Trust Board Meeting in Public  
Thursday 31 May 2018 12.30 p.m.  
Seminar Room 4, Learning and Research Centre,  
Southmead Hospital

<table>
<thead>
<tr>
<th>Agenda</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Opening Business</strong></td>
</tr>
</tbody>
</table>
| 1. Apologies and Declarations of Interest: Sue Jones.  
2. Questions from Members of the Public  
3. Minutes of the Trust Board meeting held on 5 April 2018  
   FC/Enc  
4. Action Log and Matters Arising  
   FC/Enc  
5. Chairman’s Business  
   FC/Verbal  
6. Chief Executive’s Report  
   AY/Enc |
| **Quality and Performance** |
| 7. Patient Story *(Information)*  
   CT/Verbal  
   AY/Execs/Enc  
9. CQC Inspection Action Plan Update *(Information)*  
   CT/Enc |
| **Strategy and Development** |
| 10. Research Strategy Update *(Information)*  
   CB/Presentation  
   SW/Enc |
| **Governance and Assurance** |
| 12. Directors’ Register of Interests Update *(Information)*  
   LS/Enc  
13. Provider Licence Self-Certifications *(Approval)*  
   LS/Enc  
   ND/Enc  
15. Quality and Risk Management Committee Report *(Information)*  
   ER/Enc  
16. Charity Committee Report *(Information)*  
   JMD/Enc  
17. Trust Management Team Report *(Information)*  
   AY/Enc  
18. Workforce Committee Report *(Information)*  
   TG/Enc  
19. Finance and Performance Committee Report *(Information)*  
   ER/Enc  
20. Audit Committee Report *(Information)*  
   JMD/Enc |
| **Closing Business** |
| 21. Any Other Business  
22. **Date of Next Meeting**  
   Thursday 2 August 2018, 12.30pm, Learning and Research Centre, Southmead Hospital |
Minutes of the Trust Board Meeting held in public on 5 April 2018 in Seminar Room 5, Learning and Research Building, Southmead Hospital

Present:

Mr F Collins  Chairman  Mrs A Young  Chief Executive
Ms J Davis  Non-Executive Director  Dr C Burton  Medical Director
Mr J Everitt  Non-Executive Director  Ms J Fergusson  Director of People and Transformation
Prof J Iredale  Non-Executive Director  Ms K Hannam  Director of Operations
Mr R Mould  Non-Executive Director  Mrs S Jones  Director of Nursing
Dr Liz Redfern  Non-Executive Director  Mrs C Phillips  Director of Finance
Mr R Mould  Non-Executive Director  Mr S Wood  Director of Facilities

In Attendance:

Ms N Ferris  Matron, Anaesthesia, Surgery, Critical Care and Renal Division (for item 18/4/1)
Mr S Lightbown  Director of Communications
Mr J Millett  Hospital at Home patient (for 18/4/1)

Mrs S Millett  Hospital at Home Patient’s Wife (for item 18/4/1)
Mr R Smith  Consultant in Intensive Care (for item 18/4/1)
Mr N Stibbs  Corporate Services Manager

Apologies:  Mr T Gregory, Non-Executive Director, Mr N Darvill, Director of Informatics and Ms L Storey, Interim Trust Secretary

Observers: Eight members of the public and five staff

Action

TB/18/4/1  Patient Story

Sue Jones, Director of Nursing, reported that the Trust had begun a new service entitled Hospital at Home for surgical patients. She introduced Mr and Mrs Millett, the former one of the first patients to benefit from the service and also introduced Mr Reston Smith, Consultant in Intensive Care and Ms Natalie Ferris, Matron who had instigated the service.

Reston Smith informed the Board that the service was to identify suitable ex surgical patients in Brunel who could be discharged earlier than usual but with the Trust delivering its care at their home. James Millett had been one such patient identified and he had been discharged home to his wife Susan.

James Millett explained that he was 77 and a retired professional and he would greatly recommend the service. He suffered from non-invasive cancer and had had a history of urinary tract infections treated by both primary and secondary care. When he had been admitted to the Surgical Acute Unit on 2 February he was initially given an IV but the Hospital at home Team Leader stopped it, spoke to the doctor and had the drug changed to one suitable for oral use. Unfortunately it took five hours for the drug to be delivered from pharmacy and he left...
hospital at midnight. At home he was given the correct care and treatment by the articulate nurses especially from Liam who was the only nurse with experience with urology.

Susan Millett said that it had been a comfort to have her husband at home and she had been happy to assist in his care but she had been a little daunted to be left at home at night with only a small booklet. Further helpsheets on the cannula and on hydration would have been useful. She suggested that a geriatric hospital at home service would be useful.

John Everitt, Non-Executive Director, asked if any helpline had been offered and James Millett said there was a number for a hub to be contacted if necessary at any time and also a special number between 7.00 am and 7.00 pm. John Iredale, Non-Executive Director, questioned whether modern technology could be harnessed to improve such care such as video monitoring and what ethical issues this might bring forward. Reston Smith noted that there were on-line patient records that could be monitored that gave early warning of any health issues.

In answer to Rob Mould, Non-Executive director, James Millett said he had been pleased with his discharge procedures but noted that his GP was unaware of the Hospital at Home service.

The Chairman thanked Mr and Mrs Millett for their story and Reston Smith and Natalie Ferris for their attendance and their innovative thinking.

TB/18/4/2 Declarations of Interest
No interests were declared relating to the papers to be presented.

TB/18/4/3 Questions from Members of the Public
There were no questions from the public.

TB/18/4/4 Minutes of the Trust Board meeting held on 1 February 2018
The minutes were approved as a true and correct record of the meeting subject to the correction to Ms Jane Byron’s name in Minute18/1/2.

TB/18/4/5 Action Log and Matters Arising
The Trust Board approved the closure of actions as stated on the action log and noted that there were no issues requiring action at the meeting.

TB/18/4/6 Chairman’s Report
Frank Collins, Chairman, reported that since the beginning of February he had met with Jeff Farrer, Chairman of University Hospitals Bristol (UHB) and agreed on an ongoing collaborative relationship. He had also met with Sir Ron Kerr, Chairman of the Sustainability and Transformation Programme and discussed how the senior team could work together within a framework.

He had attended an NHS Providers meeting in London where Chris
Hopson had discussed the state of health of the NHS and the previous week he had chaired the employee based committee on clinical excellence awards for consultants.

**TB/18/4/7 Chief Executive's Report**

Andrea Young, Chief Executive, presented her report and said in addition that the Board thanked the Hospital Charity for funding a free meal for all staff in thanks for the effort everyone had put in over the Winter. With reference to the Winter pressures focus groups had been held with staff on what went well and what could be changed to help relieve such pressures and these had elicited very good response. Some of the practical suggestions included flexibility about work patterns, the importance of breaks and provision of Amazon lockers.

**TB/18/4/8 Integrated Performance Report**

Andrea Young introduced the monthly Integrated Performance Report (IPR) and highlighted the following:

- the achievement only of 67.5% of patients waiting less than four hours in the Emergency Department (ED) in February although it was currently at 85%. The main reasons were waiting for assessment in ED due to gaps in junior rotas but also coincided with a period when admissions had risen by 17%;
- ongoing Winter pressures had meant the agreed Referral to Treatment (RTT) trajectory had not been met although the number of patients waiting over a year had fallen;
- the diagnostic waiting time had achieved the national target and was the best performance since October 2015;
- only three of the cancer standards had been achieved. Breaches in Urology accounted for most of the failure in the 62 day breaches due to capacity issues and it was expected that the majority of the standards would recover;
- overdue responses to complaints had fallen whilst Friends and Family response rates had been static in ED and Inpatients, improved in Maternity but declined in Outpatients.
- Agency expenditure had decreased but was above the NHS Improvement target level.

Kate Hannam, Director of Operations, reported on a divisional level review of the Winter pressures and noted that the Trust had still operated on 100 elective patients per day and on cancer patients. Staff commitment during the snowy periods had been good. Referring to the RTT performance she reported that Plastic surgery had failed to deliver the national standard mainly due to underperformance at sub-specialty level due to theatre staff sickness and a reduction in referrals rather than a growth in the backlog. It was not expected to return to the standard until the end of 2018 because of longer term staffing issues.

Liz Redfern, Non-Executive Director, questioned why the two week GP referral and for breast symptoms had failed when the Trust had for a long period achieved the standards. Kate Hannam informed her that this was due to a breast care consultant sickness in December and the loss of working days over Christmas with patients also cancelling.

Sue Jones referred to the nursing workforce data and noted the significant escalation staffing in Medicine in February but with an
improved substantive Health Care Assistant position and decreased use of bank staff. It was noted that it was patient experience week and the Trust was starting to see improvements in the nursing workload. There had been no new reported Grade 3 or 4 pressure injuries and malnutrition compliance had improved although it was not yet close to the standard and targeted work was ongoing. Compliance with the WHO Checklist had improved driven by an improvement programme overseen by the Theatre Board.

Chris Burton, Medical Director, was pleased to note the lowest ever number of annual recorded C. Difficile cases and reported that the target for the current year had been set at 42. Turning to research and innovation he was also able to report on strong patient recruitment particularly in maternity but also commercial and non-commercial studies. Since a change in national process, however, the Trust was finding it challenge to recruit the first patient within 70 days.

Liz Redfern referred to some of the comments from the Friends and Family Test about waiting for medication and Kate Hannam said this occurred sometimes because there were delays by the doctor in writing up the TTAs. The use of the discharge lounge had increased but that meant a doctor sometimes had to go there rather than write it on the ward.

Jaki Davis, Non-Executive Director, questioned how activity in March felt to the executive directors and Kate Hannam said there was no reason to expect poorer results. On some measures, such as RTT, the commissioners' guidance was only to maintain the current position. John Everitt said that he would like to see further comparative data from trust peers.

Catherine Phillips, Director of Finance, referred to the finance section and noted the deficit to the end of February at £22.8m which was £4.7m adverse to the planned position but only £1.4m adverse when the STF funding was excluded. Frank Collins said that the Board very much recognised the hard work of staff.

Referring to the compliance statement regarding plans to ensure ongoing compliance with all existing targets the Board agreed to maintain its negative answer with a review to be taken in June when the deliverability of the Operational Plan was reviewed.

Sue Jones presented the outcomes of the Care Quality Commission (CQC) inspection held in November 2017 and the draft action plan to respond to the issues outlined by the CQC. She noted that this had been the third inspection in the South West under the CQC’s revised regime and highlighted the timelines of the operational and well led inspections, the draft report and factual accuracy submission and the correction of errors in the final report. The overall rating was ‘Requires Improvement’ and within that the Outpatients service line had improved to ‘Good’. Since the previous inspection eight individual ratings had improved including one to ‘Outstanding’ and five to ‘Good’. Two had worsened. There were 22 ‘Must Do’ actions and 42 ‘Should Do’ actions.

Sue Jones said that since publication there had been good public and political comments about the positive improvements made by the Trust.
and a communications plan had been enacted for internal and external use. The action plan currently before the Board was a draft due to the timing of the meeting and the timing of its submission to the CQC. It would be reviewed by the Clinical Commissioning Group the following day and the Trust Management Team later in the month. There were immediate priority actions which included the Trust's overall plans to address the Emergency Department (ED) four hour performance and reduce the bed occupancy levels as well as improving the awareness of local teams on the statutory framework around mental capacity and deprivation of liberties.

The CQC’s remit now included a more frequent and ongoing engagement approach to providers which would encompass interactions at the corporate level and with clinical service leads and staff focus groups. Later in the month visits were planned to Women's and Children’s Services and Cossham Hospital and later in the year to ED, Medicine, End of Life Services and Surgery.

John Everitt expressed surprise that some of the simple actions had yet to be enacted and asked what assurance would be given to the Board that actions were delivered. Sue Jones said that the call bells were now in place and since Easter there had been no use of extra beds on any ward. Assurance would be given through the Quality and Risk Management Committee (Q&RMC) and the Board agreed that further assurance should come direct to the Board through the Integrated Performance Report.

Jaki Davis asked that completion dates be provided for each action for Q&RMC to monitor and Liz Redfern asked how performance monitoring by managers would be undertaken. Sue Jones reported that the divisional management teams would review their actions on the CQC report each month and the Quality Committee would receive monthly reports that would assure the Management Team of progress on actions.

Frank Collins noted that the actions needed to be embedded into the overall Operational Plan for 2018/19 and there were some issues about the revised approach by the CQC which meant that not all aspects of a large provider were or could be taken into account by the inspectors. As pointed out by Liz Redfern, however, there was much to learn for clinical leaders.

The Board agreed the approach to a virtual approval of the final version of the action plan for submission to the CQC on 19 April with its circulation to Board members immediately prior to that date.
Improvement which were consistent with pieces of work already underway. A leadership steering group had been set up to improve management development, different approaches to staff engagement had already been trialled and use of the Happy App was growing. The latter would be an aid to analysis of these improvement programmes.

The Board noted the report.

**TB/18/4/11 Quality Account Priorities 2018/19**

The Board received a paper seeking approval for the draft quality priorities for 2018/19 which were supported by the quality Committee, the Trust Management Team (TMT) and the Quality and Risk Management Committee. Sue Jones said that ongoing assurance oversight arrangement would be maintained by the Quality committee reporting to TMT and through the IPR.

Sue Jones summarised the priorities as:

- Eliminate delays in hospital to improve patient safety and reduce bed occupancy;
- Enhance the way patient involvement and feedback is used to influence care and service development;
- Continue improving the quality of end of life care across all specialities;
- Strengthen learning and action by embedding quality governance at all levels and:
- Demonstrate a stronger clinical understanding and application of the Mental Capacity Act and Deprivation of Liberty Standards.

The Board approved the priorities and the ongoing assurance processes.

**TB/18/4/12 Healthy Food CQUIN**

Simon Wood, Director of Estates, Facilities and Capital Planning presented a report outlining the progress made by the Trust in supporting the food aspects of the health and wellbeing agenda and the achievement of this year’s CQUIN criteria. He explained that the report, presented in public, formed part of the evidence for the awarding of this year’s CQUIN by the Clinical Commissioning Group.

The report outlined:

- the success of North Bristol's catering team in providing healthier choices for staff, patients and visitors;
- the meeting of all requirements to achieve the CQUIN for 2017/18 and;
- the amount of work towards the requirements for the following year’s CQUIN.

The CQUIN on NHS staff health and wellbeing was one of 13 mandatory CQUINS and its goal was to improve the food environment and the health of the food offer in hospitals making it easier for NHS staff to make healthier choices, supporting their health and wellbeing.
There was evidence from the NHS staff survey and elsewhere that improving staff health and wellbeing would lead to higher staff engagement, better staff retention and better clinical outcomes for patients. Simon Wood said that as well as the banning of price promotions and advertisements for sugary drinks and foods high in fat, sugar and salt and ensuring that healthy options were available at any part of the day and night the Trust had improved the presentation of food and changed the content of foods and the stocking drinks.

The latest changes were part of a ten year success for catering resulting in a number of external awards presented to the department recognising the changes made in using local provisions, seasonal produce, sustainable products and value for money. In answer to Rob Mould, Simon Wood said that these changes did not apply necessarily to the Costa outlets in the Brunel Atrium which were contracted to the Private Finance Initiative contractor but the laws were changing in June and he believed that Costa was working on producing better food and drink focussing on sugar content. Jaki Davis queried whether separately, Costa could be persuaded to help with the Trust's charitable funds. Simon Wood noted that the concessions were about to pass to a new contractor and he was hoping to effect some changes to the type of food offering.

The Board noted that the catering involved in the CQUIN involved the Vu Restaurant and the Coffee Shop, the Learning and Research Coffee Shop, all hospitality provided by the catering department, the volunteers' ward trolley, the patient service and the vending machines. The Department's meals had been accredited by Food for Life, it supported Sugar Smart, had joined the NHS England Voluntary Sugar Reduction Scheme and complied with the government Buying Standard for Food and Catering Services.

John Everitt welcomed the fact that the Trust appeared to be in the forefront of changes to catering in the NHS and the Board congratulated all the staff associated with the achievement over the past year.

The Board noted the report.

TB/18/4/13 Operating Plan 2018/19

Catherine Phillips presented the Operating Plan for 2018/19 which had been developed from the specialty and divisional plans. Since the draft had been seen by the Board the Government mandate to NHS England and remit to NHS Improvement (NHISI) had been published which contained a number of key deliverables and the Agenda for Change pay deal had been announced with union membership to be consulted. The financial plan assumed that both this and the tariff assumptions would be fully funded.

The key areas of focus were activity and performance, workforce, quality and finance. For the last of these, accepting the Operating Plan consisted of signing up to the control total of a £12.4m deficit and a cost improvement plan (CIP) of £37.7m. The CIP, capacity and key risks had been discussed by the Board earlier that day.

Andrea Young pointed out that there was still a gap of £7m to identify to achieve the CIP and the estimate of the capacity to deliver the
expected activity showed a gap in the bed numbers. The Board would review all the actions such as the Perform Programme and community partner plans at the end of June to reconsider the deliverability of the Operating Plan. There was confidence of this, however, in the clinical leadership.

Rob Mould stated that it was undoubtedly a stretched target and asked how it had been shared with partners. Andrea Young said that there had been meetings with them before submission of the plan and at the STP there had been an assessment of where the risks lay. A further meeting was to be held with NHSI and University Hospital Bristol to review all the system risks and challenges the following week. Rob Mould asked that the results of that meeting be communicated to the Partnership Programme Board meeting in May.

The Board approved the plan noting the potential changes arising out of national issues and a review to be held at the end of June on the bed capacity as well as the cost improvement plan.

**TB/18/4/14 Capital Planning Report**

Simon Wood, Director of Facilities, presented the monthly Capital Planning Report and noted that all the variations regarding the Private Finance Initiative were now denoted in one section.

He referred to recent Press coverage regarding the availability of capital funds from the government of £700m for which the Trust was not able to bid but £1.5bn had been set aside from the STP funds for capital bids to be submitted in July. Work had started on what schemes could fit into the draft estates strategy.

The Board noted the report.

**TB/18/4/15 Exercise of Emergency Powers**

The Board received a report from the Emergency Powers meeting attended by two non-executives, two executives, Simon Wood and some of the PFI project team on 15 March 2018. It had discussed proposals to approve a letter of intent from Project Co to enter into a contract with a demolition contractor and terminate the Construction Contract with Carillion Construction Ltd. but reserving the rights of the Trust in respect of the replacement contracts with sub-contractors.

Andrea Young said that another partner for the FM arrangements was now being sought following the withdrawal of a company from negotiations and Simon Wood noted that the Board may be asked later to repeat the emergency powers for building, landscaping and services contracts.

The Board noted the report.

**TB/18/4/16 Sustainable Development Management Plan Progress**

Simon Wood presented a progress report on the achievement of the objectives and targets of the Sustainable Development Management Plan approved by the Board in September 2017. Liz Redfern noted that
it had a positive impact on staff well-being.

Sue Jones said that it appeared that staff needed more information about recycling and Simon wood reported that because of changes across the world none of the Trust's recycling was currently being recycled.

The Board noted the report.

**TB/18/4/17 Informatics Progress Report**

David Hale, Assistant Director for Informatics, presented a progress report on 13 programmes most of which were on plan. The Electronic Document Management System had been paused whilst the concerns of 42 consultants about the quality and functionality of the product were allayed but the feedback following the response had been good. The E-referrals programme was behind time and Kate Hannam reported that this was a significant change for the NHS and no provider would be paid for activity that had not been referred electronically after September.

Other issues noted by the Board were:

- the temporary suspension of the purchase and development of Apps;
- the successful repelling of an electronic phishing attack targeting 800 email accounts;
- government funds of £600,000 had been released to NBT for cyber security measures and;
- good progress on implementing procedures to comply with the General Data Protection Regulations.

The Board noted the report.

**TB/18/4/18 Southmead Hospital Charity Committee Report**

Jaki Davis, Chairman of the Charity Committee presented the report from its meeting held on 13 March 2018 and highlighted the sustainable staffing of the team for the next two years and the pledge from the John James Foundation towards the cost of a second surgical robot.

The Board noted the report.

**TB/18/4/19 Trust Management Team Report**

Andrea Young presented the report from the Trust Management Team meetings held on 20 February and 20 March 2018. She highlighted the considerable time spent by the Team on developing the Business/Operational Plan and the Patient Flow Improvement Programme.

The Board noted the report.

**TB/18/4/20 Workforce Committee Report**

The Workforce Committee report from its meeting on 20 February 2018 was postponed.
TB/18/4/21  Finance and Performance Committee Report
Rob Mould, Chairman of the Committee, presented the report from the meeting held on 15 February 2018 and highlighted the presentation on the Perform Programme and the invitation to non-executives to attend one of its bootcamps.

The Board noted the report.

TB/18/4/22  Declarations of Interest 2017/18
The Trust Board noted the declaration of interests of all the members of the Board in 2017/18 and that these would be published on the Trust’s website.

TB/18/4/23  Appointment of Internal Audit and Counter Fraud Services
The Board noted a report from the Audit Committee setting out the appointment of KPMG as the contractors for Internal Audit and Counter Fraud services for the next three financial years.

TB/18/4/24  Skylark Rehabilitation Unit
Kate Hannam reported that the first 16 to 18 patients had been transferred to the Skylark Rehabilitation unit at the Meadows in Yate. The reaction of the patients was very positive and the environment was very good.

TB/18/4/25  Date of Next Meeting
The next meeting was to be held on Thursday 31 May 2018 at 12.30 pm in Seminar Room 4, Learning and Research Centre, Southmead Hospital.
<table>
<thead>
<tr>
<th>Meeting Date</th>
<th>Minute Ref</th>
<th>Action No.</th>
<th>Agenda Item</th>
<th>Action</th>
<th>Owner</th>
<th>Review Date(s)</th>
<th>Status</th>
<th>Info.</th>
</tr>
</thead>
<tbody>
<tr>
<td>24-Nov-16</td>
<td>TB/16/11/10</td>
<td>31</td>
<td>Sustainability &amp; Transformation Plan</td>
<td>FT membership to be engaged in ST Plans</td>
<td>SL</td>
<td>27-Jul-17 &amp; 26-Apr-18</td>
<td>O</td>
<td>Plans to be updated and awaiting governance arrangements</td>
</tr>
<tr>
<td>01-Feb-18</td>
<td>TB/18/1/15</td>
<td>7</td>
<td>Workforce Committee Report</td>
<td>Execs to consider proposal for how Board gains assurance that equality and diversity has been included in any change proposals</td>
<td>AY</td>
<td>31-May-18</td>
<td>O</td>
<td>Review of report template required.</td>
</tr>
<tr>
<td>05-Apr-18</td>
<td>TB/18/4/8</td>
<td>9</td>
<td>Integrated Performance Report</td>
<td>Compliance statement on plans to ensure ongoing compliance with all existing targets to be reviewed in June following assessment of deliverability of Operational Plan</td>
<td>AY</td>
<td>28-Jun-18</td>
<td>O</td>
<td></td>
</tr>
<tr>
<td>05-Apr-18</td>
<td>TB/18/4/9</td>
<td>10</td>
<td>CQC Inspection - Reporting &amp; Action Plan</td>
<td>Final version of CQC action plan to be circulated to Board prior to submission to CQC</td>
<td>SJ</td>
<td>26-Apr-18</td>
<td>C</td>
<td></td>
</tr>
<tr>
<td>05-Apr-18</td>
<td>TB/18/4/13</td>
<td>11</td>
<td>Operating Plan 2018/19</td>
<td>Results of Executive meeting with UHB on Operational Plan to next Partnership Programme Board meeting</td>
<td>AY</td>
<td>31-May-18</td>
<td>O</td>
<td></td>
</tr>
<tr>
<td>Report to:</td>
<td>Trust Board</td>
<td>Agenda item:</td>
<td>6</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>-------------------</td>
<td>-----------------------</td>
<td>--------------</td>
<td>---</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Date of Meeting:</td>
<td>31 May 2018</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Report Title:** Chief Executive’s Report

**Status:**

<table>
<thead>
<tr>
<th>Information</th>
<th>Discussion</th>
<th>Assurance</th>
<th>Approval</th>
</tr>
</thead>
<tbody>
<tr>
<td>X</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Prepared by:** Linda Storey, Interim Trust Secretary

**Executive Sponsor (presenting):** Andrea Young, Chief Executive

**Appendices (list if applicable):**
- Appendix 1a: Letter from Ian Dalton, Chief Executive of NHS Improvement and Simon Stevens, Chief Executive of NHS England
- Appendix 1b: Report on the next steps to align the work of NHS England and NHS Improvement.
- Appendix 1c: Healthier Together, Sustainability and Transformation Partnership (STP) for Bristol, North Somerset and South Gloucestershire (BNSSG) Accountability Arrangements.

**Recommendation:**

The Trust Board is asked to note the content of the report.
1. Purpose
1.1. To present an update on local and national issues impacting on the Trust.

2. Background
2.1. The Trust Board should receive a report from the Chief Executive to each meeting detailing important changes or issues in the external environment (e.g. policy changes, quality and financial risks in the health economy, PBR new tariffs etc.).

3. Welcome to Michele Romaine
3.1. I would like to welcome Michele Romaine to the Trust as our new Chair. Michele will be joining us formally from 1st July 2018 and has started to meet with colleagues as part of her induction. Michele will be joining us from the Royal Devon and Exeter NHS Foundation Trust where she holds the position of Vice Chair.

4. Trust Secretary Appointment
4.1. We were unable to progress with the interviews scheduled for 15th May 2018 following the withdrawal of applicants from the process. We will be reviewing the position and our approach to the recruitment later this month.

5.1. The first public Board meeting in common for NHS England and NHS Improvement was held on the 24th May 2018. The meeting discussed three sets of proposals:
   • How local NHS services can better work together, building care around patients rather than NHS institutions.
   • The NHS 2018/2019 Operating Plan covering Trusts and Clinical Commissioning Groups.
   • Agreement on how the two organisations would work more closely as system leaders for the health service.

5.2. The letter from Ian Dalton, Chief Executive of NHS Improvement and Simon Stevens, Chief Executive of NHS England together with the report on the next steps to align the work of NHS England and NHS Improvement is appended to this report. (Appendix 1a and Appendix 1b).

6. Healthier Together, Sustainability and Transformation Partnership (STP) for Bristol, North Somerset and South Gloucestershire (BNSSG)
6.1. The Healthier Together STP for BNSSG has set out its accountability arrangements in a paper (Appendix 1c).

This document could be made public under the Freedom of Information Act 2000. Any person identifiable, corporate sensitive information will be exempt and must be discussed under a 'closed section' of any meeting.
6.2. The STP is a partnership accountable to its constituent partners, with no independent legal status. This means that partner organisations remain accountable for their own activities but are also individually responsible for the STP and its success as a partnership.

6.3 A number of partners contribute to a pooled budget which funds a dedicated programme management office hosted by UHB Bristol.

6.4 A non-executive chair provides leadership for the further development and delivery of the STP and Sir Ron Kerr was appointed to this position in May 2017. The Chair’s term of office is renewable annually at the discretion of the partnership organisations and a formal review is currently in progress to inform a decision at the May 2018 meeting of the Sponsoring Body.

6.5 A Chair’s Reference Group is part of the STP oversight structure. The high level structure is shown in Appendix 1c)

6.6 To date Healthier Together has not developed any additional collective governance arrangements.

6.7 As the partnership develops, further consideration will be given to the question of a shared accountability framework, which might potentially be supported by a memorandum of understanding or other mechanism which would be subject to agreement by partner organisations.

6.8 Members of the constituent partner Boards/Governing Bodies are asked to note the current accountability arrangements.

7. Breast Screening

7.1 On the 2nd May 2018 the Secretary of State for Health and Social Care, Jeremy Hunt, made a statement in the House of Commons on breast screening.

7.2 A serious IT failure had come to light in the NHS breast screening programme overseen by Public Health England.

7.3 A computer algorithm failure dating back to 2009 meant that an estimated 450,000 women aged between 68 and 71 had not been invited to their final breast screening. An independent review has been ordered to establish the clinical impact.

7.4 We have confirmed our commitment to meet the additional capacity. I am pleased to report that our service, led by Alex Valencia has responded well to the request for additional capacity and will be offering evening and weekend appointments to the affected patient cohort. Funding will be made available.
8. New Care Quality Commission Chief Executive Announced

8.1 The new Chief Executive of the Care Quality Commission has been announced. Ian Trenholm, the current Chief Executive of the NHS Blood and Transplant Authority will take up the role in July when Sir David Behan steps down after six years.

9. Major Incident Handling Following the Fire at Bristol Haematology and Oncology Centre

9.1 During the early hours of 10th May a fire broke out at the Bristol Haematology and Oncology Centre (BHOC) resulting in 53 patients being evacuated safely to the BRI. From 7am onwards NBT took all emergencies in Bristol as University Hospitals Bristol managed their internal incident. A total of 305 patients were seen at NBT over a 24 hour period with staff from UHB emergency team coming in the evening to support our services.

9.2 The incident was well managed and demonstrated the ability of our system and Trusts to work well together.

9.3 Pleasingly our 4 hour performance during this period recovered quickly from 66% on Saturday to 93% on Sunday. Services at the BHOC are gradually being restored.

10. Healthy Weston

10.1 The programme of work to develop clinically and financially sustainable services at Weston has been refreshed to produce a set of options, generated by patients, staff and clinicians across Bristol, North Somerset and South Gloucestershire that will now be fully worked up. The timeline for this work coming together is expected to conclude with a pre-consultation business case, sponsored by the CCG, for November 2018.

10.2 Revised working arrangements are being established which will include NBT as a full partner in clinical, service and financial working groups. Further updates will come to the Board as well as being reported into the STP.

11. Secretary of State Roundtables on the Future of Health and Social Care

11.1 In response to the government’s commitment to review the future of health and social care with a fresh financial settlement, the Secretary of State for Health invited NHS leaders to a series of roundtables to seek views on the challenges ahead and transformation prospects.

11.2 At the group I attended there was a consensus around the need to reframe care for frail people, to address the workforce requirements
underpinning that care, including valuing the staff we have, and to strengthen capacity in the community settings.

11.3 It is clear that Secretary of State is seeking to frame this around a set of principles and goals which should be realistic but match our ambition for the future NHS and social care.

12. Recommendations

The Trust Board is asked to note the content of the report.
24/05/2018

To:
- Provider chief executives and chairs
- CCG accountable officers
- STP leads

Dear colleague

Creating coherent system leadership: next steps on NHS England and NHS Improvement closer working

The National Health Service is turning 70 on 5 July 2018. Over the last seven decades the NHS has helped transform the health and wellbeing of the nation and in turn has earned the enduring support of the British people. Through a process of continuous evolution and modernisation it has delivered huge medical advances, improvements in population health and innovations in patient care.

