Trust Board Meeting in Public

Thursday 25 July 2019
10.00 – 13.30
Seminar Room 5, 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 Iredale, Rob Mould	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 30 May 2019	Approval	Chair	Enc.	10:40
5.	Action Chart from Previous Meetings	Review	Trust Secretary	Enc.	10:45
6.	Matters Arising from Previous Meeting	Information	Chair	Verbal	10:50
7.	Chair's Business	Information	Chair	Verbal	11:55
8.	Chief Executive's Report	Information	Chief Executive	Verbal	11:05
QUALITY					
9.	Pressure Ulcer Update	Assurance	Director of Nursing & Quality	Enc.	11.15
9.1	Cossham Birthing Centre Update	Assurance	Director of Nursing	Enc.	11.35
10.	Safeguarding Adults Annual Report 2018/19	Assurance	Director of Nursing & Quality	Enc.	11.50
11.	Safeguarding Children Annual Report 2018/19	Assurance	Director of Nursing & Quality	Enc.	12.00
12.	Infection Prevention Control Annual Report and Programme	Assurance	Medical Director	Enc.	12.05
13.	2018 National Inpatient Survey Results and Actions	Assurance	Director of Nursing & Quality	Enc.	12.10
14.	Genomics Hub Update	Assurance	Medical Director	Enc.	12.15
15.	Patient & Carer Experience Committee Report	Assurance	Director of Nursing & Quality	Enc.	12.30
16.	Quality & Risk Management Committee Report	Assurance	Non-Executive Director	Enc.	12.35
PEOPLE					
17.	People & Digital Committee Report	Assurance	Non-Executive Director	Enc.	12.40
PERFORMANCE AND FINANCE					
18.	Integrated Performance Report – June 2019	Review	Chief Executive	Enc.	12.45

No.	Item	Purpose	Lead	Enc.	Time
19.	Month 2 Corporate Objectives Update	Review	Director of Finance	Enc.	13.05
20.	Finance & Performance Committee Report	Assurance	Non-Executive Director	Enc.	13.20
CLOSING BUSINESS					
21.	Any Other Business	Information	Chair	Verbal	13.25
22.	Questions from the Public in Relation to Agenda Items	Information	Chair	Verbal	
21.	Date of Next Meeting: Thursday 26th September 2019, 10.00 a.m. Seminar Room 4, 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.				

Public Minutes of the Trust Board Meeting, Thursday 30 May 2019
Seminar Room 5, Learning and Research Centre, 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	Dr C Burton	Medical Director
Mr T Gregory	Non-Executive Director	Mr N Darvill	Director of Informatics
Mr R Mould	Non-Executive Director	Mrs C Phillips	Director of Finance
Ms J Meekings-Davis	Non-Executive Director	Ms J Marshall	Director of People & Transformation
		Ms H Blanchard	Interim Director of Nursing & Quality
		Mr S Wood	Director of Estates, Facilities & Capital Planning

In Attendance:

Mr X Bell	Director of Corporate Governance / Trust Secretary	Mr M Pender	Deputy Trust Secretary
Mr S Lightbown	Director of Communications		

Apologies:

Prof J Iredale	Non-Executive Director

Observers: 5 members of staff / public attended.

Action

TBC/19/05/1 **Welcome**

The Chair welcomed everyone to the public meeting of the Board, particularly those members of staff who were observing.

TBC/19/05/2 **Apologies For Absence and Welcome**

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

TBC/19/05/3 **Staff Story / Freedom to Speak Up Report**

The Board received a staff story from one of the Freedom to Speak Up Guardians, which provided examples of how the Guardians were working to enable staff to raise concerns relating to risk, malpractice or wrongdoing that they felt was harming the service provided by the Trust. During the ensuing discussion the Board thanked all the FTSU Guardians for the work they did, and welcomed this initiative as an alternative way for member of staff to raise concerns outside of a formal process.

The Board then considered a report which provided an update on the Freedom To Speak Up (FTSU) Guardians programme, and it was reported that NBT now had a robust and established FTSU approach, with 13 FTSU Guardians in place across the Trust.

Xavier Bell reported that whilst NBT was within the average range of the number of concerns being raised compared to other Trusts, the data

provided indicated that in recent quarters the number of concerns being raised at NBT had dropped. The data also showed that whilst NBT was mostly aligned with the national data, the percentage of Nurses raising concerns at NBT was significantly lower than the national average, whereas there was a higher percentage of Allied Healthcare Professionals and Midwives raising concerns.

A summary of the progress made against the FTSU action plan developed from the Board session in August 2018 was provided, and overall good progress had been made. The data did however show that there was an ongoing need to improve awareness, visibility and confidence to speak up, particularly amongst the Medical and Nursing workforce.

During the ensuing discussion members of the Board commented that it was difficult to interpret the data presented in the report, particularly given the relatively small numbers involved. It was also suggested that the FTSU policy should not sit in isolation and that should be used as part of the Trust's overall approach to how it engages with people.

After further discussion it was RESOLVED that the progress against the FTSU vision, strategy and action plan be noted.

TBC/19/05/4 Declarations of Interest

John Everitt declared an interest in items 19 and 20 (Final Accounts and Annual Report 2019/20) as his daughter was an employee of the Trust in the Charity Department. He confirmed that he would not comment on these items.

TBC/19/05/5 Minutes of the Public Trust Board Meeting Held on 28th March 2019

RESOLVED that the minutes of the public meeting held on 28th March 2019 be approved as a true and correct record.

TBC/18/05/6 Action Log and Matters Arising from the Previous Meeting

The updates provided in the action log were considered and approved. It was noted that the presentation on pressure injuries had been deferred and would now be made to the July public meeting of the Board.

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

TBC/19/05/7 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 to the Board:

- It was noted that the UH Bristol's five year strategy had recently been published, and it was confirmed that NBT had been consulted during its preparation. The agenda for the forthcoming Board to Board meeting between NBT and UH Bristol was also discussed.

- Andrea Young provided an update on the Healthy Weston

consultation, and it was confirmed that in NBT's view there was a need for an ongoing, strong and sustainable service in Weston. The Board discussed the possible impact the various options for Weston would have on NBT, and it was acknowledged that there was at present a limit on the amount of work that could be absorbed from Weston by the Bristol acute Trusts.

- The Board discussed the recent BBC report on learning disability services in Somerset and the issues this raised in respect of local authorities and social care funding. The Board discussed the Trust's future role in this area of work and how it could use its estate in the future to help facilitate change.

RESOLVED that the Chief Executive's report be noted.

TBC/19/05/8 Draft Quality Account

The Board considered a report which provided the current draft of the Quality Account for review by the Trust Board. It was reported that the first draft had been reviewed by the Quality & Risk Management Committee on 9th May 2019, and an updated version, together with the draft external audit opinion, had been considered by the Audit Committee on 23rd May. The external audit opinion had not flagged any concerns, subject to a limited number of minor points that required clarification. .

Following consideration by the Board the latest version of the Quality Account would be circulated to external stakeholders for them to provide formal commentary, which would be included in the final published version of the Quality Account.

The Board provided minor corrections / amendments to the draft Quality Account, and endorsed its contents.

RESOLVED the final steps required, including external consultation on the contents, for the 2018/19 Quality Account, and the timetable for publication, be noted by the Board.

TBC/19/05/9 Quality and Risk Management Committee Report

The Board received the report from the meeting of the Quality and Risk Management Committee held on 9th May 2019. Rob Mould, Non-Executive Director highlighted particular points of interest to the Board.

The issue of Executive / Non-Executive Walkrounds was discussed and it was agreed that the format for these should be discussed at a future private meeting of the Board. **XB/HB**

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

TBC/19/05/10 People and Digital Committee Report

The Board received the report from the meeting of the People and Digital Committee held on 17th April 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/19/05/11 Staff Survey – key themes and actions

The Board considered a report which summarised the progress to date in respect of the key themes and actions arising from the 2018 staff survey, and the planned actions to take place during 2019. It was reported that whist in 2018 the Trust had improved in all areas of the survey, it had not quite achieved the national average score for acute Trusts. However, by continuing the same trajectory of progress in 2019 the aim was to achieve above average scores for the next staff survey, and targets had been set accordingly. An ambitious target for an improved staff survey completion rate of 55% had also been set, which would put NBT in the top 10% of acute trusts.

During the ensuing discussion the following points were made:

- It was suggested that the lessons learnt from the successful flu vaccination campaign conducted by the Trust during the winter of 2018/19 should be used to inform the staff survey process;

- John Everitt suggested that there needed to be clarity on which issues were at corporate level issues and which could be addressed at a more local level. Staff would only participate in this year's survey if they could see evidence of action being taken as a result of last year's survey;

- The Chair welcomed the ambition of the targets set in the report and emphasised the vital function of the survey as check for the organisation on how it looks after its staff.

RESOLVED that:

- **The 2018 Staff Survey areas for action, progress to date, and key activities to be undertaken, as outlined in the report, be noted; and**

- **The targets for improvement, including the staff survey completion rate target for 2019 of 55%, be endorsed by the Board.**

TBC/19/05/12 Integrated Performance Report – April 2019

Andrea Young introduced the Integrated Performance Report (IPR) for April 2019.

The Executive Directors summarised the contents of the sections of the IPR for which they were responsible, on which they were questioned by the Non-Executive Directors.

The following points were raised during the ensuing discussion:

- Concern was expressed regarding the overall performance of the Trust in April as set out in the IPR, and Andrea Young commented that the Executive Team recognised the seriousness of the

situation and some of the causes behind the figures. It was noted that the Trust was a national outlier in respect of the growth in demand it was experiencing, and this was accepted at a national level. The Board discussed in detail the drivers for this growth, and it was requested that whilst the Trust remained under pressure assurance was provided to the Board that the quality and safety of care was not suffering as a result.

- The pressure on the Emergency Department (ED) was discussed, and it was confirmed that the business case to allow the ED to staff up to meet the increasing demand had recently been approved. It was however recognised that there were physical limitations on the ED that would need to be addressed in future years if demand continued to rise at its current rate. It was suggested that the issue of A&E services in Bristol be discussed at the forthcoming Board to Board meeting with UHBristol.

- The current recruitment position in respect of the Cossham Birthing Centre was discussed, and it was confirmed that this would be coming back to the Board for a full discussion in July.

- Helen Blanchard highlighted the significant increase in pressure injuries seen during April, and reported that work was ongoing to understand if this was a trend or something unique to April. A 40% decrease in pressure ulcers had been seen in May to date, and staff were being reminded of the importance of moving patients regularly to avoid such injuries.

- It was reported that a recovery plan was in place in respect of complaints, and the work of the new PALS service was highlighted. Kelvin Blake reported that he had been impressed with the PALS service when he visited, and felt that that this was the correct way to address the Trust performance in respect of complaints. Rob Mould commented that the new Patient & Carer Experience Committee would be looking further into complaints as part of its work.

The Board reviewed the Board compliance statements as set out in the IPR, and particularly discussed no.10 in respect of whether the Board was satisfied that the plans in place were sufficient to ensure ongoing compliance with all existing targets. The Board came to the conclusion that at present it was satisfied that it could sign off all the compliance statements, but that they would receive further scrutiny as the year progressed.

RESOLVED: That the IPR be noted.

TBC/19/05/13 Sustainable Development Policy and Management Plan Update

The Board considered a report which provided a six monthly progress report on the Sustainable Development Management Plan's objectives and targets, and highlighted the risks and opportunities going forward.

RESOLVED that the Sustainable Development Policy and

Management Plan update report be noted.

TBC/19/05/14 Finance and Performance Committee Assurance Report

The Board received the report from the meeting of the Finance and Performance Committee held on 17th April 2019. Rob Mould, 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/19/05/15 Audit Committee Report

The Board received the report from the meeting of the Audit Committee held on 30th April 2019 and 23rd May 2019. Jacki Meekings-Davis, Non-Executive Director and Chair of the Committee highlighted particular points of interest to the Board.

RESOLVED that the Audit Committee assurance report be received and noted.

TBC/19/05/16 Provider License Self Certification

Xavier Bell introduced a report which provided evidence and recommendations to support the Board's self-certification against the Provider Licence, as required by NHS Improvement.

It was noted that it was recommended that the Board should certify "not confirmed" against condition G6, as the Trust breached its licence in 2018/19. It recommends that the Board certify "confirmed" against condition FT4, as it was taking steps to repair any breach and ensure it would not recur.

RESOLVED that the self-certification for licence conditions G6 and FT4 be approved, noting that the Trust had certified that during 2018/19 it was not fully compliant with this condition G6.

TBC/19/05/17 Final Accounts 2018/19 and Letter of Representation

The Board received for information the Annual Accounts 2018/19 and Letter of Representation. These had been approved by the Audit Committee on 23 May 2019 under delegated authority and had been signed and submitted to regulators on 29 May 2019.

RESOLVED that the Final Accounts 2018/19 and Letter of Representation be endorsed and noted.

TBC/19/05/18 Trust Annual Report and Summary Financial Statements 2018/19

The Board received for information the Trust Annual Report and Summary Financial Statements 2018/19. This had been reviewed by the Trust Board in draft at its April meeting, and was approved by the Audit Committee and the Chair and Chief Executive under delegated

authority prior to its submission on 29 May 2019.

RESOLVED that the Annual Report and Summary Financial Statements 2018/19 be endorsed and noted.

TBC/19/05/19 Any Other Business

There was no additional business raised.

TBC/19/05/20 Questions from the Public in Relation to Agenda Items

No questions were received from the public.

TBC/19/05/21 Date of Next Meeting

The next public meeting of the Board was scheduled to take place on 25th July 2019 at 10.00am, Southmead Hospital.

The meeting concluded at 12.50pm

Report To:	Trust Board Meeting in Public	**Agenda Item:**	5.0
Date of Meeting:	25 July 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 19/07/2019
Blue (Completed and will be removed from chart for next iteration)	1
Green (Status updated and on track within timescale)	1
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.

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PUBLIC BOARD ACTION CHART POST 30 MAY 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/18/11/3	Patient Story Pressure Ulcer Prevention Quality Initiative	Back to Board at the end of 6 months.	Helen Blanchard Director of Nursing.	30/05/19	Yes. To ~~30/05/19~~ 25/07/19	Update to be provided in July when the initiative has been embedded further.	Blue A
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.	Amber
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	On track	Green

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Report To:	Trust Board	**Agenda Item:**	9.
Date of Meeting:	25th July 2019		
Report Title:	Reduction & Prevention of Pressure Injuries Programme update for Trust Board July 2019		
Report Author & Job Title	Su Monk, Assistant Director of Nursing Sam Matthews, Nurse Consultant Infection Prevention Control & Tissue Viability		
Executive/Non-executive Sponsor (presenting)	Helen Blanchard, Interim Director of Nursing		

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

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

Executive Summary

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

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

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

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

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

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

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

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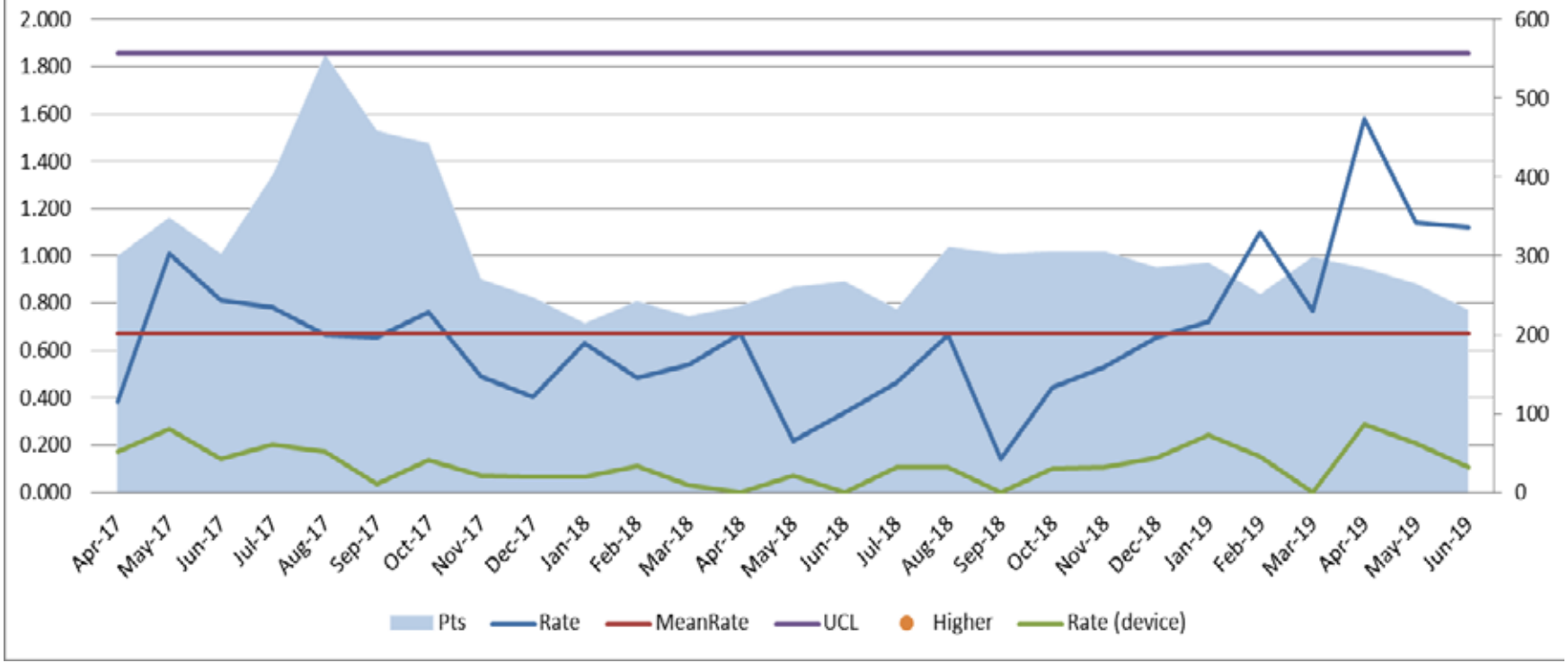
Reduction & Prevention of Pressure Injuries Programme update for Trust Board July 2019

Su Monk. Assistant Director of Nursing and Quality

Pressure Injuries - Total G2+ per 1000 Beddays
Trustwide



Reduction & Prevention of Pressure Injuries Driver Diagram (2019/20)

Reduce the incidence of pressure injuries

Infrastructure and Culture

MDT approach

Board<>Ward agenda.

Compliance with BNSSG Strategy and NHSi 29 recommendations

Patient Safety & Quality Agenda

Documentation

- Ø Review current documentation and EPR Tissue viability admission/Daily risk assessment – triangulation of Electronic > Paper (bedside folder/safety briefings). (consider research project)
- Ø Review and revise Care plans and Records of Care
- Ø Revise patient information to support the skin care.

Education/ Training

- Ø Introduce integrated programme of staff training and competency (core standards) on a range of safety elements and develop and sustain a positive safety culture:-
- Ø Patient & family education
- Ø Further development of role of TV Link Practitioner

Monitoring and Assurance

- Ø Development of pressure Injury dashboard
- Ø PI incidence report as part of integrated board report
- Ø Incident review for all hospital acquired pressure injuries grade 2 and above , SWARM reviews
- Ø Reporting into governance structure.

KPIs

95 % risk assessment compliance:

- Admission (6 hours)
- Daily

- TV link practitioner active in all clinical areas
- Mandatory training and competency compliance above 90%

- Dashboard reporting with Divisional analysis of trends
- Reporting to Trust Board with interventions and outcomes

Project KPIs

- 30% reduction Grade 2
- 30% reduction medical device related Grade 2
- SSKIN Audit compliance 95% of practice and documentation

Key

- Documentation
- Monitoring & Assurance
- Education & Training
- Infastructure & Culture

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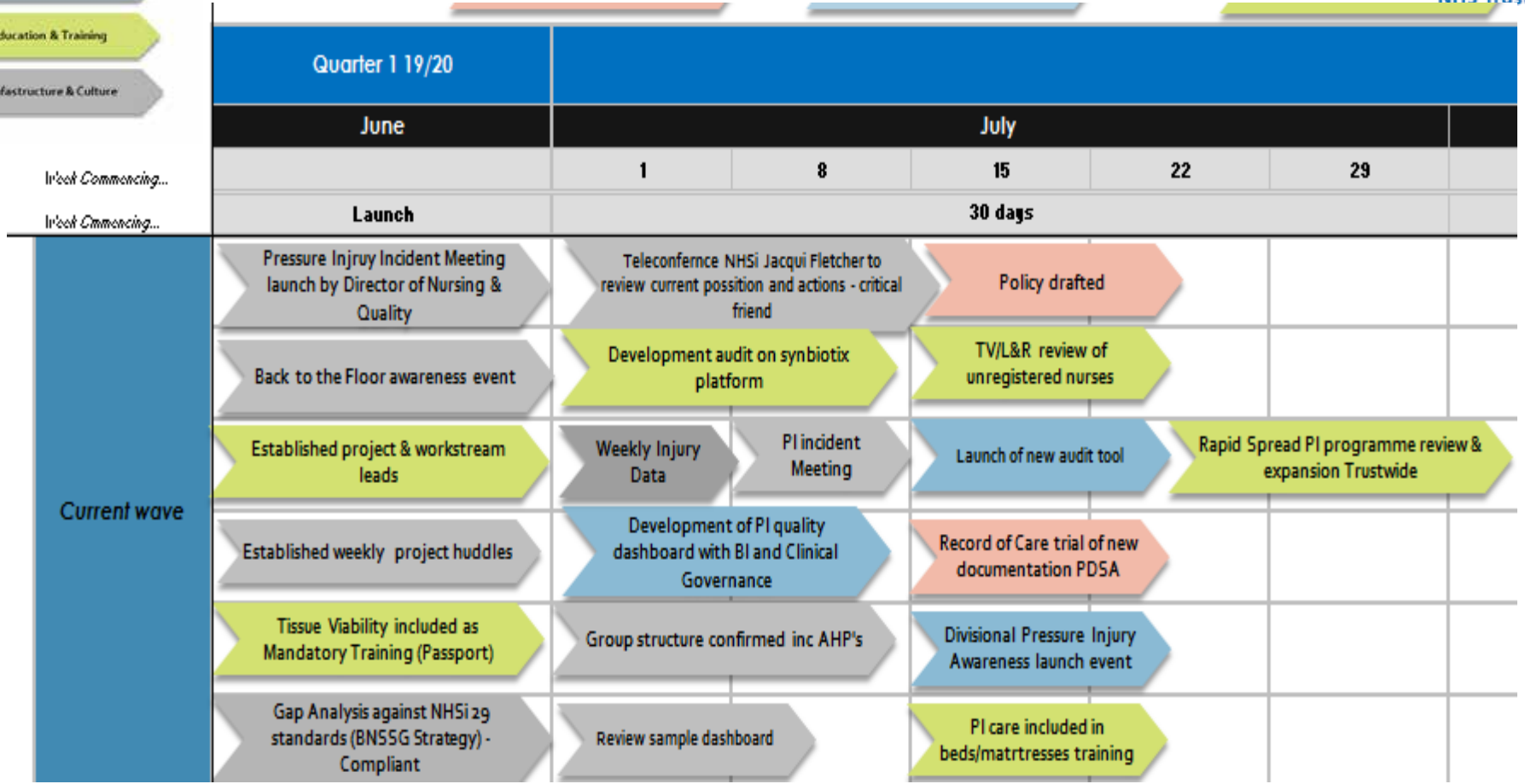

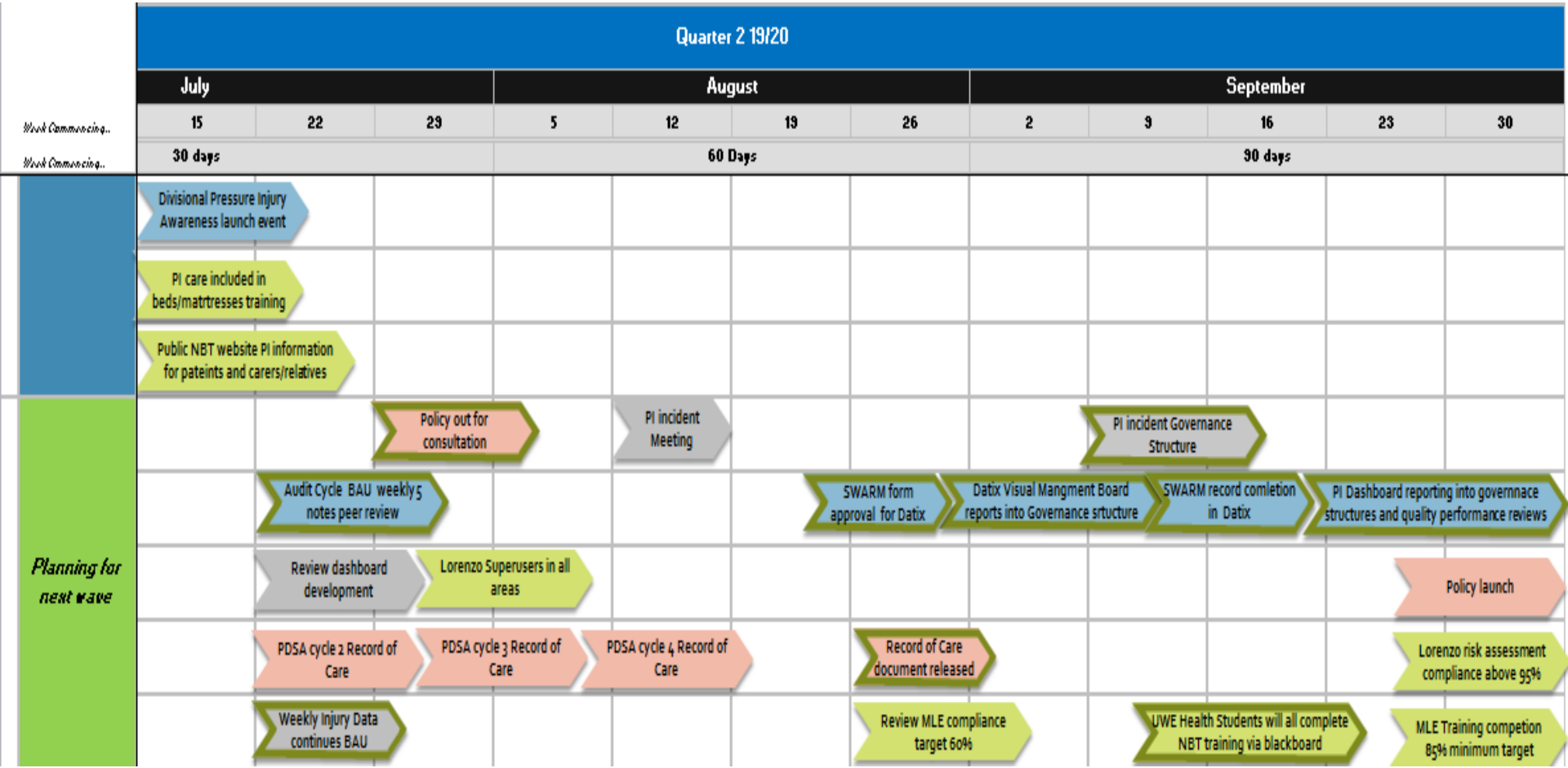
Quarter 2 19/20
July
August
September
Week Commencing..
15
22
29
5
12
19
26
2
9
16
23
30
Week Commencing..
30 days
60 Days
90 days
Divisional Pressure Injury Awareness launch event
PI care included in beds/matrtresses training
Public NBT website PI information for pateints and carers/relatives
Planning for next wave
Policy out for consultation
PI incident Meeting
PI incident Governance Structure
Audit Cycle BAU weekly 5 notes peer review
SWARM form approval for Datix
Datix Visual Mangment Board reports into Governance srtucture
SWARM record comletion in Datix
PI Dashboard reporting into governnace structures and quality performance reviews
Review dashboard development
Lorenzo Superusers in all areas
Policy launch
PDSA cycle 2 Record of Care
PDSA cycle 3 Record of Care
PDSA cycle 4 Record of Care
Record of Care document released
Lorenzo risk assessment compliance above 95%
Weekly Injury Data continues BAU
Review MLE compliance target 60%
UWE Health Students will all complete NBT training via blackboard
MLE Training competion 85% minimum target

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<table>
<tr><td>Report To:</td><td colspan="3">Trust Board</td><td>Agenda Item:</td><td>9.1</td></tr>
<tr><td>Date of Meeting:</td><td colspan="5">25 July 2019</td></tr>
<tr><td>Report Title:</td><td colspan="5">Update on the management of the temporary partial closure of Cossham Birth Centre</td></tr>
<tr><td>Report Author & Job Title</td><td colspan="5">Karen Maxfield, Divisional Operations Director – Women & Children's Health</td></tr>
<tr><td>Executive/Non-executive Sponsor (presenting)</td><td colspan="5">Helen Blanchard, Director of Nursing and Quality</td></tr>
<tr><td rowspan="2">Purpose:</td><td>Approval/Decision</td><td>Review</td><td colspan="2">To Receive for Assurance</td><td>To Receive for Information</td></tr>
<tr><td>X</td><td></td><td colspan="2">X</td><td>X</td></tr>
<tr><td>Recommendation:</td><td colspan="5">The Trust Board is asked to note:
· The temporary partial closure of the Freestanding Midwifery Unit at Cossham Birth Centre, remains in place until the end of September 2019, as approved by the Trust Board on 31 January 2019.
· Recruitment of the additional midwifery workforce required to manage the current demand in the acute unit at Southmead Hospital has continued to be good. The workforce trajectory is expected to deliver sufficient staff in post for the acute unit, having completed induction and training, by the end of September 2019, although the position has been more stable from June 2019.
· Sufficient experienced midwives will 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, including those teams associated with both birth centres, and the homebirth service, is underway with a view to implementing a new, more robust workforce model across the NBT catchment area and including the Cossham Birth Centre. A number of options are currently on the long list for further assessment. Additional time is needed to complete the review.
· Plans are in place to update and advise stakeholders, staff and users of the implications to the Cossham midwifery services.
The Trust Board is also asked to:
Approve: The proposal to reopen Cossham Birth Centre via a "Lock and Key model" from 21 October 2019 on a case by case basis.</td></tr>
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	· **Support:** plans to complete the staffing review and a potential organisational change to the staffing models for the two birth centres, community midwife team and the homebirth service.
Report History:	N/A
Next Steps:	N/A
Strategic Theme/Corporate Objective Links	Be one of the safest trusts in the UK - Maintain safe access to services.
Board Assurance Framework/Trust Risk Register Links	The decision to temporarily close Cossham Birth Centre to women in labour and to redeploy the staff partially mitigates the risk of insufficient midwifery staff at Southmead needed to meet the rising demand for obstetric led maternity care, as recorded on the divisional risk register.
Other Standard Reference	N/A
Financial implications	N/A
Other Resource Implications	£5k for a Project Lead and £10k for Birth Rate Plus assessment
Legal Implications including Equality, Diversity and Inclusion Assessment	The Board's decision for a temporary and partial closure of Cossham Birth Centre was made in response to an urgent need to utilise the Cossham midwives to maintain safe care at Southmead. Engagement prior to the original decision being taken was based upon the evidence of urgent, unexpected patient safety concerns and the need to act swiftly to address those risks. This needs to be considered in relation to further decisions as well.
Appendices:	Quality Impact Assessment – *to follow*

1. Purpose

1.1 The purpose of this paper is to update the Trust Board of the ongoing management of the temporary partial closure of Cossham Birth Centre. It aims to set out in detail the key issues, actions and risks to provide the assurance required, to guide further discussion about any additional steps required, and makes recommendations. This is with the aim of enabling the Board to make a decision about the ongoing closure or reopening of Cossham Birth Centre.

2. Background

2.1 The Maternity Service at NBT provides four options for pregnant women for place of birth: Obstetric-led care on Central Delivery Suite (CDS) on the Southmead Hospital site; Mendip Birth Centre (an Alongside Midwifery Unit or AMU), also on the Southmead site; Cossham Birth Centre (a Freestanding Midwifery Unit or FMU) at Cossham Hospital; and a home-birth service. The latter three options are all midwifery-led services.

2.2 On Friday 5 October 2018, the Women's and Children's Divisional leadership team took the decision for the second time (the first being 21 September 2018) to temporarily divert women in labour from Cossham Birth Centre to Mendip Birth Centre at Southmead Hospital. All routine antenatal and postnatal clinics at Cossham Birth Centre are unaffected and continue to run as normal. Therefore, the temporary partial closure of the birth centre affects births only, and, as such, is described as a partial closure.

2.3 The decision to temporarily close Cossham Birth Centre for births was taken because of an unprecedented high number of women needing care on CDS at Southmead Hospital for normal labour, induction of labour (IOL) or caesarean section (CS). The peak in demand for complex and specialist care was the result of a combination of increasing complexity and acuity of pregnant women, and the impact of the implementation of national guidelines in an effort to reduce the incidence of stillbirths in line with Department of Health targets. Both factors caused an increased requirement to offer more women an IOL and/or an elective CS, which has continued in 2019-20, (32% for CS and 40.1% for IOL year to date). The funded establishment of the midwifery workforce at the Southmead maternity unit was insufficient for this level of demand and additional midwives were required to staff this area. There were also not enough antenatal beds to cope with the demand for IOL and CS.

2.4 When Cossham Birth Centre closed, the midwives located there moved to Southmead and joined the Mendip Birth Centre team, enabling those midwives to be freed up to support the rest of the acute unit. This was part of the standard contingency plan to maximise the midwifery workforce on one site and maintain safe staffing levels at times of escalation. Consequently, it provided additional midwives by day and night on the Southmead site, whilst also supporting the home birth service. This action also provided additional maternity care assistants for Southmead. Six additional beds were also opened on Cotswold Ward to provide extra antenatal bed capacity.

2.5 The temporary, partial closure was endorsed by the Trust Board on 25 October 2018 until the end of February 2019. In addition, in order to meet the workforce requirement for the increased demand and acuity more sustainably, funding for 16.26 WTE additional midwives, plus a number of support staff, was also agreed. This elevated the

staffing on CDS to 9 midwives per shift plus 1 co-ordinator (9+ 1) from 7 midwives plus 1 co-ordinator (7+1) per shift and would enable the additional six beds to be covered.

2.6 Although recruitment of the additional midwifery workforce required to manage the increased demand at Southmead Hospital was good, in January it was projected that the required resource would not be in place by February 2019. Furthermore, the midwives required to resource Cossham Birth Centre and the associated homebirth service had not been expected to be available by the end of February to facilitate a reopening at this time due to vacancies and sickness.

2.7 Consequently, on 31 January 2019 the Trust Board decided to extend the closure until the end of September 2019. The reopening of the birth centre at this point would be dependent on having recruited to the required workforce at Southmead. However, it was also subject to a review of the workforce model supporting Cossham Birth Centre, Mendip Birth Centre, the community midwifery team, and the homebirth service, with a view to implementing a new, more robust workforce model before Cossham Birth Centre reopened.

2.8 Key stakeholders including the commissioners, Bristol and South Gloucestershire MP's, South West Ambulance Service, other local Maternity providers (UH Bristol NHS Foundation Trust, Bath RUH NHS Trust, Weston Area Health Trust), Bristol Community Health, Healthwatch Bristol, South Glos and B&NES, North Somerset Community Partnership, Healthwatch North Somerset, Sirona CIC, the CQC and NHS England/ Improvement (South West) were informed of the further extension. On 31 January individual letters were sent by email to:

- Joint Union Committee;
- BNSSG Maternity Voices Partnership;
- Cossham Birth Centre Stakeholder Group;
- Bristol Birth Support Doula Group.

2.9 The South Gloucestershire Council Health Overview and Scrutiny Committee (HOSC) had been consulted prior to this on 16 January 2019. The committee was satisfied for the Trust Board to make a decision about the ongoing partial temporary closure.

3. Assessment of the Current Recruitment Position

3.1 The decision by the Trust Board on 31 January 2019 was that the current partial closure would remain in place until the end of September 2019 to facilitate the continued recruitment of the additional midwifery staffing levels required on the Southmead site.

3.2 Recruitment of midwives to fill the new and vacant posts has been underway since October 2018. The total resource required at the point when the recruitment commenced was 23.8 WTE (16.26 WTE new posts and 7.54 WTE vacancies).

3.3 Subsequently to this it was determined that an over-establishment of 11 WTE against budget in the community midwifery teams essentially masked a larger vacancy in the other acute midwifery areas so the original vacancy rate stated in October was understated. Therefore, the actual vacancy rate at that time would have been closer to 34 WTE. The over-establishment against budget in the community has been necessary to meet the increase in acuity also being felt in the community, but this is being validated through the workforce review. The skill-mixes in all areas have now been re-

baselined and consequently the vacancy rates now quoted are correct (and have been adjusted for with the over-establishment against budget in the community workforce).

3.4 The Trust has seen a very positive recruitment response. Since October 2018, 19.76 WTE midwives have been recruited and have started in post. As at 26 June 2019, the vacancy rate was 14.09wte. This is a reduction in the vacancy rate of 20 WTE since October, whilst also dealing with a turnover rate of 2 WTE per month.

3.5 The forthcoming pipeline is comprised of 19 midwives with start dates over the next three months. Consequently, the vacancy has reduced to 12.64 WTE in July and 9.48 WTE in August. The service will actually be over-established by 4.7 WTE by September (again based on the status on 26 June 2019). Projected turnover of 1.7 WTE per month has been factored in (which has reduced due to improved retention).

3.6 The number of new recruits has enabled the service to fill the vacancies and deal with turnover. A comprehensive recruitment plan has been developed to ensure that any future vacancies can be filled in a timely manner and that there is robust pipeline of midwifery staff going forward, in particular for experienced Band 6 midwives.

3.7 In addition, investment to fund three new Consultant Obstetricians has been secured and this resource is now in place to support the acute unit.

4. Update on the Workforce Review for Midwifery-led services

4.1 The closure of the Birth Centre in October exposed that both the existing Cossham Birth Centre and Homebirth service staffing models were fragile and needed to be reviewed to ensure sustainability. The staffing model prior to closure was implemented in July 2017 at which time the traditional community midwives ceased to provide the on-call homebirth service and a dedicated homebirth team was implemented instead but this has not provided the service in the way that it was originally intended. NBT benchmarks as an outlier with regards to having a 24 hour community midwifery service instead of incorporating an on-call.

4.2 Consequently, with the opportunity afforded by the extension to the Cossham Birth Centre closure and as requested by the Board in January, the Divisional Senior Team embarked on a comprehensive review of the staffing models in relation to the requirements for both birth centres (Cossham and Mendip, including the way the midwives in the birth centres interact with each other and between each centre), the homebirth service and the community midwifery team to ensure a safe, effective and affordable model of care going forward whilst maintaining a flexible workforce with the required midwifery skills.

4.3 The objectives for the review include:

- To provide a sustainable homebirth service as well as ensuring both birth centres are operational;
- To maintain a flexible, multi-skilled workforce better placed to provide all midwifery-led birth place options within a robust infrastructure;
- To support a Continuity of Carer (COC) model in line with the Better Births recommendations and potentially to an increasing number of women to reach the national targets of 35% on COC pathways by March 2020.

4.4 As the review has progressed, it has been much more complicated than anticipated in order to understand the various existing staffing models for the birth centres, community and homebirth team, and how they interact with each other. In addition, the need to ensure that COC pathways are incorporated into the workforce models has provided an extra layer of complexity. A COC pilot with Mendip Integrated Team had been planned but so far it has not been possible to implement this as it will deplete the homebirth rota and risk delivery of that service.

4.5 The midwifery workforce has been involved in the review so far through membership of the Steering Group and also more widely through dedicated engagement sessions that were run throughout May. The Royal College of Midwives have also been represented on the Steering Group. The clear message from the midwives has been for the review to be thorough, and for a decision on a preferred staffing model and consequent implementation of that model not to be rushed in order to ensure a sustainable model going forward. The other overwhelming message from the community midwifery staff has been that any model involving a reinstatement of an on-call model would not be well received by them.

4.6 A number of options for the staffing model have so far been proposed. These need further work in order to run an effective options appraisal. However, most of these models are dependent on the community models undertaking an on-call rota again.

4.7 The preferred model also needs to be run through the bespoke Birth Rate Plus workforce planning tool to ensure that the correct workforce is calculated. This exercise is booked for October with the national Birth Rate Plus team for the whole maternity service. All models will be costed to determine financial affordability.

4.8 In the absence of the Director of Midwifery the review has not had the benefit of senior midwifery oversight of the options developed so far. The review needs to be transformational and look at different roles, and be informed by senior midwifery leadership involvement and users of the maternity services, this has not been possible.

4.9 As a consequence of these factors, it is recognised that further time is needed to fully conduct the review, to ensure senior midwifery leadership, and for the workforce options to be checked using the Birth Rate Plus methodology in October, and costed. It will enable a full assessment of all the options, the staff to be consulted with on the preferred option under the organisational change policy, for women to be included as part of the decision-making, and for the outcomes of the process to be implemented. All of these activities are anticipated to be completed and implemented by January 2020.

4.10 In addition, it is recommended that the COC pilot does not start in October as previously planned because it is not possible to do this at the current time with the current level of staffing. Instead, COC will be fully incorporated into the new staffing model in time for March 2020. This has been discussed with the Local Maternity System (LMS).

5. Proposal for a Phased Reopening Using “Lock and Key” model

5.1 In the absence of the above work being completed, there is still an option to reopen Cossham Birth Centre through a “Lock and Key” model.

5.2 The basis of this “Lock and Key” proposal is that the existing homebirth rota would provide low risk women assessed as eligible the opportunity to have either a Cossham birth or a homebirth i.e. the choice of one or the other. If a Cossham birth was

appropriate the midwife would meet the woman there and “open up” the birth centre. After the birth (at the agreed time post-delivery), the mum and baby would return home, and the birth centre would be “locked” again. The midwives in the homebirth team would then leave it be ready for the next birth. In reality, the birth centre would be operational in the daytime anyway for community midwifery clinics and not requiring actual unlocking/locking. However, the birth centre would have to be physically unlocked and locked at night time as no other midwifery services run overnight, although security are present.

5.3 This workforce model is based on the workforce being in place from the end of October and only be able to support one birth at a time (either a homebirth or Cossham birth) hence the case-by-case approach, and if a second woman went into labour, they would have to be directed to Mendip Birth Centre or if that was full, CDS would be offered. However, it would give women the potential to have a Cossham birth, which is currently not possible.

5.4 The homebirth rota will be sufficiently staffed to implement this model from 21 October 2019 and can support this proposal.

5.5 It has been suggested by the Women and Children’s Division that this proposed model would be positive in that a number of women could be supported in the delivery of their baby at Cossham Birth Centre, ahead of a comprehensive review of the two birth centres (Cossham and Mendip), the homebirth service and the community midwifery team discussed in part 4 of this paper. Implementation of this model would give the appropriate time to carefully and comprehensively develop the fuller options, do the necessary consultation and implementation. Although it was limited in that would only facilitate either a homebirth or Cossham birth at one time, not both, it would be an enhanced offer compared to the current situation. Both the Specialty Director for Obstetrics and also the Consultant Neonatologists have confirmed that they are happy for this proposal, as long as the normal protocols for Cossham Birth Centre remain in place.

5.6 If this proposal is endorsed, a full implementation plan will be developed, including a comprehensive training programme for the midwives on the homebirth rota, completion of the necessary Standard Operating Procedures, and for the practical steps required in order to operationalise the Birth Centre for births again.

5.7 A communications plan has been developed continue to update and advise stakeholders, staff and users of the implications to the service as the review progresses and also in view of the above proposal.

6. Summary and Recommendations

6.1 The Trust Board is asked to **note**:

6.1.1 The temporary partial closure of the FMU at Cossham Birth Centre currently remains in place until the end of September 2019, as approved by the Trust Board on 31 January 2019.

6.1.2 Recruitment of the additional midwifery workforce required to manage the current demand in the acute unit at Southmead Hospital has continued to be successful. The workforce trajectory is expected to deliver sufficient staff in post for the acute unit, having completed induction and training, by the end of September 2019.

6.1.3 Sufficient experienced midwives will 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.

6.1.4 A review of the workforce model supporting Cossham Birth Centre, Mendip Birth Centre, the community teams, including those teams associated with both birth centres, and the homebirth service, is underway with a view to implementing a new, more robust workforce model across the NBT catchment area and including the Cossham Birth Centre. A number of options are currently on the long list for further assessment. Additional time is needed to complete the review.

6.1.5 Plans are in place to update and advise stakeholders, staff and users of the implications to the Cossham midwifery services.

6.2 The Trust Board is also asked to:

6.2.1 **Approve** The proposal to reopen Cossham Birth Centre via a “Lock and Key model” from 21 October 2019 on a case by case basis.

6.2.2 **Support** plans to complete the staffing review and a potential organisational change to the staffing models for the two birth centres, community midwife team and the homebirth service.

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Quality Impact Assessment – Partial reopening of Cossham Birth Centre on lock & Key basis

Quality Impact Assessment	Comments
What is the impact on safety?	NBT's main priority for maternity services is to maintain patient safety. Cossham Birth Centre is a standalone Midwifery led unit and findings from the Birth place study (2012) showed that Midwifery led units appear to be safe for the baby and offer benefits for the mother and for "planned births in freestanding midwifery units and alongside midwifery units there were no significant differences in adverse perinatal outcomes compared with planned birth in an obstetric unit." There is a risk in relation to mothers turning up overnight. A range of actions to mitigate against the impact to patients have been highlighted for development and implementation over the next few months. **Mitigations against impact on patients include:** • Trust website to be updated about the services provided at Cossham Birth Centre including contact details on how to contact a Midwife overnight. Information will also be made available to patients through their named Midwife, PALs, posters, social media and Trust Website. • Update local Trusts & SWAST regarding change of service provision and about the midwifery staffing overnight. • SOP regarding meeting Woman in labour by Midwife overnight • SOP regarding Opening and Closing Procedures of unit each day • SOP for management of postnatal mothers who want to stay longer than 6hrs.

	• Patient safety and experience will be closely monitored to identify areas for improvement. • SOP regarding BBAs (born before arrival of Midwife) if attending Cossham birth centre out of hours. Initial contact by women is usually by telephone prior to attendance in labour: the Cossham telephone line has also been diverted to Mendip and women calling the number are being asked which birth centre they are trying to contact.
What is the impact on patient experience?	Some women will have chosen to birth in a Freestanding Midwifery Unit (FMU) and have been assessed as appropriate, therefore may be disappointed not to have their primary choice of place of birth. Some may have had previous children there, which will exacerbate the disappointment felt in not being able to replicate that experience. Alternative midwifery-led care options remain available on the Alongside Birth Centre (AMU) at Mendip Birth Centre and also the Homebirth service on a case-by-case basis, as well as the Obstetric-led Unit if required. The need to set expectations early in pregnancy by the community midwives is vital and this will help to reduce any negative impact on patient experience if women are not able to attend to have their baby, due to capacity. The experience that women and their families have when attending Cossham Birth Centre is a high priority. It is possible that a lock & key limited service of one birth at a time (Cossham birth centre or at home) may have a negative impact on patient experience. The choice available would then be either - Cossham birth Centre or Mendip Birth centre and the potential impact of this on patient experience for those mothers whose preference had been to deliver their baby at Cossham but are unable and because of capacity and choice will need monitoring closely. The risk to patient experience is assessed as moderate.
What is the impact on clinical outcomes?	Cossham Birth Centre is suitable for Low risk births. "For 'low risk' women the incidence of adverse perinatal outcomes (intrapartum stillbirth, early neonatal death, neonatal encephalopathy, meconium aspiration syndrome, and specified birth related injuries including brachial plexus injury) was low (4.3 events per 1000 births)." (Birthplace study NPEU 2012). For women having a first baby, the transfer rate during labour or immediately after the birth was 45% for planned home births, 36% for planned FMU (freestanding/Standalone birth centre) births and 40% for planned AMU (Alongside birth centre) births.

	For women having a second or subsequent baby, the proportion of women transferred to an obstetric unit during labour or immediately after the birth was 12% for planned home births, 9% for planned FMU births and 13% for planned AMU births.
What is the impact on access to services and waiting times?	This may have an impact on the number of women choosing Mendip Birth Centre and / or home birth as their preferred choice is Cossham Birth Centre. It may impact positively to reduce low risk births on CDS.
What is the impact across the Trust and/or the wider health economy?	Women who booked at Cossham Birth Centre may now not choose to attend the maternity service at the neighbouring Trust (UHBristol). There is a possible opportunity of partnership working within BNSSG and shared use of Cossham Birth with UHBristol. There is a planned meeting arranged in early August to discuss this proposal. There is an opportunity to improve the reputation of the maternity service and/or the Trust, external confidence levels may be impacted positively and there will be further media interest due future proposal of a full reopening of Cossham Birth Centre. There is still a potential impact on the morale, sickness, retention and recruitment to the homebirth team midwives as a consequence of the partial closure. The mitigation for this will be through continued co-design of the new model of working, RAG rated training programme for all staff working in model, support for junior who may rotate to the team.
What is the impact on equality and diversity? ***Refer to separate equality and diversity assessment***	No impact
Which performance measures or quality metrics will be used to monitor the impact of this scheme?	• The birth rates in all options for place of birth (FMU, AMU, OU, HB) • Quality and safety outcomes as monitored via the Maternity dashboard • Born Before Arrival (BBA) rates • Patient satisfaction as measured by Friends and Family • Number of patient complaints • Happy App feedback

Datix Risk No.	Title	Risk Type	Controls in place	Consequence	Likelihood	Risk level (current)	Risk level (with controls)	Risk level (Target)
506	Without the necessary remodelling of community midwifery staffing establishment - Cossham Birth Centre and home birth team may be unable to deliver full services.	Service Delivery, Business Continuity	Partial reopening of Cossham Birth Centre on a lock & key basis. Service provided by Homebirth team – on the basis of one birth at a time either on CBC or at home. Consultation with staff regarding a new staffing model, to create greater resilience in service provision	3	4	High Risk: 12	High Risk: 6	Moderate Risk: 4
508	Partial reopening of Cossham Birth Centre on a lock & key basis may negatively impact NBT's reputation and external confidence levels.	Reputational	**Communication plan including:** • Communications with women • Communications with CCG, stakeholders and regulators • Communication with media • Communication with MPs. A full report is being made to the Trust Board on 25th July 2019 which will set out in more detail the key issues, actions and risks to guide further discussion and decisions about any additional steps required. Key stakeholders (commissioners, the local Maternity provider - UH Bristol NHS Foundation Trust, CQC and NHS Improvement) will be informed. (Post Trust Board approval of plan)	3	4	High Risk: 12	High Risk: 6	Moderate Risk: 4

Datix Risk No.	Title	Risk Type	Controls in place	Consequence	Likelihood	Risk level (current)	Risk level (with controls)	Risk level (Target)
509	Partial reopening of Cossham Birth Centre may negatively impact the experience of patients using the service.	Patient Experience, Quality	Communication strategy that sets out proactive discussions with women that are due to birth from October 2019. Information provided on NBT website. Cossham Birth Centre's telephone lines will be diverted to Mendip Birth Centre at Southmead Hospital overnight to ensure that women/families/partner speak to someone that can discuss their options with them. Maternity Services staff have been provided with information through the communication strategy to assist in answering questions.	3	3	High Risk: 9	High Risk: 4	Low Risk: 3
507	The partial reopening of Cossham Birth Centre may impact staff morale, sickness, retention and recruitment.	Workforce, HR	Communication with staff: regular written updates/updates through safety briefing. Being open and honest about plans and timescales. Staff involved in steering groups involved in proposals for partial reopening and future modelling of services. Engagement with unions. RAG training needs analysis, has been devised with staff and will be implemented over the next few months.	3	3	High Risk: 9	High Risk: 4	Low Risk: 3

Datix Risk No.	Title	Risk Type	Controls in place	Consequence	Likelihood	Risk level (current)	Risk level (with controls)	Risk level (Target)
505	The partial reopening of Cossham Birth Centre on a lock & Key basis may impact on patient safety	Safety - Patient	Triage will be provided by homebirth Midwife to ensure continuity of carer. Out of hours (7pm-7am) automatic phone diversion from Cossham. The call will automatically divert to Mendip. SOP regarding BBAs (born before arrival of Midwife) if attending Cossham birth centre out of hours. SOP regarding meeting Woman in labour by Midwife overnight SWAST updated with SOP on calling homebirth midwife and new phased reopening Communications strategy to proactively inform women due to birth in low risk settings of added choice and limitations of availability of staff due to another birth. Low risk patient group.	3	2	Moderate Risk: 6	Moderate Risk:4	Low Risk: 3

	Likelihood score				
Consequence / impact score	**1 - Rare**	**2 - Unlikely**	**3 - Possible**	**4 - Likely**	**5 - Almost Certain**
5 Catastrophic	5	10	15	20	25
4 Major	4	8	12	16	20
3 Moderate	3	6	9	12	15
2 Minor	2	4	6	8	10
1 Negligible	1	2	3	4	5

Report To:	Trust Board (Public)		**Agenda Item:**	10.
Date of Meeting:	25th July 2019			
Report Title:	Safeguarding Adult Annual Report 2018/19			
Report Author & Job Title	Su Monk, Assistant Director of Nursing			
Executive/Non-executive Sponsor (presenting)	Helen Blanchard, Interim Director of Nursing			
Purpose:	**Approval/Decision**	**Review**	**To Receive for Assurance**	**To Receive for Information**
			x	
Recommendation:	The Trust Board is asked to receive for assurance details of the work and activity of the Safeguarding Adult service between April 2018 and March 2019			
Report History:	Draft of the annual report approved at Safeguarding Committee and endorsed at the meeting of the Quality & Risk Management Committee held on 17th July 2019.			
Next Steps:	N/A			

Executive Summary

Safeguarding is everyone's responsibility and for our patients this means protecting their rights to live safely, free from abuse and neglect. Where staff identify that an individual's rights have not been maintained, either prior to admission or during their hospital stay, through education, training and role modelling, this is highlighted and appropriately reported to the safeguarding team for advice. The numbers of contacts made to the safeguarding team each year has continued to grow as has the number of patients who require a Deprivation of Liberty Safeguard (under the Mental capacity Act, 2005) when they are unable to give informed consent to remain in the hospital.

Key successes over the year include:

- A thresholds review of all referrals to the Local Authority by the adult lead and a senior practitioner from Bristol City Council for both community and hospital acquired harm demonstrated team screening decisions are accurate and timely.
- Systems for managing the investigations process completed and simplified. Section 42 investigation requests are now logged and processed clearly and the practitioners and leads agree the terms of reference in partnership with the senior social workers based in the Trust.
- Production of a bespoke e-learning package to support accurate completion of

DoLS applications
- Response and support to staff for over 1300 concerns and monitoring of 981 DoLS

The focus for the year ahead 2019/2020
- DoLS scheme to be replaced by the Liberty Protection Safeguards following the passing of the final Bill through parliament. The safeguarding team with senior leaders to review the impact this will have as the Trust will need to authorise all of its own DoLS
- Use of additional clinical systems to streamline the process for staff seeking support from the Safeguarding Team
- Review of the Datix system as implemented in safeguarding and modification of the platforms to reduce administration and release practitioner time

A work plan has been developed that translates the 'what next' sections into actions, which will be agreed by the safeguarding committee and overseen by the Operational Group.

Strategic Theme/Corporate Objective Links	· Be one of the safest trusts in the UK · Treat patients as partners in their care
Board Assurance Framework/Trust Risk Register Links	Safeguarding adults at risk of harm, is everybody's responsibility and North Bristol NHS Trust supports all staff to contribute to the safeguarding of vulnerable adults whether they use our services, are visitors to the Trust or are our staff.
Other Standard Reference	CQC Regulation 13: Safeguarding service users from abuse and improper treatment
Financial implications	N/A
Other Resource Implications	
Legal Implications including Equality, Diversity and Inclusion Assessment	Alignment to the Bristol and South Gloucestershire Safeguarding Adult Boards evidenced by their annual reports: (note 2018-19 reports not published at the time of producing this report) · Bristol Safeguarding Adults Board Annual Report 2017/18: https://bristolsafeguarding.org/media/31879/bristol-safeguarding-adults-board-annual-report-2017-18-final.pdf · South Gloucestershire Safeguarding Adults Board Annual Report 2017/18: http://sites.southglos.gov.uk/safeguarding/wp-content/uploads/sites/221/2018/10/SGSAB-Annual-Report-2017-18-FINAL.pdf

	· Safeguarding strongly reflects the EDS2 objectives around better health outcomes, improved patient access and experience, representative and supported workforce and inclusive leadership · Safeguarding adults is statutory under The Care Act (2014) and regulatory under CQC Regulation 13
Appendices:	Safeguarding Adult NBT Annual Report 2018/19

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Safeguarding Adults Annual Report 2018 to 2019

Author: Claire Foster, Interim Professional Lead for Adult Safeguarding

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Executive Summary

Safeguarding adults at risk of harm is everybody's responsibility. North Bristol NHS Trust supports all staff to contribute to the safeguarding of those adults whether they are using our services, they are visitors or they are members of staff.

Key successes over the year include:

- Development of tools and training to support staff in their practice under the Mental Capacity Act and the Deprivation of Liberty Safeguards
- Regular contribution to multiagency forums and sub groups of the Safeguarding Adults Boards (SAB's)
- Responsive and supportive engagement by the Safeguarding Team to advise and guide staff in their safeguarding responsibilities as part of their core work
- Support to staff with over 1300 concerns raised
- Use of data from Datix to review activity and target training and support to high risk areas
- Identification of a cohort of staff to be trained at level 3 for adult safeguarding

Looking ahead to 2019/20 we will be:

- Working with divisional leads and specialists to implement cascade 'train the trainer' events focusing on assessment and documentation under the Mental Capacity Act and Best Interest decisions.
- Introducing new capacity assessment documentation that will be simpler to use and meets our legal obligations
- Updating all training and policies in line with legislation and guidance.
- Adapting current practice and policy when the anticipated changes to Deprivation of Liberty Safeguards and Domestic Abuse are enacted by Parliament
- Developing the content of the level 3 training for adult safeguarding alongside colleagues at United Hospital Bristol and Weston General Hospital and the CCG[1] to ensure parity across BNSSG[2]
- We will continue to engage in multiagency audits and develop a program of single agency audits to better understand the experiences of adults at risk and their carers who present to our services.

Through all our work we will seek to keep the person at the centre of our practice, promoting their rights and choices and maximising their opportunities to participate in the decisions that affect their care.

[1] Clinical Commissioning Group
[2] Bristol, North Somerset and South Gloucestershire

1.0 Purpose

The purpose of this report is to provide an update to the Trust Board on the developments and service delivery for 2018/19 in relation to safeguarding adults at risk of harm. This includes activity under the Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards 2009 (DoLS). It provides assurance to the Board that the Trust is fulfilling its statutory responsibilities and duties in relation to safeguarding adults. This annual report includes updates to the safeguarding team between 1st April 2018 and 31st March 2019.

2.0 Overview and Introduction

All staff have a responsibility to safeguard adults at risk as part of everyday service delivery. The Care Act 2014 defines adult safeguarding as protecting an adult's right to live safely, free from abuse and neglect. It also gives local authorities distinct legal duties and is clear that providers of care such as NHS trusts have a legal duty to cooperate with the local authority in delivering its safeguarding functions.

Over the past 5 years, there has been a significant growth in staff alerting concerns to the Safeguarding Team. The table below details this growth over this period and 2018/19 represents data captured through implementation of Datix the new electronic risk system that replaced and updated e-AIMS as a referral system into the safeguarding team.

Table 1: Contacts received by the Safeguarding Team

Year	Q1	Q2	Q3	Q4	Total
2014/15	54	57	105	98	214
2015/16	212	241	163	160	776
2016/17	258	268	352	353	1231
2017/18	395	380	351	375	1501
2018/19	321	339	322	375	1357

Following implementation of Datix we have been able to more accurately capture those contacts that have resulted in a response and actions by the safeguarding team. It should be noted that the team also provide training, telephone advice, case discussions, signposting and diversion to alternative services and screening of incidents that may relate to safeguarding adults but is not primarily referred to us and this work is not reflected in these two tables.

Table 2: Alerts resulting in actions by the Safeguarding Team

Year	Q1	Q2	Q3	Q4	Total
2018/19	230	215	240	305	990

Contact is made with the safeguarding team for a wide variety of reasons. The increase in activity is due to a combination of factors for example:

- Change in definition and threshold as introduced by the Care Act 2014
- The positive impact of training – generating greater awareness and therefore more contact with the team for support and advice
- The Safeguarding Team improved availability for support from August 2016 following recruitment of two specialist practitioners
- The broadening of the adult safeguarding agenda to include Exploitation, Domestic Abuse, Female Genital Mutilation, Modern Slavery, Trafficking, radicalisation and PREVENT
- Greater need to support practitioners with Mental Capacity Act and Deprivation of Liberty Safeguards compliance

The Trust separates adult safeguarding contacts into two distinct categories. Those that relate to community acquired harm and those that indicate hospital acquired harm. Both forms of harm can be identified by Trust staff, may be disclosed by a patient, or by a carer or relative on their behalf. The Safeguarding Team review the alert and screen it against the Care Act 2014 thresholds. Concerns relating to community acquired harm are referred to the patient's Local Social Services Authority. The Local Authority is then responsible for the ongoing safeguarding processes. The Trust will only be involved further if information is required.

The phrase hospital acquired harm refers to harm that occurs to people whilst they are receiving care and treatment within Trust services and locations. Hospital acquired harm is reported to the Safeguarding Team and is discussed in the Executive Incident Review Group. The flow chart in Appendix 1outlines the decision making process for hospital acquired harm. The table below indicates the referrals made to the Local Authority for both hospital and community acquired harm.

Table 3: Number of Alerts sent to Local Authorities 2018/19

Location	Q1	Q2	Q3	Q4
Community	19	18	30	17
Hospital	20	7	3	3

As part of Mental Capacity Act practice staff must ensure that inpatients who are unable to consent to being accommodated in hospital for their care and treatment are legally deprived of their liberty. This is done through assessment for and application of the Deprivation of Liberty Safeguards. The numbers of DoLS applications are recorded in table 4 below. Three years data is shown which indicates the continuing growth in DoLS applications.

Table 4: Number of DoLS applications over the last 3 years

Year	Q1	Q2	Q3	Q4	Total
2016/17	155	185	200	198	738
2017/18	241	206	251	245	943
2018/19	230	215*	240*	296	981

*Data for Q2 & Q3 is incomplete due to system error during change over to Datix for DoLS applications

What we achieved

- A thresholds review of all referrals to the Local Authority by the adult lead and a senior practitioner from Bristol City Council for both community and hospital acquired harm demonstrated team screening decisions are accurate and timely.
- Systems for managing the investigations process completed and simplified. Section 42 investigation requests are now logged and processed clearly and the practitioners and leads agree the terms of reference in partnership with the senior social workers based in the Trust.
- Production of a bespoke e-learning package to support accurate completion of DoLS applications
- Response and support to staff for over 1300 concerns and monitoring of 981 DoLS

What's next?

- DoLS scheme to be replaced by the Liberty Protection Safeguards following the passing of the final Bill through parliament. The safeguarding team with senior leaders to review the impact this will have as the Trust will need to authorise all of its own DoLS
- Use of additional clinical systems to streamline the process for staff seeking support from the Safeguarding Team
- Review of the Datix system as implemented in safeguarding and modification of the platforms to reduce administration and release practitioner time

3.0 Safeguarding Adults Leadership

The Director of Nursing is the Trust Board executive for safeguarding adults and children and represents the Trust at the Local Safeguarding Adults Board (LSAB) members meetings each quarter for both Bristol and South Gloucestershire. Senior management responsibility for safeguarding adults sits with the Deputy Director of

Nursing. Appendix 2 shows the attendance at LSAB Boards and sub groups for Bristol and South Gloucestershire.

2018/19 has seen changes to the structure of the safeguarding team. In January 2019 the Adult Lead left the Trust and during the recruitment period the Named Nurse for Safeguarding Children has covered both roles and management of the safeguarding team under the direction of the Deputy Director of Nursing.

The role of Adult Lead was reviewed and a new role advertised for Head of Safeguarding incorporating the Professional Lead for adult safeguarding as outlined by the Intercollegiate Document[3]. This role was appointed to in April 2019 and the new post holder will commence with the Trust in Quarter 2 of 2019/20. Working within the Trust values the Professional Lead for adult safeguarding leads on the development of a positive culture of safeguarding practice across the Trust and works closely with Designated Professionals and the LSAB's.

The Wider Safeguarding Team

Since publication of the Intercollegiate Document the Trust has considered the appointment of a Named Doctor for Safeguarding Adults and in Quarter 1 of 2019/20 this will be developed further in line with practice across the BNSSG footprint.

The team has two (1.6 WTE) Specialist Safeguarding Practitioners who work trust wide triaging concerns raised by staff and supporting staff with advice and guidance. They also manage the provision of mandatory and statutory training and may deputise for the Professional Lead as delegated at multiagency meetings.

The Trust's adult safeguarding work plan is supported by 1.0 WTE administration support based in the safeguarding team. This post also administrates the processes for DoLS via Datix.

What we achieved

- A trust wide work plan was established and clearly reflected the areas of focus for the year
- The Adult Safeguarding and Mental Capacity Act policies were updated in line with legislation and guidance

What's next?

- Development of an adult safeguarding single agency audit program linked to the updated policies, areas of focus by the LSAB's and the work plan
- Auditing of patient records across all Divisions for quality of Mental Capacity assessments to be completed Bi –Annually by the safeguarding team.
- Divisional audits as per the Mental Capacity Act trust policy monitoring for capacity assessments and DNACPR decisions.

[3] Royal College of Nursing, 2018. Adult Safeguarding: Roles and Competencies for Health Care Staff. Intercollegiate Document. First Edition

4.0 Safeguarding Adults Governance

The Safeguarding Committee meets quarterly and is chaired by the Director of Nursing and reports to the Trust Quality Risk Management Committee. Membership of the Safeguarding Committee includes the Director of Nursing, Divisional Heads of Nursing, Medical Director, Named Professionals, Trust Senior Social Worker and representatives from the CCG.

The Safeguarding Children and Adults Operational Group combined and began meeting monthly during quarter 3 of 2018/19. It provides a highlight report for the Safeguarding Committee. The Group is chaired by the Deputy Director of Nursing and core membership includes representatives from the divisions, Named and specialist professionals and specialists from other areas are invited to the group for specific pieces of work. Operational safeguarding adults' issues are discussed at this meeting.

What we achieved

- New governance arrangements were designed and implemented
- Attendance at the Safeguarding Board was maintained along with representation at the Board sub groups
- IDSVA[4] steering group has worked well but will stop meeting at the end of 2018/19 and work streams to be incorporated into the operational group

What next?

- New safeguarding arrangements in Bristol will see the combining of 4 Local Authority Boards and areas of safeguarding that sit across the child and adult fora will be combined. Joint working will benefit the Trust safeguarding team and senior representatives and contribute further to the 'Think Family'[5] agenda
- In quarter 2 the new Professional Lead and Named Nurse to review the work plans and identify items of joint working

5.0 Assurance and Quality

Commissioners received monthly reports in 2018/19 which outline the service's progress against the contractual safeguarding adults Quality Standards agreed for the period 2017-2019 which included:

- Safeguarding adults training uptake levels
- Safeguarding adults supervision provision and uptake
- Referrals to adult social care from Trust services/practitioners
- Engagement in safeguarding adult reviews and domestic homicide reviews

[4] Independent Domestic and Sexual Violence Advocate

[5] Think Family is an approach to safeguarding that encourages all services working with a patient to consider the impact of that persons needs on any dependent children or adults who rely on them for care and support.

A key quality marker is the provision of high quality education and training across the whole workforce. The monitoring of mandatory safeguarding training uptake at levels 1& 2 across the organisation's workforce is captured on the Managed Learning Environment (MLE) system. All staff, volunteers and contractors are required to undergo adult and children safeguarding training. Those who hold clinical responsibilities are also required to have Mental Capacity Act (including DoLS) training. The Trust operates a three yearly training cycle. The figures reported in this report are measured against the 90% compliance standard in the Quality Contract 2017-19. The compliance level agreed for the Quality Contract for 2019-21 is 85% for all training levels.

Table 4: Training compliance levels 2017/18 and 2018/19.

	Compliant Staff	
Training Level	Annual Average 2017/18	Annual Average 2018/19
Level 1	90%	91%
Level 2	86%	88%
MCA/DoLS	87%	90%

What we achieved

- Increased compliance across all three measures
- Training updated to reflect changes in guidance and practice
- Training tools developed utilising e-learning to allow staff flexible access to learning
- An increased focus on developing confidence in practice and practical application of the Mental Capacity Act for clinical staff
- Joint working with UHB, Weston General Hospital and the CCG to agree a cohort for Level 3 safeguarding adults training
- Brief guidance on domestic abuse incorporated into both adult and children safeguarding policies

What next?

- We will develop a program of Level 3 learning to meet the requirements of the Intercollegiate Document and implement in Quarters 3 and 4
- Domestic abuse policy to be updated in Quarter 1 of 2019/20 and in response to any changes published in new legislation expected in 2019/20
- An update of the consultants Level 2 adult training in Quarter 1 to include more information on mental capacity assessments and DNACPR

- The MARAC[6] processes in Bristol and South Gloucestershire are moving towards virtual systems. The Professional Lead for Adult Safeguarding and the Named Nurse for Child Protection will be working together to meet the requirements and highlight to the safeguarding committee any concerns that arise due to the external changes
- With the implementation of the Level 3 cohort there will be an opportunity to review safeguarding supervision offered to staff and consider using established meetings to broaden the offer to high impact staff groups across the Trust

6.0 Safeguarding Adults Reviews (SAR) and Domestic Homicide Reviews (DHR)

As an active partner of the multiagency safeguarding arrangements, the Trust participates fully in the processes conducted externally to the Trust for SAR's and DHR's. During 2018/19 the Trust engaged with 5 notifications for Safeguarding Adult Reviews and 1 notification of a Domestic Homicide Review. The Trust supplied the appropriate level of information required for all requests. One of the SAR notifications has gone to a full review and the Trust had contact with the family members involved. This is a complex SAR with multiple organisations involved with each family member. It is anticipated that the review will be published in Quarter 2 of 2019/20 and any learning or recommendations will be incorporated into the work plan and disseminated through the Trust via training and divisional information sharing routes. The single DHR notification received did not proceed to a full DHR and the Trust did not have contact with the victim.

What we achieved

- Good engagement with the SAR and DHR sub group and full participation in the decision making processes as a partner agency
- All requests for information were prioritised and actioned in timely manner to meet the statutory timeframe deadlines
- Early learning from participation in reviews is shared at the operational group and safeguarding committee to enable prompt responses and dissemination of themes to specific services and trust wide

What Next?

- Further develop the learning briefs provided by the LSAB's for use trust wide
- Develop a regular update to the safeguarding intranet pages that incorporates local and national learning
- Where specific learning is identified for Trust services, the safeguarding team will work with the divisional leads to develop action plans to be monitored via the Operational Group

[6] Multi Agency Risk Assessment Conference

7.0 Audit and Inspection

As part of the quality contract and to contribute to learning and quality improvement the Trust engages in a program of audits that are both single and multiagency. The single agency audits planned for 2019/20 are detailed in table 5 below:

Table 5: Safeguarding adult single agency audits planned for 2019/20

Lead Professional	· Domestic Abuse – new arrangements (Quarter 4)
Divisional teams	· Mental Capacity Act Audit
Safeguarding Practitioners	· Use of the Mental Capacity Act documentation · Patients who refuse care for pressure injuries (Quarter 3-4)

Throughout 2018/19 the safeguarding team contributed to a review of Mental Capacity Act practice in response to the KPMG audit and report. A report and recommendations were completed by one of the specialist practitioners. This led to the development of a new capacity assessment form and a revision of the Best Interest form to support staff to evidence the assessments they were doing and increase the visibility of this in the health record.

