Trust Board Meeting in Public

Thursday, 26 September 2019
10.00 – 12:30
Seminar Room 4, Learning and Research Centre, Southmead Hospital

A G E N D A

No.	Item	Purpose	Lead	Enc.	Time
OPENING BUSINESS					
1.	Welcome and Apologies for Absence: John Everitt, Evelyn Barker	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 25 July 2019	Approval	Chair	Enc.	10:30
5.	Action Chart from Previous Meetings	Review	Trust Secretary	Enc.	10:35
6.	Matters Arising from Previous Meeting	Information	Chair	Verbal	10:40
7.	Chair's Business	Information	Chair	Verbal	10:45
8.	Chief Executive's Report	Information	Chief Executive	Enc.	10:50
QUALITY					
9.	CQC Inspection Report	Information	Director of Nursing & Quality	Verbal	10.55
10.	Quality & Risk Management Committee Report	Assurance	Non-Executive Director	Enc.	11.05
11.	End of Life Care Annual Report	Assurance	Director of Nursing & Quality	Enc.	11.10
12.	Annual Research & Innovation Review	Assurance	Medical Director	Verbal	11.20
PEOPLE					
13.	Medical Revalidation & Appraisal Report	Assurance	Medical Director	Enc.	11.40
14.	People & Digital Committee Report	Assurance	Non-Executive Director	Enc.	11.45
PERFORMANCE AND FINANCE					
15.	Month 4 – Corporate Objectives Update	Assurance	Director of Finance	Enc.	11.50
16.	Integrated Performance Report	Review	Chief Executive	Enc.	11.55
17.	Finance & Performance Committee Report	Assurance	Non-Executive Director	Enc.	12.05
GOVERNANCE					
18.	Sustainable Development Management Plan (2019/20)	Assurance	Director of Facilities	Enc.	12.10
19.	Health & Safety Annual Report 2019/20	Assurance	Director of Facilities	Enc.	12.20
CLOSING BUSINESS					
20.	Any Other Business	Information	Chair	Verbal	12.25

No.	Item	Purpose	Lead	Enc.	Time
21.	Questions from the Public in Relation to Agenda Items	Information	Chair	Verbal	12.30
22.	Date of Next Meeting: Thursday 28 November 2019, 10.00 a.m. Seminar Room 5, 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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Minutes of the Public Trust Board Meeting held on Thursday 25th July 2019 at 10.00am Seminar Room 5, Learning & Research Building, Southmead Hospital

Present:

Ms M Romaine	Chair	Ms A Young	Chief Executive
Mr K Blake	Non-Executive Director	Ms E Barker	Chief Operating Officer
Mr J Everitt	Non-Executive Director	Ms H Blanchard	Interim Director of Nursing & Quality
Mr T Gregory	Non-Executive Director		
Ms J Meekings-Davis	Non-Executive Director	Dr C Burton	Medical Director
		Mr N Darvill	Director of Informatics
		Mrs C Phillips	Director of Finance
		Ms J Marshall	Director of People & Transformation
		Mr S Wood	Director of Estates, Facilities & Capital Planning

In Attendance:

Mr X Bell	Director of Corporate Governance & Trust Secretary	Ms S Monk	Deputy Director of Nursing
		Mr M Pender	Deputy Trust Secretary
Ms R James	Deputy Chief Operating Officer	Prof R Butler***	Head of Bristol Genetics Lab
Ms C Foster*	Named Nurse (Safeguarding Children)	Mr R Ravanan***	Clinical Director, Core Clinical Services
Ms S Matthews**	Nurse Consultant - Infection Prevention Control & Tissue Viability	Mr D Gibbs***	Pathology Services Director

*Attended for minute no.10 only.
**Attended for minute no.11 only.
*** Attended for minute no.13 only.

Observers: 1 member of staff / public attended.

Apologies:

Prof J Iredale	Non-Executive Director
Mr R Mould	Non-Executive Director

Action

TBC/19/07/1 Welcome

The Chair welcomed everyone to the public meeting of the Board.

TBC/19/07/2 Apologies For Absence and Welcome

The Board noted that apologies for absence had been received from John Iredale and Rob Mould, Non-Executive Directors.

TBC/19/07/3 Patient Story

Kathy and Reg, the parents of a 40 year old young woman who suffered from Myalgia Encephalomyelitis (ME) / Chronic Fatigue Syndrome (CFS) shared their daughter's recent experience of care at Southmead Hospital.

It was reported that in addition to ME and CFS their daughter suffered

from a curvature of the spine and had rod insertions to help provide support to her spine. She had experienced several admissions to insert and revise these rods, and had also had to manage wound infections and significant acute / chronic pain. Her story related to her latest stay in Southmead between March and June 2019, the purpose of which was to once again replace a broken spinal rod.

It was reported that the standard of surgery and specialist spinal care and treatment their daughter had received in the ICU and on the ward had been excellent. The challenge had been in helping staff to understand ME and CFS and their impact on day to day living – if she was having a bad day their daughter was unable to get out of bed, and as a result her recovery was slow and frustrating for all parties. She felt that as a patient she was not looked at as a whole, and every illness or disability brought its own complications into the healing and recovery process. This had not been uncommon in other hospitals that their daughter had attended.

During her recovery at Southmead their daughter had acquired a wound infection which had been well managed in ICU and on the ward. This set back did however have an impact on their daughter's depression and her anxiety levels. Pain management became a challenge, and the complexity of pain of management, and how important good communication between staff and patients was in dealing with this, was emphasised to the Board.

The care given by all staff was valued by Kathy, Reg and their daughter, especially as they knew they were always very busy. It was reported that ward housekeeping staff made an important difference to a patient's daily life through their conversations and kindness in 'popping in' to see if they needed anything. However, often their daughter felt that she was not heard, with staff talking over her about her own care and treatment, when she could have easily been included. The importance of help with fundamental personal hygiene such as hair washing and help with teeth cleaning was also emphasised as having a significant impact on self-esteem and personal respect and dignity whilst in hospital.

In conclusion it was stated that all hospitals needed to provide for the fundamental needs of a patient as well as providing specialist nursing care. Listening to, and seeing the patient as whole, made a significant difference to a patient's self-esteem, dignity and respect, and had a positive impact on their recovery. Kathy and Reg ended on a positive note, stating that, overall, the hospital had wonderful staff and gave great care.

In respect of learning from the above patient story, Helen Blanchard reported that this had been shared with the Supervisory Ward Sister, the Matron and the Head of Nursing in the relevant Division. In discussion with the patient's parents, the importance of seeing the whole patient was emphasised, and training was being undertaking with staff to help with this process. An apology was given for the lack of hair washing and support in the evening for teeth cleaning, and the importance of this to patients was acknowledged. Staff had been reminded of what was available for hair washing if the patient could not get out of bed, as well as offering help with personal hygiene in the

evenings. The positive feedback on the specialist care provided was very much appreciated.

The Board thanked Kathy and Reg for sharing their daughter's story and noted the actions being taken to address the issues raised.

TBC/19/07/4 Declarations of Interest

There were no declarations of interest.

TBC/19/07/5 Minutes of the Public Trust Board Meeting Held on 30th May 2019.

RESOLVED that the minutes of the public meeting held on 30th May 2019 be approved as a true and correct record.

TBC/18/07/6 Action Log and Matters Arising from the Previous Meeting

The updates provided in the action log were considered and approved. It was noted that an update on the Stepping Up Programme would be provide to the Trust Board at its August meeting.

RESOLVED that the updates to the Action Log be received and approved.

TBC/19/07/7 Chief Executive's Report

The Board considered the Chief Executive's report, which provided a summary of local and national issues impacting on the Trust. The following points were highlighted:

- Andrea Young provided highlights of the preliminary feedback received from the CQC following their inspection of the Trust in July;
- An update on the independent review of serious incident investigation into missed cervical cancer diagnosis, which had concluded in July, was provided, and it was reported that this had been shared with the deceased patient's husband for his input. An action plan was being development but many changes had already been made in respect of this;
- In respect of the ongoing tax / pensions issue, which affected higher paid staff in the NHS and which was causing operational issues in some areas, Chris Burton reported that the Trust was analysing the position and that a report would be provided to the August meeting of the Board. It was acknowledged that this issue had highlighted the NHS's dependence on senior medical staff working beyond what was stipulated in their contract. **JM**

RESOLVED that the Chief Executive's report be noted.

TBC/19/07/8 Pressure Injuries Update

The Board considered a report which provided an update on pressure injuries experienced within the Trust. It was reported that each Grade 2

and above injury relating to harm occurring in NBT was investigated with an initial swarm, followed up with a Root Cause Analysis investigation, with Grade 3 and 4 injuries being reported externally through the Strategic Executive Information System (STEIS). On six occasions since February 2019 NBT had reported an increase above the mean rate for pressure injuries, and it had been concluded that this was outside of natural variation. In response, Helen Blanchard had convened a pressure injury incident review, and provided a presentation to the Board outlining the actions taken by this group and the changes identified in clinical governance processes.

The Board welcomed the work undertaken to tackle the rise of pressure injuries at the Trust and the aim of reducing them by at least 30% over the coming months, with the ultimate aim of eliminating them completely. The possible reasons behind the recent rise were explored, and it was requested that a further update be provided to the October or November meeting of the Board **HB**

RESOLVED that the assurance provided in respect of the work and activity of the Pressure Injury Incident group be noted.

TBC/19/07/9 Cossham Birthing Centre Update

The Board considered a report which provided an update on the current position in respect of the Cossham Birthing Centre. Helen Blanchard introduced the report and reported that, as agreed by the Trust Board on 31 January 2019, the temporary partial closure of the Freestanding Midwifery Unit at Cossham Birth Centre would remain in place until the end of September 2019,

Recruitment of the additional midwifery workforce required to manage the current demand in the acute unit at Southmead Hospital continued in a positive manner, and the workforce trajectory was expected to deliver sufficient staff in post for the acute unit by the end of September 2019. Sufficient experienced midwives would therefore be available to re-open Cossham Birth Centre under a “Lock and Key” model, as well as the associated homebirth service, from 21 October 2019.

A review of the workforce model supporting Cossham Birth Centre, Mendip Birth Centre, the community teams, and the homebirth service was underway, with a view to implementing a new, more robust workforce model across the NBT catchment area, including the Cossham Birth Centre. A number of options were currently undergoing further assessment, and the review was in train.

During the ensuing discussion the Board reiterated its commitment to the reopening the maternity service at Cossham, as it had agreed to do in January, and it was noted that the decision to temporarily close it was taken for quality and safety reasons, not financial ones. There was some concern around using the term ‘lock and key’ and it was agreed that the communications with stakeholders regarding the reopening of the service, and the form it would take, would need careful consideration.

After further discussion it RESOLVED that the proposal to reopen Cossham Birth Centre with effect from 21 October 2019 via a “Lock and Key model” on a case by case basis as outlined in the report, be approved.

TBC/19/07/10 Safeguarding

The Board considered the following safeguarding reports:

- Annual Child Safeguarding Annual Report 2018/19;
- Annual Adult Safeguarding Report 2018/19;

Clare Foster, Named Nurse (Safeguarding Children) attended to present the reports. It was reported that referrals had increased during 18/19 and work was ongoing to raise awareness amongst staff in respect of the reporting threshold for referrals. The need for better joined up working amongst the relevant local agencies was discussed, and it was confirmed that information sharing with local authorities worked well. It was however acknowledged that the pressure on the services provided by local authorities remained high and this had a knock on effect for the hospital. The surprisingly high number of children seen at the hospital was also noted.

RESOLVED that the Safeguarding Adults annual report and the Safeguarding Children annual report, and the assurance provided in respect of the work and activity of the Safeguarding Adult and Children services between April 2018 and March 2019, be approved.

TBC/19/07/11 Infection Prevention and Control Annual Report & Programme

Samantha Matthews (Nurse Consultant - Infection Prevention Control & Tissue Viability) attended the meeting and presented the Infection Prevention and Control (IPC) Annual Report & Programme to the Committee.

The purpose of this annual report was to provide assurance to the Trust Board and wider healthcare community that North Bristol NHS Trust maintained a 'zero tolerance' of healthcare associated infection, and would ensure Trust wide learning would take place where cases were reported. The IPC Programme described the infrastructure and systems in place to reduce the incidence of health care associated infection, and provided the key drivers and objectives for preventing and controlling infection going forward, ensuring that safe care remained a priority for the Trust.

RESOLVED that the Infection Prevention and Control Annual Report & Programme be endorsed and recommended to the Trust Board for approval.

TBC/19/07/12 2018 National Inpatient Survey Results and Actions

The Trust Board received and noted the 2018 National Inpatient Survey Results and Actions.

TBC/19/07/13 South West Genomics Laboratory Hub Update

The Board received a presentation from Rachel Butler, David Gibbs and Rommel Ravanan in respect of the South West Genomics Laboratory Hub.

It was reported that the Bristol Genetics Laboratory had been successful in its tender to become the Lead organisation of the SW Genomics Laboratory Hub (GLH), partnering with the Exeter Genetics Laboratory. The GLH was now required to implement services in

accordance with the National Genomics Test Directory and an end-to-end pathway from patient consent, through genomic analysis and reporting, to the result being delivered back to the patient, must be produced. The GLH would be partnering with the WoE and SW GMCs, Clinical Genetics in Bristol and Exeter and the Cancer networks, and also NHSE in the delivery of this ambitious NHS project.

Following the presentation the Board discussed the future of the SW GLH and the governance arrangements that had been put in place to enable the Trust to have effective oversight of it.

It was requested that in the next six monthly update to the Board, details of NBT's contractual responsibilities arising from the SW GLH be provided. **RB**

RESOLVED that the update in respect of the SW GLH, and the responsibilities of NBT in respect of this, be noted.

TBC/19/07/14 Patient and Carer Experience Committee Report

The Board received the report from the meetings of the Patient and Carer Experience Committee held on 22nd May 2019 and 15th July 2019. Helen Blanchard highlighted particular points of interest to the Board.

RESOLVED that the Patient and Carer Experience Committee assurance report be received and noted.

TBC/19/07/15 Quality and Risk Management Committee Report

The Board received the report from the meeting of the Quality and Risk Management Committee held on 17th July 2019. Tim Gregory, Non-Executive Director highlighted particular points of interest to the Board.

RESOLVED that the Quality and Risk Management Committee assurance report be received and noted.

TBC/19/07/16 People and Digital Committee Report

The Board received the report from the meeting of the People and Digital Committee held on 21st June 2019. Tim Gregory, Non-Executive Director and Chair of the Committee highlighted particular points of interest to the Board.

RESOLVED that the People and Digital Committee assurance report be received and noted.

TBC/19/07/17 Integrated Performance Report – June 2019

Andrea Young introduced the Integrated Performance Report for July 2019 and provided a summary of the headline issues:

- It was reported that June had been a difficult month with ED not on trajectory. Some weekends had seen 360 attendances per day and so demand continued to be high.

- There was a mixed picture in respect of cancer targets, with the Trust being better on the 62 day target than the national picture.

- Bed occupancy rates had also continued to reduce during June due to a shift towards more same day emergency care.

- The NHS as a whole had reported its worst performance ever against all standards during quarter one of 2019/20, and so pressure was being felt across the system.

During the ensuing discussion the following points were made:

- John Everitt commented that, whilst some of the data was concerning, when compared to its peers the Trust's performance appeared to be good, and the Trust needed to continue to focus its efforts on the areas which would have the biggest positive impact on clinical outcomes rather than blindly chasing targets. Chris Burton confirmed that there was clinical oversight of the Trust's targets and that its focus was on the key clinical areas for improvement.

- Concern was expressed at the deterioration in diagnostic performance, and it was reported that the Finance & Performance Committee would be conducting a deep dive into this area at its August meeting. **EB**

The Board reviewed the Board compliance statements as set out in the IPR, and was satisfied that it could sign off all the compliance statements given the assurances provided.

RESOLVED: That the IPR be noted.

TBC/19/07/18 Month 2 Corporate Objectives Update

The Board received a report which provided an update on progress against all of the Trust's annual objectives identified for 2019/20 as at month 2.

RESOLVED that the update on progress against the Trust's annual objectives be noted.

TBC/19/07/19 Finance and Performance Committee Assurance Report

The Board received the report from the meeting of the Finance and Performance Committee held on 20th June 2019. John Everitt, Non-Executive Director and Chair of the Committee highlighted particular points of interest to the Board.

RESOLVED that the Finance & Performance Committee assurance report be received and noted.

TBC/19/07/20 Any Other Business

- It was suggested that a review of the IPR would be a useful exercise to undertake to ensure it was providing the necessary data to allow the Board to focus on and debate the key issues facing the Trust. It was reported that the Deputies Group was already looking at this, and it was requested that the Non-Executive Directors be consulted to ensure their views on what

should be provided were fed into the process. Initial suggestions included a greater level of trend analysis and a perspective on what 'outstanding' looked like at other Trusts.

- The Chair expressed the Board's condolences to John Iredale following the recent death of his father, and confirmed that she would be writing to John to express the Board's sympathises. **MR**

TBC/19/07/21 Questions from the Public in Relation to Agenda Items

No questions were received from the public.

TBC/19/07/22 Date of Next Meeting

The next public meeting of the Board was scheduled to take place on 26th September 2019 at 10.00am, Southmead Hospital.

The meeting concluded at 12.45pm

Report To:	Trust Board Meeting in Public		**Agenda Item:**	5.0
Date of Meeting:	26 September 2019			
Report Title:	Trust Board Action Chart			
Report Author & Job Title	Xavier Bell, Director of Corporate Governance & Trust Secretary			
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:	The Trust Board is asked to note the Trust Board action status.			
Report History:	Previously considered by the Trust Executive Team. The report is a standing agenda item.			
Next Steps:	The action chart will be updated following review at the Trust Board meeting and to include the new actions agreed during the course of the meeting.			

Executive Summary

The Trust Board action chart collates actions arising from the Trust Board meetings and enables monitoring to the point of closure.

Action chart summary:

Status	Number of Actions as at 20/09/2019
Blue (Completed and will be removed from chart for next iteration)	4
Green (Status updated and on track within timescale)	0
Amber (Status not updated/completed and/or the deadline passed.)	1
Red (Status not updated/completed and/or deadline passed by more than one month).	0

Strategic Theme/Corporate Objective Links	Links to all strategic themes.
Board Assurance Framework/Trust Risk Register Links	No specific links to the Board Assurance Framework.
Other Standard Reference	None noted.
Financial implications	None noted.
Other Resource Implications	None noted.
Legal Implications including Equality, Diversity and Inclusion Assessment	None noted.

Appendices:	None.

North Bristol NHS Trust

PUBLIC BOARD ACTION CHART POST 25 JULY 2019 TRUST BOARD MEETING

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

Minute Reference	Agenda Item	Agreed Action	Responsibility	Deadline for Completion of Action	Item for Future Board Meeting	Action Status	RAG
TBC/18/11/15	Stepping Up Programme	Review progress against the messages given in the presentation.	Jacqui Marshall Director of People and Transformation	25/07/19	Yes. To 25/07/19	Decision taken to defer due to July agenda size. -Updated at private board August 2019	
Minutes from 30 May 2019							
TBC/19/5/11	Quality and Risk Management Committee Report	Review format of Exec / Non-Exec Walkrounds	Helen Blanchard	29/08/19	Yes to 29/08/19	Verbal update to be provided at September meeting of the Board.	
Minutes from July 2019							
TBC/19/7/5	Stepping Up Programme	Update on stepping up programme to come to August board meeting.	Jacqui Marshall, Director of People & Transformation	29/08/2019	Yes. 29/08/2019	Verbal update provided to August 2019 private meeting	
TBC/19/7/8	Theatre doors update	Update to be provided on the status of theatre doors and whether windows will be added.	Simon Wood, Director of Facilities	29/08/2019	Yes. 29/08/2019	Verbal update provided to August 2019 private meeting	
TBC/19/7/9	DOLS Update	Update to be provided on the organisational implications of the changes to DOLS	Helen Blanchard, Director of Nursing & Quality	29/08/2019	Yes. 29/08/2019	Verbal update provided to August 2019 private meeting	

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Report To:	Trust Board Meeting		**Agenda Item:**	8.0
Date of Meeting:	26 September 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 monthly 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.			

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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.

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

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. Healthier Together STP updates

Healthier Together Conference – Our Five Year System Plan:

This conference is taking place on 17 October, and is expected to showcase work to date and plans for the future. The focus is on Bristol, North Somerset and South Gloucestershire's 5 year delivery plan setting out how we will meet the ambitions of the NHS Long Term Plan. There are still places available, with registration details via the Healthier Together website:

https://bnssghealthiertogether.org.uk/your-invitation-to-the-healthier-together-conference-2019/.

Healthy Weston:

The Healthy Weston decision making business case will receive public scrutiny through the North Somerset Health Overview and Scrutiny Panel on Wednesday 30 September. The meeting, which members of the public can attend, is taking place at 13:00 in the New Council Chamber at Weston Town Hall. Further details will be available on the North Somerset Council website soon.

The following day, on Tuesday 1 October, recommendations will be made to Bristol, North Somerset and South Gloucestershire CCG's Governing Body about the future shape of services at Weston Hospital.

4. Site visit - Chris Skidmore, MP

On 6 September the Trust welcomed Chris Skidmore, MP for Kingswood and then Minister for Health, to Southmead Hospital. The minister has a focus on staff recruitment and retention and what can be done to make the NHS an attractive, long-term employer and how we develop our current workforce. The minister visited the emergency department and took time to speak to staff about their careers. He then visited our catering department (who were recently highlighted for best practice in the recent Department of Health food review announcement) to tour our central production unit looking at how we produce our locally sourced, fresh patient meals. It was a productive visit and we were assured staff feedback will play into future plans.

5. New Minister of State for Health

Edward Argar was appointed Minister of State at the Department of Health and Social Care on 10 September 2019. The Minister leads on:

- Brexit
- finance, efficiency and commercial
- NHS capital, and land and estates
- operational performance
- workforce, including pay and pensions
- setting the government's mandate for NHS England
- transformation and provider policy

Edward was previously Parliamentary Under Secretary of State at the Ministry of Justice between 14 June 2018 and 10 September 2019.

He was elected as Conservative MP for Charnwood in 2015.

6. Sirona Health & Care

On 3 September Sirona Care & Health were confirmed as the provider of community health services for adults across the Bristol, North Somerset and South Gloucestershire. A contract is now in place with commissioners for services worth more than £1bn over 10 years.

Sirona care & health was announced as the high scoring bidder in July, and has secured the contract following a comprehensive period of due diligence. The organisation – a community interest company – has been delivering services in the local and surrounding area since 2011.

Services in the community will be accessed as normal for the remainder of 2019, as the services transition from current providers. NBT will be working closely with Sirona to ensure that patients received the best possible care at the interface between hospital and community.

7. HSJ Award nomination

The Trust has been nominated for no less than two HSJ Awards in 2019. The first nomination is for our staff engagement work "Empowering our frontline staff to lead" and the second for our Perform project "Digitally Enabling Patient Flow" which was also a winning entry with PwC in the HSJ Partnership Awards earlier in the year.

Members from the respective teams will be making their pitches to HSJ judging panel in the coming days, with winners announced at the HSJ Awards event on 6 November. Staff should be extremely proud of these achievements.

8. International Nurse Recruitment

In September the Trust Management Team has approved the second part of a project looking to attract international nurse recruits to work at NBT. This builds on the success of our first round of international recruitment which has seen 23 nurses join the Trust, mainly from India and the Philippines. A further 10 are expected to join by the end of September, and an overall total of 40 by the end of the calendar year. The board on behalf of the organisation should extend a warm welcome to these new staff members and also thank the team who have supported this project to date.

9. Interim Director of Midwifery / Head of Nursing

NBT is delighted to announce the appointment of Sandra Reading as Interim Director of Midwifery and Head of Nursing for Women & Children's Health. Sandra will commence in post on 7 October for a period of 6 months, supported by Ailish Edwards, Deputy Director of Midwifery/Head of Nursing.

10. Congratulations

The board should congratulate Dr Marc Griffiths on his recent appointment as Pro-Vice Chancellor and Executive Dean in the Faculty of Health and Applied Sciences at the University of the West of England, Bristol (UWE).

NBT works closely with UWE as a strategic partner across both health research and education, and looks forward to exploring further opportunities to work together in developing our workforce and improving clinical outcomes and options for our patients.

11. Recommendation

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

Report To:	Trust Board		**Agenda Item:**	11.
Date of Meeting:	26th September 2019			
Report Title:	End of Life Care Annual Report			
Report Author & Job Title	Dr Clare Kendall Palliative Medicine Consultant Nikki Jordan Palliative Care Lead Specialist Nurse			
Executive/Non-executive Sponsor (presenting)	Helen Blanchard, Director of Nursing & Quality			
Purpose:	**Approval/Decision**	**Review**	**To Receive for Assurance**	**To Receive for Information**
			X	
Recommendation:	To provide assurance on the work and activity of the Specialist Palliative Care service between April 2018 and March 2019			
Report History:				
Next Steps:	Review of CQC outcomes and work plan for next 12 months			

Executive Summary

This report reflects the period of activity for the MDT from 1st April 2018 to 31st March 2019. It contains a summary of the activity of the Specialist Palliative Care team for this period against several key performance indicators that have been outlined in NICE Quality Standards, National Audit of Care at End of Life and CQC Key Lines of Enquiry.

Key achievements in 2018/2019

- Purple Butterfly implementation and winning BMJ Award for End of Life care
- Provision of 24 hour 'out of hours' cover by NBT Palliative Medicine Consultants in place of the hospice advice line
- Completion of 2018 National Audit of End of Life Care (NACEL) with excellent results

Trust Board is requested to note the work plans for the next 12 months plan

- Palliative Care Team contribution to the trustwide implementation of ReSPECT
- Ongoing development of purple butterfly
- Development of data dashboard for Palliative and End of Life Care
- Adaption of Symptom Observation Chart to work with eOBS project to improve escalation of poorly controlled symptoms out of hours

Strategic Theme/Corporate Objective Links	Strategic themes: • Build effective teams empowered to lead • Treat patients as partners in their care
Board Assurance Framework/Trust Risk Register Links	SIR 14 Clinical Complexity
Other Standard Reference	CQC End of life Core Service
Financial implications	None
Other Resource Implications	
Legal Implications including Equality, Diversity and Inclusion Assessment	

Appendices:	Annual Report End of Life Care NBT

North Bristol NHS Trust

End of Life Care

Annual Report

1st April 2018-31st March 2019

Dr Clare Kendall

Nikki Jordan

June 2019

2. Overview, Operational Policy, Achievements and Challenges

2a. Overview

This report reflects the period of activity for the MDT from 1st April 2018 to 31st March 2019. It contains a summary of the activity of the Specialist Palliative Care team for this period against several key performance indicators that have been outlined in NICE Quality Standards, National Audit of Care at End of Life and CQC Key Lines of Enquiry. The report incorporates the team's Operational Policy and Strategic plan. The Operational Policy provides an overview of how the team operates outlining the general working processes, its patient pathway and the clinical guidelines it adheres to. The Strategic Plan summarises the key areas for growth, development and improvement of the team over the next financial year (and beyond where appropriate). Together this gives a full overview of the team, its performance and plans.

2b. Operational Policy

PHILOSOPHY and OBJECTIVES

The team aim to provide specialist palliative care to adult patients from all specialties across NBT and to support teams in providing generalist palliative and end of life care.

- in-patient or outpatient
    - NB. the team does not have a community remit
- to provide the following for palliative care patients:
    - symptom control
    - emotional and spiritual support to patients and their families
    - rapid discharge planning for patients who are dying (approximately 2 week prognosis) including occupational therapy assessment & support
    - supporting teams with complex decision making
    - involvement in Treatment Escalation discussions and advance care planning
- the team work in an advisory capacity and do not have any allocated beds or patients under their direct care
- the Occupational Therapists hold a direct responsibility for their caseload
- to provide on-going support and education to all staff caring for palliative care patients and for patients who are dying
- all team members aim to be supportive to all other members of staff and to maintain good communication and working relationships for the benefit of patient care
- to work collaboratively with colleagues in the community
- to review and adopt national strategies and guidelines as appropriate

MANAGEMENT

Management Arrangements

- the team sits within the medical directorate
- there is an assistant general manager and a support manager with responsibility for specialist palliative care

Operating Hours/Days

- the team works Monday to Friday 8.30am - 5pm
- out of hours telephone advice is provided by a Palliative Care Consultant who can be accessed via switchboard

Accommodation

- the team has an office in the resource room at gate 5, level 9, Brunel building
- the consultants and team coordinator are based in level 6 offices

Budget management

- the medical team budget is the responsibility of the medical divisional managers
- the Clinical Nurse Specialist (CNS) team leader is responsible for the CNS staff budget and a non-staff budget
- there should be a twice yearly review of the budget with the team's divisional manager

THE TEAM

Medical

- 4.0 WTE palliative medicine consultants
- Specialty registrar on rotation

Nursing

- 1 WTE Band 8a CNS Lead Nurse
- 5.0 WTE Band 7 clinical nurse specialists

Occupational therapy

- 2 WTE occupational therapists who are part of our team and prioritise seeing palliative care patients but who also have a responsibility to other in-patients

Team Coordinator

- 1 WTE team coordinator to support the team

Links with other NBT services

- we have no other extended team members but we have a named contact within the following services:
  - chaplaincy
  - pharmacy

- psychology
- dietetics
- bereavement support
- social services
- pain specialists
- patient experience team

Non-medical prescribing

- the Lead Nurse is a non-medical prescriber.

CLINICAL

Referral criteria for patients

- referrals accepted for patients with specialist palliative care and end of life needs from all specialties
- referrals accepted from all clinical areas including outpatients, Medical Day Care Unit and Emergency Department
- referrals can be made by nursing, medical and AHP teams but the named consultant must be aware of and agree with the referral
- direct referrals from patients & relatives cannot be taken but all such requests will be discussed with the patient's team
- the patients will have a life-limiting condition
- patients can be seen at any stage of their illness, e.g. at diagnosis of a life-limiting illness through to the terminal phase depending on their needs
- referral will be for
  - symptom control
  - emotional and spiritual support to patients and their families
  - rapid and complex discharge planning for patients who are dying including occupational therapy assessment & support
  - agreeing limits to treatment escalation and supporting patients with information and discussion about this, including involvement in advance care planning
  - advice and support to teams for complex decision making
  - end of life care

How referrals are made

- referrals are made by NBT's on-line ICE system
- initial referrals can also be taken more informally by phone or on the ward but should then be backed up by a formal ICE referral
- the ICE referral form also prompts the referrer to contact the palliative care co-ordinator's phone if the referral is urgent

How referrals are assessed

- ICE referrals are checked regularly throughout the working day and are assessed by the triage team of the day

Response time

- the team aim to respond to all new referrals the same day or the next working day (Monday - Friday)
- the team aim to see urgent referrals on the same day as a priority and if they can't be seen face to face then same-day phone advice will be given to the patient's team as appropriate

Assessments

- the team aim to make a joint holistic assessment of patients and their needs.
- These assessments are usually made over a series of visits depending on the patient's clinical situation and their priorities.
- After initial review, the recommendations and plan for a new patient is discussed with the referring team.

Responsibility for Care

- As a team, we aim to provide continuity of care by a range of disciplines within the team appropriate to the patient's needs

Documentation

- the team document their assessments in the main hospital patient records so it can be shared with all teams caring for the patient.
- the team also keep a record on NBT's CISS system which records the patient's basic demographics, reason for referral, a brief summary of the issues and plans for care.

Handover

Where there is concern about a patient, the team;

- Request an evening review by the twilight doctor Mon-Fri and daily review at weekends.
- ensure that the senior ward nurse highlights the concerns on the Safety Briefing
- Place an "out of hours" sticker in the patient records to highlight how to access palliative care advice
- Email the Hospital at Night team to handover the patient

Discharge of patients

- the majority of patients are discharged from the team's caseload when they are discharged from hospital.
- some patients will be discharged from the team while they are still an in-patient e.g. if their symptoms are fully resolved or they no longer require specialist support. Teams are prompted to re-refer the patient if they have any concerns.
- some patients will continue to have palliative care follow-up by telephone, in outpatient clinics or when they attend the hospital for regular treatment, e.g. medical day unit or dialysis

- the team does not have a community remit although all team members will liaise closely with the patient's GP, district nurses and hospice community nurses. When transferring the care of a patient back to the community, the team will make contact by phone, letter or email referral
- The team will support the ward team with anticipatory prescribing for end of life symptom control and input into the patient's ICE discharge summary, particularly in relation to Treatment Escalation planning.

Patient information

- patients receive a copy of the hospital discharge summary
- they can also receive a copy of their outpatient letter if they wish
- patients are given the team leaflet explaining the role of the team and contact numbers
- the team will provide additional patient information as needed, e.g. information about their illness, about advance care planning including advance decisions to refuse treatment
- the team can provide information for carers as needed and signpost them to the Macmillan Wellbeing Centre

Bereavement

If a patient known to the team dies in NBT, the team will make an initial phone call for support or send a condolence card to bereaved loved ones as appropriate for the situation. In some circumstances, we will also call the GP or community palliative care team.

DAILY ROUTINE

Board round

- the coordinator will prepare the daily list in time for the Board Round to start promptly at 08.30
- the team meet each day (Monday - Friday) at 08.30-09.00am.
- The meeting is chaired by the triage team of the day and starts with a discussion about deaths and discharges since last meeting including allocation of associated actions on the office whiteboard, review and allocation of the existing caseload for the day.
- The triage team pick up the new referrals and start planning and prioritising these.
- The team will use Flow each morning to check the location of where Purple Butterfly is in use for End of Life patients across the Trust
- During the Board Round, the coordinator will update the daily list as needed and will enter additional details of death, discharge and bereavement calls on relevant data base. A team member will dial into the St Peter’s Hospice teleconference at 09.15 to discuss patients who have been highlighted for potential transfer to their inpatient unit

Attendance at AMU board round

- Monday to Friday a member of the team will attend the Acute Medical Admissions Unit (AMU) board round so they can review new patients early in their hospital stay and be involved in their care 'at the front door'
- As part of this role, the AMU team will be guided by the palliative care team about whether it is appropriate to move patients where Purple Butterfly is in use

Palliative Care Co-ordinator

- the palliative care team co-ordinator carries the mobile phone at all times to take urgent referrals and direct queries to the relevant team member
- they will also regularly check new referrals on the ICE system throughout the working day
- The coordinator will also answer the team phone and take responsibility to deal with queries from staff, patients and relatives. They will liaise with the triage team if there are urgent messages. They will enter basic demographics of new referrals onto the CISS system, print referrals and update daily lists

Afternoon Board Round

- The team meets promptly at 4.15pm
- The triage team will chair the meeting and start by ensuring that all new referrals are accurately added to the Daily List
- The team highlight any deaths and discharges during the day
- The team highlight if a review is required by another discipline
- Any team member who will not be working on the following day gives a brief handover and highlights which patients need review
- This meeting is also a forum to discuss complex patients, raise clinical questions and as an opportunity debrief and check on wellbeing of colleagues
- If there are any patients where there is concern about symptom control, the team member responsible should email a brief SBAR handover to Hospital@Night on the SNP@nbt.nhs.uk email and ask for an evening review
- The meeting should close at 4.45pm with a prompt to complete the handover sheet and ensure the coordinator phone is in the office
- The triage team make a final check of ICE for any urgent new referrals

MULTIDISCIPLINARY TEAM

Our current practice as a multidisciplinary team continues to embrace the standards of care that were required for CNSs by Cancer Peer Review measures Eg;

- contributing to the multidisciplinary discussion and patient assessment/care planning decision of the team at their regular meetings
- providing expert nursing advice and support to other health professionals in the nurse's specialist area of practice;

  - involvement in clinical audit
  - leading on patient and carer communication issues and co-ordination of the patient's pathway for patients referred to the team - acting as the key worker or responsible for nominating the key worker for the patient's dealings with the team
  - ensuring that results of patients' holistic needs assessment are taken into account in the decision making
  - contributing to the management of the service (see note below);
  - utilising research in the nurse's specialist area of practice
- at least one clinical core member of the team has completed the training to practice at level 2 psychology support of cancer patients
- Level 2 practitioner receive a minimum of 1 hour clinical supervision by level 3 / 4 practitioner per month

Format of daily meeting

- the team (medical, nursing and occupational therapy) meet daily to discuss current patients and also to discuss discharges and patients who have died
- Patients already known to the team are also discussed and this is the forum for team members to address concerns and issues

ATTENDANCE AT SITE SPECIFIC MDTs

- the team are core members of the lung cancer, colorectal, haematology and cancer of unknown primary MDTs and a member of the team attends regularly
- the team are an extended team member of the neuro-oncology MDT

STAFF TRAINING

NBT Staff

the team have an active training programme covering pain and symptom control, communication skills, end of life care and bereavement.

- regular study days on care of the dying, assessment and communication skills for nursing staff
- regular study days for the palliative care ward link nurses
- regular teaching sessions for medical students, Foundation Year and Core specialty doctors and for higher trainees
- regular clinical visitors to team from all disciplines

Team education

- the medical members of the team maintain a Continuing Professional Development (CPD) diary as part of their annual appraisal and 5 yearly revalidation with GMC
- the CNSs maintain evidence of CPD as part of their annual appraisal and 3 yearly revalidation with NMC
- the team have education meetings

MONITORING, QUALITY and AUDIT

Data

We collate core data about referrals, deaths and discharges

Team meetings

- the team holds monthly meetings dedicated quarterly to clinical governance, team business and clinical audit
- There is a named medical and CNS lead for Clinical Governance, Clinical Audit and Team Business
- At the quarterly clinical governance meetings we discuss and address Datix incidents, concerns and complaints, items on the Risk Register and give recommendations on actions to the Medicine Division Clinical Governance meetings and End of Life Group meetings
- At the quarterly Clinical Audit meeting we discuss recently completed local and national audits, generate and review action plans, review clinical guidelines and identify new areas for audit and QI projects. The team seeks feedback on patient's/carer's experiences of the service every 2 years. On occasions this is obtained via the National Audit of Care at End of Life or NBT VOICES survey
- These are registered with the NBT Patient Safety, Assurance and Audit team
- At the team business meeting, we discuss current daily operational issues, finance, staffing, Trust business etc. One meeting per year is dedicated as an AGM to review SOP and annual report.
- A manager should attend both the business meetings and the clinical governance meetings

2c. Team Achievements and Key Service Developments over past 12 months

- Purple Butterfly implementation and winning BMJ Award for End of Life care
- Appointment of 1 replacement consultant and additional 1.4 WTE new consultants and respective locum cover for maternity leave
- Provision of 24 hour 'out of hours' cover by NBT Palliative Medicine Consultants in place of the hospice advice line
- New, dynamic, efficient triage and reviews
- Reorganisation of Clinical Governance with real time tracking of clinical incidents on Datix. High RAG rating for Clinical Governance processes in team
- New Clinical Audit structure with updated guidelines and systematic approach to National Audit
- Completion of 2018 National Audit of End of Life Care (NACEL)-large piece of audit work for team with excellent results
- Trial of face to face weekend working for Bank Holiday periods

- Nominated for funding from Southmead Hospital Charity to support developments

2d. Challenges for the Team

- Significant number of simultaneous Maternity leave
- Delays in producing reports due to lack of support with data collection and reporting

2e. Plans for the next 12 months

- Ongoing embedding of Purple Butterfly including use of icon on Flow and Clinical Practice Development Nurse
- Maintaining service through period of change with replacement of Specialty Lead and End of Life Lead
- Business case for additional CNS to support weekend and Bank Holiday working
- Embedding new Community Drug Chart processes and EoL Discharge checklist
- Adapting Symptom Observation Chart to work with eOBS project with the aim of improving escalation of poorly controlled symptoms out of hours
- Contribute to Trust wide implementation of ReSPECT
- Developing robust data dashboard for Palliative and End of Life Care
- Development of supportive care work with other non-malignant Long-term Conditions including dementia

3. Team Membership

Dr Clare Kendall	Consultant /Specialty Lead	10PA
Dr Rachel Royston	Consultant	9.0PA
Dr Laura Bernstein	Consultant (On Mat leave from Sept 2018)	7.0PA
Dr Stephannie Eckoldt	Consultant (On Mat leave from June 2019)	7.5PA
Dr Anita Brigham	Consultant (On Mat leave from April 2019)	7.0PA
Dr Simon Brooks	Locum Consultant (from October 2018)	9.0PA
Nikki Jordan	Lead Nurse Palliative Care	37.5 hours
Carol Cappell	Clinical Nurse Specialist Palliative Care	37.5 hours
Amanda Herman	Clinical Nurse Specialist Palliative Care	34 hours
Cara Case	Clinical Nurse Specialist Palliative Care	34 hours
Keri Knapp	Clinical Nurse Specialist Palliative Care	30 hours
Alice Monument	Clinical Nurse Specialist Palliative Care	34 hours
Lisa Thomas	Clinical Nurse Specialist Palliative Care	24 hours
Gill Wolfe	Lead Occupational Therapist	Band 7
Jo Lewis	Occupational Therapist	Band 6
Louise Green	Occupational Therapist	Band 6
Sarah Palmer	Team Co-ordinator	Band 4

4. Team Workload and Performance

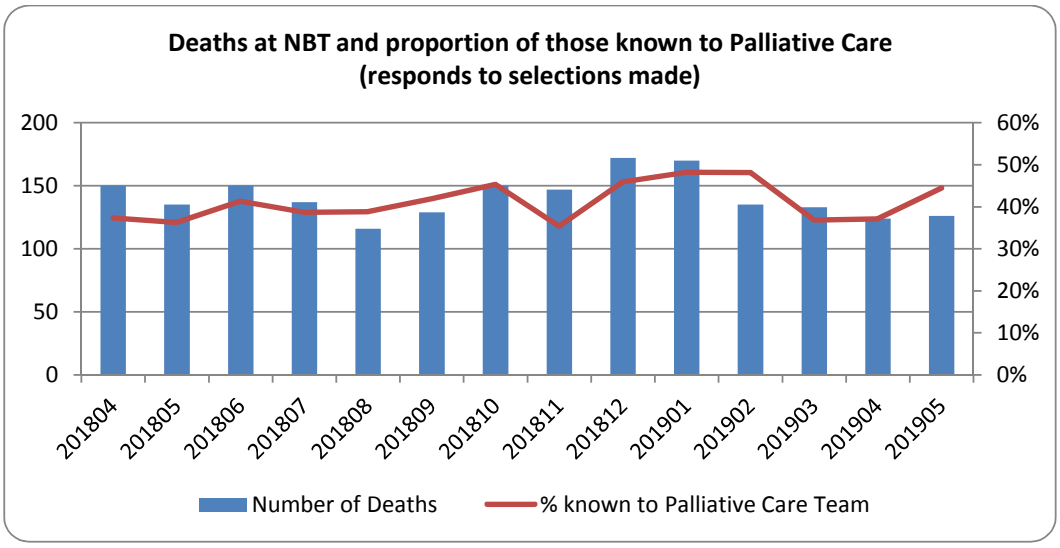
For this annual report we have had some challenges with access to data due to the planned decommissioning of the CISS system and need to retrieve data from multiple sources.

We have built a new spreadsheet to capture the data that we need so that for 2019/20 onwards we will have regular data reporting and will then build this function into the new trust CLiQ system.

1. **Deaths at NBT**
   Between 1st April 2018 and 31st March 2019, there were 1724 deaths at NBT.

   41.4% of these patients were known to the Palliative Care team.

Values	201804	201805	201806	201807	201808	201809	201810	201811	201812	201901	201902	201903	
Number of Deaths at NBT	150	135	150	137	116	129	150	147	172	170	135	133	1724
Number of Deaths known to Palliative Care Team	56	49	62	53	45	54	68	52	79	82	65	49	714
% all deaths known to Palliative Care Team	37.3%	36.3%	41.3%	38.7%	38.8%	41.9%	45.3%	35.4%	45.9%	48.2%	48.1%	36.8%	41.4%



2. **Referrals to Palliative Care Team**
   In this time period, there were 1663 referrals to the Palliative Care team. (Range 101-168 per month). Approximately 59% of these referrals were for non-malignant conditions.

Referrals were received from all Divisions and all Clinical areas of the hospital. We use this data to identify training needs in particular areas.

With the new Purple Butterfly icon on Flow, we will track the number of patients where Purple Butterfly is in use and liaise with ward teams if the patient has not been referred to palliative care. We will audit patient outcomes.

3. Responsiveness to referrals

All referrals were triaged and had first contact from the team within 1 working day of referral.

4. **Discharge data**

Of the 1663 referrals to the Palliative Care team,
39% patients died in hospital and 58% were discharged from hospital (3% current inpatients).
Of the discharged patients, 46% were discharged home,
9% were discharged to a nursing home,
3% were discharged to a local hospice,
1% were discharged to another hospital
41% were discharged back to the care of the ward team

	18/19											18/19 Total
	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	
Number of CHC Fast-Track Discharges at NBT, by discharge Month	34	33	43	37	41	29	35	45	37	46	38	31	449
Number of CHC Fast-Track Discharges known to Palliative Care Team, by discharge Month	23	27	30	24	25	22	31	36	27	35	30	25	335
Average Wait (days) CHC Funding Acceptance to Discharge	9.4	6.7	5.1	10.7	6.9	14.1	8.0	8.0	6.6	7.7	8.1	9.2	8.2

In 2018/9, there were 449 discharges from NBT with CHC Fast track funding.

Of these, 335 (75%) were patients known to the palliative care team.

Average time from acceptance of CHCFT funding to discharge with package of care was 8.2 days.

Going forward, this data will be further refined, looking at breakdown of place of discharge to see if these delays occur due to shortages of carers to provide the requested package or availability of suitable nursing home bed.

5. Incidents relating to EoL care

Incidents relating to End of Life Care are reviewed weekly by the palliative care team. From July 2018-June 2019 there were 610 incidents reported via the Datix system for patients receiving Palliative or end of life care.

Of these, 70 were for incidents relating directly to an aspect of palliative or end of life care and the palliative care team gave comments to assist the investigating manager and suggested actions to be taken.

Reasons for screening in (from July 2018 onwards)

	Jul 2018	Aug 2018	Sep 2018	Oct 2018	Nov 2018	Dec 2018	Jan 2019	Feb 2019	Mar 2019	Apr 2019	May 2019	Jun 2019	Total
Syringe pump issue	0	0	0	3	1	1	3	2	0	2	5	1	18
Medication Error	0	0	0	4	1	1	2	1	1	0	1	1	12
Discharge issue	1	1	1	1	1	0	2	1	0	1	0	0	9
End of Life Care	0	0	0	1	1	1	0	1	2	1	2	0	9
Inappropriate transfer of patient	0	0	0	0	2	1	0	1	0	1	1	1	7
Care after death	0	0	0	2	3	0	0	1	0	0	0	0	6
Clinical Management issue	0	0	0	2	1	0	0	1	1	0	0	0	5
End of Life Documentation	0	0	0	1	1	0	0	0	0	0	0	0	2
Complex Safeguarding / Communication issue	0	0	0	0	0	0	0	1	0	0	0	0	1
Miscellaneous	1	0	0	0	0	0	0	0	0	0	0	0	1
Total	2	1	1	14	11	4	7	9	4	5	9	3	70

The other 540 incidents related to other aspects of care and other teams such as safeguarding, tissue viability and pharmacy gave their comments to assist investigation.

Reasons for screening out (from July 2018 onwards)

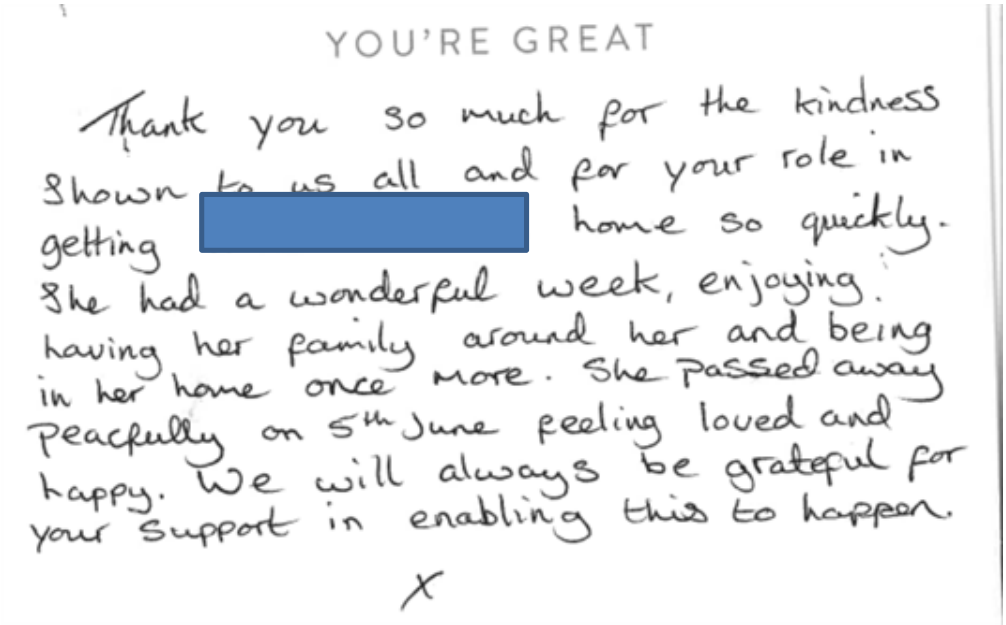
	Jul 2018	Aug 2018	Sep 2018	Oct 2018	Nov 2018	Dec 2018	Jan 2019	Feb 2019	Mar 2019	Apr 2019	May 2019	Jun 2019	Jul 2019	Total
No value	53	38	47	46	33	4	7	9	6	6	9	4	2	264
Tissue Viability	0	0	0	3	8	25	23	16	18	14	23	12	5	147
Falls	0	0	0	0	1	6	7	4	5	6	5	7	2	43
Other	0	0	0	1	2	3	7	2	2	6	5	2	1	31
Medicines Management	0	0	0	1	4	3	8	1	2	4	4	4	0	31
Health and Safety	0	0	0	0	1	2	2	1	2	0	1	0	0	9
Safeguarding	0	0	0	0	0	0	2	0	1	1	2	0	2	8
Infection Control	0	0	0	1	0	0	0	0	1	0	1	1	0	4
Discharge issues	0	0	0	0	0	0	0	0	0	2	0	0	1	3
Total	53	38	47	52	49	43	56	33	37	39	50	30	13	540

5. Patient Experience and Feedback

We have used patient and carer feedback in shaping our services. A summary of our findings includes;

1. Thank you cards received by the Palliative Care Team
2. Feedback from Bereaved carers from the VOICES survey
3. Outcomes of Patient Shadowing during the Purple Butterfly Project
4. "What Matters to You" project

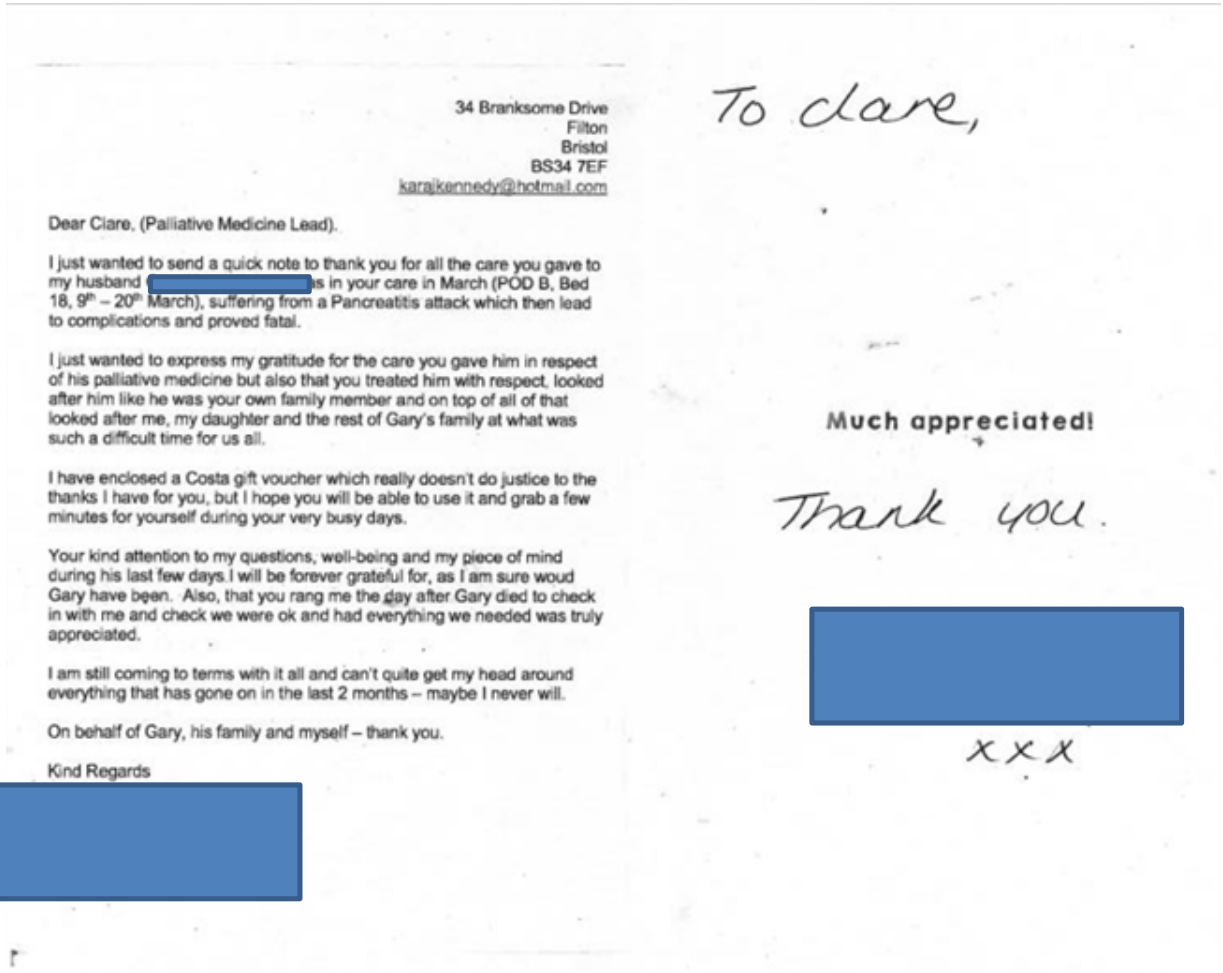
1. A sample of thank you cards received by Palliative Care Team



YOU'RE GREAT

Thank you so much for the kindness shown to us all and for your role in getting [redacted] home so quickly. She had a wonderful week, enjoying having her family around her and being in her home once more. She passed away peacefully on 5th June feeling loved and happy. We will always be grateful for your support in enabling this to happen.

X



34 Branksome Drive
Filton
Bristol
BS34 7EF
karajkennedy@hotmail.com

Dear Clare, (Palliative Medicine Lead).

I just wanted to send a quick note to thank you for all the care you gave to my husband [redacted] in your care in March (POD B, Bed 18, 9th – 20th March), suffering from a Pancreatitis attack which then lead to complications and proved fatal.

I just wanted to express my gratitude for the care you gave him in respect of his palliative medicine but also that you treated him with respect, looked after him like he was your own family member and on top of all of that looked after me, my daughter and the rest of Gary's family at what was such a difficult time for us all.

I have enclosed a Costa gift voucher which really doesn't do justice to the thanks I have for you, but I hope you will be able to use it and grab a few minutes for yourself during your very busy days.

Your kind attention to my questions, well-being and my piece of mind during his last few days I will be forever grateful for, as I am sure woud Gary have been. Also, that you rang me the day after Gary died to check in with me and check we were ok and had everything we needed was truly appreciated.

I am still coming to terms with it all and can't quite get my head around everything that has gone on in the last 2 months – maybe I never will.

On behalf of Gary, his family and myself – thank you.

Kind Regards

[redacted]

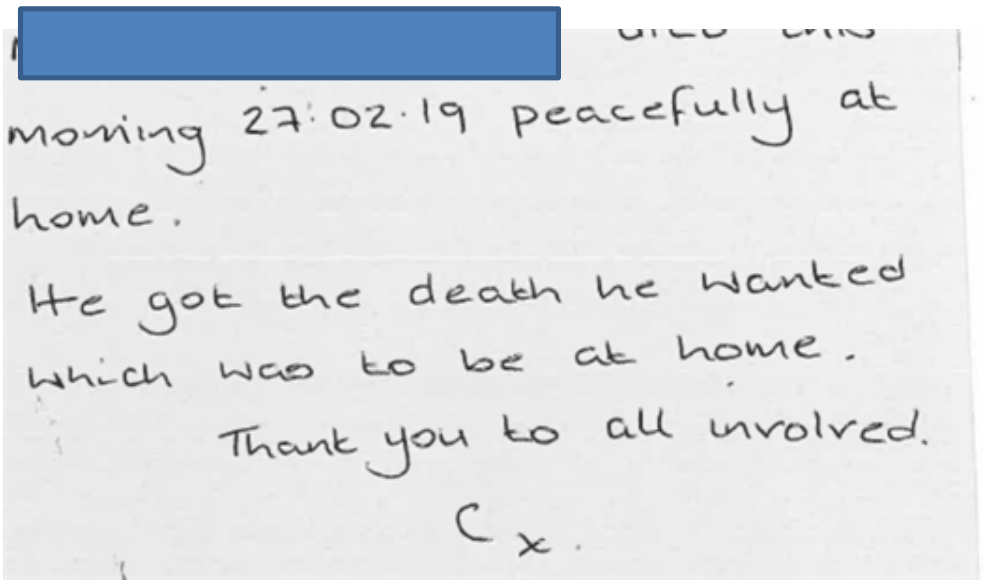
To clare,

Much appreciated!

