Trust Board Meeting in Public

Thursday 30 November 2023
10:00 - 14:10
Seminar Rooms 4 & 5, Learning & Research Building, Southmead Hospital

A G E N D A

No.	Item	Purpose	Lead	Paper	Time
OPENING BUSINESS					
1.	Welcomes and Apologies for Absence	Information	Chair	Verbal	10:00
2.	Declarations of Interest	Information	Chair	Enc.	10:01
STANDING ITEMS					
3.	Minutes - Public Board – 28 September 2023	Approval	Chair	Enc.	10:02
4.	Action Log	Approval	Trust Secretary	Verbal	10:03
5.	Matters Arising	Discussion	All	Verbal	10:04
6.	Chair's Briefing	Information	Chair	Verbal	10:05
7.	Chief Executive's Briefing	Information	Chief Executive	Enc.	10:15
KEY ITEMS					
8.	Patient Story	Discussion	Chief Nursing Officer	Enc.	10:25
9.	Madeline (Maddy) Lawrence Inquest - Actions and Progress Assurance	Discussion	Chief Medical Officer	Enc.	10:45
QUALITY					
10.	Quality Committee Upward Report 10.1 Tissue Viability Annual Report 10.2 Organ Donation Annual Report	Information	NED Chair	Enc.	11:10
11.	Infection Prevention Control Annual Report	Information	Chief Nursing Officer	Enc.	11:20
BREAK					**11:30**
12.	Patient Safety Incident Response Plan 2023-2025	Approval	Chief Medical Officer	Enc.	11:40
PEOPLE					
13.	People Committee Upward Report 13.1 Terms of Reference, People and EDI Committee 13.2 Terms of Reference, EDI Group 13.3 EDI Plan	Information	NED Chair	Enc.	11:55
14.	Freedom To Speak Up Bi-Annual Report	Discussion	Trust Secretary	Enc.	12:15
LUNCH BREAK (30 minutes)					12:30

FINANCE, IM&T & PERFORMANCE					
15.	Integrated Performance Report	Discussion	Chief Operating Officer	Enc.	13:00
16.	Finance and Performance Committee Upward Report 16.1. Finance Report - Month 7 16.2. Green Plan	Discussion	NED Chair	Enc.	13:30
GOVERNANCE & ASSURANCE					
17.	Trust Joint Modern Slavery Statement	Approval	Chief Finance Officer	Enc.	13:45
18.	Audit and Risk Committee Upward Report 18.1. Board Assurance Framework 18.2. Committee Terms of Reference	Discussion	NED Chair	Verbal	13:50
CLOSING BUSINESS					
19.	Any Other Business	Information	Chair	Verbal	14:00
20.	Questions from the Public	Information	Chair	Verbal	-
21.	Date of Next Meeting: 25 January 2024	Information	Chair	Verbal	-
22.	Exclusion of the Press and Public	Approval	Chair	Verbal	-
END					

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 • Trustee of Second Step. • Trustee of the SS Great Britain Trust • Trustee of the Robins Foundation • Member of the Labour Party.
Mr Tim Gregory	Non-Executive Director	• Nothing to declare.
Mr Richard Gaunt	Non-Executive Director	• 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. • Managing Director, HWM-Water (manufacturing company). • Director, Radcom Technologies Limited (dormant company) • Director of ASL Holdings Limited (manufacturing of communications equipment) • Director of Invenio Systems Limited (engineering) • Non-Exec Director of Advanced Electronics Limited (manufacturing)
Professor Sarah Purdy	Non-Executive Director	• Professor Emeritus, University of Bristol • Fellow of the Royal College of General Practitioners • Fellow of the Royal College of Physicians • Fellow of the Royal College of Physicians Edinburgh • Member of the British Medical Association • Member, Barts Charity Grants Committee • Shareholder (more than 25% but less than 50%) Talking Health Limited

Name	Role	Interest Declared
		Indirect Interests (ie through association of another individual eg close family member or relative) via Graham Rich who is: - Chair, Armada Topco Limited - Director, Talking Health Ltd - Chair, EHC Holdings Topco Limited
Dr Jane Khawaja	Non-Executive Director	• Employee and Member of the Board of Trustees, University of Bristol. • Director of Gloucestershire Cricket Foundation. • Director of Bristol Future Talent Partnership. • Commissioner, Bristol Commission on Race Equality. • Member of Bristol City Funds, Investment Advisory Committee.
Mr Shawn Smith	Non-Executive Director	• Bluebells Consultancy Ltd (sole shareholder) • Raytheon Ltd (contractor) • Governor of City of Bristol College • Trustee of Frank Water • Elim Housing Association (co-opted committee member)
Mr Darren Roach	Associate Non-Executive Director	• His wife works as a nurse at the University Hospitals Bristol and Weston NHS Foundation Trust • Non-Executive Director, Seable Limited, a social enterprise supporting trips and holidays for visually impaired people
Mr Omar Mashjari	Associate Non-Executive Director	• Employee of the University of the West of England (UWE) • Trustee of Human Appeal (charity) • Director of Alacrity Services Limited (London) (dormant company) • Director of Alacrity Group Limited (London) (dormant company)

Name	Role	Interest Declared
Ms Maria Kane	Chief Executive	• Advisory Group Member of CHKS, a provider of healthcare intelligence and quality improvement services (remuneration donated to charity) • Visiting Professor to the University of the West of England (unremunerated)
Mr Steve Curry	Chief Operating Officer	• Nothing to declare.
Mr Tim Whittlestone	Chief Medical Officer	• Director of Bristol Urology Associates Ltd: undertakes occasional private practice (Urology Specialty) at company office, outside of NBT contracted hours. • Chair of the Wales and West Acute Transport for Children Service (WATCh). • Vice Chair of the South-West Genomic Medicine Service Alliance Board. • Wife is an employee of the Trust. • Director of 3RO Ltd (providing medical advice to international NGOs etc).
Mr Glyn Howells	Chief Financial Officer	• Governor and Vice Chair of Newbury College (voluntary).
Professor Steve Hams	Chief Nursing Officer	• Visiting Professor, University of the West of England • Director, Curhams Limited (dormant company) • Independent Trustee and Chair of the Infection Prevention Society • Associate Non-Executive Director, Surrey Heartlands Integrated Care Board • Husband is employed by Oxford University Hospitals NHS Foundation Trust.
Mr Neil Darvill	Chief Digital Information Officer (non-voting position)	• Wife works as a senior manager for Avon and Wiltshire Partnership Mental Health Trust. • Stepbrother is an employee of the Trust, working in the Cancer Services Team.
Ms Jacqui Marshall	Chief People Officer (non-voting position)	• Nothing to declare.

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DRAFT Minutes of the Public Trust Board Meeting held virtually and in Learning & Research Building room 4 on Thursday 28 September 2023 at 10.00am

Present:			
Michele Romaine	Trust Chair	**Maria Kane**	Chief Executive Officer
Tim Gregory	Non-Executive Director	**Glyn Howells**	Chief Finance Officer
Sarah Purdy	Non-Executive Director	**Tim Whittlestone**	Chief Medical Officer
Kelvin Blake	Non-Executive Director	**Steven Hams**	Chief Nursing Officer
Kelly Macfarlane	Non-Executive Director	**Steve Curry**	Chief Operating Officer
Richard Gaunt	Non-Executive Director	**Neil Darvill**	Chief Digital Information Officer
Jane Khawaja	Non-Executive Director	**Jacqui Marshall**	Chief People Officer
Shawn Smith	Non-Executive Director		
Darren Roach	Associate Non-Executive Director		
In Attendance:			
Xavier Bell	Director of Corporate Governance & Trust Secretary	**Aimee Jordan**	Senior Corporate Governance Officer & Policy Manager *(minutes)*
Elliot Nichols	Director of Communications	**Chloe Atherton**	Public Inquiry Support Officer
Presenters:			
Paul Cresswell	Director of Quality Governance *(present for minute items TB/23/09/07 & TB/23/09/08)*	**Charly Moran**	Neuro-Oncology Physiotherapist *(present for minute item TB/23/09/07)*
Emily Ayling	Head of Patient Experience *(present for minute items TB/23/09/07 & TB/23/09/08)*	**Sarah Margetts**	Deputy Chief People Officer *(present for minute item TB/23/09/09)*
Jayne Masters	Lead Cancer Allied Health Professional *(present for minute item TB/23/09/07)*	**Caroline Heartly**	Associate Director of Culture, Leadership & Development *(present for minute item TB/23/09/09)*
Eleanor Guiney	Neuro-Oncology Speech And Language Therapist *(present for minute item TB/23/09/07)*		
Observers:			
Mike Gill	AuditOne	**Tobias Black**	Graduate Trainee
Dr Edward Mew	Doctor ST6	**Dr Mark McClure**	Locum Consultant Nephrologist
Jon Lee	Chief Allied Healthcare Professional		

TB/23/09/01 Welcome and Apologies for the Absence **Action**

Michele Romaine, Trust Chair, welcomed everyone to NBT's Trust Board meeting in public. The Trust Chair also welcomed Elliot Nichols as the new Director of Communications and members of staff who were observing the meeting.

Apologies were noted from Omar Mashjari, Associate Non-Executive Director.

TB/23/09/02 Declarations of Interest

No Declarations of Interest were received relating to the agenda, nor were any updates required to the Trust Board register of interests as currently published on the NBT website and annexed to the Board papers.

TB/23/09/03 Minutes of the previous Public Trust Board Meeting

RESOLVED that the minutes of the Public Meeting held on Thursday 27 July 2023 were approved as a true and correct record.

TB/23/09/04 Action Log and Matters Arising from the Previous Meeting

Xavier Bell, Director of Corporate Governance & Trust Secretary, presented the action log and advised of the updates to close the actions.

RESOLVED that the updates to the Action Log were noted and no matters arising were raised.

TB/23/09/05 Chair's Business

The Trust Chair informed the Board of the following:

- Jayne Mee, Trust Chair for University Hospital Bristol & Weston NHS Foundation Trust (UHBW) would be standing down at the end of her term in March 2024.
- The briefing for NHS Chairs and Chief Execs with the key messages from the national leadership team following the Lucy Letby Case. It was noted that the statutory inquiry and its terms of reference had been announced. It was recognised that it was important to wait for the outcomes of the inquiry to provide clarity on tangible actions.
- The Trust Chair conveyed appreciation for the recent Schwartz Round, emphasizing its positive impact. The session's benefits, particularly the value of visibility and active listening, were acknowledged. It was requested that all Trust Board members attend a Schwartz Round. Jane Khawaja, Non-Executive Director, advised that the next one would be focused on Black History Month and encouraged attendance.

RESOL ED that the Chair's briefing was noted.

TB/23/09/06 Chief Executive's Briefing

Maria Kane, Chief Executive, presented the Chief Executive's Briefing. In addition to the content of the written report, the following was noted:

- The ongoing impact of recent industrial action on performance and the challenges faced in mitigating the disruptions. Maria thanked teams for their support to minimise the impact on staff and patients.
- Workforce planning, with two summits held externally to align efforts with system goals. The early stages of the workforce plan were discussed, emphasizing alignment with the NHS workforce plan and the importance of Equality, Diversity And Inclusion (EDI). Additionally, the ongoing efforts related to Black History Month and the Sexual Health Charter were noted.
- The launch of the staff survey which focused on addressing areas that were highlighted from the previous year.
- The success of the genomic laboratory hub extension.
- The approval of the Elective Care Centre which was scheduled to open in January 2025. Maria thanked Glyn Howells and all the teams involved for their hard work.

In addition, Maria recognised the concerns raised re cyber security in light of recent events with Newcastle's cyber security problem. Neil Darvill, Joint Chief Digital Information Officer, provided reassurance regarding the proactive measures and ongoing updates that the Trust had in place to safeguard against potential threats. Neil also discussed the successful implementation of the new digital maternity system and recognised that the system was a landmark achievement in integrated digital programs.

Kelvin Blake, Non-Executive Director, welcomed the work on the Elective Care Centre but raised concerns re the challenges ahead, particularly in staffing and seamless integration into hospital operations. Steve Curry, Chief Operating Officer, recognised the challenges and the need for a structured approach. Glyn Howells, Chief Finance Officer, advised that a dedicated program management team was being considered.

Sarah Purdy, Non-Executive Director, raised concerns re cancer operations being cancelled due to the industrial action. Steve Curry provided reassurance regarding improved management and efforts to avoid booking procedures during strike periods.

RESOL ED that the Chief Executive's briefing was noted.

Paul Cresswell, Emily Ayling, Jayne Masters, Charly Moran, Eleanor Guiney, and Jon Lee joined the meeting.

TB/23/09/07 Patient Story

Steve Hams, Chief Nursing Officer, introduced the Patient's Story and welcomed Paul Cresswell, Director of Quality Governance, Emily Ayling, Head of Patient Experience,Jayne Masters, Lead Cancer Allied Health Professional, Charly Moran, Neuro-Oncology Physiotherapist and Eleanor Guiney, Neuro-Oncology Speech And Language Therapist to the meeting.

The Patient Story focused on the neuro-oncology prehabilitation service provided by specialist Allied Healthcare Professionals (AHPs) in cancer, and their positive impact on patient care. Patient stories from Carly and Connor were shared underscoring the significance of the services in improving patient outcomes and highlighting the importance of patient feedback. The challenges of securing recurrent funding and reducing variations in patient access, were discussed. It was noted that local evidence demonstrated a consistent reduction in length of stay for patients using the service with fewer post operative complications.

Jane Khawaja expressed disappointment re the absence of sustained funding and questioned if there was enough resource within the current funding to meet the patient's needs. Jayne Masters confirmed that they were able to meet the complex needs of patients with the current provisions. Jayne also outlined the system partnership working and the ability of the team to work dynamically to reduce appointment burden for patients.

Maria Kane recognised the value of the service and questioned the role of consultants. Tim Whittlestone, Chief Medical Officer, advised that it was the responsibility of the consultants to ensure that patients were aware of the risks and referred to the shared decision-making programme. However, it was noted that it can take a while for patients and relatives to fully understand treatment plans and to articulate their questions in the short time before surgery is scheduled and so the work of prehabilitation and the cancer AHP specialists was vitally important.

Sarah Purdy noted the importance of compassionate communication and committing to a patient-centric approach.

Shawn Smith, Non-Executive Director, noted the improved outcomes and questioned if the release of pressure on services could be demonstrated. Jayne Masters confirmed that length of stay savings could be demonstrated and that patients seen by the service were less likely to be readmitted. Shawn advised that that it would be beneficial to include the information in the business case to secure future funding.

Following a query from Kelvin Blake re the consistency of information, Jayne discussed the ongoing work to ensure consistency of information across professionals involved in patient care and to embed prehabilitation as a standard term in the cancer pathway.

Following a query from Maria Kane re funding, Jayne outlined the funding timeframes and acknowledged the need for a robust business case for continued funding. The plan to submit the business cases in the upcoming NMSK business planning round was noted.

RESOLVED that the Board welcomed the Patient Story and thanked the team for their work.

Jayne Masters, Charly Moran and Eleanor Guiney left the meeting.

TB/23/09/08 Complaints and PALS Deep Dive

Steve Hams presented the Complaints and Patient Advice and Liaison Service (PALS) Deep Dive which focused on the analysis of patient complaints (classified as clinical care and treatment) and summarised the analysis and areas for improvement.

The following key points were highlighted from the report:

- The challenge regarding collating the multiple levels of feedback and the complexity of describing complaints in multiple different ways for the various requirements from regulatory bodies.
- The ongoing plan to condense the complex descriptions to obtain more effective evidence from digital systems.
- A detailed analysis of the complaints data that identified clinical care and treatment as the highest areas of concern.
- Specific specialties driving high complaint rates were pinpointed, and subcategories of clinical care and treatment were examined.
- The proposed improvement areas and the themes of involving patients in decision-making, kindness, anticipating needs, and honesty about risks.
- The aim to align the work to the patient care experience strategy and achieve the outlined ambitions.

Steve Hams discussed the concerns about staff workload challenges impacting patient care and emphasized the need for clarity on expectations. Tim Whittlestone added that patient experience was an improvement project for the Trust and noted that the data collected would be used to drive improvement. Steve Hams advised that feedback was encouraged and that it would be monitored through the divisional performance reviews to keep services accountable.

Kelvin Blake welcomed the improvements to data collection and commented on the importance of culture and promoting good practice. Steve Hams agreed and suggested that this would be done through acknowledging achievements and sharing feedback.

Maria Kane suggested that an area of focus could be the extrapolation between the staff survey and patient feedback to see if there were any correlations. Maria also questioned what success looked like. Steve Hams explained that the key success areas included patient satisfaction that staff were consistently kind and improvements in supported decision-making.
The Board discussed how information was fed-back to staff across the organisation and were challenged by the Trust Chair to ensure that the data and information be permeated down to all staff members.

Following a query from Richard Gaunt, Non-Executive Director, re the data collection, Steve Hams outlined the next steps, which included:

- sub-analysis for more detailed reporting at board and divisional levels
- plans to streamline feedback channels to improve the efficiency of data collection and analysis.

Jane Khawaja noted the importance of being conscious of the format used to elicit feedback for vulnerable patients. Jane also recognised the recurring theme of communication challenges. Sarah Purdy commented that it would be helpful to review how patient experience was monitored through a quality lense.

Maria Kane noted the analysis of the data and raised concerns re the rising theme of 'notice of appointments'. Steve Curry explained the ongoing outpatient transformation work to involve patients in the booking process and improve accessibility of appointments.

The Trust Chair acknowledged the progress made in patient experience reporting and emphasized the importance of leadership recognition and celebration of both successes and areas for improvement. The Trust Chair also reiterated the need to cascade information to all staff.

RESOLVED the Board noted the Complaints and PALS Deep Dive.

Paul Cresswell, Emily Ayling and Jon Lee left the meeting.
{Break}
Sarah Margetts and Caroline Heartly joined the meeting.

TB/23/09/09 EDI Deep Dive & Action Plan

Jacqui Marshall, Chief People Officer, introduced the EDI Deep Dive & Action Plan and welcomed Sarah Margetts, Deputy Chief People Officer and Caroline Heartly, Associate Director of Culture, Leadership & Development to the meeting.

Sarah Margetts provided a summary of the Workforce Race Equality Standard (WRES), Workforce Disability Equality Standard (WDES) and Gender Pay Gap (GPG) data. Sarah advised that whilst progress had been made, the improvements continued to be small and slower than expected. Sarah outlined the areas of concern:

- Board representation
- Staff disparity at senior levels in the organisation
- Staff survey results that showed a disproportionate number of B.A.ME and disabled staff that were reporting discriminatory treatment, lack of equity and bullying and harassment.
- A pay gap in favour of men.

Darren Roach, Associate Non-Executive Director, raised inquiries regarding the distinctive measures being implemented. Jacqui underscored the importance of fostering diversity across all protected characteristics and highlighted that the proposed strategy focused on specific areas to effect substantial change. Additionally, Jacqui advised of the continuous efforts in recruitment, retention, and commitment to the community, to advance EDI.

Following discussion on the targeted improvements on the WDES data, Shawn Smith, Non-Executive Director, recommended that the negative data be highlighted to show areas requiring attention and remediation.
Jane Khawaja expressed disappointment regarding the lack of progress and highlighted the importance of being careful of the language and terminology used.

<u>EDI Plan</u>

Sarah and Caroline provided an overview and presented a series of slides on the EDI Plan. It was noted that the plan had been developed with staff networks and had been designed using the WRES, WDRES, GPG data to ensure the areas of focus were specific to the Trust. The key priorities included:

1. Ensuring EDI ownership & accountability
2. Eliminating discrimination, harassment, bullying & violence
3. Embedding diverse & fair recruitment
4. Closing the pay gap

The proposal to review the EDI governance structure was outlined and it was recommended that EDI be embedded into the People Committee and not sit as a separate entity.

Jane Khawaja recognised the importance EDI and agreed that the governance should be restructured to create more oversight and assurance through a People & EDI Committee. Kelvin Blake also welcomed the plan but acknowledged that further work and resource was required to embed EDI throughout the organisation. Steve Hams noted the importance of listening to colleagues, particularly those with protected characteristics, and incorporating their feedback into the plan. Jane Khawaja echoed Steve's comments and recognised the challenge of cultural change.

Maria Kane challenged the plan and questioned if further resource was required to make substantive changes before March 2024. Sarah explained that a detailed plan against the priorities would go to the next People Committee and that agreed that additional resourcing would help to deliver the action plan and embed EDI into the organisational culture. The Trust Chair agreed that tangible targets were required to focus on what would shift the dial to ensure that a difference was being made. The Trust Chair commented that leadership would play a big role in the operational process to drive change.

Following discussion, the Board agreed with the proposal for the People Committee to be restructured into the People & EDI Committee. It was acknowledged that the workplan and membership would be reviewed.

RESOLVED that the Board:

- **Noted the EDI Deep Dive & Action Plan and the EDI data returns.**
- **Agreed that the People Committee be restructured into the People & EDI Committee.**

Sarah Margetts and Caroline Heartly left the meeting.

TB/23/09/10 Quality Committee Upward Report

Sarah Purdy, Non-Executive Director and Committee Chair, presented the Quality Committee Upward Report and highlighted the quality of safeguarding discussion and the reassurance that all peri-natal deaths were reviewed using a standard framework.

RESOLVED that the Board noted the Quality Committee Upward Report.

TB/23/09/11 Safeguarding Annual Report 2022-23

Steve Hams, Chief Nursing Officer, presented the Safeguarding Annual Report 2022-23 and outlined the key improvements detailed within the report including:

- the significant improvements to the training compliance,
- the volume of activity
- the system-wide support and working.

RESOLVED that the Board welcomed the Safeguarding Annual Report 2022-23 and noted its contents.

TB/23/09/12 Insight Visits Report

Xavier Bell presented the Insight Visits Report which provided an overview to the Trust Board on the visits that had taken place and the emerging themes from the feedback. Xavier advised that the feedback from the visits would be included within the information reviewed by the new quarterly Triangulation Group, alongside other sources of data.

RESOLVED that the Board noted the update and the findings of the recent Insight Visits.

TB/23/09/13 People Committee Upward Report

Kelvin Blake, Non-Executive Director and Committee Chair, presented the People Committee Upward Report and outlined the comprehensive discussion on risk and reassurance on the corresponding mitigations in place. Kelvin also presented the revised terms of reference for Trust Board to approve.

RESOLVED that the Board noted the People Committee Upward Report and approved the Terms of Reference.

TB/23/09/14 Integrated Performance Report

Steve Curry, Chief Information Officer, introduced the responsiveness section of the Integrated Performance Report (IPR) and presented a summary across four key domains of urgent and emergency care, elective care, diagnostics, and cancer performance.

Steve Curry outlined the significant challenges as a result of the industrial action (recognising that there had been a significant number of lost appointments) but noted that operational and clinical teams were deploying remedial actions to compensate for strike-related activity losses. Positively, Steve Curry advised that the Trust was on track to deliver the national year-end target for diagnostics ahead of schedule.

The Trust Chair praised the positive work but raised concerns re the ambulance handover numbers. Steve Curry recognised the concerns and advised of the ongoing work to revise and improve the handover processes.

<u>Safety and Effectiveness</u>
Steve Hams, Chief Nursing Officer and Tim Whittlestone, Chief Medical Officer, highlighted the following key areas:

- The increase in C-difficile cases and the ongoing targeted work to reduce the figures.
- The Falls improvement work which was being led by the Chief Allied Healthcare Professional.
- The increase in reported medication incidents and the plan to bring an assurance report to Quality Committee.
- The Trust had positively been revalidated as a VTE Exemplar Centre

Kelly Macfarlane provided feedback as the Maternity Safety Champion from the clinicians and raised concerns re the wait times and the community Wi-Fi issues. The Board discussed the challenges in depth and noted that they had been reviewed with the division through the monthly Divisional Performance Review (DPR). In regard to the community Wi-Fi issues, Neil Darvill explained the context and advised that connecting solutions had been deployed but there were complexities with where it was hosted. It was agreed that the Executive team would ask that the Maternity team undertake a review so that the issues could be escalated to the system if required.

Richard Gaunt provided feedback on his visit to Infection Prevention and Control (IPC) to discuss the MSSA cases and was assured that there were good processes in place to review cases and disseminate lessons learned to teams.

Research and Innovation
Tim Whittlestone praised the team for reaching 235% of target achieved for enrolling participants in studies and positively detailed that the Trust's research portfolio remained strong with 289 studies open to recruitment.

The Trust Chair challenged the visibility of the studies and suggested that it come to the Board as part of a Patient Story. Tim agreed and accepted the challenge. **TW**

Patient Experience
Steve Hams noted the complaint response compliance rate and the actions that were being taken by the divisions to continue improvements.

People
Jacqui Marshall advised of the vacancy challenges but provided reassurance that the Midwife staffing was an improving picture and that there were good incentive schemes in place. The ongoing work to digitise and streamline the recruitment process to reduce the time taken to recruit staff into the Trust was also discussed.

RESOLVED that the Board noted Integrated Performance Report approved the regulatory compliance statements.

{Break}

TB/23/09/15 Finance & Performance Committee Upward Report

Richard Gaunt, Non-Executive Director and Committee Chair, presented the Finance & Performance Committee Upward Report and highlighted the deep dives into the Cossham review, the theatre productivity report and the estates review.

Glyn Howells updated the Board on the Finance Report (Month 5) report and highlighted the following key areas:

- the Trust had delivered a £11.3m deficit, which was a £4.4m adverse position against a planned £6.9m deficit. The main driver was the impact of industrial action and the impact of temporary staffing.
- Cost Improvement Plan (CIP) position showed £10.0m schemes fully completed.
- The total capital spend year to date was £14.6m.
- The Cash position amounted to £65.9m which was an in-month decrease of £9.4m due to the in-year deficit and timing of payment runs. Richard Gaunt highlighted that Cash would be an issue next year.

Glyn also advised of the ongoing work to gain clarity from the national team re the baseline and rules for the elective recovery funding. Following a query from Shawn Smith re the CIP delivery, Glyn confirmed that it would be in-year delivery. The Board discussed the theatre start and finishing times and noted that the biggest opportunity to improve efficiency was the finishing time.

RESOLVED that the Board noted the Finance & Performance Committee Upward Report.

TB/23/09/16 Patient & Carer Committee Upward Report

Kevin Blake presented the Patient & Carer Committee Upward Report and highlighted powerful presentation on the health and inequalities work and the update on mental health performance. Steve Hams explained the context

behind the Project SMILE: Health Inequalities in Maternity work and highlighted the uncomfortable feedback and the additional work that was required.

The Trust Chair suggested that a future patient story be focused on health inequalities in Maternity. Steve Hams agreed to work with the Head of Patient Experience to action this.

RESOLVED that the Board noted the Patient & Carer Committee Upward Report and agreed that a future patient story be on health inequalities in Maternity. **SH**

TB/23/09/17 Any Other Business

The Trust Chair reminded Board members to complete their Oliver McGowan training.

Tim Whittlestone advised that a position has arisen in the Trust for the Chair of the Organ Donation Committee and welcomed Trust Board members to put in expressions of interest. Tim explained that there was national guidance on the role and detailed that it was a bi-annual Committee and that members didn't have to be clinical to apply for the role. Kelvin Blake advised on his previous experience in a similar role and encouraged the other Non-Executive Directors to apply.

No other business was raised.

TB/23/09/18 Questions from the public

No questions were received.

TB/23/09/19 Date of Next Meeting

The next Board meeting in public was scheduled to take place on Thursday 30 November 2023, at 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 14:40pm

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
28/9/23	Integrated Performance Report	TB/23/09/14	82	A patient story on a research study be scheduled for a future Board session to increase visibility of research studies. studies.	Tim Whittlestone, Chief Medical Officer	Mar-24	Yes	Open	Work is ongoing and the patient story is scheduled to come to the Trust Board meeting in March 2024.	23/11/2023
28/9/23	Patient & Carer Committee Upward Report	TB/23/09/16	83	A patient story on health inequalities in Maternity be brought to a future Trust Board meeting.	Steve Hams, Chief Nursing Officer	Jan-24	Yes	Open	Work is ongoing to align and schedule the patient story.	23/11/2023

Report To:	Public Trust Board			
Date of Meeting:	30 November 2023			
Report Title:	Chief Executive's Briefing			
Report Author:	Suzanne Priest, Executive Co-ordinator			
Report Sponsor:	Maria Kane, Chief Executive			
Confidentiality (tick where relevant) *:	**Patient identifiable information?**	**Staff identifiable information?**	**Commercially sensitive information?**	**Other exceptional circumstances**
*If any boxes above are ticked, paper may need to be received in *private.*				
Purpose of the report:	**Approval**	**Discussion**	**Information**	**Assurance**
			X	
Recommendations:	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.		
Implications for Trust Improvement Priorities: *(tick those that apply and elaborate in the report)*	**Our Aim: Outstanding Patient Experience**	
	High Quality Care – *Better by design*	
	Innovate to Improve – *Unlocking a better future*	
	Sustainability – *Making best use of limited resources*	
	People – *Proud to belong*	
	Commitment to our Community - *In and for our community*	
Link to BAF or Trust Level Risks:	No	
Does this paper require an Equality, Diversity and Inclusion Assessment (EIA)?	No	
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 during this month.

2. Background

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

3. Performance

The Trust continues to see a number of days of significant pressure this month linked to high demand.

The Trust continues to manage a significant number of patients with No Criteria to Reside (NC2R), with the current levels increased to around an average of 26%.

Cancer performance against the 62-day and faster diagnosis targets continues its improvement trend but has been significantly challenged due to past industrial action. The industrial action has also impacted the pace of elective recovery, but work is ongoing to reduce the backlog as quickly as possible.

4. Re-accreditation for Endoscopy Service

Our in-house endoscopy service has recently had their annual review for 2022 by the Joint Advisory Group (JAG) for GI Endoscopy carried out and have been re-accredited. Gaining the JAG standard requires a higher level of achievement against diagnostic targets, more detailed governance protocols and an improved performance than that of a non-accredited service. Achievement of JAG accreditation is seen as a gold standard in endoscopy.

5. Reducing Youth Violence Roundtable – Second meeting

I invited a wide-ranging group of our staff and external organisations to take part in the second roundtable discussion. This series is looking at how we can work with the local population and communities to help reduce youth violence. Clinicians, education and training staff, Bristol Health Partners, Integrated Care System and representatives of community organisations further discussed the ways in which in-reach and out-reach work could benefit our local communities in helping to reduce the likelihood of youth violence.

A range of ideas regarding some possible projects is being put together to help identify ways in which our organisation can support in delivering a prevention strategy and improve links with the community.

6. Engagement & Service Visits

I am continuing to spend time with as many services and teams across the hospital as I can, and I meet regularly with Clinical Consultant colleagues. This enables me to gain a better understanding of the challenges and opportunities faced in different specialties and services across the Trust. This month I have met with consultant colleagues from plastics.

In the last month I visited Pathology with one of our Non-Executive Directors and the Fresh Arts programme.

7. Summary and Recommendations

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

Report To:	Public Trust Board			
Date of Meeting:	30 November 2023			
Report Title:	Patient and Carer Story			
Report Author:	Emily Ayling, Head of Patient Experience			
Report Sponsor:	Steve Hams, Chief Nursing Officer			
Confidentiality (tick where relevant) *:	**Patient identifiable information?**	**Staff identifiable information?**	**Commercially sensitive information?**	**Other exceptional circumstances**
	X	X		
*If any boxes above are ticked, paper may need to be received in *private.*				
Purpose of the report:	**Approval**	**Discussion**	**Information**	**Assurance**
		X		
Recommendations:	The Board is requested to reflect on Esther's story of her maternity care and the alignment with recent initial feedback from the Care Quality Commission (CQC) following their maternity inspection in November.			
Report History:	The story has been shared with the Maternity team. It was previously shared at the Patient & Carer Experience Committee in September.			
Next Steps:	The story may also be used in community outreach.			

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Executive Summary

Esther's story is a positive account of person-centred, safe care in maternity. This story shows how the team prioritised Esther's safety at all stages of her pathway and involved her in decisions about her care. This is particularly important as we acknowledge the increased risk of maternal difficulties and the maternal death rate for black women.

Esther's story also reflects some wider cultural biases that can impact on mother's decision-making. It widens our understanding of what matters to some women in pregnancy/childbirth and how communication and shared decision-making can help ensure the safest outcome for mother and baby.

It is pleasing to note that the reflections within Esther's story are supported by initial feedback obtained verbally and in writing from the CQC following their on-site inspection and subsequent interviews and information review in November 2023. Specifically they commented that *"We saw many examples of positive work to address health inequalities, which we will feature within the report. Examples include work with Black Maternity Matters and proactive engagement with the local prison."* We anticipate receiving their draft report in early January 2024.

	Our Aim: Outstanding Patient Experience	/

Implications for Trust Improvement Priorities: *(tick those that apply and elaborate in the report)*	High Quality Care – *Better by design*	/
	Innovate to Improve – *Unlocking a better future*	
	Sustainability – *Making best use of limited resources*	
	People – *Proud to belong*	/
	Commitment to our Community - *In and for our community*	
Link to BAF or Trust Level Risks:	N/A	
Financial implications:	N/A	
Does this paper require an Equality, Diversity and Inclusion Assessment (EIA)?	No, the subject of the story to not likely to impact people from other groups.	
Appendices:	Esther's Story https://youtu.be/lNuOJSl66Ks	

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Report To:	North Bristol NHS Trust Public Board			
Date of Meeting:	30 November 2023			
Report Title:	Madeline (Maddy) Lawrence Inquest Actions Update			
Report Author:	Tim Whittlestone, Chief Medical Officer			
Report Sponsor:	Quality Committee & Tim Whittlestone, Chief Medical Officer			
Confidentiality (tick where relevant) *:	**Patient identifiable information?**	**Staff identifiable information?**	**Commercially sensitive information?**	**Other exceptional circumstances**
	Yes but in the public domain	**No**	**No**	**No**
*If any boxes above are ticked, paper may need to be received in *private.*				
Purpose of the report:	**Approval**	**Discussion**	**Information**	**Assurance**
			X	**X**
Recommendations:	NBT Trust Board is asked to note the progress that has been made in our response to the recognition and management of patients whose condition deteriorates whilst they reside as inpatients in our hospitals.			
Report History:	Shared with Executive Management Team 22nd November 2023 and Chair, Quality Committee 20th November 2023			
Next Steps:	Board approval of actions Quality Committee ongoing oversight of action delivery			

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Executive Summary

Our Trust response to the investigation which followed the tragic death of Maddy Lawrence has been extensive and multifaceted. We made recommendations within the original related Patient Safety Investigation and then further significant commitments in advance of the Coroners Inquests and continue to evolve these into deliverable actions.

Our principal aim is to ensure that our patients can be treated in a safe environment where physiological deterioration is both recognised and responded to appropriately. We are now part way through implementation of our plans.

The timescale is balanced between the urgency of our intent and the complexities and practicalities of the measures required for improvement.

This paper seeks to provide assurance to the NBT Board that we remain 'on track' to deliver our response. It references the commitments made in advance of the Coroner's Inquest and outlines the follow up, detailed work to ensure that systems and processes are in place to provide safe and effective care for patients whose condition deteriorates whilst with us.

Oversight of the implementation of these commitments will be provided by the Quality Committee on behalf of the Trust Board.

Implications for Trust Improvement Priorities: *(tick those that apply and elaborate in the report)*	**Our Aim: Outstanding Patient Experience**	
	High Quality Care – *Better by design*	x
	Innovate to Improve – *Unlocking a better future*	
	Sustainability – *Making best use of limited resources*	
	People – *Proud to belong*	
	Commitment to our Community - *In and for our community*	
Link to BAF or Trust Level Risks:	Datix ID 1762 – Risk Score – 12 Risk of delays recognising deterioration of patients condition due to instability of Careflow Vitals digital system.	
Financial implications:	A business case for the delivery of a RAPID response team which incorporates NBT's Hospital @ Night team, augmented to provide 24 Hour care with the addition of a Critical Care Outreach Service has been developed and will be presented to NBT Private Board in December 2023	
Does this paper require an Equality, Diversity and Inclusion Assessment (EIA)?	*No*	
Appendices:	A – Deteriorating Patient Overarching Action Plan	

1. Purpose

1.1 This paper serves to inform and update the NBT Board with regards to the actions that this Trust is undertaking to improve both the recognition of and response to patients whose condition deteriorates whilst they remain patients in our hospitals.

1.2 This paper seeks to give assurance to NBT Board that we have delivered a number of actions that were agreed ahead of the Inquest into the death of Maddy Lawrence earlier this year and further, that residual actions have made progress with deliverable timelines.

1.3 Actions that address specific recommendations by the Coroner made to the Care Quality Commission in a Regulation 28 (Prevention of Future Deaths Report) are also summarised.

2. Background

2.1 Through the findings identified in the Maddy Lawrence patient safety action plan, and other subsequent (unrelated to Maddy Lawrence) learning identified, the Trust considered that deteriorating patients should be more of a focus and this was set as a new Trust level priority as part of the Trust's Patient First Strategy. Consequently, a Deteriorating Patient Working Group was established in February 2023, with five key areas of focus:- knowledge and training, recognition and deterioration, escalation of deterioration and response, delegation of tasks and investigation response. From February to August 2023, the group undertook baseline work, to include gathering information from audits, reviewing policies and guidelines and dashboard data to inform any ongoing work in the five key areas of

focus identified. This baseline information gathering assisted in formulating the actions agreed ahead of the Inquest.

2.2 The Trust's own investigation into the death of Maddy Lawrence and HM Coroner's subsequent inquest into the death of Maddy Lawrence highlighted areas in which improvement was required in the ability of NBT to comprehensively respond to inpatients with physiological deterioration.

2.3 Both investigative processes (internal and external) identified that the introduction of National Early Warning Scores (NEWS) and electronic recording of NEWS scores had not been fully embedded at NBT despite a policy being in place and training and education on NEWS/NEWS2 being part of the fundamental core competencies of training for registered nurses. There was also mandatory training on NEWS2 for new doctors joining the Trust.

2.3.1 HM Coroner's conclusion included a factual finding that (Extracted verbatim from the Regulation 28 report) - '*Observations were not performed for several hours and when undertaken confirmed her NEWS score of 4. The frequency of the observations was not increased and the provisions of NEWS toolkit and the SEPSIS6 protocol were not followed. The NEWS score later increased to 5 and again observations were not carried in a timely manner and prompt treatment for presumed sepsis was not initiated*.'

2.4 HM Coroner has issued a Regulation 28 report directed towards the CQC, on the basis of the CQC's role as a regulator, to ensure the deficiencies in Ms Lawrence's care have been addressed as per the Trust's evidence in the inquest. Specifically, the Coroner has suggested that "*The CQC should confirm that it is now satisfied that the Trust has addressed the training of current staff and has in place appropriate measures to ensure ongoing training for new staff*."

2.4.1 For the purpose of this paper, our approach to Trust wide training is a 3-step plan where the first step is to refresh the key policies that underpin the recognition and management of deterioration (NEWS, Acute Kidney Injury and Sepsis); our second step is to produce an overarching training animation that signposts all staff to our key policies; our third step is to monitor compliance of training against agreed thresholds for all clinical staff.

2.4.2 The actions promised by NBT to HM Coroner prior to the inquest, reiterated above in overall terms, are being tracked individually as set out in **Appendix A**. This reflects the progress status at 18 October 2023. A detailed set of more granular project tasks and deliverables is set beneath the headline actions and is supported as part of the Deteriorating Patient Group programme.

2.4.3 The Quality Committee reviewed the Trust's initial plans at its meeting on 10 October and supported the areas of improvement and progress at that stage. It also requested assurance reports directly to the Quality Committee from the Deteriorating Patient Group to track ongoing progress, on behalf of the Trust Board.

3. Our Recording of NEWS

3.1 The Chief Nursing Officer (CNO) and his team have introduced new metrics that allow us to monitor the timely recording of NEWS into our electronic recording system. The scrutiny of such recording has been on individual patient level, ward level, speciality level and Divisional Level.

3.2 The recording of NEWS has been discussed in Divisional Review Meetings, speciality team meetings and Ward Manager meetings.

3.3 Based on regular compliance audits, the recording of NEWS has improved significantly in every clinical Division, however further improvement is being driven forwards to continue the improvement seen to date.

3.3.1 In NMSK 'observations on time' metric 78.2% in October 2023 (cf 53 % in April 2023).

3.3.2 In ASCR 'observations on time' metric 73.4% in October 2023 (cf 58% in April 2023).

3.3.3 In Medicine 'observations of time' metric 85% in October 2023 (cf 77% in April 2023).

4. Policies that Underpin the response to Physiological Deterioration

4.1 The Chief Medical Officer (CMO) and his team, working in conjunction with the Chief Nursing Officer's team have re-written and updated 3 key policies that underpin our response to deterioration – Sepsis, Acute Kidney Injury and NEWS.

4.2 All 3 policies have now been completed and approved and are in use their use will continue to be audited.

4.3 These 3 policies will form the basis of a new wrap-around mandatory training package for clinical staff, supported by a bespoke video accessed by our training portal.

4.4 All policies are accessed by new and existing staff using 'LINK' an electronic portal and depository of trust-wide policies. The training referenced above aims to spotlight the tragic case of Maddy Lawrence and signpost staff to NBT's key policies that underpin patient deterioration.

4.5 The training video will be launched on the LEARN platform and using other staff communication media in December 2023 with compliance checked against completion of watching the video on the LEARN platform.

4.6 The Trust will consider a minimum exposure compliance of 90% for all clinical staff groups.

4.7 Compliance will be monitored through a Deteriorating Patient Improvement Group which will report progress to Quality Committee at every meeting.

5. The Development of a Rapid Response Team to augment ward care

5.1 A clinical lead for Deteriorating Patients has been appointed.

5.2 A business case for the delivery of a RAPID response team which incorporates NBT's Hospital @ Night team, augmented to provide 24 Hour care with the addition of a Critical Care Outreach Service has been developed.

5.3 The RAPID team will provide additional 'air traffic control' monitoring of compliance against observations on time, advice and guidance for ward staff, additional resource for ward staff, appropriate bedside intervention as appropriate and escalation to intensive care advice and admission.

5.4 The RAPID team will, in addition, provide 24-hour contact for patients and relatives of patients who have ongoing concerns about care and, in so doing, allow us to embrace the recommendations encompassed in 'Martha's Law' planned legislation.

6. Summary and Recommendations

6.1 The Trust Board is asked to **note**: That work continues at pace to deliver a safer hospital which recognises and responds to patients who deteriorate whilst in the care of North Bristol NHS Trust.

6.2 Our immediate actions to improve safety have focussed on the work of the Office of the CNO to ensure that observations are made on time and progress has been demonstrated.

6.3 We are committed to training our staff and have progressed to a training animation that reinforces the vital importance of NEWS, Acute Kidney Injury and Sepsis policies.

6.4 A detailed Business Case, sponsored by the CMO, to introduce a Rapid Response team was being developed. It is intended that the introduction of an additional layer of monitoring and response plus the commitment to embrace Martha's Law, will ensure that NBT can aspire to be one of the safest acute hospitals in England.

6.5 The Quality Committee, on behalf of the Trust Board, will receive ongoing assurance updates from the Deteriorating Patient Group to track delivery of actions until satisfied that this is no longer required.

6.6 The Trust continues to liaise with the CQC regarding its approach to the learning and actions arising from this serious incident and inquest and will support the CQC's ability to respond to the Regulation 28 report, as required.

Deteriorating Patient Action Plan v18.10.23

Theme	Action	Associated Coroner Letter ref.	Lead	Deadline	RAG	Narrative @ 17/10/23
					Blue: Complete; Amber: Progress on track but issues may impact de very; Green: Progress on track; Red: Progress off track requires correct ve act on	
Clinical Policies or Guidelines	**NEWS 2 and Deteriorating Patient** - to be updated and approved and made accessible to staff.	N/A - not explicitly referenced.	SS	23/10/2023	Green	Approved at CPDG 17/10/23: Rewritten policy on NEWS2 and Deteriorating Patient (updated and in line with National guidance, with clear sections on triggers, times, escalation and response)
Clinical Policies or Guidelines	**Sepsis** - to be updated and approved and made accessible to staff.	N/A - not explicitly referenced.	SS	23/10/2023	Green	Approved at CPDG 17/10/23: 1. New policy on Sepsis (in keeping with NICE guidance, rather than AoMRC; with succinct sections for trigger and response) 2. New paper pro forma for Sepsis Trigger and Sepsis 6 (should sit within Sepsis policy and be available as paper-downtime for Vitals' automatic screening as well as handy documentation sheet for clinical review).
Clinical Policies or Guidelines	**Acute Kidney Injury Pathway** - to be updated and approved and made accessible to staff.	14	SS	Implemented	Blue	
Patient Safety Governance	**Accuracy & completion of Vitals data** - *publish a reporting dashboard & implement associated framework to review and act on the information, covering;* 1. **Accuracy** of completion (enforced within the system calculations). 2. **Full set** of observations undertaken (completeness per patient %) 3. **Observations completed on time** (compliance %)	10 & 11	JH	31/10/2023	Green	CNIO discussions held and metrics clarified and agreed for current and future development. All metrics visible and under review. Next step is to formalise the review framework and ensure this is devolved within clinical divisions effectively.
Patient Safety Governance	**Effective recognition & escalation** - *publish reporting dashboard & assurance review framework:* 1. Report against national CQUIN measure (manual quarterly audit) within DP Group		PC	31/10/2023	Green	
Patient Safety Governance	**Effective recognition & escalation** - define and develop future indicators, linked to Acute Response Team establishment, for example: 1. Reporting of NEWS triggers >5 and >7 (currently being scoped) 2. Recording of appropriate management of pre-response escalation - electronic pro forma. 3. Review of appropriate clinical response		JH	31/03/2024	Green	Work commencing to consider the clinical response to specific NEWS clinical thresholds for deteriorating patients. This will continue and feed into the clinical model as it develops.
Patient Safety Governance	Review pilot of Vitals Ward Application and agree rollout plan that will be tracked within the Deteriorating Patient Continuous Improvement Group	13	JH	30/11/2023	Green	
Patient Safety Governance	Review stated actions within Coroner's Letter and agree programme ownership, workstreams and leadership responsibilities.	N/A - not explicitly referenced.	JH	Implemented	Blue	
Patient Safety Governance	Agree the specific tasks, deliverables, responsibilities and timescales with each project lead.	N/A - not explicitly referenced.	JH	31/10/2023	Green	
Patient Safety Governance	Agree the governance in relation to the Deteriorating Patient Programme to provide assurance to the Board on delivery of agreed actions and deliverables.	N/A - not explicitly referenced.	TW	31/10/2023	Green	First assurance report provided to Quality Committee on 10/10/23.
Patient Safety Governance	Establish KPIs for all project workstreams and future trajectories to deliver intended improvement and related programme dashboard (e.g. SPC charts).	N/A - not explicitly referenced.	JH	31/12/2023	Green	Initial discussions undertaken to agree Programme support with Director of Improvement.
Knowledge & Training	Lessons Learned from the case shared across the senior nursing leadership structures	N/A - not explicitly referenced.	JH/DD	Implemented	Blue	Sessions completed with DDoNs & Deputies, Matrons, Ward Managers, Specialist Nurses, AHPs
Knowledge & Training	Maddy's Training package will be developed on LEARN to provide relevant training for clinical facing staff, including bank staff. This will include Learning Objectives around deteriorating patient, sepsis, AKI and NEWS2. It will be based on NBT's policies, as updated above.	1, 4, 5, 6	DD	31/12/2023	Green	Currently on track to deliver. Task Group meeting weekly to drive delivery and content.
Knowledge & Training	335 newly created Senior Healthcare Support Workers will receive in person additional training in physiological measurement (observations) and caring for the deteriorating patient (mandatory).	2	DD	30/04/2024	Green	Current position = 70%. Forward plan to deliver 100% by agreed deadline in line with team capacity.
Knowledge & Training	All new healthcare support workers now receive in person training in physiological measurement (observations) and caring for the deteriorating patient (mandatory).	3	DD	Implemented	Blue	New HCA induction includes this training, newly introduced.
Knowledge & Training	All internationally educated nurses and medical graduates receive additional support and training in recognising deterioration, escalation and caring for the deteriorating patient during their 'OSCE Test of Competence' preparation for registration with the Nursing and midwifery Council (mandatory)	7	DD	Implemented	Blue	
Knowledge & Training	All new doctors now attend a workshop delivered by the Hospital @ Night team, which covers NEWS2, sepsis and escalation (mandatory).	8	SS	Implemented	Blue	
Knowledge & Training	All Foundation Year 1 doctors in training have training on the recognition and management of the deteriorating patient (mandatory).	9	SS	Implemented	Blue	
Knowledge & Training	We will develop a bespoke training programme for registered nurses and registered nursing associates to ensure they fully understand their professional and regulatory responsibilities when delegating tasks to junior or un-registered staff. This training will be mandatory	19	DD	31/12/2023	Green	This will be incorporated into Maddy's training to ensure it is specifically addressed.
Acute Response Team	Recruit to sepsis specialist nurse role to support the Acute Response Team.	12	JH	31/01/2024	Green	Job Description completed, recruitment to commence in November, within overall business case funding envelope for the Acute Response Team
Acute Response Team	Appoint clinical lead for Deteriorating Patients improvement work (2PAs for 3 years)	N/A - not explicitly referenced.	SS	30/11/2023	Green	EOI issued on 18/10/23.
Acute Response Team	Develop and approve business case to implement the Acute Response Team and the associated critical care outreach service, with clear boundaries and interfaces to support excellent clinical care.	15	SS	15/11/2023	Green	Support being provided to draft business case (EK), first draft to be ready by agreed deadline.
Acute Response Team	Agree and implement the service model for acute response and critical care outreach.	16	SS	31/03/2024	Green	Successful discussions held with Critical Care, Hosital@Night leads. Broad principles agreed, service model being developed.
Acute Response Team	We will establish the 'call for concern' initiative as a core component of the Acute Response Team to ensure we can support families independently of the ward team.	17	SS	30/06/2024	Green	Phase 1 of the Acute Response service will focus on implementing the core team roles, responsibilities dn interaction across the Trust, to incorporate the future requirements for Call for Concern. Phase 2 will
Acute Response Team	We have piloted the use of notifications between CareFlow Vitals e-observations and the CareFlow handover and messaging application called Connect, this functionality will be used to support the timely escalation of deteriorating patients to the acute response team when it is established.	18	SS	31/03/2024	Green	Pilot completed, this will be incorporated into the service model for Acute Response Team first phase.

Deteriorating Patient Action Plan v18.10.23

No.	Coroner's Letter Heading	Action
1	Knowledge & Training	All ward based registered nurses, registered nursing associates and healthcare support workers will undertake the online NEWS2 training (mandatory).
2	Knowledge & Training	335 newly created Senior Healthcare Support Workers will receive in person additional training in physiological measurement (observations) and caring for the deteriorating patient (mandatory).
3	Knowledge & Training	All new healthcare support workers will receive in person training in physiological measurement (observations) and caring for the deteriorating patient (mandatory).
4	Knowledge & Training	All ward based registered nurses and registered nursing associates will undertake the online deteriorating patient, recognition, and management training (mandatory)
5	Knowledge & Training	All ward based registered nurses and registered nursing associates will undertake the online assessment and differential diagnosis of sepsis training (mandatory).
6	Knowledge & Training	We will develop an online acute kidney injury training package and ensure all ward based team medical, registered nurses and registered nursing associates complete it
7	Knowledge & Training	All internationally educated nurses and medical graduates will receive additional support and training in recognising deterioration, escalation and caring for the deteriorating patient during their 'Test of Competence' preparation for registration with the Nursing and midwifery Council (mandatory)
8	Knowledge & Training	All new doctors attend a workshop delivered by the Hospital @ Night team, which covers NEWS2, sepsis and escalation (mandatory).
9	Knowledge & Training	All Foundation Year 1 doctors in training currently have training on the recognition and management of the deteriorating patient (mandatory).
10	Recognition of Deterioration	Completeness of physiological monitoring (observations) will become a key measure reviewed each month by the executive team, and the divisional leadership team held to account for improvement. In addition, the Integrated Performance Report will include these measures, so that there can be Board scrutiny. This will ensure continued focus on timely observations and corrective actions taken.
11	Recognition of Deterioration	We will undertake an annual audit of compliance with our NEWS2 policy, this will include management of sepsis and fluid balance charts for eligible patients. The results of these audits will be reviewed by the Patient Safety Committee.
12	Recognition of Deterioration	We will establish a sepsis specialist nurse role to support our improvement work and develop a robust clinical management response to sepsis.
13	Recognition of Deterioration	We will pilot the use of the Vitals Ward application which provides a live dashboard view of NEWS2 scores, pain scores, and observations which are due and overdue, so that these are continuously available for the nurse in charge of the ward to monitor and respond to deterioration or delays
14	Recognition of Deterioration	Our Acute Kidney Injury guidelines have been updated, the 'care bundle' approach has been used and is being digitised so that clinical records can be contemporaneous and used to guide care and treatment.
15	Escalation of deterioration and response	We will commit to establishing an acute response team (sometimes known as 'outreach') to deliver a consistent response to a deteriorating patient (this will extend the current night-time and weekend service to 24 hours per day and seven days per week).
16	Escalation of deterioration and response	Once fully established the acute response team will proactively search for patients with a high NEWS2 and developing acute kidney injury using existing digital systems. This proactive approach will spot deterioration earlier.
17	Escalation of deterioration and response	We will establish the 'call for concern' initiative which will support families to raise concerns independently of the ward team.
18	Escalation of deterioration and response	We have piloted the use of notifications between CareFlow Vitals e-observations and the CareFlow handover and messaging application called Connect, this functionality will be used to support the timely escalation of deteriorating patients to the acute response team when it is established.
19	Delegation of tasks	We will develop a bespoke training programme for registered nurses and registered nursing associates to ensure they fully understand their professional and regulatory responsibilities when delegating tasks to junior or un-registered staff. This training will be mandatory
20	Investigation Response	All Patient Safety Incident Investigations (PSII's) will refer to the patient by their name, to serve as reminder that even in death we maintain compassion and dignity. To not do so is insensitive and unkind.
21	Investigation Response	Where it is clear through our investigation process that there are failings in care and/or deviations from accepted local or national guidelines, we must apologies for these failings immediately. We must fulfil our statutory requirement of the Duty of Candour.
22	Investigation Response	We will undertake a systemic programme of patient safety culture across the trust using a Safety Culture Discussion Cards approach adapted by NHS Education for Scotland. The aim is to work with teams to describe their values, behaviours and beliefs and identify strengths or areas for improvement, along with actions that the team own.
23	Investigation Response	Patient Safety Partners are a key component of implementing the NHS Patient Safety Strategy and representing the role that patients/families play in learning from safety events. We are recruiting additional partners who will sit as part of our Divisional Governance and ensure that a partner is part of every Patient Safety Investigation to ensure the voice of patients and families is being represented and responded to as part of safety processes.

Report To:	Public Trust Board			
Date of Meeting:	30 November 2023			
Report Title:	Quality Committee Upward Report			
Report Author:	Aimee Jordan, Senior Corporate Governance Officer & Policy Manager			
Report Sponsor:	Sarah Purdy, Non-Executive Director and Chair of QC			
Confidentiality (tick where relevant) *:	**Patient identifiable information?**	**Staff identifiable information?**	**Commercially sensitive information?**	**Other exceptional circumstances**
*If any boxes above are ticked, paper may need to be received in *private.*				
Purpose of the report:	**Approval**	**Discussion**	**Information**	**Assurance**
				X
Recommendations:	That the Trust Board receive the report for assurance and note the activities Quality Committee has undertaken on behalf of the Board.			
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 January 2024.			

Executive Summary		
The report provides a summary of the assurances received and items discussed and debated at the Quality Committee (QC) meeting held on 14 November 2023.		
Implications for Trust Improvement Priorities: *(tick those that apply and elaborate in the report)*	**Our Aim: Outstanding Patient Experience**	
	High Quality Care – *Better by design*	✓
	Innovate to Improve – *Unlocking a better future*	
	Sustainability – *Making best use of limited resources*	
	People – *Proud to belong*	
	Commitment to our Community - *In and for our community*	
Link to BAF or Trust Level Risks:	Link to BAF risks: • Patient Flow and Ambulance Handovers • Long Waits for Treatment	
Financial implications:	No financial implications identified in the report.	
Does this paper require an EIA?	No as this is not a strategy or policy or change proposal	
Appendices:	Appendix 1: Tissue Viability Annual Report 22/23 Appendix 2: Organ Donation Annual Report 22/23	

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1. Purpose

1.1 To provide a highlight of the key assurances received, items discussed, and items for the attention of the Trust Board from the Quality Committee (QC) meeting held on 14 November 2023.

2. Background

2.1 The QC is a sub-committee of the Trust Board. It meets monthly with alternating deep-dive meetings 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.

3. Meeting on 14 November 2023

3.1 NBT Summarised Hospital-level Mortality Indicator (SHMI) Review

The Committee received the NBT Summarised Hospital-level Mortality Indicator (SHMI) Review report which covered:

- The basis of SHMI, how it works and what it measured
- Its purpose, areas of use and limitations
- The key drivers of the increasing trend line (as requested by the Trust Board)
- The hypotheses as to the drivers of those changes in data points
- The planned further mortality work

The Committee received assurance that NBT's SHMI position remained favourable compared to peers but recognised that there were some internally flagged SHMI alerts that require further consideration, including:

- Acute Cerebrovascular Disease (Stroke)
- Intracranial Injury
- Allergic reactions, aftercare & screening, R codes

The Committee noted that a Mortality Improvement programme would be initiated upon commencement of a Programme Lead in December 2023. Discussion focused on how cases were coded and the governance process that was undertaken.

The Committee welcomed the further exploration which would be undertaken at the upcoming Board education seminar scheduled for December 2023.

3.2 Maternity

The Committee were joined by the Head of Midwifery for the discussion on the Maternity items.

3.2.1 PQSM Quarter 2 report (including PMRT Q2 report and ATAIN Q2 report)

The Perinatal Quality Surveillance Matrix (PQSM) report was presented which detailed the perinatal safety intelligence.

The Committee received assurance that the Perinatal Mortality Review (PMRT) was fully complaint with the Maternity Incentive Scheme (MIS) requirements and that the Avoiding Term Admissions Into Neonatal Units (ATAIN) remained below the national target of 5%.

3.2.2 Ultrasound Scanning Capacity

The Committee received assurance that the Trust was compliant with offering ultrasound scans within the 24 hour requirements of the Saving Babies Lives criteria.

3.3 Infection Prevention & Control Annual Report

The Committee received the Infection Prevention & Control Annual Report which summarised the work undertaken at the Trust during the period 1 April 2022 to 31 March 2023. The annual report will be separately presented to the Trust Board in line with guidance from the National Quality Board

The Committee received assurance that the Trust maintains a 'zero tolerance' of Healthcare Acquired Infection (HCAI), and that post-infection reviews are undertaken, and Trust-wide learning occurs where cases are reported. The Committee recognised the work of all staff, including nurses, domestic teams and estates and facilities teams, to ensure IPC safety across the Trust.

The Committee received reassurance that work was ongoing to improve training compliance and that it was set at 95% to ensure adherence to standards. The Committee also discussed the supplier quality audit process.

The Committee thanked Dr Elizabeth Darley, who stood down from her role as infection control doctor after 20 years of service, for all her work in supporting infection prevention and control for the Trust.

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 2022-2023.

The Committee welcomed the report, which provided a great deal of assurance and showed the positive progress to reduce pressure injuries despite not achieving a reduction in the agreed Key Performance Indicators (KPI) level.

The Committee were reassured to see the commitment of the team through their understanding of the patients and thanked them for all their hard work.

3.5 C. Difficile Annual Report

The Committee were joined by the Consultant Lead for Mandatory Surveillance Organisms who presented the Clostridioides Difficile (C. Difficile) annual update which included the C. difficile position for 2022/23 and the trajectory for 2023/24.

The Committee received assurance on the key interventions and the ongoing work and actions taken to successfully decrease the infection rate.

3.6 Organ & Transplant Annual Report

The Committee received the annual report covering NBT's organ donation activities for 2022/23 and received assurance regarding the ongoing effective delivery of the services.

The Committee commended the successes of the team and recognised the positive impact on patients. The Committee also noted the work from Simon Wood to chair the Organ Donation Committee.

3.7 CQUINs – 2022-23 and 2023-24 – Improving Quality

The Committee received a report on the delivery of the Commissioning for Quality and Innovation (CQUIN) schemes which supports improvements in the quality of services and the creation of new, improved patterns of care. The report detailed the approach, performance and quality benefits of the schemes.

The Committee welcomed the update and members were invited to join the Quarterly Executive Review Groups meetings.

3.8 CQC Assurance

The Committee received a verbal update from the Director of Quality Governance on the recent Maternity CQC Inspection on the safe and well-led domains. It was noted that overall the feedback was positive and there were no immediate safety concerns. The full report was expected to be received after Christmas.

3.9 Risk Report (Quality and Patient Safety) and relevant BAF Risks

The Committee received Trust Level Risks (TLRs) across its areas of responsibility, including patient safety and patient experience risks, and the Board Assurance Framework (BAF) risks across the Committee's areas of responsibility.

The Committee noted that the BAF had recently been reviewed through the Audit and Risk Committee and received assurance that the recently discussed NHS digital risk had been added to the risk register (Datix 1800). The Committee was pleased to note that there had been positive progress for Datix risk 1644 re the service for Neuropsychopharmacology patients and that the risk would be reduced.

3.10 **Other items:**

The Committee also received the following items for information:

- Sub-committee upward report(s):
  - Drugs & Therapeutics Committee - The Committee raised concerns re the lack of progress and noted that need to refresh and restructure the Committee to reflect modern practices was being considered. The Committee also discussed the challenges regarding electronic prescribing and the need for the Executive team to have greater visibility on this area.
  - Safeguarding Committee
  - Patient Safety & Clinical Risk Committee (including the Q2 Patient Safety Quarterly Report)
- Quality Committee forward work-plan 2023/24

4. Identification of new risks & items for escalation

4.1 None.

5. Summary and Recommendations

5.1 The Trust Board is asked to receive the report for assurance and note the activities Quality Committee has undertaken on behalf of the Board.

Tissue Viability Annual Report 2022/23

Professor Steve Hams
Chief Nursing Officer

Contents

1.0 Executive summary

This is the annual report of the North Bristol NHS Trust (NBT) Tissue Viability Service (TVS) and summarises the work undertaken at the Trust to prevent and manage pressure ulcers during the period 1 April 2022 to 31 March 2023.

In the period 2022/23 the prevalence of grade 2 pressure ulcers remained static at NBT. There was an increase in the number of grade 3 and grade 4 pressure ulcers.

In 2022/23 there were:

- 197 grade 2 pressure ulcers reported and validated by the TVS, which 26 were related to medical devices.
- 8 grade 3 pressure ulcers reported and validated by TVS.
- 4 grade 4 pressure ulcers reported and validated by TVS.

The Trust continues to audit key performance indicators for pressure ulcer prevention on a weekly and monthly basis.

The TVS continues to work in collaboration with the ICB in strategic partnership, the multi-disciplined team and safeguarding to the protect and safeguard vulnerable patients from experiencing harm.

TVS will lead on strategies in 2023/24 to achieve a reduction in pressure ulcer prevalence at NBT.

Prepared by: Kim Whitlock, Tissue Viability Matron

Tissue Viability Annual Report 2022/23

2.0. Introduction

The prevention of pressure ulcers remains an NBT priority and continues as one of the Trusts Patient Safety Priorities for 2023 / 2023. The TVS continues to develop to provide wound management for complex wounds.

3.0. Tissue Viability Service

The Tissue Viability Service (TVS) is part of North Bristol NHS Trust (NBT). This annual report highlights the initiatives undertaken by the service, the training and education provided and impact of the service on improving the standard of tissue viability care at NBT during 2021/22.

The Tissue Viability team provide an inpatient service at NBT Monday to Friday leading the implementation, engagement, training, and support in the prevention and management of pressure ulcers and complex wound management.

The Tissue Viability Team currently consists of a WTE Tissue Viability matron, 0.8 band 7 Tissue Viability Clinical Nurse Specialist, 2.0 WTE band 6 Tissue Viability Nurse and 1.0 seconded Tissue Viability Nurse.

The Tissue Viability Nurses are a daily visible presence on the wards and departments. There is an active group of Tissue Viability Link Ambassadors (TVLA) across all wards and departments.

The clinical referrals consist of the following categories:
- Pressure ulcers
- Surgical wounds and infected wounds
- Complex leg ulcers, managed alongside Vascular
- Incontinence associated dermatitis (IAD) and Moisture Associated Skin Damage (MASD)
- Severe cellulitis
- Neonatal wounds
- Trauma wounds
- Wounds requiring Negative Wound Pressure Therapy (NWPT)
- Wounds requiring complex debridement such as Tissue Viability Nurse Specialist led larval therapy.

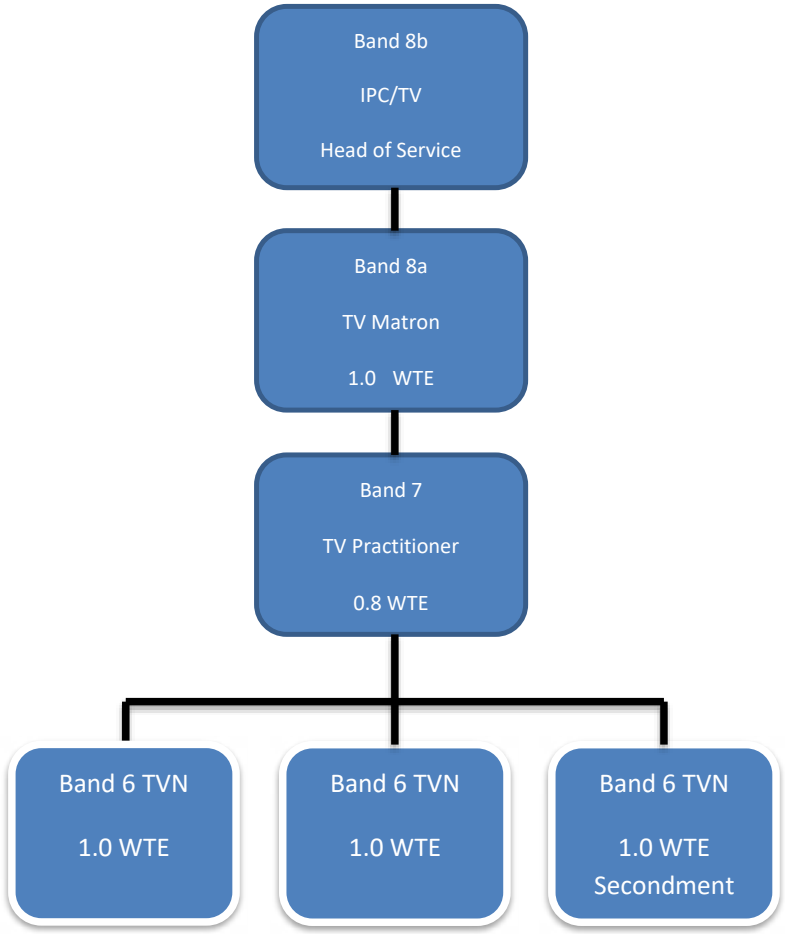


Figure 1: The WTE and structure for the Tissue Viability service.

** Band 6 1.0 WTE Secondment funded by Maria Wallen – CPD to focus on Purpose-T Pressure Ulcer Assessment roll out.

4.0 Pressure ulcers

Pressure ulcers represent a challenge for patients who develop them, and a major burden of sickness and reduced quality of life for them, their carer's, and families (DOH, 2018). Pressure ulcers remain a challenge for the healthcare profession and a key indicator of the quality of nursing care and additional financial pressures (DOH, 2018).

The TVS validate all present on admission and NBT attributable category 3 pressure ulcers, category 4 pressure ulcers, unstageable pressure ulcers and deep tissue ulcers. In addition to this, the TVS validate NBT attributable grade 2 pressure ulcers.

The Tissue Viability service continues to work as a collaborative partnership across the organisation with other clinical specialists to provide a co-ordinated and response to identified PU themes and trends. This is facilitated through the Pressure Ulcer Steering Group (PUSG). The purpose of the Pressure Ulcer Steering Group (PUSG) is to work at a strategic level as a collaborative to drive performance and ensure accountability for the delivery of the objectives relating to the strategy to reduce PU incidents at NBT. The group meet monthly to discuss the PU figures for the previous month, discuss AARs (After Action Review) and complex cases to identify emerging themes and implement strategies and workstreams to reduce PU Incidents at NBT.

At regional and system level the TVS have established partnerships and networks.

The TVS attend the ICB System Pressure Ulcer Board, and Pan Avon Formulary group with other stakeholders such as community and acute providers across the region. These forums are used to provide peer support, discuss current themes and challenges, and formulate effective and responsive solutions across the system. NBT's TVS are leading and active member of the groups.

NBT adheres to commissioning standards, the National Institute for Health, and Care Excellence (NICE) best practice recommendations (NICE, 2018), and National Reporting and Learning system framework (NRLS, 2019) for collecting and reporting incidence data.

In 2022/2023 there were:

- 171 grade 2 pressure ulcers: 3% increase
- 26 grade 2 pressure ulcers caused by medical devices: 13% decrease. Overall, a 0.5% increase from 2021/2022

- 8 grade 3 pressure ulcers: an increase of 8 from 2021/22
- 4 grade 4 pressure ulcers: 100% increase

NBT Heath Care Acquired Pressure Injury Figures 2021/22

21/22	Quarter 1			Quarter 2			Quarter 3			Quarter 4				
	April	May	June	July	August	Sept	October	Nov	Dec	Jan	Feb	March	Totals	
Grade 2 (113)	8	8	13	14	20	20	15	9	10	12	19	18	166	196
Grade 2 (d) (27)	1	2	2	3	2	3	4	3	6	4	0	0	30	
Grade 3 (0)	0	0	0	0	0	0	0	0	0	0	0	0	0	
Grade 4 (0)	0	0	0	0	0	0	0	0	1	0	1	0	2	

NBT Health Care Acquired Pressure Injury Figures 2022/23

22/23	Quarter 1			Quarter 2			Quarter 3			Quarter 4				
	April	May	June	July	August	Sept	October	Nov	Dec	Jan	Feb	March	Totals	
Grade 2	18	15	8	25	15	15	12	17	11	15	8	12	171	197
Grade 2 (d)	1	4	6	4	1	3	2	2	0	1	1	1	26	
Grade 3 (0)	0	1	1	0	0	0	2	2	1	0	0	1	8	
Grade 4 (0)	0	0	0	0	0	0	0	0	1	0	2	1	4	

Figure 2 summaries the validated pressure ulcers for 2021/22 and 2022/23.

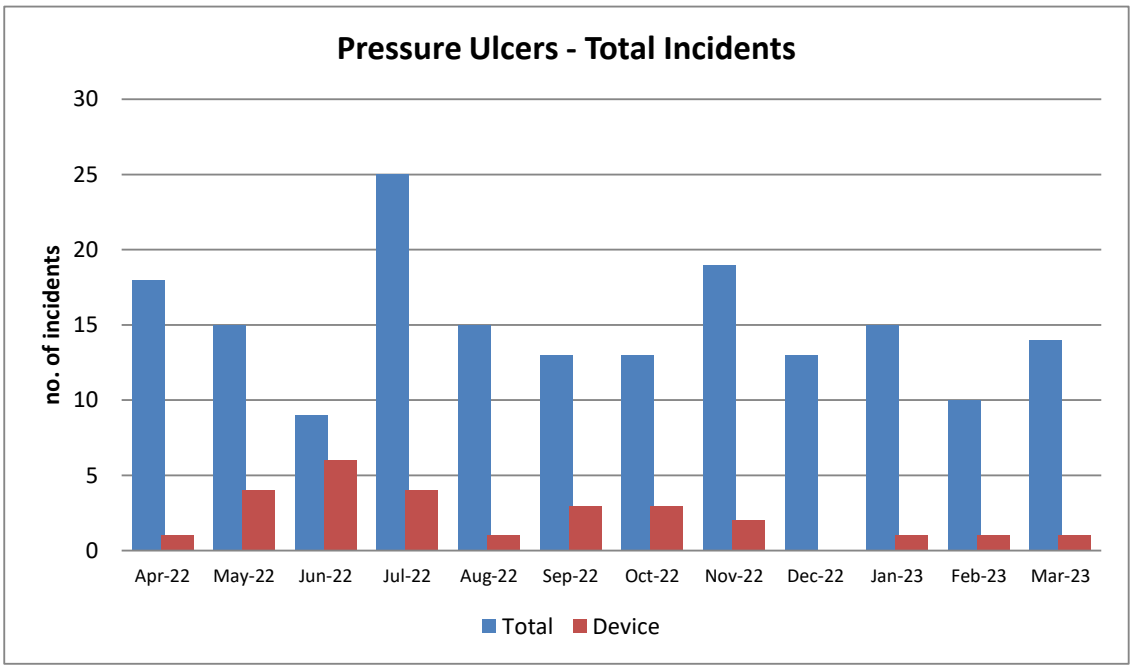


Figure 3 Total incidents of pressure ulcers.

10.1

5.0 Medical Device Related Pressure Ulcers

During 2022/23, there were a total of 26 medical device related grade 2 pressure ulcers across the Trust. This is a 13% reduction compared to 2021/22. This improves on the previous the reduction in 2021/2022.

There has been successful collaborative work between the orthopaedic wards, the plaster room and TVS to triangulate care including a creation of a plaster of paris (POP) escalation pathway, LEARN package, Careflow referrals for the plaster room and identification labels for application of POP casts.

All medical device related pressure ulcers continue to be investigated utilising the integrated SWARM documentation at ward level on the Trust reporting system.

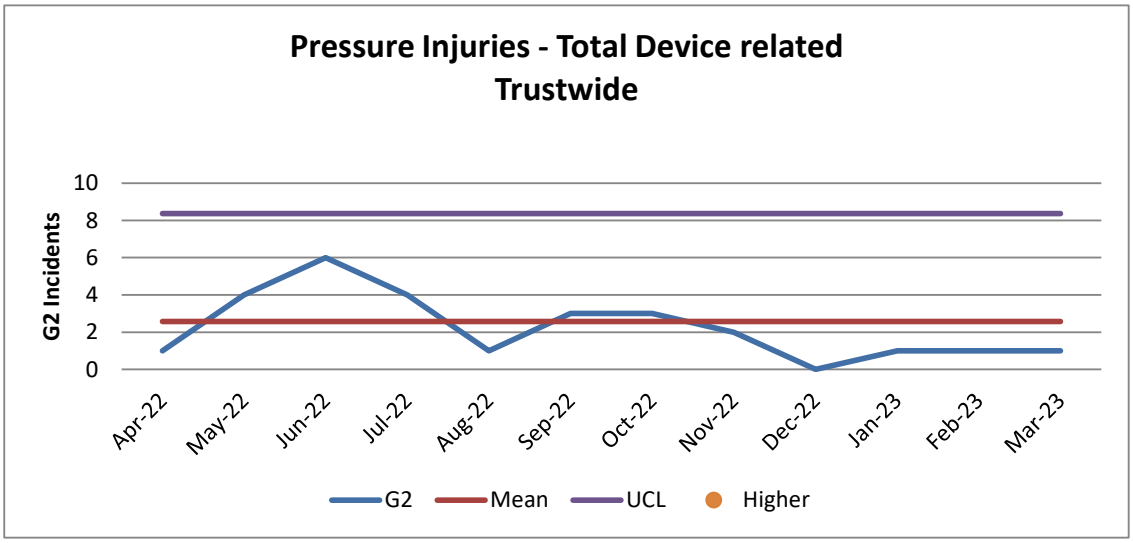


Figure 4 Numbers of NBT acquired device related pressure ulcers by number of incidents reported monthly from April 2022 – March 2023.

6.0 Estimated financial costs of pressure ulcers

During 2022/23, 209 patients developed pressure ulcers at NBT. The Department of Health (DOH) pressure ulcer calculator (Department of Health, 2010) can be used to estimate the costs associated with the treatment of pressure ulcers. The expenditure/cost elements are likely to be conservative as specialist equipment, medication and dressings are not included. Using the central estimate, the costs comprised:

197 Grade 2 pressure ulcers at approximate cost of £1,178,000

8 Grade 3 pressure ulcers at approximate cost of £79,000

4 Grade 4 pressure ulcers at approximate cost of £57,000

This is a total £1,314,000 for 2022/2023

7.0 Pressure ulcer prevalence 2022/23

2114 present on admission pressure ulcers were reported via Datix, of which 299 were unstageable, grade 3 or 4.

TVS triage Datix and validated 480 by face to face review the rest via CareFlow images. Of the TVS validated pressure ulcers of 2021/22, 214 grade 2 pressure ulcers were reported, 52 Grade 3 pressure ulcers, 66 Grade 4 pressure ulcers, 121 unstageable pressure ulcers and 306 deep tissue ulcers.

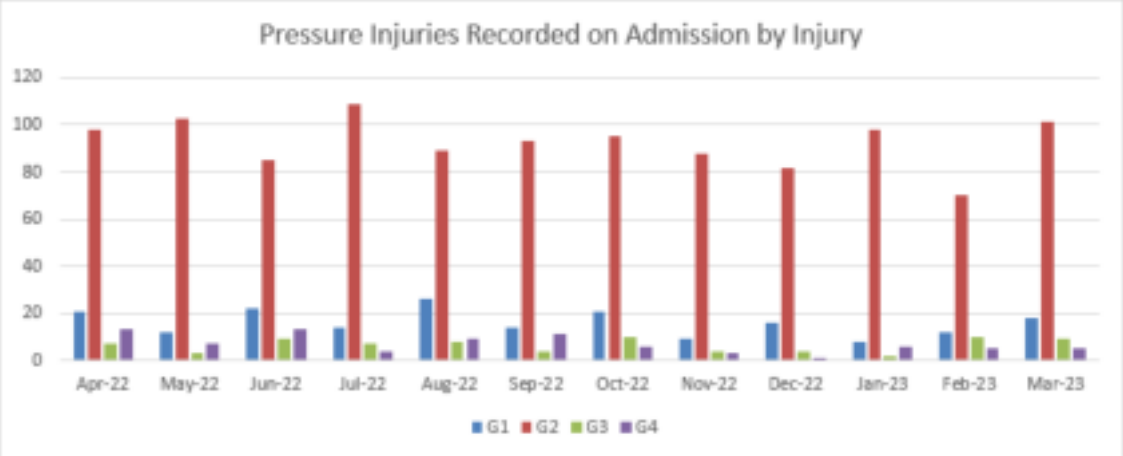


Figure 5 shows the number of patients admitted with present on admission pressure ulcers

8.0 Rates of Pressure Ulcers per 1000 bed days

To allow comparison across acute organisations, we are required to report pressure injures as per 1000 bed days. The systems in place should ensure that all pressure ulcers, irrespective of grade are reported within the patient/service user record.

Reporting of pressure ulcers on local reporting systems should ensure that data is captured which is relevant to the provider organisation i.e., rate of pressure ulcers newly acquired per 1,000 bed days (acute) / per 10,000 population (community) case load.

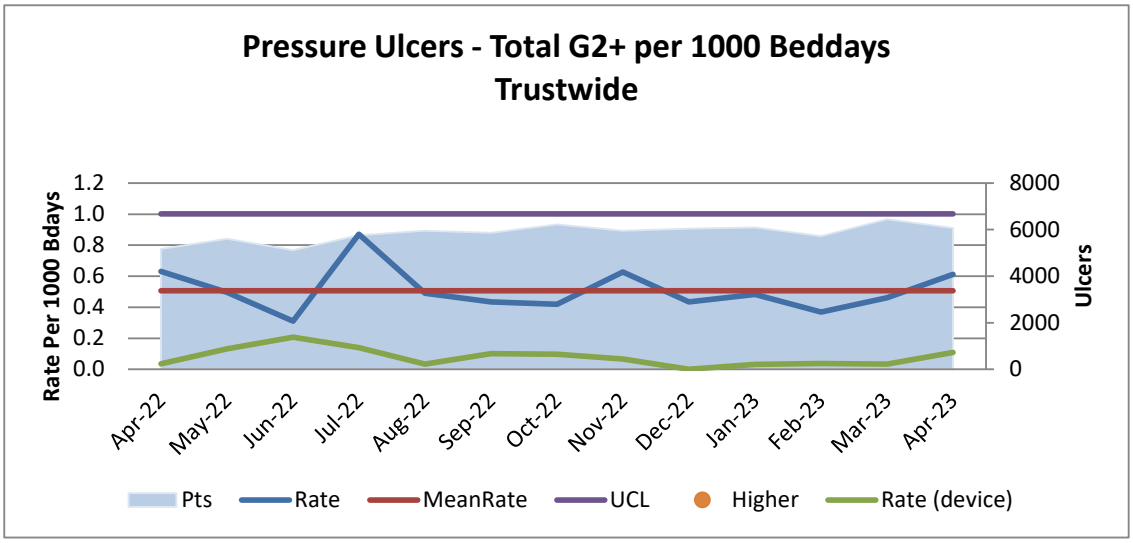


Figure 6 incidence of all NBT acquired hospital-acquired grade 2-4 pressure ulcers per 1000 bed days.

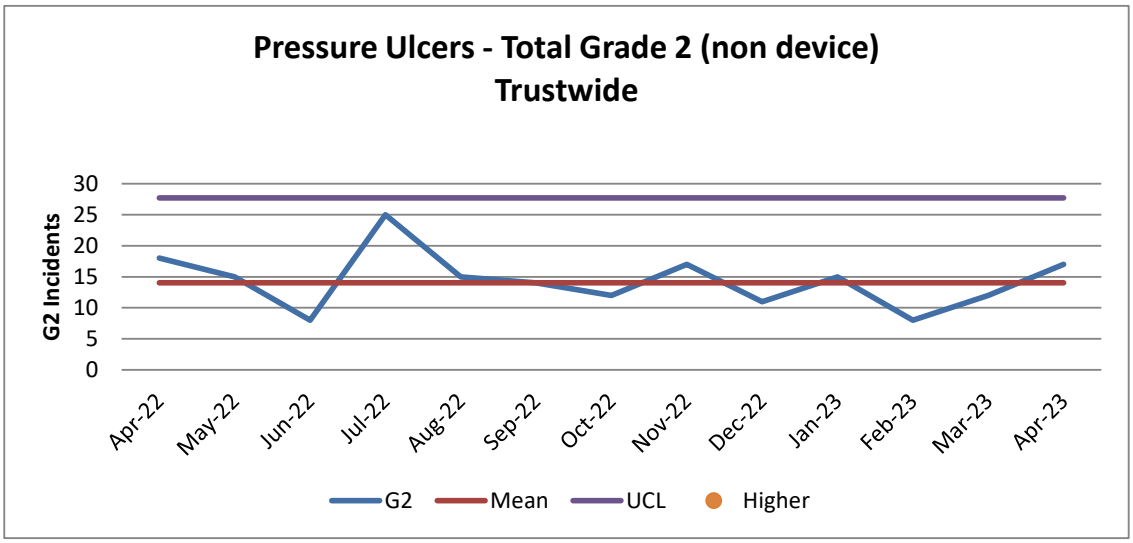


Figure 7: Grade 2 pressure ulcer trust wide on a bi-monthly basis, excluding medical device related.

This is further broken down into divisional incidence for divisional acquired pressure ulcers as shown below for the Figure 9, 10, 11 & 12 for the Clinical divisions providing inpatient care.

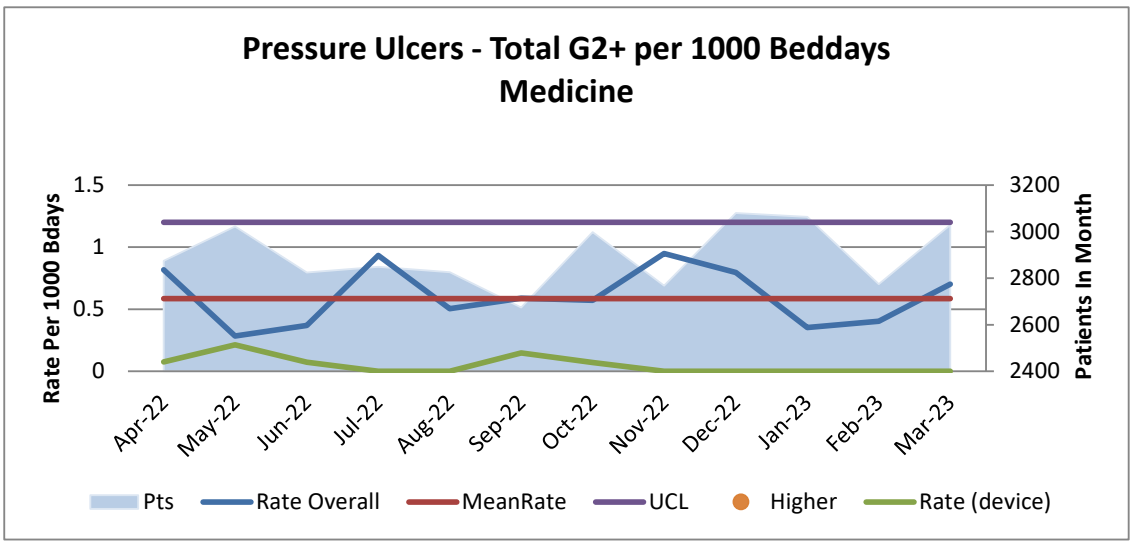


Figure 9: Medicine division validated NBT attributable pressure ulcers

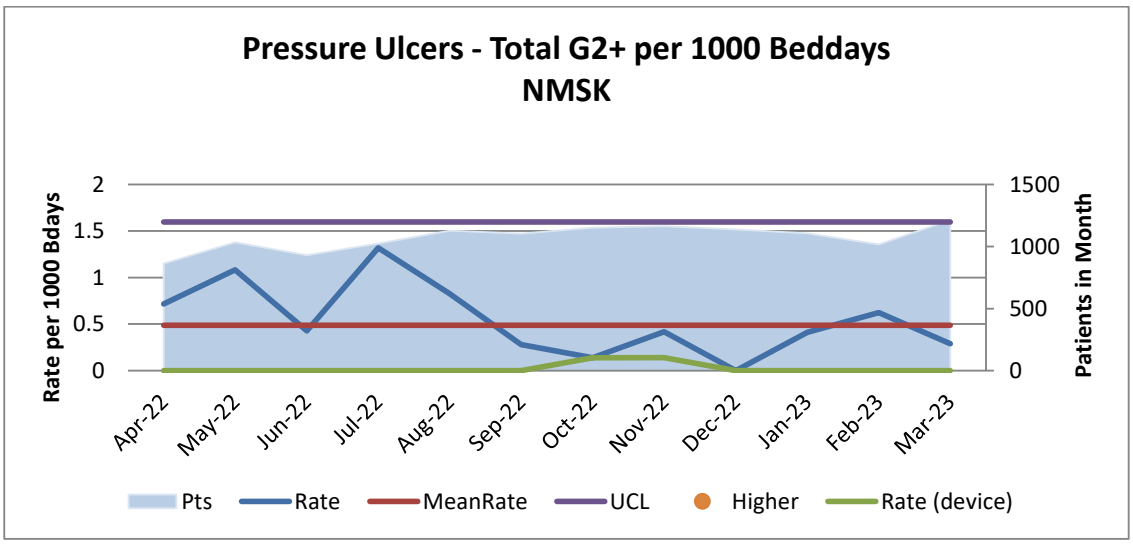


Figure 10: NMSK division validated NBT attributable pressure ulcers

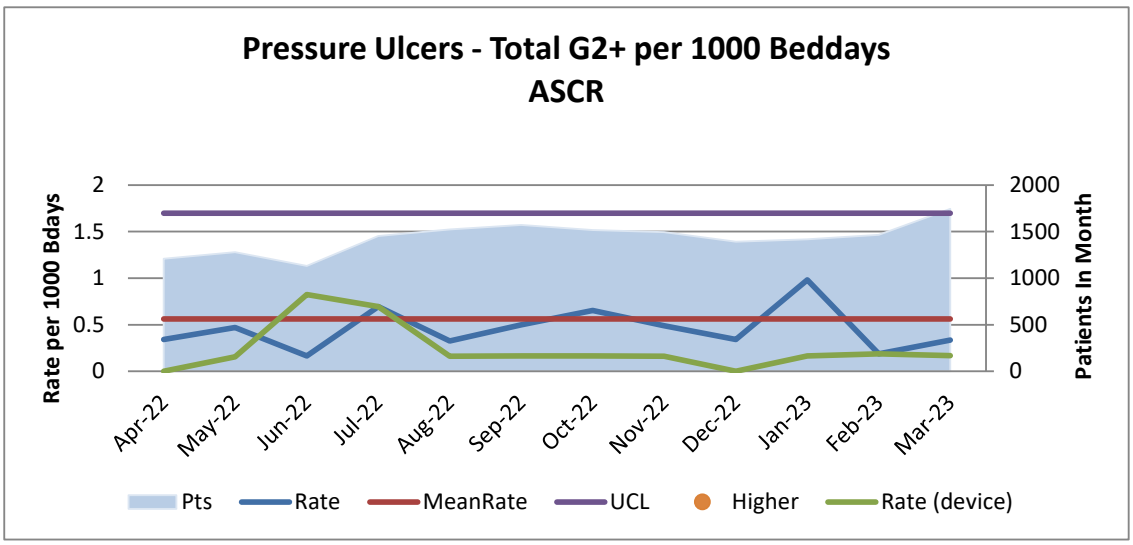


Figure 11: ASCR division validated NBT attributable pressure ulcers

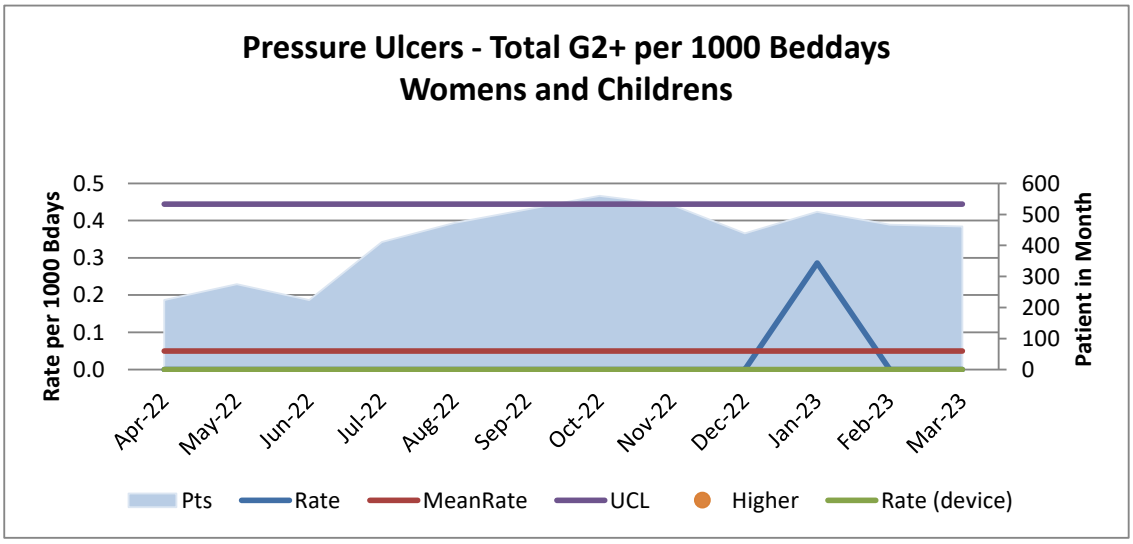


Figure 12: Women and Children's division validated NBT attributable pressure ulcers

9.0 Response to hospital acquired pressure ulcers

The Pressure Ulcer Steering Group (SPUG) was formed in early 2023 and is chaired by Juliette Hughes, Deputy Chief Nursing Officer and Sarah Wheatley, Head of Service for Infection Control and Tissue Viability. The membership includes representation from across the Trust at a strategic level to drive strategies to reduce pressure ulcer prevalence. The TVS have identified themes across the Trust. and these are in the TVS strategy for 2023/2024 (Appendix 1).

10.0 Investigation of pressure ulcers

A SWARM is safety incident huddle with two ward staff members that takes place in as short as possible a time after the incident, has a non-blame culture and leads to prompt learning and action.

Following validation by TVS of a NBT attributable Grade 2 Pressure Ulcer or Deep Tissue Ulcer, a SWARM must be completed within 7 days, using the template in the 'Learning Review' section in the trust reporting system. The SWARM findings will then be required to be presented to the Divisional Quality Huddles with a date agreed by the clinical area.

An 'After Action Review' (AAR) is required for NBT attributable unstageable, Grade 3 or Grade 4 pressure ulcers. The AAR is organised by the senior sister/charge nurse and should include the matron, divisional director of nursing, and a representative from the responsible medical team, safeguarding and TVS. The investigation is focused on identifying what went well, what could have been improved and identifying learning outcomes. The culture of the AAR is not proportioning blame and looking at thematic and organisational trends.

The AAR is adopted from the Patient Safety Incident Response Framework (PSIRF) (NHS 2022). Post implementation 18 months ago there is collaborative work with the patient safety team and the divisional governance team to fully embrace PSIRF and ensure that the process is responsive to emerging themes. TVS have created a strategy for pressure ulcer reduction that outlines workstreams of identified themes from AARs. These themes and workstreams sit within the action plan and objectives of the PUSG. The System Pressure Ulcer Group (SPUG) chaired by the Integrated Care Board (ICB) look to standardise the adoption of PSIRF across the BNSSG region. This is work is ongoing with various members at various stages of adoption.

The TVS work closely with the patient safety team to ensure that the investigation process is robust and thematic trends and emerging trends are identified. A patient safety investigation may be required if it meets the framework criteria, and this internal review would be presented at the Patient Safety Committee Group.

11.0 NBT Reporting Process

The TVS maintain data for NBT acquired pressure ulcers. This is located on MS Teams as a SharePoint document which the wards, divisions and senior nursing teams can access to obtain real time data.

The TVS send weekly emails to the Trust to advise on prevalence of pressure ulcer and deep tissue ulcers.

These figures are collated into a monthly report which is circulated across the Trust. This includes analysis, RAG rating and divisional breakdown. This supports focussed, responsive and interventional work.

Monthly reporting of validated pressure ulcers is completed via the integrated performance report (IPR) and includes a quality narrative to provide context to the figures. The Head of Service for Infection Control and Tissue Viability is responsible for providing quarterly reports to the Quality Board to provide assurance.