What we have achieved

- Regular attendance at the Multiagency Quality Assurance Sub Group
- Acquisition of the Social Care Institute for Excellence e-training package for mental capacity assessment
- Response to feedback from staff on their needs and tools that will help them confidently assess capacity

What Next?

- Reworking of the mandatory level 2 Mental Capacity Act and Deprivation of Liberty Safeguards face to face training to be more practice focused
- Contribution to work streams within palliative care and resuscitation as required to ensure mental capacity assessments and best interest decisions are completed with a special focus on DNACPR

8.0 Conclusion

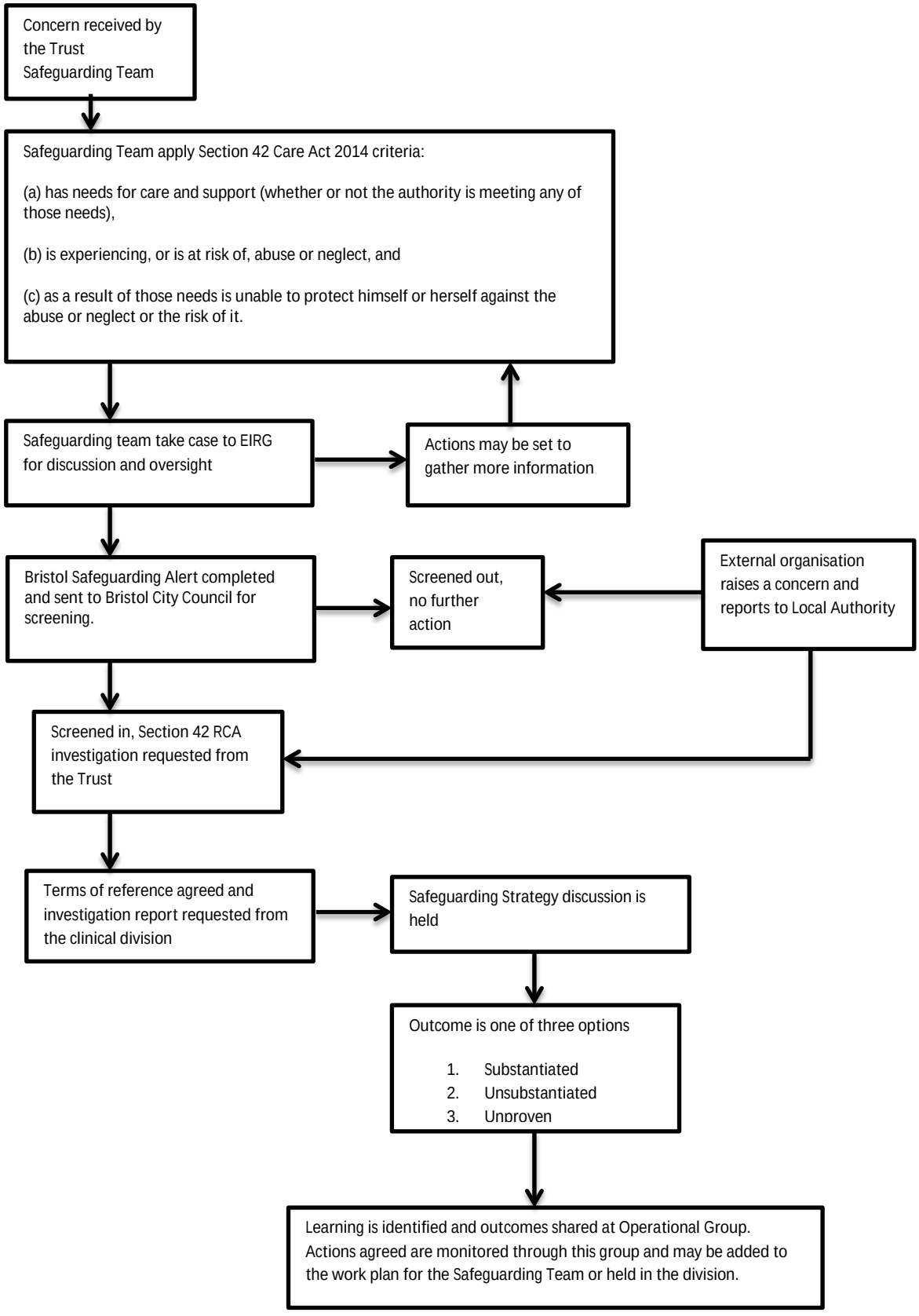
The governance structure has become firmly embedded in the service over the last year and is working well to support the safeguarding leadership in escalating concerns and disseminating information and learning. The team has maintained and further developed relationships with partners to ensure parity of service for children and adults across the trust and across BNSSG.

Looking ahead into 2019/20 there are opportunities to strengthen the safeguarding of adults within the Think Family agenda through new arrangements across the city. Support to staff in recognising and addressing patient concerns, ensuring they get the right help at the right time remains a priority for the team. Quarters 1 and 2 will see the team focus on developing staff confidence with mental capacity practice across the Trust to support delivery of the CQC action plan and embed into core work the personalisation agenda enabling all adults at risk to participate fully in decisions made regarding their care.

As the local and national safeguarding agenda broadens it is expected that contacts with the safeguarding team will continue to rise.

The 2019/20 work plan will be developed that translates the ‘what next’ sections into actions, which will be agreed and monitored by the safeguarding committee and delivered by the operational group. The focus of all the actions over the coming year is to ensure all patients in our care and our staff live in safety and free from abuse and neglect and can access support to have the best outcomes.

Appendix 1 Hospital Acquired Harm Process flow chart



Appendix 2 Safeguarding Board and Sub Group Attendance for 2018/19

Safeguarding Adults Board or Sub Group and Local Authority	**Trust Representative**	**Frequency and Time Required** (includes preparation and travel time where known)
Bristol Board South Gloucestershire Board	Director of Nursing or nominated deputy Director of Nursing or nominated deputy	Quarterly Half day Quarterly Half day
Bristol Quality Assurance	Professional Lead	Quarterly 4 Hours
South Gloucestershire Quality Assurance	Professional Lead	Quarterly 6 Hours
Bristol SAR & DHR	Professional Lead	Quarterly 4 Hours
South Gloucestershire SAR	Professional Lead	Quarterly 6 Hours
Bristol Training	Professional Lead	Quarterly 4 Hours
South Gloucestershire Training	Professional Lead	Quarterly 4 Hours
BNSSG Named Safeguarding Professional Forum	Professional Lead	Quarterly 4 Hours
South Gloucestershire PADA MARAC Steering Group	Professional Lead	Quarterly 3.5 hours
MARAC Bristol South Gloucestershire	Specialist Practitioner Lead Midwife Safeguarding Specialist Practitioner Substance Abuse Specialist Midwife	Monthly 4 Hours Monthly 3 Hours Monthly 4 Hours Monthly 3 Hours

References

HM Government. Mental Capacity Act 2005

HM Government. Deprivation of Liberty Safeguards Code of Practice 2009

HM Government. Care Act 2014

Royal College of Nursing, 2018. Adult Safeguarding: Roles and Competencies for Health Care Staff. Intercollegiate Document. First Edition

Report To:	Trust Board	**Agenda Item:**	11.
Date of Meeting:	25th July 2019		
Report Title:	Safeguarding Children Annual Report 2018/19		
Report Author & Job Title	Su Monk, Assistant Director of Nursing		
Executive/Non-executive Sponsor (presenting)	Helen Blanchard, Interim Director of Nursing		

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

Recommendation:	The Trust Board is asked to receive for assurance details of the work and activity of the Safeguarding Children service between April 2018 and March 2019
Report History:	Draft of the annual report approved at Safeguarding Committee and endorsed at the meeting of the Quality & Risk Management Committee held on 17th July 2019.
Next Steps:	N/A

Executive Summary

NBT provides a range of services for children including diagnostics, outpatient services, Emergency Care, maternity and NICU services and inpatient hospital care for 16 & 17 year olds. In total in 2017/18, NBT cared for or provided services for, 43,000 children under the age of 18.

Key successes over the past year include:

- Implementation of the Child Protection Information System in the Emergency Department and Maternity Safeguarding Team
- Positive visit and outcome of the Section 11 'Walkabout' in Maternity Services
- Key policies were updated to reflect changes in Working Together and the Intercollegiate Document
- Full update of all training packages for safeguarding children
- Effective and consistent contribution to the safeguarding agenda through multi agency working with our local Safeguarding Children's Boards and partner agencies

Looking ahead to 2019/20 we will be:

- Extending the use of the Child Protection Information System in line with NHS England and NHS Digital programmes that support professionals in identifying those children most at risk
- Working with outpatient and intensive care teams to enhance knowledge and skills in children's safeguarding

· Full internal Section 11 audit is planned for 2019/20 · Further policies aligned to safeguarding will be updated in Quarters 1 and 2. · Engaging in multiagency audits with our CCG[1] and Local Safeguarding Children's Boards (LSCB) · Quality improvement of referrals, representing the voice of the child. · Developing ways to raise awareness of Children Looked After accessing services. A work plan has been developed that translates the 'what next' sections into actions, which will be agreed by the safeguarding committee and overseen by the Operational Group. The work plan will ensure that statutory (Section 11, Children Act 2004) and regulatory (Regulation 13, CQC) requirements are met. The overarching focus of all the actions over the coming year is to ensure all children who are patients in our care or are family members of adults in our care have the best outcomes.	
Strategic Theme/Corporate Objective Links	· Be one of the safest trusts in the UK · Treat patients as partners in their care
Board Assurance Framework/Trust Risk Register Links	Safeguarding children is everyone's responsibility and North Bristol NHS Trust supports all staff to contribute to the safeguarding of both visible children, those directly accessing our services and those children that are invisible or hidden behind the adult patient we are treating.
Other Standard Reference	CQC Regulation 13: Safeguarding service users from abuse and improper treatment
Financial implications	N/A
Other Resource Implications	
Legal Implications including Equality, Diversity and Inclusion Assessment	Alignment to the Bristol and South Gloucestershire Safeguarding Children Boards evidence by their annual reports: (note 2018-19 reports not published at the time of producing this report) · Bristol Safeguarding Children Board Annual Report 2017/18: https://bristolsafeguarding.org/media/31878/bristol-safeguarding-children-board-annual-report-17-18-final.pdf · South Gloucestershire Safeguarding Children Board Annual Report 2017/18: http://sites.southglos.gov.uk/safeguarding/wp-

[1] Clinical Commissioning Group

	content/uploads/sites/221/2015/05/SGSCB-Annual-Report-2017_18-FINAL.pdf · Safeguarding strongly reflects the EDS2 objectives around better health outcomes, improved patient access and experience, representative and supported workforce and inclusive leadership · Safeguarding children is statutory under The Children Act (2004) and The Children and Social Work Act (2017) which inserted additional legal requirements into the Children's Act and regulatory under CQC Regulation 13

Appendices:	Safeguarding Children Annual Report 2018/19

Safeguarding Children Annual Report 2018 to 2019

Incorporating the Maternity Safeguarding Annual Report

Author: Claire Foster (Named Nurse Safeguarding Children)

Author Midwifery: Nicola Nelson (Lead Midwife Safeguarding)

Contents Page

Executive Summary

Safeguarding children is core business and everyone's responsibility. North Bristol Trust supports all staff to contribute to the safeguarding of both visible children, those directly accessing our services and those children that are invisible or hidden

behind the adult patient we are treating. Collated data for children directly accessing our services over the last year April 2018 to March 2019 shows in excess of 43000 children (under 18 years old) came through Trust services.

Key successes over the past year include:

- Implementation of the Child Protection Information System in the Emergency Department and Maternity Safeguarding Team
- Positive visit and outcome of the Section 11[2] 'Walkabout' in Maternity Services
- Key policies were updated to reflect changes in Working Together[3] and the Intercollegiate Document[4].
- Full update of all training packages for safeguarding children
- Effective and consistent contribution to the safeguarding agenda through multi agency working with our local Safeguarding Children's Boards and partner agencies

Looking ahead to 2019/20 we will be:

- Extending the use of the Child Protection Information System in line with NHS England and NHS Digital programmes that support professionals in identifying those children most at risk
- Working with outpatient and intensive care teams to enhance knowledge and skills in children's safeguarding
- Full internal Section 11 audit is planned for 2019/20
- Further policies aligned to safeguarding will be updated in Quarters 1 and 2.
- Engaging in multiagency audits with our CCG[5] and Local Safeguarding Children's Boards (LSCB)
- Quality improvement of referrals, representing the voice of the child.
- Developing ways to raise awareness of Children Looked After accessing services.

Through all our work we will seek to hold at the centre of our practice the desire and willingness to safeguard and promote the wellbeing of children and families who use our services.

1.0 Purpose

The purpose of this report is to provide an update to the Trust Board on the developments and service delivery for 2018/19 and next steps for safeguarding children in 2019/20 and provide assurance that the Trust is fulfilling its statutory

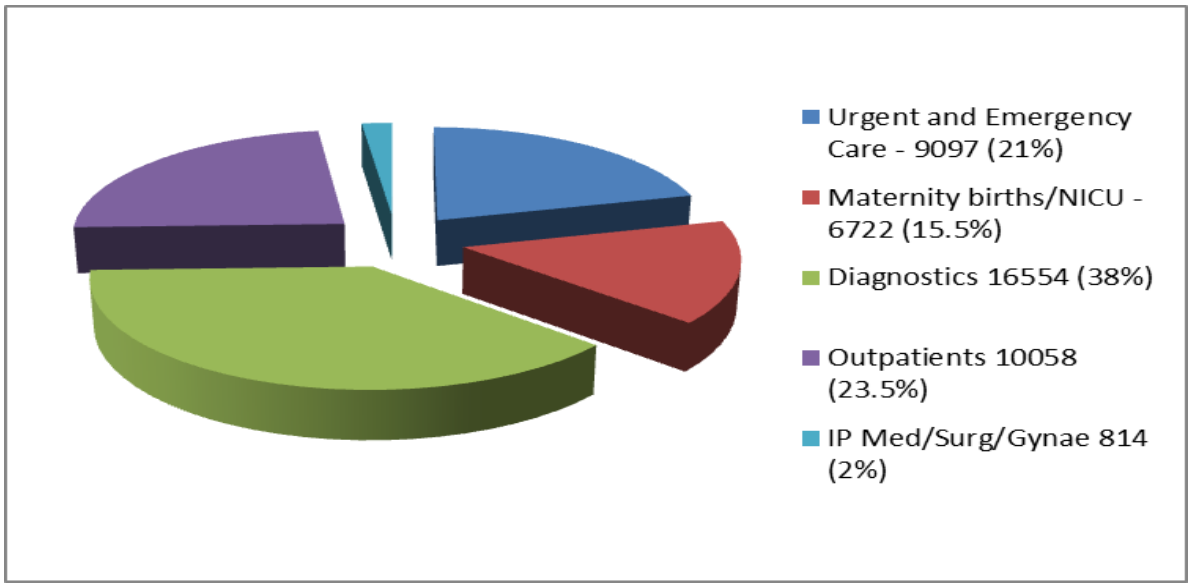
[2] Section 11 of the Children Act 2004 Places duties on a range of organisations, agencies and individuals to ensure their functions, and any services that they contract out to others, are discharged having regard to the need to safeguard and promote the welfare of children. This is audited on a 3-4 yearly cycle by Local Authority and CCG partners.
[3] Department for Education, 2018, Working Together to Safeguard Children – A Guide to Inter-agency Working to Safeguard and Promote the Welfare of Children.
[4] RCPCH, 2019, Safeguarding children and young people: Roles and competences for health care staff. Intercollegiate Document. 3rd Edition.
[5] Clinical Commissioning Group

responsibilities and duties in relation to safeguarding children. This annual report includes updates and changes to the safeguarding team between 1st April 2018 and 31st March 2019.

2.0 Overview

All staff working in the Trust have a responsibility to safeguard children[6]. Our services see in excess of 43,000 children and young people as part of everyday service delivery (see Table 1).

Table 1: Children accessing NBT services shown as percentage of all child contacts from April 2018 – March 2019

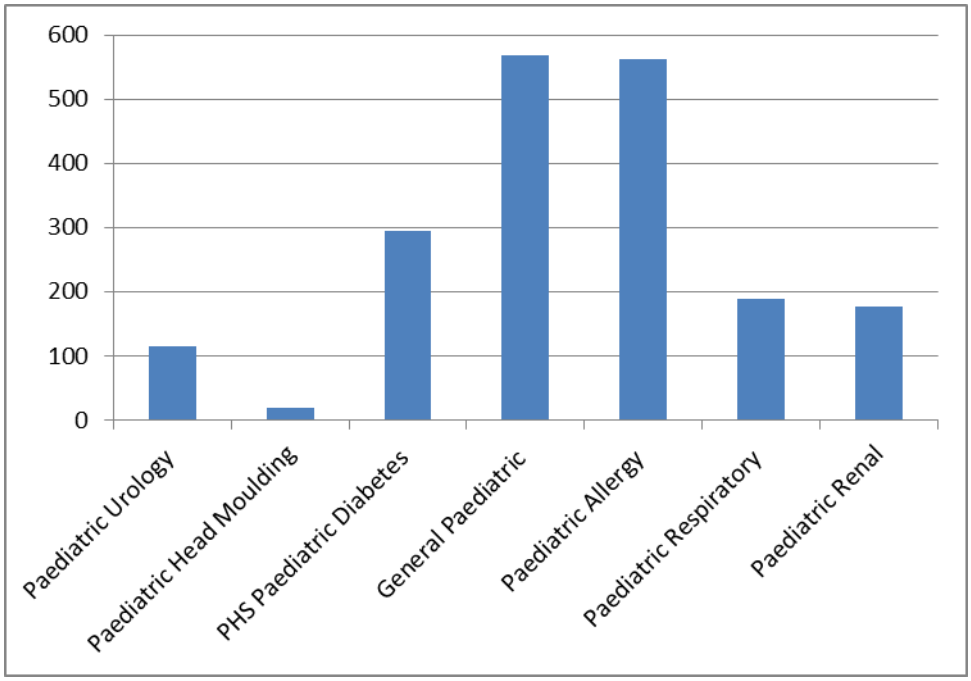


Children are seen in their largest numbers in Diagnostics, Outpatients and the Emergency Department, with smaller numbers of 16 and 17 year olds being admitted for treatment on the inpatient wards including Intensive Care.

Nursing and administrative staff from the Trust support a number of paediatric outpatient clinics on Trust sites that are for patients of University Hospitals Bristol NHS Foundation Trust (UHB) and delivered by medical staff employed by them (Table 2).

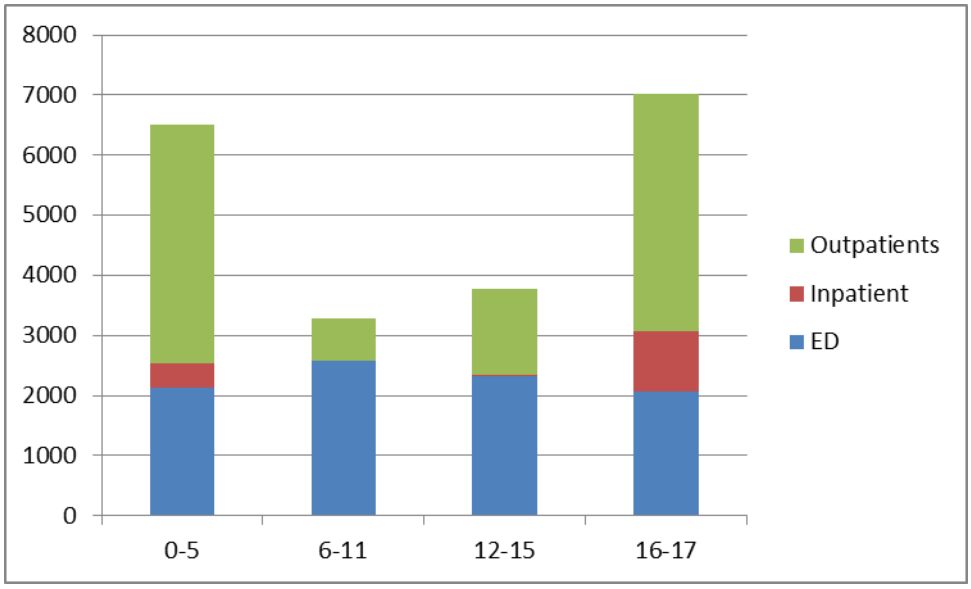
Table 2: UHB Paediatric clinics and attendance numbers

[6] A child is someone who has not yet reached their 18th birthday. Department for Education, 2018, Working Together to Safeguard Children – A Guide to Inter-agency Working to Safeguard and Promote the Welfare of Children.



General outpatient departments across the Trust see children of all ages and in significantly higher numbers than the dedicated paediatric outpatient clinics delivered for UHB. A bar chart showing the ages of children and the type of service used is displayed in Table 3.

Table 3: By age and type of services used for under 18's 2018-19 (excludes UHB paediatric clinics)



Children come on to the Trust site even though they may not be accessing the services themselves, as visitors and carers for adults treated within our services.

Adult patients accessing services come with a wide range of not only physical problems but social and safeguarding issues that can potentially impact directly on to the safety and welfare of children they are in contact with.

Parental factors such as alcohol and substance misuse, domestic abuse and mental health problems can indicate that children living under these circumstances are at an increased risk of harm[7]. All staff are trained and expected to work with a 'Think Family' approach and have a responsibility to act to safeguard children in circumstances where the adult is the patient and a concern is identified.

As part of the growing options for children in training, employment and education, we provide opportunities for children to undertake work experience and be employed at age 16 into apprenticeship/traineeship programmes in both healthcare and administrative roles. Whilst these numbers are currently small we anticipate growth in this area as options for further education are widened and developed by our partners in education.

3.0 Introduction

In common with all health care providers, we have a statutory duty to safeguard and promote the welfare of children under Section 11 and therefore it is essential that safeguarding is firmly embedded as core business for all our staff. The NHS England[8] framework sets out clearly the safeguarding roles, duties and responsibilities of all organisations providing and/or commissioning NHS health and social care.

The Trust is a member of the Bristol Safeguarding Children Board (SCB) and South Gloucestershire SCB and actively participates in multiagency partnerships and SCB sub-groups (for detail of engagement see Appendix 1).

As identified in Working Together[9] quality training and supervision is essential to underpin good practice in safeguarding children. The BNSSG[10] Quality Schedule 2017-2019 contract required us to evidence that the workforce is trained in safeguarding children commensurate to their roles as outlined in the Intercollegiate Document[11] and sets a 90% compliance rate for training and 100% for supervision (see Appendices 2 and 3 for provision).

What we achieved

[7] RCPCH, 2018, Facing the future: Standards for children in emergency care settings. Royal College of Paediatrics and Child Health.
[8] NHS England, 2015, Safeguarding Vulnerable People in the NHS. Accountability and Assurance Framework.
[9] Department for Education, 2018, Working Together to Safeguard Children – A Guide to Inter-agency Working to Safeguard and Promote the Welfare of Children.
[10] Bristol, North Somerset and South Gloucestershire.
[11] RCPCH, 2019, Safeguarding children and young people: Roles and competences for health care staff. Intercollegiate Document. 3rd Edition.

- Representatives from the safeguarding team attended and contributed to LSCB sub-groups throughout the year. Information, concerns and issues highlighted at these meetings have been reported back through the Joint Safeguarding Children & Adults Operational Group meetings and Safeguarding Committees.
- Trust Named Professionals have strong and positive relationships with the LSCB's, CCG and their equivalents in other local acute and community health providers
- The Named Nurse and Named Doctor have established and maintained a regular pattern of meeting across the year to review work plans and incidents and are working together to ensure concerns are escalated within the Trust and relationships with partners, other organisations and providers locally are developed and maintained
- Professionals from ED and Midwifery represented the Trust at both LSCB annual conferences during 2018/19 and were able to bring back learning from these days to benefit safeguarding practice trust wide
- The Named Nurse and Doctor have continued to provide extensive training across all staff groups at level's 2 and 3 for safeguarding children
- The ED and Trust core level 3 days have been updated to reflect changes in local practice and statutory guidance.
- In response to findings of an audit of referrals to Children's Social Care in Quarter 1 of 2018/19 Core level 3 training has focused on quality of referral writing, use of threshold documents and recognition of the child behind the adult patient and how to represent their voice when sharing information
- Professionals from the local authority have attended both level 3 training days to share working practices and knowledge and help improve interagency working
- The children's safeguarding service provision was reviewed and areas for development highlighted and added to the work plan. At the end of 2018/19 funding from within the current budget has been identified for a children's specialist practitioner to support the Named Nurse and Doctor trust wide in taking the work plan forward
- ED leads accessed 2:1 supervision with the Named Nurse quarterly, as part of their contracted hours

What next?

- Provision of a group offer of safeguarding supervision to the ED practitioners, ICU consultants and ICU Band 7 nurses will commence in Quarter 1 of 2019/20 provided by the Named Nurse and Doctor
- Identification of a group of experienced staff across the outpatients services who will be trained at level 3 safeguarding children to support their colleagues when they identify concerns
- Professionals from the Early Help and Families in Focus teams at First Response to contribute to training to improve awareness for staff of the wider services available to families in Bristol

- The Named Midwife, Nurse and Doctor to review the level 3 training provided across the Trust and work towards consolidating the training offered internally to staff groups

4.0 Safeguarding Children Leadership

The Director of Nursing is the Trust Board executive for safeguarding adults and children and represents the Trust at the LSCB members meetings each quarter for both Bristol and South Gloucestershire. Senior management responsibility for safeguarding children sits with the Deputy Director of Nursing.

2018/19 has seen changes to the structure of the safeguarding team. The post of Named Nurse for Safeguarding Children was filled with an interim at the start of the year and was filled permanently from October 2018. In January 2019 the Adult Lead left the Trust and during the recruitment period the Named Nurse for Safeguarding Children has covered both roles and management of the safeguarding team under the direction of the Deputy Director of Nursing.

The Named Nurse role is a statutory requirement (Working Together 2018) and reports to the Deputy Director of Nursing for the Trusts Safeguarding Children arrangements and activities. Working within the Trust values the Named Nurse leads on the development of a positive culture of safeguarding children practice across the Trust and works closely with Designated Professionals and the LSCB's.

The Named Doctor for Safeguarding Children is employed for 1 PA (4 hours) per week and supports training for medical and ED staff, works closely with the Named Nurse, attends LSCB sub-groups and contributes to multiagency and single agency audits during the year.

The Trusts children's safeguarding work plan is supported by 0.6 WTE administration support based in the safeguarding team.

Wider Children's Safeguarding Team (see Appendix 4 for organisational structure)

The Midwifery safeguarding provision is explained in chapter 7.0.

There are 2 Safeguarding Children Leads in the Emergency Department (ED) who co-ordinate and support the Level 3 training and act as a point of contact for referrals and liaison with the Named Nurse. Currently they do not have protected time and activities are integrated into their role responsibilities as agreed with the head of department.

What we achieved

- The interim Named Nurse was the successful candidate for the permanent role in October 2018 enabling a consistent and smooth transition for the service
- A trust wide work plan for safeguarding children was further developed integrating the legislative and regulatory links to each piece of work
- A permanent solution to maintaining flagging of children's records who are on a Child Protection Plan (CPP) or are Looked After Children (LAC) for the BNSSG area was established and sustained
- A process of a weekly sampling audit of referrals from the ED by the Named Nurse was commenced to aid monitoring of improvements in referral writing quality.
- Participation in the BSCB multiagency audit on quality of referrals was completed and learning informed changes in training and processing of referrals
- Awareness of, and how to use the threshold guidance tool for referrals to First Response (Bristol) and Access and Response Team (South Gloucestershire) has been incorporated into the ED training day and its use is monitored as part of the sampling audit of quality.
- The Child Protection Information System (CPIS) has been connected to Lorenzo and implemented in ED. It highlights vulnerable children from within and outside the BNSSG region who are on Child Protection Plans or are Children Looked After to alert staff to be vigilant and to their information sharing duties

What next?

- To expand the use of Connecting Care for staff out of hours to access key information relating to safeguarding children. The Connecting Care system is the vehicle used locally by children's social care to share information about children with health and social services.
- Planned two part audit of activity linked to CPIS. Part 1 to review data on contacts. This work to be done in partnership with IMT as requires access to the system and contacts. Part 2 to be an audit of knowledge and awareness of ED staff of the system and how it supports practice.
- The addition of a children's specialist safeguarding practitioner within the safeguarding team to support the trust wide children's work plan focusing on quality of information sharing from ED and working with outpatients and inpatients to support practice with teenage children and those who are Looked After and on Child Protection Plans
- Following publication of Phase 2 by NHS England and Digital to implement CPIS use in all out patients and maternity clinics

5.0 Safeguarding Children Governance

The Safeguarding Committee meets quarterly and is chaired by the Director of Nursing and reports to the Trust Quality Risk Management Committee. Membership of the Safeguarding Committee includes the Director of Nursing, Divisional Heads of Nursing, Medical Director, Named Professionals, Trust Senior Social Worker and representatives from the CCG.

The Safeguarding Children and Adults Operational Group was meeting on a bi-monthly basis at the start of the year this moved to Monthly in Quarter 3. The Group is chaired by the Deputy Director of Nursing. A highlight report is provided to the Trust Safeguarding Committee. Operational safeguarding children issues are discussed at this meeting. The core membership includes the Named and specialist professionals, Divisional Matrons and ED Safeguarding Leads. Specialists from other areas are invited for particular pieces of work.

What we achieved

- Over the year there has been an increasing approach to embedding safeguarding children's practice within the divisions and reports to the Operational Group and Safeguarding Committee reflect this.
- The Governance arrangements are working well with the Safeguarding Committee, bringing challenge and seeking assurance on all elements of safeguarding children and adults.
- Several 'walk arounds' were completed prior to the Section 11 audit and this helped to raise the profile of safeguarding children across settings.
- The Section 11 visit and report were positive for the Trust and confirmed areas of work we were already addressing. This helps us to know we are targeting training and support in the right key areas for our patients and staff.

What next?

- The 2019-2022 cycle of Section 11 audit review and visits is being planned by our partners. The CCG Designated Nurse has expressed that in the next cycle of visits they will review our services in outpatients, ED and inpatient areas. Preparation for this will utilise a similar approach to the review and visit of our maternity services.
- To support higher visibility of children using Outpatient and Inpatient services the data provided by the Children's Daily Encounter Report to be made available to Matrons and Heads of Nursing and to include flags of those children who have Child Protection Plans and are Looked After Children.
- An audit of 16 and 17 year olds in the inpatient bed base including prevalence of those with Child Protection Plans or Looked After Child status to be completed as a joint audit with the Named Nurse at UHB who will review the Bristol Royal Infirmary bed base. This will enable joint working and comparison of parity for children across Bristol's two acute trusts and test our transition policy and arrangements for young people leaving paediatric services and entering adult services.

6.0 Assurance & Quality

Commissioners received Monthly reports which outline the service's progress against the contractual safeguarding children Quality Standards agreed for the period 2017-2019 which included:

- Safeguarding children training uptake levels
- Safeguarding children supervision provision and uptake
- Referrals to children's social care from Trust services/practitioners
- Engagement in serious case reviews/case reviews/domestic homicide reviews

A key quality marker is the provision of high quality education and training across the whole workforce. The monitoring of mandatory safeguarding children training uptake at levels 1 to 4 across the organisation's workforce is captured on the Managed Learning Environment (MLE) system.

The training aligns with the requirements set out in the Intercollegiate Document[12]. The required standard in the CCG contract is that 90 % of staff attends the relevant training. The attained levels for safeguarding children training are shown below in Table 4 with the 2017/18 data for comparison.

Table 4: Training Compliance Levels 2017/18 and 2018/19

Training Level	Compliant Staff	
	Annual Average 2017/18	Annual Average 2018/19
Level 1	88%	90%
Level 2	86%	89%
Level 3	82%	83%
Level 4*	96%	96%

(*There are four Level 4 practitioners across NBT)

What we achieved

- Levels 1-3 compliance have improved compared to 2017/18 data but levels 2 and 3 remain below the 90% target
- During 2018 the Trust Prevent lead moved the face to face training 'Workshop to Raise Awareness of Prevent (WRAP)' for Level 3 practitioners to an MLE program
- Staff have been identified from within the ED department to attend specialist courses run by the LSCB to enhance the knowledge within the department staff team. Courses have included Working with adolescents with safeguarding concerns and Working with families where there is domestic

[12] RCPCH, 2019, Safeguarding children and young people: Roles and competences for health care staff. Intercollegiate Document. 3rd Edition.

abuse. Courses are identified in response to prevalence of safeguarding concerns identified by ED.

- The Named Nurse has worked with teams outside of maternity, to identify need for 'hotspot' training and guidance in teams who due to the specialist service they provide are more likely to identify females who have had or are at risk of having Female Genital Mutilation and ensure they are familiar with the recording and reporting requirements

What next?

- The new Quality Standards Contract has been agreed and reporting has moved from monthly to quarterly. There are new requirements for identifying the type of referrals sent to Children's Social Care as well as including data on children attending due to substance misuse, self-harm and activity linked to contextual safeguarding. Data collection will be reviewed to ensure we can meet the reporting requirements.
- Around 850 staff members require safeguarding children training and learning at level 3 across a 3 year cycle. A rough estimate of the hours required for training and supervision indicates this will equate to 8,800 hours of learning activity over 3 years for this cohort of staff (approx. 2930 hours per year). The Named professionals will review training and supervision provided and review current resources for meeting this need.

7.0 Maternity Services

The Trust Midwifery Safeguarding Team have a key role in promoting quality practice within the Women & Children's Health Division, supporting the local safeguarding system and processes, providing supervision, advice and expertise for fellow professionals and ensuring safeguarding training is in place. For a breakdown of the training provided by the Midwifery Safeguarding Team please see Appendix 2.

The Community Midwives provide care to women and their families across Bristol, North Somerset and South Gloucestershire. Safe practice and care of vulnerable infants on Section 17 or 47 of the Children Act 1989/2004, and their siblings/family during the antenatal and postnatal period is paramount within midwifery care. This report will review briefly the work undertaken to achieve safe care for this vulnerable caseload. The Midwifery Safeguarding Team consists of:

- Named Midwife for Safeguarding Band 8a (within Community Matron role)
- Lead Midwife for Safeguarding (Delegated role for Named Midwife)
- Specialist Substance Misuse Midwife
- Mental Health and Bereavement Lead
- Mental Health Support Midwife
- Maternity Care Assistant for Mental Health

What we achieved

- Successful recruitment to level 4 Lead Midwife post from December 2018. The Lead Midwife for Safeguarding is now the Learning Disabilities Champion for the division and is using data gathered for the Quality Standards Contract to inform support of Community Midwives attending Child Protection conferences
- Multiagency Section 11 audit visit to inpatient services in Midwifery. Positive engagement with partner agencies and good sharing of experiences working within the wider safeguarding children's agenda.
- Successful transition of FGM reporting to the FGM-Information System and stream lining of process in Midwifery
- Successful introduction of 'Egroups' to facilitate timely multiagency communication around families with complex safeguarding issues. Feed-back from Children's Social Care, Family Nurse Partnership, Health Visiting and Midwives has been very positive.
- Regular contribution to MARAC in both Bristol & South Gloucestershire and working with partners to transition to the new arrangements for each area.
- We have increased opportunities for staff to access Safeguarding Supervision within the Unit and this has demonstrated good uptake.
- Delivery of individual Preceptorship Safeguarding packages to all newly qualified Midwives on joining the Trust.
- Themes identified in supervision have been reported to senior managers and responded to with teams implementing new practices to support staff.
- The Intranet Child Protection resources for the Woman and Children's division have been refreshed and streamlined. They now include quick links to key documents and tools that support safeguarding practice.
- Use of the easy read Maternity book now embedded in practice for women diagnosed with Learning Disabilities

The Women and Children's Division aims to become an ACE (Adverse Childhood Experiences) informed service. This is in line with the Bristol Safeguarding Children Board's aim for Bristol to become an ACE aware city. This will involve provision of ACE / trauma informed safeguarding supervision and training for staff.

Over the past year the Midwifery Safeguarding Team have attended events and training including safer recruitment, NSPCC Neglect toolkit, Adverse Childhood Experiences and Safeguarding Children Practice Review authors debrief. The learning from these is disseminated to the wider staff group through training, supervision, advice and support.

What next?

- A review and update of the Section 11 Audit actions set following the Maternity visit in January 2019.
- A redesign of the electronic referral systems in Maternity to reduce human factors
- Multiagency networking event scheduled for October to raise the profile and understanding of health agencies with Social Care and Safeguarding Teams

- Mandatory and bespoke training tools redesigned to reflect areas of focus around Trauma Informed Safeguarding Practice (including ACEs) and the Voice of the Child.
- The design and provision of bespoke level 3 safeguarding training for the Neonatal Doctors in partnership with them
- Following the passing of the Domestic Abuse Bill through parliament a review of the Domestic Abuse policy will follow
- Development of a study event around the needs of women seeking asylum or victim of trafficking / modern slavery.
- Audits of Connecting Care and Initial Child Protection Conference attendance and reports.
- Quality improvement project as part of the LD champion network looking at 'Reasonable Adjustments' for parents with Learning Disabilities.

8.0 Child Deaths and the Child Death Overview Panel (CDOP).

The overall purpose of the child death review process is to understand how and why children die, to put into place interventions to protect other children and to prevent future deaths. In the area of the former county of Avon, four neighboring LSCBs (Bristol, North Somerset, South Gloucestershire and Bath & North East Somerset) have come together to form a single West of England CDOP. Regional information is published annually by the West of England Child Death Overview Panel.

What we achieved

- The Named Doctor includes in the Consultants update training how to record and report a child death and signposts to further information
- The child safeguarding pages on the intranet contain links to CDOP (Child Death Overview Panel) including the key forms required for notification when a child dies

What next?

- Following publication of Working Together 2018, the Children and Social Work Act 2017, and the implementation of the new safeguarding arrangements between the Local Authority, the police and the CCG the processes for CDOP will change during the coming year. Key professionals and managers within the Trust will engage with the discussions involved in restructuring the CDOP in line with new legislation and disseminate any relevant changes to staff.
- The CDOP report has previously identified the challenges faced by hospitals that provide emergency services but do not have paediatric provision. They recognise that these services need to ensure clinicians are appropriately skilled if receiving children 'in extremis'. Looking ahead to the planned review of ED paediatrics in 2019/2020 the Trust will consider how it can ensure paediatric patients are not disadvantaged when attending ED and staff are appropriately trained

9.0 Child Safeguarding Practice Reviews (previously known as Serious Case Reviews) and Child Protection Information Reviews (CPIR's)

Working Together to Safeguard Children (2018, p81-92) sets out the statutory duties for Child Safeguarding Practice Review's for all multiagency partners. The new guidance introduced the Rapid Review which requires partners to provide a response containing information on contact with the family within 5 working days of the notification.

Each Child Safeguarding Practice Review ends with a set of recommendations reflecting the learning from the case. Recommendations can be focused towards individual agencies or across agencies. The LSCB is asked to adopt each report's recommendations and having done so, the relevant agencies are expected to implement them.

During 2018/19 the Trust responded to 5 new requests for information for the Safeguarding Children Practice Review process. During 2018/19 Bristol LSCB published 2 reviews one of which was linked to a Domestic Homicide Review. South Gloucestershire has notified partners of one case during the year that required a rapid review, the information gathering for which was completed in Quarter 3. This went to full review but was not published during 2018/19. Bristol LSCB has also published a CPIR.

What we achieved

- We continue to engage in all Child Safeguarding Practice Review's, CPIR's and DHR's as requested by the Safeguarding Boards. The Named Nurse requests all records for the family members and children involved and check the archived records held for any family member identified. They then prepare a chronology for each family member as per the Terms of Reference set by the LSCB
- We supported attendance at the Child Safeguarding Practice Review meetings for any professionals identified during the process. Support and debriefing is undertaken at the time of publication for those involved in the review
- The Named Nurse, Lead Midwife and Named Midwife have collaborated well to meet deadlines and complete chronologies for cases that relate to infants and their families.
- Training is amended throughout the year as learning from local and national reviews is published
- The safeguarding team and the Patient Safety Assurance and Audit Service have developed good internal communication over the year contributing to patient safety and transparent working practice.

What next?

- Development of alternative formats of dissemination of learning for staff to access. For example improving content on the intranet pages in the form of

learning briefs, short MLE e-learning packages and development of a quarterly newsletter.

10.0 Audit and Inspection

The Trust has participated in a programme of both single and multiagency safeguarding audits throughout 2018/19. These are highlighted below:

Table 5: Safeguarding children single agency audits planned during 2018/19

NBT Maternity	· Asking the Domestic Abuse question. · Connecting Care and Information Sharing
Emergency Department	· 16 – 17 year olds · Non-mobile baby · Request for Help Audit
NBT Named Nurse	· Use of CPIS post implementation · 16 and 17 year olds in the inpatient bed base · Sampling Audit of ED referrals

In addition to the single agency audits the Named Nurse, through participation in the South Gloucestershire Quality Assurance Sub Group, has completed a quarterly audit of up to 10 case records of children identified by the Local Authority.

The Named Nurse and Lead Midwife have participated in 5 multiagency audits throughout the year which covered the following topics:

- Quality of Referrals to First Response Children's Services
- Case Tracking Audit for BNSSG Clinical Commissioning Group
- Quality of Child Protection Conference Reports
- Special Educational Needs and Disability Self-Assessment
- Children at Risk of Exploitation

The 2019/20 Audit plan is contained in table 6.

Table 6: Safeguarding children audit plan for 2019/20

NBT Maternity Service	· Use of Connecting Care · Initial Child Protection Conference attendance and reports. · Midwife to Health Visitor handover
NBT Emergency Department	· Quality of referrals to Children's Social Care
NBT Named Nurse	· Use of CPIS post implementation using the NHS Digital template · Looked After Children aged 16 and 17 in the inpatient bed base.

What we achieved?

- Regular attendance at the South Gloucestershire Quality Assurance Sub Group contributing to shared learning through a multiagency approach to reviewing the holistic care of vulnerable and at risk children
- A range of single agency audits completed gives a good insight into the experience of children and families in ED and Maternity
- The multiagency audits completed contributed to a growing Trust wide picture of children's experiences using our services.
- The Section 11 audit walkabout was completed visiting Maternity inpatient services in Jan 2019. This confirmed that targeted work already commenced was focused on the right areas and will be used to extend the work plan going forward into 2019/20.

What next?

- The Named Nurse will be meeting with lead clinicians and managers in Outpatients and Intensive Care to review children accessing their services and develop an audit in each area to help extend understanding of the needs children present with when accessing planned care and emergency care.

11.0 Conclusion

The overarching governance structure has become firmly embedded in the service over the last year and is working well to support the Named Professionals, escalate concerns and disseminate information and learning. Despite changes in the leadership of the safeguarding service over the year, the plan of work has continued and been reviewed to allow for the Named Nurse to cover the Adult Lead vacancy in Quarter 4 and into Quarter 1 of 2019/20.

The needs of the children's safeguarding team are clear and developing relationships both internally and externally to ensure parity of service for children and adults across the Trust and across BNSSG remains a priority. Looking ahead into 2019/20 we will be focusing on quality improvements based on learning from audits and reviews for the children that are using our services. This will strengthen the safeguarding of children and vulnerable families and support our staff in recognising and addressing concerns to ensure children get the right help at the right time.

A work plan has been developed that translates the 'what next' sections into actions, which will be agreed by the safeguarding committee and overseen by the Operational Group. The work plan will ensure that statutory (Section 11, Children Act 2004) and regulatory (Regulation 13, CQC) requirements are met. The overarching focus of all the actions over the coming year is to ensure all children who are patients in our care or are family members of adults in our care have the best outcomes.

Appendix 1: Attendance at Safeguarding Boards and sub-groups

Group and Local Authority	**NBT Representative**	**Frequency and Time Required** (includes preparation and travel time where known)
Bristol SCB Board meeting	Director of Nursing or nominated deputy	Quarterly Half day Plus preparation time

South Gloucestershire SCB	Director of Nursing or nominated deputy	Quarterly Half day Plus preparation time
South Gloucestershire LSCB Quality Assurance Sub Group	Named Nurse	Quarterly 7.5 Hours
Bristol LSCB Training Sub-Group	Named Nurse	Quarterly 4.5 Hours
Bristol LSCB Health Sub-Group	Named Nurse Named Midwife Named Doctor	Quarterly 5.5 Hours
BNSSG Named Safeguarding Professional Forum	Named Nurse Named Midwife Named Doctor	Quarterly 3.5 Hours
Regional Named Professional Group (NHSE)	Named Nurse Named Midwife Named Doctor	3 to 4 times per year
MARAC Bristol South Gloucestershire	Safeguarding Specialist Practitioner Lead Midwife for Safeguarding Safeguarding Specialist Practitioner Substance Abuse Specialist Midwife	Bristol North Monthly 7.5 + 3 Hours (Up to 7.5) + 3 Hours Monthly, 7.5 + 4 Hours Monthly, 7.5 + 3 Hours

Appendix 2: Training Provided by Named Professionals

Face to face training provided by the Named Nurse and Named Doctor Safeguarding Children.

Level of Child safeguarding	**Frequency**	**Total time per quarter** (training time only)	**Provider**
Level 2 Induction 1.5	Fortnightly	9 hours	Named Nurse

hours each			
Level 2 Mandatory Update 1.5 hours each	Approximately 16 dates per year	6 hours	Named Nurse
Level 3 core full day	5 dates per financial year	7.5 - 15 hours	Named Nurse
Level 3 Paediatric update 1.5 hours	Bi Monthly	1.5 to 3 hours	Named Nurse/Named Doctor/Lead Midwife
Level 3 ED Core day	Quarterly	6.5 hours	Named Nurse/Named Doctor
	Total Hours per quarter	30.5 – 39.5 hours	
Consultants Update	Bi Monthly 40 mins	40-80 minutes	Named Doctor

Training Provided by Midwifery Safeguarding Team

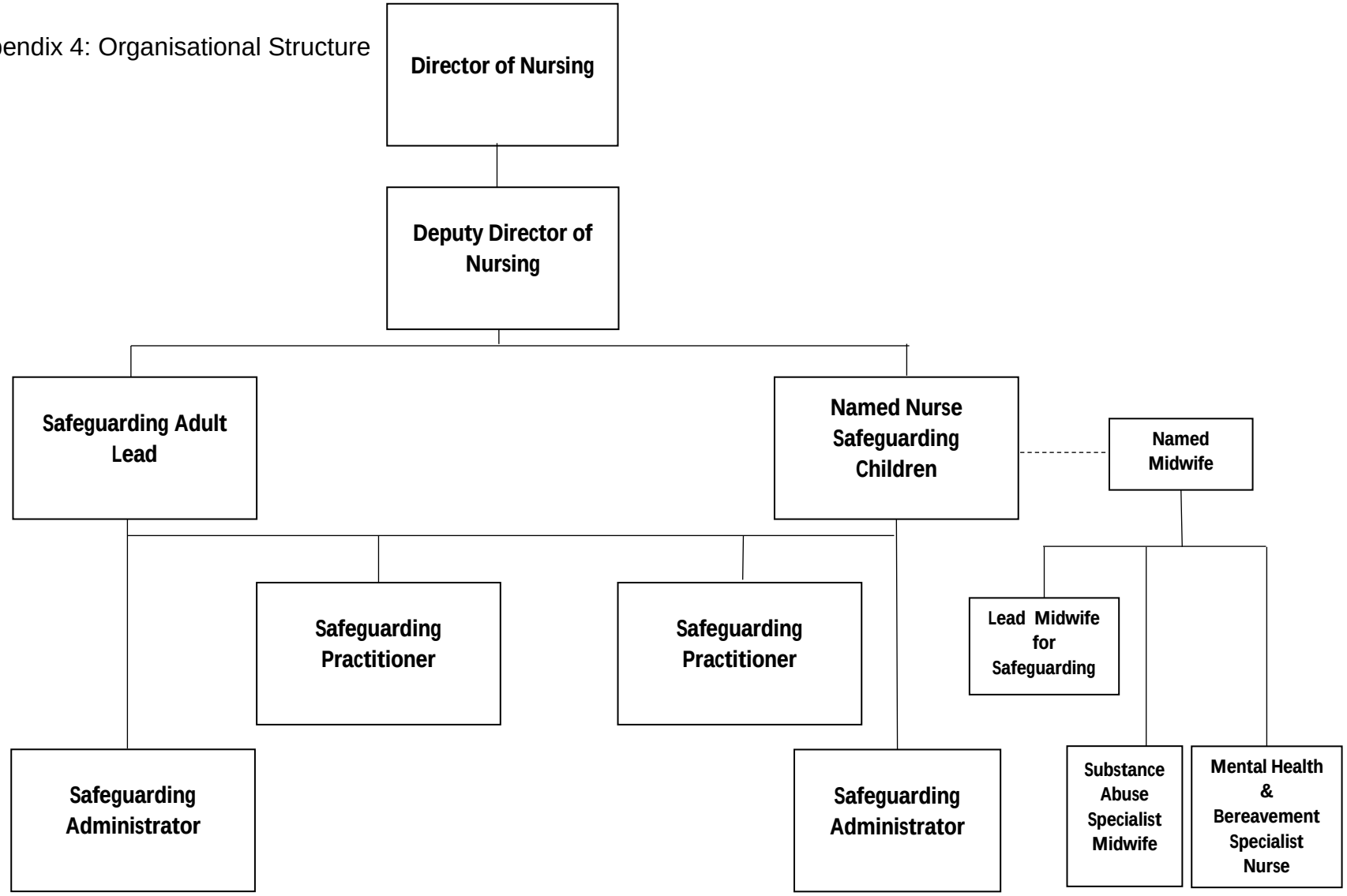
Level of Child Safeguarding	**Frequency**	**Total Time Training**	**Provider**
Level 3 Domestic Abuse and pregnancy including Trauma Informed Best Practice	Annual	7.5 hours	Lead Midwife
Level 3 Writing a Strong Request for Help including Trauma Informed Best practice	Annual	7.5 hours	Lead Midwife
Level 3 Domestic Abuse master Class	Annual	2 hours	Lead Midwife
Level 3 Graded care Tool 2 – an overview	Annual	2 hours	BSCB
New Midwives Level 3 Induction	As required	2 hours	Lead Midwife or Substance Misuse Midwife
New Rotation ST1 Drs level 3 Induction	Bi-Annual	1 hour	
Level 3 Midwives Intra partum care Safeguarding update	Monthly	1 hour	Lead Midwife or Substance Misuse Midwife
Level 3 Midwives Mandatory Safeguarding update	Monthly	1 hour	Lead Midwife or Substance Misuse Midwife
Level 3 Obstetric & Gynae Safeguarding update	Quarterly	1.5 hours	Lead Midwife

Appendix 3: Supervision of safeguarding children practitioners.

Role of supervisor	**Role of supervisee**	**Frequency**	**Total Hours per quarter**
Named Nurse	Lead Midwife for Safeguarding	Quarterly 1:1	7.5 Hours

Named Nurse	Specialist Midwife Substance Misuse	Quarterly 1:1	
Named Nurse	Specialist Practitioners X2	Quarterly 2:1	
Named Nurse	Nursery Manager	Quarterly 1:1	
Named Nurse	ED Leads	Quarterly 2:1	
Supervision provided by Named Nurse per quarter			7.5 Hours (does not include travel, prep or writing up time)
Designated Nurse	Named Nurse	Quarterly	2 Hours
Designated Doctor	Named Doctor	Quarterly	2 Hours

Appendix 4: Organisational Structure



References

HM Government. Children Act 1989 and 2004

Department for Education, 2018, Working Together to Safeguard Children – A Guide to Inter-agency Working to Safeguard and Promote the Welfare of Children.

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NHS England, 2015, Safeguarding Vulnerable People in the NHS. Accountability and Assurance Fra

Report To:	Trust Board (Public)		**Agenda Item:**	12.
Date of Meeting:	25th July 2019			
Report Title:	Infection Prevention and Control Annual Report 2018/19 Infection Prevention and Control Annual Programme 2019/20			
Report Author & Job Title	Samantha Matthews – Nurse Consultant Infection Prevention and Control/Tissue Viability			
Executive/Non-executive Sponsor (presenting)	Dr Chris Burton			
Purpose:	**Approval/Decision**	**Review**	**To Receive for Assurance**	**To Receive for Information**
	x			
Recommendation:	· The Board is requested to approve the IPC Annual Report (2018/19) and IPC Annual Programme (2019/20)			
Report History:	· The IPC Annual Report and Programme has been considered and agreed by the Control of Infection Committee on the 20th June 2019 and by the Quality & Risk Management Committee on 17th July 2019. · This IPC report and programme supersedes that of 2017/18 and 2018/19 respectively.			
Next Steps:	· The CQC will require both documents as evidence of assurance of meeting Outcome 8 (regulation 12). · The IPC Annual Programme will be monitored by the Control of Infection Committee.			

Executive Summary

IPC Annual Report (2018/19)

North Bristol NHS Trust recognises its responsibility for minimising the risks of infection and is committed to promoting a culture of risk reduction and safety for patients, visitors and staff.

The purpose of this annual report is to provide assurance to the Trust Board and wider healthcare community that North Bristol NHS Trust (NBT) maintains a 'zero tolerance' of healthcare associated infection (HCAI), and we will ensure Trust wide learning where cases are reported. It describes the arrangements within the organisation for the prevention and control of infection using an infection prevention and control nursing team supported by a Lead Infection Control Doctor, Consultant Medical Microbiologists and the Director of Infection Prevention and Control (DIPC).

IPC Annual Programme (2019/20)

The Health and Social Care Act 2008: Code of Practice on the prevention and control of infections and

related guidance requires all health and social care providers to have systems in place to monitor the prevention and control of infection. In order to achieve compliance with the CQC registration requirements the Trust must demonstrate that all criteria in the guidance can be met.

The IPC (IPC) Programme describes the infrastructure and systems that are currently in place to reduce the incidence of health care associated infection. The Programme also provides the key drivers and objectives for preventing and controlling infection going forward, ensuring that safe care remains a priority for the Trust.

Infection Prevention and Control Annual Report 2018/19

Dr Christopher Burton
Director of Infection Prevention and Control

Contents

North Bristol NHS Trust
Report to Trust Board –

Title: **Annual Report on Infection Prevention and Control 2018/19**

Purpose of paper: To provide the Board with the 2018/19 annual report from the Director of Infection Prevention and Control (DIPC).

Executive summary:

North Bristol NHS Trust recognises its responsibility for minimising the risks of infection and is committed to promoting a culture of risk reduction and safety for patients, visitors and staff.

The purpose of this annual report is to provide assurance to the Trust Board and wider healthcare community that North Bristol NHS Trust (NBT) maintains a 'zero tolerance' of healthcare associated infection (HCAI), and we will ensure Trust wide learning where cases are reported. It describes the arrangements within the organisation for the prevention and control of infection using an infection prevention and control nursing team supported by a Lead Infection Control Doctor, Consultant Medical Microbiologists and the Director of Infection Prevention and Control (DIPC).

Mandatory reporting during 2018/19

- 9 cases of healthcare-associated MRSA (meticillin resistant staphylococcus aureus) bacteraemia reported (zero tolerance plan).
- 27 cases of healthcare-associated MSSA (meticillin sensitive staphylococcus aureus) bacteraemia reported (Trust's plan fewer than 19 cases).
- 39 cases of healthcare-associated Clostridium *difficile* reported (plan fewer than 42). 23 cases were classified, using the Public Health England criteria, as having contributory lapses in care (see section 2.1.3).

The root cause analysis work undertaken by clinical Divisions for each case of MRSA and MSSA bacteraemia has highlighted a recurrent theme of improvement required with the insertion and ongoing care and management of invasive devices, relating to both central and peripheral vascular access. Action relating to this has been a key component of the Trust Staph aureus action plan, and work has and continues to be undertaken to review current policies and related practice.

Every Hospital Acquired infection is distressing for the patient and we know that the risk of getting an infection while in hospital is one of the greatest issues of concern to the public. We will continue the work in 2019/20 to reduce episodes of HCAI to an absolute minimum.

Action required: The Board is asked to note and comment on the report.
Impact on patients: Control of infection is an important public concern and impacts significantly on efficient operation of the organisation.

Impact on Patients: Patients deserve the highest level of professional standards, which includes minimal complications during care at the Trust available.

CQC Outcome: Outcome 8 (regulation 12)

Responsible Committee: Control of Infection Committee

Presented by: Dr Chris Burton DIPC and Medical Director
Prepared by: Samantha Matthews – Deputy DIPC and Nurse Consultant

Introduction

This Annual Report details the activities undertaken by the Infection Prevention and Control Team (IPCT) during the period 1st April 2018 to 31st March 2019 and should be read in conjunction with the Infection Control Annual Programme of Work for the same period. The report has been compiled according to guidelines issued by the Department of Health and will be presented to the Quality and Risk Management sub-committee of the Trust Board.

The aim of the IPCT, through the compilation and achievement of a robust Annual Programme of Work, is to devise, implement and evaluate strategies to reduce hospital-associated infection by working in collaboration with each Division. The IPCT performs a number of activities that minimise the risk of infection to patients, staff and visitors including:

1. Providing advice on all aspects of infection prevention and control

2. Outbreak and incident management

3. Conducting programmes of education

4. Audit and targeted mandatory surveillance

5. Formulating policies and procedures

6. Interpreting and implementing national guidance at local level

7. Supporting appropriate infection control practice within; refurbishment, new building and equipment projects

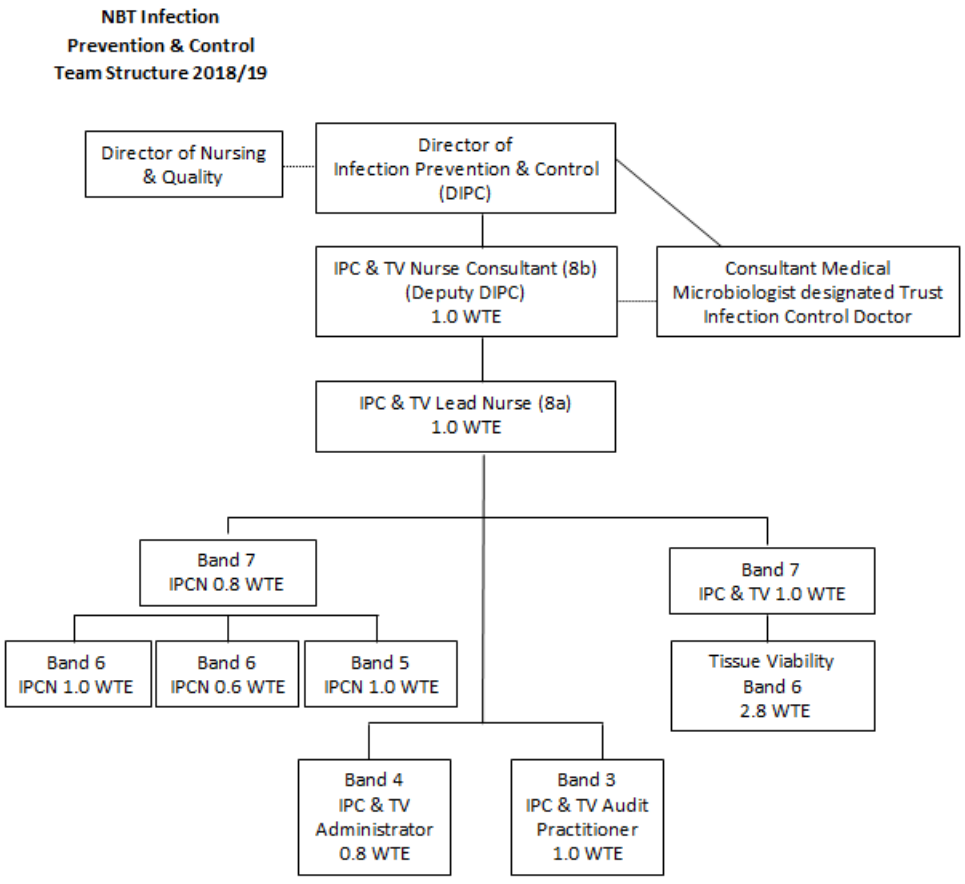
The prevention of Healthcare Associated Infection (HCAI) remains a top priority for the public, patients and staff. Avoidable infections are not only potentially devastating for patients and healthcare staff, but consume valuable healthcare resources. Investment in Infection Prevention and Control is therefore both necessary and cost effective. The resources committed by NBT to IPC can be reviewed and validated against the contents of this report.

Chapter 1: INFECTION PREVENTION AND CONTROL ARRANGEMENTS

The IPC team structure is detailed in figure 1.

Role	Band	WTE	WTE qtr. 4 review
Nurse Consultant IPC/Tissue Viability	8b	1.0	1.0
Senior Nurse IPC/Tissue Viability	8a	1.0	1.0
Senior Nurse IPC	7	0.8	Vacant
IPC Nurse	6	1.8	1.6
IPC Nurse	5	1.0	1.0
Audit Practitioner	3	1.0	1.0
Team administrator	4	0.8	0.8
IPC doctor (Medical Microbiology)	Consultant Medical Microbiologist	3 PA per week	3 PA per week

Figure 1 - North Bristol Trust Infection Prevention and Control Provision



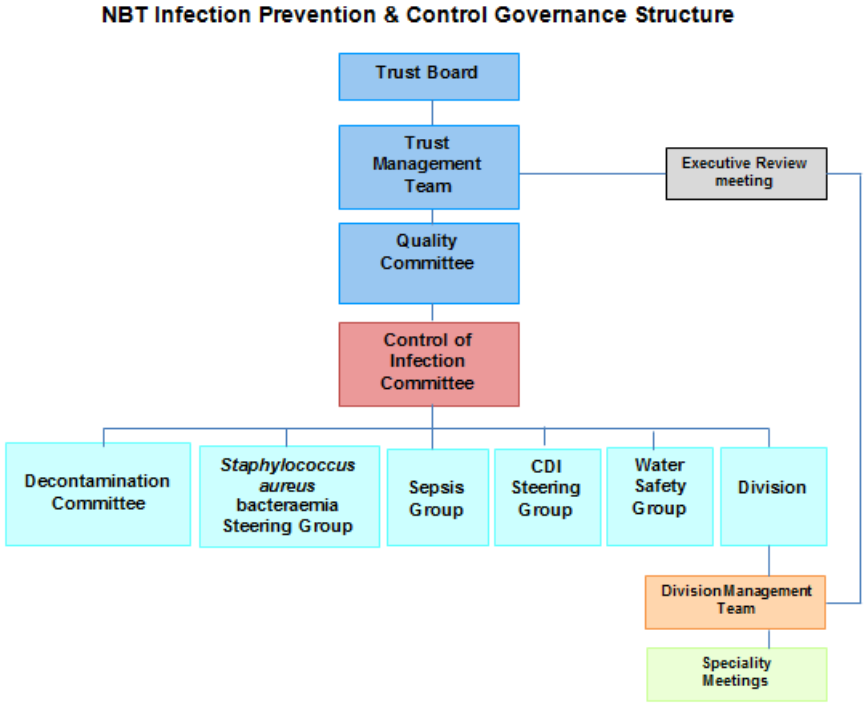
1.1 Director Infection Prevention Control (DIPC) Board Reports

The DIPC is a member of the Trust board. Monthly reports are provided to the Trust board within its integrated performance report. These include the reporting of *Clostridium difficile,* MRSA, MSSA and E coli bacteraemia; hand hygiene, bed days lost due to Norovirus and IPC Serious incidents.

The DIPC chairs the bimonthly Control of Infection Committee (COIC) and the fortnightly Infection Control Monitoring Group. During 2018/19 the COIC reported to the Trust Quality Committee providing a detailed highlight report to each meeting. The Quality Committee being a sub-committee of the Trust Management Team. During 2019/20 the board assurance mechanisms have been revised such that COIC will report to the Patient Safety and Clinical Risk sub-committee of the board Quality and Risk Management Committee.

The specialist IPC groups reporting to the COIC are described in the structure diagram below (figure 2)

Figure 2 - Reporting mechanisms:



1.2 Annual Programme

The annual programme is prepared by the Infection Prevention and Control Team, agreed by the Control of Infection Committee (COIC) and ratified by the Trust's Quality Committee. The annual programme runs from April to March.

The programme of work is mapped to the duties of the Code of Practice on the prevention and control of infections (DH 2015). Progress is monitored bi-monthly by COIC.

The IPC team continues to be represented at groups and committees within NBT providing advice in line with the Code of Practice on the prevention and control of infections. These include: Water Safety Group, Trust Decontamination Group, Clinical Effectiveness Committee, Sepsis Group, Mandatory Training Forum, and Senior Nursing & Midwifery

Professional forum, Health and Safety and Non-Pay Group. There is extensive partnership working with the commissioners HCAI Groups.

1.3 NICE Quality Standard QS61 – Infection Prevention and Control

NICE quality standards describe high-priority areas for quality improvement in a defined care or service area. QS61 has been developed as part of a group of topics on IPC for a range of settings and is the overarching quality standard for IPC. The expectations of the quality standard are to contribute to the following outcomes:

- Reduction in Infection rates
- Preventing avoidable deaths from HCAI

In 2018/19, NBT delivered a COIC approved action plan providing evidence of implementation and compliance with the quality statements within QS61. As part of the continued IPC programme, there was continued focus on the insertion and ongoing management of indwelling devices.

1.4 Infection Prevention and Control Education/Training

The Infection Prevention and Control team delivers bespoke IPC educational/teaching sessions to both clinical and non-clinical staff. The aim is to train all new staff as well as providing mandatory updates to current staff to ensure IPC practice is up to date and reflective of best practice.

Acknowledging the challenges of releasing staff in particular from clinical practice to attend study days a range of ward based teaching sessions have continued in 2018/19. Ward based teaching sessions were supported by themed monthly IPC newsletters widely distributed to clinical leads, support staff and the IPC link practitioners.

2018/19 IPC teaching sessions included:

- Mandatory - 22 sessions
- IV Therapy - 4 sessions
- Paediatric – 6 sessions
- Volunteers - 5 sessions
- Clinical Induction - 25 sessions
- Admin and Clerical staff - 4 sessions
- Consultant Mandatory update - 4 sessions
- Medical Induction – 1 session

In addition, the Infection Control Doctor delivers 8-10 Infection Control seminars to undergraduate medical students each year and delivers face-to-face induction training to every new doctor who joins NBT.

NBT IPC mandatory training compliance has consistently achieved the Trust target of 85%.

Chapter 2: INFECTION PREVALENCE IN NORTH BRISTOL NHS TRUST

2.1 Mandatory Surveillance

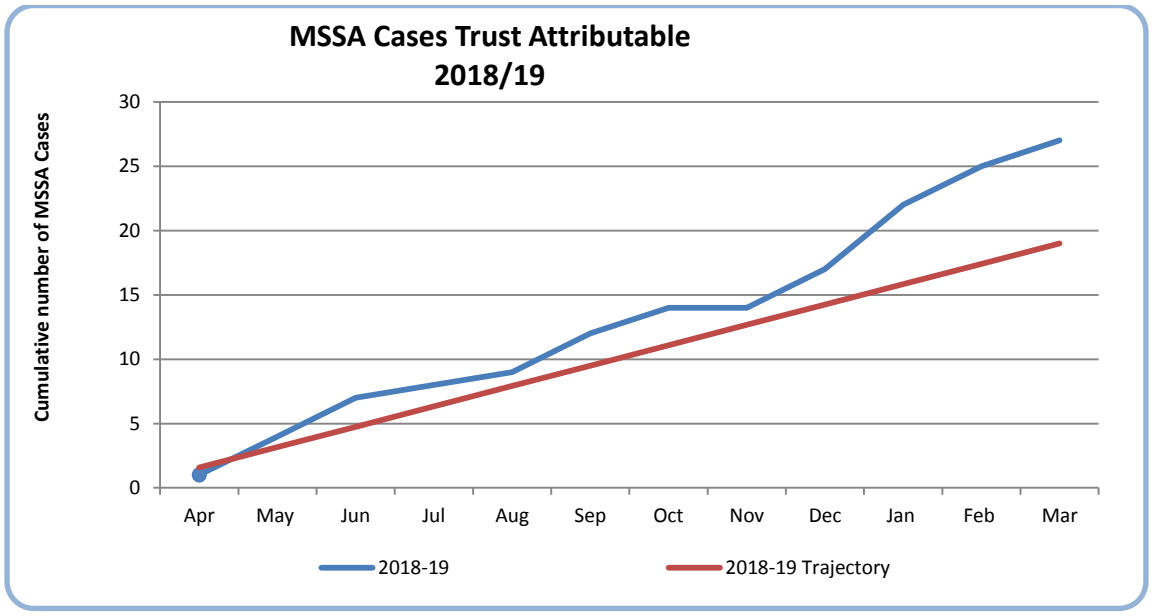
North Bristol NHS Trust complies fully with the mandatory surveillance system for healthcare-associated infections including staphylococcal (MRSA and MSSA) and E. coli bacteraemia, C. difficile and orthopaedic surgical site infections. All serious untoward incidents associated with infection are reported to commissioners and Public Health England.

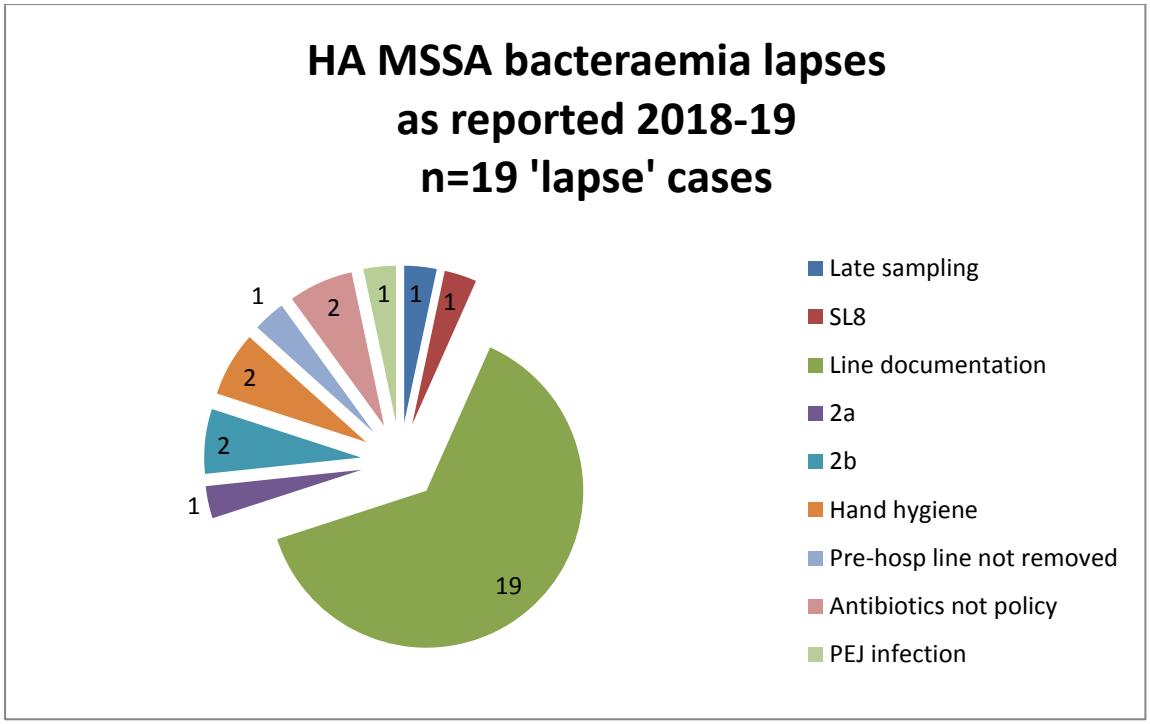
The Department of Health (DH) Mandatory Surveillance scheme is used to measure the effectiveness of IPC practices in all NHS Trusts. This surveillance monitors the agreed national outcome targets for both MRSA bacteraemia, (zero tolerance) and *C difficile,* (maximum 42 cases at NBT in 18/19). There are national definitions applied to all cases, which distinguish between those occurring within primary, community and secondary health care providers. A hospital acquired MRSA bacteraemia is attributed at day two of the patient's admission and a *C difficile* infection at day three. As part of the Local contractual agreement with the Bristol, North Somerset and South Gloucestershire (BNSSG) Commissioning Group MSSA bacteraemia is also reported with attribution of hospital acquired cases following the same format as MRSA.

