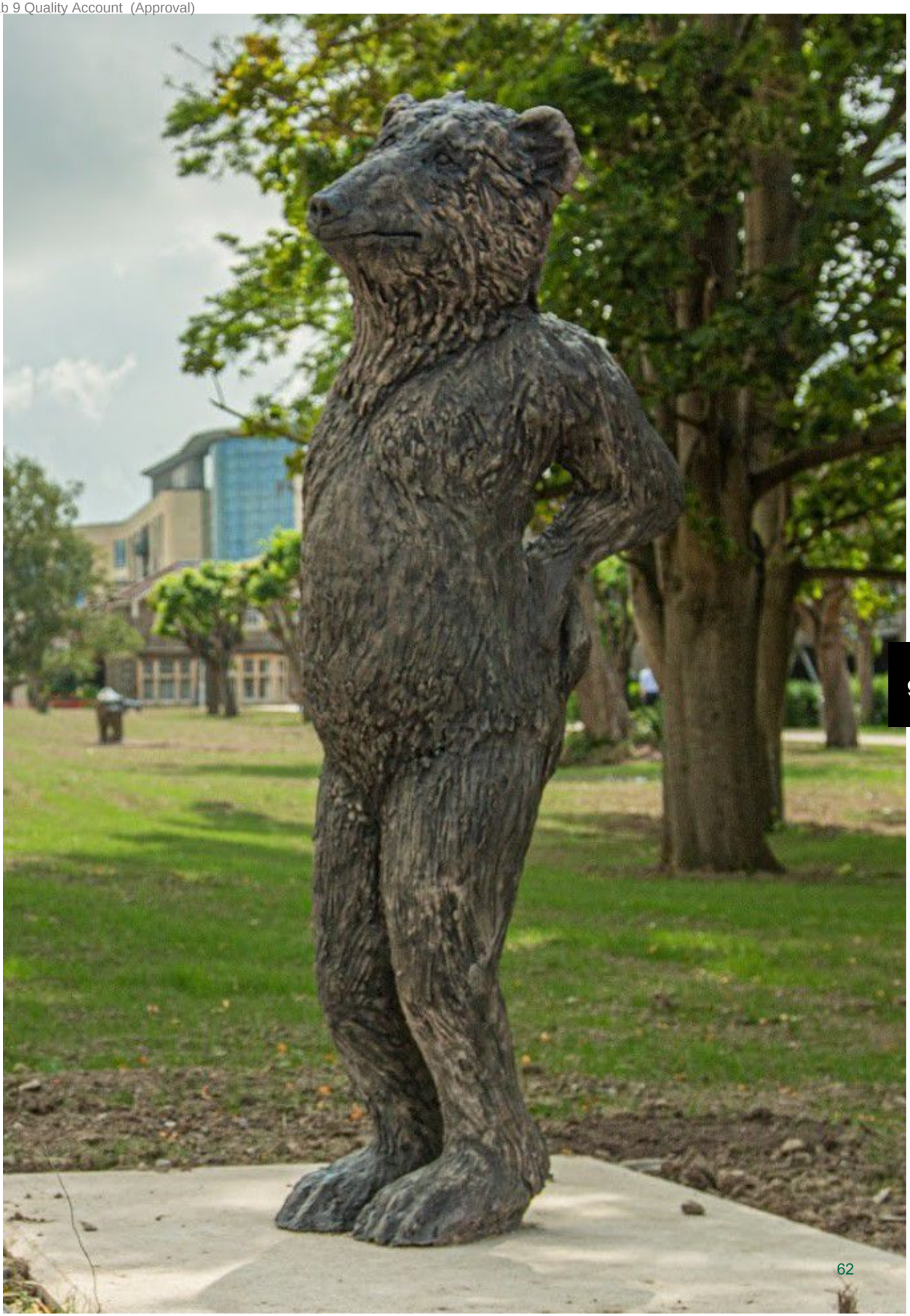


| | Mandatory indicator | NBT Most Recent | National average | National best | National worst | NBT Previous |
|---|---|---|---|---|---|---|
| 18 | **Patient Reported Outcome Measures – No. of patients reporting an improved score;** | | | | | |
| | **Hip Replacement Primary EQ-VAS** | **2018/19 NBT score 70.3% (England average 68.6%)**<br>**2017/18 NBT score 66.8%** | | | | |
| | **Hip Replacement Primary EQ 5D** | **2018/19 NBT score 89.6% (England average 89.9 %)**<br>**2017/18 NBT score 86.8%** | | | | |
| | **Knee Replacement Primary EQ-VAS** | **2018/19 NBT score 47.2% (England average 59.6%)**<br>**2017/18 NBT score 53.3%** | | | | |
| | **Knee Replacement Primary EQ 5D** | **2018/19 NBT score 76.2% (England average 82.3 %)**<br>**2017/18 NBT score 73.7%** | | | | |
| | **Varicose vein, Groin hernia** | **Not applicable** | | | | |
| | The Trust considers that this data is as described as it is obtained directly from NHS Digital.<br>The Trust will act to improve this percentage, and so the quality of its services by analysing the outcome scores and continuing to focus on participation rates for the preoperative questionnaires | | | | | |
| 19 | **Emergency readmissions within 28 days of discharge: age 0-15** | **Comparative data for 2011/12: NBT 10.2%; England average 10.0%; low 0%; high 47.6%.** | | | | |
| | **Emergency readmissions within 28 days of discharge: age 16 or over** | **Comparative data for 2011/12: NBT score 10.9%; England average 11.4%; low 0%; high 17.1%.** | | | | |
| | Comparative data since November 2011 is not currently available from the Health & Social Care Information Centre. | | | | | |

