**Trust Board Meeting in Public**  
**Thursday 28 September 2017**  

**12.30pm, Seminar Room 5, Learning and Research Centre, Southmead Hospital**

### Agenda

1. Apologies and Declarations of Interest: John Everitt, John Iredale and Andrea Young
2. Questions from Members of the Public
3. Minutes of the Trust Board meeting held on 27 July 2017
4. Action Log and Matters Arising
5. Chairman’s Business
6. Chief Executive’s Report
7. Patient Story (*Information*)
8. Emergency Care Improvement Plan (Approval)
10. Internal Winter Plan (Approval)
11. Annual Complaints Report (*Information*)
12. Adult Safeguarding Annual Report (Approval)
13. Children’s Safeguarding Annual Report (Approval)
14. Sustainable Development Management Plan (Adoption)
15. Capital Planning Report (*Information*)
16. Workforce Committee Report (*Information*)
17. Trust Management Team Report (*Information*)
18. Quality and Risk Management Committee (*Information*)
19. Any Other Business
20. **Date of Next Meeting**  
   Thursday 30 November 2017, 12.30pm, Learning and Research Centre, Southmead Hospital

### Quality and Performance

- Patient Story (*Information*)
- Emergency Care Improvement Plan (Approval)
- Monthly Integrated Performance Report *including Finance Report* (*Information*)
- Internal Winter Plan (Approval)
- Annual Complaints Report (*Information*)
- Adult Safeguarding Annual Report (Approval)
- Children’s Safeguarding Annual Report (Approval)

### Strategy and Development

- Sustainable Development Management Plan (Adoption)
- Capital Planning Report (*Information*)

### Governance and Assurance

- Workforce Committee Report (*Information*)
- Trust Management Team Report (*Information*)
- Quality and Risk Management Committee (*Information*)
Minutes of the Trust Board Meeting held in public on 27 July 2017 in Seminar Room 5, Learning and Research Building, Southmead Hospital

Present:

Mr P Rilett Non-Executive Director (Chairman) Ms A Young Chief Executive
Ms J Davis Non-Executive Director Dr C Burton Medical Director
Mr J Everitt Non-Executive Director Mr N Darvill Director of Informatics
Mr T Gregory Non-Executive Director Ms J Fergusson Director of People and Transformation
Mr R Mould Non-Executive Director Ms K Hannam Director of Operations
Dr E Redfern Non-Executive Director Mr S Jones Director of Nursing
Mr S Wood Director of Facilities

In Attendance:

Ms S Barber Mental Health and Bereavement Specialist Mr N Prosser General Manager, Anaesthesia, Surgery, Critical Care and Renal Trust Secretary
Mrs S Chappell Former Patient (until item 7/04) Mr E Sanders Deputy Director of Research (for item 7/02)
Mr M Dixon Head of Programme Management Office Dr R Smith Deputy Director of Research (for item 7/02)
Mr S Lightbown Director of Communications Mr N Stibbs Corporate Services Manager
Ms N Mowatt Director of Operational Finance Prof D Wynick Joint Director of Research (for item 7/02)

Apologies: Prof J Iredale, Non-Executive Director, Mrs C Phillips, Director of Finance

Observers: Three staff members and seven members of the public.

Action

TB/17/07/01 Welcome

The Chairman welcomed Mr Tim Gregory, Non-Executive Director, to his first meeting as a non-executive director.

TB/17/07/02 Research and Innovation Strategy

Rebecca Smith, Deputy Director of Research, and Professor David Wynick, Joint Director of Research, presented the Trust’s Research Strategy for 2017 to 2022 and highlighted:

- The large number and breadth of research studies (591 active this year) available to patients covering every division
- A desire to put patients at the heart of research and to deliver what is important to them by making them part of decision making groups
- Having a highly skilled and centralised staff with career pathways
- The desire to increase patient, public and staff awareness and to demonstrate the links between research evidence and clinical practice
- The focus of research on improving clinical services
- The identification of strengths and the aim to increase collaborative work with regional partners
She said that the strategy had a detailed delivery plan which had been developed by all the research teams. There were focussed and achievable yearly objectives. External funding and income generation was to increase. Year 1 priorities were:

- Maximise public and patient involvement
- Increase research opportunities and patient satisfaction
- Attain the next level of Investors in People award and develop a strategy for research careers
- Raise the profile of research and align grants with clinical and strategic priorities
- Support greater collaboration across the region

Years 2 to 5 priorities were:

- Improve equity of access across the West of England and the dissemination of research outcomes to patients
- Introduce succession planning and develop training and support for volunteers
- Publicise NBT expertise and implementation of research outcomes
- Develop a profile as leaders in research management

David Wynick, Joint Director of Research, stated that he considered the Research Department had done exceedingly well in the last five years. It was currently managing £30m worth of grants awarded to deliver new programmes of research. With University Hospitals Bristol the city received the seventh largest grant income in the country.

Chris Burton, Medical Director, speaking on behalf of Prof John Iredale, Non-Executive Director, who had reviewed the strategy, said that working with partners was one of the most important aspects of it and especially supporting professionals to become researchers.

Jaki Davis, Non-Executive Director, questioned whether research was going on about avoiding admissions with local authorities and commissioners. David Wynick said that research with outside organisations was undertaken through Bristol Health Partners and, in particular, by the Health Integration Teams for which the Trust provided the evidence base that underpinned the patient pathways and one of these was for frail patients. Sue Jones, Director of Nursing and Quality, commended the use of patient and public involvement and felt that the hospital could use this a great deal more as well and Peter Rilett, Chairman, considered that everyone needed to be able to read more about how research affected inpatients.

The Board approved the Research Strategy.

**Patient Story**

Sue Jones introduced Sasha Barber, Mental Health and Bereavement Specialist and Sara Chappell who had recently had a baby at Southmead.

Sara Chappell said that she had always suffered from self-diagnosed hypochondria but had managed to control it until the birth of her first child. The birth at St Michaels had mainly been a good experience but she had woken one morning about four and a half weeks after the birth
with an intense feeling that her child was being contaminated by asbestos in the house. It meant that she was unable to sleep and unable to live at her home. She spent two weeks at the mother and baby unit at Southmead suffering from severe depression and ten months in and out of the unit trying five different medicines. It nearly broke her marriage and meant her parents had to be with her on a daily basis. The right medication was found after six months but the whole family had continued to require help for the next four years.

Sara said that when she became pregnant for the second time she was living on a farm where her contamination obsessive nature was a constant worry. Referred this time to Southmead she had met Sasha Barber who she felt was a massive credit to the hospital. Sasha had been very responsive to her needs and had always visited, acted or responded in some manner within twelve hours of a request. She had arranged for an extra scan and a consultation with an obstetrician and had overseen the pregnancy without medication. They had jointly drawn up a birth plan and Sasha had briefed all the staff about her condition, some 25 to 30 of them, who were involved in the induction in a private room. She had gone back on to medication immediately after birth. At first she had been unable at times to be with her husband in the same room but Sasha had shown that with individual care she had enabled her to find all the answers from within herself.

Sasha Barber reported that she received about 60 referrals a month and made home visits during weekdays. Some of these patients required just a one-off consultation and others a weekly visit. A business case was being drawn up for a new perinatal mental health team and an emotional well being health plan developed.

The Board thanked Sara Chappell for being willing to share her emotional experiences and to Sasha Barber for her support.

TB17/07/04 Declarations of Interest
No interests were declared in the papers presented.

TB/17/07/05 Questions from Members of the Public
There were no questions from members of the public.

TB/17/07/06 Minutes of the Trust Board meeting held on 25 May 2017
The minutes were approved as a true and correct record of the meeting subject to amendment of Minute 17/5/16 and the first sentence of the second paragraph to read ‘… Director, remarked how well the IM&T team had combatted the cyber attack and ….‘.

TB/17/07/07 Action Log and Matters Arising
The Trust Board approved the closure of actions as stated on the action log.

The Board noted that it retained its database of nearly 15,000 prospective foundation trust members and they were occasionally sent updates of events regarding the Trust.

Referring to the ongoing overnight closure of the Weston Emergency Department, Kate Hannam, Director of Operations, reported that all the
proposed mitigations had been implemented and in a little over three
weeks the Trust had seen an extra 50 patients. This was less than had
been predicted.

TB/17/7/08 Chairman's Report
Peter Rilett, Chairman, said that he had nothing to report that was not
already on the agenda.

TB/17/7/09 Chief Executive’s Report
Andrea Young, Chief Executive, referred to her written report and
highlighted three issues:
  • the latest General Medical Council survey of junior doctors
    showed that those at North Bristol were the most satisfied in the
    region in relation to the quality of education and training they
    received. The Trust had welcomed 100 new foundation year
    one doctors that week;
  • the Trust had held its annual public meeting on 20 July attended
    by over 40 members of the public and staff and, as well as the
    reports on quality, operations and finance, there had been
    presentations from enthusiastic staff on the introduction of
    Schwartz Rounds and the quality and safety improvements in
    the Emergency Department;
  • thanks to the work of the 8,000 staff in the Trust, NHS
    Improvement had confirmed early in July that the Trust had
    been released from financial special measures.

TB/17/7/10 Integrated Performance Report
Andrea Young introduced the monthly Integrated Performance Report
(IPR) and highlighted four issues:
  • the four hour Accident and Emergency performance had
    improved marginally over the position in May but attendances
    remained higher than the previous year. Breaches were due
    mainly to shortfalls in workforce numbers in the Emergency
    Department and some for lack of available beds to admit. The
    latter was expected to improve;
  • the agreed recovery trajectory for referral to treatment (RTT)
    times had been achieved again with a backlog of 90 less
    patients than agreed;
  • only four of the Cancer targets had been met in May with 62 day
    breaches due to late referrals, lack of capacity and complex
    diagnostics in urology. Breaches in the two week urgent GP
    referral standard were due to a demand and capacity imbalance
    in skin and breast patients and was expected to be the only
    standard to be breached in June;
  • bed pressures remained very high with delays occurring to
    discharges and high numbers of admissions.

Referring to the ED, Kate Hannam reported that June had seen an
increase in mental health attendances and a much increased
proportion of them breaching the four hour target because of delays in
mental health expertise. The Director of Operations at Avon and
Wiltshire Mental Health Partnership (AWP) was to meet with the ED
team to discuss the issues.
She said that there was much hard work going into the achievement of the RTT trajectory towards the target of 92% of patients waiting less than 18 weeks and also the reduction in patients waiting over a year. Patients approaching the year’s threshold were being offered two or three appointments. There was underperformance in the diagnostic waiting times in June attributed particularly to DEXA scans (bone density) due to a prolonged period of staffing shortage and it was predicted to continue to underperform, along with endoscopy procedures, for the immediate future.

Kate Hannam said that the hospital was running at over 100% capacity driven by a 7% increase in emergency admissions and high ED attendances. There was a slight reduction in stranded patients (those in hospital over 7 days) and work was ongoing with the national Emergency Care Improvement Programme (ECIP) team to identify what a good system to improve patient flow should look like. There were currently 72 patients occupying beds due to external issues particularly those whose residence was in South Gloucestershire. Peter Rilett questioned whether the closure of the Yate minor injuries unit out of hours had any influence on ED attendances and Kate Hannam said that there was little evidence for this.

Liz Redfern, Non-Executive Director, noted the high number of breaches in the two week wait for urgent cancer referrals particularly for potential skin cancers and questioned whether this was a capacity and recruitment issue. Kate Hannam reported that there were medical vacancies but the new junior doctors were due in post shortly and the division had been asked to flex its capacity with the demand. Chris Burton said that the commissioners had also been asked to look at the patient pathway to prevent excessive referrals. Kate Hannam acknowledged Liz Redfern’s query about patient choice affecting the performance and said that this type of breach would be investigated.

Jaki Davis, Non-Executive Director, referred to the charts on ED performance and questioned what it told the Board. Kate Hannam said that ECIP was focussing on how the ED workforce was deployed and had suggested that an additional consultant be put on duty on a Saturday. They considered that systems and processes at ward level were at varying degrees of efficiency for pulling patients from ED and would challenge some of the issues that were making complex discharges difficult. It was also their view that whilst occupancy was above 92% ED was unlikely to achieve the four hour target. Sue Jones said that the Trust needed to concentrate on red to green issues and the safety bundle at ward level and a new 90 day swift improvement programme could be undertaken. Andrea Young noted that much improvement work was being undertaken in the current Reset operation. The executives were discussing with clinicians the ten high impact areas of best clinical practice and to improve access the availability of nursing home beds was being explored.

Referring to the Safety section, Sue Jones noted:

- that the number of Neonatal Intensive Care Unit (NICU) cots had been reduced by between four and six to meet the British Association of Perinatal Medicine standards for safe staffing following the rejection of a business case for an increase in
staff numbers by Specialist Commissioning;

- a never event of a wrong size implant in a hip replacement had been reported and safety alerts had been issued;
- a grade 3 pressure ulcer had been experienced in June and the Royal United Hospital (RUH), Bath, practice of an immersion event to reduce Grade 2 ulcers was to be introduced. Awards would be given to wards with the greatest number of months since their last Grade 2 pressure ulcer event.

Liz Redfern asked where the babies that would use the NICU had gone and Sue Jones said that it was more a question of a requirement for the transfer of midwives.

Chris Burton noted that incidents in Medicines remained unchanged in their level and type with no major incidents. The incidence of Methicillin Resistant Staphylococcus Aureus was still of concern and NHS England (NHSE) representatives had been asked to visit and look particularly at the Trust's processes around indwelling catheters. The data on mortality rates showed the Trust had returned to its very low rate. Liz Redfern commented that it was extraordinary that quality and safety had remained high despite the pressures.

The Research and Innovation statistics showed that the Trust was finding the 70 day target to initiate studies and recruitment of patients to time and target challenging but Chris Burton pointed out that no Trust was able to reach the standards overall.

The Board noted that the number of overdue complaints had risen to 46 in June although this had been reduced in early July. Sue Jones said that she was meeting with Heads of Nursing fortnightly to secure improvements to reach the overall target of less than ten overdue complaints by early September. Liz Redfern asked that the Workforce Committee discuss ways of making achievement of this target sustainable.

Jacolyn Fergusson, Director of People and Transformation, highlighted from the Well Led section that:

- the second development centre on Service Line Management had taken place in July to help divisions achieve action plans and set their strategy;
- the vacancy factor had risen in June when the Trust was looking to reduce it by half by the end of the year;
- Long term sickness had reduced slightly but short term had risen slightly. A paper proposing some health and well being actions was to be considered by executives and would be develop into a business case.

Liz Redfern questioned whether exit interviews were informing the Trust of reasons for leaving and Jacolyn Fergusson said that they were not. Factors such as automatic rotation of jobs were being considered to help retention of staff. John Everitt, Non-Executive Director asked whether the exit of Britain from the European Union (EU) was having any affect or if any forecast had been made. Liz Redfern reported that the Workforce Committee was reviewing the issue regularly and the EU
staff had been identified. The amount of nurses coming into the NHS from the rest of the world had decreased but this was felt to be a result of the new language standards introduced by the Department of Health.

Tim Gregory, Non-Executive Director, asked if the increase in vacancies was in clinical support areas and if the Trust had modelled what was the right level. Jacolyn Fergusson said that heat maps had been produced showing the areas with the greatest issues about vacancies, recruitment and retention and they were Theatres and Medirooms. She noted that the first Spanish nurses to be appointed were now about to qualify for their registration in Britain.

Nicky Mowatt, Director of Operational Finance, reported that the Trust had recorded a deficit of £7.3 million to the end of June compare to a planned deficit of £7.6m. This included income that was adverse to plan by £600k and pay and non-pay that were favourable to plan by £900k. Of concern was the level of elective activity income and of savings. Elective income was particularly low compared to plan in orthopaedics. Andrea Young noted that the first quarter figures already included the use of some contingency funds.

The Board discussed the compliance statements and agreed that because of the risks around the accident and emergency target a negative response should be continued for the agreement to meet all targets and the matter reconsidered at the September meeting.

TB/17/7/11 Safe Nurse Staffing

Sue Jones, Director of Nursing, presented the six monthly assurance report to the Board on the Trust’s position against the National Quality Board (NQB) expectations, National Institute for Clinical Excellence guidance and NHS Improvement (NHSI) recommendations for safe nurse staffing. She said that the NQB had updated its expectations in July 2016 and NHSI had issued an improvement resource to support the NQB expectations in adult inpatient wards.

She noted that the report now included trend data and over the past six months there had been a focus on activity to recruit registered and non-registered nurses. Retention programmes were also being developed within divisions including rotational posts and a Trust-wide staff engagement plan. Use of a ‘Happy App’ was being led by Theatres and Mediroom staff and an action plan was being developed following a masterclass from NHSI in June on retention.

The highest incident reporting areas of safe staffing incidents were in Medicine and Women’s and Children’s. Staff in Medicine were moved for short periods of time when there were increased numbers of patients and an escalation process introduced in NICU that required senior non ward based staff to respond at short notice. Sue Jones also noted that a series of ward moves had taken place in November 2016 which had had implications for skill mix and these were being managed closely and an acuity tool used to assess the appropriate staffing levels. In addition the Intensive Care Unit had increased to 46 beds. Liz Redfern reported that a new dashboard on staffing was being reported to the Workforce Committee and it would have to develop in...
line with national requirements. The Committee had also looked carefully at the assurance of safe nurse staffing levels for inpatient bed occupancy that was often over 100%.

The Board noted the report.

**TB/17/7/12 Medical Revalidation and Appraisal Annual Report**

Chris Burton, Medical Director, introduced a report on an audit of the Trust's progress with revalidation of doctors within its employment. The paper described the governance arrangements and the medical appraisal in 2016/17 and the Annual Organisational Audit of the 636 doctors declared as its employers, 25 doctors who were Sirona employees and nine doctors who were connected to another prescribed body but who completed appraisals at North Bristol. The report referred to the revalidation recommendations, monitoring of performance, the Trust's response to concerns and remediation, recruitment and background checks and the risks, concerns and corrective actions.

He said that very few staff were currently being revalidated because of the timing and those that were, were usually temporary staff with whom it was more difficult to maintain communications. Jaki Davis, Non-Executive Director, questioned why the Trust was responsible for Sirona staff and Chris Burton said that these were staff who had transferred to Sirona with the Community Child Health Partnership from NBT in April 2016 and for whom there was no medical director. He was accountable for ensuring they went through the revalidation process.

The Board noted the report and agreed it provided adequate assurance for the Statement of Compliance to be signed and returned to NHSE. CB

**TB/17/7/13 Nursing and Midwifery Revalidation Annual Report**

The Trust Board noted a report presented by Sue Jones, Director of Nursing, giving assurance on the Trust's processes for ensuring and supporting the revalidation of nurses and midwives in its employment. Liz Redfern said that in future this report could be reviewed by the Workforce Committee. ES

**TB/17/7/14 Quality Account 2016/17**

The Board noted the final Quality Account for 2016/17 which it had formally approved at its private meeting in June in order to meet the national deadline for publication.

**TB/17/7/15 Strategy Implementation Review**

Chris Burton, Medical Director, presented a review of the first year of the implementation of the Trust's strategy. He said that the imposition of financial special measures after the approval of the strategy had impacted on the delivery of a number of actions hence the high level of amber actions where work was taking place but had yet to reach full implementation.

Andrea Young, Chief Executive, noted that the post of Associate Director of Strategy would be filled in August 2017 and this report should be part of a six month overall review and to inform the following year’s Business Plan. Peter Rilett agreed that the next strategy look
back should be used as the context for the 2018/19 Business Plan. The Trust Board noted the report.

**TB/17/7/16 Bath Dialysis Unit**

Simon Wood, Director of Facilities, presented an update on the future location of the Bath Dialysis Unit, currently sited on the RUH, Bath, site. He reminded the Board that the RUH wished to redevelop the area occupied by the Unit and demolish the building in May 2019 in order to make way for a new Cancer Centre. The preferred alternative option was now to use part of Hillview Lodge also on the RUH site and currently owned by AWP. AWP executives supported the potential lease.

Peter Rilett, Chairman, asked if the building could be converted easily and Simon Wood said it was considered suitable for refurbishment and capable of being completed and ready for occupation by March 2019. Jaki Davis, Non-Executive Director, said that the Board would require clarity in the outline business case (OBC) on the size of the unit and the time that commissioners would be prepared to fund additional places. Simon Wood said that the commissioners supported the move and size of the plan.

Tim Gregory, Non-Executive Director noted that the programme had a tight timetable and asked what contingency plans there were if they were not attainable. Simon Wood said that there was no formal contingency but that the RUH executives understood the issues and AWP were the freeholders of the building.

The Board approved work to progress agreement on heads of terms with AWP for the use of Hillview Lodge and to receive an OBC in November 2017.

**TB/17/7/17 Capital Planning Report**

Simon Wood presented the monthly Capital Planning Report and highlighted the following:

- PFI completion had been delayed because of the asbestos removal issues and construction works would not be complete until May 2018 and tree planting until November 2018;
- Frenchay Park House sale completion had now been achieved;
- The Carillion manager who had joined the PFI project at a particularly difficult time was about to move on. She had written the contract between the organisations and had enormously helped to foster good relations. Her successor was her deputy who had good experience.

The Trust Board noted the report.

**TB/17/7/18 Quality and Risk Management Committee Report**

Liz Redfern, Committee Chairman, presented a report from the meeting of the Quality and Risk Management Committee held on 20 July 2017. She highlighted the review of arrangements made to ensure the safety of patients when the hospital bed occupancy was over 100% and the audit report on the Deprivation of Liberty standards processes. A
further report on the actions being taken and their implementation had been requested for the November meeting.

The Trust Board noted the report.

**TB/17/7/19 Trust Management Team Report**

Andrea Young, Chief Executive, presented the report of the meeting of the Trust Management Team held on 19 July 2017. She noted that the Team had concentrated on the new CQC inspection regime and how divisions were to prepare for the next inspection and on plans to address the potential shortfall of beds over the winter of 2017/18. A target of achieving a bed occupancy of 95% over the Winter had been agreed.

The Trust Board noted the report.

**TB/17/7/20 West of England Academic Health Science Network Report**

The Board note the fifteenth quarterly report from the West of England Health Science Network. Andrea Young said that the Network had received a licence to operate for a further five years and was considered to have made a good impact on patient care.

**TB/17/7/21 Date of Next Meeting**

The next meeting was to be held on Thursday 28 September 2017 at 12.30 pm in Seminar Room 5, Learning and Research Centre, Southmead Hospital.
<table>
<thead>
<tr>
<th>Meeting Date</th>
<th>Minute Ref</th>
<th>Action No.</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>FT membership to be engaged in ST Plans</td>
<td>SL</td>
<td>27-Jul-17 &amp; 30-Nov-17</td>
<td>O</td>
<td>Plans to be updated and awaiting governance arrangements</td>
</tr>
<tr>
<td>30-Mar-17</td>
<td>TB/17/3/08</td>
<td>5</td>
<td>Research Strategy to be presented by Director of Research</td>
<td>CB</td>
<td>27-Jul-17</td>
<td>C</td>
<td>Approved at July meeting</td>
</tr>
<tr>
<td>30-Mar-17</td>
<td>TB/17/3/18</td>
<td>8</td>
<td>Succession planning to be discussed in detail by Workforce Committee and then Board report for September</td>
<td>AY</td>
<td>28-Sep-17</td>
<td>C</td>
<td>Discussed at August meeting of Workforce Committee and agreed that immediate issues have been mitigated</td>
</tr>
<tr>
<td>25-May-17</td>
<td>TB/17/5/05</td>
<td>9</td>
<td>Full report on plans for Bath Dialysis Unit to Board in July</td>
<td>SW</td>
<td>27-Jul-17</td>
<td>C</td>
<td>Discussed at July meeting</td>
</tr>
<tr>
<td>25-May-17</td>
<td>TB/17/5/08</td>
<td>10</td>
<td>Stranded patients' data to be added to IPR</td>
<td>KH</td>
<td>27-Jul-17</td>
<td>C</td>
<td>Completed</td>
</tr>
<tr>
<td>27-Jul-17</td>
<td>TB/17/7/10</td>
<td>12</td>
<td>Kate Hannam to investigate any pattern in patient choice to wait for operations/treatment</td>
<td>KH</td>
<td>30-Nov-17</td>
<td>O</td>
<td></td>
</tr>
<tr>
<td>27-Jul-17</td>
<td>TB/17/7/10</td>
<td>13</td>
<td>Sustainability of complaints actions to be investigated by Quality &amp; Risk Management Committee</td>
<td>SJ</td>
<td>30-Nov-17</td>
<td>O</td>
<td></td>
</tr>
<tr>
<td>27-Jul-17</td>
<td>TB/17/7/10</td>
<td>14</td>
<td>Compliance statement on achieving targets to be reconsidered after latest September ED figures</td>
<td>AY</td>
<td>28-Sep-17</td>
<td>A</td>
<td>Item 8</td>
</tr>
<tr>
<td>27-Jul-17</td>
<td>TB/17/15</td>
<td>15</td>
<td>Look back on achievement of 2017/18 strategic priorities to be noted with business plan for 2018/19</td>
<td>CB</td>
<td>01-Mar-18</td>
<td>O</td>
<td></td>
</tr>
<tr>
<td>Meeting Date</td>
<td>Minute Ref</td>
<td>No.</td>
<td>Decision</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>
</tr>
<tr>
<td>26/1/17</td>
<td>17/1/11</td>
<td>1</td>
<td>Operational Plan 2017/18 and 2018/19 approved with minor changes regarding e-rostering</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>26/1/17</td>
<td>17/1/16</td>
<td>2</td>
<td>Revised Standing Orders approved</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>26/1/17</td>
<td>17/1/17</td>
<td>3</td>
<td>Transfer of charitable Toy and Communications Aids Fund to Claremont School and charitable funds in respect of the Riverside Unit to Avon and Wiltshire Mental Health Partnership approved</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>30/3/17</td>
<td>17/3/13</td>
<td>4</td>
<td>Sustainable Development Policy adopted</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>30/3/17</td>
<td>17/3/16</td>
<td>5</td>
<td>Charity Funds Committee revised terms of reference approved</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>30/3/17</td>
<td>17/3/18</td>
<td>6</td>
<td>Annual Cycle of Business approved with two additions</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>25/5/17</td>
<td>17/5/13</td>
<td>7</td>
<td>Self-Certification of all provider licence conditions approved</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>25/5/17</td>
<td>17/5/14</td>
<td>8</td>
<td>Q&amp;RMC terms of reference revisions approved</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>27/7/17</td>
<td>17/7/15</td>
<td>9</td>
<td>R&amp;NC terms of reference revisions approved</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>27/7/17</td>
<td>17/7/02</td>
<td>10</td>
<td>Research Strategy approved</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>27/7/17</td>
<td>17/7/12</td>
<td>11</td>
<td>Statement of Compliance on medical revalidation and appraisals agreed for signature</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>27/7/17</td>
<td>17/7/16</td>
<td>12</td>
<td>Agreement given for heads of terms to be agreed with AWP for use of Hillview Lodge</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

13  
14  
15
<table>
<thead>
<tr>
<th>Report to:</th>
<th>Trust Board</th>
<th>Agenda item:</th>
<th>6</th>
</tr>
</thead>
<tbody>
<tr>
<td>Date of Meeting:</td>
<td>28 September 2017</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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

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

**Prepared by:** Eric Sanders, Trust Secretary  
**Executive Sponsor (presenting):** Andrea Young, Chief Executive  
**Appendices (list if applicable):** None

**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. NHS Improvement - A&E Improvement Event
3.1. The Chief Executive and Trust Chairman attended an A&E improvement event held on 18 September 2017. The Trust was invited, alongside approximately 20 other Trusts, who have been challenged in meeting the national 4 Hour A&E target this year.
3.2. It was confirmed that the national priorities for NHS delivery are the 4 Hour A&E standard, delivery of the 62 day cancer standard and meeting financial control totals.
3.3. The Trust is meeting the financial control total target and the cancer standard, but will continue to ensure delivery is sustained.
3.4. To support delivery of the A&E target, a rapid improvement plan has been developed, alongside a six month plan to reduce the number of stranded patients and thus improve flow. This will support sustainable delivery of the A&E target by ensuring bed capacity for patients to move into from the Emergency Department.

4. Trust Chairman Recruitment
4.1. The panel interview to fill the Trust Chairman role occurred on Monday 25 September 2017. The panel comprised Sarah Harkness, Non-Executive Director of NHS Improvement, Richard Crompton, Chair of Plymouth Hospitals NHS Trust and Jennifer Howells, Joint Director for NHS Improvement and NHS Improvement (South). This is an NHSI managed and led process.
4.2. The outcome of the interview will not be known for several weeks to allow NHS Improvement to follow their internal governance processes. A communication will be issued once the outcome is confirmed. There was good engagement from internal and external stakeholders in focus groups with anonymised feedback given to NHSI for the panel.

5. Trust Board Development Day
5.1. The Trust Board was joined by Chris Ham, Chief Executive from The Kings Fund, to consider national developments in systems working and to help the Board consider where and how best to make it’s contribution into the Bristol, North Somerset and South Gloucestershire Sustainability and Transformation Partnership.

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. Award for Developments in Rheumatology Therapy

6.1. Rheumatology specialist pharmacist Emily Rose-Parfitt has been recognised for developing services for biologic therapy in rheumatology.

6.2. Emily was awarded the Royal Pharmaceutical Society's Innovation in Quality Practice Award for her developments in improving the use of biologic medicines for patients with inflammatory arthritis.

6.3. Her work also involves biosimilar implementation and a new dose reduction program, ‘Biologics Treatment Reduction by Interval Management (B-TRIM)’. This best practice has been shared across the region.

6.4. Emily’s work was supported by a cost comparator tool, and the biosimilar implementation and the B-TRIM program have since made significant financial savings.

6.5. In 2015 Emily won the national I Love My Pharmacist Award, which recognises pharmacists who go above and beyond the call of duty in the name of excellent patient care. She has showcased her work at a number of conferences and will be presenting at the Hospital Pharmacy Europe conference in November to help share best practice.

6.6. Emily has also been involved in a qualitative research study looking at patient perspectives on dose reduction, and has been invited to present a session at the British Society for Rheumatology’s conference next spring.

7. HSJ Award Shortlist - Improving Environmental and Social Sustainability

7.1. The Trust has been shortlisted for our commitment to improving environmental and social sustainability as part of Southmead Hospital’s re-development and the Brunel building.

7.2. The Brunel building was named the best designed large hospital internationally at the European Healthcare Design Awards earlier this year. Inspired by a Norwegian hospital, the Brunel building utilises natural light, bringing the outside indoors.

7.3. The HSJ Awards celebrate and promote the finest achievements in NHS. The shortlisting for Improving Environmental and Social Sustainability recognised a number of features in the Brunel building including the design positioned to minimise heat loss, a sustainable urban drainage system, bespoke rainwater recycling facility, an award-winning travel plan and green features throughout the site.

7.4. We will find out if we have been successful at the awards ceremony in London in November later this year.

8. Virtual tours launched for Cossham Hospital and Southmead Hospital’s Maternity unit
8.1. Two new virtual tours funded by Southmead Hospital Charity donors have been launched and are available to view online.

8.2. The tours allow users to step inside Southmead Hospital's Maternity unit and Cossham Hospital. The tours provide the opportunity for patients to familiarise themselves with the buildings in advance of a visit, giving them confidence and reassurance before they leave home.

8.3. Patients are able to virtually explore the central delivery suite at Southmead Hospital's Maternity unit, allowing them to see inside the delivery rooms and family areas. The Cossham tour takes visitors through the main entrance and along all levels of the building, including the dialysis room, imaging, and the Birth Centre, allowing expectant parents to have a look at the Geranium, Lavender and Jasmin birthing rooms.

8.4. You can view the tours at:
www.nbt.nhs.uk/insidesouthmeadmaternity
www.nbt.nhs.uk/insidecossham

9. Harmonising and Improving Bereavement Care Research

9.1. Dr Danya Baklbakhi, academic clinical fellow in Obstetrics and Gynaecology at the University of Bristol and Southmead Hospital, has been awarded £367,000 for a National Institute for Health Research [NIHR] Doctoral Research Fellowship to investigate outcomes after stillbirth.

9.2. Dr Baklbakhi has already carried out a pilot research project, hosted and funded by North Bristol NHS Trust alongside a grant from Southmead Hospital Charity. This preliminary research will help feed into the main project, named 'ICHOOSE'.

9.3. Every year stillbirth affects over 3,000 women in the United Kingdom. The loss of a baby has many effects on parents and their families in the short and long term, including poor health, depression, alcohol and drug use, unemployment and can have a significant negative impact on subsequent pregnancies. Research is needed to investigate effective interventions.

9.4. Dr Baklbakhi will develop a Core Outcome Set and identify outcome measurement tools for care (interventions) after stillbirth; as part of an international collaboration with the University of Bristol, the University of Oxford, the University of Adelaide, the University of Queensland, the Stillbirth and Neonatal Death Charity (Sands) and the COMET and CROWN initiatives.

10. Refurbished Bereavement Suite Opened in Southmead Hospital's Maternity Unit

10.1. The bereavement suite at Southmead Hospital's maternity unit has been refurbished thanks to support from Bristol Sands. The local branch of the Stillbirth and Neonatal Death Charity raised just over £14,000 this year for the refurbishment of the Maple Suite.

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.
10.2. The Maple Suite is a dedicated space for women whose babies are lost either before, during or shortly after birth so that they can give birth to their baby and spend time with them.

10.3. Every effort has been made to make the rooms as pleasant as possible for couples going through a stillbirth. But working with the Bristol branch of SANDS (the Stillbirth and Neonatal Death Charity) and Southmead Hospital Charity, work is being carried out to refurbish the rooms to improve the experience of women and their partners during labour and the time immediately after birth.

10.4. The suite allows both parents to stay for as long as they need, with en-suite facilities and simple fixtures that mean there is no need to leave the room once there; reducing the risk of being confronted with other deliveries and new babies.