2.1.1 *Meticillin Sensitive Staphylococcus Aureus* (MSSA) bacteraemia

NBT's locally set target for 2018/19 was 19 hospital acquired (HCAI) cases, representing a small reduction in number of cases compared to our previous lowest year. The trust reported 27 cases in 2018/19, which is a decrease from the previous year but did not meet the in year target.

All HCAI MSSA bacteraemia cases were investigated with a Root Cause Analysis (RCA) to establish causative factors and key risks and themes. The investigations highlighted a recurrent theme related to the insertion, ongoing care and management of invasive vascular devices (central and peripheral lines). Action to address this theme has been a key component of the Trust 2018/19 Staph *aureus* action plan, and work continues to review current policies and related practice. This work will continue to be embedded as part of the 2019/20 annual programme.





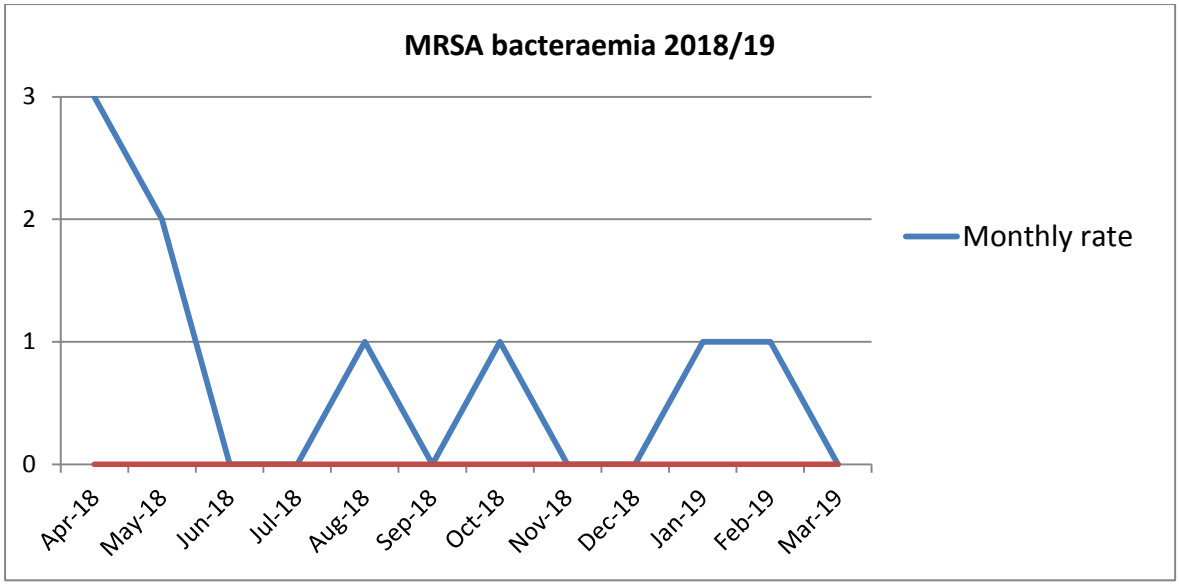
2.1.2 *Meticillin Resistant Staphylococcus aureus* (MRSA) bacteraemia

North Bristol NHS Trust has zero tolerance of MRSA bacteraemia with a local and national target of nil cases. Nine cases of MRSA bacteraemia occurred in 2018/19.

Each MRSA case generated an individual action plan based upon the lessons learnt. This has been shared and reviewed by the Trust as part of Infection Prevention and Control Governance processes. This includes meeting separately with the Divisional Clinical Leads to review each case and the resulting action plan. The lessons learnt and relevant actions are discussed widely both internally within the Trust and externally with Commissioners and NHS Improvement.

As an organisation we experienced higher than acceptable numbers of MRSA bacteraemia during the year. Similar to MSSA cases the investigations of MRSA identified the need to focus on reviewing and removing invasive devices at the earliest possible opportunity within the patient's admission.

An organisational approach to the use of the invasive devices was implemented, with the aim to reduce the numbers of bacteraemia, and in doing so preventing avoidable harm to our patient's. This work continues - see Appendix 2



2.1.3 *Clostridium difficile*

Each case of *C difficile* identified in the hospital is investigated by undertaking a formal multi-disciplinary Root Cause Analysis (RCA), with peer review at a *C difficile* Steering Group (CDSG), chaired by the Trust Infection Control Doctor. The BNSSG Commissioners are represented at this meeting as part of the Trust governance and commissioning process, in accordance with national guidance. Action plans are formulated from the lessons learnt and are followed up at subsequent meetings, through Divisional Governance and the Trust's Control of Infection Committee.

Following NHS (England) guidance all the RCA's undertaken include an assessment of lapses in care. A lapse in care would be indicated by evidence that policies and procedures consistent with national policies and standards were not followed. This would include evidence of:

- Transmission of CDI in hospital confirmed through ribotyping
- Poor compliance with cleaning standards,
- Poor compliance with infection prevention precautions such as hand hygiene
- Concerns identified with choice, duration, or documentation of antibiotic prescribing

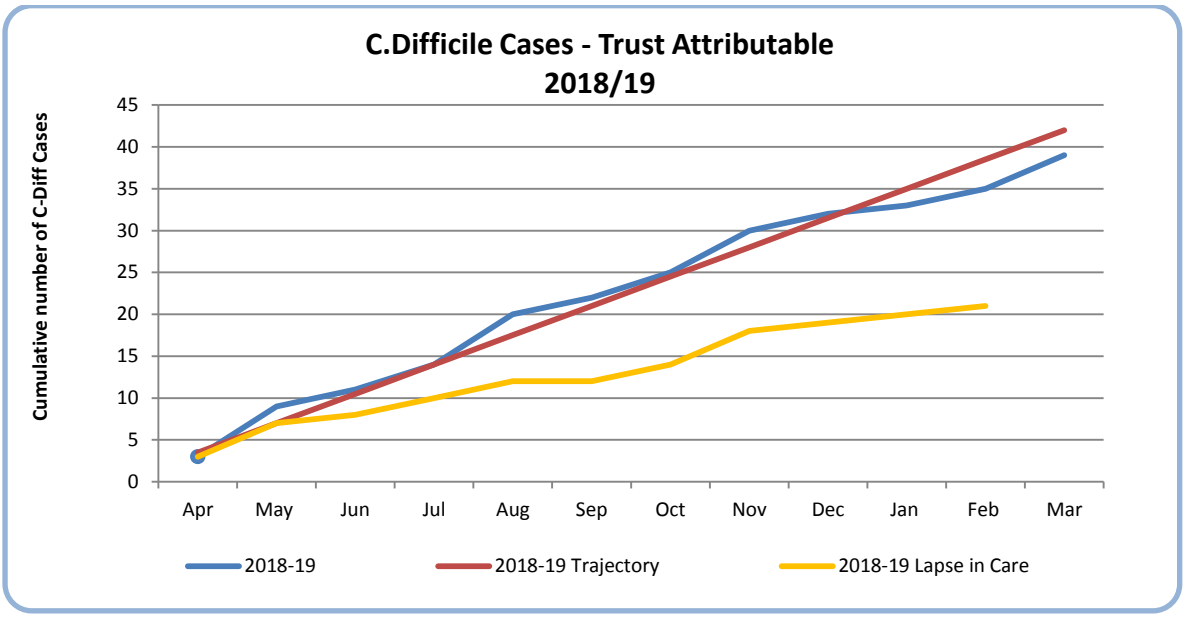
Commissioners consider the findings of every *C difficile* RCA and decide whether individual cases should count towards the agreed Trust target for reduction as specified within the commissioning contract.

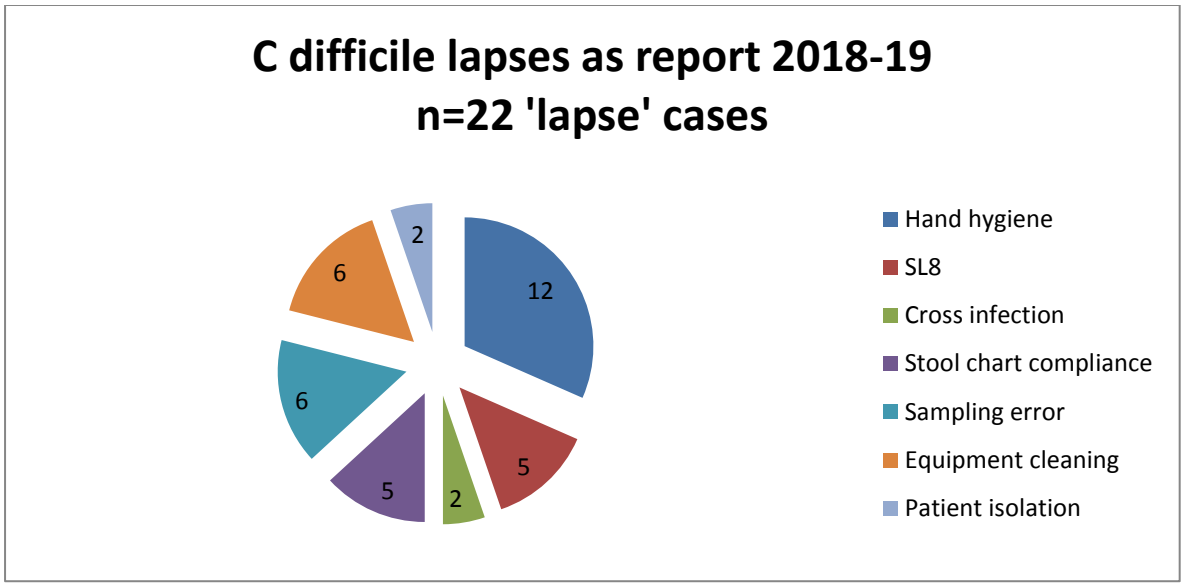
The NBT 2018/19 *C difficile* target was 42 hospital-acquired cases. This is in alignment with the National ambition to demonstrate a year on year reduction in numbers of reported cases.

The contractual maximum of 42 cases in year comprises cases where there is evidence of lapse in care in the Trust. Overall NBT for 2018/9 reported 39 cases of which 22 were considered to have been contributed to by lapses in care.

Themes identified included the need for prompt patient sampling if diarrhoea develops to ensure accurate attribution to community where appropriate. Learning points have been fed back to clinical teams in formal teaching/induction and through board rounds and local ward education.

The target for 2019/20 is set at 57 cases, the higher number resulting from a change in definition of attribution between Trust and community.





Each confirmed case of *C difficile* is sent for further strain typing (Ribotyping) to establish whether there are linked cases in either time and/or location in the hospital. In 2018/19 one Period of Increased Incidence (PII) was investigated where Ribotype within a location indicated a likely cross-infection between two patients. The cases were reviewed taking into consideration timeframes of admission, location on ward and clinical practice using audit data. The investigation concluded a cross infection had occurred but was unable to establish the index patient. This was reported as a Serious Incident.

2.2 Gram-negative blood stream infection caused by E coli, Klebsiella and Pseudomonas aeruginosa

Voluntary national data collection of Gram-negative bacteraemia cases has found that the most common ones are the *E coli*, *Klebsiella* and *Pseudomonas aeruginosa*.

Enhanced surveillance of *E. coli* bacteraemia has been mandatory for NHS hospitals since June 2011. Patient data of any *E. coli* bacteraemia is reported monthly to Public Health England. During 2018/19 there were a total of 317 cases of *E. coli* reported by the Trust compared with 297 in 2017/18.

The majority of cases reported are not 'assigned' to the Trust. During 2018/19 there were 57 'NBT-assigned' cases. The corresponding figure in 2017/18 was 62 cases. This represents a decrease for the Trust, but the increase in total cases reported is in accordance with an increasing national and local trend in these bacteraemia within the community setting.

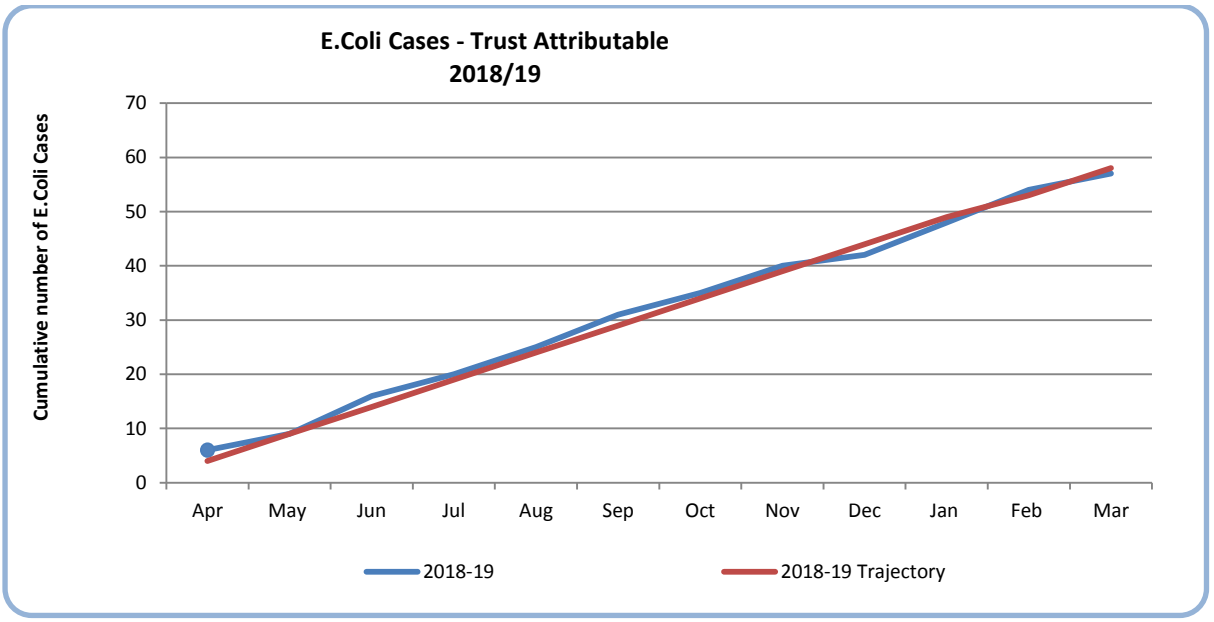
The Trust Infection Prevention and Control Plan for the forthcoming year will continue to focus on these and other Gram negative bacteraemia in line with the national priorities for the NHS in England.

Klebsiella sp is the second most common Gram-negative enteric bacterium with similar significance to *E coli*. We isolated a total of 59 cases of *Klebsiella* blood stream infections in 2017/18 and 74 cases total in 2018/19. In the past year 19 cases were 'assigned' to NBT.

In 2018/19 we isolated a total of 30 cases of *Pseudomonas aeruginosa* blood stream infections, 10 were NBT 'assigned'. In 2017/18 there were 31 cases of which 9 were NBT assigned: none of the NBT assigned cases were associated with water systems.

Root Cause Analysis was carried out on all *E coli*, *Pseudomonas aeruginosa* and *Klebsiella* bacteraemia cases to identify any specific areas of care which may have contributed to development of infection. The national ambition is to reduce the number of cases by 50% by 2024.

The main causes of bacteraemia nationally are urinary catheter associated E. coli infection and ERCP/MRCP procedure associated Gram-negative infection. ERCP (endoscopic retrograde cholangio-pancreatography) and MRCP (magnetic resonance cholangio-pancreatography) involve imaging and diagnosis of hepatobiliary and pancreatic conditions.



2.3 Respiratory Viruses

The trust continues to report all confirmed positive cases of influenza within augmented care, as part of the Public Health England (PHE) UK surveillance. Ward based, Influenza themed teaching sessions were delivered across the hospital to support knowledge awareness, and ensure appropriate use of protective equipment.

In addition to the weekly critical care recording of positive Influenza results, NHS Improvement received daily data capture from October 2018 of all positive influenza results in organisation and critical beds.

There was 87.9% uptake of influenza vaccination by staff compared with 72.6% vaccinated in the previous season. This increase in vaccination can be attributed to a robust organisational flu campaign

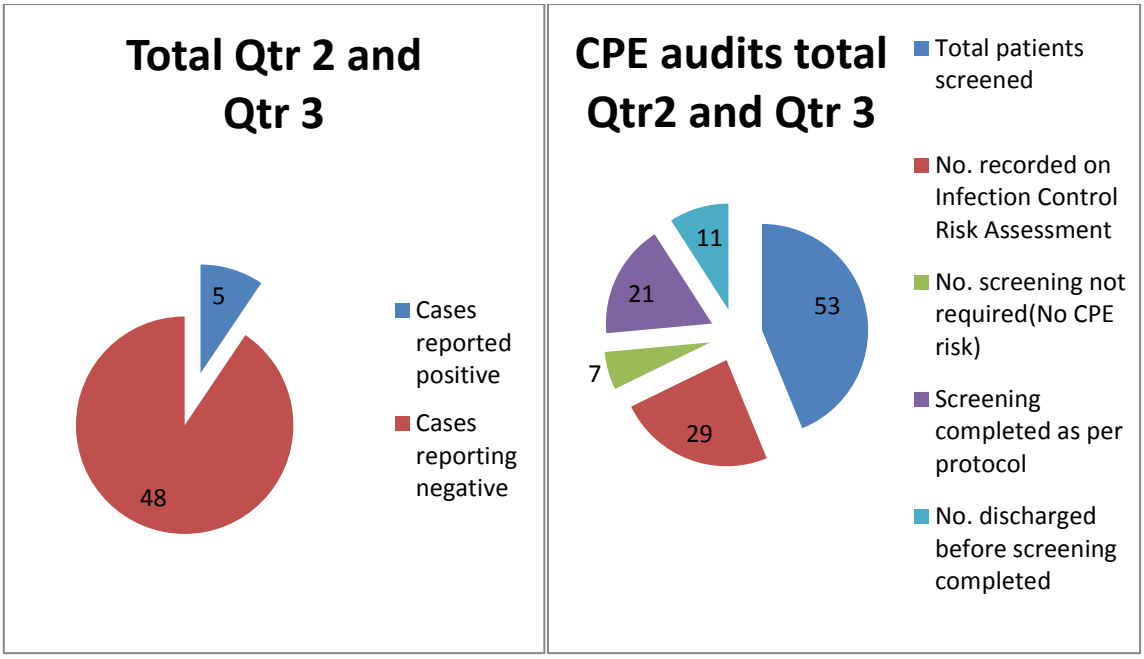
2.4 Carbapenemase Producing Enterobacteriaceae (CPE)

There are strains of Gram-negative Enterobacteriaceae that can produce carbapenemase, an enzyme capable of destroying carbapenem antibiotics. Carbapenems are a valuable family of antibiotics normally reserved for serious infections caused by drug-resistant Gram-negative bacteria (including Enterobacteriaceae). They include meropenem, ertapenem and imipenem. The presence of Carbapenemase is often associated with several other resistance genes, which makes the Enterobacteriaceae resistant to multiple antimicrobials and therefore infections caused by CPE have significantly limited treatment options. Some organisms are resistant to all available antibiotics and effectively untreatable.

Antibiotic resistance is a major public health concern and multi-resistant or completely resistant strains of very common gut bacteria (CPE) have emerged in recent years. This is a global threat and whilst still relatively uncommon in Southern England, it is increasingly being identified in Bristol. This is particularly within the context of patients being transferred or repatriated following inpatient Hospital stay in high risk overseas countries, within the last 12 months or from areas within the UK where CPE incidence is high.

It is important to be vigilant to the increased risk of colonisation or infection with CPE and NBT have implemented a CPE management pack as an appendix to Policy IC19 Multi-Drug Resistant Organism policy. The management pack and guidance it contains is aligned with the PHE Acute trust toolkit for the early detection, management and control of CPE (2013). CPE surveillance is resource intensive and patients found to be carrying these organisms require a panel of screens, until either clearance is achieved and precautions stepped down or the patient is discharged.

In 2018/19 NBT IPCT undertook a review of all patients screened for CPE in quarter 2 and 3 to test policy compliance and impact on the organisation – see below



NBT receives patients repatriated from all over the world which places the organisation at a higher risk of receiving patients with Multi Drug Resistant Organism's. 9% of patients screened in this timeframe reported positive for CPE.

Disappointingly in 2018/19 the Trust reported the transmission of a multi drug resistant micro-organism between two patients who were treated on the Intensive Care Unit (ICU) and underwent surgery in the theatre complex in Brunel. Following an investigation the root cause was assumed failure to follow Trust infection control protocols but the investigation was unable to identify a specific point of failure in either theatres or ICU. The event was reported as a Serious Incident. The action plan relating to the incident was closed by the Trust Patient Safety and Clinical Risk Committee in March 2019.

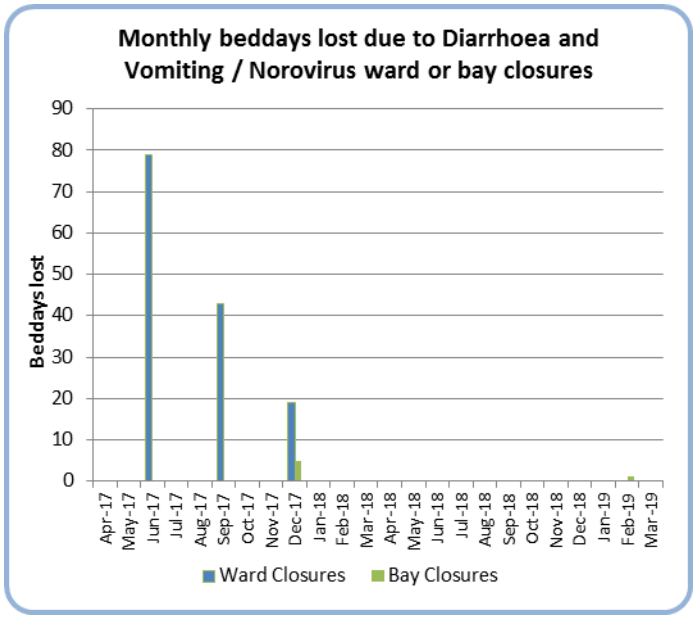
Chapter 3: OUTBREAK AND INCIDENT MANAGEMENT

3.1 Diarrhoea and Vomiting outbreaks

IPCT is involved in the investigation and management of outbreaks in the hospital environment in particular Norovirus which is a highly transmissible viral gastroenteritis. It is often referred to as “winter vomiting disease” but it can cause outbreaks at any time of year.

IPCT adheres to national guidance (the South West norovirus toolkit; Dec 2010) and NBT policy IC16 for the management of these situations with the aim being to reduce the impact and return the affected areas to normal operational status in the shortest time that is safe and feasible. The high proportion of single rooms in Brunel has significantly assisted in reducing whole ward ‘closures’ due to outbreaks.

For 2018/19 only one bed day was lost from a bay closure in Feb 2019, this compares to 48 bed days lost in 2017/18.

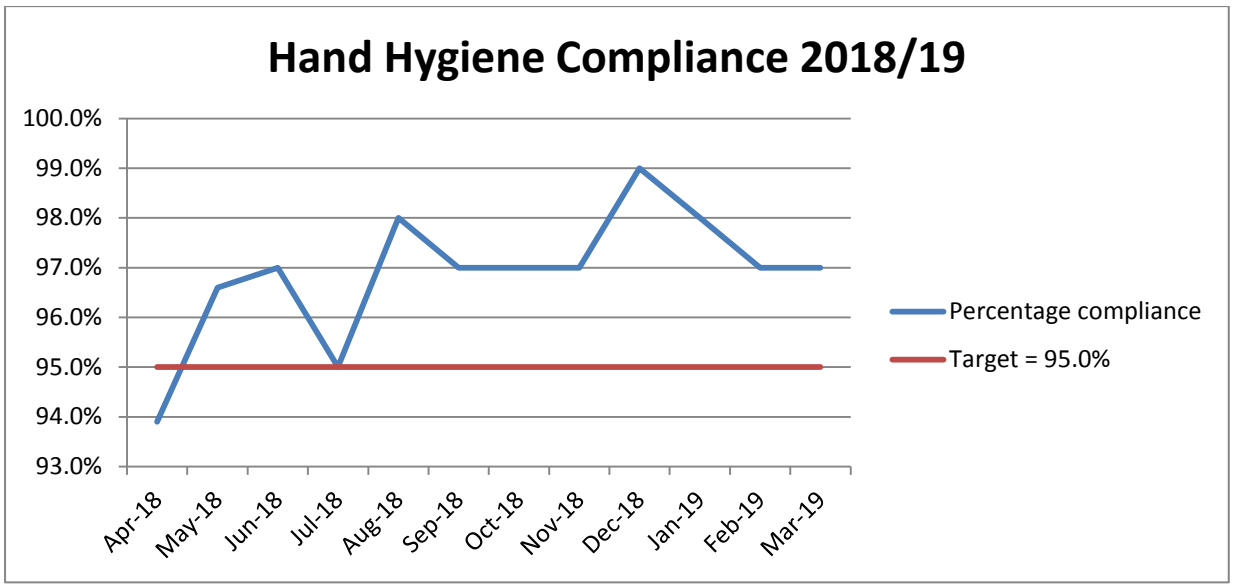


Management of Norovirus remains an integral part of winter planning and escalation in NBT and relies strongly on clinical and management engagement in close liaison with the Trust Operations and Facilities team.

Chapter 4: QUALITY INDICATORS

4.1 Hand Hygiene

The Trust has achieved the 95% compliance target for hand hygiene audit scores in 11 out of the 12 months of 2018/19.



Hand Hygiene awareness is a fundamental part of the IPC programme with the annual involvement on May 5th – in the World Health Organisation hand hygiene day which this year focused on the 'Clean care for all – It's in your hands' campaign.

Infection Prevention and Control National Policy and Guidance (NPG) Consensus Group

In June 2018, as part of an initiative by NHSI and the gram negative reduction programme, a group was established to progress the development of a national hand hygiene and PPE (personal protective equipment) policy. The group consisted of representation across England with members of the NBT IPCT (IPC Dr and Nurse Consultant) representing the South of England. The purpose of the group was to provide expert opinion and support to the development and implementation of national infection prevention and control policy (practice guide) for hand hygiene and associated resources that are acceptable for use across NHS England. The policy was successfully completed and launched as part of the Chief Nursing Officers conference in 2019.

4.2 Saving Lives Care Bundles (Audits)

The Trust continues to use the Saving Lives care bundles introduced in 2007 and revised in 2017 as a tool designed to reduce the risk and spread of HCAI by focusing on the risk factors which cause infections, for example indwelling devices. The audit tools provide a method of measuring how effective the clinical process is and a way of improving it. Nationally recognised audit tools are applied to develop key performance indicators relating to infection prevention and control.

For some clinical areas achieving the 95% compliance standard has been challenging. This forms a key focus for the team's annual programme for 2019/20, with particular focus on vascular access devices and management of urinary catheters.

The Synbiotix audit system, widely used throughout the UK, has been successfully introduced and implemented using the Trust IMT infrastructure for all infection control audits. This internet based audit system enables the visibility of real time audit data which is based upon nationally recognised audit tools and has the ability and flexibility to enable bespoke compliance solutions when required.

The implementation of 'Synbiotix' has allowed clinical areas to monitor areas compliance and those aspects of the care bundle where further support is needed. Actions are generated based upon results and ability to be able to re-audit where necessary. Dash boards are set up for each individual ward/department and can be viewed by any member of staff. Trust, Divisional and ward/department views are available.

4.3 Antibiotic Stewardship

Antimicrobial resistance is increasingly recognised as one of the major infection related Public Health challenges. The organisation's Antibiotic Stewardship Programme is one of the most well established in the country and is primarily focussed on implementing the DH recommendations in the Start Smart Then Focus (SSTF) document which was updated in March 2015. The Trust complies with the minimum standards of:

- Monitoring documentation of indication and duration
- Monitoring evidence of an antimicrobial stewardship review at 48-72h
- Monitoring adherence to local antibiotic guidelines
- Monitoring antimicrobial consumption trends

We are awaiting implementation locally of Public Health England's Second Generation Sensitivity Surveillance (SGSS) IT programme, to provide antimicrobial resistance trends based on our own in-house pathogen susceptibility testing. A gap analysis, based on SSTF and an Antibiotic Stewardship Programme Dashboard, has been developed and gaps are regularly reviewed to ensure increasing compliance with SSTF and more recent NICE guidance (2016).

The organisations Antibiotic Guidelines were reviewed in 2018. Compliance with guidelines is audited every six months as part of a point prevalence study. Results and key messages are disseminated to prescribers through divisional antimicrobial 'champions'. These champions then co-ordinate local audit and antimicrobial stewardship programmes.

There are close links between the Antibiotic Stewardship Group and the Trust's Sepsis Group ensuring that our Stewardship Programme also meets the needs of managing sepsis in patients admitted with infection and those acquiring infection during their stay.

Antimicrobial stewardship was added to the CQUIN agenda in 2016 to encourage a reduction in the use of broad spectrum and total antibiotic usage. The targets for 2018/19 were to reduce both overall and specifically carbapenem usage by a further 1% from the baseline year 2016. We were also required to ensure that at least 55% of our usage consisted of 'narrow spectrum' agents (as defined by the NHSE AWARE classification). NBT achieved all targets and reduced our total antibiotic use by 11% and carbapenem use by 33% compared to baseline.

Comparative information with other Trusts is also available through the Pharmacy DEFINE system and the Public Health England finger tips website. The audit results have been used to review the Annual Programme 2019/20.

4.4 Surgical Site Infection (SSI)

Preventing SSI is an important outcome measure. Surveillance data on SSI rates can inform and influence steps to minimize the risk of infection, as well as help clearly communicate the risk to patients.

NBT undertakes mandatory SSI reporting for infection following hip replacements, knee replacements and spinal surgery, which is coordinated by the Neuro and Musculoskeletal Division (NMSK). The compliance with national benchmarking is monitored through COIC.

Table 1 below is indicative of all NBT reported infections for these categories including those that are reported only by patients measured against specific criteria and unconfirmed (patient reported). Trusts nationally, are formally benchmarked for inpatient and readmission infections only. Infection rates are variable by calendar Quarter as a result of the small numbers of infections but nevertheless orthopaedic SSIs have been reported as higher than bench mark on a number of occasions.

The NMSK and ASCR Divisions together with the Infection Prevention and Control team have developed a programme of quality improvement to review all aspects of patient perioperative care aimed at reducing SSIs. This work is led by a Consultant orthopaedic surgeon. Examples of actions are reducing traffic through theatres at time of procedures and enhancing compliance with pre-op antibiotic prophylaxis.

Ongoing monitoring of inpatient and readmission patients continues. NMSK is participating in the 'Get it right first time' (GIRFT) audit of SSIs which is occurring as an adjunct to the PHE reporting process. The GIRFT aim is to report data on SSIs between 1st May 2019 and 31st October 2019. As well as our usual reporting of total hip and knee replacements and spinal implants we will be including total shoulders, ankles and elbows within the GIRFT data collection.

Table 1

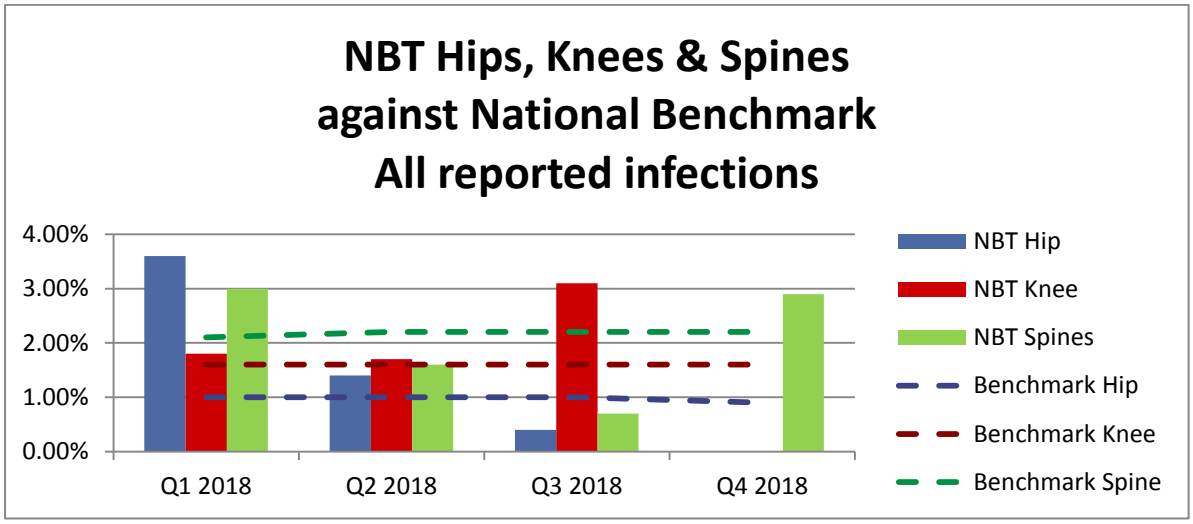
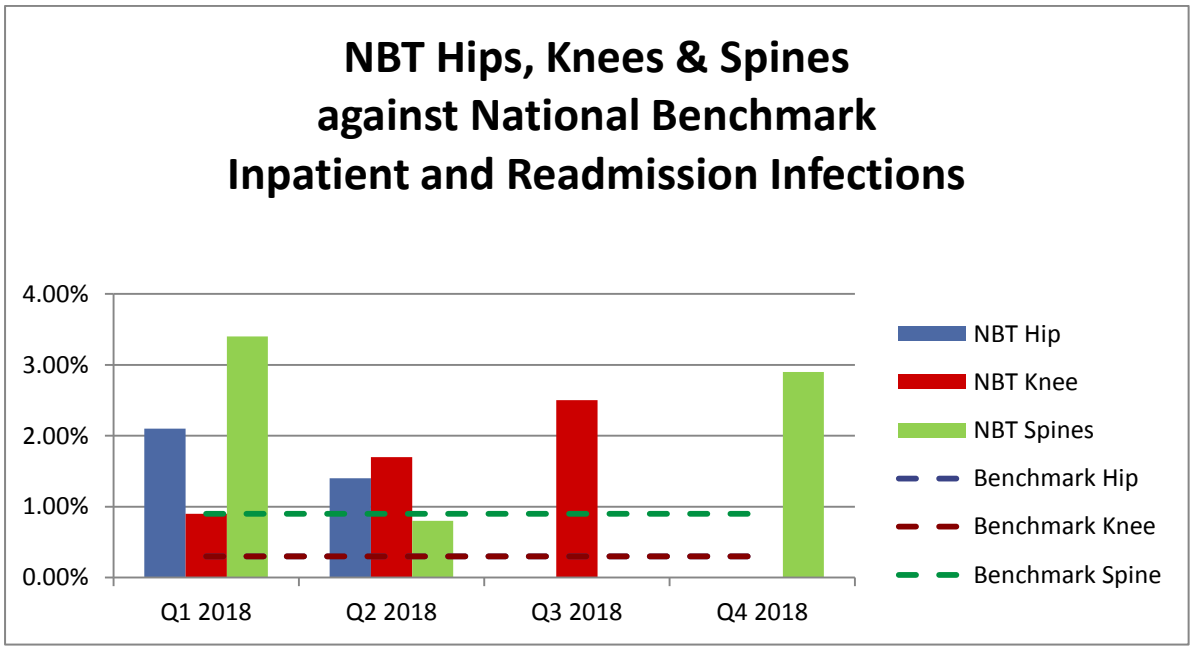


Table 2 inpatient/readmission only infections



4.5 Cleanliness

Domestic cleaning scores have exceeded all targets in all categories from May 2018. This has been achieved through enhanced performance management, regular recruitment of staff and utilising the winter team to backfill short term vacant posts. See table below.

Table 1

	Apr 19	May 18	Jun 18	Jul18	Aug 18	Sep 18	Oct 18	Nov 18	Dec 18	Jan 19	Feb 19	Mar 19
VHR	97	98	98	98	98	98	98	98	98	98	98	98
HR	96	96	97	96	96	96	96	96	97	96	96	96
Sig	96	97	96	95	95	96	95	95	95	95	95	96
Low	93	91	93	94	86	96	94	94	96	93	84	97

Historically through the winter months it has been increasingly difficult to back fill vacancies within domestic services through NBT Extra which does impact on cleaning standards. In August 2018 a decision was made to substantively recruit a cohort of staff in order to reduce the reliance upon NBT Extra through the winter. As a result of having a substantive workforce we were able to back fill shifts created through vacancies, annual leave and sickness. By doing so cleaning standards were maintained or enhanced.

As a result of collaborative working with the infection control team it was identified that the high level of throughput of patients in the Acute Medical Unit resulted in more dust accumulation than in other areas. As a result a programme of works was developed over and above the usual scheduled cleaning including high level dusting, ceilings, hoists and

vents being vacuumed and washed down. Domestic task teams have been made responsible for completing similar planned work in nursing stations, shared spaces, sluices, kitchens and reception areas. Cleaning standards/scores have improved within AMU as a result.

Further collaborative working and a combined C *difficile* reduction plan continues to be delivered. Domestic management attend 'swarm' meetings along with clinical colleagues on the identification of C difficile, MRSA and MSSA cases to identify causes and necessary actions.

4.6 Decontamination

The Trust Decontamination Lead and Chair of the Trust Decontamination Committee is the Director of Facilities. Membership of the Trust Decontamination Committee includes the Assistant General Manager for Facilities Management who also holds the position of Trust Decontamination Advisor, the Nurse Consultant for Infection Control and the Consultant Medical Microbiologist designated for decontamination. The Trust Decontamination Committee meets on a quarterly basis and is responsible for monitoring decontamination arrangements and compliance. It also reports to COIC on a quarterly basis with a highlight report.

- Decontamination Facilities Key Performance Indicators continue to be monitored and reviewed. Decontamination Facilities reprocesses all surgical and other invasive reusable medical devices, provides a high level disinfection services for all flexible endoscopes and internal audits are conducted to ensure their compliance with ISO13485 and the Directives 93/42/EEC and 2007/47/EC. The department is externally audited twice a year by a notified body (British Standard Institute). During the year April 2018 to April 2019, no minor or major non-conformances were raised by the notified body. As to internal non-conformances a breakdown of the year by type is detailed below. These continue to be monitored and acted upon to ensure operational hospital activity is not compromised.

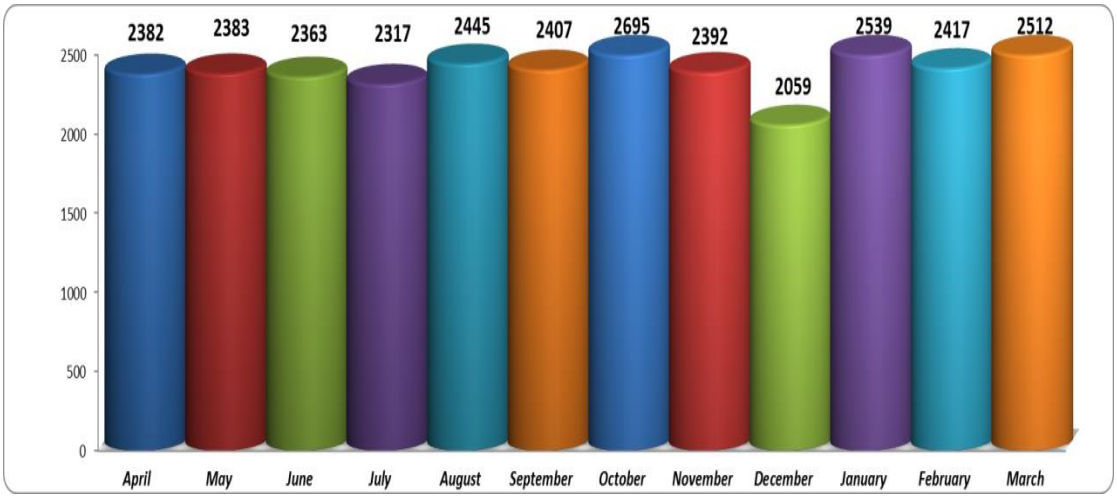
2018-19														
NC Category	Percentage of compliant Trays	April	May	June	July	August	September	October	November	December	January	February	March	Total to date
Torn Wrap	99.78%	29	35	22	23	36	13	46	19	11	26	17	22	299
Contaminated	99.96%	5	5	3	5	1	5	7	5	9	4	5	7	61
Missing Item	99.70%	35	26	24	20	21	28	60	63	34	27	33	38	409
Extra Item	99.91%	6	7	7	14	6	9	17	13	13	10	9	9	120
Wet Set	99.95%	8	4	5	8	5	8	2	3	3	3	7	6	62
Wrong Item	99.92%	12	10	5	4	5	7	18	12	9	9	17	8	116
Tracking Error	100.00%	0	0	0	0	0	0	0	0	0	0	0	0	0
Sterility	99.98%	3	1	4	2	2	0	4	0	2	2	3	7	30
Damaged Item	99.99%	0	3	1	0	1	2	1	1	0	1	0	2	12
Assembly	99.96%	6	6	3	3	1	5	9	4	9	3	3	1	53
Label Issue	99.99%	1	0	0	0	1	2	3	1	0	2	1	0	11
Checklist Mistake	99.99%	1	0	0	0	0	1	2	0	0	2	1	0	7
Other	100.00%	0	0	0	1	0	0	0	0	0	1	0	0	2
Total Complaints per Month	99.14%	106	97	74	80	79	80	169	121	90	90	96	100	1182
Tray Set Production		10912	11350	10725	11801	11542	11174	12713	11989	11062	11343	10560	11600	136771
Total Production		14867	15619	14460	15754	16294	14704	16810	15872	14949	15192	14220	15224	183965
Percentage of Non-conformances against Volume of Processed														
		0.71%	0.62%	0.51%	0.51%	0.48%	0.54%	1.01%	0.76%	0.60%	0.59%	0.68%	0.66%	0.64%

- The Trusts Decontamination stakeholders work closely with the Surgical and Theatre teams to improve upon the key performance indicators. Better management of surgical, and loan instrumentation is being achieved through collaborative working.

- Surgical instrument decontamination activity between April 2018 and 2019 is detailed below. This has maintained stability and continues to trend as predicted.

2018-19													
Packing Totals from Finger print	April	May	June	July	August	September	October	November	December	January	February	March	Total to date
Scopes	231	124	102	125	140	145	140	151	115	149	129	117	1668
Instrument Packs	393	385	371	394	361	384	371	365	351	0	291	0	3666
Singles	3331	3760	3262	3434	3741	3202	3875	3560	3421	3700	3240	3507	42033
Tray Sets	10912	11350	10725	11801	12052	10973	12424	11796	11062	11343	10560	11600	136598
Total Production	14867	15619	14460	15754	16294	14704	16810	15872	14949	15192	14220	15224	183965

- Flexible scope activity between April 2018 and 2019 is detailed below. This activity has risen over the year and continues to be monitored by decontamination facilites and all flexible scope stakeholders.



4.7 Water Safety

The Water Safety Group (WSG) is a subcommittee of the COIC. The Group formulate and monitor the effectiveness of management policies and procedures including the Trust Water Safety Policy HS14 and Written Scheme of Control. Standing members include the Trust Infection Control Doctor and IPC Nurse Consultant. The group meet bi-monthly. The North Bristol Trust site operates as two operational management sections with regards to water safety, i.e. the NBT owned and managed buildings and the Brunel building which is managed by The Hospital Company. As a result there is designation of two Responsible Persons (RP) for water safety. North Bristol NHS Trust is the Duty Holder for both sections and secures the services of an Authorising Engineer/Independent Advisor. Retained estate relates to NBT owned and managed buildings.

4.7.1 Legionella

Legionella pneumophila, which causes Legionnaires' disease, is a bacterium that lives in water, and can infect the water systems in buildings such as offices, hotels and hospitals. Human infection is caused by inhaling water droplets contaminated with the bacteria. Droplets are formed normally when devices such as taps and showers are operated. Typically those most at risk of infection are immunocompromised.

In accordance with the Approved Code of Practice (HSE L8) NBT has in place the necessary programmes to monitor the effectiveness of the written scheme of control, and the risk is minimised by ensuring that hot and cold water systems are maintained at the correct temperatures, and that no stagnation occurs in the water distribution systems. A number of capital schemes have been completed during the year which include the re-provision of water services, and the removal of steel pipe work. This year (2019) marks the completion the remedial work plan. Monitoring continues on a rolling programme to ensure the control scheme is effective.

An incident involving Legionella contaminated water supply, within a building leased from another owner by the Trust has been brought back under control. Although not formally responsible the Trust independently monitors the control scheme by sampling is accordance with guidance.

There have been no significant issues with water hygiene in either retained build or new build in 2018-19. When routine water monitoring has indicated a need for remediation this has been prompt and successful.

4.7.2 *Pseudomonas aeruginosa*

Following outbreaks of *Pseudomonas aeruginosa* infection in various parts of the UK, notably neonatal units in Wales in 2010 and Northern Ireland in 2011, the Department of Health issued its first guidelines on minimising the risk of *Pseudomonas aeruginosa* infection. A revision of the guidance was published in 2016 and the earlier guidance is now embedded in the revised document.

Appropriate monitoring has continued during 2018/19 and is overseen by the Trusts Water Safety group and Control of Infection Committee. The control systems are effective with no cause for concern in either water monitoring or patient infection in 2018/19.

The Water Hygiene Group supported a plan to carry out a programme to replace the taps within the Neonatal Unit. On commencement of the works in October 2018 it became apparent that the Integrated Panel System (IPS) was faulty and would also require replacement across the unit. The original supplier of the IPS panels, were invited to site to inspect the units, and following review agreed to replace the units free of charge. Works started in January 2019 and have progressed into 2019/20, with a planned end date of completion by June 2019.

Conclusion

Infection prevention and control is the responsibility of all clinical and support staff is fundamental when delivering the vision and values and the behavioural standards. Clinically effective infection prevention and control practice is an essential feature of patient protection.

In 2018/2019 the Trust has strived to maintain infection prevention improvements. These continue to improve the patients' experience and provide assurance in relation to safety and standards. The improvements made continue to demonstrate our positive culture of learning and our commitment to harm free care including the reduction in avoidable health-care associated infections.

A robust annual programme of work has been implemented over the last year which has been led by the Infection Prevention and Control Team, supported by colleagues at all levels within the organisation and our Commissioning partners.

The Infection Control team will continue to lead the focus on the reduction of the Gram-negative blood stream infections across the Trust and Healthcare Partners. Working to a shared strategy will enable us to achieve much more than any part of the system could deliver in isolation.

The considerable successes over the last year have only been possible due to the commitment for infection prevention and control that is demonstrated at all levels within the organisation.

Particularly notable successes include:

- achieving the *C.difficile* objective
- Implementation of a real time audit system
- Sustaining significant reduction in the outbreaks of Norovirus in the past two years

Looking to 2019-20

- Meeting HCAI reduction thresholds for MRSA bacteraemia, C difficile and Gram negative blood stream infections.
- Continuing to ensure cross boundary working with local CCGs and other provider organisations
- Maintaining motivation and engagement of clinical and non-clinical staff ensuring that " Infection Control is everybody's responsibility"

INFECTION PREVENTION AND CONTROL ANNUAL PROGRAMME APRIL 2018 – MARCH 2019

This Programme has been developed on behalf of North Bristol NHS Trust (NBT) Control of Infection Committee.

The Infection Prevention and Control Programme, which addresses both national and local priorities is in place to co-ordinate and monitor the work of the Control of Infection Committee and Team in preventing and controlling infection. The objective is to achieve this through effective communication, education, audit, surveillance, risk assessment, quality improvement and development of policies and procedures.

The programme requires all disciplines to work together to promote good infection prevention and control practice. Central to these efforts are the detailed work plans, governance systems, scrutiny and monitoring and reporting arrangements for the effective prevention and control of infection across NBT. Infection prevention and control clearly does not rest solely within the domains of our Infection Prevention and Control Committees and Teams. Everyone has infection prevention and control responsibilities. Service users who depend on NBT require all of us to follow best practice as described in the NBT Infection Prevention and Control policies.

The Infection Prevention and Control Committee and the Infection Prevention and Control Team (IPCT) with support of the link practitioners will co-ordinate delivery of this extensive body of work. All those involved in delivery of healthcare are participants in this programme by actively assisting through each individual's infection prevention and control actions whether delivering or receiving care.

Aim of the Annual Programme

The IPC Annual Programme for 2018-19 is based on utilising performance management systems to Improve patient safety, enhance quality of care and ensure compliance with the Code of Practice with particular emphasis to provide evidence based policies to reducing the risks of acquisition and spread of MRSA, C. difficile, Gram negative organisms (E-coli, Pseudomonas and Klebsiella) and antibiotic resistant organisms (i.e. CPE/GRE) and other healthcare associated infections within the healthcare environments.

Care Quality Commission

The Health and Social Care Act 2008 sets out the overall framework for the regulation of health and social care activities. Regulations made under this Act describe the health and social care activities that may only be carried out by providers that are registered with the CQC. The Code of Practice for the prevention and control of infections (The Code) states 10 criteria against which a registered provider's compliance is monitored and judged.

Compliance criterion – what the registered provider will need to demonstrate:

	Criterion
1	Systems to manage and monitor the prevention and control of infection. These systems use risk assessments and consider how susceptible service users are and any risks that their environment and other users may pose to them.
2	Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infections.
3	Ensure appropriate antimicrobial use to optimise patient outcomes and to reduce the risk of adverse events and antimicrobial resistance.
4	Provide suitable accurate information on infections to service users, their visitors and any person concerned with providing further support or nursing/medical care in a timely fashion.
5	Ensure prompt identification of people who have or at risk of developing an infection, so that they receive timely and appropriate treatment and care to reduce the risk of transmitting infection to other people.
6	Systems to ensure that all care workers (including contractors and volunteers) are aware of and discharge their responsibilities in the process of preventing and controlling infection.
7	Provide or secure adequate isolation facilities.
8	Secure adequate access to laboratory support as appropriate.
9	Have and adhere to policies, designed for the individual's care and provider organisations that will help to prevent and control infections.
10	Providers have a system in place to manage the occupational health needs and obligations of staff in relation to infection.

	Not yet Commenced **In progress** **Complete**					
	CRITERION 1: Systems to Manage and monitor the prevention of infection					
	Executive Lead Dr Burton					
Improvement Component		**Operational Lead**	**Action**	**ECD**	**RAG**	**Evidence of completion**
1	Establish clear structure for COIC to include: ● Membership - Professional representation ● Structured agenda ● Frequency and time of meeting. ● Review ToR annually & Code of Practice on the prevention and control of infections and related guidance self-assessment ●Monitor attendance and respond accordingly to DNAs ● Reports to Quality Committee ● Reports to Board	SMa	Review current reporting format delivered by Divisions on audit and surveillance data - for review in 2017/18 in light of Division structure changes		G	
			Assurance with compliance with NICE guidance - through developed action plan		G	
			Annual self-assessment compliance with Code of Practice on the prevention and control of infections and related guidance		G	
			ToR to be reviewed as part of annual review		G	
			Division rep written to by chair if DNA for 2 meeting		G	
2	Key IPC risks highlighted on Trust risk register. Reported at COIC and Clinical Risk Committee.	SMa	Review current IPC risks included in Trust risk register for example HCAI in line with performance indicators		G	
3	Divisions will have individual IPC governance structures and processes in place to monitor IPC improvement	HoN	COIC will receive bi monthly reports on behalf of the Board which will identify progress with Divisional IPC risks	On going	G	Evidence that action has commenced
			Progress on action plans following root cause analysis for HCAI/Incidents	On going	G	
			Hand Hygiene compliance with relevant actions to improve performance	On going	G	
			Saving Lives compliance with relevant actions to improve performance	On going	G	
			Mandatory training compliance with actions to improve	On going	G	

			Mandatory surveillance performance. (MRSA/CDI/MSSA/E coli)	On going	G	from Abx sub group notification to Divisions Need to est if embedded
			Mandatory SSI reporting (where applicable)	On going	G	
			Antibiotic prescribing performance and actions in response to NBT audit data	On going	A	
Improvement Component		**Operational Lead**	**Action**	**ECD**	**RAG**	**Evidence of completion**
	Present annual programme 2017/18 and DIPC annual report 2016/17 to Trust Board	CB		Sept 18	G	Quality committee achieved
	Provide Trust Board monthly IPC report.	SMa		On going	G	
	The Exec led Infection Control Monitoring Group (ICMG) will continue to meet on a 2 weekly basis. Escalation of frequency of meeting if indicated by risk		ToR of group to be reviewed annually	On going	G	
	STAPH AUREUS The Trust will continue to have a 'Zero Tolerance to avoidable MRSA bacteraemia as outlined by DH and BNSGG contract The Trust objective to reduce the number of Health care associated MSSA cases 2018/19 Trust internal target of 19 cases Introduce new initiatives as presented through local evidence and national guidance	CB	Presentation of cases by Division involved in patients care to ICMG, COIC and Exec Team	On going	G	Work on going with Datix system – 2019/20 objective in line with governance changes
			Continue data capture document (RCA) for hospital acquired cases where the initial Swarm and SBAR indicate association with surgery within the last 30 days or associated with an indwelling device (e.g. vascular access device) using Datix system	31st Oct 18	A	
			Continue completion of PIR (MRSA) by Clinical areas responsible for care – September routes for PIR will be via Datix	On going	A	
			Collaborative working with CCG and cases of MRSA bacteraemia as part of whole health economy	On going	G	
			Review MRSA policy. – changed to Staph Aureus policy to include MSSA		G	
			The Trust undertakes Elective and Emergency MRSA screening in line with current national guidance and local policy (30 day screening and weekly screening of key clinical areas (ICU, NICU and Burns)		G	

			Annual audit of MRSA policy – screening and topical treatment prescription		R	
			Review MRSA topical treatment PGD and update		R	To review necessity of PGD
Improvement Component		**Operational Lead**	**Action**	**ECD**	**RAG**	**Evidence of completion**
			Continue Trust Staph aureus steering group to review MSSA and MRSA bacteraemia investigations		G	
			Continue bespoke MSSA screening programmes within Renal and Spinal specialities.	On going	G	
			Topically treat each positive MSSA colonisation based on clinical decision by Consultant in charge of individual case (Renal & Spinal pts)	On going	G	
Improvement Component		**Operational Lead**	**Action**	**ECD**	**RAG**	**Evidence of completion**
	The Trust objective to meet the mandatory requirements for Health care associated C. difficile of 42 cases Introduce new initiatives as presented through local evidence and national guidance.	SMa/ERSD	completion of RCA by Clinical areas responsible for care September routes for PIR will be via Datix	31st Oct 18	A	Datix implementation on 2019/20
			All health care cases to continue to be monitored at CDI Steering Group. Each Trust attributable case as defined by national guidance (toxin positive from day 4 of admission) using RCA format.		G	
			Collaborative working with CCG and cases of MRSA bacteraemia as part of whole health economy		G	
			Target education and training through lessons learnt/action plans from RCA investigations.		G	
			Provide Trust Board with CDI trajectory based on NBT cases to include both lapse in care and no lapse in care (quarterly)	On going	G	Provided on IPR
Improvement Component		**Operational Lead**	**Action**	**ECD**	**RAG**	**Evidence of completion**
The Trust will work as part of the BNSSG Whole Health Economy approach to reduce Gram negative		BNSSG lead	Review of sample of previous years hospital acquired cases to establish themes/trends	On going	G	

bacteraemia by 10% in 2017/18 and 50% by 2021 with CCG as primary leads	NBT lead – SMa/ESRD	Work collaboratively with BNSGG on plan of reduction via the BNSGG HCAI group	On going	G	
	SMa	Continue data capture document (RCA) for hospital acquired cases where the initial Swarm and SBAR indicate association with surgery within the last 30 days or associated with an indwelling device (e.g. Urinary Catheter) using Datix system	31st Oct 18	A	Datix implementation 2019/20 RCA process in place managed by IPCT
		Consider implementation of the HOUDINI protocol for the insertion and removal of urinary catheters (i.e. urinary catheter policy, bladder scanner and TWOC protocols)	31 Mar 19	G	NHSI National project careplan, sticker and passport out for consult C/F 2019/20
		Implement Patient urinary catheter passport for all patients within BNSSG	31 Mar 19	G	NBT passport implemented managed as part of Continence group
Improvement Component	**Operational Lead**	**Action**	**ECD**	**RAG**	**Evidence of completion**
The Trust will fully implement the National toolkit for the early detection, management and control of Carbapenemase-producing Enterobacterceae Department of Health (2013)	SMa/ERSD	Ongoing training of CPE guidance using Trust agreed management pack as part of MDRO policy		G	
		Risk assessment to be in place for all high risk admissions from healthcare abroad/UK – regards screening and isolation		G	
		Included within IPC mandatory training		G	
		Continued liaison with PHE and primary care provider with all relevant cases – surveillance documentation		G	
		IT support system to monitor those admitted (daily email)		G	
		Collaborative working with external partners and acute trusts re information sharing and contact tracing		G	
		Review of current policy. – MDRO	31st Dec 18	A	In progress completion March 31st April COIC

	CRITERION 2: Clean and appropriate environment that facilitates the prevention and control of infection					
	Executive Lead: Dr Burton/Simon Wood					
Improvement Component		**Operational Lead**	**Action**	**ECD**	**RAG**	**Evidence of completion**
1	Implement and participate in the new Department of Health approach to annual environmental review 'Patient Led Assessment of the Care Environment' (PLACE) Led by Facilities Division	Simon Wood Matt Chick	Continue annual PLACE assessment as part of local and national 2018/19 PLACE visit		G	
			Facilities will report key themes/risks and relevant IPC actions to COIC		G	
2	The Trust will carry out an environmental Deep Clean in accordance with the Operational Cleaning Policy	Andrew Jeanes	Areas to be cleaned based on actual or potential risk of cross infection as defined within the policy (RED AMBER GREEN)		G	
Improvement Component		**Operational Lead**	**Action**	**ECD**	**RAG**	**Evidence of completion**
			Collaborative working with Supervisory Ward Sister and Domestic Team leader for audit. Which includes the environment and point of care equipment (C4C)	**30th Sept 18**	G	On target for year end Evaluate a part of synbiotix
			Audit Scores to be reported monthly to Trust Board.		G	
			Bespoke audit team to be employed by Facilities for C4C audit of the clinical areas.		G	
			C4C will be part of the IPC incident management - RCA process for example CDI		G	
			Annual IPC environmental audits for clinical areas	On going	A	
			Continue development of roles and responsibilities re cleaning between ward staff and domestic teams.		G	
			Point of care equipment will be part of the IPC incident management - RCA process for example CDI	On going	G	
Improvement Component		**Operational Lead**	**Action**	**ECD**	**RAG**	**Evidence of completion**
5	Water Safety – in line with National Guidance Management of Legionella Management of Pseudomonas aeruginosa	Simon Wood/ERSD /SMa	Provide Specialist Infection Prevention Control and Microbiology input into the Trust management of Legionella and PSEAE	On going	G	
			Guidance reviewed at the Trust Water Safety group - reports to COIC	On going	G	

			Trust Water Safety Policy in place	On going	G	
			Division assurance re Flushing within augmented care	On going	G	
			Quarterly PSEAE hand wash sinks best practice audits (DH guidance 2012)	On Going	G	
Improvement Component		**Operational Lead**	**Action**		**RAG**	**Evidence of completion**
7	The Trust Decontamination Lead will ensure that the Decontamination Committee meets and works within its terms of reference that the decontamination/sterilisation of all equipment used within NBT is in accordance to current manufacturers and National guidance. Reporting mechanism to COIC	Simon Wood	Trust Decontamination committee to meet Highlight Report presented to Trust Decontamination Committee (quarterly)		G	
			Identified programme of work - held by the Chair of both Committee and Subgroup.		G	
			Ensure Policies up to date	31st mar 19	A	CJD policy revision April COIC
			System in place for the purchase of new equipment and its decontamination.		G	
			CJD pt. risk assessment for the quarantine of invasive equipment to be reviewed as part of move into new SSD	30th Nov 18	G	
8	Provide specialist Infection Prevention Control and Microbiology input into Capital build projects and annual validation schemes occurring within NBT	SMa/ERSD	Invited to Capital Project meetings as required		G	
			Review RAMs risk assessments re aspergillosis		G	
			Aspergillosis Policy in place		G	
			IPC forms part of final sign off for refurbishment/build		G	
			Collaborative working with Estates maintenance on maintenance programmes which involve IPC for e.g. the annual inspection of ventilation systems		G	
	CRITERION 3: Secondary Driver Element: Antimicrobial use of optimise patient outcomes and to reduce the risk of adverse events and antimicrobial resistance					
	Executive Lead: Dr Burton					

Improvement Component		Operational Lead	Action		RAG	Evidence of completion
1	The Trust demonstrates a culture that promotes judicious use of antimicrobials and supports an antimicrobial stewardship programme Implement a programme of audit that supports delivery of Department of Health audit standards (standard 2). Implement a programme of activities - including audit feedback, antibiotic restriction, evidence based guidelines and surveillance of patient outcomes in line with recent DH guidelines - Start Smart, Then Focus	APM	On-going review Antimicrobial prescribing policy/guidelines		G	
			Identify requirements needed to deliver guidance locally and across the health economy - collaboratively working with local Acute Trusts and CCGs		G	
			Results of Antibiotic pharmacist audits to be disseminated to clinical leads to progress actions		G	
			Monitoring of Divisional/National Audit results and actions through COIC		G	
	CRITERION 4: Secondary Driver Element: Provide suitable and accurate information on infection in a timely fashion					
	Executive Lead: Dr Burton					
Improvement Component		**Component Lead**	**Action**	**ECD**	**RAG**	**Evidence of completion**
1	The Trust will ensure that all IPC policies are up to date and compliant with National guidelines Programme review for each policy is in place. 2017/18:	SMa/ERSD	Programme of Policy review in place	31 Mar 19	G	On target for April 2019
2	The Trust will ensure that information is available for pts/visitors/carers on HCAI	SMa/ERSD	Review and update current website - to include patient/carer access to information	31 Mar 19	A	In development with Trust comms team
3	The Trust will continue to respond to feedback from the Public	SMa/ESRD	Input as invited to patient experience group		G	
			Continue to input to complaints and local resolution meetings as invited by Division.		G	
			Ensure duty of candour applied where applicable to IPC incident by Division responsible for care		G	
4	The communication between both acute and community provider will be robust. The Trust documentation for pt. discharge will provide a summary to include IPC issues to be communicated in accordance with national guidance.		Work collaboratively with CCG and PHE, as part of whole health economy IPC strategy		G	
	CRITERION 5: Secondary Driver Element: Identification of people who have or at risk developing and infection					

	Executive Lead: Dr Burton					
Improvement Component		**Operational Lead**	**Action**	**ECD**	**RAG**	**Evidence of completion**
1	The Trust has a system in place to identify IPC risk factors of patients presenting to NBT to facilitate appropriate placement and treatments	SMa/ERSD	EPR assessment tool in line with new system being embedded into Trust		**G**	
			Work with IMT for validated data to be available on the Trust intranet		**G**	
			Address compliance through COIC.		**G**	
			To audit current IPC risk assessment on EPR and establish compliance	31 Mar 19	**A**	Further work on Lorenzo risk assessment compliance needed
			Review current process for managing D/V outbreaks (Swest tool kit) in line with 75% single room occupancy	31st Oct 18	**G**	DV policy rev April COIC
			Call Incident review meetings in line with Outbreak Policy and associated organism Policy.		**G**	
			IPC alert in place at point of sample request.		**G**	
			Continue to work collaboratively with the PHE on identification of diseases of high risk consequences admitted to NBT		**G**	
			IPC notification though Trust Electronic White Board (EWB)		**G**	

	The Trust will develop and implement an improvement programme to enhance the clinical management of I Vascular access devices		Trust Vascular access group in place to implement actions related to Driver Diagram key themes: Documentation, training, practice ,audit – implement vessel health framework	30th Nov 18	G	QI project lead by ASCR in progress will C/F as part of 2019/20 plan
			Review training and competency standards for ANTT	**30th Nov 18**	G	
			Roll out education and training programme as part of vessel health framework		A	
Improvement Component		**Operational Lead**	**Action**	**ECD**	**RAG**	**Evidence of completion**
	The Trust will develop and implement an improvement programme to enhance the clinical management of Sepsis Managed by Trust Sepsis Group reporting to Trust Quality Committee	APM	IPC to continue representation and commitment to Trust Sepsis group and related projects		G	
			IPC alert organism surveillance tool (ICNet) reviews positive blood cultures against sepsis 6 criteria		G	
			Participate in National prevention of sepsis day/month events		G	
	The Trust has robust systems in place for the monitoring and management of outbreaks and Serious Incidents	SMa/ERSD	Alert organism surveillance tool in place		G	
			Reporting of SI in accordance with national guidelines and Trust policy		G	
			SI and Outbreaks collaboratively approached with relevant external partners (PHE, Commissioners, NHSE)		G	
		SMa/IMT	Review current IPC data capture system (ICNet)	**30th Sept**	G	Business case in progress with

			Business case required to update to NG or alternative system.	**18**		IMT – potential for BNSSG wide system
	CRITERION 6: Secondary Driver Element: Staff responsibilities in the process of preventing and controlling infection					
	Executive Lead: Dr Burton					
Improvement Component		**Operational Lead**	**Action**	**ECD**	**RAG**	**Evidence of completion**
1	The Trust will ensure that it is able to provide the necessary support and education to its employees in dealing with the process of preventing infection.	SMa/ERSD	IPC Lead part of the Trust safety initiative.		**G**	
			Annual review and updated of IPC mandatory training to include e-learning 2018/19 based on national framework for MAST	**Sept 30th 18**	**G**	
					G	
			Mandatory Training programme continues for all staff - maintaining 85% compliance.		**G**	Egs inc ICU exemplar pod and team theatres
			IPC to work with relevant clinical/education teams in specific areas relating to infection control practice	ongoing	**G**	
			Staff carry out saving lives audits and are responsible for reviewing compliance and relevant actions at COIC.		**G**	
			IPC programme of audit to carry out quarterly IPS audits to support clinical areas with assurance of their results.		**G**	Part of Governance plan 2019/20
			RCA/PIR are used as tools for learning disseminated within the clinical area and Division		**G**	
			RCA/PIR Action plans monitored at Divisional level - SWS, Clinical Matrons/ DMT	31 Mar 19	**A**	C/F 2019/20
			Review and update IPC inter/intranet page to reflect service provision, policy guidance etc.	31 Mar 19	**R**	
Improvement Component		**Operational Lead**	**Action**	**ECD**	**RAG**	**Evidence of completion**

2	The Trust will have processes in place to monitor Surgical Site Infection (SSI) for specified procedures. – Division Led Hips/knees/spine - NMSK	NMSK	Divisions to manage own SSI agenda with facilitation by IPCT. (girft)	ongoing	G	Continues into 2019/20
			Identify those SSI reported as pt reported and those confirmed with clinical information.		G	
			Reporting at local Division Governance meeting - with identified actions. Collaborative working within Division to establish a consistent approach to reporting	31 mar 19	G	NMSK SSI Orthopaedic review
			Division reporting at COIC with results, actions and escalation required.		G	
	CRITERION 7: Secondary Driver Element: Provide secure isolation facilities					
	Executive Lead: Dr Burton					
Improvement Component		**Operational lead**	**Action**	**ECD**	**RAG**	**Evidence of completion**
1	The Trust has process in place to ensure that patients admitted are placed appropriately according infection risk and clinical need.	SMa/ERSD	Policies to reflect use of single room isolation and positive pressure lobbied rooms.		G	
			IPCT are part of admission process for patients admitted as transfers from healthcare institutes abroad e.g. secondary trauma; and diseases of high consequence		G	
	CRITERION 8: Secondary Driver Element: Adequate access to lab support					
	Executive Lead: Dr Burton					
Improvement Component		**Operational Lead**	**Action**	**ECD**	**RAG**	**Evidence of completion**
1	The Trust to provide a 7 day week service for testing specimens and reporting results.	David Gibbs	Communication of specimen results to IPC through ICNet system and medical liaison		G	
			Review of organism - virology specimens reported via ICNet (pathology 2)		G	
			Communication of CDI and organism involved in incident management - ICNet and verbal communication immediate response.		G	
			24/7 IPC service provided by Medical Microbiologists out of hours		G	

	CRITERION 9: Secondary Driver Element: Policies which will help prevent and control infection					
	Executive Lead: Dr Burton					
Improvement Component		**Operational Lead**	**Action**	**ECD**	**RAG**	**Evidence of completion**
1	The Trust will ensure that all IPC policies are up to date and compliant with National guidelines	SMa/ERSD	Programme review for each policy is in place.		**G**	
	2017/18 Audit schedule in place based upon Key Performance Indictors	SMa/ERSD	Implement and embed Synbiotix audit system to all clinical areas.		**G**	
			Implementation of three tier dashboard – clinical area, Division, Trust wide)	30th Nov 18	**G**	
			Divisional assurance re compliance and actions related to learning – monitor via COIC		**G**	
			Audits occurring relevant to incident/outbreak		**G**	
			Sharps audit occurs annually - by company (health and safety)		**G**	
	CRITERION 10: Secondary Driver Element: Occupational Health needs and obligations of staff in relation to infection					
	Executive Lead: Dr Burton					
Improvement Component		**Operational Lead**	**Action**	**ECD**	**RAG**	**Evidence of completion**
			Trust induction for all new employees and contractors. Review and update current presentation	31st Jan 19	**G**	
			Mandatory Training programme continues for all staff - maintaining 85% compliance. Review and update current presentation and e-learning	31st Jan 19	**G**	
			Review current staff IPC competencies in collaboration with Learning and research dept.	31st Jan 19	**G**	
2	The Trust will provide the necessary protective equipment and training to protect staff from infection associated with health and social care.	SMa/ERSD/	IPC will assist in collaboration with Emergency planning, OH Staff will continue to be trained through induction/mandatory training		**G**	

			IPC will assist in collaboration with Emergency planning, OH As part of Flu vaccination programme		G	
			Collaborate with Emergency planning and OH with necessary PPE requirements (FFP3)		G	
			IPC in collaboration with Emergency planning, OH and Health and Safety to respond to incidents as they arrive i.e. diseases of high consequence.		G	
	The Trust will continue to provide an Occupational Health Service for its Staff.		Occupational Health - standing item on COIC with representative		G	
			Collaborative working with national priorities concerning protecting Staff and patients for e.g. Flu and measles programmes		G	
			Divisions to have in place systems with OH to review staff immunisation history and relevant immunisation as part of Trust staff resilience	31st Mar 19	A	In progress OH band 5 screening RN in place C/F 2019/20
			Establish vaccination programmes for staff as they arise from specific incidents (for example measles Trust wide staff immunisation)	31st Mar 19	A	
			Divisions to ensure systems in place for staff contact tracing for specific disease (i.e. measles, chicken pox, whooping cough.)	31st Mar 19	A	

NHS North Bristol NHS Trust

NBT MRSA Bacteraemia Action Plan – February 2019

Not yet commenced In progress Complete

Improvement Component **MRSA Screening** All Patient's meeting DH criterial are screened according to Trust policy		Action	Operational Lead	Monitoring Processes	Rv Date	RAG status	Evidence of completion/Progress
1	Clinical areas are compliant with MRSA according to Trust policy	Carry out annual audit of MRSA screening within direct admission areas - AMU (31a/b), 6b, 8b, 26b,33a, ICU (37), CDS, NICU	SMa	Completion of audits with relevant action plans to audit compliance	21st Dec		2019_MRSA AUDIT.docx
		Carry out audit of MRSA treatment protocol compliance audit as per policy Point prevalence one day per week over 4 weeks. Known positive cases within hospital	SMa	Completion of audits with relevant action plans to audit compliance	21st Dec		
Improvement Component **Vascular Access Devices**		**Action**	**Operational Lead**	**Monitoring Process**	**Rv date**	**RAG**	**Evidence of completion**
2	Ensure best practice of Central line insertion and ongoing care and management (applies to clinical areas where Central Lines are used)	Complete Quality improvement project on the care and ongoing management of Vascular access devices Divisions involved ASCR/NMSK COIC QI programme sign off 22nd November	ASCR/NMSK (Divisional leads) SMa	8/11/18 QI Planning meeting 22/11/18 COIC sign off Completion of QI programme 2019/20	31st March		Lead Division ASCR 2 work streams: ANTT Vascular Access

The above plan has a series of actions underpinning each area. The actions are monitored internally through the established governance routes of Infection Prevention and Control and externally through the Clinical Commissioning Group Quality Sub Group.