12.0 Incontinence Associated Dermatitis and Moisture Associated Skin Damage (IAD/MASD)

As per the NHS Improvement 'Pressure Ulcer framework in Local Reporting systems and reporting to NRLS' (NHS, 2019) NBT organisations report moisture associated skin damage via incident reporting. This field continues to be captured within the NBT incident reporting system.

IAD and MASD are complex and are often confused for pressure ulcers. Any damage to the skin, including moisture damage increases the risk of pressure ulcers and therefore appropriate prevention and management is key for the prevention of pressure damage. IAD and MASD continue to be included in SSKIN training to promote and protect skin integrity.

13.0 Audit

Audit compliance is reviewed by the Divisional Directors of Nursing within the Clinical Divisions.

The Pressure Ulcer Prevention monthly audit overall compliance for 2022/2023 is 97% across all clinical areas.

The PU prevention monthly audit will be moved into a monthly quality audit from July 2023.

14.0 Tissue Viability Education

The TVS team have delivered over 100 hours of education in the year 202/2023. This has consisted of the HCA face to face induction, tissue viability link ambassador days, healthcare education day, nurse education day, student nurse webinars, supporting

MASD training, 'work with a TVN' and specific divisional and ward training needs. The TVS service also supported NMSK with the orthopaedic master's module. In addition, the team offer shadowing to staff members, medical staff, allied health professionals and student nurses who have an interest in tissue viability.

The SSKIN eLearning package which includes competencies continues to support the staff, wards and divisions increase their awareness of PU prevention strategies and maintain an elevated level of staff compliancy.

The TVS held a successful 'Stop the Pressure' day in November 2022. It was great to be able to have a stall and hold the event in the atrium. The event was sponsored by Medi derma, and we asked staff who visited the stall to make a pledge on how they would promote pressure prevention in their clinical practice. We had patient's attend as well, who were engaged and wanted to know more about pressure damage and the TVS in the Trust. A certificate was delivered to all that made a pledge.

The TVS in collaboration with infection control have been working on creating a student pack and programme to provide student nurse placements for the first time. TVS look forward to welcoming the first student nurses in September 2023.

15.0 Tissue Viability Link Ambassadors (TVLA)

The ward areas are expected to have at least one registered and non-registered member of staff as TVLA.

The TVS successfully relaunched the TVLA with a meeting in July that had excellent feedback. The quarterly TVLA meeting agendas and dates are now added to MS Teams with the booking of the meeting through the new LEARN platform. This has made the organisation, management and booking for the TVLAs and ward sisters a much easier and transparent process.

The MS teams' channel launched in July as well and is used to share policy, dressing selection guides, equipment selection guides and relevant pathways. There will peer support available through the chat function and an ability to contact the TVNs. Overall, the response has been positive, however has been some feedback that this is another IT application to log into along with others.

TVS has had interest from TVLAs that want to shadow TVNs to gain greater knowledge on how to support their clinical areas.

16.0 BNSSG Region Activity

The Tissue Viability Service continues to maintain the interface for communication between primary and secondary care in relation to wound care of individual patients and strategies for maintaining tissue viability.

The TVS work strategically at reducing pressure ulcers across the region as an active member of the Pressure Ulcer Board (PIG). There has been a restructure in the ICB,

and this has changed the focus of the PIG into a system wide approach (SPUG). The membership of this group is being extended to include social care and private providers of health care. This should optimise the collaborative working of the BNSSG Multi-Agency Strategy across the system. Shared objectives are identified, and task and finish groups are implemented to manage effective and sustained change.

17.0 Achievements 2022/2023

- Addressing and responding to thematic trends of pressure ulcers through trust wide focus on learning from incidents by implementing the patient safety incident response framework (PSIRF).

- Prevention of heel related pressure ulcers – 10 pairs of repose boots and 2 repose wedges delivered to every ward across the Trust. This was funded by a successful bid to NBT charity.

- Collaborative work with SWAST and purchasing or repose overlay mattresses for use on ambulance trolleys for identified vulnerable patients to mitigate pressure ulcer risk.

- TVS provided training on pressure prevention and wound care to the Orthopaedic MSc Module September 2022.

- Frailty Pathway – all patients on admission are nursed on a dynamic powered hybrid on 32a due to patient cohort. This is a test of change and led to NBT purchasing 600 hybrid dynamic mattresses to be rolled out across the Trust in 2023.

- Mattress management – working in collaboration with the clinical equipment service on training across the MDT including porters, management of mattress across the Trust, and reduction of types of mattresses to make mattress selection easier.

- Tissue Wound Interest Group (TWIG) – Launch of TWIG from NBT in March 2023 in collaboration of Convatec to deliver free educational session on Tissue Viability subjects across the region and system.

- Pressure Ulcer Steering Group re-established and meeting monthly to discuss themes and implement strategic PU reduction strategies.

- SSI reduction - TVS continue to be actively involved in the Precission project at reducing SSI rates in post caesarean section working alongside IPC and the wider MDT.

- Maintain communications with the community providers by including information in the discharge summary regarding pressure ulcers and wounds. Work with the ICB and BNSSG providers on developing tracking wounds across providers and providing cohesive joined up patient care.

- TVS accept referrals via Careflow which provides a more accessible, and transparent support and advice service.

- Tissue Viability Link Ambassador relaunch and MS team's platform for increased engagement, focussing on delivering sessions in response to the survey of Ambassadors.

- TVS reviewed data dissemination to the Trust and have provided data available in real time on the MS SharePoint platform.

- TVN staff development with post graduate course training.

- Appointment of TVS matron.

- Review and change of Annual report style to align with PSIRF culture and thematic and trend analysis.

- Band 5 TVN secondment to support and develop the service.

18.0 Recommendations for 2022/23

The KPI for reduction of NBT attributable pressure ulcer for 2023/24 are:

- 10% reduction in NBT attributable Grade 2 pressure ulcer.
- Zero tolerance to NBT attributable Grade 3 and Grade 4 pressure ulcer with a 50% reduction from 2022/23.

To achieve this KPI and sustain reduction for mandatory reportable harms, there will be specific focus on:

- Rollout of hybrid dynamic mattresses across the Trust and removal of foam mattresses unless needed for a specific reason e.g. Unstable spine.
- Recycling the removed foam mattresses by repurposing them to charities, with 340 going overseas. This equates to saving approximately 18 tonnes of CO_2 – the equivalent of flying from Bristol to Sydney seven times. Foam mattresses that were not able to be used for charities were re-used as insulation.
- SSI reduction – TVS continue to support post implementation of the Precission bundle to reduce SSI caesarean rates.

- Pressure Ulcer prevention patient leaflet to updated to Pressure Ulcer prevention boarding card in multiple languages for accessibility.
- Purpose-T Pressure Ulcer prevention assessment to be rolled out across the Trust November 2023. This has involved mapping the assessment to the EPR system and working on care plans and a pressure ulcer prevention pathway to aid clinical decision making.
- Review of the SSKIN documentation to support the new pathway and clinical decision making.
- Equipment selection guide updated in collaboration with Drive to simplify the mattress selection guide.
- PSIRF process to be updated with the clinical governance teams responsible for facilitating and ensuring that SWARMs and AARs are completed. TVS will not be responsible, the ownership will return to the divisions.
- TVN strategy for pressure ulcer reduction created and discussed at patient safety group for dissemination to the governance teams and divisions.
- Working collaboratively with the Salisbury TVN to support and prevent pressure ulcers to spinal cord ulcer patients. This work also involves the rehab teams at the Trust.

The TVS at NBT is developing to also be a 'wound care service' (WCS) in extension to the validation service for pressure ulcer prevention and management. Through restructure of the current investigation process of pressure ulcers with the ownership sitting within the divisions the TVNs will be focussed on supporting the Trust in managing complex wounds. This will mean upskilling and clinical development of the current TVNs to include negative wound pressure therapy, sharp debridement and holistic leg ulcer assessment and leg ulcer clinic. This development will ensure that patients receive holistic wound care. Despite streamlining the TVS further resource will need to be secured to facilitate this service development. The TVS will submitting a business case for a band 6 and a band 4 whilst creating a university module with UWE to generate income.

Other areas of focus for TVS not specifically related to pressure ulcer prevalence reduction.

- TVS will take NWPT (VAC) management and dressing for across the hospital following a protracted tender and asset management contract award. This will ensure that patients can access VAC treatment across the hospital and not just on specific wards. The VAC pumps (Activac) will be fitted with an active asset GPS management tag that will track the pump on discharge to the community. This is a system wide approach that will help track the pumps across providers and saving extensive resource in time and cost.
- NWPT pathway and referral to TVS to be updated. Referral process to external care providers to be ratified with the Pan Avon formulary.

- Collaborative leg ulcer pathway with Sirona Healthcare our community partners and the vascular outpatient clinic.
- Doppler and ABPI leg ulcer assessment and management for inpatients by TVN. Compression bandaging to be applied if appropriate.
- Clinical sharp debridement to be offered by TVS to inpatients where appropriate to facilitate wound healing. New policy to be written by TVS following training by band 7 and 8.
- Educational module to be created for delivery with UWE on wound healing at level 7.
- Wound care competencies for staff at NBT that are mapped to the National wound care strategy on wound care. This will involve education, development, and various levels for different health care practitioners.
- Development of an Advanced Nurse Practitioner role in wound care at NBT.
- Collaborative working on wound care across NBT with vascular outpatients, burns and plastic outpatients in relation to dressing formulary, supporting each other, and discussing challenges on delivering wound care across the system.
- TWIG meetings in conjunction with Convatec to be held at NBT.
- Regional TVN meeting to be organised by NBT for the region in Bristol.
- NBT leading on the regional/ICB 'Stop the Pressure' conference being held in November 2023.
- TVS welcoming their first student nurses to the service in September 2023.
- Collaborative work with women and children division on wound care and providing 2 full study days.
- Update on the NICU MASD pathway.
- TVS band 7 and 8 with the vascular specialist nurse presenting at a regional conference on the introduction of a collaborative leg ulcer pathway.

References

Department of Health, 2010. *Pressure ulcers: productivity calculator* Pressure ulcers: productivity calculator - GOV.UK (www.gov.uk) [accessed 09/08/2022].

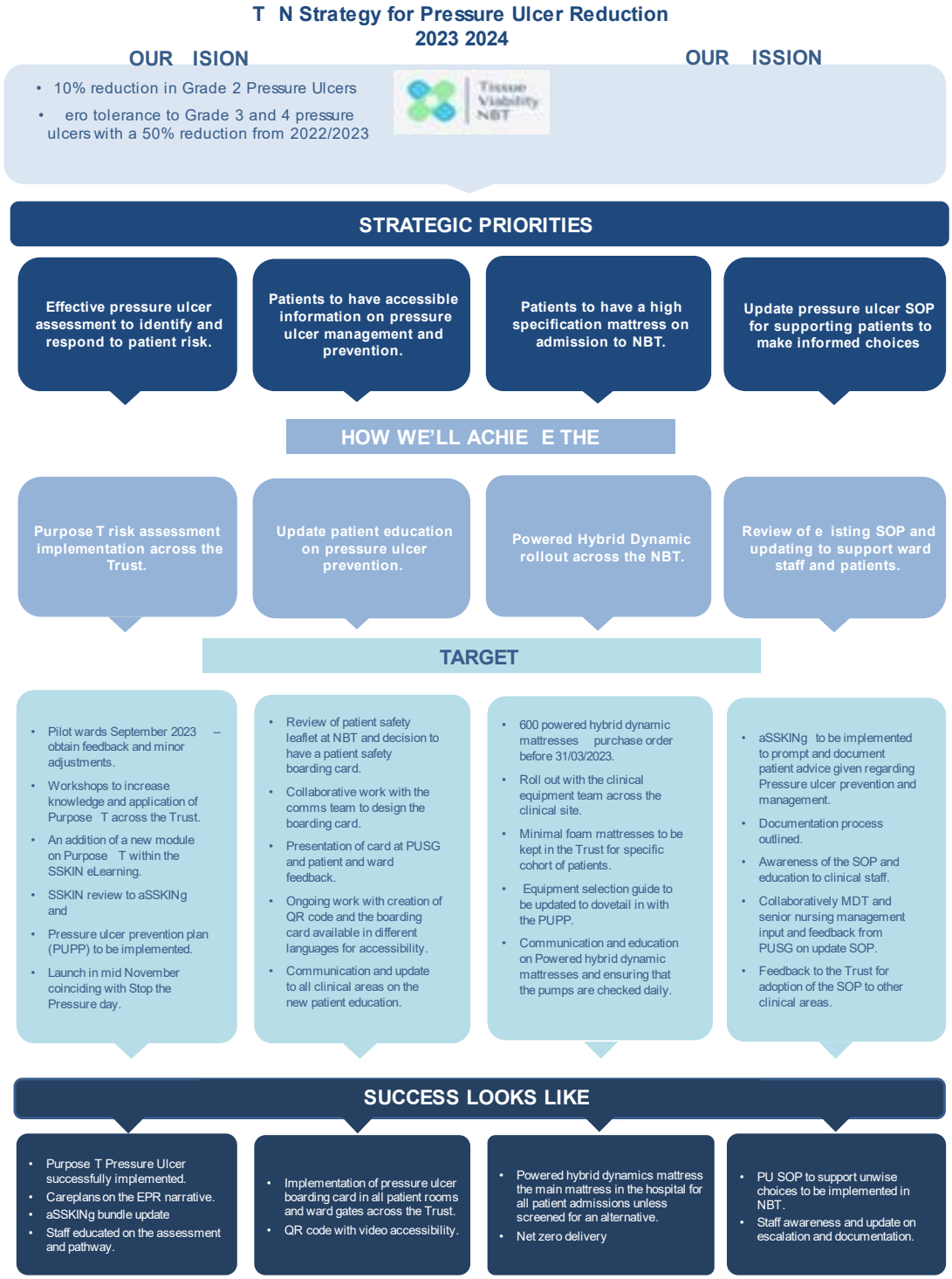
NHS England, 2022. *Patient Safety Incident Response Framework* NHS England » Patient Safety Incident Response Framework [accessed 09/08/2022].

National Institute Clinical Excellence (NICE), 2014. *Pressure ulcers: prevention and management Clinical Guideline [CG179]* Overview | Pressure ulcers: prevention and management | Guidance | NICE [accessed 27/09/2022].

NHS Improvement, 2019. *Implementing the pressure ulcer framework in local reporting systems and reporting to NRLS* Guidance-for-reporting-pressure-ulcers.pdf (england.nhs.uk) [accessed 27/09/2022].

Department of Health, 2018. *Pressure Ulcer Protocol* https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/756243/safeguarding-adults-protocol-pressure-ulcers.pdf [accessed 27/09/2022].

Appendix 1


T N Strategy for Pressure Ulcer Reduction
2023 2024
OUR ISION
• 10% reduction in Grade 2 Pressure Ulcers
• ero tolerance to Grade 3 and 4 pressure ulcers with a 50% reduction from 2022/2023
OUR ISSION
STRATEGIC PRIORITIES
Effective pressure ulcer assessment to identify and respond to patient risk.
Patients to have accessible information on pressure ulcer management and prevention.
Patients to have a high specification mattress on admission to NBT.
Update pressure ulcer SOP for supporting patients to make informed choices
HOW WE'LL ACHIE E THE
Purpose T risk assessment implementation across the Trust.
Update patient education on pressure ulcer prevention.
Powered Hybrid Dynamic rollout across the NBT.
Review of e isting SOP and updating to support ward staff and patients.
TARGET
• Pilot wards September 2023 – obtain feedback and minor adjustments.
• Workshops to increase knowledge and application of Purpose T across the Trust.
• An addition of a new module on Purpose T within the SSKIN eLearning.
• SSKIN review to aSSKINg and
• Pressure ulcer prevention plan (PUPP) to be implemented.
• Launch in mid November coinciding with Stop the Pressure day.
• Review of patient safety leaflet at NBT and decision to have a patient safety boarding card.
• Collaborative work with the comms team to design the boarding card.
• Presentation of card at PUSG and patient and ward feedback.
• Ongoing work with creation of QR code and the boarding card available in different languages for accessibility.
• Communication and update to all clinical areas on the new patient education.
• 600 powered hybrid dynamic mattresses purchase order before 31/03/2023.
• Roll out with the clinical equipment team across the clinical site.
• Minimal foam mattresses to be kept in the Trust for specific cohort of patients.
• Equipment selection guide to be updated to dovetail in with the PUPP.
• Communication and education on Powered hybrid dynamic mattresses and ensuring that the pumps are checked daily.
• aSSKINg to be implemented to prompt and document patient advice given regarding Pressure ulcer prevention and management.
• Documentation process outlined.
• Awareness of the SOP and education to clinical staff.
• Collaboratively MDT and senior nursing management input and feedback from PUSG on update SOP.
• Feedback to the Trust for adoption of the SOP to other clinical areas.
SUCCESS LOOKS LIKE
• Purpose T Pressure Ulcer successfully implemented.
• Careplans on the EPR narrative.
• aSSKINg bundle update
• Staff educated on the assessment and pathway.
• Implementation of pressure ulcer boarding card in all patient rooms and ward gates across the Trust.
• QR code with video accessibility.
• Powered hybrid dynamics mattress the main mattress in the hospital for all patient admissions unless screened for an alternative.
• Net zero delivery
• PU SOP to support unwise choices to be implemented in NBT.
• Staff awareness and update on escalation and documentation.

North Bristol NHS Trust Organ Donation Committee Annual Report

July 2023

Report Prepared by Dr Ian Thomas – Clinical Lead for Organ Donation at NBT

The purpose of this report is to review activities relating to organ donation at North Bristol NHS Trust for the period 1st April 2022 to 31st March 2023. Key performance indicators (KPI's) will be taken from the National Potential Donor Audit for the period 1st April 2022 to 31st March 2023 (full report attached as a separate file). Our vision is to ensure that organ donation is a part of usual end of life care at NBT and that every patient who is eligible to be considered as an organ donor has that possibility explored and where possible, facilitated in accordance with their wishes.

The NBT Organ Donation Committee has analysed the results from the Potential Donor Audit in order to identify areas where practice may be improved upon. We aim to not only reach but exceed national KPI's so ensuring organ donation is considered a routine part of high-quality end of life care at NBT.

Personnel

Dr Ian Thomas (Consultant in Intensive Care Medicine) remains Clinical Lead for Organ Donation (CLOD) at NBT and is also the Regional Clinical Lead for Organ Donation for the South West of England. He has also been appointed to the post of National Lead for Operational Performance in Deceased Organ Donation. Dr Ben Jordan (consultant in Emergency Medicine) continues as the Clinical Lead with responsibility for activities relating to organ donation within Emergency Departments in the South West of England.

Leanne Knight, Hannah Squibbs, Ria Newport and Sylvia Crump continue as the specialist nurses for organ donation (SNOD) based at NBT supported by Mark Whitehouse in his role as specialist requestor. Pricilla Jaffrey continues in her role as theatre link nurse. Elaine Clarke continues in her role as the NHSBT South West Team Manager with responsibility for NBT.

Simon Wood has announced that he is stepping down from his role as Chair of the Organ Donation Committee. His support, guidance and friendship have been valued and appreciated and I wish him well for the future. An appointment process for the role of Chair will need to be undertaken.

Education and Training

The education and training of all health care professionals remains a key strategy to improve performance at NBT in matters relating to organ donation. There continues to be

regular training sessions provided by the SNOD's for the ICU nursing staff and there is a close working relationship between the lead nurses for ICU education and the SNOD's. Pricilla Jaffrey (theatre link nurse for organ donation) has organised a number of teaching sessions to theatre staff including a section on well-being and support services at NBT for any member of staff who may find organ retrieval surgery emotionally demanding. Additionally, organ donation features on both the regional ICU teaching sessions for junior medical staff and in house ICU teaching sessions for ICU doctors.

The clinical lead has a regular slot (quarterly) at the ICU MDT meeting when matters pertaining to organ donation are presented and discussed. Additionally, the CLOD has lectured on training days for the FRCA candidates, FICM candidates and spoken as an invited guest at external organisations. The CLOD + SNODs are also regular members of the faculty delivering the national Deceased Donation Simulation Course.

CLOD's/SNOD's also attend South West/South Wales regional collaboratives + national meetings.

Finance:

April 2018 saw a national change to the donor reimbursement program. It is currently calculated as follows:

- There is £2 million nationally for donor reimbursement. Each Organ Donation Committee receives £1000.00 to fund activities relating to the promotion, education and training of organ donation. The remainder is divided by number of proceeding donors in previous year (1397) = £1319.26. This is then multiplied by the number of proceeding donors in each Trust and this figure is then paid to the Trust with the intention that it is available to the OD committee
- Donor reimbursement for 2022-2023 is due to be paid to NBT over the summer. It's intended for use by the Trust OD Committee for the purposes of education, research, training and promotion of organ donation
- Nationally there are proposed reductions in the amount paid in donor reimbursement funding which are likely to be introduced for the 2023-2024 financial year
- Accessing the donor reimbursement funds to support projects is proving exceptionally challenging. There does not appear to be an identifiable trail of where the funds are paid to. Whilst a budget code is attributable to 'organ donation funds' it is not clear where those funds come from and how they can be accessed. This is a source of great frustration and is a priority to address
- The Stephanie Trahar Memorial fund (held by NBT Charities) was established in 1996 for the 'promotion of organ donation amongst school children, in schools

and amongst children generally and for the promotion of organ donation amongst the general public'. The fund contains just over £5000.00.

Terms of Reference

The Organ Donation Committee Terms of Reference were approved at the NBT Organ Donation Committee meeting in June 2022.

Tissue Donation

NBT continues as part of the Alliance Site Program whereby nurses from NHSBT have honorary contracts with NBT allowing them to take on much of the education and practicalities of tissue donation at NBT. UHBristol are also part of the Alliance site programme. Nationally there are logistical challenges with timely tissue retrieval and work is ongoing to address these issues.

SUI's

1. A retrieval surgeon approached the theatre co-ordinator to discuss the possibility of WLST in a neighbouring theatre. This is not a practice that Southmead has a protocol in place for and whilst WLST in an anaesthetic room is common place in other hospitals, it cannot occur at Southmead due to the lack of anaesthetic rooms. Theatre management have been assured that this is not a practice that is supported at Southmead and there are no plans to introduce it
2. Lack of adherence to the NBT protocol of a theatre safety briefing prior to the patient being sent for. A retrieval surgeon en-route to Southmead had contacted the SNOD requesting that the patient be sent for and therefore be in theatre on the retrieval teams arrival. This would therefore have meant that the patient was sent for and be in theatre prior to any theatre introductions and safety brief. There is an expectation that visiting theatre teams will engage with, and abide by all NBT policies and protocols including the theatre safety brief. This has previously been explicitly stated by the Medical Director. Any further instances should be reported back to the CLOD who will investigate

Work continues to reduce the impact of daytime retrieval surgery on the elective and emergency capacity of theatres at NBT. NBT CLOD is part of a national working group looking at interventions on the whole donation/retrieval/transplantation pathway with the aim of reducing the amount of retrieval surgery that occurs during daytime operating so minimising the impact on theatre activity.

Performance

The latest NBT data available from the National Potential Donor Audit relates to the period 1st April 2022 to 31st March 2023 (full report attached)

In summary:

- Nationally, there has been a steady recovery following the Covid 19 pandemic in the number of patients who become organ donors and the number of subsequent organ transplants performed. Whilst not quite back to pre pandemic levels, nationally, 1397 patients became organ donors resulting in 3415 transplants in 2022-2023.

- Between 1st April 2022 to 31st March 2023 there were 27 proceeding organ donors at NBT compared to 22 for the same period in 2021 to 2022. During 2022-2023 there were no missed referrals at Southmead of patients eligible to be considered as organ donors i.e. every patient who had the potential to be an organ donor was identified and referred. This reflects the fact that organ donation is embedded within NBT culture and is considered a routine part of end of life care. It is a testament to all the members of the multi-disciplinary team involved with organ donation that as a result, 57 organs were transplanted in to 54 patients. In addition, there were 12 patients where consent for organ donation was obtained but organ retrieval did not take place (2 where donation after neurological death (DBD) was being facilitated and 10 where donation after circulatory death (DCD) was being facilitated). The reasons for not proceeding are understood and relate to suitability of organs for transplant and where patients do not die within the necessary timeframe stipulated to facilitate organ retrieval following withdrawal of life sustaining treatment.

- 14 patients became organ donors following confirmation of death according to neurological criteria and 13 following the confirmation of death according to circulatory criteria. This compares to 20 and 12 proceeding donors respectively for the same period in 2021/22.

- For a full breakdown of the type of organ retrieved and transplanted please see the attached detailed performance report.

- NBT is considered a 'level 1' hospital nationally when it comes to organ donation potential. A level 1 Trust is defined as having had 12 or more proceeding donors per year, of which there are 35 nationally. When compared to other level 1 hospitals nationally, in all measured KPI's NBT is performing at, or above the national average.

The performance against all KPI's is a reflection of the hard work, dedication and professionalism of all staff connected with organ donation, particularly the SNOD's. As recovery following on from the pandemic continues, the fact that all patients who had the potential to become organ donors were identified and referred so allowing their end-of-life choices to be explored and facilitated is something that as an organisation, we should be proud of. The aim will be to ensure that these figures are not only maintained but built upon to ensure that best practice is undertaken in all aspects relating to organ donation in the year 2023/24.

Research and Audit

- Ian Thomas is a board member of the SCORE project (Sustainability and Certainty in Organ Donation). This is a national project hosted by NHS Blood and Transplant.
- The SIGNET study is a multicentre national project looking at the use of simvastatin in patients who are to become organ donors following death diagnosed by neurological criteria. NBT is a participating organisation

2023/24 actions:

- Continuing the perceived devastating brain injury pathway
- Regular presentation slot at ICU multi-disciplinary meetings
- Continue developing and participating in the ongoing research projects discussed above
- Regular meetings between CLOD, SNOD's, NHSBT managers
- Attendance at regional collaborative and national meetings
- Monthly feedback to CLOD from SNOD's highlighting issues/obstacles/areas of practice that require improvement relating to organ donation
- Continue with development of individual performance polygons for ICU consultants to drive performance. Feedback to individual members of the medical team where missed opportunities/areas of practice that may require improvement have been identified
- Analysis of missed opportunities and development of processes to address reasons for missed opportunities
- Improve access to donor reimbursement funds and identify pathway to enable funds to be utilised
- Move artwork in atrium and look to establish an electronic information and education point relating to organ and tissue donation in the atrium
- Appoint new Chair of the Organ Donation Committee
- Look to develop closer links with the transplant community at NBT and invite additional members to join the Organ Donation Committee. This would lead to the establishment of a joint Organ Donation and Transplant Committee so increasing collaborative working

Achievements in 2022-2023

- Membership of the national Sustainability and Certainty in Organ Retrieval Project – this wide ranging project is looking at all aspects of organ donation and retrieval with the aim of increasing certainty, efficiency and sustainability associated with the process
- In June 2023 3 patients were able to donate cardiothoracic organs (heart +/or lungs). This again demonstrates the fact that organ donation and retrieval is embedded within the culture of end of life care at NBT and the multi disciplinary support and collaborative working of many teams at NBT
- Continued fantastic support from HM Coroner to facilitate organ donation where coronial approval is required
- Implementation of a SOP at NBT to ensure banked blood is not wasted where normothermic regional perfusion is used during organ retrieval following death by circulatory criteria. This followed 2 SUI's where the cold chain was broken and x-matched blood was disposed of having not been required during the retrieval process. This work was presented at a national conference and was developed by the SNODs in conjunction with the Trust lead for transfusion and senior biomedical scientist
- Ongoing regular education for nursing and medical staff
- Informal chat with new starters in operating theatres about rgan donation and retrieval
- Used ODC funds for EOL / palliative care education for Nursing staff
- Plans to contribute towards relatives' rooms makeover

I believe this report demonstrates how organ donation is embedded within the provision of high quality end of life care at NBT, the collaborative working of many individuals and teams required to facilitate organ retrieval and the compassionate nature of all staff involved. It is something we, as an organisation, should be proud of.

Ian Thomas

Clinical Lead for Organ Donation

Consultant in Intensive Care Medicine

Southmead Hospital

July 2023

Report To:	Public Trust Board			
Date of Meeting:	30 November 2023			
Report Title:	Infection Prevention & Control Annual Report			
Report Author:	Sarah Wheatley, Head of Service IPC and TV			
Report Sponsor:	Steve Hams, Chief Nursing Officer			
Confidentiality (tick where relevant) *:	**Patient identifiable information?**	**Staff identifiable information?**	**Commercially sensitive information?**	**Other exceptional circumstances**
*If any boxes above are ticked, paper may need to be received in *private.*				
Purpose of the report:	**Approval**	**Discussion**	**Information**	**Assurance**
		X		
Recommendations:	To review and comment on the Infection Prevention and Control annual report and plan.			
Report History:	Annual report to the Quality Committee			
Next Steps:	None required.			

Executive Summary

This Annual Report details the activities undertaken by the Infection Prevention and Control Team (IPCT) during the period 1st April 2022 to 31st March 2023 and should be read in conjunction with the Infection Control Annual Programme of Work for the same period. The report has been compiled according to guidelines issued by the Department of Health and Social Care and will be presented to the Trust Board.

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

1. Providing advice on all aspects of infection prevention and control
2. Outbreak and incident management
3. Conducting programmes of education
4. Audits targeted on mandatory surveillance
5. Implementation of the National Infection Control manual
6. Interpreting and implementing national guidance at local level
7. Involvement with refurbishment, new building and equipment projects

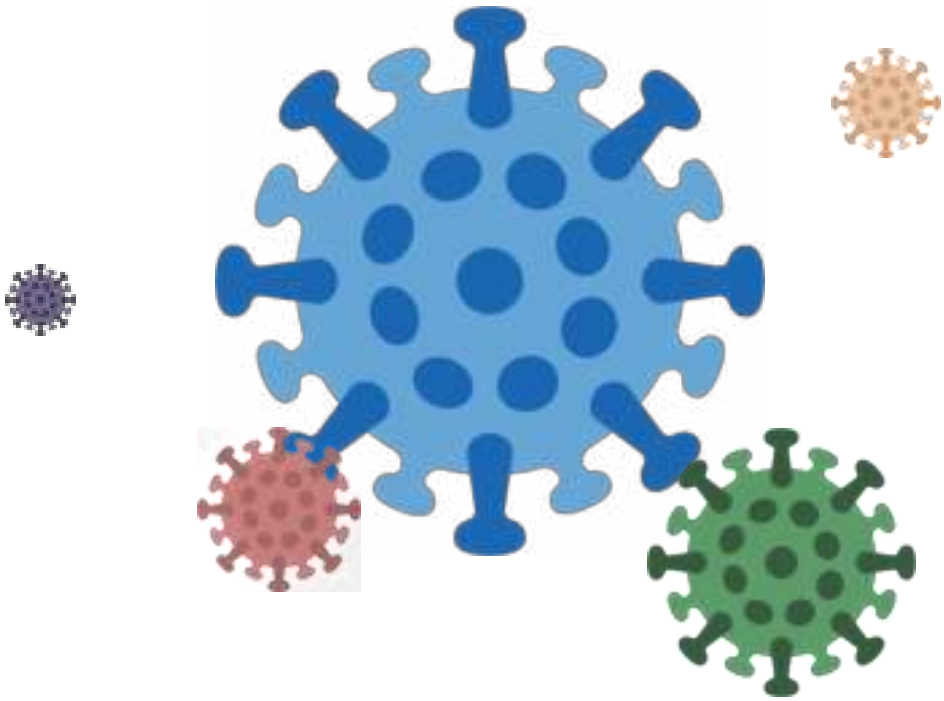
The prevention of Healthcare Associated Infection (HCAI) remains a top priority for the public, patients and staff. Avoidable infections are not only potentially devastating for patients and healthcare staff but consume valuable healthcare resources and extend duration of inpatient admission. Investment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

Implications for Trust Improvement Priorities: *(tick those that apply and elaborate in the report)*	**Our Aim: Outstanding Patient Experience**	X
	High Quality Care – *Better by design*	
	Innovate to Improve – *Unlocking a better future*	
	Sustainability – *Making best use of limited resources*	
	People – *Proud to belong*	
	Commitment to our Community - *In and for our community*	
Link to BAF or Trust Level Risks:	N/A	
Financial implications:	There are no specific financial implications associated with this paper.	
Does this paper require an Equality, Diversity and Inclusion Assessment (EIA)?	*N/A*	
Appendices:	Appendix 1 – IPC Annual Report 2022/23	

NHS
North Bristol
NHS Trust

Infection Prevention and Control

Annual Report 2022/23



11.1

Foreword

This annual report provides a summary of performance and activities for the reporting period of 1st April 2022 to 31st March 2023.

In May 2022, the NHS in England stepped down the COVID-19 level 3 incident, recognising that a result of the successful vaccination programme it was reasonable to focus efforts on restoration and recovery, and 'living with COVID'. The Infection Prevention and Control (IPC) multidisciplinary team at North Bristol NHS Trust (NBT), led by Sarah Wheatley have, since the declaration on the pandemic in January 2020 been central to ensuring patients and staff are protected. I pay tribute to these colleagues for their expertise, adaptability, humility, and commitment, we shall be indebted to this team for the many lives saved as a result of their work.

As we have progressed through the year, we have continued our focus on a variety of improvements to reduce the harm from healthcare associated infections (HCAI). The decrease in *Clostridium Difficile c*ases at NBT has been recognised regionally and nationally as a significant achievement given the increase of cases in other healthcare settings. Our mandatory training requirements for IPC are now at the highest levels since pre pandemic times, and we continue to focus on supporting learning.

Thematic reviews have been undertaking by clinical teams and clinical divisions following all cases of mandatory reported HCAI, over the year we have commenced preparations for moving to the Patient Safety Incident Response Framework approach.

Every healthcare acquired infection is distressing for the patient and we know that the risk of getting an infection while in hospital is one of the greatest issues of concern to the public. We will continue the work in 2023/24 to reduce episodes of HCAI, this will be achieved by joining national and regional projects to look at reduction strategies, quality improvement initiatives and a focus on education and continuing to provide a "Back to basics approach" to infection prevention. We will also continue to work with our pharmacy and prescribing colleagues to ensure the effective management of antimicrobial medicines.

Prevention and controlling infections in hospitals is a truly multidisciplinary endeavour, we continue to work closely with our facilities colleagues in developing and maintaining effective control measures for water, ventilation, decontamination, and cleaning. Our domestic services team have an essential 'safety critical' role in preventing and controlling infections, the team and I are grateful to each and every domestic who supports us in our efforts to reduce harm from infections.

Finally, I would like to personally thank Dr Elizabeth Darley, who stood down from her role as infection control doctor after 20 years of service, her unwavering and determined support to infection prevention and control over two decades is something we are all immensely proud of.

Prof. Steve Hams
Chief Nursing Officer
Director of Infection Prevention and Control

1. Introduction

This Annual Report details the activities undertaken by the Infection Prevention and Control Team (IPCT) during the period 1st April 2022 to 31st March 2023 and should be read in conjunction with the Infection Control Annual Programme of Work for the same period. The report has been compiled according to guidelines issued by the Department of Health and Social Care and will be presented to the Trust Board.

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Chapter 1: INFECTION PREVENTION AND CONTROL ARRANGEMENTS

The Infection Prevention and Control Team constitutes.

Role	Band	WTE	WTE qtr. 4 review
Head of Service IPC / Tissue Viability	8b	1.0	1.0
Matron IPC	8a	1.0	1.0
Senior Nurse IPC	7	1.0	1.0
IPC Nurse	6	3.6	3.6
Audit Practitioner	3	0.8	0.8
Team administrator	4	0.8	0.8
IPC doctor (Medical Microbiology)	Consultant Medical Microbiologist	3.8 Pa	3.8 pa

Development in the team has really grown in 22/ 23 in terms of an education profile with all the team studying or achieved a Pg Cert in IPC, along with leadership qualifications, quality improvement courses and conference attendance this has been a fundamental change to the team's overall approach and has contributed to the reductions in infections as well as the increased confidence clinical teams have with the team .

We have had some additional funding this year to assist with the delivery of training for staff and successfully recruited into this fixed term post and delivered over 100 hrs of additional training directly in clinical areas.

1.1 Director Infection Prevention Control (DIPC) Board Reports

The Director of Infection Prevention and Control position is held by the Chief Nursing Officer, a Board level role. The Deputy Chief Nursing Officer is the Deputy Director of Infection Prevention and control. The Monthly integrated performance reports reviewed by the Board and at monthly Divisional Performance Reviews are communicated to the Board which include data from all divisions, mandatory reporting data, Serious incidence, and upward reports from sub committees.

A detailed report highlighting the activities and decisions/approvals made by the Control of Infection Committee (COIC) is made to the Trust's Quality Committee on a bimonthly basis. Figure 2 provides a schematic of the quality governance structure for IPC.

The Infection Control Monitoring Group is the group with operational responsibility for reviewing real time data, problem solving and enacting additional control measures.

Figure 2 - Reporting mechanisms:

1.2 Annual Programme

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

The programme of work is mapped to the duties of the Code of Practice on the prevention and control of infections (DH 2015). Progress is monitored bi-monthly by COIC. Infection prevention and control continues to be represented at groups and committees within NBT providing infection prevention and control advice in line with Code of Practice on the prevention and control of infections.
These include Water Safety Group, Ventilation Safety Group, Trust Decontamination Group, Clinical Effectiveness Committee, Mandatory Training Forum, Health and Safety and Clinical Non-Pay Group. Partnership working with Integrated Care Board and HCAI Groups (BNSSG (Bristol, North Somerset, and South Gloucestershire)).

1.3 NICE Quality Standard QS61 – Infection Prevention and Control

NICE quality standards describe high-priority areas for quality improvement in a defined care or service area.

QS61 has been developed as part of a group of topics on IPC across a range of settings and is the overarching quality standard for IPC. This standard is supported by other quality standards and published guidance. The expectations of the quality standard are to contribute to the following outcomes:

- Reduction in healthcare-associated Infection (HCAI) rates
- Preventing avoidable deaths from HCAI

1.4 Infection Prevention and Control Education/Training

Ensuring that all staff have high levels of infection prevention and control awareness forms a central feature of our strategy.

The IPC team support clinical teams practically daily giving adhoc advise and training as well as formalised sessions with link ambassadors, induction programmes and all staff groups across the trust. This also extends to education to patients and their families.

The team has focused on making UKHSA (UK Health Security Agency) requirements in health care settings easy to understand for staff and helping them to operationalise this. This also involves a strategy of working alongside teams to deliver key training and update education, a member of the team being linked to each division.

NBT Infection Control Compliance Level 2

ESR Staff Group	Training Topic	Number complete	Number incomplete	Number in target group	Compliance
Medical and Dental	Infection Prevention and Control - 2 year expiry	1336	454	1790	75%
Additional Clinical Services	Infection Prevention and Control - 2 year expiry	1875	289	2164	87%
Estates and Ancillary	Infection Prevention and Control - 2 year expiry	67	10	77	87%
Allied Health Professionals	Infection Prevention and Control - 2 year expiry	477	58	535	89%
Nursing and Midwifery Registered	Infection Prevention and Control - 2 year expiry	2631	299	2930	90%
Healthcare Scientists	Infection Prevention and Control - 2 year expiry	54	4	58	93%
Add Prof Scientific and Technic	Infection Prevention and Control - 2 year expiry	33	2	35	94%
	Overall:	6473	1116	7589	85%

NBT Infection Control Compliance Level 1

ESR Staff Group	Training Topic	Number complete	Number incomplete	Number in target group	Compliance
Nursing and Midwifery Registered	Infection Prevention and Control - 3 year expiry	21	0	21	100%
Administrative and Clerical	Infection Prevention and Control - 3 year expiry	2069	225	2294	90%
Medical and Dental	Infection Prevention and Control - 3 year expiry	19	2	21	90%
Estates and Ancillary	Infection Prevention and Control - 3 year expiry	972	87	1059	92%
Additional Clinical Services	Infection Prevention and Control - 3 year expiry	527	30	557	95%
Add Prof Scientific and Technic	Infection Prevention and Control - 3 year expiry	208	12	220	95%
Healthcare Scientists	Infection Prevention and Control - 3 year expiry	419	15	434	97%
Allied Health Professionals	Infection Prevention and Control - 3 year expiry	195	5	200	98%
	Overall:	4429	377	4806	92%

Chapter 2: INFECTION PREVALENCE IN NORTH BRISTOL NHS TRUST

2.1 Mandatory Surveillance

North Bristol NHS Trust complies fully with the mandatory surveillance system for healthcare-associated infections

This includes *Staphylococcus aureus* bacteraemia (including MRSA and MSSA), C. difficile infection, Gram-negative blood stream infection caused by E coli, Klebsiella and Pseudomonas aeruginosa and orthopaedic surgical site infections

The Department of Health (DH) Mandatory Surveillance scheme is used to measure the effectiveness of IPC practices in all NHS Trusts. This surveillance system monitors the agreed national outcome targets

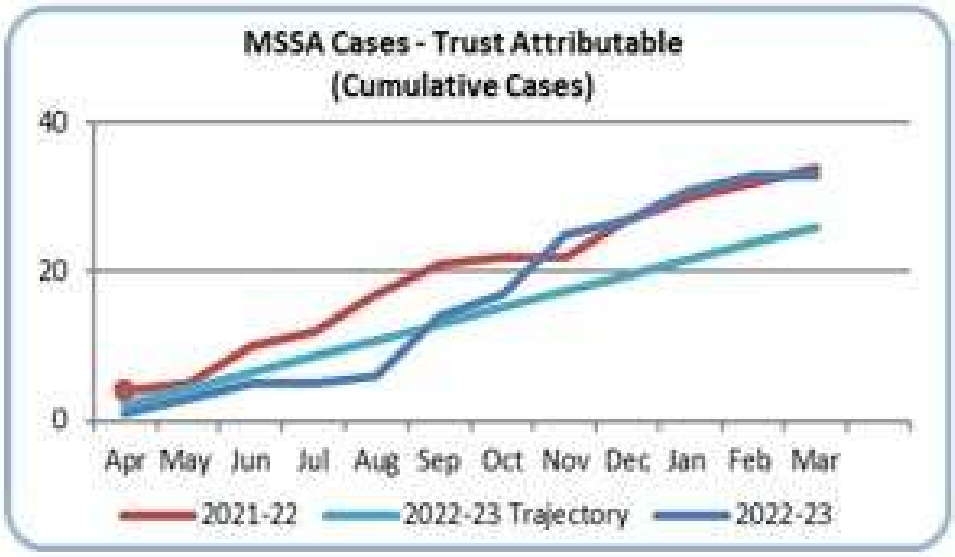
There are national definitions applied to all cases, which distinguish between those occurring within primary, community and secondary health care providers. A hospital acquired MRSA bacteraemia is attributed from day two of the patient's admission and a *C difficile* infection from day two, with admission date considered as day one.

As part of the Local contractual agreement with the Bristol, North Somerset and South Gloucestershire (BNSSG) Commissioning Group MSSA bacteraemia is reported using the same process for hospital acquired cases of MRSA.

2.1.1 *Methicillin Sensitive Staphylococcus Aureus* (MSSA) bacteraemia

During 2022/23 there were 33 reported cases of MSSA bacteraemia. This rate is comparable within the south west region. This is continually monitored and reviewed at staphylococcus steering group.

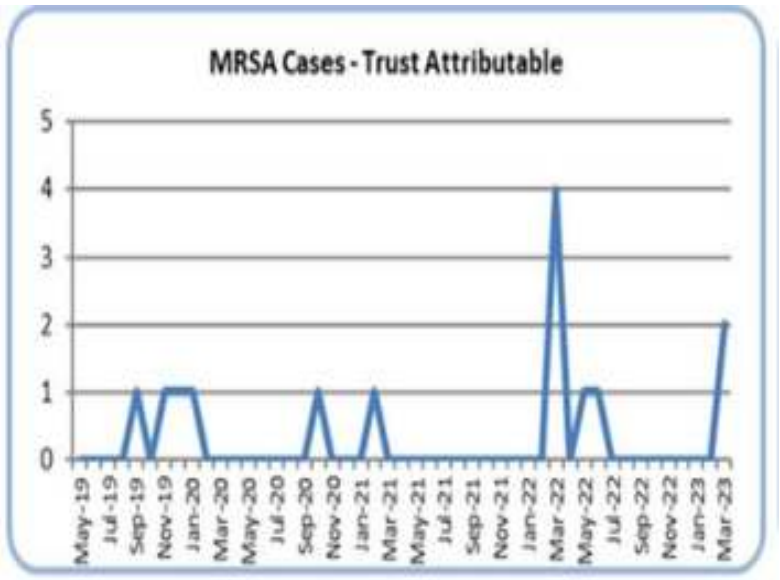
Key themes and risks are raised from post infection reviews (PIR) at divisional Control of infection committee as well as steering groups, these actions form a key part learning for all teams and we are delivering a strategy where these reviews benefit the whole team, through an integrated shared learning approach.



2.1.2 *Methicillin Resistant Staphylococcus aureus* (MRSA) bacteraemia

There were four cases of MRSA bacteraemia in 2022/23, this was the same as the previous year. There remains a zero tolerance to this in both national and regional targets.

Each case as prompted an individual action plan based upon the lessons learnt. This has been shared and reviewed by the trust and is shared both internally with in divisions and externally to clinical commissioners.



Key points of learning from these cases -

- Sampling delays – Education delivered to resolve this
- Line care – Increased surveillance focus on VIP scoring
- Documentation issues - paper vs electronic documentation
- Communication – issues identified and learning in place from medical to nursing handovers.

2.1.3 *Clostridium difficile*

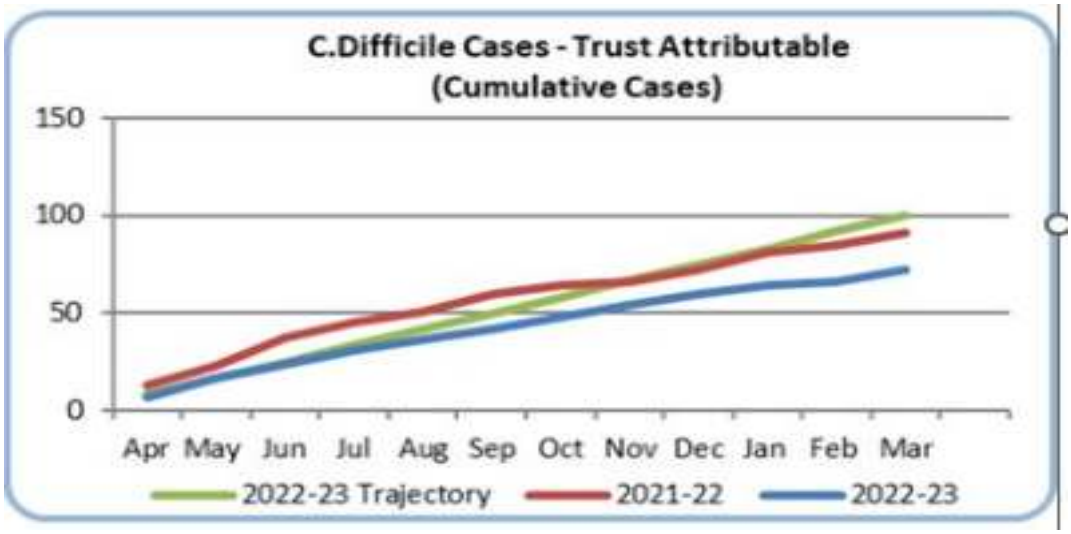
C difficile Infection (CDI) remains an unpleasant and potentially severe or in some cases fatal, infection that occurs mainly in elderly and other vulnerable patient groups, especially those who have been exposed to antibiotic treatment.

Each case of *C difficile* identified as attributable to NBT, follows a clear governance process which considers the national guidance for reporting and learning from incidents.

A formal multi-disciplinary post infection review (PIR) is undertaken with peer review and actions from learning occurring at the *C difficile* Steering Group (CDSG), This group has the same strategy as Staph aureus steering group and works as a shared learning experience to review cases.

This is really owned by the divisions and whilst responsibility is still requiring attribution, the ownership has resulted in improvements being led at a tactical level rather than strategic.

At NBT we have worked hard to understand our rate of infection, reasons why and education as prevention. The result of this has been a 20% reduction in cases from the previous year. Making NBT stand out nationally as an exemplar sight for work in reduction and quality improvement.

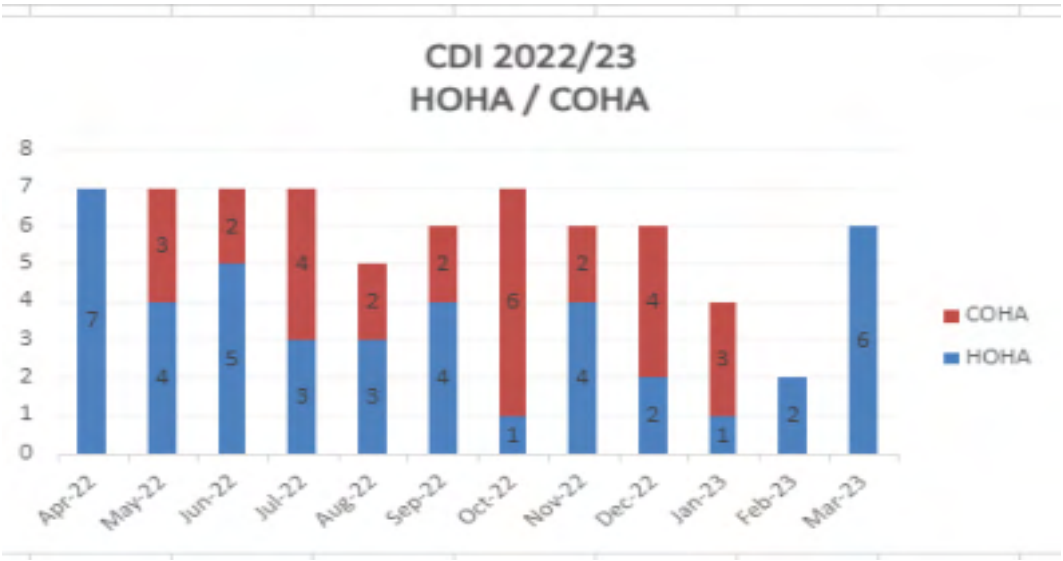


Nationally it is widely understood there is a general rise in cases, this has prompted work in the community and acute trusts to look at reduction strategies.

At NBT we have contributed to this work but have mainly seen the reduction success from a more bespoke programme integrating clinical teams to assist with a reduction programme and looking at any gaps in education and providing this support where needed.

Hospital onset healthcare associated (HOHA) - Cases that are detected in the hospital three or more days after admission

Community onset healthcare associated (COHA) - Cases that occur in community (or within two days of admission) when the patient has not been inpatient in the trust reporting the case in the previous 12 weeks but not the most recent 4 weeks



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

E coli, *Klebsiella* and *Pseudomonas aeruginosa* blood stream infection patient data is reported monthly to UKHSA.

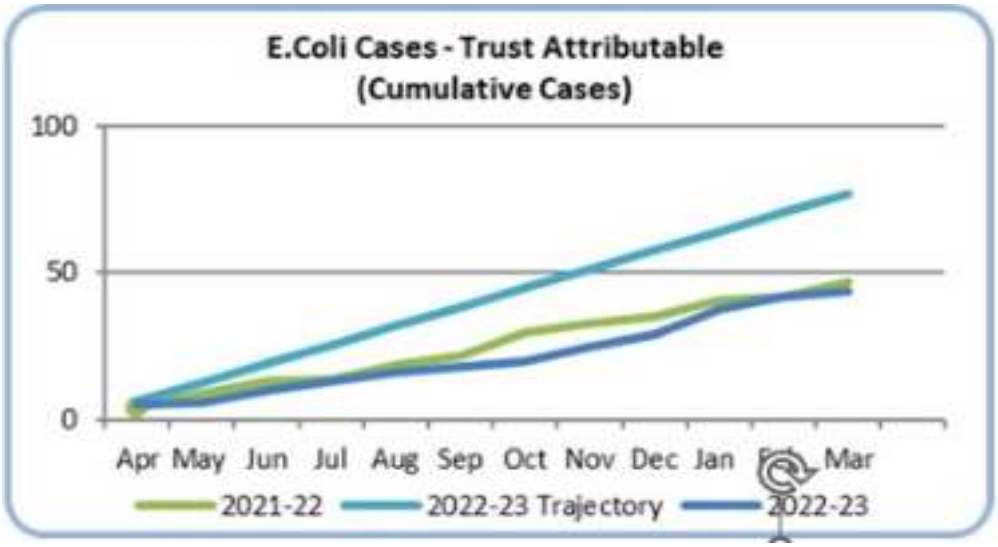
A healthcare associated Gram-Negative BSI is a laboratory-confirmed positive blood culture for a Gram-negative pathogen causing sepsis in patients who had received healthcare in either the community or hospital in the previous 28 days.

Local level data is reviewed to understand up-to-date surveillance activity at Trust and system wide levels.

Cases of *E. coli* bacteraemia is reportable to UKHSA. The number of combined community and hospital cases reported within NBT to the end March 2023 was a total of 46 cases, this giving a slight reduction from last year.

Key learning from these cases -

- Catheter passport refresh being undertaken by the Continence group
- Introduction of decaffeinated drinks and hydration project work working with new nutrition support workers
- Education to patients' information being re visited moving away from leaflets - information videos linked to QR codes



There are vaccine trials due to start in Autumn 2023 (E.mbrace) study exploring the prevention of blood stream infections caused by *E. coli* bacteraemia

Klebsiella sp is the second most common Gram-negative enteric bacterium causing blood stream infection with similar significance to *E coli*.

NBT reported a total of 19 cases of *Klebsiella* blood stream infections in 2022/23.This being a significant reduction vs a trajectory of 35 cases.

In 2022/23 NBT reported a total of 10 cases of *Pseudomonas aeruginosa* in blood stream infections This is below the trajectory of 15 cases, again a continued reduction.

2.3 Respiratory Viruses

Influenza

The trust continues to report all confirmed positive cases within augmented care (ICU), as part of the Public Health England (PHE) UK surveillance.

To support the flu vaccine programme, prevent nosocomial spread and increased risk of operational pressures the IPC team continue to educate teams and contribute to the vaccination of staff programme.

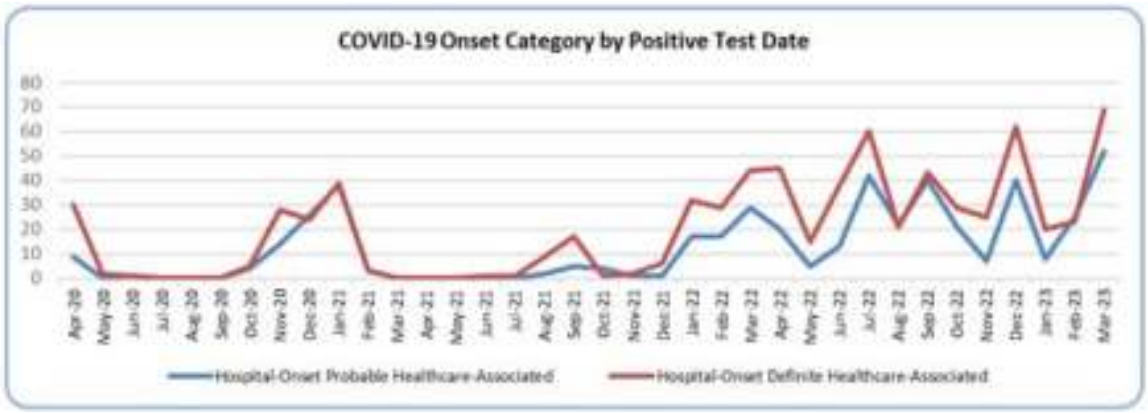
Influenza peaked in the trust in December and January cases numbers rising, this was difficult to assess numbers and potential impact of cases, so a BI data system has since been established to monitor this along with COVID numbers.

The influenza vaccination programme was run alongside COVID vaccination programme.

In 2022/23 the staff vaccination rate was reported as 59% flu and 60% Covid based on a staff number of 10,544.

2.4 SARSCoV2 (COVID-19)

The IPC team have continued to support clinical areas with operationalising national advice and “Living with Covid policies “including staff and patient testing, risk assessments and the management of positive cases.



Qlik data recording both Covid cases and Influenza positive cases available daily to monitor changes in case numbers.

Hierarchy of control and risk assessments were used to reopen areas and assess closed beds to respond to operational pressures

National reporting framework for Covid outbreak portal stood down during the year.
Cases have been managed in line with Living with Covid guidance with areas not closed so having a limited impact on bed capacity.

2.5 Carbapenemase Producing Enterobacteriaceae (CPE)

There are strains of Gram-negative Enterobacteriaceae that can produce carbapenemase, an enzyme capable of destroying carbapenem antibiotics.

Carbapenems are a valuable family of antibiotics normally reserved for serious infections caused by drug-resistant Gram-negative bacteria (including Enterobacteriaceae). Usually, these CPE organisms are resistant to most and sometimes all available antibiotics.

NBT have an established CPE management pack with guidance aligned with the “*PHE Acute trust toolkit for the early detection, management and control of CPE”* (2013). CPE surveillance and management of CPE positive patients can be very resource intense.

NBT receives repatriated patients from all over the world, but numbers of patients admitted with CPE organisms are relatively few and proactive screening has enabled most to be identified at time of admission.

In 2022/23 we managed 6 cases of CPE

Chapter 3: OUTBREAK AND INCIDENT MANAGEMENT

3.1 SARSCoV2 (COVID-19) / Influenza

The number of outbreaks has decreased with changes in management of cases and a reduction in testing.

There was a particular increase in cases in December 22 – January 23 with increased pressure on patient flow from both Covid and influenza making some complex decision making regarding double occupancy and additional bed requirements due to surge activity.

The infection control team monitor increase incidence and contact trace all exposure advising on the operational opening of beds and moving patients at the earliest opportunity to maintain patient flow.

3.2 Diarrhoea and Vomiting outbreaks

Norovirus is a highly transmissible viral gastroenteritis. It is often referred to as “winter vomiting disease” although it can cause outbreaks at any time of year The high proportion of single rooms in Brunel significantly assists with reduction of potential ward ‘closures’ due to outbreaks.

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

In 2022/23 there was only one outbreak affecting two patients and two staff – this resulted in zero bed days lost, due to the ability to use single bedrooms.

3.3 Incident Management

AER and Endoscopy washers

There was an issue identified following a change in contract to service and validate the endoscopy washers. This was further compounded with an issue to supply consumables with a very sporadic supply chain.

This situation was managed by high level management oversite from both Facilities, IPC and the partner, as well involvement from the trust Authorised Engineer (AED) for decontamination. There was a risk place on the risk register that was later removed.

Milk Bank – Paenibacillus psadenensis

The milk bank at Southmead Hospital processes approximately 20L of breast milk weekly. Pre- and post- pasteurisation testing are undertaken by UK Health Security Agency (UKHSA) Environmental and Food Laboratory Services in accordance with NICE milk bank testing guidance.

In January 2023 the milk bank was alerted by UKHSA that several post-pasteurisation samples over a short period had cultured *Paenibacillus pasadenensis* (PP), not identified previously in our donor milk samples. These donations came from 5 different donors and only in pasteurised milk. Published literature available on *P pasadenis* was scant but it was noted that it produces a heat-stable spore, associated with milk spoilage in industry.

The milk bank pasteurisation process was immediately reviewed, finding no evident breaches in handling technique or sources of possible contamination. Utensils were submitted to the UKHSA laboratory for culture, also swabs from inner seals of the dishwasher used to wash milk storage bottles. Pending results all donations were submitted for post- pasteurisation testing.

On culture, all equipment was negative for PP, but the dishwasher seals cultured an identical strain to that in the milk. The dishwasher was immediately replaced. All milk donations were submitted for post pasteurisation testing for a further 3 months, with no further positive PP cultures.

PP has rarely been reported in human infection and never yet in neonates. Contamination incidents in donor milk, with any organism capable of producing heat-stable spores, should prompt scrutiny of the whole pasteurisation process and rejection of the milk batch – irrespective of the Clonogenic cell (cfu) count.

Chapter 4: QUALITY INDICATORS

4.1 Hand Hygiene

The Trust has achieved the 95% compliance target for hand hygiene audit scores throughout 2022/23. We have a programme of observational audits completed by senior ward leaders and/or matrons. The reporting system will be changed during 2023/24 to Radar which will provide improved real time reporting.

Hand Hygiene awareness is a fundamental part of the IPC programme with the annual involvement in May – in the World Health Organisation hand hygiene day.

4.2 Saving Lives Care Bundles (Audits)

Nationally recognised audit tools are applied to develop key performance indicators relating to infection prevention and control. The Trust continues to use the Saving Lives care bundles introduced in 2007 and revised in 2017 as a tool containing action plans designed to reduce the risk and spread of HCAI by focusing on the risk factors which cause infections, for example indwelling devices.

The ‘Synbiotix’ audit system implemented in NBT in 2018/19 is an internet-based audit system that enables the visibility of real time audit data which is based upon nationally recognised audit tools with the ability and flexibility to devise bespoke compliance solutions when required, this platform is due to change to RADAR in 2023.

The use of a real time audit system allows clinical areas to monitor areas of good compliance and those aspects of care bundles where further support is needed.

Actions are generated based upon results and ability to be able to re-audit where necessary (for example if compliance in a particular area is below standard).

4.3 National Cleaning Standards

This has been successfully delivered this year with a collaboration of work from IPC and Facilities.

This provides a system that covers the mandatory requirements-

- Functional risk categories
- Elements, frequency, and performance parameters
- Cleaning responsibilities
- Audit frequency
- Star rating
- Efficacy checks
- Commitment to cleaning Charter

4.4 Antibiotic Stewardship

Antibiotic resistance is recognised as one of the major public health challenges. The Trust's antibiotic stewardship programme is focused on implementing the recommendations in the Department of Health publication "Start Smart Then Focus: Antimicrobial Stewardship Kit for English Hospitals" (SSTF).

The Trust complies with the following SSTF standards:

Monitoring documentation of indication and duration of antibiotic therapy
Monitoring evidence of antimicrobial review at 48-72hours
Monitoring adherence to local antibiotic guidelines
Monitoring antibiotic consumption trends
Monitoring adherence to SSTF principles at least annually in all clinical areas

The Trust Antimicrobial Stewardship Policy was revised and ratified in June 2022. Significant changes included expanded information on individual responsibilities, and addition of escalation processes for resolving antimicrobial prescription-related queries.

Trust-wide antimicrobial point prevalence audits were undertaken in March and November 2022. Results and key messages from the audits were discussed at the Antimicrobial Stewardship Group and distributed to divisional clinical governance leads for onward dissemination to department/directorate clinical governance leads, highlighting specific problems for divisions/directorates to address.

These audits demonstrated poor documentation of stop dates on inpatient charts, which has been an ongoing theme for several years. An amendment was made to the antimicrobial section of the inpatient drug chart to include a box for "review date" as well as "duration" to encourage documentation.

The planned introduction of an Electronic Prescribing and Medicines Administration (EPMA) system in NBT provides a potential opportunity to address this area of poor performance by the use of "hard" stop dates, however the risks/benefits of this approach need to be explored carefully.

The NHS standard contract for 2022/23 contained requirements for trusts in England to reduce use of broad-spectrum antibiotics (defined as the WHO "Watch" and "Reserve" categories) by 4.5% against 2018 calendar year baseline. Due to retirement, there was no Trust antimicrobial stewardship lead in place from June 2022 to Nov 2022, therefore severely limited resource available to support actions towards this target. The lack of electronic prescribing in NBT also presents a significant barrier to proactive antimicrobial stewardship interventions.

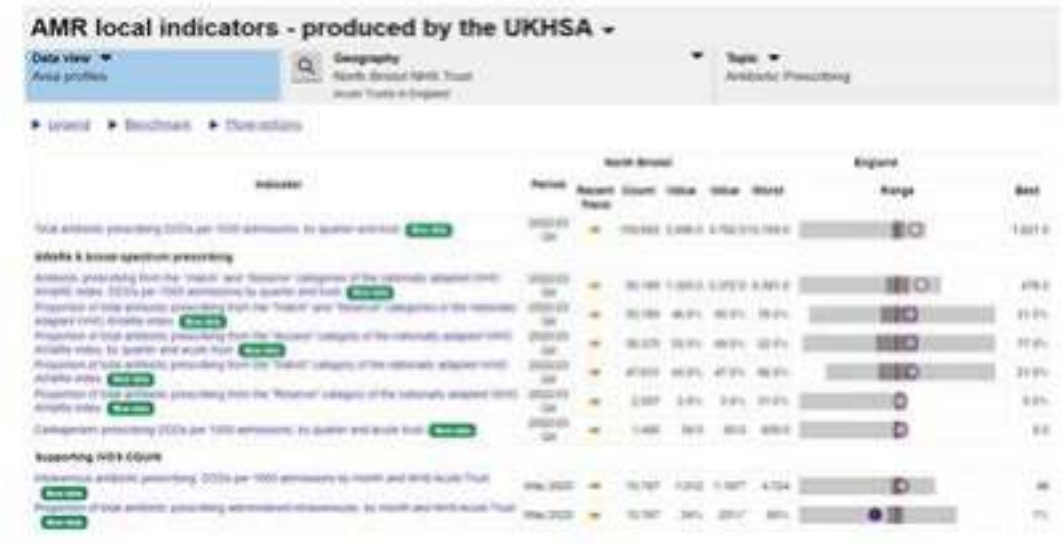
With no capacity to undertake proactive actions such as antimicrobial stewardship wards rounds and education, many actions taken were restrictive in nature and included:

- Review of where broad-spectrum antimicrobials are stocked to align with the formulary, and de-stock where appropriate.
- Implementation of meropenem 500mg QDS dosing (as opposed to 1g TDS) for many indications.
- Targeted antimicrobial stewardship wards rounds were performed on 3 wards with high broad spectrum antimicrobial use, along with engagement with the clinical teams to reinforce the restricted antimicrobial policy.
- Review of size of antibiotic TTA packs – most formulary durations are for 5 days but many TTA packs are for 7 days.
- Formulary review started in March 2023.

The provisional 2022/23 year-end position against this target is that of a 1% reduction from baseline (note HES admissions are not yet available for March 2023 therefore Q3 has been used as a proxy). For context, of the 14 Trusts in the Southwest, only 4 (29%) achieved the target reduction. This mirrors the national position where 39 out of 137 Trusts in England (29%) achieved the target reduction.

It is worth noting that NBT adopted a new Outpatient Parenteral Antimicrobial Therapy (OPAT) service in December 2021. This service has increased broad spectrum antibiotic usage but without being offset by admission days (denominator) as patients are outpatients. If OPAT antimicrobial usage is removed from the data to allow a fairer comparison with the 2018 baseline, this gives a locally calculated year end position of a 2.9% reduction. The expanding virtual ward services will impact on the ability of the Trust to deliver any future reductions based on a pre-virtual ward baseline.

Comparative information with other trusts is available on the Public Health England Fingertips website. For Q4, of all trusts in England, NBT had the fifth lowest total antibiotic usage adjusted for admissions, and the lowest in the Southwest.



NBT did not adopt any antimicrobial related CQUIN schemes in 2022/23, however have adopted a CQUIN for 2023/24 looking at timely switching of patients from IV antibiotics to oral. Work towards this CQUIN started in March 2023, with the design and ratification of a decision support tool for use in the antimicrobial guideline platform used in NBT ("MicroGuide").

Several therapies for COVID-19 were implemented in the Trust in 2022/23 in accordance with national commissioning policies.

Two Antimicrobial Stewardship Group meetings were held in 2022/23, with two meetings cancelled as there was no Trust antimicrobial stewardship lead in place from June 2022 to Nov 2022. Additional representation on the group was secured from the Emergency Department.

Information on antimicrobial stewardship was added to the Trust induction booklet given to all new junior doctors and locums. Face-to-face education was delivered on F1 and F2 induction sessions, and targeted information was disseminated periodically throughout the year via the junior doctor newsletter.

The rapid development and expansion of virtual ward workstreams has presented antimicrobial stewardship challenges. Meetings were held between stewardship and microbiology leads for NBT and University Hospitals Bristol and Weston (UHBW) to work towards aligning guidelines between NBT, UHBW and Primary Care

NHS benchmarking data shows protected antimicrobial pharmacist time in NBT for activities of antimicrobial stewardship to optimise antimicrobial prescribing (0.005WTE per 10 beds) to be significantly below the national average. This severely limits stewardship activities that can be undertaken, and challenges attainment of many targets related to stewardship. A business case is being developed to expand resourcing for stewardship in NBT.

Source: NHS Benchmarking Network - Pharmacy and Medicines Optimisation 2022 Submission Report.

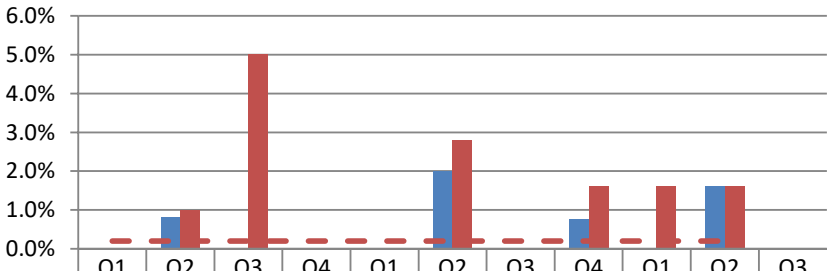
4.5 Surgical Site Infection (SSI)

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

NBT undertakes mandatory SSI reporting for infection following Hip replacements, knee replacements and spinal surgery. This is coordinated by the Neuro Musculoskeletal Division (NMSK). SSIs occurring within 30 days of the operation date are included. Any patients who have had implants such as hip replacements, knee replacements or spinal metalwork are monitored for a period of up to 12 months from their operations. The compliance against National benchmarking is monitored through COIC. The SSI rates for hip and knee replacement surgery from January 2021 – June 2023 are indicated in Figure 1 below.

Fig.1

NBT Hip and knee Inpatient and readmission infections



	Q1 2021	Q2 2021	Q3 2021	Q4 2021	Q1 2022	Q2 2022	Q3 2022	Q4 2022	Q1 2023	Q2 2023	Q3 2023
Hip	0.0%	0.8%	0.0%	0.0%	0.0%	2.00%	0.0%	0.8%	0.0%	1.60%	
Knee	0.0%	1.0%	5.0%	0.0%	0.0%	2.80%	0.0%	1.6%	1.6%	1.60%	
Benchmark Hip	0.2%	0.2%	0.2%	0.2%	0.2%	0.2%	0.2%	0.2%	0.2%	0.2%	
Benchmark Knee	0.2%	0.2%	0.2%	0.2%	0.2%	0.2%	0.2%	0.2%	0.2%	0.2%	

Elective surgical activity has been affected by COVID and most recently by Industrial action in the NHS. Ongoing monitoring of SSI has shown that knee replacement infections remain persistent but over the last 3 quarters have been consistent and not increased. Hip replacements in the last quarter have demonstrated an increase. All hip and knee infection

cases have been investigated by our RCA process based on NICE guidelines and reported to relevant infection leads, microbiology team and to the UK Health Security Agency (UKHSA). No specific patterns have been identified to date. NBT is compared against other hospitals on the readmission and inpatient infections predominantly, but all infection cases are investigated.

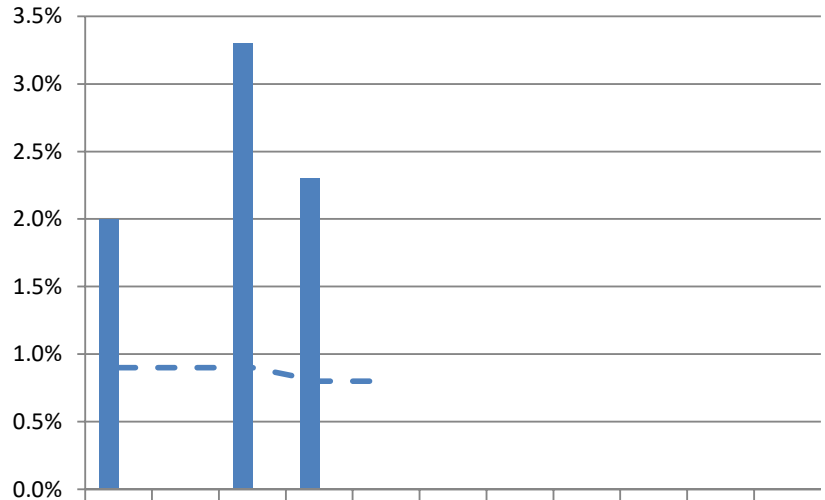
In the last quarter April-June 2023.

THRs- total of 125 operations with 1 inpatient and 1 readmission infection.
TKRs – total of 127 operations with 2 readmission and 1 patient reported only infection.

Spine Surgery
Orthopaedic spinal surgery is reported to UKHSA in conjunction with the neurosurgical spinal activity. The table in figure 2 below demonstrates inpatient and readmission orthopaedic infections only.

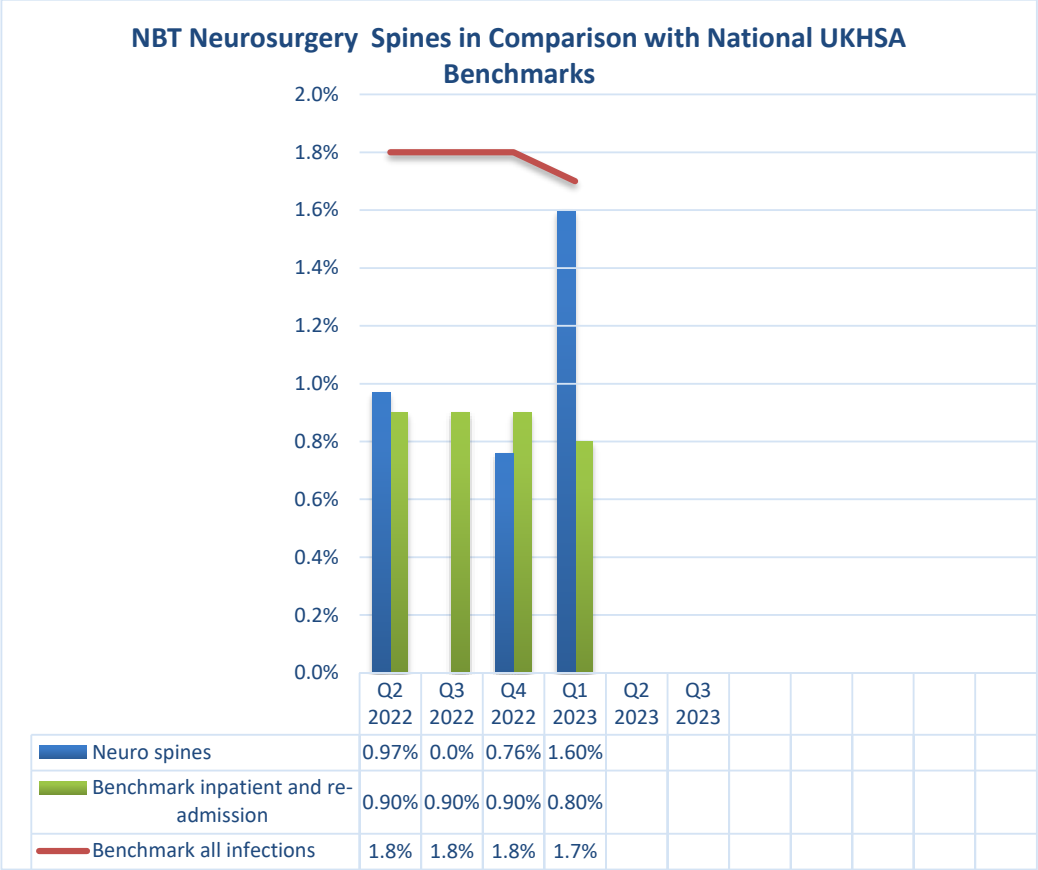
Ortho spinal – total 73 operations with 1 post discharge confirmed and 1 patient reported. No inpatient or readmission infections.

Ortho Spinal inpatient and readmission infections



	Q2 2022	Q3 2022	Q4 2022	Q1 2023	Q2 2023	Q3 2023					
Ortho spines	2.00%	0.0%	3.3%	2.3%	0.0%						
Benchmark spines	0.9%	0.9%	0.9%	0.8%	0.8%						

Neurosurgery Infection Data 2022- 2023



The total number of neurosurgery spine surgeries included in this surveillance period 2022- 2023 equates to 514 procedures, of these there were 4 infections reported up to and including March 2023 (QU1), 3 infections were reported as inpatient or re-admissions and 1 infection was patient reported, cared for by their General Practice team.

In this period, route cause analysis reviews conducted in line with the quality standards set out by NICE QS 49 (2013) and NICE Guideline125 (2019), did not demonstrate trends, themes or contributing factors apart from patient comorbidities and smoking. These reports are presented and recorded in minutes at neurosurgery and complex spine clinical governance meetings, at regular periods during the year following a submission of data to UKHSA. Quarterly infection rate data is also disseminated in the NMSK COIC report.

National Institute for Health and Care Excellence (2013) Surgical Site Infection Quality Standard, available at Surgical site infection (nice.org.uk) accessed on 26/09/2023

National Institute for Health and Care Excellence (2019) Surgical site infections: prevention and treatment, available at Surgical site infections: prevention and treatment (nice.org.uk) accessed on 26/09/2023

4.6 Cleanliness

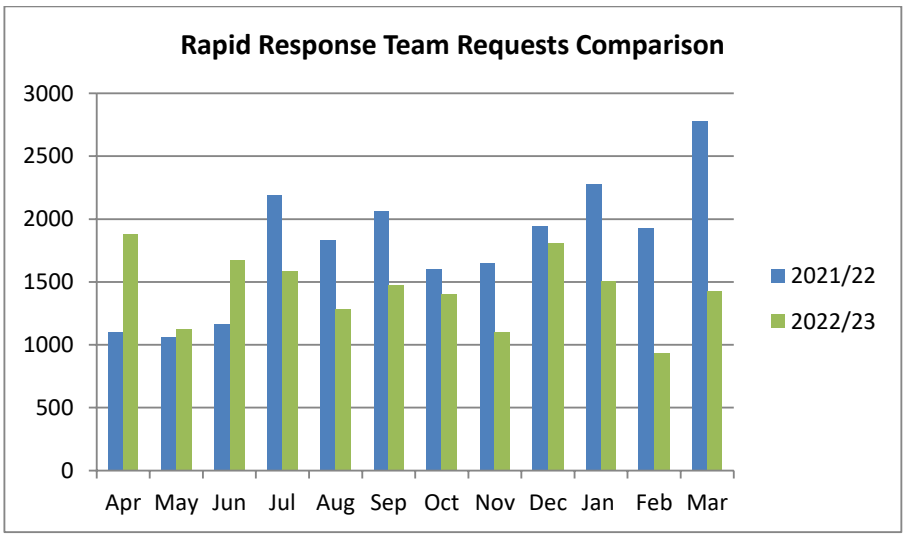
The facilities team deliver a cleaning programme based on National cleaning standards providing both in Hours and Out of hours cleaning support

Following a joint improvement programme with between IPC and facilities leads, National Standards of Healthcare Cleanliness 2021 have been successfully implemented in October 2022 and incorporated into the North Bristol Trust Cleaning Strategy.

The team also respond to the RAG rated IPC cleaning requirements, this data showing response to Red cleaning requests.

Rapid response red clean all areas where known infection has been present, these monthly numbers remain high.

	Apr 22	May 22	Jun 22	July 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23
No of Rapid Response cleans requests	1879	1130	1670	1591	1284	1479	1399	1097	1809	1504	932	1424



A revised electronic platform was launched data reported summarises results for all Functional Risk Categories, replacing the previous four categories.

Each audit produces a star rating which is a combined score result from Domestic, Estates and Nursing. Maximum is 5 Star (Excellent) to 1 Star (Poor). Monitoring these results provides education and development ensuring staff responsible for cleaning have the ability and support to maintain a clean and appropriate environment in managed premisses that facilitate the prevention and control of infections.

The below charts detail the cleaning scores in both platforms used across the year the first data April – Sept 22 pre–Functional Risk Categories – Chart 1, and the rest of the data for the year in Chart 2

Chart 1

National Cleaning Standards audit scores April 2022 – September 2023 by risk category pre–National Standards of Healthcare Cleanliness 2021 being launched.

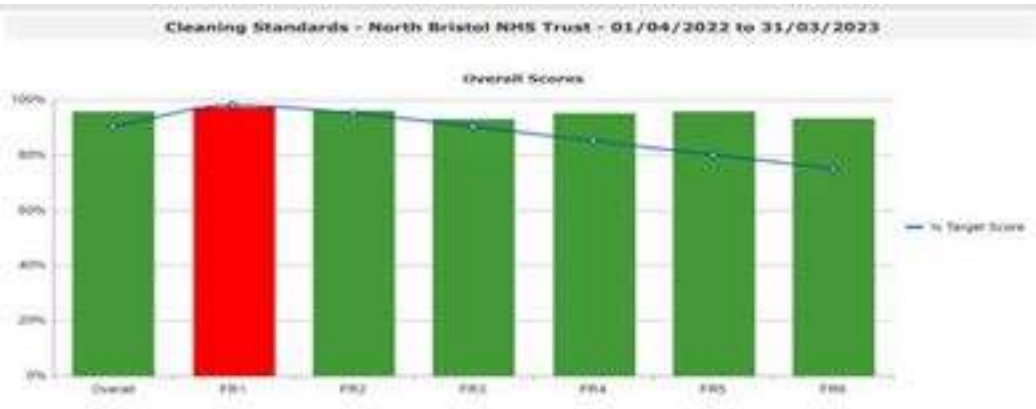
Risk Category	Apr - 22	May-22	Jun-22	Jul-22	Aug-22	Sep-22
VHR	98	98	97	98	97	98
HR	96	95	94	95	95	95
SIG	95	95	95	96	95	96
Low	92	90	95	94	91	94

Chart 2

National Standards of Healthcare Cleanliness 2021 Results 2022/2023 by FR Rating

Launched in October 2022 – Results reflect 0ctober 2022/March 2023

Risk Level	Target Score	No. of Audits	No. of Audits Passed	Audit % Passed	No or rooms audited
FR1	98.00%	1100	480	43.64%	50798
FR2	95.00%	332	253	76.20%	13577
FR3	90.00%	10	8	80.00%	232
FR4	85.00%	81	80	98.77%	1964
FR5	80.00%	9	9	100.00%	172
FR6	95.65%	23	22	95.65%	499



Commitment to Cleanliness Charters signed by a member of the board and Star Ratings are displayed for the public on the entrance to clinical areas as per NHS England guidance.

NBT have systems in place to monitor and review these standards, ensuring a continued focus on the quality and safety of patients within our care. An annual Efficacy Audit is completed it is designed to assess the process of cleaning and infection control related to cleaning. The audit is conducted by the Domestic Facilities Manager, Waste Manager, Estates/Byes Manager, Infection Prevention and Control and clinical team in the area.

Trust clinical and facilities cleaning leads are responsible for evaluating and implementing any changes in cleaning regimes with recommendations of these changes being presented to the Trust's Control of Infection Committee for ratification.

Facilities deep clean teams continue to support weekly C-Diff reduction plan, ensuring sluices in wards where IPC confirm C-diff patients are located are deep cleaned, and UV decontamination carried out to support and prevent cross contamination.

4.7 Decontamination

Decontamination Facilities reprocesses all surgical and other invasive reusable medical devices, provides a high-level disinfection service for all flexible endoscopes and internal audits are conducted to ensure their compliance with ISO13485 and the Directives 93/42/EEC and 2007/47/EC.

The department continues to be externally audited by a notified body (British Standard Institute).

The department are currently working towards obtaining the new UKCA certificate that will be required now the UK has left the European Union. Application and paperwork have been accepted by the BSI with final approval being expected at the next BSI audit in January 2024.

During the year April 2022 to March 2023, 2 Major and 5 minor non-conformances were closed at the January 2023 BSI (2 day audit) The 2 Major were rectified and closed in May

2023. At the January 2023 audit 6 minor non-conformances were issued and work continues so that these can be closed at the 2024 Audit.

As to internal non-conformances a breakdown of the year by type is detailed below. These continue to be monitored and acted upon to ensure operational hospital activity is not compromised. Overall, the department had a conformance rate of 99.75% for the year.

2022-2023														
NC Category	Percentage of compliant Trays	April	May	June	July	August	September	October	November	December	January	February	March	Total 22-23
Torn Wrap	99.91%	16	2	12	1	11	8	7	7	10	20	6	6	106
Contaminated	99.97%	2	0	0	0	5	2	4	9	2	3	3	2	32
Missing Item	99.90%	1	6	6	16	13	10	11	13	9	11	13	10	119
Extra Item	99.96%	0	4	4	5	3	0	4	3	6	8	8	3	48
Wet Set	99.97%	1	4	5	2	1	1	2	6	0	9	5	3	39
Wrong Item	99.98%	1	2	2	1	4	1	2	3	0	2	2	2	22
Tracking Error	99.997%	0	0	0	0	0	0	0	3	0	0	0	0	3
Sterility	99.99%	0	0	0	1	0	4	1	0	0	1	1	0	8
Damaged Item	99.997%	0	1	1	0	0	0	0	0	0	2	0	0	4
Assembly	99.99%	0	0	0	0	1	2	0	1	0	0	1	1	6
Label Issue	99.999%	0	0	0	0	1	0	0	0	0	0	0	0	1
Checklist Mistake	99.99%	0	0	0	0	3	1	1	0	0	1	0	1	7
Other	99.997%	0	1	0	0	0	0	0	0	1	0	1	1	4
Total Complaints per Month	99.75%	21	20	30	26	42	29	32	45	28	57	40	29	399
Tray Set Production		8832	10400	9607	8971	9501	9781	9958	10392	9890	9667	8969	10060	115418
Total Production		12197	13981	13094	12158	12912	13413	13410	14314	12544	13277	12399	14136	157835
% of Non-conformances		0.17%	0.16%	0.21%	0.20%	0.35%	0.22%	0.24%	0.34%	0.20%	0.45%	0.30%	0.23%	0.25%

The Trusts Decontamination stakeholders endeavour to work closely with the Surgical and Theatre teams to improve upon the Key Performance Indicators.

Surgical instrument decontamination activity between April 2022 and March 2023 is detailed below.

Month	April	May	June	July	August	September	October	November	December	January	February	March	Total to date
Scopes	123	126	140	113	121	137	127	121	147	135	142	166	1618
Instrument Packs	326	350	361	348	355	358	375	334	313	336	362	337	4055
Singles	2516	3105	2886	2726	2645	3137	2950	3497	2854	3139	3026	3573	36544
Tray Sets	8832	10400	9607	8971	9501	9781	9958	10392	9890	9667	8969	10060	115418
Total Production	12197	13981	13094	12158	12912	13413	13410	14314	12544	13277	12399	14136	157835

Flexible scope activity between April 2022 and March 2023 is detailed below. This activity was previously impacted upon by the COVID-19 outbreak, but we have begun to increase as activity increases.

4.8 Water Safety

The Water Safety Group (WSG) is a subcommittee of the COIC. The Group formulate and monitor the effectiveness of management policies and procedures including the Trust Water Safety Policy HS14 and Written Scheme of Control.

The North Bristol Trust site operates as two operational management sections with regards to water safety, i.e., the NBT owned and managed buildings and the Brunel building which a Private Finance Initiate (PFI) managed by The Hospital Company and the Services Provider, Bouygues.

As a result, there is designation of two Responsible Persons (RP) for water safety. North Bristol NHS Trust is the Duty Holder for the whole Estate and secures the services of an Authorising Engineer/Independent Advisor. Retained estate relates to NBT owned and managed buildings.

Heatwave plan enacted alongside Emergency planning team increasing flushing in retained estate with plans to look at remote monitoring of areas of less use.

4.8.1 Legionella

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

In accordance with the Approved Code of Practice (HSE L8) NBT has in place the necessary programmes to monitor the effectiveness of the written scheme of control, and the risk is minimised by ensuring that hot and cold-water systems are maintained at the correct temperatures, and that no stagnation occurs in the water distribution systems.

There have been no significant issues with Legionella in either retained estates or Brunel building in 2022 23. When routine water monitoring has identified sporadic low-level count of legionella species, remediation of the outlet has promptly resulted in a repeat negative count in the outlet.

IPC have actively advised on appropriateness of outlet filters, as required for outlets pending remediation and retesting to always ensure patient safety. Monitoring and review of routine and adhoc water testing results is ongoing.

4.8.2 Pseudomonas aeruginosa

Following outbreaks of *Pseudomonas aeruginosa* infection in neonatal units in Wales in 2010 and Northern Ireland in 2011, the Department of Health issued its first guidelines on minimising the risk of Pseudomonas aeruginosa infection.

A revision of the guidance was published in 2016 and the earlier guidance is now embedded in the revised document.

Appropriate monitoring of augmented care water systems has continued during 2021 22 and is overseen by the Trusts Water Safety Group and Control of Infection Committee. IPC have actively advised on issues relating to water temperatures which were outside acceptable safe range for cold water, outlets which have cultured *pseudomonas aeruginosa* on routine testing and the risk and mitigation of contamination from water in isolated flooding events in clinical areas

4.8.3 Ventilation Safety

The Ventilation Safety (VSG) group monitor the effectiveness of management policies and procedures including the Trust Ventilation Safety Policy HS04.

It reviews appropriateness of ventilation in defined clinical areas (wards, outpatients, theatres, radiology, ED) and has led review and policy for ventilation adaptations required to prevent transmission of COVID-19 in clinical and non-clinical areas in the last 3 years.

There are several risks in ventilation currently on the trust risk register .these risks are in the retained estate and are centred around WACH and relate to an aging ventilation system. These risks are managed by facilities and have regular reviews at risk management and ventilation steering committee

Critical Ventilation

Critical Ventilation system as defined in HTM 03 are required to be verified every year. The verification focuses on air change rates (dilution), clean air pathways and pressure regime.

Approximately 45% of the Trusts Ventilation systems are deemed Critical. Any deviation from agreed standards is classified as Immediate (whereby VSG quorate will be called and Divisional teams notified) or non-immediate which are logged and completed within 6 months or sooner

Chapter 5: IPC PROJECTS

5.1 IPC - Strategic Projects

The Infection Control Team play an important role in implementation of new technologies, projects and work that have a direct or indirect effect on patient care.

These have included -

- Stryker Neptune – theatre waste management systems
- Magseed Breast Probe – application of sheaths for probes
- Vanguard re purposing single use devises – working with Sustainability
- PreCISSIon – prevention of SSI post caesarean section
- Ceiling air purification devises in Elgar house
- Implementation of trust wide soap and emollient change to promote hand health as well as hand hygiene

Conclusion

Infection prevention and control is the responsibility of all clinical and support staff employed by NBT and is fundamental when delivering the vision and values and standards. Clinically effective and relevant IPC practice is an essential feature of patient protection.

2022/2023 has been another busy year for all of our staff, with the operational pressures placed upon the organisation by the continuing SARSCoV2 pandemic and Influenza; The trust has strived to maintain infection prevention improvements, supporting teams to operationalise guidance changes and ensure bed closures are kept to the minimum.

The improvements made continue to demonstrate our positive culture of learning and improvement and our commitment to harm free care including the reduction in avoidable healthcare associated infections. This is demonstrated in the steering groups managing mandatory reported infection

Eliminating avoidable healthcare associated infection has remained a top priority for the public, patients, and staff.

In response, a robust annual programme of work has been implemented over the last year which has been led by the Infection Prevention and Control Team, supported by colleagues at all levels within the organisation and our Commissioning partners and working with staff and leaders from across our healthcare economy to support further development of patient safety across BNSSG.

Infection Prevention and Control is the responsibility of all Trust staff and the Infection Prevention and Control Team do not work in isolation. The considerable successes over the last year have only been possible due to the commitment for infection prevention and control that is demonstrated at all levels within the organisation.

Looking to 2023- 2024 Maintaining motivation and engagement of clinical and non-clinical staff ensuring that “Infection Control is everybody’s responsibility”

- Support to divisions from IPC team, with allocation of a named IPCN to divisions
- Increase education and prevention of infection work
- Continue to support divisional COICs and divisional governance with highlight reports reporting to trust wide COIC
- Continue collaborative working with ICS and regional networks
- Working with Facilities team to provide assurance from Efficacy audits related to National Cleaning standards
- SSI work in WACH, Vascular and Colorectal Surgery - Precision study
- Hydration projects and reduction in UTIs – Continuance group
- Support cross city infection control practice strengthening links with UHBW IPC – ICB
- Continue work to reduce MSSA BSI and *C difficile* infection rates
- Anticipate and monitor extremely resistant organisms in patients arriving at NBT directly or indirectly from healthcare outside

Infection Prevention and Management Annual Plan 2023/24

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Ratified by :	Control of Infection Committee
Date Ratified:	2nd October 2023
Version:	1

Related Policies and Guidelines:	All IPC policies

1. Summary

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

The provision of a robust IPC programme is an essential element of ensuring that patient safety objectives are achieved. Health care associated infections (HCAIs) can be significantly reduced by using sound IPC measures and a committed approach to learning.

This document outlines the roles and responsibilities of key individuals for delivery of the Programme and recognises that all Trust staff have a duty to comply with IPC policies and the Hygiene Code (The Health and Social Care Act 2008. Code of Practice on the prevention and control of infections and related guidance. Department of Health 2015).

2. Purpose

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

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

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

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

6. Systems to ensure that all care workers (including contractors and volunteers) are aware of and discharge their responsibilities in the process of preventing and controlling infection.
7. Provide or secure adequate isolation facilities.
8. Secure adequate access to laboratory support as appropriate.
9. Have and adhere to policies, designed for the individual's care and provider organisations that will help to prevent and control infections.
10. Providers have a system in place to manage the occupational health needs and obligations of staff in relation to infection.

3. **Programme Objectives**

3.1 The Trust will have IPC policies in place, which reflect national policy, statutory requirements, latest guidance and local need.

- All policies are written in consultation with expert clinicians

All policies are ratified by the Trust's approved process

3.2 The Trust will have a robust IPC infrastructure in place, which will include clear organisational responsibilities, training and development linked to defined competencies, support and advice and performance monitoring. This is delivered through:

- The IPC Plan
- Job descriptions and appraisals
- Education of IPC Team in Msc Modules
- IPC training – induction and Mandatory training and updates for all clinical staff
- The IPC Nurses, Infection Control Doctor and Medical Microbiologists
- Surveillance of infections and Prevention of infection

3.3 The Trust will have appropriate and effective IPC systems and processes in place including:

An annual IPC work plan including identification of priorities for action to meet the needs of the organisation and ensure the safety of service users, provision of evidence that relevant policies have been implemented to reduce infections and reporting of progress against objectives of the programme in the annual IPC report. This document also forms the IPC assurance framework.

