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

Trust Board Meeting – Public

Thursday 28 July 2022
10.00 – 13.00
Virtual via Microsoft Teams
A G E N D A

No.	Item	Purpose	Lead	Paper	Time
OPENING BUSINESS					
1.	Welcome and Apologies for Absence: Neil Darvill, Chief Digital Information Officer, (David Hale to deputise)	Information	Chair	Verbal	10.00
2.	Declarations of Interest	Information	Chair	Verbal	10.02
3.	Minutes of the Public Trust Board Meeting Held on 26 May 2022	Approval	Chair	Enc.	10.05
4.	Action Chart from Previous Meetings	Discussion	Trust Secretary	Enc.	10.06
5.	Matters Arising from Previous Meeting	Information	Chair	Verbal	10.08
6.	Chair's Business	Information	Chair	Verbal	10.10
7.	Chief Executive's Report	Information	Chief Executive	Enc.	10.20
KEY DISCUSSION TOPIC(S)					
8.	Staff and Patient Story: Cossham Dialysis Unit	Discussion	Chief Nursing Officer	Pres.	10.30
PEOPLE					
9.	Guardian of Safe Junior Doctor working hours	Discussion	Chief Medical Officer	Enc.	10.50
10.	Medical Revalidation & Appraisal Annual Report	Discussion	Chief Medical Officer	Enc.	11.05
11.	People Committee Upward Report	Information	NED Chair	Enc.	11.20
BREAK (10 mins)					**11.30**
FINANCE, IM&T & PERFORMANCE					
12.	Integrated Performance Report	Discussion	Chief Operating Officer	Enc.	11.40
13.	Healthier Together ICS Green Plan	Discussion /Approval	Chief Finance Officer	Enc.	12.05
14.	Finance & Performance Committee Upward Report 14.1. Finance Month 3 Report	Information	NED Chair	Enc.	12.25
QUALITY					
15.	Quality Committee Upward Report	Information	NED Chair	Enc.	12.35

No.	Item	Purpose	Lead	Paper	Time
	15.1. Learning from Deaths Annual Report and Summary Paper 15.2. CQC Letter: Feedback from Surgery Monitoring Visit		Chief Medical Officer		
GOVERNANCE					
16.	Patient & Carer Committee Upward Report	Information	NED Chair	Enc.	12.45
CLOSING BUSINESS					
17.	Any Other Business	Information	Chair	Verbal	12.55
18.	Questions from the Public in Relation to Agenda Items	Information	Chair	Verbal	
19.	Date of Next Meeting: Thursday 29 September 2022, 10.00 a.m.				-
	Resolution: Exclusion of the Press and Public. It is recommended that, pursuant to the Public Bodies (Admission to Meetings) Act 1960, Section 1(2), the press and members of the public be excluded from further items of business, having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest.				

NHS North Bristol NHS Trust

TRUST BOARD DECLARATIONS OF INTEREST

Name	Role	Interest Declared
Ms Michele Romaine	Chair	• Nothing to declare.
Mr Kelvin Blake	Non-Executive Director	• Non-Executive Director of BRISDOC who provide GP services to North Bristol NHS Trust. • Trustee, Second Step. Provide mental health services for the Bristol North Somerset and South Gloucestershire area. • Trustee, West of England Centre for Integrated Living. Provide a range of services to disabled people living in the Bristol, North Somerset and South Gloucestershire area. • Director, Bristol Chamber of Commerce and Initiative. • Member of the Labour Party.
Professor John Iredale	Non-Executive Director	• Professor of Medical Science, University of Bristol. • Interim Executive Chair of Medical Research Council. • Trustee of British Heart Foundation • Chair of the governing board, CRUK Beatson Institute. • Board member of The Francis Crick Institute
Mr Tim Gregory	Non-Executive Director	• Employed by Cornwall Council as Service Director – Regulatory Services.
Mr Richard Gaunt	Non-Executive Director	• Non-Executive/Governor of City of Bristol College. • 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 Limited, a Halma Company.

Name	Role	Interest Declared
Professor Sarah Purdy	Non-Executive Director	• Pro Vice-Chancellor and Professor of Primary Care, University of Bristol • Shareholder (more than 25% but less than 50%) Talking Health Limited • Fellow of the Royal College of Physicians • Fellow of the Royal College of General Practitioners • Fellow of the Royal College of Physicians Edinburgh • Member of the British Medical Association • National Institute for Health Research Health and Social Care Delivery Research Funding Panel Member – will cease 31.05.22 • Vice-Chair, Board of Trustees, Venturers Trust, Bristol • Member, Board of Trustees, Bristol Student Union Indirect Interests (ie through association of another individual eg close family member or relative) via Graham Rich who is: - Chair, Armada Topco Limited - Director, Helios Ltd - Director, Talking Health Ltd - Chair, EHC Holdings Topco Limited
Ms Sandra Harding	Associate Non-Executive Director	• Founder, HCPG Ltd • Board Trustee, POhWER • Vice Chair of Governors, Marksbury Primary School • Councillor, Marksbury Parish Council • Member of the Chartered Society of Physiotherapy • Member of the Professional Development Committee of the Chartered Society of Physiotherapy • Registered with the Health and Care Professions Council

Name	Role	Interest Declared
Dr Ike Anya	Associate Non-Executive Director	• Locum Consultant in Public Health Medicine: NHS Lanarkshire, NHS Lothian, Berkshire East and Berkshire West Directorates of Public Health • Member of the British Medical Association • Fellow of the Faculty of Public Health • Honorary Senior Teaching Fellow, University of Bristol • Teach sessions on ethics and global health, London School of Hygiene and Tropical Medicine • Honorary Lecturer, Imperial College
Ms Maria Kane	Chief Executive	• Advisory Group Member of CHKS, a provider of healthcare intelligence and quality improvement services (remuneration donated to charity)
Mr Steve Curry	Chief Operating Officer	• Nothing to declare.
Mr Tim Whittlestone	Medical Director	• Director of Bristol Urology Associates Ltd. • Undertakes occasional private practice (Urology Specialty) at company office. This is undertaken outside of NBT contracted hours. • Chair of the Wales and West Acute Transport for Children Service (WATCh). • Wife is an employee of the Trust.
Mr Glyn Howells	Chief Financial Officer	• Governor and Vice Chair of Newbury College (voluntary). • £25 voucher received as a thank you gift for speaking at a Royal College of Surgeons/Society of British Neurosurgeons Leadership Development Course on 18 November 2021. Donated to Southmead Hospital Charity.

Name	Role	Interest Declared
Professor Steve Hams	Chief Nursing Officer	• Visiting Professor, University of Worcester • Director, Curhams Limited (dormant company) • Strategic Advisor, Liaison Group Limited • Independent Chair of Trustees, Infection Prevention Society • Strategic Advisory Board Member, Shiny Mind (Mental Health)
Mr Neil Darvill	Director of Information Management and Technology (non-voting position)	• Wife works as a senior manager for Avon and Wiltshire Partnership Mental Health Trust. • Stepbrother is an employee of the Trust, working in the Cancer Services Team.
Ms Jacqui Marshall	Director of People and Transformation (non-voting position)	• Nothing to declare.

DRAFT Minutes of the Public Trust Board Meeting held virtually on Thursday 26 May 2022 at 10.00am

Present:			
Michele Romaine	Trust Chair	**Maria Kane**	Chief Executive Officer
Tim Gregory	Non-Executive Director	**Steve Curry**	Chief Operating Officer
Kelly MacFarlane	Non-Executive Director	**Steven Hams**	Chief Nursing Officer
Richard Gaunt	Non-Executive Director	**Neil Darvill**	Chief Digital Information Officer
John Iredale	Non-Executive Director	**Glyn Howells**	Chief Finance Officer
Kelvin Blake	Non-Executive Director	**Tim Whittlestone**	Chief Medical Officer
Sandra Harding	Associate Non-Executive Director	**Jacqui Marshall**	Chief People Officer
Ike Anya	Associate Non-Executive Director (*present from agenda item 7*)		
In Attendance:			
Xavier Bell	Director of Corporate Governance & Trust Secretary	**Richard Thomas**	Director of Communication s
Aimee Jordan	Corporate Governance Officer (*Minutes)*	**Gifty Markey**	Patient Experience Lead (*present up to and including minute item 07*)
Presenters:			
Susan Bourne	Head of Safeguarding	**Helen Lewis-White**	Deputy Director, Research & Innovation, NBT
Gayna Scott-Angell	Mental Health Liaison Specialist Practitioner	**David Wynick**	Research Director, NBT & UHB
Hilary Sawyer	Lead FTSU Guardian		

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

TB/22/05/01	**Welcome and Apologies for Absence**	**Action**
	Michele Romaine, Trust Chair, welcomed everyone to NBT's Trust Board meeting in public, for which a recording would also be made available on the Trust's website. Apologies had been received from Sarah Purdy, Non-Executive Director.	
TB/22/05/02	**Declarations of Interest**	
	No declarations of interests were noted relating to the agenda. An update was required to the Trust Board register of interests as currently published on the NBT website and annexed to the Board papers as follows: • Neil Darvill, Chief Digital Information Officer, declared that his stepbrother was an employee of North Bristol NHS Trust.	

