Due to the impact of Coronavirus COVID-19, the Trust Board will meet virtually but is unable to invite people to attend the public session. Trust Board papers will be published on the website and interested members of the public are invited to submit questions to trust.secretary@nbt.nhs.uk in line with the Trust's normal processes. A recording of the meeting will be made available on the Trust's website for two weeks following the meeting.

Trust Board Meeting – Public

Thursday 29 July 2021
Room 5 Learning & Research Building and Virtual via Microsoft Teams
10.00 – 13.00

A G E N D A

No.	Item	Purpose	Lead	Paper	Time
OPENING BUSINESS					
1.	Welcome and Apologies for Absence:	Information	Chair	Verbal	10.00
2.	Declarations of Interest	Information	Chair	Verbal	10.02
3.	Minutes of the Public Trust Board Meeting Held on 27 May 2021	Approval	Chair	Enc.	10.05
4.	Action Chart from Previous Meetings	Discussion	Trust Secretary	Enc.	10.06
5.	Matters Arising from Previous Meeting	Information	Chair	Verbal	10.08
6.	Chair's Business - NHS Providers Forum	Information	Chair Deputy Chair	Verbal	10.10
7.	Chief Executive's Report - UHBW & NBT Board to Board mtg	Information	Chief Executive	Enc.	10.20
KEY DISCUSSION TOPIC					
8.	Staff/ Patient Story - *To follow* End of Life Care Annual Report and Team presentation (AL49)	Discussion	Director of Nursing & Quality	Pres.	10.30
PERFORMANCE					
9.	Integrated Performance Report	Discussion	Chief Executive	Enc.	10.55
10.	Accelerator Programme Update	Information	Deputy Chief Executive	Verbal	11.20
BREAK (10 mins)					11.35
FINANCE					
11.	Finance Month 3 Report	Information	Chief Finance Officer	Enc.	11.45
PEOPLE & IM&T					
12.	Guardian of Safe Junior Doctor working hours *Lucy Kirkham attending to present*	Information	Medical Director	Enc.	11.50
13.	Medical Revalidation & Appraisal Annual Report	Approval	Medical Director	Enc.	12.10
GOVERNANCE & ASSURANCE					

No.	Item	Purpose	Lead	Paper	Time
14.	Patient & Carer Experience Upward Report	Information	NED Chair	Enc.	12.25
15.	Quality & Risk Management Committee Upward Report • 2020/21 Quality Account final draft	Information Approval	NED Chair	Enc.	12.35
16.	Board Assurance Framework	Discussion	Director of Corporate Governance	Enc.	12.45
CLOSING BUSINESS					
	Any Other Business	Information	Chair	Verbal	12.55
	Questions from the Public in Relation to Agenda Items	Information	Chair	Verbal	13.00
	Date of Next Meeting: Thursday 30 September 2021, 10.00 a.m.				
	Resolution: Exclusion of the Press and Public. It is recommended that, pursuant to the Public Bodies (Admission to Meetings) Act 1960, Section 1(2), the press and members of the public be excluded from further items of business, having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest.				

TRUST BOARD DECLARATIONS OF INTEREST

Name	Role	Interest Declared
Ms Michele Romaine	Chair	• Nothing to declare.
Mr Kelvin Blake	Non-Executive Director	• Non-Executive Director of BRISDOC who provide GP services to North Bristol NHS Trust. • Trustee, Second Step. Provide mental health services for the Bristol North Somerset and South Gloucestershire area. • Trustee, West of England Centre for Integrated Living. Provide a range of services to disabled people living in the Bristol, North Somerset and South Gloucestershire area. • Lay Member of the Avon & Somerset Advisory Committee. The Committee is responsible for forming interview panels for the appointment of magistrates. • Director, Bristol Chamber of Commerce and Initiative. • Member of the Labour Party.
Mr John Everitt	Non-Executive Director	• Councillor, Newton St Loe Parish Council. • Member of Bath Abbey Appeal Committee. • Trustee, Wellsway Multi Academy Trust – an education trust that manages approx. 20 schools.

Professor John Iredale	Non-Executive Director	• Pro-Vice Chancellor of University of Bristol.
		• Member of Medical Research Council.
		• Trustee of:
		  ○ British Heart Foundation
		  ○ Foundation for Liver Research
		• Chair of the governing board, CRUK Beatson Institute.

Mr Tim Gregory	Non-Executive Director	• Employed by Derbyshire County Council – Director of Environment, Economy and Transport, commencing 03/08/2020. Likely to be until May 2021.

Name	Role	Interest Declared
Mr Richard Gaunt	Non-Executive Director	• Non-Executive/Governor of City of Bristol College. • Local Board Governor of Colston's Girls' School. • Non-Executive Director of Alliance Homes, social housing and domiciliary care provider
Ms Kelly Macfarlane	Non-Executive Director	• Sister is Centre Leader of Genesiscare Bristol – Private Oncology. • Sister works for Pioneer Medical Group, Bristol.
Mr Ade Williams	Associate Non-Executive Director	• Superintendent Pharmacist and Director of M J Williams Pharmacy Group – NHS community pharmacy contractor and private vaccination services provider. • Practice Pharmacist, Broadmead Medical Centre. • Pharmacy Ambassador and Clinical Advisor, Pancreatic Cancer Action Charity. • Non-Executive Director Southern Health NHS Foundation Trust. • Trustee of the Self Care Forum Charity.
Ms LaToyah McAllister-Jones	Associate Non-Executive Director	• Board member of Bristol Festivals • Executive Director St Pauls Carnival CIC • Board Trustee of United Communities
Ms Maria Kane	Chief Executive	• Advisory Group Member of CHKS, a provider of healthcare intelligence and quality improvement services (remuneration donated to charity)
Ms Evelyn Barker	Chief Operating Officer and Deputy Chief Executive	• Nothing to declare.
Dr Chris Burton	Medical Director	• Wife works for NBT.
Mr Glyn Howells	Chief Financial Officer	• Governor and Vice Chair of Newbury College (voluntary).

Name	Role	Interest Declared
Ms Helen Blanchard	Director of Nursing and Quality	• Nothing to declare.
Mr Neil Darvill	Director of Information Management and Technology (non-voting position)	• Wife works as a senior manager for Avon and Wiltshire Partnership Mental Health Trust.
Ms Jacqui Marshall	Director of People and Transformation (non-voting position)	• Nothing to declare.
Mr Simon Wood	Director of Estates, Facilities and Capital Planning (non-voting position)	• Member of Bristol City Council's Bristol One City Environmental Sustainability Board.

3

DRAFT Minutes of the Public Trust Board Meeting held virtually on Thursday 27 May 2021 at 10.00am

Present:

Michele Romaine	Trust Chair	**Maria Kane**	Chief Executive
Tim Gregory	Non-Executive Director	**Evelyn Barker**	Deputy Chief Executive
Kelvin Blake	Non-Executive Director	**Karen Brown**	Chief Operating Officer
John Everitt	Non-Executive Director	**Helen Blanchard**	Director of Nursing & Quality
Kelly MacFarlane	Non-Executive Director	**Chris Burton**	Medical Director
Richard Gaunt	Non-Executive Director	**Neil Darvill**	Director of Informatics
John Iredale	Non-Executive Director	**Glyn Howells**	Chief Finance Officer
Ade Williams	Associate Non-Executive Director	**Jacqui Marshall**	Director of People & Transformation
LaToyah Jones	Associate Non-Executive Director (present from minute item 06)	**Simon Wood**	Director of Estates, Facilities & Capital Planning

In Attendance:

Xavier Bell	Director of Corporate Governance & Trust Secretary	**Pete Bramwell**	Acting Director of Communications
Isobel Clements	Senior Corporate Governance Officer & Policy Manager *(Minutes)*	**Gifty Markey**	Head of Patient Experience (present up to and including minute item 07)

Presenters:

Sue Mallett	Deputy Divisional Director of Nursing, NMSK (present for minute item 07)	**Caroline Hartley**	Head of People (present for minute item 08)
Chloe Cox	Tissue Viability Nurse (present for minute item 07)	**Christopher Brooks-Daw**	Associate Director of Patient Safety (present for minute item 08)
Mike Puckley	Ward Manager, ICU (present for minute item 07)	**Hilary Sawyer**	Freedom to Speak Up Lead (present for minute item 09)
Jess Reece	Gate 25a Sister (present for minute item 07)		
Claire Ross	Gate 27a Sister (present for minute item 07)		

Observers: Due to the impact of Covid-19, the Trust Board met virtually via MS Teams, but was unable to invite people to attend the public session. Trust Board papers were published on the website and interested members of the public were invited to submit questions in line with the Trust's normal processes. A recording of the meeting was published on the website.

		Action
TB/21/05/01	**Welcome and Apologies for Absence** Michele Romaine, Trust Chair, welcomed everyone to NBT's Trust Board meeting in public. A special welcome was extended to Maria Kane, NBT's new Chief Executive. No apologies had been received.	
TB/21/05/02	**Declarations of Interest**	

There were no declarations of interest, nor updates to the Trust Board register of interests as currently published on the NBT website and annexed to the Board papers.

TB/21/05/03 Minutes of the previous Public Trust Board Meeting

RESOLVED that the minutes of the public meeting held on 25 March 2021 be approved as a true and correct record.

TB/21/05/04 Action Log and Matters Arising from the Previous Meeting

RESOLVED that all actions on the log were closed and no matters arising were raised.

TB/21/05/05 Chair's Business - None

TB/21/05/06 Chief Executive's Report

Maria Kane presented the Chief Executive's report. In addition to the content of the report, Maria also noted:

- That she had visited various areas and teams of the hospital (Infection Prevention Team, Trauma, ED, staff networks, FTSU leads) which had increased her understanding of internal stakeholder. In addition, Maria was meeting with external stakeholders such as Bristol's Chief Constable and Bristol's Mayor;
- Due to demands on Evelyn Barker's time and high expectations and national scrutiny of the Accelerator Programme, Karen Brown had been appointed as Acting Chief Operating Officer;
- The BBC had visited NBT with a focus on how NBT was optimising care pathways pre and post operations;
- A Board to Board (UHBW/NBT) was scheduled for June following the Exec to Exec which occurred in May;
- Requested the Board endorse the attached 2021/22 Trust Priorities to allow prompt communication to all staff to provide clarity for the Trust for the upcoming year;
- NBT Consultant Dr Fiona Donald had been elected as the Royal College of Anaesthetists' next President;
- The CCG's decision re public consultation on reconfiguration of stroke services in BNSSG was due shortly. Maria thanked Chris Burton, Medical Director, for his significant role in this to date and noted he would take on the clinical SRO role in the public consultation. Full papers were available on the CCG website.

LaToyah McAllister-Jones joined the meeting

Accelerator Programme: John Everitt, NED, noted that appointments to the Accelerator Programme indicated system confidence in NBT. Having said this, John raised concern regarding resourcing of the Programme especially as staff were tired following the pandemic. Maria provided reassurance that a significant amount of money had been assigned to the programme and additional resources outside of NBT had been provided from the region and system. Evelyn further noted significant buy-in and engagement from system partners including the

Local Authority and Sirona. In addition, NBT was already delivering higher activity than planned (though UHBW were not).

John Iredale, NED, stated how impressed he was that staff were involved and engaged in supporting reestablishment of effective services to best benefit of patients considering living through a pandemic and being on the front-line. John reiterated the importance of supporting staff during this time.

Priorities: Kelvin Blake, NED, wanted to further understand NBT's specific contribution to reducing health inequalities in BNSSG. It was responded that the Health & Well-Being Board – which NBT was part of - brought together many partners including housing, Local Authority, healthcare and employment. Through this, the ICS and NBT's priority to be an anchor institution, NBT intended to continue to be a good system partner and positively influence others to ensure the system was working to corporate, social and environmental responsibilities.

Jacqui Marshall, Director of People & Transformation, underlined that healthcare was the largest employer in BNSSG and NBT was leading on the Equality & Diversity Strategy for the system which included projects such as Red Card to Racism. The Trust was also providing Youth Pathways and visiting schools to encourage traineeships and apprenticeships. It was hoped data in the next 12-18 months would show the positive influence of these programmes.

Kelly Macfarlane, NED, agreed with the priorities and commended the one-page simplicity of the 'what' but noted the 'how' now needed to be determined. Kelly suggested the 'how' and above details re partner working be clarified in further communications of priorities.

RESOLVED that the Chief Executive's briefing was noted and the NBT 2021/22 Trust Priorities were endorsed.

TB/21/05/07 Staff/ Patient Story: Pressure Injury

Helen Blanchard, Director of Nursing & Quality, introduced the Staff/Patient Story as a celebration of the work and progress made in reducing Pressure Injuries (PIs) at the Trust since November 2019. Sue Mallett, Deputy Divisional Director of Nursing for NMSK, and Chloe Cox, Tissue Viability Nurse, presented.

The Trust's aim had been to reduce PI's by 30%, but the Trust had achieved a 49% reduction in grade 2 PIs, 57% reduction in medical device related PIs and 60% reduction in grade 3 PIs.

A Trust-wide PI programme was described with clear workstreams and drivers, enhanced training and awareness, new risk assessments and a focus on increasing ownership of reducing PIs in all staff from consultants to HCAs. PI themes had also been discussed at fortnightly meetings where learning was shared across teams and divisions. Sue Mallett noted that staff and teams had really taken on board the PI

reduction training and guidance and had put great effort into discussing PIs on wards daily.

Staff Stories

Mike Puckley, ICU ward manager, Jess Reece, Gate 25a Sister, and Claire Ross, Gate 27a Sister, described their work re PIs on their wards and celebrated the successes. The overarching message was of team working, shared ownership, communication, training and embedding of processes.

It was noted that the sustained decrease in PIs was noteworthy as it was maintained during the pandemic.

Patient Story

Chloe Cox emphasised that though PIs were presented as numbers, each number was a patient and each PIs could have a significant impact. A video was shown to the Board, sent from a patient who had been admitted to Southmead Hospital with a significant PI. The patient described their PI experience and the significant impact it had on his life and confidence.

2021/22 focus

The PI focus for 2021/22 was described and included a focus on investigations into incidents with a Just Culture approach to enable sharing of learning and team working.

The Board thanked the presenters for their attendance and excellent work reducing PIs across the Trust.

During the ensuing discussion the following points were noted:

- Kelvin Blake stated he was particularly interested in the Patient Story as he was also spinal injured. Kelvin was heartened to hear the patient's care at NBT was excellent and he particularly liked the systematic approach to turning of patients. Following Kelvin's query re the key to success, Sue Mallett responded that the key was engagement of all staff from junior doctors to unregistered staff giving bed-side care. Empowerment of all staff to implement their own initiatives and share learning had allowed the Trust to deliver the huge PI reduction as PIs were made everyone's job to reduce.
- John Iredale noted the brilliant results in difficult circumstances. He noted that achieving and maintaining behavioural change was the biggest challenge and that lessons learnt in this programme should be used elsewhere to elicit such success. John also queried if the ICU team had changed their policy on turning patients. It was responded that previously ICU staff were hesitant to disturb patients in ICU but now technology and techniques allowed focus on quality improvements and increased turning. It was confirmed that confidence of staff had increased which meant staff were not afraid to change behaviours to better care for patients.
- Ade Williams, Associate NED, thanked the team for translating discussions at Board into patient's real experience. Ade noted that the trust had aligned on purchasing of equipment to reduce PIs which spoke to the difference a unified effort could achieve. Ade

queried if there were any barriers or enablers of note that helped embed the culture in the organisation, and if the Board could assist with these. Sue Mallett responded that having support from the Executive Team and Board had been helpful and the reason for presenting today was to share the success from ward to Board and vice versa. Giving people time to do the work and celebrate success had also been beneficial and allowed people at all levels to speak up and be facilitators of change.

RESOLVED that the Board noted the Staff/Patient Story Pressure Injury Update and the excellent reduction in PIs across the Trust. It was requested that the team present to Board again in a year. **IC**

TB/21/05/08 Just Culture

Christopher Brooks-Daw, Associate Director of Patient Safety, and Caroline Hartley, Head of People, presented an update on progress made re developing a Just Culture at NBT. The update described creation of a vision statement, work and training with the system, region and nationally, and development of KPIs, milestones and drivers for change. It was noted that there were no official NHS culture indicators but NBT was keen to be part of their development.

It was recognised NBT was early in its journey to achieving a Restorative Just Culture, but good progress had been made on policies, partner working, training etc. Key risks and issues described were time and capacity, specifically re psychological and emotional capacity following over a year of working through a pandemic.

During the ensuing discussion the following points were noted:

- Kelly Macfarlane, John Everitt and Ade Williams noted the progress made to define tangible indicators of a Just Culture and highlighted the importance of having clear indicators and KPIs defined by objective outcomes such as disciplinary numbers. Caroline responded that internally focussed KPIs were under development including disciplinary numbers, WRES data, suspension and tribunal data and other HR measures which could be shared. What a Just Culture meant for staff on the ground was the next element to land.
- Kelly also emphasised the importance of Just Culture to the 2021/22 priorities and that continuous improvement was an enabler only possible if staff felt psychologically safe.
- LaToyah McAllister-Jones, Associate NED, highlighted that the previous PI item illustrated a Just Culture in practice and what Quality Improvements could look like. LaToyah stated it was important to use the learning and culture change re PI to inform the indicators under development.
- Richard Gaunt further requested that the team could look at what success would look like in the longer-term for example what success would look like in 24 months.
- Jacqui Marshall responded that HR data was available as Just Culture metrics and impact could already been seen in the reduction in employment tribunals, fewer suspensions, and less long-term sickness. These metrics would be provided in the next update to Board;

- Following a query from the Trust Chair, it was confirmed that the Disciplinary Policy had been re-written to reflect Just Culture and would be launched shortly.

RESOLVED that the Board:

- **Noted the Restorative Just Culture and Psychological Safety Update and supported the approach and next steps with the above suggestions to be considered in development of Just Culture KPIs.**
- **Requested a bi-annual update to Board on progress with the next update to include HR metrics and indicators.**

TB/21/05/09 Freedom to Speak Up

Xavier Bell, Director of Corporate Governance and Executive Lead for FTSU, presented the refreshed FTSU vision, strategy and action plan for approval and endorsement. It was noted that this had been supported at TMT, received previously at Board for comment, and it aligned to other Trust strategies.

Following a query regarding giving patients a voice, it was confirmed FTSU was specifically for staff, though the query was relevant to the wider Just Culture piece. It was confirmed that communications would clarify this.

Kelly Macfarlane endorsed the report and vision but requested point six of the strategy clarify staff should also demonstrate that they listen as well as speak up, and most importantly that staff respond after listening. Kelly suggested that a simple way to measure success of FTSU would be if - when asked - staff at the Trust knew exactly how to raise concerns, and that they trusted the FTSU process.

Tim Gregory, NED, suggested it would be a challenge for NBT as a historically hierarchal organisation to ensure staff at all levels feel comfortable speaking up.

John Iredale suggested it would be useful to have all FTSU data externally benchmarked.

<u>Bi-Annual Report</u>

Hilary Sawyer, FTSU lead, presented the FTSU bi-annual report detailing 2020/21 data. Hilary reiterated that she was working with the Just Culture and Equality & Diversity Teams who were all working towards the common purpose of ensuring Trust-Wide psychological safety and prevention of small problems becoming larger issues.

Key points of the report were detailed as follows:

- There was not yet comparator data for quarter four.
- The lower rate of concerns may be due to fewer issues/ staff having other priorities during the pandemic/ staff being unaware of FTSU processes. However, higher numbers of concerns were

reported in quarter four which could potentially be due to the introduction of the FTSU lead role/ as pandemic effects abated/ through increased visibility of FTSU.

- The FTSU lead was collaborating with the People and EDI teams for joined up routes of reporting concerns including bullying and harassment.
- Liaison was also occurring with the OD team to arrange listening-up training for leadership and management.
- Regarding staff groups, there was an increase in concerns raised by cleaning and estates which may reflect higher concerns or be that those staff felt more empowered. Previously there had been a lack of Healthcare Assistant concerns hence focus would be on increasing awareness for that staff group.
- Last year NBT's FTSU index was 78.1% which was comparable to similar acute trusts though NBT aspired to be in the upper quartile. From the Staff Attitude Survey, a third of NBT said they did not feel safe to speak up at NBT.

Following the ensuing discussion, it was agreed that ideally staff would raise concerns with managers or senior staff prior to FTSU and for quicker conclusions at the least cost to all. Jacqui Marshall reported that the next stage of the Just Culture roll-out would focus on staff-wide civility and respect.

Tim Gregory reiterated the need for triangulation between the initiatives described and staff feedback from informal routes. Tim expressed difficulty in extracting more than incidental themes from FTSU data. It was agreed that as Chair of People Committee, Tim would work with Jacqui Marshall to attempt to pull these elements together into a coherent picture of what and how the Trust was progressing through triangulating relevant information from Just Culture, FTSU, WRES, EDI, Staff Attitude survey etc. **JM/TG**

RESOLVED that the Board reviewed and approved the refreshed NBT FTSU Vision, Strategy and Action Plan and noted the Bi-Annual FTSU report.

TB/21/05/10 Integrated Performance Report

Maria Kane, Chief Executive, presented the Integrated Performance Report (IPR) for discussion. Karen Brown, Chief Operating Officer, highlighted the key operational performance elements of the IPR:

- Patient experience was not where the Trust wanted. Execs were working together on a 'Spring Refresh' piece of work to support wards and clinical areas to facilitate improvements in patient flow and experience.
- Waiting list size had increased but due to greater elective activity, numbers of patients waiting longer than 52 weeks had decreased.

- NBT was still struggling with two-week cancer waits specifically regarding breast. A recovery action plan had been created and the Trust had been visited by the Cancer Alliance to complete a capacity/demand piece of work. Work to tackle this would be ongoing including mutual aid.
- NBT's H1 plans had been approved and trajectories would be brought to the next Board.

Queries and comments from the Board were as follows:

- John Everitt noted concern that metrics showed NBT's performance had worsened each month. Karen Brown responded that this was true of some key areas like ED though Cancer data was retrospective and showed March's position. Karen also highlighted some patients were still concerned to come into hospital for treatment but agreed there was more work to do to get the Trust back to moving in the right direction.
- Kelly Macfarlane queried why NBT's 60minute ambulance handover performance was poor. It was responded that this month's data looked comparatively worse compared to last month as ED attendances had increased to pre-Covid-19 levels while the Trust remained working within Infection Prevention Control (IPC) guidelines and treating patients in ambulances. IPC processes were now being reviewed.
- Following a query from Kelvin Blake re if waiting lists had reached their peak, it was responded that referrals were now higher than pre-Covid-19 levels likely due to primary care lack of face to face appointments and those who had delayed seeking treatment.
- Michele Romaine observed that there were many areas of worry, but breast cancer was the area of most concern. It was requested that a deep dive into this and potential solutions be carried out at Quality & Risk Management Committee on behalf of the Board.
- Michele also noted that the pandemic had led the Trust to normalise poor performance and holding risk. Michele entreated NBT to be rigorous and challenge poor performance and Evelyn Barker responded that the Accelerator Programme was a funded pilot to get performance back on track.

Helen Blanchard invited questions on the Quality elements of the IPR and Chris Burton, Medical Director, reported on the IPC elements of the IPR:

- Chris Burton drew the Board's attention to the VTE Risk Assessment details on slide 25 where NBT would be putting particular focus. April data was not yet available.
- John Iredale noted that on slide 30 '£10.3' should be '£10.3m').

Jacqui Marshall invited questions on the IPR's key People elements:

- Kelly Macfarlane noted essential training was at its lowest level since July 2020. Jacqui Marshall reassured the Board that actions were ongoing to recover essential training completion levels.

Glyn Howells, Chief Finance Officer, highlighted the below:

- April's core £2m Trust underspend was due to £1.5m received funding for elective recovery work for which schemes had not begun.

The other £0.5m was due to lower spend on medical devices as activity was lower. Overall, the finances were in line with the budget approved at March Trust Board.

RESOLVED that the Board:

- **Noted the contents and key points of April's IPR.**
- **Approved the Provider Licence Compliance Statements.**
- **Requested that a deep dive on Breast Cancer performance be carried out at July QRMC on behalf of the Board.** **KB**

TB/21/05/11 Accountability Framework

Karen Brown presented the revised Accountability Framework for Board endorsement. It was confirmed that identification of triggers for investigations were being worked through at SLM.

RESOLVED that the Board:

- **Approved the Accountability Framework and noted the further plans for development with regards to ensuring it is fit for purpose for application to Corporate Directorates; and**
- **Noted the further development planned of KPIs for inclusion in the pack of information supporting the Accountability Framework.**

TB/21/05/12 Finance Month 1 Report

RESOLVED that the finance month one report was noted for information.

TB/21/05/13 Patient & Carer Experience Upward Report

Kelvin Blake presented the Patient & Carer Experience (P&CE) Upward Report. It was requested that the Board receive a presentation on the Annual End of Life Care Report as presented to P&CE as the service had received fantastic CQC feedback.

RESOLVED that the Board noted the P&CE Upward Report and agreed that the End of Life team be scheduled to present at a future Public Trust Board. **IC**

TB/21/05/14 Quality & Risk Management Committee Upward Report

John Iredale presented the Quality & Risk Management Committee (QRMC) Upward Report and stated the Committee had received assurance regarding C.Difficile infections, Diagnostics and Maternity including non-compliance of first trimester scanning. The Patient Safety Incident Response Plan (PSIRP) was also commended for Trust Board approval.

RESOLVED that the QRMC Upward Report was noted and the PSIRP approved.

TB/21/05/15 Audit Committee Upward Report

Richard Gaunt presented the Audit Committee Upward Report and requested approval of the amended Terms of Reference.

RESOLVED that the Audit Committee Upward Report was noted, and the amended Terms of Reference approved.

TB/21/05/16 Board Assurance Framework

Xavier Bell presented the Board Assurance Framework (BAF) Report. It was agreed that the cyber security risk remain at 3x5=15, and that the target risk be amended to 3x4=12. This acknowledged that the risk was high and perpetual but no further mitigating actions were possible.

Glyn Howells reported that financial BAF risks had been considered but had been deemed to not reach the Trust's appetite level as it was sufficiently mitigated as NBT had £100m funds in the bank.

Regarding the ICS risk (SER 4), it was queried if a target score of 8 was feasible and/or realistic. It was suggested that 12 may be a more appropriate target risk score due to elements out of the NBT's control. Neil Darvill, Director of IM&T queried if the ICS risk would change within the next year. Maria Kane confirmed that national guidance on the regulatory and legislation elements of the ICS would shortly be received. Following receipt of this, the risk would be updated.

RESOLVED that the Board:

- **Reviewed the Board Assurance Framework and noted the updates to various actions.**
- **Approved the revised risk ratings for COV2 (Covid-19 Pandemic).**
- **Requested the target risk score for the cyber security risk be amended to 3x4=12.**

TB/21/05/17 Healthier Together update report

Maria Kane presented the Healthier Together Update Report and noted further national guidance re ICS' was due. Michele Romaine noted that many details were to follow but requested that NEDs attend ICS sessions and conversations wherever possible.

RESOLVED that the Healthier Together update report was noted for information.

TB/21/05/18 Any Other Business - None

TB/21/05/19 Questions from the public – None received

TB/21/05/20 Date of Next Meeting

The next Board meeting in public is scheduled to take place on Thursday 29 July 2021, 10.00 a.m. Trust Board papers will be published on the website and interested members of the public are invited to submit questions in line with the Trust's normal processes.

The meeting concluded at 12.45pm

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

Trust Board - Public ACTION LOG

Meeting Date	Agenda Item	Minute Ref	Action No.	Agreed Action	Owner	Deadline for completion of action	Item for Future Board Meeting?	Status/RAG	Info/ Update	Date action was closed/ updated
28/05/2021	Staff/ Patient Story: Pressure Injury	TB/21/05/07	47	Pressure Injury annual update to be scheduled	**Isobel Clements, Senior Corproate Governance Officer/Helen Blanchard Director of Nursing & Quality**	Jul-21	Yes	**Open**	IC to schedule on new 2022/23 forward work-plan once created	
28/05/2021	Freedom to Speak Up	TB/21/05/09	48	Discuss how People Committee can have oversight of staff initiatives such as Just Culture and FTSU	**Jacqui Marshall, Director of People & Transformation and Tim Gregory, NED**	Jul-21	No	**Open**		
28/05/2021	Integrated Performance Report	TB/21/05/10	49	Breast cancer performance and issues deep dive to be completed at QRMC	**Karen Brown, Chief Operating Officer**	Jul-21	Yes, QRMC	**Closed**	Received at July QRMC, detailed in upward report	22/07/2021
28/05/2021	Patient & Carer Experience Upward Report	TB/21/05/13	50	End of Life Care annual Report to be presented by team at future public Trust Board	**Isobel Clements, Senior Corproate Governance Officer/Helen Blanchard Director of Nursing & Quality**	Jul-21	Yes	**A**	On July public Board agenda	07/07/2021

Report To:	Trust Board Meeting		
Date of Meeting:	29 July 2021		
Report Title:	Chief Executive's Briefing		
Report Author & Job Title	Xavier Bell, Director of Corporate Governance		
Executive/Non-executive Sponsor (presenting)	Maria Kane, Chief Executive		
Does the paper contain:	**Patient identifiable information?**	**Staff identifiable information?**	**Commercially sensitive information?**
		X	
*If any boxes above ticked, paper may be received at *private* meeting			
Purpose:	**Approval**	**Discussion**	**To Receive for Information**
			X
Recommendation:	The Trust Board is asked to: • Receive and note the content of the briefing.		
Report History:	The Chief Executive's briefing is a standing agenda item on all Board agendas.		
Next Steps:	Next steps in relation to any of the issues highlighted in the Report are shown in the body of the report.		

Executive Summary	
The report sets out information on key items of interest to Trust Board, including engagement with system partners and regulators, events, and key staff appointments.	
Strategic Theme/Corporate Objective Links	**1. Provider of high-quality patient care** **2. Developing Healthcare for the future** **3. Employer of choice** **4. An anchor in our community**
Board Assurance Framework/Trust Risk Register Links	Does not link to any specific risk.
Other Standards Reference	N/A
Financial implications	None identified.

Other Resource Implications	No other resource implications associated with this report.
Legal Implications	None noted.
Equality, Diversity and Inclusion Assessment (EIA)	N/A
Appendices:	None

1. Purpose

The report sets out information on key items of interest to Trust Board, including engagement with system partners and regulators, events, and key staff appointments.

2. Background

The Trust Board receives a report from the Chief Executive to each meeting detailing important changes or issues within the organisation and within the external environment.

3. Emergency Department Performance

As the Board will be aware, NBT is facing significant pressures in its Emergency Department (ED) and with the flow of patients in and out of the hospital. Unfortunately, for some months this has resulted in many of our patients in ED waiting much longer than NHS performance standards mandate.

During this period we have seen increases in the numbers of patients attending ED, at the same time as having many of our staff across the hospital either sick, self-isolating due to Covid-19 infection prevention control measures, or caring for family members impacted by Covid-19.

The organisation is taking steps to understand the drivers of this situation better and working both internally and with system partners to rectify this and improve the experience of our patients and staff. The Board will have the opportunity to discuss this in more detail when considering the Integrated performance report on the Board agenda.

NBT is also engaging with regional colleagues from NHS Improvement to develop a plan focused on improving our Ambulance patient-handover times.

4. Covid-19 & Infection Prevention Control

Covid-19 cases in Bristol and the surrounding areas are high. While the vaccination programme means there are fewer people falling seriously ill and being admitted to hospital as a proportion of total cases, the number of Covid-19 patients in the hospital has increased as national restrictions have been relaxed.

From 19 July 2021 most of the legal restrictions in England have been lifted; however, Public Health England's infection prevention control guidelines and hospital visiting guidance has not changed and remains in place for all staff, patients, and visitors at NBT. This includes social distancing on site and wearing an appropriate face-covering when inside hospital buildings.

The Trust is continuing to support staff in ensuring that this guidance is followed in all healthcare settings, and we retain our focus on 'hands, face, space'.

5. Board to Board with University Hospitals Bristol & Weston NHS Foundation Trust

The two Boards of UHBW and NBT have established a clear intention to work in collaboration as a means to achieve the quadruple aims of better health, better care, better value for money and reduced health inequalities.

Both Boards attended a join development session on 21 June 2021 to identify ways in which this could be achieved, focusing on the case for closer collaboration, lessons that

could be learned from other healthcare systems, and developing a shared understanding of the role that the two organisations should play in the developing Integrated Care System.

This session was extremely positive, with all Board members engaged and excited about the opportunities of more collaboration and the clear benefits for our patients. The organisations will use the existing Acute Services Review Programme to continue focusing on optimal and aligned services for patients, and this will evolve into a more formal Provider Collaborative within the Integrated Care System in due course. Draft proposals have been shared with the Healthier Together Executive Group and with Regional NHSEI colleagues.

6. System Working & Engagement

As an active system leader, I have been asked to take on the Chair role for the Healthier Together Acute Care Collaboration Steering Group, The Urgent and Emergency Care Steering Group and the West of England Pathology Network.

I am now regularly attending the Bristol City Leaders Group, and since my last report I have also had the opportunity to meet directly with a number of our local politicians and city leaders, including:

- Karin Smith, Member of Parliament for Bristol South
- Jack Lopresti, Member of Parliament for Filton and Bradley Stoke
- Councillor Asher Craig, Bristol's Deputy Mayor

7. Bristol Race Equality Gathering

On 21 July 2021 I attended Bristol's Race Equality Gathering hosted by the Deputy Mayor. This was an opportunity to hear from leaders of many of Bristol's race equality groups, discuss how to help Bristol tackle its major race inequality challenges and to share good practice across the city.

8. Care Quality Commission Engagement Meeting

On 23 June 2021 members of the Executive Team met the CQC as part of our ongoing engagement and interaction between formal regulatory inspections. This provided an opportunity to discuss priorities and areas of interest/concern at NBT, including the pressures in the Emergency Department, the Accelerator Programme and restoring planned care for our patients, our new modular theatres in the Women & Children's Health Division, which should open in August 2021.

We received very positive feedback on the recent CQC monitoring visit to NBT's Critical Care Unit. Inspectors recognised the high-quality care for patients during an extremely challenging year and commented in particular on the commitment and dedication of our outstanding staff.

9. Next Big Thing

On Monday 28 June 2021 we held the very first Next Big Thing innovation competition across the Trust. After a long deliberation by the judging panel I am delighted to report that the winning entry was:

Improving patient choice in the prescription of Heparins in Muslim Patients

The judges were highly impressed by this application, which highlighted the issue of animal products in commonly prescribed drugs. We hope this project can enable meaningful and sustainable change for our patient

Thanks to the Southmead Hospital Charity agreeing to increase its financial support to the competition, we were also able to support three other projects:

- Penicillin allergy – 'a rash decision'
- A Trust-wide project to reduce surgical site infection after abdominal surgery
- Neuro Early Supported Discharge Service

These initiatives will improve the experience and care we provide to our patients, and it was great to see the multitude of amazing ideas and proposals put forward by our colleagues. There were a number of other finalists including Hospital at Night, Perioperative Care and Palliative Care Teams. These projects will be fed into existing pieces of work and other funding mechanisms across the Trust.

10. Executive Team Reciprocal Mentoring Training

The Executive Team are participating in the reciprocal Valuing Together mentoring programme, as part of the Trust Board's commitment to improving the experiences and outcomes for Black, Asian, and Minority Ethnic (BAME) staff.

The programme will provide opportunities for colleagues from a BAME background to work as equal partners with Executive Directors, participating in a series of regular meetings with the aim of building a relationship that encourages sharing of knowledge and improving performance. In this programme each of the participants will take on the role of both mentor and mentee and will be referred to as mentoring partners. The relationship is based on sharing knowledge, experiences, and insights to develop understanding and consider actions towards a more equitable and inclusive organisation.

11. NBT Festival

The OneNBT Festival 2021 took place between 1-5 July. Many staff enjoyed the wellbeing activities on offer, from mindfulness and online music to Yogalates and nature walks around our amazing hospital site.

It was great to see so many people reconnecting with our awareness stalls and having important conversations about sustainability, work-life balance and Equality, Diversity and Inclusion.

12. Service Visits, Slice of Life & Consultant Conversations

I am determined to visit and spend time with as many services and teams across the hospital as I can. Since joining NBT, I have spent time with the:

- Emergency Department (06/05/2021)
- Infection Prevention & Control Team (19/05/2021)
- Trauma & Orthopaedics (26/05/2021)
- Acute Stroke Unit (09/06/2021)
- Neuropathology (21/06/2021)
- Centre for Enablement (29/06/2021)
- Endoscopy Department (07/07/2021)

I have also attended a number of team and network meetings, including with the:

- Disability & Neurologically Diverse Staff Network meetings
- BAME Communities forum
- Integrated Discharge Service
- IM&T and Digital Transformation Team meeting
- Dermatology
- Infectious Diseases
- Divisional Operations Directors Team meeting
- Core Clinical Services Triumvirate meeting
- Perform Improvement Team
- Medical Records
- Mental Health Liaison Team
- Major Trauma Team

I have also met with a number of Consultants from across the organisation. This has been really useful in helping me to understand the vision, priorities, and concerns of the organisation's senior medical leadership.

I have held the second monthly 'Slice of life' chat over team and cake with a mix of different colleagues, which provided another opportunity for me to get to know people across the organisation. My thanks to all who attended.

On the evening of 13 July, together with NBT's Director of Nursing & Quality and other nurse leaders, I delivered part 2 of the cup-cakes to our nursing and midwife staff working nightshifts at Southmead Hospital. Together we visited inpatients areas across the hospital in aid of acknowledging our hard working and incredible staff in aid of celebrating International Nursing Day and International Day of the Midwife that was held earlier in May.

Healthcare Support Workers Apprenticeship Celebration Event

On 12 July I attended an event recognising the achievements of Healthcare Support Workers (HCSW) who have completed a learning qualification with NBT over the last 18

months, including apprenticeships and Care Certificate learning. I joined 40 HCSWs to celebrate their success, and also mark the 10-year anniversary of NBT proudly delivering apprenticeships.

I was also able to present the first Sandra Hick's Award for Apprentice of the Year, and would like to congratulate the winner Sarah McCann, Senior HCSW in Theatres together with runners up Sarah Sheppard, Senior HCSW on Cotswold Ward, and Don Judan, HCSW on Ward 32A.

13. Dr Chris Burton

As Trust Board members will be aware, Dr Chris Burton will be retiring as NBT's Medical Director at the end of July 2021, having held the post since April 2009. I would like to thank Dr Burton for his steadfast leadership and dedication to NBT and ask Trust Board members to join me in wishing him well for the future.

14. Consultant Appointments

Since this report was last issued in May 2021 the Trust has appointed 8 new consultants across several key specialities:

Name	Specialty	Appointed From
Michael Mallia	Interventional Radiology	11.05.2021
Sarah-Jane Bailey	Care of the Elderly	08.06.2021
Naomi Patel	Plastic Surgery – Breast	22.06.2021
Islam Gamaleldin	Gynaecology	29.06.2021
Jean-Brice Rodriguez	Gynaecology	29.06.2021
Shirjel Alam	Cardiology	06.07.2021
Anjali Menon	Nephrology	13.07.2021
Saira Risdale	Nephrology	13.07.2021

15. Summary and Recommendations

The Trust Board is asked to note the content of this report and discuss as required.

Report To:	Trust Board		
Date of Meeting:	29 July 2021		
Report Title:	Integrated Performance Report		
Report Author & Job Title	Lisa Whitlow, Associate Director of Performance		
Does the paper contain	**Patient identifiable information?**	**Staff identifiable information?**	**Commercially sensitive information?**
	N/A	N/A	N/A
Executive/Non-executive Sponsor (presenting)	Executive Team		
Purpose:	**Approval**	**Discussion**	**To Receive for Information**
		X	
Recommendation:	The Trust Board is asked to note the contents of the Integrated Performance Report.		
Report History:	The report is a standing item to the Trust Board Meeting.		
Next Steps:	This report is received at the Joint Consultancy and Negotiation Committee, Operational Management Board, Trust Management Team meeting, shared with Commissioners and the Quality section will be shared with the Quality and Risk Management Committee.		

9

Executive Summary
Details of the Trust's performance against the domains of Urgent Care, Elective Care and Diagnostics, Cancer Wait Time Standards, Quality, Workforce and Finance are provided on page six of the Integrated Performance Report.
Strategic Theme/Corporate Objective Links **1. Provider of high quality patient care** a. Experts in complex urgent & emergency care b. Work in partnership to deliver great local health services c. A Centre of Excellence for specialist healthcare d. A powerhouse for pathology & imaging **2. Developing Healthcare for the future** a. Training, educating and developing our workforce b. Increase our capability to deliver research c. Support development & adoption of innovations d. Invest in digital technology **3. Employer of choice** a. A great place to work that is diverse & inclusive

	b. Empowered clinically led teams c. Support our staff to continuously develop d. Support staff health & wellbeing
Board Assurance Framework/Trust Risk Register Links	The report links to the BAF risks relating to internal flow, staff retention, staff engagement, productivity and clinical complexity.
Other Standard Reference	CQC Standards.
Financial implications	Whilst there is a section referring to the Trust's financial position, there are no financial implications within this paper.
Other Resource Implications	Not applicable.
Legal Implications including Equality, Diversity and Inclusion Assessment	Not applicable.
Appendices:	Not applicable.

NHS North Bristol NHS Trust

North Bristol NHS Trust

INTEGRATED PERFORMANCE REPORT

July 2021 (presenting June 2021 data)

CONTENTS

North Bristol Integrated Performance Report

Domain	Description	National Standard	Current Month Trajectory (RAG)	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Trend	Benchmarking (in arrears except A&E & Cancer as per reporting month)		
																		National Performance	Rank	Quartile
Responsive	A&E 4 Hour - Type 1 Performance	95.00%	72.71%	94.74%	93.47%	86.90%	87.76%	82.07%	77.95%	73.21%	68.51%	73.33%	81.05%	74.26%	72.71%	64.38%		73.18%	93/112	
	A&E 12 Hour Trolley Breaches	0	0	0	0	0	0	12	3	52	206	7	0	6	0	4		0 - 252	5/31	
	Ambulance Handover < 15 mins (%)	100%	51.07%	98.50%	98.07%	98.01%	76.69%	68.07%	67.70%	57.77%	54.95%	60.97%	58.17%	50.28%	51.07%	48.46%				
	Ambulance Handover < 30 mins (%)	100%	80.43%	99.96%	99.76%	99.83%	96.04%	93.50%	93.76%	88.44%	83.80%	92.75%	89.36%	79.42%	80.43%	73.44%				
	Ambulance Handover > 60 mins	0	199	0	0	0	4	33	26	82	180	57	83	272	199	346				
	Stranded Patients (>21 days) - month end			74	82	95	114	247	141	145	124	129	137	273	116	123				
	Right to Reside: Discharged by 5pm	50.00%		-	-	-	-	-	-	28.52%	30.53%	29.43%	30.89%	35.86%	31.84%	33.77%				
	Bed Occupancy Rate		95.24%	77.11%	82.97%	87.51%	92.30%	94.19%	92.38%	95.10%	95.86%	92.74%	92.49%	95.25%	95.24%	96.64%				
	Diagnostic 6 Week Wait Performance	1.00%	31.99%	46.56%	28.98%	32.36%	29.58%	27.47%	26.73%	32.37%	33.04%	27.20%	24.72%	29.45%	31.99%	36.13%		22.30%	195/252	
	Diagnostic 13+ Week Breaches	0	0	3161	1886	1979	1998	1697	1427	1487	1420	1358	1364	1513	1779	2054			153/213	
	Diagnostic Backlog Clearance Time (in weeks)			2.0	1.0	1.0	0.9	0.9	0.8	1.0	1.0	0.8	0.8	0.9	1.1	1.3				
	RTT Incomplete 18 Week Performance	92.00%	74.29%	58.20%	58.48%	63.96%	70.46%	74.00%	74.35%	73.18%	71.62%	70.65%	71.64%	73.59%	74.29%	74.98%		67.39%	215/399	
	RTT 52+ Week Breaches	0	1583	454	648	797	1001	1092	1249	1418	1817	2108	2088	1827	1583	1473		0 - 16816	129/164	
	RTT 78+ Week Breaches		363	-	-	-	-	-	-	-	-	-	-	363	424	448		0 - 3245	77/109	
	RTT 104+ Week Breaches		5	-	-	-	-	-	-	-	-	-	-	5	12	19		0 - 212	11/39	
	Total Waiting List		31648	25265	27512	28814	29387	30214	29632	29611	29759	29716	29580	31143	31648	32946				
	RTT Backlog Clearance Time (in weeks)			10.3	9.6	7.7	6.4	5.5	4.8	4.9	5.2	5.8	5.6	4.9	4.8	5.2				
	Cancer 2 Week Wait	93.00%	39.53%	97.29%	88.11%	78.05%	76.30%	89.01%	78.65%	63.72%	60.03%	70.87%	63.24%	39.53%	36.58%	-		87.50%	132/132	
	Cancer 2 Week Wait - Breast Symptoms	93.00%	6.18%	96.62%	96.05%	75.18%	54.04%	87.76%	61.07%	33.77%	49.64%	36.17%	15.20%	6.18%	9.21%	-		67.94%	91/103	
	Cancer 31 Day First Treatment	96.00%	94.40%	95.35%	97.51%	95.78%	90.31%	92.68%	97.01%	95.47%	89.84%	95.96%	96.62%	94.40%	97.38%	-		95.14%	53/115	
	Cancer 31 Day Subsequent - Drug	98.00%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	-		99.12%	1/33	
	Cancer 31 Day Subsequent - Surgery	94.00%	81.18%	86.96%	92.13%	89.86%	85.19%	87.76%	91.95%	92.22%	77.66%	84.44%	85.48%	81.18%	86.73%	-		88.50%	42/67	
	Cancer 62 Day Standard	85.00%	75.00%	70.12%	75.31%	73.10%	70.07%	72.87%	75.76%	77.39%	65.91%	74.34%	76.09%	75.00%	77.11%	-		72.97%	55/133	
	Cancer 62 Day Screening	90.00%	73.68%	28.57%	44.44%	66.67%	100.00%	77.14%	76.92%	86.36%	78.57%	86.79%	68.18%	73.68%	54.72%	-		74.53%	54/68	
	Mixed Sex Accomodation	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0				
	Electronic Discharge Summaries within 24 Hours	100%		85.88%	83.38%	82.76%	82.97%	84.21%	83.76%	82.96%	81.60%	83.81%	84.80%	84.62%	82.69%	83.57%				

North Bristol Integrated Performance Report

Domain	Description	National Standard	Current Month Trajectory (RAG)	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Trend
Quality Patient Safety & Effectiveness	5 minute apgar 7 rate at term		0.90%	0.97%	0.64%	0.22%	0.23%	0.64%	0.73%	0.70%	0.50%	0.51%	0.43%	0.70%	0.95%	0.69%	
	Caesarean Section Rate		28.00%	36.69%	34.60%	39.01%	35.00%	36.42%	31.16%	41.92%	35.13%	38.69%	40.28%	37.44%	33.11%	40.09%	
	Still Birth rate		0.40%	0.00%	0.40%	0.20%	0.41%	0.00%	0.23%	0.64%	0.46%	0.23%	0.00%	0.43%	0.22%	0.00%	
	Induction of Labour Rate		32.10%	34.90%	35.40%	38.60%	38.87%	36.62%	39.77%	37.55%	39.81%	33.80%	33.81%	35.24%	37.14%	35.29%	
	PPH 1000 ml rate		8.60%	11.50%	11.20%	10.68%	7.97%	10.38%	14.19%	8.93%	9.77%	11.57%	10.28%	8.99%	10.29%	13.79%	
	Never Event Occurance by month	0	0	0	0	0	0	0	0	0	1	0	0	1	0	0	
	Serious Incidents			9	11	5	5	5	6	4	3	2	4	10	2	3	
	Total Incidents			834	952	1030	1057	1210	1051	1058	1224	876	1001	1032	1028	961	
	Total Incidents (Rate per 1000 Bed Days)			46	48	49	47	50	49	49	56	45	46	46	41	42	
	WHO checklist completion		95%	99.60%	99.70%	99.70%	99.60%	99.60%	99.40%	99.95%	99.79%	99.94%	100.00%	99.92%	99.60%	99.96%	
	VTE Risk Assessment completion		95%	94.89%	95.79%	95.08%	95.15%	95.12%	94.61%	95.44%	95.28%	95.10%	95.38%	95.44%	95.31%	-	
	Pressure Injuries Grade 2			13	8	14	13	28	17	17	17	27	7	9	10	15	
	Pressure Injuries Grade 3		0	0	0	0	1	1	0	0	0	0	0	0	0	0	
	Pressure Injuries Grade 4		0	0	0	0	0	0	0	0	1	0	0	0	0	0	
	PI per 1,000 bed days			0.59	0.24	0.50	0.46	0.85	0.42	0.60	0.52	0.82	0.19	0.30	0.30	0.52	
	Falls per 1,000 bed days			8.10	7.06	7.68	6.70	9.57	8.85	8.55	9.54	8.63	8.44	8.34	8.71	8.41	
	#NoF - Fragile Hip Best Practice Pass Rate			9.43%	47.46%	63.64%	54.17%	77.27%	75.61%	63.64%	42.86%	69.05%	78.38%	31.25%	8.33%	-	
	Admitted to Orthopaedic Ward within 4 Hours			83.02%	86.44%	66.67%	79.17%	67.44%	53.66%	57.14%	39.68%	54.76%	44.68%	71.88%	55.56%	-	
	Medically Fit to Have Surgery within 36 Hours			79.25%	74.58%	72.73%	68.75%	86.05%	80.49%	79.59%	58.73%	80.95%	89.36%	71.88%	50.00%	-	
	Assessed by Orthogeriatrician within 72 Hours			98.11%	98.31%	90.91%	87.50%	93.02%	95.12%	79.59%	80.95%	97.62%	97.87%	56.25%	11.11%	-	
	Stroke - Patients Admitted			79	84	63	83	86	79	80	70	61	96	91	100	91	
	Stroke - 90% Stay on Stroke Ward		90%	86.20%	80.00%	93.20%	88.00%	84.62%	81.97%	80.88%	58.18%	83.33%	81.08%	98.26%	86.76%	-	
	Stroke - Thrombolysed <1 Hour		60%	85.70%	50.00%	60.00%	69.00%	72.73%	50.00%	33.33%	50.00%	44.00%	78.00%	100.00%	50.00%	-	
	Stroke - Directly Admitted to Stroke Unit <4 Hours		60%	88.10%	73.60%	63.30%	69.10%	61.73%	63.64%	47.83%	35.59%	60.00%	48.68%	47.89%	52.00%	-	
	Stroke - Seen by Stroke Consultant within 14 Hours		90%	94.00%	91.00%	89.00%	80.00%	86.00%	89.71%	85.92%	87.30%	91.55%	90.00%	85.14%	90.36%	-	
	MRSA	0	0	0	0	0	0	1	0	0	0	1	0	0	0	0	
	E. Coli		4	2	5	7	8	4	5	3	3	1	6	4	5	4	
	C. Difficile		5	2	4	3	5	7	5	7	4	9	4	10	6	10	
	MSSA		2	1	4	2	1	4	6	2	3	3	0	4	1	5	
Quality Caring & Experience	Friends & Family - Births - Proportion Very Good/Good			-	-	-	-	-	-	-	-	-	94.26%	95.51%	95.51%	94.74%	
	Friends & Family - IP - Proportion Very Good/Good			-	-	-	-	-	-	93.24%	94.06%	95.72%	93.68%	92.90%	94.52%	91.79%	
	Friends & Family - OP - Proportion Very Good/Good			-	-	-	-	-	-	95.60%	95.71%	95.29%	94.63%	94.90%	95.09%	94.40%	
	Friends & Family - ED - Proportion Very Good/Good			-	-	-	-	-	-	90.96%	87.49%	89.21%	87.24%	84.86%	82.00%	73.19%	
	PALS - Count of concerns			49	75	51	95	73	99	66	62	71	79	108	88	127	
	Complaints - % Overall Response Compliance		90%	98.30%	98.08%	97.06%	98.04%	94.44%	92.68%	94.64%	81.48%	84.38%	85.11%	79%	83.33%	77.03%	
	Complaints - Overdue			0	0	0	0	2	2	0	0	0	0	0	0	0	
	Complaints - Written complaints			40	59	53	46	48	39	23	37	43	42	56	67	51	
Well Led	Agency Expenditure ('000s)			364	555	822	687	875	900	1043	1233.82	543.91	1042	705	816	1029	
	Month End Vacancy Factor			5.39%	6.05%	5.14%	3.82%	3.83%	3.38%	4.59%	3.80%	3.65%	3.62%	2.66%	4.81%	5.53%	
	Turnover (Rolling 12 Months)		12.00%	12.35%	13.10%	13.41%	13.25%	12.78%	12.74%	12.73%	12.89%	12.56%	12.36%	13.37%	13.60%	13.81%	
	Sickness Absence (Rolling 12 month -In arrears)		-	4.53%	4.46%	4.46%	4.44%	4.41%	4.44%	4.38%	4.47%	4.48%	4.42%	4.32%	4.31%	-	
	Trust Mandatory Training Compliance			87.07%	85.24%	86.77%	86.26%	86.45%	86.07%	85.79%	85.90%	85.91%	85.40%	85.17%	84.95%	84.55%	

EXECUTIVE SUMMARY
June 2021

Urgent Care

Four-hour performance deteriorated to 64.38% in June with the Trust conceding 346 ambulance handover delays over one hour and four 12-hour trolley breaches. The deterioration reflects a sustained increase in the number of emergency attendances. The Trust AM discharge rates have deteriorated vs. pre-pandemic levels and is contributing to poor flow – this is an area of focus as part of the Trust's Spring and Refresh programme. The Trust position deteriorated in June, moving into the fourth quartile for the first time when compared nationally. Impact on ED performance is expected to continue in July, with a continued increase in attendance levels, alongside increasing COVID-19 positive patients and current performance at 53.52%.

Elective Care and Diagnostics

The RTT waiting list continued to increase in June resulting from a reduction in waiting list removals, particularly for Removals Other Than Treatment (ROTT). There were 1473 patients waiting greater than 52 weeks for their treatment in June; this is the fourth consecutive month that the Trust has reported a reduction in 52 week wait breaches since the beginning of the COVID-19 pandemic. The overall proportion of the wait list that is waiting longer than 52 weeks reduced to 4.47%. Nationally, the Trust positioning was static in May, remaining in the third quartile. Diagnostic performance deteriorated in May to 36.13%. When compared nationally, Trust positioning deteriorated, with 6-week performance moving into the fourth quartile from the third, and 13-week performance remaining in the fourth quartile.

Cancer Wait Time Standards

The TWW standard, impacted by issues in the Breast specialty which reported a performance of 4.61% in month deteriorated in May. Poor performance is expected to be reported in June, but significant improvements are anticipated in July. The 31-Day standard was achieved in May, with performance of 97.38%. The reported 62 Day performance for May was 77.11%; slightly better than the April performance of 75.00%. Cancer trajectories for 2021/22 have been created in line with 2021/22 planning guidance and will be approved by the Trust Board in August 2021.

Quality

Maternity services has reported compliance with all 10 of the CNST safety actions, which has been reviewed and approved by the Board via QRMC. There have been no reported Grade 3 or 4 pressure injuries in June. The Trust has seen a surge of COVID-19 cases in line with predictive modelling; there were no MRSA cases reported in June. The Trust's antenatal screening service is still experiencing challenges with demand exceeding available capacity

Workforce

Trust sickness absence saw a small reduction for the second month in a row across short and long term sickness. The Trust vacancy factor increased to 5.55% in June (from 4.82%) following a small number of non-recurrent establishment changes in June and also due to an increase in staff turnover. Turnover saw a small increase in June to 11.73% from 11.17% in May, registered nursing and midwifery is seeing the greatest increase. Temporary staffing demand saw an increase in June of 9.78% (81.52 wte) with unfilled shifts also increasing as bank capacity is impacted by COVID related pressures in the same way substantive staffing has been and this pressure is being felt by providers across BNSSG.

Finance

NHSI/E has suspended the usual operational planning process and financial framework due to covid-19 pandemic response.
For the first half of the year the trust is funded through a block contract arrangement against which it is expected breakeven. Additionally, non-recurrent income will be provided to fund non-recurrent elective recovery actions including those covered by the Accelerator programme. Income and cost estimates of £8.6m for ERF activity are included in the M3 position.

RESPONSIVENESS
SRO: Chief Operating Officer
Overview

Urgent Care

The Trust reported four-hour performance of 64.38% in June; trajectories for 2021/22 will not be set until July 2021 following the final H1 planning submission. Ambulance handover delays were reported in-month with 346 handovers exceeding one hour and the Trust conceded four 12-hour trolley breaches. ED activity increased in June with a rise in walk-in attendances, whilst ambulance arrivals remained consistent with pre-pandemic levels; handover times continue to be particularly challenged. Bed occupancy varied between 94.24% and 99.30% against the core bed base; increased occupancy and consistency continued in June, reducing the variation across the month. Performance remains challenged into July with a continued increase in attendances.

Planned Care

Referral to Treatment (RTT) - 18 week RTT performance improved marginally in May to 74.98%; trajectories for 2021/22 have not yet been confirmed. The number of patients exceeding 52 week waits in June was 1473, the majority of breaches (926; 62.86%) being in Trauma and Orthopaedics. For the fourth consecutive month since the beginning of the COVID-19 pandemic the Trust has reported a reduction in 52 week wait breaches; the overall proportion of the wait list that is waiting longer than 52 weeks has reduced to 4.47%. The Trust is still experiencing some patients choosing to defer their treatment due to concerns with regards to COVID-19 or wishing to wait until they have received the COVID-19 vaccine. The Trust is working with these patients to understand their concerns and what needs to happen for them to be able to engage with progressing their pathway.

Diagnostic Waiting Times – Diagnostic performance deteriorated in June with performance of 36.13%. Case-mix continues to impact the DM01 position with an ongoing backlog increase and reducing under 6 week position. Endoscopy performance continues to be impacted by capacity challenges, however the service has commenced an insourcing model to increase activity. Due to ongoing capacity issues, Non-Obstetric Ultrasound reported a deterioration in performance in June; actions are in progress to increase capacity in the service. The number of patients waiting longer than 13 weeks increased by 15.46% in June. Compared nationally, 13 week performance deteriorated slightly in May, remaining in the fourth quartile.

Cancer

The Trust achieved one out of the seven Cancer Wating Time (CWT) standards (31-Day first) in May The Breast service continues to have workforce and capacity constraints in both clinical and diagnostic support but have worked additional shits in the evening and weekends to clear the backlog down to C. 185 patients. The average waiting time for the Trust's one-stop Breast clinic has dropped from 32 days down to 28 days.
The Skin service capacity issues have started to impact the CWT standards and will continue to do so for the remainder of Q2. Cancer trajectories for 2021/22 have been created in line with 2021/22 planning guidance. The Trust failed to achieve the 28-Day faster diagnosis standard again this month largely due to the capacity issues in Breast, Skin and Colorectal.

Areas of Concern

The main risks identified to the delivery of national Responsiveness standards are as follows:

- Lack of community capacity and/or pathway delays fail to support bed occupancy requirements as per the Trust's response to the COVID-19 pandemic.
- The ongoing impact of COVID-19 Infection Prevention and Control guidance and Clinical Prioritisation guidance on the Trust's capacity and productivity and therefore, ability to deliver national wait times standards.

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

Improvements

Maternity : Maternity services has reported compliance with all 10 of the CNST safety actions, which has been reviewed and approved by the Board via QRMC. NBT has received confirmation of national funding to support an increase in midwives which goes towards meeting the recommendations of BirthRate+.

Pressure Injuries - There have been no reported Grade 3 or 4 pressure injuries in June and Grade 2 pressure injuries remain below the mean rate (medical device related and overall).

Infection control: There were no MRSA cases reported in June 2021.

Mortality Rates/Alerts: An increase in deaths was seen in December and January which is likely to have been the result of increasing COVID-19 infections. The numbers have returned to the expected rate since that time. There are no current Mortality Outlier alerts for the trust and continued high completion rates of mortality reviews are demonstrated.

Areas of Concern

Maternity: Our antenatal screening service is still experiencing challenges with demand exceeding available capacity. The division is working on an action plan with the regional team for resolution including outsourcing of the FTCS service which is due to start early August. A ‘deep dive’ review was undertaken at the July QRMC meeting into current challenges and actions.

Infection control: The Trust has seen a surge of cases in line with predictive modelling, however there has not been any cross infection in this wave to date. C.difficile rates remain higher than trajectory, local improvement actions are in progress and the IPC team is linking with a Southwest HCAI Collaborative to look at reduction, as this is a regional concern.

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

Corporate Objective 4: Build effective teams empowered to lead

Vacancies

The Trust reported vacancy factor increased to 5.55%% in June (from 4.82% in May). The increase has been driven by substantive establishment changes (+40.1 wte) and an increase in turnover, predominantly in registered nursing and midwifery. Registered nursing and clinical fellows had the greatest net loss, -9 wte and -7wte respectively, with the Emergency Department seeing the largest net loss of both roles. To address this we are continuing our focussed recruitment plan with direct recruitment of skilled staff and appropriate internal transfers from other areas.

Turnover

The Trust turnover is reported as 13.81% in June, excluding the impact of COVID workforce and mass vaccination the turnover rate is at 11.73%, an increase from last month (11.17%). The Turnover position deteriorating particularly in the 1st part of the year has been anticipated. The increase has been most significant in registered nursing and midwifery with the staff group experiencing a net loss of staff in Q1 of 21/22 due to a high number of leavers (recruitment remains at a similar level to 19/20 and 20/21).