Report to:	Control of Infection Committee	Date of Meeting 20th June 2019

1.	Executive Summary of the Report
The Health and Social Care Act 2008: Code of Practice on the prevention and control of infections and related guidance requires all health and social care providers to have systems in place to monitor the prevention and control of infection. In order to achieve compliance with the CQC registration requirements the Trust must demonstrate that all criteria in the guidance can be met. The IPC (IPC) Programme describes the infrastructure and systems that are currently in place to reduce the incidence of health care associated infection. The Programme also provides the key drivers and objectives for preventing and controlling infection going forward, ensuring that safe care remains a priority for the Trust.	

2.	Recommendations (Note, Approve, Discuss)
The Quality and Risk Management Committee is requested to approve the IPC Programme recommended by the Control of Infection Committee.	

3.	Legal / Regulatory Implications
It is a legal requirement to comply with Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (Part 3). Regulation 12 (Safe care and treatment) sets out the requirements for providers to prevent and control the spread of infection.	

4.	Risk (Threats or opportunities, link to a risk on the Risk Register, Board Assurance Framework etc.)
Failure to meet C. difficile threshold Failure to meet MRSA bacteraemia threshold IPC ICNet system failure risk due to sun setting current Version (with IMT)	

5.	Resources Implications (Financial / Staffing)
Nil noted at present	

7.	References to previous reports
Supersedes 2018/19 IPC Annual Programme	

8.	Freedom of Information
Public.	

Infection Prevention and Control Arrangements and Programme

Author and Title:	Samantha Matthews Nurse Consultant IPC/Tissue Viability
Responsible Director	Dr Chris Burton (Medical Director/DIPC)
Ratified by :	Control of Infection Committee
Date Ratified:	
Version:	4

Related Policies and Guidelines:	All IPC policies

Index:

1. Summary

North Bristol NHS Trust aims to continuously improve the quality of the services provided, focusing on patient safety, clinical outcomes and patient experience. Consistent with this is the effective prevention and control of healthcare associated infection which is essential to patient and staff safety and to the overall performance and reputation of the organisation.

The provision of a robust IPC programme is an essential element of ensuring that patient safety objectives are achieved. Health care associated infections (HCAIs) can be significantly reduced by using sound IPC measures and a committed approach to learning. This document outlines the roles and responsibilities of key individuals for delivery of the Programme and recognises that all Trust staff have a duty to comply with IPC policies and the Hygiene Code (The Health and Social Care Act 2008. Code of Practice on the prevention and control of infections and related guidance. Department of Health 2015).

2. Purpose

The purpose of the programme is to ensure that the Trust has suitable and sustainable IPC arrangements in place.

All healthcare workers have a duty to comply with Trust policies and the Hygiene Code underpinning the programme and as such are accountable for any breaches in policy. There are ten compliance criteria that the Trust must provide assurance on, see below:

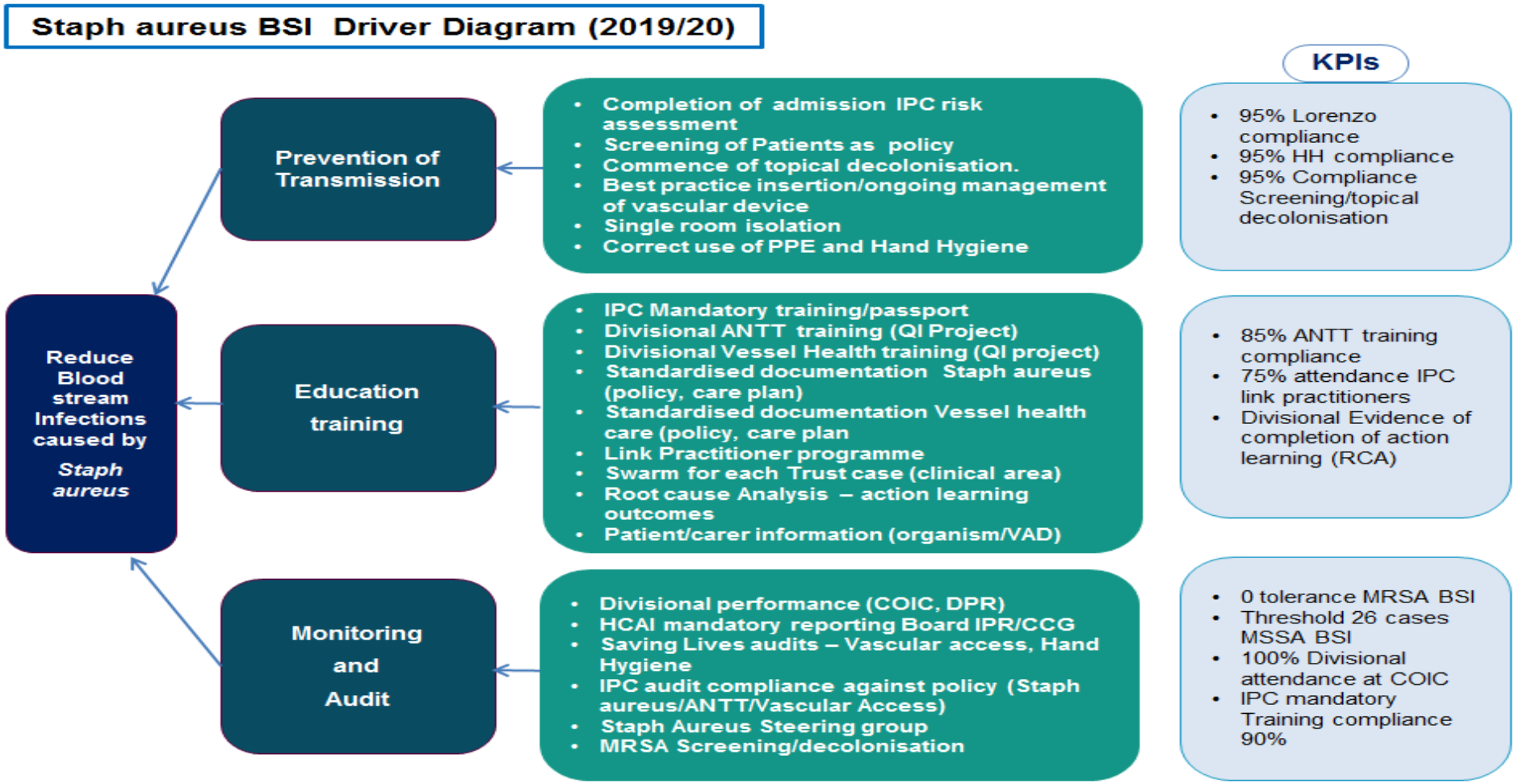
The Health and Social Care Act 2008. Code of Practice on the prevention and control of infections and related guidance. (Department of Health 2015) set out the following criterion.
Registered providers (NBT) will need to demonstrate the following:

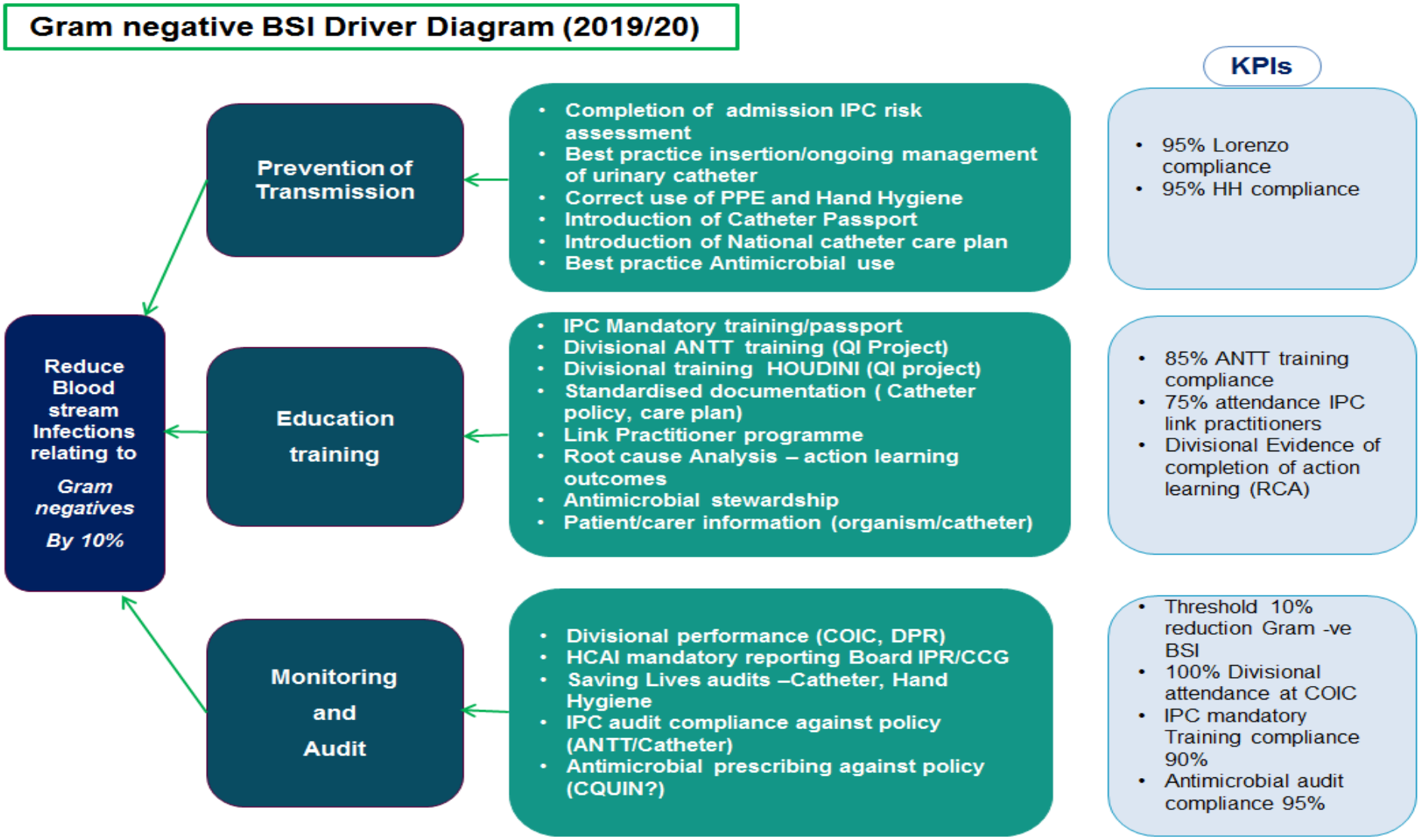
1. Systems to manage and monitor the prevention and control of infection. These systems use risk assessments and consider the susceptibility of service users and any risks that their environment and other users may pose to them.
2. Provide and maintain a clean and appropriate environment in managed premises that facilitate the prevention and control of infections.
3. Ensure appropriate antimicrobial use to optimise patient outcomes and to reduce the risk of adverse events and antimicrobial resistance.
4. Provide suitable accurate information on infections to service users, their visitors and any person concerned with providing further support of nursing / medical care in a timely fashion.
5. Ensure prompt identification of people who have or are

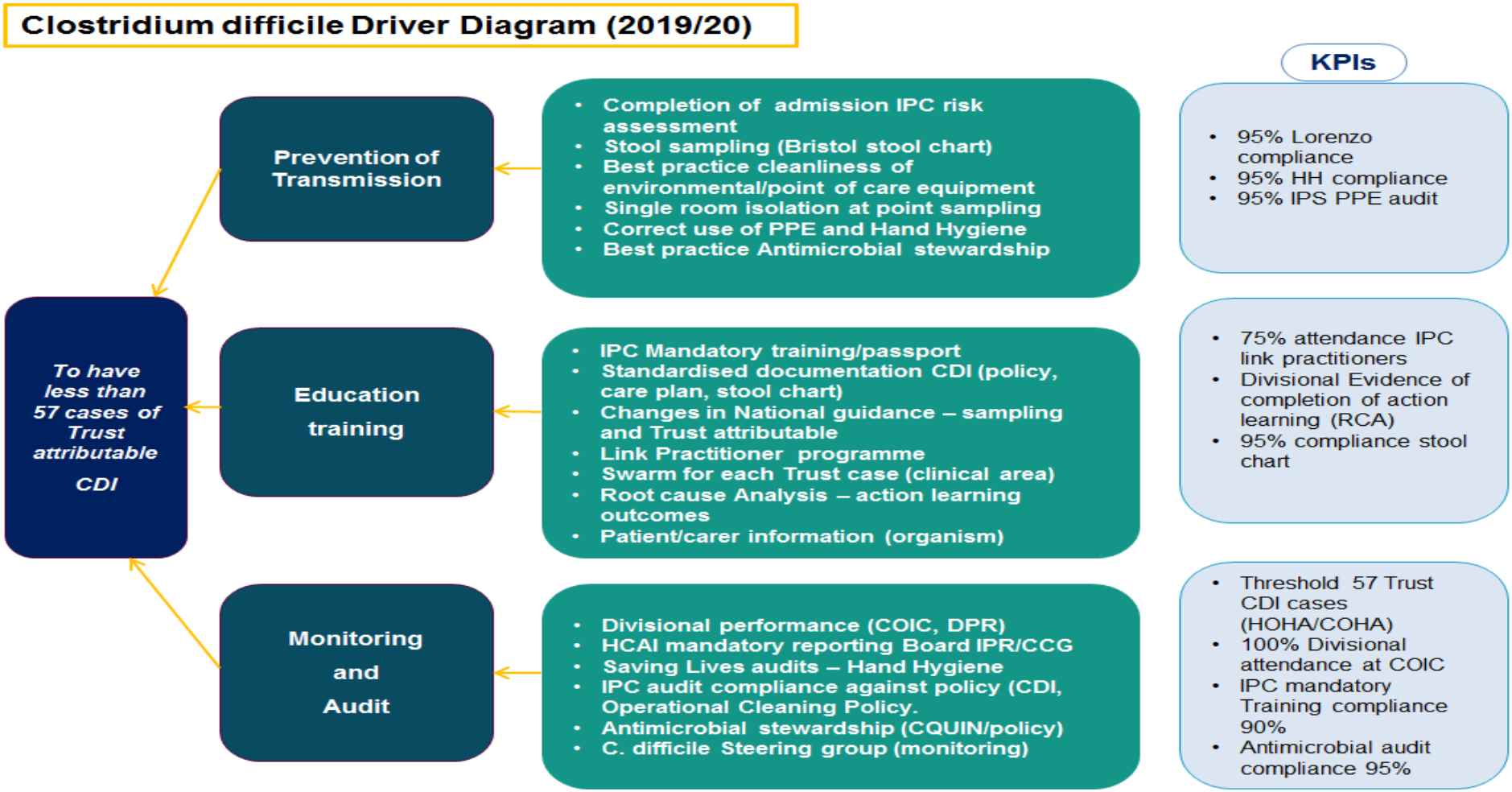
		at risk of developing an infection so that they receive timely and appropriate treatment to reduce the risk of transmitting infection to other people. 6. Systems to ensure that all care workers (including contractors and volunteers) are aware of and discharge their responsibilities in the process of preventing and controlling infection. 7. Provide or secure adequate isolation facilities. 8. Secure adequate access to laboratory support as appropriate. 9. Have and adhere to policies, designed for the individual's care and provider organisations that will help to prevent and control infections. 10. Providers have a system in place to manage the occupational health needs and obligations of staff in relation to infection.
3.	**Programme Objectives**	
	3.1	The Trust will have IPC policies in place, which reflect national policy, statutory requirements, latest guidance and local need. • All policies are written in consultation with expert clinicians • All policies are ratified by the Trust's approved process
	3.2	The Trust will have a robust IPC infrastructure in place, which will include clear organisational responsibilities, training and development linked to defined competencies, support and advice and performance monitoring. This is delivered through: • The IPC Programme • Job descriptions and appraisals • IPC training – induction and Mandatory training and updates for all clinical staff • The IPC Nurses, Doctor and Microbiologists • Surveillance of infections
	3.3	The Trust will have appropriate and effective IPC systems and processes in place including: • An annual IPC work plan including: identification of priorities for action to meet the needs of the organisation and ensure the safety of service users, provision of evidence that relevant policies have been implemented to reduce infections and reporting of progress against objectives of the programme in the annual IPC report. This document also forms the IPC assurance framework • The integration of IPC within the business planning process with evidence of the inclusion of IPC within local business plans • The systematic review of infection risks to ensure they are identified, recorded, assessed, analysed and associated risk reduction strategies implemented where possible

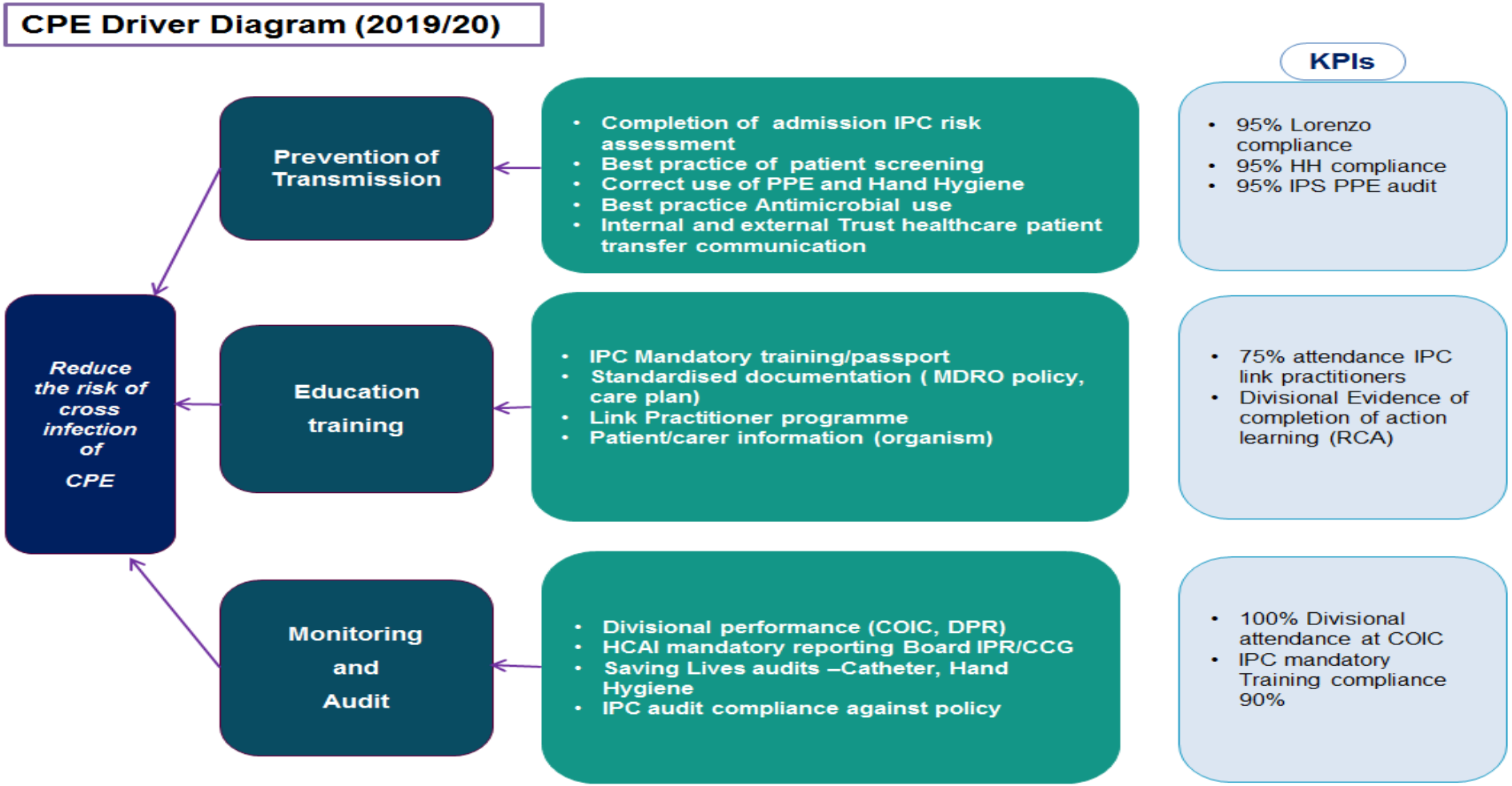
		• A process for reporting adverse events, outbreaks or failure to adhere to infection control policies. This process will utilise internal incident reporting systems and reporting of Serious Incidents related to health care associated infections externally. • 24/7 provision of reactive IPC advice through IPCT with out of hours support from the Medical Microbiologists. • Commissioning of new or altered premises and buildings in order to ensure that the principles of IPC are adhered to • Processes for medical equipment and product review prior to purchase and / or change of use. The Infection Prevention and Control Team (IPCT) are involved with providing advice on the decontamination of new equipment and products. • Robust and accessible outbreak and major outbreak plans • The development of key performance indicators based upon national, regional and locally defined outcome measures • An explicit reference to IPC responsibilities in all Trust staff job descriptions, which are reviewed at appraisal • An antimicrobial policy that is reviewed and audited regularly. Audit data must be reported back to prescribers and must also be incorporated into patient safety reporting systems led by the Trust AMR subgroup • Effective and efficient communication within the Trust and with appropriate external agencies • Effective links with key departments such as Occupational Health, Health and Safety, Estates and Facilities • Ensure that Care Quality Commission registration is maintained by meeting the requirements of the Hygiene Code
	3.4	A collaborative working relationship with local CCGs to ensure that commissioning intentions are clear and that local targets are agreed.

4. Organisational aims and key drivers for improvement




Gram negative BSI Driver Diagram (2019/20)
KPIs
Reduce Blood stream Infections relating to Gram negatives By 10%
Prevention of Transmission
Completion of admission IPC risk assessment
Best practice insertion/ongoing management of urinary catheter
Correct use of PPE and Hand Hygiene
Introduction of Catheter Passport
Introduction of National catheter care plan
Best practice Antimicrobial use
95% Lorenzo compliance
95% HH compliance
Education training
IPC Mandatory training/passport
Divisional ANTT training (QI Project)
Divisional training HOUDINI (QI project)
Standardised documentation (Catheter policy, care plan)
Link Practitioner programme
Root cause Analysis – action learning outcomes
Antimicrobial stewardship
Patient/carer information (organism/catheter)
85% ANTT training compliance
75% attendance IPC link practitioners
Divisional Evidence of completion of action learning (RCA)
Monitoring and Audit
Divisional performance (COIC, DPR)
HCAI mandatory reporting Board IPR/CCG
Saving Lives audits –Catheter, Hand Hygiene
IPC audit compliance against policy (ANTT/Catheter)
Antimicrobial prescribing against policy (CQUIN?)
Threshold 10% reduction Gram -ve BSI
100% Divisional attendance at COIC
IPC mandatory Training compliance 90%
Antimicrobial audit compliance 95%


Clostridium difficile Driver Diagram (2019/20)
To have less than 57 cases of Trust attributable CDI
Prevention of Transmission
Education training
Monitoring and Audit
Completion of admission IPC risk assessment
Stool sampling (Bristol stool chart)
Best practice cleanliness of environmental/point of care equipment
Single room isolation at point sampling
Correct use of PPE and Hand Hygiene
Best practice Antimicrobial stewardship
IPC Mandatory training/passport
Standardised documentation CDI (policy, care plan, stool chart)
Changes in National guidance – sampling and Trust attributable
Link Practitioner programme
Swarm for each Trust case (clinical area)
Root cause Analysis – action learning outcomes
Patient/carer information (organism)
Divisional performance (COIC, DPR)
HCAI mandatory reporting Board IPR/CCG
Saving Lives audits – Hand Hygiene
IPC audit compliance against policy (CDI, Operational Cleaning Policy.
Antimicrobial stewardship (CQUIN/policy)
C. difficile Steering group (monitoring)
KPIs
95% Lorenzo compliance
95% HH compliance
95% IPS PPE audit
75% attendance IPC link practitioners
Divisional Evidence of completion of action learning (RCA)
95% compliance stool chart
Threshold 57 Trust CDI cases (HOHA/COHA)
100% Divisional attendance at COIC
IPC mandatory Training compliance 90%
Antimicrobial audit compliance 95%


CPE Driver Diagram (2019/20)
KPIs
Reduce the risk of cross infection of CPE
Prevention of Transmission
Education training
Monitoring and Audit
Completion of admission IPC risk assessment
Best practice of patient screening
Correct use of PPE and Hand Hygiene
Best practice Antimicrobial use
Internal and external Trust healthcare patient transfer communication
IPC Mandatory training/passport
Standardised documentation (MDRO policy, care plan)
Link Practitioner programme
Patient/carer information (organism)
Divisional performance (COIC, DPR)
HCAI mandatory reporting Board IPR/CCG
Saving Lives audits –Catheter, Hand Hygiene
IPC audit compliance against policy
95% Lorenzo compliance
95% HH compliance
95% IPS PPE audit
75% attendance IPC link practitioners
Divisional Evidence of completion of action learning (RCA)
100% Divisional attendance at COIC
IPC mandatory Training compliance 90%

5. Key Challenges

The key challenges for IPC at North Bristol NHS Trust are:

- The level of hospital activity and capacity
- Level of experience within IPCT – new appointments into role.
- Ensuring cross boundary working with local CCGs and other provider organisations
- Increased demands for audit and surveillance data and the reporting of HCAIs. Responding to national changes in definitions and thresholds for infections which are attributable to secondary care
- Emerging infectious diseases and new strains
- Educating the workforce, patients and public
- Instilling public confidence
- Maintaining motivation and engagement of clinical and non-clinical staff ensuring that 'Infection control is everybody's responsibility'
- Ensuring sufficient resource to deliver the programme
- Meeting HCAI reduction thresholds for MRSA bacteraemia, *Clostridium difficile* and Gram negative blood stream infections plus any other organisms that may have targets added in the next three years
- Ensuring a clean and appropriate environment to deliver the programme
- Providing assurance that there is compliance with policies and objectives, which include the CCG HCAI quality schedule

6. Programme Delivery

The programme will be delivered through:

- IPC policies; these are based on national best practice guidance and performance against the policies and is monitored through a clinical audit programme
- Trust business planning processes; IPC issues must be considered in business plans and advice sought from the IPCT if required
- Training and education; the IPCT provide training for all new and existing staff. See Section 12
- Board Directors leadership; the Programme is approved by Trust Board and the delivery is supported and overseen by members of the Executive Team
- The IPCT; delivering the IPC work plan which includes the audit programme
- The IPCT will collaborate with the Divisional Surgical Site Surveillance Team as part of SSI monitoring
- The Trust Divisions; Divisional Senior leadership teams are responsible for divisional performance against the prevention and control of HCAI
- Divisional Control of Infection groups with terms of reference that include antimicrobial stewardship, review

		of incidence and quality metrics. • Local and Trust performance management; performance against HCAI trajectories are reported through the Trust key performance indicators, and Trust IPR • All Trust staff have a responsibility to adhere to IPC policies in order to reduce the occurrence of HCAI
7.	**Definition of terms**	
		• CCG – Clinical Commissioning Group – responsible for commissioning services in provider organisations • HCAI – Health care associated infection • MRSA – Meticillin resistant *Staphylococcus aureus*
8.	**Duties and Responsibilities**	
	8.1	**Chief Executive** The Chief Executive accepts on behalf of the Trust Board ultimate responsibility for all aspects of IPC within the Trust.
	8.2	**Director of IPC(DIPC) / Medical Director** The DIPC has lead executive director responsibility for IPC and will delegate local operational responsibility to the Divisional Senior Leadership Management team. The key roles of the DIPC are to: • Provide an oversight and assurance on infection prevention (including cleanliness) to the Trust Board • Be responsible for leading the organisation's IPCT • Ensure there are governance structures in place to provide assurance regarding effective management and performance for infection prevention and control • Oversee local prevention and control policies and their implementation • Be a member of the IPCT • Have the authority to set and challenge standards of cleanliness • Overseeing antimicrobial stewardship within the Trust • Assess the impact of all existing and new policies on infections and make recommendations for change • Be an integral member of the organisation's clinical governance, water safety group and patient safety teams and structures • Produce an annual report to Public Board
	8.3	**Director of Nursing and Quality** The Director of Nursing and Quality will support the DIPC in the implementation of the Programme.
	8.4	**Director of Human Resources** The Director of Human Resources will ensure that all Trust staff job descriptions contain explicit reference to IPC and where appropriate, that Occupational Health policies and procedures support the IPC programme.

	8.5	**Finance Director** The Finance Director will ensure that resources are available to finance the management and control of outbreaks of infection effectively and efficiently.
	8.6	**Director of Estates and Facilities** The Director of Estates and Facilities will ensure that: • Timely, efficient and effective communication systems are in place to alert the IPCT to forthcoming developments, refurbishments and at all stages of construction, including the final commissioning of new or upgraded facilities • The Trust's nominated board level lead for cleanliness is the Directorate of Estates and Facilities who together with the DIPC will ensure that appropriate systems and processes are in place to achieve high standards of cleanliness • The Director will also ensure close liaison regarding environmental screening, e.g. water sampling for Legionella and Pseudomonas • The Director is also the lead for decontamination and waste management • The strategic cleaning plan supported by the operational cleaning plan will enable the Trust to achieve compliance with all relevant legislation and guidance and fits within the Trust's organisational governance and risk management frameworks. The Trust is committed to demonstrating that its healthcare premises are clean and that risks from inadequate or inappropriate cleaning have been minimised
	8.7	**Infection Control Doctor** The Infection Control doctor (ICD) will work closely with the IPCNs, providing advice and assistance to all Trust employees and appropriate committees in respect of infection prevention and control measures; including direct activity in response to outbreaks with Lead IPCN. They will advise and support the IPCNs in day-to-day activities and serve as a specialist adviser on all matters relating to hospital infection prevention and control. The ICD will also assist with the review of root cause analysis investigations relating to HCAI and liaise with the Lead for antimicrobial stewardship on actions regarding antimicrobial stewardship.
	8.8	**Nurse Consultant Infection Prevention and Control/Deputy DIPC** • Supports and Deputises for the Trust DIPC • Works closely with the ICD to coordinate and direct the IPC strategy in the Trust • Responsibility for the operational management of the

		IPC programme within the Trust • Produce the Trust IPC Annual Report, the IPC programme, IPC policies and the annual IPC work plan with the ICD and DIPC • Manages the IPCT • Directs on the development, review and communication of IPC key performance indicators • Liaison with HCAI lead within CCG and NHSE/I
	8.9	**Infection Prevention and Control** The IPCT will provide a clinical infection control advice service as per the IPC work plan and support Trust staff in the delivery of the IPC programme. They are also responsible for delivering information to the public on IPC matters by providing leaflets and other written information relating to specific infections. The team also issue data relating to performance against the HCAI targets which is available to the public.
	8.10	**Divisional Senior Leadership Management Teams** • Have the responsibility of assisting the DIPC in their role in relation to infection prevention and control. They also have the responsibility for local performance management within their division and remit. • Are responsible for reporting HCAI performance to the Trust Control of Infection Committee and providing assurance that the required actions have been taken to reduce harm to patients. • Have responsibility for Divisional IPC performance and will receive HCAI key indicator data via the Trust governance framework to support this process.
	8.11	**Antimicrobial Stewardship Lead (Consultant Microbiologist)** The Antimicrobial Stewardship lead is responsible for : • Assessing the Trust's antimicrobial stewardship activities against the Tackling antimicrobial resistance 2019–2024 (DH2019) and *Start Smart Then Focus* Antimicrobial Stewardship Toolkit • Developing an action plan in order to provide assurance to the Trust Board of safe, effective and appropriate antimicrobial prescribing • Chairing the Antimicrobial Stewardship Committee • Developing evidence-based antimicrobial prescribing guidelines • Ensuring that mandatory core training in prudent antibiotic use is delivered to doctors, pharmacists and nurses. Training must cover those antibiotics that are linked to Clostridium *difficile* infection
	8.12	**Antimicrobial pharmacist** Antimicrobial pharmacist will assist the Antimicrobial

		Stewardship lead to deliver the stewardship programme as outlined in Tackling antimicrobial resistance 2019–2024 (DH2019) and *Start Smart Then Focus.* They will be responsible for managing an ongoing programme of audit and feedback to provide assurance on antimicrobial stewardship.
	8.13	**Clinical Matrons** Matrons are key role models for exemplary IPC practice and have responsibility and accountability for delivering a clean and safe care environment by maintaining standards of infection control practice within their designated clinical areas. They are also responsible for overseeing environmental audits in their areas, ensuring that equipment, e.g. commodes, are clean and working in partnership with Facilities staff on maintenance and cleanliness issues.
	8.14	**All Staff** All staff have a responsibility: • To comply with Trust IPC policies and procedures • To attend mandatory training, including induction training, as specified in the Mandatory training matrix • To attend or undertake other training sessions appropriate to their role. i.e. ANTT training, infection control e-learning, teaching sessions for staff in specific roles e.g. cleaning and portering staff • To remind and challenge colleagues of their infection control responsibilities if there is a potential or actual breach of policy
9.	**Assurance Framework**	
	9.1	**Trust Board** The Trust Board is responsible for ensuring that the Trust has appropriate IPC systems and resources in place to enable the organisation to deliver its objectives and statutory requirements, demonstrating that IPC is an integral part of clinical and corporate governance. The Trust Board receives and formally approves the Trust IPC programme and the IPC Annual report; both of which are a requirement of the Hygiene Code. The annual IPC report provides performance information from the preceding year and highlights any outstanding actions that need to be addressed during the following year.
	9.2	**Trust Management Team** Reviews local performance outcome measures via the Divisional performance framework leads. This is done monthly through reports to the Board, divisional meetings and quarterly divisional governance meetings.
	9.3	**Trust Quality and Risk Management Committee (QRMC)** The QRMC is an assurance committee. The role of the

		Committee is to ensure that all clinical risks within the Trust are appropriately identified, assessed and managed. The Committee: • Receives and monitors IPC key performance indicator reports on a quarterly basis • Receives evidence of appropriate action being taken to deal with occurrences of infection, including root cause analysis investigation if appropriate • Considers any areas of concern and areas of risk for inclusion on the Trust-wide Risk Register and brings these to the attention of the Board
	9.4	**Control of Infection Committee** The purpose of this Committee is to provide assurance that IPC standards at North Bristol Trust are compliant with The Health and Social Care Act 2008 Code of Practice on the prevention and control of infections and related guidance (2015). For Terms of Reference see Appendix 1 • Approves and disseminates reports to members of the Committee; e.g. the DIPC Report, the IPC work plan, reports on performance against HCAI thresholds, audit reports and recommendations • Monitors performance against HCAI mandatory reporting. The performance is reviewed bi-monthly and actions for improvements are agreed with the divisional representatives • Review results from IPC audits. Actions are identified from these reports and divisional representatives / matrons ensure that these are carried out. Action taken is reported back to the Committee • Receives information; policies and documents for consultation; review and dissemination • Receives assurance from the IPC Committee members' progress with implementation of policies and documents • Participates in the development of, approves and monitors progress with the IPC work plan • Reviews the effectiveness of IPC policies through the annual audit programme • Receives and reviews the annual IPC report • Reviews reports of outbreaks of infection and makes recommendations. • Identifies risks to the Trust IPC programme as raised by members or through Divisional/Speciality reports to COIC
10.	**Procedural Documents**	
		The Trust's IPC policies will be unambiguous and accessible to all staff. The Trust will have in place the core clinical care policies and those pertinent to the environment (Facilities in line with the requirements of the Hygiene Code).

		The Trust will ensure that IPC policies are in place and that all trust staff have the correct levels of expertise to undertake their infection control related activities in a competent manner, as identified in their job description and reviewed at appraisal.
11.	**Monitoring Compliance**	
		The Trust's processes for monitoring HCAI will incorporate both proactive and reactive monitoring systems, including key performance indicators, performance outcome reviews and investigation of incidents and complaints. The Trust Board will evaluate the effectiveness of IPC systems annually through the annual Director of IPC Report and work plan. The Trust will also utilise the following to support performance review and monitoring of performance, and to provide assurance regarding compliance with regulatory requirements and national guidance: • Divisional performance reports relating to infection prevention and control • Incidents relating to HCAI will be reviewed by the Control of Infection Committee, to identify trends and areas of non-compliance with the relevant IPC policies. Areas of risk will be incorporated into the group plan of work • HCAI Improvement programmes • Antimicrobial stewardship via Antimicrobial Stewardship group and representation at COIC • Audit reports and results • Other reports and publications as applicable, for example Care Quality Commission reports • Achieving compliance with the relevant domains for the CQC including the Hygiene Code – using Self-Assessment tool (NHSI) • Monitoring attendance on the IPC component of the Induction and Mandatory training programmes (Training and Development reports) • Annual Patient-Led Assessment of the Care Environment (PLACE) inspections. These inspections are led by the Facilities team.
12.	**HCAI National Targets**	
		Patient safety is the primary objective for the Trust. Reducing the prevalence of health care associated infections is key in ensuring that patients are not harmed and for the local community to have confidence in the safety of their hospital. National targets have helped to focus on where improvements need to be made and this in turn has brought about a reduction in HCAI.

		There is a mandatory requirement to report all cases of MRSA, MSSA, Gram negative (*Klebsiella, Pseudomonas aeruginosa* and *E.coli)* bacteraemia (blood stream infections) and *Clostridium difficile* infection to Public Health England. The Trust reports performance against these thresholds to the public via the Trust Board and information on HCAI rates for each organisation is available via the Public Health England website.
	12.1	**MRSA** There is a zero tolerance approach to MRSA bacteraemia. Mandatory reporting of all cases of MRSA bacteraemia is carried out according to National guidelines. A post infection review (PIR) is undertaken for all 'Trust acquired' MRSA bacteraemia cases (blood culture taken on or after day 2 of admission) and an action plan developed to address any issues which may have caused or contributed to the patient acquiring the infection. Those cases outside of this timeframe are reported to the BNSSG Commissioning team who complete the PIR.
	12.2	***Clostridium difficile*** NHS England sets a threshold for reduction of cases in the annual *Clostridium difficile* Objective. Cases reported by the Trust fall into two categories • Hospital onset healthcare associated (HOHA): cases that are detected in the hospital two or more days after admission • Community onset health care associated (COHA): cases that occur in the community (or within two days of admission) when the patient has been an inpatient in the trust reporting the case in the previous four weeks Clinical reviews for the above cases will be carried out using a multi-disciplinary approach to determine whether there are links to any lapses in care related to the care and treatment of the patient. The BNSSG commissioning team will continue to be members of the Trust C. difficile steering group to ensure that robust systems are in place to prevent, diagnose and treat C. difficile infections.
	12.3	**MSSA bacteraemia** Mandatory reporting of all cases of Meticillin Sensitive *Staphylococcus aureus* (MSSA) bacteraemia forms part of the HCAI CCG contractual obligation. A root cause analysis is undertaken for all 'Trust acquired' MSSA bacteraemia cases (blood culture taken on or after day 2 of admission) and an action plan developed to address any

		issues which may have caused or contributed to the patient acquiring the infection.
	12.4	**Gram-negative bacteraemia** *E coli, Klebsiella sp* and *Pseudomonas aeruginosa* bacteraemia are now included in mandatory surveillance reporting. The overall ambition is to continue work to halve healthcare associated Gram-negative BSIs, adopting a systematic approach to preventing infections and delivering a 25% reduction by 2021-2022 with the full 50% by 2023-2024. The work to achieve the reduction target is being led by the Clinical Commissioning Groups. All trust attributable cases of *E coli, Klebsiella sp* and *Pseudomonas aeruginosa* bacteraemia are reviewed by the IPCT where probable source of infection and any lapses in care are identified and communicated to the relevant clinical teams.
13.	**Training and Education**	
		The IPCT provide training to all new and existing Trust staff. They are also responsible for ensuring that any contractors working on site in the clinical environment receive information on how they can reduce the risk of infection either by protecting themselves or patients in the area.
	13.1	**Induction** IPC Training is provided for all new staff through the following programmes: • Corporate Induction all new Trust employees • Induction training for F1 doctors • Induction training for F2 doctors and specialist registrars Attendance is recorded and monitored as per the Induction Policy.
	13.2	**Mandatory training** Mandatory training is delivered in line with the Trust Training Matrix. All clinical staff must attend an IPC training session every two years. Mandatory training is delivered through the following programmes. Attendance is recorded and monitored as per the Mandatory Training Policy.
	13.3	**Other training** Other training sessions on IPC are delivered to: • IPC Link Practitioners, training sessions in the form of a study day linked to specific topics • Medical and Nursing Staff; e.g. Aseptic Non-Touch Technique

		• All clinical staff; e.g. PPE and hand hygiene training, on request as required Training on the control and prevention of specific infections is also provided when required, e.g. Influenza, Measles, disease of high consequence, CPE.
14.	**Communication**	
		Successful delivery of the Programme will require clear, strong and effective communication. This will need to be at all levels within the organisation. Executive and non-executive directors are required to support the Programme and seek assurance regarding progress of its delivery at Trust Board. The senior leadership management teams, matrons and other senior clinical staff must be aware of the Programme and ensure that they and their staff are aware of their responsibilities. The Programme will be available internally and externally via the intranet and external website. The IPCT are integral to the successful communication, delivery and review of the programme and will be responsible for: • Providing support and guidance to assist with compliance • Identifying and reporting areas of non-compliance • Identifying and alerting the Trust to changing priorities if and when necessary
	14.1	**Communication with stakeholders** The IPC Programme is presented to the Trust Board (public meeting) and will be available on the Trust website. The Programme will also be shared with the BNSSG Commissioning team HCAI leads and with other local IPC leads.
15.	**Review**	
		This document will be subject to a planned review every 3 years as part of the Trust's Policy Review Process. It is recognised however that there may be updates required in the interim, arising from amendments or release of new regulations, Codes of Practice or statutory provisions or guidance from NHS England or professional bodies. These updates will be made as soon as practicable to reflect and inform the Trust's revised policy and practice.

16.	References
	Department of Health (2015). The Health and Social Care Act 2008. *Code of practice on the prevention and control of infections and related guidance.* Available from: https://www.gov.uk/government/publications/the-health-and-social-care-act-2008-code-of-practice-on-the-prevention-and-control-of-infections-and-related-guidance Accessed 14 June 2016 NHS Improvement (2019) Clostridium *difficile* infection objectives for NHS organisations in 2019/20 and guidance on the intention to review financial sanctions and sampling rates from 2020/21 https://improvement.nhs.uk/documents/808/CDI_objectives_for_NHS_organisations_in_2019_12March.pdf Department of Health (2019) Tackling antimicrobial resistance 2019–2024 The UK's five-year national action plan https://www.gov.uk/government/publications/uk-5-year-action-plan-for-antimicrobial-resistance-2019-to-2024 NHS Improvement and Public Health England (2017) Preventing healthcare associated Gram-negative bloodstream infections: an improvement resource. Available from: https://improvement.nhs.uk/uploads/documents/Gram-negative_IPCresource_pack.pdf Accessed 27 June 2017 Public Health England (2015). Start Smart – Then Focus. Antimicrobial Toolkit for English Hospitals. Available from: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/417032/Start_Smart_Then_Focus_FINAL.PDF Accessed 14 June 2006

Core Accountabilities

Control of Infection Committee Terms of Reference

Purpose

- The Control of Infection Committee is established as a sub-committee of the Quality and Risk Committee. Its constitution and terms of reference are set out below, subject to amendment at future Control of Infection meetings

- The purpose of this Committee is to provide assurance that IPC standards at North Bristol Trust are compliant with The Health and Social Care Act 2008 Code of Practice on the prevention and control of infections and related guidance (2015)

  a. Strengthening the performance management of Healthcare Associated Infections (HCAI) and cleanliness across the whole Trust and to provide assurance to the board that policy, process and operational delivery of IPC results in improved patient outcome.
  b. Supporting divisional teams in the delivery of high quality safe services to the patient and also in identifying and responding effectively to incidents, risks or poor patient experience
  c. Assuring the Trust Board that appropriate IPC compliance and assurance structures, processes and controls are in place across all divisions and are 'joined up' appropriately
  d. The identification, assessment and escalation of risks within the infection prevention portfolio. Making recommendations as appropriate on IPC matters to the Board of Directors.

- The Control of Infection Committee (COIC) is responsible for driving performance and ensuring accountability for delivery of the objectives of the Clinical Governance Division, as they relate to infection prevention and control

Date Adopted	April 2019
Review Frequency	Annually
Terms of reference drafting	Nurse Consultant Infection Prevention & Control
Review and approval	Quality and Risk Management Committee
Adoption	Control of Infection Committee

1. Authority

1.1. The Control of Infection Committee is constituted as a standing sub-committee of the Quality and Risk Management Committee. Its Terms of Reference shall be as set out below; and will be subject to amendments approved by the Quality and Risk Management Committee.

1.2. The Committee is authorised to investigate any activity within its Terms of Reference. It is authorised to seek any information it requires from any member of staff and all members of staff are directed to co-operate with any request made by the Committee

1.3. The Committee is authorised by the Quality and Risk Management Committee request the attendance of individuals and authorities from outside of the Trust with relevant expertise if it considers this necessary or expedient to the carrying out of its functions

2. Membership and attendance at meetings

Membership

2.1. The membership of the Committee shall consist of:

- Director of IPC(Chair)
- Director of Nursing
- Nurse Consultant Infection Prevention & Control
- Senior Infection Prevention & Control Nurse
- Infection Control Doctor (Medical Microbiologist) (Deputy Chair)
- PHE representative
- Antimicrobial Pharmacist
- Facilities Manager (Decontamination, Water Safety, Ventilation, Domestic Services
- Divisional clinical leads for infection prevention & control (or nominated deputy)
  (Divisions are: Core clinical Services, ASCR, Medicine, MSK/Neuro, Women and Children Health
- Occupational Health representative

2.2. Additional persons, including speciality clinical leads, may be invited to attend for specific items on the agenda, as and when required.

2.3. The Committee will be considered quorate if there are not less than eight members of the Committee present of which one must have infection prevention and control in their title and five must be members other than the Infection Prevention and Control Team

2.4. Members of the Committee have a responsibility

- to attend at least 75% of meetings, having read papers beforehand
- If unable to attend, send apologies to the secretary prior to the meeting, and nominate a deputy to attend

3. Roles and responsibilities

3.1. The duties of the Committee are as follows:

3.1.1 To provide assurance that the Trust has adequate numbers of sufficiently skilled specialist Staff in IPC to discharge its duties under the relevant regulations

3.1.2 To influence, agree and direct the annual IPC Programme receiving quarterly presentations from the IPC Senior Nurse as to its progress to review and evaluate IPC surveillance and audit

3.1.3 To ratify North Bristol Trust Infection Control Policies, Procedures and Guidance escalating any risks to the Trust Governance and Risk Management Committee

3.1.4 To seek assurance from those groups affiliated to the Control of Infection Committee that outcomes are being met with risks escalated to the Committee

3.1.5 To monitor infection control performance in relation to mandatory reporting and advise on appropriate actions as required

3.1.6 Review Division IPC performance. This includes Root Cause Analysis undertaken with regard to mandatory alert organisms and incidents; with the assurance that actions from lessons learnt have been completed as part of the Division Highlight reports

3.1.7 To monitor the rates of the mandatory surgical site surveillance quarterly data against the national benchmarks and advise on necessary actions as appropriate

Assurance on Regulatory Compliance

3.2. The Committee shall:

3.2.1 Ensure that reports from external regulators are responded to properly; and that this is governed through robust review, action and follow up. The scale of response will be determined by the scope of the external review; and will focus either within the clinical or corporate division to which it relates, or on a Trust-wide basis. The Committee will identify which reports need to receive direct scrutiny at QRMC

3.2.2 Seek assurance of the Trust's record of compliance with the Care Quality Commission's Registration arrangements and outcomes, which is reported through the Trust's Quality Team

3.2.3 Collaborate with the Clinical Risk Committee and Health and Safety Committee to oversee the Trust's compliance with the response to specific incidents set within the Central Alerting System response times; and ensure that issues are rectified swiftly and effectively

Policy Management

3.3. The Committee will seek assurance that the IPCT operates a robust system governing the drafting, approval, issue, currency and ongoing availability of Trust-wide policies and procedural documents to all staff. Similar levels of assurance will be sought regarding the procedural records that are service-specific or otherwise of more limited circulation

3.3.1 The Committee has direct responsibility for reviewing and recommending to Quality and Risk Management Committee approval

of updates and revisions to the Trust-wide IPC policies

3.3.2 To collect, receive, discuss, interpret, action and disseminate evidence based research and Department of Health policy documents relevant to IPC

3.3.3 Further policies and procedural documents may be added to this list

Sub-committees and Groups reporting to (or responsible to) the committee

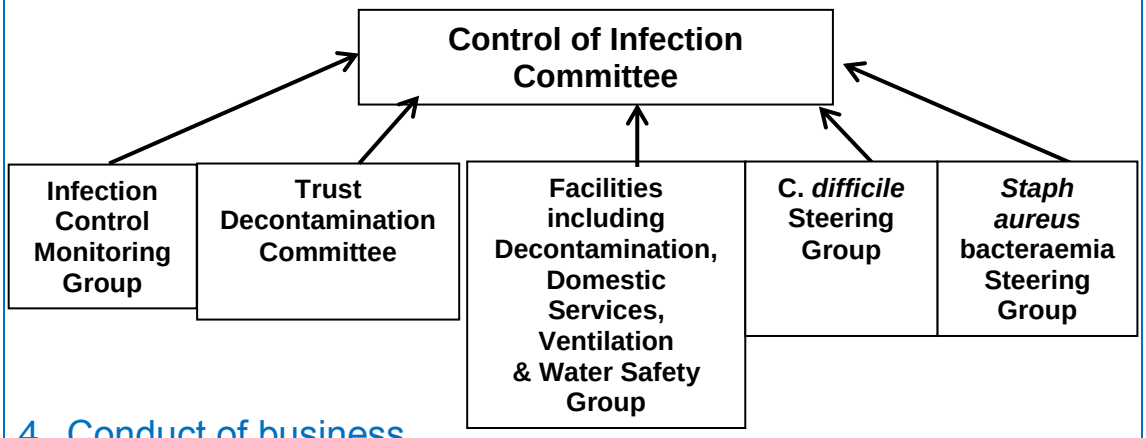
To seek assurance from the NBT Water Safety Group that all Trust managed estates are fully compliant with legislation and guidance documents pertaining to the control of Legionella, Pseudomonas aeruginosa within identified augmented care areas, and other water related organisms.

3.4. To receive the quarterly summary of assurance that the Trust is compliant with legislation and guidance by way of a quarterly summary for:

- Antimicrobial stewardship - Antibiotic Sub Group of the Drugs and Therapeutics Committee
- Surgical Site Surveillance Reports – Division of NMSK
- Occupational Health – Occupational Health Team

3.4.1 To receive a bimonthly highlight report which will incorporate all meetings within this time frame from:

Trust Decontamination Committee
Facilities Management (including the Domestic review)
Water Safety Group
The C.*difficile* Steering Group
The *Staph aureus* bacteraemia Steering Group
Each Clinical Division IPC governance meeting



4. Conduct of business

4.1. The Committee will be supported administratively by Infection Prevention & Control Administrator whose duties will be to:

- Arrange accommodation and notify attendees of the meeting arrangements
- Agree agendas with the Chair and attendees
- Collate and distribute papers before the meeting
- Record the minutes and distribute them for confirmation
- Maintain the record of matters arising and issues carried forward

- The Committee shall hold the safety of patients, public and staff, as well as the reputation of the Trust, as a core value in assessing assurance in relation to IPC
- Meetings should be conducted in a spirit of openness, collaboration and co-operation with a commitment to excellent service, delivered efficiently
- Constructive and positive challenge is encouraged within the Control of Infection Committee

Frequency

4.2. The Committee will meet a minimum of quarterly with additional meetings if necessary. Meetings will be set bi-monthly

Notice of meetings

4.3. An agenda of items to be discussed will be forwarded to each member of the Committee and any other person required to attend, no later than 1 week before the date of the meeting. Supporting papers will be sent to Committee members and to other attendees as appropriate at the same time.

4.4. In normal circumstances, a minimum notice period of two weeks must be given for any other meetings of the Committee. Emergency meetings can be arranged, at shorter notice, if this is approved and evidenced as such, by the majority of the members of the Committee

Confidentiality and Freedom of Information

4.5. The agenda and minutes of the Committee meetings may be required to be made available in response to a valid request made under the Freedom of Information Act 2000 (FoIA) Publication Scheme. Any identifiable person or corporate sensitive information is exempt and will be redacted from any part of the record that is made public.

4.6. Alternatively, the Chair may establish a Part B section for any meeting of the Committee. This will be noted in the agenda and minutes of the meeting. This part of the meeting will be regarded to be exempt from FoIA disclosure.

5. Reporting

5.1. Formal minutes of Committee meetings will be recorded; and will normally be confirmed as accurate at the next meeting of the Committee.

5.2. The Chair of the Committee, or their nominee, will present a “Highlight” report to the next meeting of the QRMC, summarising the agenda and decisions of the Committee

5.3. The agenda and minutes of the meetings of the Committee will be held on the bespoke intranet web pages, once these are established. In the mean-time, the complete finalised record will be stored securely, by the administrator, on a suitable part of the Trust’s electronic records drive.

5.4. Each committee member is responsible for disseminating information to their colleagues from the meeting and representing matters from their colleagues to the Committee.

6. Review

6.1 The Committee will review these terms of reference annually. This review will include a self-assessment of its effectiveness in discharging its responsibilities as set out; and in delivering against the needs of the Trust.

6.2 As part of this assessment, the Committee will consider whether or not it receives adequate and appropriate support in fulfilment of its role and whether or not its current workload is manageable.

Report To:	Trust Board (Public)		Agenda Item:	13.
Date of Meeting:	25 July 2019			
Report Title:	National Inpatient Survey 2018 - Results and Key Areas for Improvement			
Report Author & Job Title	Gill Brook: Head of Patient Experience			
Executive/Non-executive Sponsor (presenting)	Helen Blanchard – Interim Director of Nursing & Quality			
Purpose:	Approval/Decision	Review	To Receive for Assurance	To Receive for Information
		x		
Recommendation:	The Trust Board is asked to review and discuss the results and the areas identified for improvement.			
Report History:	· 31st May 2019: Reviewed and discussed at a specify workshop to identify areas for improvement · 2nd July 2019: Patients experience Group (PEG) to share data and confirm the areas for improvement · 15th July 2019: Patient & Carer Experience Committee to review results.			
Next Steps:	Head of Patient Experience with support from the Heads of Nursing to contact all identified leads to put in place improvement work as described in the action plan to be found in appendix A.			

Executive Summary

North Bristol Trust (NBT) has a 49% response rate. This was higher the national response rate of 45%. The results were very positive.
The CQC report (standardised data report) published on the 20th June 2019 identified NBT as **Better than other Trusts** on 3 questions:

- Q39 for being given enough privacy when discussing their condition or treatment
- Q64 for hospital staff discussing if any equipment, or home adaptions were needed when leaving hospital
- Q66 for expected care and support being available when needed after leaving hospital

Worse than other Trusts on 0 Qs
About the same as other Trusts on 60 Qs

NBT commission Picker Europe Ltd. to manage the survey. 53% of all Trusts participating in the survey also use Picker, giving a good base to monitor results against. This data is available in Appendix A
The areas for improvement described below were identified after:

- a review of all data provided by Picker and themes from FFT and complaints and concerns in the workshop with staff and patient reps on 31May 2019
- further discussion, following the above event, with other managers in the Trust

Areas for improvement:

- Change of planned admission date (Q7)
- Opportunities to talk about worries and concerns (Q37)
- Staff contradicting each other (Q33): consider the focus to be on discharge and the consistency of information
- Staff explaining the reasons for changing wards at night (Q13)
- Who to contact if worried after leaving hospital (Q63)
- Seeing, or being given, any information explaining how to complain to the hospital about care received (Q71)
- Asked to give their views about the quality of their care, during their hospital stay (Q70)

A high-level action plan is provide in Appendix A

Strategic Theme/Corporate Objective Links	· Treat Patients as partners in care · Create an exceptional workforce for the future
Board Assurance Framework/Trust Risk Register Links	· N/A
Other Standard Reference	· CQC 5 key quality standards. · NICE Quality Standard 15: Patient Experience in adult NHS services 2012 (updated 2017)
Financial implications	None
Other Resource Implications	None
Legal Implications including Equality, Diversity and Inclusion Assessment	· EDS: improve patient access and experience · NHS Constitution 2015

Appendices:	Appendix A: Summary report and action plan Appendix B: Data pack and full Picker survey results

Agenda item

NHS Inpatient Survey 2018

Results provided by Picker for North Bristol NHS Trust 2019

Report for Patient and Carer Experience Committee 15th July 2019

Executive summary (part 1 of 2)

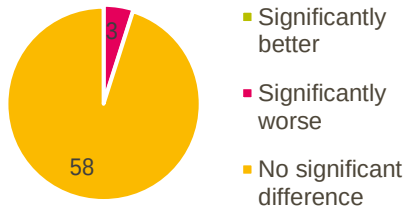
This document summarises the findings from the NHS Inpatient Survey 2018, carried out by Picker, on behalf of North Bristol NHS Trust. Picker was commissioned by 77 Inpatient organisations to run their survey – this report presents your results in comparison to those organisations.

A total of 62 questions from the survey can be positively scored. Of these 61 can be compared historically between the 2017 and 2018 surveys. Your results include every question where your organisation had the minimum required 30 respondents.

1250	1202	**49%**	43%	48%
Invited to complete the survey	Eligible at the end of survey	Completed the survey (591)	Average response rate for similar organisations	Your previous response rate

88%	Q68+. Overall: rated experience as 7/10 or more
98%	Q67. Overall: treated with respect or dignity
98%	Q24. Doctors: had confidence and trust

Historical comparison*



Comparison with average*

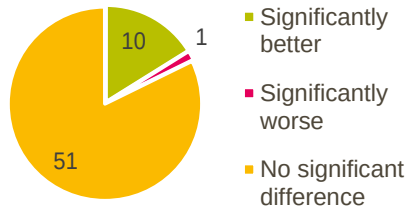


*Chart shows the number of questions that are better, worse, or show no significant difference

Picker

Who Participated ?

- Number of participants: 76,668 (NBT 591)
- Response rate: 45 per cent (NBT 49%)
- Age range: 16 years and older
- Time period: patients discharged from hospital during July 2018
- Eligibility: patients aged 16 years or older, who had at least one overnight stay
- Exclusion: patients whose treatment related to maternity or, patients admitted for planned termination of pregnancy, day case patients, private patients (non-NHS)

Executive summary (part 2 of 2)

	Top 5 scores (compared to average)
91%	Q64+. Discharge: staff discussed need for additional equipment or home adaptation
72%	Q9. Admission: did not have to wait long time to get to bed on ward
68%	Q14. Hospital: not bothered by noise at night from other patients
89%	Q66+. Discharge: expected care and support were available when needed
89%	Q21+. Hospital: got enough help from staff to eat meals

	Bottom 5 scores (compared to average)
9%	Q70. Overall: asked to give views on quality of care
74%	Q7. Planned admission: admission date not changed by hospital
56%	Q50. Discharge: was not delayed
65%	Q33. Care: staff did not contradict each other
17%	Q71. Overall: received information explaining how to complain

	Most improved from last survey
91%	Q64+. Discharge: staff discussed need for additional equipment or home adaptation
72%	Q9. Admission: did not have to wait long time to get to bed on ward
11%	Q52. Discharge: delayed by no longer than 1 hour
89%	Q21+. Hospital: got enough help from staff to eat meals
61%	Q58+. Discharge: told side-effects of medications

	Least improved from last survey
74%	Q7. Planned admission: admission date not changed by hospital
70%	Q6. Planned admission: was admitted as soon as necessary
17%	Q71. Overall: received information explaining how to complain
65%	Q33. Care: staff did not contradict each other
9%	Q70. Overall: asked to give views on quality of care

Picker

How the bottom 5 compared to average results are reflected in our other Patient Feedback

Q70. Overall: During your hospital stay, were you ever asked to give your views on the quality of your care? (9% said yes / not sure)

We conduct the Friends and Family Test 48 hours after discharge (or on discharge if the ward uses card) which gives patients an opportunity to give their views on their experience. As this question refers to their time in hospital it could indicate that we have the expectation that patients will tell us if they are unhappy with their care rather than a culture of asking the patient, carers/relatives.

Q7. Planned admission: Was your admission date changed by the hospital? (26% said yes)

Planned admission dates being changed is reflected in Complaints/Concerns we receive. Although we don't have a specific Datix category for this under we had 38 complaints/concerns between 1/1/18-1/1/19 that cite 'cancelled operation' as part of their concerns.

Q50. Discharge: On the day you left hospital, was your discharge delayed for any reason? (44% said yes)

69% of the people who replied 'yes' to this question said the reason was that they had to wait for medications, with 9% saying they had to wait to see a Doctor and 8% had to wait for an ambulance. Anecdotally when people tell us their discharge was delayed, these issues are rarely the sole or main reason someone is making a complaint and are usually a 'tipping point' in a range of issues.

Picker

How the bottom 5 compared to average results are reflected in our other Patient Feedback

Q33. Sometimes in a hospital, a member of staff will say one thing and another will say something quite different. Did this happen to you? (35% said yes)

This issue covers a broad part of communication issues and can not easily be quantified. ‘lack of information given to patient, carer/relative’ is the most comment theme in concerns and complaints relating to communication. ‘Communication’ is consistently cited as one of the top three reasons people would not recommend our inpatient service but this encompasses a vast variance of communication issues.

Q71. Overall: Did you see, or were you given, any information explaining how to complain to the hospital about the care you received? (83% said no)

The implementation of the PALS service should hopefully improve this score going forward. We have clear information on how to make a complaint on our website and a range of ways people can contact us. Leaflets are available at the Main Reception and if people ring switchboard the staff know to transfer them to the Complaints Team. It should be considered that the visual information on the wards could be improved, this forms part of the PALS project.

CQC Published Report 20th June 2019

- Provides standardised data for all participating Trusts across England
- Scores are ranked as *Better than* most Trusts: *About the same as* most Trusts & *Worse than* other Trusts

- *NBT =*
  - **Better than** on 3Qs ;
  - Q39 for being given **enough privacy** when **discussing their condition or treatment**
  - Q64 for hospital staff discussing if any equipment, or home adaptions were needed when leaving hospital
  - Q66 for expected care and support **being available when needed** after leaving hospital)
  - **Worse than** on 0 Qs
  - **About the same** on 60 Qs

https://www.cqc.org.uk/provider/RVJ/survey/3#undefined

Picker

Prioritising Areas for Improvement

- Internal review meeting 31 May 2019 .
- Review of survey data against other feedback – concerns, complaints and FFT
- Time to celebrate J J J
- Discussion with Deputy Director of Operations and Assistant Director of Nursing: 1 July 2019
- Areas identified for improvement

1. Change of **planned admission date** (Q7)
2. Opportunities **to talk about worries and concerns** (Q37)
3. **Staff contradicting each other** (Q33): consider the focus to be on discharge and the consistency of information
4. Staff explaining the **reasons for changing wards at night** (Q13)
5. **Who to contact if worried after leaving hospital** (Q63)
6. Seeing, or being given, any information **explaining how to complain** to the hospital about care received (Q71)
7. **asked to give their views** about the quality of their care, during their hospital stay (Q70)

High level action plan

NATIONAL INPATIENT SURVEY 2018 ACTION PLAN				
Areas for Improvement	**Action**	**Lead**	**By When**	**Outcome Measure**

1. Change of planned admission date	• Discussion with Deputy Director of Operations
	• Share this report with Divisions (Div.) through TMT with view to agree to take forward actions below:
	  • Identify specialities of higher numbers of cancellations within Divisions
	  • Seek to understand factors influencing cancellation
	  • QI project in specialities most needing to improve
	  • Link to current work led by Associate Director of Performance
		GB
		
		GB
		
		Div. Directors of Ops
		&
		Speciality leads
			02 07 2019 complete TMT, 16July	Decrease in the number of cancelled admissions in identified specialties
				
				2020 Survey reports improvement

2. Opportunities to talk about concerns	To undertake and QI project linked providing daily opportunity for patient and carer to talk with supervisory sister (B7) or band 6 nurse and also improve culture of listening (trial activity identified) Plan spread as per QI process and Plan	Ward 34b;Lisa Hayward Matron, Lisa Ford	Start date to be confirmed	Post intervention measures show improvement (Patient Survey & interviews) 2020 Picker survey results improved in this area
3. Staff contradicting each other (discharge date)	Reintroduce ‘Ask 3 questions’ (QI Project)	Phillip March 32b Matron, Lisa Ford	TBC following discussion	Pre and post intervention measures show improvement (and in 2020 Survey results) Measures to be confirmed & will include survey question.

High Level Action Plan

NATIONAL INPATIENT SURVEY 2018 ACTION PLAN				
Areas for Improvement	**Action**	**Lead**	**By When**	**Outcome Measure**
4. Staff explaining reasons for changing wards at night	Link into work on managing moves at night Head of Patient Experience to discuss with Head of Nursing (HoN) for Medicine on current work in this field	GB H of N Medicine	To be agreed	Improved scores in Picker data against this questions in 2020 survey
5. Discharge – who to contact if worried	Integrate into the above project	As above	As above	As above and in 2020 Survey results in response to this question
6. Information on explaining how to complain	Sustain the availability of information about PALS service on wards, in other key patient areas and on the website	Kate Plunket Reed, Patient Experience Manager	Sustain current action continuously	Increase in the number of respondents having been given or seen this information as reported in the 2020 Survey. Asking those attending PALS if they have seen the information
7. Increase patient opportunity to give their views on the quality of care	Promotion of FFT feedback through business cards across all wards. Further promote and sustain the active promotion of comments/ feedback cards, linking into current work on the wards promoting feedback ensuring 'You said, We did' feedback to patients.	GIll Brook with heads of wards and departments	June 2019 and ongoing	As above

Report To:	Trust Board (Public)		**Agenda Item:**	14.
Date of Meeting:	25th July 2019			
Report Title:	South West Genomics Laboratory Hub – Vision and Implementation plans			
Report Author & Job Title	Professor Rachel Butler, Operational Director SW GLH			
Executive/Non-executive Sponsor (presenting)	Dr Chris Burton			
Purpose:	**Approval/Decision**	**Review**	**To Receive for Assurance**	**To Receive for Information**
				X
Recommendation:	For information, as requested. For NBT Board members to have a greater understanding of the SW GLH, and the responsibilities of NBT.			
Report History:	Not previously presented			
Next Steps:				

Executive Summary	
The Bristol Genetics Laboratory was successful in its tender to become the Lead organisation of the SW Genomics Laboratory Hub (GLH), partnering with the Exeter Genetics Laboratory. The GLH is now required to implement services in accordance with the National Genomics Test Directory. 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 will 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.	
Strategic Theme/Corporate Objective Links	· Play our part in delivering a successful health and care system
Board Assurance Framework/Trust Risk Register Links	

<table>
<tr><td></td><td></td></tr>
<tr><td>Other Standard Reference</td><td>Laboratory services are required to be ISO15189 accredited</td></tr>
<tr><td>Financial implications</td><td>The Bristol Genetics Laboratory has received significant uplifts from NHSE (mobilisation funding) in 18-19 and 19-20 for the implementation of the GLH.
Funding for genetic and genomic analyses will be transferred out of tariff and made available directly to the GLH as specialised funding (expected from 20-21).
<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>
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<table>
<tr><td>Capital</td><td></td></tr>
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<tr><td>Other Resource Implications</td><td>The GLH is required to commit funding for staff, equipment, non-pay for reagents / service developments, and IT</td></tr>
<tr><td>Legal Implications including Equality, Diversity and Inclusion Assessment</td><td>Equity of access for South West patients to genomic services</td></tr>
</table>

Appendices:	Governance structure for SW Genomic Medicine Service 19-20 Q1 SW GLH RAG rating – self-assessment returned to NHSE on 12/07/2019

Main Body of the Report

1. Purpose

1.1 The South West Genomics Laboratory Hub (SW GLH) is provided by NBT. This report aims to summarise the vision and expectations of the SW GLH.

1.2 The SW GLH is tasked by NHSE with the implementation of genomic services for patients across the South West, in accordance with the National Genomics Test Directory.

1.3 This is a highly complex programme involving multiple stakeholders, including the two GMCs, two Clinical Genetic services, and the Cancer networks.

2. Background

2.1 Genetic testing services have traditionally been delivered by Regional Genetic Laboratories. The tests delivered have been developed on the basis of demand by local clinical teams. The UK Genetics Testing Network (UKGTN) was established in 2002 and removed some inequity by creating an approved list of recommended disorders / genes that should be tested. However, these were not uniformly commissioned through the UK. This resulted in a growing number of large, medium and small molecular laboratories delivering services across the UK, to variable standards.

2.2 At the same time genomic technologies have advanced dramatically. The availability of next generation sequencing, and its rapidly decreasing cost, has resulted in gene panel tests, and exome and genome sequencing becoming a possibility for NHS care.