TB/22/05/03	**Minutes of the previous Public Trust Board Meeting**	
	RESOLVED that the minutes of the public meeting held on 31 March 2022 were approved as a true and correct record.	
TB/22/05/04	**Action Log and Matters Arising from the Previous Meeting**	
	Xavier Bell, Director of Corporate Governance, presented the action log and noted that there were no actions due for completion. **RESOLVED that the Action Log was noted and no matters arising were raised.**	
TB/22/05/05	**Chair's Business**	
	The Trust Chair advised there were no updates for the Public Trust Board meeting.	
TB/22/05/06	**Chief Executive's Report**	
	Maria Kane, Chief Executive, presented the Chief Executive's report. In addition to the content of the written report, the following was added. • **Performance:** Ambulance handover breaches had improved due to the opening of the Same Day Emergency Care Unit (SDEC). The elective trajectory plans for the 104 week wait patients had been submitted and a formal thank you to the elective recovery team for their hard work and effort was noted. The cancer position remained under review and work was ongoing to look at mutual aid and recruitment. • **Leadership away day:** The national context (the impact of the increased cost of living and inflation pressures), workforce shortages and building and sustaining high performance was discussed. It was noted that a clinical strategy was being developed and work was ongoing with UHBW to ensure that it would be a cross-city clinical strategy. • **Integrated Care Board (ICB)**: ICB's were due to become statutory bodies on 1st July 2022 and a shadow Board was scheduled for 9th June 2022. The acute Trusts in BNSSG would be represented as one of the eight partners on the Board. • **Extra Corporeal Membrane Oxygenation (ECMO):** ECMO readiness review was overall positive with only a few review aeras such as workforce that needed to be addressed. • **MBE:** Steve Hams, Chief Nurse, received his MBE Queen's Honours in recognition for his services to nursing. • **Healthcare Support Worker Recruitment:** The achievements of the senior nursing team and the People team re the event was noted and positively, 200 people were recruited as a result of the event. **RESOLVED that the Chief Executive's briefing was noted and the Board extended congratulations to Steve Hams for his MBE.** *Susan Bourne and Gayna Scott-Angell joined the meeting*	
TB/22/05/07	**Staff Story: Safeguarding**	
	Steve Hams, Chief Nursing Officer, welcomed Susan Bourne, Head of Safeguarding, and Gayna Scott-Angell, Mental Health Liaison Specialist	

	Practitioner to the meeting and recognised the importance of their role in caring for most vulnerable patients and families. *Ike Anya joined the meeting* Susan Bourne and Gaynar Scott-Angell presented the Safeguarding staff story and shared how learnings through a patients journey in hospital can enable teams to be the best that they can be. The following key areas were highlighted: • The importance of the THINK FAMILY approach in safeguarding to ensure anyone vulnerable receives care. • The importance of team working, good communication and effective assessments to prevent harm to families beyond the hospital. • The benefits of a holistic approach to care. • The key learnings which included improving access to care for patients and staff. During the ensuing discussion the following points were noted: • John Iredale, NED, thanked Susan and Gaynar and commented that it served as a reminder that safeguarding was everyone's responsibility not just the responsibility of the safeguarding team. Steve Hams added that it was important that teams remained curious to achieve good outcomes for patients. • The Trust Chair endorsed John's comments and noted that one intervention could lead to a path of discovery. The Trust Chair also recognised that safeguarding was a timely process and thanked the team for all their efforts. • The importance of safeguarding patients throughout their pathway, both in and out of hospital, was discussed and it was noted safeguarding was a service-based requirement not a place-based requirement. • Kelly Macfarlane, NED, advised that this was an important topic for the Acute Collaborative Provider Board to increase communication throughout the system and improve patient outcomes. • Following a query from Kelvin Blake, NED, re the increased pressures within the local authority, Gaynar confirmed that the local authority continued to be responsive to referrals raised and that the team maintained a good relationship with the local authority. **RESOLVED that the Board noted the Safeguarding Staff Story and thanked the team for their important work.** *Susan Bourne, Gayna Scott-Angell and Gifty Markey left the meeting* *Helen Lewis-White and David Wynick joined the meeting*	
TB/22/05/08	**Research & Innovation 2021/22 Annual Update**	
	David Wynick, Director of Research NBT & UHBW and Helen Lewis-White -Deputy Director of R&I, presented the Research and Innovation update which covered the progress of research at NBT over the last 5 years, the proposed aims for the 2022-2027 research strategy and the ongoing work of the Bristol Health Partners. Key points to note included the following:	

	• The previous strategy focused on empowering patients, nurturing the workforce, visible research and becoming a regional partner and leader. • Study highlights included Covid vaccine trials, Aerator, Assist and Star trial implementation. • The new strategy would include two principles that focused on equity and inclusivity and the environmental impact. These would also be reflected in the objectives. • There was data that showed research active hospitals had better outcomes for their patient's morbidity and mortality. • Bristol Health Partners Academic Health Science Centre (AHSCC) priorities included mental health, health inequalities and children and young people. The focus areas were discussed and included improving outcomes for patients and delivering and promoting evidence-based care and interventions. It was detailed that AHSCC provided the Research and Innovation Steering Group for the Integrated Care System (ICS), and a new sub-group called the Equality, Diversity and Inclusion (EDI) in Research Working Group was being formed. During the ensuing discussing the following key points were noted: • Following a query from Steve Curry, Chief Operating Officer, re data David agreed that the quality of data was important and that they were fully engaged with the ICS and Patient First. • Steve Hams queried how new the strategy would support increasing the capability and capacity of non-trial research. Helen advised that the strategy included workforce development for all staff, not just those in the research team and work was ongoing to support non-medics to undertake research opportunities and provide a funding stream. David added that this was being done at both Trusts and that focus was on providing dedicated brought out time to give non-medics protected research time. • Jacqui Marshall, Chief People Officer, acknowledged that EDI was being built into the research strategy and offered to collaborate and share data. • Ike Anya, Associate NED, queried the extent of understanding towards participant disparities. David answered the starting point was with the quality of data in order to understand where resources need to be targeted to address the inequalities. • Neil Darvill, Chief Digital Information Officer, queried if there was further aspirations for joint working. David answered that an Associate Director had been appointed across the two Trusts and noted the benefits of the joint working model. • John Iredale recognised the challenge re the absence of career structure for Nurses and AHP'S and agreed to work with Steve Hams offline on potential career models and finance options. • Tim Gregory, NED, questioned the progress of the innovation sub-group. David recognised that it was still in the early stages, but work was ongoing to make it more a more proactive resource. • Richard Gaunt, NED, queried what the measures of success were. Helen advised that a business delivery plan would be produced but that the focus was	

	on the under representative areas and data driven research to ensure all areas of the population were being reached. **RESOLVED that the Research and Innovation update was noted, and the team were thanked and commended for their work.** *Helen Lewis-White and David Wynick left the meeting* *Hilary Sawyer joined the meeting*	
TB/22/05/09	**Bi-annual Freedom to Speak Up Report**	
	Hilary Sawyer, Freedom to Speak Up (FTSU) Lead, presented the Bi-Annual FTSU Report which detailed the number and types of concerns raised, analysis of the data and next steps and actions to improve the Speaking Up culture. Key points of the report included the continued increase to the number of concerns raised following the introduction to FTSU lead role. It was noted that this was considered positive as it reflected the increased awareness and trust in the FTSU mechanism. It was recognised that the highest levels of concerns related to behaviours and relationships and the themes of concern were similar to the last report in November. It was detailed that the key next steps included piloting a manager response form to capture clear learning and monitor response times, communication of successes and learning from workers speaking up, evolving the champion network and working to embed FTSU training. The Board were requested to complete and reflect on the FTSU eLearning modules and were invited to FTSU walkarounds and drop in events. During the ensuing discussion the following points were noted: • Jacqui Marshall encouraged Board members to go on FTSU walkabouts and recognised that the challenge was re assuring staff that action had been taken as a result of them speaking up. • Steve Curry noted that it was important to understand how the data moved as a result of heightened communication and recognised that improving the overall functioning of service would help to address some concerns. • Kelly Macfarlane queried the interventions being undertaken to ensure that leaders throughout the organisation were able to encourage staff to speak up. Jacqui Marshall advised that the Trust values were being reviewed and work was ongoing to develop management skill training to empower everyone to challenge and change behaviours. • Ike Anya raised concerns re staff that would not feel secure raising concerns regarding safe clinical practise. Jacqui agreed and noted that there was a hierarchy that still needed to be broken down. The Trust Chair highlighted that this was not acceptable, and that work was ongoing to improve this. • Following a query from Maria Kane re the awareness of the correct escalation processes, Hilary advised that further clarity was needed re which route staff needed to use but recognised that all routes had values and training for managers and leaders was key. **RESOLVED that the Board:**	

	• **Thanked Hilary commended her work as FTSU Lead.** • **Noted the Bi-annual Freedom to Speak Up Report.** • **Agreed to undertake the eLearning training modules, role model behaviours to support staff speaking up and feedback any comments re the Board Self-Assessment Review to Xavier Bell.** • **Raised the challenge to the executive team and Hilary to consider how to reach out to the groups that don't speak up.** *Hilary Sawyer left the meeting*	
TB/22/05/10	**Integrated Performance Report (IPR)**	
	Steve Curry described the key operational performance elements of the IPR: • Elective recovery programme trajectory was on track to deliver zero 104 week wait patients and reduce the 78 week wait patients to below 500 patients. Steve echoed gratitude to the planned care team for their efforts. • The unscheduled care improvement plan was being progressed. • Cancer and Diagnostics still continues to be challenging but work was ongoing to improve the workforce and clinical pathways. During the ensuing discussion the following points were noted: • Following a query from Tim Gregory re diagnostic challenges, Steve recognised the challenges and detailed the changes being implemented which included changes to clinical pathways, the recruitment of a recovery director, delivery of a progressive workforce plan and capacity increase opportunities. • Kelvin Blake recognised the importance of diagnostics in the patients journey and queried how the diagnostic position would be improved and how the recovery director would input into the process. Steve detailed that the backlog issues combined with the recurrent volume and unreliable capacity were the factors that cause the problem in terms of demand and capacity. The recovery director will look at all the issues and create a plan to improve the performance. • Further clarity re the challenges, the plan to address the challenges, the support required, and the timescale was requested. Steve Hams, Chief Nursing Officer, and Tim Whittlestone, Chief Medical Director, described the Quality elements of the IPR: • The perinatal quantity surveillance matrix (PQSM) had been included for information and would continue to be monitored • Investigation had been undertaken for the MRSA cases and all patients received post infection reviews. Key learning outcomes had been actioned and was noted to include fundamental standard re infection control. • C.Difficile rates were higher that trajectory, but teams were working hard to identify and treat patients. • Work was ongoing to set up a system wide pressure injury plan to reduce the numbers of pressure injuries.	