Prioritise the wellbeing of our staff

The rolling 12 month sickness absence saw a small reduction in May to 4.31%, from 4.34% in April. Both short and long term sickness saw a small reduction and both are lower than the same point last year.

Continue to reduce reliance on agency and temporary staffing

Temporary staffing demand increased in June by 9.78% (81.52 wte). Whilst bank use remained at the same level as May overall bank fill rate decreased due to the increase in demand not met, agency use and fill remained at a similar level to May with unfilled shift increasing from 21.41% to 27.09%, an increase of 69.43 wte. 50% of the increase in demand was for registered nursing and midwifery and the same increase in unfilled shifts was seen

This position is in line with the issues being experienced by our internal bank and by agencies, that household isolation and test and trace contact are impacting on availability of temporary staff in the same way as substantive staff. This pressures is being felt across all providers in BNSSG and analysis of workforce pressures is currently in progress across the system.

FINANCE
SRO: CFO
Overview

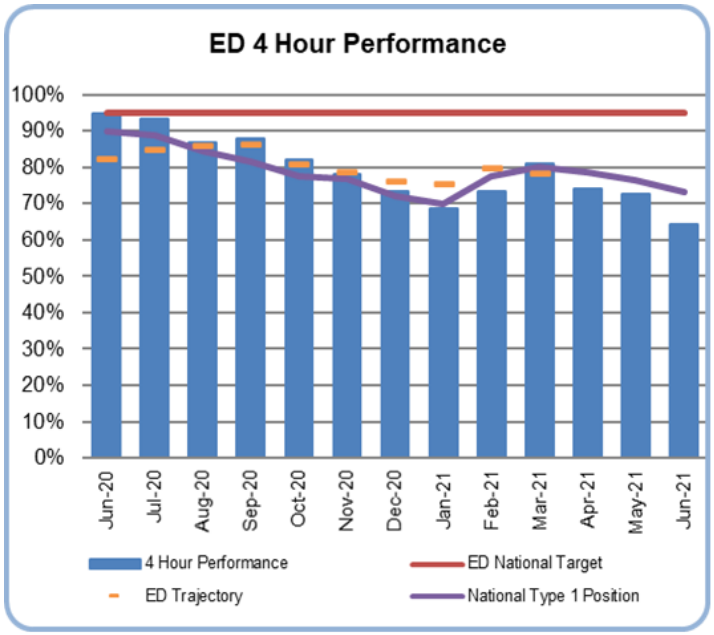
NHSI/E has suspended the usual operational planning process and financial framework due to covid-19 pandemic response.
For the first half of the year the trust is funded through a block contract arrangement against which it is expected breakeven. Additionally, non-recurrent income will be provided to fund non-recurrent elective recovery actions including those covered by the Accelerator programme. Income and cost estimates of £8.6m for ERF activity are included in the M3 position.

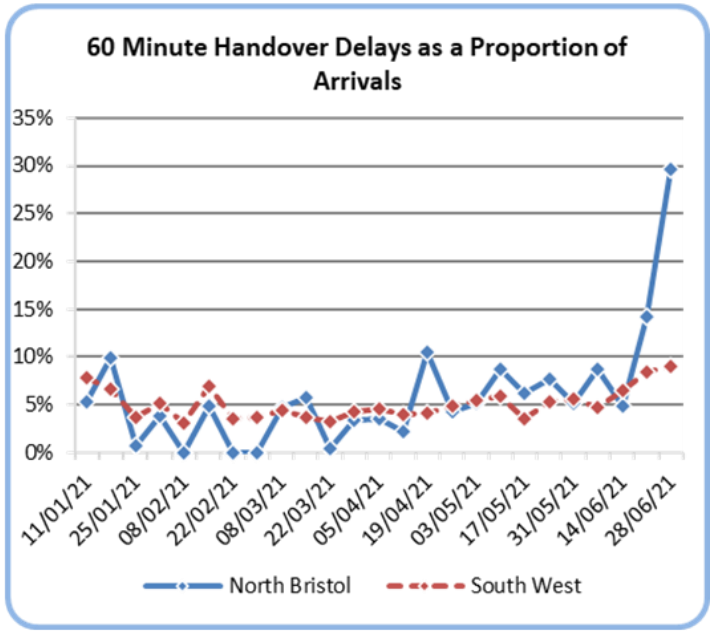
Highlights

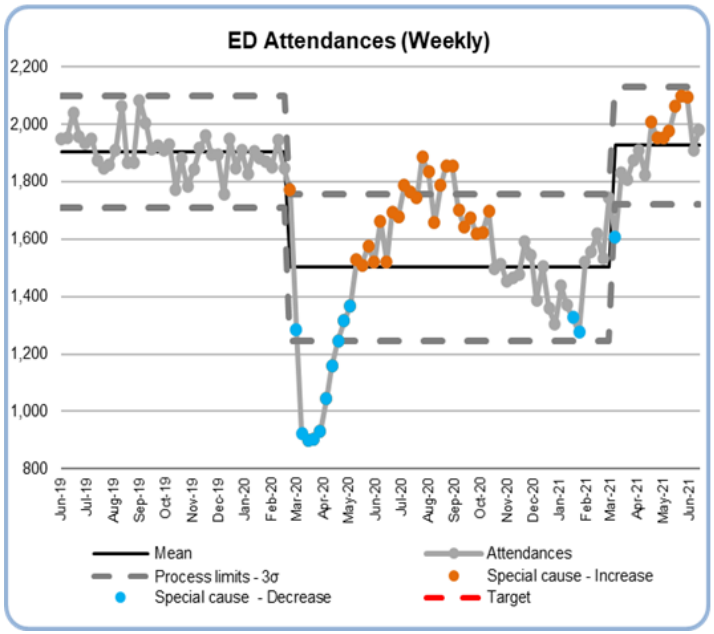
The position for the month of June shows a Year to date breakeven position deficit and an in month overspend of £5.4m.
Cash position at the end of June is a positive balance of £111.7m. (March 2021 balance £121.5m).
The total value of CIP for this financial year is £19.6m and to date £1.3m has been implemented and £3.4m of schemes are in planning. This leaves 76% of the total value of savings to be identified.
In Month capital spend is £1.1m and YTD spend is £2.8m compared to a YTD plan of £3.6m.

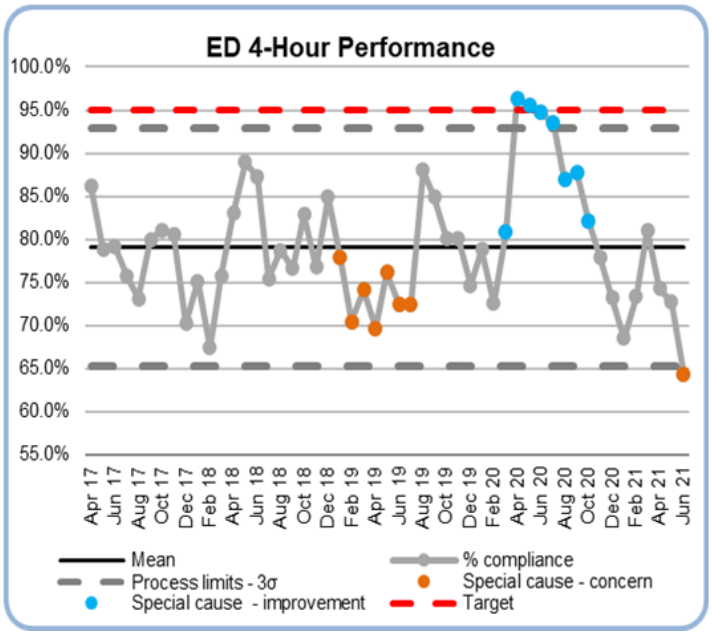
Responsiveness

Board Sponsor: Chief Operating Officer
Karen Brown









Urgent Care

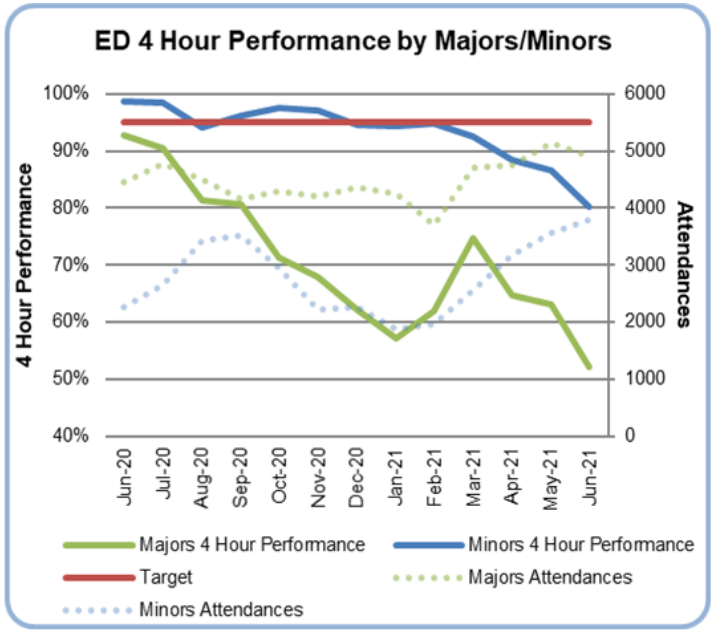
Four-hour performance deteriorated to 64.38% in June with the Trust continuing to experience a sustained increase in the number of emergency attendances.

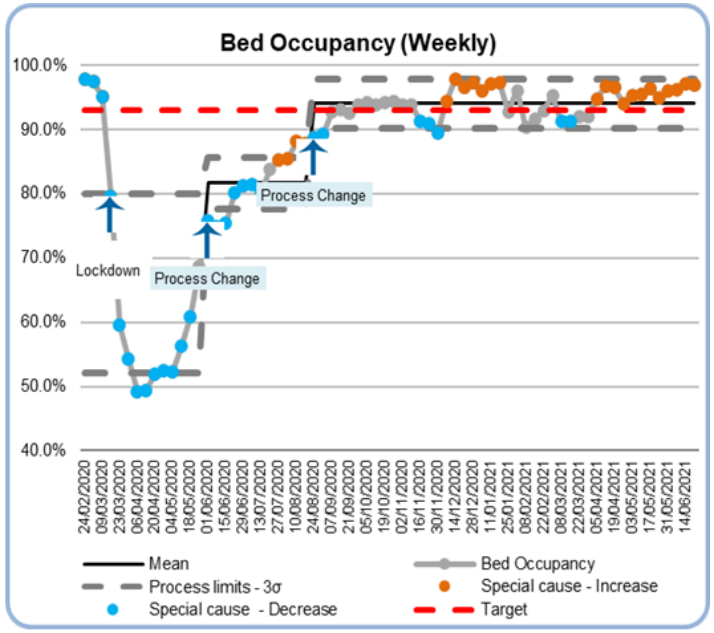
Trajectories have not yet been set for 2021/22; they will be confirmed in July 2021 following the national H1 planning submission. In June, Trust performance reported below national performance for the third consecutive month.

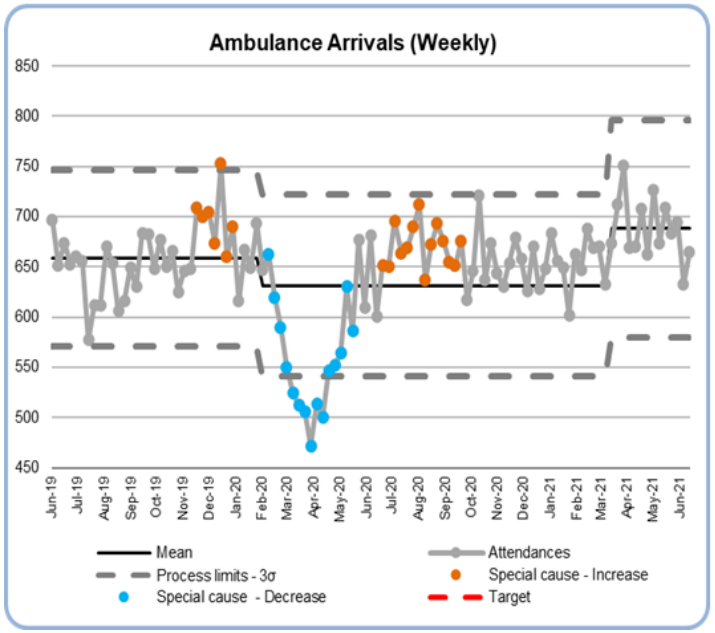
Ambulance handover times continued to be challenged, with the Trust conceding 346 ambulance handover delays over one-hour when the department was experiencing a significant surge in demand. There were four 12-hour trolley breaches conceded in month.

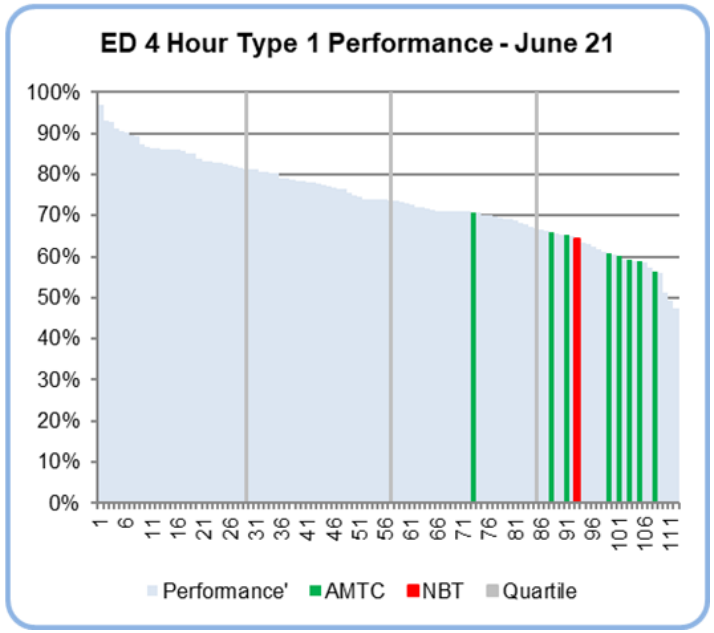
As the occupancy of the Trust has risen, flow and morning discharge rates have deteriorated. From the end of July the Trust will adopt changes to Non-elective (NEL) COVID-19 screening, which will support earlier decision making on movement of NEL patients. The Trust has yet to maximise all available capacity via the two discharge lounges and this remains a key focus though daily bed meetings.

ED performance is not expected to improve in July with current performance at 53.52%.









4-Hour Performance

In June, Minors performance deteriorated to 80.21%, whilst Majors remained most notably impacted, reporting a performance of 52.15%.

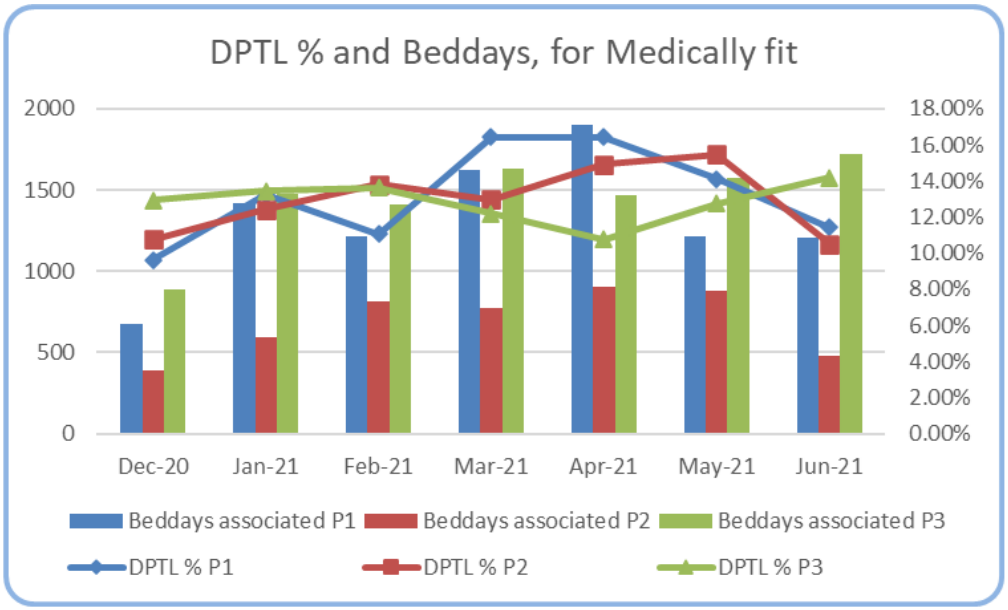
Attendances continued to increase significantly in June with walk-in attendances exceeding pre-pandemic levels. Average ambulance arrivals have also increased since April when compared with pre-pandemic levels.

For the fourth consecutive month, the predominant cause of breaches at 60.60% was waiting for assessment in ED, whilst 13.19% of breaches were caused by waiting for a medical bed.

Bed occupancy varied between 94.24% and 99.30% in June against the core bed base. There was a continued increase in occupancy and consistency in June, reducing the variation across the month.

The Trust position moved into the fourth quartile for the first time in June. ED performance for the NBT Footprint stands at 72.57% and the total STP performance was 76.20% for June. The Trust ranks fourth out of nine reporting Major Trauma Centres.

NB: The method for calculating bed occupancy changed in June and September due to reductions in the overall bed base resulting from the implementation of IPC measures.

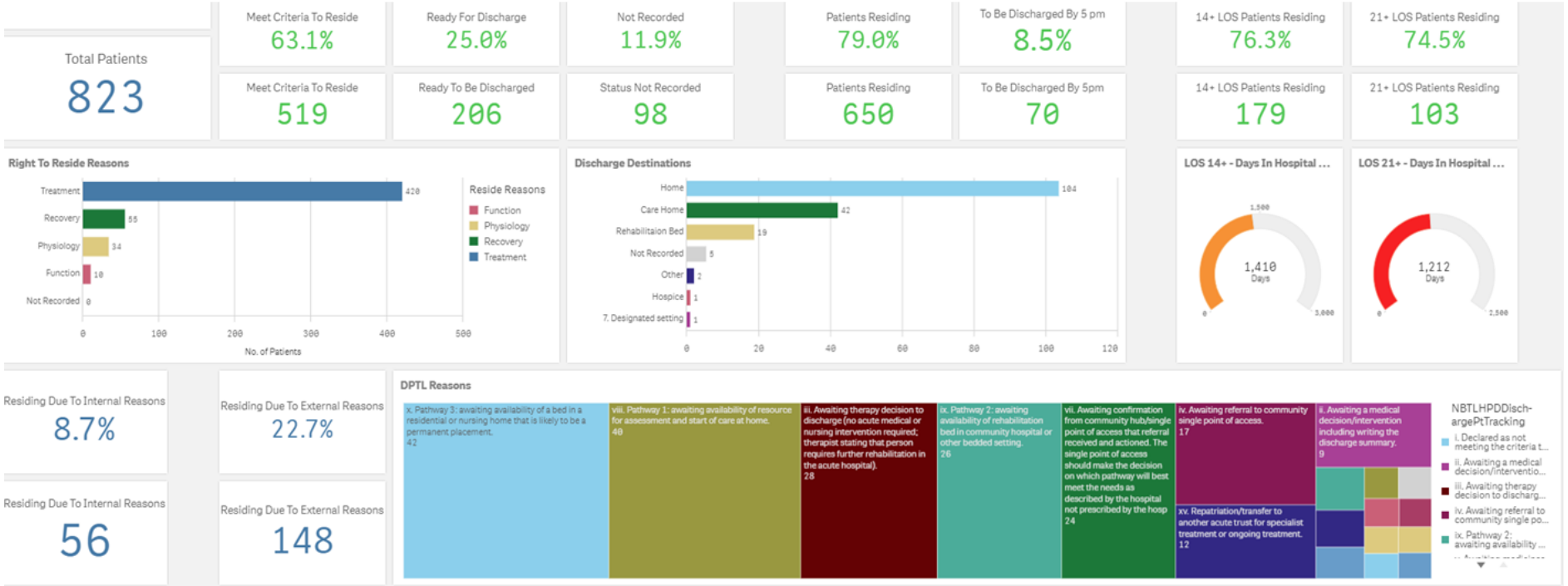


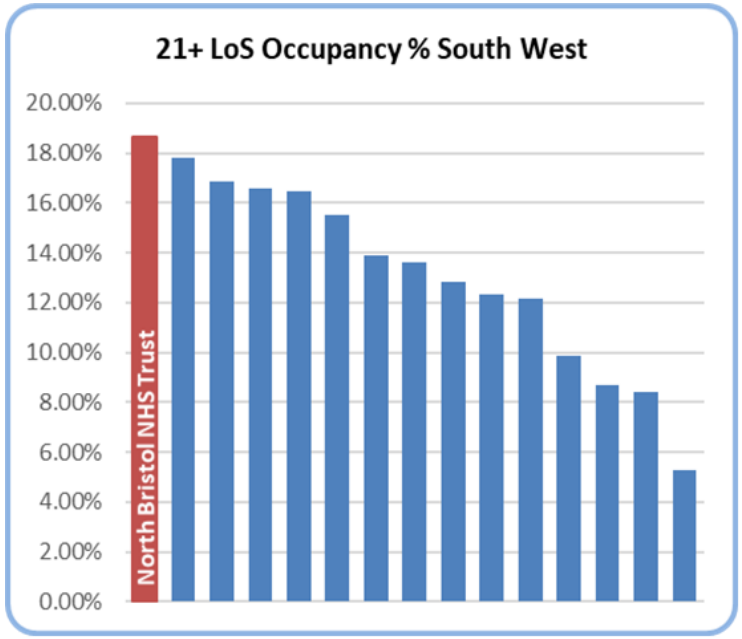
Right to Reside Report

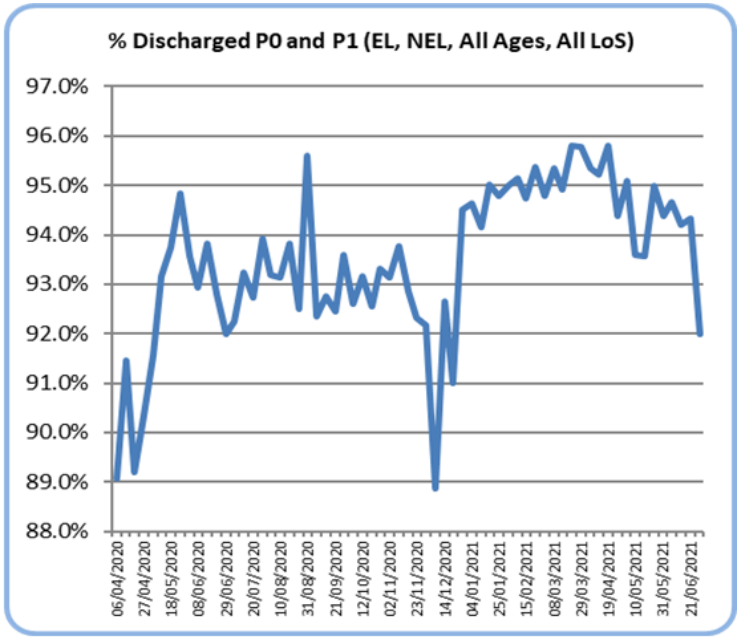
The percentage delays and bed days for medically fit patients awaiting P1 has remained the same as the previous month, while there is a significant reduction for P2 waits and a rise for P3.

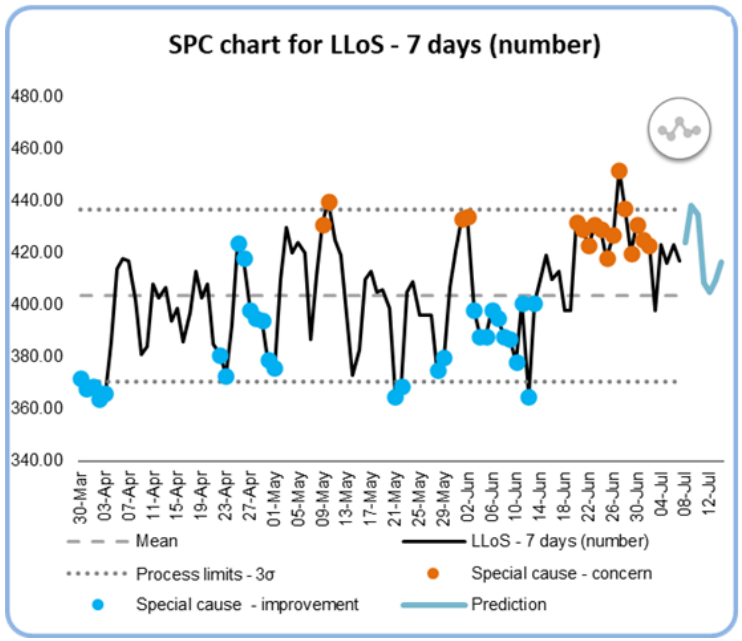
Insufficient complex community dementia beds remains an issue. The impact of recommissioning P3 capacity in May is still to be demonstrated. The Trust is building working relationships with providers to enhance trusted assessment.

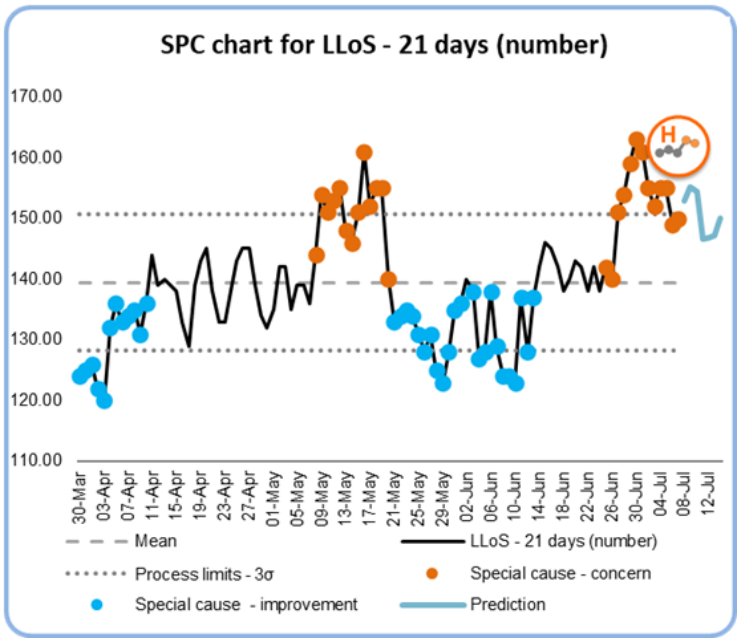
There remains a lack of capacity for Stroke patients and those with high care needs, and capacity not meeting the needs of the referred patients.











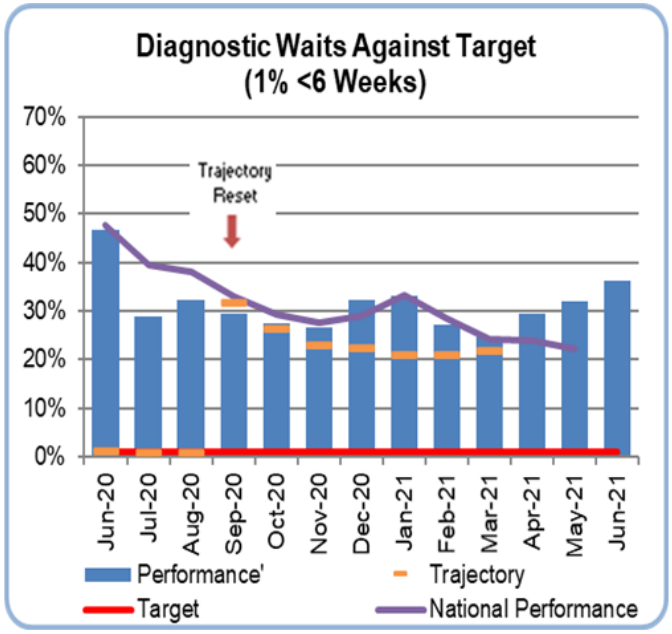
Stranded Patients

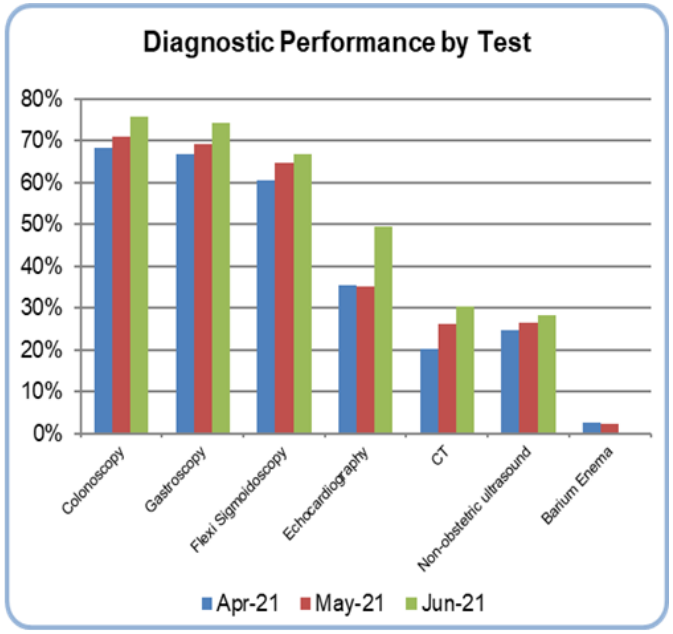
The stranded patient levels reported remain high and are first highest in the Region.

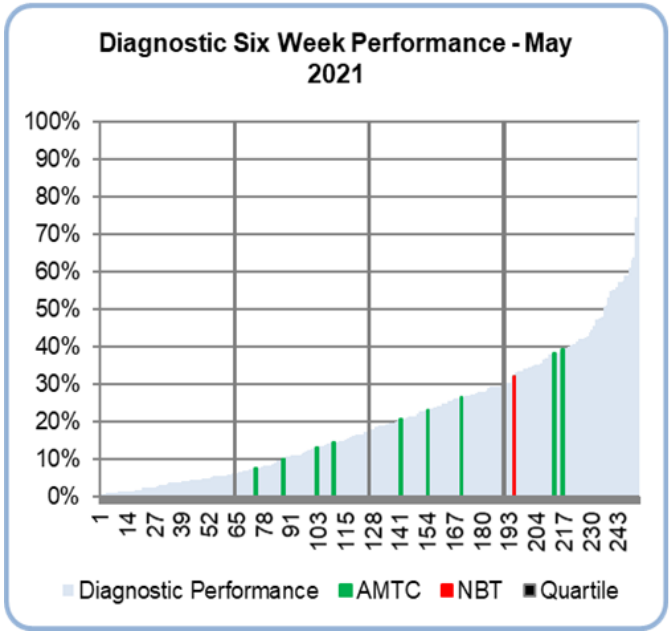
Referral numbers have not been as high in June; this may be due to the acuity of patients.

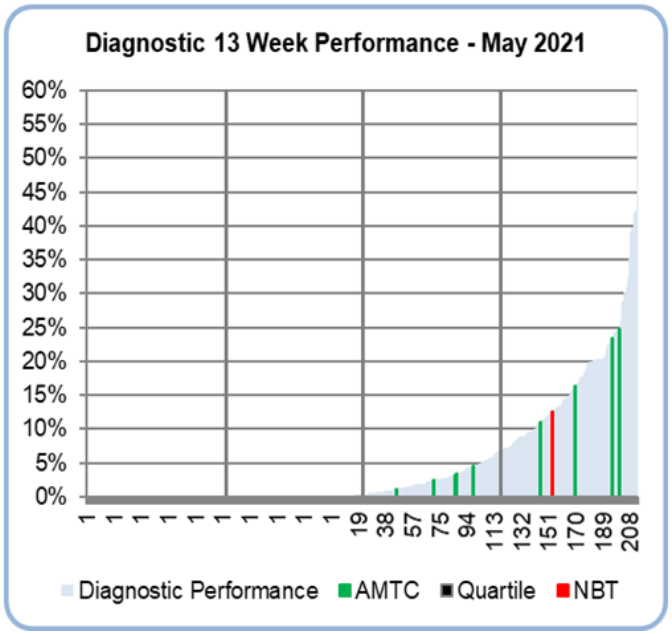
Admission to Single Referral Form (SRF) monitoring indicates some improvement in the median LoS reported levels for P3. This remains a key focus for the Urgent Care Board improvement plan; to reduce bed usage and consistency of measurement is a priority and will be reviewed weekly at a dedicated meeting.

Data Source: South region NHSI UEC dashboard, w/e 31th May









Diagnostic Waiting Times

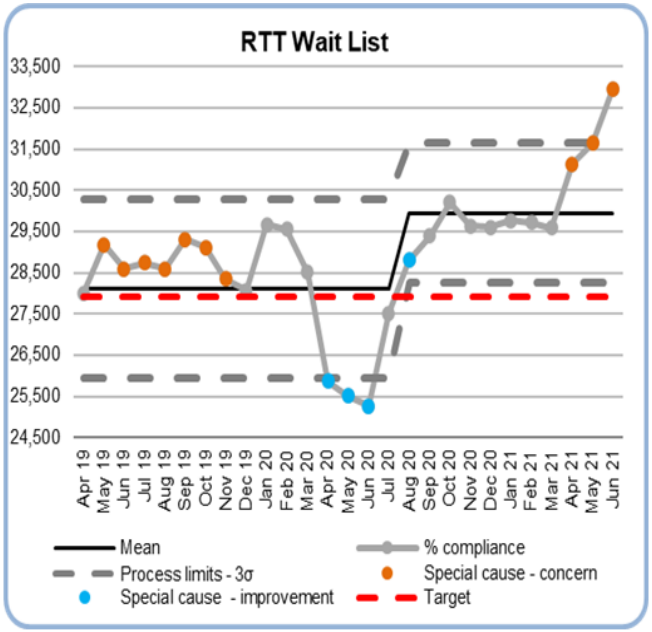
Diagnostic performance deteriorated to 36.13% in June. Some modalities showed improvement however, for the areas with the highest volume of tests there was a worsened position in month. Trajectories have been developed for 2021/22; these will be confirmed in July for August reporting.

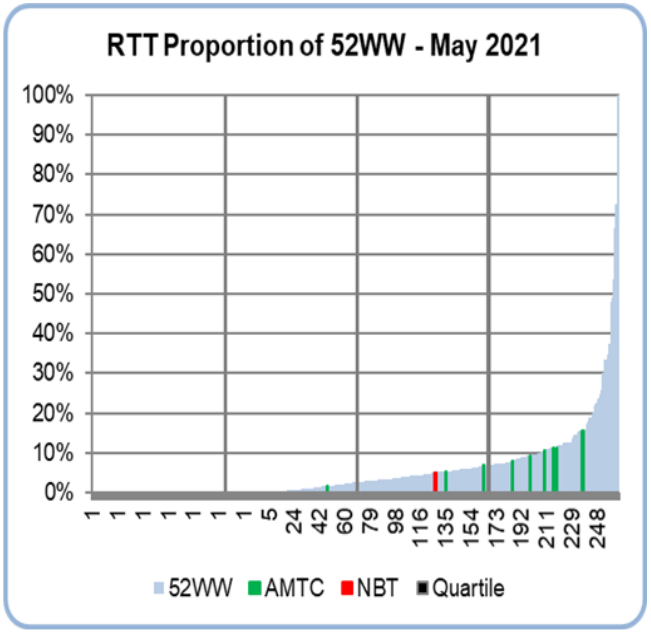
Adjusting for working days, activity increased by 1.65% in June but the position has been negatively impacted by a continued reduction in the under 6 week cohort and increase in the backlog resulting from 2WW/Urgent demand.

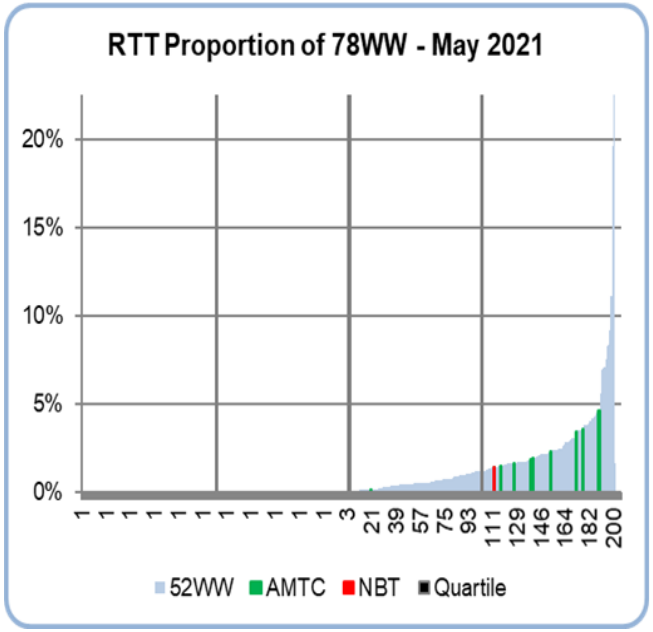
Although Non Obstetric Ultrasound reports a further deterioration on their May position, this was less than anticipated and actions to increase capacity are ongoing. Endoscopy also reported deterioration in performance for June but the service has commenced an insourcing model with weekend lists to increase capacity, along with recruitment plans to ensure staffing for additional lists.

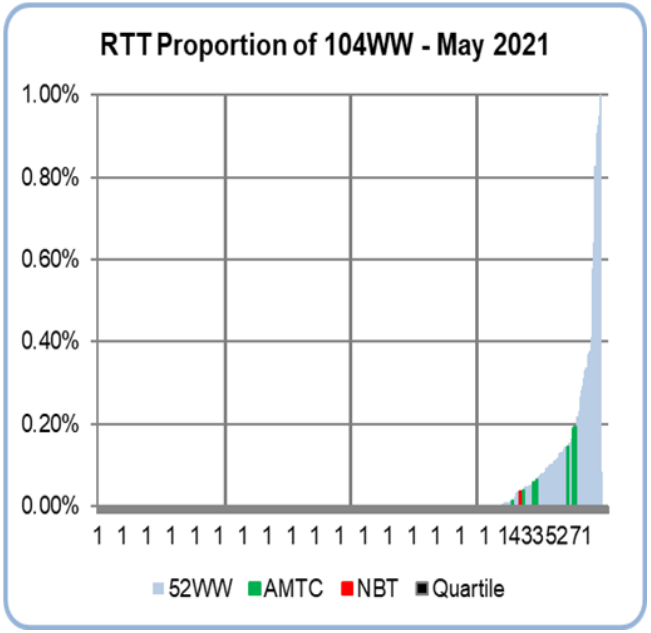
The number of patients waiting longer than 13 weeks has increased by 15.46% in June. A high level review continues to be completed for patients exceeding 13 weeks to ensure no harm has resulted from the extended wait times.

Nationally, Trust positioning deteriorated for 6-week performance, moving from the third quartile to the fourth in May. 13 week performance also deteriorated slightly, remaining in the fourth quartile.









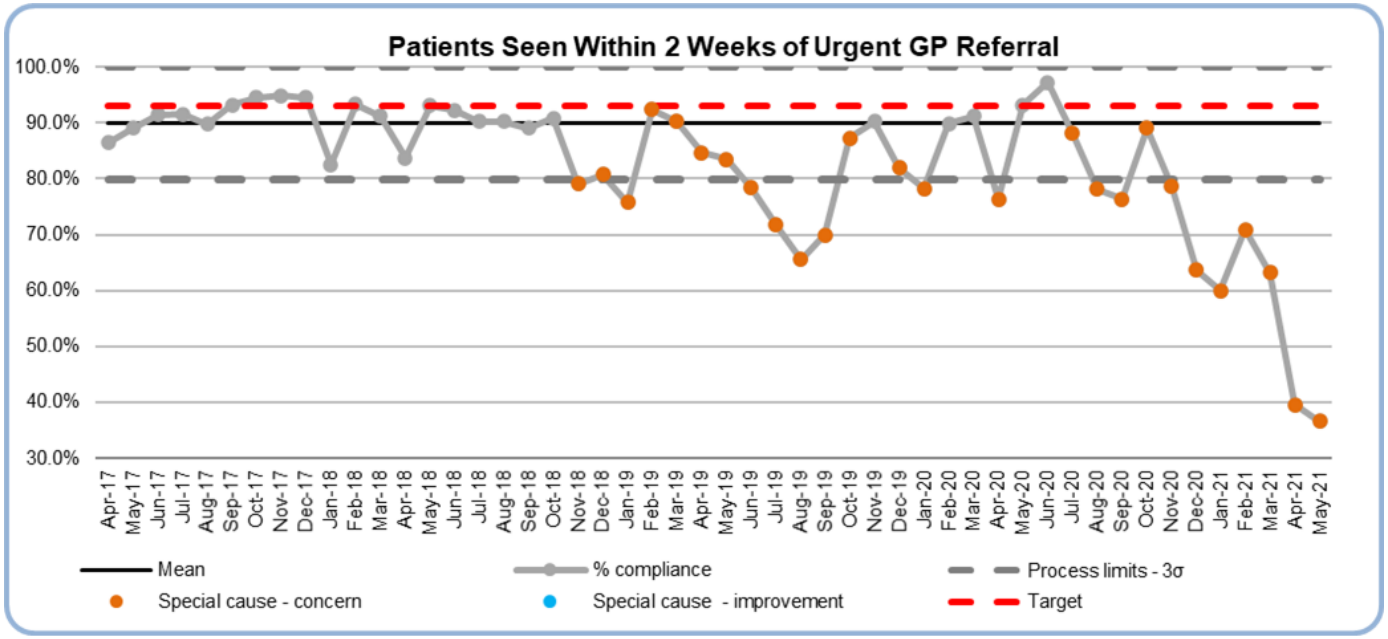
Referral to Treatment (RTT)

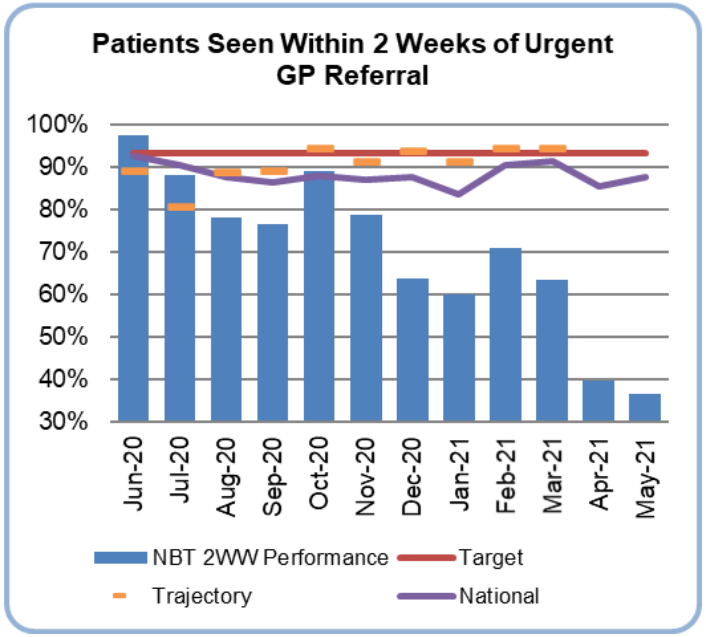
In June, the Trust reported RTT performance of 74.98% and an increase in the waiting list to 32946. Trajectories for 2021/22 are due to be confirmed in July for reporting in August. There was an 11.38% increase in clock stops and a 10.83% increase in demand in June resulting from the additional working days. Waiting list growth is the result of demand exceeding waiting list removals with a particular reduction in the number of removals other than treatment (ROTT) in June.

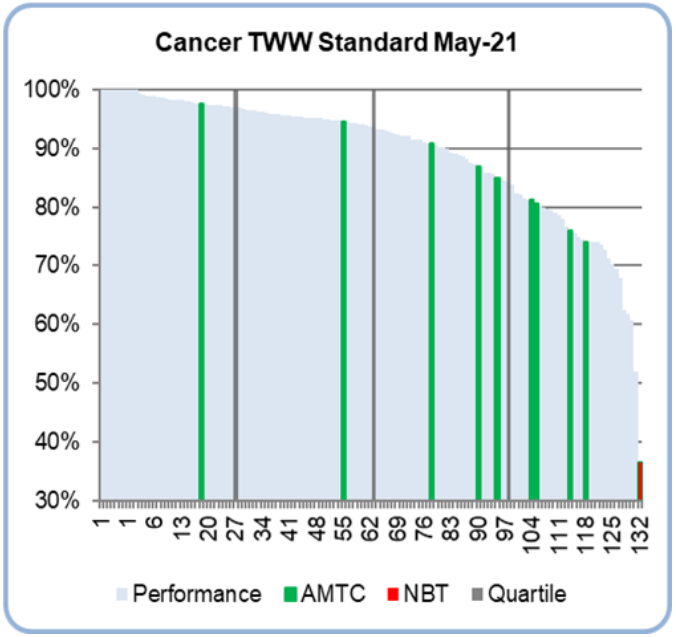
For the fourth consecutive month since the onset of the COVID-19 pandemic, the Trust has reported a reduction in 52 week wait breaches. At month end, there were 1473 patients waiting greater than 52 weeks for their treatment; 448 of these were patients waiting longer than 78 weeks, whilst 19 were waiting over 104 weeks. The majority of 52 week breaches (926; 62.86%) are in Trauma and Orthopaedics. The overall proportion of the wait list that is waiting longer than 52 weeks continued to reduce to 4.47% from 5.00% resulting from the 52 week reduction and increased wait list size.

The Trust continues to support equity of access to Clinical Immunology and Allergy services within the Region by accepting late referrals from another provider for patients waiting more than 52 weeks.

When compared nationally, the positioning of the 52 week wait breaches as a proportion of the overall wait list was static for May, remaining in the third quartile. Similarly, the positioning for 78 week waits was also static, and remains in the fourth quartile. Although in the fourth quartile for 104 week waits, the Trust ranked 23rd out of 87 providers.







Cancer: Two Week Wait (TWW)

The Trust saw 1938 patients in May reflecting a 5.38% increase on April.

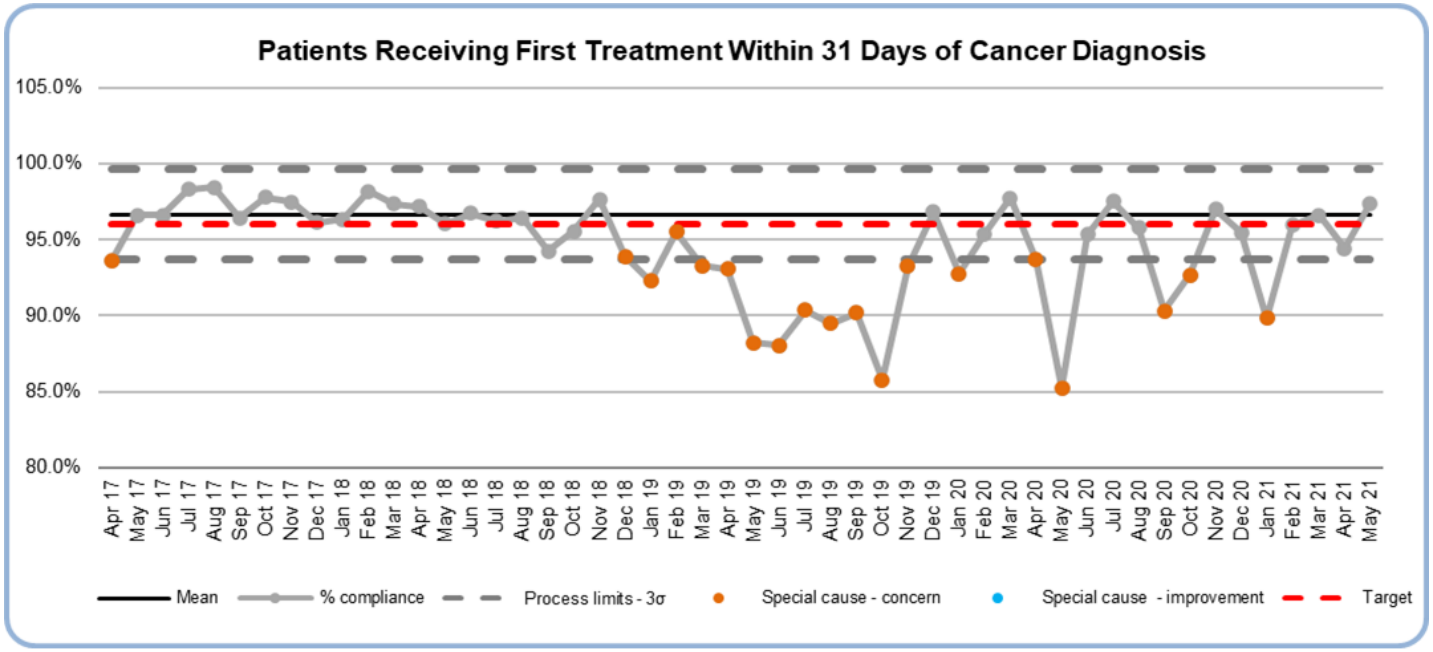
Of the 1938 patients, 1229 patients breached giving the Trust a performance of 36.58%; a decline on last months 39.53%, wholly due to the issues in Breast, Colorectal and Skin.

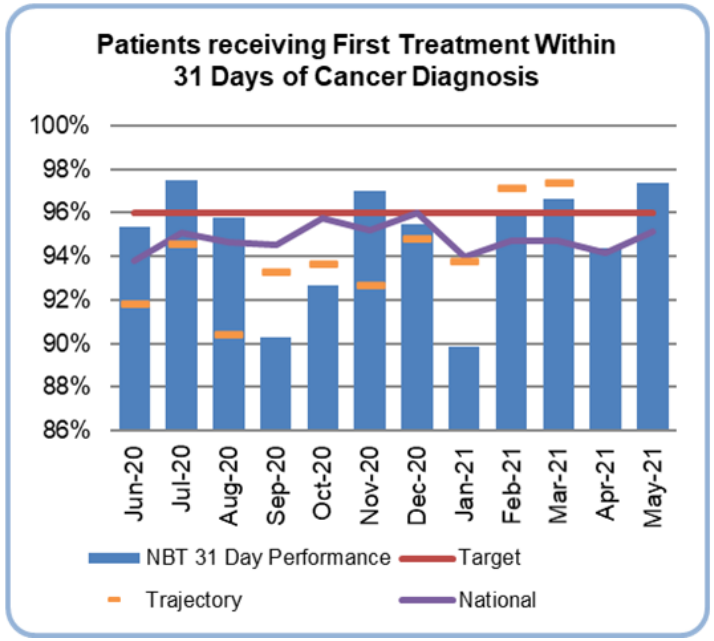
Breast saw 585 patients this month compared to 487 in April; 558 of those seen had breached the TWW standard; reporting a performance of 4.62%. The backlog has decreased down to 185 patients waiting for a TWW appointment. Impact on performance is expected to continue until September.

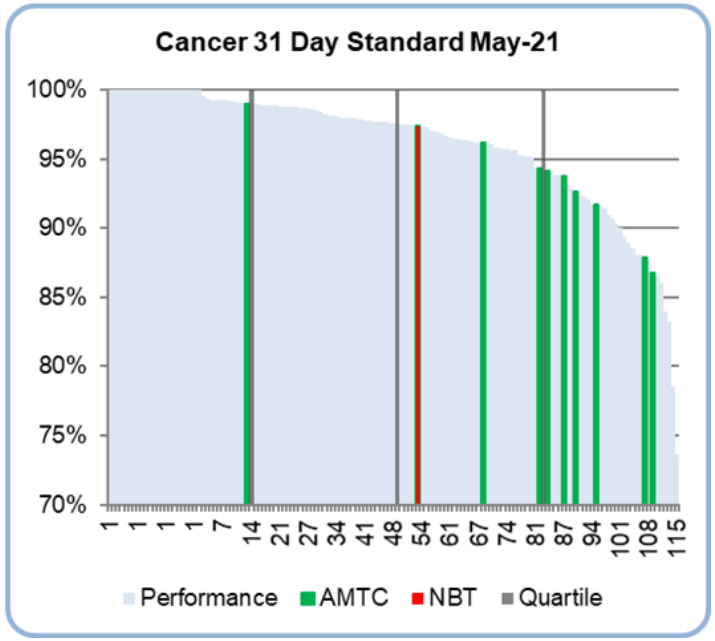
Colorectal saw 295 patients this month compared to the 311 they saw in April, but 119 patients were seen in a breach position, the majority of the breach's this month were due to the backlog and long waits in Endoscopy. This is being addressed but impact will continue until the Autumn.

Skin saw 420 patients in May. 387 patients were seen in a breach position and reported a deterioration in performance to 7.86%. The drop in performance continues to be due to lack of capacity within the service as a result of losing 2 consultants to maternity leave and being unable to cover them with locums.

The conversion rate for April 2019 was 7.23% and in April 2021 is 7.77%.







Cancer: 31-Day Standard

In May, the Trust achieved the first treatment standard with a performance of 97.38%.

There were 229 completed pathways with six breaches. The Trust continues to report in the third quartile for this standard but has improved from the lower end to the upper end of the quartile.

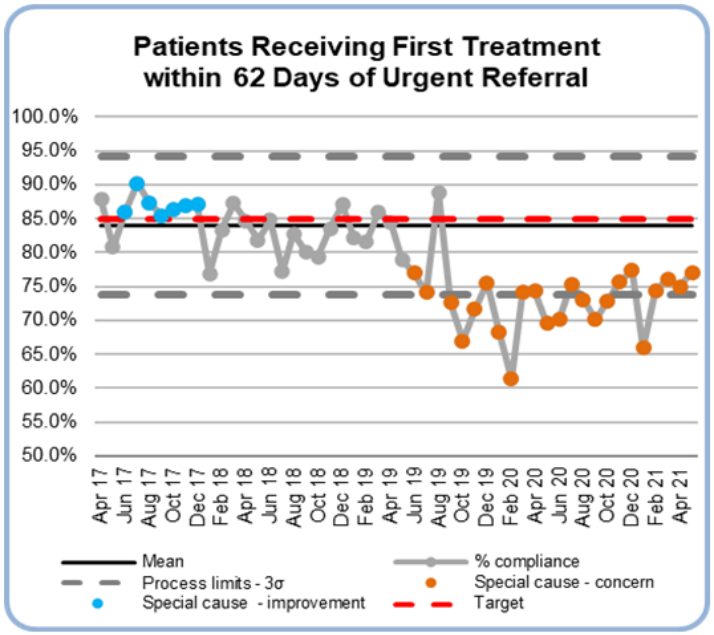
All specialties except Gynaecology and Colorectal were above 96% performance.

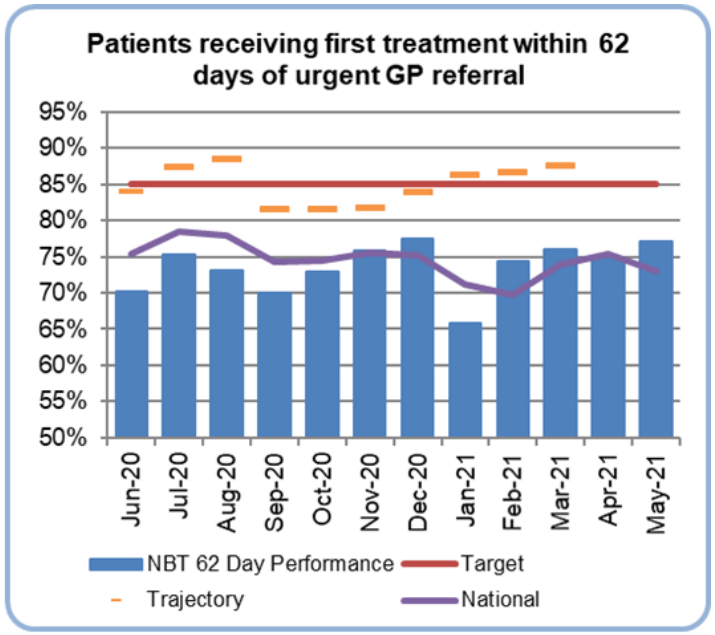
In May, the breaches were due to lack of capacity in the early part of the pathway along with complex medical issues and patient fitness to proceed with treatment.

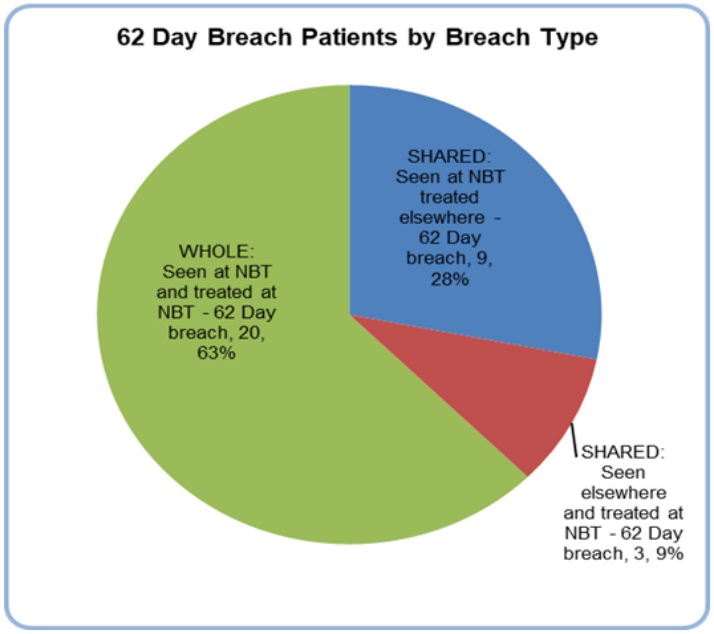
June's unvalidated position is showing as 95.5% with the majority of the 9 breaches sitting in Urology.

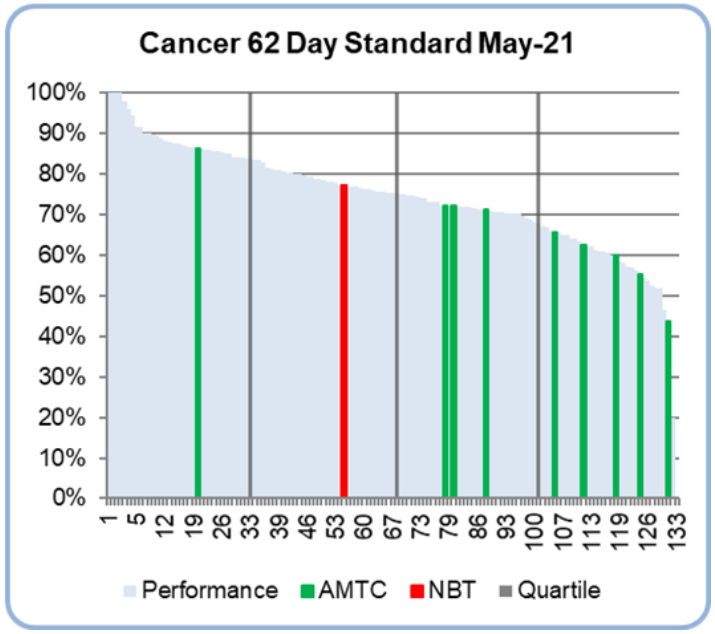
28-Day Performance - The Trust position deteriorated again this month with a performance of 52.57% compared to 64.68% in April. The Trust saw 2231 patients with 1058 breaches.

The majority of breaches were due to front end issues in the Breast pathway and complex patient pathways in Urology and Gynaecology.









Cancer: 62-Day Standard

The reported 62-Day performance for May is 77.11%; an improvement on April performance of 75.00%. 124.5 treatments were delivered, which is a reduction of 17.5 cases.

The Trust had 28.5 breaches compared to 35.5 breaches in April; the Trust failed the CWT standard of 85.00%.

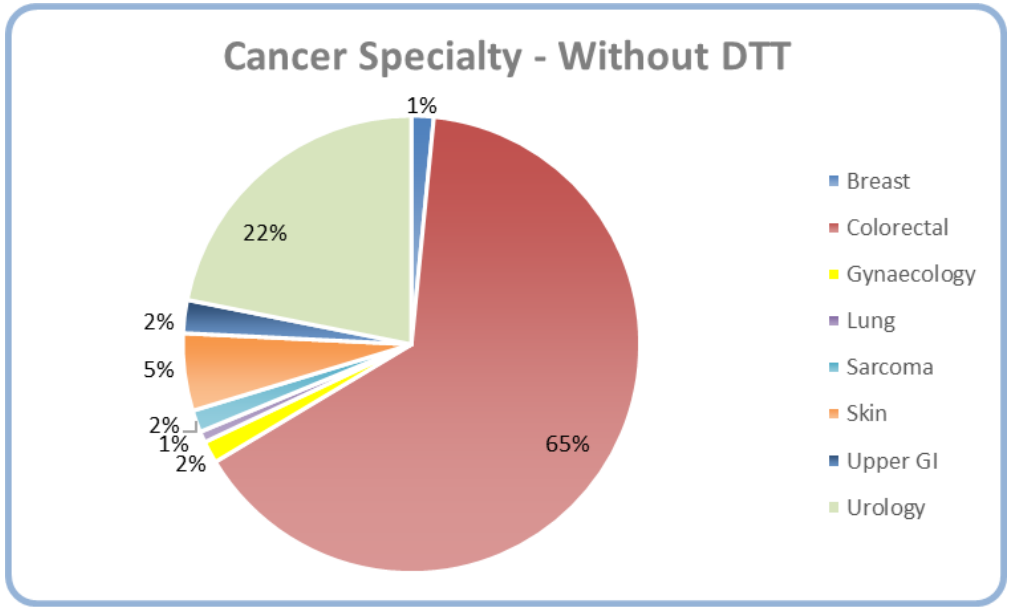
Skin was the only specialty that met the CWT standard this month.