2.3 NHSE recognised this potential and implemented the ground-breaking 100,000 genomes project working with Genomics England. 13 Genomic Medicine Centres were established across England; these were tasked with recruiting rare disease and cancer patients for whole genome sequencing, setting up logistical sample pathways, extracting DNA, and sending these to Genomics England for sequencing. The sequencing results are now being returned for interpretation and return to patients. The West of England GMC is hosted by University Hospital of Bristol Trust, and worked in partnership with the Bristol Genetics Laboratory. Similarly, the South West GMC was established in the Royal Devon and Exeter Trust.

2.4 The translation of the learning from the 100,000 genomes project was critical. NHSE took the bold decision to consolidate the very many genetic and molecular laboratories across England into just 7 geographically organised Genomic Laboratory Hubs (GLHs). A competitive tender process was held in 2018, to which laboratories were invited to work together to apply. The Bristol Genetics Laboratory and Exeter Genetics

Laboratory were jointly successful as the South West GLH, with BGL (NBT) as the Lead organisation.

2.5 The remit of a GLH is to deliver equitable genetic and genomic analyses for the patients across their region according to the National Genomic Test Directory (a long list of tests according to disease indication see https://www.england.nhs.uk/publication/national-genomic-test-directories/). Tests are categorised as either for rare disease or cancer, and can range from a simple PCR to a full genome sequence. The GLH is also responsible for ensuring that clinical referrers have the training to know what and how to request, they can take consent, and can interpret the results that are returned to them.

2.6 The network of 7 GLHs will provide the National Genomic Test Directory between them. Within each GLH, services will be rationalised such that (e.g.) only 1 lab will extract DNA, and only specified laboratories will provide services. Each GLH will provide a set of core services, and a set of nominated specialist services – provided from only 1 or 2 GLHs.

2.7 The future vision is for the GLH to work collaboratively with the two GMCs (in the SW and WoE), the two Clinical Genetics departments (in Bristol and Exeter), and the Cancer Networks, to deliver a Genomic Medicine Service. (See attached Governance diagram). The contributions and skills of all members of these teams will be essential for the delivery of this ambitious new service.

3. Main Detail of Report

3.1 This report will focus on the implementation of the **SW GLH**. The GLH is provided by NBT, reports to NHSE, provides services to patients in all 12 Trusts in the South West, and also specialist services to patients across England.

3.2 The GLH has been tasked to appoint a series of GLH roles (the other 6 GLHs have the same roles). These roles include 1.0wte Scientific Director (Professor Sian Ellard, Exeter), 1.0wte Operational Director (Professor Rachel Butler, NBT) and 0.2wte Medical Director (Professor Andrew Mumford, UHB). Other roles include leads for Informatics, Rare disease (scientific and medical), Solid tumours (scientific and medical), Haematological malignancies (scientific and medical), Pathology, Contracts, Education, Business and Quality. All roles have now been appointed, with appointments made across the SW region. These posts represent the GLH on NHSE working groups, and work across the SW to engage stakeholders as the GLH is implemented.

3.3 The ongoing implementation of the GLH is regularly assessed by NHSE through quarterly performance visits (see 19-20 Q1 SW GLH RAG rating). These assessments (usually in person), determine the progress of the GLH against a series of standards

with an expected Go Live date of April 2020. It should be noted that many GLH services are already “Live” and delivered routinely.

3.4 A SW Genomic Medicine Service (GMS) Board has been set up to include both GMCs and Clinical Genetic services in the region. The vision for the service is that the GLH must act in partnership, and therefore a collaborative governance structure was required. The GMS Board is chaired by NBTs NED Jaki Meekings-Davis. The GMS Board reports to a virtual CEOs Board, chaired by Andrea Young, with representation of all 12 CEOs across the SW. The GMS Board will send an update report to the CEOs Board following each meeting.

3.5 The GLH has a significant number of tasks to be completed to achieve implementation by April 2020. These include:

- The development of new services as specified by the National Genomics Test Directory
- Redistribution of core and specialist services both within the SW and between GLHs
- Consolidation of genetic services within the SW, requiring the closure of some laboratory services
- Establishment (or re-establishment) of sample pathways within the SW for Whole Genome Sequencing
- Mapping of activity, and current funding streams, to establish future funding models
- Upskilling and education of clinical teams to prepare for new service delivery, including consent protocols and MDTs
- Integration of Informatics tools to support requesting, data analysis, MDTs and reporting

3.6 The Informatics work programme requires the integration of the NHSE National Genomics Information Service (NGIS) with local systems. We are still B-testing NGIS, which is planned to eventually be available for test request and report receipt for all clinical users. The ambitious NGIS aims to link tests and results for patients across England. We are working with the NBT Information Governance and Clinical Safety Officers to progress this workstream.

3.7 The SW GLH is required to consolidate genetic services across the South West. At present genetic diagnostic services are provided by the Bristol Genetics Laboratory, the Exeter Genetics Laboratory, and smaller laboratories at University Hospital Plymouth, Cheltenham Hospital Trust, University Hospital Bristol and Truro Hospital Trust. Agreement has been made to transition the services (and staff) from UHB. University Hospital Plymouth have been engaged, but no agreement has been reached.

3.8 Information and contracting are critical workstreams: We are attempting to collect activity data against the new National Genomic Test Directory, across the SW. This is hampered by (a) the number of laboratories providing testing, or sending tests out of the SW, and (b) the capability of our local systems to query data against these new terms. The data is being used to baseline the funding already in the system for genetic testing, and therefore to determine the uplift in funding required. A new funding model is being developed for the GLHs.

3.9 The GLH is required to establish workflows for whole genome sequencing for approximately 25 disease areas; ~20 are for specified rare inherited diseases, plus paediatric tumours, sarcomas, AML and ALL. Whilst these were all set up by GMCs during the 100,000 genomes project, equitable patient access must now be ensured. Modifications to these pathways have also been made, including the implementation of NGIS for these patient samples.

3.10 The two laboratories are developing new tests, necessary to meet the requirements of the rare disease, and cancer test directories. The development and validation work is scheduled to take 12 months, requiring additional staff to be employed. Both laboratories have procured additional equipment to meet the anticipated increased demand, and new technological requirements.

3.11 The need for clinical team engagement and training is not insignificant. Not all clinical teams will have contributed to the 100,000 genomes project. The GLH employs 5 sessional Medical Leads (led by Prof Andrew Mumford), who will work closely with colleagues within the GMCs and Clinical Genetics, and also the GLHs Educational Lead, to deliver Training and Education to clinical teams. This will be required for patient consenting (Record of Discussion), understanding of patient pathways, introduction of NGIS, and importantly for the interpretation of genomic results, where MDT working will be recommended.

3.12 The SW GLH has received mobilisation funding of £2.1m in 19-20 (and previously received £1.45m in 18-19). The funding has been used to appoint staff for the implementation of the GLH, and for project work such as the development and validation of new services.

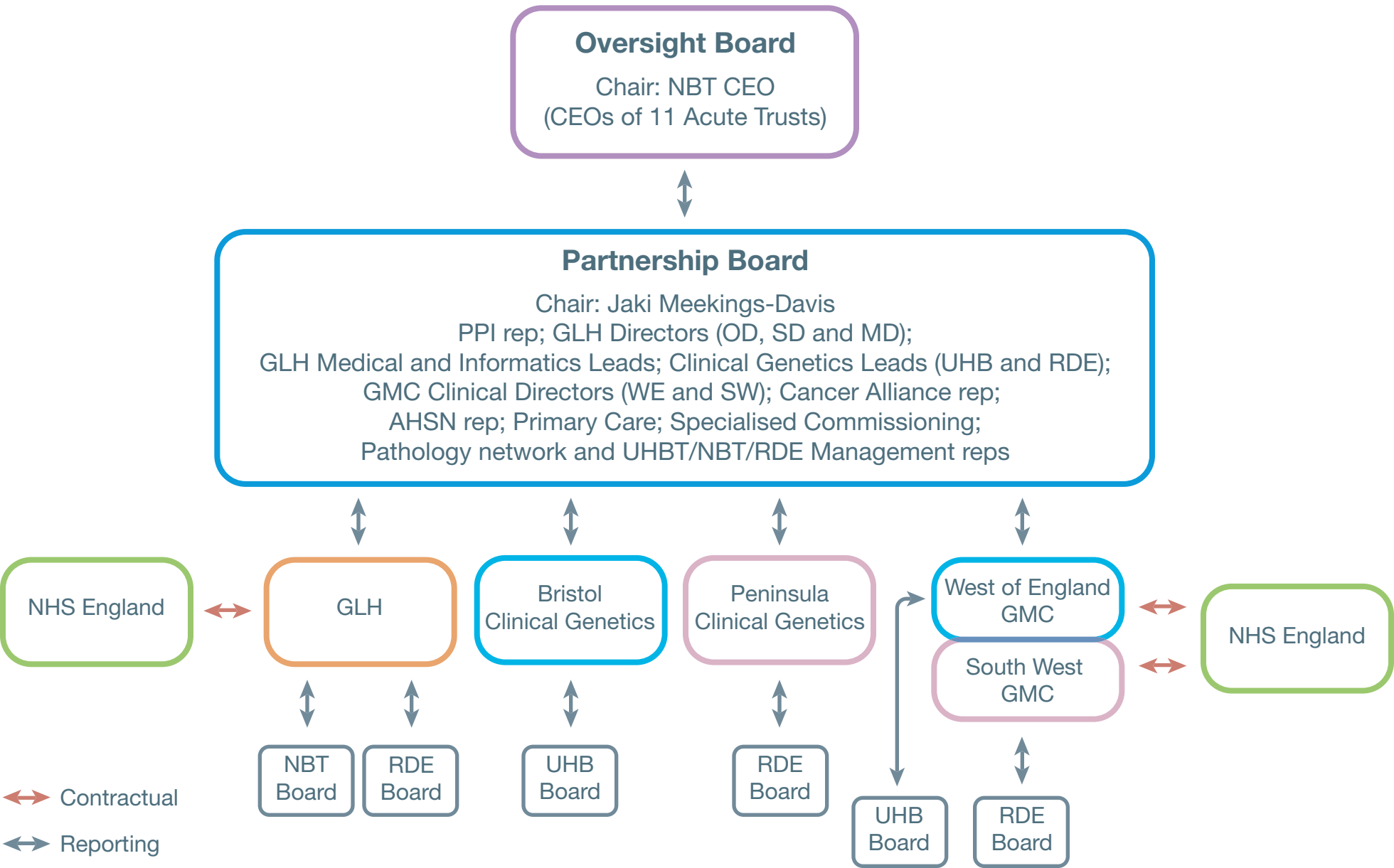
4. Recommendations

4.1 NBT Board has understanding and ownership of the SW GLH implementation.

4.2 The establishment of the SW GLH provided by NBT presents significant opportunities for the attraction of new business and partnerships, which should be explored by BGL and NBT leadership.

4.3 Risks and issues pertaining to the SW GLH implementation are escalated to the NBT Board, for information or support.

South West Genomic Medicine Service



In South West GLH RAG metrics – quarterly assurance process Q1 2019/2020

Introduction

Please complete the RAG rating table below with your self-assessment ratings for Q1 2019/2020. The ratings that were provided as part of the Q4 2018/19 assurance process are included for reference. Please also provide context and explanation for each RAG rating in the comment box.

The RAG self-assessments should be returned to ENGLAND.genomics@nhs.net by Friday 12 July 2019.

RAG rating table

		NHSE/I Q4 2018/19	GLH Q1 2019/20	NHSE/I Q1 2019/20	
	Detail	RAG			Comments
Governance					
1	Partnership Board in operation with appropriate seniority and representation from Trusts across the geography.	A	A		The governance structure for the South West Genomic Medicine Service is shown in Figure 1. Key representatives from the GLH, GMCs and Clinical Genetics services have formulated Terms of Reference and agreed membership. The first full Partnership Board meeting will be held on July 24th, chaired by Jaki Meekings-Davis. Notes from the Partnership Board meetings will be circulated to members of the CEO Oversight Board.
2	Strong engagement with all providers in the geography (for both rare disease and cancer).	A/R	A/R		Plymouth University Hospitals NHS Trust has been engaged, but have indicated that they intend to continue to deliver cancer services. The transition of services and staff from University Hospital Bristol continue with an expected completion of January 2020. Engagement with the smaller labs in Truro and Cheltenham will be initiated during Q2.
3	Recruitment of key leadership positions in line with specification.	A	A		All Medical Lead posts appointed. Solid tumour and haemato-oncology scientific leads in post. Education & Training lead appointed and Quality Improvement Lead interviews scheduled July 9th.

<table>
<tr><td>4</td><td>Integrated governance model in operation with the NHS GMC(s).</td><td>A/G</td><td>A/G</td><td></td><td>An integrated governance model is in operation with the NHS GMCs (see Figure 1).</td></tr>
<tr><td>5</td><td>Communications plans in place to raise awareness across the geography.</td><td>N/A</td><td>A</td><td></td><td>A plan on a page Communication Strategy is in development bringing together the communication plans of the two regional GMCs and the SW GLH. This includes external communications and wider engagement and will be closely aligned to the Education and Training Strategy which will include targeted communications to key stakeholders.</td></tr>
<tr><td colspan="6">Finance & Contracting</td></tr>
<tr><td>6</td><td>Contractual arrangements in place with all LGLs.</td><td>A</td><td>A</td><td></td><td>A draft version of NHS Standard Subcontract for LGL’s has been produced has been reviewed with NBTs in house legal expert. A full amended version of this subcontract cannot be completed until the NHS Standard contract for GLH hub has been completed and signed off. Key o/s elements on this contract incl. SDIP, Service Spec, KPI’s, IPR etc. will need to be stepped down into the LGL contracts as appropriate to each LGL.</td></tr>
<tr><td>7</td><td>Delivery of the financial impact assessments.</td><td>N/A</td><td>A/R</td><td></td><td>Provider mapping is complete for RD Core and Cancer for SWGLH. Specialised Services impact assessment awaiting NHSE feedback on FAQs and updated template for data collection, as discussed with Liz Durkin. Next steps in the process to be defined based on interim tariffs.</td></tr>
<tr><td>8</td><td>Use of mobilisation funding to support consolidation.</td><td>A</td><td>A/G</td><td></td><td>The following summarises the key areas of spend for the 19/20 mobilisation funding of £2.09m
<table>
<tr><th>Mobilisation Category</th><th>19/20 Plan (£)</th><th>19/20 ytd (£)</th></tr>
<tr><td>A1 posts</td><td>506,209</td><td>126552</td></tr>
<tr><td>Additional mobilisation posts</td><td>782,923</td><td>195731</td></tr>
<tr><td>Travel / Expenses</td><td>30,000</td><td>3000</td></tr>
<tr><td>Roadshow / Delivery of Training</td><td>45,000</td><td>0</td></tr>
<tr><td>Reagents</td><td>260,000</td><td>20000</td></tr>
<tr><td>Software licenses</td><td>35,000</td><td>15,000</td></tr>
</table></td></tr>
</table>

<table>
<tr><td></td><td></td><td></td><td></td><td></td><td>
<table>
<tr><td>Minor equipment</td><td>96,000</td><td>5133</td></tr>
<tr><td>Project Management costs</td><td>80,000</td><td>36,000</td></tr>
<tr><td>Minor Works</td><td>35,000</td><td>0</td></tr>
<tr><td>IT hardware</td><td>50,000</td><td>5,000</td></tr>
<tr><td>LIMS configuration</td><td>100,000</td><td>0</td></tr>
<tr><td>Contingency</td><td>70,000</td><td>0</td></tr>
<tr><td></td><td></td><td></td></tr>
<tr><td>Total</td><td>2,090,132</td><td>406,416</td></tr>
</table>

Funding allocation is across both sites Bristol and Exeter, funding applications are submitted to the Operational Director for review. There is Directorate oversight of mobilisation funding spend on a monthly basis via the NBT Directorate Performance Review (DPR). One aim of the LIMS configuration work is to align the two versions of STARLIMS more closely.</td></tr>
<tr><td>9</td><td>Standardised data collection & reporting of activity in place across the GLH and LGLs.</td><td>A</td><td>A/R</td><td></td><td>Activity is being returned from NBT and RDE. The data extracted from the Bristol STARLIMS system requires significant manipulation to code it and sort it for transfer to the current MI template this is currently resulting in delays returning the data. We are focussing efforts on the build of the test directory within STARLIMS which will streamline the data collection process.
Further work required to get consistent data from all providers across the geography however there is improved engagement from non LGLs including reporting against the test directory.</td></tr>
<tr><td colspan="6">GLH Workforce</td></tr>
<tr><td>10</td><td>GLH and LGL laboratory workforce aligned with end-state model to deliver maximum efficiency.</td><td>A</td><td>A</td><td></td><td>A work programme has been initiated to map tasks, job profiles and the current workforce in both BGL and RDE. The standardisation of job descriptions and the creation of a workforce plan will follow. This work will feed in to the national workforce review.
A peer review process between the BGL and RDE laboratories has started with the aim of identifying and implementing efficiencies. The first workshop was held on 02/05/2019.</td></tr>
<tr><td>11</td><td>Engagement and consultation with staff side representatives.</td><td>N/A</td><td>A</td><td></td><td>There are no anticipated redundancies in the SWGLH. Should TUPE apply then formal staff engagement and consultation processes will be followed supported by HR and staff side representatives. The consultation process for 7 day working at both sites has involved</td></tr>
</table>

					staff side representatives.
Operational Service Delivery					
12	National Genomic Test Directory mapped to LIMS systems for GLH and LGL(s).	A	A		The LIMS in the Exeter laboratory is mapped to the NGTD, with work underway in the Bristol laboratory to get the test directory indications built as investigations within STARLIMS. In Bristol we will implement an interim solution to capture Test Directory indication codes whilst we finalise the operational roll out plan for the TD, an impact assessment is currently being carried out. Activity information has been provided as requested to date, and can be provided against lines within the NGTD when required. In addition, activity data is now being collected for non LGL laboratories within the geographical area.
13	Consolidation of testing activity across the geography.	A	A		Testing activity in 5 Trusts across the GLH geography will be consolidated to two sites; Bristol (rare disease and cancer) and Exeter (rare disease). Rare disease test consolidation is complete with the exception of haemochromatosis where work is in progress in Exeter to streamline the reporting process and upload reports into Bristol EPR. Repatriation of core familial cancer services is in progress with out of region BRCA testing consolidating to Bristol in Q2 and integrated regional Lynch testing, inclusive of *BRAF*, *MLH1* and MSI now offered from Bristol. In-region and out-of-region cancer genomic testing has been mapped. A clear plan has been developed for consolidation from the four trusts in the geography into RDE and NBT. South Devon molecular haemato-pathology testing has recently transferred from UHP to NBT and UHBristol molecular pathology services are scheduled to transfer during Q4. Repatriation of the small volume of out of region cancer genomic testing is underway e.g. RUH(Bath) *BCR-ABL1* monitoring referrals redirected from Southampton to Bristol.

14	Consolidation of laboratory infrastructure across the geography.	A	A/G		The laboratories in Bristol and Exeter are housed in modern, state of the art facilities and integrated with pathology (Bristol) or research (Exeter). Increased NGS throughput has been achieved through the procurement of additional NextSeq550 instruments in Bristol and Exeter and procurement of additional automated liquid handling equipment is underway in Bristol. Additional capital funding has been made available from North Bristol Trust to increase capacity for the range of testing technologies required to deliver the Test Directory.
15	WGS DNA extraction sites (RD & Cancer) in line with national model.	A/G	A/G		DNA extraction for WGS is in line with the national model.
16	Referral and cross provider sample transport arrangements in place across the geography, and between GLHs.	N/A	A/R		The existing arrangements for sample transport from GP practices and satellite clinics to the pathology labs within the 12 Acute Trusts and onwards to Bristol (or Exeter) have been reviewed and assessed as being fit for purpose. Existing inter-site transport arrangements are being fine mapped and opportunities for improvement being identified. Developments will be aligned to the infrastructure being implemented to support the roll out of regional HPV services delivered from NBT. Existing haematology sample pathways have been mapped and assessed as suitable for WGS and non-WGS samples however these pathways will continue to be audited and enhanced. Fresh frozen tumour samples pathways within NBT are standard of care in NBT Paediatric Pathology and were established for the 100K genomes project within the Sarcoma team. Inter-site FF transport will utilise temperature-monitored and quality-assured transport.
17	Implementation of all testing in line with the National Genomic Test Directory.	A/R	A/R		With the exception of WGS, the majority of the Cancer and Rare Disease Test Directory (TD) has been implemented. This will be fully complete for Rare Disease by January 2020. Gene panel content has been agreed for nearly all of clinical indications within the specialist services and is ongoing for Neurology and Cardiology. Where required, the design for targeted gene panels has been updated, reagents ordered and validation is expected to be complete

					by October 2019. The cancer TD has been mapped against existing services and a strategy around supra-regional testing providers has been agreed in the respective Cancer T&F groups. For the remainder a clinical and technology-led strategy to achieve full and efficient TD compliance by April 2020 is in place. A detailed plan and compliance dashboard have been developed and key milestones embedded in the GLH project plan.
18	Implementation of specialist testing from allotted providers.	N/A	A/R		This is dependent on the conclusion of the specialist test mapping and financial and operational impact assessment work. The GLHs state of readiness and timing/phasing of moves in terms of a checklist for transfer, whilst ensuring GLHs are not financially penalised as a result of phasing needs to be resolved with NHSE. In the interim the SWGLH is streamlining NGS technical processes and procuring additional instrumentation to release capacity in preparation for transfer.
19	Clear operating model between GLH and SIHMDS networks within the geography inc. (i) DNA extraction (ii) delivery of any non-WGS testing, (iii) integrated reporting	A	A		SIHMDS mapping is complete with stakeholder representation from all regional SIHMDS established to complete fine mapping of sample, referral and reporting pathways. DNA extraction for WGS will be provided from the BGL site and a programme of work to consolidate all genomic testing to Bristol is underway as detailed separately. WGS and non-WGS reporting will be undertaken directly by GLH staff into the integrated report for the majority of sites through HILIS, the NBT SIHMDS integrated reporting system. Where HILIS is not yet in place results will be electronically transmitted to the referring SIHMDS for local integration. GLH staff are embedded in diagnostic review infrastructure which will be adapted to accommodate WGS for AML and ALL as well as expanded access to non-WGS testing.

20	Participation in all appropriate EQA schemes.	A/G	A/G		Confirmed participation in all schemes for current service profile.
21	Accreditation of all tests delivered by GLH.	A	A		All technologies currently used in Exeter and Bristol are accredited. Droplet digital PCR, mRNA analysis and SNP array technologies will require an extension to scope for the Bristol laboratory.
22	Arrangements in place for analysis and return of results across GLH.	A/R	A		Analysis and reporting of WGS data for rare disease will be undertaken by clinical scientists in Bristol and Exeter; Bristol only for cancer. We will use GEL2MDT (or University Hospitals Birmingham product) for rare disease case management and MDT meeting records. For non-WGS data the analysis will be undertaken either in Bristol or Exeter, according to the test. Results will be returned by e-mail wherever possible until direct export to EPR systems is enabled. Cancer results will be returned electronically to all referrers; either by e-mail or through direct integration into host systems where possible e.g. direct HILIS reporting. Mechanisms to report directly to local Pathology LIMS systems are in development.
23	Standardised SOPs in place across the geography.	N/A	N/A	N/A	The individual laboratories have SOPs for unique procedures. Where both sites are performing the same procedure (e.g. fresh-frozen pathways, test request, reporting results), the same SOP will be adopted. The two sites are working towards common analysis of WGS data for rare disease, and therefore a common SOP for data analysis and reporting will be developed.
Informatics					
24	Covered in GLH self-reporting template.	N/A			Awaiting issue of GLH self-reporting template
WGS					
25	SNP genotyping assay for rare disease in operation.	A	A		A v1 24 SNP Nimagen assay has been validated. Nimagen will shortly be releasing a v2 37 SNP assay and the GLH will validate and switch to this assay when available (July/Aug). Genomics England has been informed. The SOP is under development.

26	WGS pathways in operation for all RD WGS conditions identified in the National Genomic Test Directory.	A/R	A/R		Patient flow from those specialties who care for patients eligible for WGS (clinical geneticists, paediatricians, paediatric/adult neurologists and nephrologists) have been mapped across the GLH geography (mapping spreadsheet submitted to NHSE). Mapping of sample collection, handling and transport to the Bristol lab is complete and confirmed as fit for purpose. Clinical teams have been made aware of the forthcoming WGS service by GLH or GMC personnel, and/or through MDT meetings and educational events. They will be notified of the launch date and provided with full information/training for requesting tests at the appropriate time. In parallel, the GLH Training and education lead working with GMC colleagues has developed provisional educational material relating to patient choice and requesting of tests for the WGS service requesting that will be implemented at UAT stage.
27	WGS pathways in operation for Sarcoma.	A/R	A/R		The SW GLH Sarcoma WGS working group has mapped the three SW regional sarcoma services and have engaged the clinical service leads through educational presentations at the SW and WoE regional Sarcoma Clinical Advisory Groups. Fine pathway mapping and targeted discussions are in progress at all three sites to define educational and training needs and clinical pathway changes necessary for WGS roll out at each site individually. Alternative models for a regional sarcoma GTABs have been modelled locally but are dependent on national agreement of policy from the national Sarcoma T&F group. Roll out will be according to the NHSE modular implementation plan and will be phased sequentially at the three regional sites.
28	WGS pathways in operation for AML & ALL.	A/R	A/R		The SW GLH Haemato-oncology WGS working group has mapped the diagnostic pathways for acute leukaemia (AL) at all 11 of the SW sites and has designated lead clinicians at each site. High level pathway mapping was reviewed by NHSE review on 4th July. Local clinical teams have been engaged at the WoE and SW Haematology CAGs meetings, at a regional workshop WEBEX on 9th July, followed up by individual engagement visits at participating sites. At these visits, we will define the educational and training needs of and complete fine pathway mapping to identify clinical pathway changes necessary for WGS roll out at each site. We propose phased roll-out according to the NHSE modular implementation model across the sites, individualised for the

					geographical differences between sites. The AL WGS service will map to the existing Bristol SHIMDS sample collection and reporting pathway based at North Bristol trust and which oversees haemato-oncology in the largest part of the SW region).
29	WGS pathways in operation for Paediatric tumours.		A/R		The SW GLH Paediatric Cancer (PC) WGS working group has mapped the single SW regional PC services based at University Hospital Bristol for children <16yrs. PC in older children and young adults are managed in approximately 70 additional cancer pathways across region and are incompletely mapped. Fresh frozen sample collection is already in place for most PC samples for children <16yrs. Targeted clinical discussions are in progress to identify training and education needs and to alter sample collection pathways for out-of-hours neuro-oncology samples which are currently collected into formalin. Alternative models for a national or supra-regional GTABs and for germline finding reporting are currently dependent on national agreement of policy from the PC T&F group. We proposed a roll out starting with PC in children <16yrs, phased according to tumour type and delivered according to the NHSE modular implementation model.
30	Pathways in operation for NICU/PICU.	A/G	A/G		Rapid whole exome sequencing service is available across the GLH geography via provider to provider funding. NICU/PICU referrals will utilise the specific request form with a named clinical geneticist. All referrals will be checked for appropriateness by the clinical scientist team under the guidance of the GLH Medical Rare Disease Lead. DNA samples will be extracted in local laboratories and exported ASAP to Exeter (WES provider laboratory). The GLH Medical Rare Disease Lead will work with the NICUs and PICUs to support the implementation.
31	Process in place to record patient choice within the GLH.	A	A		Following entry of patient choice to the NGIS TOMS, scanned copies of patient choice forms will be uploaded to both NGIS and to the local LIMS record for the patient in order to maintain a local record of patient choice
32	Genomic MDTs in operation for WGS results.	A/R	A/R		An MDT model proposal for both RD and Cancer is being consulted on with key stakeholders.

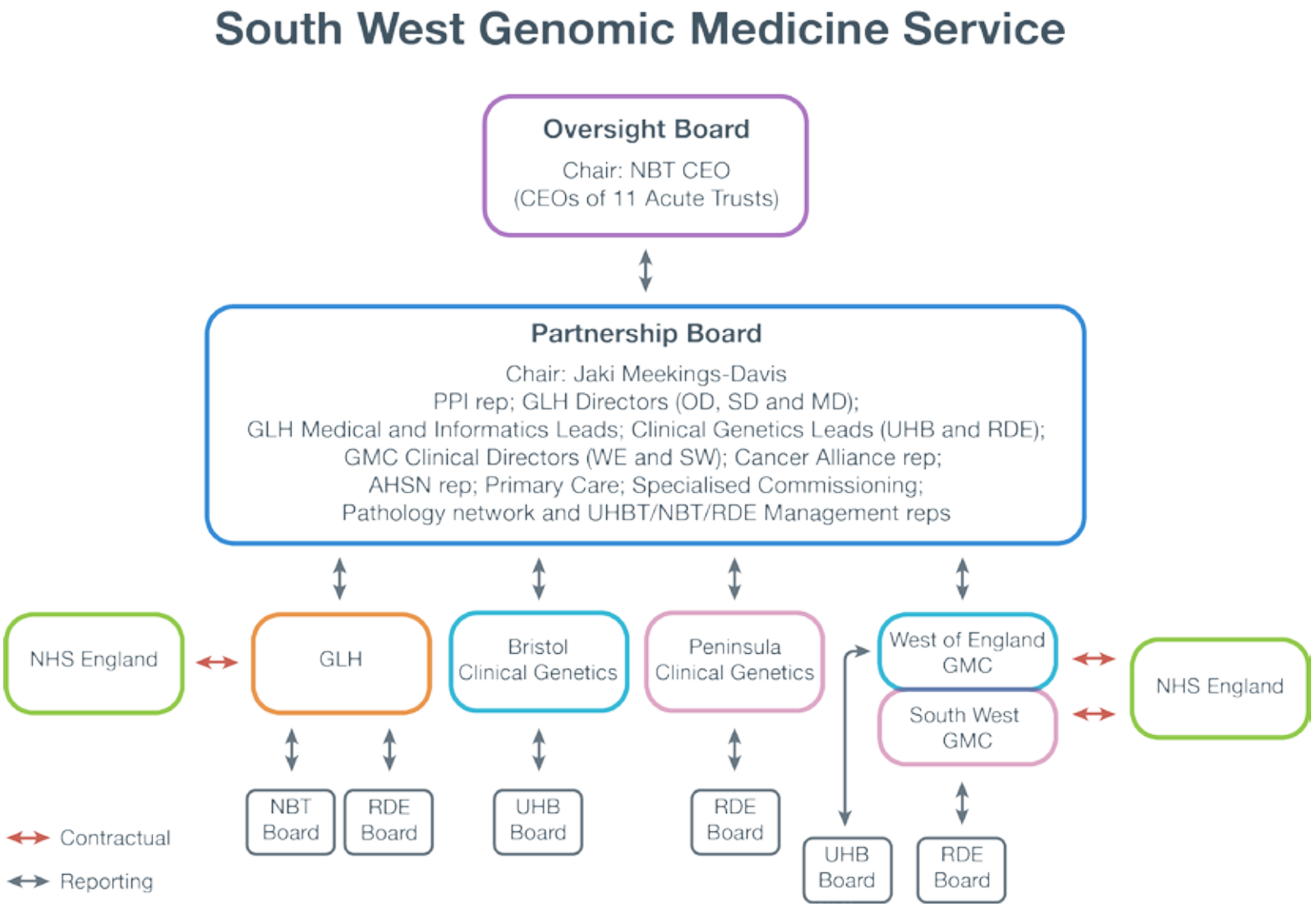
					For RD we have mapped current MDT provision and identified future MDT requirements for specialist services across the allocated wider geographies in addition to educational MDTs to support WGS tests across the SWGLH. With key stakeholders we will develop a transition plan to provide equitable geographical access to educational and patient management MDTs.  Draft for discussion SWGLH MDT v0.1.ppt The configuration of the MDT for sarcoma and paediatric cancer is dependent on finalisation of national policy determined by the respective T&F groups to which clinical and scientific leads from the SW GLH contribute. Proposals for local reporting pathways are compatible with both single national or supra-regional GTAB model. The weekly diagnostic review meeting currently undertaken in the NBT SIHMDS already encompasses genomic results and will be expanded to serve as a regional Haematology GTAB. Facilities for remote access for users from across the region are under development. Discussions are underway with key stakeholders from regarding how best to align this resource to existing clinical structures and resources within the region as well as National GTABs, for example the proposed National germline haematology GTAB.
33	Process in place in GLH for approval for WGS testing	N/A	A		Referrals will be checked for appropriateness by clinical scientists under the guidance of the GLH Medical Leads.

Definitions

Green	GLH has met the requirement/system is fully operational.
Amber/Green	GLH has a plan currently being operationalised, but not fully operational.
Amber	GLH has not met the requirement but a clear plan is in place to support delivery.

Amber/Red	GLH has started to formulate a plan, but further clarity is required.
Red	GLH has not demonstrated there is a clear plan for how the requirement will be met.

Figure 1.


South West Genomic Medicine Service
Oversight Board
Chair: NBT CEO
(CEOs of 11 Acute Trusts)
Partnership Board
Chair: Jaki Meekings-Davis
PPI rep; GLH Directors (OD, SD and MD);
GLH Medical and Informatics Leads; Clinical Genetics Leads (UHB and RDE);
GMC Clinical Directors (WE and SW); Cancer Alliance rep;
AHSN rep; Primary Care; Specialised Commissioning;
Pathology network and UHBT/NBT/RDE Management reps
NHS England
GLH
Bristol Clinical Genetics
Peninsula Clinical Genetics
West of England GMC
South West GMC
NHS England
NBT Board
RDE Board
UHB Board
RDE Board
UHB Board
RDE Board
Contractual
Reporting

Report To:	Trust Board		**Agenda Item:**	15.
Date of Meeting:	25th July 2019			
Report Title:	Patient & Carer Experience Committee Report			
Report Author & Job Title	Mark Pender, Deputy Trust Secretary			
Executive/Non-executive Sponsor (presenting)	Helen Blanchard, Interim Head of Nursing			
Purpose:	**Approval/Decision**	**Review**	**To Receive for Assurance**	**To Receive for Information**
			X	
Recommendation:	The Trust Board is recommended to receive the report for assurance.			
Report History:	The report is a standing item to each Trust Board meeting following a Patient & Carer Experience Committee.			
Next Steps:	The next report to Trust Board will be to the September 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 Patient & Carer Experience Committee meetings held on 22nd May 2019 and 15th July 2019.

Strategic Theme/Corporate Objective Links	Reports received supported the delivery of the following strategic themes and corporate objectives: · Be one of the safest trusts in the UK · Treat patients as partners in their care
Board Assurance Framework/Trust Risk Register Links	Reports received support the mitigation of the following BAF risks: N/A

Other Standard Reference	Care Quality Commission Standards.
Financial implications	No financial implications as a consequence of this report.
Other Resource Implications	No other resource implications as a result of this report.
Legal Implications including Equality, Diversity and Inclusion Assessment	No legal implications.

Appendices:	None

1. Purpose

To provide a highlight of the key assurances, any escalations to the Board and identification of any new risks from the Patient & Carer Experience Committee meetings held on 22nd May 2019 and 15th July 2019.

2. Background

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

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

3. Meeting held on 22nd May 2019

3.1 As this was the first meeting of this newly constituted Committee the terms of reference and membership were reviewed. It was noted that further work was required in respect of the Committee's membership, with further Non-Executive Directors and a lay member of the committee to be appointed. After some discussion it was felt that the terms of reference were appropriate for the moment and would be reviewed as the work of the Committee progressed.

3.2 The Committee considered the Patient Experience Group (PEG) highlight report. Helen Blanchard reported that this was a well-attended group with approximately 30 members, one third of which were patients. During the discussion it was reported that a national review of the Friends and Family Test (FFT) was due to be published shortly and work was ongoing to promote use of FFT to help drive improvements in the hospital.

3.3 The Committee considered the Carer's Strategy Group highlight report. Gill Brook reported that this group was particularly effective at representing the rights of patients, and was currently made up of 10 members. Further carer representation on the group was currently being sought. The Committee also received highlight reports from the Learning Disability & Autism Steering Group, the Dementia Group and the Carer's Strategy Group.

3.4 The Committee considered a report which provided synopsis of the work undertaken during 2018/19 in respect of listening and working with patients. This included a summary of:

- The work undertaken to collect and receive feedback from different sources;

- The key work undertaken through direct engagement and involvement with patient and carers;
- the impact of this feedback and engagement; and
- Volunteer activity and impact.

3.5 There was particular excitement around the new Patient Advice & Liaison Service (PALS) service, which had recently secured funding for permanent members of staff and to provide a dedicated space for meeting patients. It was hoped that the service would help drive a reduction in the number of complaints received by the Trust. It was suggested that the data from the PALS service should be made available in Datix, and that it would be useful for the Committee or Trust Board to hear stories from patient(s) using the service.

3.6 The Committee considered a slide-deck which provided an overview of the NHSI Patient Experience Improvement Framework. This was designed to support NHS Trusts in achieving a good or outstanding rating in their CQC inspections, and enable organisations to carry out an organisational diagnostic to establish how far patent experience is embedded in it leadership, culture and operational processes. During the ensuing discussion the issue of the privacy and safety of patients whilst in hospital was cited as an example of how patients should be kept safe and free from avoidable harm / harassment, and how patients' wishes in respect of this were not always respected by staff.

3.7 The Committee considered a report which provided the draft North Bristol NHS Trust Public Engagement Strategy. This had recently been developed by the Director of Communications and that the key aspects of the NHSI improvement patient experience framework would be incorporated into the document.

4. Meeting held on 15th July 2019

4.1 The Committee received a presentation on the ReSPECT process, which creates personalised recommendations for a person's clinical care in a future emergency in which they are unable to make or express choices. The intention was for this to be implemented across BNSSG from 10th October 2019 and work was ongoing to achieve this. The Committee welcomed the introduction of the ReSPECT process in the local area and the benefits this would bring for care of all patients, not just those at receiving end of life care.

4.2 An update was provided on the Complaints Management and Patient Advice and Liaison Service (PALS). It was reported that since the introduction of PALS complaints had been reduced by 30%, although it was too early to be sure if this was solely due to PALS and other work was ongoing to improve the Trust's performance in respect of complaints. The role of the Complaints Review Panel was discussed and it was noted that this was not currently active.

4.3 The National Inpatient Survey 2018 results and key areas for improvement were received and noted. Discussion centred on issues around patient transport and the negative impact this was having on the experience of patient and carers, and the Director of Facilities was asked to come back to the next meeting with suggestions on how the Trust could influence change in this area.

4.4 The Committee received a presentation on the National Cancer Patient Experience Survey 2017 Action Plan Update. The following key developments were highlighted:

- A sentence would be added to all patient letters welcoming them to bring a friend/family member/carer to appointments as part of the Outpatient Communications programme;

- Funding had been received from NHS England's Cancer Transformation Programme and Macmillan Cancer Support to support the further roll out of personalised care and support for cancer patients;

- Additional staff had been recruited to support the rollout – 7 new cancer support workers, a physiotherapist, dietitian, additional psychologists, administrative staff and project manager.

4.5 The patient representative on the Committee expressed concern regarding the safety of patients whilst in hospital and the measures in place to keep them safe. She was particularly concerned regarding the open nature of wards and the fact that visitors appeared to be able to access them unchallenged. The Director of Facilities reported that security measures were in place, and a balance needed to be struck between the hospital providing an open access service and the safeguarding issues highlighted. The Chair noted that this required further consideration and would be brought back to a future meeting.

5. Escalations to the Board

5.1 The framework for patient / carer / staff stories at Trust Board was discussed. It was suggested that the Board should consider having a story every month in order for it to receive regular first hand reports of the care provided by the Trust.

5.2 It was also felt that an additional Non-Executive Member was required on the Committee and the Board is asked to consider the appointment of such.

Recommendations

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

Report To:	Trust Board		**Agenda Item:**	16.
Date of Meeting:	25th July 2019			
Report Title:	Quality & Risk Management Committee Report			
Report Author & Job Title	Mark Pender, Deputy Trust Secretary			
Executive/Non-executive Sponsor (presenting)	Tim Gregory, Quality and Risk Management Committee Chair, 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 the Trust Board following each Committee meeting.			
Next Steps:	The next report will be received at the Trust Board in September 2019.			

Executive Summary
The report provides a summary of the assurances received, issues escalated to the Trust Board and any new risks identified from the Quality and Risk Management Committee Meeting held on the 17th July 2019.

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

Appendices:	None

1. Purpose

To provide a highlight of the key assurances, escalations to the Board and identification of any new risks from the Quality and Risk Management Committee meeting held on 17th July 2019.

2. Background

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

3. Key Assurances Received

3.1 The committee received an update on the Hospital Pharmacy Transformation Programme. It was reported that the final NBT Pharmacy HPTP plan has been submitted on time to NHSI and had achieved exemplar status for quality and content. All but two of the twenty identified work streams had made some progression with eight currently being RAG rated as green.

3.2 An update on progress with the trust-wide Clinical Governance Improvement Programme was received as a standing item on the agenda. It was reported that it was now felt that there had been a successful delivery of activities across the programme, which had been enabled by the positive shared engagement between clinical divisions and central functions. It was recognised that the whilst the current position had established a robust foundation for strong quality governance, ongoing work was required to embed the structures, roles and frameworks into sustainable practice.

3.3 The Committee reviewed the Trust's compliance position against the CNST Maternity Safety Standards incentive scheme for 2019/20. This was the last QRMC before the final evidence submission date of 15th August 2019 to NHS Resolution and as such QRMC members were provided with detailed evidence to support the compliance position reported. All standards (and their sub sections) were either rated as 'black' (fully achieved) or 'Green' - would be achieved by the submission date. Of these the majority needed review at this QRMC to conclude the requirement. Specific focus was given as requested in the paper to Safety Actions 1,3,4,6 and the one remaining substantive action was the final training required for Safety Action 8 – training delivery, where a session on 8 August would finalise their compliance. QRMC approved the reporting of full compliance with the 10 Maternity Safety Standards safety actions (as referenced within the report and Appendix A), subject to the achievement of the final training requirements in August, which would be reviewed by the Director of Nursing & Quality prior to submission.

3.4 The Committee considered a paper which provided ongoing assurance on the effective management of Trust risks by providing assurance on the overall risk management arrangements within NBT and reporting updates on extreme approved risks identified and managed by Divisions. It was noted that this was an interim position paper and that a revised report format would be presented to the September meeting as part of the wider changes to the way risk is reported across the Trust. It was noted that the new

format would provide more detail in respect of the nature of each risk which would allow a greater degree of scrutiny and challenge.

3.5 An internal audit into medical outliers was received and noted.

3.6 The Committee considered it workplan for the remainder of the financial year and requested that a number of subjects be added to it for its assurance. It was suggested that a deep dive at the September meeting on patient moves would be particularly helpful.

4. Escalations to the Board

4.1 The Infection Prevention and Control Annual Report & Programme was presented to the Committee, and this was endorsed for submission to the Trust Board (see separate agenda item).

4.2 The annual Child and Adult Safeguarding reports were considered by the Committee, and these were endorsed for submission to the Trust Board (see separate agenda items).

5. Identification of New Risk

No new risks were identified in the meetings.

6. Recommendations

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

Report To:	Trust Board		**Agenda Item:**	17.
Date of Meeting:	25th July 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 September 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 June 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 June 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. There was particular concern regarding the continuing problem of recruitment and retention at the Trust, and it was requested that proposal to address this, together with details on recruitment and retention hotspots and the use of bank / agency staff in overnight services, to be brought to the August 2019 meeting as part of the draft People Strategy.

3.2 The BAF risks for which the Committee was responsible for were reviewed. In respect of recruitment and retention it was felt that the risk score was currently probably too low, and it was agreed that this would be revisited when the proposals on dealing with this were discussed again in August. The Cyber Security BAF risk was also discussed and the mitigations in place were noted. Whilst it was noted that this area would always be of high risk, the ongoing work in respect of the network would help the Trust's systems to become more robust, and it was suggested that the risk score should be reviewed in quarter 4.

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. An update on the scoping work for improved workforce data / information was also requested for August meeting of the Committee.

3.4 The Committee received a presentation on Perform Wave 3 and the workplan for the period April to Jul 2019. This work was focussed on continuing to support length of stay improvements. From August the focus would be on the following areas:

- Maternity extension to ensure sustainable embedding
- Urology Admin – pilot for admin areas
- Spreading Perform and building momentum across the Trust – setting up for the transformation plan

3.5 The Committee received an update on the One NBT Leadership Programme, which provide details of the delivery and content of the programme, together with the support available for those undertaking it. It was suggested that a 'digital savvy'

module would be a useful addition to the programme, and it was asked that this be considered as the programme developed.

3.6 An update on Apprenticeships at NBT was provided to the Committee, and the following developments since the last update in December 2018were highlighted:

- Conversations on training needs analysis had taken place within Divisions;
- A draft apprenticeship strategy had been developed;
- A change in government funding rules had prompted a move towards NBT having main provider status;
- The launch of the Leadership and Management Level 3 apprenticeship;
- A successful City and Guilds external audit;
- A 100% success rate for end point assessment.

3.7 The Committee received an update on the Interim NHS People Plan from the Director of People & Transformation, which was reported to be a high level document with an emphasis on valuing staff within the NHS.

3.8 The Committee received an update report from the Medical Workforce Group, and noted that the Group was currently focussing on the following workstreams:

- E-Rostering and E-job planning
- Job planning
- Medical Workforce data and agency use
- Terms and Conditions
- Medical workforce plan
- Education and training
- Consultant wellbeing

It was reported that the new e-rostering system for junior doctors would be in place by the end of the current financial year.

3.9 The Committee received and noted the following Internal Audit Reports:

- Cyber Security – follow up
- Divisional Governance
- Agency Staff

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:	Trust Board		**Agenda Item:**	18.
Date of Meeting:	25 July 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>
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<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.

North Bristol NHS Trust

North Bristol NHS Trust
INTEGRATED PERFORMANCE REPORT
July 2019 (presenting June 2019 data)

CONTENTS

REPORT KEY

Unless noted on each graph, all data shown is for period up to, and including, 30 June 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
Med	Medicine
NMSK	Neurosciences and Musculoskeletal
Non-Cons	Non-Consultant
Ops	Operations
RAP	Remedial Action Plan
RCA	Root Cause Analysis
WCH	Women and Children's Health
MDT	Multi-disciplinary Team
PTL	Patient Tracking List

EXECUTIVE SUMMARY
June 2019

ACCESS

- In June we experienced a decline in the **4 hour urgent care standard at 72.53% and have underachieved against the Trust's trajectory of 89.23%**. The Trust had 8041 attendances, which is a 4% increase compared to June 2018. The Trust reported one >12 hour trolley breach in June during a period of Internal Critical Incident, which was declared following 3 days of high attendances and admissions. 75% of breaches were due to waits for assessment within the ED.
- The Trust has **underachieved against trajectory for Referral To Treatment (RTT)** incomplete performance for June (85.03% vs trajectory of 87.60%). The total **incomplete waiting list was 28590 against a trajectory of 28148**. The Trust has not achieved its trajectory for the number of patients waiting greater than 52 weeks from Referral to Treatment (RTT) in June (17 vs trajectory of 6). The majority of breaches are within MSK sub-specialties.
- In June, the Trust **did not deliver the diagnostic waiting time trajectory** of 6.00% with a final position of 6.84%. Plans are in place to work towards improving the Endoscopy demand and capacity imbalance and full backlog clearance of Urodynamics breaches.
- The Trust has **delivered two of the seven national cancer targets** in May– The 31 Day Subsequent Drug Treatment standard is achieved at 100% and patients treated within 62 days of screening, achieving 91.8%. The Trust's Two Week Wait performance was 83.4% in May (standard 93%), Two Week Wait for Breast Symptoms declined to 88.8% (standard 93%), 31 Day First Treatment has declined to 88.2% (standard 96%), 31 Day subsequent Surgery has improved to 82.5% (standard 94%), while the 62 Day Treatment standard reports a marginal underachievement at 78.9% (standard 85%). NHS Digital have acknowledged that there is an error in the 62 day reporting system nationally which they are working to address. Internal performance monitoring demonstrates performance should be 81.22%
- The Trust exceeded performance against the improvement trajectories for 31 day Subsequent Surgery, 31 day Subsequent Drug Treatment and 62 day Screening. The Trust failed to meet the improvement trajectory for Two Week Wait, Two Week Wait Breast Symptoms, 62 day GP Referral and 31 day First Treatment. The Trust improvement trajectory had forecasted recovery against all standards except Two Week Wait by October 2019. The timeframe for meeting 62 day GP Referral, 31 day First Treatment and 31 day Subsequent Surgery has been revised to December 2019 due to the timeframe for recruiting new staff. Forecasted recovery against the Two Week Wait standard remains as March 2020.

SAFETY

- A 30% reduction of Grade 2 pressure ulcer incidence is a focus of 2019/20 safety improvement work. In June there were 31 Grade 2 and **no Grade 3 or Grade 4 pressure injuries reported**. A presentation has been commissioned for the July meeting to provide an understanding of the current position and assurance about the improvement actions being taken. There were three serious incidents reported and **no Never Events declared in June**, with the last reported Never Event being 26 January 2019. Patient falls have remained below the national average and infection rates continue to achieve trajectory.

PATIENT EXPERIENCE

- **The number of overdue complaints was 20 in June.** The number of complaints received in month has reduced further in June from 56 (May) to 52. Maternity sustained a high percentage of patients (97%) who would recommend the service to friends and family.

WORKFORCE

- **The overall sickness levels within the workforce remains at 4.3%** compared to 4.4% last year and 4.5% nationally (Feb 2019). The OneNBT Leadership Programme is at 92% of its target of 350 staff signing up for the programme. **Mandatory and Statutory training compliance is above target at 90%.** Appraisal completion rate is lower than target in month. The overall picture on turnover and stability continues to show positive movement. There was a small increase in vacancy factor due to increases in establishment particularly in genetics. The Band 5 nursing starters are 13.2 wte behind target but it is anticipated the gap will be bridged throughout the year with the total 2019/20 starters target still being achieved.

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 June, the Trust reported a **deficit of £3.4m which is £0.1m favourable to the planned deficit**. The Trust has a 2019/20 savings target of £25m, of which £1m of £4.2m was achieved at the end of June. The Trust financial risk rating on the NHSI scale is 3 out of 4.

Key Operational Standards Dashboard

June-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		76.16%	72.53%	89.23%	▼
	12 Hour Trolley Waits QP1		0				0	1		▲
	Ambulance Handovers Within 15 minutes		100%				93.94%	93.70%	95.23%	▼
	Ambulance Handovers Within 30 minutes		100%				99.39%	98.90%	100%	▼
	Ambulance Handovers Within 60 minutes		0				0	4	0	▲
	Referral to Treatment - % Incomplete Pathways <18 weeks		92%	*86.86%	126/177		85.14%	85.03%	87.60%	▼
	Referral to Treatment - Total Incomplete Pathways						29179	28590	28148	▼
	52WW	MSK	6				13	14	6	▲
		Plastic Surgery	0				2	1		▼
		Urology	0				0	1		▲
		Other	0				1	1		►
	Diagnostic DM01 - % waiting more than 6 weeks		1%	*4.08%	142/204		5.48%	6.84%	6.00%	▲
	Cancelled Operations	Same day - non-clinical reasons	0.8%				1.33%	0.79%		▼
		28 day re-booking breach	0				1	2		▲
	Bed Occupancy QP1		95%				96.21%	95.21%		▼
	Stranded Patients (LoS >7 days : Snapshot as at month end)						341	326		▼
	Delayed Transfers of Care (DToC) QP1		3.50%				7.07%	6.07%		▼
	Mixed Sex Accomodation		0				0	0		►
	Electronic Discharge Summaries						84.08%	84.13%		▲
Responsiveness - Cancer (In arrears)	Patients seen within 2 weeks of urgent GP referral		93%	90.79%	130/145		84.70%	83.44%	91.23%	▼
	Patients with breast symptoms seen by specialist within 2 weeks		93%	78.94%	75/114		89.83%	88.83%	89.60%	▼
	Patients receiving first treatment within 31 days of cancer diagnosis		96%	95.97%	114/123		93.08%	88.24%	93.98%	▼
	Patients waiting less than 31 days for subsequent surgery		94%	92.15%	47/57		80.77%	82.52%	74.31%	▲
	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		84.40%	78.95%	83.93%	▼
	Patients treated within 62 days of screening		90%	87.44%	24/73		93.33%	91.84%	85.29%	▼

Key Operational Standards Dashboard

June-19

IPR section	Access Standard		Target	Benchmarking (*month in arrears)			Previous month's performance	Performance against Target	Performance against NBT Trajectory	Performance direction of travel from last month
	Description			National**	Rank***	Quartile				
Quality Patient Safety and Effectiveness	Never Event Occurrence by Month		0				0	0		
	WHO Checklist Compliance		95%				97.70%	97.00%		
	Hand Hygiene Compliance		95%				96.00%	98.00%		
	Pressure Injuries	Grade 2					27	31		
		Grade 3					0	0		
		Grade 4					0	0		
	MRSA						0	0		
	E. Coli						2	5		
	C. Difficile						3	5		
	MSSA						1	1		
	Venous Thromboembolism Screening (In arrears)		95%				95.89%	95.55%		

Key Operational Standards Dashboard

June-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		*12.06%	37/136		19.39%	20.56%	15.00%	▲
		Inpatient	QP2		*24.82%	154/165		17.58%	17.40%	30.00%	▼
		Outpatient	QP2					18.54%	11.74%	6.00%	▼
		Maternity (Birth)	QP2		*19.66%	52/125		20.17%	21.05%	15.00%	▲
	FFT - % Would recommend	Emergency Department	QP2		*85.58%	77/132		88.26%	88.01%		▼
		Inpatient	QP2		*95.90%	134/158		92.64%	92.82%		▲
		Outpatient	QP2		*93.72%	108/202		95.44%	95.63%		▲
		Maternity (Birth)	QP2		*97.08%	22/71		97.94%	96.74%		▼
	Complaints	% Overall Response Compliance	QP2					33.00%	71.00%		▲
		Overdue	QP2					25	20		▼
Well Led	Agency Expenditure ('000s)			£734				£1,136	£1,305		▲
	Month End Vacancy Factor			9.50%				10.12%	10.79%		▲
	Turnover (Rolling 12 Months)			15.50%				15.24%	15.47%		▲
	In Month Sickness Absence (In arrears)			4.10%				4.26%	4.27%		▲
	Trust Mandatory Training Compliance			85.00%				88.34%	89.77%		▲
	Non - Medical Annual Appraisal Compliance			11.90%				6.50%	12.01%		▲
Finance	Deficit (£m)			£4.9m 2019/20				£1.5	£3.4	£3.2	
	NHSI Trust Rating							3	3		▶

RESPONSIVENESS
SRO: Chief Operating Officer
Overview

Urgent Care

The Trust reports a decline of the 4 hour urgent care standard at 72.53% in June and continues to underachieve against the Trust trajectory of 89.23%. The 4 hour target remained challenged by high volumes of attendances overall. A period of lower attendances mid-month delivered an improved period of performance, but this was not able to be sustained, particularly in the latter part of the month where significant increases in attendances were experienced.

Planned Care

Referral to Treatment (RTT) - In month, the Trust underachieved against the RTT trajectory of 87.60%, with actual performance at 85.03%. The total waiting list reports a position of 28,590, underachieving against a trajectory of 28,148, but is a reduction in the wait list reported in May following targeted data quality work. The remaining increase in waiting list is a combination of reduced activity and increased demand. The number of patients exceeding 52 week waits continues above trajectory (6) reporting 17, a decline of one breach from May; the majority of breaches (14) being on an MSK pathway. The Trust is working towards delivery of a remedial action plan, specifically focusing on the challenged sub-specialties within MSK and Plastic Surgery.

Cancelled Operations - In month, there were no urgent operations cancelled for a subsequent time and two breaches 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 for diagnostic waiting times with a performance of 6.84% in June and reflects a deterioration from May's position of 5.48%. The Trust has also failed to achieve the recovery trajectory of 6.00%. The Trust continues to monitor Endoscopy pathways through Remedial Action Plans and outsourcing plans within Urodynamics are in place to commence clearance in July 2019.

Cancer

Cancer performance deteriorated in May, achieving two of the seven standards. Of the five standards not achieved, the Trust's Two Week Wait has reported another fall to 83.4% and the Breast symptomatic Two Week Wait reported 88.8% in May against the National standard of 93%. The majority of breaches relate to Skin (104), Colorectal (107) and Breast (41). Patients receiving first treatment within 31 days of diagnosis has not achieved the standard and reports a performance of 88.2% against 96% target. Patients waiting less than 31 days for subsequent surgery continues to underperform with a performance of 82.5% against a target of 94% but has improved from April 2019. The current national submission indicates that the Trust failed the 62 day treatment standard, with a performance of 78.9%. 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 81.22%. The Trust continues to achieve the 31 day subsequent drug treatment standard with performance at 100% and the target of patients treated within 62 days of screening at 91.8% against a target of 90%.

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

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

Patient falls - The falls-per-1000 bed days level remains below the national average (6). Ongoing improvement actions agreed to support the national CQUIN.

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

Other infection types – The Trust is below trajectory for C-Difficile, MSSA and e-Coli and continues to sustain compliance above target with Hand Hygiene requirements.

Missed Doses – The Trust is below target for the missed dose percentage and there strong governance arrangements are in place to address any individual wards that miss the target for 2 consecutive months.

Learning From Deaths & Mortality Alerts – The Trust has delivered 91% of all required case reviews and continues to ensure that high priority cases are delivered as required. There were no new notifications by a Reviewer of Overall care as Poor or Very Poor (score 1-2) within the latest review period.

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. Advice has also been sought from the Tissue Viability team at NHSI to inform our programme of work. The Board has commissioned a presentation for the July meeting to provide an understanding of the current position and assurance about the improvement actions being taken.

QUALITY EXPERIENCE
SRO: Interim Director of Nursing
Overview

Improvements

Complaint and Concerns: The number of complaints received in month has reduced further in June from 56 (May) to 52. Whilst there has been an increase in the number of concerns addressed through PALS it is too soon to attribute this to the impact of this service. The Divisional Recovery Plans continue to deliver improvement in the reduction of overdue complaints and the focus on preventing other complaints becoming over due.

Friends and Family Test: Maternity (Birth) sustained a high percentage of patients who would recommend the service to friends and family - 97%. The effective communication by staff appears to have influenced the positive experience of the Mothers. It was agreed at the Patient Experience Group that we will increase the number of patients asked the FFT question in Day Case to give us a broader understanding of the experience of patients in this area.

Areas of concern

Complaints and Concerns and Enquiries: It is crucial that the timely response to concerns and complaints is sustained by both the central and divisional teams. The weekly recovery review meetings with the Head of Patient Experience focus on responsiveness to all complaints preventing overdue responses. The Policy and Standing Operational Procedure for the management of complaints and concerns agreed at the Patient Experience Group (02.07.2019) gives clarity of roles and responsibilities and process. Recruitment is in progress in the corporate and divisional teams to clinical governance and patient experience posts which will help in this process.

Friends and Family Test. This month we had more feedback than average from patients who had come to hospital for an operation and have not had a positive experience, it is too soon to see if this is a trend, but it will be monitored.

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 improved position on sickness absence continues, with absence currently at 4.3% compared to 4.4% in 2018/19.
The activity taking place to reduce sickness absence and improve wellbeing, including the Wellbeing programme, is continuing and expanding. The positive impact on Stress / Anxiety / Depression and Musculoskeletal absence continues with 1052 less fte days lost to absence for these reasons in the last 12 months (Jun-18 – May-19) than the 12 months previously.

Improving the leadership capability and capacity of our workforce
The OneNBT Leadership programme has now met 92% (from 87% last month) of its 2019/20 target of staff signing up to the programme. Mandatory and Statutory training compliance is at 90%. Compliance with appraisal completion is below the target for this month of 12% vs a target of 19.2% (month 3). People Partners within divisions are reviewing the position and encouraging managers to increase completion.

Continue to reduce reliance on agency and temporary staffing
Agency use and expenditure increased in June predominantly in registered nursing (+20 wte), additional professional, scientific and technical (+7.8 wte) and consultant (+1.9 wte) staff groups. The Trust Management Team have signed off a system approach to reducing tier 4/non-framework spend, and; the Trust bank and agency task and finish group is moving forward with its action plan to improve the experience of our bank staff which in turn is anticipated to increase bank participation and reduce reliance on agency staff.

Vacancies
The Trust vacancy factor increased to 10.8% in June 2019 from 101% in May 2019, the increase from May 19 predominantly resulted increases in funded establishment across genetics with the greatest increase in vacancies being seen across qualified and unqualified scientific and technical staff as a result. Vacancies across registered nursing and midwifery remains higher than the year end position in 2018/19. This is due to increases in establishment resulting from the 2019/20 business planning round and an overall net loss of staff in quarter one of 2019/20, band 5 nursing also follows this trend. Despite this the position for registered nursing and midwifery (and band 5 nursing) has seen a lower number of leavers and a higher number of starters in quarter one 2019/20 compared with quarter one in 2018/19.

Turnover
The Trust turnover saw a small increase from 15.2% in May to 15.5% in June. The increase is due to a higher number of voluntary leavers in June 19 (+20 wte) than in June 18 causing the increase when comparing the rolling 12 month position. However the turnover remains over 1% lower than the start of the previous financial year (16.7% in April 2018).

Stability
The stability factor increased in June compared with May 85.5% and 85.3% respectively. The rolling 12 month position for leavers with <1 years' service improved in June, compared to the same period last year with 40.7 wte fewer leavers. The rolling 12 month position for leavers for work life balance reasons deteriorated slightly in June, compared to the same period last year with 26.1 wte fewer leavers.

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 June, the Trust reported a deficit of £3.4m which is £0.1m favourable to the planned deficit including Provider Sustainability Fund and Financial Recovery Fund.

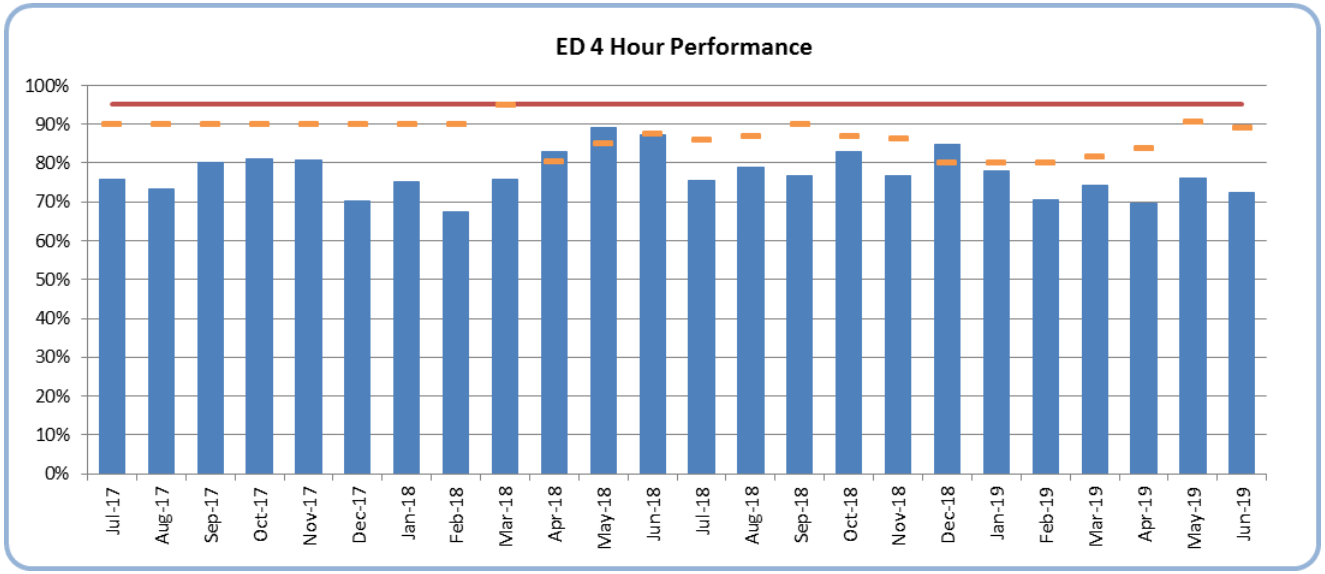
The Trust has borrowed a net £2.6m year to date to the end of June which brings the total Department of Health borrowing to £180.9m.

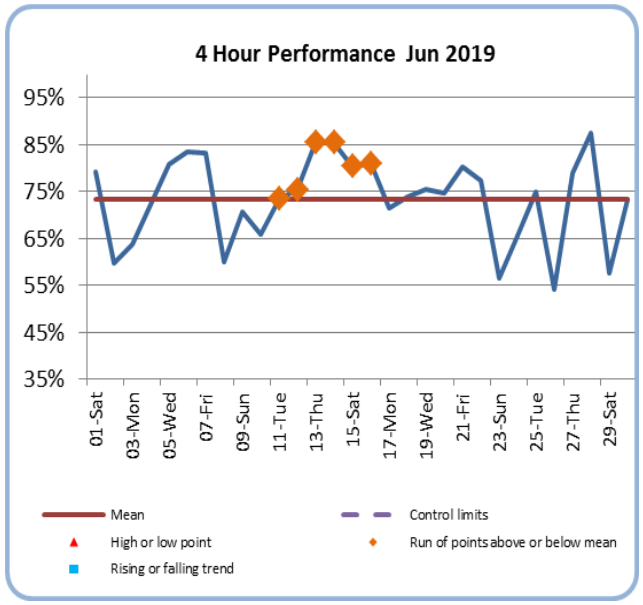
The Trust has a savings target of £25m for the year, of which £1m was achieved at the end of June against a plan of £4.2m.

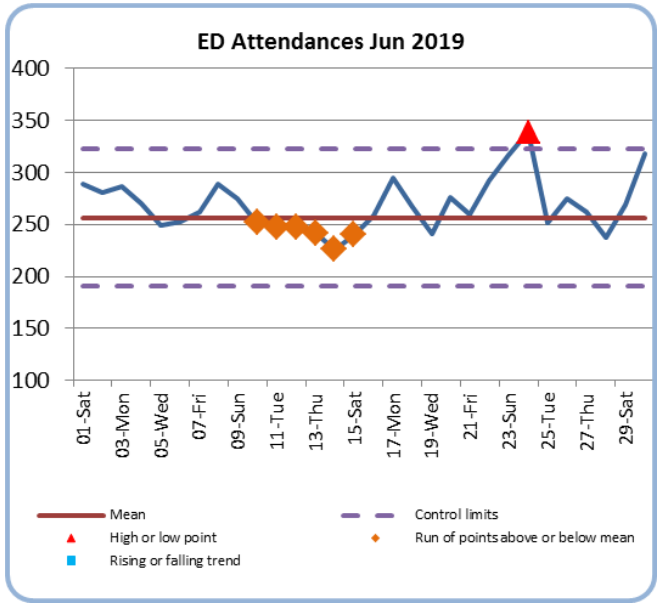
The Trust is rated 3 by NHS Improvement (NHSI).

RESPONSIVENESS

Board Sponsor: Chief Operating Officer
Evelyn Barker







Urgent Care

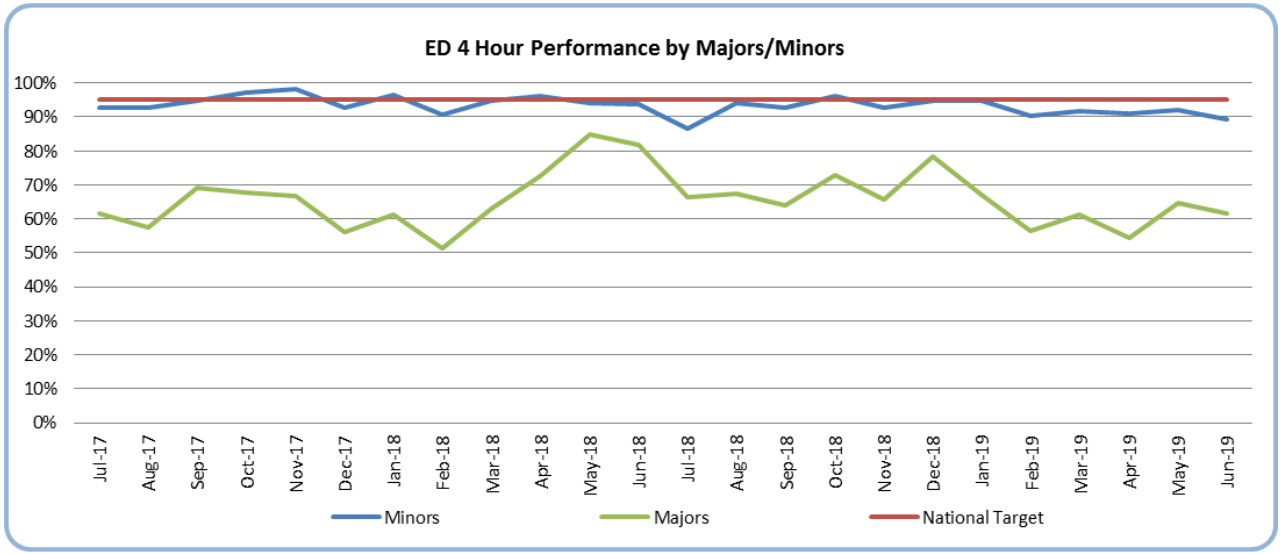
The Trust did not achieve the ED 4 hour wait trajectory of 89.23% in June 2019, with a performance of 72.53%. The position has deteriorated from May and also reflects a deterioration when compared with June 2018.

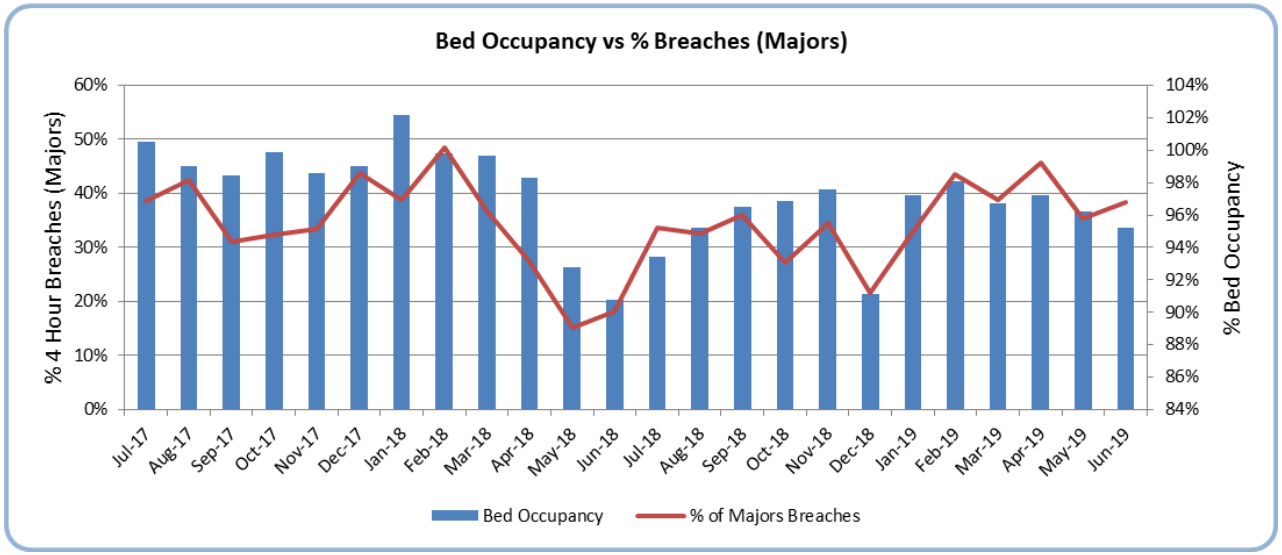
A period of lower attendances mid-month delivered an improved period of performance, but this was not able to be sustained, particularly in the latter part of the month where significant increases in attendances were experienced.