	• VTE risk assessment had deteriorated as a result of a number of complexities, but the new appointment was due to start, and a rapid action plan was being put in place to stop the deterioration. Kelly Macfarlane sadly noted the two maternal deaths and queried if there were any outstanding questions. Steve Hams responded that there were no outstanding questions as they were patients that had delivered elsewhere and came to NBT to receive intensive care treatment. Kelly also noted that it was good to see the improvement in the maternity trajectory. <u>Well Led</u> Jacqui Marshall reported that turnover was still high and raised concerns re staff retention due to the current economy. It was also highlighted that the demand for agency and bank staff had decreased whilst the planned over time had increase. <u>Finance</u> Glyn Howells reported that the system plan had formally been rejected by the National team and that the figures on the report were based on that plan. However, this was being worked through and the figures were being reviewed. **RESOLVED that the Board signed off the IPR report and agreed that a detailed overview of diagnostics and cancer performance would be scheduled at a future Board meeting.**	**SC**
TB/22/05/11	**Audit & Risk Committee Upward Report**	
	Richard Gaunt, NED and Committee Chair, presented the Audit and Risk Committee upward report and noted the positive reports and reviews from the counter fraud and auditing teams. It was noted that the significant assurance rating had been issued for the Data Security & Protection Toolkit and the team were commended for the achievement. It was recognised that there was a total value of £9,545 of outstanding debts related to the 2020/21 overpayment but it was highlighted that it would continue to be chased. **RESOLVED that the Board noted the Audit & Risk Committee Upward Report.**	
TB/22/05/12	**Laparoscopic Ventral Mesh Rectoplasty Review – Closure Report**	
	Tim Whittlestone, Chief Medical Officer, presented the Laparoscopic Ventral Mesh Rectoplasty (LVMR) review closure report and provided the context of the clinically led review. Tim expressed sincere apologies and regret on behalf of the Trust to the patients that were harmed as a result of undergoing an operation under the care of the Trust. It was noted that all patients were offered the option of being seen in clinic and meeting the independent team and all patients were offered psychological support. It was noted that any patients requiring onward treatment were offered it and in	

	some cases were referred to other centres for treatment and ongoing support continued to be offered to patients. The review concluded that of the 387 patients that received LVMR treatment 203 should have been offered an alternative prior to proceeding to surgery and on that basis they were deemed to have suffered harm. It was noted that all patients had been communicated with and were given as much information as possible re their clinical advisory review. It was concluded that procedure was undertaken satisfactorily, in terms of the technical abilities of the surgeons involved, but 203 patients could have been offered a less invasive alternative. The lessons learnt were detailed and included: • Systematic changes, including the approach to clinical governance, consent, chaperoning and the approval of new procedures. • The importance of a consistent approach to coding and accurate and timely record keeping. • Ongoing national discussions re the development of a National Standard Operating Procedure (SOP) for recall and review processes. • Ongoing work re data collection to enable systems and clinical records to be more readily able to identify all patients who have had a particular procedure, and the recording of prosthetic and implemented devices. • Improvement to Multi-Disciplinary Team meetings to ensure no one person can influence the outcomes. Following a query from the Trust Chair re psychological support, Tim Whittlestone advised that all patients were offered psychological support at Southmead or were signposted to local services. Following a query from the Trust Chair re further treatment for patients, Tim advised that due to the limited expertise in Bristol patients were being referred to London to ensure they receive the best possible care outcome. The Board expressed sincere apologies to patients that had been affected by this and recognised the learning outcomes that have been actioned as a result of the review and were hopeful that patients felt that enough support had been provided. **RESOLVED that the Board noted the Laparoscopic Ventral Mesh Rectoplasty Review Closure Report.**	
TB/22/05/13	**Quality Committee Upward Report**	
	John Iredale, NED and Committee Chair, presented the Quality Committee (QC) Upward Report and noted reassurance re the long-term plan for diagnostics and the discussion re the investment into digitisation for reporting, the recruitment challenges and the emergency department challenges. It was highlighted that C. Difficile was regular feature of QC discussions and would continue to be reviewed. <u>Ockenden</u>	

	It was noted that there was 90% compliancy against the report, leads had been identified for Immediate & Essential Actions and an Ockenden Implementation Board had been created. **RESOLVED that the Board noted the QC Upward Report.**	
TB/22/05/14	**Board & Committee Effectiveness Review Proposal**	
	Xavier Bell presented the Board & Committee Effectiveness Review Proposal and highlighted the importance of the review. **RESOLVED that the Committee approved the Board & Committee Effectiveness Review Proposal and noted the questions would be distributed via Survey Monkey for committee members to complete.**	**XB**
TB/22/05/15	**Provider License Self-Certification**	
	Xavier Bell presented the Provider license self-certification and noted that the enforcement undertaking with NHSEI had been lifted. **RESOLVED that the Board noted the provider license self-certification and approved compliancy against the conditions.**	
TB/22/05/16	**Any Other Business** – None raised.	
TB/22/05/17	**Questions from the public** – None received**.**	
TB/22/05/18	**Date of Next Meeting**	
	The next Board meeting in public was scheduled to take place on Thursday 28 July 2022, 10.00 a.m. Trust Board papers will be published on the website and interested members of the public are invited to submit questions in line with the Trust's normal processes.	

The meeting concluded at 12:50pm

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

Trust Board - Public ACTION LOG

Closed	Action completed and can be filtered out	Amber	Status not updated/completed and/or the deadline passed.
Blue	Completed and will be removed from chart for next iteration. A = On current meeting agenda.	Red	Status not updated/completed and/or deadline passed by more than one month.
Green	Status updated and on track within timescale.		

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
27/1/22	Annual Emergency, Preparedness, Resilience & Response (EPRR)	TB/22/01/ 08	65	Board to be informed once NBT is fully compliant against the NHS Core Standards for Annual Emergency, Preparedness, Resilience & Response (EPRR)	Steve Curry, Chief Operating Officer	Oct-22	Yes	Open	March update: Steve Curry noted that process were being put in place to achieve 100% compliancy and assurance would be given following a further assessment in October 2022.	31/03/2022
31/3/22	Equality, Diversity & Inclusion Committee Proposal	TB/22/03/ 08	67	A paper be received at Board in due course to provide assurance re how EDI was being embedded across recruitment and the timeline	Jacqui Marshall, Chief People Officer	Aug-22	Yes	Open	EDI awareness update scheduled for August Trust Board.	21/07/2022
31/3/22	Guardian of Safe Working (Junior Doctors) – Board Update	TB/22/03/ 10	68	The next update paper to include data showing if there was a pattern regarding the use of bank and agency staff.	Lucy Kirkham, Guardian of Safe Junior Doctor Working Hours	Jul-22	Yes	A	Lucy Kirkham informed - next paper due at July Trust Board	19/05/2022
26/5/22	Integrated Performance Report (IPR)	TB/22/05/ 10	69	It was agreed that Steve would bring a detailed overview of diagnostics and cancer performance to a future Board meeting.	Steve Curry, Chief Operating Officer	Jul-22	Yes	Closed	Scheduled on forward workplan.	21/07/2022
26/5/22	Board & Committee Effectiveness Review Proposal	TB/22/05/ 14	70	Questions would be distributed via Survey Monkey for committee members to complete.	Corporate Governance team	Jul-22	Yes	Closed	Questions distributed to Turst Board Members	

Report To:	Trust Board Meeting (Public)		
Date of Meeting:	28 July 2022		
Report Title:	Chief Executive's Briefing		
Report Author & Job Title	Suzanne Priest, Executive Co-ordinator		
Executive/Non-executive Sponsor (presenting)	Maria Kane, Chief Executive		
Does the paper contain:	**Patient identifiable information?**	**Staff identifiable information?**	**Commercially sensitive information?**
*If any boxes above ticked, paper may be received at *private* meeting			
Purpose:	**Approval**	**Discussion**	**To Receive for Information**
			X
Recommendation:	The Trust Board is asked to: • Receive and note the content of the briefing.		
Report History:	The Chief Executive's briefing is a standing agenda item on all Board agendas.		
Next Steps:	Next steps in relation to any of the issues highlighted in the Report are shown in the body of the report.		