Today was the first public Board meeting in common for NHS England and NHS Improvement where we discussed three sets of proposals. We considered how local NHS services can better work together, building care around patients rather than institutions. We discussed the NHS’ 2018/19 operating plan covering both trusts and CCGs. Finally, we agreed a new way of working – which you can find here – outlining a detailed set of proposals about how NHS England and NHS Improvement are going to work closer together as system leaders for the health service.

Since we last updated you in March, we have been exploring how we can change our culture, systems and ways of working to provide coherent system leadership, working within an environment where we can all perform at our best for patients.

The next steps outlined in the Board paper explain how the majority of our national functions will move to single integrated teams reporting to both organisations, or as hosted teams, working in one organisation on behalf of both. You can also find in the paper the final proposals for the North and Midlands and East regional geographies.

We will keep you updated as we continue to develop our new approach.

If you have any questions or feedback, please do get in touch.

Yours sincerely

Ian Dalton
Chief Executive
NHS Improvement

Simon Stevens
Chief Executive
NHS England
Meeting date: Thursday 24 May

Agenda item: 01

Report by: Ben Dyson, Executive Director of Strategy, NHS Improvement
Emily Lawson, National Director: Transformation & Corporate Operations, NHS England

Report on: Next steps on aligning the work of NHS England and NHS Improvement

Progress on delivering joint working between NHS England and NHS Improvement; specifically proposals for:

a) Joint governance and accountability
b) Integrated regional teams and new regional geographies
c) Aligning appropriate national functions
d) Managing change well

Request: The Boards are asked to consider and endorse the proposals

Introduction

1. The National Health Service is turning 70 on 5 July 2018. Over the last seven decades the NHS has helped transform the health and wellbeing of the nation and in turn has earned the enduring support of the British people. Through a process of continuous evolution and modernisation it has delivered huge medical advances, improvements in population health and innovations in patient care.

2. Now, as the NHS moves into its next decade, local health and care systems across the country are rising to the challenge of a growing and ageing population by collaborating across organisational boundaries to develop more integrated models of care. In line with the vision of the NHS Five Year Forward View, we are seeing a growing movement towards commissioners and providers focusing on population health supported by local system-wide action. This means working together to mobilise community assets and collective capabilities to improve quality of care for individuals, health outcomes for populations, and wise stewardship of taxpayers’ resources.
Rationale

3. Faced with that challenge, NHS England and NHS Improvement now need themselves to evolve and adapt, to transform the way we work to provide a single system view that supports and enables integrated care.

4. In March, our Boards agreed ambitious proposals to transform the way we work together to provide more joined-up, effective and comprehensive system leadership to the NHS. This paper sets out our next steps in moving from fragmentation to coherence, to create an operating model that best supports local health systems and the patients and public they serve. This reflects both our organisations’ duties to co-operate with each other in the exercise of our functions; to exercise those functions economically, efficiently and effectively; and to facilitate, where beneficial, integrated provision of healthcare services.

5. For NHS Improvement, this will represent a shift from regulation to improvement in order to protect and promote the needs of all those who use the NHS over the next period of its history. NHS Improvement will focus more clearly on the areas that will bring greatest value in driving improvement and transformation both for the provider sector and for local health systems – see more detail in Appendix One. This will include a significant change in the senior organisational structure in NHS Improvement to enable it to deliver its refocused purpose.

6. In designing this new approach to joint working, we recognise that the statutory framework established by Parliament assigns NHS England and NHS Improvement (Monitor) some distinctive and non-shareable functions, and that primary legislation implies separate board governance, chairs and CEOs for the two organisations. The statutory framework also establishes distinct functions for clinical commissioning groups (CCGs) and NHS trusts and foundation trusts, which are also reflected in part in the functions of each organisation, including those Secretary of State functions delegated to the NHS Trust Development Authority (TDA).

7. That need not, however, stand in the way of enhanced joint working in many areas where the NHS will benefit from our doing so. Specifically, we want to:

   a. Move from a world where local health organisations (trusts, CCGs) sometimes receive different and conflicting messages from the national bodies, to one where – through our integrated regional teams – we have a single conversation with them.

   b. Take a more holistic view of NHS resources across commissioners and providers, both locally and nationally, better aligning financial incentives and architecture for whole-system improvement.

   c. Leverage NHS England’s and NHS Improvement’s distinctive competencies across both organisations (such as NHS Improvement’s work on patient safety and trust procurement efficiencies, and NHS England’s on cancer and mental health, on care integration and on pharmaceuticals).
d. Build out capabilities where there has been a gap in national leadership (such as on NHS people management and leadership development).

e. Mobilise national implementation resource for the forthcoming NHS 10 Year Plan.

f. Reduce administrative costs for redeployment into frontline patient care, recognising the differing requirements of this on our separate organisations, and agreeing what this means for our collective resources as we work together more closely.

Transforming the way we work: key proposals

8. Our guiding principle in this work is setting ourselves up to provide effective system leadership to the NHS. This will require us to be agile and adaptive, developing a learning culture that allows us to be flexible to the changing needs of the health and care system. We are now proposing our next set of changes to support this, encompassing all aspects of our current operating models: governance, systems and processes; organisation structures and capabilities; and culture and behaviours.

9. In terms of governance, systems and processes:

a. While respecting the legal need for the NHS England and NHS Improvement Boards separately to oversee their distinctive responsibilities, the Boards will also want to consider over the next several months the extent to which some of NHS England’s and NHS Improvement’s non-executive led board committees might be reshaped and aligned, building on the recent experience of the joint finance advisory committee.

b. NHS England and NHS Improvement will establish a new NHS Executive Group. Co-chaired by the two CEOs, membership will comprise all national directors and regional directors from the two organisations.

c. A new NHS Assembly (provisional title) will be created, drawn from – amongst others – national clinical, patient and staff organisations; the voluntary, community and social enterprise (VCSE) sector; the NHS Arm’s Length Bodies (ALBs); and frontline leaders from integrated care systems (ICs), sustainability and transformation partnerships (STPs), trusts, CCGs and local authorities. It will become the forum where stakeholders discuss and oversee progress on the NHS Five Year Forward View and help co-design the proposed upcoming NHS 10 Year Plan, and will build on the recommendations of NHS England’s Empowering People and Communities Task Force.

d. We will align all our core processes so that both our internal management and our interactions with the system are conducted once, with clear accountabilities at national, regional and system level. This will include establishing a single financial and operational planning process for the health system; a single performance management process and alignment of
regulatory interventions; a single internal talent management process; and a single process for establishing and reviewing national strategic programmes such as mental health. This builds on our already integrated management of IT across the system. And we will establish a single version of the truth in reporting and sharing information about the system.

10. In terms of **organisational structures and capabilities**: 

   a. **At a regional level**, we will create integrated regional teams covering both NHS England and NHS Improvement functions, and led by regional directors with full responsibility for the performance of all NHS organisations in their region in relation to quality, finance and operational performance.

The Regional Directors will play a major leadership role in the geographies that they manage, making decisions about how best to support and assure performance within their region, as well as support the development and identity of local STPs and ICSs. This is a move to a different kind of local leadership of the NHS, where Regional Directors promote, encourage and support local systems to achieve more integrated and sustainable models of care. It also means that the locus of decision-making will be centred more on the Regional Directors and their teams, with national teams generally providing support and intervention where agreed with Regional Directors.

The Regional Directors will report to the two CEOs and be full members of the national NHS Executive Group, with responsibility for developing the overarching strategy and architecture for the NHS as well as translating that into operational plans. Through this, they will help agree where a more standardised model to policy and delivery makes sense to ensure a unified approach, alongside the areas where regional teams should have the authority and discretion to design their own approaches or to implement in a more locally specific way. Appendix Two has more detail.

b. **At a national level** we will increasingly align functions across the two organisations, creating a set of new roles to support delivery:

   i. Three national director roles will be created which will report to both CEOs:

   1. A single *NHS Medical Director*.

   2. A single *NHS Nursing Director/Chief Nursing Officer for England*.

   3. A single *Chief Financial Officer* (responsibilities include leadership of the integrated financial and operational planning and performance oversight process).

   ii. Individual national directors in NHS England and NHS Improvement will take on responsibility for a number of ‘do-once’ functions supporting both organisations, with shared governance and oversight. These functions include:
1. National service programmes such as cancer and mental health; implementation of the FYFV and NHS 10 Year Plan, the move to ICSs, digital/ttech, and the health/social care interface, led by the NHS England Deputy CEO – who will also lead NHS England’s distinct responsibilities including commissioning specialised services (£17bn portfolio), primary care, oversight of CSUs, and emergency preparedness, resilience and response (EPRR) (NHS England).

2. Strategic programmes such as life sciences, commissioning development, primary care policy, patient choice and personalisation of care, innovation and research, led by the National Director for Strategy and Innovation (NHS England).

3. A new strategic approach to configuration of the provider landscape led by the Chief Provider Strategy Officer (NHS Improvement).

4. NHS leadership and NHS people management, led by a new role of Chief People Officer (NHS Improvement).

5. System-wide improvements in quality, access and efficiency, led by a new role of Chief Improvement Officer (NHS Improvement).

6. A system-wide approach to improving estates, procurement and back-office services, led by a new role of Chief Commercial Officer (NHS Improvement).

7. A shared approach to urgent and emergency care and elective care, led by a National Director for Emergency and Elective Care (NHS Improvement).

iii. A single National Director for Transformation and Corporate Development, who reports to both CEOs, leading most corporate operations across both organisations, including organisational development – both internally and with respect to system transformation – and people functions.

iv. For other areas of our work, where the nature of the organisation’s statutory functions requires, the activity and structure will remain separate and distinct, for instance NHS Improvement’s regulatory functions in relation to pricing, competition and patient choice, and its hosting of the Healthcare Safety and Investigation Branch; and NHS England’s responsibility for tariff currency development, commissioning of specialised services and primary care, and EPRR.

v. For communications and engagement, each organisation will need its own dedicated resources to support its own distinctive functions, but we are planning further work to align our approach more closely.

vi. For analysis, we propose further work to agree where we need to establish a single team for core areas of analysis to provide 'one version of the truth'; how we develop a shared approach to professional
development across our shared analytical community; and how we develop greater agility and flexibility in deploying our collective analytical skills, knowledge and experience in ways that best support our shared business.

11. We recognise that the proposed governance and structures must operate within constraints of the existing legal framework, including the requirement that, subject to some exceptions, each body’s functions must be exercised by its own committees or staff. Specific governance and decision-making arrangements will enable effective and legally compliant joint working, and provision to avoid or manage the actual or potential conflicts which may arise in relation to the exercise of different functions.

12. The net effect of these changes is that the two organisations will increasingly be working in a combined way on a shared set of system priorities, covering most key functions and capabilities:

   a. System strategy: encompassing, amongst other topics, health inequalities reduction, patient choice/personalisation, developing the provider landscape, innovation and research.

   b. Planning and performance: operational and financial planning, performance reporting and intervention.

   c. The move to integrated care systems: a single approach to supporting STPs and ICSs.

   d. Service transformation: single national service transformation programmes, for the Five Year Forward View clinical and service priorities such as mental health, cancer, learning disabilities, maternity and integrated care for older people.

   e. Improvement: a single approach to developing specialist resources that regional teams use with local health systems to deliver continuous improvement in quality, access and efficiency.

   f. NHS leadership and workforce: a single approach to developing senior leadership in the NHS and supporting the NHS in recruiting, retaining, deploying and developing today’s NHS workforce.

   g. NHS information and digital technology: a single approach to transforming how the NHS uses digital information and technology to improve quality of care, health outcomes and efficiency.

   h. NHS estates, procurement and back office services: a single approach to helping the NHS manage its estates/facilities, equipment, consumables and corporate services more efficiently and effectively.
13. At its heart, this programme of work is about reshaping the culture, mind-sets and ways of working of our two organisations, so that rather than defining ourselves around the traditional boundaries between commissioners and providers, primary and secondary care, or the identity of NHS England or NHS Improvement (including Monitor and TDA), we collectively see our role and purpose as providing system leadership to the NHS.

14. A joint approach to culture and behaviours will be developed with all staff, building on their input about what should be maintained and what needs to change in our current operating styles and our leadership behaviours. We will also work with colleagues across both organisations to redesign core processes, using a continuous improvement methodology, in parallel with the redesign, to ensure what we put in place is both effective and efficient.

15. As part of managing this change well, we will provide support to colleagues through various mechanisms, including:

   a. Ensuring all ‘people processes’ are fair and transparent, and adhere to our existing organisational policies.

   b. Providing support on how to ‘manage through change’ to all colleagues who want to participate, including support to develop resilience and manage stress.

   c. Providing additional support to line leaders to ensure they can support and engage their teams effectively through this period of change and beyond.

16. In light of this, we will be launching a joint staff engagement programme, as part of the joint All Staff briefings on 25 May, under the umbrella of ‘Project 70.’ This programme of work will enable us to learn from staff across our organisations and ensure that they are involved in the development and implementation of this work. Appendix Three sets out more detail.

**Timeline and next steps**

17. We will make the changes to the most senior roles (at a minimum, roles reporting to the two CEOs) by September and to the changed roles at the next level during the autumn. We will continue to move quickly so as to minimise the period of uncertainty for colleagues while minimising the risk to the system of a lack of continuity. We are aiming for all changes to be made by the end of this financial year.

18. We will be agile and responsive in our approach to implementation, identifying a clear set of measurable goals so we can measure success. We will also engage regularly with our staff, Trade Unions and system partners, both to involve them
in the detailed design, including the creation of a shared culture and leadership model, and to enable us to learn as we go and course correct where necessary.

Conclusion

19. The Boards are asked to endorse these proposals.
Appendix One

Refocusing NHS Improvement’s Purpose and Operating Model

1.1 NHS Improvement has recently completed a major programme of work to identify how to improve organisational purpose and operating model to better drive continuous improvements in the quality and efficiency of the NHS provider sector.

1.2 The conclusions from this work represent a significant change in focus, operating model and senior structures that will need to form an integral part of how we develop and implement the proposed approach to joint working. It has significant implications for how we shape the proposed new functions that will be led by NHS Improvement or hosted by NHS Improvement on behalf of both organisations, particularly our Provider Strategy, People, Improvement and Commercial functions, and for the new integrated regional teams. This will entail significant changes both to the senior executive structure of NHS Improvement and to ways of working, including the style of our relationship with the provider sector.

Key conclusions

1.3 The key conclusions from this work are that NHS Improvement, both through its new partnership with NHS England – including integrated regional teams – and through the distinctive functions that it will in future host or lead, needs to orientate itself more fully towards supporting improvements in quality and efficiency of care, rather than acting primarily as (and being seen primarily as) a regulator.

1.4 By gathering evidence from our staff and from the providers and systems with whom we interact, this work has identified where the greatest sources of value lie in our work to support the provider sector and what this means in terms of our future operating model and senior executive structures. It has also provided valuable insight into the distinctive skills, capabilities and behaviours that will be needed to realise greater benefits for patients and taxpayers.

1.5 Our work identified seven sources of value where NHS Improvement and its national partners could have the greatest impact in supporting the provider sector to drive sustainable improvements in quality of care and efficient use of resources. All of these sources of value are reflected in the proposals set out in the main paper to align the work of NHS Improvement and NHS England. Four of these sources of value map to functions that NHS Improvement will lead or will host on behalf of both organisations:

- **Configuration of the provider landscape.** There is a clear need to be more proactive in shaping the future provider landscape, including organisational models (eg ‘group’ or ‘chain’ models for hospitals, mental health services or other services) and service models. Working with NHS England, providers and with local health systems, we need to identify changes that will best support long-term improvements in clinical and
financial sustainability, agree collectively the strategic benefits to be gained from these changes, and better manage the realisation of those intended benefits, supported by a stronger focus on clinical leadership and clinical engagement. Integrated regional teams will in future lead this agenda, supported by national work – led by NHS Improvement’s proposed new Provider Strategy function – to distil evidence and best practice.

- **Quality and operational improvement.** We need to streamline and consolidate the way we support both providers and local health systems in driving continuous improvements in quality and efficiency of care. This will include developing the way we work with the most challenged providers to address persistent performance problems (taking into account the context of their wider local health system), more rigorous prioritisation of improvement priorities, and more hands-on support for providers and local health systems. The new integrated regional teams will lead work on improvement in local health systems, supported by a Chief Improvement Officer who will lead national work to develop tools, data, resources and specialist support, building on the existing work of NHS Improvement’s current directorates for operational productivity and improvement.

- **NHS workforce and leadership.** While Health Education England (HEE) has a clear national role in the education and training of the future NHS workforce, there are a number of organisations working – without sufficient coordination – to support NHS organisations to recruit, retain and develop today’s workforce. Our work identified a clear need to develop a more proactive and coherent approach to supporting leadership development, including talent management and succession planning, and helping the NHS to improve its people management processes. Under the proposals in the main body of the paper, NHS Improvement will host a new directorate, led by a Chief People Officer, working on behalf of both organisations to improve leadership and people management, working closely with Health Education England, NHS Employers and other national partners. This focus on leadership and people management will also be reflected in the design and resourcing of integrated regional teams.

- **NHS estates, equipment and consumables.** A further key source of value is the work we do to support the NHS in using all its physical assets more efficiently and effectively, improving quality of care and unlocking additional resources for patient care. This is already a key part of the NHS Improvement operational productivity. The proposed new Chief Commercial Officer will lead this work on behalf of both organisations, including continuing to increase our support for local health systems in managing their estates on a more system-wide basis to support new models of care and enhance value for money.

1.6 These four sources of value will be at the heart of the work undertaken by the new Provider Strategy, People, Improvement and Commercial directorates in NHS Improvement. The functions currently carried out by NHS Improvement’s Regulation Directorate will in future be carried out by Provider Strategy, People, and Improvement, working with integrated regional teams.
1.7 A further key source of value identified through the work is in relation to **NHS information and digital technology**. NHS England and NHS Improvement are already jointly responsible – with DHSC and NHS Digital – for a programme of work to transform the way the NHS uses digital information and technology to improve quality of care, health outcomes and efficiency. Our work identified the need to go further in embedding the importance of the digital agenda in all the work we do with the provider sector, so that it is an integral part of improving quality and efficiency. Under the proposed new joint working arrangements, NHS England will host the national digital programme (which will be led by the Deputy CEO of NHS England), with shared governance and oversight to help mainstream this work in all our engagement with the provider sector.

1.8 The two final sources of value identified from this work go to the heart of the proposals for joint working between the two organisations:

- **Planning and performance review.** The work identified a range of ways to support providers and local health systems in producing credible but realistic plans, allowing more productive and supportive discussions of key risks and the support needed to address them. The work identified significant opportunities to refresh the approach to monitoring and managing performance through a greater focus on understanding what improves performance, joint problem-solving (not simply upwards assurance) and using data and analysis to identify risks at an earlier stage. This work will now feed into a single programme of work between NHS England and NHS Improvement to design our future joint approach to planning and performance, including the interface between regional teams and local health systems (STPs and ICSs), trusts and CCGs.

- **System incentives and financial architecture.** We have identified a number of practical ways of simplifying and rationalising financial flows and incentives, helping us to go further in improving efficiency and quality within provider organisations and at the same time improving value across patient pathways. This will feed into a joint programme of work, led by the new Chief Financial Officer, to design and implement a new approach to managing collective NHS resources and driving value.

**Conclusion**

1.9 In the absence of the proposed new approach to joint working, NHS Improvement would have wanted in other ways to reflect these key conclusions in its own operating model and organisational structure. The new approach to joint working across NHS England and NHS Improvement makes it easier in some ways to make the necessary changes to our operating model, particularly in relation to financial architecture and performance management. The implementation of these changes will nonetheless require considerable change management and organisational development in relation to the new Provider Strategy, People, Improvement and Commercial functions hosted by NHS Improvement and the transition from current ways of working within NHS Improvement. This will require, in particular, the development of a strong improvement-focused and engaging culture.
Appendix Two

Regional Teams

2.1 In March, the Boards agreed a new integrated regional model, with seven integrated regional teams each led by a single Director, working for and reporting into both NHS England and NHS Improvement. Since March, we have been working closely with the current Regional Directors and teams across our two organisations to develop proposals for a new integrated regional operating model, including the core functions that regional teams will be responsible for and the underlying principles that will guide their ways of working.

2.2 The new integrated regional teams will have a major leadership role driving improvement and transformation for local health systems and providing joined-up oversight across the system. We see the new regional teams as playing a crucial role as ‘translators’ between the national level and local health and care systems, helping to ensure that all our work is responsive to local system needs.

2.3 As part of moving to joint working, we need to set up the single regions to better support local health systems. NHS England and NHS Improvement are working towards an oversight model that empowers systems to take a shared or leading role in functions that affect their populations. Under this model, STPs and ICSs will relate to a single Regional Director acting on behalf of both NHS England and NHS Improvement. As they develop and mature, we envisage ICSs holding more responsibility, including:

- Developing a system vision, strategy and plans to meet operational, financial and quality requirements.
- Developing and maintaining relationships with local people, staff, local government, voluntary and independent sectors; making sure they feel engaged in their system.
- Leading on provider transformation including integrated providers and primary care networks.
- Providing first line support to organisations within their system, drawing down national and regional expertise where needed.
- Some commissioning (including current direct commissioning) not performed at national level.

2.4 Regional teams will adopt a differentiated approach as they work with local health systems at different levels of maturity. They will be agile and adaptive in their delivery of the functions outlined below, working to strengthen the leadership, capacity and capability of local systems so that they are able to becoming increasingly self-governed and require less support and oversight from regional teams.
Core functions of regional teams

2.5 We have been working across our current national and regional teams to develop the proposed core functions for the new integrated regional teams, focusing on those areas that will deliver the most value in supporting local health and care systems.

2.6 We propose that the new integrated teams deliver the following core functions:

- **Performance, improvement and intervention** – tracking performance in relation to quality of care, access, efficiency and health outcomes, developing and maintaining capacity and capability for targeted improvement support, managing regulatory interventions and promoting peer support between providers, CCGs, STPs and ICSs.

- **Strategy and system transformation** – development and oversight of STP/ICS transformation strategies, shaping national programmes and leading the regional implementation of agreed national priorities, proactively shaping the provider and commissioner landscape, and prioritising and supporting improvements in service configuration where needed.

- **Commissioning** – commissioning of specialised services, primary care services, prison healthcare, s7a public health services, and oversight of CCGs with delegated responsibility for commissioning primary medical care. There will be a clear separation between the work of these commissioning teams and NHS Improvement’s regulatory oversight of those commissioning functions.

- **Operational management** – ensuring the safe and effective day-to-day running of the NHS and providing support in the face of any emerging issues (e.g., temporary A&E closures, cybersecurity attacks). Working with the Local Resilience Forums to support local emergency preparedness, resilience and response.

- **Finance** – oversight of local system financial planning and performance to a national framework, to manage system control totals that combine commissioning expenditure and the income and expenditure of NHS providers, oversee delivery of cost improvement programmes across local systems, support systems in the design of new payment and risk-sharing methods, and prioritise STP capital proposals.

- **Specific quality responsibilities** – professional leadership for quality improvement programmes, professional leadership for clinical staff, safeguarding, managing clinical senates and networks, the statutory duties discharged by the Medical Director (Controlled Drugs Accountable Officer, Caldicott Guardian, Performers list management), oversight and governance for patient safety and clinical support and review of reconfiguration decisions.
• **Workforce and leadership** – overseeing regional systems of leadership development, talent management and succession planning, identifying pipeline of future leaders for national leadership development, working with HEE to develop robust regional workforce strategies and improvement plans.

• **Information, digital and technology** – development and oversight of system strategies to deliver the national strategy, working with NHS Digital to ensure the robustness of local systems and local implementation programmes for care records and data sharing, and overseeing the development of services to exploit opportunities of new technology.

• **Estates and procurement** – ensuring that systems develop and implement strategies to improve the use of estates and facilities, and the efficiency of procurement and back-office services.

• **Analysis and insight** – processing and analysis of specific data to inform performance and transformation interventions, assurance of local data quality, to enhance the national core data sets.

• **Communications and engagement** – communication, engagement and partnership with regional stakeholders, including local government, MPs and patient groups, alongside relationship management with ALB and government departments where relevant.

• **Corporate functions (including HR)** – utilising and overseeing locally assigned corporate resource dedicated to the region from nationally managed functions.

**Principles: interface between national and regional teams**

2.7 We propose the following principles to guide the implementation of a new integrated regional operating model, relating in particular to the interaction between regional and national teams and the authority, freedoms and accountabilities of the new Regional Directors.

2.8 Regional teams will:

• Be led by Executive Directors who are part of the senior national leadership team of NHS England and NHS Improvement, together helping to design the right support and intervention for local health systems, ensuring we create maximum value and avoid unnecessary burden.

• Decide when and how to intervene in systems, providers or CCGs in their region, or – where the seriousness of the intervention requires a national decision – make the relevant recommendations to the decision-making group.

• Be responsible for managing all interventions with – or seeking information/assurances from – systems, providers or CCGs, except where
the regional team ask another team to act on their behalf or where the wider national leadership team collectively agree a different approach.

- Treat performance management and improvement as a continuum, not only holding systems, providers and CCGs to account but having the right capacity and capability to help solve them complex problems and access the right improvement support.

- Help develop standardised national approaches to improvement and performance, but have discretion to allow systems, providers or CCGs to depart from standardised approaches where they are performing well or where the regional team consider the system, provider or CCG has a cogent alternative approach to making performance improvements.

- Have access to all relevant data and analysis about their region, easily accessible at the right time to inform local decisions.

- Are trusted to manage their resources in a way that meets the needs of their region, subject to organisational designs and policies that are agreed collectively by the senior national leadership team.

- Be held to account for the responsibilities delegated to them.

**Regional geographies**

2.9 In March, based on learning from our existing regional model and the complexity of supporting systems across large geographies, the Boards agreed that we should have seven regional teams, by splitting the North and Midlands and East regions into two. Working with the Regional Directors in the North and Midlands and East, and using detailed analysis of regional populations, patient flows and performance, we developed proposals for the new regional geographies to test with staff, trade unions and local health and care systems:

**Initial proposals**

2.10 For the North, this was:

- **North West**: Lancashire and South Cumbria; Greater Manchester; and Cheshire and Merseyside.

- **North East and Yorkshire**: Cumbria and the North East; West Yorkshire; Humber, Coast and Vale; and South Yorkshire and Bassetlaw.

2.11 For Midlands and East region, this was:

- **Midlands**: Staffordshire; Shropshire and Telford and Wrekin; Derbyshire; Lincolnshire; Nottinghamshire; Leicester, Leicestershire and Rutland; Black Country and West Birmingham; Birmingham and Solihull; Coventry and Warwickshire; and Herefordshire and Worcestershire.
- **Central and East of England**: Northamptonshire; Cambridgeshire and Peterborough; Norfolk and Waveney; Suffolk and North East Essex; Bedfordshire, Luton and Milton Keynes; Hertfordshire and West Essex; and Mid and South Essex.

**System engagement**

2.12 To ensure the most appropriate decision could be made for local systems, we then engaged with our trade unions, NHS England and NHS Improvement staff, system leaders in both regions – including CCG Accountable Officers, STP leaders, Trust Chief Executives and Chairs and the Local Government Association.

2.13 We received 69 responses to our joint letters, 28% from individuals in the North region and 72% from those in the Midlands and East region. Of these, the large majority supported the split proposed for the North region, whilst concerns were raised about the Midlands and East proposal. It appears that this would significantly impact Northamptonshire’s patient flows with Leicester and Warwickshire, especially direct commissioning of primary care and public health.

**Revised proposals**

2.14 Based on the feedback, we now would like to propose to the Boards that the North be split as initially proposed – North West; and North East and Yorkshire.

2.15 Taking into account feedback from staff and system partners, for the Midlands and East, we propose that Northamptonshire should become part of the Midlands.
2.16 This would mean that the regions would split into:

- **Midlands**: Staffordshire, Shropshire and Telford and Wrekin; Derbyshire; Lincolnshire; Nottinghamshire; Leicester, Leicestershire and Rutland; Black Country and West Birmingham; Birmingham and Solihull; Coventry and Warwickshire; Herefordshire and Worcestershire, and Northamptonshire.

- **East of England**: Cambridgeshire and Peterborough; Norfolk and Waveney; Suffolk and North East Essex; Bedfordshire, Luton and Milton Keynes; Hertfordshire and West Essex; and Mid and South Essex.

2.17 These proposals are supported by system leaders in the two regions.
Creating a shared culture

3.1 Staff have generally welcomed the direction of travel to transform how we work together, to improve the coherence and impact of our collective system leadership role. We know that working with staff to shape the implementation of these changes and agree which ways of working we want to leave behind and which we want to take forwards will be crucial to success. We are also conscious that uncertainty can be unsettling for us all and we need to take care to engage and support our staff through this process. In light of this, both organisations are committed to managing this transition well in ways that best support our staff and realise the intended benefits.

3.2 Across our two organisations, there is a wealth of knowledge on how to manage change using lessons learned from previous change programmes. We have started a dialogue with staff to hear about their experiences and ideas of how to manage this joint change programme well. In addition, we have also held a very productive initial session with both Executive teams, Chairs and Deputy Chairs, focused on agreeing what our shared change approach might look like in light of lessons learned from previous examples of leading change, both within the NHS and other sectors.

3.3 We have identified the following characteristics as key to success, and will build these into our shared change approach:

- **Clear vision and goals** – having a clear purpose and narrative of what we are trying to achieve and why, alongside a focused plan of how to get there.

- **Honesty and clarity** – communicating clearly with staff, through a frequent dialogue about what we want to achieve and how we can work together to get there. Being honest and authentic about uncertainty and sensitive to the personal impacts of change.

- **Strong leadership and transparency** – ensuring leaders at all levels authentically model the importance of this change programme and the related mind-sets, culture and ways of working. Being proactive about training leaders within our organisations to lead this programme through a network of ambassadors, with authority to identify problems and find solutions.

- **A well-managed and resourced process** – a well-resourced and well-led programme and process, with the necessary speed and agility to enable pace and the ability to course correct.

- **Stamina and perseverance** – ensuring the necessary resilience and stamina across the two organisations to ensure that lasting changes are made to culture, mind-sets and behaviours to fully transform the ways we work.
‘Project 70’ – our engagement and organisational development approach

3.4 On 25 May, at our two all-staff briefings, we will launch the new operating model with colleagues. This approach, called ‘Project 70’ will facilitate a cross-organisation dialogue with staff, about how we should transform our ways of working to provide effective system leadership for the NHS as it heads into its next 70 years. We will also be asking staff their reflections on lessons learned from previous change programmes and their views on the key success factors to get this process right. To prepare for this, we have already started to pilot a series of structured conversations across our two organisations, and staff have welcomed the chance to share honest views and shape our future ways of working.

3.5 Colleagues from our joint working programme will bring both communications and engagement and organisational development expertise to deliver ‘Project 70’, and we will source additional resource if required to deliver this engagement approach at the necessary scale. We see this engagement approach as a crucial part of enabling a frequent and frank dialogue with our staff, whilst also helping us to identify the building blocks of that shared culture and way of working that we want to build.

