Trust Board Meeting in Public

Thursday 28 November 2019
10.00 – 12:30
Seminar Room 5, Learning and Research Centre, Southmead Hospital

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.	Patient Story	Information	Director of Nursing & Quality	Verbal	10:05
4.	Minutes of the Public Trust Board Meeting Held on 26 September 2019	Approval	Chair	Enc.	10:25
5.	Action Chart from Previous Meetings	Discussion	Trust Secretary	Enc.	10:27
6.	Matters Arising from Previous Meeting	Information	Chair	Verbal	10:30
7.	Chair's Business	Information	Chair	Verbal	10:35
8.	Chief Executive's Report	Information	Chief Executive	Enc.	10:40
QUALITY					
9.	Pressure injury improvement programme	Discussion	Director of Nursing & Quality	Enc.	10:50
10.	Patient & Carer Experience Committee upward report	Discussion	NED Chair	Enc.	11:05
11.	Complaints annual report	Information	Director of Nursing & Quality	Enc.	11:15
12.	Quality & Risk Management Committee upward report	Information	NED Chair	Enc.	11:20
13.	Six-monthly safer staffing report	Information	Director of Nursing & Quality	Enc.	11:30
PERFORMANCE AND FINANCE					
14.	Integrated performance report	Discussion	Chief Executive	Enc.	11:40
15.	Month 6 2019/20 corporate objectives update	Information	Director of Finance	Enc.	11:55
GOVERNANCE					
16.	Freedom to speak up 6-monthly report	Discussion	Trust Secretary	Enc.	12:00
17.	Annual guardian of safe working (junior doctors) report	Discussion	Medical Director	Enc.	12:15
CLOSING BUSINESS					
18.	Any Other Business	Information	Chair	Verbal	12:30
19.	Questions from the Public in Relation to Agenda Items	Information	Chair	Verbal	-
22.	Date of Next Meeting: Thursday 30 January 2020, 10.00 a.m. Seminar Room 5,				

No.	Item	Purpose	Lead	Paper	Time
	Learning & Research Building, Southmead Hospital				
	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.				

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Trust Board Declarations of Interest – November 2019

Name	Role	Interest Declared
Ms Michele Romaine	Chair (from 1 July 2018)	• Nothing to declare.
Mr Kelvin Blake	Non-Executive Director (from 1 February 2019)	• Non-Executive Director of Weston Area Health Trust. • Non-Executive Director of BRISDOC who provide GP services to North Bristol NHS Trust. • Trustee, Second Step. Provide mental health services for the Bristol North Somerset and South Gloucestershire area. • 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. • Lay Member of the Avon & Somerset Advisory Committee. The Committee is responsible for forming interview panels for the appointment of magistrates. • Director, Bristol Chamber of Commerce and Initiative. • Member of the Labour Party.
Ms Jaki Davis	Non-Executive Director	• Trustee of the Cheltenham Trust. • 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. • Member of Bath Abbey Appeal Committee. • Daughter works for North Bristol NHS Trust.

Professor John Iredale	Non-Executive Director	• Pro-Vice Chancellor of University of Bristol.
		• Advisor to Novartis on liver disease.
		• Member of Medical Research Council.
		• Trustee of:
		  ○ British Heart Foundation
		  ○ Children's Liver Disease Foundation
		  ○ Foundation for Liver Research
		• Chair of the governing board, CRUK Beatson Institute.

Mr Tim Gregory	Non-Executive Director	• Nothing to declare.

Name	Role	Interest Declared
Mr Robert Mould	Non-Executive Director	• Non-Executive Director of Weston Area Health Trust. • Member of Bristol Mediation.
Ms Andrea Young	Chief Executive	• Nothing to declare.
Ms Evelyn Barker	Interim Chief Operating Officer (from 9 April 2018 to 31 December 2018) Chief Operating Officer & Deputy Chief Executive (from 1 January 2019)	• Nothing to declare.
Ms Helen Blanchard	Interim Director of Nursing and Quality (from 2 July 2018)	• Nothing to declare.
Dr Chris Burton	Medical Director	• Wife works for NBT.
Mr Neil Darvill	Director of Information Management and Technology (non-voting position)	• Nothing to declare.
Ms Jacqui Marshall	Director of People and Transformation (non-voting position)	• Nothing to declare.
Mrs Catherine Phillips	Director of Finance	• Nothing to declare.
Mr Simon Wood	Director of Estates, Facilities and Capital Planning (non-voting position)	• Nothing to declare.

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

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
30/05/2019	Quality and Risk Management Committee	TBC/19/5/11	2	Review format of Exec / Non-Exec Walkrounds	Helen Blanchard Director of Nursing & Quality	Aug-19	Yes, 29/08/2019	A	Updated proposal to be brought to December board meeting	01/11/2019
26/09/2019	Quality & Risk Management Committee Report	TBC/19/09/11	6	QRMC was tasked with seeking assurance on processes for managing patient harm for patients on diagnostic and RTT 2-week wait pathways at its next	Xavier Bell, Director of Governance	Nov-19	Yes, QRMC	Closed	On QRMC November agenda & action log, to be incl. in upward report	29/10/2019
26/09/2019	Health & Safety Annual Report 2019/20	TBC/19/09/19	7	The Board sought assurance that learning and expertise in the health and safety team around 'Slips, trips and falls' is fed into the patient safety team.	Simon Wood Director of Facilities	Nov-19	Verbal update Nov-19	Green		

Report To:	Trust Board Meeting		**Agenda Item:**	8.0
Date of Meeting:	28 November 2019			
Report Title:	Chief Executive's Briefing			
Report Author & Job Title	Xavier Bell, Director of Corporate Governance & Trust Secretary			
Executive/Non-executive Sponsor (presenting)	Andrea Young, Chief Executive			
Purpose:	**Approval/Decision**	**Review**	**To Receive for Assurance**	**To Receive for Information**
				X
Recommendation:	The Trust Board is asked to receive and note the content of the briefing.			
Report History:	The Chief Executive's briefing is a standing agenda item on all Board agenda.			
Next Steps:	Next steps in relation to any of the issues highlighted in the Report are shown in the body of the report.			

Executive Summary
The report sets out information on recent updates from our regulators, changes in senior leadership within the Trust, and other items of importance to the Board.

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

Strategic Theme/Corporate Objective Links	**Be one of the safest trusts in the UK** **Play our part in delivering a successful health and care system**
Board Assurance Framework/Trust Risk Register Links	Does not link to any specific risk.
Other Standard Reference	N/A
Financial implications	None identified.
Other Resource Implications	No other resource implications associated with this report.
Legal Implications including Equality, Diversity and Inclusion Assessment	None noted.

Appendices:	None

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North Bristol NHS Trust

1. Purpose

To present for information an update on local and national issues impacting on the Trust.

2. Background

The Trust Board should receive a report from the Chief Executive to each meeting detailing important changes or issues in the external environment. This includes guidance and policy actions which have been received from the wider regulatory and policy system, quality and financial risks in the health economy.

3. Director of Nursing & Quality

I am pleased to advise that following a competitive process Helen Blanchard has been appointed to the substantive post of Director of Nursing and Quality. Many of you know that Helen joined the Trust when our previous Director of Nursing became unwell 18 months ago and has undertaken the role on an interim basis since then. Helen impressively led the organisation and our teams to our best ever CQC result and we are delighted that she will be joining us on a longer term footing providing professional leadership to our nursing, midwifery and therapy staff and leading the Trust's quality strategy.

4. Electronic Prescribing

The Trust is in receipt of national funding to support the EPMA programme. The IM&T Division is working through the plans with NHSX on delivery and timescales of the EPMA solution.

5. Health Services Journal Annual Awards

Representatives from the Trust attended the 2019 HSJ awards night on 6 November. The Trust's Perform project with PWC "Digitally Enabling Patient Flow" received special commendation. The Trust was also shortlisted for its staff engagement work "Empowering our frontline staff to lead" and for "Collaboration in Procurement", as part of the system work with GRI on the supply of agency staff.

6. BNSSG Long Term Plan

BNSSG's Long Term Plan was submitted to regulators last week. The Partnership Board which includes Chairs and CEOs gave support to the ambition and direction of travel set out in the plan. The plan was approved on behalf of the Trust by the Chair and Chief Executive, in line with the delegated authority granted by Trust Board at its October meeting.

7. Staff Survey

The annual staff survey is currently live, and I would like to extend a big thanks to all staff who have taken the time to complete the survey. It provides extremely useful feedback on the how staff are feeling about the organisation and their jobs, and allows us to focus attention on where improvements might be needed. For 2019 the

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Trust is seeking to significantly increase the completion rate. As of 20 November the Trust's completion rate sits at 43.7%, which already exceeds the 2018 completion rate of 41%. The survey closes on Friday 29 November.

8. Flu vaccinations

The 2019/20 seasonal flu vaccination campaign has commenced, with clinics for staff commencing on 30 September 2019. The campaign will run until the end of February 2020. The 2019/20 campaign has been informed by lessons identified from previous years.

The Seasonal Influenza planning group have been meeting since May 2019 in preparation for the campaign. A broad range of divisions have been represented including staff groups and Union representatives. A comprehensive communications plan is being implemented. The vaccination programme includes 84 peer vaccinators along with 45 hours per week bank shifts to ensure a wide coverage across the Southmead site and satellite units.

The national requirement, linked to the flu vaccine CQUIN is that 80% of frontline healthcare workers receive a vaccination. As at 21 November the Trust has achieved 65.7% of all frontline staff vaccinated. A further breakdown is provided in *Appendix 1.*

9. Recommendation

The Trust Board is recommended to receive the report for information.

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Appendix 1

Seasonal Flu Vaccination uptake at 21 November 2019

Vaccinations delivered to date (all Trust staff)	**4541**
Non Directorate / Extra Bank / Volunteer	**182**
TOTAL VACCINATIONS DELIVERED	**4723**

OPT OUT

In addition, to date we have received the following 'Opt Outs'

Frontline staff	**72**
All other Trust Staff	**42**
TOTAL OPT OUTS TO DATE	**114**

Staff group	Total in Trust	Vaccinated to date	% uptake
Doctors	992	705	71.1%
Registered Nurse	1819	1126	61.9%
Registered Midwife	259	178	68.7%
All other professionally qualified staff	622	480	77.2%
Support to clinical staff	1092	653	59.8%
TOTAL FRONTLINE STAFF	**4784**	**3142**	**65.7%**
All other Trust staff	3290	1399	42.5%
GRAND TOTAL	**8074**	**4541**	**56.2%**

DIVISION	Frontline staff vaccinated (%)	All other staff vaccinated (%)	Total staff vaccinated (%)
Anaesthesia, Surgery, Critical & Renal Division	55.8%	46.2%	54.1%
Core Clinical Services Division	88.7%	36.9%	58.2%
Corporate Divisions	41.6%	55.8%	52.3%
Facilities Division	n/a	34.4%	34.4%
Medicine Division	72.0%	52.4%	68.7%
Neurosciences & Musculoskeletal Division	60.4%	38.2%	53.7%
Women and Childrens Division	65.0%	60.0%	64.3%
GRAND TOTAL	**65.7%**	**42.5%**	**56.2%**

North Bristol NHS
NHS Trust

Report To:	Trust Board	**Agenda Item:**	09.
Date of Meeting:	28th November 2019		
Report Title:	Reduction & Prevention of Pressure Injuries Programme update for Trust Board November 2019		
Report Author & Job Title	Su Monk, Assistant Director of Nursing Sam Matthews, Nurse Consultant Infection Prevention Control & Tissue Viability Sarah Chalkley, Deputy HoN ASCR Sarah Lidgett, Clinical Matron Medicine Suzanne Mallett, Clinical Matron NMSK		
Executive Sponsor (presenting)	Helen Blanchard, Interim Director of Nursing		

Purpose:	**Approval/Decision**	**Review**	**To Receive for Assurance**	**To Receive for Information**
			x	

Recommendation:	To provide assurance on the work and activity of the Pressure Injury Incident group since July 2019
Report History:	An update on report presented in July 2019
Next Steps:	Trust Board is asked to receive the report for assurance

Executive Summary

In 2014 NBT signed up to safety campaign and reduced the incidents of PI's during the programme. As an organisation we work to the

- NHS National Pressure ulcer prevention strategy
- BNSSG Strategy
- NICE guidance
- NHSi 29 standards

Pressure injuries are classified according to clinical definitions which allow the injury to be graded, and also identified when they are associated with the use of Clinical devices. Categories Grade 1-4 and are reported according to device and non-devise related injury.

Each Grade 2 and above injury relating to harm occurring in NBT are investigated with an initial SWARM and followed up with a Root Cause Analysis investigation, with Grade 3 and 4 injuries reported externally through STEIS. The Director of Nursing reported to the Board in July 2019 that on 6 occasions since February 2019 the organisation has reported an increase above mean rate, therefore it has been concluded that this is outside of natural variation. In response the Director of Nursing has convened a pressure injury incident review. The attached presentation provides assurance to the board on the actions of the group, identifies changes to clinical governance processes and an update on the work stream processes.

Strategic Theme/Corporate Objective Links	• Be one of the safest trusts in the UK
Board Assurance Framework/Trust Risk Register Links	NBT BAF SIR 14, clinical complexity and patient safety.

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Other Standard Reference	CQC S1 ; How do systems, processes and practices keep people safe and safeguarded from abuse and harm.
Financial implications	N/A
Other Resource Implications	
Legal Implications including Equality, Diversity and Inclusion Assessment	Result of increased harm to patients, litigation and regulatory action.

Appendices:	Presentation ; Reduction & Prevention of Pressure Injuries Programme update

Report To:	Trust Board		**Agenda Item:**	10
Date of Meeting:	28 November 2019			
Report Title:	Patient & Carer Experience Committee Report			
Report Author & Job Title	Kate Debley, Deputy Trust Secretary			
Executive/Non-executive Sponsor (presenting)	Robert Mould, Chair of the Patient & Carer Experience Committee and non-Executive Director.			
Purpose:	**Approval/Decision**	**Review**	**To Receive for Assurance**	**To Receive for Information**
			X	
Recommendation:	The Trust Board is recommended to receive the report for assurance.			
Report History:	The report is a standing item to each Trust Board meeting following a Patient & Carer Experience Committee meeting.			
Next Steps:	The next report to Trust Board will be to the January 2020 meeting.			

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Executive Summary
The report provides a summary of the assurances received, issues to be escalated to the Trust Board and any new risks identified from the Patient & Carer Experience Committee Meeting held on 21 November 2019.

Strategic Theme/Corporate Objective Links	Reports received supported the delivery of the following strategic themes and corporate objectives: • Be one of the safest trusts in the UK • Treat patients as partners in their care
Board Assurance Framework/Trust Risk Register Links	Reports received support the mitigation of the following BAF risks: N/A
Other Standard Reference	Care Quality Commission Standards.
Financial implications	No financial implications as a consequence of this report.

Other Resource Implications	No other resource implications as a result of this report.
Legal Implications including Equality, Diversity and Inclusion Assessment	No legal implications.

Appendices:	None

1. Purpose

To provide a highlight of the key assurances, any escalations to the Board and identification of any new risks from the Patient & Carer Experience Committee meeting held on 21 November 2019.

2. Background

The Patient & Carer Committee is a sub-committee of the Trust Board. It meets bi-monthly and reports to the Board after each meeting. The Committee was established to:

- Raise the profile and visibility of patient experience at Trust Board level and provide assurance to the Board;
- Set the strategic direction for patient experience with the purpose of achieving the Trust's strategic aims, including to 'treat patients as partners in their care';
- Monitor development and delivery of a patient experience strategy and carer strategy;
- Be the conduit for effective change and improvement to patient experience, act on feedback to challenge, influence activities that deliver an improved patient experience.

3. Key Assurances & items discussed

3.1 The Committee received a patient story, via a letter from a patient 'Alan' who is blind. As a frequent user of health services, Alan recounted his own experiences, as well as on behalf of others who have a visual impairment. In relation to accessibility of information, it was noted that the Trust's digital platforms do not currently meet Web Content Accessibility Guidelines (WCAG) standards. In addition, the Committee noted that there is insufficient information available about the culture within the organisation to be able to assess performance against the government's 'Disability Confident' scheme.

The Committee noted that the Trust has a legal obligation to comply with the Accessible Information Standards, and that there is still work required to ensure that these are embedded across the organisation.

3.2 The Committee received an update on the CCG contracted non-emergency patient transport services. It was noted that whilst the Trust does not manage this contract, this is an issue which can have a significant impact on patient and carer experience, as well as potentially wider implications in relation to outpatient flow. The importance was noted of the contractor, E-Zec, receiving and acting on patient feedback. It was reported that E-Zec are due to conduct a patient survey and it was agreed that the Head of Patient Experience should seek to provide input to the development of this survey. A note has been added to the work plan that a further update should be provided to the Committee once the survey data has been analysed.

3.3 The Head of Outpatient Services presented a deep dive into the outpatient improvement programme, patient involvement, feedback and impact. There was a

wide-ranging discussion, during which it was noted that this is a complex programme with various dependencies. Alignment with the IM&T Strategy is one of the key challenges. It was agreed that sustaining patient voice and perspective as the programme progresses will be fundamental to ensuring success. The Committee have requested a further update at its March 2020 meeting.

3.4 The Committee received the Complaints Annual Report 2018/19, which will be presented to the Trust Board at its meeting on 28 November 2019. It was agreed that the key issues to be highlighted to the Board for consideration are a review of the PALS pilot and the development of a clear methodology for learning from complaints.

3.5 The Lead Cancer Nurse presented a report on the National Cancer Patient Experience Survey 2018. The Committee noted the summary results and action plan for NBT from the Survey and were assured that governance arrangements are in place for monitoring progress against these actions. During the ensuing discussion, the question was raised as to whether the holistic model for improving cancer patient experience could be used as an exemplar for other clinical disciplines.

3.6 The Committee received a report on the findings of the Urgent and Emergency Care Survey 2018, conducted by Picker. The report was noted and the Committee were assured of the positive results and associated action plan.

3.7 The Patient Experience Group highlight report was received by the Committee and its contents noted. The Committee were assured by the progress reported against each work stream.

3.8 The Learning Disability & Autism Steering Group highlight report was received by the Committee, who were assured by the progress reported against each work stream. It was further noted that Kelvin Blake is now the learning disability champion for the Trust Board.

3.9 The Committee received and noted the Quality section of the Integrated Performance Report for September 2019. It was further noted that due to the timing of the meeting, this report had already been scrutinised by Trust Board and the Quality and Risk Management Committee.

4. Escalations to the Board

4.1 That the Board commission a piece of work to assess the organisation's disability confidence and accelerate work on information accessibility, including by prioritising the planned business case supporting implementation of the Accessible Information Standards.

4.2 That in consideration of the Complaints Annual Report 2018/19 the Trust Board have particular regard to the work of the PALS pilot and support the development of a clear methodology for learning from complaints.

4.3 That the Board consider whether there are any aspects of the Quality section of the Integrated Performance Report (October data), both in relation to the data itself and the categories of data, that the Patient & Carer Experience Committee should review at its next meeting.

5. Recommendations

5.1 The Board is recommended to receive and note the report for assurance, and consider the escalation items outlined above.

NHS North Bristol NHS Trust

Report To:	Trust Board		**Agenda Item:**	11.
Date of Meeting:	28th November 2019			
Report Title:	Complaints Annual Report 2018/19			
Report Author & Job Title	Gill Brook Head Patient Experience; Kate Plunket Reed ; Patient Experiencing Manager			
Executive/Non-executive Sponsor (presenting)	Helen Blanchard Director of Nursing and Quality			
Purpose:	**Approval/Decision**	**Review & discussion**	**To Receive for Assurance**	**To Receive for Information**
	x			
Recommendation:	• To receive the report as assurance of the work undertaken in 2018 -2019 relating to the management of complaints and concerns and the key focus from improvement for 2019 -2020			
Report History:	• Reviewed and discussed at ○ Patient Experience Group September 2019 & ○ Patient and Carer Experience Committee 21st November 2019			
Next Steps:	• The actions for 2019 /20 are being taken forward within the complaints and PALS work plan working in partnership with Divisional Patient Experience leads.			

Executive Summary

The following are the key points of information within the report:

- Number of Complaints increased in year to 723 from 592 (2017/18)
- Overdue complaints remained a challenge an average between 10 -41 per month .Key performance indicators were set for 2019/20 at 85% of complaints are responded to within the agreed time scale
- Complaint response time recovery plan established at the end of the year
- A pilot of a Patient Advice and Liaison Service (PALS) commenced in February 2019 in order to increase the opportunity for patient's concerns to be addressed as quickly as possible and person t person .
- Top key themes from complaints: Clinical care and treatment=35%:communication=24%
- Number of PHSO cases decreased to 3 from 9 with one being upheld and giving recommendations for improvement and resolution
- NHS Choices patient feedback gave the average score of 4.5 /5 for the year
- Complaints Lay Review panel made recommendations for improvement which fed into the complaint policy review and staff training .The means to sustain this important quality

checking resource is sought and once all PALS personnel in place this will be attainable
- Datix, a new case/ incident management system was implemented
- The improvement of the handling and resolution of complains was a key project, successfully delivered, in the year in the Clinical Governance improvement program during the year. This included a review of the policy and process for the management of complaint and concerns.
- Training for staff in the investigation of complaint and response letter writing was successfully delivered during the year
- The successful PALS pilot led to the provision of recurrent funding for additional staff to sustain this successful person centred service

Key focus for improvement during 2019/20 include:
- Establishing a permanent PALS service
- Revise process of the management and resolution of complaints and concerns to ensure they are person centred and roles and responsibilities are clear
- Revise Policy in line with the above
- Streamline Datix forms to reflect the process and improve recording
- Develop performance dashboard for the monitoring of the completion of complaints within agreed time scales
- Implement the recovery plan for overdue complaints through weekly monitoring reports and weekly meeting with Divisional teams
- Establish admin support for the Complaint Lay Review Panel to ensure its ongoing function
- Revise training material and deliver training on complaint investigation; de-escalation of concerns and local resolution; complaint response letter writing skills; and training on the use of Datix

Strategic Theme/Corporate Objective Links	• Treat patient as partners in their care
Board Assurance Framework/Trust Risk Register Links	None
Other Standard Reference	• The principles of good complaint handling:2009 (PHSO) • Good practice standards for NHS Complaints Handling : 2013 (Patient Association) • Commissioners Quality Contract • CQC regulation and standards
Financial implications	Seeking funding to resource and sustain a PAL Service at time of report. This has been resourced and posts appointed to
Other Resource Implications	None
Legal Implications including Equality, Diversity and Inclusion Assessment	• The NHS Constitution 2015 (revised Handbook 2019) • EDS 2. Improving Access and Experience of Patients

Agenda item 11.

NHS
North Bristol
NHS Trust

Complaints and Concerns Annual Report

2018/2019

11

Authors:

Gill Brook, Head of Patient Experience

Kate Plunket-Reed, Patient Experience Manager

Executive Summary

North Bristol NHS Trust experienced an increase in complaints in 2018/19 and although this increase was in parallel to an increase in activity, further improvements can be made.

The time taken to respond to a number of complaints is too long, exceeding the agreed response time, in some cases and this will need to be explored further with the Divisions and a recovery plan and weekly tracker system put in place to ensure the established compliance rate is achieved. Although some evidence supports that the quality of complaints responses has improved since the introduction of some training across the Trust, variation continues to exist between some Divisions in terms of clinical engagement.

There is ongoing evidence that improvement in complaints management needs to remain a priority, and the complaints system is regarded by the organisation as a valuable gauge of the patient experience at NBT. There is evidence that complaint responses regularly identify opportunities for individuals, departments and the organisation to learn from complaints. Greater sharing of issues and solutions from complaints has taken place over the last two years but can always be improved.

Although the incidence of reinvestigations and referrals to the PHSO has remained low over the past year, further work is needed to ensure patients are satisfied by the complaints handling process and are given an opportunity to input into how they want their complaint resolved, and to ensure complaints are responded to in a timely manner.

1.0 Purpose

The purpose of this report is to provide an update to the Trust Board on the management of complaints and concerns during year 2018/19.

2.0 Background and Context

NHS constitution clearly sets out the right of patients of patient in relation to raising complaints and the management of them.
https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/770675/The_Handbook_to_the_NHS_Constitution_-_2019.pdf

As a trust we value all feedback and particularly want to know when someone is not satisfied with the service provided so that we can put things right and learn from the experience of our service users. The Trust will use the principles of this policy to resolve concerns as quickly as possible, demonstrating our Trust values of:

Patient surveys, feedback forms and enquiries/concerns are useful feedback tools about the care and treatment North Bristol NHS Trust (NBT) provides but written complaints give us the clearest message about our services. It is widely recognised that patients are concerned that making a complaint may impact on their treatment and care, so it is important to investigate their concerns and maximise any learning opportunities. We know from thank you letters that whilst this does not affect the complainant's own experience, they are grateful to know that we are keen to learn when we get it wrong: this could be an individual, team or trust level. All formal complaints received have been fully investigated through the Trust's complaints procedure.

3.0 Accountability

The Trust Board has corporate responsibility for the quality of care and the management and monitoring of complaints received by our Trust. The Chief Executive has delegated the responsibility for the management of complaints to the Director of Nursing Quality. The Head of Patient Experience is responsible working with the Patient Experience Manager (Complaints and Concerns) for ensuring:

- All complaints are fully investigated appropriate to the complaint
- All complaints receive a comprehensive written response from the Chief Executive or their nominated deputy in their absence
- Complaints are responded to within local standard response time of 35 days
- Where the timescale cannot be met, an explanation is provided and an extension agreed
- When a complaint is referred to the PHSO, all enquiries are responded to promptly and openly.

The Heads of Nursing within the Division hold the Divisional responsibility for the management of the above process. The response resolution and seeking to learning from complaints and concerns remain everyone's business.

4.0 Activity

This year the overall the number of formal complaints in 2018/19 was 723 a significant increase from the annual number of 592 in year 2017/18. The increase is against a backdrop of increased patient and outpatient activity

Whenever a complaint is managed through the formal complaints process, the Trust and the complainant agree a timescale within which we will investigate the complaint and write to the complainant with, or arrange a meeting to discuss, our findings. The timescale is agreed with the complainant upon receipt of the complaint and is usually 35 working days.

The number of overdue complaints in year 2018/19 varied considerably month on month, fluctuating between a figure of 10 and 41 overdue cases a month. This indicated the need for a tracking system or weekly overdue report and whilst there has been concerted efforts made to decrease the number of overdue complaints by the Divisions, this is a key area of focus for 2019/20.

During Quarter 4 a key performance indicator was set that a requirement of 85% of complaints are responded to within the agreed time frame (agreed with Commissioners as part of the quality contract). This performance indicator gives a more reliable picture of performance. The average monthly completion rates have varied between 53% and 76% (March 2019). Recovery plans were developed with Divisions to improve setting trajectories to meet the required targets.

There is regulatory requirement for all NHS Complaints, to acknowledge them within three working days. This has been only been missed on one occasion by the Advice and Complaints Team (ACT).

The number of compliments received appeared to decrease during 2018/19 however an audit of this suggests that this is as a result of the way that compliments are currently recorded as opposed to an indication that patient experience is less satisfactory. As part of an improvement plan to be rolled out throughout 2019/20, the way in which the Trust receives and records compliments will be reviewed.

Comparison of activity levels 2016 – 2019 Activity levels 2018/19

Type	2016/17	2017/18	2018/19	Commentary
Compliments	9,065	9,440	7704	The data reflects just a proportion of the significant number of received across the Trust.
Complaints	654	592	723	The number of complaints has increased by 18% from 2017/18. The PALS service which commenced in February 2019 is enabling enquires, concerns complaints to be addressed more quickly and to the satisfaction of the 'customer.' The full impact will be seen over the coming year.
Concerns	1,394	800	744	
Enquiries	7,059	8,878	5729	
Response Time (within timescale)	77%	67%	59%	A programme of improvement work is expected to deliver significant progress in the timeliness of our response to those who have raised a complaint.

5.0 Themes

The table below provides an overview of the themes of the types of issues raised in complaints in 2018/19. This is of course subjective and is dependent on the view of the person entering the information. Further work will be undertaken with staff to increase alignment and conformity.

Themes of subject matters arising from complaints 2018/19		
Subject	**Number of times recorded**	**% of total**
All aspects of care and treatment	340	35%
Communication	242	24%
Attitude of staff	106	11%
Admission/ Discharge/ Transfer	78	11%
Delay/ cancellation of OP episode	78	8%
Other	131	14%

Clinical complaints may have their root in administrative errors, e.g. not booking a follow up appointment or sending letters to incorrect addresses. Many of the complaints about clinical care such as drug errors, on investigation show no failings in actual care but do indicate communication could be improved. For example : when medication has been changed, patient's or their relatives may not have had adequate explanation and may feel that doses have been missed by accident or too much of a drug has been given, when they have been omitted or increased deliberately as part of the treatment plan. As part of an improvement

plan to be rolled out in year 2019/20, a review of Datix recording and reports will be carried out in order to ensure greater analysis at theme level and greater sharing of learning throughout divisions at both specialty and ward level.

6.0 Cases referred to the Parliamentary Health Service Ombudsman (PHSO) 2018/19

The Ombudsman's role is to make final decisions on complaints that have not been resolved locally by the NHS in England. The Ombudsman looks at complaints where someone believes there has been injustice or hardship because an organisation has not acted properly or has given a poor service and not put things right. The Ombudsman can recommend that organisations provide explanations, apologies and financial remedies to service-users, as well as that they take action to improve services.

The number of complaints referred to the PHSO in 2018/19 was three showing a continuing decrease) see table below

Year	Number of cases referred by complainants to the PHSO	Number of cases upheld
2016/17	18	0
2017/18	9	1
2018/19	3	1

One referral is was awaiting outcome at the time of this report

Recommendation made by the PHSO in the upheld complaint

Recommendation 1

Ensure all wounds are fully documented in a wound care plan, in line with national guidance.

Outcome

New wound care plan has been implemented since patient's admission

Recommendation 2

Ensure the Trust uses an End of Life plan to document all nursing assessments and interventions.

Outcome

New End of Life documentation implemented and quality improvement project implemented in April 2018. The project is known as the 'Purple Butterfly Project' was recognised by the Health Service Journal Awards

Recommendation 3

Join Health Education England quality improvement initiative to improve mouth care in acute trusts and roll out across all wards.

Outcome

The mouth care initiative has been joined and the last teaching session is being held in April 2019. Following the completion of this it will be rolled out across all wards.

7.0 NHS Choices Website Feedback

Our current rating from feedback to NHS Choices is 4.5 out of 5. All postings are responded to and people are encouraged to contact NBT through ACT or PALS going forward, to address poor experience. All are shared with the applicable wards, department or team. Many postings are very complimentary.

8.0 Audit of Complaints by the Patient Complaints Review Panel

The Patient Complaints Review Panel continues to provide important feedback on the quality of the complaints and the process. This process allows patient representatives, who have been trained in reviewing anonymised complaints against the *Patient Association Good Practice Standards for NHS Complaints Handling (2013)*, to give feedback for incorporation into the ongoing complaints improvement plan.

The panel continues to meet every two months and from their reviews, a number of recommendations were made, to include:

- The need to improve complaint response times significantly, and to limit the time for the second date.
- Proof reading of response letters to remove typographical errors and ensure a balanced tone that is person centred.
- Ensure the apologies offered are written in a way that reflect the genuine sincerity that is meant

These recommendations, and those of the previous year, have been incorporated into the review and an update of the Complaints Policy and Procedure.

9.0 Service Improvements implemented in 2018/19

Datix: During the year a new Risk Management Software system (Datix) was implemented which contains a module to record patient feedback of complaints, concerns and enquiries. There has been further work undertaken to streamline processes and systems. This has been undertaken in the later part of the year by the Head of Patient Experience with the Complaints Coordinators from all Divisions. This has helped to give greater clarity to roles and responsibilities of staff and to make the process more people centred by calling the person raising the complaint to seek greater understanding of the matters they have raised and to resolve these as quickly as possible. This may be outside of the of the formal complaint process if the person is satisfied with this approach.

The need to improve the handling and managements of complaints has feature in CQC inspection reports and in 2018 was a key project with the trust wide Clinical Governance Improvement Programme 2018-2019;The purpose of this project was

To set and simplify the handling of complaints and concerns at NBT ensuring that

- patients' enquiries, concerns and complaints are handled accurately and timely by the correct persons,
- a person focused approach is central to all processes
- the person raising the their matters of concern or dissatisfaction is heard and responded to
- that learning is evidenced and shared

Working with staff handling complaints and concerns the following was achieved:

- Clarification of the complaints process and relationship between corporate team and divisional staff, so that expectations are clear and support can be accessed, when needed.
- Review of capacity within the central complaints team and within divisions to deliver a person centred responsive service.
- Setting expectations and giving clarity of the roles of all staff, including medical staff,
- Review of mechanisms for evaluating the quality of complaints investigations and responses (this relates to the.
- An options appraisal for the re-instigation of a PALS service within NBT. A pilot of PALS was commenced in February 2019
- Clarification of the training requirements for all staff
- Establish key performance indicators (KPI) on the management of complaints and concerns.

10.0 Pilot of Patient Advice and Liaison Service (PALS)

PALS was reintroduced as service for patients in February 2019. This has been already proved successful in a speedy resolution of patients concerns before they escalate. The top themes have included cancelled appointments/surgery, clinical care, discharge, lost property and communication. Feedback from patients and staff has been very positive and we are starting to roll out training on early resolution to all areas. All concerns are acknowledged within one working day with 82% being resolved within 3 working days and requiring no further action. This proactive response is starting to show a decrease in the number of formal complaints where some patients feel confident that their issue has been resolved fully without the need for them to proceed formally.

11.0 Learning from Complaints

The learning from complaints includes the following:

- Content of Outpatient letters (feeding into the Outpatient Service Improvement Programme).
- Developing a consistent means of sharing specific information that is crucial to a patient's wellbeing.
- Enhancing knowledge of staff in adjustments in communication required for people with Learning Disabilities and or Autism in ED (this is being taken forward across the Trust).
- Setting up a quiet, less stimulating environment in ED for patients that need this.
- Reinforcing the message to staff of the importance of explaining to patients the process and purpose of any examination, care or treatment and gaining their agreement. This has been emphasised with the revised Consent Policy.
- Ward 27b improved information in the ward leaflet by adding more information on individualised care needs and discharge.

12.0 Training

Training on the investigation of complaints and response letter writing was provided throughout the year in partnership with the Patients Association. The approach was one of application of learning during the session. This evaluated extremely well with ongoing demand from staff.

13.0 Next steps:

During 2019 we will:

- Establish a permanent Patient Advice and Liaison Service.
- Continue to work with Divisions implementing the revised processes and roles and responsibilities.
- Rollout refined Datix recording templates.
- Improve recording of data in Datix by all staff across the Trust.
- Increased resourcing into the Complaints team and a re-branding as 'Patient Experience Team' in line with national direction and standards.
- Develop a performance dashboard for ease of monitoring and reporting for Executive Directors, Divisional Teams and central teams expanding to others where possible.
- Ensure actions are completed with evidence recorded in Datix and learning is shared.
- Implement a full recovery plan and weekly tracking system to ensure the backlog of overdue complaints is reduced to 0 and that the compliance rate is improved. The trajectory for improvement in compliance is as below:

June	25	60% compliance
July	20	70% compliance
August	10	80% compliance
September	5	90% compliance
October	0 – maintain target	100% compliance
November	0 – maintain target	100% compliance

- Undertake a full review of the current complaints process and create a new and updated policy of the management of complaints and concerns and a clear standard operating procedure to support this. This will standardise the process and ensure higher quality responses and greater accountability and ensure all NBT staff are aware of their role in ensuring that patients and service users have a positive experience whilst using the Trusts services.
- Establish ongoing administrative support and facilitation for the Complaints Lay Review Panel.
- Update training content &systems for all aspects of the Complaints process including:
    - Datix training
    - Investigation/Root Cause Analysis Training
    - Writing formal letter responses
    - De-escalation of concerns and local resolution

North Bristol NHS Trust

Report To:	Trust Board		**Agenda Item:**	12
Date of Meeting:	28 November 2019			
Report Title:	Quality & Risk Management Committee Report			
Report Author & Job Title	Xavier Bell, Director of Corporate Governance & Trust Secretary			
Executive/Non-executive Sponsor (presenting)	Professor John Iredale, Quality and Risk Management Committee Chair, Non-executive Director			
Purpose:	**Approval/Decision**	**Review**	**To Receive for Assurance**	**To Receive for Information**
	X		X	
Recommendation:	The Trust Board should receive the report for assurance and: • Note the Committee discussion on the Board Assurance Framework (BAF); • approve the revised wording for BAF SIR14; • Note the Committee's support for the revised Seven Day Services Audit result; and • Approve the Committee's revised terms of reference.			
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 January 2020.			

Executive Summary
The report provides a summary of the assurances received and items discussed and debated at the Quality and Risk Management Committee Meeting held on 21 November 2019.

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

<table>
<tr><td>Strategic Theme/Corporate Objective Links</td><td>• Be one of the safest trusts in the UK
• Treat patients as partners in their care</td></tr>
<tr><td>Board Assurance Framework/Trust Risk Register Links</td><td>Link to BAF risk SIR14 relating to clinical complexity.</td></tr>
<tr><td>Other Standard Reference</td><td>CQC Standards.</td></tr>
<tr><td>Financial implications</td><td>No financial implications identified in the report.
<table>
<tr><th>Revenue</th><th>Total £'000</th><th>Rec £'000</th><th>Non Rec £'000</th></tr>
<tr><td>Income</td><td></td><td></td><td></td></tr>
<tr><td>Expenditure</td><td></td><td></td><td></td></tr>
<tr><td>Savings/benefits</td><td></td><td></td><td></td></tr>
</table>
<table>
<tr><td>Capital</td><td></td></tr>
</table></td></tr>
<tr><td>Other Resource Implications</td><td>No other resource implications identified.</td></tr>
<tr><td>Legal Implications including Equality, Diversity and Inclusion Assessment</td><td>None identified.</td></tr>
</table>

Appendices:	Appendix 1 – Revised QRMC terms of reference – Nov 2019

12

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1. Purpose

To provide a highlight of the key assurances received, items discussed, and items for the attention of Trust Board from the Quality and Risk Management Committee meeting held on 21 November 2019.

2. Background

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

3. Key assurances received & items discussed

3.1 Risk management assurance

The Committee received a report setting out the full details for trust level risks (TLRs) across the organisation. It was confirmed that since the last Committee meeting three TLRs had been added to Datix, and four risks had their score reduced below the TLR cut-off. It was noted that the report now includes actions for all of the TLRs, setting out how the risk is being mitigated/ managed; however further detail is required to ensure that delivery dates and the expected impact of the actions are clear.

The Quality Governance Transformation Lead outlined the progress of the risk management improvement plan, and confirmed that a revised and simplified version of Datix will shortly go live across the organisation.

The Committee was assured that good progress is being made in improving risk management processes and reporting across the organisation.

3.2 Quality performance report

The Committee reviewed the Safety and Effectiveness section of the Integrated Performance Report (September 2019 data). This was reviewed at the October Trust Board meeting, and it was noted that Trust Board had not delegated any specific queries or concerns for review by the Committee. The Committee did not identify any issues or concerns in the data presented.

3.3 Board assurance framework

The Committee reviewed risk SIR14 from the Trust Board's board assurance framework (BAF). The Committee had previously asked that this risk be reviewed by the responsible executive directors to ensure it remained relevant, as the Committee did not feel the wording properly captured the current risk to patients.

The Trust Secretary confirmed that the risk had been reviewed with the Medical Director and Director of Nursing & Quality and revised as follows:

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Previous wording: "*The increasing complexity of patient need risks more concern being raised about safety of clinical care. This could result in increased harm to patients, litigation and regulatory action"*

New wording: *"Increases in demand and the acuity of patients in hospital will impact on patient safety and outcomes, leading to patient harm and poorer patient experience"*

The Committee approved the revised wording, noted the actions being taken to manage/mitigate the risk and agreed to recommend the revised wording to the Trust Board.

3.4 Quality account priorities

An update on progress against the Trust's Quality Account priorities was received and reviewed.

The Associate Director of Quality Governance confirmed that the update was also discussed by the Trust Management Team earlier in the week, who had identified the need to review quality priority 1A "Supporting Patients to Get Better Faster and More Safely (Non-elective)" in more detail, as the current green rating did not reflect the ongoing delays in patient discharge and increasing DTOCs across the Trust. It was noted that the actions against that priority were progressing well; however the improvement metric was being influenced by other issues outside of the priority action plan.

The Committee was assured that progress was on track overall, and noted the ongoing actions.

3.5 CQC Inspection plan

The Committee reviewed the CQC action plan and assurance programme arising from the 2019 CQC inspection and was assured that the actions and associated governance were robust.

It was noted that there is an ongoing cycle of relationship and engagement meetings with the CQC between formal inspections, with the next meeting in December 2019. The outcomes of that meeting will be reported to the Committee in due course.

3.6 Serious Incidents/Never Events

The Quality Governance Transformation Lead presented the standing agenda item on serious incidents/never events. It was confirmed that there had been no never events in the Trust since the last Committee meeting.

The Committee discussed the content of the report and whether it provided sufficient sight of specific incidents as well as trend analysis. It was noted that the integrated performance report contains additional detail on incidents; however it was agreed that the Director of Nursing and Quality would consider what additional information could be provided to the Committee, and a deep-dive would be brought to a future Committee meeting to allow sight of trends and emerging issues.

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3.7 Cervical Screening Assurance Update

A detailed assurance report was presented, setting out how the Trust's cervical screening service benchmarks nationally. The Committee was assured that the service at the Trust performs is in line with national averages for screening that shows a false negative. It was also noted that turnaround times in the service have remained consistently excellent, and that in the last year 99.28% of cases were reported within 14 days against a national mean of 52.31%.

3.8 Seven Day Service Audit

The Medical Director presented an updated seven day service audit for the Committee's review and approval. It was noted that the Trust provides a good quality of service over seven days, but did not meet all of the standards in the audit. Following discussions with NHS England it was confirmed that based on its overall position the Trust achieves standard 8 which requires that all patients with high dependency needs should be seen and reviewed by a consultant twice daily (unless a clear pathway requires a different frequency).

The Committee concluded that the audit outcome should be recommended to Trust Board for submission to regulators.

3.9 Sub-committee upward reports / Internal audit reports

An upward report was received from the Patient safety and clinical risk committee, with no issues identified that required the Committee's attention.

An internal audit report on Learning from Deaths was received. The assurance rating of significant assurance with minor improvement opportunities was noted.

3.10 Terms of reference

The Committee discussed its terms of reference in light of the ongoing discussions at Trust Board about how the board and its committees could be more effective.

It was agreed that the membership of the Committee would be revised to reduce the number of executive directors required to attend each meeting, instead requiring them to attend where specific items required their input, and encouraging them to send briefed deputies where appropriate.

As a result of the proposed reduction in core membership the quoracy requirements for the meeting were also reduced from five members to three members, two of whom must be non-executive directors and one either the Medical Director or Director of Nursing & Quality.

The revised terms of reference are appended to this report and the Committee recommends that Trust Board approve and adopt the revised terms of reference.

4. Escalations to the Board

There were no items of concern identified for escalation to the Trust Board.

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5. Identification of New Risk

No new risks were identified in the meetings.

6. Recommendations

The Trust Board should receive the report for assurance and:

- Note the Committee discussion on the BAF;
- approve the revised wording for BAF SIR14;
- Note the Committee's support for the revised Seven Day Services Audit result; and
- Approve the Committee's revised terms of reference.

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Quality and Risk Management Committee Terms of Reference

Date Approved and Adopted	~~28th March 2019~~28 November 2019
Frequency Review	Annual
Next Review	March 2020
Terms of Reference Drafting	Trust Secretary
Review	Quality & Risk Management Committee
Approval and Adoption	Trust Board
Version Number	~~1.0~~2.0

1. Constitution

1.1. The Trust Board hereby resolves to establish a Committee to be known as the Quality and Risk Management Committee.

1.2. The Committee is constituted as a standing committee of the Trust Board. Its constitution and terms of reference shall be as set out below; and will be subject to amendments approved by the Trust Board.

2. Authority

2.1. The Committee is authorised to seek information it requires from any employee of the Trust. All members of staff are directed to co-operate with any request made by the Committee. The Committee is authorised to obtain legal or other independent professional advice and to secure the attendance of advisors with such expertise that it considers necessary.

2.2. The Committee is authorised by the Board to make decisions within its terms of reference, including matters specifically referred to it by the Board.

3. Membership

3.1. The Committee shall comprise:

- Three Non-Executive Directors one of whom will chair the Committee.
- ~~Director of Facilities~~
- Director of Nursing and Quality
- Medical Director
- ~~Director of People and Transformation~~
- Chief Operating Officer
- ~~Director of IM&T~~

3.2. In the absence of the appointed Committee Chair, another Non-Executive Director will chair the meeting.

3.3. Attendance at meetings is essential. When an Executive Director member cannot attend they must arrange for a fully briefed deputy of sufficient seniority to attend on their behalf.

~~3.2.~~3.4.

4. Attendance at Meetings

4.1. The following officers may also be ~~are~~ required to attend ~~all~~ meetings but are not members:

- Director of Facilities
- Director of People and Transformation
- Director of IM&T
- Associate Director of Quality Governance
- Director of Corporate Governance/Trust Secretary

4.2. These individuals are encouraged to send deputies in their stead where they feel this is appropriate.

~~4.2.~~4.3. The Committee can request the attendance of any other director or senior manager if an agenda item requires it.

~~4.3. Attendance at meetings is essential. In exceptional circumstances when an Executive Director member cannot attend they must arrange for a fully briefed deputy of sufficient seniority to attend on their behalf.~~

5. Quorum

5.1. The quorum necessary for the transaction of business shall be ~~five~~ three members of whom two must be Non-Executive Directors (including the chair of the committee) and either the Medical Director or Director of Nursing & Quality.

6. Frequency of Meetings and Conduct

6.1. The Committee will meet bi-monthly and will be set in advance as part of the planning of the Trust Board and Committee meetings annual calendar of business.

6.2. Further meetings can be called at the request of the Committee Chair.

6.3. An agenda of items to be discussed and supporting papers will be forwarded to each member of the Committee and any other person required to attend, no later than five working days before the date of the meeting.

6.4. Decisions may be taken by written resolution upon the agreement of the majority of members of the Committee in attendance, subject to the rules on quorum.

7. Responsibilities

The Committee shall hold the safety of patients, public and staff, as well as the reputation of the Trust, as a core value in assessing assurance, quality governance and risk.

The responsibilities of the Committee can be categorised as follows:

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7.1. Assurance

The Committee shall ensure that the Trust Board is adequately assured in relation to all quality, clinical governance and research matters which will include, but is not limited to:

- Infection control
- Clinical outcomes by specialty and consultant, including review and response to national clinical audits, national registries etc.
- Mortality rates & Learning From Deaths
- Regulatory compliance
- Safeguarding Children's and Adults
- Quality assessment of CIP projects
- CQUIN delivery
- Incident reporting
- Risk management
- Medical records
- Clinical claims management

7.2. Quality Strategy and delivery of the quality agenda

7.2.1. The Committee shall maintain oversight of the business of the Quality Strategy Delivery Committee and any associated committee sub-structure through the receipt of regular update reports, and shall ensure that the Board is adequately assured in relation to the delivery of the Trust's quality strategy;

7.2.2. The Committee shall maintain oversight of the business of the Drugs and Therapeutics Committee, the Clinical Effectiveness & Audit Committee, the Patient Safety and Clinical Risk Committee and the Safeguarding Committee through the receipt of regular reports. This shall ensure that the Committee maintains oversight of:

- Management systems and structures to ensure that sufficient analysis of incidents, complaints, claims, clinical audits, service reviews etc. is undertaken to reflect, learn and make recommendations for required changes to improve quality of care provided to patients;
- Concerns raised by the Patient Safety & Clinical Risk Committee, in regard to issues of patient safety which require attention and resolution at Executive level;
- the quality work programme and the support required for quality improvement given by Quality & Patient Safety work streams, Clinical Audit, Learning and Development, and Information Management & Technology. This includes the quality improvements relating to national CQUINs.

7.3. Regulatory Compliance

7.3.1. The Committee shall assure itself that all regulatory requirements are complied with, with proven and demonstrable assurance, and immediate and effective action is taken where this is identified as deficient.

7.3.2. The Committee shall monitor and assure itself that it can with confidence, and evidence, assure the Trust Board, patients, public, and other stakeholders (e.g.: Care Quality Commission (CQC), NHS Improvement, Department of Health, commissioners) that the Trust is complying with its regulatory requirements and can evidence this. The Committee shall seek to embed the culture of compliance within the organisation, so that it happens as part of normal business, and not as a separate activity, contributing directly to a well-run organisation and the quality of patient care.

7.3.3. The Committee shall ensure compliance with the CQC registration requirements and standards and shall oversee the detailed work plan arising from inspections, alerts or other highlighted concerns raised by the CQC. The Committee shall also monitor key areas of compliance, such as NHS insurance (NHS Resolution General Risk Management Schemes and Clinical Negligence Scheme for Trusts), the NHS Constitution, and other key areas of compliance as they arise.

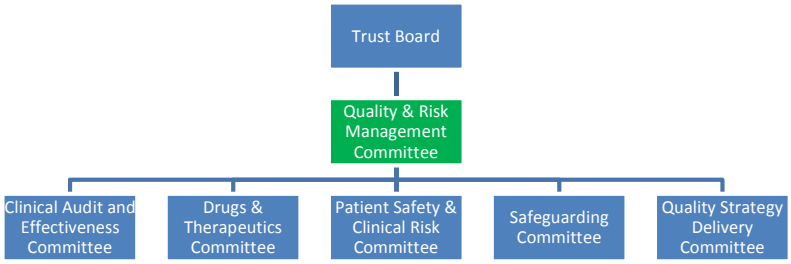
7.4. Risk Management

7.4.1. The Committee shall ensure the Trust has robust clinical and Health & Safety risk management systems and processes in place. Appropriate risk management systems and processes will remove, reduce, avoid, prevent or manage risks, whilst enabling innovation, to ensure the best possible patient care.

7.4.2. In particular, the Committee will:

- ensure that an up to date risk register is maintained, and that relevant staff are able to access the risk register to raise concerns and know that concerns will be reviewed and addressed.
- act as the forum for risk to be discussed, and ensure that where serious concerns are raised, action is taken, and that action plans are carried through to completion, and the reporting loops closed. In doing so, ensuring that there are robust links with clinical and non-clinical directorates to ensure a culture of quality and risk management is present throughout the organisation.
- Act in accordance with Board approved risk appetite and risk tolerance levels when reviewing risks.

7.5. Sub-committees and Groups reporting to, or responsible to the Committee:



8. Reporting

8.1. Formal minutes of Committee meetings will be recorded.

8.2. Full minutes will be sent in confidence to all members of the Committee and shall be made available on request to NHS Improvement and the Trust's internal and external auditors.

8.3. The Committee shall report to the Trust Board on its proceedings after each meeting to provide assurance and to escalate issues as appropriate.

8.4. The Committee will provide an annual report to the Board setting out how it has discharged its responsibilities as set out in these terms of reference.

9. Monitoring and Effectiveness

9.1. The Committee shall have access to sufficient resources to carry out its duties, including access to company secretarial assistance as required.

9.2. It shall be provided with appropriate and timely training, both in the form of an induction programme for new members and an on-going basis for all members.

9.3. It will review its own performance, at least annually, review its constitution and terms of reference to ensure it is operating at maximum effectiveness and recommend any changes it considers necessary to the Trust Board for approval.

10. Administrative Support

10.1. Meetings will be supported by the Director of Corporate Governance/Trust Secretary's office, whose duties in this respect will include:

- Agreement of agendas with the Chair and Members.
- Collation and distribution of papers.
- Minute taking.
- Keeping a record of matters arising and issues to be carried forward within an action log.
- Advising the Committee on pertinent issues/areas.
- Provision of a highlight report of the key business undertaken to the Trust Board following each meeting.

Report To:	Trust Board	**Agenda Item:**	13.
Date of Meeting:	28th November 2019		
Report Title:	Bi-Annual Staffing Review		
Report Author & Job Title	Su Monk, Assistant Director of Nursing and Quality		
Executive/Non-executive Sponsor (presenting)	Helen Blanchard, Director of Nursing and Quality		

Purpose:	**Approval/Decision**	**Review**	**To Receive for Assurance**	**To Receive for Information**
			X	

Recommendation:

The Board is asked to;

1. Note the contents of this report which outlines the progress to date and further actions planned to ensure nurse staffing levels are safe to meet the needs of our patients, are effectively managed and are being published in accordance with the National Quality Board (2016), NHS Improvement (2018) Developing Workforce Safeguards recommendations, NHS Improvement (2018) Developing Workforce Safeguards recommendations, NICE guidance and self-assessment of the NHS Improvement recommendations for safe staffing

2. Receive assurance that the Director of Nursing and Quality has undertaken a formal annual review of safe staffing for all inpatient ward areas as detailed within the report with required changes to be included within workforce Business plans for each Division.

Report History:	Six monthly review of Safe Staffing , last presented to Trust Board in March 2019
Next Steps:	Six monthly review in March 2020

Executive Summary
The purpose of this paper is to provide the Board with a 6 monthly report on Nursing and Midwifery staffing and to provide assurance that the Trust has a clear validated process in place for monitoring and ensuring safe staffing in line with current national recommendations. This report serves as the six monthly review of safe nursing staffing at North Bristol NHS Trust undertaken between September and November 2019 using the Safer Nursing Care Tool (SNCT) (Shelford 2013) with recommendations to be supported by workforce business plans. The purpose of this report is to share the results of the patient acuity and dependency data collected between 23rd September and the 12th October 2019 across the adult inpatient and neo natal inpatient areas to discuss the findings and make recommendations. Divisional Heads of Nursing & the Director of Midwifery have reviewed the results and triangulated the findings with professional judgement in reaching conclusions and making recommendations. The Head of Nursing for ASCR has also completed a forward facing review of all Critical Care units in the context of changing capacity and Guidelines for the Provision of Intensive Care Services (GPIC's). The Director of Midwifery has reviewed Midwife to Birth ratios as recommended and found within the Birthrate Plus® tool and endorsed by the Royal College of Midwives. The ratios are reviewed monthly against the recommended mean national ratio of one whole time equivalent (WTE) midwife per 29.5 births and these benchmarks are reported monthly at the Divisional Performance Reviews and to the Board in the IPR. The Trust commissioned a complete Birthrate Plus® review of staffing in October 2019 and this will be submitted to the Board separately for assurance. The final report is expected to be available in December 2019. Generally, funded establishments are appropriate to meet requirements across the Trust. With some areas identified for further review as detailed within Divisional reports and further data collection to be repeated in January 2020. For example; an outcome of the 6 monthly staffing review has identified priority areas requiring deeper review over the coming months: • Maternity – reliant on the outcomes of Birthrate Plus® • Theatre & Medirooms – reliant on an enhanced resourcing plan and review of establishment against AfPP guidance. • Wards 26a and 26b – deeper review of staffing and acuity. • Acute Medical Unit The report informs the Board of the nursing and midwifery risks on the Divisional Risk Registers which are greater than 10. The report includes the nursing and midwifery pay costs to date in this financial year 2019/20. The report highlights current staffing issues and explains actions taken to mitigate these concerns.

Strategic Theme/Corporate Objective Links	Be one of the safest trusts in the UK Treat patients as partners in their care Create an exceptional workforce for the future
Board Assurance Framework/Trust Risk Register Links	Risk to CQC registration if standards are not met Non-compliance with National Quality Board and NICE requirements on staffing

	Registered Nurse vacancies on the Risk Register
Other Standard Reference	NHS Workforce Safeguards (2018) National Quality Board Requirements (Nov 2013, April 2016 and January 2018) NICE Guidelines (2014 and 2015) CQC Regulation 9: Person Centred Care CQC Regulation 12: Safe care and treatment CQC Regulation 18: Staffing CQC Regulation 19: Fit and proper persons employed
Financial implications	Resources and financial implications to be addressed as part of the annual Trust's Business Planning cycle and informed by the Divisional priorities
Other Resource Implications	Effective recruitment of sufficient band 5 Registered Nurses to fill the vacancy deficit
Legal Implications including Equality, Diversity and Inclusion Assessment	EDS2 Improved patient access and experience and represented and supported workforce

Appendices:	Nil

Contents **Page**

1. Executive Summary

The purpose of this paper is to provide the Board with a 6 monthly report on Nursing and Midwifery staffing and to provide assurance that the Trust has a clear validated process in place for monitoring and ensuring safe staffing in line with current national recommendations.