Thank you.

[redacted]

xxx



[redacted]

morning 27.02.19 peacefully at home.

He got the death he wanted which was to be at home.

Thank you to all involved.

C x.

11

9-5-19.

To all the staff on ward 9[redacted]

My brother & I would like to say sincere thanks for all the kindness, care & compassion all the staff showed our Dad whilst he was with you last week. In particular Jenny & Tansey the nurses & the Dr who looked after Dad so well as the palliative consultant, physio & HCAs

kind & warm regards

[redacted]

To All the Amazing Nurses, wonderful Carers / Housekeepers who really looked after Dad so well

A Special thank you to the doctors & Palliative team ...very, very much.

We feel very blessed xxx to have you look after us so well

Please enjoy the little Hamper for your breaks

John & Margaret

11

2. The following feedback was given by bereaved carers when they completed our VOICES survey between April-June 2018:

Q10 Was there anything about the care of your loved one that was particularly good?

Ward	Comment
31a	Team tried hard to contact my elderly father (next of kin), very patient with him as he suffers from dementia and did not grasp the severity of the patient's condition.
	One or two of the nurses were sympathetic and tried to care for mum to the best of their abilities.
27b	S/mead Hospital. Overworked staff. Doctors working 42 hours. Overworked/underpaid.
9	I think the staff did all they could under the circumstances. Thank you for your help.
Pod 25 ICU	Very kind nurses and doctors.
28B	Room 38 and Obs ward.
A&E	Staff cared for me as well as my husband. Nothing seemed to be any trouble.
31 A/E	One word excellent!
31	All staff treated dad and ourselves with respect. Communication at all levels was great.
7A	All the staff on the ward from doctor to cleaners went well beyond what is expected and therefore made mum's final days and our memories of the time pleasant, as the circumstances could permit.
17	Level 8A. I cannot fault the care and support they gave to my husband, myself and family and I thank all the staff from the bottom of my heart.
A7	Staff were amazing, kind and compassionate at all times.
28B	During my mother's stay she was treated with kindness and compassion. Everyone from consultant to ward housekeeper looked after her so well, we couldn't have asked for better.
28	Can't think of anything bad to say. I'm sure minor improvements are always possible but I felt that everyone worked in a professional, yet friendly and sensitive manner. For that, me and the rest of our family are very grateful.
28B	Staff were lovely. [name] was very kind and caring. Special thanks to [name] and all who cared for dad.
A&E	Thank you.
7a	Really caring people from the nurses to the consultant and doctors. Great people.
Resus	2 male nurses were wonderful to my mum who was 93.
1	Elgar House, end of life care could not be faulted.
ICU	it is difficult to put into words the depth of gratitude we owe the staff. At every stage of treatment the care, concern, sympathy and professionalism has been exceptional. The way in which difficult and delicate situations have been dealt with has left an indelible impression.
28B	Everything was first rate.
IC Pod E? Bed 41.	My wife was treated with care a love, one of the nurses was crying. Whilst this might be deemed as unprofessional it was absolute proof to the excellent care [name removed] has prior to losing her. May I say thank you to all your staff.
28	This was a cardiology ward and the consultant liaised fully with haematology team.
Gate 7a	Stroke.
	ICU
3/B	Kind and caring.

38	Everyone was extremely professional and sensitive.
	Level 28. Room 18.
9B	Everyone we came into contact with who looked after dad for us, we very much appreciated it.
33B	Room 48 everything they did in caring was very good, we could not fault it.
28A	Room 7 nurse [name] - she was wonderful thank you.
Pod A ICU	Care provided by nursing staff was amazing, made a difficult situation better/bearable. Special mention to [Names removed]. Thank you.
ICU	Pod B, Bed 24 and 13. The nurses and doctors were amazing. I particularly would like to call out nurses Emily and Sophie and Dr [name].
Gate 27 Cardiology	The family would like it to be known and to thank all the staff for their care and kindness.
	Being kept up-to-date about the care.
Renal Level 4 Gate 8B	Care and consideration from all staff, auxiliary and health care, nurses and doctors, was first class. My only negative comment is that I was excluded from the room my wife was in at the moment of death. There seemed no need for it. I was the husband for 35 years and kidney donor and I had witnessed my wife vomit and be very ill on a number of occasions long before this event. So there was nothing I had not seen. My wife always wanted me to hold her hand if such a time occurred and I had the same request if the tables were turned and it was my death. Exclusion at this time was extremely hurtful and will stay with me forever.
34A	Kind and caring staff to my loved one and also to the rest of the family that visited.
Elgar	Ward 1. At all times my father was shown kindness and consideration by all staff on Elgar, ward 1. The doctors were caring, communicated with us at all times and showed compassion towards our father. We cannot fault the nursing or domestic staff and are grateful to them all.
27A	Care and empathy received from staff has been wonderful. Environment brilliant.
27A	All the doctors and nurses attend to my husband very well. As my husband when coherent was funny had good banter with all the help I would like to thank them very much.
	Not sure of ward number. It was an admission ward following treatment in A&E.
9a	On his last day a different nurse was on [unreadable comment]. She was excellent and I felt much happier. I didn't know it would be his final day. She has moved onto the training school/centre.
ICU	Nurse on night staff plaited her hair.
33b	[names removed] sat down and answered questions and were honest about the situation etc. Took care to use the lotions and perfumes we took in to make her comfortable and fragrant.
9B	Everything about the care of mum and the family was outstanding. The Purple Butterfly Award was very well deserved. Mum could not have spent her last days in a better place.
A&E	Reassurance - care of the highest standard in both departments of the hospital. The honesty and care - how the staff carry on day after day I find amazing. Thank you.
Gate 9A Level 5	Bar a couple, the nurse's care assistant and Dr [name] were brilliant. Did all they could.
Gate 31A	Very caring staff to us and my father couldn't fault how we were looked after and kept informed.
A&E	Weston General
31	As before - everyone was kind and considerate.

AMU	Nursing and medical staff spoke to my father first and to me only if they needed help due to communication difficulties of dementia. Explained what they were doing at each intervention, e.g. temperature, blood pressure check, etc. All spoke respectfully.
	I am sorry that as I am completing this a couple of months after my father's death I cannot remember the number of the ward he was in. However the last ward he was in was very nice and staff very helpful. The ward in which my father spent his first night of admission was very noisy and staff too busy to give much attention. I do think that was not their fault as their were not enough beds available for the number of people admitted that day.
31B	The time and effort of all the staff on the ward was to a very high standard - a credit to the NHS. And on behalf of my brother and myself a big, big thank you to all the staff concerned for looking after mum.
17U	Brilliant and dedicated.
9A	The help given by all the staff and palliative care workers.
	I am sorry I find it difficult to respond to this questions - utmost apologies.
27B	All the nurses on this ward performed all duties in a very loving way and showed great respect at all times, and I cannot thank them enough for their kind thoughts and consideration.
9b	Doctor and consultant were extremely professional and compassionate and clear.
AMU	[Name removed] excellent care.
7A	All the staff were kind and compassionate.
32A	Cannot speak highly enough. Professional, caring and compassionate.
31B	The doctor and nurse informed us fully about my mum's deterioration and other staff checking on her were polite and sensitive.
27B	Very well cared for.
9B	Being able to have a private room for mum was a real bonus. Staff were very responsive if asked a question. They would say if they were in the middle of something then come along. We particularly liked having a badge that meant we could use the staff canteen. The Palliative Care nurse was the first to ask mum how she was feeling. That was very helpful.
32a	I would say that the whole of the staff on Ward 32a during the 12 days that my Mum spent there were kind, caring and compassionate which helped us as a family deal with the traumatic situation in a calm and dignified way.
8A	All the nursing staff, caterers, cleaners and anybody else I may have missed were excellent and many went beyond what they needed to do.
31	We were told in a sensitive manner how ill she was, treatment was first class.
	You need to review your procedures for harvesting donor organs. Mum expressly wanted her brain and spinal [unreadable comment] to be donated to Parkinsons. I ensured copies of documents were in her notes. I wrote a letter and handed it in confirming this was the case and if she died and I was not there, they should proceed as there was a short window of opportunity for the organs to be harvested. She died about 9.30 on Saturday night. By 10 pm I had made contact with the Parkinsons Society myself and they made contact with the hospital to make the arrangements. The procedure to get the necessary paperwork signed by the hospital however took so long that it was too late for the brain and spinal chord to be taken and the donation was lost. Despite doing everything I could therefore to fulfil mum's wishes the donation failed due to the delay on the part of the hospital to sign off on the document. I appreciate it was a busy period and a weekend death but, what I suspect as a rare offer of donation, was not fulfilled and procedures need to be reviews to provide for a quick signing off where donations are being offered.

34A	I personally believe the Health Care Assistants were worth their weight in gold and they were exceptional with [name]. However, a few nurses spoke inappropriately to us and brushed us off on many occasions. We have made our complaints about one nurse in particular to the Senior Nurse in charge of the ward. A special thank you need to go to Theresa who was an exceptional nurse and looked after my father on a number of occasions. She was thorough, kind, patient and reassuring.
28A	I felt the care of my loved one was good. Although my loved one passed away less than 24hrs after being admitted to hospital so I do not feel that I can answer all the questions in this survey and to tell you more.
32A	Beth whose kindness and care helped mum drift away.
34A	[Names removed] were excellent and gave us support and advice.
31b	The nurse that looked after us as a family once he had passed away.
	The ambulance men who attended were also very good in keeping us both informed of what was happening. They came very quickly following call to 111.
7a	Thank you.
31B	My family were asked if we needed anything and drinks made.
8	Whilst my wife did not wish to know details of the deterioration of her health I was made fully aware which was a great help.
	The staff were absolutely amazing and did him proud.
32A	Lovely staff - I couldn't have asked for better service.
	We cannot fault any treatment and care he received from all the staff concerned.
28A	Dr "[name] " (don't know his last name). Excellent care.
Palliative care team.	[Names removed] amazing people - can't thank them enough.
A&E	Southmead
Resus	The young doctor was particularly kind, gentle and informative.
7A	Brilliant and dedicated.
31b	As above plus very good communication. It was only this swift communication that enabled all of our family to travel across the UK to see him before he died later that day. We are very grateful for this.
9B	[name] - Ward Manager - amazing. Healthcare assistants - [name] , [name], [name] and [name] - total, total angels. Sister[name] - wonderful. [name] Consultant - [name] - true gentlemen/totally brilliant. Whole team - incredible. My family and I could not have gotten through this awful time without their compassion, professionalism, knowledge, skills, care and support. Thank you from all my family.
273	Staff and doctors were very informative at all times also courteous and helpful. Never at anytime was anything too much trouble or we were left wondering, someone was always on hand to help.
32A	[name] who was the one who broke the news, he was kind and caring.

Q11 **Was there anything about the care of your loved one that you feel could have been done better?**

Ward	**Comment**
	Those patients who are unable to speak should be given equal treatment to those who are able to shout for assistance and help. Listen to the relatives of the patient who knows them better, don't make assumptions that a patient who can't speak has no feelings.

31	All staff acted in a professional and sympathetic manner at all times.
	No, the staff were the best we could wish for.
28B	On the Saturday before we lost mum on the Monday, a HCA made mum get out of bed to go on the commode. She was out of bed for 45mins. As she was extremely weak and frail this should not have happened! Mum's protests were ignored by the HCA.
	No, you were all so kind.
	Of all the family, the expertise and skill has been outstanding and the sympathetic and caring treatment contributed to a peaceful passing. [Name removed] is an exceptional professional, the personification of all that is superb in our NHS.
A&E	No
28	No.
	No.
	So pleased that dad's last days were here, rather than a nursing home.
	No, nothing at all.
9B	No
33B Room 48.	Yes they did everything possible for comfort and care which we truly appreciate. They were very caring, kind and compassionate.
	No.
ICU Reception.	Arrival on ICU reception was difficult when reception not manned. Many visitors frustrated at not being able to contact pod/staff. Should be manned/staffed appropriately or specific designated member of pods given responsibility to answer. Needs improvement.
ICU	The nurses often changed it would have been nice to have a little more continuity of care. I know it is difficult as you do not want them to get attached. But it was often a different nurse during the day and evening - as mum was pretty unresponsive a twitch or movement in eyes, face would have been more recognisable if someone had spent more time with her.
Gate 28a	Tried over 2 days to contact the doctor on the ward, left messages for doctor to call me back but received no call. It left me feeling disappointed. Left messages with ward reception. After death, when patients breath had expired, next of kin were expecting more information about what had happened i.e. had she died. More communication was needed for the family around the bedside from the staff nurse on duty. After patient passed away, we were given a leaflet about 'what to do when someone dies in hospital' but verbal communication would have also been reassuring but wasn't received by staff nurse on duty.
	See Q.1 to reply.
F1 on 27A	As point 4 - F1 probably reluctant due to inexperience, but no excuse - wasn't right my mother waited four hours.
	I feel that the doctor should have explained how severe mum's condition was. Because he said 'she was not dying' I went back home. The ward nurse informed me approx. 1 hour later to say that mum was not expected to survive and by the time I returned to hospital it was too late and mum had passed away.
9a	Gen. Meds. I feel he should have been on a cancer specialist ward, I had no idea he was so close to the end.
ICU	Communication with transplant team coordinators was difficult. More direct approach from medical staff was less confusing. Took me 5 minutes to realise they wanted consent for transplants.
33b	Pain and agitation could have been managed better. The smell from the catheter bag was very noticeable and only when we asked for it to be changed did it became obvious that it was badly blocked. This could have been why she was constantly complaining of back pain.

25	We mentioned infection several times and were given conflicting information about tests going to be done and whether my dad did or did not have an infection.
9B	No!
	Nothing - everything was done as well as it could be in circumstances.
A&E	No one can improve on perfection.
Gate 9A Level 5	I do feel that patients at end of life should be left to slip away in the bed they have been put in, no matter how long instead of social workers coming in and saying they are being sent to a nursing home, against family, patient wishes, no matter how much you say no it was going ahead. Not right.
A&E	It would have been good to move from A&E to a ward quicker, we waited for over 5 hours. But understand a bed had to become available. Once we were moved the facilities were better. But A&E were very kind and looked after my father and family very well. Our thanks go to them for all they did.
	No, care excellent from all staff - GP/WGH/Southmead.
31	No.
AMU	Nothing - thank you.
	See previous page.
31B	No - impossible.
	No.
9A	When he went for the procedure, he returned later than expected and we were very anxious. We were not told the reason for this until the following morning and had been expecting a late night call from the doctor following several of our own enquiries.
	I am sorry I am unable to respond to this questions. Thank you.
27B	No, not really as all the nurses worked in an extremely kind and efficient way.
	No, please pass on our thanks.
31B	No, it was made as bearable as possible.
9B	Make sure all staff understand the meaning of the 'purple butterfly' and respond accordingly.
32a	No.
	1) More care in her room so she would not have had to move to a small ward to have the necessary care. I fully realise this is not a possibility due to funding issues. 2) The issue of a speedier signing off where donation of organs is involved. Again I appreciate this did not affect the care of mum but meant I was unable to fulfil her wishes.
28A/28	I would have liked to have been notified sooner that my loved one was very poorly. Apparently they did not have my phone number and had to telephone the doctor's surgery to obtain it. I did give my telephone number to the ambulance crew and a doctor on admission to hospital. I also had a problem obtaining a death certificate, the bereavement office did not phone me when they said they would and it took me 2 weeks to make an appointment to register the death.
32A	Nothing, mum was cared for beautifully.
	I would only add that if my mother had lived any longer, I would not have permitted the first carer to have anything to do with her again.
34A	We feel the first week of admission because mum had dementia she didn't eat or drink a lot. We feel this could be improved - food was just left and then taken away uneaten - Again staff shortages were a contributing factor!
	Everything.

The full VOICES survey has been presented to the Trust End of Life Group and the Nursing, Midwifery and Therapy Forum to share the learning from the feedback.

3. Patient Shadowing as part of the Purple Butterfly Project.

Using patient-centred methodology along with the Point of Care Foundation, staff observed End of Life care being delivered as part of the Purple Butterfly project, to inform changes to our delivery of care.
We cannot recommend this highly enough. Other than being a patient yourself or being a relative alongside a loved one, there is no better way of seeing the care that people receive from their perspective.
We sat in a room and watched how staff entered, how staff approached and introduced themselves to patients-did they appear as though they had lots of time and cared (even if they were really busy) or did they make people feel as though they were a nuisance? How they explained what they were doing, how they responded to buzzers, how long it was until staff came back again and how that felt, how staff noticed little things such as whether call bell was in reach or they had a drink in reach etc..

There were several practical outcomes from this that are making an ongoing difference to patients daily, in particular the development of the Purple Butterfly menu.

4. "What Matters to You?"

As part of the Purple Butterfly project, we identified a potential to improve patient and carer involvement in both their nursing and medical care and in enabling them to convey what is really important to them. We designed a form called "What Matters to You", based on "This Is Me" form for patients with dementia and gave patients, families and staff opportunities to share this information to enhance their experience of care. We recognised that this is a big project in its own right and Keri Knapp, Palliative Care CNS is undertaking an evaluation of the form and acceptability of it as an MSc module.

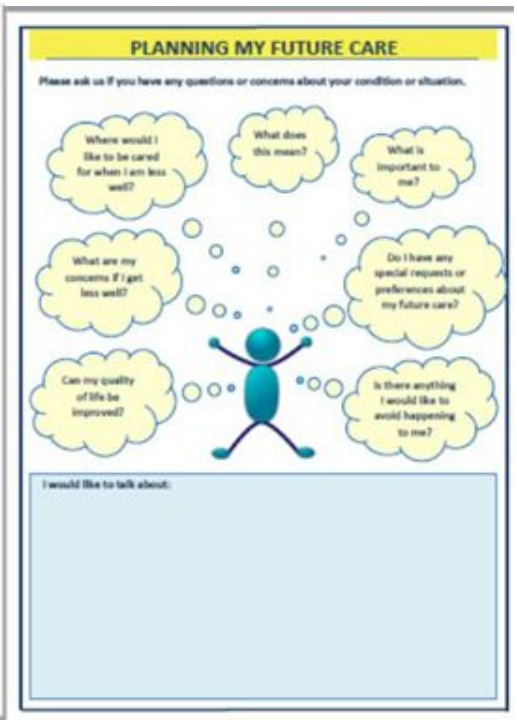
NHS
North Bristol

What Matters To You?

Whilst you are in hospital, we would like to involve you in your care as much as possible and as much as you want to be. It will help us to do this if we know a bit more about you.

If you would like to, please use this form to tell us about things that really matter to you. This may be about you, your life and your family:

If you would like to, please tell us about anything that will help us to care for you. For example, things that make you feel safe and comfortable or things that may worry or upset you:



PLANNING MY FUTURE CARE

Please ask us if you have any questions or concerns about your condition or situation.

Where would I like to be cared for when I am less well?

What does this mean?

What is important to me?

What are my concerns if I get less well?

Do I have any special requests or preferences about my future care?

Can my quality of life be improved?

Is there anything I would like to avoid happening to me?

I would like to talk about:

11

6. Clinical Audit

In the past year the team has completed several audits:

1. National Audit of Care at End of Life (NACEL) 2018
2. NBT Syringe Pump Audit
3. Audit of completion of Purple Butterfly End of Life Documentation

1. **NACEL 2018.** Summary of results as presented to the NBT EoL group May 2019.
   Overall, the results are very encouraging, with NBT being above or equal to the national results on 50 out of 59 measures (85%). We did not participate in the Quality Survey part of the NACEL audit because we were in the middle of our VOICES survey at the time. Sarah Waters has matched the VOICES results to the Quality Survey and our results compare very favourably with the national results, with NBT receiving >89% agreement with each positive statement.
   Where we did not do so well was in documentation of spiritual and cultural assessments of patient and carers, provision of face to face visits at weekends by palliative care team and in documenting preferred place of death. The Palliative Care Team reviewed the results in their audit meeting and have recommended some actions which were discussed by the group today:
   Re Spiritual Care: BD reported that Lorenzo functions do not easily support the chaplaincy team in producing a report of their activity. SW will look at this with BD.
   The EoL group agreed with a suggestion that a sticker inserted into the patient notes by the chaplains with a signature to say they have visited would be very helpful clinically and for audit purposes. BD will put this in place.
   It was discussed that often staff do not make an assessment because they don't know how to open the discussion. It was agreed that prompts will be agreed and the Purple Butterfly paperwork will be amended, in order to assist staff.
   Re Palliative Care weekend working: NJ and CK have started discussions with Medicine AGMs to put in a business case for this following successful trials of weekend working at Christmas and Easter extended Bank Holidays.
   Re Recording of Preferred Place of Death: The group agreed with the suggestion to amend the Purple Butterfly paperwork to check with patients that hospital is an acceptable place for them to die. This is more representative of the situation as many people who die here have little social support or high care needs and they would not be able to be cared for at home. We still facilitate many EoL discharges for patients who want to be out of hospital and for whom suitable care is available.

   CK met with Sarah Waters and put this in place as an Action Plan. Implementation of this will be monitored by the Palliative Care Audit Lead and reviewed as we undertake the 2019 NACEL audit between June and October.
   The results will be shared with ward teams via the EoL Newsletter.

2. NBT Syringe Pump Audit 2018.

Aim To identify whether the T34 syringe pump is being prescribed, set up and monitored effectively within NBT

Results will be used to determine a strategy for improving practice with the overall aim of improving safety and pain and symptom control for palliative and end of life patients where a syringe pump is in use.

Objectives Gather and collate data about current practices. Compare practice to accepted best practice.

Syringe pumps will be safely and appropriately prescribed, according to guidelines and policy

All patients who have opioid in a syringe pump will have appropriate PRN analgesia

Syringe pumps should ne titrated in line with PRN use or in the presence of symptoms

The main drug chart will refer to the T34 prescription chart

Syringe pumps will be set up according to best practice guidelines

Syringe pumps will be set up as soon as appropriate to optimise symptom control

Syringe pumps will be monitored according to best practice guidelines.

All patients at end of life will have their medications appropriately rationalised

Appropriate PRN medication will be prescribed where a syringe pump is in use

Determine how practice may be improved to meet best practice

Standards/guidelines/evidence base

Guideline for best practice and which training is based upon is guideline for the use of the CME Medical McKinley T34 syringe pump in adult palliative care. Regionally agreed standards of practice.

Methodology

Sample

Prospective sample over 8 week period until a minimum of 60 syringe pumps audited, Inclusion criteria- adult patients being cared for at NBT using a CME Medical T34 syringe pump for palliative care purposes

Action Plan:

Recommendation		Actions required *(specify "None", if none required)* **How / Where is the recommendation going to be achieved?**	Action by date	Person responsible *(Name and grade)*	Evidence required to show recommendation has been implemented (Training log, minutes, new documentation)
1	Review of the Basic and Update T34 syringe pump teaching	Update the teaching to better cover areas which require improvement. Particular attention needed in use of keypad lock, selecting correct syringe, setting up pumps in a timely fashion and use of PRN doses if indicated at this time.	16/07/18	Keri Knapp and Amanda Herman (CNS)	The revised teaching for T34
2	Palliative Care Team to be proactive in ensuring syringe pumps prescribed in a timely fashion and PRN doses given if indicated	Team members able to prescribe pumps to ensure that this is communicated to fully to the ward team caring for the patient as the time of prescription to avoid delay Those not able to prescribe must be proactive in ensuring that pumps are prescribed as a priority and to advocate the use of PRN doses at this interval to cover the period where this is being set up and until symptom control achieved. To be communicated to team at next team meeting	26/06/18	Keri Knapp (CNS)	To be added to agenda for next team meeting and included in the minutes
3	Review of the T34 prescription chart	Review digital version of chart to see if able to add time of prescription	July 18	Keri Knapp /Amanda Herman (CNS)	Revised chart
4	Ongoing work with wards to ensure correct cannulas and infusion lines in use	Purple butterfly project roll out now underway and as such trolleys now on all wards with stock lists including EROS codes for correct lines. To remove old stocks if identified in clinical areas	20/06/18	Palliative Care Team	At re-audit and in review in practice

Recommendation		Actions required *(specify "None", if none required)* **How / Where is the recommendation going to be achieved?**	Action by date	Person responsible *(Name and grade)*	Evidence required to show recommendation has been implemented (Training log, minutes, new documentation)
5	Liaison with equipment services	Discussion with equipment services regarding feasibility of reducing syringe choices on the T34. Also to discuss where pumps are currently serviced and how/if they follow up this these are done annually.	July 18	Keri Knapp/Amanda Herman	Keri/Amanda to feedback following this discussion
6	SPCT to review all Datix forms relating to End of Life	All Datix forms completed that relate in any way to end of life care are now reviewed by the palliative care team. This will allow any issues/incidents related to use of the T34 syringe pump to be brought to our attention and appropriate action taken	July 18 and ongoing	Clare Kendall and SPCT	Datix reviews

3. Audit of End of Life Care Documentation 2018

- Baseline retrospective audit for purple butterfly (End of life documentation), although given this was during the role out of purple butterfly, there was a mix of the old and new documentation used
- Looked at deaths in April 2018 (so using same database as NACEL)

- 54 sets of notes reviewed on EDMS (50 available/ scanned; 40 expected deaths – 2 not recognised but could have been)
- 28 pts EoL documentation in place
- 12 pts no formal documentation in place

Overall improvement in:

- DNACPR being signed by consultant
- PRN medications accurately prescribed
- In majority of cases prn use was matched to symptom control chart (91%)
- Good evidence of daily review generally – AB queried breakdown between medical/ surgical wards
- Overall well documented conversations with the family/ relatives
- SPCT were involved in 50% of sample

Main areas identified for improvement:

- Very poor evidence of spiritual assessment - This is also corroborated by recent NACEL data CK has had previous discussions with chaplaincy about documenting in the notes that they have been to see patient, however, this is currently not the case. Discussed often just thought of as 'religious' needs, however, need to somehow train staff in recognising the importance of asking about wider spiritual and cultural needs, fears, priorities etc. as well. AB raised we need to find out the barriers there are in staff asking about this. AM suggested CNS team may be able to cover this in the planned communication skills sessions that will be run for nurses.

- Poor evidence of escalation for sustained uncontrolled symptoms (about 50%), which is also what we as a team have noticed as an ongoing issue in daily practise
- Poor completion of ICE notification of death letters sent out to GPs (46%), although better than previous sample which was approx. 20%
- Nursing staff initial assessment form only completed for 71% of patients – this may however have improved since moving to purple butterfly documentation and this being a separate document, therefore will be helpful to see results of re-audit

Actions:

- **Team to make greater effort to check nursing assessment prior to reviewing patients and to ensure to document spiritual assessment if we assess this during our assessment – either in body of notes or on initial assessment form**
- **CNS team to take forward a focus on completing spiritual assessment in EoL training for N/Staff**
- **Re-audit 2019**

The team audit programme is designed to reflect core standards as identified through our Clinical Governance programme with review of DATIX themes and as required by CQC:

- Based on CQC core standards of care
    - Safety
        - EoL prescribing audits (ideally as part of EoL documentation audit)
        - Community drug chart audit
        - Baseline purple butterfly audit when flow board running
        - SD audit
        - Purple butterfly
    - Effective
        - NACEL*
        - Time from referral to seen by team* – would be quite easy to collect data from CISS
        - EOLC discharge – audit of DC summaries looking at current handover of care to community also reviewing whether this is then being translated into an EoL record

        - DNACPR audit - should be led by resus team; rhythms at resus reviewed at EoL group – CK planning to look with resus team at patients with non-shockable rhythms at resus to gain a better understanding as to why those patients did not have a DNACPR in place. Audits before now have in fact reflected that NBT is one of the best Trusts in the country for the numbers of resuscitation calls for non-shockable rhythms.
    - Responsive
        - Audit of rapid discharges* – agreed would be good to audit all CHC FT forms submitted, funding agreed and then time to discharge which would then help to identify the main cause of delays. Potentially possible to interrogate this data from the flow board once up and running
        - Readmission rates – could do a root cause analysis of reasons behind re-admission of patients discharged from NBT and look if there are any ways to avoid such readmissions
- Arising from Datix
  Audit ideas which arise from these themes are covered by audits already discussed above
- Our internal guidelines
    - Hypercalcaemia management against new guidelines
- Care after death audit (NJ)
- CC raised whether we need to re-audit MR opioid prescribing
- Hypercalcaemia and MR opioid prescribing audits are potentially quite straightforward and contained projects which could be done by a junior doctor/nurse/pharmacy student so worth having as ideas for when we have colleagues approach us looking to do an audit in palliative care

(Audit priorities highlighted by *)

Audit priorities for 2019/20:

1. Repeat End of life Documentation audit
2. NACEL 2019
3. Patient survey
4. Audit of Community Drug chart and EoL Discharge Checklist
5. Syringe Pump Audit with update data collection for assurance following Gosport inquiry

Report To:	Trust Board	**Agenda Item:**	13.
Date of Meeting:	26th September 2019		
Report Title:	Annual Medical Revalidation and Appraisal Quality Report		
Report Author & Job Title	Nick Standen - Medical Revalidation Support Manager Dr Monica Baird - Deputy Medical Director		
Executive/Non-executive Sponsor (presenting)	Dr Chris Burton		

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

Recommendation:	The board are asked to review the content of the report in order to confirm a statement of compliance to NHS England (Appendix A)
Report History:	This report has been reviewed and endorsed at the Trust Management Team on 15th July 2019 and the People & Digital Committee on 21st August 2019.
Next Steps:	Statements of compliance (Appendix A) to be signed and returned to NHS England by the deadline of the 27th September 2019

Executive Summary

At the 31st March 2019 North Bristol Trust was the designated body supporting the revalidation and appraisal of 707 doctors in a number of grades. Well established processes are in place to quality assure the appraisal process and to identify doctors who have missed their appraisals.

The medical appraisal year runs from April - March. This report refers to the 2018/19 appraisal year which ended on the 31st March 2019.

The Trust's appraisal systems were last inspected by NHS England in September 2015 and received an "Excellent" rating in all domains. The next full inspection is due in 2020. A shorter visit took place by NHS England in February 2017. The NHS England team were happy with the current progress with no recommendations made as a result.

Strategic Theme/Corporate Objective Links	• Create an exceptional workforce for the future • Treat patients as partners in their care • Play our part in delivering a successful health & care system
Board Assurance	Revalidation is a legal requirement for all GMC licenced doctors. Failure to comply with the revalidation requirements

Framework/Trust Risk Register Links	can put the doctor's licence to practice at risk and result in suspension from work. This paper describes the processes in place to support doctors in their revalidation.
Other Standard Reference	N/A
Financial implications	N/A
Other Resource Implications	None - sufficient resource is available to fulfil the requirements of appraisal and revalidation at NBT
Legal Implications including Equality, Diversity and Inclusion Assessment	• Revalidation is a legal requirement for doctors registered with a GMC licence to practice. • Diversity information is not collected within the appraisal and revalidation system.

Appendices:	Appendix A - Designated Body Statement of Compliance

Contents

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1. Introduction

Legislation supporting the licencing of doctors (Revalidation) was introduced in April 2013, so systems in place are now in their 6th year.

At the 31st March 2019; 707 doctors had a prescribed connection to North Bristol NHS Trust meaning that NBT is their designated body for the purposes of medical revalidation. Each year every doctor must complete an appraisal that meets the GMC requirements. The fifth year of revalidation detailed in this report covers the period from 1st April 2018 - 31st March 2019.

NBT supports appraisal and revalidation for consultants, academics, clinical fellows, specialty doctors, associate specialists and a small number of Trust locums. There are also a further 11 doctors who complete annual appraisals at NBT but maintain a connection to another designated body in line with GMC designated body rules. Doctors in training grades maintain a connection to Health Education England for revalidation.

NBT also provided an appraisal service for the Community Child Health Partnership staff that transferred from NBT to Sirona Care & Health in 2016. NBT charged Sirona for this service. This agreement came to an end on the 31st March 2019 as the process has now been taken in house by Sirona.

2. Purpose of the Paper

The purpose of this report is to communicate the results of an annual organisational audit of the Trust's progress with revalidation which cross references The Medical Profession (Responsible Officers) Regulations 2010 (amended in 2013). This will enable the Trust Board to sign a statement of compliance **(Appendix A)** that must be returned to NHS England before the 27th September 2019.

All the sections below are referenced from The Medical Profession (Responsible Officer) Regulations in order to inform the board of the Trusts compliance. It is also to ensure effectiveness in supporting medical governance in keeping with the General Medical Council (GMC) handbook on medical governance.

Section 1 – General

AOA Report

RO Regulation - The Annual Organisational Audit (AOA) for this year has been submitted.

The NHS England revalidation framework of quality assurance requires the Trust (as a designated body) to return an Annual Organisational Audit (AOA) to NHS England following the end of the 2018/19 appraisal year.

The AOA was returned on the 20th May 2019 and includes the 2018/19 appraisal compliance for all doctors with a prescribed connection to the Trusts designated body at the 31st March 2019.

At the 31st March 2019, the Trust declared that 707 non-training grade doctors were connected to its designated body. This is a rise in 40 from last year.

There were two additional groups of doctors completing appraisals on the NBT appraisal system who are not included in the 707 doctors mentioned above. These are:

- Sirona employees (referenced in the introduction). Details of these were returned in a separate AOA report by Sirona.

- 11 doctors who completed appraisals at NBT but who hold a prescribed connection to another designated body. These 11 doctors were all compliant with their appraisals and the details of this were returned in a separate AOA report by their designated bodies.

The below table reflects the figures with the submitted AOA for the 2018/19 appraisal report

NHS North Bristol NHS Trust

AOA Appraisal Compliance 2018/19					
Only doctors with a prescribed connection to the Trusts designated body at the 31st March 2019 are included within this data	**N° of Doctors with a prescribed connection**	**Completed Appraisals**	**Approved incomplete or missed appraisals**	**Unapproved incomplete or missed appraisals**	**% Appraisal Completion**
Consultants (permanent employed consultant medical staff including honorary contract holders)	433	416	17	0	**96%**
Associate Specialists & Specialty Doctors	46	46	0	0	**100%**
Temporary and short term contract holders (temporary employed staff including locums who are directly employed, trust doctors and clinical fellows)	219	182	37	0	**83%**
Other doctors (retired NBT doctors paying for a revalidation service)	9	9	0	0	**100%**
Total	**707**	**653**	**54**	**0**	**92%**

Fifty four doctors had an approved missed appraisal at the end of the year. This number consists of:

3 doctors working overseas
5 doctors on maternity leave
1 doctor currently suspended from work

The remaining Fourty Five doctors are a mix of individuals who are overdue their appraisals and also doctors who had joined the Trust in the past month (at the time of the report) and had not yet declared their previous appraisal meeting date. All of the Fourty Five doctors mentioned above are being managed through the Trusts missed appraisal escalation process and are aware of the requirement to complete the appraisal soon.

The Trust has issued a small number of REV6 forms to the GMC over the past 12 months for doctors with an unapproved missed appraisal. At the 31st March 2019 all of these individuals had engaged with the process. A record of these is maintained by NBT and the GMC.

Comparator Information

The below table shows the Trusts appraisal compliance for the 2018/19 year compared to other Designated Bodies of a similar size within the same sector and also compared to all Designated Bodies (DBs) across all sectors of the NHS.

	NBT	DBs in the same sector as NBT	DBs from all sectors
% of doctors with a complete appraisal	92.4%	89.6%	91.5%
% doctors with an approved missed appraisal	7.6%	6.7%	6.4%
% doctors with an unapproved missed appraisal	0%	3.7%	2.1%

Previous AOA data

The below table presents the 2018/19 AOA appraisal compliance at NBT compared to previous years.

AOA Appraisal Year	No. of prescribed connections	% of appraisals completed
2018/19	707	92%
2017/18	667	92%
2016/17	636	89%
2015/16	636	88%
2014/15	575	87%
2013/14	519	87%

Responsible Officer

RO Regulation - An appropriately trained licensed medical practitioner is nominated or appointed as a responsible officer.

The revalidation team at NBT consists of:

- Responsible Officer: Dr Chris Burton, Medical Director
- Deputy Medical Director & Revalidation Lead: Dr Monica Baird
- Revalidation Support Manager: Nick Standen

Dr Burton has received the appropriate training for the Responsible Officer Role

Within each division there is an appraisal lead that provides a link between the revalidation team, the divisional management team and the doctors within the division.

The Trust also provides a lay member who attends the annual revalidation steering group

Funding

RO Regulation - The designated body provides sufficient funds, capacity and other resources for the responsible officer to carry out the responsibilities of the role.

Funding is provided from the Trusts Medical Personnel budget (B41768) to cover the cost of the electronic appraisal system and the revalidation support manager.

Designated Body Connection

RO Regulation - An accurate record of all licensed medical practitioners with a prescribed connection to the designated body is always maintained.

To ensure that the list of doctors with a prescribed connection to North Bristol NHS Trust is accurate, the following processes are in place:

Doctors joining NBT:

The Medical Personnel team inform the Revalidation Support Manager each month of doctors joining the Trust. The Revalidation Support Manager assesses whether NBT should be the doctor's designated body as per the GMC guidelines. The doctor is then added to the Trusts designated body via an online database GMC-Connect.

When a doctor joins the Trust; the Revalidation Support Manager issues a request to the individual doctor's previous designated body to identify the date of the doctor's most recent appraisal and details of any concerns relating to the individual. Returned forms are inserted into the individuals NBT appraisal portfolio for the doctor to access and any details of concerns are shared with the Trusts RO.

Doctors leaving NBT:

The Medical Personnel team inform the Revalidation Support Manager when a doctor leaves the Trust. The doctor's connection to NBT is removed via the online system GMC-Connect.

Policies

RO Regulation - There is a medical appraisal policy in place that is compliant with national policy and has received the Board's approval (or by an equivalent governance or executive group). All policies in place to support medical revalidation are actively monitored and regularly reviewed.

The NBT appraisal and revalidation policy and user guide was updated and signed off by the Joint Local Negotiating Committee (JLNC) in September 2016. All other Trust policies that link with the medical appraisal process are monitored and updated on a regular basis as part of usual review process.

Processes Review

RO Regulation - A review has been undertaken of this organisation's appraisal and revalidation processes. The appraisal system in place for the doctors in your organisation is subject to a quality assurance process and the findings are reported to the Board or equivalent governance group.

Audit South West completed an audit of the Trusts revalidation and appraisal processes in February 2015 which received an overall green assurance opinion rating and a low impact assessment rating.

NHS England also conducted a review (independent verification visit) of the Trusts appraisal and revalidation processes in September 2015. The review provided an 'Excellent' outcome which meets all core standards. Independent Verification Visits by NHS England will be carried out at least once per revalidation cycle (5 years). The next review at NBT is likely to take place around 2020.

A shorter visit took place by NHS England in February 2017. The NHS England team were happy with the current progress with no recommendations made as a result.

Locum / Short Term Placements

RO Regulation - A process is in place to ensure locum or short-term placement doctors working in the organisation, including those with a prescribed connection to another organisation, are supported in their continuing professional development, appraisal, revalidation, and governance.

All doctors employed in short term contracts or via the Trusts internal locum bank are provided with an appraisal portfolio and access to a medical appraiser. The appraisal is expected to meet the same standard as it does for substantive employees. Fixed term doctors (such as clinical fellows) have access to study leave in line with SAS doctors. Locum at NBT is generally used to describe a single or short run of shifts; these would not attract additional study leave or budget.

Section 2 – Effective Appraisal

Appraisal Compliance

RO Regulation - All doctors in this organisation have an annual appraisal that covers a doctor's whole practice, which takes account of all relevant information relating to the doctor's fitness to practice (for their work carried out in the organisation and for work carried out for any other body in the appraisal period), including information about complaints, significant events and outlying clinical outcomes. Where this does not occur, there is full understanding of the reasons why and suitable action is taken.

Every doctor has an annual appraisal due date on the Trust's appraisal system. A doctors due date will remain the same each year regardless of when the individual last completed the appraisal to ensure that the required 5 annual appraisals take place over the 5 year revalidation cycle.

The Trusts appraisal system PReP was due to expire in March 2019. Following an in depth tendering process over the course of the 2018/19 year, the Trust changed to a new appraisal system called Fourteen Fish in April 2019. This system has been purchased along with University Hospitals Bristol NHS Foundation Trust (UHB) and Weston Area Health NHS Trust on a 5 year contract with a possibility to extend by a further 2 years.

The tender process was conducted with the Bristol & Weston NHS Purchasing Consortium and a recommendation was made in January 2019 to award the contract to Fourteen Fish. This followed an in depth review of 7 companies that bid which included presentations and hands on testing of each system under a strict specification. The new system is now up and running and all historical data has been transferred from PReP to Fourteen Fish. There have been some issues with data migration which is currently being resolved by the Revalidation Support Manager.

The table below shows the Cash Releasing Savings (CRES) that will be delivered as result of the competitive tender process in the first year of the contract and over the full term of the contract:

Fourteen Fish Appraisal System		
Organisation	**CRES In-Year Savings** (Excl. VAT)	**CRES Full-Term Savings** (Excl. VAT)
NBT	£17,836	£124,852
UHBristol	£15,246	£106,722
WHAT	£27,099	£189,693
Total	**£60,181**	**£421,267**

Two reports are produced each month by the Revalidation Support Manager:

1. Revalidation appraisal figures report

Issued to the Responsible Officer / Deputy Responsible Officer / Deputy Medical Director / Trust People Business Partners / Information Management Department.

The report highlights the following:

- Number of appraisals that were due by the current point in the appraisal year and % that have been completed
- Number of appraisals in the current appraisal year that are:
  - Completed
  - Missed
  - Due date not yet set (for doctors who joined NBT in the past month)
  - Not due yet

The report also contains the following metrics for the Trusts Integrated Performance Report:

- Rolling % of doctors, by grade, who completed an appraisal within the past 15 months

- Total number of revalidation recommendations made in each of the past 12 months.

  a. No. of positive recommendations
  b. No. of deferrals
  c. No. of non-engagement recommendations

2. Missed appraisal report

This report is issued to Clinical Directors / Directorate Appraiser Leads / Trust HR Business Partners / General Managers

The report is presented by directorate and highlights all the individual doctors who have passed their appraisal due date without a completed appraisal and any reasons given for the delay.

Where an appraisal is missed and highlighted in the above report there is an escalation process in place as detailed below.

- 2 weeks after the appraisal due date – reminder sent from system
- 6 weeks after the appraisal due date – reminder sent from the Trusts Deputy Medical Director
- 8 weeks after the appraisal due date – REV6 form sent to GMC giving a 4 week final deadline

Failure to meet this GMC final deadline will result in a non-engagement recommendation being made which will put the doctor's license to practice at risk.

Quality assurance of appraisals

- Fourteen Fish allows the appraisal conversation to be summarised and captured electronically providing an audit trail of each individual step in the process
- An appraisee is required to make mandatory pre-appraisal probity statements in the system
- The appraisal inputs are required to be submitted to the appraiser prior to the date of appraisal. This provides the appraiser with sufficient time to review the content and return the form for editing if necessary.
- Information regarding closed complaints, audits, quality improvement projects, Trust MLE training and formal HR concerns are included into the appraisal for every doctor by the Revalidation Support Manager to ensure they are included for discussion with the appraiser. This provides assurance that all elements set out as needing discussion by the GMC during appraisal are included.

  Reports on clinical incidents are currently not being added to the appraisal inputs by the Revalidation Support Manager as the Datix system is not yet able to generate them for the revalidation process. Doctors are expected to add details of incidents to their portfolio themselves until this can be done on their behalf.
- Information from private practice is expected to be included in an appraisal and everyone is provided with a form to complete for this. Appraisers are aware of the requirement for this and will not progress the appraisal until the information has been provided.
- Any information that the Responsible Officer deems appropriate for inclusion into a doctor's appraisal is also sent to the Revalidation Support Manager to upload to the system. This is placed in the system with mandatory reflection required. This may include letters of advice sent as a result of disciplinary processes etc.
- 360 feedback is collected through the Fourteen Fish system which provide anonymous reports meeting GMC guidance for feedback

For the appraisers:

- Appraisers are required to reflect on their performance as an appraiser during their own appraisal. As part of completing an appraisal, the appraisee is required to complete an online questionnaire about the performance of the appraiser. These feedback results and comments are then anonymised and uploaded into the appraisers portfolio by the Revalidation Support Manager.
- Appraisers will also attend the appraiser half day training days annually which will provide CPD and appraiser networking which will feed into their own appraisals.
- Appraisers are also asked to attend any directorate appraiser meetings which are setup by the directorate appraiser leads.
- During a doctor's revalidation, the Deputy Responsible Officer reviews all appraisal inputs and outputs for that individual. The quality of the appraisal outputs are assessed and fed back to the appraiser with suggestions for improvement where necessary. The Trust policy update includes a new process for any appraisers who are not meeting the expectations of the role.

For the organisation:

- User feedback on the systems in place is gathered during directorate appraiser meetings, steering groups and through the appraiser training days.
- The monthly appraisal compliance reports provide a continuous audit of appraisal compliance. The revalidation team has also complied with every appraisal report required by NHS England to date which is requested four times per year.
- The Trust has processes outside of the appraisals to investigate and manage complaints and incidents as they occur. The outcomes from these are included in appraisals for doctors to reflect on and learn from.
- The Revalidation Support Manager contacts all specialty leads every 6 months to identify any low level concerns for doctors that have not been picked up by the Trusts formal processes. Any concerns received are shared with the RO.
- Two key audits from Audit South West and the NHS England Independent Verification Visit

Appraisers

RO Regulation - The designated body has the necessary number of trained appraisers to carry out timely annual medical appraisals for all its licensed medical practitioners. Medical appraisers participate in ongoing performance review and training/ development activities, to include attendance at appraisal network/development events, peer review and calibration of professional judgements.

The number of appraisers required to support revalidation is monitored within each division based on the division's number of appraisees. It is based on an appraiser conducting a minimum of five appraisals per year for which they receive 0.25 SPA per week.

New appraiser training is provided where a drop in the number of appraisers in a division occurs or the number of appraisees rises. In 2018/19 Dedici Ltd provided new appraiser training for NBT doctors. The content of the training course had been reviewed by the revalidation support team to ensure they meet the GMC requirements and is nationally recognised for CPD.

Existing appraisers are expected to attend a half day update training session each year facilitated by an external trainer/coach. The training days are supported by the Deputy Medical Director and the Revalidation Support Manager. The 2018/19 sessions focused on using appraisal to investigate and foster professional resilience in doctors in the early, middle and late stages of their careers. The next sessions are due in November/October 2019 and will focus on coaching skills for medical appraisals.

Section 3 – Recommendations to the GMC

Timely Recommendations

RO Regulation - Timely recommendations are made to the GMC about the fitness to practise of all doctors with a prescribed connection to the designated body, in accordance with the GMC requirements and responsible officer protocol.

The list of revalidation recommendations that are due are reviewed weekly via the GMC Connect website and the Fourteen Fish system. The Revalidation Support Manager reviews each doctor's portfolio in advance and provides the Revalidation Lead with a suggested recommendation. The Revalidation Lead and Responsible Officer then make a final decision which is returned to the GMC online.

The number of revalidation recommendations due in the 2018/19 year rose significantly as doctors entered their second revalidation cycle.

Appraisal Year	Revalidations Due	Positive	Deferral	Non-Engagement	% Deferrals Made
2018/19	145	108	37	0	**26%**
2017/18	45	35	9	1	**20%**
2016/17	44	32	12	0	**27%**
2015/16	202	172	30	0	**15%**
2014/15	189	164	25	0	**13%**
2013/14	96	86	10	0	**10%**

The percentage of deferrals made in the 2018/19 year has risen by 6% from last year. The majority of deferrals are due to incomplete colleague and patient feedback. The revalidation team are working on automatic emails from the system to remind individuals to complete this at an earlier stage.

From March 2019 the GMC are now collecting further information on the reasons for a deferral. This information will be provided each time a deferral is submitted.

Communicating Recommendations

RO Regulation - Revalidation recommendations made to the GMC are confirmed promptly to the doctor and the reasons for the recommendations, particularly if the recommendation is one of deferral or non-engagement, are discussed with the doctor before the recommendation is submitted.

When a positive recommendation is made, the doctor is notified in writing by the Trusts Revalidation Lead. As a doctor's portfolio is reviewed in advance of their revalidation date, the individual is notified of any gaps in their portfolio which may result in a deferral. The doctor is notified by the Trusts revalidation lead once the deferral is made. In the case of a non-engagement recommendation, the Trusts revalidation team will exhaust all of their internal communications to the doctor before advising them of the decision.

Section 4 – Medical Governance

Effective Governance Environment

RO Regulation - The organisation creates an environment which delivers effective clinical governance for doctors. Effective systems are in place for monitoring the conduct and performance of all doctors working in our organisation and all relevant information is provided for doctors to include at their appraisal.

The revalidation team, directorate appraiser leads and other identified individuals who support the revalidation and appraisal processes meet once a year at the revalidation steering group to discuss current processes and possible improvements.

For the purposes of revalidation the following information is included in each doctor's appraisal portfolio. The doctor is expected to reflect on the content of all these reports within their appraisal and discuss any outcomes with their appraiser:

a. Complaints (run from the Trusts Datix system)

The advice and complaints team maintain a process by which doctors are informed of all incoming and outgoing correspondence concerning complaints with which they are involved. A retrospective report from the preceding 12 months is uploaded to the individual's e-portfolio eight weeks prior to their appraisal for reflection and discussion at appraisal.

b. Clinical audit (produced by the Clinical Audit department)

The Trust's Clinical Audit department produces a report of all completed, registered clinical audits for each doctor. A retrospective report from the preceding 12 months is uploaded to the individual's e-portfolio eight weeks prior to their appraisal for reflection and discussion at the appraisal.

c. Quality improvement projects (produced by the Quality & Safety Improvement Team)

The Trust's Quality Improvement department produces a report of all completed and ongoing registered quality improvement projects for each doctor. A retrospective report from the preceding 12 months is uploaded to the individual's e-portfolio eight weeks prior to their appraisal for reflection and discussion at the appraisal.

d. Formal fitness to practice concerns (produced by the HR department)

The Trust's HR department maintain records of all doctors who are going through a formal management process due to fitness to practice concerns. A retrospective report from the preceding 12 months is uploaded to the individual's e-portfolio eight weeks prior to their appraisal for reflection and discussion at appraisal. Concerns are only included into an e-portfolio when they are closed or when formal remedial actions have been agreed with the individual.

e. Formal HR concerns - Bristol University

The University of Bristol HR department maintains a record of all formal concerns for doctors employed with the university. Those with honorary contracts with NBT are appraised and revalidated through the Trusts Designated Body. A transfer of information request is sent to the university eight weeks prior to their appraisal and a retrospective report from the preceding 12 months is uploaded to the individual's e-portfolio for reflection and discussion at the appraisal.

f. Low level fitness to practice concerns; produced in a six monthly report from the individuals clinical manager

Specialty leads are provided with a list of all doctors within their specialty every six months and are asked to make a statement, for each doctor, whether there are any low level fitness to practice concerns (not in a formal management process). Where a concern is identified an exception report is produced where more detail is provided and this is uploaded to the individual's e-portfolio for reflection and discussion at appraisal. Concerns are only included in an e-portfolio if the specialty lead is able to confirm that the individual has been made aware of the concern.

g. Formal HR concerns - Sirona

Sirona Care & Health HR department maintains a record of all formal concerns for doctors employed with Sirona. NBT Provides an appraisal and revalidation service for these doctors. A transfer of information request is sent to Sirona eight weeks prior to their appraisal and a retrospective report from the preceding 12 months is uploaded to the individual's e-portfolio for reflection and discussion at the appraisal. This process will no longer be in place for the 2019/20 year as NBT is no longer supporting Sirona appraisals.

The following levels of access have been provided to the users of Fourteen Fish to ensure security and effective governance:

- The e-portfolio is accessed by a unique user name and password for each user
- Responsible Officer and Deputy Responsible Officer has access to all e-portfolios through a user name and password
- The Revalidation Support Manager has limited access to all individual e-portfolios for the purpose of providing individual system support and to upload centrally produced supporting information:
- Appraisers only have access to their own agreed appraisee portfolios to view appraisal forms and supporting information and to complete Output forms. Appraisees can change this at any time.

Fourteen Fish is ISO 27001 compliant for Information Security Management. Patient identifiable information is neither allowed nor required to be uploaded to individual's e-portfolios. The system met all the necessary I.T. requirements as part of the tender process.

<u>Responding to Concerns</u>

RO Regulation - There is a process established for responding to concerns about any licensed medical practitioner's fitness to practise, which is supported by an approved responding to concerns policy that includes arrangements for investigation and intervention for capability, conduct, health and fitness to practise concerns. The system for responding to concerns about a doctor in our organisation is subject to a quality assurance process and the findings are reported to the Board or equivalent governance group. Analysis includes numbers, type and outcome of concerns, as well as aspects such as consideration of protected characteristics of the doctors.

Safeguards are in place to ensure clinical governance arrangements for doctors including processes for responding to concerns about a doctor's practice are fair and free from bias and discrimination (Ref GMC governance handbook).

The NBT Medical Staff Remediation Policy and User Guide describes the approach of the Trust to the identification, classification and response to the performance issues of members of the medical staff for whom North Bristol Trust is the designated organisation.

Remediation programmes are designed to meet the needs of the individual doctors and as such are not formally laid out in the policy or user guide. The Trust also has methods of responding to complaints and incidents as they occur.

NBT has a Medical Staff Decision Making Group, Chaired by the Deputy Medical Director and attended by the Medical Director, Head of Medical Workforce, Medical Revalidation Manager, HRBPs and other representatives for the Divisions. This group guides the informal and formal (MHPS) management of performance concerns about medical staff, whether on grounds of conduct or capability.

Doctors who are undergoing a process under MHPS have a nominated NED Board member to support and oversee and NCAS (PPA) is involved early in each case. A monthly Board report is submitted about the progress of MHPS for any excluded doctors.

Transferring Information

RO Regulation - There is a process for transferring information and concerns quickly and effectively between the responsible officer in our organisation and other responsible officers (or persons with appropriate governance responsibility) about a) doctors connected to your organisation and who also work in other places, and b) doctors connected elsewhere but who also work in our organisation

Information about a doctor's fitness to practice is requested from the previous designated body when a doctor joins the Trust. The NBT appraisal system expects that a doctor declares their whole scope of work as required by the GMC. This ensures that the appraiser, revalidation support team and Responsible Officer can identify other places where the doctor works for the purposes of sharing fitness to practice information.

During an appraisal doctors must include information from private practice including a statement of no concerns signed by the private employer. Appraisers do not proceed with the appraisal until this information has been included.

Section 5 – Employment Checks

Recruitment

RO Regulation - A system is in place to ensure the appropriate pre-employment background checks are undertaken to confirm all doctors, including locum and short-term doctors, have qualifications and are suitably skilled and knowledgeable to undertake their professional duties.

All pre and post-employment checks at NBT comply with the NHS Employment Check standards which apply to all applications for NHS positions and staff in ongoing NHS employment. The NHS standards are regularly reviewed to ensure ongoing compliance. The relevant regulations with which NBT complies are described below:

All NHS providers are required to be registered with the *Care Quality Commission (CQC)* and, as part of this registration are required to comply with *the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010* and the *Care Quality Commission (Registration) Regulations 2009*.

The CQC's Essential Standards of Quality and Safety outline core standards which must be met, including robust recruitment practices in place. NHS providers should therefore provide evidence of compliance with the NHS Employment Check Standards as part of the CQC's regulatory framework. The NHS Employment Check Standards are also embedded in the *Crown Commercial Service,* National Agency Framework Agreement and there are annual audit checks of agencies, to assure compliance with the standards.

Section 6 – Summary of Comments and Overall Conclusion

Developments Over the 2018/19 year

- The missed appraisal escalation process has been reviewed and changed to reflect that NHS England no longer accepts a 3 month delay to appraisals. The process has reduced by 2 months prompting GMC communication at 14 months since the last appraisal.

- The Datix system has now been developed to accurately report on complaints for medical appraisal and revalidation.