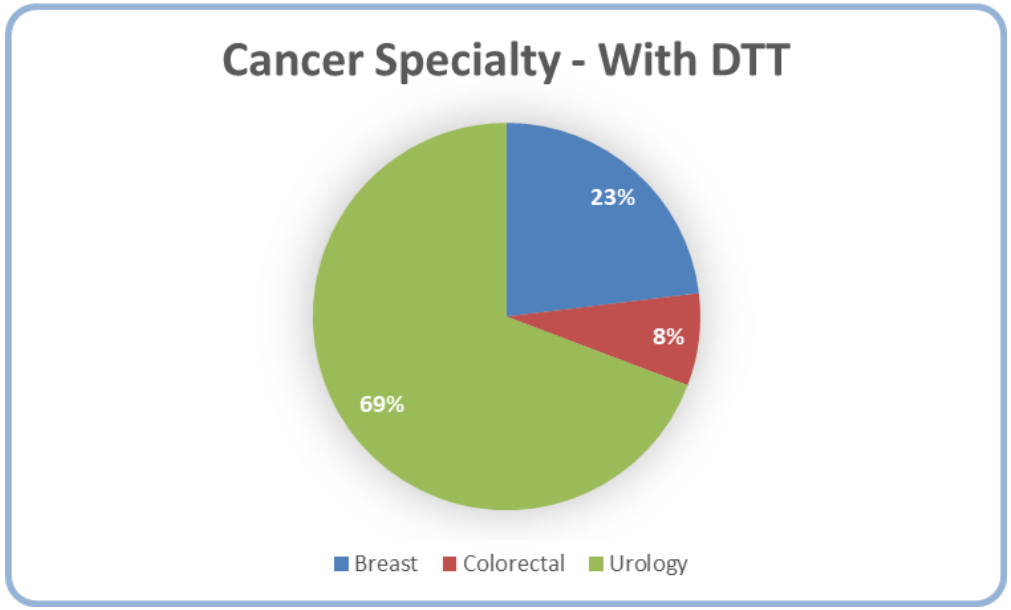
Breast 62-Day performance was 60.00% compared to 67.57% in April. Breast treated 22 patients with 13.5 breaches. Most of these breaches were caused by the known delays at the front end of the pathway within TWW plus complex pathways.

Colorectal failed to achieve the standard with 61.90% but saw a significant improvement on last months performance of 38.00%. Colorectal treated 10.5 patients with 4 breaches in May. Most of this month's breaches were due to complex pathways, medical delays and patient choice.

No harm as a result of the delay has been found in the normal harm review process.

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





Cancer
104-Day Patients Live PTL Snapshot as of 14/07/2021

There are 141 patients currently waiting over 104-Days; 128 of them are without a decision to treat.

Instances of clinical harm is low month-on-month and the Trust has only identified 1 moderate harm in the last 12 months as a result of delays >104-Days.

Patient anxiety surrounding COVID-19 and wanting to defer until after receiving a vaccination is still present but is decreasing; however we continue to ask for clinical review of these patients and ensure they understand the risk of deferring their investigation and/or treatment.

There has been a significant impact from delays within Colorectal pathways for patient follow-up of diagnostics and confirmation of discharge from cancer pathways, and staffing pressures having a negative effect on tracking. This is resulting in patients hitting 104-Days that likely should have been removed from the cancer pathway earlier.

The two main cancer sites of concern are Colorectal and Urology.

In May, the number of 104-Day waiting patients that required a clinical review to determine the level of harm, if any, was 9. The Trust has seen an increase in the last three-months largely due to the Breast situation and increase in complex pathways.

NHS North Bristol NHS Trust

Safety and Effectiveness

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

NBT - PQSM	Jan-21	Feb-21	Mar-21	Q4 total / Average	Apr-21	May-21	Jun-21	Q1 total / Average	YTD Total /Average
Activity									
Number of babies born alive at 16 to 23+6 weeks gestation									
Number of babies born alive at >=22 to 23+6 weeks gestation									
Number of babies born alive at 24 to 36+6 weeks gestation	437	441	502	1380	462	448	467	1377	2757
Number of births all gestations from 22+0 weeks	430	432	496	1358	456	445	464	1365	2723
Induction of Labour rate %	39.8%	33.8%	33.8%	35.8%	35.2%	36.9%	35.3%	35.8%	35.8%
Unassisted Birth rate %	54.1%	49.7%	48.0%	50.6%	53.1%	53.5%	47.5%	51.4%	51.0%
Assisted Birth rate %	10.8%	11.7%	11.7%	11.4%	9.5%	13.3%	12.4%	11.7%	11.6%
Caesarean Section rate (overall) %	35.1%	38.7%	40.3%	38.0%	37.4%	33.3%	40.1%	36.9%	37.5%
Elective Caesarean Section rate %	15.9%	16.1%	18.8%	16.9%	16.7%	15.3%	19.4%	17.1%	19.0%
Emergency Caesarean Section rate %	19.2%	22.6%	21.5%	21.1%	20.7%	18.0%	20.7%	19.8%	20.5%
Perinatal Morbidity and Mortality inborn									
Total number of perinatal deaths	2	1	0	3	2	1	0	3	6
Number of stillbirths 16 to 23+6 weeks excl TOP	0	0	0	0	0	0	0	0	0
Number of stillbirths (>=24 weeks excl TOP)	2	1	0	3	2	1	0	3	6
Number of neonatal deaths : 0-6 Days	0	2	1	3	0	0	2	2	5
Number of neonatal deaths : 7-28 Days	1	0	1	2	0	0	0	0	2
Suspected brain injuries in inborn neonates (no structural abnormalities) grade 3	1	1	1	3	0	0	1	1	4
Maternal Morbidity and Mortality									
Number of maternal deaths (MBRRACE)	0	0	0	0	0	0	0	0	0
Number of women who recieved level 3 care	0.2%	0.2%	0.0%	0.2%	0.0%	0.2%	0.0%	0.1%	0.15%
Insight									
Number of datix incidents graded as moderate or above (total)	3	1	2	6	1	2	2	5	11
Datix incident moderate harm (not SI)	2	0	0	2	0	2	2	4	6
Datix incident SI (excl HSIB)	1	1	2	4	1	0	0	1	5
New HSIB SI referrals accepted	0	0	0	0	0	0	1	1	1
HSIB/NHSR/CQC or other organisation with a concern or request for action made directly with Trust	0	0	0	0	0	0	1	1	1
Coroner Reg 28 made directly to Trust	0	0	0	0	0	0	0	0	0
Workforce									
Minimum safe staffing in maternity services: Obstetric cover (Resident Hours) on the delivery suite	83	83	83		83	83	83		
Minimum safe staffing in maternity services: Obstetric middle grade rota gaps	1	1	1		0	0	0		
Minimum safe staffing in maternity services: Obstetric Consultant rota gaps	0	1	1		1	1	1		
Minimum safe staffing in maternity services: anaesthetic medical workforce (rota						0	0		
Minimum safe staffing in maternity services: Neonatal Consultants workforce (rota						1	1		
Minimum safe staffing in maternity services: Neonatal Middle grade workforce							2		
Minimum safe staffing: midwife minimum safe staffing planned cover versus actual prospectively (number unfilled bank shifts)						11%	13.58%		
Vacancy rate for midwives (black = over establishment, red = under establishment	14.52	10.52	15.91		15.91%	14.00%	5.67%		
Minimum safe staffing in maternity services: neonatal nursing workforce (% of nurses BAPM/RCN trained)						47%	47%		
Vacancy rate for NICU nurses						7.7	7.7		
Datix related to workforce (service provision/staffing)	5	12	33		14	21	27		
MDT ward rounds on CDS (minimum 2 per 24 hours)						57%	57%		
One to one care in labour (as a percentage)						98.60%	99.6%		
Number of times maternity unit attempted to divert or on divert	0	1	0		0	0	1		
Involvement									
Service User feedback: Number of Compliments (formal) - Ai	12	8	12		29	39	10		
Service User feedback: Number of Complaints (formal)	8	12	14		21	15	9		
Staff feedback from frontline champions and walk-abouts (number of themes)	3	3	2		0	4	3		
Improvement									
Progress in achievement of CNST /10	7	8	8		9	10	10		
Training compliance in maternity emergencies and multi-professional training	45%	40%	53%		58%	72%	76%		
training compliance core competency 4 personalised care						0%	0%		
Continuity of Carer (overall percentage)	19.7%	20.6%	16.9%		21.1%	18.9%	16.7%		

COVID-19 Maternity

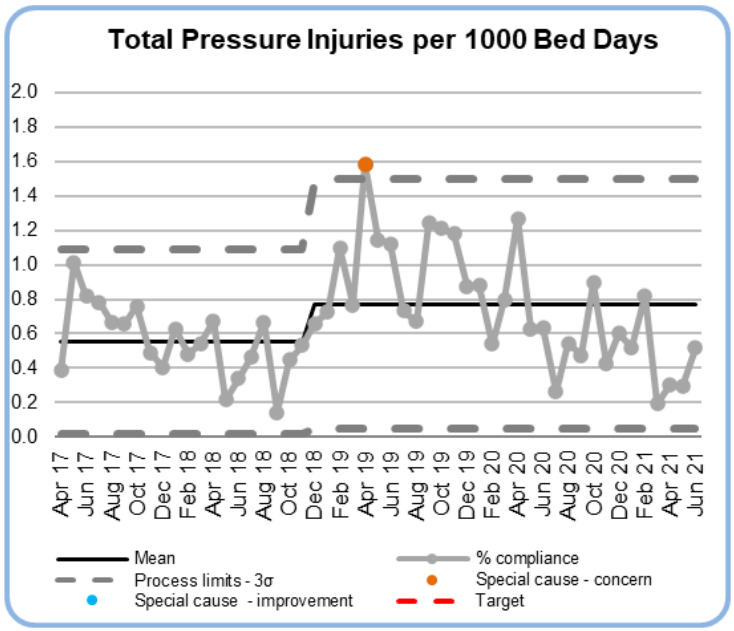
There was one positive case of COVID-19 in maternity in June. In line with National guidance, maternity visiting is working on restoration to pre-pandemic arrangements with regular risk assessments and infection prevention and control guidance. Self isolation and increase in cases among staff is having an impact on operational services however, the service is at present able to mitigate risk.

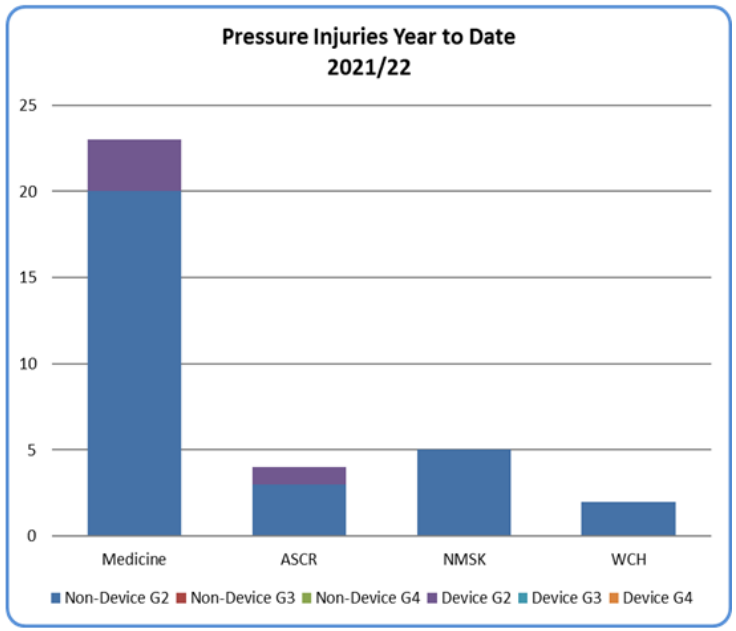
Perinatal Quality Surveillance Tool

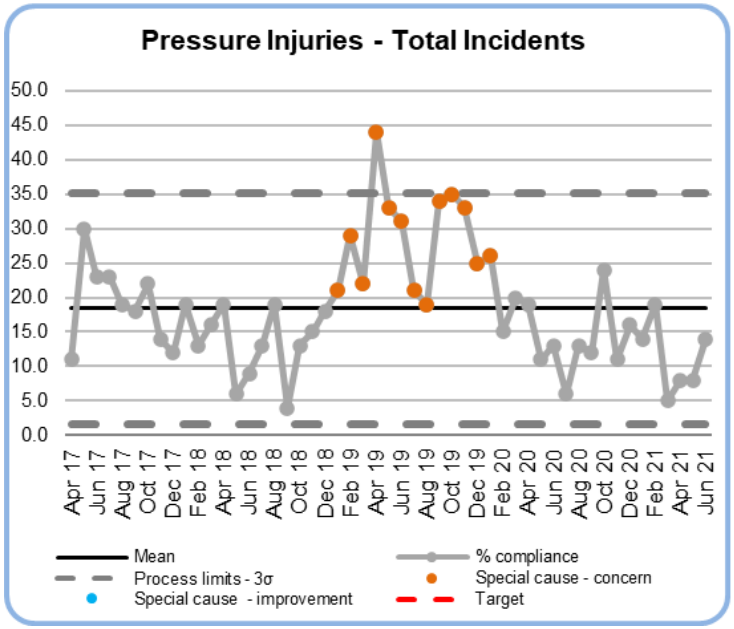
The information provided represents the recommended information from the Ockenden investigation report, to ensure the Board is informed of safety metrics and indicators.

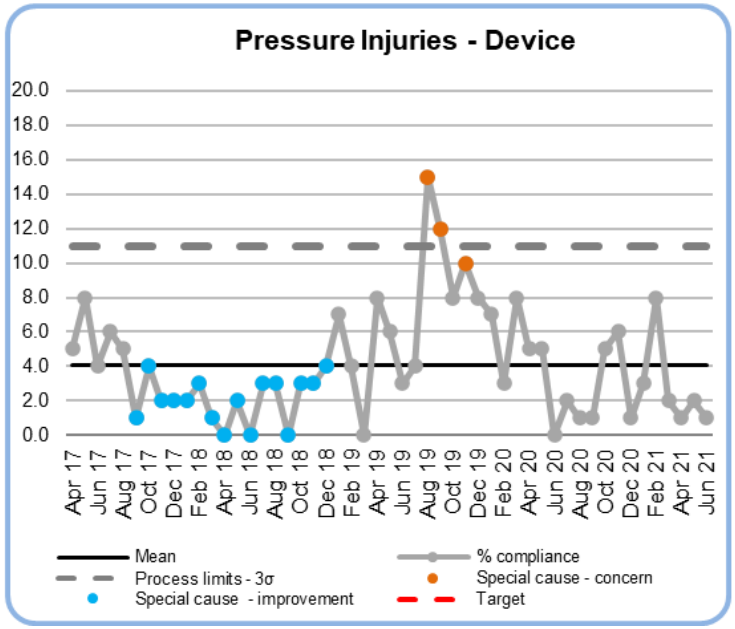
- **Neonatal Deaths: (2)** Both complications in pregnancy
- **CNST** Maternity services has confirmed submission of full compliance with the CNST Maternity Incentive Scheme. Validation of this position, with supporting evidence, has been overseen via QRMC.
- **Serious Incidents:** 2 serious harm incidents : 1) Delay in escalation and recognition of emergency 2) Injury to baby following maternal collapse.
- **Midwifery vacancy rate** is sitting at +5.67wte due to over-establishment and unfunded posts – NBT has received confirmation of national funding to support an increase in midwives which goes towards meeting the recommendations of BirthRate+.
- **Datix – workforce concerns:** 27 datix forms were submitted relating to relating to staff shortfalls at a time of high acuity. This reflects the situation described at the start of this slide.
- **Patient Involvement –** 9 complaints have been raised about maternity services, 2 formal complaints, both relating to communication and 7 PALS concerns, 4 of which related to communication regarding appointments in the ANC. Themes identified in safety champion walkabouts: staffing/COVID concerns/COVID impact on staffing.
- **Service delivery:** Our antenatal screening service is still experiencing challenges with demand exceeding available capacity. The division is working on an action plan with the regional team for resolution including outsourcing of the FTCS service which is due to start early August. **Training compliance core competency. personalised care:** The service has began working on full incorporation of this in our annual training programme as per Ockenden core competencies and will monitor progress via the PQSM.
- **Continuity of care (c of c): T**he plan is developing action plan for the c of c to ensure this becomes the default model of care by March 2022 as per the national transformation plan.

QP2









Pressure Injuries

The Trust ambition for **2021/22** is:

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

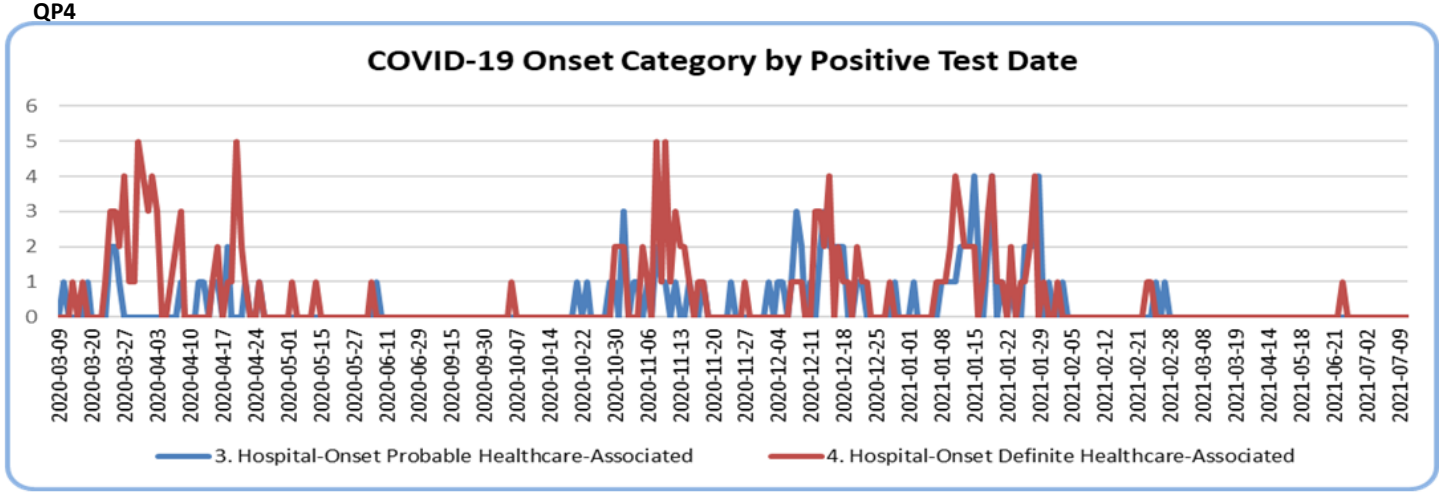
There have been no reported Grade 3 or 4 pressure injuries in June.
15 Grade 2 pressure injuries were reported of which 2 were related to a medical device.

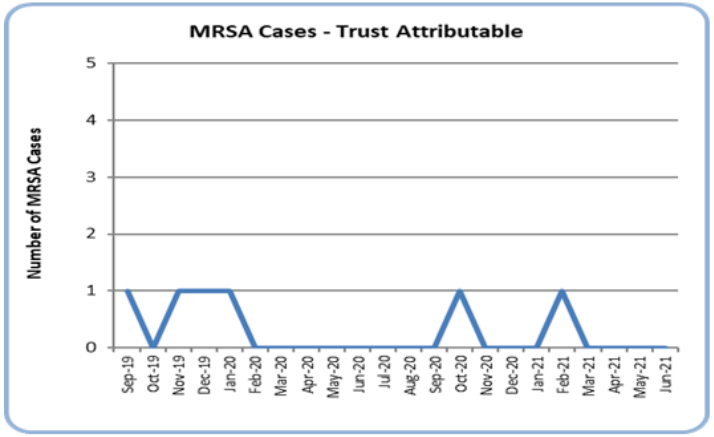
The incidence summary for the month is as follows:

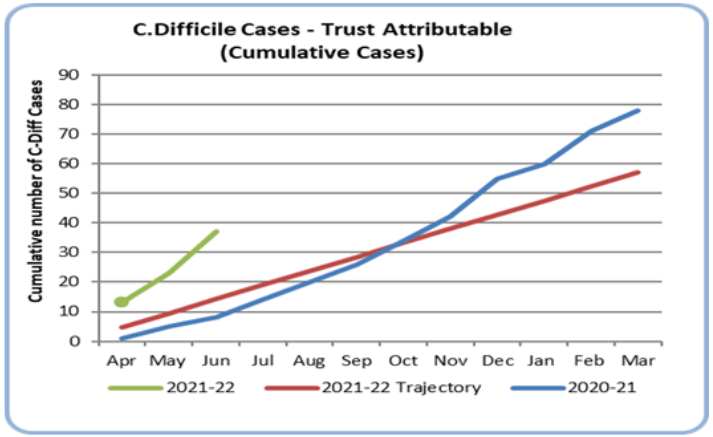
Medical Devices: 13%
Heels: 40%
Sacrum/ Natal Cleft: 34%
Coccyx/Buttock: 13%

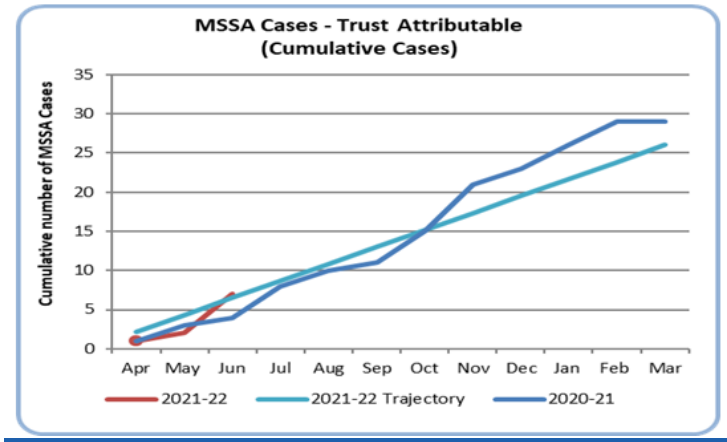
In June, there has been no increase in medical device related grade 2 pressure injuries, and this remains well below the mean rate. There has been an increase in the number of Grade 2 pressure injuries in June however this remains below the mean rate.

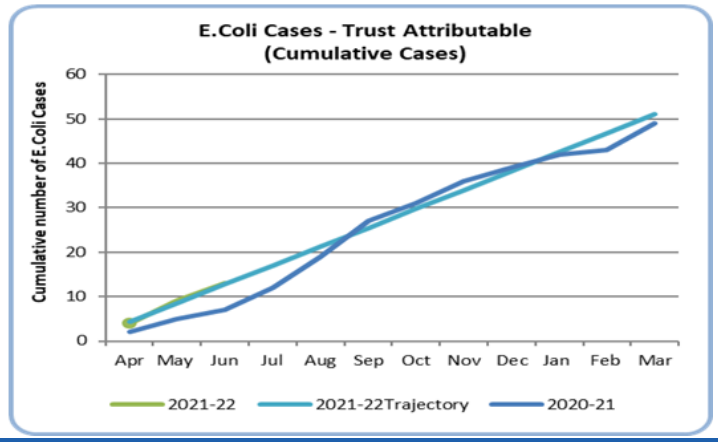
NBT is collaboratively working with RUH Bath, due to their noted sustained reduction in hospital acquired pressure injuries to not only achieve the KPI for 2021/22 but develop further strategies for the sustained reduction across the Trust.











COVID-19 (Coronavirus)

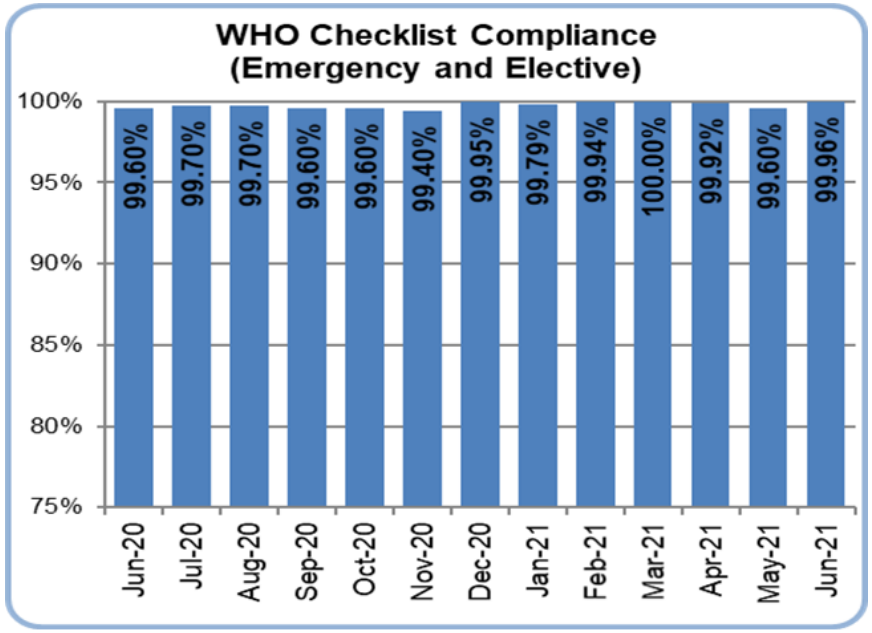
The Trust has seen a surge of cases in line with predictive modelling. The Trust has seen no cross infection in this wave, but have an Outbreak investigation/ management plan in place if required. The IPC Team continue to support the COVID wards, and assist with escalation of additional wards as required.
Changes have also been made with antibiotic prescribing.

MRSA
Last bacteraemia was reported in Feb 2021.

C. difficile
C.difficile rates remain higher than trajectory.
Divisions have had some focused teaching via link nurse practioners , Matrons Forum have also received a presentation focusing on this as a key improvement additionally IPC senior team are linking with a Southwest HCAI Collaborative to look at reduction, as this is a regional concern.

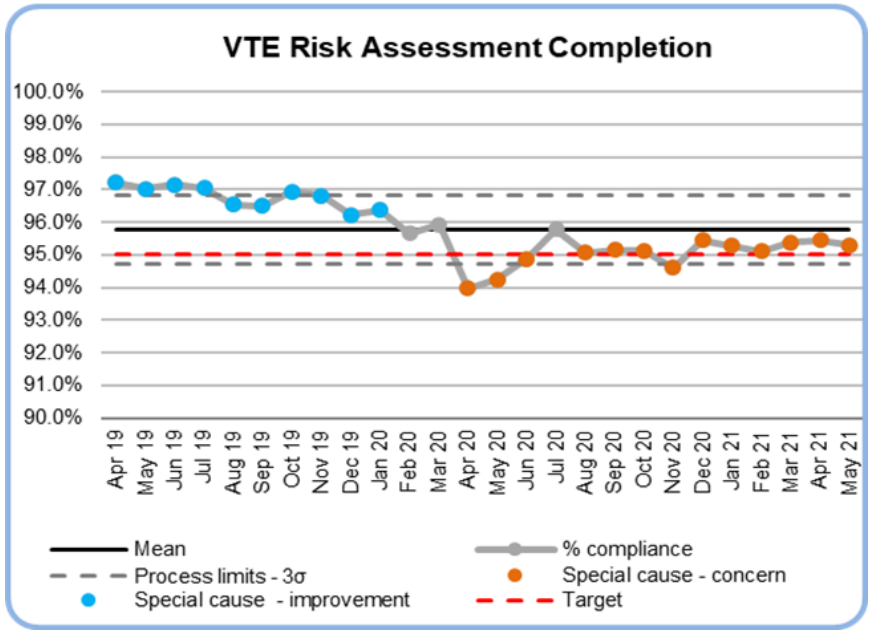
MSSA
There has been a rise noted in cases following the trajectory set. A relaunch of ANTT (Aseptic No Touch Technique) is planned for September

QP2



WHO Checklist Compliance

The Board expects that a WHO surgical safety checklist will be completed and documented prior to each operation in theatres. The IPR report of less than 100% is due to issues with data capture. All cases where WHO was not recorded electronically are reviewed to ensure that checklist compliance was recorded in the paper medical records.

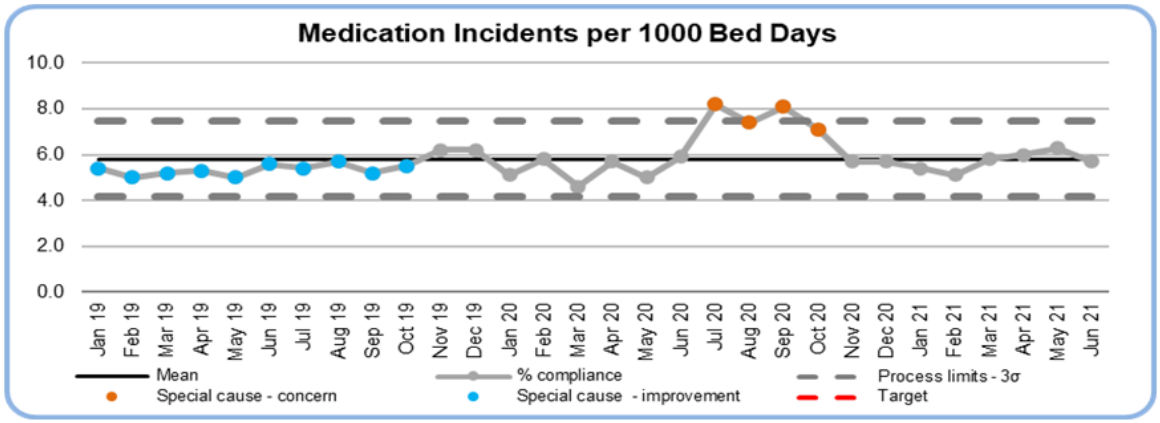


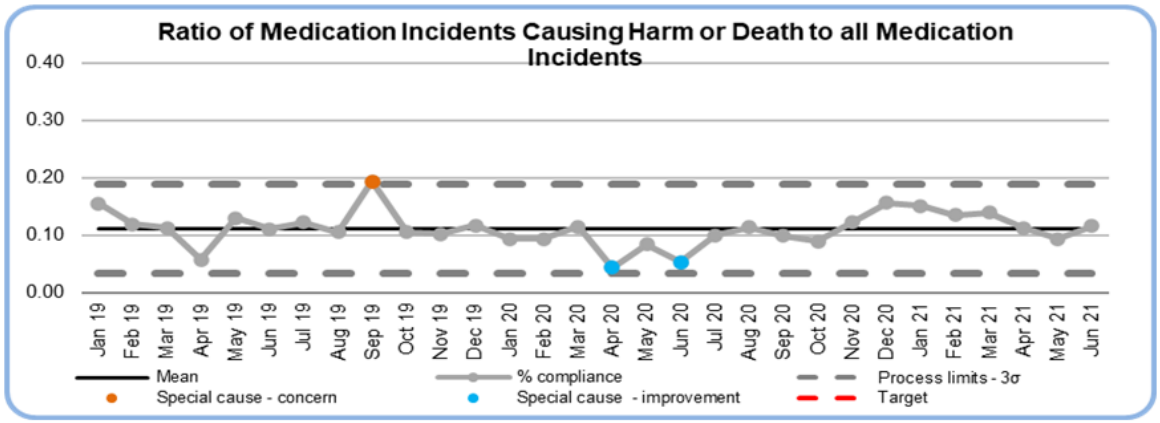
VTE Risk Assessment

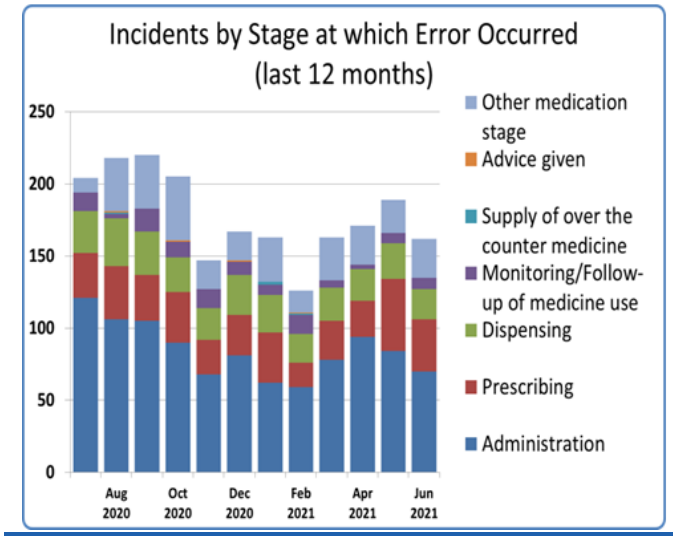
VTE risk assessment compliance is targeted at 95% for all hospital admissions.

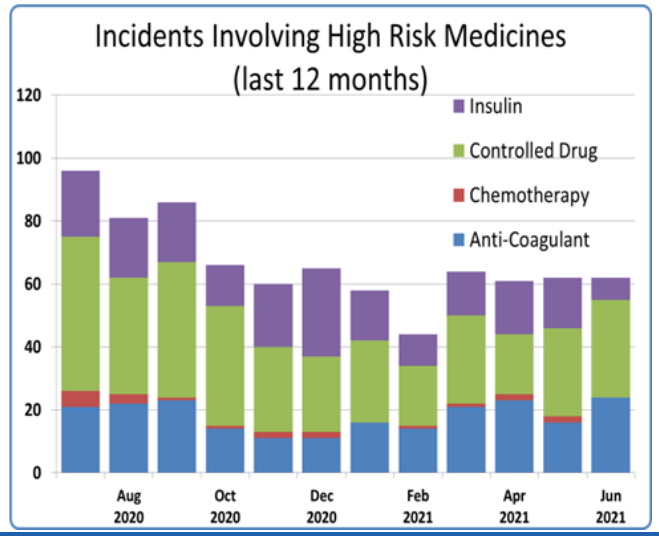
Compliance with this target fell during 2020/21. The Thrombosis committee has been considering the reasons and remedial actions have restored this to acceptable level during 2021/22.

The data is reported one month in arears because coding of assessment does not take place until after patient discharge.









Medicines Management Report – June 2021

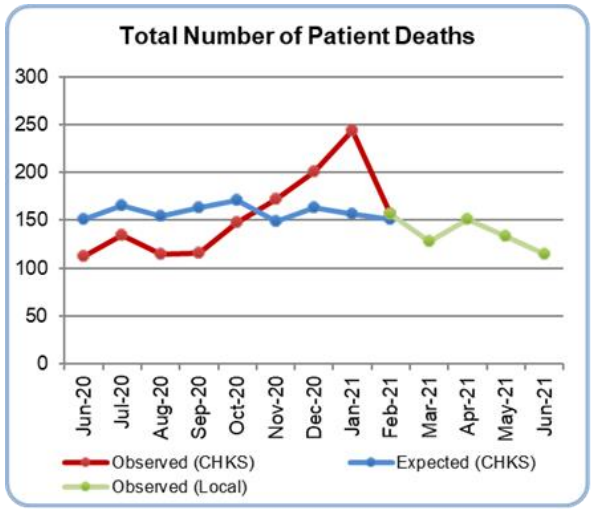
Medication Incident Rate per 1000 Bed Days
NBT had a rate of 5.7 medication incidents per 1000 bed days. This is the mean average in the last 6 months, and we encourage reporting to identify where improvements are required. A benchmark of good medicines safety practice is to have continual monitoring of which of these reports are no and low harm compared to harm, fostering a strong safety culture.

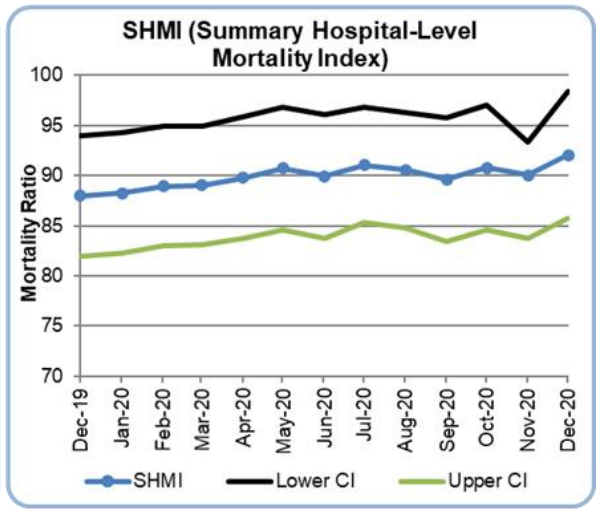
Ratio of Medication Incidents Reported as Causing Harm or Death to all Medication incidents
During June 2021, c. 12% of all medication incidents are reported to have caused a degree of harm (depicted here as a ratio of 0.12). This is close to the mean average over the last 6 months.
Therefore “no harm“ incidents accounted for 88% of all NBT reported medication incidents.

Incidents by Stage
The graph demonstrates that in June c.43% of all incidents occurred at the administration stage. c.22% occurred at the prescribing stage.

High Risk Drugs
The Medicines Governance Team monitor the number of incidents which involve high risk medicines. The graph demonstrates a relatively consistent trend in the overall rate of these incidents in recent months, with a reduction in the number of incidents involving insulin in June. Work continues across NBT and the STP to reduce the overall number of incidents involving high risk medicines.

Mortality Outcome Data





Mortality Review Completion

May 20-April 21	Completed	Required	% Complete
Screened and excluded	1211*		
High priority cases	273		
Other cases reviewed	325		
Total reviewed cases	1809	1882	96.1%

Overall Score	1=very poor	2	3	4	5= Excellent
Care received	0.0%	4.2%	23.3%	48.8%	23.7%

Date of Death	Jun 20 – Apr 21
Scrutinised by Medical Examiner	744
Referral to Quality Governance team	87

In response to increased operational pressures as a result of wave 2 of the COVID-19 pandemic as agreed at the February CEAC meeting the window for screening was extended by 1 month this has now reverted to the usual 2 month window.

Mortality Outcome Data
An increase in deaths was seen in December and January which is likely to have been the result of increasing Covid-19 infections and has since reduced. There are no current Mortality Outlier alerts for the trust.

Mortality Review Completion
The current data captures completed reviews from May 20 – April 21. In this time period 96.1% of all deaths had a completed review, which includes those reviewed through the Medical Examiner system.
Of all "High Priority" cases, 92% completed Mortality Case Reviews (MCR), including 21 of the 22 deceased patients with Learning Disability and 23 of the 26 patients with Serious Mental Illness.

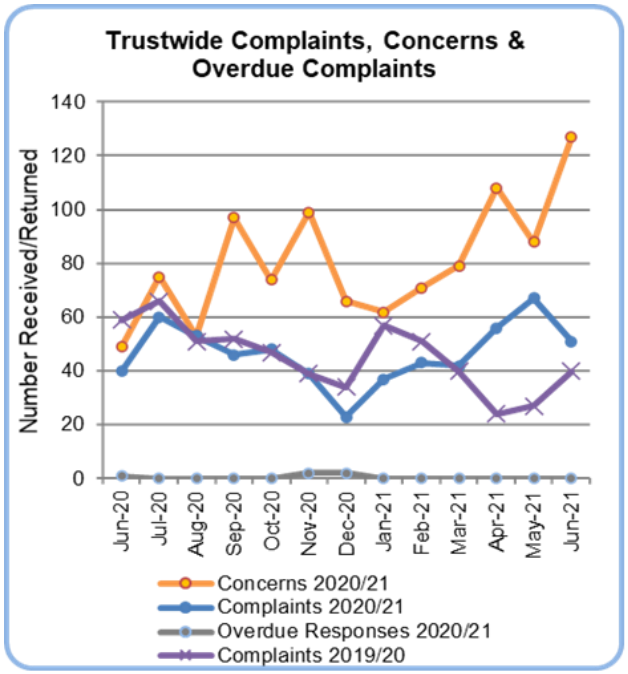
Mortality Review Outcomes
The percentage of cases reviewed by MCR with an Overall Care score of adequate, good or excellent is 96% (score 3-5). There have been 18 mortality reviews with a score of 1 or 2 indicating potentially poor, or very poor care which undergo a learning review through divisional governance processes.

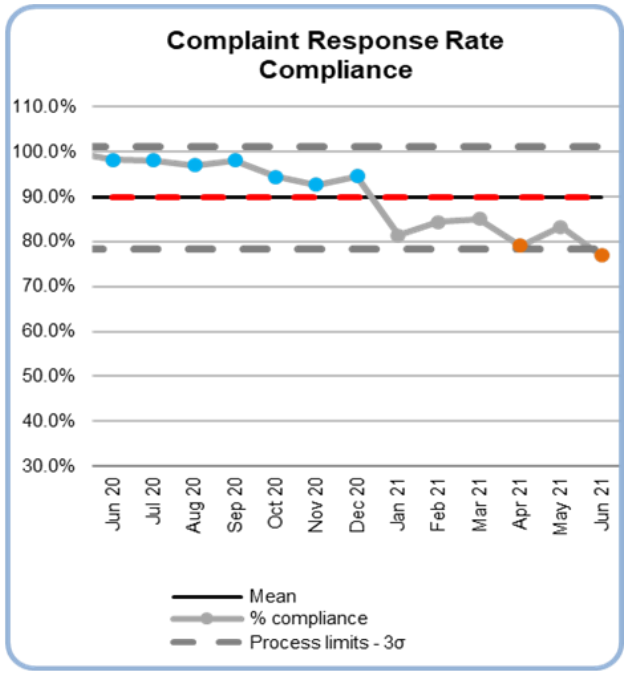
Ongoing Development
The second learning from deaths development session took place in June and focused on training and support for clinicians undertaking mortality review. The next session will take place in July and will move onto the second development theme of linking learning from deaths with existing governance processes within the trust and enhancing their effectiveness.

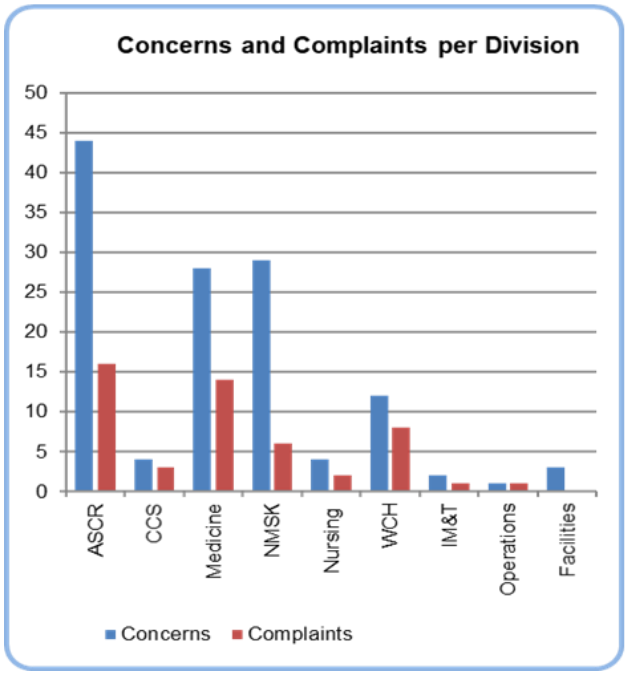
Wave 2 Pandemic Report
The wave 2 pandemic mortality review report was reviewed at the Clinical Effectiveness and Audit Committee in July. Initial analysis shows that a high level of care was maintained during this period, with some learning points in a couple of specific cases identified and actions agreed in the Committee.

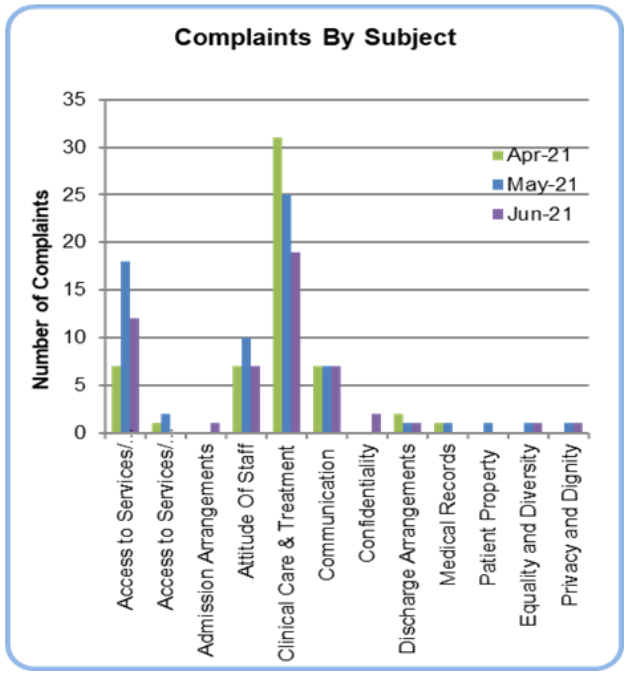
Patient Experience

Board Sponsor: Director of Nursing and Quality
Helen Blanchard









Complaints and Concerns

In June 2021, the Trust received 51 formal complaints. This is decrease on the previous month where 67 complaints were received. The most common subject for complaints remains 'Clinical Care and Treatment'.

The 51 formal complaints can be broken down by division: (the previous month total is shown in brackets)

ASCR	16 (20)	CCS	3 (1)
Medicine	14 (20)	NMSK	6 (12)
WCH	8 (13)	IM&T	1 (0)
Operations	1 (0)	N & Q	2 (1)

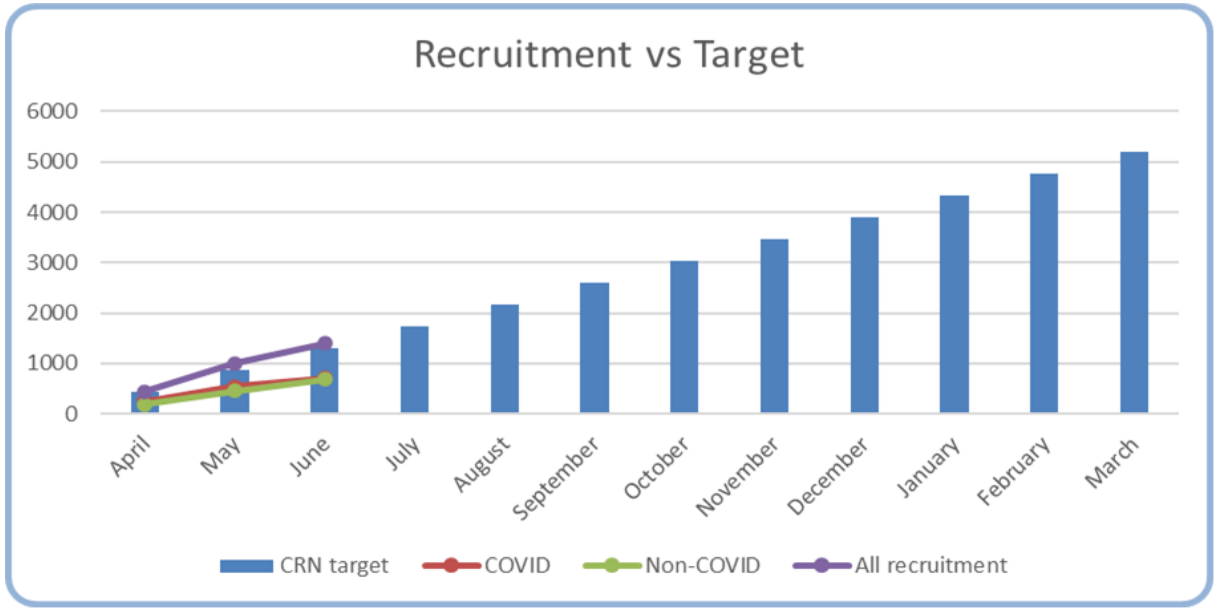
In June, a total of 68 enquiries and 127 PALS concerns were received. This is the highest number of PALS concerns received in any reporting month to date. A review of PALS concern shows the most common subjects are 'Access to Services-Clinical' and 'Communication'. There is a spread of PALS concerns across all divisions with high volumes in Emergency Medicine, Neurology and Urology.

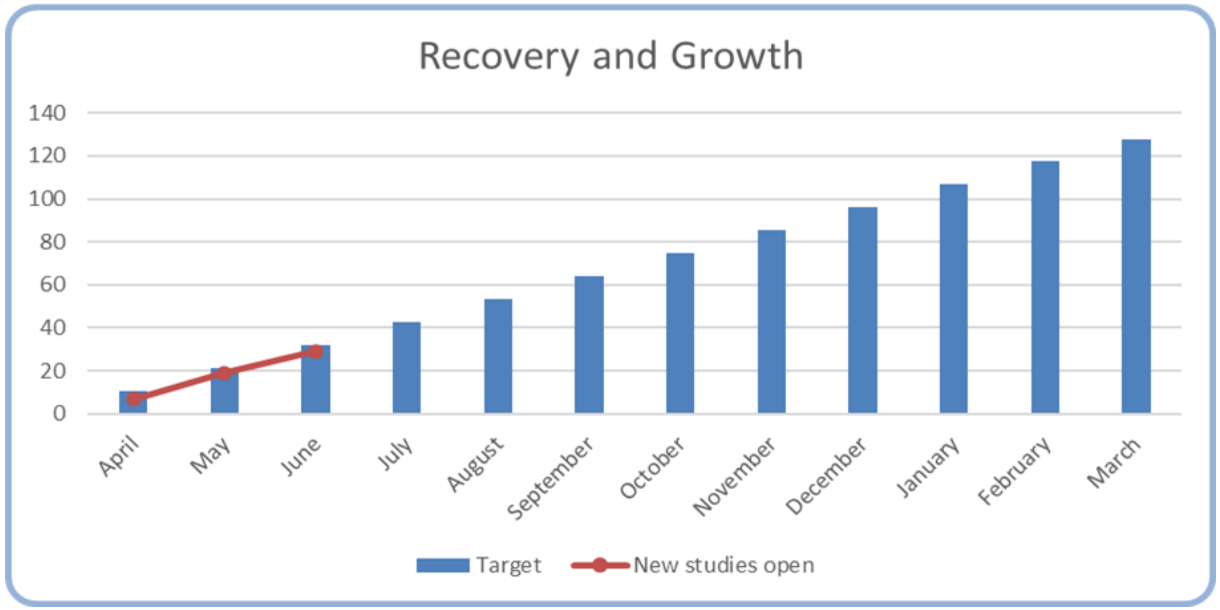
Complaint Response Rate Compliance

The chart demonstrates the % of complaints responded to within agreed timescales. Since January the response rate has been below the Trust target of 90%. This is likely to reflect operational pressures from COVID and staff vacancies across divisional patient experience teams. In June the % compliance dropped to 77%. Particular areas that struggled with compliance were WaCH and ASCR. There have also been delays in the corporate teams with regards to changes in the sign off process.

'You said we did'

In Colorectal Survey the team received a complaint regarding communication. As a result they are implementing a patient contact record. This will ensure a record is kept with information about when and why patients are contacting the team so they can ensure concerns are escalated to more senior managers if they remain unresolved.





Research and Innovation

NBT has set a participant recruitment target comparable to last years target, as assessing the longer term impact of Covid on research is difficult to assess at this point in time. Strong non-Covid performance in addition to Covid recruitment means NBT is currently achieving 107% ytd.

NBT is striving to restore research to pre-Covid levels. The Recovery and Growth slide shows the number of studies against the pre-Covid average. In addition to opening the new studies, R&I have reviewed and approved 34 restart studies, suspended due to Covid.

The pan regional work continues and is now expanding beyond vaccine delivery to the wider research endeavour, including with our regional partners to map working with the network and regional partners collating lessons learned and implementing appropriate new ways of working to consolidate these improvements.

NBT currently leads 57 research grants (NIHR, charity, industry and other) to a total value of £25.9m. This includes the recently awarded prestigious NIHR HTA grant 'Conservative versus standard care for primary spontaneous Pneumothorax' (CONSEPT) led by Prof. Nick Maskell, worth £2m. In addition NBT is a partner on 54 externally-led research grants to a total value of £10.3m to NBT.

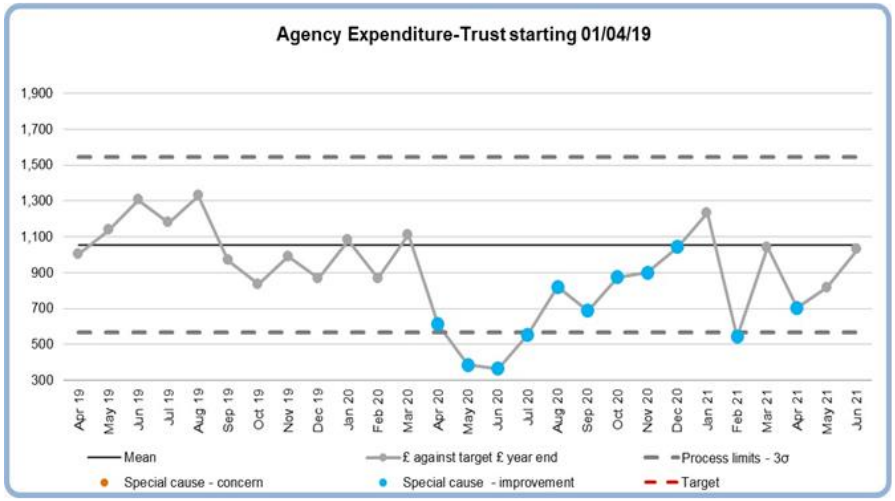
The SHC Research Fund call (2020/21) closed on 12th April 2021. We received 23 EoI applications, of which 14 were shortlisted for full stage application, deadline 30th June. Our Patient Public Involvement panel will meet to review and score the full stage applications prior to the main awarding panel. The SHC Research Fund welcomes any NBT staff member wishing to undertake a research project (up to £20k) in any subject area to apply.

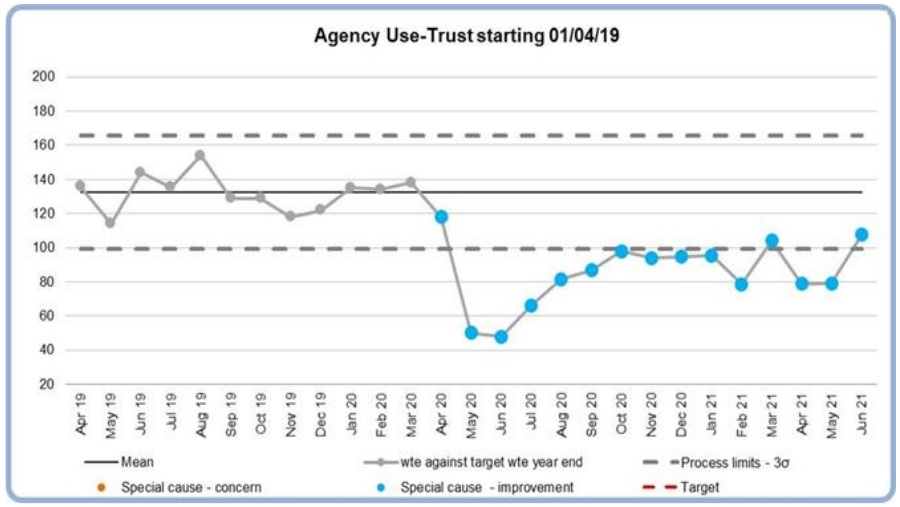
NHS North Bristol NHS Trust

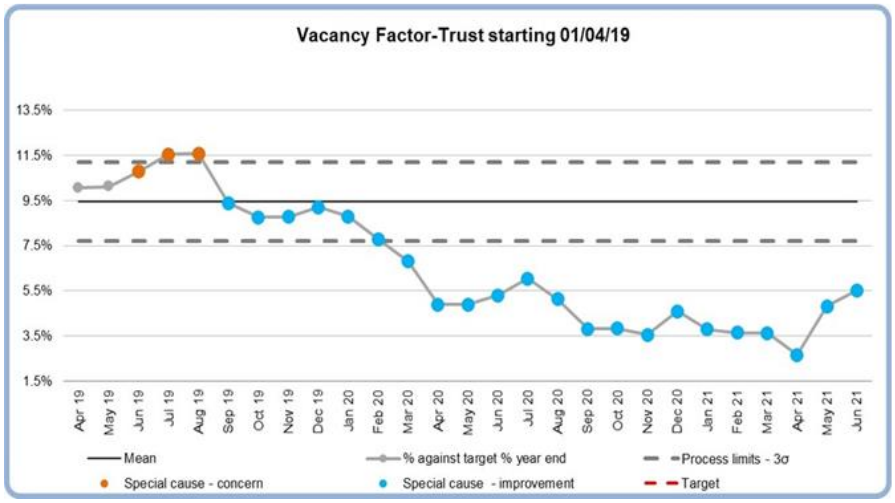
Well Led

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

Workforce







Temporary Staffing

Agency spend increased in June, due to an increase in demand for short notice RMN requirements along with general nurse shortages from framework suppliers. Non-framework supply also had to be used to meet the need from the Trust as self isolation related absences affected all substantive and temporary staff groups.

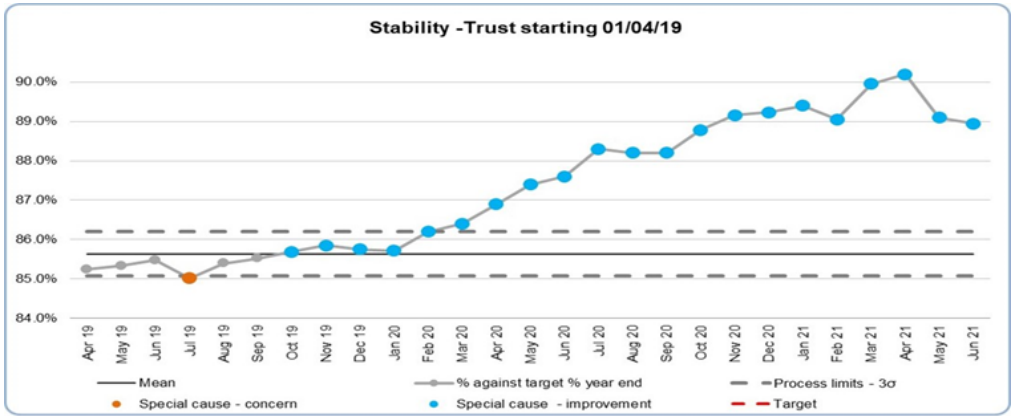
NBT eXtra bank team continue to support the high demands for temporary resource into the Mass Vaccination project at Ashton Gate and across the community and Primary Care network, as well as the new UWE site.

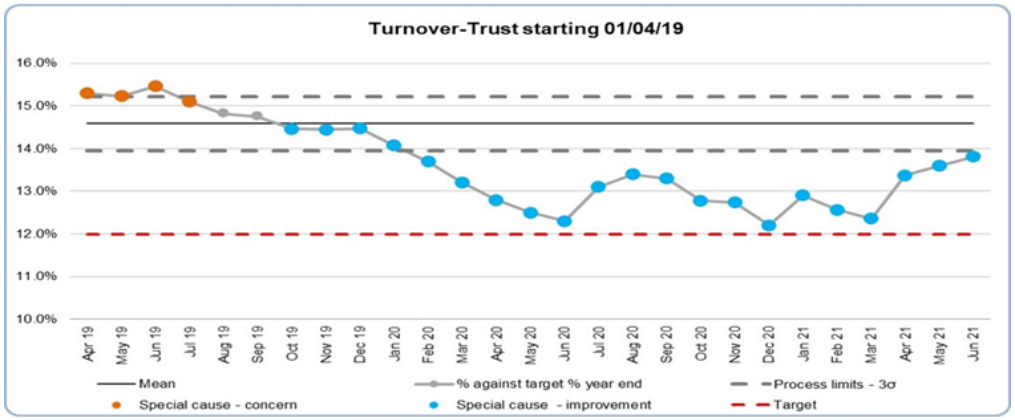
Nursing and Midwifery Resourcing

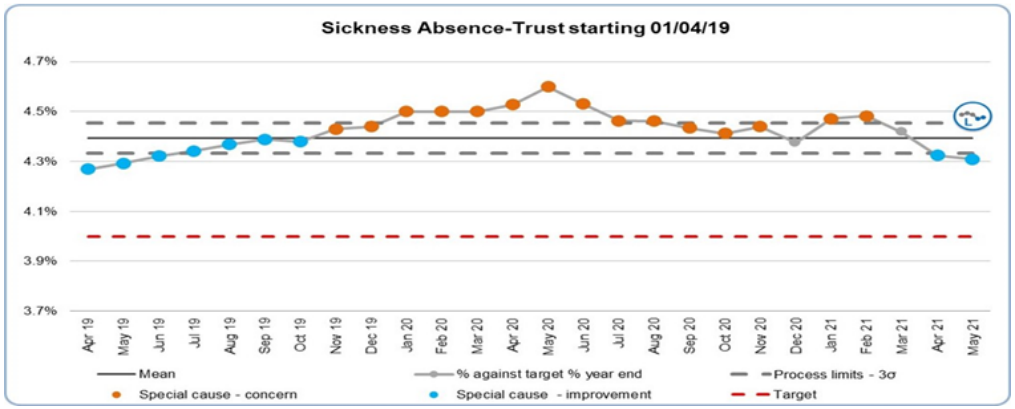
June saw 19 band 5 starters and the pipeline continues to be healthy with 127 staff due to start in Trust in the next 3 months. We made 36 offers for band 5 nursing roles in June. International Recruitment welcomed 11 new Nurses in June as Indian travel restrictions were lifted**.**

The TA team held another successful digital event in June with eight offers made on the day as part of the monthly total. HCA Recruitment saw 17 new starters overall in June and band 2 recruitment continues with regular digital assessment centres and the pipeline for this staff group currently stands at 33 against a vacancy total of 18. We are also increasing our skills targeted band 3 recruitment activity.