# Annex 7: Abbreviations



| | |
|---|---|
| A&E | Accident and Emergency |
| BAME | Black and Minority Ethnic |
| BNSSG | Bristol, North Somerset, South Gloucestershire |
| BSR | British Spine Registry |
| CCG | Clinical Commissioning Group |
| CEAC | Clinical Effectiveness and Audit Committee |
| CGA | Comprehensive Geriatric Assessment |
| CP-IS | Child Protection Information Sharing |
| CQC | Care Quality Commission |
| CQUIN | Commissioning for Quality and Innovation |
| CT | Computed Tomography |
| DHR | Domestic Homicide Review |
| DoLS | Deprivation of Liberty Safeguards |
| DQIP | Data Quality Improvement Plan |
| DSP | Data Security and Protection |
| DToC | Delayed Transfer of Care |
| EIA | Early Inflammatory Arthritis |
| e-Obs | Electronic Observations |
| EQ-VAS | EuroQol Visual Analogue Scale |
| eRS | e-Referral Service |
| FFT | Friends and Family Test |
| FTSU | Freedom to Speak Up |
| GIRFT | Getting it Right First Time |
| GMP | General Medical Practice |
| GP | General Practitioner |
| HES | Hospital Episode Statistics |
| HIV | Human Immunodeficiency Viruses |
| HSIB | Healthcare Safety Investigation Branch |
| HSMR | Hospital Standardised Mortality Ratio |
| IG | Information Governance |
| IM&T | Information Management and Technology |
| IP | Inpatients |
| IT | Information Technology |
| KPMG | Klynveid Peat Marwick Goerdeler |
| LD | Learning Disabilities |
| LPS | Liberty Protection Safeguards |
| MCA | Mental Capacity Act |
| MDT | Multi-disciplinary Team |
| MHA | Medical History Assurance |
| MNHSC | Maternal Neonatal Health Safety Collaborative |
| MRSA | Methicillin-Resistant Staphylococcus Aureus |
| MSSA | Methicillin-Sensitive Staphylococcus Aureus |
| NBT | North Bristol NHS Trust |
| NEWS2 | National Early Warning Score |
| NHS | National Health Service |
| NHSE | National Health Service England |
| NICU | Neonatal Intensive Care Unit |
| NICU | Neonatal Intensive Care Unit |
| NIHR | National Institute for Health Research |
| NNAP | National Neonatal Audit Programme |
| OASI | Obstetric Anal Sphincter Injury |
| PALS | Patient Advice and Liaison Service |
| PHE | Public Health England |
| PPH | Post-Partum Haemorrhage |
| PROMPT | Practical Obstetric Multi-Professional Training |
| PSS | Prescribed Specialised Services |
| QI | Quality Improvement |
| RAS | Referral Assessment Services |
| RTT | Referral to Treat |
| SABs | Safeguarding Adults and Joint Boards |
| SAR | Serious Adult Review |
| SHMI | Summary Hospital Mortality Index |
| SIM | Simulation |
| SJR | Structured Judgement Review |
| TWW | Two week wait |
| UCLH | University College London Hospitals |
| UHB | University Hospitals Bristol |
| UHBW | University Hospitals Bristol and Weston |
| UTI | Urinary Tract Infection |
| UWE | University of the West of England |
| VTE | Venous Thromboembolism |
| WHO | World Health Organisation |



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| | | | |
|---|---|---|---|
| **Report To:** | Trust Board | | |
| **Date of Meeting:** | 30 July 2020 | | |
| **Report Title:** | Quality Strategy 2020-24 | | |
| **Report Author & Job Title** | Paul Cresswell, Associate Director of Quality Governance | | |
| **Executive Sponsor (presenting)** | Helen Blanchard, Director of Nursing & Quality and Chris Burton, Medical Director | | |
| **Purpose:** | **Approval** | **Discussion** | **To Receive for Information** |
| | X | X | |
| **Recommendation:** | The Trust Board is requested to:<br>• **Review** the updated Quality Strategy noting the recommended approval from the Quality & Risk Management Committee (QRMC).<br>• **Approve** the Strategy. | | |
| **Report History:** | The Draft Quality Strategy was provided for comments to Trust Management Team in January 2020 with an outline of the next steps, which have been followed as planned.<br>The intention was to then review and approve the Quality Strategy, annual quality priorities and submit to Trust Board in March 2020.<br>However, the COVID-19 pandemic meant this was deferred and on that basis it was not provided to the March QRMC, which was also postponed for the same reason.<br>The version now presented has been updated in light of the Covid-19 pandemic and wording refreshed to make it more user friendly.<br>The QRMC meeting on 17th July 2020 reviewed and endorsed this version of the Strategy and recommend it for Board approval. | | |
| **Next Steps:** | • Communication plan for Quality Strategy – to be integrated with other key staff messages to ensure it is fully aligned.<br>• Monitoring of in year delivery for 2020/21 priorities. | | |

**Executive Summary**

Quality Strategy

The Quality Strategy is provided for final review and approval, following on from previous versions reviewed and commented upon at Trust Management Team (TMT) in January 2020, in March 2020 and again in June 2020. The version presented now for approval was discussed and supported at the QRMC meeting on 17th July.

The Strategy has been developed over a number of months, with the majority of updates made during 2020 taking account of TMT feedback and subsequent consultation with Clinical Divisions (via Management Boards or governance meetings) and within the three Trust level executive

chaired committees that link to the three themes, as follows;

1. Theme 1 – Exceptional Personalised Care – Patient Experience Committee (Chaired by Director of Nursing & Quality)
2. Theme 2 – Safe and Harm Free Care – Patient Safety & Clinical Risk Committee (Chaired by Director of Nursing & Quality)
3. Theme 3 – Clinical Effectiveness & Audit Committee (Chaired by Medical Director)

From an external perspective, positive consideration of the Quality Strategy was provided at the CCG Quality Sub Group and in discussions with NHSI/E regional quality team.

The version now presented reflects more recent changes made to take account of the pandemic impact but recognising that as a strategic document the fundamental themes and quality goals in the main remain as previously envisaged.

Ongoing Monitoring/Oversight of Quality Strategy

The Trust-wide governance of delivery against the quality goals is proposed as shown below;

| Theme | Operational Oversight | Quality Governance |
|---|---|---|
| 1 – Exceptional Personalised Care | Trust Management Team | Patient Experience group |
| 2 – Safe & Harm Free Care | Trust Management Team | Patient Safety & Clinical Risk Committee |
| 3 – Excellence in Clinical Outcomes | Trust Management Team | Clinical Effectiveness & Audit Committee |

The quality account priorities have been reflected in the Trust's Operational Plan, to bring alignment between the quality governance systems and those driving operational planning.

Clinical Divisions have taken the themes and quality goals and tailored the priorities and actions for their specialities and services, whilst ensuring contribution to the trust level goals.

Working with the Head of Business Planning, we are now establishing Key performance Indicators that will provide the in-year reporting for year 1 of the Strategy. This will then become embedded within the business planning cycle each year.