- The electronic appraisal and revalidation system has changed following a successful tender exercise. The new system provides a simpler process for the doctors. Appraisal compliance has dropped in the first quarter of the 2019/20 due to the implementation of the new system and NHS England was informed of this. Improvements are being made to the background of the new system to ensure processes are improved from the old system.

Developments for the 2019/20 year

- Improved reminders and engagement of 360 colleague and patient feedback to reduce the deferral rate.

- Clinical incidents still need to feed into the medical appraisal process. This will be reviewed over the course of the 2019/20 year.

The board is asked to accept the report and consider the Statement of Compliance (Appendix A) to decide if there is sufficient assurance for this to be signed and returned to the Trusts Revalidation Support Manager.

Appendix A

Designated Body Statement of Compliance

Section 7 – Statement of Compliance:

The Board of North Bristol NHS Trust has reviewed the content of this report and can confirm the organisation is compliant with The Medical Profession (Responsible Officers) Regulations 2010 (as amended in 2013).

Signed on behalf of the designated body

Chief Executive or Chair

Official name of designated body: North Bristol NHS Trust

Name: _ _ _ _ _ _ _ _ _ _ _ _ Signed: _ _ _ _ _ _ _ _ _ _ _ _

Role: _ _ _ _ _ _ _ _ _ _ _ _

Date: _ _ _ _ _ _ _ _ _ _

Report To:	Trust Board		**Agenda Item:**	14.
Date of Meeting:	26th September 2019			
Report Title:	People & Digital Committee Report			
Report Author & Job Title	Mark Pender, Deputy Trust Secretary			
Executive/Non-executive Sponsor (presenting)	Tim Gregory, Chair of the People & Digital 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 People & Digital Committee.			
Next Steps:	The next report to Trust Board will be to the November 2019 meeting.			

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 People & Digital Committee Meeting held on the 21st August 2019.

Strategic Theme/Corporate Objective Links	Reports received supported the delivery of the following strategic themes and corporate objectives: **Create an exceptional workforce for the future:** • Increase the overall engagement score in the staff survey from 3.72 to national average (3.78 in 2017). • Improved scores achieved in the staff survey in the health and wellbeing categories, so that exceeding the average of all trusts. **Devolve decision making and empower clinical staff to lead:** • Deliver the Service Line Management development

	programme for the specialty leads and their triumvirate teams (clinical specialty lead, Matron and assistant general manager). **Maximise the use of technology – right information for the right decisions:** • Deliver the 2018-19 Informatics Programme.
Board Assurance Framework/Trust Risk Register Links	Reports received support the mitigation of the following BAF risks: • SIR2 Workforce Stability. Risk score 3 x 3 = 9. • SIR3 Staff Engagement. Risk score 3 x 2 = 6. • SIR5 Data & Analytic Capacity. Risk score 4 x 3 = 12.
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 People & Digital Committee meeting held on 21st August 2019.

2. Background

The People & Digital 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 strategic direction and board assurance in relation to all workforce and IM&T issues.

3. Key Assurances Received

3.1 The People and Transformation risk register was reviewed and the key issues noted.

3.2 The BAF risks for which the Committee was responsible for were reviewed. The Committee felt that the risks ratings for the recruitment and retention risks (SIR2 and SER6) were currently set too low and that these should be reviewed in detail at its next meeting.

3.3 The programme of work being managed and governed by the Informatics programme department was reviewed, as was the risk register for IM&T.

3.4 An update on the e-rostering project was provided, and it was agreed that a further update should be provided to the December meeting of the Committee.

3.5 Dr Kathryn Holder, Guardian of Safe Junior Doctor Working, attended the meeting and presented her six monthly report to the Committee.

3.6 The current position in respect of the development of NBT's People Strategy was provided, and it was agreed that this should be reviewed in detail at the September meeting of the Committee.

3.7 The Committee reviewed the contents of the Medical Revalidation Report and recommended it to the Trust Board for approval.

4. Escalations to the Board

4.1 There were no escalations to the Trust Board from this meeting.

5. Recommendations

The Board is recommended to received and note the report for assurance.

Report To:	Board Meeting		**Agenda Item:**	15.
Date of Meeting:	26 September 2019			
Report Title:	M4 Corporate Objectives Report			
Report Author & Job Title	Tim Keen, Associate Director of Strategy			
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 4 delivery of Trust objective			
Report History:	Month 2 progress was reported to July Board			
Next Steps:	Progress will be further reported for Month 6			

Executive Summary	
The Board is asked to note the attached report on progress towards corporate objectives at Month 4.	
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?**

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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	Is this in the budget (revenue and/or capital) If not, how will it be funded?
Other Resource Implications	
Legal Implications including Equality, Diversity and Inclusion Assessment	

Appendices:	Appendix A: Month 4 objectives delivery report

Main Body of the Report

1. 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

3.1 The report provides a brief description of the Key Deliverables and Key Result Areas and provides an indication of the progress of the Key Deliverable at M4 alongside a forecast position for the year.

3. Recommendations

4.1 The Board is asked to note the report on month 4 delivery of Trust objective.

Objective 1: Be one of the safest trusts in the UK

Key Deliverables	Key Result Areas	M4 Update	M4 YTD	Exec Fcast	Governance	Key Metrics/ Milestones	Exec
Achieve "good" CQC rating	• Achieve "good" or better assessments from next CQC visit	Draft Report received, Factual Accuracy check in Progress for return to CQC by 13/9/2019			TMT & Quality & Risk Management Committee (QRMC)	Unannounced inspection undertaken 25-27 June 2019. Well Led inspection concludes 18/7/2019 Post inspection written feedback letter form CQC (timeframe not known) Draft reports received 29/8/19 Factual Accuracy response due by 13/9/19, publication publically to follow from CQC.	Director of Nursing and Quality
Build on our Perform programme	• Sustaining 18/19 levels of LOS in 19/20Q1-Q3	Average LOS of 2.45 days for April 2019 - July 2019. This is identical to the LOS between June-July 2018 following the implementation of Perform and therefore LOS improvements have been sustained despite an increase in demand. Review of LOS excluding assessment areas and EDOU shows a similarly sustained LOS of 2.90 days suggesting we have sustained LOS for non-zero LOS patients.			Transformation Board	Flow Metrics reported in Perform dashboard	Director of People and Transformation
Invest in clinical governance for learning and improvement	• Implementation of planned clinical governance capacity	Clinical divisional structures being recruited to, majority of posts now filled and commenced. Trustwide workshop for Clinical Governance scheduled for 151/0/2019.			Quality & Risk Management Committee (QRMC)	Recruitment into clinical governance posts and induction/training programme - roles recruitment by 30/9/2019 CGIP phase 2 (embedding and benefits delivery) - programme updated and deliverables agreed by 30/9/2019	Director of Nursing and Quality
	• Deliver milestones in Trust Quality Strategy	Updates to Quality Strategy in progress, discussed with Medical Director & Director of Nursing & Quality to align with wording and focus of revised Trust Strategy. May need to revise timeframe to align to Trust Strategy outputs.			TMT to monitor delivery	Deferral agreed to September Board to align to overall Strategy refresh (30 Sept 2019) Establish review mechanism for quality strategy workstreams (31 Oct 2019) Integrate into Business Planning process 2020/21 (from Sept 2019)	Director of Nursing and Quality
Deliver the digital programme	• Performance against digital programme milestones	All milestones have now been completed. There are 3 clinical Informaticians working within informatics and leading the projects to consolodate systems. This is ongoing and feedback is provided through the IM&T Committee and the People & Digital Committee. The ADI owner of this work has now been transferred to Casper Fons. The CCIO's have a group of clinical leads that they liaise with on a regular basis to drive the Digital transformation change. A project manager has been appointed and an OBC has been written and due to go through the various Boards and committee's in October			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	Careflow Connect - Clinical Messaging App - Pilot is due to commence in September due to technical messaging issues identified. This has therefore delayed the proof of concept. The process to procurement the system on approval of the Benefits realisation will now take place as part of the PAS procurement and will not be a seperate Full Business Case			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)	Due to a delay in resolving the interface issues, where the final fate message wasn't being sent back to the pathology system, the project missed the window to implement the system before the summer period. The issue has since been resolevd and the project board has approved a new timeline for implementation. A September go live has now been approved. The go live will now take place in a 2 phase approach with the kiosks, Enquiry and PDA TX on 16th October. Full roll-out of the system is expected to be completed by end March 2020.			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	Due to delays with the national funding there was a delay in finalising the procurement and signing contracts. This has now been completed however this has caused a delay to the implementation. The first Board is taking place in September and the implementation plan will become clearer following this meeting			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	M4 Update			Governance	Key Metrics	Exec
Cut waiting times for cancer treatment	• Performance against improvement trajectory	Performance in month 4 remains below trajectory across most cancer metrics. Permance target met for31 days drug treatment target. Trajectories have been reset for 2 week wait and 62 day standard for the rest of the year which confirm ongoing non-compliance for rest of year. Please see separate paper to September Board detailing revised performance trajectories, underlying issues and actions planned.				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	Performance improved in M4 but remains below target and trajectory. Trajectories have been revised for remainder of year. Please see separate paper to September Board detailing revised performance trajectories, underlying issues and actions planned.				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

Objective 2: Improve patient access and experi	Significantly increase Emergency Zone staffing	• Performance against A&E improvement trajectory	Performance at M4 remains below trajectory. Despite improvements in August and September to date, there remains a risk with regards to bed gap in the winter plan. Please see separate paper to September Board on the Winter plan.				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. ED workforce plan now in "intensive support" with weekly meeting with MD/ DoN and COO.	Chief Operating Officer
		• Delivery of new emergency care models with increased staffing	Business Case for GP streaming model has been submitted to CCG for approval.				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	Performance at M4 is below trajectory although improved from Q1. Please see separate paper to September Board detailing revised performance trajectories, underlying issues and actions planned.				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	Autism elearrnging and face 2 face training is in place for staff to access. Promotion to increase uptake has started. Learning Disability training packages are in development but slightly behind scheude for deployment which may impact delivery of overall target.			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	KPIs not identified. Programme in development.			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**	**M4 Update**			**Governance**	**Key Metrics**	**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	Acute Care Collaboration Strategy finalised and going through Boards for approval			ACC Steering Group		Medical Director
		• Delivery of Integrated Care System development and system digital programme milestones	Video Consultation - in the processes of being scoped. Careflow Connect - update in line 7 WiFi access - completed and will be enahnced as part of the network project 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				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	Slippage on thrombectomy service due to medical stroke workforce constraints. Expected to deliver increased thrombectomy provision in Q3.			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	Merger of Breast services is on track with fully merged services expected to commence in Q4. Urology merger is at risk of delay due emerging risks in financial case and infromation gaps which need to be addressed before a decision can be undertaken. Histopathology transfer from Weston to NBT complete 2nd April 2019. All services now integrated across BNSSG except breast pathology which is currently being outsourced for Weston patients due to a lack of reporting resource.					Medical Director
	Key Deliverables	**Key Result Areas**	**M4 Update**			**Governance**	**Key Metrics**	**Exec**
npowered to lead	Prioritise the health and wellbeing of our staff.	• Improved employee engagement and take-up of wellbeing offer	Both MSK and SAD related absence as tracked through the IPR shows a reduction in line with the target from last year. The takeup of the EAP in the year to 30/06/19 was recorded at 5.4%, exceeding the target set.			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	Overall sickness absence is slightly above target (4.3% VS 4.2% target) but absence for Stress/Anxiety/Depression and MSK reasons has sustained improvement. Stability remains stable . The Trust vacancy factor increased to 11.6% in July 2019 from 10.8% in June			Metrics are monitored through the IPR which is reviewed by the People an Digital	Health and Wellbeing: Sickness Absence Health and Wellbeing: Time lost to sickness absence Stress/Anxiety/Depression and MSK	Director of People and Transformation

Objective 4: Build effective teams en		• Expanded usage of new roles	2019. Substantive funded establishment increased by 74 wte wte across all staff groups with the biggest increase in unregistered nursing and midwifery. Overall, the Trust saw a net gain of staff in July (26.4 wte) with the biggest gain in unregistered nursing.			Committee and Vacancy Factor, Sickness Absence are monitored through Divisional Performance Review accountability framework	Stress, Anxiety, Depression, and, MSK Sustainability: Stability Index % Sustainability: Vacancy Factor % Sustainability: Engagement – Happy App Positive/Neutral	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	Agency use and expenditure decreased in July, predominantly in administration, estates and professional technical staff. However usage and expenditure remains above plan. The BNSSG Reduction in High Cost Agency Project have agreed to implement increased and simplified pay and charge rates with a soft launch from August for Tier 1 & 2 Framework suppliers to support the work to reduce high cost agency usage.			Metrics are monitored through the IPR which is reviewed by the People and Digital Committee and through Divisional Performance Review accountability framework. 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
	Key Deliverables	**Key Result Areas**	**M4 Update**			**Governance**	**Key Metrics**	**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	At the end of July, the Trust reported a deficit of £3.3m which is £0.6m adverse to the planned deficit. The Trust has a 2019/20 savings target of £25m, of which £4.1m was achieved at the end of July against a plan of £5.9m. The Trust is expecting to deliver the full savings plan this year.			TMT		Director of Finance
		• Monthly CIP delivery against plan	Plan fully identified againt requirment. £20m risk assessed against £25m requirement.			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)	Transformation Board has been establisehd and development of 5 year transformation programme on track.			Transformation Board	Refer to business case	Director of People and Transformation
			Programme in place. Timeline for Managed Equipment Service being revised following advice on regulator approvals and procurement process.			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
			Primary care Streaming in place (GP in ED) Emergency Zone workforce business Case approved. Reduce bed requirement for expected levels of NEL activity Shift sub acute Rehab from Acute Bed Base to community Perform focus on criteria-led discharge			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	Development of Strategy on track for proposals to go to TMT and Board in August alongside transformation plan. Final draft narrative likely to go to Oct Board following period of engagement with staff and partners.			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 sustainability plan has been developed alongside strategy and transformaiton and expected to be finalised for October Board			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	Project on track, ISOS dialogue largely complete final ducument review underway for requesting outline solutions from bidders. Site visits planned for October 2019 to inform this process			West of England Pathology Network Board	Issue Invitation to Submit Detailed Solution (ISDS) to shortlisted bidders by 20 December 2019	Medical Director
		• Pathology Networking	Draft SOC for network under consideration by project board ahead of final version for Trust Board in October/November. This will be accompanied by an MOU for board review/approval.			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:**	16.
Date of Meeting:	26 September 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.

<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.

NHS North Bristol NHS Trust

North Bristol NHS Trust

INTEGRATED PERFORMANCE REPORT

September 2019 (presenting August 2019 data)

CONTENTS

REPORT KEY

Unless noted on each graph, all data shown is for period up to, and including, 31 August 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
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
WCH	Women and Children's Health
WTE	Whole Time Equivalent

EXECUTIVE SUMMARY
August 2019

Urgent Care

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.

Elective Care and Diagnostics

Elective Care performance continues to be mixed, with a reduction in the overall wait list size (total numbers of patients waiting for treatment). The number of patients waiting greater than 52 weeks for their treatment has remained static in month with 14 breaches reported;. The Trust will now be unable to deliver its undertakings to clear the backlog of long-waiting patients by the beginning of October. Overall diagnostics performance is 9.39% in month, which is anticipated to be the peak in underperformance. The majority of diagnostics will be delivering the national standard from September with CT planned to recover in January 2020 and Endoscopy recovery planned for March 2020.

Cancer wait time standards

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.

Quality

There has been a significant reduction in the number of overdue complaints in August, with only one reported. This is following the successful introduction of a weekly divisional tracker improving visibility and monitoring of the timeliness of responses.

In August, there has been an increase in the rate of patient falls with 6.6 per 1000 bed days reported. The increase is mostly within the low and no-harm categories. Required improvements are being addressed by the Falls Prevention Group and overseen by the Quality and Risk Management Committee.

Workforce

The Trust vacancy factor has remained stable at 11.58% in August 2019 from 11.55% in July 2019 and turnover saw a small decrease from 15.1% in July to 14.8% in August, continuing the trajectory of improvement. Sickness absence has not changed from the previous month's position with no significant shifts in any staff group. The Band 2, 3 and 4 nursing resourcing plan delivered 21 new starters in August against a target of 18. For Band 5 nurses year to date the Trust is 32 wte starters behind target, however, September and October's pipelines are forecast to correct this shortfall with current projections showing in excess of 145 starters against a target of 100. In addition, 38 Nursing / Midwifery staff joined the bank in August following the launch of a bank recruitment campaign.

Finance

The Trust has a planned deficit of £4.9m for the year in line with the agreed control total with NHS Improvement. At the end of August, the Trust reported a deficit of £4.2m which is £1m adverse to the planned deficit. The Trust has a 2019/20 savings target of £25m, of which £5.2m was achieved at the end of July against a plan of £7.6m. The Trust is expecting to deliver the full savings plan this year. Our financial risk rating on the NHSI scale is 3 out of 4.

Key Operational Standards Dashboard
August-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%	77.15%	93/119		72.49%	87.89%	81.49%	▲
	12 Hour Trolley Waits	QP1		0				0	0		▶
	Ambulance Handovers Within 15 minutes			100%				94.02%	97.20%	87.44%	▲
	Ambulance Handovers Within 30 minutes			100%				98.93%	99.78%	98.85%	▲
	Ambulance Handovers Within 60 minutes			0				0	0	0	▶
	Referral to Treatment - % Incomplete Pathways <18 weeks			92%	*85.81%	126/177		85.25%	83.43%	87.70%	▼
	Referral to Treatment - Total Incomplete Pathways							28726	28573	28155	▼
	52WW	MSK		5				11	12	5	▲
		Plastic Surgery		0				3	1		▼
		Urology		0				0	1		▲
		Other		0				0	0		▶
	Diagnostic DM01 - % waiting more than 6 weeks			1%	*3.52%	142/204		8.16%	9.39%	5.10%	▲
	Cancelled Operations	Same day - non-clinical reasons		0.8%				0.71%	0.94%		▲
		28 day re-booking breach		0				1	1		▶
	Bed Occupancy		QP1	95%				95.46%	94.83%		▼
	Stranded Patients (LoS >7 days : Snapshot as at month end)							354	370		▲
	Delayed Transfers of Care (DToC)		QP1	3.50%				5.41%	7.78%		▲
	Mixed Sex Accomodation			0				0	0		▶
	Electronic Discharge Summaries							84.64%	83.65%		▼
Responsiveness - Cancer (In arrears)	Patients seen within 2 weeks of urgent GP referral			93%	90.79%	130/145		78.44%	71.79%	90.79%	▼
	Patients with breast symptoms seen by specialist within 2 weeks			93%	78.94%	75/114		76.97%	96.75%	93.10%	▲
	Patients receiving first treatment within 31 days of cancer diagnosis			96%	95.97%	114/123		88.03%	90.35%	92.73%	▲
	Patients waiting less than 31 days for subsequent surgery			94%	92.15%	47/57		77.88%	83.33%	66.41%	▲
	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		76.99%	74.10%	80.00%	▼
	Patients treated within 62 days of screening			90%	87.44%	24/73		84.31%	85.00%	91.86%	▲

Key Operational Standards Dashboard

August-19

IPR section	Access Standard: Description		Access Standard: Target	Benchmarking (*month in arrears): National**	Benchmarking (*month in arrears): Rank***	Benchmarking (*month in arrears): Quartile	Previous month's performance	Performance against Target	Performance against NBT Trajectory	Performance direction of travel from last month
Quality Patient Safety and Effectiveness	Never Event Occurrence by Month		0				0	0		
	WHO Checklist Compliance		95%				97.50%	97.70%		
	Hand Hygiene Compliance		95%				98.00%	98.00%		
	Pressure Injuries	Grade 2					24	34		
		Grade 3					1	0		
		Grade 4					0	0		
	MRSA						0	0		
	E. Coli						2	6		
	C. Difficile						8	3		
	MSSA						5	3		
	Venous Thromboembolism Screening (In arrears)		95%				95.89%	94.14%		

Key Operational Standards Dashboard

August-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		*12.39%	37/136		19.57%	19.05%	15.00%	▼
		Inpatient	QP2		*26.08%	154/165		18.50%	16.54%	30.00%	▼
		Outpatient	QP2					10.64%	10.32%	6.00%	▼
		Maternity (Birth)	QP2		*21.35%	52/125		18.11%	17.19%	15.00%	▼
	FFT - % Would recommend	Emergency Department	QP2		*84.74%	77/132		84.03%	91.00%		▲
		Inpatient	QP2		*95.97%	134/158		93.95%	93.23%		▼
		Outpatient	QP2		*93.87%	108/202		95.16%	94.96%		▼
		Maternity (Birth)	QP2		*96.82%	22/71		96.67%	93.90%		▼
	Complaints	% Overall Response Compliance	QP2					89.00%	91.00%		▲
		Overdue	QP2					9	1		▼
Well Led	Agency Expenditure ('000s)			£622				£1,179	£1,329		▲
	Month End Vacancy Factor			9.25%				11.55%	11.58%		▲
	Turnover (Rolling 12 Months)			15.50%				15.10%	14.82%		▼
	Sickness Absence (Rolling 12 month -In arrears)			4.10%				4.30%	4.31%		▲
	Trust Mandatory Training Compliance			85.00%				88.30%	90.01%		▲
	Non - Medical Annual Appraisal Compliance			11.90%				18.87%	27.75%		▲
Finance	Deficit (£m)			£4.9m 2019/20				£3.3	£4.2	£3.2	
	NHSI Trust Rating							3	3		▶

RESPONSIVENESS
SRO: Chief Operating Officer
Overview

Urgent Care

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 also exceeded the England position for the month despite the continuing increase in demand. Improvements in performance are predominantly as a result of increased staffing levels, with marked improvement in performance at weekends. Higher levels of performance have continued into September. Sustained high levels of DToC patients (7.78% vs. 3.5% target) continue to be experienced, with regular escalation across the system seeking to address delays and in particular with social care partners.

Planned Care

Referral to Treatment (RTT) - 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.

Cancelled Operations - In month, there were no urgent operations cancelled for a subsequent time and one breach of the 28 day re-booking target. Root cause analyses have been completed for all patients breaching the standard.

Diagnostic Waiting Times - The Trust has not achieved the national target or its recovery trajectory for diagnostic waiting times with a performance of 9.39% in August and reflects an anticipated deterioration from July's position of 8.16%. Urodynamics has delivered backlog clearance in advance of their trajectory with no breaches against the 6 week waiting time standard in month.

Cancer

Cancer performance saw a further deterioration in July, meeting one of the seven standards. The current national submission indicates that the Trust failed the 62 day treatment standard, with a performance of 74.10%. NHS Digital have acknowledged that there is an error in the 62 day reporting system and internal performance monitoring shows performance should have been declared as 75.19%. The Trust treated 81.65% of all patients who were referred to and treated at NBT within the national standard. There are recovery action plans in place with Urology and Skin to recover the 2WW and 62 day positions.

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 Interim Director of Nursing
Overview

Improvements

Maternity Services – Recruitment of midwives and other key leadership posts has completed and the Board has approved the plan for re-opening Cossham Birth centre on a phased basis.

Never events –There were no Never Events in July 2019, with the last reported Never Event being 26 January 2019. The related CCG Contract Performance Notice was closed on 16 July 2019.

Patient falls - In August the falls per 1000 bed days increased to 6.6 per 1000 bed days which is above the Trust average of 5.9. A deep dive review is being undertaken of falls and will be presented to the Patient Safety and Clinical Risk Committee and QRMC

MRSA cases - There have been no cases of MRSA bacteraemia in August 2019, the last being reported in February 2019.

Areas of Concern

Incidence of pressure injuries - For the current financial year there has been a significant increase in the number of reported Grade 2 injuries, whilst the July position showed an improvement with an incidence of 0.87 per 1000 bed days, August has seen an incidence of 1.2 per 1000 bed days. This is increase is related to the increase in device related pressure injuries. 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.

QUALITY EXPERIENCE
SRO: Interim Director of Nursing
Overview

Improvements

Complaint and Concerns:

Responding to complaints within agreed timescale continues to improve. The overall achievement for August being at 91%.

The backlog of overdue complaints across the Trust has also reduced significantly and efforts are being focused on sustaining this, and following up the actions and learning. Divisions are starting to put in place action plans and post local resolution meeting workgroups to focus on actions that will drive service improvement. To embed the new processes the new 'Management of Concerns and Complaints Policy' has been rolled out to Divisional Governance teams throughout August and will be further rolled out at the Divisional Governance meetings throughout September. Training sessions in local resolution, investigation training and complaint letter response writing will follow.

Friends and Family Test: The %age of ED patients who would recommend ED increased considerably in August, and is above national performance.

Areas of concern

Complaints and Concerns and Enquiries: The focus is on sustaining the improvement in response rates, aiming for all complaint response times to be met in September ahead of the improvement trajectory. This is integral to the weekly meetings with the Divisions.

Friends and Family Test. The ongoing concerns raised by patients experiencing care in ED relating to the waiting time remains the focus from improvement by ED. All response rates decreased ,with the inpatient areas showing the greatest fall. Actions to improve this being undertaken.

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

Corporate Objective 4: Build effective teams empowered to lead

Improving the sustainability and wellbeing of our workforce
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

Improving the leadership capability and capacity of our workforce
The OneNBT Leadership programme has met 90% of its 2019/20 target of staff signing up to the programme, a small reduction from last month as some staff have left the programme, those that stated work pressure reasons have signed up for the following year.
Mandatory and Statutory training compliance is at 90%. Compliance with appraisal completion is below the target for this month of 28% vs a target of 35.5% (month 5). Feedback from divisions confirms appraisals are taking place and work is ongoing to increase reporting on this once complete.

Continue to reduce reliance on agency and temporary staffing
Agency use and expenditure increased in August predominantly in support to clinical staff, specifically expenditure for registered nursing went up this month compared with July.
The Trust Management Team have committed to the BNSSG project to reduce tier 4/non-framework spend and this went live on 2 September 2019. As part of the risk mitigation to the project, the Trust is moving forward with its action plan to improve the experience of our bank staff and review bank rates , which in turn is anticipated to increase bank participation and reduce reliance on agency staff .

Vacancies
The Trust vacancy factor has remained stable at 11.58% in August 2019 from 11.55% in July 2019. Substantive funded establishment increased by 41.4 wte with modest across all staff groups, largely due to additional work in Pathology. Overall the Trust saw a modest gain of staff in August which was evenly spread across all roles. The month of August normally contains higher staff movement due to the rotation of medics.

Turnover
The Trust turnover saw a small decrease from 15.1% in July to 14.8% in August, continuing the trajectory of improvement.

Stability
The stability factor rose slightly from 85.0 to 85.4% in August compared with July. This is against a target of 85.2%

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 August, the Trust reported a deficit of £4.2m which is £1m adverse 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 £1.6m year to date to the end of August which brings the total Department of Health borrowing to £179.8m.

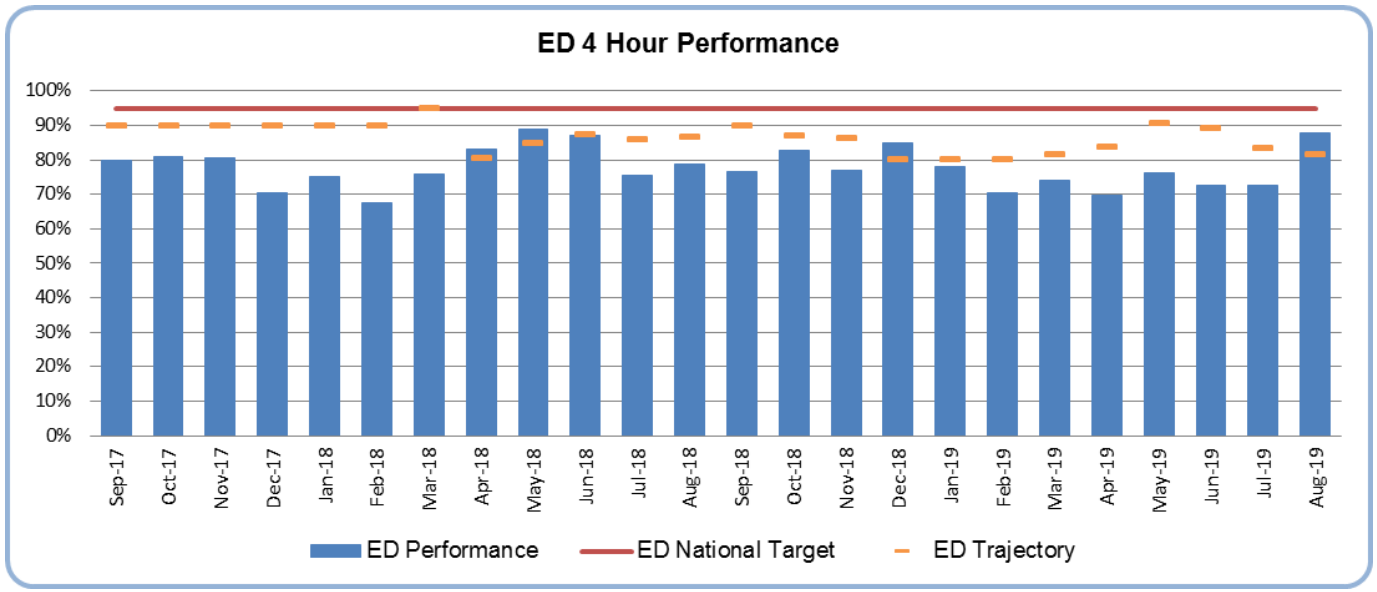
The Trust has a savings target of £25m for the year, of which £5.2m was achieved at the end of August against a plan of £7.6m.

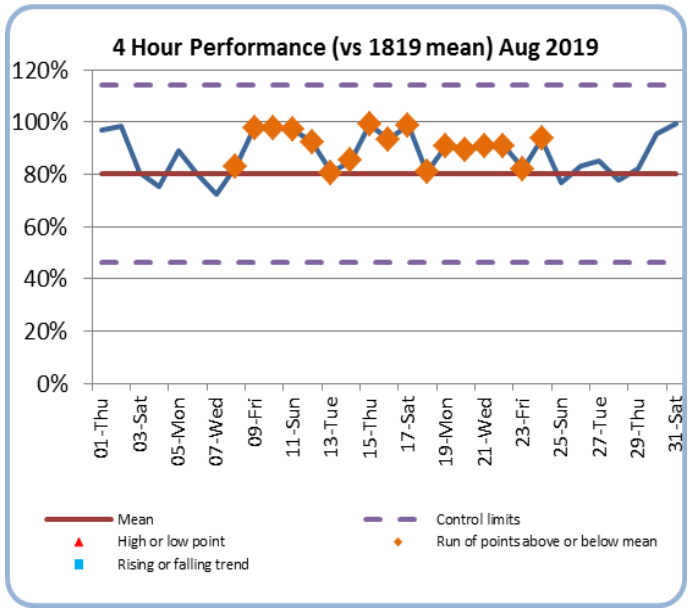
The Trust is rated 3 by NHS Improvement (NHSI).

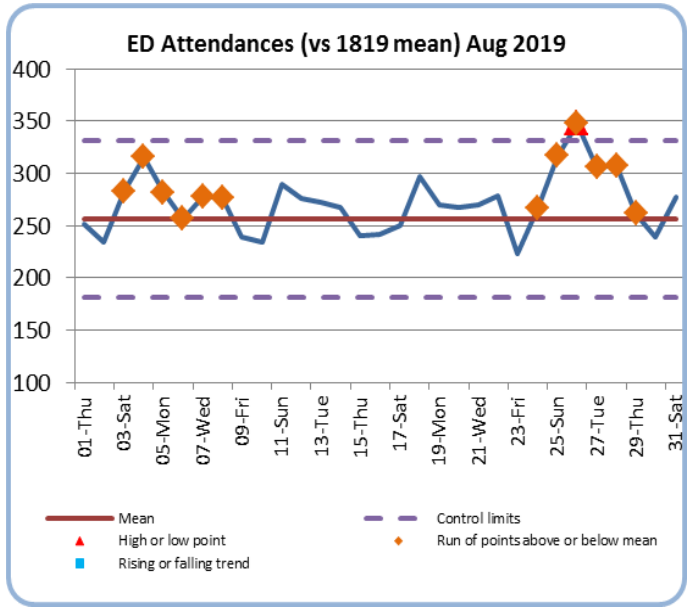
North Bristol NHS Trust

RESPONSIVENESS

Board Sponsor: Chief Operating Officer
Evelyn Barker







Urgent Care

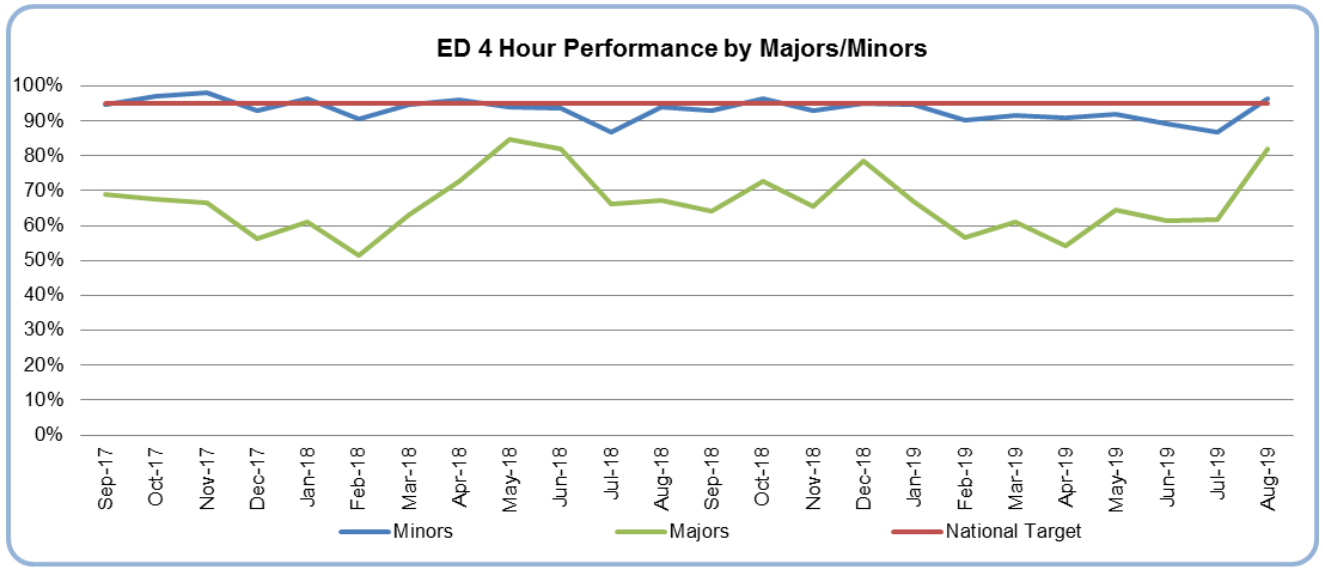
The Trust achieved the ED 4 hour wait trajectory of 81.49% in August 2019, with a performance of 87.89%. The position has greatly improved from 72.49% in July and also reflects an improvement when compared with August 2018 which was 78.76%. This is the highest level of ED 4 hour performance reported by the Trust since May 2018. The Trust reported no 12 hour trolley breaches in August.

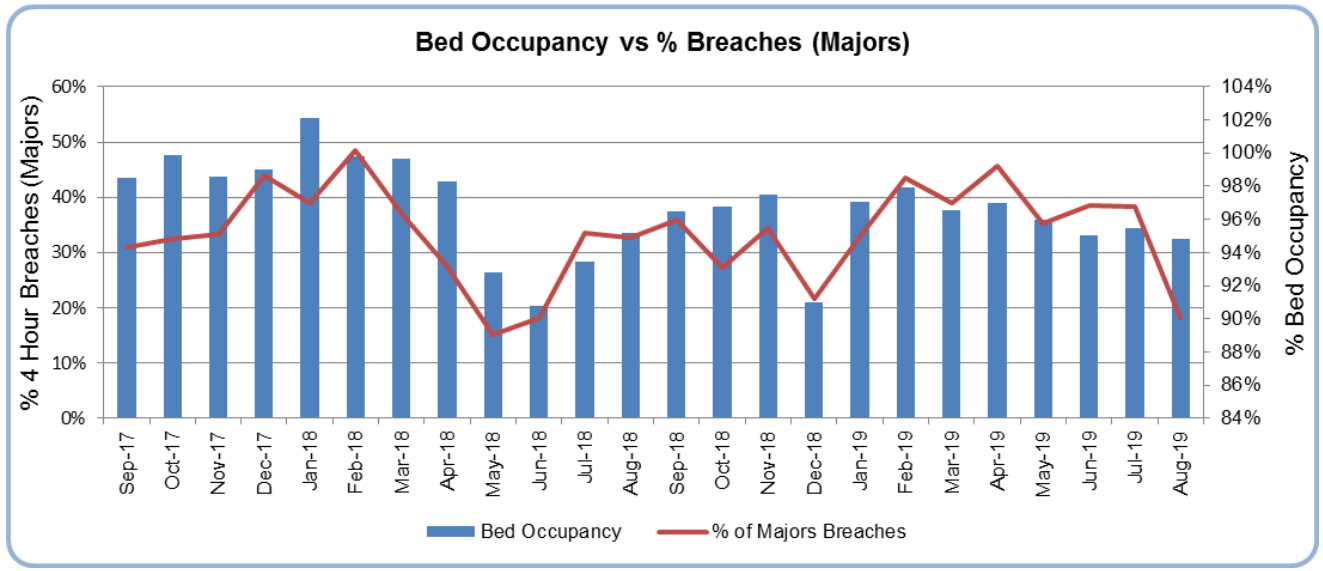
There was an average of 272 attendances per day and five exceeding 300. At 8420, there were 730 (9%) more ED attendances in August 2019 when compared with August 2018.

ED performance for the NBT Footprint stands at 91.34% and the total STP performance was 88.42% for August.

There was far less variation in 4 hour wait times performance during the month, varying between 72.66% and 99.28%, with four occasions of >95% performance reported.

Ambulance arrivals in August were 2767, this represents a 5.41% increase on the same period last year. Of patients arriving by ambulance, 97.40% had their care handed over to the ED department within 15 minutes and 99.78% were handed over within 30 minutes. There were no 60-minute handover breaches in month. The increase in ambulance conveyances is subject to an Activity Query Notice between SWASFT and Commissioners. An audit of activity has been undertaken and a final action plan is awaited.



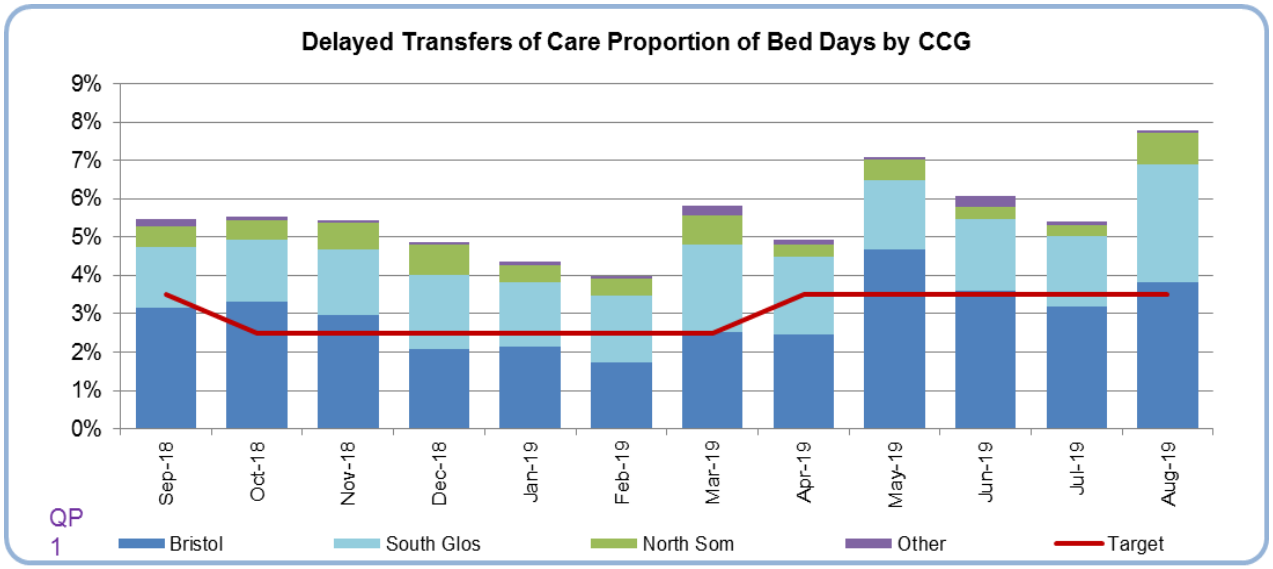


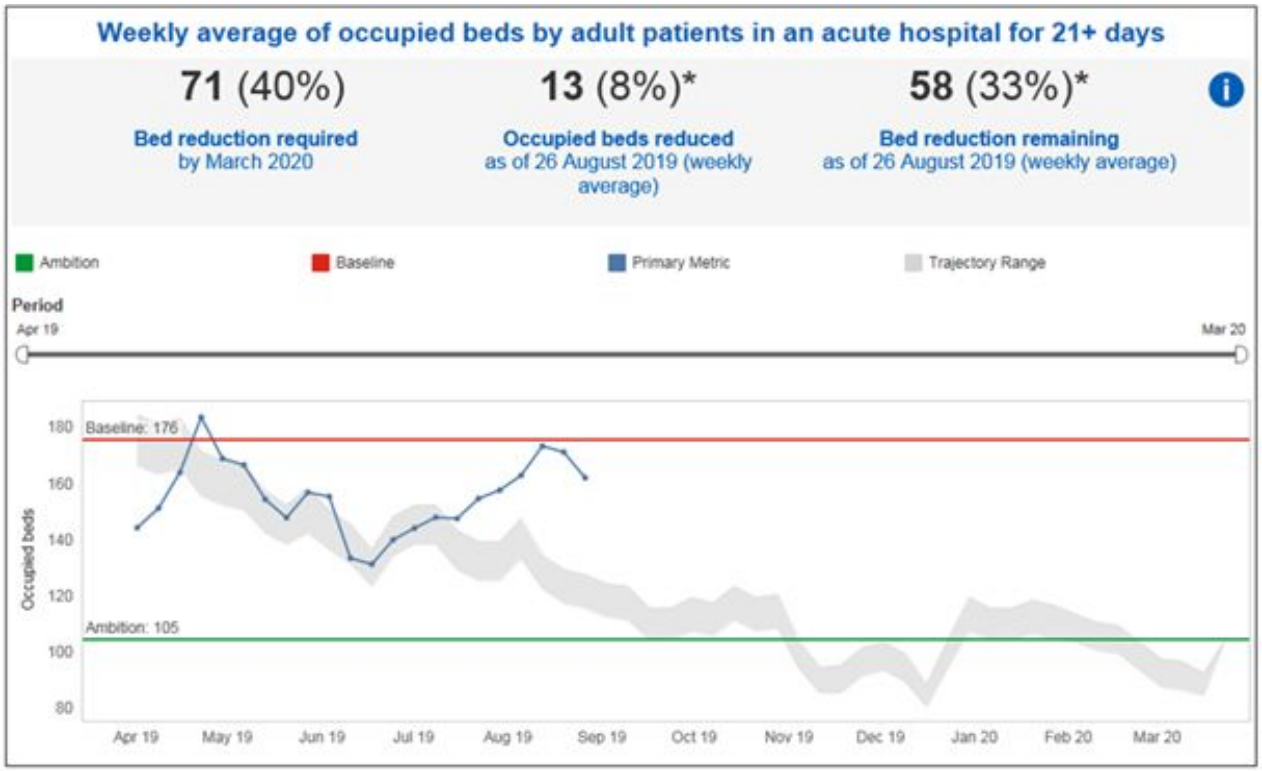
4 Hour Performance

43.53% of breaches in August were a result of waits to be seen in ED. The workforce pipeline indicated that there would be an improvement in clinical hours in August, which has come to fruition and has been a significant factor in securing improvements in 4 hour performance. This improvement has continued into September to date. The most marked improvement in performance has been at the weekends, where performance has historically been most challenged. However, staffing remains below the level required to manage the continued increase in demand sustainably, therefore, approval for a second phase of investment in staffing is being sought.

In month there has been an increase in breaches due to wait for beds despite the overall bed occupancy position decreasing slightly to 94.83% in August compared with 95.46% in July. This is due to slow flow 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 Board. 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; length of stay reduction plans; and operational surge protocols.





DToCs and Stranded Patients

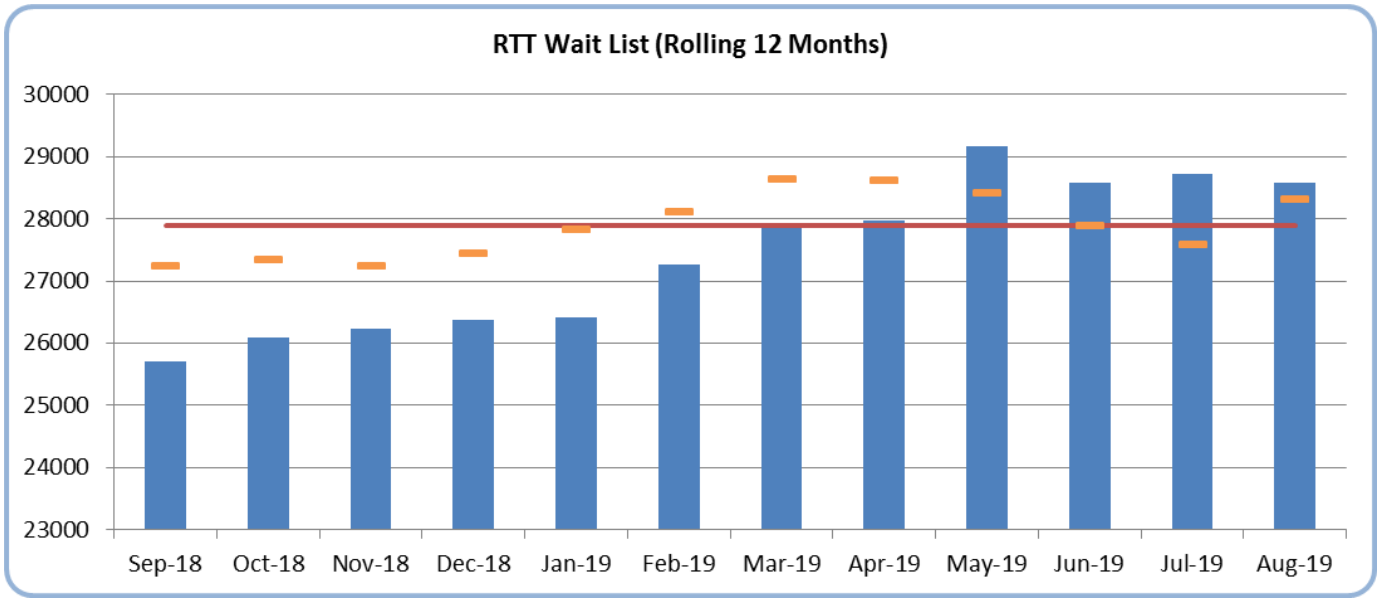
The DToC rate for the month of August was 7.78%. If the System were at national target levels of 3.5% it would have release 37 beds to the Trust.

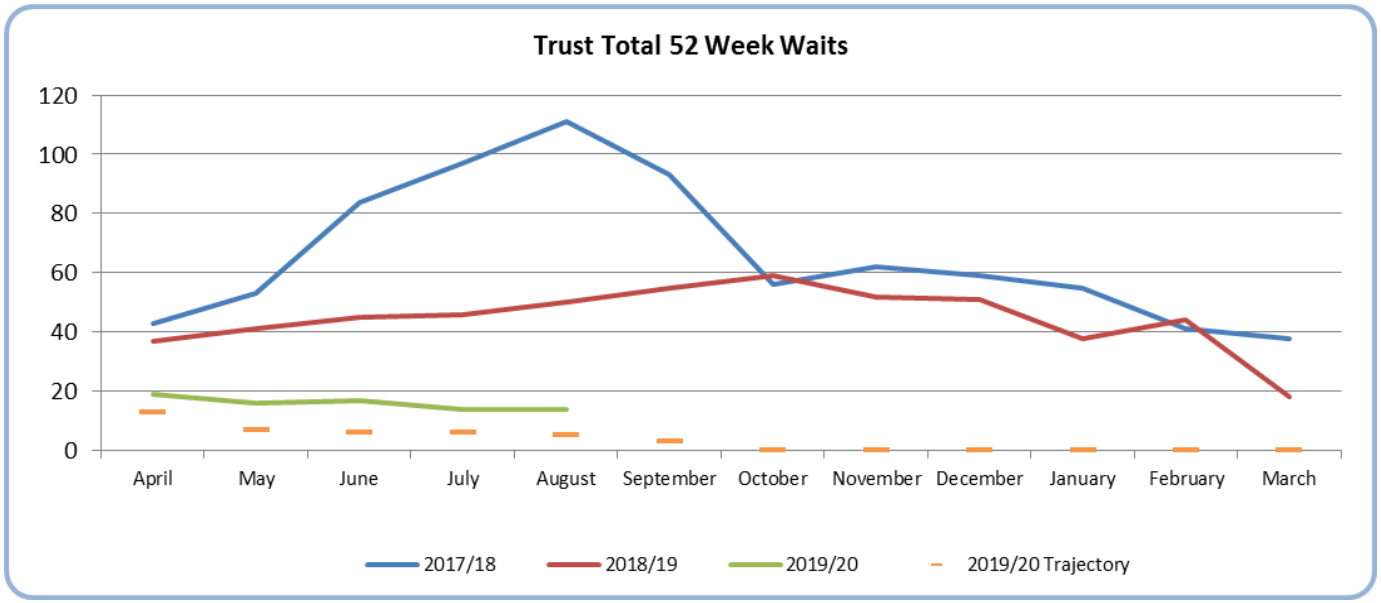
Delays are driven by a lack of capacity in reablement (particularly in Bristol) and Pathway 2 (P2) beds across BNSSG. In particular, there is a mismatch in capacity to meet the needs of patients with complex manual handling requirements. The commissioned P2 stroke specific beds, of which there are only four at Henbury, do not meet expected demand levels and will be addressed as part of the Stroke STP project. Capacity for packages of care across the community for all providers does not meet the current demand with a shortfall in interim placement availability as an alternative.
Waiting times for neurology specialist rehab are growing and are the subject of Executive Level escalation with Specialist Commissioners. Restricted capacity in the region is likely to continue in Quarter 3 and Quarter 4 of 2019/20.

Despite good progress across Quarter 1, the Trust at the end of August is significantly above the trajectory to achieve a 40% reduction in beds occupied by patients with a LoS of >21 days by March 2020.

Attempts in month to decrease acute delays focused on reducing community bed delays in order to facilitate quicker step down from acute settings.

The NHSI Long Length of Stay (LLoS) process has been continued and extended to include all patients with a 7+ day LoS with partners & wards to try and progress earlier discharges.





Referral to Treatment (RTT)
The Trust has not achieved the RTT trajectory in month with performance of 83.39% against trajectory of 87.68%.

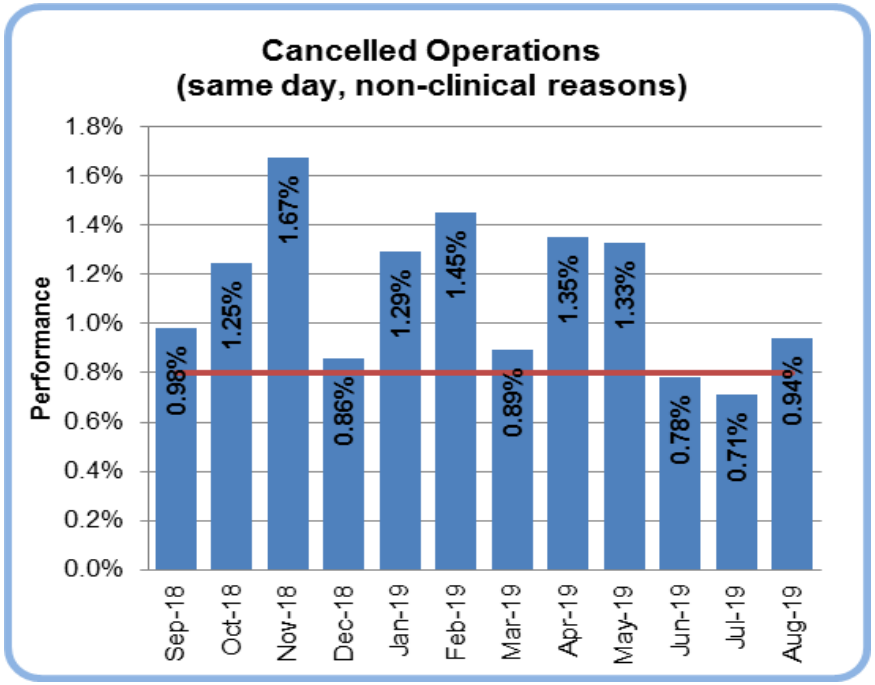
The total RTT wait list size in month is above plan by an additional 427 patients. This is a 1.5% variance to plan vs. a 1.7% variance last month. Urology has sustained performance against the 92% standard. Areas with the greatest decline in performance include Respiratory, Gynaecology, Neurology, Rheumatology, Clinical Immunology and Allergy and Plastic Surgery, all of which are subject to delivery of Remedial Action Plans.

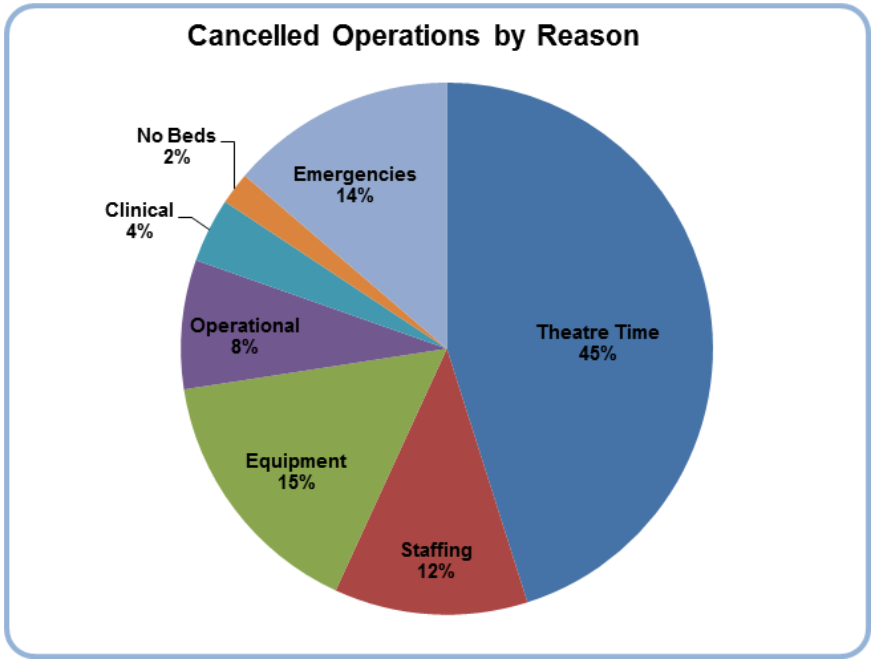
The Trust has reported a total of 14 patients waiting more than 52 weeks from referral to treatment in August 2019. 12 patients under Trauma and Orthopaedics; one in Urology; and one in Plastic Surgery.

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

Six of the 14 patients have requested their surgery between October and December and will therefore, continue to breach in subsequent month's reports.

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 August 2019 was 0.94%, failing the 0.8% national target.

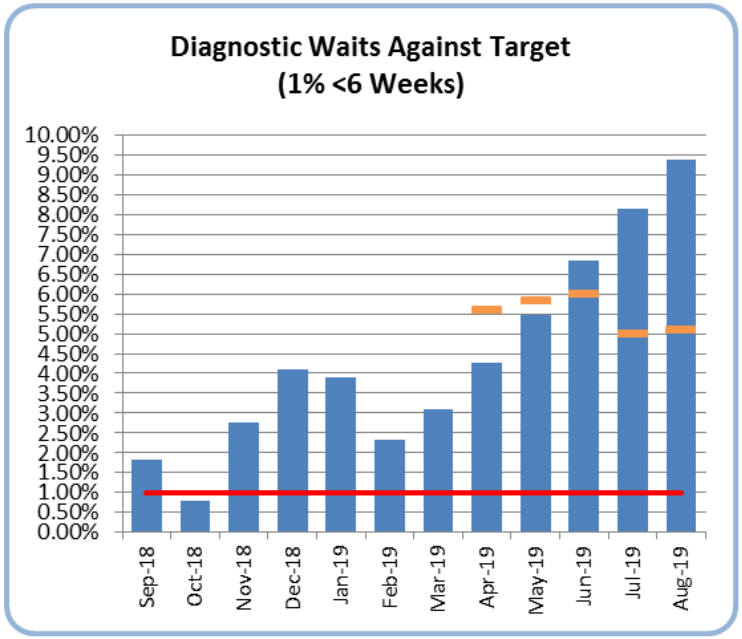
For the third consecutive month there were no urgent operations cancelled for a second time.