Engagement and Wellbeing







Turnover and Stability

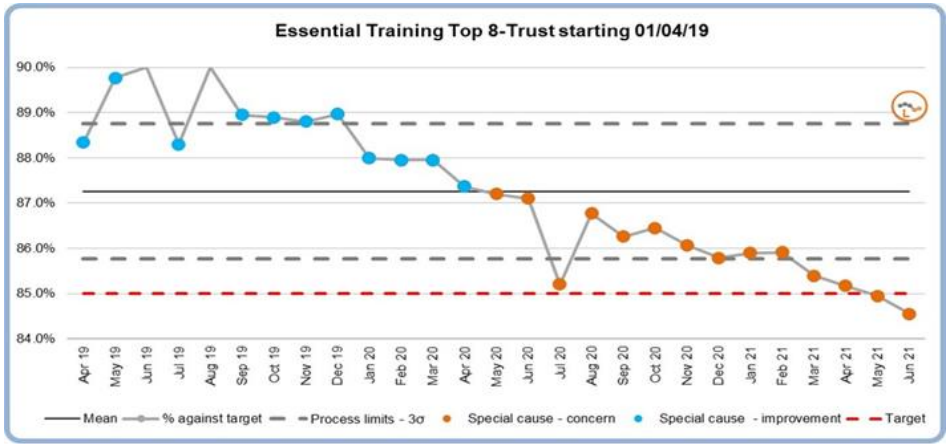
Recent and on-going work includes:

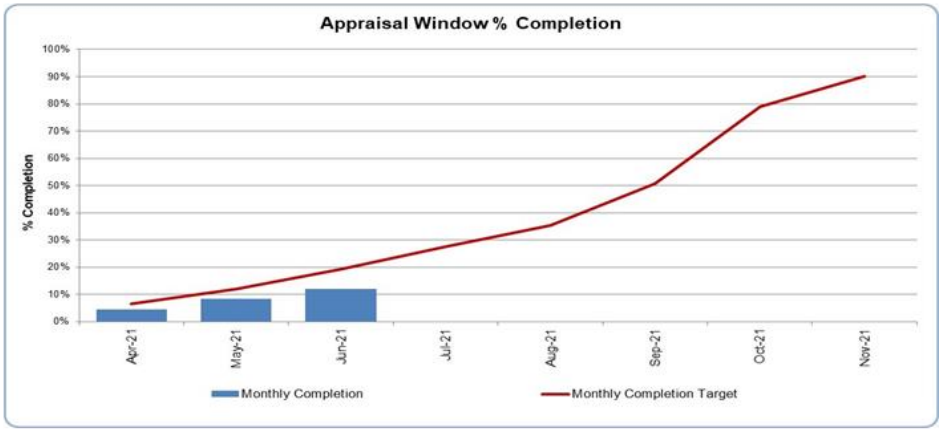
- The Redeployment Policy has just been refreshed and agreed and includes clearer opportunities for redeployment as a way of retaining staff at NBT;
- The People Team's new 'Early Resolution Framework' is now live to staff and managers on LINK, with the formal comms and launch commencing in August. This will support managers and staff to have constructive, compassionate conversations aimed at nipping important issues and concerns in the bud.

Sickness and Health and Wellbeing

Work undertaken to help improve sickness absence includes:

- People Team engaging stakeholders with the Sickness policy review as part of the policy development work
- The refresh and re-launch of the Bullying and Harassment Helpline is almost complete, alongside the development of a new resource pack for B&H advisors;
- Embedding of the Employee Relations Case Tracker which will support managers to proactively manage short and long term sickness cases
- Post shielding case conferences have successfully led to the safe return of all staff who were previously shielding, with the exception of a very few staff in the final trimester of pregnancy
- We continue to hold monthly high level case reviews for the 'top 30' LTS with People Business Partners and senior People representatives. Partners have found these sessions helpful in supporting the effective management of the Trust's longest sickness cases.





Training Topic	Variance	May-21	Jun-21
Child Protection	0.0%	85.9%	85.9%
Adult Protection	-0.3%	87.1%	86.8%
Equality & Diversity	-0.7%	88.9%	88.2%
Fire Safety	-0.5%	85.7%	85.2%
Health &Safety	-0.4%	87.5%	87.2%
Infection Control	-0.1%	91.4%	91.3%
Information Governance	0.6%	80.8%	81.4%
Manual Handling	-2.0%	70.6%	68.6%
Waste	-0.4%	86.7%	86.3%
Total	**-0.4%**	**84.95%**	**84.55%**

Essential Training

Throughout the pandemic, compliance of essential training has shown a downward trend across the Trust. This has now dropped below the minimum compliance threshold level of 85%. The main driver relates to sessions that can only be delivered face to face (e.g. Manual Handling) where social distancing requirements restrict the number of delegates allowed in each group. Wherever possible additional sessions have been added to compensate for this.

Launching in July, the Qlik Workforce app will better empower operational leads to drill into their mandatory training compliance data. The new functionality provides improved visual formatting of data, making it much easier for operational leads to identify focus areas/teams.

Leadership & Management Development

All Leadership & Management learning activity has resumed including the OneNBT Leadership Programme and the Matron Leadership Programme.

The suite of OneNBT Management workshops are all available for enrolment on our learning portal (MLE).

All learning activity is now delivered with a blended approach of both online and face to face facilitation.

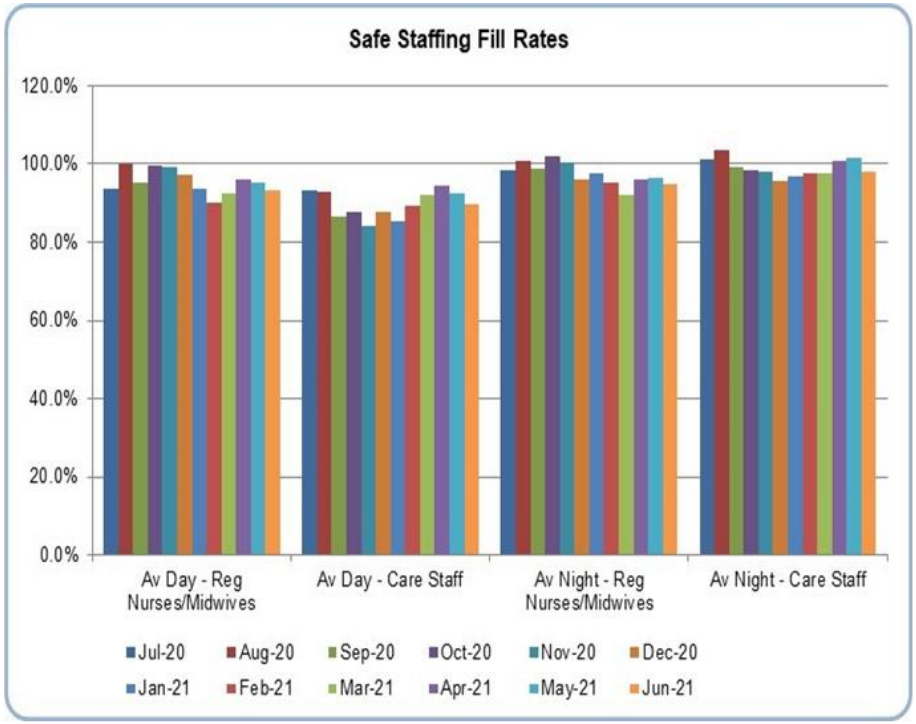
Apprenticeship Centre

Wherever feasible, Apprenticeship activity continued throughout the pandemic. Apprenticeship assessors have now returned to clinical areas and classroom catch-up support sessions commenced in May. This has been planned in a systematic way to ensure safe staffing levels within clinical areas.

Celebrating Success

This month the Learning & Organisational Development team hosted a series of learning celebration events. The events recognised the achievements of 231 learners who within the last 12 months have completed either an Apprenticeship, a Care Certificate, an ILM qualification or the OneNBT Leadership programme.

2021 also marked the 10-year anniversary of NBT proudly delivering Apprenticeships.



Jun-21	Day shift		Night Shift	
	RN/RM	CA Fill	RN/RM	CA Fill
Southmead	93.2%	89.5%	94.7%	98.0%

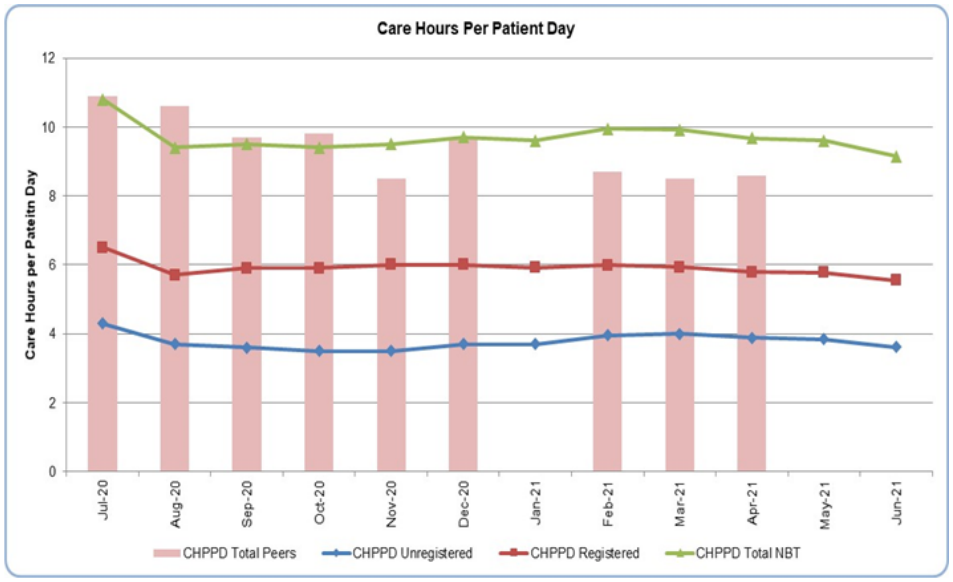
The numbers of hours Registered Nurses (RN) / Registered Midwives (RM) and Care Assistants (CA), planned and actual, on both day and night shifts are collated. CHPPD for Southmead Hospital includes ICU, NICU and the Birth Suite where 1:1 care is required. This data is uploaded on UNIFY for NHS Choices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

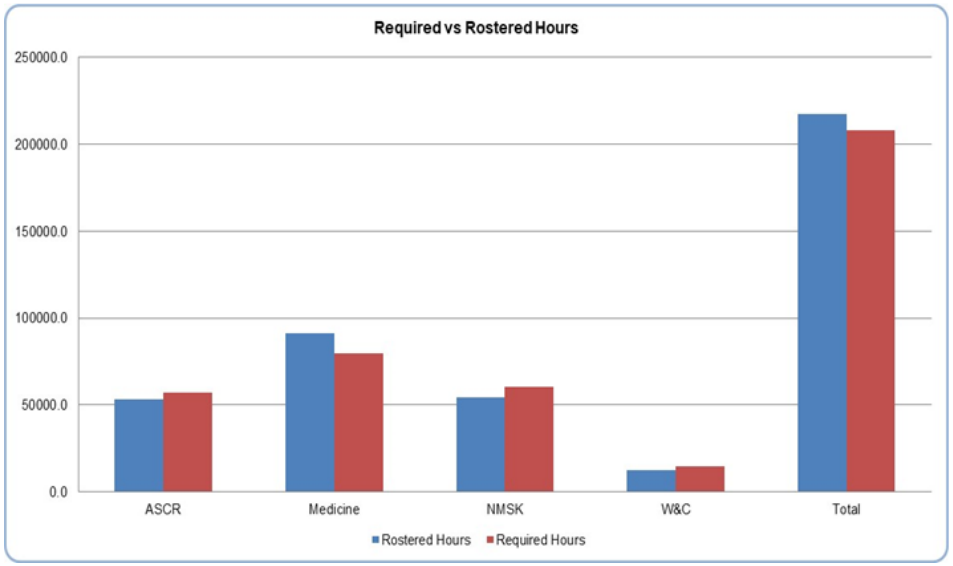
The safe staffing report now requires the wards to identify Nursing Associates including Trainees and AHP staff employed in an inpatient area. There are however ongoing issues with the reporting and this has been escalated to Allocate the roster provider. We will be back reporting as soon as it is possible.

Wards below 80% fill rate for Registered Staff:
for all areas safe staffing maintained through daily staffing monitoring and supplementing with unregistered staff as required
Cotswold (68.8% Day) Reduced occupancy
Percy Phillips (76.3% Day) staffing deployed as required to meet patient needs across the service
Mendip (79.5% Day) staffing deployed as required to meet patient needs across the service.

Wards below 80% fill rate for Care Staff:
for all areas safe staffing maintained through daily staffing monitoring and supplementing with registered staff as required
Cotswold Ward (62.6% Day) Reduction in HCSW required due to lower occupancy
Medirooms (61% Day / 70% Night) Unregistered staff vacancies safe staffing maintained through daily staffing monitoring and supplementing with registered staff as required
7a (76.5% Day) 7a is a green ward which is intermittently running below full occupancy
NICU (42% Day / 45.8% Night) Unregistered staff vacancies, safe staffing maintained through daily staffing monitoring and supplementing with registered staff as required.
Rosa Burden (74% Day . 56% Night) is a green ward which is intermittently running below full occupancy
34b (74.5% Day / 76.9% Night)) Unregistered staff vacancies, safe staffing maintained through daily staffing monitoring and supplementing with registered staff as required.

Wards over 150% fill rate for Care Staff:
33a (194.3% Night) patients requiring enhanced care support
6b (160.2% Night) patients requiring enhanced care support





Care Hours per Patient Day (CHPPD)

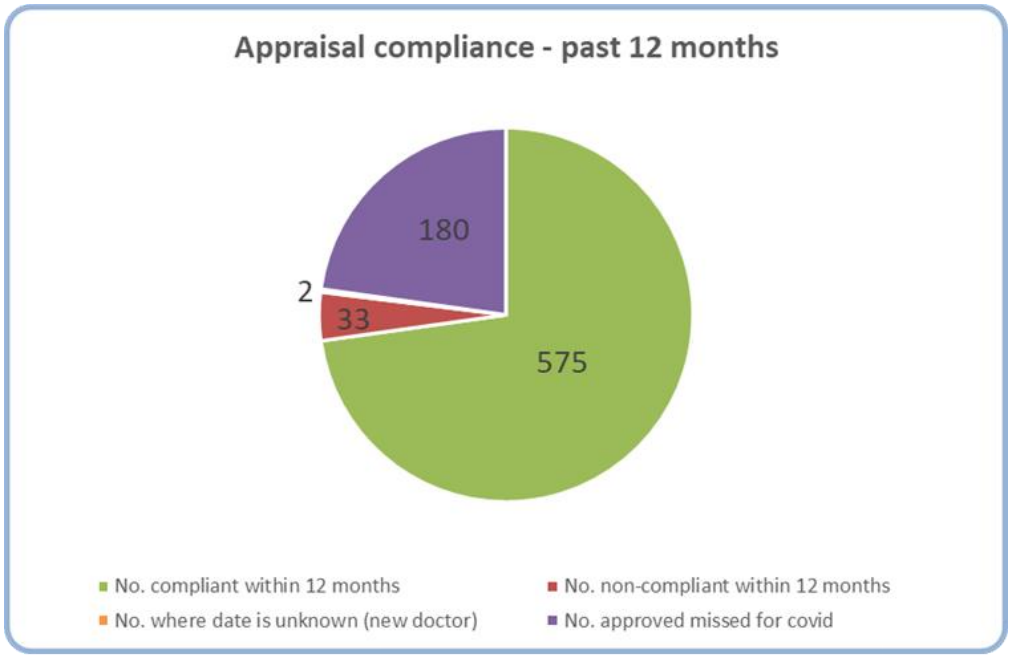
The chart shows care hours per patient day for NBT total and is split by registered and unregistered nursing. The chart shows CHPPD for the Model Hospital peers (all data from Model Hospital).

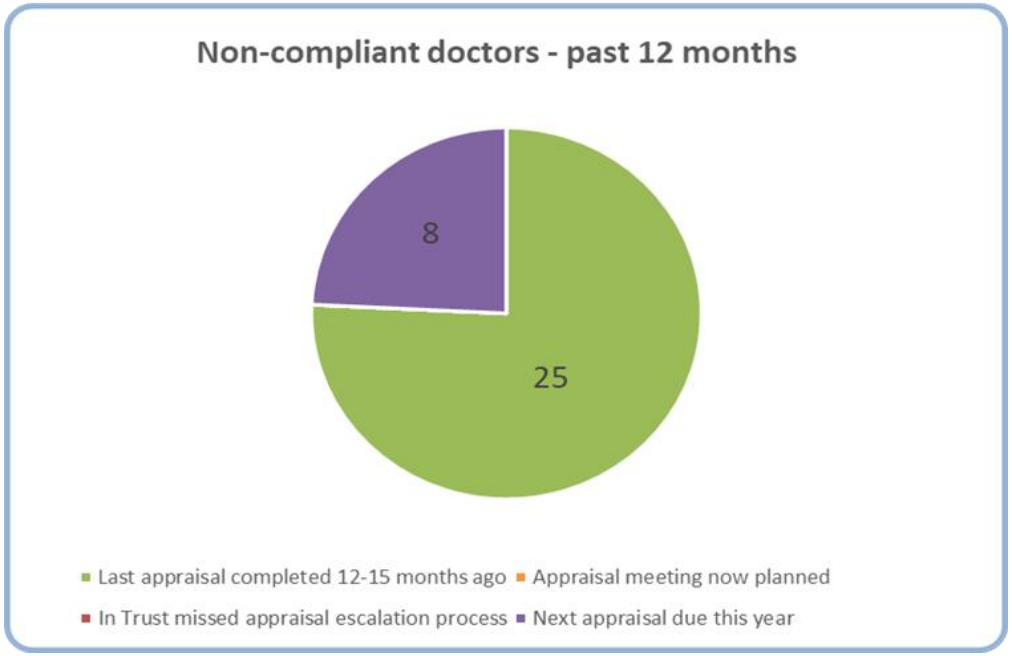
CHPPD are consistent with last month, rostered hours overall are above the required hours due to the decreased patient census and reduced lists.

Safe Care Live (Electronic Acuity Tool)

The acuity of patients is measured three times daily at ward level. The Safe Care data is triangulated with numbers of staff on shift and professional judgement to determine whether the required hours available for safe care in a ward/unit aligns with the rostered hours available.

Staff will be redeployed between clinical areas and Divisions following daily staffing meetings involving all Divisions, to ensure safety is maintained in wards/areas where a significant shortfall in required hours is identified, to maintain patient safety.





Medical Appraisal

Medical appraisals returned to a mandatory process for all doctors from the 1st April 2021 using a nationally agreed light touch approach. The Fourteen Fish system has been adapted for this process. Appraisals unable to be completed prior to April 2021 will be marked as an approved missed appraisal due to the pandemic.

The information in this page refers to appraisal compliance within the last 12 months. Doctors without an appraisal in the last 12 months includes doctors completing their last appraisal earlier than when it was due, doctors having missed an appraisal while being employed with another organisation, or doctors who are simply overdue their current appraisal (some of which have a meeting date set). Doctors who are overdue their appraisal from the last 12 months which should have taken place at NBT will fall under the Trusts missed appraisal escalation process. Doctors with an acceptable reason for not completing an appraisal in the last 12 months will have a new appraisal date set this year.

All revalidations prior to the 16th March 2021 were automatically deferred by the GMC for 12 months. The process restarted in full in March 2021. Due to these automatic deferrals, the number of revalidations due in 2021/22 has now risen. Where possible, the revalidation team are making revalidation recommendations early for those doctors who were automatically deferred in order to reduce the number that will be due in 2021/22.

Finance

Board Sponsor: Chief Financial Officer
Glyn Howells

	Within Funding Envelope		Within Funding Envelope		Outside Funding Envelope		Total	
	COVID-19		CORE Trust		Mass Vaccination			
	M3	YTD	M3	YTD	M3	YTD	M3	YTD
Contract Income	1.0	3.0	63.0	170.9	0.0	0.0	64.0	173.9
Other Income	0.0	0.0	5.9	17.3	0.8	2.3	6.7	19.6
Total Income	1.0	3.0	68.9	188.2	0.8	2.3	70.7	193.5
Pay	(0.8)	(1.4)	(35.2)	(104.5)	(0.7)	(1.9)	(36.7)	(107.8)
Non-Pay	(0.1)	(0.3)	(39.2)	(85.0)	(0.1)	(0.4)	(39.4)	(85.7)
Total Expenditure	(0.9)	(1.7)	(74.4)	(189.5)	(0.8)	(2.3)	(76.1)	(193.5)
Surplus/(Deficit)	0.1	1.3	(5.5)	(1.3)	0.0	0.0	(5.4)	0.0

Statement of Comprehensive Income

Assurances

Trust total for June is an overspend of £5.4m which delivers a year to date breakeven in line with forecast

COVID-19 costs incurred in June totalled £0.9m

There are no further key issues to report.

Statement of Financial Position

Assurances

The strong cash position of £111.7m (£9.7m down since March) is the result of settlement of a number of capital creditors at year end.

Key Issues

The level of payables is reflected in the Better Payment Practice Code (BPPC) performance for June is 89.0% by value compared to an average of 87.1% for financial year 2020/21.

Financial Risk Ratings , Capital Expenditure and Cash Forecast

Capital expenditure for the month is £1.1m. Spend for the year to date is now £2.8m compared to an original plan of £3.6m.

Financial Risk Rating

The new financial framework means that a Financial risk rating is no longer calculated or reported to NHSI.

Rolling Cash forecast

No cash flow forecast has been prepared yet for 21/22 financial year. The cash balance of £111.7m is in line with expectations and no issues are anticipated .

NHS North Bristol NHS Trust

Regulatory

Board Sponsor: Chief Executive
Maria Kane

Monitor Provider Licence Compliance Statements at June 2021
Self-assessed, for submission to NHSI

Ref	Criteria	Comp (Y/N)	Comments where non compliant or at risk of non-compliance
G4	Fit and proper persons as Governors and Directors (also applicable to those performing equivalent or similar functions)	Yes	A Fit and Proper Person Policy is in place. All Executive and Non-Executive Directors have completed a self assessment and no issues have been identified. Further external assurance checks have been completed as appropriate and no issues have been identified.
G5	Having regard to monitor Guidance	Yes	The Trust Board has regard to NHS Improvement guidance where this is applicable.
G7	Registration with the Care Quality Commission	Yes	CQC registration in place. The Trust received a rating of Good from its inspection reported in September 2019. A number of mandatory actions were identified which are being addressed through an action plan. The Trust Board receives updates on these actions via its Quality and Risk Management Committee.
G8	Patient eligibility and selection criteria	Yes	Trust Board has considered the assurances in place and considers them sufficient.
P1	Recording of information	Yes	A range of measures and controls are in place to provide internal assurance on data quality, including an annual Internal Audit assessment.
P2	Provision of information	Yes	The trust submits information to NHS Improvement as required.
P3	Assurance report on submissions to Monitor	Yes	Scrutiny and oversight of assurance reports to regulators is provided by Trust's Audit Committee and other Committee structures as required.
P4	Compliance with the National Tariff	Yes	NBT complies with national tariff prices. Scrutiny by CCGs, NHS England and NHS Improvement provides external assurance that tariff is being applied correctly. It should be noted that NBT is currently receiving income via a block arrangement in line with national COVID-19 financial arrangements.
P5	Constructive engagement concerning local tariff modifications	Yes	Trust Board has considered the assurances in place and considers them sufficient. It should be noted that NBT is currently receiving income via a block arrangement in line with national COVID-19 financial arrangements.
C1	The right of patients to make choices	Yes	Trust Board has considered the assurances in place and considers them sufficient. It should be noted that the Trust is currently implementing national COVID-19 guidance on service restoration.
C2	Competition oversight	Yes	Trust Board has considered the assurances in place and considers them sufficient.
IC1	Provision of integrated care	Yes	Range of engagement internally and externally. No indication of any actions being taken detrimental to care integration for the delivery of Licence objectives.

Appendix 1: Glossary of Terms

Unless noted on each graph, all data shown is for period up to, and including, 30 June 2021 unless otherwise stated.

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

NBT Quality Priorities 2020/21

QP1 Enhance the experience of patients with Learning Disabilities and / or Autism by making reasonable adjustments which are personal to the individual

QP2 Being outstanding for safety – at the forefront nationally of implementing the NHS Patient Safety Strategy within a 'just' safety culture.

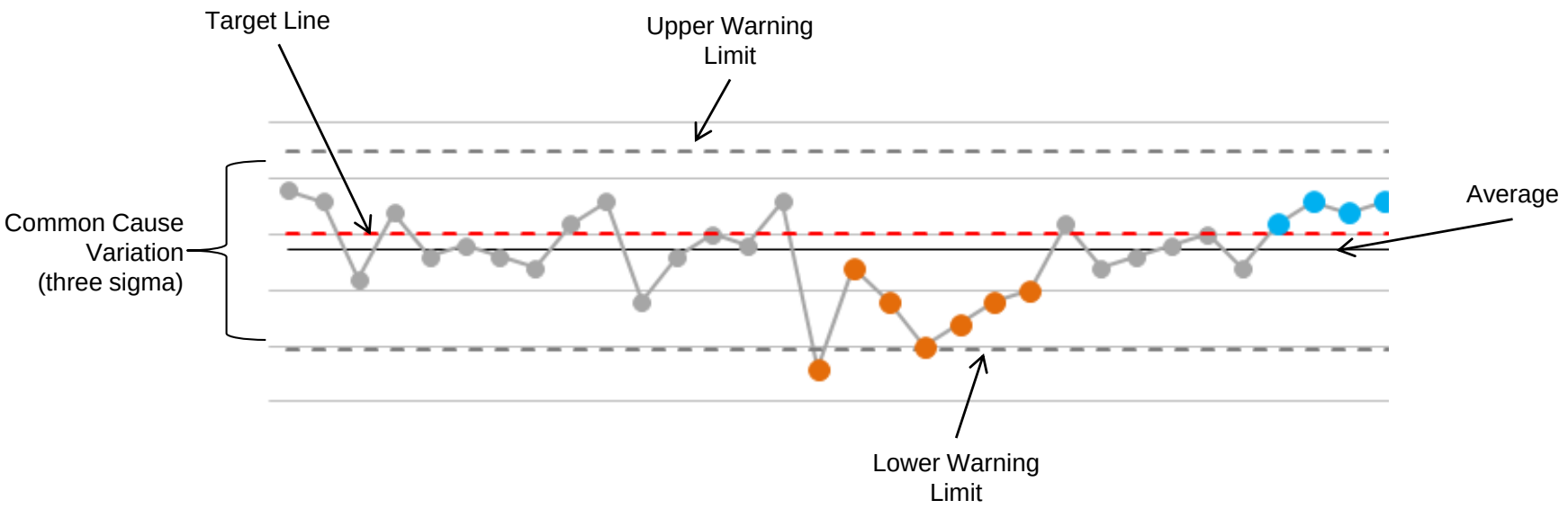
QP3 Ensuring excellence in our maternity services, delivering safer maternity care.

QP4 Ensuring excellence in Infection Prevention and Control to support delivery of safe care across all clinical services

Abbreviation Glossary

AMTC	Adult Major Trauma Centre
ASCR	Anaesthetics, Surgery, Critical Care and Renal
ASI	Appointment Slot Issue
CCS	Core Clinical Services
CEO	Chief Executive
Clin Gov	Clinical Governance
CT	Computerised Tomography
DDoN	Deputy Director of Nursing
DTOC	Delayed Transfer of Care
ERS	E-Referral System
GRR	Governance Risk Rating
HoN	Head of Nursing
IMandT	Information Management
IPC	Infection, Prevention Control
LoS	Length of Stay
MDT	Multi-disciplinary Team
Med	Medicine
MRI	Magnetic Resonance Imaging
NMSK	Neurosciences and Musculoskeletal
Non-Cons	Non-Consultant
Ops	Operations
P&T	People and Transformation
PTL	Patient Tracking List
qFIT	Faecal Immunochemical Test
RAP	Remedial Action Plan
RAS	Referral Assessment Service
RCA	Root Cause Analysis
SI	Serious Incident
TWW	Two Week Wait
WCH	Women and Children's Health
WTE	Whole Time Equivalent

Appendix 2: Statistical Process Charts (SPC) Guidance



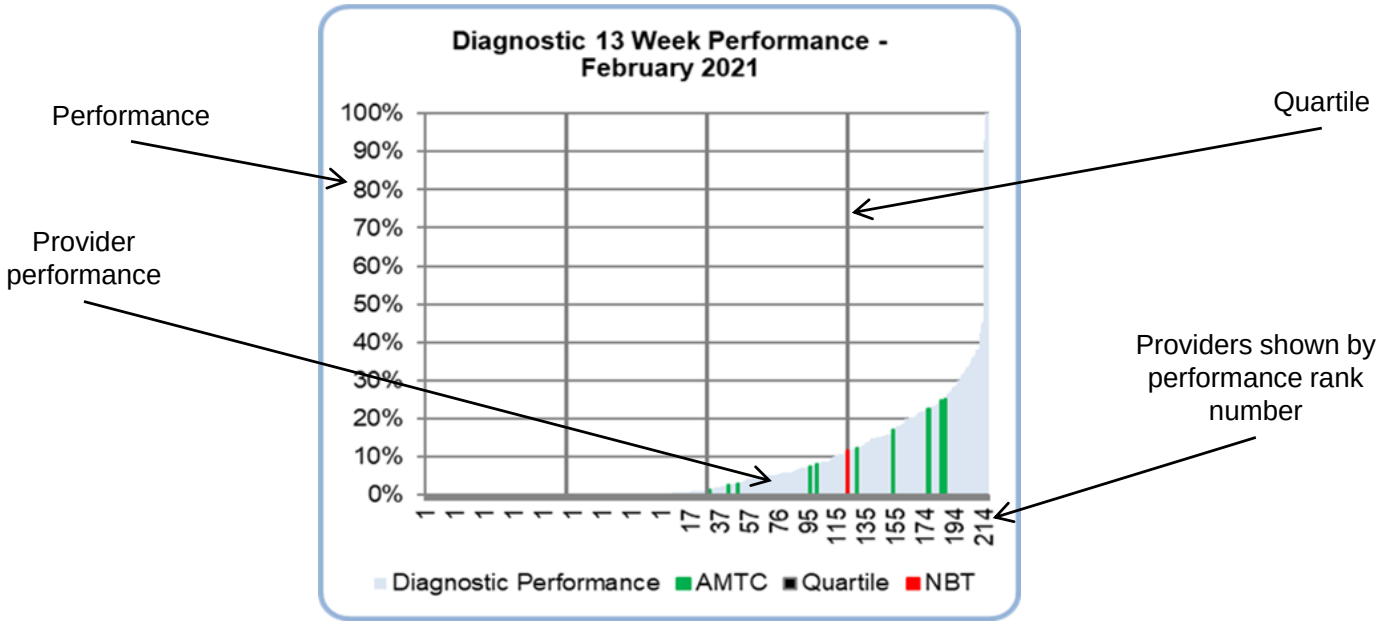
Orange dots signify a statistical cause for concern. A data point will highlight orange if it:
A) Breaches the lower warning limit (special cause variation) when low reflects underperformance or breaches the upper control limit when high reflects underperformance.
B) Runs for 7 consecutive points below the average when low reflects underperformance or runs for 7 consecutive points above the average when high reflects underperformance.
C) Runs in a descending or ascending pattern for 7 consecutive points depending on what direction reflects a deteriorating trend.

Blue dots signify a statistical improvement. A data point will highlight blue if it:
A) Breaches the upper warning limit (special cause variation) when high reflects good performance or breaches the lower warning limit when low reflects good performance.
B) Runs for 7 consecutive points above the average when high reflects good performance or runs for 7 consecutive points below the average when low reflects good performance.
C) Runs in an ascending or descending pattern for 7 consecutive points depending on what direction reflects an improving trend.

Special cause variation is unlikely to have happened by chance and is usually the result of a process change. If a process change has happened, after a period, warning limits can be recalculated and a step change will be observed. A process change can be identified by a consistent and consecutive pattern of orange or blue dots.

Further reading:
SPC Guidance: https://improvement.nhs.uk/documents/2171/statistical-process-control.pdf
Managing Variation: https://improvement.nhs.uk/documents/2179/managing-variation.pdf
Making Data Count: https://improvement.nhs.uk/documents/5478/MAKING_DATA_COUNT_PART_2_-_FINAL_1.pdf

Appendix 3: Benchmarking Chart Guidance



Vertical axis represents the performance value.

Horizontal axis shows the performance ranking for each provider respectively. Each bar within the graph represents a providers performance value with Adult Major Trauma Centres highlighted in green and NBT highlighted in red.

Quartiles have been calculated based on the full spread of performance values and are represented as grey bars.

Ranking has been calculated based on unique performance values i.e. if multiple providers have reported the same performance value for any given month then they will be attributed the same ranking.

Missing bars represent a performance value of 0 or 0%. In the chart above, a number of providers have reported a performance position of 0% and have therefore all been attributed the ranking of 1, or first.

NHS North Bristol NHS Trust

Report To:	Trust Board			
Date of Meeting:	29 July 2021			
Report Title:	Finance Report for June 2021			
Report Author & Job Title	James Drury, Deputy Director of Finance – Financial Management			
Executive/Non-executive Sponsor (presenting)	Glyn Howells, Chief Financial Officer			
Purpose:	**Approval/Decision**	**Review**	**To Receive for Assurance**	**To Receive for Information**
				X
Recommendation:	The Trust Board is asked to note: • the revised financial framework that the Trust is operating in • the spend and recovery for Covid-19 response and mass vaccinations in relation to the revised framework • the spend and income for Core Trust services in relation to previous months • the cash position of the Trust.			
Report History:	N/A			
Next Steps:	N/A			

Executive Summary
The financial framework for months 1 to 6 of 21/22 requires the Trust to operate core operations within an agreed financial envelope and, in addition, to recover costs incurred in dealing with the Covid-19 pandemic in line with national guidance. The forecast Trust position for the first three months of 21/22 is to breakeven. A phased plan has been developed and submitted on 24th May to NHSI. The cumulative actual result for month 3 is a breakeven position with an overspend against plan of £5.4m in month 3. Cash at 30th June amounts to £111.7m. Capital expenditure for the year to date amounts to £2.8m versus a plan of £3.8m. The Trust has recognised an estimate of Elective Recovery Fund (ERF) non-recurrent earnings of £8.6m for the first quarter. This remains subject to validation, which requires various gateways to be met at a system level. The Trust has accrued costs of delivery of the ERF activity to offset this income estimate as costs are expected to be incurred within the system.

Strategic Theme/Corporate Objective Links	Change how we deliver services to generate affordable capacity to meet the demands of the future
Board Assurance Framework/Trust Risk Register Links	
Other Standard Reference	N/A
Financial implications	N/A
Other Resource Implications	N/A
Legal Implications including Equality, Diversity and Inclusion Assessment	Delivery of Trust statutory financial responsibilities

1. Purpose

1.1 This report is to inform and give an update to Trust Board on:

- the further revisions to the financial framework that the Trust is operating in.
- financial performance for June 2021 and the year to date position as at the end of June 2021.
- This report is a standing item to the Trust Management Team and Finance and Performance Committee (FPC) or Trust Board if FPC is not meeting in a given month.

2. Summary

- NHSI/E has suspended the usual operational planning process and financial framework due to covid-19 pandemic response.
- For the first half of the year the Trust is funded through a block contract arrangement against which it is expected breakeven. Additionally, non-recurrent income will be provided to fund non-recurrent elective recovery actions including those covered by the Accelerator programme. Income and cost estimates of £8.6m for ERF activity are included in the M3 position.
- The position for the month of June shows a year to date breakeven position and an in month overspend of £5.4m.
- The cash position at the end of June is a positive balance of £111.7m. (March 2021 balance £121.5m).
- The total value of CIP for this financial year is £19.6m and to date £1.3m has been implemented and £3.4m of schemes are in planning. This leaves 76% of the total value of savings to be identified.
- In month capital spend is £1.1m and YTD spend is £2.8m compared to a YTD plan of £3.6m.

3. Financial Performance

The table below shows overall Trust income and expenditure for year to date and the month of June split between Core Activities, COVID-19 (funded within the envelope) and Mass Vaccination. The Mass Vaccination is funded through a mechanism similar to retrospective top-up in 20/21.

	Within Funding Envelope		Within Funding Envelope		Outside Funding Envelope		Total	
	COVID-19		CORE Trust		Mass Vaccination			
	M3	YTD	M3	YTD	M3	YTD	M3	YTD
Contract Income	1.0	3.0	63.0	170.9	0.0	0.0	64.0	173.9
Other Income	0.0	0.0	5.9	17.3	0.8	2.3	6.7	19.6
Total Income	1.0	3.0	68.9	188.2	0.8	2.3	70.7	193.5
Pay	(0.8)	(1.4)	(35.2)	(104.5)	(0.7)	(1.9)	(36.7)	(107.8)
Non-Pay	(0.1)	(0.3)	(39.2)	(85.0)	(0.1)	(0.4)	(39.4)	(85.7)
Total Expenditure	(0.9)	(1.7)	(74.4)	(189.5)	(0.8)	(2.3)	(76.1)	(193.5)
Surplus/(Deficit)	0.1	1.3	(5.5)	(1.3)	0.0	0.0	(5.4)	0.0

Overall, the Trust delivered a breakeven position for the year to date. Against the requirement to break even, for the month of June the Trust delivered a deficit of £5.4m of which £5.5m related to core activities. The deficit is driven by a provision for expected system costs of £6.9m, which is explained in more detail in section 3.2.

The Trust has recognised an estimate for Elective Recovery Fund (ERF) non-recurrent earnings of £8.6m for the first quarter. This remains subject to validation and requires various gateways to be met at a system level. Costs have been accrued in line with the income estimate due to uncertainty at this stage of where costs will sit within the system.

The Trust has made no changes to its forecast outturn and will formally review at month 6 and month 9 and report this to Board in October and January. The normalised / underlying position will be reported from month 4.

3.1. Covid 19

The share of system funding being paid to the Trust assumes direct costs of the Covid 19 response will continue at approx. £1m per month. During June the Trust incurred £0.7m of additional I&E costs and identified an additional £0.2m relating to prior months. The current assumption is that any surplus non-recurrent covid funding can be retained by the Trust. There is a potential risk that the surplus of income over Covid expenditure of £0.8m YTD may need to be returned to commissioners later in this financial year.

Covid costs incurred in June 2021 totalled £0.9m, as described below.

- £0.8m was spent in additional pay costs as a result of staff who are self-isolating or shielding of which £0.2m was identified in respect of prior months,
- £0.1m was spent on non-pay costs including additional clinical equipment, decontamination costs and other social distancing measures.

3.2 Trust trends

The table below sets out the trends for the last three months:

£m

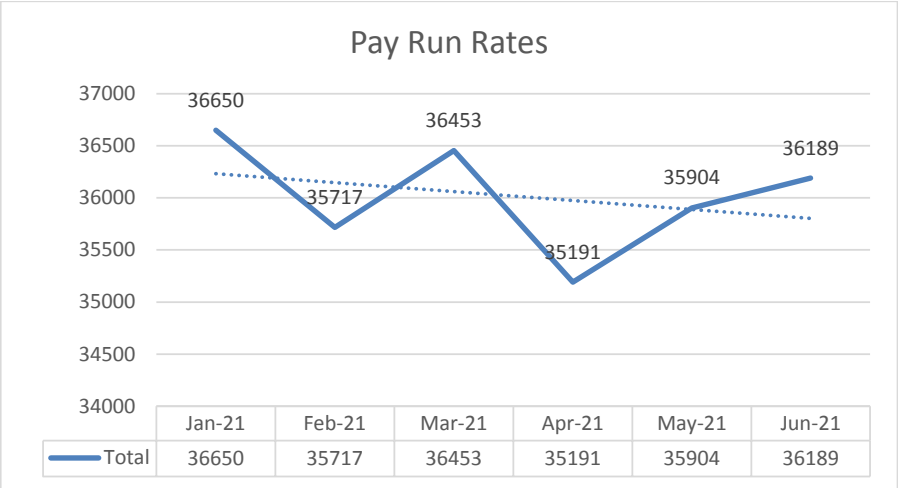
Activity	Apr	May	Jun	YTD
Revenue From Patient Care	53.3	56.6	64.0	173.9
Non Patient Related income	6.4	6.5	6.7	19.6
Total Income	**59.7**	**63.1**	**70.7**	**193.5**
AHP's and STT's	(2.4)	(2.5)	(2.5)	(7.3)
Medical	(14.2)	(14.6)	(14.5)	(43.3)
Nursing	(9.4)	(9.5)	(9.9)	(28.7)
Other Non Clinical Pay	(9.3)	(9.4)	(9.8)	(28.4)
Total Pay	**(35.2)**	**(35.9)**	**(36.7)**	**(107.8)**
Clinical Supplies (Incl Blood)	(3.3)	(3.2)	(3.3)	(9.8)
Drugs	(4.0)	(4.0)	(4.1)	(12.0)
Other Non-Pay	(6.3)	(7.5)	(22.6)	(36.4)
Premises Costs	(3.7)	(3.5)	(4.2)	(11.5)
Supplies & Services	(5.1)	(5.7)	(5.2)	(16.0)
Total Non-Pay	**(22.5)**	**(23.8)**	**(39.4)**	**(85.7)**
Total Expenditure	**(57.7)**	**(59.8)**	**(76.1)**	**(193.5)**
Grand Total	**2.0**	**3.3**	**(5.4)**	**(0.0)**

Trust income, after adjusting for £8.6m of ERF activity, is in line with plan but lower than May when additional income of £2.0m in respect of prior months was recognised. Normalising for the ERF income and the May adjustment shows income is flat at circa. £55m per month.

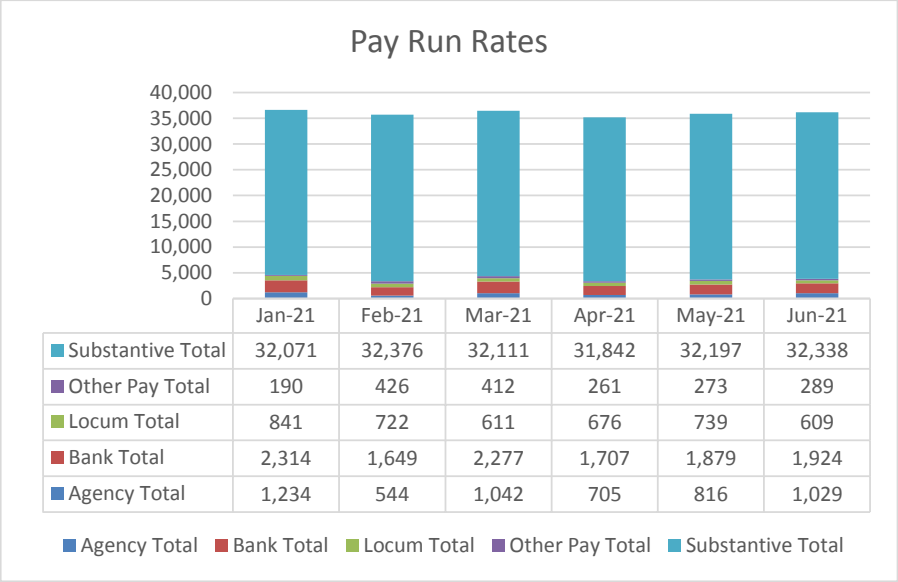
Total pay has increased by £0.8m from the prior month reflecting an increase in both substantive staff costs and agency nursing costs. The additional agency pay costs were driven by higher levels of staff isolation in June and were charged to Covid recovery.

The Trust has included a provision in respect of payment of system costs in month 3 of £6.9m After adjusting for this provision, non pay is in line with May levels.

Trust pay excluding the COVID agency costs referred to above.



The table below sets out the trend analysis in respect of staff categories:



For June substantive and nurse agency costs have increased by £0.1m and £0.2m respectively. This was partially offset by a reduction in locum expenditure of £0.1m.

The table below sets out the non pay costs of the Total Trust:

Categories	Overall Trust Total M1	M2	M3	YTD
Clinical Supplies (Incl Blood)	(3.3)	(3.2)	(3.3)	(9.8)
Drugs	(4.0)	(4.0)	(4.1)	(12.0)
Other Non-Pay	(6.4)	(7.5)	(22.5)	(36.4)
Premises Costs	(3.7)	(3.5)	(4.3)	(11.5)
Supplies & Services	(5.1)	(5.7)	(5.1)	(15.9)
Grand Total	**(22.5)**	**(23.9)**	**(39.3)**	**(85.7)**

Excluding the provision for expected system costs of £6.9m and estimated costs of ERF of £8.6m there are no significant variances in non pay by category.

3.3 Mass Vaccination

During June 2021 the Trust has continued delivery of Mass COVID-19 Vaccinations, which resulted in additional costs of £0.8m which is in line with the approved budget. The majority of costs incurred are staff related as consumables and drugs costs are being met with nationally supplied push stock. Income in line with expenditure was recorded and a breakeven position for year to date and month 3 is reported.

4. Nightingale Hospital Financial Position

4.2 These figures are no longer reported as the facility is now closed.

5. Balance Sheet , Capital and BPPC

5.1 The balance sheet is shown below with comparators to the year end position and the previous month. Month 12 20/21 has now been externally audited.

Balance Sheet Category (ledger signage)	20/21 M12 balance £m	21/22 M2 balance £m	21/22 M3 reported £m	In-month change £m	YTD change £m
Non Current Assets					
Total Property plant and equipment	579.3	576.9	576.0	(0.9)	(3.3)
Intangible Assets	14.8	13.7	13.2	(0.5)	(1.5)
Non-current debtors	1.7	1.7	1.7	0.0	0.0
Total non-current assets	**595.8**	**592.4**	**591.0**	**(1.4)**	**(4.8)**
Current Assets					
Inventory	8.5	8.5	8.6	0.0	0.0
NHS debtors (invoiced)	7.4	7.9	22.1	14.1	14.6
NHS debtors (accrued)	3.5	6.2	7.6	1.5	4.2
Total non-NHS debtors	25.5	26.8	25.4	(1.4)	(0.1)
Cash and cash equivalents (GBS)	121.4	114.7	111.7	(3.0)	(9.8)
Total Current Assets	**166.3**	**164.2**	**175.3**	**11.2**	**9.0**
Current Liabilities (< 1 year)					
Trade and Other payable - NHS	(27.3)	(21.2)	(21.4)	(0.2)	5.9
Trade and Other payable - Non NHS	(98.2)	(90.2)	(103.6)	(13.4)	(5.4)
Deferred income	(8.5)	(9.8)	(12.8)	(3.1)	(4.4)
PFI liability	(12.3)	(15.0)	(15.0)	0.0	(2.7)
Finance lease liabilities	(2.8)	(2.8)	(2.8)	0.0	0.0
Total Current Liabilities	**(149.1)**	**(139.0)**	**(155.7)**	**(16.6)**	**(6.6)**
Trade Payables and deferred Income	(7.8)	(8.5)	(8.4)	0.1	(0.6)
PFI liability	(368.7)	(367.2)	(366.4)	0.8	2.2
Finance lease liabilities	(3.9)	(3.8)	(3.3)	0.6	0.7
Total net assets	**232.6**	**238.0**	**232.6**	**(5.5)**	**(0.1)**
Capital and Reserves					
Public Dividend Capital	448.7	448.7	448.7	(0.0)	(0.1)
Revaluation reserve	162.0	162.0	162.0	0.0	0.0
In-year Income and Expenditure	3.0	5.4	0.0	(5.4)	(3.0)
Retained earnings	(381.1)	(378.1)	(378.1)	0.0	3.0
Total Capital and Reserves	**232.6**	**238.0**	**232.6**	**(5.5)**	**(0.1)**

5.2 There are no significant balance sheet movements in month 3.

5.3 The cash balance at M3 is £111.7m, a decrease of £3.0m from £114.7m at 30th April 2021. This decrease is in line with working capital movements in the year to date. The Trust expects to break even under the H1 financial regime and therefore expects to have sufficient cash to manage its affairs without any external support over the period for which the financial regime has been announced.

5.4 Our capital plan for 2021/22 sets out our priorities for the development and ongoing maintenance of our estate, our facilities and equipment and for continuing with our digital vision. The Trust identified our priorities for investment through a comprehensive process of challenge and review of all requests for funding for 2021/22 and beyond. Initial proposals for the year from across the Trust were reviewed and prioritised to within the agreed £32m allocation (NB – assumes an over commitment of approx. £10m). These plans amount to £32.0m as compared to CRL of £21.7m. The plan is over committed to account for potential slippage and or receipt of additional funding in year.

5.5 Priorities for capital investment in 2021/22 are:

- Backlog maintenance of critical retained estate, focusing on high priority clinical areas requiring plant replacements; including the completion of the 2 new modular theatres for CDS/Gynae, fire improvements across all Trust sites and the demolition of Monks Park house.
- Replacement and new medical equipment. The priorities for 2021/22 include a replacement MRI, CT, Neuro Robot and Cath lab, one new Cath Lab and investment in replacing a further approx. £6m+ of life expired equipment across all Divisions.
- Divisional priority schemes include an extension at Cossham to house a new CT and a replacement MRI , the replacement of 5 endoscope washers and the installation of an additional 5 washers in Brunel as well as several smaller schemes to deliver improvements to areas within Brunel and the retained estate.
- Significant investment continues to be made in our IM&T infrastructure and delivering the ongoing 10-year digital strategy. The priority project for progression in 2021/22 is the ongoing delivery of the Electronic Patient record project as well as a significant number of other projects that will support clinical provision and developments.

5.6 The 21/22 capital plan has been over committed to allow for the management of in year slippage or the receipt of additional funding. The table below shows the planned spend against the year to date actual (invoices received) as well as the total allocated budgets and the level of over commitment.

2021/22 Capital Expenditure	2021/22 Plan	Permitted Over-Commitment	Year to date Plan £000	Year to date Actual £000	Year to date Variance from Plan £000
Internally funded:					
Divisional Schemes	3,500	6,000	500	188	(312)
CRISP	6,000	8,500	1,000	1,744	744
Medical Equipment	5,500	8,500	500	176	(324)
IM&T	5,492	9,000	1373	674	(699)
Other	1,167		292	0	(292)
Internal sources of funds					
Totally internally funded	21,659	32,000	3,665	2,782	(883)

11

5.7. The Trust is currently forecasting to achieve its core capital plan and fully spend against its £21.7m capital envelope for financial year 2021/22.

5.8. Capital YTD is £2.8m compared to a plan of £3.6m. In Month spend is £1.1m.

5.9. The Trust has been notified that its capital spend limit has been increased by £5.8m for 2021/22 as part of the Accelerator scheme. This capital will spent on additional capital equipment to support the delivery of higher levels of elective activity and will be incorporated into the routine capital reporting processes from month 4.

6. Assumptions, opportunities and risks

6.1. The trust has assumed that any surplus covid cost funding from the system can be retained.

6.2. The trust has assumed that it will be required to fund expected system costs relating to ERF. Should these costs not materialise then there may be an upside to the forecast financial position.

6.3. There is a risk that non-recurrent funding is being used to cover recurrent costs as block contracts are being rolled over based on 2019/20 costs whilst inflation and other pressures are increasing the recurrent cost base of the Trust. Further recurrent investments in quality and safety have been approved in advance of confirmation of potential commissioner funding. Mechanisms for allocating recurrent funding across the system are not yet developed.

6.4. The Trust has chosen to set annual budgets whilst the finance regime has only announced income levels for the first half of the year. There is a potential risk that assumptions may differ for the second half of the year, though verbal confirmation has been given that the regime is likely to be similar to the first half of the year.

6.5. The system has been selected as an Accelerator site which will increase the levels of non-recurrent funding being received by the Trust in Q1 and Q2.

6.6. M3 includes an estimate of ERF monies earned by the system on activity delivered by the Trust offset by estimates of the cost of delivery. It should be noted that the thresholds for ERF have increased with effect from month 4 so potential income will reduce in Q2

6.7. Potential risks to the delivery of the Trust cost improvement programme may arise.

7. Cost Improvement Program

7.1. The budget reduction targets set for each division and the amounts delivered to date are as below.

	FYE Target £k	Completed Schemes £k	Schemes In Implementation £k	Schemes in Planning £k	Total FYE	Pipeline	% Gap to be closed
ASCR	4,427	0	271	1,240	1,512	2,941	66%
CCS	3,893	0	433	353	786	380	80%
CORP	1,610	0	231	68	299	20	81%
FAC	1,910	0	100	0	100	25	95%
MED	3,179	0	0	671	671	310	79%
NMSK	3,316	0	295	1,029	1,324	410	60%
WCH	1,344	0	17	17	34	60	97%
Totals	19,679	0	1348	3,379	4,727	4,146	76%

- The Trust CIP target for 2021/22 is £19.68m of full year effect savings with a minimum expectation of £10m to cover investment requirements.
- The current identified CIP position is £4.7m with a further £4.1m of schemes in development
- Executive-led monthly CIP reviews are in progress and further schemes totalling £2.5m across Medicine, Facilities and Finance have been identified. The transformation office is liaising with teams to progress the reporting of these.
- Completed schemes are currently zero
- Please note the definitions of the status categories now aligns with the revised CIP Cut format. The progress categories used are:

Completed Schemes	**CIP saving adjustment agreed by Divisions and Finance. Recurring savings recorded (posted) in Finance ledgers.**
Schemes in Implementation	**QIA process is approved. Project in the implementation phase, with a detailed plan and where appropriate an approved business case. Recurring CIP saving forecast mature with minimal project delivery risks or issues.**
Schemes in Planning	**The decision has been taken to initiate the CIP scheme and it is live. The scheme is in the scoping or planning stage but the delivery plan and saving forecast still carries a degree of risk and more work/support is required to develop and mature these elements to pass QIA scrutiny. The scheme must complete QIA process and be approved to move out of the planning phase.**
Pipeline	**Recurring CIP saving scheme at the idea stage and requires more work to establish its viability and savings value.**

8. Summary and Recommendation

8.1. The Trust Board is asked to note:

- the revised financial framework that the Trust is operating in,
- Financial performance for the month and year to date
- The associated assumptions, opportunities and risks.
- the spend on Mass Vaccinations and Covid-19 expenditure areas
- Delivery of Cost Improvement Plan savings and how they compare with divisional targets.
- The cash position and Capital spend levels for the Trust.

NHS
North Bristol
NHS Trust

Report To:	Trust Board		
Date of Meeting:	29 July 2021 (Report covering 1/3/21 – 30/6/21)		
Report Title:	Guardian for Safe Junior Doctor Working Report		
Report Author & Job Title	Dr Lucy Kirkham Trust Guardian for Safe Junior Doctor Working		
Executive/Non-executive Sponsor (presenting)	Dr Lucy Kirkham		
Purpose:	**Approval**	**Discussion**	**To Receive for Information**
		X	X
Recommendation:	The New Junior Doctors' Contract was introduced with effect from October 2016, subject to a phased implementation between October 2016 and August 2017. There was a 2019 Contract Refresh agreed but since March 2020 when the coronavirus pandemic began, the contract rules have reverted to the 2016 contract with further relaxation where unavoidable. The Board of Directors will discuss current pandemic contract issues and as a public authority must, in the exercise of its functions, have due regard to the need to: • All contractual obligations in place • Be satisfied that the role of Trust Guardian is being fulfilled • Exception Reports being acted upon • Gaps on Junior Rotas being filled as a priority • Risks to Trust considered – Guardian fines; accountability; staffing		
Report History:	This paper sets outs the background and context around the introduction of the Guardian of Safer Working as part of the 2016 Terms and Conditions for Junior Doctors and implementation of that role in the Trust. It shows:- • Exception Report data • Locum data		
Next Steps:	• Promote and support exception reporting system to consultants and trainees		

Executive Summary

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

- Safety reasons
- Excess hours – Leading to TOIL or Payment
- Excess hours leading to work pattern reviews
- Missed education sessions

12

Junior Doctor Forum - principally these forums advise the Guardian of Safe Working who oversees the processes in the new contract designed to protect junior doctors from being overworked. Addition of DME attendance to discuss educational reports and issues.
Fines – when there is a breach of hours agreed the first compensation should be time off in lieu (TOIL). If this cannot be arranged then the trainee will be paid for the hours worked. In addition, a review of the work schedule should be done to ensure that the breach does not recur. A department that has recurring breaches that lead to more than an average of 48 hours' work per week (max 72 hours in a week) may be subject to a Guardian Fine.

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

Some changes came into effect from August 2019 and these include:

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

In March 2020 NHS Employers agreed a joint statement with the British Medical Association on the application of the 2016 terms and conditions of service contract limits for the duration of the coronavirus pandemic.

https://www.nhsemployers.org/-/media/Employers/Documents/Pay-and-reward/Junior-Doctors/Joint-statement-on-managing-rotas-NHS-Employers-and-BMA.pdf?la=enHYPERLINK "https://www.nhsemployers.org/-/media/Employers/Documents/Pay-and-reward/Junior-Doctors/Joint-statement-on-managing-rotas-NHS-Employers-and-BMA.pdf?la=en&hash=A91E5E8C448CEE795862F54877F20B7B2E587B4E"&HYPERLINK

This statement outlines that where an employer is unable to meet its obligations under the definitions of appropriate levels of cover, within the 2016 terms and conditions of service, there may be agreement to suspend contractual provisions in discussion with the trainees. This led to some relaxation of rules during pandemic but NBT rotas managed to maintain:

- 72 hours max per week (any 168 hour period)
- Maximum of 8 consecutive shifts
- 48 hour week average
- 11 hour breaks between shifts
- <1:3 weekends worked over the last year

Strategic Theme/Corporate Objective Links	• Junior Contract 2016 conditions with amendments under discussion by NHS Employers and BMA • Follow the timelines for implementation of the 2019 and 2020 contract refreshes • Trust aim should be for all rotas to be fully staffed
Board Assurance Framework/Trust Risk Register Links	• eRostering to alert contract breaches and enable leave booking for trainees. • Exceptions alert ISCs

High Level Data

Total number of trainees and Clinical Fellows = 576 (~176 are Fellows – July data)

All are on the 2016 T&Cs including the Clinical Fellows

Unfilled rota slots:

DIVISION	NOW	AUGUST 2021
ASCR	2CF & 3 trainees	6CF & 1 trainee
NMSK	5CF & 1 trainee	6CF
Core Clinical	0	0
W&C	1 trainee	1 CF & 1 trainee
Medicine	10 CF (+1 gone to Weston) & 2 trainee	0 (potential of 1)

All August gaps are being advertised to be filled.