The Trust Board is requested to;

- **Review** the updated Quality Strategy noting the recommended approval from the Quality & Risk Management Committee (QRMC).
- **Approve** the Strategy.

| | |
|---|---|
| **Strategic Theme/Corporate Objective Links** | **1. Provider of high quality patient care**<br>a. Experts in complex urgent & emergency care<br>b. Work in partnership to deliver great local health services<br>c. A Centre of Excellence for specialist healthcare<br>d. A powerhouse for pathology & imaging<br>**2. Developing Healthcare for the future**<br>a. Training, educating and developing out workforce |

| | |
|---|---|
| | b. Increase our capability to deliver research<br>c. Support development & adoption of innovations<br>Invest in digital technology |
| **Board Assurance Framework/Trust Risk Register Links** | **BAF ref.SIR14** - Sustained demand and increased acuity of patients in hospital will impact on patient safety and outcomes, leading to harm in patients and poorer patient experience.<br>(Current risk rating = 12) |
| **Other Standard Reference** | Care Quality Commission Regulations |
| **Financial implications** | None specifically relating to the development of this document aside from staff time. |
| **Other Resource Implications** | As above |
| **Legal Implications including Equality, Diversity and Inclusion Assessment** | No legal implications are specifically linked to the development of this overarching Strategy. Individual legislation applies within many of the areas covered and will be fully considered within the related workstreams. |
| **Appendices:** | Quality Strategy 2020-24 Final Draft |

# The North Bristol NHS Trust Quality Strategy

NHS
North Bristol
NHS Trust


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## 2020 – 2024

one NBT

Exceptional healthcare, personally delivered

# Contents



# Foreword from the Director of Nursing & Quality and Medical Director

**We launch this Quality Strategy during what is the most challenging time for the NHS in its history. The focus of this strategy and the themes we will set out is quality of care. It is crucial that quality is something that runs through everything we do as we strive to provide exceptional healthcare, personally delivered.**

We had planned for this document to support our ambitious new five year strategy for the Trust which was published at the start of the year. That document set out our plans for the future and our equally ambitious transformation agenda. However, the Covid-19 pandemic, and our response to it, has required us to pause and take a period of reflection so we can question whether what we intended to say in this Quality Strategy still applied or required reassessment.

We recognise the significant challenges this presents our staff and are extremely proud of the great response we've seen everywhere to rise to the challenge. Supporting our staff has never been more crucial and we have a strong range of staff wellbeing options available to all staff at all levels of the organisation. In addition, our improvement work within our 'Perform' approach continues to act as a way to establish great team-working. Much of this work is outlined in greater detail in our Trust People Strategy.

Healthcare is changing rapidly, locally, nationally and internationally and that pace of change is only likely to increase as we look to provide care in response to Covid-19. This care needs to not only meet the expectations of staff and patients but be delivered and developed in collaboration with them.

We are committed to ensuring that quality of care is at the forefront of this change. This includes ensuring strong patient, public and staff engagement to influence the decisions made, the compassion we show when delivering care and in highlighting the impact of this engagement in quality improvements. This is reflected in our first quality theme of *'exceptional personalised care.'*

We have a strong track record of patient safety and quality improvement work at NBT and are building on this, embracing the approaches set out in the NHS Patient Safety Strategy of July 2019. We aspire to be outstanding in this area and have a number of clear goals that we will deliver in our first year. This thinking underpins our second theme *'safe and harm free care.'* Similarly, theme three reflects our commitment to *'excellent clinical outcomes'* across our services and ensuring the availability of high quality information to prioritise and support further improvement work.

The scale and pace of change required will not be possible without high quality digital systems. We also have a strong Trust-wide Digital Strategy and are therefore well placed to both improve and streamline our understanding and delivery of high quality care. Fundamental to this is the strong clinical leadership in our digital programme, with Chief Clinical Information Officers (CCIO) and a Chief Nursing Information Officer (CNIO) at the forefront, working with technical specialists and front line teams.

Without good quality governance we cannot be sure our improvement agenda will achieve what we want it to. We have made great progress in this area, as reflected in our most recent CQC inspection. We continue to embed this as close to the delivery of care as possible, with a focus on learning and improvement as the primary aim.

This Quality Strategy is for the period 2020-2024 for a reason. It cannot be a one year document as improving our quality of care is not something you do once and then stop and celebrate. It has to continue to improve each year. That is why we are committing to agree Trust level improvement goals to shape our areas of focus and will develop this in partnership with our staff and patients.

Chris Burton

Helen Blanchard

# Our Vision & Values

The Trust's Five Year Strategy for 2019-2024, sets out a strong vision of working collectively to achieve our ambitions. As stated in that document the best health and care is not the work of an individual, a single team or one organisation. Partnership and collaboration is fundamental.

## Our Strategy for 2019-2024

**By enabling our teams to be the best that they can be, we will provide exceptional healthcare, personally delivered**

*'Exceptional healthcare'* means our patients will recognise that we are exemplars of safe, harm free care and that we give them the best possible health improvement. We will do this through outstanding Emergency Care, our centres of excellence for Specialist Services, our great Local Services and as a Powerhouse for Pathology and Imaging.

*'Personally delivered'* means patients are in charge of their own care and the decisions that need to be made for their health and wellbeing. Patients tell us they want their voice to matter and that they need to be equal partners in the care they receive. A genuine partnership with patients and the public is at the heart of any changes we make and will ensure an outstanding patient and carer experience.

Our four values, shown below, underpin everything we do. These values are promoted and embedded in our recruitment, training and ongoing delivery of care. They actively encourage a culture of openness and learning within effective teams that bring together the expertise and skills of different professionals to continuously improve.

### Putting patients first

Understanding the impact of every role on patient care, even if you're not in direct contact

Taking the time to listen and care

Protecting patient confidentiality, privacy and dignity

Being open and transparent when things go wrong

Intervening when others have not, speaking up when necessary

Treating your patient as you would expect a loved one to be cared for

### Working well together

Engaging with colleagues and patients to pro-actively resolve issues

Demonstrating commitment to shared objectives

Including and consulting others when making decisions that affect them

Offering encouragement and feedback to others

Becoming trusted and respected by staff and patients

### Recognising the person

Making staff and patients feel valued and worth your time

Looking everyone in the eye, acknowledging them, recognising they are people

Appreciating differences and the strength that diversity can bring

Helping the patient understand their condition, involving them in decision making

Taking a holistic approach to care

### Striving for excellence

Continuously reviewing what we do, to seek new ideas for improvement

Demonstrating commitment to continuous learning and development

Celebrating efforts and successes

Recognising your own limitations, using mistakes as learning opportunities and remaining resilient when facing challenges

Going the extra mile to make a difference to patients and staff, even if this is indirectly

# Quality & Safety

The Trust Strategy sets out how we will come together as OneNBT to provide the very best care that we can. It does this over four themed chapters which are set out below.