10.5. Bristol Sands received numerous donations and contributions towards their fundraising, however the main contributions came from sponsorship raised by Rachael Senneck and Jenny Bowcher who ran the London Marathon in April.

10.6. They also received a donation of £5,000 raised by the customers and staff at the M&S branch in Broadmead Bristol and funds from the Portishead branch of Waitrose and employee benefits provider, Unum Ltd.

11. Rotary Club Donation

11.1. The Rotary Club of Bristol Breakfast has donated a very generous £24,300 to us. The Trust was chosen as the main beneficiary of the Club’s Dragon Boat Festival this year, and the money received will go towards our Prostate Cancer Care Appeal.

12. Recommendations

12.1. The Trust Board is asked to note the content of the report.
Report to: Trust Board  
Date of Meeting: 28 September 2017

<table>
<thead>
<tr>
<th>Report Title:</th>
<th>Integrated Performance Report (IPR)</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>Lisa Whitlow, Associate Director of Performance and Sustainability</td>
</tr>
<tr>
<td>Executive Sponsor (presenting):</td>
<td>Executive Team</td>
</tr>
<tr>
<td>Appendices (list if applicable):</td>
<td>IPR</td>
</tr>
</tbody>
</table>

**Recommendation:**

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

**Executive Summary:**

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.
North Bristol NHS Trust

INTEGRATED PERFORMANCE REPORT
September 2017
(presenting August 2017 data)
ACCESS
Overall July performance against the four hour target was 73.16%, a 2.54% decrease to July’s position. The majority of break reasons were ED attributable, followed by a wait for beds. The Trust has commenced a 6 week rapid improvement programme with the aim of achieving 90% by the end of October and hitting 95% by the end of Quarter 4.
The Trust has not met the agreed recovery trajectory for Referral To Treatment (RTT) incomplete performance for August (86.73% vs trajectory of 87.10%). The waiting list backlog stands at 3804 vs a target of 3669. This is the first time in 2017/18 that the Trust has failed to meet its recovery trajectory. The Trust continues to experience an increase in patients waiting greater than 52 weeks from Referral to Treatment (RTT) (111 in August). The main reasons for these breaches are lack of capacity for Upper Limb operations and patients choosing to defer their treatment.
The Trust has failed to achieve the national target (1.00%) for diagnostic performance with actual performance of 5.72% in August. In the main, underperformance relates to ongoing staff shortages in Endoscopy and backlog clearance in DEXA Scans. Endoscopy performance is predicted to improve in September and the DEXA Scan backlog should be cleared by the end of November.
The Trust has delivered 6 of the 7 national cancer targets in July. The 62 day standard was exceeded in July with performance at 90.84% vs the 85.00% standard. There continues to be underperformance against the Two Week Wait urgent GP referrals standard, where there has been demand and capacity imbalance for skin patients in particular.

SAFETY
Nursing staff levels continue to be monitored closely, but one ward triggered the Quality Effectiveness and Safety Trigger Tool (QuESTT) in August. The Director of Midwifery/Head of Nursing is monitoring and supporting the ward area.
Harm Free Care continues to be better than the national average and is the best reported for 12 months at 95%.
Incidence of pressure ulcers in August were 19 reported Grade 2 pressure injuries, nil reported Grade 3 and nil reported at Grade 4. The Trust remains on target to achieve a 50% reduction of pressure injuries over the three year period, April 2015 - March 2018.
The Trust reported 2 cases of MRSA and 3 cases of C. Difficile in different clinical areas in August.

PATIENT EXPERIENCE
The number of complaints decreased from 47 in July to 40 in August. Concerns remain steady in August. Friends & Family response rates have seen a decrease in August 2017 in three of the four areas. The Maternity response rate increased in August to 13.24%, but remains below the national target and benchmarks. The Maternity Team is promoting feedback to mothers to encourage others to respond.
NHS Choices ratings for both Southmead Hospital and Cossham Hospital are both 4.5 stars.

WORKFORCE
The Trust vacancy factor decreased from 9.1% in July to 8.40% in August. The biggest reduction in vacancies was seen in medical staff.
The in-month turnover rate decreased in August to 1.30% which is above the target rate of 1.0%. The in-month sickness rate has increased in July to 4.36%, from 3.98% in June, and remains above the 3.7% target submitted to NHSI.

FINANCE
The Trust has planned a deficit of £18.7m for the year in line with the agreed control total with NHS Improvement. The financial position for the end of August is £1.1m adverse to plan. As of July 2017, the Trust is no longer in Financial Special Measures. The Trust is currently rated 3 by NHSI. Continued focus on delivering the full savings required, as well as full delivery of planned activity and income for the year, will be crucial to ensure delivery of the Trust’s control total.
Key / Notes

Unless noted on each graph, all data shown is for period up to, and including, 31 August 2017.

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

All target lines
All improvement trajectories

Performance improved
Performance maintained
Performance worsened
### Overview

#### Urgent Care
August’s four hour A&E performance was 73.16%. The majority of breach reasons were ED attributable, followed by a wait for beds. The Trust has been identified as one of 20 Trusts being asked to take urgent action to improve four hour performance in ED. The Trust has developed an action plan to target improvements in performance, supported by an accelerated 6 week rapid improvement plan. In partnership with the BNSSG providers and commissioners, the ambition to improve performance to delivery 90% by the end of October and 95% by the end of Quarter 4 has been set.

Delayed Transfers of Care (DTOC) has deteriorated in the month with 5.03% patients delayed against a National standard of 3.5%. The Trust continues to work with partners to accelerate the improvements required to support the Rapid Improvement Plan delivery.

#### Referral to Treatment (RTT)
In month, the Trust has not achieved the trajectory of 87.10%, with actual performance at 86.73%. This is the first month in 2017/18 that the Trust has not delivered the in month recovery trajectory. This is due to a combination of underperformance in Gastroenterology, Respiratory, Neurosurgery and T&O and ongoing data validation, which has reduced the backlog, but also the total waiting list.

At the end of August the Trust has seen a further increase in greater than 52 week waiters. The number of patients choosing to wait greater than 52 weeks for their treatment continues to be a challenge. In addition, a number of breaches have been identified due to lack of capacity in specific sub-specialties within MSK – in particular upper limb surgery. The Trust has met the recovery trajectory for Neurosurgery at the end of August at five breaches. The Epilepsy trajectory has not been met in month, but continues to be on track for clearance of all breaches by the end of Quarter 3 of 2017/18.

#### Cancelled Operations
In month, there were five breaches of the 28 day re-booking target; bringing the year to date total to eight. This is an increase on previous months, but still within recovery trajectory.

#### Diagnostic Waiting Times
The Trust has failed to achieve the 1.00% target for diagnostic performance in August with actual performance at 5.72%. August has seen an increase in Flexible Sigmoidoscopy breaches (51 July v 111 August), Colonoscopy breaches (52 July v 96 August) and Non Obstetric Ultrasound breaches (43 July v 96 August) which has adversely impacted the Trust aggregate position. DEXA scans continue to breach the standard, but clearance is expected in November.

#### Cancer
Cancer performance in July has achieved six of the seven standards. The Trust has met and exceeded the 62 day standard in July at 90.84% (Target 85.00%). Although steadily improving since April, there continues to be underperformance against the Two Week Wait urgent GP referrals standard, where there has been demand and capacity imbalance for Skin patients in particular. There are early indications that this position will be improved in September.

### Areas of Concern
The system continues to monitor the effectiveness of all actions being undertaken, with weekly and daily 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.
### Key Operational Standards Dashboard

#### August 2017

<table>
<thead>
<tr>
<th>Access Standard</th>
<th>Performance against National Target</th>
<th>NBT Trajectory</th>
<th>Performance direction of travel from last month</th>
<th>Year end forecast position</th>
</tr>
</thead>
<tbody>
<tr>
<td>Emergency Attendances &lt;4 hour standard</td>
<td>73.16%</td>
<td>90.00%</td>
<td>▼</td>
<td>95.00%</td>
</tr>
<tr>
<td>Referral to Treatment % incomplete pathways &lt;18 weeks</td>
<td>86.73%</td>
<td>87.10%</td>
<td>▼</td>
<td>88.03%</td>
</tr>
<tr>
<td>Referral to Treatment 52 Week Waits - Neurosurgery and Epilepsy</td>
<td>13</td>
<td>5</td>
<td>▼</td>
<td>0</td>
</tr>
<tr>
<td>Referral to Treatment 52 Week Waits - Other</td>
<td>98</td>
<td>0</td>
<td>▼</td>
<td>N/A</td>
</tr>
<tr>
<td>Trust Wide Referral to Treatment Backlog</td>
<td>3804</td>
<td>3669</td>
<td>▼</td>
<td>3341</td>
</tr>
<tr>
<td>Diagnostic DM01 % waiting more than 6 weeks</td>
<td>5.72%</td>
<td>N/A*</td>
<td>▼</td>
<td>1.00%</td>
</tr>
<tr>
<td>Cancelled Operations Same day - non-clinical reasons</td>
<td>1.26%</td>
<td>N/A</td>
<td>▲</td>
<td>N/A</td>
</tr>
<tr>
<td>Cancelled Operations 28 day re-booking breach</td>
<td>5</td>
<td>6</td>
<td>▼</td>
<td>N/A*</td>
</tr>
</tbody>
</table>

*Trajectories being set and awaiting internal sign off and agreement with Commissioners.*
Responsiveness
Urgent Care
Board Sponsor: Director of Operations

Overview of Urgent Care
Sustained pressure experienced within both the ED and the Trust during August resulted in a significant number of patients waiting in excess of the four hour target.

Over 93% of minors patients were treated within four hours with 57% of majors patients also receiving treatment within the four hour standard.

The Trust has been identified as one of around 20 trusts being asked to take urgent action to improve four hour performance in the Emergency Department (ED). The Trust has begun to deliver a 6 week rapid improvement plan to achieve steady and consistent improvement in performance with the ambition of achieving 90% by the end of October and hitting 95% by the end of Quarter 4. Weekly trajectories for improvement have been set.

The Trust is working with partners to accelerate existing system plans. The Trust is also taking a number of additional internal actions including: aligning ED workforce to demand profiles; setting up a Control Room as a point of escalation for resolving delays in a patients pathway; introducing a ‘breach spotter’ in ED and daily reviews of stranded patients.
Responsiveness
Urgent Care
Board Sponsor: Director of Operations

4 Hour Breaches
Patients experienced delays due to a combination of issues - workforce shortages in particular within the medical grades of ED resulting in delays in assessment; timely transfer to the assessment unit due to extremely high occupancy levels within the hospital limiting flow. Actions contained in the rapid improvement plan aim to tackle these main areas to improve performance.

12 Hour Trolley Waits
There were six 12 hour trolley breaches in August, an increase from four in July. This reflects ongoing issues with imbalance of capacity available to meet the peaks in demand of patients requiring admission. Of the six breaches, one was a mental health breach and five were NBT attributable.

Mental Health Breaches
August saw an increase in numbers of mental health attendances in the Emergency Department; 71 in August v 60 in July. The proportion of breaches attributed to mental health delays decreased in August, accounting for 69.2% of the total four hour breaches for mental health patients.
Despite a reduction in total attendances in August, the proportion of major patients presented continue to rise as demonstrated through the increase in emergency admissions in the month.
Stranded Patients
August showed an improvement in the number of patients staying over seven days, 903 v 912 in July. A decrease was also seen in the numbers of patients staying over 14 days, down from 479 in July to 456 in August.

Medically fit for discharge (MFFD) patients remain high, 311 overall across the Trust (equivalent to 36.16% of the core bed base an increase from the 35.81% reported in July 2017).
Responsiveness
Length of Stay by Division
Board Sponsor: Director of Operations

Stranded Patients - Length of Stay
Work continues to provide a focussed review of any patient tipping over seven days and an audit of patients with a LoS between seven to 14 days across all Divisions.

Each Division is targeting 2 schemes which will support reducing the total number of stranded patients by 50% within the next six months. Progress against delivery of these schemes is being managed via a programme of Executive Director led checkpoint meetings, as part of the wider Four Hour Improvement Programme governance structure.
Delayed Transfers of Care

Delayed Transfers of Care (DToC) continued to rise through August ending the month with an increased position of 5.03%. The numbers of patients recorded on LHPD has remained stable over the period.

There remain concerns with the level of social care delays which have significantly increased throughout the summer period. In addition, there have been concerns about timely assessment by care homes, with homes unable to assess whilst managers are on leave. This has been escalated to the contracts teams for resolution and will be discussed at the Care Home forums. All local authority leads have been alerted to the increases in delays.

The increase in choice delays has led to a further review of the Managing Expectations Protocol, which will ensure early information is shared with patients and carers to ensure there is a clear message that when a patient no longer requires acute care, they will be expected to leave.
Responsiveness
Bed Occupancy and Re-admissions
Board Sponsor: Director of Operations

Bed Occupancy
Bed Occupancy for August was reported at 98.67% for the month, a decrease from the 100.23% reported in July 2017. This level of occupancy exceeds the 95% occupancy set to maintain flow. Bed occupancy remains high and when escalation beds are taken into account, has been greater than 100% beds occupied.

30 day Emergency Re-admissions
Detailed analysis is being undertaken with our partners to understand if there are any opportunities to avoid patients being readmitted into NBT.

<table>
<thead>
<tr>
<th>Clinical Division</th>
<th>Occupancy</th>
</tr>
</thead>
<tbody>
<tr>
<td>ASCR</td>
<td>94.16%</td>
</tr>
<tr>
<td>Medicine</td>
<td>102.68%</td>
</tr>
<tr>
<td>NMSK</td>
<td>97.75%</td>
</tr>
<tr>
<td>W_and_C</td>
<td>89.30%</td>
</tr>
<tr>
<td>Total Occupancy</td>
<td>98.67%</td>
</tr>
</tbody>
</table>

% of Emergency Readmissions within 30 days following Elective Spell

% of Emergency Readmissions within 30 days following Non-Elective Spell
Referral to Treatment (RTT)
The Trust has not met the RTT trajectory in month with performance of 86.73%. The Trust failed to achieve the RTT backlog trajectory, reporting 3804 against trajectory of 3669. This is the first month in 2017/18 that the Trust has not delivered the in month recovery trajectory. This is due to a combination of underperformance against trajectory in a number of specialties and ongoing data validation, which has reduced the backlog, but also the total waiting list.

Trauma and Orthopaedics, Gastroenterology, Respiratory Medicine, and Neurosurgery at a specialty level failed to meet their planned recovery trajectories in month. Remedial action plans are in place to monitor progress across a number of specialties who are not meeting the constitutional standards.
Responsiveness
Elective Operations
Board Sponsor: Director of Operations

Cancellations
The same day non-clinical cancellation rate in August was 1.26% against the national target of 0.8%, down from 1.66% reported in July. The majority of cancellations (26%) relate to theatre timing issues.

In month there were two operations cancelled for a subsequent time.

The Theatres Board is overseeing the monthly performance for the Trust cancelled operations with an aim to further reduce cancellations. The Theatres Board is also overseeing a delivery plan to address theatres productivity and to introduce changes to scheduling.

In month, there were five breaches of the 28 day re-booking target. The predominant cause of this was theatre and consultant capacity.
Responsiveness
Referral to Treatment 52 week waits
Board Sponsor: Director of Operations

Referral to Treatment 52 Week Waits
The Trust has met the trajectory for Neurosurgery at the end of August reporting five breaches against a trajectory of five breaches. Whilst the Epilepsy trajectory has not been met in month, the number of breaches in August, eight, have decreased from the ten reported in April and the service remains on track to clear all >52 week waiters by the end of Quarter 3 of 2017/18.

There were a total of 111 patients waiting over 52 weeks in July:
5 Neurosurgery.
8 Epilepsy.
98 Others (patient choice; lack of capacity; pathway delays).

The number of patients choosing to wait greater than 52 weeks for their treatment continues to be a challenge with 38 patients currently choosing to defer their treatment. Root Cause Analyses have been completed for all patients, with dates for patients’ operations being agreed at the earliest opportunity in line with the patient’s choice.

In addition, a number of breaches have been identified due to lack of capacity in particular for upper limb surgery.
Responsiveness
Diagnostics
Board Sponsor: Director of Operations

Diagnostics Waiting Times
In August, the Trust underperformed against the diagnostic six week wait standard with performance of 5.72%.

Of the 13 diagnostic tests, seven have reported underperformance in August: Flexible Sigmoidoscopy; Gastroscopy; DEXA Scan; Colonoscopy; Cystoscopy; Urodynamics; and Non Obstetric Ultrasound are continuing to report below the standard this month.

The largest number of breaches were for DEXA Scans (120), which were 117 breaches above threshold for that test type.

The decline in DEXA Scan breach performance relates to a prolonged period of staffing shortages and training need within the department. This has led to a growing backlog of patients who have breached their planned test date. Recovery against the backlog is predicted to be November 2017.

Endoscopy (Colonoscopy, Flexible Sigmoidoscopy and Gastroscopy) performance is predicted to improve from September.
### Key Operational Standards Dashboard

**July 2017**  
*One Month in Arrears*

<table>
<thead>
<tr>
<th>Access Standard</th>
<th>Description</th>
<th>National Target</th>
<th>Performance against National Target</th>
<th>NBT Trajectory</th>
<th>Performance direction of travel from last month</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Patients seen within 2 weeks of urgent GP referral</td>
<td>93%</td>
<td>91.59%</td>
<td>N/A</td>
<td>▶</td>
</tr>
<tr>
<td></td>
<td>Patients with breast symptoms seen by specialist within 2 weeks</td>
<td>93%</td>
<td>94.90%</td>
<td>N/A</td>
<td>▼</td>
</tr>
<tr>
<td></td>
<td>Patients receiving first treatment within 31 days of cancer diagnosis</td>
<td>96%</td>
<td>98.30%</td>
<td>N/A</td>
<td>▶</td>
</tr>
<tr>
<td></td>
<td>Patients waiting less than 31 days for subsequent surgery</td>
<td>94%</td>
<td>95.65%</td>
<td>N/A</td>
<td>▼</td>
</tr>
<tr>
<td></td>
<td>Patients waiting less than 31 days for subsequent drug treatment</td>
<td>98%</td>
<td>100.00%</td>
<td>N/A</td>
<td>▲</td>
</tr>
<tr>
<td></td>
<td>Patients receiving first treatment within 62 days of urgent GP referral</td>
<td>85%</td>
<td>90.84%</td>
<td>85.97%</td>
<td>▶</td>
</tr>
<tr>
<td></td>
<td>Patients treated within 62 days of screening</td>
<td>90%</td>
<td>97.67%</td>
<td>N/A</td>
<td>▼</td>
</tr>
</tbody>
</table>

*Please note: Monthly positions are provisional and may not match final quarterly position.*
Responsiveness
Cancer
Board Sponsor: Director of Operations

The July 2017 cancer performance for the Trust shows the Trust met six of the seven national waiting time standards.

Whilst there was an improvement from June performance, the Trust continues to fail the Two Week Wait (TWW) standard with a performance of 91.58%. The Trust received 2045 TWW referrals in July and there were 171 breaches. 83 breaches were in Skin, 25 in Colorectal and 20 in Breast.

The increase in referral rates and failed TWW performance will continue into August 2017. TWW performance is steadily improving from the April position into September and the Trust is predicted to attain the TWW standard for October. The majority of patients that breach are offered an appointment by day 14, however these appointments can be offered at short notice and between day 12 and 14 of their pathway. Additional capacity is currently being provided within Skin and the service has made a significant improvement in performance in September.

The Trust passed the Breast non-symptomatic screening standard with a performance of 94.90%. There were five breaches in total, all due to patients being unable to attend the appointments offered.
Responsiveness
Cancer
Board Sponsor: Director of Operations

The Trust passed the 62 day national standard for July 2017 with a performance of 90.84% against the 85% target. The Trust is now being measured against the new national breach reallocation policy however there is no system for NHSE to collect this performance data as yet so the Trust has declared performance as 90.20% under the former rules.

There were 18 patients that breached in July and, of those, 13 started their pathway at NBT. Of the 13 patients, nine had their first appointment at NBT after day seven. Delays in radiology resulted in one whole breach and contributed to three others. Delays in pathology contributed to three breaches.

Five Urology patients were transferred in to the Trust from other providers for treatment in June beyond day 38 of their pathway. The Urology department managed to treat four of these patients within 24 days of transfer and this enabled the Trust to reallocate two half breaches back to the referring providers for these patients.

The Trust will be undertaking work on implementing the new National Optimal Lung Pathway over the coming months to enable improvements to performance for Lung against the 62 day standard.
Cancer

The Trust passed the 31 day first treatment performance standard with a performance of 98.30%. This is an improvement on June performance. There were four breaches in total; three in Skin and one in Urology. Two breaches were due to elective capacity, one was a medically appropriate breach and one patient was cancelled on the day of surgery.

NBT achieved the 31 day subsequent treatment targets in June 2017 for both surgical and drug treatments. The Trust also passed the 62 day screening target with a performance of 97.67%.

The Trust has appointed a band five patient pathway coordinator funded by NHSE with the purpose of reducing breaches for patients that transfer between NBT and UHB. The main focus will be on the Lung pathway and will aim to support NHSE’s aim that all trusts in the South region must pass 62 day performance in September 2017.
Quality Patient Safety & Effectiveness  
SRO: Medical Director & Director of Nursing

<table>
<thead>
<tr>
<th>Section Summary</th>
</tr>
</thead>
</table>
| **Improvements:**  
Harm free care remains above the national average and nutrition assessment is now meeting the target required. Hospital Acquired Pressure Ulcers are at the lowest level for a quarter with zero grade 3s and 19 grade 2s. |
| **Areas of Concern:**  
Cotswold Ward is the only ward triggering QuESTT. The gynaecology ward has been supporting estates work within maternity throughout the summer, this work is due to conclude within weeks.  
Agency use was higher than expected through August due to vacancies and bed capacity requirements. This has improved into September as new recruits have started. |
## Patient Safety Dashboard

<table>
<thead>
<tr>
<th>Standard (target)</th>
<th>August 2017</th>
<th>Quarterly Trend (Q4 2016/17 vs Q1 2017/18)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Performance against National Target</td>
<td>Performance direction of travel from last month</td>
</tr>
<tr>
<td>Never Event Occurrence by Month</td>
<td>0</td>
<td>1 (Q4 2016/17) - 0 (Q1 2017/18)</td>
</tr>
<tr>
<td>Safety Thermometer Overall Compliance</td>
<td>94.30%</td>
<td>92.57% (Q4 2016/17) - 93.41% (Q1 2017/18)</td>
</tr>
<tr>
<td>Malnutrition Screening</td>
<td>90.70%</td>
<td>91.04% (Q4 2016/17) - 90.04% (Q1 2017/18)</td>
</tr>
<tr>
<td>Hand Hygiene Compliance (in arrears)</td>
<td>98.00%</td>
<td>96.43% (Q4 2016/17) - 97.27% (Q1 2017/18)</td>
</tr>
<tr>
<td>MRSA</td>
<td>2</td>
<td>1 (Q4 2016/17) - 1 (Q1 2017/18)</td>
</tr>
<tr>
<td>C. Difficile</td>
<td>3</td>
<td>8 (Q4 2016/17) - 9 (Q1 2017/18)</td>
</tr>
<tr>
<td>MSSA</td>
<td>2</td>
<td>9 (Q4 2016/17) - 6 (Q1 2017/18)</td>
</tr>
<tr>
<td>Venous Thromboembolism Screening (in arrears)</td>
<td>95.26%</td>
<td>95.51% (Q4 2016/17) - 95.35% (Q1 2017/18)</td>
</tr>
</tbody>
</table>
Safe Staffing
Quality, Effectiveness & Safety Trigger Tool (QuESTT), Acuity & Dependency
Board Sponsor: Director of Nursing

QuESTT
In August there was one area of non-submission, this has been reviewed by the Head of Nursing, scored as nine and confirmed as not triggering. One ward this month has triggered for action.

Cotswold: Score 15
Actions: Recruitment is underway, new ward sister in post, managing additional maternity work in reduced bed base due to estates work. Director of Midwifery/Head of Nursing monitoring and supporting ward area score has reduced from the previous month and is expected to come under 12 next month.

Safe Care Live (Electronic Acuity tool). The acuity of patients is measured three times daily and staff are moved between Divisions to ensure safety is maintained where a significant shortfall in required hours is identified.
Data validation is continuing to ensure consistency of patient assessments by all staff. The Head of Nursing for the Medical Division is working with each ward to improve census completion.
Nursing Workforce

There remains an ongoing increase in August in over-estimation of Health Care Assistants (HCA) with a small number of over-estimation of Registered Nurses (RN).

NMSK

Increases in HCA requirements to cover enhanced care for cognitive impairment and high risk of falls.

Medicine

Staffed significant escalation areas over August and struggled with vacancies / waiting for new starters to start. Recruitment pipeline remains healthy. HCAs used to fill RN gaps and enhanced care / one-to-one instead of RMN usage.

ASCR

Increases RN/ODP’s to cover sickness in Theatres / Medirooms and also for the use of Medirooms as a bed escalation area. Increased requirement for HCAs for enhanced care and RMNs across surgical wards to ensure safety.

Actions in place:

RNs and HCAs in the pipeline due to start over the next three months to support shortfall. Cross Trust working to support areas where vacancies are increased. The agency expenditure in August increased to 4.72% from 3.89% in July, this is reflective of the increased use of both framework and non-framework agencies used to cover vacancies and to ensure safety.
Safe Staffing
Nursing Workforce
Board Sponsor: Director of Nursing

Southmead Nursing Fill Rate and CHPPD
Registered Nurses (RN) on both day and night shift and Care Assistants (CA) on days has decreased on last month in line with workforce capacity for August. The fill rate for CA on nights remained static as per last month, these hours are reflective of the enhanced care requirements across the Trust. CHPPD has increased due to the closure of a post natal ward for maintenance work with the staff being allocated to the ward but reallocated across the Division daily.

Wards below 80% fill rate are:
NICU: Reduced fill rate for CA Day. NICU staffing is monitored closely alongside cot dependency with RN’s used instead of CA’s if required. To ensure safety is maintained there has been a reduction in the number of cots by four to six, dependent on acuity.
ICU: Reduced fill rate for CA day and night shifts. Following a review of staffing the skill mix has now been formally changed which provides an increase in RNs and workforce redesign for nursing support role.
Maternity Services: Mendip Birth Suite/ Quantock/ Percy Phillips and Central Delivery Suite (CDS): There has continued to be a reduced bed base this month, therefore the shortfall for some CA shifts have not been filled with bank when not required. Safety has been maintained by moving midwives across the Division to support CDS and other areas within the Unit and Matrons working clinically when required.

Wards over 200% fill rate:
Neuro: 25a and 6b CA nights due to the enhanced care needs of patients. These are filled from the specialist team within the Division.
Gate 33a: Increased bed base of the ward due to the transfer of the Burns Clinic. This has resulted in an increase staffing requirement day and night as well as providing enhanced care and mental health care.

Aug 2017 Care Hours Per Patient Day (CHPPD)

<table>
<thead>
<tr>
<th>Area</th>
<th>Cumulative Pt.census</th>
<th>CHPPD RN</th>
<th>CHPPD CA</th>
<th>Overall</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cossham</td>
<td>52</td>
<td>24.9</td>
<td>13.6</td>
<td>38.5</td>
</tr>
<tr>
<td>Southmead</td>
<td>29132</td>
<td>4.7</td>
<td>3.4</td>
<td>8.2</td>
</tr>
</tbody>
</table>

The numbers of hours Registered Nurses (RN) / Registered Midwives (RM) and Care Assistants (CA) / Maternity Care Assistants (MCA), 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.
Safe Staffing
Maternity
Board Sponsor: Director of Nursing

This report provides information about midwifery staffing and will track occasions when the Central Delivery Suite (CDS) was unable to take admissions and why.

In August 2017 the unit closed on two occasions. This was due to a lack of beds on CDS and NICU being closed to emergency admissions.

The Midwife to birth ratio was maintained at 1:30 in August 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.

There were 506 births in August with a normal birth rate of 60.7%. Cossham Birth Centre had 35 births and Mendip Birth Centre had 68 births.

78.1% of births were on CDS, with an increase in the total births in birth centre locations from 17.1% to 20.5%.

There was a decrease in the Caesarean rate from 27.9% in July to 26.5% in August.

One to one care in labour was provided for 97.7% of women in our care.
Additional Safety Measures

Serious Incidents (SI)

6 serious incidents were reported to STEIS in August 2017:
- 3 x Delayed treatment
- 2 x Fall
- 1 x Incorrect test results

Two serious falls were identified as SIs for externally reporting through the SWARM process.

SI & Incident Reporting Rates

Incident reporting has decreased to 36 PBD. Serious incidents rate has also decreased and is now at 0.26.

Directorates:
SI Rate by 1000 Bed Days

CCS* – 1.61
WCH – 0.31
Med – 0.24
NMSK – 0.24
ASCR – 0.23

*CCS Bed Base Intentional Radiology only
Quality & Patient Safety
Additional Safety Measures
Board Sponsor: Director of Nursing

Incident Reporting Deadlines for RCA submission
Five serious incidents breached their August completion deadline for submission of Root Cause Analysis reports to commissioners, as follows:
• Medicine - 3 Breaches
• ASCR - 1 Breach
• Women and Children’s - 1 Breach

Three were subsequently submitted in August and two have since been submitted in September. The submission compliance is significantly improved to date in September. The ongoing position is reviewed at each week’s Executive Review Group and has also been escalated at the Patient Safety and Clinical Risk Committee.

There are a range of key steps in the coming months to improve our management of incidents, including the implementation of the Datix system and revised governance processes, initiation of a regular operational review group and an enhanced oversight role for the Clinical Risk Committee.

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

Top SI Types in Rolling 12 Months
Falls are the most prevalent of reported SI’s, followed by Delayed Treatment and Pressure Injuries.

Central Alerting System (CAS)
16 New alerts reported, none breaching alert target.

<table>
<thead>
<tr>
<th>CAS Alerts - August 2017</th>
<th>Patient Safety</th>
<th>Facilities</th>
<th>Medical Devices</th>
</tr>
</thead>
<tbody>
<tr>
<td>New Alerts</td>
<td>1</td>
<td>7</td>
<td>8</td>
</tr>
<tr>
<td>Closed Alerts</td>
<td>0</td>
<td>4</td>
<td>4</td>
</tr>
<tr>
<td>Open alerts (within target date)</td>
<td>1</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>Breaches of Alert target</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>
Harm Free Care

The ‘harm free’ care report now includes both overall harm free care and the new harm rates which are reflective of ‘hospital acquired harm’. This month shows an ongoing improvement to 98.3% for hospital acquired harm. This reflects a decrease in the number of hospital acquired pressure ulcers. Validation of all pressure ulcers reported on the day was undertaken with the tissue viability team.

Overall Falls

There were 211 falls in August, of which four resulted in serious injury.

These were on four separate wards, two within Neurosciences and two in Medicine. A falls audit report is currently being compiled to inform a review of the current overarching actions and plans.
Pressure Injury
Pressure injury incidence per thousand bed days observed a reduction this month at 0.6.

- Grade 4: Nil reported in August
- Grade 3: Nil reported in August
- Grade 2: 19 reported in August occurring on 19 patients.

Divisions are undertaking local Swarms for grade two pressure injuries which enable the prompt actions to lessons identified.

The Trust remains on target to achieve a 50% reduction of all pressure injuries over the three year period, in line with the target set at the outset of the national ‘Sign up to Safety’ programme.

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.

The Trust has applied for VTE exemplar centre status and the required accreditation visit date has been set for October 2017.
**Safety**

**Additional Safety Measures**

Board Sponsor: Director of Nursing

---

**Malnutrition**

Malnutrition compliance for August was 90.70%; All Divisions have achieved the target. Greatest improvement was from W&C who have undertaken targeted work with the ward teams. Weekly compliance lists continue to be sent to the Heads of Nursing to share with their teams.

---

**WHO Checklist Compliance**

Measured compliance with the WHO checklist was 95.80% in August 2017.

The WHO checklist compliance improvement programme continues to be overseen by the Theatre Board and a system is in place for reviewing the WHO safer surgery compliance by speciality and theatre to ensure we are accurately reporting against all activity.
The work of the NBT Patient Safety Medicines Management team continues but with less input due to patient flow pressures.

**Missed Doses**
The percentage of missed doses is only just within target. Recent rises are thought to be indicative of patient flow pressures and are highlighted through Heads of Nursing meetings.

**Incidents**
The Medication Safety Subgroup reviews all drug related incidents from eAIMS and includes Division representatives to improve shared learning across the hospital.

We are currently reviewing incidents linked with allergies.

**Major/Catastrophic Incidents**
One major incident is under investigation and one catastrophic incident was also investigated by RCA, externally reported and found to be unavoidable.

**Themes/Types/High risk drugs**
Common causes of incidents over the past 12 months are shown.
MRSA
There have been two reported cases of MRSA bacteraemia in August.
The Trust position remains at three in 2017/18 and ten in the past 12 months.
The cases occurred within the Medicine and NMSK Divisions. The RCAs carried out by the Multi-disciplinary teams for both of these cases has highlighted learning for continued assessment for the use of peripheral lines and the prompt blood culture sampling of a patient who presents with a presumed diagnosis of urinary sepsis.

The Trust has a remedial action plan in place will be reviewed to reflect learning from the recent cases. Work continues with the Divisions to reduce risk of further cases as agreed with commissioners and NHSI. It remains a principle work stream for the infection control annual 2017/18 programme.

C. Difficile
There have been three reported cases in August occurring within different clinical areas. The infection prevention and control team and clinical teams continue to investigate each case and review lessons learnt.
E.Coli
In May 2017 the Department of Health published national guidance on the reduction of gram negative blood stream infections. The ambition is set at a 10% reduction across the whole healthcare community for this year, with a 50% reduction by 2020. There were three reported cases of E.Coli in August, an investigation occurs for each case to establish themes and learning outcomes.