The integration of IPC within the business planning process with evidence of the inclusion of IPC within local business plans.

The systematic review of infection risks to ensure they are identified, recorded, assessed, analysed and associated risk reduction strategies implemented where possible.

A process for reporting adverse events, outbreaks or failure to adhere to infection control policies. This process will utilise internal incident reporting

systems and reporting of Serious Incidents related to health care associated infections externally.

24/7 provision of reactive IPC advice through IPCT with out of hours support from the Medical Microbiologists following consultation and working with Winter plan this will extend to a 7 day working week for the IPC team.

Commissioning of new or altered premises and buildings in order to ensure that the principles of IPC are adhered to.

Processes for medical equipment and product review prior to purchase and / or change of use. The Infection Prevention and Control Team (IPCT) are involved with providing advice on the decontamination of new equipment and products.

Robust and accessible outbreak and major outbreak plans.

The development of key performance indicators based upon national, regional and locally defined outcome measures.

An explicit reference to IPC responsibilities in all Trust staff job descriptions, which are reviewed at appraisal.

An antimicrobial policy that is reviewed and audited regularly. Audit data must be reported back to prescribers and must also be incorporated into patient safety reporting systems led by the Trust AMR subgroup.

Effective and efficient communication within the Trust and with appropriate external agencies.

Effective links with key departments such as Occupational Health, Health and Safety, Estates and Facilities.

Ensure that Care Quality Commission registration is maintained by meeting the requirements of the Hygiene Code.

3.4 A collaborative working relationship with local ICBs to ensure that commissioning intentions are clear and that local targets are agreed.

4. Organisational aims and aspects for improvement

Trajectories 2023/24

C Diff	E Coli	Pseudomonas	Klebsiella	MRSA	MSSA
75	73	10	29	0	30

Clostridium Difficile

Nationally and regionally cases have increased however in NBT we have noted a 20% reduction in year 2022/23.

The learning from this has been extended into this years plan and shared within the region and national working groups.

Prevention of Transmission- IPC risk assessment, Early identification, Stool sampling, environmental / equipment cleaning and antibiotic stewardship.

Education and training- Focused training with Link ambassadors Ribotyping each case, SWARM analysis and review, understanding testing limitations.

Monitoring and Audit - Divisional COIC HCAI Reporting, Saving lives audit, C. difficle Steering Group

Staph aureus

Target remains to reduce Blood stream infections caused by Staph aureus. This has become the HCAI requiring the most focus this year with the requirement to put in place robust MSSA reduction plans.

Prevention of Transmission – Completion of IPC risk assessment on admission, Commence of topical decolonisation, best practice line insertion, line care, Isolation and PPE / Hand hygiene, use of PICC lines for lengthy IV therapy

Education and training – Link ambassador training programme have recommenced, ANTT trust wide has been adopted through the whole trust

Monitoring and Audit - Divisional COIC, Staph Aureus Steering Group

Gram Negative

Target has previously been to reduce by 10% - there was a reduction last year at this level. Additional working with Continence Group focusing on hydration and the use of decaffeinated products across the Trust.

Prevention of Transmission – Risk assessment, best practice linked to catheter insertion and management, Catheter care plan, hydration of patients

Education and training – Link Ambassador Training Programme, Antimicrobial Stewardship, Divisional support at COIC

Monitoring and Audit – HCAI mandatory reporting, Saving Lives Audit, IPC audit compliance

CPE

Focus on Prevention of Infection and increased education linked with operational management regarding management of repatriations. - Screening prior to accepting pts.

Screening and education via Link Nurse practitioners, IPC / saving Lives Audit

Training to divisions and Operations team to understand risk assessment.

5.Key Challenges

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

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

6. Programme Delivery

The programme will be delivered through:

- IPC policies: these are based on national best practice guidance and performance against the policies and is monitored through a clinical audit programme

- Trust business planning processes: IPC issues must be considered in business plans and advice sought from the IPCT if required
- Training and education; the IPCT provide training for all new and existing staff.
- Board Directors leadership: the Programme is approved by Trust Board and the delivery is supported and overseen by members of the Executive Team
- The IPCT; delivering the IPC work plan which includes the audit programme
- The IPCT will collaborate with the Divisional Surgical Site Surveillance Team as part of SSI monitoring adding in Precision BNSSG plan to WACH
- The Trust Divisions: Divisional Senior leadership teams are responsible for divisional performance against the prevention and control of HCAI
- Divisional Control of Infection groups with terms of reference that include antimicrobial stewardship, review of incidence and quality metrics.
- Local and Trust performance management; performance against HCAI trajectories are reported through the Trust key performance indicators, and Trust IPR
- All Trust staff have a responsibility to adhere to IPC policies in order to reduce the occurrence of HCAI

7. Definition of terms

ICB – Integrated Care Board
IPC – Infection Prevention and Control
HCAI – Health care associated infection
MRSA – Methicillin resistant *Staphylococcus aureus*
WACH – Women's and Children's Division

8. Duties and Responsibilities

8.1 **Chief Executive**

The Chief Executive accepts on behalf of the Trust Board ultimate responsibility for all aspects of IPC within the Trust.

8.2 **Director of IPC (DIPC)**

The DIPC has lead executive director responsibility for IPC and will delegate local operational responsibility to the Divisional Senior Leadership Management team.

The key roles of the DIPC are to:

Provide an oversight and assurance on infection prevention (including cleanliness) to the Trust Board.

Be responsible for leading the organisation's IPCT.

Ensure there are governance structures in place to provide assurance regarding effective management and performance for infection prevention and control.

Oversee local prevention and control policies and their implementation.

Be a member of the IPCT.

Have the authority to set and challenge standards of cleanliness.

Overseeing antimicrobial stewardship within the Trust.

Assess the impact of all existing and new policies on infections and make recommendations for change.

Be an integral member of the organisation's clinical governance, water safety group and patient safety teams and structures.
Produce an annual report to Public Board.

8.3 **Chief Nursing Officer**

The Director of Nursing and Quality will support the DIPC in the implementation of the Programme.

8.4 **Chief Finance Officer**

The Finance Director will ensure that resources are available to finance the management and control of outbreaks of infection effectively and efficiently.

8.5 **Director of Estates and Facilities**

The Director of Estates and Facilities will ensure that:

Timely, efficient and effective communication systems are in place to alert the IPCT to forthcoming developments, refurbishments and at all stages of construction, including the final commissioning of new or upgraded facilities and any other activity likely to have impact on infection control and prevention.

The Trust's nominated board level lead for cleanliness is the Directorate of Estates and Facilities who together with the DIPC will ensure that appropriate systems and processes are in place to achieve high standards of cleanliness.

The Director will also ensure close liaison regarding environmental screening, e.g. water sampling for Legionella and Pseudomonas. The Director is also the lead for decontamination and waste management.

The strategic cleaning plan supported by the operational cleaning plan will enable the Trust to achieve compliance with all relevant legislation and guidance and fits within the Trust's organisational governance and risk management frameworks.

The Trust is committed to demonstrating that its healthcare premises are clean and that risks from inadequate or inappropriate cleaning have been minimised.

8.6 **Infection Control Doctor**

The Infection Control doctor (ICD) will work closely with the IPCNs, providing advice and assistance to all Trust employees and appropriate committees in respect of infection prevention and control measures, including direct activity in response to outbreaks with Lead IPCN.

They will advise and support the IPCNs and provide expert advice to the DIPC in day-to-day activities and serve as a specialist adviser on all matters relating to infection and microbiology and hospital infection prevention and control.

The ICD will also assist with the review of root cause analysis investigations relating to HCAI and liaise with the Lead for antimicrobial stewardship on actions regarding antimicrobial stewardship.

8.7 **Head of Infection Prevention and Control**

Works closely with the ICD to coordinate and direct the IPC strategy in the Trust.

Responsibility for the operational management of the IPC programme within the Trust.

Produce the Trust IPC Annual Report, the IPC programme, IPC policies and the annual IPC work plan with the, DIPC Dep DIPC.

Manages the IPCT.

Directs on the development, review and communication of IPC key performance indicators.

To advise the DIPC.

Liaison with HCAI lead within CCG and NHSE/I.

8.8 **Deputy Chief Nurse (Deputy DIPC)**

The Deputy Director of Nursing and Quality supports and Deputises for the Trust DIPC in the implementation of the Programme.

8.9 **Infection Prevention and Control Team (see Appendix 2)**

The IPCT will provide a clinical infection control advice service as per the IPC work plan and support Trust staff in the delivery of the IPC programme.

They are also responsible for delivering information to the public on IPC matters by providing leaflets and other written information relating to specific infections.

The team also issue data relating to performance against the HCAI targets which is available to the public.

8.10 **Divisional Senior Leadership Teams**

Have the responsibility of assisting the DIPC in their role in relation to infection prevention and control.

They also have the responsibility for local performance management within their division and remit.

Are responsible for reporting HCAI performance to the Trust Control of Infection Committee and providing assurance that the required actions have been taken to reduce harm to patients.

Have responsibility for Divisional IPC performance and will receive HCAI key indicator data via the Trust governance framework to support this process.

8.11 **Antimicrobial Stewardship Lead (Consultant Microbiologist)**

The Antimicrobial Stewardship lead is responsible for :

Assessing the Trust's antimicrobial stewardship activities against the Tackling antimicrobial resistance 2019–2024 (DH2019) and *Start Smart Then Focus* Antimicrobial Stewardship Toolkit.

Developing an action plan in order to provide assurance to the Trust Board of safe, effective and appropriate antimicrobial prescribing
Chairing the Antimicrobial Stewardship Committee working closely with the antimicrobial pharmacist.

Developing evidence-based antimicrobial prescribing guidelines
Ensuring that mandatory core training in prudent antibiotic use is delivered to doctors, pharmacists and nurses.

Training must cover those antibiotics that are linked to Clostridium *difficile* infection.

Provide support to steering groups to investigate infections.

8.12 **Antimicrobial Pharmacist**

Antimicrobial pharmacist will assist the Antimicrobial Stewardship lead to deliver the stewardship programme as outlined in Tackling antimicrobial resistance 2019–2024 (DH2019) and *Start Smart Then Focus.*

They will be responsible for managing an ongoing programme of audit and feedback to provide assurance on antimicrobial stewardship.

8.13 **Clinical Matrons**

Matrons are key role models for exemplary IPC practice and have responsibility and accountability for delivering a clean and safe care environment by maintaining standards of infection control practice within their designated clinical areas.

They are also responsible for overseeing environmental audits in their areas, ensuring that equipment, e.g. commodes, are clean and working in partnership with Facilities staff on maintenance and cleanliness issues.

8.14 **All Staff**

All staff have a responsibility:

To comply with Trust IPC policies and procedures
To attend mandatory training, including induction training, as specified in the Mandatory training matrix
To attend or undertake other training sessions appropriate to their role. i.e. ANTT training, infection control e-learning, teaching sessions for staff in specific roles e.g. cleaning and Portering staff
To remind and challenge colleagues of their infection control responsibilities if there is a potential or actual breach of policy

9. Assurance Framework

9.1 **Trust Board**

The Trust Board is responsible for ensuring that the Trust has appropriate IPC systems and resources in place to enable the organisation to deliver its objectives and statutory requirements, demonstrating that IPC is an integral part of clinical and corporate governance.

The Trust Board receives and formally approves the Trust IPC programme and the IPC Annual report; both of which are a requirement of the Hygiene Code. The annual IPC report provides performance information from the preceding year and highlights any outstanding actions that need to be addressed during the following year.

9.2 **Trust Management Team**

Reviews local performance outcome measures via the Divisional performance framework leads. This is done monthly through reports to the Board, divisional meetings and quarterly divisional governance meetings.

9.3 **Trust Quality and Risk Management Committee (QRMC)**

The QRMC is an assurance committee. The role of the Committee is to ensure that all clinical risks within the Trust are appropriately identified, assessed and managed.

The Committee:
Receives and monitors IPC key performance indicator reports on a quarterly basis
Receives evidence of appropriate action being taken to deal with occurrences of infection, including root cause analysis investigation if appropriate

Considers any areas of concern and areas of risk for inclusion on the Trust-wide Risk Register and brings these to the attention of the Board

9.4 **Control of Infection Committee (COIC)**

The purpose of this Committee is to provide assurance that IPC standards at North Bristol Trust are compliant with The Health and Social Care Act 2008 Code of Practice

on the prevention and control of infections and related guidance (2015). For Terms of Reference see Appendix 1.

Approves and disseminates reports to members of the Committee, e.g. the DIPC Report, the IPC work plan, reports on performance against HCAI thresholds, audit reports and recommendations.

Monitors performance against HCAI mandatory reporting. The performance is reviewed bi-monthly and actions for improvements are agreed with the divisional representatives.

Review results from IPC audits. Actions are identified from these reports and divisional representatives / matrons ensure that these are carried out. Action taken is reported back to the Committee.

Receives information; policies and documents for consultation; review and dissemination.

Receives assurance from the IPC Committee members' progress with implementation of policies and documents.

Participates in the development of, approves and monitors progress with the IPC work plan.

Reviews the effectiveness of IPC policies through the annual audit programme.

Receives and reviews the annual IPC report.
Reviews reports of outbreaks of infection and makes recommendations.

Identifies risks to the Trust IPC programme as raised by members or through Divisional/Speciality reports to COIC

10 Procedural Documents

The Trust's IPC policies will be unambiguous and accessible to all staff. The Trust will have in place the core clinical care policies and those pertinent to the environment (Facilities in line with the requirements of the Hygiene Code).

IPC policies are linked to the National Infection Prevention and Control Manual for England. Infection Prevention and Control Manual for England

The Trust will ensure that IPC policies are in place and that all trust staff have the correct levels of expertise to undertake their infection control related activities in a competent manner, as identified in their job description and reviewed at appraisal.

11 Monitoring Compliance

The Trust's processes for monitoring HCAI will incorporate both proactive and reactive monitoring systems, including key performance indicators, performance outcome reviews and investigation of incidents and complaints.

The Trust Board will evaluate the effectiveness of IPC systems annually through the annual Director of IPC Report and work plan.

The Trust will also utilise the following to support performance review and monitoring of performance, and to provide assurance regarding compliance with regulatory requirements and national guidance:

Divisional performance reports relating to infection prevention and control.

Incidents relating to HCAI will be reviewed by the Control of Infection Committee, to identify trends and areas of non-compliance with the relevant IPC policies. Areas of risk will be incorporated into the group plan of work.

HCAI Improvement programmes antimicrobial stewardship via Antimicrobial Stewardship group and representation at COIC.

Audit reports and results.

Other reports and publications as applicable, for example Care Quality Commission reports.

Achieving compliance with the relevant domains for the CQC including the Hygiene Code – using Self-Assessment tool (NHSI).
Monitoring attendance on the IPC component of the Induction and Mandatory training programmes (Training and Development reports).

Annual Patient-Led Assessment of the Care Environment (PLACE) inspections. These inspections are led by the Facilities team.

12 HCAI National Targets

Patient safety is the primary objective for the Trust. Reducing the prevalence of health care associated infections is key in ensuring that patients are not harmed and for the local community to have confidence in the safety of their hospital. National targets have helped to focus on where improvements need to be made and this in turn has brought about a reduction in HCAI.

There is a mandatory requirement to report all cases of MRSA, MSSA, Gram negative (*Klebsiella, Pseudomonas aeruginosa* and *E.coli)* bacteraemia (blood stream infections) and *Clostridium difficile* infection to Public Health England.

The Trust reports performance against these thresholds to the public via the Trust Board and information on HCAI rates for each organisation is available via the Public Health England website.

12.1 **MRSA**

There is a zero-tolerance approach to MRSA bacteraemia. Mandatory reporting of all cases of MRSA bacteraemia is carried out according to National guidelines.

A post infection review (PIR) is undertaken for all 'Trust acquired' MRSA bacteraemia cases (blood culture taken on or after day 2 of admission) and an action plan developed to address any issues which may have caused or contributed to the patient acquiring the infection.

Those cases outside of this timeframe are reported to the BNSSG Commissioning team who complete the PIR.

12.2 ***Clostridium difficile***

NHS England sets a threshold for reduction of cases in the annual *Clostridium difficile* Objective. Cases reported by the Trust fall into two categories. Hospital onset healthcare associated (HOHA): cases that are detected in the hospital two or more days after admission.

Community onset health care associated (COHA): cases that occur in the community (or within two days of admission) when the patient has been an inpatient in the trust reporting the case in the previous four weeks.

Clinical reviews for the above cases will be carried out using a multi-disciplinary approach to determine whether there are links to any lapses in care related to the care and treatment of the patient.

Upward reports are then submitted with theme discussions to the ICB BNSSG.

12.3 **MSSA bacteraemia**

Mandatory reporting of all cases of Methicillin Sensitive *Staphylococcus aureus* (MSSA) bacteraemia forms part of the HCAI CCG contractual obligation.

A root cause analysis is undertaken for all 'Trust acquired' MSSA bacteraemia cases (blood culture taken on or after day 2 of admission) and an action plan developed to address any issues which may have caused or contributed to the patient acquiring the infection.

Collaboration with regional and national MSSA reduction plans as well as DRIPP (Device Related Infection Prevention Practices) to improve practice and reduce infection.

12.4 **Gram-negative bacteraemia**

E coli, Klebsiella sp and *Pseudomonas aeruginosa* bacteraemia are now included in mandatory surveillance reporting.

The overall ambition is to continue work to halve healthcare associated Gram-negative BSIs, adopting a systematic approach to preventing infections.

The work to achieve the reduction target is being led by the Clinical Commissioning Groups.

13. Training and Education

The IPCT provide training to all new and existing Trust staff. They are also responsible for ensuring that any contractors working on site in the clinical environment receive information on how they can reduce the risk of infection either by protecting themselves or patients in the area.

13.1 **Induction**

IPC Training is provided for all new staff through the following programmes:

Corporate Induction all new Trust employees
Induction training for junior doctors and specialist registrars
Induction training for all new doctors joining NBT – all grades
Consultant training from IPC doctor and Head of Service

13.2 **Mandatory training**

Mandatory training is delivered in line with the Trust Training Matrix. All clinical staff must attend an IPC training session every two years.

Mandatory training is delivered through LEARN/face-to-face training

Attendance is recorded and monitored as per the Mandatory Training Policy.

13.3 **Other training**

Other training sessions on IPC are delivered to:

IPC Link Ambassadors, training sessions in the form of a study day linked to specific topics
Medical and Nursing Staff, e.g., Aseptic Non-Touch Technique
All clinical staff: e.g. PPE and hand hygiene training.

Training on the control and prevention of specific infections is also provided when required, e.g., Influenza, Measles, disease of high consequence, CPE.

Additional training for hand hygiene awareness day, IPC week and adhoc organisms delivered as required.

14. Communication

Successful delivery of the Plan will require clear, strong and effective communication. This will need to be at all levels within the organisation.

Executive and non-executive directors are required to support the Programme and seek assurance regarding progress of its delivery at Trust Board.

The senior leadership management teams, matrons and other senior clinical are aware of the Programme and ensure that staff are aware of their responsibilities. The Programme will be available internally and externally via the intranet and external website.

Additionally, communication with Facilities teams and Comms team are integral to delivery of the Plan

The IPCT are integral to the successful communication, delivery and review of the programme and will be responsible for:

- Providing support and guidance to assist with compliance
- Identifying and reporting areas of non-compliance
- Identifying and alerting the Trust to changing priorities if and when necessary

14.1 **Communication with stakeholders**

The IPC Programme is presented to the Trust Board (public meeting) and will be available on the Trust website.

The Programme will also be shared with the BNSSG Commissioning team HCAI leads and with other local IPC leads.

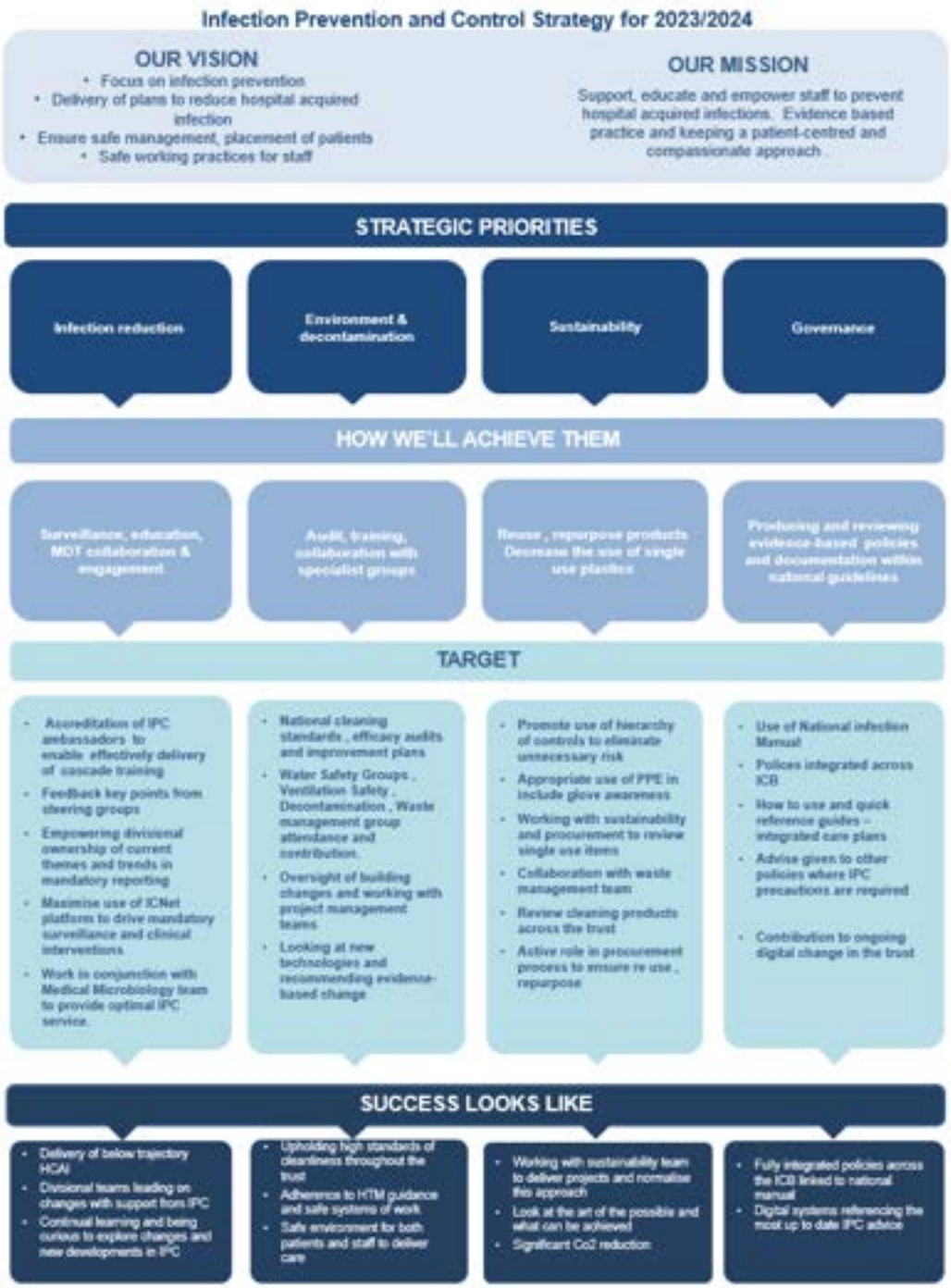
15. Review

This document will be subject to a planned review every 3 years as part of the Trust's Policy Review Process.

It is recognised however that there may be updates required in the interim, arising from amendments or release of new regulations, Codes of Practice or statutory provisions or guidance from NHS England or professional bodies.

These updates will be made as soon as practicable to reflect and inform the Trust's revised policy and practice.

Appendix 1


Infection Prevention and Control Strategy for 2023/2024
OUR VISION
• Focus on infection prevention
• Delivery of plans to reduce hospital acquired infection
• Ensure safe management, placement of patients
• Safe working practices for staff
OUR MISSION
Support, educate and empower staff to prevent hospital acquired infections. Evidence based practice and keeping a patient-centred and compassionate approach
STRATEGIC PRIORITIES
Infection reduction
Environment & decontamination
Sustainability
Governance
HOW WE'LL ACHIEVE THEM
Surveillance, education, MDT collaboration & engagement
Audit, training, collaboration with specialist groups
Reuse , repurpose products Decrease the use of single use plastics
Producing and reviewing evidence-based policies and documentation within national guidelines
TARGET
• Accreditation of IPC ambassadors to enable effectively delivery of cascade training
• Feedback key points from steering groups
• Empowering divisional ownership of current themes and trends in mandatory reporting
• Maximise use of ICNet platform to drive mandatory surveillance and clinical interventions
• Work in conjunction with Medical Microbiology team to provide optimal IPC service.
• National cleaning standards , efficacy audits and improvement plans
• Water Safety Groups , Ventilation Safety , Decontamination , Waste management group attendance and contribution.
• Oversight of building changes and working with project management teams
• Looking at new technologies and recommending evidence-based change
• Promote use of hierarchy of controls to eliminate unnecessary risk
• Appropriate use of PPE in include glove awareness
• Working with sustainability and procurement to review single use items
• Collaboration with waste management team
• Review cleaning products across the trust
• Active role in procurement process to ensure re use , repurpose
• Use of National infection Manual
• Polices integrated across ICB
• How to use and quick reference guides – integrated care plans
• Advise given to other policies where IPC precautions are required
• Contribution to ongoing digital change in the trust
SUCCESS LOOKS LIKE
• Delivery of below trajectory HCAI
• Divisional teams leading on changes with support from IPC
• Continual learning and being curious to explore changes and new developments in IPC
• Upholding high standards of cleanliness throughout the trust
• Adherence to HTM guidance and safe systems of work
• Safe environment for both patients and staff to deliver care
• Working with sustainability team to deliver projects and normalise this approach
• Look at the art of the possible and what can be achieved
• Significant Co2 reduction
• Fully integrated policies across the ICB linked to national manual
• Digital systems referencing the most up to date IPC advice

17 References

Department of Health (2015). The Health and Social Care Act 2008. *Code of practice on the prevention and control of infections and related guidance.* Available from: https://www.gov.uk/government/publications/the-health-and-social-care-act-2008-code-of-practice-on-the-prevention-and-control-of-infections-and-related-guidance Accessed 1 August 2022

NHS Improvement (2019) Clostridium *difficile* infection objectives for NHS organisations in 2019/20 and guidance on the intention to review financial sanctions and sampling rates from 2020/21 https://improvement.nhs.uk/documents/808/CDI_objectives_for_NHS_organisations_in_2019_12March.pdf

Department of Health (2019) Tackling antimicrobial resistance 2019–2024 The UK's five-year national action plan https://www.gov.uk/government/publications/uk-5-year-action-plan-for-antimicrobial-resistance-2019-to-2024

NHS Improvement and Public Health England (2017) Preventing healthcare associated Gram-negative bloodstream infections: an improvement resource. Available from: https://improvement.nhs.uk/uploads/documents/Gram-negative_IPCresource_pack.pdf Accessed 1 August 22

Public Health England (2017). Start Smart – Then Focus. Antimicrobial Toolkit for English Hospitals. Available from: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/417032/Start_Smart_Then_Focus_FINAL.PDF Accessed July 2022

Report To:	Public Trust Board			
Date of Meeting:	30 November 2023			
Report Title:	Patient Safety Incident Response Plan			
Report Author:	Ashley Windebank-Brooks, Head of Patient Safety and Patient Safety Specialist			
Report Sponsor:	Tim Whittlestone, Chief Medical Director Joydeep Grover, Deputy Medical Director and Patient Safety Specialist			
Confidentiality (tick where relevant) *:	**Patient identifiable information?**	**Staff identifiable information?**	**Commercially sensitive information?**	**Other exceptional circumstances**
*If any boxes above are ticked, paper may need to be received in *private.*				
Purpose of the report:	**Approval**	**Discussion**	**Information**	**Assurance**
	x			
Recommendations:	The Board is asked to: - approve the draft Patient Safety Incident Response Plan and the associated safety priorities for 2023-2025. - support the priorities as improvement programs under Patient First (where this does not already exist)			
Report History:	A Patient Safety Incident Response Plan is in place for the Trust covering the period from 2021-2023. This proposal provides an update covering the next two years.			
Next Steps:	Following approval of this plan, it will be published on the Trust website for public view, and the plan will be implemented.			

Executive Summary

This plan provides an update to the Trusts Patient Safety Incident Response Plan.

This plan analyses the Trusts incident profile and identifies priorities for the next two years which will inform the continuation or development of patient first improvement programs.

Following analysis of our incident profile, the following priorities are recommended for adoption:

- Inpatient falls
- Medication
- Responding well to clinically changing conditions
- Patient Flow (focussing on the clinical connections between different parts of a patients journey through NBT)

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In proposing these themes as safety priorities, it is not to say there are other areas which are of equal importance for quality improvement and preventing harm, for example pressure ulcers. In proposing these themes, they represent topics that are not well understood by the trust in what human factors drive incidents within our systems and processes, or where there is not yet structured and well-defined improvement programs that is yet seeing evidence based changes. The plan also proposes our approach to a drive positive patient safety to anticipate and respond early to patient safety matters.		
Implications for Trust Improvement Priorities: *(tick those that apply and elaborate in the report)*	**Our Aim: Outstanding Patient Experience**	
	High Quality Care – *Better by design*	x
	Innovate to Improve – *Unlocking a better future*	
	Sustainability – *Making best use of limited resources*	x
	People – *Proud to belong*	x
	Commitment to our Community - *In and for our community*	
Link to BAF or Trust Level Risks:	Risk 1802 relates to the Trusts ability to respond to patient safety incidents to prevent them from reoccurring and embedding changes in our systems which should prevent future patient harm. This is due to variable quality and timeliness of patient safety incident reviews (for example SWARMS, After Action Reviews and Patient Safety Incident Investigations) which is not robustly identifying all relevant learning. In addition, the lack of a quality improvement function limits the ability to provide clinical teams with the skills to make changes because of incident learning, or to undertake trust wide improvement programs.	
Financial implications:	Not applicable	
Does this paper require an Equality, Diversity and Inclusion Assessment (EIA)?	Yes- an Equality Impact Assessment has been completed and is in the process of being approved.	
Appendices:	Appendices 1 - Patient Safety Incident Response Plan	

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1. Purpose

1.1 This paper presents an updated Patient Safety Incident Response Plan that proposes the Trust's safety priorities for the next two years and how we will respond to incidents to identify learning and influence change.

2. Background

2.1 The national Patient Safety Strategy was released in July 2019 with a commitment to continuously improve patient safety through building on two foundations of a patient safety culture and a patient safety system. To achieve this there are three strategic aims:

- improving understanding of safety by drawing intelligence from multiple sources of patient safety information *(Insight)*
- equipping patients, staff and partners with the skills and opportunities to improve patient safety throughout the whole system *(Involvement)*
- designing and supporting programmes that deliver effective and sustainable change in the most important areas *(Improvement).*

2.2 A key enabler of the Patient Safety Strategy is the implementation of the Patient Safety Incident Response Framework (PSIRF).

2.3 PSIRF replaces the previous Serious Incident Framework and sets out expectations for how trusts should identify and respond to incidents. It provides a range of requirements linked to training, engagement/involvement of patients and methods for understanding how incidents occur based on system thinking and human factors.

2.4 The Trust implemented the Patient Safety Incident Response Framework two years ago as an early adopter of PSIRF. A requirement of the framework is for providers to create a patient safety incident response plan that describes the profile of patient safety for the organisation (*insight*) and how they intend to respond to patient safety incidents to influence change (*improvement*).

3. Patient Safety Incident Response Plan 2023-2025

3.1 The proposed plan refreshes the priorities and approach to proportionately responding to patient safety events. The full plan is provided at Appendices 1.

3.2 Following analysis of our incident profile, the following priorities are recommended for adoption:

- Inpatient falls
- Medication
- Responding well to clinically changing conditions
- Patient Flow (focussing on the clinical connections between different parts of a patients journey through NBT)

3.3 The plan also proposes an advancement in our practice to trial divisional level safety priorities for Women and Childrens. The intention is to trial in this version of the plan and expand to all divisions in the 2025 update. The safety priorities are:

- Listening to Patients and Families
- Delays in Care

3.4 Since the first plan was adopted, the Trust has launched new objectives. This plan directly aligns to this through enabling improvement for high quality care and supporting sustainability through best use of resources.

3.5 In adopting this plan, the priorities are expected to translate into improvement programmes using Patient First methodologies. Monitoring delivery of these programmes would fall under the responsibilities of Patient Safety Committee with a quarterly update to Quality Committee providing an overview of patient safety activity along with trend analysis.

3.6 Currently the only priority which falls under Patient First is Responding well to clinically changing conditions.

3.7 The plan also describes the emphasis to drive proactive patient safety through developing culture, leadership, governance, and the use of data. The aim of this is to anticipate and prevent problems occurring in patient care.

4. Summary and Recommendations

4.1 This report gives an overview of the proposed patient safety priorities and provides a path for the continued focus on patient safety, and a proportionate response to incidents.

4.2 The Committee is asked to:

- approve the 2023-2025 Patient Safety Incident Response Plan.
- agree for the priorities falling under the Patient First programme as supported projects.

4.3 Oversight of the plan will be considered through Patient Safety Committee with quarterly update to Quality Committee on progression against the priorities and overview of the key trends and themes within patient safety incidents.

Patient safety incident response plan

Effective date: 1st November 2023

Estimated refresh date: 31st October 2025

	NAME	TITLE	SIGNATURE	DATE
Author	**Ashley Windebank-Brooks**	**Head of Patient Safety and Patient Safety Specialist**		**25/08/2023**
Reviewer	**Patient Safety Committee Members**	**Chief Nurse, Deputy Chief Nurse, Director of Quality Governance, Quality Improvement & Patient Safety Team member, Divisional Director of Nursing/Midwifery and Quality from each clinical Division, Senior Clinical Representative from each clinical division, nominated by each divisional management team, Associate Director of Pharmacy, Trust Solicitor/Deputy Claims Manager, Patient Partnership Representative**	**As per minutes of meeting**	**01/09/2023**
Authoriser	**NBT Board**	**NBT Board**		

Contents

Forword

Ensuring the safety and well-being of every patient is the cornerstone of any healthcare system, and it is with pleasure that I present this Patient Safety Incident Response Plan. In today's rapidly advancing medical landscape, our commitment to patient safety stands unwavering, fuelled by the collective efforts of compassionate healthcare professionals.

This Patient Safety Incident Response Plan reflects the commitment of our healthcare organisation to continuously improve our practices, prevent harm, and enhance patient outcomes. Within these pages, you will find a blueprint designed to foster a culture of safety, underpinned by evidence-based strategies, and the pursuit of excellence. Our Plan recognises that safety is not a solitary endeavour, but a collective responsibility shared by every member of our healthcare community.

In drawing together this plan we have reflected on the successes of the last two years. This updated version is a continuation of implementing PSIRF following our role as an early adopter within the NHS. In that time, we have developed our understanding of how to proportionately respond and utilise other ways to learn. For example, our recent thematic review of never events has received positive feedback across our region. While looking at our successes we have reflected on the areas we need to improve. The need to provide our staff with the right environment, skills to reflect and identify learning, and how to collaborate with patients and families through the safety processes are key parts informing the future of our work.

By emphasizing transparency, communication, and the active involvement of patients and their families, we aim to forge a partnership that places patient safety at the forefront of decision making, action and the future design of services. This document outlines how we will respond proportionately to safety incidents and ensure our resources are used in the best way possible, enabling the focus to be on the delivery of change.

As you engage with this Plan, I encourage you to embrace the principles of positive patient safety, consider its impact on your daily practice, and become an ambassador for what we are aiming to achieve. By doing so, we will collectively foster an environment where patients are confident in knowing they are receiving the safest, most compassionate care possible.

I extend my deepest gratitude to every member of our healthcare team, whose dedication and expertise support safe care. It is your unwavering commitment to the well-being of our patients that drives us forward and serves as a beacon of hope for those we are privileged to serve.

I hope this Patient Safety Incident Response will function as a catalyst to inspire a culture of curiosity, and continuous improvement, where patients and our staff work together for the betterment of the NHS.

Tim Whittlestone
Medical Director
North Bristol Trust
July 2023

Introduction

We are delighted to present our second Patient Safety Incident Response Plan for North Bristol NHS Trust (NBT).

This patient safety incident response plan sets out how we intend to respond to patient safety incidents over the next of 12 to 18 months, building on the work as an early adopter and implementing the new patient safety framework over the last two years.

The Patient Safety Incident Response Framework (PSIRF) sets out a renewed focus on learning and improvement, with the emphasis placed on the system and culture that support continuous improvement and patient safety management. The underpinning principles of PSIRF is recognising a proportionate approach to responding when incidents occur, utilising a data-driven approach which prioritises engagement with those affected, and the need to embed a system view of learning that considers every aspect of how healthcare services are delivered when incidents are identified.

Our Patient Safety Incident Response Plan is one part of delivering the overall vision for North Bristol NHS Trust by delivering outstanding patient experience that puts the patient first.

Through adoption of this plan, PSIRF aligns to our strategic objectives and priorities through figure 1. This strategy embraces continuous improvement, which we call our 'Patient First approach'. This approach focuses deeply on a small number of Improvement Priorities, developing improvement capability across the organisation, and living our NBT Values through our behaviours.

Over the last two years we have developed our understanding and insight to patient safety. Our journey is an ongoing one where we will

adapt and adopt new ways to understand how our systems function. In adopting this plan, we will remain flexible and consider the specific circumstances in which patient safety issues and incidents occurred and the needs of those affected.

Fig 1: PSIRF Alignment to North Bristol NHS Trust Strategy	
Improvement Priority	**PSIRF Alignment**
High Quality Care: Better by Design	PSIRF is all about patient safety which is integral to quality. In applying systems thinking to our patient safety practice, this will improve how we understand variation in delivering care and influence the development of new ways to provide services for patients.
Sustainability: Making best use of our limited resources	Through utilising PSIRF we look at improvement to maximise the potential of available resources.
People: Proud to Belong	Through creating psychological safety, trust and adopting a just culture, we will empower our staff to reflect with openness, improve resilience and create satisfaction through influencing tangible change to their work areas.
Commitment to our Community: In and for our community	PSIRF advocates a closer relationship with those affected by patient safety to listen and engage them actively in learning.

Our services

NBT is a centre of excellence for health care in the Southwest as one of the largest hospital trusts in the UK with tertiary specialist services and district general services. Our commitment is that each patient is treated with respect and dignity and, most importantly of all, as a person.

NBT is a complex system with many interrelated components that are crucial to ensuring that everything works. We have reviewed all patient safety activities and our network of key stakeholders across NBT who are integral to the Patient Safety agenda.

This Trust has 7 Corporate Directorates. The central Patient Safety Team works alongside the Patient Experience Team. Quality Audit & Assurance Team and Quality Governance Systems Team, within the Nursing & Quality Directorate.

There are 5 clinical Divisions consisting of Medicine, Women and Children's Health (WCH), Neurosciences and Musculoskeletal (NMSK), Anaesthesia, Surgery Critical Care and Renal

(ASCR) and Core Clinical Services (CCS). These are supported by Divisional Quality Governance and Patient Involvement & Experience teams. These teams provide operational support, working collaboratively with the central governance, safety, and experience teams.

Core patient safety activities undertaken at NBT include:

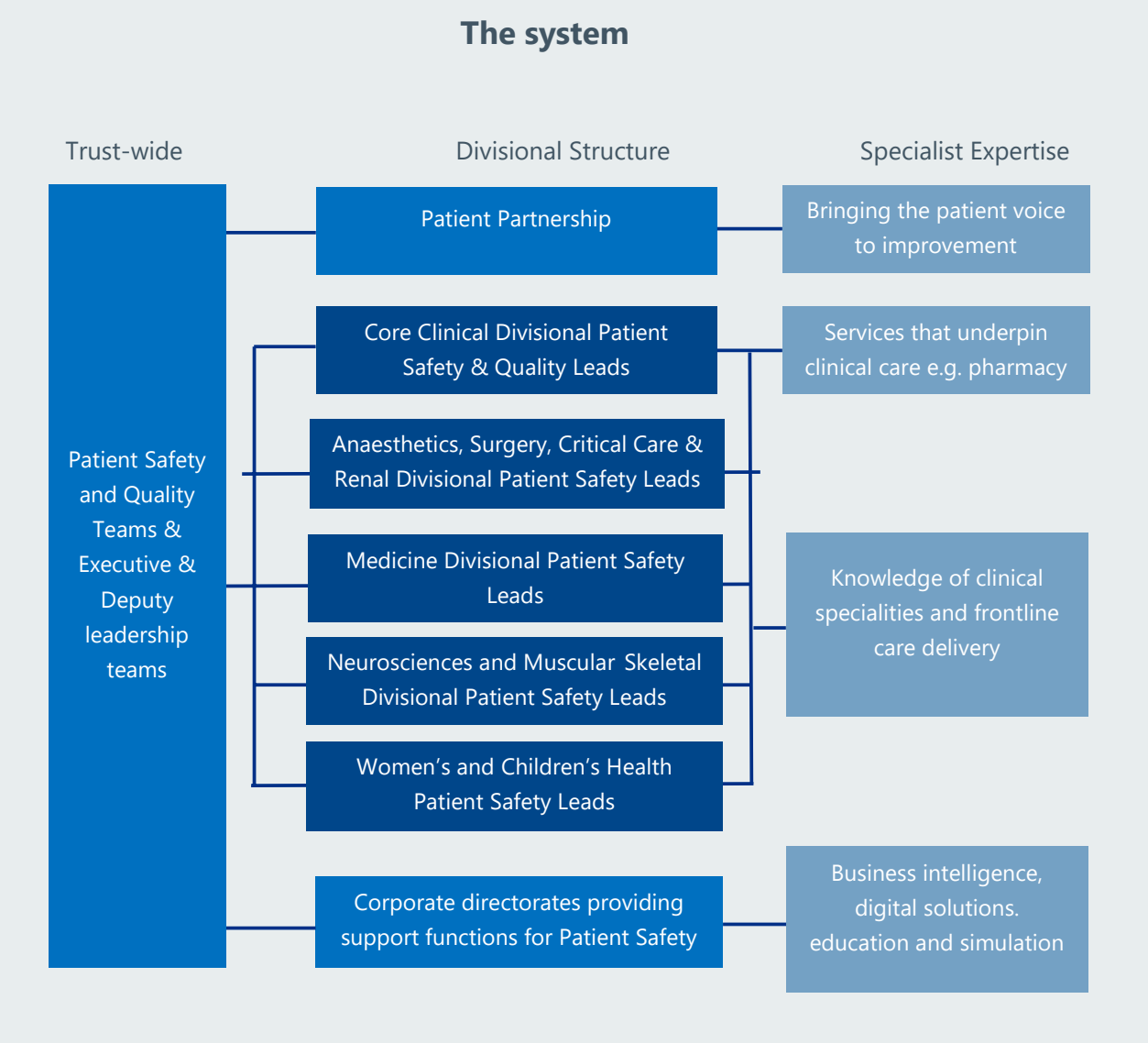
- NHS Patient Safety Strategy
- Patient Safety Programme
- Patient Safety Culture
- Patient Safety Incident Response Framework
- Patient Safety Partners involvement
- Risk Management
- Central Alert System (CAS)
- Supporting improvement programmes
- Providing a range of patient safety training
- Compliance with Duty of Candour
- Involving patients and families in keeping themselves safe
- Implementing actions in response to patient safety incidents.

Other activities within the Trust that provide insights to patient safety include Structured Judgement Reviews, Learning from Deaths, Freedom to Speak Up, complaints and other patient or carer feedback and inquest responses.

The operational ‘work-as-done’ for these patient safety activities is predominantly owned by our colleagues on the front-line. This is teamed with support from their respective Divisional Quality Governance colleagues who are supported through strategic, educational and subject matter expert support flowing from the Corporate Directorates.

This system has been built to fit and respond to the size of hospital we are and the nuances of the teams, services and structures we work in. We call this system our ‘Patient Safety Network’. This involves key people & teams within NBT who are integral in facilitating our patient safety system and patient safety culture, on our road to implementing PSIRF.

System overview – our networks



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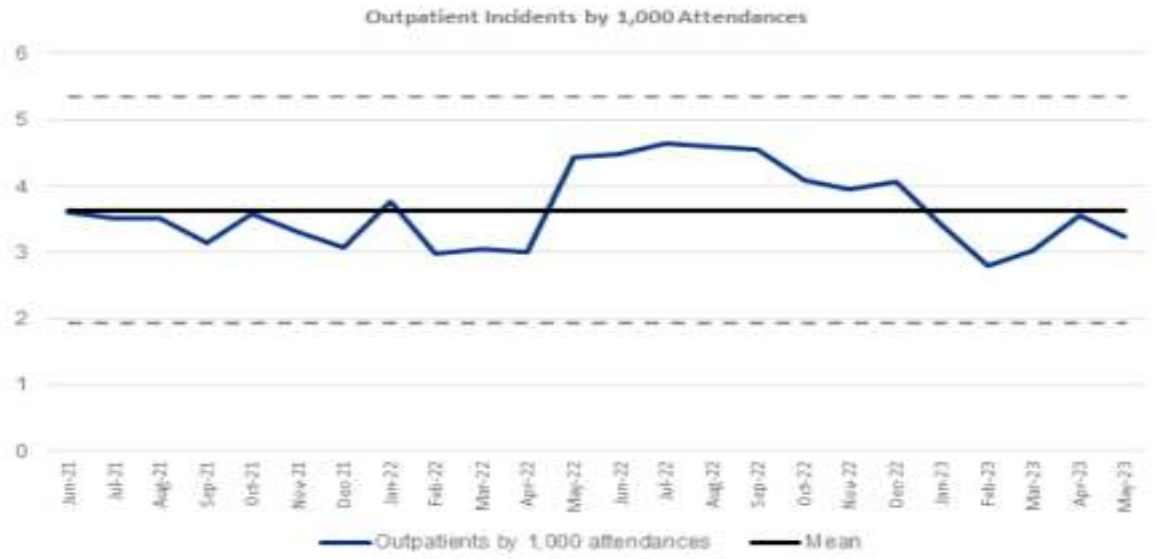
Situational Analysis of Patient Safety Activity

Historically, NBT reported more than 36,000 patient safety incidents, with less than 0.4% of them being investigated as serious incidents under the framework pre-dating PSIRF. A large proportion of these were time consuming and a disproportionate amount of time was spent carrying out serious incident investigations limiting the trust's ability to learn thematically or implement change.

A key part of developing our approach is to understand the amount of patient safety activity the trust has undertaken over the last few years. This enables us to plan appropriately and ensure that we have the people, system and processes in place.

Over the last two years the rate of reporting for inpatient incidents has been impacted by the Covid-19 pandemic and the resulting capacity and flow challenges. The biggest extended peak in incident reporting began at the height of the second wave of the pandemic from January 2022 to April 2022. The last six months has seen a more consistent reporting rate.



In the 2021-23 PSIRP, the local priorities identified were:

- Inpatient falls
- Medication
- Responding well to clinically changing conditions
- Pressure injury
- Discharge

The Patient Safety Incident Investigation related activity undertaken can be broken down as follows:

Activity	Definition	Number completed in the last 2 years	Average over last 2 years
Incidents Resulting in Death	incident requiring investigation which met the standard investigation timeframe and resulted in patient's death.	16	8
Never Events	Incident meeting criteria for never events framework	8	4
Local Priorities/others	Incidents requiring PSII which met one of the identified priorities for 2021-23, or incidents where learning was not well understood.	4	2

In addition, the Trust has tracked 15 incident which resulted in investigations led by HSIB.

Within our previous PSIRP covering 2021-2023 the trust identified that it expected to undertake 20-25 investigations per year. Over the last two years we conducted less than the expected level with a total of 28 PSII.

Due to the impact of COVID and recovery of services in the aftermath of national lockdowns, it has not been possible to advance the local priorities thematic analysis and improvement programmes as much as expected. This is reflected in the reoccurrence of a number of these priorities in this refreshed plan and potentially less than expected PSII completed in the last two years.

Defining our patient safety incident profile

In refreshing this plan, our starting position was an understanding that it has not been possible to progress improvement as expected over the last 2 years and we have adjusted to a post-covid position in managing the wider healthcare pressures which has impacted the delivery of

improvement programmes. To define our priorities for 2023-2025 we analysed patient safety incident and investigation data between June 2021 (when PSIRF was implemented) – May 2023 to test any changes or to confirm that the areas of priority remain appropriate. Our original incident profile also considered sources of insight such as complaints, concerns, inquest.

We have also aimed to provide a more nuanced picture of safety incidents for each Division. The hope is that though identifying division specific priorities will enable targeted improvement and empower locally led changes driven by data and patient safety principles. In this plan we have taken the first step towards this through identifying priorities for our Women and Childrens Division.

Shortlisting of our refreshed patient safety priorities was considered alongside identified programmes of improvement work which exist within NBT and are outlined in the next section to identify where we should focus our in-depth insight resource to best effect. The outputs of this process are described in the next section.

In September 2023 this plan was agreed by the Patient Safety Committee and the board sub committee for Quality. In addition, we have also linked with our partners in the Bristol, North Somerset and South Gloucestershire Integrated Care Board (ICB).

Defining our Trust patient safety improvement profile

Our patient safety improvement profile comes from a range of sources and includes:

- The Trust Patient First Programme which has identified organisation-wide improvement areas.
- Existing quality improvement programmes
- Existing Patient Safety Improvement Programmes
- ICS operational improvement projects
- National Patient Safety Improvement programmes
- Learning from the 2021-2023 Patient Safety Incident Response Plan

As part of reviewing our priorities, the trust considered if there is existing in-depth insight about the risk presented and what that might mean if this is de-prioritised; and whether there is an existing workstream of improvement already established with clear understanding of the issues driving the risks to patients.

The outcome of this consideration is below:

Theme from Analysis	Existing Improvement Workstream	Shortlisted as Key Priority for 2023-25	Rationale
Service Provision	Partial	No	This is the most reported category of incident and often relates to service capacity and staffing levels. Staffing recruitment, wellbeing, and retention is subject to improvement

			programmes led by the people team. Capacity and demand is subject to monitoring through operational performance teams. Capacity and staffing challenges are identified within other incident types as contributory factors.
Patient Falls	Partial	Yes	A falls program has been re-started however it is in its early stages of forming. Analysis of trends and themes has commenced with further work needed to understand the human factors influencing falls.
Medication	Yes	Yes	A refreshed Medicines Safety Programme is planned for 2023. Consistently reported as one of the highest reported incident categories. Focus on delayed or administration of medication.
Tissue Viability	Yes	No	This is a trust improvement priority with an established programme for change. Previous incident learning has informed this structured plan for improvement and the matters influencing tissue viability incidents is well understood. Monitoring of delivery of this trust priority will be through the patient safety governance structure. Although not proposed as a PSIRP priority for 2023-25, incidents will continue to be monitored and learning checked through periodic thematic analysis.
Admission/Discharge/ Transfer/ Transport	Yes	Yes	The challenges around the speed and complexity of discharge are recognised. One key strategic initiative is the development and implementation of a Transfer of Care Hub to better align support, signposting and completion of safe, timely discharges.
Treatment or Procedure	Yes	Yes	Deteriorating patient improvement programme informed by quality indicators and learning from reviews is underway. Further focus is required to understand contributory factors.
Clinical Assessment or Review	Yes	Yes	

			NATSSIP2 improvement project is being formed within 2023. This is informed by learning from Never Events.
Infection Control	Yes	No	National IPC improvement workstreams are in place, with embedded local and system processes for learning from healthcare associated infections (Post Infection Reviews).
Documentation	Partial	No	There is no one program which improves documentation, although the wider digital programme is a constant driver of change, with increasing digitisation of current paper records. A range of improvement work includes aspects of the timely review and ongoing quality of documentation.
Appointments	No	Yes	This is reported within the top ten most reported incidents and relates to missed, cancelled, or delayed appointments.

In reviewing the top areas of reporting, it is identified there is a similarity of theme across category types. 'Appointments', 'Admission/Discharge/Transfer/Transport' and 'Service Provision' have aspects relating to communication, handover, clinical systems and the interconnectedness of different parts of the NBT system. This is closely linked to hospital flow as a principle of right care, right time, right place. The impact of this may also not be fully recognized and can often be a contributory factor within other incident types.

It is difficult to make meaningful connections between operational pressure and incidents due to the complexity of factors. It is possible that some reduced reporting experienced under these headings can be attributed to wider system pressures and reporting fatigue. This is not an area well understood and would benefit from applying a system thinking approach to understanding the human factors to then drive improvement.

Responding well (or deteriorating patient) can be seen as a subset of two incident types in 'Treatment or Procedure' and 'Clinical Assessment or Review'. A trust improvement workstream exists and the factors influencing a patients care or deterioration can be complex and varied, therefore understanding these requires a continued focus to ensure the change program is targeting the right areas.

Within the 'Treatment or Procedure' category also sits learning from never events concerning the implementation of the National Safety Standards for Invasive Procedures. The overall number of incidents proportionately remain low, however the impact on patients can be high. This is not recommended for a specific priority as the learning is well understood and an improvement project will seek to deliver the required changes. Whilst this is not a specific priority, this is an area that the patient safety will monitor, and proportionate decisions made on any learning response required.

For both Medication and Falls incident categories there is a significant amount of learning available however the improvement programmes are in the early stages of refresh. It is considered important to keep these incident types as a priority to ensure that current learning informs the developing improvement work.

Based on this analysis, the patient safety priorities for NBT are identified as:

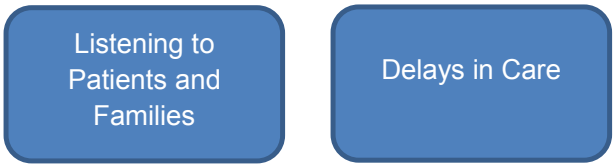
Defining our Divisional patient safety improvement profile

One of the Trust's aims is to develop tailored priorities with our 5 clinical divisions reflective of their services. In this plan the trust is commencing this approach through the development of specific improvement priorities for the Women and Childrens Division.

In understanding the profile of Women and Childrens incidents, the following have been used as sources of insight:

Improvement to Maternity and Neonatal services has and continues to be a national priority and a number of reviews, reports, audits and other external sources of recommendations and learning have been published. The Trust participates and actively contributes to the national

and external opportunities wherever possible. These provide an additional source of information. In considering these, the patient safety priorities for the Woman and Childrens Division are:



In addition, the review of insights identified that medication and responding well to clinically changing conditions (deteriorating patient) also occur as priority areas. As they align to trust level themes they are not included as separate divisional priorities. Any divisional improvement will be contributed to through trust wide programmes.

Our patient safety incident response plan: national requirements

Some events in healthcare require a specific type of response as set out in national policies or regulations. These responses include mandatory patient safety incident investigation (PSII) in some circumstances and review by/referral to another body or team, depending on the nature of the event.

The Guide to responding proportionately to patient safety incidents defines this requirement and sets out whether mandated responses needs to be a PSII or some other response type, including referring the event to another organisation to manage.

In addition, as guidance develops and is updated, there may be times that a response type is mandated but not yet available in the current national guidance. The Patient Safety Team will track these and ensure that NBT respond appropriately. At the time of preparing this plan, the following additional mandated responses have been identified:

National Requirement	Response Required	Lead Body for Response
Blood Transfusion Incidents meeting the definition for reporting under Blood Safety and Quality Regulations (BSQR)(2005) (as amended)	PSII	NBT

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Our patient safety incident response plan: local focus

Deciding what to investigate through a Patient Safety Incident Investigation (PSII) process or use other methodologies will be a flexible approach, informed by the local and national priorities. Our objective is to facilitate an approach that involves decision making through a "convening authority" approach that is commonly used in the military and aviation to commission investigations and receive findings and recommendations.

Apart from the national priorities described above, the decision to carry out a patient safety incident should be based on:

- the patient safety incident is linked to one of North Bristol NHS Trust's Patient Safety Priorities that were agreed as part of the situational analysis.

- the patient safety incident is an emergent area of risk. For example, a cluster of patient safety incidents of a similar type or theme may indicate a new priority emerging. In this situation, a proactive investigation can be commenced, using a single or group of incidents as index cases.

In understanding the methodologies available to the trust to use, we will follow those described within the Patient Safety Incident Response Framework. Within the framework MDT is identified as one option for responding to patient safety incidents. To avoid confusion with clinical MDT's that are often used as part of diagnostic or treatment decision making, NBT will refer to these as Round Table Reviews.

Our proposed approach to these priorities are:

Patient safety incident type or issue	Planned response	Anticipated improvement route
Trust Level		
Patient Flow	PSII or thematic review	Create local safety actions and feed these into quality improvement programmes where scope to do so has been identified
Patient Falls	Thematic Analysis or Swarm	Development of a new falls improvement programme
Medication	PSII or thematic review	Create local safety actions and feed these into trust quality improvement where possible
Responding well to clinically changing conditions	Round Table Review or PSII	Continuation and evolution of the deteriorating patient workstream

Woman and Childrens Specific		
Listening to Patients and Families	After Action Review, Swarm or Round Table Review Complaints investigation and response and/or Local resolution meetings	Learning will be reviewed and channelled into the three-year delivery plan improvement work.
Delays in Care	After Action Review, Swarm or Round Table Review	Create local safety actions and feed these into Divisional quality improvement where possible

National guidance recommends that 3-6 investigations per priority are conducted per year. When combined with patient safety incident investigations from the national priorities this will likely result in 26-30 investigations per year. Attempting to do more than this will impede our ability to adopt a systems-based learning approach from thematic analysis and learning from excellence.

To deliver these investigations we will use existing structures to support the process of decision making. For trust level and national priorities, an established weekly meeting with the Chief Nursing Officer and Chief Medical Officer, in which potential incidents and other emerging patient safety issues are discussed, will make agreements made on the most proportionate response. Responsibility for identification of incidents in scope of a PSII and any investigation will be sourced from within Divisions or leads for improvement programmes.

For Divisional led priorities, the Woman and Childrens Divisional Governance team will have oversight of commissioning, investigation, and approval of these investigations which fall within scope of their services. Approvals will be granted through their Divisional Management Team. Oversight of learning, trends and themes will be taken to the trust wide Patient Safety Committee.

As PSIRF is a new way of responding to incidents and uses new investigation models for in-depth investigations, the trust is on a continuous journey to develop new tools for understanding why incidents happen. To support Divisions, the central Patient Safety Team will provide expertise, advice, and guidance to enable a consistent application of this plan.

Involvement of patients, families and carers following incidents

We recognise the significant impact patient safety incidents can have on patients, their families and carers.

Getting involvement right with patients and families in how we respond to incidents is crucial, particularly to support improving the services we provide.

As part of our policy framework, we will continue to develop our practice and procedures to support staff in how to work with patients and family as part of responding to patient safety incidents.

In some cases, incidents will meet the statutory duty of candour thresholds. There is no legal duty to investigate a patient safety incident. However, once an incident that meets the Statutory Duty of Candour threshold has been identified, the legal duty, as described in Regulation 20 says we must:

1. Tell the person/people involved (including family where appropriate) that the safety incident has taken place.
2. Apologise. For example, “we are very sorry that this happened”
3. Provide a true account of what happened, explaining whatever you know at that point.
4. Explain what else you are going to do to understand the events. For example, review the facts and develop a brief timeline of events.
5. Follow up by providing this information, and the apology, in writing, and providing an update. For example, talking them through the timeline.
6. Keep a secure written record of all meetings and communications.

Involvement and support for staff following incidents

We are on an ambitious journey at the Trust to ensure it is a safe and fair place, where everyone’s voice is encouraged, valued, and listened to, helping us to continually learn, inspire change and improve.

When a colleague reports an incident or is providing their insights into the care of a patient for an investigation, we will actively encourage a safe space to discuss the events, explore the system in which they work and listen openly without judgement. Our new policy, procedures and guidance will support this in practice.

We recognise that many staff will be involved with a patient safety incident at some point in their careers and this can be a traumatic experience. We have a wealth of excellent psychological wellbeing support for all staff with information available through our staff intranet pages.

Our patient safety incident pro-active plan: local focus

Patient Safety can be focussed on learning from things that have already happened, however the move to PSIRF encourages a more systematic consideration of the risks presented to delivering healthcare to patients. At NBT we want to stretch ourselves to focus on how we can utilise proactive patient safety to anticipate and prevent problems before they occur.

Our plan to achieve proactive patient safety focusses around a number of priorities:

Patient Safety Culture: this priority has three main aspects, all centred around making sure our staff are empowered to speak up, feel safe, and can make changes within areas of their control.

Through adopting a 'just culture' and creating psychological safety, we can support our staff to be more resilient, achieve better levels of communication, create an openness to learning, improve performance, and influence positive attitudes.

The benefit to patient safety is that this creates an environment for our staff which is based on respect, honesty and open dialogue. This is especially important when incidents occur and is a foundation to the reflective practice our staff undertaken when understanding what happened. No one comes to work to get in trouble or sanctioned because something has gone wrong, a just culture enables us to view things in a different way without blame or fear of consequence. Ultimately this is about building trust between peers, teams and the organisation which directly impacts how we perform and achieves better outcomes for our patients.

To achieve this we will undertake activities across the year to support us in gaining insights to our culture. This may be through looking at triangulating themes across different parts of NBT, such as our staff survey results and Freedom to Speak Up. We will also engage our teams directly using national patient safety tools to support understanding our culture, staff and team awareness and inform changes where improvement is needed.

Patient Safety Governance: Our governance mechanisms at Trust level and the interfaces with clinical divisions are being re-evaluated as part of the refresh of the PSIRP and in light of the Trust's Strategy and Patient First approach. Existing governance mechanisms for proactively reviewing incidents and other intelligence in relation to safe and harm free care continue whilst this evolves, with primary workstreams being:

- Patient Falls
- Pressure Injuries
- Infection Prevention & Control
- Medication Safety
- Identifying and responding to deterioration of patients' clinical condition
- VTE prevention & response
- Safe Maternity Care – which extends into the wide range of proactive and measures covered through the Perinatal Mortality Surveillance tool
- Learning From Deaths – including through Medical Examiner concerns/referrals and Structured Judgment Reviews

As part of our continued refinement to our approach to the Patient Safety Incident Reporting Framework (PSIRF), we are considering the interrelationships between different risks of harm and how we take a more holistic way of approaching continuous improvement to identify and respond to areas of learning before incidents occur. It is our intention to bring individual workstreams and assurance processes that already exist into a combined programme of work, with stronger governance and improvement oversight.

Health Inequalities: understanding how NBT's services impact different people is important in minimising harm and reducing variation in patient outcomes. As we take this plan forward, we will explore if and how those within protected characteristics are kept safe, and to proactively consider their needs within the design of care pathways.

In addition, as we increasingly seek to empower people to be active in their own healthcare, and within patient safety to understand how incidents occurred, there is a need for the Trust to build on how we support those with specific needs. Aligned with our Patient and Carer

Experience Strategy we will create opportunities for those from diverse backgrounds to be involved as Patient Safety Partners.

Generative leadership: linked to culture within our organisation is the role of leaders. We will build on the work that leaders are already undertaking to ensure ward to board connectivity, and presence to demonstrate support to safe care. Generative leadership is not just about adapting but being creative, and empowering people to be engaged in change and not just observing others apply it to them.

An example of where we have already made this happen already is using safety champions within the Woman and Childrens Division. These champions are a mix of senior staff and the clinical team, along with the Non-Executive Director with responsibility for Maternity Services, the Chief Nurse, and Head of Patient Safety. In fulfilling this role, the group engage directly with the service through a programme of walk arounds focussed on patient safety where they talk to staff and patients and observe the environment around them. These observations are then distilled into points of good practice or actions which the division take forward to make improvement.

Development of Human Factors knowledge and Skills: Through supporting staff to be curious and speak up we need to enable them to view opportunities for change through the right lens. Human factors focus on optimising human performance through better understanding the behaviour of individuals, their interactions with each other and with their environment. By acknowledging human limitations, human factors offer ways to minimise and mitigate human frailties, thereby creating consistent delivery of care. We will develop training and resources to provide individuals with the skills they need to consider human factors in their everyday work to inform quality improvement in teams and services, support change management, and help to emphasise the importance of the design of equipment, processes, procedures, and care.

Implementation and development of the national Learning from Patient Safety Events: NHSE are implementing a new way of nationally capturing incident information and requires organisations to collect certain types of data. Within this are specific asks which will enable the Trust to consider a proactive response through identification of incidents that have not yet affected patients, and a greater emphasis on identification of risks.

This is one part of how we use data to our advantage and understand the risks to patient safety. We will develop ways that draw combined data on the quality and performance of services to triangulate learning and take action to prevent harm occurring to patients. For example, the trust has recently developed a triangulation group which brings our people team, freedom to speak up, patient safety, safeguarding, health and safety and our PALS & Complaints team together to understand what is affecting the safety of patients and staff.

Recognising when things go well: Much of patient safety is responding after incidents have occurred and understanding why something has gone wrong. In further developing our patient safety practice linked to the national implementation of the Patient Safety Incident Response Framework, we will develop ways to explore examples of how our teams provide outstanding care. Utilising principles such as appreciative enquiry we will focus on strengths, successes, and opportunities rather than solely on identifying weaknesses and problems. Through understanding what enables our teams to provide the best care possible, we can then spread that to other parts of our organisation.

Report To:	Public Trust Board			
Date of Meeting:	30 November 2023			
Report Title:	People Committee Upward Report			
Report Author:	Aimee Jordan, Senior Corporate Governance Officer & Policy Manager			
Report Sponsor:	Kelvin Blake, Non-Executive Director, and Chair of People Committee			
Confidentiality (tick where relevant) *:	**Patient identifiable information?**	**Staff identifiable information?**	**Commercially sensitive information?**	**Other exceptional circumstances**
*If any boxes above are ticked, paper may need to be received in *private.*				
Purpose of the report:	**Approval**	**Discussion**	**Information**	**Assurance**
				X
Recommendations:	That the Trust Board: • receive the report for assurance and note the activities People Committee has undertaken on behalf of the Board. • Approve the Terms of Reference • Note the approved EDI plan			
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 January 2024.			

Executive Summary		
The report provides a summary of the assurances received and items discussed and debated at the People Committee meeting held on 16 November 2023.		
Implications for Trust Improvement Priorities: *(tick those that apply and elaborate in the report)*	**Our Aim: Outstanding Patient Experience**	
	High Quality Care – *Better by design*	
	Innovate to Improve – *Unlocking a better future*	
	Sustainability – *Making best use of limited resources*	
	People – *Proud to belong*	✓
	Commitment to our Community - *In and for our community*	✓
Link to BAF or Trust Level Risks:	Reports received support the mitigation of various BAF risks.	
Financial implications:	No financial implications as a consequence of this report.	
Does this paper require an EIA?	No, as this is not a strategy or policy or change proposal	
Appendices:	1. People & EDI Committee and EDI Group Terms of Reference 2. EDI Plan	

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1. Purpose

1.1 To provide a highlight of the key assurances received, items discussed, and items for the attention of the Trust Board from the People Committee meeting held on 16 November 2023.

2. Background

2.1 The People Committee is a sub-Committee of the Trust Board. It meets quarterly and reports to the Board after each meeting. The Committee was established to provide strategic direction and board assurance in relation to all workforce issues.

3. Meeting on 16 November 2023

3.1 Chief People Officer Update

The Committee received an update from the Chief People Officer, which focused on the ongoing work in the following key areas:

- Work was underway on the next iteration of the Long Term Workforce Plan working up next year's activities and building on key enablers. Important to note that this is now fully embedded in the annual business planning process.
- The vibrant success of Black History month in October feedback concluding this was our best ever Black History month thanks to so much staff input especially from staff networks. The ambition to recreate the positive feedback for December's Disability month was noted.
- The improvements to the recruitment processes including:
  - Streamlining and digitising internal processes to improve efficiency.
  - Working with UHBW on joined up recruitment processes.
- The upcoming dates and impact of the industrial action and the various actions taken by the Trust to mitigate the risks and to support and maintain patient safety were also reviewed.

The Committee discussed the changes to the recruitment process, noting the improvements in efficiency and time to hire, and received reassurance that all due diligent checks a clearances were unchanged. The Committee noted huge amount of work and progress in the Long Term Workforce Plan.

3.2 Revised Governance Structure and Draft Terms of Reference for combined People & EDI Committee

The Committee received the revised governance structure and draft terms of reference for the combined People & EDI Committee and for the new EDI Group and endorsed them for Trust Board approval.

3.3 Equality, Diversity & Inclusion Action Plan

The Committee received the Equality, Diversity & Inclusion (EDI) Action Plan that had been updated following discussion at September's Trust Board.

The revised plan outlined a 12-point plan which included clear and measurable targets and actions against each EDI priority at Trust level, leadership level and at divisional level. The Committee noted the EDI plan was now being showcased at Regional level.

The Committee recognised the challenging timeline of the plan and discussed the importance of having focused actions to make progress. The Committee received reassurance that resource was being reprioritised to provide support for the plan. The importance of operationalising the plan for divisions to undertake the actions was also recognised.

The Committee discussed the 'zero tolerance' process referred to in the plan and received reassurance from the Chief People Officer that work was ongoing to develop and embed the new policy, communicate and educate all staff to ensure what the Trust deemed as unacceptable behaviour. It will be vital to work with line managers and staff networks to ensure staff with protected characteristics are not discriminated against.

The Committee approved the plan and welcomed its launch. The full plan is appended to the report.

3.4 Allied Healthcare Professional (AHP) Development Plan update

The Committee received an update from the Chief Allied Healthcare Professional (AHP) on the Allied Healthcare Professional Development Plan which outlined the progress made so far (six months into the delivery of the three-year plan). It was noted that there was a two phased approach to the plan with phase one focused on governance, structure and communication and phase two focused on programme delivery across 5 domains:

- Leadership and Culture
- Attracting, growing and retaining
- Workforce planning, productivity & digital
- Visibility, representation and partnership
- Quality, Safety and Research

The update highlighted the key priorities, the ongoing positive system partnership working, the workforce engagement and the challenges with regards to capacity and resource to deliver the plan.

Discussion focused heavily on the workforce challenges, particularly the use of international recruitment and the pipeline challenges. The need to engage with universities to develop the right training courses and expand placement capacity and applicant to course was also discussed in depth. The challenges of encouraging applicants were recognised, and the Committee were informed that work was underway to undertake career promotions in local schools and develop a comprehensive work experience model. The Committee were also informed that the Chief Nursing Officer was progressing the ongoing work with the universities to develop courses and mitigate the skill shortage risk.

The Committee welcomed the development plan and thanked the team for the positive progress.

3.5 Health & Safety Committee Upward Report (including Security Annual Report)

The Committee received the Health & Safety Committee Upward Report (including the Security Annual Report) which provided assurance on the oversight and management of Health and Safety compliance in the organisation. An update was provided on:

- The internal and external audits carried out across the Trust Estate.
- The major incidents that occurred over the last 3-month period.
- The Health & Safety risks and the management of the mitigating actions.
- RIDDOR incidents and the work into reported incidents of violence and aggression.

The Committee noted the ongoing work to educate staff and improve the reporting and quality of reporting for RIDDOR events. The Committee requested that timeframes were put against actions to ensure effective monitoring.

The Committee discussed the process of reporting violence and aggression incidents and received assurance on the Executive and Board oversight process. In addition, the Committee were reassured that a sexual violence sub-group was being created to monitor all cases (from multiple data sources).

3.6 Trust-Level Risks and BAF

The Committee received an update on the Trust Level Risk (TLRs) across its areas of responsibility, including the Health and Safety and Workforce risks, and reviewed the related workforce Board Assurance Framework (BAF) risks. The Committee received assurance that the TLRs were being actively monitored and reviewed through the Risk Management Group.

The Committee noted that the risk score for the Datix risk 1596 around industrial action would be revised due to the changing situation.

4. Other items:

The Committee also received the following items for information:

- Apprenticeship Centre Update
- Workforce Data Quarterly Report (Including Resourcing Performance Report)
- Sub-committee upward report(s):
  - People Oversight Group
  - EDI Committee
- People Committee forward work-plan 2023/24

5. Identification of new risks & items for escalation

5.1 No specific new risks were identified.

6. Summary and Recommendations

6.1 The Trust Board is asked to:

- receive the report for assurance and note the activities People Committee has undertaken on behalf of the Board.
- approve the Terms of Reference for the new People & EDI Committee and the EDI Group.
- note the approved EDI Plan.

NHS North Bristol NHS Trust

Terms of Reference for the People, Equality, Diversity, and Inclusion Committee

Chair:	Non-Executive Director
Other Members:	Membership of the Committee shall include: • Three Non-Executive Directors one of whom will chair the Committee. • Chief People Officer • Chief Nursing Officer • Chief Medical Officer • Chief Finance Officer • Chair of JCNC Staff Side The members set out above may appoint a named deputy to attend a particular meeting in their place, subject to the Chair's pre-approval. A deputy should be nominated only in exceptional circumstances, for a particular meeting. In the absence of the appointed Committee Chair, another Non-Executive Director will chair the meeting.
Other Attendance:	The Committee may invite non-members to attend all or part of its meetings as it considers necessary and appropriate, at the discretion of the Chair. In addition to members of the Committee, the following shall normally attend all meetings and may contribute to discussions, but have no voting rights nor contribute to the quorum: • Director of Corporate Governance/Trust Secretary • Director of Operational Estates & Facilities • Deputy Chief People Officer • Associate Director of Culture, Leadership and Development • Head of Equality, Diversity, and Inclusion • Deputy Chief Operating Officer (where required for specific agenda items) The Committee can request the attendance of any other director or senior manager if an agenda item requires it. Attendance at meetings is essential. In exceptional circumstances when an Executive Director member cannot attend they must arrange for a fully briefed deputy of sufficient seniority to attend on their behalf. Executive Director attendance to be flexible and agenda-specific for non-formal members
Quorum:	The quorum for the Committee is at least three members of whom one must be a Non-Executive Director who will chair the meeting and two Executive Directors (or their nominated Deputies).

Declaration of Interests	All members must declare any actual or potential conflicts of interest relevant to the work of the Committee, which shall be recorded in the minutes accordingly. Members should exclude themselves from any part of a meeting in which they have a material conflict of interest. The Chair will decide whether a declared interest represents a material conflict.
Frequency of Meetings:	The Committee will meet bi-monthly and will be set in advance as part of the planning of the Trust Board and Committee meetings annual calendar of business.
Notice of Meetings:	Additional meetings shall be called at the request of the Chair. Unless otherwise agreed, notice of each meeting confirming the venue, time and date together with an agenda of items to be discussed and supporting papers, shall normally be forwarded to each member, and any other person required to attend, no later than five working days before the date of the meeting. Decisions may be taken by written resolution upon the agreement of the majority of members of the Committee in attendance, subject to the rules on quorum.

Inputs:	The Committee will receive reports on issues within the remit of the meeting, so as to ensure timely discussion and decision-making. This will include:
	
	• Specific assurance reports relating to Equality, Diversity, and Inclusion (usually from the People Oversight Group)
	• Workforce Data Reports (including WRES and WDES)
	• Trust-Level Risks and BAF report (Workforce and Health & Safety)
	• Bi-annual Safe Staffing: Nursing & Midwifery reports
	• Security Annual Report
	• Freedom to Speak Up Annual Report
	• Apprenticeship Centre Reports
	• Gender & Ethnicity Pay Gap Reports
	• Security Annual Report
	• Health & Safety Annual Report
	• Upward reports from:
	  ○ The Health & Safety Committee
	  ○ The People Oversight Group
	
	Individual members may also raise concerns/risks/issues relevant to the meetings remit on an ad hoc basis but will do so with sufficient notice to ensure that meeting agenda can be set and managed effectively.
	
	The Committee can request a report on any subject or issue relevant to its terms of reference.

Outputs:	The Committee shall produce a set of minutes and a log of actions arising. The Committee shall issue an upward report to Trust Board following each meeting.

Responsible for the following Strategies and Policies:	Strategies: • The People/Workforce Strategy • The Equality, Diversity, and Inclusion Plan Policies: • People Policies • Health & Safety Policies
Sub-Committees:	• Health & Safety Committee • People Oversight Group
Committee Secretary:	The Corporate Governance Team is responsible for: • Agreement of agenda and collation of papers. • Taking the minutes and keeping a record of actions arising and issues to be carried forward. • Provision of a highlight report of the key business undertaken to the Trust Board following each meeting.

1. Purpose

1.1 The Committee is established to be a sub-Committee of the Trust Board and is the Board assurance committee for:

- People/Workforce matters,
- Equality, Diversity, and inclusion,
- and Health & Safety function.

2. Authority

2.1 The Committee is a sub-group of the Trust Board from which it receives its authority. Its constitution and terms of reference shall be as set out in this document, subject to amendment.

3. Duties

3.1 The primary role and function of the Committee is as follows:

3.1.1 **People**

- Developing and advising the Board on a people strategy taking into account relevant best practice and alignment with strategic objectives for the Trust;
- Reviewing senior leadership succession and development plans;
- Maintaining oversight of the Trust's Human Resources function;
- Monitoring the development of the future workforce, through a 'fit for purpose' workforce plan;
- Monitoring an agreed set of HR related Key Performance Indicators;
- Ensuring that feedback from staff surveys are appropriately analysed, improvement actions taken where necessary to drive employee engagement and desired organisational culture;
- Ensuring that the Trust has a suitable framework to deliver the strategy and HR policy of the organisation. Ensuring these align with the relevant CQC and NHS Improvement workforce standards;
- Overseeing the development and implementation of initiatives to maintain the organisation as a major Teaching Hospital;
- Providing Board level leadership in creating an working environment where staff would be 'proud to belong';

- Oversee and influence key relationship with educational partners to maximise the benefit of these relationships to the Trust;
- Maintaining oversight of the business of the People Oversight Group through the receipt of regular update reports;
- Receive regular reports from the Joint Consultation and Negotiation Committee for information; and
- Other HR related activity as requested by the Board.

3.1.2 **Equality, Diversity, and Inclusion**

- Provide a Board Committee level forum for the promotion and progress of Equality, Diversity, and Inclusion at NBT, providing meaningful leadership and challenge, and ensuring that NBT becomes a more inclusive and diverse organisation, which is representative of the population it serves;
- Monitor key integrated people initiatives which support the Trust's Equality, Diversity and Inclusion vision, values, and strategic objectives;
- Seek assurance on the coordination and delivery of the wider Equality, Diversity, and Inclusion agenda and work programmes at NBT;

3.1.3 **Risk**

- Receive the People Trust Level Risks (including any relating to Equality, Diversity, and Inclusion) and the Health and Safety Trust Level Risks to review assurance on risk mitigation and controls including any gaps in control;
- Receive relevant risks from the Board Assurance Framework (namely those relating to People and Health and Safety) to review assurance on risk mitigation and controls including any gaps in control for the risks allocated to the Committee;
- Assess any risks within the People/workforce and Health and Safety portfolios brought to the attention of the Committee and identify those that are significant for escalating as appropriate.

3.1.4 **Health & Safety**

- Provide assurance to the Board on Health & Safety compliance;
- Provide assurance to the Board on the implementation of the Trust's Health and Safety Management Strategy;
- Maintain oversight of the business of the Health & Safety Committee and its committee sub-structure through the receipt of regular update reports.

4. Monitoring and Effectiveness

4.1 The Committee shall have access to sufficient resources to carry out its duties, including access to company secretarial assistance as required.

4.2 It shall be provided with appropriate and timely training, both in the form of an induction programme for new members and an on-going basis for all members.

4.3 It will review its own performance, at least annually, review its constitution and terms of reference to ensure it is operating at maximum effectiveness and recommend any changes it considers necessary to the Trust Board for approval.

4.4 As per NHSE/I requirements the Committee will carry out an annual self-assessment to inform above review of its Terms of Reference.

Version:	4.3
Ratified by / responsible committee:	Trust Board

Date ratified:	30 November 2023
Name of originator / author:	Trust Secretary
Lead for Executive Team Meeting:	Jacqui Marshall, Chief People Officer
Date issued:	30 November 2023
Review date:	30 November 2023

DRAFT Terms of Reference for the Equality, Diversity and Inclusion (EDI) Operational Group

Chair:	Associate Director of Culture, Leadership and Development
Other Members:	Membership of the EDI Group shall include: • Head of EDI and/or EDI team representative • People Business Partner (all Divisions represented) • Other divisional representatives with key EDI responsibilities or interests • Head of Staff Experience • Deputy Chief Nursing Officer • Chief AHP • Staff network representatives (B.A.ME, LGBTQ+, Disabled and Neurodiverse, Women's network) • Associate Director of Medical Workforce (or Deputy) • Associate Director of People (or Deputy) • Head of Patient Experience • Associate Director of Resourcing (or Deputy) • Learning and OD Lead • Trade Union representative • Cultural and Inclusion Ambassador representative
Other Attendance:	The EDI Group may invite non-members to attend all or part of its meetings as it considers necessary and appropriate, at the discretion of the Chair. It is expected that members or a nominated appropriate representative will attend a minimum of 70% of the EDI Group meetings a year. Others, including service leads may be required to attend meetings of the Group at the invitation of the Chair or other core members, to present and inform a particular item(s). Either the Associate Director of Culture, Leadership and Development or the Head of EDI shall Chair meetings of the EDI Group.
Quorum:	The quorum necessary for the transaction of business shall be 50% of the members including one clinical representative and representatives from all divisions
Declaration of Interests	All members must declare any actual or potential conflicts of interest relevant to the work of the EDI Group which shall be recorded in the minutes accordingly. Members should exclude themselves from any part of a meeting in which they have a material conflict of interest. The Chair will decide whether a declared interest represents a material conflict.
Frequency of Meetings:	Every two months, 90 minutes

Notice of Meetings:	Additional meetings shall be called at the request of the Chair. Unless otherwise agreed, notice of each meeting confirming the venue, time and date together with an agenda of items to be discussed and supporting papers, shall normally be forwarded to each member, and any other person required to attend, no later than 7 calendar days before the date of the meeting.
Inputs:	The EDI Group will receive reports on issues within the remit of the meeting to ensure timely discussion and decision-making. This will include EDI related information, trends or themes arising from the Data Triangulation Group Individual members may also raise concerns/risks/issues and matters for decision making relevant to the meetings remit on an ad hoc basis but will do so with sufficient notice to ensure that meeting agenda can be set and managed effectively.
Outputs:	The EDI Group shall produce a set of notes and a log of actions arising. The Chair of the Group shall report to the People Oversight Group on the activities and progress of the EDI Group and shall make whatever recommendations are deemed appropriate, on any area within the remit of these terms of reference where disclosure, action or improvement is considered necessary. The Group meetings will structured as follows: - I hour: update and review of local (Divisional) EDI plans and progress - 30 minutes: update, review and discussion around Trust-wide and national EDI programmes of work, including identifying risks and issues for onward escalation. The Group shall approve a statement for inclusion in the Annual Report about its activities. The Group will also provide assurance to the Executive Management Team and the People and EDI Committee on workforce issues
Responsible for the following Strategies, Policies and Reporting:	Strategies/plans: • NBT's 3- year EDI plan • In year Divisional EDI plans • NHSE EDI Improvement Plan • EDI policy and related EDI guidance • NHS EDI reporting framework • Equality Delivery Schemes 22 (Domains 2 & 3) • Equality Impact Assessments
Sub-Committees:	The following groups will report into this Group: • Staff network groups - chairs and co-chairs • Task & finish groups may be set up as required

Committee Secretary:	The administrative EDI resource is responsible for: • Agreement of agenda and collation of papers (agenda to be agreed by the end of the previous month) • Taking the minutes • Keeping a record of the names of those present and those in attendance. Maintaining and updating the actions arising and issues to be carried forward.

1. Purpose

1.1 The EDI Group is established to provide operational oversight, guidance and co-ordination of the EDI agenda and work programmes at NBT. It is also required to provide assurance to both the People Oversight Group and People and EDI Committee, that EDI plans and priorities are being delivered and progress made. The group will:

a) Lead on the implementation and monitoring of NBT's 3-year EDI Plan
b) Drive through and ensure delivery against agreed KPIs and milestones
c) Provide specialist EDI oversight, advice and guidance on Divisional EDI priorities and targets.
d) Agree any new programmes of EDI work (including those that may be ICS-led) and review the progress of any working groups which report into it.
e) Review relevant papers before submission to the Board and People and EDI Committee such as the Staff Survey, WRES, WDES and actions arising from these.
f) To promote and monitor integrated people initiatives which support the Trust's EDI vision, values, and strategic objectives.
g) Provide assurance to Senior Leadership Team, People Oversight Group, the Trust Board and the People and EDI Committee that these obligations are being met, with remedy and risks being identified and reported as appropriate.

2. Authority

2.1 The EDI Group is a sub-group of the People Oversight Group from which it receives its authority. Its constitution and terms of reference shall be as set out in this document, subject to amendment.

3. Duties

The duties of the EDI Group are to:

a) Promote an integrated EDI agenda that recognises and connects the national and local EDI agenda to Divisional work and priorities and engages with multi-professional stakeholders.
b) Ensure core delivery and progress of all EDI work programmes by tracking progress and identifying where further support, guidance or resource is needed.
c) Shape the development of further or future EDI priorities, aligning these with the Trust's other strategic plans.
d) Maintain oversight of the Trust's EDI project plan.

e) Recommend approval from the Executive Management Team (EMT) for Trust wide EDI initiatives and decisions (where deemed necessary by the Deputy/Chief People Officer).
f) Recommend EDI objectives and initiatives to the Executive Management Team (EMT) and subsequently review performance and progress.

Version:	1.0
Ratified by / responsible committee:	
Date ratified:	
Name of originator / author:	
Lead for Executive Team Meeting:	
Date issued:	
Review date:	

Report To:	People Committee			
Date of Meeting:	16 November 2023			
Report Title:	Draft 3-year Equality, Diversity and Inclusion (EDI) Plan			
Report Author:	Caroline Hartley, Associate Director of Culture, Leadership and Development			
Report Sponsor:	Jacqui Marshall, Chief People Officer			
Confidentiality (tick where relevant) *:	**Patient identifiable information?**	**Staff identifiable information?**	**Commercially sensitive information?**	**Other exceptional circumstances**
*If any boxes above are ticked, paper may need to be received in *private.*				
Purpose of the report:	**Approval**	**Discussion**	**Information**	**Assurance**
	X			
Recommendations:	To review and approve the final draft EDI Plan			
Report History:	People Committee 14.9.23, SLG 19.9.23, Trust Board 28.9.23, EDI Committee 5.10.23			
Next Steps:	Once this final draft EDI plan has been approved, it will be formally launched, and the actions implemented.			

Executive Summary

Following previous discussion at EDI Committee and with the Trust Board, it was agreed that NBT should develop a clear and comprehensive EDI plan. This would set out NBT's EDI agenda and direction of travel over the next 1-3 years and describe key areas of focus and priority actions for the year ahead. These would be actions which could be clearly articulated to, and understood by, the organisation and would be linked to areas of EDI where we most need to improve or make progress.

The work to develop NBT's plan coincided with NHS England's publication of its national EDI Improvement Plan which sets out the 6 'High Impact Actions' it expects NHS organisations and ICBs to implement between now and 2026. It was therefore appropriate to ensure that NBT's plan was assessed against the national agenda, to ensure that our priority actions were aligned.

Through this process and our review of NBT EDI data and intelligence, we have developed an EDI plan which describes the background and context in which we are working, our areas of challenge and what that means in terms of actions and areas of focus over the next 3 years. The plan proposes 4 priorities, to occur over the next 12 months, and beyond. These are:

- Ensuring EDI ownership & accountability
- Eliminating discrimination, harassment, bullying & abuse
- Embedding diverse & fair recruitment
- Closing the pay gap

Underpinning each of these broad priority areas are a suggested set of clear actions, with accompanying metrics and measures of success. These have now been broken down even further into immediate actions which will be taken Trust-wide, at Leadership level and at Divisional/Service level across NBT. The Plan then describes some longer terms actions we will take, including those which are aimed at addressing the negative experiences of staff with individual protected characteristics, as defined in the Equality Act 2010. Finally, the Plan sets out some changes to the governance of EDI at NBT which were agreed during the consultation and engagement phase of this plan's development. This includes setting up a new EDI group, with Divisional representation, and combining the People and EDI Committees. The draft Terms of Reference underpinning these changes have been drafted and are being shared via a separate Committee paper.		
Implications for Trust Improvement Priorities: *(tick those that apply and elaborate in the report)*	**Our Aim: Outstanding Patient Experience**	
	High Quality Care – *Better by design*	
	Innovate to Improve – *Unlocking a better future*	
	Sustainability – *Making best use of limited resources*	
	People – *Proud to belong*	✓
	Commitment to our Community - *In and for our community*	✓
Link to BAF or Trust Level Risks:	N/A	
Financial implications:	N/A	
Does this paper require an Equality, Diversity and Inclusion Assessment (EIA)?	N/A	
Appendices:	Appendix 1: Draft EDI Plan	

1. Purpose

1.1 The purpose of this paper is to share the final draft of NBT's new EDI Plan, following discussion and feedback from a wide range of stakeholders, groups and committees, and to seek approval of this plan.

13.3

2. Background

2.1 Following previous discussion at EDI Committee and with Trust Board, it was agreed that NBT should develop a clear and comprehensive EDI plan. This would set out NBT's EDI agenda and direction of travel over the next 1-3 years and describe key areas of focus

and priority actions for the year ahead. These would be actions which could be clearly articulated to, and understood by, the organisation and would be linked to areas of EDI where we most need to improve or make progress. NBT has developed a number of EDI priorities and action plans previously, some of which were being undertaken collaboratively across the ICS. While progress has been made in some areas, in others a lack of clear focus, ownership and oversight of the delivery of agreed actions has meant that we have not made the progress we would have wished.

3. Draft EDI Plan

3.1 Against this background we have developed a draft EDI plan which describes the context in which we are working, our areas of challenge and what that means in terms of actions and areas of focus over the next 3 years. The plan proposes 4 immediate priorities, to occur over the next 12 months, and beyond as necessary. These are:

- Ensuring EDI ownership & accountability
- Eliminating discrimination, harassment, bullying & abuse
- Embedding diverse & fair recruitment
- Closing the pay gap

3.2 Underpinning each of these broad priority areas are a suggested set of clear actions, with accompanying metrics and measures of success.

The Plan then describes some longer terms actions we will take, including those which are aimed at addressing the negative experiences of staff with individual protected characteristics, as defined in the Equality Act 2010.

3.3 Following feedback on the previous iteration of this Plan, a final draft has been developed which incorporates the suggestions and feedback received. The feedback received was positive and confirmed that the four suggested priority areas of focus were the right ones for NBT. However, it was requested that the actions described in the plan be made more focussed and immediate, with some very specific, practical and measurable activities which could be undertaken immediately (accepting that some of the actions described will take further planning and time to operationalise).

3.4 The four priority areas have therefore been broken down even further into immediate actions which will be taken Trust-wide, at leadership level and at Divisional/Service level, over the coming weeks. Meetings have been set up with Divisional leads to talk through these actions in more detail and work has already commenced on implementing the Trust-wide actions detailed in the plan.

3.5 Underpinning this plan is a more detailed project plan, used to identify ‘leads’ for each action and track progress and success against each metric.

3.6 This plan also describes changes to the governance of EDI at NBT which were agreed during the consultation and engagement phase of its development. This includes setting up a new EDI group, with Divisional representation, and combining the People and EDI Committees. The draft Terms of Reference underpinning these changes have been drafted and are being shared via a separate Committee paper.

4. Summary and Recommendations

The People Committee is asked to discuss and **approve this EDI Plan.**

13.3

NHS
North Bristol
NHS Trust

EQUALITY, DIVERSITY & INCLUSION (EDI) 3 YEAR PLAN

November 2023

NBTCARES

Amanda Pritchard
Chief Executive
NHS England

"Our NHS is built on the values of everyone counts, dignity and respect, compassion, improving lives, working together for patients, and commitment to quality. These values underpin how healthcare is provided but must also extend to our NHS workforce.

Ensuring our staff work in an environment where they feel they belong, can safely raise concerns, ask questions and admit mistakes is essential for staff morale - which, in turn, leads to improved patient care and outcomes . This can only be done by treating people equitably and without discrimination."

"The NHS must welcome all, with a culture of belonging and trust. We must understand, encourage and celebrate diversity in all its forms"
NHS People Plan 2020

We are compassionate and inclusive

"Diversity without Inclusion doesn't work"
Dr Jane Khawaja
Non-Executive Director,
North Bristol NHS Trust

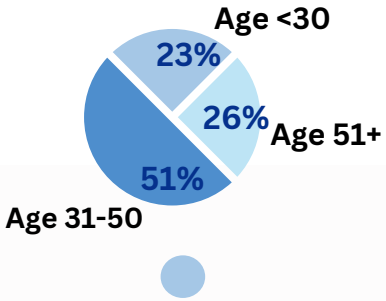
NBTCARES

Who we are...

NHS North Bristol NHS Trust

2.55% Disabled staff

22.86% B.A.ME staff

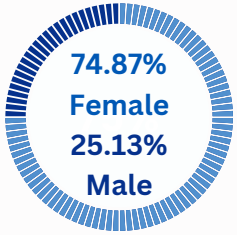


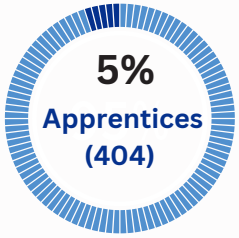
South Gloucestershire

- Total population expected to grow 20% by 2043
- Age profile similar to England with 19% aged 65+, increasing to 20% by 2043
- Lower rate of premature mortality than England average
- Low ethic diversity with 95% White population

Bristol

- Total population expected to grow 12% by 2043
- Younger age profile with 13% aged 65+, increasing to 14% by 2043
- Higher rate of premature mortality than England average
- More ethnically diverse with 84% White, 6% Black, 5.5% Asian and 3.6% Mixed





Our estate

Our sites include a range of physical estate across BNSSG from which we provide our local and tertiary services.