Executive Summary	
The report sets out information on key items of interest to Trust Board, including engagement with system partners and regulators, events, and key staff appointments.	
Board Assurance Framework/Trust Risk Register Links	Does not link to any specific risk.
Financial implications	None identified.
Equality, Diversity and Inclusion Assessment (EIA)	N/A
Appendices:	N/A

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 over the past 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.

3. Performance

Significant activity is still presenting to the ED with attendances up on pre-Covid levels by almost 4%. As of 14 July, new measures have been rolled out across the hospital to try to create more space at the front door and reduce ambulance handover delays. In its first few days, the longest ambulance waits have been reduced significantly with an average of 86% of ambulances now offloaded within one hour.

The levels of Covid infection in the community continue to increase, and the number of inpatients with Covid currently stands at 53, with a peak of 65 last week.

Our elective and cancer improvement trajectories remain under constant review, with improvements seen against the 28 day Faster Diagnosis Standard, and the 31 day first cancer treatment. We are an outlier on 62 day waits, and are in a tiered system whereby we expect high levels of support and scrutiny. We continue to deliver on our RTT trajectories in line with agreements with NHS England.

4. Integrated Care Board (ICB)

Integrated Care Boards became legal entities as of 1 July. The BNSSG board is working on its recruitment to a number of key executive positions, as well as focusing on the creation of its strategic plans for the next five years.

5. Roll of out the new Electronic Patient Record (EPR)

As a result of over three years of planning, development and delivery, CareFlow went live on 4 July across the whole of the trust. CareFlow is the new patient information system and replaces Lorenzo as the key application for maintaining our patient records.

The roll out has been well supported by teams of staff from the IT department who have been working hard to support their clinical colleagues and respond to queries, questions and issues.

6. Women and Children's Services New Rest Area

Work has begun in the last couple of weeks in laying the foundations for the New Rest and Wellbeing areas for staff. The actual 'pod' will be constructed off site and the installation is expected to be at the end of the month. This will be very welcome news for the division.

7. New Elective Care Centre

An early planning application has been submitted to Bristol City Council to request permission to build a new Elective Care Centre which would be situated in the Monks Park area of the Southmead site. This is a pre-emptive move in the hope that we will be successful in our bid for funding as part of the Targeted Investment Fund which would see the creation of a new clinical building which could deliver over 5,000 more operations a year on behalf of the system.

The proposal, which includes four surgical theatres and 40 beds, is still at a very early stage and there will be many competing demands on the central NHS funding we are hoping to secure, but we have submitted a request for planning permission now to allow us to hit the ground running should our bid for funding be successful. The building would be sited in the Monks Park area of the Southmead site.

8. Pride at Bristol

The Trust celebrated Pride this month with a number of activities, which included the rainbow flags outside the front of the Brunel Building, rainbow lanyards for staff and support at the Pride event in Bristol. Staff from our Trust and from the Southmead Hospital Charity volunteered to help run a stall and took part in the march.

9. ICS Big Conversation

BNSSG ICS has just commenced a nine week public engagement exercise which is hoped to help drive the development of its strategy by ensuring that communities have key input into what the system delivers.

Insights gathered over the course of the engagement will help the ICS to ensure that the health and wellbeing needs of the local population are met over the next two, five, 10 and 20 years. The engagement runs until 2 September 2022 and will use a number of ways, including engagement events and meetings for people to be able to have a say. There is also an online survey which can be found at the following link: https://bnssghealthiertogether.org.uk/haveyoursay/

10. Engagement & Service Visits

I am continuing to visit and spend time with as many services and teams across the hospital as I can to help gain a better understanding of the challenges and opportunities faced in different specialties and practices across the Trust. In July I visited the following areas:

- Knowle Health Centre
- Weston General Hospital - Urology, Breast and Renal
- Alcohol Service
- IT service

I also continue to meet individually with our senior medical staff, and this month I have seen consultant colleagues from Care of the Elderly, ICU, Neurology, Renal, Breast and Emergency Medicine.

11. Consultant Appointments

Since I last reported on consultant recruitment in May 2022, the Trust has appointed the following consultants across several key specialities:

Consultant:	**Specialty:**
Roshina Gnanadurai	Microbiology – Infection
Christopher Wearn	Burns & Plastic Surgery
Ovidiu Tica	Histopathology

12. Summary and Recommendations

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

Report To:	Trust Board - Public		
Date of Meeting:	28th July 2022		
Report Title:	Staff Story and Patient Story – Cossham Hospital		
Report Author & Job Title	Gifty Markey (Head of Patient Experience)		
Executive/Non-executive Sponsor (presenting)	Steve Hams, Chief Nursing Officer		
Does the paper contain:	**Patient identifiable information?**	**Staff identifiable information?**	**Commercially sensitive information?**
	X	**X**	
*If any boxes above ticked, paper may need to be received at *private* meeting			
Purpose:	**Approval**	**Discussion**	**To Receive for Information**
		X	
Recommendation:	For Board update and insight - A staff and Patient story of managing and delivering essential treatment during the pandemic		
Report History:	N/A		
Next Steps:	• The team to continue to work on improving Patient Experience through collecting feedback		

Executive Summary
• Cossham Dialysis Unit is a 24 bedded unit for dialysis patients • During the pandemic, the unit became the central treatment centre for all dialysis patients who were covid -19 positive. • This story shows how the team risks assessed their patients to ensure continuity of essential treatment • It also shows how the team risk assessed their staff and supported them to provide this essential treatment for patients who were extremely vulnerable • It highlights the impact of the staff wellbeing and how they were supported to cope. • Also highlights some positive feedback of patients on their experience of treatment during this time • PowerPoint presentation attached for details.

Does this paper require an Equality, Diversity and Inclusion Assessment (EIA)?	No
Appendices:	Appendix 1: Staff and Patient story

NHS North Bristol NHS Trust

Cossham Dialysis Unit Staff and Patient Story

Managing and Delivering Essential Treatment during the Pandemic

Gifty Markey

Head of Patient Experience

Alice Raju

Supervisory Sister – Cossham Dialysis Unit

Exceptional healthcare, personally delivered

Putting the patient first

NBT Vision & Values

Recognising the person

- **Our aim is to provide our patients with best practice, high quality care and treatment that is comparable to the best in the world. We want to care for our patients in a safe environment and ensure that everyone has an outstanding experience**
- **Our vision is to enable our teams to be the best they can be ,we will provide Exceptional Healthcare, Personally Delivered.**

Working well together

Striving for excellence

NHS North Bristol NHS Trust

Background

- 24 bedded unit for dialysis
- The unit became the central place for treatment of covid-19 positive patient during the pandemic
- Risk assessment of patients
- Evidence of how staff worked together to support vulnerable patients and each other in a difficult time
- Shows the impact of the pandemic on staff own and patient's wellbeing
- This story was put together as a result of two feedbacks received from patients who used the unit during the pandemic

My Experience during Covid in the Renal Unit was worrying in the beginning, but as time progressed and with a better understanding of Covid I was more settled. The staff were very helpful and understanding as to my worries of catching Covid. The staff were very good at keeping patients at a safe distance from each other. Their level of cleaning was impeccable at all times.

My only concern was other people's cleanliness. A small amount not washing hands or sanitising, also some not wearing masks properly in the waiting room and not keeping a proper distance.

It was also nice that Covid injections were done while I was on dialysis which cut down a lot of stress and anxiety, as time has gone on it has become easier as we have all got into a routine.

Janet Noad

NHS North Bristol NHS Trust

Patient's Feedback

NHS North Bristol NHS Trust

Patient's Feedback

As a dialysis patient at Cossham my experience on the treatment and care during the Pandemic was safe and controlled as could possibility be. I has no concerns going for treatment 3 mornings each week as we were checked and given clean masks every visit. We have no choice as we have dialysis to keep us alive. So from a personal point of view I accepted the situation and got on with it. The staff were extremely careful and did everything possible to keep us safe and are still doing so.

Stella Milsom

Putting the patient first

Recognising the person

Working well together

Striving for excellence

Exceptional healthcare, personally delivered

Cossham Dialysis Unit

Staff story of providing essential care and treatment during the Pandemic

https://www.youtube.com/watch?v=_ebi9K8Sg14

What Next ?

- Team will continue to work with the patient experience team to set up their local surveys and Friends and Family Test for improvement work
- Triangulate complaint data and work on improvement projects
- Continue to seek patient feedback for improvement

NHS North Bristol NHS Trust

Report To:	Public Trust Board		
Date of Meeting:	28 July 2022 (Report covering 01/03/22 – 31/06/22)		
Report Title:	Guardian for Safe Working (Junior Doctors)		
Report Author & Job Title	Dr Lucy Kirkham Trust Guardian for Safe Junior Doctor Working		
Executive/Non-executive Sponsor (presenting)	Direct to Trust Board		
Purpose:	**Approval**	**Discussion**	**To Receive for Information**
		X	X
Recommendation:	The Board of Directors will discuss current Junior Doctor contract issues and as a public authority must, in the exercise of its functions, have due regard to the need to: • All contractual obligations in place • Be satisfied that the role of Trust Guardian is being fulfilled • Exception Reports being acted upon • Gaps on Junior Rotas being filled as a priority • Risks to Trust considered – Guardian fines; accountability; staffing		
Report History:	This paper sets outs the background and context around the introduction of the Guardian of Safer Working as part of the 2016 Terms and Conditions for Junior Doctors and implementation of that role in the Trust. It shows: • Exception Report data • Locum data • Guardian's actions • Gaps on rotas and plans to fill		
Next Steps:	• Promote and support exception reporting system to consultants and trainees • Continue to look at creative workforce and IT solutions to minimise gaps		

Executive Summary

The New Junior Doctors' Contract was introduced with effect from October 2016, subject to a phased implementation between October 2016 and August 2017. In 2019 there was a further contract refresh agreed covering April 2019 - March 2023.