Resourcing and managing change

3.6 We have mobilised a joint programme team to support the implementation of this change programme. The team, reporting jointly to Emily Lawson and Ben Dyson, is operating as a joint resource across both organisations to coordinate the overall operating model design work alongside key enablers such as HR processes and organisational development activities. A snapshot of key activities is provided below:

- **Supporting teams through change.** Alongside implementation of our change policies and HR processes, we will be providing a bespoke offer of career transition support to teams and individuals affected by change. There will also be a broader offer of support to equip all line-managers with the resources they need to support their teams and ensure their own personal resilience.

- **Leadership and culture change.** We are developing a joint set of leadership capabilities, working with staff across both organisations to co-create a leadership model and culture fit for the future. This will be followed by development sessions for all staff, focused on:
  o equipping staff to live the new leadership model
  o equipping staff to take responsibility for improving their area of work
  o supporting staff to build resilience and adaptability so that they can deliver their best work even through periods of uncertainty and change.

- **Developing effective team working capability.** We are developing a programme of work to support the development of new joint teams and inter-team working across both organisations and with our system partners.
• **Ensuring that the right enablers are in place.** We are working to ensure that the right enablers, including the use of IT and Estates, our internal finance and budgeting processes are in place to support this transition.

• **Engaging system partners and the public.** In addition to engaging with staff, we are working closely to jointly engage our Trade Union partners at key points within this process. We will be developing a broader external engagement strategy to engage more fully with the public, patients, local systems and ALB partners through the next phase of this work.
SUSTAINABILITY AND TRANSFORMATION PARTNERSHIP ACCOUNTABILITY

TEMPLATE TEXT FOR COVER PAPER

Sponsor: [For you to complete]  
Author: Robert Woolley, Joint Lead, BSNSSG STP  
Freedom of Information status: Closed

Purpose

The purpose of this item is to brief [insert committee name] about the accountability arrangements for Healthier Together, the Sustainability and Transformation Partnership (STP) for Bristol, North Somerset and South Gloucestershire, which is hosted by the Trust.

Key points

This paper makes clear that the STP is a partnership accountable to its constituent partners, with no independent legal status. It outlines the current oversight arrangements for the STP.

Partner organisations remain accountable in statute for their own activities but are also individually responsible for the STP and its success as a partnership endeavour, both in the delivery of collective ambitions and demonstrating collective accountability to the local population.

An earlier version of this paper was reviewed by the STP Sponsoring Board on 26 March 2018, which agreed to recommend its consideration by each partner institution’s board or equivalent. Revisions have been made in this version to incorporate reference to the Next Steps on the NHS Five Year Forward View and to expand the paragraph describing the role and status of the STP independent chair, as well as minor wording changes elsewhere.

Recommendation

Members are asked to:

Note the current accountability arrangements for Healthier Together, the Sustainability and Transformation Partnership for Bristol, North Somerset and South Gloucestershire.
SUSTAINABILITY AND TRANSFORMATION PARTNERSHIP ACCOUNTABILITY

1. INTRODUCTION

This paper is intended to provide a level of clarification to partner boards and governing bodies about issues of authority and accountability relating to *Healthier Together*, the Sustainability and Transformation Partnership (STP) for Bristol, North Somerset and South Gloucestershire, as it currently stands. It does not, except in passing, discuss the wider question of STP accountability to the local population.

It assumes a prior level of understanding of the rationale for development of STPs nationally and the aims of *Healthier Together* locally.

2. CONTEXT

STPs represent “a significant change in working practices, moving from a focus on individual organisations and market competition to system working” (HFMA, 2017).

The *Five Year Forward View* set out the scale of the transformation challenge facing the NHS and the arguments for greater collaborative working inside geographically delineated systems.

“The move towards locally-based collaboration rather than competition as the key driver of improvement in the system marks a significant shift in national policy, not least given that much of the latter is underpinned legislatively by the Health and Social Care Act 2012. While the current legal frameworks certainly do not prevent partnership working and integration in different forms, this makes for a complex environment … to navigate.” (NHS Providers, 2018)

As STPs have developed over the last two years, questions about their authority in relation to the statutory responsibilities of sovereign organisations have naturally arisen. “The issue of organisational accountability is a concern for many. Developing governance arrangements need to take into account individual organisations’ plans, existing planning units and networks - which often have differing boundaries to the footprint - and regulators. Consequently, STP governance arrangements are a work in progress” (Hempsons, 2017).

3. STATUS OF STPs

There should be no doubt about the current formal status of STPs. In the absence of new legislative measures, “STPs are not new statutory bodies. They supplement rather than replace the accountabilities of individual organisations. It’s a case of ‘both the organisation and our partners’, as against ‘either/or’” (NHS England & NHS Improvement 2017).
Moreover, “STP partnerships are not statutory bodies and individual boards cannot
delegate accountability for the activities they are responsible for…….The accountabilities
of individual organisations remain unchanged. The regulation of STPs is through NHS
improvement’s Single oversight framework for providers and NHS England’s
improvement and assessment framework for clinical commissioning groups” (HFMA, 2017).

At the same time, there is a clear drive on the part of arm’s length bodies to incentivise
local collaboration and increasingly to apply these planning and performance
management frameworks at a system level.

Local NHS boards are already familiar with the challenge of balancing their
responsibilities to the organisation with their duties to the population they serve.
The collective position of providers is that “NHS trusts support the principle of
collaboration at the heart of the STP/ACS approach; it provides one solution to the
challenges facing health and care by focusing on local system partnerships rather than
isolated activity by any single organisation” (NHS Providers, 2018).

4. LOCAL POSITION

*Healthier Together*, therefore, is a partnership accountable to its constituent partners.
It follows that partner organisations are individually responsible for the STP and its
success as a partnership endeavour, both in the delivery of collective ambitions and in
demonstrating collective accountability to the local population.

A number of partners (but not all) contribute to a pooled budget which funds a
dedicated programme management office (PMO). The PMO is hosted by UH Bristol
whose policies, procedures and standing financial instructions apply.

A non-executive chair provides leadership for the further development and delivery of
the STP, holding the respective partner organisations to account for their contribution.
Sir Ron Kerr was appointed to this position in May 2017, by agreement at the then
BNSSG System Leadership Group. The chair’s term of office is renewable annually at
the discretion of the partnership organisations – a formal review is currently in progress
to inform a decision at the May 2018 meeting of the Sponsoring Board.

A Chair’s Reference Group is part of the STP oversight structure and met for the first
time in January 2018. The high-level structure is shown at Annex 1.

Further non-executive involvement in the oversight of the STP, other than that rightly
exercised through each relevant board’s responsibility for the partnership, is neither
practical nor necessary at the current time.

*Healthier Together* has not to date developed any additional collective governance
arrangements (although these may be introduced in time), such as:

- a memorandum of understanding
- delegated decision rights
- pooled budgets
- shared risk management arrangements.
The STP reports regularly to local overview and scrutiny committees. A brief written update of STP activities is circulated weekly. In 2018/19, a regular progress report to partner boards/governing bodies will be introduced.

5. NEXT STEPS

As *Healthier Together* develops momentum, further steps towards collective governance will be necessary to maintain clarity of authority and accountability in the system.

However, “Developing shared accountability frameworks that satisfy existing arrangements while promoting shared outcomes, and outlining where accountability lies, is extremely challenging” (Health Foundation, 2016).

NHS Clinical Commissioners have produced a checklist of useful questions which can be used to test the way that *Healthier Together* operates over time (NHS Clinical Commissioners, 2018).

The development of shared accountability arrangements does not rest entirely in the hands of local systems, however, with NHS Providers calling for “an honest conversation [with regulators] about how to develop governance and accountability mechanisms which support system-level partnerships and complement the statutory obligations of their component organisation” (NHS Providers, 2018).

6. CONCLUSIONS

This paper has set out the accountability of *Healthier Together* to its partner organisations.

As the partnership develops, further consideration will be given to the question of a shared accountability framework, potentially supported by a memorandum of understanding or other mechanism, subject to consideration and agreement by partner organisations.

**Robert Woolley, Joint lead, Healthier Together**

13 March 2018 (revised 11 April 2018)

References
- *STPs and accountable care, background briefing.* NHS Providers, January 2018
- *In brief: Simpler, clearer, more stable, Health Foundation summary and analysis*, Health Foundation, October 2016
- *STP checklist for governance and engagement.* NHS Clinical Commissioners, Jan 2018
ANNEX 1: STP PROGRAMME STRUCTURE

Legend:
- Reporting/accountability
- Inform/advise
* Includes LWAB
** Includes connecting care board

Stakeholder Engagement arrangements
The Trust Board is asked to note the contents of the Integrated Performance Report.

Details of the Trust's performance against the domains of Access, Safety, Patient Experience, Workforce and Finance are provided on page 2 of the Integrated Performance Report.
## CONTENTS

<table>
<thead>
<tr>
<th>CQC Domain / Report Section</th>
<th>Sponsor / s</th>
<th>Page Number</th>
</tr>
</thead>
</table>
| Performance Dashboard and Summaries | Chief Operating Officer  
Medical Director  
Director of Nursing  
Director of People and Transformation | 5           |
| Responsiveness              | Chief Operating Officer  
Director of Partnerships                                         | 13          |
| Safety and Effectiveness    | Medical Director  
Director of Nursing                                                 | 29          |
| Research and Innovation     | Medical Director                                                 | 45          |
| Quality Experience          | Director of Nursing                                              | 47          |
| Facilities                  | Director of Facilities                                           | 53          |
| Well Led                    | Director of People and Transformation  
Medical Director                                                     | 55          |
| Finance                     | Director of Finance                                             | 65          |
| Regulatory View             | Chief Executive                                                 | 70          |
REPORT KEY

Unless noted on each graph, all data shown is for period up to, and including, 30 April 2018.

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

NBT Quality Priorities 2018/19

QP1 Eliminate delays in hospital to improve patient safety and reduce bed occupancy ('home is best')

QP2 Enhance the way patient involvement and feedback is used to influence care and service development

QP3 Continue improving the quality of end of life care across all specialities

QP4 Strengthen learning and action by embedding quality governance at specialty, cluster and divisional level

QP5 Demonstrate a stronger clinical understanding and application of the Mental Capacity Act and Deprivation of Liberty Standards

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
April 2018

ACCESS
April’s position against the 4 hour standard was 83.03% against a National position of 82.34% and the Trust trajectory of 80.52%. The majority of breach reasons were attributable to a wait for bed, a shift from wait for ED assessment, with attendances at their highest rate since October 2017, not matched by discharge volumes. Perform Bootcamps continue to be booked out at all staff levels and are expected to result in more effective flow through the hospital to achieve improvement towards national standard of 95%.

The Trust has met the agreed recovery trajectory for Referral To Treatment (RTT) incomplete performance for April (85.65% vs trajectory of 85.50%). The waiting list backlog stands at 3886 vs a target of 3995. The Trust has again reduced the number of patients waiting greater than 52 weeks from Referral to Treatment (RTT) (37 in April v. 38 in March).

The Trust has marginally failed to meet the national target (1.00%) for diagnostic performance with actual performance of 1.04% in April.

The Trust has delivered 5 of the 7 national cancer targets in March. The 62 day standard has been exceeded in March with performance of 86.67% against the target of 85%. The Trust has achieved the 62 day standard for the second consecutive year with performance for 2017/18 at 85.20%. Two Week Wait has not achieved standard with performance of 91.23% against the 93% standard. Two Week Wait Breast has also failed to meet the 93% standard with performance of 87.50%. Against both of the Two Week Wait standards there have been high levels of patients declining appointments offered within two weeks of referral, especially around the Easter period.

SAFETY
Nursing staff levels continue to be monitored closely, no wards triggered the Quality Effectiveness and Safety Trigger Tool (QuESTT) in April. Incidence of pressure ulcers in April were 19 reported Grade 2 pressure injuries, nil reported at Grade 3 and nil at Grade 4. There were 3 reported cases of MRSA in April. The Trust reported 3 cases of C. Difficile in April.

PATIENT EXPERIENCE
The number of overdue complaints has decreased to 15 in April from 16 in March. Friends and Family response rates have increased across all four areas. NHS Choices ratings for both Southmead Hospital and Cossham Hospital are both 4.5 stars.

WORKFORCE
The Trust vacancy factor increased from 7.69% in March to 8.77% in April. Agency expenditure decreased in April to £564k from £583k in March, but is above NHSI target levels (£530k). The in-month sickness rate in March was 3.96%, an improvement from February (4.30%) but above the 3.92% target submitted to NHSI for the month. Recruitment actions and support to health and wellbeing continue.

FINANCE
The Trust has planned a deficit of £18.4m for the year in line with the agreed control total with NHS Improvement. At the end of April the Trust is reporting a deficit of £2.7m which is in line with the plan. The Trust has a savings target of £37.7m, of which £25.8m is already identified. The Trust has ended the month with £17.2m cash after receipt of £3.4m loan financing from the Department of Health to support the ongoing deficit. The Trust is currently rated 3 by NHSI.
<table>
<thead>
<tr>
<th>Description</th>
<th>Target</th>
<th>Previous month’s performance</th>
<th>Performance against Target</th>
<th>Performance against NBT Trajectory</th>
<th>2017/18 Average Monthly Performance</th>
<th>Q1 (QTD)</th>
<th>Q2</th>
<th>Q3</th>
<th>Q4</th>
<th>2018/19 YTD Average Monthly Performance</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Responsiveness</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Referral to Treatment - % incomplete pathways &lt;18 weeks</td>
<td>92%</td>
<td>85.56%</td>
<td>85.65%</td>
<td>85.50%</td>
<td>87.81%</td>
<td>85.65%</td>
<td></td>
<td></td>
<td></td>
<td>85.65%</td>
</tr>
<tr>
<td>Trust Wide Referral to Treatment Backlog</td>
<td>3382</td>
<td>3922</td>
<td>3886</td>
<td>3955</td>
<td>3662</td>
<td>3886</td>
<td></td>
<td></td>
<td></td>
<td>3886</td>
</tr>
<tr>
<td>ED 4 Hour Performance</td>
<td>QP1</td>
<td>95%</td>
<td>75.77%</td>
<td>83.03%</td>
<td>80.52%</td>
<td>76.94%</td>
<td>83.03%</td>
<td></td>
<td></td>
<td>83.03%</td>
</tr>
<tr>
<td>12 Hour Trolley Waits</td>
<td>QP1</td>
<td>0</td>
<td>39</td>
<td>0</td>
<td>28</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Neurosurgery and Epilepsy</td>
<td>0</td>
<td>2</td>
<td>1</td>
<td></td>
<td>5</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>MSK</td>
<td>0</td>
<td>12</td>
<td>10</td>
<td>44</td>
<td>35</td>
<td>10</td>
<td>10</td>
<td>10</td>
<td>10</td>
<td></td>
</tr>
<tr>
<td>Ortho-Spinal</td>
<td>0</td>
<td>14</td>
<td>12</td>
<td></td>
<td>4</td>
<td>12</td>
<td>12</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td>0</td>
<td>10</td>
<td>14</td>
<td></td>
<td>31</td>
<td>14</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Diagnostic DM01 - % waiting more than 6 weeks</td>
<td>1%</td>
<td>0.60%</td>
<td>1.04%</td>
<td></td>
<td>2.39%</td>
<td>1.04%</td>
<td>1.04%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cancelled Operations</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Same day - non-clinical reasons</td>
<td>0.8%</td>
<td>2.59%</td>
<td>0.77%</td>
<td></td>
<td>1.70%</td>
<td>0.77%</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>28 day re-booking breach</td>
<td>0</td>
<td>5</td>
<td>9</td>
<td></td>
<td>4</td>
<td>9</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Bed Occupancy</td>
<td>QP1</td>
<td>95%</td>
<td>99.63%</td>
<td>98.29%</td>
<td>99.33%</td>
<td>98.29%</td>
<td></td>
<td></td>
<td></td>
<td>98.29%</td>
</tr>
<tr>
<td>Stranded Patients (LoS &gt;7 days : Snapshot as at month end)</td>
<td>397</td>
<td>384</td>
<td></td>
<td></td>
<td>4.34%</td>
<td>5.08%</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Responsiveness - Cancer (In arrears)</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Patients seen within 2 weeks of urgent GP referral</td>
<td>93%</td>
<td>93.34%</td>
<td>91.23%</td>
<td></td>
<td>91.04%</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Patients with breast symptoms seen by specialist within 2 weeks</td>
<td>93%</td>
<td>94.87%</td>
<td>87.50%</td>
<td></td>
<td>91.09%</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Patients receiving first treatment within 31 days of cancer diagnosis</td>
<td>96%</td>
<td>98.17%</td>
<td>97.32%</td>
<td></td>
<td>96.93%</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Patients waiting less than 31 days for subsequent surgery</td>
<td>94%</td>
<td>97.09%</td>
<td>94.68%</td>
<td></td>
<td>93.07%</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Patients waiting less than 31 days for subsequent drug treatment</td>
<td>98%</td>
<td>100%</td>
<td>100%</td>
<td></td>
<td>100.00%</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Patients receiving first treatment within 62 days of urgent GP referral</td>
<td>85%</td>
<td>83.10%</td>
<td>86.67%</td>
<td>86.54%</td>
<td>85.75%</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Patients treated within 62 days of screening</td>
<td>90%</td>
<td>89.87%</td>
<td>96.83%</td>
<td></td>
<td>94.40%</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>IPR section</td>
<td>Description</td>
<td>Target</td>
<td>2017/18 Average Monthly Performance</td>
<td>Q1 (QTD)</td>
<td>Q2</td>
<td>Q3</td>
<td>Q4</td>
<td>2018/19 YTD Average Monthly Performance</td>
<td></td>
<td></td>
</tr>
<tr>
<td>----------------------------</td>
<td>------------------------------------</td>
<td>--------</td>
<td>-------------------------------------</td>
<td>----------</td>
<td>----</td>
<td>----</td>
<td>----</td>
<td>------------------------------------------</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Never Event Occurrence by Month</td>
<td>0</td>
<td>0</td>
<td>97.94% 97.22%</td>
<td>0</td>
<td>0</td>
<td></td>
<td></td>
<td>97.22%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Safety Thermometer - Hospital Compliance</td>
<td>95%</td>
<td>97.41%</td>
<td>96.28% 96.28%</td>
<td>94.51%</td>
<td>96.28%</td>
<td></td>
<td></td>
<td>96.28%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>WHO Checklist Compliance</td>
<td>95%</td>
<td>95.3%</td>
<td>93.90% 93.90%</td>
<td>96.53%</td>
<td>93.90%</td>
<td></td>
<td></td>
<td>93.90%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hand Hygiene Compliance</td>
<td>95%</td>
<td>95%</td>
<td>95% 96.10% 96.28% 96.28% 96.28%</td>
<td>95% 95% 95% 95% 95%</td>
<td>96.10% 96.28% 96.28% 96.28% 96.28%</td>
<td></td>
<td></td>
<td>96.28%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Grade 2 Pressure Injuries</td>
<td>164 2018/19</td>
<td>14</td>
<td>19</td>
<td>204</td>
<td>19</td>
<td></td>
<td>19</td>
<td>19</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Grade 3 Pressure Injuries</td>
<td>0 2018/19</td>
<td>2</td>
<td>0</td>
<td>15</td>
<td>0</td>
<td></td>
<td>0</td>
<td>0</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Grade 4 Pressure Injuries</td>
<td>0 2018/19</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td></td>
<td>0</td>
<td>0</td>
<td></td>
<td></td>
</tr>
<tr>
<td>MRSA</td>
<td>0 2018/19</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>3</td>
<td></td>
<td>3</td>
<td>3</td>
<td></td>
<td></td>
</tr>
<tr>
<td>E. Coli</td>
<td>58 2018/19</td>
<td>4</td>
<td>6</td>
<td>5</td>
<td>6</td>
<td></td>
<td>6</td>
<td>6</td>
<td></td>
<td></td>
</tr>
<tr>
<td>C. Difficile</td>
<td>42 2018/19</td>
<td>4</td>
<td>3</td>
<td>3</td>
<td>3</td>
<td></td>
<td>3</td>
<td>3</td>
<td></td>
<td></td>
</tr>
<tr>
<td>MSSA</td>
<td>19 2018/19</td>
<td>2</td>
<td>1</td>
<td>2</td>
<td>1</td>
<td></td>
<td>1</td>
<td>1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Venous Thromboembolism Screening (in arrears)</td>
<td>95%</td>
<td>95.10% 95.00%</td>
<td>95.31% 95.00%</td>
<td>95.00%</td>
<td>95.00%</td>
<td>95.00%</td>
<td>95.00%</td>
<td>95.00%</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Quality Experience

<table>
<thead>
<tr>
<th>Description</th>
<th>2017/18 Average Monthly Performance</th>
<th>Q1 (QTD)</th>
<th>Q2</th>
<th>Q3</th>
<th>Q4</th>
<th>2018/19 YTD Average Monthly Performance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Emergency Department</td>
<td>QP2</td>
<td>85.65% 85.26%</td>
<td>85.96% 85.26%</td>
<td>85.26%</td>
<td>85.26%</td>
<td>85.26%</td>
</tr>
<tr>
<td>Inpatient</td>
<td>QP2</td>
<td>91.63% 92.12%</td>
<td>91.51% 92.12%</td>
<td>92.12%</td>
<td>92.12%</td>
<td>92.12%</td>
</tr>
<tr>
<td>Outpatient</td>
<td>QP2</td>
<td>93.67% 94.06%</td>
<td>93.62% 94.06%</td>
<td>94.06%</td>
<td>94.06%</td>
<td>94.06%</td>
</tr>
<tr>
<td>Maternity (Birth)</td>
<td>QP2</td>
<td>91.89% 92.78%</td>
<td>92.81% 92.78%</td>
<td>92.78%</td>
<td>92.78%</td>
<td>92.78%</td>
</tr>
<tr>
<td>% Overall Response Compliance</td>
<td>QP2</td>
<td>56.00% 63.00%</td>
<td>68.33% 63.00%</td>
<td>63.00%</td>
<td>63.00%</td>
<td>63.00%</td>
</tr>
<tr>
<td>Complaints acknowledged in &lt;3 days</td>
<td>QP2</td>
<td>95% 100% 100%</td>
<td>100.00% 100.00%</td>
<td>100.00%</td>
<td>100.00%</td>
<td>100.00%</td>
</tr>
<tr>
<td>Overdue</td>
<td>QP2</td>
<td>&lt;10 15</td>
<td>29</td>
<td>15</td>
<td>15</td>
<td>15</td>
</tr>
</tbody>
</table>
## Key Operational Standards Dashboard
### April 2018

<table>
<thead>
<tr>
<th>IPR section</th>
<th>Access Standard</th>
<th>Target</th>
<th>Previous month’s performance</th>
<th>Performance against Target</th>
<th>Performance against NBT Trajectory</th>
<th>Performance direction of travel from last month</th>
<th>Quarter Performance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Well Led</td>
<td>Agency Expenditure (’000s)</td>
<td>£530</td>
<td>£583</td>
<td>£564</td>
<td>▲</td>
<td>▲</td>
<td>£524</td>
</tr>
<tr>
<td></td>
<td>Month End Vacancy Factor</td>
<td>7.40%</td>
<td>7.69%</td>
<td>8.80%</td>
<td>▲</td>
<td>▲</td>
<td>7.57%</td>
</tr>
<tr>
<td></td>
<td>In Month Turnover</td>
<td>1.20%</td>
<td>1.30%</td>
<td>1.40%</td>
<td>▲</td>
<td>▲</td>
<td>1.30%</td>
</tr>
<tr>
<td></td>
<td>In Month Sickness Absence (In arrears)</td>
<td>3.92%</td>
<td>4.30%</td>
<td>3.96%</td>
<td>▲</td>
<td>▲</td>
<td>4.32%</td>
</tr>
<tr>
<td></td>
<td>Trust Mandatory Training Compliance</td>
<td>85.00%</td>
<td>82.30%</td>
<td>85.10%</td>
<td>▲</td>
<td>▲</td>
<td>83.97%</td>
</tr>
<tr>
<td></td>
<td>Non - Medical Annual Appraisal Compliance</td>
<td>90% Nov. 2018</td>
<td>65.15%</td>
<td>63.97%</td>
<td>▲</td>
<td>▲</td>
<td>59.19%</td>
</tr>
<tr>
<td>Finance</td>
<td>Deficit (£m) 2018/19</td>
<td>£18.4m</td>
<td>£20.7 (FY)</td>
<td>£2.7</td>
<td>▲</td>
<td>▲</td>
<td>▲</td>
</tr>
<tr>
<td></td>
<td>NHSI Trust Rating</td>
<td>3</td>
<td>3</td>
<td>▲</td>
<td>▲</td>
<td>▲</td>
<td>3</td>
</tr>
</tbody>
</table>
## Urgent Care

April's position against the 4 hour standard was 83.03%, a 7.26% increase to March reported performance. This is the highest performance achieved by the Trust since April 2017. The primary cause of delays in month remains wait for a bed (47%), closely followed by wait for ED assessment (45%). Wait for bed continues to be a clear driver for poor performance, due to operating at 100%+ occupancy within the main admission wards. The urgent care improvement plan and trajectory is being revisited by the Trust and the System, focusing on reducing stranded patients through addressing unnecessary delays in a patient's pathway and also supporting the principle of 'Home is Best'.

## Planned Care

### Referral to Treatment (RTT)

In month, the Trust has achieved the Trust RTT trajectory of 85.50%, with actual performance at 85.65%. The number of patients exceeding 52 week waits in April was 37 (the majority of which (32) were due to capacity issues). This represents an ongoing reduction in the number of long waiters. The Trust is delivering against a remedial action plan specifically focusing on the challenged sub-specialties within MSK and in Plastic Surgery.

### Cancelled Operations

In month, there were nine breaches of the 28 day re-booking target. One urgent operation was cancelled for a subsequent time.

### Diagnostic Waiting Times

The Trust has failed to achieve the 1.00% target for diagnostic performance in April with actual performance at 1.04%. There has been a recognised need in Urology to review bladder cancer patients who did not have a follow up, these patients have now been added to a waiting list. As planned patients, their planned date for cystoscopy, the 6 week diagnostic and 18 week referral to treatment time has started, which has resulted in a number of breaches and we have therefore not passed the national diagnostic standard. We are organising additional capacity where possible to date these patients as quickly as possible.

## Cancer

Cancer performance in March has achieved five of the seven standards. The Trust has exceeded the 62 day standard at 86.67% (Target 85.00%), with performance of 85.20% for 2017/18. This is the second consecutive year that the Trust has achieved the 62 day standard.

- Two Week Wait urgent GP referrals failed to achieved the national standard (93%) with performance at 91.23%.
- Two Week Wait Breast has also fallen short of the National standard (93%) with reported performance of 87.50%.

Urology breaches accounted for 66% of total Trust breaches for March, with all internal breaches on the Prostate pathway. Capacity issues in Radiology, Joint Oncology clinics, Template Biopsy and Robotic Theatres continue to limit the ability to meet the 62 day standard.

## 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 Urgent Care Recovery Plan (UCRP) are as follows:

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

**Improvements**

There has been a further small reduction in Agency Nursing this month to 3.0%, with no wards triggering on the early warning trigger tool.

Whilst the number of falls was higher in April than in March, the rate remains consistent with previous months and there were no serious incidents resulting from falls in April.

The rate of C.Difficile infection remains within trajectory.

Number of deaths in hospital is below the Dr Foster 'expected' rate in data including January 2018.

Data on performance with respect to fractured neck of femur (NoF) and stroke are presented in the IPR for the first time. Work is ongoing to develop the relevant performance targets where they do not currently exist.

**Areas of Concern**

Three MRSA bacteraemias in April is a significant concern and an extra meeting of the Trust Control of Infection Committee has been convened to determine appropriate actions.

A new approach to malnutrition screening is being considered as the data is showing unsatisfactory performance over the past few months.
Improvements and Actions

The number of complaint cases that were overdue at the end April increased slightly from the CCG target of 10 in March to 15 in April. Work continues with the Divisional teams to address this slight deterioration and return to the agreed trajectory.

Patient Experience week (23 – 27 April 2018) was well received by patients and staff alike and the Patient Experience Team used this as an opportunity to talk with patients in the atrium and received some useful and constructive feedback. A wall of comments was collated, mostly positive but with some feedback that has enabled issues to be addressed with teams that patients/carers raised – an example was that the Brunel car park does not support parking for adapted vans that carry power assisted wheelchairs due to the restricted headroom.
WELL LED
SRO: Director of People and Transformation and Medical Director
Overview

Strategic Priority 4. Create an exceptional workforce for the future

Vacancies
The vacancy factor increased in April from 7.7% to 8.7% (an increase of around 86 WTE vacancies.) The biggest vacancy gap is in Nursing and Midwifery, but the vacancy gap also increased in HCA and Medical and Dental staff groups. This can be attributed mostly to cost pressures now being funded and included in April budgeted establishment (in the larger Clinical Divisions), although an increase in turnover generally and a decrease in starters in this month have also contributed.

Turnover
Registered nursing and midwifery turnover remains an ongoing issue for the Trust. Rolling year turnover in April 2018 stood at 16.2%, having averaged 13.5% two years ago in April 2016. Turnover has risen slowly but steadily over this time. The two key reasons for leaving continue to be work-life balance and relocation.
The Trust’s Retention Steering Group continues to develop actions to support a reduction in turnover. Key actions include undertaking some focussed work linked to carers as well as working with and supporting an ageing workforce. The 'Itchy Feet' campaign continues to be publicised and there are a small but steady number of staff utilising this service.

Health and Well-being

Sickness
Sickness absence decreased in March 2018 (the second consecutive month of reduction), so that it is now just slightly above target at 3.9% (lower than March 2017 absence which averaged 4.4%).
For the fifth month in a row musculoskeletal/back problems was not recorded as one of the top five reasons for short term absence. In addition, for the second month in a row stress, anxiety and depression also remained outside of the top five reasons for short term absence. This continued improvement is regarded as a result of the proactive programme of work currently underway within the Trust to support staff on their mental health resilience and physical health. However, stress, anxiety and depression remains the main reason for long term sickness absence and is a key focus for the Trust.

Strategic Priority 5. Devolve decision making and empower clinical staff to lead

Mandatory and Statutory Training (MaST) - Trends
Due to the 52% increase in e-learning completions compared to Q1 2017, overall compliance in the MaST topics is now regularly at 85%. It is also worth noting that 66% of all recorded training activity on the MLE is now being achieved via ELearning.

Leadership
The Trust’s Leadership Steering Group are developing a leadership framework to ensure that we develop all leaders across the Trust. Integrated into the leadership framework is the Perform programme specifically aimed at improving patient flow though out the hospital. Perform is well underway with a series of ‘Bootcamps’, kicking off the interventions. PwC and NBT Perform coaches have started their intensive work on wards.
The Trust has planned a deficit of £18.4m for the year in line with the control total agreed with NHS Improvement. At the end of April the Trust reported a deficit of £2.7m which is in line with the plan. The position assumes receipt of £0.8m of provider sustainability funding, as per plan. Income excluding donations is £1.3m favourable to plan, pay is £0.1m favourable to plan, whilst non-pay (excluding finance costs) is £1.4m adverse.