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13.3

Developing the Plan

NHS North Bristol NHS Trust

Jacqui Marshall
Chief People Officer

"We need a focused plan with a small set of priorities and actions that will enable us to make the real difference that is needed"

1. Review and consideration of the National and Regional EDI agenda
2. NBT current data and intelligence analysis from EDI reporting frameworks
3. Overlaying and alignment of NBT areas of concern with the NHS EDI Improvement Plan 6 High Impact Actions
4. Analysis and alignment of required actions/ priorities with existing programmes of work
5. One-1 year + EDI draft priorities identified based on gaps, risks and immediate areas of concern
6. Engagement and discussion with stakeholders

Final plan, priorities and immediate actions agreed

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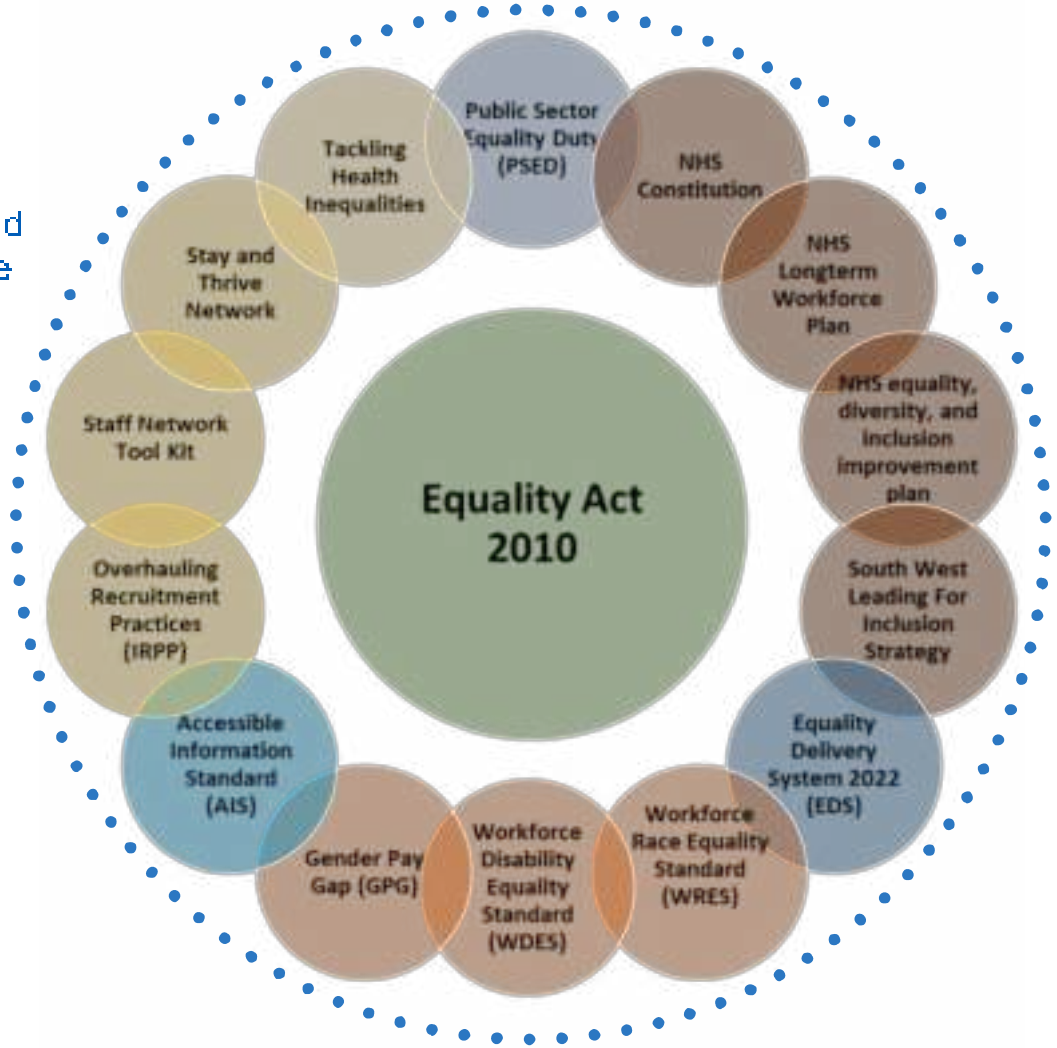
NHS North Bristol NHS Trust

EDI Drivers

Context: This diagram from NHS England sets out the 'drivers' for EDI work in the South West

- Legislation
- NHS Policies
- NHS Reporting Framework
- NHS Standard Contract
- NHS Standard
- Work Streams



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Enablers & Interdependencies

There are a range of internal/external, national/local enablers and interdependencies that form part of this plan.

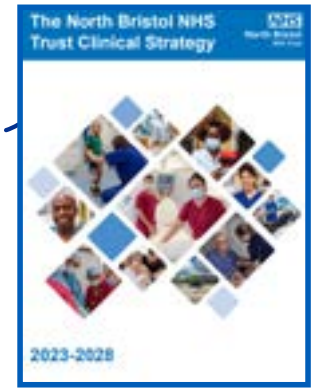
NBT Cares values & behaviours

NBT Putting Patients First Strategy

In, and for, our Community: a plan to improve opportunities that help reduce inequalities and improve health outcomes

Proud to Belong: a 1 and 5 year plan that will improve staff experience and retention

NBT Clinical Strategy



NHS EDI Improvement Plan

"This improvement plan sets out targeted actions to address the prejudice and discrimination – direct and indirect – that exists through behaviour, policies, practices and cultures against certain groups and individuals across the NHS workforce."

NHS People Promise

NBT EDI Data

National Staff Survey
WRES
WDES
Bank WRES
MWRES
GPG
EDS2
NETS

NBTCARES

NHSE EDI Improvement Plan (June 2023)

The NHSE plan prioritises the following 6 high impact actions to address the widely known intersectional impacts of discrimination and bias. These actions have been embedded into our plan for NBT.

6 High Impact Actions

Measurable objectives on EDI for Chairs Chief Executives and Board members.

Success metric

1a. Annual Chair/CEO appraisals on EDI objectives via Board Assurance Framework (BAF).

Overhaul recruitment processes and embed talent management processes.

Success metric

2a. Relative likelihood of staff being appointed from shortlisting across all posts

2b. NSS Q on access to career progression and training and development opportunities

2c. Improvement in race and disability representation leading to parity

2d. Improvement in representation senior leadership (Band 8C upwards) leading to parity

2e. Diversity in shortlisted candidates

2f. NETS Combined Indicator Score metric on quality of training

Eliminate total pay gaps with respect to race, disability and gender.

Success metric

3a. Improvement in gender, race, and disability pay gap

Address Health Inequalities within their workforce.

Success metric

4a. NSS Q on organisation action on health and wellbeing concerns

4b. National Education & Training Survey (NETS) Combined Indicator Score metric on quality of training

4c. To be developed in Year 2

Comprehensive Induction and onboarding programme for International recruited staff.

Success metric

5a. NSS Q on belonging for IR staff

5b. NSS Q on bullying, harassment from team/line manager for IR staff

5c. NETS Combined Indicator Score metric on quality of training IR staff

Eliminate conditions and environment in which bullying, harassment and physical harassment occurs.

Success metric

6a. Improvement in staff survey results on bullying / harassment from line managers/teams (ALL Staff)

6b. Improvement in staff survey results on discrimination from line managers/teams (ALL Staff)

6c. NETS Bullying & Harassment score metric (NHS professional groups)

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WHAT DOES OUR DATA TELL US?...

Key Headlines

Workforce Race Equality Standard (WRES)

- Despite an increase of 3.24% staff from B.A.ME backgrounds in 2022, B.A.ME staff still remain under-represented in medium and upper bands, compared to their proportion within the Trust.
- 72.3% of B.A.ME staff are within lower bands (Band 5 and below)
- The biggest proportion of newly recruited NBT B.A.ME staff are international recruits.
- This suggests our numbers of B.A.ME staff from the local population is not increasing.

Gender Pay Gap 2022/23

- For NBT, female and male staff, the mean gap was £4.40 (23.33%) and the median gap was £0.11 (0.63%) in favour of male staff.

Workforce Disability Equality Standard (WDES)

- Harassment Bullying or Abuse from managers towards disabled staff: year on year reduction across all staff groups.
- Staff with long term health conditions: Harassment Bullying and abuse from colleagues down 3.1% over 5 years.

Discrimination Bullying & Harassment

- Percentage of ethnic minority staff experiencing harassment, bullying or abuse from Manager / team leader: no improvement since 2018.
- B.A.ME staff almost 3 times more likely to experience managerial discrimination compared to 6% of NBT White staff.

HR Cases

- The chances of B.A.ME staff entering a formal disciplinary process compared to white staff in 2022/23 has decreased since 2021/22.
- 18% of HR recorded cases involve B.A.ME colleagues compared to last year's rate of 25%
- The reduction is despite an increase of the number people recorded as going through HR disciplinary process.

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Chief People Officer
Jacqui Marshall

This Equality, Diversity and Inclusion (EDI) Plan sets out our priorities over the next 3 years and includes some very clear actions that we will take in the next 12 months. We will aim to refresh these actions each year to check that we are truly making a difference, and I expect us to hold ourselves and each other to account for delivering these and making the change that is needed.

NHS England developed an EDI Improvement Plan for the NHS in June 2023. This outlines where NHS organisations can make the greatest difference by focusing on 6 key areas (known as 'High Impact Actions'). Here at NBT we have reviewed these actions alongside our existing programmes of work and against where our own EDI data tells us that we need to improve. This has led us to develop 4 priority areas, which will be our core EDI focus.

These priorities are:

We will set ourselves targets and key performance indicators (KPIs) against which we will measure our success and progress. This will be monitored and reported directly to our Board on a regular basis, and we expect to see improvement and the change that's needed for everyone to feel proud to belong here.

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NHS North Bristol NHS Trust

EDI PRIORITIES

1. **Ensuring EDI ownership & accountability**
2. **Eliminating discrimination, harassment, bullying & violence**
3. **Embedding diverse & fair recruitment**
4. **Closing the pay gap**

Commitment to our Community

Caring · Ambitious · Respectful · Supportive

Proud to belong

NBTCARES

Why these priorities?...

Ensuring EDI ownership & accountability

We understand that we will only make real progress if we <u>all</u> proactively 'own' and are responsible and accountable for the EDI agenda and delivery of change.

Eliminating discrimination, harassment, bullying & abuse

Workforce data and information shows us that we need to provide more proactive support to staff with protected characteristics, whose experience at NBT is not always positive. To do this, we need to put a stop to discrimination, harassment, bullying and abuse.

Embedding diverse & fair recruitment

We want to increase the number of people recruited from local communities and ensure those we recruit from overseas have a career with us. Our data shows we can do more to offer an equitable, open and transparent approach to recruitment and career progression, and improve our disparity ratio.

Closing the pay gap

Our data tells us that we have not made real progress on our pay gap and we need to take more focused action to understand why and address this.

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ACTION PLAN
These are the actions that we will undertake over the next 12 months against our priorities

Priority 1

Ensuring EDI Ownership & Accountability

Action	How	When	Success Metric	Link to NHSE High Impact Action?
Action 1: Every board and executive team member to have EDI objectives that are SMART and are assessed against these as part of their annual appraisal process	• Arrange Board Development session led by EDI expert • Review best practice case studies across the NHS • Agree at least 1 'team' EDI objective and 1 personal objective • Link these to the priority actions in this plan • Share and publish these objectives with each other and with the Senior Leadership Group	**By 31.3.24**	Annual chair and chief executive appraisals on EDI objectives- Board Assurance Framework	✓ 1
Action 2: NHS board to review relevant data to establish EDI areas of concern and prioritise actions	• Boards to receive EDI reporting data on a regular basis and discuss what it is telling us, including identifying areas of concern • Develop a revised EDI governance and assurance framework to ensure clear progress and oversight of agreed actions	**By 31.3.24**	Identification of prioritised actions Revised framework in place	✓ 1
Action 3: Work closely with Divisions and teams to ensure that they develop practical actions, plans and SMART objectives around NBT's key areas of EDI focus.	• Ensure that each Division works towards 2 EDI objectives and targets and that these are part of their core plans, • Objectives to be linked to areas of concern or challenge in that Division/team • ***Positive Action**** to be a one of those core objectives for all Divisions as it will support diversity, inclusion and disparity ratios	**By 31.3.24**	Divisional EDI plan and dashboard in place by 31 March 2024 Regular EDI reviews occurring at DRs from 1.4.24	✓ 6 ✓ 2
Action 4: Grow and develop staff and Divisional engagement, understanding and knowledge of the EDI agenda	• Develop a new network of Divisional EDI ambassadors • Invest further in Staff Networks as a source of support, expertise and delivery of EDI priorities • Bring EDI training back 'in-house', review content and deliver to staff in a way that is accessible and sustainable. This to include specific cultural awareness training for teams	**By 31.3.24**	Ambassador network established; review utlisation metrics Training underway	✓ 6

Positive action is the deliberate use of proportionate measures to eliminate or reduce discrimination, or its effects to overcome disadvantage, or low participation in key areas such as recruitment, education and training. It is for groups of people who share a 'protected characteristic' (for example, race, sex, or sexual orientation) in order to level the playing field.

NBTCARES

Priority 2

Eliminating discrimination, harassment, bullying & violence

Action	How	When	Success Metric	Link to NHSE High Impact Action?
Action 1: Review data by protected characteristic on bullying, harassment, discrimination and violence.	• Review data and intelligence through a wide range of mechanisms and sources • Utilise the Data Triangulation Group • Review disciplinary and ER processes. Obtain insights on themes/trends and via case reviews • Agree and set a reduction target • Develop and implement a plan aligned to themes and data • Review the effectiveness of *'Red Card to Racism/abuse',* refresh and re-launch programme	Agree target and plan **by 31.3.24** **By 31.3.24**	Year-on-year reduction in incidents of bullying and harassment from staff (reduce from 23.5% to 21% (B.A.ME staff) **NHS Staff Survey** Improvement in staff survey results on discrimination from line manager: B.A.ME staff: reduce from 17% to 15% to 10% over 2 years Disabled staff reduce from 13.4% to 10% to 8% over 2 years	✓ 6
Action 2: Ensure safe and effective policies and processes in place to support staff affected by domestic abuse and sexual violence (DASV)	• Review current policies and processes • Links with the Violence and Aggression Group • Review reporting processes, engaging a range of multi-professional stakeholders • Ensure effective and accessible support for all • Develop a DASV policy for staff	**By 30.6.24**	New DASV policy developed and in place Evidence of staff utilising the policy and sources of support	✓ 6
Action 3: Create an environment where staff feel able to speak up and raise concerns with specific focus on the impact of culture and protected characteristics on speaking up.	• Review and refresh as necessary all of our 'speaking up' processes; • Ensure comprehensive psychological support for all individuals who report that they have been a victim of bullying, harassment, racism, discrimination or violence • Ensure mechanisms are in place so that staff who raise concerns are protected and feel safe	**From 31.3.24**	Improvement in staff survey results on these questions, when analysed by protected characteristic Data Triangulation Group metrics	✓ 6

Embedding diverse & fair recruitment

Priority 3

Action	How	When	Success Metric	Link to NHSE High Impact Action?
Action 1: Enhance our induction, onboarding and development programme for internationally recruited staff.	• Implement the NHSE recommendations including clear communication, guidance and support, a comprehensive onboarding programme for international recruits. Cultural awareness training. Ensuring access to development opportunities. • Implement the 'Adapt' programme for international recruits	**By 31.3.24**	Seek feedback from international staff after 1 and 3 months in post to assess effectiveness of pre-appointment support Utilise/review Post-grad department systems, data and feedback on induction and on-boarding for IMGs	✓ 5
Action 2: Create and implement a talent management plan to improve the diversity of executive and senior leadership teams.	• Review current data • Develop action plan and associated steps to achieve this.	**By 31.3.24**	Improved EMT, SLG and Board diversity	✓ 2
Action 3: Action 3: Implement a plan to widen recruitment opportunities within local communities, aligned to the NHS Long Term Workforce Plan. Include the creation of career pathways into the NHS such as apprenticeship programmes and graduate management training schemes.	• Progress Fairer Recruitment project including reduction of the Trust's disparity ratio. • Sign up to and participate in the ICS-led 'Diverse Panel Pool' project • Implement Commitment to our Community plan to increase new hires from our most deprived communities.	**By 30.06.24** **By 31.10.23**	Reduction in disparity ratio Increase in new hires from our most deprived communities *Specific metric to be agreed/defined*	✓ 6

NBTCARES

Priority 4

Closing the Pay Gap

Action	How	When	Success Metric	Link to NHSE High Impact Action?
Action 1: Further understand and analyse what is driving our gender and race pay gap at NBT	• Complete the *'Addressing your gender pay gap'* self-assessment checklist provided by NHS Employers; develop follow-up actions • Develop actions around the 6 key areas: *Branding, Communication and Transparency; recruitment and promotion processes; Maternity, Paternity and Parental leave policies; well-being and retention; supporting female staff; data analysis* • Support and enable NBT's new Women's network to flourish and grow	**By 31.3.24**	Plan in place and being implemented by March 2024 Year-on-year reductions in the gender and race pay gaps - Pay Gap Reporting	✓ 3
Action 2: Implement the *Mend the Gap* review recommendations for medical staff and develop a plan to apply these to senior non-medical workforce	• Key stakeholders to read and consider the review • Review the recommendations, including any gaps in our practices at NBT and any best practice which we can emulate and implement • Develop a plan aligned to these areas using A3 problem-solving approach	**By 31.3.24**	Plan in place with clear targets Year-on-year reductions in the gender and race pay gaps - Pay Gap Reporting	✓ 3

13.3

12-point Plan - Our Immediate Actions

NHS North Bristol NHS Trust

Ensuring EDI ownership & accountability

Eliminating discrimination, harassment, bullying & violence

Embedding diverse & fair recruitment

Closing the pay gap

TRUST WIDE ACTIONS

1. Launch new EDI governance structure by 31st Dec 23
4. Launch a zero-acceptance campaign and approach to discrimination, harassment, bullying and abuse by 31st January 24
7. Launch Positive Action campaign by 30th November 23. New recruitment policy embedding Fairer Recruitment principles launched by 31st March 24
10. Review and commence implementing actions from the 'Mend the Gap' review for medical workforce, by 31st January 24

LEADERSHIP LEVEL ACTIONS

2. Agree one smart EDI objective for all Board members and senior leaders by 31st March 24
5. EMT & SLG 'Senior Leader Champions' identified and assigned to tackle each theme identified by the Triangulation Group by 31st March 24
8. All posts Band 8a/above advertised as 'positive action' from 1st December 23; diverse interview panels in place for all Band 8a/above posts by 31st March 24
11. Complete NHSE gender pay gap self-assessment by 31st December and publish pay gap action plans for gender and ethnicity by 31st March 24

DIVISIONAL / SERVICE ACTIONS

3. Each Division/Service to identify at least one area of improvement in EDI based on their data by 31st March 24
6. Individual 'Speaking Up campaigns launched for every Division by 31st March 24, focussing on bystander to upstander
9. Track divisional/service improvement in disparity ratio and hires from deprived communities via new EDI governance structure by 31st January 24
12. Run divisional campaigns to increase staff network involvement, supporting the release of staff, by 31st March 24

Enabling Delivery...

We will ensure delivery of our 12-point plan and the other short, medium and long-term actions, in the following ways:

1. Work to clear and agreed KPIs and success metrics
2. Utilise and resource our staff networks to support delivery of key actions
3. Use the new EDI Operational Group to oversee delivery and offer EDI support and guidance to divisions
4. Use existing Divisional Reviews as a mechanism to formally report Divisional progress
5. Develop an underpinning project plan to track progress of delivery
6. Report and highlight progress and risk through the revised EDI Governance and Assurance process

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OUR STAFF NETWORKS

Our staff networks in NBT enable staff to come together around a shared purpose to improve staff experience within the Trust. They are a hugely valuable part of NBT and working together will help us to deliver and embed our EDI priorities and actions.

As part of our EDI plan we will...

Engage

Engage with and support our networks to continue to develop and build their influence, agency, and impact.

Develop

Work with our networks to embed the NHSE Staff Network guidance and Toolkit, ensuring that we are utilising the resources to help develop all our networks across the Trust.

Deliver

Work with our networks to continually check effectiveness, ensuring we are delivering for the needs of our staff and helping to achieve our collective aims, objectives, and priorities.

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LOOKING AHEAD
We will refresh our actions each year to check that we are truly making a difference. Over the next 3 years there are further actions we will take as part of our plan. All actions are aligned with the national NHSE EDI Improvement Plan.

A LOOK AHEAD: YEARS 2 AND 3 ….

Theme	WHAT…	WHEN	LINK TO HIGH IMPACT ACTION ICS collaboration?
EDI Ownership and Accountability	Board members to demonstrate how organisational data and lived experience have been used to improve culture	By March 2025	✓ 1
Fair and inclusive recruitment processes and talent management strategies	Evidence progress of implementation of the plan to create and implement a talent management plan to improve the diversity of executive and senior leadership teams.	By June 2025	✓ 2 **ICS collaboration Also, NBT strategy 'In and for our Community' and disparity ratio**
Closing the Pay Gap	Plans should be in place to improve/close the pay gap: disability **by 2025** and other protected characteristics **by 2026**	By 2025: disability By 2026: other PCs	✓ 3
Improve Health Inequalities	Work in partnership with community organisations, facilitated by ICBs working with NHS organisations and arm's length bodies, such as the NHS Race and Health Observatory. For example, local educational and voluntary sector partners can support social mobility and improve employment opportunities across healthcare	By April 2025	✓ 4 **ICS collaboration**

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Going even further...

Over the next 3 years there are further interventions we want to take to address the negative experiences of staff with individual protected characteristics, as defined in the Equality Act 2010.

No person is only one protected characteristic, and so we need to consider the impact of intersectionality, when implementing any interventions.

These actions supplement the NHSE intersectional high impact actions outlined in our action plan and will help us to go further in specific areas.

We will use robust datasets for each protected characteristic and continue to consider and address the experience of all staff at NBT in light of their protected characteristics to help identify where further interventions may be needed.

This will be tracked through our governance structure and monitored alongside our 4 key priorities with the support and guidance of our EDI Team, ICS colleagues and Staff Networks.

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Actions we will take...

Age

01

[illegible] to have meaningful conversations with their teams, to align personal aspirations with jobs to ensure requirements. This includes the option of phasing retirement and exploring alternative work patterns.

02

Encourage flexible working as part of good attraction, recruitment, retention and return processes. Promote the NHS Pension Scheme and highlight its value across the career journey, with specific focus on flexible retirement for staff in their later careers.

03

Work in partnership with local educational institutions and voluntary sector partners to support social mobility by improving recruitment from local communities, and by considering alternative entry routes to the NHS, such as apprenticeships and volunteering.

NBTCARES

Disability

Actions we will take...

01

Demonstrate a year-on-year improvement in disability declaration rates and that ESR data is accurate about disabled people as measured by the WDES.

02

Promote the visibility of disabled workers through effective campaigns alongside providing secondments and career development opportunities tailored to disabled staff. Progress to be measured by tracking the number of disabled staff in leadership roles.

03

Take steps to continue to address discrimination at levels of bullying and harassment experienced by disabled staff.

04

Implement recommendations from the NHS Inclusive recruitment and promotion practices programmes, and ensure each stage of the recruitment pathway is accessible, does not discriminate and encourages people with disabilities to apply for roles. Track this via the WDES, using Trac data.

05

Ensure our talent management and career development programmes are fully accessible and inclusive. Progress to be measured by tracking the number of Disabled people in secondment roles.

06

Ensure our reasonable adjustments policy is effectively and efficiently implemented and achieves year-on-year improvement in NHS Staff Survey metrics relating to reasonable adjustments at work.

NBTCARES

Race

Actions we will take...

01

The Board to demonstrate their understanding of and progress towards race equality, an essential criterion in job descriptions for board members and all very senior manager (VSM) grades. Appraisals of senior executives will include a focus on EDI, as recommended by the Messenger Review.

02

Board to use the EDI dashboard to establish internal data driven accountability and scrutinise progress at an organisational, divisional, departmental, occupation, and site level to address underrepresentation and pay gaps.

03

To tackle race discrimination effectively the Board will give due consideration to national policies and recommendations from other arms length bodies such as the Equality and Human Rights Commission inquiry and General Medical Council. In addition, the Board to proactively raise awareness of their commitment with patients and public.

04

The Board to ensure concerns raised about race discrimination are dealt with in a proactive, sensitive, thorough and timely manner, including encouraging diversity in Freedom to Speak Up Guardians.

Religion or belief

Actions we will take...

01

TSR are qualitative data to be tracked to highlight the experiences of people with different faiths or no faith through all stages of the employment journey.

02

Review our policies and processes to ensure they are supportive of religious expression in the workplace. This includes access to facilities for prayer, understanding of cultural differences, including religious clothing, and flexibility around religious observances such as the Sabbath and Ramadan.

03

Take actions to ensure concerns raised about religious discrimination are dealt with in a proactive, preventative, thorough and timely manner, including by encouraging diversity in Freedom to Speak Up champions.

NBTCARES

Sex, pregnancy & maternity

Actions we will take...

01

Focus on closing the gender pay gap and improving the experiences of the lowest paid people, delivering the Messenger review recommendations for medical workforce to the wider workforce.

02

Ensure that our flexible working policy is easily accessible and suitable for all staff supporting their work-life balance, management of caring responsibilities, health and wellbeing, and enabling continued professional development.

03

Continue to support menopause awareness, adopting NHS policy and ensuring we are fully supporting colleagues experiencing menopause, maximising their wellbeing and allowing them to work for as long as they wish to contribute.

NBTCARES

Gender reassignment & sexual orientation

Actions we will take...

01

Where our colleagues feel comfortable to, actively encourage LGBT+ staff to self-declare their sexual orientation on ESR and TRAC, emphasising how this can improve the experiences of LGBT+ staff. We recognise that cultural changes in ESR ones, be more before trans and non-binary staff are able to do so.

02

Review our data for LGBT+ staff across multiple sources such as ESR, TRAC, NHS Staff Survey and local qualitative and quantitative data from LGBT+ staff networks and communities in the pipeline. Identify areas of concern that need to be addressed.

03

Ensure that diversity training on gender reassignment and sexual orientation is included within mandatory training.

04

The EMT to continue to actively talk about the benefits of allyship as well as exemplify and sponsor LGBT+ staff networks. Also build the concept of allyship into existing and new development programmes.

05

Ensure that LGBT+ staff are closely involved in the development and delivery of our LGBT+ training and educational interventions and our health & wellbeing programmes so that these are fully inclusive.

NBTCARES

Governance

Prior to launch of the EDI plan, it is recommended that we review the governance structure for our EDI priorities. Do we currently have this right? Could we improve this?

Background - EDI currently reports into the EDI Committee which then reports into People Committee, which reports into Board. The EDI Committee is chaired by a NED with Executive level membership and the terms of reference are a combination of operational/delivery items as well as strategy and assurance. It meets once a quarter and there is no divisional representation on Committee currently, although this is being explored. There are no other working groups overseeing the EDI agenda for the Trust. The People Committee receive upward reports from the EDI Committee, but the agenda is often full and there is insufficient time to ensure more in-depth assurance around our EDI priorities.

Proposal - It is proposed that EDI should report directly to Board – this sets the right tone for the importance of this and would enable the Board to receive greater assurance and monitoring of our progress in this area. In addition, it is proposed that we set up a new EDI Group under the workforce governance structure – reporting into the new People Oversight Group. This group will be responsible for overseeing the delivery of the EDI Plan and monitoring and measuring progress and impact. **There are 3 potential options for the EDI Committee:**

Option A

Retain the existing EDI Committee reporting into the People Committee. Adjust the terms of reference to make it clear whether this is an assurance Committee or operational group.

Option B (Preferred option)

Rename the People Committee to the People & EDI Committee and adjust the terms of reference to ensure that this Committee is overseeing the EDI agenda directly and reporting progress to the Board.

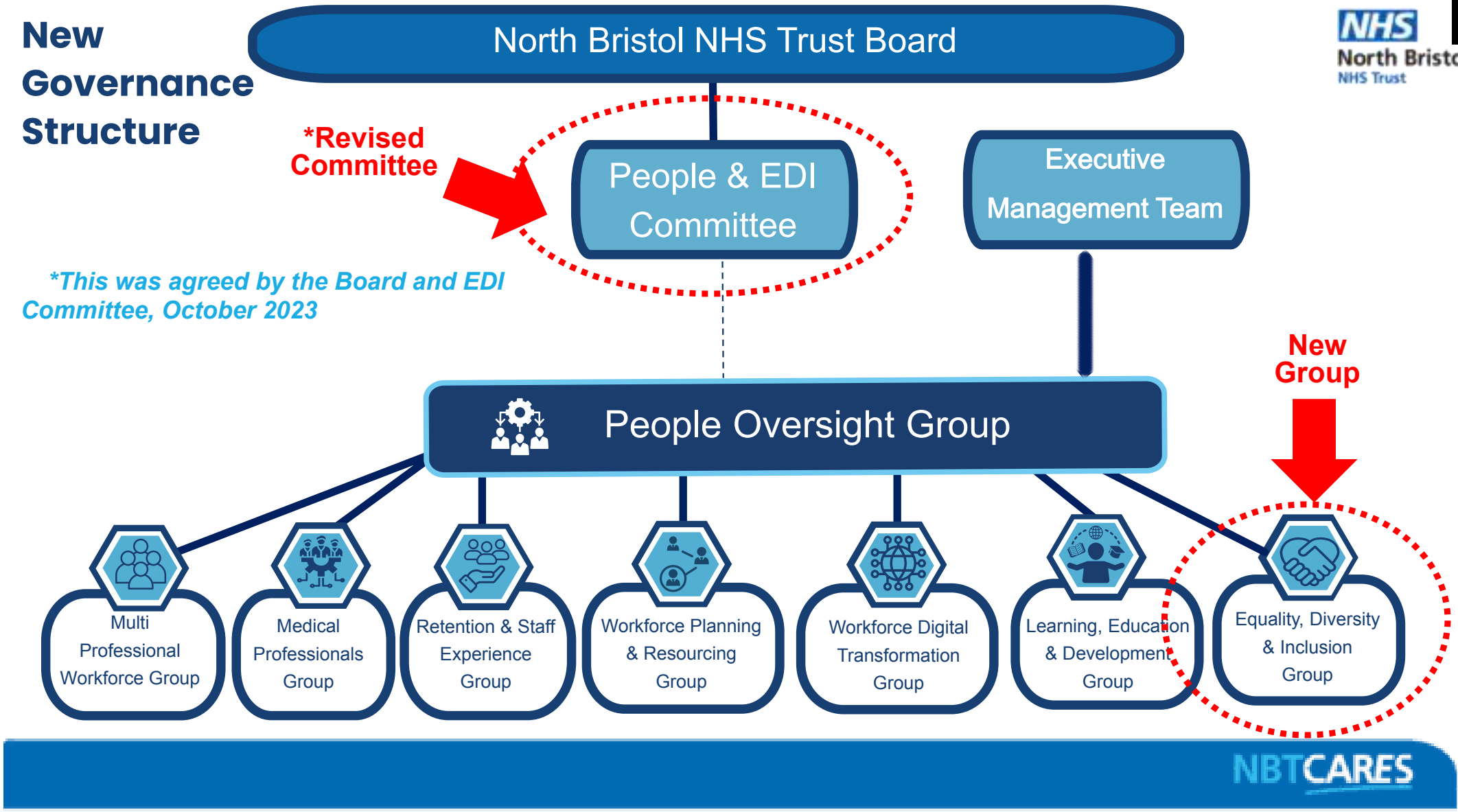
Option C

Repurpose the existing EDI Committee as an assurance Committee and move the reporting line straight in to the Board. This would require 2 additional NEDs on this Committee.

NBTCARES

13.3

New Governance Structure




NHS
North Bristol
NHS Trust
THANK YOU!
NBTCARES

Report To:	Trust Board			
Date of Meeting:	30 November 2023			
Report Title:	Freedom to Speak Up Bi-Annual Report November 2023			
Report Author:	Hilary Sawyer, Lead Freedom to Speak Up Guardian			
Report Sponsor:	Xavier Bell, Director of Corporate Governance & Trust Secretary			
Confidentiality (tick where relevant) *:	**Patient identifiable information?**	**Staff identifiable information?**	**Commercially sensitive information?**	**Other exceptional circumstances**
*If any boxes above are ticked, paper may need to be received in *private.*				
Purpose of the report:	**Approval**	**Discussion**	**Information**	**Assurance**
		x		
Recommendations:	Trust Board is: **Asked to:** • Review and discuss the updated FTSU data, trends and themes. • Note the updated organisational FTSU self-reflection review and related NHSE FTSU guidance. **Note:** • The current NBT FTSU policy (published 10/01/23). **Reminded to:** • Complete the HEE/NGO FTSU e-learning module: 'Follow-up' module for leaders • Role-model and regularly communicate the value to NBT of workers speaking up, consistent with NBT's refreshed Values and Behaviours Framework, encouraging workers to feel empowered and safe to do so.			
Report History:	There is a bi-annual report to Trust Board. The last report was in May 2023.			
Next Steps:	See body of report.			

Executive Summary
Effective speaking up arrangements help protect and improve patient safety and support and improve the experience of NHS workers through empowered, respected, and valued worker voice. Freedom to Speak Up Guardians proactively promote a 'business as usual' speaking up culture for continuous learning through listening, active response, and positive cultural change. **Summary position on 2023/2024 Q1 and Q2 data:**

The data shows sustained increase in concerns raised since early 2021; the majority of concerns are related to workplace attitudes, behaviours and worker wellbeing (and process and pressures). The data suggests some hotspots of relative silences in terms of speaking up through FTSU. **This report:** • Outlines the most recent data and high-level themes around concerns being raised • Outlines steps taken to triangulate the data with other sources • Highlights planned high-level next steps, and suggested actions for NBT Leadership		
Implications for Trust Improvement Priorities: *(tick those that apply and elaborate in the report)*	**Our Aim: Outstanding Patient Experience**	x
	High Quality Care – *Better by design*	x
	Innovate to Improve – *Unlocking a better future*	
	Sustainability – *Making best use of limited resources*	
	People – *Proud to belong*	x
	Commitment to our Community - *In and for our community*	
Link to BAF or Trust Level Risks:	Freedom to Speak Up is an important mitigation for the workforce risk recorded on the Board Assurance Framework The Care Quality Commission (CQC) assesses a Trust's speaking up culture under the Well-Led domain of its inspections	
Financial implications:	The Lead FTSU Guardian role is now funded recurrently at 0.9 WTE. This will need to be monitored to reduce risk of 'single point' resourcing and also consider aspects of diversity and representation.	
Does this paper require an Equality, Diversity and Inclusion Assessment (EIA)?	Freedom to speak up relies upon a fair, inclusive, and open culture that supports all workers, including those with protected characteristics, to speak up and bring diversity of voice and experience. Demographic/equalities data of staff speaking up is challenging to collect robustly however will be a focus of improvement. The Trust is working to gradually improve the diversity and representation of all worker groups within the FTSU network.	
Appendices:	Appendix 1: Organisational Freedom to Speak Up reflection and planning self-review	

1. Purpose

1.1 The purpose of this report is to update the Senior Leadership Group on Freedom to Speak Up (FTSU) activity and themes of issues raised by colleagues at North Bristol NHS Trust (NBT) over the past 6 months for learning and provide assurance on the work to help workers speak up and feel valued for doing so.

2. Background

2.1 Freedom to Speak Up Guardians were introduced to NBT from November 2017. The number of volunteer Guardians has varied and is now four, with an increasing network of FTSU Champions being recruited to increase visibility, awareness, reach and diversity, and to support engagement and accessibility of FTSU. A substantive Lead Guardian role (0.6WTE) was introduced in mid-January 2021 since when awareness of speaking up and the FTSU Guardian role has increased and improved (the lead role was extended to 0.9WTE from April 2023).

2.2 The Lead Guardian role brings ring-fenced time to support:

- NBT workers to be able to speak up (including awareness and response)
- a positive speaking up culture of continuous learning through listening and response
- the organisation in becoming a more open and transparent place to work, where staff speaking up is highly valued, influencing the organisation's improvement
- training for managers and leaders in 'listening up' and 'following up'
- identification of, and actions to address, any barriers to speaking up
- assessment of trends and responses to issues being raised

and hold the Board to account for taking appropriate action to create a positive speaking up culture across NBT.

3. Update of data, themes and activity

The following provides information as outline the NHSE FTSU guidelines on:

3.1 Part 1: Assessment of FTSU cases

3.2 Part 2: Actions taken to improve speaking up culture

3.3 Part 3: Recommendations

4. Summary and Recommendations

4.1.1 The Board is asked to:

- Review the Recommendations as above in the coversheet.
- Role-model and regularly communicate the value to NBT of workers speaking up, consistent with NBT's refreshed Values and Behaviours Framework.

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National Guardian
Freedom to Speak Up

NHS

Freedom to Speak up

A reflection and planning tool

Introduction

The senior lead for FTSU in the organisation should take responsibility for completing this reflection tool, at least every 2 years.

This improvement tool is designed to help you identify strengths in yourself, your leadership team and your organisation – and any gaps that need work. It should be used alongside Freedom to speak up: A guide for leaders in the NHS and organisations delivering NHS services, which provides full information about the areas addressed in the statements, as well as recommendations for further reading.

Completing this improvement tool will demonstrate to your senior leadership team, your board or any oversight organisation the progress you have made developing your Freedom to Speak Up arrangements.

You may find that not every section in this tool is relevant to your organisation at this time. For this reason, the tool is provided in Word format to allow you to adapt it to your current needs, retaining the elements that are most useful to you.

If you have any questions about how to use the tool, please contact the national FTSU Team using england.ftsu-enquiries@nhs.net

The self-reflection tool is set out in three stages, set out below.

Stage 1

This section sets out statements for reflection under the eight principles outlined in the guide. They are designed for people in your organisation's board, senior leadership team or – in the case of some primary care organisations – the owner.

You may want to review your position against each of the principles or you may prefer to focus on one or two.

Stage 2

This stage involves summarising the high-level actions you will take over the next 6–24 months to develop your Freedom to Speak Up arrangements. This will help the guardian and the senior lead for Freedom to Speak Up carry out more detailed planning.

Stage 3

Summarise the high-level actions you need to take to share and promote your strengths. This will enable othersin your organisation and the wider system to learn from you.

Stage 1: Review your Freedom to Speak Up arrangements against the guide

What to do

- Using the scoring below, mark the statements to indicate the current situation.

  1 = significant concern or risk which requires addressing within weeks

  2 = concern or risk which warrants discussion to evaluate and consider options

  3 = generally applying this well, but aware of room for improvement or gaps in knowledge/approach

  4 = an evidenced strength (e.g., through data, feedback) and a strength to build on

  5 = confident that we are operating at best practice regionally or nationally (e.g., peers come to use for advice)

- Summarise evidence to support your score.
- Enter any high-level actions for improvement (you will bring these together in Stage 2).
- Make a note of any areas you score 5s in and how you can promote this good practice (you will bring these together in Stage 3).

Principle 1: Value speaking up

For a speaking-up culture to develop across the organisation, a commitment to speaking up must come from the top.

Statements for the senior lead responsible for Freedom to Speak Up to reflect on	Score 1–5 or yes/no
I am knowledgeable about Freedom to Speak Up	Yes
I have led a review of our speaking-up arrangements at least every two years	Yes
I am assured that our guardian(s) was recruited through fair and open competition	Yes
I am assured that our guardian(s) has sufficient ringfenced time to fulfil all aspects of the guardian job description	3
I am regularly briefed by our guardian(s)	Yes
I provide effective support to our guardian(s)	Yes

Enter summarised commentary to support your score.

(Completed by Xavier Bell, prior to Glyn Howells taking on Executive Lead responsible for FTSU):

I have acted as FTSU Guardian in the past and provide close support to the current FTSU Guardian. I have completed the HEE FTSU training and remain abreast of current NGO guidance as it relates to FTSU.

With the support of the FTSU Guardian I have completed the NGO self-review in March 2021 and taken this through the Trust Board for discussion and endorsement. This helped to inform a refreshed FTSU Vision, Strategy, and Action Plan which was approved in May 2021. This included development of the FTSU Champion model. The self-review was refreshed in May 2022 and taken through Trust Board for discussion.

The Lead FTSU Guardian was recruited via a competitive process in late 2020 (advertised internally only). Several candidates were interviewed, ensuring a truly competitive process. Similarly, the FTSU Champion recruitment process involves an open (internal) EOI and interview process.

The amount of ring-fenced time has been increased in 2023/24 to 0.9 WTE by agreement with the Lead FTSU Guardian, and some administrative support also made available. This ring-fenced time is recurrently funded. Discussions are underway as part of 2024/25 planning to identify resource for additional support such as a part-time deputy FTSU Guardian.

I meet with the Lead FTSU Guardian weekly, and there is a quarterly catch-up with all Guardians and Champions. I am available to speak to any of the Guardians or Champions any time and am occasionally contacted by the volunteer Guardians.

As well as weekly meetings with me, the Lead FTSU Guardian has also had some independent coaching in 2022/23, which she can access again in 2023/24, and we are piloting a regular support session with NBT's lead staff support psychologist.

In September 2023 Glyn Howells, Chief Finance Officer, took on the role as Executive Lead for FTSU. Xavier Bell will continue to remain involved as deputy senior lead. Regular 1:1 meetings and tri-partite meetings are in place.

High-level actions needed to bring about improvement (focus on scores 1, 2 and 3)

1. Continue to keep the ring-fenced time under review and explore additional resource to reduce risk of "single point of failure".

Statements for the non-executive director lead responsible for Freedom to Speak Up to reflect on	Score 1–5 or yes/no
I am knowledgeable about Freedom to Speak Up	Yes
I am confident that the board displays behaviours that help, rather than hinder, speaking up	Yes
I effectively monitor progress in board-level engagement with the speaking-up agenda	Yes
I challenge the board to develop and improve its speaking-up arrangements	Yes
I am confident that our guardian(s) is recruited through an open selection process	Yes
I am assured that our guardian(s) has sufficient ringfenced time to fulfil all aspects of the guardian job description	3
I am involved in overseeing investigations that relate to the board	Yes
I provide effective support to our guardian(s)	Yes

Enter summarised evidence to support your score.

- I make use of online resources and tool kits for Non-Executive FTSU leads, attend Guardians meetings and regularly check in with the lead Guardian. I am able to compare and contrast FTSU culture with ways of working outside of the NHS in the private sector.
- FTSU is regular and protected Board agenda item. The guardian is invited to attend, present, respond to and pose questions for the Board in the spirit of healthy challenge and support. Board meeting minutes evidence that these discussions take place and the richness of them.
- I have challenged the board to improve its speaking up agenda through regular engagement with the Executive lead, the guardian by championing the need for the role to be a ring fenced one, for it to be full time and for the Board to challenge the timescales for responding to and closing cases.
- I reviewed the selection process for the guardian/s and was invited to be part of the process to assure this.
- I am assured our guardian has ring fenced time to fulfil the role competently, I believe considering the size and scale of NBT, the individual needs more time for our approach to FTSU to be frontier level/best practice and I continue to champion and support this.
- We have not had any issues relating to investigations that relate to the Board. I am aware of and do discuss in confidence with the lead guardian where we might have concerns relating to divisional areas that are the accountability of Board members. I am

confident the FTSU guardian and Exec lead would ask for my support if required to oversee any investigation should the need arise.

- I have regular 121 catch ups with our guardian, and we have conducted walk arounds together so I believe I am providing effective support.

High-level actions needed to bring about improvement (focus on scores 1, 2 and 3)

1. Support increase of hours so the FTSU Guardian is full time, considering the size and scale of NBTs workforce and operation.

Principle 2: Role-model speaking up and set a healthy Freedom to Speak up culture

Role-modelling by leaders is essential to set the cultural tone of the organisation.

Statements for senior leaders	Score 1–5 or yes/no
The whole leadership team has bought into Freedom to Speak Up	Yes
We regularly and clearly articulate our vision for speaking up	3
We can evidence how we demonstrate that we welcome speaking up	2
We can evidence how we have communicated that we will not accept detriment	3
We are confident that we have clear processes for identifying and addressing detriment	3
We can evidence feedback from staff that shows we are role-modelling the behaviours that encourage people to speak up	2
We regularly discuss speaking-up matters in detail	2

Enter summarised evidence to support your score.

Discussions at Senior Leadership Group and Trust Board in May 2023 confirmed commitment from senior leaders; however, 2022 staff survey results identify the need for more effective communications and engagement in this space:

- Speaking up to the organisation about general concerns (rather than harassment and bullying or behavioural/relationship concerns) is a weakness based on staff survey results.
- Results showed that staff did not feel able to raise concerns, particularly clinical concerns or those linked to clinical safety. This is felt likely to be due to pressures (felt nationally) including staff shortages and vacancies and is linked to the very poor response we have around staff recommending NBT as a place to receive treatment to friends and family. (Conversely, the question around staff recommending NBT as a place to work was very strong).
- The raising concerns issue is further expressed in the free text staff survey comments where the vast majority of concerns linked to staffing levels.

- The staff survey question around staff feeling assured that NBT would take action in response to concerns raised, was also quite poor. This indicates that there is a lot to be done around making it feel 'safe' for staff to raise these kinds of issues.
- In August 2023 a People & Quality Triangulation Group was formed, bringing together various senior leaders from across patient safety, workforce, EDI, patient experience, risk, health and safety and staff wellbeing/support teams. This group meets quarterly, reviewing data and looking for trends and triangulation of overarching issues.

High-level actions needed to bring about improvement (focus on scores 1 ,2 and 3)

1. Continue to evolve the People & Quality Triangulation Group as a forum for triangulating feedback and areas of concern
2. Re-focus the communications around speaking up to emphasise that the organisation welcomes speaking up, and that leaders see responding to concerns as a core responsibility of all managers and leaders
3. Continue to engage with senior leadership to support responsibilities around embedding the speak up/listening culture
4. Use the HELM Leadership Development programme to reinforce leadership responsibilities in speaking up
5. Support communication of organisational response to themes of issues raised

Statements for the person responsible for organisational development	Score 1–5 or yes/no
I am knowledgeable about Freedom to Speak Up	Yes
We have included creating a speaking-up culture (separate from the Freedom to Speak Up guardian process) in our wider culture improvement plans	Yes
We have adapted our organisational culture so that it becomes a just and learning culture for our workers	Yes
We support our guardian(s) to make effective links with our staff networks	3
We use Freedom to Speak Up intelligence and data to influence our speaking-up culture	3

Enter summarised evidence to support your score.

- Currently into year 3 of embedding a Restorative Just Culture approach at NBT
- This has meant a focus on listening to and learning from staff and situations where something may not have gone according to plan – avoiding blame and focussing on accountability and future learning
- This approach is enshrined in our Disciplinary Policy and draft Fairness at Work Policy and in our work with Trade Unions
- Over 50 leaders from a range of clinical and non-clinical roles have undertaken the formal Mersey Care Just and Learning training
- We are now rolling training out NBT's Just Culture training Trust-wide. 90 managers have so far undertaken this training
- We have formal learning de-briefs at the conclusion of formal HR cases
- We are now into year 2 of utilising our 'Early Resolution Framework' – a NBT toolkit which supports staff and managers to have early and supportive conversations when they wish to raise something which may be causing them concern
- In 2022 we refreshed and re-launched our confidential Harassment and Bullying (H&B) phone line and recruited new, H&B advisors
- We offer regular CPD and de-briefs to advisors, linking them in with FTSU guardians/champions and Cultural Ambassadors.
- In 2022 we trained several internal mediators, who are available to support staff when they have relationship difficulties at work
- We have undertaken focussed work and developed resources on the Bystander effect and linked this into our training on Civility Saves Lives, which has initially been focussed in the Women' and Children's Division but which we intend to extend more widely

- We have seen a very positive and sustained improvement over the last 3 years in the Staff Survey on the question of staff reporting bullying and harassment and on the question of staff experiencing bullying and harassment at work
- The People (HR) team attend corporate induction so that we can talk to new staff about the different methods of support available for them at NBT. We also give out small cards which state our Trust values and the speaking up mechanisms available to them
- We record our HR cases on electronic tracker system and regularly the volume and types of complaints and grievances being raised

High-level actions needed to bring about improvement (focus on scores 1, 2 and 3)

1. Supporting FTSU Guardians and staff networks to connect consistently to continue to support the priorities of all staff networks and worker voice–We can do this by ensuring there is support for network leads/chairs and the Lead Guardian/Guardians to ensure a regular two-way feedback mechanism for both sharing high level feedback on FTSU/speaking up themes and for escalating and taking forward any issues or concerns which are raised by that particular network
2. We use Freedom to Speak Up intelligence and data to influence our speaking-up culture – we will ensure triangulation of FTSU intelligence with other relevant data is better supported, and then take action accordingly. We will do this by supporting regular check-ins with key stakeholders, reviewing the data and intelligence from their areas and agreeing shared actions. This should ideally include ensuring that the national 'Speak Up, Listen Up, Follow Up' message is referenced in management training, including the newly developed 'HELM' Management and Leadership Programme (see below also – principle 4 and 6).

Statements about how much time the guardian(s) has to carry out their role	Score 1–5 or yes/no
We have considered all relevant intelligence and data when making our decision about the amount of ringfenced time our guardian(s) has, so that they are able to follow the National Guardian's Office guidance and universal job description and to attend network events	Yes
We have reviewed the ringfenced time our Guardian has in light of any significant events	Yes
The whole senior team or board has been in discussions about the amount of ringfenced time needed for our guardian(s)	Yes
We are confident that we have appropriate financial investment in place for the speaking-up programme and for recruiting guardians	2

Enter summarised evidence to support your score.

The decision to ring-fence FTSU Guardian time was taken in 2020, based on an assessment by the then Lead Guardian and a survey of volunteer FTSU Guardian's across the organisation. 0.6 WTE was chosen as it was initially felt that the volunteer Guardian arrangements would continue. In practice, the number of volunteer Guardian's has reduced, and most of the activity has fallen to the Lead FTSU Guardian, at the same time as an increase in concerns and activity (linked to having a Guardian with ring-fenced time in post). In 2022 we benchmarked against other organisations in the region and have concluded that more ring-fenced time was needed.

The capacity of the FTSU Guardian was discussed at the November Trust Board meeting as part of the bi-annual FTSU report (evidenced in the minutes), with support from the Board for ensuring that NBT had ring-fenced specific time. The Lead Guardian's ring-fenced time was increased to 0.9 WTE from the beginning of 2023/24 and this is now recurrently funded. Discussions will continue into 2024/25 planning round to identify additional resource to ensure no single point of failure in the FTSU function.

High-level actions needed to bring about improvement (focus on scores 1, 2 and 3)

1. In 2023/24 the ring-fenced time was increased to 0.9 WTE, administrative resource was allocated, and some non-pay funding also provided for awareness raising. This will remain under review with additional resource sought via planning for 2024/25.

Principle 3: Make sure workers know how to speak up and feel safe and encouraged to do so

Regular, clear and inspiring communication is an essential part of making a speaking-up culture a reality.

Statements about your speaking-up policy	Score 1–5 or yes/no
Our organisation's speaking-up policy reflects the 2022 update	Yes
We can evidence that our staff know how to find the speaking-up policy	Yes

Enter summarised evidence to support your score.

NBT's FTSU Policy was refreshed over November/December 2022 using the 2022 updated template. The refreshed policy was launched in January 2023.

The launch of the policy was covered in the Chief Executive's Weekly message (18/01/2023) and is available on the policies intranet page and also appears as one of the search results if "Freedom to speak up" is entered as a search term.

Data analytics from LINK Intranet suggests that staff are accessing the policy.

High-level actions needed to bring about improvement (focus on scores 1, 2 and 3)

1. Link the policy directly in the weekly communications update (not just the FTSU link page)

Statements about how speaking up is promoted	Score 1–5 or yes/no
We have used clear and effective communications to publicise our guardian(s)	Yes
We have an annual plan to raise the profile of Freedom to Speak Up	Yes
We tell positive stories about speaking up and the changes it can bring	3
We measure the effectiveness of our communications strategy for Freedom to Speak Up	2

Enter summarised evidence to support your score.

- The FTSU Guardians are referenced in every weekly Operational Update.
- The Lead FTSU Guardian regularly blogs via the intranet
- The Chair regularly references FTSU in her monthly videos
- The Lead FTSU Guardian undertake regular visits across the organisation, independently and with the Chair, Chief Executive, and other Executives
- Posters with FTSU Guardian and Champion details are shown across the organisation and regularly updated
- The Lead FTSU Guardian undertakes focused awareness raising in FTSU Month (October)

Anecdotally, it appears that far more staff are aware of FTSU function (identified via engagement with staff on site visits).

High-level actions needed to bring about improvement (focus on scores 1, 2 and 3)

1. As part of the refreshed FTSU Strategy we need a specific section focused on updated communications, building on the Senior Leadership Group discussions about focusing on leaders and managers having a responsibility for listening to concerns

2. Need to agree specific Communications Team support for FTSU/speaking up. This would ideally include:
    - a single, responsive point of contact in the Comms team with time to support regular newsletters.
    - Regular sections within Operational Updates focused on the Speak Up, Listen Up, Follow Up theme (“you said, we did")
3. As discussed at Trust Board in November 2022, the communication approach needs to transition away from only raising awareness of the FTSU function, and focus more on “you said, we did” (Speak Up, Listen Up, Follow Up) – the tangible results and benefits of speaking up. This needs to be in all communications, not just communications linked to the FTSU function.

Principle 4: When someone speaks up, thank them, listen and follow up

Speaking up is not easy, so when someone does speak up, they must feel appreciated, heard and involved.

Statements about training	Score 1–5 or yes/no*
We have mandated the National Guardian's Office/Health Education England training	Yes
Freedom to Speak Up features in the corporate induction as well as local team-based inductions	Yes
Our HR and OD teams measure the impact of speaking-up training	No

Enter summarised evidence to support your score.

NBT mandated the NGO / HEE training in 2022. It now appears as a topic that must be completed on all staff "LEARN" accounts.

FTSU has a specific slot at the corporate induction day, and either the Lead FTSU Guardian, or the Senior Lead for FTSU, attends in person to speak to new staff. There is variable coverage of "speaking up" at local induction. The Lead Guardian is sometimes invited to speak as specific local induction sessions for various staff groups including nursing students and preceptors, but this is not consistent.

High-level actions needed to bring about improvement (focus on scores 1, 2 and 3)

1. Need to ensure that organisational guidance on local induction includes a prompt about signposting to FTSU (such as commitment from line manager to always listen to concerns, plus details of FTSU champions, including any local to their team)

2. Via the People & Quality Triangulation Group, consider how the impact of speaking up (and listening up) training might be measured.

Statements about support for managers within teams or directorates	Score 1–5 or yes/no
We support our managers to understand that speaking up is a valuable learning opportunity and not something to be feared	Yes
All managers and senior leaders have received training on Freedom to Speak Up	3
We have enabled managers to respond to speaking-up matters in a timely way	3
We are confident that our managers are learning from speaking up and adapting their environments to ensure a safe speaking-up culture	2

Enter summarised evidence to support your score.

Managers are required to undertake training on FTSU (NGO/HEE training online). This was launched in 2022, so has not yet been completed across the organisation.

The Lead FTSU Guardian attends some leadership forums (e.g., nursing leaders forum, Facilities managers) and other staff groups to provide speaking up training and awareness raising.

NBT is commissioning a Leadership and Development programme for leaders and managers, and this will include elements covering a leader's responsibility to listen and respond to concerns and ensure organisational learning.

High-level actions needed to bring about improvement (focus on scores 1, 2 and 3)

1. Need to review NGO/HEE training compliance via LEARN and ensure regular reminders/communications. Consider including a prompt in the 2022/23 appraisal documentation.

2. Need to ensure that the Leadership and Development Programme contains a module on "speaking up" and our expectations on how managers will respond and action.

3. Implement a process whereby Divisional/Directorate leads receive regular and consistent feedback from the Lead FTSU Guardian on speaking up activity and themes within their areas of responsibility.

Principle 5: Use speaking up as an opportunity to learn and improve

The ultimate aim of speaking up is to improve patient safety and the working environment for all NHS workers.

Statements about triangulation	Score 1–5 or yes/no
We have supported our guardian(s) to effectively identify potential areas of concern and to follow up on them	Yes
We use triangulated data to inform our overall cultural and safety improvement programmes	Yes

Enter summarised evidence to support your score.

Executives and Divisional/Corporate Leaders have engaged with the Lead FTSU Guardian and the Senior Lead for FTSU when concerns have been raised within their areas of responsibility, and have engaged/supported investigations, meetings with staff, and improvement plans where appropriate.

A new People & Quality Triangulation Group has been set up (June/July 2023), which will focus on providing a forum for regular organisational-wide triangulation of data to inform cultural and safety improvement programmes

High-level actions needed to bring about improvement (focus on scores 1, 2 and 3)

1. Use the People & Quality Triangulation Group to effectively triangulate organisational data
2. Ensure that the Lead FTSU Guardian is included as a key contributor in wider cultural and safety improvement development (via closer links to relevant teams in People and Quality directorates).

Statements about learning for improvement	Score 1–5 or yes/no
We regularly identify good practice from others – for example, through self-assessment or gap analysis	Yes
We use this information to add to our Freedom to Speak Up improvement plan	Yes
We share the good practice we have generated both internally and externally to enable others to learn	Yes

Enter summarised evidence to support your score.

We have undertaken self-assessments most recently in 2021 and 2022. We have a gap analysis against NGO reviews and reports.

The Lead Guardian remains in close contact with counterparts from neighbouring Trusts (UHBW and AWP in particular). Good practice is shared (e.g., learning around Champion models, ring-fenced time, policies etc.). The Lead Guardian is also engaged in the regional FTSU network which includes sharing of good practice.

This self-review will inform a refresh of NBT's FTSU Strategy and Action Plan.

High-level actions needed to bring about improvement (focus on scores 1, 2 and 3)

1. NBT FTSU Strategy and Action Plan to be refreshed in 2023/24 for launch in 2024/25

Principle 6: Support guardians to fulfil their role in a way that meets workers' needs and National Guardian's Office requirements

Statements about how our guardian(s) was appointed	Score 1–5 or yes/no
Our guardian(s) was appointed in a fair and transparent way	Yes
Our guardian(s) has been trained and registered with the National Guardian Office	Yes

Enter summarised evidence to support your score.

Competitive recruitment process run in 2020. Multiple internal candidates were interviewed.

The Lead FTSU Guardian has undertaken NGO and refresher training, and the volunteer Guardians have undertaken online refresher training.

The ring-fenced time for the FTSU Guardian was increased to 0.9 WTE (from 0.6 WTE) in 2023/24, and some administrative support made available.

High-level actions needed to bring about improvement (focus on scores 1, 2 and 3)

1. None

Statements about the way we support our guardian(s)	Score 1–5 or yes/no
Our guardian(s) has performance and development objectives in place	Yes
Our guardian(s) receives sufficient one-to-one support from the senior lead and other relevant executives or senior leaders	Yes
Our guardian(s) has access to a confidential source of emotional support or supervision	Yes
There is an effective plan in place to cover the guardian's absence	Yes
Our guardian(s) provides data quarterly to the National Guardian's Office	Yes

Enter summarised evidence to support your score.

The Lead FTSU Guardian's performance objectives are the actions set out in the FTSU Strategy and Action Plan.

The Lead FTSU Guardian had a development coach in 2022, with specific objectives agreed. This will be available again in 2023.

The Lead FTSU Guardian meets weekly with the Senior Lead for FTSU and has regular catchups with the Chief Executive and Chair, as well as the NED FTSU Lead and other Executives as required.

We are piloting a confidential support arrangement with NBT's staff psychology service, which has started in 2023.

High-level actions needed to bring about improvement (focus on scores 1, 2 and 3)

1. Need to ensure that the pilot with the NBT staff psychologist is reviewed in 2023, and a permanent arrangement agreed (either internally or externally).

Statements about our speaking up process	Score 1–5 or yes/no
Our speaking-up case-handling procedures are documented	Yes
We have engaged with managers and other key stakeholders on the role they play in handling speaking-up cases	3
We are assured that confidentiality is maintained effectively	Yes
We ensure that speaking-up cases are progressed in a timely manner within the teams or directorates we are responsible for	3
We are confident that if people speak up within the teams or directorates we are responsible for, they will have a consistently positive experience	2

Enter summarised evidence to support your score.

Our policy has clear processes within it, and we hold supplementary SOPs to ensure that information sharing between teams (such as Patient Safety, HR etc.) is consistent.

Managers are required to undertake FTSU NGO/HEE training. The Lead FTSU Guardian undertakes awareness raising, and FTSU is included within corporate induction. This needs to form part of the wider Leadership and Development Programme.

The Lead FTSU Guardian maintains concerns data on an access-controlled folder. Only anonymised data is shared within the FTSU Report.

In November 2022 on the back of an internal audit into FTSU processes (Significant Assurance with Minor Improvement Opportunities) we began monitoring the time it takes to close a concern. This is being monitored, as there is area for improvement.

Feedback received by the Lead FTSU Guardian is overwhelmingly positive about the FTSU process. In reality, anecdotal evidence and informal feedback suggests that raising a concern, and being involved in any following actions (discussions, facilitated meetings, mediation, investigation) is intense, and can be difficult for staff involved. We remain cognisant of this reality and try to ensure that the FTSU Guardians/Champions are available, and staff are sign-posted to support as appropriate.
High-level actions needed to bring about improvement (focus on scores 1, 2 and 3)
1. Need to ensure that the HELM Leadership and Development Programme contains a module on “speaking up” and our expectations on how managers will actively listen, respond and action concerns raised to them.

Principle 7: Identify and tackle barriers to speaking up

However strong an organisation's speaking-up culture, there will always be some barriers to speaking up, whether organisation wide or in small pockets. Finding and addressing them is an ongoing process.

Statements about barriers	Score 1–5 or yes/no
We have identified the barriers that exist for people in our organisation	2
We know who isn't speaking up and why	2
We are confident that our Freedom to Speak Up champions are clear on their role	Yes
We have evaluated the impact of actions taken to reduce barriers?	3

Enter summarised evidence to support your score.

We are aware that there are barriers to speaking up, and these have been explored generally with staff on walk-arounds, via Staff Network meetings, FTSU Champion feedback. These barriers are also clear from national guidance and shared learning, such as language, cultural expectations, access to IT etc. Some engagement work around barriers and suggested actions from workers has been carried out in 2023 by the Lead Guardian. The staff survey data provides some insight into staff groups and areas that are less likely to speak up, but this is not something that we have explored specifically outside of Lead FTSU and Senior Lead for FTSU. Since the introduction of a Lead FTSU Guardian with ring-fenced time, and then the FTSU Champion role, the number of concerns and staff contacts has gradually increased, which could be linked to a reduction in barriers (through an increase in diversity of routes to raise concerns, and increased coverage and opportunity).

High-level actions needed to bring about improvement (focus on scores 1, 2 and 3)

1. Utilise the new People and Quality Triangulation Group to specifically consider barriers to speaking up generally in the organisation, consider further engagement and take action from feedback, and monitor the impact

Statements about detriment	Score 1–5 or yes/no
We have carried out work to understand what detriment for speaking up looks and feels like	No
We monitor whether workers feel they have suffered detriment after they have spoken up	Yes
We are confident that we have a robust process in place for looking into instances where a worker has felt they have suffered detriment	Yes
Our non-executive director for Freedom to Speak Up is involved in overseeing how allegations of detriment are reviewed	Yes

Enter summarised evidence to support your score.

Feedback from concerns suggests that workers are not suffering detriment, but there is clearly an effect on workers raising concerns – fatigue, stress and additional effort involved in any discussions, investigations etc.

Detriment processes have not been tested at NBT but would involve the Non-Executive Director being involved in a review, as per the FTSU policy.

High-level actions needed to bring about improvement (focus on scores 1, 2 and 3)

1. Consider whether there is a more robust process for ensure all those involved in FTSU have a specific opportunity to feed back on the effects of being involved in FTSU, even if it does not involve detriment.

Principle 8: Continually improve our speaking up culture

Building a speaking-up culture requires continuous improvement. Two key documents will help you plan and assess your progress: the improvement strategy and the improvement and delivery plan.

Statements about your speaking-up strategy	Score 1–5 or yes/no
We can evidence that we have a comprehensive and up-to-date strategy to improve the speaking-up culture	Yes
We are confident that the Freedom to Speak Up improvement strategy fits with our organisation's overall cultural improvement strategy and that it supports the delivery of related strategies	Yes
We routinely evaluate the Freedom To Speak Up strategy, using a range of qualitative and quantitative measures, and provide updates to our organisation	Yes
Our improvement plan is up to date and on track	Yes

Enter summarised evidence to support your score.

NBT has a strategy, due to be refreshed in 2023/24. At the time of development, it aligned with the People Strategy and the Just and Restorative Culture work. It will need to be revisited in 2023/24 alongside developments in the Trust's overall cultural and improvement approach, including the new Trust Values and Behaviours, Patient First improvement approach, Leadership Development etc. Progress against the actions linked to the strategy can be evidenced.

High-level actions needed to bring about improvement (focus on scores 1, 2 and 3)

1. Revisit the Trust's FTSU Strategy in 2023/24 in light of the Trust's overall cultural and improvement approach, including the new Trust Values and Behaviours, Patient First improvement approach, Leadership Development etc.

2. Ensure that the FTSU Guardian is feeding into the wider cultural improvement work, through links to the relevant functions within the organisation and visibility in development and decision-making forums

Statements about evaluating speaking-up arrangements	Score 1–5 or yes/no
We have a plan in place to measure whether there is an improvement in how safe and confident people feel to speak up	No
Our plan follows a recognised 'plan, do, study, act' or other quality improvement approach	2
Our speaking-up arrangements have been evaluated within the last two years	Yes

Enter summarised evidence to support your score.

Internal Audit review in 2022 provided "Significant Assurance with Minor Improvement Opportunities" in relation to the Trust's FTSU processes, and the Trust has completed the previous iteration of the FTSU self-assessment document in 2021 and 2022.
The Trust uses the Staff Survey as its main evidence source for how safe and confident people feel in speaking up. 2022 Staff Survey results show that the number of staff who are confident raising concerns about unsafe clinical practice has deteriorated, as has the number of staff who feel the organisation would act in response to a concern being raised.

High-level actions needed to bring about improvement (focus on scores 1, 2 and 3)

1. Actions to address deterioration in relevant staff survey responses being progressed through improved communications, leadership role-modelling, and alignment of improvement and culture initiatives.

2. Organisational focus on high-quality appraisals also intended to improve opportunities for colleagues to speak to their managers

Statements about assurance	Score 1–5 or yes/no
We have supported our guardian(s) to structure their report in a way that provides us with the assurance we need	Yes
We have we evaluated the content of our guardian report against the suggestions in the guide	Yes
Our guardian(s) provides us with a report in person at least twice a year	Yes
We receive a variety of assurance that relates to speaking up	Yes
We seek and receive assurance from the relevant executives/senior leaders that speaking up results in learning and improvement	2

Enter summarised evidence to support your score.

The FTSU report follows the overall structure set out in the guidance, although there is opportunity to improve how we report on "action taken to improve speaking up culture" and ensure that it links to wider cultural improvement initiatives.

High-level actions needed to bring about improvement (focus on scores 1, 2 and 3)

1. Continue to improve the reporting structure and focus on action taken to improve speaking up culture, using the new People and Quality Triangulation Group to ensure that cultural improvement initiatives are targeting areas of specific need.

Stage 2: Summarise your high-level development actions for the next 6 – 24 months

Development areas to address in the next 6–12 months	Target date	Action owner
1. Evolve the People & Quality Triangulation Group as a forum for: • triangulation of concerns/issues data and themes across the organisation, and • exploring barriers to speaking up Review effectiveness after 12-months.	31/08/2024	Xavier Bell, Director of Corporate Governance
2. Ensure that the HELM Programme covers leadership and management responsibilities for responding to concerns and creating a culture of “speak up, listen up, follow up”	31/01/2024	Sarah Margetts, Deputy Chief People Officer
3. Ensure appropriate links between the FTSU function and the wider organisational development and cultural functions within the organisation, by including the Lead FTSU Guardian as a key partner and participant in relevant OD programmes and forums.	28/02/2024	Caroline Hartley, Associate Director of Culture and OD
4. Develop a co-created Communications Plan for speaking up, aligned with wider OD and cultural work, focused on “speak up, listen up, follow up”, with single point of contact Communications support.	30/04/2024	Elliot Nichols, Director of Communications & Engagement
5. Monitor the ring-fenced time for the FTSU Guardian and ensure recurrent funding available.	Ongoing – review in Jan 2024 as part of planning	Glyn Howells, Chief Finance Officer
6. Use the new People function governance (People Oversight Group) to oversee organisational response to staff survey results, particularly the speaking up questions, and monitor changes in responses in 2023 and future years.	31/07/2024	Sarah Margetts, Deputy Chief People Officer

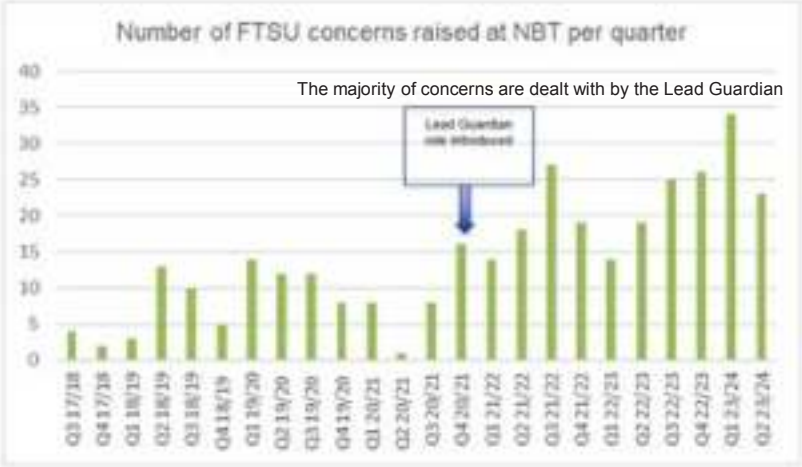
7. Refresh the FTSU Strategy in 2023/24, aligned to wider People, Quality, and OD strategies and plans.	30/04/2024	Hilary Sawyer, Lead FTSU Guardian
Development areas to address in the next 12–24 months	**Target date**	**Action owner**
1. Deliver the speaking up elements of the new 3-year Equality, Diversity and Inclusion Plan, one aim of which is to address cultural issues and barriers to speaking up through a 'top down and bottom up' approach.	31.3.2025	Associate Director of Culture, Leadership and Development
2. Deliver a campaign of work on zero acceptance of discrimination, harassment, bullying and violence, with a specific focus on key protected characteristics	31.3.2025	Associate Director of Culture, Leadership and Development
3. Review and relaunch and improve our 'Red Card to Racism' campaign, to support those speaking up about racist behaviour or actions towards them or their colleagues, with resulting improved outcomes	1.12.2024	Head of Equality, Diversity and Inclusion
4. Develop policies and processes to support staff affected by domestic abuse and sexual violence (DASV) and evaluate effectiveness	31.3.2025	Associate Director of Culture, Leadership and Development
5. Ensure staff are able to speak up against and about sexual violence and misconduct at work by implementing the ten commitments described within the NHS England 'Sexual Safety in Healthcare Organisational Charter', which NBT has signed up to.	31.7.2024	Chief People Officer
6. Further develop our psychological support services for staff and build on existing interventions which support psychological safety (e.g., Compassionate Conversations, Me and My Team, Start Well, End Well)	31.12.25	Associate Director of Culture,

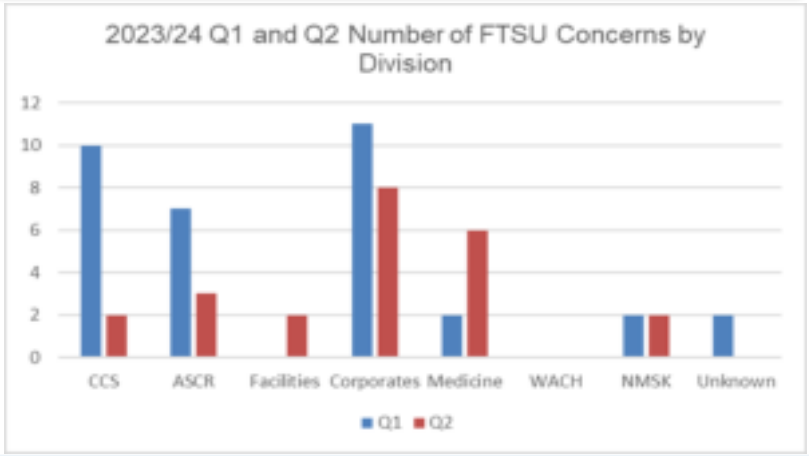
		Leadership and Development
7. Refresh and rebrand our existing cultural/behavioural training and interventions under the strategic theme of 'Proud to Belong', with an emphasis on kindness, civility and respect and inclusion.	31.3.2025	Associate Director of Culture, Leadership and Development
8 Double our number of Cultural Ambassadors and ensure they operate as an additional and effective form of support for staff who may be raising concerns or going through a formal HR process.	31.3.2024	Head of Equality, Diversity and Inclusion

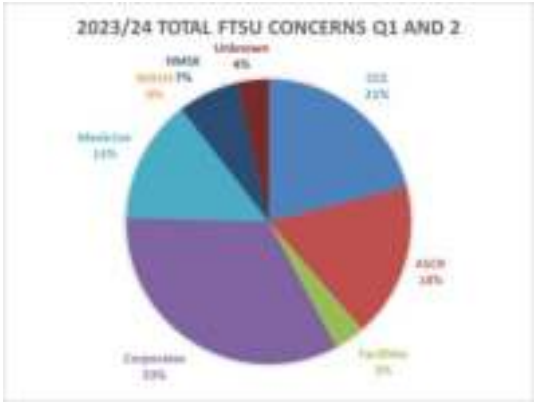
Stage 3: Summary of areas of strength to share and promote

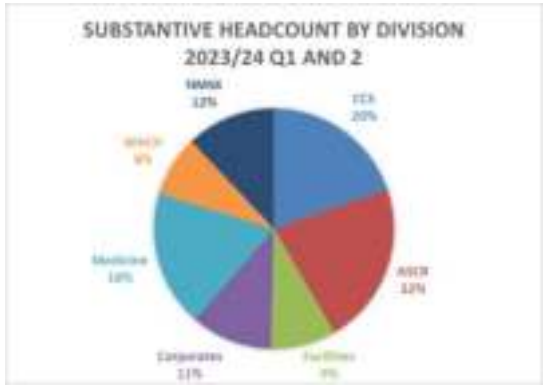
High-level actions needed to share and promote areas of strength (focus on scores 4 and 5)	Target date	Action owner
1		
2		
3		
4		
5		
6		
7		
8		

FTSU Board report November 2023: Part 1: Assessment of NBT FTSU 'cases'



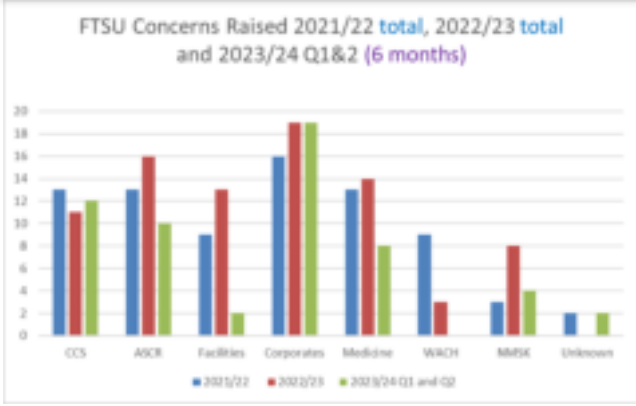






What do the data tell us?

- The number of FTSU concerns raised remains increased since introduction of the Lead Guardian role
- FTSU concerns were raised across Divisions in Q1 and Q2, other than WACH. A lower number of concerns have been raised from Facilities than previously.
- A relatively high proportion of concerns have been raised through Corporate areas – this appears to reflect increased pressures and also behaviours and relationships between team members



2023/24	CCS	ASCR	Facilities	Corporates	Medicine	WACH	NMSK	Unknown	Total
Q1	10	7	0	11	2	0	2	2	34
Substantive Head Count by Division	1938	2176	870	1079	1806	806	1187		
Q2	2	3	2	8	6	0	2	0	23
Substantive Head Count by Division	2004	2234	886	1133	1880	831	1232		

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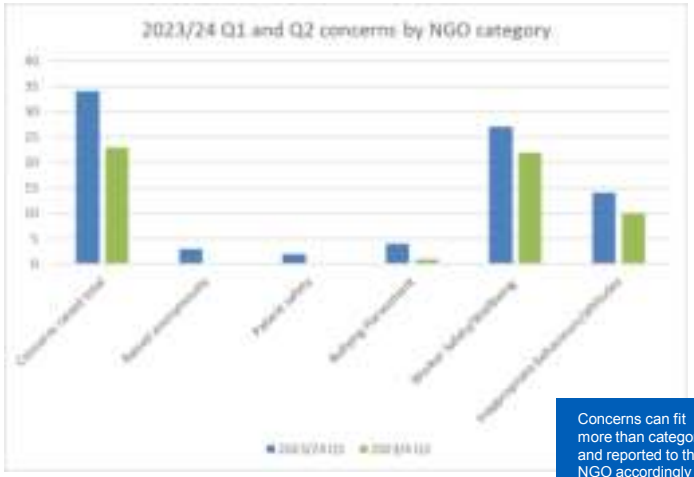
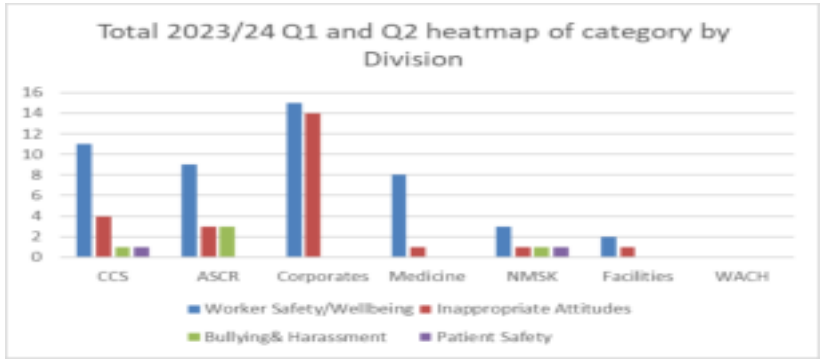
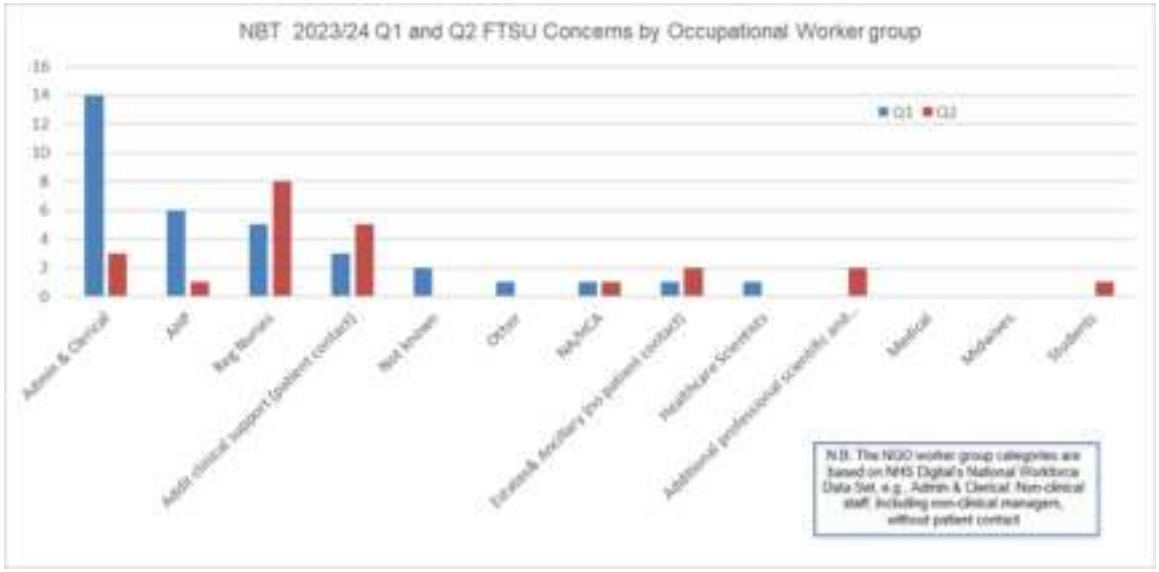


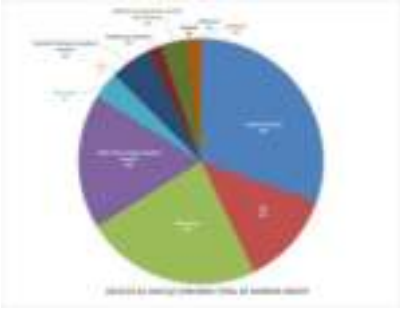
Concerns can fit more than category and reported to the NGO accordingly

What do the data tell us?

- The majority of concerns were related to the NGO categories of 'Inappropriate behaviours/attitudes' and 'Worker wellbeing/safety' rather than 'Patient Safety' or 'Bullying and Harassment'.
- Few cases have been raised anonymously (the majority are raised confidentially)
- There was a relatively high number of concerns from 'Admin and Clerical' workers in Q1 and a lower number from registered Nurses than usual
- Notably few concerns are raised to FTSU by Medical staff generally and Midwives and workers in WACH. This will continue to be factored into ongoing plans to ensure these professionals feel able to speak up through various routes, consider barriers, and increase confidence in the organisational response.







FTSU Board report November 2023: Part 1: Assessment of NBT FTSU 'cases' (continued)

FTSU process timeframes:

(To provide assurance that matters spoken up about are acknowledged, evaluated, escalated and responded to in a timely manner)

Q1 and Q2 data	Average (mode)	Range
Time taken for initial acknowledgement by a FTSU Guardian	1 working day. >96% acknowledged within the specified 2 working days.	Same day to 7 working days (three outliers: 3,5,7 working days due to Guardian leave; email redirection was in place however staff member waited for Guardian to return)
Time to closure (calendar days/months):	1.5 months	2 days to 4 months (depending on the situation) ~28% took more than one month to resolve

- Number of cases from Q1 and Q2 remaining open as of 10/11/23: 7 (either relatively complex system issues needing robust consideration, or more recent concerns raised, needing time to close robustly)
- Factors in protracted length to closure include: sickness/leave of worker, responsiveness and proactiveness of manager/leader, Guardian leave, FTSU workload balancing multiple cases and nuance, reflection and appropriate escalation/action.
- Time from escalation to effective response by a manager that assures of appropriate action that issues are addressed (where appropriate): currently manual, improvement of analysis will be considered for future as part of new case management system development
- Typical actions taken by FTSU Guardians: Depending on the situation (following active listening), action can range from: logging the issue informing themes and organisational actions, or supporting the staff member to speak up to a more senior manager themselves, or escalation with, or on behalf, of the staff member to a manager, senior manager or senior leader.
- Learning from concerns in Q1 and Q2 has included: process review, communication aspects e.g., timeliness, style when under pressure, feedback effectiveness, confidentiality and sensitiveness of handling. Issues raised through FTSU around recruitment previously are being fed into the Recruitment improvement work.

Additional assurance: The Guardian checks in subsequently with those speaking up, to ensure that workers feel that they have not suffered any disadvantageous treatment, which also serves as opportunity to ensure change has occurred, from worker perspective, as a result, and re-occurrence prevented.

FTSU Board report November 2023: Part 1: Assessment of NBT FTSU 'cases' (continued)

NHS North Bristol NHS Trust

FTSU Service User feedback:

- Easy service to contact with quick response. I felt confident that information was kept confidential, and most importantly I felt listened to with space and time given to consider possible actions.
- I found it easy to find information on how to contact the FTSU team which made things much easier.
- Having an unbiased person to speak with is extremely helpful in working out how to raise issues further and discuss ways to structure conversations with managers and consider thoughts and feelings well.
- Having space to work through some complex issues has been really helpful in finding a possible way through together.
- This is a vital service in the Trust. It can be easy to say 'speak to your manager' however without support that can be difficult when you have tried before. Staff are more reluctant to speak up and tackle issues and have felt that leaving the organisation has been, or maybe, their only route.
- I was daunted about approaching the service and was quite anxious however I quickly overcame this after meeting in person. My communications felt secure, I felt listened to and that my points were valid. This helped my confidence in speaking up.
- This service feels like a blessing. I am really grateful.
- I was really satisfied with the FTSU process and will use the service again if I need to. The service was really helpful and responsive.
- I have chosen for matters not to be taken further with managers currently, as I don't feel they have been receptive, but will consider doing so in future.
- I was really happy with the support and have told my colleagues about this service if they ever need it.
- I wasn't sure of the value of FTSU before, but now I do.
- I have felt heard at last. The Guardian was very easy to speak with. Thank you, I really appreciate the support.
- I have valued obtaining some advice and then raised the matter again myself, feeling assured that I could return to the Guardian if further support was needed.

Several workers reflected approaching FTSU as they either had felt unheard, or wanted some learning to be taken from their experience in the workplace, to prevent other people experiencing similar.

No formal reports of disadvantageous treatment has been reported to the FTSU Guardian(s) in Q1 and Q2:

- Protocol is for any concerns around disadvantageous behaviour to be logged as a discrete concern and where appropriate escalated to the Non-Executive Lead for FTSU (and notified to the Executive and Deputy Lead for FTSU).

NBTCARES

FTSU Board report November 2023: Part 1: Assessment of NBT FTSU 'cases' (continued)

NBT FTSU Themes 2023/24 Q1 and Q2

(**Rider:** concerns can be challenging to theme/group together and discuss in an informative/meaningful/sufficiently accurate manner while dealing with these sensitively and confidentially, and not creating unintended 'false narrative')

- Discrete concern around clinical practice
- One concern around staff safety and lone working and patient aggression

Attitudes and behaviours:

- Relationships, behaviours and civility between colleagues, or with manager, or within the team
- Feeling demoralised by the approach of manager/s - felt to be undermining and not feeling heard
- Impact of line manager approach to specific situations – fairness, sensitivity and confidentiality
- Reflections of belittling, undermining behaviours or lack of support
- Impact on wellbeing of not feeling able to influence senior management actions – individual or team impact
- Impact on wellbeing of organisational changes and not feeling heard over time with related matters ahead
- Impact of line management approach historically
- Feeling there is a lack of communication, or inconsistent communication
- Fairness – access to training and opportunity

Process/System-related

- Pressures and workload
- Resourcing, finance, use of funding, issues around project work
- Processes including management of return from maternity leave, extended leave, support for those involved in People processes
- Concern around timeliness, fairness and impact on staff going through grievance processes
- Working environment (for example noise in open offices)
- Recruitment process issue
- Management of colleagues felt not to be 'pulling their weight' fairly in terms of workload
- Lump-sum AfC payment for substantive staff on short-term unpaid leave (timing issue)
- One query around parking capacity/arrangements

Impact on staff wellbeing of the above

FTSU Board report November 2023: Part 1: Assessment of NBT FTSU 'cases' (continued)

Triangulation

(*How speaking up matters fit into a wider patient safety and worker experience context to help build a broader picture of speaking up culture and opportunities to learn and improve. What has been learnt and what improvements have been made as a result of workers speaking up.)*

Trust-wide triangulation:

The key themes of concerns being raised to Freedom to Speak Up were felt not to be changing significantly over the last two years. The organisation needs to move from evaluating and knowing the challenges to taking improvement action and communicating change. FTSU should be the safety valve. Until we make further inroads in improving the organisational speaking up environment, the FTSU Guardian responsive arm will be challenged in capacity to robustly support improvement of the proactive listening up culture, through the intelligence gained from those that have, and are, speaking up.

Previous bi-annual FTSU Board reports attempted to provide triangulation with specific sources of information at different points, e.g. National Staff Survey, Patient Safety Thematic Review, Patient Experience Report, People data.
This was not felt to be fulfilling the aims outlined in the NHSE guidance on FTSU in terms of identifying wider issues and actions needed in a joined-up manner.

A quarterly People and Quality Triangulation Group has been instigated to share high level information around thematic concerns and issues and any hotspots, identified to ensure that Trust-wide joined up action is being taken to tackle and ultimately prevent these.
The themes from FTSU concerns were supported by intelligence presented from other partners, including a high number of referrals to the Staff Wellbeing Psychology team, including difficulties in working relationships and team support requests.

The Lead Guardian is part of a recently formed informal NBT Culture Group with various partners considering a possible framework of existing interventions of targeted support for hotspot areas, and prevention or self-management, including aims to maintain and support civility, respect and kindness.

Divisional triangulation:

From Q1 2023/24, an agreement was made to provide Divisional and Directorate leadership with more-detailed, but still high-level FTSU information to indicate issues being raised locally (and outline action taken by the Guardian) to potentially triangulate with local sources of intelligence, for appropriate action. This information is provided in such a way that appropriate confidentiality and sensitivity is safeguarded.

FTSU Board report November 2023: Part 2: Actions taken to improve speaking up culture:

(How speaking up matters fit into a wider patient safety and worker experience context to help build a broader picture of speaking up culture and opportunities to learn and improve.)

Promotion of all speaking-up channels:

- A **'Speaking Up Flowchart'** was introduced (24/06/23) which covers the various routes of speaking up
- This was supplemented by **introduction of an Executive Hotline** communicated through the Midweek Message on 26/07/23.

These (along with an updated FTSU Guardian poster including the Executive Lead) have also been highlighted during October Speak Up Month communications and through staff training sessions.

- Divisional 'speaking up' posters are in development with Divisional teams to support local speaking Up
- Internal communications through various routes (including NBT social media)

Engagement and training:

- NHSE FTSU guidance and relevant data provided to Divisional leadership teams with dialogue invited
- Coverage of speaking up routes and FTSU at fortnightly corporate induction sessions
- Regular tailored sessions for new Student nurses, Trainee Nurse Associates, Preceptors, as part of GMC in-person sessions for International Medical Graduates, and Internationally Educated Nurse 'Adapt' sessions
- Speak Up Month activity (see separate slide)
- NBT E-learning compliance for national FTSU Senior Leadership Module: Board: 83%, SLG 70% (Speak Up module compliance 46%, Listen Up module compliance 25%, Follow Up module (all leaders) 29%)

FTSU network visibility: Walkarounds including with the CEO, Chair, Executive Lead and Deputy Lead for FTSU, and during Speak Up Month (particularly focussed out of routine hours), promotion of FTSU network Champion profiles, new Champion profiles being developed

Actions taken to support workers who may be unaware of speaking up processed or who find it difficult to speak up:

- see Speak Up Month activity (in Appendix 1)
- Pan Bristol FTSU Guardian letter for University students updated
- Pan Bristol FTSU Guardian letter for agency workers updated and circulate
- Communication to NBT Extra colleagues
- Addition of further FTSU Champions and plans to introduce further in early 2024

FTSU Board report November 2023: Part 2: Actions taken to improve speaking up culture (continued):

(How speaking up matters fit into a wider patient safety and worker experience context to help build a broader picture of speaking up culture and opportunities to learn and improve.)

NHS North Bristol NHS Trust

Assurance that FTSU arrangements are continually evaluated, and improvement identified:

- Organisational FTSU self-review updated with stakeholder partner input invited – appended
- Gap analysis in 2022/23 did not identify any significant gaps
- Feedback is requested from workers speaking up to Freedom to Speak Up (FTSU)
- The Lead Guardian attends the annual NGO conference and considers any NGO case reviews for learning and action
- The Lead Guardian attends quarterly SW Guardian network meetings for peer learning and support
- Regular meetings are convened to discuss and share practice with Bristol Lead Guardians (UHBW, AWP, Sirona, Spire)
- FTSU Guardians are required to complete annual online refresher training
- The Bristol Lead Guardians organised a Bristol/Bath FTSU Champion conference day (mid-September 2023) for peer-learning
- Feedback from workers on Barriers to Speaking Up through engagement with staff through walkarounds, engagement, training sessions and the Inclusion network, including during Speak Up Month, is currently being reviewed. This feedback will inform updated plans for further organisational action, including through the FTSU Strategy Refresh
- There were a couple of approaches to the FTSU service where initial contact was made, however the person did not proceed or respond further to the Guardian, presumably due to fear around organisational response.

FTSU Board report November 2023: Part 2: Actions taken to improve speaking up culture:(continued)

(How speaking up matters fit into a wider patient safety and worker experience context to help build a broader picture of speaking up culture and opportunities to learn and improve).

Barriers to speaking up (routinely):

The key barriers of 'Fear and Futility' are known nationally: NGO report: Fear-and-Futility-NHS-Staff-Survey-1.pdf (nationalguardian.org.uk)

Similar themes have been reflected through engagement work at NBT:

- Managers being, or at least seeming, too busy – which was also felt can be a key challenge for managers engaged with
- Fear of consequences, repercussion or treatment, or being made the problem and whether the relative risk is worthwhile
- Lack of trust and psychological safety to raise issues, or concern around bias, due to long term relationships in teams
- Concern around confidentiality when an issue is dealt with
- Concern around fairness in processes
- Feeling that issues will be dismissed or not genuinely listened to, to understand
- Feeling some aspects are not dealt with and then confusion over whether all their concerns were reasonable
- Feeling that there has been a lack of action or response or feedback (even sensitively)

Staff approaching a FTSU Guardian at NBT have, in the majority of cases, attempted to speak up to a manager first, where possible, or then do so themselves having spoken to a Guardian for advice and support. Some still decide not to do so themself, or for the Guardian to do so, for fear of repercussion.

The majority of workers approaching FTSU at NBT do so confidentially for fear of potential detriment; this has included those speaking up at exit point for fear of effect on employment if they decide to return in future.

More detailed engagement work responses around barriers to speaking up at NBT already conducted, and the suggested actions to be taken, will inform the FTSU Strategy refresh and action plan.
There were some comments that there can be lack of confidence in which route to use, and skills to speak up, or managers to listen up.

The above should be balanced with feedback on walkarounds and in training sessions, where workers reflected ability to speak up easily to their line or other managers routinely with any daily concerns and that when they had, there had been good response.
Anecdotally more workers appear to be aware of speaking up and the Freedom to Speak Up route, than was apparent, two years ago.