Junior Doctor Contract Refresh - 2019

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

- Leave for life changing events – employers must allow leave for life changing events (it is for the doctor to decide what is a deemed life a changing event)
- Breaks for nights shifts – a nights shift of 12 hours or more will require a 3rd 30 minute break.
- Facilities – where a non-resident on-call rota requires the trainee to be on site within a specified time or where the department specify the distance from the Trust when NROC then the department will meet the cost of overnight accommodation.

- Facilities – where a trainee has worked a night and is too tired to drive home the Trust must provide rest facilities (which we do anyway) or the department must meet the cost of travel home and reasonable expenses on the return to work.
- Exception reporting – extension of what can be exception reported i.e., missed supervisor meetings or no time provided for coming audits / e-portfolio.

August 2021: BMA statement on the TCS (2016 Terms and conditions of service for NHS doctors and dentists in training in England) and junior doctor rostering during the response to the COVID-19 pandemic

https://www.bma.org.uk/news-and-opinion/statement-on-junior-doctor-rostering-and-workforce-management-during-the-covid-19-pandemic

The NBT Trust Guardian for Safe Junior Doctor Working will:

1. Interact with the Trust Board in a structured report covering rota gaps, gap management, locum usage exception reporting and the Postgraduate Doctors Forum (PDF)

2. Ensure Exception Reporting by junior doctors for breaches of contract are acted upon. These comprise exceptions for:
   - Safety reasons
   - Excess hours – Leading to TOIL (the preference) or Payment where TOIL is not possible
   - Excess hours leading to work pattern reviews
   - Missed education sessions

3. Set up and attend a PDF – these forums harness the junior doctor's ideas and energy on better ways of working as well as offering a channel to discuss contract, education and rota issues. The DME, HR and exec attendance is desirable.

4. The Guardian may levy a fine if a breach of the following occurs:

   - The 48-hour average weekly working limit
   - Contractual limit on maximum of 72 hours worked within any consecutive 7-day period
   - Minimum 11-hour rest has been reduced to less than 8 hours
   - Where meal breaks are missed on more than 25 per cent of occasions over a 4-week period.
   - The minimum 8 hours total rest per 24-hour non-resident on-call (NROC) shift
   - The minimum NROC overnight continuous rest of five hours between 22:00 & 07:00
   - The maximum 13-hour shift length
   - The minimum 11 hours rest between resident shifts

Penalties will be levied against the department where the doctor works; the fine will be set at four times the basic or enhanced rate of pay applicable at the time of the breach. The doctor will receive 1.5 times the applicable locum rate, and the JDF will retain the remainder of the penalty amount.

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

HIGH LEVEL DATA – ROTA GAPS, GAP MANAGMENT, LOCUM USAGE, EXCEPTION REPORTING & PDF

Total number of Doctors in Training (DiT) and Clinical Fellows (CF) = **571** (194 are Clinical Fellows)
All are on the 2016 T&Cs including the Clinical Fellows

NBT rota designs have continued to meet the 2016 junior doctor contract requirements

1. **ROTA GAPS** - All gaps are detrimental to patient care and Postgraduate Doctor training; every effort should be made to fill them.

Gap data is difficult to meaningfully gather as it is one snapshot in time.

I am currently working with Ben Pope (Strategic workforce and planning) to produce a report on vacancies in the DiT and CF positions against establishment. Moving forward this report in conjunction with the NBT locum requests will help identify 'hot areas' and plot what policies have been effective at stabilising the workforce over time.

The preliminary report documents variance >1 WTE between April and July at ST1/CT1/IMT1 level and above. The Emergency Dept have had 6 resignations between April and June.:

Specialty	6th April 22	6th July 2022	Variance Apr - Jul
339 01291 Emergency Dept Specialty	31.7	22.1	-9.6
339 28106 ICU Medical Staff	30.8	27.6	-3.2
339 05412 Infectious Diseases inc HIV Specialty	4.0	2.0	-2.0
339 09046 BIRU	4.6	2.6	-2.0
339 28117 Neurology	10.6	9.1	-1.5
339 01113 Cardiology Specialty	13.6	12.6	-1.0
339 01190 Sm Trauma & Ortho Med	29.8	28.8	-1.0
339 01310 Immunology Specialty	2.0	1.0	-1.0
339 01403 NBT Histo/Cell Path	11.4	10.4	-1.0
339 05601 Diabetes Specialty	6.0	5.0	-1.0
339 28122 General Surgery Med Staff	28.6	27.6	-1.0
Specialty	**6th April 22**	**6th July 2022**	**Variance Apr - Jul**
339 28104 NBT Anaesthetic - Medical Staff	27.0	29.7	2.7
339 05604 Care of the Elderly Specialty	15.2	17.8	2.6
339 05420 Acute Medicine Specialty	10.0	12.0	2.0
339 01152 Renal Medical Staff	15.0	17.0	2.0
339 05402 Stroke Specialty	5.8	6.8	1.0
339 05611 Gastro Specialty	7.0	8.0	1.0
339 28128 Neurosurgery Med Staff	18.0	19.0	1.0

This picture looks improved for the August in-take. Gaps known about for August by Division:

- ASCR – 3 DiT, 0 CF
- W&C – 1 DiT, 0 CFs
- Core Clinical – 5 DiT, 0 CFs
- NMSK – 0 DIT, 4 CFs – currently being advertised
- Medicine – 0 DITs, 1 CF – currently being advertised

2. GAP MANAGEMENT

A. CF Adverts

- Recruitment into CF gaps is continuous and ongoing
- 11 new starters recruited into April gaps.
    - 7 of these are currently Medical Support Workers (MSW)
        - All bar one will be 100% clinical
        - Once in the role of a clinical fellow a MSW can work as a doctor, within their competency. All have passed the English language test for GMC registration.

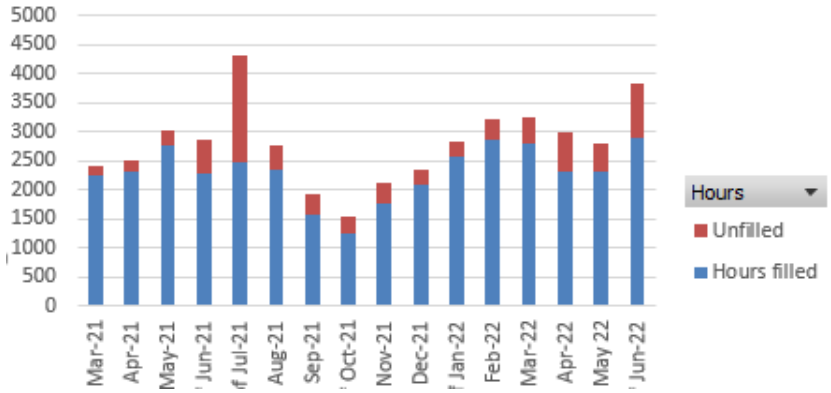
B. Medical Support Workers

- 29 Doctors from Myanmar started at NBT Nov 2021 – 1 year contract
- MSW lead looking to put together a business case for extending MSW use at NBT.

C. Optimising NBT locum reach

- PDF suggestion of using 'Locum Nest' app – successfully used at Gloucester/Cheltenham
- A pilot of LocumNest was approved at NBT Workforce Transformation Programme Board on 17/2/22
- HR are currently engaged in the sharing of the requisite data sets / creation of end user mapping etc so the platform can be aligned to the systems and people that will interface with it.
- HR are working towards a go live date towards the end of July.

Medicine Division is the largest requestor of Bank locum shifts. Below shows their total hours requested split into filled and unfilled. It will be interesting to see if the unfilled hours decreases if NBT moves to Locum Nest (following the pilot run) as a means more effectively accessing a wider locum pool.



It was discussed at the previous Trust Board that there was no obvious link between gaps and locum spend. It was asked if there was a pattern in the locum spend and whether we could draw parallels with how nursing gaps are monitored and covered.

Minimum staffing for Postgraduate doctors is not outlined Nationally as it is for nursing. Minimum staffing is calculated by each specialty to staff their rotas and safely care for patients based on acuity and number of patients. The 'need' for locums to be found for absent trainees (gaps or sickness) varies between specialties. In some specialties - such as anaesthetics (40 postgrad doctors in ASCR) daily theatre work is contractually covered by consultants with trainees being largely supernumerary. Anaesthetic locum cover is virtually never requested other than for out of hours on call work.

Whereas Medicine (which accounts for ~40% of the postgrad doctor workforce) needs to cover most absences with a locum due to shift work and ward care thus accounting for their large Bank usage.

Number of postgraduate doctors:

ASCR	~202
Core clinical	~43
Medicine	~217
NMSK	~90
W&C	~36

I think with so many variables; shifting gaps, absolute need to cover the absence, differing minimum staffing levels it is very difficult to infer too much from Bank usage by specialty.

As a result of the PDF HR are looking toward a larger piece of work in the future as to how NBT minimum staffing levels are set and whether the current levels are appropriate.