In June there was a small reduction in the total number of attendances compared to May 2019 at 8041. With an average of 268 attendances per day and four days exceeding 300. At 8041, there were 294 (4%) more ED attendances in June 2019 when compared with June 2018.

ED performance for the NBT Footprint stands at 80.69% and the total STP performance was 83.59% for June.

4 hour wait times performance fluctuated throughout the month, varying between 59.64% and 93.09%. Surges in attendances led to operational challenges. ED staff vacancies have reduced the Trust's ability to deal with surges in attendances, driving the days of sub 60% performance.





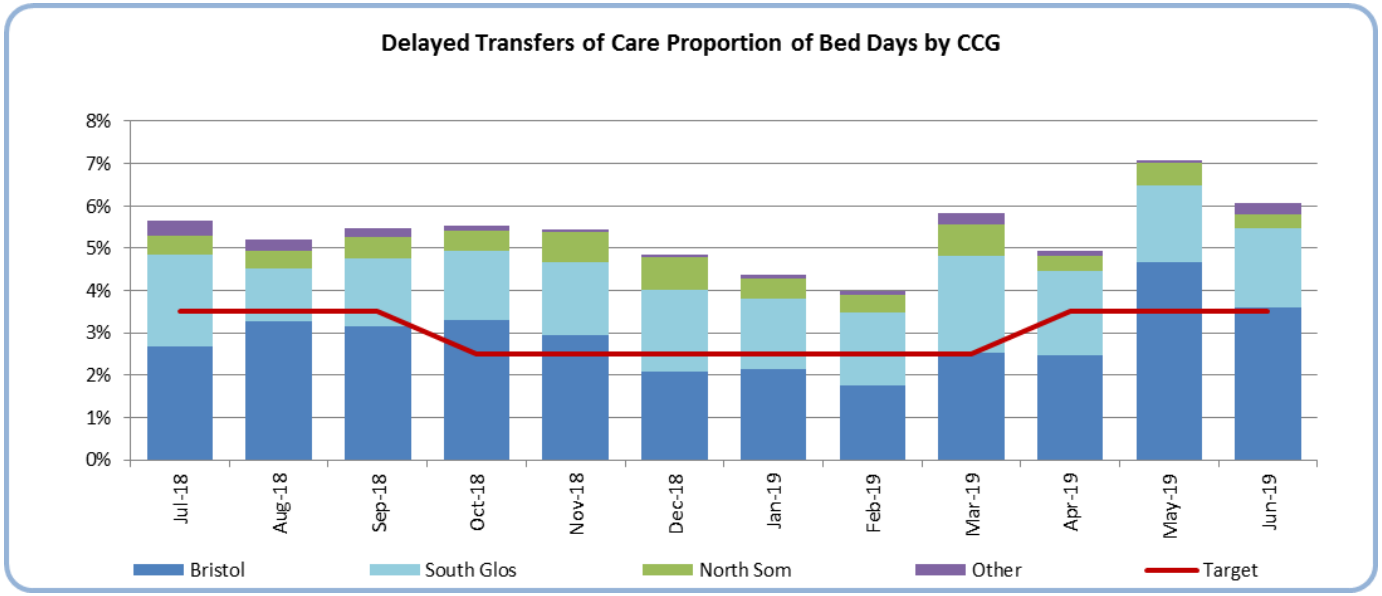
4 Hour Performance

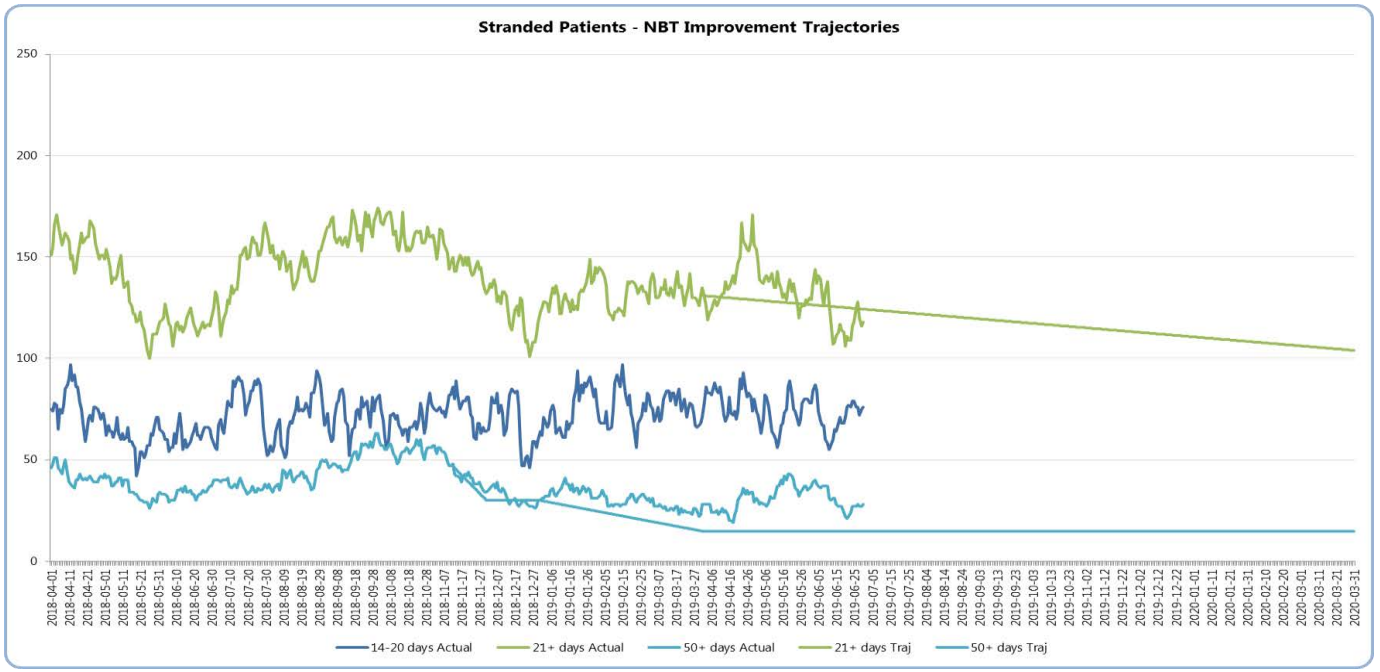
In June the majority of breaches (75%) were attributable to 'waiting ED assessment'. ED assessment breaches have been driven by surges of walk-in attendances and ambulances and staffing gaps in Tier 1 and Tier 2 roles, especially at weekends.

The Trust reported one 12 hour trolley breach on 25 June 2019 during a period of Internal Critical Incident, which was declared following 3 consecutive days of high attendances and admissions. Internal actions to drive the 4 hour recovery are overseen by the Urgent Care Steering Group. Key work streams include: increasing the proportion of same day emergency care across all divisions; criteria led discharge supported by 'Perform'; implementation of primary care streaming in ED; length of stay reduction plans; and operational surge protocols.

Ambulance arrivals in June were 2750, this represents a 4.9% increase on the same period last year. Of patients arriving by ambulance, 93.70% had their care handed over to the ED department within 15 minutes and 98.90% were handed over within 30 minutes. There were four 60-minute handover breaches in month.

The overall bed occupancy position again improved to 95.21% in June from 96.21% in May. On average across the month emergency admissions to the main bed base marginally reduced in June compared to May. However, this is an increase of 21 emergency admissions per day when compared to the same period last year.





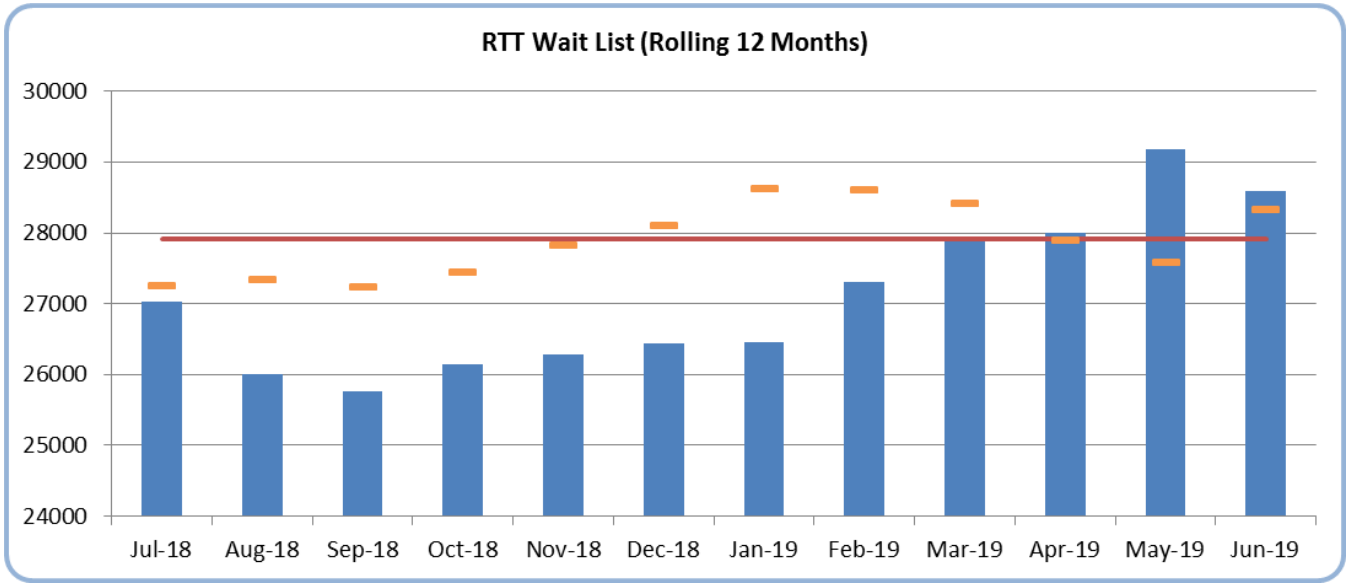
DToCs and North Bristol Operational Standards

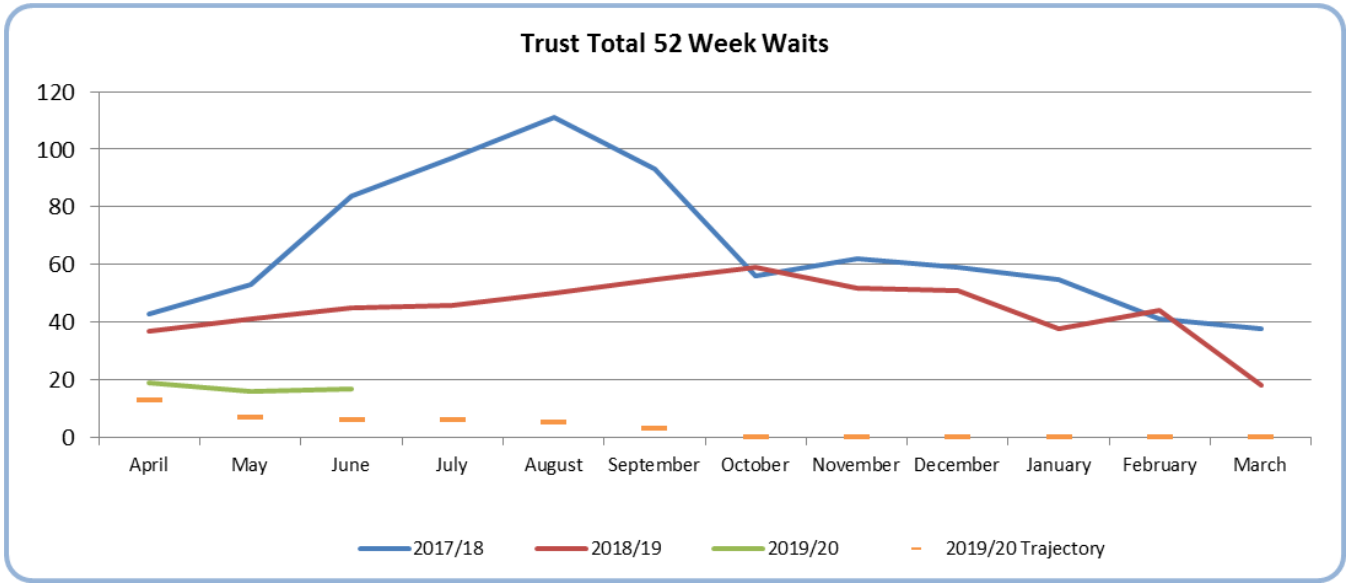
The DToC remained steady during June as a whole but there was an improvement in delays in Bristol. This was linked to the additional Social Work capacity provided by peripatetic social workers undertaking assessment. However, there remained a significant cohort of Bristol delay linked to Home First and delays in accessing Reablement.

For South Glos., the reported delays increased for P2 as there was an increase in stroke referrals and the capacity could not be extended to manage demand. In addition, the numbers waiting for placement increased in the month.

Stranded patient levels for over 21 days did improve in June, however levels for over 50 days increased. The delays in moving complex strokes and neuro through to either P2 or NHSE specialist commissioned beds within BIRU has led to extended delays in both pathways. The latter has been escalated to CCG leads.

The NHSI Long Length of Stay process has been initiated to include reviews with partners and ward teams to further inform the Trust and system partners of the level of demand for internal and external action to promote discharge. The first full month of results will be reported in July.



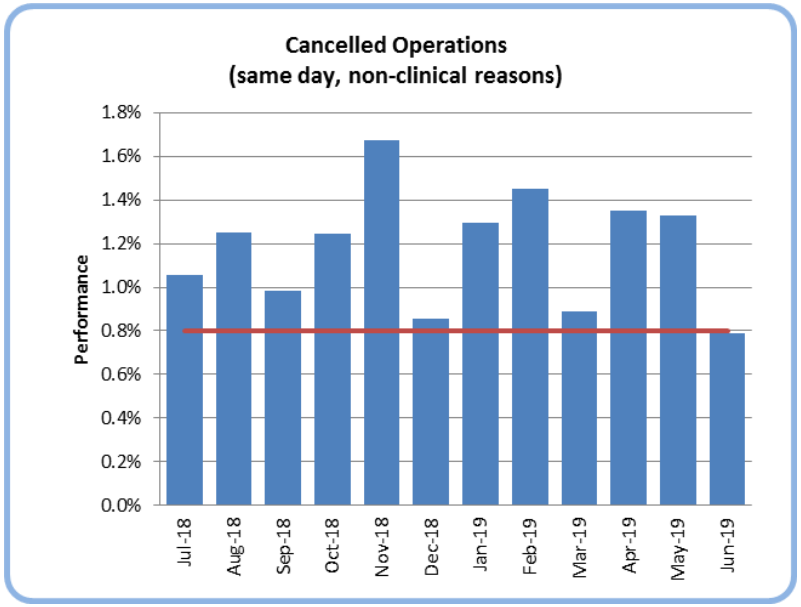


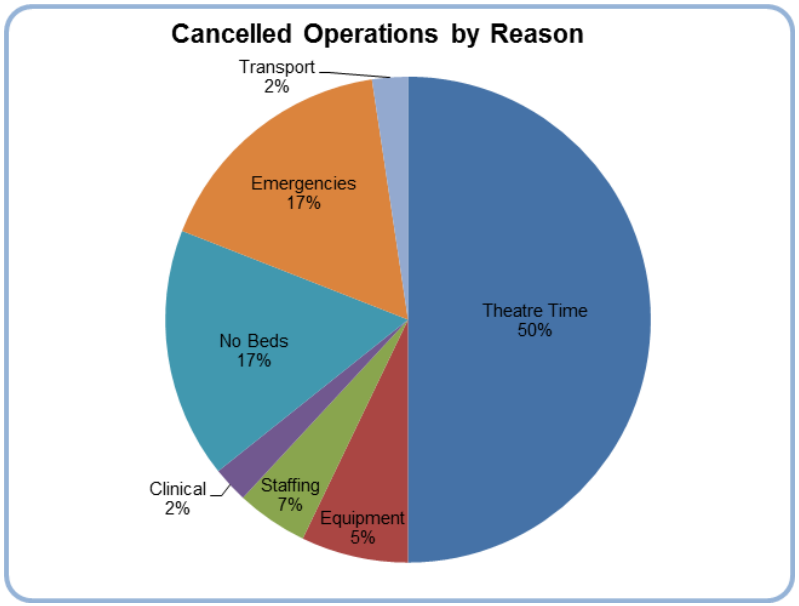
Referral to Treatment (RTT)
The Trust has not achieved the RTT trajectory in month with performance of 85.03% against trajectory of 87.60%.

The RTT wait list size has not been achieved for June, reporting 28,590 against a trajectory of 28,148, but did decrease compared to May following a targeted piece of data quality work. The remaining waiting list increase is primarily for patients waiting less than 18 weeks. This is driven by a mixture of reduced activity in some specialties (Urology, Breast Surgery and Gynaecology) and an increased demand in others (Plastic Surgery and Gastroenterology). The RTT Incomplete performance gain, that would be expected from an increase in patients waiting less than 18 weeks, has been offset by a deterioration in performance for Neurology.

The Trust has reported a total of 17 patients waiting more than 52 weeks from referral to treatment in June 2019. These patients were within the following specialties:
14 Trauma and Orthopaedics;
1 Plastic Surgery;
1 Urology; and
1 Neurology.

12 of the 14 Orthopaedic long waiters and all other speciality breaches are as a result of capacity issues, with the remaining two of the 14 Orthopaedic breaches attributable to pathway delays. 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.



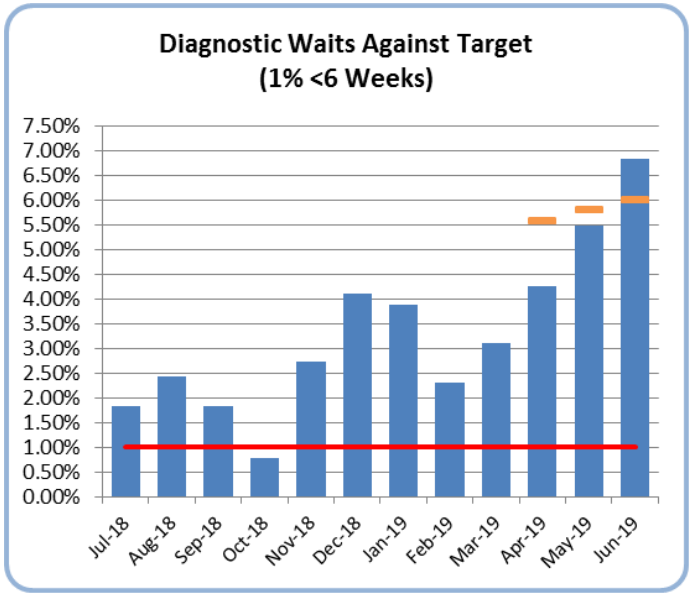


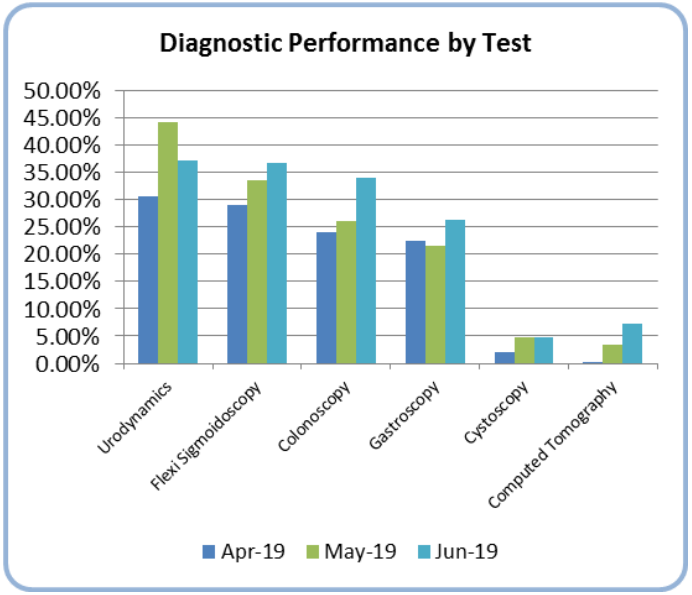
Cancellations
The same day non-clinical cancellation rate in June 2019 was 0.79%, which attained the 0.8% national target for the first time in 12 months.

In month, there was no urgent operation cancelled for a subsequent time.

There were two operations that could not be rebooked within 28 days of cancellation in June 2019. Both Nephrology patients were cancelled on the day due to an urgent transplant patient. Unfortunately due to other Urgent and Transplant patients taking priority, these patients were unable to be rebooked within 28 days; these patients have now been treated.

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





Diagnostic Waiting Times

The Trust did not achieve the 1.00% target for diagnostic performance in June 2019 with actual performance at 6.84%. This is a decline in performance from the May 2019 position, and did not achieve the trajectory of 6.00% for June 2019. This is the first time this year that the trajectory has not been delivered.

Six test types have reported in month underperformance: Urodynamics; Computed Tomography (CT); Flexi-Sigmoidoscopy; Colonoscopy; Gastroscopy; and Cystoscopy.

Urodynamics has reported an improved position in June at 37.17% from 44.33% in May. There were 100 patients waiting more than 6 weeks in month. Outsourcing of activity has been agreed with six lists arranged with an alternative provider. The first three of these lists are being delivered in July with a further three lists planned for August. This will allow rapid backlog clearance. Any residual backlog following delivery of these lists will be reviewed for September and outsourced if required. The recurrent capacity within the service should then be back in balance with demand.

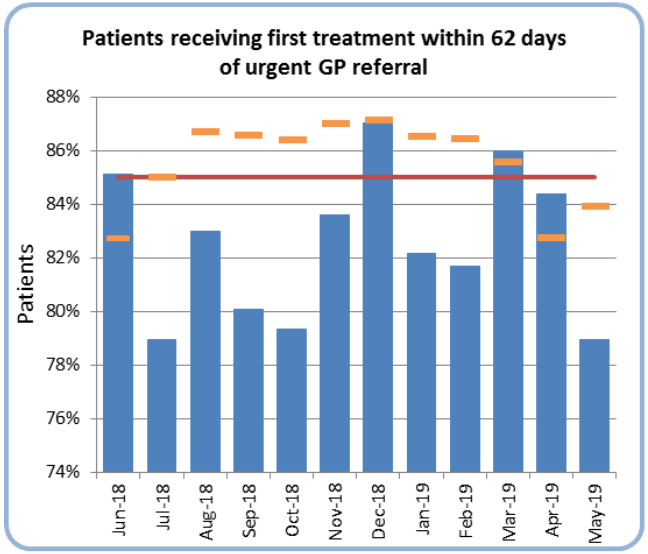
Flexi-Sigmoidoscopy test position reports another decline in performance at 36.75% in June from 33.54% in May with 122 patients breaching the 6 week waiting time standard against a total wait list size of 332. The Colonoscopy position deteriorated further in June with performance at 34.04% from 26.13%, with 176 patients waiting over six weeks against a total wait list of 517. Gastroscopy have reported a declined position of 26.35% in June from 21.52% in May, with 146 patients waiting over six weeks.

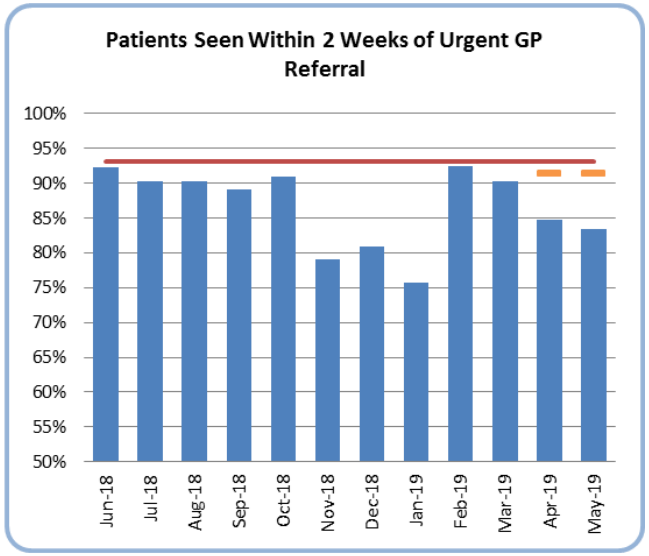
Contracts for insourcing of Endoscopy activity have been agreed and the Contract for outsourcing has been progressed. The work with Commissioners on demand management across the system has commenced this month. The recovery trajectory for these tests is being reset to take account of the impact of this increased capacity.

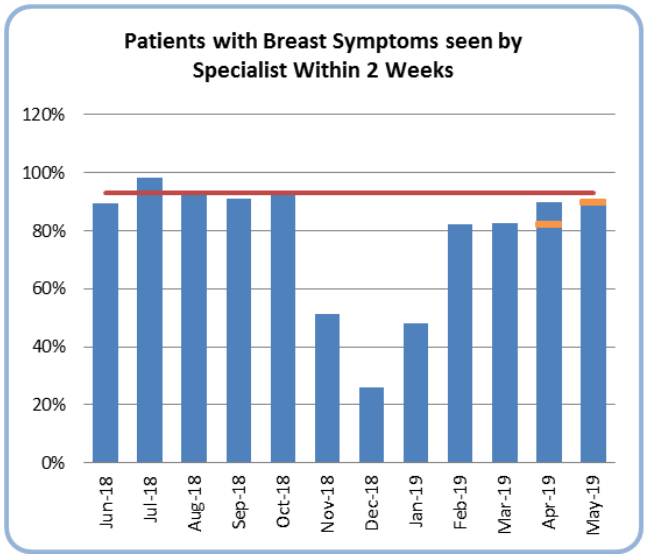
Cystoscopy test position has again breached the national target in June with an almost static performance of 4.79% from 4.82% in May. As at June, there were still 16 patients waiting more than six weeks for a Cystoscopy against a total wait list of 334.

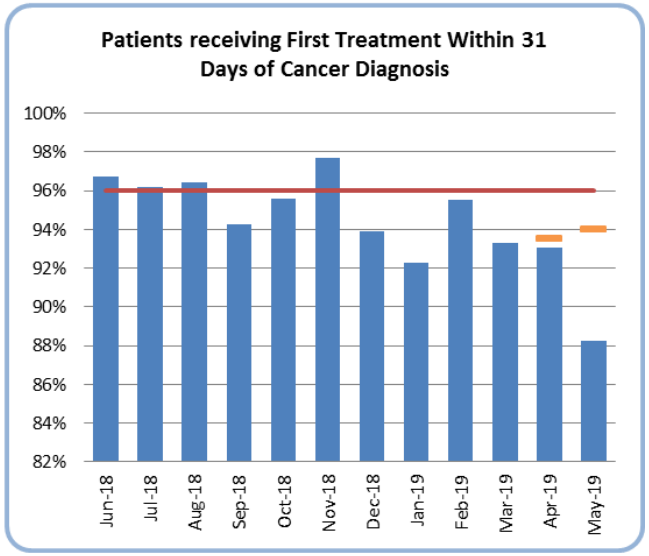
CT has again breached the national target in June with performance of 7.22% from 3.44% in May. There are 155 patients waiting more than six weeks against a total wait list of 2146. Despite running additional weekend lists the Trust is experiencing higher levels of breaches in CT as a result of staffing issues. The Trust will need to reduce outpatient CT capacity in the short term to ensure adequate cover for the 24/7 Emergency CT rota. This will continue to have an adverse impact on the DM01 position. The Imaging Team is seeking to mitigate the current staffing shortages through the appointment of locums.

All other test types have reported patient diagnostic waiting times within the six week standard.









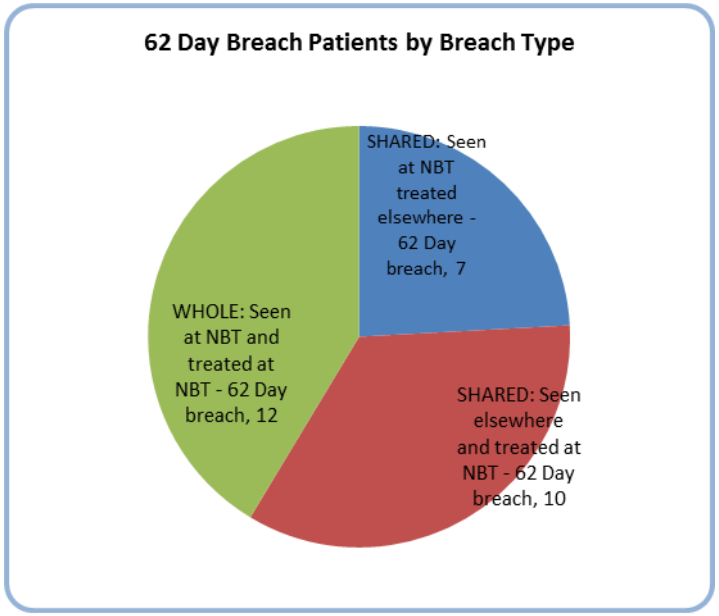
Cancer

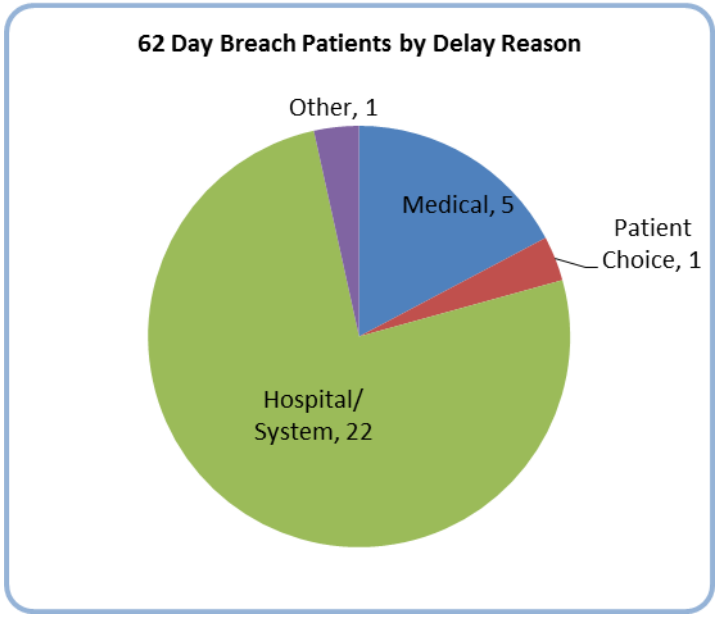
The nationally reported cancer position for May 2019 shows the Trust achieved two of the seven cancer waiting times standards. The Trust failed the TWW standard with performance of 83.4% which is a worsened position from April. The Trust saw 2049 TWW referrals in May and there were 340 breaches; the majority were in Skin (breaches-104, referrals-566), Colorectal (breaches–107, referrals-362) and Breast(breaches–41, referrals-450).

Of the 340 breaches, 196 patients declined or cancelled the appointments offered within target. If these were attended then performance would have been 92.73%. The Trust is undertaking a joint investigation and action plan with the CCG to address ongoing performance issues against this standard.

Capacity issues within Endoscopy and Radiology caused significant performance issues within straight to test pathways for Colorectal, Upper GI and Lung. The Trust is forecasting ongoing issues with capacity for Skin through out the summer and the speciality is currently trying to address these issues.

The Trust failed the 31 day first treatment standard with a performance of 88.2% against the 96% target. There were 28 breaches in total; 22 in Urology, two in Breast, two in Colorectal, one in Sarcoma and one in Skin. Urology breaches were due to delays to robotic surgery, due to a continued increase of patients requiring these procedures as first and subsequent treatments which will be resolved when the second robot is fully operational and the backlog cleared. The Skin breach was a medically appropriate delay and all other breaches were due to capacity for surgery.





The national submission for the 62 day standard in May indicates the Trust failed the 62 day treatment standard with a performance of 78.91%. There has been acknowledgement from NHS Digital that the new national reporting system implemented in April 2019 is not calculating performance correctly and the Trusts internal monitoring shows that 62 day performance was actually 81.22%. This would still be a fail against the 85% standard but a significant difference to the nationally reported position. The Trust has escalated this issue to the CCG and NHSE through the Access and Performance Group.

In May, 31 patients breached the 62-day standard, 21 of which started their pathway at NBT. Of these 21 patients, 20 had their first appointment at NBT after day seven.

Urology breaches accounted for 71% of total Trust breaches for May. Capacity issues in radiology, biopsy, joint oncology clinics and robotic theatres continue to limit the ability to meet the 62 day standard for Urology. Radiology capacity for prostate patients was increased in June which should enable all patients to receive their MRI on the day of first appointment. Reporting of these scans within adequate timeframes will remain an issue

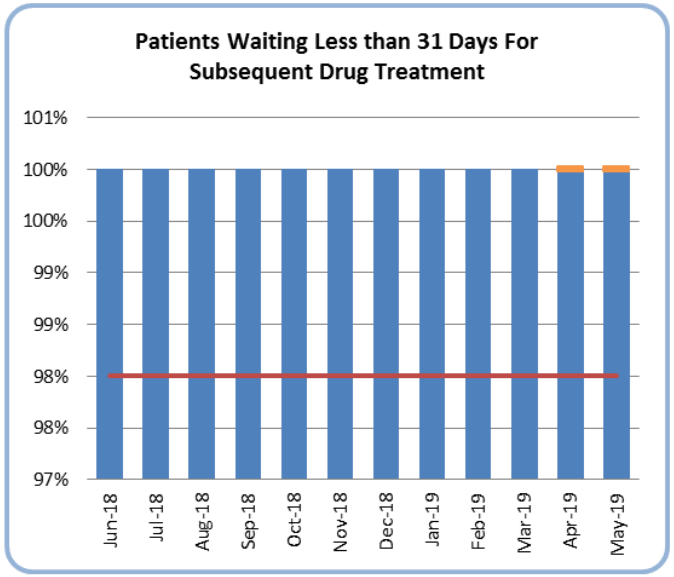
The continued delays for Oncology outpatient appointments and robotic surgery capacity will continue to impact performance for the foreseeable future. The Trust continues to address delays for Oncology capacity with University Hospitals Bristol and a draft SLA for Oncology provision requirements has been submitted to UHB.

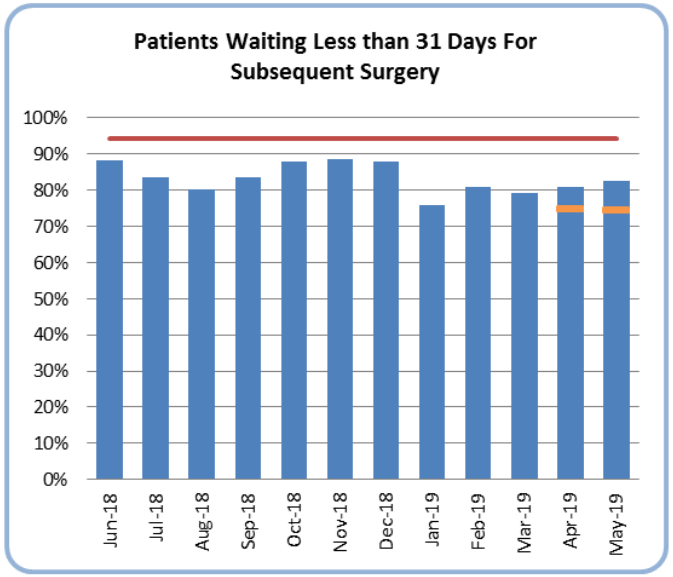
The Urology RAP and recovery trajectory is now predicting recovery of the standard in December/January. This is due to the ongoing recruitment of additional pelvic oncology surgeons and the existing backlog of patients requiring robotic surgery that will require clearing.

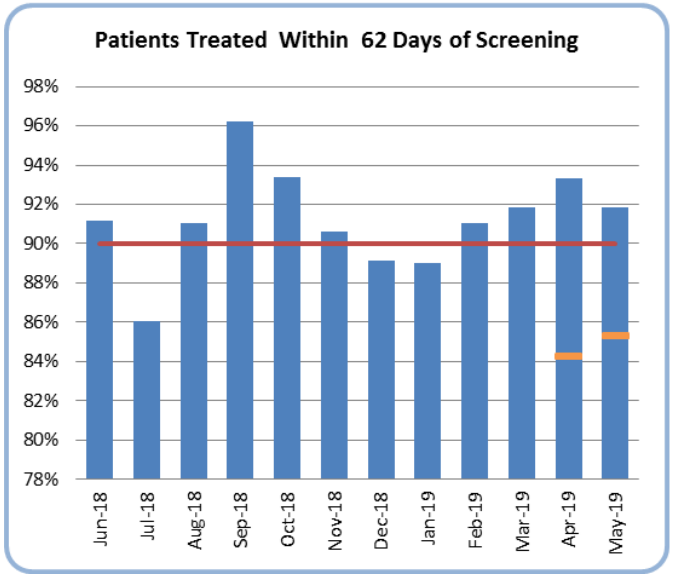
The continued increase of late tertiary transfer patients from elsewhere in the region and the clearing of the associated backlog has continued to impact on Urology performance. Of the 22 Urology breaches, 10 were transferred in from other providers for treatment, nine of which were beyond the agreed national transfer date, accounting for 4.5 additional breaches. Nine of these patients had exceeded the 62 day pathway prior to being referred to the Trust.

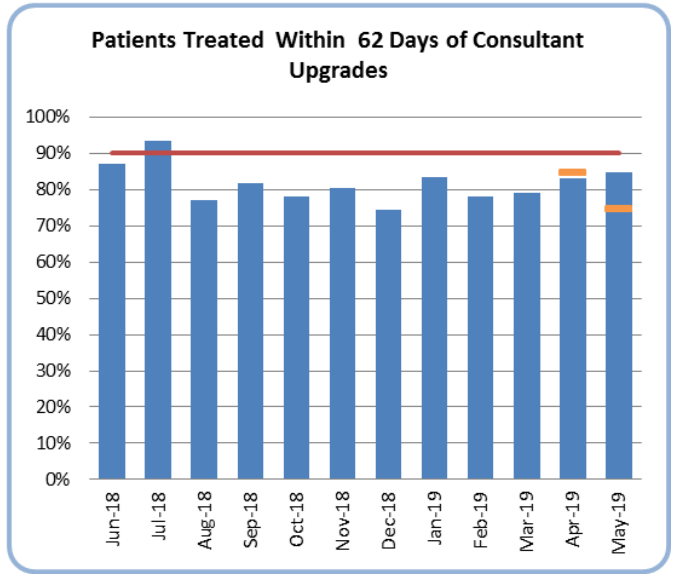
Other breaches recorded in May were; three in Breast (all complex pathways), one in Colorectal (patient delayed treatment), two in Gynaecology (one administrative delay at UHB and one complex pathway), one in Haematology (complex pathway), one in Lung (delays to diagnostics) and one in Upper GI (complex pathway).

As part of performance improvements the Trust has been monitoring it's internal performance against the 62 day standard. The Trust treated 87.6% of all patients who were referred to and treated at NBT within the national standard. This shows the Trust passed the standard for internal patients including Urology.









The Trust failed the 31 day subsequent treatment target in May 2019 for patients requiring surgery with a performance of 82.5% against the 94% standard. This is an improved position from April and has achieved the trajectory for May.

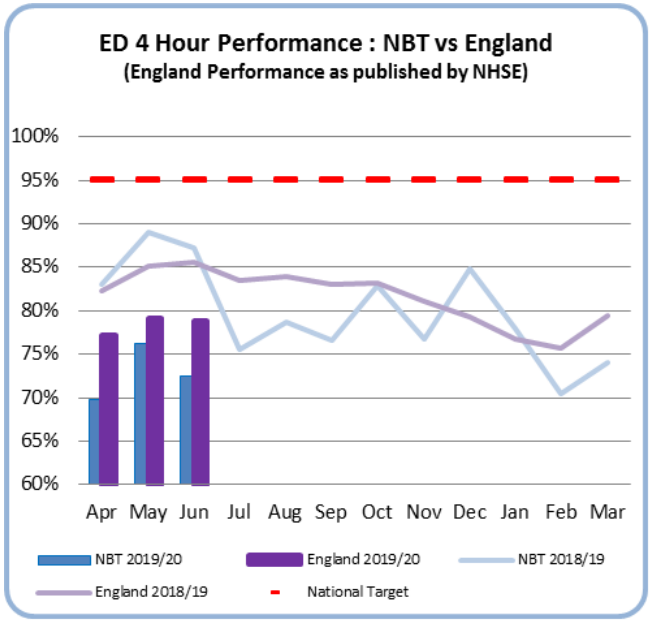
The continued failure against this standard has resulted in a contract performance notice being issued by the CCG. The Trust has submitted an action plan to recover this position, with significant improvements now forecasted from December 2019.

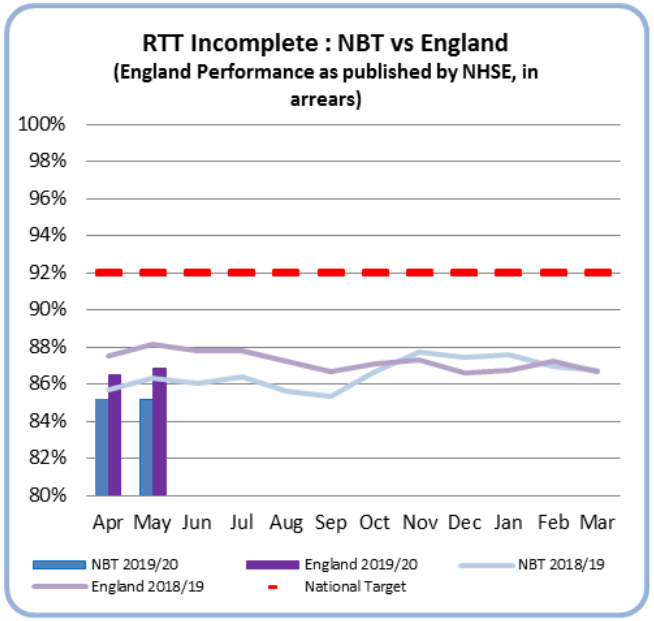
There were 17 breaches in total; three of which were in Skin and 14 in Urology. Performance against this standard will improve once the second robot and associated staffing is fully operational and the significant backlog is cleared. The new theatre schedule was implemented the beginning of April the Skin performance against this standard has improved as forecasted.

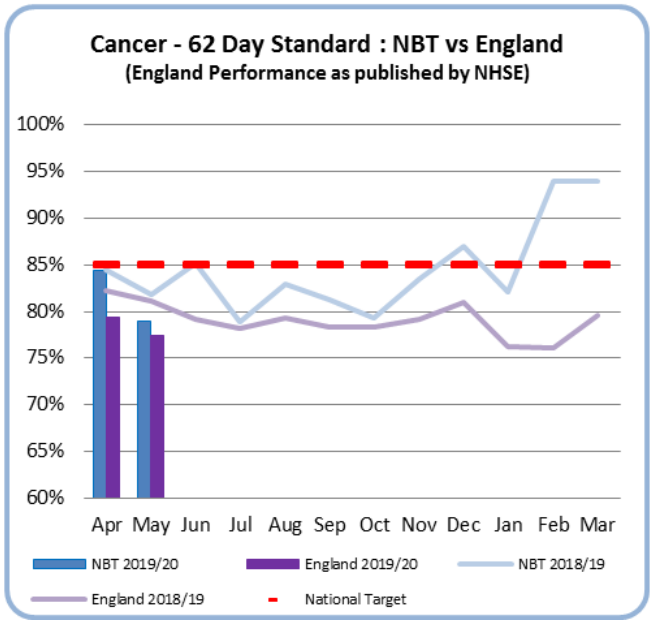
The Trust achieved the 31 day subsequent standard for patients receiving anti cancer drugs with a performance of 100%.

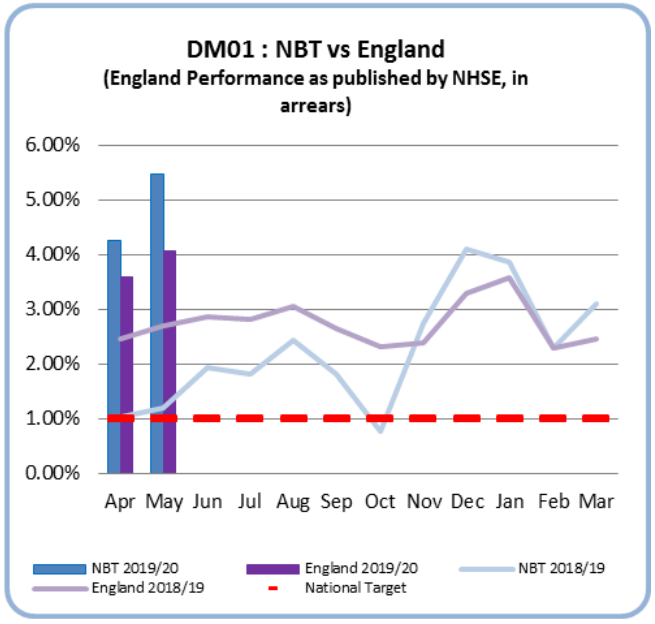
The Trust achieved the 62 day screening target with a performance of 91.8% against the target of 90%.

There were two breaches in Breast. Two were due to patient choice delay within the pathways and one due to a complex pathway requiring multiple diagnostics. There was one breach in Colorectal due to patient delaying their pathway.







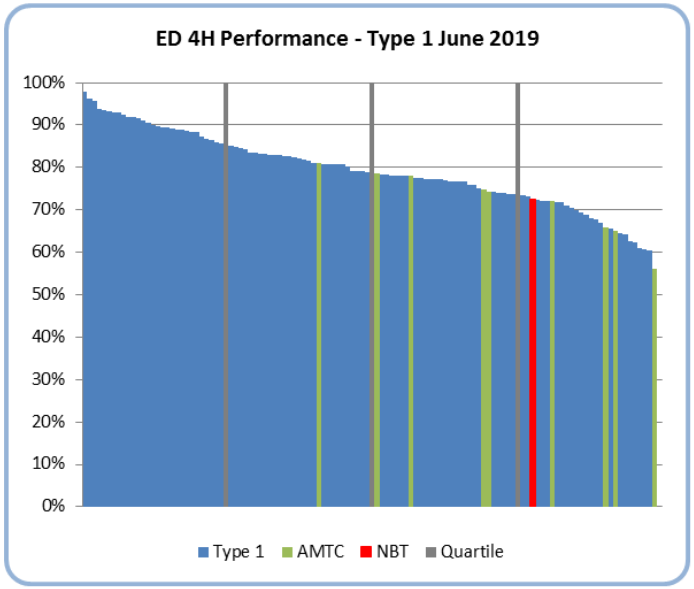


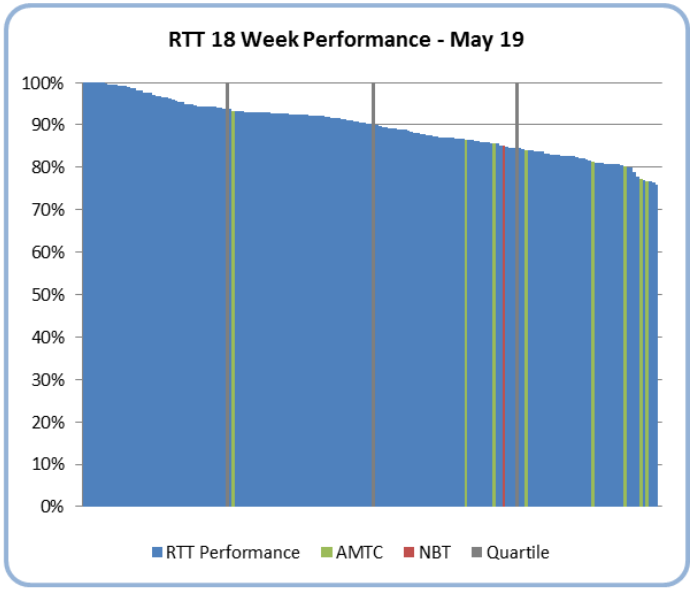
ED 4 Hour Performance
NBT ED performance in June 2019 is 72.53% compared to a national Type 1 position of 78.80%. The position reflects an decline from May and a deterioration when compared to the same period last year.

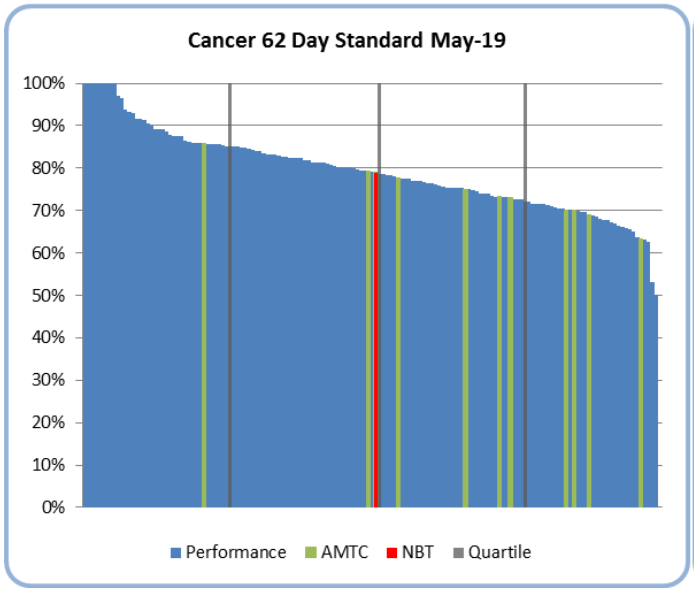
RTT Incomplete
The Trust reported an May 2019 position of 85.14%. This position reflects an decline on last year but falls under the national position of 86.86%.

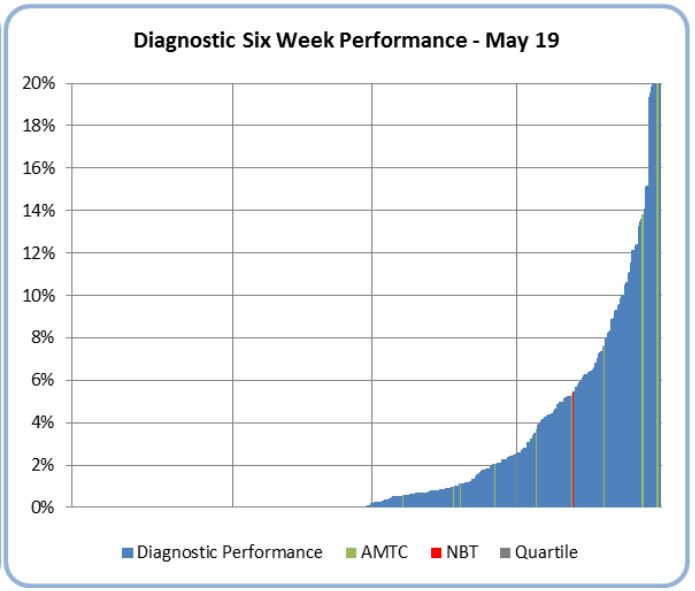
Cancer – 62 Day Standard
NBT has reported 78.95% performance for May and continues to outperform the national position of 77.45%.

DM01
NBT, in May 2019, failed to achieve the National standard of 1% with a performance position of 5.48%, against the national position of 4.08%.









ED 4 Hour Performance
In June, NBT moved from a position of #75 to #93 out of 119 reporting Type 1 Trusts. This decline has moved the Trust back into the 4th quartile. The Trusts ranking among the 10 Trauma centres declined from 3rd to 6th in June 2019.

RTT Incomplete
RTT performance in May 2019 reports a deteriorated NBT position of #126 out of 177 reported positions. The Trust now ranks 5th out of 11 other adult major trauma centres.

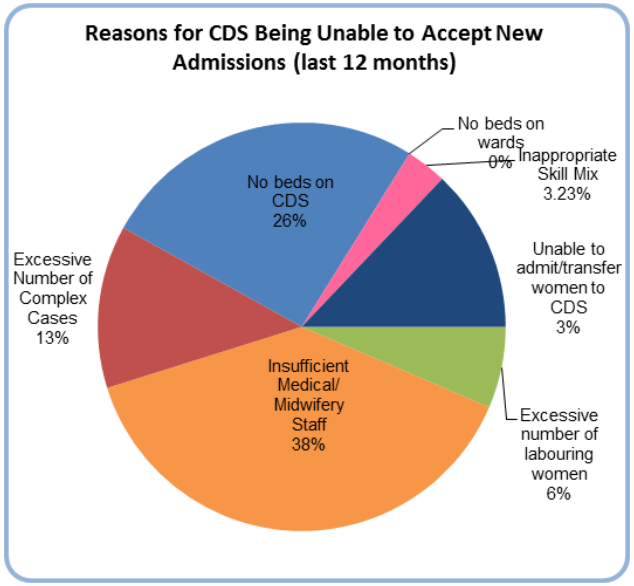
Cancer – 62 Day Standard
At position #66 of 138 reported positions, NBT reports performance of 78.95%. This represents a deterioration in positioning from April 2019 and ranks 3rd out of 11 major trauma centres.

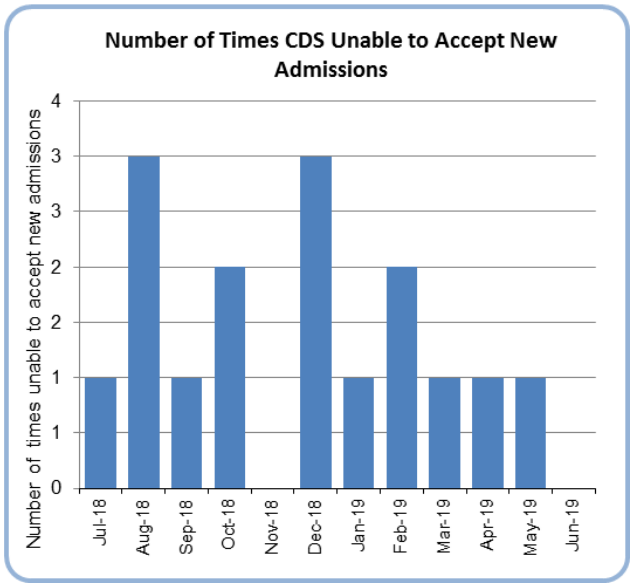
DM01
NBT reports a deteriorated position of #142 out of 204 reported diagnostic positions, with a performance of 5.48% in May. This position ranks 8th out of 11 adult major trauma centres.

Safety and Effectiveness

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

Birth		Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19
Total Births		511	534	543	515	535	497	491	478	458	448	439	490	454
Midwife to birth ratio		01:30	01:30	01:33	01:33	01:33	01:30	01:31	01:30	01:30	01:28	01:27	01:30	01:28
Normal birth rate		56.0%	56.1%	56.4%	60.1%	51.8%	53.1%	51.1%	56.0%	51.1%	55.7%	53.7%	56.3%	56.1%
Caesarean birth rate		29.1%	28.5%	31.2%	27.3%	34.1%	32.1%	34.4%	32.1%	37.9%	32.0%	35.0%	30.8%	30.4%
Emergency caesarean birth rate		18.0%	17.3%	17.1%	14.6%	18.7%	19.2%	19.1%	18.0%	23.0%	17.7%	22.4%	19.30%	21.2%
Induction of labour rate		34.1%	35.0%	33.1%	35.7%	34.7%	34.9%	33.4%	34.0%	37.7%	38.3%	41.5%	36.10%	43.0%
Total births in midwife led environment		17.8%	19.9%	19.3%	18.8%	13.4%	14.3%	7.9%	14.9%	12.0%	14.5%	15.3%	17.90%	14.1%
Birth location	Cossham BC	5.7%	6.1%	6.4%	2.8%	0.2%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0%	0.0%
	Mendip BC	11.5%	12.9%	12.1%	14.3%	12.1%	12.9%	6.7%	12.6%	10.7%	13.4%	12.8%	16.6%	12.8%
	Home	0.6%	0.9%	0.4%	1.4%	3.0%	1.2%	1.2%	2.3%	1.3%	1.1%	2.5%	1.2%	1.3%
	CDS	81.0%	79.2%	80.4%	79.8%	83.7%	84.5%	89.6%	83.7%	86.7%	83.3%	84.0%	80.3%	83.6%
One to one care in labour		96.9%	97.0%	95.7%	95.4%	96.4%	95.4%	95.9%	97.4%	97.7%	96.0%	98.3%	98.3%	100.0%
Stillbirth	Actual	4	0	1	1	2	1	2	2	3	5	2	2	2
	Rate	0.80%	0.00%	0.20%	0.20%	0.40%	0.20%	0.40%	0.41%	0.60%	1.10%	0.2%	0.0%	0.0%





Recruitment

- Recruitment of midwives to fill the new and vacant posts has been underway since October 2018. The total resource required at that point was 23.8 WTE (16.26 WTE new posts and 7.54 WTE vacancies). The forthcoming pipeline is comprised of 19 midwives with start dates over the next three months: two between July and August, followed by 17 midwives in September 2019.
- Interviews for the substantive post of Bereavement Midwife are taking place on 22nd July 2019. This vital post will provide support to women and their families following the introduction of new national bereavement care pathways.
- Interviews for the QI Lead Midwife will take place on 02 August 2019. This is a Band 7 substantive post and will lead on quality improvement programme agenda.
- We are currently recruiting to the post of Lead Sonographer role which is out to national advert.
- We will also be advertising shortly for a Band 7 IT Maternity Lead.

Midwifery Led Services

- A temporary closure of Cossham Birth Centre has been in place since October 2018 due to a shortage of midwives and increasing inductions of labour at Southmead Hospital. The closure will be reviewed by Trust Board on 25 October.
- A review of Midwifery Led Services at NBT from a quality, safety and efficiency perspective is ongoing and has included engagement sessions with staff A progress update will be presented to the Trust Board in July 2019.

CQC Inspection

- The anticipated CQC inspection of Women & Children's Health commenced on 25 June 2019.
- Inspectors visited clinical areas and spoke with staff. Information requests were submitted and meetings with senior Divisional staff took place.
- An out of hours visit to the unit took place on 11 July 2019.
- Feedback is awaited.

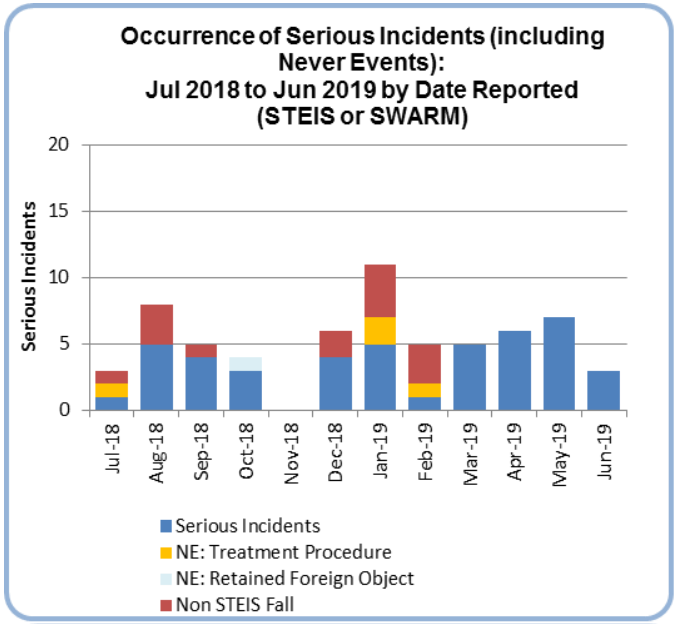
'My Pregnancy @ NBT' smartphone app launched on 04 May 2018 to replace patient information leaflets and give women and families access to evidence based care 'on-the-go' wherever and whenever they choose.

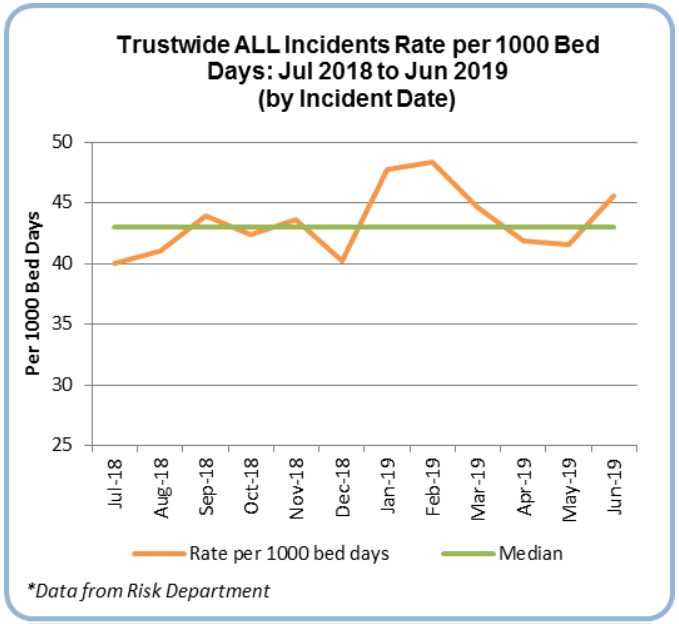
Wave 3 Maternity & Neonatal Health Safety Collaborative (MNHSC)

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

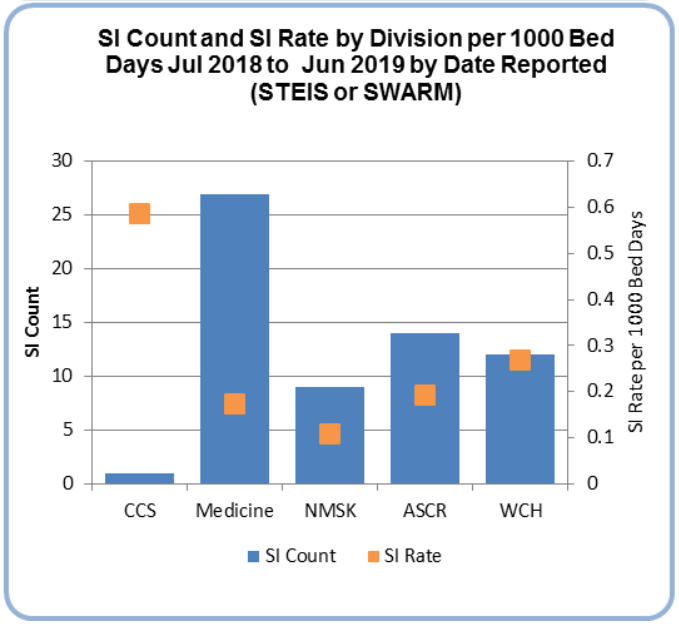
Quality & Patient Safety - Additional Safety Measures

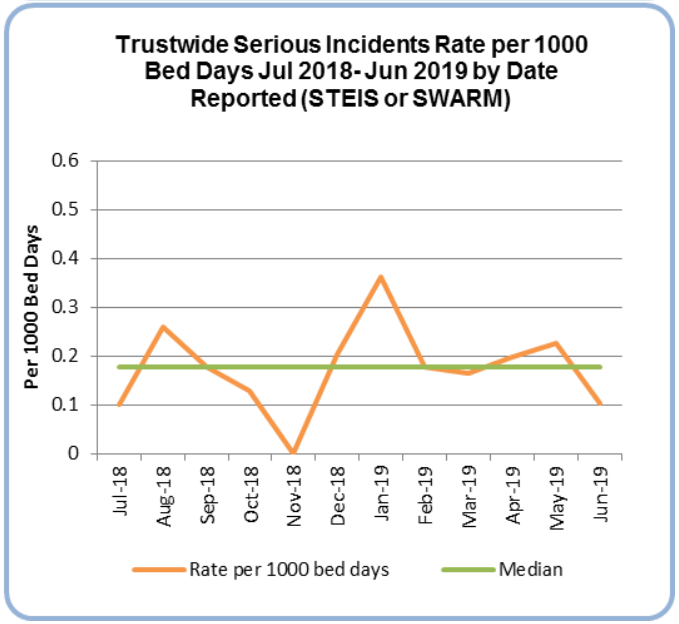
Board Sponsor: Director of Nursing





Data from Risk Department





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

- 1 x Patient Falls*
- 1 x Safeguarding
- 1 x Maternity & Obstetrics

The Board is asked to note that from April 1st onwards NBT will declare on STEIS all "Serious Falls" as Serious Incidents. Therefore, "non-STEIS falls" will no longer be reflected as a separate category. This means that Falls represents our most frequently occurring Serious Incident.

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

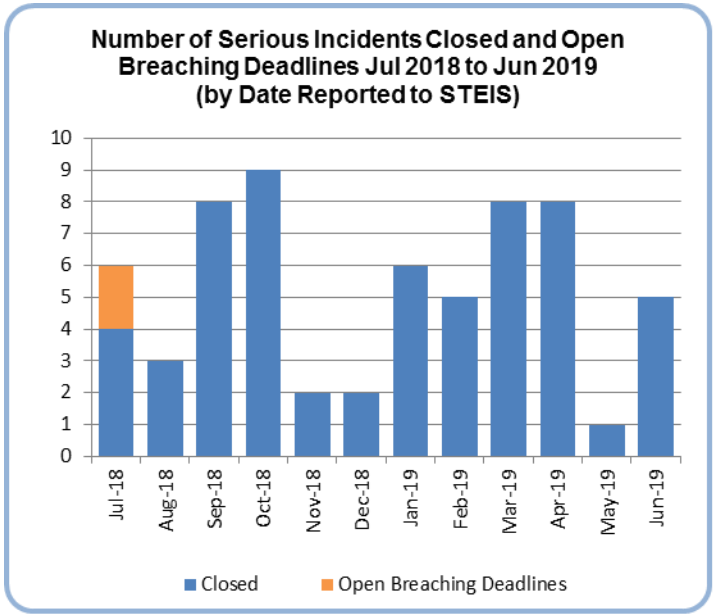
SI & Incident Reporting Rates
Incident reporting has increased slightly in June to 45.6 per 1000 bed days. Whereas NBT's rate of reporting patient safety incidents remains within national parameters, it is noted that we are in the lower quartile of similar NHS Trusts.

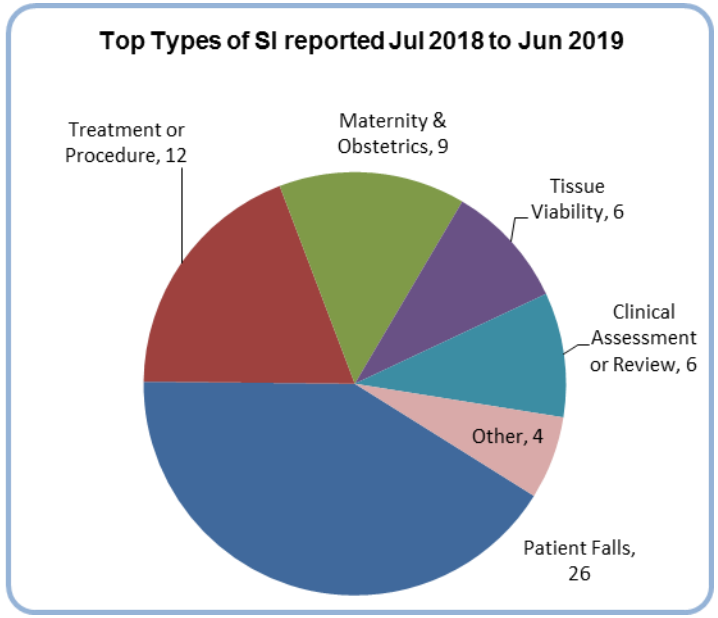
The Patient Safety Incident Improvement Project is focusing on improving our rates of reporting to facilitate learning.

Divisions:
SI Rate by 1000 Bed Days
CCS – 0.58
WCH – 0.27
ASCR – 0.19
Med – 0.17
NMSK – 0.11

Quality & Patient Safety - Additional Safety Measures

Board Sponsor: Director of Nursing





Incident Reporting Deadlines for Serious Incident Investigation submission

No serious incidents breached their June 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, with an update being provided to the next Patient Safety and Clinical Risk Committee (June 2019).

This is followed by Treatment or Procedure Maternity & Obstetrics.

"Other" Category:

1 Appointment
1 Medication
1 Fluid Management
1 Safeguarding

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

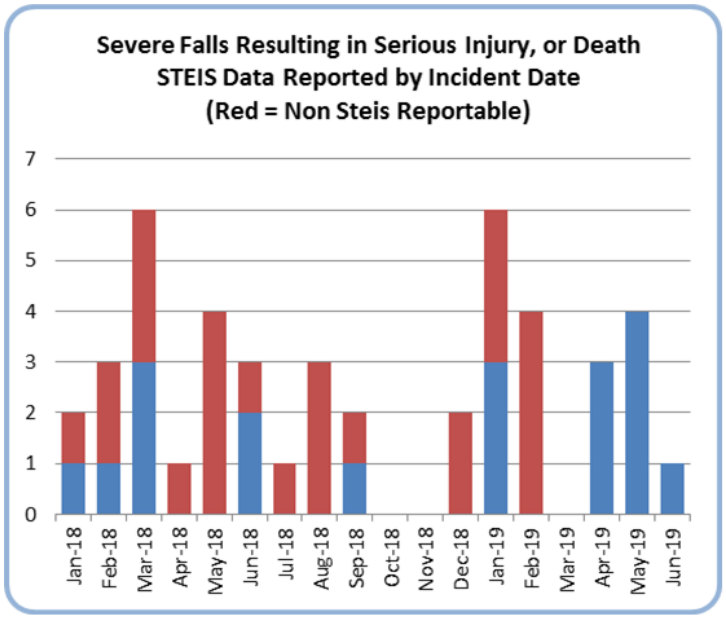
Data Reporting basis

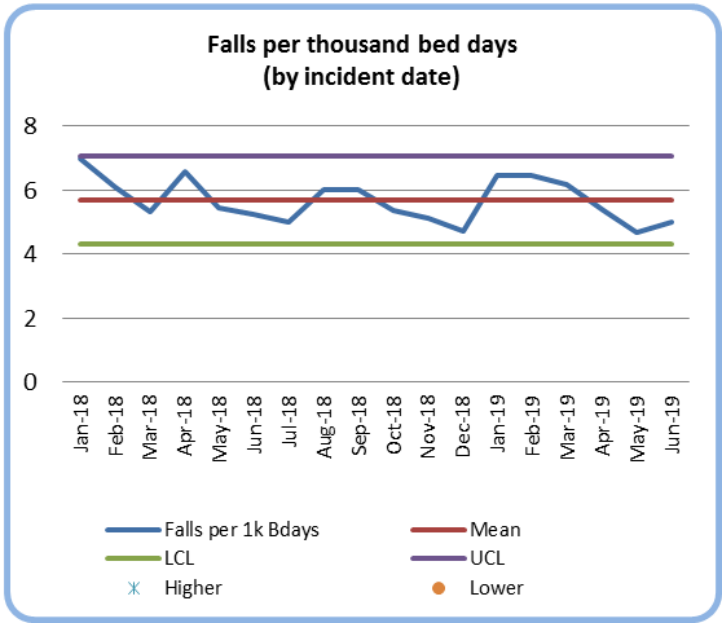
The data is based on the date a serious incident is reported to STEIS. Serious incidents are open to being downgraded if the resulting investigation concludes the incident did not directly harm the patient i.e. Trolley breaches. This may mean changes are seen when compared to data contained within prior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

Central Alerting System (CAS)

4 new alerts reported, with none breaching their alert target dates.