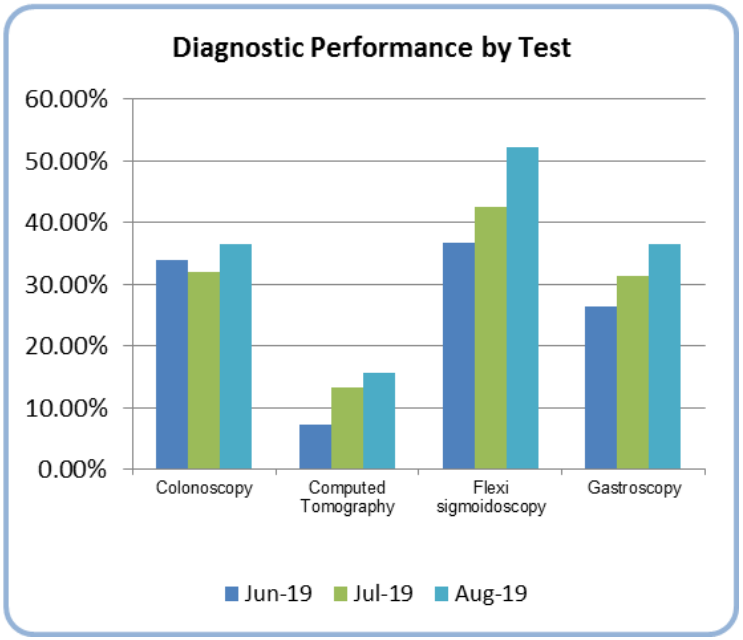
The number of urgent patients who were cancelled on the day increased to 14 patients in August compared with seven in July, 19 in June and 24 in April and May.

There was one operation that could not be rebooked within 28 days of cancellation in August 2019, in Urology. The patient was cancelled on the day due to the surgeon being unavailable. The patient was offered surveillance or rebooking and chose to be rebooked outside of 28 days; the patient has a date for treatment in September.

Following sustained delivery of the recovery trajectory for 28 day rebooking breaches, Commissioners have closed the Contract Performance Notice.

Root cause analyses have been completed to ensure that there is no patient harm.





Diagnostic Waiting Times

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 longest waiting patient reported in August has been waiting for 22 weeks and is awaiting a Colonoscopy.

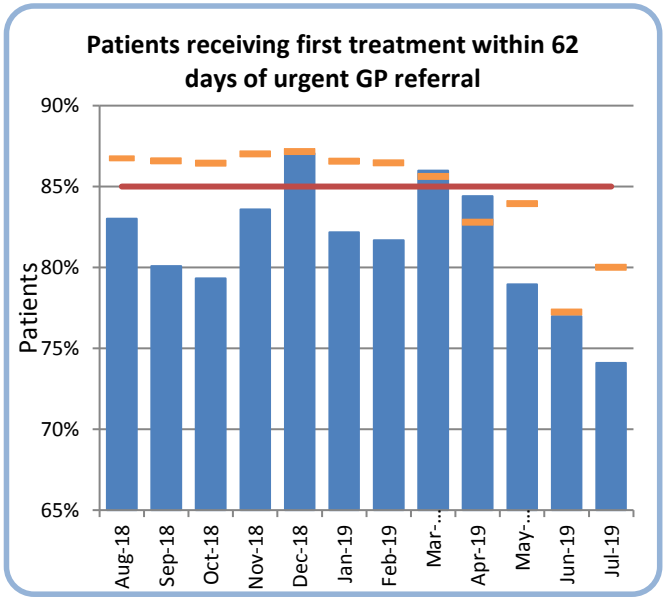
Test Type	Total Wait List	Patients waiting >6-weeks	% Performance Aug-19	% Performance Jul-19
Computed Tomography	2353	367	15.60%	13.24%
Colonoscopy	497	181	36.42%	32.07%
Flexi sigmoidoscopy	348	182	52.30%	42.57%
Gastroscopy	680	249	36.62%	31.31%

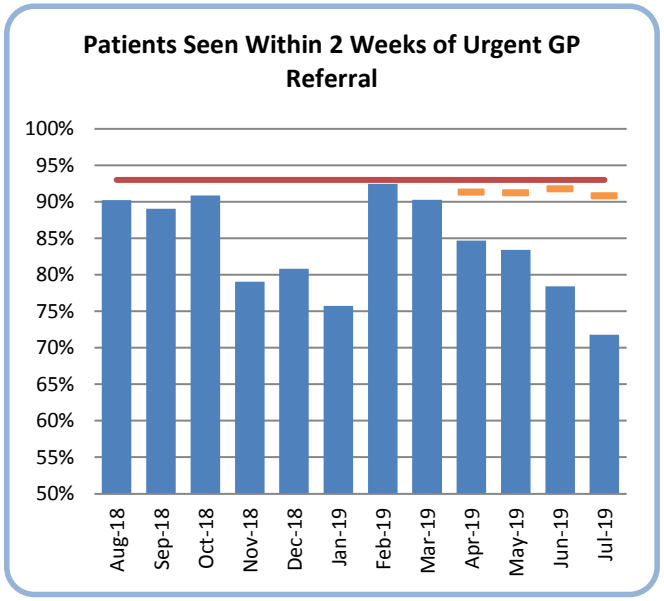
Improvements in CT performance are expected to begin in September after the return to work of a substantive Radiographer following maternity leave and the commencement of three new substantive Radiographers. The earliest clearance of the CT backlog is anticipated to be in January 2020.

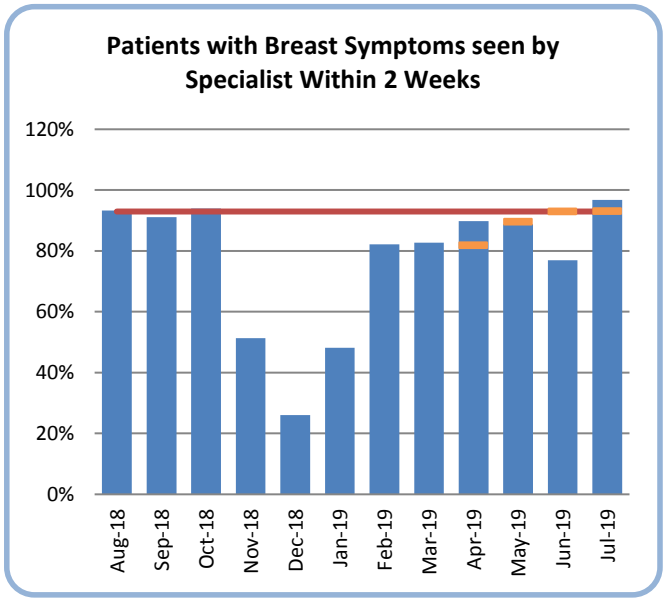
A number of plans have been implemented to improve Endoscopy performance including weekend activity undertaken by 18 Weeks and GLANSO, increased internal capacity through 6-day nursing cover and system-wide work to reviewed demand and capacity enabling establishment of longer-term plans.

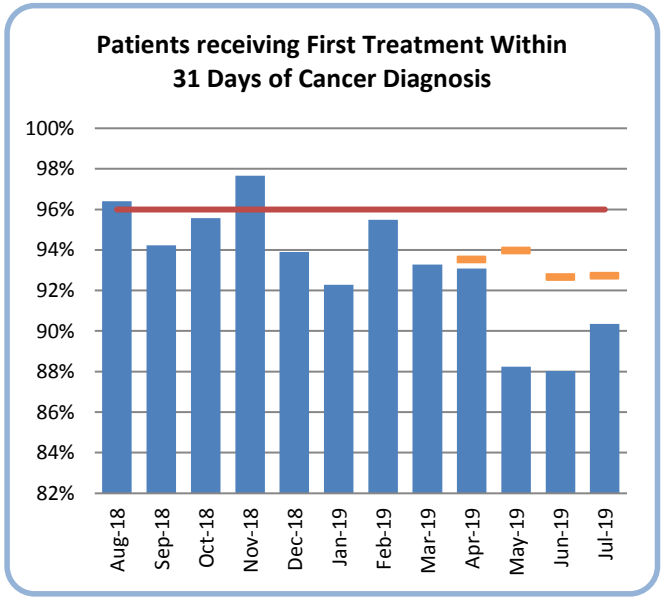
All other test types have reported patient diagnostic waiting times within the six week standard, with Urodynamics returning to standard ahead of recovery trajectory following successful delivery of plans to clear the backlog.

Given slippage in year of recovery plans, the trajectory has been updated. There is no change to the original year end performance of 2.5%, however, in the intervening months the level of breach has grown (resulting in 535 more patients breaching the 6 week standard vs. the original trajectory in month). A proposal to purchase additional outsourced capacity to return to DM01 compliance by March 2020 is awaiting commissioner approval.









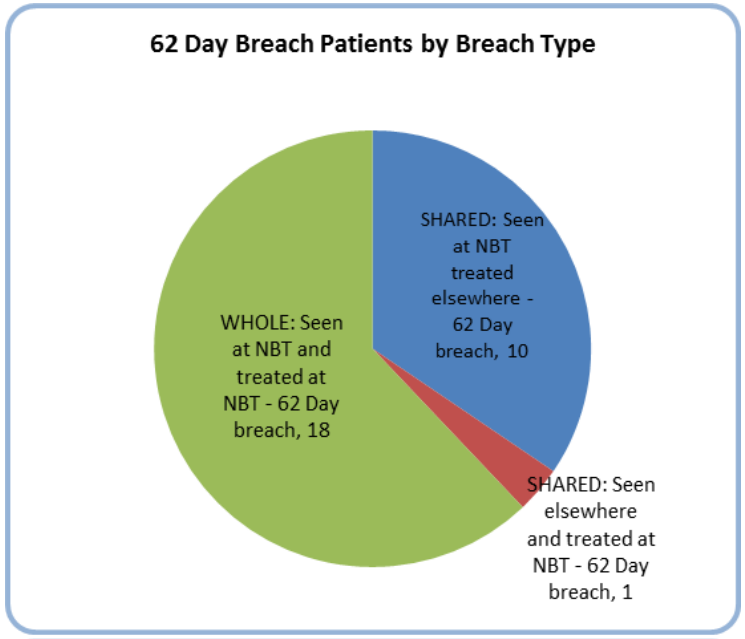
Cancer

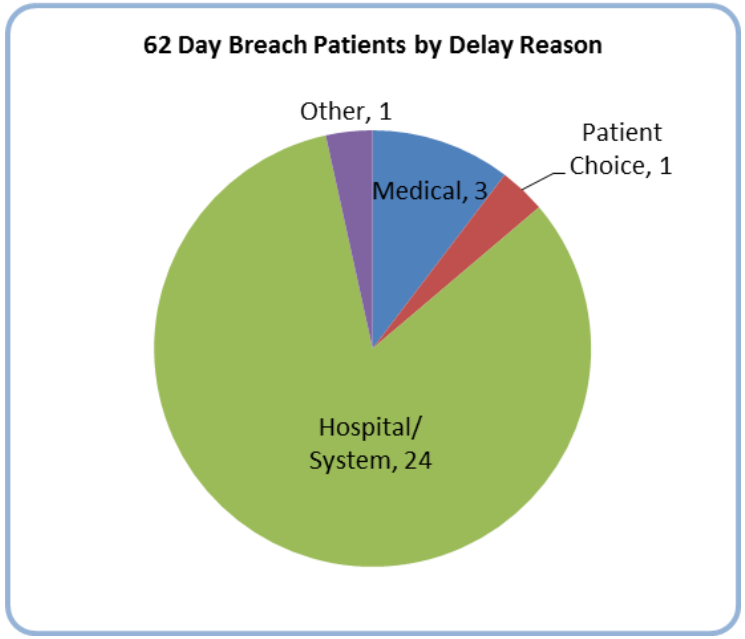
The nationally reported cancer position for July 2019 shows the Trust achieved one of the seven cancer waiting times standards. The Trust failed the TWW standard with performance of 71.79%. The Trust saw 2283 TWW patients in July and there were 644 breaches; the majority were in Skin (breaches were 505 , patients seen 629), Gynaecology (breaches 44, seen 196), Colorectal (breaches were 38, patients seen 382) and Breast were significantly better this month (breaches were 27, patients seen 579).

Of the 644 breaches, 131 patients declined the first offer of an appointment date requesting a later date. If there were no breaches due to patients choosing later dates the performance would have been 77.65%. The Trust and CCG have a joint action plan in Skin focused on demand management. The speciality, with the help of executive support, has submitted recovery plans; including running additional on and off site clinics as well as a range of pathway changes.

The ongoing capacity issues within Endoscopy and Radiology continue to cause delays to the straight to test pathways for Colorectal.

The Trust failed the 31 day first treatment standard with performance of 90.35% against the 96% target. There were 22 breaches in total: 12 in Urology; two in Breast; four in Skin; and four in Sarcoma. Urology breaches were due to delays to robotic surgery, as a result of continued increase in patients requiring these procedures as first and subsequent treatments. The Skin and Sarcoma breaches were due to no surgeon capacity to treat.





The national submission for the 62 day standard in July indicates the Trust failed the 62 day treatment standard with a performance of 74.10%. NHS Digital has acknowledged that the new national reporting system implemented in April 2019 is not calculating performance correctly and the Trust's internal monitoring shows that 62 day performance was actually 75.19%. This would still be a fail against the 85% standard. The Trust has escalated this issue to the CCG and NHSE/I through the Access Performance Group and they have launched an investigation. NBT are providing data to support.

In July, 32.5 patients breached the 62 day standard, 20 of which started their pathway at NBT, discussions are underway with the specialties to agree mitigation plans to improve the positon.

Urology breaches accounted for 38% of total Trust breaches for July. Capacity issues in radiology, biopsy, joint oncology clinics and robotic theatres continue to limit the ability to meet the 62 day standard for Urology, as well as late referrals from other providers. Radiology capacity for prostate patients was increased in June which enabled patients to receive their MRI on the day of first appointment, this is reflected in the Urology 2WW July performance. Reporting of these scans within adequate timeframes will remain an issue.

The Trust has been successful in a bid for cancer Alliance funding to lead the regional implementation of template biopsy to support regional recovery of Urology performance; a key driver for sustainability given we are a tertiary service. In July, eight Urology patients were transferred to the Trust beyond day 38 of their pathway accounting for an additional 4.5 breaches.

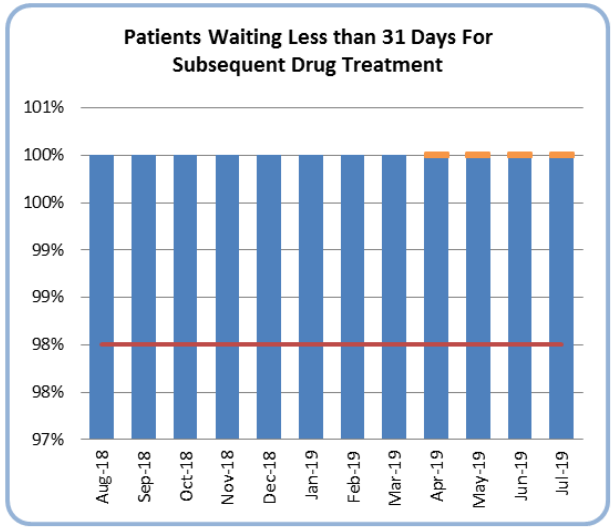
The Urology remedial action plan and recovery trajectory is now predicting recovery of the standard in the first quarter of 2020/21. This is due to slippage in the recruitment timeline for additional pelvic oncology surgeons and the resultant growth in the backlog of patients requiring robotic surgery.

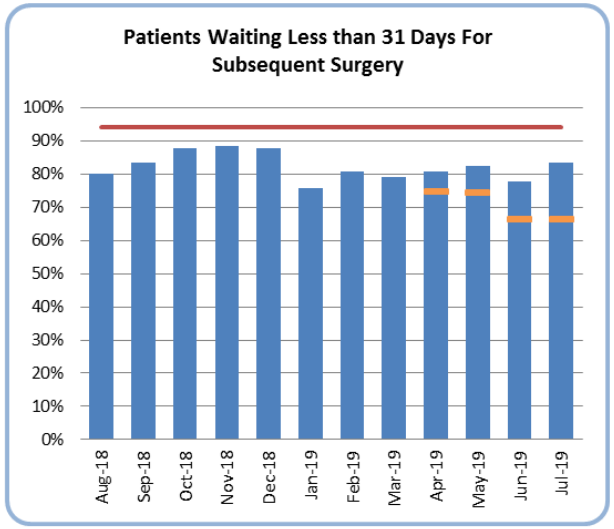
Other breaches recorded in July were: two in Breast (diagnostic delay and complex pathway); four in Gynaecology (complex pathway); two in Colorectal (late referral and patient choice); three in Lung (late referral); one in Sarcoma (surgical capacity); four in skin (capacity); and two in Upper GI (late referral to treating Trust).

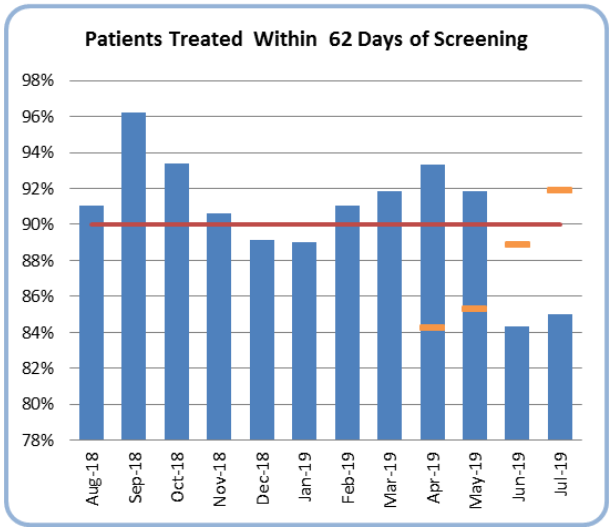
The Trust continues to address delays for Oncology capacity with UHBT and an SLA for Urology Oncology provision requirements has been submitted to UHBT.

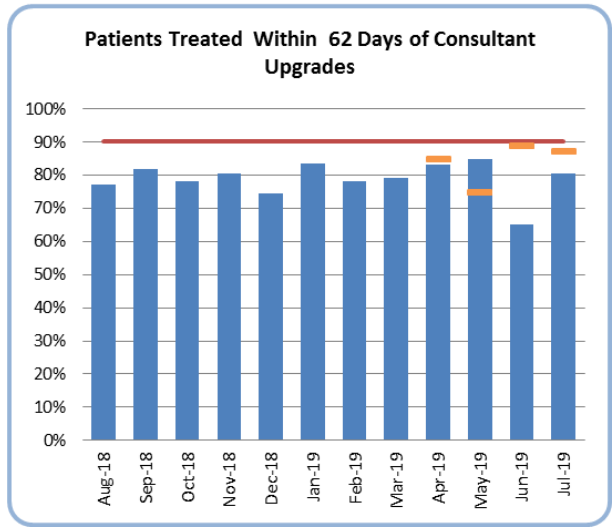
As part of performance improvements the Trust has been monitoring its internal performance against the 62 day standard. The Trust treated 81.65% of all patients who were referred to and treated at NBT within the national standard.

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 July for patients requiring surgery with performance of 83.33% against the 94% standard.

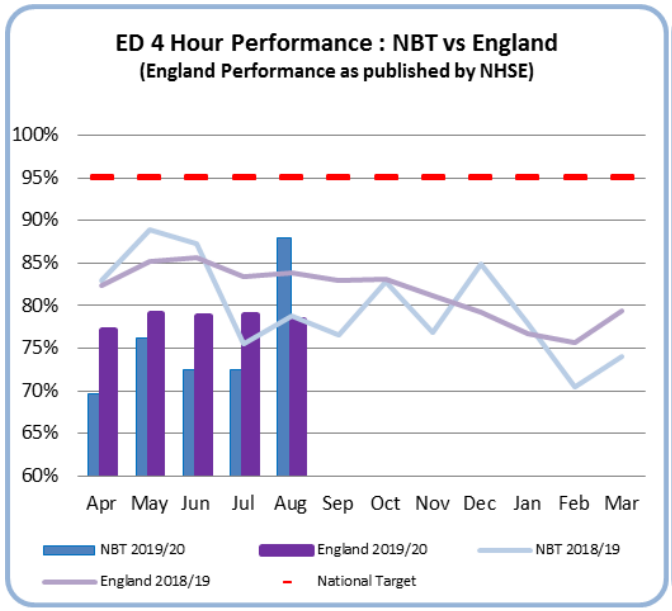
The Trust has an action plan to recover this position, with significant improvements now forecasted from quarter one of 2020/21. Revised trajectories have been developed with particular focus on Urology and Skin.

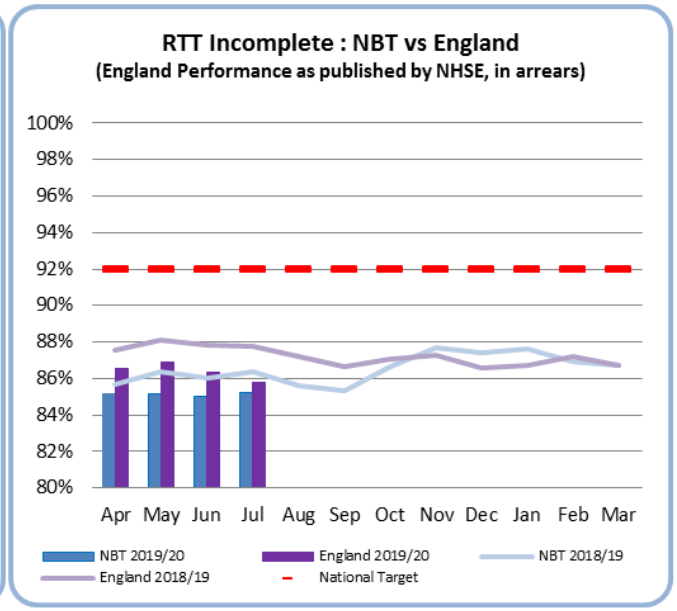
There were 16 breaches in total: 9 in Skin, 7 in Urology Main reasons for skin breaches is capacity, and in Urology surgical capacity.

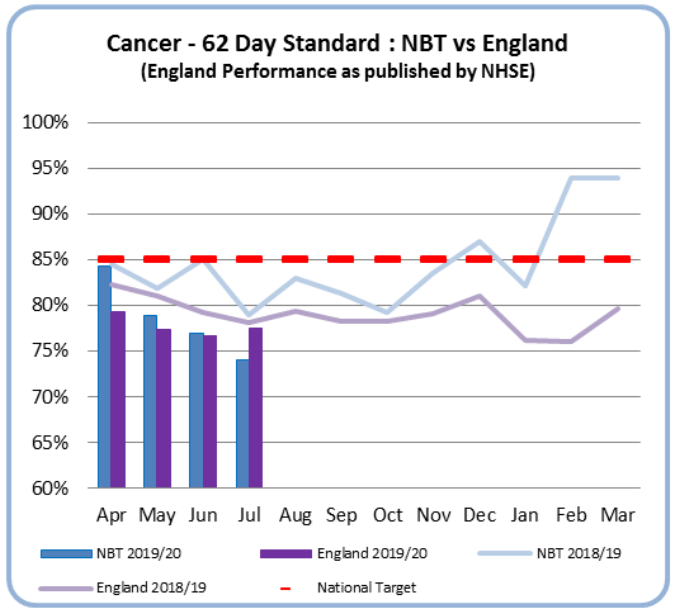
The Trust achieved the 31 day subsequent standard for patients receiving anti cancer drugs with performance of 100%.

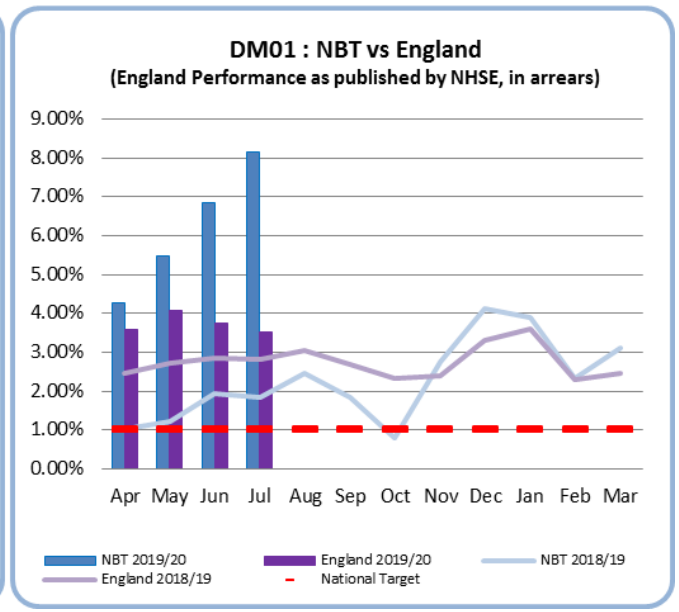
The Trust failed the 62 day screening target with performance of 85.00% against the target of 90%. There were 4 breaches in Breast; two were due to patient choice, two for medical reasons.

There were 15 104 day breaches in July; harm reviews are in progress. Urology remains the greatest volume of reported 104 day breaches. Since the harm review process for patients waiting over 104 days was introduced in 2019, no instances of harm have been found.







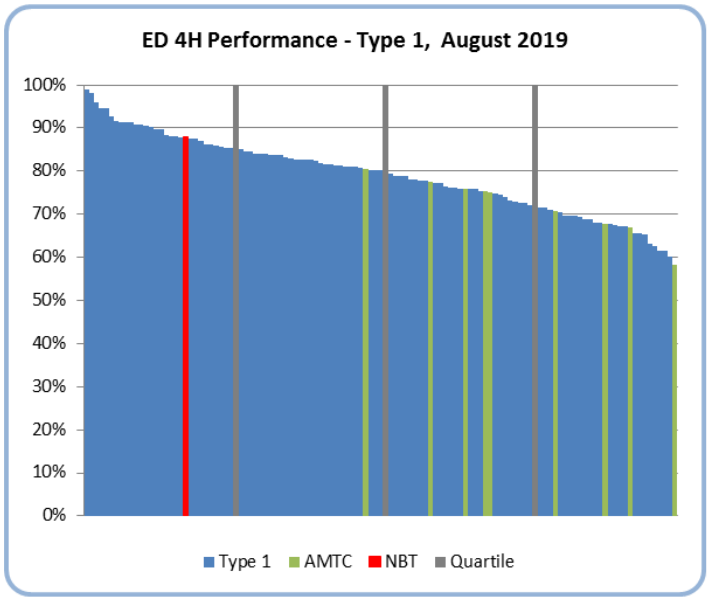


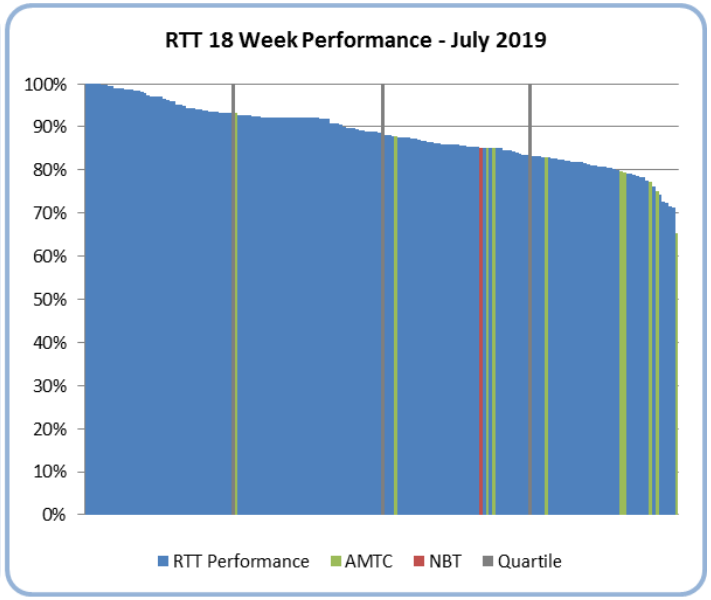
ED 4 Hour Performance
NBT ED performance in August 2019 was 87.89% compared to a national Type 1 position of 78.32%. The position reflects a significant improvement from July and an improvement when compared to the same period last year.

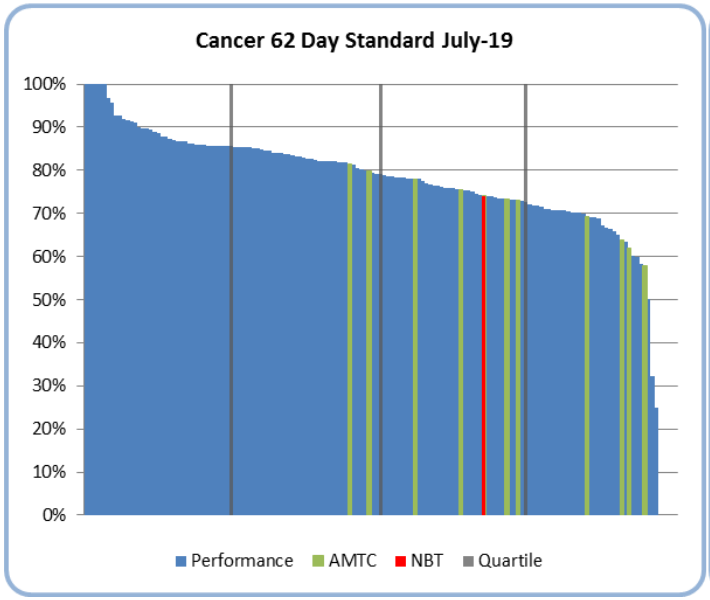
RTT Incomplete
The Trust reported a July 2019 position of 85.21%. This position reflects a decline on last year and falls under the national position of 85.81%.

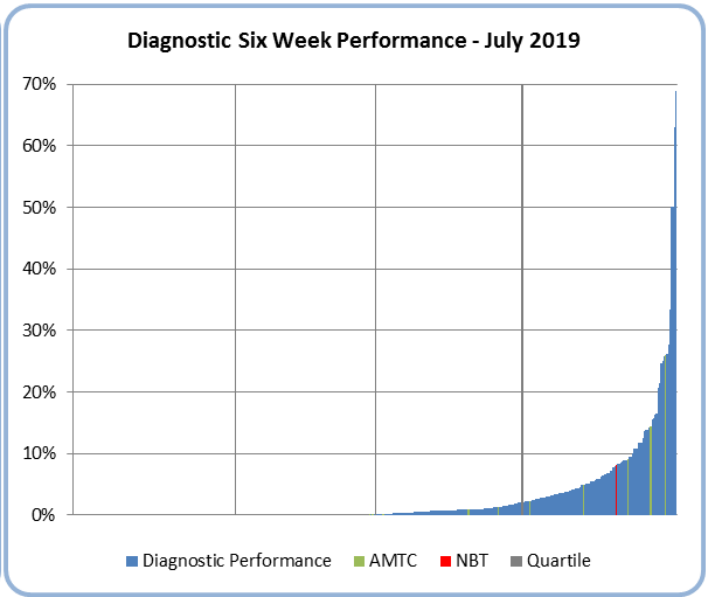
Cancer – 62 Day Standard
NBT has reported 74.10% performance for July, which is less than the national position of 77.56%.

DM01
In July 2019, NBT failed to achieve the national standard of 1% with a declined performance position of 8.16%, against the national position of 3.52%.









ED 4 Hour Performance
In August, NBT moved to a position of #21 from #95 out of 119 reporting Type 1 Trusts. This improvement has meant the Trust has moved into the 1st quartile. The Trusts ranking among the 10 Trauma centres improved from 6th to 1st in August 2019.

RTT Incomplete
RTT performance in July 2019 reports an improved NBT position of #118 out of 179 reported positions. The Trust improved to rank 3 out of 11 other adult major trauma centres. The Trust is reporting within the 3rd quartile.

Cancer – 62 Day Standard
At position #98 of 145 reported positions, NBT reports a performance of 74.10%. This represents a deterioration in positioning from June 2019 and ranks the Trust 5th out of 11 major trauma centres and within the 3rd quartile.

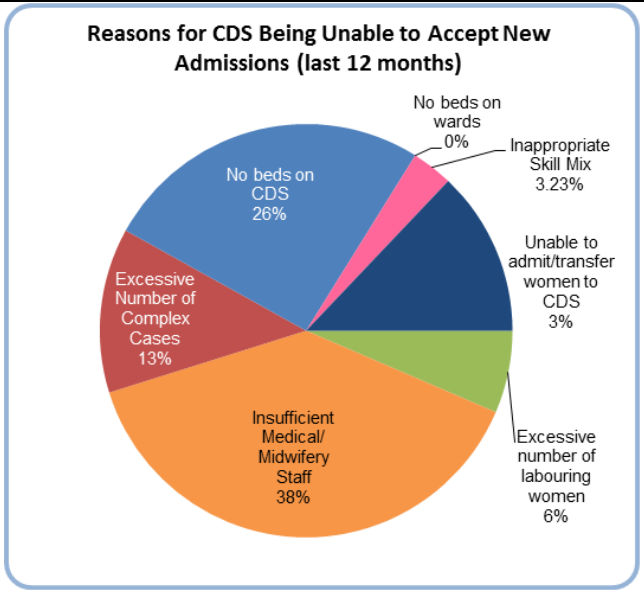
DM01
NBT reports a further deteriorated position of #167 out of 203 reported diagnostic positions, with a performance of 8.16% in July. This position ranks 8th out of 12 adult major trauma centres and have remained within the 4th quartile.

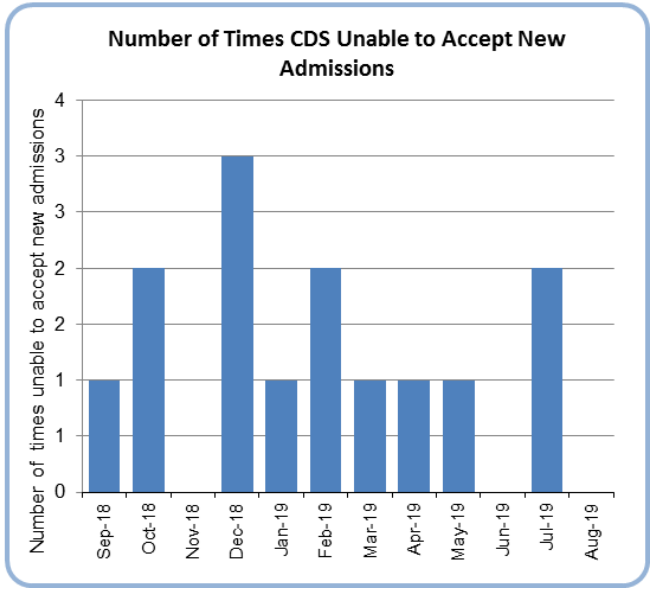
Cancelled Operations 28 day re-booking breaches
Based on quarterly national reporting, the Trust has ranked #84 out of 158 reporting Trusts, having reported four breaches in the period.

Safety and Effectiveness

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

Birth		Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19
Total Births		543	515	535	497	491	478	458	448	439	490	454	524	481
Midwife to birth ratio		01:33	01:33	01:33	01:30	01:31	01:30	01:30	01:28	01:27	01:30	01:28	01:32	01:28
Normal birth rate		56.4%	60.1%	51.8%	53.1%	51.1%	56.0%	51.1%	55.7%	53.7%	56.3%	56.1%	53.8%	52.9%
Caesarean birth rate		31.2%	27.3%	34.1%	32.1%	34.4%	32.1%	37.9%	32.0%	35.0%	30.8%	30.4%	31.6%	34.0%
Emergency Caesarean birth rate		17.1%	14.6%	18.7%	19.2%	19.1%	18.0%	23.0%	17.7%	22.4%	19.30%	21.2%	16.0%	20.0%
Induction of labour rate		33.1%	35.7%	34.7%	34.9%	33.4%	34.0%	37.7%	38.3%	41.5%	36.10%	43.0%	36.5%	38.2%
Total births in midwife led environment		19.3%	18.8%	13.4%	14.3%	7.9%	14.9%	12.0%	14.5%	15.3%	17.90%	14.1%	13.4%	13.6%
Birth location	Cossham BC	6.4%	2.8%	0.2%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0%	0.0%	0.0%	0.2%
	Mendip BC	12.1%	14.3%	12.1%	12.9%	6.7%	12.6%	10.7%	13.4%	12.8%	16.6%	12.8%	12.4%	12.6%
	Home	0.4%	1.4%	3.0%	1.2%	1.2%	2.3%	1.3%	1.1%	2.5%	1.2%	1.3%	1.0%	0.8%
	CDS	80.4%	79.8%	83.7%	84.5%	89.6%	83.7%	86.7%	83.3%	84.0%	80.3%	83.6%	84.1%	85.1%
One to one care in labour		95.7%	95.4%	96.4%	95.4%	95.9%	97.4%	97.7%	96.0%	100.0%	100.0%	100.0%	100.0%	98.3%
Stillbirth	Actual	1	1	2	1	2	2	3	5	2	2	2	1	2
	Rate	0.20%	0.20%	0.40%	0.20%	0.40%	0.41%	0.60%	1.10%	0.5%	0.4%	0.4%	0.2%	0.4%





Wave 3 Maternity & Neonatal Health Safety Collaborative (MNHSC)

- This is going well with excellent multi-disciplinary engagement and attendance at the daily huddle.
- NBT focus is Post Partum Haemorrhage.
- A programme is ongoing to communicate and update all staff via a 'tea trolley' on CDS and also the PPH Station at the intrapartum study day.

'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.

Recruitment

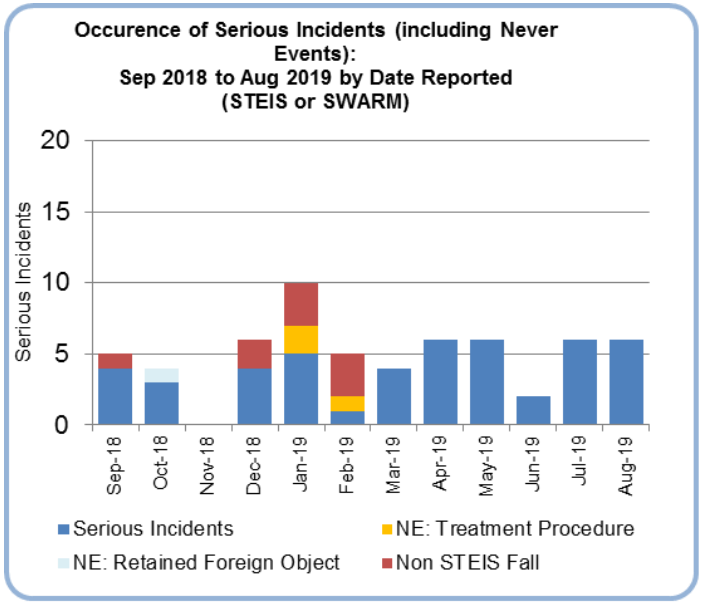
- Recruitment of midwives - The forthcoming pipeline is comprised of 14 midwives with start dates over the next two months: 12 midwives in September 2019 and two Midwives in October 2019.
- The new Bereavement Midwife starts on the 28 October 2019.
- Adverts are currently on NHS Jobs for Quality improvement lead and Lead Sonographer for WACH.
- An interim Director of Midwifery has been appointed for six months and is due to start 07 October.

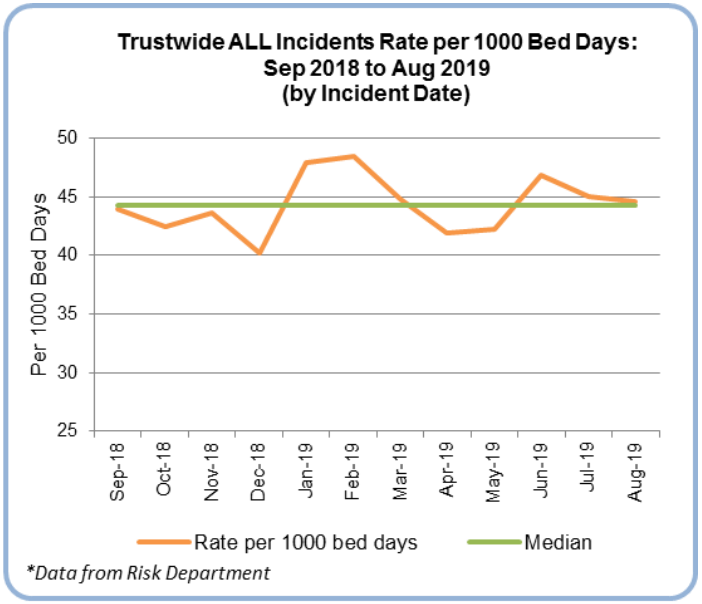
Midwifery Led Services

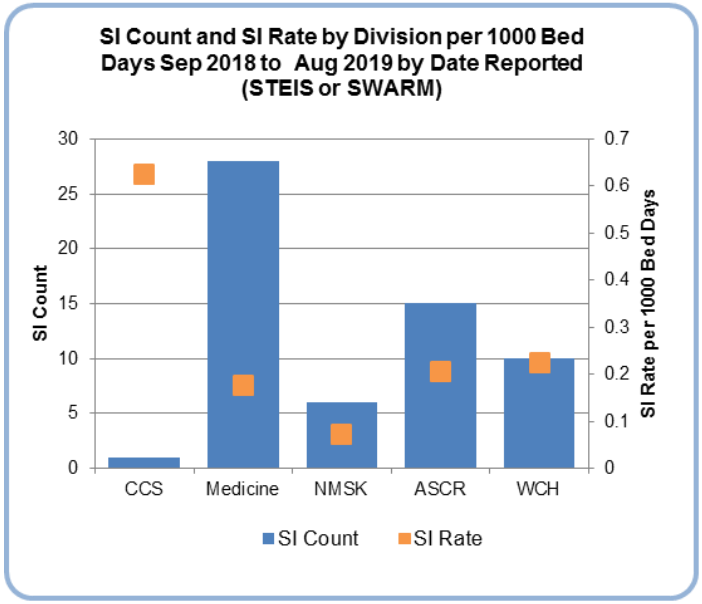
- Plans are ongoing to ensure the opening of Cossham Birth Centre on an interim open on arrival model. Staff are currently involved in a consultation and appropriate training to enable a successful launch.
- A review of Midwifery Led Services at NBT from a quality, safety and efficiency perspective is ongoing and has included engagement sessions with staff. This project is ongoing and will progress over the next few months with support from an external midwifery consultant and Birth rate plus workforce planning team.

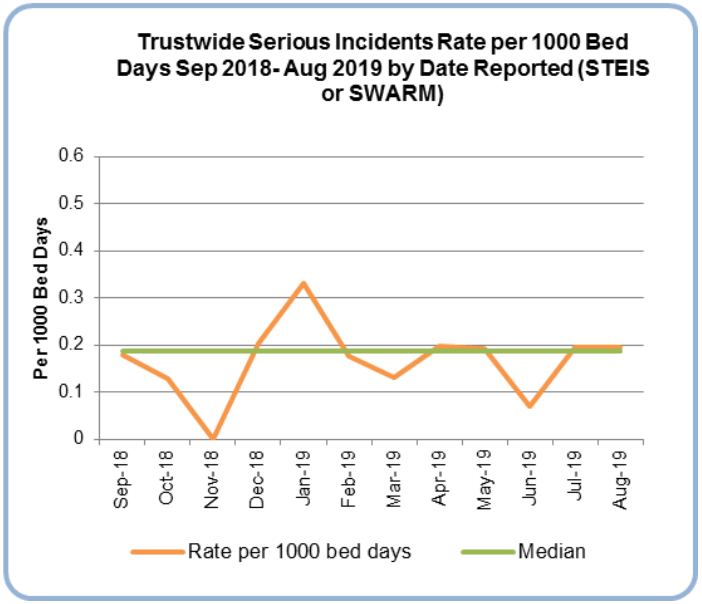
Quality & Patient Safety - Additional Safety Measures

Board Sponsor: Director of Nursing









Serious Incidents (SI)
Six serious incidents were reported in August 2019:

- 4 x Patient Falls*
- 2 x Clinical Assessment or Review

The Board is asked to note that from 01 April onwards NBT has declared on STEIS all "Serious Falls" as Serious Incidents. Therefore, will no longer reflect "non-STEIS falls" as a separate category. This means that falls represents our most frequently occurring Serious Incident.

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

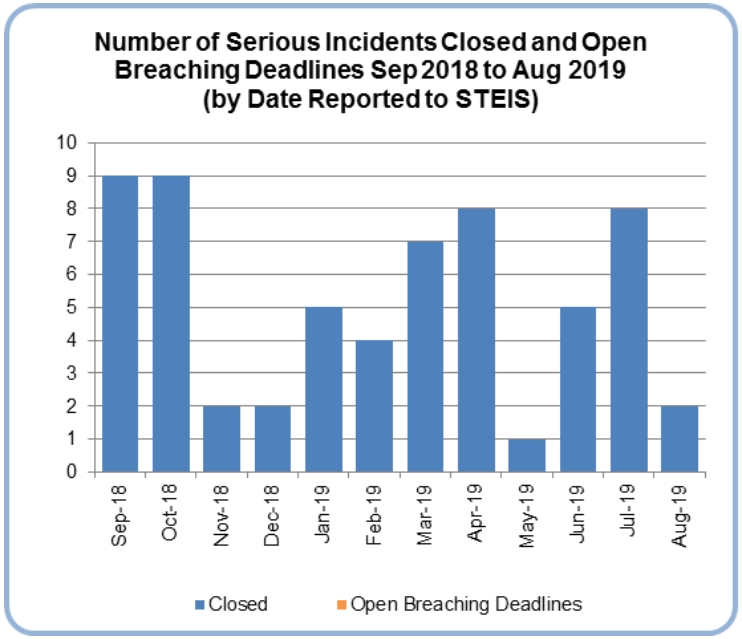
SI & Incident Reporting Rates
Incident reporting has increased slightly in August to 44.27 per 1000 bed days. Whereas NBT's rate of reporting patient safety incidents remains within national parameters, it is noted that we are in the lower quartile of similar NHS Trusts.

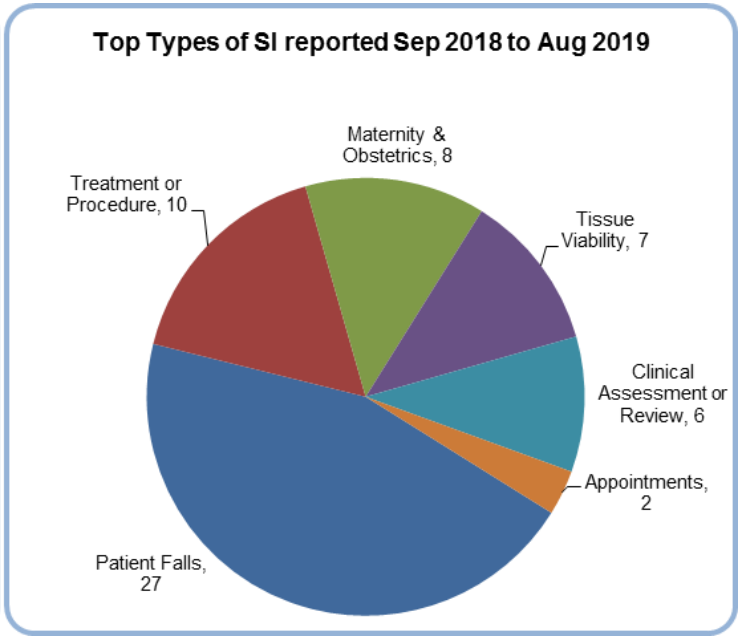
The Patient Safety Incident Improvement Project is focusing on improving our rates of reporting to facilitate learning.

Divisions:
SI Rate by 1000 Bed Days
CCS – 0.63
WCH – 0.22
ASCR – 0.21
Med – 0.18
NMSK – 0.07

Quality & Patient Safety - Additional Safety Measures

Board Sponsor: Director of Nursing





CAS Alerts – August 2019				
Alert Type	**Patient Safety**	**Facilities**	**Medical Devices**	**Supply Distribution Alerts**
New Alerts	0	0	1	1
Closed Alerts	0	0	0	0
Open alerts (within target date)	0	0	1	1
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)
Two new alerts were reported, with none breaching their alert target dates.

From June 2019, the Patient Safety and Clinical Risk Committee has received a monthly status report on CAS alerts. This report will provide information on new alerts with updates for open alerts.

Incident Reporting Deadlines for Serious Incident Investigation submission

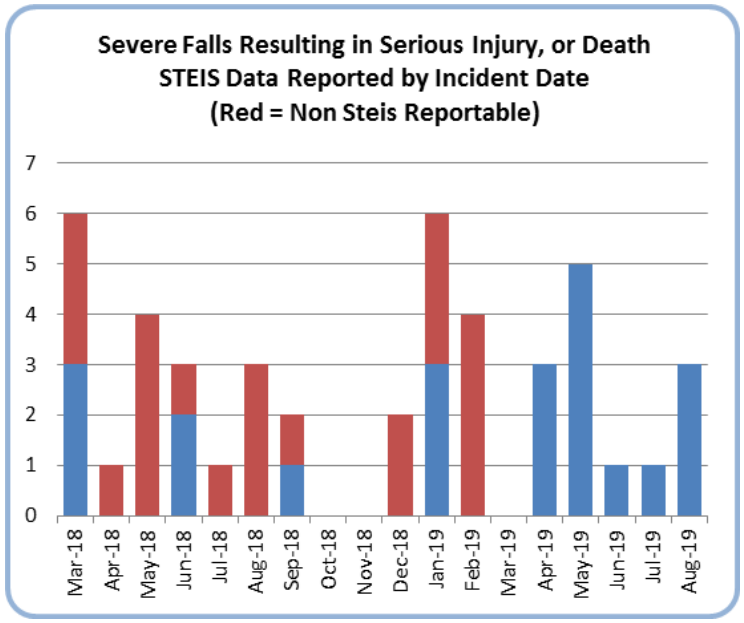
No serious incidents breached their August 2019 reporting deadline to commissioners. There have been no breaches since July 2018.

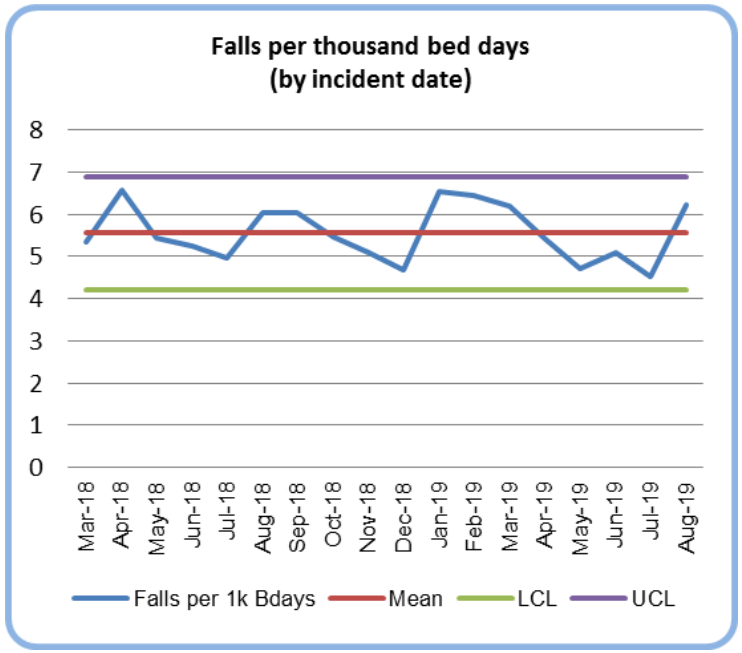
Top SI Types in Rolling 12 Months

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, but a more detailed thematic review has been requested.

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





Falls

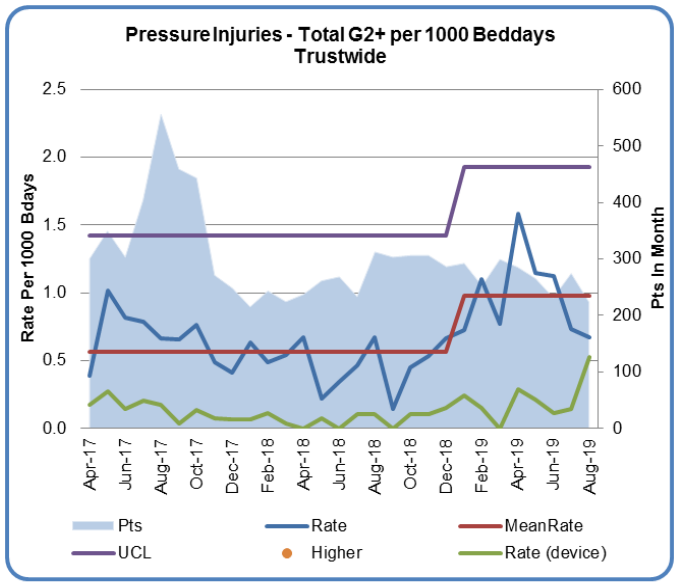
In August 2019, 193 falls were reported of which three resulted in severe harm, five were categorised as moderate, 41 low and the remaining 144 as no-harm. This increase in reported falls is most represented in the low and no-harm categorises.

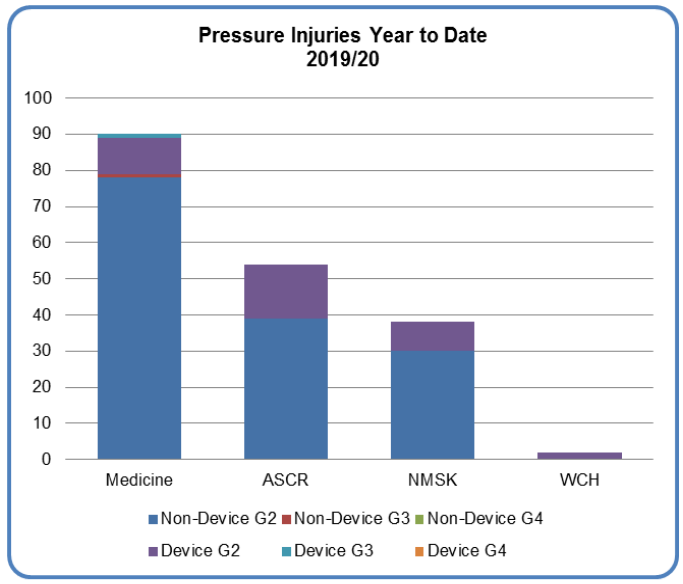
The majority of reported falls occurred within Medicine Division (98), with the others occurring in NMSK (57), ASCR (34), and Women's and Children (4).

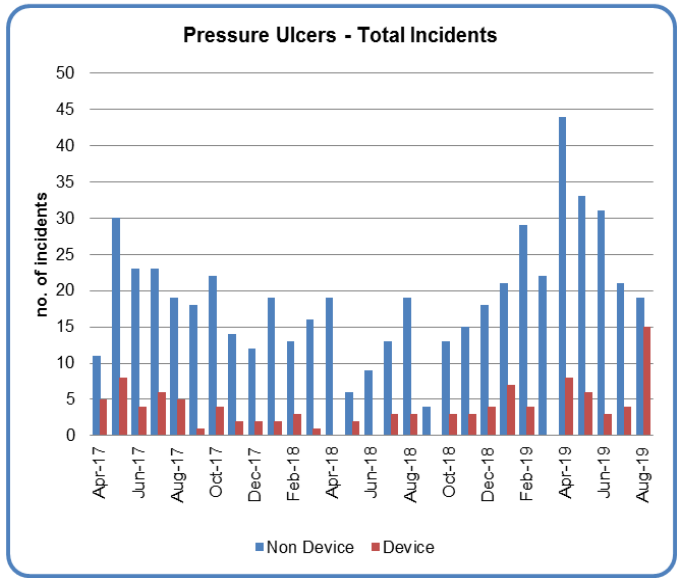
The falls per 1000 bed days level was 6.6 which is above the Trust's 2 year average of 5.9 and will be reviewed at the September Falls Prevention Group Meeting.

The training compliance for falls is > 90% and is currently required every five years. The Falls Prevention Group is considering recommendations to reduce this timescale to two or three years to improve its impact and relevance.

Following the presentation of a highlight report at the Patient Safety and Clinical Risk Committee in September, changes to the current driver diagram (highlighting required outcomes, improvement drivers and key actions) will be addressed by the Falls Prevention Group.







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 August 2019.