This report serves as the six monthly review of safe nursing staffing at North Bristol NHS Trust undertaken between September and November 2019 using the Safer Nursing Care Tool (SNCT) (Shelford 2013). The purpose of this report is to share the results of the patient acuity and dependency data collected between 23rd September and the 12th October 2019 across the adult and neonatal inpatient areas to discuss the findings and make recommendations. The Divisional Heads of Nursing & the Director of Midwifery have reviewed the results and triangulated the findings with professional judgement in reaching conclusions and making recommendations. Trustwide Care Hours Per Patient Day (CHPPD) for in-patient wards has remained in line with national benchmarks.

The Head of Nursing for ASCR has also completed a forward facing review of all Critical Care units in the context of changing capacity and Guidelines for the Provision of Intensive Care Services (GPIC's).

The Director of Midwifery has reviewed Midwife to Birth ratios as this is recommended and found within the Birthrate Plus® tool and is also endorsed by the Royal College of Midwives. The ratios are reviewed monthly against the recommended mean national ratio of one whole time equivalent (WTE) midwife per 29.5 births and these benchmarks are reported monthly at the Divisional Performance Reviews and to Board in the monthly IPR. The Trust has commissioned a complete Birthrate Plus® review of staffing in October 2019 and this will be submitted to the Board separately for assurance. The final report is expected to be submitted in December 2019.

No national workforce tool can incorporate all factors and therefore triangulation is essential to arrive at optimal staffing levels. The role of professional judgement and local intelligence should not be underestimated and should be applied to increase confidence in recommended staffing levels and provide assurance. Variables in terms of ward layout and number of side rooms have an impact on the number of nurses required but this is not reflected in the SNCT. The SNCT data whilst recommending staffing establishment figure does not replace professional judgment and it is recommended that very few single data collection period should form the basis of altering establishments, due to the seasonal variances that can be seen in acute care settings. In general the funded establishments are appropriate to meet the requirements across the Trust. Areas where the SNCT data suggested an alternative establishment have been reviewed and no changes have been recommended at the current time. However, an outcome of the 6 monthly an outcome of the 6 monthly staffing review has identified priority areas requiring deeper review over the coming months:

- Maternity – reliant on the outcomes of Birthrate Plus®
- Theatre & Medirooms – reliant on an enhanced resourcing plan and review of establishment against AfPP guidance.
- Wards 26a and 26b – deeper review of staffing and acuity.
- Acute Medical Unit

Daily safe staffing meetings occur between Divisions which are overseen by a Head of Nursing, where real time data of actual staffing levels and patient acuity can be viewed and staff redeployed as required. The staffing meetings assess the level of risk, identify

areas where increased care hours are required and inform the movement of staff between clinical areas to balance the risk across the organisation.

2. Purpose

The purpose of this report is to share the results of the patient acuity and dependency data collected between 23rd September and the 12th October 2019 across adult and neonatal inpatient areas to discuss the findings, and make recommendations.

3. Background

Following the Francis report, the National Quality Board (NQB) published guidance that set out the expectations for safe nursing and midwifery staffing, in order to deliver high quality care and the best possible outcomes for patients. The Lord Carter Review (2016) highlighted the importance of ensuring that workforce and financial plans are consistent in order to optimise delivery of clinical quality and use of resources.

The National Quality Board (NQB) publication *Supporting NHS Providers to Deliver the Right staff, with the Right skills, in the Right place at the Right time: Safe, Sustainable and Productive Staffing (2016)* outlines the expectations and framework within which decisions on safe staffing should be made to support the delivery of safe, effective, caring, responsive and well-led care on a sustainable basis.

3.1 Nursing

The Safer Nursing Care Tool (Shelford Group, 2013) is the most commonly used method (previously known as the AUKUH Acuity and Dependency Measurement Tool)

The Safer Nursing Care Tool (SNCT):

- Is an evidence based tool which allows nurses to assess patient acuity and dependency. The data is collected and matched with pre-set staffing multipliers to ensure that nursing establishments reflect patient needs in acuity / dependency terms. The recommended number of staff following analysis is in whole time equivalent only (i.e. registered and unregistered staff and includes 21% uplift (holiday, sickness, study leave etc.). There is no reference to skill mix, allocation for a supervisory ward co-coordinator (if appropriate) or supervisory ward leader.
- Recommended staffing levels are based on an analysis of the actual patient acuity and dependency on the ward at the time of data collection
- The tool is appropriate for use in any acute hospital.

However, no national workforce tool can incorporate all factors and therefore triangulation is essential to arrive at optimal staffing levels. The role of professional judgement and local intelligence should not be underestimated and should be applied to increase confidence in recommended staffing levels and provide assurance. Variables in terms of ward layout and number of side rooms have an impact on the number of nurses required but this is not reflected in the SNCT. The SNCT data whilst recommending staffing establishment figure does not replace professional judgment and it is recommended that no single data collection period should form the basis of altering establishments, due to the seasonal variances that can be seen in acute care settings.

There are also a minimum number of nurses required to deliver safe care regardless of ward size, 11.5 whole time equivalent (wte) Registered Nurses (RN's) are required to provide 2 nurses 24/7. The SNCT data may indicate that smaller wards are over established however the reality is reductions in staffing levels would be inappropriate. Therefore caution is advised when interpreting results from smaller areas.

The Trust uses the Allocate SafeCare module to capture live acuity and dependency data to support daily deployment of nursing resource. SafeCare uses the SNCT (Shelford Group) Acuity and Dependency Measurement Tool and calculates the staffing requirement for each shift based on this information. Data is provided as CHPPD and hours and is reviewed by the Senior Nursing Team to ensure that the right staff are in the right place to provide safe care.

In previous few years the Trust has used SafeCare data to formulate this report, the publication of the Workforce Safeguards (2019) document has highlighted the requirement to utilise a validated tool for undertaking safe staffing reviews The SNCT is one of a few validated tools available. In undertaking the bi-annual review the data has been produced using the SNCT tool to suggest numbers of staff required based on the patient acuity and bed occupancy for September/October period 2019.

3.2 Midwifery

The Trust regularly monitors and reports it Midwife to Birth ratios as this is recommended and found within the Birthrate Plus® tool and is also endorsed by the Royal College of Midwives. The ratios are reviewed monthly against the recommended mean national ratio of one whole time equivalent (WTE) midwife per 29.5 births and these benchmarks are reported to Board on the monthly IPR. The Trust has commissioned Birthrate Plus® to undertake a review of midwifery staffing levels and a will be reported to Board separately once completed.

3.3 Neonatal Unit

The service specification from NHS England and the BAPM staffing standards, state that the minimum standards for nurse staffing levels for each category for care are:

- neonatal intensive care: 1:1 nursing for all babies
- neonatal high dependency care: 1:2 nursing for all babies
- neonatal special care: 1:4 nursing for all babies.

4. NQB Expectations: A Triangulated Approach to Staffing Decisions

The NQB three expectations (right staff, right skills, right place and time) support an approach to determining safe staffing levels based on patients' needs, acuity and risks, monitored from 'ward to board'. This triangulation approach to staffing decisions, rather than making judgments based solely on numbers or ratios of staff to patients, is supported by the CQC.

4.1 NQB Expectation One: right staff (Workforce Plans)

The bi-annual review of all divisional ward skill mixes was most recently undertaken in October and November 2019. This review, led by the Director of Nursing and Quality, was to understand the baseline staffing position across the inpatient wards.

The methodology used for these reviews includes patient acuity, professional judgment, ward quality metrics and the national resource tools available and evidence based guidance from Royal Colleges including the Royal College of Nursing. The Trust also compares local staffing with metrics available from an appropriate peer group within the Model hospital dashboard, recognising that the specific ward design for the Brunel Wards also needs to be appropriately benchmarked.

4.1.1 Model Hospital Benchmarking

In line with all Trusts, NBT reports CHPPD on a monthly basis. CHPPD is calculated by adding the total monthly hours worked of registered nurses and health care assistants on the rosters (which includes the hours delivered by temporary staff) divided by the total patient bed days (sum of the patient count at midnight accumulated over a month). The scores across the organisation are accumulated to create a Trust score.

The data enclosed in the table below is July 2019 data, the latest data available through the Model Hospital. A more detailed breakdown of this metric per division is included in Expectation three: right place right time. This table below shows NBT in the top quartile of CHPPD at 8.7, a reduction from December 2018 CHPPD which was 8.9.against a national average of 8.2.

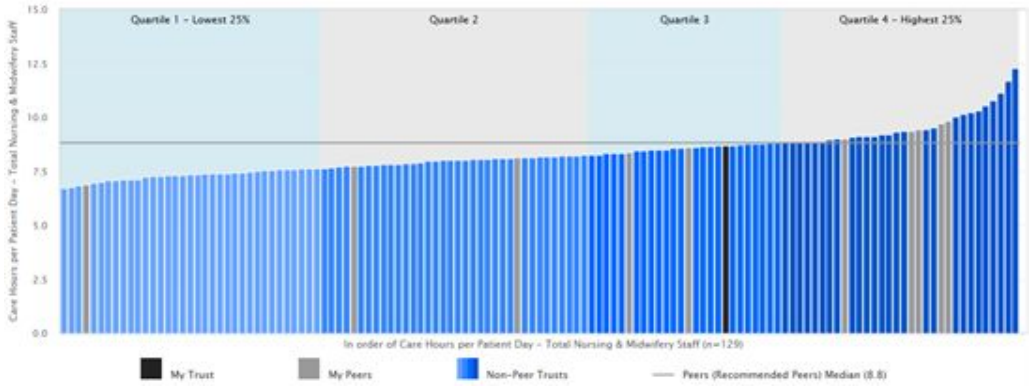


Table 1: CHPPD comparison, nationally (blue), peer (grey) and NBT in (black).

The Model Hospital also uses a measure called Weighted Activity Unit (WAU) which shows the Trust spend on Nursing and Midwifery staff, based on ESR data (so excludes temporary staffing costs), compared to the total NHS clinical activity provided by the Trust within the 2017/18 financial year (last year available). Table 2 shows the NBT position which shows us just above the lowest quartile (lower being more cost efficient). This position is reflective of the ongoing vacancy position.

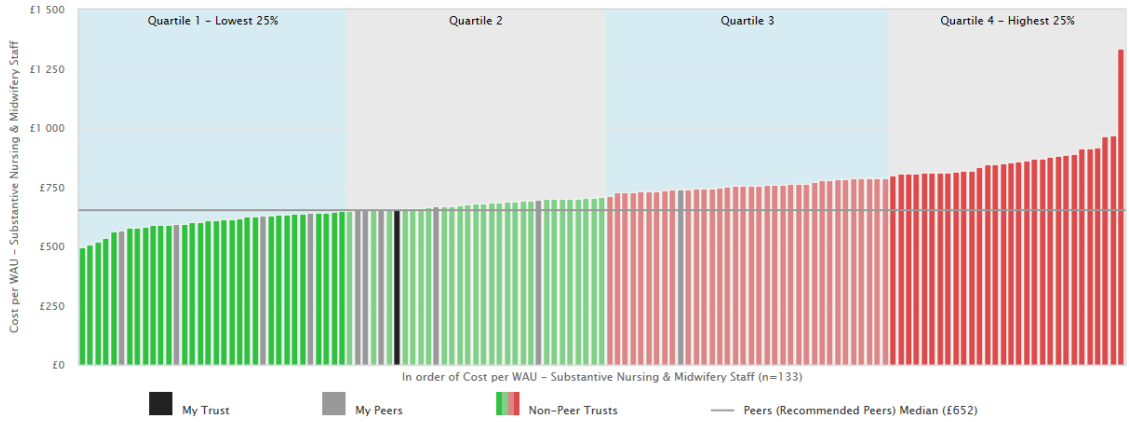


Table 2: WAU based on 2017/18 financial position, NBT (black), national (green/red), peers (grey).

4.1.2 Winter bed model

This year saw a positive approach to winter bed modelling with both NMSK and ASCR each sharing wards with medicine as part of the planned winter bed model. This had a positive impact on the ability to provide the appropriate and necessary medical and nursing care. Staffing requirements are consistently discussed at the bed and staffing meetings and concerns can be escalated to the Heads of Nursing along with the Director/Assistant Director of Nursing.

4.2 NQB Expectation Two: right skills

The Trust is committed to ensuring that clinical staff have the appropriate training and the right competencies to support the patient care within services.

The Trust has demonstrated a commitment to investing in new roles and skill mix reviews which enables registered nurses to spend more time to focus on clinical duties and decisions about planning and implementing nursing care.

The *Shape of Caring* report (2015) recommended changes to education, training and career structures for registered nurses and care staff. In light of this NBT has continued with the development of its workforce in support of this report. Assistant Practitioner roles have been well embedded within NBT and the role is continuing to be developed across the hospital with a number using it as a stepping stone into further education to commence degree level nurse education.

The NHS Improvement Resource recommends taking account of the wider multidisciplinary team who may or may not be part of the core ward establishment including allied health professionals, advanced clinical practitioners, administrative staff and volunteers. It is recognised that the range of specialist and advanced practitioners at NBT provide expert advice, intervention and support to ward based teams, along with the 'link nurse' model which is in place for certain specialties e.g. Tissue viability, Diabetes.

4.3 NQB Expectation Three: right place and time

Each month the Trust submits the ward planned and actual staffing levels including Care Hours per Patient Day (CHPPD) via Unify. The nursing and midwifery fill rates (showing the percentage of filled shifts) and CHPPD for the Trust for the past 6 months can be viewed in Table 3

	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19
RN Day	92.1%	92.6%	91.6%	90.1%	88.7%	87.5%	88.14%	91.4%
HCA Day	97.1%	95.1%	95.6%	94.2%	94.1%	96.0%	94.6%	97.2%
RN Night	96.8%	97.8%	96.9%	96.4%	94.8%	94.4%	94.7%	98.6%
HCA Night	107.7%	106.1%	104.4%	105.0%	102.4%	102.2%	105.9%	104.9%
CHPPD	8.7	8.8	8.8	8.8	8.7	8.6	8.6	8.7

Table 3: Fill Rates and CHPPD for last 6 months

When there is a shortfall of registered nurses, on occasions unregistered staff are being utilised to ensure safe staffing. In addition the greater than 100% fill rates in Health Care Assistants (HCA) numbers are due to additional HCAs utilised to provide enhanced care.

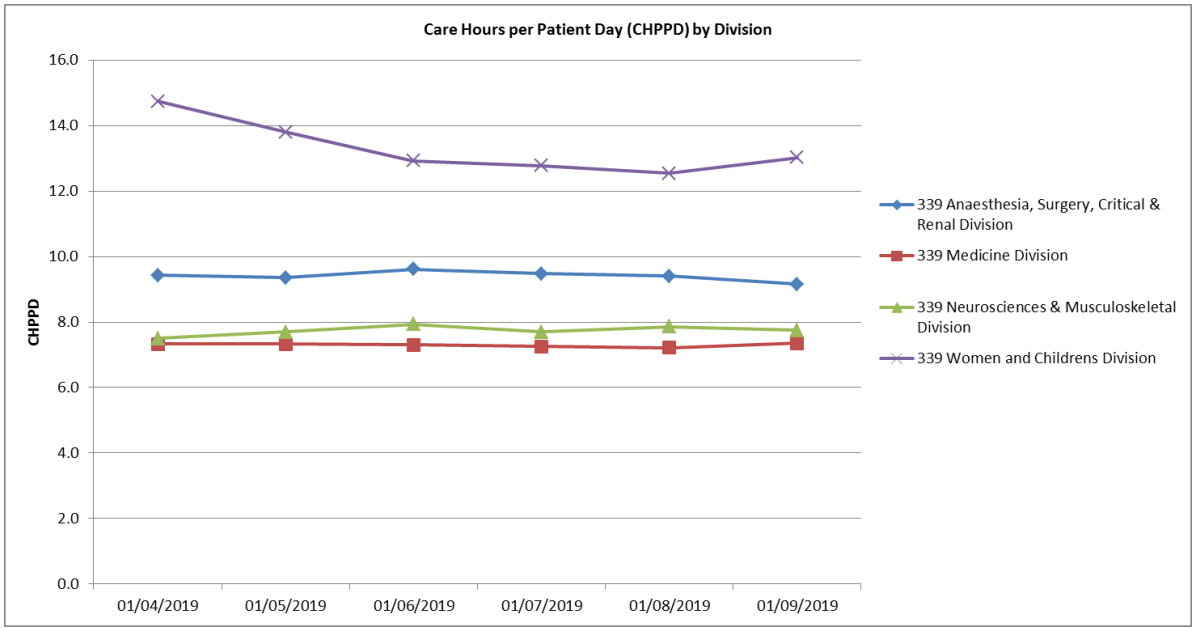


Table 4: Details the breakdown of the Model Hospital CHPPD metric by Division

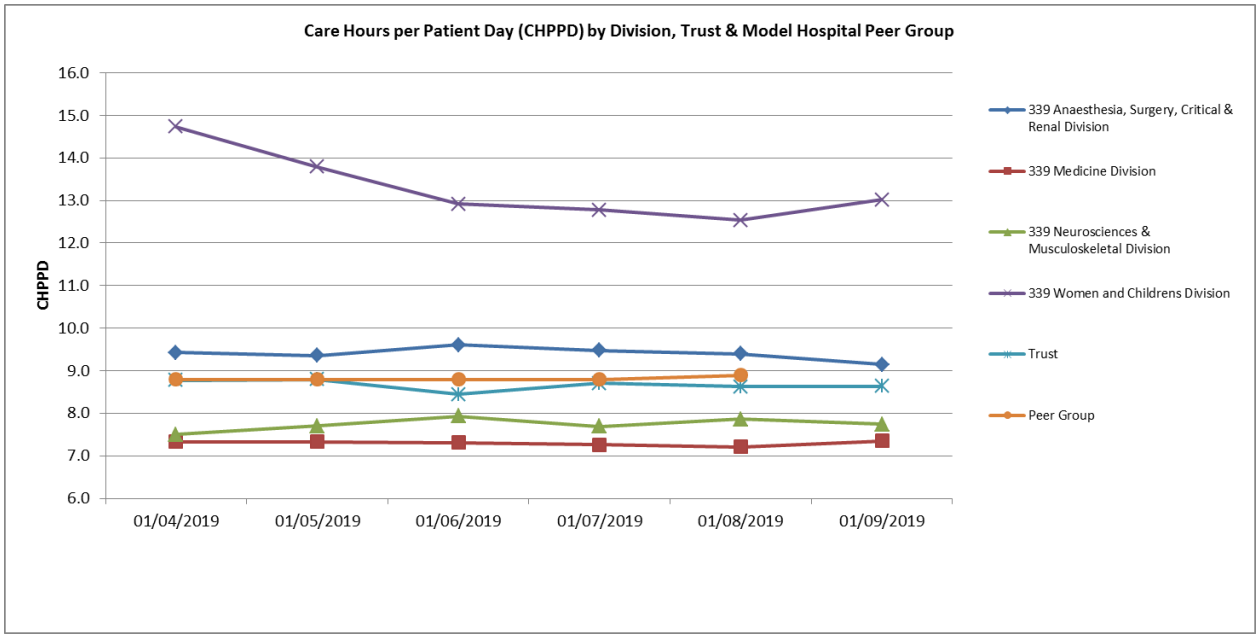


Table 5: Details the breakdown of the Model Hospital CHPPD metric Trust wide against peer group

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This demonstrates that the care hours for medicine, ASCR, Medicine and NMSK have remained static and in line with national benchmarks with the biggest fluctuation being in Women & Children. Work to understand this fluctuation is ongoing but initially appears to be related to Cotswold Ward where women receive care and midnight census periods and do not reflect activity within the day and staffing in the midwifery led birth services as staff are rostered and available 24/7 but there may not be a

woman in the unit at the midnight census. The ongoing work is to understand how other midwifery led units utilise this metric and why we appear to be an outlier.

4.3.1 Managing safe staffing every day

The process for managing safe nurse staffing on a daily basis is set out in a Safe Staffing Standard Operating Procedure to ensure consistency in the process of managing safe staffing and a clear process for the escalation of shifts. This articulates the triangulated approach to safe staffing that NQB require and ensures robust decision making for all staff around the safe care of our patients.

Daily safe staffing meetings occur between Divisions, overseen by a Head of Nursing for the week, where real time data of actual staffing levels and patient acuity can be viewed and staff redeployed as required. The staffing meetings assess this level of risk and move staff between clinical areas to balance the risk across the organisation.

The triangulated approach uses three reference points:

- The Safe Care live Acuity tool which is available on Health Roster, to ensure that there is an appropriate system and process in place for the safe deployment of staff and to manage the organisational staffing resources on a day to day basis. This works on a RAG rating basis and identifies when there is a cause for concern (red). Safe Care works by taking the planned hours from the rota including any extra shifts filled and balances this against the Acuity and Dependency and results in a rating based on the utilisation of these 2 figures. This ranges from dark green where the acuity and dependency matches the hours available on the roster, to light green, amber and then red, which identifies a significant deficit in required care hours and places the area as high risk.

- Actual numbers of staff on a shift with a RAG rating identifying the agreed funded staffing levels (green) and the number of staff when there is a cause for concern (red) (see example below)

Medicine	RN	B4	HCA		RN	B4	HCA		RN	B4	HCA
8a Gastro high care /acute bleed beds x 4											
Day	6	0	5		4	0	5		3	0	4
Night	5	0	4		3	0	4		2	0	4
9a Resp / cardio step down											
Day	5	1	5		4	1	5		3	1	5
Night	4	0	4		3	0	3		2	0	3

Table 6: An example of the skill mix numbers in the Safe Staffing Standard Operating Procedure showing funded numbers (Green) and numbers where there is a cause for concern and action may be required

- Professional judgement which is a discussion between the Nurse in Charge and Matron about the outcome of the Safe Care assessment and actual numbers of staff on a shift. There may be times when both metrics are red but care can be delivered safely to the patients and the other end of the spectrum where both metrics could be amber but not adequate to meet the safe care needs of the patients.
-

5. Governance

5.1 Nursing and Midwifery Workforce Group

The Nursing and Midwifery Workforce Group (NMWG) was established in September 2018 to provide robust monthly governance around safe nursing and midwifery staffing with actions being taken to address this including the introduction of new roles, band 2 – 4 competencies and skill matrix, and divisional staffing reports including risks and E-Rostering metrics and opportunities for improvement. The group has recently been extended to include AHP's.

5.2 New roles

The Director of Nursing and Quality has initiated a pre and post registration workforce group to provide ongoing governance to support the education and development of nursing, midwifery and AHP roles and oversee the development and design of new roles. This committee will report into Nursing, Midwifery & AHP workforce group and to upwards to the People and Digital Committee.

5.3 Nursing & Midwifery Demand & Supply Group

Nursing and Midwifery Demand & Supply Group, this is attended by senior staff from Nursing/Midwifery and People & Transformation team and chaired by the Assistant Director of Nursing. The group was established to provide the NMWG (Nursing Midwifery Workforce Group) chaired by the Director of Nursing with assurance that there are robust and integrated mechanisms in place to ensure detailed consideration and oversight of the Trust's Nursing & Midwifery workforce improvement plans and monitor and design recruitment and retention plans.

6. New Opportunities

6.1 Ward based therapists

A new programme to include Occupational Therapists and Physiotherapists to supplement the band 5 ward nursing workforce has been developed in the Medicine Division in the Elgar re-enablement unit and the respiratory unit. Working closely with the therapy teams, 2 occupational therapists are to join the enablement teams to supplement the existing nursing and therapy provision and to provide additional skills. These posts will be funded from within the budgeted nursing establishment.

In line with the Workforce Safeguards, the Head of Nursing for Medicine with the support of the People Partner completed a Quality Impact Assessments for the development of the new roles in medicine which were discussed and ratified at the April Nursing & Midwifery Workforce Group by the Director of Nursing and Quality. .

6.2 ACP roles

Following NHSI support, a programme to implement the Advanced Care Practitioner (ACP) role into the Emergency Department is in progress. This brings a blended approach to senior clinical decision makers into Urgent and Emergency care to support vacancies in the medical rotas. These practitioners can be a either nurses and therapists educated to Masters Level and undertaking an approved Royal College of Emergency Medicine competency programme supervised by consultants in ED. Whilst this programme is in its infancy and will not release qualified practitioners for a number of years, it has been shown to have a positive impact on locum doctor spend and continuity of care in other Trusts in the country. The apprenticeship commenced at UWE in May 2019. In line with the Workforce Safeguards, the Head of Nursing for Medicine with the support of the People Partner has completed a Quality Impact Assessments for the development of the this new role which was discussed and

ratified at the April Nursing & Midwifery Workforce Group by the Director of Nursing and Quality. .

6.3 Nursing Associates

In April 2017 the Trust as part of the Bristol, North Somerset and South Gloucestershire Sustainability and Transformation Plan along with Bath became a pilot site for Trainee Nursing Associates with ongoing recruitment for programmes starting in 2019/20. The first Nursing Associates complete their programme in April 2019 and the work to align their competencies with team skill mixes is taking place within the divisions and the opportunities will be discussed in the divisional section of this report. A QIA was completed and presented to the April 2019 Nursing & Midwifery Workforce group and a skills matrix developed to support their clinical practice. The Trust medicine management policy is in the process of being updated by the Assistant Director of Nursing and the Deputy Director of Pharmacy to ensure support registered NA's with administration of medications in accordance with their NMC registration and scope of practice.

There are considerable opportunities and benefits in deploying Nurse Associates within the nursing workforce and their implementation requires a structured systematic approach to planning, implementing and monitoring while deploying the role to ensure quality and safety for patients and service users, and to provide the necessary assurance to the board, commissioners and regulators. The Assistant Director of Nursing and a group of senior nurses are attending a regional NHS England event to further explore the role of Nurse Associate within the NBT nursing workforce and will feedback to the Nursing and Midwifery Workforce Group.

The NQB safe and sustainable and productive staffing guidance: *An improvement resource for the deployment of nursing associates in secondary care (2018)* recommends that as part of the governance process in implementing this new role into our skill mix, we assess the potential impact on quality through the completion of a Quality Impact Assessment (QIA). QIAs focus on systematically assessing and recording the likely impact on quality and safety of the implementation of this new role specifically, the impact on patients, service users and staff. This will involve anticipating, monitoring and measuring the consequences of activities and making sure that, as far as possible, any negative consequences are eliminated or mitigated, and any positive impacts are identified and maximised.

7. Vacancies and turnover

Vacancies remain the biggest risk to the delivery of the 2019/20 bed model for the organisation. The organisational vacancies are demonstrated in table 6 below broken down by Registered and Unregistered nurses and by division.

New workforce models will continue to be explored to meet this gap and reflect the national profile of Registered Nurse vacancies. The rolling 12 month turnover for the Trust is included at table 7 also broken down to reflect the divisional picture and shows an improved position with turnover reducing from 18.9% to 17.3% in the 6 month period since March 2019 in registered and unregistered nursing. The impact of the Nursing and Midwifery retention programme has seen 20% (26 wte) fewer band 5 nurses and 37% (38wte) fewer unregistered nurses and midwives leave the Trust than the same period last year

Staff Group	Directorate	Vacancy Including External Staff	Vacancy Factor %
Unregistered Nursing and Midwifery	339 Anaesthesia, Surgery, Critical & Renal Division	59.4	20.7%
	339 Core Clinical Services Division	23.3	31.2%
	339 Medicine Division	59.1	14.3%
	339 Neurosciences & Musculoskeletal Division	28.6	16.0%
	339 Women and Childrens Division	10.6	8.7%
Unregistered Nursing and Midwifery Total		**181.0**	**16.8%**
Nursing and Midwifery Registered	339 Anaesthesia, Surgery, Critical & Renal Division	122.7	14.7%
	339 Core Clinical Services Division	4.2	8.5%
	339 Medicine Division	78.7	12.4%
	339 Neurosciences & Musculoskeletal Division	39.1	14.3%
	339 Women and Childrens Division	10.3	3.0%
Nursing and Midwifery Registered Total		**255.0**	**11.9%**
Grand Total		**436.0**	**13.6%**

Table 7: The table above shows the Registered and Unregistered Vacancies in the Trust at the end of September 2019 expressed as WTE and as a percentage of the total workforce and by division

Staff Group	Division	Rolling 12 Month Leavers	Rolling 12 Month Turnover %
Unregistered Nursing and Midwifery	339 Anaesthesia, Surgery, Critical & Renal Division	41.4	17.2%
	339 Core Clinical Services Division	9.0	17.5%
	339 Medicine Division	72.1	19.5%
	339 Neurosciences & Musculoskeletal Division	41.4	21.6%
	339 Women and Childrens Division	19.6	16.5%
Unregistered Nursing and Midwifery Total		**183.5**	**18.9%**
Nursing and Midwifery Registered	339 Anaesthesia, Surgery, Critical & Renal Division	118.4	17.9%
	339 Core Clinical Services Division	4.6	10.9%
	339 Medicine Division	105.5	19.6%
	339 Neurosciences & Musculoskeletal Division	29.1	12.7%
	339 Women and Childrens Division	40.8	12.0%
Nursing and Midwifery Registered Total		**298.4**	**16.5%**
Grand Total		**481.8**	**17.3%**

Table 8: The table above shows the position at the end of September 2019 and includes leavers in the last 12 months and the rolling 12 month turnover broken down by Registered and Unregistered nurses and by division

8. Recruitment and Retention

Over the past 6 months there has been a continued focus in the activity of both Registered and Unregistered Nurse recruitment including:

- Open days for Registered Nurses, continue to be successful and form a significant role in the Trust domestic recruitment programme.
- Specialist Divisional national recruitment programmes are managed by the Trust Resourcing Team in collaboration with the Divisional Heads of Nursing and People Partners.
- International Recruitment programme has been successful with the first oversees nurses arriving in- June 2019 and 100% success rate with obtaining NMC registration through OSCE support programme at Yeovil.

Each Division has a detailed understanding of their vacancies and they track both recruitment and turnover closely to ensure that they are proactively recruiting and positively impacting on the retention of existing staff. With additional recruitment

resource is in place in ASCR and Medicine given the ongoing use of agency staff in Theatres, Medirooms and Intensive Care to support the filling of vacancies and retention of staff. There is a Trust Wide Nursing Demand & Supply Steering Group in place with agreed actions and a number of ongoing projects in place supported by senior nurses, People Partners, Trust Workforce Planning Lead and the and Temporary Staffing Bureau managers, which reports to the Nursing & Midwifery Workforce Committee.

9. Adult inpatient wards benchmarking data

The general adult ward nursing staffing levels and skill mixes are reviewed annually for budget setting and areas of concern with this reports providing assurance of the review completed between September & November 2019.

Recommended benchmarks

The national recommended benchmarks that have been used to support reviews of nurse staffing levels on inpatient wards are:

- NICE: Safe Staffing for nursing in adult inpatient wards in acute hospitals (2014) recommends that the Registered Nurse (RN) to patient ratio should not be greater than 8 patients per RN during the day shift

These national guides do not take into account the development of the new band 4 Nurse Associate role. As described in the Workforce Safeguards, any implementation of new roles requires a detailed Quality Impact Assessment to determine the impact on patient safety and the delivery of high quality of care. From a regulatory perspective, the CQC stated their position in a briefing for providers in January 2019. Their perspective is that nursing associates are not registered nurses and they expect health and care providers to consider this when deploying them into their workforces. As with the introduction of any other new role, they will not be prescriptive about how we as a Trust deploy nursing associates, but they will require assurance that using them is safe and supports the delivery of high-quality care. More recently NHS Improvement have requested Nurse Associates are reported as an individual group in the Unify submission, we are working with our e-rostering system provider to identify this newly developed staff group from our RN and HCA workforce in our national reporting.

10. Ratio of Registered Nurses to patients

The budgeted ratio of one RN to eight patients during a day shift has been reviewed against funded staffing establishments in the 2019/20 budgets. NICE guidance for RN to patients is only recommended for the day shift where activity is increased, as opposed to the night shift. All inpatient ward establishments at NBT meet this RN to patient ratio on days. At night, all wards are funded to support 1RN to 10 patients except 32a, Elgar 1 and 2 which are outside of this metric. These wards have increased healthcare assistant support at night in comparison to the other wards to ensure the delivery of safe care. The Head of Nursing and Matron have critically reviewed these wards and approved the staffing levels as being appropriate in Elgar 1 and 2, particularly as patients are medically fit for discharge and that the patient acuity, dependency support the agreed skill mix.

At present, the band 4 Assistant Practitioner roles in the ward establishments have been included in the unregistered HCA lines. However as the band 4 Nursing Associate role is implemented more widely into the organisation, consideration will have to be given to how these are integrated and reported in the workforce numbers. CQC's Regulation 18: Staffing, requires us to deploy sufficient numbers of suitably qualified, competent, skilled and experienced staff to make sure that we can meet people's care and treatment needs, and meet the other regulatory requirements. This applies to nursing associates in the same way as employing other registered healthcare professionals.

11. SNCT Data 2019

Overall the Trust nursing establishments have been reviewed using the Safer Nursing Care Tool (SNCT) (Shelford, 2013) and the findings have been triangulated with existing establishment data, nurse sensitive indicators and professional judgement of the Divisional Head of Nursing/Midwifery within the staffing reviews. The Trust wide overall nurse staffing levels when compared against the SNCT data can be seen below in Table 8.

Division	Required Reg.	Required Unreg.	Required Total	Total Establishment	Reg. Establishment	Unreg. Establishment
339 Anaesthesia, Surgery, Critical & Renal Division	121.8	83.9	205.7	197.6	112.8	84.7
339 Medicine Division	337.1	325.9	662.9	609.4	313.7	295.7
339 Neurosciences & Musculoskeletal Division	206.5	143.2	349.7	339.9	172.2	167.7
339 Women and Childrens Division	8.2	6.1	14.4	23.9	13.7	10.2
Grand Total	**673.6**	**559.1**	**1232.7**	**1170.8**	**612.4**	**558.4**

Table 9: Trust wide SNCT establishment setting data

12. Divisional safe staffing reports

ASCR

A detailed breakdown of the nursing position in WTE and finance against the funded position for the division is enclosed below. It is broken down by substantive (blue), bank (red) and agency (green).

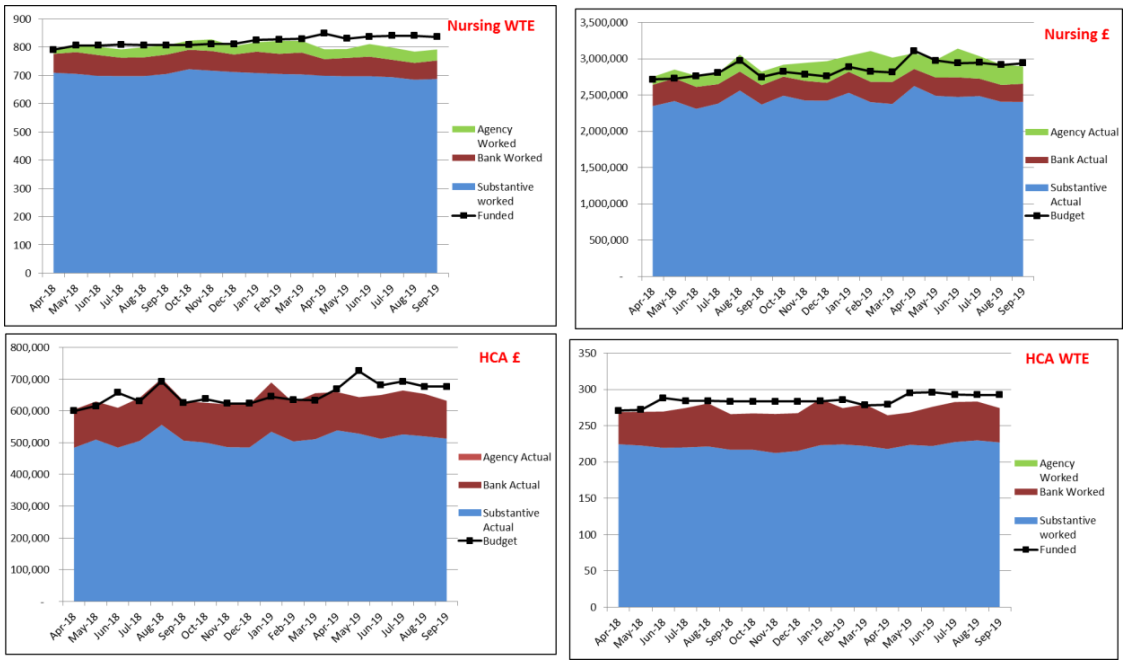

Table 10: ASCR profile of worked WTE and spend compared to funded establishments

A review of all areas of the Division for safe staffing has been completed in November 2019 between the Director of Nursing, Divisional Head of Nursing and Assistant Director of Nursing. The number of substantively funded registered and un-registered posts within the Division have been reviewed and areas of concern

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with vacancies in Theatre Nursing and Mediroom staffing raised by the Head of Nursing. Actions being taken within the division to address this are:

- Incorporating new roles to support delivery of care eg nursing assistants.
- Bespoke resourcing plans for Theatres and Medirooms and participation in Trust wide recruitment days
- Ensuring band 4 recruitment and development of Nursing Associate roles throughout the division. The Division has a workforce plan to incorporate the Nursing Associate role into the nursing workforce and increase their numbers over the next 2 years as further cohorts of registered practitioners become available. The increase in the supply will allow for the project to be rolled out across the Division.

The Head of Nursing for ASCR has completed a forward facing review of all Critical Care units in the context of changing capacity and Guidelines for the Provision of Intensive Care Services (GPIC's) and no changes are required at this time. With the unit staffing complying with 1:1 nursing for ITU level care and 1:2 nursing for HDU level care.

The Divisional Head of Nursing will be undertaking a further review of the Theatre and Mediroom nurse staffing levels against the Association for Peri-Operative Practice guidance (AfPP) to ensure that the current establishment is appropriate to meet the demands of the elective and emergency theatre schedule. .

Cost Centre	Required Reg.	Required Unreg.	Required Total	Total Establishment	Reg. Establishment	Unreg. Establishment
339 14104 Ward 32B	22.8	17.5	40.3	47.1	26.6	20.4
339 14324 Ward 34B (Urology)	25.9	17.6	43.5	38.1	22.3	15.8
	48.7	35.1	83.8	85.2	48.9	36.2
339 14411 Ward 8B (Renal - 38 Bed)	25.7	17.3	43.0	40.3	22.4	17.8
	25.7	17.3	43.0	40.3	22.4	17.8
339 14221 Ward 33A Surgical	24.1	9.0	33.1	31.4	21.3	10.1
339 14222 Ward 33B Surgical	23.4	22.5	45.9	40.8	20.1	20.6
	47.4	31.5	78.9	72.1	41.5	30.7
	121.8	**83.9**	**205.7**	**197.6**	**112.8**	**84.7**

Table 11: ASCR SNCT data

Areas of Concern

Divisional Staffing Risks

Risk Type	ID	Division	Manager	Last updated	Title	Rating (current)
Workforce	479	Anaesthesia, Surgery, Critical Care and Renal	Izzard, Julie	Keith Davies 12/09/2019 14:38:31	ICU Staffing	12

Table 12: ASCR Staffing risk

The Division has particular challenges related to vacancies in Registered Nurses in Medirooms and this service needs an enhanced resourcing plan to be delivered by the division's recruitment and retention lead supported by the Trust resourcing team, the risk is being added by the Divisional Head of Nursing. Since the last report in April 2019 the ASCR Division has transferred the Bath Dialysis service to another provider which has subsequently reduced the whole time equivalent nursing team and vacancies within Dialysis services.

Medicine

A detailed breakdown of the WTE and finance against the funded position for the division is enclosed below. It is broken down by substantive (blue), bank (red) and agency (green).

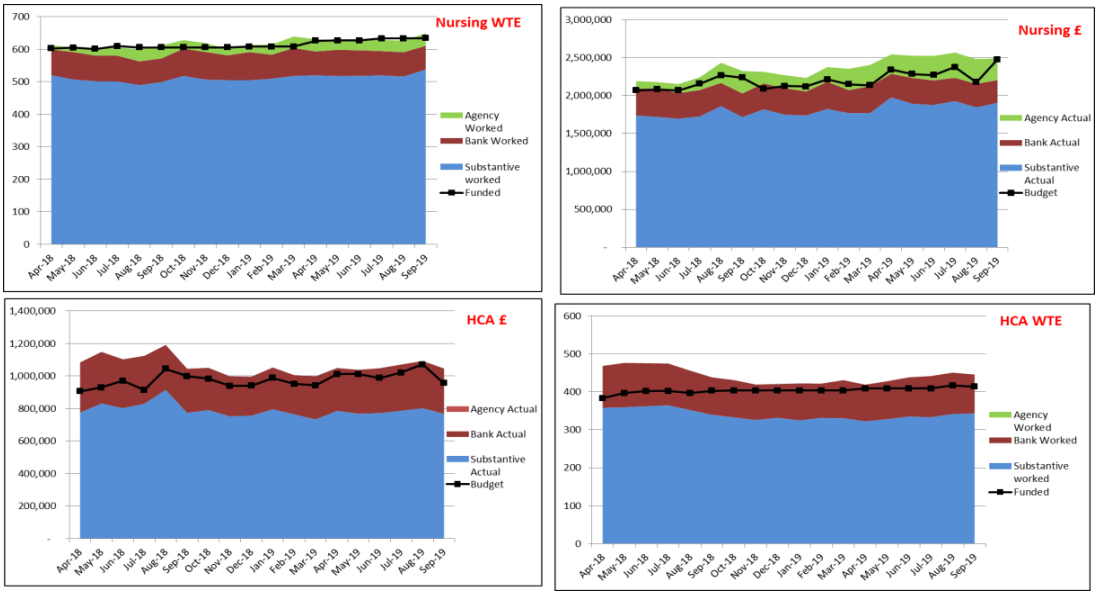

Table 14: Medicine profile of worked WTE and spend compared to funded establishments

Cost Centre	Required Reg.	Required Unreg.	Required Total	Total Establishment	Reg. Establishment	Unreg. Establishment
339 14031 Acute Medical Unit Gate 31A&B	69.2	32.8	102.0	103.2	70.0	33.1
339 14103 Ward 32A	20.5	29.4	49.9	43.8	18.0	25.8
339 14325 Ward 34A (Colorectal)	18.6	22.6	41.2	45.3	20.1	25.2
339 14402 Ward 27A	27.2	16.6	43.8	41.8	26.0	15.9
339 14403 Ward 27B	38.6	21.3	59.9	59.2	38.1	21.1
339 14410 Ward 8A (Flex Capacity)	26.8	21.1	47.9	43.8	24.5	19.3
339 14501 Ward 9B Flex Capacity	22.3	28.5	50.7	45.9	20.1	25.8
339 14502 Ward 28A (Complex)	22.0	28.2	50.2	45.9	20.1	25.8
339 14503 Ward 9A	21.8	27.9	49.7	45.9	20.1	25.8
339 14520 Ward 28B (Complex)	24.7	26.3	50.9	41.9	20.5	21.5
339 17002 Elgar Ward 2	21.2	33.8	55.0	46.7	18.0	28.7
339 17003 Elgar Ward 1	24.2	37.4	61.6	45.9	18.0	27.9
Grand Total	**337.1**	**325.9**	**662.9**	**609.4**	**313.7**	**295.7**

Table 15: SNCT Data Medicine In-Patient Wards

Through the review of staffing in November the are areas of concern raised by the Head of Nursing are the vacancies of 72 WTE Registered Nurses with vacancy hotspots identified on 27b and Elgar 2.
Actions being taken within the division to address this are:

- Developing more new roles to support ward delivery of care eg ward based therapists / combined therapy / nursing assistants.
- Bespoke recruitment campaigns for hard to recruit areas and participation in Trust wide recruitment days
- Ensuring band 4 recruitment and development of Nursing Associate roles throughout the division. The Division has a workforce plan to incorporate the Nursing Associate role into the nursing workforce and increase their

numbers over the next 2 years as further cohorts of registered practitioners become available. The increase in the supply will allow for the project to be rolled out across the Division.

Voluntary turnover in medicine is 19.5% overall with hot spots identified in 27b (33%), 34a (31%) and Elgar 2 (23%). The recruitment and retention matron is focusing on staff wellbeing / staff feedback and rotation programmes to address this. Overall the Medicine Division has seen improvements in the retention of both registered and unregistered nursing staff since April 2019.

Further work is required regarding funding requirements for the use of the ambulatory care unit for escalation capacity and the impact this has on AMU overnight and the costs for staffing the ED and AMU corridors when the Trust is in high escalation. The development of new ANP/ACP roles brings both opportunities and threats whilst their implementation and impact is considered.

Divisional staffing risks

Risk Type	ID	Division	Manager	Last updated	Title	Rating (current)
Workforce	261	Medicine	Goddard, Luisa	Holly Beange 01/11/2019 15:55:41	High Vacancies in Nursing	12

Table 16: Medicine staffing risk

Medicine hold a divisional risk relating to the high numbers of vacancies within the division with a clear recruitment and retention plan to address this and a pipeline of new starters in progress.

NMSK

The acuity and dependency of NMSK patients varies significantly due to the emergency nature of the specialities and the requirement for enhanced observation in patents. To support this variation there is an element of funding for temporary staffing within the funded establishment which enables care hours to be increased in response to patient need. There remains a gap between the hours required and the hours rostered due to challenges in accessing temporary staffing at short notice. In order to maintain safety the division has a senior nurse on site every day and ward based bleep holders overnight to facilitate team working across the wards and to ensure that safety is maintained and risk is managed. At a divisional level funded care hours are generally sufficient to maintain safe care, but these are monitored on a ward basis to identify changes in dependency trends.

However current areas under review are the Major Trauma Ward 26b where acuity / dependency shows a sustained increase in the last six month, and the Elective Orthopaedic ward 26a where the reduced length of stay for elective orthopaedic patients has led to more rapid turnover and higher acuity. These areas require further review.

A detailed breakdown of the WTE and finance specifically against the funded position for the division is enclosed below. It is broken down by substantive (blue), bank (red) and agency (green).

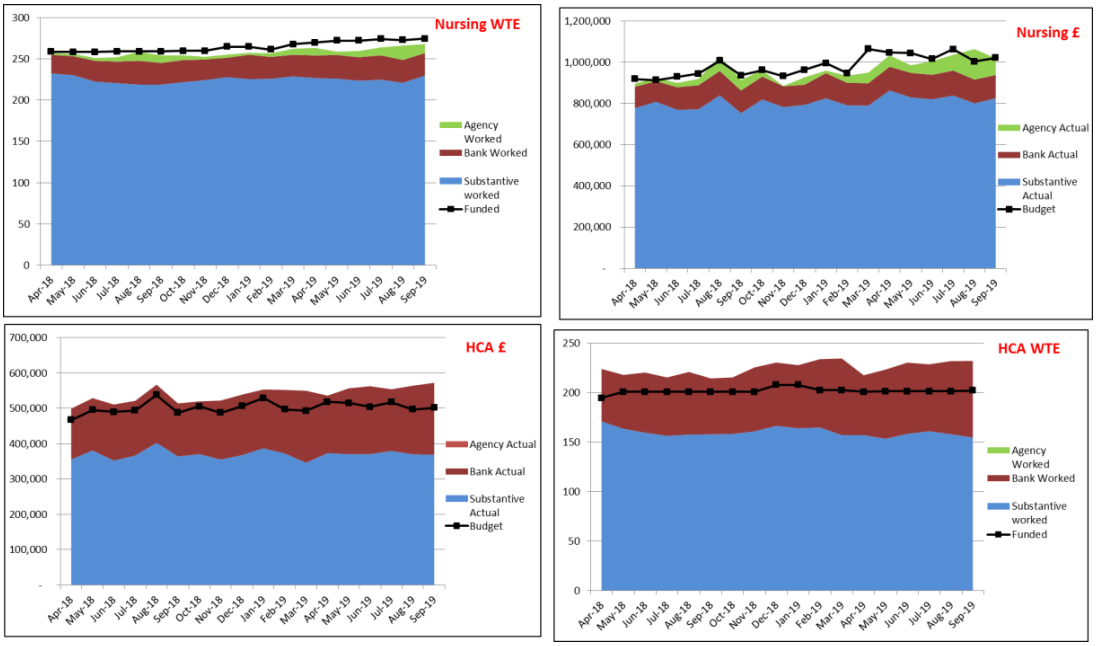

Table 17: NMSK profile of worked WTE and spend compared to funded establishments

Cost Centre	Required Reg.	Required Unreg.	Required Total	Total Establishment	Reg. Establishment	Unreg. Establishment
339 14211 Ward 6B (Mainly Neuro)	31.9	15.5	47.4	51.2	26.9	24.3
339 14241 Ward 25A Neuro	33.2	16.2	49.4	51.7	26.9	24.8
	65.1	31.8	96.9	102.9	53.8	49.2
339 14242 Ward 25B MSK	28.0	24.1	52.1	42.2	20.1	22.1
339 14311 Ward 26A Musculo	21.1	19.9	41.0	33.0	16.7	16.3
339 14312 Ward 26B Surgery	26.6	20.0	46.5	35.4	20.0	15.4
	75.6	64.0	139.6	110.6	56.9	53.8
339 14302 Ward 7A (Neurology/Stroke)	28.2	20.7	48.9	67.5	32.5	34.9
339 14303 Ward 7B (MSK, some Neuro)	29.0	22.9	51.8	45.7	20.0	25.8
339 25000 Neuropsychiatry (non Medical)	8.6	3.9	12.5	13.2	9.1	4.1
	65.8	47.5	113.2	126.4	61.5	64.8
	206.5	**143.2**	**349.7**	**339.9**	**172.2**	**167.7**

Table 18: SNCT Data NMSK In-Patient Wards

Vacancy and Turnover

In line with the National Picture recruitment and retention of Registered Nurse remains a key challenge for NMSK. The stroke unit on 7a is a particular area of concern following the increase in funded Registered Nurse posts by 5.2wte to support the expansion of Thrombectomy services. This risk is on the divisional Risk Register. As well as engaging in Trust wide recruitment events, a bespoke recruitment plan for Stroke and Trauma has been developed which includes showcase events, and specific recruitment campaigns to raise the profile of these specialities in North Bristol NHS Trust and promote the experience and development opportunities available to Registered Nurses working in these teams.

There is a continued challenge in relation to the un-registered workforce retention, with the rolling 12 month turnover for this group of staff whilst having improved since April 2019 it is currently at 19.2%. It is recognised that although working in the NMSK specialities can be very rewarding it can also be very challenging. The senior NMSK nursing team are engaging proactively in discussions with potential recruits during the recruitment process to ensure that they have a good understanding of the specific needs of our patient group, and the

demands of the roles. The division has also invested in De-escalation and Physical Intervention training to equip staff to deal with challenging behaviour.

Development of New Roles
NMSK have historically embraced new roles into their nursing teams. Many of the wards have a full rota of Assistant Practitioners who are working to the full extent of their roles and effectively supporting the Registered Nursing workforce and the quality of patient care. The division has developed the role of Behaviour HCA, individuals who specialise in the care and support of neuro and trauma patients with cognitive impairment. Nursing Associates are currently working within the Division with a further opportunity to review our nursing workforce and the establishment of each ward to incorporate these roles further.

Risk Type	ID	Division	Manager	Last updated	Description	Consequence (current)	Likelihood (current)	Rating (current)
Patient Safety	605	Neurosciences and Musculoskeletal	Mallett, Suzanne	Ruth Bardell 24/07/2019 09:15:30	Vacancies in Stroke and Neurology Ward Nursing	Minor	Likely (Will probably happen/recur but it is not a persistent issue)	8
Service Delivery	574	Neurosciences and Musculoskeletal	Smithers, Joanna	Ruth Bardell 02/04/2019 11:23:33	Shortage of staff in Movement disorder team.	Minor	Likely (Will probably happen/recur but it is not a persistent issue)	8

Risks Table 19: NMSK divisional staffing risk

Women's and Children's Division
A detailed breakdown of the WTE and finance against the funded position for the division is enclosed below. It is broken down by substantive (red), bank (green) and agency (orange).

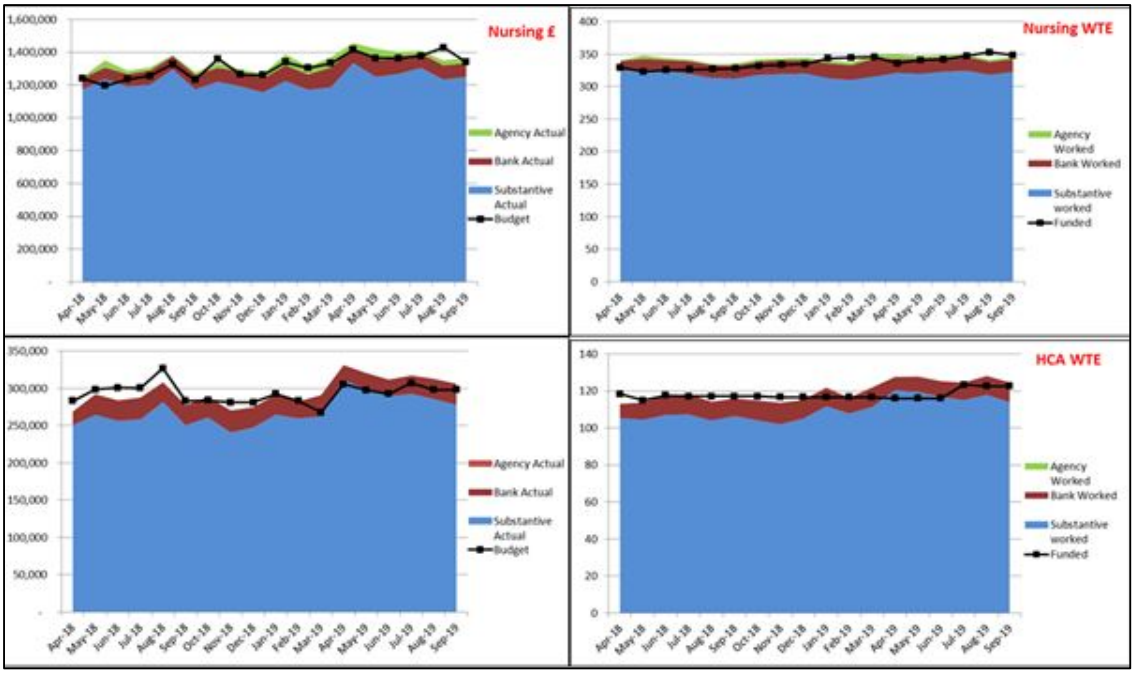

Table 20: NICU & Cotswold profile of worked WTE and spend compared to funded establishments

Cotswold Ward
Cotswold Ward has a total of 25 beds. However currently it is funded and staffed to provide care for 15 Gynaecology patients and 4 beds allocated to surgical specialities. The bed modelling supported by the divisional team and executive team was taken to

admit suitable surgical patients from ASCR at times of Trust escalation and 4 beds were allocated for this. Cotswold Ward also has a 10 bed 'Day Case' unit, with the majority of gynaecology procedures being performed as a Day Case or in Outpatients.

The ward is staffed according to the acuity / enhanced care needs of the patient, and increases its staffing numbers accordingly, an example being a patient with medical termination of pregnancy requiring 1:1 nursing care.

Cost Centre	Required Reg.	Required Unreg.	Required Total	Total Establishment	Reg. Establishment	Unreg. Establishment
339 01269 Cotswold Ward	8.2	6.1	14.4	23.9	13.7	10.2
	8.2	**6.1**	**14.4**	**23.9**	**13.7**	**10.2**
	8.2	**6.1**	**14.4**	**23.9**	**13.7**	**10.2**

Table 21: SNCT Data Cotswold In-Patient Ward

Neonatal Intensive Care Unit (NICU)
An ongoing concern was staff vacancies in NICU and following successful recruitment programmes just 56% of all staff are Qualified in Specialty (QIS) trained with the British Association of Perinatal Medicine (BAPM) standard being 70%. The 9 month programme usually commences after 1 – 2 years in post, taking 3 – 5 years to reach QIS level and up to 5 years to achieve the competencies and confidence of a neonatal nurse in ITU. To currently maintain safe staffing within NICU the number of cots have been reduced to 32 with a further 2 cots opening in March 2020 returning the unit to full occupancy. Nurse staffing is monitored and managed closely by the Divisional Management team. Three times daily an SBAR is completed which help inform decisions about the staffing requirements in line with acuity of babies. There is an escalation process in place for staff to be used from other areas and the supervisory ward sister and matron provide additional support. Gaps are covered by bank and agency when required.