### 1. Provider of high quality patient care

- Experts in complex urgent and emergency care
- Work in partnership to deliver great local health services
- A Centre of Excellence for specialist services
- A powerhouse for pathology and imaging
- Personal delivery of care
- Leading and working with partners

### 2. Developing healthcare for the future

- Educating, training and developing staff and teams of the future
- A growing research and innovation portfolio

### 3. Employer of choice

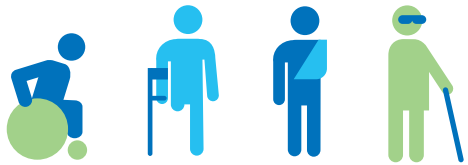
- Enabling our staff to be the best they can be, making maximum use of their skills and capabilities
- An agile organisation enabling our staff to make the decisions they need on behalf of their patients

### 4. An anchor in our community

- An integral part of the community local people are proud of
- A large and established employer
- Working with our community to enhance people's health and wellbeing

This Quality Strategy is one of nine enabling strategies set out in the overarching Trust Strategy. The Quality Strategy sets out our strategic plan for quality and safety by:

- Strengthening a culture of delivering high quality, personalised care to patients with inter-professional team-working at the heart of what we do and supported by the Trust's People Strategy
- Setting Trust-wide quality improvement themes and goals
- Describing our approach to achieving positive change and setting improvement goals in all parts of the hospital
- Embedding quality governance arrangements to ensure clear accountability and responsibilities at all levels



# Where are we now?

As evidenced by our response to the Covid-19 pandemic we, as a nation, have never been more proud of the NHS. This pride is very much felt here at NBT, not only in our services but in the high standards of care provided and the staff who deliver them.

We launch this Quality Strategy after a period of sustained and widespread improvement. This was highlighted in 2019 when we achieved an overall 'Good' rating from the Care Quality Commission, we were also rated as 'Outstanding' in the Caring and Well Led domains. All of our clinical core services are rated as 'Good' with End of Life Care rated as 'Outstanding.'

**Ratings for the whole trust**

| Safe | Effective | Caring | Responsive | Well-led | Overall |
|---|---|---|---|---|---|
| Good ▲ Sept 2019 | Good ▲ Sept 2019 | Outstanding ▲ Sept 2019 | Requires improvement ⋈ Sept 2019 | Outstanding ▲ Sept 2019 | Good ▲ Sept 2019 |

The rating for well-led is based on our inspection at trust level, taking into account what we found in individual services. Ratings for other key questions are from combining ratings for services and using our professional judgement.

Our culture of continuous improvement has led to many examples of excellent services and teams and recognition of these are given in many ways, the most prominent of which is our annual Exceptional Healthcare Awards.

We will continue to build on our philosophy of sustained improvement and continue to demonstrate high quality, safe care with excellent patient outcomes and feedback.

Continuous improvement will be underpinned by an open and fair safety culture in which everyone is comfortable with speaking up when things are not right, learns when things do not go to plan and from practice that results in excellence. Our learning will be strengthened by working in partnership with patients, carers and families to reduce any future harm.

The 'public' view of our care quality is reflected externally on the Trust's website, as referenced below;

**Trust Website**

- Trust Strategy: **NBT Strategy 2019-2024**
- Quality Strategy: this document
- Quality Account: **Trust Quality Account 2018-19**
- Trust Business Plan: **Trust Business Plan 2019-20**
- Divisional Business plans: Held locally

**External Website**

- Care Quality Commission (CQC) rating – Rated as "Good" (Sept. 2019): **CQC - North Bristol NHS Trust rating**

# Where are we heading?

We have developed three Trust–level quality themes to drive our improvement work. These reflect the priorities within the national NHS long Term Plan published in January 2019.

The goals have been developed through extensive engagement with many groups in the Trust that lead on safety, effectiveness and patient experience as well as with our Patient Participation Group, the Trust Management Team and external stakeholders such as the BNSSG CCG.

**Theme 1: Exceptional Personalised Care**

"We will ensure that patients are in charge of their own care and the decisions that need to be made for their own health and wellbeing. A genuine partnership with patients and the public is at the heart of any changes we make and will ensure an outstanding patient and carer experience."

**We will achieve this by;**

1. Minimising delays in patients' treatment, enabling their safe care and discharge from hospital.
2. Patients and staff actively engaging in shared decision making for care and treatment.
3. Learning & improving from active patient & carer engagement.
4. Meeting the identified needs of patients with Learning Disabilities, Autism or both.
5. Identifying and supporting patients' mental health needs in balance with their physical needs.

**Theme 2: Safe & Harm Free Care**

"We will improve quality of care through learning from best practice and addressing areas of concern within a fair and open culture."

**We will achieve this by;**

1. Being outstanding for safety, becoming a leader in implementing the NHS Patient Safety Strategy within a 'just' safety culture.
2. Ensuring excellence in our maternity services, delivering safe maternity care.
3. Patients whose condition is deteriorating will receive a timely, coordinated clinical response with personalised, inter-professional decision-making.
4. Keeping patients safe by delivering harm-free care in our hospital, including safe management of medicines.
5. Ensuring excellence in Infection Prevention and Control to support delivery of safe care across all clinical services.

**Theme 3: Excellence in Clinical Outcomes**

"We will drive continuous improvement in our clinical services and pathways to deliver demonstrably excellent outcomes for our patients."

**We will achieve this by;**

1. Providing clear, integrated and intelligent clinical outcome data, including from patients (e.g.. PROMs) to clinical teams to support quality improvement.
2. Ensuring effective Multi-Disciplinary care in both cancer and benign clinical services.
3. Delivering expert, complex urgent and emergency care.
4. Reducing clinical variation through strong specialist networks and partnership working.
5. Providing high quality Diagnostic and Imaging services that underpin treatment outcomes.



# Our Approach to Quality Improvement

Our exceptional and highly skilled staff work across a range of clinical disciplines supported by highly-effective administrative and management teams. High quality care is provided when skilled and motivated staff share the same values. Our approach to recruiting, supporting and developing staff is set out in the Trust's People Strategy.