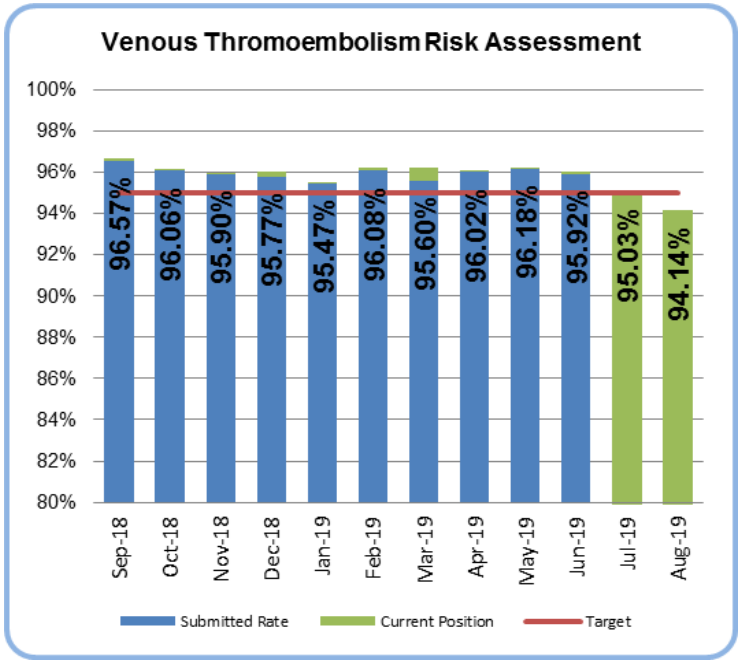
The Trust are reporting 34 Grade 2 injuries for August, which occurred to 28 patients.

The break down of injury is as follows:
38% Sacrum/ buttock,
12% Heels,
44% Medical device related .

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.

The weekly formal review of all Grade 2 hospital acquired cases, chaired by the Heads of Nursing has commenced, enabling a proactive cross divisional response to the increased incidences of device related harm with the use of Laser (Learning About Safety by Experiencing Risk) documentation for neck collars and oxygen therapy.

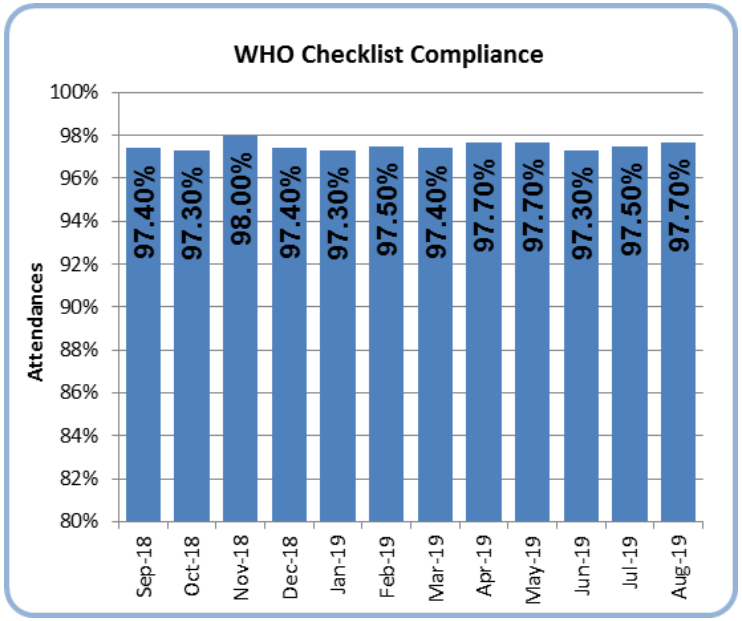
Divisional commencement of staff competency assessment which will enable us to gain assurance of staff knowledge against current education and training programmes continues, using the established Tissue Viability Link Practitioner system.



VTE Risk Assessment

The Board expects a VTE risk assessment to be carried out for all appropriate in-patients. Where certain procedures are considered to be of low risk, the assessments may be agreed as a patient cohort. Cohorts are signed off by the Medical Director. This process is periodically audited externally as part of the annual Quality Account – this was last completed for the 2018/19 Quality Account audit reported in May 2019, with no concerns identified.

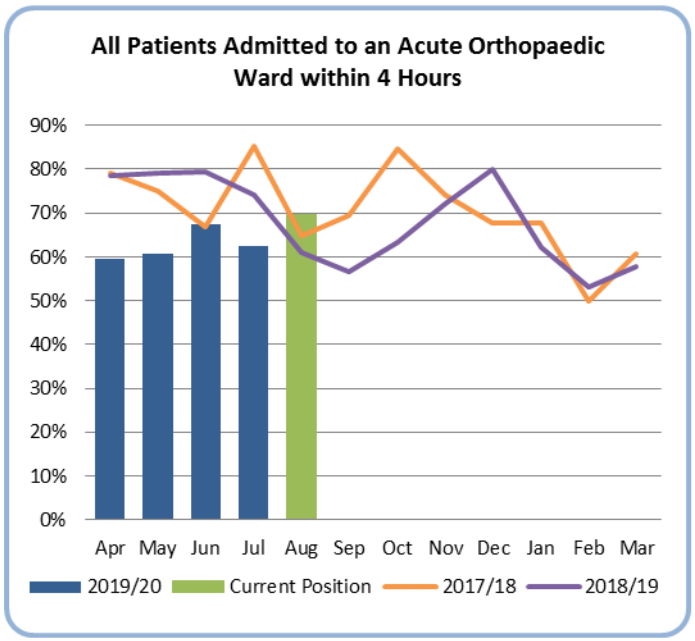
The Trust continues to meet the national standard of 95% of patients having a documented risk assessment in their records at the point of coding the discharge, with the current position for August being 94.14% which is likely to increase as the remaining patients admitted in June are discharged and coded.

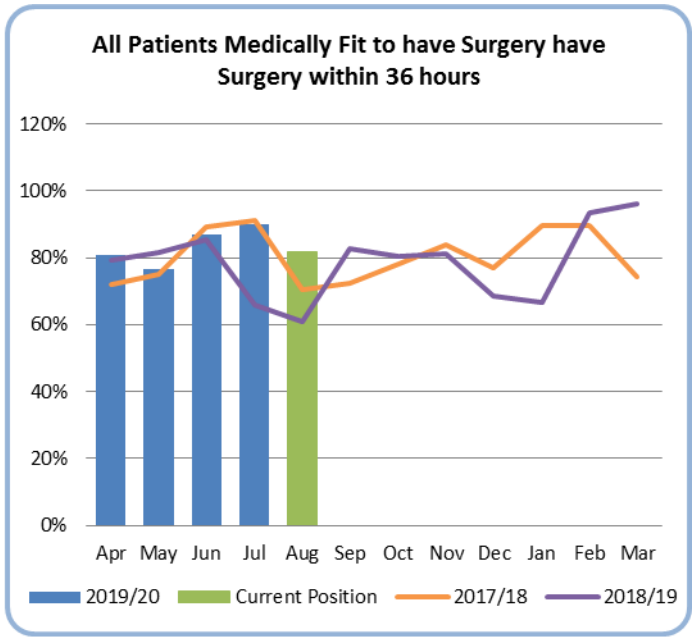


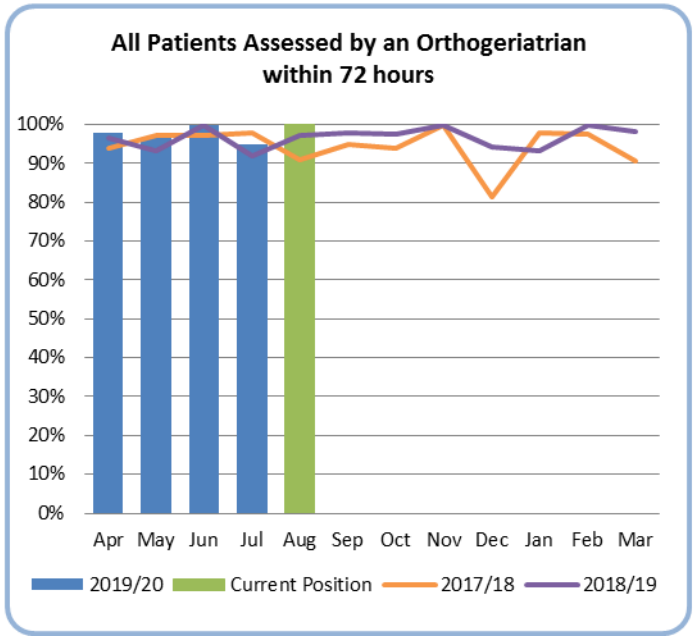
WHO Checklist Compliance

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

Measured compliance with the WHO checklist was 97.70% in August 2019. WHO checklist compliance is monitored by the Theatre Board with any areas failing to record compliance with the requirement being 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.

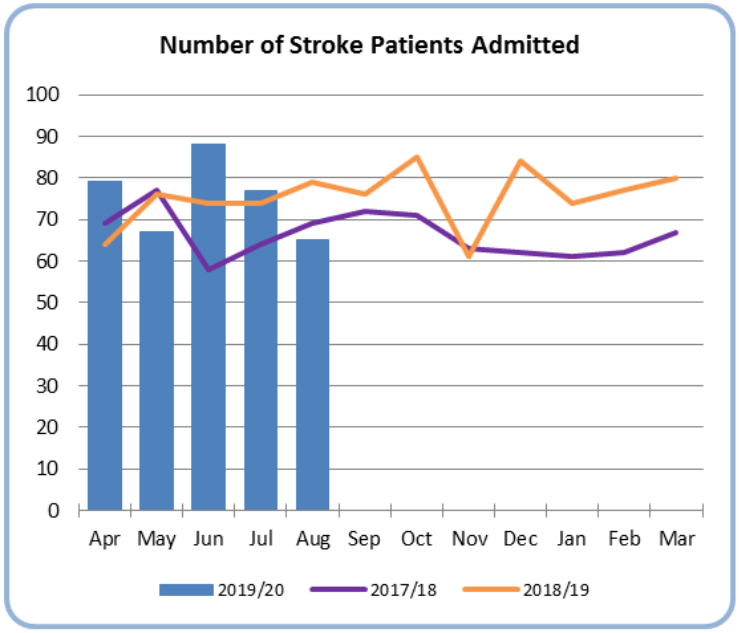
In July 2019 the percentage of patients who were admitted to Hip Fracture unit within 4 hours was 62.5% against an England average of 37.7%.

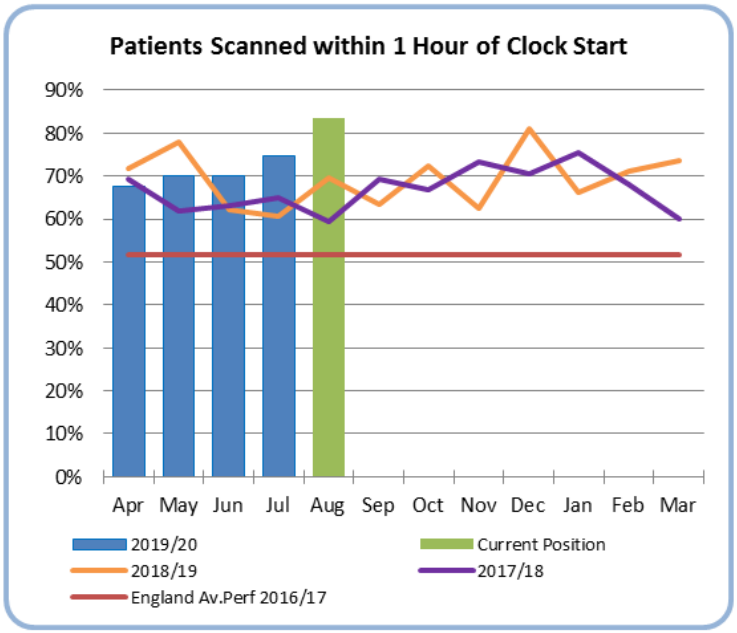
Patients medically fit to have surgery have surgery within 36 hours.

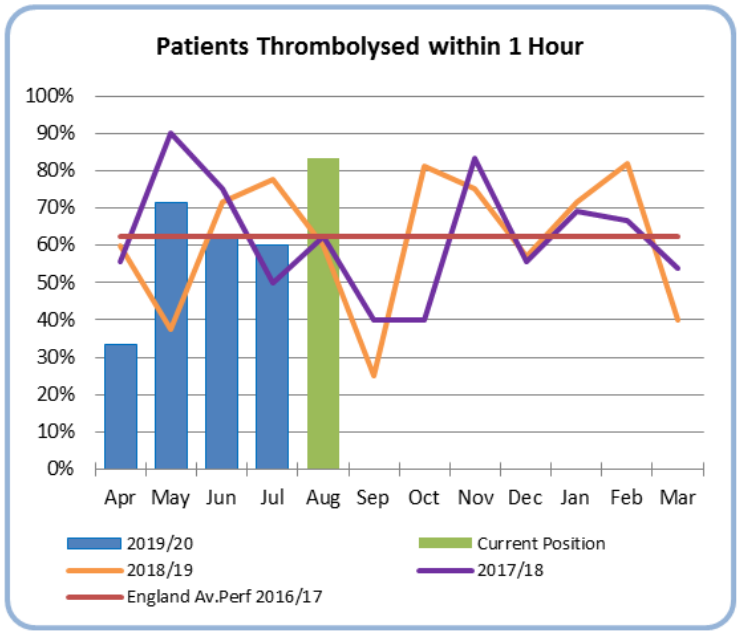
In July, 90% of patients received surgery within 36 hours compared to the England average of 71.2%.

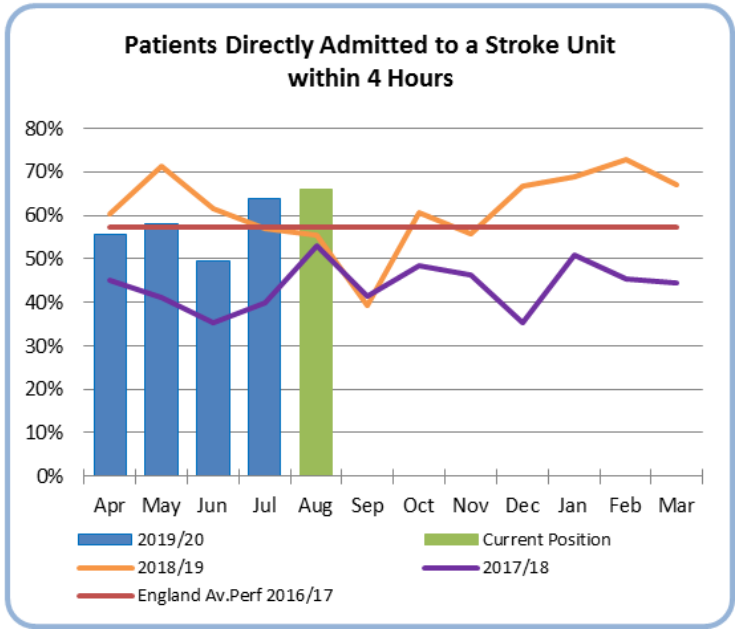
Patients assessed by an Orthogeriatrician within 72 hours.

In July 2019, 95% of patients were seen by an Orthogeriatrician within 72 hours compared to England National average of 92.3%.









Stroke

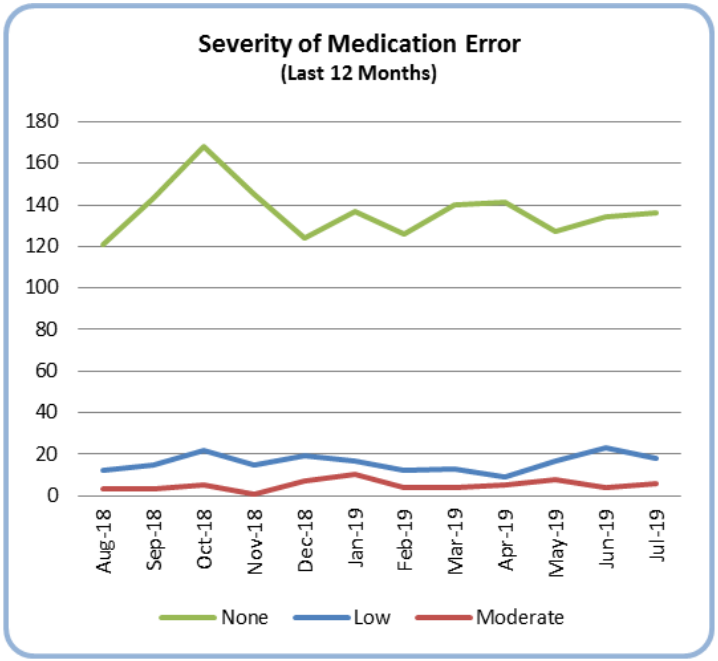
Stroke data is reported one month in arrears with the current month included for reference.

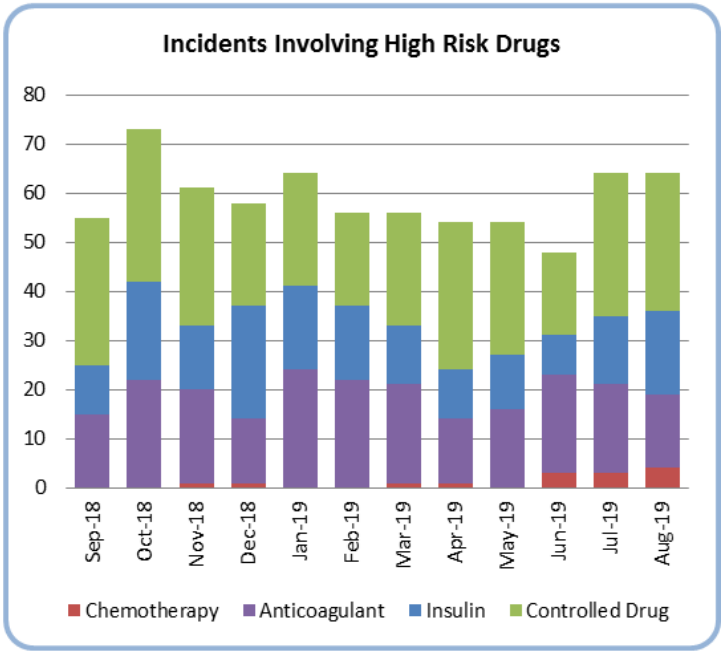
There were 65 patients admitted to Southmead hospital with stroke in July 2019.

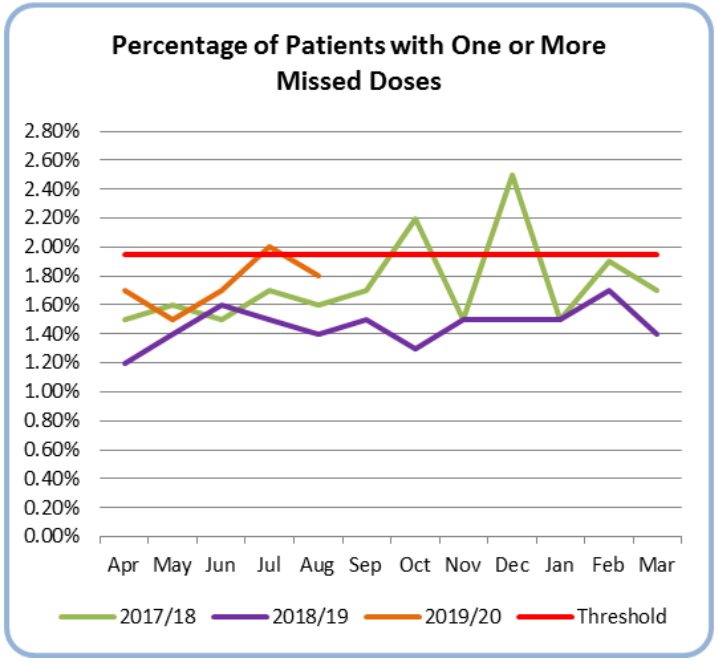
60% of stroke patients requiring thrombolysis received this within 1 hour which is comparable to the England average.

Admission to a stroke unit within 4 hours of presentation remains a challenge with performance at 63.8% in July 2019. The Stroke service is working with the Operations team to ensure the availability of stroke beds at all times.

The number of patients scanned within 1 hour remains higher than the England National average at 74.7% in July 2019.

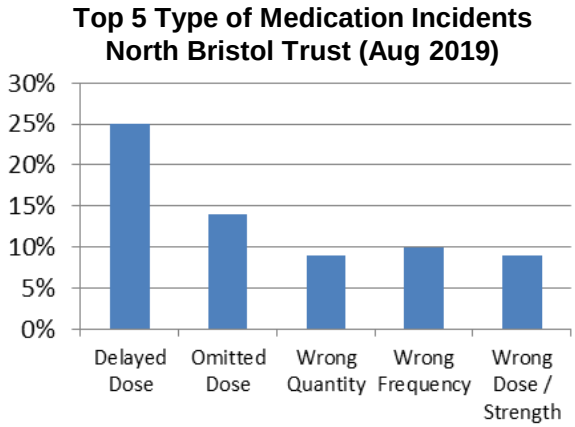






Medication Safety.
Be One of the Safest Trusts in the UK

Reducing medicines-related harm requires a clear understanding of where, when and what type of errors occur.



Medicines Management

Severity of Medication Error

During August 2019, the number of "No Harm" medication errors represented approximately 91% of all medication errors; reinforcing the strong culture of reporting across the Trust.

The Medicines Governance Group continues to monitor the 'low harm' incidents to identify and share the learning.

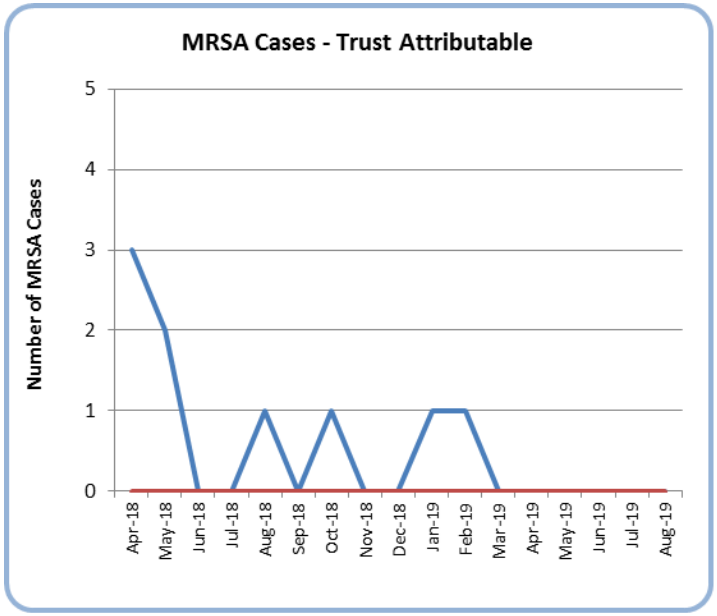
High Risk Drugs

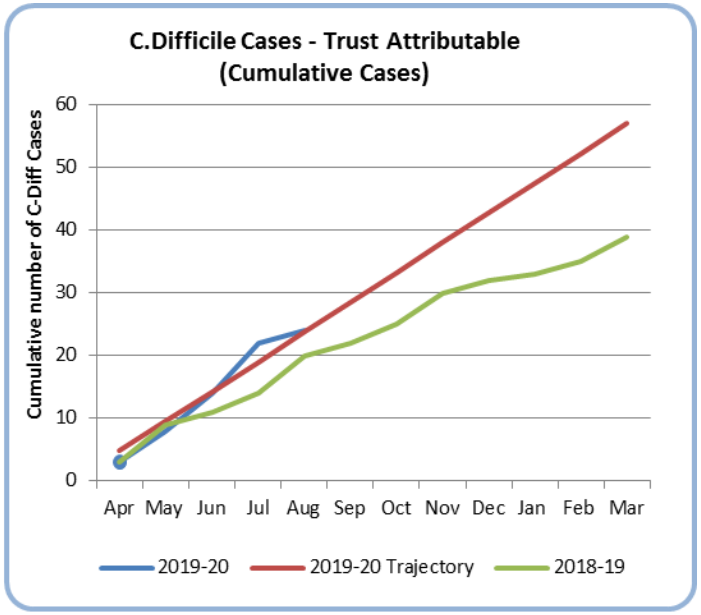
High Risk Drugs formed approximately 31% of all medication incidents reported during August 2019. All incidents relating to high risk drugs are closely monitored by the Medicines Governance team and reported to the Medicine Governance Group.

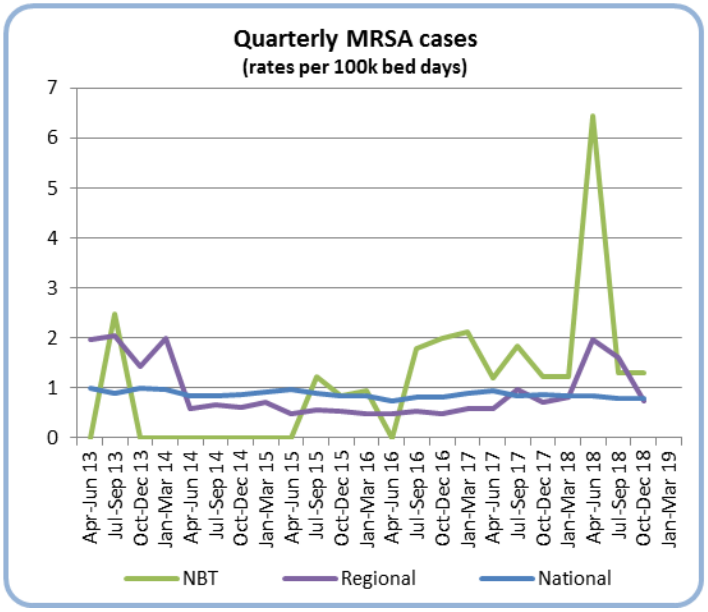
Missed Doses

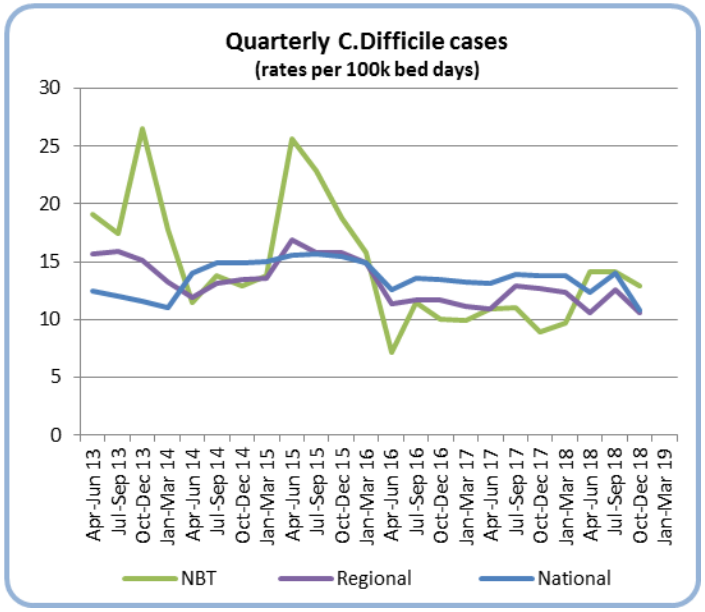
The clinical pharmacy team continues to closely monitor the KPI's associated with all missed doses. Any ward(s) that breach the missed dose target of <1.95% on two consecutive months undertake an intensive 2-week "missed dose audit".

The audit results are shared with ward staff to help the team develop an action plan to improve standards. The Medicines Governance Group will be monitoring the effectiveness of these action plans to ensure performance is improved.









MRSA

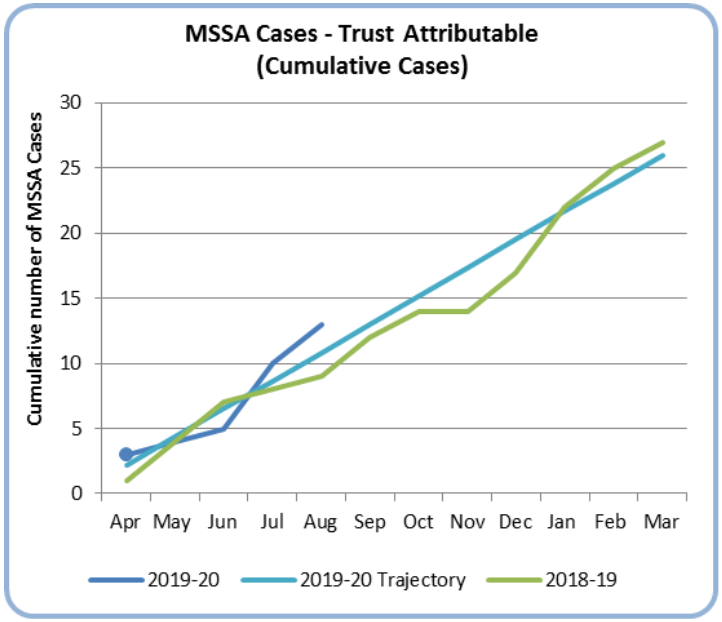
There have been no cases of MRSA bacteraemia in August 2019.

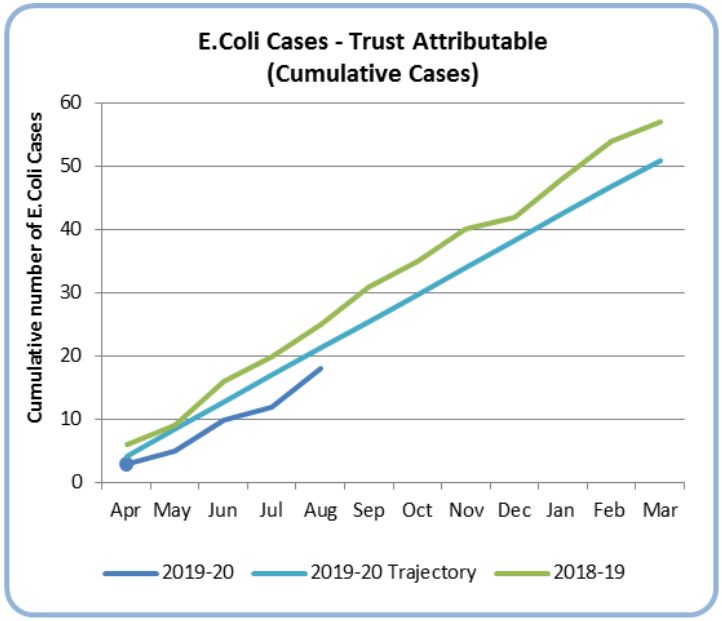
C. Difficile

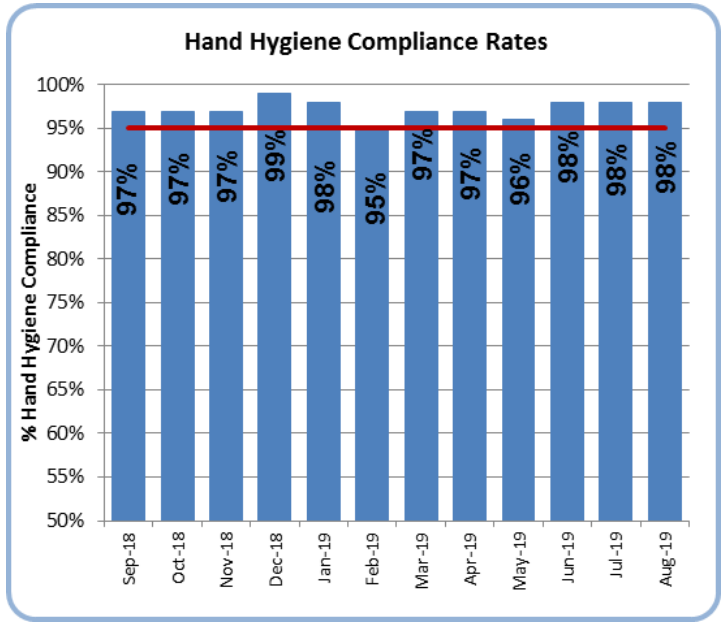
In August there were three cases reported against the trajectory. Two cases were hospital onset and one case were community onset.

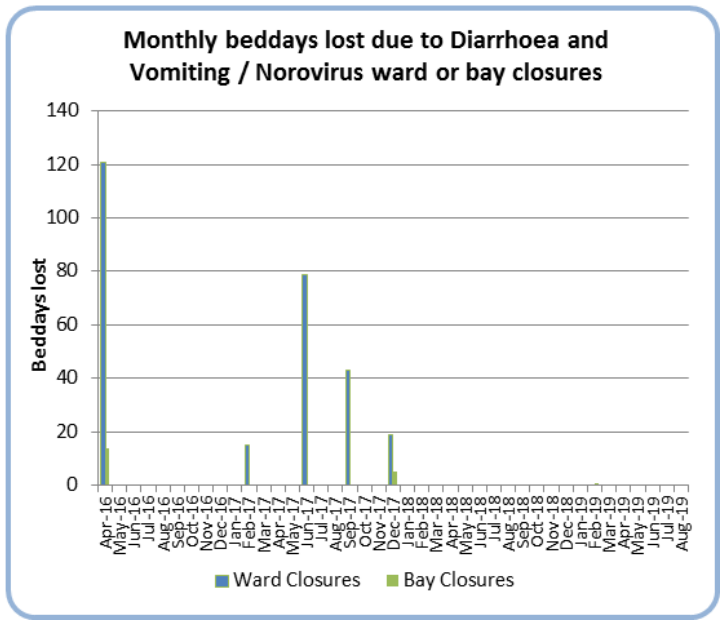
MSSA

There were three reported cases of MSSA bacteraemia in August, which is above trajectory for this point of the year. Review of the cases have identified a continued theme around line care documentation. The Trust quality improvement initiative continues, aiming to reduce incidence of bacteraemia associated with indwelling devices.





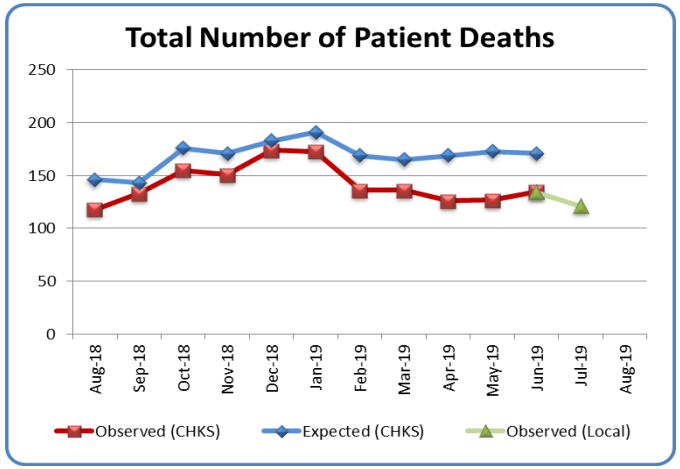


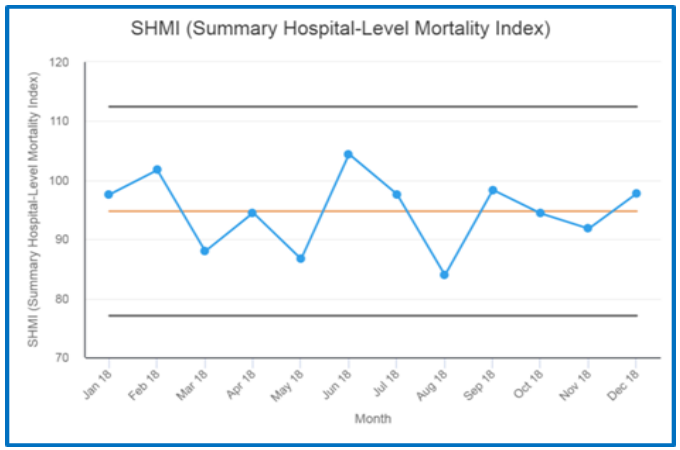


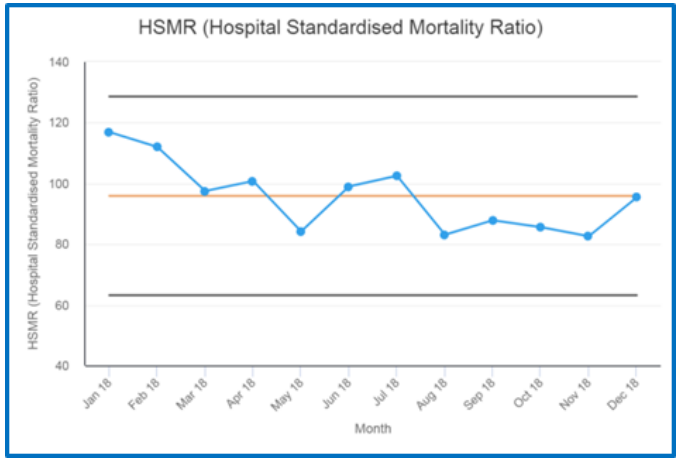
E. Coli.
The Trust target for 2019/20 is 51 bacteraemia representing a 10% reduction on the previous year. There were six cases of E. Coli bacteraemia reported in August. The focus for improvement is on the management of urinary catheters.

Hand Hygiene
Hand Hygiene compliance has been maintained**.**

Pseudomonas water testing
As reported in the last IPR, routine testing of water within augmented care areas in August demonstrated some outlets with raised pseudomonas counts.
Recent water sample results in September have indicated an improved position with outlets responding to remediation. Where necessary we are still using mitigation actions to ensure patient safety. No increase in patient infections has been found.







Overall Mortality
The HSMR and SHMI data charts illustrate continued mortality outcomes within the expected range.

A deep dive review of the Trust's approach to mortality review was undertaken at the Quality & Risk Management Committee on 19 September.

Mortality Review Completion
The current data captures completed reviews up to 31 May 2019. In this time period, 93% of all deaths have a completed review. 97% of "High Priority" cases have completed Mortality Case Reviews (MCR), including 16 deceased patients with Learning Disability and 12 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 remains 97% (score 3-5). There have been 20 mortality reviews with a score of 1 or 2 indicating potentially poor, or very poor care.

All cases that score 1 or 2 are reviewed through Division governance processes to determine if further investigation is required.

One case has been declared as a Serious Incident Requiring Investigation (SIRI). Those cases not declared as SIRIs have been reviewed with evidence of the outcome held on NBT's incident reporting system (Datix).

Mortality Review Completion

	Completed	Required	% Complete
Screened and Excluded	1126		
High Priority Cases	238		
Other Reviewed Cases	552		
Total Reviewed Cases	1696	1823	93.0%

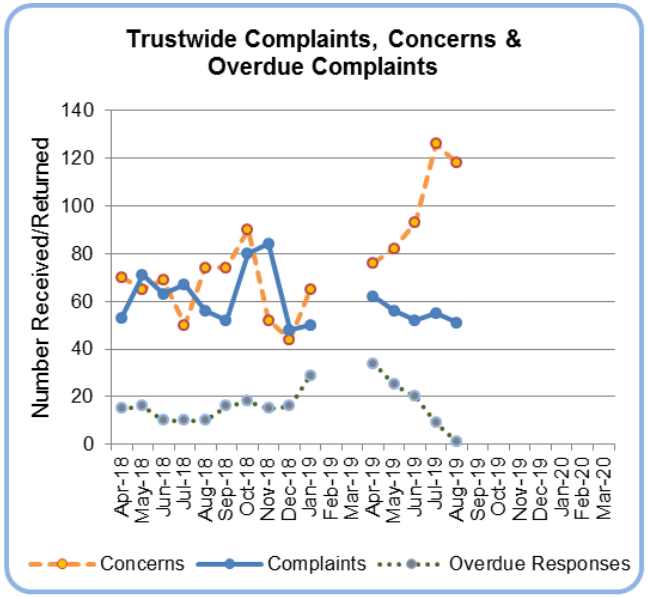
Date of Death	Apr 18 to May 19
In Progress	0
Reviewed Not SIRI	19
Reported as SIRI	1
Total Score 1 or 2	20

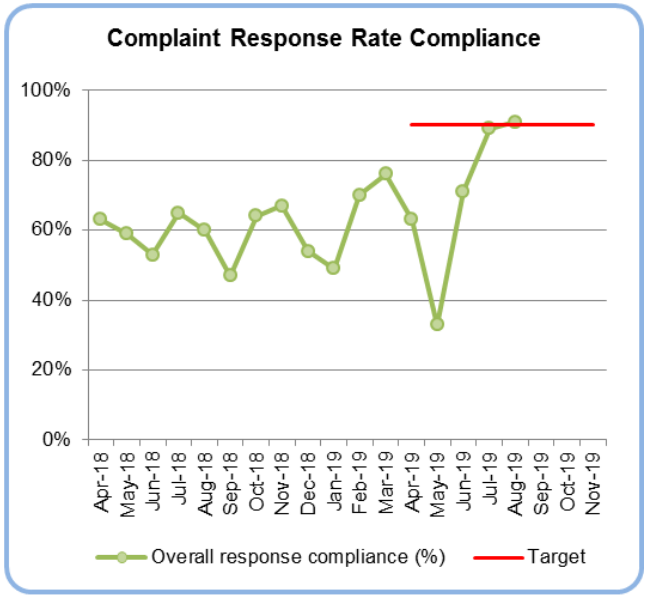
Overall Score	1	2	3	4	5
Care Received	0.0%	2.9%	19.3%	54.6%	23.2%

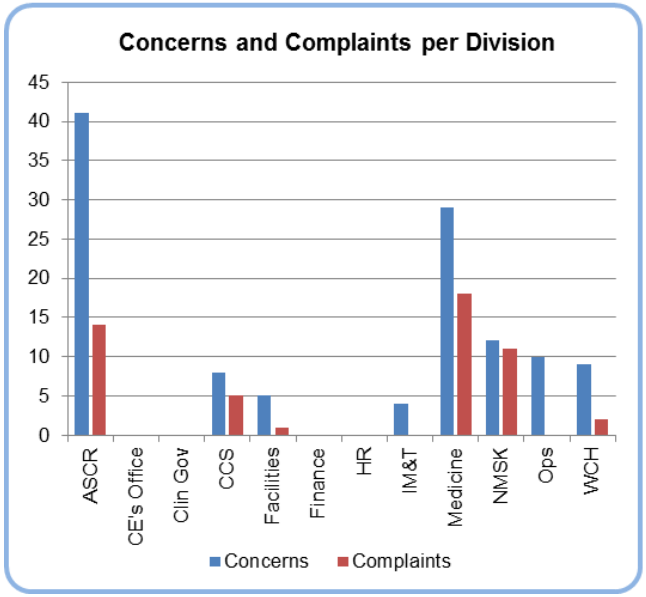
NHS North Bristol NHS Trust

Quality Experience

Board Sponsor: Interim Director of Nursing
Helen Blanchard







	Total closed in August	Total overdue at end of August
Medicine	15	0
NMSK	17	0
ASCR	20	1
CCS	6	0
WACH	5	0
Clin Gov	1	0
Ops	1	0
IM&T	1	0

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 August 2019 the Trust received 51 formal complaints and 118 PALS concerns.

The 51 formal complaints can be broken down by division:

ACSR:	14	CCS:	5	Facilities:	1
Medicine:	18	NMSK:	11	WACH:	2

The number of formal complaints received in month continues to reduce. This continues to reflect the embedding of the Patient Advice and Liaison Service (PALS) and the success in locally resolving patients concerns before they escalate. A local audit has shown that 91% of complainants now opt for local resolution as opposed to taking a formal route.

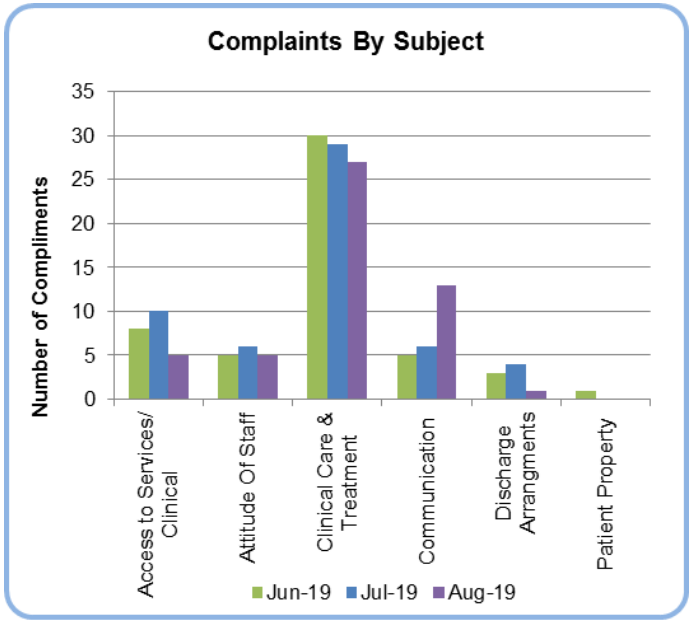
Final Response Rate Compliance

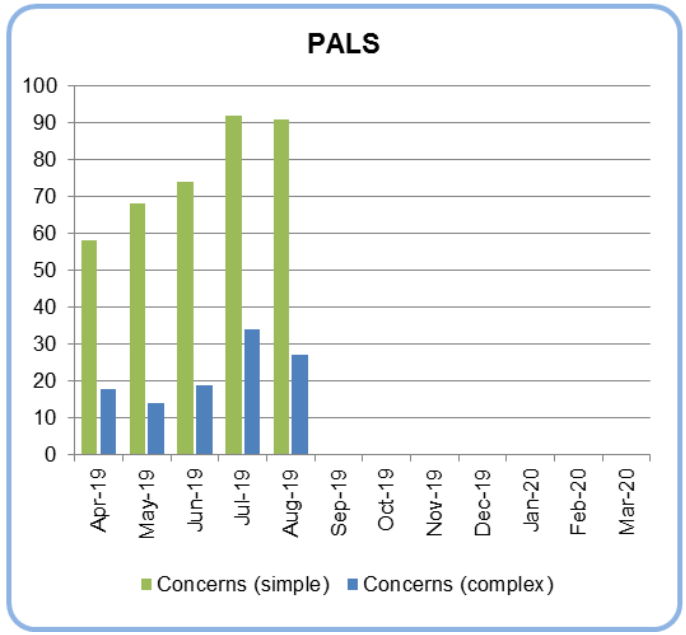
Implementation of the recovery plan across the Trust has contributed 91% of complaints being responded to within the timescale.

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

Overdue complaints

The total number of overdue complaints at the end of August sat at 1 overdue. The introduction of a weekly complaints tracker circulated to divisions has proved a success and will continue as a monitoring and validation process for formal complaints to ensure the 100% compliance becomes sustainable.





Complaints By Subject

There was a slight reduction in the number of complaints within the area of clinical care and treatment. This is a broad theme area and a deep dive is currently ongoing to provide further breakdown. This will be available at the end of Q2 report being taken to the Patient Experience Group in November 2019.

Compliments

A more systematic approach will be developed to capture compliments and will be developed as part of the ongoing improvement programme. This will follow the current priorities of addressing the complaints backlog and establishing a permanent PALS service. This is included in the Corporate Patient Experience Team work plan with an anticipated finish date of November 2019.

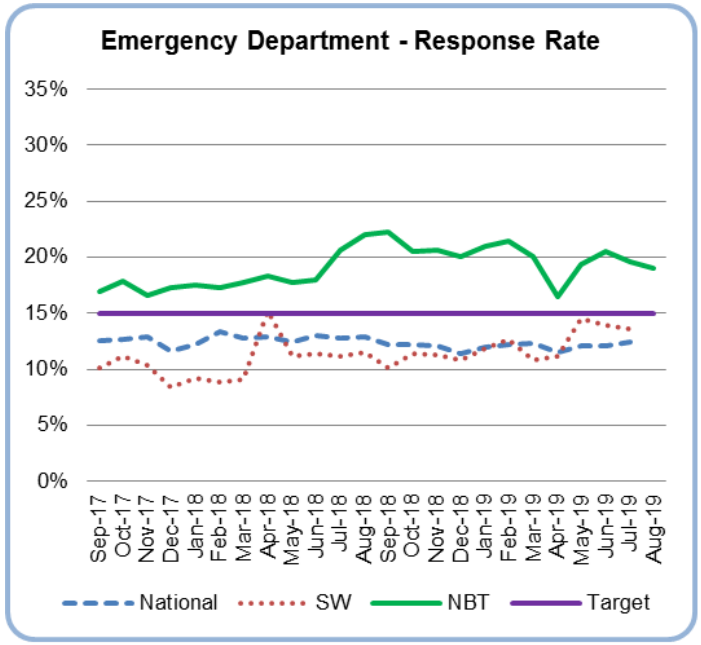
Example compliments received in August 2019.

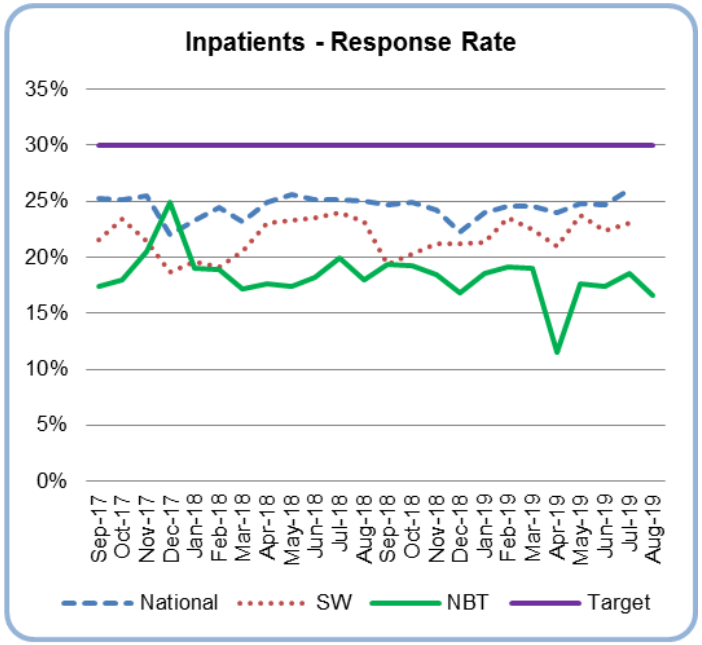
"Our son was cared for in Southmead following a major trauma. Members of staff at every level showed immense care to our son and the professionalism on display was very impressive. The strong team work that we saw in action suggested that people enjoy working there and their common aim of returning patients to health is such a huge testament to the value that the NHS brings to our country and to all our lives. Following my son's discharge, we still have contact with a trauma coordinator who, despite being rushed off her feet, is always responsive and helpful. Thank you."

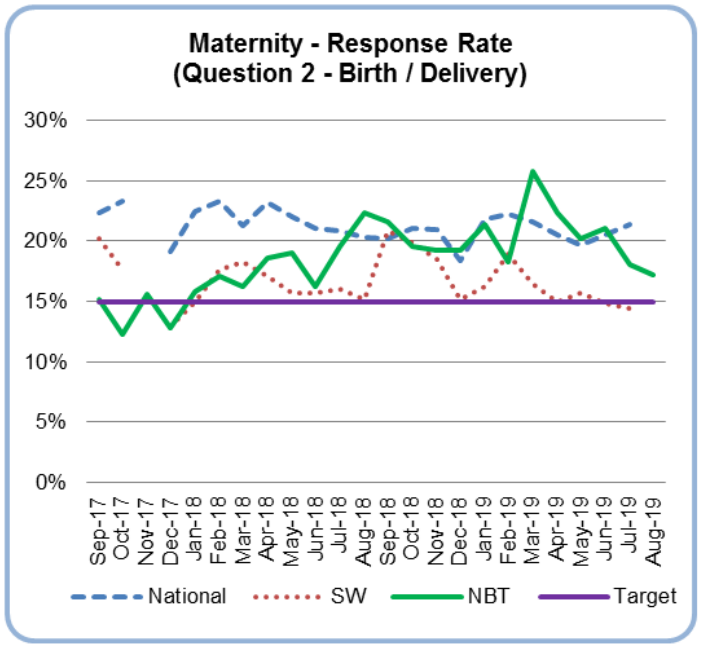
"I was admitted to Southmead AMU last week ….I was an inpatient for almost a week. It's hard to express how grateful I am to all the staff who cared for me while I was there. I met so many nurses, doctors, porters, medical students, domestic staff, phlebotomists and the consultant and they were so warm 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."

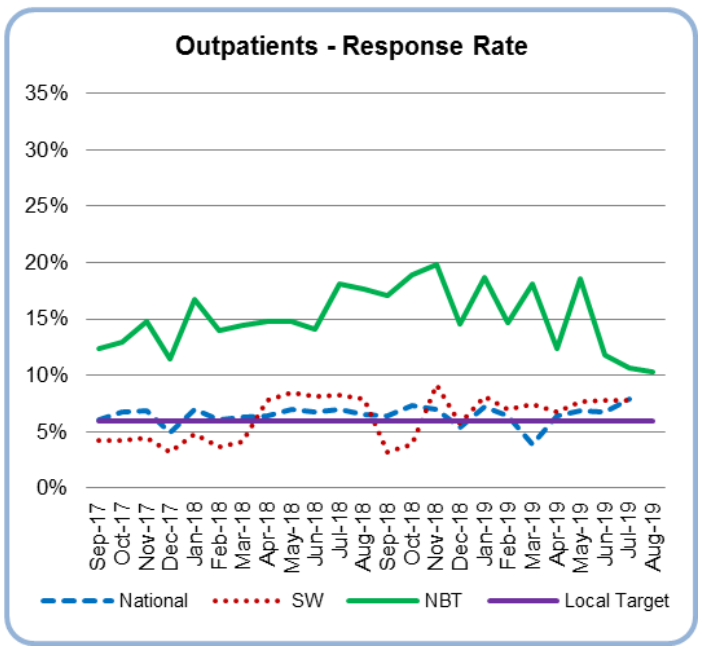
Patient Advice and Liaison Service (PALS)

118 PALS concerns were received in August 2019. Of the 118 PALS concerns received, 91 (77%) can be classified as more simple concerns and 27 (23%) warranted more in depth investigation from within the division and were classified as complex concerns. The PALS team continue to work closely with governance staff within the divisions to identify areas of concern for improvement. Currently the team is looking at discharge concerns, an area that continues to increase, and will begin to liaise with the divisions and discharge teams to feedback ahead of any potential increase in the lead up to winter.









Friends and Family Test

FFT Response Rate	Target	NBT Actual
ED	15%	19.05%
Inpatients	30%	16.54%
Outpatients	6%	10.32%
Maternity (Birth)	15%	17.19%

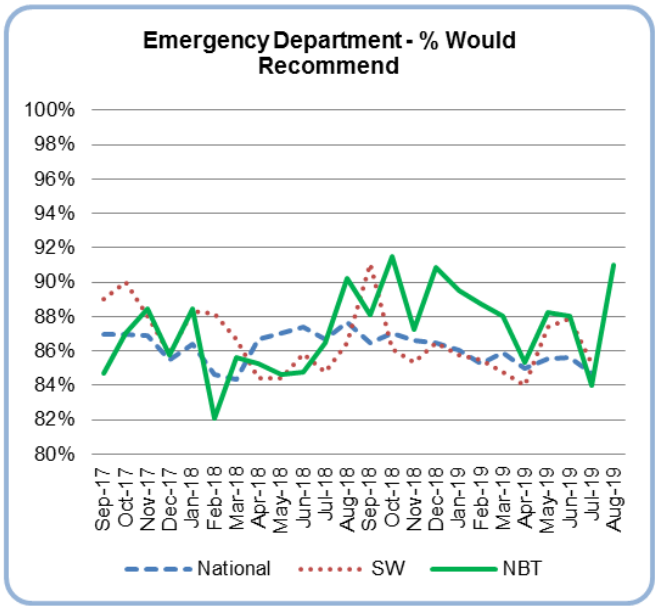
The Emergency Department have maintained their good response rate.

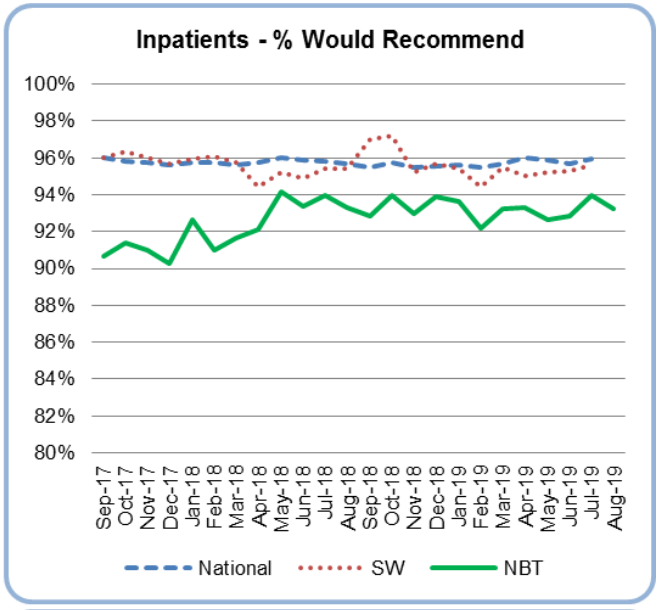
The Inpatient response rate has decreased from 18.5 % in the last month to 16.54%. NHS England require that the overall In patient reported data includes day case responses. A plan to increase the amount of day case patients that are being surveyed is being put in place, as agreed at the Patient Experience Group in July 2019, with the intention to improve the over all reported response rate.The results of this should be seen within October FFT data & onwards.