D. Potential to decrease dependence on CFs by converting some CF posts into Physicians Associate posts

- OMB report written by Sue Nutland and the PA lead (Dr Phil Braude) ready for discussion. This outlines the role of PAs, benefits to the organisation, and business case model to convert existing clinical fellow posts. Therefore, the case is based upon staffing skill mix rather than additional investment.
- Not taking this report to OMB now, as there needs to be a wider piece of work on alternative roles, and this will now fall under the new Associate Director for Resourcing and Workforce Planning

Advantages of PAs:

- Already have 8 working at NBT with calls currently for up to 8 more across the Divisions
- We train 24 a year so have an in-house pool familiar with NBT ways of working
- Permanent experienced member of the team – helps with JD changeover time
- Can train juniors
- Work at Junior Doctor level – admitting, discharging, examining, taking blood, forming a differential, can transcribe drug charts
- Not subjecting NBT to seasonal departure gaps
- Work clinically 100% (majority of current CFs are 80% clinical)
- Can work out of hours

Disadvantages of PAs:

- Currently cannot order X-ray or CT or prescribe – this will change once under GMC regulation >2023
- Not on 2016 JD T&Cs so integration into JD minimal ward staffing levels and leave allocation needs consideration

3. LOCUM USAGE - BANK AND AGENCY – 01/03/22 – 30/06/22

BY DIVISION: Biggest user of Bank – Medicine (drop in spend due to drop in winter pressure and NMSK spend)

Locum Bookings (Bank) by Department	Requested Shifts	Requested Hours	Filled Hours	Estimated Cost
⊞ ASCR Division	593.00	5025.75	4534.25	£263,257.50
⊞ Clinical Governance Division	10.00	60.00	60.00	£2,702.50
⊞ Core Clinical	57.00	502.00	379.00	£26,212.50
⊞ Finance Division	11.00	98.00	98.00	£5,190.00
⊞ HR Division	3.00	19.50	19.50	£1,312.50
⊞ Medicine Division	1452.00	12879.01	10362.03	£548,684.45
⊞ Neuro & MSK Division	702.00	7198.83	5457.08	£295,013.75
⊞ W&C Division	109.00	1075.25	1059.00	£72,025.00
⊞ Winter Pressures	762.00	6335.33	5284.83	£257,200.00
Grand Total	**3699.00**	**33193.67**	**27253.69**	**£1,471,598.20**

Previous 4 months:	**3593**	**32649**	**25987**	**£1,681,241**

Locum Bookings (Agency) by Department	Requested Shif	Agency Filled	Requested	Agency Filled	Estimated Cost
⊞ Neuro & MSK Division	71	71	689	689	£46,612.04
Grand Total	**71**	**71**	**689**	**689**	**£46,612.04**

BY GRADE: Commonest grade is F2/ST1-2

Locum Bookings (Bank) by Grade	Requested Shifts	Requested Hours	Filled Hours	Estimated Cost
⊞ Locum F1	145	1250.35	797.37	£33,854.05
⊟ Locum F2				
F2	5	46.5	12.5	£735.00
Locum F2/ST1-2 Core	2641	23466.53	18851.53	£921,378.15
ST/CT1	2	13	9	£510.00
⊞ Locum ST3+	900	8351.29	7517.29	£511,423.50
⊞ ST/CT2	5	53.5	53.5	£2,992.50
⊞ JCF	1	12.5	12.5	£705.00
Grand Total	**3699**	**33193.67**	**27253.69**	**£1,471,598.20**

Locum Bookings (Agency) by Grade	Requested Shif	Agency Filled	Requested	Agency Filled	Estimated Cost
⊟ Locum F2					
Locum F2/ST1-2 Core	54	54	459	459	£30,637.04
⊞ Locum ST3+	17	17	230	230	£15,975.00
Grand Total	**71**	**71**	**689**	**689**	**£46,612.04**

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

Locum Bookings (Bank) by Request Reason	Requested Shifts	Requested Hours	Filled Hours	Estimated Cost
Additional Capacity	1766	15445.35	13058.6	£709,773.25
Annual Leave	50	342.58	317.08	£18,129.80
Bank Only Paid Study Day	1	2.5	2.5	£112.50
Bereavement Leave	7	63.5	34	£1,907.50
Covid 19	144	1412.04	969.54	£47,843.50
Emergency Domestic Carer Leave	3	28.5	6.5	£309.35
Sickness	251	2282.54	1902.79	£124,308.45
Study Leave	6	51.25	35.25	£1,663.75
Vacancy	1441	13268.41	10663.43	£548,740.10
Waiting List Initiative	15	118.5	118.5	£7,692.50
Supernumerary	1	8	0	£0.00
Parental Leave	13	157.5	132.5	£10,257.50
Allocate on Arrival	1	13	13	£860.00
Grand Total	**3699**	**33193.67**	**27253.69**	**£1,471,598.20**

Locum Bookings (Agency) by Request Reason	Requested Shif	Agency Filled	Requested	Agency Filled	Estimated Cost
Additional Capacity	67	67	641	641	£43,312.04
Vacancy	4	4	48	48	£3,300.00
Grand Total	**71**	**71**	**689**	**689**	**£46,612.04**

4. EXCEPTION REPORTS - 01/03/22 – 30/06/22

Exception Reports (ER) over past 4 months		Number flagged as immediate safety concern (ISC)
Number relating to hours of working	99	3
Number relating to pattern of work	0	0
Number relating to educational opportunities	7	0
Number relating to service support available to the doctor	3	1
TOTAL NUMBER OF EXCEPTION REPORTS	**109**	**4**

109 reports in previous 4-month period

BREAKDOWN OF REPORTS

IMMEDIATE SAFETY CONCERNS – 4

Grade	Rota	Issues & actions
F1	Medicine	Worked overtime by 2 hours on BH weekend ward cover 9a/9b. Unable to complete all daily reviews and jobs handed over by weekday team. Multiple acutely unwell patients. Delayed in assessing unwell patients due to workload. I believe this is an unsafe shift with inadequate cover.
CF	Respiratory medicine	Under minimum agreed staffing level on the ward due to sickness
F1	Urology	Sick patient managed well by junior with phone advice from reg (busy with another emergency) and IR consultant support. Junior felt out of depth. Debriefed with consultant - Advised to call consultant on call if reg busy.
F1	General Surgery	No registrar was found for the shift hence my-self and the SHO had a heavier workload.

EDUCATIONAL EXCEPTION REPORTS - 7

Number of exceptions	Rota	Issues
1	F1 – T&O	Poor staffing affecting ability to leave. D/W supervisor.
1	CF – Resp Med	Unable to attend clinic due to 10 days below minimum staffing due to sickness
2	F2 – O&G	Extreme staffing issues in O&G. Unable to attend F2 teaching. F2 prog Director D/W trainee and flagged to rota writers and will monitor.
3	F1 – Gen Med	Below minimum staffing unable to attend F2 teaching

***All F1/2 mandatory teaching is available as a video recording and is sent out to doctors unable to attend**

'HOURS' EXCEPTION REPORTS BY ROTA - Most reports from medicine rotas

Rota	TOTAL Reports
F1 Medicine	**37**
Clinical Fellow CT1-2 Medicine	**25**
General Surgery F2 - CT	**16**
F2/CT Acute Block A & B	**6**
Renal Medicine F1 NWD	**5**
FY1 13 slots	**1**
Medicine ST3+ 22 doctor	**1**
Vascular CT NWD	**2**
Neurosci F2 - C/ST2 15	**1**

T&O F1	**1**
NWD Clinical Fellow Medicine	**2**
Psychiatry F1	**2**
TOTAL	

5. **POSTGRADUATE DOCTOR FORUM** – Held in person and via Teams in May 2022 and July 2022
   - Improved engagement asked for by Trust Board:
     - Guest speakers trialled – 1st speaker – Expedition Medicine – July PDF
     - Refreshed posters in Mess
     - Offer of £5 Vu voucher for all PDF attendees
     - Banner added to intranet and dates on LINK calendar
     - Re-recorded GOSW videos for Induction and Educational Supervisors
     - Continue to recruit new Reps via posters and monthly email – currently 23 reps across specialties
   - Ideas generated in PDF – app for locum contacts, Lanyard to indicate at end of shift to encourage timely departure

Other issues arising:

1. **Rotas sent out late – It is a contractual requirement that doctors receive their individualised rotas 6 weeks before commencing duties**
   - Neuro, T&O, Histo/Cell Pathology, Radiology, ED, Medicine – All sent out rotas late
   - 2 complaints received from trainees about late rotas impacting their personal lives
   - No specific IT or workforce deficit identified as a cause by HR

2. **Planning leave is challenging at NBT for postgrad doctors**
   - Rotas are not made available for the year (unlike some other Trusts) – acute block allocation in medicine may be a factor
   - Using e-roster to swap shifts is laborious
   - HR are looking at whether enhanced access (planner view) is possible for trainees to enable easier shift swap planning

3. **Possible lack of awareness of process/value of exception reporting**
   - → New hyperlink to Allocate on Trust all apps intranet space – May 2021
     - Signposted via posters in Mess
   - →Refreshed video for junior induction for August
   - →Lecture delivered to Foundation doctors – plan to deliver each August
   - → Reps appointed - part of role to champion exception reporting
   - →Monthly GOSW update newsletter with tips on exception reporting
   - →Monthly 'You said, we did' exception reporting element in a new GOSW newsletter to all trainee doctors

4. **Anecdotal evidence that exception reporting is seen as 'complaining' by some consultants and trainees**
   - →New video for educational supervisor update days recorded asking them to signpost and encourage exception reporting at their first trainee meetings