The Trust has a savings target of £37.7m, of which £25.8m has been identified. The Trust has ended the month with £17.2m cash after receipt of £3.4m loan financing from the Department of Health to support the ongoing deficit. Capital expenditure is £1.0m for the year to date against a plan of £0.8m.

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

Board Sponsor: Chief Operating Officer and Director of Partnerships
Evelyn Barker and Kate Hannam
Overview of Urgent Care

ED performance for April 2018 was 83.03%, a 7.26% improvement to March’s reported position of 75.77%. This position exceeds the Trust’s planned trajectory of 80.52% by 2.51% and is the first time the Trust has met trajectory since March 2017.

ED attendances in March were, at 7429, the highest seen by the Trust since October 2017. Seeing an average of seven additional attendances per day compared to March, April acuity remained high with majors patients equating to 55.77% of all ED attendances.

Emergency admissions in the month continue to rise and are higher than those levels seen in the last six months, which has resulted in occupancy levels at above 100% for the majority of the month. The number of medical patients being cared for outside of the core medicine bed base (month average 45) has improved through April and is continuing to improve into May.

The inability to match discharges to the surges in flow resulted in 27.40% of majors patients and 3.83% of minors patients waiting more than four hours in ED. The challenges for timely transfer from the ED to the wards continue to be a major contributor to the reasons patients were waiting in excess of the four hours into April. This is a particular area of focus within the revised Urgent Care Improvement Plan.
The number of minors patients treated within the four hour target has continued to improve in April with performance of 96.17%, an increase of 1.41% compared to March’s position.

Majors performance against the four hour standard for April was 72.60%, a further increase to March performance and an increase of 21.17% from February which was the lowest level in 2017/18 at 51.44%.

4 Hour Breaches
The primary cause of delays in month is attributed to wait for a bed rather than wait for ED assessment, as seen in March.

There is focussed project work ongoing to address issues in patient flow and the wait for beds:
- ‘Flow’, an IT system, now provides real time bed states to enable accurate, ‘live’ site management.
- Perform bootcamps, accessible to all staff across the organisation, focussing on ‘One NBT’. These solution focussed sessions encourage staff to work together - wards, ED and the site management team - with new bed meeting structures, improved planning of discharge dates and releasing beds earlier in the day, so flow through the hospital can be better planned.

These projects compliment existing work around ‘Home is Best’ and #EndPJParalysis.
ED Attendances in April, at 7429, are in the same region as levels seen in April 2017, at 7413 attenders. Despite overall attendance numbers plotting at very similar levels, April 2018 had an additional eight majors patients per day when compared to April 2017.

April’s conversion rate is 33.82%, 0.51% higher than April 2017 (continuing the pattern of higher conversion ratios when comparing winter and spring / summer trends). The higher conversion rate has led to a continued higher demand for beds.

The number of patients who are managed within our short stay medical and surgical admission units continues to meet National best practice for the number of patients treated in less than 48 hours.

High occupancy levels (98.29%) in the Trust remains the prime reason for ineffective flow through the hospital and remains the main area targeted for improvements - both from an internal and a system perspective. During April, on average, there have been 45 Medicine patients bedded outside of the core bed base, a 47% improvement to March.
Ambulance Handovers
April 2018 had 2474 ambulance attendances, an increase of 153 when compared to April 2017 but 157 fewer than March 2018.

Delays against the 15 minute handover target have reduced in month with 91.60% of patients handed over to Trust staff within 15 minutes of arrival.

Ambulance handovers within 30 minutes of arrival at Trust has also exceeded trajectory of 98.34% in April with actual performance of 98.90%. This is the best reported performance against this metric in over a year with April 2018 reporting 12.94% more ambulances handed over within 30 minutes than was reported in April 2017.

There was one 60 minute handover breach in month. In April 2017, there were two ambulance handovers taking in excess of 60 minutes.

12 Hour Trolley Waits
There were no 12 hour trolley breaches in April, a position which has not been seen since September 2017.
Referral to Treatment (RTT)
The Trust has achieved the RTT trajectory in month with performance of 85.65% against trajectory of 85.50%. With the Trust also having met the RTT backlog trajectory in month, reporting 3886 against trajectory of 3995. This is the first month both targets have been met since November 2017.

Remedial action plans are in place for specialties where performance is an issue.

Thirteen specialties have failed to deliver the national standard of 92% in April although four of these specialties have met their local trajectory targets. The nine specialties which have failed to achieve agreed trajectory are across three Clinical Divisions; Women and Children’s, ASCR and NMSK.

Urology has fallen short of delivering the national standard in April with performance of 86.45% but has exceeded the internal trajectory of 86.28% and, as such, are improved from end of year 2017/18. Reasons for underperformance are multifactorial, but in the main relate to the impact of Junior Doctor shortages, Cancer Nurse Specialist sickness and a growth in referrals c. 180 per month. A return to standard is anticipated at the end of 2018/19 - beginning of 2019/20.
Referral to Treatment 52 Week Waits

The Trust has reported a total of 37 breaches in April 2018. These patients were within the following specialties:
1 Neurosurgery;
0 Epilepsy;
12 Orthopaedic Spinal;
10 MSK;
5 Urology; and
9 Plastic Surgery.

Root Cause Analyses have been completed for all patients, with dates for patients’ operations being agreed at the earliest opportunity and in line with the patient’s choice.

MSK, Ortho Spinal and Neurosurgery are reporting improvements exceeding planned trajectory in April.

ASCR specialties have produced RAPs and recovery trajectories; clearance of the 52ww backlog is anticipated by August 2018 for Urology with Plastic Surgery planned to clear in September 2018.

The Trust has classed patient choice as any patient choosing to wait beyond 52 weeks when two reasonable offers with three weeks advance notice have been made prior to week 28 in their pathway. The patients will have been clinically reviewed as per best practice guidance that the most appropriate course of action is for them to continue to wait as per their choice.

N.B. MSK 52ww performance is managed against the RAP agreed with the CCG
N.B. Epilepsy and Neurosurgery 52ww performance is managed against the RAP agreed with NHSE Specialised Commissioning
Cancellations

The same day non-clinical cancellation rate in April was 0.77%, achieving the national target of 0.8% for the first time since before April 2014.

There were nine operations that could not be rebooked within 28 days of cancellation in April 2018, five more than in March. Patients were unable to be rebooked within target due to capacity and RCAs have been completed for each of these cases to understand the reasoning and to ensure that there was no patient harm.

In month there was one urgent operation cancelled for a subsequent time. Initially cancelled owing to a patient from a different specialty taking emergency priority, the patient was subsequently cancelled owing to another, more clinically urgent, patient taking emergency priority.
Diagnostic Waiting Times

The Trust has marginally failed to achieve the 1.00% target for diagnostic performance in April with actual performance at 1.04%.

Six test types have reported in month underperformance; Cystoscopy, Gastroscopy, Neurophysiology, DEXA Scan, Colonoscopy and Urodynamics.

Cystoscopy test position is 17.78%, with 64 breaches, a 15.8% increase to March’s position. There has been a recognised need in Urology to review bladder cancer patients who did not have a follow up or a follow up request made. Through undertaking this review, a number of patients have been identified as needing surveillance cystoscopies. These patients have been added to a waiting list and dated accordingly. As they are planned, their planned date for cystoscopy, the six week diagnostic and 18 week referral to treatment time has started, which has resulted in a number of breaches and we have therefore not passed the national diagnostic standard. The Trust is organising additional capacity where possible to date these patients as quickly as possible, with new capacity online in May, the Trust has new flexible cystoscopes to support this meeting. There is one further cohort of patients that need review and the Trust anticipate further breaches will be identified.

Despite achieving standard for the entirety of Quarter 4 2017/18, Gastroscopy have a reported eight breaches and a test position of 2.33% in April 2018.

Neurophysiology, at 1.94%, have breached the 1% target for the first time since February 2016 where performance reached a high of 16.67% for this test type. There were two wait breaches in month for this test type, which do not indicate a systemic or capacity issue.

DEXA has reported an improvement of 5.02% March to April, with April performance of 1.43%. This is a significant improvement, over the last six months, to the 42.99% performance reported in November 2017.

Colonoscopy have, at 0.96%, improved in April with performance now achieving the 1% standard with three breaches.

Urodynamics has achieved the 1% standard for the second continuous month at 0.64% and a single breach. The last time this position, two consecutive achieving months, was achieved for this test type was ten months ago, in June 2017.

In month, CT has reported a 0.45% improvement to March, remaining within the standard, with performance at 0.31% with five breaches.
Clinic Letter Typing
Three of five Clinical Divisions’ average typing turnaround time continues to report within the contractual obligation which has decreased from ten to seven days for 2018/19.

There are, at month end, seven specialties which will require a reduction in current typing turnaround time to meet the 2018/19 contractual standard of seven operational days, an improvement of five specialties when compared to 2017/18 year end.

CCS and Women and Children’s continue, at specialty level, to fulfil the contractual obligation.

Diabetes is the only Medicine specialty which has failed to achieve the 2018/19 typing turnaround time in April with clinic letters taking between two and three weeks to be typed.

Taking an average of 102 days, Urology continues to have the longest typing delays. Early indications are that the position has now stabilised and the backlog is starting to reduce.

Discharge Summaries
2018/19 starts the year matching the best position seen in 2017/18 at 80% available on ICE within 24 hours.

Improvement projects, specifically around the content and timeliness of ED Discharge Summaries, continue from 2017/18.

*Where data is unavailable, an average of the previous fortnight’s performance is calculated for chart purposes.
Cancer
The Trust achieved five of the seven Cancer Waiting Times Performance for March 2018.

The Trust failed the TWW standard with performance of 91.23%. The Trust saw 1,961 TWW referrals in March and there were 176 breaches, of which the majority were in Urology (33), Skin (44), Breast (28) and Colorectal (25).

Of the 176 breaches, 165 were due to patients not accepting the appointments offered which was within two weeks of referral. 11 breaches were due to lack of capacity to offer appointments within two weeks of referral.

The Trust failed the Breast Non-Symptomatic TWW standard with a performance of 87.50% against the 93% target.

There were seven breaches in total, all due to patients declining appointments offered within two weeks of referral.

The Trust continues to pass the 31 day first treatment standard with a performance of 97.32% against the 96% target.

There were six breaches in total. One in Breast, one in Skin, one in Sarcoma and three in Urology. All breaches were due to a lack of capacity to offer surgery within 31 days of decision to treat.
The Trust passed the 62 day national standard for March 2018 with performance of 86.00% against target of 85%. The Trust is now being measured against the new national breach reallocation policy. However, official monitoring of this will not commence until July 2018. The Trust reported a performance of 86.67% against the new rules.

The Trust passed the 62 day standard for the year 2017/2018 with a performance of 85.20%. This is the second consecutive year that the Trust has achieved this.

25 patients breached in March, 15 of which started their pathway at NBT. Of these 15 patients, 13 had their first appointment at NBT after day seven. Delays in radiology contributed to five of these breaches.

Urology breaches accounted for 66% of total Trust breaches for March, with all internal breaches on the Prostate pathway. Capacity issues in Radiology, Joint Oncology clinics, Template Biopsy and Robotic Theatres continue to limit the ability to meet the 62 day standard in Urology. Urology have implemented a Cancer RAP and monthly meetings are held between the department and Cancer Services. The trajectory for Urology shows performance improvements from June 2018 with the standard being met in September.

Eight Urology patients were transferred in from other providers for treatment beyond day 38 of their pathway, accounting for four additional breaches.

NB: The charts show the breakdown of breach reasons for both whole and shared 62 day breaches for the month. Breakdown of breach reason may not match total published performance due to time of which data was captured. Data is extracted from a live system.

<table>
<thead>
<tr>
<th>New National Policy Applied</th>
<th>62 Day (Urgent GP) - Target 85 %</th>
</tr>
</thead>
<tbody>
<tr>
<td>March</td>
<td>Total treated</td>
</tr>
<tr>
<td>Brain</td>
<td>0</td>
</tr>
<tr>
<td>Breast</td>
<td>18</td>
</tr>
<tr>
<td>Colorectal</td>
<td>12</td>
</tr>
<tr>
<td>CUP</td>
<td>0</td>
</tr>
<tr>
<td>Gynaecology</td>
<td>3.5</td>
</tr>
<tr>
<td>Haematology</td>
<td>8</td>
</tr>
<tr>
<td>Head and Neck</td>
<td>0</td>
</tr>
<tr>
<td>Lung</td>
<td>4.5</td>
</tr>
<tr>
<td>Sarcoma</td>
<td>3</td>
</tr>
<tr>
<td>Skin</td>
<td>31</td>
</tr>
<tr>
<td>Upper GI</td>
<td>4</td>
</tr>
<tr>
<td>Urology</td>
<td>36</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>120</strong></td>
</tr>
</tbody>
</table>
The Trust transferred four patients to treating providers later than day 38 of their pathway. One was due to complex medical issues, one was due to requirement of additional diagnostics, one was due to administrative delay. One patient was transferred in target but then required further diagnostics which were requested at NBT.

Weekly PTL monitoring and meetings continue to highlight patients who have been delayed on their pathways and to expedite diagnostics and treatment decisions.

The Trust passed the 31 day subsequent treatment target in March 2018 for patients requiring surgery with a performance of 94.68% against the 94% standard.

There were five breaches in total, two in skin and three in Urology. All breaches were due to capacity to perform the surgery following decision to treat.

The Trust passed the 62 day screening target with a performance of 96.83% against the target of 90%. There was one breach which was due to delays in performing diagnostics.
ED 4 Hour Performance
NBT ED performance in April 2018 reports at 83.03%. At 0.69% higher than the England performance, this is the best reported ED performance at NBT since April 2017.

RTT Incomplete
RTT performance in April 2018 is 85.65%, an improvement from the 2017/18 year end position and a move towards the nationally expected standard.

Cancer – 62 Day Standard
NBT Cancer 62 day performance has out performed the England position every month in 2017/18, excluding January 2018. Despite a fall under the National standard in January 2018, NBT performance recovered within two months to exceed the National Target at year end with performance above the England position at 86.67%.

DM01
NBT has, in April 2018, reported a position which is 0.70% improved to that of April 2017. This is a slight increase from year end 2017/18 and marginally fails to meet the national standard of 1% with actual performance at 1.04%.

Cancer performance is reported a month in arrears.
The number of patients recorded as formal delays (DToCs) remains above target levels (5.08%) with particular pressures experienced for Bristol patients which have been increasing since February.

Extra capacity in terms of Discharge to Assess (D2A) pathway two beds and pathway one support was delivered in April. The bedded capacity has been filled to 100% occupancy. Further work is needed to maximise pathway one capacity – both in terms of NBT referrals and community team allocation and re-enablement support to match demand.

Overall demand continues to outstrip supply across all pathways and further work is needed across BNSSG to mitigate against this position.

Opportunities to reduce internal delays and therefore bed days (over 2000 bed days Trust wide) continue to be the focus of patient flow improvement plans.

*Owing to submission and data availability dates, the latest month DToC position is unvalidated.
The number of patients who are exceeding standards remains at 68 at the end of April with the most significant delays noted within the MDT section – this represents a culmination of a number of delays including: patients waiting a best interest meeting; patients waiting for specialist stroke and neuro rehab and patients waiting for a decision on their discharge pathway.

Patients waiting for ongoing community support represent the next biggest delay but an improvement has been seen in this area over the past couple of months.

Previous delays in social care assessment and allocation has improved as staffing within these areas has improved and the output from an external review in this area has noted a requirement to increase capacity for Bristol in particular which is being actioned.

The Whole System Operational Group (WSOG) oversees performance in this area and has identified areas of focus for 2018/19 which is expected to significantly reduce delays for patients waiting for externally supported discharge.

<table>
<thead>
<tr>
<th>Operating Standards</th>
<th>Delay Reason</th>
<th>15 Feb</th>
<th>22 Feb</th>
<th>01 Mar</th>
<th>08 Mar</th>
<th>15 Mar</th>
<th>22 Mar</th>
<th>29 Mar</th>
<th>05 Apr</th>
<th>12 Apr</th>
<th>19 Apr</th>
<th>26 Apr</th>
<th>03 May</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Within</strong></td>
<td>D2A Pathway 1</td>
<td>6</td>
<td>12</td>
<td>7</td>
<td>2</td>
<td>13</td>
<td>7</td>
<td>3</td>
<td>9</td>
<td>8</td>
<td>14</td>
<td>5</td>
<td>7</td>
</tr>
<tr>
<td></td>
<td>D2A Pathway 2</td>
<td>10</td>
<td>9</td>
<td>10</td>
<td>12</td>
<td>11</td>
<td>10</td>
<td>12</td>
<td>5</td>
<td>2</td>
<td>8</td>
<td>9</td>
<td>8</td>
</tr>
<tr>
<td></td>
<td>D2A Pathway 3</td>
<td>4</td>
<td>3</td>
<td>3</td>
<td>1</td>
<td>3</td>
<td>1</td>
<td>3</td>
<td>1</td>
<td>5</td>
<td>2</td>
<td>2</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>Awaiting MDT Ward Decision</td>
<td>28</td>
<td>18</td>
<td>28</td>
<td>18</td>
<td>21</td>
<td>20</td>
<td>25</td>
<td>27</td>
<td>29</td>
<td>19</td>
<td>30</td>
<td>23</td>
</tr>
<tr>
<td></td>
<td>Further Care - NHSE Commissioned</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>1</td>
<td>0</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>Residential Placements - N&amp;RH (All funders)</td>
<td>6</td>
<td>8</td>
<td>9</td>
<td>4</td>
<td>12</td>
<td>11</td>
<td>10</td>
<td>1</td>
<td>5</td>
<td>15</td>
<td>15</td>
<td>6</td>
</tr>
<tr>
<td></td>
<td>Homecare (All Funders)</td>
<td>10</td>
<td>9</td>
<td>15</td>
<td>8</td>
<td>3</td>
<td>6</td>
<td>10</td>
<td>6</td>
<td>12</td>
<td>8</td>
<td>10</td>
<td>9</td>
</tr>
<tr>
<td></td>
<td>Managing Expectations (Choice)</td>
<td>2</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>3</td>
<td>2</td>
<td>1</td>
<td>5</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>Rehab</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>Social Care (Assessment)</td>
<td>14</td>
<td>21</td>
<td>20</td>
<td>19</td>
<td>19</td>
<td>12</td>
<td>9</td>
<td>15</td>
<td>11</td>
<td>22</td>
<td>16</td>
<td>19</td>
</tr>
<tr>
<td></td>
<td>Internal Hospital Delay</td>
<td>10</td>
<td>5</td>
<td>8</td>
<td>12</td>
<td>5</td>
<td>3</td>
<td>5</td>
<td>6</td>
<td>9</td>
<td>8</td>
<td>3</td>
<td>6</td>
</tr>
<tr>
<td></td>
<td>Further Care - CCG Commissioned</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>2</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>Other Categories</td>
<td>4</td>
<td>6</td>
<td>3</td>
<td>9</td>
<td>5</td>
<td>12</td>
<td>12</td>
<td>4</td>
<td>2</td>
<td>8</td>
<td>4</td>
<td>6</td>
</tr>
<tr>
<td></td>
<td>Not Suitable</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td><strong>Total (within)</strong></td>
<td>94</td>
<td>92</td>
<td>103</td>
<td>87</td>
<td>94</td>
<td>87</td>
<td>89</td>
<td>83</td>
<td>94</td>
<td>100</td>
<td>96</td>
<td>90</td>
<td></td>
</tr>
<tr>
<td><strong>Exceeds</strong></td>
<td>D2A Pathway 1</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
<td>3</td>
<td>4</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>D2A Pathway 2</td>
<td>12</td>
<td>9</td>
<td>6</td>
<td>10</td>
<td>8</td>
<td>7</td>
<td>9</td>
<td>11</td>
<td>11</td>
<td>11</td>
<td>1</td>
<td>4</td>
</tr>
<tr>
<td></td>
<td>D2A Pathway 3</td>
<td>1</td>
<td>2</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>0</td>
<td>2</td>
<td>1</td>
<td>1</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>Awaiting MDT Ward Decision</td>
<td>4</td>
<td>11</td>
<td>7</td>
<td>12</td>
<td>11</td>
<td>0</td>
<td>2</td>
<td>1</td>
<td>1</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>Further Care - NHSE Commissioned</td>
<td>2</td>
<td>3</td>
<td>3</td>
<td>3</td>
<td>2</td>
<td>2</td>
<td>0</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>Residential Placements - N&amp;RH (All funders)</td>
<td>18</td>
<td>12</td>
<td>16</td>
<td>12</td>
<td>11</td>
<td>14</td>
<td>12</td>
<td>12</td>
<td>12</td>
<td>8</td>
<td>9</td>
<td>9</td>
</tr>
<tr>
<td></td>
<td>Homecare (All Funders)</td>
<td>7</td>
<td>4</td>
<td>4</td>
<td>7</td>
<td>8</td>
<td>8</td>
<td>10</td>
<td>11</td>
<td>4</td>
<td>7</td>
<td>6</td>
<td>5</td>
</tr>
<tr>
<td></td>
<td>Managing Expectations (Choice)</td>
<td>8</td>
<td>4</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td>Rehab</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>Social Care (Assessment)</td>
<td>8</td>
<td>4</td>
<td>1</td>
<td>4</td>
<td>6</td>
<td>10</td>
<td>2</td>
<td>9</td>
<td>10</td>
<td>11</td>
<td>4</td>
<td>4</td>
</tr>
<tr>
<td></td>
<td>Internal Hospital Delay</td>
<td>6</td>
<td>9</td>
<td>2</td>
<td>8</td>
<td>10</td>
<td>11</td>
<td>2</td>
<td>6</td>
<td>5</td>
<td>4</td>
<td>8</td>
<td>7</td>
</tr>
<tr>
<td></td>
<td>Further Care - CCG Commissioned</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>Other Categories</td>
<td>7</td>
<td>1</td>
<td>2</td>
<td>8</td>
<td>8</td>
<td>7</td>
<td>5</td>
<td>10</td>
<td>7</td>
<td>7</td>
<td>5</td>
<td>8</td>
</tr>
<tr>
<td></td>
<td>Not Suitable</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td><strong>Total (exceeds)</strong></td>
<td>77</td>
<td>64</td>
<td>48</td>
<td>72</td>
<td>70</td>
<td>78</td>
<td>57</td>
<td>79</td>
<td>77</td>
<td>66</td>
<td>68</td>
<td>68</td>
<td></td>
</tr>
</tbody>
</table>
Safety and Effectiveness

Board Sponsors: Medical Director and Director of Nursing
Chris Burton and Sue Jones
Early Warning Trigger Tool
No wards triggered this month although compliance has declined from last month (96% compliance March). A reminder has been sent via the Heads of Nursing to those not submitting this month.

Safe Care Live (Electronic Acuity tool)
The acuity of patients is measured three times daily at ward level. This demonstrates that rostered hours, were below in all Divisions than required in April, an ongoing pattern, reflecting the acuity and dependency of patients in our hospital beds.

Professional judgement is one pillar of three utilised to maintain safe staffing levels, the other two being numbers of staff on the shift and the Safe Care data.

Staff are redeployed between clinical areas and Divisions following a twice daily staffing meetings involving all divisions, to ensure safety is maintained where a significant shortfall in required hours is identified, to maintain patient safety.
Nursing Workforce
April workforce position has improved with a reduction in the use of escalation capacity and the subsequent reduced requirement for agency staff to support activity.

Agency Nursing
Agency usage has reduced in April to 3% of the nursing workforce following peaks in January and February 2018.

Actions in place
Cohesion continue to support the recruitment of the HCA Band 2s and some Band 5 Registered Nurses although ASCR and NMSK have been more successful than Medicine.

A Specific Medicine recruitment plan has now been developed to support recruitment in parallel with a robust retention plan supported by the Trust Wide Retention Steering Group.

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>N&amp;M</td>
<td>Agency</td>
<td>36</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Bank</td>
<td>195</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Substantive</td>
<td>1942</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Total</td>
<td>2173</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>HCA</td>
<td>Agency</td>
<td>0</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Bank</td>
<td>224</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Substantive</td>
<td>947</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Total</td>
<td>1171</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Southmead Nursing and Midwifery Fill Rates and Care Hours per Patient Day (CHPPD)

Nursing and midwifery fill rates for April are down again with the exception of RN which is up 2.5%. This is getting closer to the expected fill rates following the budget and skill mix reviews for the inpatient wards. CHPPD this month at 8.7 is back to the normal range for the Trust as the midnight census also returns within the Trust’s range.

Wards below 80% fill rate are:

**NICU:** Reduced fill rates for CA at night; NICU staffing is closely monitored each shift. In order to maintain safety the unit has been closely supported by the CDS coordinator and staff sent to support as necessary. Additional duties have been reassigned to days where practice development staff and the Matrons have supported the unit to ensure these tasks are completed. The recruitment of 5.5 WTE to the unit has started to have an impact with day shift now above the 80% fill rate.

**MSS:** CA fill rate days: 67.5% Care assistants on nights are prioritised with days being supported by theatre staff flexibly across the floor and senior nurses. The theatres figure are not represented within the safe staffing matrix and MSS is predominantly an evening and night-time function.

**IR:** CA fill rate days: 74.7% Care assistants are being used across the unit including in the labs and where necessary the new unit manager is working clinically and additional RNs are being used. The planned staffing is being monitored closely and any changes required will be reflected in the numbers in the coming month.

**Cossham Midwifery Fill Rate and CHPPD:**
The new rota for Cossham Birth Suite has commenced last month with significant improvement to the RM fill rates as a result. This will rebalance over the next two published rotas. All fill rates are the same as last month with no changes Cossham Birth Suite midnight census dropped again this month to 30 from 35, the CHPPD has therefore increased.

---

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.
Maternity Staffing
In April 2018 the unit closed on four occasions due to high activity and acuity. No women were transferred during this time.

Average Births / Day (2018)
February 17
March 16
April 17

The Midwife to birth ratio remains at 1:30 and has been a constant since April 2016.

The birth rate plus report continues to be used to inform business planning for the future workforce plan, alongside the introduction of integrated working between the birth centres and the community. The midwife to birth ratio is currently being re-evaluated in accordance with updated acuity tools.

Better births work streams established to implement BNSSG Local Maternity Systems four key themes:
- Personalised care
- Continuity of carer
- Safer care
- Better postnatal care

‘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.
Serious Incidents (SI)
Five serious incidents were reported to STEIS in April 2018:
- 2 x Unexpected Admission to NICU
- 1 x Fall
- 1 x Surgical/Invasive Procedure
- 1 x Medication Error

One Serious Fall identified for external reporting through the SWARM process.

Never Event Description - None

SI and Incident Reporting Rates
Incident reporting has increased slightly to 42.6 PBD.
Serious incidents rate has decreased and is now at 0.2.

Directorates:
SI Rate by 1000 Bed Days

- CCS* - 1.04
- WCH - 0.37
- ASCR - 0.33
- Med - 0.30
- NMSK - 0.21

*CCS Bed Base Interventional Radiology only
Incident Reporting Deadlines for RCA submission

One serious incident breached its April 2018 reporting deadline to commissioners.

Top SI Types in Rolling 12 Months

Delayed Treatment are the most prevalent of reported SI's, followed by Serious Falls (by SWARM).

*Other Categories:
2 Incorrect Test Results
2 Lost to Follow Up
2 Infection Control
1 Adverse Media Event
1 Transfusion Error
1 Operating without Valid Consent
1 Wrong Site Surgery
1 Delayed Treatment of Deteriorating Patient

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):

Ten new alerts reported, none breaching alert target dates.

One previously issued alert Patient Safety Alert remains in breach of its deadlines:


### CAS Alerts – April 2018

<table>
<thead>
<tr>
<th>Alert Type</th>
<th>Patient Safety</th>
<th>Facilities</th>
<th>Medical Devices</th>
</tr>
</thead>
<tbody>
<tr>
<td>New Alerts</td>
<td>2</td>
<td>6</td>
<td>2</td>
</tr>
<tr>
<td>Closed Alerts</td>
<td>0</td>
<td>5</td>
<td>0</td>
</tr>
<tr>
<td>Open alerts (within target date)</td>
<td>2</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Breaches of Alert target</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Breaches of alerts previously issued</td>
<td>1</td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>
Harm Free Care
The ‘harm free’ care reporting includes both overall harm free care and the new harm rates which are reflective of ‘hospital acquired harm’. This month shows 97.22% for harm free care compliance (adjusted for hospital acquired harm) and is a static position.

Falls
There were no serious events among the 200 falls in April, nine were moderate, 45 low and 146 resulting in no harm.

The Medicine Division accounted for 94 falls with 21 in Elgar house. The leadership in Elgar is doing excellent work bringing the two wards together with a particular focus on falls prevention and enhancing their support for people with associated cognitive impairment. The teams on Elgar now conduct ‘local’ SWARMS for all falls and we will be evaluating the benefits in forthcoming Falls Prevention Meetings.
Pressure Injuries
Pressure injury incidence per thousand bed days observed an increase this month at 0.60 per 1000 bed days.

2018/19 Trust objectives for the reduction of pressure injuries remain a zero tolerance for Grade 4 and 3 and a 20% reduction (164 cases) for Grade 2.

Grade 4: Nil reported
Grade 3: Nil reported
Grade 2: Nineteen reported occurring in 16 patients. 63% were validated on heels and 21% to sacrum - the clinical teams are completing local level reviews to look for themes and trends.

The Trust is part of the BNSSG multi-agency strategy for the prevention and management of pressure injuries.

VTE Risk Assessment
Timely VTE Risk Assessments above the 95% national standard have continued.

The emphasis on broader quality improvement work in relation to cases of hospital acquired thrombosis continues, overseen by the Thrombosis Committee and in line with the approach endorsed within the ward of VTE Exemplar Centre status in October 2017.
Malnutrition

Malnutrition compliance for April was 82.97%, a slight improvement on the position in March (79.17%). All Divisions were non compliant with the 90% target and this compliance with the screening tool remains unchanged despite a targeted approach from the Matrons and Heads of Nursing.

A paper proposing the changes to the current risk assessment process is going to the Nutrition Steering Group on 04 June 2018. The proposed change, supported by a training package is being developed – aligning with the CQC action plan delivery. To ensure engagement with the implementation, frontline staff are involved in the development of the care plans and testing the training package for its usability.

WHO Checklist Compliance

Measured compliance with the WHO checklist was 96.28% in April.

WHO safer surgery list compliance is led by the Theatre Management Team, linking with each speciality cluster, the programme is reporting into Theatre Board.
Fractured Neck of Femur in Patients aged 60 years and over.