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





Falls

In June 2019, 152 falls were reported of which one resulted in severe harm, five were categorised as moderate, 43 low and the remaining 103 as no-harm.

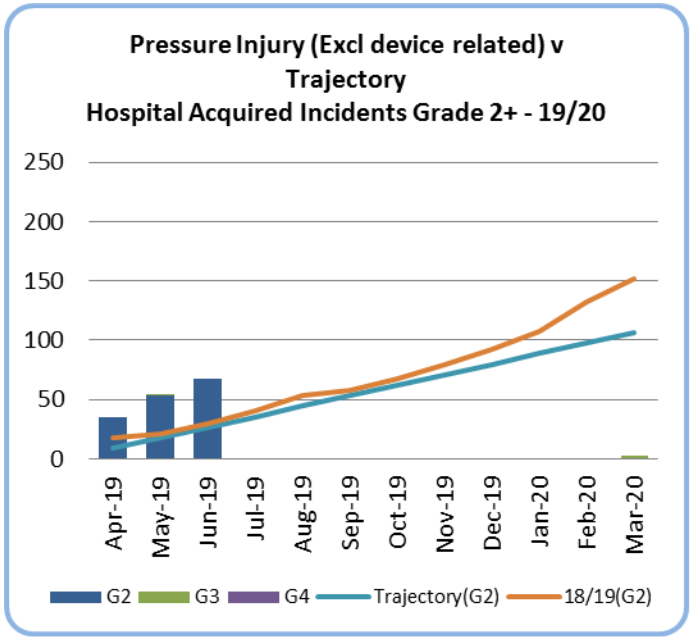
The majority of reported falls occurred within Medicine Division (81), with the others occurring in NMSK (53), ASCR (16), in CCS (3) and Women's and Children (1).

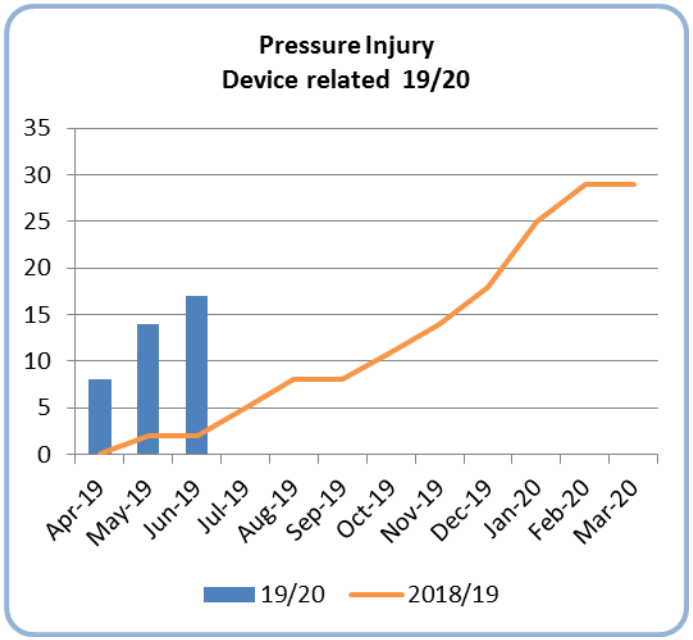
The falls-per-1000 bed days level continues to sit below the considered national average (6.1).

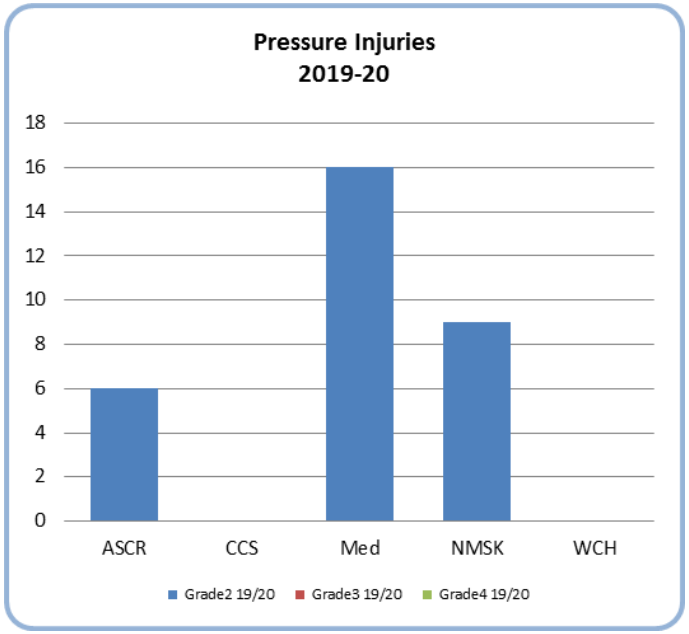
The mandated risk assessment fields are now in place on LORENZO and the data collection process is fully underway for the Falls national CQUIN for 2019/20. This will enable the achievement of the CQUIN standards.

Currently 30 of the 100 patient submissions have been collected for the first quarter. It is anticipated that all 100 will be completed before the submission deadline. The main challenge sits with the completion of lying to standing blood pressure assessments. Additional teaching has been is continuing for the Falls Link Nurses for dissemination across the wards.

The initial submissions show that compliance with the other 2 criteria, recording of sedation medication and mobility assessments, are good.







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 4 and Grade 3 pressure injuries.

No grade 3 or 4 pressure injuries were reported in June 2019.

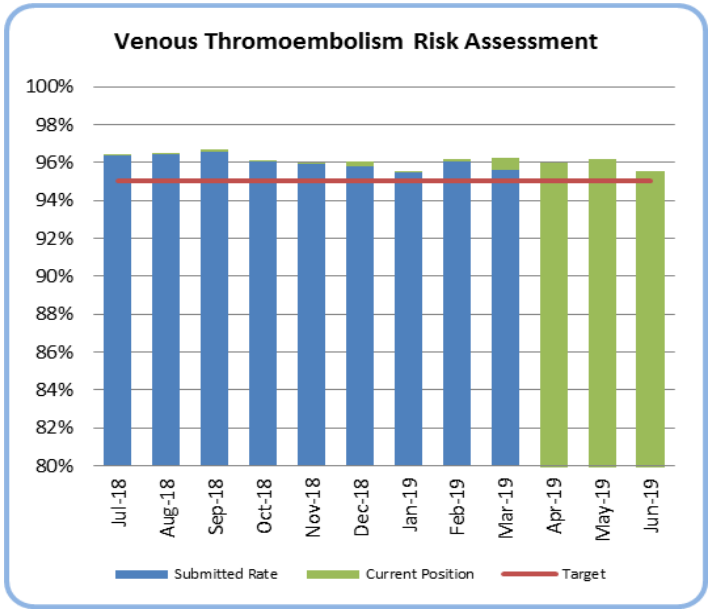
There were 31 reported Grade 2 injuries which occurred to 27 patients.

The break down of injury is as follows: 61% Sacrum/ buttock, 13% Heels, 6% Face and 10% 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:

- Actions to prevent PIs,
- education and training,
- monitoring and audit.

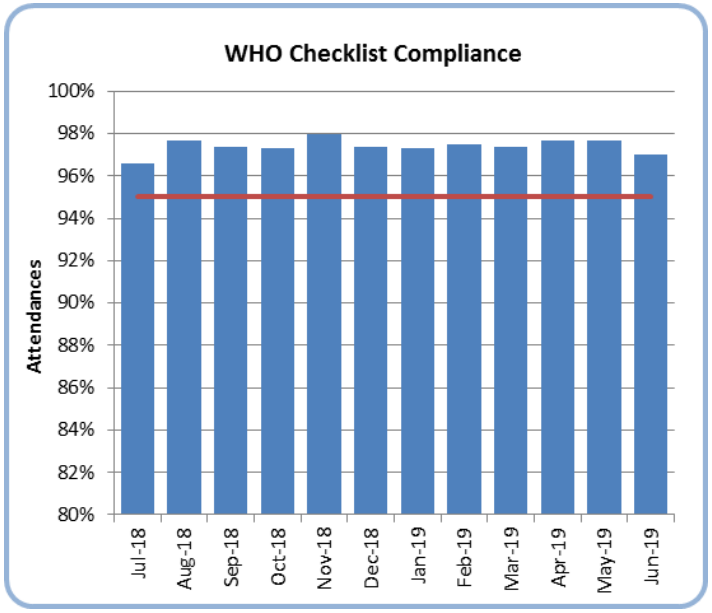
Advice has also been sought from the Tissue Viability team at NHSI to inform our programme of work.

The Board has commissioned a presentation for the July meeting to provide an understanding of the current position and assurance about the improvement actions being taken.



VTE Risk Assessment

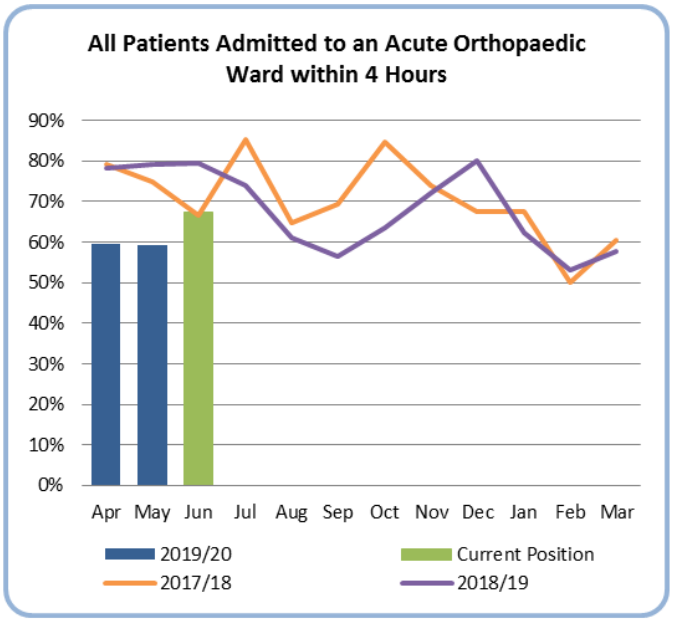
The Board expects a VTE risk assessment to be carried out for all appropriate in-patients. Where certain procedures are considered to be of low risk, the assessments may be agreed as a patient cohort. Cohorts are signed off by the Medical Director. The Trust continues to meet the national standard of 95% of patients have a documented risk assessment in their records at the point of coding the discharge.

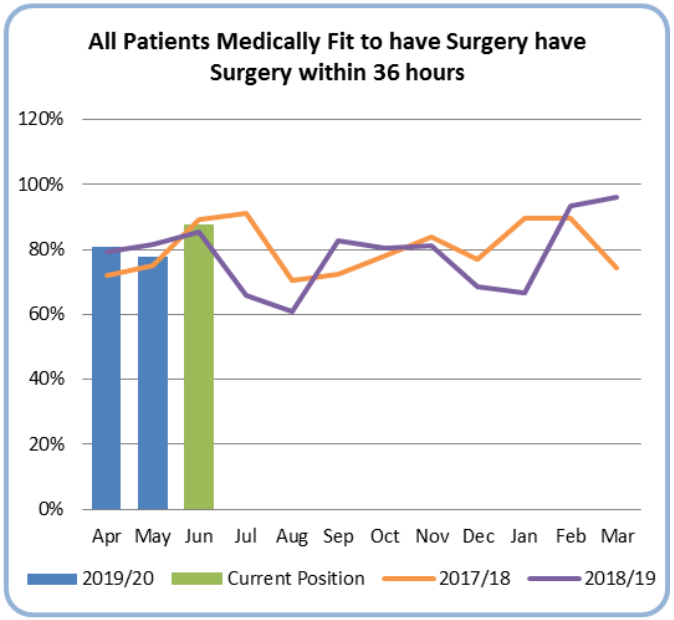


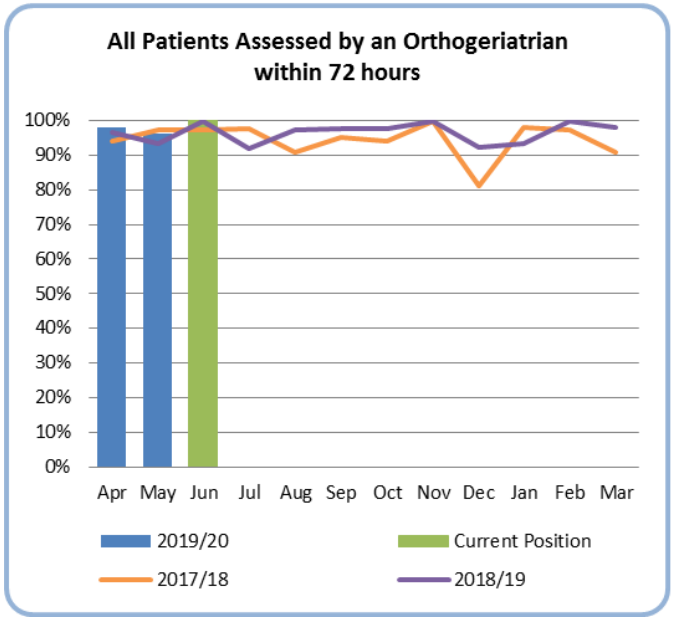
WHO Checklist Compliance

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

Measured compliance with the WHO checklist was 97.0% in June 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.





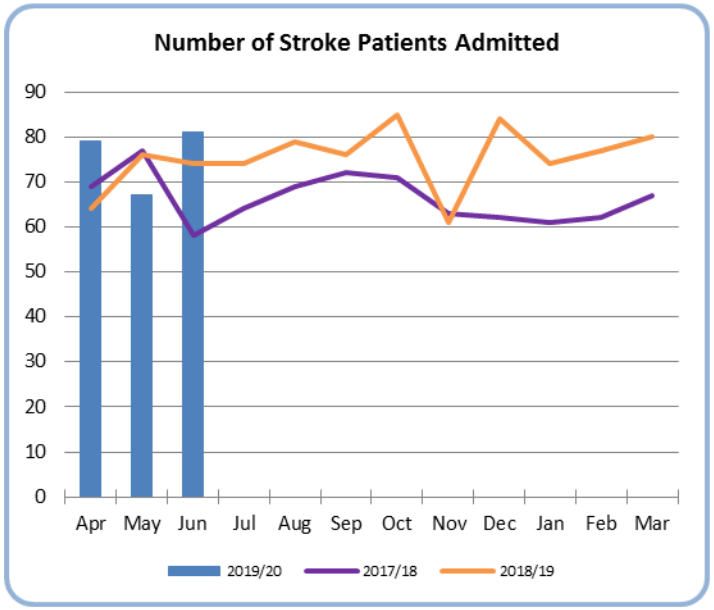


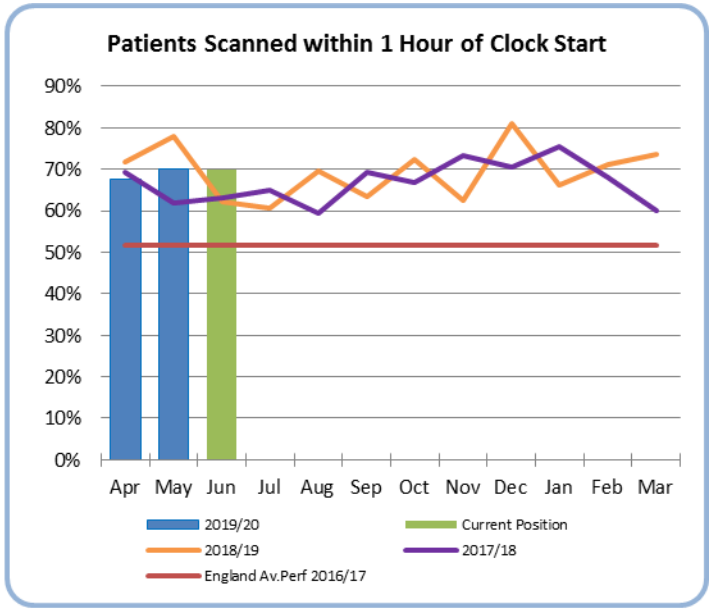
Fractured Neck of Femur in Patients aged 60 years and over
Patients admitted to an acute orthopaedic ward within four hours.
Hip Fracture data is reported one month in arrears with current month included for reference.

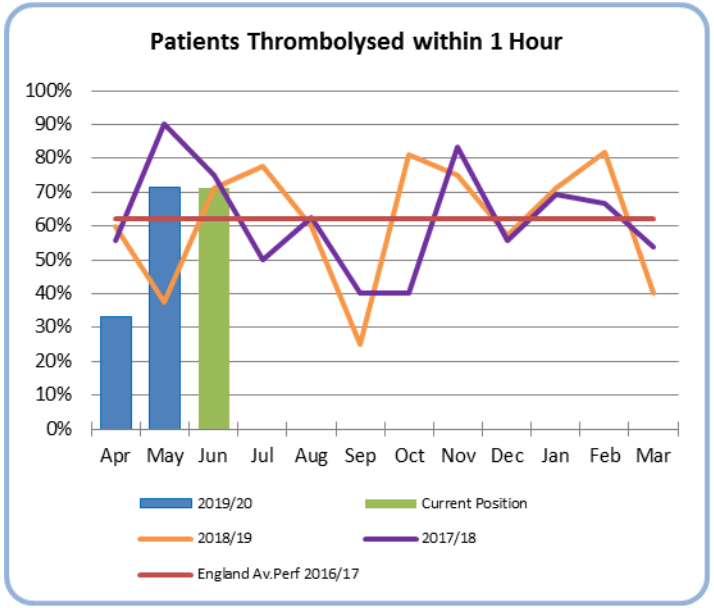
In May 2019 the percentage of patients who were admitted to Hip Fracture unit within 4 hours was 59.3% against an England average of 41.4%.

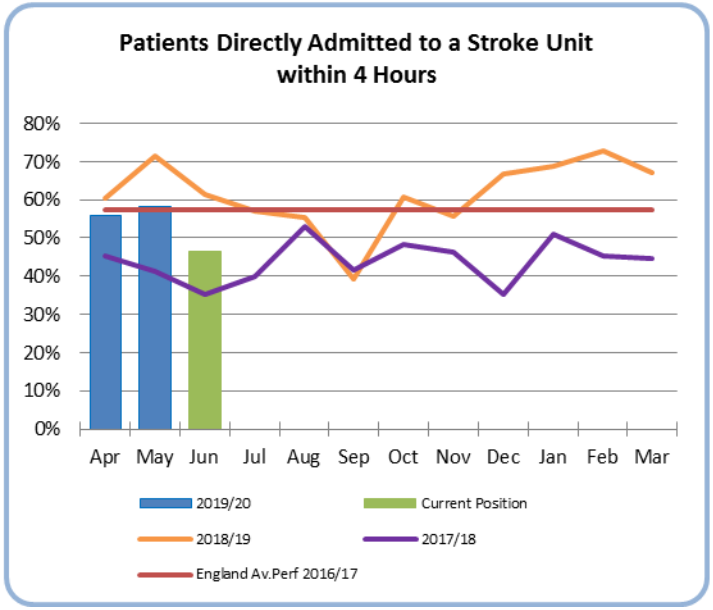
Patients medically fit to have surgery have surgery within 36 hours.
In May 77.8% of patients received surgery within 36 hours compared to the England average of 71.8%. North Bristol NHS Trust is investing in additional trauma co-ordinators with a view to further improving this.

Patients assessed by an Orthogeriatrician within 72 hours.
In May 2019, 96.3% of patients were seen by an Orthogeriatrician within 72 hours.









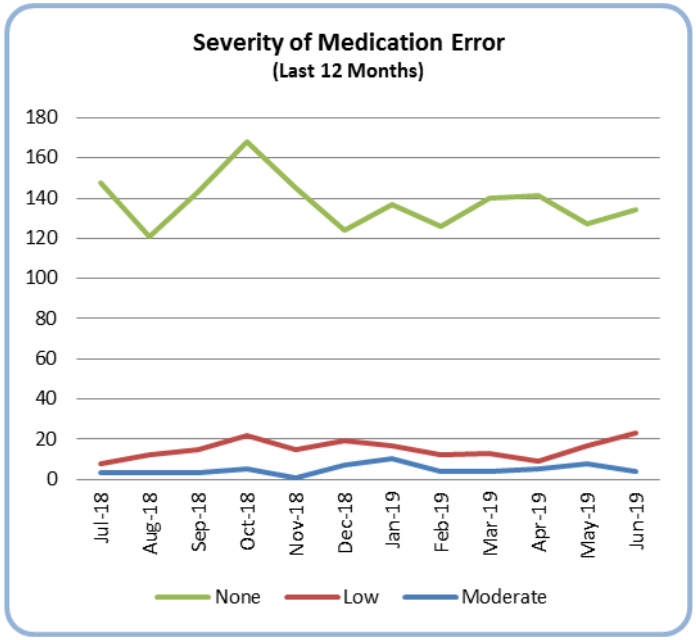
Stroke
Stroke data is reported one month in arrears with current month included for reference.

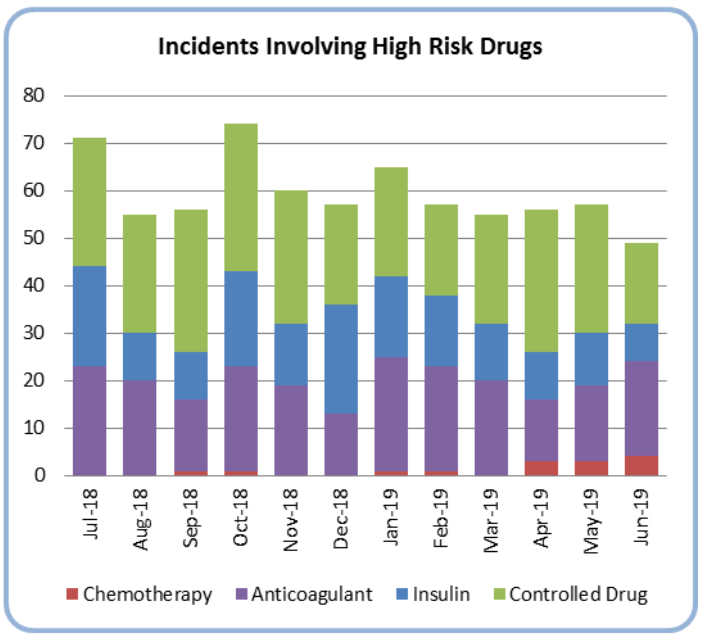
67 patients were admitted to Southmead hospital with stroke in May 2019.

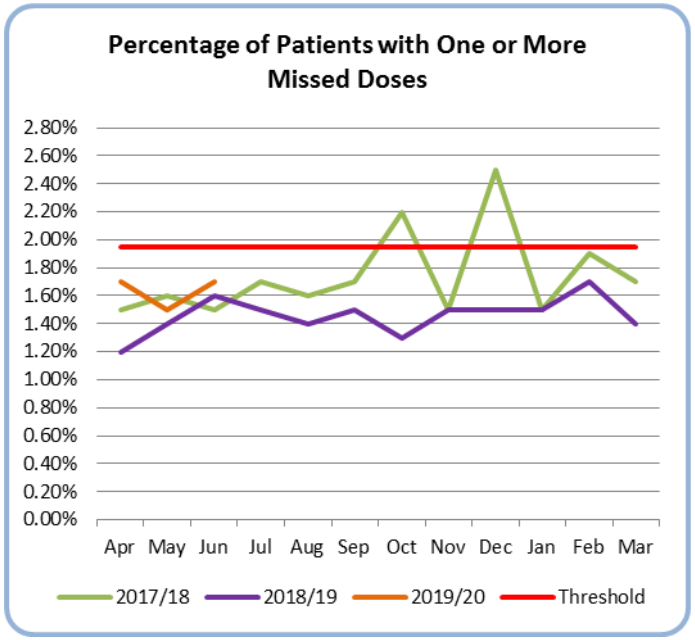
71.4% of stroke patients requiring thrombolysis received this within 1 hour which is sustained performance better than the England average but continues to be a focus in the stroke team.

Admission to a stroke unit within 4 hours of presentation remains a challenge with performance at 58.2% in May 2019. The main problem is the overall bed occupancy and 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 70% In May 2019.

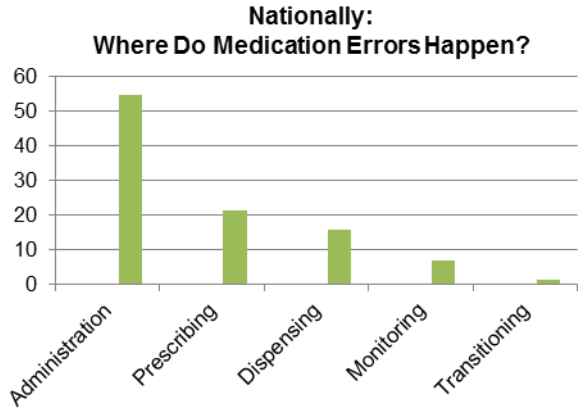






Medication Safety.
Be One of the Safest Trusts in the UK

Reducing medicines-related harm requires a clear understanding of where and when errors occur. Nationally 237.4 million medication errors occur every year in England and 28% have the potential to cause harm.



Medicines Management

Severity of Medication Error

During June 2019, the number of "No harm" medication errors represented c.83% of all medication errors demonstrating a strong reporting culture.

The Medicines Governance Group is investigating a small rise in 'low harm' incidents to determine what actions are required.

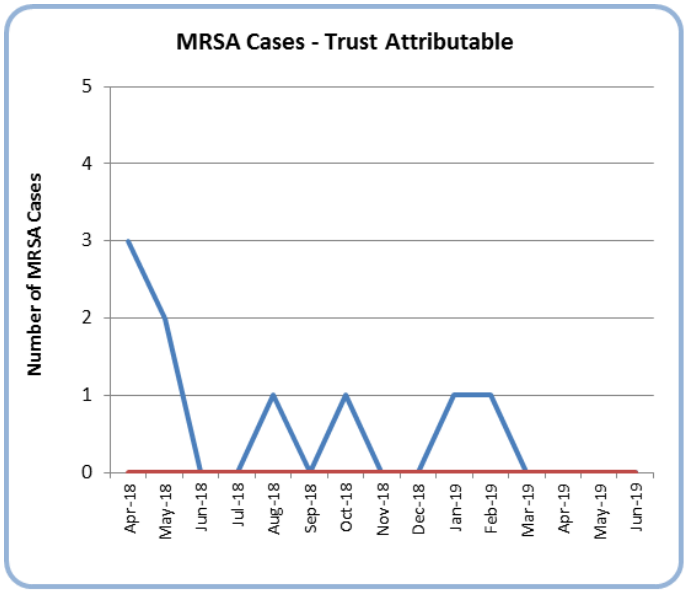
High Risk Drugs

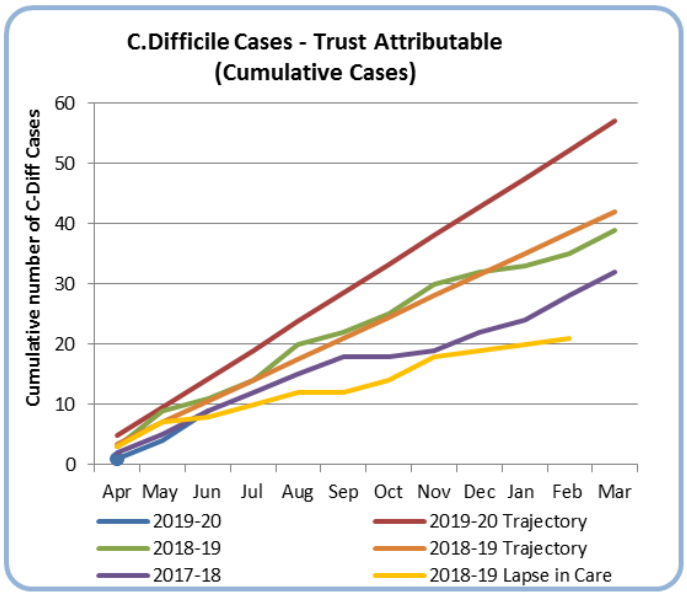
High Risk Drugs formed c.27% of all medication incidents reported during June 2019. All incidents relating to high risk drugs are closely monitored by the Medicines Governance team.

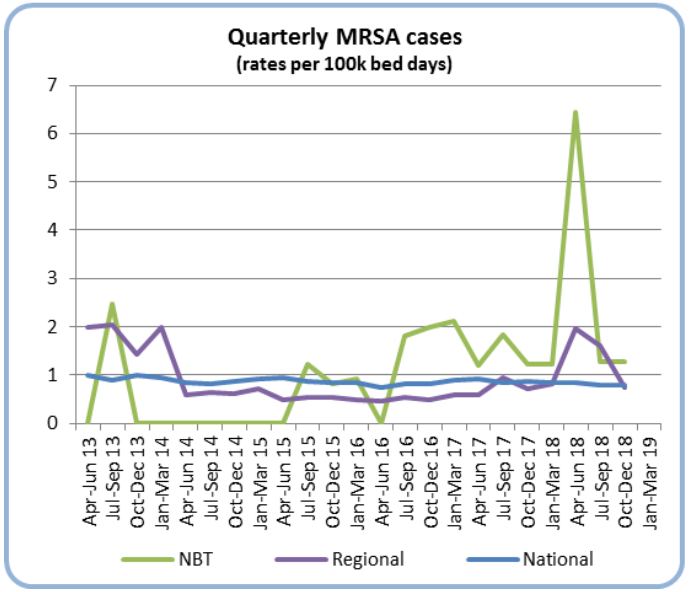
Missed Doses

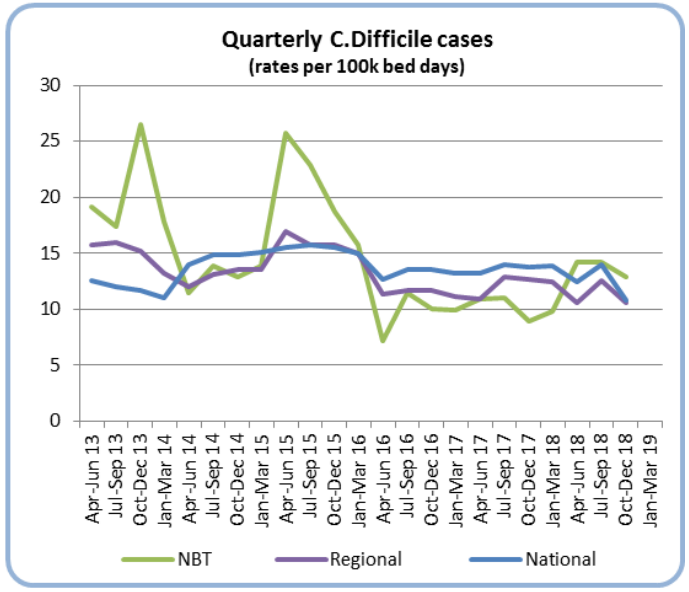
The clinical pharmacy team continues to closely monitor the KPI's associated with all missed doses. Any ward(s) that breach the missed dose target of <1.95% on two consecutive months undertake an intensive 2-week "missed dose audit".

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 June 2019.

In June an increased incidence of MRSA colonisation was reported within the Neonatal Intensive Care Unit. An Incident Meeting was held, which established evidence of cross infection. There have been no new cases reported since 23 June 2019, with all colonised babies have been discharged.

C. Difficile

NHS Improvement have changed the measurement methodology for C. diff resulting in a new 19/20 target total of 57 cases.

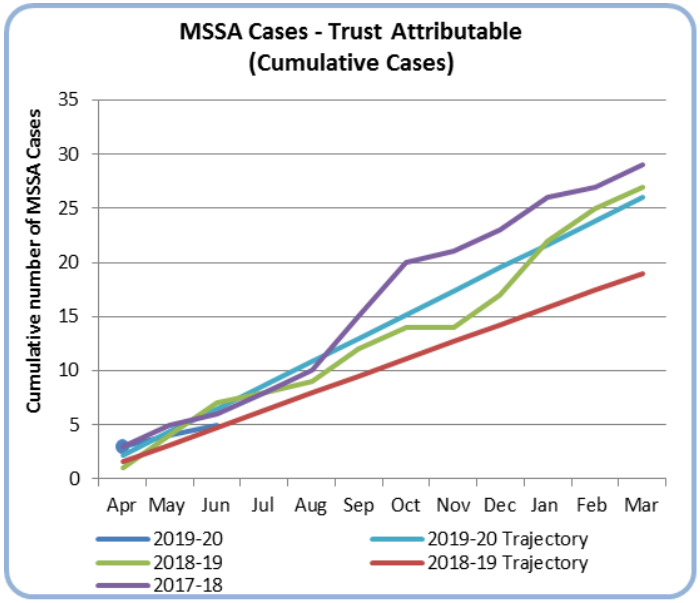
In June there were six cases reported against the trajectory. Five cases were hospital onset and one case was community onset.

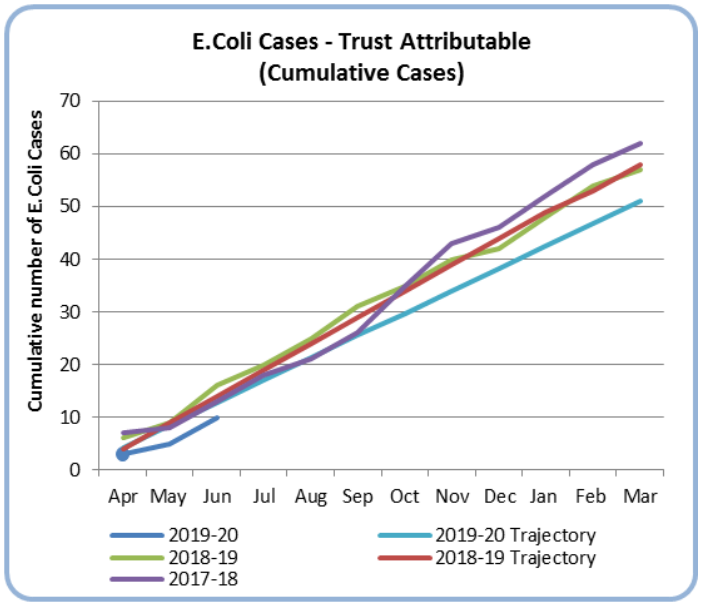
Clinical reviews will be carried out using a multi-disciplinary approach to determine whether there are links to any lapses in care.

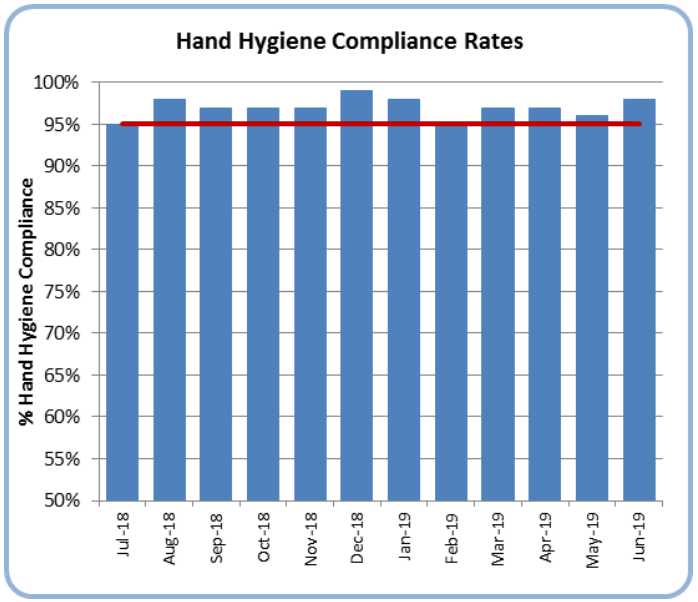
MSSA

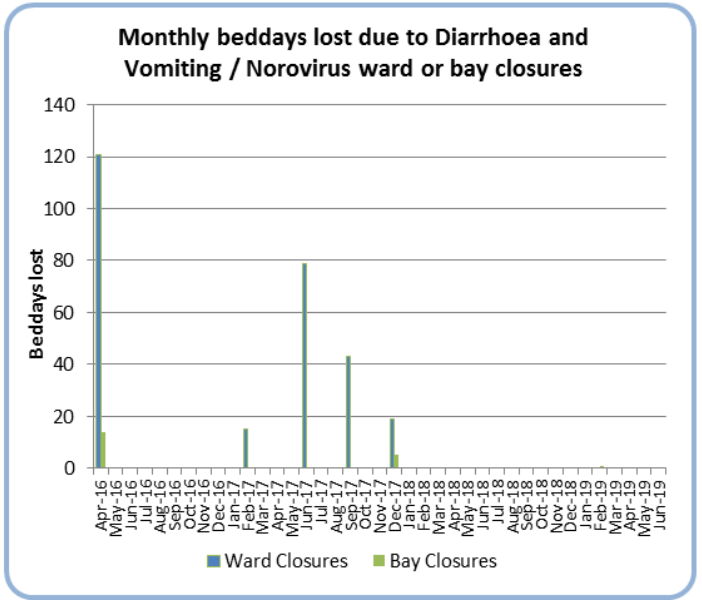
The Trust target for 2019/20 is fewer than 26 cases.

There was one reported case of MSSA bacteraemia in June within the Medical division. A Trust quality improvement initiative continues, aiming to reduce incidence of bacteraemia associated with indwelling devices.









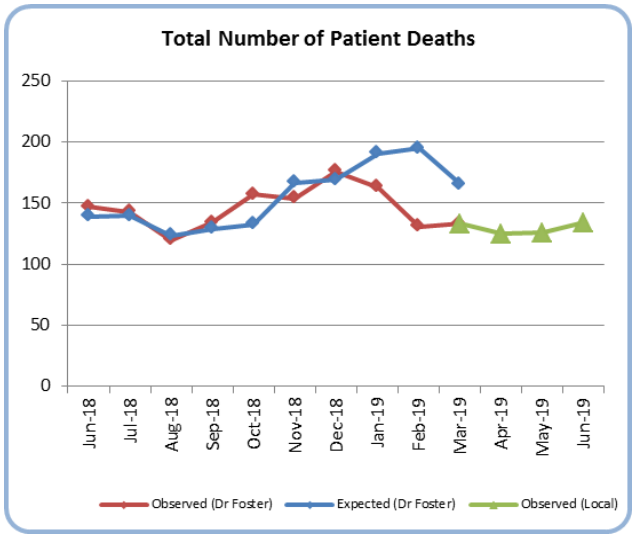
E. Coli.
The Trust target for 2019/20 is 51 bacteraemias representing a 10% reduction on the previous year. There were five cases of E. Coli bacteraemia reported in June. The focus for improvement is on the management of urinary catheters.

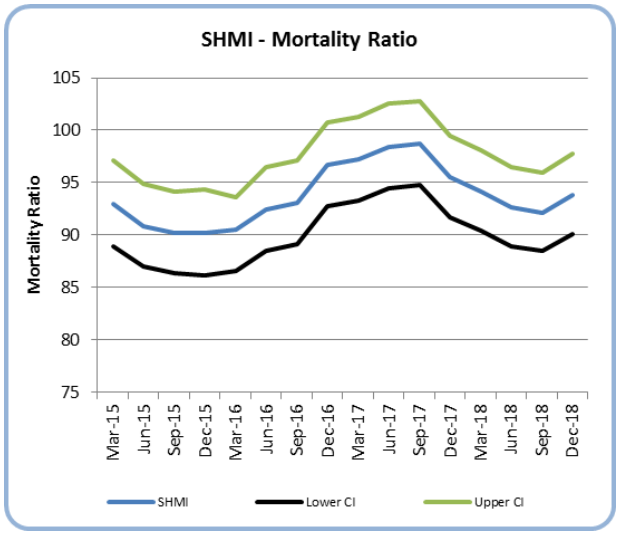
Hand Hygiene
Hand Hygiene compliance has been maintained.

Surgical Site Infection Reporting
NBT undertakes mandatory SSI reporting for infection following hip and knee replacements, which is coordinated by the NMSK Division. There is monitoring though the Control of Infection Committee.

During 2018/19 orthopaedic SSIs have been higher than the national bench mark. A quality improvement programme, led by a Consultant orthopaedic surgeon, is in place to review all aspects of the patients pathway from referral to discharge.

This divisional collaboration involves stakeholders from NMSK, ASCR and Infection Prevention and Control.





Overall Mortality

The Trust's SHMI Mortality Ratio for the most recently calculated period is within the expected range. (Due to changes in national reporting, there has been no change to the SHMI reported from last month).

Mortality Review Completion

The current data captures the completed reviews up to 31 March 2019. In this time period, 90.93% of all deaths have a completed review. 97.3% of "High Priority" cases have completed Mortality Case Reviews (MCR) including 15 deceased patients with Learning Disability and 15 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 were no new notifications by a Reviewer of Overall care as Poor or Very Poor (score 1-2) in March 2019.

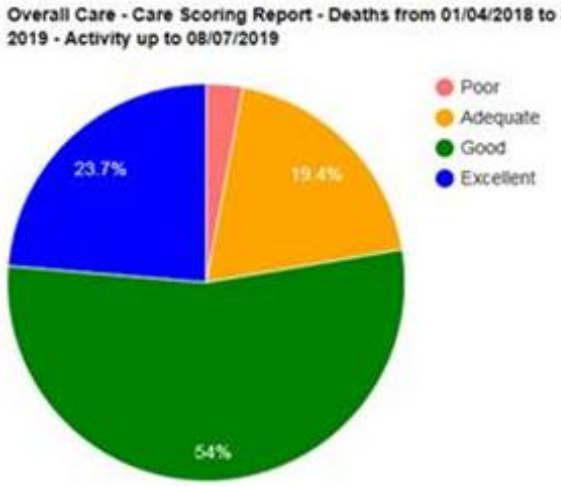
Mortality Review Completion

For 01/04/2018 - 31/03/2019	Completed	Required	% Complete
Screened and Excluded	970		
High priority Cases	159		
Other (Non-priority) MCR completed	525		
Total reviewed	1654	1819	90.93

Mortality Review Outcomes

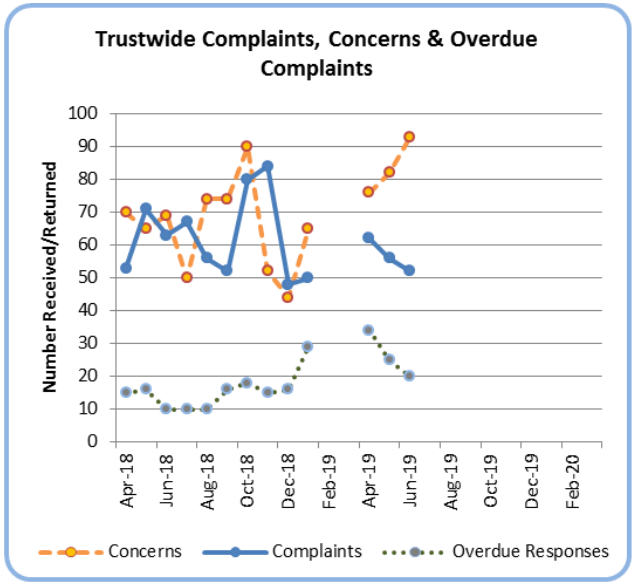
Overall Score:	1	2	3	4	5	Count of responses
Care Received:	0 (0%)	18 (2.98%)	117 (19.37%)	326 (53.97%)	143 (23.68%)	604

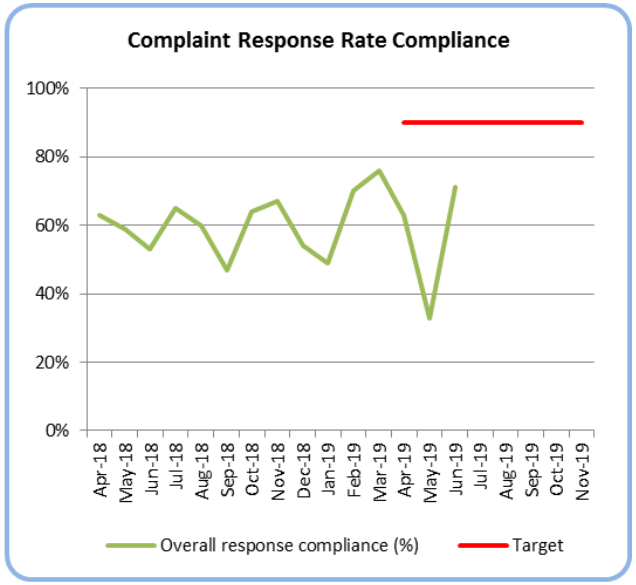
	April 2018 to March 2019
New Notification	0
In Progress	0
Reviewed not SIRI	13
Reported as SIRI	1

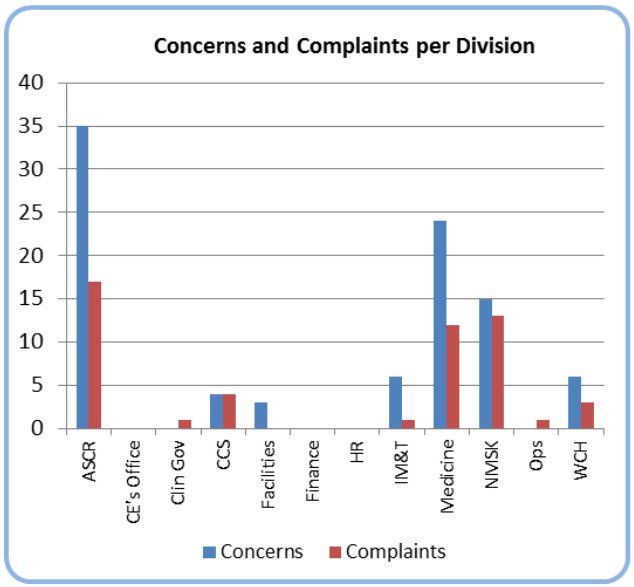


Quality Experience

Board Sponsor: Interim Director of Nursing
Helen Blanchard







Division	Total closed in June	Total overdue at end of June
Medicine	16	4
NMSK	12	2
ACSR	16	11
CCS	3	1
WACH	1	1
Clin Gov	1	1
Total	**49**	**20**

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 June 2019 the Trust received 52 formal complaints and 93 PALS concerns.

The 52 formal complaints can be broken down by division:

ACSR:	17	CCS:	4
Medicine:	12	NMSK:	13
Ops:	1	WACH:	3
Clin. Gov:	1	IM&T:	1

This shows a continued slow decrease in the number of formal complaints. It is too early to attribute this to the impact of PALS. The Clinical Governance complaints related to a safeguarding issue whilst the IM&T complaint related to access to medical records.

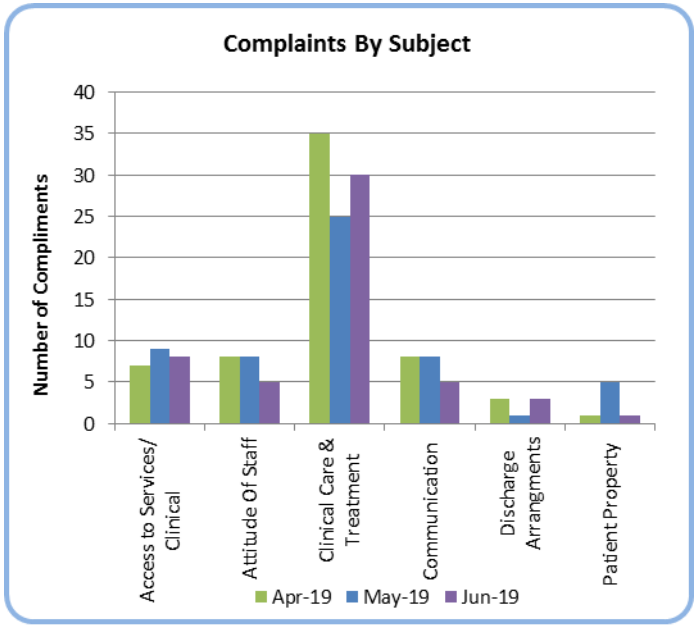
Final Response Rate Compliance

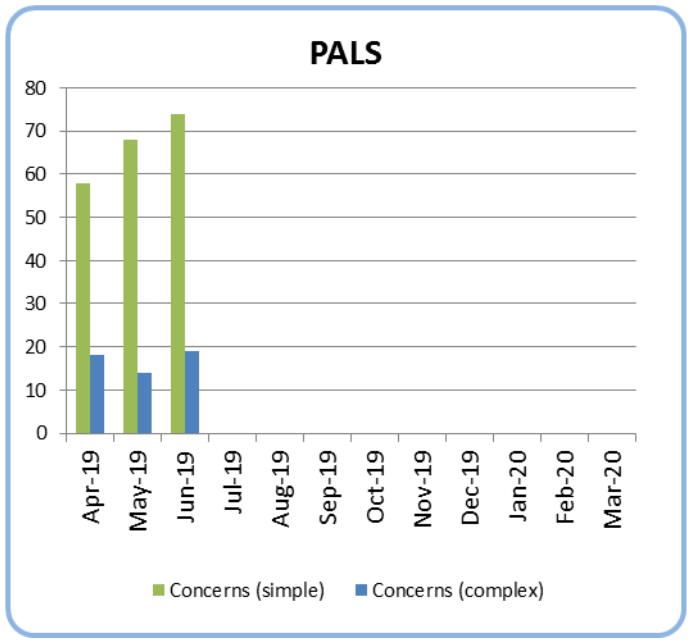
Following the successful roll out of corporate and divisional recovery plans throughout June, the compliance with providing timely responses at end of month of June had risen to 71%.

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

Overdue complaints

The total number of overdue complaints at the end of June sat at 20. At the week of 10th July this had reduced further to 11 overdue cases, reflecting the success of the recovery plans.





Compliments

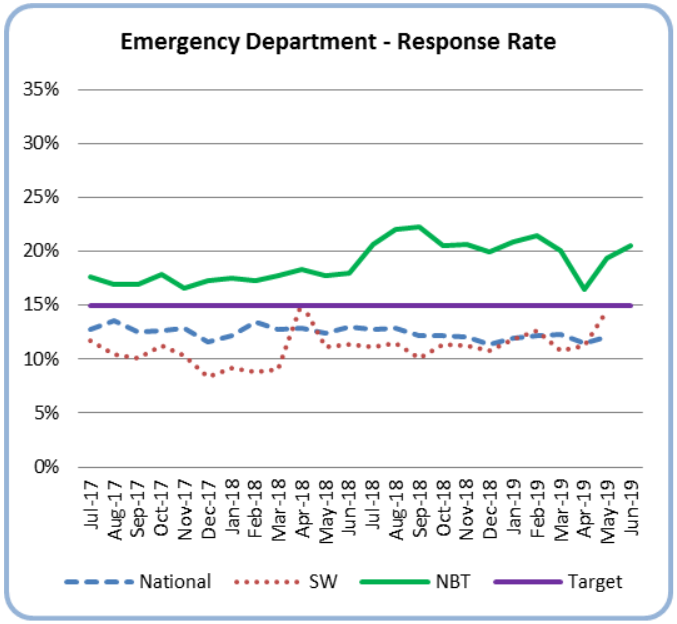
A more systematic approach will be developed to capture compliments and will be developed as part of the ongoing improvement programme. This will follow the current priorities of addressing the complaints backlog and establishing a permanent PALS service.

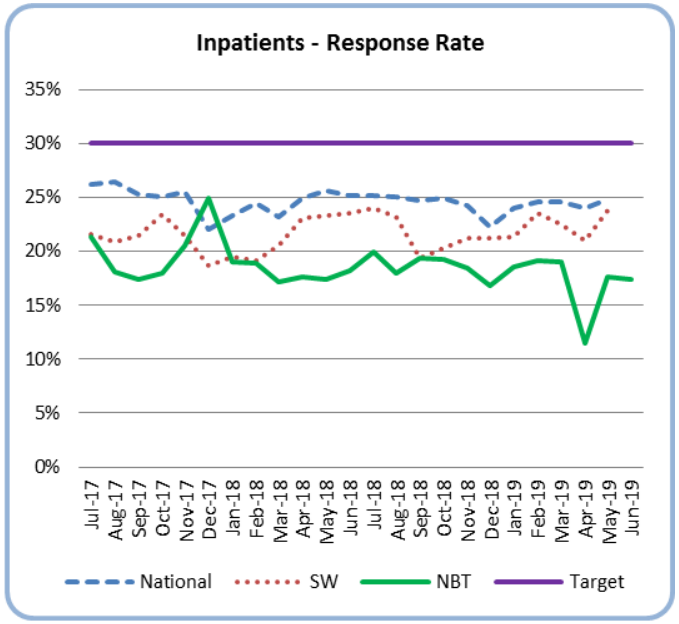
Patient Advice and Liaison Service (PALS)

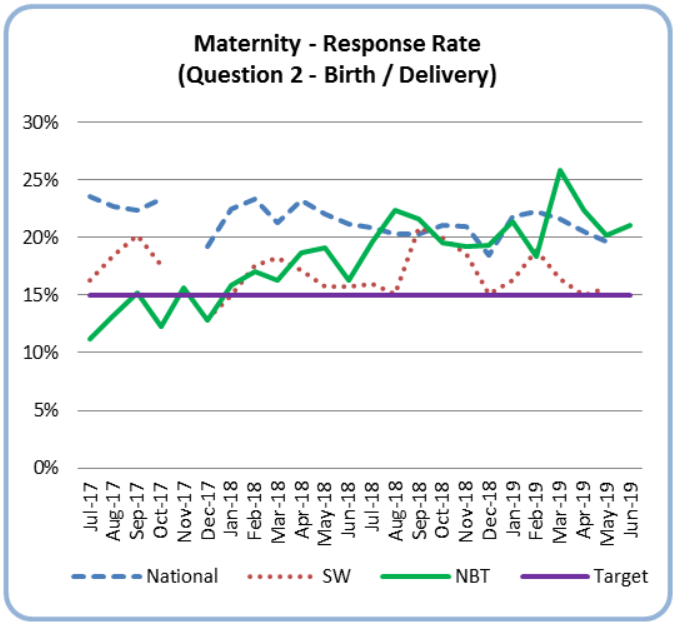
Following a pilot of the PALS service between Feb-Apr 2019, a new PALS concern chart is now included to give an overview of service provision going forward.

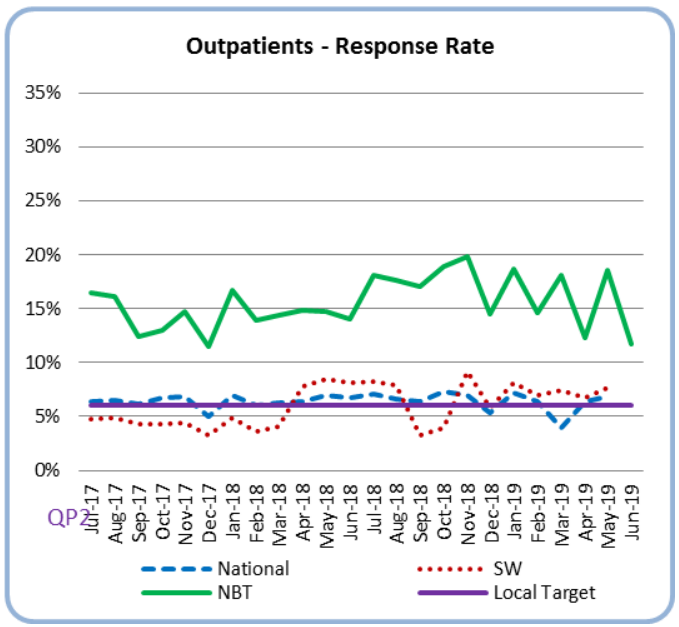
93 PALS concerns were received in June 2019 (82 in May). Of the 93 PALS concerns received in June 2019, 74 (80%) can be classified as more simple concerns and 19 warranted more in depth investigation from within the division and were classified as complex concerns. The issues arising through concerns are recorded and there will be reporting in a similar way to concerns once capacity has increased in the team through the appointment of a PALS manager.

A revised policy **'CG20 – Policy & Procedure for Management of Complaints and Concerns**' together with a new standard operating procedure **'Management of Complaints and Concerns'** was approved at the Patient Experience Group (PEG) meeting of 02 July. This will be rolled out throughout the Trust together with training sessions on investigation of complaints, writing formal complaint responses and the local resolution of concerns. The SOP includes process flowcharts on the new triage process and categorisation and compliance standards for formal complaints & PALS concerns. A Datix training programme will also be rolled out alongside the policy.









Friends and Family Test

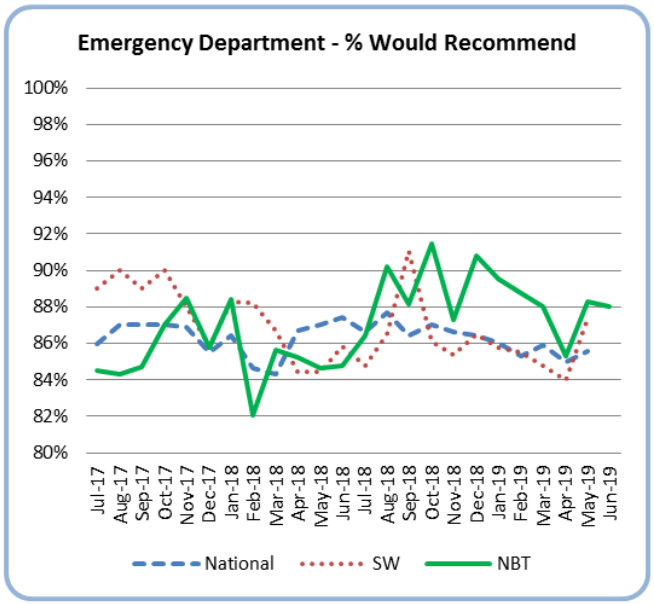
FFT Response Rate	Target	NBT Actual
ED	15%	20.56%
Inpatients	30%	17.40%
Outpatients	6%	11.74%
Maternity (Birth)	15%	21.05%

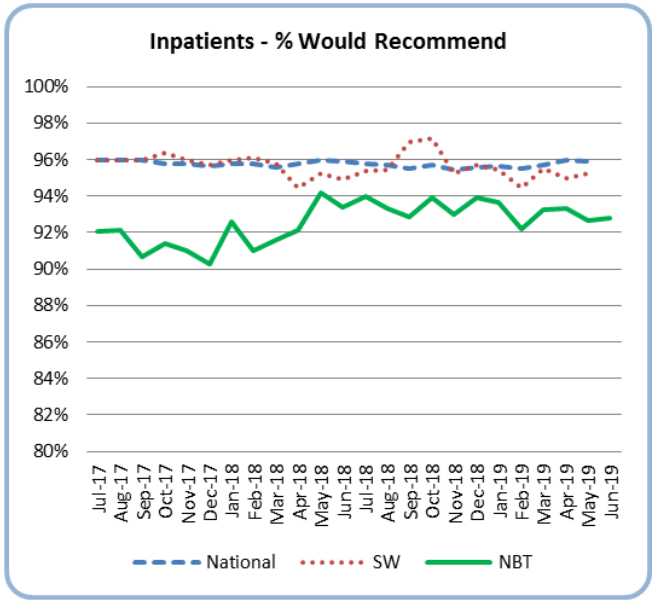
Following the resolution of the issue identified that effected the Interactive Voice Message (IVM) FFT which we use to survey all patients over 60, which continued until 09 May, we have now seen response rates return to normal parameters.

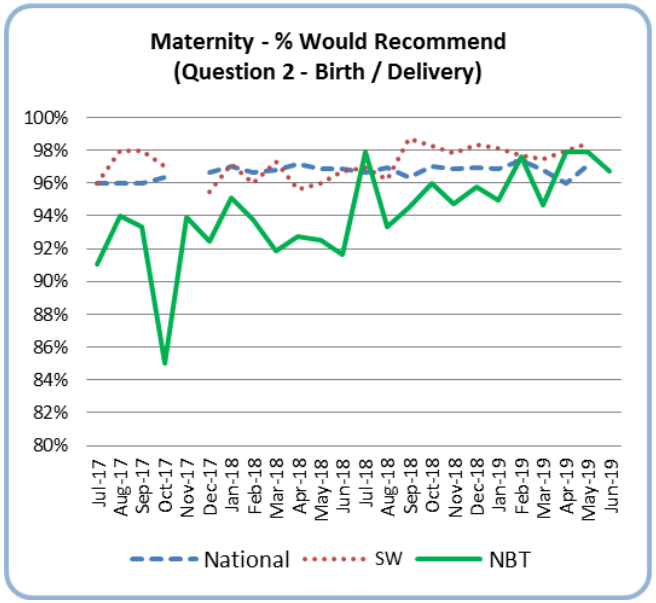
Following a period of decline, ED have continued to improve their response rate.

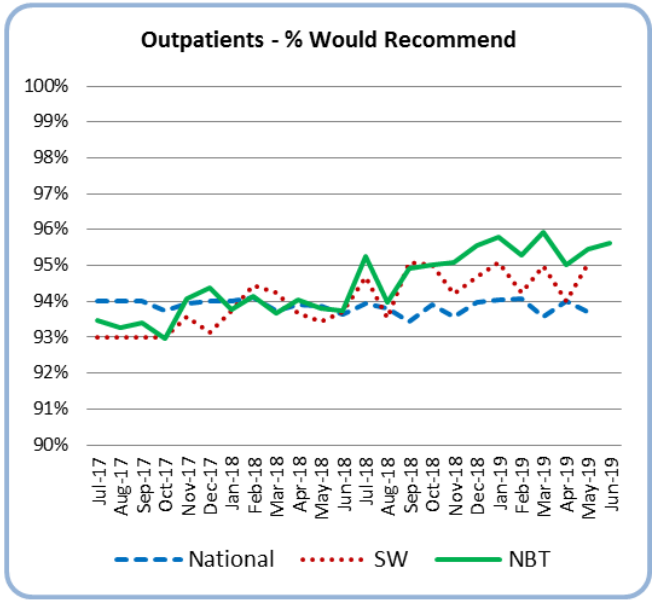
Owing to technical issues, NHS England have not published maternity FFT data for November 2017.

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









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FFT Recommend Rate	Target	NBT Actual
ED	90%	88.01%
Inpatients	95%	92.82%
Outpatients	95%	95.63%
Maternity (Birth)	95%	96.74%

There has been no significant change in the percentage of patients saying they would recommend the Inpatient wards. Outpatients remain within normal levels and are achieving the target. Maternity (Birth) have achieved a fantastic result of almost 97% of patients recommending their services.
After a period of decline ED continue to make an improvement.

What are people saying about our services?

Within inpatients, the majority of negative feedback relates to people who have come in to hospital for an operation. The feedback ranges from inadequate environment for recovery due to mixed sex bathrooms a long walk from bed, lack of after care information and cancellations. In response to this continuing trend we will increase our provision to survey more day case patients to fully establish the issues arising.

Within ED the feedback remains to be around waiting times and the lack of communication around this.

Maternity received no negative feedback again (Birth), the staff and their communication are cited as the main reasons for the positive experiences.

Friends and Family Test

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

ED – (1)
Everyone I met from the paramedics that came and took me to hospital, through to the nursing staff and lovely doctor who looked after me were superb. It was a very busy night with over 70 patients to be treated but I was still very well cared for with thoroughness, kindness and consideration. I was kept informed of the progress of my tests and what would happen next and never left wondering what was happening.

Outpatients - Urology (5)
My appointment was at 9am. I was kept waiting for nearly an hour and a half. No explanation was offered. I was not advised I would be kept waiting.

Cotswold – Gynae (5)
Hospital ward was very cold unfriendly was at hospital all day waiting for op hungry thirsty then to be told at 6pm op cancelled! (after already been given pain meds for after op) it feels like you are just left with no communication at all.

Outpatients - Radiology (5)
The discussions with Dr about my problems and results of MRI were in an open waiting area where everyone (members of the public) could hear. Excruciatingly embarrassing.

9a – (1)
Due to my health issues, I've been in a few hospitals. If this ward is anything like your other wards then you're doing something right. the consultant team, nursing staff, cleaners and food are excellent. I'll be writing a letter of thanks when I get out, great ward Gate 9a.

26a (1)
I was greeted by a nurse who informed me that she would be with me up until the time I went to theatre. The nurse explained any tests and made me comfortable. All involved explained their role and encouraged me to ask questions. Post operative care was excellent and a nurse called my family informing them I was now on ward. Pain relief and monitoring was regular and nursing staff were encouraging and reassuring in their care.

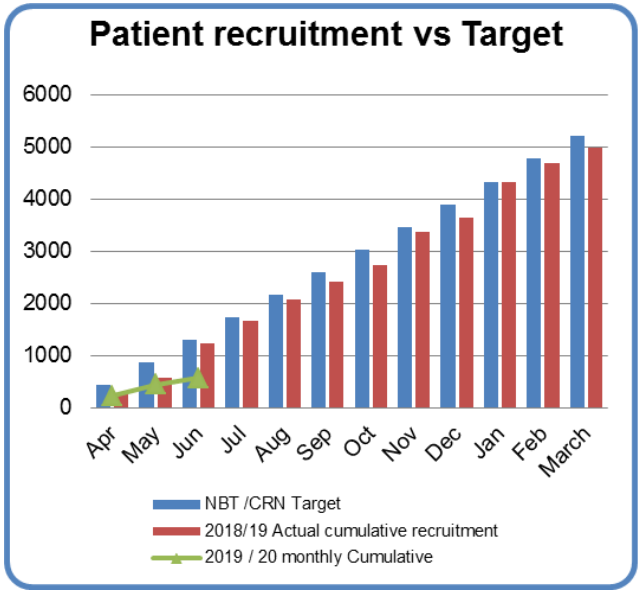
ED (5)
Really long wait. Gave up and left after being told that some people had been waiting 8 hours. There was a cat in the hospital which although I like cats, seems a bit unhealthy and my partner is allergic.

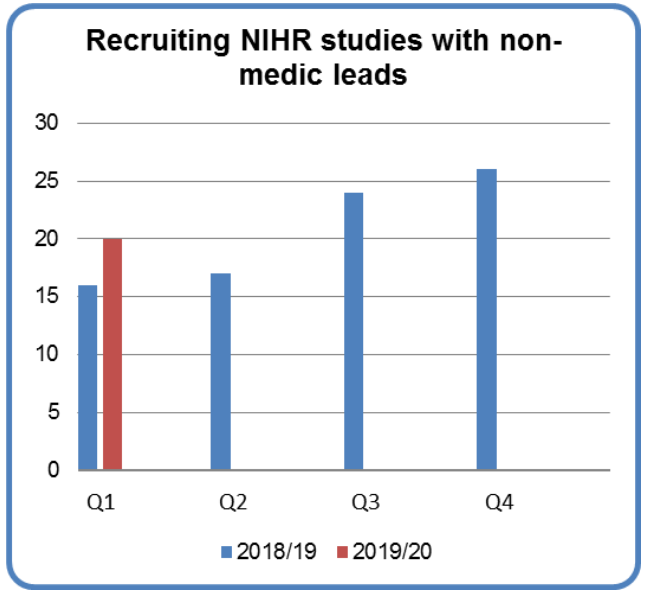
Outpatients - Gastro (3)
Reducing the waiting time!! I had to wait 90 minutes (1 HR 30) for my appointment. The delays were known early in the day, so why couldn't a message be sent to advise of slips and to arrive 30 minutes or 1 HR later than expected? And why didn't the 2nd scheduled doctor arrive that day?

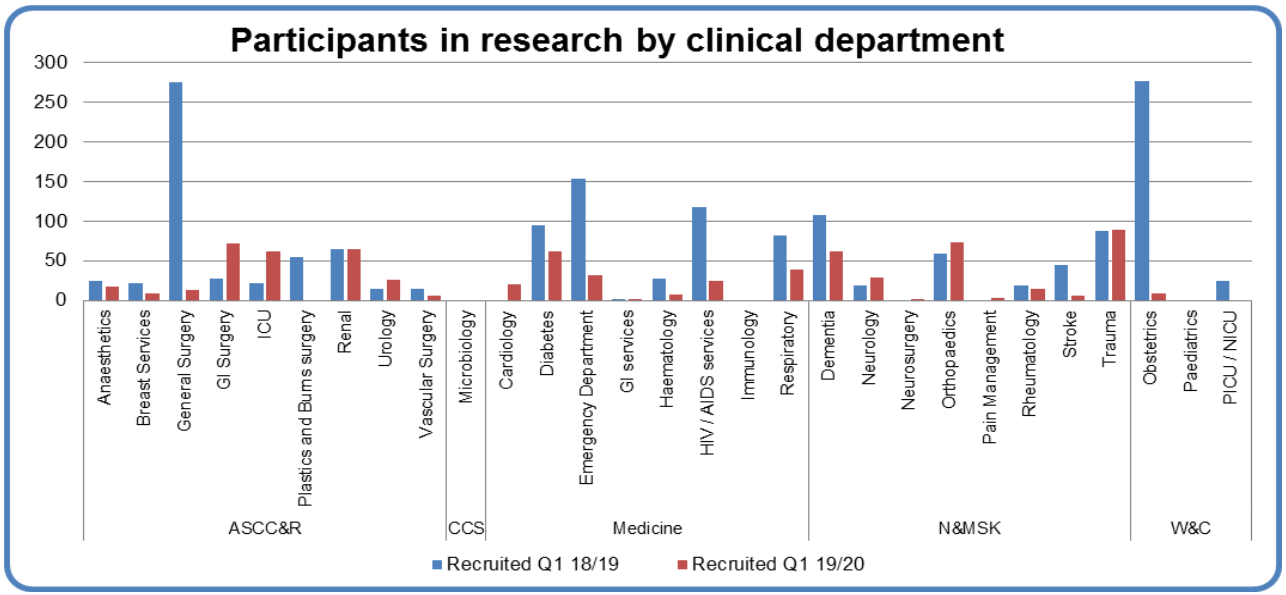
Elgar 1 (1)
All the staff who work on Elgar 1 are very kind and serving you could not get better treatment anywhere else. I thank you all for what you have done for me.

Research and Innovation

Board Sponsor: Medical Director







In line with last year, and regional patterns NBT is currently behind the linear target. However a number of large recruiting studies are due to open within the next 2 months which it is anticipated will address the current shortfall.

The number of NIHR studies lead by non-medic researchers has continued to show strong performance.

Due to a generous charitable donation to the NBT Research Fund, R&I will be opening a Trust-wide open call for applications to fund research projects up to £20k each. The call will open at the end of July 2019.

NBT received it's 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.

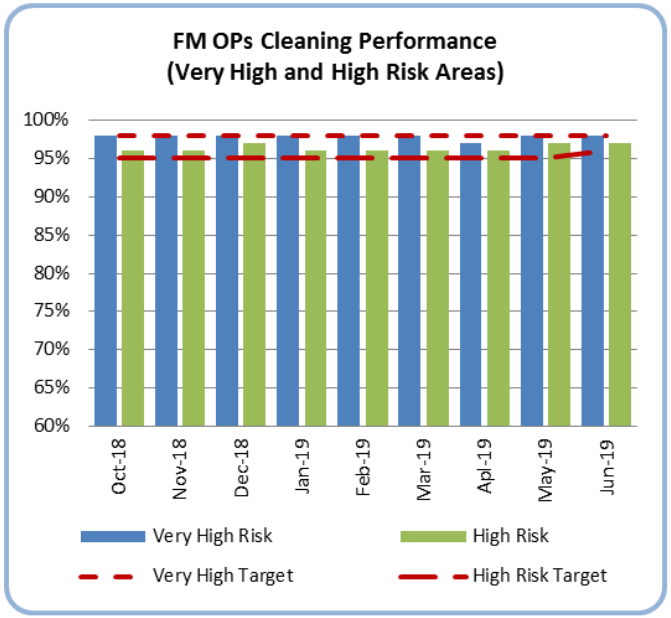
As a result we were able to open a call for applications from NBT researchers to fund key posts within their team to develop future NIHR grant applications. From this call we have agreed to fund 1.5wte Research Facilitator posts within the Medicine Division and Respiratory and Stroke research teams.