EXCEPTION REPORTS - 1/3/21 – 30/6/21

Exception Reports (ER) over past 4 months – 1/3/21 – 30/6/21		Number flagged as immediate safety concern (ISC)
Number relating to hours of working	167	3
Number relating to pattern of work	2	
Number relating to educational opportunities	6	
Number relating to service support available to the doctor	0	
TOTAL NUMBER OF EXCEPTION REPORTS	175	3

BREAKDOWN OF REPORTS

IMMEDIATE SAFETY CONCERNS

Rota name	ISC	Steps taken on the day	Outcome	Other exceptions in this rota
F1 Medicine	1 Junior down	Sickness. Cons and Reg supported on day Spare staff and outlier locum not available	1 hr TOIL	**49 total** 46 – hrs 2 - educational 1 - pattern
F1 Medicine	2 junior down	Sickness. Consultant helped out. Medical outliers locum requested – never turned up	2.5 hr payment	
CT3 medicine	3 juniors, 16 admissions	Stayed 1hr 15 late	Pending	**11 total** All hours

12

EDUCATIONAL EXCEPTION REPORTS

Rota	Variance from work schedule	Steps taken to resolve
F2/CT Medicine	Required to cover a different medical ward rather than usual Cardiology job as Cardiology team had adequate staffing. Usually would have been able to attend clinic, but this was not possible because of need for service provision.	No other option at the time, medical cover was required. (Consultant support was good and helpful)
F2/CT Medicine		
F1 Medicine	The ward was on minimum staffing and was too busy with complex and sick patients to attend teaching.	I will re-watch this teaching via the recording provided.
F1 Medicine		
Renal Medicine F2-CT	Inability to attend scheduled out-patient clinics due to staff shortages on the ward. Missed 6 clinics in total throughout the course of the placement	Raised issue with rota coordinator
CT2 Medicine	Unable to attend scheduled clinic as below minimal staffing on ward	Discussed with senior hoping to do ILD clinic following week

'HOURS' EXCEPTION REPORTS BY ROTA AND OUTCOME

Most reports from medicine rotas

Rota	Outcome TOIL	Outcome Payment	Pending	No further action	TOTAL Reports
Clinical Fellow CT1-2 Medicine	12	32	22		**66**
F1 Medicine	12	19	15	1	**47**
NWD Clinical Fellow Medicine	10	1	3		**14**
F2/CT Medicine - 3 Month Rotas	4	6	1	1	**12**
Haematology ST3+	7	3			**10**
Microbiology ST3+ 1:11	1	7			**8**
General Surgery F1		3			**3**
Neurosci F2 - C/ST2 15		1	1		**2**
Medicine ST3+ 22 doctor	2				**2**
T&O F1		1			**1**
1RW NICU ST1-3				1	**1**
F2-ST2 Obs & Gynae			1		**1**
	48	73	43	3	**167**

JUNIOR DOCTOR LOCUM EMPLOYMENT – 01/3/21 – 31/6/21

1. BY DEPARTMENT: Biggest user Medicine

Locum Bookings (Bank) by Department	Requested Shifts	Requested Hours	Filled Hours	Estimated Cost
⊞ ASCR Division	381.00	3705.25	3483.75	£208,331.50
⊞ Clinical Governance Division	31.00	187.00	187.00	£9,845.00
⊞ Core Clinical	15.00	202.50	202.50	£13,895.25
⊞ HR Division	4.00	13.50	10.50	£590.00
⊞ Medicine Division	1199.00	10811.75	9641.75	£539,450.70
⊞ NBT Extra Bank Division	2.00	25.00	25.00	£1,325.00
⊞ Neuro & MSK Division	410.00	3749.89	3052.39	£192,840.85
⊞ Projects Division	2.00	12.00	0.00	£900.00
⊞ W&C Division	57.00	579.75	566.75	£36,421.25
⊞ Winter Pressures	460.00	3632.66	3051.16	£160,012.20
Grand Total	**2561.00**	**22919.30**	**20220.80**	**£1,163,611.75**

Locum Bookings (Agency) by Department	Requested Shifts	Agency Filled Shifts	Requested Hours	Agency Filled Hours	Estimated Cost
⊞ Neuro & MSK Division	14	14	112	112	£9,667.35
Grand Total	**14**	**14**	**112**	**112**	**£9,667.35**

2. BY GRADE: Commonest grade is F2

Locum Bookings (Bank) by Grade	Requested Shifts	Requested Hours	Filled Hours	Estimated Cost
⊞ Locum CF	384	3416.67	2990.17	£155,687.35
⊞ Locum F1	49	495.52	367.52	£20,108.60
⊞ Locum F2	1400	12378.97	10894.47	£563,764.70
⊞ Locum Senior CF	2	17.5	17.5	£977.50
⊞ Locum ST3+	726	6610.64	5951.14	£423,073.60
Grand Total	**2561**	**22919.3**	**20220.8**	**£1,163,611.75**

Locum Bookings (Agency) by Grade	Requested Shifts	Agency Filled Shifts	Requested Hours	Agency Filled Hours	Estimated Cost
⊞ Locum ST3+	14	14	112	112	£9,667.35
Grand Total	**14**	**14**	**112**	**112**	**£9,667.35**

3. BY REQUEST REASON – Commonest reasons are vacancy and then additional capacity

Locum Bookings (Bank) by Request Reason	Requested Shifts	Requested Hours	Filled Hours	Estimated Cost
Additional Capacity	926	8146.89	7105.89	£428,958.15
Annual Leave	58	497.75	471.75	£30,571.25
Bank Only Paid Study Day	2	6	3	£270.00
Bereavement Leave	2	19	19	£872.50
Covid 19	83	851.5	808	£39,975.00
Sickness	159	1603.79	1415.29	£89,129.25
Study Leave	12	123	123	£5,677.50
Vacancy	1241	11253.45	9861.45	£542,297.50
Waiting List Initiative	75	395.75	395.75	£24,476.25
Supernumerary	1	12	12	£825.00
Parental Leave	2	10.17	5.67	£559.35
Grand Total	**2561**	**22919.3**	**20220.8**	**£1,163,611.75**

Locum Bookings (Agency) by Request Reason	Requested Shifts	Agency Filled Shifts	Requested Hours	Agency Filled Hours	Estimated Cost
Additional Capacity	14	14	112	112	£9,667.35
Grand Total	**14**	**14**	**112**	**112**	**£9,667.35**

Issues arising:

1. **Possible lack of awareness of process/value of exception reporting**
   - → New hyperlink to Allocate on Trust all apps intranet space – May 2021
     - Signposted via posters in Mess and PGME news letter
     - Reason why to exception report and potential benefits outlined in posters
   - →Refreshed video for junior induction for August

2. **Anecdotal evidence that exception reporting is seen as 'complaining' by some consultants and trainees**
   - →New video for educational supervisor update days recorded asking them to signpost and encourage exception reporting at their first trainee meetings
   - May need wider Trust level comms to relay Exec level support for the Exception reporting process
   - →Monthly 'You said, We did' exception reporting element to the Fri PGME news-letter

3. **Rota pattern issues discussed with the departments and HR since last Board presentation**
   A. Division of medicine rota gaps increased within the last 3 months (due to CF seasonal departure) causing increased pressure on juniors resulting in increased exception reporting for hours, lack of ability to take all annual leave and low morale.
      - →Acknowledgment of gaps and locum requests sent out by MD
      - Bank possibly exhausted as evidenced with increasing unfilled hours within medicine:

	Requested bank hours	Filled bank hours	Deficit hours
Mar	2408	2257	151
Apr	2524	2307	217
May	3028	2775	253
June	2850	2300	550

      - →Agency locum use approved for ED
      - →Comms to juniors sent out that they can get paid for up to 5 days of untaken A/L (where reasonable effort was made to take it but it could not be accommodated)
      - →CF gaps resolved for Aug within medicine
      - →Plan to look at CF posts and locum usage within medicine

   B. Haem rota – impact of shielding on small rotas possibly underestimated by Trust. Discussions re escalating for locum and cross cover arrangements

   C. Neuro ST3+ rota – no exceptions reported. E-roster highlights non-compliant with 2016 contracts for average hrs and minimum break between shifts. Survey sent to trainees to pick up perception of rota and reason for no exception reporting .
   →Rota adjusted with neuro and HR to make it compliant.

Junior Doctor Forum – Held in person and via Teams on 16/6/21

- Trial of format change after D/W junior BMA reps – Solo forum with Committee (meeting with executives) to occur 1-2 weeks after every other JDF
- Increase engagement at forums by broadening scope to include educational matters and shortening to 30mins
- Terms of reference refreshed (attached)
- Re-instate reps at for juniors doctors across all specs from August

Networking

- The Guardian is in contact by Whatsapp and Zoom with national and regional groups
- NHS-Employers remote meetings in May and June to network with them and other Guardians, plan for a webinar conference, Allocate software support and induction package for new Guardians and plan to approach NHSI to open exception reporting software design up to other developers to drive improvements and support
- BMA rep – 26/5/21 - discussion re CF numbers and contracts – 2016 T&C – NBT is an outlier in terms of large numbers of CFs

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

Summary

NBT is compliant with:

- BMA contract rules during the pandemic
- Electronic reporting system in place (eAllocate)
- Junior Doctor Forum – meetings being held as required by New Contract
- Exception Reporting Policy
- LNC involvement
- All national requirements as listed by NHS Employers

Concerns

- Unfilled gaps in junior medical and surgical rotas remain a concern.
- 1 x non-complaint rota - NEURO ST3+ - now resolved
- Are the current levels of exception reporting a true representation of junior doctor hours/breaks?
- Management of seasonal departure of CFs and the gaps that leaves on the rota

Recommendations

1. NHS Employers recommends the GOSW report to Trust Board quarterly. However, in light of the bi-monthly nature of Trust Board the GOSW asks The Board if reporting at every other Board i.e. 3 x a year is acceptable with the caveat that any urgent arising matters would be presented at the next occurring Board.
2. The Board are asked to read and note this report from the Guardian of Safe Working
3. The Board are asked to note ongoing Junior Doctor Contract changes.
4. The Board are asked what further information they would like to see presented.

Dr Lucy Kirkham, Trust Guardian for Safe Junior Doctor Working

North Bristol NHS
NHS Trust

North Bristol NHS Trust (NBT) Junior Doctors Forum (JDF)

Terms of Reference refresh - June 2021

Introduction

The 2016 junior doctor terms and conditions of service include a requirement for junior doctor forums to be set up. Principally these forums will advise the Guardian of safe working who will oversee the processes in the new contract designed to protect junior doctors from being overworked. The Guardian and Director of Medical Education in each Trust and relevant organisation shall jointly enable a nomination/election process to establish a Junior Doctors Forum (or fora) to advise them and make appropriate arrangements to enable the elected representatives time off for their activities & duties in connection with their role.

Election onto the forum will be for the period of rotation and replacements must be sought for any vacancies

Aims and Objectives of the JDF

1. **The junior doctors of the JDF primarily represent trainees* at NBT in addressing concerns pertaining to working conditions and education and training**. The Junior Doctors Forum will **support and scrutinise the work of the Guardian** to ensure that the junior doctors' working hours and conditions are effectively monitored and their contractual rights upheld. More specifically, the JDF:

   *Around 30% of the junior doctor workforce at NBT is made up of Clinical fellows. All Clinical Fellows are on the 2016 T&Cs. Clinical Fellows are given access to Allocate and encouraged to exception report in the same manner as trainees and can be outcome in the same way. Therefore Clinical Fellows will be represented at the JDF)

12

- Will take part in the scrutiny of the distribution of income drawn from fines.
- Will collaborate with the Guardian of safe working hours to devise the allocation of funds. These funds must not be used to supplement the facilities, IT provision and other resources that are already defined by HEE as fundamental requirements for doctors in training and which should be provided by the employer as standard.
- Will performance manage the Guardian. Where there are concerns regarding the performance of the Guardian, or the JDF should raise those concerns with the Trust Medical Director or the relevant director with responsibility for managing the Guardian. These concerns can be escalated to the senior independent director on the Board of Directors where they are not properly addressed or resolved

2. The JDF also supports the Guardian in his/her role within NBT by:

- Providing a **forum for ideas** and suggestions to be discussed and put forwards for consideration by the appropriate committee
- Provide **a forum for the Trust to engage with** and harness the energy and vision of junior doctors in developing and improving its services, working conditions, education and training.
- Contribute on the effectiveness of the operation of the process of exception reporting and whether any improvements are needed (appendix)

There is however no contractual requirement to widen the remit in this way
The JDF will function within its remit but may refer to the LNC Chair for guidance

Membership (Quorate *)

- ***Chair: Guardian of Safe Working**
- ***Junior doctor BMA LNC representatives**
- LNC Chair (or a another member of the LNC should there be a conflict of interest)
- ***Director of Medical Education or nominated deputy**
- ***Head of Medical HR or nominated deputy**
- ***Trust Rota Coordinator or equivalent**
- BMA Industrial Relations Officer

- ***Sufficient junior representatives** to ensure there is representation of various sub groups or Directorates within the junior doctor population covered by the forum, including but not limited to:
    - Less than full time trainees
    - Academic trainees
    - GP trainees
    - Dental trainees
- Executive Director

Meetings

1. JDF

- Meet bi-monthly (and at a minimum quarterly).
- Agenda should be circulated to members 5 working days before each meeting. Agenda items should include (not limited to):
    - Minutes of last meeting
    - Report/update from the Guardian of safe working, to include volume of exception reports, rota gaps, locum requests/use, fines levied, funds accrued
    - Feedback from Junior Doctor representatives, including specialty specific-issues
    - Disbursement of fines
    - Any other business
    - Date of next meeting

2. JDF to Executives meeting

- Representatives from the JDF will meet with a member of the Executive Board (Chief Executive or Medical Director) after every other meeting (Minimum of 3 times a year) to discuss the JDF issues and ideas.
- This meeting will be scheduled within 2 weeks of the JDF. Any urgent matters can be escalated by the GOSW and a JDF junior representative between meetings.

In addition, members/representatives of JDF will attend other meetings where the above are discussed and their input is needed. Administrative and IT support for the forum including the minutes will be provided by the Employer.

Reporting

The JDF will provide the minutes to the Local Negotiating Committee (LNC)

The Guardian will report to the Trust Board quarterly

Monitoring

The JDF will be accountable to the LNC Chair who will monitor compliance with these T&Cs

Review

Whilst the JDF establishes itself, the T&Cs will be reviewed on an annual basis initially and then every 3 years thereafter. Review must be carried out and agreed by the JLNC.

Appendix

2016 contract on Exception reporting:

Purpose

1. The purpose of exception reports is to ensure prompt resolution and / or remedial action to ensure that safe working hours are maintained. The purpose of work schedule reviews is to ensure that a work schedule for a doctor remains fit for purpose, in circumstances where earlier discussions have failed to resolve concerns.

Exception reporting

2. Exception reporting is the mechanism used by doctors to ensure compensation for all work performed and uphold agreed educational opportunities. The activities to which exception reporting applies include (but is not limited to):

a. all scheduled NHS work under this contract (e.g. any patient facing and non-patient facing activities that is required as part of the doctor's employment) and /or

b. any activities required for the successful completion of the doctors ARCP, including any additional educational or development activities explicitly set out in the doctors agreed personalised work schedule and/or

c. any activities that are agreed between the doctor and their employer, such as quality improvement, attendance at the JDF or patient safety tasks directly serving a department or wider employing organisation, and/or

d. any professional activities that the doctor is required to fulfil by their employer (e-portfolio, induction, e-learning, Quality Improvement and Quality Assurance projects, audits, mandatory training / courses)

Unless required by your employer or agreed with the educational supervisor, exception reporting does not apply to occasions where an individual may choose to undertake educational activities for personal development or career enhancing purposes which are outside of contractual requirements, the agreed personalised work schedule or are not an essential activity to pass ARCP.

3. Doctors can use exception reporting to inform the employer when their day-to-day work varies significantly and/or regularly from the agreed work schedule. Primarily these variations are likely to include (but are not limited to):

a. differences in the total hours of work (including opportunities for rest breaks)
b. differences in the pattern of hours worked
c. differences in the educational opportunities and support available to the doctor, and/or

d. differences in the support available to the doctor during service commitments.

4. Exception reports allow the employer the opportunity to address issues as they arise, and to make timely adjustments to work schedules.

5. Exception reports should include:

a. the name, specialty and grade of the doctor involved
b. the identity of the educational supervisor
c. the dates, times and durations of exceptions
d. the nature of the variance from the work schedule, and
e. an outline of the steps the doctor has taken to resolve matters before escalation (if any).

6. The reviewal process for exception reports must be locally agreed by; the Guardian of Safe Working Hours, the JDF, and the Joint Local Negotiating Committee. Regardless of the reviewal process that is agreed, all reports should be copied to a trainee's educational supervisor irrespective of whether the educational supervisor is required to action the type of report.

a. When deciding who should be the actioner for the different types of report, consideration should be given to ensure the actioner is appropriate with significant insight into issues raised and be able to propose suitable resolutions.

b. In any locally agreed review process, it should not be a requirement for an in-person meeting between the doctor submitting the report and the report's actioner, to be held for all individual exception reports, except for reports relating to; educational issues, service support, or immediate safety concerns. However, a doctor or the actioner of a report, must be able to request a meeting to discuss any report they submit, or receive.

North Bristol NHS Trust

Report To:	Trust Board Meeting		
Date of Meeting:	29th July 2021		
Report Title:	Annual Medical Revalidation and Appraisal Report		
Report Author & Job Title	Nick Standen, Medical Revalidation & Job Planning Manager Dr Monica Baird, Deputy Medical Director & Revalidation Lead		
Executive/Non-executive Sponsor (presenting)	Dr Chris Burton		
Does the paper contain: [enter a X in any box applicable box]	**Patient identifiable information?**	**Staff identifiable information?**	**Commercially sensitive information?**
*If any boxes above ticked, paper may need to be received at *private* meeting			
Purpose: [enter a X in the correct box]	**Approval**	**Discussion**	**To Receive for Information**
	X		**X**
Recommendation:	The board are asked to review the content of the report for information and sign the statement of compliance in Appendix A		
Report History:	Last report provided on 20th September 2020		
Next Steps:	Approve & sign the statement of compliance in Appendix A for return to NHS England		

Executive Summary

North Bristol Trust is the designated body supporting the revalidation of 776 non-training grade doctors and the annual appraisal of 784 non-training grade doctors. Well established processes are in place to quality assure the appraisal process and to identify doctors who have missed their appraisals.

The medical appraisal year runs from April – March which is set by NHS England. This report refers to the 2020/21 appraisal year which ended on the 31st March 2021.

The Trust's appraisal systems were last inspected by NHS England in September 2015 and received an "Excellent" rating in all domains. A shorter visit took place by NHS England in February 2017. The NHS England team were happy with the current progress with no recommendations made as a result. KPMG are expected to audit the processes in 2021.

Strategic Theme/Corporate Objective Links	**2. Developing Healthcare for the future** a. Training, educating and developing our workforce b. Increase our capability to deliver research c. Support development & adoption of innovations **3. Employer of choice** a. A great place to work that is diverse & inclusive b. Support our staff to continuously develop c. Support staff health & wellbeing
Board Assurance Framework/Trust Risk Register Links	Revalidation is a legal requirement for all GMC licenced doctors. Failure to comply with the revalidation requirements can put the doctor's licence to practice at risk and result in suspension from work. This paper describes the processes in place to support doctors at NBT in their revalidation.
Other Standard Reference	N/A
Financial implications	N/A
Other Resource Implications	Sufficient resource is available to fulfil the requirements of appraisal and revalidation at NBT
Legal Implications including Equality, Diversity and Inclusion Assessment	• Revalidation is a legal requirement for doctors registered with a GMC licence to practice. • Diversity information is not collected within the appraisal and revalidation system.

Appendices:	NHSE Statement of compliance – Appendix A

13

Contents

1. Introduction

Legislation supporting the licencing of doctors (Revalidation) was introduced in April 2013.

At the 31st March 2021; 776 doctors had a prescribed GMC connection to North Bristol NHS Trust meaning that NBT is their designated body for the purposes of medical revalidation. Each year every doctor must complete an appraisal that meets GMC requirements.

NBT supports appraisal and revalidation for consultants, academics, clinical fellows, specialty doctors, associate specialists and Trust locums. Doctors in training grades maintain a connection to Health Education England for revalidation.

In addition to the 776 mentioned above, there are a further 8 doctors who complete annual appraisals at NBT but maintain a connection to another designated body in line with GMC designated body rules.

There are also a further 28 doctors who are registered for an appraisal at NBT but cannot be added to the Trusts designated body due to being granted temporary licences for covid support. These 28 doctors are not subject to GMC revalidation. They have been offered the chance to have an appraisal discussion around their workload and wellbeing which they can choose to take up or not at present.

2. Purpose of the Paper

This paper is to inform the Trusts board that the processes in place for medical appraisal and revalidation are robust and that doctors are compliant with the GMC rules. NHS England have produced a *Framework of Quality Assurance for Responsible Officers and Revalidation*. This report provides assurance that the Trust meets these requirements.

Under normal circumstances this report would be used to communicate the results of an NHSE annual organisational audit to enable the Trust Board to sign a statement of compliance that must be returned to NHS England. Due to Covid-19, the annual organisational audit is not required however appraisal numbers within the year have still been provided within this paper. A statement of compliance is still required for return to NHSE which has been included within Appendix A.

13

Section 1 – Medical Appraisals

The appraisal process

Medical appraisal compliance is captured on an annual basis with each appraisal year running from 1st April - 31st March. All doctors have an annual appraisal due date and in a normal year, they must complete their appraisal by the due date to ensure that they complete an appraisal each year. Appraisals may be missed for circumstances such as maternity or long term sick leave.

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

Appraisals during the pandemic

On the 20th March 2020 the medical appraisal process was suspended due to the pandemic to allow doctors additional time. NHS England confirmed that appraisals suspended during this period will be regarded as cancelled and not postponed. The process restarted again at the end of June 2020.

As the process restarted, all doctors were encouraged to hold an appraisal however this was not mandatory and the doctor could cancel their appraisal if they were unable to complete this due to the pressures of responding to the pandemic. Any cancelled appraisals were marked as an approved missed appraisal.

The appraisal process restarted with a 'light touch' approach to portfolio preparation which was supported by NHSE. Doctors were given permission to undertake an appraisal without the usual range of CPD and quality improvement evidence in their portfolio. This information would instead, be discussed and reflected upon verbally during the appraisal meeting. GMC statements and declarations were still required in the doctor's portfolio along with any details of involvement in any complaints and incidents. Appraisers were asked to focus more on the wellbeing of the doctor and discussing the impact the pandemic had on the doctor's workload.

This new light touch approach to appraisal preparation meant that the doctor could spend less time preparing a portfolio prior to the appraisal which would be discussed in more detail during the meeting. Appraisers were advised to ensure that they had documents the appraisal discussion in detail within the appraisal outputs.

The process of appraisal continued throughout the 2020/21 appraisal year and was approved for revalidation by the GMC. NHSE has decided to continue to support the use of this appraisal process throughout the next year.

The appraisal process became mandatory for all NBT doctors again from the 1st April 2021. Any appraisals due prior to this date could still be marked as an approved missed appraisal if they did not take place. The light touch approach to appraisal preparation remains in place for all mandatory appraisals due from the 1st April 2021 onwards.

2020/21 Appraisal Compliance

The below table shows the medical appraisal rates at the 31st March 2021. These numbers cover the year April 2020 – March 2021 while appraisals were recommended but not mandatory.

Directorate	Nº of Doctors	Appraisals due in 2020/21 year	Completed appraisals	Approved Covid missed appraisal	Incomplete appraisal	% Appraisal compliance
ASCR	280	272	215	35	22	**92%**
Core Clinical Services	86	84	65	13	6	**93%**
Medical Education	11	11	9	2	0	**100%**
Medicine	207	205	140	29	36	**82%**
MSK-Neuro	156	151	120	13	18	**88%**
Womens and Childrens	44	44	30	5	9	**80%**
Total	**784**	**767**	**579**	**97**	**91**	**88%**

- 784 doctors were registered for an appraisal on the system at the 31st March 2021
- 767 doctors were due to have an appraisal within the year
- 579 doctors completed an appraisal either with NBT or with their previous employer prior to joining the Trust
- 97 doctors requested an approved missed appraisal due to the pressures of the pandemic
- 91 appraisals remained incomplete at the end of the year. These doctors all expressed an interest to complete their appraisal within the year. These appraisals will be counted towards an approved missed appraisal due to the pandemic if they are not completed.
- There are a further 17 doctors not included within these numbers:
    - 11 doctors are not required to complete an appraisal due to long term leave (sickness or maternity) and new to UK doctors
    - 6 doctors are new employees and we await their previous appraisal information

- The 28 doctors with temporary GMC licences to support the pandemic are not included in these numbers. Their appraisals are optional.

Previous Appraisal Years

The below table presents the appraisal compliance from previous years. The number of doctors requiring an appraisal at NBT has risen each year and now stands at 812.

Appraisal Year	No. of doctors due an appraisal	% of appraisals completed
*2019/20	617	94%
2018/19	707	92%
2017/18	667	92%
2016/17	636	89%
2015/16	636	88%
2014/15	575	87%
2013/14	519	87%

*Year incomplete due to the pandemic. 812 doctors were due for the whole year.

Section 2 – Quality Assurance

Revalidation Team / RO

NHSE require that an appropriately trained licensed medical practitioner is nominated or appointed as a responsible officer.

The revalidation team at NBT consists of:

- Responsible Officer: Dr Chris Burton, Medical Director
- Deputy Medical Director & Revalidation Lead: Dr Monica Baird
- Revalidation Support Manager: Nick Standen (part time)
- Revalidation Support Administrator: Helen Booth (part time)

Dr Burton & Dr Baird have received the appropriate training for the Responsible Officer Role

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

Funding

NHSE require the designated body to provide sufficient funds, capacity and other resources for the responsible officer to carry out the responsibilities of the role.

Funding is provided from the Trusts Medical HR budget (B41768) to cover the cost of the electronic appraisal system (Fourteen Fish), CPD training for medical appraisers and the salary for the Revalidation Support Manager.

Designated Body Connection

NHSE require that an accurate record of all licensed medical practitioners with a prescribed connection to the designated body is always maintained.

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

Doctors joining NBT:

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

When a doctor joins the Trust, a request is sent to the individual doctor's previous designated body to identify the date of the doctor's most recent appraisal and details of any concerns relating to the individual. Returned forms are inserted into the individuals NBT appraisal portfolio for the doctor to access and any details of concerns are shared with the Trusts RO. Where a doctor has come from a training post with Health Education England, a copy of the doctors recent ARCP is requested in place of a request to their previous designated body.

Doctors leaving NBT:

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

Policies

NHSE require that all policies in place to support medical revalidation are actively monitored and regularly reviewed. That there is a medical appraisal policy in place that is compliant with national policy and has received the Board's approval (or by an equivalent governance or executive group).

The NBT appraisal and revalidation policy and user guide was recently updated and signed off by the Joint Local Negotiating Committee (JLNC) in 10th May 2021. All other Trust policies that link with the medical appraisal process are monitored and updated on a regular basis as part of usual review process.

Processes Review

NHSE require a peer review to be undertaken of this organisation's appraisal and revalidation processes. That the appraisal system in place for the doctors in the organisation is subject to a quality assurance process and the findings are reported to the Board or equivalent governance group.

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

NHS England also conducted a review (independent verification visit) of the Trusts appraisal and revalidation processes in September 2015. The review provided an 'Excellent' outcome which meets all core standards.

A shorter visit took place by NHS England in February 2017. The NHS England team were happy with the current progress with no recommendations made as a result. The Trust will be conducting an internal audit, supported by KPMG, of the revalidation and appraisal processes. This was due to begin in December 2020 but due to the pandemic, has been pushed back to a later date to be confirmed in 2021.

Locum / Short Term Placements

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

Doctors employed in short fixed term contracts or via the Trusts internal locum bank are provided with an appraisal portfolio and access to a medical appraiser if their employment status meets the GMC rules for access to the Trusts designated body. The appraisal is expected to meet the same standard as it does for substantive employees.

Appraisal Compliance

The Trusts appraisal system Fourteen Fish was procured in March 2019 following a lengthy tender process. This system has been purchased along with University Hospitals Bristol NHS Foundation Trust (UHB) and Weston Area Health NHS Trust (now jointly UHBW) on a 5 year contract with a possibility to extend by a further 2 years.

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

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

1. Medical Appraisal & Revalidation figures report

Issued to the Responsible Officer / Deputy Responsible Officer / Trust People Business Partners / Divisional Clinical Directors / Information Management Department.

The report highlights the following:

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

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

- Rolling % of doctors, who completed an appraisal within the past 12 months including any missed appraisals
- Breakdown of the missed appraisals
- Total number of revalidation recommendations made in each of the past 12 months.
    a. No. of positive recommendations
    b. No. of deferrals
    c. No. of non-engagement recommendations

2. Missed appraisal report

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

The report details all the individual doctors who have passed their appraisal due date without a completed appraisal or any reasons given for the delay.

Where an appraisal is missed and highlighted in the above report there is an escalation process in place as detailed below. This ensures that within any 15 month period all doctors will have either completed their appraisal or been referred to the GMC for a final deadline.

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

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

In the 2020/21 appraisal year, this escalation process was placed on hold during the pandemic. The process is due to restart in July 2021.

Since the introduction of revalidation in 2013, two doctors have failed to meet the final GMC deadline, triggering the process to remove their licence to practice.

<u>Quality assurance of appraisals</u>

- Fourteen Fish allows the appraisal conversation to be summarised and captured electronically providing an audit trail of each individual step in the process
- An appraisee is required to make mandatory pre-appraisal probity statements in the system
- The appraisal inputs are required to be submitted to the appraiser prior to the date of appraisal. This provides the appraiser with sufficient time to review the content and return the form for editing if necessary.

- Information from private practice is expected to be included in an appraisal and everyone is provided with a form to complete for this. Appraisers are aware of the requirement for this and will not progress the appraisal until the information has been provided.
- Any information that the Responsible Officer deems appropriate for inclusion into a doctor's appraisal is also sent to the Revalidation Support Manager to upload to the system. This is placed in the system with mandatory reflection required. This may include letters of advice sent as a result of disciplinary processes etc.
- 360 feedback is collected through the Fourteen Fish system which provides anonymous reports meeting GMC guidance for feedback
- The Deputy RO reviews all appraisals before making a revalidation recommendation. Examples of good practice and opportunities for improvement are fed back to appraisers and appraisees at this stage.

For the appraisers:

- Appraisers are required to reflect on their performance as an appraiser during their own appraisal. As part of completing an appraisal, the appraisee is required to complete an online questionnaire about the performance of their appraiser.
- Appraisers will also attend appraiser half day training days annually which will provide CPD and appraiser networking which will feed into their own appraisals.

For the organisation:

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

<u>Appraisers</u>

NHSE require that the designated body has the necessary number of trained appraisers to carry out timely annual medical appraisals for all its licensed medical practitioners.

The number of appraisers required to support revalidation is monitored within each division based on the division's number of appraisees. It is based on an appraiser conducting a minimum of five appraisals per year and a maximum of 10 per year for which they receive 0.25 SPA per week.

New appraiser training is provided where a drop in the number of appraisers in a division occurs or the number of appraisees rises. In January 2021 new appraiser training was provided for 5 NBT doctors. The training was provided by an external independent trainer approved for use by NHSE and the content of the training course had been reviewed by the revalidation support team to ensure it met the expected requirements. Further training will be provided later in 2021.

NHSE also require appraisers to participate in ongoing performance review and training/ development activities, to include attendance at appraisal network/development events, peer review and calibration of professional judgements

Existing appraisers are expected to attend a half day update training session each year facilitated by an external trainer/coach or internally at NBT. The training days are supported by the Deputy Responsible Officer and the Revalidation Support Manager. The 2020/21 sessions were run by the Trusts medical wellbeing team and focused on methods to discuss mental health and wellbeing with appraisees in light of the pandemic during appraisals. The next sessions have been postponed by covid and expected to start in late 2020. Two further courses are planned for later in 2021.

Section 3 – Recommendations to the GMC

Revalidations during Covid

On the 17th March 2020 all revalidations due prior to the end of September 2020 were automatically deferred for 12 months by the GMC due to Covid-19. This was put in place to free up time for both doctors and the Trusts Responsible Officer and Revalidation lead. In June 2020 the GMC then automatically deferred all remaining revalidations due prior to the 16th March 2021 for 12 months.

Due to these automatic deferrals, the number of revalidations due in 2021/22 has now risen significantly. Data produced at the end of June 2021 shows that there are still 151 doctors approaching revalidation in the 2021/22 year. A further 96 doctors who were due to revalidate in the 2021/22 year have now had a positive recommendation made to the GMC. The revalidation support team are continuing to work through all portfolios for doctors revalidating in 2021 and chasing doctors for outstanding information.

Timely Recommendations

NHSE require that timely recommendations are made to the GMC about the fitness to practise of all doctors with a prescribed connection to the designated body, in accordance with the GMC requirements and responsible officer protocol.

In order to make timely recommendations to the GMC, the list of revalidation recommendations that are due are reviewed via the GMC Connect website and the Fourteen Fish system. The Revalidation Support Administrator & Manager reviews each doctor's portfolio in advance and provides the RO & Revalidation Lead with a suggested recommendation.

The RO and Revalidation Lead then make a final decision which is returned to the GMC online. The number of revalidation recommendations due each year is listed below.

Appraisal Year	Revalidations Due	Positive	Deferral	Non-Engagement	% Deferrals Made
2021/22	247	96 (so far)	-	-	**-**
2020/21	Postponed - Covid	N/A	N/A	N/A	**N/A**
2019/20	231	170	60	1	**26%**
2018/19	145	108	37	0	**26%**
2017/18	45	35	9	1	**20%**
2016/17	44	32	12	0	**27%**
2015/16	202	172	30	0	**15%**
2014/15	189	164	25	0	**13%**
2013/14	96	86	10	0	**10%**

The majority of deferrals are due to incomplete colleague and patient feedback. The revalidation support team are working with Fourteen Fish to develop a new method of engaging doctors with their feedback earlier in the revalidation cycle to reduce the number of deferrals due to lack of feedback.

Communicating Recommendations

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

When a positive recommendation is made, the doctor is notified in writing by the Trusts Revalidation Lead. As a doctor's portfolio is reviewed in advance of their revalidation date, the individual is notified of any gaps in their portfolio which may result in a deferral. The doctor is notified by the Trusts revalidation lead or Support Manager in advance of making a deferral. In the case of a non-engagement recommendation, the Trusts revalidation team will exhaust all of their internal communications to the doctor (including a face to face meeting) before advising them of the decision. The GMC also send confirmation of a revalidation decision to the doctor once it has been made.

Section 4 – Medical Governance

Steering Group

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

System Access

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

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

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

Appraisal supporting information

NHSE require that NBT have effective systems are in place for monitoring the conduct and performance of all doctors working in our organisation and all relevant information is provided for doctors to include at their appraisal.

Where a doctor is involved in a formal concern or investigation, the RO may wish to ensure that information is included in the doctor's appraisal for discussion and reflection. In this circumstance, the RO will pass information to the Revalidation Support Manager to upload into the doctor's appraisal portfolio. The doctor will be notified of this.

The Revalidation Support Team no longer input the details of complaints and incidents into doctors' portfolios for appraisals, however this information is available to all doctors employed in the Trust. The Fourteen Fish system also requires statements from each doctor as mandatory before the appraisal can continue.

Responding to Concerns

NHSE require that there is a process established for responding to concerns about any licensed medical practitioner's fitness to practise, which is supported by an approved responding to concerns policy that includes arrangements for investigation and intervention for capability, conduct, health and fitness to practise concerns.

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

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

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

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

NHSE require that system for responding to concerns about a doctor is subject to a quality assurance process and the findings are reported to the Board or equivalent governance group. Analysis includes numbers, type and outcome of concerns, as well as aspects such as consideration of protected characteristics of the doctors.

The Medical Decision Making group is guided by the Just Culture policy at NBT. The Board receives a regular report detailing all doctors who are in or have recently left an MHPS process.

NHSE require that safeguards are in place to ensure clinical governance arrangements for doctors including processes for responding to concerns about a doctor's practice, are fair and free from bias and discrimination

Concerns raised about a doctor's practice may be received through appraisal, revalidation, morbidity and mortality, and many other routes. The response to concerns will depend on the nature of the concerns. If serious these concerns may be managed through the DMG and an MHPS process as above although this is highly unusual.

Transferring Information

NHSE require that there is a process for transferring information and concerns quickly and effectively between the responsible officer and other responsible officers (or persons with appropriate governance responsibility) about doctors connected to NBT who also work in other places, doctors connected elsewhere but who also work in our organisation.

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

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

Section 5 – Employment Checks

Recruitment

NHSE requires that NBT has a system in place to ensure the appropriate pre-employment background checks are undertaken to confirm all doctors, including locum and short-term doctors, have qualifications and are suitably skilled and knowledgeable to undertake their professional duties.

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

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

Section 6 – Summary of Comments and Overall Conclusion

Developments over the 2020/21 year

- A sufficient relaxation in appraisal compliance allowed doctors to focus more on the pandemic
- The Fourteen Fish system has been adapted quickly to the new light touch approach for appraisals. Appraisers were given an option to learn more about this process.
- Appraiser CPD sessions have been run to focus on tackling wellbeing during medical appraisals
- New appraisers continued to be trained in the role
- New Revalidation Lead in post
- Various upgrades & improvements have been made to the Fourteen Fish system which is now in its 3rd year at NBT
- Medical Revalidation & Appraisal policy has been reviewed and updated

Developments for the 2021/22 year

- Return all appraisals to a mandatory process following the pandemic. The escalation process is expected to restart in July 2021.

- The Revalidation Support Manager will be stepping away from the role for a minimum 12 month period. Sufficient backfill will be required.

- Run further appraiser CPD sessions on wellbeing

Overall conclusion

Sufficient processes, funding and support is in place to run the medical revalidation process to meet the required standards. The 2020/21 year saw a big change in the way appraisals were conducted for doctors which is set to continue. The system was adjusted to meet national guidance and has been well received by most.

A record of all approved missed appraisals during the pandemic has been maintained in the system and the process is now back to a mandatory status. Another significant change to the process saw the removal of central reports being added to appraisal portfolios. It is unclear yet whether this process will restart.

If the board are satisfied with this report, the statement of compliance in Appendix A will need to be signed and returned to NHSE.

Appendix A

NHSE Statement of Compliance

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

Signed on behalf of the designated body

Chief executive or Chairman

Official name of designated body: North Bristol NHS Trust

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

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

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

Report To:	Trust Board		
Date of Meeting:	29 July 2021		
Report Title:	Patient & Carer Experience Committee Report		
Report Author & Job Title	Kate Debley, Deputy Trust Secretary		
Executive/Non-executive Sponsor (presenting)	Kelvin Blake, Non-Executive Director and Committee Chair		
Purpose:	**Approval**	**Discussion**	**To Receive for Information**
			X
Recommendation:	The Trust Board is recommended to receive the report for assurance.		
Report History:	The report is a standing item to each Trust Board meeting following a Patient & Carer Experience Committee meeting.		
Next Steps:	The next report to Trust Board will be to the September 2021 meeting.		

Executive Summary	
The report provides a summary of the assurances received, issues to be escalated to the Trust Board and any new risks identified from the Patient & Carer Experience Committee Meeting held on 21 July 2021.	
Strategic Theme/Corporate Objective Links	1. **Provider of high quality patient care** a. Work in partnership to deliver great local health services b. A Centre of Excellence for specialist healthcare 2. **Developing Healthcare for the future** a. Training, educating and developing our workforce 3. **Employer of choice** a. Empowered clinically led teams b. Support our staff to continuously develop 4. **An anchor in our community** a. Create a healthy & accessible environment
Board Assurance Framework/Trust Risk Register Links	Reports received support the mitigation of the following BAF risks: N/A
Other Standard Reference	Care Quality Commission Standards.

Financial implications	No financial implications as a consequence of this report.
Other Resource Implications	No other resource implications as a result of this report.
Legal Implications including Equality, Diversity and Inclusion Assessment	No legal implications
Appendices:	None

1. Purpose

To provide a highlight of the key assurances, any escalations to the Board and identification of any new risks from the Patient & Carer Experience Committee meeting held on 21 July 2021.

2. Background

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

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

3. Key Assurances & items discussed

3.1 Trust Board should note that due to current operational pressures within the Trust, two items were stood down from the planned agenda and deferred to the September meeting as follows:

- Patient/Carer Story on Volunteer Services.
- Report on the Urgent and Emergency Care Survey 2020.

3.2 <u>Shared Decision Making and Consent</u>
The Committee received a presentation on shared decision making and consent projects.

In relation to consent, the Committee heard that in the majority of cases consent forms are handwritten and there is a reliance on medical terminology and acronyms which many patients do not understand. This process is also time-consuming for clinicians, who are required to repeatedly enter the same information for the most commonly undertaken procedures.

The Committee were provided with a demonstration of a new digital consent form that has been developed by a consultant neurosurgeon and which is now being rolled out to seven further specialties across the Trust. The first section of the form automatically populates standard risks for specific procedures in an easy to read and understandable digital format which can also be personalised for individual patients as appropriate. The second section of the form is completed by the patient in order that the clinician can understand the key issues and concerns that are most important to them. The Committee heard that this process allows for most of the consent process to be completed in advance of the procedure, meaning that on the day the clinician is able to focus on the elements that are most important to the patient.

In parallel with the work on consent, the Committee heard about a shared decision-making research project, led by the Bristol Biomedical Research Centre, which enables patient feedback on the consent process to be received and acted upon in real-time.

The Committee were reassured that, whilst the scale of the project is very large, incremental steps are being taken with roll out to a limited number of specialties at a time over the next eighteen months. It was further noted that this work would also be undertaken in conjunction with the Electronic Patient Record project.

The Committee welcomed this work, noting that it would improve communication with patients and enable a clearer understanding of treatments and pathways which may consequently lead to better outcomes.

3.3 Complaints and Concerns Annual Report

The Committee reviewed the Complaints and Concerns Annual Report and it was noted that that for the second consecutive year the number of complaints received by the Trust had fallen. It was acknowledged that a decrease in activity due to the Covid pandemic was likely to have been a factor in this and the Committee heard that as expected, an increase in complaints was now being seen. The Committee asked for analysis to be undertaken into the numbers of complaints being received by specific services, noting that this may provide opportunities for shared learning.

The Committee welcomed the relaunch in November 2020 of the Complaints Lay Review Panel. The Panel is made up of several patient representatives who review and audit a selection of complaints against the Patient Association's principles for good complaints handling as well as the Trust's internal procedure.

The Committee also discussed the complaints response process, noting that this involves an initial draft being prepared by the clinician, which is then finalised by a complaints manager. Clinicians in attendance at the meeting noted their experience that this process can sometimes result in some of the original meaning and intent of a response becoming lost, whilst acknowledging that there are also benefits to involving

individuals in the process who have expertise in wording responses in a positive way. It was felt that increased access to complaints training for clinicians would help reduce the requirement for substantial editing of initial drafts.

The Committee noted that to date formal complaints training has not been widely available for clinicians, but were reassured that training will be an area of focus in the coming year for the Complaints team and that this will also link with Just Culture work being carried out by the Patient Safety and Learning and Development teams.

3.4 Patient Experience Risk Report

The Committee reviewed the Patient Experience Risk Report, noting and discussing all new and high level risks. The Committee asked that the Patient Experience Manager undertake a review of all current risks to ensure that they are still valid from a patient experience perspective.

3.5 Patient Experience Group Highlight Report

The Committee received a highlight report from the Patient Experience Group. The active role of the Patient Partnership Group was noted and welcomed by the Committee and it was agreed that future highlight reports should include a report on activities from the Group's Chair.

3.6 Additional updates received on:

- Learning Disability & Autism Steering Group Highlight Report
- Integrated Performance Report – Quality Section (June data)

4. Escalations to the Board

4.1 No risks or items of concern were identified for escalation to Trust Board.

5. Recommendations

5.1 The Board is recommended to receive the Report for assurance.

14

Report To:	Trust Board - Public		
Date of Meeting:	29 July 2021		
Report Title:	Quality & Risk Management Committee Upward Report		
Report Author & Job Title	Xavier Bell, Director of Corporate Governance & Trust Secretary Isobel Clements, Senior Corporate Governance Officer & Policy Manager		
Executive/Non-executive Sponsor (presenting)	John Iredale, Non-Executive Director and Chair of QRMC		
Does the paper contain:	**Patient identifiable information?**	**Staff identifiable information?**	**Commercially sensitive information?**
*If any boxes above ticked, paper to be received at *private* meeting			
Purpose:	**Approval**	**Discussion**	**To Receive for Information**
	X		**X**
Recommendation:	The Trust Board should receive the report for assurance and note the activities QRMC has undertaken on behalf of the Board; and Approve the Quality Account 2020/21 final draft attached at Appendix 1.		
Report History:	The report is a standing item to the Trust Board following each Committee meeting.		
Next Steps:	The next report will be received at Trust Board in September 2021.		

Executive Summary
The report provides a summary of the assurances received and items discussed and debated at the Quality and Risk Management Committee (QRMC) meeting held on 15 July 2021.

Strategic Theme/Corporate Objective Links	**Provider of high-quality patient care** a. Experts in complex urgent & emergency care b. Work in partnership to deliver great local health services c. A Centre of Excellence for specialist healthcare d. A powerhouse for pathology & imaging **Employer of choice** e. A great place to work that is diverse & inclusive f. Empowered clinically led teams

	g. Support our staff to continuously develop h. Support staff health & wellbeing
Board Assurance Framework/Trust Risk Register Links	Link to BAF risk SIR14 relating to clinical complexity, risk COV 2 relating to overwhelming effects of Covid-19 locally and risk SIR1 relating to lack of capacity affecting performance and patient safety.
Other Standards Reference	CQC Standards.
Financial implications	No financial implications identified in the report.
Other Resource Implications	No other resource implications identified.
Legal Implications	None identified.
Equality, Diversity and Inclusion Assessment (EIA)	Process TBC
Appendices:	Appendix 1: Quality Account 2020/21 final draft

1. Purpose

1.1. To provide a highlight of the key assurances received, items discussed, and items for the attention/ approval of Trust Board from the QRMC meeting held on 15 July 2021.

2. Background

2.1. The QRMC is a sub-committee of the Trust Board. It meets bi-monthly (additional deep-dive meetings scheduled for October 2021 and February 2022) and reports to the Board after each meeting. It was established to provide assurance to the Trust Board on the effective management of quality governance and risk management.

3. Meeting on 15 July 2020

3.1 Quality Account 2020/21 – Final with external stakeholder comments

The Committee received an update on the final version, including a verbal update on external stakeholder responses. The feedback was constructive and positive and the Committee posed some questions which will be considered, and a response provided both directly to the stakeholder and within the Quality Account.

It is recommended that Trust Board approve the Quality Account 2020/21 provided at Appendix 1.

3.2 Quality Strategy – Quality Plan 2021/22

The Committee received an update on the planning undertaken for 2021/22, aligned the NBT's priorities. Work is ongoing to further develop the details sitting behind some of the programmes including appropriate resourcing. The Committee will receive regular updates on the progress of the plan.

3.3 CQC Assurance Report

The Committee received a short summary of the new CQC strategy launched in 2021. Next steps will include a review by the CQC of their Key Lines of Enquiry and focus on being able to respond more swiftly when data flags a concern at a provider. The Committee also had sight of and discussed the most recent CQC Insight Data.

The CQC's next engagement visit will be to Maternity Services in August 2021.

3.4 Tissue Viability Annual Report

The Committee received the annual report which summarised the work undertaken at the Trust to manage pressure injuries during 2020-2021. The Committee welcomed the report, which provided a great deal of assurance and showed a substantial reduction in pressure injuries over the 12-month period. The Committee acknowledged the successes of the team and thanked them for their ongoing work.

3.5 Maternity:

The Committee was joined by the Interim Divisional Director of Nursing and Interim Divisional Operations Director for Women & Children's Division.

Maternity Safety Dashboards

The Committee reviewed the dashboard and received an update on work to continue to improve the data. The Committee were also updated on two incidents that took place and the learning opportunities identified.

The Committee reviewed the dashboard overall and noted in particular staffing gaps and pressures. The team acknowledged this and updated the Committee on the action being taken to engage with staff and provide forums for them to provide feedback and to receive support, as well as the improvement programme that has now formally launched.

The Committee also specifically discussed the shortfall in Consultant-led ward rounds on the weekend and confirmed that this had been acknowledged in the Trust's Ockenden compliance submission. The Committee was reassured that a business case was under development to deal with the weekend gaps.

The Committee challenged the team on whether the aim to complete a workforce/staffing review by November 2021 was sufficiently urgent, given the known issues and national focus on this area. The team committed to providing some additional clarity on the various staffing gaps and confirmed that a business case for consultant gaps would progress within the next two weeks.

The Committee were partially reassured by the discussion with the divisional team but reiterated the need for more clarity and detail in workforce review and improvement plans.

Trust Board receives the Perinatal Quality Surveillance Tool Dashboard (referred to as the Maternity Dashboard within this report) monthly within the 'Safety and Effectiveness' section of the Integrated Performance Report.

Ockenden Review Report – Actions

An update was provided on the Trust's progress against the actions identified in the Ockenden Review.

3.6 Breast Cancer Service Review

The Committee was joined by Michelle Mullan, Consultant Breast Surgeon

The Committee received an update on the issues that have caused the performance challenges, alongside the recovery actions that are being taken to recover to meet the standard and reduce clinical risk introduced by a delay in the pathway.

The Committee were also advised that this increased referral rate had not resulted in any increase in the rates of cancer being detected, and that clinically there was no risk of worse outcomes for the delayed patients (waiting 24 days instead of 14), acknowledging the anxiety and wellbeing impact of having to wait longer.

The Committee noted that one of the main drivers was a lack of Breast Radiologist capacity nationally, alongside a massive increase in referrals, and that support and mutual aid from partners was being sought.

The Committee was reassured that the number of waiting patients had reduced, and that there are actions in train aimed at mitigating the risk and changing workforce and pathway delivery to enable recovery and a sustained position. The waiting time is expected to return to 14 days by the third week of July.

3.7 Sub-committee upward report(s): Clinical Effectiveness & Audit Committee; Patient Safety & Clinical Risk Committee; and Drugs & Therapeutics Committee

The Committee received upward reports from its sub-groups. Under the Clinical Effectiveness & Audit Committee report, the Medical Director provided a brief update on the outstanding actions from the Avon Breast Screening Service Quality Assurance Visit from 2019. The four outstanding actions are being progressed with Executive input, liaising with system partners as appropriate.

3.8 Risk Registers

The Committee reviewed the Trust Level risk register, the mass vaccination risk register and relevant risks from the Board Assurance Framework.

3.9 Infection Prevention Control Board Assurance Framework:

The Medical Director presented the updated framework, noting that NBT's IPC processes are strong, but flagging possible confusion on national announcements relating to Covid-19 regulations and guideline changes. NBT will continue to comply with PHE guidelines for hospitals, which will see social distancing and facemasks remaining in place.

3.10 Other items:

The Committee also received updates on:

- Quality Performance Report;
- QRMC forward work-plan 2021/22.

4. Identification of new risk & items for escalation

None identified.

5. Recommendations

The Trust Board should receive the report for assurance and note the activities QRMC has undertaken on behalf of the Board; and

Approve the Quality Account 2020/21 final draft attached as Appendix 1.

Report To:	Trust Board		
Date of Meeting:	29th July 2021		
Report Title:	Quality Account (2020/21) – Final draft for review		
Report Author & Job Title	Paul Cresswell, Associate Director of Quality Governance		
Executive Sponsor (presenting)	Helen Blanchard, Director of Nursing & Quality		
Purpose:	**Approval**	**Discussion**	**To Receive for Information**
	X		
Recommendation:	The Trust Board is requested to: • **Note** the positive comments of the external stakeholders and the Trust's response to comments from Bristol City Council • **Approve** this final version for publication on NHS Choices and the NBT external website.		
Report History:	The first draft was presented to the TMT, QRMC and Trust Board in June 2021. All comments and requested changes were incorporated in the final draft which was approved by the QRMC 15.07.21 and TMT 20.07.21 prior to presentation to the Trust Board for final approval and sign off for publication.		
Next Steps:	• Publish on Trust website and NHS Choices by 31.07.21.		

Executive Summary

Quality Account 2020/21

Following a late national decision to avoid temporary regulatory changes, the statutory publication timescale of 30th June 2021 has not been extended again this year as originally advised. The requirement for an external audit of the Quality Account has however been waived, as last year, and will be an optional requirement going forward.

North Bristol Trust has aligned with University Hospital Bristol & Weston to publish this year's Quality Account on 31st July 2021, which is as soon as feasible after the national timescale.

The compilation of the Quality Account has been carried out by the Quality Governance team, taking information obtained during the year and data available from Trust information systems and reporting, such as the Board Integrated Performance Report (IPR).

The responsible clinical or operational leads for each of the sections have either written or approved the content for this year's Quality Account and it has been reviewed/edited by the Associate Director of Quality Governance. It has been reviewed and approved by the members of the Trust Management Team (TMT) and the Quality and Risk Management Committee. The Chief Executive's statement on quality has been reviewed and approved by Maria Kane, CEO.

The quality priorities for 2020/21 have been carried over to 2021/22 in order to allow additional time to focus on the identified areas for improvement. This strategy is in recognition of the pressures throughout the past year and was agreed by the Quality & Risk Management Committee, Trust Management Team and via consultation with the Patient Partnership Group.

Considering the updated review and approval dates, and the requirement for a 30-day external stakeholder consultation, the timeline for production is as follows:

Date	Activity	Status
15.06.21	First draft issued – TMT virtual review and comment	Complete
16.06.21	First draft – Special QRMC – review, comment and approval for external consultation	Complete
	First draft – Trust Board (private)	Complete
17.06.21	Update following TMT/QRMC/Trust Board feedback	Complete
18.06.21	External consultation phase (30 days until 17.07.21)	Complete
15.07.21	QRMC approval *(with external comments received by 07.07.21)*	Complete
17.07.21	Finalise publishing with external comments	Complete
20.07.21	TMT formal review/approval *(with external comments received by 13.07.21)*	Complete
29.07.21	Board approval of final draft	Pending
31.07.21	Publish on website and with NHS Choices.	Pending

Following the external consultation phase responses were received from:

- Bristol City Council Health Scrutiny Committee
- Patient Partnership Group
- Healthwatch Bristol, North Somerset and South Gloucestershire
- North Somerset Health Overview and Scrutiny Committee
- NHS England & NHS Improvement Specialised Commissioning – South West.
- Bristol, North Somerset and South Gloucestershire CCG

These comments were overwhelmingly positive about the Trust's service delivery during an exceptionally challenging year and also the format and content of the Quality Account itself. Specific comments/requests from the Bristol Health Scrutiny Committee were considered by the Director of Nursing & Quality, the Director of Corporate Services & Trust Secretary and the Associate Director of Quality Governance and a response supplied to the Committee. Comments were also made by Healthwatch which were acknowledged and will be further responded to by the Head of Patient Experience upon her return from leave. All comments received and the Trust's responses are included at Annex 3 of the Quality Account.

Following approval by QRMC and TMT the members of the Trust Board are requested to **review and approve** this year's Quality Account for publication on the NHS Choices website and NBT external website as required by statute. The final draft Quality Account 2020/21 for review and approval is attached at **Appendix A.**

Appendices:	A – Quality Account 2020/21 Final Draft for Trust Board Approval

North Bristol NHS Trust
Quality Account
2020/21 (FINAL DRAFT)

Exceptional healthcare, personally delivered

15.1

Contents

Part 1

A statement on quality from the Chief Executive

Exceptional healthcare, personally delivered

15.1

1 A statement on quality from the Chief Executive

Managing the impact of COVID-19

Even as 2020/21 began, we were already starting to tackle the impact of COVID-19. The pandemic touched every aspect of our work at North Bristol NHS Trust - from measures to cope with high numbers of COVID-19 patients, through to restrictions on people visiting loved ones and the impact on our dedicated workforce, 2020/21 was a year unlike any other.

As the new Chief Executive of NBT, I am proud to see the way our teams worked and rose to the challenges that faced them and continued to provide high quality patient care.

Our colleagues have demonstrated their commitment and resilience like never before, showing willingness and ability to adapt, creating innovative solutions to tackle the unique challenges of the pandemic. This has brought opportunities to introduce new technology for appointments and consultations, to fast-track our digital transformation and modernise services.

COVID-19 has given us new problems to solve through a Quality Improvement approach, such as how to continue providing personalised care whilst wearing PPE, developing ways to see patients virtually and importantly for families to stay connected through virtual visiting.

We recognised the need to further enhance our wellbeing support for staff and find ways to help staff to feel connected, particularly with so many people working from home for an extended period and many more shielding. We reached out to staff in a number of ways, including the popular Operational Update email to all staff and regular videos from the Executive to 'check in' and provide visible leadership. We also introduced our 'Start Well, End Well' initiative that was developed to support all staff through the challenging first wave of the pandemic response. This has been shared and implemented across other Trusts in the South West.

Meanwhile, our important research work needed to continue, despite the focus on the pandemic. Our research teams were involved in 33 new studies, including 18 looking at COVID-19. These ranged from treatments for COVID-19, the longer-term impact of the disease on those affected by it and trials of vaccines.

Continuing to improve our care quality

I am also pleased to reflect that, amidst managing the impact of COVID-19, we have retained a continuous improvement focus in other aspects of delivering safe, high quality care, in line with our Quality Strategy.

Our continued commitment to improve support to patients with a Learning Disability has resulted in expanded 7-day service provision, establishment of over 100 champions across the organisation and signing up to the 'Hidden Disabilities' sunflower scheme. We are also piloting an innovative approach to seeking patient feedback around the quality of their consent for surgery as part of their care pathway. This work will expand across the Trust in 2021/22. We have also continued to respond to complaints and concerns in a timely way, recognising the importance this feedback provides, especially during such a challenging time for us all.

We have actively participated in the national 'Getting It Right First Time' (GIRFT) programme, which reported notable good practice in six different clinical specialities. We have also participated in national clinical audits to a high standard, with excellent outcomes reflecting the high-quality clinical services we provide, for example within the Fractured Neck of Femur, Maternal, New-born and Infant Clinical Outcome Review Programme and the Neurosurgical National Audit Programme (NNAP).

1 A statement on quality from the chief executive

The National Patient Safety team welcomed North Bristol Trust as an early adopter organisation of the NHS Patient Safety Strategy, recognising the significant work already undertaken on our system and culture, as well as our commitment to improving patient safety. One great example of the impact of a really focused approach to patient safety was our achievement of reductions in pressure injuries of all types. We are very well placed to accelerate our safety improvement work during 2021/22.

Our ongoing engagement with the Care Quality Commission provided strong external assurance across a range of areas, including our approach to COVID-19 infection control requirements, delivery of safe medical care in our emergency zone, setting up the Mass Vaccination Centre and an on-site inspection of our Gynaecology service.

Working well with our partners

The last year has seen us work more closely with our local partners in health and social care for the benefit of our local population, particularly with the leadership role we took for the Bristol, North Somerset and South Gloucestershire Vaccination programme and in setting up the Nightingale Hospital Bristol. This has set great foundations for the future.

While the pandemic has brought opportunities, we have also been left with the legacy of longer waiting times for diagnostic and elective procedures, as reflected within the performance information shown in this report. We have continually reviewed our waiting lists to ensure patients are treated in order of clinical need and applied innovative solutions, such as taking part in a pilot using capsule cameras for colonoscopies. This sees patients swallow a miniature camera and the diagnostic procedure can then be completed from home.

We are also proud that Bristol, North Somerset and South Gloucestershire has been named in the national elective accelerator programme to tackle the surgical backlog, carrying out additional appointments and procedures over the summer as we move to restore the services that were affected by the pandemic.

Now is the time for us to build back stronger from the experiences of the past year. To build on the achievements made in these challenging times and to focus on providing high quality, safe and personalised care for our local community and beyond.

I hope you find our Quality Account an informative and interesting read.

Maria Kane

Chief Executive

North Bristol NHS Trust

Part 2

Priorities for improvement and statements of assurance from the Board

Exceptional healthcare, personally delivered

15.1

2.1 Priorities for improvement

Every year the Trust sets priorities for improvement which are consulted upon internally and externally. These priorities represent areas where we would like to see significant improvement over the course of the year. Due to the operational pressures caused by COVID-19 during 2020/21 the Trust proposed that these priorities continued for 2021/22. Quality Priority 4 has been expanded to reflect the Trust's wider post-COVID-19 focus for this year. This was discussed with, and agreed by, the Trust Management Team and by the Patient Participation Group.

These priorities are aligned with the Trust Quality Strategy which was approved by the Board in July 2020. In line with the principles set out within the strategy, improvement priorities are monitored by a Trust-wide Committee or Group which is responsible for agreeing and overseeing delivery against specific improvement actions. These are a mixture of both quantitative and qualitative measures.

Our priorities for 2021/22 are:

1. Ensure quality and safety of services is sustained whilst recovering from the impact of the COVID-19 pandemic:

- Maintaining excellence in infection prevention and control (COIC)
- Ensuring the appropriate clinical priorities for recovery work (CEAC)
- Keeping people waiting for planned care safe (CEAC)
- Maintaining safety and excellent outcomes from emergency care (CEAC)

Quality Strategy Theme 2: Safe & Harm Free Care

Oversight: Control of Infection Committee (COIC) and Clinical Effectiveness and Audit Committee (CEAC)

2. Being Outstanding for safety—a national leader in implementing the NHS Patient Safety Strategy.

Quality Strategy Theme 2: Safe & Harm Free Care

Oversight: Patient Safety & Clinical Risk Committee

3. Ensuring excellence in our maternity services, delivering safe and supportive maternity care.

Quality Strategy Theme 2: Safe & Harm Free Care

Oversight: Patient Safety & Clinical Risk Committee

4. Meeting the identified needs of patients with learning disabilities, autism, or both.

Quality Strategy Theme 1: Exceptional Personalised Care

Oversight: Learning Disability & Autism Steering Group

2.1 Priority 1: Ensure quality and safety of services is sustained whilst recovering from the impact of the COVID-19 pandemic

Our commitment:

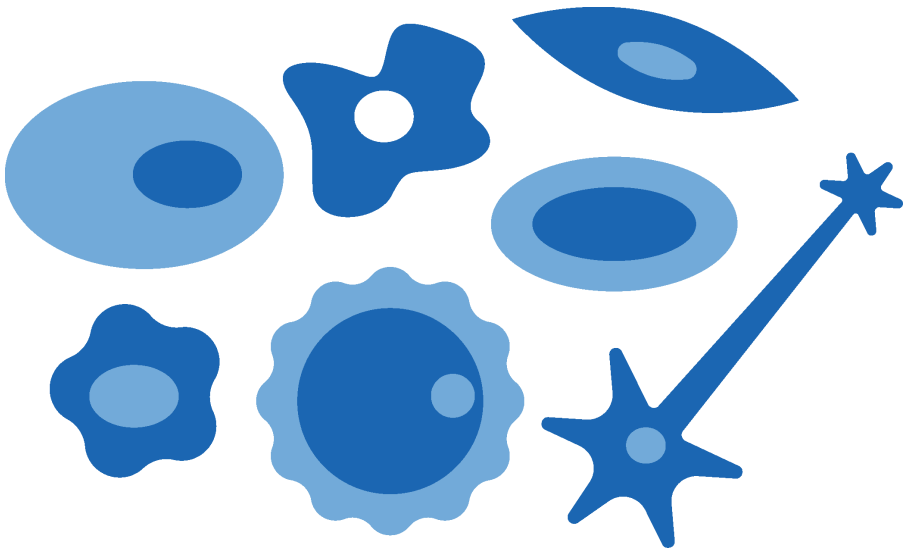
- **We will maintain excellence in infection prevention and control.**
- **Ensure the appropriate clinical priorities for recovery work.**
- **Keep people who are waiting for planned care safe.**
- **Maintain safety and excellent outcomes from emergency care.**

In 2019/20 Priority 4 focused on achieving excellence in infection prevention and control to support delivery of safe care across all our clinical services. This had even greater importance as COVID-19 became more prevalent. In 2020/21 this priority will continue, however has also been expanded to include the Trust's wider focus on the post-pandemic recovery of safe care and provision of excellent outcomes.

The Infection Control team have worked closely with staff throughout 2019/20 to support the provision of safe care throughout the pandemic. This also extended to visitors and patients to the Trust at all of our sites and clinics.

Effective infection prevention and control ensures that patients receive a high standard of care, with an improved clinical outcome. It is also seen as an indicator of the quality and safety of patient care and therefore ongoing compliance is continuously monitored and reported each month to the Board.

Our compliance with national guidance was validated by the Care Quality Commission (CQC) in response to the national Infection Prevention and Control (IPC) Board Assurance Framework, developed by NHS England/Improvement. The Trust received very positive feedback from the CQC as a result of the review.



2.1 Priority 1: Ensure quality and safety of services is sustained whilst recovering from the impact of the COVID-19 pandemic

Key achievements in 2020/21:

Throughout 2020/21 the Infection Prevention and Control (IPC) team took a key role in the Trust's response to the management of the COVID-19 pandemic.