FTSU Board report November 2023: Part 3: Recommendations

Interim reminder for draft: NHSE guidance: Recommendations for any required action, from data/intelligence

Next steps:

- The Board is requested to **approve** the appended completed organisational self-review, and approve the action plan

Key next steps include:

Action	Target Dates	Action Owner(s)
Implement the organisational self-review action plan (see appended) to move further toward a Speak Up, Listen Up, Follow Up environment as routine normal	As per action plan	As per action plan. Oversight via People Oversight Group
Refresh the NBT FTSU Strategy including the communications plan	End of April 2024	Lead FTSU Guardian, Deputy Lead for FTSU, Executive Lead for FTSU
Further FTSU Champion expression of interest process (in particular to improve representation and increase diversity of the network, breaking down barriers further)	Initiate by 31 Jan 2024 Complete by 31 March 2024	Lead FTSU Guardian, Deputy Lead for FTSU

Ongoing Lead FTSU Guardian actions include:

- Continue to work with senior leadership and Divisional leaders and managers to ensure confidence in provision of a healthy, proactively relational, curious, compassionate listening environment, responding well to colleagues' concerns and ideas for learning and improvement; Lead FTSU Guardian to further deliver related support input, dialogue, material and training
- Strengthen processes for escalation and support through managers/leaders to resolve concerns in a timely, but nuanced, and appropriate manner
- With partners and stakeholders collaboratively, further consider the factors, and preventative, and responsive actions to strengthen NBT as a proactive listening organisation that responds robustly to staff speaking up, with clear learning and improvement, fostered by a relational rather than transactional approach

Challenge: What will **you** do to break down barriers to speaking up across the organisation, including for specific groups of workers, improve communication of learning and actions from all routes of speaking up, to improve confidence in the value of speaking up?

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Appendix 1: Recent FTSU Communications

- Executive Lead announcement
- Speak Up Month

Announcement of the Executive Lead for FTSU

NHS North Bristol NHS Trust

Speaking up matters

Message on behalf of Glyn Howells,
Executive Freedom to Speak Up Lead and Chief Finance Officer.

Dear colleagues,

I am delighted to announce that I have been asked to take on the role of the Executive Lead for Freedom to Speak Up (FTSU) here at NBT. There are few things which matter more than that every member of staff feels able to 'speak up' when they feel it necessary. Not only does it protect and support each other, it is essential to patient safety.

As you may be aware this month is Speak Up Month and as such, I will be spending it meeting as many of you as possible – working with the fantastic team of FTSU champions to promote just how important it is.

If you see something that you feel is not right and that gets in the way of the ability to deliver safe high-quality care including working life, be it a patient safety concern, bullying, harassment, or anything else, then please speak up. You can do so via your supervisor, their manager, or other managers in the department. If in doubt, please speak up – you never know how it might help.

If you don't feel comfortable with speaking up this way, for whatever reason, or if you feel your concerns aren't listened to or the response isn't appropriate, then please speak with the FTSU Guardian who is contactable via speakitup@nbt.nhs.uk **or Tel: 07880 005382**. If a concern is raised with the FTSU Guardian, they will speak with you, listen to your concerns, and help direct your concern to a person or process that can address it. Any sharing of the information will only be done with your permission – it can be **completely confidential** if that is your preference.

We are at our best when we pull together as one team. Feeling safe, respected, and heard are essential components of any team. Everyone should feel comfortable about Speaking Up within our Trust.

If you are a supervisor or a manager, then a key part of your role is to thank anyone who has raised a concern and then actively Listen Up and Follow Up. It can be difficult and challenging, but this just makes it all the more important.

I fully acknowledge that there may be times when none of the above processes feel right to you. If you find yourself in this position then please be assured that you can contact me directly on a confidential basis. We also have Kelly Macfarlane, one of our non-Executive Directors, who has a duty to ensure that the Trust has appropriate speaking up processes in place and whose role is to hold the Executive team to account in this area. Finally, if all else has failed you can contact the Chief Exec's Hotline on **07880 952587**, and the CEO or one of the Executive team will get back to you.

To celebrate Speak Up Month, a stall will be in the Atrium on Monday 16 October from 10:30am to 1pm to answer any questions you have about speaking up.

No one should feel that something wrong has or might happen and yet feel unable to challenge it. There is always something that can be done– please speak up, so we can listen and **act.**

Best wishes,

Glyn Howells

Freedom to Speak Up

You will have seen in an announcement this week that Glyn Howells has taken on the role of the Executive Lead for Freedom to Speak Up with NBT and has made his pledge this Speak Up Month.

I want to remind staff that if you see something that you feel is not right, and that gets in the way of the ability to deliver safe, high quality care, be it a patient safety concern, bullying, harassment, or anything else, then I encourage you to speak up with your supervisor, their manager or other managers in the relevant area. If you don't feel comfortable doing so, then please speak with the FTSU Guardian who is contactable **via** SpeakUp@nbt.nhs.uk **or Tel: 07880 005382**.

NBTCARES

SPEAK UP MONTH 2023

BREAKING BARRIERS

Aims and key actions

(Key strands of activity – adjusted to capacity)

NHS North Bristol NHS Trust

Refocus on routine Speaking Up and Listening and Follow up routes and responsibilities pan-organisation, expectations of Divisional/Directorate leadership and management (FTSU should be the safety valve)	Breaking Down Barriers to Speaking Up By highlighting barriers, the NGO hope to give people the confidence to influence to overcome barriers and make speaking up business as usual. The NGO will be sharing perspective on removing the barriers to speaking up throughout the month including a new podcast series, blogs and videos.	Provide support material for managers and leaders (including NBT material and links to internal courses e.g., Bitesize: Important Conversations and external) for managers and leaders in listening up (and following up)	Continue to flag FTSU availability: • Focus on FTSU Champions as key agents of breaking down barriers to speaking up • Drop-in availability and walkaround by the Lead Guardian (and various leaders)
• NBT Communications on Speak Up routes • Introduction of Exec Lead Divisional leadership engagement (including Divisional leadership posters supporting Speaking Up locally) to circulate • Encourage Divisional leaders to do informal walkarounds	• Inclusion network (and staff networks) (two simple) questions around barriers and actions • Engagement with staff around barriers and actions on walkarounds • Bristol Guardian letter for students, agency workers. • Comms for Bank workers, volunteers, and ideally medical colleagues • Encourage Divisional leaders to do informal walkarounds	Encourage leadership reflection and dialogue further (from e.g., NHSE guidance) within Divisions and Directorates • Engagement directly • Reflection questions	• FTSU Champion profile feature through Comms and network • Lead Guardian to provide drop-ins at various times. • Local Guardian to provide drop-in in Facilities if possible • Other Guardians to be visible as possible
Joint stakeholder stall 16th Oct	• Walkarounds particularly out of routine hours and across NBT including specific groups • Encourage more potential future Champions through walkaround • Linking with BHM and NSS • NGO material as issued	e.g., Medicine Leadership Away morning including Speaking Up as a focus	• Introduce new Champions late October/November • Encourage more for 2024

Freedom to Speak Up Guardian

NBTCARES

Speak Up Month 2023 Activity:

Speak Up Month

October is also Speak Up Month.

It is critical that everyone feels both confident and comfortable in raising concerns.

Your voice **always** matters - regardless of your background, position, role, working hours or circumstances. The difference it makes is very real and helps both staff and patients.

You can find out more information in our Speaking Up flowchart and Freedom to Speak Up Champions LINK page.

Breaking Barriers

The theme for Speak Up Month 2023 nationally is "**Breaking Barriers**"

- By speaking up, you can help NBT learn and improve
- By listening up, the organisation can make sure what needs to change is understood
- By following up we can ensure that learning leads to action and improvement

NHS North Bristol NHS Trust

Operational Update – Thursday 12 October

NBT Communications
To: All Exchange Email Users

https://youtu.be/WB0_2rAg2lM

Speak Up Month

Speak Up Month is here and Chief Finance Officer and executive lead for Freedom to Speak Up, Glyn Howells, wants you to know what speaking up means to NBT.

To celebrate Speak Up Month, a stall will be in the Atrium on Monday 16 October from 10.30am to 1pm to answer any questions you may have about speaking up.

No one should feel that something wrong has or might happen and yet feel unable to challenge it. There is always something that can be done – please speak up, so we can listen and act.

NBTCARES

Report To:	Trust Board			
Date of Meeting:	30 November 2023			
Report Title:	Integrated Performance Report			
Report Author:	Lisa Whitlow, Associate Director of Performance			
Report Sponsor:	Executive Team			
Confidentiality (tick where relevant) *:	**Patient identifiable information?**	**Staff identifiable information?**	**Commercially sensitive information?**	**Other exceptional circumstances**
	N/A	**N/A**	**N/A**	**N/A**
*If any boxes above are ticked, paper may need to be received in *private.*				
Purpose of the report:	**Approval**	**Discussion**	**Information**	**Assurance**
			✓	
Recommendations:	The Trust Board is asked to note the contents of the Integrated Performance Report.			
Report History:	The report is a standing item to the Trust Board Meeting.			
Next Steps:	This report is received at the Joint Consultancy and Negotiation Committee, Operational Management Board, Trust Management Team meeting, shared with Commissioners and the Quality section will be shared with the Quality and Risk Management Committee.			

Executive Summary		
Details of the Trust's performance against the domains of Urgent Care, Elective Care and Diagnostics, Cancer Wait Time Standards, Quality, Workforce and Finance are provided in the Integrated Performance Report.		
Implications for Trust Improvement Priorities: *(tick those that apply and elaborate in the report)*	**Our Aim: Outstanding Patient Experience**	✓
	High Quality Care – *Better by design*	✓
	Innovate to Improve – *Unlocking a better future*	✓
	Sustainability – *Making best use of limited resources*	
	People – *Proud to belong*	✓
	Commitment to our Community - *In and for our community*	
Link to BAF or Trust Level Risks:	The report links to the BAF risks relating to internal flow, staff retention, staff engagement, productivity, and clinical complexity.	
Financial implications:	Whilst there is a section referring to the Trust's financial position, there are no financial implications within this paper.	
Does this paper require an Equality, Diversity and Inclusion Assessment (EIA)?	N/A	
Appendices:	Appendix 1: IPR Slide Deck Appendix 2: Maternity PQSM	

15.1

North Bristol NHS Trust

INTEGRATED PERFORMANCE REPORT

November 2023

(presenting October 2023 data)

Contents

North Bristol Integrated Performance Report

Domain	Description	Regulatory	National Standard	Current Month Trajectory (RAG)	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	May 23	Jun 23	Jul 23	Aug 23	Sep 23	Oct 23	Trend	Benchmarking (in arrears except A&E & Cancer as per reporting month)	
																			Peer Performance	Rank
Responsiveness	A&E 4 Hour - Type 1 Performance	R	95.00%	69.68%	57.47%	58.29%	55.61%	71.94%	79.69%	78.35%	80.16%	70.74%	75.15%	71.49%	71.94%	64.33%	60.56%		52.92%	2/11
	A&E 12 Hour Trolley Breaches	R	0	-	482	433	786	312	9	135	2	39	10	12	17	23	223		9-2343	4/11
	Ambulance Handover < 15 mins (%)		65.00%	-	23.70%	16.88%	14.09%	24.15%	31.94%	28.00%	38.76%	33.96%	34.54%	32.21%	26.14%	25.74%	25.35%			
	Ambulance Handover < 30 mins (%)	R	95.00%	-	48.03%	41.40%	30.37%	56.74%	73.94%	70.60%	82.40%	73.03%	78.48%	74.86%	70.85%	64.84%	57.57%			
	Ambulance Handover > 60 mins		0	-	672	778	1041	457	105	267	87	231	164	165	182	317	620			
	Average No. patients not meeting Criteria to Reside			-	278	276	243	254	217	239	208	190	198	200	198	195	218			
	Bed Occupancy Rate			97.07%	98.57%	98.76%	98.22%	97.93%	96.77%	97.21%	96.08%	97.14%	96.99%	95.81%	93.63%	95.59%	97.05%			
	Diagnostic 6 Week Wait Performance		1.00%	15.00%	39.36%	38.62%	38.56%	32.21%	22.45%	16.03%	17.44%	17.48%	18.64%	15.10%	14.18%	12.50%	11.40%		29.75%	3/10
	Diagnostic 13+ Week Breaches		0	525	4627	4204	3663	2459	1497	939	740	593	595	300	124	59	17		43-4930	2/10
	RTT Incomplete 18 Week Performance		92.00%	-	66.31%	65.58%	62.05%	63.87%	63.87%	63.37%	62.66%	63.23%	61.02%	60.97%	60.50%	60.53%	61.52%		53.29%	8/10
	RTT 52+ Week Breaches	R	0	2569	3062	2980	2984	2742	2556	2576	2684	2798	2831	2689	2599	2306	2124		65-16918	2/10
	RTT 65+ Week Breaches			389	1062	1021	1105	895	742	547	591	594	619	624	606	582	545		0-5663	2/10
	RTT 78+ Week Breaches	R		55	375	319	306	223	167	69	65	84	59	44	48	48	55		0-669	3/10
	Total Waiting List	R		42959	48871	47418	46523	46266	46327	47287	47861	47731	49899	50119	50168	48969	48595			
	Cancer 2 Week Wait	R	93.00%	87.35%	30.86%	47.53%	56.62%	55.01%	63.52%	56.84%	41.63%	39.10%	42.67%	52.00%	52.22%	47.79%	-		56.83%	9/10
	Cancer 31 Day First Treatment		96.00%	95.03%	90.39%	86.49%	87.16%	82.41%	89.90%	91.04%	79.58%	83.51%	86.27%	90.77%	87.80%	81.59%	-		86.52%	7/10
	Cancer 62 Day Standard	R	85.00%	67.88%	52.45%	48.86%	49.00%	41.54%	57.82%	61.62%	55.29%	50.00%	53.20%	54.21%	52.15%	50.81%	-		56.30%	6/10
	Cancer 28 Day Faster Diagnosis	R	75.00%	72.65%	42.88%	55.74%	55.48%	62.66%	77.41%	78.17%	68.05%	62.72%	66.43%	65.14%	57.36%	54.96%	-		59.23%	6/10
	Cancer PTL >62 Days		242	197	328	329	328	335	191	140	178	207	171	183	236	276	250			
	Cancer PTL >104 Days		0	18	63	47	23	26	41	29	25	40	45	46	41	47	49			
	Urgent operations cancelled ≥2 times		0	-	1	0	0	0	0	1	0	0	0	0	0	0	-			

RAG ratings (Red/Green) are against Current Month Trajectory. For metrics with no trajectory, RAG rating is according to comparison with previous month, except for Urgent Operations Cancelled ≥ 2 times which is RAG rated against National Standard.

North Bristol Integrated Performance Report

Domain		Description	Regulatory	National Standard	Current Month Trajectory (RAG)	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	May 23	Jun 23	Jul 23	Aug 23	Sep 23	Oct 23	Trend
Quality, Safety and Effectiveness	Trust Quality Metrics	Summary Hospital-Level Mortality Indicator (SHMI)				0.96	0.96	0.98	0.96	0.97	0.98	0.98	0.99	0.99	0.98	-	-	-	
		Never Event Occurrence by month		0	0	0	2	1	1	0	0	0	0	0	0	0	1	1	
		Commissioned Patient Safety Incident Investigations				0	7	1	3	3	3	2	4	0	0	2	2	2	
		Healthcare Safety Investigation Branch Investigations				0	4	0	1	0	0	0	0	0	0	0	0	0	
		Total Incidents				1264	1252	1320	1171	973	1188	1027	1121	1111	1035	1114	1159	1346	
		Total Incidents (Rate per 1000 Bed Days)				40	41	44	37	36	39	37	38	38	35	39	41	44	
		WHO checklist completion			95.00%	97.53%	97.95%	97.91%	97.43%	97.30%	97.76%	99.20%	96.97%	97.77%	99.01%	98.54%	97.68%	99.08%	
		VTE Risk Assessment completion	R		95.00%	94.24%	95.07%	94.97%	95.41%	95.28%	94.77%	95.39%	94.87%	94.77%	94.45%	94.03%	93.42%	-	
		Pressure Injuries Grade 2				14	19	11	16	9	13	20	15	18	17	12	14	11	
		Pressure Injuries Grade 3			0	2	2	1	0	0	1	0	0	0	0	2	1	0	
		Pressure Injuries Grade 4			0	0	0	1	0	2	1	0	0	0	0	1	0	0	
		Pressure Injuries rate per 1,000 bed days				0.41	0.62	0.43	0.48	0.37	0.46	0.63	0.45	0.55	0.47	0.46	0.46	0.26	
		Falls per 1,000 bed days				7.25	6.35	6.52	7.31	6.29	6.25	5.92	6.39	5.66	4.91	5.73	4.96	6.45	
		MRSA	R	0	0	0	0	0	0	0	2	0	0	1	1	0	0	1	
		E. Coli	R		4	2	5	4	9	4	2	8	4	7	4	2	7	5	
		C. Difficile	R		5	1	4	2	1	2	6	1	4	11	6	2	5	4	
		MSSA			2	3	8	2	4	2	0	1	2	6	9	5	2	4	
		Observations Complete				95.40%	-	98.75%	96.12%	95.84%	96.64%	99.14%	99.05%	98.89%	99.22%	97.56%	96.48%	99.02%	
		Observations On Time				59.79%	-	55.83%	59.42%	60.67%	59.75%	41.65%	42.49%	45.38%	48.37%	61.62%	69.58%	73.33%	
		Observations Not Breached				71.06%	-	66.98%	70.31%	71.20%	70.39%	52.73%	53.66%	57.47%	58.21%	73.78%	80.83%	85.17%	
	Maternity	5 minute Apgar 7 rate at term			0.90%	1.26%	0.49%	0.49%	0.48%	0.58%	0.45%	0.79%	0.00%	0.72%	0.93%	0.45%	0.64%	0.68%	
		Caesarean Section Rate				43.45%	41.74%	44.57%	44.27%	43.99%	42.03%	36.41%	42.80%	44.37%	40.65%	46.33%	47.02%	42.89%	
		Still Birth rate			0.40%	0.19%	0.22%	0.22%	0.00%	0.00%	0.21%	0.24%	0.21%	0.44%	0.43%	0.21%	0.29%	0.21%	
		Induction of Labour Rate			32.10%	28.97%	31.25%	34.62%	35.73%	38.52%	34.91%	36.89%	35.91%	33.55%	38.04%	32.08%	30.65%	34.31%	
		PPH 1500 ml rate			8.60%	3.77%	3.79%	1.81%	3.60%	3.83%	2.80%	3.16%	4.09%	2.87%	4.13%	2.31%	2.68%	3.97%	
	Fragile Hip	Fragile Hip Best Practice Pass Rate				14.89%	0.00%	21.88%	47.06%	57.14%	60.34%	68.42%	55.00%	43.10%	62.00%	54.00%	51.92%	-	
		Admitted to Orthopaedic Ward within 4 Hours				17.02%	13.04%	9.09%	26.47%	38.78%	48.28%	48.21%	47.50%	27.59%	40.00%	48.00%	36.54%	-	
		Medically Fit to Have Surgery within 36 Hours				21.28%	0.00%	3.64%	44.12%	59.18%	65.52%	71.43%	67.50%	44.83%	62.00%	58.00%	55.77%	-	
		Assessed by Orthogeriatrician within 72 Hours				27.66%	2.17%	7.27%	67.65%	95.92%	94.83%	96.43%	85.00%	93.10%	96.00%	98.00%	96.15%	-	
	Stroke	Stroke - Patients Admitted				65	102	89	111	64	115	94	121	181	132	187	162	114	
		Stroke - 90% Stay on Stroke Ward			90.00%	55.88%	54.29%	71.88%	68.12%	82.00%	80.95%	86.36%	87.01%	85.71%	89.02%	80.91%	84.62%	-	
		Stroke - Thrombolysed <1 Hour			60.00%	83.33%	66.67%	35.29%	57.14%	62.50%	80.00%	56.25%	42.86%	73.33%	44.44%	68.18%	52.38%	-	
		Stroke - Directly Admitted to Stroke Unit <4 Hours			60.00%	41.67%	36.99%	36.92%	43.84%	48.08%	55.68%	73.24%	58.97%	61.86%	66.67%	58.93%	56.19%	-	
		Stroke - Seen by Stroke Consultant within 14 Hours			90.00%	92.31%	83.13%	89.04%	85.06%	94.23%	92.39%	93.59%	77.42%	84.11%	80.00%	86.89%	87.93%	-	

RAG ratings (Red/Green) are against Current Month Trajectory. For metrics with no trajectory, RAG rating is according to comparison with previous month, except for Urgent Operations Cancelled ≥ 2 times which is RAG rated against National Standard.

North Bristol Integrated Performance Report

Domain	Description	Regulatory	National Standard	Current Month Trajectory (RAG)	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	May 23	Jun 23	Jul 23	Aug 23	Sep 23	Oct 23	Trend
Quality & Caring Patient Experience	Friends & Family Positive Responses - Maternity				91.79%	92.94%	95.48%	88.29%	90.06%	91.98%	94.44%	93.50%	91.79%	88.81%	91.00%	89.49%	89.49%	
	Friends & Family Positive Responses - Emergency Department				70.56%	74.42%	76.52%	87.92%	87.59%	87.57%	86.07%	79.57%	81.95%	81.75%	83.58%	74.74%	72.80%	
	Friends & Family Positive Responses - Inpatients				92.21%	92.21%	92.67%	93.51%	94.56%	93.58%	92.85%	93.29%	91.62%	93.65%	93.70%	93.37%	91.96%	
	Friends & Family Positive Responses - Outpatients				94.07%	94.83%	95.64%	95.10%	94.57%	95.24%	95.53%	95.43%	94.67%	95.46%	95.13%	94.04%	94.65%	
	PALS - Count of concerns				143	141	126	106	139	156	120	141	141	145	123	135	139	
	Complaints - % Overall Response Compliance			90.00%	75.76%	72.21%	72.43%	80.82%	82.14%	79.63%	73.17%	79.49%	80.00%	79.63%	64.10%	71.11%	65.00%	
	Complaints - Overdue				7	5	12	5	3	4	3	1	6	5	4	5	9	
	Complaints - Written complaints				76	66	51	62	41	41	38	57	44	42	48	49	60	
Workforce	Agency Expenditure ('000s)				2616	1992	1675	2030	1809	2485	2485	2485	2485	2485	2485	2485	2093	
	Month End Vacancy Factor				8.69%	8.61%	8.93%	8.64%	8.44%	7.88%	6.21%	7.96%	8.03%	8.25%	7.69%	7.16%	6.62%	
	Turnover (Rolling 12 Months)	R		-	17.17%	17.32%	17.10%	16.99%	16.77%	16.76%	16.56%	16.29%	15.90%	15.19%	15.03%	14.59%	14.13%	
	Sickness Absence (Rolling 12 month)	R		-	5.49%	5.49%	5.56%	5.49%	5.43%	5.30%	5.19%	5.08%	5.07%	4.94%	4.92%	4.91%	4.89%	
	Trust Mandatory Training Compliance				83.49%	83.56%	83.65%	86.34%	87.23%	88.71%	80.99%	82.00%	84.23%	84.73%	86.69%	87.04%	89.39%	

RAG ratings (Red/Green) are against Current Month Trajectory. For metrics with no trajectory, RAG rating is according to comparison with previous month, except for Urgent Operations Cancelled ≥ 2 times which is RAG rated against National Standard.

Executive Summary – November 2023

Urgent Care

Four-hour performance was 60.56% in October. A deteriorating position, which appears to be reflected across England given NBT ranked second out of 11 reporting AMTC peer providers. 12-hour trolley breaches were higher than the previous month, reporting at 223, whilst ambulance handover delays over one-hour increased to 620. A combination of factors combined to result in increased UEC pressure, including a peak in COVID inpatient numbers, continued industrial action impact, together with a rise in ED attendances. The Trust continues to work closely with system partners on a range of measures aimed at reducing the exit block from acute hospitals. However, the community-led D2A programme remains central to ongoing improvement. Work also progresses around development of a "Transfer Of Care" Hub (TOC Hub) modelled on recommendations from the national UEC plan and aimed at reducing barriers to transfers of care through a single multi-disciplinary and multi-agency hub. In the meantime, internal hospital flow plans continue to be developed and implemented.

Elective Care and Diagnostics

Despite significant impacts from repeated periods of industrial action, the Trust has maintained zero capacity breaches for patients waiting >104-weeks for treatment and for 78-weeks. The Trust continues to treat patients based on their clinical priority, followed by length of wait. In-year RTT target ambitions remain significantly challenged due to the ongoing impact of industrial action – varying to plan by approximately 150 breaches. Urgent work is underway to compensate and recover the position. Diagnostics performance achieved its year-end objective of no more than 15% of patients waiting greater than six weeks. There has been a lesser impact of industrial action on diagnostic work which has allowed the Trust to deliver its year-end objective several months ahead of schedule. Non-Obstetric Ultrasound challenges continue, but the team have made progress on the in-year position within the last month. Work is underway to consolidate the current performance achievement and to re-profile the year-end achievement towards the anticipated target for 2024/25 i.e. 5%.

Cancer Wait Time Standards

The Trust has been able to make substantial improvement in the total cancer waiting list, however, there has been a significant impact from industrial action on the Trust total PTL size and waiting times. A revised plan to recover the position is in place – focussing on two higher volume tumour sites i.e. Gynaecology and Skin cancer. As these pathways improve, headline performance will deteriorate in October and early November, improving to target compliance for FDS in December/January. If the contingencies deliver as planned, the Trust would still be able to meets its year-end FDS commitment of 75%. The current approach is to sustain the previously improved PTL, deliver the FDS requirement to 75% which, in turn, provides the basis for ultimately achieving the overall 62-Day pathway. However, it has become even more apparent that, in the absence of demand management initiatives at system and primary care levels, the ability to achieve sustained improvement is questionable. Our CMO is working closely with the system CMO to achieve primary care engagement in an ongoing demand management approach.

Executive Summary – November 2023

Quality

Within Maternity, there were no moderate harm incidents, HSIB referrals or final reports during September One case reviewed using the Perinatal Mortality Review Tool had one element of care scored as C, which related to the bereavement care provided to the family. Actions have been put in place following this. The Avoiding Term Admissions into Neonatal units (ATAIN) percentage remains below the national target of 5% and training compliance for PROMPT and Fetal Wellbeing is on track to meet MIS requirements. The national CQC Maternity Inspection visit was undertaken within the Southmead unit on 2nd November, with subsequent interviews, focus groups and data/document reviews the following week. Positive overall verbal feedback (with some specific areas to work on) was provided on 15 November and the draft report is anticipated in early January 2024. Infection control data for October showed a continued reduced incidence of C-Difficile, which is moving closer to the annual trajectory and E-Coli cases continue to track below trajectory. One new MRSA case was identified and there is ongoing work around the sustained increase in MSSA rates which reflects regional trends and related actions. Increases in MRSA and Covid-19/flu were reported. An improving trend in falls rates over the past 9 months has been sustained and the rate of for pressure injuries has reduced for the third consecutive month, which reflects active improvement work in both areas. There is a sustained increase in medication incidents reported over the past 8 months, however a 'deep dive' review has clarified that there has been no noticeable increase in incidents resulting in harm – suggesting that reporters are recognising and responding to no harm incidents, which is indicative of good safety practice. The rate of VTE Risk Assessments has improved over the past 6 months overall but actions continue to bring reported compliance to above 95%. Notwithstanding this, the external revalidation of NBT's status as a national **VTE Exemplar centre** was confirmed on 8 September 2023. Overall progress in delivering the year 1 workplan for Patient & Carer Experience against each of the four Strategy commitments is good, as referenced in the new IPR summary slide. Friends & Family Test positive responses overall slightly improved in October to 92.5% but did fall again in ED (primarily about waiting times) and for inpatients (concerns around night-time staff availability and noise). The response rate compliance for complaints dropped to 65% in October, with 9 overdue at month end. The decline is performance is likely to reflect staffing shortages and vacancies within ASCR and WaCH divisions. These have now been resolved. The Patient Experience Manager is meeting with the Divisional Patient Experience Leads in these divisions to agree a trajectory for improvement. All complaints are acknowledged within 3 working days in line with expected national standards.

Workforce

The Trust vacancy factor was 6.62% (622.89wte) in October down from 7.16% (669.72wte) in September. The greatest reduction in vacancies continues to be seen in Registered Nursing and Midwifery, with an increase in staff in post seeing the vacancy position fall by 33.36wte from September to October. Rolling 12-month staff turnover decreased from 14.59% in September to 14.13% in October continuing the improvement trend since November 2022. The Trust rolling 12-month sickness absence rate declined slightly to 4.89% in October from 4.91% in September. Overall temporary staffing demand increased by 0.51% (4.98wte) from September to October, driven by a small increase in demand for registered nursing and midwifery staff (+4.31wte,1.13%). While agency use decreased -14.76% (-26.11wte), Bank use increased +3.90% (24.52wte), resulting in a small decrease in unfilled shifts (0.63%, -0.94wte), from September to October.

Finance

The financial plan for 2023/24 in Month 7 (October) was a deficit of £1.5m. The Trust has delivered a £2.2m deficit, which is £0.7m worse than plan. The year-to-date position is a £8.9m adverse variance against a planned £0.7m deficit. The year-to-date position is being driven by £3.3m of costs related to industrial action. In month, the Trust has recognised the impact of industrial action on elective recovery income, in line with revised NHSE guidance. Therefore, £5.5m of the adverse position is driven by industrial action. Temporary staffing costs in the year-to-date position is creating a £4.3m adverse variance to plan, the impact of which is offset by delays in investments and vacancies. The Trust cash position at Month 7 is £71.9m, a reduction of £32.1m from Month 1. The forecast outturn for 2023/24 sees the Trust cash balance reduce to £49m by Month 12. This is driven by the Trust underlying deficit and capital spend. The Trust is currently forecasting a £5.3m overspend on capital by Month 12. This overprogramming is being managed in year by the Capital Planning Group. The Trust has delivered £12.0m of completed cost improvement programme (CIP) schemes at month 7. There are a further £4.4m of schemes in implementation and planning that need to be developed, and £5.4m in the pipeline

15.1

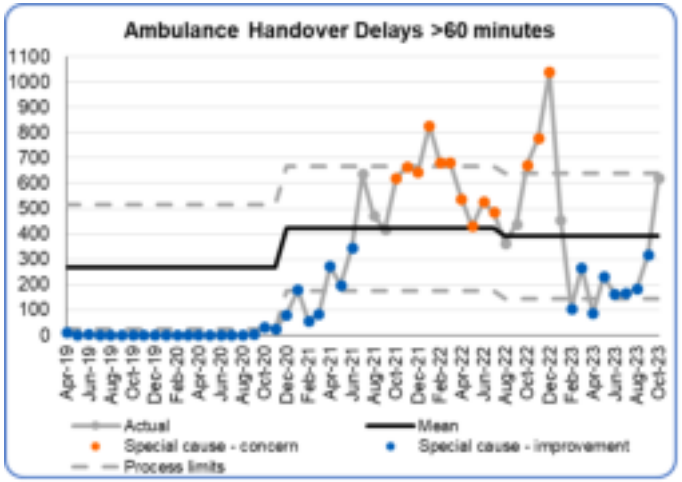
Responsiveness

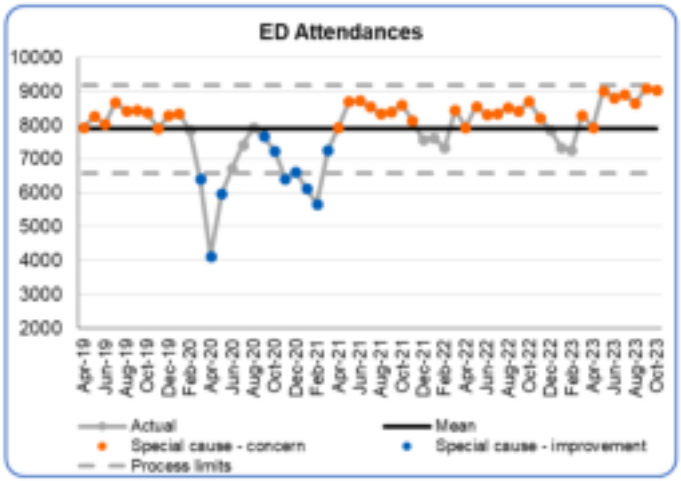
Board Sponsor: Chief Operating Officer
Steve Curry

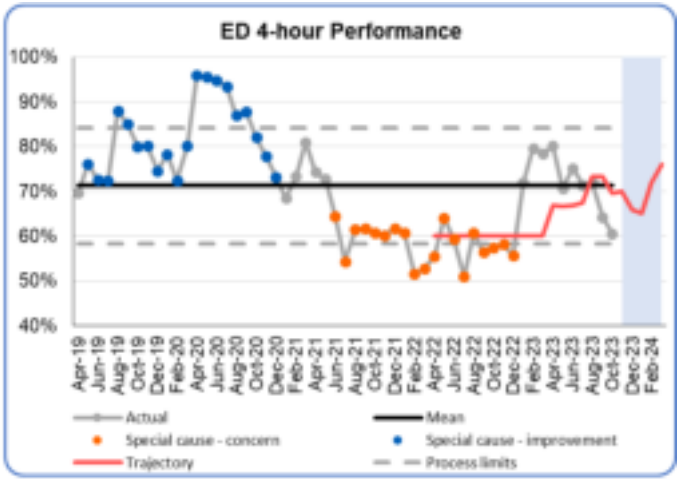
Responsiveness – Indicative Overview

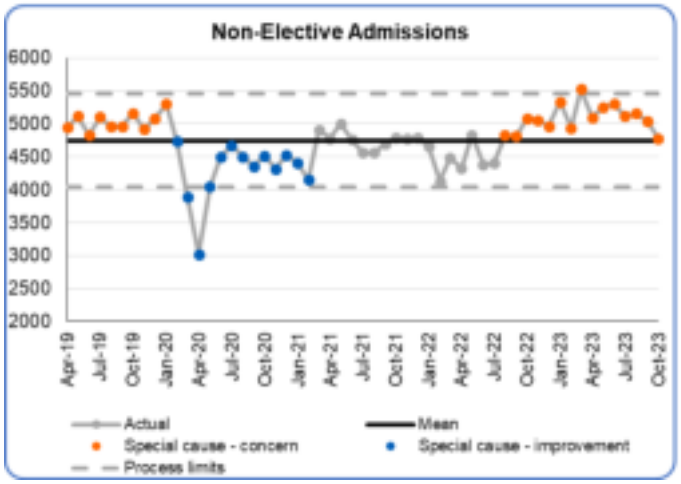
Delivery Theme	Delivery Indicator	Key Improvement /Delivery Action
Urgent & Emergency Care	UEC plan	Internal and partnership actions continue
	Transfer of Care Hub	Three phases, May-Dec. Phase 1 on track (System capital funding outstanding)
	NC2R/D2A	Gradual increase in NC2R numbers with proposed reduction in community bed access
RTT	65 week wait	Off track due to repeated periods of industrial action (IA)
Diagnostics	15% 6-week target	Achieved
	13-week waits	Now running ahead of trajectory – IA contingencies continue with good impact
	CDC	First phase (mobiles) in place opening April 2024, fixed CDC to open August 2024.
Cancer PTL	28 day FDS standard	Impact of IA. Remedial plans focussed on Gynaecology and Skin cancer underway

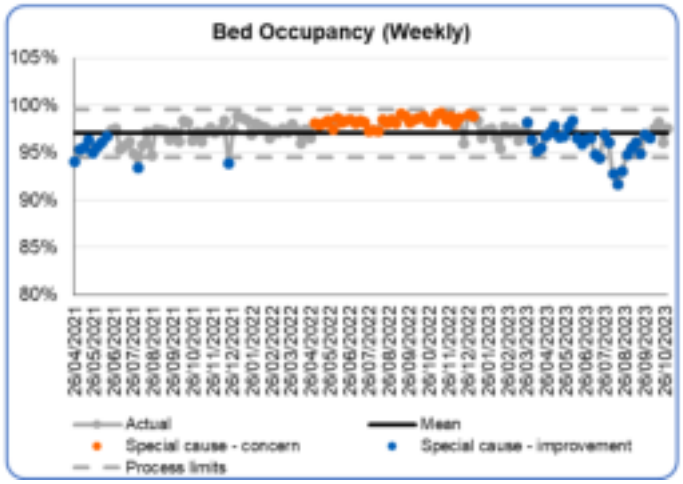
Urgent and Emergency Care

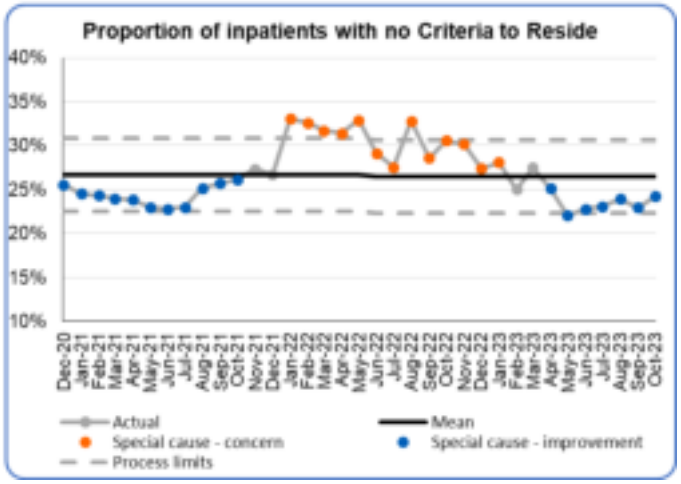












Urgent and Emergency Care

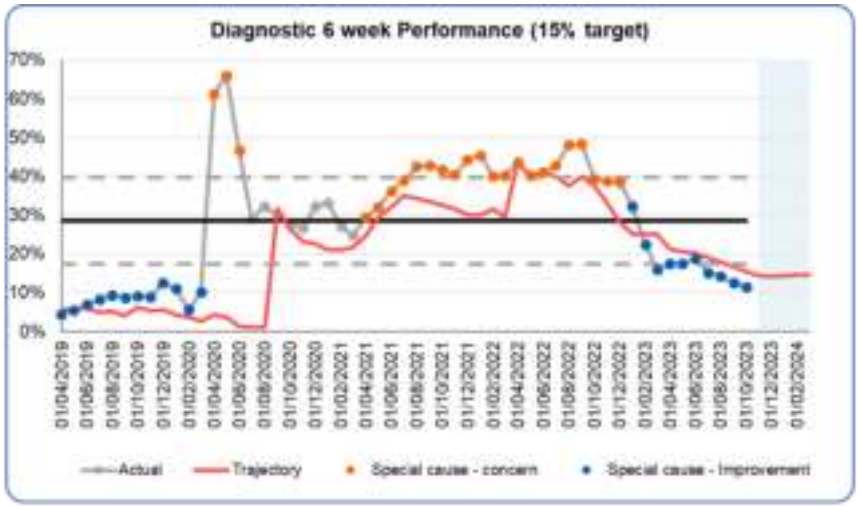
What are the main risks impacting performance?

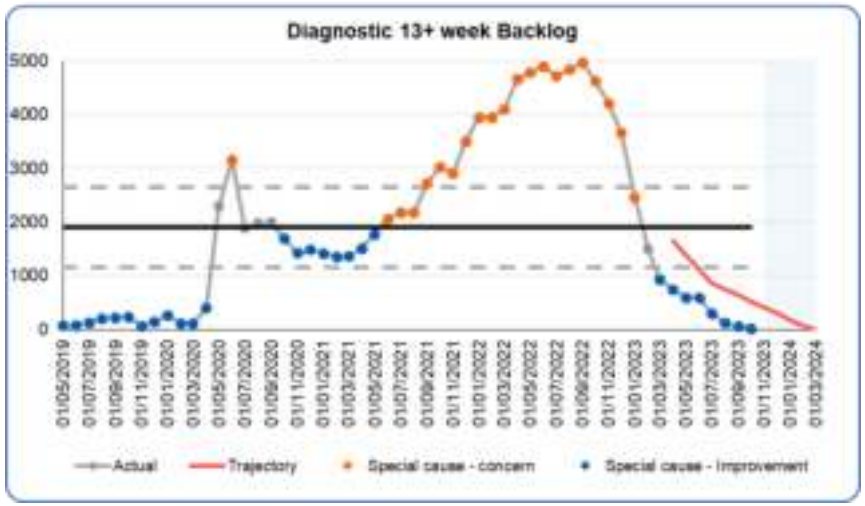
- The already high level of NC2R volumes increased significantly in October to compound UEC pressures from increased ED attendances – this appears to coincide with the beginning of a planned reduction in community beds
- Improved inpatient bed occupancy throughout summer, starting to regress
- Additional bed demand driven by COVID backlogs and/or prolonged access to primary care
- Increased and greater fluctuation in ED attendances; the increase between August and September has been sustained and attendances in October were 3.96% higher than the same month last year.
- Clinical cover and discharge activity impacted by industrial action, both during and for a period subsequent.

What actions are being taken to improve?

- The Trust has escalated concerns regarding community bed reductions with system partners and the impact this is having on hospital exit block and headline UEC performance.
- Ambulance handovers – the Trust continues to implement the pre-emptive ED transfer process. Use of double occupancy and boarding on wards, and emphasis on early discharge of P0 patients all enacted on all Trust wards.
- Ongoing introduction of the UEC plan for NBT; this includes key changes such as implementing a revised SDEC service, mapping patient flow processes to identify opportunities for improvement and implementing good practice ward level patient review and discharge processes (including actions recommended from the ECIST review).
- Having deployed the sixth floor as bed additionality throughout the winter period, the operational plan for the summer period will change to maintain ringfencing of surgical beds, increase the surgical bed footprint to pre-COVID levels, and to downsize the medical bed footprint to drive discharge process improvement and allow for a subsequent re-expansion as part of the coming winter plan.
- Development of a “Transfer Of Care” Hub (TOC Hub) modelled on recommendations from the national UEC plan and aimed at reducing barriers to transfers of care through a single multi-disciplinary and multi-agency hub.

Diagnostic Wait Times





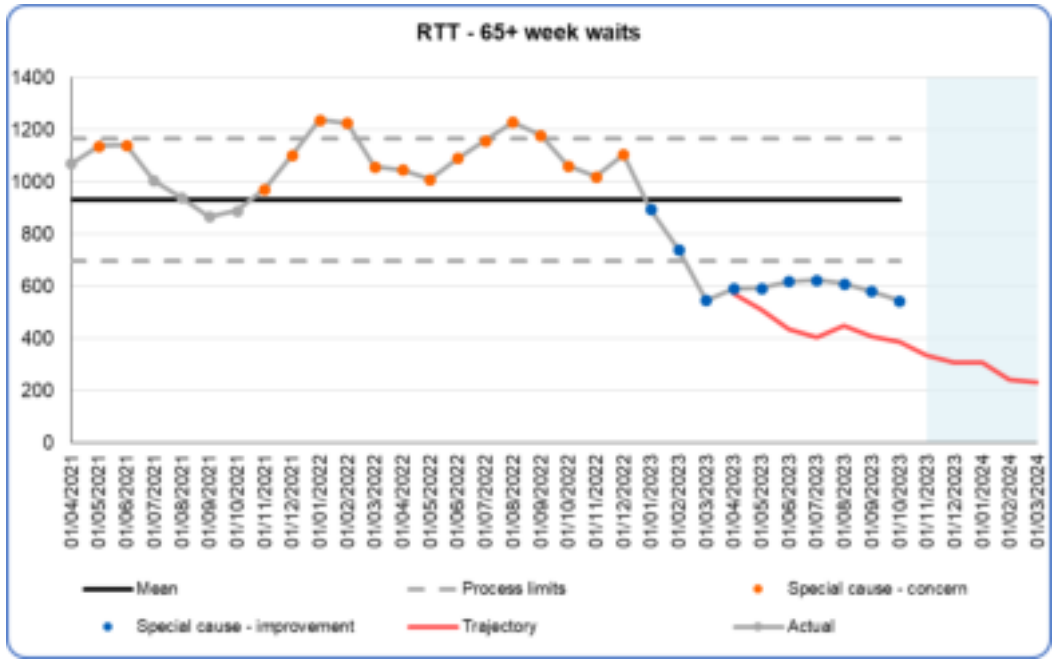
What are the main risks impacting performance?

- The Trust continues to achieve the objective of no more than 15% patients breaching 6-weeks. This was achieved 7 months ahead of the initial year-end target.
- The Trust continues to be on track to clear zero >13-week breaches.
- New staffing gaps within the Sonography service and a surge in urgent demand means that the NOUS position remains vulnerable. Given the volume of this work, any deterioration can have a material impact on overall performance.
- Risks of imaging equipment downtime, staff absence and reliance on independent sector. Further industrial action and staff sickness remains the biggest risk to compliance.

What actions are being taken to improve?

- Work is underway to consolidate the current performance achievement and to re-profile the year-end achievement towards the anticipated target for 2024/25 i.e. 5%.
- Endoscopy – Utilising capacity from a range of insourcing and outsourcing providers, transfers to the IS, WLIs and employment of a Locum. The Dep CEO and COO has agreed a change in where Endoscopy sits within the organisation. The Endoscopy service has transitioned from the Medicine Division to the CCS Division as of the 1st November. This will ensure it receives the appropriate level of oversight and support and aligns it with other diagnostic services as we transition to the development of CDCs. The CCS leadership team has a key role in the development of the CDCs and is best placed to transition Endoscopy services accordingly.
- Divisional Non-Obstetric Ultrasound – The Trust continues to utilise capacity from Medicare Sonographers. In addition, substantive staff are delivering WLIs and outsourcing continues to PPG.
- New appointment times introduced increasing future capacity in CT and MRI. Weston CT capacity ongoing as well as MRI and CT at Nuffield.
- Echocardiography – Ongoing use of Xyla insourcing and capacity, and use of IMC agency commenced in Sept-22. Proactive workforce development and planning continuing to yield some positive results.
- WLIs are helping to mitigate impact of staffing shortfalls during the week.

Referral To Treatment (RTT)



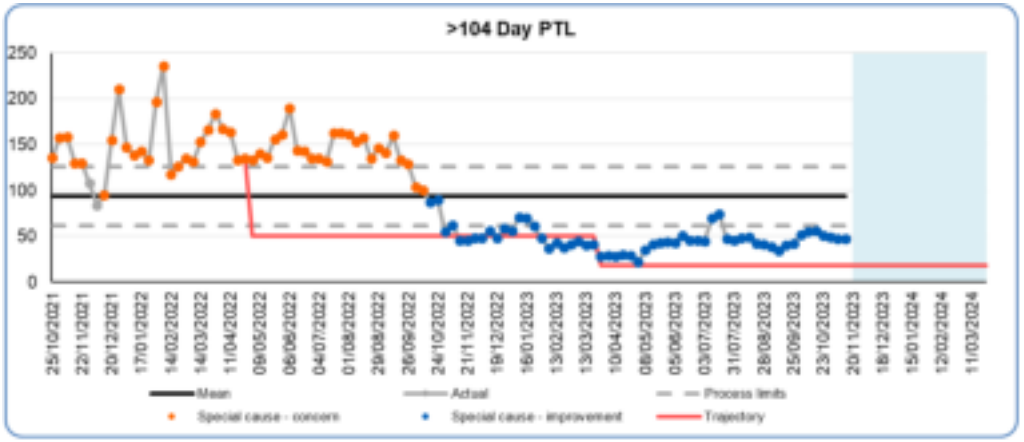
What are the main risks impacting performance?

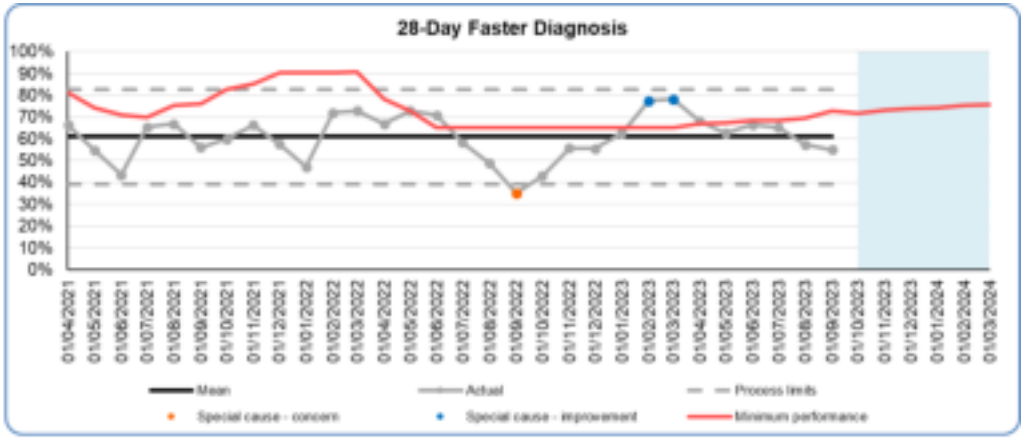
- The continued impact of repeated periods of industrial action is having a material adverse impact on the position.
- Rebooking of cancelled cancer and urgent patients is displacing the opportunity to book long-waiting patients.
- Continued reliance on third party activity in a number of areas.
- Staff shortages in some key areas e.g. operating theatres.
- The potential impact of UEC activity on elective care.

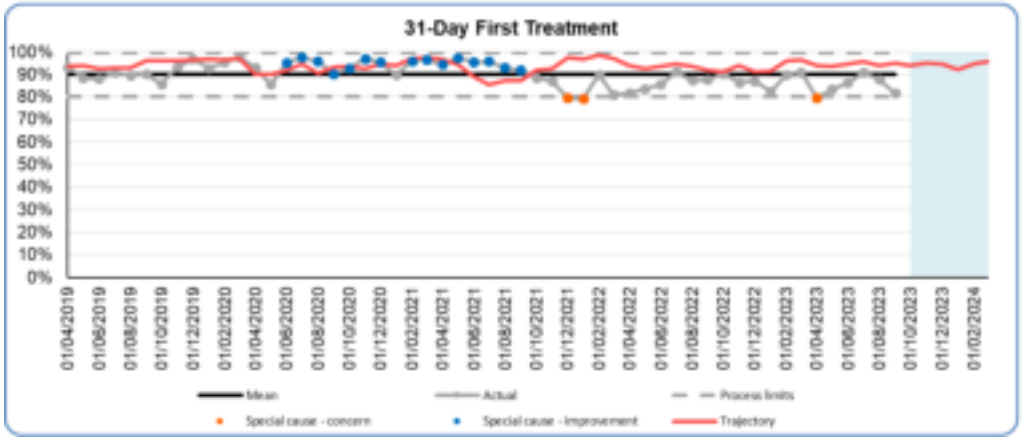
What actions are being taken to improve?

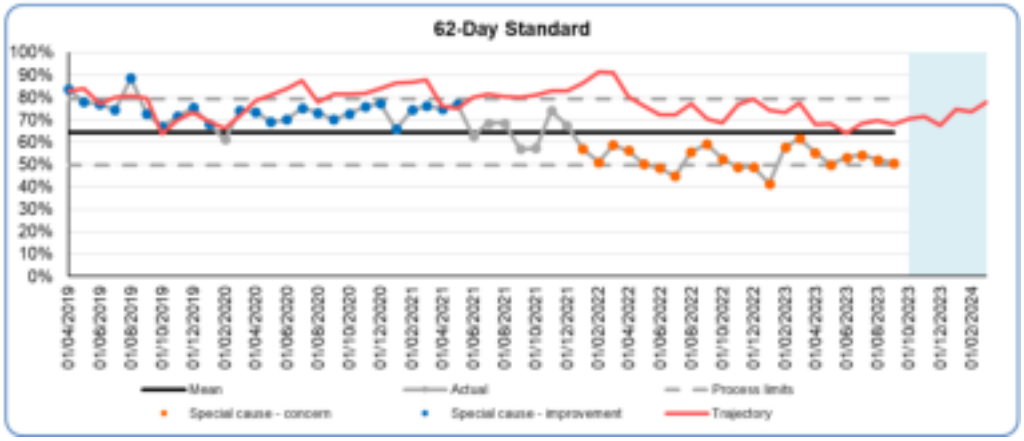
- Focused work on maintaining 104ww and 78ww positions continues.
- Work is ongoing to eliminate the year end risk volume of 65-week wait potential breaches – working with clinical teams to agree a balance of clinical priority and long waits.
- Speciality level trajectories have been developed with targeted plans to deliver required capacity in most challenged areas; including outsourcing to the IS for a range of General Surgery procedures and smoothing the waits in T&O between Consultants.
- Options for Independent Sector (IS) transfer are limited to patients meeting IS treatment criteria. The Trust has transferred all suitable patients into available capacity across local IS Providers.
- The Trust is actively engaged with the Getting It Right First Time (GIRFT) programme of work and working with specialists in theatre utilisation improvements to ensure use of available capacity is maximised.

Cancer Performance









Cancer Performance

What are the main risks impacting performance?

- Significant impact of industrial action resulting in escalation actions
- Ongoing clinical pathway work reliant on system actions remains outstanding.
- Reliance on non-core capacity.
- Increased demand is now a significant driver – Skin referrals, Gynaecology referrals and Endoscopy referrals.

What further actions are being taken to improve?

- Significant additional activity has been commissioned to recover industrial action related deteriorations in Skin and Gynaecology.
- Recovery actions can only be made sustainable through wider system actions. The CMO is due to participate in a system clinical workshop in November to reform cancer referral processes at a primary care level.
- Focus remains on sustaining the absolute >62-Day Cancer PTL volume and the percentage of >62-Day breaches as a proportion of the overall wait list. This has been challenged by recent high volume activity losses (industrial action related) within areas such as Skin.
- High volume Skin 'poly-clinics' enacted to recover cancer position. Having achieved the improved >62-Day cancer PTL target, the next phase will be to ensure the revised actions and processes are embedded to sustain this improvement. At the same time, design work has commenced to fundamentally improve patient pathways, which will improve overall Cancer wait time standards compliance.
- Following steady improvement in 28-Day FDS, recent industrial action impact has resulted in a deterioration in performance as activity continues to be lost and the backlog of patients are seen/informed and treated.
- Moving from an operational improvement plan to a clinically-led pathway improvement plan for key tumour site pathways such as Skin and Urology (e.g. prostate pathway).

15.1

Quality, Safety and Effectiveness

Board Sponsors: Chief Medical Officer and Chief Nursing Officer
Tim Whittlestone and Steven Hams

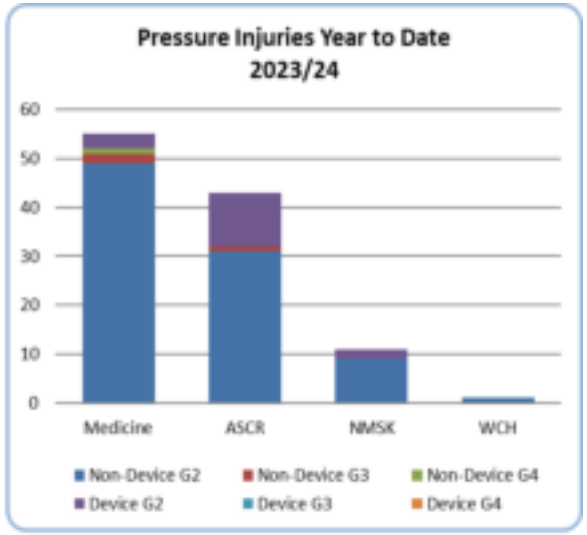
Maternity: Perinatal Quality Surveillance Matrix (PQSM) Tool
September 2023 data

	Jul-23	Aug-23	Sep-23	Oct-23	TREND
Activity					
Number of women who gave birth, all gestations from 22+0 gestation	467	477			
Number of babies born alive >=22+0 weeks to 26+6 weeks gestation (Regional Team Requirement)	1	4	1		
Number of women who gave birth (>=24 weeks or <24 weeks live)	460	477			
Number of babies born (>=24 weeks or <24 weeks live)	468	483			
Number of babies born alive >=24+0 - 36+6 weeks gestation (MBRRACE)	37	31			
No of livebirths <24 weeks gestation	1	3			
Induction of Labour rate %	38.0%	32.1%			
Spontaneous vaginal birth rate %	49.3%	45.9%			
Assisted vaginal birth rate %	10.0%	7.8%			
Caesarean Birth rate (overall) %	40.7%	46.3%			
Planned Caesarean birth rate %	18.3%	20.8%			
Emergency Caesarean Birth rate %	22.4%	25.6%			
NICU admission rate at term (excluding surgery and cardiac - target rate 5%)	4.7%	2.9%	3.80%		
Perinatal Morbidity and Mortality inborn					
Total number of perinatal deaths (excluding late fetal losses)	3	2	3	2	
Number of late fetal loses from 16+0 to 23+6 weeks excl. TOP (for SBLCBV2)	1	2	0	1	
Number of stillbirths (>=24 weeks excl. TOP)	2	1	1	1	
Number of neonatal deaths : 0-6 Days	0	1	0	0	
Number of neonatal deaths : 7-28 Days	0	0	1	0	
PMRT grading C or D cases (themes in report)	0	0	1	1	
Suspected brain injuries in inborn neonates (no structural abnormalities) grade 3 HIE 37+0 (HSIB)	0	0	0	0	
Maternal Morbidity and Mortality					
Number of maternal deaths (MBRRACE)	0	1	0	0	
Direct	0	1	0	0	
Indirect	0	0	0	0	
Number of women recieving enhanced care on CDS	19	14			
Number of women who received level 3 care (ITU)	0	1			
Insight					
Number of datix incidents graded as moderate or above (total)	0	0	0	0	
Datix incident moderate harm (not SI, excludes HSIB)	0	0	0	0	
Datix incident PSII (excludes HSIB)	0	0	0	0	
New HSIB referrals accepted	0	0	0	0	
Outlier reports (eg: HSIB/NHSR/CQC/NMPA/CHKS or other organisation with a concern or request for action made directly with Trust)	0	0	0	0	
Coroner Reg 28 made directly to Trust	0	0	0	0	
Workforce					
Minimum safe staffing in maternity services: Obstetric cover (Resident Hours) on the delivery suite	83	83	83	83	
Minimum safe staffing in maternity services: Obstetric middle grade rota gaps	2	1	1	1	
Minimum safe staffing in maternity services: Obstetric Consultant rota gaps	2	2	2	2	
Minimum safe staffing in maternity services: anaesthetic medical workforce (rota gaps)	1	0	0	0	
Minimum safe staffing in maternity services: Neonatal Consultants workforce (rota gaps)	1	1	1	1	
Minimum safe staffing in maternity services: Neonatal Middle grade workforce (rota gaps)	1	1	0	0	
Minimum safe staffing: midwife minimum safe staffing planned cover versus actual prospectively (number unfilled bank shifts).	38%	38%	16.87%	11%	
Vacancy rate for midwives	18.45%	18.18%	11.91%		
Minimum safe staffing in maternity services: neonatal nursing workforce (% of nurses BAPM/QIS trained)	60%	50%		45%	
Vacancy rate for NICU nurses	31	23	24	12	

		Jul-23	Aug-23	Sep-23	Oct-23	TREND
Datix related to workforce (service provision/staffing)		6	3	4	7	
Consultant led MDT ward rounds on CDS (Day to Night)		84%	87%	73%	65%	
Consultant led MDT ward rounds on CDS (Day)		77%	83%	100%	94%	
One to one care in labour (as a percentage)		100%	100%	100%	100%	
Compliance with supernumerary status for the labour ward coordinator		100%	100%	100%	100%	
Number of times maternity unit attempted to divert or on divert					1	
in-utero transfers						
in-utero transfers accepted						
in-utero transfers declined					0	
ex-utero transfers						
ex-utero transfers accepted						
ex-utero transfers declined					24	
NICU babies transferred to another unit due to capacity/staffing					3	
Number of consultant non-attendance to 'must attend' clinical situations		0	0	0	0	
Involvement						
Service User feedback: Number of Compliments (formal)		64	48	37	38	
Service User feedback: Number of Complaints (formal)		2	7	4	1	
Friends and Family Test Score % (good/very good) NICU		100	100			
Friends and Family Test Score % (good/very good) Maternity		92	91	85		
Staff feedback from frontline champions and walk-abouts (number of themes)		0	3	4	0	
Improvement						
Progress in achievement of CNST /10		7	7	7		
Training compliance in annual local BNLS (NICU)		100%	100%			
Training compliance in maternity emergencies and multi-professional training (PROMPT) * note: includes BNLS	***Overall***	83%	81%	79%	79%	
	Obstetric Consultants	78%	78%	75%	84%	
	Other Obstetric Doctors	86%	53%	52%	70%	
	Anaesthetic Consultants	90%	90%	86%	87%	
	Other Anaesthetic Doctors	76%	83%	79%	100%	
	Midwives	85%	88%	93%	84%	
	Maternity Support Workers	84%	93%	91%	71%	
	Theatre staff	Data Not Available (DNA)				
	Neonatologists	Data Not Available (DNA)				
	NICU Nurses	Data Not Available (DNA)				
Fetal Wellbeing and Surveillance	***Overall***	78%	67%	65%	75%	
	Obstetric Consultants	61%	72%	69%	68%	
	Other Obstetric Doctors	79%	44%	44%	44%	
	Midwives	95%	86%	83%	72%	
Trust Level Risks		7	6	6	6	
Proportion of midwives responding with 'Agree or Strongly Agree' on whether they would recommend their trust as a place to work or receive treatment (Reported annually)						
Proportion of specialty trainees in Obstetrics & Gynaecology responding with 'excellent or good' on how they would rate the quality of supervision out of hours (Reported annually)						

- This report summarises the PQSM data for September 2023.
- ATAIN remained below the national target of 5%
- One case reviewed at PMRT had one element of care scored as C. This related to the bereavement care provided to the family. Actions have been put in place following this.
- There were no PSII or MNSI reviews commissioned in September, and no final reports received.
- There are 3 Trust Level Risks relating to workforce. The division continues to work on recruitment and retention initiatives. Full details are available on Datix.
- Training compliance for PROMPT and Fetal Wellbeing is on track to meet MIS requirements.

Please Note: data from Sept-23 onwards is partial due to implementation of BadgerNet and provisional until validation by the Divisional Perinatal Quality Committee.



Pressure Injuries

What does the data tell us?

In October there was another decrease in the number of grade 2 pressure ulcers:

There were 11 grade 2 pressure ulcers with 3 being attributable to medical devices.

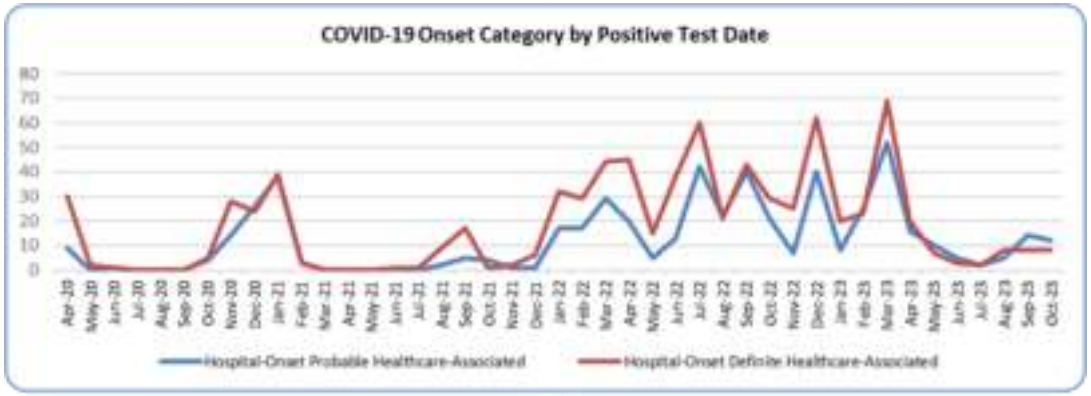
There were 6 unstageable pressure ulcers. The total number of pressure ulcers per 1000 bed days has continued to drop since August 2023 and to just under 0.3 rate per 1000 bed days. Previous target shown on the graph is 0.5.

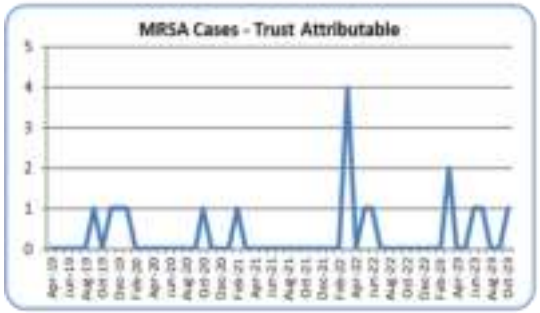
There was a decrease in the prevalence of DTIs from the previous month, to 13 DTI's, 2 x attributable to a medical device from bandaging.

The targets for PU reduction in 2023/2024:
- 10% reduction on grade 2 pressure ulcers. We are on target to achieve this.
- Zero tolerance for grade 3 and grade 4 pressure ulcers with a 50% reduction from 2022/2023.

What actions are being taken to improve?

- The Tissue Viability (TV) team provide a pressure ulcer prevention and validation service, working collaboratively within NBT and strategically across the health system to reduce harm, identify emerging themes, respond and improve patient outcomes.
- The Pressure Ulcer Prevention and Management policy has been updated to include Purpose-T as the risk assessment and include the updated Prevention Pathway (PUPPS) and clinical pathway. The updated mattress selection guide has also been included in response to the hybrid dynamic rollout.
- TVS have commenced collaborative working with the admission zones to complete a skin assessment within 6 hours of arrival. The Purpose-T risk assessment has a screening section which could be adapted and added to the SHINE document at triage.
- The collaborative NBT decision matrix for referral to safeguarding for concerns regarding pressure ulcers has been presented at both TVN and social care and safeguarding forums. There is a positive response from all parties and once the document has been ratified this will be shared with our colleagues across the system.





Infection Prevention and Control

What does the data tell us?

COVID-19 (Coronavirus) / Influenza - .Vaccination programme remains in place numbers remain steady with NBT working up a winter testing policy for respiratory virus with capacity to manage surge

MRSA – 3 cases this year , x2 cases in ITU prompting a thematic analysis with learning and some changes recommended and implemented in the unit.

C. Difficile – Increased numbers of cases in the summer continue to plateau , work underway with documentation and sampling particularly in medical division.

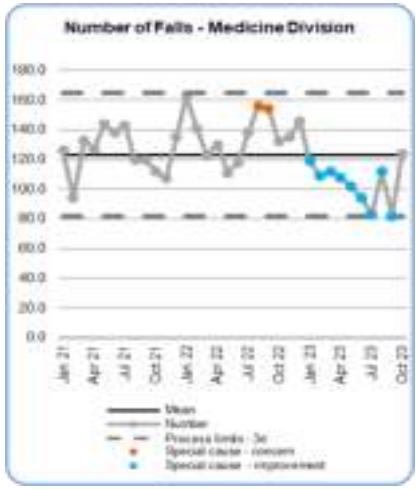
MSSA – Independent review of all cases taken place this month from NHSi and ICB. This reflects the increased number of cases seen in the summer and a review of the reduction plan implemented .Focus work continues with regional reduction plan as well as DRIPP (Device Related Infection Prevention Practices)

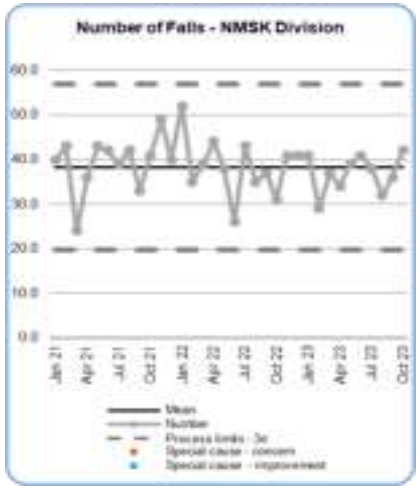
IPC team working alongside vascular access team to review cases and in act recommendations with correct device selection for patients and reinvigorating this programme and roll out along with vascular access passports.

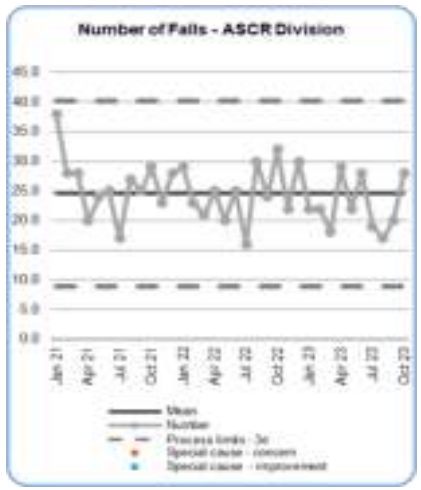
Gram negative – Below trajectory position. Working with continence group and new hydration /nutrition clinical support teams to deliver QI projects. These projects include decaffeinated products and increased hydration in frailty units- coloured jug project. Vaccine trial in place – E.mbrace to target reduction of E Coli

What actions are being taken to improve?

- IPC team to provide 7-day service started enabling safer placement of patients and early detection of cases requiring input OOH , early detection of clusters of cases and monitoring of potential surge of cases.
- QI project to work with Admission units and triage advise to correctly place pts , avoiding issues in multi occupancy areas such as 10a , Elgar
- Supporting new AMT unit - increasing patient flow
- Working with Regional / national improvement targeting MSSA / MRSA reduction
- Vascular access focus through DRIPP work and re looking at device selection and policy
- Winter education to teams with IPC national manual role out and new NBT IPC policy linked to this delivered and signed off at COIC
- Focused work understanding ventilation risks in WACH working with facilities and division







Falls

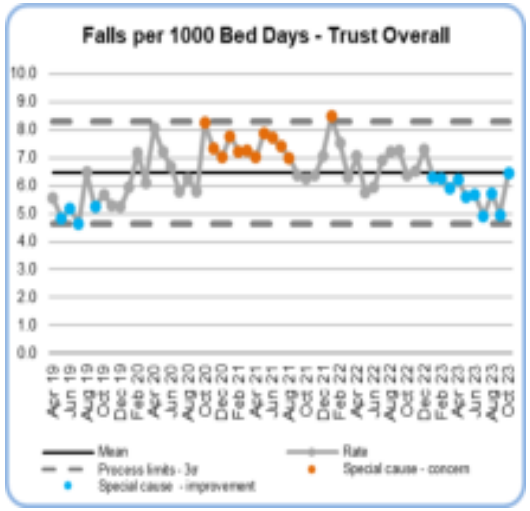
Falls incidents per 1000 bed days
NBT reported a rate of 6.45 falls incidents per 1000 bed days in October 2023 which is aligned with our average rate of 6.46.

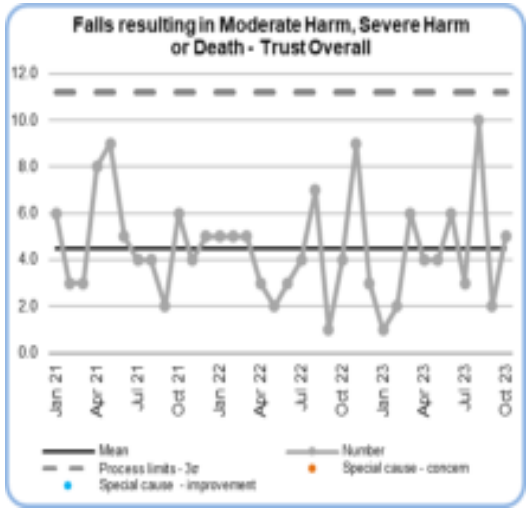
Falls review
Of the 5 incidents reported for moderate and above harm, 2 remain under review. One of the incidents related to a major intrinsic event (seizure). 1 resulted in a fractured femur which was promptly treated. 4 of the falls were unwitnessed. No themes identified in this group of falls.

When reviewing all falls there is a higher proportion of falls in older age groups. 48% of falls in over 80's, 28% in 65-79 and under 65's accounting for the remaining 24%.

Patients experiencing multiple falls accounted for 11% of the total falls.

Core clinical reported above average rate of falls this month at 2 (average <1). Both these falls the patients were assisted to the floor and no harm occurred. All other divisions were within the average range.



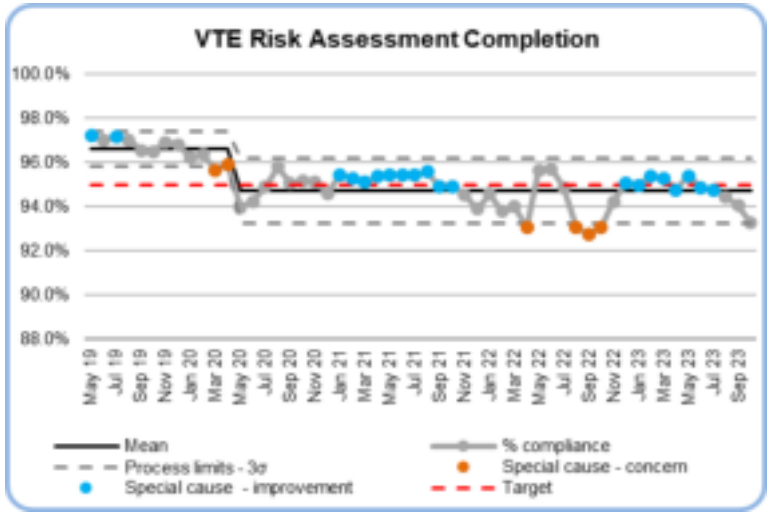


What actions are being taken to improve?
Inpatient falls is a patient safety priority under the patient safety incident response plan (PSIRP).

The newly appointed Falls team assumed their roles in September and have designed a falls management and delivery plan with identified priorities for delivery aligned to the end of March '24 as well as long term development opportunities.

The short-term strategic priority areas for improvement include: embedding robust structure and governance, training and education, data-driven risk analysis, monitoring, assurance, as well as the alignment of policies and procedures with evidence-based practices.

List of current actions and accomplishments:
- Leading a working group consulting on changes to the post falls action document. Bringing the document in line with latest evidence base, incorporating learning from regulation 28 and creating a platform for enhanced information gathering immediately following a fall.
- The existing eLearning package has been reviewed and compared with national packages of Falls education. Revamping the training in now underway to ensure the training delivered includes the most recent evidence base.
- Contributed to the falls care plan as part of the digital transformation.
- Ongoing Reviews of Moderate and above harm falls and exploring themes and patterns in all reported falls.
- Representing NBT at BNSSG Falls collaboratives.



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

WHO Checklist Compliance

What does the data tell us?

In October, WHO checklist compliance increased to 99.08%. 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 and solely indicates a failure to 'sign out' on completion of the list. All cases where WHO was not recorded electronically are reviewed to ensure that checklist compliance was recorded in the paper medical records, therefore meaning that the correct checks were undertaken in practice. When a manual check confirms that the WHO check list was not completed a Datix is recorded.

VTE Risk Assessment

What does the data tell us?

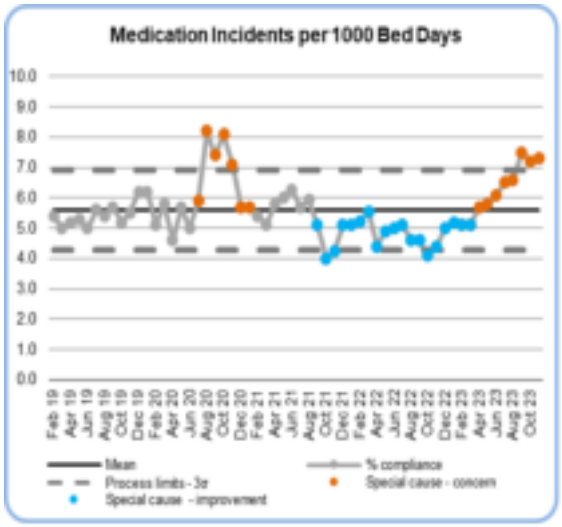
In September, the rate of VTE Risk Assessments (RA) performed on admission was reported as 93.27%. VTE risk assessment compliance is targeted at 95% for all hospital admissions. The decline in compliance seen from July-22 (exacerbated by the CareFlow changeover, though not the primary factor) has improved overall in recent months, however, there is still work to be done to ensure further improvement.

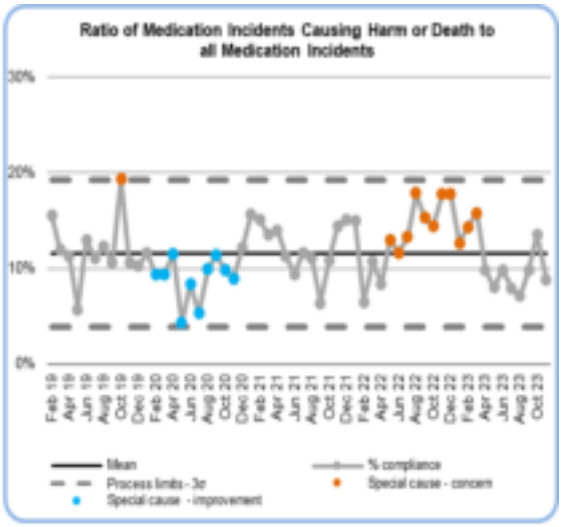
Notably, the Trust was revalidated as a VTE Exemplar Centre by the national accreditation body on 8 September, recognising the trust's ongoing commitment to reduce avoidable harm and improve patient outcomes (as demonstrated to the Centre) and an active response to ongoing challenges.

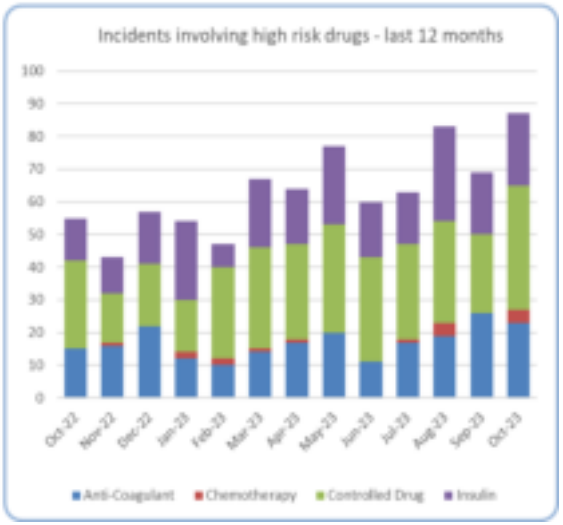
What actions are being taken to improve?

Clinical leadership responsibilities agreed with direct oversight of the CMO and the Thrombosis Committee which reconvened to engage and drive actions across the Trust.

An improvement plan is in place this year. Central to that plan is the introduction of a novel digital VTE assessment and recording tool. This was successfully implemented in 3 clinical areas and moved to large scale deployment in June 2023. The current data continues to represent a combination of paper assessments and some digital assessments, both of which are subject to delayed validation. During this time, we rely on self-assessments and audits from divisions for assurance.







Medicines Management Report

What does the data tell us?

Medication Incidents per 1000 bed days
During October 2023, NBT had a rate of 7.3 medication incidents per 1000 bed days. This slightly above the 6-month average of 6.9 for this measure.

Ratio of Medication Incidents Reported as Causing Harm or Death to all Medication incidents
During October 2023, c.8.9 % of all medication incidents are reported to have caused a degree of harm. This is slightly below the 6-month average of 9.5%. Breakdown of the 'harm' incidents seen in October is as follows:

Low harm – 20
Moderate Harm -2
Severe Harm/Death – 0

(This information has been included as an indicator of the composition of the 'harm' incidents. It is of note however that these categorisations are subject to change as incidents reviewed and closed. As an example, the October meeting data suggested there had been 4 moderate harm incidents but on looking at Datix information now all incidents have been processed this figures has been reduced to 1)

Incidents by Stage
In keeping with the picture seen over the last 6 months most incidents are reported to occur during the 'administration' stage.

High Risk Medicines
During October 2023, c.36% of all medication incidents involved a high-risk medicine which matches the 6-month average of 34%.

What actions are being taken to improve?
The Patient Safety Team and Medicines Governance Team have produced a report which provides a 'deep dive' into medication safety data. This has confirmed that whilst reporting figures show a month on month increase since February there has been no noticeable increase in incidents resulting in harm – suggesting that reporters are recognising and responding to no harm incidents which is indicative of good practice. This may be related to a positive upturn in staffing levels in clinical areas.
It also noted that there has been an increase in administration errors but again there has not been an increase in the proportion of these causing harm - in some cases reporting has been of a 'near miss' which is a very positive indicator in terms of reporting culture.
The Pharmacy Team and Medicines Governance Team are working to create a Medicines Safety forum – the plan is for this to be multidisciplinary meeting where issues such as the above are discussed, actions agreed and workstreams to address issues supported.

15.1

Patient Experience

Board Sponsor: Chief Nursing Officer
Steven Hams

Patient & Carer Experience – Strategy Delivery Overview November 2023

A	Amber - Progress on Track but known issues may impact on plan	C	Complete
G	Green - Progress on Track with no issues	R	Red - Progress is off Track and requires immediate action

Patient & Carer Experience Strategy Commitment	Commitments	Key improvement/action
Listening to what patients tell us	We will ensure that the patient experience data given to front-line teams is reliable and reflective of their services.	• Data is therefore reliable. Due to Badgernet changeover in maternity there is no FFT data for Maternity in October. • **'Patient Conversations'** our real-time feedback opportunity has been signed off with 4 visits planned for November.
	A near real-time feedback offer to patients (for example 15 step challenge or observe and act)	

Working together to support and value the individual and promote inclusion	We will deliver the Accessible Information Standard (AIS).	• AIS Steering Group met in August, reviewed AIS Delivery Plan and this continues to be on track.
		• **Faith Leaders engagement event** planned for November to learn more about how we can work to support different faith groups across BNSSG.
		• **Great patient partner recruitment!**
		  • 1 new patient partner in role with a focus in NMSK.
		  • 1 new patient partner recruited with a focus on physical accessibility.
		  • 3 other partners are completing the onboarding process and will be working with Maternity, and Cancer Services.
		• **New Access & Inclusion Lead role** in place. Starting engagement with the Gypsy Roma & Traveller community and people experiencing homelessness.

	We will continue to provide an inclusive person-centred holistic, spiritual, pastoral, and religious care (SPaRC) service.	
	We will develop wider representation within our Patient and Carer Partnership, reflecting a broader range of lived experiences and providing insights from specific conditions or demographic backgrounds.	
	We want to understand what good patient experience means to all our patients, in particular, those seldom-heard voices in our local community so we can act upon this.	
Being responsive and striving for better	We will consistently respond to 90% of complaints within agreed timescales.	• **Complaint response compliance rates have reduced**, primarily in WaCH and ASCR • Overall FFT scores are improving for the Trust however there has been a small decline in Inpatient scores and in ED. • **PHSO NHS Complaints Standards action plan is on track** and is monitored through DPEG. • Timescales for Radar implementation have slipped in year due to the complexity of workflows. Revised timescale agreed and on track for Q1 2024.
	Improved FFT scores, as set out within our Patient First priorities.	
	We will ensure our complaint process reflects the new PHSO NHS Complaints Standards.	
	We will optimise our reporting and management of PALS and Complaints through our new quality governance system.	
Putting the spotlight on patient and carer experience	We will ensure that the patient's voice is heard from the ward to the Board through patient stories. We will not shy away from hearing stories where things have not gone well.	• New Patient Story Framework signed off at PCEC **& stories delivered to Board in line with plan.** • 1 PSP in place, need to recruit more in line with Patient Safety • Internal and External article shared highlighting the work of the Patient & **Carer Partnership and 20th anniversary celebrations.** Planned radio interviews with Patient and Carer Partners in late November.
	We will introduce Patient Safety Partners (PSPs) in line with the Framework for Involving Patients in Patient Safety; this work is an integral part of our Patient Safety Strategy	
	We will increase the visibility of patient experience across the Trust by working with our Communications team and agreeing on a plan for sharing progress and developments within Patient Experience.	

Patient & Carer Experience - Overview November 2023

Our new 'Real-time feedback opportunity'

At the end of October, we launched our new real-time feedback opportunity- 'patient conversations'.

The approach is the result of many months of piloting similar initiatives from other Trusts, such as 'Observe and Act' and 'the 15 step-challenge'. A task and finish group consisting of a Patient and Carer Partner, the HoPE, Patient Experience Manager and Divisional Patient Experience Leads trialled different models and refined these to reach NBT's approach.

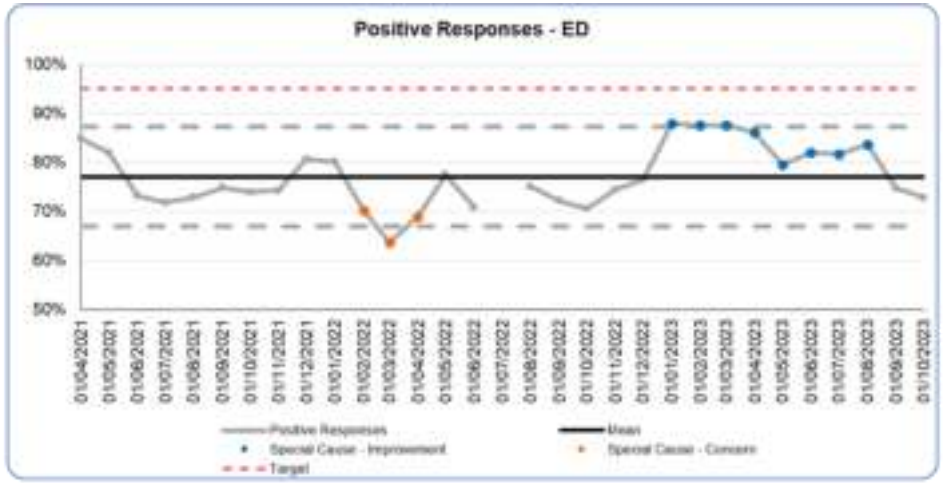
The idea is simple, two volunteers will visit a ward, they will use the FFT question as a prompt to strike up a conversation with a few patients, and then listen to the patient talk about how their experience has been. The conversation will be open, allowing the patient to share what matters most to them. The volunteers will then share feedback with staff on the ward in 'real time' so this can be acted upon immediately.

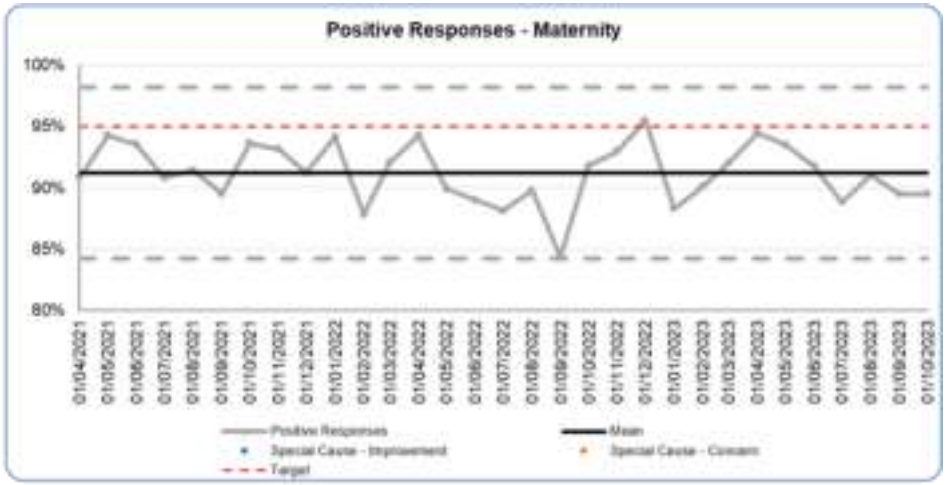
Following the visit key themes will be drawn out and shared to ensure these form part of our wider patient experience insight.

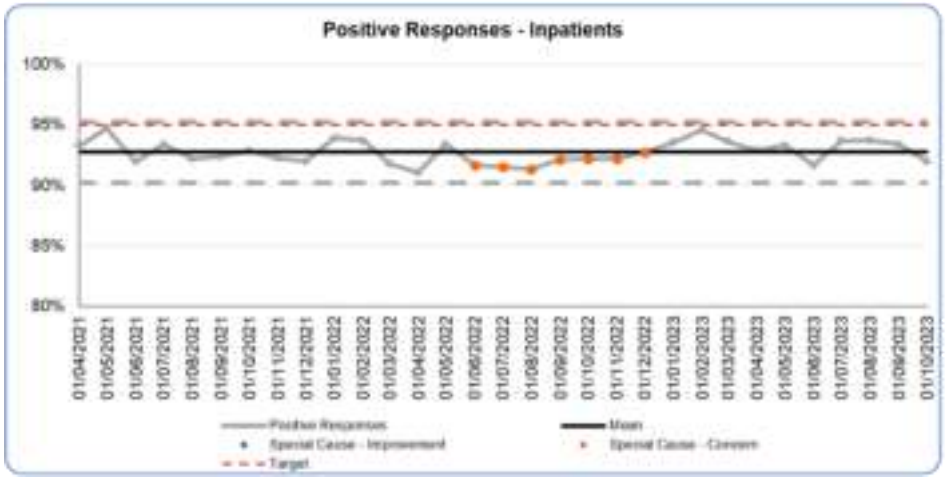
Early feedback has been extremely positive. Patients have enjoyed having someone to speak with, ward staff have encouraged visits and often received lovely feedback, and volunteers have found the role really rewarding.

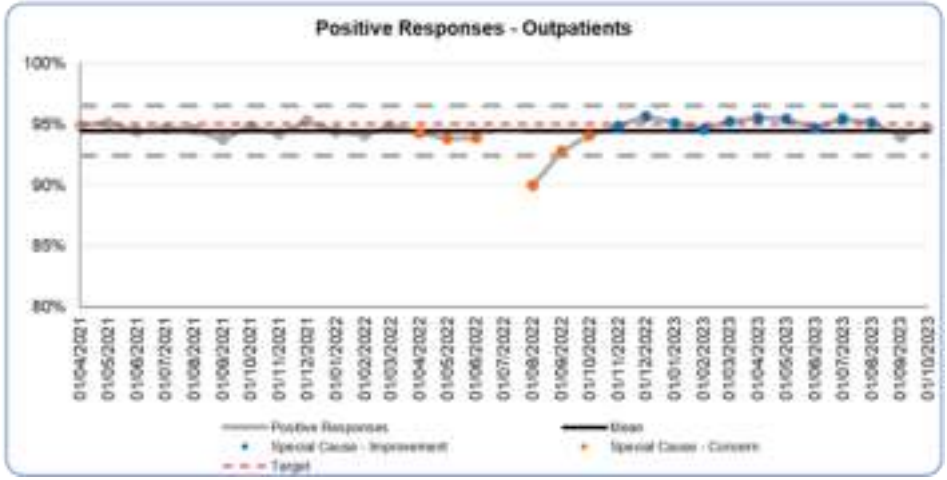
We look forward to sharing some of the learning and improvements from this initiative.

Patient Experience









N.B. no data available for the month of July for ED and Outpatients due to an issue with CareFlow implementation

Patient Experience

What does the data tell us - Trust?

- In October, 9,771 patients responded to the Friends and Family Test question. 7,153 patients chose to leave a comment with their rating, 379 less than the previous month.
- We had a Trust-wide response rate of 15%.
- 92.5% of patients gave the Trust a positive rating. This was a small increase of 0.8% from last month, remaining within the expected range of performance.
- Positive themes from comments**:** staff, waiting time and clinical treatment
- Negative themes from comments: waiting time, communication and staff.

Maternity FFT data update

- Maternity FFT is currently paused due to the implementation of Badgernet.
- During this transition, BI staff are working on exercises to prioritise data quality. FFT will resume once they are satisfied that there will be no unintended impact on patients.
- We will send FFT in arrears to as many patients as possible from the affected period, to ensure we continue to capture experiences of care, particularly during this crucial transition period to Badgernet.

What does the data tell us – Outpatients?

- Positive responses have increased marginally by 0.7% from September to 94.6%. The % of negative responses has decreased marginally by 0.1% to 2.3%.
- Most comments are left by Outpatients, with 5297 people leaving a comment after an appointment.
- Overwhelmingly, Outpatients reported positive experiences with staff. This theme had more than double the number of comments than the second positive theme, waiting time.

"I cannot fault my experience. From the minute I walked in, the receptionist was lovely. I was seen immediately and both the doctor and chaperone were so professional. I felt very comfortable. A very positive experience from the whole team. Thank you."

"My experience from beginning to end was 100% professional. All staff were courteous and respectful and made me feel at ease. I felt like I received the best care possible and I'd like to thank everyone for their service. Thank you."

What does the data tell us - Inpatients?

- The % of inpatient positive responses has decreased from 91.1% to 87.5%. This is now showing a special cause. Negative responses has increased slightly but within the expected range increasing by 0.8% to 6%.
- Positive themes from comments remain staff, clinical treatment and waiting time. Negative themes from comments are staff, communication and waiting time.
- Analysis of the comments showed several patients raised concerns about a lack of staffing during night shifts, and some commented on the quality of care being poorer at night. There were also several comments about the noise at night:

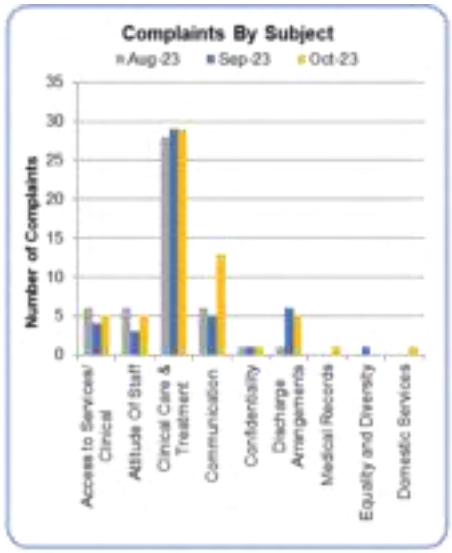
"My experience with the staff was excellent. They were all lovely right from the cleaner up to the top nurses and doctors. Nothing was too much …The only negative was when the two shifts changed at 6.30am. The noise of 20/30 people meeting and greeting was rather difficult to deal with when you had hardly slept all night."