Patients admitted to an acute orthopaedic ward within four hours. For the majority, 2017/18 showed better performance than 2016/17. Despite a fall below the previous year in February 2018, performance on average across the year was 8.63% improved to 2016/17.

Patients medically fit to have surgery have surgery within 36 hours. Performance is varied but has remained above 70% for the last year. Both 2016/17 and 2017/18 show a performance drop February to March although this recovers in April. 2018/19 begins the year reporting 1.10% shy of the performance high point in July 2017.

Patients assessed by an Orthogeriatran within 72 hours. April 2018 reports 100% of patients seen by an Orthogeriatran within 72 hours, a position not seen since November 2017. Performance against this measure is consistently high, reporting above 93% for the last two years.
Stroke

Patients admitted to a stroke unit within four hours.
NBT have reported performance under the national position for the last four years, 2017/18 data not yet available. Despite this, local performance has shown year on year improvement at an average rate of 7.60% per year against the varying national position which shows fluctuations across 2%.

Patients who spent at least 90% of their stay on a stroke unit.
NBT has reported consistently high performance of over 86%, in excess of the national position, for the last three years.

Patients thrombolysed within one hour.
Performance against this metric is varied, but has out performed the national position in three of the last four years, most significantly in 2016/17 where NBT thrombolysed 10% more patients within one hour than nationally, reporting performance at 72.2%. This is a 9.4% improvement to NBT’s previous best performance of 62.8%, in 2014/15, against a national position of 56.1%.

Data from the SSNAP (Sentinel Stroke National Audit Programme)
Medicines Management

Severity of Medication Error

We have again seen an increase in reporting of low harm events. This is related to increased focus on incident reporting now that Datix is becoming embedded in practice. What we hope to see is more reporting of incidents, but with a none/low harm rating and a reduction in moderate harm, as we learn from these reports.

High Risk Drugs

There has been an increase in reporting of incidents relating to high risk drugs with Opiates +8, Heparin +6, Warfarin +6. The increase does not appear to be related to any particular area. It is unclear whether there has been an under reporting over the last seven months in the run up to and implementation of Datix and we are returning to previous reporting patterns. This will be kept under review and actions derived from the learning within the incident reports.

Themes of Medication Error

Delayed doses are, once again, the top theme this month although much reduced.

Missed Doses

The increased focus on missed doses – local audits, back to the floor meeting, is having the desired effect and overall reporting is continuing on a downward trend.
MRSA
There were three reported cases of MRSA bacteraemia in April. Investigations have concluded that one case was related to the management of a central vascular device, a second was related to the management of peripheral vascular devices and the third case was an ongoing MRSA bacteraemia infection with three previously reported community cases within the last six months. An urgent meeting of the Control of Infection Committee has been convened on 24 May to consider immediate actions required in view of this increase in incidence.

C. Difficile
The Trust objective for 2018/19 is 42 cases. There were three reported cases in April, occurring within the ASCR and Medical Divisions. The RCA for each case is reviewed at the bimonthly C. Difficile steering group with agreed learning and actions taken forward by the clinical area supported by their Division.

An external audit is currently being carried out by Grant Thornton as part of the Trust Quality review.

Public Health England (PHE) Benchmarks
Data from the latest published report is shown.
There were six cases of E. Coli bacteraemia reported in April. There is a BNSSG system action plan in place to address this infection to which NBT is contributing. The focus being predominantly on the management of urinary catheters.

**MSSA**

There was one reported case of MSSA bacteraemia in April.

The RCAs for cases are reviewed and presented at a bi-monthly steering group chaired by the Trust infection control doctor. Good management of indwelling devices is the focus of the Trust improvement action plan.

**Hand Hygiene**

Hand Hygiene compliance reported 93.9%. Falling short of the 95% standard, an action plan is in place to return compliance to the Trust standard.
Learning from Deaths
All deaths should be reviewed (either screened or full case note review) within three months of the death. For this reason, the data for the IPR is shown up to 31 January 2018. The completion rate of SCRs from April 2017 to 31 January 2018 is at 66%.

In this report time period (31 December 2017 – 31 January 2018) there have been no deaths where overall care scores were rated as poor or very poor. Overall care was rated as good or excellent in 90% of cases. At the time of reporting there have been no deaths in this period where poor care has been identified that was more likely than not to be contributory to the death.

In this report time period there have been two deaths of patients with known learning disabilities. One of these deaths was reviewed under the Serious Incident reporting framework. The second death was reviewed under the mortality review process and Overall Care was rated Good.

Areas of work in our quality improvement programme identified from learning from deaths and other patient safety reviews include: Ceiling of Treatment decisions, Purple Butterfly Project for End of Life Care, Insulin Safety, Sepsis and Early Warning Scores.
Research and Innovation

Board Sponsor: Medical Director
Chris Burton
Research and Innovation

Recruitment at the start of 2018/19 has been acceptable, with recruitment at 60% of the CRN target. The target set by the CRN includes an aspirational element. Due to changes from the network the recruitment target will represent a challenge to meet in 2018/19 however contingency and correction plans are being implemented to address the shortfall. We are specifically focusing on increasing the number of non-medics leading studies to increase our portfolio.

The percentage of studies recruiting the first patient within 70 days continues to present a challenge for NBT and also nationally. The implementation of a detailed feasibility tool, designed with the research infrastructure, is expected to decrease the time taken to recruit patients. National work is underway to review this benchmark following national process changes.

NBT currently holds 15 NIHR research grants worth £16.6m. The most recent has been awarded to Professor Marcus Drake; an NIHR Research for Patient Benefit grant worth £150k to undertake first-in-human testing of a novel urinary catheter to improve bladder drainage.

The Research and Innovation department is committed to demonstrating the value of the research undertaken at NBT. We have recently become first NHS Trust to acquire licence to use the ‘ResearchFish’ data platform to systematically capture and report the outcomes of NBT lead and NBT funded research.

Effectiveness - Board Sponsor: Medical Director
Quality Experience

Board Sponsor: Director of Nursing
Sue Jones
Overall response rates have increased across all four areas. Outpatients and Maternity Services are exceeding their targets whilst the Emergency Department is almost at target - 18.31% with a target of 20%. Inpatients is now the area of focus with a response rate of 17.60% against target of 30%.

44.54% of all patients discharged during April 2018 were invited to give us feedback through the FFT survey. This resulted in response rates from those invited of:

<table>
<thead>
<tr>
<th>Area</th>
<th>Response Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>ED</td>
<td>21%</td>
</tr>
<tr>
<td>IP</td>
<td>38%</td>
</tr>
<tr>
<td>DC</td>
<td>42%</td>
</tr>
<tr>
<td>OP</td>
<td>28%</td>
</tr>
<tr>
<td>Maternity</td>
<td>19%</td>
</tr>
</tbody>
</table>

Inpatient wards performance is being given to Divisional Management Teams with step targets for response rates. Advice and guidance will be available from the Patient Experience Team.

A business card has been produced for staff to give to patients as they leave hospital to invite them to give us feedback. The business card also provides the online address to the survey which enables those excluded from the messaging system due to survey fatigue to have the opportunity to provide their views. Business cards and posters are currently being rolled out with the instructions and rationale for use.

The investigation into those patients not being invited to feedback due to an error in the telephone number sent to our FFT service provider is still ongoing.

The draft SOP for FFT is being finalised following discussion at the Patient Experience Group. This will be accompanied by the expected improvement trajectory for identified areas.

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 the IPR.
The % would recommend is up in all patient groups, though still not achieving the Trust target of 95%, except for the Emergency Department where there has been a drop of 1.49%. There was a fall in '% Would Recommend' on 09,11 and 23 April and a rise in '%Would Not Recommend' on those same days.

Whilst the Maternity service % would recommend is up the number who would not recommend is also up. This is a positive sign of the work being undertaken with maternity services. Staff are engaging with patients to ask for feedback both positive and negative. Previously negative comments were very rare which did not help the team to identify the areas for improvement.

The Patient Experience Team talked with patients in the atrium during International Patient Experience Week, working with teams since to resolve some of the issues patients were experiencing i.e. parking spaces for users of power assisted wheelchairs with adapted vans.

Facilities teams are being brought on-board to review FFT reports on the Envoy Platform to provide feedback about non-clinical issues such as the environment, food, parking etc.

A number of quality improvement projects relating to Patient Experience were displayed in the atrium of Brunel Building as part of International Patient Experience Week.

During April a workshop was delivered by Picker where the results of the National Inpatient Survey 2017 were presented and discussed. Key priorities identified were: Eating, Drinking, Discharge, Communication, Patients taking their own medicines, Being listened to / being asked to feedback. An action plan has been prepared to focus on these issues.

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.
Friends and Family Test

“Please tell us the main reason for the answer you chose.”

**Key: Would you recommend?**
1. Extremely Likely
2. Likely
3. Neither Likely nor Unlikely
4. Unlikely
5. Extremely Unlikely
6. Don’t know

---

1 – Gate 21 Daycase

- Attentive staff who kept me updated and explained the process. Made me feel comfortable in a stressful situation.

2 – Antenatal

- Really impressed that I met the same midwife for each app/ This did not happen when I had my son. Much more efficient and a nicer feeling.

3 – Birth, Southmead

- The visiting hours are really bad, I wasn’t able to see my 2 year old daughter and I felt really distressed when my family members were not being told clearly the visiting hours while other patients would have their visitors nearly all day.

4 – Gate 26b

- I was transferred twice after admission, you lost my meds and did not supply the correct meds on discharge. Discharge also took nearly all day, again without pain relief because pharmacy as usual wandered off with my drugs chart. The whole process needs to be revised and made more seamless.

5 – Physio Assessment, Gate 24

- Late by 30 minutes and can’t book an Appointment in the time frame they want me to come back in. Initially impressed by the check in process but then downhill afterwards. There are many gates for the same number and it wasn't until nearer my appointment time that I found out I was sitting in the wrong area -3 seating areas for section 24 that I could see. Also I went to a receptionist to find out why appointment was delayed. It wasn't obvious that one receptionist dealt with one particular area of 24. Maybe you need to label the receptionists better because I ended up standing in a queue twice unnecessary. The boards that say your name are easily missed - especially when your appointment is not on time.

1 – ED

- I arrived at 11am. Was taken in and paperwork completed. Taken to the waiting area with no tv or reading material where I was left for 5 hours with no contact from any member of staff. After the op I did not see a doctor so have left the hospital not knowing what I can or cant do with my arm. I know I have to have the stitches out in 2 weeks.

3 – Gate 21 Daycase

- Friends and Family Test

"Please tell us the main reason for the answer you chose."
Complaints and Concerns
In April there were 53 complaints, compared to last month there has been a decrease of 20, and 70 concerns received, which is an decrease of 13. In total, 123 complaints and concerns were received.

Compliments
The number of compliments returned to the advice and complaints team for recording for April was 688.

NHS Complaints National Guideline Targets
The three day acknowledgment was achieved for all complaints (100%).

Overdue Cases
The number of cases that were overdue at the end of the month increased slightly from the CCG target of 10 in March to 15 in April.

Final Response Compliance
Of the cases closed in April 2018 (to account for late responses), 44 (63%) were completed within the agreed timescale. The exceptions were:

10 x 1-10 days overdue
9 x 10-20 days overdue
5 x greater than 20 days overdue.
Complaint Handling

The top three categories of complaints in April reflect a trend of issues raised surrounding clinical care and treatment, communication and staff attitude. There are also a number of issues raised under an ‘other’ subject heading that do not fit into the existing categories. A review of the categories will be undertaken to capture this information to use for trend analysis. The advice and complaints team are continuing to work closely with divisions to inform good practice in responding to complainants.

NHS Choices Web posts

For April 2018 Southmead Hospital has an overall star rating of 4.5 out of 5 from 256 reviews. Cossham Hospital has a rating of 4.5 out of 5 from 17 reviews. In April 2018 the star ratings given were:

- 3 x 5 stars
- 2 x 4 stars
- 1 x 5 stars

The advice and complaints team provide feedback comments to each reviewer, usually within a day of receipt.

Ombudsman Cases

No new cases were either referred to the Ombudsman or closed by them in April 2018. No Ombudsman referrals have been received since December 2017 which is a positive indication that complaint resolution is increasing.
Facilities

Board Sponsor: Director of Facilities
Simon Wood
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 have remained high throughout April with targets being exceeded, except in very high risk areas where performance has remained stable at 97%, one point off target.

Mandatory training compliance for April still exceeds the 85% target and is currently at 93%.

Communication remains a key theme over the past 12 months. We try to reach as many of our staff as possible through a variety of local and wider engagements. We have handover books in many locations across site as well as bright ideas boxes on each level where staff can raise issues anonymously.
Well Led

Board Sponsors: Medical Director and Director of People and Transformation
Chris Burton and Jacolyn Fergusson
Substantive Staff

In April actual pay expenditure was slightly lower than the budgeted expenditure, reflecting a position which was last reached in July 2017.

Worked WTE dropped against the funded establishment. However total vacancies rose from 605 WTE in March 2018 to 692 WTE in April 2018, due mainly to an increase in the overall funded establishment of around 78 WTE in April 2018. The biggest funded increases, of between 15 to 22 WTE, were in strategic corporate functions, NMSK and Medicine.
Bank and Agency

April has seen a slight increase in bank expenditure, due to a high demand on bank usage, as a result of the vacancy position in some divisions.

The Neutral Vendor (dePoel) arrangements for agency supply are in month five of the contract. Agency expenditure continues to reduce for the third month in a row and work continues with dePoel to reduce spend, particularly as usage at Tier 2 or Tier 3 rates remains high and use of non framework agencies continues.

NBT eXtra continue to recruit to both clinical and non clinical roles, with a strong pipeline of new staff starting in the coming weeks.

Work continues to be carried out with external partners in the recruitment of FM bank staff, with our first successful training and recruitment campaign completed. This has produced an increase in bank fill rates for domestics and catering shifts.
While April 2018 contracted staff in post has reduced slightly from the previous month, a comparison between the last two financial years shows a net increase of around 47 additional staff in post in 2017/18.

However, it should be noted that funding for some workforce cost pressures has now been allocated to April’s budgets, increasing the budgeted establishment, and this has had an impact upon contracted staff in post.

The biggest increase by staff group is in Additional Clinical Services (HCAs), reflecting the targeted recruitment campaign undertaken by the Trust. The biggest reduction can be seen within the Health Care Scientist group and Allied Health Professionals.
Nurse/HCA Recruitment

Cohesion

For HCAs, recruitment against turnover continues, with 256 offers accepted to date since the approach with Cohesion began in September 2017.

Experienced Band 5 nursing recruitment has seen 51 offers accepted to date, again through the Cohesion approach.

SLA

Time to recruit has risen to 23 working days - five days above the SLA of 17. This has been as a result of capacity in the Resourcing team and the issues with the Trusts internet speed, which severely impacted the recruitment system (Trac).

A number of mitigating actions are now in place and is enabling good progress on clearing the backlog. It is expected that the time to recruit will reduce back down to within the 17 day SLA over coming weeks.
Refer a Friend Scheme

NBT’s recently launched a ‘Refer a Friend’ recruitment scheme continues for Band 5 Registered Nurses. One “friend” has already secured a role with the Trust and will receive their £1000 reward once they have completed their first six months of service at NBT.

Turnover

The number of staff leaving the Trust has increased since last month, with the biggest impact being seen in the Additional Professional, Scientific and Technical and HCA staff groups.

The majority of HCA leavers had less than two years service and gave ‘work-life’ balance as their reason for leaving.

The Retention Steering Group are developing a “Stay” campaign, which will target those areas most affected by turnover.
Sickness absence decreased in March (the second consecutive month of reduction) and is now just slightly above target at 3.9% (lower than March 2017 absence which averaged 4.4%).

Absence decreased across all staff groups, apart from registered nursing and midwifery, which saw an increase of 2.72%.

A reduction in short-term absence was the key reason for this, with long-term sickness absence levels remaining fairly static over the last four months. Most days lost due to short-term absence were attributed to cough, colds and flu.

For the fifth month in a row musculoskeletal/back problems was not recorded as one of the top five reasons for short term absence. In addition, for the second month in a row stress, anxiety and depression also remained outside of the top five reasons for short term absence.

This continued improvement is regarded as a direct result of the proactive programme of work currently underway within the Trust to support staff on their mental health resilience and physical health.

However, stress, anxiety and depression remains the key reason for long-term absence in the Trust and work will continue to improve staff health and wellbeing, particularly in these areas.
### In Month Sickness Absence by Staff Group

<table>
<thead>
<tr>
<th>Staff Group</th>
<th>Variance</th>
<th>Feb-18</th>
<th>Mar-18</th>
</tr>
</thead>
<tbody>
<tr>
<td>Add Prof Scientific and Technic</td>
<td>-1.49%</td>
<td>4.23%</td>
<td>2.74%</td>
</tr>
<tr>
<td>Additional Clinical Services</td>
<td>-0.85%</td>
<td>6.34%</td>
<td>5.49%</td>
</tr>
<tr>
<td>Administrative and Clerical</td>
<td>-0.32%</td>
<td>5.37%</td>
<td>5.05%</td>
</tr>
<tr>
<td>Allied Health Professionals</td>
<td>-0.16%</td>
<td>2.62%</td>
<td>2.46%</td>
</tr>
<tr>
<td>Estates and Ancillary</td>
<td>-0.37%</td>
<td>6.08%</td>
<td>5.71%</td>
</tr>
<tr>
<td>Healthcare Scientists</td>
<td>-0.36%</td>
<td>2.46%</td>
<td>2.10%</td>
</tr>
<tr>
<td>Nursing and Midwifery Registered</td>
<td>2.72%</td>
<td>0.90%</td>
<td>3.62%</td>
</tr>
<tr>
<td>Medical and Dental</td>
<td>-2.76%</td>
<td>3.68%</td>
<td>0.92%</td>
</tr>
<tr>
<td>Estates and Ancillary</td>
<td>-0.37%</td>
<td>6.08%</td>
<td>5.71%</td>
</tr>
<tr>
<td>Healthcare Scientists</td>
<td>-0.36%</td>
<td>2.46%</td>
<td>2.10%</td>
</tr>
<tr>
<td>Nursing and Midwifery Registered</td>
<td>2.72%</td>
<td>0.90%</td>
<td>3.62%</td>
</tr>
<tr>
<td>Medical and Dental</td>
<td>-2.76%</td>
<td>3.68%</td>
<td>0.92%</td>
</tr>
<tr>
<td><strong>Trust</strong></td>
<td><strong>-0.34%</strong></td>
<td><strong>4.30%</strong></td>
<td><strong>3.96%</strong></td>
</tr>
</tbody>
</table>

### Rolling 12 Month Sickness Absence

<table>
<thead>
<tr>
<th></th>
<th>Feb-18</th>
<th>Mar-18</th>
<th>Variance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Absence</td>
<td>4.36%</td>
<td>4.33%</td>
<td>-0.03%</td>
</tr>
</tbody>
</table>

### Long Term Sickness

**Top 5 Reasons (WTE Days) March 2018**

- **357.31** days: S10 Anxiety/stress/depression/other psychiatric illnesses
- **570.75** days: S98 Other known causes - not elsewhere classified
- **587.10** days: S12 Other musculoskeletal problems
- **788.03** days: S99 Unknown causes / Not specified
- **1415.60** days: S11 Back Problems

### Short Term Sickness

**Top 5 Reasons (WTE Days) March 2018**

- **524.28** days: S13 Cold, Cough, Flu - Influenza
- **616.38** days: S12 Other musculoskeletal problems
- **369.23** days: S98 Other known causes - not elsewhere classified
- **772.59** days: S99 Unknown causes / Not specified
- **157.30** days: S11 Back Problems
Essential Training

The increase in eLearning noted in last month's commentary has been maintained.

Some 66% of all of the Trusts training completions/attendances in Quarter 1 have been achieved via eLearning. Compliance with the overall Trust Target of 85% for MaST topics is being maintained.

Divisions are taking a more proactive approach to dealing with non compliant staff and have been requesting more focussed reports to individual managers.

Appraisal compliance remains at 65%. Simplified appraisal forms are anticipated to improve compliance in the 2018/19 appraisal round.

<table>
<thead>
<tr>
<th>Training Topic</th>
<th>Variance</th>
<th>Mar-18</th>
<th>Apr-18</th>
</tr>
</thead>
<tbody>
<tr>
<td>Infection Control</td>
<td>-0.1%</td>
<td>85.3%</td>
<td>85.3%</td>
</tr>
<tr>
<td>Health and Safety</td>
<td>0.5%</td>
<td>88.8%</td>
<td>89.2%</td>
</tr>
<tr>
<td>Waste</td>
<td>9.9%</td>
<td>79.0%</td>
<td>88.9%</td>
</tr>
<tr>
<td>Information Governance</td>
<td>9.0%</td>
<td>72.1%</td>
<td>81.1%</td>
</tr>
<tr>
<td>Child Protection</td>
<td>0.2%</td>
<td>86.2%</td>
<td>86.5%</td>
</tr>
<tr>
<td>Equality and Diversity</td>
<td>0.1%</td>
<td>85.4%</td>
<td>85.4%</td>
</tr>
<tr>
<td>Fire</td>
<td>1.2%</td>
<td>83.9%</td>
<td>85.1%</td>
</tr>
<tr>
<td>Manual Handling</td>
<td>0.2%</td>
<td>79.6%</td>
<td>79.8%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>2.9%</strong></td>
<td><strong>82.3%</strong></td>
<td><strong>85.1%</strong></td>
</tr>
</tbody>
</table>
Medical Appraisal and Revalidation

The fifth appraisal and revalidation year started on 01 April 2017 and ended on the 31 March 2018. 90% of the appraisals that were due within this period were completed. The remaining 10% are being managed by the Trust’s medical appraisal and revalidation team in order to reach 100% in the shortest possible timescale. At the end of the 2016/17 appraisal year, this figure stood at 92%.

The sixth appraisal and revalidation year has now started and will run until 31 March 2019. Appraisal compliance has been lower in April 2019 than it was in April 2017 and 2018. Divisional management teams will be provided with the names of individuals to chase compliance.

The number of doctors connected to the Trust’s designated body for appraisals and revalidation stands at 666. This includes consultants, specialty doctors, associate specialists, clinical fellows, Trust locum doctors and a small number of recently retired consultants. The Trust also provides an appraisal service for an additional 25 community paediatricians employed by Sirona and a further ten doctors who have connections to other designated bodies.

The Trust has currently deferred 19% of all revalidation recommendations due over the past 12 months. This number has been slowly decreasing since August 2017 when it reached its peak of 43%. The overall number of revalidation recommendations were low in 2017 with the vast majority of them being for clinical fellows. The number of doctors going through revalidation is now rising sharply in 2018 and the deferral rate is expected to continue to drop as more consultants go through their second revalidation since the process began in 2012. One non-engagement recommendation was made to the GMC in May 2017. This is the only non-engagement recommendation made at NBT since the introduction of revalidation in 2012.

The Trust’s revalidation support team have continued to provide medical appraiser CPD update training in 2017 with a further session available to appraisers in 2018. The PReP system remains the mandatory system for medical appraisals for all non-training grade doctors employed by the Trust. The current contract for PReP is in place until November 2018 and is currently under review by the revalidation support team.

An annual report representing the 2017/18 appraisal year will be due for completion and return to NHS England now that the appraisal year has come to an end. An annual report will also be presented to the NBT Trust board following the annual NHSE report.
Finance

Board Sponsor: Director of Finance
Catherine Phillips
### Statement of Comprehensive Income

**Assurances**

The financial position at the end of April shows a deficit of £2.7m, in line with the planned deficit.

### Key Issues

**Contract income** is £1.6m favourable to plan, driven mainly by non-elective activity.

Pay is £0.1m favourable to plan with reduced nursing spend against Quarter 4 in 2017/18.

Non pay is £1.4m adverse to plan primarily relating to clinical consumables spend.

Finance costs (excluding depreciation on donated assets) are on plan.

---

<table>
<thead>
<tr>
<th>Prior year actual to 30 April 2017 £m</th>
<th>Position as at 30 April 2018</th>
<th>Variance (Adverse) / Favourable £m</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>18.19 Plan  £m</td>
<td>Actual £m</td>
</tr>
<tr>
<td><strong>Income</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Contract Income</td>
<td>38.0</td>
<td>39.6</td>
</tr>
<tr>
<td>Other Operating Income</td>
<td>6.4</td>
<td>6.1</td>
</tr>
<tr>
<td>Donations income for capital acquisitions</td>
<td>0.0</td>
<td>0.0</td>
</tr>
<tr>
<td><strong>Total Income</strong></td>
<td>44.4</td>
<td>45.7</td>
</tr>
<tr>
<td><strong>Expenditure</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pay</td>
<td>(25.7)</td>
<td>(28.6)</td>
</tr>
<tr>
<td>Non Pay</td>
<td>(13.5)</td>
<td>(14.9)</td>
</tr>
<tr>
<td>PFI Operating Costs</td>
<td>(0.5)</td>
<td>(0.5)</td>
</tr>
<tr>
<td><strong>(41.8)</strong></td>
<td>(42.7)</td>
<td>(44.0)</td>
</tr>
<tr>
<td><strong>Earnings before Interest &amp; Depreciation</strong></td>
<td>1.7</td>
<td>1.7</td>
</tr>
<tr>
<td>4.6%</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Depreciation &amp; Amortisation</strong></td>
<td>(1.9)</td>
<td>(2.0)</td>
</tr>
<tr>
<td><strong>PFI Interest</strong></td>
<td>(2.9)</td>
<td>(2.9)</td>
</tr>
<tr>
<td><strong>Interest receivable</strong></td>
<td>0.0</td>
<td>0.0</td>
</tr>
<tr>
<td><strong>Interest payable</strong></td>
<td>(0.4)</td>
<td>(0.4)</td>
</tr>
<tr>
<td><strong>PDC Dividend</strong></td>
<td>0.0</td>
<td>0.0</td>
</tr>
<tr>
<td><strong>Other Financing costs</strong></td>
<td>0.0</td>
<td>0.0</td>
</tr>
<tr>
<td><strong>YTpaiment</strong></td>
<td>0.0</td>
<td>0.0</td>
</tr>
<tr>
<td><strong>(3.5)</strong></td>
<td>(3.5)</td>
<td>(3.6)</td>
</tr>
<tr>
<td><strong>Operational Retained Surplus / (Deficit)</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Add back Items excluded for NHS accountability</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Donations income for capital acquisitions</td>
<td>0.0</td>
<td>0.0</td>
</tr>
<tr>
<td>Depreciation of donated assets</td>
<td>0.0</td>
<td>0.1</td>
</tr>
<tr>
<td>Impairment</td>
<td>0.0</td>
<td>0.0</td>
</tr>
<tr>
<td><strong>(3.4)</strong></td>
<td>(3.5)</td>
<td>(3.5)</td>
</tr>
<tr>
<td>STF</td>
<td>0.7</td>
<td>0.8</td>
</tr>
<tr>
<td><strong>Adjusted surplus / (deficit) for NHS accountability (incl STF)</strong></td>
<td>(2.7)</td>
<td>(2.7)</td>
</tr>
</tbody>
</table>
Statement of Financial Position

Assurances
The Trust received new loan financing in April of £3.4m, which takes the total Department of Health borrowing to £166m.

The Trust ended the month with cash of £17.2m, £2.2m higher than plan. The higher balance is required in order to meet contractual payments prior to receipts being received from commissioners in May.

Concerns and Gaps
The level of payables is reflected in the Better Payment Practice Code (BPPC) performance for the year which is below the required 95% with 81% by volume of payments made within 30 days.

Actions Planned
The focus continues to be on maintaining payments to key suppliers, reducing the level of debts and ensuring cash financing is available.

<table>
<thead>
<tr>
<th>31 March 2018</th>
<th>Statement of Financial Position as at 30th April 2018</th>
<th>Plan £m</th>
<th>Actual £m</th>
<th>Variance above / (below) plan £m</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Non Current Assets</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Property, Plant and Equipment</td>
<td>516.7</td>
<td>516.9</td>
<td>0.2</td>
</tr>
<tr>
<td></td>
<td>Intangible Assets</td>
<td>17.0</td>
<td>17.0</td>
<td>0.0</td>
</tr>
<tr>
<td></td>
<td>Non-current receivables</td>
<td>14.0</td>
<td>14.0</td>
<td>0.0</td>
</tr>
<tr>
<td></td>
<td>Total non-current assets</td>
<td>547.8</td>
<td>547.9</td>
<td>0.2</td>
</tr>
<tr>
<td></td>
<td>Current Assets</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Inventories</td>
<td>11.2</td>
<td>11.2</td>
<td>(0.0)</td>
</tr>
<tr>
<td></td>
<td>Trade and other receivables NHS</td>
<td>27.3</td>
<td>30.3</td>
<td>3.0</td>
</tr>
<tr>
<td></td>
<td>Trade and other receivables Non-NHS</td>
<td>28.5</td>
<td>33.2</td>
<td>4.7</td>
</tr>
<tr>
<td></td>
<td>Cash and Cash equivalents</td>
<td>15.0</td>
<td>17.2</td>
<td>2.2</td>
</tr>
<tr>
<td></td>
<td>Total current assets</td>
<td>82.1</td>
<td>91.9</td>
<td>9.8</td>
</tr>
<tr>
<td></td>
<td>Non-current assets held for sale</td>
<td>0.0</td>
<td>0.0</td>
<td>0.0</td>
</tr>
<tr>
<td></td>
<td>Total assets</td>
<td>629.8</td>
<td>639.8</td>
<td>10.0</td>
</tr>
<tr>
<td></td>
<td>Current Liabilities (&lt; 1 Year)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Trade and Other payables - NHS</td>
<td>9.2</td>
<td>9.8</td>
<td>0.7</td>
</tr>
<tr>
<td></td>
<td>Trade and Other payables - Non-NHS</td>
<td>66.5</td>
<td>76.6</td>
<td>10.1</td>
</tr>
<tr>
<td></td>
<td>Borrowings</td>
<td>40.1</td>
<td>40.1</td>
<td>0.0</td>
</tr>
<tr>
<td></td>
<td>Total current liabilities</td>
<td>121.0</td>
<td>126.5</td>
<td>5.5</td>
</tr>
<tr>
<td></td>
<td>Net current assets/(liabilities)</td>
<td>(34.9)</td>
<td>(34.6)</td>
<td>0.3</td>
</tr>
<tr>
<td></td>
<td>Total assets less current liabilities</td>
<td>514.1</td>
<td>513.3</td>
<td>0.8</td>
</tr>
<tr>
<td></td>
<td>Trade payables and deferred income</td>
<td>9.2</td>
<td>8.6</td>
<td>(0.6)</td>
</tr>
<tr>
<td></td>
<td>Borrowings</td>
<td>534.1</td>
<td>534.0</td>
<td>(0.1)</td>
</tr>
<tr>
<td></td>
<td>Total Net Assets</td>
<td>(26.5)</td>
<td>(26.5)</td>
<td>(0.1)</td>
</tr>
<tr>
<td></td>
<td>Capital and Reserves</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Public Dividend Capital</td>
<td>242.5</td>
<td>242.5</td>
<td>0.0</td>
</tr>
<tr>
<td></td>
<td>Income and expenditure reserve</td>
<td>(358.5)</td>
<td>(358.5)</td>
<td>(0.0)</td>
</tr>
<tr>
<td></td>
<td>Income and expenditure account - current year</td>
<td>(16.8)</td>
<td>(16.8)</td>
<td>(0.1)</td>
</tr>
<tr>
<td></td>
<td>Revaluation reserve</td>
<td>106.3</td>
<td>106.3</td>
<td>0.0</td>
</tr>
<tr>
<td></td>
<td>Total Capital and Reserves</td>
<td>(26.5)</td>
<td>(26.5)</td>
<td>(0.1)</td>
</tr>
</tbody>
</table>
Rolling Cash Forecast, In-year Surplus/Deficit, Capital Programme Expenditure and Financial Risk Ratings

The overall financial position was £2.7m adverse, in line with plan.