Building on existing infection control policies and practices, the team responded to new and often rapidly changing local and national guidance as the pandemic unfolded and more was learnt about the virus.

With the heightened focus on infection prevention and control, and the need to protect patients and staff from potential infection, there were key areas of focus for the team, e.g. comprehensive communication of the safeguards that had been put in place and education of all staff, patients and carers within both clinical and non-clinical areas. Support and advice were provided for all staff as new Public Health England guidance was implemented.

The team also contributed to the Trust-wide command and control process, as well as devising and implementing new COVID-19 secure patient pathways.

Any outbreaks of the virus in the Trust were careful managed and investigated, and were also subject to daily command and control reviews to maintain clinical safety for patients and staff. All outbreaks followed the national reporting system as well as being subject to our internal review process.

Due to clinical pressures the surveillance and monitoring groups were temporarily reduced, however all of the groups have now been re-established.

During this period we saw a reduction in all other infections, with the exception of C Difficile.

Further actions for 2021/22:

- Be an active partner in the BNSSG 'System Accelerator' programme to restore and optimise system-wide and NBT/UHBW planned care pathways and capacity; reducing wait lists as a result of the pandemic and providing safe care for our patients across the region.
- Implement the 'Spring and Refresh' programme to safely reduce the length of stay of patients through continuous improvement of our discharge pathways.
- Continue to closely monitor cancer wait lists through the Trust Cancer Patient Tracking List (PTL) and carry out regular reviews to assess any potential clinical harm for delayed or patient deferred treatments.
- Continue to work with system partners, including South West Ambulance Service (SWASFT), mental health and social care, to support the provision of safe care and delivery of ED performance at a time of national post-pandemic increased demand.
- The Infection Prevention and Control Team will implement a robust plan to return to more 'normal' ways of working across the Trust by supporting Clinical Divisions, contributing to Divisional Control of Infection Committees, staff education to support the prevention of all infections and re-launching Link Practitioner roles. A key focus will be the reduction of C Difficile infections across our health system in collaboration with BNSSG CCG due to a rise in cases across the South West region.

2.1 Priority 2: Being outstanding for Safety - a national leader in implementing the NHS Patient Safety Strategy

Our commitment: In 2021/22 we will launch and implement the Patient Safety Incident Response Plan in North Bristol Trust.

We will establish continuous improvement programmes to support ongoing learning associated with our 5 patient safety priorities identified when developing our Patient Safety Incident Response Plan.

North Bristol Trust has always put patient safety at the forefront of its vision for patient care. The new NHS Patient Safety Strategy, which NBT will be adopting in June 2021, will enable us to take the next step in learning and improving through how we respond to patient safety incidents.

The strategy challenges us to look at our underlying systems and culture through identifying patient safety priorities. These priorities are individual to the Trust, set by us and based on analysis of patient safety activity and identification of risk within the organisation.

This involves changing how we have responded to incidents for decades, and it will support us in ensuring we put patients at the heart of our services and care delivery.

We have a strong focus on culture, striving for an organisation that lives a restorative just culture in which people feel psychologically safe to be part of learning and improvement.

2.1 Priority 2: Being outstanding for Safety - a national leader in implementing the NHS Patient Safety Strategy

Key achievements in 2020/21:

- The National Patient Safety team welcomed North Bristol Trust as an early adopter organisation of the NHS Patient Safety Strategy. They recognised the significant work already undertaken on our system and culture as well as our commitment to improving patient safety.
- During 2020/21 the Falls Academy Improvement Programme was launched. The approach taken within the Academy aligns with the patient safety strategy model of identifying themes and trends for ongoing improvement and learning related to patient falls.
- We undertook a thorough and considered review of the existing system and structures underpinning patient safety activity within North Bristol Trust. We conducted a thematic analysis of patient safety activity over a three year period to identify areas 5 key patient safety priorities;
    1. Inpatient falls,
    2. medication management,
    3. responding well to clinically changing conditions,
    4. pressure injuries, and
    5. discharge planning.
- Delivered training in culture and healthcare incident investigations to equip NBT with the knowledge, skills and understanding to embrace learning and continuous improvement.

Further actions for 2021/22, we will:

- Launch the Trust's Patient Safety Incident Response Plan (PSIRP) in June 2021. This plan will explain how NBT will implement the National Patient Safety Strategy. The PSIRP will be followed by new policies and processes to ensure that the plan is achievable and realistic.
- The five patient safety priorities will each have a programme developed collaboratively by subject matter experts, our patient partners and frontline staff, along with patients and families. Each programme will set out improvement actions and monitor their impact.
- Alongside the structured improvement work looking at underlying systems and processes, NBT will focus on improving the culture of psychological safety within the organisation, which is a fundamental value that enables a positive safety climate.
- We will enable our patients and staff to feel empowered to discuss their concerns openly through supportive reporting and feedback methods, supported by clear and compassionate leadership.

2.1 Priority 3: Ensuring excellence in our maternity services, delivering safe and supportive maternity care

Our commitment: In 2021/22 we continue to strive to deliver the ambitions of "Better Births" and the National Maternity Transformation Programme.

Our approach is one of continuous improvement, creating the right environment for our staff to be able to implement best practice.

Our commitment is to provide high quality maternity care that is safe, effective and centred on the women and babies that need it and the people that work in it.

Maternity Services at North Bristol NHS Trust provide a full range of maternity care to our population. More than 6,000 babies are born with us every year and our dedicated midwives, doctors, maternity healthcare assistants (MCAs) and support staff are committed to providing safe, personalised care of the highest standard.

Our maternity facilities offer en-suite birth rooms, birth pools, both complementary and pharmaceutical analgesia options for support during labour, and free parking for women in active labour, and their partners, on the Southmead Hospital site. We also have a 24-hour seven days a week Antenatal Assessment Unit and a family room available at Southmead Hospital. We have a variety of single and shared rooms to respond to the requirements of our patients. The Cossham Birth Centre is a standalone Birth Centre led by midwives, based in Kingswood, and offers a birth place option for women without complications who have been assessed antenatally as suitable by their midwife.

Our Community Midwifery teams are based across GP surgeries, Health Centres, Clinics and Children's Centres. Alongside our maternity care assistants (MCA) they work as a team to provide holistic care throughout the antenatal and postnatal period across Bristol, North Somerset and South Gloucestershire (BNSSG) and intrapartum care for home births.

2.1 Priority 3: Ensuring excellence in our maternity services, delivering safe and supportive maternity care

Key achievements in 2020/21:

- The continued provision of high quality care for families, whilst maintaining a COVID-19 safe environment and implementing COVID-19 precautions across our maternity services in the hospital and community.
- Opened new Obstetrics theatres to provide a better environment for women in labour.
- Continued to implement the Maternity Transformation Programme, including increasing both personalised care and continuity of care.
- Worked closely with the Maternity Voices Partnership (MVP) to ensure the voice of the service user is at the heart of everything we do.
- Maintained our research profile in Obstetric and Maternity at national and international level e.g. the ASSIST trial and the Pan-COVID-19 maternity study.
- Completed a self-assessment of our compliance against the essential and immediate actions within the Ockenden report published in December 2020.

Further actions for 2021/22:

Linked to our objective to being outstanding for safety, ensuring excellence in our maternity services and delivering safe care is one of the objectives of our Quality Strategy.

- We will continue to restore our services following the impact of COVID-19.
- We will work in partnership with our Local Maternity System (LMS), Maternity Voices Partnership and the regional team to co-produce services in line with the workstreams set out in the Maternity Transformation Programme, with a shared goal of family friendly, safe, kind, professional and personalised services.
- Following our self-assessment of compliance with the recommendations of the Ockenden report in December 2020, we have developed an action plan which considers learning identified in the report and links to the safety actions set out in the NHS Resolution maternity incentive scheme. This has enabled us to understand and inform our drive for continuous improvement. This will be a focus for the service during 2020/21.

Our maternity services work very closely with our Trust Board, with both executive and non-executive director safety champions engaged with the maternity team to strive for excellence across safety and experience.

2.1 Priority 4: Meeting the identified needs of patients with learning difficulties, autism or both

Our commitment: We will deliver the three NHS Improvement priority standards to improve care delivery to patients and through the new Learning Disability and Autism Steering Group drive work at ward level to train staff and deliver tangible improvements in care quality.

Over a million people in England have a learning disability and we know they often experience poorer access to healthcare than the general population. The NHS Long Term Plan commits the NHS to ensuring all people with a learning disability, autism, or both, can live happier, healthier, longer lives.

In June 2018, NHS Improvement launched the National Learning Disability Improvement Standards for NHS trusts. These were designed with people with a learning disability, carers, family members and healthcare professionals to drive rapid improvement of patient experience and equity of care.

The three standards which apply to all NHS trusts cover:

Respecting and protecting rights

Inclusion and engagement

Workforce

North Bristol Trust completed a self-assessment exercise against these 3 standards and our feedback is incorporated in our improvement plan and strategy. Benchmarking via a patient and staff survey and organisational questions were completed and submitted to NHS Improvement in 2019 and 2020.

2.1 Priority 4: Meeting the identified needs of patients with learning difficulties, autism or both

Key achievements in 2020/21:

- Our 3 year plan for improvement was further reviewed during August to September 2020 and builds on the NHS England/Improvement (NHSE/I) standards and incorporates the Bristol, North Somerset & South Gloucestershire (BNSSG) Learning Disabilities Mortality Review (LeDeR) annual report outcomes.
- The Learning Disability Liaison Team expanded to a seven day service in April 2020 at the start of the first COVID-19 lockdown. Benefits include ensuring reasonable adjustments are made, clinical teams are supported, and patients with a learning disability, autism, or both, can access healthcare and ensure their needs are met.
- We signed up as an organisation to the 'Hidden Disabilities' sunflower scheme. Lanyards were sponsored by the hospital Charity and can be provided for patients to provide a discreet way for an individual to choose to make the invisible visible. It indicates to people that the wearer may need additional support, help, or a little more time.
- We have over 100 Learning Disability and Autism champions at ward level and a Non Executive Director, Kelvin Blake, as a Board Level Champion to support Board to Ward awareness and oversight.
- Autism training for the Learning Disability Team, Emergency Department staff & Mental Health Liaison Team was provided by Bristol Autism Spectrum Service (BASS). An Autism Passport and reasonable adjustment checklist has been implemented in partnership with other local providers.

Further actions for 2021/22, we will:

- Continue work with other providers in the region to transition and prepare young people and their families for care in an adult setting.
- Continue to progress quality improvement programmes of work including 'Poo Matters' preventing and managing constipation in collaboration with system partners.
- Establish our Hospital User Group (HUG), and benefit from the experience of our patients with learning disability and autism
- Implement the Oliver McGowan Mandatory Training in Learning Disability and Autism which is currently being piloted nationally.
- Further develop our online interactive training materials and provision.

2.2 Review of Services

The trust has reviewed all the data available to them on the quality of care in all of the NHS services listed below.

Medicine

Emergency Medicine
Acute Medicine
Mental Health Liaison
Immunology / Infectious Diseases / HIV
Haematology
Acute Oncology
Medical Day Care
Palliative Care
Cardiology
Care of the Elderly
Clinical Psychology
Diabetes / Endocrinology
Gastroenterology
Respiratory
Endoscopy

Anaesthesia, Surgery, Critical care and Renal

Critical Care
General surgery
Vascular Network
Breast Services
Plastics, Burns and Dermatology
Anaesthetics
Renal & Transplant
Elective Care
Urology
Emergency Care

Women's and Children's Health

Maternity Services
Gynaecology
Fertility Services
Neonatal Intensive Care Unit (NICU)

Core Clinical Services

Pharmacy Services
Outpatients
Clinical Equipment Services
Therapy Services:
- Nutrition & Dietetics
- Speech and Language Therapy
- Occupational Therapy
- Physiotherapy

Severn Pathology:
- Pathology Services
- Blood Sciences
- Cellular Pathology
- Infection Sciences
- Genetics

Imaging Services:
- Medical Photography & Illustration

Interventional Radiology

Neurosciences and Musculoskeletal

Elective orthopaedics
Trauma
Major trauma
Bristol Centre for Enablement
Rheumatology
Neurosurgery
Spinal Service
Neurology
Stroke Service
Neurophysiology
Neuropsychiatry
Neuropsychology
Neuropathology
Chronic pain

2.2 Review of Services

The Trust reviews data and information related to the quality of these services through regular reports to the Trust Board and the Trust's governance committees. To provide data quality assurance there is a Data Quality Tracker, which is updated daily and made available to all staff. The Data Quality Tracker is one of the leading quality management products used by the Data Quality Marshalls within Information Management and Technology (IM&T). This team triages both internal and external data quality queries, ensuring that any item raised is logged, assigned, tracked, and ultimately resolved, engaging wider resources as required.

There is a monthly North Bristol Trust Data Quality Meeting, focusing on all internal and external quality issues. The outcome from this Board is then visible internally to higher level quality forums and to the IM&T Committee, and externally to our commissioners via our Data Quality and Improvement Plan Meeting and Finance Information Group meetings, all of which are held monthly.

Throughout 2020/21, this governance structure has continued to report Data Quality as green and an area of increasing assurance.

In line with the principles of Service Line Management embedded during 2018/19 the leadership teams of our five clinical divisions are responsible for their own internal assurance systems. Clinical divisions are subject to regular executive reviews during which performance against standards of quality and safety are assessed. Through these mechanisms the Trust reviews all of the data available on the quality of care across its services.

The income generated by the NHS services reviewed in 2020/21 represents 100% of the total income generated from the provision of NHS services by North Bristol NHS Trust for 2020/21.

2.2 Care Quality Commission

Overall Rating	Safe	Effective	Caring	Responsive	Well-Led
Good	Good	Good	Outstanding	Requires Improvement	Outstanding

North Bristol NHS Trust is required to register with the Care Quality Commission under section 10 of the Health and Social Care Act 2008. NHS trusts are registered for each of the regulated activities they provide, at each location they provide them from.

As at 31/03/2021, the Trust's registration status is that it is registered for all of its regulated activities, without any negative conditions, such as enforcement actions, during the reporting period.

CQC Engagement Meetings

Quarterly meetings are held with the CQC Inspection Manager and Lead Inspector for the Trust, with specific thematic areas also covered as agreed during the year. Meetings held during the past 12 months are as follows;

04.03.2020 – Scheduled quarterly executive engagement meeting (in person).

20.05.2020 – Virtual meeting particularly focused on COVID-19 pandemic. All subsequent meetings agreed to be 'virtual' due to COVID-19 restrictions.

21.07.2020 – Infection Prevention & Control Board Assurance Framework review

22.09.2020 – Scheduled quarterly executive engagement meeting

30.10.2020 – 'Patient First' publication review.

02.12.2020 – Scheduled quarterly executive engagement meeting

08.12.2020 – DNACPR national review

10.12.2020 – Gynaecology inspection (on site)

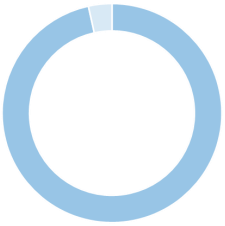
16.03.2021 – Mass Vaccination Centre 'roundtable review'

24.03.2021 - Scheduled quarterly executive engagement meeting

Infection Control Board Assurance Framework

NHSI/E infection control experts created a board assurance document so that boards could assess the management of COVID-19 infection control in their organisations.

The NBT infection control team made an assessment of the current position in the Trust in relation to the assurance document which provided assurance against **56/58** of the Key Lines of Enquiry. Gaps in assurance were identified as follows:



97%
assurance against KLOE

- Segregation screening, e.g. for reception staff not in place in all areas
- Staff social distancing e.g. during meal breaks

The Quality and Risk Management Committee were reassured that the gaps would continue to be addressed to reduce the gaps in assurance, but accepted that this would take time as it involved a staff culture change .

Mass Vaccination Centre Review

February 2021
CQC issued a set of national Key Lines of Enquiry for Vaccination Centres

February 2021
We performed a self-assessment against the KLOEs

March 2021
NBT hosted a roundtable review to present findings

Feedback

No concerns were raised and we received excellent verbal feedback from the CQC. The key points were:

- Clear, strong, co-ordinated effort from NBT as host and across the system to establish the Ashton Gate site.
- Clearly integrated infection control and safeguarding policies and linkages to established NBT governance systems.
- Strong controls for medicines management and supply chain.
- Impressed with approach taken of patient consent, particularly for patients lacking capacity, such as patients with dementia.
- Very impressed with the Learning Disability specialist clinic.
- Finally, the encouragement for uptake using specialist clinics in the community, with support from local community leaders, was also impressive.

2.2 Care Quality Commission

CQC Focused Inspection of Gynaecology Service December 2020

The CQC visited the Trust on 10th December 2020 to carry out a focused announced inspection of the Gynaecology service, reviewing the safe, effective, responsive and well-led key questions, primarily focusing on cancer-related pathways. The inspection was scheduled as the CQC had not inspected the service since 2016 and wanted to test improvements made in recent years. These included the development of clinical guidelines, support for trainee doctors and strengthened governance processes.

Two inspectors from the CQC were on site for one day where they reviewed documentation, held virtual staff focus groups and interviews. They also met with the divisional and speciality management team who gave a presentation of the specialty's leadership as well as key achievements and improvements made in the service.

We received excellent initial feedback after the inspection and the report was published on 18th February which supported this. The report provides extremely positive findings on the quality of services and identified only 2 'should do' actions which the service is in the process of responding to.

A formal rating was not given as the service was not inspected as a whole.

Feedback

Incidents: The service managed patient safety incidents well. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support.

Multidisciplinary working: Doctors, nurses and other healthcare professionals worked together as a team to benefit patients. They supported each other to provide good care.

Access and flow: People could access the service when they needed it and received the right care. Waiting times from referral to treatment had however deteriorated due to the impact of the coronavirus pandemic. This included long waiting times of over 52 weeks for non-urgent treatment.

Learning from complaints and concerns: The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff. The service included patients in the investigation of their complaint.

Leadership: Leaders had the skills and abilities to run the service. They understood and managed the priorities and issues the service faced. They supported staff to develop their skills and take on more senior roles.

Management of risk, issues and performance: Leaders and teams used systems to manage performance effectively. They identified and escalated relevant risks and issues and identified actions to reduce their impact.

Internal Mock Inspections

Mock inspections are not only an important preparation tool for a CQC inspection, but also a good opportunity for reflection to ensure we are providing the best possible care for our patients.

The mock inspection team act as a 'critical friend' and provide constructive challenge to the service being reviewed. They observe clinical practices, speak with patients and staff, review documentation, e.g. patient records and performance data, before compiling their findings in a report with a rating and recommendations for action by the core service or Division.

How are they performed?

Focused mock inspections are unannounced and conducted by a team of at least five clinical and non-clinical staff from varying departments across the Trust. The team use an inspection pack made up of supporting data and a targeted mock inspection tool template.

Teams spend between 4-5 hours in the departments observing practices, speaking with staff and patients and reviewing documentation before coming together to draw conclusions on their findings and deliver high level feedback to the Divisional Management Team.

Internal Mock Inspections

These included a review of actions completed following the 2019 inspection.

October 2020

- ✓ Emergency Department
- ✓ Maternity
- ✓ Theatres

February 2021

- ✓ Maternity (follow-up)

March 2021

- ✓ Emergency Department (follow-up)
- ✓ Theatres (follow-up)

2021/22

Further follow-up activity and mock inspections are planned for 2021/22 and are included as part of NBTs Internal Assurance Programme

2.2 Research and Innovation

North Bristol Trust has had great success in 2020/21, being awarded five National Institute for Health Research (NIHR) grants, designed and led by staff, supported by our patient advisers. We now have a total portfolio of research grants worth £31 million.

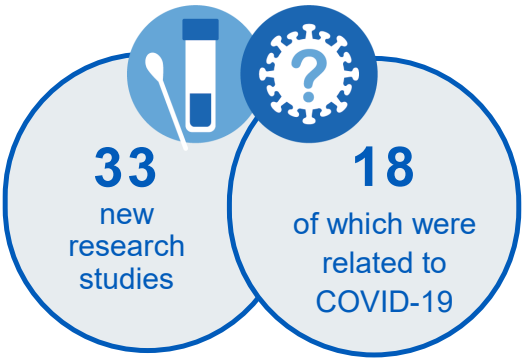
NIHR | National Institute for Health Research

We were awarded £632,000 by the NIHR to identify the amount and type of aerosol generated when medical procedures are performed to improve guidance for safety during pandemics. Through the **Aerator** study an evidence base is being provided to a variety of healthcare settings, from ICU to dentistry. This will support the development of policies and procedures to help ensure proportionate social distancing and personal protective equipment is used.

COVID-19 AvonCap Study: This is a three year Pandemic Respiratory Surveillance Study, funded by Pfizer and in partnership with the University of Bristol. It uses clinically collected data to estimate population-based levels of lower respiratory tract infections. The findings from this study will be used to inform policymakers about the effects of different interactions and vaccinations.

DISCOVER Study [COVID-19]: This pragmatic study is being hosted by the Trust on behalf of the NHS Health Research Authority to look at the identification of diagnostic and severity markers of COVID-19 to enable rapid triage.

The study recruits patients with a diagnosis of COVID-19 and analyses blood samples and medical information, with additional tests at specific time intervals. These follow-up clinics have in turn initiated further fields of study to look at different elements of Long COVID.



9423

The number of patients receiving relevant health services provided by North Bristol NHS Trust in 2020/21 that were recruited to participate in research approved by a research ethics committee.

In addition to the study collaborations NBT has been working with Acute Trusts within the region to develop novel ways of working; supporting other Trusts to develop their own COVID-19 vaccine trials. Through these collaborations NBT has supported increased accessibility across a wider geographic area and ensured rapid recruitment and evaluation of the safety and effectiveness of vaccines. As part of this collaboration staff from across the region have moved around the local healthcare economy as part of the training and also to support sites to deliver the study effectively.

Public contribution

We have developed new ways to enable patients and public partners to contribute to our research virtually, and have worked together to design research that matters to our community. We have worked with our patient and public partners to help us decide which research to support with the Southmead Hospital Charity Research Fund. This has led to ground-breaking research into Long COVID-19, the psychological impact of COVID-19 on staff and how to better deliver respiratory diagnostic tests at home.

What next?

Next year we will restore our research portfolio, enabling people across a diverse range of diseases an opportunity to participate in research, as well as increasing research in new areas such as infection and vaccines. We also aim to focus more research towards priorities identified with our regional partners, focusing on improving the health and wellbeing of our whole community.

2.2 Operational Performance

The provision of cancer services was impacted by COVID-19 throughout 2020/21, however every effort was made to protect surgical services using a combination of NBT and Independent Sector resources. Cancer patients were clinically prioritised by all divisions in line with national guidance.

The largest impact to the cancer pathways was a reduced diagnostic capacity which resulted in delays. At the start of COVID-19, aerosol generating endoscopic procedures were also suspended. The procedure was resumed in Quarter 2 with a reduced capacity, but the suspension had created backlogs which added long waits to cancer pathways. The primary breach reason was patient delay, due in part to concerns about coming into hospital during a pandemic, despite reassurances of the patient safety measures that had been put in place.

Throughout the pandemic there were a number of national and local changes to cancer services processes and pathways. The Trust put in place safety nets across all of the pathways to ensure that every patient was tracked through these changes. This provided assurance that all patients were being managed safely and appropriately.

Our performance

During 2020/21 performance against the 62 day cancer standard failed to achieve national standards or the Trust trajectory, with an average of 72.36% against a planned trajectory of 80%. This performance was slightly lower than 2019/20. Most of the treatment delays are attributed to patient choice to defer until after COVID-19 vaccination, clinical prioritisation to delay start of treatment, as well as access to theatres and diagnostic capacity. Urology were able to continue with their backlog clearance plans from 2019/20, with performance continuing to improve as a result.

The two week wait (2WW) performance across the year was 77.26%, with the highest performance of 97.18% in June 2020; this was due to a drop in referrals as a result of lockdown. The achievement of 77.26%, compared to the overall performance of 2019/20 (without COVID-19 impact) of 80.87%, was due to agile changes in the way 2WW appointments were delivered in terms of virtual clinics, triage and utilising the changes in response to national guidance.

The 31-day first treatment target was achieved three times in 2020/21; with a yearly performance of 93.49% which also exceeded the Trust trajectory of 81.09%. Clinical prioritisation and patients being offered alternative treatment options considered safer during Covid-19 allowed us to maintain a steady performance throughout the year, with an achievement of over 90% for ten of the twelve months.

Cancer Multidisciplinary Team (MDT) Performance	Target	Q1 20/21	Q2 20/21	Q3 20/21	Q4 20/21
Patients seen within 2 weeks of urgent GP referral	93%	91%	81%	77%	65%
Patients with breast symptoms seen by specialist within 2 weeks	93%	96%	75%	57%	29%
Patients receiving first treatment within 31 days of cancer diagnosis	96%	91%	93%	95%	94%
Patients waiting less than 31 days for subsequent drug treatment	98%	100%	100%	100%	100%
Patients waiting less than 31 days for subsequent surgery	94%	80%	89%	90%	78%
Patients receiving first treatment within 62 days of urgent GP referral	85%	72%	72%	75%	71%
Patients treated within 62 days of screening	90%	66%	87%	83%	81%

15.1

2.2 Operational Performance

52 Week Waits

The Trust has historically experienced a number of patients waiting in excess of 52 weeks on Referral to Treatment pathways in a number of specialties. Exceptional actions have been taken to reduce the number of long waiting patients and clear the backlog. These include:

- Demand management through restrictions to access of services;
- outsourcing to the independent sector;
- waiting list initiatives; and
- locum appointments.

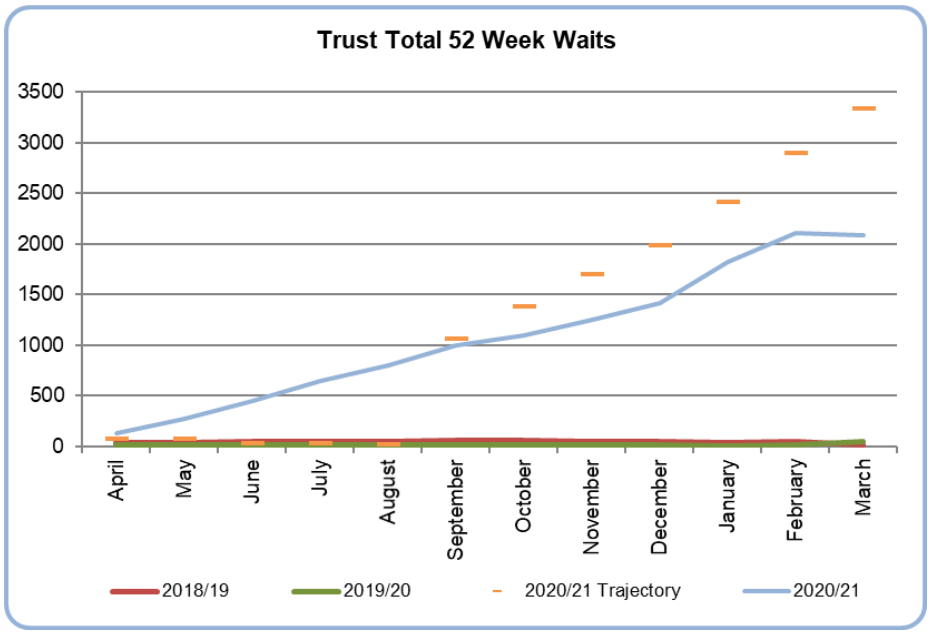
These actions have been largely successful in minimising the number of patients with extended waits for treatment, with only 43 patients waiting in excess of 52 weeks at the end of March 2020.

The Trust anticipated an increase in the number of patients waiting in excess of 52 weeks for their first definitive treatment in 2020/21 due to:

- recurrent workforce and staffing capacity issues
- commissioner affordability
- non-elective pressures on elective care.

This has been significantly exacerbated by the need to respond to the COVID-19 pandemic. Nationally patients with a lower clinical priority have had their treatment delayed and this has also been experienced by our patients.

Trust Total 52 Week Wait 2018/19, 2019/20 and 2020/21 actuals and 2020/21 trajectory



15.1

2.2 Operational Performance

Referral to Treatment

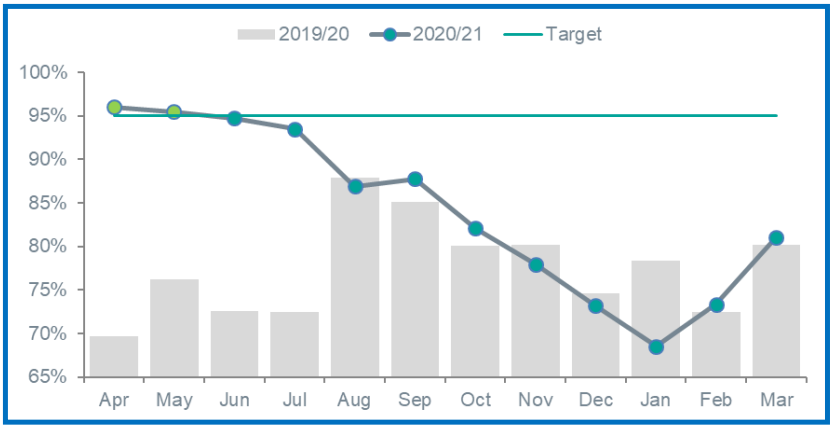
The Trust set a Referral to Treatment (RTT) trajectory predicting a performance position of 63.12% by the end of 2020/21; taking into account the anticipated impact of the COVID-19 response on RTT performance. The postponing of routine elective activity and the introduction of the Royal College of Surgeons clinical prioritisation guidance has adversely impacted the overall performance position, however this has been partially offset by the reduction in demand from new referrals and the maximisation of delivery of Elective activity in the periods when bed occupancy of COVID-19 positive patients was lower.

Actual performance for 2020/21 is 71.64%, with a backlog of 8,390 patients waiting over 18 weeks. The overall wait list size was 29,580 patients at the end of March 2021 against a trajectory of 35,167.

The Trust is ranked 193/399 in the reported performance positions by Acute Trusts nationally, and is in the third quartile as at March 2021. The Trust reported higher than the national average percentage performance and was second out of the eleven national Adult Major Trauma Centres in March 2021.

Emergency Department (ED) Maximum Waiting Time

Performance against the four-hour ED waiting time standard improved significantly during the first half of 2021/21. This was due in part to demand for Emergency Care being reduced in line with national trends during the initial response to the COVID-19 pandemic and national restrictions. During the period April 2020 to September 2020 attendances dropped to an average of 6,644, compared with 8,300 in the first 6 months of 2019/20.



The Trust exceeded the full-year 2020/21 trajectory for the four-hour ED waiting time standard, with performance of 84.14% against trajectory of 80.99%. The Trust has frequently performed better nationally for Type 1, four-hour performance, with the exception of January and February 2021. The Trust regularly reports the highest performance amongst Adult Major Trauma Centres.

Bed Occupancy

Bed occupancy during 2020-21 was an average of 76.20% compared to 95.31% for the same period in the previous year. The level of reduction in bed occupancy in the first pandemic wave was not however experienced again during subsequent periods of national restrictions/lockdown, which had an adverse impact on performance in the second half of the year.

2.2 Operational Performance

Clinical Prioritisation

On 18 September 2020, NHSE/I wrote to all acute NHS Trusts setting out a nationally mandated programme of work, requiring clinical prioritisation and validation of elective waiting lists for admitted patients.

All patients on the admitted waiting list, waiting over 18 weeks and with lower clinical priority, as determined by the Royal College of Surgeons clinical prioritisation guidance, were sent a letter apologising for the delays due to the response to the COVID-19 pandemic.

Patients were able to respond to the letter by choosing from one of four options:

1. Already received treatment
2. Wished to be removed from the waiting list
3. Would like a review with a Clinician
4. Had no changes in condition and wished to remain on the waiting list.

3,566 patients were sent a validation letter during December 2020 and January 2021.

77% response rate

2755 patients responded. Approximately 200 patients who did not respond had either been offered a date for their procedure or had been treated since the validation letter had been sent.

Feedback from patients was extremely positive. The Trust was recognised by the national team as having a **higher than average response rate** and for implementing robust processes.

The validation process is to be embedded into 'business as usual' operational processes by all surgical specialities. It is expected that similar processes will be undertaken for patients awaiting Diagnostic tests and Outpatient appointments throughout 2021/22.

Safe to Wait

During 2020/21, the Trust has also introduced robust processes for the management of the most clinically urgent patients to ensure they are treated within the 4 weeks indicated, reviewed to ensure they continue to be 'safe to wait' or whether their treatment should be expedited. This is overseen by a Clinical Surgical Prioritisation Group.

Throughout the response to the COVID-19 pandemic, the Trust continued to prioritise treatment for patients who were assessed as requiring urgent treatment, including cancer patients. This included utilising available capacity within the local Independent Sector Providers where appropriate.

2.2 Operational Performance

Elective Capacity / Waiting Lists

The Trust's implementation of national guidance, and its local response to the COVID-19 pandemic, has led to an unavoidable increase of patients on the Trust's various wait lists. This is a national trend which has been experienced by providers across the country.

Whilst the Trust has experienced a reduction in demand in referrals which has reduced the overall wait lists, this has been more than offset by the reduction in outpatient and inpatient elective activity, leading to an overall growth in the wait lists. This is partly due to changes resulting from enhanced Infection, Prevention and Control measures which restricted the Trust's physical capacity to undertake Elective activity.

During the COVID-19 pandemic response, patient care prioritisation was changed, with greater risk stratification of patients and the introduction of the Royal College of Surgeons clinical prioritisation guidelines. This has impacted the overall Referral to Treatment (RTT) wait list, with a disproportionate number of patients experiencing extended waits in specialties with less clinical urgency, e.g. Orthopaedics.

It is expected that nationally there will be an introduction of additional clinical prioritisation categories for patients awaiting Outpatient and Diagnostic appointments. This will further impact the waiting list profiles.

Waiting List Figures as at March 2021

Wait List	March 2020	March 2021
RTT overall wait list	28,516	29,580
RTT >52 week wait breach patients	43	2,088
RTT >78 week wait breach patients	0	276
RTT >104 week wait breach patients	0	3
No of patients on eRs awaiting placement on PAS, ASI, RAS and AFB worklists	1,993	5,728
Overdue follow-ups	27,827	39,623
Diagnostic 6 week wait overall	10,641	11,943
Diagnostic >6-week wait breach patients	596	3,249
Diagnostic >13-week wait breach patients	113	1,358

15.1

2.2 Hospital Episode Statistics and DQIPs

Hospital Episode Statistics

The Trust submits a wealth of information and monitoring data centrally to our commissioners and the Department of Health. The accuracy of this data is of vital importance to the Trust and the NHS to ensure high-quality clinical care and accurate financial reimbursement. Our data quality reporting, controls and feedback mechanisms are routinely audited and help us monitor and maintain high-quality data. We submit to the Secondary Users' Service (SUS) for inclusion in the Hospital Episode Statistics (HES) which are included in the latest published data. Within this data we are expected to include a valid NHS number and the General Medical Practice (GMP) Code and report this within each year's Quality Account.

We have continued to exceed national averages for all measurement criteria in 2020/21; matching or improving upon 2019/20 performance. The summary of our data quality is detailed below.

M13-Final	2018/19		2019/20		2020/21		2020/21 (National Ave)	
	NHS No	GMP Code	NHS No	GMP Code	NHS No	GMP Code	NHS No	GMP Code
Admitted Patient Care	99.75%	99.99%	99.76%	99.96%	99.87%	99.80%	99.47%	99.80%
Outpatients	99.66%	99.97%	99.81%	99.98%	99.85%	99.99%	99.66%	99.72%
A & E	98.44%	99.9%	98.50%	99.95%	99.02%	100.00%	97.97%	99.02%

Commissioner Data Quality Improvement Plans (DQIPS)

As part of contractual reporting requirements all Trusts must agree and undertake Data Quality Improvement Plans (DQIP's) for both NHS England and the regional Clinical Commissioning Group. At the start of 2018/19 the Trust had the largest DQIP in the commissioning region, however, after demonstrating unprecedented improvement in data quality no DQIP was required by BNSSG CCG in 2019/20. In 2020/21, we have again had no formal DQIP from either commissioner, and only a small number of ongoing ad-hoc data queries. Progress is detailed in the table below:

There are no plans for a DQIP to be issued in 2021/22 from either NHSE or BNSSG CCG. Processes for raising ad hoc data quality queries are in place, and will be utilised on an ongoing basis to support the existing governance structures around quality and performance. Both Commissioners and key Trust stakeholders will be advised of data quality performance via established governance structures, and DQIPs may be instigated in future should the need arise and with the agreement of all parties.

The performance against our Data Quality plans has been a recurring item for assurance to key governance forums, receiving praise from Commissioners and the Trust's Audit Committee.

Commissioner DQIP/Ad-hoc Data Query Performance	Contractual DQIP Items	Ad-hoc Data Queries Raised	Ad-hoc Data Queries Resolved	% Ad-hoc Data Queries Complete	Status
NHS England	0	24	22	92%	GREEN
BNSSG CCG	0	14	12	86%	GREEN

2.2 Clinical Coding

What is Clinical Coding?

Clinical Coding is the process whereby information written in the patient notes is translated into coded data and entered onto hospital information systems for statistical analysis and financial reimbursement from Commissioners via the National Tariff Payment System.

Coding provides an essential service to the Trust, benefitting quality of care, patient safety, income from activity, and supports research and best practice initiatives. Accurate coding is widely recognised by the NHS as an essential element for benchmarking performance against peers.

As part of the annual Data Security & Protection Toolkit submission (formerly known as the IG Toolkit), we are required to demonstrate the accuracy of our clinical coding.

Clinical Coding Performance

Clinical Coding Performance	DSP Toolkit Met	2019/20	2020/21	↓↑
Primary Diagnosis	90%	90.25%	96.03%	5.78%
Secondary Diagnosis	80%	91.69%	94.16%	2.47%
Primary Procedure	90%	93.36%	92.73%	- 0.63%
Secondary Procedure	80%	84.21%	89.13%	4.92%

The 2020/21 performance has shown a marked improvement on the performance of 2019/20, with progress in three of the four areas examined.

The following factors influenced the results obtained this year:

Expanded audit regime: The audit regime greatly increased during 2019/20, this identified areas for improvement, with results reflected in the improved 2020/21 audit results. The expanded audit regime has continued throughout 2020/21.

Engagement of external coding auditors: NBT continue to engage highly specialised external clinical coding auditors to ensure a fully impartial and transparent level of scrutiny and assurance, complete with recommendations for further improvement.

Integration into Coding Improvement strategy: Full incorporation of audit work into the Clinical Coding Improvement Strategy – areas of improvement and opportunity are being actively sought out and aligned with recommendations from GIRFT and benchmarking sources.

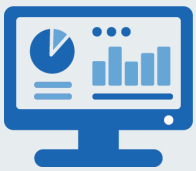
The service has continued to perform to high standards and demonstrated improved results against the backdrop of a national pandemic, ensuring internal and external audit programmes continued, while embracing additional scrutiny and an expanded audit regime.

The overall 2020/21 performance is indicative of Standards Met assurance rating within the Data Security & Prevention (DSP) Toolkit. In isolation primary and secondary diagnosis meet the 'Standards Exceeded' assurance levels within the DSP Toolkit.

2.2 Clinical Coding Improvement Strategy

In the face of a national pandemic, the Clinical Coding team have continued to meet operational demands, improved data quality and accuracy, and upheld the continual improvement plan and Trust wide engagement.

The Clinical Coding Improvement Strategy has been updated and maintained into 2020/21, leading to the following material advancements:



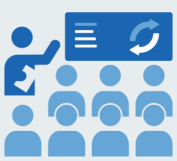
Data Analytics: The Clinical Coding Qlik Sense data analytics application continued to revolutionise clinicians' engagement with the inpatient coding process, with a refreshed Clinical Coding Validation report and senior management awareness of the Coding Team's operational throughput. Depth of Coding benchmarking was established and utilised in support and development of the annual improvement plan.

Annual Improvement Plan: The annual Clinical Coding Improvement Strategy and plan of improvement works was agreed and implemented to ensure a long-term and measurable programme of continual improvement across clinical divisions; adapted to fit around the response to the COVID-19 pandemic. Evidence of improvement is obtained via enhancement in average Healthcare Resource Group (HRG) (indicative tariff used as block contract in place due to pandemic), and Depth of Coding benchmark performance.

Partnerships & External Communications: Our Coding function continues to partner with 3M, following the production of the online webinar hosted by Healthcare Financial Management Association detailing our strategic improvement agenda during 2019/20. The national pandemic has delayed subsequent engagement, however this is due to resume during 2021/22.

Engagement: Attendance at Divisional Management Team and Specialty Team meetings, supported by 1-2-1's with Consultants (primarily virtually due to the pandemic) , bespoke specialised clinical coding audits, group coding awareness sessions (virtual and reduced volume due to pandemic), and reviews of processes, policies and proformas continued throughout the year.

Technology: Medical History Assurance (MHA) coding quality software delivered an additional **£520,000** of assured income from planned inpatient activity during 2020/21.



Training: A new comprehensive and robust internal training programme was developed and will be launched in Q1 of 2021/22 (delayed implementation due to pandemic).

2.2 Data Security & Protection Toolkit

What is the Data Security & Protection Toolkit?

The Data Security & Protection Toolkit replaced the Information Governance Toolkit in 2018/19. It is an online self-assessment tool that allows us to measure our performance against the National Data Guardian's data security standards.

It provides us with assurance that we are practising good data security and that personal information is handled correctly.

In 2019/20 the Trust achieved 'Standards Met' across the toolkit submission. In 2020/21, the toolkit assessment has been expanded to include criteria relating to cyber assurance and related compliance measures. While NBT remains on-track to maintain compliance, the deadline for submission has been moved to June 2021 to enable Trusts to recover from the COVID-19 pandemic responses and mass vaccination programme.

The table below therefore reflects the prior period's performance, the expansion of the Toolkit criteria in 2020/21, and that overall performance is to be confirmed during 2021/22.

	2019/20	2020/21
Mandatory Evidence items provided	116	74*/111
Non-mandatory evidence items provided	4	14*/72
Assertions confirmed	44	22*/42
Assessment status	Standards Met	TBC June 2021*

Part 3

Our quality indicators

Exceptional healthcare, personally delivered

15.1

3.1 Patient Safety Indicators

The safety of our patients is at the heart of our approach and culture at NBT. We aim to be outstanding for safety and are at the forefront nationally in implementing the NHS Patient Safety Strategy as an early adopter organisation.

Patient safety incidents that are reported by our staff provide us with key insights into the safety of our patients. Our Patient Safety Incident Response Plan (PSIRP), which went live in June 2021, outlines how we will be responding to incidents to allow us to improve and learn.

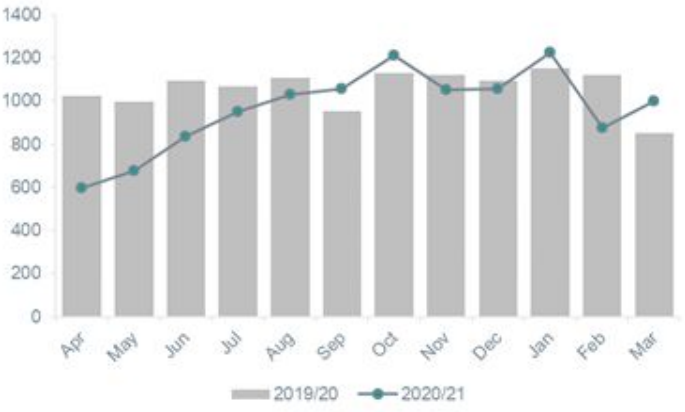
2020-21 was a challenging year for the organisation during the pandemic and our frontline services underwent tremendous pressure. Patient safety was at the forefront of the Trust's focus when responding operationally to the increasing demand and patient admissions. Although some improvement programme work was paused during periods of increased capacity the vision for patient safety and quality were regularly reviewed and considered. We adopted an agile approach to patient safety and risk management during this time to ensure that we were able to plan proactively but also respond reactively to emerging risks.

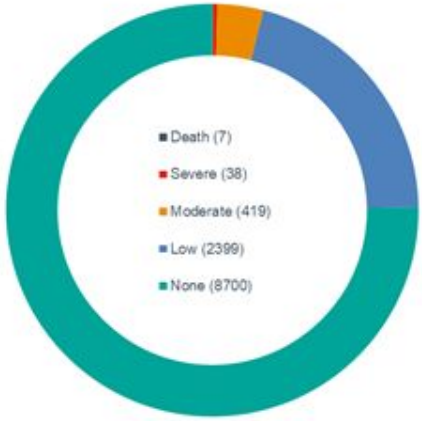
During 2020-21 we developed the strategy that will underpin our approach to responding to patient safety incidents in the coming financial year which is laid out in the PSIRP. We engaged with our staff, patient partners and stakeholders to form a plan that puts system and culture at the heart of patient safety. We thematically reviewed multiple sources of patient safety activity to define 5 patient safety priorities that we will use to build continuous improvement programmes of work.

In 2021-22 we will be putting the PSIRP into action. We will be launching new policies and processes that will enable the organisation to learn about how we can improve our systems and processes to ensure that they are safe and resilient. We will also be focusing on the underlying culture of our organisation to ensure that patients and staff feel supported and safe to speak up.

The pandemic has affected the number of incidents being reported as the Trust has adapted to the operational pressures over the past financial year. Low occupancy during the first wave resulted in a lower number of incidents being reported.

A review of the incidents that were reported indicate that there were no significant changes in the types of incidents being reported





68% of patient safety incidents resulted in no harm to a patient.

Incidents occurring within the 20/21 financial year have been internally validated for level of harm.

15.1

3.1 Freedom to Speak Up

Freedom to Speak Up (FTSU) is an initiative resulting from the Francis Report recommendations (Mid Staffordshire NHS Foundation Trust public enquiry) to give staff the opportunity to raise issues or concerns in a supportive forum. Effective speaking up arrangements help to protect patients and improve the experience of NHS staff.

FTSU Guardians have been in place at NBT since 2017, with currently 10 Guardians recruited across different areas and groups within the Trust e.g. junior doctors, nursing, support and corporate staff. This gives staff an additional route to raise issues and concerns, and enables the Trust to respond and deal with concerns more effectively. Recruitment is ongoing to encourage a diverse representation of our staff members.

2020/21	Q1	Q2	Q3	Q4
NBT	8	1	8	16
South West Average	19.5	27	25	tbc

Key achievements in 2020/21

In early 2020, the Board approved plans for a restructure of the FTSU Guardian network and the creation of a Lead FTSU Guardian post to align NBT with the best practice highlighted by the National Guardians Office (NGO). The new Lead FTSU Guardian joined the Trust in January 2021 and has protected time to enable a more focused and proactive FTSU presence.

Throughout the COVID-19 pandemic FTSU has continued to be promoted via local communications, including a regular operational update, and in October 2020 a roadshow took place around the Trust to raise awareness and encourage staff to speak up if they had any concerns.

During 2020/21 there was a drop in the number of concerns being raised at NBT from the previous year, and a reduction when compared to the national average reported by the NGO. However, the reasons for concerns aligned generally with the national position. A high proportion of concerns were raised anonymously at NBT (67% versus a national average of 13%), which may be a reflection of perceived barriers across the Trust in relation to speaking up. NBT regularly monitors both national and internal FTSU data, triangulates the 'speaking up' data with the findings from local pulse surveys and reports every six months to the Board.

Focus for 2021/22

We will complete a refreshed Board/ Organisational self-assessment and carry out a review across the Trust to identify barriers to speaking up and look at the high percentage of anonymous concerns. This will then feed into the refreshed FTSU vision and strategy and updated improvement plan, with a focus on the following areas:

- Alignment with other work-streams in the Trust, e.g. staff voice, 'just culture' and psychological safety;
- Engagement with the Trust's BAME Networks via the network chairs;
- A proactive and 'tech-savvy' communications and awareness raising strategy.

3.1 Guardian for Safe Working Hours

193 Live	**1822** Exceptions in total	**47** Exceptions last 30 days	**18** Exceptions last 7 days
0 ISCs last 30 days	**0** ISCs last 7 days	**179** Overdue	**24** Action required

Exception Reporting

The change due to COVID working patterns and the reduction in elective work from March 2020 led to a decrease in exception reporting. Numbers of exception reports are beginning to increase however as the trust begins restoration work of services.

There has been more emphasis on giving clinicians payment for any extra hours worked because of the continuing lack of available capacity to enable Time Off in Lieu.

Safety Reports

There have been no safety reports received during this reporting period.

Trainee teaching

Since COVID-19, trainee teaching has been provided remotely via Microsoft Teams. This has proved to be more accessible and as a result there has been an increased trainee attendance and good feedback has been received.

Junior Doctor Forum meetings

The Junior Doctor Forums are open to all trainees with the Guardian for Safe Working Hours and these are held approximately every quarter. The last meeting was held on 23rd March 2021.

Networking

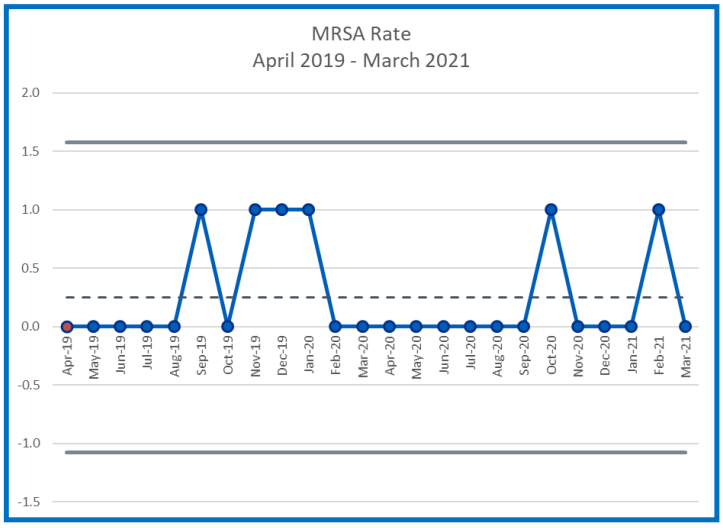
The NBT Guardian is a member of the Regional Forum of Guardians for Safe Working Hours. The Guardian is also in regular contact by WhatsApp with national and regional groups, as well as having email contact with a number of other Guardians in the region to share updates.

3.1 Quality Indicators

Methicillin-resistant staphylococcus aureus (MRSA)

There were 2 cases of MRSA throughout 2020/21.

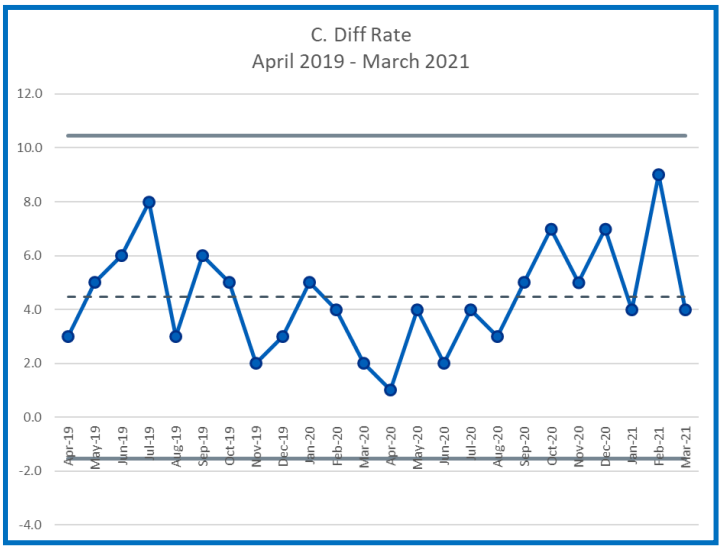
This was a continued reduction from 4 cases in 2019/20.



Clostridium Difficile (C-Diff)

The Trust has seen a large rise in cases in 2020/21; 78 cases against a trajectory limit of 57 cases.

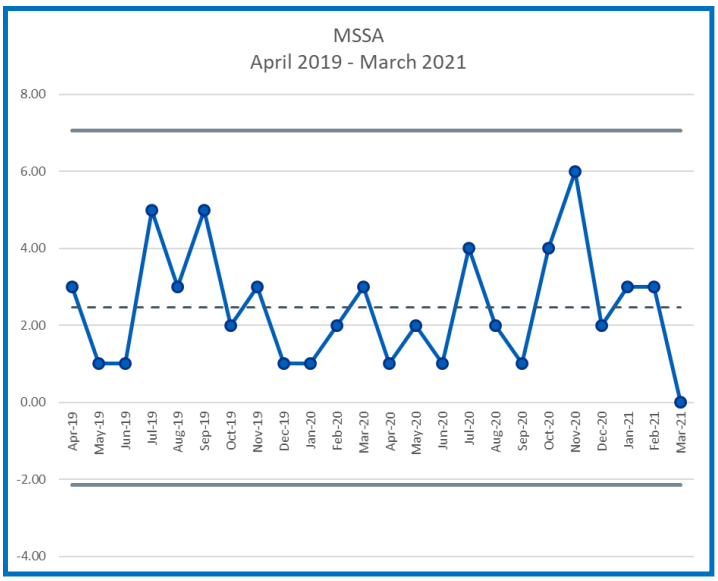
This rise has been seen across the BNSSG Clinical Commissioning Group network and a quality improvement initiative will be formed to drive reductions in cases, which will be monitored at the C-Difficile Steering Group.



Methicillin-Susceptible Staphylococcus Aureus (MSSA)

There were 28 reported cases of MSSA Bacteraemia in 2020/21. This is a slight reduction since 2019/20.

This rate is comparable with the region, who have also noted a reduction of cases. MSSA is continually monitored and reviewed at the Staphylococcus Steering Group.



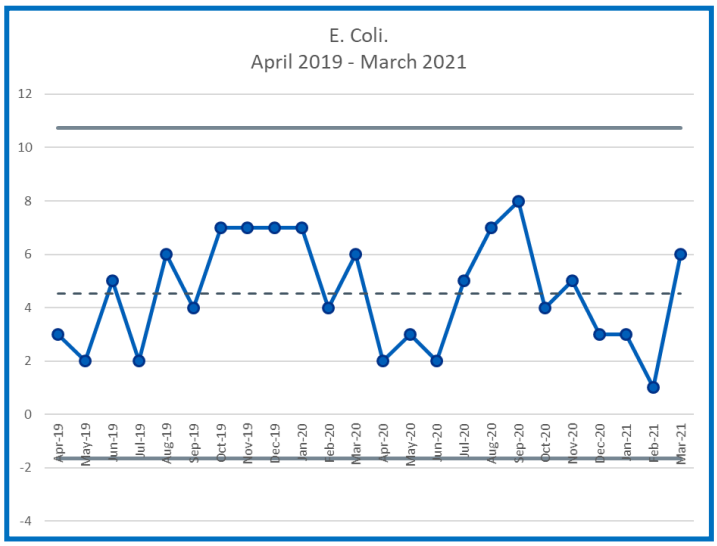
3.1 Quality Indicators

Escherichia Coli (E-Coli)

There has been a significant reduction in cases of E-Coli across the region, as well as at NBT.

The Trust reported 48 cases in 2020/21 against 60 reported in 2019/20.

Community work originally planned for 2020/21 was not able to take place due to COVID-19, however there was still a reduction in cases of 13%.



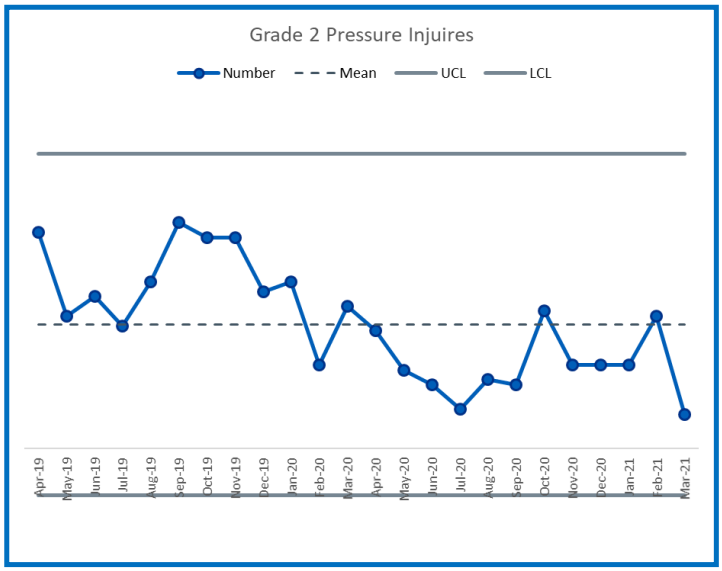
Pressure Injuries

The Trust achieved a reduction in pressure injuries in 2020/21:

60% reduction in Grade 3 pressure injuries

49% reduction in Grade 2 pressure injuries

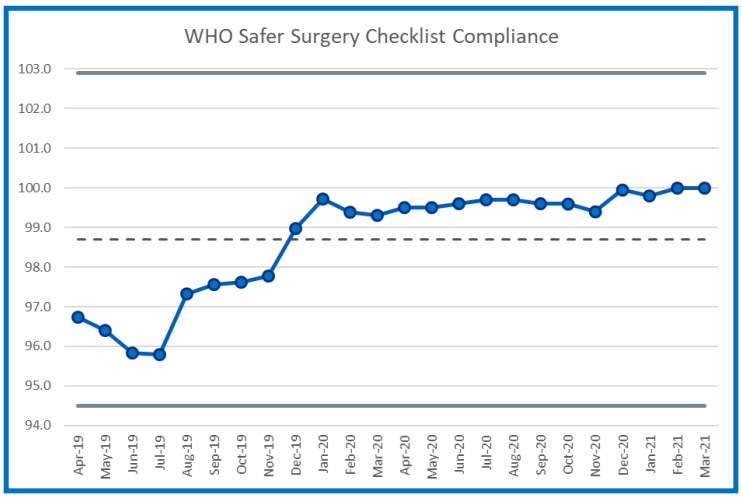
57% reduction in medical device related pressure injuries



WHO Safer Surgery Checklist

Surgical safety checklists are completed prior to every operation carried out in Theatres.

NBT has maintained a completion rate of over 95%. This slightly decreased in November 2020 due a change in the Theatre system, however this has now returned to the previous compliance rate.



3.1 Safeguarding Adults

North Bristol NHS Trust has a duty and responsibility to protect adults at risk of abuse or neglect due to their needs for care and support. The Trust is committed to ensuring full understanding of roles and responsibilities within the complex and increasing scope of the safeguarding agenda. Safeguarding advice, guidance and support to clinicians and practitioners is provided across the NBT system and wider safeguarding partnerships within BNSSG. This was however reduced in 2020/21 due to the impact and restrictions around the COVID-19 pandemic.

Key achievements in 2020/21

Liberty Protection Safeguards (LPS): The national LPS code of practice and regulations has been delayed, however preparations have begun, in particular scoping the assumed extent of the responsibilities to be transferred to NBT from Local Authorities under the current Deprivation of Liberty Safeguards (DoLS)

Training: Safeguarding adults' level 3 training was impacted by clinical pressures, COVID-19 restrictions on face to face training and winter pressures. Additional sessions have been provided and training continues to be promoted.

Compliance is expected to improve significantly in 2021-22 with the support and encouragement of divisional leads.

The Domestic Abuse Bill (2020): This was delayed due to the pandemic, therefore the development of local strategy, policies and procedures will be rolled into 2021/22. The legislation creates a statutory definition of domestic abuse and introduces a number of statutory and legal responses. Domestic abuse related presentations have increased across the system during the pandemic.

Mental Capacity Act (MCA) and Best Interests: Improvements have continued to be embedded, with continued provision of robust safeguarding advice and guidance, as well as direction and hands-on support with more complex challenging scenarios.

System working: The Safeguarding Team participates in the South Gloucestershire Safeguarding Adults Board and the Keeping Bristol Safe Partnership (KBSP).

They have been active partners in the domestic abuse, safeguarding adult/domestic homicide review and quality assurance sub-groups and also within the partnership in identifying and contributing to learning for NBT and the wider safeguarding system.

Deprivation of Liberty Safeguards (DoLS): There were 2,009 DoLs applications in 2020/21; over 100% increase on the previous year.

Focus for 2021/22

- Scope/review the safeguarding team core functions and working capacity with the NBT senior team.
- Continue to forge meaningful and positive partnership working within the BNSSG safeguarding system as the Trust works towards becoming an Integrated Care System (ICS).
- Work with divisional leads to ensure all staff can access and receive the relevant appropriate level of training as per the safeguarding intercollegiate document.
- The Safeguarding Team will be key players in supporting the Trust to prepare for the LPS and continue to embed and support best practice in the MCA and Best Interest process.
- Continue to share lessons and outcomes from Safeguarding Adult Reviews and safeguarding related incidents and support staff to identify learning.

3.1 Safeguarding Children

The safeguarding children requirements promote the welfare of children who are patients or family members of our adult patients, protecting them from maltreatment or impairment of their health and development, and supporting children to grow up in circumstances consistent with the provision of safe and effective care. We continually seek to safeguard and promote the wellbeing of children and families who use our services. As a healthcare provider we engage with children and their families as they use our services, which can highlight where early help may prevent harm and contribute to better outcomes.

The impact of the pandemic has heightened awareness of the importance of health contacts for the 'Think Family' approach to safeguarding children. Many children and families have been adversely affected by the pandemic and this will impact the health and development of children and the welfare of families and wider society in the months ahead.

Key achievements in 2020/21

Flexible COVID-19 support: Children's safeguarding activity and reporting continued Trust-wide, supported by experienced safeguarding practitioners. The Named Nurse for Safeguarding Children relocated to the ED during the first lockdown to give additional support for children's social care referrals and as a safeguarding resource for staff temporarily redeployed to support the ED.