MSSA
There were two reported cases of MSSA bacteraemia in August. The RCAs for these cases are now reviewed and presented bi-monthly to ensure lessons learnt.

Hand Hygiene
The Trust Hand Hygiene compliance continues to meet the Trust standard.

Norovirus
There were no areas placed under restricted access in August.

Public Health England (PHE) Benchmarks
Data from the latest published report is shown.
The new mortality review tool called the Structured Case note Review (SCR) was launched in July 2017 and is now being used within all specialties apart from Neurosurgery. A specific SCR module will be ready for this specialty in November 2017. The Specialty will continue to use their own review system until then.

The standard is that all deaths will be reviewed either through mortality screening or full SCR within three months of the death. For this reason the data for September’s IPR only includes all deaths up until 31st May 2017.

Mortality Screening of notes has started in four specialties with a weighted sample of those screened out taken through to full SCR. A policy for Mortality Reviews will be approved at Quality Risk Management Committee on 21st September 2017.

Data on how many deaths occurred where ‘care delivery problems’ contributed, will be published in the Board report from the end of quarter 2.
The Trust hosted a MHRA GCP regulatory inspection between the 29th August and the 1st September. The inspection report is due within six weeks. The inspector has indicated the Trust will receive three major findings, which was in line with Trust expectations. In addition NBT was commended for it’s overall approach and has been asked to act as a mentor site for other Trusts.

The Trust is awaiting confirmation of the Q1 performance data (which is vetted by the NIHR) for trials recruiting to time and target and trials set up within 70 days.

The research and innovation five year strategy has been finalised and will be launched publically on September 27th. A detailed delivery plan has been developed outlining how the strategy will be implemented against specific targets and objectives.

NBT currently holds 12 NIHR research grants worth £18m. In addition, three NIHR grants worth £950k total are under contract negotiation and will become active mid-2017. This includes a grant recently awarded to Dr Mehool Acharya to undertake a randomised controlled trial of surgical versus non-surgical treatment of lateral compression injuries of the pelvis with complete sacral fractures (LC1) in the non-fragility fracture patient.

There are currently six charity funded grants in delivery worth a total of £397,071 to NBT including £170k for Ronelle Mouton (Vascular surgery) and two grants worth £73k each for Christy Burden and Stephen O’ Brien (Women and Children’s).
## Section Summary

**Improvements & Actions:**
Progress continues with overdue complaints, that have further decreased to 20 in August and will be ten or less in September. Actions in place are addressing sustained improvement.

**Trends:**
Friends and family test response rates for inpatient wards and maternity are not showing the progress that we would like. Recruitment is underway for the patient experience team, these posts will support Divisions and reenergise this important source of patient feedback.
Caring
Friends & Family Test
Board Sponsor: Director of Nursing

Note: NHS England FFT Official stats publish data one month behind current data presented in this IPR.

Inpatient Experience
National and regional comparisons % of respondents that would recommend the service they have experienced at NBT to a friend and family:

July comparisons
- National Average = 96%
- SW Region = 96%
- NBT = 92%

August NBT = 92.14%

Outpatient Experience
July % recommend national & regional comparisons
- National = 93%
- Regional = 94%
- NBT = 93%

August 93.26% would recommend

Staff attitude: has the largest number of positive and negative comments emphasising the importance of a customer focused positive attitude.

Waiting time: The number of negative comments received has increased during August.
Caring Friends & Family Test
Board Sponsor: Director of Nursing

Emergency Department

July % recommend benchmarks
National = 86%
Regional = 89%
NBT = 84%

August % recommend for NBT is 84.29%.

Staff attitude continues to be the largest contributor to positive comments.
Clinical Treatment: has received an increase in positive comments.

Maternity Department (Birth)

July % recommend NBT benchmarking
National = 96%
Regional = 95%
NBT = 91%

August % recommend for NBT would recommend is 94.03% an increase by 3% on last month

Action by Division to improve:
- Review of qualitative data to seek understanding on responses on likely and unlikely to recommend responses.
- Triangulation of data is required with other sources of feedback for example: complaints, concerns etc. to seek understanding of experience of mothers.

Staff attitude and implementation of care remain the largest positive aspect of care.
Response Rates

Maternity Department
July Benchmarking response rates
National = 23.60%
Regional = 16.30%
NBT = 11.2%

NBT August response rate increased to 13.24%. The graph shows the overall downward trend of response rates. Action:
• Promotion of feedback to mothers and use of other methods of feedback.

Emergency Department
July Benchmarking response rates
National = 12.80%
Regional = 11.70%
NBT = 17.6%

NBT August response rates = 16.98%. A continuing decrease since May, but remain above national and regional average.

Outpatient Department
Response rates remain well above the locally agreed response rate of 6% and continually exceed the Regional and National average response rates. NBT response rate has decreased from July 16.37% to 16.03% in August.

Inpatient Department
July Benchmarking response rates:
National average = 26.20%
Regional = 21.60%
NBT = 21.4%

August response rate NBT = 18.05% A disappointing downward trend and a priority focus for Divisions and the October Patient Experience Group.
Caring
Friends & Family Test - Patient Comments
Board Sponsor: Director of Nursing

From the new parking system to the general cleanliness to reception in the Brunel building and the professional who dealt with me I couldn't have been taken better care of.

For the most part they were friendly and professional, the receptionist was welcoming and understanding from the initial point of contact which is always a positive.

Many things could have been improved, practically, clinically and in terms of care provision. Staff generally were good with some outstanding. However given any choice I would have gone home days earlier.

Within about ten minutes I had been assessed and admitted to resus cubicle. Staff were quick and efficient and at the same time kind and attentive. Treatment was very thorough and the procedures explained which put me at ease straight away. My thanks to the whole team. I would have every confidence in recommending to family and friends.

Scored you this as they had booked five people with the same time as me which made me an hour and twenty minutes late going in. Also there are notes everywhere telling patients to look at the screen if your consultant is running late this was not done the whole time we were there. The nurse had asked the receptionist to let patients know of the delay this was not done. I am more than grateful for the treatment and kindness of staff but this situation lets everyone down.

Because I have been treated with wonderful respect, friendliness and made sure not bored or want for anything. Your staff at all levels are wonderful. I have the greatest respect for you all. The meals are very good, it's very clean here. It's better than staying in a 5 star hotel. I have been really spoilt and well cared for. Please keep up good work.

Care very good but lighting poor and noisy at night. Very long delays in answering alarm calls. Discharge procedure an absolute shambles.

The midwives were absolutely fantastic and ensured I had the birth I wanted. I avoided potentially painful interventions and felt very confident in them. The care I received after the birth was good too.
Caring
Complaints & Concerns
Board Sponsor: Director of Nursing

Complaints and Concerns:
The Trust received 40 Complaints and 55 Concerns in August 2017.

Compliments:
The number of compliments received increased from 95 (July) to 236 (August) following an increased reporting to ACT from NMSK Division.

NHS Complaints National Guideline Targets:
The three day acknowledgement target was met.

Overdue Cases:
The number of overdue complaints across the Trust has reduced to 20.

Key Action:
Director of Nursing and Quality continues to meet with Heads of Nursing bi-weekly, to review overdue complaints and actions required to close them. Progress is being made against the Trusts remedial action plan for delivery in September and sustainable improvement.

Final Response Compliance
Of the cases closed in August (to account for late responses), those completed within agreed timescale were 83 (62%). The exceptions were:
• 12.69% (17) were 1 to 10 days overdue.
• 7.46% (10) were 10 –to 20 days overdue.
• 17.91% (24) were greater than 20 days overdue.
Caring
Complaints & Concerns
Board Sponsor: Director of Nursing

Complaint Handling
The top three categories of complaints in August 2017 reflect the ongoing trend of clinical care, communication (including staff attitude), delays and cancellations. This correlates with FFT data.

The Advice and Complaints team work closely with Divisions to inform good practice in responding to complainants.

NHS Choices web-posts continue to show very positive comments. Southmead Hospital has an overall star rating of 4.5 out of five from 241 reviews and Cossham has a rating of 4.5 out of five from 22 reviews.

In August 2017 the star ratings given were:
12 x five stars
3 x one star

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

Ombudsman Cases
There was one new case referred to the PHSO for August 2017.

<table>
<thead>
<tr>
<th>Parliamentary Health Service Ombudsman (PHSO) Cases</th>
<th>Q3 16/17</th>
<th>Q4 16/17</th>
<th>Q1 17/18</th>
<th>Jul-17</th>
<th>Aug-17</th>
</tr>
</thead>
<tbody>
<tr>
<td>New Cases referred to PHSO</td>
<td>3</td>
<td>5</td>
<td>5</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>No. of cases fully upheld</td>
<td>Nil</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>No. of cases partially upheld</td>
<td>1</td>
<td>3</td>
<td>1</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>No. of cases not upheld</td>
<td>3</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Fines levied</td>
<td>1</td>
<td>0</td>
<td>350</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Corrective Actions Compliant within timescales</td>
<td>1</td>
<td>2</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Non-compliant</td>
<td>Nil</td>
<td>Nil</td>
<td>Nil</td>
<td>Nil</td>
<td>Nil</td>
</tr>
</tbody>
</table>

N.B. If all avenues for complaint resolution have been exhausted and the complainant is still dissatisfied with the Trust’s response, the complainant has the right to take their complaint to the PHSO. Cases can take many Months from ‘new’ to ‘decision’ which means the volumes shown represent differing time periods and will not therefore ‘add up’ within any given period.
Facilities Management

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)

Board Sponsor: Director of Facilities

Cleaning scores have been sustained in Very High and High Risk areas with Significant & Low risk areas continuing to exceed their targets.

Mandatory training compliance for August still exceeds the 85% target, currently at 92%. 89% of staff appraisals have been completed against the 90% target.

Staff engagement has been a key feature of the past 12 months - to increase the frequency of engagement we are now holding regular and local staff meetings alongside wider quarterly staff engagements with the senior management team. All sessions are minuted and followed by regular newsletters.

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

Improvements & Actions:

Staff Attitude Survey
Preparations are underway for the 2017 National Staff Attitude survey, which will be launched at the end of September. This year, as part of the Trust’s commitment to improve staff engagement a survey will be sent to all eligible staff, rather than a sample of staff. A communications plan is being developed to encourage as many staff as possible to participate. This will include information on actions taken as a result of last year’s results, for example, the introduction to Happy App and increased investment in staff health and well being initiatives. The results will continue to provide a solid baseline assessment of staff views and an indication of progress.

Staff Health & Wellbeing
Work has begun on the implementation of the recently agreed expanded range of wellbeing initiatives. The annual flu vaccination campaign is also due to be launched with staff, regarded as particularly important given the impact of flu on the Southern Hemisphere during their winter.

Resourcing - SLA Performance Headlines
The Resourcing Delivery Team’s programme of process improvement is progressing well. The review aims to improve the recruitment timelines to meet the target of 17 day conditional offer to unconditional offer SLA by 1st October 2017. The team has already made a significant impact with the SLA currently at 21 days, reduced from 31 days in June 2017.

Trends:
- Sickness absence slightly increased in July and reached its highest point of the year to date. The increase was predominantly in short term sickness and as such the Trust performance remains above the NHSI target of 3.7% for July.

Areas of Concern:
- Bank expenditure increased in August and remains significantly above the NHSI expenditure target. Levels of use and expenditure have seen very little variation for the last three months. We continue to closely monitor expenditure.
- Agency expenditure reduced slightly in August but remains just above the NHSI target with the NHSI expenditure trajectory for the remainder of the year requires a month on month reduction.
- The Trust vacancy factor reduced from 9.1% in July to 8.4% in August.
- In month turnover decreased in August to 1.3%, an improvement on the in month turnover in July. This was due to a large reduction in nursing and midwifery registered leavers. Retention reduction initiatives are being developed to pilot in theatres.
## Key Operational Standards Dashboard

<table>
<thead>
<tr>
<th>Access Standard</th>
<th>August 2017</th>
<th>Quarterly Trend (Q4 2016/17 vs Q1 2017/18)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Agency Expenditure ('000s)</strong></td>
<td>£525</td>
<td>£2,818 (Q4 2016/17) - £1,405 (Q1 2017/18)</td>
</tr>
<tr>
<td><strong>Month End Vacancy Factor</strong></td>
<td>8.40%</td>
<td>9.44% (Q4 2016/17) - 8.26% (Q1 2017/18)</td>
</tr>
<tr>
<td><strong>In Month Turnover</strong></td>
<td>1.30%</td>
<td>1.10% (Q4 2016/17) - 1.24% (Q1 2017/18)</td>
</tr>
<tr>
<td><strong>In Month Sickness Absence</strong> (In arrears)</td>
<td>4.36%</td>
<td>4.88% (Q3 2016/17) - 4.72% (Q4 2016/17)</td>
</tr>
<tr>
<td><strong>Trust Mandatory Training Compliance</strong></td>
<td>82.40%</td>
<td>83.09% (Q4 2016/17) - 83.55% (Q1 2017/18)</td>
</tr>
<tr>
<td><strong>Non - Medical Annual Appraisal Compliance</strong></td>
<td>46.98%</td>
<td>57.25% (Q4 2016/17) - 58.41% (Q1 2017/18)</td>
</tr>
</tbody>
</table>
Well Led
Workforce Utilisation
Board Sponsor: Director of People & Transformation

Trust Position
Worked WTE increased by 0.7% in August, whereas expenditure increased by 2.5% when compared with July.

Overall Worked WTE
Worked WTE increased across substantive, bank, agency and locum in August when compared with July with worked WTE exceeding funded establishment for the first time in 2017/18.

Temporary Staffing Worked WTE
Use of temporary staffing slightly increased in August. The highest percentage use increase was in administrative and clerical and allied health professional staff but the biggest overall users remained registered and unregistered nursing. The increase in agency staff use is predominantly attributed to registered nursing and midwifery and estates and ancillary with both seeing an increase of 27% in their usage compared with July.

Expenditure
Expenditure increased in August when compared with July, this is commensurate with the increase in overall worked WTE. Medical staff saw the biggest increase in expenditure related to the net increase of junior following August trainee rotation.
Well Led
Workforce Utilisation
Board Sponsor: Director of People & Transformation

Bank and Agency
Overall bank expenditure continues to rise this month, with a decrease in both framework and non framework usage compared to July.

ICU, NICU and Theatres still have a high demand for agency use but with current recruitment projects and healthy pipelines of new starters it is anticipated that the demand will decrease over the coming weeks.

The BNSSG Consortium have now awarded a Neutral Vendor contract to De Poel who will manage all our requests for agency staff for Nursing and Midwifery, with the aim to bring rates into cap.

The new contract will be implemented early in November 2017 and communications will be available from week commencing 25th September 2017.

In the meantime NBT eXtra continue work to increase the capacity of bank in all staffing groups and to encourage agency members of staff to join the internal bank or to apply for substantive positions within the Trust.

Greater capacity in the Resourcing Team will support the growth of NBT eXtra and reduce the time to hire for temporary and substantive staff.
Alignment between ESR and the Trust’s Financial System is a recommendation of the Carter Review. A 95% minimum alignment is required.

Compliance with this metric continues to remain steady; not dropping below 98%.
Vacancy Factor
The vacancy factor decreased from 9.1% in July to 8.4% in August with the biggest reduction in vacancies seen in medical staff.

Nurse Recruitment Open Day
The Trust continues to hold nurse recruitment open days approximately every six weeks. Our next Open Day is planned for 6th October 2017. The Trust is also holding its first Theatre/Medirooms Open Doors event on 14th October.

The following actions are in progress to continue to improve the recruitment timeline:

- ‘Proactive phone use’ rather than email contact expected to reduce the SLA by several days,
- A ‘team working approach’ - individuals prioritise recruitment cases based on urgency rather than working within their personal caseload,
- Use of day plans and proactive TRAC dashboard management to maximise productivity.

<table>
<thead>
<tr>
<th>Staff Group</th>
<th>Vacancy Factor Jul-17</th>
<th>Vacancy WTE Jul-17</th>
<th>Vacancy Factor Aug-17</th>
<th>Vacancy WTE Aug-17</th>
<th>Variance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Add Prof Scientific and Technic</td>
<td>11.2%</td>
<td>18.5</td>
<td>8.9%</td>
<td>14.7</td>
<td>-2.2%</td>
</tr>
<tr>
<td>Additional Clinical Services</td>
<td>9.6%</td>
<td>140.4</td>
<td>10.1%</td>
<td>146.4</td>
<td>0.5%</td>
</tr>
<tr>
<td>Administrative and Clerical</td>
<td>9.0%</td>
<td>129.5</td>
<td>8.8%</td>
<td>126.3</td>
<td>-0.2%</td>
</tr>
<tr>
<td>Allied Health Professionals</td>
<td>8.0%</td>
<td>28.9</td>
<td>8.5%</td>
<td>30.9</td>
<td>0.5%</td>
</tr>
<tr>
<td>Estates and Ancillary</td>
<td>11.6%</td>
<td>85.9</td>
<td>11.6%</td>
<td>86.2</td>
<td>0.1%</td>
</tr>
<tr>
<td>Healthcare Scientists</td>
<td>5.1%</td>
<td>17.5</td>
<td>3.9%</td>
<td>13.4</td>
<td>-1.2%</td>
</tr>
<tr>
<td>Medical and Dental</td>
<td>8.2%</td>
<td>77.4</td>
<td>4.6%</td>
<td>43.3</td>
<td>-3.6%</td>
</tr>
<tr>
<td>Nursing and Midwifery Registered</td>
<td>9.0%</td>
<td>188.9</td>
<td>8.2%</td>
<td>172.9</td>
<td>-0.8%</td>
</tr>
<tr>
<td>Trust</td>
<td>9.1%</td>
<td>687.1</td>
<td>8.4%</td>
<td>634.0</td>
<td>-0.7%</td>
</tr>
</tbody>
</table>
August saw a net increase in staff for the first time since April 17. The largest net gain was in medical staff following the impact of the junior doctor trainee rotation. Unregistered nursing also saw a net gain of staff. Whilst still showing a net loss, the number of leavers in the nursing and midwifery registered staff group significantly decreased in August when compared with July.
Sickness
Sickness has increased in July due to a small increase in short term sickness. July saw a 34% increase in FTE days lost for anxiety/stress/depression/other psychiatric illness and a 58% increase in sickness attributed to other known causes not elsewhere specified.

The recently agreed expanded range of wellbeing initiatives is specifically aimed at the underlying reasons for this type of sickness absence.

A pilot will is now underway for an on sight nurse screening service. This outreach service is funded by Bristol City Council and will mean that staff aged 40+ who are registered with a Bristol GP will be able to have their over 40’s health check on site, rather than at their GP surgery. Impact of this initiative will be monitored and rolled out further across the trust if successful.

Ongoing work is taking place with Divisions to better categorise sickness absence. There was a 24% reduction in FTE days lost to long term sickness attributed to reason unknown causes in July compared to June. Work is still required to see an improvement in this classification for short term sickness which has remained at the same level for the last four months.
In Month Sickness Absence by Staff Group

<table>
<thead>
<tr>
<th>Staff Group</th>
<th>Variance</th>
<th>Jun-17</th>
<th>Jul-17</th>
</tr>
</thead>
<tbody>
<tr>
<td>Add Prof Scientific and Technic</td>
<td>-1.08%</td>
<td>1.88%</td>
<td>2.97%</td>
</tr>
<tr>
<td>Additional Clinical Services</td>
<td>-0.76%</td>
<td>5.97%</td>
<td>6.73%</td>
</tr>
<tr>
<td>Administrative and Clerical</td>
<td>-0.72%</td>
<td>4.26%</td>
<td>4.98%</td>
</tr>
<tr>
<td>Allied Health Professionals</td>
<td>-0.08%</td>
<td>2.08%</td>
<td>2.16%</td>
</tr>
<tr>
<td>Estates and Ancillary</td>
<td>-0.42%</td>
<td>5.54%</td>
<td>5.96%</td>
</tr>
<tr>
<td>Healthcare Scientists</td>
<td>0.44%</td>
<td>2.70%</td>
<td>2.25%</td>
</tr>
<tr>
<td>Nursing and Midwifery Registered</td>
<td>-0.03%</td>
<td>4.22%</td>
<td>4.24%</td>
</tr>
<tr>
<td>Medical and Dental</td>
<td>-0.30%</td>
<td>0.49%</td>
<td>0.79%</td>
</tr>
<tr>
<td>Trust</td>
<td>-0.38%</td>
<td>3.98%</td>
<td>4.36%</td>
</tr>
</tbody>
</table>

Rolling 12 Month Sickness Absence

<table>
<thead>
<tr>
<th></th>
<th>Jun-17</th>
<th>Jul-17</th>
<th>Variance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Absence</td>
<td>4.49%</td>
<td>4.49%</td>
<td>0.00%</td>
</tr>
</tbody>
</table>

Long Term Sickness Top 5 Reasons (WTE Days) July 2017

- 996.48
- 714.20
- 653.65
- 270.59
- 269.55

Short Term Sickness Top 5 Reasons (WTE Days) July 2017

- 815.33
- 874.71
- 874.71
- 575.95
- 575.95
- 387.82

- S10 Anxiety/stress/depression/other psychiatric illnesses
- S98 Other known causes - not elsewhere classified
- S12 Other musculoskeletal problems
- S17 Foreign and malignant tumours, cancers
- S99 Unknown causes / Not specified
- S10 Anxiety/stress/depression/other psychiatric illnesses
- S98 Other known causes - not elsewhere classified
- S25 Gastrointestinal problems
- S99 Unknown causes / Not specified
- S12 Other musculoskeletal problems
Well Led
Staff Engagement
Board Sponsor: Director of People & Transformation

Essential Training Actions
Compliance for August saw a slight increase compared to the previous month.

A new format for corporate induction which will allow staff to learn more about the organisation, its vision and values alongside completing the training required for their post within their own work environment. The programme will be introduced in September 2017.

Following the summer period appraisal compliance is anticipated to increase in line with the historic loading of appraisals taking place in October.
Medical Appraisal

The fifth appraisal and revalidation year started on 1st April 2017. 79% of the appraisals that were due between April and August have been completed. Four appraisals remain incomplete from the previous appraisal year which ended in March 2017. This number has reduced by two in the past month. These four appraisals are being managed through the Trust’s escalation process.

The August 2017 doctors changeover has seen the number of clinical fellows employed by the Trust increase by 18. As these individuals are not in recognised training posts, they will be required to appraise and revalidate with NBT.

The Trust has currently deferred 43% of all revalidation recommendations due over the past 12 months. The current number of recommendations due are low and the vast majority of them are for clinical fellows. The number of doctors going through revalidation will rise again in 2018 and the deferral rate is expected to drop again during this time.

The Trust’s first non-engagement recommendation was made to the GMC in May 2017 following the continuous failure of an individual to engage with the process and meet agreed deadlines. The GMC had decided to withdraw the individual’s licence to practice in July 2017. The individual appealed the decision following eventual engagement with the process. The GMC have decided to allow the doctor to continue to practice with a new revalidation date now set in 2018.

An annual report representing the 2016/17 appraisal year was returned to NHS England in May 2017. Details from this were included in an annual Trust Board report which was presented to the Trust Board on 27th July 2017. A statement of compliance was signed and submitted to NHS England on 30th July 2017.
## Section Summary

### Summary

The Trust has a planned deficit of £18.7m for the year in line with the control total agreed with NHS Improvement.

- At the end of August the Trust is reporting a deficit of £11.8m compared with a planned deficit of £10.7m, £1.1m adverse to plan.
- The adverse variance is partly driven by loss of Sustainability and Transformation Funding (STF) of £0.6m related to non-delivery of A&E performance trajectories. However, this in itself would not preclude the Trust from receiving the element of STF dependent on financial performance as NHS Improvement measure delivery of control total on the position excluding STF, however this has deteriorated this month to £0.5m adverse to plan. The control total excluding STF needs to be achieved.
- Non-pay (excluding finance costs) was £0.9m favourable, whilst income and pay were £0.2m and £0.9m adverse to plan respectively.
- Savings delivery was £3.7m less than the £14.3m required in the year to date. The failure to achieve the required £1m step up in savings delivery in month has continued.
- The main areas of concern relate to the level of elective activity income against planned levels as well as savings delivery which is behind plan. This is despite the fact that the overall financial plan profile reflects a savings profile that is lower in Quarter 1.
- The Trust has ended the month with £9.8m cash after receipt of £2.4m loan financing from the Department of Health to support the ongoing deficit.
- Capital expenditure was £2.9m for the year to date against a plan of £4.4m.
- The Trust is rated 3 by NHS Improvement (NHSI).

### Key areas of concern:

- Continued focus on delivering the full savings required as well as full delivery of planned activity and income for the year will be crucial to ensure delivery of the Trust’s control total.
Assurances

The financial position at the end of August shows a deficit of £11.8m, £1.1m adverse to the planned deficit of £10.7m. However, the position excluding STF is £0.5m adverse.

Key Issues

- Delivery of savings was £3.7m less than the £14.3m required to date.
- Contract income is £0.4m adverse to plan reflecting primarily under-performance in electives. Other income is £0.2m favourable including an increase in overseas income.
- Pay is £0.9m adverse to plan mainly due to under-delivery of savings of £0.6m but also significant escalation costs.
- Non pay is £0.9m favourable to plan with materially lower independent sector along with a non-recurrent benefit of £0.6m partially offset by higher consumable costs.

Actions Planned

Continued focus on identification of the full savings required as well as full delivery of planned activity and income for the year will be crucial to ensure delivery of the Trust’s control total.

### Finance

#### Statement of Comprehensive Income

**Board Sponsor: Director of Finance**

<table>
<thead>
<tr>
<th>Prior year actual to 31 August 2016 £m</th>
<th>Position as at 31 August 2017</th>
<th>Variance (Adverse) / Favourable £m</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Income</strong></td>
<td><strong>Plan</strong> £m</td>
<td><strong>Actual</strong> £m</td>
</tr>
<tr>
<td>Contract Income</td>
<td>197.0</td>
<td>196.6</td>
</tr>
<tr>
<td>Other Operating Income</td>
<td>30.7</td>
<td>30.9</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>227.7</td>
<td>227.5</td>
</tr>
<tr>
<td><strong>Expenditure</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pay</td>
<td>137.7</td>
<td>138.6</td>
</tr>
<tr>
<td>Non Pay</td>
<td>75.6</td>
<td>74.7</td>
</tr>
<tr>
<td>PFI Operating Costs</td>
<td>2.5</td>
<td>2.4</td>
</tr>
<tr>
<td><strong>Total Expenditure</strong></td>
<td>(215.8)</td>
<td>(215.7)</td>
</tr>
<tr>
<td><strong>Earnings before Interest &amp; Depreciation</strong></td>
<td>11.9</td>
<td>11.8</td>
</tr>
<tr>
<td><strong>Depreciation &amp; Amortisation</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pay</td>
<td>(10.6)</td>
<td>(10.9)</td>
</tr>
<tr>
<td>PFI Interest</td>
<td>(14.1)</td>
<td>(14.0)</td>
</tr>
<tr>
<td>Interest receivable</td>
<td>0.0</td>
<td>0.0</td>
</tr>
<tr>
<td>Interest payable</td>
<td>(1.8)</td>
<td>(2.3)</td>
</tr>
<tr>
<td>PFI Dividend</td>
<td>0.0</td>
<td>0.0</td>
</tr>
<tr>
<td>Other Financing costs</td>
<td>0.0</td>
<td>0.0</td>
</tr>
<tr>
<td>Impairment</td>
<td>0.0</td>
<td>0.0</td>
</tr>
<tr>
<td><strong>Operational Retained Surplus / (Deficit)</strong></td>
<td>(14.6)</td>
<td>(15.4)</td>
</tr>
<tr>
<td><strong>Add back items excluded for NHS accountability</strong></td>
<td></td>
<td>(6.8%)</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>0.3</td>
</tr>
<tr>
<td>Impairment</td>
<td>0.0</td>
<td>0.0</td>
</tr>
<tr>
<td><strong>Adjusted surplus /(deficit) for NHS accountability (excl STF)</strong></td>
<td>(14.6)</td>
<td>(15.1)</td>
</tr>
<tr>
<td><strong>STF</strong></td>
<td>3.9</td>
<td>3.3</td>
</tr>
<tr>
<td><strong>Adjusted surplus /(deficit) for NHS accountability (incl STF)</strong></td>
<td>(10.7)</td>
<td>(11.8)</td>
</tr>
</tbody>
</table>
Assurances

The Trust received new loan financing in August of £2.4m. This is £14.5m out of the £18.7m planned for this year, which takes the total Department of Health borrowing to £149.8m.

The Trust ended the month with cash of £9.8m, £5.8m higher than plan. The higher balance is required in order to meet contractual payments prior to receipts being received from commissioners in September.

Concerns & 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 75% 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 2017</th>
<th>Statement of Financial Position as at 31st August 2017</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>510.9</td>
<td>511.1</td>
<td>0.2</td>
</tr>
<tr>
<td>518.0</td>
<td>Intangible Assets</td>
<td>10.9</td>
<td>15.0</td>
<td>4.1</td>
</tr>
<tr>
<td>15.8</td>
<td>Non-current receivables</td>
<td>19.0</td>
<td>20.0</td>
<td>1.0</td>
</tr>
<tr>
<td>20.0</td>
<td>Total non-current assets</td>
<td>540.8</td>
<td>546.1</td>
<td>5.3</td>
</tr>
<tr>
<td></td>
<td>Current Assets</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>10.2</td>
<td>Inventories</td>
<td>9.7</td>
<td>9.9</td>
<td>0.2</td>
</tr>
<tr>
<td>27.2</td>
<td>Trade and other receivables NHS</td>
<td>25.3</td>
<td>19.2</td>
<td>(6.1)</td>
</tr>
<tr>
<td>26.7</td>
<td>Trade and other receivables Non-NHS</td>
<td>30.8</td>
<td>31.4</td>
<td>0.6</td>
</tr>
<tr>
<td>4.7</td>
<td>Cash and Cash equivalents</td>
<td>4.0</td>
<td>9.8</td>
<td>5.8</td>
</tr>
<tr>
<td>68.7</td>
<td>Total current assets</td>
<td>69.8</td>
<td>70.3</td>
<td>0.6</td>
</tr>
<tr>
<td>1.6</td>
<td>Non-current assets held for sale</td>
<td>0.0</td>
<td>0.0</td>
<td>0.0</td>
</tr>
<tr>
<td>624.2</td>
<td>Total assets</td>
<td>610.6</td>
<td>616.4</td>
<td>5.8</td>
</tr>
<tr>
<td></td>
<td>Current Liabilities (&lt; 1 Year)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>9.5</td>
<td>Trade and Other payables - NHS</td>
<td>9.5</td>
<td>10.6</td>
<td>1.1</td>
</tr>
<tr>
<td>71.8</td>
<td>Trade and Other payables - Non-NHS</td>
<td>70.7</td>
<td>65.5</td>
<td>(5.2)</td>
</tr>
<tr>
<td>40.1</td>
<td>Borrowings</td>
<td>11.5</td>
<td>40.1</td>
<td>28.7</td>
</tr>
<tr>
<td>121.4</td>
<td>Total current liabilities</td>
<td>91.7</td>
<td>116.2</td>
<td>24.5</td>
</tr>
<tr>
<td>(51.1)</td>
<td>Net current assets/(liabilities)</td>
<td>(21.9)</td>
<td>(45.9)</td>
<td>(23.9)</td>
</tr>
<tr>
<td>502.8</td>
<td>Total assets less current liabilities</td>
<td>518.9</td>
<td>500.2</td>
<td>18.7</td>
</tr>
<tr>
<td>9.9</td>
<td>Trade payables and deferred income</td>
<td>18.5</td>
<td>9.7</td>
<td>(8.8)</td>
</tr>
<tr>
<td>514.3</td>
<td>Borrowings</td>
<td>516.9</td>
<td>524.1</td>
<td>7.2</td>
</tr>
<tr>
<td>(21.4)</td>
<td>Total Net Assets</td>
<td>(16.5)</td>
<td>(33.5)</td>
<td>(17.1)</td>
</tr>
<tr>
<td></td>
<td>Capital and Reserves</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>241.7</td>
<td>Public Dividend Capital</td>
<td>241.5</td>
<td>241.7</td>
<td>0.2</td>
</tr>
<tr>
<td>(312.4)</td>
<td>Income and expenditure reserve</td>
<td>(353.8)</td>
<td>(363.5)</td>
<td>(9.6)</td>
</tr>
<tr>
<td>(51.1)</td>
<td>Income and expenditure account - current year</td>
<td>(10.8)</td>
<td>(12.1)</td>
<td>(1.3)</td>
</tr>
<tr>
<td>100.4</td>
<td>Revaluation reserve</td>
<td>106.7</td>
<td>100.4</td>
<td>(6.3)</td>
</tr>
<tr>
<td>(21.4)</td>
<td>Total Capital and Reserves</td>
<td>(16.5)</td>
<td>(33.5)</td>
<td>(17.1)</td>
</tr>
</tbody>
</table>
The overall financial position was £1.1m adverse against plan at the end of August.

Capital expenditure was £2.9m compared to a plan of £4.4m for the year to date. The plan for the year is £21.8m.

### Assurances and Actions Planned

- Monitoring of capital expenditure with project leads to ensure essential schemes are progressing.
- Cash for our planned deficit for the year to date has been made available to the Trust via the interim working capital facility and DH loan.

### Concerns & Gaps

The Trust is rated at 3 (a score of 1 is the best) in the finance and use of resources metric. This means the financial position remains a concern but is no longer at the highest score of 4.
Assurances
£38.4m of efficiencies have been identified at the end of August, although this has reduced by £1m from the fully identified plan in July.

Concerns & Gaps
Under-delivery of £3.7m in the first five months against a target of £14.3m.

The graphs show forecast delivery of £39.4m. £31.3m is rated as green or amber, which is a further improvement of £2m since July.