5. **Allocate not very user friendly/does not 'encourage' exception reporting**
   - Consideration when Allocate contract expires (18 months) of moving to competitor DRS because:
     - DRS developing an App - trainees can complete exception at home rather than staying even later
     - Allows trainees to notify one other trainee when they exception report (an 'I am Spartacus' idea to show others it is ok to exception report)
     - Interacts with roster to add on any TOIL to the trainee's rota if agreed
     - Shows trainee what they are paid if payment is agreed
     - Calculates fines
     - Greater end user refinement in defining exception types

Networking

- The Guardian is in contact by WhatsApp and Zoom with national and regional groups
- NHS-Employers remote meetings to network with them and other Guardians
- Allocate training sessions x 3
- Webinar BMA GOSW conference – 22/6/22 - attended

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

SUMMARY

NBT is compliant with:

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

Concerns:

- Unfilled gaps in rotas remain a concern.
- Late sharing of individualised rotas with postgrad doctors after the 6-week deadline in several specialties
- Are the current levels of exception reporting a true representation of junior doctor hours/breaks?
- Is Allocate the best system for encouraging exception reporting?
- Management of seasonal departure of CFs and the gaps that leaves on the rota

Recommendations:

1. The Board are asked to read and note this report from the Guardian of Safe Working
2. The Board are asked to note ongoing Junior Doctor Contract changes.
3. The Board are asked to consider the appointment of PA to previously held CF posts
4. The Board are asked to look competitively at other providers of exception reporting software when the current contract expires

Dr Lucy Kirkham, Trust Guardian for Safe Junior Doctor Working

Report To:	Trust Board Meeting		
Date of Meeting:	28th July 2022		
Report Title:	Annual Medical Revalidation and Appraisal Report		
Report Author & Job Title	Joe Marriott, Medical Revalidation Manager Dr Sanjoy Shah, Deputy Chief Medical Officer & Revalidation Lead		
Executive/Non-executive Sponsor (presenting)	Mr Tim Whittlestone, Chief Medical Officer		
Does the paper contain:	**Patient identifiable information?**	**Staff identifiable information?**	**Commercially sensitive information?**
*If any boxes above ticked, paper may need to be received at *private* meeting			
Purpose: [enter a X in the correct box]	**Approval**	**Discussion**	**To Receive for Information**
			X
Recommendation:	The board are asked to review the content of the report for information and sign the statement of compliance in Appendix A		
Report History:	Last report provided on 27th July 2021		
Next Steps:	Approve & sign the statement of compliance in Appendix A for return to NHS England		

Executive Summary

North Bristol Trust is the designated body supporting the revalidation of 850 non-training grade doctors and the annual appraisal of 838 non-training grade doctors. Well established processes are in place to quality assure the appraisal process and to identify doctors who have missed their appraisals.

The medical appraisal year runs from April – March which is set by NHS England. This report refers to the 2021/22 appraisal year which ended on the 31st March 2022.

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

April 2022 and were satisfied overall with the current appraisal systems, with only minor recommendations for improvement (which have been subsequently brought into effect). The report also highlights some of the changes that have taken place over the past 12 months to improve the quality management of the appraisal and revalidation processes within the past 12 months.	
Strategic Theme/Corporate Objective Links	**2. Developing Healthcare for the future** a. Training, educating and developing our workforce b. Increase our capability to deliver research c. Support development & adoption of innovations **3. Employer of choice** a. A great place to work that is diverse & inclusive b. Support our staff to continuously develop c. Support staff health & wellbeing
Board Assurance Framework/Trust Risk Register Links	Revalidation is a legal requirement for all GMC licenced doctors. Failure to comply with the revalidation requirements can put the doctor's licence to practice at risk and result in suspension from work. This paper describes the processes in place to support doctors at NBT in their revalidation.
Other Standard Reference	N/A
Financial implications	N/A
Other Resource Implications	Sufficient resource is available to fulfil the requirements of appraisal and revalidation at NBT
Legal Implications including Equality, Diversity and Inclusion Assessment	• Revalidation is a legal requirement for doctors registered with a GMC licence to practice. • Diversity information is not collected within the appraisal and revalidation system.

Appendices:	NHSE Statement of compliance – Appendix A

1. Introduction

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

At the 31st March 2022; 838 doctors had a prescribed GMC connection to North Bristol NHS Trust meaning that NBT is their designated body for the purposes of medical revalidation. Each year every doctor must complete an appraisal that meets GMC requirements.

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

In addition to the 838 mentioned above, there are a further 12 doctors who complete annual appraisals at NBT but maintain a connection to another designated body in line with GMC designated body rules.

There are also a further 13 doctors who are registered for an appraisal at NBT but cannot be added to the Trusts designated body due to being granted temporary licences for covid support. These 13 doctors are not subject to GMC revalidation. They have been offered the chance to have an appraisal discussion around their workload and wellbeing which they can choose to take up or not at present.

2. Purpose of the Paper

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

Section 1 – Medical Appraisals

The appraisal process

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

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

Last year's report detailed how in March 2020 the medical appraisal process was suspended due to the pandemic to allow doctors additional time. NHS England confirmed that appraisals suspended during this period will be regarded as cancelled and not postponed. The appraisal process became mandatory again for all NBT doctors from the 1st April 2021. Any appraisals due prior to this date could still be marked as an approved missed appraisal if they did not take place.

The appraisal process has restarted with a continued 'light touch' approach to portfolio preparation, which was supported by NHSE. This new light touch approach to appraisal preparation means that a doctor can spend less time preparing a portfolio prior to the appraisal which is to be discussed in more detail during the meeting. Appraisers are advised to ensure that they have documented the discussion in detail within the appraisal outputs section of the form. This approach is supported by NHSE.

From September 2022, NBT will be introducing a new Appraisal Template for doctors to be completed via Fourteen Fish. This template will form the basis of a discussion point between the appraiser and appraisee and will include once again the requirement to disclose any significant events or complaints, as well as reconfirm their statutory obligations. Predominantly however, this new template will focus on the quality of the discussion with a particular emphasis on a doctor's personal health and wellbeing.

Health and wellbeing is a key focus for us at NBT, not only in appraisals, but within the wider medical workforce team agenda. The Revalidation Team, working closely with the Chief Medical Officer (CMO) and Deputy Chief Medical Officer (Deputy CMO), have set up new processes to highlight any concerns about individual's wellbeing that may have been disclosed during the appraisal. Closing the loop between the appraisal discussion and the divisional management team is essential moving forward as often the appraiser is not within the appraisee's own specialty or even Division. The process put in place now consists of weekly reviews of upcoming revalidations with the Revalidation Team and Deputy Chief Medical Officer. This consists of looking through the appraisal highlights and where there are any issues the Deputy CMO will take this forward with the individual and division concerned to ensure appropriate support is in place.

2021/22 Appraisal Compliance

The below table shows the medical appraisal rates at the 31st March 2022. These numbers cover the year April 2021 – March 2022.

Directorate	Nº of Doctors	Appraisals Due by 31st March 2022	Compliant Appraisals	Missed / Awaiting Completion	% Appraisal Compliance to date
ASCR	286	286	242	31	**85%**
Core Clinical Services	89	89	76	10	**85%**
Medical Education	11	11	10	1	**91%**
Medicine	228	228	185	29	**81%**
Neuro-MSK	165	165	130	21	**79%**
Womens and Childrens	46	46	33	11	**72%**
COVID-19 Support	13	13	12	1	**92%**
Total	**838**	**838**	**688**	**104**	**82%**

- 838 doctors were registered for an appraisal on the system at the 31st March 2022
- 825 doctors were due to have an appraisal within the year
- 688 doctors completed an appraisal either with NBT or with their previous employer prior to joining the Trust
- 104 appraisals remained incomplete at the end of the year. These doctors all expressed an interest to complete their appraisal within the year.
- There are a further 46 doctors not included within these numbers:
    - 17 doctors are not required to complete an appraisal due to long term leave (sickness or maternity) and new to UK doctors
    - 29 doctors are new employees and we await their previous appraisal information

- The 13 doctors with temporary GMC licences to support the pandemic are included in these numbers. Their appraisals are optional.

Previous Appraisal Years

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

Appraisal Year	No. of doctors due an appraisal	% of appraisals completed
2021/22	825	87%
*2019/20	617	94%
2018/19	707	92%
2017/18	667	92%
2016/17	636	89%
2015/16	636	88%
2014/15	575	87%

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

Section 2 – Quality Assurance

Revalidation Team / RO

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

The revalidation team at NBT consists of:

- Responsible Officer: Dr Tim Whittlestone, Chief Medical Officer
- Deputy Chief Medical Officer & Revalidation Lead: Dr Sanjoy Shah
- Revalidation Support Manager: Joe Marriott
- Revalidation Support Administrator: Helen Booth (part time)

Dr Whittlestone & Dr Shah have received the appropriate training for the Responsible Officer Role.

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

Funding

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

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

Designated Body Connection

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

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

Doctors joining NBT:

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

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

Doctors leaving NBT:

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

Policies

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

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

Processes Review

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

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

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

A shorter visit took place by NHS England in February 2017. The NHS England team were happy with the current progress with no recommendations made as a result.

The Trust conducted an internal audit, supported by KPMG, of the revalidation and appraisal processes in April 2022. The overall findings of this audit was of "significant assurance with minor improvement opportunities". In other words, the audit's findings were positive of the Trust's mechanisms for both appraisal and revalidation, with no concerns raised and only low-level, minimal adjustments advised to improve them. These included codifying the number of required patient and colleague feedback forms into the Trust's Appraisal and Revalidation policy, and a yearly audit of administrative access rights to the Fourteen Fish software. Both recommendations have been implemented.