'Drive in' swab centres: These were recognised nationally as a safe opportunity for people to seek professional help if experiencing abuse. The team developed additional information to enable staff supporting the centres to manage disclosures about domestic abuse.

Multi agency working: The team engaged in multiagency safeguarding response cells led by the Keeping Bristol Safe Partnership to frequently review children's safeguarding procedures and the challenges faced by support services in response to redeployments and frequently changing restrictions and Government guidance. The Safeguarding Children Workplan was reviewed with the CCG Designated Nurse for Safeguarding Children to ensure that statutory, regulatory and contractual requirements were prioritised and met throughout the year. NBT contributed to and supported multiagency partnership working across BNSSG, enabling secure and smooth sharing of information at a time of unprecedented challenge and change.

Training: Virtual options for mandatory training were provided, alongside face to face training in COVID-19 secure settings, to ensure staff were informed and aware of new developments in safeguarding knowledge and practice e.g. risk management; assessment of needs and onward referral to partner agencies.

Focus for 2021/22

- Work with NBT colleagues to develop the safeguarding children components of the Electronic Patient Record.
- Continue to offer flexible blended learning options for staff training, including use of partnership webinars and e-learning.
- Work with leads across the safeguarding partnerships to understand the longer-term impact of the pandemic on children and families living in BNSSG.
- Review practice and process in line with legislative changes for the Liberty Protection Safeguards (LPS) and Domestic Abuse.

3.1 GIRFT

GETTING IT RIGHT FIRST TIME

Current GIRFT Trust-wide projects

Improve quality and depth of **clinical coding**: improvement already in neurosciences and vascular.

Share and learn from **litigation**: starting to disseminate litigation and trial proceedings to the divisions for quality improvement, learning and adopting good practice.

Create and expand a **blended workforce**: currently looking to accelerate our Physicians Associate and Advanced Care Practitioner roles.

Reduce **surgical site infections**: commissioned audits and projects in Theatres, Orthopaedics and Breast Surgery.

Veterans Covenant Healthcare Alliance (VCHA) accreditation 2018. Re-accreditation as a Veteran Aware Hospital is expected Autumn 2021. The GIRFT Veteran Aware team continuously raise awareness of the needs of Armed Forces families at NBT e.g. staff induction and our internal and external websites. NBT is an active member of BNSSG local Armed Forces Covenant Groups and collaborates with other SW Trusts and National GIRFT Veteran Group to learn, disseminate good practice and prepare for the forthcoming Armed Forces Bill 2021 public sector duty.

Specialties which have received a GIRFT visit during 2020-2021

2020: Cranial Neurosurgery, Imaging and Radiology, Plastic Surgery and Burns, Rheumatology, Gastroenterology and Hepatology.

2021: Pathology, Acute and General Medicine.

Notable good practice observed

Cranial neurosurgery has the second best length of stay for non-elective patients in the country.

Plastic Surgery and Burns records very low numbers of pressure ulcers and short lengths of stay; good management pre-operatively supporting other services and community.

Rheumatology is recognised as exemplar in their holistic approach to systemic pain issues. They were also commended for the speed at which biosimilars are switched, which is one of the highest that the GIRFT team have seen.

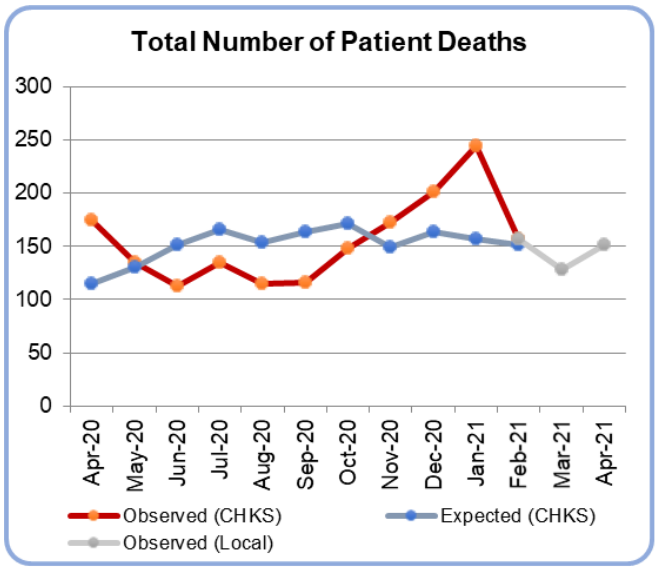
Imaging and Radiology has created their own portering service and hot/cold areas in their emergency zone to help prioritise patients and improve flow.

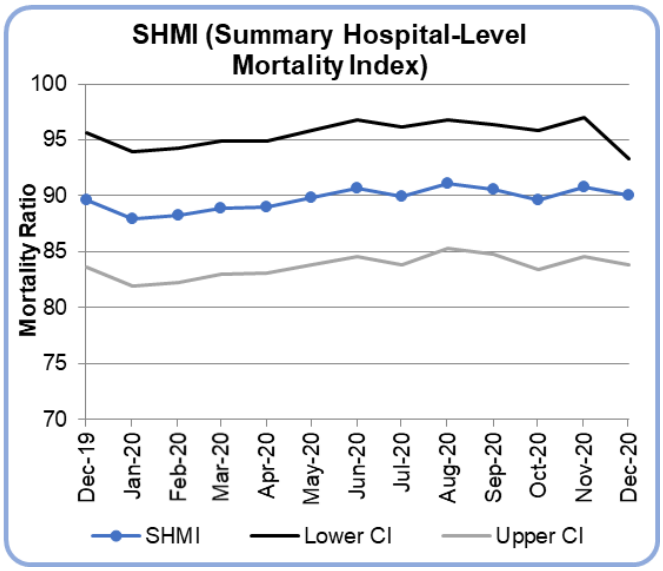
Gastroenterology and Hepatology has a pre-assessment service for direct-to-test colonoscopy, a dedicated segmented portal hypertension endoscopy list, a Lynch syndrome register and a proactive liver service with a Hepatology patient helpline. They were also commended by the day-case rate for paracentesis and for being an early adopter for the Infliximab biosimilar.

Pathology has good Diabetic Diagnosis/ Monitoring and AKI Monitoring. They were also commended for their Haematology and Biochemistry Emergency Zone Result Timeliness and for their Immunology Test Timeliness for Connective, as well as their Tissue Disease/Vasculitis Pathway.

No final report for the visit to **Acute and General Medicine** was available at the time of writing this report.

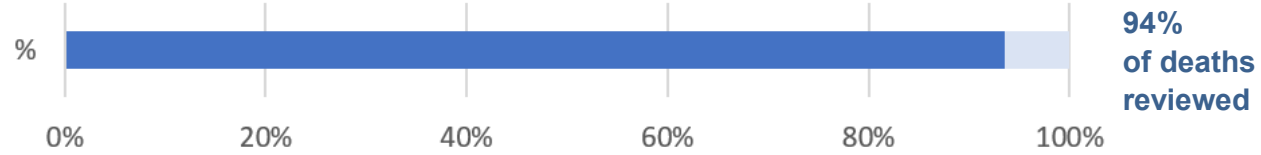
3.1 Mortality and Learning from Deaths





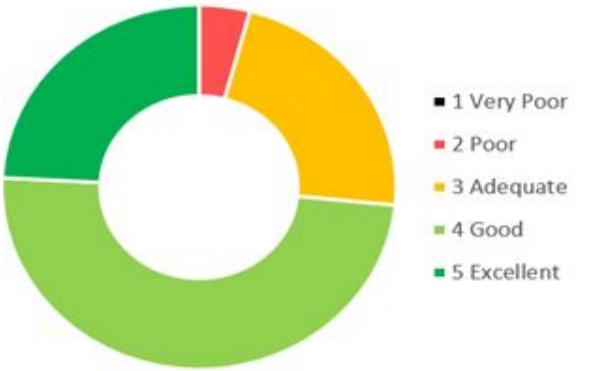
Activity

Despite the challenges presented by the pandemic NBT has maintained an excellent rate of review across deaths occurring at the Trust.



Level of Care

NBT has also maintained a high level of care, with 96% of care being rated as 'adequate' or above, and no cases where 'very poor' care has been identified.



Key Achievements

- Over the course of 2020/21 NBT has undertaken two cohort mortality reviews, firstly on patients that died in hospital during the first wave of the pandemic, and secondly specifically for patients with a learning disability who died in hospital during the first wave.
- The results of these specific cohort reviews have driven improvement actions across the Trust that not only helped to tailor our response to the pandemic, particularly during the second wave, but also allowed us to improve care for patients with learning disabilities.
- We are committed to undertaking more patient cohort reviews during 2020-21 to ensure that we are responsive to our mortality data and proactively undertake quality improvement.

3.1 Medical Examiner Service

The national Medical Examiner (ME) service was established nationally in 2019 to provide independent scrutiny of the cause and circumstances of all deaths in hospitals. This will eventually be expanded to also include all deaths in primary care (outside of hospital). The key aims of the ME service are to:

- Improve patient safety
- Ensure the quality and accuracy of Medical Certificates of Cause of Death (MCCDs)
- Ensure accurate and appropriate referrals to the HM Coroner
- Support local learning
- Drive improvements in clinical governance processes.

The ME Service also provides important confidential support and transparency to bereaved families, by answering any queries or concerns they may have at a difficult time, escalating these where needed, and providing advice and signposting to support or other services.

Progress to date

In April 2020, North Bristol NHS Trust (NBT) and University Hospitals Bristol and Weston NHS Foundation Trust (UHBW) joined together to develop and then host the ME service for the population of Bristol, North Somerset and South Gloucestershire (BNSSG). This collaborative approach has enabled processes and reporting to be developed and streamlined, with visibility across this local system. NBT has created a clear referral framework to record and act upon any concerns, or areas of good practice that the MEs bring to the attention of the Trust.

The ME team currently review an average of 66% of all adult deaths in NBT. This is the mean average of percentage scrutinised every week since recording began at the beginning of January 2021. The expectation is that the service will expand to review all adult deaths and also extend to include neonatal and maternal deaths. The ME service awaits national guidance on the scrutiny of paediatric deaths, which are planned to become statutory by April 2022.

Of the 369 adult deaths that the ME service has reviewed between 1st January and 31st March 2021, approximately 16% (59 cases) have resulted in referrals to the Trust. These referrals include both positive feedback and areas for the Trust's attention for learning purposes or for further scrutiny if required. Of these, in February 2021, 3.8% were referred for Structured Judgement Review (case note review by a consultant), 4.8% as a potential patient safety concern, and 1.9% were signposted to the Patient Advice Liaison Service or Complaints.

Early Benefits

The ME service has reported that this has been very well received by the bereaved, who are overwhelmingly grateful and pleased to be able to speak with an independent party.

The independent review by a trained consultant (ME) also provides good opportunity for the Quality Attending Practitioners (usually junior doctors) to discuss any aspects of the case they wish to, which aids their own learning and provides opportunity for concerns or positive feedback to be fed back into the specialities involved in patient care.

3.1 National Clinical Audit

Participation in National Clinical Audits

During 2020/21 North Bristol NHS Trust participated in 44 out of the 45 National Clinical Audits the Trust was eligible to take part (for full details please refer to Annex 5).

Quality Improvement as a result of National Clinical Audit

The results of national clinical audits are reviewed at divisional level and areas of focus for improvement identified. The following are some examples of the improvement work undertaken across a cross-section of national clinical audits that have published reports during 2020/21:

Maternal, New-born and Infant Clinical Outcome Review Programme (MBRRACE)

2020/21 saw the continuation of various pieces of improvement work originally inspired by national clinical audit data, including work to reduce postpartum haemorrhage and obstetric anal sphincter injuries. These two projects have seen successes individually, but are now working in collaboration with the ambition that greater improvements will be seen in the future.

The work as part of the **PERIPrem** project has also been very successful. Although the theory of most care-bundle elements was not new to North Bristol Trust, the processes and multi-disciplinary working across the specialties have been examined and led to improvements in compliance and teamworking.

In response to findings from the use of the Perinatal Mortality Review Tool (PMRT), improvement work took place in October 2020 to produce a local guideline regarding histological investigation of the placenta. An audit scheduled to take place during 2021 will evidence the increased compliance rate apparent from regular case reviews. The need for improvement work in this area was highlighted in several of the MBRRACE-UK reports this year so this is clearly a national theme, rather than just a local one.

More recently, at the beginning of 2021, a service evaluation has started to examine mortality outcomes and ethnicity. The need for this examination is highlighted multiple times in the MBRRACE-UK reports and it is hoped that the findings will identify future areas for improvement, as well as areas of good practice.

Neurosurgical National Audit Programme (NNAP)

NBT received a strongly positive report in October 2020. The Trust was a positive outlier at the 99.8% limit for low 30-day mortality rates, as compared to peers using case-mix adjustment.

There were no areas of concern raised in the report. Our unadjusted rate for non-procedural deaths was recorded as higher than the national rate, but after querying this with the Society of British Neurological Surgeons (SBNS) it was discovered that there was an issue with the data capture. NBT clinicians were subsequently invited onto the NNAP group to help improve aspects of the data collection and reporting to address the issue.

3.2 National Clinical Audit

Royal College of Emergency Medicine (RCEM) Fractured Neck of Femur (NOF) Audit

NBT performed well on:

- the use of the analgesic ladder for prescribing analgesia
- patients that had a suspected neck of femur fracture had an x-ray quickly to diagnose their fracture
- patients that were in pain on initial presentation to the department were reassessed to see whether further analgesia was administered within a timely manner.

The focus for improvement during 2020/21 was on improving knowledge of the NOF pathway in the department—engaging with staff regarding the pathway and raising awareness across the department. The clinical team developed a teaching method on how to perform a fascia illiaca block which is currently undergoing re-audit. This aims to improve the time from x-ray to FI block which will overall improve our patients' experience. The importance has also been highlighted to clinical staff of the need to document whether a bladder scan was considered for the patient, therefore ensuring that the fluid status of the patient has been reviewed.

Outlier Response

North Bristol NHS Trust reported good outcomes for the majority of national clinical audits during 2020/21. The responsibility to ensure national clinical audits are reviewed and actions are taken forward lies within individual specialties and divisions.

Where there is a national audit 'outlier' (meaning it is of potential concern to the Trust) the investigation, response and improvement actions are escalated to the Clinical Effectiveness and Audit Committee (CEAC), chaired by the Trust Medical Director. This ensures we respond in a timely manner, and improvement actions are approved and undertaken.

The Trust was notified that NBT was presenting as an outlier on certain measures within 3 of 45 national clinical audits during 2020/21 (7%). The Trust undertook reviews of all outcomes that were outside the expected levels and used the learning from these reviews to implement improvement work to better our outcomes in these areas. Details of the learning and reviews are outlined below.

National Bowel Cancer Audit (October 2020)

30 day unplanned readmission rate

The investigation showed this to be a coding issue whereby NBT includes Surgical Hot Clinic day attendances, some day stoma therapy attendances and all ward day attendances for catheter removal as readmissions. Accounting for this, NBT's readmission rate is in line with the national figure at 10.9% versus 11.8% for England and Wales. NBT's readmission rate has improved since 2019.

3.2 National Clinical Audit

National Neonatal Audit Programme (NNAP) (October 2020)

Documented consultation with parents by a senior member of the neonatal team within 24hrs of a bay's first admission

Following investigation this appears to be an issue with documentation rather than a failure of communication. As part of the NNAP action plan for 2019 a Data Support Manager has been appointed and we anticipate an improvement in documentation and data input for this audit.

National Lung Cancer Audit (February 2021)

Patients assessed by a lung cancer nurse specialist (LCNS)

This outlier alert originally refers to December 2019, but due to COVID-19 the National Lung Cancer Audit paused their outlier management process. This was restarted in February 2021 and the response to this outlier was submitted at this time. NBT have recruited an additional Lung Cancer Nurse Specialist (LCNS) as the Trust had been operating below the minimum recommended requirement. The Trust is confident that with an additional LCNS in post it will be possible to achieve the target recommended for LCNS contact and presence at diagnosis.

In addition to recruiting a further LCNS, NBT have undertaken the following:

- Increased the allied cancer workforce to support the LCNS and reduce additional demands on their time.
- Recruited a lung cancer coordinator to support the administrative demands associated with the lung cancer diagnostic pathway.
- Sourced funding for a cancer navigator position to work closely with patients at the early stages of their pathway, further easing pressure on the LCNSs.

It is recognised that actions taken in response to the 2018 results may not be reflected in the audit results for another year or more.

Clinical Audit focus for improvement for 2020/21

1. Enhanced recovery programmes for intrinsic tumour and pituitary surgery.
2. Improved early management of spinal cord injury patients through better documentation (proforma re-written), new collar care advice and early input of ICU to review ward-based patients to predict early respiratory decline.
3. Proactive response to changes in key metrics (such as mortality) using CHKS—the online mortality indicator system which benchmarks nationally. For example, we have previously responded to CCG concerns about traumatic brain injury mortality rates, which use Dr Foster metrics, by demonstrating that the analysis is not appropriate for our patient cohort. Rather than being reactive to these CCG requests, we are now using CHKS mortality ratios to proactively seek out time periods when such an alert may occur and respond in advance of a formal request.

3.3 Learning from Patient Feedback

Friends and Family Test

The Friends and Family Test (FFT) is an important feedback tool that enables people using our services to give real-time feedback about their experiences. Last year NHS England and NHS Improvement released new FFT guidance to improve accessibility for all patients. This became effective on 1st April 2020 and we have successfully implemented the requirements across the Trust. The changes included new questions: '*Overall, how was your experience of our service*?' and '*Please tell us why you gave your answer'.*

National submissions to NHS England were paused in March 2020 as a result of the COVID -19 pandemic, however these resumed in December 2020. Locally, we opted to resume collection of FFT feedback earlier, on 4th July 2020.

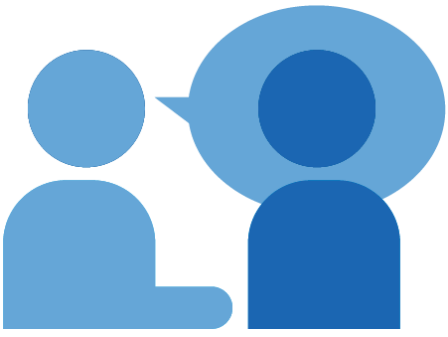
NHS England will continue to monitor response levels but there is no longer a requirement to meet 'target' response rates, or collect feedback at specific times. The emphasis is now on demonstrating how we use FFT feedback and this will be a focus in 2021/22 to ensure a consistent, Trust-wide model. Between 1st April 2020 to 31st March 2021 (including the pause in FFT between April—July 2020) 69,306 responses were received in total. 93.6% of responses were positive and the overall response rate was 19%. This is slightly higher than the average in 2019/20 of 18%.

FFT Feedback	Response Rate	Positive	Negative
Trust wide	19%	93.60%	3.24%
Inpatients	23%	91.24%	3.94%
Outpatients	23%	88.86%	6.70%
Emergency Department	17%	94.68%	2.46%

Using FFT to engage staff, embed good practice and make improvements

In the Theatres department, the governance team has been working hard to improve staff engagement with FTT, share results and feedback and make improvements. FFT data for each of the theatre areas, learning identified from comments and sharing of positive feedback and best practice is shared at the monthly Theatre Governance Meeting

As a result Theatre FFT response rates have shown sustained improvement since September 2020, with March 2021 data showing L2 theatres at 26.4% (up from 8.9%) and L3 theatres at 46.4% (up from 22.5%).



By reviewing their FFT feedback regularly, the Theatres team have been able to spot frequent issues being raised, e.g. the lack of a shelter for the admissions area. In order to improve this, the team have engaged with Estates and Facilities to arrange a shelter/covered area for the admissions area. This demonstrates the potential of FFT to signpost positive changes for patient experience.

3.3 Learning from Patient Feedback

Complaints

The overall number of formal complaints received in 2020/21 was 490; a 22% decrease compared with the previous year of 626. This may reflect the impact of the COVID-19 pandemic and the level of reduced activity across the Trust as clinical prioritisation and reduced visiting numbers came into effect.

In March 2020, following guidance from NHS England, the PALS and Complaints team introduced an escalation process for the management of complaints and concerns during the COVID-19 pandemic. This process was introduced as many staff were re-deployed from their usual roles to support the delivery of clinical care. All non-urgent complaints and concerns were placed on hold and cases that had been received before the escalation process were reviewed and resolved where possible, or temporarily placed on hold.

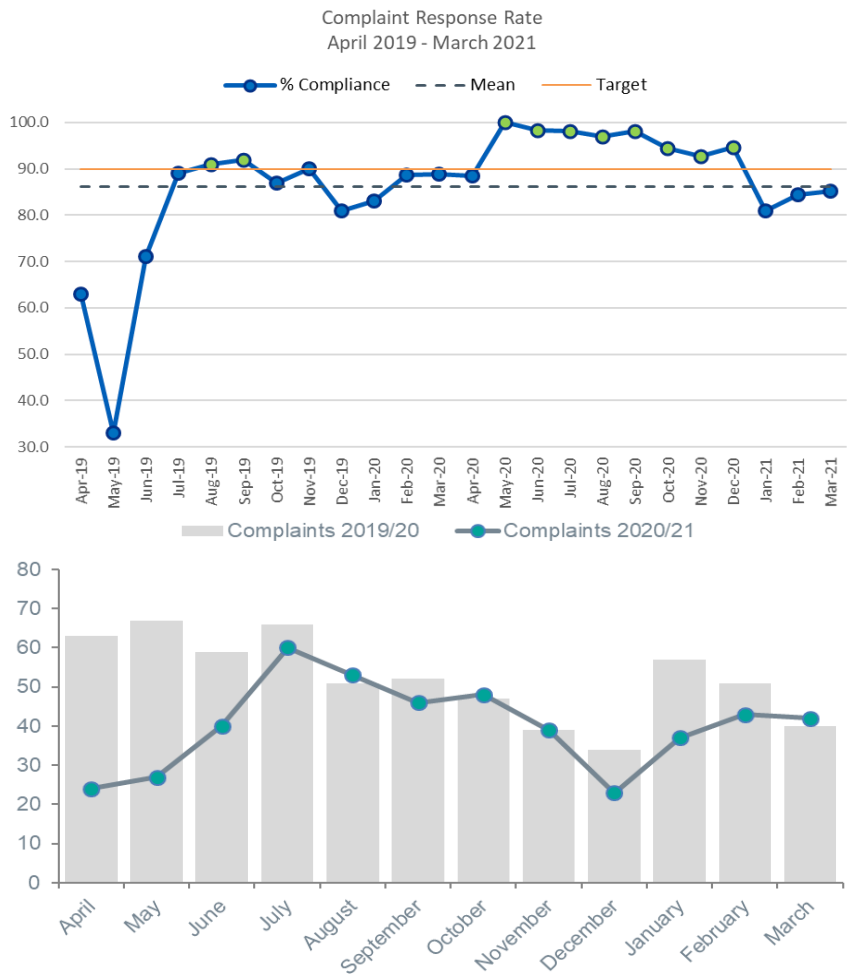
The Trust resumed 'business as usual' (BAU) on 4th May 2020 and cases that had been placed on hold were resumed.

The decrease in complaints may also be the positive result of changes in policy and processes. On 1st May 2020 the policy for 'Managing Complaints and Concerns' was re-launched. We have also continued developing PALS, and increasingly more issues are being successfully dealt with at an earlier stage. All PALS and Complaint Officers are able to work interchangeably across both services, which enables our officers to triage issues raised by patients, carers or relatives and advise of the most appropriate route to resolving an issue quickly and effectively.

Performance

We continue to work very hard to reduce the number of overdue responses. Since April 2020 we have consistently kept the number of overdue complaints low, with 8 months with no overdue complaints. This is a significant achievement which we will continue to monitor and maintain in 2021/2022.

Overdue Complaint Response 2020/21		
Apr	May	Jun
2	1	0
Jul	Aug	Sep
0	0	0
Oct	Nov	Dec
2	2	0
Jan	Feb	Mar
0	0	0



15.1

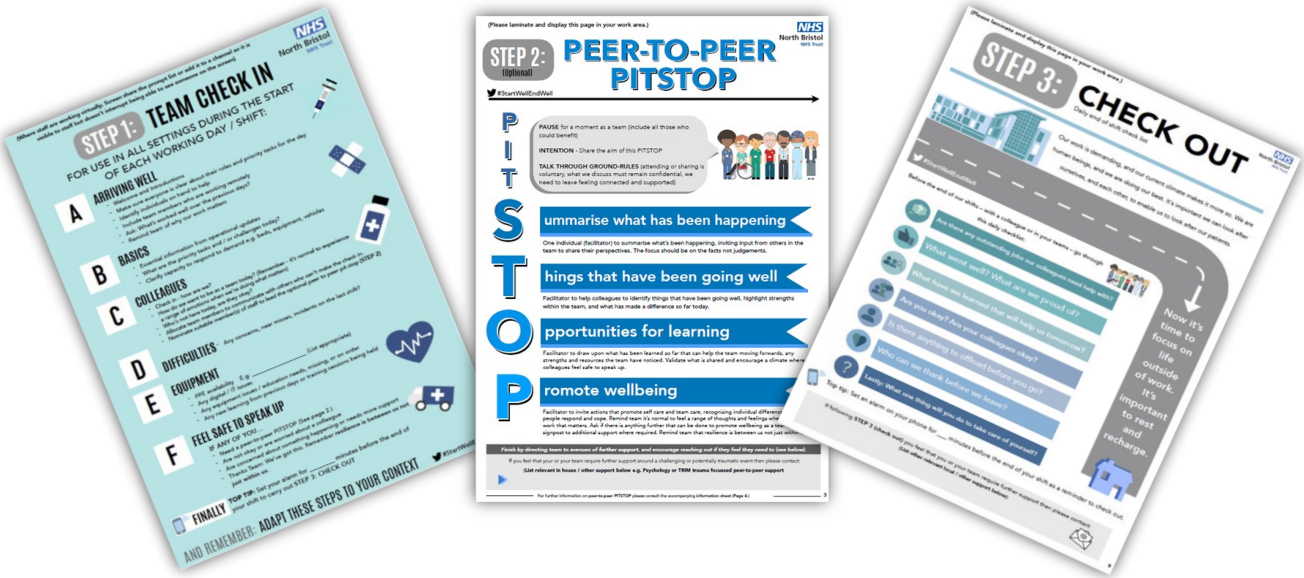
3.3 Quality Improvement Initiatives

Virtual Visits

As a result of the pandemic response visiting restrictions were put in place as part of the Trust's Infection Control Policy. In the first wave we initiated the use of virtual calls to enable patients and family to stay in touch during the patient's stay, regardless of where they were in the hospital. These calls were facilitated by staff redeployed to a family liaison team. This team agreed with the family a time and date for the virtual visit and then attended the ward to support the visit. This has since been adapted throughout the year to ward staff using the 'Attend Anywhere' app on the ward handheld devices to facilitate the calls.

Clinical Communication

Due to the visiting restrictions and families being unable to physically attend the hospital there was a need to ensure that patients and loved ones were kept well informed of their condition, treatment plans, and given reassurance that they were being supported and cared for. A communication model was established to ensure that relatives could expect the same level of communication based on the clinical condition of the patient, at each stage of their patient journey, regardless of where they were in the hospital. This provided an invaluable link with patients and families at a very difficult time and ensured they were kept as informed as possible.



Start well, end well

Start well, end well is an initiative that was developed to support all staff through the challenging first wave of the pandemic response. Due to the need to prioritise clinical care, 'mega teams' were formed, often with staff redeployed from other departments. It was recognised that staff, both on site and working virtually, needed support with their own health and wellbeing at this time. A three step framework was put in place to bring teams together at the beginning and end of each shift, along with peer-to-peer pitstops whenever needed. These steps encouraged the daily sharing of experiences, promoting health and wellbeing, and identifying whether additional support was needed in response to a challenging or potentially traumatic event. This was an opportunity for shared learning during a period of rapidly evolving pandemic guidelines and ways of working and has since been implemented by other Trusts in the South West.

3.3 Quality Improvement Initiatives

Patient Consent & Shared Decision Making Programme

Shared decision making between clinical professionals, patients and carers is at the heart of our approach to delivering high quality care. One of the biggest decisions any of us can make is to proceed with surgical treatment, whether simple or complex. These are significant choices and not always easy to make and therefore require excellent communication between clinicians and patients to appreciate what really matters in this decision-making process.

During 2020-21 we have embarked upon a development programme to really understand how well we support patients in making these decisions, including how we use our processes and documentation to support good conversations prior to the day of surgery. This entails:

1. **Improved consent documentation**: a focus on the use of plain English, more space for a tailored emphasis on the individual needs of the patient, including a much greater emphasis on wider social, religious, family and professional factors.
2. **Real time patient feedback:** piloting a new digital system, that enables patients to provide feedback on whether they feel empowered to make informed choices about their care and treatment, helping us to understand where they wish to make alternative decisions.

Improved Consent Documentation

Working collaboratively with patients within the Neurosurgery specialty and patient representatives in the consent working group we have developed improved documentation that helps to really focus on what matters most to patients. Some examples of feedback from patients involved in reviewing the re-design are shown below:

"…The new form gives you more of a voice. A narrative can be completed…"

"…space to be heard…"

"…Likes the section 'this is what is important to me'…"

"…very good because it looks at each patient as an individual…"

"…the form uses layman's terms…"

"…links on form to the internet are excellent… "

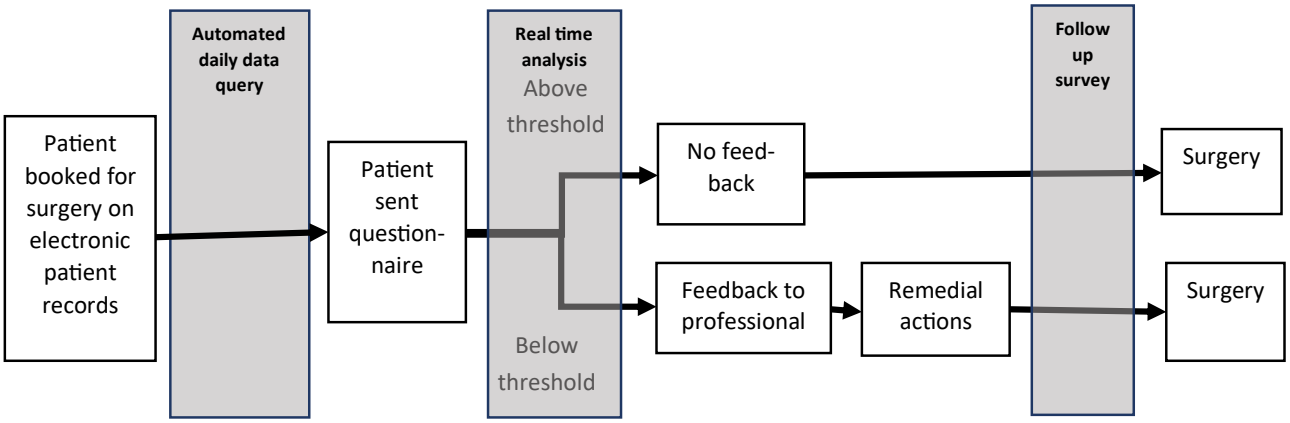
"…A lot more appealing on the eye…"

Real Time Patient Feedback

We have implemented a new system to seek effective understanding of Informed Consent in clinical practice using validated patient-reported measures, which went live on 1st April 2021.

This is a proof of concept project, underpinned by academic research through the University of Bristol which will help us to rigorously assess its impact and determine its ongoing benefits.

The approach utilises simple feedback questionnaires to understand how informed patients are prior to and after receiving treatment or an intervention, and the level of shared decision making and patient involvement.



3.3 NHS Nightingale Hospital and Vaccination Delivery

Southmead Hospital Vaccination Hub

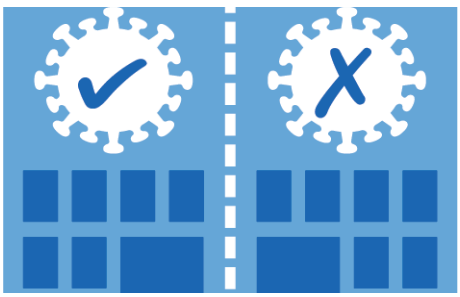
The Vaccination Hub at Southmead Hospital was one of 50 hospital hubs established across the country to provide the safe provision of vaccines to public and staff. It delivered the first vaccine in Bristol to a 97 year old gentleman on 8th December 2020, and just over 100 days later had delivered 30,000 doses. The hub was staffed by NBT permanent and bank staff, with the support of volunteers to ensure that patients and staff were vaccinated in a safe, socially distanced manner. With the rollout of additional vaccine provision across the region the Hub officially closed in March 2021 and resumed its primary function.

Ashton Gate Mass Vaccination Centre

NBT was also commissioned to set up and deliver the Ashton Gate Mass Vaccination Centre, which is one of ten vaccination centres across the country with the capacity to vaccinate more than a thousand people per day, 12 hours per day and seven days per week.

The Centre has hosted a series of dedicated clinics for vulnerable groups, for example people with mild to severe learning disabilities.

North Bristol Trust continues to support Bristol, North Somerset and South Gloucestershire's whole system approach to the COVID-19 vaccination programme, which brings GPs, pharmacies, hospital hubs and mass vaccination centres together to offer people a vaccination in the most appropriate setting possible as they become eligible.



NHS Nightingale Hospital Bristol was one of seven critical care temporary hospitals established by NHS England in response to the first wave of the COVID-19 pandemic. It was created in April 2020 to improve the resilience of the Severn hospital network and provide additional critical care capacity of 300 beds if needed, with space to treat up to 1,000 people in total.

North Bristol NHS Trust was commissioned by NHS England to set up the new hospital which was based in the University of the West of England Exhibition and Conference Centre at Frenchay.

The environment, equipment, staff and clinical pathways were rapidly designed, tested and 'ready to go' within a short timeframe of just three weeks. Partnership working with many other organisations was fundamental to this unprecedented achievement and ensured that, in the event that the additional capacity was required, patients would receive safe quality patient care.

Whilst, thankfully, it was not needed to play its original role, the hospital has played an invaluable part in supporting non-COVID routine care in the region. More than 7,000 non-COVID patients of Bristol Royal Hospital and the Bristol Eye Hospital have attended daytime paediatric services and patient assessments. During this time it continued to remain on standby to provide intensive care capacity if needed.

The NHS Nightingale Hospital Bristol was officially decommissioned on 31st March 2021, however there have been long term systemic improvements that have resulted through the new, innovative solutions developed there, such as;

- All seven Intensive Care Units across the system are now linked together in a strengthened and robust critical care network, with a single IT system.
- Adaptable models of step-down care supporting patient flow in hospitals have been developed, and the skills, expertise and experience of staff have been expanded as a result.
- Organisational relationships have strengthened and stronger professional networks developed which is benefitting partnership working across the health and social care system.
- A joint mentoring programme between NBT and the Ministry of Defence has been developed and recently launched.

3.3 Volunteers

Together with the rest of NBT, the COVID--19 pandemic brought Volunteer Services many challenges.

To ensure the safety of patients and volunteers a significant proportion of volunteers temporarily stepped down from their patient facing roles.

Existing volunteer roles were adapted and new ones created to ensure that the volunteers could continue to support patients and staff throughout the pandemic.

Our volunteers supported **Southmead Hospital Charity** to distribute donations of food and gifts to staff throughout the hospital. They also supported the collection of mask adjusters and scrubs bags for staff.

Our **Fresh Arts Music Team** has conducted over **150 hours of live piano music,** playing for patients and staff. This has been implemented by 15 volunteers, 12 of whom are NBT staff.
New volunteers were recruited for special performances to celebrate Black History Month.

The **Complaints Lay Review Panel** has adapted to virtual working, with support from the Patients Association and the flexibility and willingness of the members of the panel.

The Panel's work is hugely important to ensure the quality of our complaints process, ensuring we adhere to regulations, internal policy and that we deliver a person-centred approach in all that we do.

We currently have over **100 active volunteers**, and we are looking forward to welcoming our temporarily stepped down volunteers back when it is safe to do so across the Trust.

These include our **Spiritual and Pastoral Care Volunteers**, **Macmillan Wellbeing Centre Volunteers,** our ward based befrienders and many, many more who provide invaluable support to our patients, carers and staff.

A new remote **Volunteer Reader** role was created to support the communications team to receive feedback on patient leaflets and other reading material.

The **Move Maker Team** continued our meet and greet service, supporting check-in and promoting mask wearing and hand hygiene measures. In addition, the team delivered patient belongings to wards to support the visiting policy restrictions. The team also supported the Vaccination Centre to improve the patient welcome experience.

The team also contributed to the Hidden Disability Sunflower Scheme by providing lanyards and bracelets to those who require one. This year the Move Maker service donated more than **20,000** hours of time.

Special short term roles were created in response to the pandemic, such as; **Bereavement Services support,** an **Adverse Weather Volunteer Driver team** to transport staff into work; and a team to deliver letters to patients from loved ones who were unable to physically attend due to the visiting restrictions

The **Response Volunteer** role was adapted to focus on supporting the pharmacy to deliver medications to wards, with the aim of freeing up ward staff to focus on clinical tasks.

This dedicated team of volunteers have passionately committed to these roles, donating over **2,000** hours of their time.

A new **Antenatal Meet and Greet** role was created to support the flow of patients through the waiting area during scan visiting restrictions, donating over **1,000** hours of volunteer time.

Our **peer support** roles have been adapted so that they can be conducted safely over the telephone instead of face to face. A small team of volunteers have continued to support outdoor workshops with our **Head Injury Therapy Unit.**

3.3 Patient Partnership Group

The Patient Partnership Group (PPG) is an important part of North Bristol NHS Trust, supporting the provision of consistent high quality care by providing a patient perspective and voice across a wide range of forums in the Trust. All members of the group are volunteers and give many hours of their time each year to attend and take part in meetings, interviews, focus groups, workshops and projects.

The members of the PPG are proactive participants in a variety of Committees, e.g. the Patient Safety Committee, Clinical Effectiveness and Audit Committee, as well as the Patient and Carer Experience Committee and the newly established Clinical Policies and Documentation Group.

By reviewing papers and policies, and taking part in the subsequent discussions in meetings, they provide an invaluable patient view and help to guide and influence the work of the Trust.

Due to the pandemic the majority of meetings in the Trust have been held virtually, however the Patient Partnership Group have remained committed and have adapted to working virtually to maintain their presence and input.

They have continued to be active participants on core committees and governance, but also research and finance working groups across the Trust, for example the Medical Research Group and Losses and Compensation Group, as well as the Southmead Hospital Charity Research Allocation and Patients Association.

The members of the group have also been involved in the recruitment process for staff in key roles, with attendance at Consultant interview focus groups and the recent interview panel for the new Head of Patient Experience.

The membership of the Patient Partnership Group have also supported many projects across the Trust, including the Pain Relief Project, and the Consent & Shared Decision Making Project.

Future projects will include the development of the new Digital Strategy.

The members of the Patient Partnership Group are highly valued and appreciated members of the North Bristol family.


THE NHS
HEROES
SAVING
LIVES
FOR
U
Bristol
east

Annex 1

A statement of directors' responsibilities for the quality report

The directors are required under the Health Act 2009, National Health Service (Quality Accounts) Regulations 2010 and National Health Service (Quality Account) Amendment Regulation 2011 to prepare Quality Accounts for each financial year. The Department of Health has issued guidance on the form and content of annual Quality Accounts (which incorporate the above legal requirements).

In preparing the Quality Account, directors are required to take steps to satisfy themselves that:

- the Quality Account presents a balanced picture of the Trust's performance over the period covered;
- the performance information reported in the Quality Account is reliable and accurate;
- there are proper internal controls over the collection and reporting of the measures of performance included in the Quality Account, and these controls are subject to review to confirm that they are working effectively in practice;
- the data underpinning the measures of performance reported in the Quality Account is robust and reliable, conforms to specified data quality standards and prescribed definitions, is subject to appropriate scrutiny and review; and
- the Quality Account has been prepared in accordance with Department of Health guidance.

The directors confirm to the best of their knowledge and belief they have complied with the above requirements in preparing the Quality Account.

By order of the Board

Michele Romaine
Chairman

Signed Date

Annex 2 COVID-19 Governance and Controls

From 16 March 2020 North Bristol Trust implemented formal central command and control arrangements in response to the COVID-19 crisis:

- **Silver Command:** Meeting twice daily and overseeing the organisational response to the emerging pandemic. Silver Command is supported by a series of Bronze-level cells focusing on specific areas including workforce, communications, facilities, out-patients, divisional management teams, personal protective equipment, and finance and logistics.
- **Clinical Reference Group:** Bringing together senior clinical leaders from across the Trust, this group provides advice to both Silver and Gold Commands, and is responsible for determining clinical thresholds and guidelines.
- **Gold Command:** Chaired by the Chief Operating Officer with the Medical Director and Director of Nursing & Quality, Gold Command provided strategic direction and coordination and acted as a point of escalation for Silver Command. It was the key liaison with BNSSG Health and Care Silver Command and connected with regulators and other external bodies. Gold Command provided reports to Trust Management Team and Trust Board on all COVID-19 related matters.

The Trust Board ratified the command and control arrangements at its meeting on 27 March 2020, and agreed a series of amendments to the Trust's Standing Orders and Standing Financial Instructions, creating a streamlined process for financial decision making related to the COVID-19 response, while still maintaining appropriate risk-based controls. These amendments were also reviewed by the Trust's Audit Committee on 7 April 2020 to ensure they were robust and appropriate in the circumstances.

The command and control framework remains in place, flexing in line with operational decision-making needs at differing stages of the pandemic, for example with changes in the frequency of meetings. The one recent exception to this is that financial decision-making powers have been suspended and all recommendations on spend have to go to Executive Directors.

NHS Nightingale Hospital Bristol

On 30 March 2020 NBT was identified as the host organisation for the NHS Nightingale Hospital Bristol, accountable for the setting up and operation of the new unit. This involved the creation of a new Nightingale division within the NBT governance structure.

A quality governance framework and model was approved by the Board, following NBT policies and processes to ensure the safe and accountable provision of high quality care. These included the development of key quality metrics, audit systems, incident and risk registers and reporting mechanisms, bespoke policies, safeguarding, Mental Capacity Act, DNACPR, learning from deaths and clinical governance. Also included were procedures to manage complaints and concerns, as well as Freedom to Speak Up (FTSU).

NHS Nightingale Bristol was registered as a separate centre with the Intensive Care National Audit Research Centre (ICNARC). It was also registered as a separate location with the CQC as part of North Bristol NHS Trust. A comprehensive approach to risk management was established, summarised within a risk register which was regularly refreshed and approved by the executive team. It was then reported into the NBT Quality and Risk Management Committee (QRMC), which is a Board sub committee chaired by a Non Executive Director.

The NHS Nightingale Hospital Bristol was decommissioned 31st March 2021.

Ashton Gate Mass Vaccination Centre (MVC)

NBT assumed responsibility (approved at the Trust Board on 26 November 2020) for the setting up and operation of one of the national COVID-19 vaccination hubs at Ashton Gate, which is vaccinating people from 8am to 8pm, 7 days a week. A strong collaborative approach has ensured effective coordination of vaccine providers across the system. These include the Primary Care Networks (of GP practices), hospital hubs, the Ashton Gate Mass Vaccination Centre and rapid community pharmacies. Also included is a comprehensive roaming model. NBT is responsible for coordinating responses and reports upwards to the regional and national vaccination teams.

The MVC has been reviewed by the Care Quality Commission (a roundtable review against CQC key lines of Enquiry) and also by the National COVID-19 Vaccination Programme (NHSE). The outcomes of these reviews were both very positive. Some points identified for further development, primarily around potential workforce future models, are being considered and progress overseen by QRMC.

Annex 3 Consultation with External Organisations

External Comments on the Quality Account

The draft Quality Account was circulated to the organisations listed below for review and comment during the period 18th June to 17 July 2021.

We would like to thank all of our external stakeholders for their review and all comments received have been included within this Annex.

- Bristol, North Somerset and South Gloucestershire CCG
- Bristol— Health Scrutiny Committee
- Healthwatch Bristol , North Somerset and South Gloucestershire
- North Bristol Patient Partnership Group
- North Somerset Health Overview and Scrutiny Panel
- South Gloucestershire Public Health Scrutiny Committee
- NHS England and NHS Improvement Specialised Commissioning—South West

Bristol, North Somerset & South Gloucestershire CCG

This statement on the North Bristol NHS Trust's Quality Account 2020/21 is made by Bristol, North Somerset & South Gloucestershire (BNSSG) Clinical Commissioning Group (CCG).

BNSSG CCG welcomes the North Bristol NHS Trust (NBT) Quality Account, which provides a review on the overall quality and performance of the provider during 2020/21. The data presented has been reviewed and is in line with data provided throughout the year, predominantly via the monthly Integrated Performance Report (IPR), our discussions with the provider and more recently through the monthly quality assurance meetings. Additionally, the CCG commends the provider's approach to the account which provides an informative account for both lay and professional audiences.

BNSSG CCG acknowledges that the period under review has been one of the most challenging in history as we respond and adapt to the onset and management of the COVID-19 pandemic, affecting a wide range of performance indicators.

NBT's previous priorities will continue for 2021/22, mapped against their quality strategy themes, with clear oversight and governance processes. BNSSG CCG notes that progress has been made amidst the disruptions of the necessary response to the COVID-19 pandemic.

Priority 1 – 'Meeting the identified needs of patients with learning difficulties, autism or both'

The CCG notes the progress which has been made including the Learning Disability Liaison Team providing a seven day service from April 2020, enabling support to clinical teams, and applying reasonable adjustments, to ensure individual needs are met. Learning Disability and Autism champions at ward and board level also promote awareness and oversight.

Priority 2 – 'Being outstanding for safety - a national leader in implementing the NHS Patient Safety Strategy'.

The CCG commends the Trust on being accepted as an early adopter of the new national strategy which is recognition of commitment and work on systems, processes and culture. This has led to the identification of the 5 key patient safety themes which are in patient falls, medicines management, responding well to changing clinical conditions, pressure injuries and discharge planning. The progression of the Patient Safety Incident Response Framework will undoubtedly provide some challenges in 2021/22 and the CCG will support NBT with its implementation and associated work streams including the falls academy.

Annex 3 Consultation with External Organisations

Additionally, the CCG congratulates NBT in achieving significant reductions in pressure injuries of all types including those associated with medical devices.

Priority 3 – 'Ensuring excellence in Maternity Services, delivering safe and supportive maternity care'.

In 2020/21 NBT demonstrated progress with this priority in a number of ways which included maintaining a COVID-19 secure environment across maternity services in hospital and the community, providing improved facilities for women in labour with the opening of new obstetric theatres, participation in a number of maternity initiatives and national and local research programmes. The CCG also acknowledges the completion of the Trust self-assessment against the seven immediate and essential actions published from the Ockenden Independent Review of Maternity Services at The Shrewsbury and Telford NHS Trust; the CCG look forward to seeing the implementation of the resulting action plan which addresses areas requiring ongoing improvement which will result in the delivery of safe and supportive maternity care.

Priority 4 – 'Ensure quality and safety of services is sustained whilst recovering from the impact of the COVID-19 pandemic'.

The CCG acknowledge the challenge and difficulties of maintaining a COVID-19 secure environment and pathways. During 2020/21, national guidance was reviewed and circulated on a frequent basis, requiring clear communication processes to ensure both clinical and non-clinical staff were working to the latest available guidance. The CQC reviewed NBT's compliance with the national Infection Prevention and Control Board Assurance Framework and the CCG notes the positive feedback provided. The CCG welcomes the further focus planned for this priority, whilst recovering from the impact of the COVID-19 pandemic for 2021/22.

We welcome and thank the trust for its continuing engagement in national audits and national enquiries, contributing to national datasets and associated guidance. The CCG also wishes to acknowledge and extend its thanks for NBT's contribution to the body of research on COVID-19, both in the studies to support safety during pandemics and other initiatives looking at long COVID and enabling patients to be involved in vaccine trials.

The CCG acknowledges the reduction in hospital onset MRSA, MSSA and E.coli bacteraemia cases. Across our local BNSSG systems, a significant increase in Clostridium difficile has been reported during 2020/21, which is also noted by NBT. The CCG is supportive of NBT's intention to clarify roles and responsibilities in healthcare acquired cases of C. difficile which includes education and antibiotic stewardship.

Patient experience through the Friends and Family Test was re-introduced in July 2020, following a pause due to COVID-19. Over 69000 responses were received during 2020/21 and 93.6% rate the service positively.

BNSSG CCG reiterates that 2020/21 has been one of the most challenging for the NHS and our local providers during the year. The CCG would like to thank NBT for providing additional leadership and support in setting up and preparing for the opening of the Nightingale hospital in Bristol and the successful establishment of the Mass Vaccination Centre at Ashton Gate. We note the areas that have been identified by the Trust for further improvement and we look forward to working with the Trust in 2021/22 to achieve these improvements.

Sandra Muffett

Head of Clinical Governance & Patient Safety

Annex 3 Consultation with External Organisations

Bristol — Health Scrutiny Committee

The Health Scrutiny Committee (Sub-Committee of the People Scrutiny Commission) discharges the statutory health scrutiny function for Bristol City Council. The Committee received a copy of the North Bristol NHS Trust draft Quality Account 2020/21 on the 18 June 2021.

Due to time constraints it was agreed that the Health Scrutiny Committee would not request a briefing or meet to discuss the report. Instead Members of the Committee would provide comments to the Chair, Councillor Graham Morris. This would form the Committee's statement to the Trust, detailed in this letter;

- The Committee noted the impact of COVID-19 to the cancer pathways, including reduced diagnostic capacity and also patient concerns about coming in to the hospital during the pandemic, and felt the report would benefit from further commentary on whether the vaccination programme had helped reduce deferred appointments; and what was planned to further reassure patients that safety measures were in place which enabled patients to be managed safely and appropriately (reference p.22).

  Trust response: This report covers the financial year 2020-21 when the vaccination programme was just beginning, therefore any potential impact on the reduction of deferred appointments will be addressed in our 2021-22 Quality Account.

- Members acknowledged the 'exceptional actions' the Trust needed to take to minimise the number of patients with extended waits for treatment and that this had been largely successful. The Committee recommended that there should be some commentary which detailed who was responsible for any additional and remedial work and care following operations outsourced to the independent sector (reference p.23).

  Trust response: The Trust made extensive use of the independent sector in 2020-21 under nationally funded and contracted arrangements in order to limit the impact of COVID-19 on access to services. The use of the independent sector has continued during 2021-22, but under locally funded and contracted arrangements. The bulk of independent sector activity during both years was largely diagnostic or elective—day-case or inpatient. The independent sector is not routinely commissioned for any additional or remedial activity. This would typically be undertaken in-house, although patients could be re-referred if appropriate.

- The Committee noted the Trust's anticipated increase in the number of patients waiting in excess of 52 weeks for their first definitive treatment in 2020-21, and that the reasons for this included 'recurrent workforce and staffing capacity issues.' Members felt this section required commentary to explain those issues and what plans were in place to resolve them (reference p.23).

  Trust response: The issues referred to in the report are a combination of factors, seen nationally during the pandemic, while maintaining the safe prioritisation of services. In particular these include the impacts of the pandemic on staff and staff wellbeing. For example, the requirement to self-isolate, staff contracting COVID-1, the redeployment of many staff to areas of high pressure, and subsequent potential 'burnout'. This is monitored on a daily basis and actions taken where required.

  As a Trust we have recognised the need to focus on the wellbeing of our staff and have in place initiatives such as Start Well, End Well for both clinical and non-clinical teams (page 48). Staff have been kept informed of changes in status and practices throughout the pandemic via regular team meetings, cascade learning and newsletters, and have been supported to ensure they had the skills required if deployed to prioritised teams.

Annex 3 Consultation with External Organisations

- The Committee commended the focus and commentary on safeguarding children; Members appreciated the attention to the wellbeing of, and engagement with, children and families who use health services, and the acknowledgement that 'Many children and families have been adversely affected by the pandemic and this will impact the health and development of children and the welfare of families and wider society in the months ahead' (reference p.38).

- The Committee commended the principles of the Getting It Right First Time programme, and recommended further commentary on the Veterans Covenant Healthcare Alliance re-accreditation of North Bristol Trust as a Veteran Aware Hospital (reference p.39).

  Trust response: Page 39 has been expanded to provide additional commentary.

- Members were pleased to read that all seven Intensive Care Units across the system were now operating on the same IT systems, and commended this approach to enable closer and stronger links (reference p. 49).

The Committee commended the report, that it was clear and well written, language appropriate for the audience, and accessible.

Councillor Morris and the Committee would like to thank the North Bristol NHS Trust for its positive work over the past year and its wide-ranging achievements as set out in the report, especially with all the challenges the pandemic has brought. The Committee's comments are made within the context of supporting the Trust's priorities and being a 'critical friend' to help enable positive outcomes for Bristol.

Dan Berlin

Scrutiny Advisor

Annex 3 Consultation with External Organisations

Healthwatch Bristol, North Somerset and South Gloucestershire

Dear North Bristol Trust,

Thank you for this opportunity for respond to your Quality Account 2020/21. It has been a troubling year for the whole nation and especially for your Hospital staff having managed to work with Covid 19 all through this time. We are full of praise and thanks for the efforts of all of them.

We have read the Trust's summary of performance over this past year while knowing that many of the benchmarks for quality and performance were set aside in 20/21. A lower bed occupancy at 76% would have helped to manage workload in the first lockdown, but this did not occur in the subsequent one, when occupancy rose back to normal 95% levels.

We are pleased to see that it would appear NBT carried on performing well and was able to rearrange facilities to achieve Covid safe environments without huge impact. However, one aspect of the CQC score is your responsiveness to patient need, which is rated as 'requires improvement'. This is conditional on a follow-up inspection, and we look forward to hearing how this can be improved.

There is already a recognition that you are going to focus on better personalised care, connecting families to their loved ones in hospital & offering virtual opportunities where they are appropriate. Adding to your difficulty is the huge drop in volunteer numbers at the Trust, until Covid is fully under control.

We applaud the priorities set this year around caring for people with autism and/ learning disabilities, safe and effective maternity care, and safety for patients both waiting for or having care in a post Covid recovery. Signing up to the sunflower scheme for hidden disabilities and using lanyards and champions is to be welcomed. NBT could recognise more of the hidden disabilities in this scheme, which include deafness or visual impairments, Chronic Fatigue, Epilepsy, Chron's, Diabetes and brain injury. The aim to create a Hospital User Group of people with lived experience of autism and/or a learning disability is a necessary step towards understanding these patients' needs, as will the implementation of the Oliver McGowan mandatory training in 2021/22.

The culture of learning at NBT is evidenced from the fact that the PALs service is performing well and problems are dealt with quickly. It would be helpful to report on more than just the complaints category. You divide PALS contacts into complaints, concerns, and enquiries. The 'concerns' are at an equal or greater number to complaints under this new system. Themes of the top concerns could be helpful to recognise too.

Annex 3 Consultation with External Organisations

We can expect waiting times for elective treatments will become an increasingly difficult issue for patients. Your operations, except for cancer were virtually stopped during Covid. For the over 2000 patients now waiting over a year for elective surgery, your commitment to sustaining and managing clinical priorities for recovery work, are essential. Being part of the national accelerator programme to manage backlogs of elective surgery is fantastic news.

Trust response: The points raised will be discussed with our Head of Patient Experience for action as required.

Yours sincerely

Georgie Bigg
Chair of Trustees
Healthwatch Bristol North Somerset and South Gloucestershire

Vicky Marriott
Area Manager

North Bristol Patient Partnership Group

The continuing challenges that face not only NBT, but the NHS as a whole cannot be underestimated. It is a source of constant amazement to me how the resilience, strength, commitment, and selflessness of NBT staff never waivers.

Whilst the Patient Partnership has had to adjust its way of working, we have managed to maintain our relationship alongside NBT staff ensuring the Patient/Carer/Family voice is very much heard. This is most evidence around the work to implement PSIPR in June 2021, together with the introduction of the National Patient Safety Strategy.

NBT continues to be a very Patient Safety focused Trust and remains passionate about implementing actions from learning after incidents, thus helping to ensure such incidents do not reoccur.

As a PPG, our main priority is to ensure the safe care and treatment of patients. However, as such, we also need to ensure that the staff that provide such wonderful care are themselves cared for in order that they too do not become patients. This is why it is so important that we get regular, up to date presentations with reports on the processes which NBT has in place to provide support for their staff. As there is such a nationwide shortage of staff working in the NHS it is imperative that such support exists and we are, as a group, very impressed with the processes that NBT has in place.

We continue to be hugely grateful and therefore fully committed to our work with these truly wonderful people. There is much exciting work in the pipeline for the coming years and we look forward to working alongside them to ensure the success of these works.

Christine Fowler

Chair, NBT Patient Partnership Group

Annex 3 Consultation with External Organisations

NHS England and NHS Improvement Specialised Commissioning—South West

I have reviewed the Quality Account which seems comprehensive and testament to great achievement despite the challenging year.

One point of note, organisationally we are not: NHS Specialised Commissioning. Could this be amended to: NHS England and NHS Improvement Specialised Commissioning – South West

Trust response: The document has been amended.

Greg Martin
Senior Commissioner
Specialised Commissioning
NHS England and NHS Improvement – South West

North Somerset Health Overview and Scrutiny Panel

We have circulated the NBT QA to Members but have not received any feedback. To be honest, I'm not surprised given the unprecedented circumstances and the understandable lack of the usual level of contact we have had with our healthcare providers during these difficult times.

Having discussed this with the Chairman, he has agreed that we will not provide an official response to the Trust's QA this year.

That should though in no way detract from our full recognition of the huge challenges faced by all of our health and social care colleagues and the amazing way they have responded to this crisis.

Leo Taylor, Scrutiny Officer
North Somerset Council

South Gloucestershire Public Health Scrutiny Committee

No statement was received for inclusion by the Committee on this occasion.

Annex 3

Annex 4 Learning from Deaths

27.1 During 2020/21 1,908 of NBT's patients died. This comprised the following number of deaths which occurred in each quarter of that reporting period:

435 in the first quarter
374 in the second quarter
547 in the third quarter
552 in the fourth quarter

27.2 By 18/05/2021, 1,723 case record reviews and 61 investigations have been carried out in relation to 1,908 of the deaths included in item 27.1. In 0 cases a death was subjected to both a case record review and an investigation.[1]

The number of deaths in each quarter for which a case record review or an investigation was carried out was:

428 in the first quarter
364 in the second quarter
527 in the third quarter
465 in the fourth quarter

27.3 0 representing 0% of the patient deaths during the reporting period is judged to be more likely than not to have been due to problems in the care provided to the patient. In relation to each quarter this consisted of:

0 representing 0% for the first quarter
0 representing 0% for the second quarter
0 representing 0% for the third quarter
0 representing 0% for the fourth quarter

27.4 Recent learning from deaths identified in item 27.3:

Not applicable

27.5 Recent actions undertaken as a result of the learning outlined in item 27.4:

Not applicable

27.6 The impact of the actions undertaken in section 27.5

Not applicable

27.7 225 case record reviews and 9 investigations completed after 03/06/2020 which related to deaths which took place before the start of the reporting period.

27.8 0 representing 0% of the patient deaths before the reporting period, are judged to be more likely than not to have been due to problems in the care provided to the patient. This number has been estimated by counting those deaths that were subject to an investigation as a result of it being more likely than not that the death was due to problems in care.

27.9 0 representing 0% of the patient deaths during 2019/20 are judged to be more likely than not to have been due to problems in the care provided to the patient.

[1] This is because where a death is covered by another investigation the mortality review request is withdrawn from the system

Annex 5 National Clinical Audit Case Ascertainment List 2020-2021

During 2020/21 114 local clinical audits were completed and reviewed. Actions from these audits have been put onto the Trust action log.

During 2020/21 43 national clinical audits and 2 national confidential enquiries covered NHS services that NBT provides. Of these, NBT were eligible and participated in 42 national clinical audits and 2 national confidential enquiries.

The data collected for all relevant national clinical audits and national confidential enquiries during 2020/21 are listed below, alongside the number of cases submitted to each audit or enquiry as a percentage of the number of registered cases required by the terms of that audit or enquiry. Where only a percentage is shown, actual submission numbers were not available.