Capital expenditure was £1.0m compared to a plan of £0.8m for the year.

Assurances and Actions Planned
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 and Gaps
The Trust is rated at 3 (a score of 1 is the best) in the finance and use of resources metric.

<table>
<thead>
<tr>
<th>Weighting</th>
<th>Metric</th>
<th>Year to date</th>
<th>Forecast</th>
</tr>
</thead>
<tbody>
<tr>
<td>0.2</td>
<td>Capital service cover rating</td>
<td>4</td>
<td>4</td>
</tr>
<tr>
<td>0.2</td>
<td>Liquidity rating</td>
<td>4</td>
<td>4</td>
</tr>
<tr>
<td>0.2</td>
<td>I&amp;E margin rating</td>
<td>4</td>
<td>4</td>
</tr>
<tr>
<td>0.2</td>
<td>I&amp;E margin: distance from financial plan</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>0.2</td>
<td>Agency rating</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td><strong>Overall finance risk rating</strong></td>
<td><strong>3</strong></td>
<td><strong>3</strong></td>
</tr>
</tbody>
</table>
Savings
Assurances
Identified CIP schemes total £25.8m at the end of April against the target of £37.7m.

Concerns and Gaps
The graph shows the phased forecast in-year delivery totaling £25.8m which is below the required level for the year by £11.9m. £14.1m is rated as green or amber.

Actions Planned
Continued monitoring of actions required to deliver required savings in 2018/19.
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 therefore, whilst indicative, the figures presented are not necessarily reflective of the Trust’s final position which is finalised 25 working days after the quarter.

We are scoring ourselves against the Single Operating Framework (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 statements - number 4 (going concern) and number 10 (ongoing plans to comply with targets) warrant continued Board consideration in light of the in year financial position (as detailed within the Finance commentary) and ongoing performance challenges as outlined within this IPR. The Trust is committed to tackling these challenges and recovery trajectories are scrutinised on an ongoing basis through the Monthly Integrated Delivery Meetings.

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

*C These services are no longer provided by NBT.

<table>
<thead>
<tr>
<th>Regulatory Area</th>
<th>May-17</th>
<th>Jun-17</th>
<th>Jul-17</th>
<th>Aug-17</th>
<th>Sep-17</th>
<th>Oct-17</th>
<th>Nov-17</th>
<th>Dec-17</th>
<th>Jan-18</th>
<th>Feb-18</th>
<th>Mar-18</th>
<th>Apr-18</th>
</tr>
</thead>
<tbody>
<tr>
<td>Finance Risk Rating (FRR)</td>
<td>Red</td>
<td>Red</td>
<td>Amber</td>
<td>Amber</td>
<td>Amber</td>
<td>Amber</td>
<td>Amber</td>
<td>Amber</td>
<td>Amber</td>
<td>Amber</td>
<td>Amber</td>
<td>Amber</td>
</tr>
<tr>
<td>Board non-compliant statements</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Prov. Licence non-compliant statements</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>CQC Inspections</td>
<td>RI</td>
<td>RI</td>
<td>RI</td>
<td>RI</td>
<td>RI</td>
<td>RI</td>
<td>RI</td>
<td>RI</td>
<td>RI</td>
<td>RI</td>
<td>RI</td>
<td>RI</td>
</tr>
</tbody>
</table>
## Monitor Provider Licence Compliance Statements at April 2018

**Self-assessed, for submission to NHSI**

<table>
<thead>
<tr>
<th>Ref</th>
<th>Criteria</th>
<th>Comp (Y/N)</th>
<th>Comments where non compliant or at risk of non-compliance</th>
</tr>
</thead>
<tbody>
<tr>
<td>G4</td>
<td>Fit and proper persons as Governors and Directors (also applicable to those performing equivalent or similar functions)</td>
<td>Yes</td>
<td>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.</td>
</tr>
<tr>
<td>G5</td>
<td>Having regard to monitor Guidance</td>
<td>Yes</td>
<td>The Trust Board has regard to Monitor guidance where this is applicable.</td>
</tr>
<tr>
<td>G7</td>
<td>Registration with the Care Quality Commission</td>
<td>Yes</td>
<td>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.</td>
</tr>
<tr>
<td>G8</td>
<td>Patient eligibility and selection criteria</td>
<td>Yes</td>
<td>Trust Board has considered the assurances in place and considers them sufficient.</td>
</tr>
<tr>
<td>P1</td>
<td>Recording of information</td>
<td>Yes</td>
<td>A range of measures and controls are in place to provide internal assurance on data quality. Further developments to pull this together into an overall assurance framework are planned through strengthened Information Governance Assurance Group.</td>
</tr>
<tr>
<td>P2</td>
<td>Provision of information</td>
<td>Yes</td>
<td>Information provision to Monitor not yet required as an aspirant Foundation Trust (FT). However, in preparation for this the Trust undertakes to comply with future Monitor requirements.</td>
</tr>
<tr>
<td>P3</td>
<td>Assurance report on submissions to Monitor</td>
<td>Yes</td>
<td>Assurance reports not as yet required by Monitor 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.</td>
</tr>
<tr>
<td>P4</td>
<td>Compliance with the National Tariff</td>
<td>Yes</td>
<td>NBT complies with national tariff prices. Scrutiny by CCGs, NHS England and NHS Improvement provides external assurance that tariff is being applied correctly.</td>
</tr>
<tr>
<td>P5</td>
<td>Constructive engagement concerning local tariff modifications</td>
<td>Yes</td>
<td>Trust Board has considered the assurances in place and considers them sufficient.</td>
</tr>
<tr>
<td>C1</td>
<td>The right of patients to make choices</td>
<td>Yes</td>
<td>Trust Board has considered the assurances in place and considers them sufficient.</td>
</tr>
<tr>
<td>C2</td>
<td>Competition oversight</td>
<td>Yes</td>
<td>Trust Board has considered the assurances in place and considers them sufficient.</td>
</tr>
<tr>
<td>IC1</td>
<td>Provision of integrated care</td>
<td>Yes</td>
<td>Range of engagement internally and externally. No indication of any actions being taken detrimental to care integration for the delivery of Licence objectives.</td>
</tr>
<tr>
<td>No.</td>
<td>Criteria</td>
<td>Comp (Y/N)</td>
<td>No.</td>
</tr>
<tr>
<td>-----</td>
<td>----------</td>
<td>------------</td>
<td>-----</td>
</tr>
<tr>
<td>1</td>
<td>The Board is satisfied that, to the best of its knowledge and using its own processes and having had regard to the TDA’s oversight model (supported by Care Quality Commission information, its own information on serious incidents, patterns of complaints, and including any further metrics it chooses to adopt), the Trust has, and will keep in place, effective arrangements for the purpose of monitoring and continually improving the quality of healthcare provided to its patients.</td>
<td>Yes</td>
<td>8</td>
</tr>
<tr>
<td>2</td>
<td>The board is satisfied that plans in place are sufficient to ensure ongoing compliance with the Care Quality Commission’s registration requirements.</td>
<td>Yes</td>
<td>9</td>
</tr>
<tr>
<td>3</td>
<td>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.</td>
<td>Yes</td>
<td>10</td>
</tr>
<tr>
<td>4</td>
<td>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.</td>
<td>Yes</td>
<td>11</td>
</tr>
<tr>
<td>5</td>
<td>The board will ensure that the Trust remains at all times compliant with regard to the NHS Constitution.</td>
<td>Yes</td>
<td>12</td>
</tr>
<tr>
<td>6</td>
<td>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.</td>
<td>Yes</td>
<td>13</td>
</tr>
<tr>
<td>7</td>
<td>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.</td>
<td>Yes</td>
<td>14</td>
</tr>
</tbody>
</table>

Comment where non-compliant or at risk of non-compliance
As the Trust has not yet achieved a sustainable position in relation to delivery of the 4 Hour AandE and RTT standards due to a reliance on external system changes/factors, the Trust is unable to confirm compliance with this statement

Timescale for compliance: N/A
<table>
<thead>
<tr>
<th>Report to:</th>
<th>Trust Board</th>
</tr>
</thead>
<tbody>
<tr>
<td>Agenda item:</td>
<td>9</td>
</tr>
<tr>
<td>Date of Meeting:</td>
<td>31 May 2018</td>
</tr>
<tr>
<td>Report Title:</td>
<td>CQC Action Plan &amp; In Year Engagement</td>
</tr>
<tr>
<td>Status:</td>
<td>Information</td>
</tr>
<tr>
<td></td>
<td>X</td>
</tr>
<tr>
<td>Prepared by:</td>
<td>Paul Cresswell, Associate Director of Quality Governance</td>
</tr>
<tr>
<td>Executive Sponsor (presenting):</td>
<td>Carole Tookey, Deputy Director of Nursing &amp; Quality</td>
</tr>
<tr>
<td>Appendices (list if applicable):</td>
<td>A – CQC Feedback letter (Women’s &amp; Children’s visit)</td>
</tr>
<tr>
<td></td>
<td>B – CQC Feedback Letter (Cossham visit)</td>
</tr>
<tr>
<td>Summary &amp; Recommendation:</td>
<td>The Trust Board is requested to:</td>
</tr>
<tr>
<td></td>
<td>1. <strong>Note</strong> the Action Plan progress to date and <strong>review</strong> the thematic summary of key actions that will have the biggest impact on overall delivery.</td>
</tr>
<tr>
<td></td>
<td>2. <strong>Note</strong> the positive feedback received from the first two thematic engagement visits from the CQC to Women’s &amp; Children’s division and Cossham location.</td>
</tr>
<tr>
<td></td>
<td>3. <strong>Note</strong> the updated in-year monitoring schedule, following review at Quality Committee on 1st May 2018.</td>
</tr>
</tbody>
</table>

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

1.1 A weekly review meeting is in place led by the Director of Nursing & Quality to track progress of actions immediately due and those approaching their due date and to assess ongoing confidence in delivery.

1.2 The CQC action plan references existing action plans in order to avoid duplication.

1.3 Actions are closed upon receipt of suitable supporting evidence and this is stored on a central database available at: [http://nbsvr16/qualitygovernance/CQCActionPlan/default.aspx](http://nbsvr16/qualitygovernance/CQCActionPlan/default.aspx). Any actions not closed by their due date are rated ‘red’ anywhere doubt exists of their deliverability by the agreed date are rated ‘amber’ and those on track are rated ‘green.’ Completed actions are rated ‘blue.’

1.4 The current position (for actions due at the end of April 2018, where evidence has been reviewed and is being validated):

<table>
<thead>
<tr>
<th>Theme / Service</th>
<th>Regulation</th>
<th>No. of Actions</th>
<th>Completed</th>
<th>On track</th>
<th>Risks overdue</th>
<th>Overdue / Concern</th>
</tr>
</thead>
<tbody>
<tr>
<td>Person-centred care</td>
<td>Regulation 9</td>
<td>6</td>
<td>6</td>
<td>6</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dignity and respect</td>
<td>Regulation 10</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Safe care and treatment</td>
<td>Regulation 12</td>
<td>5</td>
<td>5</td>
<td>5</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Safeguarding service users from abuse and improper treatment</td>
<td>Regulation 13</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Premises and equipment</td>
<td>Regulation 15</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Patient Records</td>
<td>Regulation 17</td>
<td>4</td>
<td>4</td>
<td>4</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Staffing</td>
<td>Regulation 18</td>
<td>2</td>
<td>1</td>
<td>1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Urgent &amp; Emergency Services</td>
<td>n/a</td>
<td>1</td>
<td></td>
<td>1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medical Care</td>
<td>n/a</td>
<td>13</td>
<td>4</td>
<td>9</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Surgery</td>
<td>n/a</td>
<td>16</td>
<td>2</td>
<td>14</td>
<td></td>
<td></td>
</tr>
<tr>
<td>End of Life Care</td>
<td>n/a</td>
<td>5</td>
<td>3</td>
<td>2</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Outpatients</td>
<td>n/a</td>
<td>7</td>
<td>1</td>
<td>6</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

| Total | 22 | 42 | 2 | 10 | 20 | 32 | 0 | 0 | 0 | 0 |
Overarching Themes

1.5 Within the CQC Action Plan there are 22 ‘Must Do’ actions (these are the formal requirement notices that represent a regulatory breach) and 42 ‘should do’ actions, which are advisory in nature. There are 6 key themes for action that collectively address the the Action Plan (36 actions). The primary actions that will drive the biggest impact (criteria: more than 2 actions affected, at least one being a ‘Must Do’ action) are as follows;

<table>
<thead>
<tr>
<th>Theme</th>
<th>Must Do Actions</th>
<th>Should Do Actions</th>
<th>Key Indicators to Track</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Improving Patient Flow &amp; reducing DTOCs and Ambulance handovers.</td>
<td>MD1, 2, 3, 4, 8</td>
<td>SD1</td>
<td>• Reduced Bed Occupancy – 95%</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• ED 4 Hr – 90% (both by 30/9/18)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• Reduce DTOC to 3.4% (31/8/18)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• Improved 15-minute Time to Triage</td>
</tr>
<tr>
<td>2. Reducing and improving safe use of escalation capacity, with suitable patients' privacy &amp; dignity.</td>
<td>MD6, 7, 9, 10, 11, 16</td>
<td>None</td>
<td>• Reduced Bed occupancy – 95%</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• Use of 1 &amp; 2 up on wards (no. of times)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• Appropriate Use of other escalation capacity</td>
</tr>
<tr>
<td>3. Basic safety checks – wards, other areas</td>
<td>MD12,13</td>
<td>SD3, 5, 7, 8, 10, 11, 23, 24, 25, 35</td>
<td>• Revamping matrons walkthroughs – new ward peer reviews &amp; real time feedback/action - Synbiotix</td>
</tr>
<tr>
<td>4. Statutory &amp; Mandatory training</td>
<td>MD22</td>
<td>SD2, 15, 31, 37</td>
<td>• Compliance &gt;85%</td>
</tr>
<tr>
<td>5. Improving understanding and application of MCA &amp; DoLS</td>
<td>MD 14, 15</td>
<td>SD16</td>
<td>• Staff trained</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• Staff competence assessments</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• Audit of documentation</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• MCA/DoLS incidents</td>
</tr>
<tr>
<td>6. Medical Records – Completion, secure storage</td>
<td>MD19, 20</td>
<td>SD6, 36</td>
<td>• Improved completion of Lorenzo Risk Assessments</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• Compliance with records SOP (Synbiotix audits)</td>
</tr>
</tbody>
</table>

2. Ongoing CQC Engagement Approach & Future Inspections

2.1 As previously advised, the CQC remit for all providers now includes a more frequent ongoing engagement approach. This encompasses more frequent formal interactions at the corporate level and direct engagement with clinical service line leads outside of formal inspections and includes conducting staff focus groups.

2.2 The first two such visits have been undertaken with service leads, as planned. These went well and the feedback letters were positive, as shown at Appendices A & B. The overall draft plan for engagement visits is as follows following review at Quality Committee on 1st May;
### Date | Service | Status | Notes
--- | --- | --- | ---
11/4/18 | Women's & Children's, inc. Gynaecology | Completed | Feedback letter received (*Appendix B*)
25/4/18 | Cossham (all services) | Completed | Feedback letter received (*Appendix C*)
July 2018 | Urgent & Emergency Care & Medical Care | To confirm details with CQC | Very sizeable visit – realistic in single day?
Nov. 2018 | Surgery & End of Life Care | To confirm details with CQC | Very sizeable visit – realistic in single day?
Mar. 2019 | Critical Care & Outpatients | To confirm details with CQC | Switch with Surgery as CC not recently inspected?

2.3 The Associate Director of Quality Governance is liaising with the CQC and frontline teams to agree the approach and to support the logistics and information required for each visit.

2.4 In addition to the service line visits, at a corporate level the CQC will interact through:
- Ad-hoc concerns/requests
- Monthly calls – CQC Lead (ADQG)
- Quarterly Meetings – MD, DoN, ADQG
- Twice Yearly Board observations

2.5 Formal inspections will be undertaken as follows:
- Annual – Well Led & Use of Resources (planned)
- Annual – Service Lines (unannounced)
- Ad-Hoc – specific concerns, or thematic

The CQC inspection regime has two other ‘corporate’ focused domains – ‘Well Led’ (as previously) and now ‘Use of Resources’ (new for 2018). The Trust’s approach to these is as follows:

2.6 **Well Led Domain – CQC Meeting**
A review of the Well Led domain is being undertaken by the Interim Trust Secretary and will inform a meeting arranged with Mary Cridge, Head of Hospital inspection, CQC and the Trust’s local inspector, Marie Cox on 11<sup>th</sup> June 2018. This will be attended by the CEO, Medical Director, Director of Nursing & Quality, Trust Secretary and AD Quality Governance. The aim is to clarify the conclusions reached in some areas of the 2017 inspection, ensure clear actions for improvement have been identified and to support good preparation for the next inspection.
2.7 *NEW* Use of Resources Domain – Post Consultation

A new Use of Resources (UoR) domain has been added to every Trust’s inspection framework following the conclusion of a national consultation early 2018. The UoR rating will be determined by NHS Improvement and ‘signed off’ for inclusion as part of our CQC rating. *It ranks equally alongside the existing 5 domains.*

The ‘Trigger’ for timing of the review will be the Provider Information request (PIR) instigated by the CQC as part of the overall inspection preparation. In 2017 this was received in August for the November inspection. It also states that NHSI will get in touch with the trust’s CEO too, with the UoR assessment usually completed BEFORE the Well Led review – giving at least one month’s notice of an upcoming assessment.

There are 5 key areas of review, each of which has a number of subsidiary Key Lines of Enquiry (KLOE) in a similar format to the other 5 domains. The areas are:

- Clinical Services
- People
- Clinical support services
- Corporate services, procurement, estates and facilities
- Finance

One of the key components is the Getting It Right First Time (GIRFT) programme and links to the Model Hospital work, for which a recent visit by the NHSI team to NBT on 18 May was relevant. The approach to reviewing this new framework and ensuring the Trust is fully prepared for the evaluation, is under discussion by the Executive Team.

3. Recommendation

3.1 The Trust Board is requested to;

1. **Note** the Action Plan progress made to date and **review** the thematic summary of key actions that will have the biggest impact on overall delivery.
2. **Note** the positive feedback received from the first two thematic engagement visits form the CQC to Women’s & Children’s division and Cossham location.
3. **Note** the updated in-year monitoring schedule, following review at Quality Committee on 1st May 2018.
19 April 2018

Follow up letter – CQC monitor visit of women’s and children’s health division

Reference number: ENQ1-5117399441

Dear Mrs Young,

We write to you to provide a summary of the CQC monitor visit to the women’s and children’s health division on 11 April 2018. During this visit we spoke with staff and had a tour of the children’s and young people’s, the maternity, and the gynecology core services provided at Southmead Hospital.

We would like to thank you for the time and effort your staff put in to facilitate the visit. Everyone we spoke with was kind, friendly and proud of their service.

We spoke with the senior triumvirate within the women’s and children’s health division who described the structure of the service line and how it fit in the wider hospital structure. They discussed how the service was to develop in the future and how it was to align with the wider healthcare economy. They also discussed the challenges to meeting the ever evolving best practice guidelines and standards and gave examples of how they worked with HR and finance to manage risks.

We had a tour of Cotswold ward, outpatients, maternity and the neonatal units. During these walk arounds we discussed how medical outliers tested staff but found they felt supported to manage these patients safely. In the maternity unit we discussed the good work that the milk bank is doing to support premature babies and how the induction suite was having a positive impact on patient experience. In the neonatal unit we discussed the experiences of parents and how they engage with the unit to improve the service. We also discussed the impact that the new accommodation was having on parents to allow them to stay near their babies.

Several positive themes throughout the day included how proud the staff were of the outcomes they were achieving, particularly in the maternity and neonatal services. Also the high level of support provided to patients and their babies. However, staff described the limitations of the building they were in was going to have an impact on services as they develop and grow.
We held a drop in focus group to give all staff within the women’s and children’s health division the opportunity to share with CQC their work. During this we spoke with nine staff which included the bereavement midwife who shared the positive work she was doing to support bereaved families and the risk midwife who described various ongoing quality improvement projects. We spoke with the infant feeding midwife who described the positive work being done to ensure baby friendly accreditation. We also spoke with a training midwife who described the national and international work done around PROMPT and how they were working with the Healthcare Safety Investigations Branch to develop the standards being assessed nationally.

It was good to have several people from Cotswold Ward in the focus group who were interested in CQC, our new inspection regime and were keen to engage with us. This is a positive mindset to have for any future inspections and something we would encourage.

We would like to thank you and your team again for facilitating the visit. We are looking forward to the next visit to Cossham Hospital.

This visit does not replace any published reports nor does it replace any ongoing regulatory action against the trust. This visit was for our information to enable CQC to monitor services.

Yours sincerely

Carl Crouch
Hospitals Inspector
Follow up letter – CQC monitor visit of Cossham Hospital

Reference number: ENQ1-5153923291

Dear Mrs Young,

We write to you to provide a summary of the CQC monitor visit to Cossham Hospital on 25 April 2018. During this visit we spoke with staff and patients and had a tour of the dialysis, maternity, diagnostic imaging, and outpatient services provided at Cossham Hospital.

We would like to thank you for the time and effort your staff put in to facilitate the visit. Everyone we spoke with clearly loved their jobs and were passionate to share this with us.

We spoke with the senior leaders within the various service lines operating from Cossham Hospital during the visit.

We had a tour of the dialysis unit. During this walk around we discussed how dialysis units worked and how they linked in with GP’s and community services to ensure a smooth running patient pathway. We discussed how outcomes were collected and benchmarked against other providers. We discussed how patients had their confidence and knowledge built up to have shared care and eventually self-care for their dialysis. We were lucky enough to speak with two patients going using this service who were both complimentary of the help received and proud they were able to take control of their own care.

We discussed the new Bath unit and share the excitement of the senior team in what the new state of the art department could achieve for patients in the area.

We had a tour of the midwife led birthing center. Senior leaders discussed how the community services had integrated into one service as part of the better births developments. We were also told about the challenges the unit had faced as a result of this close working and were told that confidence amongst staff was being rebuilt and had resulted in a stronger service. We also discussed how outcomes were recorded and demonstrated to expectant mothers to ensure informed decision making when
deciding where to give birth. We discussed plans within the unit to advertise the service more and to show the expectant mothers of Bristol what could be offered on the site.

We had a brief tour of the outpatient’s service who discussed the impact not having a staff room had on the staff’s ability to ‘recharge their batteries’. We were also shown examples of compliments received by the service. Managers discussed the improvements being made at Southmead Hospital regarding outpatients and some of the challenges they have faced since the inspection in November 2017.

We had a tour of the diagnostic imaging service. Senior leaders discussed the challenges of having a ‘walk in service’ for plain X-ray and how increasing demand was putting pressure on staff both at Cossham Hospital and at Southmead Hospital. We discussed how occasionally inappropriate referrals came to the service at Cossham Hospital and the disruption some of these referrals can have.

During the focus group we spoke with five radiographers and an imaging support worker. However, it was disappointing not to get the opportunity to speak with staff from other services at Cossham Hospital during the drop in focus group.

The people we spoke with were all passionate about the community ‘feel’ of the hospital. One radiographer said “we fight to come and work up here” as the constant pressures of a large acute service were not felt at Cossham. We were also told of examples where patients had been put at ease during intimate procedures as a result of the additional time available to staff to talk to the patients and the calming environment the hospital encourages.

We would like to thank you and your team again for facilitating the visit.

**This visit does not replace any published reports nor does it replace any ongoing regulatory action against the trust. This visit was for our information to enable CQC to monitor services.**

Yours sincerely

**Carl Crouch**

**Hospitals Inspector**
Research at NBT; year 1 of the 5 year strategy

Becca Smith, Deputy Director of Research
David Wynick, Director of Research
Delivering the year 1 priorities

• **Broaden** our research portfolio
  – We opened 119 new research studies
  – 4810 new patients participated in research, 1.7% increase

• **Develop** a five year strategy implementation plan

• **Invest** in our workforce and facilities
  – opened a new state of the art research pharmacy facility
  – Provided £164,320 to provide dedicated research time for our staff to develop research ideas

• **Increase** patient satisfaction
  – Held 36 sessions for patients to help design and prioritise research studies
  – Our Friends and family test shows that 93% of people are extremely likely to recommend our service

• **Make** research more visible and accessible
  – We introduced research in all patient leaflets
  – We launched our strategy
  – We have introduced videos to our website highlighting research
<table>
<thead>
<tr>
<th>Patients as partners in research</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Patients worked with our researchers to make sure that quality of life is a main focus of a study looking at end of life care for patients with kidney disease</td>
</tr>
<tr>
<td>• Patients are helping to produce a plan to make sure the results of a trial looking at physiotherapy after knee replacement reach all stakeholders</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Support and nurture a sustainable, skilled workforce</th>
</tr>
</thead>
<tbody>
<tr>
<td>• We funded 4 nurses to develop their own research ideas</td>
</tr>
<tr>
<td>• Developed a Nurse Researcher career pathway</td>
</tr>
<tr>
<td>• Upskilled our administrators to work with patients on research studies</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Research will be visible in the day to day business of the Trust</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Pop up research banners have been trialed in out-patients</td>
</tr>
<tr>
<td>• Research is being supported by all NBT divisions</td>
</tr>
<tr>
<td>• Research is featured on check in screens and TV screens across Brunel</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Work with our regional partners</th>
</tr>
</thead>
<tbody>
<tr>
<td>• The Bristol Biomedical Research Centre was launched</td>
</tr>
<tr>
<td>• Developed a regional portfolio in reproductive health and child birth</td>
</tr>
</tbody>
</table>
Year 2 priorities

• Increase research information in patient areas
• Develop training and support for the patients that work with us as research partners
• Share more patient experiences of research participation on our website
• Identify and increase engagement with departments at NBT that are not research active
• Increase the number of research studies designed and led by Nurses, midwives and Allied Health professionals (AHPs)
Increasing research led by our nurses, midwives and AHPs

- Increased awareness of opportunities to lead rather than just helping to deliver research studies
- Providing dedicated funding to protect their research time
- Providing support –
  - Involving patients in design
  - Research design and statistics
  - Training opportunities
  - Links with academic partners
Case History: Improving patient care

- Prestigious Florence Nightingale scholarship to undertake a PhD
- Multiple Sclerosis Society Fellowship
- Helped develop a new career structure for nurses leading research at NBT
- Improving the care of individuals with incontinence
  - Questionnaire that is used globally to help provide more effective continence care and support for patients
  - Improving symptom management and evidence implementation

“Feeling that continence care is being prioritised has been a breath of fresh air”

“Opportunities for patients to be involved in designing research with me ensures that I focus on what matters to patients most”

MS Patient

Nikki Cotterill
Report to: Trust Board
Agenda item: 11.

Date of Meeting: 31 May 2018

Report Title: Capital Planning Update

Status:

<table>
<thead>
<tr>
<th>Information</th>
<th>Discussion</th>
<th>Assurance</th>
<th>Approval</th>
</tr>
</thead>
<tbody>
<tr>
<td>X</td>
<td></td>
<td></td>
<td>X</td>
</tr>
</tbody>
</table>

Prepared by: Karen Shrimpton, Estate Development Manager

Executive Sponsor (presenting): Simon Wood, Director of Facilities

Appendices (list if applicable): Capital Planning Report

Recommendation:
The Trust Board is asked to note the position on each principal issue and the actions being taken to address them

Executive Summary:
See following report.
1. Purpose & background

1.1 The attached report updates on progress and issues in relation to matters being managed by the Sustainable Health & Capital Planning Team.

2. Operational PFI

2.1 Bouygues have now signed as the Agent of Operation and are working closely with the Trust and THC to start to involve themselves in all ongoing issues across the PFI. Brunel Compliance Issues are reviewed and managed at regular meetings with NBT, Bouygues / Carillion services and THC.

3. PFI Construction Works

3.1 Following the Carillion liquidation all schemes (demolition and Phase 2 completion works) are on hold pending the outcome of discussions with THC to establish a programme of works going forward.

3.2 Negotiations are progressing to finalise the legal and contractual documentation requirements to allow this programme of work to move forward.

3.3 Once negotiations are complete an updated programme will be circulated confirming current expected timescales for delivery.

4. Capital Projects

4.1 The new CRISP (critical retained infrastructure scheme plan) totalling £1.7M was approved by CPG and is progressing. Feasibility works have begun on a number of schemes due to be completed this financial year and work is beginning with Divisions to ensure client needs and requirements are being supported and managed within the individual schemes.

4.2 Other capital projects are progressing as planned although there has been a halt on progress on the Renal re-development scheme pending further discussions of the potential final location. This is being fully investigated with the Divisional management team.

4.3 Replacement capital medical equipment procurement for 18/19 has begun and is on programme. Orders have already begun to be placed and a project plan showing planned order / delivery dates for all items has been circulated to the Divisional teams.

5. PFI – Variations

5.1 Approved variations are progressing with support from THC and Gleeds. Bouygues have been supporting and are expected to take a more prominent role now that they are confirmed as the Agent of operation.

5.2 Work programmes, costs and timescales are being reviewed and will be reported when received.

6. Recommendations

6.1 The Trust Board is asked to note the current position and actions.
Capital projects 18/19

Capital replacement infrastructure works: £1.7M programme of works for 18/19 approved by CPG. Feasibility studies have begun on planned schemes and detailed specifications are being pulled together in liaison with Divisional teams.

Additional CT and MRI reprovision at Cossham: Tender pack is being compiled ready for issue in June for project team to progress this works package.

Renal refurbishment at RUH: Project on hold pending review of proposed location. Negotiations being led by the Divisional management team.

Monks park house: Somerset house (Nursery) works due to complete in June.
Westgate house feasibility in progress with tender documentation being drawn together. Discussions with potential Lessor's are ongoing to establish building requirements.

Space utilisation: Feasibility studies being undertaken on a number of corporate space utilisation proposals. An option appraisal is being drafted for Exec team to review.