Actions Planned
Continued monitoring of actions required to deliver required savings in 2017/18 and catch up the year to date shortfall.
The Governance Risk Rating (GRR) for ED 4 hour performance continues to be a challenge through 2017/18, 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 waitsers (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>Regulatory Area</th>
<th>Sep-16</th>
<th>Oct-16</th>
<th>Nov-16</th>
<th>Dec-16</th>
<th>Jan-17</th>
<th>Feb-17</th>
<th>Mar-17</th>
<th>Apr-17</th>
<th>May-17</th>
<th>Jun-17</th>
<th>Jul-17</th>
<th>Aug-17</th>
</tr>
</thead>
<tbody>
<tr>
<td>Board non-compliant statements</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td>2</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>

CQC reports history (all sites)

<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>Apr-16</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>Apr-16</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>

* These services are no longer provided by NBT.
<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 and again in December 2015. 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>
</tbody>
</table>
## Regulatory View

### Board Compliance Statements at August 2017

**Board Sponsor:** Chief Executive Officer

Self-assessed, for submission to NHSI

<table>
<thead>
<tr>
<th>No.</th>
<th>Criteria</th>
<th>Comp (Y/N)</th>
<th>No.</th>
<th>Criteria</th>
<th>Comp (Y/N)</th>
</tr>
</thead>
<tbody>
<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>
<td>The necessary planning, performance, corporate and clinical risk management processes and mitigation plans are in place to deliver the annual operating plan, including that all audit committee recommendations accepted by the Trust Board are implemented satisfactorily.</td>
<td>Yes</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>
<td>An Annual Governance Statement is in place, and the Trust is compliant with the risk management and assurance framework requirements that support the Statement pursuant to the most up to date guidance from HM Treasury (<a href="http://www.hm-treasury.gov.uk">www.hm-treasury.gov.uk</a>).</td>
<td>Yes</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>
<td>The Trust Board is satisfied that plans in place are sufficient to ensure ongoing compliance with all existing targets (after the application of thresholds) as set out in the relevant GRR; and a commitment to comply with all known targets going forwards.</td>
<td>No</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>
<td>The Trust has achieved a minimum of Level 2 performance against the requirements of the Information Governance Toolkit.</td>
<td>Yes</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>
<td>The Trust Board will ensure that the Trust will at all times operate effectively. This includes maintaining its register of interests, ensuring that there are no material conflicts of interest in the Board of Directors; and that all Trust Board positions are filled, or plans are in place to fill any vacancies.</td>
<td>Yes</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>
<td>The Trust Board is satisfied that all Executive and Non-executive Directors have the appropriate qualifications, experience and skills to discharge their functions effectively, including: setting strategy; monitoring and managing performance and risks; and ensuring management capacity and capability.</td>
<td>Yes</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>
<td>The Trust Board is satisfied that: the management team has the capacity, capability and experience necessary to deliver the annual operating plan; and the management structure in place is adequate to deliver the annual operating plan.</td>
<td>Yes</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 A&E 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:

Q3 2017/18 - for RTT
Report to: Trust Board

Date of Meeting: 28th September 2017

Report Title: Complaints Annual Report 2016 /17

Status: Information | Discussion | Assurance | Approval

Prepared by: Summary : Gill Brook Had of Patient Experience

Full Report: Steve Sykes (ACT Manager) & Sue Needs (ACT deputy Manager)

Executive Sponsor (presenting): Sue Jones Director of Nursing and Quality

Appendices (list if applicable): Complaints Annual Report 2016 /117

Recommendation:
To review & accept the report, noting key areas for improvement and objectives for 2017/18

Executive Summary:
Key element from the Complaints Annual Report for 2016/17 in relation to performance, achievement & challenge are summarised follows:

- Total of 654 complaints received and processed (821 in 2015/16)
- Total of 739 concerns raised and acted upon; a decrease of 65 from the previous year
- Performance against regulatory measures:
  - All complaints acknowledged within 3 working days: Achieved
  - All cases concluded within 6 months: one case outstanding at year end (concluded within a few days of this deadline)

- NHS Choices overall star rating for NBT increase to 4.0 from 3.5 (2015/16)
- The positive use of local resolution meetings has increased by 32% on last year, with 86 being held, allowing face to face
resolution of matters

- A new model of Directorate management of complaints successfully piloted in the Medical Directorate, now ready for rollout in other Directorates
- Investigation training successfully delivered to 30 staff in partnership with the Patients Association
- Patient Complaints Review Panel established in partnership with the Patients Association enabling trained volunteers to review against the Patient Association *Good Practice Standards for NHS Complaints Handling (2013)* with recommendations already implemented.

Improvement across NBT is required in the following:

- Monitoring and completion of action plans
- Demonstrations of and share learning from complaints and concerns
- Meeting agreed response times
- Consistent approach to the quality of investigations and efficient management of complaints
- Triangulation of data from other sources of patient / carer feedback to identify key focus for improvement work

Objectives for 2017/18

- To roll out the complaints management process piloted within Medicine Division
- To participate in the development, implementation and use of Datix. (Datix is a risk management software system with applications for use in patient safety and patient feedback allowing analysis of data, reporting of trends etc.)
- Improve analysis, reporting and monitoring (from the use of Datix) by the Advice and Complaints Team and Divisions
- Continue to learn from the review of complaints against the Patient Association standards by the Patient Review Panel and the CCG review
- Continue Trust wide focus on reducing and maintaining overdue complaints to a total of 10 or under
- Improve triangulation and reporting of patient experience data
Complaints Annual Report
2016-2017

Author: Steve Sykes: Advice and Complaints Team Manager

Version control and Approval

<table>
<thead>
<tr>
<th>Version</th>
<th>Approved by</th>
<th>Role</th>
<th>Organisation</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sue Jones</td>
<td>Director of Nursing</td>
<td>NBT</td>
<td></td>
<td>July 2017</td>
</tr>
<tr>
<td>Paul Cresswell</td>
<td>Associate Dir. of Quality Governance</td>
<td>NBT</td>
<td></td>
<td>May 2017</td>
</tr>
<tr>
<td>Gill Brook</td>
<td>Head of Patient Experience</td>
<td>NBT</td>
<td></td>
<td>May 2017</td>
</tr>
<tr>
<td>Steve Sykes</td>
<td>Advice and Complaints Team Manager</td>
<td>NBT</td>
<td></td>
<td>April 2017</td>
</tr>
</tbody>
</table>
1. Introduction

1.1. This report provides an overview of the activity and progress made during the year 1st April 2016 to 31st March 2017. The key messages in this year’s report are:

- The Healthcare environment remains very challenging, with high patient expectations particularly around waiting times and responsiveness set against a national backdrop of financial challenge.
- The Advice and Complaints Team processed 654 formal complaints, 167 less than in the 2015/16 financial year. 739 concerns were also raised and acted upon, representing a decrease of 65. These figures reflect the continued stabilisation and improvement of clinical services delivered from within the Brunel Building, and the upgraded site facilities as the redevelopment has continued.
- The Trust’s star rating on NHS Choices increased from 3½ to 4 stars midway through the year reflecting the improvements in patients’ and visitors experiences.
- There are two key regulatory measures for NHS Complaints:
  1) To acknowledge all complaints with 3 working days. During the year the acknowledgement target was 100% achieved in every month..
  2) To conclude all cases within 6 months. During the year just 1 case was not cleared within this timescale, (but this has now been cleared) and resulted from a non-clinical department failing to respond to repeated requests for an investigation into a poor discharge. The case was a few days after the deadline.
- Those responses not delivered within the agreed timescales improved again. 335 cases failed this measure during the year, and remains an area where the Trust continues to seek improvements (see paragraphs 5 and 12 below).
- A further bespoke programme of support and training for the directorate complaint teams, was delivered in partnership with the Patients’ Association, for approximately 30 staff.

2. Accountability

2.1. The Board has corporate responsibility for quality of care and monitoring of complaints and improvements. Formal complaints are fully investigated with comprehensive and personally written responses signed off by the Chief Executive.

2.2. The Director of Nursing has responsibility at Board level for all complaints, and is chair of the Patient Experience Group which has strong patient and public representation.

2.3. During the year a substantive appointment was made to the new post of Head of Patient Experience. This role supports a stronger drive towards using the feedback from complaints as a valuable learning opportunity rather than purely a process that must be delivered.

2.4. To provide complaints process quality checks from an independent source (in addition to the Clinical Commissioning Group), the Trust has worked with the Patients Association to develop an anonymised audit process that allows real time feedback on a random sample of the previous quarters complaints. This process, the first developed with the Patients Association in the country, has allowed patient representatives to give real-time feedback into the ongoing complaints improvement plan.

3. The Complaints Process

3.1. The Trust’s complaints procedure conforms to the “The Local Authority Social Services and National Health Service Complaints (England) Regulations 2009”, and it also reflects the Parliamentary and Health Service Ombudsman’s Principles of good complaint handling.

3.2. Complaints are centrally managed by the Advice and Complaints Team on behalf of the Chief Executive. The Advice and Complaints Team log and acknowledge the reported issues, decide on which of the hospital’s directorates need to investigate, and disseminate the information accordingly. The Advice and Complaints Team then consolidate information received from the investigation and prepare the final reply letters for the Chief Executive to approve and sign.

3.3. The Advice and Complaints Team also:
- Maintains a record of compliments received across the Trust
Monitors responses, escalate overdue cases and manage any returned cases
Arranges Local Resolution Meetings (attend and digitally record details and manage the actions)
Provides reports for Trust Board, Patient Association and the Patient Experience Group;
Undertakes local ad-hoc training
Issue alerts to enable appropriate interventions where themes are apparent
Support directorate actions in respect of quality and learning from complaints in accordance with CQC Regulation 16: Receiving and acting on complaints, by monitoring Actions Plans, arising from Moderate or High risk complaints.

3.4. The Advice and Complaints Team progress some issues as concerns. This less formal complaint category is responded to, under delegated authority, by the Advice and Complaints Team manager.

3.5. NBT does not operate a Patient Advice and Liaison Service (PALS). Instead the Advice element of the service is managed by the Advice and Complaints Team who respond to telephone or email requests for information with the emphasis on ‘fixing the problem’ swiftly without the necessity of a more formal process. The option to proceed with a formal process is always made available even when this approach is taken.

3.6. On behalf of the Trust, the Advice and Complaints Team’s key priorities in handling complaints and concerns are to:
- Create a culture that encourages and welcomes patient and service user feedback, with a commitment to avoid discrimination against complainants, or the patients for whom they are acting
- Provide equality of access with clear and widely available information on how complaints and concerns can be made and how they are handled, in language and formats that are appropriate to the complainants’ needs
- Provide complainants with sufficient support to participate fully in the complaints process
- Promote a timely, open and flexible dialogue to facilitate a meaningful investigation
- Provide a full and understandable response that maintains accountability and confidentiality
- Act on feedback received to assist directorates to improve the Trust’s services
- Gather evidence of learning and follow-up actions where appropriate.

4. Numbers of complaints received During 2016/17

4.1. The total number of complaints received during the year was 654. The Trust is required to submit quarterly statistics on all formal complaints categorised by the Department of Health, see below. (Fig. 1)

<table>
<thead>
<tr>
<th>Complaints By Directorate</th>
<th>Total Number of complaints 2012/13</th>
<th>Total Number of complaints 2013/14</th>
<th>Total Number of complaints 2014/15</th>
<th>Total Number of complaints 2015/16</th>
<th>Total Number of complaints 2016/17</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinical Governance</td>
<td>0</td>
<td>2</td>
<td>2</td>
<td>6</td>
<td>3</td>
</tr>
<tr>
<td>Core Clinical Services</td>
<td>74</td>
<td>49</td>
<td>78</td>
<td>57</td>
<td>31</td>
</tr>
<tr>
<td>Facilities</td>
<td>13</td>
<td>12</td>
<td>39</td>
<td>25</td>
<td>25</td>
</tr>
<tr>
<td>Finance</td>
<td>1</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>IM&amp;T</td>
<td>13</td>
<td>11</td>
<td>16</td>
<td>7</td>
<td>6</td>
</tr>
<tr>
<td>Medicine</td>
<td>165</td>
<td>176</td>
<td>251</td>
<td>176</td>
<td>161</td>
</tr>
<tr>
<td>Musculoskeletal</td>
<td>132</td>
<td>121</td>
<td>169</td>
<td>101</td>
<td>66</td>
</tr>
<tr>
<td>Neurosciences</td>
<td>85</td>
<td>77</td>
<td>81</td>
<td>82</td>
<td>74</td>
</tr>
<tr>
<td>Operations</td>
<td>2</td>
<td>5</td>
<td>4</td>
<td>6</td>
<td>2</td>
</tr>
<tr>
<td>Renal &amp; Outpatients *</td>
<td>11</td>
<td>5</td>
<td>54</td>
<td>43</td>
<td>53</td>
</tr>
<tr>
<td>Surgery</td>
<td>207</td>
<td>193</td>
<td>212</td>
<td>213</td>
<td>160</td>
</tr>
<tr>
<td>Women’s &amp; Children’s</td>
<td>108</td>
<td>84</td>
<td>104</td>
<td>105</td>
<td>73</td>
</tr>
<tr>
<td><strong>Totals</strong></td>
<td>832</td>
<td>757</td>
<td>1010</td>
<td>821</td>
<td>654</td>
</tr>
</tbody>
</table>

* Includes Outpatients for 2014/15 to 2016/17

4.2. At the start of the year the reasons for complaints held on the data base was changed to align them with the Friends and Family Test. Appendix 1 shows the breakdown of complaints by category for 2016/17 with an indication of the totals received.
4.3. Communication issues remain a factor in many complaints. This continues to be tackled by the Trust's iCARE initiative, which is designed to help staff consider their approach and communication from the patients' perspective. The Friends and Family Test data and the National Inpatient Survey have also continued to highlight the issue of the timing and arrangements for discharge from hospital. This has been a key priority for improvement work in 2016/17.

4.4. The problems experienced in 2014 through 2015 in tracking and obtaining patient notes improved significantly 2016/17 and further improvements will ensue in the coming year from the delivery of the ongoing Electronic Document Management initiative.

5. Performance Statistics - Complaints Response Times

(Fig. 2)

5.1. The number of complaints completed within the negotiated response times increased significantly to its highest rate since before 2012/13, as illustrated in Fig. 2 above. The chart shows the impact of the improvement work undertaken over the last few years. Whilst this is welcome, this is still below the aspirations the Trust has for significantly improving our approach and work will continue to improve compliance in 2017/18.

5.2. Although informal complaints (concerns) received in 2016/17 decreased by a further 8.80% they counted for more than 50 percent of the overall cases recorded (approximately 53%) indicating that the severity of the issues experienced has decreased.

5.3. The directorates that received the most complaints were the three largest; reflecting their relative size and patient throughput. The total number they received last year (2015/16) is shown in in brackets:

- ASCC 160 (213)
- Medicine 161 (176)
- Musculo Skeletal 74 (101)
5.4. The actual performance of each directorate is shown in the table below, which shows complaint numbers and rate per 1000 bed-days for the clinical directorates. The decrease in complaints and concerns did not reveal any particular overall trend. (Fig. 3)

5.5. If a complaint or concern is not satisfactorily answered, the complainant is always invited to contact the Advice and Complaints Team to ensure their further concerns can be fully addressed. These “returned” issues are logged and the reasons recorded to support further learning.

5.6. Overall returns decreased to 152 (160) but those concerns that were due to unaddressed or unresolved issues and therefore could be considered as avoidable stood at 50 (45) cases. This represents an increase on 2015/16 and may have in part resulted from the pressure for directorates to provide more timely responses.

5.7. The Advice and Complaints Team’s performance for acknowledging complaints and concerns within 3 days of receipt has remained above the 95% target despite the increase in numbers, with the highest level of compliance since 2013/14, as illustrated below:

(Fig.4)

<table>
<thead>
<tr>
<th>Acknowledgements (Target 95%)</th>
<th>2013/14</th>
<th>2014/15</th>
<th>2015/16</th>
<th>2016/17</th>
</tr>
</thead>
<tbody>
<tr>
<td>Average time (including telephone and email contact)</td>
<td>99.27 %</td>
<td>96.39 %</td>
<td>99.84 %</td>
<td>99.85 %</td>
</tr>
</tbody>
</table>
6. Advice Service

6.1. This service has seen a high yet decreasing level of calls over the last year reflecting the changes described at paragraph 1.1 above. The comparison of totals by criteria with 2015/16 is illustrated by Fig 5 below. As can be seen the two areas where enquiries increased related to the pressures to clear backlogs, and the delays in delivering test results, in the early part of the year or providing information about appointments associated with the replacement Lorenzo system.

6.2. The number of people unable to make effective contact with the correct area within the Trust remains a concern. The continued lack of a current and accurate internal telephone directory and the failure of many staff to adhere to the Trust email protocols, which asks for a signature containing key data including a telephone number, added significantly to the Advice and Complaints Team’s workload in making appropriate contact to resolve simple enquiries.

(Fig.5)

<table>
<thead>
<tr>
<th>Enquiries Received 2015/16 to 2016/17</th>
</tr>
</thead>
<tbody>
<tr>
<td>Add to a complaint/Return complaint/Update on going complaint</td>
</tr>
<tr>
<td>Complaints advice/How to complain</td>
</tr>
<tr>
<td>Inpatient concern (in progress now)</td>
</tr>
<tr>
<td>SEAP/MPs/PHSO/Other Trusts</td>
</tr>
</tbody>
</table>

7. Learning Lessons

7.1. The Trust embraces the ethos of learning from all complaints and concerns where possible and this forms part of the investigation and response process. In line with best practice, learning from complaint investigations is being used to inform and reform our practices. During the year some examples of the many changes made to procedures and practices are provided below:

- Guidance on interaction with the deaf community was improved following feedback that the information with patients and family was not always clearly communicated.
- “John’s Campaign” was formally adopted by the Trust and compliments our open visiting policy and carers strategy. The use of Johns Campaign has helped to improve patient/relative/carer experience. Carers are able to stay overnight, and the carers policy includes use of the canteen facilities, and free car parking.
- Action to ensure that there is now a paragraph incorporated into letters that indicates that patients may not be able to drive themselves home after their procedure.
- Pharmacy are taking actions to improve the screening processes in the dispensary and design a poster for the front of the dispensary, so patients can more fully understand what happens to prescriptions when they are handed in.
- All patients are now being kept in the outer waiting rooms until the consultant is ready to see them. This will stop unnecessary overcrowding of the ‘sub wait’ areas of the hospital outpatient clinics.
• Work has been undertaken in orthopaedics to improve providing consistent good quality discharge information both to trauma medical team and patients.
• Training undertaken to improve the communication and care for patients care with autism.

8. Second Stage Reviews
8.1. Local Resolution Meetings (LRMs) support an approach that allows the complainant and the Trust to explore issues in a more dynamic way than can be achieved via correspondence. Complainants are invited to attend with a friend or family for support and the Trust ensures that senior staff are present to address their concerns and take forward any agreed actions/outcomes. A digital recording of the meeting is provided as confirmation of the discussions and the agreed actions.

8.2. In line with the overall drive to increase direct liaison with complainants, as promoted through the combined workshops with the Patients Association, 86 LRMs were held during the year. This was an increase of 32% on 2015/16 and sustained the upward trend seen over the past 5 years.

9. Ombudsman Referrals
9.1. If after attempts at local resolution the complainant remains dissatisfied, they may request the Parliamentary Health Service Ombudsman (PHSO) to consider their case. The relative rulings from the PHSO over the last 3 years are shown below at Fig 6. During 2016/17, the Trust is aware of 18 complainants who contacted the Ombudsman where they subsequently decided to review the actions of the Trust and call for the complaints file. Of these 5 cases have been closed by the Ombudsman; and no complaints were wholly upheld, 4 were found to be partly justified and 9 dismissed. The Trust was asked to extend apologies for all the partially justified cases and to pay compensation in 2 cases amounting to a total of £900 in respect of cases concluded in 2016/17.

9.2. For partially or fully justified rulings the Trust produce an action plan to record any new points of learning, or to illustrate any learning already actioned. These are shared with both the Ombudsman and the complainant. On occasion this will also be followed by regular updates until the identified actions can be shown to have been completed.
10. Compliments and Feedback

10.1. Over the year, the Advice and Complaints Team recorded 9065 compliments, a welcome reversal of the lower levels seen in prior years. We do acknowledge that the system for collecting, collating and learning from positive feedback continues to need strengthening. The Head of Patient Experience role within the Trust aims to bring a greater strategic approach to obtaining feedback and using it to improve services. Compliment categories have from this year been aligned with the Friends and Family Test to enable much closer comparison and thematic review to highlight how good practice makes a difference to patients.

<table>
<thead>
<tr>
<th>Compliments Received</th>
<th>2011/12</th>
<th>2012/13</th>
<th>2013/14</th>
<th>2014/15</th>
<th>2015/16</th>
<th>2016/17</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total</td>
<td>7,120</td>
<td>6,822</td>
<td>6,729</td>
<td>4,396</td>
<td>6,618</td>
<td>9065</td>
</tr>
</tbody>
</table>

10.2. Other positive feedback has been received via the NHS Choices and Patient Opinion websites. All posts using this media were specifically tracked for 2016/17. The NHS Choices rating for Southmead hospital for 2016/17 is shown below, (Cossham is not formally rated). During the year the rating increased from 3½ to 4 stars.

11. Key Risks

11.1. In 2014/15 the Trust recognised that the system to manage complaints and affect learning was under considerable strain due to the increased numbers and demands on staff as they adapt to a new working environment. As a consequence Directorate Heads of Nursing were allocated responsibility for the directorate processes. After their intervention and the training provided during 2015/16 and 2016/17 in collaboration with the Patients' Association (see paragraph 1.1) the Trust has continued to improve the complaints and concerns resolved within the negotiated timescales, (see figure 2 above). The ability to respond within the timescales agreed remains a top priority.

11.2. The key risks to the Trust's reputation and delivery of a safe and caring service that can arise from shortcomings in the complaints service are:

- Failure to share and learn lessons from complaints across all areas of the Trust
- Insufficient monitoring of themes to ensure all concerns are addressed and improvements made
- Inconsistent directorate complaints processes, and a lack of effective deputies during leave period, which impact on response times.
- Delayed responses, which undervalue those making complaints
- Inadequate systems and processes to ensure directorate and central teams are managing cases consistently and efficiently.
- Insufficient identification and review of positive patient experience, including compliments received.
- Failure to effectively implement the replacement database (which will help address some of the issues above). This may impact on the service and draw resources away from the key role.
Delivery of the Advice and Complaints Team Objectives for 2016/17

11.3. The following has been delivered:
   a) Work has continued in partnership with the Patients Association throughout the year to identify and seek improvements across the service.
   b) The overall response times achieved for call cases (complaints and concerns) continued to improve.
   c) The database was amended to ensure the recorded reasons for complaints used the Friends and Family Test criteria to provide more consistent reporting.
   d) The Patient Panel Audit suggestions were adopted for acknowledgement and response letters to improve and clarify information to complainants.
   e) The Patient Panel also influenced the process in respect of communicating to patients what to expect when making a complaint and reinforced the need for a named contact to be appointed to ask the complainant what they want to achieve.
   f) NHS Choices feedback was tracked and recorded on the complaints database to provide analysis for Patient Experience Group.
   g) Training was delivered to complaint investigators in collaboration with the Patients Association.
   h) A test of change used to evaluate the allocation of named clinical directorate contacts to improve complainants’ overall experience. This model will be adopted as the standard by all directorates over the forthcoming year.

12. Key Objectives for 2017/18

12.1. The following key activities are planned for next year:
   a) Continue Trust wide focus on reducing and maintaining overdue complaints to 10 or under
   b) To continue work with the Patients Association to improve responsiveness and the quality of investigations and responses.
   c) To implement a new database to provide improve data tracking and reporting.
   d) To roll-out the named directorate contact model of complaint handling to improve patients’ experience of the service.
   e) To survey the experience of complainants using a complaints questionnaire, independently collated by the Patients Association, to allow future process improvements to be measured.
   f) To participate in the development and implementation and use of Datix – (the new information management system being implemented in 2017/18

13. Conclusion

13.1. North Bristol NHS Trust has made progress with regard to the process and management of complaints, concerns and enquiries, and while the performance in responding in a timely way has improved considerably, the resource demands on directorates continue to prove challenging. The Trust will continue to work with the Patients Association to strengthen the process and ensure a better experience for all involved.

13.2. The aim of improving the service and our partnership with the Patient’s association has delivered a national first of achieving lay person anonymised audits of the complaints process resulting in quality improvements.

13.3. Patients’, relatives’ and carers’ views remain very important to NBT and their feedback has again been effective in influencing change and improving practices across all disciplines and in all clinical areas.
• Improve reporting and monitoring (from the use of Datix) by the Advice and Complaints Team and Divisions
• Continue to learn from the review of complaint against the Patient Association standards by the Patient Review Panel and the CCG
• .
Annual Complaints Report
2016/2017

Types of Complaints and Concerns Received in 2016/17

<table>
<thead>
<tr>
<th>Concern</th>
<th>Lead by</th>
</tr>
</thead>
<tbody>
<tr>
<td>Other Trusts</td>
<td>Formal Complain</td>
</tr>
<tr>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>91</td>
<td>25</td>
</tr>
<tr>
<td>81</td>
<td>22</td>
</tr>
</tbody>
</table>
**Report to:** Trust Board  
**Agenda item:** 12  
**Date of Meeting:** Trust Board  28th September 2017

**Report Title:** Adult Safeguarding Annual Report  
**Status:** Information  Discussion  Assurance  Approval  
- x  
- x

**Prepared by:**  
Exec Summary: Gill Brook Head of Patient Experience  
Full Report: Sean Collins Adult Safeguarding Annual Report  2016 /17

**Executive Sponsor (presenting):** Sue Jones, Director of Nursing and Quality

**Appendices (list if applicable):** Appendix 1 : Adult Safeguarding Annual Report  2016/17

**Recommendation:**  
The Board is asked to review and receive this annual report, noting the key points in the executive summary

---

**Executive Summary:**  
2016/17 was a year of team change and development as well as increasing activity.  
The following key points of activity and change are as follows:

- **Increase in activity:** the number of safeguarding alerts continues to rise (2015/16 = 776 to 2016/17 = 1231). Some of key reasons relate to the ongoing impact of the change in the definition of harm and thresholds for alerting/ referral provided in the Care Act 2014; the increased awareness of staff through training; the addition of Domestic Abuse, Female Genital Mutilation, Modern Slavery and Prevent to the Adult Safeguarding Agenda.

- **Team:** There have been significant changes to the structure of the NBT safeguarding team, with the aim of developing a more ‘think family’ approach by bringing together safeguarding adults and children professionals. The Head of Safeguarding appointed ( also covering the Named Nurse role for Child Protection); 1.6 WTE specialist safeguarding leads were appointed ( an increase of 0.6).

- **Training:** The KPI for safeguarding adult training is set by Commissioners at 90%. Training compliance for quarter 4 was 82% for level one and 80% for level 2. Wards and departments are reminded of the updates required

- **Mental Capacity Assessment:** As well as an internal awareness, CQC, in their visit in 2015 identified the identified the need for
focus on supporting staff in developing their practice with focus within wards in the Medical Division. This took place through the year. Helping staff understand that capacity is decision specific is key including how to assess and record the decision of capacity

- **Deprivation of Liberty Safeguards (DoLS):** When a patient is admitted into Hospital, if they cannot consent to being in Hospital, the Law requires that a DoLS authorisation is completed. Once an application is made the Local Authority are required to assess whether the legal grounds have been met. A decision is required within 7 days. The number of assessments made within this time frame are small as is shown within the report. The local authorities are actively addressing the resource required for full assessment to be made. This is a nationwide issue. The quality of DoLS applications is focus of training for staff by the safeguarding team.

- **The focus for 2017/18 is as follows:**
  - Continue to promote a ‘think family’ approach across NBT
  - Introduction of the Datix System which will enable improved data collection and trend analysis (October 2017).
  - Coordinate & contribute to the training with staff on application of Mental Capacity Act & assessments and quality of DoLS applications
  - Embed good practice regarding Domestic abuse detection and support. To include the supporting the new provider of the Independent Domestic & Violence Advocate (IDVA) service in introducing and developing the IDVA maternity project (they are already providing a service out of the NBT Emergency Department)
  - Review and develop a new policy framework for adult and child safeguarding to include
    - A review of the allegations management process within the Trust.
    - A standalone Domestic Abuse Policy
    - A Deprivation of Liberty Management Policy
    - An update of the Mental Capacity Act 2005 Policy.
Safeguarding Vulnerable Adults
Annual Report

April 2016 – March 2017
1.0 Overview

The purpose of this report is to provide an update to the North Bristol Trust (NBT) Board on the previous year’s developments and service delivery in relation to safeguarding adults at risk of harm, and to provide assurance to the Board that NBT is fulfilling its statutory responsibilities and duties in relation to safeguarding adults at risk.

The Safeguarding of adults at risk remains a high priority for the Trust and requires the maintenance of collaborative working with other Health Providers, Health and Social Care Commissioners, the Local Authority and the Police.

2.0 Introduction

Responsibilities for safeguarding are enshrined in legislation. The legislation and guidance for safeguarding adults at risk relevant to the NHS include the following:

- Care Act 2014
- Counter Terrorism and Security Act 2015

NBT, in common with all health care providers, has a statutory responsibility to safeguard adults at risk of harm as directed in the Care Act 2014. Therefore it is essential that safeguarding is firmly embedded within the wider duties of NBT.

The NHSE Safeguarding Vulnerable People in the NHS – Accountability & Assurance Framework (2015) sets out clearly the safeguarding roles duties and responsibilities of all organisations providing and/or commissioning NHS health and social care.

The NBT safeguarding team has a wide remit within the Trust. Activities undertaken by the team are:

- Screening of EAims, complaints and other data sources in relation to safeguarding alerts. Those reaching the threshold are sent to Bristol social care. Alerts are divided into community acquired and hospital acquired harm.
- Managing safeguarding inquiries and attending safeguarding strategy meetings with investigators including recording actions that require completion within an agreed timescale.
- Recording Deprivation of Liberty Applications.
- Supporting the clinical frontline clinical staff by providing advice in relation to safeguarding adults, Mental Capacity Act practice (including DoLS), Mental Health Act practice, domestic abuse, human trafficking and PREVENT.
- Providing all safeguarding adults training including bespoke training sessions in relation to item 4 and 5 above.
- Managing and representing the Trust at Domestic Homicide and Safeguarding Adult Reviews.
• Attending Multi-Agency meetings i.e. Safeguarding Adult Boards and sub groups, Partnership against Domestic Abuse, PREVENT forums and Mental Capacity Act Forums

Section 43 to section 45 of the Care Act sets out the statutory objectives for Local Safeguarding Adult Boards (LSAB’s):

• To coordinate what is done by each person or body represented on the LSAB for the purposes of safeguarding adults at risk of harm
• To ensure the effectiveness of what is done by each such person or body for those purposes

3.0 Safeguarding Adults at risk of harm

Section 42 of the Care Act 2014 states that safeguarding duties apply to an adult who:

• has needs for care and support (whether or not the local authority is meeting any of those needs)
• is experiencing, or at risk of, abuse or neglect
• as a result of those care and support needs is unable to protect themselves from either the risk of, or the experience of abuse or neglect

4.0 NBT Safeguarding Adults Governance Structure

The Director of Nursing is the NBT Board executive for safeguarding adults and children.

There have been significant changes to the structure of the NBT safeguarding team, with the aim of developing a more ‘think family’ approach by bringing together safeguarding adults and children professionals.

The Head of Safeguarding came into post on the 30 January 2017 on a 0.8 WTE.

The role of the Head of Safeguarding incorporates the responsibilities of the Named Nurse for children and is accountable to the Director of Nursing and Quality via the Head of Patient Experience for the Trusts Safeguarding Children and Adults arrangements and activities, working within the Trust Values. The aim of this post is to provide a strategic and corporate direction and in partnership with the Adult Safeguarding Lead provide complex professional advice on matters relating to safeguarding vulnerable groups (adults & children)

The Adult Safeguarding Lead is employed full-time and provides leadership on adult safeguarding adults at risk including MCA, Deprivation of Liberty and is the Prevent and Domestic Abuse lead for the Trust.

There are 2 Safeguarding Specialists who came into post in August 2016 and are managed by the Adult Safeguarding Lead and cover 1.6 WTE

The safeguarding team are supported by 1.6 WTE administration support (covered by 2 individuals)
Chart 1: NBT Organisational Safeguarding Structure

The Safeguarding Committee for NBT meets quarterly and is chaired by the Director of Nursing. A highlight report is provided to the Trust Quality Committee.

Membership of the Safeguarding Committee include the Head of Patient Experience, Divisional Heads of Nursing, Medical Director, Head of Safeguarding, Safeguarding Adult Lead, Named Doctor, Named Midwife, Deputy Director HR and Senior Social Worker (Based in NBT team)

The revised Governance arrangements set up in 2015/16 are working well with the Safeguarding Committee bringing challenge and seeking assurance on all elements of safeguarding children and adults. This has enabled the identification of issues and remedial actions set out above to be progressed during the year with the involvement of internal and external parties and appropriate scrutiny of progress made. As the revised team structure embeds during 2017/18 we will accelerate our improvement plans in conjunction with our external partners and anticipate this delivering more efficient and systematic approach.

The Safeguarding Adults Operational Group (SAOG) provides a highlight report for the Trust Safeguarding Committee. The SAOG is now chaired by the Head of Safeguarding (Named Nurse Safeguarding). Operational safeguarding adults’ issues are discussed at this meeting. Representation and frequency of these meetings has been under review. 2017/18 will see an increase in frequency of meetings and the new Trust divisions will be requested to ensure representation.
Chart 2: Organisational Safeguarding Governance

5.0 Assurance & Quality

Commissioners receive regular reports which outline the service's progress against the contractual safeguarding Key Performance Indicators (KPI's)

A key quality marker is in the provision of high quality education and training across the whole workforce. The KPI for safeguarding adult training is 90%. Training compliance for quarter 4 was 82% for level one and 80% for level 2. The oversight and monitoring of the safeguarding adult training programme is managed by the Trust Learning & Research department. Uptake by levels 1 and 2 across the organisation's workforce is captured on the Managed Learning Environment (MLE) system.