The service specification from NHS England and the BAPM staffing standards, state that the minimum standards for nurse staffing levels for each category for care are:

- neonatal intensive care: 1:1 nursing for all babies
- neonatal high dependency care: 2:1 nursing for all babies
- neonatal special care: 4:1 nursing for all babies.

The Division have been in discussion with the specialist commissioners at NHSE to resolve the additional investment in nursing capacity required for NICU to re-open the 4 closed cots. This has resulted in the successful re-opening of 2 cots with the remaining 2 cots scheduled to open in March 2020. The Division has been working collaboratively to review local NICU service review with University Hospitals Bristol NHS Foundation Trust and further updates will follow in future reports.
A detailed breakdown of the WTE and finance against the funded position for the division is enclosed below. It is broken down by substantive (red), bank (green) and agency (orange).

Risks

Risk Type	ID	Division	Manager	Last updated	Title	Rating (current)
Workforce	521	Women's & Children's Health	Reading, Sandra	Jodie da Rosa 30/04/2019 09:41:35	Midwifery Staffing	12

Table 22: Two risks identified in relations to NICU staffing

Midwifery
Many influences on safe staffing in maternity services affect the number of specialists required to keep staffing safe and sustainable. Examples are population mix, social care needs, health inequalities, specific health needs, health complexities, safeguarding children and vulnerable adults services, and a fluctuating birth rate. Increasing complexities in health have led to an increase in obstetric, anaesthetic and neonatal interventions driven by concerns for patient safety. Maternity settings face many workforce challenges because pregnant women with co-morbidities and complexities require more specialist input from obstetric, anaesthetic, neonatal and midwifery professionals.

Midwife to Birth ratio
The Trust regularly monitors and reports its staffing of Midwife to Birth ratios as this is recommended and found within the Birthrate Plus® tool and is also endorsed by the Royal College of Midwives. The ratios are reviewed monthly against the recommended mean national ratio of one whole time equivalent (WTE) midwife per 29.5 births and these benchmarks are reported to Board on the monthly IPR. A review of the Maternity unit staffing was undertaken by BirthRate Plus ® in October 2019 and a further report once the outcome has been received will be presented to Board.

13. Trust Wide Nursing and Midwifery staffing
A detailed breakdown of the WTE and finance against the funded position for the whole nursing and midwifery workforce is enclosed below. It is broken down by substantive (green), bank (red) and agency (blue).

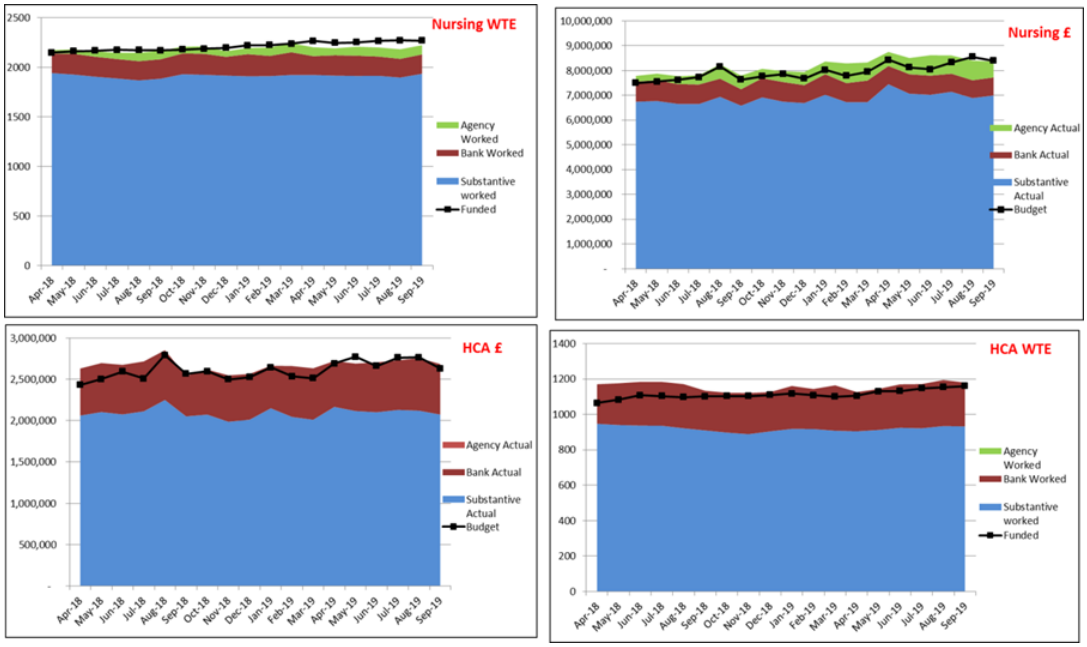

Table 23: Trust wide profile of worked WTE and spend compared to funded establishments

The overall Trust position shows the impact of the vacancies on temporary staffing use. Whilst the WTE worked more for both registered and unregistered is more closely aligned to that of the funded position as a result of the controls in place, the impact of the cost of agency to fill the vacancies remains a significant concern.

13

Worked WTE		Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19
Registered Nursing & Midwifery	Substantive	1,924	1,916	1,909	1,911	1,923	1,923	1,916	1,913	1,914	1,896	1,935	1,981
	Bank	212	189	223	204	229	190	205	204	194	189	195	217
	Agency	75	57	63	86	90	90	70	91	92	97	93	92
	Total	**2,211**	**2,162**	**2,195**	**2,201**	**2,242**	**2,202**	**2,191**	**2,208**	**2,200**	**2,182**	**2,223**	**2,290**
Unregistered Nursing & Midwifery	Substantive	889	904	918	917	908	904	912	925	922	934	932	945
	Bank	233	222	242	226	256	222	232	246	250	260	248	241
	Agency	-	-	-	0	-	-	-	-	-	-	-	-
	Total	**1,121**	**1,126**	**1,161**	**1,144**	**1,164**	**1,126**	**1,144**	**1,170**	**1,172**	**1,195**	**1,180**	**1,186**
Grand Total		**3,332**	**3,289**	**3,356**	**3,345**	**3,407**	**3,329**	**3,336**	**3,378**	**3,372**	**3,376**	**3,403**	**3,475**

Table 24: The monthly profile of WTE registered and unregistered nurses from April 2019 to October 2019 broken down by substantive, bank and agency

Expenditure (£'000)		Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19
Registered Nursing & Midwifery	Substantive	6,747	6,692	7,026	6,729	6,725	7,451	7,068	7,026	7,146	6,893	6,997	7,355
	Bank	793	723	831	768	874	736	786	773	729	719	728	820
	Agency	439	527	510	795	731	567	655	822	737	796	642	613
	Total	**7,978**	**7,941**	**8,367**	**8,292**	**8,329**	**8,754**	**8,509**	**8,621**	**8,612**	**8,408**	**8,367**	**8,788**
Unregistered Nursing & Midwifery	Substantive	1,986	2,012	2,150	2,046	2,011	2,167	2,116	2,102	2,130	2,121	2,074	2,185
	Bank	562	554	515	616	623	556	575	604	600	637	612	579
	Agency	0	0	0	0	0	0	0	0	0	0	0	0
	Total	**2,548**	**2,566**	**2,665**	**2,662**	**2,634**	**2,723**	**2,691**	**2,706**	**2,730**	**2,758**	**2,686**	**2,764**
Grand Total		**10,526**	**10,507**	**11,032**	**10,954**	**10,963**	**11,477**	**11,200**	**11,326**	**11,342**	**11,166**	**11,053**	**11,552**

Table 25: The monthly profile of registered and unregistered nurse spend from April 2019 to October 2019 broken down by substantive, bank and agency

14. Temporary Staffing

Bank usage

The recruitment of both registered and non-registered nurses to the temporary staffing bank continues and staff are supported by the Clinical Lead to ensure new starters and existing staff are supported with revalidation and maintaining of high professional standards. The bank remains unable at present to meet the demands due to the number of vacancies across the organisation. Table 26 above details the WTE volumes and table 27 the monthly cost of bank usage since April 2019.

Agency usage

Table 26 above details the WTE volumes and table 27 the monthly cost of agency usage since April 2019

NBT has clear plans in place and is working towards an ongoing reduction in the use of agency nursing staff in line with the NHS Improvement agency rules. Tier 4 agency nurse approval is via the Director and Assistant Director of Nursing or on call Executive out of hours.

In November 2017 across BNSSG the use of a neutral vendor was implemented in order to further reduce agency spend through improved pay rates below the NHSI cap, with framework agencies. The current arrangements were reviewed by Directors of Nursing across BNSSG and in September 2019 a change to the way agencies were commissioned and engaged by GRI was undertaken by the Directors of Nursing across BNSSG and Bath, the removal of Tier 2 with a revised tariff and merger of Tiers 1 and 2 and increased controls put in operation within each organisation for the use of Tier 3 and Tier 4 agencies.

The Safe Staffing SOP supports the consistent decision making required for managing non-framework agency usage. Over the last 6 months we have seen an increase in the fill rates for agency nursing shifts from Tier 1 agencies, with 69% of our current fill in November 2019 at Tier 1 compared to 386% in April within cap. 17% of our supply continues to be from Tier 4 agencies which are non-framework and therefore expensive.

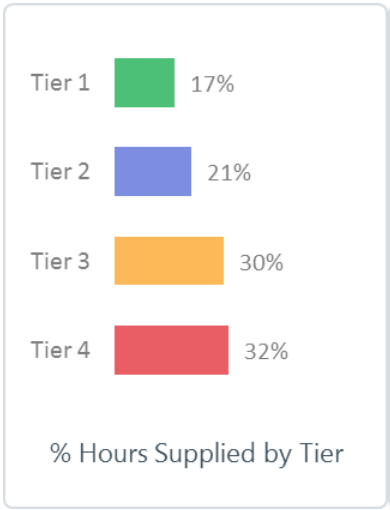

Table 26
Tier usage April 2019 until BNSSG project Launch in September 2019

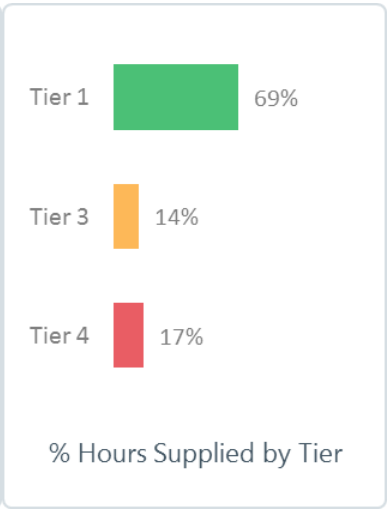

Table 27
Breakdown of Tier usage November 2019

15. Patient quality measures

Current analysis of patient feedback is via complaints, concerns, letters of appreciation and friends and family feedback. Staff are encouraged to report unsafe staffing incidents via electronic reporting which are reviewed at the Nursing and midwifery Workforce Group, the use of the 'happy app' in certain areas and via the 'Freedom to Speak up Guardians'. A new quality dashboard is in development, a first draft was completed as part of Clinical Governance Improvement Programme in April 2019 and triangulates nurse sensitive quality metrics including patient feedback with workforce data to triangulate the patient experience and outcomes with nurse staffing to ensure delivery of quality patient care and experience. Further development of the dashboard is scheduled for 2020 as part of the continued improvement programme led by the Director of Nursing and Quality.

16. Conclusion

This paper has reviewed the approach North Bristol NHS Trust takes to manage safe nurse staffing. This includes the triangulated approach of the NQB expectations (July 2016) for safe staffing and has demonstrated the outcomes of the actions which have progressed over the past 6 months. Current actions to support recruitment and retention and how staffing is managed daily to support safe and quality patient care is also included. Nurse staffing will continue to be reviewed daily by the Heads of nursing and a further review SNCT data collection will be undertaken in January 2020 to bring NBT staffing data collection periods back in line with SNCT guidance of data collection in January and June .

17. Recommendations

This report has demonstrated to the Trust Board that the Annual assessment of nurse staffing in line with business planning and against the triangulated approach to staffing of the NQB expectations has taken place.

The Trust Board is asked to:

1. Note the contents of this report which outlines the progress to date and further actions planned to ensure nurse staffing levels are safe to meet the needs of our patients, are effectively managed and are being published in accordance with the National Quality Board (2016), NHS Improvement (2018) Developing Workforce Safeguards recommendations, NHS Improvement (2018) Developing Workforce Safeguards recommendations, NICE guidance and self-assessment of the NHS Improvement recommendations for safe staffing

2. Receive assurance that the Director of Nursing and Quality has undertaken a formal annual review of safe staffing for all inpatient ward areas as detailed within the report with required changes to be included within workforce Business plans for each Division.

Report To:	Trust Board		**Agenda Item:**	14.0
Date of Meeting:	28 November 2019			
Report Title:	Integrated Performance Report			
Report Author & Job Title	Lisa Whitlow, Associate Director of Performance			
Executive/Non-executive Sponsor (presenting)	Executive Team			
Purpose:	**Approval/Decision**	**Review**	**To Receive for Assurance**	**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.			

Executive Summary
Details of the Trust's performance against the domains of Access, Safety, Patient Experience, Workforce and Finance are provided on page three of the Integrated Performance Report.

14

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

<table>
<tr><td>Strategic Theme/Corporate Objective Links</td><td>This report covers all Strategic Themes with the exception of Maximise the use of technology – right information for the right decisions.</td></tr>
<tr><td>Board Assurance Framework/Trust Risk Register Links</td><td>The report links to the BAF risks relating to internal flow, staff retention, staff engagement, productivity and clinical complexity.</td></tr>
<tr><td>Other Standard Reference</td><td>CQC Standards.</td></tr>
<tr><td>Financial implications</td><td>Whilst there is a section referring to the Trust’s financial position, there are no financial implications within this paper.
<table>
<tr><th>Revenue</th><th>Total £’000</th><th>Rec £’000</th><th>Non Rec £’000</th></tr>
<tr><td>Income</td><td></td><td></td><td></td></tr>
<tr><td>Expenditure</td><td></td><td></td><td></td></tr>
<tr><td>Savings/benefits</td><td></td><td></td><td></td></tr>
</table>
<table>
<tr><td>Capital</td><td></td></tr>
</table></td></tr>
<tr><td>Other Resource Implications</td><td>Not applicable.</td></tr>
<tr><td>Legal Implications including Equality, Diversity and Inclusion Assessment</td><td>Not applicable.</td></tr>
</table>

Appendices:	Not applicable.

14

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NHS North Bristol NHS Trust

North Bristol NHS Trust

INTEGRATED PERFORMANCE REPORT

November 2019 (presenting October 2019 data)

CONTENTS

REPORT KEY

Unless noted on each graph, all data shown is for period up to, and including, 31 October 2019.

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

Performance improved

Performance maintained

Performance worsened

Upper Quartile

Lower Quartile

NBT Quality Priorities 2019/20

QP1	Supporting patients to get better faster and more safely
QP2	Meeting the identified needs of patients with Learning Disabilities /Autism
QP3	Improving our response to deteriorating patients
QP4	Learning & improving from Patient & Carer feedback (e.g. FFT, complaints, compliments, surveys)
QP5	Learning & improving from statutory & regulatory quality systems (e.g. incidents, mortality reviews, inquests, legal claims, audits)

Abbreviation Glossary

ASCR	Anaesthetics, Surgery, Critical Care and Renal
CCS	Core Clinical Services
CEO	Chief Executive
Clin Gov	Clinical Governance
GRR	Governance Risk Rating
HoN	Head of Nursing
IMandT	Information Management
LoS	Length of Stay
MDT	Multi-disciplinary Team
Med	Medicine
NMSK	Neurosciences and Musculoskeletal
Non-Cons	Non-Consultant
Ops	Operations
P&T	People and Transformation
PTL	Patient Tracking List
RAP	Remedial Action Plan
RCA	Root Cause Analysis
TWW	Two Week Wait
WCH	Women and Children's Health
WTE	Whole Time Equivalent

EXECUTIVE SUMMARY
October 2019

Urgent Care

For the third consecutive month the Trust has exceeded the England position for ED 4 hour wait performance (Type 1). This is despite October being a more challenged month. The Trust also continues to be ranked first among the 11 Adult Major Trauma Centres for 4 hour wait performance by a significant margin.

Elective Care and Diagnostics

In October, there has been a reduction in the overall waiting list size. There were 13 patients waiting greater than 52 weeks for their treatment in October against a trajectory of 19. The majority of patients breaching are awaiting an Orthopaedic operation. Overall diagnostics performance is 9.09% in month, which has not met the revised recovery trajectory of 6.25%. CT is planned to be compliant with national standard in January 2020 and Endoscopy will deliver against the national standard in March 2020 with agreed outsourcing of activity aiding delivery. There were no urgent operations cancelled for a subsequent time and no breaches of the 28 day re-booking target.

Cancer wait time standards

As anticipated, the Trust did not achieve the 62 day waiting time standard in September with Performance of 72.58%. This is the result of planned backlog clearance within Urology and is expected to worsen in October in line with the Urology Recovery Trajectory. Sustained delivery of the national wait time standard is on track to achieve the 85% target from the end of Quarter 1 of 2020/21. The Two Week Wait standard was not achieved in September as a result of backlog clearance within the Skin specialty. Performance has since improved and it is expected the Skin will be compliant by year end. An overall return to TWW standard is not expected until Quarter 2 of 2020/21, as longer-term plans to close the demand and capacity gap are required.

Quality

The number of overdue complaints reduced to one at the end of October. In order to ensure compliance, weekly divisional meetings take place and a revision of escalation processes in some divisions have been implemented to facilitate timely responses. The Trust's overall compliance rate has returned to standard in October.

In October WHO compliance reached its highest level for the past 12 months at 98.50%. Performance has been sustained for hip fracture care and no never events or cases of MRSA have been reported for October.

Workforce

Overall there has been a positive shift in workforce related indicators in October with a decrease in vacancy factor and the Trust is now achieving the 14.5% Turnover target. Agency use continued to decrease in October compared with September despite a slight increase in demand for temporary staff.

Finance

The Trust has a planned deficit of £4.9m for the year in line with the agreed control total with NHS Improvement (NHSI). At the end of October, the Trust reported a deficit of £4.4m which is £1.9m adverse to the planned deficit including Provider Sustainability Fund and Financial Recovery Fund. The Trust has a 2019/20 savings target of £25m of which £7.8m was achieved at the end of October against a plan of £11.9m. The Trust financial risk rating on the NHSI scale is 3 out of 4.

Key Operational Standards Dashboard
October-19

IPR section	Access Standard: Description		Target	Benchmarking (*month in arrears): National**	Rank***	Quartile	Previous month's performance	Performance against Target	Performance against NBT Trajectory	Performance direction of travel from last month
Responsiveness	ED 4 Hour Performance	QP1	95%	74.46%	32/119		85.14%	80.04%	83.49%	
	12 Hour Trolley Waits	QP1	0				0	4		
	Ambulance Handovers Within 15 minutes		100%				97.30%	94.09%	92.48%	
	Ambulance Handovers Within 30 minutes		100%				99.80%	99.19%	99.45%	
	Ambulance Handovers Within 60 minutes		0				0	0	0	
	Referral to Treatment - % Incomplete Pathways <18 weeks		92%	*84.78%	79/158		83.20%	83.28%	88.29%	
	Referral to Treatment - Total Incomplete Pathways						29313	29118	28276	
	52WW	MSK	15				12	12	19	
		Plastic Surgery	1				3	1		
		Urology	0				1	0		
		Other	3				0	0		
	Diagnostic DM01 - % waiting more than 6 weeks		1%	*3.79%	142/204		8.69%	9.09%	6.25%	
	Cancelled Operations	Same day - non-clinical reasons	0.8%				0.94%	1.30%		
		28 day re-booking breach	0				1	0		
	Bed Occupancy	QP1	95%				95.18%	96.49%		
	Stranded Patients (LoS >7 days : Snapshot as at month end)						346	340		
	Delayed Transfers of Care (DToC)	QP1	3.50%				8.90%	7.29%		
	Mixed Sex Accomodation		0				0	0		
	Electronic Discharge Summaries						84.44%	84.70%		
Responsiveness - Cancer (In arrears)	Patients seen within 2 weeks of urgent GP referral		93%	90.79%	130/145		65.54%	69.92%	62.34%	
	Patients with breast symptoms seen by specialist within 2 weeks		93%	78.94%	75/114		94.64%	96.08%	93.86%	
	Patients receiving first treatment within 31 days of cancer diagnosis		96%	95.97%	114/123		89.47%	90.20%	96.07%	
	Patients waiting less than 31 days for subsequent surgery		94%	92.15%	47/57		82.56%	75.23%	93.52%	
	Patients waiting less than 31 days for subsequent drug treatment		98%	99.31%	1/31		100%	100%	100%	
	Patients receiving first treatment within 62 days of urgent GP referral		85%	77.45%	66/138		88.84%	72.58%	79.70%	
	Patients treated within 62 days of screening		90%	87.44%	24/73		92.59%	90.00%	91.57%	

Key Operational Standards Dashboard

October-19

IPR section	Access Standard		Benchmarking (*month in arrears)			Previous month's performance	Performance against Target	Performance against NBT Trajectory	Performance direction of travel from last month
	Description	Target	National**	Rank***	Quartile				
Quality Patient Safety and Effectiveness	Never Event Occurrence by Month	0				0	0		
	WHO Checklist Compliance	95%				97.50%	98.50%		
	Pressure Injuries – Grade 2					46	43		
	Pressure Injuries – Grade 3					0	0		
	Pressure Injuries – Grade 4					0	0		
	MRSA					1	0		
	E. Coli					4	7		
	C. Difficile					6	5		
	MSSA					5	2		
	Venous Thromboembolism Screening (In arrears)	95%				95.89%	94.27%		

Key Operational Standards Dashboard

October-19

IPR section	Access Standard: Description			Target	Benchmarking (*month in arrears): National**	Rank***	Quartile	Previous month's performance	Performance against Target	Performance against NBT Trajectory	Performance direction of travel from last month
Quality Experience	FFT - Response Rates	Emergency Department	QP2		*12.22%	27/133		18.74%	20.00%	15.00%	▲
		Inpatient	QP2		*24.98%	133/168		17.88%	16.83%	30.00%	▼
		Outpatient	QP2					17.16%	18.95%	6.00%	▲
		Maternity (Birth)	QP2		*20.02%	48/122		20.92%	18.39%	15.00%	▼
	FFT - % Would recommend	Emergency Department	QP2		*85.25%	35/132		91.22%	92.97%		▲
		Inpatient	QP2		*95.91%	132/157		93.72%	93.52%		▼
		Outpatient	QP2		*93.71%	93/185		95.36%	95.31%		▼
		Maternity (Birth)	QP2		*97.05%	45/71		95.60%	93.26%		▼
	Complaints	% Overall Response Compliance	QP2					92.00%	87.00%		▼
		Overdue	QP2					4	1		▼
Well Led	Agency Expenditure ('000s)			£481				£968	£836		▼
	Month End Vacancy Factor			8.20%				9.39%	8.75%		▼
	Turnover (Rolling 12 Months)			15.20%				14.75%	14.46%		▼
	Sickness Absence (Rolling 12 month -In arrears)			4.00%				4.35%	4.36%		▲
	Trust Mandatory Training Compliance			85.00%				88.95%	88.89%		▼
Finance	Deficit (£m)			£4.9m 2019/20				£4.4	£4.4	£2.5	
	NHSI Trust Rating							3	3		▶

RESPONSIVENESS
SRO: Chief Operating Officer
Overview

Urgent Care

The Trust has not delivered its recovery trajectory for the ED 4 hour standard with performance of 80.04% vs a trajectory of 83.49%. Despite falling short of the October trajectory the Trust continues to perform well when compared nationally. The decline in ED performance can be attributed to a deterioration in admitted breach performance. Four 12-hour trolley breaches have been reported during the period of extreme system-wide pressure, including declaration of a system-wide Internal Critical Incident from 17 to 20 October. Bed occupancy averaged at 96.49% across the month. High levels of DToC patients (7% vs. 3.5% target) continue to be experienced and the average number of medically fit patients is 170. This pressure has continued into November and BNSSG is planning a Hard System Reset week from 11 December.

Planned Care

Referral to Treatment (RTT) - The Trust has not achieved the RTT trajectory in month with performance of 83.28% against trajectory of 88.29%. The total RTT wait list size in month is above plan by an additional 842 patients, reporting 29118 against a trajectory of 28276. The number of patients exceeding 52 week waits was 13 against a trajectory of 19, an improved position from September; the majority of breaches (12) being in Trauma and Orthopaedics. The volume of patients choosing not to accept reasonable offers of dates for treatment within 52 weeks continues to be a risk going into 2020/21 and has been flagged as an issue with the regional NHSI team.

Cancelled Operations - In month, there were no urgent operations cancelled for a subsequent time and no breaches of the 28 day re-booking target.

Diagnostic Waiting Times - The Trust did not achieve the recovery trajectory of 6.25% for diagnostic waiting times with a performance of 9.09% in October. This is an unplanned deterioration in performance, largely attributable to unexpected increased demand for CT scans in October. Plans have been implemented to increase capacity in November to assist in backlog reduction. A new trajectory has been agreed with commissioners and is in place as of October. Agreement has been reached with Commissioners to outsource Endoscopy activity to enable the Trust to comply with the national diagnostic wait time standard by the end of March 2020.

Cancer

The nationally reported Cancer performance for September 2019 shows the Trust achieved three of the seven standards in month. The 62 day standard reports an anticipated deterioration with a performance position of 72.58%. The deterioration of this standard is the result of planned backlog clearance within Urology and is expected to decline further in October. Two Week Wait performance is adversely effected by issues within the Skin specialty. Performance for Skin has since improved and is on track to deliver by year end. Trajectories have been revised and implemented as of September and recovery plans are in place for Urology and Skin.

Areas of Concern

The system continues to monitor the effectiveness of all actions being undertaken, with daily and weekly reviews. The main risks identified to the delivery of the Urgent Care Improvement Plan (UCIP) are as follows:

- UCIP Risk: Lack of community capacity and/or pathway delays fail to meet bed savings plans as per the bed model.
- UCIP Risk: Length of Stay reductions and bed occupancy targets in the bed model are not met leading to performance issues.

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

Improvements

Maternity Services – Recruitment of midwives and other key leadership posts has been completed. BirthRate + workforce tool has been completed to inform ongoing staffing requirements linking into the business planning round.

Never events – There were no Never Events in October 2019, with the last reported Never Event being 26 January 2019. Trust actively contributed to a CCG organised Never Event workshop in October.

WHO Checklist – Compliance reached its highest level for the past 12 months at 98.50%.

Quality of Hip Fracture Care - There was sustained performance against key metrics for hip fracture care.

MRSA cases - There were no cases of MRSA bacteraemia in October. There has been one case in 2019/20.

Areas of Concern

MSSA – Higher than expected numbers of MSSA bacteraemia are under investigation.

VTE risk assessment – The target continues to be met ,but the relatively lower levels recently are under investigation by the Thrombosis committee.

QUALITY EXPERIENCE
SRO: Director of Nursing
Overview

Improvements

Complaint and Concerns:

The overall compliance rate for responding to complaints within agreed timescales for October was 87% remaining in line with the improvement trajectory. The compliance rate includes all cases with a due date for completion within October . Weekly tracker review meetings continue to support the compliance in meeting response times .

Friends and Family Test: In October the Emergency Department received the highest percentage of patients recommending ED over the past 12 months remaining above the regional and national requirement.

FFT is changing in April 2020. The focus will be on the providing an opportunity to everyone to give feedback at a time that is best for them using the question; 'Overall how was your experience of the service?' with the rating of very good to very poor / don't know.

Areas of concern

Complaints and concerns:

The ASCR Division continue to have overdue complaints on their weekly tracker. This is being reviewed at the Divisional Governance meetings by the Head of Nursing with actions to address the identified challenges. This includes refreshing staff of their roles and responsibilities and in the use of Datix.

Friends and Family Test:. In patient response rate remains below the expected level (30%) at 16.83%. The Divisional Patient Experience leads are taking forward actions to increase the response rate. There is greater staff engagement in FFT over the past month.
Maternity (Birth) are showing a decreasing trend in the percentage of patients who recommend the service. It is difficult to understand the cause of this from the small amount of qualitative data provided by respondents. Data will be triangulated with national survey data in the review workshop on 22 November 2020.

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

Corporate Objective 4: Build effective teams empowered to lead

Continue to reduce reliance on agency and temporary staffing
Expenditure on registered nurse agency reduced by £28k in October compared with September, this totals a reduction of £182k compared with August's expenditure as a result of a reduction in Tier 4 (non-framework) and Tier 3 agency use. In October this reduction was despite a slight increase in overall demand for temporary staff, with Tier 1 and bank fill increased, in line with Trust expectations of the project.

Vacancies
The Trust vacancy factor has decrease from 9.4% in September to 8.7% in October, a reduction of 53 wte vacancies. This was due to an overall net gain of staff across the Trust in October with the largest net gains of staff were in Band 2 (5.9 wte), Band 3 (15.4 wte) and Band 5 (17 wte) nursing.

Turnover
The Trust turnover has improved in October and has reached 14.5%, the target the Trust set for 2019/20. With ongoing focus on retention this position is anticipated to improve in line with the current trend of improvement since April 2018. It is not anticipated that the winter period will adversely affect turnover as the improvement trend continued over the winter period in 2018/19.

Stability
The stability factor for October 2019 is 85.7% a small positive improvement from September's position.

Improving the sustainability and wellbeing of our workforce
The rolling 12 month sickness remained at 4.4% in October. There has been a small increase in MSK related absence meaning that for the first time this year we are slightly above the level of MSK absence this time last year. Stress related absence has reduced since last month but not as much as this time last year, meaning that MSK absence is now at the same level as it was this year. This may be in part due to staff shortages in the staff wellbeing psychology and physiotherapy teams over the summer. The psychologist gap is now resolved and actions are in place to fill the Physiotherapist gap.

Improving the leadership capability and capacity of our workforce
The OneNBT Leadership programme has met 91% of its 2019/20 target of staff signing up to the programme, an increase of 3% from September. There has also been an increase in participation with the programme and the number of staff signed up but yet to book onto modules reduced from 62 to 41.

FINANCE
SRO: Director of Finance
Overview

The Trust has planned a deficit of £4.9m for the year. This is in line with the control total agreed with NHS Improvement of £5.4m after excluding a planned profit on sale of £0.5m which is no longer allowed to contribute to delivery of the control total under the new business rules for 2019/20.

At the end of October, the Trust reported a deficit of £4.4m which is £1.9m adverse to the planned deficit including Provider Sustainability Fund and Financial Recovery Fund. However, note that the Trust's forecast for Quarter 3 identified an error in the phasing of the Quarter 3 plan agreed with NHS Improvement and so whilst the Trust missed plan by £1.9m in October, this performance is in line with its forecast which achieves both the Quarter 3 and full year plan position.

There are a number of risks to delivery of the year end control total including elective income recovery and delivery of savings. However, the Trust has identified a number of mitigating actions and is forecasting to deliver the control total.

The Trust has borrowed a net £1.0m year to date to the end of October which brings the total Department of Health borrowing to £179.3m.

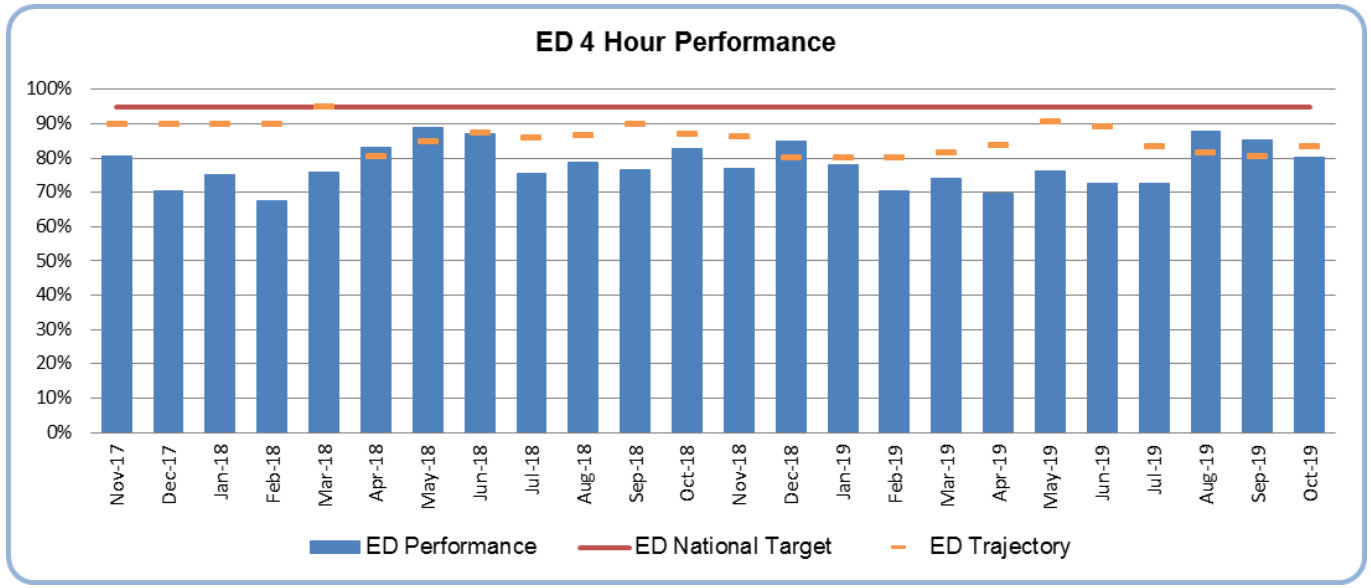
The Trust has a savings target of £25m for the year, of which £7.8m was achieved at the end of October against a plan of £11.9m.

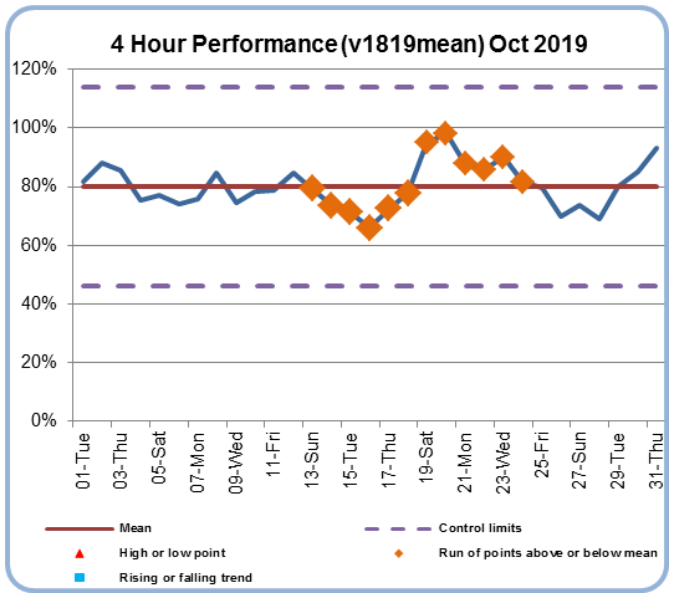
The Trust is rated 3 by NHS Improvement (NHSI).

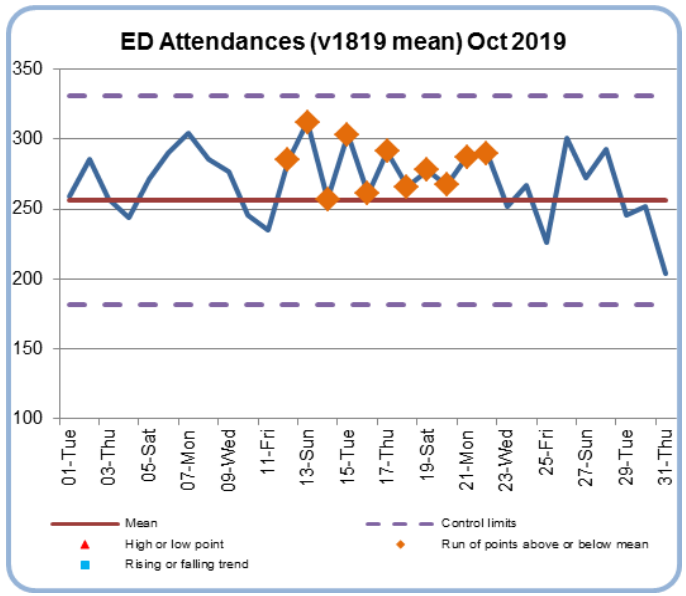
NHS North Bristol NHS Trust

RESPONSIVENESS

Board Sponsor: Chief Operating Officer
Evelyn Barker







Urgent Care

The Trust did not achieve the ED 4 hour wait trajectory in October (performance of 80.04% vs a trajectory of 83.49%). The Trust reported four 12 hour trolley breaches in month during a period of extreme system-wide pressure.

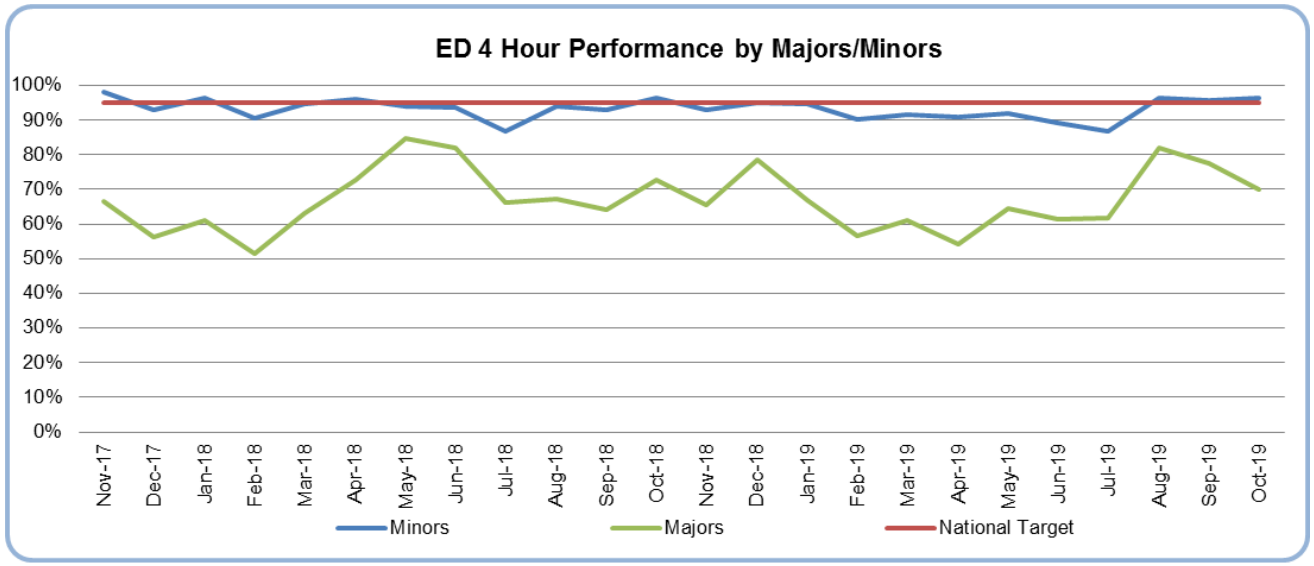
There was an average of 270 attendances per day and four days where attendances exceeded 300. At 8365, there were 517 (6.59%) more attendances when compared with October 2018 and 0.89% more than SLA.

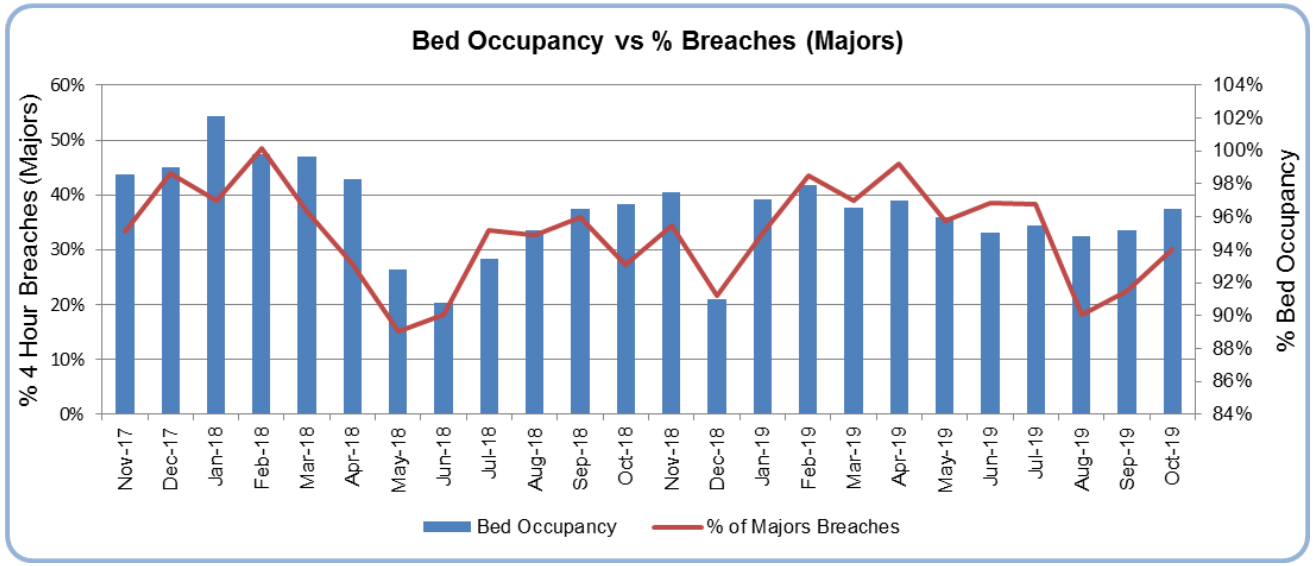
ED performance for the NBT Footprint stands at 85.87% and the total STP performance was 85.37% for October.

There was much greater variation in 4 hour wait times performance during the month, varying between 65.90% and 98.13% and greater variation in attendances.

Ambulance arrivals in October were 2946 compared to an average of 2796 YTD, representing a 9% increase from September and 285 more (c.9 per day) as compared to last year. Turnaround times slightly dipped in October with 94.09% of patients handed over to the ED department within 15 minutes and 99.19% were handed over within 30 minutes. For the fifth consecutive month, there were no 60-minute handover breaches in month despite record numbers of ambulance arrivals being received by the Trust .

The increase in ambulance conveyances vs. 2018/19 is subject to an Activity Query Notice between SWASFT and Commissioners. An audit of activity has been undertaken and a final report has been received however; the Trust is yet to agree the associated action plan with SWASFT and commissioners.





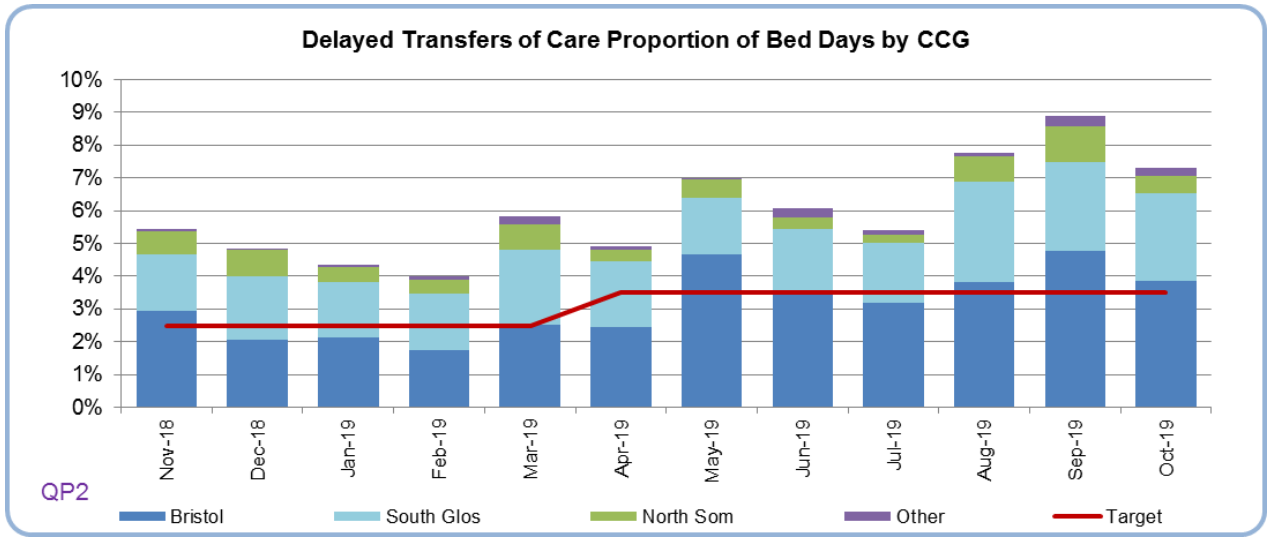
4 Hour Performance

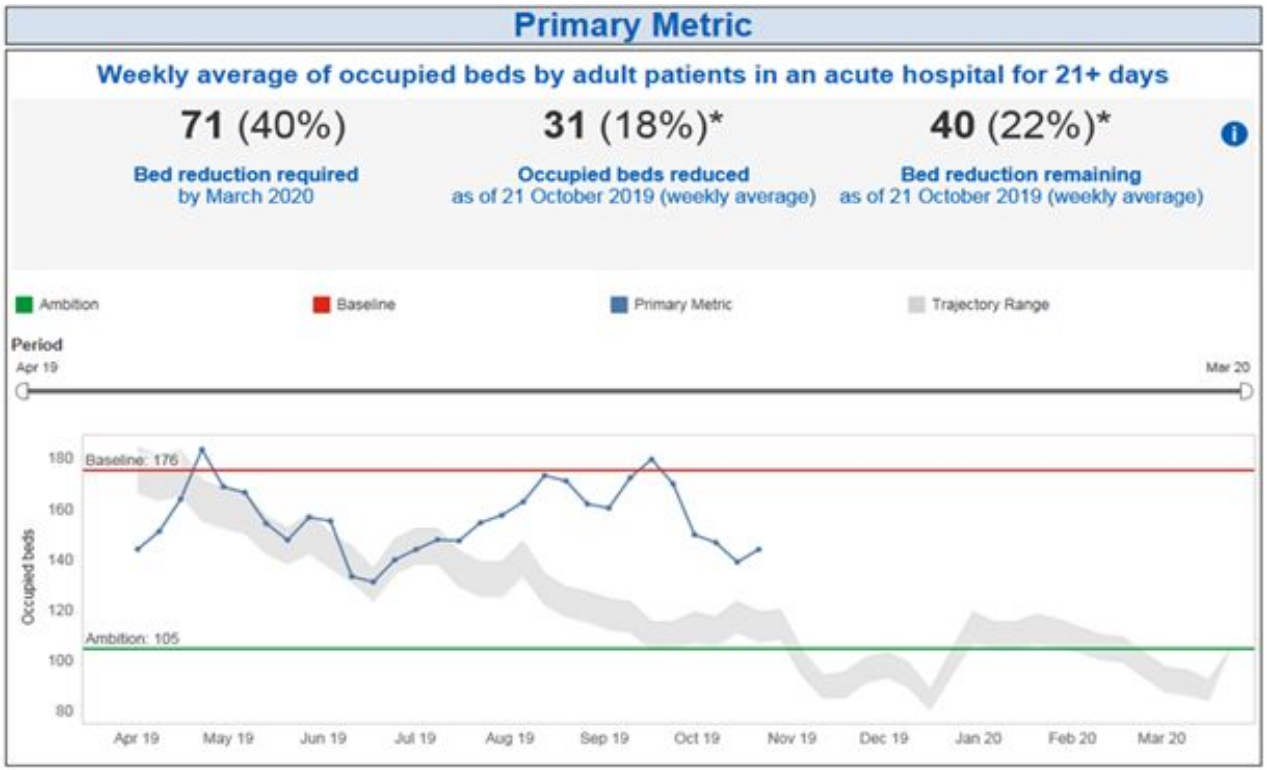
Of the breaches within ED in October, 59.76% were a result of waits for a bed whilst 21.14% were a result of awaiting assessment within the ED.

The deterioration in ED performance can be largely attributed to a decline in admitted breach performance. Non-admitted breach performance remained reasonably static and continued to achieve the 95% standard.

The overall bed occupancy position increased to 96.49% in October, compared with 95.18% in September. Bed occupancy varied between 92.61% and 99.19% in month, with a period of high occupancy coinciding with a deterioration in admitted waiting time performance. This is due to an increase in the numbers of patients presenting requiring beds and continued delayed transfers of care out of the hospital (as described in the DToC and Stranded Patient section of this report), which impacts on timely bed availability, particularly during times of surge in emergency demand.

Internal actions to drive the 4 hour recovery are overseen by the Urgent Care Improvement Steering Group. Key work streams include: increasing the proportion of same day emergency care across all divisions; criteria led discharge supported by 'Perform'; implementation of primary care streaming in ED and length of stay reduction plans.





DToCs and Stranded Patients

The DToC rate for the month of October was 7.24% of occupied bed days. If the System were at national target levels of 3.5%, this would have released 28 beds to the Trust. Extra domiciliary care and interim capacity has been established in October, which has supported the decrease in levels.

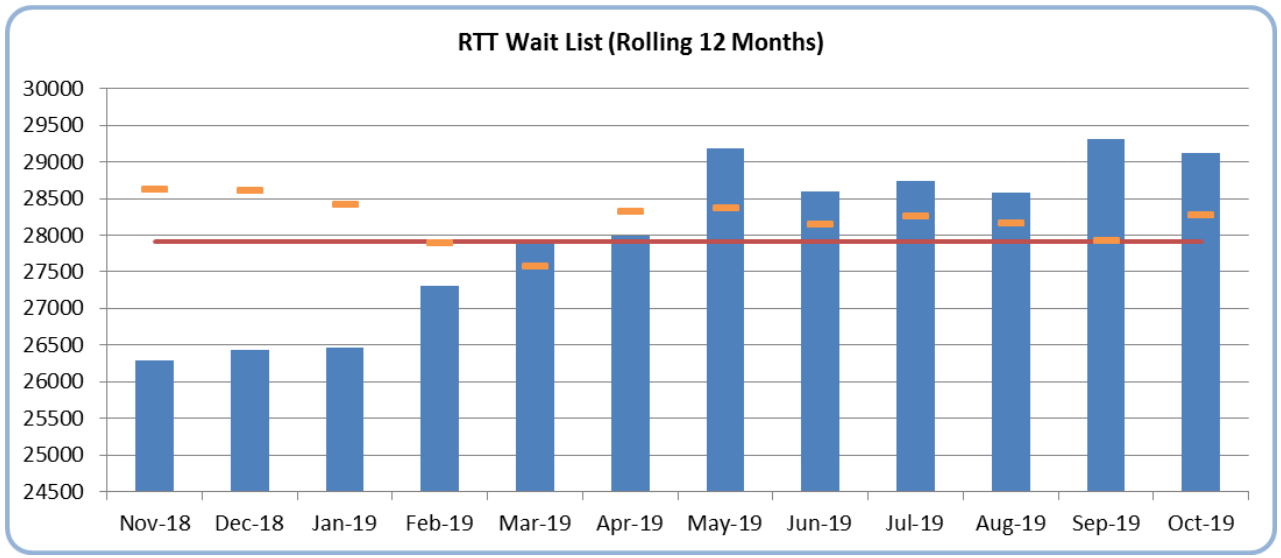
With a weekly average of 261 cases on the Leaving Hospital Patient Database in October 2019 against the September average of 218.5, the number of patients being actively progressed for complex community supported discharge and/or repatriation to another acute Trust significantly increased again through October. This is reflected in the highest level of SRFs recorded (577) since the initiation of the ICB.

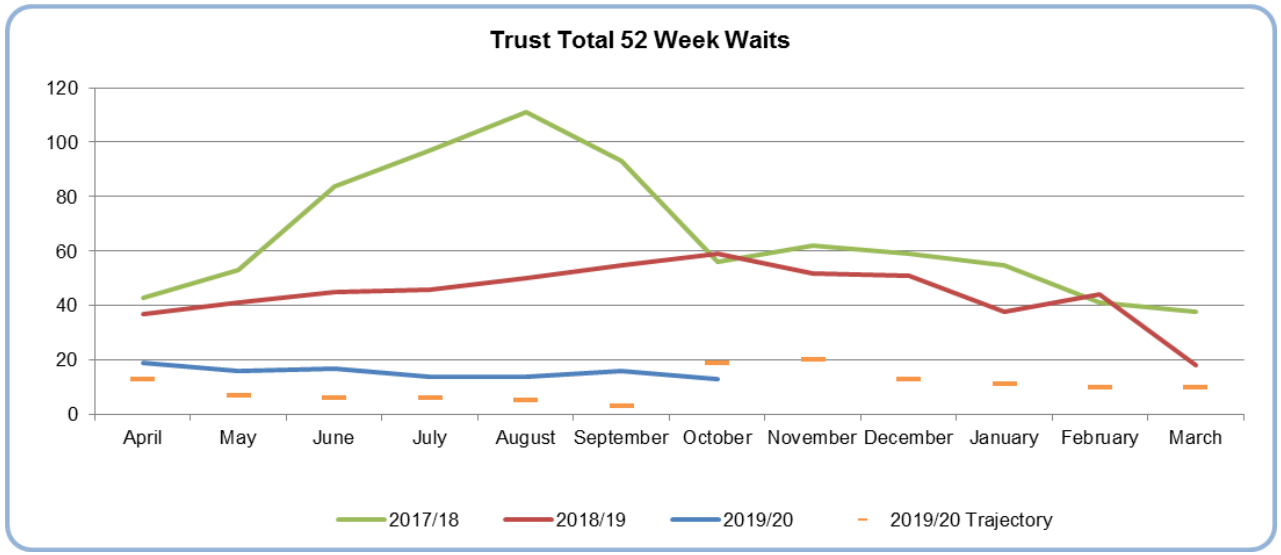
There was a reduction in reported numbers outside operational standards with 429 in total in October vs 482 in September. The top drivers of delays were:

- Waits for Pathway 1 and 2 remained high across the month with delayed bed days in total of 1650; and
- Waits for placement across all categories were reported with total bed days of 1565.

The system has reviewed these delays and have identified actions required to address including;

- Rapid response to support reablement capacity in OPEL 4 situations in Bristol;
- Capacity in Local Authority bed base that is not appropriate for rehabilitation to be available for patients waiting for reablement if not sourced within 72 hours; and
- Review of SRF to be completed to support the Trusted assessment approach.





Referral to Treatment (RTT)

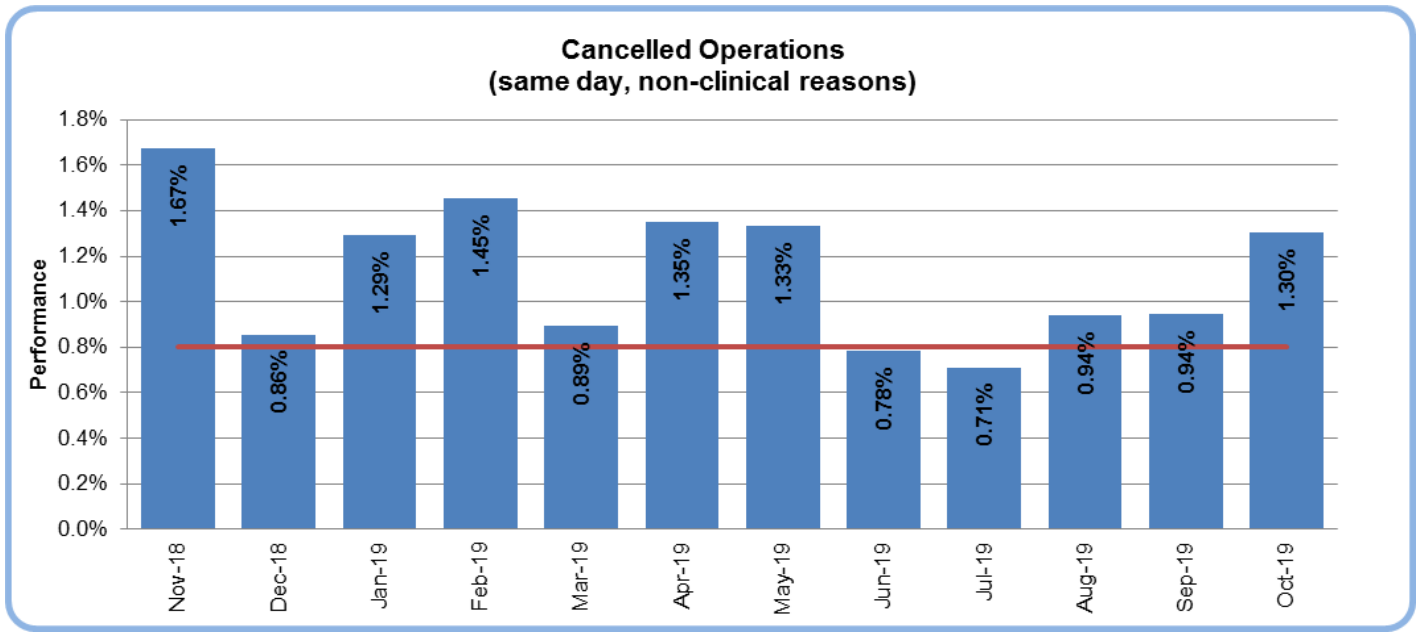
The Trust has not achieved the RTT trajectory in month with performance of 83.28% against trajectory of 88.29%.