We are fortunate to have a wealth of expertise throughout the many specialities within the Trust. A core commitment at NBT is enabling our staff to use this expertise and apply their skills to improve quality of care within a culture of learning and openness.

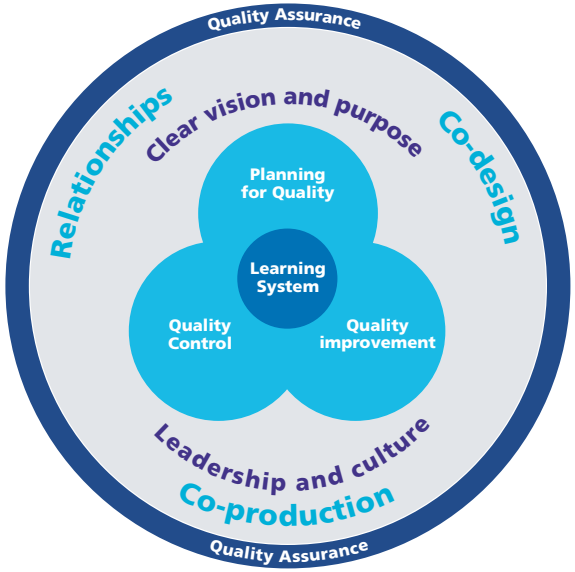
We will create the best possible conditions where teams feel empowered to make positive change, have the capability to design and deliver improvements in their services and are able to draw support from a highly-connected team of experts in change management. This 'learning system' brings together Quality planning, improvement and assurance as shown in Figure 1.

We actively engage across the wider healthcare system though networks such as the West of England Academic Health Science Network (AHSN) and the South West Maternity Safety Collaborative, with many examples of system-wide improvement for patients.

Our commitment to creating a way for our staff to continually learn is aligned to the following shared principles:

- Connecting with our teams, patients and local partners to develop a clear understanding of what needs to improve
- Creating a clear vision centred on what matters to our patients, applying the principles of co-design and co-production to work in partnership
- Local problem-solving through small scale testing and change
- Coaching teams to be empowered to deliver improvements
- Sharing and celebrating data and outcomes

## Figure 1: Learning System




Source: Healthcare Improvement Scotland: High-Level Quality Management System Framework, December 2019, http://www.healthcareimprovementscotland.org/previous_resources/policy_and_strategy/quality_management_system.aspx

The philosophy of improvement is embedded in our transformation teams including the Perform Academy and the Quality and Safety Improvement Team (#QSIT) who are connected with our Programme Management Office, our Library and Knowledge Services and Research and Innovation.

Enabling our staff to be the best they can be is fundamental to our core beliefs. This is evidenced through our award winning Perform Approach which is embedded in all levels of the hospital.

Continuous quality improvement is key part of our long term strategic plans and our Perform Methodology (Figure 2) recognises that creating exceptional teams is a key enabler to our overall programme of learning and development. Effective working in complex teams is a core reason for our recent success at NBT.

Thousands of staff from across the hospital have already received sessions in quality improvement in the form of Perform Bootcamps, Quality Improvement inductions, Quality Improvement Bronze Level workshops and #QSIT bespoke sessions. A weekly QI Hub also provides teams with coaching and 1:1 improvement capability development.

All of our staff from doctors in clinical training to consultants, nurses, pharmacists, allied health professionals and the many non-clinical support teams have used the skills from these learning events to develop many improvements in their areas of service.

## Figure 2: Perform Methodology


### Moving Forward

We will continue to enhance our patient safety improvement capability. In line with the NHS Patient Safety Strategy we will build this capability to develop our internal curriculum and development programme for patient safety investigations in 2020 and beyond. This includes our maternity service delivering training for investigators as part of the national Healthcare Safety Investigation Branch (HSIB) work in partnership with Cranfield University and developing this more widely within the Trust.

At ward level we will implement a ward accreditation model during 2020/21 which will support clinical staff to continuously improve care quality, with clear responsibilities and expectations. We will celebrate those who deliver exemplar care and support a culture of continuous quality improvement.

Developing a 'just culture' which will reflect our approach to reviewing clinical incidents will be a vital part of creating our safety culture. We will have a culture of openness and learning where staff feel safe and confident to speak up when things go wrong.

We are leading the local Medical Examiner service implementation, as an integrated service provided across NBT, and University Hospitals Bristol & Weston. This will be an exemplar for the national model, providing quicker and more accurate death certification and coroner's referrals, independently flagging care concerns swiftly and supporting families and carers both administratively and also where they have questions or concerns.

# How will we know we are improving?

### 1. Development and Delivery of Improvement Plans

Our core purpose is to deliver the standard of clinical care that we would expect our own families to receive. The Trust Board is responsible for seeking and providing assurance that we are doing just that and that the services we provide are the very best they can be.

Improving quality of care is a fundamental part of the Trust business cycle. In writing the annual Quality Account we engage the organisation, our patients and stakeholders in developing the annual quality priorities. These are interwoven in to the Trusts annual business plan from which the Trusts, Divisions and Individuals objectives follow. The Quality Account and Business Plan are owned by the Trust Management Team and by the Board.

Annual plans will be established for each improvement goal in order to;

- Agree the deliverable actions;
- Clarify the measures to assess impact; and
- Align accountability and resources to their delivery

Clinical Divisions are accountable for delivery through their services and teams and their internal governance structures provide oversight that is monitored by the Trust Board.