Table one shows the safeguarding adults training compliance for 2016/17.

Table 1 Training Compliance 2016/17

<table>
<thead>
<tr>
<th></th>
<th>Quarter 1 2016/17</th>
<th>Quarter 2 2016/17</th>
<th>Quarter 3 2016/17</th>
<th>Quarter 4 2016/17</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding Adult Training Compliance</td>
<td>% received</td>
<td>% received</td>
<td>% received</td>
<td>% received</td>
</tr>
<tr>
<td>Level 1 - Safeguarding Adults</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Level 2 - Safeguarding Adults</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Safeguarding Adults training covers the following:

- Mental Capacity Act (including Deprivation of Liberty)
- PREVENT awareness as well as the WRAP programme.
- Domestic Abuse and Violence and
- Female Genital Mutilation
- Human Trafficking awareness.
Training is provided as part of the statutory mandatory programme (which includes induction, 3 year refresh, and specialist training). All Trust employees should receive the required level of safeguarding adults at risk training commensurate with their role. There is great emphasis placed on delivering face to face training which has received consistently high positive participant feedback.

Safeguarding Adults Referrals

We are now a year on from the Implementation of the Care Act 2014. The Care Act 2014 shifted adult safeguarding from Government policy to becoming Statutory Law.

Table 2 below shows the growth of safeguarding alerts from the Trust into the Safeguarding Team.

Table 2 number of safeguarding alerts into the Safeguarding Team by Quarter 2016/17

<table>
<thead>
<tr>
<th>Year</th>
<th>Q1</th>
<th>Q2</th>
<th>Q3</th>
<th>Q4</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>2013/14</td>
<td>22</td>
<td>12</td>
<td>42</td>
<td>34</td>
<td>100</td>
</tr>
<tr>
<td>2014/15</td>
<td>54</td>
<td>57</td>
<td>105</td>
<td>98</td>
<td>214</td>
</tr>
<tr>
<td>2015/16</td>
<td>212</td>
<td>241</td>
<td>163</td>
<td>160</td>
<td>776</td>
</tr>
<tr>
<td>2016/17</td>
<td>258</td>
<td>268</td>
<td>352</td>
<td>353</td>
<td>1231</td>
</tr>
</tbody>
</table>

The growth in alerts can be explained by the following factors:

- Change in definition and threshold as required by national requirements
- The effect of training – generating greater awareness and therefore more referrals
- Adult Safeguarding Team improved availability for support
- The addition of Domestic Abuse, Female Genital Mutilation, Modern Slavery and Prevent to the Adult Safeguarding Agenda
- Greater need to support practitioners with Mental Capacity Act and Deprivation compliance.

NBT process for raising a safeguarding alert:

NBT Trust frontline staff make safeguarding alerts using the EAIMS system when there is a consideration that a patient(s) may have come to harm. To a lesser extent alerts are also received by the NBT safeguarding team via email, phone and in person. Complaints and clinical risk alerts are also reviewed and considered by the team for safeguarding actions. Alerts are distinguished by being either: Community acquired harm or Hospital acquired harm. The following table (3) show the amount of alerts received for both types of harm.
Table 3: Rates of Hospital and Community attributed harm alerts

Members of the NBT Safeguarding Team review the alert and assess against the threshold criteria for a potential safeguarding inquiry under Section 42 of the Care Act 2014. Section 42 means that the Local Authority (often referred to as Adult Services, Adult Social Services, or Social Work teams) must:

- Make enquiries, or cause others to do so;
- An enquiry should establish whether any action needs to be taken to prevent or stop abuse or neglect, and if so, by whom.

The following table shows how many alerts/referrals were sent by NBT safeguarding team that were progressed to a Section 42 inquiry (the decision to cause an inquiry is in the responsibility of the Local Authority).

Table 4: Referrals sent to the Local Authority and those progressed to a Section 42 inquiry

Mental Capacity Assessment:

Training is provided at induction and in update training, to all staff that deliver care to patients, on the assessment of Mental Capacity. It is important that staff understand that mental capacity is decision specific. The application of the training and the
recording of the assessment is variable across wards and specialities. The CQC Inspection in December 2015 identified the need for focus on supporting staff in developing their practice with focus within wards in the Medical Division. This training is being delivered to develop the skills of staff.

Deprivation of Liberty Safeguards (DoLS)

When a patient is admitted into Hospital, if they cannot consent to being in Hospital, the Law requires that a DoLS authorisation is completed. Once an applications is made the Local Authority are required to assess whether the legal grounds have been met. A decision is required within 7 days. The chart below shows how many DoLS applications were made by NBT during 2016/17 and how many applications were assessed within the legal timeframes. There are a small number of assessments undertaken within this time frame. There may be more as the Safeguarding Team are most often not made aware of the assessment by the assessor. Overall they remain low. The local authorities are actively addressing the resource required for full assessment to be made. This is a nationwide issue.

Chart 3: DoLS applications made by NBT during 2016/17 and number of applications assessed by the Local Authority within the legal timeframe

6.0 Multi-Agency Working

NBT actively participates in multi-agency partnerships and Safeguarding Adult Board (SAB) sub-groups. The Head of Patient Experience represents NBT on both SABs. The Adult Safeguarding Lead represents NBT on the following sub groups:

- **Bristol**
  - Training
  - Serious Adult Review (SAR’s)
  - Performance & Intelligence

- **South Gloucestershire**
  - Training
  - SAR’s
  - Policy & Procedures
  - Quality Assurance
  - Partnership Against Domestic Abuse (PADA)
There were two Serious Case Reviews (SCRs) published by the BSAB in the year 2016-17. As these were commissioned before The Care Act (2014) they are SCRs and not Safeguarding Adult Reviews. Work continues on a third SCR commissioned in 2015. This is due to be published in 2017-2018.

There have been 3 domestic homicide reviews carried out in Bristol and 2 in South Gloucestershire

Any relevant learning from the reviews is included in the Trust safeguarding training programme and/or communicated to staff.

7.0 Focus for 2017/18

For the next year the Safeguarding Adult Team will be focussing on the following:

- Continue to promote a ‘think family’ approach across NBT
- Introduction of the Datix System which will enable improved data collection and trend analysis (October 2017).
- Coordinate & contribute to the training with staff on application of Mental Capacity Act & assessments and quality of DoLS applications
- Embed good practice regarding Domestic abuse detection and support. To include the supporting the new provider of the Independent Domestic & Violence Advocate (IDVA) service in introducing and developing the IDVA maternity project (they are already providing a service out of the NBT Emergency Department)
- Review and develop a new policy framework for adult and child safeguarding to include
  - A review of the allegations management process within the Trust.
  - A standalone Domestic Abuse Policy
  - A Deprivation of Liberty Management Policy
  - An update of the Mental Capacity Act 2005 Policy.
Report to: Trust Board  
Agenda item: 13

Date of Meeting: 28 September 2017

Report Title:  Children’s Safeguarding Annual Report 2016/17 (incorporating Maternity service)

Status: Information Discussion Assurance Approval

Prepared by: Sophia Swatton: Head of Safeguarding : Nicola Hennighan: Safeguarding Support Nurse Maternity Services

Executive Sponsor (presenting): Sue Jones, Director of Nursing and Quality

Appendices (list if applicable): List appendices or state none

Recommendation:
To review and receive the report noting activity, service improvements & focus for 2017/18

Executive Summary:
This report incorporates the safeguarding activity within Maternity Services. The definition of child is those below the age of 18 years of age

Context:
- Community Child Health Partnership Services moved from NBT to Sirona in April 2016. This year has, therefore, been one of transition, as the children’s services provided an important infrastructure to safeguarding processes of children (all under 18 years of age) within NBT. A full review of children’s safeguarding was undertaken by the interim Named Nurse
- There have been changes to the safeguarding team structure in 2016/17 with the aim of developing a ‘think family’ approach, bringing together safeguarding adults and children under the leadership and management of a Head of Safeguarding (appointed in January 2017) who also has the role of Named Nurse (safeguarding children)
A significant number of children (0-17yrs) are seen across NBT

- Children seen in ED (0-17 years of age) = 9435 which is 11% of total number of patients seen in the department (9974 in 2015/16)
- There are also number of children seen as inpatients across Medical, Surgical and Gynae admissions as well as those coded under Maternity services. Neonatal infant admissions are 689
- Outpatient services also review a high number of children attending in both Paediatric and other Outpatient services (see p3 for breakdown)

**Training**

- The KPI for safeguarding children training is set by Commissioners at 90% across all levels. Training compliance for the year has varied between 69% and 86%. There has been a review of quality of recoding of training on MLE against that delivered across the Trust as well as the review of training attendance with promotion as required. This is ongoing work as data is reported monthly to the CCG
- A training needs analysis has been commenced by the Head of Safeguarding as recommended in the internal review
- Identified staff in Maternity Services have undertaken additional training in relation to perinatal mental health care in response to the wider leaning from a serious case review.

**Service improvement focus :**

In response to the internal safeguarding review, requirement to secure compliance under section 11 Audit (Children Act) and other national mandated requirements there is ongoing work on the following matters:

- Identification, reporting and recording of Female Genital Mutilation (FGM) – delivery of training on the identification of FGM reporting (to police) and recording and reporting to NHS England (systems now setup on Lorenzo, improved system required in Euroking in maternity services
- Audit programme review and development as required by Local Safeguarding Boards
- Training need analysis (Children Safeguarding and Child protection) and exploration of alternative learning opportunities
- Safe transfer of referrals to Local Authority safeguarding teams: secure email (nhs.net) now in place in ED and safeguarding team
- Improvement in quality and content of safeguarding referrals – with focus on content to ensure sufficient information to assess

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.
against threshold levels. Audit completed and training in place

- Flagging of children on child protection plans on Lorenzo: review underway in Q4 of 2016/17
- Review of safeguarding supervision. Q4 - undertaken by Head of Safeguarding and initial steps taken for improving provision
- Seeking protected time for the safeguarding leads in the ED
- Ensuring participation in the relevant sub groups of the Local Authority Safeguarding Children Boards
- Ensure the attendance of members of the Trust Safeguarding Committee
- Secure the required provision of Independent Domestic Violence Advocacy Service within NBT (CCG commissioned service with local authority)
- Review of children safeguarding polices & development of FGM policy. This was commenced in Q4 under the guidance of the Head of Safeguarding.

Ongoing work for 2017 18 is based around all the above.
Safeguarding Children Annual Report

(Incorporating Maternity Services)

April 2016 – March 2017
# CONTENTS

<table>
<thead>
<tr>
<th>Section</th>
<th>Title</th>
<th>Page No</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.0</td>
<td>Overview</td>
<td>1</td>
</tr>
<tr>
<td>2.0</td>
<td>Introduction</td>
<td>2</td>
</tr>
<tr>
<td>3.0</td>
<td>Defining Safeguarding Children</td>
<td>3</td>
</tr>
<tr>
<td>4.0</td>
<td>Safeguarding Children Governance</td>
<td>3</td>
</tr>
<tr>
<td>5.0</td>
<td>Safeguarding Children Leadership</td>
<td>5</td>
</tr>
<tr>
<td>6.0</td>
<td>Assurance &amp; Quality</td>
<td>7</td>
</tr>
<tr>
<td>7.0</td>
<td>Maternity Services Report</td>
<td>10</td>
</tr>
<tr>
<td>8.0</td>
<td>Child Deaths</td>
<td>14</td>
</tr>
<tr>
<td>9.0</td>
<td>Serious Case Reviews</td>
<td>15</td>
</tr>
<tr>
<td>10.0</td>
<td>Audits</td>
<td>15</td>
</tr>
<tr>
<td>11.0</td>
<td>Conclusion</td>
<td>16</td>
</tr>
<tr>
<td></td>
<td>Appendix 1: Health Provider Roles &amp; Responsibilities</td>
<td>17</td>
</tr>
<tr>
<td></td>
<td>Appendix 2: NBT Safeguarding Children Review</td>
<td>18</td>
</tr>
</tbody>
</table>

**Table 1**
- Under 18 Activity

**Table 2**
- Representation at LSCB’s

**Table 3**
- Training Compliance

**Table 4**
- Deaths Notified over 5yrs

**Table 5**
- Location of Death for Child Dying within NBT

**Table 6**
- Audits 2016/17

**Table 7**
- Audit Plan 2017/18

**Chart 1**
- NBT Organisational Safeguarding Structure

**Chart 2**
- NBT Safeguarding Governance Structure
1.0 Overview

The purpose of this report is to provide an update to the North Bristol Trust (NBT) Board on the previous year’s developments, service delivery and challenges in relation to safeguarding children and to provide assurance to the Board that NBT is fulfilling its statutory responsibilities and duties in relation to safeguarding children.

This is the first annual report since the health care provider split which took place on 1 April 2016. At this point NBT relinquished the Community Child Health Partnership (CCHP) which included services such as health visiting, school nursing, community paediatrics and child & adolescent mental health services (CAMHs) and the named nurse for safeguarding went with CCHP. This situation prompted an essential review of the NBT safeguarding arrangements.

All staff working in North Bristol Trust have a responsibility to safeguard children. Despite the split, NBT, in its new form, still sees children as part of service delivery. Children are seen in Emergency Department (ED), Maternity, Adult & Paediatric Outpatients and 16 and 17 year olds are admitted for treatment on to the wards. The table below provides data of children and young people accessing NBT services as a percentage of total Trust activity. The paediatric out-patient figure* is not a clear representation of how many children visit out-patients, as it does not capture the data for consultations with visiting clinicians i.e. UHB.

<table>
<thead>
<tr>
<th>CQC Core Service</th>
<th>Total Activity</th>
<th>Under Eighteen</th>
<th>Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Urgent care</td>
<td>84975</td>
<td>9435</td>
<td>11.1%</td>
</tr>
<tr>
<td>Medical</td>
<td>44448</td>
<td>395</td>
<td>0.9%</td>
</tr>
<tr>
<td>Surgery</td>
<td>127127</td>
<td>504</td>
<td>0.4%</td>
</tr>
<tr>
<td>Gynae</td>
<td>4645</td>
<td>60</td>
<td>1.3%</td>
</tr>
<tr>
<td>Maternity</td>
<td>15592</td>
<td>110</td>
<td>0.7%</td>
</tr>
<tr>
<td>Services for children &amp; young people</td>
<td>689</td>
<td>689</td>
<td>100.0%</td>
</tr>
<tr>
<td>OP-Paediatric*</td>
<td>272</td>
<td>270</td>
<td>99.3%</td>
</tr>
<tr>
<td>OP Non-Paediatric</td>
<td>575621</td>
<td>10985</td>
<td>1.9%</td>
</tr>
<tr>
<td>Diagnostics (Radiology)</td>
<td>426230</td>
<td>16523</td>
<td>3.9%</td>
</tr>
</tbody>
</table>

Table 1: Under 18 activity – percentage of total Trust activity
Children come on to the Trust site even though they may not be accessing the services themselves. Adults treated at NBT come with a wide range of not only physical problems but social and safeguarding issues that can potentially impact directly on to the safety and welfare of children they are in contact with.

This annual report outlines the progress during the past year and identifies the key challenges going forward into 2017/18.

2.0 Introduction

Responsibilities for safeguarding are enshrined in legislation. The legislation and guidance for safeguarding and promoting the welfare of children relevant to the NHS include the following:

- Children Act 1989 and 2004
- Promoting the Health & Well-being of Looked After Children (2015) – statutory guidance

NBT, in common with all health care providers, has a statutory responsibility to safeguard and promote the welfare of children under Section 11 of the Children Act 2004. It is essential, therefore, that safeguarding is firmly embedded within the wider duties of NBT.

The NHSE Safeguarding Vulnerable People in the NHS – Accountability & Assurance Framework (2015) sets out clearly the safeguarding roles, duties and responsibilities of all organisations providing and/or commissioning NHS health and social care. See appendix 1 for Health Provider roles and responsibilities.

Section 14 of the Children Act (2004) sets out the statutory objectives for Local Safeguarding Children Boards (LSCB’s):

- To coordinate what is done by each person or body represented on the LSCB for the purposes of safeguarding and promoting the welfare of children in the area and
- To ensure the effectiveness of what is done by each such person or body for those purposes

These are further defined in WTSC (2015, p65-66). NBT is a member of the Bristol SCB and South Gloucestershire SCB. NBT Director of Nursing represents NBT on both SCBs. NBT actively participates in multi-agency partnerships and SCB sub-groups as reported in the table below.

<table>
<thead>
<tr>
<th>South Gloucestershire LSCB - Quality Assurance Sub Group</th>
<th>Head of Safeguarding Named Midwife</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bristol LSCB Training Sub-Group Health Sub-Group</td>
<td>Head of Safeguarding Head of Safeguarding Named Midwife</td>
</tr>
</tbody>
</table>

4
<table>
<thead>
<tr>
<th>BNSSG Name Safeguarding Professional Forum</th>
<th>Head of Safeguarding Named Midwife Named Dr</th>
</tr>
</thead>
<tbody>
<tr>
<td>Regional Named Professional Group (NHSE)</td>
<td>Head of Safeguarding Named Midwife Named Dr</td>
</tr>
<tr>
<td>MARAC Bristol South Gloucestershire</td>
<td>Safeguarding Specialist Safeguarding Specialist Midwife Safeguarding Specialist Substance Abuse Specialist Midwife</td>
</tr>
</tbody>
</table>

Table 2: Representation at LSCB & Multi-Agency meetings

3.0 Defining Safeguarding Children

WTSC (2015) defines safeguarding children as:

- Protecting children from maltreatment
- Preventing impairment of children’s health and development
- Ensuring children grow up in circumstances consistent with safe and effective care
- Taking action to enable all children to have the best outcomes.

A child is defined as anyone who has not yet reached their 18th birthday (WTSC, 2015)

4.0 Safeguarding Children Governance at NBT

The Director of Nursing is the NBT Board executive for safeguarding adults and children.

There have been significant changes to the structure of the NBT safeguarding team, with the aim of developing a more ‘think family’ approach by bringing together safeguarding adults and children professionals.

The Head of Safeguarding came into post on the 30 January 2017 on 0.8 WTE. Prior to this there was an interim Named Nurse in post between April 2016 and October 2016.

The role of the Head of Safeguarding incorporates the responsibilities of the Named Nurse for children and is accountable to the Director of Nursing and Quality via the Head of Patient Experience for the Trusts Safeguarding Children and Adults arrangements and activities, working within the Trust Values. The Head of Safeguarding leads on the development of a robust culture of safeguarding practice across the Trust, providing strategic and corporate direction including complex professional advice on matters relating to safeguarding vulnerable groups (adults & children).

An Adult Safeguarding Lead is managed by the Head of Safeguarding and is 1 WTE, they provide leadership on adult safeguarding, MCA, Deprivation of Liberty and is the Prevent lead for NBT.
There are 2 Safeguarding Specialists who came into post in August 2016 and are managed by the Adult Safeguarding Lead and provide 1.6 WTE.

The safeguarding team are supported by 1.6 WTE administration support (covered by 2 individuals).

There is also a Named Doctor Safeguarding Children for 1 PA (4 hours/week).

The Named Midwife role is within the role and responsibilities of the Community Midwifery Manager post –which is 1.0 WTE.

The Safeguarding team within the maternity services is made up of the following:

- a Safeguarding support midwife 1.0 WTE
- a mental health and bereavement specialist 1.0 WTE
- a substance abuse specialist midwife 1.0 WTE

The post holders work closely together across the Women and Children’s Directorate to support the safeguarding of children and adults under their care.

There are 2 Safeguarding Children Leads in the Emergency Department (ED). They do not, however, have protected time and activities are integrated into their role responsibilities as agreed with the head of department, with the 2 individuals often carrying out work in their own time.

Chart 1: NBT Organisational safeguarding structure
A review of safeguarding children across NBT was carried out during October 2016 by the interim Named Nurse Safeguarding Children and is included as an appendix to this report (appendix 2). The review includes recommendations that need to be considered and included as challenges within this report. In particular, regarding the need for a robust system of ‘flagging’ safeguarding/child protection concerns and the need for a review of the safeguarding policies & procedures (following the split with the CCHP services) to ensure that they are fit for purpose.

Challenge

- Continuing to promote a ‘think family’ approach across NBT
- Lack of protected time for ED Safeguarding Children Leads to adequately support the quality improvement of referrals into Children’s Social Care and safeguarding training and supervision.

5.0 Safeguarding Children Leadership at NBT

The Safeguarding Committee for NBT meets quarterly and is chaired by the Director of Nursing. A highlight report is provided to the Trust Quality Committee.

Membership of the Safeguarding Committee include the Head of Patient Experience, Divisional Heads of Nursing, Medical Director, Head of Safeguarding, Named Doctor, Named Midwife, Safeguarding Adult Lead, Deputy Director HR and Senior Social Worker (Based in NBT team).

The revised Governance arrangements set up in 2015/16 are working well with the Safeguarding Committee bringing challenge and seeking assurance on all elements of safeguarding children and adults. This has enabled the identification of issues and remedial actions set out above to be progressed during the year with the involvement of internal and external parties and appropriate scrutiny of progress made. As the revised team structure embeds during 2017/18 we will accelerate our improvement plans in conjunction with our external partners and anticipate this delivering a more efficient and systematic approach.

The Safeguarding Children Operational Group (SCOG) meets on a monthly basis. A highlight report is provided for the Trust Safeguarding Committee. The SCOG is now chaired by the Head of Safeguarding (Named Nurse Safeguarding).

Operational safeguarding children issues are discussed at this meeting which have tended to focus on maternity services and the emergency department as to date it is these two departments that are represented at the meetings.

Membership of the Safeguarding Children Operational Group include the Head of Patient Experience, Named Doctor, Safeguarding Adult Lead, Named Midwife, Specialist Safeguarding Midwife, Divisional Matrons and ED Safeguarding Leads.
Chart 2: NBT Safeguarding Governance Structure

**Challenge**

- To ensure that there is appropriate attendance at the SCOG and Safeguarding Committee that takes into account the newly formed divisions and encourages participation/representation of all departments.

6.0 **Assurance & Quality**

Commissioners receive regular reports which outline the service’s progress against the contractual safeguarding children Key Performance Indicators (KPI’s) which include:

- Safeguarding children training uptake levels
- Safeguarding children supervision provision and uptake
- Referrals to children’s social care
- Engagement in serious case reviews/case reviews/domestic homicide reviews
- Midwifery specific data:
  - Number of referrals
  - Number of invitations received for child protection conferences for an unborn baby
  - Number of child protection reports produced for conference
  - Number of conferences for which reports produced and midwifery attendance
  - Number of unborn infants subject to a child protection plan
  - Number of pregnant women under 18 years
A key quality marker is in the provision of high quality education and training across the whole workforce. The monitoring of mandatory safeguarding children training uptake by levels 1 to 3 across the organisation's workforce is captured on the Managed Learning Environment (MLE) system. The provision and monitoring also includes the Prevent training.

NBT staff are trained to recognise, understand and report safeguarding concerns for children and young people. All training is delivered in line with the requirements set out in the document *Safeguarding children and young people: Roles and competences for health care staff. Intercollegiate Document. 3rd Edition. March 2014.* The required standard set by our Commissioners is that 90% of staff requiring a particular level are attending the relevant training. The attained levels are shown below in Table 3.

<table>
<thead>
<tr>
<th>Training level</th>
<th>Compliant Staff</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>2016/17 Quarterly Range</td>
</tr>
<tr>
<td>Level 1</td>
<td>80 – 86%</td>
</tr>
<tr>
<td>Level 2</td>
<td>82 – 88%</td>
</tr>
<tr>
<td>Level 3</td>
<td>69 – 81%</td>
</tr>
</tbody>
</table>
Table 3: Training Compliance Levels 2016/17

The lowest level of compliance was seen in Quarter 3 (October – December 2016) 69%, which was driven by a number of factors. These included:

- Capacity of the central team to deliver all the training
- Incomplete recording of medical staff training and of the in-department training in the Emergency Department.

Prevent training which meets awareness raising standards and ensures that staff understand the prevent duty, information sharing and how to access advice is included in the mandatory training schedule.

As part of the United Kingdom’s Counter-terrorism strategy – CONTEST, Health is involved in the fourth aspect of PREVENT, which looks at identifying and supporting individuals who may be vulnerable and at risk of radicalisation before they become radicalised. As this process is primarily looking at individuals who are at risk, it links to the safeguarding agenda.

The NBT Prevent lead is the Adult safeguarding lead who acts as a single point of contact for the regional co-ordinators and is responsible for implementing Prevent within the organisation.

During 2016-17 the following developments were completed:

- 6940 (78%) staff are in date with basic Prevent training
- 800 staff require Workshop to Raise Awareness of Prevent (WRAP) training of which 186 (23%) are in date
- 3 members of staff are accredited WRAP 3 trainers
- 2 referrals were made to the Bristol Channel coordinator
- Information was provided on 2 Bristol Channel cases
- Prevent is a standing item on the NBT safeguarding committee

Challenges

- Ensure that assurance and quality are demonstrated through a constant programme of review via the NBT committee structures.
- Need for a review of recording on and reporting from the MLE system with the manager of this service.
- Need for clarity of what training is being delivered, when and to and by whom within ED and maternity services
- Need for a safeguarding children training needs analysis to include:
  - A training matrix (staff groups requiring training and at what level)
  - Review of types of learning (E-Learning/case reviews/face to face training etc.)
  - Accessibility and recording of training
- Need to refresh strategy to provide WRAP training to relevant staff to include:
  - Continue to provide basic awareness prevent training during mandatory safeguarding training
  - A matrix (staff groups requiring WRAP training)
  - Training provision plan
• Need to refresh strategy for the provision of Female Genital Mutilation (FGM) and recording on Lorenzo system training to include:
  ➢ Continue to provide awareness training during mandatory safeguarding children training
  ➢ Highlight departments who are more likely to come into contact with females who have had or are at risk of having FGM performed on them

• Need for a safeguarding children supervision needs analysis
  ➢ To include supervision matrix
  ➢ Analysis to inform a NBT safeguarding supervision policy to include the maternity service safeguarding supervision process guidance

7.0 Maternity Services

North Bristol community midwives provide care to women and their families across Bristol, North Somerset and South Gloucestershire. Community midwifery teams consist of a Team leader (senior Band 7 Midwife), Band 6 and Band 5 Midwives and Maternity care assistants (Band 3).

NBT maternity services have a Maternity Safeguarding team who oversee complex cases and ensure appropriate referral and information sharing. The team consists of a Safeguard Support Midwife (deputising to Community Midwifery Manager and Named Midwife for Safeguarding), Specialist Substance Misuse Midwife and a Mental Health and Bereavement Lead Specialist for maternity services.

Update from the Specialist Substance Misuse Midwife (SSMM):

This year, the SSMM has continued to offer routine home visits for all women with concerns around substance misuse and, in 2016/2017, this service was extended to women who are also experiencing difficulties with ceasing cannabis use.

This role aims to ensure:

• Provision of individualised care packages to substance misusing women and their families, including attendance at Safeguarding Conferences and all associated meetings.
• To attend to meet with the clients via home visits in the ante natal period and at least one post-natal visit (ward or home).
• A new service was introduced in 2016 which ensures all pregnant women in HMP Eastwood Park receive ante natal education classes (once monthly). Senior Student Midwives are encouraged to attend these also, to facilitate their learning re these vulnerable clients.
• Regular education sessions for all Maternity Healthcare Professionals re caring for substance misusing women and Prisoners.
• The provision of contraception advice and the offer to administer Long Acting methods to all young mothers or vulnerable women, prior to discharge from hospital.

Additional Roles undertaken in 2016/2017 by the NBT Midwifery Safeguarding Team:

• SSMM: To work closely with Outreach Nurses at Central Health clinic to ensure all young mums and their families receive up to date information.
• SSMM: To offer contraception to the young people to try to prevent further pregnancies until such a time the young person is ready.
• Safeguard Support Midwife and Learning Disabilities Nurse now undertake regular home visits to assess safeguarding needs and support clients who have been identified as having moderate learning disabilities, to ensure individualised care packages are in place for the woman and her family.
• The NBT Midwifery Safeguard Team offer both antenatal and postnatal care to all women residing in New Horizons Mother and Baby Unit.

Midwifery Mental Health & Bereavement Lead Specialist

Up to one in five women and one in ten men are affected by mental health problems during pregnancy and the first year after birth. Unfortunately, only 50% of these are diagnosed. Without appropriate treatment, the negative impact of mental health problems during the perinatal period is enormous and can have long-lasting consequences on not only women, but their partners and children too. However, this is not inevitable. When problems are diagnosed early and treatment offered promptly, these effects can be mitigated.

Following a successful Department of Health bid BNSSG launched its new perinatal mental health services in February 2017 - the service has been gradually rolling out across the service and supports women in addition to acute maternity services. We now hold regular triage meetings to facilitate a timely handover of high risk pregnant women.

NBT maternity services also offer:

• Three (more when required) mental health clinics per week (approximately 12-15 clients per week, each receiving one hour consultation with a Specialist. There is an option for immediate referral to Consultant Obstetrician on the same day.
• Birth trauma and tokophobia support given to pregnant and postnatal women with the option of accessing the REWIND technique which can help to de-traumatise.
• Home visits to vulnerable, antenatal and postnatal clients: approximately 2-3 clients per week, each client receiving one to two hours consultation with specialist.
• Bereavements clients: On-going support which may range from 2-6 per month; Specialist offers consultation whilst as inpatient and follow up at home; consultations are not time-specific but can range from one – three hours as required.
• Teaching on Intra Partum study days (multi-disciplinary) and mandatory study days for midwives and MCA’s. Teaching on induction day for new midwives. Teaching on induction days for new obstetric doctors (safeguard process).
• Level 3 Maternity Specific study days; Perinatal Mental Health – 8 full day,
• Facilitating referral to specialist mental health services including New Horizons, and follow on support both antenatal & postnatal care for women on New Horizons and offer assistance/attend meetings for any safeguard issues for these women.
• Sign-posting to community services and liaising with community health care professionals around care-planning and future medication. Overseeing complex social situations.
Referring to partner mental health agencies.

We support women during their pregnancy with appointments and individualised emotional wellbeing plans.

Working with other agencies to support women with mental health issues such as ‘Bluebell and Mother’ for Mothers (charity that supports women and their families with anxiety and depression).

Training made available to all health care professionals (WCH) 2016/2017

In 2016/2017 the NBT Midwifery Safeguard Team provided the following training to maternity staff:

- Domestic Abuse Study Day (full day – Level 3) for midwives and maternity care assistants.
- Perinatal Mental Health Study Day (full day – Level 3)
- Midwifery Serious Case Review: Learning Lessons (2 hours) - Level 3.
- X4 Peer presentations (Level 3).
- PREVENT training has now been rolled out to all health care professionals within Women & Children’s Health Division.

NBT Midwifery Team training:

- NBT Midwifery Safeguard team has undertaken the ASSIST Suicide Prevention two-day training course
- The SSMM and the Mental Health & Bereavement Specialist have undertaken the Perinatal and Infant Mental Health two-day training course in order that both may roll out perinatal mental health training to other professionals within the Women & Children’s Health Division
- The Specialist Safeguarding Midwife has undertaken the UWE Perinatal Mental Health Module
- The SSMM and the Safeguard Support Midwife completed the Leadership Programme for Safeguarding Children (via NHS England) – three day course (Level 4).

Midwifery Supervision:

The Maternity Safeguard Team continues to offer supervision via:

- One-to-one child protection supervision was commenced as of 01.10.2016, for all community midwives who are supporting parents whose infant has been placed on a Child Protection plan. This oversees both professional oversight of case and the health care professional personal well-being/training needs etc.

- Peer Supervision is offered to all maternity staff on a quarterly basis, reviewing recent Serious Case Reviews in line with on-going cases in the unit, and sharing lessons learned and good practice.

- Each community team has quarterly small group supervision where local cases are discussed.
Staff working within the maternity unit are able to access supervision on an ad-hoc basis and monthly via the NBT Midwifery Safeguard team.

A new Preceptorship Programme (Safeguard specific) is now underway for all new midwives commencing employment within Women & Children's Division. A full day of midwifery-specific safeguard training will be part of this Preceptorship programme and six monthly one-to-one reviews (for the first two years following recruitment). All midwives rotating into the community (from the maternity unit) will also receive half-day community-specific safeguarding training.

The Maternity Safeguard Team receive monthly individual supervision and on an ad-hoc basis as needed. There is also a bi-monthly Safeguard Team supervision meeting.

Communication:

NBT Maternity Safeguard Team hold a monthly Maternity Service Safeguard meeting, in which representatives from Maternity, Community midwifery, NICU and Health Visiting Child Protection Supervisors attend. The aims of this meeting are:

- A two-way process of feed-down and feed-back from representatives of the meeting to the Safeguard Operational Group
- Case Reviews, including in-depth discussion of cases currently under Child in Need or Child Protection Plan
- National Guidance and National topic updates
- Review and update (as required) NBT Midwifery Safeguard guidelines.

New communication aid for women with Learning Disabilities or those where English is not their first language:

- A new resource pack has been trialled for women with Learning Disabilities and/or non-English speaking women and will be launched with the half-day study days re Pregnancy and Learning Disabilities.

Audits:

Completed audits during 2016:

- To assess changes in practice regarding supplementary evidence records where there are safeguarding concerns (see attached for outcomes)
- Quality of Communication of Handover, between Community Midwife and Health Visitor in Substance Misusing Women.