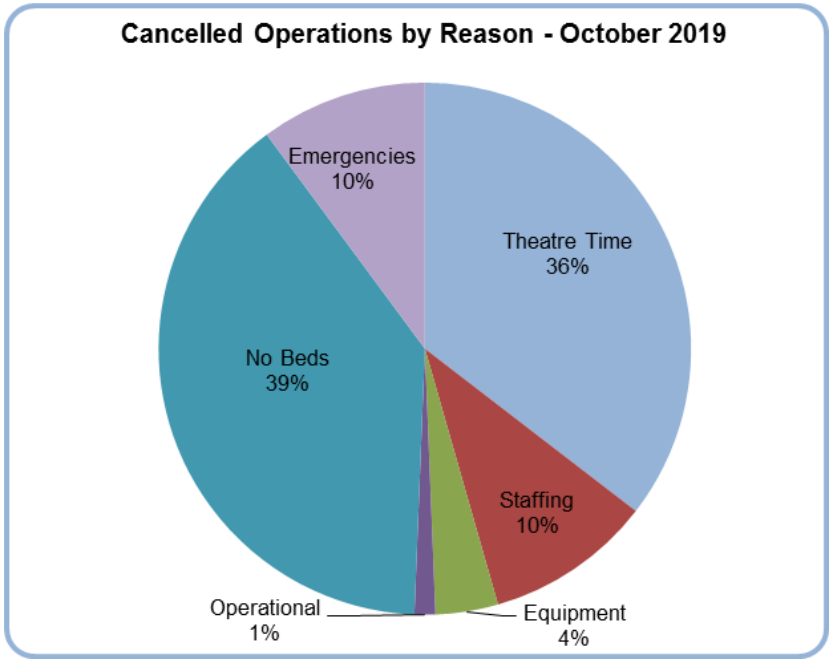
The RTT wait list size reduced in October reporting a total of 29118, down from 29313 in September. Although improved, the wait list continues to exceed the October trajectory of 28276 (2.98% variance to plan vs. a 4.97% variance last month). The reduction in October is primarily the result of increased activity in Gastroenterology. The increase during recent months is due to a combination of speciality level demand and capacity imbalance (e.g. Neurology and Gynaecology), reduction in ASIs and patients awaiting booking via a Referral Assessment Service (RAS) on eRS (coming on to the active waiting list) specifically Neurology, Rheumatology and Respiratory. Improvements in data quality are planned in November, following a shortage of validation staff within Neurology and Rheumatology specialities.

The Trust has reported a total of 13 patients waiting more than 52 weeks from referral to treatment in October 2019 against a trajectory of 19. There were 12 patients under Trauma and Orthopaedics and one in Plastic Surgery. Urology are now reporting within standard.

In the majority of cases there was capacity to treat ahead of the 52 week breach date, but not meeting the Trust expectations of two reasonable dates offered for treatment prior to week 28 in the patients' pathway.

Root cause analyses have been completed for all patients, with future dates for patients' operations being agreed at the earliest opportunity and in line with the patient's choice.





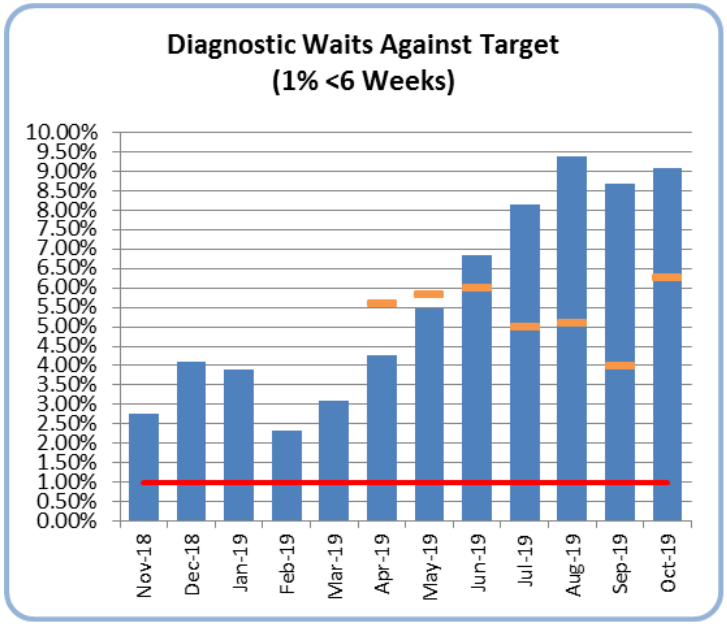
Cancellations

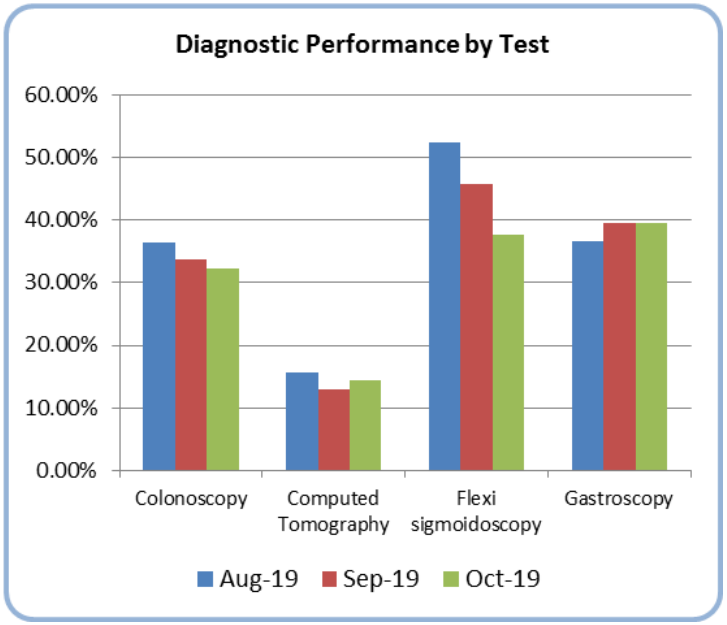
The same day non-clinical cancellation rate in October 2019 was 1.3%, failing the 0.8% national target.

For the fifth consecutive month there were no urgent operations cancelled for a second time.

The number of urgent patients who were cancelled on the day increased to 28 patients in October compared with 23 in September.

For the first time this year there have been no operations that could not be rebooked within 28 days of cancellation.





Diagnostic Waiting Times

The Trust did not achieve the national 1% target for diagnostic performance in October 2019 with actual performance at 9.09%. This is an unplanned deterioration in performance from the September 2019 position and did not achieve the Trust's recovery trajectory of 6.25%.

The same four test types have reported in month underperformance: Colonoscopy; Computed Tomography (CT); Flexi-Sigmoidoscopy; and Gastroscopy – with 1006 patients in total waiting beyond 6 weeks for their test, which is an increase from September of 953 patients. Mini Root Cause Analyses are being undertaken for any patients waiting greater than 13 weeks for their test to ensure there has been no harm as a result of the extended wait.

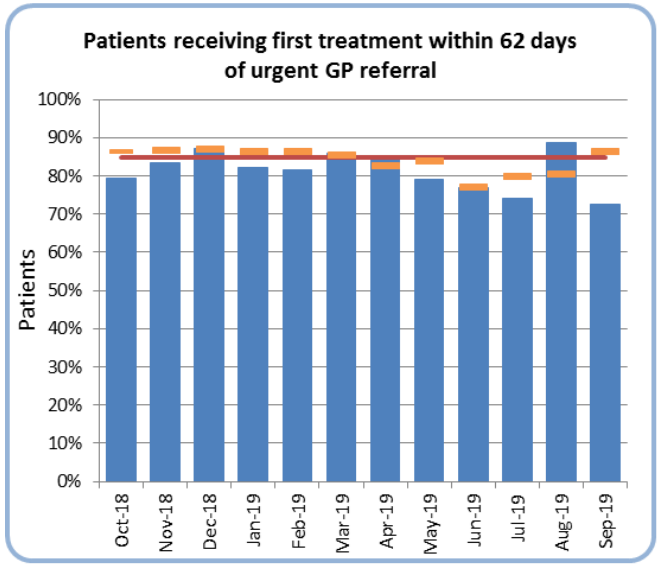
Test Type	Total Wait List	Patients waiting >6-weeks	% Performance Oct-19	% Performance Sep-19
Computed Tomography	2723	395	14.51%	12.88%
Gastroscopy	692	274	39.60%	39.45%
Colonoscopy	631	203	32.17%	33.75%
Flexi sigmoidoscopy	322	121	37.58%	45.73%

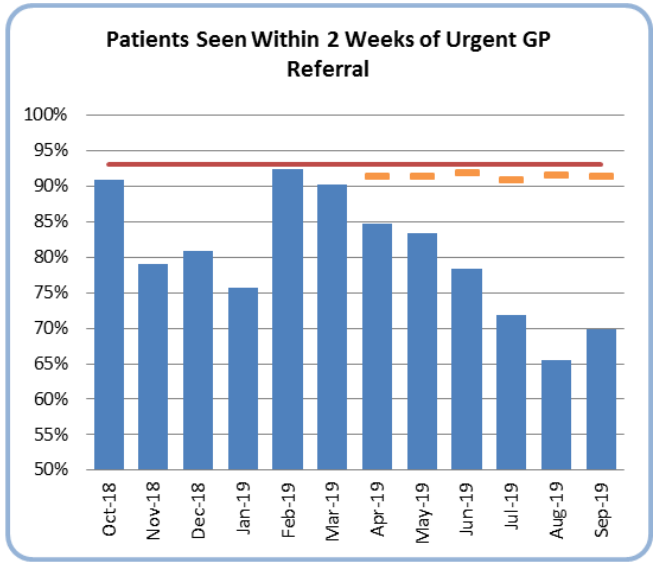
Following a large spike in demand, October CT performance reports a deterioration from September and has not met the trajectory of 13%. Additional weekend lists and outsourced capacity have been secured to help address the backlog. Clearance of the CT backlog is planned to be in January 2020.

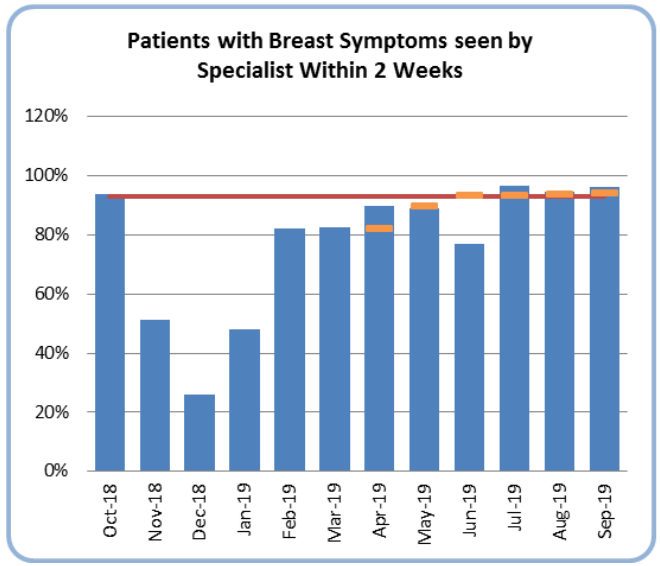
A number of plans have been implemented to improve Endoscopy performance including weekend activity undertaken by 18 Weeks and GLANSO, increased internal capacity through 6-day nursing cover and system-wide work to reviewed demand and capacity enabling establishment of longer-term plans.

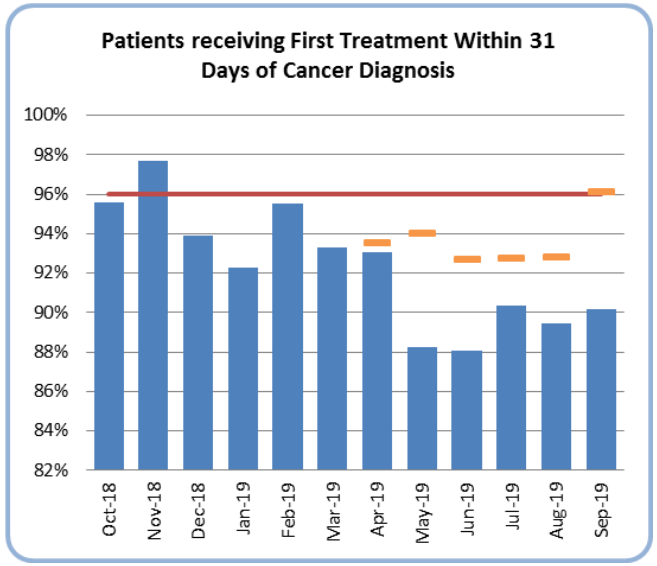
In addition, agreement has been reached with Commissioners for the Trust to outsource Endoscopy activity to an Independent Provider to enable the Trust to deliver compliance with the national wait time standard by the end of March 2020. This is an improvement against the current year-end trajectory of 2.52%.

The recovery trajectory is being reset to reflect this additional capacity and will be reported from next month onwards.









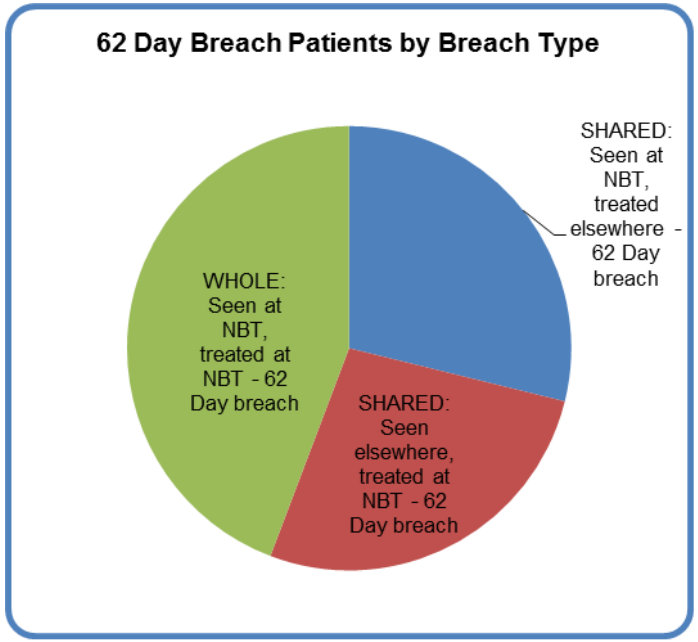
Cancer

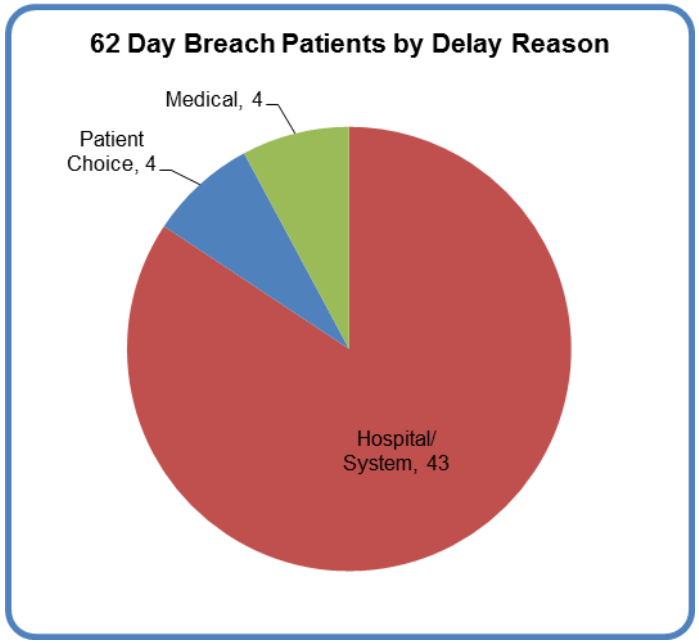
The nationally reported cancer position for September 2019 shows the Trust achieved three of the seven cancer waiting times standards – Breast Symptomatic, 31 day subsequent drug and 62 day screening. Compliance of the 62 day standard forecasted from quarter one of 2020/21 remains on track.

The Trust failed the TWW standard with performance of 69.92%. The Trust saw 2144 TWW patients in September and there were 645 breaches; the majority were in Skin (breaches 548, patients seen 701), Gynaecology (breaches 19, seen 178), Colorectal (breaches 34, patients seen 340) and Breast (breaches 12, patients seen 471). Of the 645 breaches, 533 related to internal capacity issues mostly within outpatients, radiology and endoscopy. 104 patients declined the first offer of an appointment date requesting a later date; the main reason given - patient on holiday.

The Skin speciality achieved all but one of the national standards in September, failing 2WW with 21.83% due to backlog clearance. Performance is much better in October/November therefore we expect Skin to be compliant by year end.

The Trust failed the 31 day first treatment standard with performance of 90.20% against the 96% target. There were 25 breaches in total: 22 in Urology; 1 in Breast; 1 in Skin; and 1 in Colorectal – the majority of which were related to lack of capacity.





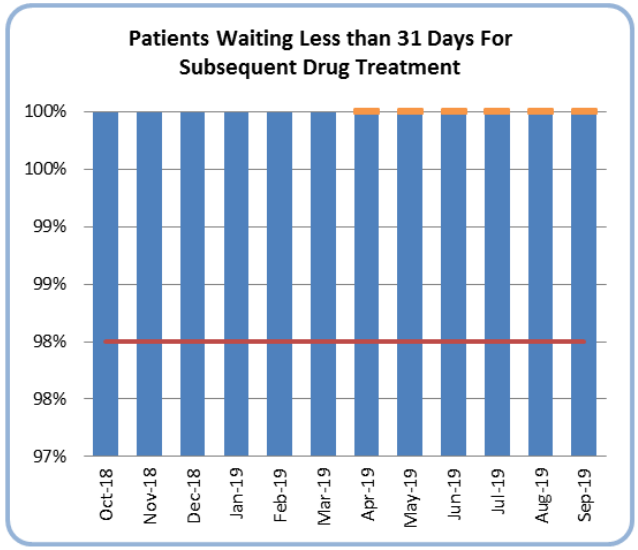
The Trust did not achieve the 62 day standard in September with a performance of 72.58%. The earlier August achievement was unstainable. Urology's performance for September is 51.06%. This is expected to worsen in October due to the RALP backlog clearance plan.

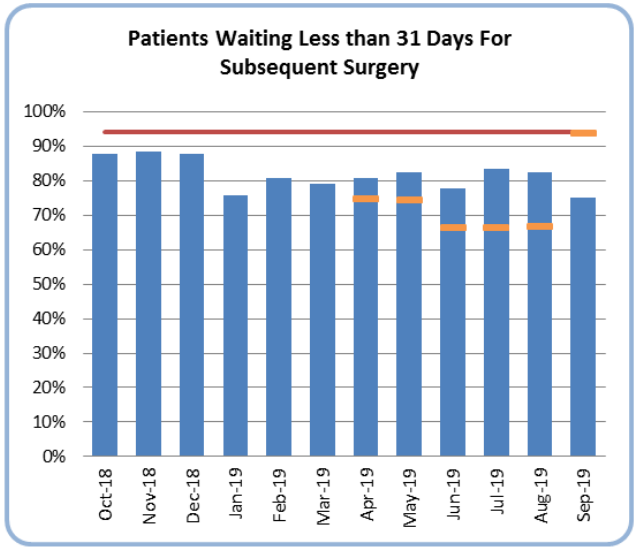
In September, 42 patients breached the 62 day standard, fourteen of which started their pathway elsewhere and were treated at NBT, 8 of the fourteen were referred beyond 38 days.

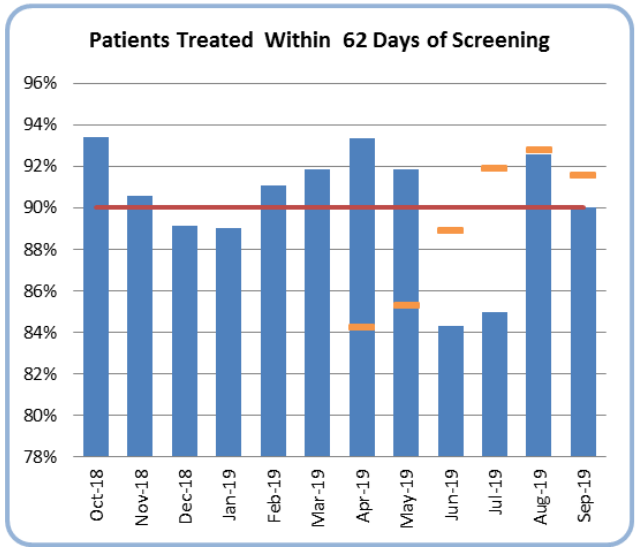
The Trust submission for 31 Day first treatment was 90.20%, with 25 breaches, 22 of the breaches were in Urology, two of which were transferred into the Trust beyond day 38 of their pathway. Other 31 day breaches recorded in September were: 1 in Breast (patient choice); 1 in Skin (capacity); and 1 Colorectal (Complex Pathway).

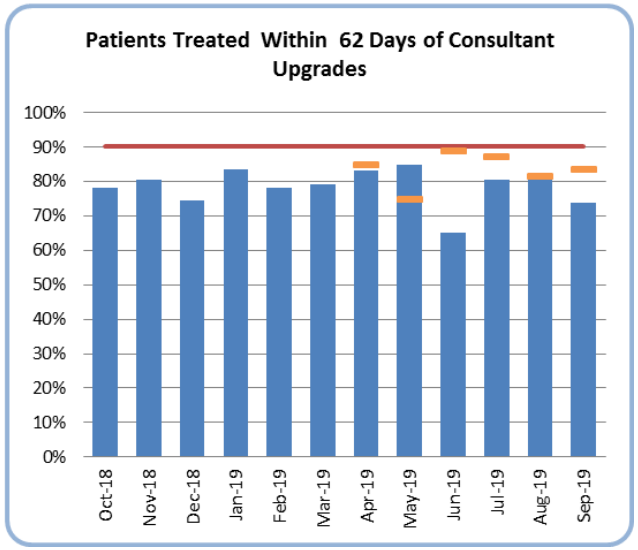
As part of performance improvements the Trust has been monitoring its internal performance against the 62 day standard. The Trust treated 72.61% of all patients who were initially referred to and treated at NBT within the national standard.

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









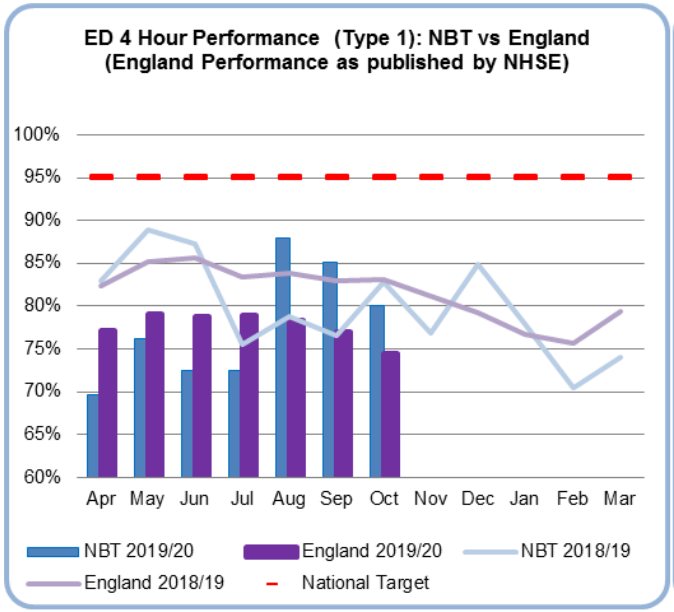
The Trust failed the 31 day subsequent treatment target in September for patients requiring surgery, with a performance of 75.23% against the 94% standard.

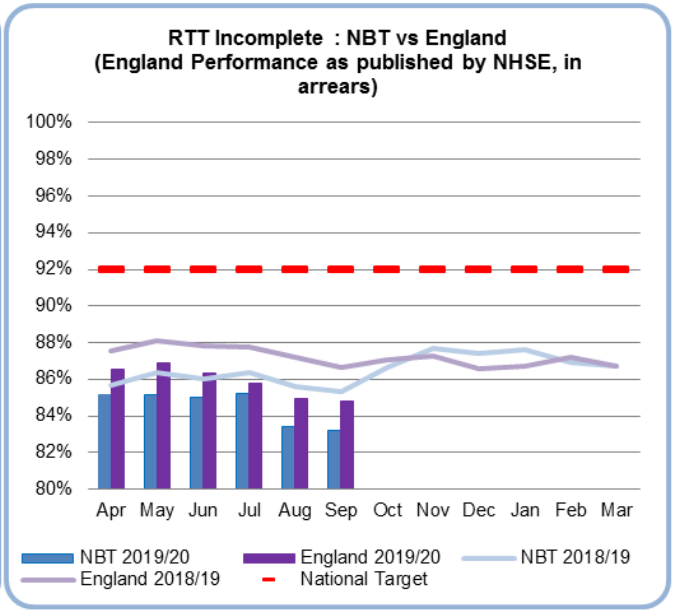
In September there were 27 breaches in total: 12 in Urology, 11 in Skin, 3 in Breast and 1 in Sarcoma. The main reason for the breaches was surgical capacity.

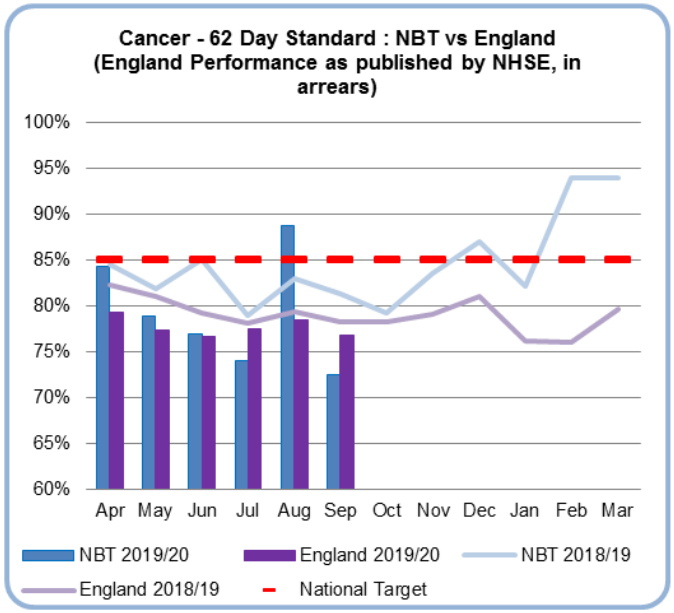
There were 23 over 104 day breaches in September; 19 required a harm review at NBT via Datix, 3 were treated elsewhere and will be subject to their internal process of harm review. 2 breaches were active monitoring and 2 were late transfers.

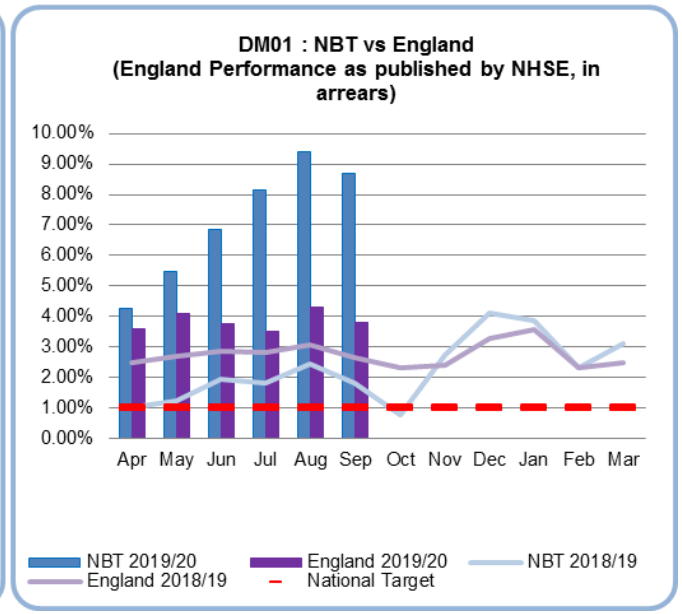
Urology remains the only specialty with 104 day breaches; 19 are under review.

Since the harm review process for patients waiting over 104 days was introduced in 2019, no instances of harm have been found.









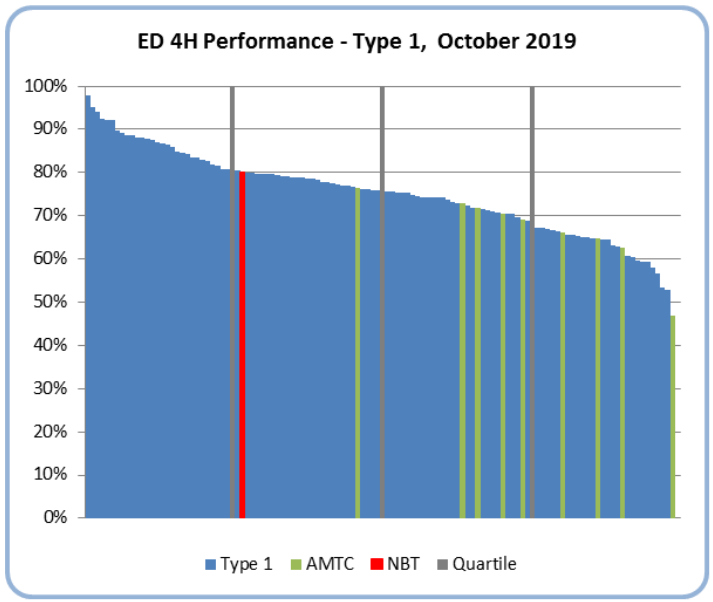
ED 4 Hour Performance
NBT ED performance in October 2019 was 80.04% compared to a national Type 1 position of 74.46%. This is the third consecutive month NBT outperformed the national position. The position reflects a decline from September.

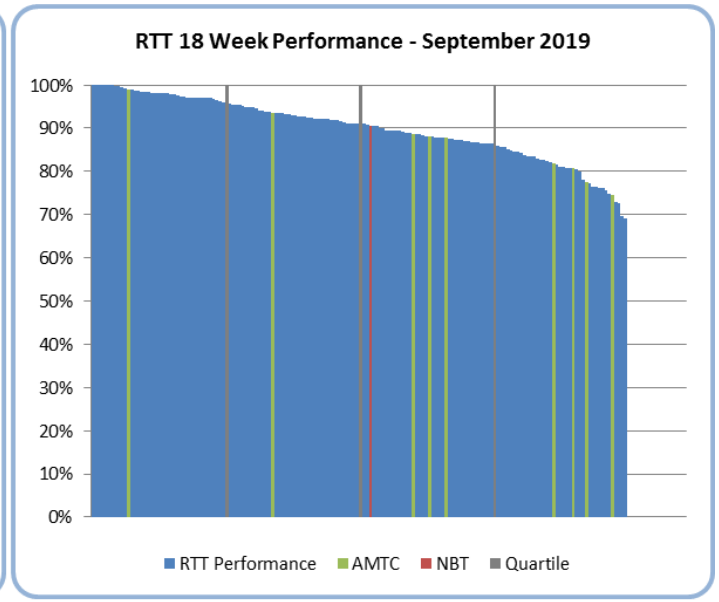
RTT Incomplete
The Trust reported a September 2019 position of 83.20%. This position reflects a decline on last year and falls under the national position of 84.78%.

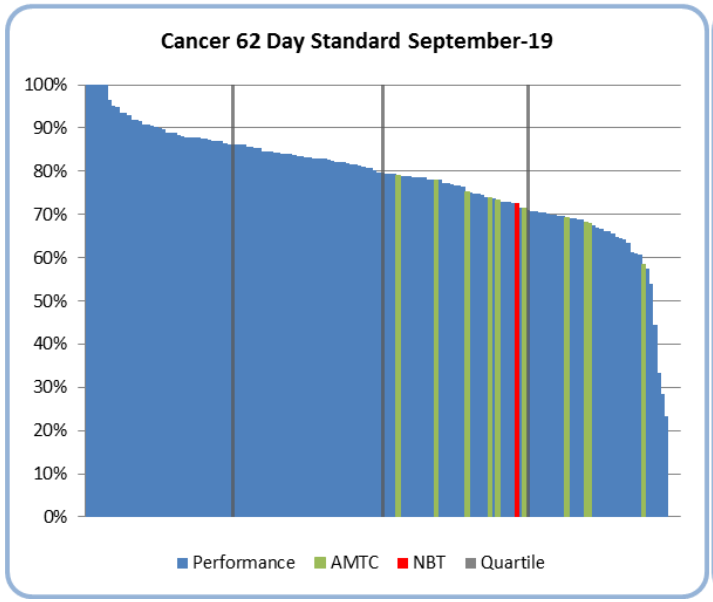
Cancer – 62 Day Standard
NBT has reported an anticipated decline in performance for September reporting at 72.58%, which is less than the national position of 76.58%.

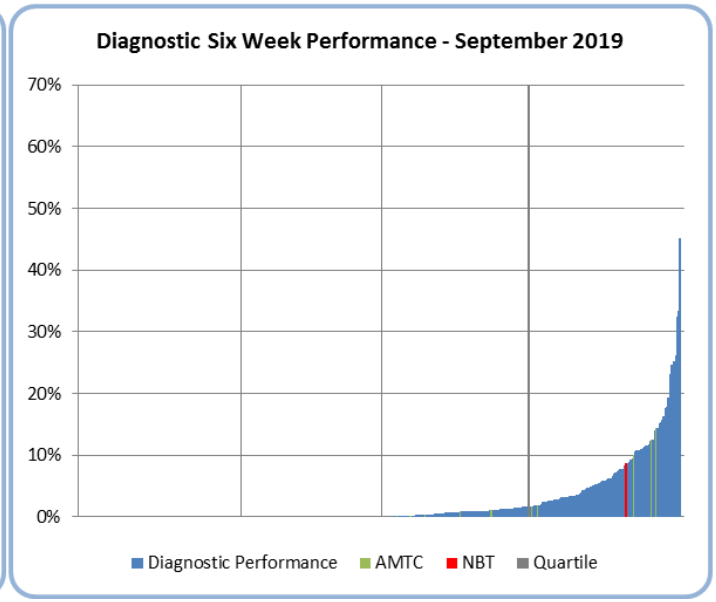
DM01
In September 2019, NBT failed to achieve the national standard of 1% with an improved performance position of 8.69%, against the national position of 3.79%.

Performance across all four standards for both the local NBT position and the national position show a deterioration from October 2018.









ED 4 Hour Performance
In October, NBT moved to a position of #32 from #23 out of 119 reporting Type 1 Trusts. This has meant the Trust has marginally missed the upper quartile. The Trust's ranking among the 10 Adult Major Trauma Centres remained as 1st by a significant margin in October 2019, despite the decline in performance.

RTT Incomplete
RTT performance in September 2019 was a reported NBT position of #79 out of 158 Providers. The Trust moved to rank 4 out of 10 other Adult Major Trauma Centres. The Trust is reporting within the 3rd quartile.

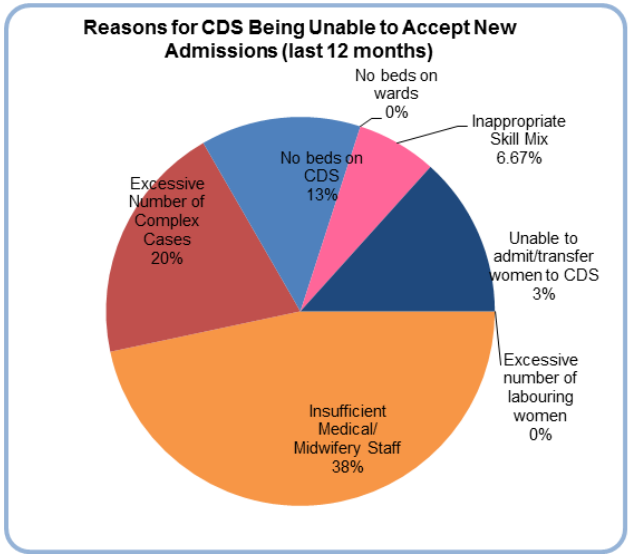
Cancer – 62 Day Standard
At position #105 of 145 reported positions, This represents a planned deterioration in positioning from August 2019 and ranks the Trust 6th out of 11 Adult Major Trauma Centres and within the 3rd quartile.

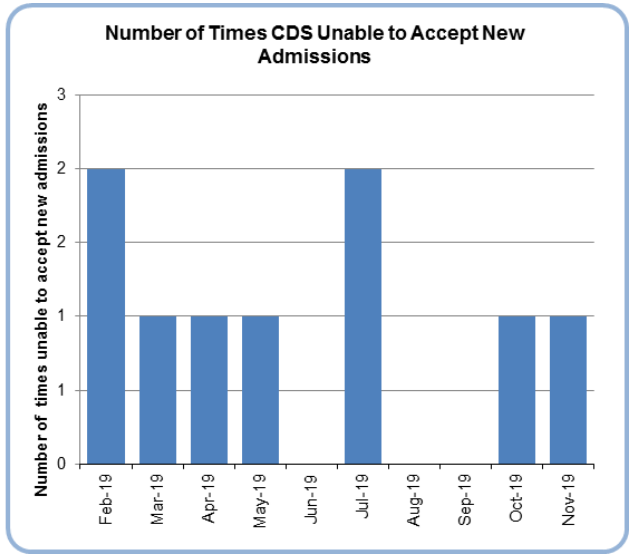
DM01
NBT reports a static position of #156 out of 192 reported diagnostic positions, with a performance of 8.69% in September. This position ranks 8th out of 11 Adult Major Trauma Centres and remains within the 4th quartile.

Safety and Effectiveness

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

Birth		Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19
Total Births		497	491	478	458	448	439	490	454	524	481	455	497
Midwife to birth ratio		01:30	01:31	01:30	01:30	01:28	01:27	01:30	01:28	01:32	01:29	01:28	01:30
Normal birth rate		53.1%	51.1%	56.0%	51.1%	55.7%	53.69%	56.26%	56.08%	53.80%	53.04%	53.90%	53.24%
Caesarean birth rate		32.1%	34.4%	32.1%	37.9%	32.0%	35.02%	30.80%	30.41%	31.58%	33.96%	32.29%	32.79%
Emergency Caesarean birth rate		19.2%	19.1%	18.0%	23.0%	17.7%	22.35%	19.30%	21.17%	15.98%	19.92%	18.04%	16.19%
Induction of labour rate		34.9%	33.4%	34.0%	37.7%	38.3%	41.47%	36.14%	43.02%	36.45%	38.16%	36.53%	38.46%
Total births in midwife led environment		14.3%	7.9%	14.9%	12.0%	14.5%	15.37%	17.86%	14.13%	13.37%	13.60%	13.11%	8.87%
Birth location	Cossham BC	0.0%	0.0%	0.0%	0.0%	0.0%	0.00%	0.00%	0.00%	0.00%	0.21%	0.00%	0.00%
	Mendip BC	12.9%	6.7%	12.6%	10.7%	13.4%	12.84%	16.63%	12.78%	12.40%	12.55%	11.78%	7.86%
	Home	1.2%	1.2%	2.3%	1.3%	1.1%	2.52%	123.00%	1.35%	0.97%	0.84%	1.33%	1.00%
	CDS	84.5%	89.6%	83.7%	86.7%	83.3%	84.17%	80.29%	83.63%	84.11%	85.15%	86.00%	89.31%
One to one care in labour		95.4%	95.9%	97.4%	97.7%	96.0%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%
Stillbirth	Actual	1	2	2	3	5	2	2	2	1	2	3	4
	Rate	0.20%	0.40%	0.41%	0.60%	1.10%	0.45%	0.41%	0.44%	0.19%	0.41%	0.66%	0.80%





Recruitment

- Successful recruitment to vacant posts in line with the current and projected plan.
- New lead midwife appointed for Antenatal Clinic.
- Senior midwife (SBAR) in progress for Saving Babies Lives v2 required to meet the improvements in CTG interpretation and training across the service.
- Birth rate plus workforce tool has been completed and initial findings discussed and agreed with the team.

Findings suggest shortfall in midwives based on increased acuity and shortfall in specialist posts (scoping currently in progress along with SBAR/business planning process) .

Midwifery Led Services update

- Cossham Birth Centre opened – currently running with an open on arrival model supported by an on call. Audit of all deliveries, transfers and feedback from women in place.
- Audit in progress of Babies Born before Arrival during the year and postnatal readmissions to assess the impact of the community midwifery on call and the plans to reinstate.

Areas of concern

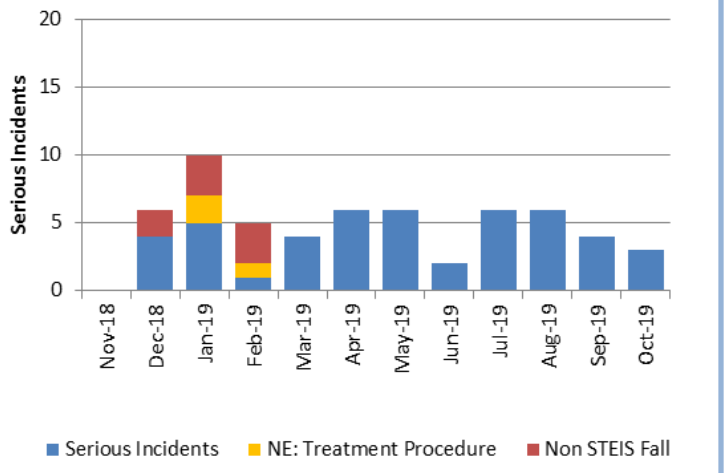
- Impact of national guidance driving significantly increased numbers of women requiring Induction of Labour (IOL). Delays in care impact - outcomes and women's experience .

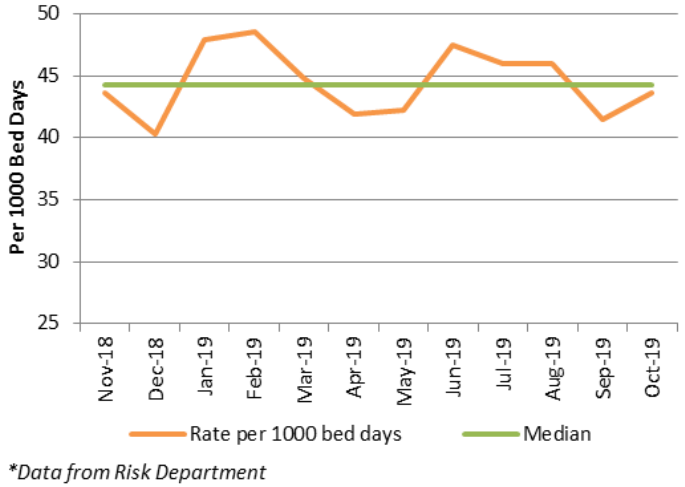
Action – IOL suite adjacent to CDS in development. Trial period in December with official opening date of 7 January 2020.

'My Pregnancy @ NBT' smartphone app launched on 04 May 2018 to replace patient information leaflets and give women and families access to evidence based care 'on-the-go' wherever and whenever they choose – new anaesthetic videos designed and attached November 2019

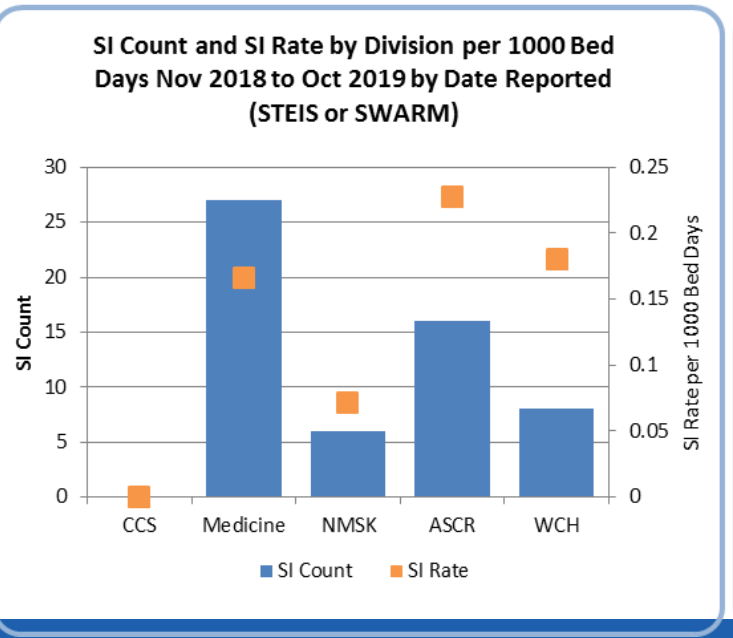
Quality & Patient Safety
Additional Safety Measures

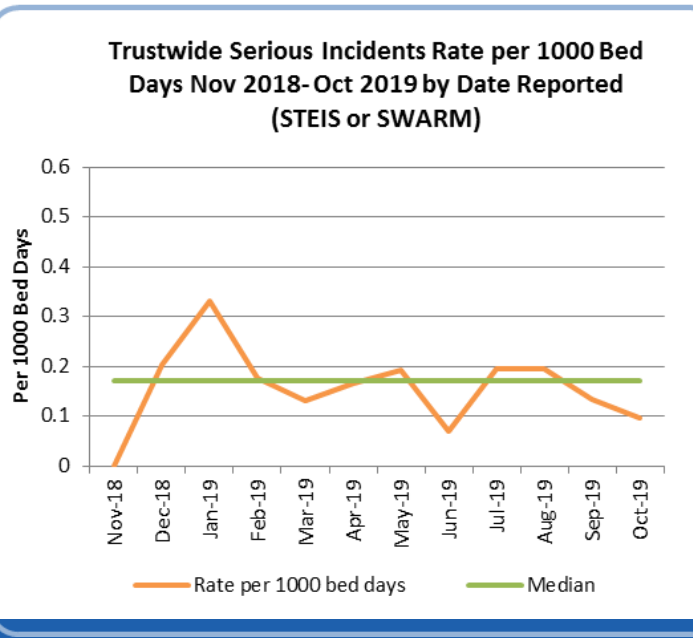
Board Sponsor: Director of Nursing & Quality





*Data from Risk Department





Serious Incidents (SI)
Three serious incidents were reported in October 2019:

- 2 x Patient Falls
- 1 x Treatment or Procedure

Never Events:

There were no Never Events in October 2019, with the last reported Never Event being 26 January 2019.

SI & Incident Reporting Rates

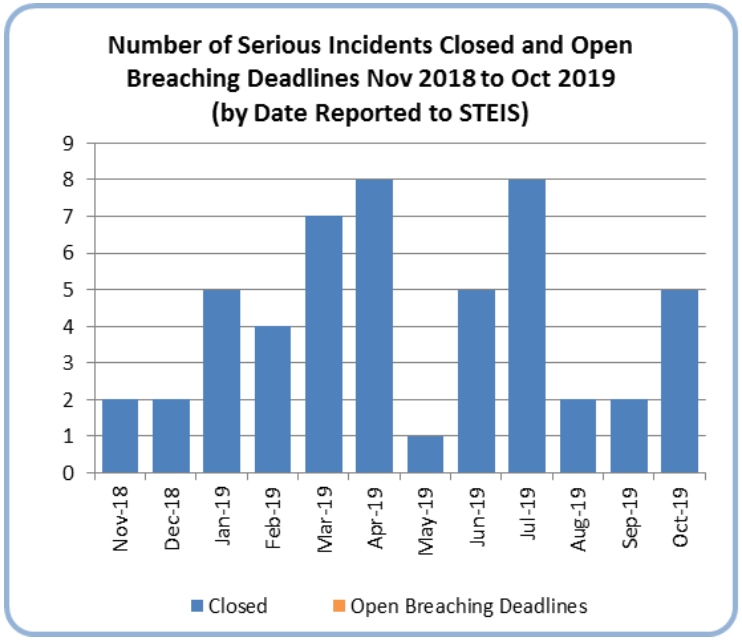
Incident reporting has increased in October to 44.23 per 1000 bed days. Whereas NBT's rate of reporting patient safety incidents remains within national parameters, it is noted that we are in the lower quartile of similar NHS Trusts.

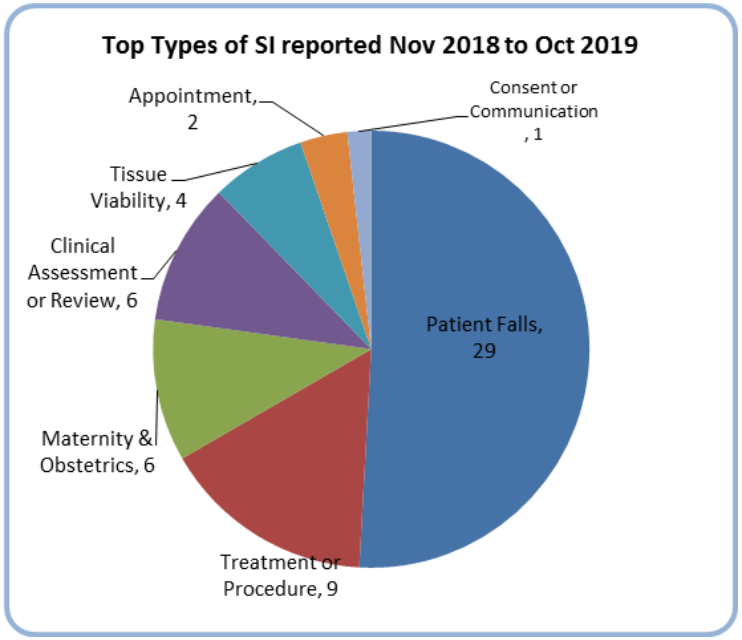
The Patient Safety Incident Improvement Project is focusing on improving our rates of reporting to facilitate learning.

Divisions:
SI Rate by 1000 Bed Days
ASCR – 0.23
WCH – 0.18
Med – 0.16
NMSK – 0.07
CCS – 0

Quality & Patient Safety
Additional Safety Measures

Board Sponsor: Director of Nursing & Quality





CAS Alerts – October 2019				
Alert Type	**Patient Safety**	**Facilities**	**Medical Devices**	**Supply Distribution Alerts**
New Alerts	0	1	8	3
Closed Alerts	0	0	6	3
Open alerts (within target date)	0	1	2	0
Breaches of Alert target	0	0	0	0
Breaches of alerts previously issued	0	0	0	0

Data Reporting basis
The data is based on the date a serious incident is reported to STEIS. Serious incidents are open to being downgraded if the resulting investigation concludes the incident did not directly harm the patient i.e. Trolley breaches. This may mean changes are seen when compared to data contained within prior Months' reports

Central Alerting System (CAS)
12 new alert reported, with none breaching their response target dates.

Incident Reporting Deadlines for Serious Incident Investigation submission

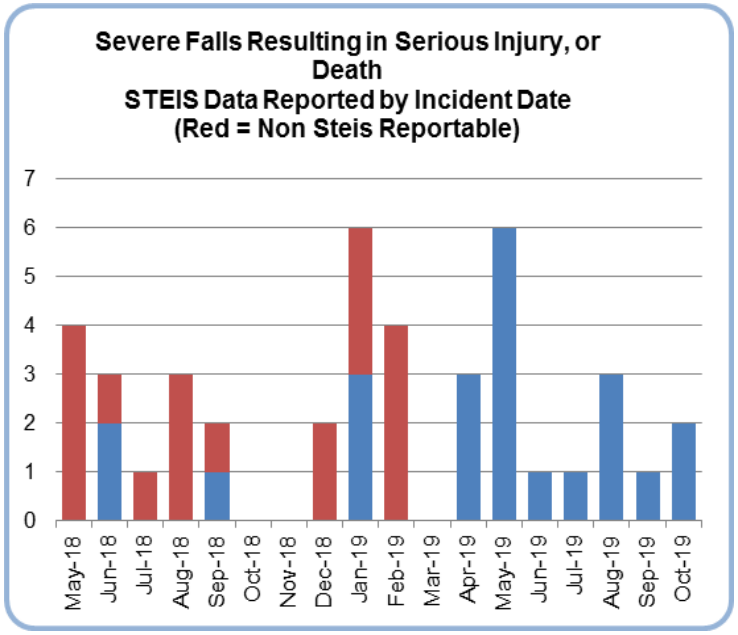
No serious incidents breached their October 2019 reporting deadline to commissioners. There have been no breaches since July 2018.

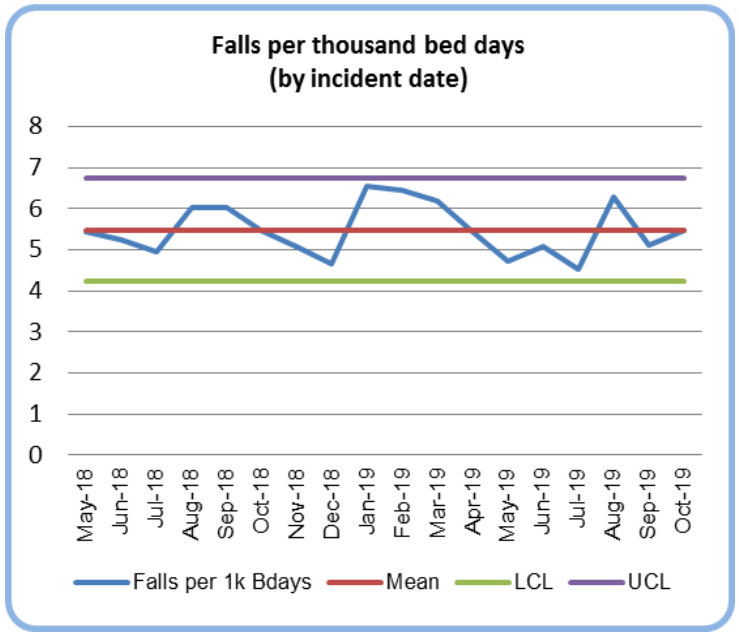
Top SI Types in Rolling 12 Months

Patient Falls remain the most prevalent of reported SIs. These are monitored through the Trust Falls Group.

A Falls presentation was given to the September 2019 Patient Safety & Clinical Risk Committee.

This is followed by
- Treatment or Procedure
- Maternity & Obstetrics.
- Clinical Assessment or Review





Falls

In October 2019, 173 falls were reported of which; two resulted in severe harm, two were categorised as moderate, 42 low and the remaining 127 as no-harm. The majority of reported falls occurred within Medicine Division (108), with the others occurring in NMSK (42), ASCR (21), CCS (1) and Women's and Children (1).

The falls per 1000 bed days level was 6.6 which is an upturn as a consequence of more no-harm reported falls.

Falls CQUIN Quarter 2 WebEx Feedback

The picture from Providers who shared their Quarter 2 data highlighted a large variance in performance.