Our quality governance and assurance arrangements provide the framework within which quality of services is reviewed, evaluated and actions taken for improvement

### 2. Using Digital Systems to accelerate Quality Improvement

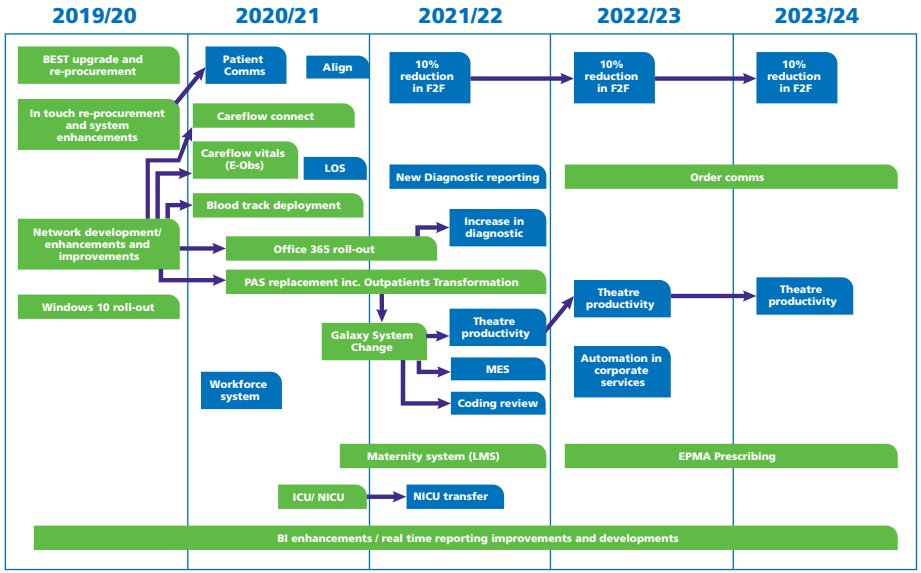
We know the benefits that digital technology can bring from remote consultations to e-observations. Our learning over past  months will enable us to build on our exciting and Board approved, Digital Strategy and also assess where we can go further and at an increased pace. Our Digital Strategy is a critical enabler of continuous quality improvement and we are developing clinically led digital solutions into every patient interaction which will ultimately  improve the quality of care and experience of our patients.

We are developing these systems through strong clinical engagement with our staff to ensure they support our workforce providing safe and efficient tools.

Set out below are the future projects that support this vision. All clinical projects are led by a Trust clinician. In addition the Trust Information Management & Technology Committee includes the designated Consultant Chief Clinical Information Officers (CCIOs) and Chief Nursing Information officer (CNIO) who provide clinical input and support for the strategic direction of travel.

| What is Governance? | What Is Assurance? |
|---|---|
| Governance is the combination of structures and processes at and below board level which lead Trust-wide quality performance including:<br>• Ensuring **accountability for quality** and required standards<br>• **Identifying, sharing** and ensuring **delivery** of best-practice<br>• Ensuring the **organisation's culture** supports effective engagement on quality<br>• Driving **continuous improvement**<br>• Identifying and **managing risks** to quality of care<br>• **Investigating** and **taking action** on sub-optimal performance, reducing variation | Assurance is part of good governance.<br>It refers to the way in which the Trust Board (and its sub-committees) are provided with **accurate** and **timely information** on the **efficiency and effectiveness** of trust policies and operations, and the status of the organisations **compliance** with its statutory obligations. |

## Digitally Enabled Transformation




Green boxes show by product of Digital strategy and the interconnectivity with the relevant programmes within the transformation plan.

# Conclusion

### 3. Taking Responsibility

Achieving the ambitions we have set out in this document will require everybody, no matter their role, to take responsibility for the quality of care we provide. Clinical teams are already responsible for reviewing the care they deliver through review of the data that's available to them. By doing this we can assure ourselves that we are striving at all times to provide the very best standard of care. This will also enable us to embed the development of learning and quality improvement actions as close to the delivery of frontline patient care as possible.

Clinical Divisions through their divisional governance arrangements are accountable for;

- Improving the safety, quality and efficiency of patient care,
- Realising the goals of the Trust's strategy and ambitions for patients; and
- Improving the consistency of healthcare governance, building up from the point of clinical service delivery

The **Trust Management Team** oversees the delivery of clinical services, informed by the outcomes from review meetings between Clinical Divisions and the Executive Team.

The **Patient & Carer Experience Board Sub-committee**, chaired by a Non-Executive Director supports the Board oversight in this area.

The **Quality and Risk Management Board Sub-Committee** with a Non-Executive Director chair scrutinises quality information and that provided through sub-committees on the quality of care provided.

The **Trust Board** seeks assurance that high quality services are being delivered. Through its sub-committees and presentation of data within the monthly Integrated Performance Report.

### 4. External Assurance

Our aim is to lead a strong organisation as part of a vibrant local and regional healthcare system. It is pleasing to note that within our two most recent CQC inspections positive references have been made about our culture.

*"The leadership, governance and culture promote the delivery of high-quality person-centred care. Governance processes had improved since our last inspection. Leaders were experienced and approachable with a clear vision for the services they delivered. Staff were encouraged to report incidents and there was a good learning culture."*

(CQC inspection report dated 24/9/2019, page 9)

*"Staff described a good culture and enjoyed their work at the hospital. We spoke with staff of different grades and seniority and working in many different roles. The overall feedback was staff enjoyed their work even though it the hospital was busy."*

(CQC inspection report dated 6/3/2018, page 85)

We are continuously enhancing this culture, addressing concerns swiftly when they arise and ensuring we learn and act effectively to improve care quality. This includes actively promoting and responding to the Freedom to Speak Up agenda to support staff when they wish to raise concerns outside of their usual reporting line.

We will continue to build on our relationships with our many partners in other organisations. This includes engagement with Commissioners (local CCG and NHS England) and Regulators (Care Quality Commission and many other statutory and regulatory organisations) to provide the assurance they require on the quality of our services to enable them to discharge their responsibilities.

The quality of care delivered by the staff at North Bristol NHS Trust is something we are already very proud of. We know that by continuously improving our care through strong team work and partnership with our patients, carers and families, we can take this further.

We will also continue to play a leading role in the wider health and social care system as services and clinical pathways beyond traditional hospital boundaries are opened up and our digital strategy will play a key part in ensuring this is supported safely and efficiently.