### 8.0 Child Deaths

- Information taken from the West of England Child Death Overview Panel annual report April 2015-March 2016

<table>
<thead>
<tr>
<th>Region</th>
<th>2011/12</th>
<th>2012/13</th>
<th>2013/14</th>
<th>2014/15</th>
<th>2015/16</th>
</tr>
</thead>
<tbody>
<tr>
<td>BANES</td>
<td>8</td>
<td>6</td>
<td>6</td>
<td>8</td>
<td>8</td>
</tr>
<tr>
<td>Bristol</td>
<td>30</td>
<td>43</td>
<td>30</td>
<td>31</td>
<td>35</td>
</tr>
<tr>
<td>North Somerset</td>
<td>15</td>
<td>10</td>
<td>13</td>
<td>6</td>
<td>14</td>
</tr>
<tr>
<td>South Gloucestershire</td>
<td>11</td>
<td>15</td>
<td>12</td>
<td>12</td>
<td>13</td>
</tr>
</tbody>
</table>
Table 4: Deaths notified over the 5 year period reported by area of residence

- Table 4 indicates that a large proportion of notifications each year come from areas outside the West of England region (BANES, Bristol, North Somerset and South Gloucestershire), either within the South West region (Other South West) this includes Wiltshire, Gloucestershire, Somerset, Swindon, Devon, and Cornwall, or outside the South West region (Out of Region) this includes South Wales and children visiting the area from other parts of the UK. This is because Bristol contains tertiary referral units for neonates and children and specialist services including cardiology, oncology and neurology.

- Over the five-year period 12% (71/581) of all child deaths occurred at hospitals within NBT (Southmead and formerly Frenchay Hospitals).

<table>
<thead>
<tr>
<th>Other South West</th>
<th>48</th>
<th>43</th>
<th>37</th>
<th>37</th>
<th>36</th>
</tr>
</thead>
<tbody>
<tr>
<td>Out of Region</td>
<td>12</td>
<td>12</td>
<td>14</td>
<td>9</td>
<td>3</td>
</tr>
<tr>
<td>Total</td>
<td>126</td>
<td>129</td>
<td>112</td>
<td>103</td>
<td>109</td>
</tr>
</tbody>
</table>

Table 5: Location of death for children dying within NBT Hospitals

<table>
<thead>
<tr>
<th>Paediatric/Neonatal Intensive Care Units (PICU/NICU)</th>
<th>Emergency Department</th>
<th>Theatres/Central Delivery Suite</th>
<th>Adult ICU</th>
</tr>
</thead>
<tbody>
<tr>
<td>43 (NICU)</td>
<td>3</td>
<td>21</td>
<td>4</td>
</tr>
</tbody>
</table>

9.0 Serious Case Reviews (SCR’s)

- WTSC (2015, p75-77) sets out the statutory duties in terms of SCR’s:
- Regulation 5 of the LSCB’s Regulation 2006 sets out the functions of LSCB’s. This includes the requirement for LSCBs to undertake reviews of SCR’s in specified circumstances
  - Regulation 5(1) (e) and (2) set out an LSCB’s function in relation to SCR’s, namely:
    - 5 (1) (e) undertaking reviews of serious cases and advising the authority and their Board partners on lessons to be learned.
    - (2) For the purpose of paragraph (1) (e) a serious case is one where:
      - (a) Abuse or neglect of a child is known or suspected and;
      - (b) Either – (i) the child has died or
      - (ii) the child has been seriously harmed and there is cause for concern as to the way in which the authority, their Board partners or other relevant persons have worked together to safeguard the child.
  - SCR’s are not inquiries into how a child died or who is to blame; this is a matter for the judicial system. Each review ends with a set of recommendations reflecting the learning from the case. Recommendations can be focused towards individual agencies or across agencies. The LSCB is asked to adopt each report’s recommendations and having done so, the relevant agencies are expected to implement them.

Neither Bristol nor South Gloucestershire LSCB published any SCR’s during 2016/17. There are 6 SCR’s in progress with 2 being published April 2017.
10.0 Audit

NBT has participated in a programme of both single and multi-agency safeguarding audits

| Maternity                                                                 | • To assess changes in practice regarding supplementary evidence records where there are safeguarding concerns (see attached for outcomes)  
|                                                                           | • Quality of Communication of Handover, between Community Midwife and Health Visitor in Substance Misusing Women. |
| Emergency Department                                                     | • Quality Assurance Audit of ED Referrals to Children’s Social Care  
|                                                                           | • Safeguarding information sharing with Primary Care (Multi-Agency)  
|                                                                           | • 16-17 year olds presenting to ED |

Table 6: Safeguarding audits carried out during 2016/17

Audit Plan for 2017/18

| NBT Maternity Service | • Request for Help Audit (Looking at 3/12 of referrals)  
|                       | • Referral rate of 8 specific perinatal mental health conditions to the mental health antenatal clinic | Nicola Hennighan & Linda Hicken  
|                       |                                                             | Sacha Barber |
| NBT Emergency Department | • 16 – 17 year olds  
|                           | • Non-mobile baby  
|                           | • Request for Help Audit | Adam Brown  
|                           |                                                             | Adam Brown with support from SS/NH  
|                           |                                                             | Adam Brown with support from SS |

Table 7: Safeguarding audits plan for 2017/18

Challenges:

Need to consider appropriate audit for adult services

11.0 Conclusion

This Annual report has provided an update on the developments, service delivery and challenges in relation to safeguarding children and to provide assurance to the Board that NBT is committed to fulfilling its statutory responsibilities and duties in relation to safeguarding children

2016/17 has been a challenging and developmental time for NBT since the split with the CCHP which has necessitated an essential review of the NBT safeguarding arrangements.
A key area of activity for 2017/18 is to translate the challenges highlighted in this report into a NBT safeguarding children work plan which is agreed and monitored by the Safeguarding Committee.
Appendix 1

Roles & Responsibilities

Health Provider

It is strongly recommended that safeguarding forms part of any mandatory training in order to develop and embed a culture within their organisation that ensures safeguarding is acknowledged to be everybody’s business from ‘the board to the floor’

All health providers are required to have effective arrangements in place to safeguard children and to ensure themselves, regulators and their commissioners that these are working. These arrangements include:

- Safe recruitment practices and arrangements for dealing with allegations against people who work with children or vulnerable children as appropriate
- A suite of safeguarding policies including a chaperoning policy
- Effective training of all staff commensurate with their role and in accordance with the intercollegiate competences 2014
- Effective supervision arrangements for staff working with children/families
- Effective arrangements for engaging and working in partnership with other agencies
- Identification of a named doctor and a named nurse and a named midwife, for safeguarding children
- Developing an organisational culture such that all staff are aware of their personal responsibility to report concerns and to ensure that poor practice is identified and tackled
- Policies, arrangements and records to ensure consent to care and treatment is obtained in line with legislation and guidance including the Children Act 1989/2004 and the MCA 2005

Named Professionals

Named professionals have a key role in promoting good professional practice within their organisation, supporting the local safeguarding system and processes, providing advice and expertise for fellow professionals and ensuring safeguarding training is in place. They should work closely with their organisation’s safeguarding lead, Designated Professionals and the LSCB.

(Safeguarding Vulnerable People in the NHS – Accountability & Assurance Framework, 2015, p19-20)
Appendix 2

Review of Children’s Safeguarding across NBT

October 2016

Author: Mary Mason

Title: Interim Named Nurse Child Protection

North Bristol Trust (NBT)
1.0 Introduction

NBT changed as an organisation when a provider split occurred on April 1st 2016. At this point Community Child Health Partnership (CCHP) moved taking with it community services including Health Visitors, School Nurses and Community Paediatricians. The Named Nurse for Child Protection role went with CCHP and so NBT in its new structure employed a Named Nurse.

The role of Named Midwife for Child Protection is within the role and responsibilities of the Community Midwifery Manager post –which is 1.0 WTE.

The Safeguarding team within the maternity services is made up of the following:

- a Safeguarding support midwife 1.0 WTE,
- a mental health and bereavement specialist 1.0 WTE
- a substance abuse specialist midwife 1.0 WTE

The post holders work closely together across the Women and Children’s Directorate to support the safeguarding of children and adults under their care.

The Head of Patient Experience has requested a review of the provision of service for children’s safeguarding across NBT to ensure that it is robust and fit for purpose following the change in the provider organisation.

2.0 Background

NBT, in its new form, still sees children as part of service delivery. Children are seen in ED, Maternity, Paediatric Outpatients and 16 and 17 year olds are admitted for treatment to the wards. Children come on to the Trust site even though they may not be accessing the services themselves.

Adults treated at NBT come with a wide range of not only physical problems but social and safeguarding issues that can potentially impact directly on to the safety and welfare of children they are in contact with.

3.0 Safeguarding Children Governance Structure at NBT

The Director of Nursing has responsibility across NBT for the safeguarding of adults and children who come into contact with the Trust.

The Head of Patient Experience manages the Named Nurse and Doctor for Child Protection roles.

The structure of the Safeguarding Team for Adults and Children is currently under review but at the present time the structure is as follows for the children’s safeguarding side:

Named Nurse - 1WTE

Named Doctor - 4 hours per week

PA to the Named Nurse - 22.5 hours per week

The Named Midwife for Child Protection role is within the role and responsibilities of the Community Midwifery Manager post –which is 1.0 WTE.
The Safeguarding team within the maternity services is made up of the following:

- a Safeguarding support midwife 1.0 WTE,
- a mental health and bereavement specialist 1.0 WTE
- a substance abuse specialist midwife 1.0 WTE

The post holders work closely together across the Women and Children’s Directorate to support the safeguarding of children and adults under their care.

2 Child Safeguarding Leads in ED – No specified protected hours the activities are integrated into their role responsibilities as agreed with the head of department.

4.0 Leadership in NBT for Safeguarding Children

The Safeguarding Committee for NBT meets quarterly and is chaired by the Director of Nursing who also attends the Bristol and South Gloucester Safeguarding Children’s Boards.

The Safeguarding Children Operational Group (SCOG) meets on a monthly basis and feeds into the NBT Safeguarding Committee. The SCOG is chaired by the Head of Patient Experience who has senior management responsibility for the Safeguarding Service across the Trust.

Membership of the Safeguarding Committee includes the Heads of Nursing and Medical Director, Named Nurse and Doctor, Named Midwife and the Safeguarding Adult Lead.

5.0 Maternity

Maternity is provided with two WTE safeguarding children posts, a Named Safeguarding Midwife and a Safeguarding Support Midwife and there is also a Drug and Alcohol Midwife and a Mental Health Midwife. The first two roles showed a strong commitment by NBT for safeguarding the unborn and neonates and should always operate as WTEs because of the volume of work involved in their role. The last two roles are also invaluable in supporting the safeguarding of children.

Across Maternity the Safeguarding Midwives have worked tirelessly to build good multiagency information sharing. The referrals are quality assured and the thresholds for each referral cited on the forms. The safeguarding children policies are adhered to and supervision and training are of a high quality.

1. Governance Structure

   ![Women's and Children's Structure A](image)

2. Midwifery Safeguarding Children Supervision – SOP as per attached

   ![SOPProcedureJuly16.docx](image)

3. Maternity MARAC Procedure
4. Link for the Injuries in Non-Mobile Babies Policy for Bristol Safeguarding Children Board;


The final signoff for the Policy is still to happen in South Gloucester and North Somerset but is used presently in all areas.

5. Escalation – South West Child Protection Procedures;

These are promoted in training to emphasise the importance of constructive challenge;

http://www.proceduresonline.com/swcpp/bristol/p_escalation.html?oom_highlight=escalation+policy

6. Thresholds; are accessed via http://www.proceduresonline.com/swcpp/ for all areas, Bristol, North Somerset and South Gloucester

5. Training undertaken by Midwifery Safeguarding Team 2015/2016

Domestic Abuse – Level 3    full day

- There have been four Level 3 domestic abuse study days so far in 2016 and there is one more being delivered. There are currently 123 midwives/MCAs trained and a further 36 booked on for the last training on 11.10.2016.

Perinatal Mental Health – Level 3    full day

Midwifery Serious Case Review:   Level 3

Safeguard Peer presentations – quarterly

General Safeguarding Overview – Level 3 – full day

Mandatory IP Study day:  1 hr: Domestic Abuse: Asking the Questions & information sharing

Mandatory Midwifery Study Day:  Prevent/WRAP – 1 hr (Trust topic for 2016/2017 – which completes in April 2017)

- 85 have attended WRAP training so far this year and 119 are booked on to attend in October and November with more sessions being delivered from January to April 2017

6. Audits 2015/2016:

- The audits are annual and there are generally two a year carried out in Women and Children’s Health
i. Audit No: CA34382:
Quality of Communication of handover between community midwife and health visitor in substance misusing women

ii. Audit No: CA65870:
An audit examining the transfer of information between healthcare professionals for women identified with safeguarding concerns for the unborn baby (including review of supplementary evidence)

April 2017 audits will be:

- Review of effectiveness of home visits for women with infants on Child Protection, including substance misuse clients
- The efficacy of the new midwifery safeguard preceptorship programme for safeguarding

(These have not been registered as yet and will commence in April 2017 if agreed with SCOG).

6.0 Emergency Department

ED at NBT treats children with minor injuries/illness. Major presentations and ambulance cases/traumas in children are seen at other Bristol settings. Averages of 12 to 15,000 children a year are seen at NBT ED. The Named Doctor is based in ED along with two safeguarding leads. The safeguarding lead roles are undertaken by 2 nursing staff in the department and they do this because of their interest in safeguarding children. There is no protected time for the safeguarding element of their role and therefore the time can be compromised by clinical demands when the department is busy which the case is more often than not.

Information sharing from ED

Referrals to Children's Social Care (CSC) are made if there are concerns for safeguarding children and this can happen even if the child is not present. Risk assessment is done where a presenting adult’s behaviour or condition may have or will pose a risk to a child’s safety and wellbeing.

NBT Safeguarding Children’s Team receive a faxed copy of all referrals to CSC. The Health Visitor and School Nurse and GP also receive information about all children attending and CSC referrals and also where adults being treated have caused a concern or a family may be in need of extra support.

Concerns:

There have been some difficulties with secure transfer of information to other agencies which are currently being urgently addressed by IT in ED. An ED Team NHS net account will be set up.

An ED Audit was carried out on the 29th September on ‘Quality of Referrals from ED to Children’s Social Care’ and has been reported on attached Appendix 1
7.0 Domestic Abuse and ED

There are Independent Domestic Violence Advocates (IDVAs) commissioned through Survive who are based in ED. There is 1 WTE IDVA and 2 PT supportive posts, one of 15 hours and one of 10 hours.

IDVAs will do a Domestic Abuse, Stalking and Harassment and Honour Based Violence (DASH) Risk Assessment on patients and decide what the best course of action to safeguard them is. They will also consider the needs and risks if there are children involved in the situation.

The IDVAs will also cross to Maternity to do assessments if requested but this is an informal arrangement

There are no IDVAs operational within other departments and wards of NBT despite patient coming in routinely for treatment and disclosures of domestic abuse being made.

This is currently under review and the service is going out to tender again and a decision to be made in November 2016 about commissioning arrangements across South Gloucester and Bristol from April 2017.

8.0 Children’s Outpatients Department

The Safeguarding Support Midwife is Safeguarding Lead for NBT Children’s Outpatients and there are Lead Doctors in children’s Out Patients. These Leads are accessible for advice and support on safeguarding to the department.

All the staff in the department have completed Level 2 and 3 training and have annual mandatory updates. All the staff including the receptionist have Level 3.

Safeguarding supervision on cases is provided by named leads and by the NBT Safeguarding Team on an ad hoc basis.

To refer to Children’s Social Care, Children’s Outpatients use the Bristol First Response system and online form and for child protection a formal referral is made through the secure NHS net email.


Children’s Outpatients staff contact the NBT Safeguarding Team to ensure everything has been covered. The line managers from NICU are also involved and the child’s paediatrician and Health Visitor or School Nurse to ensure that information is shared.

There are a varied number of clinics run for up to 19 year olds;

- Diabetic
- Respiratory
- Immunology
- General Surgery
- General Paediatrics
Neurology
Neuro Developmental
Vaccination
Prolonged Jaundice
Venepuncture Clinic
New born blood spot catch ups with children born out of the country
Urology
Renal
Genetics 100,000 Genome Project
Dietetics
Neonatal Clinics

General Paediatric Clinics are also run at Cossham Memorial Hospital.

All staff in Children’s Outpatients are employed directly by NBT and work under the umbrella of NICU as the managers are responsible for both settings.

All the doctors (except for the Neonatal Team), and Specialist Nurses are employed by University Hospital Bristol (UHB). These nurses have responsibility for respiratory, diabetic and allergy clinics. Children’s Outpatients also work with the Community Neonatal Nurses.

Children’s Outpatients use the very robust UHB Did Not Attend (DNA) Policy. All other policies relating to children are the NBT Policies. There is a Policies Book kept in the Paediatric Outpatients Department and, as an example, the toy cleaning policy is used that was devised by NBT Infection Control Team.

9.0 Children’s Safeguarding Training

There has been some negative feedback recently from delegates attending safeguarding adult and children training about repetition within the induction program and some confusion about the safeguarding adults and children agenda as they are delivered together for Level 1.

Safeguarding adults and children’s training needs to be done separately to prevent confusion and to clarify the response requirements as they differ legally.

Children’s safeguarding training is based on Safeguarding Children and Young people: roles and competences for health care staff Intercollegiate Document March 2014

Level 1

All non-clinical staff require a Level 1 training every 3 years for 2 hours.

Level 2

All clinical staff who come into contact with adults or children require 3 to 4 hours of training delivered 3 yearly

Level 3

All clinical staff who deliver care to children require a minimum of 6 hours training every 3 years.
Those moving into a substantive career grade require 8 hours in their first year.

Those in specialist level competencies require 16 hours over 3 years.

Once a professional has reached a Level 3 CP training there is no need to repeat Levels 1 or 2

Looking at the current structure of the induction training the following would be ideal;

As Level 1 and 2 safeguarding children can be trained concurrently, training to all staff at induction could take place over a 3 hour slot.

Doctors’ Induction BAWA

All new doctors at induction at NBT should have had the appropriate safeguarding children training and so could receive a short session signposting them to the Safeguarding Team for support and advice and the NBT intranet page for contacts and policies and Local Safeguarding Children Boards.

Level 3 CP training

These trainings are organised by safeguarding leads for the various directorates and are delivered in Midwifery, ED and Children’s Outpatients. A program of Level 3 training should be devised from now until the beginning of April 2017 taking into consideration the numbers across NBT to be trained to this level and the number of trainer hours available.

Quality Assurance of Training

All current safeguarding children training packages delivered in NBT have been quality assured by the Named Nurse for CP against the standards set in Safeguarding Children and Young people: roles and competences for health care staff Intercollegiate Document March 2014 and standards are achieved attached Appendix 2

10.0 Flagging Records

There is work being taken forward to reinstate the flagging on Lorenzo of children on Child Protection Plans. This ceased when the providers split in April 2016 and the Admin Team responsible for this task went with CCHP. The Safeguarding Team and IT are currently working to resolve the problem.

11.0 Female Genital Mutilation (FGM)

Training and Awareness

The Adult Safeguarding team have been supportive in developing the FGM work and future learning in NBT.

The current training programme is in the process of being cascaded across the organisation. It has been focused in the early weeks at the known ‘hot spot’ areas such as ED, Urology and Midwifery where professionals are most likely to encounter FGM because of their clinical work.

All Directorates now have identified FGM Leads to support this and future work across the organisation.
Collation of information

Currently two data systems are in use across the Trust. ‘Euroking’ is used in Maternity Services and Lorenzo for the wider NBT. The reporting of FGM is incorporated within Lorenzo as a power form. All the information will be pulled from both systems to support the national data. Having the two systems’ codes currently proves problematic and the uploading of data has to be inputted manually by the nursing staff.

Policy

The Adult Safeguarding Policy has been amended to reflect the management of FGM (requiring ratification by the Clinical Effectiveness Committee as an updated policy).

12.0 Summary

NBT since reorganisation in April 1st 2016 is effectively a new organisation. Since the provider split there is recognition by NBT management of the risk this poses to effective safeguarding of children because of a number of factors. Reorganisation disrupts known pathways of referral and can mean a loss of expertise within organisations on safeguarding children. It takes a long time for professionals to grow good and robust relationships with each other which then enables good decision making in safeguarding. This is also the foundation on which good safeguarding children supervision is built.

There are areas in NBT where safeguarding children is well bedded and there are excellent examples of practice and overall a continual striving to maintain this. In other areas of the Hospital, although there are some examples of good recognition and response, it is hard to determine whether there is an overall robust culture of safeguarding children and whether cases go unrecognised. Southmead Hospital is viewed by some as a site that cares for adult patients.

With the continued approach the Safeguarding Children Team have begun, NBT will continue to strengthen their responses where children require agency input or their health or welfare may be at risk.

13.0 Recommendations

1. Safeguarding roles within the Safeguarding Children Team and Midwifery in NBT must have protected time to deliver the service. This should on no account be undermined or compromised because of budget cuts or delivery of clinical work. Safeguarding children requires adequately resourced posts to a respond to risk. In the event of inadequate response to a child safeguarding issue that comes to light, the Trust could be heavily criticised.

2. Terms of Reference, membership and frequency of Safeguarding Children’s meetings will be reviewed to ensure they are fit for purpose.
3. Safeguarding Children Policies and Procedures and those relating to children are being updated and this work needs completing.
4. Delivery of safeguarding children training in NBT should be delivered separately from safeguarding adults at induction. A review of how best to deliver all the levels of training to ensure delegates benefit and measure how practice is improved needs
to be undertaken. Training delegates together from across directorates on Level 3 safeguarding children would increase the understanding of roles within NBT in and share best practice examples.

5. Safeguarding children training packages must be quality assured annually against the Intercollegiate Document; Safeguarding children and young people: roles and competences for health care staff March 2014. There is work by the Bristol CCG to have peer review in place for safeguarding children training and NBT must engage with this while it continues.

6. IT must support safeguarding across the Trust to ensure information sharing to other agencies meets the standards for data protection. This includes access to secure email addresses for departments.

7. The flagging of NBT Lorenzo records, where children are or have been on child protection plan, is under review. This has yet to be resolved and remains a high priority for the Safeguarding Children Team and IT and must be completed.

8. The role and distribution of the Independent Domestic Violence Advocates is under review at NBT. This will be considered further when the Domestic Abuse provider for South Glos and Bristol is settled on in December 2016. Currently IDVAs are available in ED and also in Maternity in NBT when called on. NBT will look at the figures across the rest of the Trust on DA to decide whether further provision needs to be sought.

9. The ED would benefit from an operational member of the Safeguarding Children Team to support and supervise members of ED staff. This would enable improvement in quality of referrals (as has been proven in Maternity) and ensure that referrals are appropriate and reach the Thresholds for Bristol and South Glos Children’s Social Care. The existence of the role would enable a reorganisation of tasks within the Safeguarding Children Team and prevent the duplication of processes.
Appendix 1

Quality Assurance Audit of ED Referrals to Children’s Social Care First Response Bristol and ART in South Glos

September 2016

Author: Mary Mason
Title: Interim Named Nurse Child Protection
North Bristol Trust (NBT)

Contents

1. Purpose Page 4
2. Background Page 4
3. Methodology Page 5
1. **Purpose**

North Bristol Trust (NBT) Safeguarding Children Team along with the Emergency Department (ED) decided to undertake an audit of referrals to Children’s Social Care in Bristol and South Gloucester from ED.

Some of the Serious Case Reviews (SCRs) in Bristol have indicated a range in the quality of referrals going into First Response. Social Care themselves have raised questions about the
appropriateness of referrals from agencies. Health also recognises that when information is shared it may not be clear what is being requested of Children Social Care Departments.

The aim of this quality review is to identify what is being documented on the referral forms and whether there is a training need to support staff in making good referrals and identifying the thresholds for referral.

The report will be taken to the NBT Safeguarding Children Operational Group for sign off and presented at the NBT Safeguarding Committee.

2. Background

A review had been done on midwifery referrals to First Response by Bristol CCG in 2015 because First Response cited they were in receipt of large numbers of referrals which did not meet the threshold for intervention. Since the audit was undertaken there has been excellent work carried out by NBT’s Safeguarding Support Midwife to train midwives on better referrals and use of the Threshold Document:

https://www.bristol.gov.uk/documents/20182/34452/Final%20Thresholds%20guidance%20February%202014.pdf/a38fc4c0-3d82-4869-9e0f-97bc33ce9e60

This has resulted in a hugely improved quality of referrals to First Response as reported back to NBT Midwifery Services by First Response.

A quality assurance exercise of Health Referrals to First Point (South Gloucester) was undertaken by the Named Nurse and Safeguarding Leads at NBT and reported on in May 2015. With the provider split on the 1st April 2016, it is timely to conduct a re-audit of ED referrals 6 months after this to quality assure them.

The referrals need to be audited for several reasons which include recommendations made from the CQC Inspection of NBT conducted in December 2015 and reported on the 6th April 2016. These are as follows:

- Ensure IT systems used at Southmead hospital ED contain prompts for staff to ascertain any safeguarding concerns at the outset of triage rather than relying on staff professional curiosity to ask those questions at a later stage.
- Ensure systems are in place at Southmead hospital ED to record accurately family details of children and young people in attendance, including detail of adults with parental or carer responsibilities.
- Ensure practitioners at Southmead hospital ED are appropriately trained and aware of how to articulate risk and provide clear analysis when making referrals to children’s social care and that those referrals are subjected to robust audit.
- Ensure systems are in place to prompt ED practitioners at Southmead hospital to record ethnicity of children and young people attending the unit and that practitioners are aware of the importance of doing so.
3. Methodology

This audit is reviewing the quality of referrals made to Children’s Social Care over the first two weeks of July 2016 from July 1st to July 15th. The Health auditors were to complete a quality review proforma (Appendix 1) for referrals made over this two week period.

An audit date was set for 29th August 2016 where three Health professionals reviewed the referrals together. These were as follows:

- Interim Named Nurse for Child Protection for NBT
- Safeguarding Support Midwife
- Safeguarding Lead Nurse ED

Over the two week period there had been 22 referrals made to Children’s Social Care although one of the referral forms was illegible due to the poor quality of the FAX and so 21 forms were included in the audit.

4. Results

The results are taken from the proforma questions and the agreed responses of the reviewers on the 29th September 2016.

<table>
<thead>
<tr>
<th>1. Is the child in ED?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
</tr>
<tr>
<td>No</td>
</tr>
<tr>
<td>N/K</td>
</tr>
</tbody>
</table>

33
1. Of the 21 referrals audited 32% children were present in ED, 55% were not present and 14% had no record of the child in ED either way. The 55% referrals made were for information sharing only where the adult had presented intoxicated having drugs or alcohol or both in their system or following a domestic assault.

2. Explicit information about parents' consent/or clear explanation why no consent sought?

3. Child on Child Protection Plan or Child in Need Plan?

2. Of the 21 referrals audited 71% had sought consent to refer, 24% had ‘no’ as a response but there was no explanation as to whether consent had been sought and refused or whether a decision to refer without parental consent had been for any other reason (e.g. child safety or professional safety). One form had a blank response.

3. Of the 21 referrals only 5% were affirmed as on a plan, 33% children were not but the majority of 62% were not known.
4. Of the 21 referrals 57% recorded the accompanying adults, 19% did not and 19% had put ‘not applicable’ indicating the child either attended alone or the referral was regarding the parent of a child attending. On one form this information was illegible.

5. Of the 21 referral forms 48% recorded the biological parents and 43% did not. One was illegible and one said ‘not available’ as the child was in police custody and the information was not available.
6. Of the 21 referral forms, 76% made it clear the reason for referral to CSC but 24% did not.

7. Of the 21 referral forms 24% had information on other services or agencies involved with the child, 67% had no information and 10% had written non applicable with no explanation.

6. Is there clarity on what the safeguarding issues are and reason for the referral?

- Yes
- No
- N/A

7. Have the parents provided any information on other agencies/services involved?

- Yes
- No
- N/A
8. Of the 21 referral forms 62% clearly stated why the presenting incident impacted on or related to the child/ren and the possible influence on the care of the child/ren. 29% did not give this information and 10% had written not known.

9. Of the 21 referral forms 71% had filled in safeguarding standards, 10% did not at all and 19% were partially filled in and the reasons for this in the last 6 of these forms were because of uncooperative patients or parents who were unable to because of their presenting condition.
10. Of the 21 referral forms ethnicity of the child was recorded on 33% and not on 52% and on 9% it was filled in with non-applicable and in one the relevant page was missing.

11. Auditors comments regarding Referral Forms

   a. This is a vulnerable adult not a child being referred. Uncertain re the need for referral as there is no risk of harm to the infant who does not reside in the UK.
   b. The first page of the FAX form is missing.
   c. Most of the information on the FAX form is unreadable due to poor quality.
   d. Pages missing for two forms.
   e. Old FAX form used.
   f. 5 referrals made because of parental problems of mental health or drug and/or alcohol misuse and information only to Children’s Social Care.

5. Discussion and Conclusions

Of the 21 referral forms audited it was notable than in 55% of these children were not present in the ED at the time. The referrals in these cases were made because staff were concerned that the presenting adults may have posed a risk to their child/ren as their condition had indicated the possibility of this. These presentations were variously related to domestic abuse, mental health issues, and deliberate self-harm and drug and/or alcohol abuse in these cases.

Reason for some of the referrals was cited as ‘for information sharing’ to CSC but there was no clear documentation regarding any use of the threshold guidance available for professionals on the South Glos and Bristol Safeguarding Board websites.
Consent for referral was gained in 71% of cases and not in 24% and in 5% there was a ‘not known’ response. The narrative on the forms did not detail why no consent was gained, whether the question was asked but consent refused, or whether it was not possible to ask the consent question.

Of the 21 referrals only 5% were affirmed as on a Child Protection Plan, 33% children were not but the majority of 62% were not known. Currently the flagging of Lorenzo records at NBT to indicate whether a child is currently, or has been on a CP Plan, is not up to date and work is underway to reinstate the process of flagging.

Of the 21 referrals 57% recorded the accompanying adults, 19% did not and 19% had put ‘not applicable’ indicating the child either attended alone or the referral was regarding the parent of a child attending. On one form this information was illegible. It would be useful to ask and document, where possible, who is currently caring for the child/ren whilst a parent is attending ED.

Of the 21 referral forms 48% recorded the biological parents and 43% did not. One was illegible and one said ‘not available’ as the child was in police custody and the information was not available. This is an unacceptably high number of forms on which basic information has not been collected which Children's Social Care should be party to for contacting parents.

Of the 21 referral forms, 76% made clear the reason for referral to CSC but 24% did not. It is essential that agencies understand clearly why children are being referred to be able to respond appropriately. If the thresholds are not reached or are unclear the cases will not be accepted which does not safeguard children. It also floods the system with potentially inappropriate referrals wasting professionals’ time and resources.

Of the 21 referral forms 24% had information on other services or agencies involved with the child, 67% had no information and 10% had written non applicable with no explanation. Assessing what is already in place for the vulnerable child and their family means that decision making around the necessity for referral is robust. It also ensures that children don’t get put through a child protection route when this is unnecessary.

Of the 21 referral forms 62% clearly stated why the presenting incident impacted on or related to the child/ren and the possible influence on the care of the child/ren. 29% did not give this information and 10% had written not known. Assessing potential impact of an incident on a child’s safety or welfare precludes a decision as to whether or not this warrants a referral to Children’s Social Care. It is essential to good multi agency working and child protection work.

Of the 21 referral forms 71% had filled in safeguarding standards, 10% did not at all and 19% were partially filled in and the reasons for this in the last 6 of these forms were because of uncooperative patients or parents who were unable to because of their presenting condition. Generally in the selection of referral forms audited, staff had filled in the safeguarding standards sections which ask about risks, what’s working well with the family, what they wanted to achieve from the referral, the child’s development, the parenting capacity and the family and environmental factors. However the quality of the information
collected was disparate and often not well written or narrative to help build a picture of the child’s circumstances.

Of the 21 referral forms ethnicity of the child was recorded on 33% and not on 52% and on 9% it was filled in with ‘non-applicable’ and in one the relevant page was missing. Recording of ethnicity is an essential component of robust assessment of risk as culture and religion can pose additional safeguarding challenges when working with vulnerable children and families. NBT is providing services to a multicultural city and so this is a pertinent issue.

There was also a discussion at the conclusion of the audit by those involved. A recognition of the number of referrals made to Children’s Social care where only the adult was within ED, posed a question as to whether some of the adults should have been referred to Adult Social Care for their own needs to be addressed.

There was also concern about the FAXing of referral forms to the Safeguarding Children Team within NBT as the FAXes are sometimes incomplete and the quality as times poor.

6. **Recommendations**

1. Liaison with Children’s Social Care in Bristol and South Gloucester to enable updates for ED on what is required to make robust referrals.
2. Liaise with NBT Midwifery Safeguarding Leads to share their good practice on referring to Children’s Social Care and use of the Threshold Document and Threshold Matrix.
3. Level 3 training in ED to include the Assessment Framework (Appendix 1) as an aide memoire to professionals when they are doing referrals.
4. Children on, or who have been on Child Protection Plans to be flagged on Lorenzo NBT records.
5. Ensure that all CQC recommendations from CQC Report on Southmead Hospital 2016 are fully implemented as follows;
   - Ensure IT systems used at Southmead hospital ED contain prompts for staff to ascertain any safeguarding concerns at the outset of triage rather than relying on staff professional curiosity to ask those questions at a later stage.
   - Ensure systems are in place at Southmead hospital ED to record accurately family details of children and young people in attendance, including detail of adults with parental or carer responsibilities.
   - Ensure practitioners at Southmead hospital ED are appropriately trained and aware of how to articulate risk and provide clear analysis when making referrals to children’s social care and that those referrals are subjected to robust audit.
   - Ensure systems are in place to prompt ED practitioners at Southmead hospital to record ethnicity of children and young people attending the unit and that practitioners are aware of the importance of doing so.
6. Implementation of the recommendation from ‘Review of Children’s Safeguarding across NBT’ October 2016;

‘The ED needs an operational member of the Safeguarding Children Team to support and supervise members of ED staff. This would enable quality assurance and improvement of the referrals and the process (as has been proven in Maternity). This is a vitally important role and would also make safeguarding practices in ED more robust. The existence of the role would mean a reorganisation of tasks within the Safeguarding Children Team and prevent the duplication of processes.’