The Trust's performance has improved in Quarter 2 as demonstrated in the figures below, especially with the 'lying to standing blood pressure assessments':

CQUIN standards:

1. Patients prescribed high risk drugs have clear rationale for doing so
2. Patients have Lying and Standing Blood Pressure checked at least once during admission
3. Patients receive a) mobility assessment and b)mobility aid within 24 hours of admission

Quarter 1 delivery:

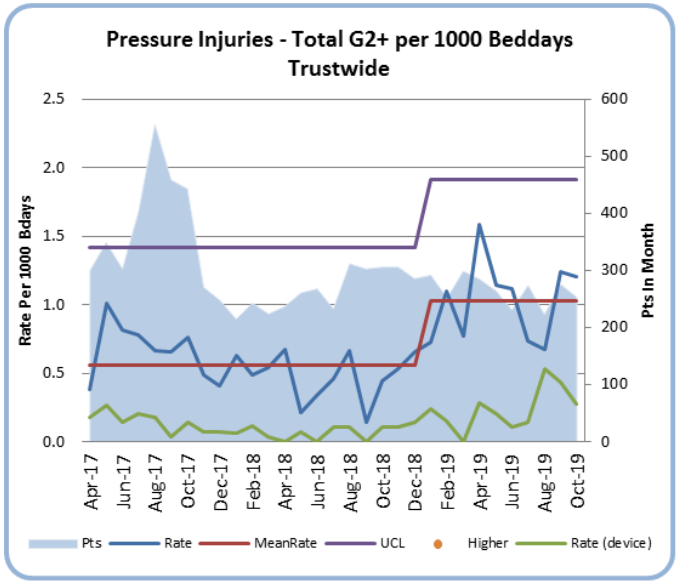
1. 80% achieved
2. 19% achieved
3. a) 93% and b) 97% achieved

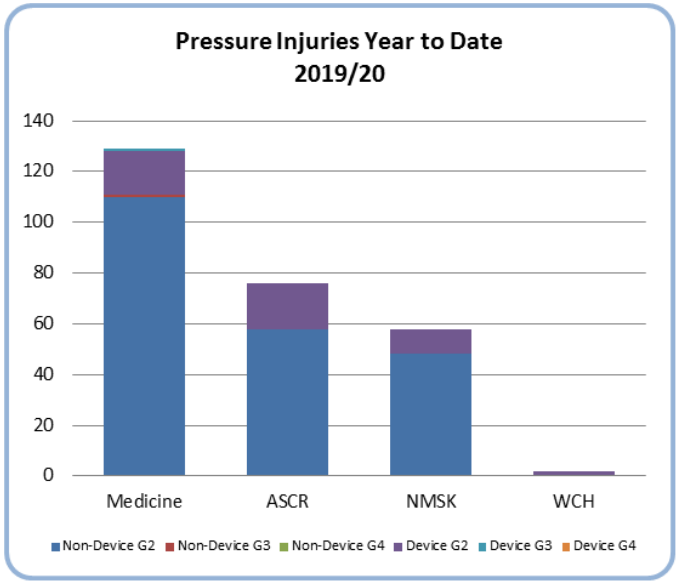
Quarter 2 delivery:

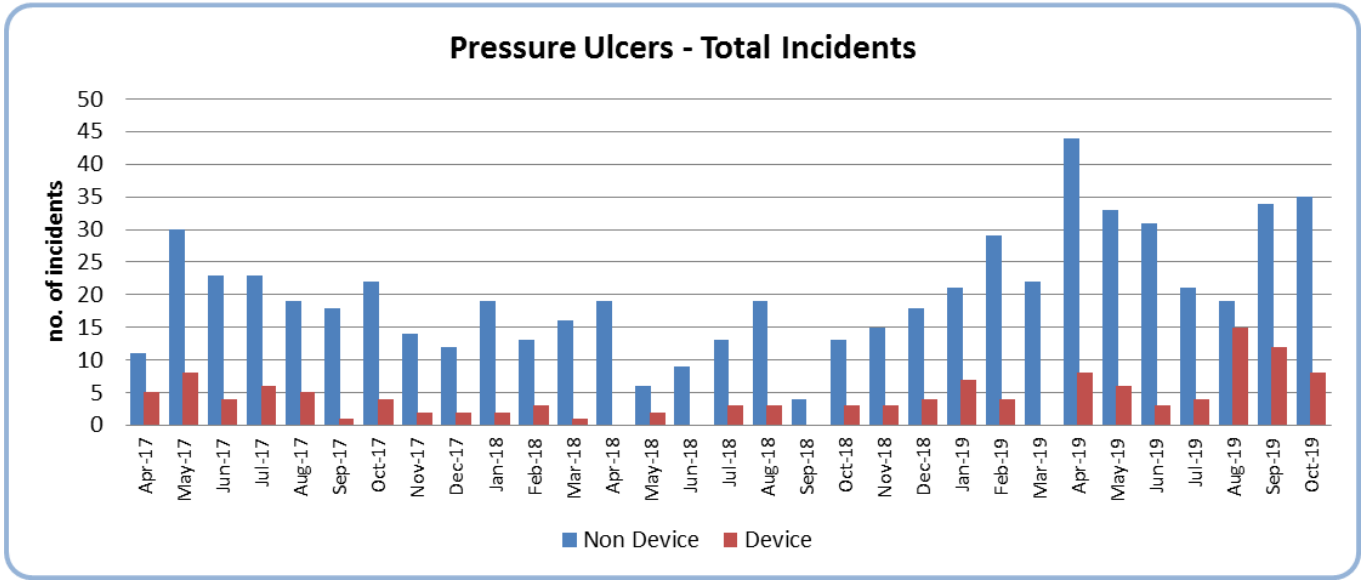
1. 87.5% achieved
2. 57% achieved
3. a) 96% and b)100% achieved

A strong network of Falls Champions continues to be developed to support our improvement work as close to the point of care delivery as possible.

One of the highest performing Providers is using a band 2 patient safety link role in AMU. This person is responsible for completing/making sure Lying and Standing Blood Pressure assessments are completed. This role could also incorporate other safety aspects within an assessment unit environment. This will be discussed with AMU and the case for investment will be considered.







Pressure Injuries (PIs)

The Trust ambition for 2019/20 is a

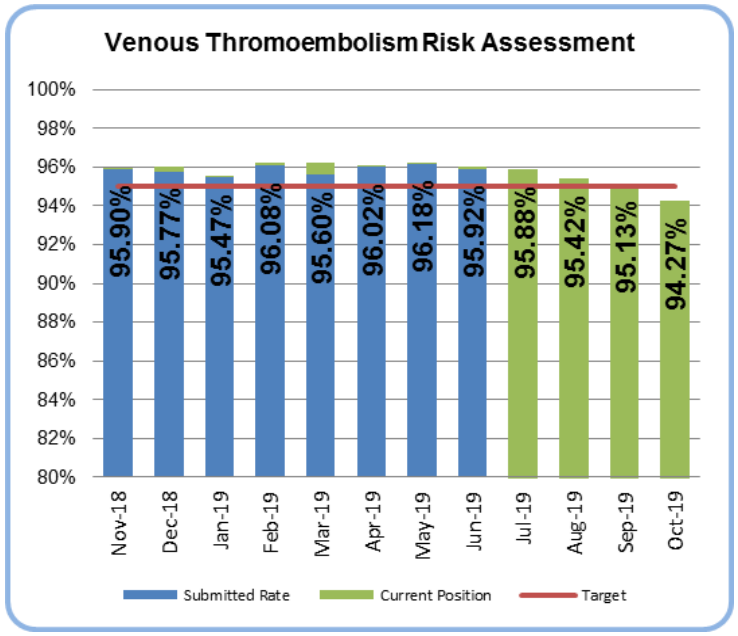
- 30% reduction of Grade 2 pressure injuries.
- 30% reduction of device related pressure injuries
- Zero for both Grade 3 and Grade 4 pressure injuries.

No Grade 4 or 3 pressure injuries were reported in October 2019.

The Trust reported 43 Grade 2 injuries for October, which occurred to 33 patients, which is a slight decrease on the previous month, with a reduction in device related injury. The break down of injury is as follows:

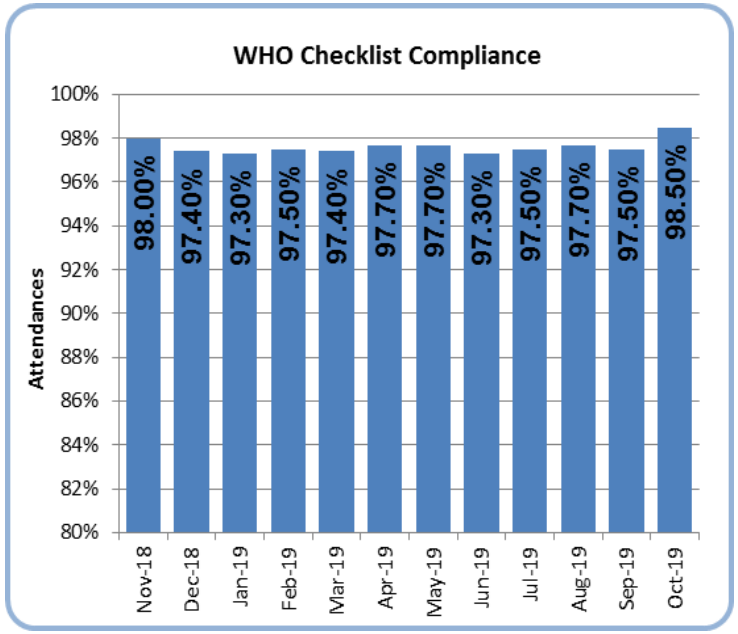
Buttocks / Natal cleft: 35%
Heel: 23%
Other: 21%
Medical device: 21%

The organisational response to the increase in the incidence of pressure injuries, continues with the Heads of Nursing and matrons across inpatient areas undertaking key elements of quality improvement. Progress on the pressure injury reduction will be presented at this months board by representatives of the clinical divisions.



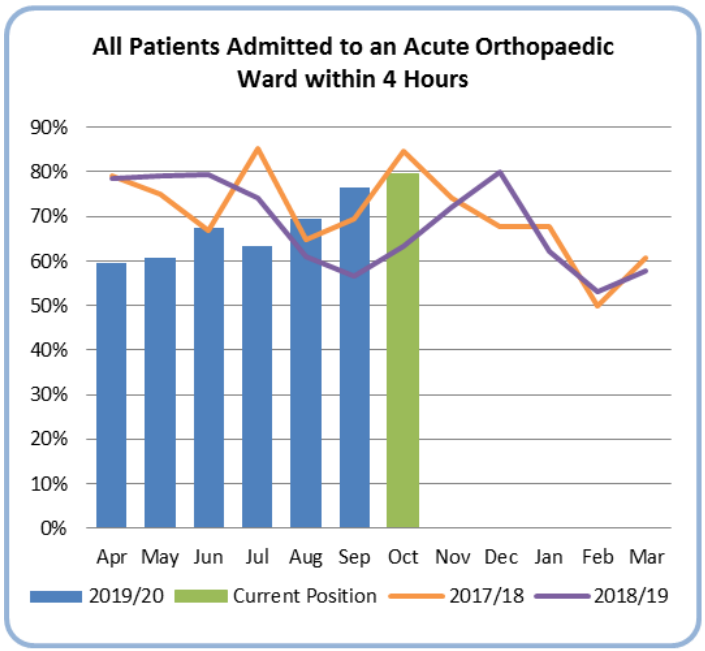
VTE Risk Assessment

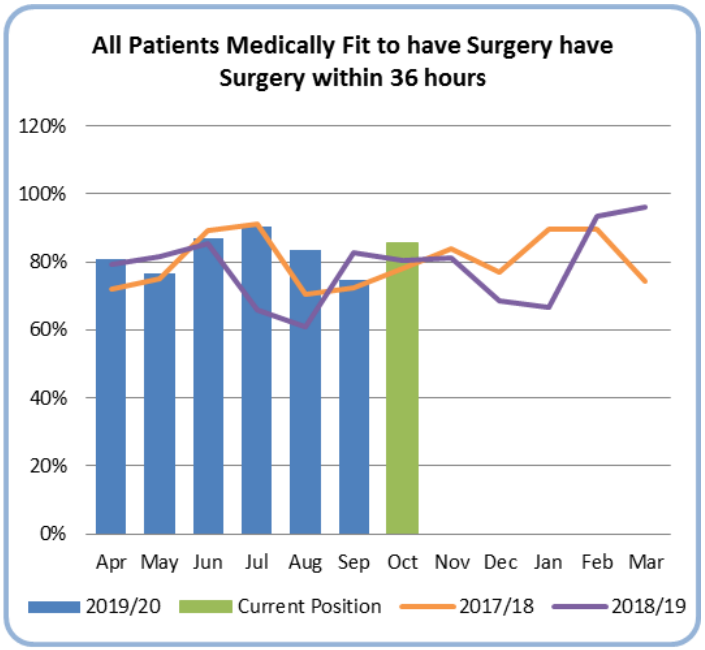
The Board expects a VTE risk assessment to be carried out for all appropriate in-patients. Performance in recent months has met the target but been less secure and the Thrombosis Committee are considering the key actions that will ensure sustained delivery.

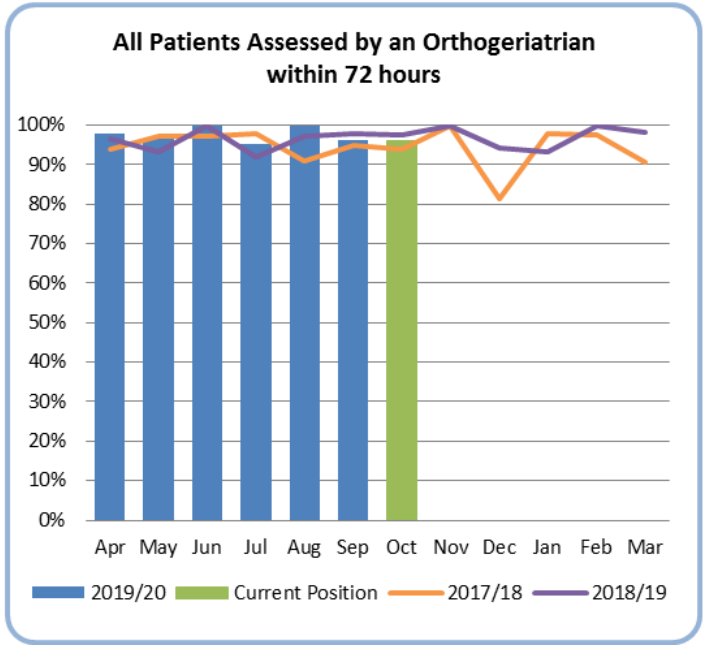


WHO Checklist Compliance

The Board expects that a WHO surgical safety checklist will be completed and documented prior to each operation in theatres. Any areas failing to record compliance are addressed by the relevant leadership team.





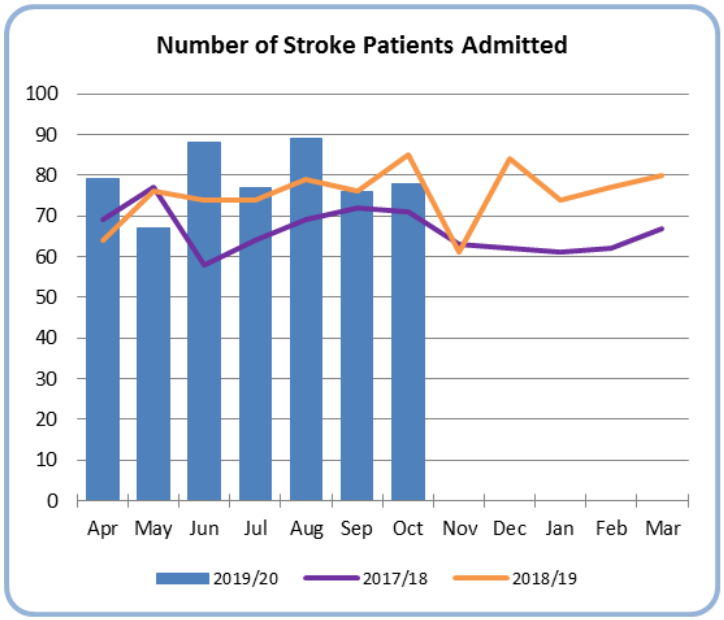


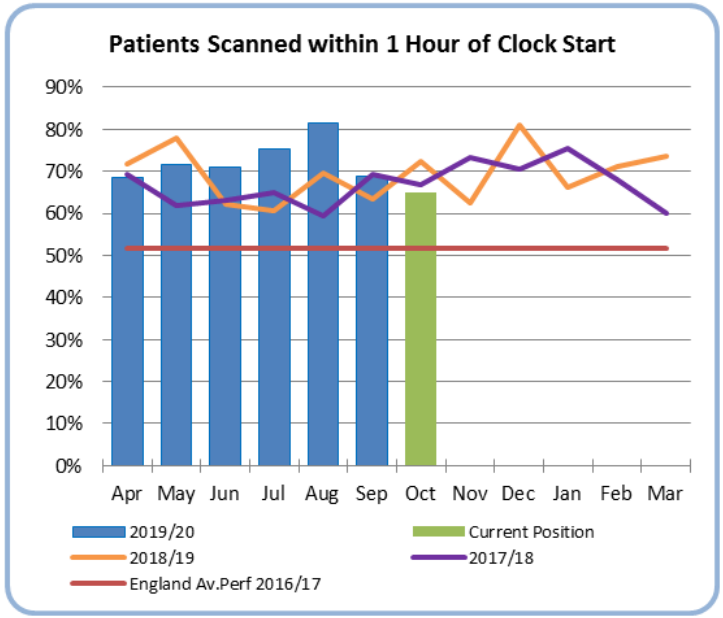
Fractured Neck of Femur in Patients aged 60 years and over

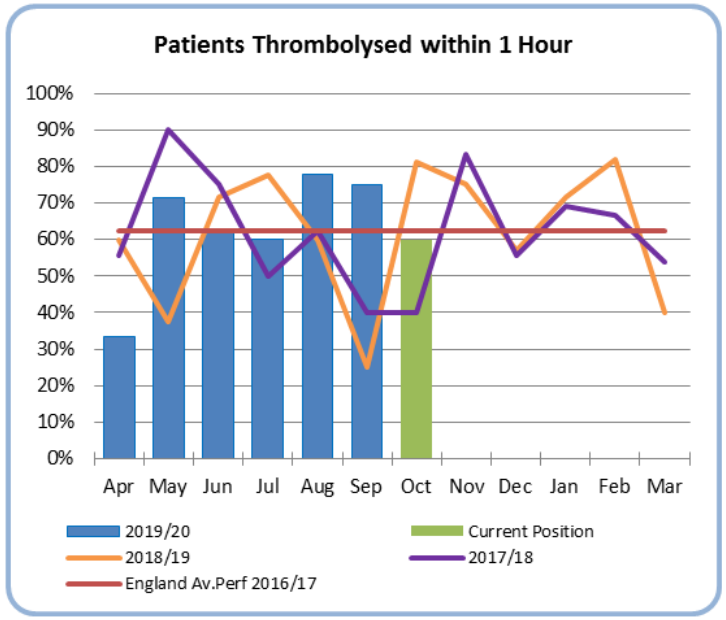
Patients admitted to an acute orthopaedic ward within 4 hours

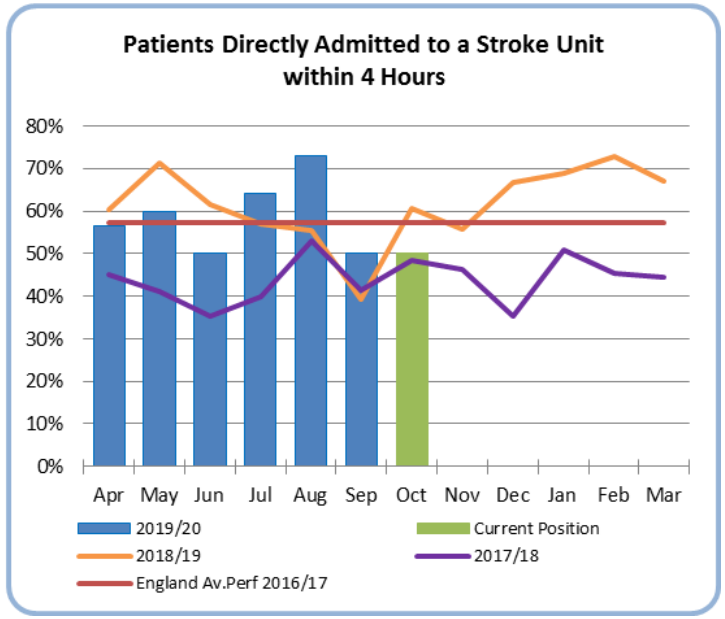
Hip Fracture data is reported one month in arrears with the current month included for reference.

There was sustained performance against key metrics for hip fracture care.







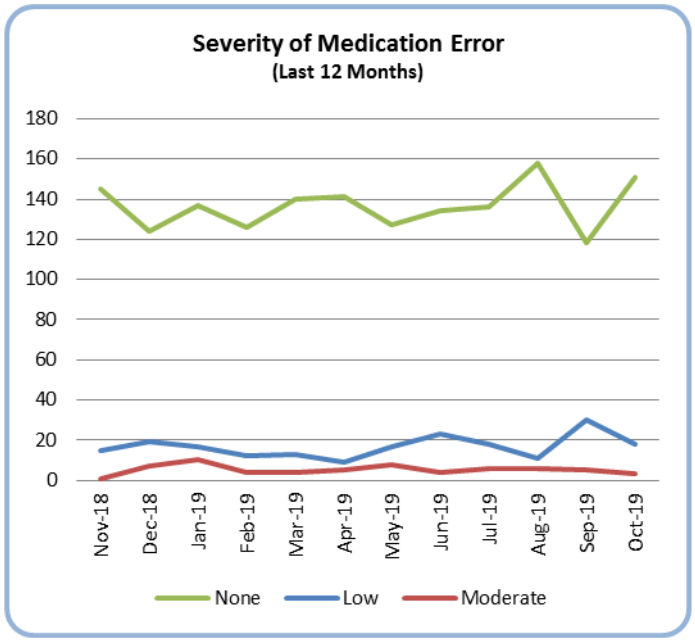


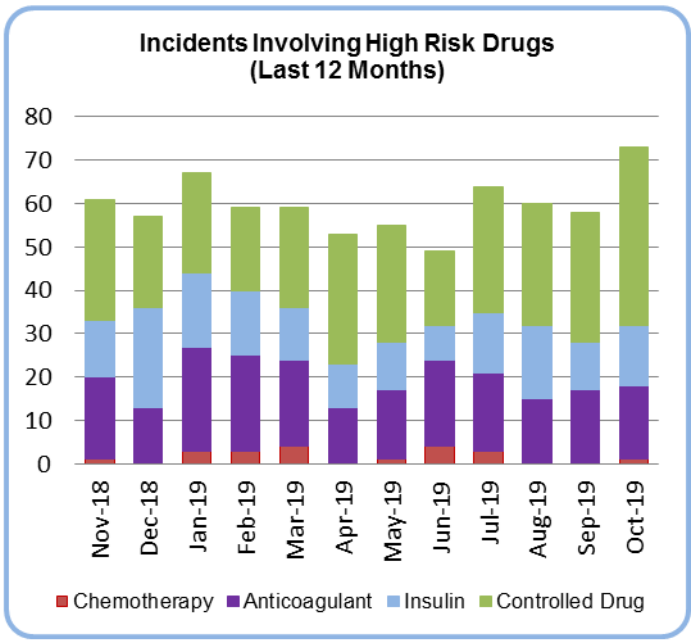
Stroke

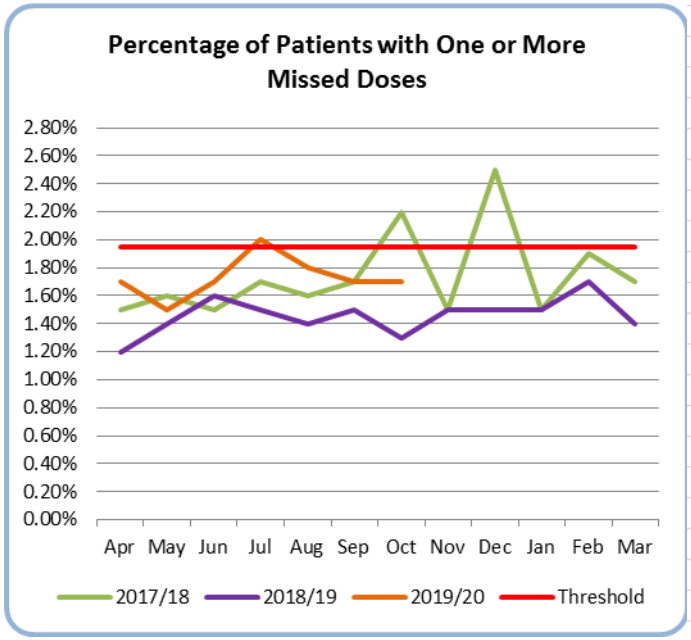
Stroke data is reported one month in arrears with the current month included for reference.

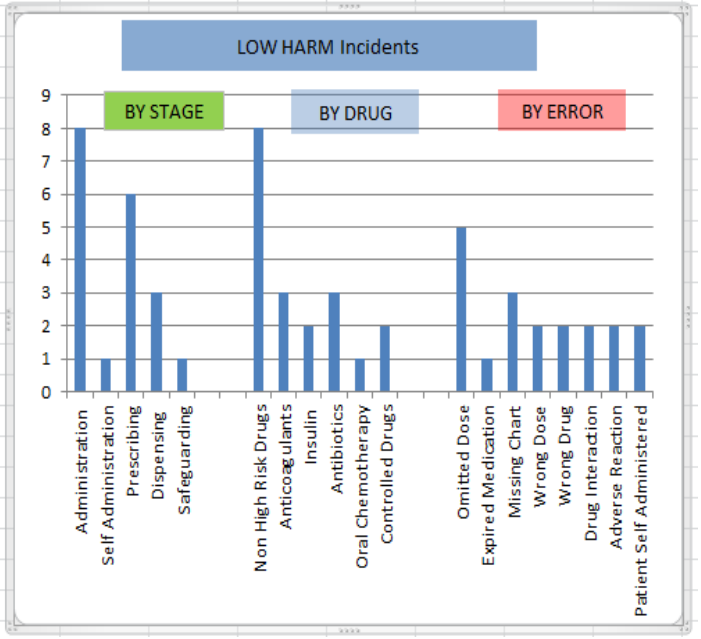
76 stroke patients were admitted during the month of October 2019 with 75% of stroke patients who required thrombolysis receiving this within 1 hour which is above the England average.

Admission to a stroke unit within 4 hours of presentation is a key metric in the NHS Long Term Plan. This continues to be a challenging target for all units in BNSSG and NBT performance was at 50% in October 2019.









Medicines Management

Severity of Medication Error

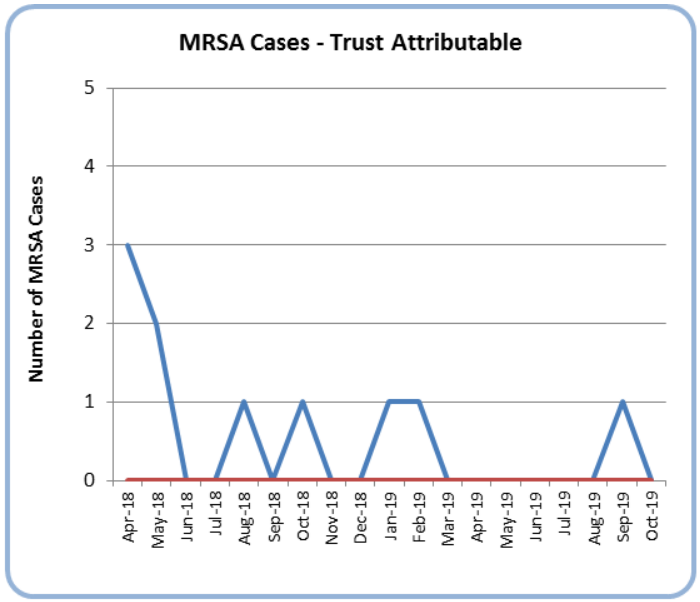
During October 2019, the number of "No Harm" medication errors represented c.88% of all medication errors; reinforcing the strong culture of reporting across the Trust

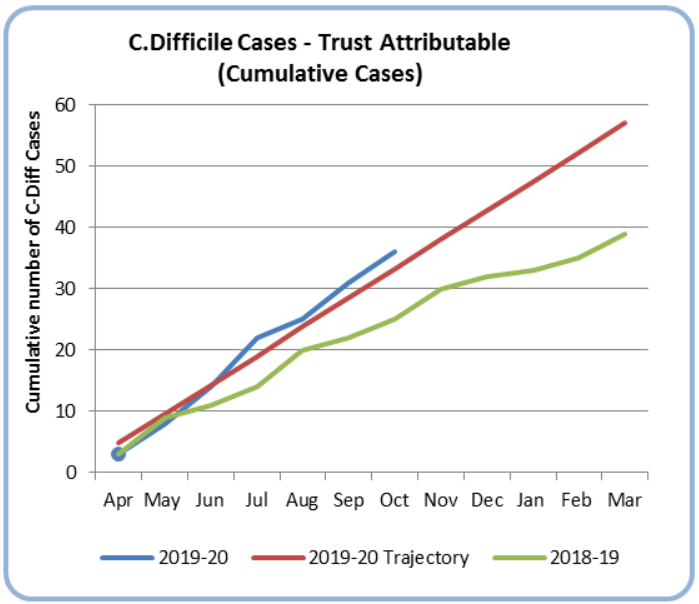
High Risk Drugs

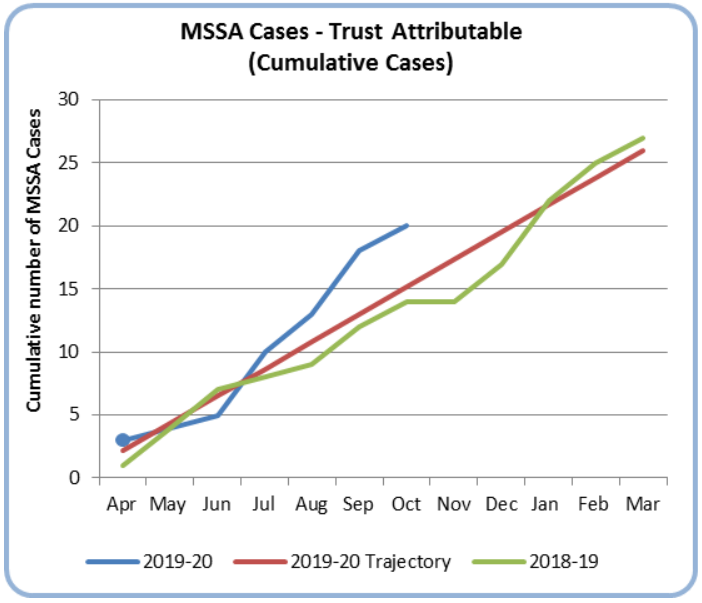
High Risk Drugs formed c.38% of all medication incidents reported during October 2019. All incidents relating to high risk drugs are closely monitored by the Medicines Governance team

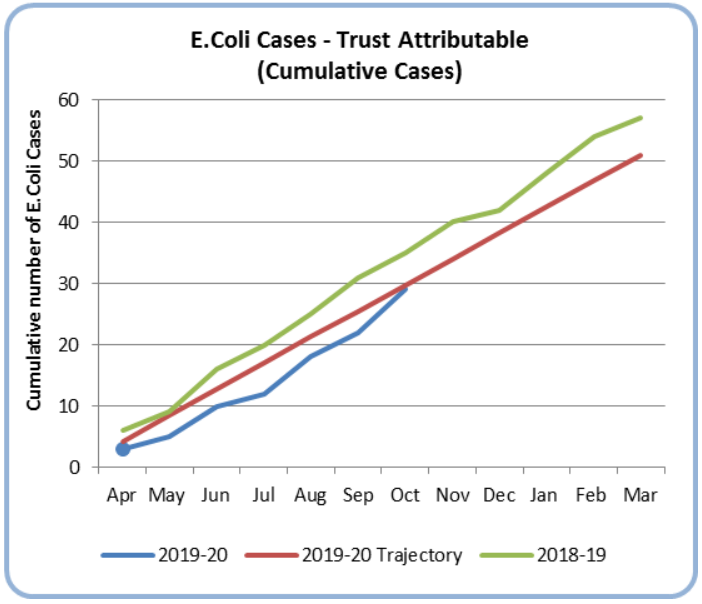
Missed Doses

The pharmacy team closely monitors the KPI's associated with all missed doses. Any ward(s) that breaches the missed dose target of <1.95% on two consecutive months undertake an intensive 2-week "missed dose audit".









MRSA
There were no cases of MRSA bacteraemia in October. Year to date there has been one reported case for the organisation.

C. Difficile
In October there were five cases reported against the trajectory. Three cases were hospital onset and two cases were community onset.

MSSA
There were two reported cases of MSSA bacteraemia in October. As an organisation we remain above trajectory and previous experience in NBT although the rate is comparable to regional and national benchmarks. The Trust staphylococcus steering group continues to monitor and review cases.

E. Coli.
The Trust target for 2019/20 is a 10% reduction on the previous year.
The focus for improvement is on the management of urinary catheters.

Mortality Review Completion

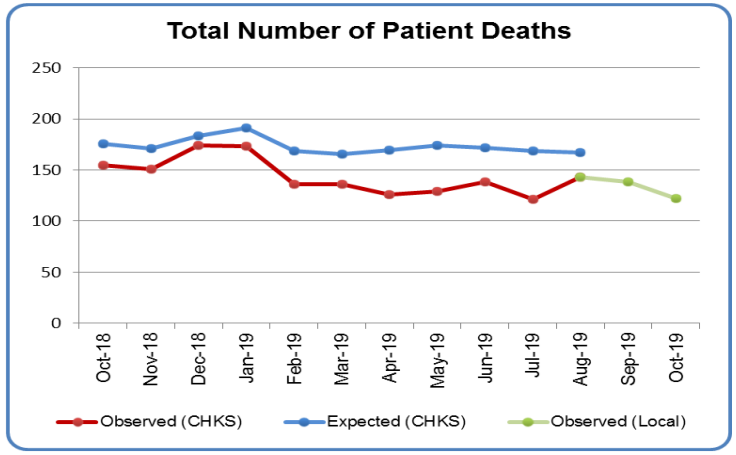
Sep 18 to Aug 19	Completed	Required	% Complete
Screened and Excluded	1040		
High Priority Cases	155		
Other Reviewed Cases	344		
Total Reviewed Cases	1539	1804	85.3%

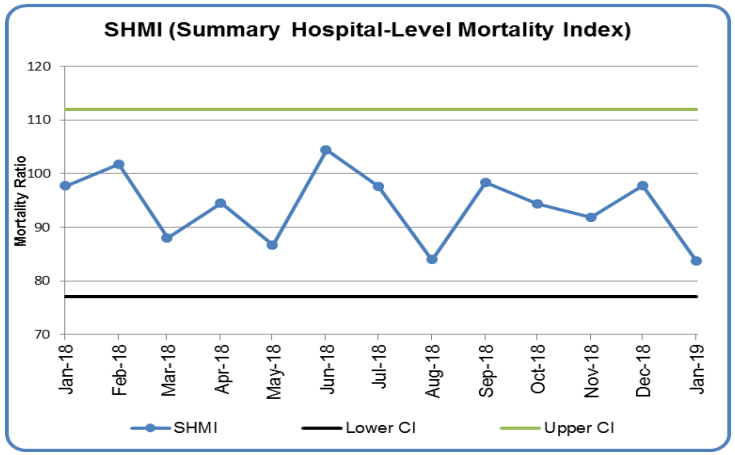
Overall Score	1	2	3	4	5
Care Received	0.0%	3.1%	18.6%	57.1%	21.2%

Date of Death	Sep 18 to Aug 19
In Progress	1
Reviewed Not SIRI	13
Reported as SIRI	0
Total Score 1 or 2	14

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

Mortality Outcome Data





Overall Mortality

Mortality data has remained within the expected range.

Mortality Review Completion

The current data captures completed reviews from 01 Sep 2018 to 31 Aug 2019. In this time period (this is now reported as a 12 month rolling time frame), 85.3% of all deaths had a completed review. Of all "High Priority" cases, 92% completed Mortality Case Reviews (MCR), including all fourteen deceased patients with Learning Disability and six 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 remained at 96.9% (score 3-5).

A review of the findings of the fourteen cases where care was considered poor or very poor is being conducted and will present learning themes to Mortality Review Group in January 2020.

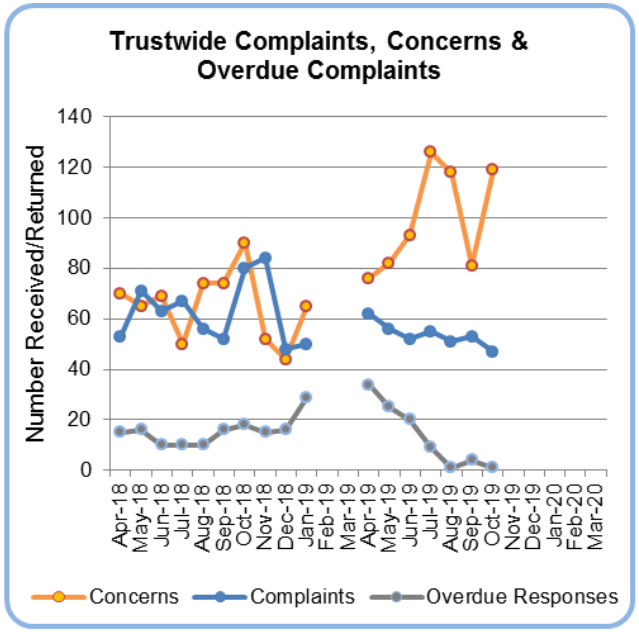
Learning from Deaths Internal Audit:

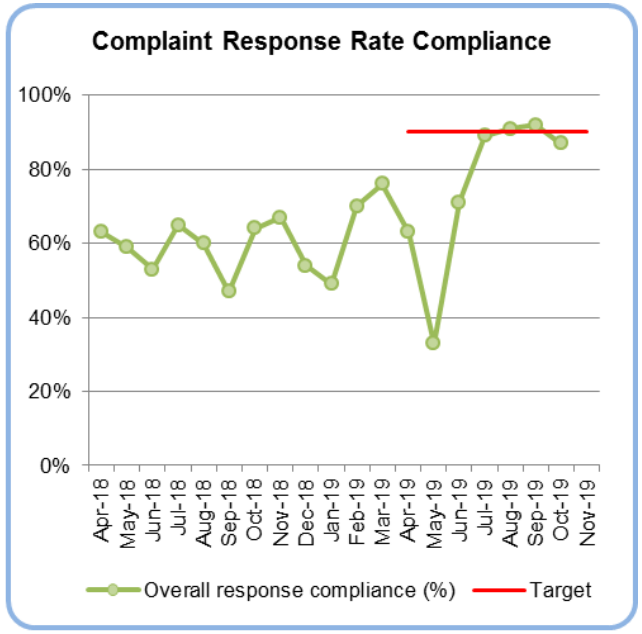
NBT's Internal Auditors, concluded an audit of our process with an opinion of "Significant Assurance, with minor improvement opportunities".

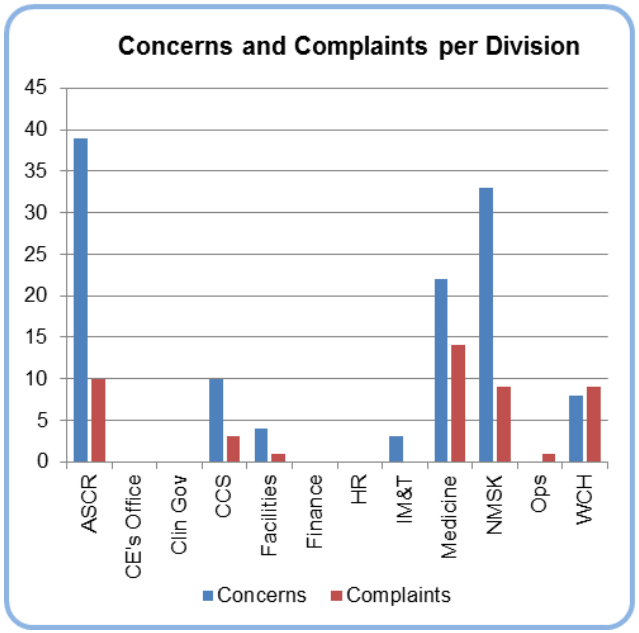
NHS North Bristol NHS Trust

Quality Experience

Board Sponsor: Director of Nursing and Quality Helen Blanchard







Division	Total Closed for Oct	Total Overdue at end of Oct
ASCR	13	1
CCS	3	
Medicine	14	
NMSK	9	
WCH	3	
Facilities	2	
Finance	1	

N.B. Trust-wide chart showing 2019-20, starting April 2019 and will show rolling data going forward. Feb-19 and Mar-19 data has been removed for complaints, concerns and overdue complaints owing to data quality issues.

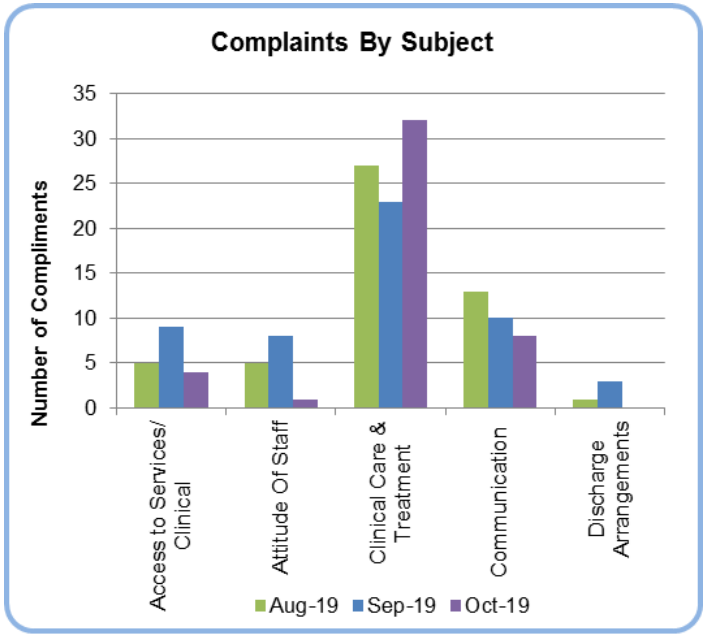
Complaints and Concerns
In October 2019 the Trust received 47 formal complaints and 119 PALS concerns.

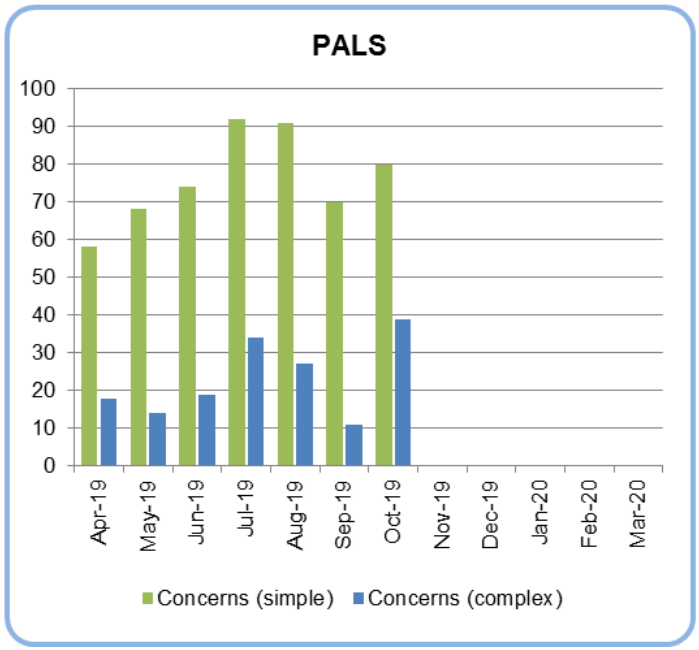
The 47 formal complaints can be broken down by division:
ACSR: 9 CCS: 4 Medicine: 14
NMSK: 9 WACH: 9
Finance: 1 IM&T: 1

The number of formal complaints (47) received in month was less than the monthly average between 50 to 60. This may reflect the embedding of the Patient Advice and Liaison Service (PALS) as an increase in PALs concerns was observed from 81 in September to 119 in October 2019. A further roll out of training, together with a new Complaints policy reinforced taking opportunities for local resolution on the ward before a problem reaches the PALS office.

Final Response Rate Compliance
Implementation of the recovery plan across the Trust contributed to 87% of complaints being responded to within the timescale. This includes ALL cases with due date for completion within the last month (October).

Overdue complaints
In order to ensure the compliance target is sustainable, weekly meetings take place with divisions. Support in identifying the cause of the over due complaints being provided in particular with ASCR with the highest number of overdue complaints.





Complaints By Subject

There was an increase in the number of complaints within the area regarding clinical care and treatment. This is a broad theme area and a deep dive is currently ongoing to provide further breakdown. The deep dive into understanding the key elements of this category is now planned to be undertaken through the work stream of the Divisional Operational Leads Group. Thus increasing ownership and the opportunity for shared learning . The process will include triangulation with FFT data. A full report will be provided to Patient Experience Group (PEG) at the end of Quarter 4 and an update report at the January 2020 PEG meeting.

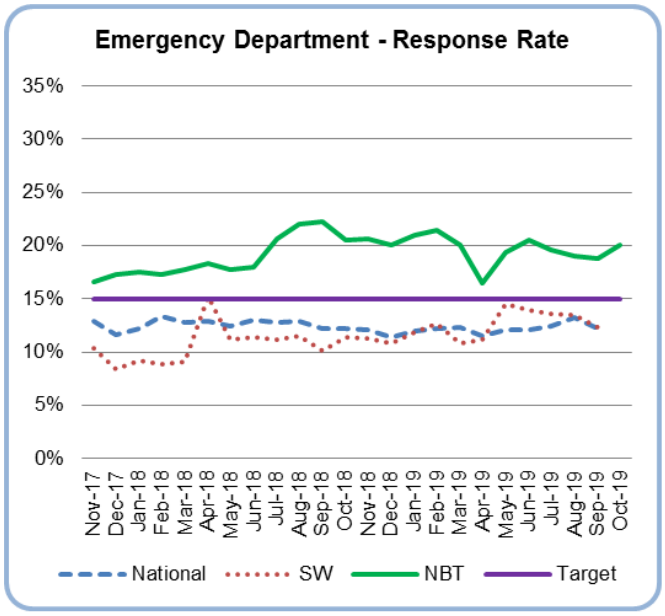
Example compliments received by the Trust in October 2019:

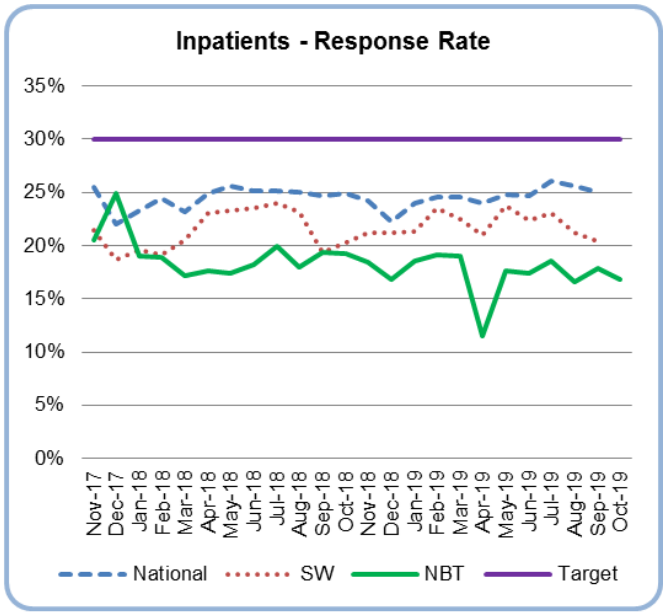
"I was admitted to Southmead AMU last week and later moved to the Infectious Diseases ward because they had a bed available. I was an inpatient for almost a week. It's hard to express how grateful I am to all the staff who cared for me while I was there. I met so many nurses, doctors, porters, medical students, domestic staff, phlebotomists and the consultant and they were so warm and kind when I was the most vulnerable and sick I've ever been. Everything was so organised from making sure I had enough to eat and drink, to medication, to sending me for scans. Everything was kept spotlessly clean. I can't thank you all enough for how well you treated me. I was so unwell and I never once felt anxious or worried - they made me feel completely confident in them and I will always be grateful."

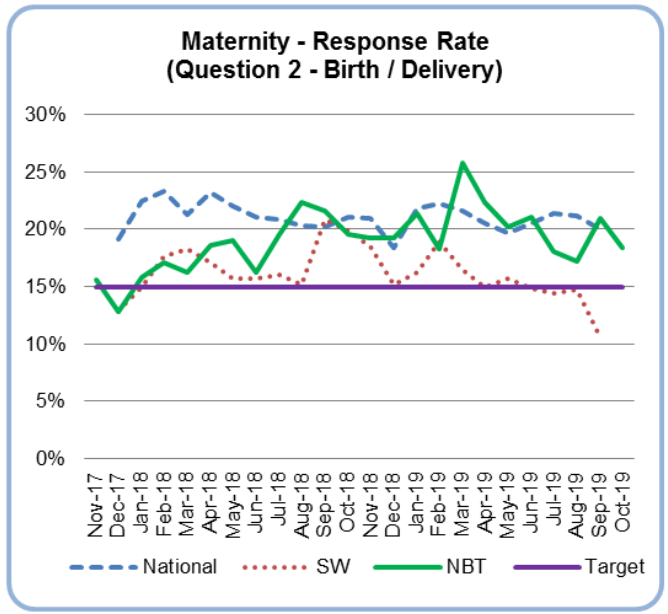
"I attended Southmead hospital for my first appointment, The surgeon I seen was very professional very understanding and won my trust in regards to my future treatment, I just want to thank you guys at Southmead for giving me hope again after a very stressful year in personal matters . I have faith that I'll be able to return to half decent life again even though I can't return to my normal trade, thank you Southmead roll on my surgery date and this is to better things to come"

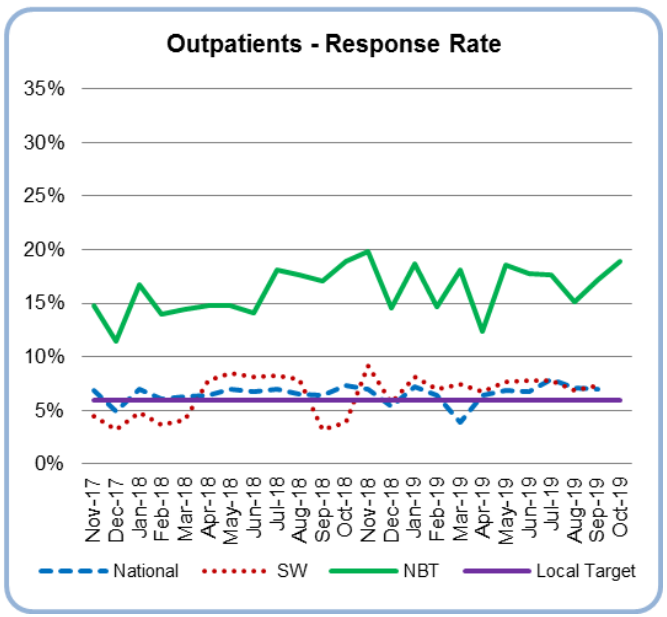
Patient Advice and Liaison Service (PALS)

In the month of October, 119 PALS concerns were received. Of the 119 PALS concerns received, 80 were classified as more simple concerns and 39 warranted more in depth investigation from within the division, and were classified as complex concerns. The introduction of a new Standard Operating Procedure and an Employee Guide to Local Resolution has proved effective at supporting and empowering staff to address concerns locally at ward level.









Friends and Family Test

FFT Response Rate	Target	NBT Actual
ED	15%	20.00%
Inpatients	30%	16.83%
Outpatients	6%	18.95%
Maternity (Birth)	15%	18.39%

The Emergency Department have maintained their good response rate. The rate is above the national and SW (north) regional rates.

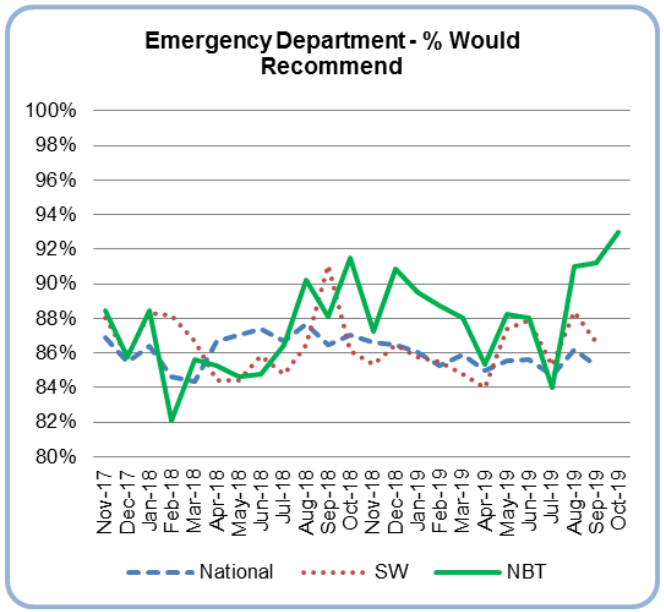
The Inpatient response rate continues to fluctuate between 16 and 17%. Business cards were provided to all wards in the month of September promoting the FFT. Improving response rates across in patients are a key action within the current CQC improvement plan. Divisions are taking action In promoting feedback opportunity .

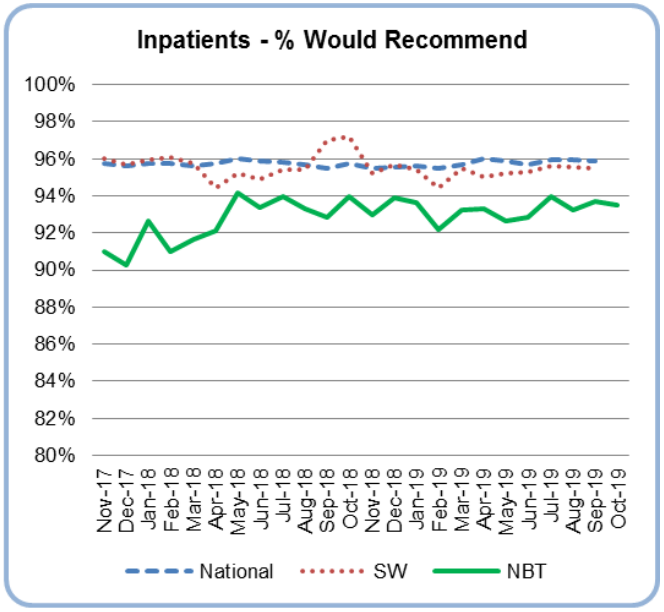
Out patient response rate continue to be very positive, having identified the correct data source of eligible patients in September .

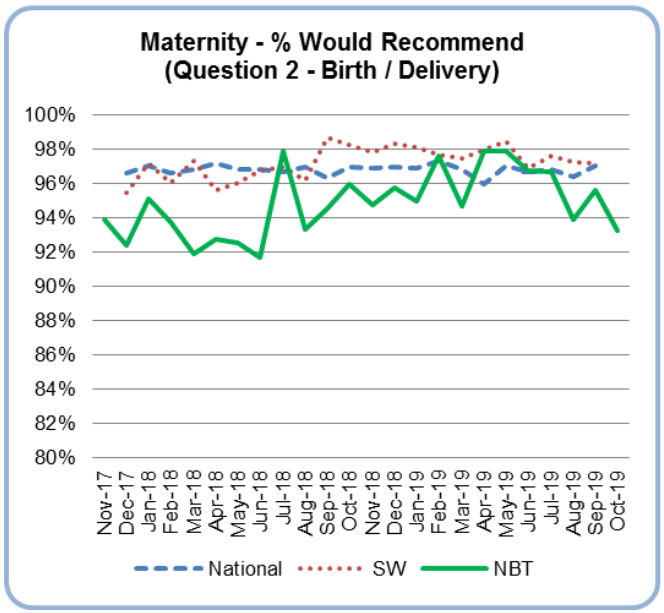
Maternity remained above target although the response rate fluctuates. The promotion of the FFT opportunity is in progress with the provision of FFT business cards to all patients explaining how they can give feedback.