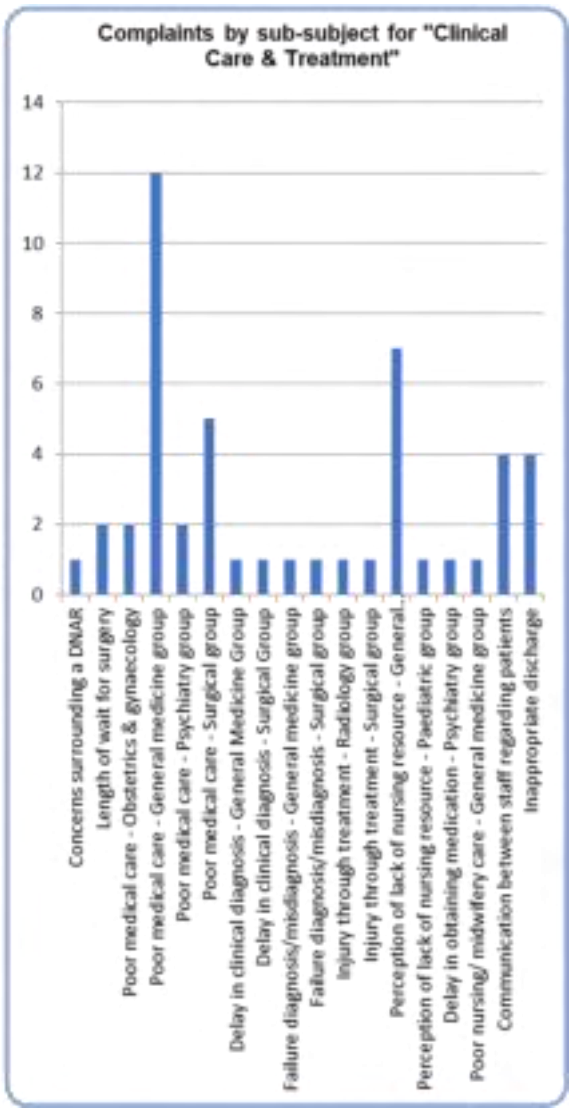
- Carers raised concerns about communication:

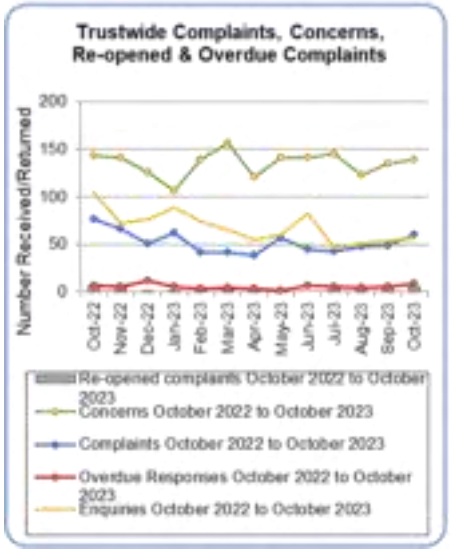
"It is not easy for relatives to get information especially when there are several doctors and nurses involved."

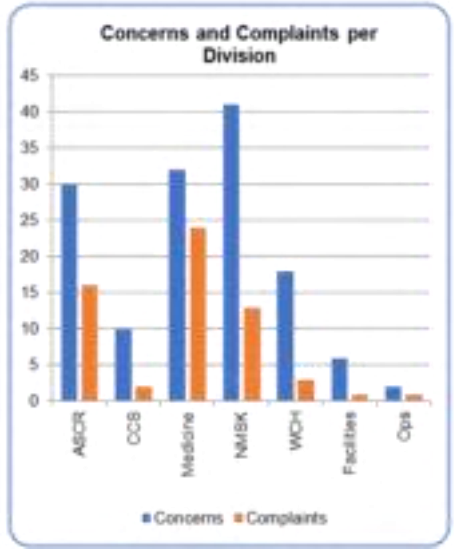
What does the data tell us - Emergency Department?

- The % of positive responses has declined again from last month from 75.7% to 72.8%, though this remains within expected ranges. The % of negative responses has also increased from 15.6% to 18.1%.
- The top negative theme remained waiting time.
- Analysis of results has shown that over the past quarter, comments concerning 111 directing patients to ED, where they are told to return the following morning or contact their GP. The Medicine Patient Experience Team is due to present this finding to ED staff, including staff involved in work to tackle these system-level issues.
- ED are actively taking steps to make improvements by undertaking a Local Survey to engage patients during their wait. They are working to understand if the reason for waiting is communicated with patients and what could improve their waiting experience.









Complaints and Concerns

What does the data tell us?

In October 2023, the Trust received 60 formal complaints. This is 11 more than in September but 16 fewer than the same period last year.

The most common subject for complaints is 'Clinical Care and Treatment' (29). A chart to break down the active sub-subjects for "Clinical Care and Treatment" has been added.

There were 4 re-opened complaints in October; 3 for ASCR and 1 for WaCH.

The overall number of PALS concerns received has increased slightly to 139.. The average response timeframe for PALS in October remained the same as the previous month, 9 days.

The response rate compliance for complaints has decreased in October to 65% and is now showing special cause for concern. A breakdown of compliance by clinical division is below:

ASCR – 42% NMSK- 68%

WaCH- 40% Medicine – 81%

The number of overdue complaints at the time of reporting has increased to 9, 4 more than in September. The overdue complaints are with NMSK (3), WaCH (3), MED (2) and ASCR (1).

The decline is performance is likely to reflect staffing shortages and vacancies within ASCR and WaCH. These have now been resolved. The Patient Experience Manager will be meeting with the Divisional Patient Experience Leads in these divisions to agree a trajectory for improvement.

In October 100% of complaints were acknowledged within 3 working days and 100% of PALS concerns were acknowledged within 1 working day.

15.1

15.1

Commissioning for Quality and Innovation (CQUIN)

Board Sponsor: Chief Nursing Officer
Steven Hams

Commissioning for Quality and Innovation (CQUIN) Schemes – 2023/24

CQUIN Scheme Ref. / Title	Description	Lead Division	Q1	Q2	Q3 (Forecast)	Q4 (Forecast)	Comment (*forecasts are % of £ CQUIN value*)
CQUIN01: Flu vaccinations for frontline healthcare workers	Achieving 80% uptake of flu vaccinations by frontline staff with patient contact.	Operations, Trustwide	N/A	N/A	🔴	🟡	***Target range 75%-80%.*** Ongoing delivery programme.
CQUIN02: Supporting patients to drink, eat and mobilise (DrEaM) after surgery	Ensuring 80% of surgical inpatients are supported to drink, eat and mobilise within 24 hours of surgery ending	ASCR	🟢	🟢	🟢	🟢	***Target range 70%-80%.*** Full achievement Q1 and Q2
CQUIN03: Prompt switching of intravenous to oral antibiotic	Achieving 40% (or fewer) patients still receiving IV antibiotics past the point at which they meet switching criteria (Please note that for this indicator, a LOWER % = better performance)	CCS	🟢	🟢	🟢	🟢	***Target range 60%-40%*** Full achievement Q1 and Q2
CQUIN05: Identification and response to frailty in emergency departments	Achieving 30% of patients aged 65 and over attending A&E or same-day emergency care (SDEC) receiving a clinical frailty assessment and appropriate follow up	Medicine	🟢	🟢	🟢	🟢	***Target range 10%-30%.*** Full achievement Q1 and Q2
CQUIN07: Recording of and response to NEWS2 score for unplanned critical care admissions	Achieving 30% of unplanned critical care unit admissions from non-critical care wards having a timely response to deterioration, with the NEWS2 score, escalation and response times recorded in clinical notes	Trustwide	🟢	🟢	🟢	🟢	***Target range 10%-30%.*** Full achievement Q1 and Q2
CQUIN08 - Achievement of revascularisation standards	Achievement of revascularisation standards for lower limb Ischaemia (within 5 days for unplanned inpatient admission)	ASCR	🟡	🔴	🔴	🔴	***Target range 45%-65%.*** At risk until permanent procurement of equipment is completed.
CQUIN10: Treatment of non small cell lung cancer (stage I or II) in line with the national optimal lung cancer pathway	Achieving 85% of adult patients with non-small-cell lung cancer (NSCLC) stage I or II and good performance status (WHO 0-2) referred for treatment with curative intent.	Medicine	🟢	🟢	🟢	🟢	***Target range 80%-85%.*** Full achievement Q1 and Q2
CQUIN11: Achieving high quality Shared Decision Making (SDM) conversations in specific specialised pathways to support recovery	Achieving high quality shared decision (SDM) making conversations to support patients to make informed decisions based on available evidence and their personal values and preferences and knowledge of the risks, benefits and consequences of the options available to them.	NMSK ASCR Clinical Governance	N/A	🟢	N/A	🟢	***Target range 65%-75%.*** Full achievement Q2

🟢 **Full: ≥ max target %** | 🟡 **Partial: ≥ min target % and < max target %** | 🔴 **Not met: < min target %**

15.1

Workforce

Board Sponsors: Chief Medical Officer, Director of People and Transformation
Tim Whittlestone and Jacqui Marshall

Well Led Introduction

Vacancies

The Trust vacancy factor was 6.62% (622.89wte) in October down from 7.16% (669.72 wte) in September. The greatest reduction in vacancies continues to be seen in registered nursing and midwifery with an increase in staff in post seeing the vacancy position fall by 33.36wte from September to October, additional clinical services and administrative and clerical also saw decreases in their vacancy position of 10.55wte and 14.77wte respectively.

Turnover

Rolling 12-month staff turnover decreased from 14.59% in September to 14.13% in October continuing the improvement trend since November 2022; with additional clinical services turnover falling from a highpoint of 25.06% in November 2022 to 18.52% in October 2023, and registered nursing and midwifery declining from a highpoint of 16.41% in September 2022, to 13.08% in October 2023. As the Trust has seen consistent improvement across most divisions and staff groups, the 2024/25 turnover target and longer-term turnover target of 13% by 2027/28 will be reviewed via the Retention and Staff Experience group and inform both the 2024/25 operational planning process and the next iteration of the Long-Term Workforce Plan scheduled for Mar-24.

Patient First target for 2023/24: 16.5% or below

Prioritise the wellbeing of our staff

The Trust rolling 12-month sickness absence rate declined slightly to 4.89% in October from 4.91% in September. However, wte days lost increased from 12,392.98 in September to 13,354.57 in October, predominantly driven by increases in cold, cough, flu-influenza (1,100.37 to 2,014.61).

Trust Target for 2023/24 (based on moving from 3rd to 2nd quartile of all national acutes): 5.2%

Temporary Staffing

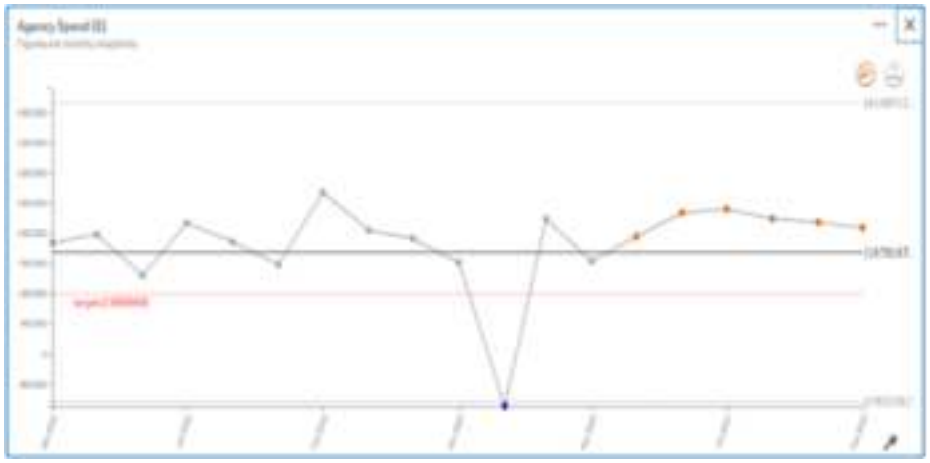
Overall temporary staffing demand increased by 0.51% (4.98wte) from September to October, driven by a small increase in demand for registered nursing and midwifery staff (+4.31wte,1.13%). While agency use decreased -14.76% (-26.11wte), Bank use increased +3.90% (24.52wte), resulting in a small decrease in unfilled shifts (0.63%, -0.94wte), from September to October. The decrease in unfilled shifts was mostly seen in estates and ancillary staff.

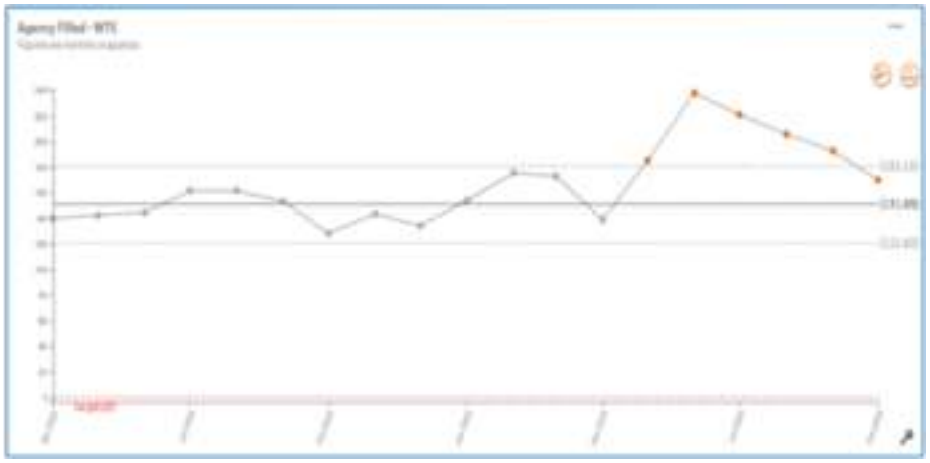
wte = whole time equivalent

Well Led Introduction – Actions

Theme	Action	Owner	By When
Vacancies	Review of recruitment processes inititiated via Patient First 'Faster Fairer Recruitment' and now ongoing through the Recruitment Services Reconfiguration (RSR) and extending performance management timeframes to 150 days to ensure sustainability improvements. Implementing digital on boarding forms from October '23 to further enhance recruitment processes / candidate experience	Deputy Chief People Officer	Oct-23
Turnover	Immediate retention actions commenced linked to HCA turnover in first 12 months of employment in hotspot areas , with additional interventions being implemented aligned to NBT's 2023-24 Retention Plan	Associate Director Culture, Leadership & Development	Mar-24
Staff Development	Launch the first cohort of 'Mastering Management' delivered by University of West of England - now complete New Action - Scope requirements for online appraisal system	Associate Director Culture, Leadership & Development	Dec-23
Wellbeing	Implementing financial wellbeing projects to support our staff including Citizens Advice Bureau 1:1 sessions for advice on debt, benefits, housing and consumer rights. Review of the role and scope of Wellbeing Champions underway	Associate Director Culture, Leadership & Development	Jan-24
Temporary Staffing	The Agency Oversight Board has been expanded to include the Bank Optimisation work and will now be known as the Temporary Staffing Oversight Board. The Temporary Staffing winter plan is under development with expected recommendations to be presented to the People Oversight Group at the end of November.	Deputy Chief People Officer	Oct-23

Temporary Staffing





What Does the Data Tell Us
Agency use saw a reduction of 26.11wte overall, 19.18wte of which was in Nursing and Midwifery Registered. This position was driven predominantly by a reduction in agency use in the Acute Medical Unit (AMU), Wards 9A, 9B, 25A and 34B.

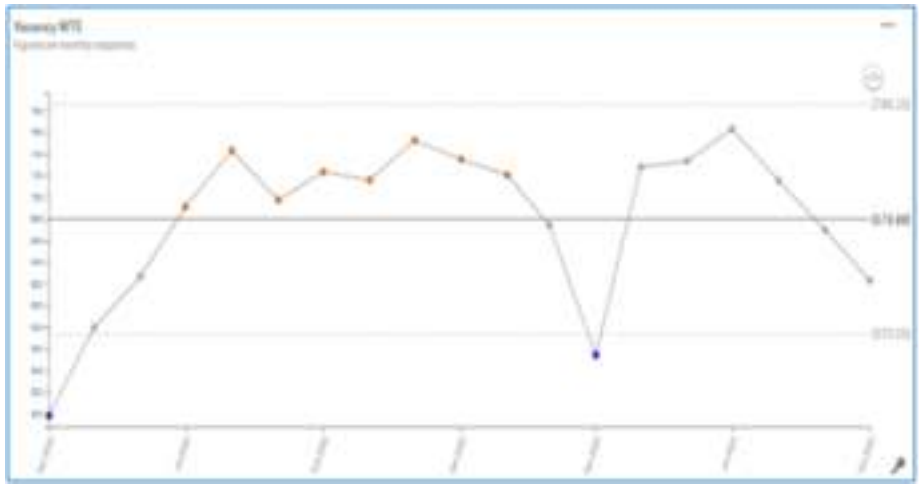
Critical Care (ICU) and Urology Theatres saw growth in agency use of 10..27wte and 1.60wte respectively. these teams saw a reduction in break glass use or used no break glass shifts at all in September.

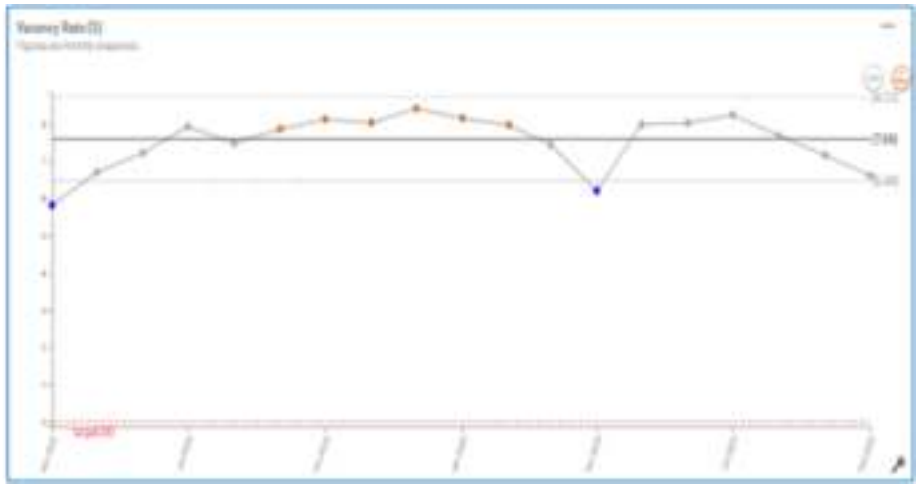
Agency Registered Mental Health Nurse (RMN) use declined by 15.01wte from September to October, driven by reduced usage in AMU, ward 9A and Ward 9B.

Actions
1.Initial project plan for the Bank Optimisation programme is in draft format. Wider socialisation and alignment to the agency reduction programme is underway
2.Nursing and midwifery task and finish group established led by the deputy chief nurse to identify opportunities and interventions to support agency reduction. Group will meet every 2 weeks. A key focus is on managing our demand management and agency authorisation and escalation processes.
3.The development of the Temporary Staffing winter plan is underway to ensure a Bank led response to anticipated increased operational pressures minimising the requirement for increased agency usage. Proposals will be socialised across staff groups and Joint Union Committee (JCNC) prior to presentation at the People Oversight Group.

Agency Reduction: Continued focus on demand management for Nursing and solutions for long term Medical Locums.
Bank Optimisation: Project plan in draft format to be socialised with leads and timescales agreed. Listening events and focus groups a priority for completion Q3 to support development of next step interventions and opportunities.

Vacancy Position





Talent Acquisition Recruitment Activity
Unregistered Nursing and Midwifery
1.Offers: 20.01wte of offers for Health Care Support Worker (HCSW) roles were made in October: 3.6wte for band 2 and 16.49wte for band 3
2.Pipeline: 66.6wte of candidates with offers being processed. Current withdrawal rates have dropped to 8% of HCSW roles suggest that 61.28wte will join over next three months (between November and January) which is lower than last year where 72.07wte joined, however there are 138.56 more staff in post this year compared with last year.
Registered Nursing and Midwifery
1.Offers: 50.01wte of offers to band 5 experienced and newly qualifying nurses across the Trust
2.Pipeline: Domestic 130.08wte band 5 candidates with offers being processed. Current withdrawal rate is at 8% and we have launched a pipeline engagement plan to lower this withdrawal rate over the coming months.
3.Pipeline International: There are 22wte in the pipeline allocated to start in November which is higher than last year where 10wte joined. A further 25 are booked to join in December

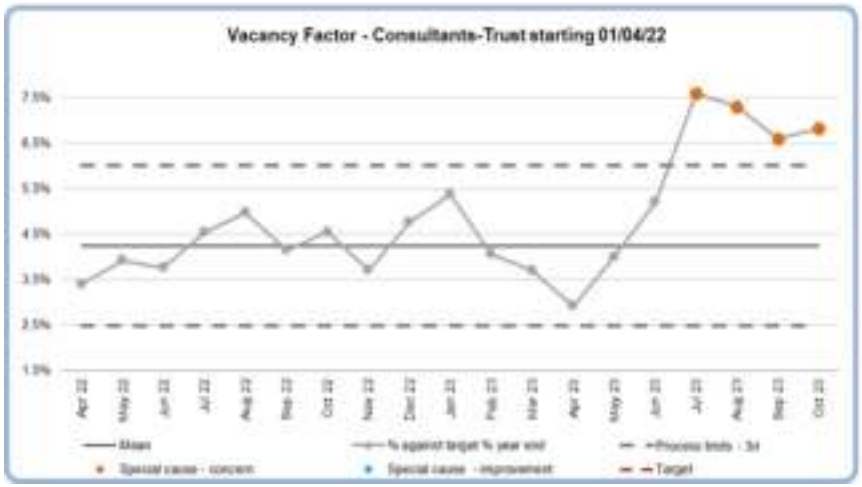
Recruitment Activity
1.In October, the Trust attended 4 recruitment fairs including our internal Autumn Nursing and Midwifery Exhibition. We made 22 offers to nurses and midwives on the day.
2.International Recruitment: We welcomed 26 Internationally educated Nurses to the Trust in October

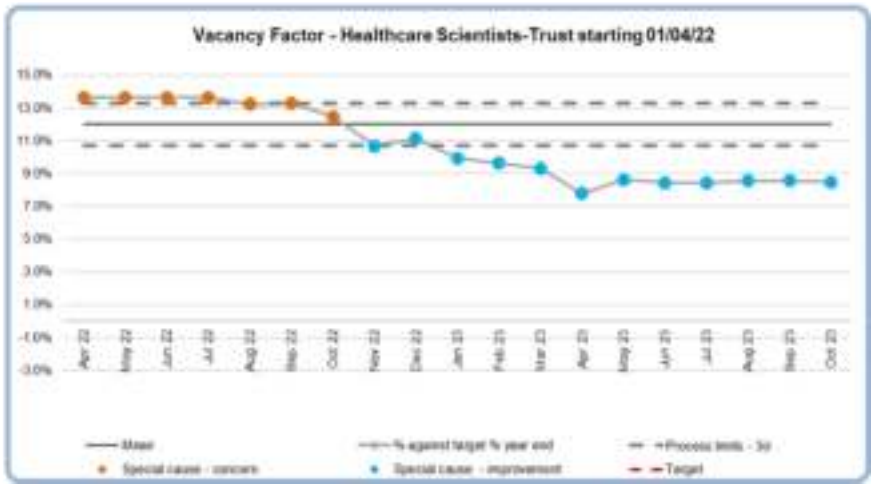
Current actions being taken to mitigate withdrawal rates:
1.Midwifery incentivisation programme in place – Withdrawal rates now at 8%
2.Pipeline Engagement Open Days now running monthly with attending candidates receiving site visit and tour with Divisional representation.

Vacancy

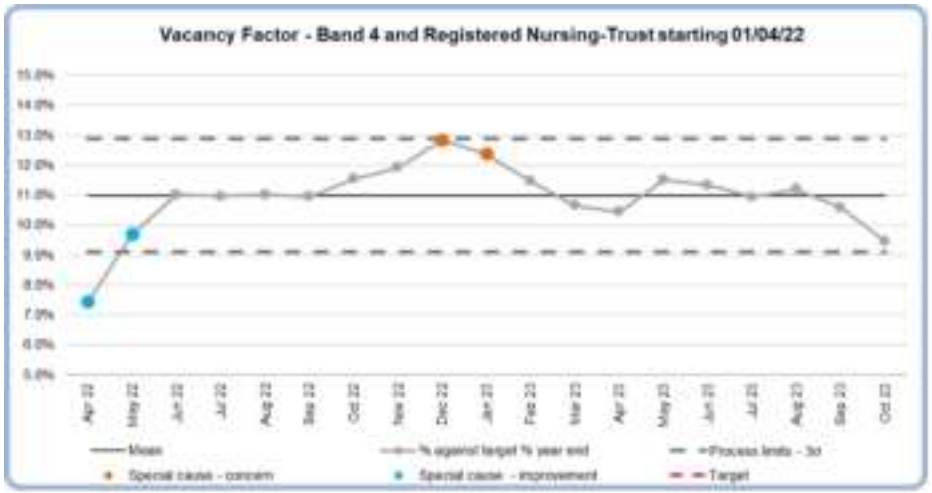

Vacancy Factor - Ad Prof Sci & Technical Staff-Trust starting 01/04/22

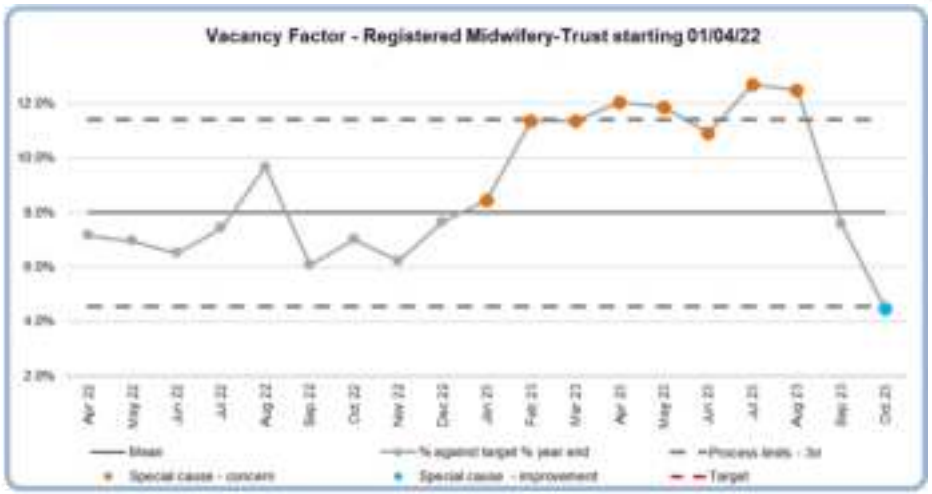

Vacancy Factor - Allied Health Professionals-Trust starting 01/04/22

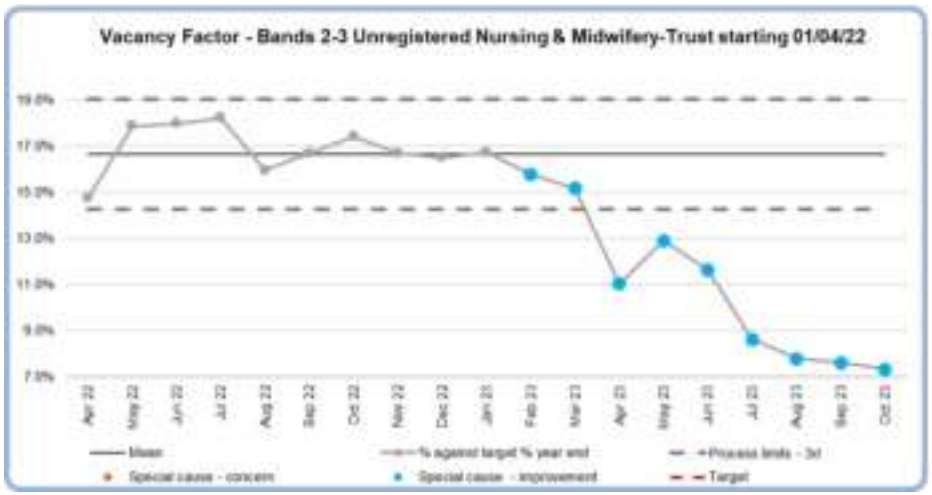

Vacancy Factor - Consultants-Trust starting 01/04/22

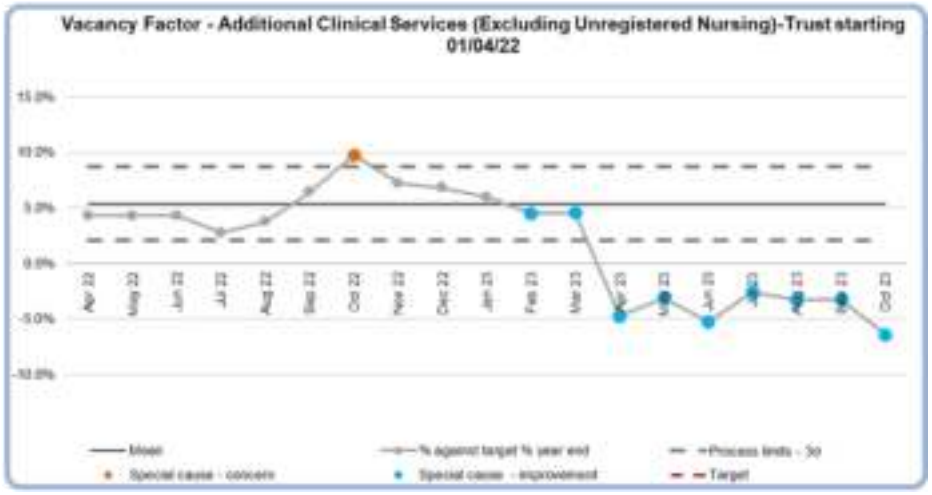

Vacancy Factor - Healthcare Scientists-Trust starting 01/04/22

Vacancy

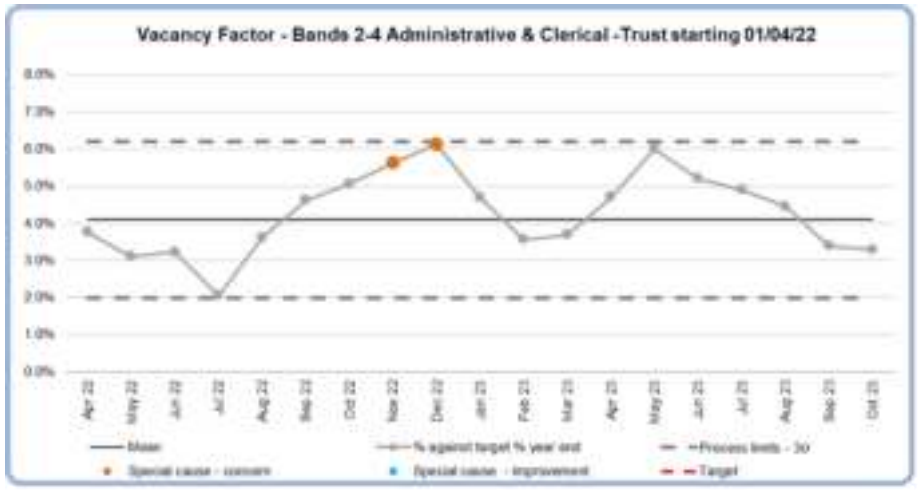

Vacancy Factor - Band 4 and Registered Nursing-Trust starting 01/04/22
Mean
% against target % year end
Process limits - 3σ
Special cause - concern
Special cause - improvement
Target

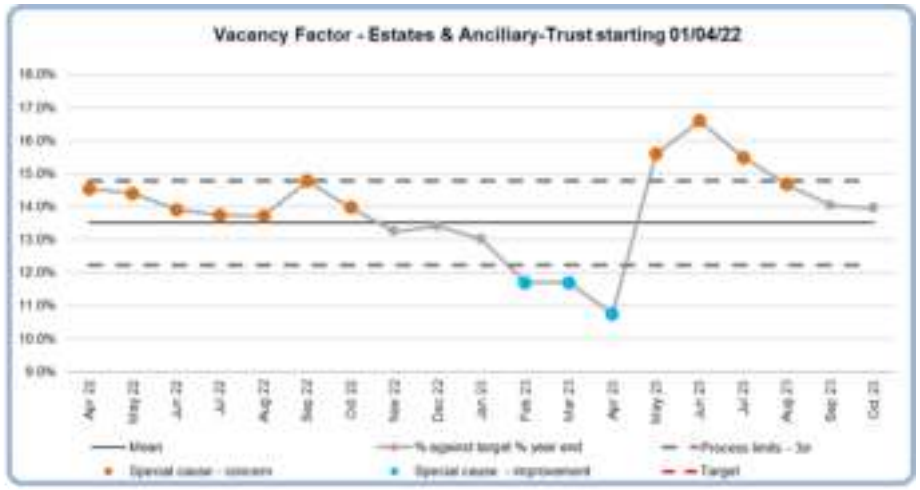

Vacancy Factor - Registered Midwifery-Trust starting 01/04/22
Mean
% against target % year end
Process limits - 3σ
Special cause - concern
Special cause - improvement
Target

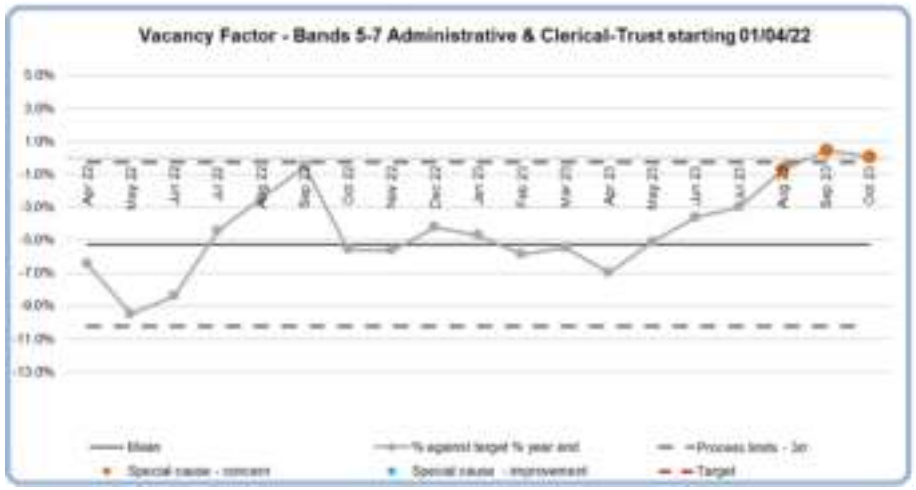

Vacancy Factor - Bands 2-3 Unregistered Nursing & Midwifery-Trust starting 01/04/22
Mean
% against target % year end
Process limits - 3σ
Special cause - concern
Special cause - improvement
Target

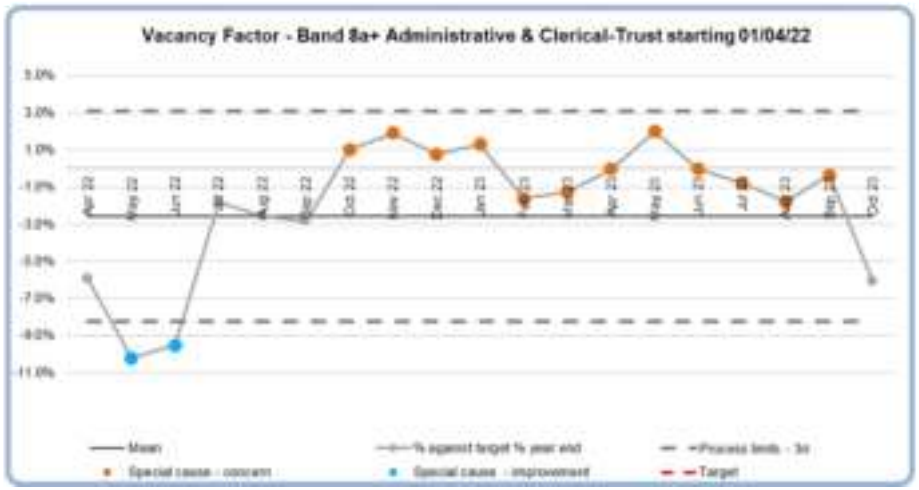

Vacancy Factor - Additional Clinical Services (Excluding Unregistered Nursing)-Trust starting 01/04/22
Mean
% against target % year end
Process limits - 3σ
Special cause - concern
Special cause - improvement
Target

Vacancy

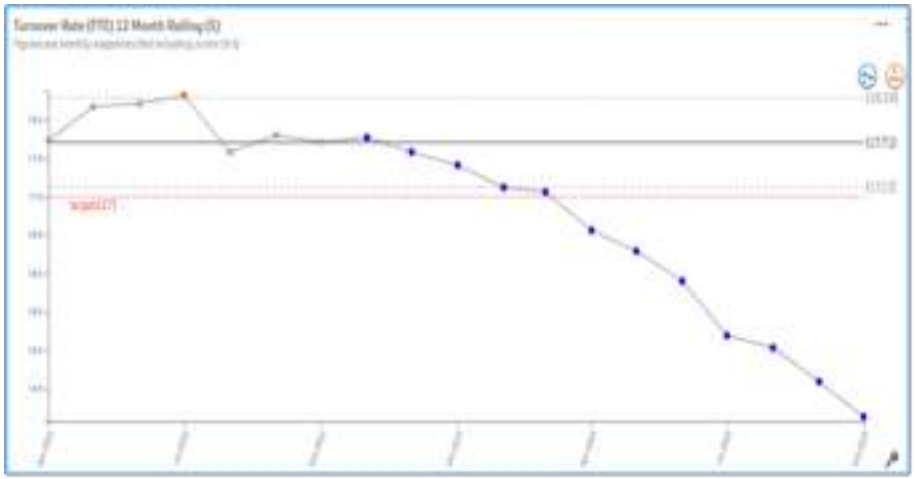

Vacancy Factor - Bands 2-4 Administrative & Clerical -Trust starting 01/04/22

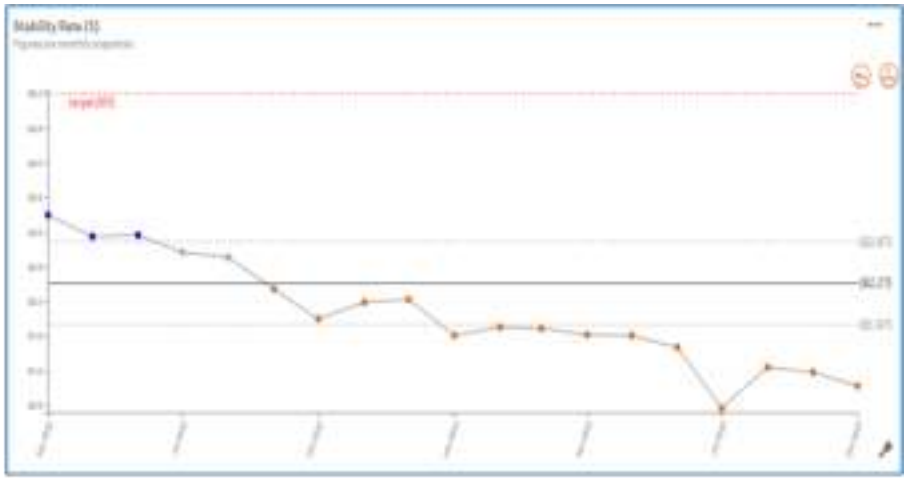

Vacancy Factor - Estates & Ancillary-Trust starting 01/04/22

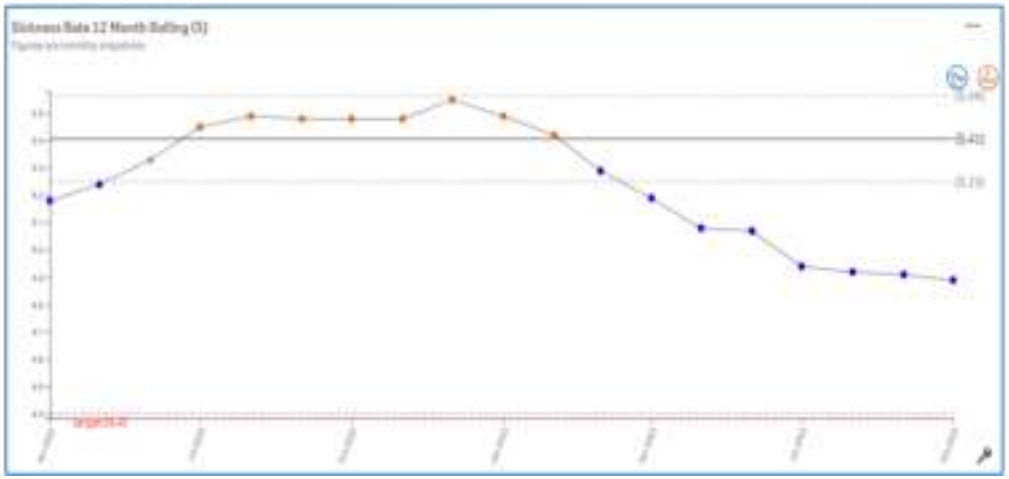

Vacancy Factor - Bands 5-7 Administrative & Clerical-Trust starting 01/04/22


Vacancy Factor - Band 8a+ Administrative & Clerical-Trust starting 01/04/22

Engagement and Wellbeing







People support and engagement

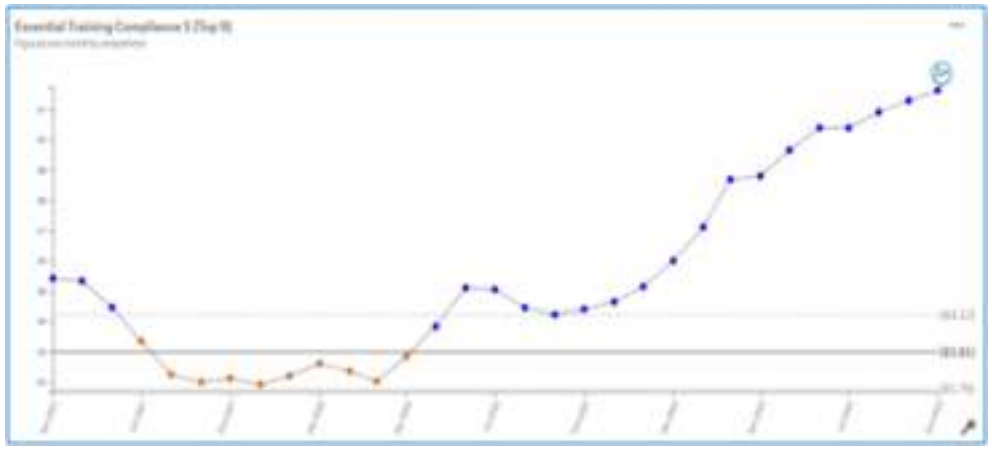
Actions delivered: (Associate Director of People)
- Buying and selling annual leave policy agreed
- Support for People Partners embedded and in place
- Rebuilding partnership working with Trade Union colleagues – development sessions run, and improvement workstreams in place.

Actions in Progress:
- Website with bitesize management training in development, providing just in time advice and support (**December**)
- Long term absence deep dive aligned to partner support model (**December**)
- Let's talk Flex – campaign on flexible working and consideration of revised Agenda for Change (AfC) conditions (**January)**
- Policies under development include car parking, pay progression, partnership working and disputes, relationships at work, recruitment and storage and retention of documents
- Internal bank of investigators in development **(January)**
- Campaign to support new fairness at work policy, early resolution and RJC (**March)**

Retention and Staff Experience (including Health and Wellbeing)
Actions Delivered: (Associate Director Culture, Leadership & Development)
Staff Survey Comms Plan delivered, and survey response rates are positive
- Final draft 3-year Equality Diversity and Inclusion (EDI) plan approved by People Committee
- Legacy Mentor roles (Integrated Care System funding) agreed and being advertised
- Successful recruitment to the Associate Director of APOHS (Avon Occupational Health Service)
- Comms plan agreed for Disability History Month
- Winter 2023/24 wellbeing programme of support developed

Actions in Progress: (Associate Director of Culture, Leadership & Development)/Associate Director of People)
- Further Citizens Advice sessions (4 x per week) for anyone seeking advice on debt, benefits, housing, consumer rights and legal issues, available until the **end of March 2024**
- Implementation of EDI Plan (12 point plan) actions, and socialisation and embedding of plan with Divisions (**November – March 2024)**
- Trust retention working group to continue, developing and implementing retention plans and developing the 5- year plan **(April 2023 – January 2024)**
- Review and refresh role of wellbeing champions framework at NBT **(end January 2024)**
- Commission further training for more Cultural Ambassadors at NBT**(January 2024)**
- Set up new, operational EDI Group to support and drive delivery of the 3-year EDI Plan, with divisional representation **(December 2023)**
- Culture Group to continue work on developing a clear culture framework to support and underpin delivery of our strategic priorities and work programmes **(January 2024)**
- Listening events (**November and December 2023**) and actions linked to the new 'Sexual Safety in Healthcare Group' **(November – July 2024)**
- New Staff Experience Team video **(launching December 2023)**

Essential Training



What Does the Data Tell Us - Essential Training (Head of Learning and Development)

- QLIK (11 Oct 23) shows compliance as: All staff 89.75%, Permanent Staff 93.46%, Fixed Term Temp 85.41%, Other 77.03% (NBT eXtra 80.71%).
- Outliers in Training Compliance by Job Staff Group & Number of Staff:
- Medical and Dental 76.44% (Risen from 69.78% last month)
- Training Compliance By Training Title (Top 9) shows Information Governance is at 86.87%, below **the 95% compliance target**.
- The largest number of training expirations in the next 3 months are Information Governance, Patient Handling and Fire.

Actions – Essential Training (Head of Learning and Development)

- Weekly Mandatory and Statutory Training (MaST) reports raise the visibility of compliance within divisions. Divisional Directors of Nursing and People Partners are acting on the data and working with their divisions to increase compliance.
- NBT eXtra have emailed all bank staff directly and have set up MaST sessions in the computer suites to increase compliance.
- Inclusion of 5 MaST subjects in corporate induction has helped to increase day 1 compliance.
- Oliver McGowan mandatory e-learning is at 57.93%. All staff must complete this. Face-to-face modules at capacity (85 staff out of ~4k able to attend).

Leadership & Management Learning (Leadership Development Manager)

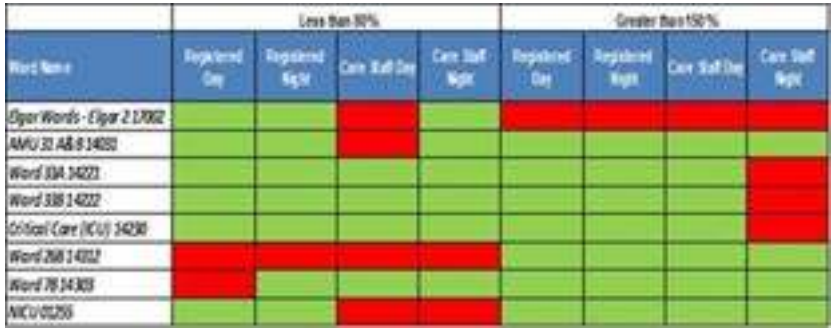
- **Mastering Management**: Cohort 1 has completed all 4 modules and now has its remaining 4 action learning sets. Cohort 2 has completed modules 1-3. Cohort 3 has completed module 1. There are 72 delegates (bands 5 - Very Senor Manager). Inclusivity 39%. Cohorts 4 and 5 are currently being filled, continuing to work with University of the West of England (UWE) on dates for Cohorts 6-10, and progressing first payments to UWE.
- **Excellence in Management**: Cohorts 1 and 2 are in progress. Cohort 1 has passed half-way and finishes on 27th February with Review & Celebration Event. 48 delegates (band 5-8c). Inclusivity 31% (race, sex, disability). Recruiting for Cohorts 3 and 4, 2024-2025.
- **Leading for Change**: John Drummond 12 Dec 23, Laura Ashley-Timms 20 Feb 24, booking speakers for 2024.
- **Accelerate**: The facilitator sent dates for the facilitator sent dates for cohorts. Seven in cohort 2 and have 7 in cohort 2 and need to get numbers up - the deadline is the end of Jan.
- **ILM Leadership and Team Skills**: Cohort 1 Mar 23 - 11/13 delegates completed the award, and two are working towards completion. Cohort 2 Jul 23 - 9/14 has passed, and five are working towards completion. Cohort 3 Sep 23 - 16 learners started. The first assignments were submitted, and we are working towards the final assignment, due to be completed in December 2023. The next cohort is due March 2024; applications open from 13 Nov 23 to 8 Jan 24.
- **Coaching and Mentoring**: procuring PLD platform. Completed a DPIA and am now awaiting support from IT systems. The potential go-live date is scheduled for late 2023.

(Head of Apprenticeships and Early Careers)

- **Trust Apprenticeships and Widening Engagement**
- Expired Funds & Utilisation: Expired funds in October - £76,039 Transferred Levy funds - £8099 to support community development, Levy utilisation – 49%.
- Current number of staff on an apprenticeship: 420 + 23 on a Break in Learning.
- Working within trust divisions to support the development needs by accessing levy funds and utilising spend where an apprenticeship can do.
- The Apprenticeship Centre has received confirmation that they have been successful in an application to receive funding to support a project as part of the Mayoral Priorities Skills fund, this is specifically to support funding for widening engagement and apprenticeship support, with the total project value being £240K. This project will run from Nov 23 – April 25.
- **Apprenticeship Centre**
- Current number of learners enrolled: 66 Direct – 109 Non-Direct.
- Number of completed apprenticeships last month: 1 Direct - 4 Non-Direct.
- Number due to be complete next Month: 4 Direct - (16 Out of funding) and 7 Non-Direct (26 Out of funding).
- Mitigation is in place to continue to closely review timely completion of apprenticeships.
- A paper was submitted to the Nov People Committee to provide further details on the success of the 22/23 academic year.
- Ofsted visit pending, expected between April Oct.

Safe Staffing

Oct-23	Day shift		Night Shift	
	RN/RM	CA Fill	RN/RM	CA Fill
Southmead	96.27%	90.76%	100.24%	103.76%



Safe Staffing Shift Fill Rates:
Ward staffing levels are determined as safe, if the shift fill rate falls between 80-150% , this is a National Quality Board (NQB) target.

What does the data tell us?
For October 2023, the combined shift fill rates for days for RNs across the 34 wards was 96% and 100% respectively for nights for RNs. The combined shift fill for HCSWs was 91% for the day and 104% for the night. Therefore, the Trust as a collective set of wards is within the safe limits for October.

October *registered nursing* fill rates:
- 9.68% of wards had daytime fill rates of less than 80%
- 3.23 % of wards had night-time fill rates of less than 80%
- 3.23% of wards had daytime fill rates of greater than 150%
- 3.23 % of wards had night-time fill rates of greater than 150%

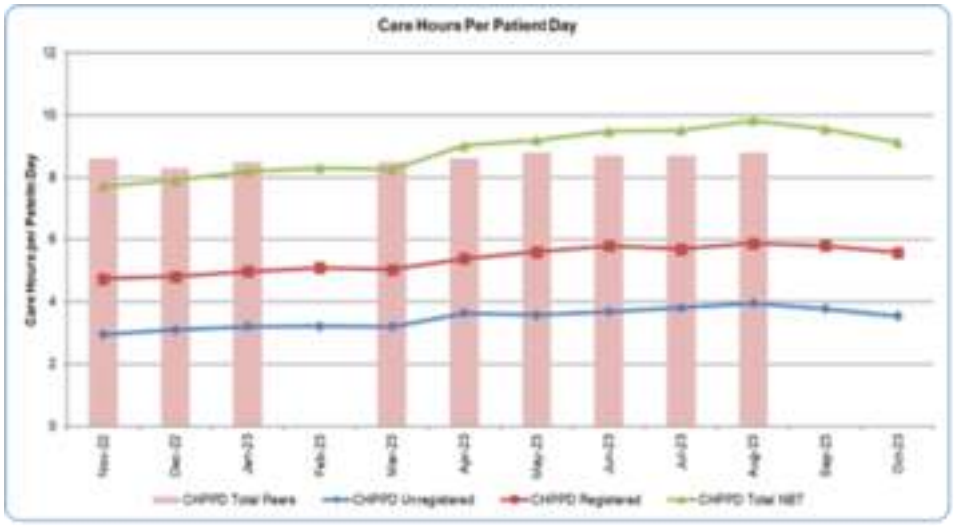
October *care staff* fill rates:
- 9.68% of wards had daytime fill rates of less than 80%
- 6.45 % of wards had night-time fill rates of less than 80%
- 3.23% of wards had daytime fill rates of greater than 150%
- 12.90 % of wards had night-time fill rates of greater than 150%

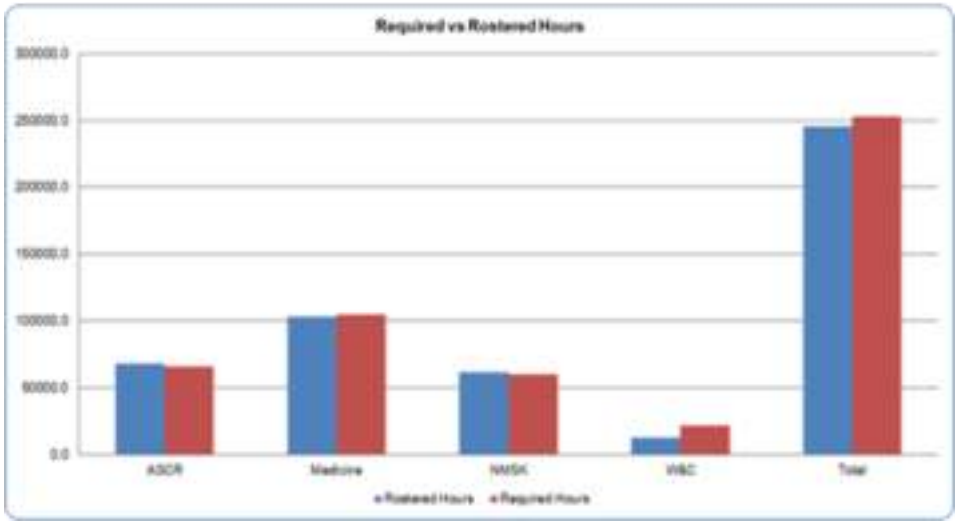
The “hot spots” as detailed on the heatmap which did not achieve the fill rate of 80% fill rate for both RNs and HCSWs have been reviewed. Gate 26b were working at a lower skill mix than planned as not all the beds were open. The increased fill rates for the percentage of HCSWs at night reflects the deployment of additional staff in response to patient acuity and increased levels of therapeutic observation (enhanced care) in order to maintain patient safety (33a, 33b, Elgar and ICU). The Healthroster for 7b has now been corrected to remove an additional shift which was a legacy from when the ward was converted to medical during the pandemic.

Compliance:
SafeCare data supports safe staffing by providing snap shots of patient acuity and dependency in a clinical area. For the tool to be used most effectively NBT compliance is required. The compliance data for NBT will be demonstrated for future IPR's for on-going monitoring. There are plans to strengthen the compliance of the safer staffing data through the twice daily staffing meetings.

15.1

Care Hours





Care Hours per Patient Day (CHPPD)
The chart shows CHPPD for the Model Hospital peers (all data from Model Hospital). CHPPD data provides a picture of how staff are deployed and how productively. It provides a measure of total staff time spent on direct care and other activities such as preparing medications and patient records. This measure should be used alongside clinical quality and safety metrics to understand and reduce unwanted variation and support delivery of high quality and efficient patient care.

What does the data tell us?
Compared to national levels the acuity of patients at NBT has increased and exceeded the national position.

Required vs Roster Hours
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 are 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.

What does the data tell us
The required hours have been augmented using the completion rate for SafeCare patient census data. Where the census completion was less than 100% the required hours have been supplemented by an assumption that for the census periods not completed the patient mix would have been the same on average. The data demonstrates that the total number of required hours has exceeded the available rostered hours.

Medical Appraisal

What does the data tell us?

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.

15.1

Finance

Board Sponsor: Chief Financial Officer
Glyn Howells

Statement of Comprehensive Income at 31st October 2023

	Month 7			Year to date		
	Budget £m	Actual £m	Variance £m	Budget £m	Actual £m	Variance £m
Contract Income	66.0	67.1	1.0	456.2	455.5	(0.6)
Income	4.8	9.5	4.7	39.6	54.3	14.8
Pay	(44.7)	(46.7)	(2.0)	(306.4)	(314.4)	(8.0)
Non-pay	(27.6)	(32.1)	(4.5)	(190.0)	(205.1)	(15.1)
Surplus/(Deficit)	**(1.5)**	**(2.2)**	**(0.7)**	**(0.7)**	**(9.6)**	**(8.9)**

Assurances

The financial position for October 2023 shows the Trust has delivered a £0.7m deficit against a £1.5m planned surplus which results in a £0.7m adverse variance in month and £8.9m adverse variance year to date.

Contract income is £1.0m favourable to plan. The favourable variances include the Junior Doctor pay award (£0.8m) and the recognition of Mobile CDC income (£0.3m).

Other income is £4.7m favourable to plan. This is driven by new funding adjustments where the Trust is receiving £3.0m of new funding since the plan was approved which is offset by costs, as well as £0.9m of income to cover mobile theatre costs (offset in non-pay).

Pay expenditure is £2.0m favourable to plan. New funding adjustments, offset in other income, have caused a £1.4m adverse variance. The remaining adverse variance is caused by the impact of increased temporary staffing costs.

Non-pay expenditure is £4.5m adverse to plan. New funding adjustments, offset in other income, have caused a £1.2m adverse variance. The Trust has seen a £0.9m of costs relating to the mobile theatre, which is offset in other income. Divisional non-pay is £1.6m adverse from in-tariff drugs overspend, increased independent sector spend and the impact of the Community Diagnostic Centre (CDC) not in the original plan.

Statement of Financial Position at 31st October 2023

	22-23 Month 12 £m	Month 6 £m	Month 7 £m	In-Month Change £m	YTD Change £m
Non-Current Assets	**510.6**	**520.9**	**519.7**	**(1.2)**	**9.2**
Current Assets					
Inventories	10.0	10.1	9.9	(0.2)	(0.2)
Receivables	57.2	54.0	50.4	(3.6)	(6.9)
Cash and Cash Equivalents	104.0	72.3	71.9	(0.4)	(32.1)
Total Current Assets	**171.3**	**136.3**	**132.2**	**(4.2)**	**(39.1)**
Current Liabilities (< 1 Year)					
Trade and Other Payables	(125.2)	(95.9)	(92.9)	(2.9)	(32.3)
Deferred Income	(17.2)	(28.3)	(29.1)	0.8	12.0
Financial Current Liabilities	(17.1)	(17.7)	(17.7)	0.0	0.7
Total Current Liabilities	**(159.5)**	**(141.9)**	**(139.8)**	**(2.0)**	**(19.6)**
Non-Current Liabilities (> 1 Year)					
Trade Payables and Deferred Income	(6.7)	(7.2)	(7.1)	(0.0)	0.4
Financial Non-Current Liabilities	(355.2)	(352.3)	(351.3)	(1.0)	(3.9)
total Non-Current Liabilities	**(362.0)**	**(359.5)**	**(358.5)**	**(1.0)**	**(3.5)**
Total Net Assets	**160.4**	**155.9**	**153.6**	**(2.3)**	**(6.7)**
Capital and Reserves					
Public Dividend Capital	469.1	471.8	471.8	0.0	2.7
Income and Expenditure Reserve	(371.3)	(376.7)	(376.7)	0.0	(5.4)
Income and Expenditure - Current Year	(5.4)	(7.2)	(9.4)	(2.3)	(4.1)
Revaluation Reserve	68.0	68.0	68.0	0.0	0.0
Total Capital and Reserves	**160.4**	**155.9**	**153.6**	**(2.3)**	**(6.7)**

Capital is £18.5m year-to-date (excluding leases). The full year forecast is £5.3m above currently confirmed funding sources. This represents the agreed level of over-programming and the gap is expected to be bridged by additional national funding, further delays/underspend against the forecast and recognition of capital receipts from previous years.

Cash is £71.9m at 31 October, a £0.4m decrease compared with the previous month. The decrease in month is mostly driven by marginal movements in working capital.

15.1

Regulatory

Board Sponsor: Chief Executive
Maria Kane

NHS Provider Licence Compliance Statements at November 2023 - Self-assessed, for submission to NHS

Ref	Criteria	Comp (Y/N)	Comments where non compliant or at risk of non compliance
G3	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.
G4	Having regard to NHS England Guidance	Yes	The Trust Board has regard to NHS England guidance where this is applicable. The Organisation has been placed in segment 3 of the System Oversight Framework, receiving mandated support from NHS England & Improvement. This is largely driven be recognised issues relating to cancer wait time performance and reporting.
G6	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 Committee.
G7	Patient eligibility and selection criteria	Yes	Trust Board has considered the assurances in place and considers them sufficient.
C1	Submission of Costing Information	Yes	A range of measures and controls are in place to provide internal assurance on data quality, including an annual Internal Audit assessment.
C2	Provision of costing and costing related information	Yes	The trust submits information to NHS Improvement as required.
C3	Assuring the accuracy of pricing and costing information	Yes	Scrutiny and oversight of assurance reports to regulators is provided by Trust's Audit and Risk Committee and other Committee structures as required.
P1	Compliance with the NHS Payment Scheme	Yes	NBT complies with national tariff prices. Scrutiny by local commissioners, 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 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 financial arrangements.
IC1	Provision of Integrated Care	Yes	The Trust is actively engaged in the ICS, and leaders participate in a range of forums and workstreams. The Trust is a partner in the Acute Provider Collaborative.
IC2	Personalised Care and Patient Choice	Yes	Trust Board has considered the assurances in place and considers them sufficient.
WS1	Cooperation	Yes	The Trust is actively engaged in the ICS and cooperates with system partners in the development and delivery of system financial, people, and workforce plans.
NHS2	Governance Arrangements	Yes	The Trust has robust governance frameworks in place, which have been reviewed annually as part of the Licence self-certification process, and tested via the annual reporting and auditing processes

Appendix 1: General guidance and NBT Quality Priorities

Unless noted on each graph, all data shown is for period up to, and including, 31 October 2023 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 2023/24
Outstanding Patient Experience
We will put patients at the core of our services, respecting their choice, decisions and voice whilst becoming a partner in the management of conditions.
High Quality Care
We will support our patients to access timely, safe, and effective care with the aim of minimising patient harm or poor experience as a result.
We will minimise patient harm whilst experiencing care and treatment within NBT services.
We will demonstrate a proactive and positive culture of safety based on openness and honesty, in which concerns about safety are listened to, safety events are investigated and reported thoroughly, and lessons are learned to continually identify and embed good practices.
We will make Maternity and Neonatal care safer, more personalised, and more equitable

Appendix 2: Abbreviation Glossary

Abbreviation	Definition
AHP	Allied Health Professional
AMTC	Adult Major Trauma Centre
AMU	Acute medical unit
ASCR	Anaesthetics, Surgery, Critical Care and Renal
ASI	Appointment Slot Issue
AWP	Avon and Wiltshire Partnership
BA PM/QIS	British Association of Perinatal Medicine / Quality Indicators standards/service
BI	Business Intellligence
BIPAP	Bilevel positive airway pressure
BPPC	Better Payment Practice Code
BWPC	Bristol & Weston NHS Purchasing Consortium
CA	Care Assistant
CDC	Community Diagnostics Centre
CDS	Central Delivery Suite
CEO	Chief Executive
CHKS	Comparative Health Knowledge System
CHPPD	Care Hours Per Patient Day
CIP	Cost Improvement Programme
Clin Gov	Clinical Governance
CMO	Chief Medical Officer
CNST	Clinical Negligence Scheme for Trusts
COIC	Community-Oriented Integrated Care
CQC	Care Quality Commission
CQUIN	Commissioning for Quality and Innovation
CT	Computerised Tomography
CTR/NCTR	Criteria to Reside/No Criteria to Reside
D2A	Discharge to Assess
DivDoN	Deputy Director of Nursing
DoH	Department of Health
DPEG	Digital Public Engagement Group
DPIA	Data Protection Impact Assessment
DPR	Data for Planning and Research
DTI	Deep Tissue Injury
DTOC	Delayed Transfer of Care
ECIST	Emergency Care Intensive Support Team
EDI	Electronic Data Interchange
EEU	Elgar Enablement Unit

Appendix 2: Abbreviation Glossary

ERF	Elective Recovery Fund
ERS	E-Referral System
ESW	Engagement Support Worker
FDS	Faster Diagnosis Standard
FE	Further education
FTSU	Freedom To Speak Up
GMC	General Medical Council
GP	General Practitioner
GRR	Governance Risk Rating
HCA	Health Care Assistant
HCSW	Health Care Support Worker
HIE	Hypoxic-ischaemic encephalopathy

HSIB	Healthcare Safety Investigation Branch
HSIB	Healthcare Safety Investigation Branch
I&E	Income and expenditure
IA	Industrial Action
ICB	Integrated Care Board
ICS	Integrated Care System
ICS	Integrated Care System
ILM	Institute of Leadership & Management
IMandT	Information Management
IMC	Intermediate care
IPC	Infection, Prevention Control
ITU	Intensive Therapy Unit

Abbreviation	Definition
JCNC	Joint Consultation & Negotiating Committee
LoS	Length of Stay
MaST	Mandatory and Statutory Training
MBRRACE	Maternal and Babies-Reducing Risk through Audits and Confidential Enquiries
MDT	Multi-disciplinary Team
Med	Medicine
MIS	Management Information System
MRI	Magnetic Resonance Imaging
MRSA	Methicillin-Resistant Staphylococcus Aureus
MSSA	Methicillin-Susceptible Staphylococcus Aureus
NC2R	Non-Criteria to Reside
NHSEI	NHS England Improvement
NHSi	NHS Improvement

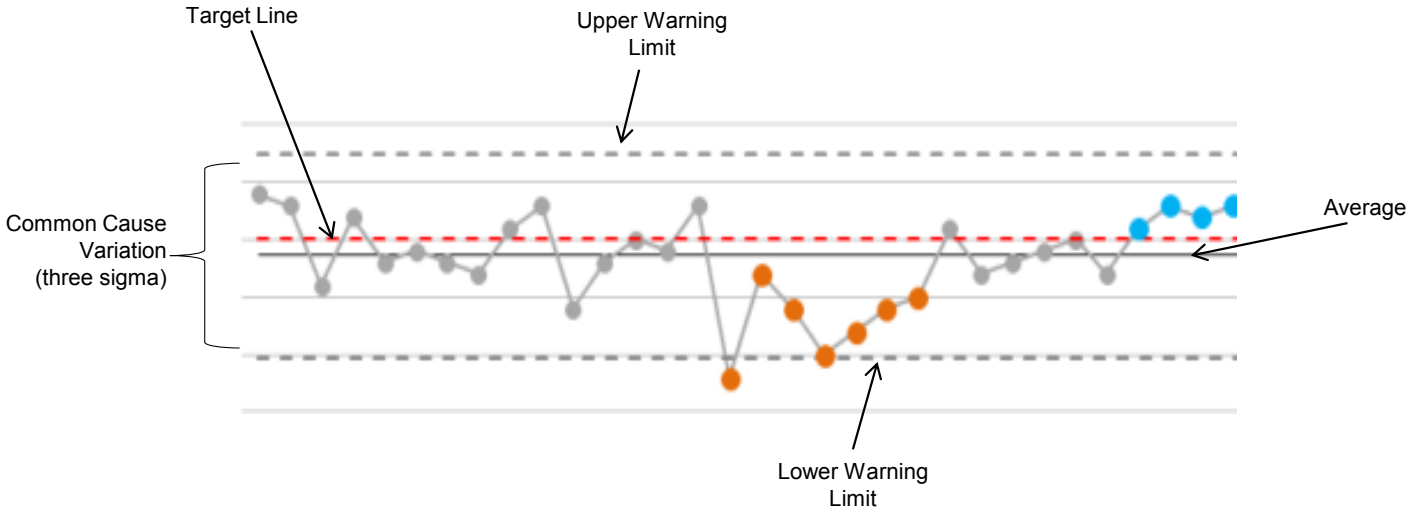
Appendix 2: Abbreviation Glossary

Abbreviation	Definition
NICU	Neonatal intensive care unit
NMPA	National Maternity and Perinatal Audit
NMSK	Neurosciences and Musculoskeletal
Non-Cons	Non-Consultant
NOUS	Non-Obstetric Ultrasound Survey
OOF	Out Of Funding
Ops	Operations
P&T	People and Transformation
PALS	Patient Advisory & Liaison Service
PCEG	Primary Care Executive Group
PDC	Public Dividend Capital
PE	Pulmonary Embolism
PMRT	Perinatal Morality Review Tool
PPG	Patient Participation Group
PPH	Post-Partum Haemorrhage
PROMPT	PRactical Obstetric Multi-Professional Training
PSII	Patient Safety Incident Investigation
PTL	Patient Tracking List
PUSG	Pressure Ulcer Sore Group
QC	Quality Care
qFIT	Faecal Immunochemical Test
QI	Quality improvement
RAP	Remedial Action Plan
RAS	Referral Assessment Service
RCA	Root Cause Analysis
RJC	Restorative Just Culture
RMN	Registered Mental Nurse
RTT	Referral To Treatment
SBLCBV2	Saving Babies Lives Care Bundle Version 2
SDEC	Same Day Emergency Care
SEM	Sport and Exercise Medicine
SI	Serious Incident
T&O	Trauma and Orthopaedic
TNA	Trainee Nursing Associates
TOP	Treatment Outcomes Profile
TVN	Tissue Viability Nurses
TWW	Two Week Wait

Appendix 2: Abbreviation Glossary

Abbreviation	Definition
UEC	Urgent and Emergency Care
UWE	University of West England
VSM	Very Senior Manager
VTE	Venous Thromboembolism
WCH	Women and Children's Health
WHO	World Health Organisation
WLIs	Waiting List Initiative
WTE	Whole Time Equivalent

Appendix 3: Statistical Process Charts (SPC) Guidance



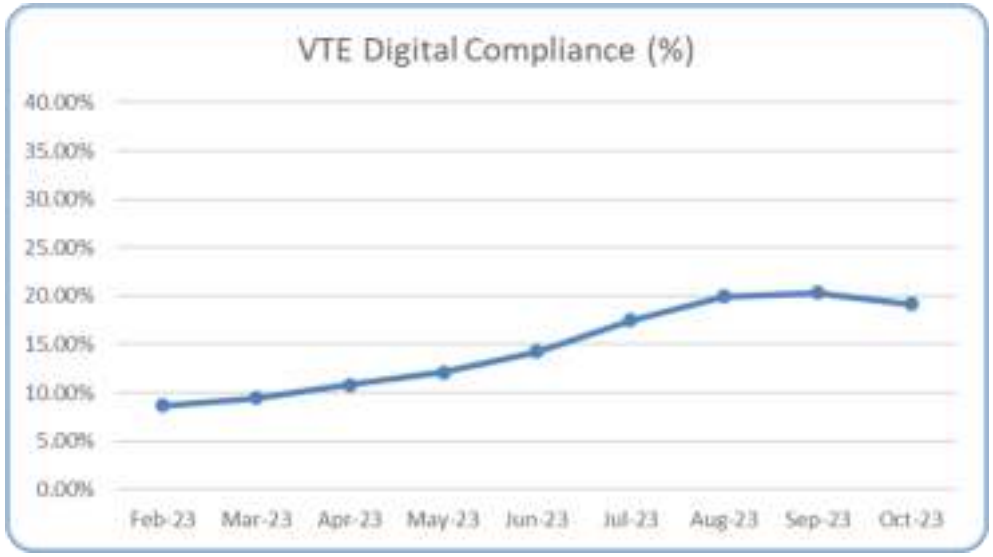
Orange dots signify a statistical cause for concern. A data point will highlight orange if it:
A) Breaches the lower warning limit (special cause variation) when low reflects underperformance or breaches the upper control limit when high reflects underperformance.
B) Runs for 7 consecutive points below 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 4: VTE Risk Assessment Digital Completion



NBT rolled out a new standardised digital VTE Risk Assessment form on CareFlow to replace paper assessments across all NBT adult Inpatient areas from February 2023. Shown is the improving compliance since the move to digital completion.

Maternity Perinatal Quality Surveillance Matrix

Please note data from September 2023 onwards is partial due to BadgerNet implementation.

		Target	Apr-23	May-23	Jun-23	Q1 total / Average	Jul-23	Aug-23	Sep-23	Oct-23	TREND
Activity											
Number of women who gave birth, all gestations from 22+0 gestation			418	464	459	N/A	467	477			
Number of babies born alive >=22+0 weeks to 26+6 weeks gestation (Regional Team Requirement)			4	0	3	N/A	1	4	1		
Number of women who gave birth (>=24 weeks or <24 weeks live)			412	465	453	1330	460	477			
Number of babies born (>=24 weeks or <24 weeks live)			420	470	459	1349	468	483			
Number of babies born alive >=24+0 - 36+6 weeks gestation (MBRRACE)			35	34	41	110	37	31			
No of livebirths <24 weeks gestation			3	1	1	5	1	3			
Induction of Labour rate %			36.9%	35.9%	33.6%	35%	38.0%	32.1%			
Spontaneous vaginal birth rate %			53.9%	48.4%	45.9%	49%	49.3%	45.9%			
Assisted vaginal birth rate %			9.7%	8.8%	9.7%	9%	10.0%	7.8%			
Caesarean Birth rate (overall) %			36.4%	42.8%	44.4%	41%	40.7%	46.3%			
Planned Caesarean birth rate %			18.2%	18.3%	19.9%	19%	18.3%	20.8%			
Emergency Caesarean Birth rate %			18.2%	24.5%	24.5%	22%	22.4%	25.6%			
NICU admission rate at term (excluding surgery and cardiac - target rate 5%)			2.6%	3.0%	3.9%	3.2%	4.7%	2.9%	3.80%		
Perinatal Morbidity and Mortality inborn											
Total number of perinatal deaths (excluding late fetal losses)			4	3	4	11	3	2	3	2	
Number of late fetal loses from 16+0 to 23+6 weeks excl. TOP (for SBLCBV2)			2	1	4	7	1	2	0	1	
Number of stillbirths (>=24 weeks excl. TOP)			1	1	2	4	2	1	1	1	
Number of neonatal deaths : 0-6 Days			2	2	2	6	0	1	0	0	
Number of neonatal deaths : 7-28 Days			1	0	0	1	0	0	1	0	
PMRT grading C or D cases (themes in report)			0	1	0		0	0	1	1	
Suspected brain injuries in inborn neonates (no structural abnormalities) grade 3 HIE 37+0 (HSIB)			0	0	0	0	0	0	0	0	
Maternal Morbidity and Mortality											
Number of maternal deaths (MBRRACE)			0	0	0	0	0	1	0	0	
Direct			0	0	0	0	0	1	0	0	
Indirect			0	0	0	0	0	0	0	0	
Number of women recieving enhanced care on CDS			12	27	17		19	14			
Number of women who received level 3 care (ITU)			0	0	0	0	0	1			
Insight											
Number of datix incidents graded as moderate or above (total)			2	3	0	5	0	0	0	0	
Datix incident moderate harm (not SI, excludes HSIB)			2	2	0	4	0	0	0	0	
Datix incident PSII (excludes HSIB)			0	1	0	1	0	0	0	0	
New HSIB referrals accepted			0	0	0	0	0	0	0	0	
Outlier reports (eg: HSIB/NHSR/CQC/NMPA/CHKS or other organisation with a concern or request for action made directly with Trust)			0	0	0	0	0	0	0	0	
Coroner Reg 28 made directly to Trust			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	83	
Minimum safe staffing in maternity services: Obstetric middle grade rota gaps			2	2	2		2	1	1	1	
Minimum safe staffing in maternity services: Obstetric Consultant rota gaps			2	2	2		2	2	2	2	
Minimum safe staffing in maternity services: anaesthetic medical workforce (rota gaps)			0	0	0		1	0	0	0	
Minimum safe staffing in maternity services: Neonatal Consultants workforce (rota gaps)			2	2	1		1	1	1	1	
Minimum safe staffing in maternity services: Neonatal Middle grade workforce (rota gaps)			0	1	1		1	1	0	0	
Minimum safe staffing: midwife minimum safe staffing planned cover versus actual prospectively (number unfilled bank shifts).			39%	31%	34%	35%	38%	38%	16.87%	11%	
Vacancy rate for midwives			11.60%	16.20%	15.50%	14%	18.45%	18.18%	11.91%		
Minimum safe staffing in maternity services: neonatal nursing workforce (% of nurses BAPM/QIS trained)			40%	60%	60%	53%	60%	50%		45%	
Vacancy rate for NICU nurses			27	30	31	29.33333	31	23	24	12	
Datix related to workforce (service provision/staffing)			3	6	5	4.666667	6	3	4	7	
Consultant led MDT ward rounds on CDS (Day to Night)			70%	90%	80%		84%	87%	73%	65%	
Consultant led MDT ward rounds on CDS (Day)			83%	90%	80%	84%	77%	83%	100%	94%	
One to one care in labour (as a percentage)			100%	100%	100%	100%	100%	100%	100%	100%	
Compliance with supernumerary status for the labour ward coordinator		100%	100%	100%	100%	100%	100%	100%	100%	100%	
Number of times maternity unit attempted to divert or on divert										1	
in-utero transfers											
in-utero transfers accepted											
in-utero transfers declined										0	
ex-utero transfers											
ex-utero transfers accepted											
ex-utero transfers declined										24	
NICU babies transferred to another unit due to capacity/staffing										3	
Number of consultant non-attendance to 'must attend' clinical situations			0	0	0	0	0	0	0	0	
Involvement											
Service User feedback: Number of Compliments (formal)			72	35	74	181	64	48	37	38	
Service User feedback: Number of Complaints (formal)			5	4	3	12	2	7	4	1	
Friends and Family Test Score % (good/very good) NICU			100	100	100		100	100			
Friends and Family Test Score % (good/very good) Maternity			94	93	93	93.33333	92	91	85		
Staff feedback from frontline champions and walk-abouts (number of themes)			3	0	4	7	0	3	4	0	
Improvement											
Progress in achievement of CNST /10			7	7	7		7	7	7		
Training compliance in annual local BNLS (NICU)			100%	100%	100%		100%	100%			
Training compliance in maternity emergencies and multi-professional training (PROMPT) * note: includes BNLS	***Overall***	**90%**	65%	55%	76%		83%	81%	79%	79%	
	Obstetric Consultants		69%	50%	72%		78%	78%	75%	84%	
	Other Obstetric Doctors		59%	54%	75%		86%	53%	52%	70%	
	Anaesthetic Consultants		81%	65%	81%		90%	90%	86%	87%	
	Other Anaesthetic Doctors		54%	50%	74%		76%	83%	79%	100%	
	Midwives		71%	61%	78%		85%	88%	93%	84%	
	Maternity Support Workers		57%	51%	75%		84%	93%	91%	71%	
	Theatre staff		Data Not Ava lable (DNA)								
	Neonatologists		Data Not Ava lable (DNA)								
	NICU Nurses		Data Not Ava lable (DNA)								
Fetal Wellbeing and Surveillance	***Overall***	**90%**	67%	64%	72%		78%	67%	65%	75%	
	Obstetric Consultants		75%	61%	50%		61%	72%	69%	68%	
	Other Obstetric Doctors		51%	64%	77%		79%	44%	44%	44%	
	Midwives		74%	66%	90%		95%	86%	83%	72%	
Trust Level Risks			9	4	6	DNA	7	6	6	6	
Proportion of midwives responding with 'Agree or Strongly Agree' on whether they would recommend their trust as a place to work or receive treatment (Reported annually)											
Proportion of specialty trainees in Obstetrics & Gynaecology responding with 'excellent or good' on how they would rate the quality of supervision out of hours (Reported annually)											

Report To:	Public Trust Board			
Date of Meeting:	30 November 2023			
Report Title:	Finance & Performance Committee (F&PC) Upward Report			
Report Author:	Aimee Jordan, Senior Corporate Governance Officer and Policy Manager			
Report Sponsor:	Richard Gaunt, Non-Executive Director & Committee Chair			
Confidentiality (tick where relevant) *:	**Patient identifiable information?**	**Staff identifiable information?**	**Commercially sensitive information?**	**Other exceptional circumstances**
*If any boxes above are ticked, paper may need to be received in *private.*				
Purpose of the report:	**Approval**	**Discussion**	**Information**	**Assurance**
				X
Recommendations:	The Trust Board is asked to: • receive the report for assurance and note the activities Finance & Performance Committee has undertaken on behalf of the Board. • discuss and agree suitable areas of focus for targeted deep-dives into areas of operational performance.			
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 January 2024.			

Executive Summary		
The following report provides a summary of the assurances received, issues to be escalated to the Trust Board and any new risks identified from the 23 November 2023 F&PC.		
Implications for Trust Improvement Priorities: *(tick those that apply and elaborate in the report)*	**Our Aim: Outstanding Patient Experience**	
	High Quality Care – *Better by design*	✓
	Innovate to Improve – *Unlocking a better future*	✓
	Sustainability – *Making best use of limited resources*	✓
	People – *Proud to belong*	
	Commitment to our Community - *In and for our community*	
Link to BAF or Trust Level Risks:	Reports received at the meeting support the mitigation of various BAF and Trust Level risks, particularly those relating to patient flow, access to elective care, finance and IMT/Cyber security risks.	
Financial implications:	Business cases approved by the Committee are within the delegated limits as set out in the Trust's Standing Financial Instructions and Scheme of Delegation.	
Does this paper require an EIA?	No as this is not a strategy or policy or change proposal	
Appendices:	Appendix 1: Finance Report – Month 7 Appendix 2: Green Plan Progress Report	

1. Purpose

1.1 To provide a highlight of the key assurances, escalations to the Board and identification of any new risks from the Finance and Performance Committee meeting held on 23 November 2023.

2. Background

2.1 The Finance and Performance Committee is a sub-committee of the Trust Board. It meets bi-monthly and reports to the Board after each meeting. The Committee was established to provide assurance to the Trust Board that there are robust and integrated systems in place overseeing the Trust's finance, IM&T, transformation, and performance and that they are in line with the organisation's objectives.

3. Key Assurances & matters for the attention of Trust Board

3.1 Operational performance summary

The Committee discussed the most recent performance data across unscheduled care and planned care, including diagnostics, referral to treatment (RTT), and cancer treatment:

- With regards to Unscheduled Care, it was noted that the level of No Criteria To Reside volumes had significantly increased, and the challenges were compounded by the increased Emergency Department attendances.
- With regards to Planned Care, the in-year target remained challenged due to due to the ongoing impact of industrial action. The Committee recognised that speciality level trajectories have been developed with targeted plans (such as outsourcing) to deliver the required capacity in the most challenged areas.
- With regards to Diagnostics, the Trust was delivering the national year-end target of fewer than 15% patients breaching 6-weeks and was on track to deliver the internal stretch target. Additionally, the Trust continued to be on track to clear >13-week breaches.
- With regards to Cancer performance, work was underway to sustainably improve the backlog position, particularly in Skin and Gynaecology, which will improve the overall cancer wait time standards compliance.

The Committee discussed the operational performance in depth and noted that achieving the national year-end target for planned care would be challenging but were assured that actions were being taken to mitigate the main risks impacting performance.

The Committee raised concerns regarding the No Criteria To Reside trajectory and noted the ongoing work to mitigate the risk such as the development of a "Transfer Of Care" (TOC) hub. Following further discussion on the TOC hub, the Committee received reassurance on the staffing model and requested that further detail on the metrics be brought to a future Committee.

The Committee also noted the work that had commenced to fundamentally improve patient pathways (such as the skin triage process) and recognised that aligning demand and capacity would have the biggest impact on the performance.

3.2 Medical Equipment Replacement Risk Deep-Dive

The Committee received the report which outlined the position statement, and the work undertaken, on NBT's plans to manage and mitigate the ongoing limited capital funding with a large equipment replacement backlog.

The Committee were informed that spend on medical equipment would need to be considered alongside other capital needs through a risk based assessment process.

The Committee noted that a 10-year capital plan would be coming to the Finance and Performance Committee in January 2024 and would provide granular detail on the capital replacement programme and the forecasted spend against the full capital plan.

The Committee discussed the importance of replacing medical equipment and the governance process of ensuring the risk profile doesn't increase as the estate ages. The Committee requested that the governance detail be included the 10-year capital plan paper.

3.3 Fee Paying Programme

The Committee received an update on the work to formalise a framework and improve the processes for Fee Paying. The Committee discussed the importance of the Trust providing consistent guidance to all staff across the organisation on the framework for private work.

The Committee received assurance that NHS activity is not being compromised by Private Practice. The Committee were also reassured on the private practises that were bring offered at the Trust and recognised that it was often complex, specialist work that could not be offered elsewhere. The Committee supported the next steps to progress scoping and implementing new activity.

3.4 Month 7 - Finance Report

The Committee received the Month 7 finance report which outlined that the Trust had delivered a £9.6m deficit, which was a £8.9m adverse position against a planned £0.7m deficit. The main driver was the impact of industrial action regards to costs, the reduction in elective recovery income caused by the strikes and the impact of temporary staffing.

Discussion focused on the Cost Improvement Programme (CIP) position, and it was recognised that the key focus for divisions was on recurrent savings to ensure that recovery of the underlying deficit was prioritised.

The Committee also received clarity on the Capital position and noted that the Elective Care Centre would be included in the forecast from January 2024. The full Finance report is appended.

3.5 Green Plan Progress Report

The Committee were joined by the Sustainability Manager who outlined the progress made by the Trust towards the Integrated Care System (ICS) Green Plan objectives which it adopted in 2022 and the Trust's performance against the net zero carbon by 2030 goal.

The Committee noted that the most significant or impactful aspect to focus on for improvement was within the procurement process and staff and patient travel. The Committee also discussed the potential for sustainability to become embedded in business planning.

The Committee received reassurance that there was no penalty for not achieving the net zero carbon by 2023 goal. The full Green Plan report is appended.

3.6 Digital Collaboration Update

The Committee received an update from the Joint Chief Digital Information Officer on the ongoing joint digital collaboration work with University Hospitals Bristol and Weston NHS Foundation Trust (UHBW).

The Committee discussed the timeframe for the infrastructure work and noted the importance of aligning systems for better access to data to facilitate smooth and efficient information sharing between primary and secondary care.

3.7 Digital Change Programme Delivery

The Committee received a detailed update on the status of each digital programme including areas of challenge and improvement.

The Committee discussed the IM&T risks and the risks relating to the Digital Change Programme in depth and received reassurance that mitigating actions were in place and the risks were being addressed.

The Committee were reassured of the inclusion of clinical teams in the digital change programmes and recognised their guidance for the implementation work. The Committee also received reassurance that the coding issue would be resolved in-month after bringing forward the winter escalation coding resources.

3.8 Risk Report

The Committee received and discussed the relevant Trust Level Risks (TLR) across Finance, Performance, Service Delivery and IM&T and Board Assurance Framework (BAF) risks within its purview.

It was agreed that future reports would identify where risk scores were not changing over time, allowing the Committee to focus future deep-dives on areas which might need more attention and scrutiny. Alongside this, it was also agreed that the Committee would seek to undertake more targeted deep-dives into areas of operational performance rather than reviewing the same overarching performance data as Trust Board. Trust Board is asked to discuss and agree suitable areas of focus.

3.9 **Other items:**

The Committee also received the following items for information:

- An update from the Business Case Review Group
- Noted a System Aseptic Services Outline Business Case and recommended it to Trust Board for approval.
- Received the System Forecast Supplementary Return for information.
- Finance and Performance Committee forward work-plan 2023/24

4. Identification of new risks & items for escalation

4.1 None

5. Summary and Recommendations

5.1 The Trust Board is asked to:

- receive the report for assurance and note the activities Finance & Performance Committee has undertaken on behalf of the Board.
- discuss and agree suitable areas of focus for targeted deep-dives into areas of operational performance.

Report To:	Finance & Performance Committee			
Date of Meeting:	23 November 2023			
Report Title:	Finance Report for October 2023 (Month 7)			
Report Author:	Simon Jones, Assistant Director of Finance – Financial Management			
Report Sponsor:	Glyn Howells, Chief Financial Officer			
Confidentiality (tick where relevant) *:	**Patient identifiable information?**	**Staff identifiable information?**	**Commercially sensitive information?**	**Other exceptional circumstances**
*If any boxes above are ticked, paper may need to be received in *private.*				
Purpose of the report:	**Approval**	**Discussion**	**Information**	**Assurance**
			X	
Recommendations:	The Finance & Performance Committee are asked to note the report.			
Report History:	Finance Report is a standing agenda item for F&PC.			
Next Steps:	Trust Board – 30 November 2023			

Executive Summary
The financial plan for 2023/24 in Month 7 (September) was a deficit of £1.5m. The Trust has delivered a £2.2m deficit, which is £0.7m worse than plan. This is predominately driven by temporary staffing costs. Year to date (YTD) the Trust has delivered a £9.6m deficit, which is a £8.9m adverse position against a planned £0.7m deficit. The main driver is the impact of industrial action regards to costs, and the reduction in elective recovery income caused by the strikes. The Trust is also seeing the impact of temporary staffing. The Month 7 CIP position shows £12.0m schemes fully completed. The Trust has a further £4.4m in implementation and planning, and a further £5.4m of schemes identified in the pipeline. Cash at 30 September amounts to £71.9m. Total capital spend year to date, excluding leases, was £18.0m.

Implications for Trust Improvement Priorities: *(tick those that apply and elaborate in the report)*	**Our Aim: Outstanding Patient Experience**	
	High Quality Care – *Better by design*	
	Innovate to Improve – *Unlocking a better future*	
	Sustainability – *Making best use of limited resources*	X
	People – *Proud to belong*	
	Commitment to our Community - *In and for our community*	
Link to BAF or Trust Level Risks:	N/A	
Financial implications:	The Financial implications are set out in the paper.	
Does this paper require an EIA?	No	
Appendices:	Presentation: Board Report: Month 7 2023/24	

NHS North Bristol NHS Trust

Finance Performance Report

Board Report: Month 7 2023/24

16.1

Author: Simon Jones (Assistant Director of Finance)

Sponsor: Glyn Howells (Chief Finance Officer)

NBTCARES

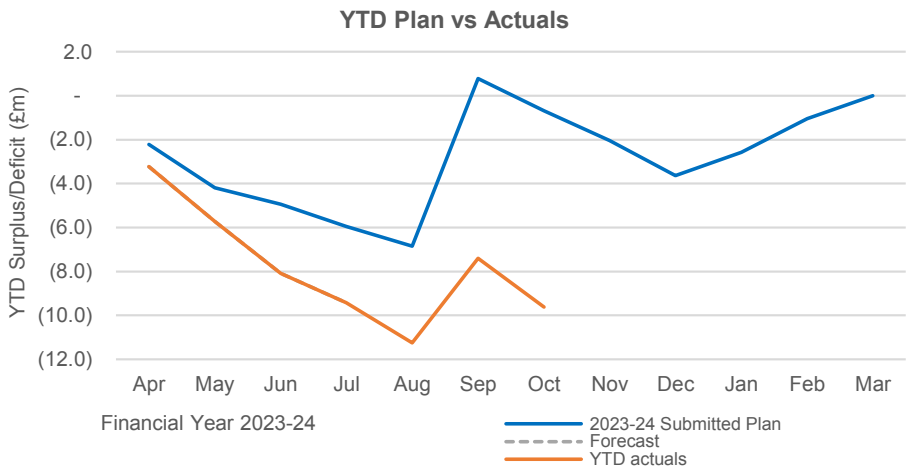
Finance Performance Report

Month 7 (October 2023)

NHS North Bristol NHS Trust

Finance Summary

	Month 7			Year to date		
	Budget	Actual	Variance	Budget	Actual	Variance
	£m	£m	£m	£m	£m	£m
Contract Income	66.0	67.1	1.0	456.2	455.5	(0.6)
Income	4.8	9.5	4.7	39.6	54.3	14.8
Pay	(44.7)	(46.7)	(2.0)	(306.4)	(314.4)	(8.0)
Non-pay	(27.6)	(32.1)	(4.5)	(190.0)	(205.1)	(15.1)
Surplus/(Deficit)	**(1.5)**	**(2.2)**	**(0.7)**	**(0.7)**	**(9.6)**	**(8.9)**
Industrial Action						
Costs			(0.0)			(3.3)
ERF			(0.3)			(2.2)
Temporary Staffing			(1.1)			(4.3)
Other			0.7			0.9



16.1

Key messages:

- The financial plan for 2023/24 in Month 7 (October) was a deficit of £1.5m. The Trust has delivered a £2.2m deficit, which is £0.7m worse than plan. The year to date position is a £8.9m adverse variance against a planned £0.7m deficit.
- The in month and year to date position is being driven by £0.0m and £3.3m respectively of costs related to industrial action. In month, the Trust has recognised the impact of industrial action on elective recovery income, in line with revised NHSE guidance. Therefore, £5.5m of the adverse position is driven by industrial action.
- Temporary staffing costs in the year to date position is creating a £4.3m adverse variance to plan, the impact of which is offset by delays in investments and vacancies.
- The Trust cash position at Month 7 is £71.9m, a reduction of £32.1m from Month 1. The forecast outturn for 2023/24 sees the Trust cash balance reduce to £49m by Month 12. This is driven by the Trust underlying deficit and capital spend.
- The Trust is currently forecasting a £5.3m overspend on capital by Month 12. This overprogramming is being managed in year by the Capital Planning Group.
- The Trust has delivered £12.0m of completed cost improvement programme (CIP) schemes at month 7. There are a further £4.4m of schemes in implementation and planning that need to be developed, and £5.4m in the pipeline.
- A waterfall showing the I&E drivers is shown on slide 3 and a detailed I&E position is shown on slide 19 in the Appendix.

NBTCARES

Income and Expenditure: I&E waterfall

16.1

Finance Performance Report

Month 7 (October 2023)

NHS North Bristol NHS Trust

Finance Summary – In Month

Overall

Income and Expenditure (I&E) performance in Month 7 generated a £2.2m deficit against a £1.5m planned deficit, which is £0.7m worse than plan.

Income

Commissioning income including pass-through income was £1.0m better than plan. The favourable variances include the Junior doctors Pay Award (£0.8m), the recognition of Mobile CDC income (£0.3m).

Non-NHS income was £4.7m better than plan. This is driven by new funding adjustments (£3.0m fav) where the Trust has received new funding (offset by costs) since the plan was approved. The Trust has also released £0.9m income to cover mobile theatre costs, offset in non-pay.

Pay

Pay costs were £2.0m worse than plan. New funding adjustments offset in Non-NHS income was £1.4m adverse. Revised pay variance is £0.6m adverse to plan. The Trust saw the impact increased temporary staffing costs (£1.1m adverse). This was offset by underspends on other staff due to vacancies (£1.3m fav). In year delivery on pay CIP is £0.9m adverse to plan due to the delayed start of full year schemes, however this is offset by benefits from delayed in year investments and service developments.

Non pay

Non-pay costs including pass-through drugs and devices were £4.5m worse than plan. New funding adjustments offset in Non-NHS income were £1.2m adverse. The revised variance is £3.3m adverse. The Trust has seen a £0.9m invoice relating to the mobile theatre, which offsets in Non-NHS income. Divisional non-pay is £1.6m adverse from in-tariff drugs overspend, increased independent sector spend, the impact of the Community Diagnostic Centre (CDC) not in the original plan, the new IM&T network and Bristol ambulance costs in Facilities. This is offset by benefits from capital charges and delayed in year investments and service developments.