If you have any questions or comments about this or any other guides please contact a member of the communications team by emailing

**NBTCommunications@nbt.nhs.uk**

| | | | |
|---|---|---|---|
| **Report To:** | Trust Board - Public | | |
| **Date of Meeting:** | 30 July 2020 | | |
| **Report Title:** | Quality & Risk Management Committee Report | | |
| **Report Author & Job Title** | Isobel Clements, Corporate Governance Officer | | |
| **Executive/Non-executive Sponsor (presenting)** | John Iredale, Non-Executive Director and Chair of QRMC | | |
| **Purpose:** | **Approval/Decision** | **Discussion** | **To Receive for Information** |
| | | X for assurance | |
| **Recommendation:** | The Trust Board should receive the report for assurance and note the activities QRMC has undertaken on behalf of the Board, in particular approval of the Quality Strategy and review of the following annual reports:<br>• Infection Prevention Control;<br>• Quality & Safety Improvement Team (QSIT); and<br>• Safeguarding Children and Adults. | | |
| **Report History:** | The report is a standing item to the Trust Board following each Committee meeting. | | |
| **Next Steps:** | The next report will be received at the Trust Board in September 2020. | | |

**11.1**

| **Executive Summary** |
|---|
| The report provides a summary of the assurances received and items discussed and debated at the Quality and Risk Management Committee (QRMC) meeting held on 17 July 2020. |

| | |
|---|---|
| **Strategic Theme/Corporate Objective Links** | • Be one of the safest trusts in the UK<br>• Treat patients as partners in their care |
| **Board Assurance Framework/Trust Risk Register Links** | Link to BAF risk SIR14 relating to clinical complexity, risk COV 1 relating to waiting-list and backlogs of care, and risk COV 2 relating to overwhelming effects of Covid-19 locally. |
| **Other Standard Reference** | CQC Standards. |
| **Financial implications** | No financial implications identified in the report. |
| **Other Resource Implications** | No other resource implications identified. |
| **Legal Implications including Equality, Diversity and Inclusion Assessment** | None identified. |

| | |
|---|---|
| **Appendices:** | None. |

## 1. Purpose

To provide a highlight of the key assurances received, items discussed, and items for the attention of Trust Board from the QRMC meeting held on 17 July 2020.

## 2. Background

The QRMC is a sub-committee of the Trust Board. It usually meets bi-monthly and reports to the Board after each meeting and was established to provide assurance to the Trust Board on the effective management of quality governance and risk management.



## 3. Meeting on 17 July 2020

3.1 Infection Prevention and Control (IPC)

The committee received and approved the retrospective Infection Prevention and Control (IPC) Annual Report for 2019/20. The report was positive and assured QRMC on behalf of the Board that NBT maintains a 'zero tolerance' of healthcare associated infections with Trust wide learning ensured where cases are reported. It also reported a reduction in MRSA cases compared to the previous year, and completed actions regarding divisionally-specific infection control issues.

The committee also received and approved the IPC Annual Programme for 2020/21 which described the infrastructure and systems that are currently in place to reduce the incidence of health care associated infection. The Programme also provides the key drivers and objectives for preventing and controlling infection going forward, ensuring that safe care remains a priority for the Trust. QRMC approved the proposal of the IPC annual plan as recommended by the Control of Infection Committee which will monitor the programme on an ongoing basis.

The Committee also received the NHSI/E board assurance document which had been created to assist Boards in assessment of Covid-19 infection control management within their Trusts. Using the NHSI/E framework, gaps in assurance within NBT were as follows:

- Segregation screening, e.g. for reception staff is not in place in all areas
- Staff social distancing e.g. during meal breaks

QRMC were reassured the above would continue to be worked on to reduce the gap in assurance but accepted that this would take time as it involved culture change for staff.

3.2 Safeguarding Annual Reports

The Committee received the 2019/20 annual safeguarding reports for children and adults which provided assurance that the Trust is fulfilling its statutory responsibilities and duties in relation to safeguarding adults and children. Developments and service delivery for 2019/20 in relation to safeguarding adults at risk and safeguarding children were described.

The reports also identified next steps to continue to provide protection in 2020/21. The Committee were advised that there is likely to be an increase in adult to adult and adult to child violence and psychological abuse due to Covid-19 lockdown. The Safeguarding team had taken a number of additional steps to support staff to deal with increased safeguarding issues such as briefing staff who carried out swabbing that this may present an opportunity for disclosure.



3.3 Quality Strategy

The committee reviewed and approved the final draft of the Quality Strategy and commended it to Trust Board for approval.

3.4 Quality and Safety Improvement Team (QSIT) Annual Report

The Committee received the QSIT annual report and a presentation from the QSIT team. The report described the team's work to enable the OneNBT vision of 'Exceptional Healthcare, Personally Delivered' including detailing work on Quality Improvement and Enabling Capability and Staff Wellbeing.

Barriers to the transformative work supported by the QSIT were discussed. Staff time and headspace, and funding, were identified as the biggest barriers. QRMC asked the QSIT team to bring to the committees attention any issues that could be resolved at Board level.

3.5 Suicide prevention update – Brunel Building

The Committee received a report on Suicide Risk Prevention in the Brunel Building. The committee supported the approach of closer liaison with Avon & Wiltshire Mental Health Partnership (AWP) colleagues to prevent suicide wherever possible.

The Committee were assured that risks of injury from heights had been mitigated as far as possible.

3.6 Other items:

The Committee also received additional updates, including:

- Quality account – Final Draft;
- Serious Incidents/Never Events Report
- Risk Management Report;
- Patient Safety & Clinical Risk Committee Sub-committee upward report;
- Quality Performance Report as presented to Trust Board in June as part of the Integrated Performance Report;
- CQC action plan update.

## 4. Identification of new risk & items for escalation

No significant risks or issues were identified.

## 5. Recommendations

The Trust Board should receive the report for assurance and note the activities QRMC has undertaken on behalf of the Board, in particular approval of the Quality Strategy and commendation to Trust Board for approval; and review of the Infection Prevention Control, Quality & Safety Improvement Team (QSIT) and Safeguarding annual reports.

| | | | |
|---|---|---|---|
| **Report To:** | Trust Board | | |
| **Date of Meeting:** | 30 July 2020 | | |
| **Report Title:** | Fit and Proper Persons Update | | |
| **Report Author & Job Title** | Kate Debley, Deputy Trust Secretary | | |
| **Executive/Non-executive Sponsor (presenting)** | Xavier Bell, Director of Corporate Governance & Trust Secretary | | |
| **Purpose:** | **Approval** | **Discussion** | **To Receive for Information** |
| | | | **X** |
| **Recommendation:** | That the Trust Board:<br>• Note that all directors have submitted a 2020 fit and proper person regulation (FPPR) self-declaration.<br>• Note that all FPPR checks are up-to-date and complete. | | |
| **Report History:** | This is an annual report to the Trust Board. | | |
| **Next Steps:** | N/A | | |

| **Executive Summary** |
|---|
| All board members have completed an annual FPPR self-declaration for 2020 (see template form at **Appendix 1**), confirming that they are fit and proper persons to hold office within the Trust, as defined in Regulation 5 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. In addition, the full suite of FPPR checks have been conducted for the three recently appointed Non-Executive Directors. |