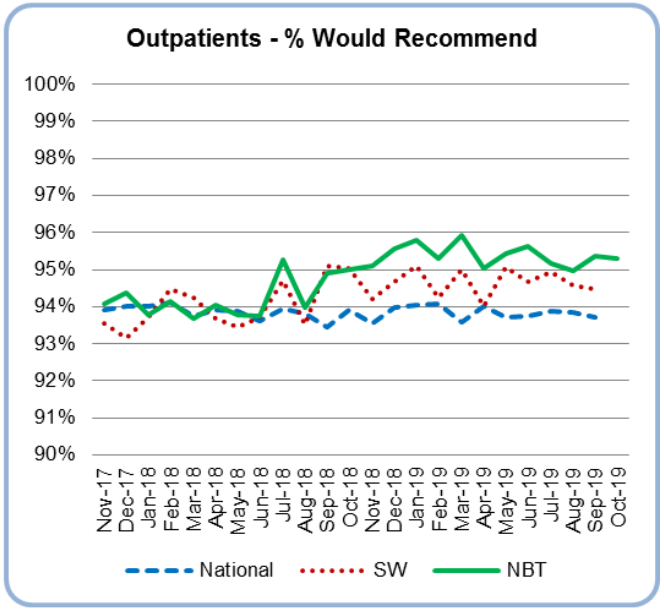
Owing to technical issues, NHS England have not published maternity FFT data for November 2017.

N.B. NHS England FFT Official stats publish data one month behind current data presented in this IPR.
May 2018, South West region has been split to SW (North) and SW (South). NBT is now plotting against SW (North).









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N.B. NHS England FFT Official stats publish data one month behind current data presented in this IPR. May 2018, South West region has been split to SW (North) and SW (South). NBT is now plotting against SW (North).

FFT Recommend Rate	Target	NBT Actual
ED	90%	92.97%
Inpatients	95%	93.52%
Outpatients	95%	95.31%
Maternity (Birth)	95%	93.26%

In October the Emergency Department received the highest percentage of patients recommending the ED over the past 12 months remaining above the regional and national requirement . The theme relates to positive staff attitude with reports of by kind professional , friendly and helpful staff. Waiting times remain the are of most concern.

The percentage of inpatients recommending the hospital remain between 92 and 94% . Staff attitude remains the most positive theme.

Maternity (Birth) is showing a decreasing trend in the percentage of patients who recommend the service. It is difficult to understand the cause of this from the small amount of qualitative data provided by respondents. Data will be triangulated with national survey data in the review workshop on 22 November 2020.

The percentage of Out patients who would recommend OPs remains above the SW (North) regional & national . Negative feedback relate to waiting times and communication with positive feedback relating to staff attitude and clinical care. This is reflective of wider current feedback from those attending out patients. This is integrated into the improvement plan.

Friends and Family Test

"Please tell us the main reason for the answer you chose."

Gate 31(4)

Confusing information given, and a 2hr 40 minute wait for medication after being discharged.

Gate 6b (1)

The care and support I have received has been outstanding, everyone has been so friendly and caring no matter how busy and understaffed they have been. Huge thank you from me!

OP Radiology: (1)

The staff are amazing. Communication was good throughout and I was so well taken care of. I feel so lucky that Southmead is my nearest hospital, and to have the wonderful care of the NHS.

OP Urology – Gate 36 (4)

Wait for 90 mins to be seen. No indication that clinic was running late. And how does clinic run late when I'm the 3rd person to be seen. If as the consultant says this might be a clinic delivering difficult news then plan ahead, review which patients are seen and get enough staff to run it effectively. Its even more critical that this clinic runs to time

Maternity Post delivery (1)

The care I received at Southmead throughout my time was first class. Every staff member I came across took the time to listen and support me through labour and the issues I had post birth. They ensured I knew how to care for my new baby girl and worked hard to form positive relationship with myself and my husband. Thank you so much to everyone at Southmead maternity unit!

Birth (1)

The staff went over and above, couldn't have asked for a better support network. Forever grateful for bringing our boy into the world safely

Gate 8a (3)

More care staff for people who need one to one care due to health issues like epilepsy as well as more services for young people under 21 as I felt very alienated being only 17 on a adult ward with people at least 30+

ED (1)

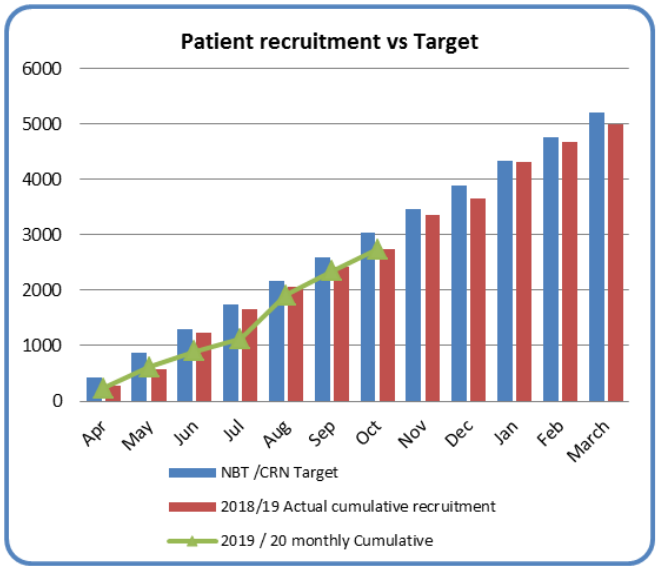
They understood what I was going through, they didn't sugar coat it or try to tell me you'll be okay soon they were just honest and they spoke to me as if they were going through it with me and I didn't feel alone

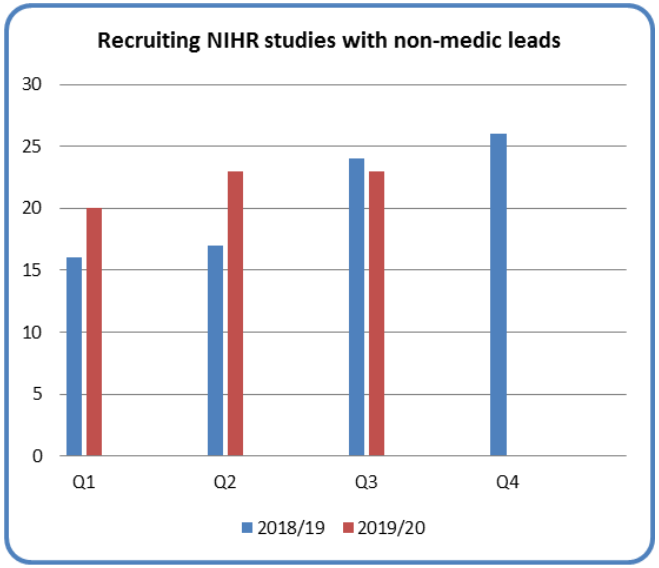
ED (5)

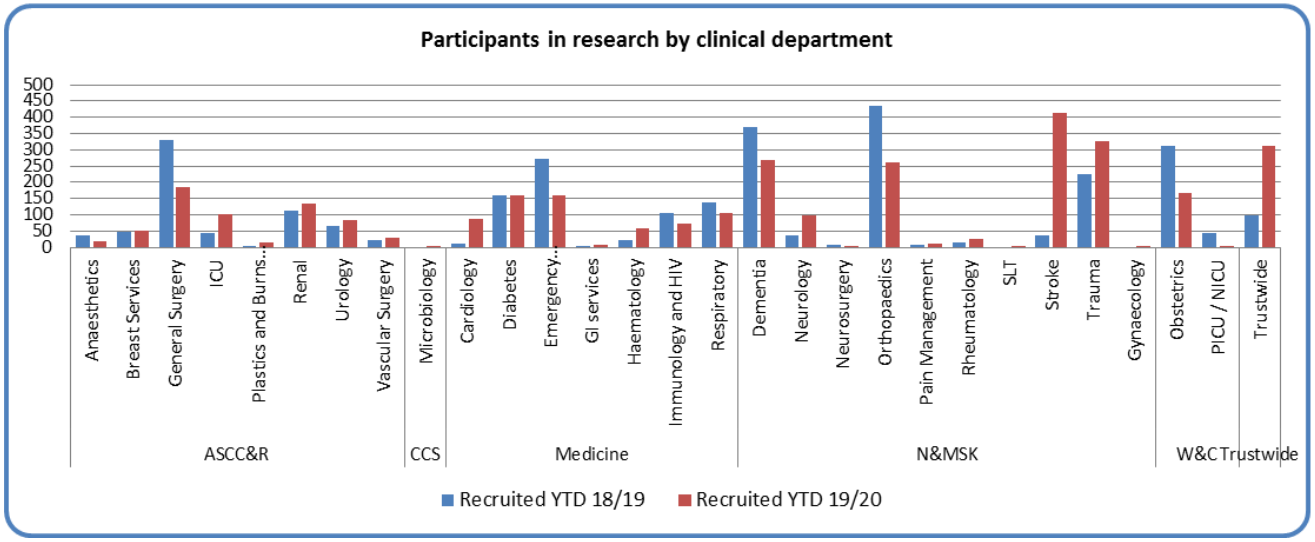
Communication between staff . I was told to stay by one doctor then kicked out by another at 12.30 at night, when I was in so much pain I couldn't sit down.

Research and Innovation

Board Sponsor: Medical Director







Patient recruitment into research studies is 92% of the target. While the target remains a challenging one it is one which R&I have established plans and expect to meet.

Due to a generous charitable donation to the NBT Research Fund, R&I opened a Trust-wide open call for applications to fund research projects up to £20k each. The call closed on 18th September 2019 and 28 applications have been received.

NBT currently holds 35 research grants (NIHR, charity and other) to a total value of £21m, with 6 NBT-led grants in set-up (£3.2m).

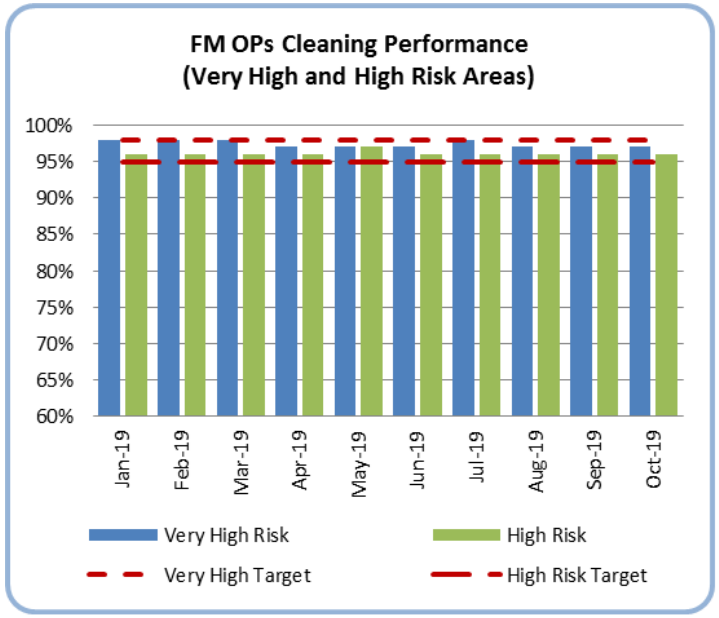
NBT R&I has been shortlisted for Investors in People Employer of the Year, Silver Category. The winner will be announced on the 19th November in London.

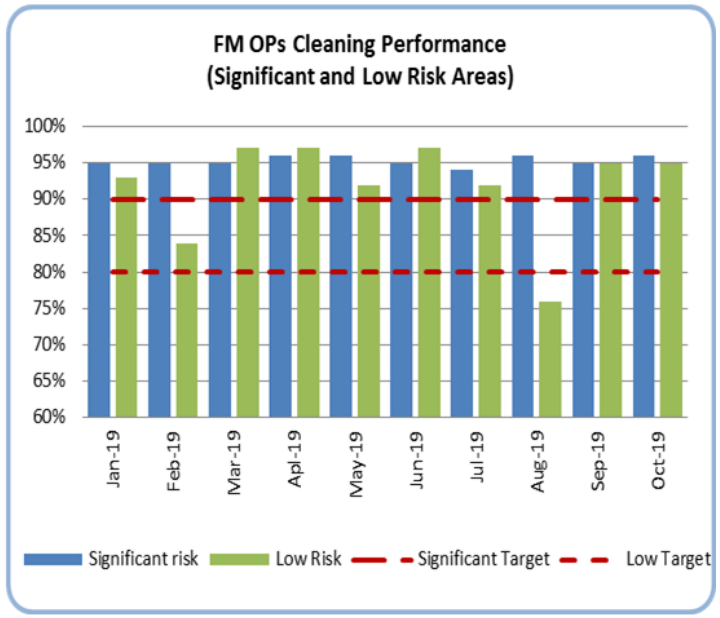
"The Bladder and Bowel Confidence (BABCON) Health Integration Team was approved by Bristol Health Partners in October providing an identity for continence care across the city. NBT are the proud sponsor of this fantastic collaboration of patients, the public, UWE, UoB, Bristol City Council, AWP, BNSSG CCG and UHBristol to focus on improving continence care, education, research and inclusion citywide.

NHS North Bristol NHS Trust

Facilities

Board Sponsor: Director of Facilities
Simon Wood





Very High Risk Areas Target Score 98% Audited Weekly	Include: Augmented Care Wards and areas such as ICU, NICU, AMU, Emergency Department, Renal Dialysis Unit
High Risk Areas Target Score 95% Audited Fortnightly	Include: Wards, Inpatient and Outpatient Therapies, Neuro Out Patient Department, Cardiac/Respiratory Outpatient Department, Imaging Services
Significant Areas Target Score 90% Audited Monthly	Include: Audiology, Plaster rooms, Cotswold Out Patient Department
Low Risk Areas Target Score 80% Audited Every 13 weeks	Include: Christopher Hancock, Data Centre, Seminar Rooms, Office Areas, Learning and Research Building (non-lab areas)

Operational Services Report on Cleaning Performance against the 49 Elements of PAS 5748 v.2014 (Specification for the planning, application, measurement and review of cleanliness in hospitals)

Cleaning scores remained above target through October during a very busy period at NBT.

The Domestic relief team continues to play a critical role maintaining service by covering for vacancies that arise out of leave or sickness, reducing the reliance on NBT Extra.

Domestic task teams continue to support areas that require additional work

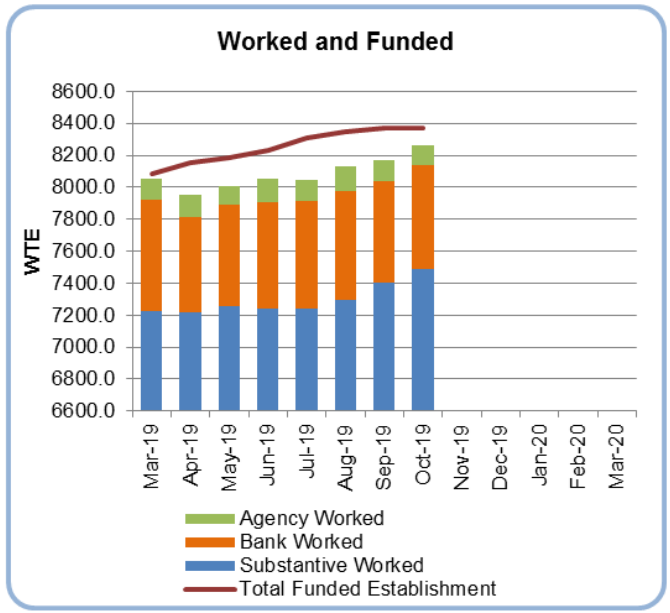
Over 1000 deep cleans were completed in October. 98% were carried out within the 4 hour requirement.

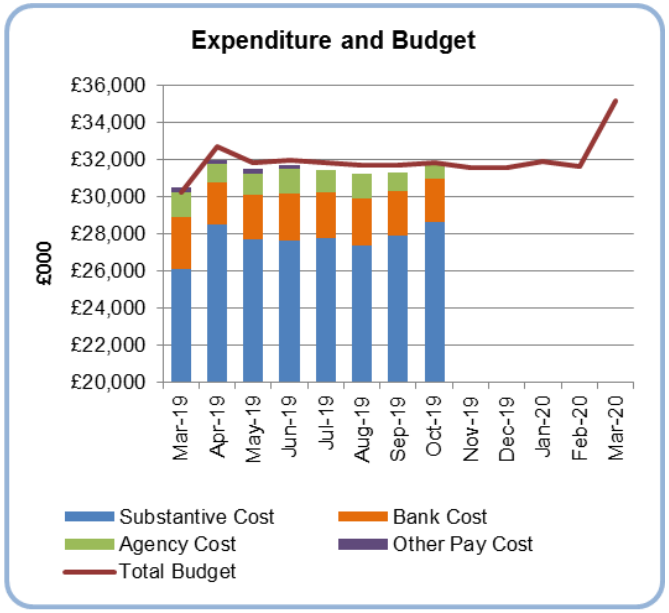
Deep clean work is also ongoing in support of the Trusts C-Diff reduction plan alongside the day to day reactive work.

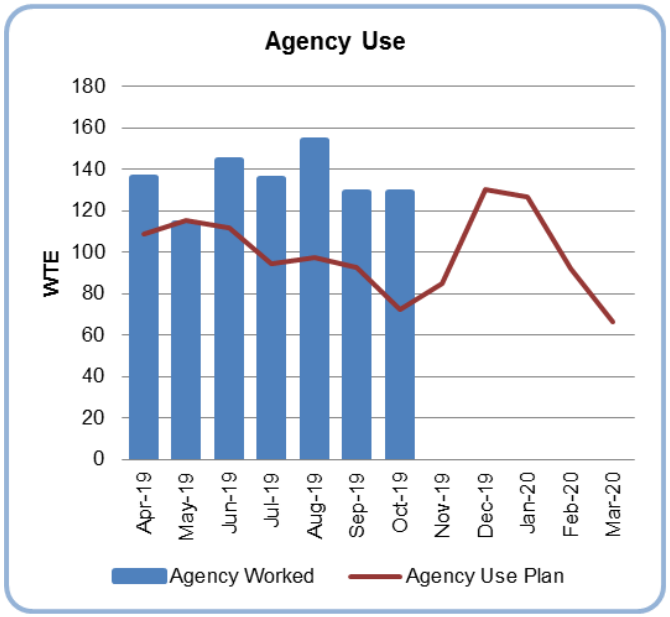
NHS North Bristol NHS Trust

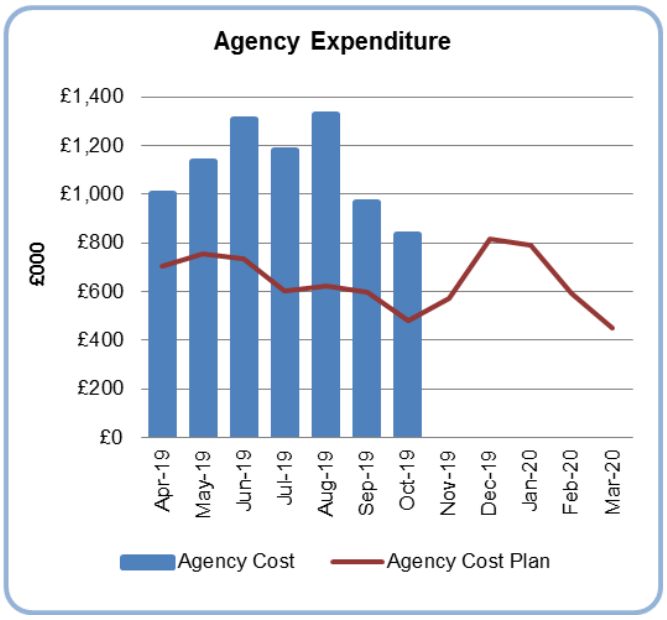
Well Led

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









Pay

Substantive worked wte increased by 99.5 wte in October to be 102.5 wte under the funded establishment. Pay expenditure was £0.359m over budget in October and non-consultant medical staff and registered nursing and midwifery remain the staff groups most adverse.

The increase was 85 wte in substantive, predominantly nursing in line with the high intake of nurses in September and October and increase of 22 wte in bank use. This is predominantly in registered nursing and midwifery, in line with work to improve bank fill rates. There was also a small reduction in medical bank and agency use.

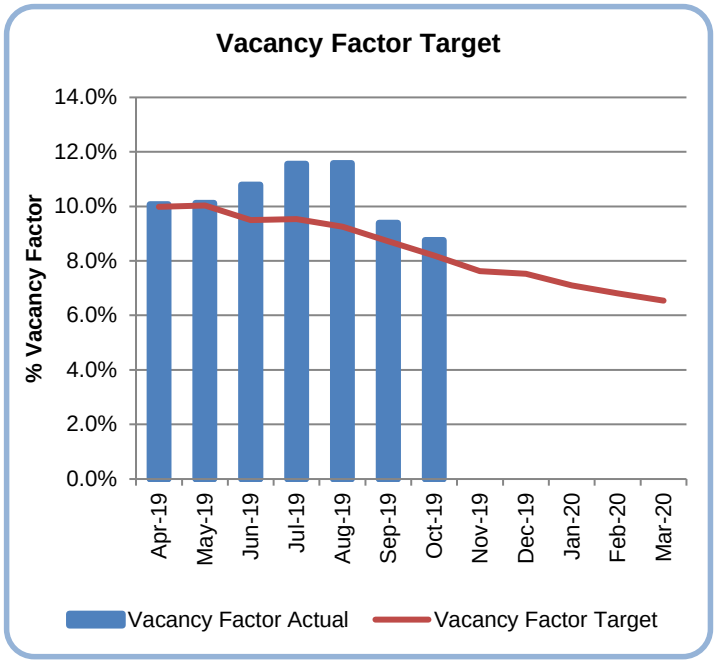
Temporary Staffing

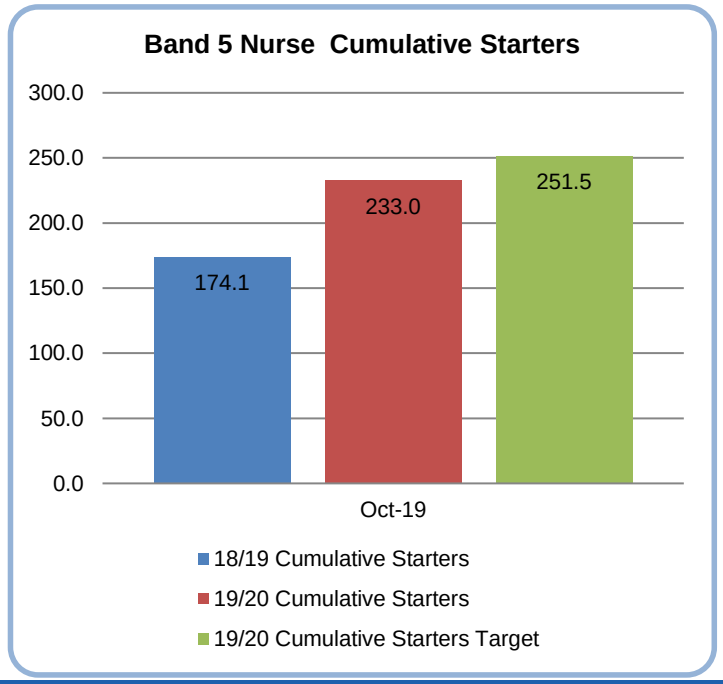
As we move into the second month of the new agency pay rates we have seen a steady flow of agency nurses start to migrate to Tier 1 agencies which has supported the increase in the Tier 1 fill rate. In addition new agencies are joining the panel to support the supply of agency nurses to the Trust.

A Tier 1 engagement day was held this month where we invited 10 agencies who have not yet supplied staff to the Trust with a view to promoting our services and encouraging more supply of agency nurses, whilst highlighting hot spots without Theatres and other areas.

Agency expenditure has reduced for a second month due to the changes in the agency rates. Work continues to reduce the use of high cost agency as the BNSSG project looks to go into the second stage in December.

Our bank fill rates across all staffing groups continue to increase with Winter recruitment campaigns underway.





Unregistered Nursing and Midwifery Recruitment

The Band 2, 3 and 4 resourcing plan, identifying the continuous talent attraction initiatives scheduled between April 2019 – March 2020 remains in place. In October the Trust had 45 new starters compared to October 2018 starters of 26. Additional recruitment and assessment activity is in place following agreement with divisions as part of overall winter planning.

Band 5 Nursing

October's starters were slightly under the target set for the month (40 wte vs target of 57 wte) which means the year to date position is behind the target. Recruitment activity continues with internal and external engagement events to deliver the year end target of 363 wte band 5 starters.

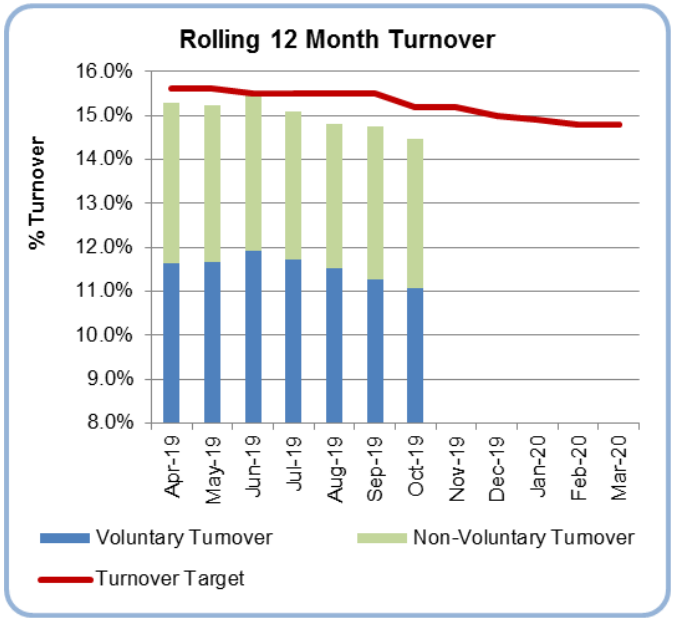
Recruitment and Engagement events in October;

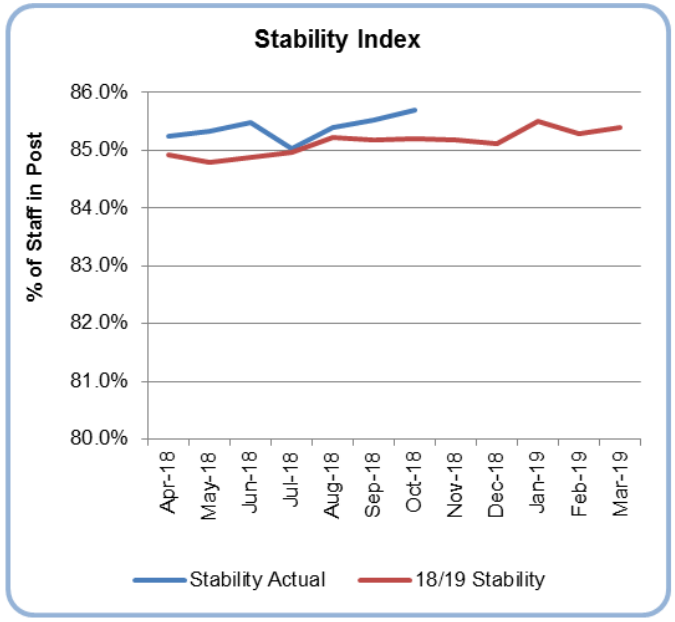
- National Stroke Nursing Forum – 1 October
- UWE Meet the Employer day – 18 October
- Internal Nursing Engagement day – 26 October – 80 attendees
- 10 assessment centres for unregistered Nursing and Bank specific recruitment

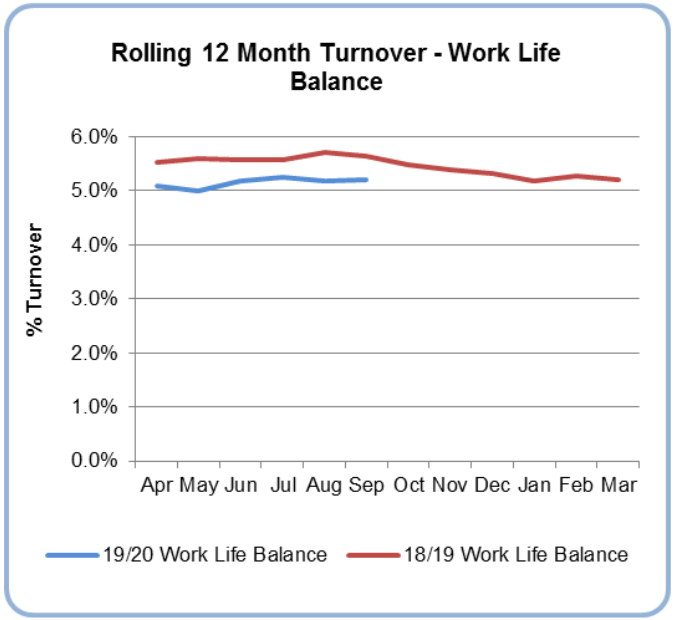
Overseas Nurse and Midwife Recruitment

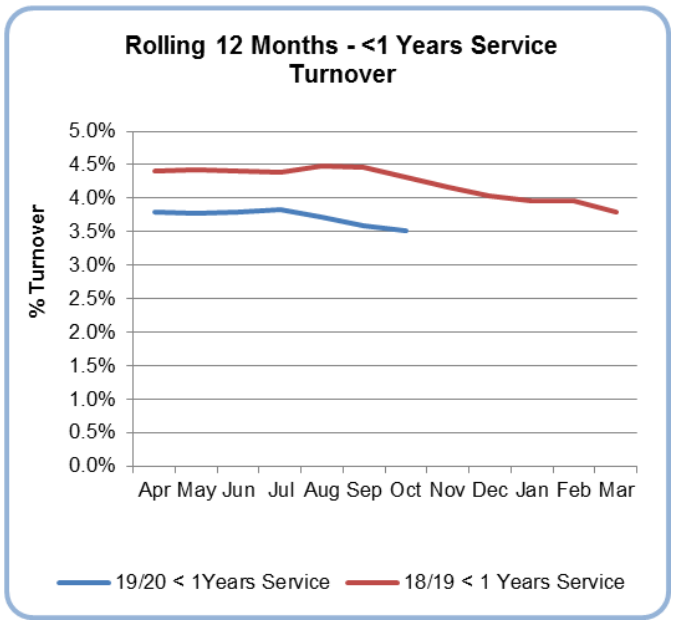
The International Nurse Recruitment project continues to deliver experienced, permanently employed nurses from the Yeovil pipeline. To date 40 nurses are now working in the Trust, with 18 Nurses, representing a 100% pass rate, having passed the OSCE examination and now fully registered.

The business case for Phase 2 for International recruitment has been signed off, approving an additional 30 experienced overseas Nurses through the Trust partnership with Yeovil District Hospital Trust .VRP approval has also been granted to support internal international staff who have previous nursing experience, to gain their full NMC registration for 8 existing employees to be supported.







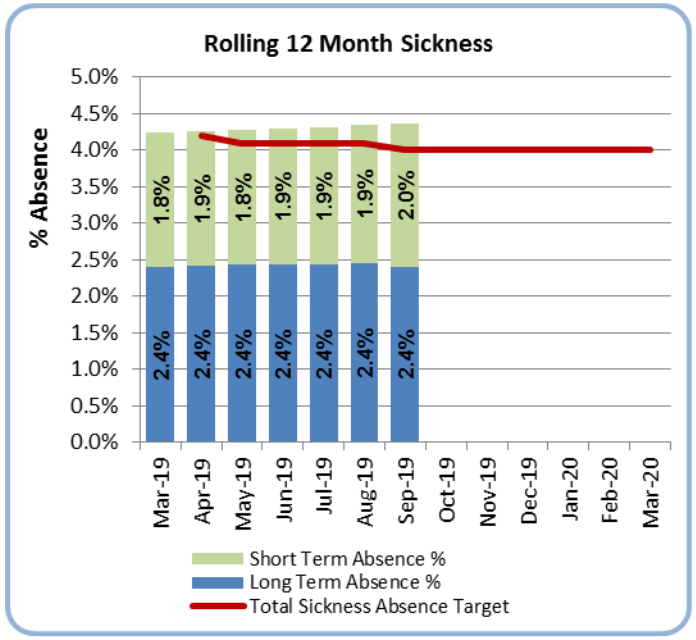


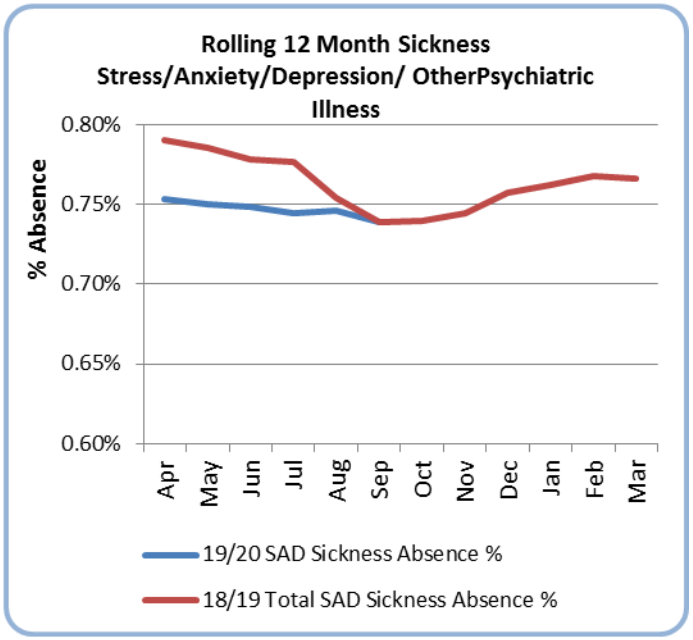
Trust

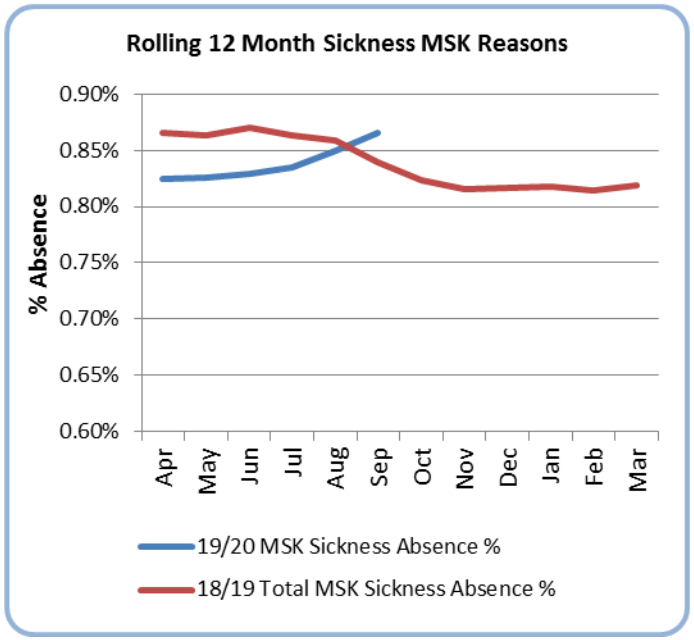
Turnover continues to improve across the Trust with registered nursing and midwifery turnover under 16% for the 1st time since January 2018.

People and Transformation (P & T) Team Actions

- Work-life balance webinar occurred this month which was recorded and is available for viewing on the HR Portal. It has already had la large number of 'hits';
- NHSI /NBT retention action plan being developed, around the key themes of Starting Well, Staying Well and Stopping Well;
- Work-life balance/Flexible Working 'brochure' almost complete, as a 'go-to' guide for managers and staff, with case studies, guidance and example of best practice;
- Continued promotion of new exit tool to ensure continued high response rate linked to reasons for leaving





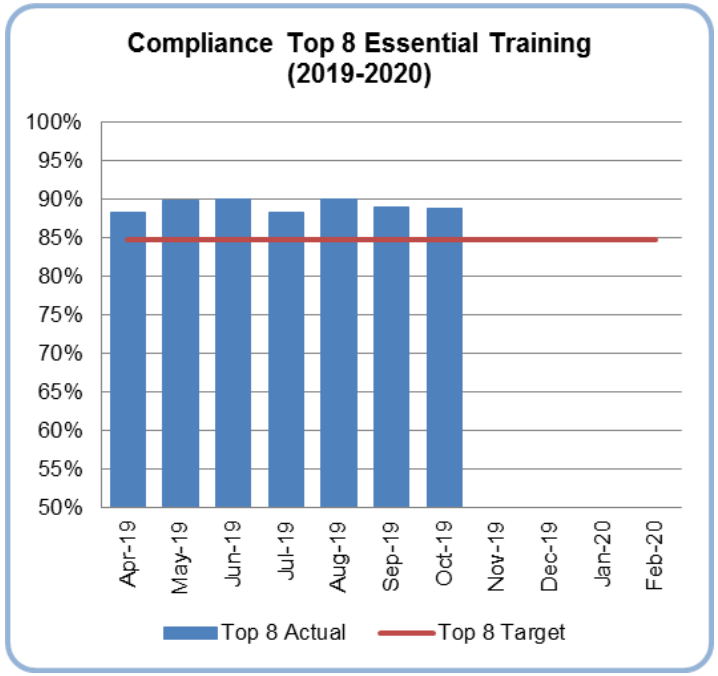


Sickness

Sickness remained at 4.4% in September. There was little movement across staff groups from last month.

People and Transformation team actions

- Action plan following an audit into the application of the short-term sickness policy is now being implemented;
- Stage 3 (Short-term sickness) training has been reviewed and re-framed to be more effective and so that it specifically targets managers who have stage 3 meetings imminently;
- Continued work to help improve long-term sickness absence in the Women and Children's Division, with action plan developed;
- The new ER Case Tracker is now live and sickness cases now being logged and managed via this system. This will allow for better visibility of all formal sickness cases and mean automatic prompts for managers.



Training Topic	Variance	Sep-19	Oct-19
Child Protection	-0.2%	88.5%	88.4%
Equality & Diversity	0.4%	90.7%	91.1%
Fire Safety	-0.2%	88.7%	88.4%
Health &Safety	0.3%	91.8%	92.2%
Infection Control	-0.2%	90.9%	90.7%
Information Governance	0.7%	85.9%	86.6%
Manual Handling	-0.3%	84.5%	84.2%
Waste	-1.1%	90.2%	89.2%
Total	**-0.1%**	**88.95%**	**88.89%**

Top 8 Statutory / Mandatory Compliance:
The Top 8 Statutory / Mandatory training compliance rate for October was 89.36% NBT had the highest ever number of eLearning completions last month, at 7,887. This in response to the planned halting of stat / man training during the winter pressure period.

OneNBT programme:
The programme has seen an increase of 10 staff since last month moving to a total of 319. 41 staff have yet to sign up to modules (including 10 new joiners this month) . There is ongoing work to improve sign up and participation:

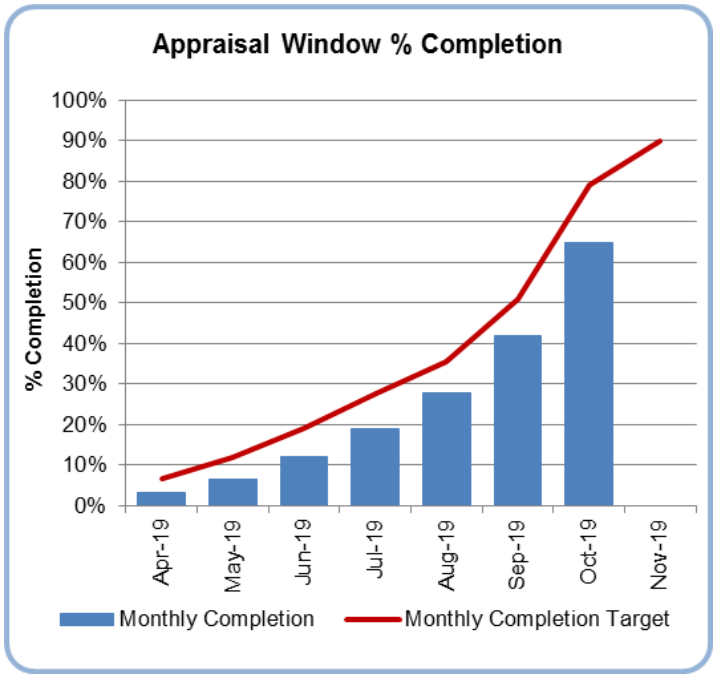
-Working with people partners to target individuals and their managers
- Email reminders to complete the first steps of the programme
- Chasing for participants to communicate to us if they have withdrawn and capturing reasons within the tracker

Planned work to increase engagement:
- Gain feedback directly from managers and staff on the programme regarding the enrolment process and the programme as a whole
- Feedback to divisions the withdrawal data and key themes
- Take lessons learnt from key themes to improve enrolment processes

Apprenticeships and other programmes:
Alongside the OneNBT leadership programme, 28 staff are enrolled in the apprenticeship Leadership and Management Level 3 qualification.

Two staff remain on the Level 6 Chartered Manager Degree Apprenticeship with UWE and one staff member remains on the Level 7 – Senior Leader Masters Apprenticeship.

Division	No of Participants	% of allocated spaces
Medicine	63	20%
ASCR	68	22%
Core Clinical	43	14%
NMSK	41	13%
W&C's	26	8%
Facilities	13	4%
Corporate	55	18%
Total	**309**	88%



Appraisal Completion

Appraisal completion is at 65% against a target of 79%.

People and Transformation Team Actions

- Final call to action around appraisal completion in the Bulletin and Message of the Day this month;
- P&T Team continuing with 'appraisal talk and tours' and distribution of appraisal 'top tip' flyers.

Equality, Diversity and Inclusion Metrics

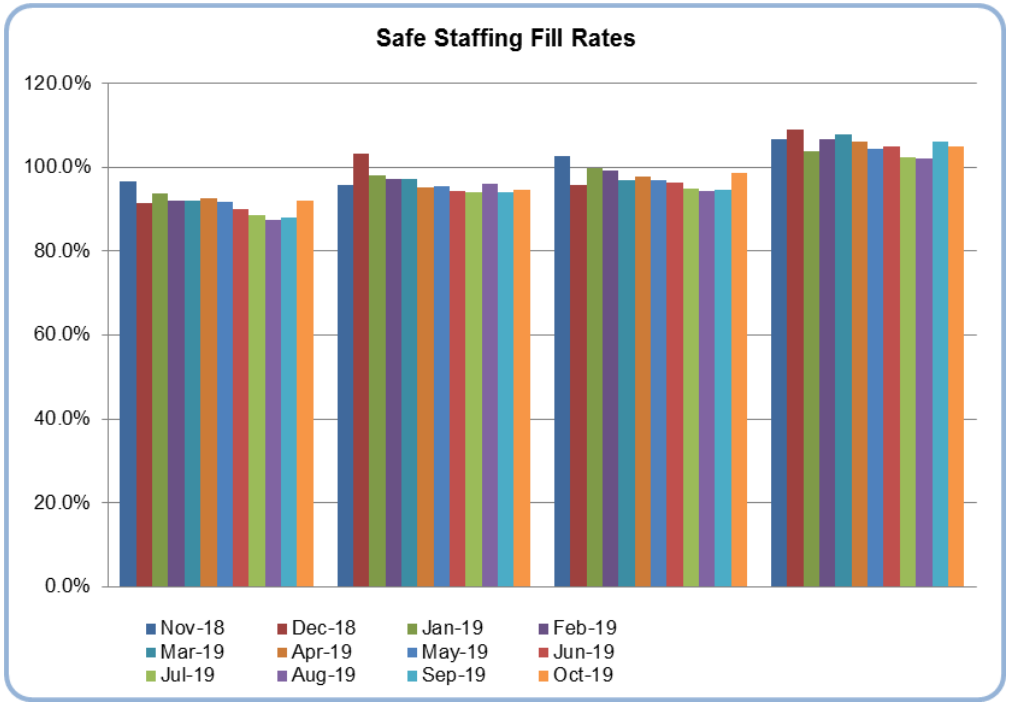
- No adverse differences are apparent from the data reported on ethnicity through the appraisal data.

- Although we have a majority female workforce the % of men having completed appraisals in comparison to women has reduced further since last month.

Equality Diversity and Inclusion Metrics

Ethnic Origin	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19
BAME	3.3%	8.1%	15.6%	20.6%	28.3%	42.4%	63.9%
White	3.4%	6.3%	11.3%	18.6%	27.6%	41.9%	64.8%
Undisclosed	0.0%	1.4%	10.5%	17.9%	32.5%	40.0%	60.5%

Gender	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19
Female	3.1%	6.1%	11.5%	18.1%	27.2%	42.3%	65.5%
Male	3.9%	8.0%	13.9%	22.1%	29.7%	40.3%	61.3%



Oct-19	Day shift		Night Shift	
	RN/RM	CA Fill	RN/RM	CA Fill
Southmead	88.1%	94.1%	94.7%	106.0%

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.

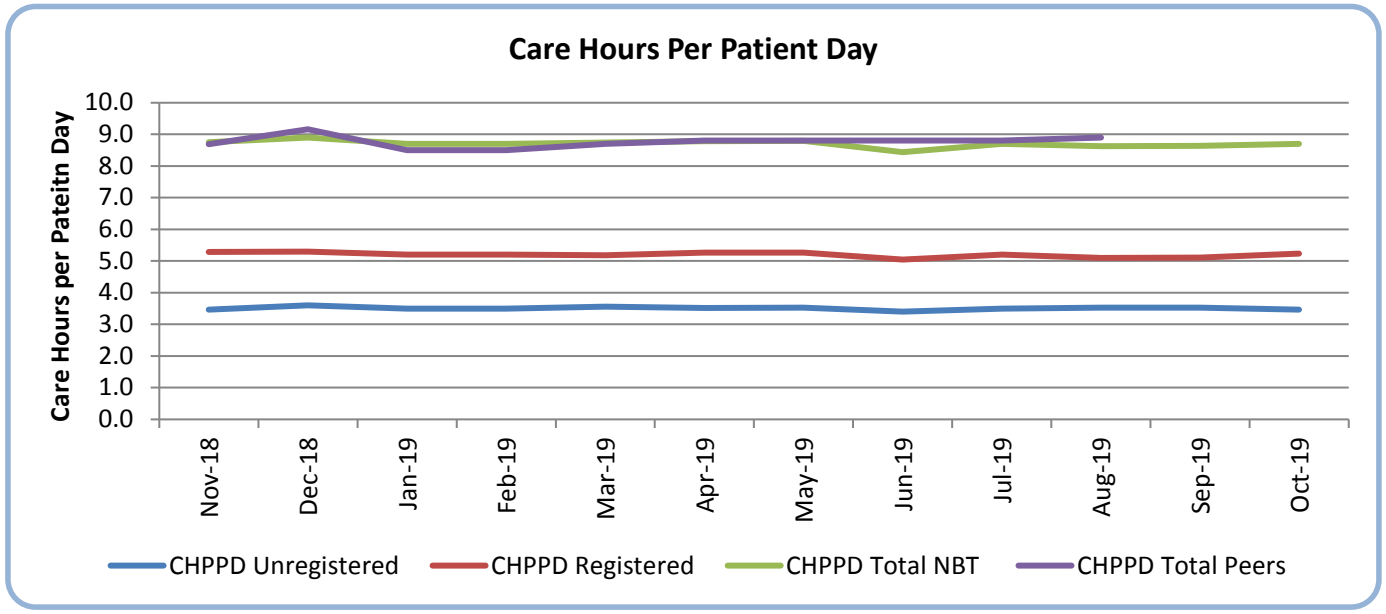
The staff staffing report now requires the wards to identify Nursing Associates including Trainees and AHP staff employed in an inpatient area. The current version of the roster system is unable to break this down however changes are anticipated and will be back reported as soon as it is possible.

Wards below 80% fill rate are:

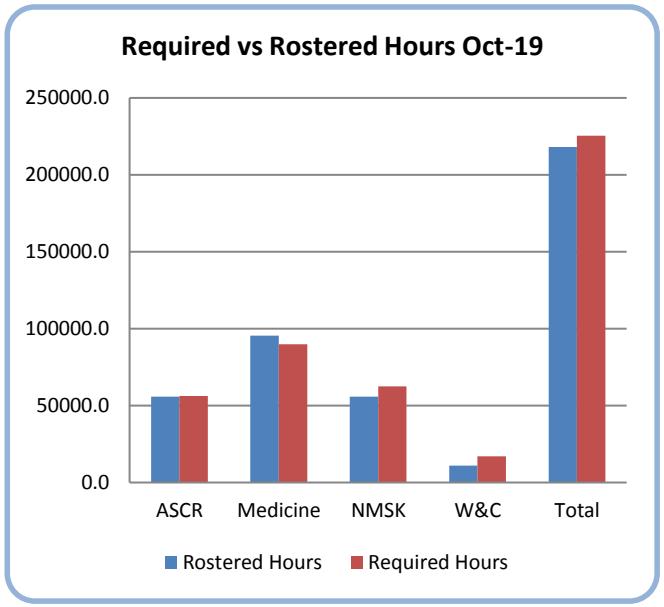
Gate 37 ICU: Care Assistants : Day 51.2% Night 79. 4%
There are a number of vacancies at Band 2. Priority is given to the night shift to fill as there are more staff to support direct patient care in the day. Shifts at CA level are unable or not required to be backfilled.
Gate 19: CA Days 56.4.% This area is reported as it has been open as escalation capacity for more than three consecutive nights. The fill rate is due to vacancy across the gate which includes the labs, the base template is currently under review. The area will only admit patients to the number of staff available, and is being closely monitored to the SOP by the matron to maintain patient safety.
Quantock: MCA 75.1% Days 74.5% MCA nights. The unit continues to have a high number of STS and LTS and the team are working with HR to resolve this. Whilst staffing is challenged, the extended bed base has remained on Percy Philips, where there is a constant midwife presence to ensure patient safety. The coordinating Midwife on CDS maintains overnight to ensure safety and support to the unit, this is often less that the reportable 2 hours.
NICU: 0% Fill rate for MCAs on both days and night. Due to a significant change in the underlying template for planned care assistant hours we are unable to create a return for planned V actual hours for October due to the inaccuracy of the manual collection. The base template has been fixed within the rota so reporting will be accurate and recordable.
32B: Care Staff Day 75.1%. Unable to fill vacant HCA shifts with Bank. Back fill into shifts by allocation of staff from other areas; support from Student Nurses. Staffing levels monitored by Matron and SWS to ensure patients remain safe and well cared for.
33B Care Staff Day 76.1% night 75% the baseline template was built to allow for the nursing associate role as explained above. The nursing associate role is not fully recruited into and are being filled by RNs this is reflected in the elevated RN fill rate of 111.1% and 121.1% respectively

Medirooms: Day Shift RN 76.4% Ca 78.2% The fill rate are due this this being predominately an over night surgical recovery where many patients leave in the morning therefore staff are moved to support through the rest of Medirooms returning to support those who need an extended stay in the area in the evening.

Ward over 150% fill rate: No wards this month.



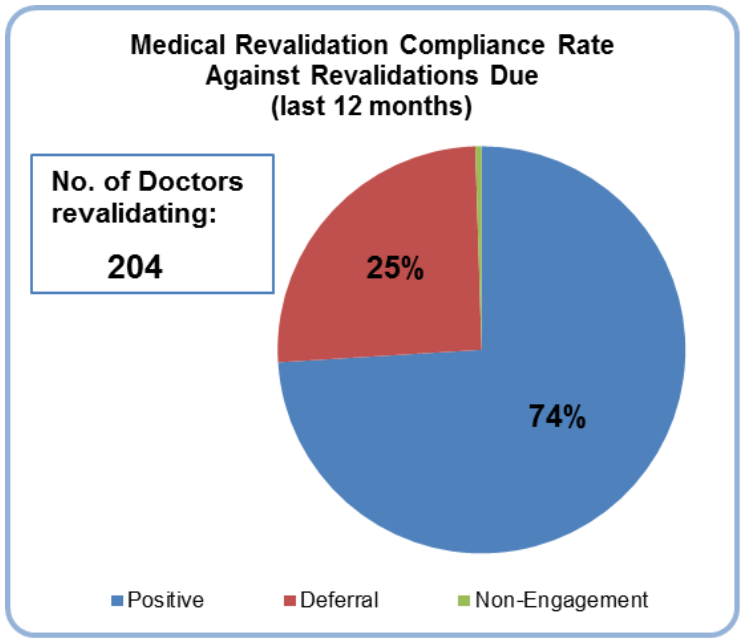
Care Hours per Patient Day (CHPPD)
The chart shows care hours per patient day for NBT total and is split by registered and unregistered nursing. The chart shows CHPPD for our Model Hospital peers (all data from Model Hospital. Peer values are only available to Feb 2019).

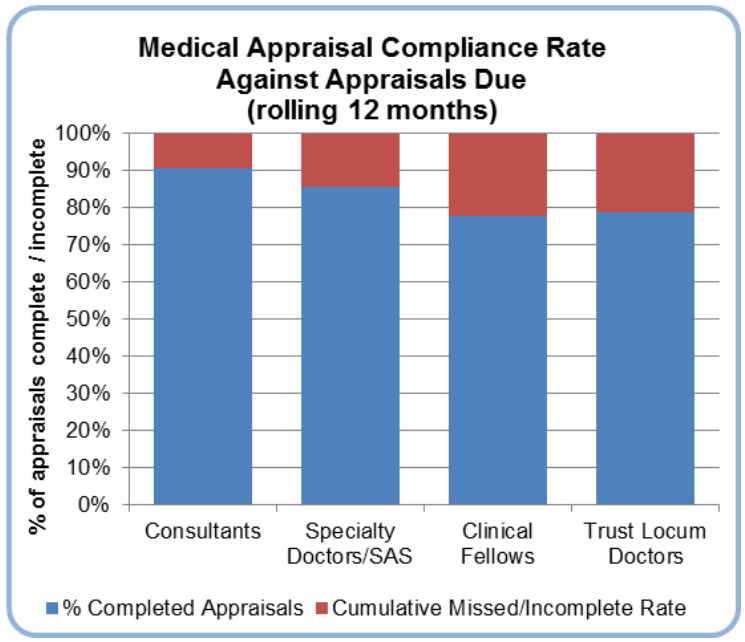


Safe Care Live
(Electronic Acuity tool)
The acuity of patients is measured three times daily at ward level.

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.





Medical Appraisal

Within the current appraisal year (1 April 2019 - 31 March 2020), 85% of the appraisals that are due by now have been completed. Those with an overdue appraisal are being managed through the missed appraisal process.

The doctors connected to the Trusts Designated Body for appraisals and revalidation includes consultants, specialty doctors, associate specialists, clinical fellows and trust locum doctors. Junior doctors in training are revalidated by Health Education England.

The Trust has deferred 25% of all revalidation recommendations due over the past 12 months. This is comparable to other designated bodies. From March 2019, the GMC has been collecting further information for the reasons of each deferral.

NHS North Bristol NHS Trust

Finance

Board Sponsor: Director of Finance
Catherine Phillips

	Position as at 31 October 2019		Forecast as at October 2019	
	Actual	Variance (Adverse) / Favourable	Full year Forecast	Variance (Adverse) / Favourable
	£m	£m	£m	£m
Contract Income	307.0	(3.9)	527.7	(1.6)
Other Income	47.5	(1.7)	84.4	(0.1)
Total Income	**354.5**	**(5.6)**	**612.1**	**(1.7)**
Pay	**(222.1)**	**2.3**	**(384.3)**	**2.0**
Non-Pay	**(107.4)**	**1.5**	**(186.7)**	**(1.2)**
Depreciation	(14.1)	(0.2)	(23.9)	0.6
PFI Operating Costs	(3.6)	0.1	(6.2)	0.1
PFI Interest	(20.0)	(0.1)	(34.2)	0.0
Other Financing costs	(2.8)	0.3	(5.1)	0.2
Loss on Disposal	(0.2)	(0.2)	(2.1)	0.0
Adjusted surplus / deficit for NHS accountability (exc PSF)	**(15.7)**	**(1.9)**	**(30.4)**	**0.0**
PSF	11.3	0.0	25.0	0.0
Adjusted surplus / deficit for NHS accountability (inc PSF)	**(4.4)**	**(1.9)**	**(5.4)**	**0.0**
Gain on disposal	0.0	0.0	0.5	0.0
Control total	**(4.4)**	**(1.9)**	**(4.9)**	**0.0**

Statement of Comprehensive Income

Year to date position

Assurances

The financial position at the end of October shows a deficit of £4.4m, £1.9m adverse to the planned deficit. This adverse performance was forecast as it the result of a known phasing issue within the plan. The position is forecast to recover back inline with plan by the end of the quarter to allow the Trust to stay within the control total by the end of the year.