National Clinical Audit and Clinical Outcome Review Programmes		Host Organisation	NBT Eligible	NBT Participating	Case Ascertainment	Data Year
1	Antenatal and New-born National Audit Protocol 2019 to 2022	Public Health England	Y	Y	N/A	N/A
2	BAUS Urology Audit – Cystectomy	British Association of Urological Surgeons (BAUS)	Y	Y	96.1% (220/229)	2017-2019
3	BAUS Urology Audit – Female Stress Urinary Incontinence	British Association of Urological Surgeons (BAUS)	Y	Y	150	2017-2019
4	BAUS Urology Audit – Nephrectomy	British Association of Urological Surgeons (BAUS)	Y	Y	93% (650/699)	2017-2019
5	BAUS Urology Audit – Percutaneous Nephrolithotomy	British Association of Urological Surgeons (BAUS)	Y	Y	156	2017-2019
6	BAUS Urology Audit – Radical Prostatectomy	British Association of Urological Surgeons (BAUS)	Y	Y	89% (856/959)	2017-2019
7	Case Mix Programme (CMP)	Intensive Care National Audit and Research Centre (ICNARC)	Y	Y	100% (2617/2617)	2018-2019
8	Child Health Clinical Outcome Review Programme	National Confidential Enquiry into Patient Outcome and Death (NCEPOD)	N	N	N/A	N/A
9	Cleft Registry and Audit Network (CRANE)	Royal College of Surgeons	N	N/A	N/A	N/A
10	Elective Surgery – National PROMs Programme	NHS Digital	Y	Y	52.6% (643/1223)	2018 - 2019

Annex 5 National Clinical Audit Case Ascertainment List 2020-2021

	National Clinical Audit and Clinical Outcome Review Programmes	Host Organisation	NBT Eligible	NBT Participating	Case Ascertainment	Data Year
11	Emergency Medicine QIPs—Pain in Children	Royal College of Emergency Medicine	Y	Y	+100% (59/50)	2020-2021
12	Emergency Medicine QIPs—Infection Control	Royal College of Emergency Medicine	Y	Y	+100% (80/50)	2020-2021
13	Emergency Medicine QIPs—Fractured Neck of Femur	Royal College of Emergency Medicine	Y	Y	+100% (116/50)	2020-2021
14	Falls and Fragility Fractures Audit Programme (FFFAP) Fracture Liaison Service Database National Audit of Inpatient Falls National Hip Fracture Database	Trauma Audit Research Network (TARN)	Y Y Y Y	Y Y Y Y	 100% (2093/2093) 100% (18/18) 100% (541/541)	 2018 2020 2020
15	Inflammatory Bowel Disease (IBD) Audit	IBD Registry	Y	N	N/A	N/A
16	Learning Disabilities Mortality Review Programme (LeDeR)	University of Bristol/ Norah Fry Centre for Disability Studies	Y	Y	100% (26/26)	2020-2021
17	Mandatory Surveillance of Healthcare Associated Infections (HCAI)	Public Health England	Y	Y	MRSA 100% (2) MSAA 100% (29) CDI 100% (68)	2020 - 2021
18	Maternal and New-born Infant Clinical Outcome Review Programme	University of Oxford/ MBRRACE-UK	Y	Y	N/A	N/A
19	Medical and Surgical Clinical Outcome Review Programme In Hospital Management of out of Hospital Cardiac Arrest	National Confidential Enquiry into Patient Outcome and Death (NCEPOD)	Y	Y	100% (2/2)	2020
20	Mental Health Clinical Outcome Review Programme	National Confidential Inquiry into Suicide and Homicide in Mental Health (NCISH)	N	N/A	N/A	N/A

Annex 5 National Clinical Audit Case Ascertainment List 2020-2021

	National Clinical Audit and Clinical Outcome Review Programmes	Host Organisation	NBT Eligible	NBT Participating	Case Ascertainment	Data Year
21	National Asthma and Chronic Obstructive Pulmonary Disease (COPD) Audit Programme (NACAP)	Royal College of Physicians (RCP)	Y	Y		
	Paediatric Asthma Secondary Care		N	N	N/A	
	Asthma (Adult and Paediatric) and COPD Primary Care – Wales only		N	N	N/A	
	Adult Asthma Secondary Care		Y	Y	33% (135/405)	2019-20
	Chronic Obstructive Pulmonary Disease (COPD) Secondary Care		Y	Y	69	2020-21
22	National Audit of Breast Cancer in Older People (NABCOP)	Royal College of Surgeons	Y	Y	100% (770/770)	2018
23	National Audit of Cardiac Rehabilitation	University of York	Y	Y	100%	2020
24	National Audit of Care at the End of Life (NACEL)	NHS Benchmarking Network	Y	Y	100% (40/40)	2019-2020
25	National Audit of Dementia (NAD)	Royal College of Psychiatrists (RCPsych)	Y	Y	100% (50/50)	2018
26	National Audit of Pulmonary Hypertension	Royal College of Paediatrics and Child Health (RCPCH)	N	N/A	N/A	N/A
27	National Audit of Seizures and Epilepsies in Children and Young People (Epilepsy 12)	Royal College of Paediatrics and Child Health (RCPCH)	N	N/A	N/A	N/A
28	National Bariatric Surgery Registry (NBSR)	British Obesity and Metabolic Surgery Society (BOMSS)	Y	Y	100% (416/416)	April 16 – March 19
29	National Cardiac Arrest Audit (NCAA)	Intensive Care National Audit and Research Centre (ICNARC)/ Resuscitation Council UK	Y	Y	100%	2019-2020
30	National Cardiac Audit Programme (NCAP) – National Audit of Cardiac Rhythm Management	Bart's Health NHS Trust	Y	Y	100% (141/141)	2020
31	National Clinical Audit of Anxiety and Depression	Royal College of Psychiatrists (RCPsych)	N	N/A	N/A	N/A

Annex 5 National Clinical Audit Case Ascertainment List 2020-2021

	National Clinical Audit and Clinical Outcome Review Programmes	Host Organisation	NBT Eligible	NBT Participating	Case Ascertainment	Data Year
32	National Clinical Audit of Psychosis	Royal College of Psychiatrists (RCPsych)	N	N/A	N/A	N/A
33	National Comparative Audit of Blood Transfusion Programme – 2020 Audit of the Management of Perioperative Paediatric Anaemia	NHS Blood Transplant	N	N/A	N/A	N/A
34	National Diabetes Audit – Adults	NHS Digital	Y	Y		
	National Diabetes Foot Care Audit		Y	Y	100% (195/195)	2015-2019
	National Diabetes Inpatient Audit (NaDIA)		Y	Y	100% (147/147)	2019
	NaDIA – Harms		Y	Y	-	Data not available
	National Core Diabetes Audit		Y	Y	100% (77/77)	2020
	National Pregnancy in Diabetes Audit		Y	Y	100% (75/75)	2016-2018
35	National Early Inflammatory Arthritis Audit (NEIAA)	British Society for Rheumatology (BSR)	Y	Y	100% (619/619)	2019-2020
36	National Emergency Laparotomy Audit (NELA)	Royal College of Anaesthetists (RCOA)	Y	Y	82% (191/233)	2018/-2019
37	National Gastro-Intestinal Cancer Programme	NHS Digital	Y	Y		
	National Oesophago-gastric Cancer (NOGCA)		Y	Y	<65% (67/150-199)	2017-2019
38	National Joint Registry (NJR)	Healthcare Quality Improvement Partnership (HQIP)	Y	Y	100% (1660/1660)	2019

Annex 5 National Clinical Audit Case Ascertainment List 2020-2021

National Clinical Audit and Clinical Outcome Review Programmes		Host Organisation	NBT Eligible	NBT Participating	Case Ascertainment	Data Year
39	National Lung Cancer Audit (NLCA)	Royal College of Physicians (RCP)	Y	Y	100% (312/312)	2018
40	National Maternity and Perinatal Audit (NMPA)	Royal College of Paediatrics and Child Health (RCPCH)	Y	Y	100%	2016-2017
41	National Neonatal Audit Programme – Neonatal Intensive and Special Care (NNAP)	Royal College of Paediatrics and Child Health (RCPCH)	Y	Y	100% (624/624)	2019
42	National Ophthalmology Audit (NOD)	Royal College of Ophthalmologists (RCOphth)	N	N/A	N/A	N/A
43	National Paediatric Diabetes Audit (NPDA)	Royal College of Paediatrics and Child Health (RCPCH)	N	N/A	N/A	N/A
44	National Prostate Cancer Audit	Royal College of Surgeons (RCS)	Y	Y	100% (757/757)	2020
45	National Vascular Registry	Royal College of Surgeons (RCS)	Y	Y		
	AAA		Y	Y	100% (48/48)	2020
	CEA		Y	Y	100% (88/88)	2020
	Bypass		Y	Y	100% (606/606)	2020
	Angioplasty		Y	Y	100% (401/401)	2020
	Amputation		Y	Y	100% (225/225)	2020
46	Neurosurgical National Audit Programme	Society of British Neurological Surgeons	Y	Y	100% (3493)	2020
47	NHS Provider Interventions with Suspected/ Confirmed Carbapenemase Producing Gram Negative Colonisations/ Infections	Public Health England	Y	Y	100% (49)	2020-2021
48	Out-of-Hospital Cardiac Arrest Outcomes (OHCAO) Registry	University of Warwick	N	N	N/A	N/A

Annex 5 National Clinical Audit Case Ascertainment List 2020-2021

	National Clinical Audit and Clinical Outcome Review Programmes	Host Organisation	NBT Eligible	NBT Participating	Case Ascertainment	Data Year
49	Paediatric Intensive Care Audit (PICANet)	University of Leeds/ University of Leicester	N	N/A	N/A	N/A
50	Perioperative Quality Improvement Programme (PQIP)	Royal College of Anaesthetists	Y	Y	N/A	N/A
51	Prescribing Observatory for Mental Health UK (POMH-UK)	Royal College of Psychiatrists	N	N	N/A	N/A
52	Sentinel Stroke National Audit Programme (SSNAP)	King's College London (KCL)	Y	Y	90%+	2019-2020
53	Serious Hazards of Transfusion: UK National Hemovigilance Scheme	Serious Hazards of Transfusion (SHOT)	Y	Y	100%	2019
54	Society for Acute Medicine's Benchmarking Audit (SAMBA)	Society for Acute Medicine (SAM)	Y	Y	100%	2019
55	Surgical Site Infection Surveillance Service Hip replacement Knee replacement	Public Health England (PHE)	Y Y Y	Y Y Y	 100% (625/625) 100% (652/652)	 2019-2020 2019-2020
56	The Trauma Audit & Research Network (TARN)	The Trauma Audit & Research Network (TARN)	Y	Y	N/A	N/A
57	UK Cystic Fibrosis Registry	Cystic Fibrosis Trust	N	N	N/A	N/A
58	UK Registry of Endocrine and Thyroid Surgery	British Association of Endocrine and Thyroid Surgery (BAETS)	Y	Y	103	2013-2017
59	UK Renal Registry National Acute Kidney Injury Programme (AKI)	UK Renal Registry	Y	Y	100%	2018

Annex 6 Mandatory Indicators

	Mandatory indicator	NBT Most Recent	National average	National best	National worst	NBT Previous
	Venous thromboembolism (VTE) risk assessment	**94.87% Apr 20—Mar21**	**The VTE data collection and publication is currently suspended to release capacity in providers and commissioners to manage the COVID-19 pandemic.**			**95.81% Mar 19-Dec 19**
23	The Trust considers that this data is as described as there is a continued close focus on VTE risk assessment performance given that it is a board reported quality metric within the Integrated Performance Report. It is also regularly scrutinised through the Thrombosis Committee as part of the wider reviews undertaken of Hospital Acquired Thrombosis and related Root Cause Analyses (mini RCAs). In 2017 the effectiveness of this work was recognised by the awarding of VTE Exemplar Status to the Trust.					
	Clostridium difficile rate per 100,000 bed days (patients aged 2 or over) - Trust apportioned cases only	**8.9 2019/20***	**13.2**	**0.0**	**51.1**	**12.4 2018/19***
24	The Trust considers that this data is as described as it is directly extracted from Public Health England National Statistics and the trend variation from previous year is consistent with internal data intended to inform ongoing improvement actions. *Latest national data published on https://www.gov.uk/government/statistics/clostridium-difficile-infection-annual-data is 2019/20 2020/21 data will be published in July 2021 after the Quality Account has been published.					
	Rate of patient safety incidents reported per 1,000 bed days	**49.8 Oct 19—Mar 20**	**47.0**	**140.6**	**16.9**	**40.2 Oct 18—Mar 19**
25	**Rate of patient safety incidents resulting in severe harm or death per 1,000 bed days**	**0.2 Oct 19—Mar 20**	**0.1**	**0.0**	**0.5**	**0.1 Oct 18—Mar 19**
	The Trust considers that this data is as described as it is supplied by the National Reporting and Learning System (NRLS) and is consistent with internal data reviewed on a monthly basis during the year and reported to the Board. The Trust will continue to act to increase the overall rate of reporting, which is a sign of a positive safety culture, whilst also acting upon lessons learned to identify improvements to practice. This has already shown a reduction in the proportion of severe harm or death related incidents in the period stated above.					
	Responsiveness to inpatients' personal needs	**70.2 2019/20**	**67.1**	**84.2**	**59.5**	**69.2 2018/19**
20	The Trust considers that this data is as described as it is directly extracted from National Survey data and the trend variation from previous year is consistent with internal surveys intended to inform ongoing improvement actions.					
	Percentage of staff who would be happy with standard of care provided if a friend or relative needed treatment	**83% 2020**	**73%**	**96%**	**50%**	**80% 2019**
21	The Trust considers that this data is as described as it is directly extracted from National Survey data and the trend variation from previous year is consistent with internal surveys intended to inform ongoing improvement actions.					
	Summary Hospital-level Mortality Indicator (SHMI) value and banding	**October 2019—September 2020 NBT Score 89.99 (Peer average 100.75) October 2018—September 2019 NBT Score 90.37 (Peer average 99.08)**				
12	The Trust considers that this data is as described as it is directly extracted from the CHKS system and analysed through the Trust's Mortality Group, the medical Director and within specialties. The rate is also consistent with historic trends and the Trust's understanding of the increased acuity of patients being seen within different specialties.					

Annex 6 Mandatory Indicators

	Mandatory indicator	NBT Most Recent	National average	National best	National worst	NBT Previous
	Patient Reported Outcome Measures – No. of patients reporting an improved score;					
18	**Hip Replacement Primary EQ-VAS**	**2019/20 NBT score 66.7% (England average 70.0%)** **2018/19 NBT score 72.5% (England average 70.1%)**				
	Hip Replacement Primary EQ 5D	**2019/20 NBT score 87.4% (England average 90.4%)** **2018/19 NBT score 91.4% (England average 90.9 %)**				
	Knee Replacement Primary EQ-VAS	**2019/20 NBT score 48.0% (England average 59.9%)** **2018/19 NBT score 53.0 (England average 59.5%)**				
	Knee Replacement Primary EQ 5D	**2019/20 NBT score 75.0% (England average 83.2%)** **2018/19 NBT score 80.0% (England average 82.9 %)**				
	Varicose vein, Groin hernia	**Not applicable**				
	The Trust considers that this data is as described as it is obtained directly from NHS Digital. The Trust will act to improve this percentage, and so the quality of its services by analysing the outcome scores and continuing to focus on participation rates for the preoperative questionnaires					
19	**Emergency readmissions within 28 days of discharge: age 0-15**	**Comparative data for 2011/12: NBT 10.2%; England average 10.0%; low 0%; high 47.6%.**				
	Emergency readmissions within 28 days of discharge: age 16 or over	**Comparative data for 2011/12: NBT score 10.9%; England average 11.4%; low 0%; high 17.1%.**				
	Comparative data since November 2011 is not currently available from the Health & Social Care Information Centre.					

Annex 7 Abbreviations

AKI	Acute Kidney Injury
BAME	Black, Asian and Minority Ethnic
BASS	Bristol Autism Spectrum Service
BNSSG	Bristol, North Somerset & South Gloucester-shire
BAU	Business As Usual
CQC	Care Quality Commission
CCG	Clinical Commissioning Group
CEAC	Clinical Effectiveness and Audit Committee
C-Diff	Clostridium Difficile
DQIPS	Commissioner Data Quality Improvement Plans
DSP	Data Security & Prevention
DoLS	Deprivation of Liberty Safeguards
DNACPR	Do Not Attempt Cardio-Pulmonary Resuscita-tion
ED	Emergency Department
E-Coli	Escherichia Coli
FTSU	Freedom to Speak Up
FFT	Friends and Family Test
GMP	General Medical Practice
GP	General Practitioner
GIRFT	Getting it Right First Time
HRG	Healthcare Resource Group
HES	Hospital Episode Statistics
HUG	Hospital User Group
IPC	Infection Prevention and Control
IM&T	Information Management & Technology
ICS	Integrated Care System
ICNARC	Intensive Care National Audit Research Centre
LeDeR	Learning Disabilities Mortality Review
LPS	Liberty Protection Safeguards
LMS	Local Maternity System
LCNS	Lung Cancer Nurse Specialist
MVC	Mass Vaccination Centre
MCA	Maternity Care Assistants
MVP	Maternity Voices Partnership
MCCDs	Medical Certificates of Cause of Death
ME	Medical Examiner
MHS	Medical History Assurance
MCA	Mental Capacity Act
MRSA	Methicillin-Resistant Staphylococcus Aureus
MSSA	Methicillin-Susceptible Staphylococcus Aureus
MBRRACE	Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries
MDT	Multidisciplinary Team
NGO	National Guardians Office
NHS	National Health Service
NHSE/I	National Health Service England / Improve-ment
NIHR	National Institute for Health Research
NOF	Neck of Femur
NNAP	Neurosurgical National Audit Programme
NBT	North Bristol NHS Trust
PALS	Patient Advice and Liaison Service
PPG	Patient Partnership Group
PSIRP	Patient Safety Incident Response Plan
PMRT	Perinatal Mortality Review Tool
PPE	Personal Protective Equipment
RTT	Referral to Treatment
SUS	Secondary Users' Service
SBNS	Society of British Neurological Surgeons
2WW	Two Week Wait

www.nbt.nhs.uk

0117 950 50 50


twitter.com/northbristolNHS


www.facebook.com/NorthBristolNHSTrust


www.youtube.com/user/NorthBristolNHSTrust/


www.instagram.com/north_bristol_nhs/


uk.linkedin.com/company/north-bristol-nhs-trust

Report To:	Trust Board		
Date of Meeting:	27 May 2020		
Report Title:	Board Assurance Framework Report		
Report Author & Job Title	Xavier Bell, Director of Corporate Governance		
Executive/Non-executive Sponsor (presenting)	Xavier Bell, Director of Corporate Governance		
Does the paper contain:	**Patient identifiable information?**	**Staff identifiable information?**	**Commercially sensitive information?**
*If any boxes above ticked, paper may need to be received at *private* meeting			
Purpose:	**Approval**	**Discussion**	**To Receive for Information**
		X	
Recommendation:	That the Board: • **Review and discuss** the Board Assurance Framework • **Note** the updates to various actions		
Report History:	Presented quarterly		
Next Steps:	Ongoing monitoring of BAF risks and actions.		

Executive Summary

Board Assurance Framework:

The Board Assurance Framework (BAF) enables the Board to:

- review key risks aligned to strategic objectives/themes;
- ensure that there are sufficient controls in place to manage these risks to delivery; and
- to understand the assurance there is on the effectiveness of these controls.

This report reflects the strategic themes approved by the Board in the Trust's Five-year Strategy 2019-2024. Relevant risks have been reviewed by the responsible committees, with updates reported to Trust Board throughout the last quarter.

Key changes since May 2021:

Various risks have been updated, and the score for SIR1 (demand management and flow) and COV1 (pandemic) have been increased.

The format of the BAF has also been updated to incorporate recommendations from the most recent internal audit report:

Assurances for each risk have been categorised to show the level of assurance that they provide, using the “three lines of defence” model.

This model categorises assurances into:

1. First line - Functions that own and manage risks
2. Second line - Functions that oversee risks
3. Third line - Functions that provide independent assurance

With third line providing the most independent assurance.

A page showing how the residual and target risks have changed over time is also now provide, alongside some narrative on whether risks are controllable or uncontrollable.

Strategic Theme/Corporate Objective Links	**1. Provider of high-quality patient care** **2. Developing Healthcare for the future** **3. Employer of choice** **4. An anchor in our community**
Board Assurance Framework/Trust Risk Register Links	The Board Assurance Framework captures strategic risks identified at Board level and updated quarterly.
Other Standards Reference	The Board Assurance Framework captures strategic risks identified at Board level and updated quarterly.
Financial implications	N/A
Other Resource Implications	Risks relating to financial areas are incorporated in routine risk management reports. The costs of risk management processes are not separately captured.
Legal Implications	N/A
Equality, Diversity and Inclusion Assessment (EIA)	N/A
Appendices:	Appendix 1: Board Assurance Framework – July 2021

NHS North Bristol NHS Trust

Board Assurance Framework (BAF)

Introduction

The following document is the Trust's Board Assurance Framework (BAF) for 2021/22. The Board Assurance Framework defines and assesses the principle strategic risks to the Trust's objectives. It provides the Trust Board with assurance that those risks are being proactively managed and mitigated.

The BAF is designed to provide the Trust Board with a simple but comprehensive method for the effective and focussed management of principal risks to its strategic and business objectives. The Board defines the principal risks and ensures that each is assigned to a lead director as well as to a lead committee:

- The lead director is responsible for assessing any principal risks assigned to them by the Board and for providing assurance as to the effectiveness of primary risk controls to the lead committee;
- The role of the lead committee is to review the lead director's assessment of their principal risks, consider the range of assurances received as to the effectiveness of primary risk controls, and to recommend to the lead director any changes to the BAF to ensure that it continues to reflect the extent of risk exposure at that time;
- The Audit Committee is responsible for providing assurance to the Trust Board that the BAF continues to be an effective component of the Trust's control and assurance environment;
- The Trust Board reviews the whole BAF on a quarterly basis to ensure that the principal risks are appropriately rated and are being effectively managed; and to consider the inclusion within the BAF of additional risks that are of strategic significance.

A guide to the criteria used to grade all risks within the Trust is provided in Appendix A.

Trust Strategic & Business Plan Objectives:

Strategic Theme:	Aligned BAF Risk:
1. Provider of high quality patient care	SIR1 COV2 SIR8 SIR14 SIR15
2. Developing Healthcare for the future	COV2 SIR10 SER4

RESPONSIBLE COMMITTEES/BOARDS:

Finance & Performance Committee
- SIR1 (with QRMC)
- SIR8
- SIR10 (with P&DC)
- SIR16
- SIR15
- SER4

People Committee
- SIR2

Quality & Risk Management Committee
- SIR1 (with F&PC)
- COV1
- SIR14

Board Assurance Framework (BAF)

3. Employer of choice	COV2 SIR2 SIR8 SIR14 SER4
4. An anchor in our community	COV2 SIR8 SIR10 SIR16

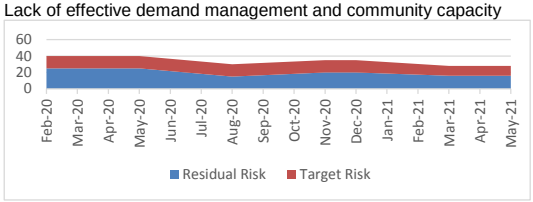
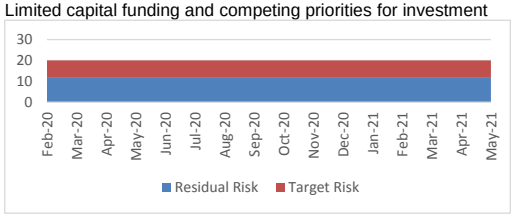
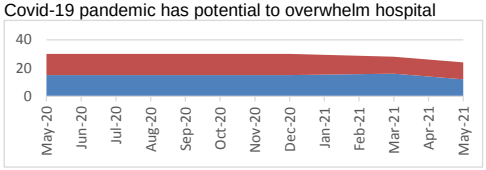
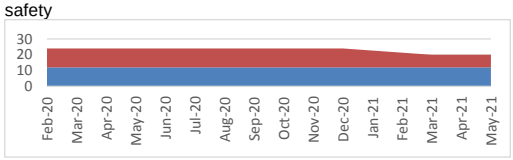
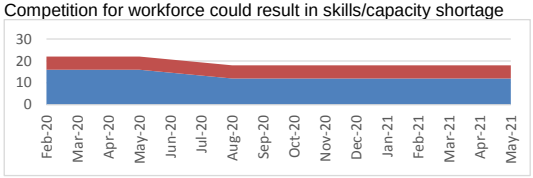
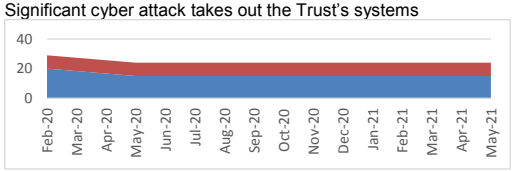
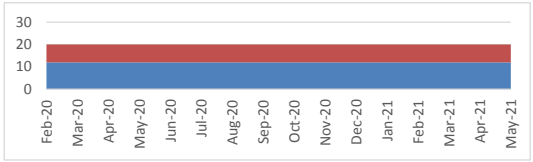
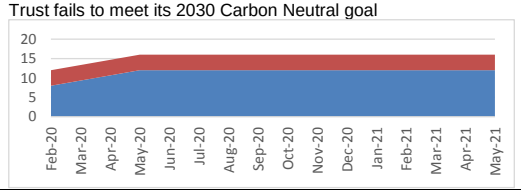
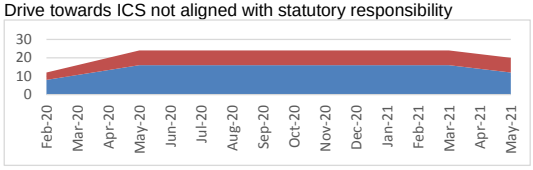
Version Control:

Version:	Summary of changes:	Reported to:
V1	Approved by Trust Board 26/02/2020	Trust Board 26/02/2020
V2	All risks updated in May 2020, two new Covid-19 risks proposed, plus climate change risk added	Trust Board 28/05/2020
V3	Covid-19 risk scores reduced	QRMC 16/06/2020
V4	Covid-19 risk score (Cov-1) increased following discussion at QRMC	To Trust Board August 2020
V5	BAF – alignment to strategy/business plan updated Actions across all risks updated. Risk ratings on SIR 1, SIR 2, COV1 and COV2 updated.	Extracts to F&P Committee (18/08/2020) and P&D Committee (19/08/2020) Full BAF to Trust Board 27/08/2020.
V6	Updates to SIR8 and SIR10	Extract to F&P Committee (20/10/2020)
V7	BAF redrafted, risks consolidated, and overall number reduced. Actions updated in January 2021	Relevant risks to QRMC (19/11/2020), People & Digital (9/12/2020), Finance & Performance (10/12/2020)
V8	BAF risks updated and actions updated Feb/March 2021	To Trust Board 25/03/2021 Extracts to F&PC 22/04/2021
V9	BAF risks updated and actions updated May 2021 Version 9.1 contains further updates from May 2021 Version 9.2 contains updates from internal Audit report 2021	To QRMC 11/05/2021 To Trust Board 27/05/2021 To Trust Board 29/07/2021

NHS North Bristol NHS Trust

Board Assurance Framework (BAF)

Summary of Risks

Risk	Current Residual Risk	Risk Summary and Trend	Forecast Trajectory (next 12 months)	Risk	Current Residual Risk	Risk Summary and Trend	Forecast Trajectory (next 12 months)
SIR1	16	Lack of effective demand management and community capacity 	⇔	SIR10	12	Limited capital funding and competing priorities for investment 	⇔
COV2	12	Covid-19 pandemic has potential to overwhelm hospital 	⇔	SIR14	12	Sustained demand and increased acuity will impact on patient safety 	⇔
SIR2	12	Competition for workforce could result in skills/capacity shortage 	⇔	SIR15	15	Significant cyber attack takes out the Trust's systems 	⇔
SIR8	12	Lack of investment in retained estate results in inappropriate spaces to deliver care 	⇔	SIR16	12	Due to lack of resource and complexity of required planning, Trust fails to meet its 2030 Carbon Neutral goal 	⇔
SER4	12	Drive towards ICS not aligned with statutory responsibility 	⇔				

Assurances set out for each risk in the Board Assurance Framework are categorised in line with the 'three lines of defence' model of risk management:

Key:

(1) **First line - Functions that own and manage risks**
(2) **Second line - Functions that oversee risks**
(3) **Third line - Functions that provide independent assurance**

Board Assurance Framework (BAF)

Trust Strategic Theme:	Provider of high quality patient care Employer of choice		

Ref	Lead Director / Lead Committee	Principal risk:	Inherent risk score	Primary controls	Assurances	Residual risk score	Gaps in control or assurance	Planned actions *(including owner and delivery date)*	Target risk score
SIR 1	**Karen Brown, Chief Operating Officer** Last reviewed: 08/07/2021 **Finance & Performance Committee** **Quality & Risk Management Committee** Last reviewed: QRMC 11/05/2021	**Lack of effective demand management and community capacity, together with the increased acuity of patients (including Covid-19 patients) may result in a reduction in patient flow across the hospital.** **This affects the performance of the hospital against key operational performance and quality targets. In turn this:** - **affects patient experience;** - **leads to potential patient harm; and** - **affects the reputation of the Trust and of the NHS.** Note: Elements of this risk are outside of the Trust's direct control (demand management & community capacity) – actions are focused on those areas that are within the organisation's influence. EXTERNALLY AND INTERNALLY DRIVEN RISK	Inherent likelihood: **5 (Almost certain)** Inherent impact: **5 (Catastrophic)** Inherent risk rating: **25** **(Extreme)**	Internal: FLOW boards (real-time bed state) Right to Reside data Integrated Discharge Service Repatriation Policy Urgent Care Improvement Board (internal) Winter plan Escalation & COVID-19 surge policies/procedures COVID-19 Command & Control (Internal) Winter Plan 2020 (approved October 2020) External: COVID-19 Command & Control (External) Whole System Operational Group (WSOG – external) - over 21 day LoS Patients reviewed in detail Significant engagement in system forums (Whole System Operational Group, OOH Delivery Group) Discharge Programme Investment Re-launched internal Urgent Care Board action plan	**Internal Assurance** Board rounds and site management processes [1] Integrated Performance Report [2] Patient flow metrics – daily control centre information [1] Executive Team weekly review of dashboards and ED quality metrics [2] Performance report to Finance & Performance Committee [2] Finance & Performance Committee deep-dives into operational performance [2] QRMC Deep-dives into patient harm [2] Divisional Performance Reviews [2] **External Assurance** Urgent & Emergency Care Steering Group (external) [2] System Delivery & Operational Group (external) [2] CQC 2019 inspection – Urgent and Emergency Services rated Good [3]	Residual likelihood: **5 (Likely)** Residual impact: **4 (severe)** Residual risk rating: **20** **(Severe)** Previous residual risk rating: **3x5=15 4x5=20 5x4=20** Residual risk rating last changed: **22/10/2020 09/03/2021 08/07/2021** Forecast trajectory (next 12 months): 	Planned care backlogs and waiting lists June/July ED performance significantly below national targets	The Trust is involved in the BNSSG Accelerator Programme (NBT SRO), bringing in additional resource and focused planning on the recovery of planned care across the system. Significant impact should be seen by end of July 2021 **Due Date: July/August 2021** **Owner: COO** A "Spring & Refresh" Programme is underway over July to support FLOW across the organisation including within the Emergency Department. This will utilise the Trust's PERFORM methodology with QI support. **Due Date: review end of July 2021** **Owner: COO** The Urgent Care Action Plan is being updated with additional actions and learnings from recent South West CQC ED inspections. **Due Date: various; action plan to TMT August 2021** **Owner: COO**	Target likelihood: **3 (Possible)** Target impact: **4 (Severe)** Target risk rating: **12** **(High)**

NHS North Bristol NHS Trust

Board Assurance Framework (BAF)

Trust Strategic Theme:	Provider of high quality patient care Developing healthcare for the future Employer of choice Anchor in the community		

Ref	Lead Director / Lead Committee	Principal risk:	Inherent risk score	Primary controls	Assurances	Residual risk score	Gaps in control or assurance	Planned actions *(including owner and delivery date)*	Target risk score
COV 2	**Karen Brown, Chief Operating Officer** Last reviewed: 08/07/2021 **Quality & Risk Management Committee** Last reviewed: 11/05/2021	**The global COVID-19 pandemic and the specific local impacts as described via PHE/NHSEI modelling data has the potential to overwhelm the hospital. This would likely impact across several areas including:** - **Capacity to provide effective and safe care to COVID-19 and non-COVID-19 patients;** - **Reduction in staff numbers due to staff sickness, self-isolation, and shielding; and** - **Public confidence in the hospital and the NHS.** Note: drivers of this risk are outside of the organisation's direct control (Covid-19 infection rates) – actions are focused on those areas that are within the organisation's influence. EXTERNALLY DRIVEN RISK	Inherent likelihood: **5 (Almost certain)** Inherent impact: **5 (Catastrophic)** Inherent risk rating: **25** **(Extreme)**	**Internal** COVID-19 Command and Control structures in NBT, including groups overseeing: - Data analytics - IPC - Workforce - PPE - Staff testing Development of new staffing model (mega-teams) Surge and super-surge plans for ICU and general acute capacity, testing and mortuary Increased capacity for remote working **External** Significant engagement in system and regional forums Engagement and leadership role in Severn Critical Care Network System COVID-19 Command and Control structures National Vaccination Programme	**Internal Assurance** COVID-19 sit-rep [1] NBT specific pandemic modelling [1] COVID-19 reports to Trust Board and TMT (monthly) [2] Integrated Performance Report [2] **External Assurance** Regional and local specific pandemic modelling [3] Reports and updates via local and regional forums [3]	Residual likelihood: **4 (Likely)** Residual impact: **4 (Severe)** Residual risk rating: **16** **(Severe)** Previous residual risk rating: **3x4=12** **4x4=16** **5x5=25** **4x3=-12** Residual risk rating last changed: **15/01/2021** **09/03/2021** **17/05/2021** **16/07/2021** Forecast trajectory (next 12 months): 	The national lock-down reduced the prevalence of Covid-19 within the community; however, the Delta Variant is now leading to an increase with another "peak" expected at the end of July 2021. The national vaccination programme is not expected to have full effect until September 2021. The Trust continues to maintain appropriate IPC controls in line with DHSC and PHE guidance including a weekly revision of NBT's Covid-19 status.	The Trust is maintaining a reduced schedule of command and control meetings (Gold/Silver/Bronze) to manage the ongoing Covid-19 impact on the hospital. This will remain under regular review. Note that the Trust moved to Covid-19 level 3 in mid-July 2021. **Due Date: monthly review via Trust Board Covid-19 update** **Owner: Chief Operating Officer**	Target likelihood: **3 (Possible)** Target impact: **4 (Severe)** Target risk rating: **12** **(High)**

Board Assurance Framework (BAF)

Trust Strategic Theme:	Employer of choice		

Ref	Lead Director / Lead Committee	Principal risk:	Inherent risk score	Primary controls	Assurances	Residual risk score	Gaps in control or assurance	Planned actions *(including owner and delivery date)*	Target risk score
SIR 2	**Jacqui Marshall, Director of People & Transformation** Last reviewed: 22/07/2021 **People Committee** Last reviewed: Not yet reviewed: 08/03/2021	**National/system competition for workforce in key specialties/ professions, together with increasing demands on remaining staff plus post-Covid-19 fatigue could result in skills/capacity shortages within the Trust and increased instability in the workforce.** **Consequences would include** - **Increased reliance on expensive agency staff;** - **Higher turnover, which could result in dramatic increase in recruitment activity and associated costs.** Elements of this risk are outside of the Trust's direct control (training of professionally registered medics and other specialists) – actions are focused on those areas that are within the organisation's influence. INTERNALLY & EXTERNALLY DRIVEN RISK	Inherent likelihood: **4 (Likely)** Inherent impact: **5 (Catastrophic)** Inherent risk rating: **20** **(Extreme)**	BNSSG Workforce Strategy Nursing Workforce Group overseeing mitigating work Medical Workforce Group overseeing mitigation work Retention steering group & Pathfinder Programme Retention interventions (overseen by Retention steering group) Covid-19 Recovery & Restoration Programme Award-winning, nationally recognised Staff Health & Wellbeing offering Buying & selling annual leave policy Itchy feet campaign Flexible working offer expanded Strong development and leadership offer Increased opportunities through SLM Programme BNSSG workforce recovers cell in place from Feb 2021 BNSSG development of EVP offer BNSSG integrated staff bank	**Internal Assurance** Integrated Performance Report – HR/Well-Led section (2) People Committee deep-dives and performance review (2) People Balanced Scorecard (1) Staff survey results & action plans (2) Voice Programme (1) Happy App (1) Exit interview data (1) Pulse Surveys (1) Freedom to Speak Up Report (2) Recruitment & retention deep-dive – March 2021 People Committee meeting (2) **External Assurance** Gender pay-gap report (2018) (3) National Retention Data (3)	Residual likelihood: **3 (Possible)** Residual impact: **4 (Severe)** Residual risk rating: **12** **(Extreme)** Previous residual risk rating: **4x4=16** Residual risk rating last changed: **12/08/2020** Forecast trajectory (next 12 months): ⇔	There is potential competition between providers within the BNSSG STP for the same staff, and there are identified differentials in grading between similar roles.	An STP-level career pathway review is underway, to create BNSSG as a "career destination" to reduce competition for staff within the system. There is ongoing work as part of Covid-19 response which feeds into this. EVP Programme development. **Due date: work ongoing – reviewed regularly, due end summer (August 2021)** **Owner: Director of People & Transformation**	Target likelihood: **2 (Unlikely)** Target impact: **3 (Moderate)** Target risk rating: **6** **(Moderate)**

NHS North Bristol NHS Trust

Board Assurance Framework (BAF)

Trust Strategic Theme:	Provider of high quality patient care Employer of choice An anchor in our local community		

Ref	Lead Director / Lead Committee	Principal risk:	Inherent risk score	Primary controls	Assurances	Residual risk score	Gaps in control or assurance	Planned actions *(including owner and delivery date)*	Target risk score
SIR 8	**Simon Wood, Director of Facilities** Last reviewed: 22/07/2021 **Finance & Performance Committee** Last reviewed: 22/04/2020	**A lack of investment in retained estate results in inappropriate spaces to deliver care, and estate which does not comply with relevant legislation. This may result in issues with staff retention, patient experience and complaints, compliance concerns and an impact on financial and operational sustainability** Note: The Trust has control over its internal capital spend. This risk is considered a controllable risk. INTERNALLY DRIVEN RISK	Inherent likelihood: **4 (Likely)** Inherent impact: **5 (Catastrophic)** Inherent risk rating: **20** **(Extreme)**	Capital Planning Group & sub-structure Capital Plan and Estates Strategy/Masterplan approved 2020 Health & Safety Committee & policies Preventative Maintenance Programme 2019/20 and emerging 2020/21 capital programme Facilities help-desk (to advise on any deterioration of estate) Facilities Management walk-arounds/inspections Executive walk-arounds Expected capital programme slippage used as a contingency for unexpected works in the retained estate.	**Internal Assurance** Capital Planning reports to Finance & Performance Committee (twice-yearly) (2) Health & Safety reports to People & Digital Committee (quarterly + annual report) (2) ERIC Benchmarking confirms relative position to other Trusts (annual process) (2) WACH – condition and H&S survey (2018) (1) South Bristol Dialysis and Westgate House condition survey (2018) (1) Fire risk audits undertaken regularly across the site (1) Six Facet Survey completed 2020 (3) Estates Master Plan (August 2020) (1) **External Assurance** Fire Safety Assurance Survey (Brunel - 2019) (3)	Residual likelihood: **3 (Possible)** Residual impact: **4 (Severe)** Residual risk rating: **12** **(High)** Previous residual risk rating: **N/A** Residual risk rating last changed: **N/A** Forecast trajectory (next 12 months): ⇔	There is ongoing uncertainty around the financial framework and funding mechanism for the NHS long-term (post Covid-19). The Trust continues to ensure that there is regular capital investment in Critical Infrastructure towards compliant and appropriate clinical accommodation. However, this is limited by all other Trust-wide requirements therefore some programmes will be delivered over extended periods. It is assumed that major estates improvements will be specifically externally funded.	NBT is remaining engaged in system discussions to ensure that it is able to respond to changing national requirements. **Owner: Chief Executive** **Due Date: October 2021 (MOU finalisation)** The Trust Estates/Capital Team are progressing various significant schemes to "shovel ready" state, in anticipation of national funding calls becoming available. Elective Care Centre, W&C Estates and Accommodation Projects are specifically being progressed in this manner. Update to F&PC Planned for Q2 2021/22. **Owner: Director of Estates, Facilities & Capital Planning** **Due Date: Sept 2021**	Target likelihood: **2 (Unlikely)** Target impact: **4 (Severe)** Target risk rating: **8** **(High)**

Board Assurance Framework (BAF)

Trust Strategic Theme:	Developing Healthcare for the future An anchor in our local community		

Ref	Lead Director / Lead Committee	Principal risk:	Inherent risk score	Primary controls	Assurances	Residual risk score	Gaps in control or assurance	Planned actions *(including owner and delivery date)*	Target risk score
SIR 10	**Neil Darvill, Director of IM&T &** **Simon Wood, Director of Estates, Facilities and Capital** Last reviewed: 22/07/2021 **Finance & Performance Committee** Last reviewed: 22/04/2021	**The Trust has limited capital funding and many competing priorities for investment (as well as other non-capital cost pressures). The gradual move towards system involvement in capital prioritisation an approval adds an additional layer of complexity in capital planning.** **Lack of investment in appropriate technologies and infrastructure in a timely manner impacts the ability of the Trust to deliver:** - **operational targets** - **financial performance and** - **quality improvement.** Note: The Trust has control over its internal capital spend. This risk is considered a controllable risk. INTERNALLY DRIVEN RISK	Inherent likelihood: **5 (Almost certain)** Inherent impact: **4 (Severe)** Inherent risk rating: **20** **(Extreme)**	Annual capital investment planning process, prioritised with divisional and executive input (aligned to strategy) OneNBT Digital Strategy and vision OneNBT Transformation Plan (5-year plan) National Digital Investment opportunities NBT Director of IM&T is system Digital lead, ensuring STP alignment Chief Clinical Information Officer & Chief Nursing Information Officer roles Clinical Digital Leads for key projects such as EPR	**Internal Assurance** People & Digital Committee oversight of OneNBT Digital Strategy delivery (2) Capital Planning reports to Finance & Performance Committee (twice-yearly) (2) OneNBT Transformation Plan governance structure (approved 2019) (1) Six Facet Survey completed 2020 – 5-year cost view for building related capital and 30-year view for M&E investment. (3) Draft 2021/22 Capital Plan (February 2021 Trust Board) (2) **External Assurance** None.	Residual likelihood: **3 (Possible)** Residual impact: **4 (Severe)** Residual risk rating: **12** **(High)** Previous residual risk rating: **4x4=16** Residual risk rating last changed: **13/01/2019** Forecast trajectory (next 12 months): 	The Trust has a significant medical equipment replacement requirement, which is currently not being fully covered in the annual capital plan. This will need to be rebalanced in future years.	Discussions are being undertaken with the charity to determine what medical equipment needs would lend themselves to charitable support. **Due date: Q3 2020/21 (delayed due to Covid-19 wave 2)** **Owner: Director of Estates, Facilities & Capital Planning** <u>Update May 2021:</u> The Charity are represented on the capital planning group, which allows this conversation to take place. This action will be closed.	Target likelihood: **2 (Unlikely)** Target impact: **4 (Severe)** Target risk rating: **8** **(High)**
							Not yet clear agreement on how capital funding is to be allocated/approved at ICS-level.	NBT CFO is an active member of the ICS "System DOFs" group. The ICS constituent partners are currently working on framework documents, including the ICS MOU and the financial framework / scheme of delegation which will outline agreed processes. **Due date: September 2021 / April 2022 (for statutory ICS go-live)** **Owner: Chief Finance Officer & Director of Corporate Governance**	

NHS North Bristol NHS Trust

Board Assurance Framework (BAF)

Trust Strategic Theme:	Provider of high quality clinical care Employer of choice		

Ref	Lead Director / Lead Committee	Principal risk:	Inherent risk score	Primary controls	Assurances	Residual risk score	Gaps in control or assurance	Planned actions *(including owner and delivery date)*	Target risk score
SIR 14	**Chris Burton, Medical Director Helen Blanchard, Director of Nursing & Quality** Last reviewed: 08/07/2021 **Quality & Risk Management Committee** Last reviewed: 11/05/2021	**Sustained demand and increased acuity of patients in hospital will impact on patient safety and outcomes, leading to harm in patients and poorer patient experience.** Note: while this risk is externally driven, there are element of the risk that the trust can control through efficient and effective working. INTERNALLY & EXTERNALLY DRIVEN RISK	Inherent likelihood: **5 (Almost certain)** Inherent impact: **5 (Catastrophic)** Inherent risk rating: **25** **(Extreme)**	Safety and quality work across the Trust Clinical Risk Operational Group oversees all SI and adverse events Patient Safety & Clinical Risk Committee Divisional quality governance structures reporting to Divisional Boards Investment in Divisional governance in 2019 Divisional quality reviewed in Divisional performance review meetings Patient experience work across the Trust Learning from Deaths process and new Medical Examiner function Freedom to Speak Up structure and function Patient harm reviews for delayed cancer patients - overseen by Cancer Board Patient Safety Incident Response Framework (NBT Early Adopter)	**Internal Assurance** Quality and patient outcomes monitored by QRMC and its governance sub-structure (2) Safer staffing reviews every 6 months with daily monitoring (1) Patient experience and outcomes monitored by Patient & Carer Experience Committee and its governance sub-structure (2) Integrated Performance Report - Quality Data (2) QRMC oversight and deep dive reviews e.g. long-wait patient harm, falls etc.(2) Clinical audit outcomes and action plans - reported to QRMC (2) Quality Accounts (1) Internal Audit processes - Divisional Governance Audit (repeat in 2019/20) & audit of GE governance review (2019/20) (3) Freedom to speak up reports to board (biannual) (2) CQC Reports (3) CQC service level visits (3) Medical Examiner Model (jointly with UHBW) (2) **External Assurance** Annual national patient survey results & FFT (3)	Residual likelihood: **3 (Likely)** Residual impact: **4 (Severe)** Residual risk rating: **12** **(High)** Previous residual risk rating: **3x3=9 3x4=12 4x4=16** Residual risk rating last changed: **21/10/2020 15/01/2021 17/03/2021** Forecast trajectory (next 12 months): ⇔	Current attendance and performance pressures in the Emergency Department are creating sustained demand on the hospital, with increasing number of Covid-19-positive patients.	A “Spring & Refresh” Programme is underway over July to support FLOW across the organisation including within the Emergency Department. This will utilise the Trust’s PERFORM methodology with QI support. **Due Date: review end of July 2021** **Owner: COO** The Urgent Care Action Plan is being updated with additional actions and learnings from recent South West CQC ED inspections. **Due Date: various; action plan to TMT August 2021** **Owner: COO**	Target likelihood: **2 (Possible)** Target impact: **4 (Severe)** Target risk rating: **8** **(High)**

Board Assurance Framework (BAF)

Trust Strategic Theme:	Provider of high quality patient care		

Ref	Lead Director / Lead Committee	Principal risk:	Inherent risk score	Primary controls	Assurances	Residual risk score	Gaps in control or assurance	Planned actions *(including owner and delivery date)*	Target risk score
SIR 15	**Neil Darvill, Director of IM&T** Last reviewed: 17/05/2021 **Finance & Performance Committee** Last reviewed: 22/04/2021	**A significant cyber-attack takes out the Trust's IT systems leading to an inability to treat patients and the potential loss of critical data.** Note: while this risk is externally driven, there are element of the risk that the trust can control through mitigations and additional back-up/protection. EXTERNALLT DRIVEN RISK	Inherent likelihood: **4 (Likely)** Inherent impact: **5 (Catastrophic)** Inherent risk rating: **20** **(Extreme)**	IT security measures Daily immutable system back-ups Business continuity and recovery plans Timely server and software updates NHS Digital cyber security programme Care Cert Server and Network vulnerability scanners STP Cyber Security Group aligning organisational standards and ensuring best practice. Extensive migration to Windows 10 and Office 365 during 2020/21 Updated Enterprise Network completed in Q4 2019/20 NHS Digital South West Regional Cyber Security Group for direction and access to national solutions.	**Internal Assurance** Data security protection return (draft presented to October 2020 People & Digital Committee) (2) Cyber security report (monthly to IM&T Divisional Board and F&P Committee) (2) **External Assurance** Information Commissioner Audit December 2019 (3) Penetration Tests and assessments, October 2020(2) KPMG Data Security Protection Toolkit audit May 2021 (3)	Residual likelihood: **3 (Possible)** Residual impact: **5 (Catastrophic)** Residual risk rating: **15** **(Extreme)** Previous residual risk rating: **4x5=20** Residual risk rating last changed: **22/05/2020** Forecast trajectory (next 12 months): ⇔	Significant work has been completed in 2019/20 and early 2020/21 to reduce the likelihood of a cyber-security incident, through updating networks and migration to up-to-date operating systems. Work is now planned in 2020/21 to reduce the impact of any successful cyber-security attack.	Additional work is underway to implement software tools to proactively monitor network activity and quickly identify and respond to any changes to normal activity. **Owner: Phil Wade** **Due Date: Q3 2020/21** Update May 2021: Active Directory Log Data is now uploaded for analysis as part of the South West Regional Security Information and Event Management (SIEM) solution. Update July 2021: Firewall log data is now uploaded for analysis as part of the South West Regional Security Information and Event Management (SIEM) solution.	Target likelihood: **3 (Possible)** Target impact: **4 (Severe)** Target risk rating: **12** **(High)**
								The Trust's online back-up solution is being updated, which will allow more effective restoration of activity lost in the event of a cyber-security attack. **Owner: Phil Wade** **Due Date: Q3 2020/21** Update May 2021: The solution has been implemented and migrations to the platform are now underway. Final completion expected Q3 2021/22	
							The Trust does not yet have cyber security insurance in place. This is consistent with other NHS organisations due to the immaturity of this particular insurance market	A key entry criterion for insurance is to obtain Cyber Essentials Plus certification. The Trust is pursuing this certification and hopes to complete this in Q2 2020/21 and then investigate appropriate insurance cover. **Owner: Director of IM&T** **Due date: end of Q2 2021/22**	

NHS North Bristol NHS Trust

Board Assurance Framework (BAF)

Trust Strategic Theme:	An anchor in our Community		

Ref	Lead Director / Lead Committee	**Principal risk:**	**Inherent risk score**	**Areas of influence/controls**	**Monitoring/assurance**	**Residual risk score**	**Gaps in influence or monitoring/assurance**	**Planned actions *(including owner and delivery date)***	**Target risk score**
SIR 16	**Simon Wood, Director of Estates, Facilities & Capital Planning** Last reviewed: 21/07/2021 **Finance & Performance Committee** Last reviewed: 22/04/2021	**There is a risk that due to lack of resource and the complexity of the required planning, the Trust fails to meet its 2030 Carbon Neutral goal (i.e. key objective in Business Plan not met)** **This would constitute a failure to support Bristol's One City Plan and Climate Strategy and would represent a reputational risk** Note: The Trust has control over setting its internal priorities. This risk is considered a controllable risk. INTERNALLY DRIVEN RISK	Inherent likelihood: **4 (Likely)** Inherent impact: **4 (Severe)** Inherent risk rating: **16** **(Extreme)**	NBT's has a Sustainable Development (SD) structure in place and formally approved to lead and steer An annual, Board approved, Green Plan There is an SD Steering Group with multi-disciplinary and NED membership. An understanding of NBT's current basic carbon footprint already exists. Monitoring of annual carbon emissions occurs Business Planning process includes a Carbon Assessment Tool to support Divisions/Directorates in identifying carbon reduction opportunities. Procurement and spending choices will be available to the Trust Representation with Civic and local Partners is in place at many levels and multiple streams which can assist influencing around Carbon 2030 progress	NBT carbon footprint is calculated and reported using the national NHS tool (1) Sustainable Development Steering Group and TMT / Trust Board approve annual Green Plan (ex-SDMP) which details carbon reduction efforts (2) National Sustainable Development Unit takes an overview of Trust SD activities (3) ERIC/Model Hospital comparative data (1) Possible Occasional Internal Audit assessments (2) Carbon and Energy Manager, Senior Sustainability Partner and Sustainability Partner (FM) posts (1)	Residual likelihood: **3 (Possible)** Residual impact: **4 (Severe)** Residual risk rating: **12** **(Severe)** Previous residual risk rating: **N/A** Residual risk rating last changed: **N/A** Forecast trajectory (next 12 months): ⇔	Insufficient in-house expertise to identify and prioritise the full range of measures/actions required to achieve carbon neutrality by 2030, (including measures outside of our control.) Carbon Assessment Tool is not being completed by all Divisions/Directorates	Appointed a consultant to develop a Carbon 2030 Route-map (prioritised plan) to inform 2022/23 business planning. 11 month programme agreed, running from March 2021. Headlines in Nov 2021. **Owner: Sustainable Development Unit** **Due Date: February 2022** Recruit Carbon 2030 champions from each Div/Dir to support identification of measures, implementation of projects and progress monitoring. Sustainability Advocate role description shared, tested effectively with Medicine, roll-out in Sept 2021 **Owner: Sustainable Development Unit** **Due Date: Sept 2021** Additional funding (£2.3M) has been awarded from the Public Sector Decarbonisation Scheme (with £700K NBT contribution) to support investment in energy efficiency/renewables. Individual business cases required to determine if the Trust can accept the funding and spend within 21/22 **Owner: Director of Estates, Facilities & Capital Planning** **Due Date: outcome of expected July/Aug 2021**	Target likelihood: **2 (Unlikely)** Target impact: **2 (Minor)** Target risk rating: **4** **(Moderate)**

Board Assurance Framework (BAF)

Trust Strategic Theme:	Developing healthcare of the future Employer of choice		

Ref	Lead Director / Lead Committee	Principal risk:	Inherent risk score	Areas of influence	Monitoring/assurance	Residual risk score	Gaps in influence or monitoring/assurance	Planned actions *(including owner and delivery date)*	Target risk score
SER 4	**Maria Kane, Chief Executive** **Xavier Bell, Director of Corporate Governance** Last reviewed: 17/05/2021 **Finance & Performance Committee** Last reviewed: 22/04/2021	**The national drive towards ICS and "system first" management and regulatory oversight is not always aligned with the statutory responsibility and accountability of individual system partners.** **This gives rise to a risk that organisations will face inconsistent and/or incompatible requirements from regulators and the system.** **Consequences could include an impact on the organisation's ability to deliver its strategy** Note: while the Trust can influence ICS development, the drivers behind this risk are largely outside the Trust's control. EXTERNALLY DRIVEN RISK	Inherent likelihood: **4 (Likely)** Inherent impact: **4 (Extreme)** Inherent risk rating: **16** **(Extreme)**	Chair and Chief Executive relationships with senior regulators Lobbying at regional/national level (Chair & Executives), and lobbying via NHS Providers NBT Executive and Chair attendance at formal Healthier Together governance meetings such as Partnership Board and Healthier Together Executive Meeting NBT represented in system by CEO, COO and DOF via key meetings such as: - System DOFs meeting - System Delivery Oversight Group - System CEO meetings Director of Corporate Governance involved in Healthier Together governance working group Trust Board fed into BNSSG Healthier Together response to NHSE/I ICS consultation 2020/21 Trust Board Chair submitted NBT response to NHSEI ICS consultation 2020/21	CCG Board Reports (local) [(1)] NHSE/I Board Reports (national and specialised commissioning) [(1)] System Operational Planning and Long-Term Plan processes [(1)] Healthier Together Reports [(1)] Healthier Together Development Programme Participation [(1)] Government White Paper February 2021[(1)] Engagement in ICS Development Programme – run by Healthier Together [(1)]	Residual likelihood: **3 (Possible)** Residual impact: **4 (Severe)** Residual risk rating: **12** **(Extreme)** Previous residual risk rating: **4x4=16** Residual risk rating last changed: **17/05/2021** Forecast trajectory (next 12 months): ⇔	ICS development and formal governance structures (MOU/Financial framework etc.) are still under development Government White Paper outlines proposal for giving ICS a statutory footing, together with associated changes to regulatory framework allowing/encouraging collaboration and joint-working at system-level. Still lacks clarity on detail of implementation.	Participation in ongoing MOU development work throughout summer of 2020/21. MOU to be finalised in September/October 2021. **Due date: September 2021** **Lead: Director of Corporate Governance** NBT & UHBW working together via Acute Services Review Programme Board (joint committee). Discussions underway to consider scope of collaboration and how to use joint committee most effectively to ensure ICS success. Update June 2021: A board to board took place in June 2021 and both organisations are working to expand the join committee into a more formal Provider Collaborative. Updates planned for August/September Trust boards. **Due date: Sept 2021** **Lead: Medical Director**	Target likelihood: **2 (Rare)** Target impact: **4 (Severe)** Target risk rating: **8** **(High)**

Board Assurance Framework (BAF)

APPENDIX A: RISK SCORING MATRIX

Every risk recorded within the Trust's risk registers is assigned a rating, which is derived from an assessment of its Impact Score (severity of potential hard) and its Likelihood Score (the probability that the risk event will occur). The risk grading criteria summarised below provide the basis for all risk assessments recorded within the Trust's risk registers, at strategic, operational and project level.

Impact Score (severity of potential harm)

	1	2	3	4	5
Risk Type	**Negligible**	**Minor**	**Moderate**	**Severe**	**Catastrophic**
Patient Experience	Unsatisfactory patient experience not directly related to patient care Peripheral element of treatment or service suboptimal Informal complaint/inquiry	Unsatisfactory patient experience – readily resolvable Overall treatment or service suboptimal Formal complaint (stage 1) Local resolution Minor implications for patient safety if unresolved	Mismanagement of patient care Repeated failure to meet internal standards Formal complaint (stage 2) complaint Local resolution (with potential to go to independent review) Major patient safety implications if findings are not acted on	Serious mismanagement of patient care Multiple complaints/ independent review Non-compliance with national standards with significant risk to patients if unresolved	Totally unacceptable level or quality of treatment/service Inquest/ombudsman inquiry Gross failure of patient safety if findings not acted on
Patient Safety	Minimal injury requiring no/minimal intervention or treatment.	Low harm injury or illness, requiring minor/short-term intervention. Increase in length of hospital stay by 1-3 days	Moderate injury requiring professional intervention Increase in length of hospital stay by 4-15 days	Severe injury leading to long-term incapacity/disability Increase in length of hospital stay by >15 days Mismanagement of patient care with long-term effects	Incident leading to death Multiple permanent injuries or irreversible health effects
Health & Safety	No time off work	Requiring time off work for <3 days	Requiring time off work for 4-14 days RIDDOR / MHRA / agency reportable incident	Requiring time off work for >14 days	Multiple permanent injuries or irreversible health effects
Workforce	Short term low staffing level temporarily reduces service quality (< 1 day)	Ongoing low staffing level reduces service quality.	Late delivery of key objective / service due to lack of staff. Minor error due to insufficient training. Ongoing unsafe staffing level.	Uncertain delivery of key objective / service due to lack of staff. Serious error due to insufficient training.	Non-delivery of key objective / service due to lack of staff. Loss of key staff. Very high turnover. Critical error due to insufficient training.
Performance, Business Objectives	Interim and recoverable position Negligible reduction in scope or quality Insignificant cost increase	Partial failure to meet subsidiary Trust objectives Minor reduction in quality / scope Reduced performance rating if unresolved	Irrecoverable schedule slippage but will not affect key objectives Definite reduction in scope or quality Definite escalating risk of non-recovery of situation Reduced performance rating	Key objectives not met Irrecoverable schedule slippage Low performance rating	Trust Objectives not met Irrecoverable schedule slippage that will have a critical impact on project success Zero performance rating
Service Delivery & Business Continuity	Loss/interruption of >1 hour	Loss/interruption of >8 hours	Loss/interruption of >1 day	Loss/interruption of >1 week	Permanent loss of service or facility
Financial	No or minimal impact on cash flow	Readily resolvable impact on cash flow Loss of 0.1–0.25 per cent of Trust's annual budget	Individual supplier put Trust "on hold" Loss of 0.26–0.5 per cent of Trust's annual budget	Major impact on cash flow Purchasers failing to pay on time Uncertain delivery of key objective Loss of 0.6–1.0 per cent of Trust's annual budget	Critical impact on cash flow Failure to meet specification/ slippage Non-delivery of key objective/ Loss of >1 per cent of Trust's annual budget
IM&T	Information system issue affecting one service user	Information system issue affecting one department Poor functionality of trust wide system, readily resolvable and not impacting service delivery	Information system issue affecting one division Poor functionality of trust wide system impacting service delivery, but readily resolvable.	Information system issue affecting more than one division. Poor functionality of trust wide system impacting service delivery, not readily resolvable	Complete failure of trust wide information system that directly impacts service delivery.
Reputational	Rumours	Local Media – short term	Local Media – long term	National Media < 3 days	National Media ≥ 3 days. MP Concern (Questions in House)
Statutory Duty & Inspections	No or minimal impact or breach of guidance/ statutory duty Minor recommendations	Non-compliance with standards reduced rating. Recommendations given.	Single breach in statutory duty Challenging external	Enforcement Action Multiple challenging recommendations	Prosecution Multiple breaches in statutory duty

Board Assurance Framework (BAF)

	1	2	3	4	5
Risk Type	**Negligible**	**Minor**	**Moderate**	**Severe**	**Catastrophic**
			recommendation Improvement notice	Improvement notices Critical report	Complete systems change required Severely critical report

Likelihood Score

The Likelihood Score is calculated by determining how likely the risk is to happen according to the following guide. Scores range from 1 for rare to 5 for almost certain.

Likelihood score	**1**	**2**	**3**	**4**	**5**
Descriptor	**Rare**	**Unlikely**	**Possible**	**Likely**	**Almost certain**
Broad descriptor	This will probably never happen/recur	Do not expect it to happen/recur	Might happen or recur occasionally	Will probably happen/recur but it is not a persisting issue	Will undoubtedly happen/recur, possibly frequently
Frequency	Not expected to occur for years	Expected to occur at least annually	Expected to occur at least monthly	Expected to occur at least weekly	Expected to occur at least daily
Probability Will it happen or not?	<0.1 per cent	0.1–1 per cent	1.1–10 per cent	11–50 per cent	>50 per cent

The **Risk Score** is determined by the Impact x Likelihood.

Likelihood score	**1**	**2**	**3**	**4**	**5**
	Rare	**Unlikely**	**Possible**	**Likely**	**Almost certain**
5 Catastrophic	5	10	15	20	25
4 Severe	4	8	12	16	20
3 Moderate	3	6	9	12	15
2 Low	2	4	6	8	10
1 Negligible	1	2	3	4	5

Risk Grade:

1-3	Low Risk
4-6	Moderate Risk
8-12	High Risk
15 - 25	Extreme Risk