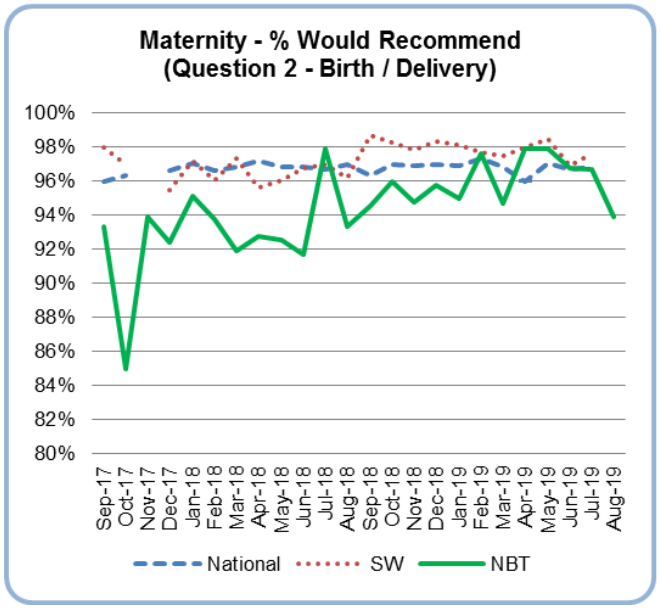
Maternity have remained above target. The promotion of the FFT opportunity is in progress with the provision of FFT business cards to all patients explaining how they can give feedback.

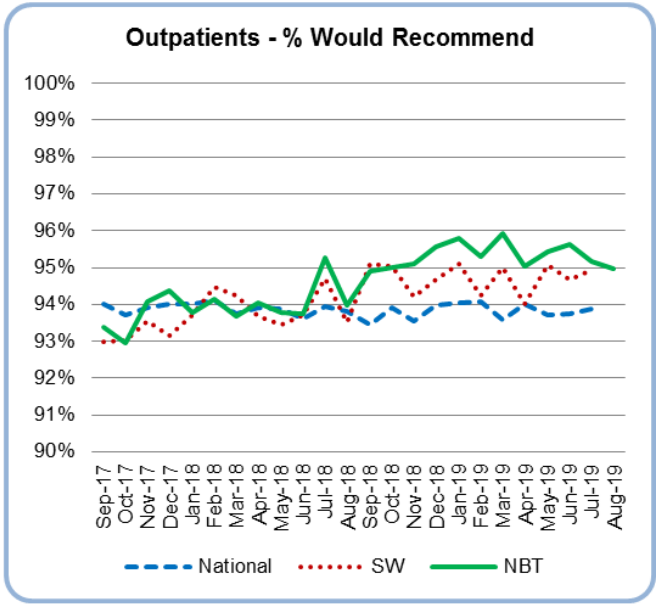
Owing to technical issues, NHS England have not published maternity FFT data for November 2017.

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).









FFT Recommend Rate	Target	NBT Actual
ED	90%	91.00%
Inpatients	95%	93.23%
Outpatients	95%	94.96%
Maternity (Birth)	95%	93.90%

Just under 95% of patients providing feedback using the FFT system Inpatients, Outpatients and Maternity (Birth) would recommend NBT to friends and family.

ED have seen a seen a significant increase of 7% in the number of people who would recommend the service this month. Bringing them back above the national performance.

<u>What are people saying about our services?</u>
Within inpatients the main negative comments relate to one specific ward, this has been raised with the ward manager to review and will be reviewed and monitored via the Patient Experience Group triangulation of FFT, complaints and concerns reporting mechanism. The wards identified as requiring improvement, from the triangulation of data, have all improved.
The majority of inpatient feedback is positive, particularly in relation to helpful and friendly staff attitude
Within ED the feedback remains to be around waiting times and the lack of communication around this. The feedback on poor staff attitude is being monitored. The detail of this feedback is being investigated by the Division supported by the Patient Experience Lead

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).

Friends and Family Test

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

Emergency Dept – (1)

So quick and efficient at getting scans and checks done for me at very short notice. Every single member of staff I met that afternoon were caring and friendly and professional. I felt truly humbled by the service they provided and would like to say a big thank you.

Colposcopy (1)

I cannot thank (name) and the team enough for conducting the procedure in such a professional and cheerful manner. They put me at ease completely. I would assure any other ladies who may need this procedure - do not worry you are in safe hands here. Thank you.

Birth (3)

The staff were amazing. Very friendly and helpful and cant praise them enough but not enough bed spaces. Could not have an induction due to lack of beds which caused problems later on and resulted in a longer stay

Day Case – Gate 13 (1)

The staff were very friendly. Kept me informed before the scan as to how long I would to wait as there was a computer problem. They also kept me fully informed during the scan and after. Lovely people, made a potentially embarrassing procedure as relaxing as possible.

Outpatients – Trauma and Ortho (5)

I didn't even get to see my consultant, I turned up and was sent for x rays by the time I got back I was told the consultant had gone home, I find this absolutely disgusting!!! I had an hour and a half's drive to the hospital totally wasted a day and I'm no better off still in pain with a broken hip

25a (1)

Wow where do I begin? The speed and efficiency that I was met with was outstanding! Everyone whom I came into contact with treated me with the utmost respect, dignity and care. All the staff were amazing and I cant thank them all enough and when I say all the staff that is from the lovely cleaners, housekeeping right up to the doctors. The food was delicious and nourishing which was a pleasant surprise.

Gate 19 (3)

Pre op experience good (could have been better if appointment letter and info booklet had arrived before and not 3 days AFTER APPOINTMENT). Care during investigations/ diagnosis/planning/ information/ advice/ support was very good particularly from the Drs.

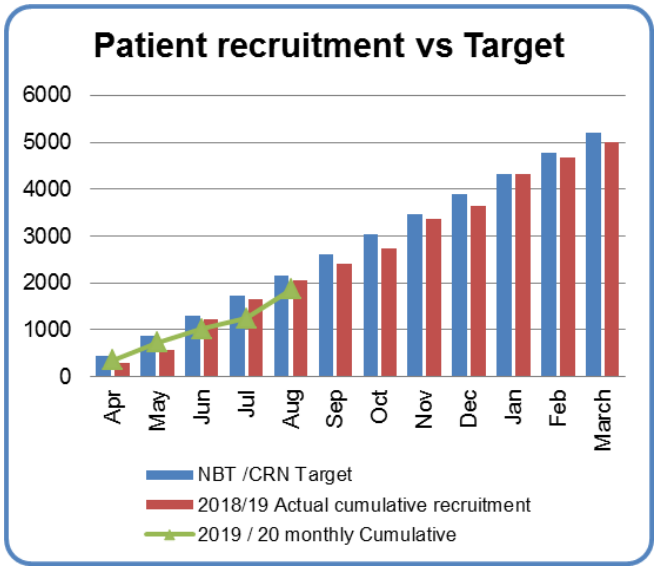
32b (1)

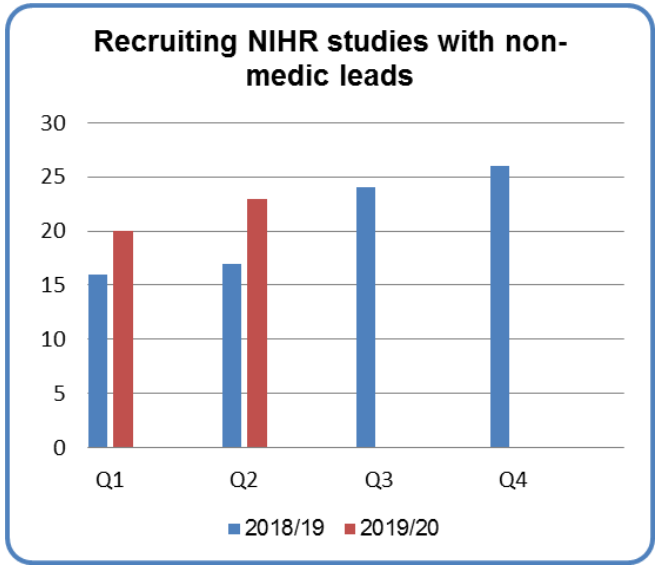
The reason for top marks is that from the very start of my visit, everyone one was so attentive, doctors, nurses & reception were absolutely lovely and so very kind and understanding and I thank them all so much..

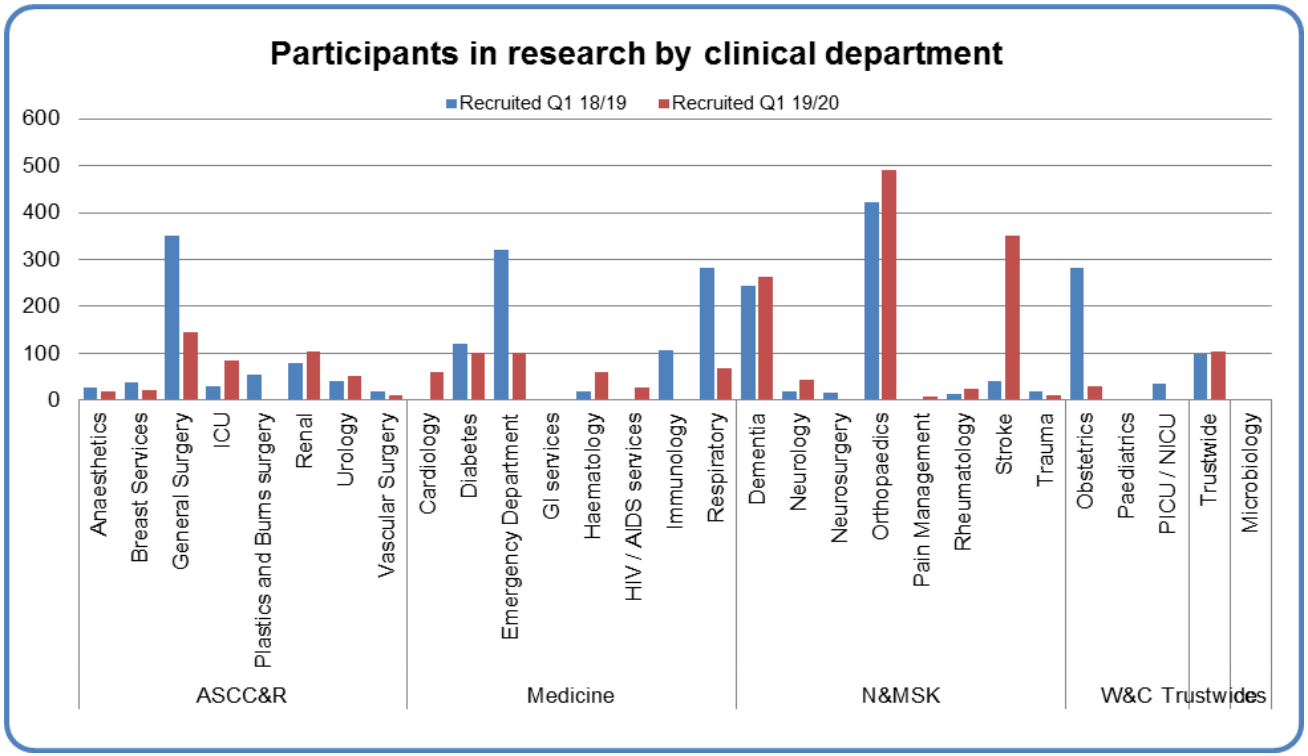
Emergency Dept (5)

I respect the NHS but the mental health services are poor and I felt no one cared I was there waited 13 hours and had no one speak to me and I was handed a leaflet at the end and I came out feeling worse

Research and Innovation (R&I) - Board Sponsor: Medical Director







In line with last year, and regional patterns, NBT is currently behind the linear target for recruiting patients / participants to research studies. However three large recruiting studies have opened in August and we are beginning to see the benefits of that recruitment.

The number of NIHR studies lead by non-medic researchers has continued to show strong performance. Work is underway to also increase the number of non-medic researchers leading multi-centre studies.

Due to a generous charitable donation to the NBT Research Fund, R&I has opened a Trust-wide open call for applications to fund research projects up to £20k each. The call will close 18 September 2019.

NBT received the 2019/20 Research Capability Funding (RCF) allocation from DoH and, at £1.1m, this represents a 34% increase to last years budget, resulting from NBT's NIHR grant success over the last year.

NBT currently holds 30 research grants (NIHR, charity and other) to a total value of £19.2m, with 14 NBT-led grants in set-up (£4.2m).

NBT R&I hosted an Investors in People assessment and been awarded a silver award standard.

Further NBT R&I has been shortlisted for Investors in People Employer of the Year, Silver Category. This is a particularly proud achievement as the only public sector organisation shortlisted for the category.

CQUINS

Board Sponsor: Medical Director and Interim Director of Nursing
Chris Burton and Helen Blanchard

Ref/Title	Description	Ann. Value ('000)	Lead Division	Q1 (A) no £ values	Q2 (F)	Q3 (F)	Q4 (F)	Comment (*forecasts are % of £ CQUIN value*)
1a. Antimicrobial Prescribing - UTI	Achieving 90% of antibiotics treatment for lower UTI in 65+ IP	£182.4k	Trust-wide & Clin. Gov.	🔴	🔴	🔴	🔴	**17% FORECAST.** Challenges with practice change for urine dipstick tests.
1b. Antimicrobial Prescribing - Colorectal	Achieving 90% of antibiotics surgical prophylaxis treatment for elective colorectal surgery	£182.4k	ASCR	🟢	🟢	🟢	🟢	**100% FORECAST**
2. Flu Vaccines	Uptake of flu vaccinations by frontline clinical staff of 80%	£364.8k	Operations	N/A	N/A	N/A	🟢	**100% FORECAST**
3a. Risky Behaviours - Screening	Achieving 80% Timely Screening (Alcohol & Tobacco)	£121.6k	Medicine (ED) & Clin. Gov.	🟢	🟢	🟢	🟢	**100% FORECAST**
3b. Smoking Brief Advice	Achieving 90% of identified smokers given brief advice.	£121.6k	Clin. Gov.	🔴	🟡	🟡	🟡	**75% FORECAST** for each measure. Lorenzo changes enabling practice improvement & compliance (forcing measure in risk assessments)
3c. Alcohol Brief Advice	90% of patients identified as drinking above low risk levels, given brief advice or offered a specialist referral.	£121.6k	Medicine & Clin. Gov.	🔴	🟡	🟡	🟡	
7. Falls Prevention	Achieving 80% of 65+ inpatients receiving key falls prevention actions	£364.8k	Trustwide & Clin. Gov.	🔴	🔴	🔴	🔴	**27% FORECAST** Lying & Standing blood Pressure practice challenges. Consistent with national picture.
11a. Same Day Emergency Care (Pulmonary Embolus)	75% of patients with confirmed pulmonary embolus being managed in a same day setting	£121.6k	Medicine/ Operations	Unreliable audit	🔴	🔴	🔴	**40% FORECAST** Audit criteria being clarified locally & with national leads. Requirement is to prove NICE guidelines followed whilst delivering SDEC in each pathway .
11b. Same Day Emergency Care (Tachycardia with AF)	75% of patients with confirmed atrial fibrillation being managed in a same day setting	£121.6k	Medicine/ Operations	Unreliable audit	🔴	🔴	🔴	
11c. Same Day Emergency Care (CAP)	Patients with or confirmed Community Acquired Pneumonia should be managed in a same day setting	£121.6k	Medicine/ Operations	Unreliable audit	🔴	🔴	🔴	
Total (£ value and % achieved of quarterly amount available)		**£1.82M**	**Q1 = Baseline only (no £ value)**	**£N/A**				**FULL YEAR £1.13M (61.8%)**

Target met	Target partially achieved	Target not met

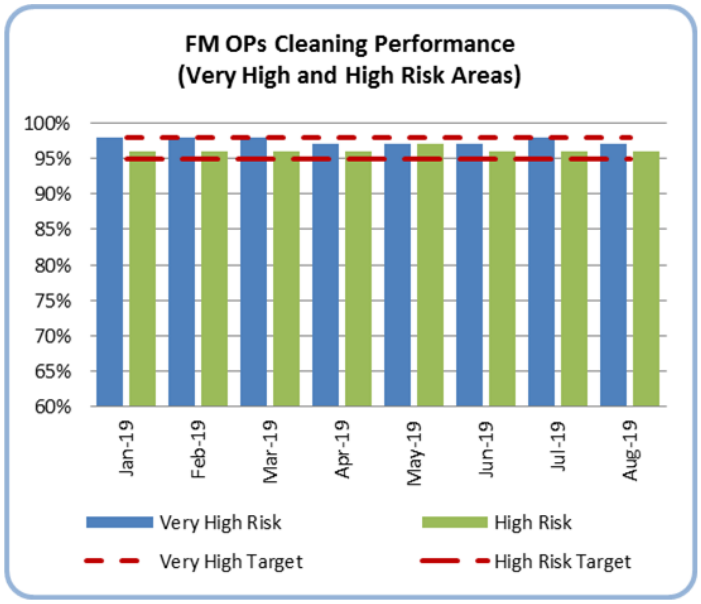
Ref/Title	Description	Ann. Value ('000) rounded	Lead Division	Q1	Q2	Q3	Q4	Comment
1. Medicines Optimisation	1. Improving efficiency in the IV chemotherapy pathway from pharmacy to patient. 2. Supporting national treatment criteria through accurate completion of prior approval proformas (Blueteq). 3. Faster adoption of prioritised best value medicines and treatment. 4. Anti-Fungal Stewardship.	£333.6k	CCS					Q1 achieved in full.
2. Severe Asthma	1. Appropriate initiation prescribing and annual review of biologics by a severe asthma centre. 2. Virtual network MDTs. 3. Network spokes prescribe repeat medication. 4. Completion of data to the UK Severe Asthma Registry and NHS England Quality Dashboard.	£163.0k	Medicine	N/A	N/A	N/A		All triggers are measured in Q4.
3. Spinal Network	1. Spinal Network MDT Oversight. 2. Data entry on BSR. 3. Concentration of Specialised Surgery. 4. Avoidance of unnecessary interventions.	£240.0k	NMSK					Q1 achieved in full.
4. Promoting Transplantation (Renal)	1. Establish a Network. 2. Organ utilisation. 3. Donor and recipient experience in networked providers. 4. Promoting donation.	£200.0k	ASCR	N/A	N/A	N/A		All triggers are measured in Q4.
5. Breast Screening	1. Production of a Workforce Development Plan.	£72.9k	ASCR					Q1 achieved in full.
Total (£ value and % achieved of quarterly amount available)		**£1,009.5k**		**£117k (100%)**	**£134k (100%) Forecast**	**£167k (100%) Forecast**	**£590k (100%) Forecast**	

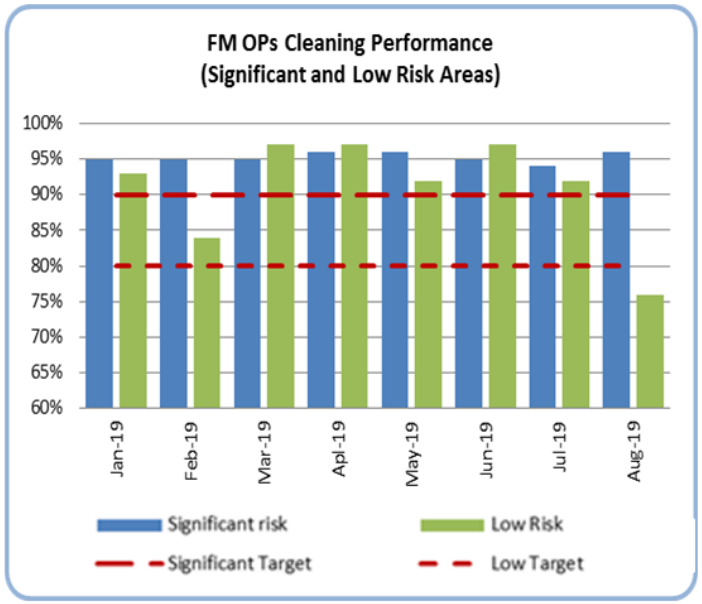
Target met	Target partially achieved	Target not met

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)

Low risks scores have dropped in August. Work is underway to return performance to normal.

Domestic relief team continues to provide cover 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.

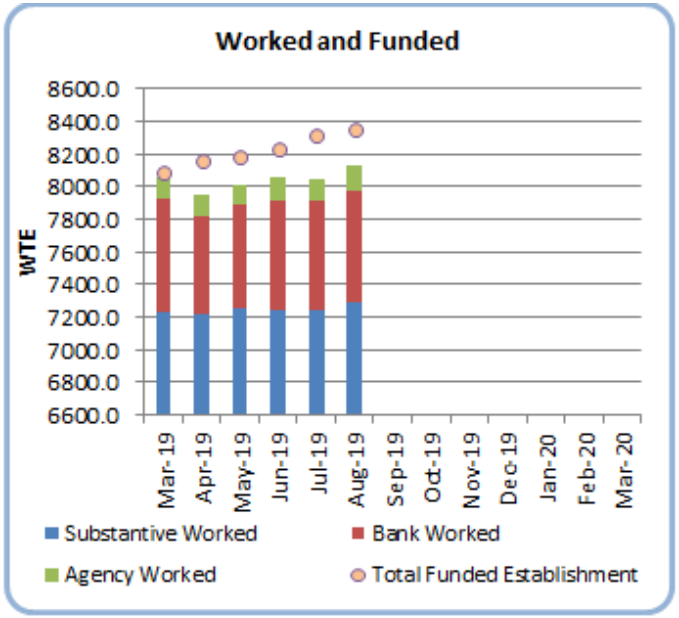
Monthly performance meetings with an areas Facilities Manager are conducted to highlight any recurring issues.

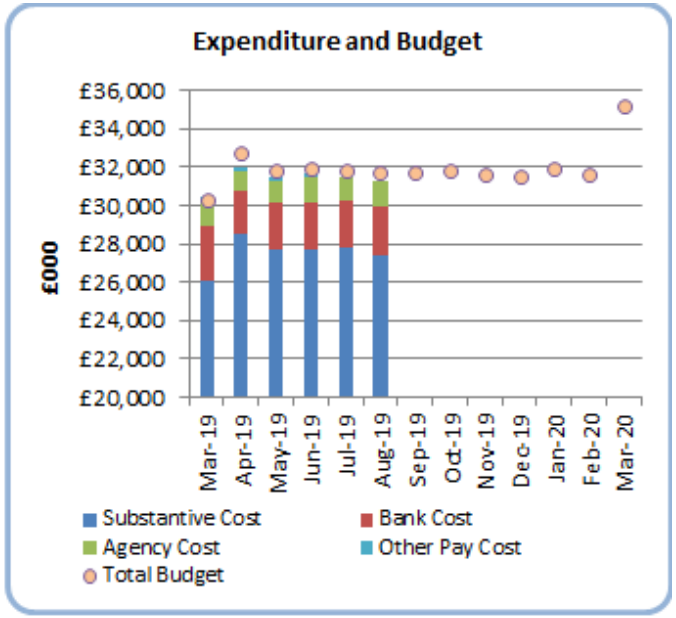
Deep clean numbers per week were in line with the previous month with an average of 270 carried out per week, 97% of which were above the key performance indicator for 4 hour breaches. Work is currently underway to identify the cause of such a high number of deep cleans being requested.

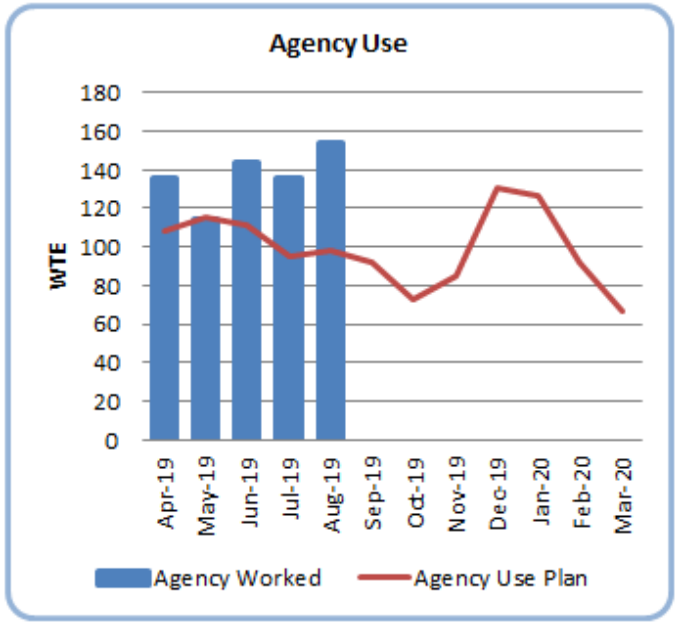
NHS North Bristol NHS Trust

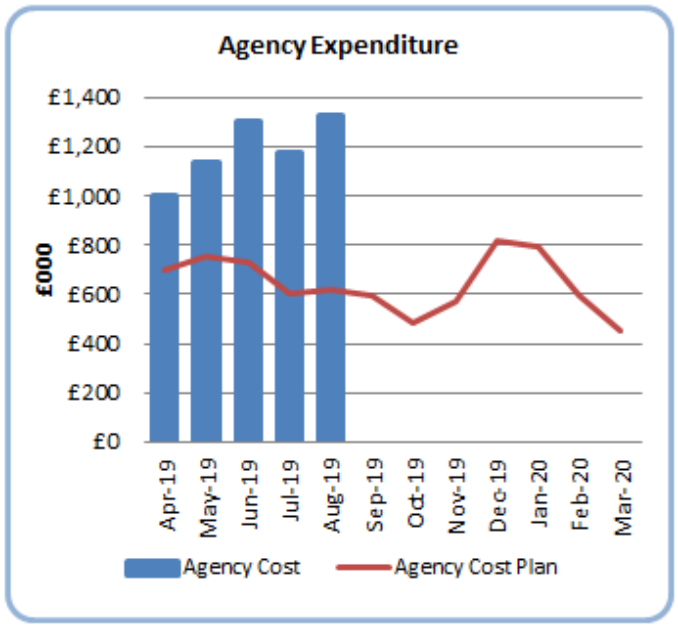
Well Led

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









Substantive

August expenditure is £363k below budget, £1.8m year to date due to current pay reserves. However some individual staff groups are above budget, predominantly medical and nursing and midwifery staff,due to ongoing agency use.

Worked wte is under funded by 220 wte across all staff groups, predominantly made up of 90 registered nursing and midwifery wte and 96 administration wte.

Temporary Staffing

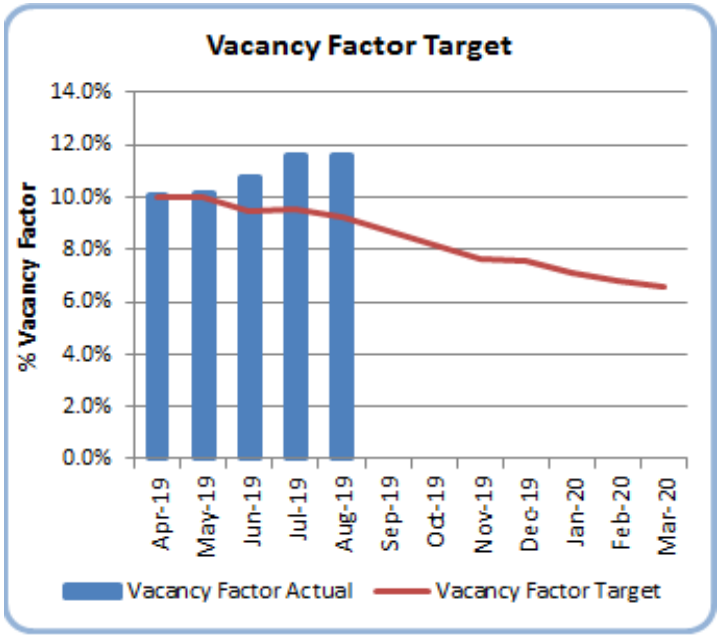
NBT Extra

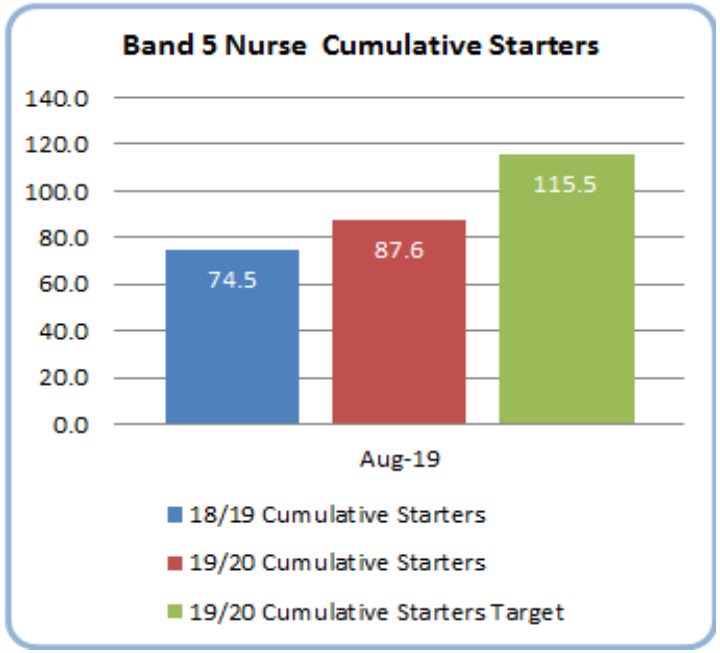
System wide nurse recruitment compliance standards are now in operation across the BNSSG for nursing agency staff to ensure consistency is achieved across the region and processing efficiency is improved. A review will be carried out to determine system approval for "Clear for one, clear for all" approach.

A bespoke recruitment campaign and drop in sessions with NBT eXtra managers commenced to increase bank numbers of both substantive and external workers, highlighting improvements in payment regularity and other available NBT benefits. As a result recruitment increased with 38 Nursing / Midwifery staff joining the bank in August.

Agency

Agency expenditure increased from last month and demand still remains high for registered nurses. The BNSSG Reduction in High Cost Agency Project formal "Go live" was on 2nd September with an increase in framework suppliers to support the work to minimise impact.





Unregistered Nursing and Midwifery Recruitment

A Band 2, 3 and 4 resourcing plan, identifying the continuous talent attraction initiatives scheduled between April 2019 – March 2020 is in place. In August the Trust had 21 new starters against a target of 18, and a further 35 offers were made. Additional recruitment and assessment activity is In discussion stage with divisions as part of overall winter planning.

Band 5 Nursing

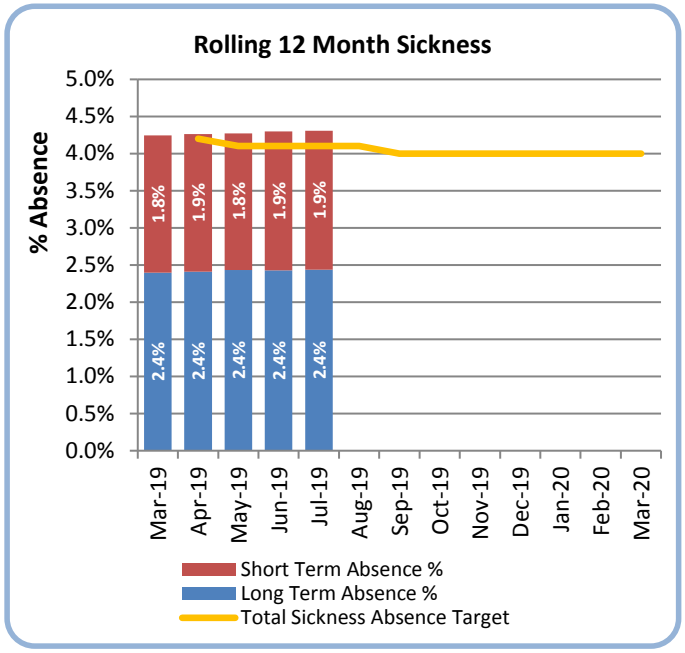
The Band 5 nursing vacancy positon in August is 301 wte (23%) across the five clinical divisions. There were 17 new starters in August which means year to date the Trust is 32 wte starters behind target. September and Octobers pipelines are forecast to correct this shortfall with current projections showing in excess of 145 starters against a target of 100.

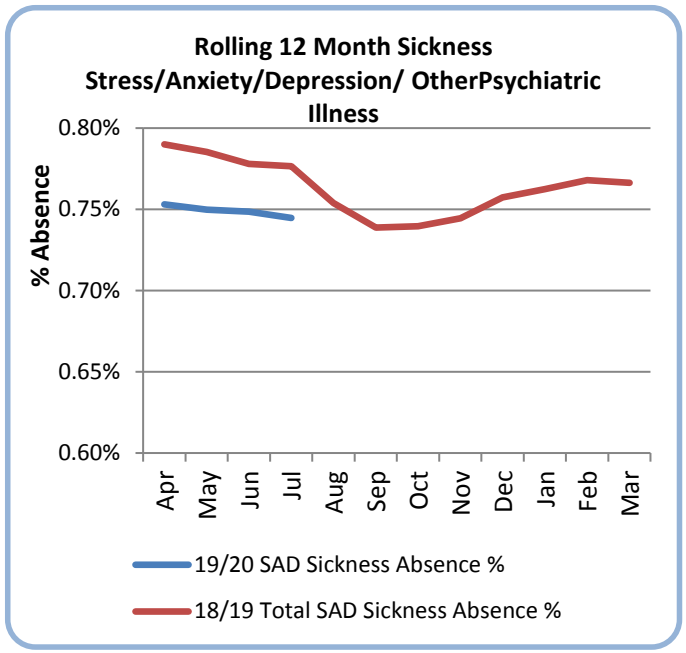
August is a quieter month seasonally and the resourcing plan delivered the following key external engagement events in August;

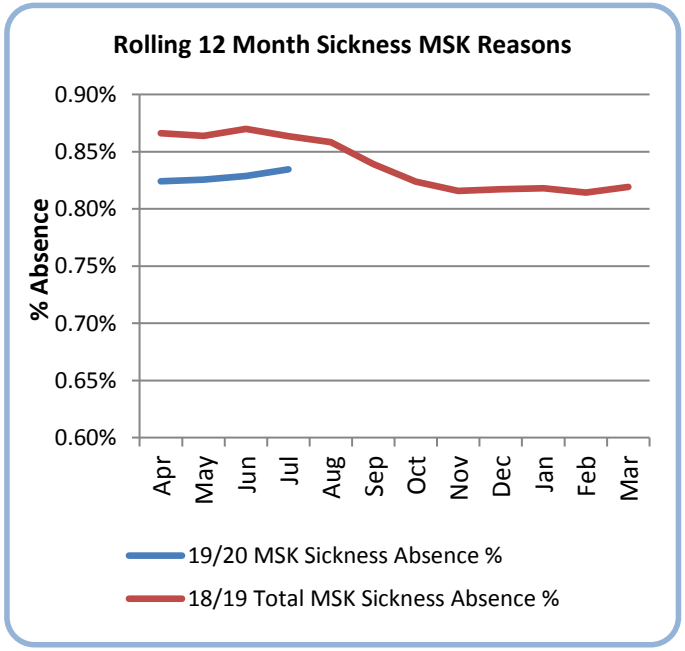
- Stroke CPD event
- 2 x NBT Extra Drop in sessions – to promote Bank opportunities.

Overseas Nurse and Midwife Recruitment

The International Nurse Recruitment project continues to deliver experienced, permanently employed nurses from the Yeovil pipeline and to date 23 nurses are now working in the Trust. Visa processing delays with the Home Office continue to create a lag in the anticipated timeframes, with final numbers anticipated to be 40 nurses from this pilot with Yeovil by the end of October 2019. Recommendations are being produced regarding further international recruitment. The OSCE and Pastoral Care team continue with high quality support and training. 8 Nurses have taken the OSCE exam to date, with 7 passes and one planned retake. (pass rate 87.5%)







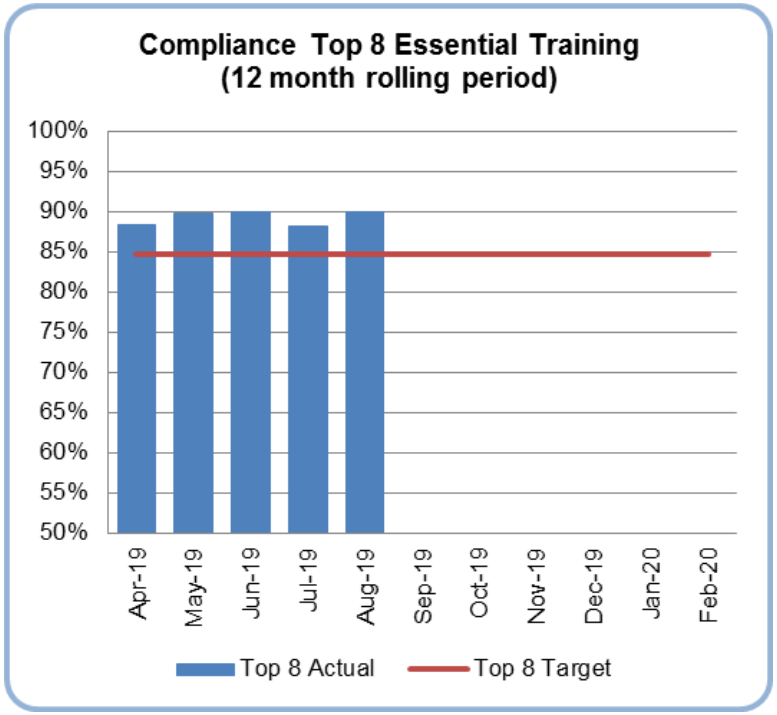
Sickness

Sickness absence has not changed from the previous months position with no significant shifts in any staff group.
We continue to remain slightly above the target absence level.

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.

Actions

- Following the agreed permanent funding of the wellbeing programme, the 2 wte temporary physios have been permanently appointed, which will allow more long term development of the service including preventative work.
- A business review of the occupational health service APOHS has taken place and recommendations made to ensure the long term financial sustainability and performance of the service.
- A business case for increased mental health support for consultants through the provision of a peer support network and dedicated psychologist support is being submitted to Trust Charity.



Division	No of Participants	% of allocated spaces
Medicine	63	92%
ASCR	65	71%
Core Clinical	41	14%
NMSK	41	56%
W&C's	27	77%
Facilities	13	295%
Corporate	63	163%
Total	313	89%

Training Topic	Variance	Jul-19	Aug-19
Child Protection	2.1%	87.4%	89.5%
Equality & Diversity	2.4%	88.5%	90.9%
Fire Safety	1.7%	87.6%	89.3%
Health &Safety	2.1%	90.7%	92.7%
Infection Control	0.3%	91.0%	91.3%
Information Governance	2.7%	83.2%	85.9%
Manual Handling	0.7%	89.7%	90.4%
Waste	1.3%	88.5%	89.7%
Total	**1.7%**	**88.3%**	**90.0%**

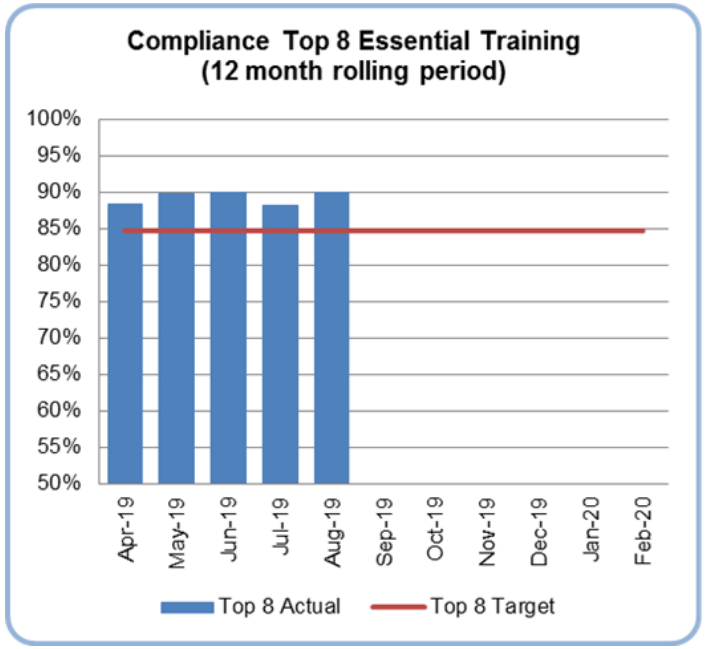
Top 8 Statutory / Mandatory Compliance:

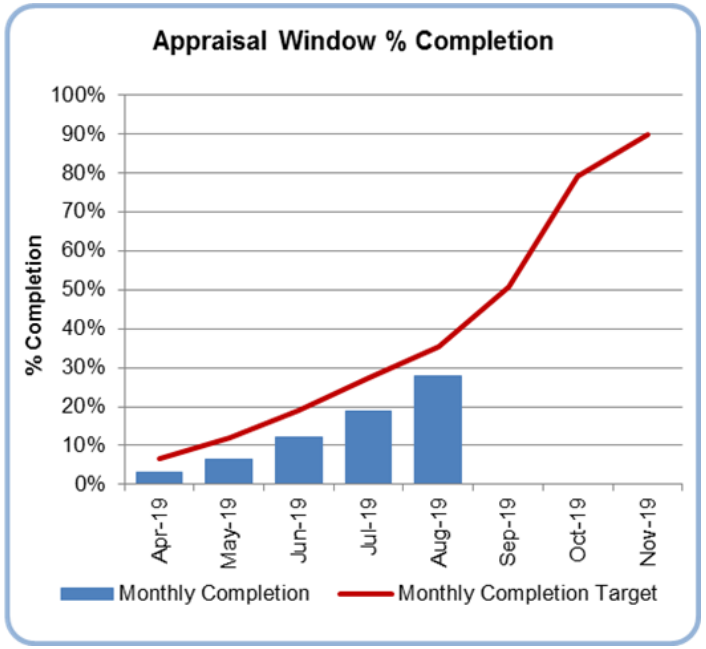
The Top 8 Statutory / Mandatory training compliance rate was 90%. eLearning completions continue to strongly contribute towards compliance, with some 69% of all Stat / Man training being completed by eLearning in August 2019.

Leadership Development

OneNBT programme:
The programme has seen a drop of three staff since last month. Of the 313 staff who have signed up to the programme, 254 have booked or attended sessions with 59 still to engage. The corporate leadership development team and divisional HR people partners are working with individuals and their managers to remind and support them to attend. Overall participants on the programme are at 89% of our target of 350 staff. Feedback continues to be positive for all modules, and the positive action modules for BME staff launched this month.

Apprenticeships and other programmes:
Alongside the OneNBT leadership programme, 21 staff are enrolled in the apprenticeship Leadership and Management Level 3 qualification. We have three staff due to start the Level 6 Chartered Manager Degree Apprenticeship with UWE in September and one staff member enrolling on the Level 7
– Senior Leader Masters Apprenticeship, starting in October. We continue to run the 2 day ILM level 2 course, which is particularly suitable for new managers.





Appraisal Completion

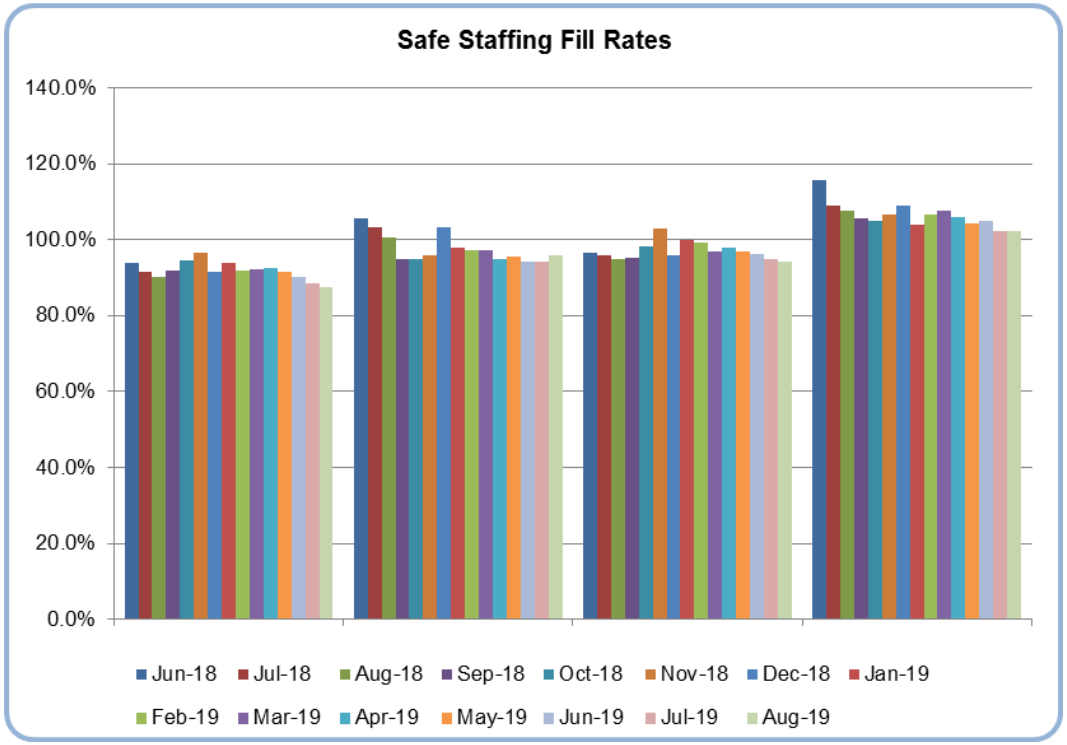
We are now into month 5 of the 2019 Appraisal window. Compliance continues to rise with the target population at 28% at the end of August 2019.

- Fortnightly progress checks in place with local line management/department follow ups in place
- Progress tracking against previous year appraisal delivery to ensure appraisals delivered in line with expectations / targets within appraisal window.
- Appraisal Delivery Plans in place where appropriate.

Appraisal Round Completion

Ethnic Origin	Apr-19	May-19	Jun-19	Jul-19	Aug-19
BAME	3.3%	8.1%	15.6%	20.6%	28.3%
White	3.4%	6.3%	11.3%	18.6%	27.6%
Undisclosed	0.0%	1.4%	10.5%	17.9%	32.5%

Gender	Apr-19	May-19	Jun-19	Jul-19	Aug-19
Female	3.1%	6.1%	11.5%	18.1%	27.2%
Male	3.9%	8.0%	13.9%	22.1%	29.7%



Aug-19	Day shift		Night Shift	
	RN/RM	CA Fill	RN/RM	CA Fill
Southmead	87.5%	96.0%	94.4%	102.2%

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

Wards below 80% fill rate are:

ICU: Care assistants 67.1% days and 63.8% Nights ICU is predominately staffed by Registered Nurses and the lower fill are of Care assistants was monitored by the Matron/Head of Nursing and supported by the Registered Nursing staff were required to support safe patient care.

MSS: RN Days 78% The fill rate is due to this being predominately an overnight surgical recovery ward where many patients leave in the morning, therefore staff are moved to support the rest of Medirooms, returning to support those who need an extended stay in the area in the evening.

8B: RN Days 75.2%Safe Staffing reviewed daily by Matrons and Head of Nursing. Nurse Associates and Assistant Practitioners supported SafeCare and staff deployed from other areas to support acuity and dependency across the Division where temporary staff were not available**.**

Gate 19: RN Days 58.9% nights 35.3% 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 included 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.

25B: RN days 79.7% Safe Staffing reviewed daily by Matrons and Head of Nursing. Nurse Associates and Assistant Practitioners supported safecare and staff deployed from other areas to support acuity and dependency across the Division where temporary staff were not available.

7A: RN days 76.6% Safe Staffing reviewed daily by Matrons and Head of Nursing. Nurse Associates and Assistant Practitioners supported safecare and staff deployed from other areas to support acuity and dependency across the Division where temporary staff were not available.

7B: RN Days Safe Staffing reviewed daily by Matrons and Head of Nursing. Nurse Associates and Assistant Practitioners supported SafeCare and staff deployed from other areas to support acuity and dependency across the Division where temporary staff were not available.

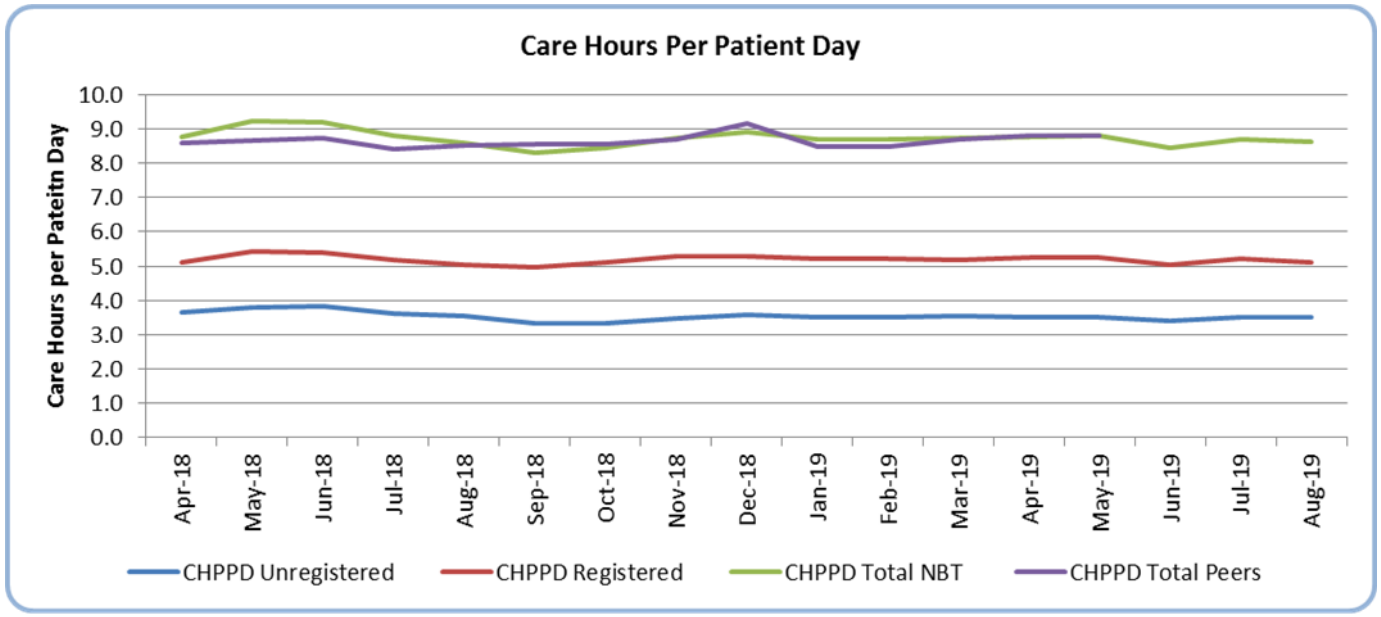
Quantock: 73.9% RM Days, 78.5% RM nights and 63.7% MCA nights. The unit has a high number of STS and LTS and working with HR to resolve this. Whilst staffing is challenged, the extended bed base has remained on Percy Philips, where there is a constant midwife presence to ensure patient safety.

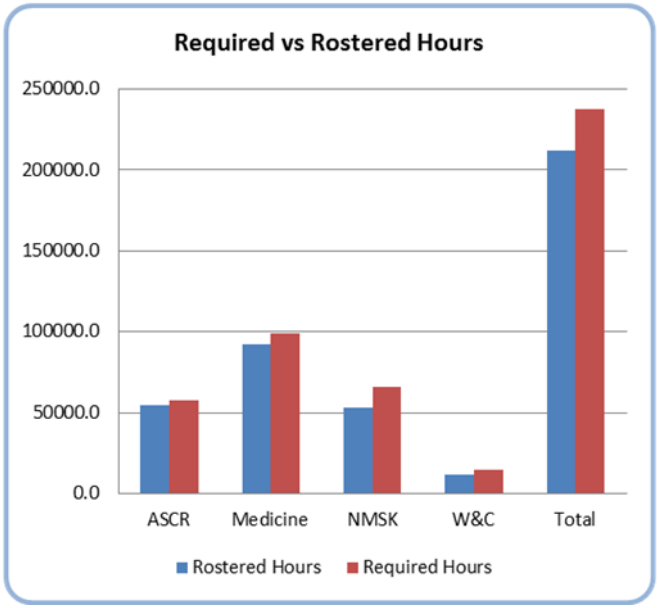
NICU: 72.7% MCA on nights. NICU have now fully recruited to MCA roles, however there are a few who remain supernumerary.

Cotswold: 78.7% RN Days

Ward over 175% fill rate:

No wards had fill rates over 175%.



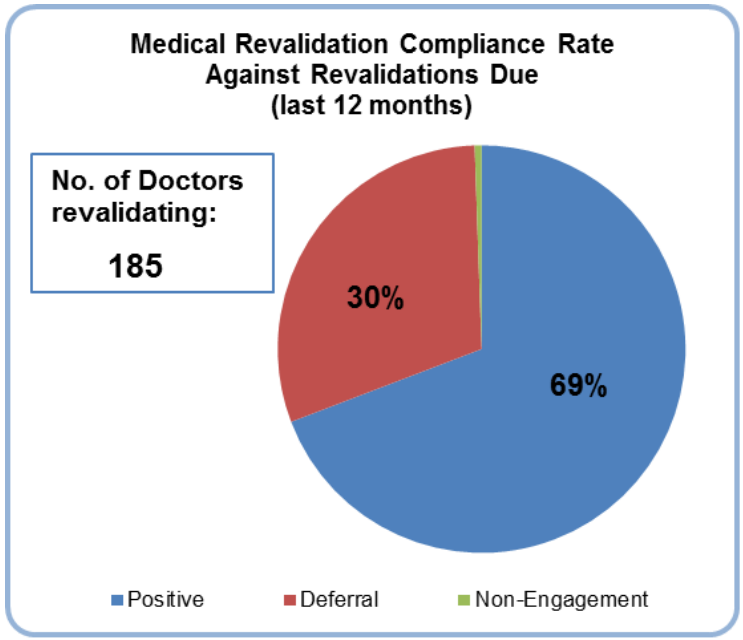


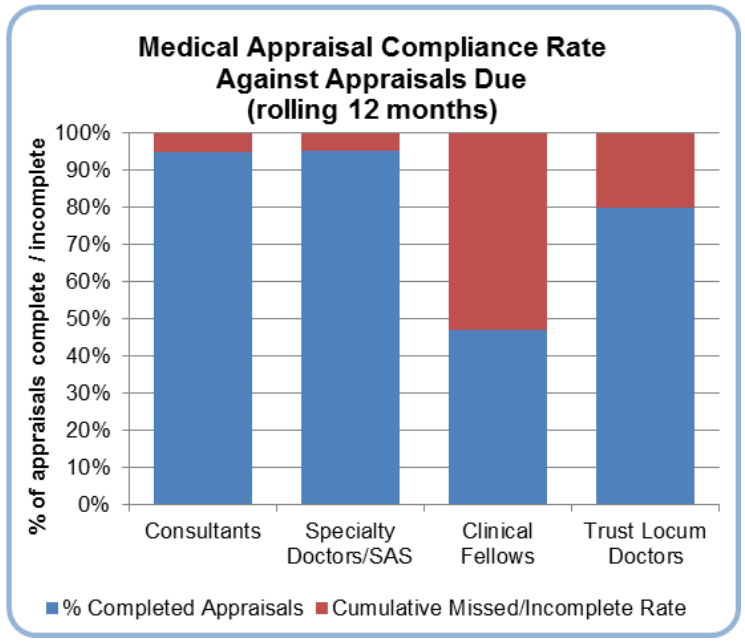
Care Hours per Patient Day (CHPPD)
The chart shows care hours per patient day for NBT total and split by registered and unregistered nursing and shows CHPPD for our Model Hospital peers (all data from Model Hospital. Peer values only available to Feb 2019).

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 (01 April 2019 - 31 March 2020), 81% of the appraisals that are due by now have been completed. Those with an overdue appraisal are being managed through the missed appraisal process.

Due to the August 2019 junior doctor rotation, there are a large number of clinical fellows who are new to the Trust and we do not yet know when their last appraisal took place. Once this information has been captured, appraisal compliance should rise further. If these individuals do not provide this information then an appraisal due date will be set for the doctor to ensure compliance.

The Trust has currently deferred 30% of all revalidation recommendations due over the past 12 months. From March 2019, the GMC has been collecting further information for the reasons of each deferral.

In June 2019 a non-engagement recommendation was made for a doctor who works abroad but holds an honorary contract with NBT. The individual was deferred in February 2019 and had made insufficient progress by June 2019. The GMC have approved the non-engagement recommendation and the Trust are awaiting to hear the outcome of this.