Key Issues

- Contract income is £3.9m adverse to plan largely due to under-performance in elective and non-elective inpatient activity.
- Other operating income is £1.7m adverse to plan due a number of factors including unachieved CIP which is likely to recover.
- Pay is £2.3m favourable to plan reflecting substantive vacancies offset in part by temporary staffing.
- Non pay is £1.5m favourable to plan mainly in clinical supplies and drugs.
- The savings shortfall at October was £4.1m, the impact of which has been offset by a number of one-off benefits.

Forecast Outturn

- The Trust is forecasting to meet its control total.
- This reflects anticipated improvements in both elective inpatient activity and in non-elective case-mix.
- Under-performance of income and under achievement of savings represent risks to the delivery of the Trust's control total, however a number of opportunities have also been identified to mitigate against this.

31 March 2019 £m	Statement of Financial Position as at 31st October 2019	Plan £m	Actual £m	Variance above / (below) plan £m
	Non Current Assets			
558.1	Property, Plant and Equipment	556.3	549.8	(6.5)
17.0	Intangible Assets	15.3	15.3	0.0
8.5	Non-current receivables	8.5	8.5	0.0
583.6	**Total non-current assets**	**580.2**	**573.6**	**(6.5)**
	Current Assets			
12.8	Inventories	11.2	12.3	1.1
35.5	Trade and other receivables NHS	51.6	27.4	(24.2)
37.1	Trade and other receivables Non-NHS	21.7	35.1	13.3
10.2	Cash and Cash equivalents	8.0	21.1	13.1
95.7	**Total current assets**	**92.5**	**95.8**	**3.3**
0.0	Non-current assets held for sale	0.0	0.0	0.0
679.3	**Total assets**	**672.7**	**669.5**	**(3.2)**
	Current Liabilities (< 1 Year)			
9.4	Trade and Other payables - NHS	9.4	7.4	(2.0)
64.8	Trade and Other payables - Non-NHS	62.7	65.9	3.1
70.8	Borrowings	70.1	68.0	(2.2)
145.0	**Total current liabilities**	**142.3**	**141.2**	**(1.0)**
(49.3)	**Net current assets/(liabilities)**	**(49.7)**	**(45.4)**	**4.3**
534.3	**Total assets less current liabilites**	**530.4**	**528.2**	**2.2**
7.8	Trade payables and deferred income	7.6	7.6	0.0
517.8	Borrowings	514.9	514.6	(0.3)
8.7	**Total Net Assets**	**7.9**	**6.0**	**(1.9)**
	Capital and Reserves			
243.9	Public Dividend Capital	245.5	245.1	(0.3)
(375.2)	Income and expenditure reserve	(381.6)	(381.6)	0.0
(6.4)	Income and expenditure account - current year	(2.5)	(4.0)	(1.5)
146.5	Revaluation reserve	146.5	146.5	0.0
8.7	**Total Capital and Reserves**	**7.9**	**6.0**	**(1.9)**

Statement of Financial Position

Assurances

The Trust has received net new loan financing for the year to date of £1.0m. This brings total borrowing from the Department of Health and Social Care to £179.3m.

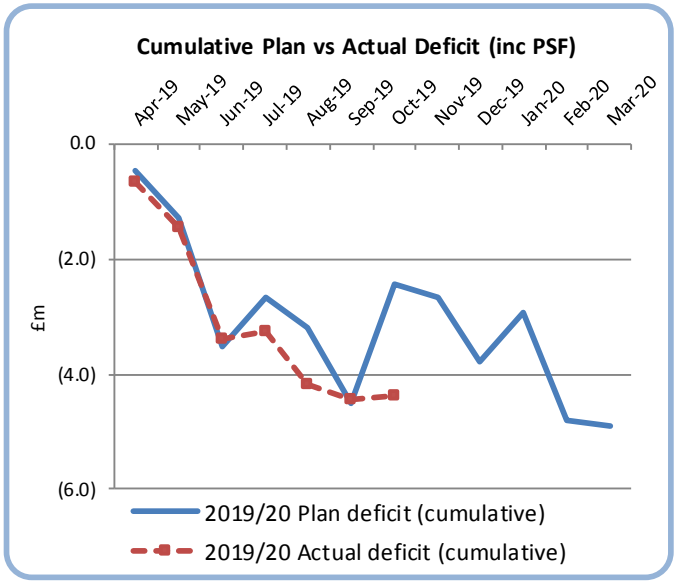
The Trust ended the month with a cash balance of £21.1m, compared with a plan of £8.0m. This higher balance is partly due to £6.1m of year to date slippage on the capital expenditure, along with 2018/19 over performance monies received in year but not yet utilised to reduce trade payables. .

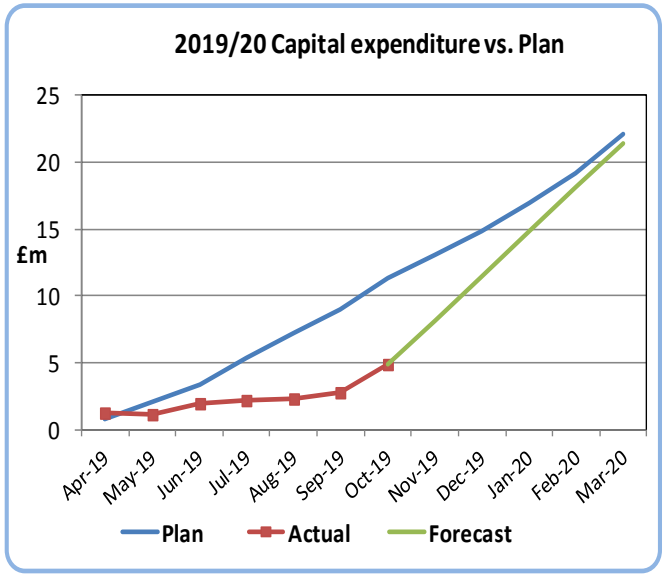
Concerns & Gaps

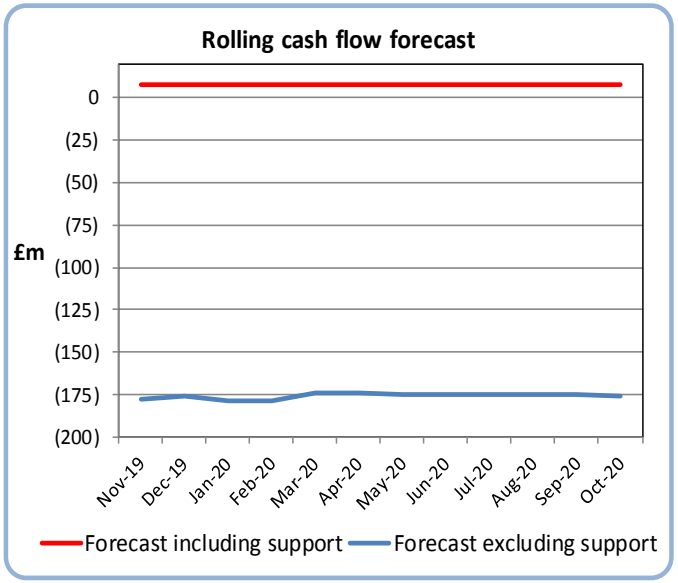
The level of payables is reflected in the Better Payment Practice Code (BPPC) performance for the year which is 74% by volume of payments made within 30 days against the target of 95%.

Actions Planned

The focus going into 2019/20 continues to be on maintaining payments to key suppliers, reducing the level of debts and ensuring cash financing is available.







Weighting	Metric	Year to date	Forecast
0.2	Capital service cover rating	4	4
0.2	Liquidity rating	4	4
0.2	I&E margin rating	4	3
0.2	I&E margin: distance from financial plan	1	1
0.2	Agency rating	1	1
	Overall finance risk rating	**3**	**3**

Rolling Cash Forecast, In-year Surplus/Deficit, Capital Programme Expenditure and Financial Risk Ratings

The overall financial position shows a £4.4m deficit, £1.9m adverse to plan.

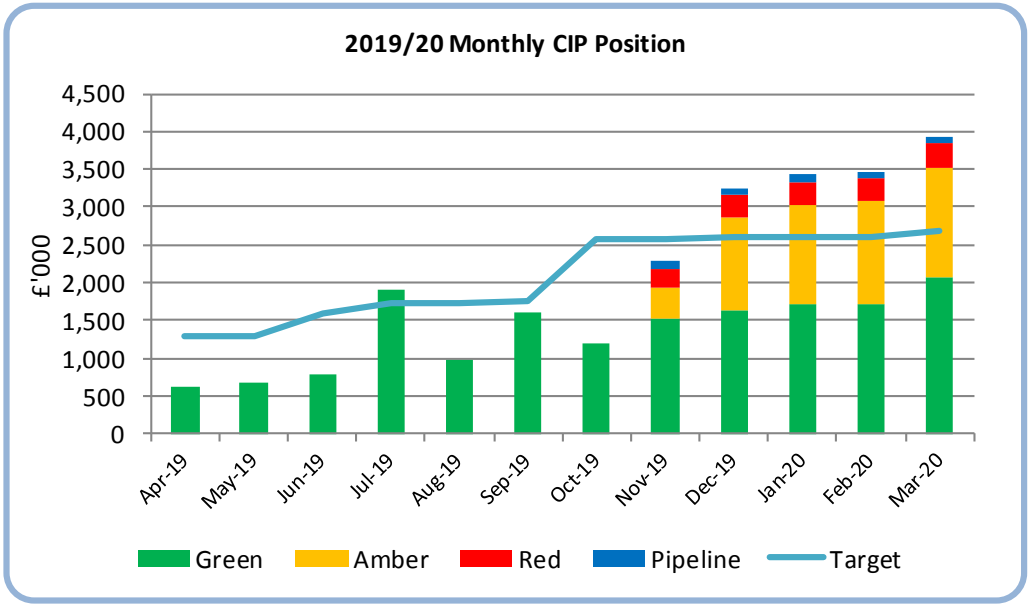
The capital expenditure for the year to date is £4.9m. The revised expenditure forecast for 2019/20 is £21.4m.

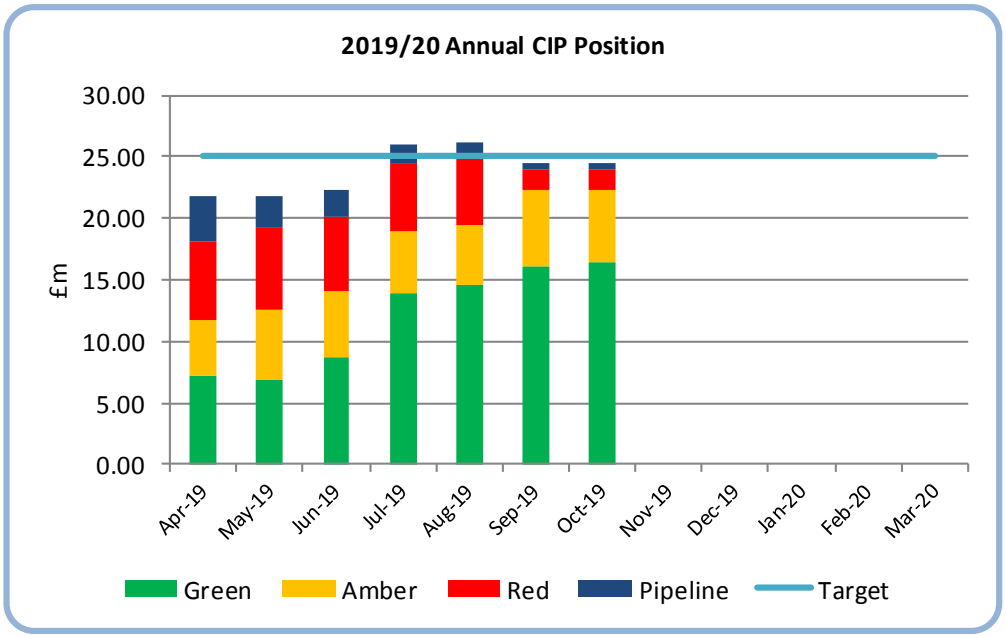
Assurances and Actions

- Ongoing monitoring of capital expenditure with project leads.
- Cash for our planned deficit for the year to date has been made available to the Trust via DH borrowing.

Concerns & Gaps

The Trust has a forecast rating of 3 out of 4 (a score of 1 is the best) in the overall finance risk rating metric.





Savings

Assurances

The savings target for 2019/20 is £25m against which £24.4m has been identified as at the end of October.

Concerns & Gaps

The graph shows the phased forecast in-year delivery of the £24.4m identified schemes. £22.4m of these are rated as green or amber.

Savings delivery is £7.8m as at the end of October, £4.1m adverse against a plan of £11.9m.

Of the £24.4m identified savings in 2019/20, £16.4m is recurrent with a full year effect of £21.6m.

Actions Planned

Maintain focus on identifying opportunities and improving the rate at which ideas and opportunities are turned into full plans for delivery.

Continued monitoring of actions required to deliver identified savings for 2019/20.

Regulatory

Board Sponsor: Chief Executive
Andrea Young

The Governance Risk Rating (GRR) for ED 4 hour performance continues to be a challenge, actions to improve and sustain this standard are set out earlier in this report. A recovery plan is in place for RTT incompletes and long waiters (please see key operational standards section for commentary). In quarter, monthly cancer figures are provisional because the Trust's final position is finalised 25 working days after the quarter end.

We are scoring ourselves against the Single Oversight Framework for NHS Providers (SOF). This requires that we use the performance indicator methodologies and thresholds provided and a Finance Risk Assessment based upon in year financial delivery.

Board compliance statement number 4 (going concern) warrants continued Board consideration in light of the in-year financial position (as detailed within the Finance commentary). The Trust has trajectories for any performance below national standard and scrutinises these through quarterly oversight meetings with NHS Improvement.

Regulatory Area	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19
Finance Risk Rating (FRR)	Amber	Amber	Amber	Amber	Amber	Amber	Amber	Amber	Amber	Amber	Amber	Amber
Board non-compliant statements	0	0	0	0	0	0	0	0	0	0	0	0
Prov. Licence non-compliant statements	0	0	0	0	0	0	0	0	0	0	0	0
CQC Inspections	RI	RI	RI	RI	RI	RI	RI	RI	RI	RI	Good	Good

CQC reports history (all sites)

Location	Standards Met	Report date
Overall	Good	September 2019
Southmead Hospital	Good	September 2019
Cossham Hospital	Good	February 2015
Frenchay Hospital*	Requires Improvement	February 2015

* No longer a separately CQC registered site, and will not appear in future iterations of this report.

Monitor Provider Licence Compliance Statements at October 2019
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.
P5	Constructive engagement concerning local tariff modifications	Yes	Trust Board has considered the assurances in place and considers them sufficient.
C1	The right of patients to make choices	Yes	Trust Board has considered the assurances in place and considers them sufficient.
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.

Board Compliance Statements at October 2019.
Self-assessed, for submission to NHSI

No.	Criteria	Comp (Y/N)	No.	Criteria	Comp (Y/N)
1	The Board is satisfied that, to the best of its knowledge and using its own processes and having had regard to the TDA's oversight model (supported by Care Quality Commission information, its own information on serious incidents, patterns of complaints, and including any further metrics it chooses to adopt), the Trust has, and will keep in place, effective arrangements for the purpose of monitoring and continually improving the quality of healthcare provided to its patients.	Yes	8	The necessary planning, performance, corporate and clinical risk management processes and mitigation plans are in place to deliver the annual operating plan, including that all audit committee recommendations accepted by the Trust Board are implemented satisfactorily.	Yes
2	The board is satisfied that plans in place are sufficient to ensure ongoing compliance with the Care Quality Commission's registration requirements.	Yes	9	An Annual Governance Statement is in place, and the Trust is compliant with the risk management and assurance framework requirements that support the Statement pursuant to the most up to date guidance from HM Treasury (www.hm-treasury.gov.uk).	Yes
3	The board is satisfied that processes and procedures are in place to ensure all medical practitioners providing care on behalf of the Trust have met the relevant registration and revalidation requirements.	Yes	10	The Trust Board is satisfied that plans in place are sufficient to ensure ongoing compliance with all existing targets (after the application of thresholds) as set out in the relevant GRR; and a commitment to comply with all known targets going forwards.	Yes
4	The board is satisfied that the Trust shall at all times remain an ongoing concern, as defined by the most up to date accounting standards in force from time to time.	Yes	11	The Trust has achieved a minimum of Level 2 performance against the requirements of the Information Governance Toolkit.	Yes
5	The board will ensure that the Trust remains at all times compliant with regard to the NHS Constitution.	Yes	12	The Trust Board will ensure that the Trust will at all times operate effectively. This includes maintaining its register of interests, ensuring that there are no material conflicts of interest in the Board of Directors; and that all Trust Board positions are filled, or plans are in place to fill any vacancies.	Yes
6	All current key risks have been identified (raised either internally or by external audit and assessment bodies) and addressed – or there are appropriate action plans in place to address the issues – in a timely manner.	Yes	13	The Trust Board is satisfied that all Executive and Non-executive Directors have the appropriate qualifications, experience and skills to discharge their functions effectively, including: setting strategy; monitoring and managing performance and risks; and ensuring management capacity and capability.	Yes
7	The board has considered all likely future risks and has reviewed appropriate evidence regarding the level of severity, likelihood of it occurring and the plans for mitigation of these risks.	Yes	14	The Trust Board is satisfied that: the management team has the capacity, capability and experience necessary to deliver the annual operating plan; and the management structure in place is adequate to deliver the annual operating plan.	Yes

NHS North Bristol NHS Trust

Report To:	Public Trust Board		**Agenda Item:**	15.
Date of Meeting:	28 November 2019			
Report Title:	M6 Corporate Objectives Report			
Report Author & Job Title	Carl Lander, Business Planning Manager			
Executive/Non-executive Sponsor (presenting)	Catherine Phillips, Director of Finance			
Purpose:	**Approval/Decision**	**Review**	**To Receive for Assurance**	**To Receive for Information**
			x	
Recommendation:	Note the report on Month 6 delivery of 19/20 Trust objectives			
Report History:	Month 4 progress was reported to the September Board Month 6 progress was reported to November's TMT			
Next Steps:				

Executive Summary	
The Board is asked to note the attached report on progress towards corporate objectives at Month 6.	
Strategic Theme/Corporate Objective Links	
Board Assurance Framework/ Trust Risk Register Links	
Other Standard Reference	
Financial implications	**Total cost:** **Is this capital and/or revenue?** **Is this in the budget (revenue and/or capital) If not, how will it be funded?**
Legal Implications including Equality, Diversity and Inclusion Assessment	

Appendices:	Appendix A: Month 6 objectives delivery report.

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

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North Bristol NHS Trust

Purpose

1.1. Our five-year strategy, published in 2016, sets out our longer term ambitions for NBT. Annual objectives are set in our plans which are aligned to delivery of our strategy and address the priorities for the year ahead.

1.2 Progress against our objectives is tracked with Key Result Areas and reported to the Board.

2. Background

2.1. Annual corporate objectives are developed and agreed during the annual operational planning process. For 19/20, the Business Planning team will coordinate reports on delivery progress at Month 2, Month 4 and Month 6, this report being the final report for the financial year.

3.1 The report provides a brief description of the Key Deliverables and Key Result Areas with provides an indication of the progress of the Key Deliverable at M6 alongside a forecast position for the year.

3. Key Points

3.1. Of the thirty five objectives the following table sets out the current and forecast RAG rating for each objective.

	M6 RAG Rating, M4 in parentheses	**Forecast RAG Rating,** M4 in parentheses
Green	15 (15)	21 (19)
Amber	16 (15)	10 (11)
Red	3 (4)	3 (4)

3.2. Red rated objectives relate to performance targets on cancer waiting times, A&E 4 hrs and 52 week waits. Each of these objectives has a recovery plan in place, however these plans will not enable the Trust to make an in year recovery to meet the planned trajectories.

- Cancer waiting times remains at risk due to high levels of demand vs. capacity to deliver,
- DM01 diagnostic waiting times the plan is forecast to meet the Trust position (as agreed with commissioners), but will not achieve national compliance,
- Referral to Treatment Time 52 week wait trajectory remains above plan with breaches remaining static.

4. Recommendations

4.1 TMT is asked to note the report on Month 6 delivery of Trust objectives.

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	Key Deliverables	Key Result Areas	M6 Update	M6 YTD	Exec Fcast	Governance	Key Metrics / Milestones	Exec
Objective 1: Be one of the safest trusts in the UK	Achieve "good" CQC rating	• Achieve "good" or better assessments from next CQC visit	Final Inspection Report published - overall Good rating achieved, with ratings of Outstanding achieved for 'Caring' and 'Well Led' domains.			TMT & Quality & Risk Management Committee (QRMC)	Unannounced inspection undertaken 25-27 June 2019. Well Led inspection undertaken 16-18 July 2019 Final reports published 25/9/2019. Action Plan approved by Board 31/10/2019 Action Plan submission to CQC 1/11/2019	Director of Nursing and Quality
	Build on our Perform programme	• Sustaining 18/19 levels of LOS in 19/20Q1-Q3	LoS hot spots have been identified in NMSK and ASCR and are the subject of further work overseen by the Urgent Care Improvement Steering group, supported by Perform. High levels of DToC patients (9% vs. 3.5% target) continue to be experienced, with regular escalation across the system seeking to address delays in community capacity and domiciliary care.			Transformation Board	Flow Metrics reported in Perform dashboard and in Qliksense inpatient report which compares length of stay by month and area.	Director of People and Transformation
	Invest in clinical governance for learning and improvement	• Implementation of planned clinical governance capacity	Quality governance day held with all clinical divisions as planned on 15/10/19 and priorities agreed for future development, including quarterly 1/2 day workshops. Divisional posts now in place. Quality Governance Improvement Programme (Phase 2) scheduled to commence with Programme Board 15/11/19 to shape the projects and deliverables over next 9 months.			Quality & Risk Management Committee (QRMC)	Recruitment into clinical governance posts and induction/training programme - roles recruitment by 30/9/2019 QGIP phase 2 (embedding and benefits delivery) - programme updated and deliverables to be set at first Programme Board meeting scheduled 11/11/2019.	Director of Nursing and Quality
		• Deliver milestones in Trust Quality Strategy	M6 Quality Account priorities review going to November TMT & QRMC meetings. Quality Strategy timeframe revised in light of Trust Strategy updates. Now scheduled for November or December Board.			TMT to monitor delivery	Deferral agreed to November Board to align to overall Strategy refresh (31 Oct 2019) Qualtoiy Account Priorities M6 update also to be provided to QRMC and Board (operational delivery of Quality Strategy goals) Integrate into Business Planning process 2020/21 (from Oct 2019)	Director of Nursing and Quality
	Deliver the digital programme	• Performance against digital programme milestones	The EPR Project Board has now been established and is chaired by Dr. Ben Jordan, Consultant Emergency Medicine. The Outline Business Case for the EPR change has been approved at the various groups, committees and Boards in October and the project will now move into the procurement phase. A Chief Nursing Information Officer (CNIO) has been appointed.			CCIO The Project Board is chaired by the COO. IMT Committee	IM&T Committee in April and May 19 approved inclusion of Speciality leads in the Digital Engagement group and appointment of 2 more band 8A Clinical Informaticians to lead the consolidation of Systems task and finish group. A project manager has been appointed to draft the OBC starting July 19.	Director of Informatics
	Introduce three clinical IT systems	• Delivery of Clinical Messaging & handover App	The Careflow connect project board has been established and Mel-de Witt, Head of Nursing is chairing the project board. The pilot is on-going on ward 9b and 34b and the results of the pilot are due to be presented to the Committees and Boards in December. Further funding has been received via the HSLI funding (£236k) process to complete the procurement and roll-out of the full implementation of the Careflow Connect following approval of the benefits realisation.			IMT Committee reports to TMT and Board	Selection of product for Proof of Concept (Apr 19) Proof of Concept across 2 specialities (June 19) Full Business Case for full system roll-out (Sept 19) Trust Wide roll-out commences (Jan 20) Project Completion (March 20)	Director of Informatics
		• Delivery of Blood Tracking Solution (**replaced EPMA)	The phase 1 part of the roll-out has been successful with the Kiosk and Enquiry now live across the whole organisation. Phase 2 is due to roll-out on 11th November in Medical Day Care Until in gate 5. This will involve the pilot of the PDA's. Phase 3 is due to go live 6th January and this is dependent on the network connectivity for the WiFi. However further delays may be expected if the Go Live is rejected due to winter pressures			IMT Committee reports to TMT and Board	Software installed (March 19) All kiosks installed and all training complete (May 19) Full Trust roll-out (July 19) Project Completion (Sept 19)	Director of Informatics
		• Delivery of E-Observations	The Careflow Vitals project board has now been established and is being chaired by Nigel Lane, AMU consultant. Work with System C is progressing well. All tasks are on track for a pilot Go Live in February 2020.			IMT Committee reports to TMT and Board	Implementation planning commenced (May 19) Phase 1 implementation complete (Dec 19) Phase 2 implemenation Trust Wide roll-out commenced (Jan 20) Project Completion (March 20)	Director of Informatics

	Key Deliverables	Key Result Areas	M6 Update	M6 YTD	Exec Fcast	Governance	Key Metrics / Milestones	Exec
Objective 2: Improve patient access and experience	Cut waiting times for cancer treatment	• Performance against improvement trajectory	Urology breaches accounted for c.38% of total Trust breaches for July against the 62 day wait time standard. The Urology remedial action plan and recovery trajectory is predicted to deliver the standard in quarter 1 of 2020/21. The Trust is delivering one of the other six cancer wait time standards in month, which is for 31 day subsequent treatment standard for patients receiving anti-cancer drugs, with performance of 100%. The area of greatest challenge for the Trust has been the summer demand for patients with suspected skin cancer requiring their first appointment within two weeks. Plans are in place for in-year improvements, such as delivery of a 'super clinic' to see c.100 patients in one day. However, a return to standard is not expected during 2019/20 as demand outstrips current capacity.			Performance discussed at Divisional Performance Review meetings, Deep dives in Finance & Performance Committee and Quality & Risk Management Committee	Cancer Board. Weekly PTL meetings in all Divisions Performance reported against key metrics within monthly IPR - received by OMB, TMT and Board. Full Remedial Action plans (RAP) in place and discussed monthly with CCG via Access and Performance Group Monthly.	Chief Operating Officer
	Deliver DMO1 waiting times for diagnostics	• Performance against improvement trajectory	The Trust did not achieve the national 1% target for diagnostic performance in August 2019 with actual performance at 9.39%. This is an anticipated decline in performance from the July 2019 position, and did not achieve the trajectory of 5.10%. This is the third consecutive month that the trajectory has not been delivered, but is expected to be the peak in underperformance in 2019/20. Four test types have reported in month underperformance: Colonoscopy; Computed Tomography (CT); Flexi-Sigmoidoscopy; and Gastroscopy – with 1023 patients in total waiting beyond 6 weeks for their test. Mini Root Cause Analyses are being undertaken for any patients waiting greater than 13 weeks for their test to ensure there has been no harm as a result of the extended wait. The forecast is return to Trust trajectory (as per undertakings) not 1% compliance by the end of the financial year.			Performance discussed at Divisional Performance Review meetings, Deep dives in Finance & Performance Committee and Quality & Risk Management Committee	Weekly performance meetings with relevant divisions to monitor DM01 perf times Performance reported against key metrics within monthly IPR - received by OMB, TMT and Board.	Chief Operating Officer
	Significantly increase Emergency Zone staffing	• Performance against A&E improvement trajectory	For the first time in 2019/20, the Trust has delivered its recovery trajectory for the Emergency Department 4 hour standard with performance of 87.89%. This has exceeded the England position for the month. Improvements in performance are predominantly due to increased staffing with marked improvement in performance at weekends. Higher levels of performance have continued into September.			Performance discussed at Divisional Performance Review meetings, Trust Management Team and Trust Board. External partner engagement via STP structures.	Urgent Care Improvement Board chaired by the COO. Updates relating to undertakings from NHSI reported to private Board monthly. Performance reported against key metrics within monthly IPR - received by OMB, TMT and Board. Winter plan signed off by the Board in October but noted there is increased risk vs. the plan last year due to system C&D gap and progress to date on Stranded Action plan	Chief Operating Officer
		• Delivery of new emergency care models with increased staffing	Resource agreed to continue GP streaming pilot for Q3. Business case for Q4 will be presented at CCG Commissioning Exec in Nov 19. This will also detail intentions to continue beyond 19/20 and become routine service provision.			Business cases for increased ED staffing approved via Trust Management Team and Trust Board. Performance discussed and monitored via Divisional Performance Review meetings.	CCG/NBT project group meets weekly. Progress overseen by the Urgent Care Improvement Board chaired by the COO	Chief Operating Officer
	Eliminate all 52 week waits for operations.	• Profile against trajectory of improved numbers of 52 week waiters towards year-end target of zero	6/11 - no call out to Lisa as she is in meetings B2B all day. The Trust has not achieved the RTT trajectory in month with performance of 83.39% against trajectory of 87.68%. The total RTT wait list size in month is above plan by an additional 427 patients, reporting 28587 against a trajectory of 28160. This is a 1.5% variance to plan vs. a 1.7% variance last month. The number of patients exceeding 52 week waits continues above trajectory (5) reporting 14, a static position from June; the majority of breaches (12) being on an MSK pathway.			Performance discussed at Divisional Performance Review meetings, Deep dives in Finance & Performance Committee and Quality & Risk Management Committee	Weekly intensive support for MSK and Plastic Surgery. Updates relating to undertakings from NHSI reported to private Board monthly. Performance reported against key metrics within monthly IPR - received by OMB, TMT and Board. Deep dive of 52 week issues and trajectory presented at June F&PC.	Chief Operating Officer
	More responsive care for people with learning disabilities, autism or both	• Roll out training to front line staff	In addition to previous autism training the Trust has sourced eLearning training for patients with a Learning Disability and will be available to staff by mid-December and will be part of mandatory training for all staff.			Reports progress into LD and Autism Steering Group chaired by Helen Blanchard as part of groups workplan	Target is 85% uptake across the Trust. Monitored via a quarterly report through MLE	Director of Nursing and Quality
		• Improve identification of patient needs and make reasonable adjustments to care	Some progress made through our Learning Disability Champions and the use of the patient passport. Consistent identification of patient needs across the Trust is required and will be taken forward through the Learning Disability and Autism Steering Group meeting in December. There are some examples of excellent practice of adjustments made by teams to support patients access to care and treatment having giving a positive experiences and outcomes			Reports progress into LD and Autism Steering Group chaired by Helen Blanchard as part of groups workplan	KPIs to be developed as part of the programme	Director of Nursing and Quality

	Key Deliverables	Key Result Areas	M6 Update	M6 YTD	Exec Fcast	Governance	Key Metrics / Milestones	Exec
Objective 3: Work more closely with other hospitals, community services, GP practices and social care	More tests, treatments and advice in homes and health centres	• Progress on Acute Care Collaboration programmes	The LMS continues to meet regular and progress the workstreams that were delineated. NBT continue to participate fully in those workstreams. The NICU Cross-city project has produced the OBC which was passed by both boards of NBT and UHB. The HOSC has also been informed of the plans. Work is progressing on the FBC.			ACC Steering Group		Medical Director
		• Delivery of Integrated Care System development and system digital programme milestones	Video Consultation - in the processes of being scoped as part of the outpatient transformation project. Careflow Connect - update above WiFi access - completed and will be enahanced as part of the network project which is due to complete in Feb 2020. Discharge summaries - all discharge summaries are digitally sent to GP practises however a % of them are sent direct from ICE and not Connecting Care. ICNet - a project manager has been assigned and NBT are working with UHB to deliver a single system / joint procurement of the ICNet solution			People and Digital Committee	Proof of concept of Remote Video Consultations commenced (July 19) Proof of concept for Careflow Connect handover and treatment messaging with out of hospital services (Aug 19) Implementaion of WiFi access at remote locations for staff (Sept 19) All discharge summaries delivered to Connecting Care (Oct 19) Joint STP procurement for a single Infection Control System (Dec 19)	Director of Informatics
	Faster stroke treatment and rehabilitation for all patients.	• Performance against agreed key milestones in System stroke pathway development in 2019/20	BNBT Specific Update - Thrombectomy Service has extended operating hours from 09.00 to 17.00 to 08.00 to 20.00 in M6. A business case has been produced to redesign the service and increase Hyper Acute Stroke beds from 6 to 10 to meet local population demand. STP Update - appointed new Programme Management team and acute and rehabilitation models are close to finalisation.			The STP work reports into the BNSSG Stroke Reconfiguration Board. The internal NBT work reports in to the Stroke Development Steering Group.	STP - Complete service redesign and implementation by August 2020. NBT - Thrombectomy increased provision by August 2019. (8-8) NBT - Further increase in thrombectomy cover October 2019 (7 day service)	Medical Director
	Deliver NBT's excellent breast, urology and histopathology services for people in Weston	• Delivery of Breast, Histopathology and Urology services at Weston	Breast service transfer agreed. Likely to be implemented in April 2020.			ASCR DMT TMT ACC Steering Group	Service transfer on Breast Business case on Urology	Medical Director

	Key Deliverables	Key Result Areas	M6 Update	M6 YTD	Exec Fcast	Governance	Key Metrics / Milestones	Exec
Objective 4: Build effective teams empowered to lead	Prioritise the health and wellbeing of our staff.	• Improved employee engagement and take-up of wellbeing offer	The rolling 12 month sickness position remains at 4.3%. The improvement in time lost for MSK Reasons and Stress/Anxiety/Depression/Other psychiatric illness has levelled off, there have been approximately the same number of FTE days lost to absence for these reasons in the last 12 months that the same period last year. There has been a small increase in MSK related absence and a small decrease in Stress related absence; although overall the position for both absence types is improved from this time last year			Sickness is monitored throguh Divisional Reviews and the IPR and reviewed by the People and Digital Committee	Continue trajectory of reduction in absence due to MSK related reasons over rolling 12 months in 18/19: -5.4% for the year. Continue trajectory reduction in absence due to stress, anxiety, depression related reasons in 18/19: -3.0% for the year. Takeup of wellbeing programme by staff: indicator target is EAP programme used by 5% of staff.	Director of People and Transformation
		• Employed establishment target against funded establishment	The rolling 12 month sickness increased slightly to 4.4%. This means that we are slightly above the target absence level set for the year. There has been a small increase in MSK related absence; and stress related absence is at the same level as last month. Action is in place to mitigate this position, including recruitment underway to vacant physio direct position.			Metrics are monitored through the IPR which is reviewed by the People an Digital Committee and Vacancy Factor, Sickness Absence are monitored through Divisional Performance Review accountability framework	Health and Wellbeing: Sickness Absence Health and Wellbeing: Time lost to sickness absence Stress/Anxiety/Depression, and; MSK Sustainability: Stability Index % Sustainability: Vacancy Factor % Sustainability: Engagement – Happy App Positive/Neutral	Director of People and Transformation
		• Expanded usage of new roles	The Trust vacancy factor decreased to 9.4% in September from 11.6% the previous month. This was predominantly due to the new intake of registered nurses and our international recruits, however, vacancies decreased across all staff groups and retention remains stable (see below). The Trust turnover remains at 14.8% in September 2019, this is the first time rolling 12 month turnover has dropped below 15% since April 2016. Provided the improvement seen year to date continues the Trust is on target to meet its turnover target of 14.5% for 19/20.					Director of People and Transformation
	Expand leadership development programme for staff	• Leadership development programmes for more staff groups, including apprentice programme	Leadership programme launched on 7th June with first Core Leadership day. Evaluation feedback has been positive.			Reporting updates to People and Digital Committee.	Numbers booking on programme are being tracked on MLE Weekly reports generated for divisions to monitor numbers on programme.	Director of People and Transformation
	Flexible working to use fewer agency and locum staff	• Agency and temporary expenditure against plan / monthly target	Expenditure on registered nurse agency reduced by £154k in September compared with August as a result of a reduction in tier 4 (non-framework) and tier 3 agency use. This was offset by a commensurate increase in tier 1 agency and bank, the intended consequence of the BNSSG high cost agency reduction project and Trust internal actions to increase bank capacity . Agency use decreased in September compared with August predominantly in ancillary staff and administration, with projects in patient records and clinical coding having the greatest impact.			Metrics monitored through IPR which is reviewed by People and Digital Committee and through monthly Divisional Reviews. Nursing and Midwifery Workforce Group monitor monthly.	Temporary Staffing: Agency worked WTE Temporary Staffing: Agency cost £	Director of People and Transformation
	Increase opportunities to do clinical research.	• Staff engagement in research	12m objective against strategy with final delivery of 10% increase expected by M12.			Reporting to RIG	Increase staff enagement with research - % of staff engaged with research	Medical Director

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	Key Deliverables	Key Result Areas	M6 Update	M6 YTD	Exec Fcast	Governance	Key Metrics / Milestones	Exec
Objective 5: Become financially secure for the long term	Live within our budget for fourth year in a row	• Monthly financial performance against plan	TThe Trust has planned a deficit of £4.9m for the year. This is in line with the control total agreed with NHS Improvement of £5.4m after excluding a planned profit on sale of £0.5m which is no longer allowed to contribute to delivery of the control total under the new business rules for 2019/20. At the end of September, the Trust reported a deficit of £4.4m which is £0.1m favourable to the planned deficit including Provider Sustainability Fund and Financial Recovery Fund. There are a number of risks to delivery of the year end control total including elective income recovery and delivery of savings. However, the Trust has identified a number of mitigating actions and is forecasting to deliver the control total. The Trust has borrowed a net £4.3m year to date to the end of September which brings the total Department of Health borrowing to £182.5m. The Trust has a savings target of £25m for the year, of which £6.8m was achieved at the end of September against a plan of £9.4m. The Trust is rated 3 by NHS Improvement (NHSI).			TMT F&PC		Director of Finance
		• Monthly CIP delivery against plan	Trust is on target to deliver its 19/20 CIP with £25m identified during 19/20, with £21m identified as recurring CIP			TMT	CIP identified vs NHSI-submitted target of £25m in year and £25m FYE CIP in-month delivered vs identified	Director of People and Transformation
	Deliver our transformational programme	• Monthly progress against milestones for Trust-wide themes (theatres, workforce, urgent care)	MES Business Case has been approved by both TMT and going to F&PC for approval in December			Transformation Board	Refer to business case	Director of People and Transformation
			Additional capacity in place as per agreed business plan for 19/20. utilisation has proven challenging during Q1 and Q2. recovery plans in place during Q3 and Q4.			Theatre Board	New Theatre capacity into the programme April 19 - complete theatre productivity programme to be delivered (Q2) Managed Equipment Service for theatres (Q3)	Director of People and Transformation
			LOS in medicine mantained from 18/19, hot spots in NMSK and ASCR to be supported over winter by PERFORM. CLD project behind plan overall but remains part of winter bed mitigations			Urgent care Programme Board	4 hr % performance Aggregated patient delay Assessed within 15 mins/ treated within 60 mins AEC / AMU and SDAU/ SAU metrics	Chief Operating Officer
	Refresh our five-year strategy and financial plan	• Strategy refresh agreed by Board	Board agreed strategy narrative at October meeting and expects to publish final version in January.			Strategy Steering Group, TMT and Board	Strategy expected to be finalised in September alongside long term financial model and transformation programme	Medical Director
		• Long Term Financial Model, aligned to strategy	Trust Board reviewing sustainabiliity plan in November.			TMT and Board		Director of Finance
	Achieve value in our services using clinical benchmarking	• Transformation and Improvement Programme informed by model hospital, GIRFT and 7-day working	Transformation Board has agreed internal GIRFT governance process. GIRFT implementation plan shared with BNSSG CCG. Gynae, Spinal and Urology to identify top 3 areas. 10 specialties have submitted their Top 3 focus areas.			Transformation Board	Report quarterly on progress on specialty focus areas of opportunity (to be confirmed).	Medical Director
	Make better use of our pathology resources	• Pathology Managed Services Contract (MSC) procurement	Outline solutions now due 11th November, evaluation process defined and resourced for completion in December. Agreement on sub contract break points complete and published. Proposal for linking the procurement to the pathology network process drafted and will be discussed at next project board.			West of England Pathology Network Board	Issue Invitation to Submit Detailed Solution (ISDS) to shortlisted bidders by 20 December 2019	Medical Director
		• Pathology Networking	SOC to be reviewed at BCRG 4th November before being submitted for final approval in November. Legal dialogue on impact of usinf MSC procurement to inform network decisions has taken place and will be discussed atnext WoEPN Board meeting on 3rd December			West of England Pathology Network Board	Submit Strategic Outline Case to Trust Boards and NHSI by end July 2019	Medical Director

Report To:	Trust Board		**Agenda Item:**	
Date of Meeting:	28 November 2019			
Report Title:	Freedom to Speak Up Bi-Annual Report November 2019			
Report Author & Job Title	Millie Warrington, Staff Engagement & Wellbeing Consultant			
Executive/Non-executive Sponsor (presenting)	Xavier Bell, Director of Corporate Governance & Trust Secretary			
Purpose:	**Approval/Decision**	**Review**	**To Receive for Assurance**	**To Receive for Information**
		X		
Recommendation:	Board are asked to: • Review progress against the FTSU vision, strategy and action plan and note the additions made in relation to the CQC recommendations • Review the FTSU data triangulated against other information • Discuss the report and findings			
Report History:	• Vision, Strategy and Action plan developed from Board session on 31 August 2018. • Bi-annual Freedom to Speak Up Board report reviewed at Trust Board on 29 November 2018 and 30 May 2019			
Next Steps:	• Monitor implementation of vision, strategy and action plan • Refresh FTSU strategy as part of the overall People Strategy • Continue to support and promote Freedom to Speak Up at North Bristol NHS Trust			

Executive Summary
Freedom To Speak Up (FTSU) Guardians have been in place at North Bristol NHS Trust (NBT) since November 2017 and the programme has been continually developing since that time. This report explores the most recent data around concerns being raised and compares with the National Average for Medium Acute Trusts for 2018/19, indicating that NBT are again broadly within the range of the number of concerns being raised. NBT's Speaking Up data indicates that we have seen an increase in the number of concerns

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being raised in the first two quarters of 2019/20 compared to the previous two quarters. National comparison data for this period is not yet available from the National Guardian's Office.

This report compares the type of concerns being raised through FTSU with the national average for medium sized acute trusts. The national average data shows a consistent pattern of the number of concerns gradually increasing over time and the proportions of different types of concern remaining consistent. Whilst NBT's record of concerns raised varies in volume and theme each quarter; overall the volume and breakdown of concerns is broadly in line with the national picture

This report also triangulates Speaking Up data with data from Happy App - showing the mood reported within different divisions over the same time period and the breakdown of different comment themes being posted. The data presented in the report suggests that FTSU is further embedding itself across the trust due to the number of concerns raised by divisions and the diversity in the range of themes being raised through FTSU.

The report also highlights the findings made as a result of the Well Led part of our recent Care Quality Commission (CQC) inspection, which resulted in a 'Good' overall rating, and a rating of 'Outstanding' in the Well-Led domain (which includes consideration of FTSU). In specific relation to FTSU, it found that overall, "the arrangements for speaking up had been strengthened and improved since our last inspection". However, it also found that a few key actions need to be taken in relation to:

- FTSU relationships with Trade Unions;
- accessibility of FTSU Guardians in Medicine;
- awareness of FTSU in surgery and pharmacy; and
- an ongoing need to continue to improve awareness and visibility of the Guardians and confidence of staff to speak up across the Trust.

The report also looks at progress made against the FTSU action plan developed following the Trust Board development session in August 2018, where good progress has been made, although the actions have been amended in light of the above CQC findings.

Finally, the report provides a short update on recently refreshed guidance from regulators on how FTSU should be arranged and embedded in NHS organisations, and outlines planned next steps to refresh the Trust's FTSU strategy and vision.

The Board are asked to review the data in the report, and note progress made against the action plan and additions to it.

Strategic Theme/Corporate Objective Links	Strategic Themes: Be one of the safest trusts in the UK Create an exceptional workforce for the future
Board Assurance Framework/Trust Risk Register Links	Having robust and effective FTSU arrangements is likely to improve the attractiveness of NBT as an employer, and may mitigate against risks to retention and recruitment, both of which are identified as strategic risks on the Board Assurance Framework (SIR2 and SER6).
Other Standard Reference	Freedom to Speak Up arrangements form part of the CQC Well

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	Led inspection. July 2019 FTSU guidance: https://improvement.nhs.uk/resources/freedom-speak-guidance-nhs-trust-and-nhs-foundation-trust-boards/
Financial implications	N/A
Other Resource Implications	N/A
Legal Implications including Equality, Diversity and Inclusion Assessment	EDS2 Objective: Better Health Outcomes EDS2 Objective: Representative and Supported Workforce

Appendices:	Appendix 1 – FTSU Vision, Strategy and Action Plan Appendix 2 – FTSU guidance (July 2019)

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1. Purpose

1.1 The purpose of this report is to update the Board on Freedom To Speak Up (FTSU) activity at North Bristol NHS Trust (NBT) over the past 6 months; providing information on the nature of concerns raised; comparing this activity where possible to the national picture, relevant internal data and identifying progress made against our strategy and actions. It also provides an update on recently updated FTSU guidance from regulators and reflections on findings and recommendations from the recent Care Quality Commission (CQC) report.

2. Background

2.1 Freedom to Speak Up Guardians have been in role since November 2017. The infrastructure is in place and the number of Freedom to Speak Up Guardians has increased further, with 14 current Guardians from diverse roles across the trust, representing the key employee groups and different levels of seniority. Since the last paper was received by the Board, two new Junior Doctors have been appointed into a FTSU Guardian Role, and an additional representative for NMSK has also been appointed. It should also be reported that there has been sufficient interest from various other staff across the organisation that there may be the option to consider “terms of office” for guardians.

2.2 The Board undertook the NHS Improvement self-assessment review in August 2018, which led to the creation of a vision, strategy and action plan for FTSU at NBT, which was also discussed and endorsed at the FTSU Guardians’ quarterly meeting in December 2018. The vision, strategy and action plan is enclosed as Appendix 1.

2.3 In May the Board received a bi-annual update on FTSU activity, triangulating data against the 2018 results from the NHS Staff Survey. This report indicated a decline in the number of FTSU cases being logged in the previous two quarters – compared to the National Average as reported by the National Guardian’s Office.

3. How NBT Compares to the National Picture

3.1 The National Guardians Office has been in the process of changing their online data submission portal for the past few months. The new portal went live on 7 October 2019, which means that the national FTSU data for the last two quarters is unavailable for comparison.

3.2 Chart 1 below shows the number of cases raised at NBT since Q1 17/18 compared to the national average. In the report presented to Board in May 2019, the data for that period (Q3 and Q4 18/19) indicated a reduction in the number of cases being raised at NBT, in contrast to the national picture. However, the chart also shows that in the last two quarters

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there has been an increase in concerns raised back to a level comparable to the likely national average. It will be important to review this again once the national average data is available; however it shows a more reassuring picture about the extent to which concerns are being raised at NBT than appeared to be the case in May 2019. This could be attributed a combination of natural fluctuations in the number of concerns being raised over time, as well as progress being made against the FTSU Action Plan over the past 6 months, with trust-wide communications continuing and further Guardian's being recruited into roles.

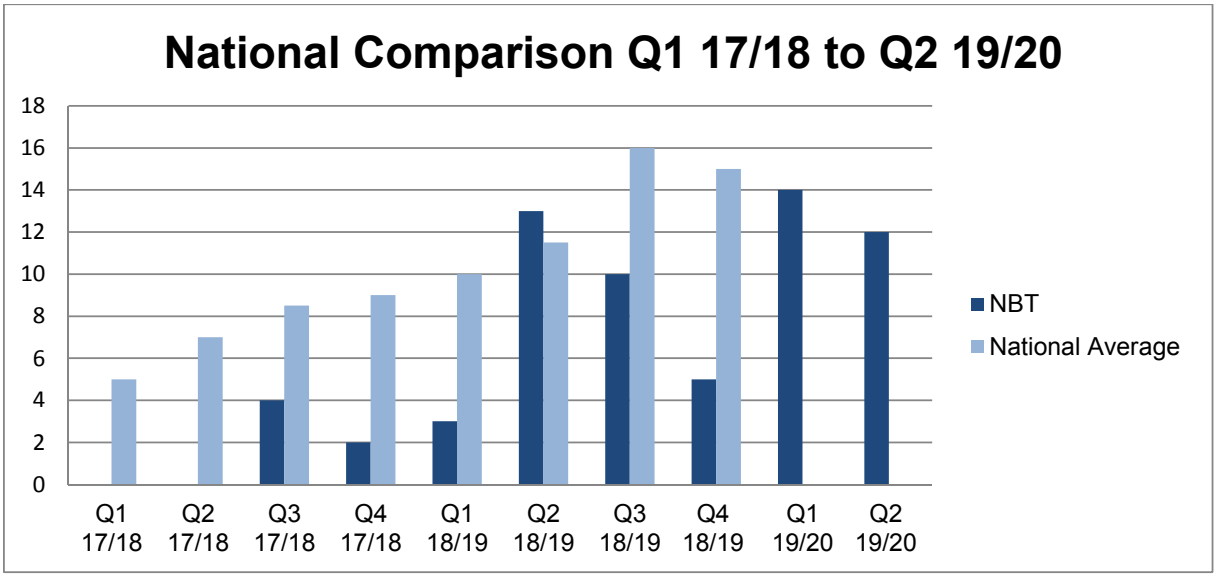

Chart 1: Number of FTSU Concerns raised at NBT in comparison to the National Average (up to Q4 18/19)

3.3 The below charts (2 to 5) compare the reasons for concerns being raised for NBT for Q1 to Q4 18/19 and compares this with the returns made for all Medium Acute NHS Trusts[1], this data is only accessible up to Q4 2018/19 at present.

3.4 This data shows that there is significant fluctuation in the reasons staff are speaking up over time. In the previous report, it appeared that NBT was in contrast to the national average with a high proportion of patient safety concerns being raised during 18/19 (Q2 in particular). However, looking at the pattern over Q3 and Q4 18/19, and then Q1 and Q2 19/20; the reasons for concerns are balanced more in line with the national average, suggesting that Q2 18/19 was an anomaly.

[1] Medium Acute Trusts are all Acute Trusts with a workforce between 5,000 and 10,000

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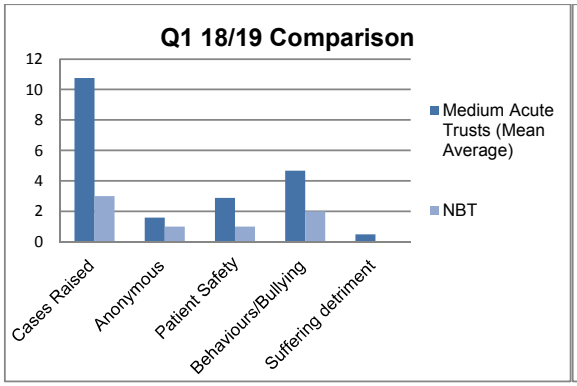

Chart 2: Q1 18/19 Comparison with Acute Medium Trusts

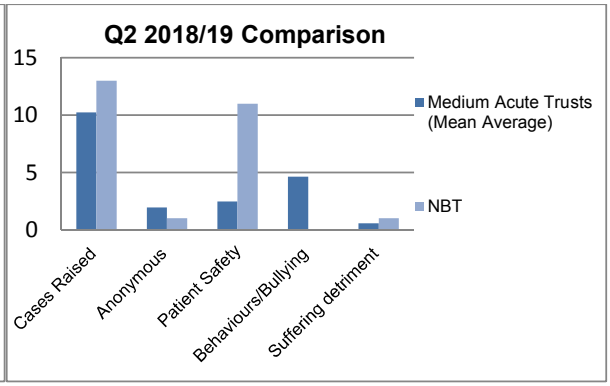

Chart 3: Q2 18/19 Comparison with Acute Medium Trusts

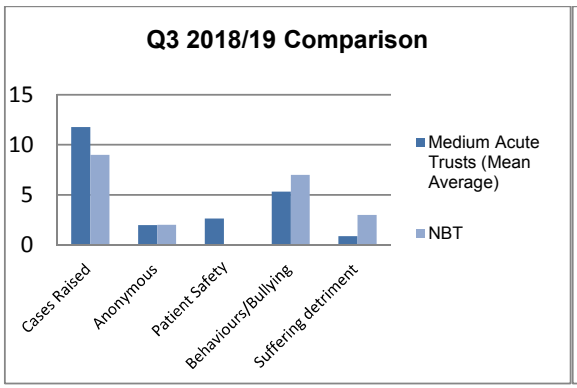

Chart 4: Q3 18/19 Comparison with Acute Medium Trusts

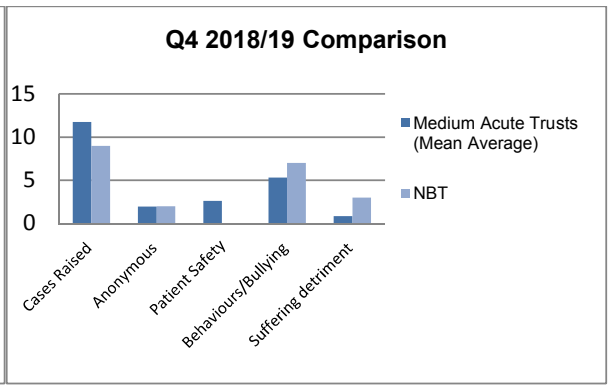

Chart 5: Q4 18/19 Comparison with Acute Medium Trusts

(NB. A concern may occupy more than one category at a time).

3.5 In addition, there was a concern that the proportion of staff reporting that they were suffering a detriment as a result of speaking up was higher than the national average. Whilst the data is unavailable for national comparison for Q1 – Q2 2019/20 the below charts indicates a decline in the number of staff speaking up who are suffering detriment to zero for all 26 cases over the 6 month period.

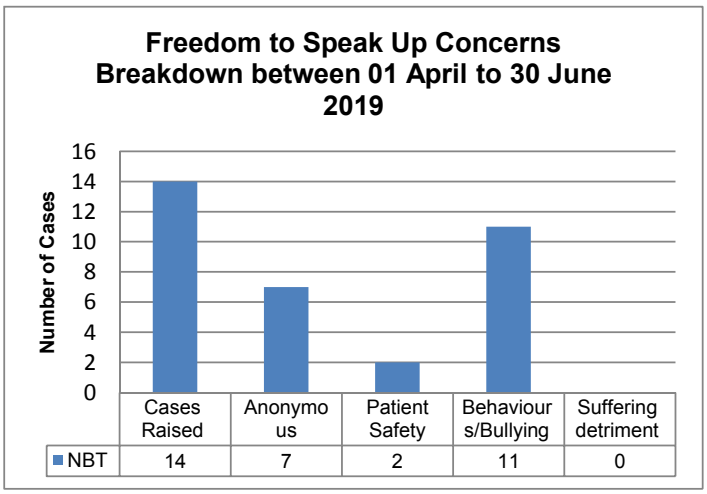

Chart 6: NBT FTSU Breakdown for Q1 19/20

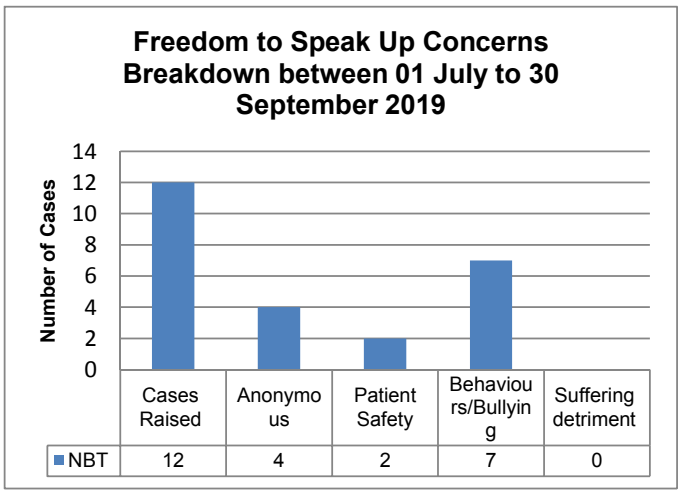

Chart 7: NBT FTSU Breakdown for Q2 19/20

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3.6 Demographic data continues to be collected by the FTSU Guardians in relation to the concerns raised at NBT and it is now possible to report further on some of these categories. Chart 8 below details the variety in cases being raised using length of service of those speaking up.