7. Liaison with Adult Social Care to look at thresholds for referral of vulnerable adults.

Bibliography


Standards for Children and Young People in Emergency Care Settings: Pub RCPCH 2012
http://www.rcpch.ac.uk/sites/default/files/page/Intercollegiate%20Emergency%20Standards%202012%20FINAL%20WEB.pdf

South West Child Protection Procedures
http://www.proceduresonline.com/swcpp/

Threshold Guidance Bristol
https://www.bristol.gov.uk/documents/20182/34452/Final%20Thresholds%20guidance%20February%202014.pdf/a38fc4c0-3d82-4869-9e0f-97bc33ce9e60

Threshold Matrix South Glos
http://edocs.southglos.gov.uk/journeyofneed/

Working Together to Safeguard Children 2015
Appendix 1

Assessment Framework

CHILD'S DEVELOPMENTAL NEEDS

Health
Education
Emotional & Behavioural Development
Identity
Family & Social Relationships
Social Presentation
Selfcare Skills

PARENTING CAPACITY

Basic Care
Ensuring Safety
Emotional Warmth
Stimulation
Guidance & Boundaries
Stability

FAMILY & ENVIRONMENTAL FACTORS

Community Resources
Family Social Integration
Income
Employment
Housing
Wider Family
Family History & Functioning

CHILD Safeguarding & promoting welfare

Appendix 2

42
Audit Tool

Client’s initials:…………………………

Audit/Quality Assurance First Response Referral Review Tool

Do the records contain information regarding:

1. Is the child in ED?
   - Yes
   - No

2. Explicit information about parents’ consent/or clear explanation why no consent sought?
   - Yes
   - No

3. Child on Child Protection Plan or Child in Need Plan?
   - Yes
   - No

4. Recording of the accompanying adult/s with the child/ren and their details?
   - Yes
   - No

5. Where there has been a CSC Referral does the information include details of biological parents, all relevant family members and others living in the household?
   - Yes
   - No

6. Is there clarity on what the safeguarding issues are and reason for the referral?
   - Yes
   - No

7. Have parents provided any information on other agencies/services involved?
   - Yes
   - No
8. If the incident is related to the child, (this includes impact on how the child is being currently cared for), how is this affecting the child/children?

Yes     No

9. Has the practitioner completed the safeguarding standards section?

Yes     No

10. Is there clear recording of ethnicity of the child?

Yes     No

Comments.................................................................................................................................................................
........................................................................................................
........................................................................................................
........................................................................................................
# Appendix 2

## Quality Assurance for Safeguarding Children and Adult Training Template NBT

**April 2016-March 2017**

<table>
<thead>
<tr>
<th>Level</th>
<th>Core Competencies and Content</th>
<th>Evidence in Training QAed</th>
<th>Delivered By</th>
<th>When delivered</th>
<th>QAed By</th>
<th>Recommendations</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Level 1</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td><em>Ideally split the Adult and Children’s Safeguarding Training at Level 1&amp;2 can be run concurrently for children</em></td>
</tr>
<tr>
<td>Combined Adults and Children</td>
<td>Recognising signs of abuse in Adults and Children</td>
<td></td>
<td>Safeguarding Team</td>
<td>At Induction arranged by L&amp;R</td>
<td>Mary Mason</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Physical Abuse/FI</td>
<td>Definition in PP slide</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Emotional Abuse</td>
<td>Definition in PP slide</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Sexual Abuse</td>
<td>Definition in PP slide</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Neglect</td>
<td>Definition in PP slide</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Child Trafficking</td>
<td>Definition in PP slide</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>FGM</td>
<td>Definition in PP slide</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>Impact of Risk of Parents</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Domestic Abuse</td>
<td>Definition in PP slide</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Online and social networking</td>
<td>PP slide</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Mental Health</td>
<td>PP slide</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Drug and Alcohol Abuse</td>
<td>PP slide</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>Basic Legislation</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Children Act 1989/2004</td>
<td>PP slide</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Sexual Offences Act 2003</td>
<td>PP slide</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>Reporting Concerns/Seeking Advice</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Local Policies</td>
<td>PP slide and links</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>
</tr>
<tr>
<td>Sharing Information</td>
<td>PP slide</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>What to do if they are not listened to</td>
<td>PP slide and link</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Awareness of referral process</td>
<td>PP slide and link</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Safeguarding Contacts</td>
<td>PP slide and link</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Level 2 Child Protection</th>
<th>Named Nurse and Safeguarding Children Trained members of Safeguarding Team</th>
<th>At Induction and Level 2 Updates arranged by L&amp;R</th>
<th>Mary Mason</th>
<th>Must be delivered by Children's Trained Nurse or Health Visitor or School Nurse qualified</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Normal Child Development</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Impact of abuse on this</td>
<td>PP slide</td>
</tr>
<tr>
<td>Behaviour and mental health</td>
<td>PP slide</td>
</tr>
<tr>
<td>Factors associated with abuse</td>
<td>PP slide</td>
</tr>
<tr>
<td>More in depth DA /Parental mental health/drug and alcohol misuse</td>
<td>PP slide</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Needs of LAC</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Youth Offending and further vulnerability</td>
<td>PP slide</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Awareness of legal/professional/ethical responsibilities</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Use of assessment frameworks</td>
<td>PP slide assessment framework triangle</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Best Practice in documentation/record keeping/data protection/info sharing</th>
<th>PP slide</th>
</tr>
</thead>
<tbody>
<tr>
<td>Awareness to alert Primary Care Professionals</td>
<td>PP slide and discussion</td>
</tr>
<tr>
<td>Purpose and guidance for SCRs etc</td>
<td>PP slide</td>
</tr>
<tr>
<td>Level 3</td>
<td>Voice of the Child</td>
</tr>
<tr>
<td>---</td>
<td>---</td>
</tr>
<tr>
<td>Attitudes</td>
<td>PP slide</td>
</tr>
<tr>
<td><strong>Level 3</strong></td>
<td>Child Sexual Exploitation</td>
</tr>
<tr>
<td>Sexual Abuse</td>
<td>PP slide</td>
</tr>
<tr>
<td>FGM</td>
<td>PP slide</td>
</tr>
<tr>
<td>SCRs</td>
<td>PP slide</td>
</tr>
<tr>
<td>Resolution of Professional Differences</td>
<td>PP slide</td>
</tr>
<tr>
<td>Information Sharing</td>
<td>PP slide</td>
</tr>
<tr>
<td><strong>Case Study</strong></td>
<td>Delivered on all day Level 3 courses with group work. In shorter time slots cases discussed with delegates.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Level 3</th>
<th>All day training covering quality of referrals to Children's Social Care, Thresholds, Signs of Safety, Serious Case Reviews, Domestic Abuse; recognition and response, MARAC</th>
<th>Quality of referrals to Children's Social Care, Thresholds, Signs of Safety, Serious Case Reviews, Domestic Abuse; recognition and response, MARAC.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Days set by Midwifery in the Unit for Midwives and affiliated clinicians</td>
<td>Mary Mason</td>
</tr>
<tr>
<td><strong>Midwives</strong></td>
<td>Safeguarding Midwives</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Level 3</th>
<th>Quality of referrals to Children's Social Care, legislation, information sharing, Assessment Framework Triangle, recording information in patient records, response to sexually active children, child sexual exploitation</th>
<th>Quality of referrals to Children's Social Care, legislation, information sharing, Assessment Framework Triangle, recording information in patient records, response to sexually active children, child sexual exploitation</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Sessions set and delivered by Named Doctor and Safeguarding Leads in ED</td>
<td>Mary Mason</td>
</tr>
<tr>
<td><strong>ED</strong></td>
<td>Addition of information to PowerPoint on sexual consent and children the Assessment Framework Triangle</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Level 3</th>
<th>40 minutes on Brooke Serious Case</th>
<th>40 minutes on Brooke</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Sessions</td>
<td>Mary</td>
</tr>
<tr>
<td><strong>Level 3 update</strong></td>
<td>Level 3 update</td>
<td></td>
</tr>
<tr>
<td>Updates for NICU and Consultants</td>
<td>Review, child sexual abuse, Bristol and South Glos SCB policy on injuries in non-mobile babies and Resolution of Professional Differences Policy</td>
<td>Serious Case Review, child sexual abuse, Bristol and South Glos SCB policy on injuries in non-mobile babies and Resolution of Professional Differences Policy</td>
</tr>
</tbody>
</table>
Report to: The Trust Board

Date of Meeting: 21st September 2017

Report Title: Sustainable Development Management Plan 2017/2018

Status: Information

Prepared by: Esther Coffin-Smith, Sustainable Development Manager
Tanya Saker, Environmental Management Systems Co-ordinator

Executive Sponsor (presenting): Simon Wood, Director of Estates, Facilities & Capital Planning

Appendices (list if applicable):
- Appendix A Sustainable Development Management Plan (SDMP) 2017/2018

Recommendation:
The Trust Board is asked to review and approve the annual Sustainable Development Management Plan for 2017/18 in line with the recommendations of the national NHS Sustainability Strategy. Following approval, the SDMP will be published on the Trust’s website.

Executive Summary:
See following report.
1. Purpose
The NHS Sustainable Development Strategy (2014-2020), Sustainable, Resilient, Healthy People and Places, requires NHS organisations to have a Trust Board approved Sustainable Development Management Plan (SDMP).

This report introduces our third annual Sustainable Development Management Plan (SDMP) for 2017/2018 for approval by Trust Board. This is included at Appendix A.

The SDMP is updated on an annual basis and made available as a public document as part of our ongoing Sustainable Development work at NBT. This SDMP replaces the current SDMP 2016/2017.

2. Background
The NHS Sustainability Strategy dovetails with the Trust’s Strategy, the NHS Five Year Forward View and the Sustainability and Transformation Plan (STP) which sets out the requirement for the prevention of avoidable illnesses to secure sustainability within the NHS and the future health of the population.

NBT has a significant part to play to contribute towards prevention. By managing our own environmental impacts, we can deliver positive co-benefits to the Trust’s financial sustainability and the long term health and wellbeing of our staff, patients and community to deliver a healthy, resilient and sustainable healthcare service fit for the future.

The national strategy addresses the challenge of how we go about this within the available financial, social and environmental resources. Understanding these challenges and developing plans to reduce our environmental impact and promote health and wellbeing whilst delivering continued high quality care is the essence of sustainable development.

3. Our SDMP
The SDMP details what North Bristol NHS Trust has achieved over the last twelve months and our plans for the year ahead in line with the national NHS Sustainability Strategy. This is laid out through a series of Sustainable Development objectives which focus on specific key work areas:

- Corporate vision and governance
- Leadership, engagement and development
- Healthy, sustainable and resilient communities
- Sustainable clinical and care models
- Carbon Abatement (Carbon Hotspots, Procurement, Energy and Water, Travel and Transport, Waste and Recycling)
- Food and Catering
- Biodiversity
- Metrics / Good Corporate Citizen Assessment (GCCA) Sustainable Development Indicators

New sections for 2017/18 include:

- Innovation – to demonstrate how as a Trust we are finding innovative ways to achieve environmental, social and financial improvements.
• Social Value – demonstrating how our services deliver quality social value (for the environment and health), not just financial value.

4. Highlights from 2016/2017
There have been many key areas of progress over the last year; these are documented in detail within the SDMP. A few of the more significant achievements are outlined below.

4.1 Corporate Vision & Governance
The Trust continues to emerge as a leader in the field of Sustainable Healthcare through the delivery of the SDMP. The recently revised Sustainable Development Policy (adopted by the Trust Board in March 2017) is testament to the Trust’s commitment to achieving this.

Progress is also reflected in the latest Good Corporate Citizen Assessment, which increased from 52% to 57% overall, demonstrating improvement in facilities management, workforce, community engagement and the buildings categories.

NBT was recognised at the Travel West Awards winning two awards: Most Improved Workplace and Organisation of the Year 2016 for Sustainable Travel initiatives.

The Trust received a Certificate of Excellence for sustainability reporting from NHS Improvement, HFMA and the Sustainable Development Unit in March 2017.

4.2 Leadership, Engagement & Development
The second year of the Green Impact staff award scheme was launched in October 2016 during Healthy City Week. The scheme promotes sustainable behaviour change and raises awareness on both the positive and preventative co-benefits sustainable development can deliver for patient and staff health and wellbeing, improving patient care, protecting the environment and delivering longer term cost savings.

During 2016/17 Green Impact achieved estimated cost savings of at least 289,849kg of carbon dioxide equivalent (CO₂e) and £51,500 financial savings through the actions of 30 teams.

4.3 Carbon Hotspots
The SDMP reports the Trust’s total carbon footprint (from procurement, travel, energy, water and waste) calculated using the national Sustainable Development Unit’s carbon model and based on annual spend and patient contact. The document also reports progress and annual trends against the Trust’s 2% targets for energy, water, waste and travel.

The SDMP sets out the Trust’s 2020 Carbon Target which aims to achieve 28% carbon reduction savings through energy alone by 2020 (based on 2013 baseline).

4.4 Sustainable Development Indicators
Sustainable Development indicators are published within the SDMP to communicate simply and clearly NBT’s progress in these areas.

4.5 Innovation
In 2016/17 the Southmead Hospital Charity, along with Carillion and The Hospital Company sponsored the planting of a medicinal, culinary and therapeutic herb garden on the restaurant roof terrace to promote staff health and wellbeing, encourage biodiversity and provide an ongoing supply of fresh herbs for patient and staff meals.

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.
5. Priorities for 2017/2018

Whilst successes have been documented above, there are still key pieces of work which need prioritising in the coming year. These work areas are outlined below.

5.1 Corporate Vision & Governance

The Trust will be working to deliver the actions set out in the Pathway to Wellbeing Project to improve the health and wellbeing of our staff, patients and our local community.

5.2 Leadership, Engagement & Development

Following the significant successes of Green Impact last year, the Trust plans to run Green Impact during 2017-2018 by taking on an apprentice through NBT’s apprenticeship scheme to deliver the project.

5.3 Healthy, Sustainable and Resilient Communities

The Trust is preparing a five year Climate Change Adaptation Plan, outlining the significant risks and opportunities climate change poses to NBT and identifying key actions going forward.

5.4 Carbon Hotspots

The Carbon Abatement Plan sets out the energy efficiency projects to deliver cost and carbon savings.

5.5 Commissioning, Procurement and Social Value

The Public Services (Social Value) Act (2012) “requires public services to consider taking into account economic, social and environmental value, not just price, when buying goods and services”. This has significant implications for NBT for procuring goods and services to meet our operational requirements, but also for contracts we bid for as a healthcare provider. North Bristol NHS Trust is developing a Sustainable Procurement Policy with Bristol and Weston Purchasing Consortium to ensure the Trust is legally compliant with the Public Services (Social Value) Act 2012. The policy will include the provision of training and resources for all staff involved in the procurement process.

5.6 Innovation

The Trust will be fundraising to establish a staff and patient allotment onsite.

6. Summary

The SDMP is the Trust Board approved public-facing document which details our progress and commitment towards the national Sustainable Development Strategy ‘Sustainable, Health and Resilient People and Places’.

The actions detailed within the SDMP will be delivered through the Sustainable Development Governance structure and associated working groups.

7. Recommendations

The Trust Board is asked to review and approve the draft annual Sustainable Development Management Plan in line with the recommendations of the national NHS Sustainability Strategy. Following approval, the SDMP will be published on the Trust’s website.

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.
SUSTAINABLE DEVELOPMENT MANAGEMENT PLAN
2017/2018
Foreword

North Bristol NHS Trust is one of the largest healthcare providers, employers and consumers in the region. As such, we recognise both the positive and negative environmental and health impacts that our services can have on our community and our local environment.

As a healthcare provider, we must ensure we do everything we can to reduce the harmful impacts and maximize opportunities to promote the health and wellbeing of our staff and our patients by embracing the co-benefits of health and sustainability.

We must adapt and react to climate change to ensure we are resilient and embed financial, social and environmental sustainability across the Trust.

This Sustainable Development Management Plan outlines our contribution to improving health and sustainability for everyone to ensure we succeed in our vision to be a healthy, resilient and sustainable healthcare service ready for changing times and climates, both now and for future generations.

Andrea Young
Chief Executive

Peter Rillett
Chairman
Contents

Foreword 1
Contents 2
Introduction to climate change and health 3
Corporate vision and governance 4
Sustainable development governance 5
Leadership engagement and development 6
Healthy, sustainable and resilient communities 7
Sustainable clinical care models 8
Innovation 9
Social value 11
Carbon abatement 12
  - Procurement 13
  - Energy and water 14
  - Travel and transport 16
  - Waste and recycling 17
  - Food and catering 18
Biodiversity 19
Metrics 20
Good Corporate Citizen Assessment (GCCA) 21
Sustainable development indicators 22
Contact information 23

Image: Southmead Hospital Travel West Road Show 2017
Introduction to Climate Change and Health

Climate change is described by the World Health Organisation as “the biggest global threat to health facing the twenty first century”.

Climate change is the change in climatic patterns largely attributed to the increased levels of atmospheric carbon emissions produced by the use of fossil fuels. It is predicted to increase the number of heat and cold related illness and deaths, increase the amount of food, water and vector-borne diseases (e.g. malaria), increase skin cancers and sun burn, increase the health impacts of respiratory disease from poor air quality and aeroallergens and likely bring about an increase in mental health issues as a result of local social impacts such as displacement by flooding.

NHS England’s Sustainability Strategy 2014-2020, “Sustainable, Resilient, Healthy People and Places” lays out the vision for a sustainable healthcare system which reduces these atmospheric carbon emissions, minimizes waste and pollution, makes the best use of scarce resources, builds resilience to a changing climate and nurtures community strengths and assets.

The Strategy requires the NHS to adopt an integrated, aligned and coordinated approach to deliver social, economic and environmental sustainability in a changing climate.

The Strategy places greater emphasis on the prevention of avoidable illnesses by reducing our own impact on the environment and by strengthening our relationships with our staff, contractors, suppliers, patients, visitors and our local community to realise the true potential of the health co-benefits of sustainability.

The Sustainability Strategy dovetails with the NHS Five Year Forward View and the Sustainability and Transformation Plans (STP), both of which require the efficient use and delivery of our services and the prevention of avoidable illness to secure sustainability within the NHS for the future.

North Bristol NHS Trust has a significant part to play to contribute towards these goals to deliver long term sustainability. By managing our own environmental impacts, we can contribute to the national target to reduce carbon by 80% by 2050 and achieve a sustainable healthcare service.
Corporate Vision and Governance

We value the importance of protecting our natural environment for the benefit of the physical and mental health and wellbeing of our community, including our patients and staff, now and in the future.

The Trust Board recognises North Bristol NHS Trust is one of the largest healthcare providers, employers and consumers in the region, and as such aims to deliver a successful, sustainable and resilient organisation, playing a full part in an effective health and care system.

The Trust aspires to be a leader in the field of sustainable healthcare through committed leadership, innovation, culture change and system wide engagement and development.

The organisation must adapt to the impacts of climate change to ensure a healthy, resilient and sustainable healthcare system ready for changing times and climates.

We must strive to improve staff and patient experience by moving towards more sustainable models of care and workplace practices. As a Trust we recognise the environmental impact we have on the natural environment and the potential co-benefits of minimising this impact.

These values are reflected within our recently updated Sustainable Development Policy which was approved by Trust Board in March 2017.

The Sustainable Development Policy replaces the Environmental Policy previously in place and commits to the following:

- To implement an Environmental Management System
- To protect and enhance the environment, including the prevention of pollution
- To comply with all relevant obligations in relation to the environment
- To reduce our environmental impact
- To engage with our staff, patients, visitors, stakeholders and the wider local community
- To prepare our community for climate change through adaptation, resilience and response.
- To train our staff on sustainable development
- To work with our suppliers and contractors to reduce the environmental impact of the goods and services we buy
- To source local, organic, seasonal and fairly traded food where possible
- To publicly report on our progress towards sustainable development.

This Sustainable Development Management Plan reports our progress on delivering the commitments set out within the Sustainable Development Policy here at North Bristol NHS Trust.
Sustainable Development Governance

The Director of Estates, Facilities and Capital Planning, Simon Wood, is the Executive Lead for Sustainability, supported by Liz Redfern, Non-Executive Director.

The Sustainable Development Steering Group meets quarterly and is chaired by the Executive Lead. The Steering Group consists of Executive and Non-Executive Directors, specialist Public Health Advisors, Senior Management, our PFI partner and representatives from the Patient Panel and Trade Unions. The group drives forward the sustainable development agenda at NBT.

The Trust’s Sustainable Development Unit (SDU) is a small group of specialist advisors providing advice and support across the Trust to assist in the delivery of sustainable development at NBT. The SDU sits within the strategic Sustainable Health and Capital Planning (SHCP) Department within the Facilities Division. SHCP aspires to deliver a healthy, resilient, energy efficient and sustainable healthcare service ready for changing times and climates, both now and for future generations.

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

We have....

- A Trust Board approved Sustainable Development Management Plan
- A Trust Board approved Sustainable Development Policy
- Established the Sustainable Health and Capital Planning Department

We will....

- Promote health and wellbeing within the sustainability agenda and through the Pathway to Wellbeing action plan;
  - Promote physical activity and exercise
  - Promote relaxation and creativity
  - Promote social activities for staff
- Implement the Management System ISO14001:2015

Image: Promoting health and wellbeing through outside learning, Southmead Hospital
Leadership,
Engagement and
Development

We aspire to be a leader in the field of sustainable healthcare through committed leadership, innovation, culture change and system wide engagement and development.

The Trust recognises the value in engaging staff by providing opportunities to staff to learn about how they can make simple choices to embed a system wide culture change at NBT.

To support staff development and understanding, the Trust has created an online Sustainable Healthcare Training Package to provide a good introduction to sustainable development in a healthcare setting and inform staff about what they can do to further embed sustainable practices in the workplace.

Over the past year, the Trust has spearheaded the second year of the Green Impact scheme and as a result, provided a wide array of opportunities for staff to get involved in simple activities to create a happier, healthier workplace.

Green Impact saw an increase in staff engagement during 2016/2017 with a total of thirty teams (197 staff) across clinical and administrative services achieving 913 actions ranging from energy, waste and water efficiency campaigns through to health and wellbeing by encouraging healthy lifestyle choices such as active travel, healthy eating and lunchtime walks.

Green Impact Teams were recognised for all their hard work at a joint award ceremony with the University of Bristol and the University Hospital Bristol NHS Foundation Trust in June 2017.

Green Impact 2016/2017 saved an estimated £51,500 and achieved carbon savings of 289,849kgCO2e.

We have...

- Completed two years of our Green Impact engagement scheme
- Engaged staff, patients and visitors on the links between sustainability and health and wellbeing through innovative events including NHS Sustainability Day, Green Impact and Travel Smart roadshows
- Developed a sustainable healthcare training package for staff on the Managed Learning Environment (MLE)
- Adopted an environmental management procedure for estates staff and contractors and delivered accompanying training
- Embedded sustainability within our HR paperwork

We will...

- Develop sustainable Procurement training for Bristol and Weston Purchasing Consortium and wider NBT staff

Image: National Clean Air Day 2017
Healthy, Sustainable and Resilient Communities

We must adapt to the impacts of climate change to ensure a healthy, resilient and sustainable healthcare system ready for changing times and climates.

Climate change adaptation is the understanding and implementation of resilience measures to enable our Trust to be ready for the future. The promotion of personal resilience and the encouragement of self-management of the health and wellbeing of our staff, patients and the local community can reduce the demand on our services and promote sustainable models of care.

During 2016/2017, the Trust established a Pathway to Wellbeing working group and delivery plan to promote the health and wellbeing of our staff, patients and the local community through the improvement and provision of access to high quality green space, the arts, the environment, healthy food choices, and exercise.

Likewise, by ensuring the resilience of our organisation through emergency preparedness and response and business continuity planning, we are ready for unexpected situations.

Consideration must also be given to the secondary impacts of climate change, such as the effects of severe weather on our infrastructure and access to our supply chain and vital resources such as medical equipment, water, energy, fuel and food to ensure continuity of service in times of scarcity.

We have…
- Worked with local NHS providers to assess the risk of climate change
- Undertaken a climate change risk assessment
- Established a Ways to Wellbeing working group and delivery plan
- Supported Bristol Healthy City Week (October 2016)
- Established a Sustainability Impact Assessment (SIA) for all capital planning business decisions
- Launched weekly staff lunchtime healthy walks
- Promoted personal resilience through the staff vaccination programme

We will…
- Prepare an NBT climate change adaptation plan
- Undertake a climate change adaptation risk assessment

Image: Southmead Hospital staff lunchtime health walk 2017
Sustainable Clinical and Care Models

We strive to improve staff and patient experience by moving towards more sustainable models of care and workplace practices.

One of the key elements of climate change adaptation is to move towards more sustainable clinical care models. It is increasingly important to consider the environmental and social impact of how our services are delivered to ensure long term financial, social and environmental sustainability is achieved as part of the Five Year Forward View and local STP.

We aim to deliver exceptional care within the resources available. This has always been a challenge and will become increasingly so as costs escalate and scarce resources diminish.

Transforming the way we deliver our healthcare service provides an opportunity to take a whole systems approach to sustainability and the long term health co-benefits which sustainable models of care can deliver.

By enabling our patients to live well through self-management, and by providing the right support, prevention, early intervention and acute and specialist rehabilitation, we can further promote patient health and reduce the pressures on our services and their associated environmental impacts in the longer term.

Taking account of the environmental and social impacts of our services supports the development and delivery of more integrated and sustainable models of care in line with the STP to deliver long term financial sustainability for the Trust.

We have…

- Secured greater HR representation on the Sustainable Development Steering Group to identify and drive forward sustainable workplace practices.
- Begun educating and raising awareness amongst clinical staff about how they can contribute to sustainable health care delivery including tackling carbon hotspots

We will…

- Further engage clinicians to identify and pursue the delivery of sustainable models of care across the Trust.
Innovation

We strive to adopt innovative ways to achieve multiple benefits which reduce our environmental impact, lower our costs, improve quality of care and health outcomes, and enhance social value as part of our services.

One recent innovation is the establishment of the Sustainable Healthcare charitable funding pot. The Southmead Hospital Charity, together with the Trust’s Sustainable Development Unit have set up a funding pot to deliver a range of health and wellbeing projects for the benefit of our patients and their families as well as our own staff and the local community.

The Sustainable Healthcare fund aims to:

- Promote social cohesion and raise awareness of personal resilience and the prevention of avoidable illness through innovative engagement on sustainable lifestyle choices
- Promote improved mental and physical health and wellbeing by recognising the therapeutic benefits of better access to and creative use of green space.
- Support the delivery of excellence in patient experience by nurturing a happier, healthier and more sustainable workplace.

Southmead Hospital Allotment

The Trust is currently fundraising to create an allotment onsite at Southmead Hospital for use by patients and staff. The allotment will promote staff health and wellbeing, whilst also providing an outdoor activity for patients going through rehabilitation.

Fundraising so far has included:

Southmead Lavender Project

The Southmead Hospital Move Makers and members of staff have been harvesting Southmead lavender and to make soothing lavender bags for sale.

Fairtrade Fortnight Cake Sale

Environmental Awareness Reps (EARs) and Green Impact Team members from across the Trust raised money during Fairtrade Fortnight selling homemade Fairtrade goodies for staff and patients to enjoy.

If you would like to donate or find out more about the Sustainable Healthcare Charity Fund (ref 2243), please contact The Southmead Hospital Charity www.southmeadhospitalcharity.org.uk

Images: Fundraising Activities 2017
Southmead Herb Garden

For 2016/2017 The Southmead Hospital Charity, in conjunction with Carillion and The Hospital Company sponsored the transformation of the staff roof terrace in the new Brunel Building into a culinary, medicinal and therapeutic herb garden to support the wellbeing of our patients and staff.

It is widely acknowledged that access to high quality green space and the opportunity to see and interact with nature provides enrichment for people and improves health and wellbeing.

The hospital setting can be a stressful and emotionally challenging environment for clinical staff who provide high quality care for patients in critical situations. Access to quality outside space has been proven to reduce these negatives and offer health benefits to all.

Jekka McVicar, a locally based and internationally acclaimed herb expert and RHS Ambassador for Horticulture and Health and Wellbeing designed and planted the herb garden for the hospital as she wanted to give something back to the staff.

The garden is designed to provide organic, home-grown fresh herbs for use by the Catering Department for both staff and patient meals, adding colour and flavour replacing fat, sugar and salt as well as providing powerful antioxidants and health giving properties.

In addition to providing a valuable sensory haven for staff, the herb garden also benefits the hospital in the following ways;

- The garden can be used by clinicians to assist in active therapy to promote recovery
- The garden encourages biodiversity through the provision of pollen rich plants to support bees and other smaller insects to flourish

We have…

- Established a “Sustainable Healthcare” Charitable Funding pot for the delivery of projects which will contribute to the health and wellbeing of our patients and staff.
- Planted a medicinal and culinary herb garden for the health and wellbeing for our staff.

We will…

- Identify further innovative projects to deliver sustainable development improvements

Images:
The Vu Roof Terrace Herb Garden,
Jekka McVicar and Andrea Young CEO,
Bumblebee on Hissop
Social Value

We recognise the importance of adding social value to our local community and across our healthcare service.

Our Learning and Development Division delivers traineeships and apprenticeships in clinical and non-clinical roles as part of our approved Trust Traineeship and Apprenticeship Scheme.

The Trust is one of the founding members in the South West Association of Training Providers Ltd (SWATPro) which has gone on to deliver pioneering apprenticeships in the health sector.

The Learning and Development strategy identified the need to develop our talent and succession planning through learning pathways which meet employer and learner need.

It has also supported the work we do to deliver work experience opportunities and progression into work within our local community.

We have been able to showcase what is good about working in the health sector and our learners have become ambassadors for the organisation and their professions.

Apprenticeships offer the ideal combination of knowledge and practical skills development to support learners in gaining competence in the role.

Learners also value the ability to earn a wage whilst they’re learning and this has helped to develop loyalty to the organisation and the services they deliver. Every year we recognise our apprentices and trainees as part of the national apprenticeship week and through our own award ceremony.

We have...

- Achieved GOOD from OFSTED for our Apprenticeship delivery partnership – South West Training Providers Association (SWATPro)
- Developed an online e-portfolio
- Celebrated our apprentices and trainees at our annual award ceremony during National Apprenticeship Week.

We will...

- Explore the opportunity to recruit an apprentice within the Sustainable Development Unit
- Further embrace technology to support the apprenticeship / traineeship scheme.
- Work with Bristol and Weston Purchasing Consortium (BWPC) to ensure social value is included within our procurement processes.

Image: NBT Healthcare Apprenticeship Award Ceremony 2017
Carbon Abatement

NHS England has set an ambitious goal to reduce carbon dioxide equivalent emissions across building energy use, travel and procurement of goods and services by 34% by 2020.

The Trust has identified its carbon hotspots where we need to prioritise our carbon reduction activities (see Figure 2). These carbon hotspots are predominantly procurement, energy and travel (please see figure 2), however our activities across waste and recycling and also the provision of food are also highlighted as potential carbon hotspots which require mitigation.

Our Carbon Footprint

The Trust has calculated the carbon footprint using the NHS Sustainable Development Unit’s model which considers total operating costs against the total number of patient contacts over the year (total patient contacts are calculated from emergency department, inpatients, and outpatients and follow up appointments).

This enables the Trust to compare the annual trend of carbon emissions against a backdrop of an increasing demand for the provision of healthcare in the local area, which also continues to rise.

Over the last year, the Trust has seen an increase in the proportion of carbon emissions from both our procurement activity (60% to 66%) and from our patient travel (8% to 10%). Both of these figures are representative given the increase in patient contacts over the last year. Proportionally, our emissions from direct energy consumption have reduced (30%-24%).

The following sections outline the actions the Trust has taken to reduce our carbon emissions over the last year and our plans for the coming year.

Figure 1 NHS Carbon Footprint against CO₂e baseline to 2020 with Climate Change targets

Figure 2 NBT’s Carbon Footprint Proportions 2016/2017

Figure 3 NBT’s Carbon Emissions by Scope 2014-2017

Figure 4 NBT’s Carbon Footprint by Patient Contact
- Procurement

We are committed to …

working with our key suppliers and contractors to reduce the environmental impact of the goods and services we buy.

The national healthcare system spends in excess of £40 billion each year on the procurement of goods and services which presents a significant opportunity to not only influence the suppliers of these goods and services but to develop more environmentally, financially and socially responsible practices. Procurement for NBT represents 66% of the Trust’s total carbon emissions. Our procurement demand is not something the Trust can control directly given it directly correlates with patient contact, however using our influence and through our procurement processes, we aim to encourage suppliers to reduce the environmental impact from the goods and services they provide.

Anesthetic Gases, Medical Devices and Pharmaceuticals

Anesthetic gases, medical devices and pharmaceuticals represent a significant spend, correlating directly to patient demand.

Figures 5 & 6 Pharmaceuticals, Medical Devices & Anesthetic Gases

We have…

- Drafted a Sustainable Procurement Policy
- Identified how sustainability can be embedded within our sourcing processes.
- Established a sustainable procurement working group

We will…

- Adopt the Sustainable Procurement Policy
- Embed sustainability into our procurement processes
- Develop sustainable procurement training for all staff to be made available on the Managed Learning Environment (MLE).
- Establish what North Bristol NHS Trust can do to further promote Social Value through our commissioning and procurement processes.

We have…

- Drafted a Sustainable Procurement Policy
- Identified how sustainability can be embedded within our sourcing processes.
- Established a sustainable procurement working group

We will…

- Adopt the Sustainable Procurement Policy
- Embed sustainability into our procurement processes
- Develop sustainable procurement training for all staff to be made available on the Managed Learning Environment (MLE).
- Establish what North Bristol NHS Trust can do to further promote Social Value through our commissioning and procurement processes.

Image: Materials Management Supplies, Theatres, Southmead Hospital
Energy and Water

We are committed to...