Appraisal compliance has dropped within the first quarter of the 2019/20 year due to the implementation of the new system in March 2019. NHS England were notified of this in advance and it is expected that this will be recovered in Quarter 2.

Finance

Board Sponsor: Director of Finance
Catherine Phillips

	Position as at 31 August 2019			
	Plan £m	Actual £m	Variance (Adverse) / Favourable £m	Forecast Outturn £m
Income				
Contract Income	221.1	217.5	(3.6)	529.9
Other Operating Income	35.1	33.5	(1.6)	77.4
Additional 2018/19 PSF bonus	0.0	0.7	0.7	0.7
Donations income for capital acquisitions	0.0	0.0	0.0	0.4
Total Income	**256.2**	**251.7**	**(4.5)**	**608.4**
Expenditure				
Pay	(160.1)	(158.3)	1.8	(384.4)
Non Pay	(77.4)	(74.9)	2.5	(181.0)
PFI Operating Costs	(2.7)	(2.6)	0.1	(6.2)
	(240.2)	**(235.8)**	**4.4**	**(571.6)**
Earnings before Interest & Depreciation	**16.0**	**15.9**	**(0.1)**	**36.8**
Depreciation & Amortisation	(9.9)	(10.5)	(0.6)	(24.7)
PFI Interest	(14.2)	(14.2)	0.0	(34.2)
Interest receivable	0.0	0.0	0.0	0.1
Interest payable	(2.2)	(2.1)	0.1	(5.2)
PDC Dividend	0.0	0.0	0.0	0.0
Other Financing costs	0.0	0.0	0.0	0.0
Impairment	0.0	0.0	0.0	0.0
Gains / (Losses) on Disposal	0.0	0.0	0.0	(2.1)
Operational Retained Surplus / (Deficit)	**(10.3)**	**(10.9)**	**(0.6)**	**(29.3)**
Add back items excluded for NHS accountability				
Donations income for capital acquisitions	0.0	0.0	0.0	(0.4)
Depreciation of donated assets	0.0	0.3	0.3	0.7
Additional 2018/19 PSF bonus	0.0	(0.7)	(0.7)	(0.7)
Impairment	0.0	0.0	0.0	0.0
Adjusted surplus /(deficit) for NHS accountability (excl PSF)	**(10.3)**	**(11.3)**	**(1.0)**	**(29.7)**
PSF / FRF / MRET (includes additional 2018/19 PSF bonus)	7.1	7.1	0.0	25.0
Adjusted surplus /(deficit) for NHS accountability (incl PSF)	**(3.2)**	**(4.2)**	**(1.0)**	**(4.7)**

Statement of Comprehensive Income

Assurances

The financial position at the end of August shows a deficit of £4.2m, £1m adverse to the planned deficit.

Key Issues

- Contract income is £3.6m adverse to plan largely due to under-performance in elective inpatient and non-elective activity.
- Other operating income is £1.6m adverse to plan due a number of factors including unachieved CIP which is likely to recover.
- Pay is £1.8m favourable to plan reflecting substantive vacancies offset in part by temporary staffing.
- Non pay is £2.5m favourable to plan mainly in clinical supplies and drugs.
- The savings shortfall at August was £2.4m, the impact of which has been offset by a number of one-off benefits.
- Under-recovery of income and under achievement of savings represents a risk to the delivery of the Trust's control total and the current forecast indicates a potential adverse variance against the control total (excl PSF) of £9.1m. However, the Trust has identified a series of mitigating actions and with these is forecasting to achieve the control total of a £5.4m deficit.

31 March 2019 £m	Statement of Financial Position as at 31st August 2019	Plan £m	Actual £m	Variance above / (below) plan £m
	Non Current Assets			
558.1	Property, Plant and Equipment	555.9	553.6	(2.3)
17.0	Intangible Assets	15.8	13.1	(2.7)
8.5	Non-current receivables	8.5	8.5	0.0
583.6	**Total non-current assets**	**580.3**	**575.3**	**(5.0)**
	Current Assets			
12.8	Inventories	11.2	12.5	1.2
35.5	Trade and other receivables NHS	49.4	23.7	(25.8)
37.1	Trade and other receivables Non-NHS	23.1	36.8	13.7
10.2	Cash and Cash equivalents	8.0	22.7	14.7
95.7	**Total current assets**	**91.7**	**95.6**	**3.8**
0.0	Non-current assets held for sale	0.0	0.0	0.0
679.3	**Total assets**	**672.0**	**670.9**	**(1.1)**
	Current Liabilities (< 1 Year)			
9.4	Trade and Other payables - NHS	9.4	8.5	(0.9)
64.8	Trade and Other payables - Non-NHS	63.7	67.9	4.2
70.8	Borrowings	70.1	64.7	(5.4)
145.0	**Total current liabilities**	**143.2**	**141.2**	**(2.1)**
(49.3)	**Net current assets/(liabilities)**	**(51.5)**	**(45.6)**	**5.9**
534.3	**Total assets less current liabilites**	**528.8**	**529.7**	**(1.0)**
7.8	Trade payables and deferred income	7.6	7.7	0.0
517.8	Borrowings	515.6	517.1	1.5
8.7	**Total Net Assets**	**5.5**	**5.0**	**(0.5)**
	Capital and Reserves			
243.9	Public Dividend Capital	243.9	243.9	0.0
(375.2)	Income and expenditure reserve	(381.6)	(381.6)	0.0
(6.4)	Income and expenditure account - current year	(3.2)	(3.8)	(0.5)
146.5	Revaluation reserve	146.5	146.5	0.0
8.7	**Total Capital and Reserves**	**5.5**	**5.0**	**(0.5)**

Statement of Financial Position

Assurances

The Trust has received net new loan financing for the year to date of £1.6m. This brings total borrowing from the Department of Health and Social Care to £179.8m.

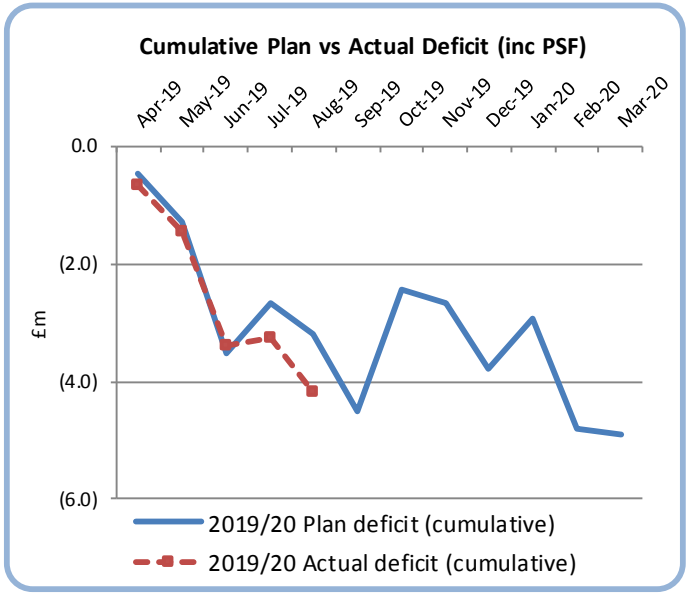
The Trust ended the month with a cash balance of £22.7m, compared with a plan of £8.0m. This higher balance is due to the receipt from NHS England of £10.1m activity related over-performance monies relating to 2018/19.

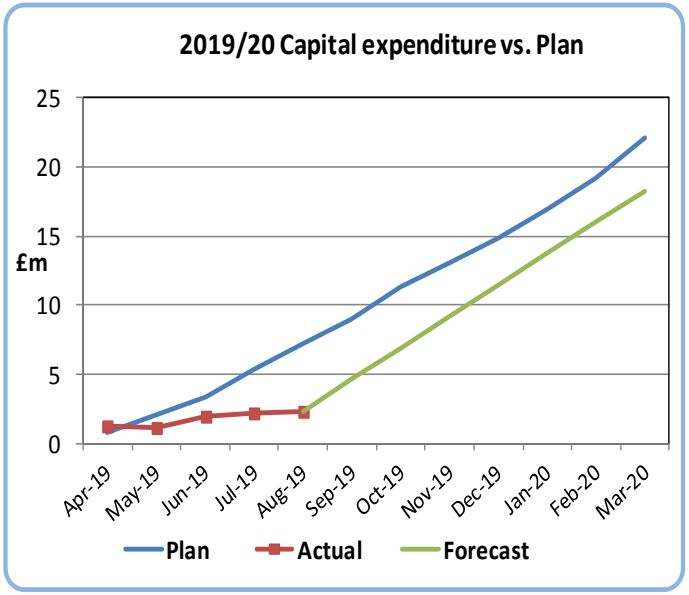
Concerns & Gaps

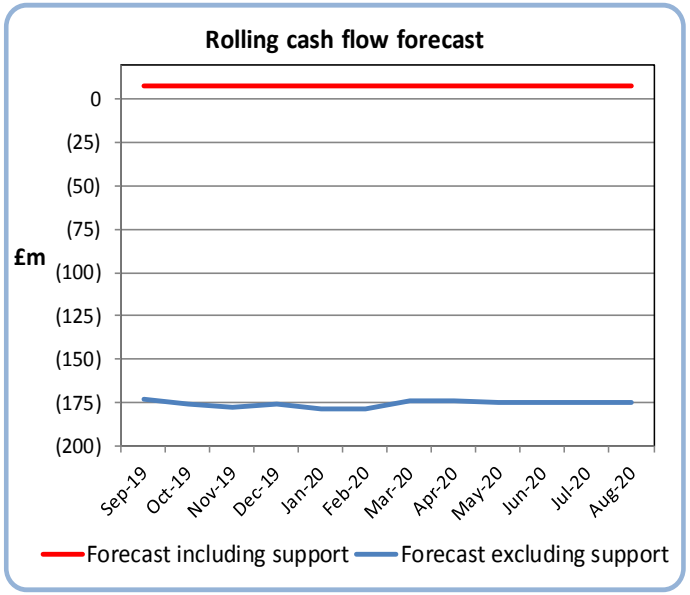
The level of payables is reflected in the Better Payment Practice Code (BPPC) performance for the year which is 69% by volume of payments made within 30 days against the target of 95%.

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 £4.2m deficit, £1m adverse to plan.

The capital expenditure for the year to date is £2.2m. The 2019/20 forecast was reduced to £18.3m as part of the national exercise to reduce capital expenditure by 20%. This is now being reviewed in the light of recent changes in the guidance from NHS Improvement.

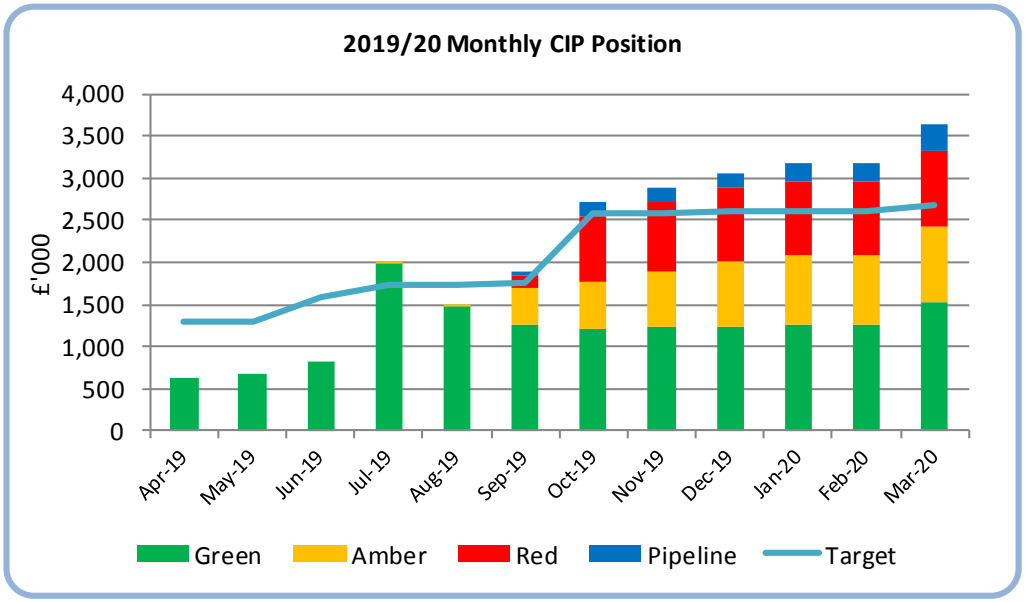
Assurances and Actions

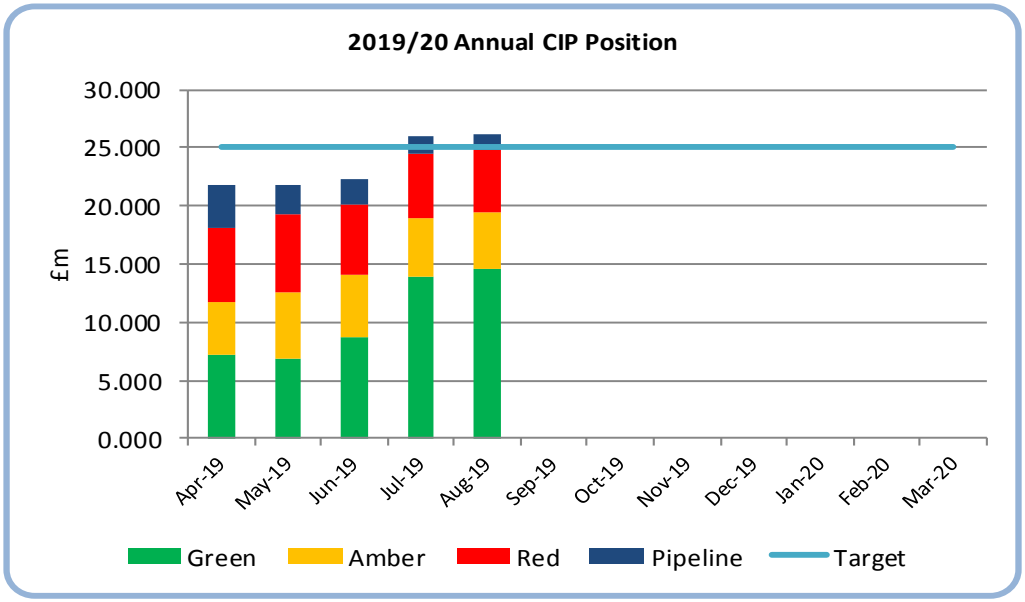
- Ongoing monitoring of capital expenditure with project leads.

- 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 £26.2m has been identified as at the end of August.

Concerns & Gaps

The graph shows the phased forecast in-year delivery of the £26.2m identified schemes. £19.6m of these are rated as green or amber.

Savings delivery is £5.2m as at the end of August, £2.4m adverse against a plan of £7.6m.

Of the £26.2m identified savings in 2019/20, £18.5m is recurrent with a full year effect of £23.7m.

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

CQC reports history (all sites)

Location	Standards Met	Report date
Overall	Requires Improvement	Mar-18
Child and adolescent mental health wards (Riverside) *	Good	Feb-15
Specialist community mental health services for children and young people *	Requires Improvement	Apr-16
Community health services for children, young people and families *	Outstanding	Feb-15
Southmead Hospital	Requires Improvement	Mar-18
Cossham Hospital	Good	Feb-15
Frenchay Hospital	Requires Improvement	Feb-15

* These services are no longer provided by NBT.

Monitor Provider Licence Compliance Statements at August 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. Updated DBS checks for directors are underway.
G5	Having regard to monitor Guidance	Yes	The Trust Board has regard to Monitor/NHSI guidance where this is applicable.
G7	Registration with the Care Quality Commission	Yes	CQC registration is in place. The Trust received a rating of Requires Improvement from its inspection in November 2014, December 2015 and November 2017. A number of compliance actions were identified, which are being addressed through an action Plan. The Trust Board receives regular updates on the progress of the action plan through the IPR.
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. The Finance & Performance Committee is scheduled to review and test these controls and assurances in 2019.
P2	Provision of information	Yes	The Trust provides information to NHS Improvement as required.
P3	Assurance report on submissions to Monitor	Yes	Assurance reports not as yet required by Monitor/NHSI since NBT is not yet a FT. However, once applicable this will be ensured. Scrutiny and oversight of assurance reports will be provided by Trust's Audit Committee as currently for reports of this nature.
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 August 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 NHSI'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 board is reviewing a number of the organisations' performance improvement trajectories to test whether the plans in place are sufficient to ensure ongoing compliance with all existing targets (after the application of thresholds) and improvement trajectories. Revised plans and trajectories may be agreed as appropriate.	Under review
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 evidence submitted by the Trust and the 2019 internal audit results indicates that the Trust is at a level 2 equivalent in relation to the requirements of the Data Security and Protection Toolkit.	Yes
5	The board will ensure that the Trust remains at all times compliant with regard to the NHS Constitution, noting that key constitutional performance targets are not currently being met; however improvement plans are in place.	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

North Bristol NHS Trust

Report To:	Trust Board Meeting		**Agenda Item:**	17.
Date of Meeting:	26th September 2019			
Report Title:	Finance and Performance Committee Report			
Report Author & Job Title	Mark Pender, Deputy Trust Secretary			
Executive/Non-executive Sponsor (presenting)	John Everitt, Chair of Finance and Performance Committee, 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 Finance and Performance Committee.			
Next Steps:	The next report to Trust Board will be to the November 2019 meeting.			

Executive Summary
The report provides highlights of the issues discussed and the outcomes reached at the Finance and Performance Committee Meeting held on 22nd August 2019 as well as items for escalation to Trust Board.

Strategic Theme/Corporate Objective Links	Reports received supported the delivery of the following strategic themes and corporate objectives: **Change how we deliver services to generate affordable capacity to meet the demands of the future:** • Deliver the financial plan to achieve an improved year end deficit of £18.4m. • Improve the flow of patients through the hospital by ensuring a maximum bed occupancy of 95%. **Be one of the safest trusts in the UK:** • Maintain safe access to services: improve access to emergency care, maintain delivery of the national cancer standard, ensure there are no 52-week breaches and no increases in the overall waiting list for elective care. • Achieve an overall CQC rating of 'Good'.
Board Assurance Framework/Trust Risk Register Links	Reports received at the meeting support the mitigation of the following BAF risks: • SIR1 Internal Flow – risk score 5 x 5 = 25. • SIR11 Productivity – risk score 5 x 3 = 15. • SER 1 Growth - 5 x 5 = 25.
Other Standard Reference	Links to key lines of enquiry within the CQC regulatory framework.
Financial implications	Business cases approved by the Committee are within the delegated limits as set out in the Trust's Standing Financial Instructions and Scheme of Delegation.
Other Resource Implications	No other resource implications associated with this report.
Legal Implications including Equality, Diversity and Inclusion Assessment	None identified.

Appendices:	None.

1. Purpose

To provide a highlight of the key assurances, escalations to the Board and identification of any new risks from the Finance and Performance Committee meeting held on the 22nd August 2019.

2. Background

The Finance and Performance 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 that there are robust and integrated systems in place overseeing the Trust's financed and performance and that they are in line with the organisation's objectives.

3. Key Assurances Received

3.1 The operational performance figures for July were considered. In respect of 52 week waits, the Committee was assured that by October / November 52 week breaches would not occur unless this was due to patient choice or a late referral from UHBristol. In respect of 62 day performance, it was agreed that the Board should be informed when the backlog in Urology has been cleared.

3.2 The Committee undertook a deep dive into Diagnostics, and details of the recovery plans in place were provided. The Committee was assured that a recovery plan was in place and was broadly satisfied that these would deliver the required improvements. There was a good understanding within the Trust of past problems, and appropriate action was being taken. It was noted that the performance in endoscopy would only be achieved if the SLA was successfully renegotiated with the CCG. The Committee was also assured that there was an appropriate route to report updates / concerns if required. It was suggested that the longer term strategy for Diagnostics for the periods to 2025 needed to be picked up in the wider Trust strategy and LTFM.

3.3 The Month 4 Finance Report was received. The Committee was assured that there was a path to the delivery of the control total. However, the Committee was concerned that there were insufficient mitigating actions to provide contingency to give confidence that the control total could definitely be delivered. It was requested that the detailed forecast be discussed further at the October meeting to provide this assurance, with confirmation of actions to close any gap; proposals for further contingency actions; and clear information with respect to the service/patient impact of all actions.

3.4 The Committee received an update on the Cost Improvement Programme and welcomed the greater level of assurance provided that the plan would be delivered. It was felt that acceleration in the long term planning process would be helpful going forward, and it was requested that the position with respect to this year's and next year's CIP together with an update on progress with the integrated transformation plan be brought to the October meeting of the Committee.

3.5 The Committee approved the Strategic Outline Case (SOC) for the Theatre 2020 Efficiency Plan. The Committee approved the SOC subject to a number of caveats.

4. Identification of New Risk

4.1 No new risks were identified in the meeting.

5. Recommendations

5.1 The Board is recommended to receive and note the report for assurance.

North Bristol NHS Trust

Report To:	Trust Board		**Agenda Item:**	18.
Date of Meeting:	Thursday 26th September			
Report Title:	Sustainable Development Management Plan 2019-20 (SDMP)			
Report Author & Job Title	Tanya Saker, Environmental Management System Coordinator			
Executive/Non-executive Sponsor (presenting)	Simon Wood, Director of Estates, Facilities and Capital Planning			
Purpose:	**Approval/Decision**	**Review**	**To Receive for Assurance**	**To Receive for Information**
	x			
Recommendation:	• Trust Board is asked to approve the draft annual Sustainable Development Management Plan (SDMP)			
Report History:	• Trust Management Team • NBT Sustainable Development Steering Group			
Next Steps:	• The SDMP will be published online			

Executive Summary

The SDMP reports progress on NBT's aspiration to be a leader in the field of sustainable healthcare and sets out plans for the year ahead. This plan replaces the SDMP 2018/19.

NBT is assessed on progress towards sustainable development by;

- **The Care Quality Commission** within the "Use of Resources" and "Well Led" reviews
- **The Clinical Commissioning Group** within the requirements of the NHS Standard Contract
- **NHS England** within the new requirements of the NHS Long Term Plan which focus on carbon reduction and emissions from NHS fleet vehicles.
- **National Sustainable Development Assessment Tool (SDAT)** for which NBT has achieved 58% (increased from 39% last year)

Highlights from 2018/19 include; reviewing and updating our sustainable development policy, undertaking an energy review of the PFI, ensuring sustainability is incorporated in the Trust business planning process; refreshed the Trust's Travel Plan; prepared a Biodiversity Management Plan; developed multiple sustainable models of care and launched our successful staff engagement scheme, Green Impact for the 4th year.

Plans for 2019/20 include; adopting the BNSSG climate change adaptation plan, embed sustainable development within the Trust's revised strategy, deliver year one of the NBT Travel Plan and finalise our pathway to wellbeing programme, including the installation of the staff and patient green gym and

allotment. Please see the SDMP at appendix 1.	
Strategic Theme/Corporate Objective Links	• Change how we deliver services to generate affordable capacity to meet the demands of the future • Play our part in delivering a successful health and care system • Create an exceptional workforce for the future • Be one of the safest trusts in the UK
Board Assurance Framework/Trust Risk Register Links	• Risk of non-compliance with the NHS Standard Contract which requires a Trust Board approved Sustainable Development Management Plan (SDMP).
Other Standard Reference	• Compliance with NHS Long Term Plan (2019-2029) • Compliance with the National Sustainability Strategy (2014-2020) • Compliance with the National Climate Change Adaptation Programme (2018-2023) • Compliance with Health Technical Memoranda 00-07 • Compliance with NHSI guidance on SDMP reporting (2018)
Financial implications	• Costs associated with the delivery of the SDMP will be addressed within separate business cases going forward. • Potential penalties for noncompliance with NHS Standard Contract
Other Resource Implications	• The Sustainable Development Unit is resourced to manage the delivery of the SDMP • Additional resources required for specific work programmes within the SDMP will be addressed within separate business cases going forward
Legal Implications including Equality, Diversity and Inclusion Assessment	• Compliance with legal obligations which include but are not limited to; Climate Change Act (2008), Environmental Protection Act (1990), Civil Contingencies Act (2004) and Public Services (Social value) Act 2012. • The SDMP has been prepared in consultation with the Sustainable Development Steering Group which includes a wide range of stakeholders (staff, contractors, specialist advisors, stakeholders, trade unions and local community interest groups). • The SDMP supports better health outcomes (for patients and staff) and improved patient access and experience through various work streams and individual projects outlined within the SDMP.

Appendices:	• Sustainable Development Management Plan 2019-20 (SDMP) report

NHS
North Bristol
NHS Trust

DRAFT

Sustainable Development Management Plan

2019-2020

Foreword

There is no question that sustainability is one of the most important challenges facing us all in the 21st century and it is one that unites our staff, our patients and our communities.

North Bristol NHS Trust believes it has a responsibility to find ways to deliver great healthcare that is also environmentally, socially and financially sustainable.

In 2018/19 we have continued to make good progress on many things that will contribute significantly to a sustainable footprint.

We are playing our part in the Bristol One City Plan which has committed to making the city carbon neutral by 2030 and have our own sustainable travel plans which will support staff and patients. Our land surrounding the Southmead site is managed in a way that actively supports biodiversity and we have plans to increase this further.

Inside the hospital we are reducing single use plastics everywhere from theatres to the coffee shops and even finding ways to reduce the use of volatile gases in surgery. Our wheelchair recycling project and re-use initiatives such as Warp-it help us to recycle furniture and later this year we will finalise our staff and patient allotments and our green gym.

We are proud that our staff have joined us so wholeheartedly on our “sustainability journey”. Each day we see them inspired to take simple actions to reduce our impact on the planet.

There is still much to do such as changes to purchasing and supply chains but sustainability is at the heart of the NBT Strategy and we are proud to be able to make a public commitment to do everything we can to contribute to a sustainable future.

Andrea Young
Chief Executive

Michele Romaine
Trust Chair

NHS North Bristol NHS Trust

Contents

1. Introduction

North Bristol NHS Trust is a centre of excellence for health care in the South West. We have more than 8000 members of staff committed to treating our patients with respect and dignity and, most importantly of all, as a person.

We aim to deliver excellent clinical outcomes and a great experience for everyone who uses our services. Our vision is to be the provider of choice for patients needing our specialist care, delivering innovative services with excellent clinical outcomes.

In order to achieve our vision, we rely on the availability of natural resources such as energy, food and water alongside other man made products such as pharmaceuticals, anaesthetic gases and medical equipment, all of which contribute to our carbon footprint.

Our carbon emissions contribute to increased levels in the atmosphere and changes in our climate. These climatic changes are predicted to bring about health conditions such as increased heat and cold related illness and deaths, incidences of skin cancers and sun burn and increase the health impacts of respiratory disease from poor air quality and aero-allergens.

Other health related impacts of our changing climate could include an increase in mental health issues as a result of local social impacts and changes in water and vector borne diseases are also expected. These health impacts of climate change will increase the demand on our services, and the need for further natural resources to treat our patients.

The NHS therefore plays a significant role in both mitigating and adapting to our changing climate. By seeking to reduce our reliance on fossil fuels and our consumption of finite natural resources we can both reduce our impact on the environment and protect patient health in the long term.

The recently published NHS Long Term Plan recognises this critical relationship between the use of resources and our health, particularly in relation to vehicle emissions and the health impacts associated with poor air quality.

This recognition by NHS England, along with increased public awareness and expectations around single use plastics has placed sustainable healthcare firmly on the agenda.

Here at NBT, we have committed to reduce our impact on the environment and embed sustainable development across our sites and services to ensure we are a resilient service fit for the future.

NHS North Bristol NHS Trust

44,396kWh
solar energy generated onsite

16,163 electric vehicle miles

Saved **£11,000** and recycled **74 tonnes** through our wheelchair recycling project

2018-2019 at a glance….

We removed 60% of plastic drink bottles from our shelves

57%
NBTstaff travel to work sustainably

Twitter engagements @NBTSustHealth

We reduced our carbon footprint from electricity and gas by 3,536 tonnes during 2018-19

£33,217
Saved through our Green Impact teams

£43,000
Saved through our furniture re-use scheme Warp-It

133
Trees, plants and shrubs planted onsite

Exceptional healthcare, personally delivered

2. Drivers for change

Sustainable healthcare in the NHS is predominantly driven through local and national policy, legislative and mandated requirements and healthcare specific specifications from the Department of Health and NHS England.

The delivery of sustainable healthcare is also a contractual obligation through the NHS Standard Contract (2019-20) which requires Trusts to manage their resources sustainably and have a Trust Board approved Sustainable Development Management Plan (SDMP).

During 2018/2019, there were some significant step changes in sustainable development drivers, at both a local and national level.

- The National Adaptation Programme (2018) outlines key requirements and associated actions for the NHS to ensure climate change adaptation and mitigation measures are addressed.

- The NHS Long Term Plan (2019-2029) set out key expectations regarding carbon emissions, energy efficiency, vehicle exhaust emissions and the use of single use plastics within the supply chain. The Long Term Plan commits to the carbon targets set out in the UK government Climate Change Act (2008) to reduce emissions (on a 1990 baseline) by:

    - 34% by 2020
    - 51% by 2025

    This work will include projects to reduce the carbon footprint of inhalers and anaesthetics.

    The NHS also committed to improve air quality by:

    - Cutting business mileage by 20% by 2023/24
    - Ensuring that at least 90% of the NHS fleet uses low-emissions engines (including 25% ultra-low emissions) by 2028

- In June 2019 the UK Government committed to reduce its greenhouse gas emissions to net zero by 2050 under the terms of a new government plan to tackle climate change. The Government's announcement stated cutting emissions would benefit public health and cut NHS costs.

- More locally, the Bristol One City Plan (2019-2050) spans a collective of organisations with shared goals across the city led by Bristol City Council alongside our local universities, police, NHS, business community, voluntary sector, unions and faith groups. The plan aspires to deliver a sustainable city, with a low impact on our planet and a healthy environment for all by 2050. The plan sets out a series of objectives across the backdrop of the United Nations Global Goals for Sustainable Development with key commitments for Bristol which include carbon neutral status by 2030.

- Public awareness and staff expectation has never been so high following national campaigns and publicity on action against plastic. The response to plastic pollution has brought about a real step change in behavior by many, enabling and inspiring people to make meaningful choices around their use of plastic. This behavior change is reflective of staff and patient expectation at NBT, with much greater interest around what the Trust is doing with plastics.

3. Our Vision

Our Sustainable Development Policy sets out our aspiration to be a leader in the field of sustainable healthcare through committed leadership, innovation, culture change and system wide engagement and development.

We are committed to embedding sustainable development across our sites and services as laid out within our recently updated Sustainable Development Policy.

We will deliver our Sustainable Development Policy commitments through our SDMP by;

- Maximising the environmental, financial and health opportunities associated with sustainable development and the co-benefits to our staff, patients and the local community.
- Valuing the importance of protecting our natural environment for the benefit of the physical and mental health and well-being of our community, now and in the future.
- Striving to improve staff and patient experience by moving towards more sustainable models of care and workplace practices.

North Bristol NHS Trust

4. Governance

Our Sustainable Development Management Plan (SDMP) is approved by Trust Board on an annual basis, with a six monthly progress report submitted half way through the year.

Sustainable development is championed by the Trust's Chair Michele Romaine and the Director of Estates, Facilities and Capital Planning, Simon Wood.

Simon Wood chairs the sustainable development steering group which meets quarterly. The steering group consists of our Trust Chair, specialist Public Health Advisers, Senior Management, our PFI partner and representatives from the local community and Trade Unions.

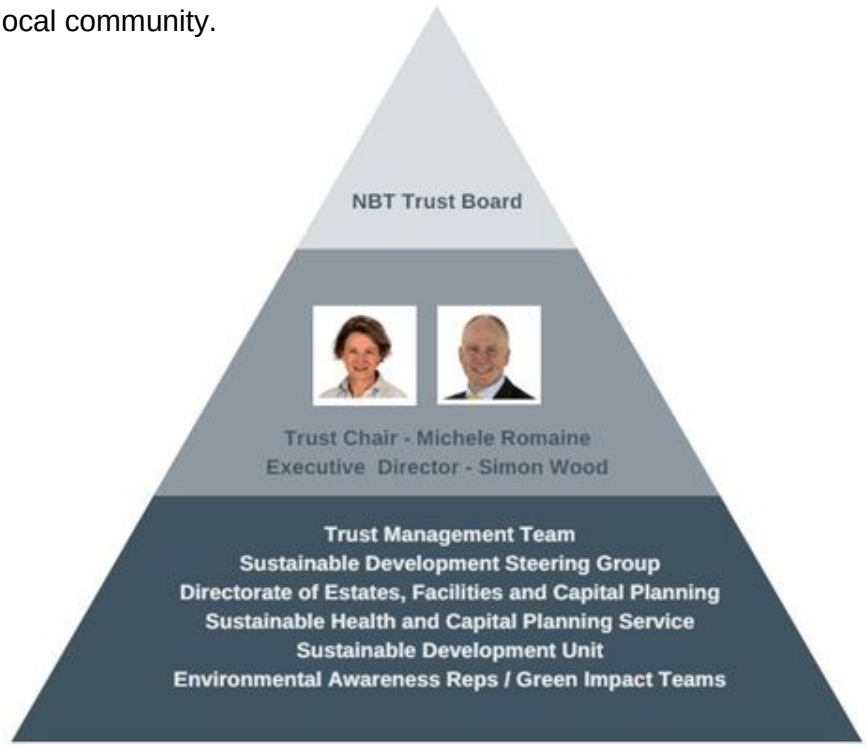
The group drives forward the sustainable development agenda at the Trust by setting objectives, reviewing progress and delivering assurance on a regular basis. The group promotes collaborative working with external partners to bring external benefits to the trust and support the local community.

The Sustainable Development Unit (SDU) is a small team of specialists providing advice and support across the Trust to assist in the delivery of sustainable development.

The SDU sits within the Sustainable Health and Capital Planning (SHCP) Service within the Facilities Division.

To further support the delivery of the policy commitments, the Trust has an active network of Environmental Awareness Reps (EARs) and Green Impact teams spread throughout the organisation to raise awareness, engage and enthuse the wider workforce.

NBT is also a member of the Bristol, North Somerset and South Gloucestershire Sustainability Transformation Partnership (STP) “Healthier Together”, along with other major health and care providers in the region. The STP has developed a Climate Change and Sustainability work stream into which all organisations are expected to contribute.



5. Communications and Engagement

Our vision to be a leader in the field of sustainable healthcare requires system-wide engagement and development through simple and effective communication.

We communicate with our stakeholders using various channels and means to get our messages out to our staff, patients and wider community, notably through our website and social media outlets, annual reports and numerous, innovative engagement events and opportunities throughout the year.

Engagement Activities 2018/9

- Staff insect hotel building (Jun 2018)
- NHS Sustainable Health and Care Week (June 2018)
- Clean Air Day (June 2018)
- 30 Days Wild (June 18)
- Southmead Festival (July 2018)
- Cycle to workday (Aug 2018)
- Southmead Hospital Lavender Project events (June – Dec 2018)
- Apple pressing in partnership with The National Trust (Oct 18)
- SDMP Launch event October 2018
- MOVEmber (Nov 18)
- NBT Sustainable Healthcare Twitter account launch (Nov 18)
- Green Impact Awards (Dec 2018)
- Travel Plan consultation (Dec 18)
- Sustainable Development Policy consultation (Jan 18)
- Urban Buzz Wildflower planting with volunteers (Jan 19)
- Travel to Work Survey (Mar 2019)
- NHS Sustainability Day (Mar 2019)
- Community Farm weekly fruit and veg stall
- 11 monthly SDUpdate e-newsletters
- 100 staff lunchtime walks
- 86 Tweets
- 79,600 Tweet engagements

6. Sustainable Development Assessment Tool (SDAT)

The Sustainable Development Assessment Tool (SDAT) is the national bench mark used by Public Health England and NHS England to measure improvement across the health and care system.

The assessment determines progress against the implementation and delivery of sustainable development across the health and care system and is aligned to the UN Sustainable Development Goals.

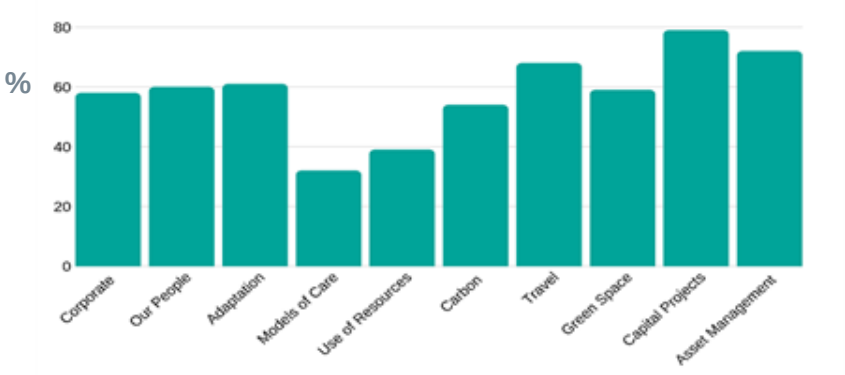
The SDAT is designed to help the NHS and other healthcare organisations understand their work, measure progress and create the focus of and action plans for their sustainable development management plans (SDMP). Each benchmark undertaken reports how the Trust is contributing to the 17 UN Sustainable Development Goals.

SDAT consists of ten areas which are assessed against four cross-cutting themes; governance and policy, core responsibilities, procurement and supply chain and working with staff. During 2018/19, North Bristol NHS Trust achieved an overall score of 58%, which is a 49% improvement from 2017/18.

United Nations Sustainable Development Goals

The 17 Sustainable Development Goals (SDGs) were adopted by all United Nations Members States in 2015 and represent an urgent call for action by all countries in a global partnership. The SDAT measures progress against the SDG's. The Trust is starting to contribute to 12 of the 17 SGDs at a local level.

Figure 1: North Bristol NHS SDAT Assessment 2018/19



NORTH BRISTOL NHS TRUST

58%

North Bristol NHS Trust

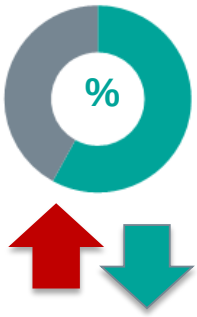
7. Corporate Objectives

North Bristol NHS Trust has developed ten key objectives in line with the SDAT themes laid out in the diagram below.

Each objective has a set of actions set for the year ahead to drive forward sustainable development at NBT.

The following pages outline the Trust's progress against each theme undertaken in 2018/19 and our plans for the year ahead.

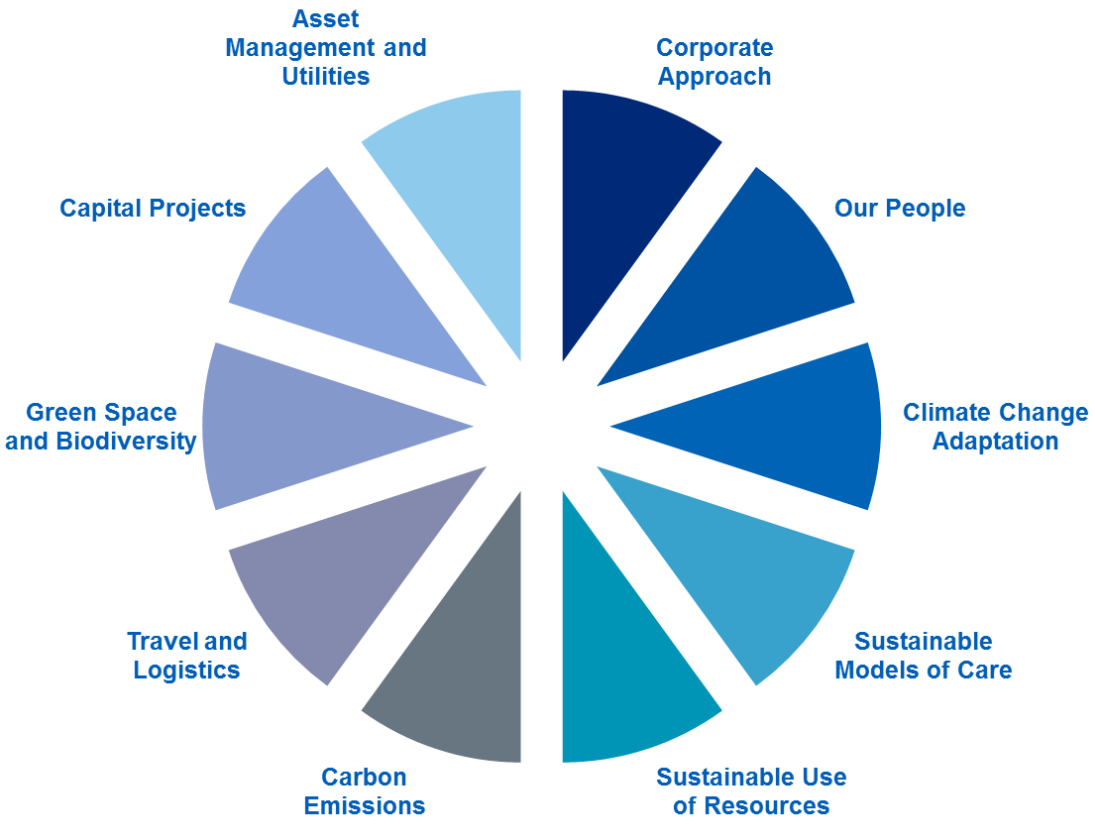
At the top of each page, we have reported our SDAT progress score against each theme.

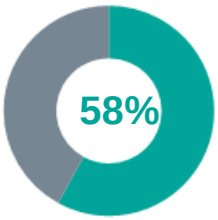


2018/19 SDAT score

Further action required

Colour/arrow indicates increase/decrease since 2017/18





7.1 Corporate Approach

The Trust strategy recognises the great potential of our organisation by empowering our skilled and caring staff to deliver high-quality, sustainable services in state-of the-art facilities. Our Trust Strategy is currently being updated.

During 2018-19 we reviewed and updated our Sustainable Development Policy to ensure it is reflective of the national sustainable development agenda. Our Sustainable Development Policy underpins our decision making process, which now includes Sustainability Impact Assessments for all key decisions.

We have welcomed the Southmead Development Trust onto our Sustainable Development Steering Group to maximize the opportunities to support our local community through joint ventures and communication and engagement opportunities. We regularly support their activities and events such as the annual Southmead Festival and encouraged our local staff to be part of the Neighbours Connect Project, promoting health and wellbeing in our local community.

We will continue to work closely with them as we continue to deliver exceptional healthcare facilities whilst also supporting the needs of the local community. We hope to achieve this by ensuring any developments become a valuable resource for the local community, through the provision of accessible green space and future capital developments as part of the One Public Estate.

OBJECTIVE 1

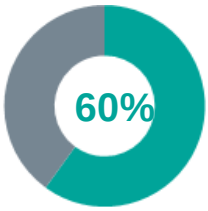
The Trust aspires to be a leader in sustainable healthcare

We have:

- Reviewed and updated our Sustainable Development Policy
- Worked with partners in our local community, the Southmead Development Trust
- Ensured sustainable development and social value are a material consideration in all business cases through the requirement of Sustainability Impact Assessments.
- Delivered sustainable procurement and waste training for our Environmental Awareness Reps

We will:

- Embed sustainable development within the Trust's updated Strategy.
- Work collaboratively to deliver the Bristol One City obligations
- Review our Sustainability Impact Assessment process to promote ease of use
- Engage with our suppliers, contractors and commissioned services to reduce the impacts of the goods and services we buy
- Embed sustainable development within the annual corporate business planning process
- Commence external Environmental Management System ISO14001:2015 audits for the Directorate of Estates, Facilities and Capital Planning



7.2 Our People

The Trust recognises that a healthy, happy and resilient workforce is key to ensuring we operate sustainably, and as such, every single member of staff has an important role to play in helping us achieve this.

The Trust's Sustainable Development Policy outlines individual staff responsibilities to ensure efficient resource use through simple, everyday actions.

The Sustainable Development Unit encourages staff to get involved in activities and events throughout the year as part of the Green Impact Engagement scheme. During 2018-19, we successfully completed our third year of Green Impact with 25 teams taking part across the Trust. The scheme provides innovative ways for staff to get involved in sustainability in the workplace and celebrating those that did with an awards ceremony in December in collaboration with University Hospitals Bristol NHS Foundation Trust and the University of Bristol.

Looking ahead, our joint charity funded project with Fresh Arts to deliver the Pathway to Wellbeing programme will begin to take shape with the appointment of a project manager to coordinate a series of engagement opportunities for staff, patients and the local community, linking the great outdoors and health and wellbeing.

The project will be supported through the delivery of physical improvements onsite including the completion of Lime Walk Park, a new dedicated green space, the Southmead Hospital allotment and the installation of the Green Gym.

OBJECTIVE 2

Engage our staff, patients, visitors, stakeholders and our wider community on sustainable development

We have

- Launched our staff Green Impact engagement scheme for the fourth consecutive year
- Launched the Pathway to Well-being programme

We will

- Complete Green Impact year 4, aiming to achieve a 50% increase in teams across the Trust, specifically targeting clinical areas.
- Complete construction of the staff and patient allotment at Southmead Hospital
- Complete the installation of Green Gym equipment at Southmead Hospital
- Hold at least 6 sustainable healthcare engagement events
- Ensure greater engagement with the local community on sustainability activities at the Trust
- Complete the Pathway to Wellbeing programme in partnership with Fresh Arts

Green Impact Case Studies

Complex Assessment Liaison Service (CALs)

The CALs team embraced the ethos of Green Impact and began segregating their food waste to take home and compost, as well as other initiatives such as a veg-growing competition and 'fruity Fridays', designed to encourage healthier food choices.

The team also recognised the value of green spaces around the Trust so they started to schedule frequent walks to promote health and wellbeing.

The Move Makers

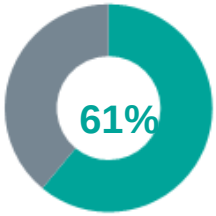
The Move Makers are real ambassadors of Green Impact. They are committed to continually improving the sustainability of their service.

Sustainability is raised in all one-to-ones and appraisals so that all everyone is aware of their responsibilities. Jill used the office to good effect in displaying relevant information and organising bring-and-share lunches around local, Fairtrade or organic themes.

Research and Innovation

This team embedded Green Impact into their daily routines.

The team almost immediately switched their stash of sugary cakes for fresh fruit and made a host of other changes over the year as well, so much so that the team managed to achieve not only our Bronze award, but our silver award in the first year as well, making them NBT's 'Most Improved Team'.



7.3 Climate Change Adaptation

The Trust is committed to adapting to the impacts of climate change by working to deliver a healthy, resilient and sustainable healthcare system ready for changing times and climates.

The Trust has been working across the region with STP partners to finalise the Bristol, North Somerset and South Gloucestershire Climate Change Adaptation Plan. The plan identifies the shared risks and opportunities in our region, including the anticipated health impacts and serves to prioritise actions and deliver shared opportunities to achieve regional benefits going forward.

The plan sits within the wider Bristol, South Gloucestershire and North Somerset STP Estates Group and aims to reduce our combined impact on the environment, reduce our organisational running costs, ensure our business continuity plans are in place and reduce health inequalities.

North Bristol NHS Trust has already implemented a number of schemes on site to promote adaptation through sustainable design and infrastructure, notably through the development of the Brunel Building which includes sustainable urban drainage and energy efficient design.

The Trust has also been working to promote patient and staff resilience through health and wellbeing via the provision of access to high quality green space and the natural environment. Consideration is also given to the secondary impacts of climate change, such as the effects of severe weather on our infrastructure, supply chain and vital resources such as medical equipment, water, energy, fuel and food to ensure continuity of service in times of scarcity.

OBJECTIVE 3

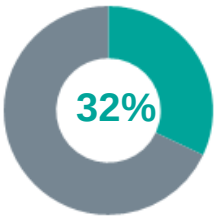
We will adapt our sites and services ready for a changing climate

We have

- Finalised our Climate Change Adaptation Plan
- Recognised climate change adaptation as a significant driver within our NBT Estate Strategy
- Embedded the outcomes of our climate change adaptation plan into the wider Bristol, North Somerset and South Gloucestershire regional Sustainability Transformation Partnership Estates Strategy

We will

- Ensure climate change is considered within our corporate business planning process
- Add climate change onto our organisation's risk register
- Complete the Healthier Together Climate Change Adaptation Plan by working with our partners across the Bristol, North Somerset and South Gloucestershire region



7.4 Sustainable Models of Care

The Trust is committed to improve staff and patient experience by moving towards more sustainable models of care and workplace practices.

During 2018-19, the Trust worked closely with the NBT Quality Improvement team to embed sustainability across our quality improvement projects. Sustainability is a domain of quality in healthcare, ensuring we consider the wider resource use and sustainability impacts of our improvement projects, not just clinical outcomes and costs. These improvement projects have changed the way we work, transforming our processes and developing more sustainable models of care.

The NBT pressure point injury quality improvement project embedded sustainability from the start, ensuring that the project didn't just consider the statistics and patient experience, but also the wider resource use and efficiency improvement opportunities to reduce the risk of these injuries in the first instance, thus reducing the number of injuries, but also the resource use (extended bed days, dressings, pharmaceuticals, staff resource, patient flow, etc.)

OBJECTIVE 4

We will adopt sustainable models of care across our services

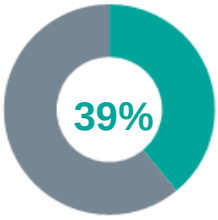
We have

- Embedded sustainable models of care within the Quality Improvement programme, which promotes smarter, more efficient ways of delivering our clinical services and improving patient flow
- Worked with the Heads of Nursing to embed sustainability within the Pressure Point Injury Project to reduce the number of injuries and improve patient outcomes
- Worked with NBT Anaesthetists' to develop a Sustainable Model of Care to reduce the use of volatile anaesthetic gases

We will

- Prepare training for staff on the identification and development of Sustainable Models of Care
- Work with citywide partners developing a bid to deliver the Warmer Homes Project, ensuring those patients being discharged to a cold home receive the support they need to ensure their homes are warm and to prevent readmission
- We will capture Sustainable Models of Care submitted through Trust business cases and Green Impact teams.

Figure 2: Sustainable Model of Care; Pressure point injury expected outcomes 2018



7.5 Sustainable Use of Resources

We are committed to working with our key suppliers and contractors to reduce the environmental impact of the goods and services we use.

The NHS spends in excess of £40 billion each year on critical natural resources to deliver services. Our demand for resources is not something the Trust can control directly given resource use increases with patient contact, however using our influence through the procurement processes we can embed social value (environmental improvements, local social capital and economic value) to encourage our suppliers to adopt sustainable practices for the products and services they provide.

In line with the NHS Long Term Plan, the Trust needs to work with the Bristol and Weston Purchasing Consortium and suppliers to address the use of single-use plastics and encourage more suppliers to provide recyclable packaging.

OBJECTIVE 5

We will manage our resources sustainably, reducing our direct environmental impacts across our healthcare services in energy, waste, water, food and anaesthetic gases

We have

- Embedded sustainability within the specification of all new Facilities Management service contracts to promote the sustainable use of resources, reduce consumption and promote efficiency throughout the duration of these contracts
- Worked with our new PFI Provider Bouygues Energy Services to undertake a high level energy review of the PFI to identify energy efficiency opportunities going forward
- Engaged clinical staff in a recycling campaign to raise awareness and promote good waste segregation to improve recycling rates
- Launched a single use plastic recycling project in theatres
- Reduced our consumption of volatile anaesthetic gases

We will

- Adopt and implement a Resource Action Plan to include energy, waste, water, food, paper, pharmaceuticals, medical devices, fuel and anaesthetic gases
- Undertake a comprehensive waste review to identify further opportunities to reduce our carbon emissions
- Launch a clinical waste campaign with our clinical waste contractor SRCL to raise awareness and enable staff to make informed decisions when disposing of their waste

Resource Use Case Studies

Southmead Hospital Charity Eco Coffee Cups

The Southmead Hospital Charity team launched reusable Eco-coffee cups for sale to help reduce the amount of waste generated through the use of disposable coffee cups at NBT.

The reusable coffee cups have been a real success, with staff receiving a discount if they take their coffee cups to staff coffee shops.

Theatres Plastic Recycling Project

Theatre staff identified a specific waste stream of small colourful clinical plastics generated at NBT. These plastics which included bottle tops, syringe sheaths and tube racks were not accepted for recycling.

Staff started segregating these plastics and sending them to the Children's Scrapstore in Bristol for reuse within the community. The project was such a success it soon spread nationally and raised awareness of single use plastics amongst the manufacturers via a successful Twitter campaign.

Volatile Anaesthetics Reduction Project

Anaesthetists have been working to reduce the use of Desflurane, a volatile anaesthetic gas which has sixty times the environmental impact of other less harmful greenhouse gases or anaesthetic alternatives such as total intravenous anaesthetic (TIVA).

Staff have been raising awareness through stickers on equipment - a local campaign amongst staff which has resulted in a significant reduction in Desflurane!

7.5.1 Energy Consumption

The Trust is committed to reduce the environmental impacts of energy.

During the last year we have seen an increase in electricity consumption; however we have also seen an increase in renewable energy generated onsite from our solar arrays on the Learning and Research Building and Elgar House. Gas consumption decreased slightly during 2018/19.

The Trust, alongside its new PFI partner Bouygues Energy Services has undertaken a comprehensive review of the energy generation and efficiency opportunities onsite.

The findings and proposals identify significant opportunities to reduce the Trust's scope 1 and scope 2 carbon emissions in line with the NHS Long Term Plan and the government's recent commitment to achieve net zero carbon by 2050.

Figure 3: Owned onsite renewable energy generation (solar) (kWh) 2012-2019

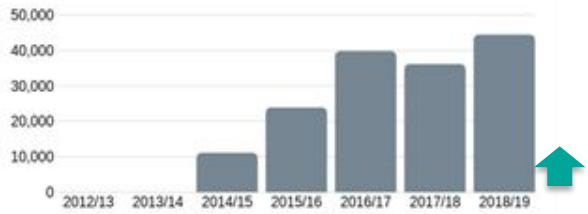


Figure 4: Owned onsite renewable energy generation (Biomass) (kWh) 2012-2019

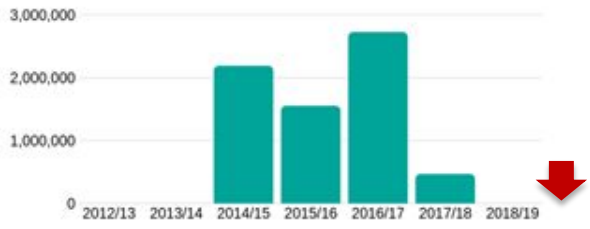


Figure 5: Electricity consumption (kWh) 2012-2019

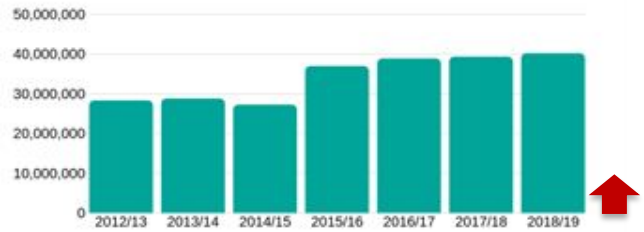


Figure 6: Electricity source breakdown 2018/19

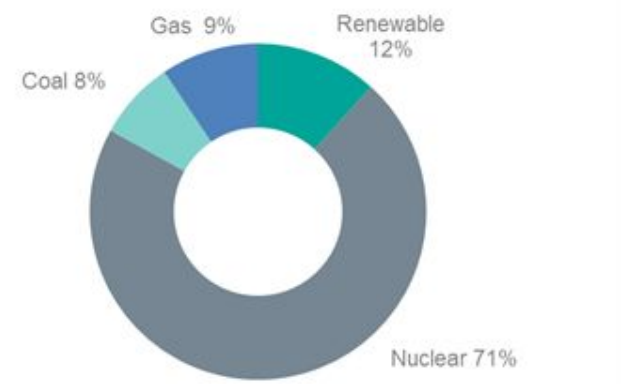


Figure 7: Gas consumption (kWh) 2012-2019

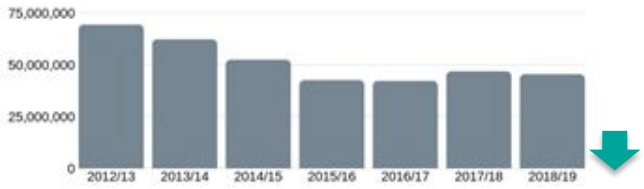
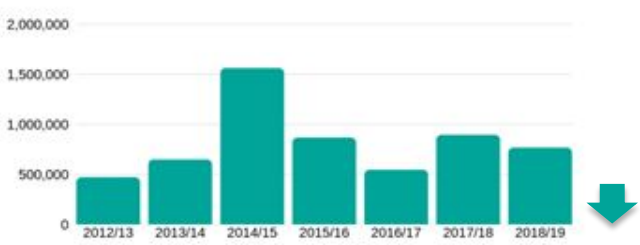


Figure 8: Oil consumption (kWh) 2012-2018



7.5.2 Waste and Recycling

The Trust is committed to reducing the environmental impacts of waste. Our recycling rates have remained low during 2018-2019 due to low quality recyclates and mixed media waste such as medical packaging no longer being accepted by our current waste contractor. As a result of this issue, the majority of our dry mixed recycling was sent for energy recovery rather than recycling.