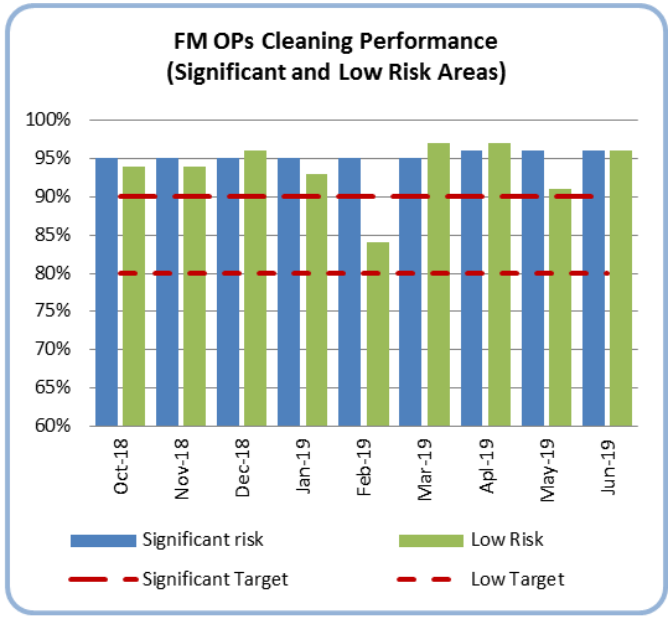
NBT currently holds 31 research grants (NIHR, charity and other) to a total value of £18.2m, with 14 NBT-led grants in set-up (£4.94m).

NBT R&I hosted an Investors in People assessment and have now progressed to a silver award standard.

Facilities

Board Sponsor: Director of Facilities
Simon Wood





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

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

Cleaning scores for the 2nd month in succession for all risk categories' have met or exceeded their target.

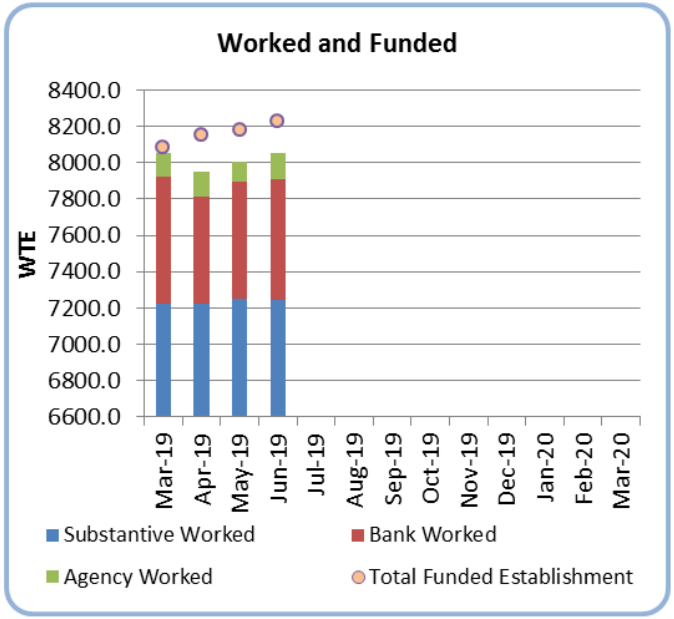
The ED Task Team have been in place since 03 June. We have received positive feedback from our clinical colleagues regarding the high standards of cleanliness and responsiveness. We have started to see a steady improvement in cleaning scores within ED. A Task Team has been created to work in AMU replicating the ED model, this team went live as of 01 July.

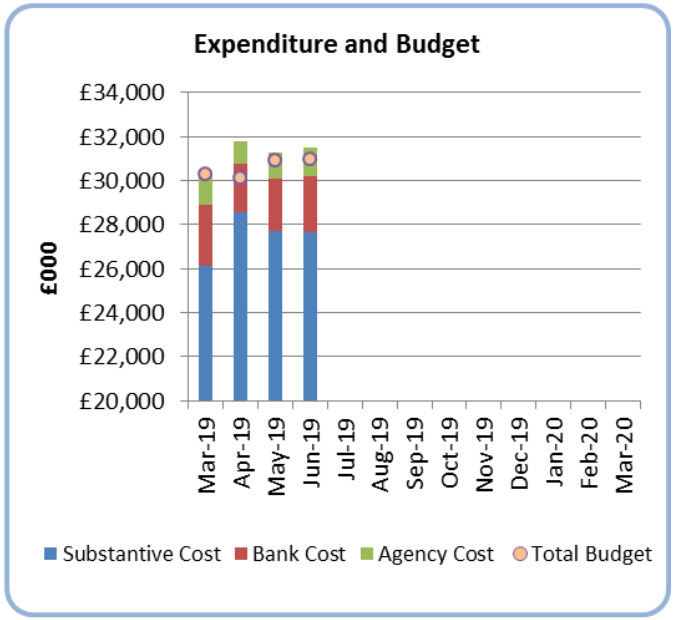
The total number of whole time equivalents within the Relief Team stands at 45 (2.5 vacant). The team is used to provide cover for vacancies that arise out of leave or sickness, reducing the reliance upon NBT extra to backfill shifts.

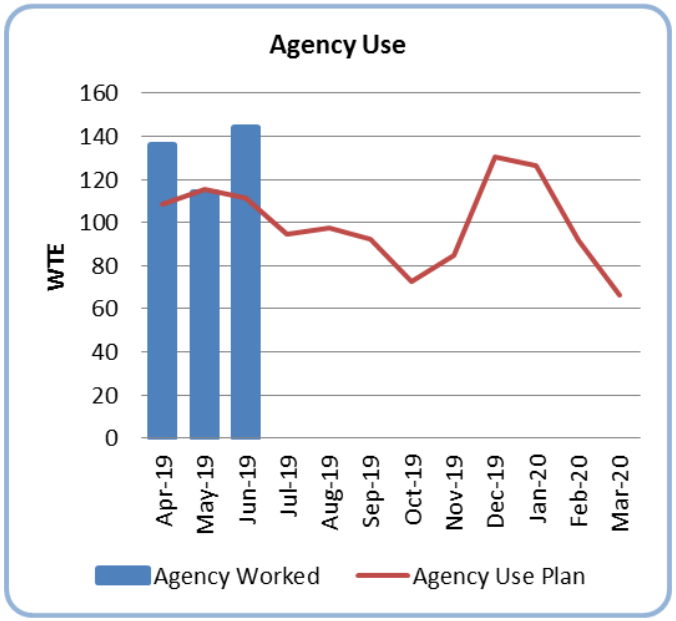
Deep clean numbers per week were in line with the previous month with an average of 247 carried out per week 96.63% of which were above the key performance indicator for 4 hour breaches. Work is currently underway to identify the cause of such a high number of deep cleans being requested.

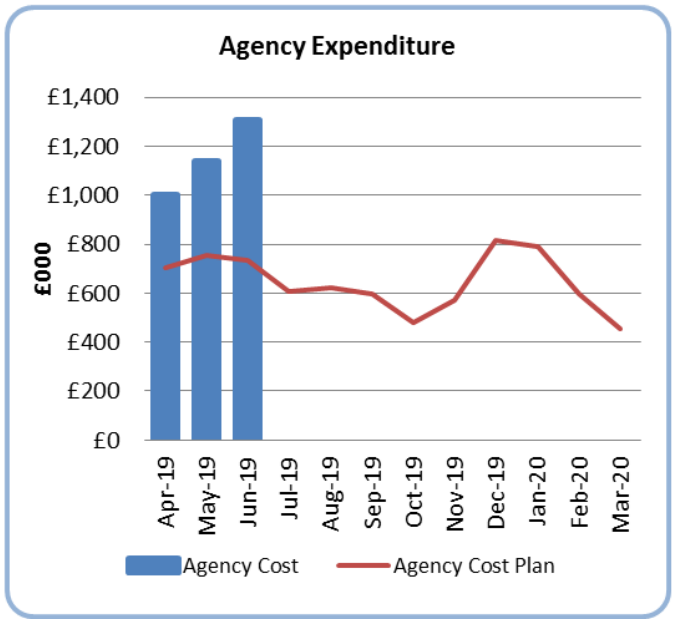
Well Led

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









Substantive
June expenditure is 187k under budget. The Trust is £1.27m under budget year to date. June worked wte is 178 wte under funded establishment.

Temporary Staffing

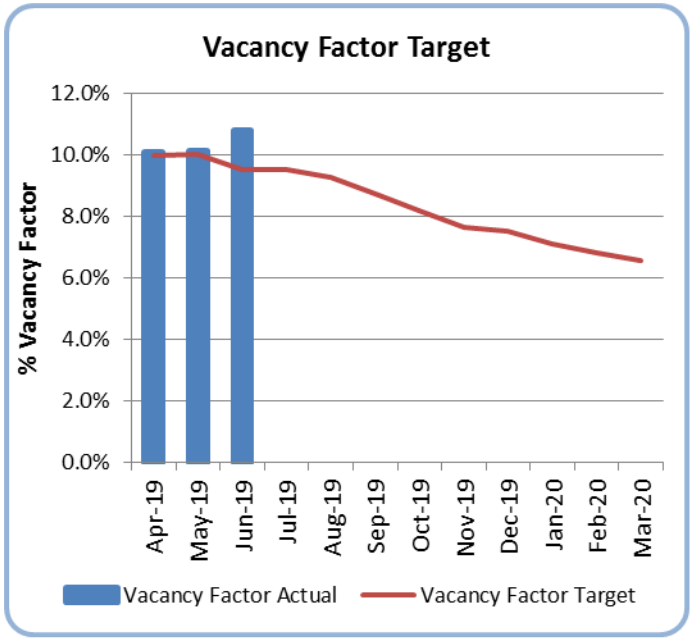
NBT Extra
Work is being completed to increase the attraction to bank for all staffing groups as we enter the summer holiday period.

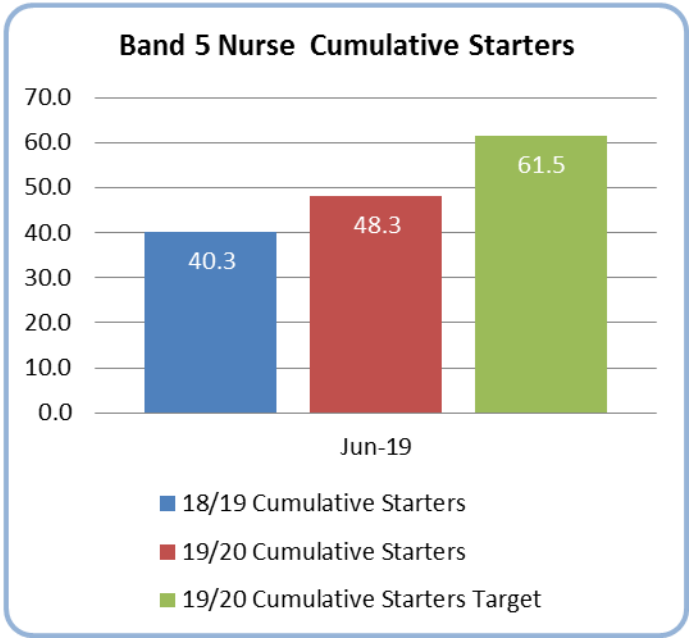
Standards have now been finalised for the BNSSG wide compliance checks process, so that consistency is achieved across the region and processing efficiency is improved.

The current bank rates are under review as part of the Bank rates Task and Finish Group with further updates to follow in the forth coming months

Agency
Agency expenditure has increased during June due to high demands for registered nurses.

The BNSSG Agency Project which is working to reduce high cost agency usage has now meet with all agencies suppliers to agree setting a standardised charge rates which will mirror rates introduced by the Welsh Trusts back in 2017 which enabled the exclusion of non framework high cost agencies in the region.





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. This will be supported by an improved reporting process for vacancies, retention and numbers of new starters for this staff group to ensure consistent Trust wide visibility. In June the Trust had 17.6 external new starters, the year to date position is 60.8 wte against a target of 43 wte.

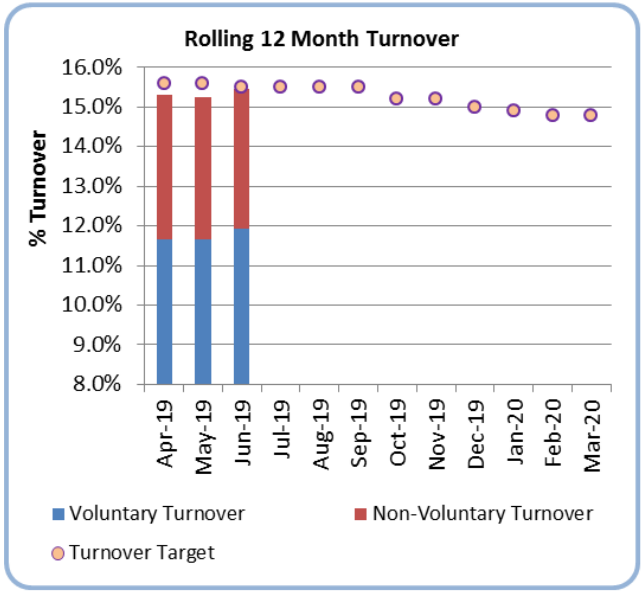
Band 5 Nursing
The Band 5 nursing vacancy gap increased in June due to 294 wte across the five clinical divisions. There were eight new starters in June which means year to date the Trust is 13.2 wte starters behind target.

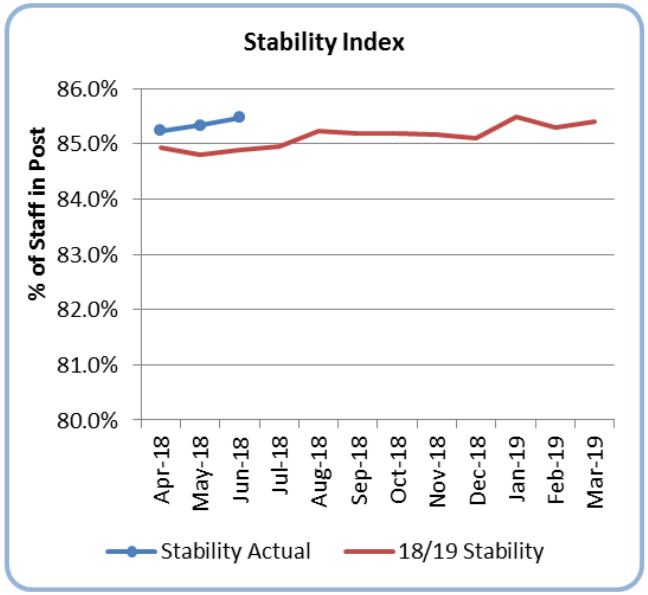
However the continuing programme of events in the resourcing plan delivered 3 key engagement events in June;

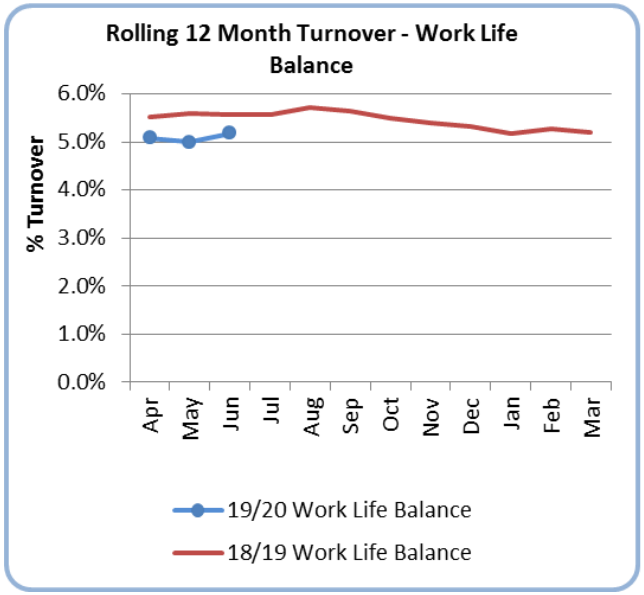
- RCNI Careers Day in Bristol, including a 2 seminars from the Clinical Simulation and Stroke teams
- Nursing Times Careers event in London
- Facebook live webinar delivered by the Complex Care team to an audience of 150 viewers

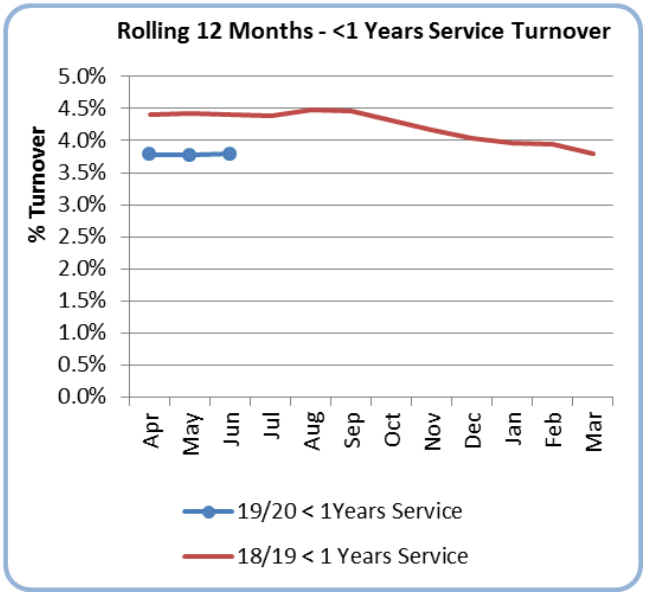
June also saw 60 offers made for start dates between July and September which will bring the trend back in line with annualised targets and the planned reduction in the Trust wide vacancy factor. In additional bespoke recruitment plans were signed off for Renal and Theatre.

Overseas Nurse and Midwife Recruitment
The International Nurse Recruitment project continues to deliver experienced permanently employed Nurses from the Yeovil pipeline. One nurse started in June with 12 more to start in July. Visa processing delays have created a lag in the anticipated timeframes with final numbers anticipated to be 37 nurses from this pilot with Yeovil by the end of September 2019. The OSCE and pastoral care team are delivering their wrap around welcome and support to the nurses as they arrive at the Trust and we are receiving positive feedback from the Nurses on their experiences with the Trust to date. A review of the pilot will take place in July 2019 as well as additional potential pipelines and recommendations will be made to the Nursing and Midwifery Nursing Group on the Trusts future approach to international recruitment as a whole.









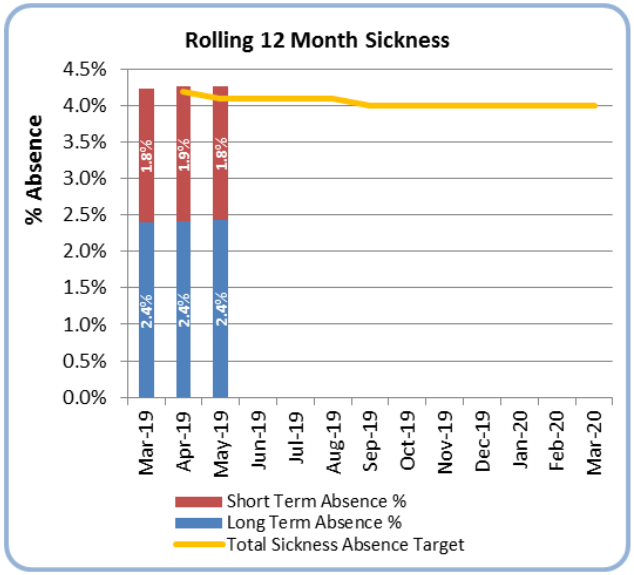
Stability and Turnover

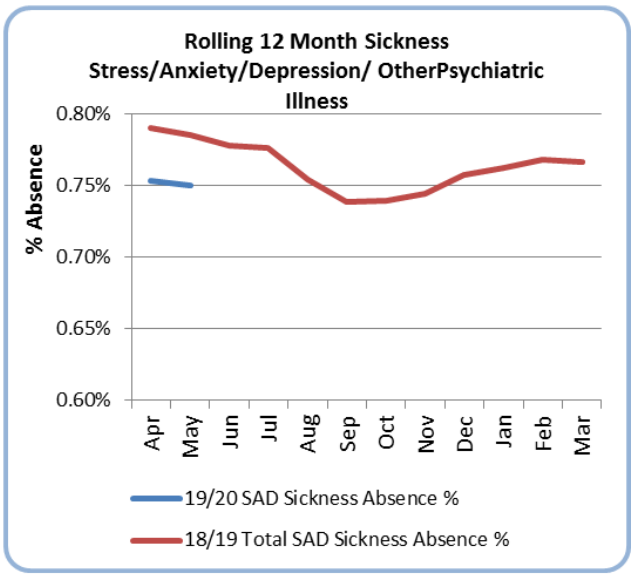
Overall the retention indicators all show a positive movement over time, however the rolling 12 month voluntary turnover positon did increase in June 2019 along with the leavers for work life balance reasons. There were more voluntary leavers in June 2019 than June 2018 that cause the increase form last month.

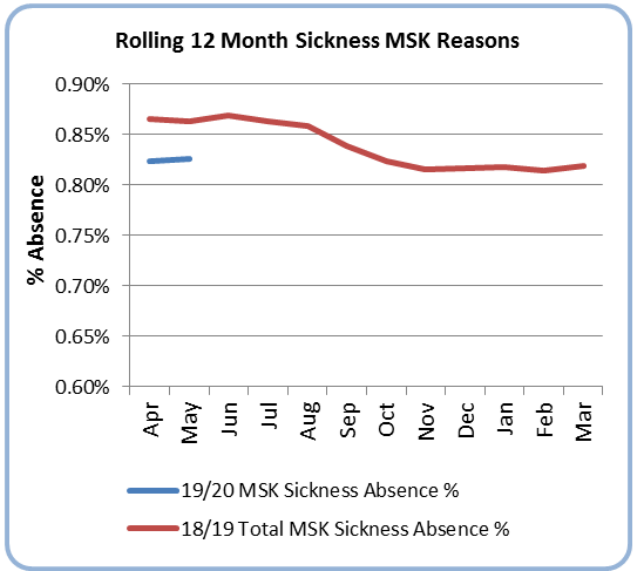
As with overall voluntary leavers the rolling 12 month position for work life balance leavers deteriorated slightly as the number of leavers for this reason was higher in June 2019 than in June 2018. Increases in registered and unregistered nursing and midwifery contributed to this movement.

Actions

- New Leavers Questionnaire and process to be rolled out from August, which should give more real-time data on reasons for leaving;
- We are developing a programme of P&T support for new, international nurse recruits to ensure they feel well-supported during their first months in post;
- Work continuing around re-promoting flexible working via a new brochure-type resource for staff and managers which details all the options, links and guidance around flexible working.





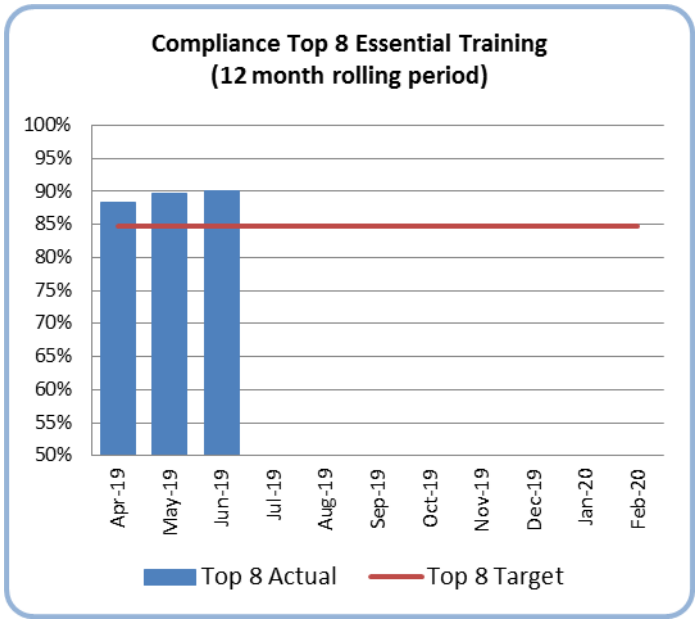


Sickness

Sickness absence for Stress, Anxiety and Depression (SAD), and Musculoskeletal (MSK) reasons is targeted by the Wellbeing Programme. SAD absence has fallen slightly again since last month, remaining below the May 19 level. MSK absence has risen slightly but remains below the May 19 level.

Actions

- Engagement sessions have occurred and Intranet information is now available detailing the new 'adjustment passport' for staff requiring work place adjustments;
- New ER (Case Management) Tracker to be rolled out from August, which will allow more robust tracking of sickness cases and issues;
- The wellbeing programme continues to grow in awareness and usage. There has been a steady and marked increase in take up of the EAP. For example, in May 2019 there were 43 calls to the helpline and 23 face to face counselling sessions, compared to 18 calls and 9 counselling sessions in November 2018.
- 2 WTE Psychologists are being recruited permanently to the programme and will start in October 2019
- Our wellbeing programme continues to gain recognition by winning a second national award – the NHS Parliamentary Wellbeing at Work Award.

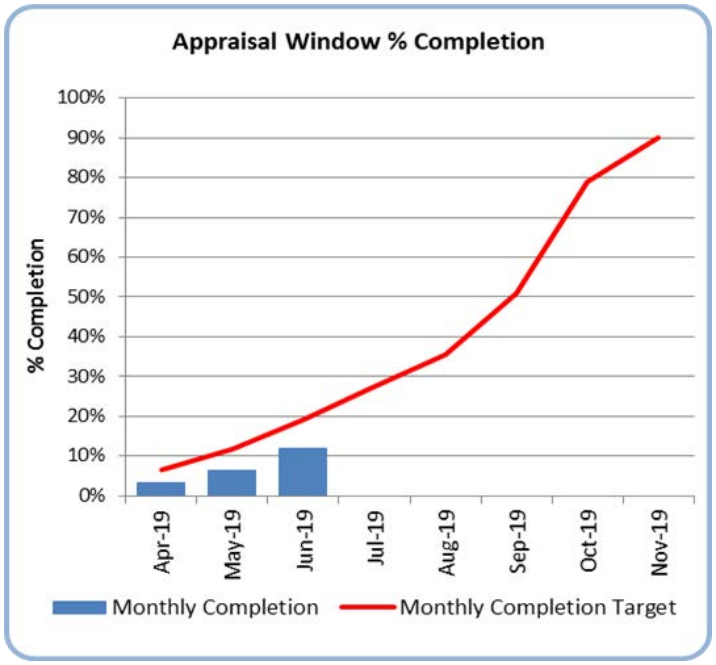


Training Topic	Variance	May-19	Jun-19
Child Protection	0.5%	88.4%	88.9%
Equality & Diversity	0.1%	90.2%	90.3%
Fire Safety	0.1%	89.7%	89.8%
Health &Safety	0.4%	92.6%	93.0%
Infection Control	0.3%	91.2%	91.5%
Information Governance	0.0%	85.0%	85.0%
Manual Handling	0.4%	90.9%	91.4%
Waste	0.1%	90.2%	90.2%
Total	**0.2%**	**89.8%**	**90.0%**

Mandatory & Statutory Training
The Top 8 Statutory / Mandatory training topics continue to show their sustained increase to the current 90%.

Division name	Number participants	% allocated spaces
Medicine	66	97%
ASCR	73	80%
Core Clinical	46	63%
NMSK	41	106%
Women's and Children's	27	77%
Facilities	13	295%
Corporate	57	147%
Total	**323**	92%

Leadership Development
The one NBT Leadership programme launched in June 2019 with the delivery of the first core day. We are still taking nominations from divisions and have over 300 participants which is 92% of our estimated target of 350 learners in year 1.



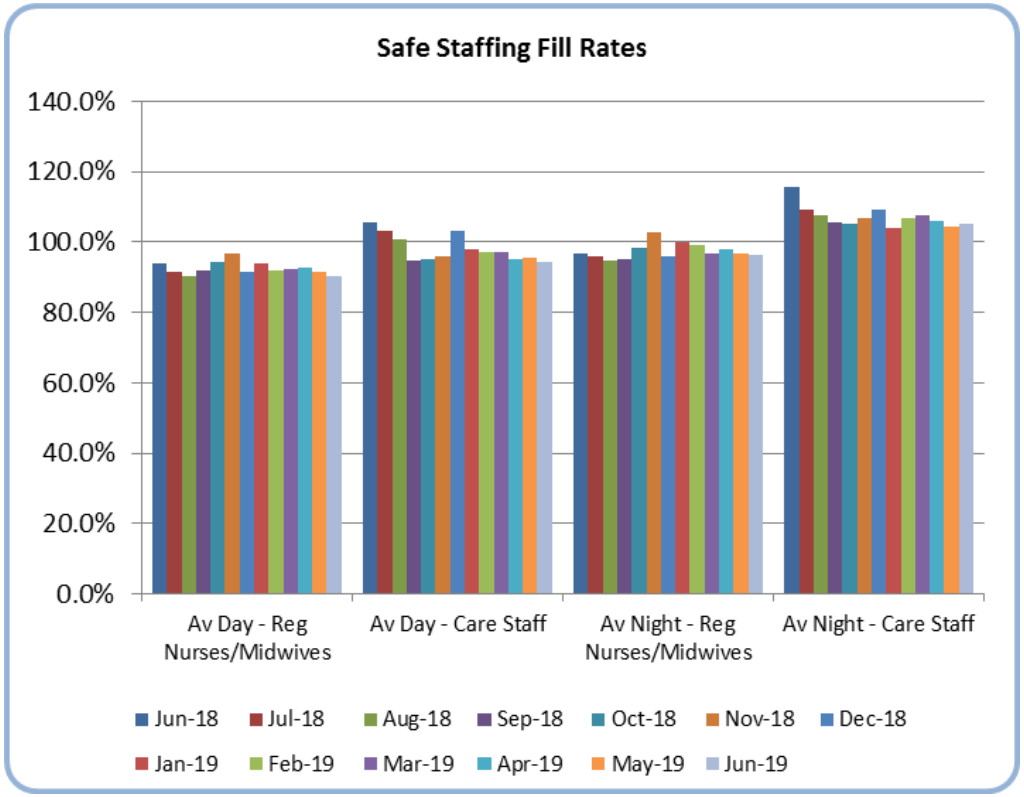
Appraisal Completion
We are now into month 3 of the 2019 Appraisal window. Compliance with the target population was 12% at the end of June 2019.

Equality, Diversity and Inclusion
To ensure there is no disproportionality in outcome and experience of certain staff groups and to start understanding where specific focus should be given to improvement, the IPR will now build a core set of workforce KPIs split by gender and ethnicity. The KPIs will be appraisal, MaST training, sickness and turnover.

If identified gaps between female and male staff and BaME and white staff increase disproportionately, further investigation will take place and appropriate actions will be designed to address any underlying issues.

Gender	Appraisal Completion
Female	12%
Male	14%
Total	**12%**

Ethnicity	Appraisal Completion
BaME	16%
White	11%
Undisclosed	11%
Total	**12%**



Jun-19	Day shift		Night Shift	
	RN/RM	CA Fill	RN/RM	CA Fill
Southmead	90.1%	94.2%	96.4%	105.0%

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

Wards below 80% fill rate are:

Quantock: 79.9% RM Days and 73.3% MCA nights. The unit has a high number of STS and LTS and working with HR to resolve this. To keep the people attending the unit safe the extended bed base has been moved from Cotswold to Percy Philips, where there is a constant midwife presence.

NICU: 74% MCA on nights. NICU have now fully recruited to MCA roles, however some remained supernumerary in June. When there is a gap if acuity dictates, this is covered by registered staff. If acuity is low and number of babies is low then the shift is not covered.

32B: 66.8% CA days. This is due to a template change in the ward requirement for the NA role. The ward has been monitored through leadership and flow to maintain safety.

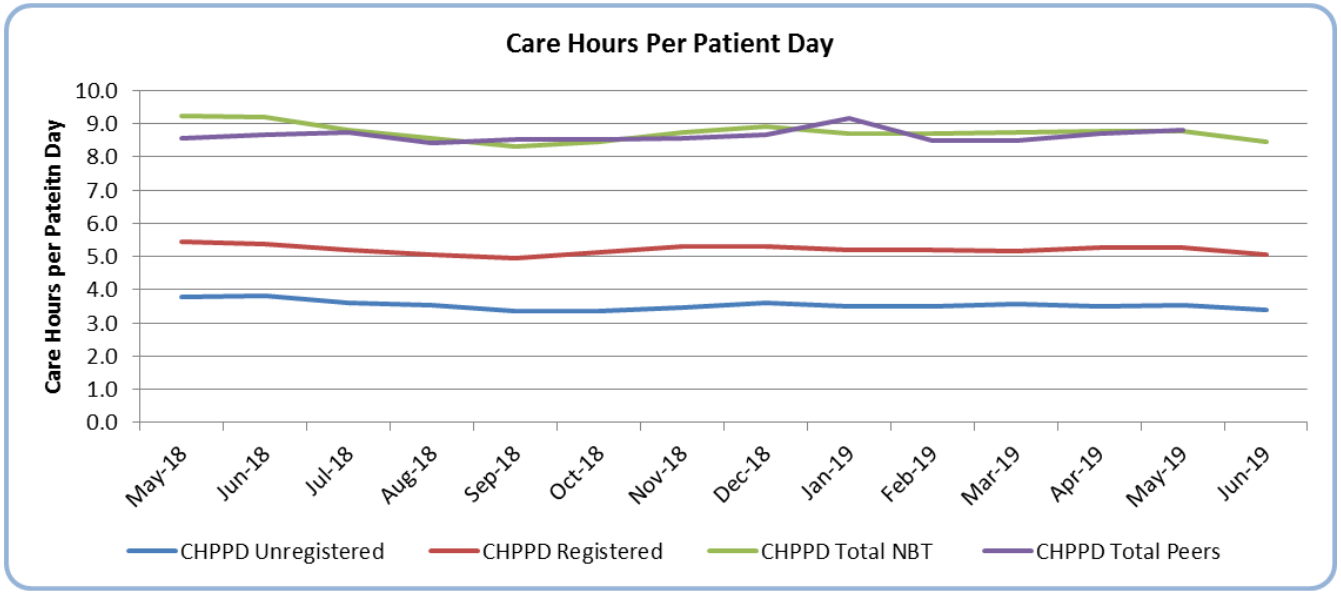
MSS: 83% RN and 86.2% CA on days. The fill rate are due this this being predominately an over night surgical recovery where many patients leave in the morning therefore staff are moved to support through the rest of Medirooms returning to support those who need an extended stay in the area in the evening.

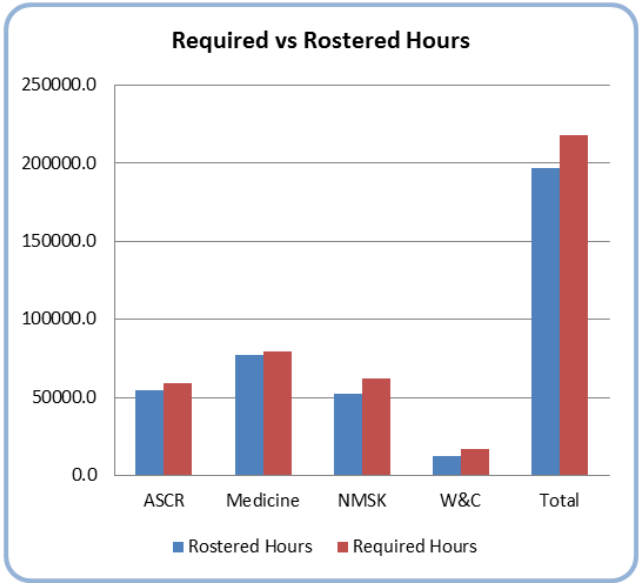
9A: 79.3% RN Nights. This is due to the vacancy on the ward. Shift have been filled as required based on the A&D of the ward. oversight has been maintained and reviewed for safety through leadership and flow.

Gate 19: 67.8% CA days and 65% CA nights. This area is reported as it has been open as escalation capacity for more than 3 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.

Ward over 175% fill rate:
No ward were over 175% this month

Cossham
Remains closed to women and not reported externally.



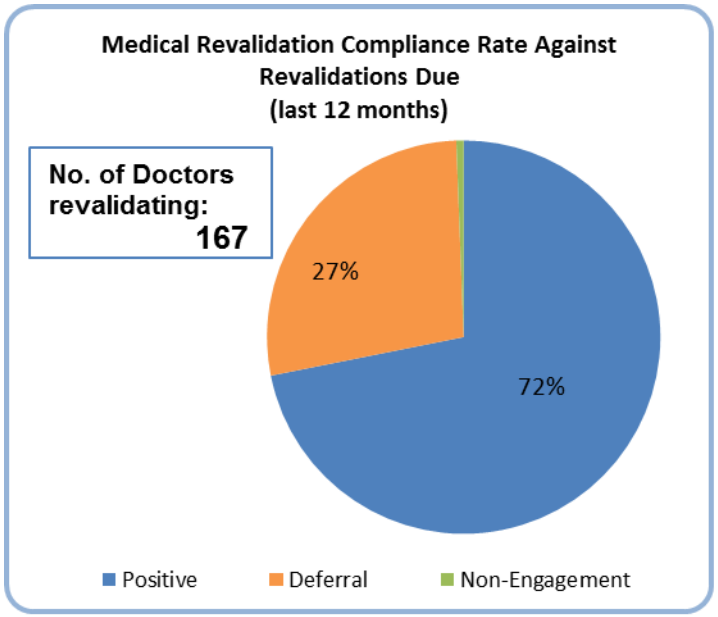


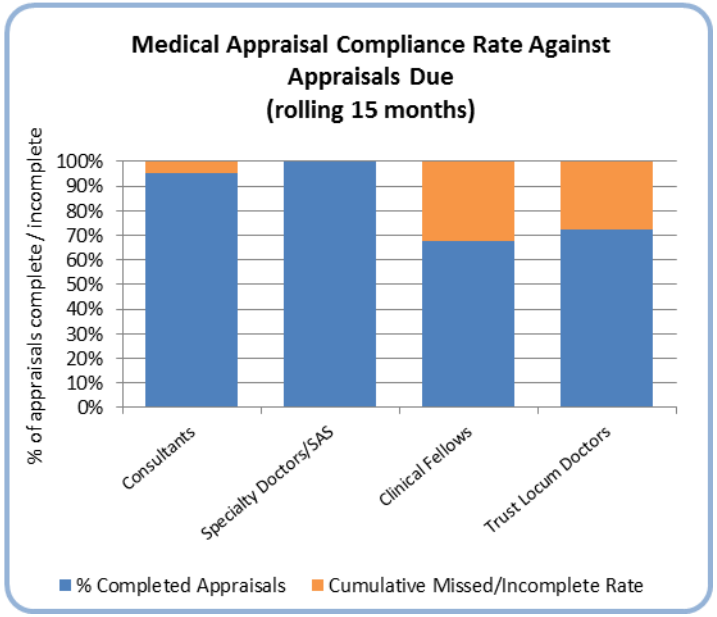
Care Hours per Patient Day (CHPPD)
The chart shows care hours per patient day for NBT total and split by registered and unregistered nursing and shows CHPPD for our Model Hospital peers (all data from Model Hospital, peer values only available to Feb 2019).

Safe Care Live
(Electronic Acuity tool)
The acuity of patients is measured three times daily at ward level. The latest data for March demonstrates there are occasions the rostered hours do not meet the required hours.

The Safe Care data is however 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

The General Medical Council requires that all licensed doctors complete an annual appraisal. The NBT system demonstrates that 100% compliance was achieved in 19/20. The board will receive a full annual report in September 2019.

To date in 19/20, 56% of the appraisals due have been completed. This is reduced performance compared to previous years and is considered to be due to implementation of the new Fourteen Fish appraisal software system in March 2019. The issues related to implementation and user familiarisation with the new software are being resolved and it is anticipated that the appraisal delays will be recovered in year. A small number of doctors who are new to the Trust do not yet know their appraisal dates and this is more common in locum and clinical fellow grades which contributes to the lower appraisal compliance in these groups.

The Trust has an active process for managing those who miss their expected appraisal date. Persistent failure will lead to notification to the General Medical Council (GMC) that the doctor is not 'engaged' with the system.

The Trust has currently deferred 28% of all revalidation recommendations due over the past 12 months. There are a number of legitimate reasons for deferral but the relative increase in percentage deferred over the past 12 months is contributed to by the small overall numbers needing revalidation in the final year of the five year cycle. From March 2019, the GMC will be collecting further information for the reasons of each deferral.

In June 2019 a non-engagement recommendation was made for one doctor who holds an honorary contract with NBT.

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Finance

Board Sponsor: Director of Finance
Catherine Phillips

	Position as at 30 June 2019		
	Plan £m	Actual £m	Variance (Adverse) / Favourable £m
Income			
Contract Income	131.7	130.1	(1.6)
Other Operating Income	21.1	19.9	(1.2)
Donations income for capital acquisitions	0.0	0.0	0.0
Total Income	**152.8**	**150.0**	**(2.8)**
Expenditure			
Pay	(96.5)	(95.2)	1.3
Non Pay	(46.2)	(43.9)	2.3
PFI Operating Costs	(1.6)	(1.5)	0.1
	(144.3)	**(140.6)**	**3.7**
Earnings before Interest & Depreciation	**8.5**	**9.4**	**0.9**
Depreciation & Amortisation	(5.9)	(6.3)	(0.4)
PFI Interest	(8.6)	(8.6)	0.0
Interest receivable	0.0	0.0	0.0
Interest payable	(1.3)	(1.2)	0.1
PDC Dividend	0.0	0.0	0.0
Other Financing costs	0.0	0.0	0.0
Impairment	0.0	0.0	0.0
Gains / (Losses) on Disposal	0.0	0.0	0.0
Operational Retained Surplus / (Deficit)	**(7.3)**	**(6.7)**	**0.6**
Add back items excluded for NHS accountability			
Gains on Disposal	0.0	0.0	0.0
Donations income for capital acquisitions	0.0	0.0	0.0
Depreciation of donated assets	0.0	0.2	0.2
Additional 2018/19 PSF bonus	0.0	(0.7)	(0.7)
Impairment	0.0	0.0	0.0
Adjusted surplus /(deficit) for NHS accountability (excl PSF)	**(7.3)**	**(7.2)**	**0.1**
PSF / FRF / MRET	3.8	3.8	0.0
Adjusted surplus /(deficit) for NHS accountability (incl PSF)	**(3.5)**	**(3.4)**	**0.1**

Statement of Comprehensive Income

Assurances

The financial position at the end of June shows a deficit of £3.4m, £0.1m favourable to the planned deficit.

Key Issues

- Contract income is £1.6m adverse to plan largely due to under-performance in elective inpatient activity.
- Other operating income is £1.2m adverse to plan due a number of factors including unachieved CIP which is likely to recover.
- Pay is £1.3m favourable to plan reflecting substantive vacancies offset in part by temporary staffing.
- Non pay is £2.3m favourable to plan mainly in clinical supplies and drugs.
- The savings shortfall at June was £3.2m the impact of which has been offset by a number of one-off benefits. The under achievement of savings, if not recovered, represents a risk to the delivery of the Trust's control total.

31 March 2019 £m	Statement of Financial Position as at 30th June 2019	Plan £m	Actual £m	Variance above / (below) plan £m
	Non Current Assets			
558.1	Property, Plant and Equipment	555.9	554.5	(1.4)
17.0	Intangible Assets	16.3	16.3	0.0
8.5	Non-current receivables	8.5	8.5	0.0
583.6	**Total non-current assets**	**580.7**	**579.3**	**(1.4)**
	Current Assets			
12.8	Inventories	11.2	12.8	1.5
35.5	Trade and other receivables NHS	61.1	47.7	(13.4)
37.1	Trade and other receivables Non-NHS	24.3	37.4	13.2
10.2	Cash and Cash equivalents	8.0	10.7	2.7
95.7	**Total current assets**	**104.5**	**108.5**	**4.0**
0.0	Non-current assets held for sale	0.0	0.0	0.0
679.3	**Total assets**	**685.2**	**687.8**	**2.6**
	Current Liabilities (< 1 Year)			
9.4	Trade and Other payables - NHS	9.4	9.1	(0.2)
64.8	Trade and Other payables - Non-NHS	74.8	81.4	6.5
70.8	Borrowings	70.1	65.6	(4.6)
145.0	**Total current liabilities**	**154.4**	**156.1**	**1.7**
(49.3)	**Net current assets/(liabilities)**	**(49.9)**	**(47.6)**	**2.3**
534.3	**Total assets less current liabilites**	**530.8**	**531.7**	**(0.9)**
7.8	Trade payables and deferred income	7.7	7.7	0.0
517.8	Borrowings	517.9	518.1	0.2
8.7	**Total Net Assets**	**5.2**	**5.9**	**0.7**
	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	(3.5)	(2.8)	0.7
146.5	Revaluation reserve	146.5	146.5	0.0
8.7	**Total Capital and Reserves**	**5.2**	**5.9**	**0.7**

Statement of Financial Position

Assurances

The Trust has received net new loan financing for the year to date of £2.6m. This brings total borrowing from the Department of Health and Social Care to £180.9m.

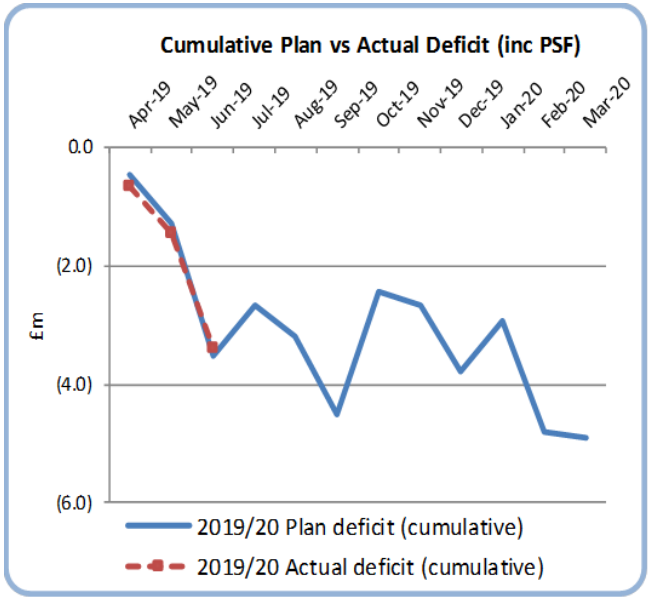
The Trust ended the month with cash of £10.7m, compared with a plan of £8.0m.

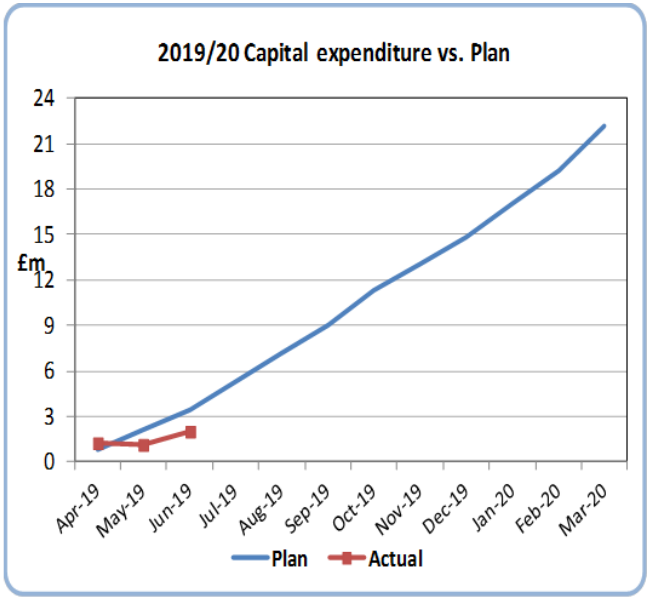
Concerns & Gaps

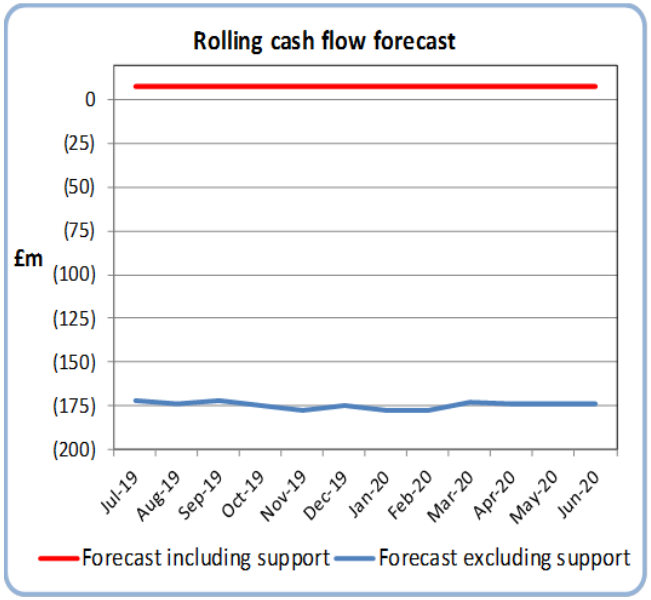
The level of payables is reflected in the Better Payment Practice Code (BPPC) performance for the year which is 68% by volume of payments made within 30 days against the target of 95%.

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	2	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 £3.4m deficit, £0.1m favourable to plan.

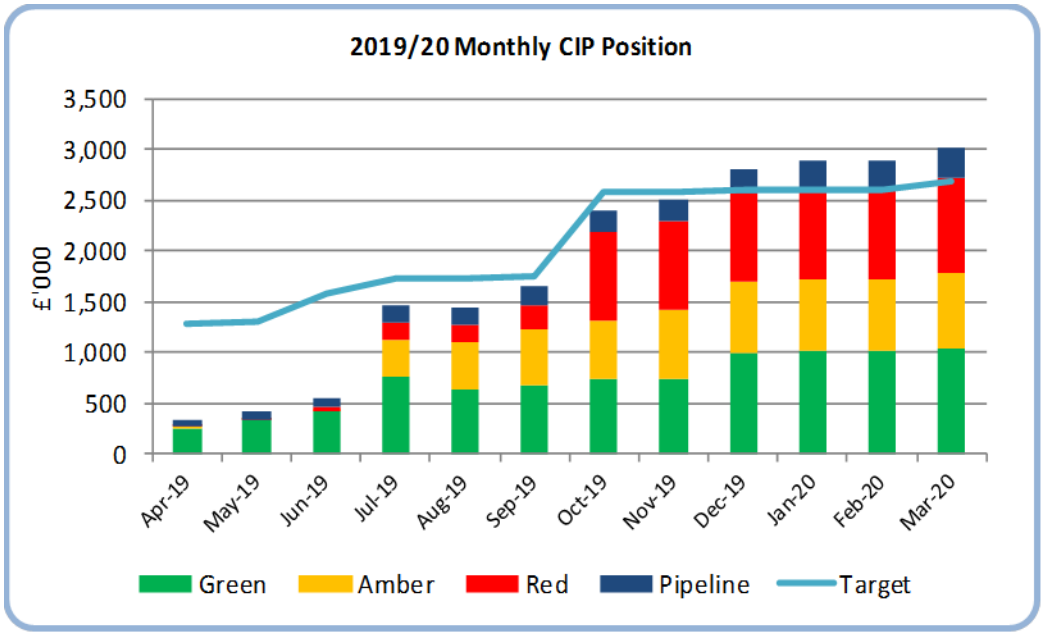
The capital expenditure for the year to date was £2.0m.

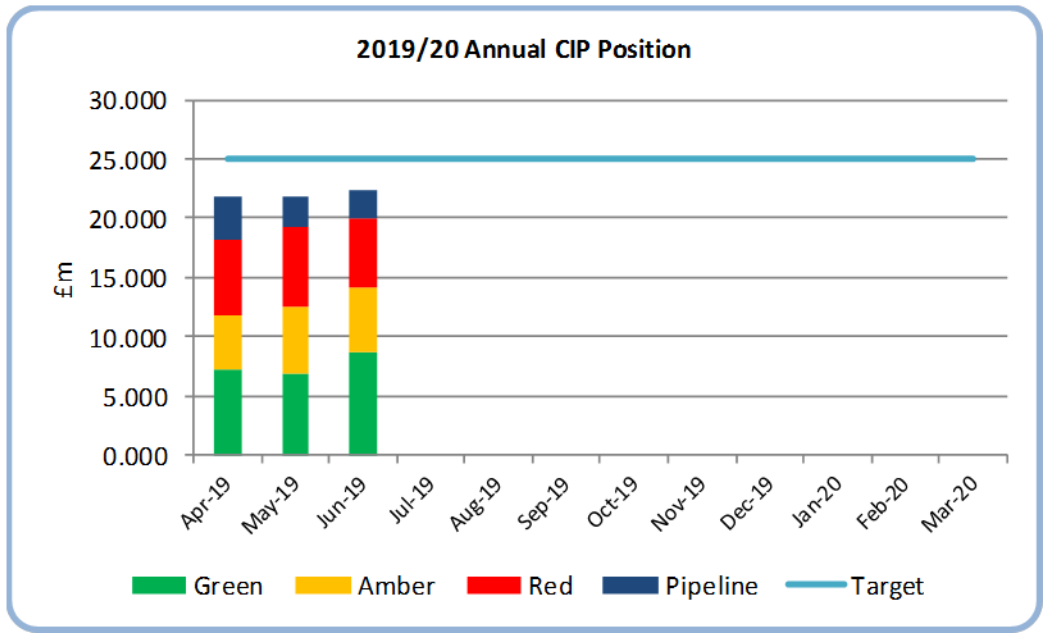
Assurances and Actions

- 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 of which £22.4m has been identified as at the end of June. This is below the required level for the year by £2.6m.

Concerns & Gaps

The graph shows the phased forecast in-year delivery of the £22.4m identified schemes. £14.1m are rated as green or amber.

Savings delivery is £1m as at the end of June, £3.2m adverse against a plan of £4.2m.

Of the £22.4m identified savings in 2019/20, £15m is recurrent with a full year effect of £19.9m.

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	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-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 June 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 June 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 Trust Board is satisfied that plans in place are sufficient to ensure ongoing compliance with all existing targets (after the application of thresholds); and a commitment to comply with all known targets or improvement trajectories going forwards.	Yes
4	The board is satisfied that the Trust shall at all times remain an ongoing concern, as defined by the most up to date accounting standards in force from time to time.	Yes	11	The 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:	Board Meeting		**Agenda Item:**	19.
Date of Meeting:	25 July 2019			
Report Title:	M2 Corporate Objectives Report			
Report Author & Job Title	Karen Michael-Cox, Head of Business Planning			
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 2 delivery of Trust objective			
Report History:	Reported at 18 July TMT			
Next Steps:	Progress will be further reported at Month 4 and Month 6			

Executive Summary	
The Board is asked to note the attached report on progress towards corporate objectives at Month 2.	
Strategic Theme/Corporate Objective Links	
Board Assurance Framework/Trust Risk Register Links	
Other Standard Reference	N/A
Financial implications	N/A
Other Resource Implications	N/A
Legal Implications	N/A

including Equality, Diversity and Inclusion Assessment	

Appendices:	Appendix A: Month 2 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 all of the objectives identified for 2019/20 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 at Month 2, Month 4 and Month 6

3.1 The report gives a brief description of the Key Deliverables and Key Result Areas and provides an indication of the progress of the Key Deliverable at M2 alongside a forecast position for the year.

3. Recommendations

4.1 The Board is asked to note the report on month 2 delivery of Trust objective.

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

Key Deliverables	Key Result Areas	M2 Update	M2 YTD	Exec Fcast	Governance	Key Metrics/ Milestones	Exec	Owner
Achieve "good" CQC rating	• Achieve "good" or better assessments from next CQC visit	*CQC Well Led inspection concludes 18/7/2019.*			TMT	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 report (FA repsonse within 10 working days) Final Report publication timeframe- 3 months from end of Well Led inspection (i.e. 18/10/2019).	Helen B	Paul Cresswell
Build on our Perform programme	• Sustaining 18/19 levels of LOS in 19/20Q1-Q3	*19/20 till Q3 focus for Perform is Flow. LOS is broadly in line with 18/19 but here are hot spots across the Trust where the improvements are not sustaining.* *Q4 focus to be determined - Key result areas for Perform from Q4 are under development*			Transformation Board	Flow Metrics reported in Perform dashboard	Jacqui M	Matt Dixon
Invest in clinical governance for learning and improvement	• Implementation of planned clinical governance capacity	*CGIP Programme Board 28/6/19 reviewing recruitment progress within Clinical Divisions into new roles. Also undertaking stock take of project delivery and benefits.*			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	Helen B	Paul Cresswell
	• Deliver milestones in Trust Quality Strategy	*Quality Strategy reviewed at Board - May 2019. Update required at July Board.*			New oversight group to report into QRMC 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)	Helen B	Paul Cresswell
Deliver the digital programme	• Performance against digital programme milestones	*The Project continues on track, with first stage of new core equiptment installed during Apr 19. The draft JD has been created and submitted to Banding Panel*			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.	Neil D	Kath Kaboutian Phil Wade
Introduce three clinical IT systems	• Delivery of Clinical Messaging & handover App	*Product selected inline with Digital Strategy and in collaboration with UHB. Care of the Elderly and Vascular are pilot wards and will commence in June '19.*			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)	Neil D	Kath Kaboutian Phil Wade
	• Delivery of Blood Tracking Solution (**replaced EPMA)	*Software and kiosks have been installed. The project board have approved a change to the roll -out plan which means training will now take place until July*			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)	Neil D	Kath Kaboutian Phil Wade
	• Delivery of E-Observations	*FBC approved at Trust Board in April 2019. Signing of contract with System C has been delayed due funding issues in NHS England.*			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)	Neil D	Kath Kaboutian Phil Wade
Key Deliverables	**Key Result Areas**	**M2 Update**			**Governance**	**Key Metrics**	**Exec**	**Owner**
Cut waiting times for cancer treatment	• Performance against improvement trajectory	*The nationally reported cancer position for April 2019 shows the Trust achieved two of the seven cancer waiting times standards and five out of seven against the Trust's recovery trajectory.* *The Trust failed the TWW standard with performance of 84.70% which is a worsened position from March.* *The Trust failed the 31 day first treatment standard with a performance of 93.08% against the 96% target.* *The Trust achieved the 62 day recovery trajectory in April with a performance of 84.40%.* *In April, 29 patients breached the 62-day standard, 18 of which started their pathway at NBT.* *Urology breaches accounted for 76% of total Trust breaches for April.*				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.	% performance against the 7 national cancer wait times standards/recovery trajectories.	Rosanna James
Deliver DMO1 waiting times for diagnostics	• Performance against improvement trajectory	*The Trust does not have a recovery trajectory in year to achieve DM01 and at M2 has experienced decon issues in Endoscopy, resulting in further deterioration in performance*				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.	% performance against the national DM01 standards/recovery trajectories.	Rosanna James

Objective 2: Improve patient access and experience	Significantly increase Emergency Zone staffing	• Performance against A&E improvement trajectory	*The Trust did not achieve the ED 4 hour wait trajectory of 90.77% in May 2019, with performance of 76.16%. The position has improved from April but reflects a deterioration when compared with May 2018.* *At 8266, May confirmed the highest number of attendances to be received by the Trust in a month. Since April, the Trust has received 13 more attendances per day when compared to the same period last year. An increase in Delayed Transfers of Care (DToC) further impacted waiting times in May.*				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.	% A&E 4-hour performance against national standard/recovery trajectory There are a number of supporting and balancing metrics found within the IPR.	Rosanna James
		• Delivery of new emergency care models with increased staffing	*GP streaming model - CCG and NBT pilot underway. Deadline for Business Case to establish full service from November off track. ACP workforce model to increase Tier 1 and 2 staffing model (non medical posts). Lead ACP appointed and 4 further training posts our to recruit*				CCG/NBT project group meets weekly. Progress overseen by the Urgent Care Improvement Board chaired by the COO		Valerie Clarke
	Eliminate all 52 week waits for operations.	• Profile against trajectory of improved numbers of 52 week waiters towards year-end target of zero	*In May 2019, the Trust reported 16 breaches (13 x MSK; 2 x Plastic Surgery; 1 x Neurology) and has a RAP and recovery trajectory in place to support clearance of all 52 week waiters by the end of September 2019. Two specialities are receiving intensive support: Plastics and MSK due to the performance in April and May and forecast for the next few months, which includes breaches for MSK beyond the end of September 2019.* *Risks related to patients choosing to wait longer than 52 weeks remain, but in reducing the long waiting tail of patients, occurrences should be greatly reduced and more easily managed.* *As per current forecast of 2019/20 the potential fining position is c. £225k.*				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.	Number of 52 week waiters on an incomplete RTT pathway versus the recovery trajectory.	Lisa Whitlow
	More responsive care for people with learning disabilities, autism or both	• Roll out training to front line staff	*Statutory autism awareness e-learning is available and being accessed* *L&R have worked with autism specialists at AWP to devise face to face training at 2 levels for specific staff groups.* *Currently exploring LD awareness training*			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	Helen B	Gill Brook
		• Improve identification of patient needs and make reasonable adjustments to care	*LD champions from different staff groups in place in most ward, working on addressing the needs of patients with LD and we are training LD champions in assessing need and making reasonable adjustments. Next steps are to* *1. consider patient needs and reasonable adjustments for patients and staff with autism* *2. formalise a programme of reasonable adjustments*			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	Helen B	Gill Brook
Objective 3: Work more closely with other hospitals, community services, GP practices and social care	**Key Deliverables**	**Key Result Areas**	**M2 Update**			**Governance**	**Key Metrics**	**Exec**	**Owner**
	More tests, treatments and advice in homes and health centres	• Progress on Acute Care Collaboration programmes	*NICU OBC progressed through approvals*			ACC Steering Group		Chris B	Dave Gibbs Karen Maxfield Sam Wadham Kiaran Flanagan
		• Delivery of Integrated Care System development and system digital programme milestones	*Working with solution provders on possible solutions to commence a pilot in Qtr. 2*				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)	Neil D	Kath Kaboutian Phil Wade
	Faster stroke treatment and rehabilitation for all patients.	• Performance against agreed key milestones in System stroke pathway development in 2019/20	*STP options have been designed and will be discussed with all stakeholders.* *BNSSG group moving towards scoring of the options available.*			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)	Chris B	Nicholas Smith
	Deliver NBT's excellent breast, urology and histopathology services for people in Weston	• Delivery of Breast, Histopathology and Urology services at Weston	*Aiming for July/ August TMT for urology merger business case, with full mergers of both Breast and Urology to be undertaken by Q3*					Chris B	Dave Gibbs Niall Prosser

Objective 4: Build effective teams empowered to lead

Key Deliverables	Key Result Areas	M2 Update			Governance	Key Metrics	Exec	Owner
Prioritise the health and wellbeing of our staff.	• Improved employee engagement and take-up of wellbeing offer	*Baseline sickness absence reduction trajectory set for 19/20 set based on trajectory achieved in 18/19.* *Target of wellbeing programme takeup set as 5% of staff using EAP programme. Current takeup is 3% of staff.*			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.	Jacqui M	Guy Dickson
	• 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 (Apr-19 rolling 12 month position improved from previous month). Stability has remained stable (85.2% Apr-19 and 85.3% May-19) and is an improved position from the same point last year (May-18, 84.8%) . Vacancy factor remains stable but is slightly above target (10.1%. vs 10%). Happy App positive/neutral % for April and May was 44.2% below target of 60%.*			Metrics are monitored through the IPR which is reviewed by the People an Digital Committee and Vacancy Factor, Sickness Absence are monitored through Divisional Performance Review accountability framework	Health and Wellbeing: Sickness Absence Health and Wellbeing: Time lost to sickness absence Stress/Anxiety/Depression, and; MSK Sustainability: Stability Index % Sustainability: Vacancy Factor % Sustainability: Engagement – Happy App Positive/Neutral	Jacqui M	Liz Perry Ben Pope
	• Expanded usage of new roles						Jacqui M	Liz Perry Ben Pope
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. Evaluations from first core day have been positive. Over 300 staff nominated for programme with divisions still putting forward participants.*			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.	Jacqui M	Harriet Attwood
Flexible working to use fewer agency and locum staff	• Agency and temporary expenditure against plan / monthly target	*Agency hours reduced particularly in key staff groups, consultants and registered nursing. Agency expenditure continues to be above target exacerbated by May being 5 week month for invoicing. A bank and agency task and finish group has been established and will focus on maximising the use of the staff bank within the Trust and supporting the BNSSG collaborative project to reduce high cost agencies.*			Metrics are monitored through the IPR which is reviewed by the People and Digital Committee and through Divisional Performance Review accountability framework	Temporary Staffing: Agency worked WTE Temporary Staffing: Agency cost £	Jacqui M	Liz Perry Ben Pope
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	Chris B	Rebecca Smith

Objective 5: Become financially secure for the long term

Key Deliverables	Key Result Areas	M2 Update			Governance	Key Metrics	Exec	Owner
Live within our budget for fourth year in a row	• Monthly financial performance against plan	*Deficit of £1.5m, £0.2m adverse to plan; Main risks relate to income recovery and delivery of £25m CIP*			TMT		Catherine P	Nicky Mowatt
	• Monthly CIP delivery against plan	*In year: £21.7m identified vs £25.0m* *FYE: £18.6m identified vs £25.0m* *£0.89m CIP delivered vs £2.59m in NHSI plan at end of M2*			TMT	CIP identified vs NHSI-submitted target of £25m in year and £25m FYE CIP in-month delivered vs identified	Jacqui M	Niall Prosser
Deliver our transformational programme	• Monthly progress against milestones for Trust-wide themes (theatres, workforce, urgent care)	***Workforce*** *TiS interface Live; ePayslips to go live 22 Aug 2019; training pack being written, email addresses being updated* *Funding approved and additional Allocate modules for Junior Drs eRostering and Medics ejob planning purchased* *Junior Drs posts in ESR; Medics posts in progress*			Transformation Board	Refer to business case	Jacqui M	Niall Prosser
		Theatres: *Additional capacity is now in place.* *Challenges to deliver additional activity through productivity as list uptake has been impacted by workforce challenges.* *Managed Equipment Service business case is aiming for August TMT and board*			Theatre Board	New Theatre capacity into the programme April 19 - complete theatre productivity programme to be delivered (Q2) Managed Equipment Service for theatres (Q3)	Jacqui M	Niall Prosser
		Urgent Care 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	Evelyn B	Rosanna James
Refresh our five-year strategy and financial plan	• Strategy refresh agreed by Board	*Board workshop with clinical directors in April.*			Strategy Steering Group, TMT and Board	Strategy expected to be finalised in September alongside long term financial model and transformation programme	Chris B	Tim Keen

Objective 5									
		• Long Term Financial Model, aligned to strategy	*Work ongoing on sustainability plan with particular focus at present on activity base case and drivers of deficitfor Trust Board in June*					Catherine P	Nicky Mowatt
	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, and this has been circulated to Divisions. GIRFT implementation plan shared with BNSSG CCG. Gynae, Spinal and Urology to identify top 3 areas. 10 specialties have submitted*			Transformation Board	Report quarterly on progress on specialty focus areas of opportunity (to be confirmed).	Chris B	Monica Baird
	Make better use of our pathology resources	• Pathology Managed Services Contract (MSC) procurement	*All West of England Pathology providers fully engaged and procurement process with supplier dialogue meetings commencing next week on target for the agreed timeline.*			West of England Pathology Network Board	Issue Invitation to Submit Detailed Solution (ISDS) to shortlisted bidders by 20 December 2019	Chris B	Dave Gibbs
		• Pathology Networking	*All organisations have completed a target operating model (TOM), work commenced on a strategic outline case and memorandum of understanding to drive process forward. No overall agreement on operating model for network or level of integration/consolidation.*			West of England Pathology Network Board	Submit Strategic Outline Case to Trust Boards and NHSI by end July 2019	Chris B	Dave Gibbs

Report To:	Trust Board Meeting		**Agenda Item:**	20.
Date of Meeting:	25 July 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 September 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 20th June 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 20th June 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 May were considered. It was reported that the RTT trajectory had not been achieved in May and stood at 85%. This was due to a number of issues, including staff absences and increased demand in plastics and gastro. The 52 wait performance was however ahead of trajectory in May, although still not meeting the national standard.

3.2 It was reported that May had seen the highest attendances ever in A&E, and four hour performance was at 71.6 for the month. The position had improved slightly in June with the performance at 74% to date. The Committee requested that it receive assurance that the quality of care in A&E was not being comprised whilst the Trust was not achieving its A&E performance targets, and to this end it requested that a mechanism to allow this to monitored be developed and reported to the next meeting. It was also requested that in future the most recent available IPR data should be submitted to the committee a week in advance of the meeting, with a coversheet setting out known movements and issues in month. The most recent data should then be tabled / circulated at the meeting itself.

3.3 The Committee undertook a deep dive into RTT 52 week-waits. It was reported that from April 2019, Providers and Commissioners would be fined £2,500 per patient with an incomplete RTT pathway waiting over 52 weeks at the end of every month that they were breaching, and therefore this needed particular attention by the Trust. The Committee considered the measures in place to ensure that by December 2019 there were no 52 week wait breaches, and the areas within the Trust where there were particular challenges. During the discussion it was confirmed that there was no evidence of patient harm as a result of the Trust's 52 week wait performance.

3.4 The Month 2 Finance Report was received. It was reported that at the end of May the Trust was reporting a deficit of £1.5m, £0.2m adverse to plan. Income was £2.9m below plan, of which £1.2m was in clinical income, offset by lower pay and non-pay costs. Other income was below plan due to a number of factors including a phasing issue related to income CIP.

3.5 The Committee received an update on the Financial Sustainability Plan from the Director of Finance.

3.6 The Committee received and reviewed the 2019/20 CIP programme. Concern was expressed at the number of projects flagged as 'red' in the programme, and it was requested that by the end of July there should be clarity on the position in respect of these projects to allow the Trust to be in a position to identify what would be delivered in year, and make decisions accordingly.

3.7 The Committee approved the business case for the vacation of the Cribbs Causeway Medical Records Library.

3.8 The Committee considered the recently completed Data Quality Internal Audit Report, and requested that it receive an update when recommendations as outlined in the report had been completed for assurance.

3.9 The Committee considered it workplan for the remainder of the financial year and requested that a number of subjects be added to it for its assurance.

4. Escalations to the Board

4.1 At the meeting on the 20th June 2019 the following business cases were recommended to the Trust Board for approval as they were beyond the delegated limits of the committee:

- Outline Business Case - NICU Reconfiguration
- Microsoft Licencing and Office 365: Enterprise Licence Agreement

In respect of the NICU Reconfiguration Outline Business Case, the Committee commented that this was a major strategic decision for the Trust, and it made the following comments:

- Some key principles around the proposal needed to be bottomed out for it to proceed, particularly in respect of where the risks sat for each organisation;
- An indication of the timelines involved would be useful;
- The proposal should be developed in tandem with the review of maternity services in Bristol;
- The proposal should not result in further detriment to the Trust's financial position.

The above business cases were subsequently considered and approved at the Private Trust Board meeting on 27th June 2019.

5. Identification of New Risk

5.1 No new risks were identified in the meeting.

6. Recommendations

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