Variation - Brunel Gate 24: Trust Board approved the business case in January. Works due to complete in Quarter 4 (18/19). With Bouygues now appointed as Agent of Operation the impact of the Carillion delay is being reviewed and will be reported back when the revised programmes are issued.

Variation - Plastics wet room and assisted bathroom conversions: Programme of works is due to complete with beds being available in Quarter 3 (18/19). With Bouygues now appointed as Agent of Operation the impact of the Carillion delay is being reviewed and will be reported back when the revised programmes are issued.

Variation - Road safety: Scope of works agreed. Programme of works due to complete in Quarter 2 (18/19).

Variation - Mortuary cold storage: Purchase of new storage units due for delivery in Quarter 1 (18/19).

PFI Construction Works Progress

Carillion Liquidation: Projects on hold pending an agreed way forward with THC/NBT. Negotiations are progressing to finalise the legal and contractual documentation required to allow these works to resume.

Limewalk, Sherston & Brecon buildings: Project on hold pending final legal and contractual documentation completing. All buildings were handed over in August for demolition. Additional asbestos has had an impact on the programme.

Southmead Way - Phase 3 completion works: Project on hold. Completion of this road is part of the negotiations with THC and is part of the ongoing legal and contractual discussions.

Capital Planning Report 25 May 2018

Brunel Compliance Issues

<table>
<thead>
<tr>
<th>Issue</th>
<th>Action Required</th>
</tr>
</thead>
<tbody>
<tr>
<td>Carillion liquidation event</td>
<td>Bouygues have been appointed Agent of Operation. Work is ongoing to manage the transition to the new service provider. All hospital operational services continue to operate as normal.</td>
</tr>
<tr>
<td>Fire Integrity</td>
<td>NBT has received the Exova Report and meeting held with all Parties. THC are developing a close out strategy and action plan.</td>
</tr>
<tr>
<td>Critical Care &amp; Theatre Ventilation</td>
<td>THC are developing a close out strategy and action plan. Risks are managed and updated on the risk register.</td>
</tr>
<tr>
<td>SP21 Works arising from Statutory Inspections</td>
<td>Integration will follow transition to Bouygues as the service provider.</td>
</tr>
<tr>
<td>ICU burns</td>
<td>THC are developing a close out strategy and action plan.</td>
</tr>
<tr>
<td>Window and Atrium Cleaning</td>
<td>Works will follow integration to Bouygues.</td>
</tr>
<tr>
<td>Humidification of Imaging areas</td>
<td>THC are developing a close out strategy and action plan.</td>
</tr>
</tbody>
</table>
**Report to:** Trust Board  
**Agenda item:** 12  
**Date of Meeting:** 31 May 2018

<table>
<thead>
<tr>
<th>Report Title:</th>
<th>Directors’ Register of Interest Update</th>
</tr>
</thead>
<tbody>
<tr>
<td>Status:</td>
<td>Information</td>
</tr>
<tr>
<td></td>
<td>x</td>
</tr>
<tr>
<td>Prepared by:</td>
<td>Linda Storey, Interim Trust Secretary</td>
</tr>
<tr>
<td>Executive Sponsor (presenting):</td>
<td>Linda Storey, Interim Trust Secretary</td>
</tr>
<tr>
<td>Appendices (list if applicable):</td>
<td>None</td>
</tr>
</tbody>
</table>

**Recommendation:**
The Trust Board is asked to note the report

**Executive Summary:**
Under the Standards of Business Conduct for NHS Staff, the Codes of Conduct and Accountability, the Professional Standards of Board Members and to help comply with the Bribery Act 2011 all voting members of the Trust Board must declare any relevant and material interests and those declarations must be recorded in the Public Minutes.

The register is updated as Directors’ interests change and are reported. This report represents changes notified to the Trust Secretary since the last report to the Trust Board in April 2018. The Changes are highlighted in the table below which links to the Trust's Annual Report for 2017/2018.
In summary the changes are:

- Mr Frank Collins, Chair: ceased role as Chair of JRI Orthopaedics Ltd from 1 May 2018.
- Dr Elizabeth Redfearn, Non-executive Director: new interest declared: Trustee of Children’s Hospice South West
- Professor John Iredale, Non-Executive Director: new interest declared: Chair of the governing board, CRUK Beatson Institute.
- Ms Jaki Davis, Non-Executive Director: new interest declared: Trustees of the Friends of the Wilson Museum and Art Gallery in Cheltenham.
- Mr John Everitt, Non-executive Director: new interest declared: daughter is a member of staff at North Bristol NHS Trust.
### NORTH BRISTOL TRUST
DIRECTORS’ DECLARATIONS OF INTEREST 2017/2018

<table>
<thead>
<tr>
<th>BOARD MEMBER</th>
<th>INTEREST DECLARED</th>
</tr>
</thead>
</table>
| 1. Mr Peter Rilett  
Chairman  
(untill 1 November 2017) | 1. Non-Executive Director of:  
Watts of Lydney Ltd  
Bordeaux Quay Ltd  
Cotswold Homes Ltd  
Business West Ltd  
2. Trustee of:  
St. Monica’s Trust  
3. Board Advisor to:  
Centaur Services Ltd  
4. Chairman of Governors of City of Bristol College  
5. Wife is Chairman of Board of University of West of England |
<table>
<thead>
<tr>
<th>No.</th>
<th>Name</th>
<th>Roles and Positions</th>
</tr>
</thead>
<tbody>
<tr>
<td>2.</td>
<td>Mr Frank Collins</td>
<td>Chairman of: Frontier Medical Ltd, JRI Orthopaedics Ltd (ceased role of Chair from 1 May 2018), Bracebridge Corporate Finance Ltd, Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Foundation Trust</td>
</tr>
<tr>
<td></td>
<td>Interim Chairman</td>
<td>Advisor to Life Sciences Board: Mercia Technologies Ltd</td>
</tr>
<tr>
<td></td>
<td>(from 2 November 2017)</td>
<td>Hon. Treasurer/Trustee: Friends of Idlicote Church</td>
</tr>
<tr>
<td>3.</td>
<td>Mr Robert Mould</td>
<td>Member of: Bristol Mediation</td>
</tr>
<tr>
<td></td>
<td>Non-Executive</td>
<td></td>
</tr>
<tr>
<td>4.</td>
<td>Dr Elizabeth Redfern</td>
<td>Director/Owner of: Liz Redfern Partnership</td>
</tr>
<tr>
<td></td>
<td>Non-Executive Director</td>
<td>Trustee of Children’s Hospice South West</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5.</td>
<td>Mr Andrew Willis</td>
<td>Associate of: King’s Fund, Hay Group</td>
</tr>
<tr>
<td></td>
<td>Non-Executive Director</td>
<td>Non-Executive Director of: Royal Devon and Exeter NHS Foundation Trust</td>
</tr>
<tr>
<td></td>
<td>(until 30 April 2017)</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>---</td>
<td>---</td>
<td></td>
</tr>
<tr>
<td>3.</td>
<td>Chairman of: United Communities Housing Association</td>
<td></td>
</tr>
<tr>
<td>4.</td>
<td>Trustee of: EDP Drug and Alcohol Services</td>
<td></td>
</tr>
</tbody>
</table>
| 6. **Professor John Iredale**  
Non-Executive Director | 1. Pro-Vice Chancellor of: University of Bristol |
|   | 2. Advisor to: Novartis on liver disease |
|   | 3. Member of: Medical Research Council |
|   | 4. Trustee of: British Heart Foundation  
Children’s Liver Disease Foundation  
Foundation for Liver Research |
|   | 5. **Chair of the governing board, CRUK Beatson Institute** |
| 7. **Ms Jaki Davis**  
Non-Executive Director | 1. Trustee of: National Council for Palliative Care (until 31 March 2018)  
The Cheltenham Trust |
<p>|   | 2. <strong>Trustees of the Friends of the Wilson Museum and</strong> |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
</table>
| **8. Mr John Everitt**<br>Non-Executive Director | **Art Gallery in Cheltenham** | 1. Chairman of Newton St Loe Parish Council  
2. Member of Bath Abbey Appeal Committee (to end May 2018)  
3. Wife is a Member of Above and Beyond Charity  
4. Daughter works for North Bristol NHS Trust. |
| **9. Mr Tim Gregory**<br>(from 1 July 2017) | None |   |
| **10. Ms Andrea Young**<br>Chief Executive | None |   |
| **11. Mrs Catherine Phillips**<br>Director of Finance | None |   |
| **12. Mrs Sue Jones**<br>Director of Nursing and Quality | None |   |
| **13. Dr Chris Burton**<br>Medical Director | None |   |

*This document could be made public under the Freedom of Information Act 2000.*

Any person identifiable, corporate sensitive information will be exempt and must be discussed under a 'closed section' of any meeting.
<table>
<thead>
<tr>
<th>14. Ms Kate Hannam</th>
<th>None</th>
</tr>
</thead>
<tbody>
<tr>
<td>Director of Partnerships</td>
<td></td>
</tr>
</tbody>
</table>
Report to: Trust Board
Agenda item: 13.

Date of Meeting: 31 May 2018

<table>
<thead>
<tr>
<th>Report Title:</th>
<th>Provider Licence - Self-Certifications</th>
</tr>
</thead>
<tbody>
<tr>
<td>Status:</td>
<td>Information</td>
</tr>
<tr>
<td>Prepared by:</td>
<td>Linda Storey, Interim Trust Secretary</td>
</tr>
<tr>
<td>Executive Sponsor (presenting):</td>
<td>Linda Storey, Interim Trust Secretary</td>
</tr>
<tr>
<td>Appendices (list if applicable):</td>
<td>Appendix 1 - NHS Provider Licence – Self-Certifications – Evidence and Responses</td>
</tr>
</tbody>
</table>

Recommendation:

The Trust Board is asked to consider the evidence aligned to each element of the provider licence conditions, which the Board is required to self-certify against, and confirm its response.
1. **Purpose**

1.1. To provide evidence of compliance against the Provider Licence to support a decision by the Board.

2. **Background**

2.1. NHS Trusts are required to self-certify that they can meet the obligations set out in the NHS Provider Licence. Although NHS trusts are exempt from needing the provider licence, directions from the Secretary of State require NHS Improvement to ensure that NHS trusts comply with conditions equivalent to the licence as it deems appropriate.

2.2. The Single Oversight Framework (SOF) bases its oversight on the NHS Provider Licence. NHS Trusts are therefore legally subject to the equivalent of certain provider conditions (including Conditions G6 and FT4) and must self-certify under these licence provisions.

2.3. NHS trusts are therefore required to self-certify that they can meet the obligations set out in the NHS Provider Licence (which itself includes requirements to comply with the National Health Service Act 2006, the Health and Social Care Act 2008, the Health Act 2009 and the Health and Social Care Act 2012, and to have regard to the NHS Constitution) and that they have complied with governance requirements. The self-certification requirement set out in CoS7(3) does not apply to NHS trusts.

3. **Self-Certification Requirements**

3.1. Providers need to self-certify the following after the financial year-end:

<table>
<thead>
<tr>
<th>NHS provider licence condition</th>
</tr>
</thead>
<tbody>
<tr>
<td>The provider has taken all precautions necessary to comply with the licence, NHS Acts and NHS Constitution (Condition G6(3))</td>
</tr>
<tr>
<td>The provider has complied with required governance arrangements (Condition FT4(8))</td>
</tr>
</tbody>
</table>

3.2. It is up to providers how they undertake the self-certification however a number of templates have been provided which the Trust has used as the basis of the document in Appendix 1.

3.3. Trusts are required to state either “confirmed” or “not-confirmed” against each element of the licence condition, and if the Trust chooses "not-confirmed" must provide an explanation why.

3.4. Boards must sign off on self-certification no later than:

- G6: 31 May 2018
- FT4: 30 June 2018

3.5. Providers must publish their G6 self-certification within one month following the deadline for sign-off (as set out in Condition G6(4)).

3.6. From July 2018 NHS Improvement will contact a select number of trusts to ask for evidence that they have self-certified. This can be through providing the completed templates or relevant board minutes and papers recording sign-off.

4. **Proposed Outcome**

4.1. The Trust Secretary has reviewed the statements and evidence sets and is proposing that the Trust Board
responds with "confirmed" for all elements. The evidence to support the response is outlined in Appendix 1.

4.2. The evidence to support compliance with general condition 6 has also been discussed with the Trust's internal auditors, KPMG, who have confirmed that their Head of Internal Audit Opinion is a key piece of evidence for this statement. The opinion for 2017/18 was “Significant assurance with minor improvements can be given on the overall adequacy and effectiveness of the organisation’s framework of governance, risk management and control.”

4.3. For FT4, the Board is required to self-certify against six statements and to consider any risks and mitigating actions for each element of the provider licence condition.

4.4. The FT4 evidence relates to the structures, checks and balances that the Trust has put in place in relation to corporate governance including but not limited to the information contained with the Annual Governance Statement, Trust Standing Orders, Standing Financial Instructions and Scheme of Delegation.

5. Recommendations

5.1. The Trust Board is asked to consider the evidence aligned to each element of the provider licence conditions, which the Board is required to self-certify against, and confirm its response.
<table>
<thead>
<tr>
<th>FT4 - Corporate Governance Statement</th>
<th>Response</th>
<th>Evidence</th>
<th>Risks</th>
<th>Mitigating Actions</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 The Board is satisfied that the Licensee applies those principles, systems and standards of good corporate governance which reasonably would be regarded as appropriate for a supplier of health care services to the NHS.</td>
<td>Confirmed</td>
<td>Annual Governance Statement  Well-filled Framework self-assessment  Head of Internal Audit Opinion 2017/2018  Board Assurance Framework  Board annual effectiveness evaluation  Standing Orders, Standing Financial Instructions &amp; Scheme of Delegation  Board Committee Terms of Reference in place.</td>
<td>The size and complexity of the organisation means there is a risk that good governance is not fully embedded in all areas.</td>
<td>The Trust utilises its management and committee structures to ensure that good governance is embedded. This is complemented by the risk, performance and planning frameworks. Guidance and advice is provided by the Trust Secretary.</td>
</tr>
<tr>
<td>2 The Board has regard to such guidance on good corporate governance as may be issued by NHS Improvement from time to time</td>
<td>Confirmed</td>
<td>As above plus:  Alignment of performance reports to the Single Operating Framework  NHSI Information shared in Chief Executive’s Report to Trust Board.  External Audit sector guidance reports to Audit Committee.  Strategic Annual Internal Audit Plan</td>
<td>Failure to ensure that the Board is not updated on current guidance on good corporate governance, caused by capacity and capability gaps may result in out of date principles, systems and standards being applied and non-compliance with current best practice.</td>
<td>The Trust Secretary and Executive Directors receive regular updates on corporate governance guidance from NHS Improvement and other sources (NHS Providers, internal and external audit, NHS Improvement and the Care Quality Commission) and ensure that the board is kept abreast of good practice guidance and complies with it as necessary. Internal and external audit consider application of good governance during their audit programmes.</td>
</tr>
<tr>
<td>3 The Board is satisfied that the Licensee has established and implements:  (a) Effective board and committee structures;  (b) Clear responsibilities for its Board, for committees reporting to the Board and for staff reporting to the Board and those committees; and  (c) Clear reporting lines and accountabilities throughout its organisation.</td>
<td>Confirmed</td>
<td>Committee annual effectiveness reviews  Each Sub Committee regularly reviews its terms of reference, membership &amp; work programme each year.  Standing Orders, Scheme of Reservation and Delegation and Standing Financial Instructions - reviewed annually  Committee Terms of Reference  Executive portfolios clearly articulated  Governance Structure and Reporting Lines  Head of Internal Audit Opinion  Annual Governance Statement  Board reports on the BAF  Risk Management reports to Quality &amp; Risk Management Committee  Divisional and Corporate Structure Charts. Service Line Management</td>
<td>If we don’t have effective accountability and escalation arrangements, the executive team and the board may be unaware of important risk issues, significant control weaknesses and patient safety concerns in the rest of the organisation. This may lead to failure to act to protect against patient safety and potential regulatory intervention.</td>
<td>The systems and processes are regularly tested through the internal and external audit programmes as well as through deep dive reviews by the Assurance Committees.</td>
</tr>
<tr>
<td>FT4 - Corporate Governance Statement</td>
<td>Response</td>
<td>Evidence</td>
<td>Risks</td>
<td>Mitigating Actions</td>
</tr>
<tr>
<td>-------------------------------------</td>
<td>----------</td>
<td>----------</td>
<td>-------</td>
<td>--------------------</td>
</tr>
<tr>
<td>4 The Board is satisfied that the Licensee has established and effectively implements systems and/or processes: (a) To ensure compliance with the Licensee’s duty to operate efficiently, economically and effectively; (b) For timely and effective scrutiny and oversight by the Board of the Licensee’s operations; (c) To ensure compliance with health care standards binding on the Licensee including but not restricted to standards specified by the Secretary of State, the Care Quality Commission, the NHS Commissioning Board and statutory regulators of health care professions; (d) For effective financial decision-making, management and control (including but not restricted to appropriate systems and/or processes to ensure the Licensee’s ability to continue as a going concern); (e) To obtain and disseminate accurate, comprehensive, timely and up to date information for Board and Committee decision-making; (f) To identify and manage (including but not restricted to manage through forward plans) material risks to compliance with the Conditions of its Licence; (g) To generate and monitor delivery of business plans (including any changes to such plans) and to receive internal and where appropriate external assurance on such plans and their delivery; and (h) To ensure compliance with all applicable legal requirements.</td>
<td>Confirmed</td>
<td>Head of Internal Audit Opinion CIP programme Budget setting Financial reporting Benchmarking against peers Monthly Integrated Performance Report Committee Deep Dives Quality &amp; Risk Management Committee oversight of quality and CQC regulatory compliance including CQC Action Plan. External Audit of the Trust Annual Accounts Risk Management Strategy Risk Register - Operational Risks Board Assurance Framework - Strategic Risks - internal and external focus Business Plan, metrics linked to the IPR PMO function Operational Plan. Auditor’s report on the 2017/2018 financial accounts. Board and Committee Calendar of Meetings &amp; associated governance framework to support the Board and Committee business. Clinical Governance structures. Establishment of the Perform Programme to effect change.</td>
<td>The Trust’s internal control systems are not sufficiently robust to ensure compliance.</td>
<td>The systems, structures and processes are standard for financial and budgetary control and performance management and the internal audits of the financial systems provide assurance over the Trust’s recording and reporting of its financial position. There is a CIP Programme and PMO in place. The systems and processes are regularly tested through internal and external audit programmes as well as through deep dive reviews by the Assurance Committees.</td>
</tr>
<tr>
<td>5 The Board is satisfied that the systems and/or processes referred to in paragraph 4 (above) should include but not be restricted to systems and/or processes to ensure: (a) That there is sufficient capability at Board level to provide effective organisational leadership on the quality of care provided; (b) That the Board’s planning and decision-making processes take timely and appropriate account of quality of care considerations; (c) The collection of accurate, comprehensive, timely and up to date information on quality of care; (d) That the Board receives and takes into account accurate, comprehensive, timely and up to date information on quality of care; (e) That the Licensee, including its Board, actively engages on quality of care with patients, staff and other relevant stakeholders and takes into account as appropriate views and information from these sources; and (f) That there is clear accountability for quality of care throughout the Licensee including but not restricted to systems and/or processes for escalating and resolving quality issues including escalating them to the Board where appropriate.</td>
<td>Confirmed</td>
<td>Board Skills and Knowledge Review Board Development Programme Non-Executive Director and Executive Challenge of proposals Integrated Performance Report Active engagement with local Health Scrutiny, Health &amp; Wellbeing Boards and Healthwatch Patient Experience programme of activities Quality Assurance Framework including Quality Committee, QRMC, incident reporting, risk management, whistleblowing/raising concerns policies etc. Board Walkrounds programme and reporting of activity to Quality and Risk Management Committee. Patient stories to Trust Board. Annual Quality Account. Remuneration and Nominations Committee review of executive director succession plan. Remuneration and Nominations Committee review of executive director succession plan. Quality Impact Assessments in relation to decision making.</td>
<td>The Trust’s internal control systems are not sufficiently robust to ensure compliance.</td>
<td>The systems and processes are regularly tested through internal and external audit programmes as well as through deep dive reviews by the Assurance Committees.</td>
</tr>
<tr>
<td>6 The Board is satisfied that there are systems to ensure that the Licensee has in place personnel on the Board, reporting to the Board and within the rest of the organisation who are sufficient in number and appropriately qualified to ensure compliance with the conditions of its NHS provider licence.</td>
<td>Confirmed</td>
<td>Board Skills and Knowledge Review Service Line Management Implementation Plan including development programme Six Monthly Nurse Staffing Reviews Remuneration and Nominations Committee reports &amp; minutes. Doctor Revalidation process and reports to Board. Staff Appraisal process. Conduct an annual Board effectiveness questionnaire to inform our Board Development programme.</td>
<td>There is a risk of unforeseen changes at Board level which may impact on the requirements</td>
<td>There are deputies in post for all Executive Directors. The Board has six Non-Executive Directors and therefore has some flexibility should vacancies arise. Non-Executive Directors have different end of tenure dates.</td>
</tr>
<tr>
<td>General condition 6 - Systems for compliance with license conditions (FTs and NHS trusts)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>FT4 - Corporate Governance Statement</td>
<td>Response</td>
<td>Evidence</td>
<td>Risks</td>
<td>Mitigating Actions</td>
</tr>
<tr>
<td>-------------------------------------</td>
<td>----------</td>
<td>----------</td>
<td>-------</td>
<td>-------------------</td>
</tr>
</tbody>
</table>
| 1 Following a review for the purpose of paragraph 2(b) of licence condition G6, the Directors of the Licensee are satisfied that, in the Financial Year most recently ended, the Licensee took all such precautions as were necessary in order to comply with the conditions of the licence, any requirements imposed on it under the NHS Acts and have had regard to the NHS Constitution. | Confirmed | Annual Governance Statement  
Head of Internal Audit Opinion  
Risk Management Strategy  
Risk Register - Operational  
Board Assurance Framework - Strategic Risks  
Integrated Performance Report  
Performance Trajectories  
Patient Choice Protocols  
Patient Experience Programme | N/A | N/A |
<table>
<thead>
<tr>
<th>Report to:</th>
<th>Trust Board</th>
</tr>
</thead>
<tbody>
<tr>
<td>Agenda item:</td>
<td>15.</td>
</tr>
<tr>
<td>Date of Meeting:</td>
<td>31 May 2018</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Report Title:</th>
<th>Quality &amp; Risk Management Committee Report</th>
</tr>
</thead>
<tbody>
<tr>
<td>Status:</td>
<td>Information</td>
</tr>
<tr>
<td></td>
<td>X</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Prepared by:</th>
<th>Linda Storey, Interim Trust Secretary</th>
</tr>
</thead>
<tbody>
<tr>
<td>Executive Sponsor (presenting):</td>
<td>Liz Redfern, Non-Executive Director</td>
</tr>
<tr>
<td>Appendices (list if applicable):</td>
<td>None</td>
</tr>
</tbody>
</table>

**Recommendation:**

The Trust Board is asked to note the discussions of the Committee meetings held on 29 March 2018 and 24 May 2018.
1. Purpose

1.1. To present an update from the Committee following its meetings held on 29 March 2018 and 24 May 2018.

2. Background

2.1. As a formal Committee of the Trust Board, the Committee is required to report after each meeting to highlight the key discussions, risks identified, decision taken and future business. The following report provides this update to the Trust Board.

3. Business Undertaken

Mortality Screening/Learning from Deaths Update (April Meeting)

3.2. The Committee received a report from the Associate Director for Safe Care about the ongoing work to meet the national standards for mortality reviews and changes to the national mortality tool.

3.3. The key issues noted were:

- All the requirements up to the end of December 2017 including an aim for all deaths in the majority of specialties to undergo a full case note review had been met.

- Approval was given to a change in Trust policy in relation to mortality screening. Under the Trust’s policy four specialties were permitted to screen cases rather than complete the Royal College of Physicians (RCP) Structured Judgement Review (SJR). The RCP had removed the avoidability section from its SJR as it considered that the methodology did not allow such a judgement to be made. A change in the Trust policy was therefore agreed to reflect this and to require a specialty to review cases where the overall care was judged to be ‘Poor’ of ‘Very Poor’ in their mortality and morbidity meetings. Any conclusion that the care delivery problems might have contributed to death would be notified to the Clinical risk team that a serious incident had occurred and the root cause analysis process would be started.

Risk Management Assurance Update

3.4. At the March meeting the Committee received the first data drawn from the newly implemented Datix System. It was noted that there was a training requirement for Divisions in order that staff could utilise the system to its full potential.

3.5. The Extreme Risks were reviewed and the Committee requested that the risk in relation to the quality of service for patient transport provided by Arriva be the subject of a deep dive at the next meeting.
3.6 A deep dive was undertaken at the May meeting where it was reported that there had been an improvement in the delivery of the service. This included a co-ordinated approach to taxi usage whereby specific companies were used for specific patients and regular meetings being held with Arriva. The approach taken had resulted in a reduction in complaints relating to the service.

3.7 At the meeting in May the Committee received a presentation and report on the implementation of the Datix System. The Committee was advised that the key objective had been to increase the incident reporting rate at the Trust from its national lower quartile position and that this objective had been achieved and sustained.

3.8 The Committee was advised of a number of other system benefits including:

- Staff had found it easy to use the system and report incidents during the challenging winter period.
- The Trust was now paper-lite on incident reporting.
- A landing page gave a clear overview of the status of current issues within a division and Governance Leads were now overseeing this with the reports going to divisional and specialty meetings.

3.9 At the May meeting the outcome of the Risk Management internal audit was reported as being significant with minor improvements. The audit had focussed on the Anaestheiss, Surgery, Critical Care and Renal and the facilities divisions.

3.10 Three new extreme risks were reviewed at the May meeting:

- Risk 103 Lack of electronic system(s) in place for end to end, vein to vein administration of blood. The Committee noted that the risk would remain an extreme risk until the blood tracking system was implemented.
- Risk 124: Absence of chemotherapy electronic prescribing system. The Committee noted that the risk related to the actual protocols and guidance required to use the system effectively.
- Risk 336: Reduced number of IR Radiologists and risk to IR service provision. The
Committee noted that the risk score was expected to reduce and the risk downgraded for the next meeting as there was a plan to cover the rotas which was due to be signed off shortly.

3.11 Five Extreme Risks had been mitigated and downgraded to a lower risk score (May Meeting):

- Risk 56: Bluespier server.
- Risk 101: Management of bed capacity and flow.
- Risk 104: Timely and successful handover of FLOW system to IT at risk.
- Risk 81: Blood Transfusion Training for Clinical Staff.

Update on GE Healthcare Review (May Meeting)

3.12 The Committee received an update on the GE Healthcare Review and actions. Key issues were noted as:

- Work had been undertaken to theme the work.
- Some transitional resource had been agreed in principle and required formal approval once clarity on the structure, roles and finances was provided.

- The Committee would oversee the delivery of the action plan and an updated plan would be presented to the next meeting.

Quality Performance Report (May Meeting)

3.13 The following was highlighted:

- A proposal that the number of stillbirths be reported to the Trust Board.
- The next Board report would show 3 MRSA cases which would be discussed at the Infection Control Committee.
- Falls had reduced and the Trust was on track to reduce falls over a 3 year period.
- There had been a spike in deaths in January. The Dr Foster data has since been published which showed that this was in line with expectation and related to winter.

Care Quality Commission Report and Action Plan (May Meeting)

3.14 The Committee noted that at the end of April all of the actions due to be closed at that point had been closed and the evidence to support their closure validated.

3.15 Work was underway and on track to close the end of May actions.

Pathology Quality Management Controls (April Meeting)
3.16 An update on pathology management controls was given. The Committee was advised that recent regulatory visits had focussed on the quality of management systems and deep dives. Issues had been identified in relation to the speed with which monitoring was undertaken and in the ability to clearly describe the quality management process.

3.17 A first draft of a dashboard with key performance indicators was being developed. The dashboard aimed to address a number of internal audit processes that had been slow to close down.

3.18 The Committee requested that a further update be presented at the September meeting to cover the clarification of the links to the Trust’s governance framework including clarity of reporting lines and performance against the regulatory requirements.

**Perform Stranded Patient Project (April Meeting)**

3.19 The Committee received a presentation outlining the key activities of the Perform Programme to date. The Committee agreed that at least one of the Non-executive Director should attend one of the Perform Bootcamps.

3.20 The Committee noted that it was anticipated that changes would start to be seen at the six week point.

3.21 The importance of sustainability of the programme once PwC were no longer with the Trust was highlighted.

3.22 The Committee noted that the organisation needed to be aware of counter indicators such as a rise in readmission rates and requested that PwC share other counter indicator measures identified from their work with other organisations in order that the Trust could be in as strong a position as possible once PwC had left.

**Quality Priorities 2018/19 (April Meeting)**

3.23 The Committee received and approved the following Quality Account Priorities for 2018/19 which were submitted to the Trust Board for approval on the 26th April 2018:

- Eliminate delays in hospital (home is best).
- Enhance the way patient involvement and feedback is used to influence care and service development.
- Continue to improve the quality of end of life care.
- Strengthen learning and action by embedding quality governance.
- Demonstrate a stronger clinical understanding and application of the Mental Capacity Act and Deprivation of Liberty Standards.
NHS Resolution Clinical Negligence Scheme for Trusts Maternity Safety Strategy 10 Actions (May Meeting)

3.24 The Committee received a detailed report outlining the evidence to support the progress against each of the ten maternity safety actions. The Committee was requested to consider whether the information supplied demonstrated with/achieved the maternity safety actions sufficiently to provide assurance for the Trust Board to be able to sign off the self-certification in June.

3.25 The process was a new national approach. The information had been reviewed by the Director of Nursing and the Associate Director of Clinical Governance. The process required regular meetings between the service and the executive director – the first of which had been held.

3.25 The ten actions were:

- Are you using the National Perinatal Mortality Review Tool to review perinatal deaths?
- Are you submitting data to the maternity Services Data Set (MSDS) to the required standard?
- Can you demonstrate that you have transitional care facilities that are in place and operational to support the implementation of the ATAIN Programme (Avoiding Term Admissions Into Neonatal units)?
- Can you demonstrate an effective system of medical workforce planning?
- Can you demonstrate and effective system of midwifery workforce planning?
- Can you demonstrate compliance with all four elements of the Saving Babies’ Lives care bundle?
- Can you demonstrate that you have a patient feedback mechanism for maternity services such as the Maternity Voices Partnership Forum, and that you regularly act on feedback?
- Can you evidence that 90% of each maternity unit staff group have attended an ‘in-house’ multi-professional maternity emergencies training session within the last training year?
- Can you demonstrate that the Trust Safety Champions (Obstetrician and Midwife) are meeting bi-monthly with Board level champions to escalate locally identified issues?
- Have you reported 100% of qualifying incidents under NHS Resolution’s Early Notification scheme?