| | |
|---|---|
| **Strategic Theme/Corporate Objective Links** | **1. Provider of high quality patient care**<br>a. Experts in complex urgent & emergency care<br>b. Work in partnership to deliver great local health services<br>c. A Centre of Excellence for specialist healthcare<br>d. A powerhouse for pathology & imaging<br>**2. Developing Healthcare for the future**<br>a. Training, educating and developing out workforce<br>b. Increase our capability to deliver research<br>c. Support development & adoption of innovations<br>d. Invest in digital technology<br>**3. Employer of choice**<br>a. A great place to work that is diverse & inclusive |

| | |
|---|---|
| | b. Empowered clinically led teams<br>c. Support our staff to continuously develop<br>d. Support staff health & wellbeing<br>**4. An anchor in our community**<br>a. Create a health & accessible environment<br>b. Expand charitable support & network of volunteers<br>c. Developing in a sustainable way |
| **Board Assurance Framework/Trust Risk Register Links** | This report is not linked to any specific risks, but aligns to the Well-Led CQC domain. |
| **Other Standard Reference** | CQC Fit & Proper Person Regulation<br>CQC Well-Led Inspection Framework |
| **Financial implications** | The costs of undertaking updated FPPR checks on board members have a small financial implication (approximately £300 per DBS check and £10 per Trust-Online check).<br>This is covered by the People and Trust Secretary budgets respectively. |
| **Other Resource Implications** | N/A |
| **Legal Implications including Equality, Diversity and Inclusion Assessment** | Failure to ensure that all members of the board comply with Regulation 5 (FPPR) may result in regulatory action being taken by the CQC. |
| **Appendices:** | Appendix 1 – FPPR self-declaration form |

## 1. Purpose

1.1 To present the outcome of the annual FPPR self-declaration checks.

1.2 To present the outcome of FPPR checks for NBT's three recently appointed Non-Executive Directors.

1.3 To provide evidence of the Trust's compliance with the Care Quality Commission (CQC) regulation 5 relating to fit and proper persons.

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## 2. Background

2.1 The Trust's Fit and Proper Person Requirement (FPPR) for Directors Policy establishes the Trust's commitment to ensuring that all persons appointed as directors, or performing the functions of, or functions equivalent or similar to those of a director satisfy the Fit and Proper Person Requirements as directed by the CQC Regulation 5. The scope includes executive, non-executive, permanent, interim and associate

directors who are members of the board, no matter whether they fill existing, interim or permanent posts, and irrespective of voting rights.

2.2 In line with Trust policy, NBT Directors have each year since 2015 completed an annual self-certification form to confirm that they are a 'fit and proper person' and do not fall within any of the categories listed and to confirm they are not aware of any pending proceedings or matters which may call such a declaration into question in the future.

2.3 Additionally, three new Non-Executive Directors were appointed to the Trust Board in March 2020 and have undergone the required FPPR checks for the first time.

## 3. Executive and Non-Executive Directors Status July 2020

3.1 The annual self-declaration returns have been completed and all directors have confirmed compliance with the regulation.

3.2 In line with the Trust's policy, FPPR checks were updated in 2019 for several longstanding directors (both executive and non-executive) who had not previously had checks updated since 2015 (including DBS checks).

3.3 FPPR checks have been completed for the three Non-Executive Directors appointed to the Trust Board in March 2020. The Director of Corporate Governance & Trust Secretary has reviewed the FPPR evidence for each of these individuals and confirmed that the requirements of the CQC regulation have been met.

## 4. Summary and Recommendations

4.1 The Trust Board is asked to **note** that:

- All directors have submitted a 2020 fit and proper person regulation (FPPR) self-declaration.
- FPPR checks for all Directors are up-to-date and complete.

North Bristol NHS Trust

## "FIT AND PROPER PERSON" SELF DECLARATION

1. Non-Executive and Executive roles in the NHS are positions of significant public responsibility and it is important that those appointed can maintain the confidence of the public, patients and NHS staff. The Trust has a duty to ensure that those we appoint to NHS boards are of good character, will ensure an open and honest culture across all levels of the organisation. The "Fit and Proper Person" requirements are set out in the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

2. By signing the declaration below, you are confirming that you are a "fit and proper person" outlined at (3), that you do not fall within any of the categories outlined at (4) or (5) below and that you are not aware of any pending proceedings or matters which may call such a declaration into question in the future.

3. The regulations require you are:

   (a) of good character;
   (b) have the necessary qualifications, competence, skills and experience; and
   (c) are able by reason of your health, after reasonable adjustments are made, of properly performing tasks which are intrinsic to the office or position.

4. Do any of the following conditions apply to you? You are asked to confirm that you are not:

   (a) a person who has an unspent conviction (unless you are being appointed to a role which requires a standard or enhanced DBS Check, in which case full disclosure of both spent and unspent convictions is required) in the United Kingdom of any offence or been convicted elsewhere of any offence which, if committed in any part of the United Kingdom, would constitute an offence;
   (b) a person who has been erased, removed or struck off a register of professionals maintained by a regulator of health care or social work professionals;
   (c) an undischarged bankrupt, or a person whose estate has had a sequestration awarded in respect of it and who has not been discharged;
   (d) the subject of a bankruptcy restrictions order or an interim bankruptcy restrictions order or an order to like effect made in Scotland or Northern Ireland;
   (e) a person to whom a moratorium period under a debt relief order applies under Part VIIA (debt relief orders) of the Insolvency Act 1986(40);
   (f) a person who has made a composition or arrangement with, or granted a trust deed for, creditors and not been discharged in respect of it;
   (g) included in the children's barred list or the adults' barred list maintained under section 2 of the Safeguarding Vulnerable Groups Act 2006, or in any corresponding list maintained under an equivalent enactment in force in Scotland or Northern Ireland;
   (h) a person who has been responsible for, privy to, contributed to or facilitated any serious misconduct or mismanagement (whether unlawful or not) in the course of carrying on a regulated activity, or discharging any functions relating to any office or employment with a service provider.

**DECLARATION**

☐ I confirm that I do not fit within any of the categories listed and that there are no other grounds under which I would be ineligible for appointment. If appointed, I undertake to notify the Trust immediately of any change of circumstances that may affect my eligibility to remain in post.

☐ I wish to declare the following information which may be relevant to my eligibility for this role:

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|---|
| **Signature:** |
| **Name:** |
| **Date:** |