- Reducing the environmental impacts of energy and water

Energy

The carbon emissions associated with energy consumption have reduced over the last year as part of the Trust’s total carbon footprint (see page 12).

Energy use, particularly from natural gas (direct scope 1 emissions) has continued to decline since the closure of Frenchay Hospital. The use of oil (direct scope 1 emissions) remains low, due to the minimal use of backup generators onsite.

However, electricity consumption (indirect scope 3 emissions) has seen a slight increase commensurate with the provision of a twenty-first century healthcare building using increased amounts of technology and treating more patients.

![Energy Consumption Graph]

Figure 7: NBT Energy Consumption 2008-2017

* This data reflects the ERIC report (see page 20) and does not reflect the annual report (16/17) which included energy consumption used by other organisations on our site.

This increase in electricity consumption can also be attributed to the movement of Public Health England into the new Pathology Building in the Science Quarter.

In order to achieve the carbon reduction required to meet the 2020 target (28% from 2013 baseline), the Trust is working to deliver a Carbon Abatement Plan (CAP).

The CAP sets out the Trust’s ambition to achieve 5% carbon savings year on year, putting the Trust on track to achieve its overall carbon target of 28% by 2020.

The Trust aims to meet this target through the actions and energy efficiency improvements set out in the Carbon Abatement Plan to achieve both cost and carbon savings over the next three years.

![Energy Carbon Emissions Graph]

Figure 8: NBT Energy Carbon Emissions 2009 -2020
Water

Water consumption continues to fall since the closure of Frenchay Hospital, even with the opening of the new Sterile Services Department onsite at Southmead as part of the phase 2 completion works.

We have...

- Drafted an Energy and Water Policy
- Established an Energy Conservation working group with our PFI Partner
- Developed a Carbon Abatement Plan
- Completed phase 2 of the hospital redevelopment which includes extensive sustainable urban drainage systems.
- Promoted Energy Awareness through the following Green Impact initiatives targeting energy and water conservation measures:
  - TLC (Turn off, Lights out, Close doors)
  - Get Fit Take the Stairs campaign
  - Less waste, more care: Turn off taps

We will...

- Adopt and implement the Energy and Water Policy
- Prioritise and deliver the Carbon Abatement Plan to include;
  - Energy efficient reviews and upgrades
  - Review additional renewable energy options for site
  - Staff engagement and behavior change
  - Optimise building management systems (BMS)
  - Improve heating controls
  - Improve the efficiency of chillers
  - Investigate further water efficiency saving opportunities

Figure 9: NBT Water Consumption 2008-2017

Image: Attenuation Pond, Sustainable Urban Drainage, Southmead Hospital
- Travel and Transport

We are committed to...

- Reducing the environmental impacts of our travel and transport

Active travel plays a significant part in both reducing traffic on the roads whilst also promoting health and wellbeing. The Trust runs the Travel Smart scheme aimed at encouraging staff, patients and visitors to travel sustainably where they can. This is reflected in the Trust’s Travel Plan.

Travel Smart promotes cycling, walking, public transport and lift-sharing as alternative ways to travel to work. During 2017, the Trust launched a new lift share scheme to further reduce the number of cars on the road in line with the new lift share policy.

Grey Fleet

Grey Fleet (business mileage) is monitored through the staff expenses system. Data from 2016/2017 shows a significant reduction in mileage by staff using their own vehicles, which is as a result of the loss of the Children’s Community Health Partnership (CCHP) from North Bristol NHS Trust at the end of March 2016.

Figure 10: NBT Grey Fleet Mileage 2010-2017

We have...

- Won Most Improved Workplace Award and “Organisation of the Year Award (Travel West Awards 2016)
- Installed 460 new cycling spaces (Brunel Cycle Hub and Pathology)
- Adopted and launched a Lift Share Policy (50 lift share spaces)
- A staff bike scheme in place
- Measured our staff travel through the “Big Commuter Count” and our own NBT Staff Travel Survey
- Undertaken a patient and visitor travel survey
- Launched a “switch off when you drop off” campaign to improve local air quality

We will...

- Retain our Silver Star Accreditation Travel Plan
- Promote the Southmead Quiet Way to further encourage more walking and cycling to site
- Increase lift share spaces onsite

Image: Designated staff lift share spaces at Southmead Hospital
- Waste and Recycling

We are committed to:

- Reducing the environmental impacts of waste

North Bristol NHS Trust generates a significant volume of waste on a daily basis, which increases incrementally with the demand for healthcare and increased patient contact.

Waste production and recycling have both increased during 2016/2017 in line with increased levels of activity at the Trust.

Recycling rates have significantly improved this year following operational improvements and better segregation of bagged waste, although there is more to be done in this area around engagement and awareness, particularly for recycling.

The roll-out of offensive hygiene waste (non-infectious clinical waste) to all wards has seen an increase to 17% in the weight of waste being sent to deep landfill instead of autoclaving.

Further roll-out of offensive hygiene waste into all applicable outpatient areas will be complete soon and theatres will follow.

Food waste from the onsite retail outlets is now being segregated for disposal via energy generation and coffee grounds from the staff restaurant are given away to staff as a soil improver.

The Trust introduced the online re-use platform Warp-It in September 2016 and since then has avoided nearly 5 tonnes of reusable furniture and equipment from going to landfill, saved 16 tonnes of carbon dioxide and achieved financial savings of over £37,000.

Figure 11: NBT Waste and Recycling 2008-2017

We have...

- Developed a Trust Waste Compliance Group
- Launched Warp-it, an NBT wide re-use scheme to reduce waste going to landfill.
- Promoted waste and recycling within Green Impact, our staff engagement scheme
- Established food waste, coffee grounds and coffee cup recycling schemes from our concession based onsite.
- Promoted re-use through the use of travel mugs and lunchboxes for staff
- Rolled out offensive waste within most of the Brunel Building and Cossham and Thornbury Hospitals
- Introduced a dedicated Waste Portering Team

We will...

- Roll out offensive waste within theatres
- Undertake a trial for the use of alternative containers for IV drip and pharmaceutical waste disposal

Don't waste it, WARP-IT.
- Food and Catering

We are committed to:

- Sourcing local, organic, seasonal and fairly traded ingredients for the food we serve

North Bristol NHS Trust prepares and serves approximately 3000 meals a day to our patients and staff. As a healthcare provider, we have a unique opportunity to raise awareness, lead by example and create a health-promoting environment serving appetising, nutritious and sustainable meals to all.

The Trust is part of the Soil Association’s Hospital Leaders Programme, which recognises the importance of good nutrition for health, recovery and rehabilitation. The scheme also acknowledges the importance of sustainable food provision, by choosing locally sourced, organic and seasonal produce where we can.

Our progress on this is reflected within our Food for Life Bronze and Silver Catering Mark achieved for staff and patient meals.

To further deliver our commitment to sustainable food sourcing, the hospital is preparing a Food and Drink Strategy.

The Strategy recognises the important link between health and wellbeing and delivery of sustainable healthcare. By ensuring our food choices are healthy and sustainable, maximising local and seasonal sourcing where we can and minimising food and drink waste, the Trust is also demonstrating its commitment to being a Good Corporate Citizen, which will be reflected within the Good Corporate Citizen Assessment benchmark.

Our progress towards Fairtrade has shifted over the last year following a commercial decision to switch the coffee offering in the Vu café to Rainforest Alliance. This explains the reduction in Fairtrade food provision within the sustainable development indicators; however the café continues to support Fairtrade through the sale of Fairtrade chocolate in the café.

We have…

- Established a Food and Drink Strategy working group and drafted a Food and Drink Strategy
- Retained The Soil Association Bronze and Silver Food for Life Catering Mark for our staff and patient meals
- Promoted local, seasonal and organic produce through the weekly fruit and veg stall provided by The Community Farm.
- Promoted Fairtrade Fortnight
- Promoted “Sugar Smart” and the “The Cardiologists Kitchen” to encourage healthy eating
- Planted a culinary herb garden

We will…

- Finalise our Food and Drink Strategy
- Maintain the Soil Association Food for Life Catering Marks for Staff and Patient meals.

Image: The Community Farm weekly organic fruit and veg stall, Southmead Hospital
Biodiversity

We are committed to...

- Protecting and enhancing the environment, including the prevention of pollution

The Trust is responsible for the upkeep and maintenance of green spaces across all our sites in Bristol.

We recognise our green spaces provide an important habitat for wildlife which contributes to Bristol’s wider green biodiversity network.

There is mounting research evidence that access to green space and biodiversity can provide health, social, environmental and financial benefits. By managing our green spaces effectively can lead to improved biodiversity, improved air quality, noise reduction, can provide local cooling and shading and reduce local surface water flooding.

However one of the most important elements for the Trust is the inclusion of green infrastructure across our hospital sites for the benefit of staff and patient health and wellbeing.

The Pathway to Wellbeing project emphasises the importance of spending time outside and enjoying our green space and using and sharing it as a resource.

We have...

- Established a biodiversity working group
- Installed a sustainable urban drainage scheme at Southmead hospital to reduce surface water runoff.
- Undertaken a biodiversity survey and developed an action plan with Avon Wildlife Trust
- Built and installed insect hotels at Southmead Hospital
- Planted a pollen rich culinary and sensory herb garden to promote biodiversity onsite

We will...

- Promote biodiversity through our Ways to Wellbeing delivery plan;
  - Develop a staff and patient allotment
  - Explore My Wild Hospital funding opportunities
  - Install bat boxes and insect hotels onsite
  - Increase wild flowers and pollen rich plants
  - Explore opportunities to establish bee hives onsite

Image: Buff Tailed Bumblebee, Beaufort House, Southmead Hospital
Metrics

There is a requirement on North Bristol NHS Trust to report progress on sustainable development in line with national guidance. These reporting requirements are laid out below.

NHS Standard Contract

The NHS Standard Contract requires the Trust to take all reasonable steps to minimise adverse impacts on the environment. The contract specifies that North Bristol NHS Trust must demonstrate progress on climate change adaptation, mitigation and sustainable development and must provide a summary of that progress in the annual report. In addition to the Standard Contract requirements, NHS Trusts have an obligation to complete the sustainability reporting template to the national Sustainable Development Unit. Equally this is required of NBT through our contract with our local Clinical Commissioning Group.

Estates Return Information Collection (ERIC)

The Department of Health requires Trusts to report ERIC (Estates Return Information Collection) data. ERIC data comprises essential statistics on waste, energy and water (amongst other data sets) from Estates and Facilities.

Sustainable Development Management Plan (SDMP)

The NHS Sustainability Strategy requires Trusts to report progress in a Trust Board approved Sustainable Development Management Plan (SDMP). A detailed SDMP action plan drives forward the SDMP objectives and sets out specific actions in line with the national strategy.

Performance against the SDMP action plan is reported to the Sustainable Development Steering Group on a quarterly basis.

The annual Trust Board approved SDMP is published in September and is available on the North Bristol NHS Trust website.

Image: First Bus, Brunel Building, Southmead Hospital
**Good Corporate Citizen Assessment**

The Good Corporate Citizen Assessment model was developed for Trusts to benchmark progress on sustainable development. The assessment allows Trusts to measure how well their activities support sustainability both inside the organisation and outside in the community.

By 2018 the Trust should be achieving 25% across all sections, plus four sections with at least a score of 50%. The assessment for 2017 highlights that the Trust priorities should focus on procurement, community engagement, adaptation and sustainable models of care.

**We have...**

- Been awarded “Excellence in Sustainability Reporting” from HFMA, NHS Improvement and the national Sustainable Development Unit (March 2017)
- Reported against the NHS Standard Contract requirements.
- Reported against the actions outlined within the Sustainable Development Management Plan to the Steering Group on a quarterly basis.
- Reported against the Estates Return Information Collection data (ERIC)
- Assessed ourselves against the Good Corporate Citizen criteria in 2016/17 and published the results.

**We will...**

- Continue to report against the GCCA requirements

*Figure 12: NBT Good Corporate Citizen Assessment 2017*
## Sustainable Development Indicators

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>CARBON</strong></td>
<td>Carbon Footprint (energy, waste, water, travel and procurement)</td>
<td>Tonnes CO2e</td>
<td>108,153</td>
<td>106,057</td>
<td>✓</td>
</tr>
<tr>
<td><strong>ENERGY</strong></td>
<td>Electricity</td>
<td>KW/h KW/h</td>
<td>38,499,476</td>
<td>37,058,071</td>
<td>38,828,428</td>
</tr>
<tr>
<td></td>
<td>Gas</td>
<td>KW/h</td>
<td>52,861,111</td>
<td>43,376,291</td>
<td>42,115,642</td>
</tr>
<tr>
<td></td>
<td>Heating Oil</td>
<td></td>
<td>1,259,671</td>
<td>865,098</td>
<td>543,381</td>
</tr>
<tr>
<td><strong>RENEWABLE ENERGY</strong></td>
<td>Renewable (Solar PV and biomass)</td>
<td>KW/h</td>
<td>2,197,794</td>
<td>1,572,423</td>
<td>2,762,216</td>
</tr>
<tr>
<td><strong>WATER</strong></td>
<td>Water</td>
<td>M3</td>
<td>300,858</td>
<td>261,961</td>
<td>241,944</td>
</tr>
<tr>
<td><strong>TRANSPORT</strong></td>
<td>Business Travel</td>
<td>Miles</td>
<td>/</td>
<td>/</td>
<td>/</td>
</tr>
<tr>
<td></td>
<td>Grey Fleet</td>
<td>Km</td>
<td>1,609,097</td>
<td>1,725,973</td>
<td>857,369</td>
</tr>
<tr>
<td><strong>TRAVEL</strong></td>
<td>Staff commute – Single occupancy vehicles</td>
<td>%</td>
<td>45.5</td>
<td>-</td>
<td>43</td>
</tr>
<tr>
<td></td>
<td>Staff commute – Cycling</td>
<td>%</td>
<td>20</td>
<td>-</td>
<td>21</td>
</tr>
<tr>
<td></td>
<td>Staff commute – Public transport</td>
<td>%</td>
<td>12</td>
<td>-</td>
<td>9</td>
</tr>
<tr>
<td></td>
<td>Staff commute – Walking</td>
<td>%</td>
<td>10.5</td>
<td>-</td>
<td>13</td>
</tr>
<tr>
<td></td>
<td>Staff commute – Lift share</td>
<td>%</td>
<td>8</td>
<td>-</td>
<td>7</td>
</tr>
<tr>
<td><strong>RECYCLING</strong></td>
<td>Recycling</td>
<td>Tonnes</td>
<td>961</td>
<td>820</td>
<td>1266.03</td>
</tr>
<tr>
<td><strong>WASTE</strong></td>
<td>Incineration</td>
<td>Tonnes</td>
<td>220.5</td>
<td>196.1</td>
<td>220.45</td>
</tr>
<tr>
<td></td>
<td>Autoclave</td>
<td>Tonnes</td>
<td>613.1</td>
<td>709.8</td>
<td>724.88</td>
</tr>
<tr>
<td></td>
<td>Landfill</td>
<td>Tonnes</td>
<td>1209.8</td>
<td>1241.8</td>
<td>1495.62</td>
</tr>
<tr>
<td><strong>FOOD</strong></td>
<td>Local (50 miles)</td>
<td>%</td>
<td>20.6</td>
<td>23.7</td>
<td>35%</td>
</tr>
<tr>
<td></td>
<td>Organic</td>
<td>%</td>
<td>2.3</td>
<td>3.7</td>
<td>2.5%</td>
</tr>
<tr>
<td></td>
<td>Fairtrade</td>
<td>%</td>
<td>3.5</td>
<td>4.8</td>
<td>1.5%</td>
</tr>
</tbody>
</table>
We would welcome your views

We are continually striving to improve sustainable development here at North Bristol NHS Trust and would welcome your views on how we can do this.

Please send any comments, ideas, suggestions or feedback you may have to;

Sustainable Development Unit
Sustainable Health & Capital Planning
North Bristol NHS Trust
Trust Head Quarters
Southmead Hospital
Bristol
BS10 5NB

E: SustainableDevelopment@nbt.nhs.uk  T: 0117 4148523/4145422
Report to: Trust Board

Date of Meeting: 28 September 2017

Report Title: Capital Planning Update

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

Prepared by: Martin Warren, 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 The key risks and challenges are set out on the attached report of the Brunel Compliance Issues which are reviewed and managed at regular meetings with Carillion and The Hospital Company (THC).

3. PFI Construction Works

3.1 Some of the Phase 2 defects in relation to the Multi Storey Car Park are still stalled but THC are endeavouring to obtain costs from both Carillion contractors in order to make some progress.

3.2 The demolition programme has been delayed due to delays in the removal of asbestos in Limewalk Sherston and Brecon buildings. All 3 buildings were handed over to Carillion in August, but unfortunately additional asbestos has been discovered during the soft strip of the Limewalk building. The impact of this on the demolition programme is not yet known.

3.3 Completion of the PFI construction works are currently expected in May 2018 and final tree planting in November 2018.

4. Capital Projects

4.1 The greatest challenge within these projects is still to agree the best way to relocate all occupants of Monks Park House and establishing when the building can be emptied.

5. Recommendations

5.1 The Trust Board is asked to note the current position and actions.
Capital Planning Report 20 September 2017

Capital Projects

Thornbury & Frenchay Lands including HSCC

- Development: Final decision regarding the HSCC development has been postponed by BNSSG and Sirona whilst BNSSG undertakes a system review of how patients requiring rehabilitation, reablement and recovery can best be served across the area covered by the combined Clinical Commissioning Group. Land will be reserved for the potential HSCC. The Trust has been advised that a decision regarding use of Frenchay and Thornbury could be made by BNSSG Frenchay and Thornbury by the end of October 2017, although the full plan for rehabilitation may not be made until March 2018.

- Bath Renal Satellite Unit: New site identified, initial design being developed. User design group to meet W/C 25th September. OBC due November 2017

- Monks Park House: Progress made with workstreams and finding new accommodation for current occupants.

- Brunel Gate 24: Stage 3 design complete. Project management strategy agreed.

- Brunel ICU garden: Initial design reviewed and modified, updated cost plan being reduced

- Beaufort House: Landscaping works are due to complete by end of September

- Frenchay: A contractor has been appointed to complete the drainage section 106 provision at Frenchay by November. The current scheme allows Redrow to connect to existing drainage on site and then connection to the new drainage system.

- Frenchay Public Open Space: Registration as Village Green has been completed and Transfer to Winterbourne Parish Council is being progressed but is dependent on the completion of the S106 works by the developer expected in Spring 2018.

- Frenchay Park House and West Lodge: Both transfers have been completed.

Estate Capital Replacement Programme

- Phases 2 & 3 of the Water Safety works in Women’s Sector: Decant work in Quantock Ward were completed. Percy Phillips Ward was decanted into Quantock to allow pipework alterations and extensive improvement works in Percy Phillips including fire safety, sanitary, lighting, flooring and environmental improvements. Works are approaching their latter stages before 2 weeks of deep cleaning and fogging. The remainder of the works to A/B Block continue until the end of October.

- Central Delivery Suite: Improvement works to upgrade the kitchen, sluices, bathrooms and other areas. It is planned to undertake design this year and undertake the works along with other improvements to the rooms at this time next year.

- Public Parking: The scheme to re-provide public car parking in the upper 3 floors of Beaufort multi-storey car park received approval. The proposal is to provide 3 pay machines and modify the barrier system at level 2 to allow automatic number plate recognition. The provision of electronic information boards on the status of available spaces in both multi-storeys has been included in the scheme. Staff will use the lower 2 levels of the multi-storey accessed from the Christopher Hancock surface car park barrier which requires access control modifications. Compensatory parking for staff is being explored at Monk’s Park, Late Shift in Tyndalls Way and Sherston & Brecon area when the buildings have been demolished.

- Elgar House: This scheme plans to replace the water storage tanks this year and is currently at the tendering stage.
The Trust Board is asked to note the update from the meeting held on 24 August 2017.
1. Purpose
   1.1. To present an update to the Board following the meeting of the Committee on 24 August 2017.

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:

   **Sickness Absence**
   3.2. The Committee received a deep dive into the Trust’s approach to the management of sickness absence, focusing on the work underway in the Medirooms.

   3.3. The Committee were advised that although overall sickness absence was over 3.6%, short term sickness absence was decreasing and longer term sickness absence was increasing. There was a further differential between staff groups, with a larger proportion of the longer term sickness absence affecting the unregistered nursing workforce. Turnover was also above 24%.

   3.4. A number of measures were being employed to support staff including regular monitoring of information through the Happy App, improved supervisory capacity, late start meetings and Schwartz Rounds. The Happy App in particular allowed for real time monitoring of staff feelings about their day giving the potential for real time action to address issues as they arose. The feedback from TU sources is that staff are finding it increasingly difficult to achieve a work life balance.

   **GMC Survey**
   3.5. The Committee received the results of the post graduate junior doctor annual survey by the General Medical Council.

   3.6. A letter from the head of division in England had been received congratulating the Trust on being rated the top acute trust in the Severn region for overall satisfaction by medical trainees and increasing its satisfaction levels when the national trend was decreasing.

   3.7. It was particularly pleasing to note the high improvement on last years result for neurosurgical foundation trainees. The challenge would be to maintain the levels of satisfaction.

   3.8. The Committee noted that pressure of workload and workforce gaps especially in Medicine and Renal was an issue. Extra effort was being put into recruiting clinical fellows and to train physician assistants to support junior staff. A further issue was that new job plans developed in the last year had been felt by many consultants to inadequately cover supervision.
Service Line Management (SLM) Update

3.9. The Committee received an update on the SLM programme. It was noted that the programme was progressing well, with continued high engagement with the work from all areas.

3.10. A review of the clinical division’s capability had been undertaken by the Executives and this had been shared with the group. To support the directors a number of interventions were planned including providing Executive mentoring.

Equality & Diversity Annual Report

3.11. The Committee received the annual Equality Statistics for 2016, the Workforce Race Equality Standard (WRES) report, the draft Trust Equality Objectives for 2017-21 and the Equality Calendar for 2017.

3.12. The Committee focused its attention on the details of the ethnicity of staff by pay bands and the lack of representation above band 5. It was noted that the profile did not mirror the local demography of the catchment area of the Trust and this would need to be an area of focus.

Staff Engagement – Learning from Other Trusts

3.13. The Committee received and discussed a summary of three case studies of Trust’s that had achieved much improved results from their staff attitude surveys having introduced specific programmes and of the King’s Fund paper on staff engagement.

3.14. It was noted that the Board had allocated a development day to focus on staff engagement which would be facilitated by The Kings Fund.

3.15. The Committee discussed the opportunity to utilise existing systems within the Trust to maximise staff engagement and considered the need for more up to date information on the levels of staff engagement instead of waiting for the annual survey.

4. Key Risks Identified and Impact

4.1. The key workforce risks were considered which included:

   4.1.1. Capability of staff within the new divisional structures below divisional team level
   4.1.2. Lack of staff engagement to support the delivery of the Trust’s objectives
   4.1.3. Delivery of workforce savings and changes to the medical workforce.

5. Key Decisions

5.1. The Committee approved the annual Equality Statistics for 2016, the Workforce Race Equality Standard (WRES) report, and the draft Trust Equality Objectives for 2017-21

6. Exceptions and Challenges

6.1. There were no exceptions or challenges to report.
7. Governance and Other Business

7.1. The membership of the Committee was considered in relation to the adoption of IM&T within its portfolio. It was noted that there were ongoing discussions which would need to be agreed by the Board.

8. Future Business

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

8.1.1. Consideration of the role of the Guardian of Safe Working and receive an update on progress

8.1.2. Delivery of the 5% workforce reductions

8.1.3. The Workforce and People Plans

9. Recommendations

9.1. The Trust Board is asked to note the update from the meeting held on 24 August 2017.
<table>
<thead>
<tr>
<th>Report to:</th>
<th>Trust Board</th>
<th>Agenda item:</th>
<th>17</th>
</tr>
</thead>
<tbody>
<tr>
<td>Date of Meeting</td>
<td>28 September 2017</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Report Title:** Trust Management Team Report

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

**Prepared by:** Eric Sanders, Trust Secretary

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

**Appendices (list if applicable):** None

**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 22 August and 19 September 2017.

2. Background

2.1. The Trust Management Team 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:

**Patient Flow Improvement**

3.2. The Management Team supported the view from the executives and NHS Improvement (NHSI) that the Trust’s biggest priority was to focus clinical efforts to improve patient flow through the hospital by reducing the number of stranded patients (patients staying over seven days). The system for ensuring the development and implementation of plans to achieve a 50% reduction within six months was approved.

3.3. There is strong evidence that keeping elderly patients in hospital for longer than seven days deconditioned them and cost the health and social care services more in the longer term than the short term health care measures. Maintaining a high bed occupancy meant caring for patients outside of their specialty bed base, patients staying longer in hospital and a potential to lead to a higher mortality rate.

3.4. A number of processes and outcomes were considered such as starting every day with empty beds on a ward and maintaining sufficient capacity in the assessment units to meet demand throughout the day. These reinforced the existing systems such as red to green and tasking all ward staff with ensuring there was no wasting of patients’ time in hospital. The opportunities for improvement for each division had been modelled and it was believed there was potential to save 80 to 120 beds using internal processes.

3.5. To accelerate the overall process a four hour rapid improvement internal plan was being put in place and partner organisations asked to provide a target figure for six weeks time to reduce the number of delayed transfer patients due to external reasons.

3.6. NHSI had requested to see an action plan for reducing the number of stranded patients and this had been submitted on 14 September 2017.

**CQC Inspection Regime**

3.7. TMT noted the self-assessment by divisions against the five CQC domain standards. This had
been prompted by the collation of a large amount of information for the CQC at its request and which might mean an inspection would be likely to be held within three months. All the evidence was to be reviewed by the Directors of Nursing and Director of People and Transformation before submission to ensure no obvious omissions or discrepancies.

3.8. Divisions were asked to identify the 2-3 key actions to reduce length of stay and release beds within 2 weeks. Further corporate actions would be taken forward to support delivery of the overall occupancy target.

2017/18 Cost Improvement Plan

3.9. An updated Cost Improvement Plan (CIP) showed that there had been slippage in the implementation of CIP schemes. The Programme Management Office was to review all the 31 schemes valued at over £100k and estimate the risks against lower value schemes. Most of the effort for 2017/18 now needed to be on bringing forward the known schemes rather than finding new ones.

End of Life Care

3.10 Related to the CQC domain standards, Sue Jones, Director of Nursing, presented evidence of the improvements made in the last year on end of life care. Royal Hampshire Hospital which had received an outstanding assessment had been visited and some of its actions would be implemented.

3.11 Mandatory training had been introduced for all clinical staff, the national Purple Butterfly scheme was being rolled out across the Trust, feedback was being collected from bereaved carers and mortality reviews were looking at the quality of end of life care.

3.12 Work was being undertaken with partners to provide a 24 hour advice line, reviewing the training effectiveness and developing a system for collating themes from incidents and complaints.

Winter Plan

3.13 A draft Winter Plan was being developed on the assumption that no support would be forthcoming from community services, nevertheless, commissioners had been asked to find alternative accommodation for the patients receiving rehabilitation on the Southmead site. It was understood that some physical resources had been identified but planning for the funding and implementation had yet to take place.

3.14 Capital monies to increase the bed capacity were also being considered including a modular ward and direct use of nursing home beds. Further work to refine the costs and timescales was requested as part of the development of the business case.
3.15 The Winter Plan would incorporate many of the specific patient flow schemes.

**Key Risks Identified and Impact**

3.16 TMT recognised and discussed risks relating to:
- the delivery of the Trust's cost improvement programme, achievement of income targets and the control total
- potential insufficient bed capacity which would impact on the delivery of planned elective care and to manage the forecast increase in demand over Winter
- delivery of an improved CQC rating based on current and forecast activity levels

4. **Key Decisions**

TMT approved:

4.1. The target to reduce the number of stranded patients by 50% within six months

4.2. A revised vacancy review process

4.3. A neutral vendor supplier appointment

4.4. The 2017/18 Sustainable Development Management Plan for adoption by the Board.

5. **Exceptions and Challenges**

5.1. There were no exceptions or challenges.

6. **Governance and Other Business**

6.1. The TMT received an update on the proposal to formally merge the three clinical commissioning groups in Bristol, North Somerset and South Gloucestershire and on the implementation of Service Line Management in the Trust.

6.2. Also received were reports on the ongoing improvement work streams and the Research Strategy for 2017 to 2022.

7. **Future Business**

7.1. The TMT will be focusing on the following areas over the next three months:

- Bed capacity plans
- Delivery of the business plan and cost improvement targets
- Reviewing the Winter Plan and plans to reduce the number of ‘stranded’ patients.

8. **Recommendations**

8.1. The Trust Board is asked to note the update provided on the work of the TMT.
<table>
<thead>
<tr>
<th>Report to:</th>
<th>Trust Board</th>
<th>Agenda item:</th>
<th>18</th>
</tr>
</thead>
<tbody>
<tr>
<td>Date of Meeting:</td>
<td>28 September 2017</td>
<td></td>
<td></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>
<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 discussions of the Committee meeting held on 21 September 2017.
1. Purpose

1.1. To present an update from the Committee following its meeting held on 21 September 2017.

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

Learning from Deaths Policy

3.1. The Committee received a report from the Associate Medical Director for Safe Care on the good progress made in the implementation of the national mortality review guidance. This included a need for a Trust policy for Learning from Deaths.

3.2. The Associate Medical Director reported on the progress made across all directorates in implementing reviews. The committee noted the differing requirements allowed by the guidance for different patient groups.

3.3. It is a requirement that specified data on deaths be publicly reported and the first of these reports would be in the October 2017 Integrated Performance Report to the Board.

3.4. A steering group had been created to develop the policy and every specialty had been engaged. The Trust's Quality Committee had approved the policy for review by the Quality and Risk Management Committee.

3.5. The Committee was assured by an assessment of the policy against all the elements of the national guidance from the National Quality Board although some aspects remained as work in progress. The Policy was approved with the proviso that some of the language be strengthened to reflect a more mandatory element to actions and it was noted that it would be posted on the Trust’s website before the end of the month.

Cossham Birth Centre

3.6. The Committee received a brief presentation from the acting Head of Midwifery for the Women’s and Children’s Division on transfers of pregnant women and/or babies from Cossham to Southmead. National data on the safety of Midwifery Units showed that ‘low risk’ women experience less adverse outcomes and no different adverse perinatal outcomes than planned births in obstetric units.

3.7. Cossham transferred roughly the same number of women in childbirth as the other six freestanding units of the same size in England and Wales. The most common reason for transfer was a lack of progress in the birth. There were also some
perinatal events such as third degree tears and retained placenta that could not be managed at Cossham.

3.8. All women exercising their choice to give birth at Cossham were given full information about the potential reasons for possible transfer. The reasons for all transfers and their numbers that were scrutinised on a weekly basis.

3.9. The constriction of the ring road at Bromley Heath had had no effect on the transfer times.

Risk Management

3.10. The Committee noted that the new Datix risk management system project was to receive its final go/no go stage the following week. It reviewed the extreme risks and was pleased to note the number of risk with reduced scores.

Emergency Preparedness

3.11. The Committee received a presentation on the Trust's Emergency Preparedness Resilience and Response from the EPRR manager. It noted the requirement for Trusts to respond safely and effectively to a full range of hazards and disruptive events.

3.12. The Committee was particularly pleased to note that the Trust was held to be an exemplar on Chemical, Biological, Radiological and Nuclear issues, Training and Exercising, Risk Assessment especially its links with the community, its plans and its business continuity plans.

3.13. For the future it was noted that business continuity within the organisation needed to be linked to assurance and audit data and exercise spreadsheets to test responsiveness developed for all divisions. The EPRR manager also advised that mini and Trust wide EMERGO exercises would be beneficial and Personal Protective Equipment and FFP3\(^1\) awareness and technique training for infectious diseases should be widened.

3.14. The Director of Operations informed the committee of the impending retirement of the EPRR manager and congratulated her on all the work she had done to ensure the Trust was seen nationally as an exemplar. A recruitment process to replace her had started but the committee noted how difficult it can be to recruit.

3.15. CQC Regime and Information Request

3.16. The Committee received the self-assessment of the Trust that had been submitted to the Care Quality Commission on 31 August 2017. The Medical Director commented that it might be difficult to justify the good rating for emergency care and responsiveness given the current performance issues.

3.17. The Committee also reviewed the CQC’s own Insight data and discussed the lack of Speak Up Guardians and acknowledged that the Board had yet to formally review whether it wished to appoint

---

\(^1\) Indicates the highest level of respirator protection level
an independent guardian. The executives agreed to discuss these issues with Rob Mould within the next two weeks and make recommendations to the Board.

**Sustaining Improvement in Complaints Management**

3.18. The Committee received the remedial action plan that had been produced in response to a Contract Performance Notice from the commissioners. The number of overdue complaint responses were now down to 20 and the objective was to reduce this still further to ten by the end of September 2017. The overall plan was to roughly maintain or reduce this still further on a permanent basis and to improve the quality of responses.

3.19. The new Datix system would provide easy visibility to divisions of any areas where complaints responses were proving difficult.

**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 related to pressures on the hospital wards and the actions being taken, risks on the implementation of the Datix System and future cyber-attacks and to the perceived provision of medical records to theatres and clinics.

**5. Key Decisions**

5.1 To approve the Learning from Deaths Policy.

5.2. To seek recommendations from the executives on Speak Up Guardianship.

**6. Exceptions and Challenges**

6.1 There were no exceptions or challenges identified.

**7. Governance and Other Business**

7.1 The deep dive forward plan was discussed and it was agreed to take the review of medical records and safety data from the Emergency Department as agenda items to the next meeting. A deep dive on the Stranded Patient Project should be held in January 2018 along with a look into the implementation of the Consent Policy.

**8. Future Business**

8.1 The Committee will, at its next meeting review the above information:

**9. Recommendations**

9.1 The Trust Board is asked to note the discussions of the Committee meeting held on 21 September 2017.