To address the problem, we have been raising awareness amongst our staff promoting what can be recycled by our current waste contractor and we are pleased to report that from April 2019 all dry mixed recycling (plastics, paper and cardboard) will be reintroduced back into the Trust's recycling streams.

Our disposal to landfill has increased marginally due to improved offensive waste segregation which is a legal requirement (this is both a positive and a negative impact).

The Trust also runs a series of innovative recycling projects to remove unnecessary items from our waste streams. During 2018/19, the Trust launched the plastic recycling project in theatres which segregates small single use plastics which cannot be accepted for recycling. These plastics were donated to Bristol Children's Scrapstore for reuse within the community.

The Bristol Centre for Enablement (BCE) continues the innovative wheelchair recycling programme by successfully recycling damaged and retuned wheelchairs.

During March 2019, the Trust undertook an external waste review to identify any opportunities to make improvements to our waste segregation and recycling across the Trust. The audit report identified a series of opportunities which the Trust will review going forward to increase our recycling rates during 2019/20.

Figure 9: Waste recovery (energy from waste through incineration) tonnes 2012-2019

Figure 9: Recycling (IT WEEE, scrap metal, dry mixed recycling) tonnes 2012-2019

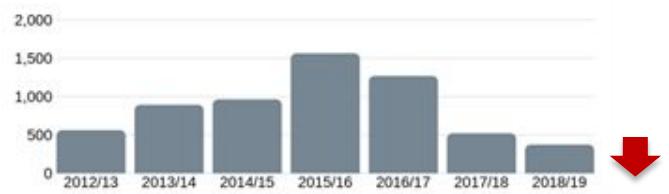
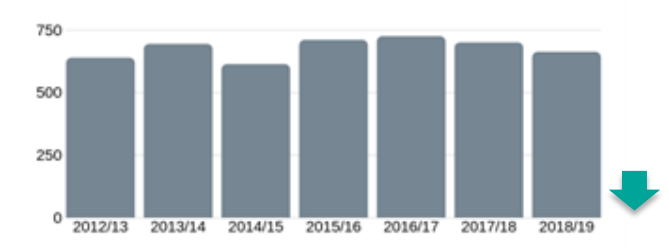


Figure 10: Landfill (tonnes) 2012-2019

Figure 11: Autoclave (tonnes) 2014-2019



7.5.3 Anaesthetic Gases, Pharmaceuticals and Medical Devices

The consumption of anaesthetic gases, pharmaceuticals and medical devices varies in line with patient contact, the more patients we treat the more products we use.

During 2018-19, the anaesthetists at NBT have been switching away from using volatile anaesthetic gas such as sevoflurane and desflurane to using intravenous anaesthesia as an alternative for some patients. Intravenous anaesthetic has a considerably lower carbon footprint.

As a result of the work undertaken by staff, we have seen a significant reduction in the use of these gases and hope to continue to see significant reductions going forward into 2019-20.

Figure 12: Anaesthetic Gas; Desflurane (litres) 2012-2019

Figure 13: Anaesthetic Gas; Isoflurane (litres) 2012-2019

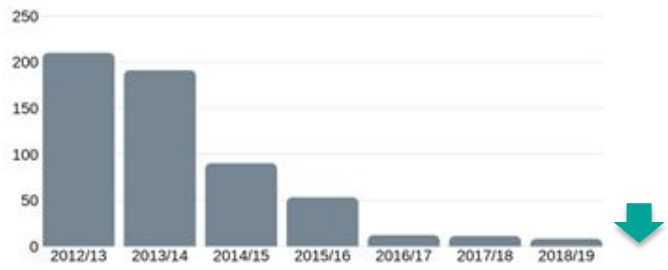


Figure 14: Anaesthetic Gas; Sevoflurane (litres) 2012-2019

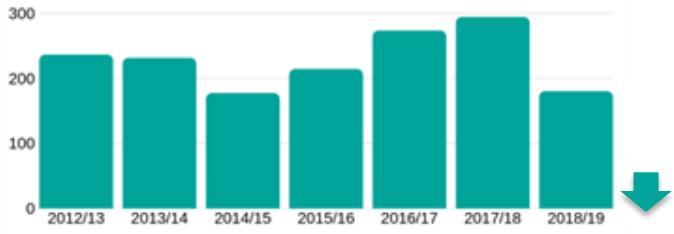


Figure 15: Anaesthetic Gas; Nitrous Oxide (litres) 2012-2019

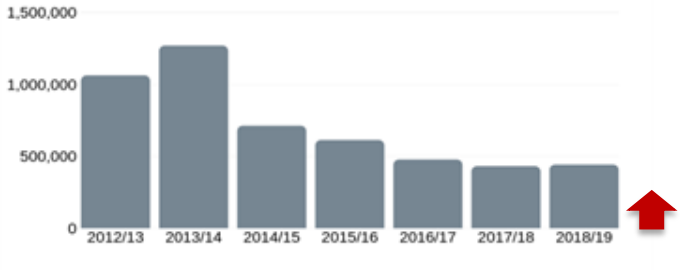


Figure 16: Pharmaceuticals (£) 2012-2019

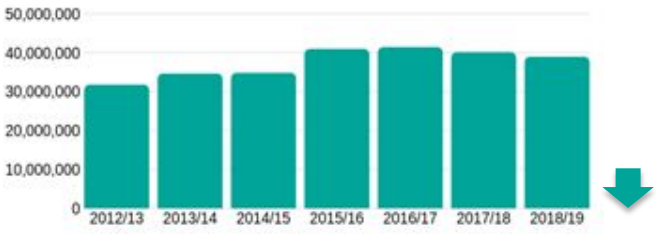
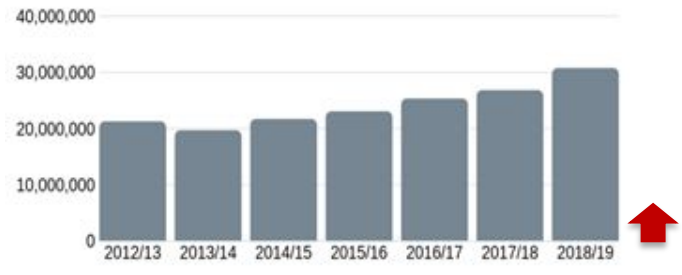


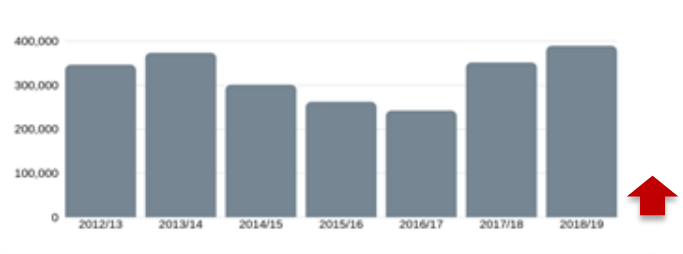
Figure 17: Medical Devices (£) 2012-2019



7.5.3 Water consumption

During 2018-19, NBT suffered two major water leaks, which significantly affected our water consumption figures. Both leaks were detected and corrected at the earliest opportunity; however background water consumption continues to increase in line with patient contact and changes in services.

Figure 18: Water Consumption (m3) 2012-2019



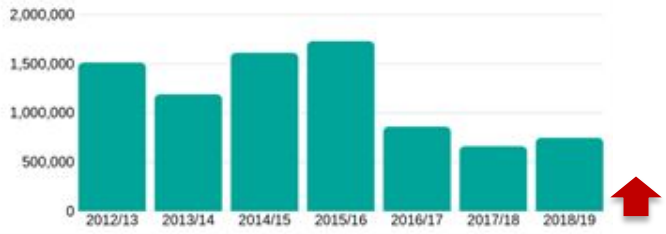
7.5.4 Fuel Consumption

Data for 2018-2019 shows an increase in grey fleet mileage (staff using their own vehicles for business use). This is likely due to the launch of the Hospital at Home service which provides acute healthcare to patients in the comfort of their own home.

The service is delivered by a team of specially trained nurses who visit each patient in their home to deliver the care they need, scheduling regular visits, daily or more frequently, dependent on individual need. Whilst the service generates emissions for staff travelling out to the patients, it avoids the emissions of patients travelling in to Hospital.

To reduce the impact of emissions from vehicles used for business mileage the Trust provides 3 hybrid pool cars available for staff.

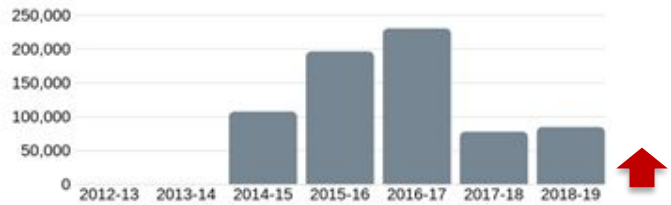
Figure 19: Grey Fleet Mileage (km) 2012-2019

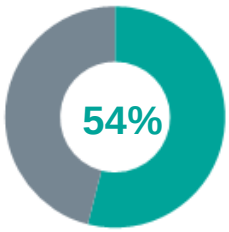


7.5.5. Paper Consumption

During 2018-19, the Trust's paper consumption increased slightly following a significant decrease during 2017-18. Earlier this year, the Trust published One NBT Digital Vision, setting out how we intend to move towards more digital communication which will further reduce paper consumption moving forwards.

Figure 20: Paper Consumption (£) 2012-2019





7.6 Carbon and Greenhouse Gases

The Trust is committed to reducing our carbon emissions.

The UK Government has set an ambitious target to be net zero carbon by 2050. This target supersedes the target set out in the Climate Change Act (2008).

NBT's carbon total footprint has increased by 2040 tonnes of Carbon Dioxide (1.8%) during 2018/19. This is as a direct result of increased patient contact over the year (35,000+ patients)

OBJECTIVE 6

We will manage our carbon emissions in line with the NHS Long Term Plan

We have

- Identified that the Trust is not on target to reduce carbon emissions in line with the UK Government's net zero carbon target by 2050

We will

- Establish a Trust Carbon and Energy Plan to ensure we meet the Governmental carbon target emphasized in the NHS Long Term Plan

Figure 21: NBT Carbon Emissions (tCO2e)

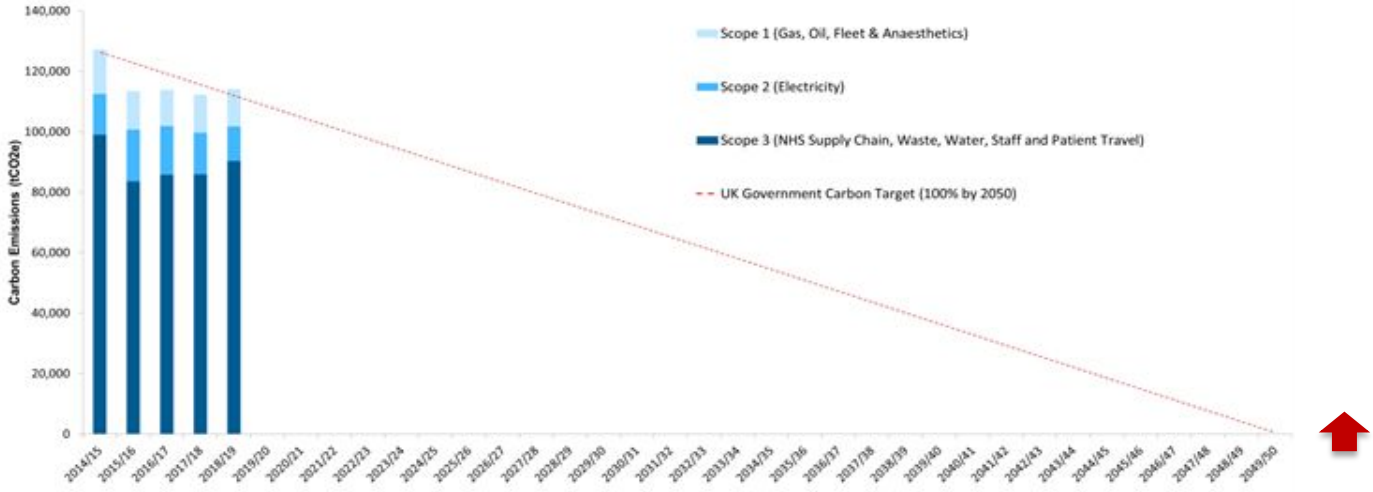
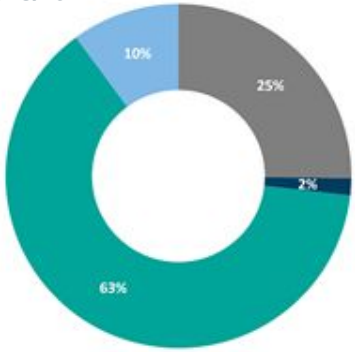
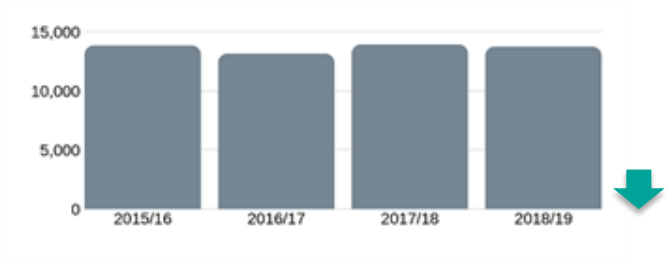


Figure 22: NBT Carbon Emissions Breakdown (tCO2e) 2018/19



- ***Core emissions:*** *Scope 1, 2, 3 and emissions from energy, waste, water, business travel and transport and anaesthetic gases*
- ***Commissioning:*** *Scope 3 emissions*
- ***Supply chain:*** *All scope 3 emissions (goods, services and buildings procured)*
- ***Community:*** *All emissions (Scope 1, 2, 3 from staff commute, patient and visitor travel).*

Figure 23: Scope 1 (Direct) Carbon Emissions (tCO2e) 2015 – 2019

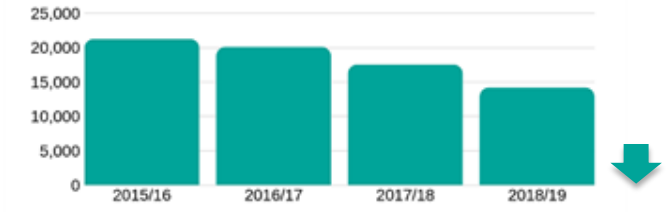


The Trust's direct carbon emissions (Scope 1) have reduced in line with decreased gas and oil consumption during the year. However scope 1 carbon emissions specifically from NBT fleet vehicles and anaesthetic gas use have increased. Carbon from fleet vehicles is due to more robust data capture and reporting, however carbon from anaesthetic gas consumption is a direct result of increased patient contact during 2018/19.

Table 1: Scope 1 Carbon Breakdown (tCO2e) 2015 – 2019

	2015/16	2016/17	2017/18	2018/19
Gas	8,905	8,802	9,914	9,641
Oil	276	172	292	244
Fleet	0	0	0	98.7
Anaesthetics	4,639	4,158	3,701	3,740
TOTAL	13,820	13,132	13,907	13,724

Figure 24: Scope 2 Carbon Emissions (tCO2e) 2015 - 2019



Electricity consumption increased during 2018/19; however the carbon associated with it decreased in line with the decarbonisation of the national grid. The Trust procures electricity from EDF, which consists of a mixture of renewable and non-renewable sources.

Table 2: Scope 2 (Indirect) Carbon Breakdown (tCO2e) 2015 – 2019

	2015/16	2016/17	2017/18	2018/19
Electricity	21,236	20,067	17,515	14,162
TOTAL	21,236	20,067	17,515	14,162

Figure 25: Scope 3 (indirect) Carbon Emissions (tCO2e) 2015 – 2019

Scope 3 represents the largest proportion of carbon emissions from NBT. These emissions include carbon associated with the commissioning of services, procurement of medical devices, patient travel, waste and water. These emissions are indirect, which means the Trust has no direct control over the management of them, only influence

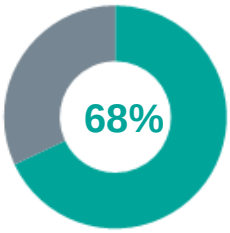
Table 3: Scope 3 Carbon Breakdown (tCO2e) 2015 – 2019

	2015/16	2016/17	2017/18	2018/19
Procurement	66,961	67,507	67,823	72,025
Commissioning	0	0	2,030	1,853
Travel	3,117	11,463	10,893	11,948
Waste	350	508	135	131
Water	237	216	325	354
TOTAL	70665	79694	81206	86311

Over the last year we have seen a significant increase in patient contact (35,000+) which has resulted in a similar increase in consumption of associated medical devices, water and patient travel.

Table 4: Patient Contact 2015 – 2019 (outpatients; new and follow up, elective, emergency admissions)

	2015/16	2016/17	2017/18	2018/19
Patient contact	433,000	659,177	648,950	683,610



7.7 Travel and Logistics

The Trust is committed to reducing the impacts of our travel and transport.

Active travel plays a significant part in both reducing traffic on the roads whilst also promoting health and wellbeing through exercise and improving local air quality.

The Trust runs the TravelSmart scheme aimed at encouraging staff, patients and visitors to travel sustainably where they can. TravelSmart promotes cycling, walking, public transport and lift-sharing as alternative ways to travel to work.

During 2018-19, the Trust updated its Travel Plan which was approved at Trust Board, alongside the accompanying action plan. Progress so far has included the installation of 12 new electric vehicle charging points, and pedestrian and cycle improvements to the Southmead Hospital site in collaboration with Bristol City Council.

North Bristol NHS trust was shortlisted for the local Travel West Sustainable Travel Awards and the national Sustainable Health and Care Awards for travel and logistics, winning Highly Commended for the latter.

OBJECTIVE 7

We will reduce the impacts from our travel and transport services

We have

- Reviewed and updated our Travel Plan which has been approved by Trust Board
- Installed 12 electric vehicle charging points at Southmead Hospital
- Extended the provision of personal travel plans to patients and visitors
- Delivered 18 Bike maintenance sessions
- Delivered 10 Travel Smart Roadshows
- Loaned 68 bicycles to staff
- Commenced automatic monitoring of patient travel modes

We will

- Implement our travel plan
- Assess progress using the national Sustainable Development Unit's HOTT Tool
- Undertake scoping study for fleet rationalisation
- Commit to embed the Hospital Clean Air Framework

Travel Smart Case Studies

North Bristol NHS Trust Travel Plan 2019-2023

We updated our five year Travel Plan which outlines the progress we've made so far and our plans for the future for enabling sustainable and active travel to be a choice accessible for all.

The plan looks at reducing the number of single occupancy vehicles for staff alongside reducing air pollution from our business and fleet mileage.

Staff Bike Maintenance Lessons

In October we facilitated 7 staff maintenance lessons for staff to come and learn the skills needed to maintain and repair their own bicycles.

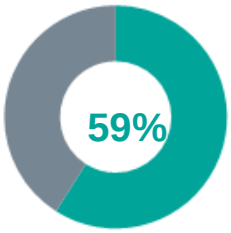
38 staff members learnt how to safety check their bicycles adjust their gears and brakes and fix a puncture.

These skills enable staff to be independent and assured they are safely cycling to work.

National Clean Air Day 2018

We joined the national campaign for clean air; asking staff, patients and visitors to pledge an action to reduce air pollution. Over 25 staff pledged to make changes such as swapping short car journeys with walking and investigate replacing their current car with an electric or hybrid model.

We also offered advice and information on how to avoid air pollution. Choosing to walk/cycle along side streets and making sure your home is well ventilated were a couple of the top tips.



7.8 Green Space and Biodiversity

The Trust is committed to protecting and enhancing the natural environment, including the prevention of pollution.

The Trust recognises the value of the natural environment which plays a key role in our health, improving patient recovery rates and patient experience. As a result, the inclusion of green infrastructure across the hospital estate is vital as a resource going forward. These green spaces also provide an important habitat for wildlife which contributes to Bristol's wider biodiversity network.

Managing our green spaces effectively can lead to improved biodiversity, improved air quality, noise reduction, provide essential shading during times of extreme heat and also reduce local surface water flooding.

During 2018-19, the green spaces onsite have undergone significant change as the final part of the hospital redevelopment takes place. To coincide with the works, the Urban Buzz project, along with some local volunteers, helped sow native plants, shrubs and wildflowers at the main entrance to Southmead Hospital.

During 2018/19, the Trust was shortlisted for a national Sustainable Health and Care Award for its green spaces.

Looking ahead, the Trust will complete the Southmead Hospital redevelopment in July which will include Lime Tree Park, a community green space with accompanying wildflower meadows.

The Biodiversity Management Plan identifies the priority areas and opportunities for improvement across the NBT estate, ensuring green spaces are protected and managed for the future.

OBJECTIVE 8

We will protect and enhance the environment and prevent pollution

We have

- Planned a space for the cultivation of food through the planned allotment, providing opportunities for staff and volunteers to get involved with growing onsite, before extending the project to patients and the local community
- Provided staff with opportunities in the maintenance of green spaces and biodiversity such as building insect hotels, bird and bat boxes etc
- Undertaken an ecological survey to the rear of the Brunel Building.
- Planted 133 native trees and shrubs and wildflowers across Southmead Hospital site
- Planted new lavender beds outside Elgar House
- Installed a wildlife interpretation panel for staff adjacent to the wildlife ponds
- Worked with local college SGS and using donated materials from Robins Timber built 25 bird boxes for Southmead Hospital
- Collaborated with Bristol City Council to win the Future Parks Accelerator bid to safeguard the future of green spaces and urban parks in Bristol

We will

- Finalise our Biodiversity Management Plan for the Southmead site and seek approval from Trust Board
- Start to implement the actions in our Biodiversity Management Plan

NHS North Bristol NHS Trust

Green Spaces Case Studies

Southmead Hospital Insect Hotels

During the summer of 2018, clinical and non-clinical staff from across the Trust helped build an insect hotel during their lunchbreak.

The insect hotel is built from of old wooden pallets and materials donated by local businesses.

This is the Trust's second Insect Hotel and can be found adjacent to the wildlife ponds off Avon Way.

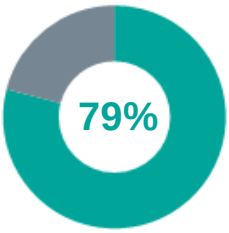
Wildflower planting by Urban Buzz

During March 2018, Urban Buzz, a local project to preserve wild bees in Bristol joined forces with students from the University of the West of England to help plant a new bed at the main entrance to the Hospital off Monks Park Way.

The students planted a variety of native shrubs and wildflower seeds which are pollinator friendly.

Bird Boxes from SGS College, Filton

During 2018, students from local college SGS teamed up with local business Robins Timber to build 25 new bird boxes for the Southmead Hospital site.



7.9 Capital Projects

The Trust is committed to reducing the environmental impacts from our buildings, critical infrastructure and equipment essential for the smooth running of the hospital.

The Trust's Capital Programme ensures the delivery of services and enables resources to be managed more effectively through critical infrastructure and material improvement works across our Estates.

The programme ranges from major demolition and construction works through to refurbishment projects as well as energy efficiency projects and the purchase of critical medical equipment.

Over the last year, sustainability impact assessments have been completed for 20 capital projects, ensuring that sustainability is considered from the outset of any project going forward.

Sustainable Development has been included as a key driver within the newly revised Estates Strategy.

OBJECTIVE 9

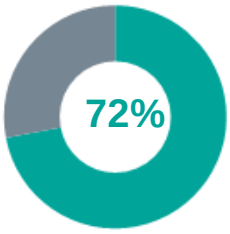
We will embed sustainable design and construction within our capital projects

We have

- Expanded the Sustainability Impact Assessments to include all capital projects regardless of cost.
- Ensured all contractors are assessed against sustainability as part of the tender process for capital projects.
- Completed 20 Sustainability Impact Assessments for capital projects over the last 12 months

We will

- Include sustainable development requirements in all capital project tenders for construction works
- Include sustainable development in all new tenancy leases



7.10 Asset Management and Utilities

The Trust is committed to reducing the sustainability impacts from our operational assets and buildings.

The Trust's Critical Retained Infrastructure Scheme Programme (CRISP) oversees the replacement of these assets and equipment. Once installed, these assets are maintained through the Planned Preventive Maintenance schedule (PPM). This is a cyclic schedule used to manage maintenance activity with the objective of maintaining safety, efficiency and keeping loss of service through break-downs or emergency maintenance activity to a minimum.

The Planned Preventive Maintenance schedule should be able to focus on maintaining new energy efficient equipment, rather than trying to maintain ageing assets which are no longer sustainable to run and at higher risk of failure.

OBJECTIVE10

We will manage our operational assets and critical infrastructure to promote longevity and efficiency of use

We have

- Required all business cases going forward to undertake a Sustainability Impact Assessment.
- Delivered environmental management training to estates Maintenance staff

We will

- Develop a clear policy and process for our Estates Strategy that demonstrates our commitment to sustainability.
- Deliver 94% of the Planned Preventive Maintenance (PPM) works within the Retained Estate and PFI
- Ensure the PFI Building is maintained to the NHS Estates Code B Condition
- Ensure the replacement of equipment in the PFI considers whole lifecycle costs
- Include sustainability and energy performance of assets into the scope of the building condition surveys of the Retained Estate
- Undertake a contractor compliance review, ensuring all our contractors are vetted against environmental compliance as part of the tender process.

8. Finance

The Trust strives to adopt innovative ways to embed sustainable development within our services to deliver environmental, social and financial benefit.

The current financial impact of each key area (energy, waste and water) is documented. Data for fleet transport is not currently available.

Over the coming years, the Trust aims to significantly reduce its carbon emissions and improve energy efficiency across the estate.

Figure 26: Total Energy Costs (£) 2011 - 2019

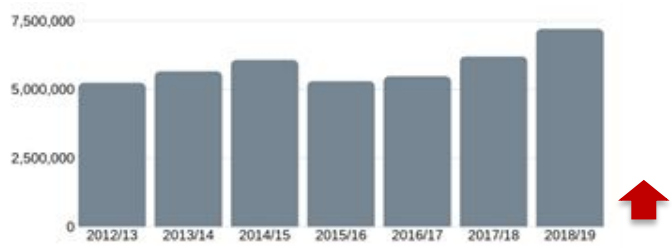
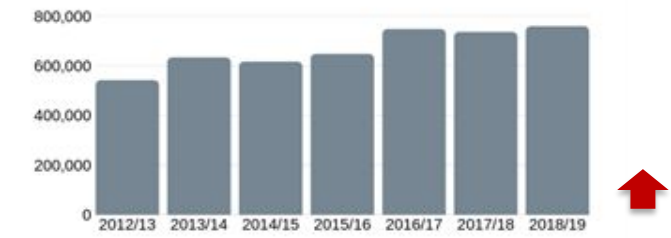


Figure 27: Total Water and Sewerage Costs (£) 2012 - 2019

Figure 28: Total Waste and Recycling Costs (£) 2012 - 2019



We have

- Saved £43,000 through Warp-it, the Trust's furniture re-use programme
- Saved £33,2017 through Green Impact Year 3

We will

- Save £50,000 through Warp-It during 2019/20
- Save £60,000 through Green Impact Year 4

8.1 Charitable Funds

To further support innovative sustainable healthcare projects, Southmead Hospital Charity's Sustainable Healthcare fund delivers a range of sustainability and health and wellbeing projects for the benefit of patients, visitors and staff.

The fund aims to promote social cohesion and personal resilience through the prevention of avoidable illness through access to green space. Innovative engagement projects such as the Lavender Project, the Green Gym, and other engagement activities such as a staff and patient allotment and improving green spaces on our sites will promote health and wellbeing.

Southmead Hospital Lavender Project

The Lavender Project is led by volunteer Chris Lindop and the Move Makers at Southmead Hospital. The project encourages staff, volunteers and the local community to get involved in making and selling homemade lavender bags from lavender grown on site.

This is the third year the project has run, raising over £1000 in total during 2018/19. The proceeds have been used to plant new lavender beds at the Hospital and will continue to be used to enhance our outside spaces for staff, patient and wildlife benefit.

Charitable Donations

During 2018/19, local businesses and staff took part in various fundraising activities to raise money for the Sustainable HealthCare fund.

A huge thank you to GKN Aerospace, a global company based locally whose staff raised over £1800 for the Hospital Allotment Project.

Thanks also to our Sustainable Development Manager and her husband for abseiling off the Hospital building, raising another £470 for the funding pot.

North Bristol NHS Trust

9. Reporting

North Bristol NHS Trust has an obligation to report progress on sustainable development in line with national reporting requirements.

The NHS Standard Contract requires the Trust to take all reasonable steps to minimise adverse impacts on the environment. The contract specifies that North Bristol NHS Trust must demonstrate progress on climate change adaptation, mitigation and sustainable development and must provide a summary of that progress in the annual report.

In addition to the Standard Contract requirements, NHS Trusts have an obligation to complete the HM Treasury sustainability reporting template on behalf of NHS England and Public Health England.

The Department of Health requires Trusts to report ERIC (Estates Return Information Collection) data. ERIC data comprises essential statistics on waste, energy and water from Estates and Facilities.

The national Sustainability Strategy also requires Trusts to report on progress against sustainable development in a Trust Board approved SDMP. Progress against the SDMP is reported to the Steering Group quarterly and Trust Board 6 monthly, before final approval and publication in September each year. North Bristol NHS Trust's annual SDMP report is available on the Trust website:

www.nbt.nhu.uk/sustainablehealthcare

10. Risks and Opportunities

Risks and opportunities related to sustainable development are managed by the Sustainable Health and Capital Planning service through the Environmental Management System within the Directorate of Estates, Facilities and Capital Planning.

Significant risks and opportunities associated with compliance obligations, objectives, targets and project delivery are reported directly to the Director of Estates Facilities and Capital Planning and FM Board through the management review process.

These risks and opportunities are also communicated to the Sustainable Development Steering Group and to Trust Board twice a year. Significant sustainability risks are recorded on the Trust's risk register and managed accordingly.

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11. Sustainable Development Indicators

Theme	Indicator	Metric	2015/16	2016/17	2017/18	2018/19	Trend
Carbon Emissions	Scope 1 (gas, oil, fleet, anaesthetic gas)	(tCO2e)	13,820	13,132	13,907	13,724	
	Scope 2 (electricity)	(tCO2e)	21,236	20,067	17,515	14,162	
	Scope 3 (NHS supply chain, waste, travel, etc)	(tCO2e)	70,665	79,694	81,207	86,311	
	Total Carbon (Scopes1, 2 & 3)	(tCO2e)	105,721	112,893	112,628	114,197	
Energy	Electricity consumption	kWh	36,937,547	38,828,428	39,295,816	40,147,116	
	Gas consumption	kWh	42,548,780	42,115,642	46,759,825	45,390,730	
	Oil consumption	kWh	865,098	543,381	892324	765,375	
Onsite Renewable Energy Generation	Biomass	kWh	1,548,610	2,722,499	463,088	0	
	Solar	kWh	23,813	39,717	36,057	44,396	
Water	Water	m^3	261,961	241,944	351,561	389,225	
Waste	Recovery	tonnes	196	227	1,972	1,779	
	Landfill	tonnes	1,231	1,487	191	204	
	Recycling	tonnes	1,561	1,266	518	386	
Travel	Grey Fleet	miles	1,072,470	532,744	409,137	461,973	
	NBT Fleet	miles	-	-	-	540,792	N/A
	Electric Fleet	miles		14,473	18,094	16,163	
Anaesthetic Gas	Desflurane	litres	338	216	159	131	
	Isoflurane	litres	53	12	11	8	
	Sevoflurane	litres	214	273	294	279	
	Nitrous oxide	litres	613,800	477,900	432,000	442,800	
	Nitrous oxide with oxygen	litres	10,629,500	10,877,700	10,078,200	10,588,800	

Contact Us

We welcome your views....

We are continually striving to improve sustainable development here at North Bristol NHS Trust and would welcome your views on how we can do this.

Please send any comments, ideas, suggestions or feedback you may have to:

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Sustainable Health and Capital Planning
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Trust Headquarters
Southmead Hospital
Bristol
BS10 5NB

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0117 4148523 /4145422
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www.nbt.nhs.uk/sustainablehealthcare

Report to:	Trust Board	**Agenda item:**	19.
Date of Meeting:	26th September 2019		

Report Title:	Health and Safety Annual Report to the TMT			
Status:	**Information**	**Discussion**	**Assurance**	**Approval**
	X		**X**	
Prepared by:	Andrew Smith, Head of Health and Safety Services (HSS)			
Executive Sponsor (presenting):	Simon Wood, Lead Director for Health and Safety			
Appendices (list if applicable):	Appendix A: Health and Safety Annual Report.			

Recommendation:
For information and assurance.

Executive Summary:
This report contains the Annual Health and Safety Report for 2018/19.


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ANNUAL HEALTH & SAFETY REPORT 2018/19

CONTENTS

1. HEALTH AND SAFETY (H&S) ANNUAL REPORT

Introduction

This report identifies the progress made in managing H&S Risks in the Trust during 2018/19. It highlights actions against indicators and reviews, many through the Trust's H&S Committee and its sub-groups.

The year saw a plateauing of overall incident numbers and a further reduction in the more serious (RIDDOR-reportable) incidents. It is thought this is as a result of a gradual tightening of our systems and processes as well as less significant construction work taking place, particularly on the Southmead site.

Performance Monitoring

No enforcement action for H&S non-compliance has been brought against the Trust during the report period.

All the Trust Divisions and Directorates have been sample audited by H&S Services (H&SS) over the past year. This is the second year of this revised approach which increases frequency of sampling. The table below summarises the results:

	Total Audits	Overall %		Highest		Lowest	
W&CH	3	96.81%		Quantock	97.33%	CDS	96.43%
Core Clinical	6	85.09%		Infectious Sciences	97.62%	Pharmacy	74.07%
Neuro & MSK	4	66.20%		26A	73.81%	26B	57.14%
ASCR	4	70.25%		33B	79.00%	32B	55.00%
Facilities	6	82.89%		R&D Services	93.33%	M&E Supt Mgt	71.79%
Medicine	4	77.78%		Palliative Care	91.67%	Acute Oncology	61.90%
Total	**27**	**78.47%**		**Infectious Sciences**	**97.62%**	**32B**	**55.00%**

The improved, better-structured tool for self-audit (Appendix B to Trust H&S Policy, HS01) has received good feedback and has been widely adopted. This continues to be actively monitored by H&SS.

H&S Statutory & Mandatory training maintained or exceeded the Trust's 85% compliance target throughout the year.

Analysis of the Trust's RIDDOR incidents (reported to HSE) reflected a 3rd consecutive reduction in spite of enhanced measures to assess and identify them. In excess of 40% of all DATIX incident reports related to Violence and Aggression and Sharps-related incidents - action is being taken to address these two persistent causes.

Action Plans, monitored by the Trust's H&S Committee's sub-committees and subgroups, continued to be developed and delivered

.

2. SIGNIFICANT HEALTH & SAFETY RISKS

(As identified throughout the NHS as a whole)

Manual Handling
The Trust's Manual Handling Team lead risk reduction initiatives and this is monitored by the H&S Steering Group and Trust Health and Safety Committee.
The team has been actively involved in incident investigations and have integrated key learning outcomes into training content. Work continues with reviewing and evaluating training which has led to new e-learning courses and pre-course learning prior to classroom sessions. This has been in preparation for in-house practical training in some areas e.g. theatres and a move toward alternative methods of delivering training.
There has been pro-active joint working with colleagues in Occupational Health and Physiotherapy with a second MOVE week and on-going staff/workplace assessments.
Complex patient assessments and equipment requests continue to be referred to the team.
The Manual Handling Risk Assessor's course has been redesigned and now forms an integrated course with the General Risk Assessors module.

Work-Related Stress
The Wellbeing Group monitors risk reduction initiatives. An updated Trust-wide Risk Assessment is now in place and a number of initiatives to develop and communicate NBT Wellbeing programmes. This area of work is split: HR on wellbeing and H&SS on stress assessments and management generally.

Radiation Safety
The Radiation Protection Committee manages and monitors risk from Radiation. New Radiation legislation (IIR17) has resulted in more stringent exposure limits coming into force in early 2018. This has particularly affected eye exposure to radiation. There is ongoing work to manage exposure and tighten controls. This is being overseen by our Radiation Protection Advisor (RPA) and Radiation Protection Supervisors (RPS).

Violence and Aggression
The Personal Safety Group continues to consider and promote risk reduction initiatives through its Action Plan. A Business Case has been prepared for introducing enhanced Conflict Avoidance training. Neuro/MSK Division has successfully undertaken and rolled out Train- the Trainer modules and it is anticipated that the remaining Clinical Divisions will participate within the next 6 months.

Sharps Injuries and Exposure to Hazardous Substances

The Trust's H&S Steering Group oversees action in this area.
The Purchasing Consortium, Avon Occupational Health, UHB, NBT and Weston have evaluated safer hypodermic needles and a preferred supply has been agreed. NBT is currently evaluating the business case for the switch as there is a significant cost implication.

There has been a roll-out of a Patient policy to encourage the self-administration of insulin in hospital.

Occupational Health and H&SS continue to work closely to cross-check the reporting of contamination incidents. The introduction of Datix is enabling this task to be more accurate and efficient, reducing omissions.

In response to the continued high level of incidents a focus on awareness briefings and

training has taken place.

Slips, Trips and Falls
The Action Plan identifying the risk reduction initiatives related to employee and non-patient slips, trips and falls is monitored by the H&S Steering Group. . Various remedial projects have been undertaken to reduce risks and for the first time in a number of years there has been a reduction in the number of incidents resulting in slips, trips no longer being in the top five of incident causes. A quarterly inspection takes place by H&SS to identify external slip, trip and fall hazards on NBT sites.

Water Safety
The Trust's Water Safety Group (WSG) monitors risk reduction initiatives including Legionella and Pseudomonas control. These have included work on the retained estate and tightening arrangements with our Service Provider in respect of the Brunel building.

Asbestos
The Trust's Estates Maintenance Compliance & Governance Group manages and promotes risk reduction initiatives related to asbestos. The quantity of asbestos in the Trust's estate has continued to reduce as a number of older buildings containing asbestos have been appropriately demolished in 2018/19.

Road Safety -Southmead
The overall plan for the management of vehicle movements on the Southmead site is heading towards completion with the new Southmead Way now operational. The informal crossings continues to prove to be one of the most significant causes of contention and confusion for pedestrians and car drivers. A number of different approaches are currently being evaluated to establish how this can be improved. New signage at the entrances will help emphasise the importance of pedestrian safety.

3. ENFORCEMENT ACTION

No enforcement action has been brought against the Trust. An issue regarding a brief loss of containment in Pathology and which was investigated by the HSE has now been closed without further enforcement agency involvement.

4. MONITORING OF THE TRUST'S HEALTH AND SAFETY PERFORMANCE

Active Monitoring
This has included a periodic examination of documents. H&SS has sample audited all five Clinical Divisions and the Trust Corporate Directorates under the 2nd year of its audit programme.
The table in section 1 gives an indication of the preliminary audit results from 2018/19.

H&SS Training Records
The compliance level is shown in Appendix D. H&S training was above the 85% Trust target and finished the year at 92%. Non-Patient Handling was also above the compliance level and finished at 92%. Patient Handling finished at 79%, a 2% rise on the previous year, but still short of the 85% target. Porters' Manual Handling finished at 97% reflecting a similar 2% rise. Some changes were made to the MLE system in late 2017 which may continue to positively impact these figures e.g. more frequent reminders to staff when renewal is due.

Reactive Monitoring

Accident, Incident and Ill Health statistics and trends since Dec 2017 are being captured and reported on DATIX. Appendix A, B, and C show analysis of Trust incidents that have been reported to the HSE under RIDDOR. The number is slightly down from 2017/18.

As part of the H&SS commitment to ensure all reportable incidents are appropriately reported there will be a continued focus to ensure that patient related incidents which meet the RIDDOR criteria are reported.

Although this year there has been a decrease in overall RIDDOR reportable incidents there are still some incident types which have shown a slight rise. In particular: 2018/19 saw an increase in reporting on “injured by something fixed or stationary” and a decrease in Slips, Trips and Falls, though the latter remains the joint biggest cause of RIDDORS (9 incidents equaling 22.5%) alongside Needlesticks/Contaminations.

5. PERFORMANCE - HEALTH & SAFETY SERVICES

The year has seen greater stability following a period of change. The team Administrator post was upgraded to Co-ordinator reflecting professional development and a substantially extended role. This has helped spread the general team workload. An additional P/T Manual Handling trainer also joined the team to help meet training demands.

What’s happened in 2018/19?

- The year saw a slight reduction of serious incidents (RIDDORs) which has built on the lowering of incidents seen in the previous year.
- DATIX has become further established and helped facilitate better analysis. It has enabled us to produce regular Divisional dashboard reports. As a Department we are actively involved in following up incidents to ensure managers investigate and take appropriate remedial action before closing the incident.
- The second year of internal audits has taken place and resulted in good to strong results across the Divisions / Directorates so far. Feedback and action plans are being created to address shortcomings.
- There has been a sustained focus on Fire Safety with an increase in training for Fire Wardens and a focus on addressing a small number of remaining fire defects in the PFI. A survey to identify weaknesses and remedial actions regarding fire stopping in the Retained Estate has also taken place.
- A project looking at how to improve Theatre storage has been underway which has made a number of recommendations. A business case supporting the implementation of improved storage facilities will now be developed.
- The HSE investigation into the Pathology Lab has now been closed. This was following an incident where there was a short temporary loss of pressurised airflow to a controlled containment area. There continues to be focus and work to reduce the likelihood of this ever occurring again.
- There is continued ownership and responsibility assigned within the Health and Safety Services team for a Division / Directorate. This continues to build healthy engagement and support in areas where it is needed most.
- New Radiation legislation has resulted in more stringent exposure limits. As a result a number of Consultants had been ‘classified’. There is ongoing work to monitor exposure and tighten controls around exposure. This is being led by the Radiation Protection Committee and our Radiation Protection Advisor.

What have been the issues in 2018/19?

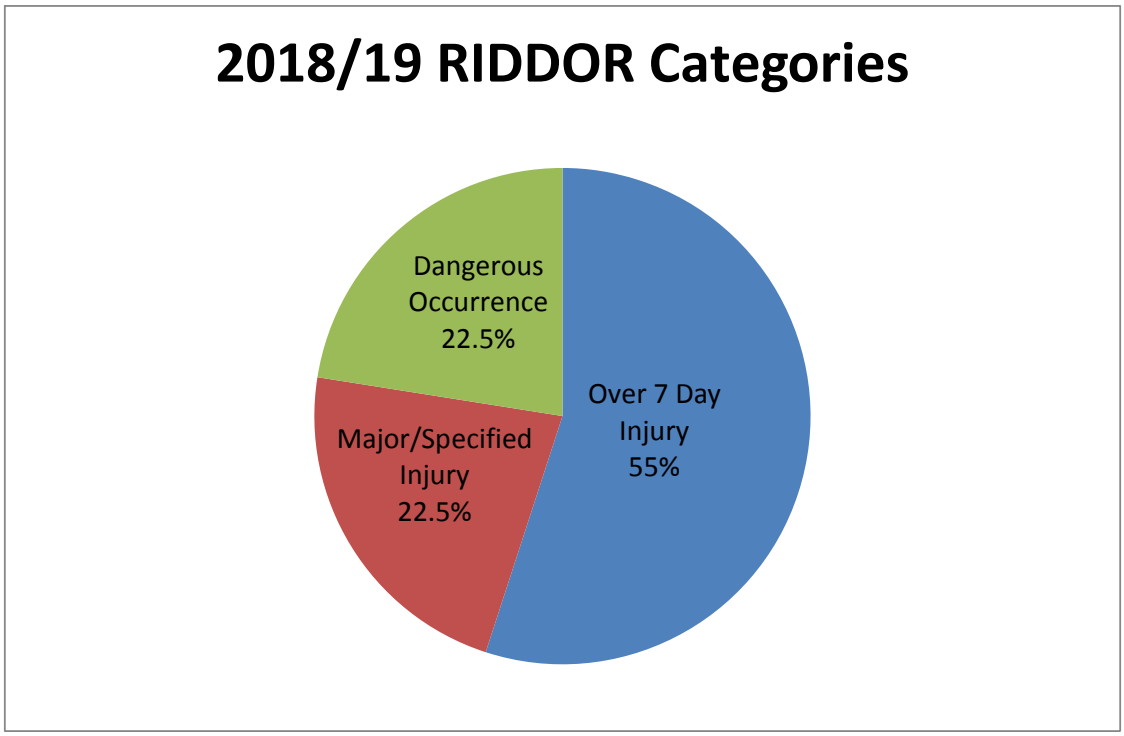
- There have been challenges regarding training compliance levels particularly in the area of Manual Handling. This has been partially addressed through the appointment of a part-time trainer in the department to support additional training delivery and establish additional courses.
- A challenge has been to maintain engagement with the Clinical Divisions and encourage attendance at H&S meetings. This is resulting in a review of the way we run meetings in 2019/20.
- There were delays in the demolition of Sherston, Brecon and the Lime Walk buildings due to asbestos. This has delayed wider changes to improve road safety and in particular the trialling of a new type of crossing on Southmead Way which will now start in Spring / Summer 2019.
- Violence and Aggression continues to remain a high cause of incidents. One Division began a new programme of training – it is expected that others will follow this lead and develop tailored approaches which address their needs. This will better equip staff to diffuse conflict and aggression and manage difficult situations.

What are the plans / challenges in 2019/20?

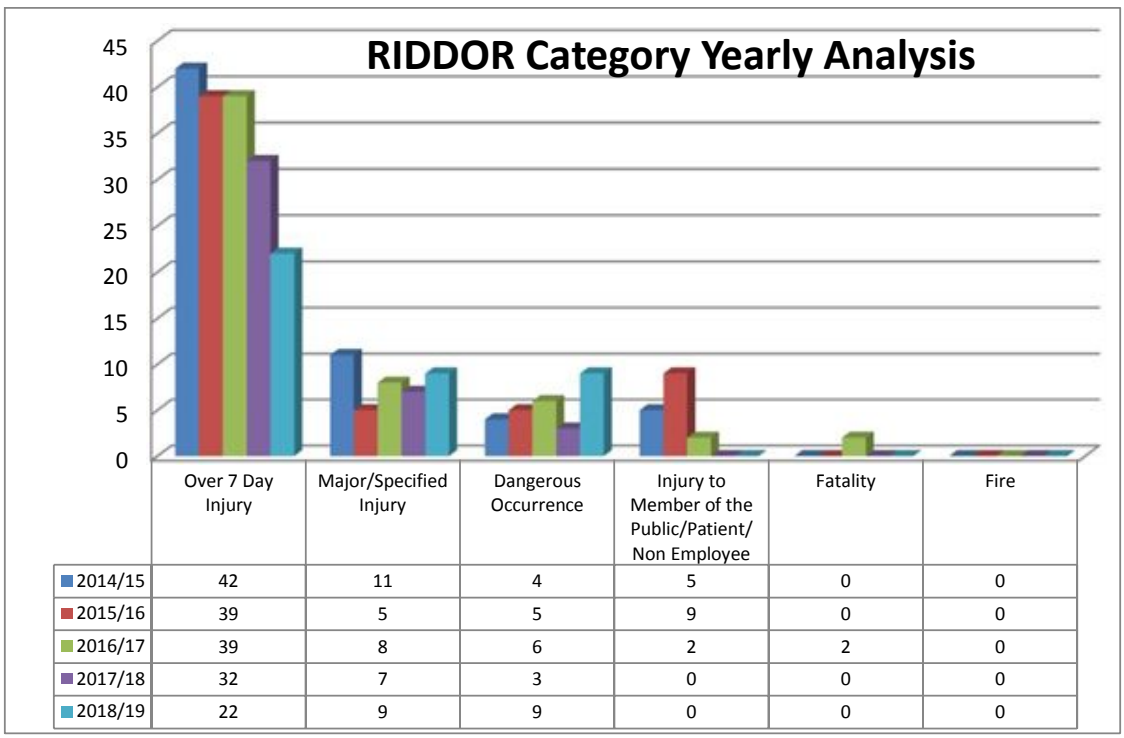
- At the beginning of 2019/20 there will be a trial to establish if improvements can be made to the way we work with Divisions. This will initially involve embedding a member of the team in Medicine to establish if both Manual Handling and Safety can be more effectively promoted and delivered.
- We'll continue to simplify Policies and make documents and best practice more accessible and forms easier to use.
- A significant update to the Managers Responsibilities Training will take place to ensure it is contributing to strengthening our safety culture and equipping our managers to lead.
- We will target significant accident causes through four behavioural campaigns to raise awareness of injury causes and equip staff with the knowledge to avoid incidents.
- A new joint Risk Assessors training course is to be developed along with competency based assessment and support for trained staff in the workplace.
- The use of Safer Sharps continues to be an area of focus and a business case. Incident numbers have remained high. A campaign will launch in this subject area in early 2019/20 to raise awareness of the dangers.
- Fire Safety – a big push will take place in 2019/20 to further raise fire safety standards by addressing historic defects and areas of potential improvement. This will include a 'Love your Building' campaign to reduce unintentional damage to fire doors and other fittings, a campaign to reduce false activations of the alarm system and a continued push to increase fire safety training compliance levels.

Andrew Smith
Head of Health & Safety Services

APPENDIX A – RIDDOR CATEGORIES

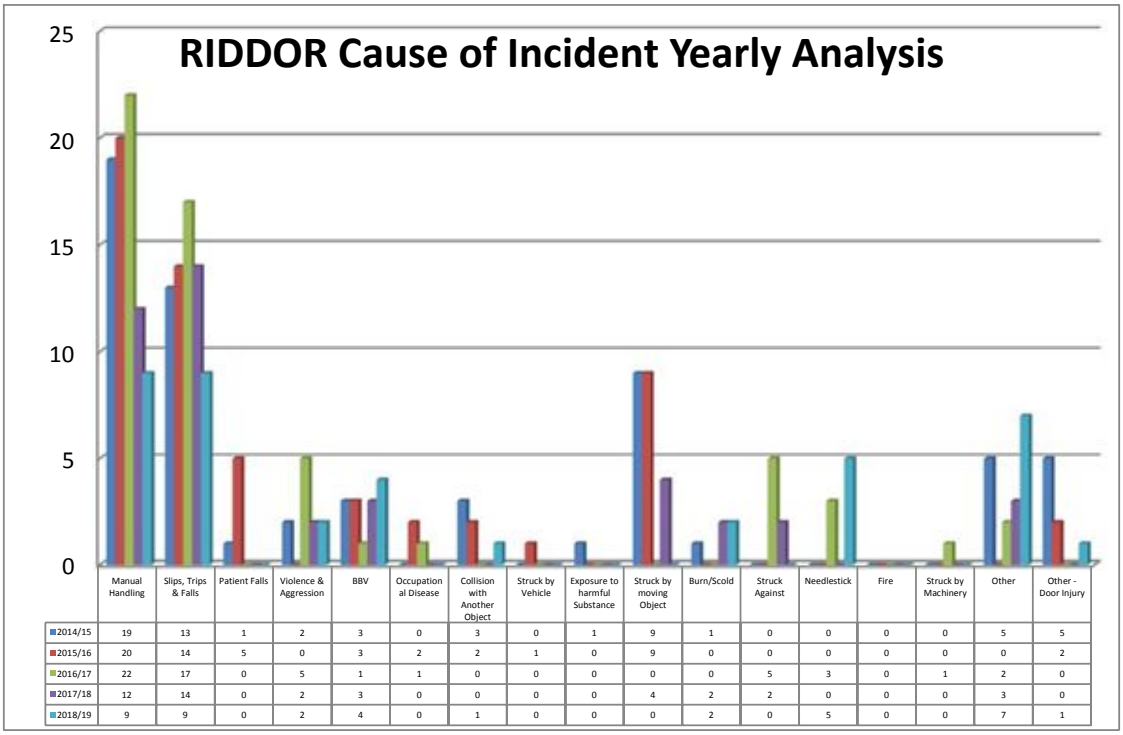


APPENDIX B – RIDDOR CATEGORIES BY YEAR



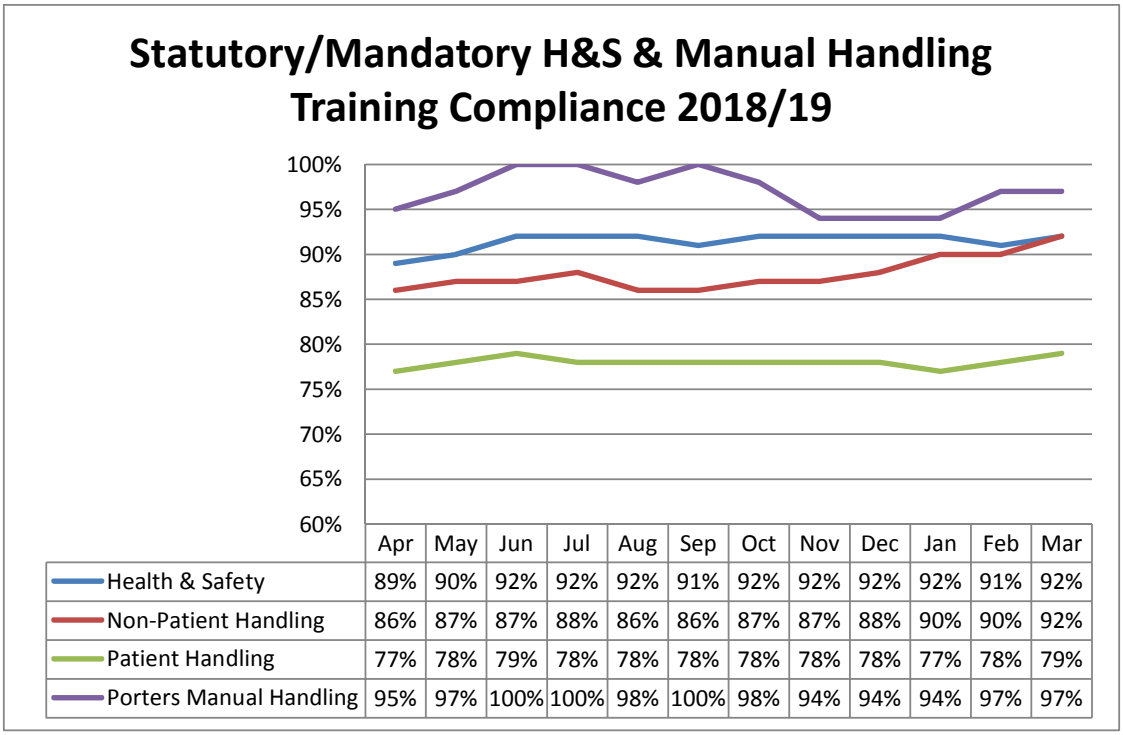
	Over 7 Day Injury	Major/Specified Injury	Dangerous Occurrence	Injury to Member of the Public/Patient/ Non Employee	Fatality	Fire
2014/15	42	11	4	5	0	0
2015/16	39	5	5	9	0	0
2016/17	39	8	6	2	2	0
2017/18	32	7	3	0	0	0
2018/19	22	9	9	0	0	0

APPENDIX C – RIDDOR CAUSES BY YEAR



	Manual Handling	Slips, Trips & Falls	Patient Falls	Violence & Aggression	BBV	Occupational Disease	Collision with Another Object	Struck by Vehicle	Exposure to harmful Substance	Struck by moving Object	Burn/Scold	Struck Against	Needlestick	Fire	Struck by Machinery	Other	Other - Door Injury
2014/15	19	13	1	2	3	0	3	0	1	9	1	0	0	0	0	5	5
2015/16	20	14	5	0	3	2	2	1	0	9	0	0	0	0	0	0	2
2016/17	22	17	0	5	1	1	0	0	0	0	0	5	3	0	1	2	0
2017/18	12	14	0	2	3	0	0	0	0	4	2	2	0	0	0	3	0
2018/19	9	9	0	2	4	0	1	0	0	0	2	0	5	0	0	7	1

APPENDIX D – TRAINING



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Health & Safety	89%	90%	92%	92%	92%	91%	92%	92%	92%	92%	91%	92%
Non-Patient Handling	86%	87%	87%	88%	86%	86%	87%	87%	88%	90%	90%	92%
Patient Handling	77%	78%	79%	78%	78%	78%	78%	78%	78%	77%	78%	79%
Porters Manual Handling	95%	97%	100%	100%	98%	100%	98%	94%	94%	94%	97%	97%