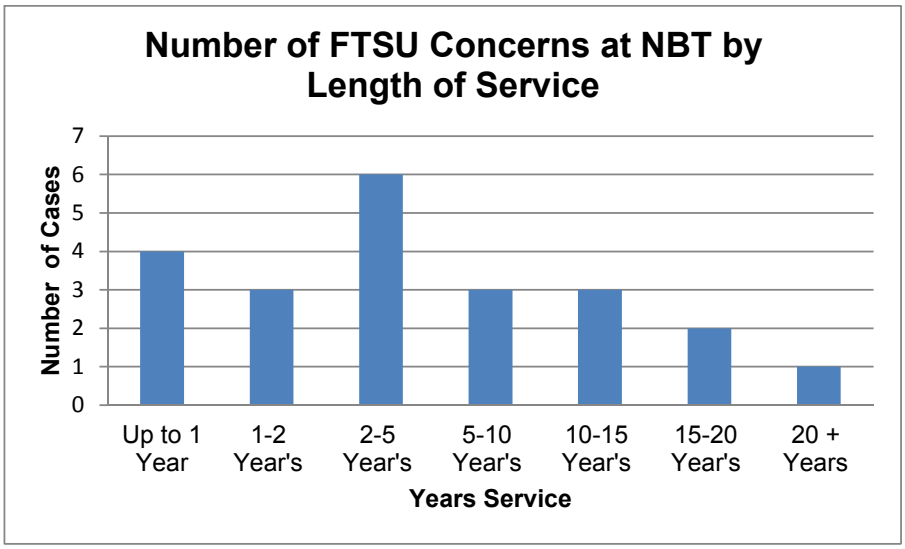

Chart 8: Number of cases raised at NBT based on Staff Length of Service.

3.7 The chart indicates that there is a relatively even spread of cases across staff groups with varying length of service, with a greater likelihood that staff will raise concerns within the first 5 years of their employment. However it should be noted that of the 47 cases logged, information is only held for 25 of these cases linked to length of service.

3.8 Only 11 of the 47 cases logged have data relating to the demographics of age, gender and ethnicity, making this difficult to report on at present. Looking only at these 11 concerns, there were 7 logged by female staff, 4 by male staff, and 2 of the 11 concerns were logged by BAME staff.

3.9 Guardians have discussed the gathering of this additional demographic data, and have agreed that every effort will be made to collect it in the future; however it will not be collected if there is any danger that it could identify an individual (such as someone raising a concern from within a small team).

3.10 The staff groups speaking up at NBT had previously been combined and compared with data available nationally; and this was included in the report provided to the Board in May 2019. Since then it can be seen from the below table that the data captured at NBT in the last two quarters has seen the figures align more closely with the national average, with more nurses speaking up in recent quarters than previously at NBT.

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Proportion of Concerns Raised by Professional Groups at NBT			
Group	**NBT 2017 to March 2019**	**NBT April 2019 to September 2019**	**National Average***
Nurses	5%	31%	29%
Administrative	10%	19%	15%
Allied Healthcare	24%	4%	13%
Other	5%	27%	13%
Healthcare Assistants	10%	0%	9%
Doctors	5%	8%	8%
Cleaning, Estates & Ancillary	5%	12%	5%
Corporate	14%	0%	5%
Midwives	19%	0%	1%
Dentists	0%	0%	<0.5%
Board	0%	0%	<0.5%

*NB National Average data is only currently available up to Q4 2018/19

4. Triangulation of Speaking Up Data Against Other Data

4.1 Best practice is to triangulate the information we have about concerns raised via Freedom to Speak Up and other types of information about concerns raised at NBT. In May 2019 the Board report focussed on the results from the 2018 NHS Staff Survey. The 2019 NHS Staff Survey is currently live and data not available until early 2020. Instead, reports from Happy App have been analysed and triangulated against the FTSU data, to identify any trends or patterns in NBT's speaking up culture.

4.2 In Charts 9-12 below, the number of negative "unhappy" hits recorded per division on Happy App during the period from 01 April 2019 – 30 September 2019 is compared to the number of concerns raised per division during the same period through the Freedom to Speak Up route. It is important to note that some divisions are larger than others, and some divisions are more prolific users of Happy App than others.

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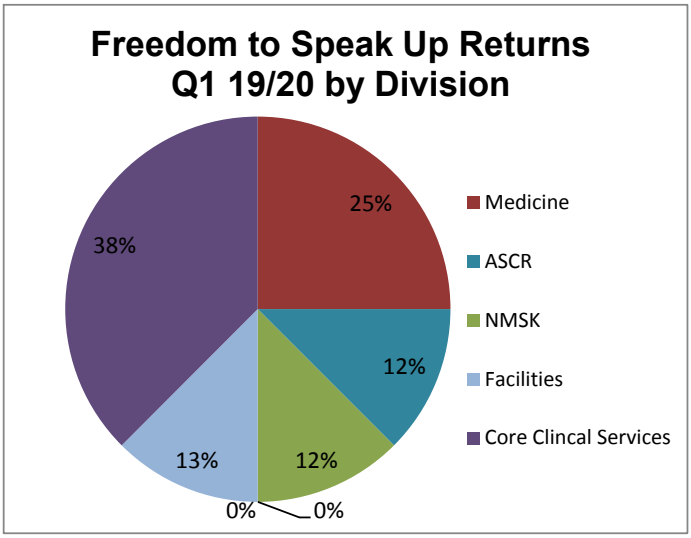

Chart 9: FTSU concerns raised by Division for Q1 19/20

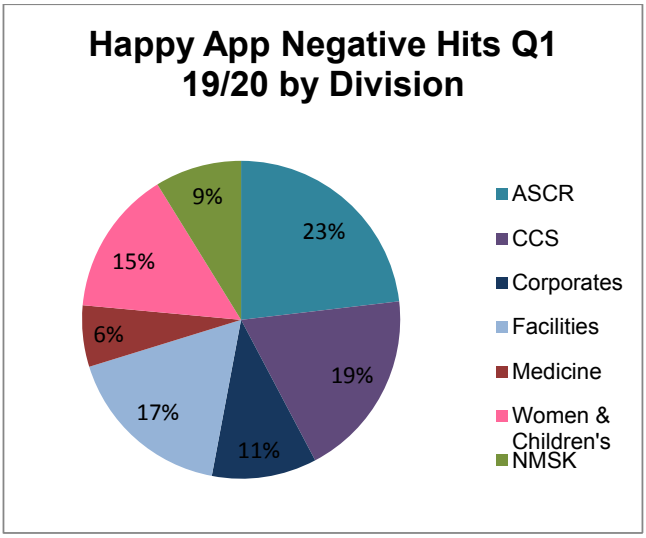

Chart 10: Happy App Negative Hits by Division for Q1 19/20

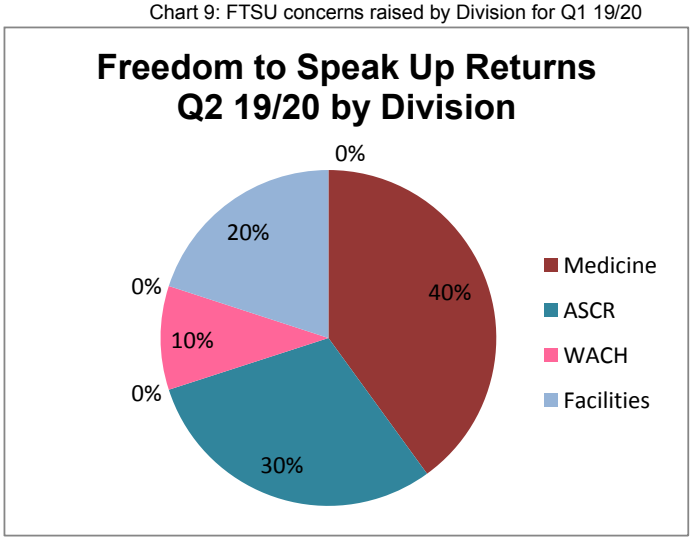

Chart 11: FTSU concerns raised by Division for Q2 19/20

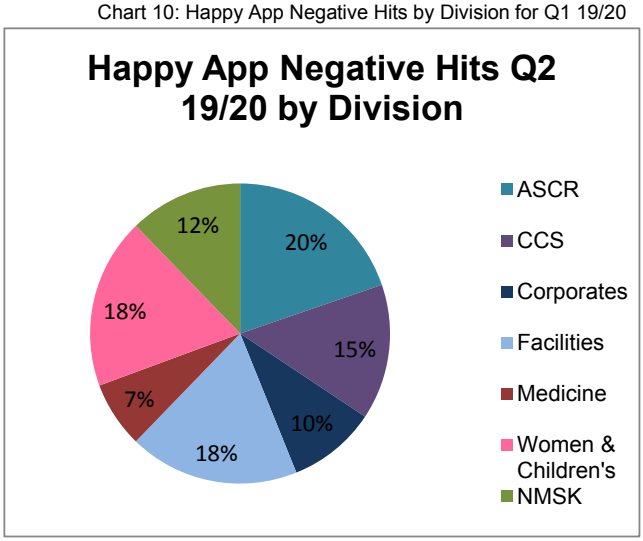

Chart 12: Happy App Negative Hits per Division for Q2 19/20

4.3 Overall, the charts above indicate a broad correlation between the concerns raised in FTSU and negative hits raised through Happy App. This indicates that where we see low mood / unhappiness logged in Happy App, we are more likely to see FTSU concerns raised. The exception to this pattern is Medicine. This is thought to be because Medicine is a large division who have only recently adopted Happy App so usage is comparatively low.

4.4 Whilst comments and hits on Happy App are categorised in a similar way to the information captured through FTSU Guardians, these are not identical categories and therefore direct comparison is not available. However, the below charts explore the difference in negative hits on Happy App to the set themes, which can be compared with the trends identified in the FTSU reporting.

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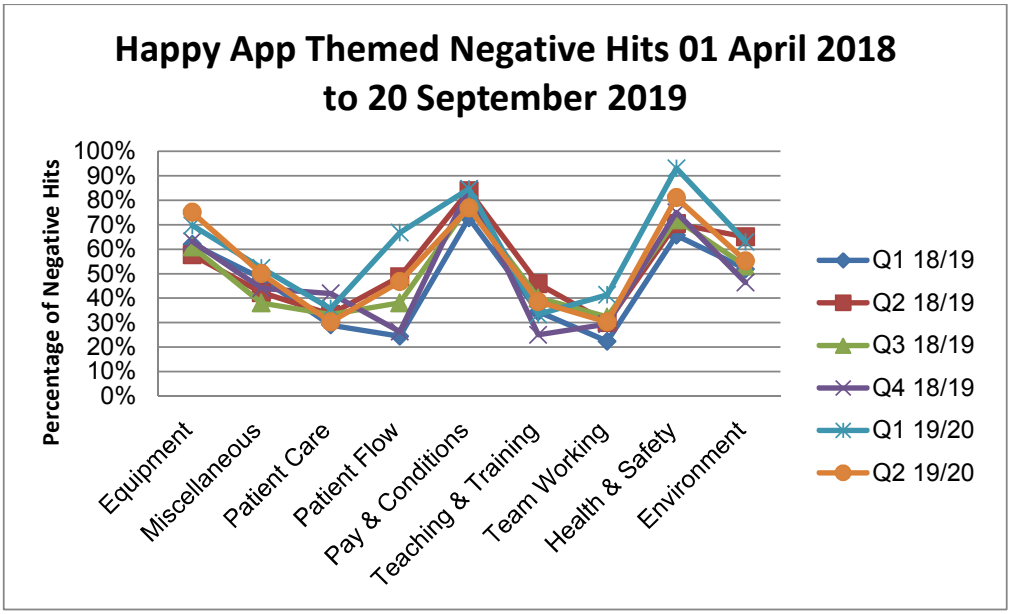

Chart 13: Happy App Negative Data for Theme Analysis Over Time

4.5 From the above chart, it can be seen that the majority of negative hits on Happy App, are linked to Pay and Conditions and Health and Safety. This data indicates that over-time the themes recorded on Happy App are broadly similar with minimal change in the general 'mood' for each theme.

4.6 Chart 14 below shows the theme analysis for FTSU concerns being raised in the same period as that explored through Happy App in Chart 13. This data shows that unlike the Happy App analysis, there is no clear pattern to the concerns raised by theme through FTSU over the period detailed. This indicates that FTSU is being used within NBT to speak up around a variety of concerns, which could suggest that FTSU is embedded well at NBT as it highlights that staff are aware that they can discuss a range of concerns with the Guardians.

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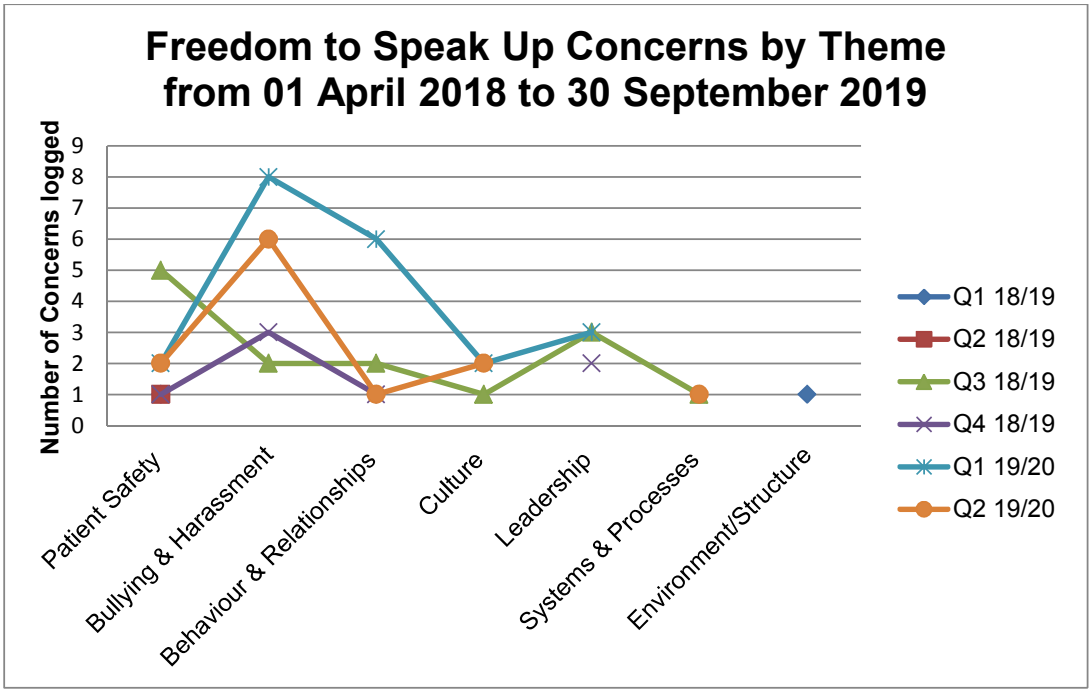

Chart 14: Freedom to Speak Up Concerns by Theme from Q1 18/19 to Q2 19/20

5. Summary of Data Analysis Findings

5.1 Overall, whilst the number of concerns being raised is increasing at NBT, given the comparison to Medium Acute Trust's National Average, there is more work to be done to encourage staff to speak up and ensure a culture of speaking up is maintained at NBT.

5.2 The report indicates that a range of divisions and staff groups are accessing FTSU, however based on the recommendations from the previous report presented to Board in May, it is recommended that concerns continue to be logged with as much demographic data as possible to ensure that this can continue to be monitored over time to consider whether there may be trends arising or indications of cultural issues.

5.3 Overall, the strategy and action plan for FTSU at NBT still looks appropriate, although an additional focus on communication, awareness raising and championing of speaking up is recommended.

6. Communications Update

6.1 A communications plan to promote FTSU throughout the trust is in place, which includes regular updates through internal communication channels. The Intranet homepage has recently been updated with the FTSU logo to ensure the FTSU Guardians page is easily accessible to all staff in one click; and updated screensavers have been launched which include reference to FTSU at NBT.

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6.2 The FTSU posters have been updated to reflect recent changes to the FTSU Guardians and will be redistributed around the trust.

6.3 FTSU continues to be included in the new starter induction and new starters are encouraged to speak up with any concerns and to tell their colleagues about speaking up.

6.4 Freedom to Speak Up featured in the Wigwam of Wellbeing as part of the NBT Festival of Engagement on 29 May 2019, which saw a number of Guardian's engage with staff to discuss FTSU and further distribute posters and leaflets to increase awareness.

6.5 The FTSU Roadshow took place on Wednesday 23rd October, which saw a number of FTSU Guardian's tour the Trust and promote FTSU to all staff.

6.6 Guardians have spoken at a number of forums in the last 6 months, including an F2 Doctor Teaching day with the GMC and a number of nurse staff forums.

6.7 It is recommended that a short update of the Board's considerations of FTSU at each 6 monthly review is shared with staff via the regular Friday 5 communication.

7. Care Quality Commission Feedback

7.1 NBT was inspected by the Care Quality Commission in June and July 2019. This included a 'well led' inspection – which included assessing the effectiveness of the FTSU arrangements at NBT. Overall the rating for the 'well led' domain was 'Outstanding', an increase from the last assessment of 'Requires Improvement' in November 2017.

7.2 The summary feedback in relation to FTSU arrangements was: "The trust had appointed a Freedom to Speak Up Guardian and provided them with sufficient resources and support to help staff to raise concerns, but not all staff felt safe to do so. Freedom to Speak Up (FTSU) Guardians had been in place for approximately 18 months and were well established. We found the arrangements for speaking up had been strengthened and improved since our last inspection".

7.3 However, despite the recognition of a positive direction, there were a few key areas highlighted by CQC for action. These are as shown below:

Action to take	**Related CQC Comment(s)**
Appoint another FTSU Guardian in Medicine, at a junior level, perhaps in a non-nursing profession	"in medical care … some staff told us they did not feel confident to raise concerns which related to leadership to the medicine division's Freedom to Speak up Guardian, due to their level of seniority" "Consider further Freedom to Speak Up Guardians within the medicine division of varying job roles or

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	levels of seniority."
Continue to raise awareness of FTSU, particularly targeting Surgery and Pharmacy	"in some divisions and staff groups, knowledge of the guardian's role was variable for example in surgery and pharmacy" "Surgery - Promote the support available to staff from freedom to speak up guardians. Awareness of the freedom to speak-up guardians was limited across the service"
Improve confidence in staff to use the FTSU Guardians – comms to emphasise this message	"Not all staff felt safe to do so [raise concerns]" "Staff mostly told us during inspection they knew who the guardians were and how to use the whistle-blowing process, but not all staff were confident about using it"
Improve engagement on FTSU with Trade Unions	"Arrangements for collaboration and communication with staff side needed strengthening, in particular with the freedom to speak up guardians" "Further work was needed in terms of some wider relationships, for example with trade unions"

7.4 The existing Trust action plan covered in the section below has been amended to incorporate these actions.

7.5 The full CQC evidence which they considered is shown in Appendix 1.

8. Vision, Strategy, Action Plan and Regulatory Guidance

8.1 A vision, strategy and action plan for FTSU at NBT was established from the Board development session on 31 August 2018. Part of the recommended strategy is for Board to be monitor progress against the strategy and action plan. An update on the progress of actions is shown below, with the additions resulting from CQC recommendations highlighted in green:

No	Action	Owner / Date	Progress
1	A 6 monthly report to be provided to Board, from November 2018	Guy Dickson / Rob Mould From Nov 2018	Complete Regular 6 monthly report being shared at Board meetings (Public).
2	Guardian meetings to cover the recommended items at least quarterly:	Guy Dickson From Dec 2018	Complete Guardian meetings have been held quarterly since November 2017. All items recommended by NHSI are now included as a standard agenda.

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3	Recruit more FTSU Guardians from diverse / vulnerable groups eg BAME; *and different levels of seniority and job types.*	Guy Dickson	**Re-opened** Recent appointments have increased the diversity of the Guardian group to better reflect our staff demography. This will be kept under review. *We will now look to recruit more junior FTSU Guardians in different types of role, including in Medicine. We will also reinforce communications messages that staff can approach any guardian, not just the one sitting within their division.*
4	Non-Executive Director to instigate and lead an auditing approach of concerns raised.	Rob Mould Annually beginning 2019	Ongoing – consideration to be given to using internal audit to assess FTSU processes in 2020/21.
5	Communication to the Trust as a whole about Freedom to Speak Up:	Guy Dickson / All FTSU Guardians / *Communications* Oct 2018 - *ongoing*	Ongoing Under review at each quarterly Guardian meeting. *Annual FTSU Roadshow in October. Particular focus on communications in Surgery and Pathology. Communications to focus on improving confidence in staff to raise concerns* *Specific engagement with Trade Unions around FTSU processes and policy, understand and address any concerns.*
6	Leadership development framework and programme to be developed to support Freedom to Speak Up principles / behaviours . To be delivered and monitored through the Workforce Committee.	Harriet Attwood Nov 2018 onward	Ongoing This work will be taken forward as part of the OneNBT Leadership programme, ensuring that the leadership development aligns with FTSU behaviours.

8.2 NHS England and NHS Improvement released updated guidance for boards on FTSU in July 2019. The guidance is attached as Appendix 2, and can also be located here.[2] The guidance clarifies the role of the board, the chair, chief executive, lead executive and NED as well as the part the human resources team plays in FTSU and in creating a culture of speaking up and listening to concerns.

[2] https://improvement.nhs.uk/resources/freedom-speak-guidance-nhs-trust-and-nhs-foundation-trust-boards/

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8.3 The guidance makes it clear that the board should play a leading part in improving the organisation's speaking up culture, and that this is best placed within a wider programme of work to improve culture more generally. The programme should include a focus on creating a culture of compassionate and inclusive leadership; the creation of meaningful values that all workers buy into; tackling bullying and harassment; improving staff retention; reducing excessive workloads; ensuring people feel in control and autonomous and building powerful and effective teams.

8.4 Much of this work is already in progress at NBT. To ensure that the FTSU strategy and plan remains relevant and up-to-date, it will be reviewed and updated as part of the developing People Strategy. This will ensure that it remains aligned with the overall organisational people approach, and the other cultural change initiatives.

8.5 The regulatory guidance also sets out an expectation that the board review and refresh its FTSU self-review tool every two years. The board last undertook this process in August last year. A workshop session to review this document will be scheduled alongside the next six-monthly board report.

9. Recommendations

Board are asked to:

- Review progress against the FTSU vision, strategy and action plan
- Review the FTSU data triangulated against other information
- Continue to champion FTSU and encourage a culture of speaking up at NBT

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Appendix 1 – CQC Detailed Evidence

The trust had appointed a Freedom to Speak Up Guardian and provided them with sufficient resources and support to help staff to raise concerns, but not all staff felt safe to do so.
Freedom to Speak Up (FTSU) Guardians had been in place for approximately 18 months and were well established. We found the arrangements for speaking up had been strengthened and improved since our last inspection. There was an executive, and non-executive lead, and a FTSU report was presented to board twice a year; we found these reports to be comprehensive. The FTSU guardians met quarterly to discuss ongoing issues and concerns, and to provide support, they attended the board meetings and had regular contact with the chair.
There were 13 freedom to speak up guardians within the trust in different areas and job roles. However, there was no representation from portering, domestic or therapies staff groups, and although we were told they were well supported by their managers, FTSU guardians did not have protected time for FTSU work. The trust had a speak up policy, which was being refreshed and widely consulted on, and clear processes to follow when concerns were raised. A poster had been produced for staff including names and contact details for each guardian.
The number and type of concerns being raised were broadly in line with the national picture, although there were proportionally more concerns relating to patient safety and quality at the trust than nationally. In August 2018 the Trust Board completed the NHS Improvement self-assessment tool to assess their effectiveness around Freedom to Speak Up (FTSU) within the trust including concerns being raised around bullying. The trust identified a number of areas where further work was needed, which then led to a FTSU strategy, vision and action plan being established and published in November 2018. The trust told us support and engagement was good from the executive team and there was a real appetite to get the listening side of their culture right. Further work was needed in terms of some wider relationships, for example with trade unions.
Staff were made aware of the speaking up routes through a range of corporate communications including: email bulletins, the chief executives 'Friday Five' message, stands at the canteen and wellbeing festival, leaflets, posters, intranet pages, screensavers; and since last year, a new dedicated section of the mandatory corporate induction.
Staff mostly told us during inspection they knew who the guardians were and how to use the whistle-blowing process, but not all staff were confident about using it, and in some divisions and staff groups, knowledge of the guardian's role was variable for example in surgery and pharmacy. The trust acknowledged they were aware of issues within the trust around staff feeling able to speak up when they have a concern, including concerns around bullying, and this was also identified in the staff survey findings for 2018 as set out above. In response to this, they had identified "Speaking Up" as one of the 5 key priority areas for action this year, which has been shared with staff. Some ongoing actions included:

- Launch of a staff feedback system called HappyApp – a web tool that enables staff to anonymously say how they feel each day. This enables staff to raise issues including problem behaviours, as well as enabling the Trust to identify 'hotspot' areas to address targeted support
- Wellbeing Programme which supports staff who are encountering difficult situations at work, including a 24/7 Employee Assistance Programme helpline, and 1:1 Psychological Wellbeing support
- Human Resources Helpline, where staff can raise concerns about their managers, and are given advice about how to safely challenge, and signposted to other avenues of support as appropriate
- An "Itchy Feet" campaign has been running for the last year, where staff who are thinking of leaving the trust can call in confidence to talk about why they want to leave. The trust told us concerns around bullying have been raised and supported via this route

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- There is a dedicated in-house Bullying and Harassment Helpline run by the Diversity and Inclusion Team, which has been in place for the last 5 years, receiving approximately 15-20 calls a year.

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National Guardian
Freedom to Speak Up

NHS

Guidance for boards on Freedom to Speak Up in NHS trusts and NHS foundation trusts

July 2019

Contents

Introduction

Effective speaking up arrangements help to protect patients and improve the experience of workers. We know the main reasons workers do not speak up are because they fear they might be victimised or because they do not believe anything will change.

Since we first launched this guidance the NHS has published its interim People Plan, setting out its vision for people who work for the NHS to enable them to deliver the best care possible. Ensuring that everyone feels they have a voice, control and influence is at the forefront of the plan.

This guide supports boards to create that culture; one where workers feel safe and able to speak up about anything that gets in the way of delivering safe, high quality care or affects their experience in the workplace. This includes matters related to patient safety, the quality of care, and cultures of bullying and harassment. To support this, managers need to feel comfortable having their decisions and authority challenged: speaking up should be embraced. Speaking up, and the matters that speaking up highlights, should be welcomed and seen as opportunities to learn and improve.

We have aimed this guide at senior leaders because it is the behaviour of executives and non executives (which is then reinforced by managers) that has the biggest impact on organisational culture. How an executive director (or a manager) handles a matter raised by a worker is a strong indicator of a trust's speaking up culture and how well led it is.

Meeting the expectations set out in this guide will help a board create a culture responsive to feedback from workers and focused on learning and improving the quality of patient care and the experience of workers. Our expectations are accompanied by a self-review tool. Regular and in-depth reviews of leadership and governance arrangements in relation to Freedom to Speak Up (FTSU) will help boards to identify areas for further development.

The Care Quality Commission assesses a trust's speaking up culture under Key Line of Enquiry (KLOE) 3 as part of the well-led domain of inspection. This guide forms part of the resource pack given to inspectors ahead of well-led inspections.

Completing the self-review tool and developing an improvement action plan will help trusts to reflect on their current speaking up culture as part of their overall strategy and create a coherent narrative for their patients, workforce and oversight bodies. Details of the support available to do this are on page 10.

About this guide

This guide has been produced jointly by NHS Improvement and the National Guardian's Office, with input from a group of executives and non-executive directors (which included chief executives and chairs), FTSU Guardians and leading academics in culture and leadership.

The guide sets out our expectations, details individual responsibilities and includes supplementary resources.

We expect the executive lead for FTSU to use the guide to help the board reflect on its current position and the improvement needed to meet our expectations. Ideally the board should repeat this self-reflection exercise at least every two years.

It is not appropriate for the FTSU Guardian to lead this work as the focus is on the behaviour of executives and the board as a whole. But obtaining the FTSU Guardian's views would be a useful way of testing the board's perception of itself.

The improvement work the board does as a result of reflecting on our expectations is best placed within a wider programme of work to improve culture. This programme should include a focus on creating a culture of compassionate and inclusive leadership; the creation of meaningful values that all workers buy into; tackling bullying and harassment; improving staff retention; reducing excessive workloads; ensuring people feel in control and autonomous, and building powerful and effective teams.

The good practice highlighted here is not a checklist: a mechanical 'tick box' approach to each item is not likely to lead to better culture. Equally, focusing on process and procedure at the expense of honestly reflecting on how you respond when someone speaks up will not improve the way the board leads the cultural improvement agenda. The attitude of the board to the review process and the connections it makes between speaking up and improved patient safety and staff experience are much more important.

We will review this guide in 2021. In the meantime, please provide any feedback to nhsi.ftsulearning@nhs.net

Our expectations

Behave in a way that encourages workers to speak up

All executive directors have a responsibility for creating a safe culture and an environment in which workers are able to highlight problems and make suggestions for improvement. FTSU is a fundamental part of that. They also understand that an organisational or department culture of bullying and harassment or one that is not welcoming of new ideas or different perspectives may prevent workers from speaking up which could put patients at risk, affect many aspects of their staff's working lives, and reduce the likelihood that improvements of all kinds can be made.

Executive directors understand the impact their behaviour can have on a trust's culture and therefore how important it is that they reflect on whether their behaviour may inhibit or encourage someone speaking up. To this end executive directors:

- are able to articulate both the importance of workers feeling able to speak up and the trust's own vision to achieve this
- speak up, listen and constructively challenge one another during board meetings
- are visible and approachable and welcome approaches from workers
- have insight into how their power could silence truth
- thank workers who speak up
- demonstrate that they have heard when workers speak up by providing feedback
- seek feedback from peers and workers and reflect on how effectively they demonstrate the trust's values and behaviours
- accept challenging feedback constructively, publicly acknowledge mistakes and make improvements.

Executive directors could test how their behaviour is perceived with direct and incidental feedback from staff surveys; pulse surveys; social media comments; reverse mentoring, 360º feedback and appraisals.

Demonstrate commitment

The board demonstrates its commitment to creating an open and honest culture where workers feel safe to speak up by:

- having named executive and non-executive leads responsible for speaking up, who can demonstrate that they are clear about their role and responsibility and can evidence the contribution they have made to leading the improvement of the trust's speaking up culture. **Section 1 of the supplementary information pack** sets out the responsibilities of the executive and non-executive lead
- including speaking up and other related cultural issues in its board development programme
- having a sustained and ongoing focus on the reduction of bullying, harassment and incivility
- sending out clear and repeated messages that it will not tolerate the victimisation of workers who have spoken up and taking action should this occur with these messages echoed in relevant policies and training. The executive lead for FTSU is responsible for gaining assurance that the experience of workers who speak up is a positive one
- investing in sustained and continuous leadership development
- having a well-resourced FTSU Guardian and champion model. **Section 2 of the supplementary information pack** sets out suggestions of how to assess your FTSU Guardian's capability and capacity
- supporting the creation of an effective communication and engagement strategy that encourages and enables workers to speak up and promotes changes made as a result of speaking up. **Section 3 of the supplementary information pack** sets out suggestions of how to evaluate the effectiveness of your communication strategy
- inviting workers who speak up to present their experiences in person to the board.

Have a strategy to improve your FTSU culture

Boards have a clear vision for the speaking up culture in their trust that links the importance of encouraging workers to speak up with patient safety, staff experience and continuous improvement. The vision is supported by a strategy that has been developed by the executive lead for FTSU; this sits under the trust's overarching strategy and supports the delivery of other relevant strategies.

The board discusses and agrees the strategy and is provided with regular updates. The executive lead for FTSU reviews the FTSU strategy annually, including how it fits with the overall trust strategy, using a range of qualitative and quantitative measures, to assess what has been achieved and what hasn't; what the barriers have been and how they will be overcome; and whether the right indicators are being used to measure success.

It doesn't matter whether the strategy document is called a plan or a strategy; as long as the executive lead has well-thought-out goals that are measurable and have been signed off by the board. **Section 4 of the supplementary information pack** sets out suggestions for what should be in your strategy and provides a checklist to help with the evaluation of your strategy.

Support your FTSU Guardian

Boards demonstrate their commitment to creating a positive speaking up culture by having a well-resourced FTSU Guardian, supported by an appropriate local network of 'champions' if needed. FTSU Guardians need access to enough ringfenced time and other resources to enable them to meet the needs of workers in your organisation. See **Section 2 of the supplementary information pack.**

The executive lead and the non-executive lead, along with the chief executive and chair meet regularly with the FTSU Guardian and provide appropriate advice and support. The FTSU Guardian has ready access to senior leaders and others to enable them to escalate urgent matters rapidly (preserving confidence as appropriate). **Section1 of the supplementary information pack** sets out the individual responsibilities of relevant executives.

Relevant executive directors ensure the FTSU Guardian has ready access to applicable sources of data and other information to enable them to triangulate speaking up issues and proactively identify patterns, trends, and potential areas of concerns. **Section 5 of the supplementary information pack** sets out the kind of data and other information you could triangulate.

Finally, executive directors encourage and enable their FTSU Guardian to develop bilateral relationships with regulators, inspectors, and other FTSU Guardians, and attend regional network meetings, National Guardian conferences, training and other related events.

Be assured your FTSU culture is healthy and effective

The board needs to be assured that workers will speak up about things that get in the way of providing safe and effective care and that will improve the experience of workers. **Section 6 of the supplementary information pack** sets out the different elements that the board should consider seeking assurance for.

Boards may need further assurance when there have been significant changes, where changes are planned, or there have been negative experiences such as:

- before a significant change such as a merger or service change
- when an investigation has identified a team or department has been poorly led or a culture of bullying has developed
- when there has been a service failing
- following a Care Quality Commission (CQC) inspection where there has been a change in rating

It is the executive lead's responsibility to ensure that the board receives a range of assurance and regular updates in relation to the FTSU strategy.

An important piece of assurance is the report provided in person by the FTSU Guardian, at least every six months and **Section 7 of the supplementary information pack** sets out the kind of information the board should expect to be in the FTSU Guardian's report. To be clear this should not be the only assurance the board receives.

Another important piece of assurance is an audit report of the trust's speaking up policy. The trust's speaking up arrangements must be based on an up-to-date speaking up policy that reflects the minimum standards set out by NHS Improvement and should be audited at least every two years. **Section 8 of the supplementary information pack** sets out what a comprehensive audit should cover. The audit report should not focus solely on FTSU Guardian activity but on the effectiveness of all the speaking up channels as well as the whole speaking up culture.

If the board is not assured its workers feel confident and safe to speak up, it should consider getting external support to understand what is driving that fear.

Be open and transparent with external stakeholders

A healthy speaking up culture is created by boards that are open and transparent and see speaking up as an opportunity to learn. Executives routinely discuss challenges and opportunities presented by the matters raised via speaking up with commissioners, CQC, NHS Improvement and their local quality surveillance groups. The board welcomes engagement with, and feedback from, the National Guardian and her staff.

The board regularly discusses progress against the FTSU strategy and (respecting the confidentiality of individuals) themes and issues arising from speaking up (across all the trust's speaking up channels) at the public board. The trust's annual report contains high level, anonymised data relating to speaking up, as well as information on actions the trust is taking to support a positive speaking up culture.

To enable learning and improvement, executive directors discuss learning from speaking up reviews, audits and complex cases among their peer networks. To support this learning, ideally, reviews and audits are shared on the trust's website.

The executive lead for FTSU requests external improvement support when required.

Conclusion

Meeting the expectations in this guide will help boards to send the message that ideas, concerns, feedback, whistleblowing and complaints are all seen as opportunities to stop and reflect on whether something could be done differently.

Valuing workers' opinions and acting on them, publicising the good that comes from speaking up, and making clear and unequivocal statements that you will not tolerate staff being victimised for speaking up, will all encourage workers to use their voice for the benefit of patients and their colleagues.

We have provided useful resources as supplementary information to this guide but if having completed your review you would like further support to improve aspects of your FTSU arrangements, please get in touch with:

- nhsi.ftsulearning@nhs.net for the following support to the executive lead:
  - review FTSU policy, strategy or action plans and provide feedback to bring them in line with national policy or recognised best practice
  - design and facilitate workshops to develop board understanding of speaking up and behaviour that encourages or inhibits it
  - host online surveys and facilitate focus groups with workers to identify issues, causes and solutions
  - facilitate an assessment of your trust's FTSU arrangements against national guidance and support the executive lead to build a FTSU improvement action plan
- enquiries@nationalguardianoffice.org.uk who will arrange for support for the FTSU Guardian in relation to their role.

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NHS North Bristol NHS Trust

Report To:	Trust Management Team Meeting		**Agenda Item:**	17.
Date of Meeting:	28th November 2019			
Report Title:	NBT Trust Board			
Report Author & Job Title	Dr Kathryn Holder Trust Guardian for Safe Junior Doctor Working			
Executive/Non-executive Sponsor (presenting)	Dr Kathryn Holder			
Purpose:	**Approval/Decision**	**Review**	**To Receive for Assurance**	**To Receive for Information**
		x	x	
Recommendation:	The New Junior Doctors' Contract was introduced with effect from October 2016, subject to a phased implementation between October 2016 and August 2017. The Board of Directors will discuss 2019 refresh of the contract and as a public authority must, in the exercise of its functions, have due regard to the need to: • All contractual obligations in place • Be satisfied that the role of Trust Guardian is being fulfilled • Exception Reports being acted upon • Gaps on Junior Rotas being filled as a priority • Risks to Trust considered – Guardian fines; accountability; staffing; rota compliance			
Report History:	This paper sets outs the background and context around the introduction of the Guardian of Safer Working as part of the 2016 Terms and Conditions for Junior Doctors and implementation of that role in the Trust. It shows:- • Exception Report data • BMA Junior Doctor 2019 Contract update LNC - Guardian report sent to meeting on 19/7/19.			
Next Steps:	• Constant attention to filling rota gaps • E-rostering essential for communication • Continued education to trainee and consultants			

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Executive Summary

On August 3rd 2016, the New Junior Doctor contract became live with doctors moving to the new terms and conditions from October 2016. At NBT, the first doctors required to move to the new contract were Foundation Year one doctors on December 7th 2016. The NBT Trust Guardian for Safe Junior Doctor Working needs to interact with the Trust Board in a structured way and ensure electronic Exception Reporting by junior doctors of breaches of contract worked for:-

- Safety reasons
- Excess hours
- Missed education sessions

Junior Doctor Forum - principally these forums advise the Guardian of Safe Working who oversees the processes in the new contract designed to protect junior doctors from being overworked.
Fines – when there is a breach of hours agreed the first compensation should be time off in lieu (TOIL). If this cannot be arranged then the trainee will be paid for the hours worked. In addition, a review of the work schedule should be done to ensure that the breach does not recur. A department that has recurring breaches that lead to more than an average of 48 hours' work per week (max 72 hours in a week) will be subject to a Guardian Fine.
Guardian Trust Board Reports – presented to Workforce Committee 22/11/16; 22/6/17; 20/02/18; 21/06/18; 18/10/18; 17/4/19 and Trust Board 30/11/18.

Junior Doctor Contract 2019
The BMA's Junior Doctors Committee has endorsed an offer negotiated with NHS Employers which would see changes being made to, and additional investment in, the 2016 Junior Doctors contract alongside a multi year pay deal.

Full agreements can be seen at:-
https://www.nhsemployers.org/-/media/Employers/Documents/Pay-and-reward/Junior-Doctors/Framework-Agreement.pdf

Some changes come into effect from August and these include:

- Leave for life changing events – employers must allow leave for life changing events (it is for the doctor to decide what is a deemed life a changing event)
- Breaks for nights shifts – nights shifts of 12 hours or more will require a 3rd 30 minute break.
- Facilities – where a non-resident on-call rota requires the trainee to be on site within a specified time or where the department specify the distance from the Trust when NROC then the department will meet the cost of overnight accommodation.
- Facilities – where a trainee has worked a night and is too tired to drive home the Trust must provide rest facilities (which we do anyway) or the department must meet the cost of travel home and reasonable expenses on the return to work.
- Exception reporting – extension of what can be exception reported i.e. missed supervisor meetings or no time provided for coming audits / e-portfolio

Changes from December 2019 :-

-maximum of 72 hours work in any consecutive 168 hours and therefore the count should start from the start of the first shift.This is all on page 4 of the implementation framework

(https://www.nhsemployers.org/-/media/Employers/Documents/Pay-and-reward/Junior-Doctors/Implementation-timetable.pdf) and there is a specific paragraph on the software issue:

"To enable employers to implement this provision it has been necessary to wait for software system updates to be made

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(DRS and Allocate systems). This existed as an optional functionality in the Allocate system for some time, so we are aware that many employers may have already implemented this provision. All other employers are encouraged to implement this provision as soon as is practicable and, in any event, concluded by December 2019."

Safety limits

Recommended to be reflected in rotas for October 2019 rotations. To be included in rotas for December 2019 rotations and all other rotas to be updated no later than February 2020.

- Rest after night shifts
- Maximum 1 in 3 weekend frequency

Strategic Theme/Corporate Objective Links	• Junior Contract 2019 conditions • Trust aim should be for all rotas to be fully staffed • eRostering introduction
Board Assurance Framework/Trust Risk Register Links	• eRostering to alert contract breaches and enable leave booking for trainees. Online systems currently under consideration. • ICU rotas will not be compliant with new 168 hour rule until Feb 2020 • 1:3 weekend frequency introduction delayed but will be in place Aug 2020

NBT High level data –12th August 2019

Number of doctors / dentists in training (total):

Number of doctors / dentists in training on 2016 TCS (total):

Amount of time available in job plan for guardian to do the role: 2 Pas/ 8 hours per week

Amount of job-planned time for educational supervisors: 0.125 PAs per trainee

FROM GUARDIAN DASHBOARD to 20/11/19:-

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13/08/19-13/11/19 Total 236 reports:-

Type of Report:-

Hours	230 reports
Pattern	4 report
Education	4 reports
Safety	2 report

Safety Reports :-

1. T&O Oct 2019 – hours – dealt with in timely manner
2. Neurosurgery – rota error – untrained personnel rostered for weekend cover – safely corrected by employing neurosurgery locum

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Exception reports by Rota – 13/08/19-13/11/19 Total 236 reports

Rota	No. Reports
1-5 with Cons KJ 2016 Microbiology ST3+	2
1st F2/CT2 rota Medicine Aug 18	58
24 week Medicine F1 Dec18	105
3rd F2/CT2 rota Medicine Aug 18	2
Medicine ST3+ 22 doctor Aug 18	6
CF rota Medicine August 18	20
CT1-CT2 - 11 slots	1
Emergency Medicine F2-CT2 18 week Aug19	1
FINAL OP 2016 Rota Urology SMD Registrar	2
NA Gen Surg Dec 16 1 in 13 F1	9
NB/MR Neurosci FCY F2 - C/ST2 15	2
Oct 18 Gen Surg Reg (2016) 1:13	1
GenSurg Apr 2018 F2 - CT(14)	2
SH 2016 T&O F1	11
SS Obs&Gynae F2-ST2 2019	3
Stroke F1 Aug 18	10
Vascular middle grade (2016) Oct 18	1

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Outcome by Rota – Compensation given

Rota	Toil	Overpayment	No further action
1-5 with Cons KJ 2016 Microbiology ST3+	1		
1st F2/CT2 rota Medicine Aug 18	6	41	1
24 week Medicine F1 Dec18	23	73 1 Compensation & work schedule review	2
3rd F2/CT2 rota Medicine Aug 18		2	
Medicine ST3+ 22 doctor Aug 18		6	
CF rota Medicine August 18	3	12	2
Emergency Medicine F2-CT2 18 week Aug19		1	
NA Gen Surg Dec 16 1 in 13 F1	1	6	
NB/MR Neurosci FCY F2 - C/ST2 15		2	
SH 2016 T&O F1		9	2
SS Obs&Gynae F2-ST2 2019		2	
Stroke F1 Aug 18			4
Vascular middle grade (2016) Oct 18		1	

TOTAL HOURS PAID = 101.5

Guardian Fines

These are calculated at 4x hourly rate of pay for the breach period.

Elderly Care currently has a fine of £2000 as a possibility but are working on reducing this with Time Off in Lieu for trainee concerned.

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Locum Bookings (Bank) by Department August - November 2019	Total Requested Shifts	Total Filled Shifts	Total Agency Filled Shifts	Total Requested Hours	Total Filled Hours
Acute Medicine Specialty 05420	217.00	200.00	157.00	1657.98	1546.98
Anaesthetic Specialty 28104	163.00	112.00	42.00	903.86	501.27
Bank Internal Commission 01387	12.00	12.00		70.00	70.00
BIRU Specialty 09046	18.00	14.00	2.00	147.00	114.00
Breast Care Screening 18003	3.00		3.00	14.00	0.00
Breast Care WLI 01228	5.00		5.00	22.00	0.00
Cardiology Specialty 01113	280.00	246.00	133.00	2371.60	2109.12
Cardiology W L Initiative 14931	30.00	29.00		263.00	255.00
Care of the Elderly Specialty 05604	209.00	177.00	3.00	1554.25	1366.00
Dermatology Specialty 05612	1.00		1.00	4.00	0.00
Diabetes Research 01524	10.00	7.00		62.50	43.00
Diabetes Specialty 05601	81.00	71.00	50.00	651.83	571.83
Emergency Dept Specialty 01291	868.00	784.00	70.00	6225.91	5538.91
Gastro Specialty 05611	81.00	14.00	64.00	237.50	65.00
General Surgery Specialty 28122	343.00	269.00	41.00	2490.00	1924.00
GWAAC Recharge - 01392	116.00	116.00		116.00	116.00
Haematology Specialty 05600	95.00	48.00	59.00	544.00	312.00
Infectious Diseases in HIV Specialty 05412	7.00	5.00		38.50	34.00
Major Trauma Specialty 07307	149.00	146.00		199.00	175.00
Med - Renal Specialty 01152	29.00	21.00		226.96	134.46
Med - SP Resp 01384	12.00	11.00		96.00	88.00
Med - SP Take 01384	6.00	2.00		34.00	6.50
NBT Extra Mngt 01195	2.00	2.00		13.00	13.00
NBT Histo/Cell Path 01403	21.00	20.00	21.00	182.75	174.25
NBT Microbiology 01404	2.00	2.00		11.00	11.00
Neurology Specialty 28117	46.00	41.00	1.00	299.66	265.66
Neuropsychiatry Specialty 28132	24.00	22.00		192.00	176.00
Neurosurgery Specialty 28128	134.00	40.00	88.00	1403.00	260.00
NICU Specialty 01178	46.00	22.00	2.00	425.75	205.25
Obs/Gynae Specialty 01140	161.00	150.00	10.00	955.51	917.51
Pain Clinic 24000	1.00		1.00	3.75	0.00
Palliative Care 01379	1.00	1.00		15.00	15.00
Plastic Surgery Specialty 28129	103.00	77.00		711.50	565.00
Plastic WLI 01221	72.00	5.00	63.00	408.50	45.00
Prosthetics 33004	5.00	5.00		40.00	40.00
Radiology Specialty 28130	73.00	51.00	29.00	763.50	466.50
Renal Management 14603	21.00	12.00	1.00	136.00	108.50
Respiratory Specialty 01116	63.00	47.00	34.00	489.50	376.50
SP 27B 01384	8.00	5.00		38.50	21.50

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Locum Bookings (Bank) by Department August - November 2019	Total Requested Shifts	Total Filled Shifts	Total Agency Filled Shifts	Total Requested Hours	Total Filled Hours
SP 28B 01384	94.00	77.00		742.50	618.00
SP 34A 01384	112.00	97.00	1.00	907.00	785.00
SP 9A 01384	7.00	2.00		46.50	4.50
SP AEC 01384	168.00	151.00		489.00	438.00
SP AMU clerk 01384	6.00	6.00		24.00	24.00
SP AMU Ward 01384	19.00	11.00		136.50	88.00
SP CALS 01384	9.00	7.00		67.50	59.50
SP Clerking 01384	3.00			18.00	0.00
SP Elgar 1 01384	14.00	10.00		76.00	44.00
SP Elgar 2 01384	8.00	6.00		52.48	36.48
SP General 01384	88.00	72.00		890.00	728.00
SP Outliers 01384	180.00	163.00		1458.50	1322.50
SP TTA 01384	12.00	4.00		76.00	24.00
Stroke Specialty 05402	214.00	197.00	168.00	1690.50	1584.50
Surgery WLI 01091	2.00			27.00	0.00
Symptomatic Breast Care 18002	25.00	1.00	24.00	167.00	4.00
Trauma & Ortho Specialty 01190	104.00	101.00	7.00	681.00	671.00
Urology Specialty 01200	155.00	149.00		1026.75	987.25
Vascular Service Transfer 14978	56.00	42.00	13.00	423.50	328.50
Grand Total	**4794.00**	**3882.00**	**1093.00**	**33018.54**	**26378.97**

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Locum Bookings (Agency) by Department August - November 2019	Total Requested Shifts	Total Agency Filled Shifts	Total Requested Hours	Total Agency Filled Hours
Acute Medicine Specialty 05420	217.00	157.00	1657.98	1257.00
Anaesthetic Specialty 28104	163.00	42.00	903.86	369.17
Bank Internal Commission 01387	12.00		70.00	0.00
BIRU Specialty 09046	18.00	2.00	147.00	16.00
Breast Care Screening 18003	3.00	3.00	14.00	14.00
Breast Care WLI 01228	5.00	5.00	22.00	22.00
Cardiology Specialty 01113	280.00	133.00	2371.60	1052.50
Cardiology W L Initiative 14931	30.00		263.00	0.00
Care of the Elderly Specialty 05604	209.00	3.00	1554.25	18.00
Dermatology Specialty 05612	1.00	1.00	4.00	4.00
Diabetes Research 01524	10.00		62.50	0.00
Diabetes Specialty 05601	81.00	50.00	651.83	400.00
Emergency Dept Specialty 01291	868.00	70.00	6225.91	684.50
Gastro Specialty 05611	81.00	64.00	237.50	161.00
General Surgery Specialty 28122	343.00	41.00	2490.00	278.50
GWAAC Recharge - 01392	116.00		116.00	0.00
Haematology Specialty 05600	95.00	59.00	544.00	354.00
Infectious Diseases in HIV Specialty 05412	7.00		38.50	0.00
Major Trauma Specialty 07307	149.00		199.00	0.00
Med - Renal Specialty 01152	29.00		226.96	0.00
Med - SP Resp 01384	12.00		96.00	0.00
Med - SP Take 01384	6.00		34.00	0.00
NBT Extra Mngt 01195	2.00		13.00	0.00
NBT Histo/Cell Path 01403	21.00	21.00	182.75	182.75
NBT Microbiology 01404	2.00		11.00	0.00
Neurology Specialty 28117	46.00	1.00	299.66	8.00
Neuropsychiatry Specialty 28132	24.00		192.00	0.00
Neurosurgery Specialty 28128	134.00	88.00	1403.00	1077.50
NICU Specialty 01178	46.00	2.00	425.75	21.50
Obs/Gynae Specialty 01140	161.00	10.00	955.51	36.50
Pain Clinic 24000	1.00	1.00	3.75	3.75
Palliative Care 01379	1.00		15.00	0.00
Plastic Surgery Specialty 28129	103.00		711.50	0.00
Plastic WLI 01221	72.00	63.00	408.50	332.50
Prosthetics 33004	5.00		40.00	0.00
Radiology Specialty 28130	73.00	29.00	763.50	360.00
Renal Management 14603	21.00	1.00	136.00	3.00
Respiratory Specialty 01116	63.00	34.00	489.50	271.50
SP 27B 01384	8.00		38.50	0.00

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Locum Bookings (Agency) by Department August - November 2019	Total Requested Shifts	Total Agency Filled Shifts	Total Requested Hours	Total Agency Filled Hours
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SP 34A 01384	112.00	1.00	907.00	8.00
SP 9A 01384	7.00		46.50	0.00
SP AEC 01384	168.00		489.00	0.00
SP AMU clerk 01384	6.00		24.00	0.00
SP AMU Ward 01384	19.00		136.50	0.00
SP CALS 01384	9.00		67.50	0.00
SP Clerking 01384	3.00		18.00	0.00
SP Elgar 1 01384	14.00		76.00	0.00
SP Elgar 2 01384	8.00		52.48	0.00
SP General 01384	88.00		890.00	0.00
SP Outliers 01384	180.00		1458.50	0.00
SP TTA 01384	12.00		76.00	0.00
Stroke Specialty 05402	214.00	168.00	1690.50	1314.00
Surgery WLI 01091	2.00		27.00	0.00
Symptomatic Breast Care 18002	25.00	24.00	167.00	163.00
Trauma & Ortho Specialty 01190	104.00	7.00	681.00	56.00
Urology Specialty 01200	155.00		1026.75	0.00
Vascular Service Transfer 14978	56.00	13.00	423.50	80.00
Grand Total	**4794.00**	**1093.00**	**33018.54**	**8548.67**

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Issues arising

Rota compliance – difficulties with timely introduction of ICU rotas compliant with new 168 hour counting rule. Trainees consulted and would prefer to remain on old rotas until Feb. Weekend frequency change to max 1:3 is allowed to be delayed until Aug 2020 and all rotas will be compliant then.

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

Junior Doctor Forum – most recent meeting 30th October 2019 with Chief Executive, Andrea Young, in attendance at the following Committee meeting. New (more formal) terms to be agreed for these meetings. Next to be held 26th Nov 2019. Discussions regarding

Exception reporting policy – written and available on Trust PGME Intranet page http://nbsvr16/sites/askhr/LearningandDevelopment/Pages/ContractsExceptionReporting.aspx

Junior Doctor Rota Policy – nearing publication with Medical HR. Clarifies contract rules for rota managers at NBT.

Clinical Fellows

Clinical Fellows can now Exception Report as from early 2019. Currently not entitled to compensation.

Education – ongoing process with trainees and consultants. Guardian attends departmental meetings (most recently Respiratory medicine) and with individuals (when requested) to continually update NBT medical staff.

Exception Report Summary – sent 6-8 weekly to both Specialty and Education Leads to make them aware of all reports in their departments and not just those they have had to deal with personally. New administrative support for Guardian now in place so this report will be sent to departments monthly.

eRostering – to be available for NBT trainees soon. This will enable all trainee leave booking and will automatically check on roster compliance (including swapped shifts).

Networking - The Guardian has attended national training meetings (and is a member of the regional forum of safer working guardians) as well as having email contact with a number of other Guardians in the region to share updates etc. Attended Regional Guardian 31st January 2019 (Bath) – am satisfied that North Bristol Trust is following due process. Regional Guardian Link In online sessions led by Dr A Johnson (UBHT). Links with Junior Doctors via specialty meetings; F1 teaching sessions and the Guardian Forum. Nationally, there is a project for a standardised Guardian of Safe Working Board report.

Payroll – process in place for payment of excess hours worked. Excellent and efficient service has continued from NBT Payroll.

Junior Doctor Contract meetings – held 6 weekly. Initiated by Deputy Medical Director, Dr Monica Baird. Discussion and update between Dr Baird, Dr Katherine Finucane, DME, Susan Nutland, Medical HR Lead and myself.

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LNC – Guardian attends meetings or sends reports to each meeting. Increases awareness of current issues and interfaces with BMA.

Summary

NBT is compliant with:-

- HR distribution of Junior Doctor work schedules at required deadline and in future will issue rosters 8 weeks prior to start of post (deadline is 6 weeks)
- Electronic reporting system in place (eAllocate)
- Junior Doctor Forum – meetings being held as required by New Contract and supported by the attendance of Andrea Young, Chief Executive and Dr Chris Burton, Medical Director.
- Exception Reporting Policy
- LNC involvement

Concerns –

- **unfilled gaps in junior medical and surgical rotas proving difficult to fill. Clinical Fellows often do not stay for the full contract of employment. This is a major concern.**
- **ICU rotas for December**
- **Work on 1:3 weekend frequency**

Recommendations

1. The Board are asked to read and note this report from the Guardian of Safe Working
2. The Board are asked to note the 2019 Junior Doctor Contract changes.
3. The Board are asked what further information they would like to see presented.

Kathryn Holder, Trust Guardian for Safe Junior Doctor Working

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