Saving

Savings In month the Trust delivered a further £0.2m of savings to move the position from £11.8m in Month 6 to £12.0m in Month 7.

Capital & Cash

Gross capital expenditure was £0.8m in month, which is in line with forecast. Of this, £0.5m related to the Cossham CT and MRI project and £0.3m to the Fire Compartmentation project.

Cash is £71.9m at 31 October, a £0.4m decrease compared with the previous month. The decrease in month is mostly driven by marginal movements in working capital.

16.1

NBTCARES

Finance Performance Report

Month 7 (October 2023)

NHS North Bristol NHS Trust

Finance Summary – Year to Date

Overall

Income and Expenditure (I&E) performance to Month 7 generated a £9.6m deficit against a £0.7m planned deficit, which is £8.9m worse than plan.

Income

Commissioning income including pass-through income is £0.6m worse than plan. The main driver being an ERF adjustment of £2.6m for the expected ERF underperformance (driven largely by industrial action activity), reduced ICB funding (£1.9m), along with reduced income (£0.5m) relating to Demand & Capacity (D&C) projects and other service developments (SDF) which are yet to commence. Countered with income relating to the Pay Award (£3.3m), to cover announced pay awards, and the recognition of Mobile CDC funding (£1.2m).

Non-NHS income was £14.8m better than plan. This is driven by new funding adjustments, explained in the in month position, and pass-through items (£10.8m fav) and prior year invoicing in clinical divisions.

Pay

Pay costs were £8.0m worse than plan. Excluding the new funding the revised position is £8.2m adverse to plan – see table.

	YTD Variance
	£m
Temporary staffing above plan	(4.3)
Impact of industrial action	(3.3)
Medical pay award	(4.0)
Unidentified CIP	(5.4)
Slippage on investments	6.5
Vacancies	1.9
Other	0.4
Total	**(8.2)**

Non pay

Non-pay costs including pass-through drugs and devices were £15.1m worse than plan. Excluding new funding and plan adjustments the revised position is £7.2m adverse. This is driven by in-tariff drugs, increased independent sector spend, the new IM&T network, Bristol ambulance costs, and inflation related costs in Facilities. This is offset by underspends on utilities and cost of capital from reduced depreciation and PDC following the asset revaluation. In year delivery non-pay CIP is £1.6m adverse to plan.

Saving

Savings performance to Month 7 full year effect was £1.1m behind plan with the Trust having £12.0m complete schemes. The Trust has a further £4.4m of schemes in implementation and planning, and £5.3m of schemes in pipeline. This leaves a £2.6m shortfall against the annual £24.2m target.

Capital and Cash

Gross capital expenditure is £18.5m year-to-date (excluding leases). It is mostly driven by major projects, the Kendon Way Office (£4.1m), PSDS Low Carbon (£2.8m) and Cossham CT & MR works (£1.9m). Current spend on the Elective Centre is £0.9m year-to-date.

Cash is £71.9m in September, a £32.1m reduction year-to-date. This is due to carried forward and in-year payments for capital projects and improved BPPC performance together with the in-year I&E deficit. It is expected the trend will continue, resulting in the overall reduction of cash position to around £49m.

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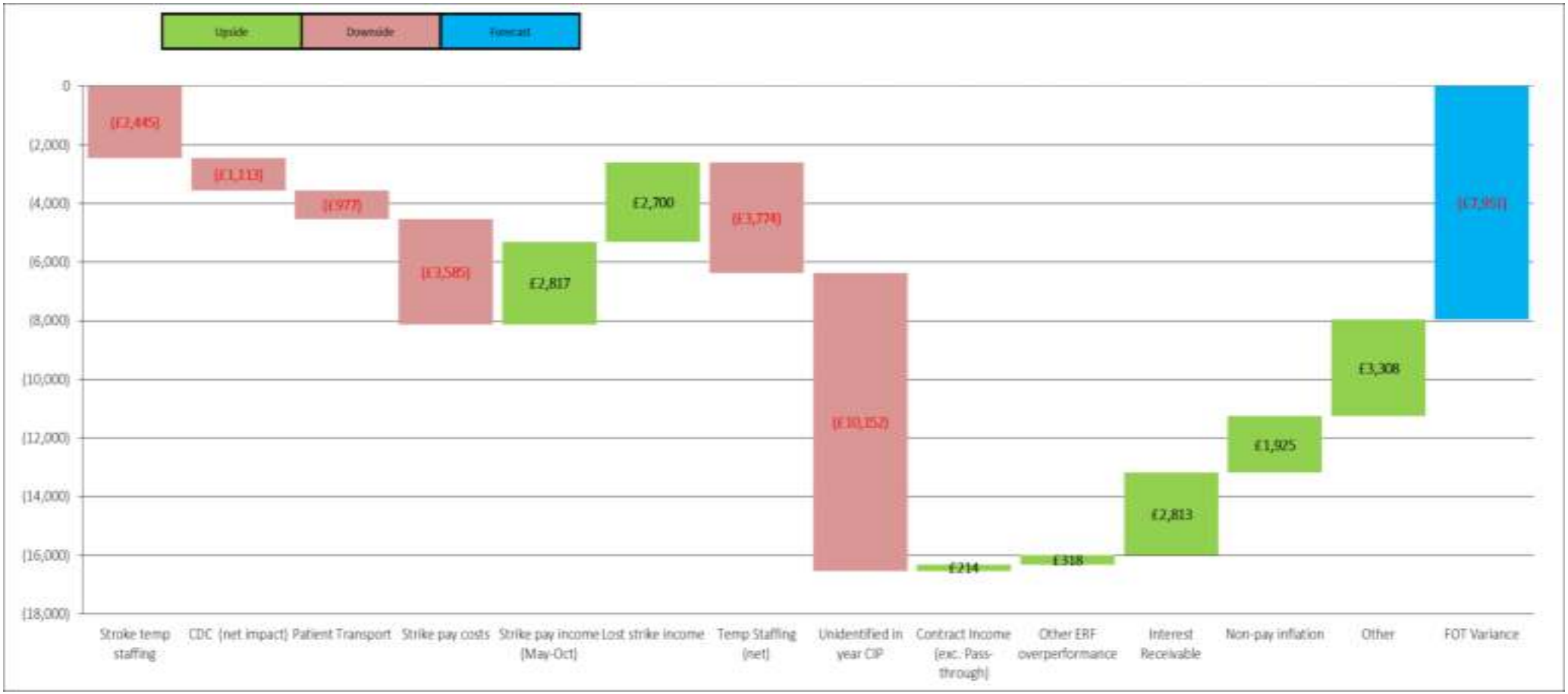
NBTCARES

Finance Performance Report

Month 7 (October 2023)

NHS North Bristol NHS Trust

Finance Summary – Forecast before Mitigations and Funding Announcements



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NBTCARES

Finance Performance Report

Month 7 (October 2023)

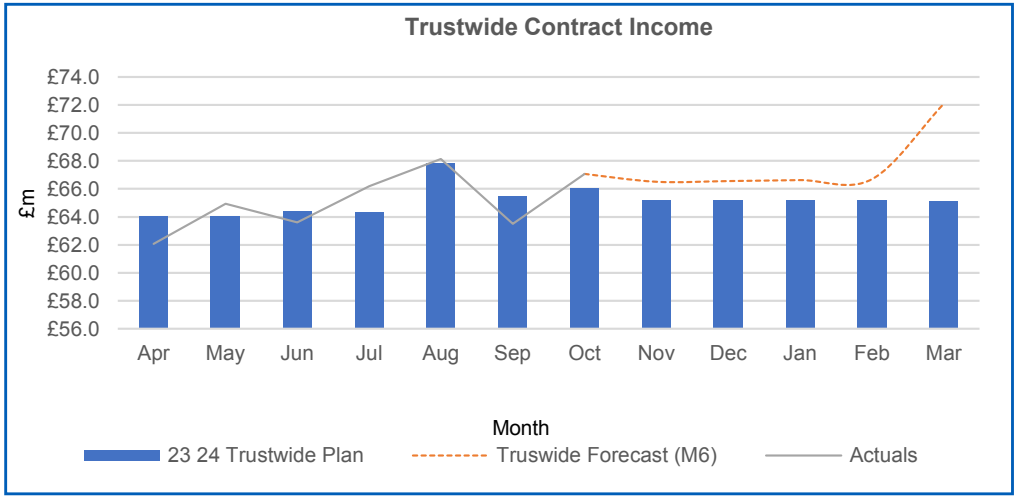
Finance Summary – Forecast – with Mitigations but before Funding Announcements

Category	£ m
Month 6 FOT Outturn	**(8.0)**
Mitigations:	
CDC	0.5
Temp staffng	2.0
Div CIP	0.6
Trustwide CIP	0.5
Divisional mitigations	1.2
Corporate Other	0.1
Further mitigations	3.1
Mitigated position	**0.0**

Forecast

- The Trust has completed a detailed forecast based on the month 6 financial position.
- Before mitigations the forecast shows a £8.0m deficit position against a year end breakeven position. This includes assumptions around the Trust recovering lost costs and income caused by Industrial Action between April and October. No further industrial action has been forecast, so any further strikes will impact the year end position.
- The Trust has worked up a range of mitigations that need to be delivered in the remaining months of 2023/24 to enable a breakeven position to be delivered.
- Divisions are being asked to deliver a further £3.8m of improvements to their positions through temporary staffing reductions, divisional efficiencies and further divisional mitigations.
- The Trust still has £3.1m of further mitigations that are unidentified at this stage. A plan is currently being worked up to identify these and the Trust is confident that breakeven will be achieved.
- Recent funding announcements to cover the impact of industrial action are being worked through.
- The current indication is that there is sufficient cover for the impact of strike costs and lost income.
- In addition, changes to the Elective Recovery baseline unrelated to strike action should benefit the Trust and further close the gap.

Contract Income Overview



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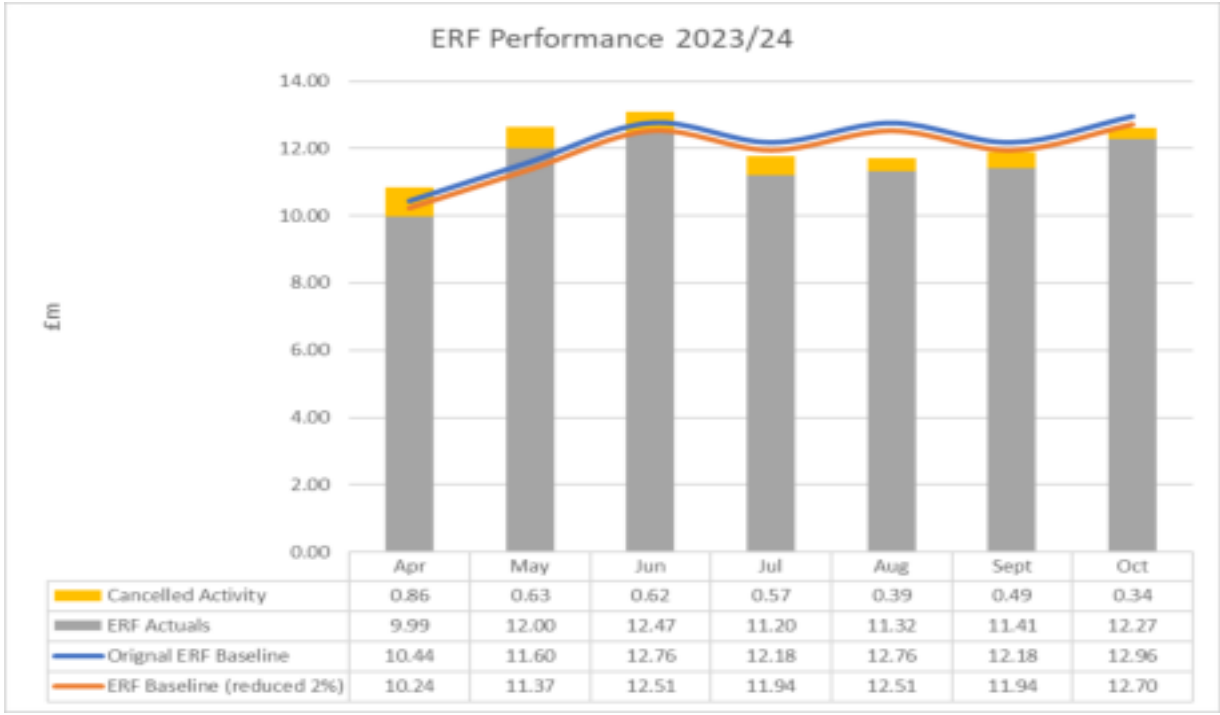
Contract Income **In month: £1.1m Fav** **YTD: £0.6m Adv**	**In month** • In month Trust wide Contract Income is £1.0m favourable to plan. The favourable variances include the Junior doctors Pay Award (£0.8m), the recognition of Mobile CDC income (£0.3m). **Year to date** • Year to date the Trustwide Contract Income position is £0.6m adverse to plan. The main driver being an ERF adjustment of £2.6m for an expected ERF underperformance (driven largely by industrial action activity), the reduction of ICB funding (£1.9m), along with reduced income (£0.5m) relating to Demand & Capacity (D&C) projects and other service developments (SDF) which are yet to commence, these items all offset in expenditure. • These downside variances are being countered with income relating to the Pay Award (£3.3m), to cover announced pay awards, the recognition of Mobile CDC funding (£1.2m) and an over performance for Welsh patient activity.
Trend Analysis	• Contract Income trend shows a £3.6m increase on Month 6 and a £2.3m increase on the year to date average. The month-on-month upside is driven by the recognition of ERF underperformance in September. The upside on Month 1 to 6 average is partly due to the favourable movement in the ERF position in-month, along with additional income recognised for Renal Transplants, High Costs Drugs and Mobile CDC.
ERF Analysis	• ERF is currently £2.6m adverse to plan year to date as a result of reduced activity due to industrial action.

Elective Recovery Fund Performance

NHS North Bristol NHS Trust

16.1

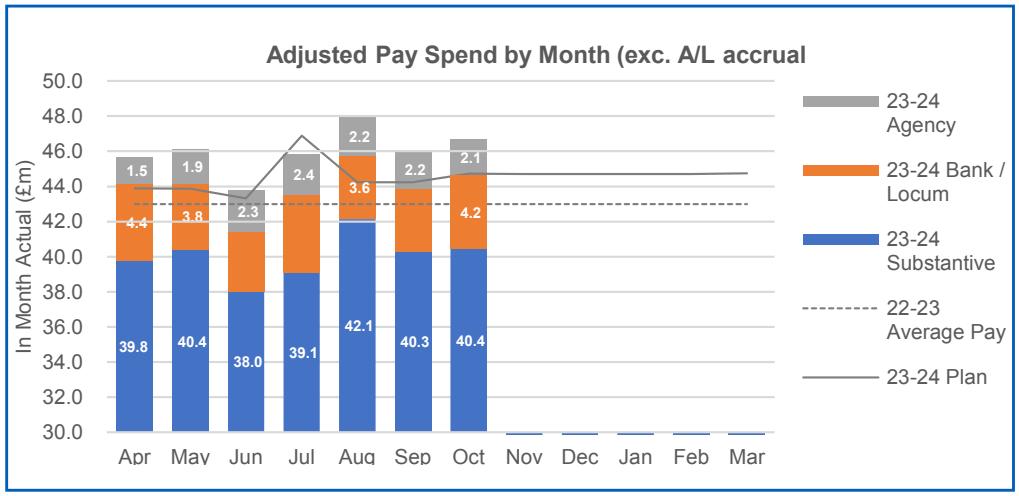
- Year to date Elective Recovery Fund (ERF) Performance is £2.6m adverse to current national baselines due to lower than planned levels of activity being delivered.
- The baselines nationally have been subject to revision and refinement since the start of 2023/24.
- Nationally mandated baselines have been reduced by 2% to allow for the impact of April industrial action. The National team have phased this reduction across the whole year which means that only seven months of the benefit has been realised as at month seven (£1.66m).
- The operations teams have analysed activity and assessed industrial activity to have had a year-to-date impact of £3.89m in terms of lost activity.
- The table right illustrates that without the impact of industrial action and when baselines are increased to their original value ERF income is still £0.35m behind plan.
- Measuring the impacts of industrial action is intrinsically challenging and the operational teams are investigating other ways to assess the impact of industrial action on our current levels of activity.

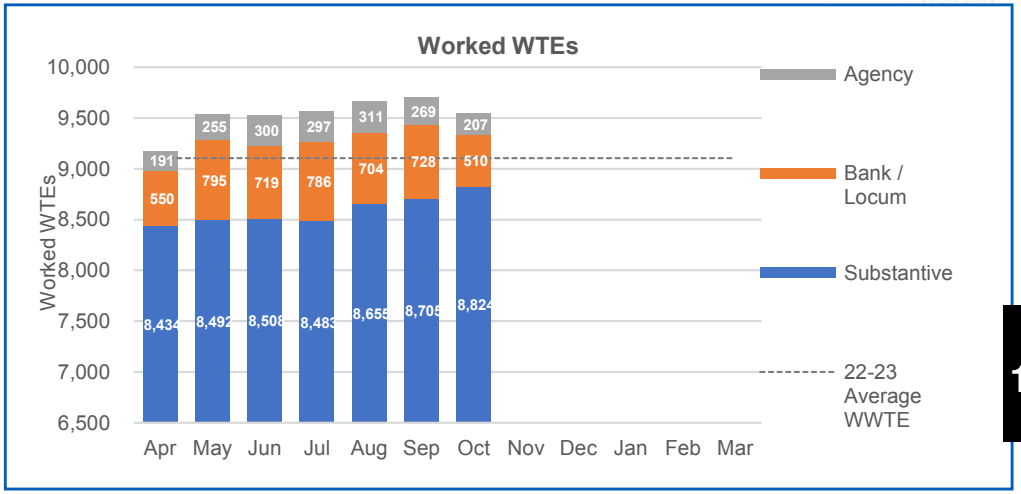


	Apr £m	May £m	Jun £m	Jul £m	Aug £m	Sept £m	Oct £m	Total £m
ERF Variance	(0.25)	0.62	(0.04)	(0.75)	(1.19)	(0.54)	(0.44)	**(2.58)**
Impact of Industrial action on activity	0.86	0.63	0.62	0.57	0.39	0.49	0.34	**3.89**
2% reduction of national baselines	(0.20)	(0.23)	(0.25)	(0.24)	(0.25)	(0.24)	(0.25)	**(1.66)**
Variance Adjusted for Industrial Action	**0.40**	**1.03**	**0.32**	**(0.42)**	**(1.05)**	**(0.28)**	**(0.35)**	**(0.35)**

NBTCARES

Pay Overview





*Note: Average 22-23 pay has been inflated by 5% for Agenda for Change staff and adjusted for one-offs throughout the year (pensions, non-consolidated pay award, annual leave accrual)

Pay

In month spend: £46.7m

In month: £2.0m adv

YTD: £8.0m adv

In month

- Trust wide pay spend is £46.7m driving a £2.0m adverse variance to plan. New funding adjustments offset in Non-NHS income was £1.4m adverse therefore revised pay variance is £0.6m adverse to plan. The Trust has seen the impact of temporary staffing (£1.1m adverse), and from delayed in year delivery of pay savings (£0.9m adverse). This position has been offset by a favourable position of £1.3m in other AfC vacancies (mostly CCS Division) and delayed investments and service developments.
- In month agency spend is £2.1m and bank/locum £4.1m. Slides 23 and 24 in the appendix have a more detailed breakdown.

Year to date

- Year to date Trust wide pay is £314.4m which is £8.0m adverse to plan. Excluding the plan mitigations and in year adjustments, the revised position is £8.2m adverse to plan. Temporary staffing is £4.2m adverse, industrial action costs are £3.3m, Medical pay award is £4.0m (this is offset in contract income), and in year delivery of pay CIP is £5.4m adverse. This is offset by delayed investments and service developments £6.5m, and staff vacancies £1.9m.

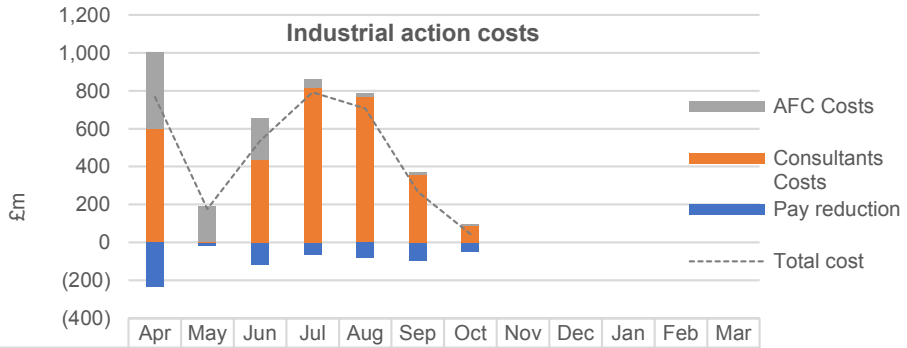
Trend Analysis

(further analysis shown in the Appendix)

- In October, the pay spend was £46.7m compared to the adjusted pay in September of £46.1m, a £0.6m increase. The key increase was Bank/Locum pay costs which was in several divisions including with the Emergency Department.
- WTE's in October were 9,541 compared to 9,702 in September.
- There has been a £0.8m increase on the 2023/24 year to date average. WTEs have increased by 11 on the year-to-date average which is predominantly driven by substantive recruitment.

16.1

Industrial action Overview



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
AFC Costs	404	185	221	43	20	10	10					
Consultants Costs	601	6	435	815	770	356	85					
Pay reduction	(236)	(16)	(121)	(67)	(84)	(99)	(52)					
Total cost	768	175	535	791	706	267	43					

Industrial action dates 2023/24

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Total
Consultant				3	3	3	3						**12**
Junior Doctor	4		3	5	4	3	3						**22**
Nursing	1	1											**2**
Total	**5**	**1**	**3**	**8**	**7**	**6**	**6**	**0**	**0**	**0**	**0**	**0**	**36**

16.1

Industrial action

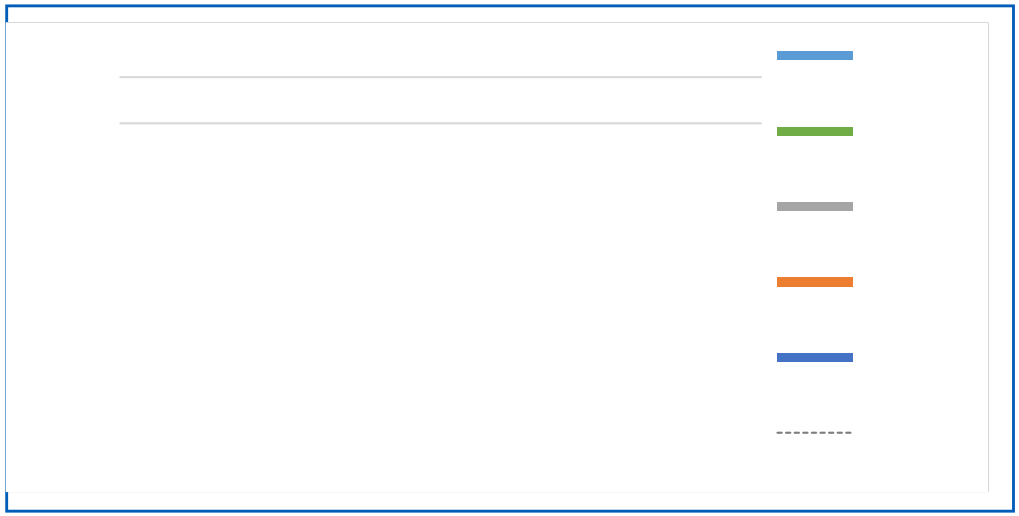
In month spend: £0.1m

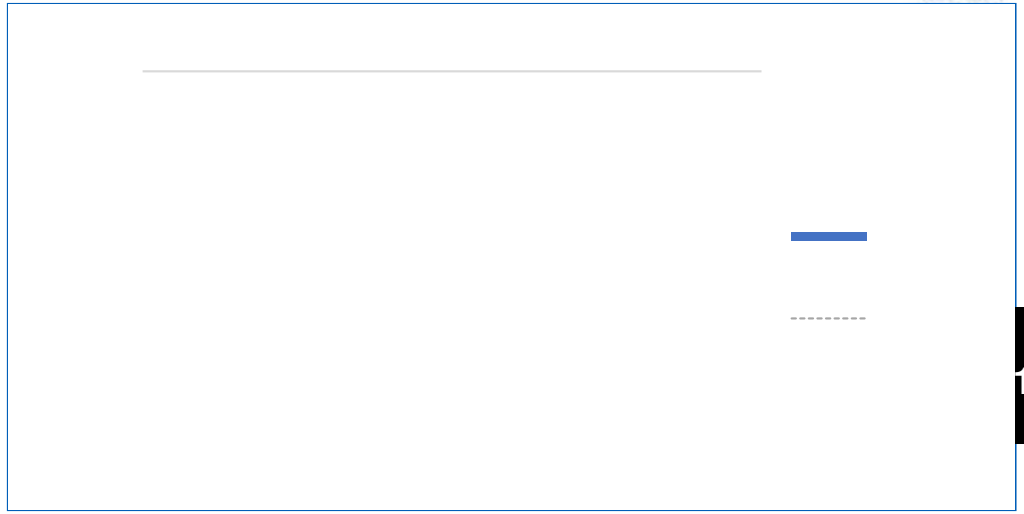
In month deductions: £0.1m

YTD spend: £3.3m

- The Trust has seen industrial action from nursing staff in April and May, from junior doctors in April, June, July, August, September and October, and from consultants in July, August, September and October.
- The graph shows that the Trust has seen salary reductions of £0.7m for all industrial action in 2023/24 so far.
- The additional cost of covering industrial action has been £4.0m with this split £3.1m for medical staff, mainly consultants, covering junior doctor shifts, and £0.9m for agenda for change (AfC) staff.
- The Trust has agreed a range of enhanced rates during industrial action periods to ensure the hospital is safe for patients.
- The Trust saw minimal additional costs for industrial action in October. This is driven by 'Christmas day cover' being provided therefore enhanced rates were not provided.

Non-pay & Non-commissioned Income Overview





*Note: Average 22-23 non-pay has been inflated by 4% for non-pay inflation, and adjusted for one-offs (Apprentice Levy and Stock)

Non pay

In month spend: £32.1m

In month: £4.5m adv

YTD: £15.0m adv

Non NHS Income

In month income: £9.5m

In month: £4.7m fav

YTD: £14.8m fav

16.1

Savings

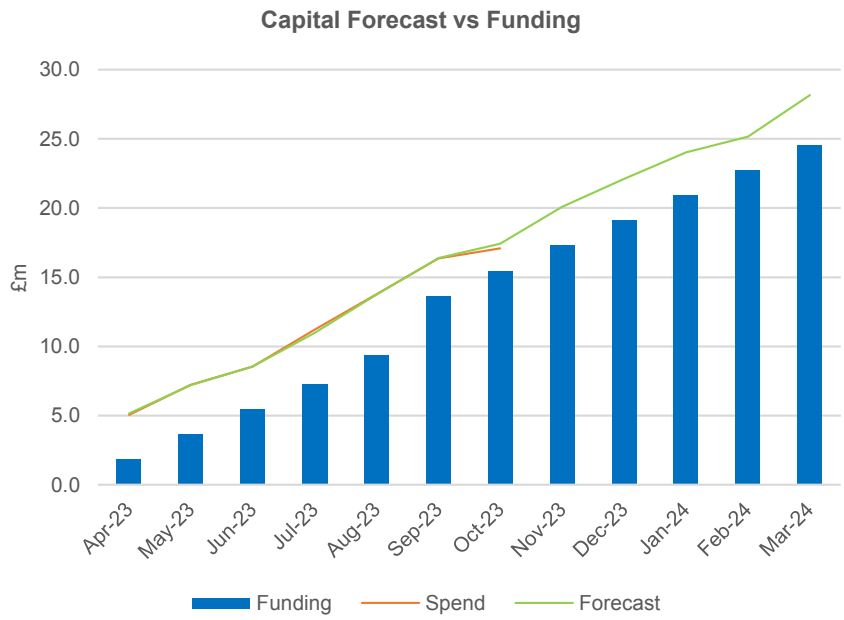
Summary Division	FYE Target	Completed Schemes	Schemes in Implementation	Schemes in Planning	Total FYE	Variance FYE	Schemes in Pipeline	Total FYE inc Pipeline
ASCR	4.8	1.3	0.1	0.1	1.6	(3.2)	2.7	4.3
CCS	3.9	1.5	0.3	0.6	2.4	(1.5)	0.1	2.5
MED	3.0	0.8	0.0	0.5	1.3	(1.7)	1.0	2.3
NMSK	3.8	1.6	0.7	1.1	3.5	(0.4)	0.0	3.5
WCH	1.1	0.6	0.1	0.1	0.8	(0.3)	0.4	1.2
FAC	1.8	0.8	0.2	0.3	1.3	(0.5)	0.4	1.7
Corp	0.8	0.3	0.1	0.0	0.5	(0.3)	0.3	0.7
Central	5.1	5.1	0.0	0.0	5.1	0.0	0.4	5.5
Total	**24.2**	**12.0**	**1.6**	**2.8**	**16.4**	**(7.8)**	**5.3**	**21.6**

16.1

- The CIP plan for 2023/24 is for savings of £24.2m with £13.1m planned to be delivered by Month 7.
- At Month 7 the Trust has £12.0m of completed schemes on the tracker. There are a further £4.4m of schemes in implementation and planning leaving a remaining £7.8m of schemes to be developed, against this we have £5.3m of schemes identified in the pipeline.
- The shortfall on the tracker is £2.6m with pipeline included, with further schemes currently being worked up.
- In the table above the Trust has reflected delivery of £12.0m of savings in 2023/24. This is the full year effect figure that will be delivered recurrently. Due to the start date of CIP schemes this creates a mis-match between the 2023/24 impact and the recurrent full year impact.
- At Month 7 the Trust is showing a £7.0m adverse variance for delays due to in year delivery of CIP, which reflects the fact that almost half of the schemes completed year to date are not impacting fully until 2024/25 and beyond. The I&E impact of this is being managed through vacancy factors in funded budgets and delays on implementing investments.
- The impact of industrial action on clinical teams is diverting resource and attention from prioritising savings delivery and therefore leads to a risk on delivery later in the year.

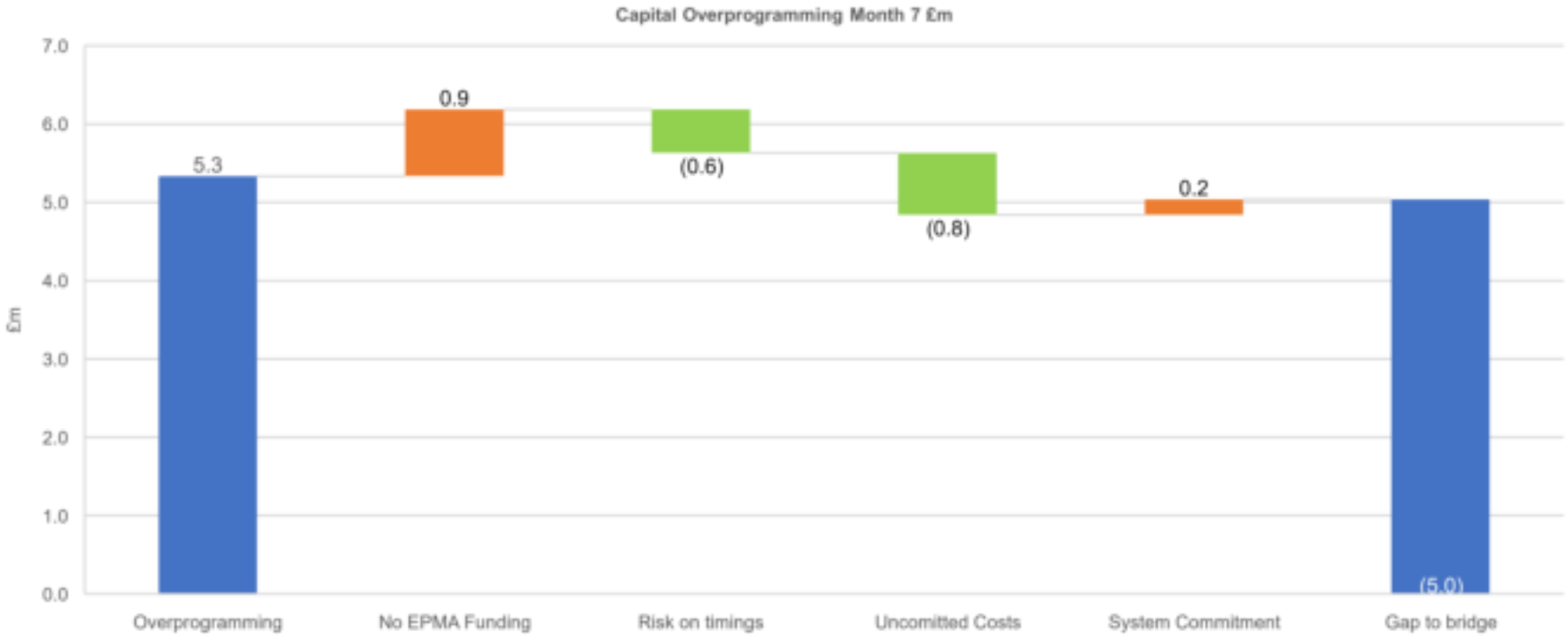
Capital

Expenditure	FY Funding (£m)	FY Forecast (£m)	FY Forecast Variance (£m)	YTD Spend (£m)
Divisional Schemes	4.6	2.4	(2.3)	0.5
CRISP Schemes	4.3	18.7	14.5	12.9
IM&T Schemes	2.9	2.5	(0.4)	1.2
Medical Equipment	10.1	4.4	(5.7)	2.5
Core Spend	**21.9**	**27.9**	**6.0**	**17.1**
Endoscopy Capacity PDC	0.7	0.7	(0.0)	0.0
MRI Enabling PDC	0.3	0.0	(0.3)	0.0
Biplane Equipment PDC	1.6	0.0	(1.6)	0.0
Imaging Network PDC	0.2	0.0	(0.2)	0.0
Pathology Scanners PDC	0.2	0.2	0.0	0.0
Subtotal	**24.7**	**28.8**	**4.1**	**17.1**
Elective Centre	20.4	21.6	1.2	0.9
Total	**45.1**	**50.4**	**5.3**	**18.0**
Charity & Grant Funded	0.5	0.5	0.0	0.5
PFI & Leases	5.9	6.7	0.8	3.6
Grand Total	**51.5**	**57.6**	**6.2**	**22.1**



- The capital plan currently has £5.3m of forecast overprogramming against projects within the Trust's core capital envelope. This overprogramming is actively managed throughout the year by the Capital Planning Group, with opportunities for reducing spend and bidding for additional income being explored. The spend year to date is £18.0m, driven by spend on the Kendon Way Office (£4.1m), PSDS Low Carbon (£2.8m) and Cossham CT & MR works (£1.9m).
- The Elective Centre project is currently moving into a contracting phase with the main supplier ahead of works beginning. Current spend this year is £0.9m.
- In addition to this, the Trust's spend on leases is forecast to be £0.8m above the initial allocation of funding. The regional finance team have been made aware of the updated forecast spend as a system, BNSSG is currently forecast to underspend against our allocation. The IT Network lease, which drives the overspend, was recognised in August.

Capital – Risks & Mitigations



16.1

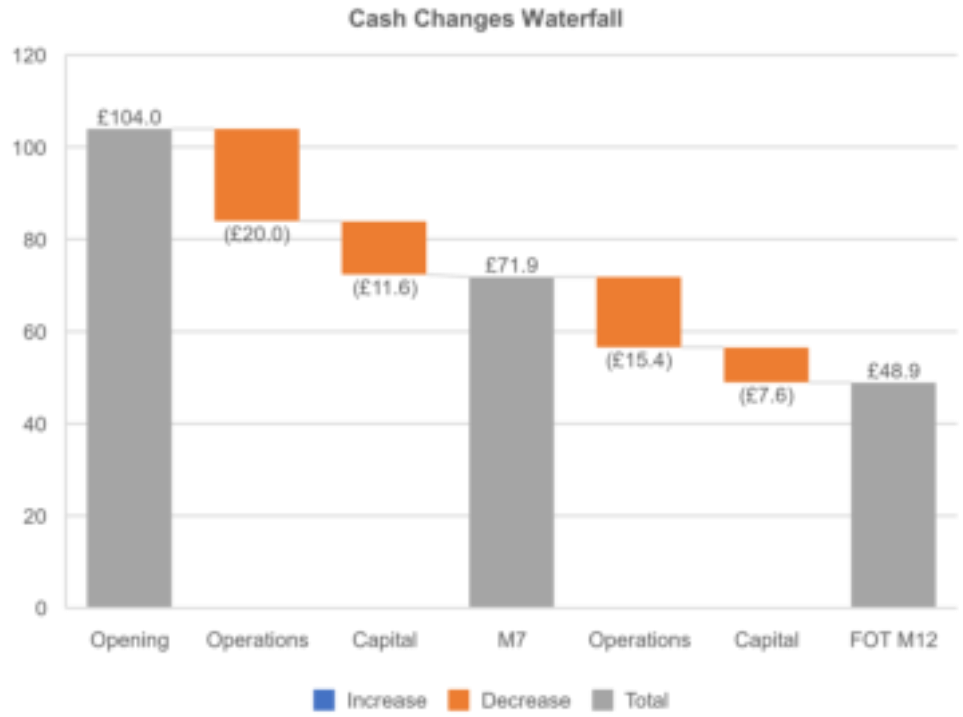
- Current known risks and mitigations reduces the overprogramming forecast value of £5.3m to £5.0m. This is being actively managed and mitigated by the Capital Planning Group. "Risk on timings" represents a net figure of all potential changes in completion times based on the known operational risks. "Uncommitted costs" represents the projects that have not yet started and are not contractually committed to be delivered this financial year, hence can be put on hold or delayed if required.
- Further clarity is expected on the impact of the Elective Centre project once the contract with the main supplier has been finalised.
- In addition to above items, there is a number of areas with uncertainty around additional funding that may become available as the year progresses, such as additional national funding and recognition of historic capital receipts.

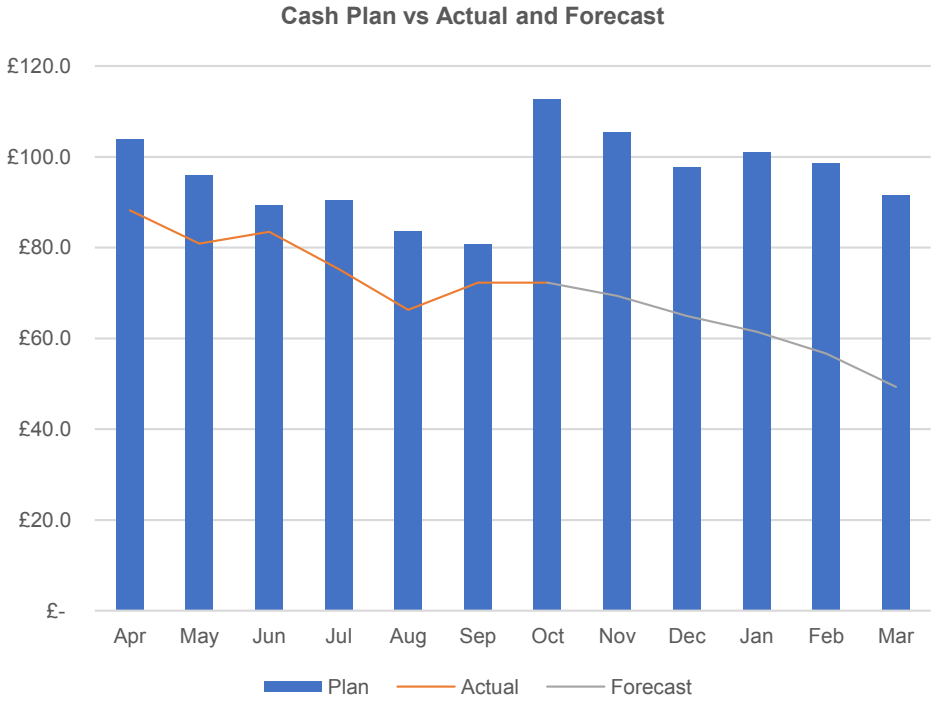
Capital – Large Project Update

Capital Project	£m					
	Approved Budget	Pre 23/24 Spend	Forecast 23/24 Spend	Forecast Future Year Spend	Forecast Total Project Spend	Variance
CT Scanner	1.2	-	1.5	-	1.5	(0.3)
Fire Integrity	3.3	-	1.5	1.8	3.3	-
EPMA	2.6	-	0.9	1.7	2.6	-
Digital equipment provision	1.2	-	1.2	-	1.2	-
Cossham CT & MRI Extension	3.9	1.8	2.9	-	4.7	(0.8)
PSDS Low Carbon	2.8	1.2	4.9	-	6.2	(3.4)
Convert Level 6 Gate 10A into a clinical ward	5.2	5.0	1.5	-	6.5	(1.3)
Kendon Ofice - Phase 2 (THQ)	5.8	1.7	4.0	-	5.7	0.1

- The above table presents the current capital projects with budget of over £1m.
- The budget for the CT Scanner project reflects the cost of the equipment and the overspends shows the expected cost of the installation works. An updated Business Case to capture these costs is being prepared.
- Fire Integrity and EPMA projects are multiyear projects currently in their first year. Future year spend for these projects is currently expected to match the Business Case figures.

Cash Position

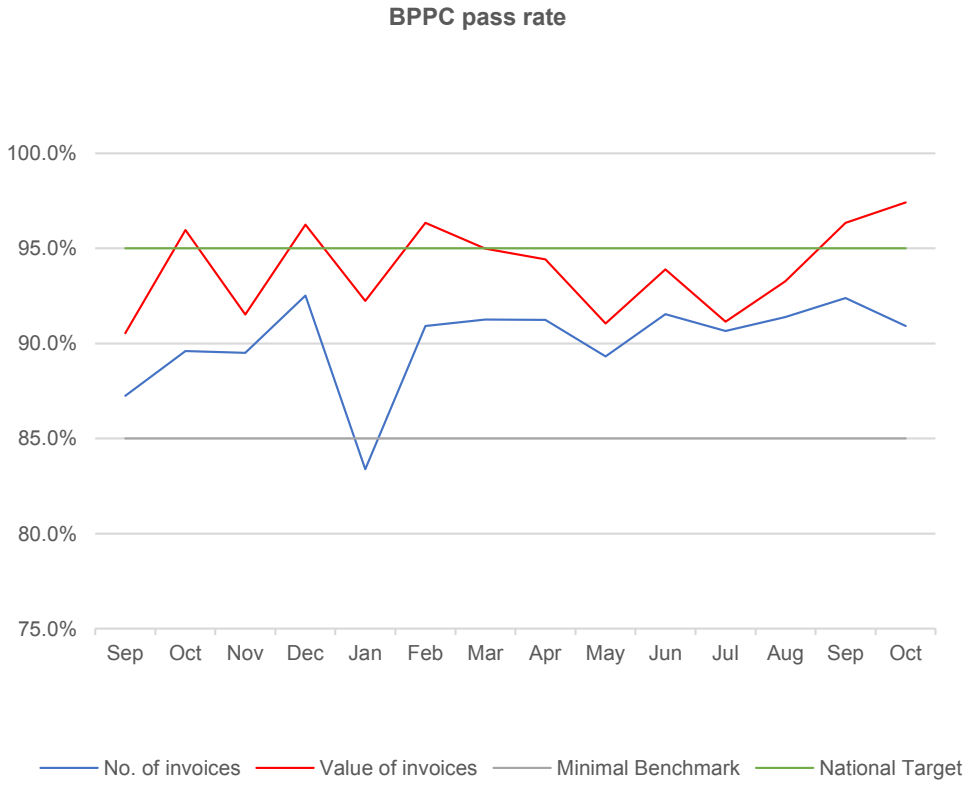


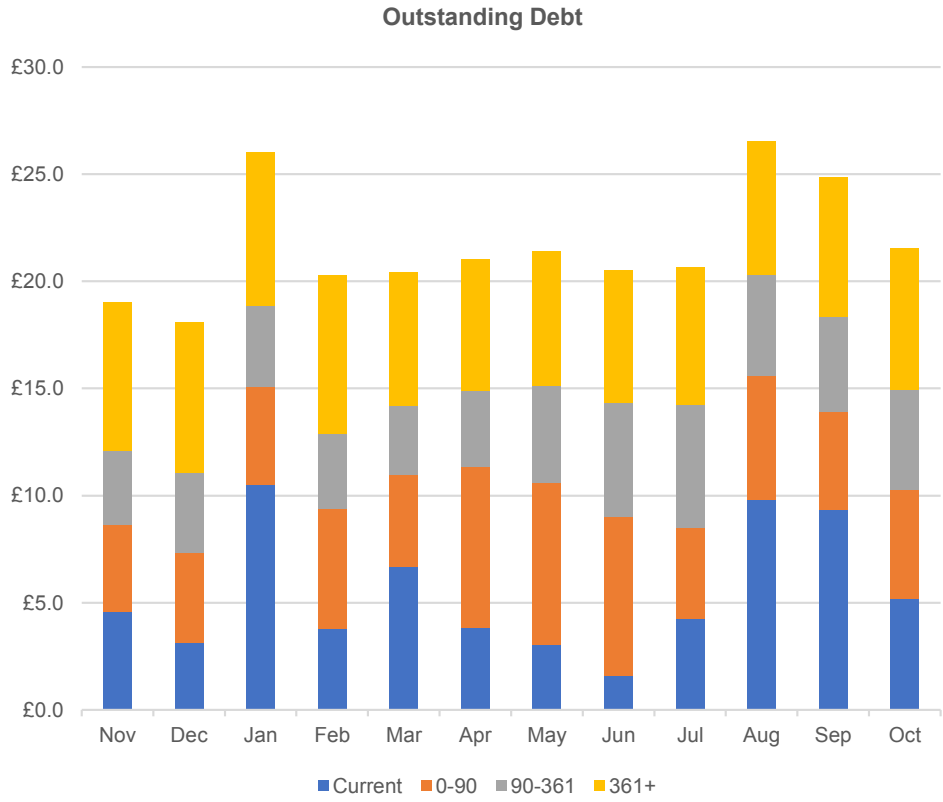


16.1

- In month cash held steady at £71.9m, which is a £0.4m decrease based mostly on the working capital movements.
- The cash balance decreased by £32.1m year to date, which is predominantly due to carried forward and in-year payments for capital projects and improved BPPC performance together with the I&E deficit.
- It is expected the trend will continue, resulting in the overall reduction of cash position to around £49m. This is primarily due to a deficit on both operating and capital cash flow during the year. The difference from the I&E forecast to the change in cash forecast largely relates to mitigations reducing the I&E deficit but not improving cash position, expected changes to working capital and capital expenditure in excess of the depreciation.
- The current estimate includes £22.5m of identified risk, which if to materialise would result in a year end outturn of £27.5m. These include a reduction in prepayments balances of £5m, a reduction in late payments versus historic run-rate due to improved BPPC of £13m, and £5m of various additional one-off inflows based on the historical trends. These will be reviewed and monitored throughout the year.
- Current forecast is below plan due to the cash profile changes for the Elective Centre, capital cash payment carried forward from the prior year, and changes in working capital.

BPPC and Debt position





16.1

- BPPC pass rates continues to outperform minimum benchmark of 85%, with a fairly steady upwards trend. The October value performance was the best the Trust has recorded in the last two years.
- The reduction in current debt is due to a £6m invoice being withdrawn as part of discussions with commissioners, offset by £2.6m of new invoices to UHBW.
- 51% of Debt over 361 days (£3.3m) relates to Overseas patients.

System position / Underlying position / Productivity

System financial position

- The ICS position at month 7 is a £18.8m adverse variance, this is a deterioration of £0.6m in month.
- The in month deterioration has been driven by worsening positions in the acute Trusts and the drive to reflect the impact of industrial action on variable activity.
- The ICS is forecasting a breakeven position at the year end, assuming funding for industrial action impact and implementation of recovery actions.

Underlying position

- The underlying position for 2022/23 was a deficit of £20.5m.
- The submitted plan for 2023/24 showed an underlying position of £33.1m deficit.
- The Trust is undertaking a high level review of the underlying position in month 7 based on an updated in year forecast outturn.
- Non-delivery of savings and changes to Specialised Commissioning allocations are likely to drive a deterioration in the Trust position.

Productivity

- Productivity and the way in which it is measured continues to evolve.
- The regional team are changing the way in which they assess NBT's productivity. NBT are working with NHSE to influence the methodology.
- It is the intention that once this work is completed an analysis of this data will be shares as part of this Board pack.
- In addition, unit costing will continue to be calculated and shared with Divisions. Unit costs are currently undergoing a full refresh to align with 2022/23 apportionments.

Risks & Mitigations

Issue	YTD Position £m	Risk	FOT £m	Mitigations	FOT £m	Actions
Reduction in ERF income driven by cancelled activity during industrial action	(2.2)	No ability to recover the activity in year	(2.2)	Additional national funding	2.2	Confirm national funding approach
Pay costs driven by incentives to cover industrial action	(3.3)	No ability to recover the costs in year	(3.3)	Additional national funding	3.3	Confirm national funding approach
Temporary staffing spend, including locums, agency, and RMN above plan.	(4.3)	Continuation of temporary staffing spend to forecast levels.	(6.2)	Introduce further controls and decrease spend	2.0	Review of drivers to be completed by each division.
Under delivery of in year savings	(7.0)	Under delivery of in year savings	(10.2)	Slippage elsewhere and further saving identified	1.1	Further action to identify recurrent savings
The impact of further industrial action and uncertainty over Elective Recovery	0.0	The impact of further industrial action and uncertainty over Elective Recovery	tbc	Clarity on national position	tbc	Confirm national funding approach
Non-recurrent in year benefits, including on capital charges, additional income, vacancies and delays in investments	7.9			Continuation of non-recurrent in year benefits	8.4	Review SoFP for mitigations
				Divisional recovery actions	1.8	Individual targets for each division to support recovery
				Actions and mitigations to close the gap	3.1	Trustwide recovery plan to be developed
Total	**(8.9)**		**(21.9)**		**21.9**	

- The Trust undertook a forecast review at Month 6 which showed a £8.0m deficit before mitigations. However, this did assume that there was national funding for industrial action costs and industrial action impacted activity.
- The recent national announcement in relation to the impact of Industrial Action funding is being worked through and will be reflected in future forecasts.
- The Elective Recovery target has been amended to reduce by 2% for April industrial action only.
- In addition, Elective Recovery mechanisms and calculations are still lacking detail. Information has only been made available for April to July and there are a number of queries outstanding on this data.
- Further it is recognised nationally that the impact of industrial action is affecting the ability for efficiencies.
- The Trust will, however, need to deliver reductions to agency spend and fully identify savings in order to achieve a breakeven position.

16.1

NHS North Bristol NHS Trust

Appendix – Financial Statements

16.1

Income and Expenditure: Main Heading

	Month 7			Year to Date		
	Budget	Actual	Variance	Budget	Actuals	Variance
	£m	£m	£m	£m	£m	£m
Contract Income	66.0	67.1	1.0	456.2	455.5	(0.6)
Other Income	4.8	9.5	4.7	39.6	54.3	14.8
Total Income	**70.8**	**76.6**	**5.7**	**495.7**	**509.9**	**14.2**
AHP's and STT's	(7.0)	(6.6)	0.5	(47.7)	(45.4)	2.3
Medical	(13.3)	(13.6)	(0.3)	(85.9)	(94.9)	(9.0)
Nursing	(18.3)	(17.0)	1.3	(118.5)	(116.9)	1.6
Other Non Clinical Pay	(6.1)	(9.4)	(3.4)	(54.3)	(57.2)	(2.9)
Total Pay	**(44.7)**	**(46.7)**	**(2.0)**	**(306.4)**	**(314.4)**	**(8.0)**
Drugs	(4.7)	(5.4)	(0.7)	(32.9)	(35.5)	(2.6)
Clinical Supplies (Incl Blood)	(5.3)	(6.1)	(0.8)	(30.4)	(37.7)	(7.3)
Supplies & Services	(6.7)	(6.6)	0.1	(44.2)	(44.1)	0.1
Premises Costs	(4.8)	(5.9)	(1.1)	(33.1)	(34.0)	(0.9)
Other Non-Pay	(6.1)	(8.1)	(2.0)	(49.5)	(53.8)	(4.3)
Total Non-Pay Costs	**(27.6)**	**(32.1)**	**(4.5)**	**(190.0)**	**(205.1)**	**(15.1)**
Surplus/(Deficit)	**(1.5)**	**(2.2)**	**(0.7)**	**(0.7)**	**(9.6)**	**(8.9)**

16.1

- Detailed Trustwide month 6 and year to date position shown by key headings. This shows further detail from the table shown on slide 2.

Statement of Financial Position

	22/23 Month 12	23/24 Month 06	23/24 Month 07	In Month Change	YTD Change
	£m	£m	£m	£m	£m
Non-Current Assets	**510.6**	**520.9**	**519.7**	**(1.2)**	**9.2**
Current Assets					
Inventories	10.0	10.1	9.9	(0.2)	(0.2)
Receivables	57.2	54.0	50.4	(3.6)	(6.9)
Cash and Cash Equivalents	104.0	72.3	71.9	(0.4)	(32.1)
Total Current Assets	**171.3**	**136.3**	**132.2**	**(4.2)**	**(39.1)**
Current Liabilities (< 1 Year)					
Trade and Other Payables	(125.2)	(95.9)	(92.9)	(2.9)	(32.3)
Deferred Income	(17.2)	(28.3)	(29.1)	0.8	12.0
Financial Current Liabilities	(17.1)	(17.7)	(17.7)	0.0	0.7
Total Current Liabilities	**(159.5)**	**(141.9)**	**(139.8)**	**(2.0)**	**(19.6)**
Non-Current Liabilities (> 1 Year)					
Trade Payables and Deferred Income	(6.7)	(7.2)	(7.1)	(0.0)	0.4
Financial Non-Current Liabilities	(355.2)	(352.3)	(351.3)	(1.0)	(3.9)
total Non-Current Liabilities	**(362.0)**	**(359.5)**	**(358.5)**	**(1.0)**	**(3.5)**
Total Net Assets	**160.4**	**155.9**	**153.6**	**(2.3)**	**(6.7)**
Capital and Reserves					
Public Dividend Capital	469.1	471.8	471.8	0.0	2.7
Income and Expenditure Reserve	(371.3)	(376.7)	(376.7)	0.0	(5.4)
Income and Expenditure - Current Year	(5.4)	(7.2)	(9.4)	(2.3)	(4.1)
Revaluation Reserve	68.0	68.0	68.0	0.0	0.0
Total Capital and Reserves	**160.4**	**155.9**	**153.6**	**(2.3)**	**(6.7)**

Items to note:

Non Current Assets: Movements driven by capital expenditure (please see details on slide 13 and 14) offset by in-year depreciation and amortisation.

Inventories: Only Pharmacy is counted on a monthly basis, hence, the year-to-date movement is minimal.

Receivables: The year-to-date movement is mostly driven by receiving payments for year-end accruals, such as £16m funding for the 2022/23 non-consolidated pay award, offset by the build-up of in-year accruals, prepayments and invoiced debt as per the regular cycle. The in-month movement is driven by a decrease in receivables from the commissioners, offset by increase in debt from other NHS partners. More detail on the debt position can be found in Slide 16.

Cash and Cash equivalents: Please refer to the detailed analysis of key movements on Slide 15.

Trade and Other Payables: The year-to-date movement is driven by paying major year-end accruals (for example, 2022/23 non-consolidate pay award) and invoiced balances, including major capital projects, such as Kendon 2 and PSDS. The in-month movement is driven by a reprofiling of capital payables and clearance of supply chain invoices

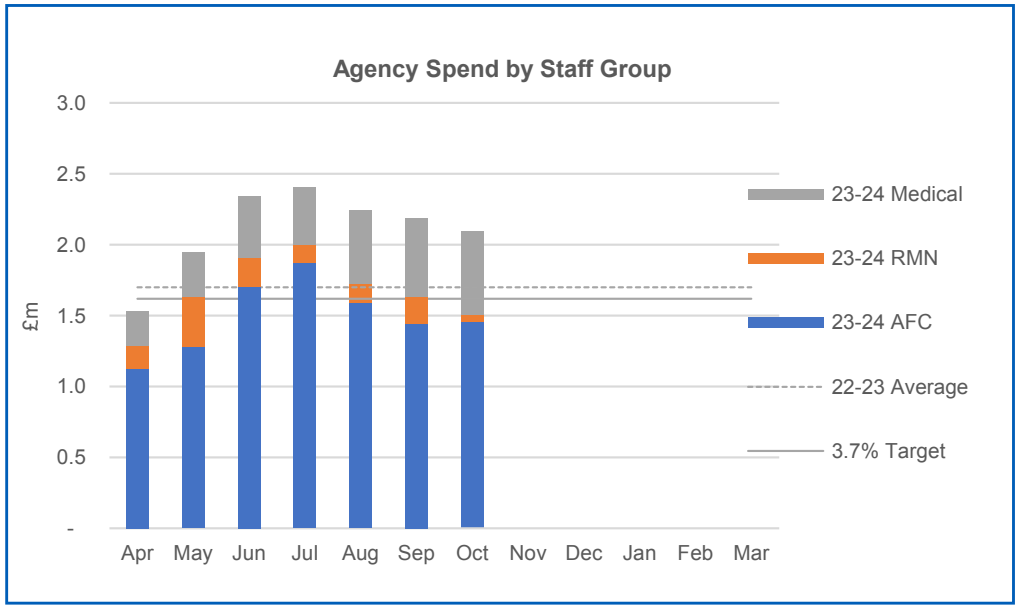
Deferred income: The year-to-date and in-month movements follow a regular cycle of payments in advance from Health Education England, Research Grants and Commissioners.

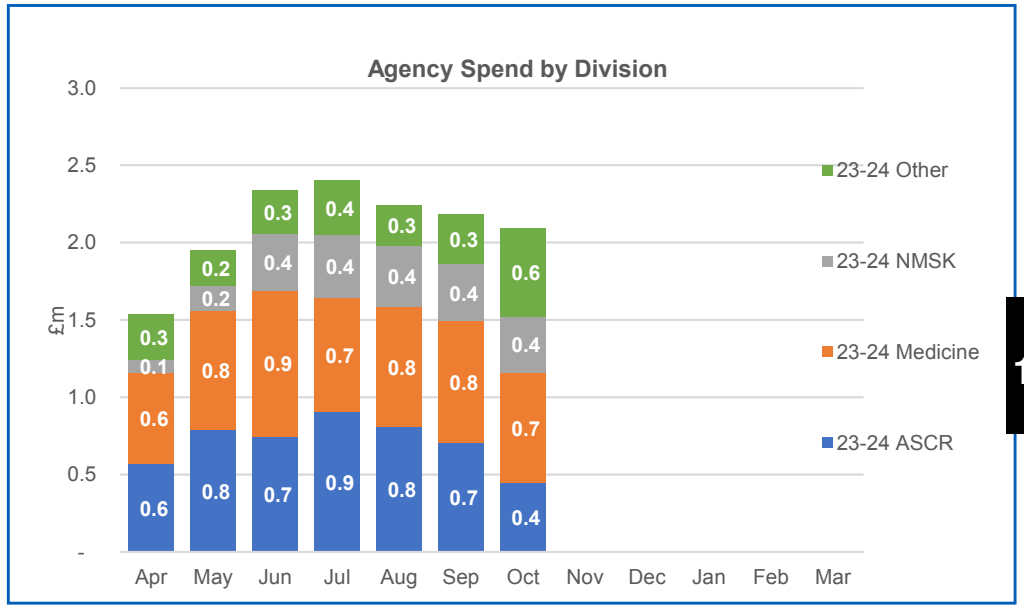
Financial Liabilities: The year-to-date movement relates to the repayment of the capital element of the PFI.

Income and expenditure reserve: The year-to-date movement represents a rollover of the final I&E balance from the prior year.

Income and expenditure account - current year: The year-to-date movement represents the cumulative year-to-date I&E position.

Pay: Temporary Staffing - Agency





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Note: 3.7% target is calculated based on 2023-24 budgeted pay expenditure. The final figure is based on 3.7% of 2023-24 outturn, which will not be known until Month 12.

Agency analysis

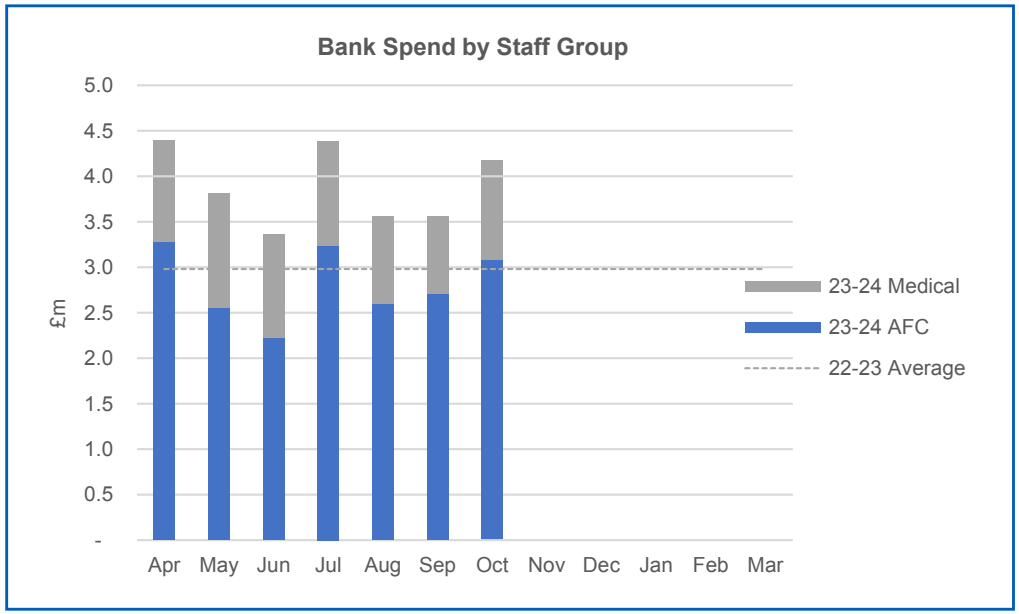
Monthly Trend

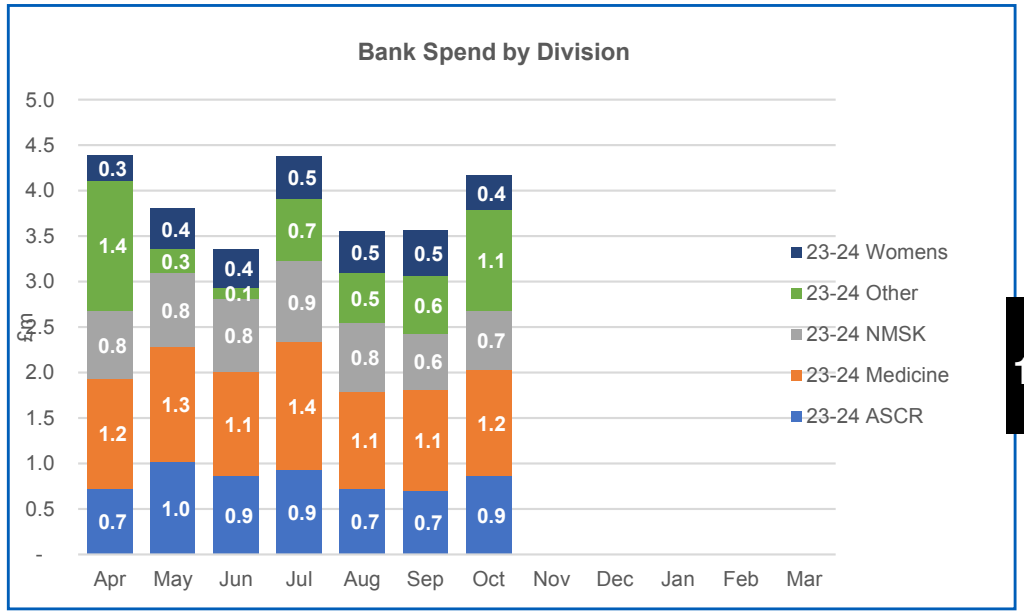
- Agency spend in October has reduced from September by £0.1m but remains high. Temporary staffing spend in October is £0.5m higher than the 3.7% NHSE target.
- Overall spend is driven by safer staffing (ASCR and NMSK), ODP incentives in theatres (ASCR), increased dependency in ICU (ASCR), stroke service reconfiguration (NMSK) and agency costs covering vacancies across clinical divisions in Nursing and Consultants.
- The decrease in comparison to September for RMNs is driven by Medicine due to reduction in patients requiring enhanced care.
- In Nursing, the increase seen in July to August in comparison to the beginning of the year has been driven predominantly by registered nurse spend in ICU and stroke due to the impact of the reconfiguration going live in May 2023. Medical consultant agency spend has also increased in Medicine (covering vacancies) and NMSK (stroke reconfiguration).

In Month vs Prior Year

- Trustwide agency spend in October is significantly higher than 2022/23 spend. Registered nurse spend is higher which is driven by ICU (acuity), stroke (reconfiguration) and theatres in ASCR (vacancies).
- Consultant agency spend has also increased in NMSK (stroke reconfiguration and maternity leave) and Medicine (vacancies/maternity leave).

Pay: Temporary Staffing - Bank





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Bank analysis

Monthly Trend

- In October, bank spend has increased:
  - Other Medical locum usage has increased. ASCR have seen increased spend in Urology due to sickness and Medicine spend has increased due to pressures in the hospital.
  - AFC spend has slightly increased in month due to Nursing spend in Medicine. This is driven by increased spend from seasonal pressures.
  - HCA bank spend is at lower levels than earlier months as high spend was seen relating to supernumerary costs for new starters in Medicine.
  - April and July saw high levels of bank spend. This was driven by changing the methodology in which ERF costs are recognised. In April, ERF costs were recognised centrally in line with remaining budgeted costs. However, this was reversed in May and June, reducing costs centrally which will be offset across substantive, bank and agency. Excluding this, spend in the first 4 months of the year was consistently high.

In Month vs Prior Year

- Bank spend in month is higher than 2022/23 average spend. This has been driven mostly by Nursing and HCA spend across clinical divisions due to break glass rates as well as increased fill rates.

Green Plan 2022-23
Progress Report

Contents

1. North Bristol NHS Trust Sustainability Goals and Ambitions

In 2022-23, North Bristol NHS Trust (NBT) began working collaboratively across the Integrated Care System (ICS) to deliver the Healthier Together Bristol, North Somerset and South Gloucestershire (BNSSG) ICS Green Plan. The delivery of the Green Plan will ensure the ICS achieves net zero carbon by 2030 to improve the health of our population. This report will outline the progress made throughout 2022-23 towards achieving the Green Plan and the work planned for 2023-24.

1.1 Healthier Together BNSSG ICS Green Plan

The ICS Green Plan has been going through an approval process with all the boards of ICS organisations and has been published on the ICB website. The ICS sustainability team, made up of staff within partner organisations, spent 2022-23 establishing the governance processes to deliver the Green Plan and setting up the workstreams for each of the key Green Plan areas that are responsible for co-ordinating action across the ICS. Subject matter experts and responsible persons have been invited to attend each workstream which comprises staff from the ICB, NBT, UHBW, AWP, Sirona and One Care. NBT and UHBW have been working very collaboratively, sharing knowledge and expertise on projects to deliver net zero carbon and address the ecological emergency.

1.2 Being an Anchor in the Community

The Trust continued to embed itself as an anchor in the community throughout 2022-23 through our green space improvement work and hosting nature activities on our site. Our Nature Recovery Ranger delivered forest school sessions for the Saplings Nursery and the local Rainbows group, provided work experience for A-level students and hosted dissertation projects at Southmead Hospital. We also delivered Green Social Prescribing training for Bristol City Council Park Volunteers. The most successful anchor project of 2022-23 was the planting of the Frenchay Orchard by local community volunteers which was transferred to Winterborne Parish Council in 2023 as part of the Town and Village Green.

The valuable work completed by our Nature Recovery Ranger has been recognised at WECA's 2022 Bee Bold Awards, on Ujima Radio and at the Welsh NHS Board's Biophilic Conference which had 300 attendees.

Our Fresh Arts team have contributed significantly to the Trust's role as an anchor institution through its provision of the Dance for Dementia and Parkinsons programmes and drug and alcohol support group allotment sessions.

1.3 Patient First

In 2023 the Trust introduced the Patient First Strategy through which sustainability was identified as an improvement priority. The strategy aspires to deliver healthcare sustainably to release resources to improve patient care. Making best use of our resources and achieving net zero carbon by 2030 are inextricably linked whereby reducing what we use and optimising the way we use our resources will reduce our Trust carbon footprint.

2. Performance against targets towards Net Zero Carbon by 2030

In 2022-23 NBT reduced its carbon footprint by 20,641 tonnes CO_2e compared to a total of 89,790 tonnes CO_2e compared to the previous year of 110,431 tonnes CO_2e, a 19% reduction (Appendix A, Figure 1). Despite this reduction, the Trust's carbon footprint has not yet returned to pre-covid levels although significant reductions have been made in the supply chain.

Scope 1 emissions (direct emissions owned or controlled by NBT) increased by just 1% due to increases in gas and oil consumption which were offset by reductions in Trust fleet mileage and Nitrous Oxide use in anaesthesia.

Scope 2 emissions (indirect emissions due to the energy we purchase) decreased by 10% due to energy efficiency projects and the decarbonisation of the national grid.

Scope 3 emissions (indirect emissions created by our supply chain) decreased by 22% due to reductions in waste sent to landfill and reduced spend on bedding and textiles, patient clothing, chemicals and reagents, pharmaceuticals, dressings and patient appliances.

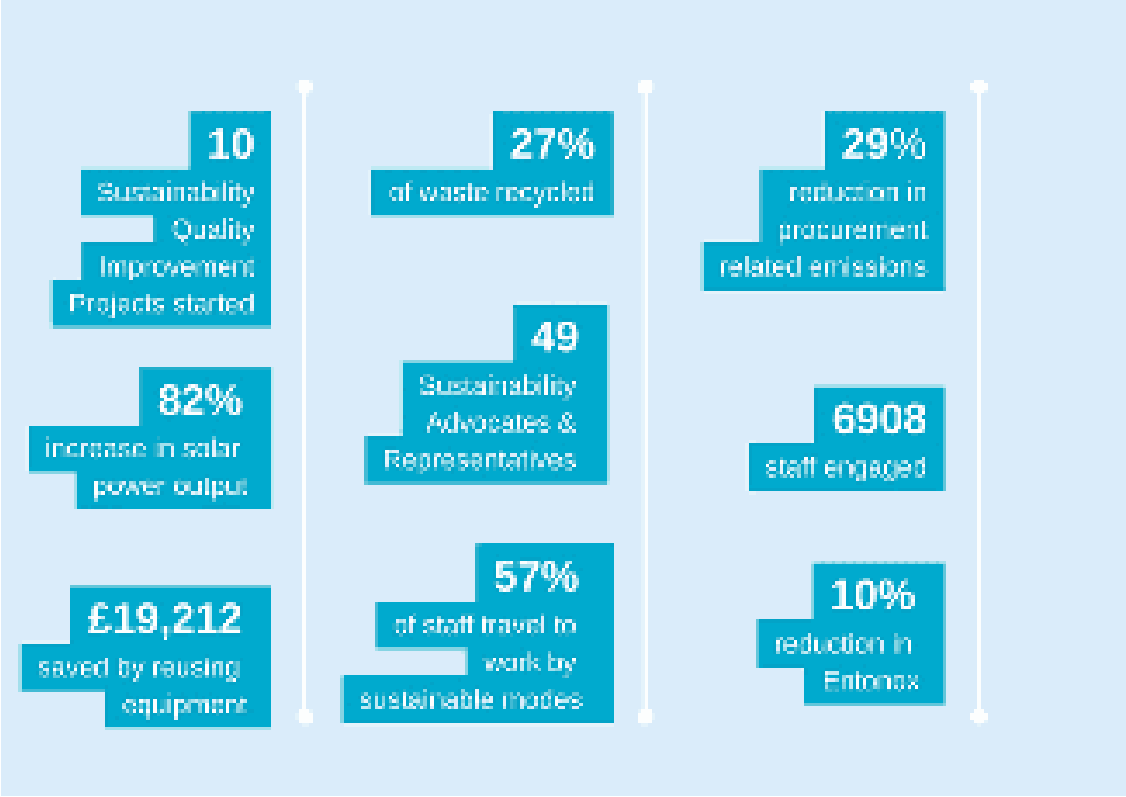
NBT needs to reduce its emissions by 12,827 tonnes CO_2e each year to achieve net zero carbon by 2030 (Appendix A, Figure 1). The Trust must therefore aim to reduce its carbon footprint by 14% next year. This percentage reduction will increase year on year up to 2030 and will increase if the 14% target is missed next year.

Carbon emissions per patient contact, per penny of operating expenditure and per meter square of occupied internal floor area reduced across all scopes in 2022-23 (Appendix A, Figures 2, 3 and 4).

In 2022-23, carbon emitted from procurement and the supply chain was responsible for 60% of the Trust's carbon footprint (Appendix A, Figure 5). This is particularly challenging as supply chain emissions are particularly difficult to influence and reduce. Carbon emitted from heating and cooling our buildings and water consumption contributed 23% whilst travel and transport contributed 13%. Anaesthesia and inhalers contribute 2% which is slightly below average with waste also contributing 2% which is a 1% increase due to increased generation of highly infectious waste (Appendix A, Figure 5).

3. Sustainability Achievements

This section will highlight the key achievements delivered against the key Green Plan area objectives by the Trust throughout 2022-23. More detail on these projects is reported in section 4.



Key area	Objective	2022/23 Achievements
Supply Chain & Procurement	Drive supply chain to net zero and have an ethical approach at the centre of our procurement decisions.	• Hosted a supplier day with Dell to learn of social value and sustainability initiatives • Social value & Net Zero discussions with category managers. • Procurement completed social value training
Medicines	Reduce the environmental impact of our medicines and medical devices towards net zero.	• Trialled Volatile Capture Device in theatres • Review of inhaler prescribing and published BNSSG Inhaler Guidance. • South West Medicines Optimisation Workstream. • Replacing Ethyl Chloride Cold Spray in Obstetrics.
Travel, Transport & Air Quality	Improve air quality and active travel uptake to improve population health.	• Brunel Cycle Centre achieved capacity milestone, 95% full. • Introduced tiered parking permit system linked to carbon emissions of vehicles. • BYES e-cargo bike trialled in facilities.
Digital Transformation	Maximise the environmental benefits of digital enablers, whilst minimising their impact on the environment.	• Launched ICCA ICU Go Live • CareFlow Connect (EPR) Launch: CareFlow Connect & Vitals, Flow Boards, Patient Administration System (PAS), Clinical Narrative Electronic Assessment Forms, Bluepier, Electronic Outcoming, Outpatients forms. • Five Careflow EPR Flow Digital Whiteboards launched in Maternity to enable remote monitoring of real-time bed state across the whole unit. • Digital Patients Benefits Realisation workshop.
Sustainable Models of Care	Embed carbon reduction principles throughout care delivery.	• Charity-funded reusable theatre hats for ASCR • Propofol waste in theatres QI project results presented to clinical governance • WACH Urine Catch Pots: Moving plastic to pulp • Dance for Parkinsons and Dementia • Infection control sustainability special interest group • Investigating Entonox use in ED • New Green Carpal Tunnel Pathway Toolkit • Blood Sample ICE Labels • A sustainability audit and review of literature urine infection after flexible cystoscopy
People & Engagement	Demonstrate commitment to delivery of the sustainability agenda through leadership and people development.	• Clinical Fellow recruited as Anaesthetic environmental trainee lead and sustainability business case developed for Dietician post. • Carbon & Energy Manager recorded Salix COP 27 promotion video. • Launched Greener Together with 488 staff members registered in the first year. • 16 lunch and learns delivered with 229 attendees. • Attended 7 huddles with 225 attendees. • Presented at UHBW Health Matters event: making our hospitals greener • Bristol Mayor and Maria Kane walkaround and visit. • CFO and Chief Exec signed the Healthy Climate Prescription • Presented at the UWE Climate Change conference for the nursing students.
Food & Nutrition	Positively contribute to the environment and citizens through food provision.	• Eating and Growing Seasonally and Sustainably guidance for NHS Staff completed • Developed allotment planting plan with VU head chef • University of Basque researchers undertook research at Southmead Hospital to develop a Sustainable Food Procurement Tool for healthcare • NBT part of the Bristol Good Food 2030 Framework. • Gloucestershire Royal Trust visit to Southmead to design kitchen garden to supply hospital food.

Adaptation	Identify shared climate risks and implement an action plan to mitigate.	• Finance audit climate adaptation and risk assessment. • Review Trust Heatwave Policy to include IPPC AR6 findings • Began recording overheating incidents • Mowing dry meadow to reduce wildfire risk. • NHS South Central and West CSU volunteers replanted Beaufort House drought-tolerant plant bed. • NHS Forest website article - Drought Tolerant Planting case studies.
Biodiversity	Conserve and enhance biodiversity for our sites and across the region.	• Completed biodiversity improvement works for ICU Roof Terrace, Rose Garden, CDS Maple Suite, Brain Centre Garden, Rose Burden Garden, HITU garden, ED garden, Breast Care Centre, Gardens for Wellbeing project, VU under the Willow. • Contributed towards Director of Public Health report. • Wildflower meadow creation, seed sowing and bird feeder workshops. • 537 trees planted on NBT estate and in the local community.

4. Sustainability Performance and Carbon Emissions

4.1 Supply Chain and Procurement

Objective	SDU 2022-23 Achievements	2023-24 Work Plan
Drive supply chain to net zero and have an ethical approach at the centre of our procurement decisions.	• Provided sustainability criteria for Printers, Linen and Pathology Transport Tender Specifications. • Advised on social value response for Pathology, Cell Path and Toxicology bid. • Completed Social Value and Life Cycle Risk Assessment for IM&T category • Embedded Warp It reuse portal into EROS NPR process • Created Sustainable Procurement Resource Catalogue for ICS procurement teams • Presented Carbon calculator to Finance Business Partners.	• Identify top carbon products and target in category plans and tenders • Roll out sustainable procurement training to all ICS staff • Suppliers to begin reporting carbon footprints of products and services via SAP • All tenders to include social value and quantify value added • Publish Sustainable Procurement Policy • Quantify savings made via SIA • Work with NHS Supply Chain to initiate single use plastic reduction projects • Complete social value and sustainability risk assessments for all procurement categories • Publish Modern Slavery Statement • Embed social value and sustainability in laundry, catering and language and translation services tenders

The carbon footprint of the supply chain was calculated from e-class spend data and excludes finance data as this is not currently defined into e-class categories which is required for carbon emission calculations. The carbon emissions reported here do not provide a complete representation of the carbon footprint of the supply chain and procurement activity.

Carbon emissions due to supply chain and procurement reduced by 29% (22,212 tCO2e) in 2022-23 compared to the previous year (Appendix B, Figure 6). This was due to reductions in carbon across dressings (69%), chemicals and reagents (39%), patient appliances (82%), hardware crockery (52%), pharmaceuticals and blood products (88%), bedding, linen and textiles (86%) and patient clothing (96%). These reductions are most likely a result of the reduced supplies required in the aftermath of the covid response.

Only four e-class categories increased carbon in 2022-23 which were medical and surgical equipment (1%), food and catering (437%), staff and patient consulting services and expenses (27%) and furniture fittings (75%). The increase in furniture

and fittings is mostly likely caused by the refurbishment of office spaces and food and catering from the return of staff and patients to site post covid. The significant increase in food and catering emissions is most likely due to global food price inflation that occurred in 2022 and 2023.

Medical and surgical equipment has the largest carbon footprint in supply chain and procurement contributing 23% which is then followed by office equipment, telecoms and stationery making up 15% and food and catering making up 12% of the footprint (Appendix B, Figure 7 and 8). Dressings are the most carbon intensive product purchased within the NHS which is why they still make up 7% of the supply chain emissions despite emissions being reduced by 69%.

4.2 Buildings and Energy

Objective	SDU 2022-23 Achievements	2023-24 Work Plan
Decarbonise our buildings and infrastructure through upgrades, optimisation and switching our energy source.	• Developed heat decarbonisation plans for all buildings on retained estate through LCSF • Installed roof and cavity wall insulation and double glazing on retained estate buildings • Installed LED lighting upgrades which will produce 1,236,971kWh a year and save the Trust £457k, 261tonnes CO2e per year, equivalent to powering 426 homes. • Installed 1083 new solar panels which will produce 415,231 kWh a year and save the Trust £153k and 87 tonnes CO2e per year, equivalent to powering 135 homes. • Switched retained estate generators from diesel to hydro-treated vegetable oil • Replaced 78 toilet flush mechanisms to low flow • Recruited Energy Officer • Initiated project to increase electrical capacity to enable electrification of heat and fleet. • Carbon & Energy Manager awarded Energy Manager of the Year Award. • Submitted business case for Elective Care Centre to be built to net zero carbon.	• Removing steam from NBT estate • Installing LED lighting in Brunel Building stair cores, corridors, Multi Storey Car Park and Beaufort Multi Storey Car Park • Installing heat pumps to serve the Central Delivery Suite, Antenatal and Percy Philips • Publishing NBT's Buildings and Energy Decarbonisation Strategy • Commissioning heat decarbonisation plans for the PFI • Upgrade of high voltage electrical connection to enable transition from fossil fuels • Switching solar arrays online • Completing surveys across retained estate for thermal installation on hot water pipework expected to save 510,830 kWh of gas per year

Carbon emissions related to energy consumption reduced by 4% in 2022-23, despite a 4% and 8% increase in gas and oil consumption respectively, due to a 1% decrease in electricity consumption and the decarbonisation of the national grid (Appendix C, Figure 9 and 10).

Thanks to the success of the Trust obtaining the Public Sector Decarbonisation Phase 3c funding, multiple renewable energy and energy efficiency projects were delivered in 2022-23, with the savings anticipated to be reflected in the 2023-24 data.

- 1083 solar panels installed on Learning and Research, Percy Philips, Elgar, CHB, Clinical Research and the Data Centre which will produce 415,231 kWh a year and save the Trust £153k and 87 tonnes CO_2e per year. This is equivalent to powering 135 homes.
- LED lighting upgrades to Pathology, CHB, Elgar, Pathology 2, Learning and Research, CDS, Frenchay Beckspool and SBDU which will produce 1,236,971kWh a year and save the Trust £457k, 261tonnes CO_2e per year which is equivalent to powering 426 homes.

- Roof and cavity wall insulation installed in NICU, Elgar, A-block, CHB, Antenatal, Percy Phillips, CDS, B-Block, Pines and Steps, and BCE
- Double glazing installed in Elgar House, CHB and Antenatal.

Carbon emissions due to water consumption reduced by 7% due to a 25,384 m^3 and 24,115 m^3 reduction in water consumption and wastewater production respectively (Appendix C, Figure 11 and 12). This reduction in water consumption can be attributed to the identification of three leaks and resolving the issue of constantly flushing urinals in the Learning and Research building.

In the July 2022 heatwave and drought, 8,000 m^3 more water was consumed due to increased flushing of taps and pipes to alleviate legionella risk. It is strongly recommended that this practice is reviewed to understand if it is essential and necessary for all Trust areas to be doing this. This could significantly reduce water consumption and associated carbon emissions and will alleviate the pressure on local water sources in drought conditions.

4.3 Travel and Transport

Objective	SDU 2022-23 Achievements	2023-24 Work Plan
Improve air quality and active travel uptake to improve population health	• 59 bikes loaned to staff, reducing carbon emissions by 6,695 kg CO2. • Expanded electric bike fleet. • 106 staff bikes checked by Dr Bike. • Introduced ULEV Salary Sacrifice Scheme and Join My Journey platform launched. • Donated 3 e-bikes to the Bristol Bike Project and 15 bikes to NBT staff through Circulate Project, avoiding 6,700 kg CO2. • Consulted on the agile working policy to include net zero recommendations • Responded to WECA consultation on North Fringe Vision, Big Choices on Buses	• Installing an air quality monitoring system at Southmead. • Recruiting a Fleet Manager to develop fleet decarbonisation strategy. • Taking part in the WECA Urban Freight trial. • Installing the WECA Mobility Hub. • Submitting business case to increase secure cycle parking across NBT estate. • Publishing NBT Travel Plan. • Tendering staff travel benefits package. • Installing electric vehicle charge points. • Standardise travel information on external website and appointment letters.

Carbon emissions associated with travel and transport decreased by 2% in 2022-23 mainly due a 74,908 mile reduction in NBT fleet travel which led to a 16% reduction in associated carbon emissions and a 1,145,827 mile reduction in patient and visitor travel which resulted in a 4% reduction in carbon emissions (Appendix D, Figures 13, 14 and 15).

There was a 172,000 mile increase in grey fleet travel which increased associated carbon emissions by 47% (Appendix D, Figures 13 and 16). This increase in grey fleet travel may be due to the increase in delivering care in patients homes and the community. The miles driven by petrol and diesel grey fleet vehicles both increased by 48% and the miles driven by hybrid vehicles increased by 50% (Appendix D, Figure 16) which reflects the increasing uptake of hybrid vehicles by staff. Business travel emissions increased by 2% due to 47,761 miles more miles being travelled by rail and air in 2022-23 (Appendix D, Figure 16).

Miles travelled via staff commute increased by 462,927 miles due to an increase in staff walking, driving and taking the train to work (Appendix D, Figure 14) although this only resulted in a minor increase of 17 tonnes CO_2e (Appendix D, Figure 13).

The majority of staff commute to work by car however the second most popular commuting mode is by bike.

4.4 Medicines

Objective	SDU 2022-23 Achievements	2023-24 Work Plan
Reduce the environmental impact of our medicines and medical devices towards net zero.	• Collaborated with Bristol Waste and UHBW on Mobility Aids Return Scheme • Established multidisciplinary Medical Gas Waste Group, mapped out nitrous use across the Trust and estimated 557,850 litres of medical gas waste from various sources. • Worked alongside Colorectal Surgery to complete RSC's Green Theatre Checklist. • Supported the Vanguard Device Remanufacturing Pilot Project in Theatres	• Work with Urology to collect harmonic scalpels and purchase remanufactured devices. • Support trust-wide roll out of cold sticks to replace Ethyl Chloride Cold Spray. • Support and co-ordinate a Net Zero Operating Day in Neurosurgery. • Support rationalisation of theatres • Trial nitrous destruction unit in Endoscopy • Work alongside BOC and MEMO to address sources of medical gas waste • Setting up patient and ward hormone pen recycling and inhaler recycling scheme • Cease use of desflurane

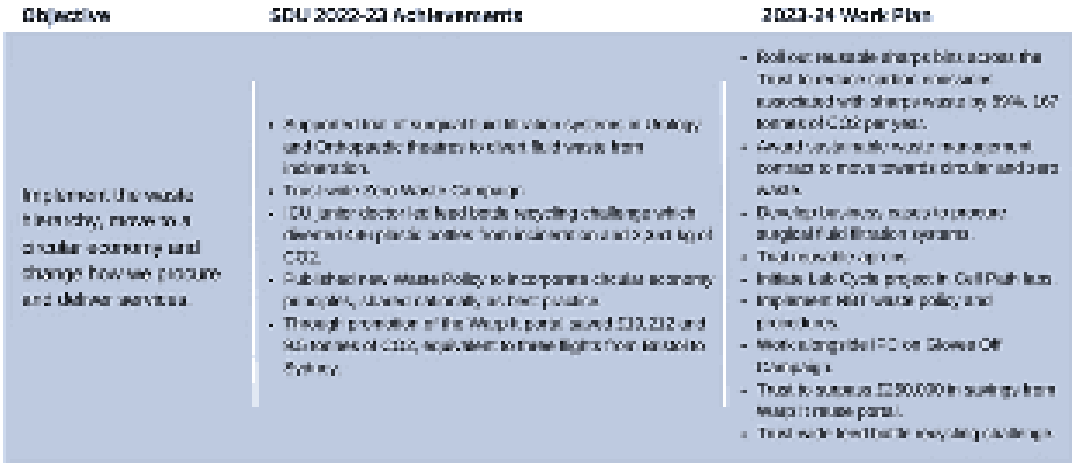
Inhalers and anaesthesia make up 2% of the Trust's total carbon footprint due to the greenhouse properties of nitrous oxide and Entonox and the propellants used in inhalers.

In 2022-23, the volume of nitrous oxide purchased decreased by 40,500 litres and the volume of Entonox purchased decreased by 629,000 litres which equates to an overall 20% reduction in carbon emissions (Appendix E, Figure 17). It's difficult to attribute this reduction due to the complexity in measuring clinical usage however it is worth noting the Emergency Department moved to using portable cylinders of Entonox in 2022-23 which may have reduced medical gas waste.

In 2022-23, pharmacy stock of desflurane and isoflurane expired and were sent for destruction. The last issue of desflurane to theatres was in November 2022. The increased volume of purchase desflurane and isoflurane has increased associated carbon emissions by 342% and 38% respectively (Appendix E, Figure 18). The remaining stock of desflurane has now been exhausted and Pharmacy will not be purchasing anymore. Isoflurane continues to be used in low volumes but hasn't been issued since February 2023. The amount of sevoflurane used in theatres reduced by 23% in 2022-23 (Appendix E, Figure 18).

The carbon footprint associated with inhalers increased by 5% due to the 5% increase in prescribed pressurised metered dose inhalers (pDMI) and the 21% increase in breath actuated inhalers which are the two most carbon intensive inhalers (Appendix E, Figure 19). Despite this, low carbon dry powder inhalers (DPI) were the second most commonly prescribed inhalers after pDMIs (Appendix E, Figure 19).

4.5 Waste



Carbon emissions associated with waste reduced by 7% in 2022-23 due to a 55% reduction in carbon associated with alternative waste, a 53% reduction in carbon associated with landfill and a 26% reduction in carbon emitted from composting (Appendix F, Figure 20). There was however a 44% increase in carbon emissions associated with domestic incineration as the tonnage of general waste increased by 45% (Appendix F, Figure 21). This corresponds to more waste being classified as non-infectious in both clinical and non-clinical areas which is evident in the 54% decrease in infectious waste which demonstrates a return to pre-covid figures (Appendix F, Figure 21). The tonnage of weight recycled remained the same (Appendix F, Figure 21). Highly infectious waste increased by 358 tonnes (470% increase) due to failed audits from July 2022 to April 2023 which classified all waste destined for alternative treatment (orange-bagged) as highly infectious waste (yellow-bagged). Compliance has since improved, and this figure should significantly reduce in the 2023-24 data if compliance levels continue. Sharps waste increased by 16 tonnes (9% increase, Appendix F, Figure 21).

The composition of waste produced within the Trust is 58% non-clinical (Appendix F, Figure 22). The waste produced consists mostly of general waste (31%), followed by recycled waste (23%), infectious waste (18%) and highly infectious waste (14%, Appendix F, Figure 22). The weight of waste classified as offensive was only 2% (Appendix F, Figure 22). It is essential that the amount of waste classified as offensive increases and the amount of waste classified as highly infectious decreases in order to decarbonise carbon emissions associated with waste.

The majority of waste was incinerated at a low temperature (33%, Appendix F, Figure 23). A very high proportion of waste was treated by high temperature incineration (31%) which contributes massively to the carbon footprint of waste (Appendix F, Figure 20).

The recycling rate remained the same. Clinicians have demonstrated initiative and best practices within their areas throughout 2022-23. A junior doctor within ICU conducted a waste audit of ICU in September 2022 and led a feed bottle recycling

challenge in March 2023 whereby 446 feed bottles were recycled, diverting 15.6kg of plastic from incineration and avoiding 2351 kg CO_2e which is equivalent to ten flights from Bristol to Barcelona.

In 2022-23 1% of the total waste produced by the Trust was reused through the warp it portal and our WEEE waste contractor which was a 12 tonne increase compared to 2021-22. Through the warp it portal the Trust saved £19,212 and 9.5 tonnes CO_2e in 2022-23 in avoided procurement and waste costs. This is equivalent to three flights from Bristol to Sydney.

In 2022-23 the Trust performed poorly against the NHS Clinical Waste Strategies clinical waste segregation target of achieving 20:20:60 across HTI (high temperature incineration), AT (alternative treatment), and OW (offensive waste) by 2026 (Appendix F, Figure 24). The Trust recorded a 76:18:6 ratio for clinical waste segregation highlighting that too much waste is being classified as highly infectious waste, pharmaceutical or sharps waste and not enough waste is being classified as non-infectious.

5. 2023/24 Work Plan

In November 2023/24, the Green Plan delivery plan will be finalised followed by Trust Board approval. The Sustainable Development Unit (SDU) will work alongside key stakeholders to develop fully-costed business cases to deliver priority actions within the delivery plan ready to go through the business case review group, capital process, the ICS capital prioritisation process and to support bids that arise.

Key ICS actions will be delivered in 2023-24 such as the installation of an air quality monitoring system at Southmead Hospital, the recruitment of a Fleet Manager, the implementation of reusable sharps containers, tendering the sustainable waste management contract and installing heat pumps.

The SDU will be responsible for starting the ICS sustainable food workstream to deliver actions within the Green Plan and Bristol Good Food Framework and publishing the ICS Communications and Engagement Strategy.

The SDU is currently maintaining a list of unmet needs in relation to achieving net zero carbon which will be shared with NHS Supply Chain, prioritised and developed into project charters. The SDU will co-ordinate key stakeholders to deliver priority projects.

To extend a support offering to departments across the Trust and ICS, the SDU will develop a sustainability evaluation template for completing sustainability audits across sites and benchmarking departments against sustainable healthcare best practice. This will be shared nationally with the IPS Sustainability Special Interest Group.

NBT is currently trialling a new Sustainability Impact Assessment with an embedded carbon calculator as part of the business case review process. For the remainder of 2023-24, the SDU will work alongside the Finance team to establish a process whereby projects that emit excessive carbon and do not take reasonable mitigation measures may pay a carbon price to fund carbon reduction projects within the Trust.

Glossary

BAI – Breath-actuated metered dose inhaler, 1 dose (2 puffs) is equivalent to 500 g CO_2e.