3.26 The Committee was advised that of the ten actions detailed below, the action was met in all cases except for two where partial evidence was
available. The two partial evidence actions related to the fourth element of the ‘Saving Babies Lives Care Bundle’ (effective foetal monitoring in labour) and to ‘Multi-professional Training’.

3.27 The Committee concluded that it noted the process that had been undertaken to present the data and that an ongoing process of reviews would take place. The Committee considered that the process as outlined was appropriate and requested that work be ongoing to the end of June to ensure that the evidence submitted was sufficiently robust. The Committee requested that should any risks of issues materialise prior to the end of June that it be advised.

3.28 The Committee noted that it would check with the Board in relation to the delegation of the assurance to the Committee.

12 Hour Trolley Reviews (May Meeting)

3.29 Following delegation from the Trust Board the Committee received a report setting out the review into a number of 12 hour trolley waits in the Emergency Department to see whether the breach had attributed to or caused harm.

3.30 The Committee noted that whilst nothing had been identified that a serious incident or death had resulted as a result of the breaches, there was a requirement to provide further clarity on what the review of harm was and where there had been reviews what the conclusion was.

3.31 The Committee requested that the next meeting receive a report summarising what was found together with a commitment that the breaches be minimised.

4. Key Risks Identified and Impact

4.1 In addition to the specific risks covered in the risk management report the Committee noted the risks relating to ensuring sustainability of the Perform Programme once PwC were no longer with the Trust.

5. Key Decisions

5.1 Approval of policy change in relation to mortality screening (April Meeting).

5.2 Recommendation of the Quality Account Priorities for 2018/2019 to the Trust Board (April Meeting).

5.3 Approval of the process and evidence submitted relating to the NHS Resolution Clinical Negligence Scheme for Trusts Maternity Safety Strategy 10 Actions (May Meeting).

6. Exceptions and Challenges

6.1 A request was made in relation to the 12 Hour Trolley Review report that further work be undertaken and presented back to the next meeting to provide clarity on what was found.

6.2 A request was made that an ongoing process of evidence review be undertaken in relation to the CNST maternity evidence and any risks or issues
be drawn to the notice of the Committee prior to the June sign off.

7. **Governance and Other Business**
   7.1 In relation to the CNST Maternity Safety Actions, the Board was requested to confirm that it was in agreement with the process to delegate the review of the detail to the Committee.

8. **Future Business**
   8.1 The Committee at its next meeting will focus on the following:
   - The updated GE Healthcare Review action plan.
   - The Care Quality Commission action plan.

9. **Recommendations**
   9.1 The Trust Board is asked to note the discussions of the Committee meeting held on 29th March 2018 and 24th May 2014.
## Report to:
Trust Board

## Agenda item:
16

## Date of Meeting:
31st May 2018

<table>
<thead>
<tr>
<th>Report Title:</th>
<th>Southmead Hospital Charity Committee Report</th>
</tr>
</thead>
<tbody>
<tr>
<td>Status:</td>
<td>Information</td>
</tr>
<tr>
<td>Prepared by:</td>
<td>Elizabeth Bond, Head of Fundraising, Southmead Hospital Charity</td>
</tr>
<tr>
<td>Executive Sponsor (presenting):</td>
<td>Jaki Meekings Davis, Chair, Southmead Hospital Charity Committee</td>
</tr>
<tr>
<td>Appendices (list if applicable):</td>
<td>None</td>
</tr>
</tbody>
</table>

## Recommendation:
1. Purpose
This paper reviews the items discussed at the Southmead Hospital Charity (SHC) Committee meeting on 26th May 2018.

2. Background
The Southmead Hospital Charity Committee meets once a quarter to discuss the strategic direction, income generation, charity management, funding and application requests and financial management of Southmead Hospital Charity.

3. Business Undertaken
3.1. Annual accounts
Findings of the internal audit were presented by Grant Thornton. The Committee approved the:

a) North Bristol NHS Trust Charitable Audited Accounts for 2017/2018
b) Letter of representation for 2017/2018
c) Draft trustees report for 2017/2018

3.2 Strategic direction and income generation
- Summary of 2017/2018 activity
Income was reported as £1,349,811 at year end. The Charity’s biggest area of income was legacies which is typical of the industry standard. Against industry standard was our flourishing community activity which significantly outperformed against target by over £100k during 2017/2018.

- The Committee approved the Committee and Charity team work plan and targets for 2018/19. Both financial and non-financial key performance indicators have been set for the team.

3.3 Funding and application requests
- It was reported that the General Funds balance currently stands at £1.28 million.
- The following application requests were approved:
  a) £96k Ultrasound Gastroscope
  b) £46,614 Employee Assistance Programme as part of the trust Health and Wellbeing scheme for staff
  c) £10k to fund Trust’s PJ Paralysis programme
- An updated paper was presented to set up a General Fund Review Committee to look at applications to the General Fund. Terms of Reference and an additional information pack were presented to the committee. It was agreed to proceed when Finance confirmed the updated balance on the general fund.

3.3 Finance
- Single transactions over £10,000 were noted.
- The Committee noted the performance of the investment portfolio for the quarter and the dividends received.

4. Any Other Business
There was no additional business.

5. Key Risks Identified and Impact
No risks were identified.

6. Key Decisions
There were no other key decisions taken in addition to those reported above.

7. Exceptions and Challenges
This document could be made public under the Freedom of Information Act 2000. Any person identifiable, corporate sensitive information will be exempt and must be discussed under a ‘closed section’ of any meeting.
There were no exceptions or challenges.

8. Governance and Other Business

The Committee agreed to continue to support Graham Pelton recommendations following the Charity Review.

9. Future Business

The Committee will be focusing on the following:

Continue to promote the Prostate Cancer Care appeal and explore fundraising opportunities.

10. Recommendations

No recommendations were made.
**Report to:** Trust Board  
**Agenda item:** 17  
**Date of Meeting:** 31 May 2018

<table>
<thead>
<tr>
<th>Report Title:</th>
<th>Trust Management Team Report</th>
</tr>
</thead>
<tbody>
<tr>
<td>Status:</td>
<td>Information</td>
</tr>
<tr>
<td></td>
<td>X</td>
</tr>
<tr>
<td>Prepared by:</td>
<td>Linda Storey, Interim Trust Secretary</td>
</tr>
<tr>
<td>Executive Sponsor (presenting):</td>
<td>Andrea Young, Chief Executive</td>
</tr>
<tr>
<td>Appendices (list if applicable):</td>
<td>None</td>
</tr>
</tbody>
</table>

**Recommendation:**

The Trust Board is asked to note the content of this report.
1. Purpose
   1.1. To present an update on the business transacted by the Trust Management Team (TMT) at its meetings held on 17 April 2018 and 22 May 2018.

2. Background
   2.1. The TMT is the key delivery group in the Trust and consists of the Executive Directors, Clinical Directors and Divisional Managers.

   2.2. It is good practice that all Committees which report to the Trust Board should report after each meeting.

3. Business Undertaken
   3.1. The TMT focused its attention on the following areas:

   Care Quality Commission Action Plan

   3.2 The meeting in April reviewed the draft action plan, developed by clinical divisions to comply with the recommendations from the CQC inspection report.

   3.3 A number of refinements were agreed including the identification of executive director leads on a number of the actions; clarity on the RAG rating status and a summary of the actions into key themes which would have the biggest impact on overall delivery and which could be used to describe to staff what the Trust should look like in 12 months as a result of the changes made to address the recommendations.

   3.4 The meeting in May received an update on progress which showed that the April actions had been delivered and work was on track to deliver the actions due in May.

   3.5 The meeting in May also noted the positive feedback received from the first two thematic engagement visits from the CQC to the Women’s and Children’s Division and Cossham hospitals.

   Business Planning

   3.6 The April meeting received an update on progress with the operational plan for 2018/2019 which had been endorsed by the Board at its meeting on the 5th April 2018. The meeting was advised that the Board had agreed that a refresh be presented at the end of Quarter 1 to address the two key risks identified relating to the capacity in the bed model to meet planned activity during 18/19 and residual gaps in the CIP programme of c.£7m.

   3.7 The May meeting received an update on the financial plan and was advised that information had been received from NHSI that the control total had been moved to a deficit after Sustainability and Transformation Funding (STF) of £18.4m from £12.4m in recognition of the challenges facing the Trust and as a result of the pressures of the previous winter. The change meant a deficit position of £1.5m after STF each month.
3.8 The meeting discussed the approach to be taken and concluded that whilst endorsing the revised control total teams would aim to deliver the £12.4m deficit which would return NBT to break even at the end of 2019/2020.

3.9 The meeting received a report setting out an approach to support the Board’s assurance on the delivery of the Business Plan and the associated corporate objectives. The report included a proposal of quarterly reporting of KPIs aligned to the corporate objectives to the Board. This would be supported by the executive team with monthly reporting to executives and the TMT.

3.10 The report illustrated the framework of strategic themes and associated corporate objectives together with the responsible executive director leads and the proposed KPIs.

3.11 It was agreed that the improvement of retention should be included as a separate corporate objective and the sign off of the digital strategy should be included as a key indicator for the objective to deliver the informatics programme.

3.12 The ongoing work on the bed capacity model was explained and it was noted that further work was required including factoring in the changes as a result of the reduction in the number of outliers. The importance of applying consistency to the numbers of beds for reporting purposes was highlighted. The Urgent Care Improvement Steering Group was being established into which the NBT Acute Flow Group would report into.

3.13 The latest CIP position was reported which showed that whilst the total value of schemes had not moved, the numbers of schemes moving from red to green status had increased. The requirement to move pipeline ideas into the plan was a key focus to close the gap by the end of Quarter 1.

3.14 A paper clarifying business case approvals processes was discussed and it was agreed that a small task force to include divisional staff would be established to review the current process to identify changes for improvement. Related to this a discussion was held about the requirement for training in relation to writing business cases and it was explained that a recently convened informal group of the corporate deputies aimed to provide a coaching approach to achieving a better success rate of approved business cases.

**Stroke Rehabilitation Business Case**

3.15 A business case to increase to invest in stroke services to reduce the length of stay and the number of stranded patients and improve quality of care was reviewed and recommended for approval by the Finance and Performance Committee.

3.16 The case proposed an increase of the number of therapists on wards at weekends and an increased early supported discharge capacity to...
support early discharge home of patients with continued therapy input.

3.17 The plans were included in the Trust’s bed model and the required investment had been costed and included in the Trust Operating Plan that had been signed off by the Trust Board.

**Perform Programme Update**

3.18 TMT received an update on the Perform Programme. The highlights to date were:

- The programme was on plan at week 5.
- Engagement across the Trust had been good with positive feedback from the bootcamps.
- The NBT coaches were growing in confidence.
- The contractual metrics with PwC had been signed off and it was emphasised that these were the Trust’s success factors.
- An improving communications focus in recent weeks.
- Handover planning had started.
- An end of May deadline had been set for a high level sustainability plan for ward improvements and the identification of Wave 3 work.
- A key focus on three key outcomes: compliance with flow from wards and one version of the truth; understanding roles and responsibilities in order that everyone understands how they contribute and everyone understanding the data and what the performance is telling us.
- The dashboards were in place at ward and divisional level and were being developed for individual specialties.
- Feedback was received from NBT coaches who reported positively on their learning which included enthusiasm from the wards to be involved; a learning of how to appropriately challenge, the importance of celebrating success and the importance of quicker, open and constructive conversations.

A Perform update was a standing item at the monthly TMT meeting.

**Sub-Committees**

3.18 TMT received highlight reports from the meetings held by the following sub-committees: Retention Steering Group, Leadership Steering Group, IM&T Board and the Capital Planning Group.

**4. Key Risks Identified and Impact**

3.16 TMT recognised and discussed risks relating to:

- the business plan for 2018/19, specifically the delivery of the CIP programme and need for further work on winter plan, bed modelling throughout the year and mitigations to be worked up into concrete delivery plans.
5. Key Decisions
5.1. The TMT approved:
   - Amendments to the Care Quality Commission Action Plan.
   - Recommended the stroke services business case to the Finance and Performance Committee for approval.
   - Agreed further work on bed model, and winter plan to take place with Divisions and the COO before next TMT in June.

6. Exceptions and Challenges
6.1. The discussion on the business case approval routes resulted in agreement to establish a small task force to review the process in order that any changes might be identified to improve the quality of business cases and the timeliness of approvals.

7. Governance and Other Business
7.1. There were no governance issues.

8. Future Business
8.1. The TMT will be focusing on the following areas over the next three months:
   - The Perform Programme.
   - Delivery of improvements in operational performance, reducing the numbers of stranded patients and improving patient flow.
   - Further mitigation of the bed constraints set out in the operational plan
   - Further development of CIP opportunities.

9. Recommendations
9.1. The Trust Board is asked to note the update provided on the work of the TMT
The Trust Board is asked to note the update from the meetings held on 20 February and 3 May 2018
1. Purpose
   1.1. To present an update to the Board following the meeting of the Committee on 20 February and 3 May 2018.

2. Background
   2.1. The Workforce Committee, as a sub-committee of the Board, is required to report to the Board after each meeting.

3. Business Undertaken
   3.1. The Committee considered the following issues:

   **Guardian of Safe Working**
   3.2. The Committee received a summary of the work of the Guardian of Safe Working Hours. Of the 375 exception reports received since her appointment, by far the majority concerned excess hours and most were related to elderly care medicine. Consultants were increasingly engaged with resolving issues and no fines had been issued for recurring breaches. Sue Jones reported that the Trust’s emphasis was to promote a culture where day work was completed within the day and not left for the night staff.

   3.3. Following the nationally reported Bawa-Garba case the Trust had reiterated its support for e-portfolio reflection and following complaints from junior staff rest rooms had been improved which included the provision of extra beds and comfortable chairs. Clinical Fellows were now being included in the exception reporting process.

   **Winter Workforce Resilience**
   3.4. The Committee reviewed an analysis of the nursing workforce experience over the Winter in four areas. Temporary staffing demand had risen by 15% compared to the Winter of 2016/17 and there had been 357 more unfilled nursing shifts. The number of required care hours had risen and overall hours of sickness had risen by 1.2%.

   3.5. The Committee noted that more recruitment and better retention and e-rostering processes were required.

   **Workforce Cost Improvement Planning 2018/19**
   3.6. The Committee received an analysis on the workforce opportunities within the Cost Improvement Programme for 2018/19 especially regarding a reduction in turnover and sickness rates. It was estimated that up to £7.5m a year could be saved by reducing backfill costs, improved productivity and efficiency and reduced recruitment costs. There were also some non-cash releasing benefits to be had through improved team working, staff morale and release of time from undertaking recruitment, induction and orientation activities.

   3.7. The proposed business plans from divisions identified nearly £4m, achieving the national average for sickness and turnover would deliver more than £1.3m and achieving the upper quartile a further £2.2m. Some of the plans would not
deliver fully within the year but quarterly progress reports would be made to the Committee.

Happy App Analysis

3.8. The Committee received a report from an outside agency on the interpretation of the results from the use of the Happy App. Comments were anonymous from staff so it was not possible to identify whether all staff grades and professionals were using the system. Where there were areas of high staff issues the executives were asking the divisional management teams to consider putting in the Happy App and daily monitoring showed how quickly managers were responding to comments.

3.9. The Committee agreed to review the issue again during the Summer but the important Board assurance needed was to see how staff frustrations were closed.

PERFORM Update

3.10. The Committee noted the good attendance at the ‘bootcamps’ and the positive feedback and energy derived from the events. Ten staff, including two doctors, had been appointed to supplement the PwC coaches and continue the training once PwC left. A deep dive had been held by the Quality and Risk Management Committee and it would continue to monitor key performance indicators.

SLM Update

3.11. The Committee noted the latest update on progress on the service line management programme. The Committee asked that details on what was being devolved and the governance arrangements for the new system be reported to it in July 2018.

Risk Register Review

3.12. The Committee noted the latest review of the workforce risk register and that the human resources directorate focus had moved to the People Partners in the divisions and junior roles. There were ‘hotspots’ in terms of expected medical vacancies in Cancer Services and Pathology.

NHS Professionals – NBT Bank

3.13. At both meetings the Committee reviewed the proposal to appoint NHS Professional as the host of the Trust’s Bank staff. A bank staff consultation was being held until mid May which included the current delivery team, recruitment and payroll staff and the trade unions. A full business case was expected to be put to the Finance and Performance Committee in June.

Staff Survey

3.14. The initial results from the 2017 Staff Attitude Survey were received at the meeting on 20 February and the Board also received them on 5
April. A further in depth report was received at the May meeting.

3.15. The Committee had some difficulty in understanding the three or four actions that would sustain the overall improvement identified by the survey and the Director of People and Transformation noted that the Retention Steering Group had been established to coordinate this type of work but there were ongoing actions for staff health and well being that had already had positive feedback and one clear issue to address was flexible working. Self rostering was being trialled in areas of good team working.

3.16. The Committee asked that a timeline be estimated for implementing changes and how much, how often and to which groups the results and actions were communicated.

4. Key Risks Identified and Impact

4.1. The key workforce risks were considered which included:

4.1.1. lack of sufficient or appropriate resources because of high levels of turnover, vacancies or sickness absence;
4.1.2. lack of staff engagement to support the delivery of the Trust’s objectives;
4.1.3. lack of management capacity;
4.1.4. expected junior medical vacancies affecting cancer services and pathology;
4.1.5. inability to achieve cost improvements.

5. Key Decisions

5.1. The Committee agreed to receive a quarterly report on sickness and turnover.
5.2. The Quality and Risk Management Committee (Q&RMC) to review specific staff groups where there is a lack of sufficient resources through high levels of turnover, vacancies or a large proportion of novices.
5.3. To receive a trajectory on implementation of staff survey actions.
5.4. Q&RMC to review key performance indicators from the PERFORM programme.

6. Exceptions and Challenges

6.1. There were no exceptions or challenges to report.

7. Governance and Other Business

7.1. As noted under Key Decisions.

8. Future Business

8.1. The Committee will be focusing its attention on the following issues:

8.1.1. A full review of the way freedom to speak up processes are currently undertaken;
8.1.2. Revalidation and appraisal of medical staff processes;
9. Recommendations

9.1. The Trust Board is asked to note the update from the meetings held on 20 February and 3 May 2018.
Report to: Trust Board  
Date of Meeting: 31 May 2018

<table>
<thead>
<tr>
<th>Report Title:</th>
<th>Finance &amp; Performance Committee Report</th>
</tr>
</thead>
<tbody>
<tr>
<td>Status:</td>
<td>Information</td>
</tr>
<tr>
<td></td>
<td>x</td>
</tr>
<tr>
<td>Prepared by:</td>
<td>Nick Stibbs, Corporate Services Manager</td>
</tr>
<tr>
<td>Executive Sponsor (presenting):</td>
<td>Rob Mould, Non-Executive Director</td>
</tr>
<tr>
<td>Appendices (list if applicable):</td>
<td></td>
</tr>
</tbody>
</table>

Recommendation:
The Trust Board is asked to note the report from the meeting held on 19 April 2018
1. Purpose

1.1. This report outlines the business discussed at the Finance & Performance Committee (F&PC) meeting held on 19 April 2018.

2. Background

2.1. The F&PC meets bi-monthly and was established to provide assurance to the Trust Board that there are robust and integrated systems in place overseeing the Trust’s finance and performance and that they are in line with the organisation’s objectives.

3. Business Undertaken

Enterprise Network Outline Business Case

3.1. The Committee received a refreshed outline business case (OBC) for the Enterprise Network and Wireless Replacement project. The capital issues had been resolved but the slippage in the major expenditure of the project (£1.5m in 2018/19 and £6.7m in 2019/20) meant a delay in implementation of hand held IT projects.

3.2. The Committee was reminded that the procurement process ended with a sole supplier with costs significantly above the estimate. KPMG had been asked to provide independent advice on the adequacy of the procurement process, compliance with Trust policies and an evaluation of the bid against the business case. It had given the project a rating of significant assurance with some minor improvements.

3.3. The system would eventually save the Trust £400,000 of recurrent costs and provide significant improvements in cyber security by enabling earlier detection. It would be installed in parallel with the old system and be covered by a number of failsafe power systems.

3.4. The Committee recommended the Board approve the OBC. (Subsequently approved on 26 April).

Operational Performance

3.5. The Committee received a report outlining performance to the end of March 2018 against national standards, the remedial action plans where the Trust was not achieving targets, the improvement trajectories and the metrics of other key issues that affected the flow of patients. The basic data is set out separately in the latest Integrated Performance Report (IPR) elsewhere on the Board agenda but of particular note to the Committee were:

- the failure to achieve the 62 day cancer target which was mainly due to urology where the death of a consultant had reduced capacity particularly regarding use of the robot and
- trajectories for improving delayed transfers of care and standard operating procedures would be placed and monitored in future in the IPR.
Pathology Managed Equipment Service OBC

3.6. A detailed OBC on the proposed replacement pathology managed equipment service was received. It had been written for the Boards of the four local trusts with the strong possibility of the involvement of the regional part of Public Health England, which had been closely involved in the OBC’s development, from the start. Gloucestershire Hospitals was also interested as part of the NHSI proposed local network but its current contracts had longer to run.

3.7. The split of services had broadened in favour of NBT following the transfer of histopathology from University Hospital Bristol and the growth of genomics was likely to grow the service further. Best and final offers were expected to be evaluated by all partners in the Summer of 2019. Recurrent savings were expected to be of the order of 8% with further savings on VAT.

3.8. The Committee asked that the capital costs of all equipment proposed to be supplied be included in the tenders and it noted that a partnership agreement was being drawn up to be signed by all parties before the OJEU was published.

3.9. The Committee recommended the Board approve the OBC (subsequently approved on 26 April).

Genomics Joint Bid

3.10. The Committee received a proposed tender response to NHS England for a South West Genomic Laboratory Hub in partnership with the Royal Devon and Exeter NHS Foundation Trust.

3.11. It was noted that the Board had approved the approach to respond to be one of seven national hubs in England in February 2018. Whilst the two partners would provide the majority some specialist services would be sub-contracted to Cardiff and Vale University Health Board and NHS Blood and Transplant.

3.12. The modelling for the service was based upon an untested pricing structure with a number of NHSE mandated managerial roles treated as a fixed cost. Activity numbers indicated by NHSE were considered ambitious but it was expected, to bring financial balance and eliminate the current £500,000 deficit.

3.13. The Committee recommended the Board authorised the submission of the Trust’s tender and, if successful, give delegated authority to the Director of Finance and Medical Director to approve any variations agreed with NHSE provided they did not expose the Trust to any significantly greater risk or liability.
3.14. The Committee noted that with the analysts employed directly by the divisions activity and financial data would be integrated and the first information in this guise would be seen by the F&PC in June 2018.

4. Key Risks Identified and Impact

4.1. The key strategic, business planning and contracting risks were reviewed and were considered in relation to the work plan of the Committee.

4.2. Risks and mitigations were also identified in:

- the transfer of services formerly provided by Carillion;
- delays to the Enterprise Network procurement would risk other system failures and data unavailability;
- the size of the implementation of the Enterprise Network project could create network downtime periods affecting services;
- potential duplication of pathology services leading to inefficiencies in the network provision;
- implementation of IFRS 16 could attract capital charges on equipment supplied under the managed equipment services contract;
- the level of activity proposed for the Genomics service could be over-estimated leading to financial risks and;
- incorrect weightings supplied for the Genomics bid could jeopardise the cost estimates;

5. Key Decisions

5.1. The Committee agreed to recommend the Board approve the Enterprise Network and Pathology Managed Equipment Services OBCs and the submission of a bid for the Genomics Hub to NHSE.

Exceptions and Challenges

5.2. There were no exceptions or challenges which prevented the Committee from undertaking its work.

6. Governance and Other Business

6.1. There were no issues of governance regarding the Committee itself.

7. Future Business

7.1. The Committee will be considering:

- an OBC for Scan for Safety
orthopaedic activity
• a refined Integrated Performance Report
• a long term financial strategy
• profitability of some services
• a review of the Committee’s effectiveness

8. Recommendations

8.1. The Trust Board is asked to note the report from the meeting held on 19 April 2018.
<table>
<thead>
<tr>
<th>Report to:</th>
<th>Trust Board</th>
</tr>
</thead>
<tbody>
<tr>
<td>Agenda item:</td>
<td>20.</td>
</tr>
<tr>
<td>Date of Meeting:</td>
<td>31 May 2018</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Report Title:</th>
<th>Audit Committee Report</th>
</tr>
</thead>
<tbody>
<tr>
<td>Status:</td>
<td><img src="#" alt="Table" /></td>
</tr>
<tr>
<td>Information</td>
<td>X</td>
</tr>
<tr>
<td>Discussion</td>
<td>X</td>
</tr>
<tr>
<td>Assurance</td>
<td>X</td>
</tr>
<tr>
<td>Approval</td>
<td>X</td>
</tr>
<tr>
<td>Prepared by:</td>
<td>Linda Storey, Interim Trust Secretary</td>
</tr>
<tr>
<td>Executive Sponsor</td>
<td>Jaki Davis, Chairman of the Audit Committee</td>
</tr>
<tr>
<td>Appendices (list if applicable):</td>
<td>None</td>
</tr>
</tbody>
</table>

**Recommendation:**

The Trust Board is asked to discuss and consider the activities of the Audit Committee.
1. **Purpose**

1.1. To provide an update to the Board following the meetings of the Audit Committee held on 24th April and the 24th May 2018. The main focus of the meeting on the 24th May was the close down of 2017/18 and reporting for year end.

2. **Background**

2.1. The Audit Committee meets approximately once a quarter and is responsible, on behalf of the Board, for ensuring that the Trust has sufficient controls and systems in place to run an efficient, effective and continually improving service in line with the organisation’s objectives.

3. **Business Undertaken**

   **External Audit and Year End Business**

3.1. At the April meeting the External Auditors gave an update on the progress of the external audit which had commenced the previous day. No significant issues on system processes had been found in the fieldwork and it was indicated that the Value for Money Conclusion (VfM) would again be a ‘qualified except for’ VfM. The Committee questioned the reasoning for this in the light of the Trust’s improved financial performance having exited Financial Special Measures in year and taking into account its Reference Cost Index of 100. It was explained that whilst the improvement in year was recognised, the scale of the underlying financial deficit justified the opinion which had been tested in a national consistency panel. The VfM conclusion was confirmed as ‘Qualified except for’ at the meeting on the 24th May 2018.

3.2. At the May meeting the external Auditors presented their audit findings reports which gave an unqualified audit opinion on the financial accounts and the VfM conclusion as identified in section 3.1 above. Confirmation was given that the accounts for 2017/18 had been prepared on a Going Concern basis.

3.3. At the May meeting the Committee received and noted the management responses on fraud and key issues which were provided to Grant Thornton as part of their audit process by the Director of Finance and Chair of the Audit Committee and Charity Committee.

3.4. At the May meeting the Letter of Representation was noted as being the standard letter with no additional items included and was recommended to the Trust Board for approval.

3.5. At the May meeting the Annual Accounts for 2017/18 were reviewed and recommended to the Trust Board for adoption.

3.6. The Annual Governance Statement of the Chief Executive was reviewed in draft at the April Meeting and in final form at the May meeting where it was reviewed and noted as incorporated into the Annual Report. The two significant control issues at the end of the statement were...
noted as being patient flow and bed occupancy and the financial position.

3.7. The Annual Report for 2017/2018 was reviewed and recommended to the Trust Board for approval.

3.8 The Internal Audit Annual Report was received and noted and the Head of Internal Audit opinion on 2017/18 noted as being: “Significant assurance with minor improvements can be given on the overall adequacy and effectiveness of the organisation’s framework of governance, risk management and control.”

Internal Audit – Audit Reviews

3.9 Audit Reviews had been completed on four subjects. There were no high priority recommendations made for any of the reports. A number of medium priority recommendations were identified for the reports and these are shown in brackets beside the report name below:

3.10 Three of the reports had been rated as significant assurance with minor improvement opportunities They were:

- Information Governance Toolkit (2);
- North Bristol Trust Network Procurement (1);
- Risk Management (3);

The fourth review, CQC Compliance, was rated as partial assurance with improvements required and 12 medium priority recommendations.

Local Counter Fraud

3.11 The Committee received and noted the Counter Fraud Annual Report at its meeting on the 24th April 2018. At its meeting on the 24th May, the Committee received a report from KPMG as the new providers of the service on its approach to the three year local counter fraud plan. It was explained that a risk based approach would be adopted seeking to identify with the high risk departments if there were any opportunities for fraud in order to devise the plan. The terms of reference were to be agreed shortly.

Losses

3.12 At the meeting in May the Committee noted 138 individual losses reported amounting to £367,931 at the 31st March 2018 for the period January to March 2018. This included a stock loss of £267,354 relating to stock managed by Materials Management which was reviewed by the Committee and approved in accordance with the Trust’s Standing Financial Instructions.

Quality Account 2017/2018

3.13 The external auditors presented the progress to date of the audit findings on the Quality Account. It was noted that the report was not the final findings report as the national deadline for submission was the 30th June 2018. Work had been undertaken in parallel with the financial statements audit and it was noted at the present stage a number of mandatory disclosures
including comments from other external bodies were yet to be received. To date no issues had been identified on work relating to mandatory disclosures.

3.14 Two indicators for sample testing had been selected for the year: C Difficile and Venous Thromboembolism Assessments (VTE). There had not been any issues identified in relation to C Difficile. In relation to VTE issues had been identified regarding identification of EDMS records for two samples and once this had been concluded the final report would be completed for submission to the Trust Board at the end of June.

3.15 The Committee received the latest version of the Quality Account for 2017/2018 and noted that it was proceeding in accordance with the publication timetable.

3.16 Joint presentations had been made to the Health Scrutiny Committees and a site visit had been hosted on the 27th April.

3.17 The Committee requested that the early section of the document balance the quality picture for the year with reference to some of the challenges facing the Trust.

4. Key Risks Identified and Impact

4.1 The Committee identified the following risks and mitigations:

- the potential for additional capital costs for the removal of asbestos from the Lime Walk building;
- the accuracy of key performance indicators that require cyclical assurance;
- evidence to support the Trust’s assessment against the Information Governance Tool which may not be available until the end of the year.

5. Key Decisions and Recommendations

5.1 The Committee agreed the following:

- recommended that the Boards of STP organisations should receive headline reports on the progress of STP projects and KPIs.
- Recommended the Annual Report and Accounts 2017/2018 for Trust Board adoption.

6. Exceptions and Challenges

6.1 There were no exceptions or challenges which prevented the Committee from undertaking its work.

7. Governance and Other Business

7.1 At the meeting on the 24th April the Charitable Funds external audit plan for 2017/18 was received and noted.

8. Future Business

8.1 The Committee will be focusing on the following over the next six months:

- Review of effectiveness
- Audit Committee working and Sustainability and Transformation Programmes.

9. Recommendations
9.1 The Trust Board is asked to discuss and consider the activities of the Audit Committee.