Biodiversity – the variety and variability of plant and animal life in the world or in a particular habitat. Biodiversity is a measure of variation at the genetic, species, and ecosystem level.

Climate change – long-term shifts in temperature and weather patterns, typically over decades or more, that is attributed to increased levels of atmospheric carbon dioxide and other greenhouse gases produced by the combustion of fossil fuels.

DPI – Dry powder inhaler, 1 dose is equivalent to 20 g CO_2e.

Ecology - the relationships between living organisms, including humans, and their physical environment.

Green Space – a community space consisting of grass, trees, or other vegetation that exists for recreational or aesthetic purposes in an otherwise urban environment.

Grey fleet – the use of personal staff vehicles for business travel e.g. visiting patients homes, attending conferences or training.

Net zero – an organisation, activity or building is deemed to have achieved net zero carbon when it has reduced all carbon emissions associated with its direct and indirect activity by 90-95% against an established baseline. The remaining carbon emissions must be offset through accredited carbon offsetting schemes.

pDMI – Pressurised metered dose inhaler, 1 dose (2 puffs) is equivalent to 500 g CO_2e.

Scope 1 emissions – carbon emitted directly produced by NBT activity. This includes carbon emitted through oil, gas, fleet, anaesthesia and refrigerants.

Scope 2 emissions – carbon emitted indirectly from the energy purchased to heat and cool buildings. This includes carbon emitted through electricity.

Scope 3 emissions – carbon emitted indirectly through the purchasing of goods and services and the supply chain. This includes carbon emitted through waste generation, purchasing of office equipment, medicines and medical equipment, business travel and staff and patient commute.

SMI – Soft mist inhaler, lowest carbon inhaler.

Sustainability – the integration of environmental health, social equity and economic vitality in order to create thriving, healthy, diverse and resilient communities for this generation and generations to come. The practice of sustainability recognises the interconnectedness of these issues and that it requires a systems approach and an acknowledgment of complexity. Sustainability is achieved when there is a balance between environment, equity and economy.

Sustainable Models of Care – a health or social care pathway that reduces carbon emissions, improves staff and patient health and wellbeing, or increases efficiencies.

tCO_2e – tonnes of carbon dioxide equivalent, the standard unit for carbon accounting to quantify greenhouse gas emissions, emissions reductions and carbon credits. This unit standardises the global warming impact of different greenhouse gases.

Appendix A – Carbon Footprint

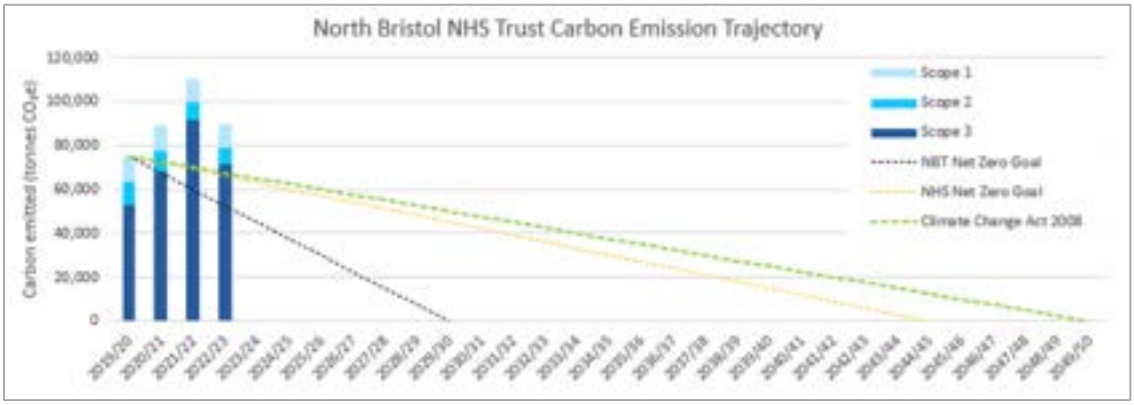


Figure 1 Carbon footprint of NBT broken down by scope for each financial year between 2019-2023. Plotted carbon emission trajectories for NBT to achieve net zero carbon by 2030, by 2045 and by 2050 against NBT's 2019-20 carbon baseline.

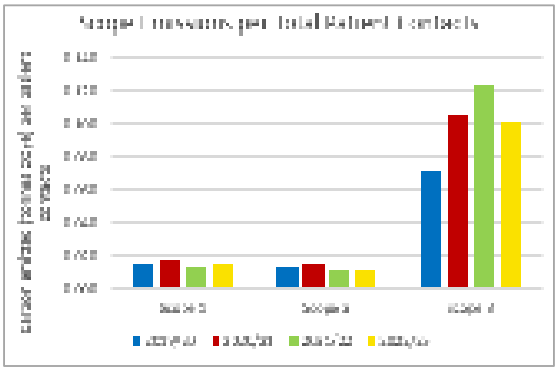


Figure 2 Carbon emitted per patient contact across scope 1, 2 and 3 emissions from 2019-23.

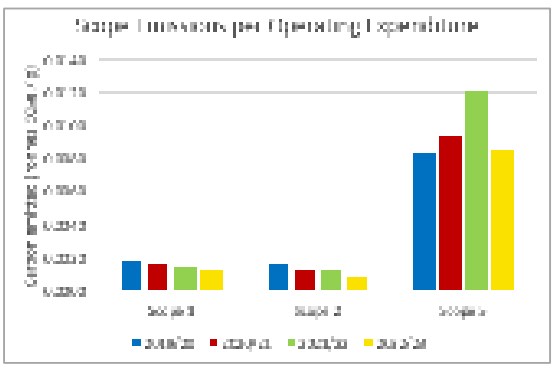


Figure 3 Carbon emitted per penny of operating expenditure across scope 1, 2 and 3 emissions from 2019-23.

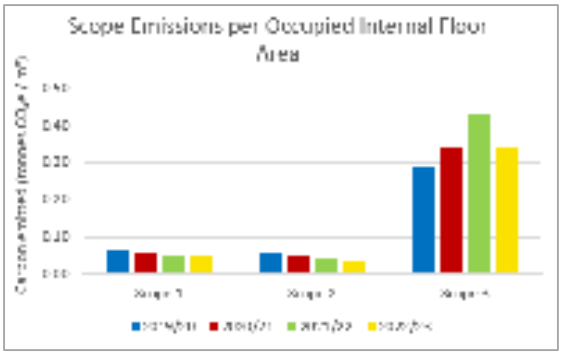


Figure 4 Carbon emitted per meter square of occupied internal floor area across scope 1, 2 and 3 emissions from 2019-23.

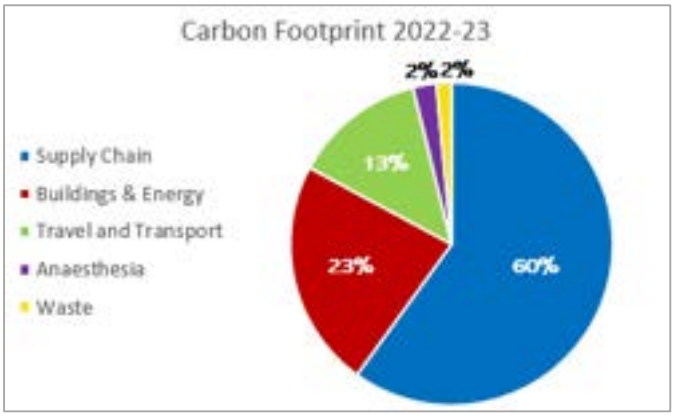


Figure 5 Proportion of key emission sectors responsible for NBT's total carbon footprint.

Appendix B – Supply Chain and Procurement Graphs

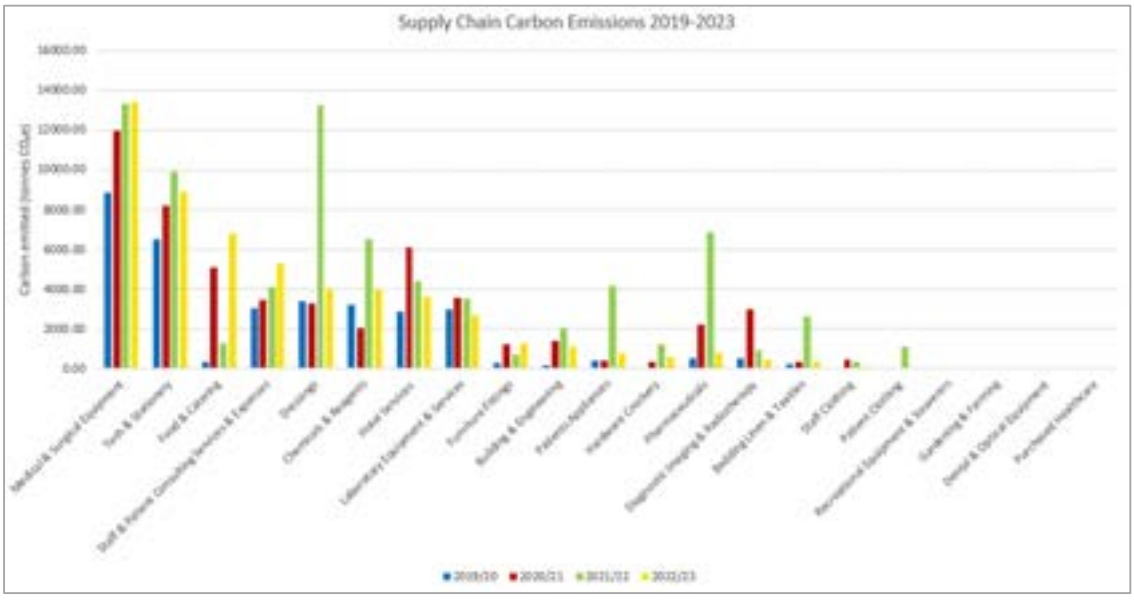


Figure 6 Carbon footprint of supply chain and procurement broken down by e-class I categories for each financial year between 2019-23.

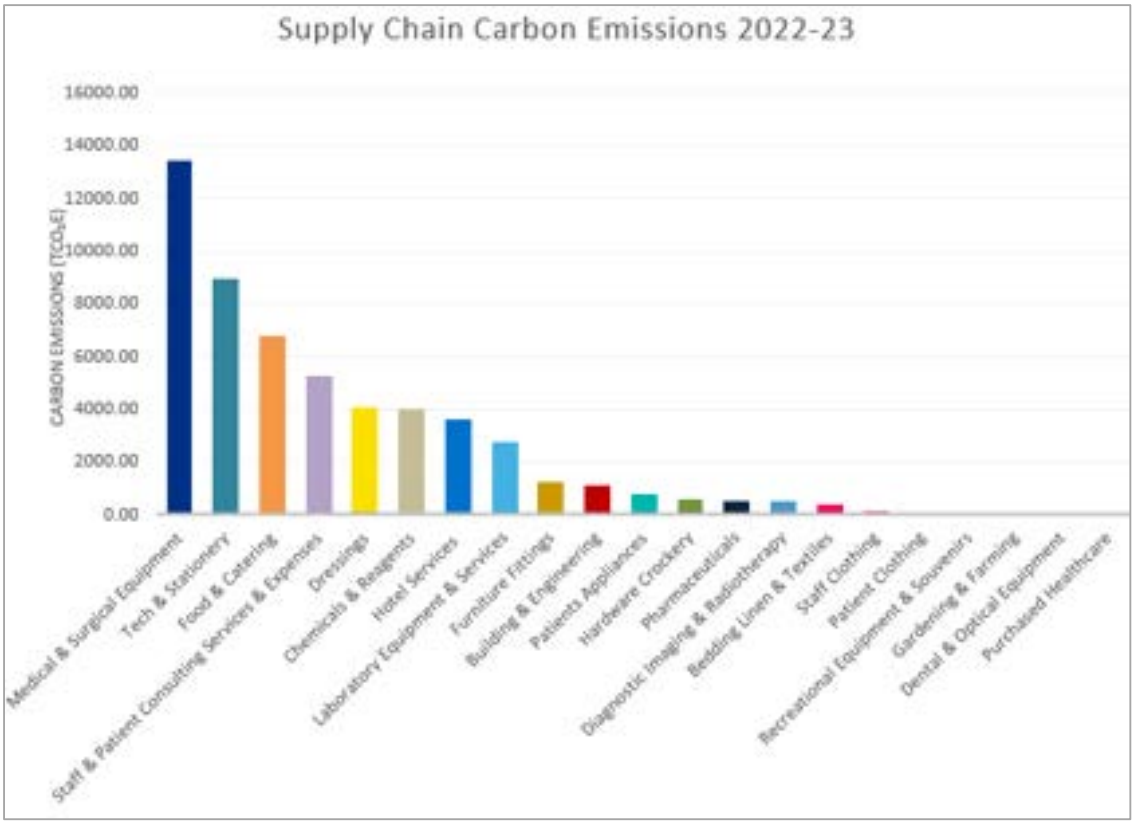


Figure 7 Carbon emissions of each e-class I category for 2022-23.

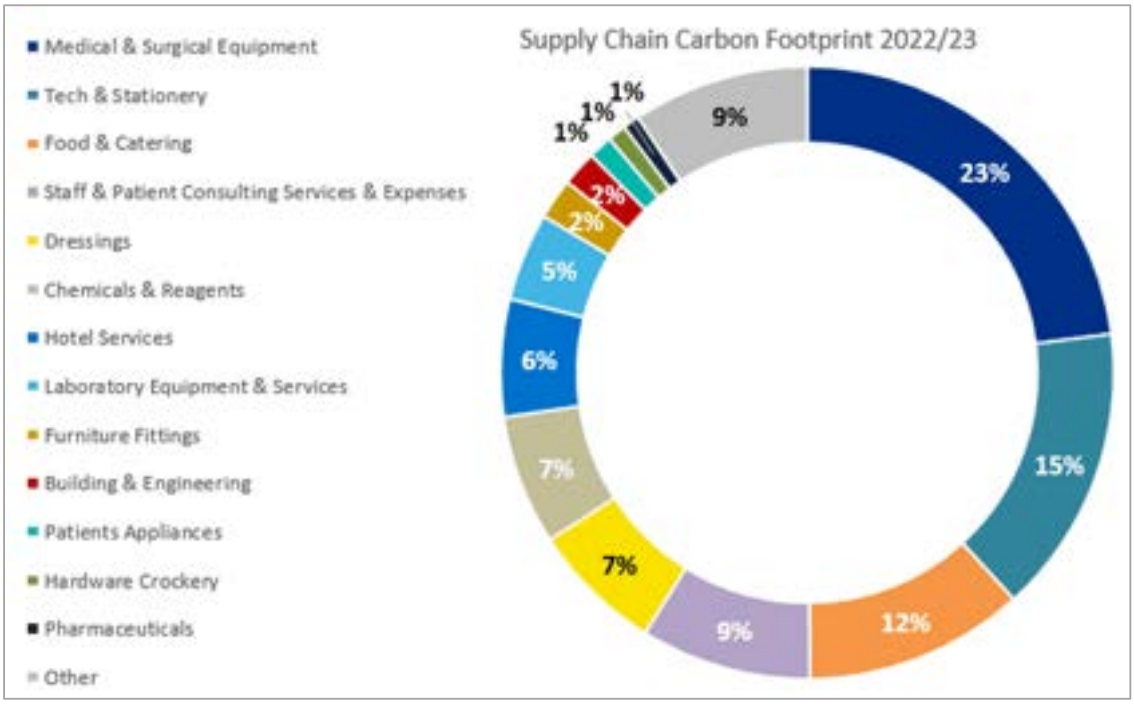


Figure 8 Proportion of e-class I categories in the supply chain and procurement carbon footprint for 2022-23.

Appendix C – Buildings and Energy Graphs

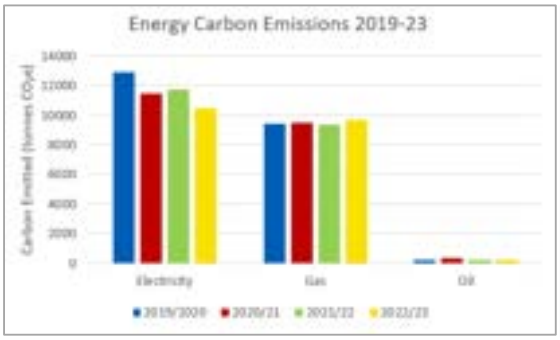


Figure 9 Carbon emissions due to energy consumption in each financial year between 2019-2023.

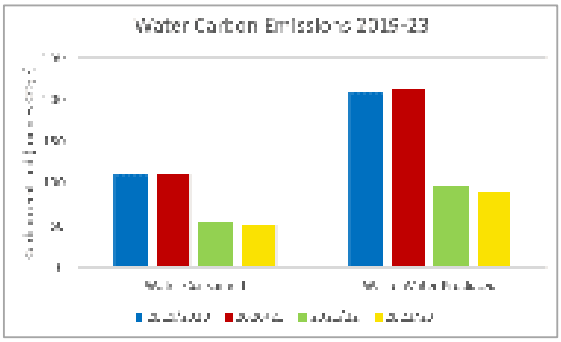


Figure 11 Carbon emissions due to water consumption and wastewater production in each financial year between 2019-2023.

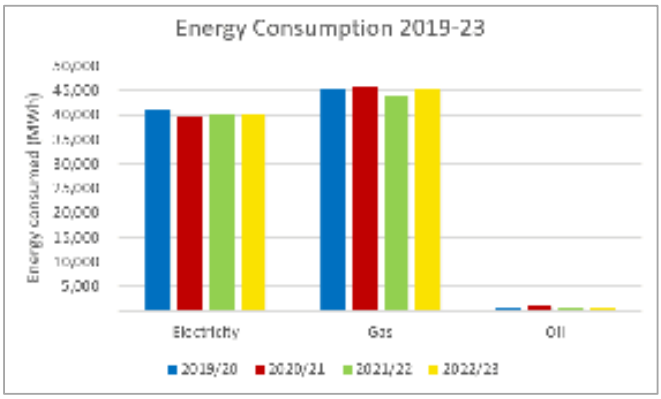


Figure 10 Energy consumed from electricity, gas and oil for each financial year from 2019-2023.

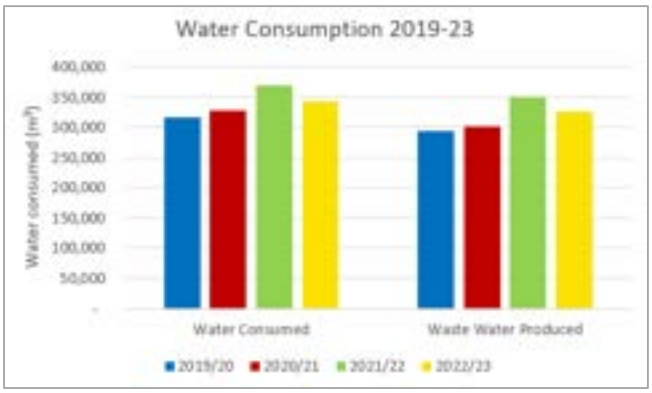


Figure 12 Water consumed and wastewater produced for each financial year between 2019-2023.

Appendix D – Travel and Transport Graphs

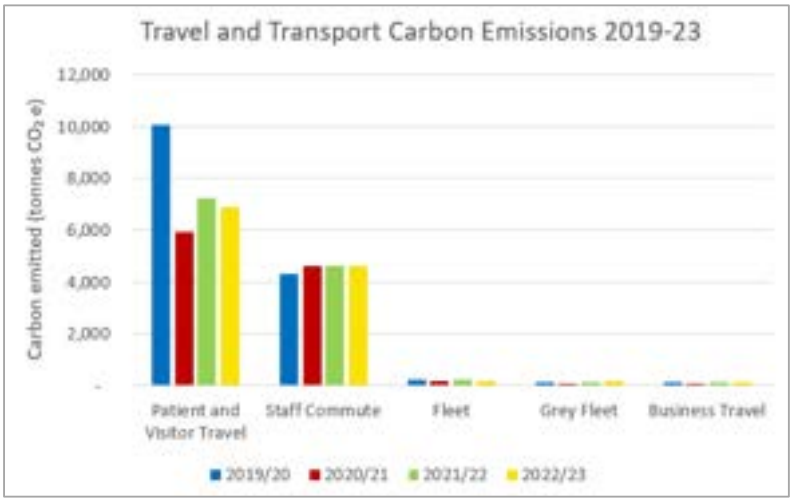


Figure 13 Carbon emissions associated with travel and transport for each financial year between 2019-2023.

Figure 14 Miles travelled by staff, patients and visitors to commute to work, attend an appointment and visit a patient for each financial year between 2019-2023.

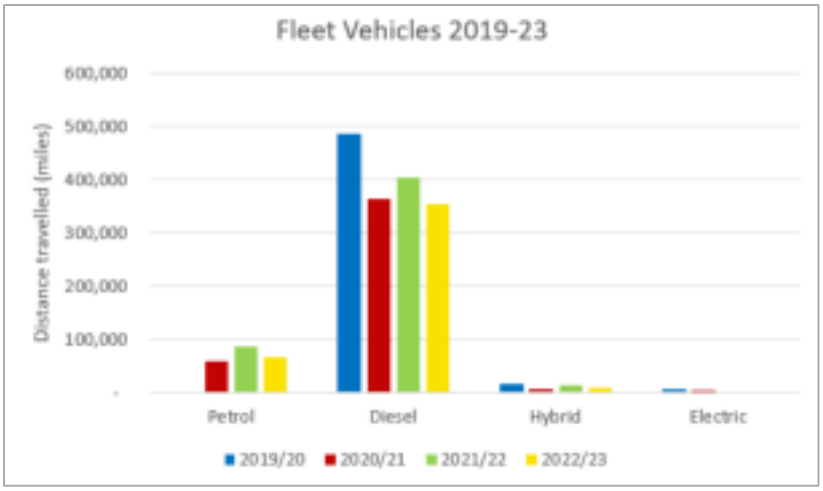


Figure 15 Miles travelled by NBT owned and leased fleet vehicles across each vehicle type for each financial year between 2019-2023.

Figure 16 Miles travelled for business activity for each financial year between 2019-2023.

Appendix E – Medicine Graphs

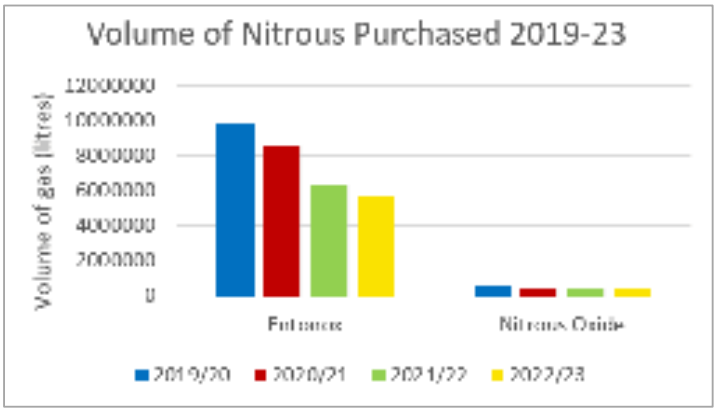


Figure 17 Volume of Nitrous Oxide and Entonox purchased for anaesthesia for each financial year between 2019-2023.

Figure 18 Volume of volatile agents purchased for each financial year between 2019-2023.

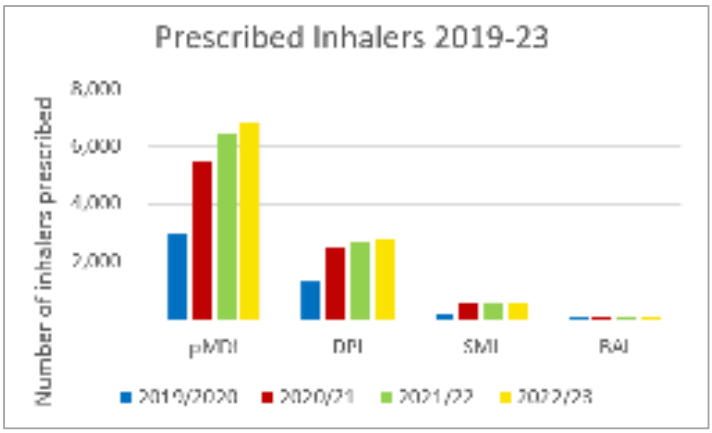


Figure 19 Inhalers prescribed to patients by inhaler type for each financial year between 2019-2023.

Appendix F – Waste Graphs

Figure 20 Carbon emissions across waste treatment types for each financial year from 2019-2023.

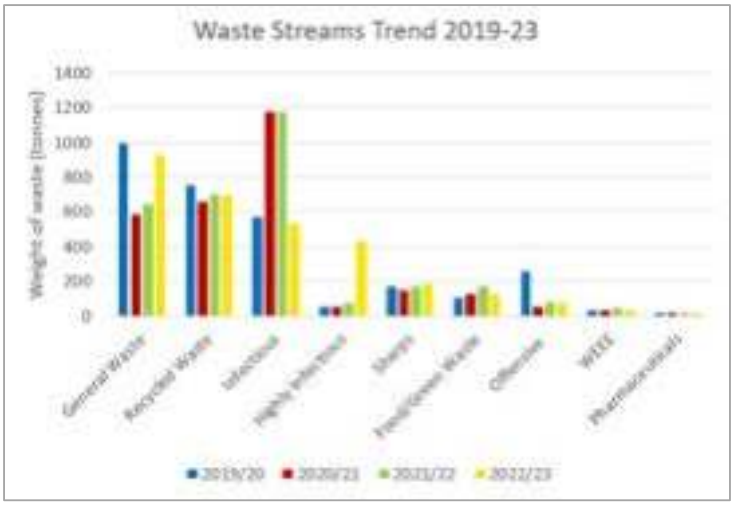


Figure 21 Tonnage of each waste stream produced for each financial year between 2019-2023.

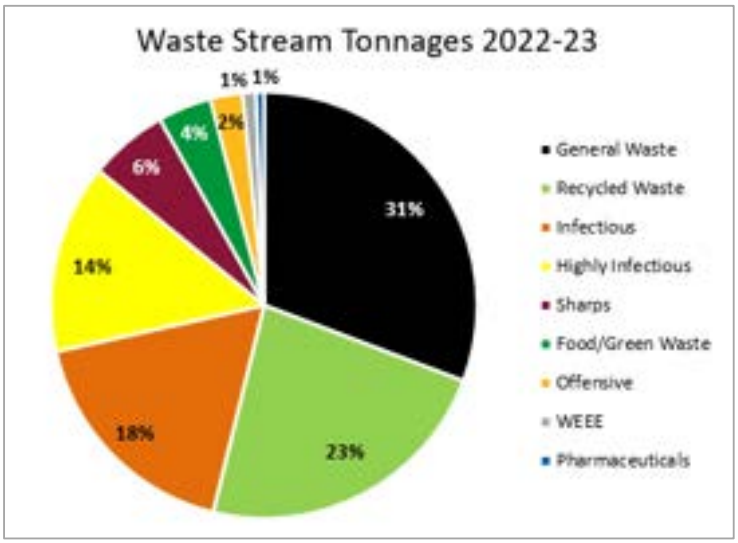


Figure 22 Proportion of waste streams by weight for 2022-23

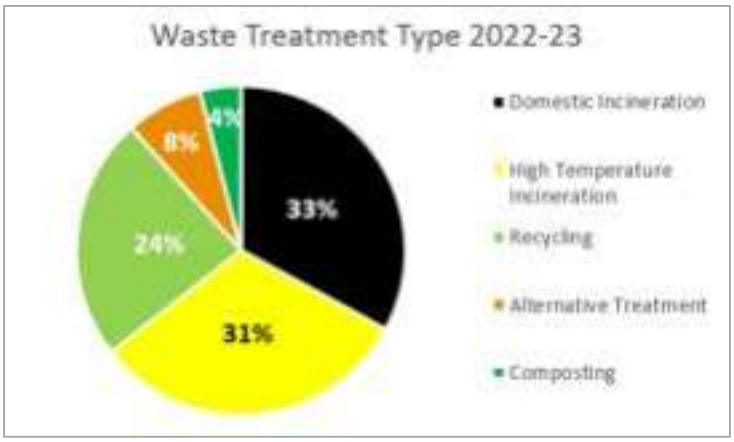


Figure 23 Proportion of waste treatment types by weight for 2022-23

Figure 24 The percentage composition of waste by tonnage classified as high temperature incineration waste (HTI), alternative treatment waste (AT) and offensive waste (OW) for each financial year from 2019-2023.

Report To:	Public Trust Board			
Date of Meeting:	30 November 2023			
Report Title:	Modern Slavery Statement			
Report Author:	David Druett, Director of Procurement BWPC			
Report Sponsor:	Glyn Howells, Chief Finance Officer			
Confidentiality (tick where relevant) *:	**Patient identifiable information?**	**Staff identifiable information?**	**Commercially sensitive information?**	**Other exceptional circumstances**
*If any boxes above are ticked, paper may need to be received in *private.*				
Purpose of the report:	**Approval**	**Discussion**	**Information**	**Assurance**
	X			
Recommendations:	To approve the publication of the Trust's Joint Modern Slavery Statement with UHBW.			
Report History:	Executive Management Team – 15/11/2023			
Next Steps:	To align approval with UHBW and publish the Joint modern slavery statement. To issue the Modern Slavery statement to the registry on GOV.UK			

Executive Summary

Following the Transparency in Supply chains consultation and public pressure the Government committed to extending section 54 of the Modern Slavery Act 2015 to public bodies in England and Wales.

This requires the Trust to produce an annual modern slavery statement setting out the steps taken over the course of the financial year to prevent modern slavery in their operations and supply chains.

Given that the bulk of the modern slavery risk sits within the Trust's supply chains, and procurement for the trust is conducted through consortium arrangements with UHBW it was agreed to create a joint modern slavery statement. The creation of joint modern slavery statements is encouraged where it is appropriate.

This paper proposes the Trust's first Joint Modern slavery statement for issue (attached).

Implications for Trust Improvement Priorities: *(tick those that apply and elaborate in the report)*	**Our Aim: Outstanding Patient Experience**	
	High Quality Care – *Better by design*	X
	Innovate to Improve – *Unlocking a better future*	
	Sustainability – *Making best use of limited resources*	X
	People – *Proud to belong*	X
	Commitment to our Community - *In and for our community*	X

Link to BAF or Trust Level Risks:	None identified.
Financial implications:	N/A
Does this paper require an Equality, Diversity and Inclusion Assessment (EIA)?	*No* Monira Chowdhury Head of Equality, Diversity & Inclusion has been consulted through the development of the statement.
Appendices:	Modern Slavery Statement

1. Purpose

1.1 The purpose of this paper is to seek approval for the Trusts Modern Slavery Statement.

2. Background

2.1 Following the Transparency in Supply chains consultation and public pressure the Government committed to extending section 54 of the Modern Slavery Act 2015 to public bodies in England and Wales.

2.2 This requires the Trust to produce an annual modern slavery statement setting out the steps taken over the course of the financial year to prevent modern slavery in their operations and supply chains.

2.3 Given that the bulk of the modern slavery risk sits within the Trusts supply chains, and procurement for the trust is conducted through consortium arrangements with UHBW it was agreed to create a joint modern slavery statement. The creation of joint modern slavery statements is encouraged where it is appropriate.

3. Guidance provided for evaluating a modern slavery statement

3.1 To aid the exec in reviewing the statement Government guidance on producing a modern slavery statement is that it should:

3.1.1 Be transparent about instances or indicators of modern slavery found within the operations and supply chains as well as actions that have been undertaken in response

3.1.2 They should prioritise activity where the organisation can have most impact

3.1.3 Demonstrate progress by setting and reporting against clear targets.

4. Summary and Recommendations

4.1 The Trust Board is asked to **approve** the publication of the Trusts Joint Modern Slavery Statement with UHBW

Modern Slavery Statement 2022/23

Overview

Modern slavery is the removal of personal freedoms in order to exploit human beings for financial or personal gains. It can take many forms including forced labour, human trafficking and sexual exploitation. It is a complex issue with a global reach. There were an estimated 50 million people in modern slavery in 2021[1] and these numbers are increasing. We recognise that modern slavery will exist in our supply chain, and we are committed to do all we can to identify and manage the risks that our business and purchasing activities pose.

The Modern Slavery Act 2015 introduced changes in UK law, which focus on increasing transparency in supply chains. To support this we have prepared and published this statement. We aim to be open and transparent about the work we are doing but also about the areas where we can do more. This statement provides a foundation upon which we can continually improve.

Our Statement

This Modern Slavery and Human Trafficking statement is for the financial year ending 31 March 2023. It outlines the shared commitment and actions that have been carried out by Bristol and Weston NHS Purchasing Consortium (B&WPC), North Bristol NHS Trust (NBT) and University Hospitals Bristol and Weston NHS Foundation Trust (UHBW) over this time period. In the statement, terms such as ‘our’ and ‘we’ refer to all three organisations.

This is the first modern slavery statement that we have produced. It covers the following areas of our business activities;

1. The recruitment of both temporary and permanent employees
2. The working conditions and practices for our employees
3. The procurement of goods and services.

Organisation Structure and Supply Chains

Bristol and Weston Purchasing Consortium

B&WPC provide a comprehensive range of purchasing services to support local Trust and Healthcare Providers.

B&WPC staff are NHS employees, hosted by North Bristol NHS Trust and the services provided include all aspects of clinical and non-clinical purchasing and supply chain management. B&WPC’s main clients include both NBT and UHBW and cover an annual spend of approximately £750m. B&WPC work closely with both Trusts to support compliance with all purchase-to-pay procedures and deliver improved efficiencies.

North Bristol NHS Trust

NBT has over 12,000 staff delivering healthcare across main sites at Southmead Hospital Bristol, Cossham Hospital and Bristol Centre for Enablement and within the local community of Bristol, North Somerset and South Gloucestershire. NBT is a regional centre for neurosciences, plastics, burns, orthopaedics and renal services. NBT’s aim is to deliver an

[1] Global Slavery Index | Walk Free

outstanding patient experience and its values of caring, ambitious, respectful and supportive underpin everything that we do.

University Hospitals Bristol and Weston NHS Foundation Trust

UHBW has a workforce of over 13,000 staff, delivering over 100 different clinical services across 10 different sites serving a core population of more than 500,000 people locally and from across the southwest.

With services from the neonatal intensive care unit to care of the elderly, UHBW provides care to the people of Bristol, Weston and the southwest from the very beginning of life to its later stages.

Our Supply Chain

Our supply chain is large, multi-tiered, global and complex. We procure a wide range of clinical and non-clinical goods, services and works. This includes medical equipment, personal protective equipment and uniforms, dressings, mattresses and bed linen, laptops, software, furniture and mechanical and electrical services to name but a few.

Many of our purchases are from sectors that are known to be high risk for modern slavery. Our approach to identifying and managing modern slavery risks must be embedded into any new procurement activity and within our existing contracts to be effective.

We let contracts over a range of timescales from medium to long term relationships to one-off purchases. As part of our procurement policy, we actively seek to utilise frameworks provided by public sector organisations such as NHS Supply Chain and Crown Commercial Services. We have over 2,500 tier 1 suppliers and over 1,000 active contracts in place.

Policies in relation to slavery and human trafficking

A number of national regulations and mandates have been set over the past 12 months that allow for modern slavery to be prioritised as a topic for consideration in the purchases that we make.

The Health and Care Act 2022 allow for regulations to be set to eradicate modern slavery and human trafficking in NHS supply chains. NHS England has also adopted the mandatory inclusion of Net Zero and Social Value criteria in the evaluation of all tenders. This is also mandated for all NHS Trust procurements. Modern slavery can be a topic addressed under social value where it is proportionate and relevant to the contract.

We have created two policies that build on this national level focus to address to this issue. The B&WPC procurement strategy 2022-25 is published online and is publicly available having been signed off and approved by the Trust Boards of both NBT and UHBW.

1. B&WPC Procurement Strategy 2022-25.
   This document sets out our values and outlines the areas of focus for B&WPC to ensure that we are maximising the value obtained from our external spend. There are 4 objectives within the strategy. The Anchor in the Community objective includes a clear commitment to remove modern slavery for our supply chain and to use our market leverage to drive an ethical supply chain. The aim is to ensure that our supply chains and procurement processes are ethical, free from worker abuse and exploitation and provide safe working conditions. An away day was held with all

B&WPC staff to engage with and explore the strategy and what its aims mean in the short, medium and long term to the team.

2. Joint Ethical Procurement Strategy.
   This document will reflect our joint vision and aims to support the delivery of exceptional healthcare services in a sustainable manner. Included within the definition of 'sustainable' is ethical conduct and social value. We will document a specific commitment to ensure that our supply chain and procurement processes are ethical, free from worker abuse and exploitation and provide safe working conditions. This policy will be approved and be available publicly during 23/24.

Our existing recruitment policies set out the processes that cover the recruitment of both our temporary and permanent employees. The overall approach is governed by compliance with legislative and regulatory requirements and the maintenance and development of good practice in the fields of employment.

Our recruitment processes are robust and adhere to safe recruitment principles. We have a range of policies and procedures to protect staff from poor treatment and/or exploitation which comply with all respective laws and regulations. This includes policies on recruitment, pay and equality, diversity and inclusion.

In addition to this, we have clear systems and polices in place to encourage the reporting of concerns, speaking up and the protection of whistleblowers Our policies such as Safeguarding Adults and Children, Dignity at Work, Grievance procedure and Freedom to Speak Up policy provide additional platforms for our employees to raise concerns about poor and inappropriate working practices. We have a number of dedicated Freedom to Speak Up Guardians and Executive and Non-Executive Director leads for Freedom to Speak Up. Whilst these are not exclusively for the purpose of raising concerns for modern slavery and human trafficking, their remit covers any issues linked to this.

Risk Assessment and Management

A category level environmental, social and governance risk assessment has been carried out for our spend profile. This assessment included the identification of modern slavery risks across the lifecycle of goods and services purchased on criteria including the risk of forced labour, child labour, working conditions and discrimination.

The following purchasing categories were identified as high risk:

- Construction
- Information Technology (IT)
- Food and Catering
- Medical Equipment
- Textiles (clothing, bed linen etc)
- Waste Management
- Temporary Staff and Recruitment Services

Due Diligence Process

Our robust recruitment processes are in line with relevant employment legislation and adhere to safe recruitment principles. We follow strict pre-employment checks on all directly employed staff, Bank Workers and others undertaking work within our organisation. These include identification, right to work, qualification, registration and reference checks. Our pre-

employment checks are in line with the NHS employment check standards and our Resourcing functions oversee fair and equitable recruitment and selection practices.

We align to nationally negotiated NHS pay rates and terms and conditions of employment. We consult and negotiate with recognised Trade Unions on proposed changes to working arrangements, policies and contractual terms and conditions.

Only approved frameworks are used for the recruitment of temporary agency staff. All providers are audited to provide assurance that pre-employment clearance has been obtained in line with the NHS Employment Check Standards.

We also provide access to learning and development opportunities and provide a comprehensive staff benefits and health and wellbeing offer.

As part of our standard checks within our procurement process, bidders are checked (where relevant) for their compliance with the Modern Slavery Act (2015).

We have been engaging with our category leads and main suppliers within our IT category to raise awareness and understand the maturity levels of work across the sector in this area. We aim to replicate this approach for other high-risk categories. We will use this to inform the due diligence processes we need to implement.

We recognise that our current due diligence processes are not adjusted to reflect the risk associated with the purchase involved. We will develop our process over the coming year to ensure that our due diligence processes are proportionate to the risk posed by the purchase in question.

KPIs to measure effectiveness of steps being taken

We have a robust governance mechanism for monitoring the delivery of the commitments set out in our policies. The Sustainable Procurement Workstream as part of the ICS Green Plan Implementation Group is made up of representatives from all three organisations. It is responsible for driving the delivery of the commitments and reporting on their progress to the Green Plan Steering Group that sits above this and feeds into Executive and Board level activities at each organisation.

Training on Modern Slavery and Human Trafficking

We provide advice, training and support about modern slavery and human trafficking to all staff through our safeguarding children and adults mandatory training, our safeguarding policies and procedures and our safeguarding teams.

We also ensure that all staff receive a comprehensive induction programme which includes information on, and guidance regarding modern slavery and human trafficking.

Specifically within our procurement function, B&WPC has been developing a capability framework for all procurement job roles. This framework will be completed in the next financial year and will include modern slavery and social value.

A list of available training resources, including those on modern slavery, has been complied and is available for B&WPC staff to access.

UHBW and NBT plan to develop education resources and make them available to their staff and, over the coming year, map the key stakeholders who are involved in the procurement and contract management process to focus engagement efforts and further drive our shared commitment to eradicate modern slavery and human trafficking from our supply chains.

Signed by

Next update due

Report To:	Public Trust Board			
Date of Meeting:	30 November 2023			
Report Title:	Audit and Risk Committee Upward Report			
Report Authors:	Richard Gwinnell, Deputy Trust Secretary Xavier Bell, Trust Secretary			
Report Sponsor:	Shawn Smith, Non-Executive Director (Committee Chair)			
Confidentiality (tick where relevant) *:	**Patient identifiable information?**	**Staff identifiable information?**	**Commercially sensitive information?**	**Other exceptional circumstances**
*If any boxes above are ticked, paper may need to be received in *private.*				
Purpose of the report:	**Approval**	**Discussion**	**Information**	**Assurance**
	X			**X**
Recommendations:	The Trust Board is recommended to: (1) note the Audit and Risk Committee Upward Report, along with the Board Assurance Framework for assurance purposes (2) agree that no changes are required to the Trust's Standing Orders, Standing Financial Instructions or Scheme of Delegated Authority (3) agree that no changes are required to the Audit and Risk Committee's terms of reference.			
Report History:	The report is a standing item to each Trust Board meeting following an Audit and Risk Committee meeting.			
Next Steps:	The next upward report from this Committee to the Trust Board will be to the Trust Board's meeting in March 2024.			
Executive Summary				
The report provides assurances received, issues escalated to the Trust Board and any new risks identified from the Audit and Risk Committee Meeting held on 9 November 2023.				
Implications for Trust Improvement Priorities: *(tick those that apply and elaborate in the report)*	**Our Aim: Outstanding Patient Experience**			
	High Quality Care – *Better by design*			X
	Innovate to Improve – *Unlocking a better future*			
	Sustainability – *Making best use of limited resources*			X
	People – *Proud to belong*			
	Commitment to our Community - *In and for our community*			
Link to BAF or Trust Level Risks:	The Audit and Risk Committee has oversight of the Trust's overall risk management systems and processes. No risks arise from this report.			

Financial implications:	None within this report.
Does this paper require an Equality, Diversity and Inclusion Assessment (EIA)?	No
Appendices:	Appendix 1: Board Assurance Framework Appendix 2: Standing Orders, Standing Financial Instructions, Scheme of Delegated Authorities Appendix 3: Audit and Risk Committee terms of reference

1. Purpose

1.1 To provide a highlight of the key assurances, escalations to the Board and identification of any new risks arising from the Audit and Risk Committee meeting held on 9 November 2023, alongside the Board Assurance Framework and Trust Level Risks.

2. Background

2.1 The Audit and Risk Committee is a sub-committee of the Trust Board. It meets five times a year and reports to the Board after each meeting. The Committee was established to receive assurance on the Trust's systems of internal control by means of independent review of financial and corporate governance, risk management across the whole of the Trust's activities and compliance with law, guidance and regulations governing the NHS.

3. Meeting on 9 November 2023

3.1 External Audit Progress Report and Sector Update

3.2 The Trust's External Auditors provided an update on national challenges for the NHS around financial sustainability and cost improvement programmes (CIP), along with an update on their work programme, including the timetable and progress of planned reports and the Auditor's opinion on the final accounts and on value for money, which would be submitted in spring 2024. Discussion took place about the need for early engagement between the External Auditor and NBT officers on any issues and on the need for a special meeting of the Audit and Risk Committee in June, to consider the Auditor's opinion on the final accounts.

3.3 Internal Audit Progress Report and Action Tracker

Internal Auditors provided an update on their work programme, including the timetable and progress of planned reviews for 2023/24, which are on track, as are the vast majority of management actions in response to previous audits. Discussion took place about dates for management actions and the need to be realistic about timescales and avoid slippage wherever possible. The Committee was assured that actions to address previous audits

were progressing on schedule and that, where there was an occasional exception, revised dates were justified and had been agreed between management and Internal Auditors.

Internal Auditors (IA) gave detailed reports on risk management (green rating: significant assurance), capital spend and expenditure controls (green to amber rating: significant assurance with minor improvement opportunities) and health and safety governance and incident reporting (green to amber rating: significant assurance with minor improvement opportunities). The IA also updated the Committee on the Trust's Provider Finance in-year Monitoring Return (Quarter 1). The Committee discussed improvement opportunities and timescales in detail and was assured by the good practice evident from the reports.

3.4 Counter Fraud Progress Report

The Local Counter-Fraud Specialist (LCFS) updated the Committee on progress with the counter-fraud reviews currently being undertaken, giving detailed reports on their reviews of mandate fraud (green rating: significant assurance) and conflicts of interest (green to amber rating: significant assurance with minor improvement opportunities). The Committee discussed the detail of the LCFS reviews and was assured by the evidence presented.

3.5 Update on Audit of Cancer Multi-Disciplinary Team Meetings (MDTMs)

The Committee was informed of progress since the Internal Audit review of Cancer MDTs. A new standard operating procedure (SOP) had been prepared and was presented to the Committee, which would ensure standardisation of practice and the completion of standard forms across various cancer sites, as far as possible. The Committee discussed the increasing need for local and IT solutions and was assured by the progress made.

3.6 Procurement

The Committee received and noted a dashboard report showing continued improvement in compliance with proper procurement processes, systems and policy and noted good progress with the planned implementation of a new purchasing system, to be rolled out early in 2024. Encouraging progress was reported in terms of a reduction in the number and value of single tender actions and an increase in the number of contracts and purchase order spend. The increase in the threshold for BWPC involvement in contracts (from £5k to £25k, agreed in August 2023) was having positive effects on BWPC workload and the Committee welcomed and was assured by the reported progress.

3.7 Risk Report

The Committee was assured that the Trust's approach to risk management was maturing and improving, with good processes and systems in place, and acknowledged the recent Internal Audit report on risk management, which gave significant assurance (green rating). The Committee welcomed the improvement in the quality of the data and discussed their role in ensuring good risk management processes and systems overall (rather than exploring each individual risk in detail, which was the role of other relevant Trust Board Committees). The Committee asked for future reports to focus on the extent to which Trust-level risks were changing (or not changing) and reasons why.

3.8 The Committee also:

- Noted the publication of the National Cost Collection data for 2021/22 and the forthcoming submission to NHS England of the required data for 2022/23.
- Agreed that no changes were required to the Trust's Standing Orders, Standing Financial Instructions or Scheme of Delegated Authority.
- Noted losses and overpayments for the review period and actions to address them, as well as the reduction in losses and overpayments compared to previous periods.
- Noted a six-monthly update on declarations of interests (DOI) and good progress with DOI system compliance.
- Agreed to the questions to be asked in their annual committee effectiveness survey.
- Agreed that no changes were required to the Committee's terms of reference.
- Agreed to make recommendations to the Board on a variety of capital overspends (this is referred to in a separate report to the Board).
- Agreed (in a meeting of the Auditor Panel) the appointment of Internal Auditors for the next financial year (this is referred to in a separate report to the Board).

4. New risks or items for escalation

No risks or issues were flagged by the Committee for escalation to the Trust Board.

5. Summary and Recommendations

5.1 The Trust Board is recommended to:

(1) note the Audit and Risk Committee Upward Report, along with the Board Assurance Framework for assurance purposes
(2) agree that no changes are required to the Trust's Standing Orders, Standing Financial Instructions or Scheme of Delegated Authority
(3) agree that no changes are required to the Audit and Risk Committee's terms of reference.

Board Assurance Framework (BAF)

Introduction

The following document is the Trust's Board Assurance Framework (BAF) for 2023/24. 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 & Risk 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.

BAF Risks should be kept under review regularly, with a formal review and update mandated ahead of each meeting of the Audit & Risk Committee (meeting quarterly)

A guide to the criteria used to grade all risks within the Trust is provided in Appendix A.

Trust Strategic & Business Plan Objectives:

Strategic Objectives: (2023/24)	Aligned BAF Risk:
1. Deliver Great Care	SIR1 SIR1.1 SIR8 SIR15 SIR17
2. Healthcare for the future	SIR17

RESPONSIBLE COMMITTEES/BOARDS:

Finance & Performance Committee
- SIR1 (with QC)
- SIR1.1 (with QC)
- SIR8
- COV2 (with QC)
- SIR15
- SIR 17

People Committee
- SIR2

Quality Committee
- SIR1 (with F&PC)
- SIR1.1 (with QC)
- COV2 (with F&PC)

Board Assurance Framework (BAF)

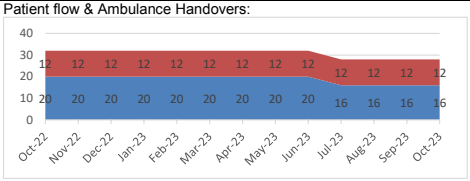
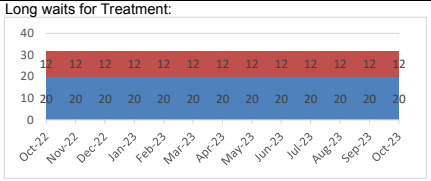
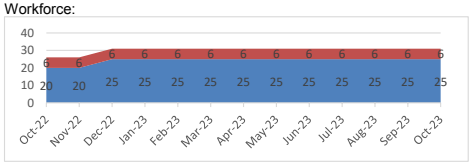
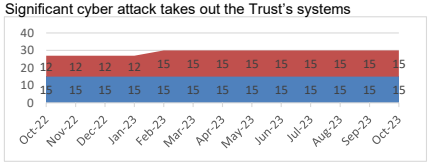
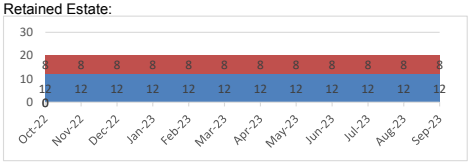
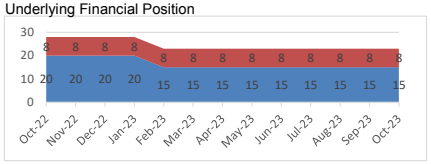
4. Anchor in our community	SIR8 SIR17

Version Control (2023/24):

Version:	Summary of changes:	Reported to:
V1.1	Undertaking full BAF update for the beginning of 2023/24 – alignment to Patient First Trust Objectives and risk update	Trust Board 25 May 2023
V1.2	Incorporating changes approved at Trust Board 25 May 2023 (removal of Covid-19 risk)	Various Committees June/July 2023
V1.3	Updates from lead Executives ahead of August Audit & Risk Committee meeting	Trust Board 31 August 2023
V1.4	Updates from lead Executives ahead of the November Audit & Risk Committee meeting	A&R Committee 9 November 2023

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	Patient flow & Ambulance Handovers: 		SIR 1.1	20	Long waits for Treatment: 	
SIR2	25	Workforce: 		SIR15	15	Significant cyber attack takes out the Trust's systems 	
SIR8	12	Retained Estate: 		SIR17	15	Underlying Financial Position 	

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**

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Board Assurance Framework (BAF)

Trust Strategic Objectives:	Deliver Great Care Healthcare for the Future	**Patient First Improvement Priorities:**	High Quality Care – Better by design People – Proud to belong

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	**Steve Curry, Chief Operating Officer** Last reviewed: ~~13/07/2023~~ 06/10/2023 Lead Committee: **Finance & Performance Committee** Also monitored by: **Quality Committee** Last reviewed: QC 07/09/2023 FPC 21/09/2023 Risk added to BAF: **Pre-2019**	**Patient flow & Ambulance Handovers:** Due to a combination of factors, primarily high number of patients with no criteria to reside, but also including constrained community and primary care capacity and workforce pressures, the flow of patients across the hospital is constrained. This results in delays to key targets within the Emergency Zone, including the timely treatment of patients and delayed ambulance handovers. In turn this has the potential to result in patient harm, poor patient experience, and reputational damage to the Trust. Note: Elements of this risk are outside of the Trust's direct control – 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) Criteria to Reside data Integrated Discharge Service Repatriation Policy UEC Board and Improvement Plan OPEL/ICI Escalation & COVID-19 surge policies/procedures Accountability Framework Divisional Review assessment of and support to Divisions. Internal Professional Standards Clinically led dynamic risk assessed approach to pre-emptive transfers out of the emergency department Winter bed capacity contingency secured (circa 50 beds) through surgical redesignation and medical flex-down. **External:** ~~COVID-19 Command & Control (External)~~ Whole System Operational Group (WSOG – external) OPEL escalation process in system forums (Whole System Operational Group, OOH Delivery Group) Initiation of NHSEI UEC Recovery Model Engagement with National UEC Improvement Team Discharge to Assess Winter pressure funding mechanisms UEC improvement plan New Same Day Emergency Care (SDEC) Model	**Internal Assurance** Board rounds and site management processes (1) Integrated Performance Report (2) Patient flow metrics – daily control centre information (1) Executive Team review of dashboards (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) UEC Board (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: **4** **(Almost Certain)** Residual impact: **4** **(Severe)** Residual risk rating: **16** **(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** **13/07/2023** Forecast trajectory (next 12 months): ↑	Not yet seeing evidence that investment in "Discharge 2 Assess" initiative is delivering planned improvements to discharge numbers or reducing proportion of patients with no criteria to reside (led by BNSSG/Sirona).	Working with ICS via the system Chief Executive group and the D2A Board to identify bridging strategies and short term mitigations to compensate for delayed D2A impact. (e.g., Transfer of care hub – see below) **Owner: Various (COO & CEO)** **Delivery date: Ongoing – review in August 2023** Trust is progressing in line with the national UEC plan, and is taking the lead on the establishment of a "Transfer of Care Hub", which will be a phased approach, intended to be fully functional for winter 2023/24 October 2023 Update: Some of the benefits of the ToC Hub are starting to be realised, but full functionality expected February 2024. **Due Date: February 2024 ~~October/December 2023~~** **Owner: COO**	Target likelihood: **3** **(Possible)** Target impact: **4** **(Severe)** Target risk rating: **12** **(High)**
							Other actions:	Urgent and Emergency Care Improvement Plan actively overseen and sponsored by Executive Leads. This plan has been revised for 2023/24 and is focused on internal actions, including revised discharge/flow process management (process improvement). **Owner: COO** **Due date: various actions – aiming for improvement ahead of winter 2023 (Oct/Dec 2023)**	
							BNSSG currently implementing a re-	Concerns raised via Integrated Care Board and Chief Executive	

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Board Assurance Framework (BAF)

				~~2022/23 BNSSG Care Hotel (15 beds for NBT)~~ ~~Brunel Level Six Additional Beds~~			procurement exercise which will reduce community bed access for NBT. Re-provision / compensatory provisioning via the local authority is not yet realised.	discussions. These discussions are ongoing. **Owner:** COO & Chief Executive **Due Date:** Winter 2023/24	

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Board Assurance Framework (BAF)

Trust Strategic Objectives:	Deliver Great Care Healthcare for the Future	**Patient First Improvement Priorities**	High Quality Care – Better by design People – Proud to belong

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 1.1	**Steve Curry, Chief Operating Officer** Last reviewed: ~~13/07/2023~~ 06/20/2023 Lead Committee: **Finance & Performance Committee** Also monitored by: **Quality Committee** Last reviewed: QC 07/09/2023 FPC 21/09/2023 Risk added to BAF: **January 2022**	**Long waits for Treatment** **The impact of the Covid-19 pandemic, together with high numbers of patients with no criteria to reside, workforce/skills shortages, and complex clinical pathways, has resulted in a demand/capacity gap in cancer services, diagnostics, and planned care. This has the potential to result in long-waiting patients deteriorating and coming to harm, poor patient experience, and reputational damage to the Trust.** Note: drivers of this risk are outside of the organisation's direct control 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:** FLOW boards Integrated Discharge Service Repatriation Policy OPEL/ICI Escalation & COVID-19 surge policies/procedures Accountability Framework Internal Professional Standards Protected ~~Green~~ Elective Capacity. Use of WLI Use of independent sector Clinical Long-wait Harm Review Process (no wait related harm identified) Fortnightly Cancer Steering Group Cancer Improvement Plan Diagnostics Plan RTT Recovery Plan Agile and responsive IPC controls Well-rehearsed contingency process for managing immediate impacts of industrial action (i.e., safety heat-map, strike period booking avoidance etc.) ~~Brunel Level Six Additional Beds~~ **External:**	**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 [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] Trust Board presentations on Planned Care Trajectories, Cancer Performance 2022 [2] **External Assurance** System Delivery & Operational Group (external) [2]	Residual likelihood: **5** **(Almost Certain)** Residual impact: **4** **(Severe)** Residual risk rating: **20** **(High)** Previous residual risk rating: Residual risk rating last changed: Forecast trajectory (next 12 months): ⇔	Not yet seeing evidence that investment in "Discharge 2 Assess" initiative is delivering planned improvements to discharge numbers (led by BNSSG/Sirona), to allow increased surgical activity.	Ring fence additional elective capacity (Achieved Phase 1 in 2022 and maintained over winter. Phase 2 is underway and involves redesignating beds given to Medicine during Covid, back to surgery October 2023: this capacity has been secured and contributes to the controls for this risk. **Due date: June/July 2023** Longer term recovery relies on Community Diagnostics Centre and exploring opportunities for additional Elective Care Capacity in BNSSG via national Targeted Investment Fund (possible Elective Care Centre – Outline Business Case approved February 2023) October 2023: ECC business case approved. Moving to implementation. Expected go-live of January 2025. **Owner: CFO** **Due Date: ~~Full Business Case June 2023, and comes online 2024/25~~January 2025**	Target likelihood: **3** **(Possible)** Target impact: **4** **(Severe)** Target risk rating: **12** **(High)**

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Board Assurance Framework (BAF)

				Whole System Operational Group (WSOG – external) OPEL escalation process in system forums (Whole System Operational Group, OOH Delivery Group) Elective Recovery Fund Access (system-wide) EPRR metallic structures to oversee Industrial action (meeting commensurate with strike action)	National Tier 1 Cancer Escalation Status removed in December 2022 (3)		Issues that impact this risk, and which are being actively managed/mitigated: - Confirmed junior doctor and consultant strikes have and will continue to significantly impact planned care	Other actions: RTT Recover Plan Actions overseen at Executive level. Progress being impacted by ongoing industrial action; however, remedial actions ongoing. ~~Good progress and line of sight to national improvement targets.~~ (Ongoing – review ~~August~~ January 2024~~3~~) Diagnostics Plan to be compliant with national improvement trajectories by 31 March 2023 – delivered for 2022/23, revised plans for 2023/24. October 2023: This was achieved. **Owner: COO**	

Board Assurance Framework (BAF)

Trust Strategic Objectives:	Deliver Great Care Healthcare for the Future	**Patient First Improvement Priorities**	People – Proud to belong Commitment to our Community – In, and for, our 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 2	**Jacqui Marshall, Chief People Officer** Last reviewed: ~~25/07/2023~~ 31/10/2023 **People Committee** Last reviewed: 14/09/2023 Risk added to BAF: **Pre-2019**	**Workforce** **Due to healthcare workforce shortages at a national level, exacerbated by the local high cost of living, workforce demand is outstripping supply in key areas, including nursing, midwifery, and specialist consultant roles. This gives rise to the risk of:** - **Increased workload intensity leading to staff turnover,** - **Uncontrolled spend on expensive agency/temporary staff.** - **Increase in recruitment activity and associated costs.** - **Poor staff morale, and** - **Poor patient safety & experience.** ~~**High levels of turnover, coupled with national/system healthcare workforce shortages, exacerbated by cost of living crisis, means that demand is outstripping supply in key areas, including nursing.**~~ ~~**Consequences include**~~	Inherent likelihood: **5 (Almost Certain)** Inherent impact: **5 (Catastrophic)** Inherent risk rating: **25** **(Extreme)**	~~BNSSG~~ NBT Long Term Workforce Strategy & Plan People Oversight Group and sub-structure approved via People Committee and Trust Board in 2023. ~~Multi-professional Workforce Group overseeing mitigating work~~ ~~Medical Workforce Group overseeing mitigation work~~ ~~Retention & Staff Engagement Group~~ Retention interventions underpinned by Patient First Improvement Priority delivering a 1 and 5 year retention plan Award-winning, nationally recognised Staff Health & Wellbeing offering Buying & selling annual leave policy Itchy feet campaign ~~(relaunched)~~ Flexible working offer expanded Strong development and leadership offer (HELM) Increased opportunities through HELM Programme Increased use of traineeship and apprenticeships. Shared recruitment material and Employee Value Proposition for system recruitment. Faster Recruitment Process System-wide recruitment campaigns (e.g., HCA2022 and 2023) System Workforce Incentives Group	**Internal Assurance** Integrated Performance Report – HR/Well-Led section [2] People Committee deep-dives and performance review (quarterly) [2] Staff survey results & action plans [2] Exit interview data [1] Pulse Surveys [1] Freedom to Speak Up Reports [2] Triangulation Group Reports [1] Trust Board People Deep-dive March 2023 [2] Trust Board Safe Staffing Deep-dive April 2023 [2] Six-monthly update on Long Term Workforce Plan to Trust Board [1] ~~System-level workforce cell monitors and shares terms and conditions data and any operational WLI proposals to ensure transparency and parity.~~ ~~[2]~~ **External Assurance** Gender pay-gap report and WRES/WDES data [3] National Retention Data [3] Staff Survey Results [3]	Residual likelihood: **5 (Almost certain)** Residual impact: **5 (Catastrophic)** Residual risk rating: **25** **(Extreme)** Previous residual risk rating: **4x4=16 3x4=12 5x4=20** Residual risk rating last changed: **12/08/2020 05/10/2021 05/01/2023** Forecast trajectory (next 12 months): ⟺	There is a significant gap in growing our own apprenticeships to mitigate future workforce gap risks. There is potential competition between providers within the BNSSG ICS and the wider South West for the same staff, and there are identified differentials in grading between similar roles.	Business case being developed as part of the workforce plan. **Owner: Sarah Margetts** **Due date: 31 March 2024** Long Term Workforce Plan priorities are: Developing apprenticeship pathways by 6% Developing new clinical roles and innovating team design Deliver 1 and 5 year Retention Plan Enhanced recruitment Oversight will be via the People Operational Group and progress reports to People Committee/Trust Board on a six monthly basis **Owner: Jacqui Marshall** **Due date: 24 March 2023** ~~BNSSG Workforce Programme Board focusing on development of shared workforce priorities, to inform system workforce plan. Being relaunched early 2023/24.~~ ~~**Owner:** Deputy Chief People Officer~~ ~~**Due Date:** outputs expected August/September 2023.~~	Target likelihood: **3 (Possible)** Target impact: **4 (Severe)** Target risk rating: **12** **(High)**

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Board Assurance Framework (BAF)

		~~Increased reliance on expensive agency staff~~ ~~increasing turnover, which result in dramatic increase in recruitment activity and associated costs~~ ~~Poor staff morale~~ ~~Poor patient safety & experience due to staff shortages.~~ Elements of this risk are outside of the Trust's direct control (numbers of professionally registered medics and other specialists controlled via HEE national quotas and royal colleges) – actions are focused on those areas that are within the organisation's influence. INTERNALLY & EXTERNALLY DRIVEN RISK		Financial wellbeing offering (overseen by Culture & Wellbeing working group).	NHS England Workforce Plan 2023 [3]		There are insufficient trained staff in certain professions (including nursing, sonographers, histopathologists etc.) to meet ongoing and increasing needs.	Expanded International recruitment pipeline – ongoing for 2023/24. **Due date: review Q4 2023/24** **Owner: CPO** Creating an internal People Oversight Group, with sub-groups to look at 3-6 month rosters, recruitment and retention hot-spots and to review the use of incentives. **Delivery date:** June 2023 (complete) **Owner:** CPO Delivery of new "Faster, Fairer Recruitment" process to streamline processes and target hot spots **Delivery date:** Next Update to Executive Management Team June 2023 **Owner:** Deputy CPO Divisional Workforce Planning sessions being scheduled for 2023/24 to support development of clear forward plans within clinical divisions (informing Five-year workforce plan) **Owner:** Deputy Chief People Officer **Due Date:** meetings from June 2023 Developing clear Balanced People Scorecard to provide better "one-stop" assurance on People priorities. **Owner:** Deputy Chief People Officer **Due Date:** first iteration available July 2023.	

Board Assurance Framework (BAF)

Trust Strategic Objectives:	Deliver Great Care Anchor in the Community	Patient First Improvement Priorities	Sustainability – Making best use of limited resources

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	**Glyn Howells, Chief Finance Officer** Last reviewed: ~~27/07/2023~~ 04/10/2023 **Finance & Performance Committee** Last reviewed: 21/09/2023 Risk added to BAF: **Pre-2019**	**Retained Estate** **Parts of the retained estates are aging and approaching the point where significant refurbishment is required. Without decant facilities or alternative provision this work cannot be undertaken in a proactive manner, exposing the Trust to the risk of unplanned service failure, and associated degradation of patient safety, operational performance, and patient/staff experience.** 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 10-year Estates Capital Plan (CRISP) Interim Estates Plan 2022 Health & Safety Committee & policies Preventative Maintenance Programme Facilities help-desk (to advise on any deterioration of estate) Executive and Board Insight walk-arounds Expected capital programme slippage used as a contingency for unexpected works in the retained estate Up-to-date Fire Safety Policy and Fire Safety Manager appointed (November 2022) 2023/24 Capital Plan approved prioritising significant fire and ventilation remediation spend	**Internal Assurance** Capital Planning reports to Finance & Performance Committee (twice-yearly) [2] Health & Safety reports to People Committee (quarterly + annual report) [2] 2022 Fire Safety Audit Actions progress reported to People Committee (only ~~two~~ one outstanding actions remain – ~~May~~ October 2023) [3] Fire and ventilation risks are understood and recorded on a granular (building) level, with individual remediation plans. [3] Compliance Governance committees reviewing risks and incidents; COIC, Water Safety Group, Ventilation Safety Group, Electrical Safety Group, Fire Safety Group [2] ERIC Benchmarking confirms relative position to other Trusts backlog status (annual process) [2] Fire risk audits undertaken regularly across the site [1] Interim Estates Plan 2022 [1] Report to Finance & Performance Committee on Retained Estates Trust Level Risks and mitigations – September 2023. [1] Health & Safety Internal Audit Report – Green Amber Rating – provides	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): ⇔	Weaknesses in the Trust's Fire Safety governance has been identified, including training and audits. This is reflected on the Trust's operational risk register. 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. There is a growing concern that due to the nature of the improvement works that are needed in the retained estate that there will be a need to decant buildings to facilitate this work namely, Elgar House, NICU, CDS and Gynae Theatres. These works are mainly related to fire	Longer-term Fire Improvement Plan has been created and is being delivered and embedded. Update May 2023: only two items arising from the Fire Improvement Plan remain to be completed. On track to deliver by September 2023 Update September 2023: only one action remains outsanding. **Due Date: ~~September 2023~~January 2024** **Owner: Operational Director of Estates & Facilities** Developing a long-term WACH Estates remediation plan. For 2023/24 Gynae theatres and CDS ventilation are being prioritised for completion. **Due Date:** - Remediation plan ~~September~~ October 2023 - 2023/24 prioritized areas March 2024. **Owner:** CFO/Director of Operational Estates and Facilities Elective Care Centre ~~OBC~~ FBC approved nationally in ~~February~~ September 2023. ~~FBC under development.~~ Go-live anticipated to be February 2025. While this	Target likelihood: **2 (Unlikely)** Target impact: **4 (Severe)** Target risk rating: **8** **(High)**

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Board Assurance Framework (BAF)

					assurance of robust oversight function. [3] **External Assurance** Six Facet Survey completed 2020 [3]		improvement works and ventilation improvement works. Revised System capital allocation and prioritisation processes had added complexity and delay to capital planning and resulted in reduced capital availability.	will be focused on elective recovery. it will provide contingency in the event of catastrophic failure of other theatres and will ultimately be available for decant in year to come. ~~July update: FBC approved by NBT and ICB in June/July. Submission to national team imminent.~~ **Due date:** ~~August~~ Feb 2025~~2023~~ **Owner:** Chief Finance Officer Close system working and aligned Acute view via the Acute Provider Collaborative. Better planning system being developed for 2023/24. September 2024: update: Aligned Acute provider business planning has commenced. **Due date:** ~~September~~ April 2024~~3~~ **Owner:** Chief Finance Officer Working with ICB to undertake system capital prioritisation focus on critical estates/clinical risks in all partner organisation to inform discussion with regional and national finance teams. **Due date:** November 2023 **Owner:** Chief Finance Officer	

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Board Assurance Framework (BAF)

Trust Strategic Objectives:	Deliver Great Care Healthcare for the Future	Patient First Improvement Priorities	High Quality Care – Better by design Innovate to Improve – Unlocking a better future

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: ~~06/03/2023~~ 29/09/2023 **Finance & Performance Committee** Last reviewed: FPC 21/09/2023 Risk added to BAF: **Pre-2019**	**Cyber Security** ~~**A significant cyber-attack takes out the Trust's IT systems leading to a failure of business continuity and the inability to treat patients.**~~ **A significant cyber-attack results in the loss of all Trust IT systems for an extended period leading to a failure of business continuity and the inability to treat patients.** 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 such as password policies and information governance training Daily immutable system back-ups Business continuity and recovery plans Timely server and software updates Continuous upgrades to supported versions of Windows and Microsoft 365 Ongoing assessments of software with removal or mitigations for outdated and unsupported products Ongoing monitoring and software upgrades (see further information under "gaps" and "planned actions")** Office 365 cloud-to-cloud backups for email and teams data NHS Digital cyber security programme Care Cert Server and Network vulnerability scanners Ongoing monitoring and software upgrades (see further information under "gaps" and "planned actions")** Office 365 cloud-to-cloud backups for email and teams data Microsoft Defender Endpoint (antivirus) live across Microsoft Windows estate BNSSG Cyber Security Governance Group aligning organisational standards and ensuring best practice.	**Internal Assurance** ~~Data security protection toolkit return (Highest compliance in 2022)~~ [1] ~~Cyber security report (monthly to IM&T Divisional Board and Audit & Risk Committee)~~ [2] ~~Audit Committee Assurance Report (February 2022 and scheduled March 2023)~~ [1] Data security protection toolkit return ("Standards Met" 2023) [1] Cyber security report (monthly to IM&T Divisional Board and Audit & Risk Committee) [2] Audit Committee Assurance Report (six monthly) (March 2023, August 2023, scheduled March 20204) [1] **External Assurance** Information Commissioner Audit December 2019 [3] ~~Penetration Tests and assessments, October 2020~~ [2] ~~KPMG Data Security Protection Toolkit Audit 2022 "significant Assurance"~~ [3] ~~KPMG Data Security Protection Toolkit Audit March 2023~~ [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 to reduce the likelihood of a cyber-security incident, through updating networks and migration to up-to-date operating systems. In 2022-2023: - Over 8000 end point devices upgraded to latest version of Windows 10 ~~Legacy Windows servers reduced from 40 to 6~~ - Legacy Windows 2008 servers eradicated - Vulnerability scanner in operation across the trust networks	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: see below** ~~SW SIEM is live and operational for log retention; however, it requires additional investment or a switch to an alternative product to increase functionality.~~ ~~**Target for change: June 2023.**~~ The SW SIEM log retention tool has been decommissioned due to lack of national funding. This has been replaced with a new local solution which better meets our needs. **Target for change: June 2023 - Met.** Ongoing remediation work for areas highlighted by the vulnerability scanner. The BNSSG Cyber Security Governance Group has been established with NBT leading its creation and operating as chair. The group is focusing on governance reporting across the ICS and considering converging Cyber Security toolsets. **Target April 2023 - Met.** Following the NHS Digital backup audit we are creating a business case for funding in 2024/25 to improve or replace the existing solution. **Target June 2023, for completion of review - met.** New target June 2024 for business case review.	Target likelihood: **3 (Possible)** Target impact: **5 (Catastrophic)** Target risk rating: **15** **(High)**

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18.1

Board Assurance Framework (BAF)

				NHS Digital South West Regional Cyber Security Group for direction and access to national solutions	Penetration Tests and assessments, February 2023 (2) KPMG Data Security Protection Toolkit Audit 2023 "significant Assurance" (3) KPMG Data Security Protection Toolkit Audit March 2023 (3)			Network micro-segmentation project to block access and restrict spread cyber attacks: **Target June 2023 for Business Case approval – Met**. Project completion December 2024. Remove or mitigate 146 Windows 2012 servers from the estate; currently 74 remain. **Target completion March 2024.** New planned actions: - Increase risk and audit updates from annual to six monthly Improve email filtering using additional tools ~~New BNSSG Cyber Security Governance Group to be established to assess compliance across the ICS and look to converging Cyber Security toolsets. Target April 2023.~~ ~~Identify improvements to backup infrastructure to improve capability in line with NHS Digital backup audit. Target June 2023.~~ ~~Network micro-segmentation project to block access and restrict spread cyber attacks: Funding June 2023, Completion July 2024~~ ~~Remove or mitigate 146 Windows 2012 servers from the estate, completion March 2024.~~	

18.1

Board Assurance Framework (BAF)

Trust Strategic Objectives:	Deliver Great Care Healthcare for the Future	**Patient First Improvement Priorities**	Sustainability – Making best use of our limited resources

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 17	**Glyn Howells, Chief Finance Officer** Last reviewed: ~~27/07/2023~~ 04/10/2023 Lead Committee: **Finance & Performance Committee** Last reviewed: 21/09/2023 Risk added to BAF: October 2022	**Underlying Financial Position** There is a risk that if the Trust does not deliver its planned financial position sustainably, and reduce its underlying deficit, it will be subject to increased regulatory intervention. This may include a loss of decision-making autonomy, increased scrutiny, and increased reporting requirements.	Inherent likelihood: **4 (Likely)** Inherent impact: **5 (Catastrophic)** Inherent risk rating: **20** **(Extreme)**	**Internal:** Internal Planning Processes Divisional Reviews Business Case Review Group Financial Sustainability Reviews CIP Board oversight of plans Exceptions to Budgeted Establishment Group (EBE) Procurement controls (enhanced) Monthly Budget Monitoring 2022 Training and support for Clinical Divisions - CIP development and delivery Procurement "Grip & Control" training available to Divisions and Directorates HELM Leadership Programme **External:** ICS Directors of Finance (DoF) Group System Planning Processes System Finance & Estates Group Monthly Financial Returns and review with NHSE	Monthly Finance Report (Trust Board, FPC, Exec Management Team, Senior Leadership Group) (2) Divisional Reviews (2) Weekly CIP Monitoring Reports (1) Monthly consolidated System Finance Report (2) Annual Internal Audit Report – Financial Controls (3) External Audit – Value for Money Review (3) Model Hospital Benchmarking (3) Reference Costs Submission (3) 90% of 2023/24 CIP has been identified (1)	Residual likelihood: **3 (Possible)** Residual impact: **5 (Catastrophic)** Residual risk rating: **15** **(High)** Previous residual risk rating: **4x5=20** Residual risk rating last changed: **01/03/2023** Forecast trajectory (next 12 months): ↓	10% of CIP for 2023/24 remains unidentified Uncertainty around recurrent funding for recurrent inflationary pressures and recurrent elective services recovery costs	Revised CIP planning approach in place, Central Trust-wide ~~14~~schemes receiving enhanced support to develop CIP plans. July 2023: 25% of 2023/24 CIP is delivery in Q1. This represents significant improvement on 2022/23. October 2023: 50% of CIP is on track for delivery by the time of Month 6 reporting. **Delivery date:** To be reviewed in ~~November~~ January 2024~~3~~. **Owner:** CFO Providing evidence of impact and lobbying national NHS leadership. Using longer term purchasing strategy to mitigate inflationary pressures. July 2023: NBT engaged in regional procurement approach for energy. This is ongoing. **Delivery date:** 31 March 2024 **Owner:** CFO Ongoing discussions with System partners regarding appropriate funding for service changes in 2023/24. This remains an ongoing issue.	Target likelihood: **2 (Unlikely)** Target impact: **4 (Severe)** Target risk rating: **8** **(High)**

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Commented [XB1]: Likely to reduce as CIP continues to be delivered and the size of the potential shortfall drops below 1% of turnover (£8m). The score will reduce to 3x4. Likely to be in December/January based on current trajectory.

18.1

Board Assurance Framework (BAF)

							Culture of robust financial control has reduced during the Covid-19 pandemic due to different financial rules and leadership/staff turnover	July 2023 update: most issues resolved. Final queries to be finalise by ~~Sepetmber~~September September 2023: Only remaining issues is around national rules for allocation of elective recovery funding and the impact of industrial action. Clarity expected by January 2024. **Delivery date:** ~~30 September 2032~~January 2024 **Owner:** Deputy Chief Finance Officer HELM is being rolled out. Additionally, a new procurement system has been approved and will be in place by ~~31/03/2024~~end of June 2024.	

18.1

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

Terms of Reference for the Audit & Risk Committee

Chair:	Non-Executive Director
Other Members:	The Committee will be appointed by the Trust Board from amongst the non-executive directors of the Trust and shall consist of not less than three members. One of the members will be appointed Chair of the Committee by the Trust Board. At least one of the members of the Committee will have recent and relevant financial experience. The Chair of the Trust will not be a member of the Committee.
Other Attendance:	The Audit & Risk Committee may invite non-members to attend all or part of its meetings as it considers necessary and appropriate, at the discretion of the Chair. In addition to members of the Audit & Risk Committee, the following shall normally attend all meetings and may contribute to discussions, but have no voting rights nor contribute to the quorum: • Chief Finance Officer • Assistant Director of Finance (Financial Services) • Director of Corporate Governance/Trust Secretary • Deputy Trust Secretary • Head of Internal Audit • Senior management representatives from the appointed external auditors • Counter Fraud Specialist • Director of Procurement (for relevant agenda items only) The Accountable Officer should be invited to attend meetings and should discuss at least annually with the Committee the process for assurance that supports the annual governance statement. The Accountable Officer should also attend when the Committee considers the draft annual governance statement and the annual report and accounts. Other executive directors/managers should be invited to attend, particularly when the Committee is discussing areas of risk or operation that are the responsibility of that director/manager. Attendance at meetings is essential. In exceptional circumstances when an Executive Director cannot attend, they must arrange for a fully briefed deputy of sufficient seniority to attend on their behalf. Representatives from other organisations and other individuals may be invited to attend on occasion. The Trust Chair may be invited to attend meetings of the Committee in order that they can understand how the Committee works but will have no voting rights.

	The Head of Internal Audit, the representative of External Audit and the Counter Fraud Specialist have a right of direct access to the Chair of the Committee. The Committee may ask any or all of those who normally attend but who are not members to withdraw to facilitate open and frank discussion of particular matters.
Quorum:	The quorum for the Audit & Risk Committee is at least two Non-Executive Director member.
Declaration of Interests	All members must declare any actual or potential conflicts of interest relevant to the work of the Audit & Risk Committee, which shall be recorded in the minutes accordingly. Members should exclude themselves from any part of a meeting in which they have a material conflict of interest. The Chair will decide whether a declared interest represents a material conflict.
Frequency of Meetings:	The Audit & Risk Committee will meet at least five times a year, timed in accordance with the discharge of its key responsibilities. At least once a year the Committee will meet privately with the external and internal auditors.
Notice of Meetings:	The Chair may call additional meetings where these are deemed necessary. The Trust Board, Accountable Officer, external auditors or head of internal audit may request an additional meeting if they consider that one is necessary. Unless otherwise agreed, notice of each meeting confirming the venue, time and date together with an agenda of items to be discussed and supporting papers, shall normally be forwarded to each member, and any other person required to attend, no later than five working days before the date of the meeting. Decisions may be taken by written resolution upon the agreement of the majority of members of the Committee in attendance, subject to the rules on quorum.
Inputs:	The Audit & Risk Committee will receive reports on issues within the remit of the meeting, so as to ensure timely discussion and decision-making. This will include: • Trust-Level Risks and BAF report • External Audit Progress Report • Internal Audit Progress Report & Recommendation Tracker • Counter Fraud Progress Report • Bi-Annual Conflict of Interest Report • Losses and Salary Overpayments

	• Single Tender Actions Individual members may also raise concerns/risks/issues relevant to the meetings remit on an ad hoc basis but will do so with sufficient notice to ensure that meeting agenda can be set and managed effectively. The Audit & Risk Committee can request a report on any subject or issue relevant to its terms of reference.
Outputs:	The Audit & Risk Committee shall produce a set of minutes and a log of actions arising. The Committee shall issue an upward report to Trust Board following each meeting. The Committee will provide the Trust Board with an Annual Report, timed to support finalisation of the accounts and the Annual Governance Statement, summarising its conclusions from the work it has done during the year and including the following: • The fitness for purpose of the Trust's assurance framework. • The completeness and 'embeddedness' of risk management in the Trust. • The integration of the governance arrangements. • The appropriateness of the evidence that shows the organisation is fulfilling regulatory requirements relating to its existences as a functioning business. • The robustness of the processes behind the quality accounts. • A description of how the Committee has fulfilled its terms of reference. • Give details of any significant issues that the Committee considered in relation to the financial statements and how they were addressed.
Responsible for the following Strategies and Policies:	Strategies: • Risk Policies: • Finance • Standing Orders • Risk
Sub-Committees:	N/A
Committee Secretary:	The Corporate Governance Team is responsible for: • Agreement of agenda and collation of papers. • Taking the minutes and keeping a record of actions arising and issues to be carried forward. • Provision of a highlight report of the key business undertaken to the Trust Board following each meeting

1. Purpose

1.1 The Audit & Risk Committee is established to be a sub-Committee of the Trust Board and is the Board assurance committee for risk management, internal audits, external audits and counter fraud.

2. Authority

2.1 The Audit & Risk Committee is a sub-group of the Trust Board from which it receives its authority. Its constitution and terms of reference shall be as set out in this document, subject to amendment.

3. Duties

3.1 The primary role and function of the Committee is as follows:

3.1.1 **Integrated Governance, Risk Management and Internal Control**

3.1.1.1 The Committee shall review the establishment and maintenance of an effective system of integrated governance, risk management and internal control, across the whole of the organisation's activities (clinical and non-clinical), that supports the achievement of the organisation's objectives.

3.1.1.2 In particular, the Committee will review the adequacy of:

- All risk and control related disclosure statements, in particular the Annual Governance Statement attached to the Annual Report and Accounts, together with any accompanying Head of Internal Audit Statement, external audit opinion or other appropriate independent assurances, prior to submission to the Trust Board.
- The underlying assurance processes that indicate the degree of the achievement of corporate objectives, the effectiveness of the management of principal risks and the appropriateness of the above disclosure statements.
- The policies for ensuring compliance with relevant regulatory, legal and code of conduct requirements and related reporting and self-certification
- The policies and procedures for all work related to counter fraud, bribery and corruption as set out in the NHS Standard Contract and as required by the NHS Counter Fraud Authority 7.3 In carrying out this work the Committee will primarily utilise the work of internal audit, external audit and other assurance functions, but will not be limited to these sources. It will also seek reports and assurances from directors and managers as appropriate, concentrating on the over-arching systems of integrated governance, risk management and internal control, together with indicators of their effectiveness.

3.1.1.3 This will be evidenced through the Committee's use of an effective assurance framework to guide its work and that of the audit and assurance functions that report to it.

3.1.1.4 The Committee shall also ensure that the Trust has robust risk management systems and processes in place and shall receive a regular report setting out all Trust Level Risks and the Board Assurance Framework. The Committee will actively seek assurance that:

- an up-to-date risk register is maintained, and that relevant staff are able to access the risk register to raise concerns and know that concerns will be reviewed and addressed.
- act as the forum for risk to be discussed, and ensure that where serious concerns are raised, action is taken, and that action plans are carried through to completion, and the reporting loops closed. This may be progressed directly by the Committee or via

delegation to other key committees (see below). In doing so, the Committee will ensure that there are robust links with clinical and non-clinical directorates to ensure a culture of effective risk management is present throughout the organisation. 7.6 As part of its integrated approach, the Committee will have effective relationships with other key committees - for example the four other assurance committees of the Trust Board - (Finance and Performance, People, Charity, Quality, and Patient and Carer Experience Committee) so that it understands processes and linkages. These other Committees must not usurp the Committee's role.

3.1.2 **Internal Audit**

3.1.2.1 The Committee will ensure that there is an effective internal audit function that meets the requirements of the Public Sector Internal Audit Standards 2017 and provides appropriate independent assurance to the Committee, Accountable Officer and the Trust Board. This will be achieved by:

- Considering the provision of the internal audit service and the costs involved.
- Review and approving the annual internal audit plan and more detailed programme of work, ensuring that this is consistent with the audit needs of the Trust as identified in the assurance framework and with reference to the risk register.
- Considering the major findings of internal audit work; and management's response to recommendations made.
- Ensuring co-ordination between the internal and external auditors to optimise the use of audit resources.
- Ensuring that the internal audit function is adequately resourced and has appropriate standing within the organisation.
- Carrying out an annual review of the effectiveness of internal audit.
- Regular monitoring of key performance metrics aligned to the delivery of the service.

3.1.3 **External Audit**

3.1.3.1 The Committee will review and monitor the external auditors' independence and objectivity and the effectiveness of the audit process. In particular, the Committee will review the work and findings of the external auditors and consider the implications and management's response to their work. This will be achieved through:

- Considering the appointment and performance of the external auditors, as far as the rules governing the appointment permit.
- Discussing and agreeing with the external auditors, before the audit commences, the nature and scope of the audit as set out in the annual plan.
- Discussing with the external auditors their evaluation of audit risks and assessment of the Trust and the impact on the audit fee.
- Reviewing all external audit reports, including the report to those charged with governance (before its submission to the Trust Board) and any work undertaken outside the annual audit plan, together with the appropriateness of management responses.
- Ensuring there is in place a clear policy for the engagement of external auditors to supply non-audit services.
- Regular monitoring of key performance metrics aligned to the delivery of the service.

3.1.4 **Counter Fraud**

3.1.4.1 The Committee will satisfy itself that the Trust has adequate arrangements in place for counter fraud, bribery and corruption that meet NHS Counter Fraud Authority's standards and will review the outcomes of work in these areas.

3.1.4.2 Specifically it will:

- Approve the Trust's Counter Fraud strategy and Local Counter Fraud Specialist annual work plan, including the resources allocated for the delivery of the strategy and work plan.

- Receive and review progress reports of the Local Counter Fraud Specialist against the four principles of the overall NHS Counter Fraud Strategy.
- Monitor the implementation of management actions arising from counter fraud reports.
- Receive and discuss reports arising from quality inspections by the counter fraud service.
- Make recommendations to the Trust Board as appropriate in respect of counter fraud at the Trust.
- Receive, review and approve the annual report of the Local Counter Fraud Specialist.

3.1.5 **Other Assurance Functions**

3.1.5.1 The Committee will review the findings of other significant assurance functions, both internal and external to the Trust; and consider the implications to the governance of the Trust.

3.1.5.2 These will include, but will not be limited to:

- Any reviews by Department of Health and Social Care arm's length bodies, or regulators and inspectors, - for example the Care Quality Commission, NHS Resolution etc.
- Professional bodies with responsibility for the performance of staff or functions – for example, Royal Colleges and accreditation bodies.

3.1.5.3 The Committee will review the work of other committees within the Trust, where their work can provide relevant assurance to the Audit Committee's own scope of work. In particular, this will include the four other assurance committees of the Trust Board (Finance and Performance, People, Charity, Quality, and Patient and Carer Experience Committee).

3.1.5.4 In reviewing the work of the Quality Committee, and issues around clinical risk management, the Audit Committee will wish to satisfy itself on the assurance that can be gained from the clinical audit function.

3.1.5.5 The Committee will review and make recommendations to the Trust Board for any changes to the Standing Orders, Standing Financial Instructions and Scheme of Delegation.

3.1.5.6 The Committee will examine the circumstances associated with each occasion when Standing Orders are waived.

3.1.6 **Management**

3.1.6.1 The Committee will request and review reports, evidence and assurances from directors and managers on the overall arrangements for governance, risk management and internal control.

3.1.6.2 The Committee may also request specific reports from individual functions within the Trust, for example, clinical audit, as may be appropriate to the understanding of the overall arrangements.

3.1.7 **Financial Reporting**

3.1.7.1 The Committee will monitor the integrity of the financial statements of the Trust and any formal announcements relating to the Trust's financial performance.

3.1.7.2 The Committee will ensure that the systems for financial reporting to the Trust Board, including those of budgetary control, are subject to review for completeness and accuracy of the information provided.

3.1.7.3 The Committee will review the Trust Annual Report and financial statements before submission to the Trust Board. It will focus on:

- The wording in the Annual Governance Statement and other disclosures relevant to the terms of reference of the Committee.

- Changes in, and compliance with, accounting policies, practices and estimation techniques.
- Unadjusted misstatements in the financial statements.
- Significant judgements in preparation of the financial statements.
- Significant adjustments resulting from the audit.
- Letters of Representation.
- Explanations for significant variances.

4. Monitoring and Effectiveness

4.1 The Committee shall have access to sufficient resources to carry out its duties, including access to company secretarial assistance as required.

4.2 It will review its own performance, at least annually, review its constitution and terms of reference to ensure it is operating at maximum effectiveness and recommend any changes it considers necessary to the Trust Board for approval.

4.3 As per NHSE/I requirements the Committee will carry out an annual self-assessment to inform above review of its Terms of Reference.

Version:	1.4
Ratified by / responsible committee:	Approved by Audit Committee – 10 November 2022 To be ratified by Trust Board on 24 November 2022
Date ratified:	Trust Board – 24 November 2022
Name of originator / author:	Trust Secretary
Lead:	Glyn Howells, Chief Finance Officer
Date issued:	November 2022
Review date:	November 2023

Terms of Reference for the Auditor Panel

Chair:	Non-Executive Director
Other Members:	The auditor panel will comprise the entire membership of the Audit & Risk Committee with no additional appointees. This means that all members of the auditor panel are independent Non-Executive Directors. The Chair of the Audit & Risk Committee will be appointed Chair of the auditor panel by the Trust Board. The Chair of the Trust will not be a member of the auditor panel. The auditor panel Chair and/or members of the panel can be removed in line with rules agreed by the Trust Board.
Other Attendance:	The auditor panel's Chair may invite executive directors and others to attend depending on the requirement of each meeting's agenda. These invitees are not members of the auditor panel.
Quorum:	To be quorate, independent members of the auditor panel must be in the majority AND there must be at least two independent members present or 50% of the auditor panel's total membership, whichever is the highest.
Declaration of Interests	Conflicts of interest must be declared and recorded at the start of each meeting of the auditor panel. A register of panel members' interests must be maintained by the panel's Chair and submitted to the Trust Board in accordance with the Trust's existing conflicts of interest policy. If a conflict of interest arises, the Chair may require the affected panel member to withdraw at the relevant discussion or voting point.
Frequency of Meetings:	The auditor panel will consider the frequency and timing of meetings needed to allow it to discharge its responsibilities but as a general rule will meet on the same day as the Audit & Risk Committee.
Notice of Meetings:	The Chair may call additional meetings where these are deemed necessary. The Trust Board, Accountable Officer, external auditors or head of internal audit may request an additional meeting if they consider that one is necessary. Unless otherwise agreed, notice of each meeting confirming the venue, time and date together with an agenda of items to be discussed and supporting papers, shall normally be forwarded to each member, and any other person required to attend, no later than five working days before the date of the meeting. Decisions may be taken by written resolution upon the agreement of the majority of members of the Committee in attendance, subject to the rules on quorum.

Inputs:	Auditor panel business will be identified clearly and separately on the agenda and audit committee members will deal with these matters as auditor panel members NOT as Audit & Risk Committee members. The panel's Chair shall formally state at the start of each meeting that the auditor panel is meeting in that capacity and NOT as the audit committee.
Outputs:	The Chair of the auditor panel must report to the Trust Board on how the auditor panel discharges its responsibilities. The minutes of the panel's meetings must be formally recorded and submitted to the Trust Board by the panel's Chair. The Chair of the auditor panel must draw to the attention of the Trust Board any issues that require disclosure to the full Trust Board, or which require executive action.
Responsible for the following Strategies and Policies:	N/A
Sub-Committees:	N/A
Committee Secretary:	The Corporate Governance Team is responsible for: • Agreement of agenda and collation of papers. • Taking the minutes and keeping a record of actions arising and issues to be carried forward. • Provision of a highlight report of the key business undertaken to the Trust Board following each meeting

1. Purpose

1.1 The Trust Board hereby resolves to nominate its Audit Committee to act as its auditor panel in line with schedule 4, paragraph 1 of the *Local Audit and Accountability Act 2014*.

1.2 The auditor panel is a Non-Executive Committee of the Trust Board and has no executive powers, other than those specifically delegated in these terms of reference.

2. Authority

2.1 The auditor panel is authorised by the Trust Board to carry out the functions specified below and can seek any information it requires from any employees/relevant third parties. All employees are directed to co-operate with any request made by the auditor panel.

2.2 The auditor panel is authorised by the Trust Board to obtain outside legal or other independent professional advice – for example, procurement specialists, and to secure the attendance of outsiders with relevant experience and expertise if it considers this necessary. Any 'outsider advice' must be obtained in line with the organisation's existing rules.

3. Duties

The auditor panel's functions are to:

3.1 Advise the Trust Board on the selection and appointment of the external auditor. This includes:

- Agreeing and overseeing a robust process for electing the external auditors in line with the organisation's normal procurement rules.
- Making a recommendation to the Trust Board as to who should be appointed.
- Ensuring that any conflicts of interest are dealt with effectively.

3.2 Advise the Trust Board on the maintenance of an independent relationship with the appointed auditor.

3.3 Advise (if asked) the Trust Board on whether or not any proposal form the external auditor to enter into a liability limitation agreement as part of the procurement process is fair and reasonable.

3.4 Advise on (and approve) the contents of the Trust's policy on the purchase of non-audit services from the appointed external auditor.

3.5 Advise the Trust Board on any decision about the removal or resignation of the external auditor.

4. Monitoring and Effectiveness

4.1 The terms of reference will be reviewed on an annual basis.

Version:	0.3
Ratified by / responsible committee:	Approved by Audit Committee – 10 November 2022 To be ratified by Trust Board on 24 November 2022
Date ratified:	Trust Board – 24 November 2022
Name of originator / author:	Trust Secretary
Lead:	Glyn Howells, Chief Finance Officer
Date issued:	November 2022
Review date:	November 2023