Moreover, the Revalidation Support Manager and Revalidation Support Administrator meet fortnightly with the Deputy Chief Medical Officer to discuss any current issues with doctors, as well as how processes can be improved for doctors appraising and revalidating with the Trust. The emphasis in this regard has been on increased user-friendliness with appraisal and revalidation processes for doctors, in a bid to comprehensively make appraising and revalidating with the Trust a simpler and less daunting experience whenever possible.

Locum / Short Term Placements

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

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

Appraisal Compliance

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

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

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

1. Medical Appraisal & Revalidation figures report

The report highlights the following:

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

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

- Rolling % of doctors, who completed an appraisal within the past 12 months including any missed appraisals

- Breakdown of the missed appraisals

- Total number of revalidation recommendations made in each of the past 12 months.

  a. No. of positive recommendations
  b. No. of deferrals
  c. No. of non-engagement recommendations

2. Missed appraisal report

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

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

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

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

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

Quality assurance of appraisals

- Fourteen Fish allows the appraisal conversation to be summarised and captured electronically providing an audit trail of each individual step in the process
- An appraisee is required to make mandatory pre-appraisal probity statements in the system
- The appraisal inputs are required to be submitted to the appraiser prior to the date of appraisal. This provides the appraiser with sufficient time to review the content and return the form for editing if necessary.
- Information from private practice is expected to be included in an appraisal and everyone is provided with a form to complete for this. Appraisers are aware of the requirement for this and will not progress the appraisal until the information has been provided.
- Any information that the Responsible Officer deems appropriate for inclusion into a doctor's appraisal is also sent to the Revalidation Support Manager to upload to the system. This is placed in the system with mandatory reflection required. This may include letters of advice sent as a result of disciplinary processes etc.
- 360 feedback is collected through the Fourteen Fish system which provides anonymous reports meeting GMC guidance for feedback
- The Deputy RO reviews all appraisals before making a revalidation recommendation. Examples of good practice and opportunities for improvement are fed back to appraisers and appraisees at this stage.

For the appraisers:

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

For the organisation:

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

- Two key audits from Audit Southwest and the NHS England Independent Verification Visit

Appraisers

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

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

New appraiser training is provided where a drop in the number of appraisers in a division occurs or the number of appraisees rises. So far in 2022 new appraiser training has been provided for 6 NBT doctors, with 1 more doctor currently scheduled to attend new appraiser training later in July. The training was provided by an external independent trainer approved for use by NHSE, and the content of the training course had been reviewed by the revalidation support team to ensure it met the expected requirements.

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

Existing appraisers are required to attend a half day update session each year facilitated by an external trainer/coach or internally at NBT. The training days are supported by the Deputy Responsible Officer and the Revalidation Support Manager. The next such update training session is currently scheduled to occur in October 2022.

In addition to the above update training sessions, workshops were run by the Trust's Wellbeing team for appraisers in December 2021 that focused on methods to discuss mental health and wellbeing with appraisees in light of the pandemic during appraisals. With positive feedback being received by medical staff to this session more are currently being planned.

Section 3 – Recommendations to the GMC

Revalidations during Covid

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

Due to these automatic deferrals, the number of revalidations due in 2021/22 rose significantly. Data produced via the GMC's Revalidation software, GMC Connect, shows that there were 233 doctors approaching revalidation in the 2021/22 year. By the end of the 2021/22 appraisal year, 204 of these doctors had been successfully revalidated. 28 deferred their revalidation to a later date (due to either insufficient evidence or mitigating circumstances). 1 doctor failed to engage with the revalidation process and was

subsequentially a letter of non-engagement was submitted regarding them to the GMC. However, the individual concerned subsequently provided the evidence required and received their revalidation.

Trust Requirements for a Positive Recommendation

In keeping with NHSE guidance, the Trust requires the following from a doctor in order to make a positive recommendation to the GMC for revalidation:

- Evidence of 5 completed annual appraisals/ARCPs over a five year period. This number can be lowered, providing there exist suitable mitigating circumstances that would have resulted in a doctor missing a year (such as maternity leave, sickness absence, the doctor practicing abroad, etc.). Appraisals were also made optional in the 2020/21 appraisal year and this is equally brought into account.
- Evidence of 12 completed feedback forms from colleagues commenting on the doctor's quality of practice.
- Evidence of 17 completed feedback forms from patients commenting on the doctor's quality of practice.

All this required evidence is accumulated within a doctor's Fourteen Fish record for review by the CMO's office prior to making a decision on recommendation.

It is worth highlighting here that while other Trusts/employers of Medical staff may choose to require differing numbers of completed patient/colleague feedback forms North Bristol NHS Trust has chosen to require 12 and 17 accordingly based upon NHSE guidance. These numbers in turn have recently been included within the Trust's Medical Revalidation Policy (see previous).

Timely Recommendations

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

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

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

Appraisal Year	Revalidations Due	Positive	Deferral	Non-Engagement	% Deferrals Made
2022/23 (to date)	102	24	3	0	**3%**
2021/22	233	204	28	1	**12%**
2020/21	Postponed - Covid	N/A	N/A	N/A	**N/A**
2019/20	231	170	60	1	**26%**

2018/19	145	108	37	0	**26%**
2017/18	45	35	9	1	**20%**
2016/17	44	32	12	0	**27%**
2015/16	202	172	30	0	**15%**
2014/15	189	164	25	0	**13%**

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

Communicating Recommendations

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

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

Section 4 – Medical Governance

Steering Group

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

System Access

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

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

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

Appraisal supporting information

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

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

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

Responding to Concerns

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

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

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

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

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

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

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

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

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

Transferring Information

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

Information about a doctor's fitness to practice is requested from the previous designated body when a doctor joins the Trust. The NBT appraisal system expects that a doctor

declares their whole scope of work as required by the GMC. This ensures that the appraiser, revalidation support team and Responsible Officer can identify other places where the doctor works for the purposes of sharing fitness to practice information.

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

Section 5 – Employment Checks

Recruitment

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

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

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

Section 6 – Summary of Comments and Overall Conclusion

Developments over the 2021/22 year

- Appraiser CPD sessions have been run to focus on tackling wellbeing during medical appraisals, continuing from the 2020/21 year
- New appraisers continued to be trained in the role
- New Chief Medical Officer / Revalidation Officer and Deputy in post
- New Revalidation Manager in post
- Various upgrades & improvements have been made to the Fourteen Fish system, which is now in its 4th year at NBT
- Internal Audit of the Appraisal and Revalidation process at NBT has been conducted, with the assistance of our partners at KPMG – this has shown the process works extremely well at present and meets all needed requirements.

Developments for the 2022/23 year

- Run further appraiser CPD sessions on wellbeing, with a session already booked in for October 2022
- Endeavour to further utilise appraisers and Appraisal Leads to help encourage timely appraisals amongst medical staff across NBT.

Overall conclusion

Sufficient processes, funding and support is in place to run the medical revalidation process to meet the required standards. The 2021/22 year saw a big change in the way appraisals were conducted for doctors which is set to continue. The system was adjusted to meet national guidance and has been well received by most.

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

Appendix A

NHSE Statement of Compliance

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

Signed on behalf of the designated body

Chief executive or Chairman

Official name of designated body: North Bristol NHS Trust

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

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

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

Classification: Official

Publications approval reference: B0614

A framework of quality assurance for responsible officers and revalidation

Annex D – annual board report and statement of compliance

Version 1, July 2021

Contents

Introduction:

The Framework of Quality Assurance (FQA) for Responsible Officers and Revalidation was first published in April 2014 and comprised of the main FQA document and seven annexes A – G.

In 2019 a review of the Annual Organisational Audit (AOA), Board Report template and the Statement of Compliance concluded with a slimmed down version of the AOA (Annex C) and a revised Board Report template (Annex D), which was combined with the Statement of Compliance (previously listed as Annex E) for efficiency and simplicity.

Annual Organisational Audit (AOA):

At the end of April 2021, Professor Stephen Powis wrote to Responsible Officers and Medical Directors in England letting them know that although the 2020/2021 AOA exercise had been stood down, organisations will still be able to report on their appraisal data and the impact of adopting the Appraisal 2020 model, for those organisations who have, in their annual Board report and Statement of Compliance.

Board Report template:

Following the revision of the Board Report template in June 2019 to include the qualitative questions previously contained in the AOA, the template has been further updated this year to provide organisations with an opportunity to report on their appraisal data as described in the letter from Professor Stephen Powis.

A link to the letter is below:

https://www.england.nhs.uk/coronavirus/publication/covid-19-and-professional-standards-activities-letter-from-professor-stephen-powis/

The changes made to this year's template are as follows:

Section 2a – Effective Appraisal

Organisations can use this section to provide their appraisal information, including the challenges faced through either pausing or continuing appraisals throughout and the experience of using the Appraisal 2020 model if adopted as the default model.

Section 2b – Appraisal Data

Organisations can provide high level appraisal data for the period 1 April 2020 – 31 March 2021 in the table provided. Whilst a designated body with significant groups of doctors (e.g. consultants, SAS and locum doctors) will find it useful to maintain internal audit data of the appraisal rates in each group, the high-level overall rate requested is enough information to demonstrate compliance.

With these additional changes, the purpose of the Board Report template is to help the designated body review this area and demonstrate compliance with the responsible officer regulations. It simultaneously helps designated bodies assess their effectiveness in supporting medical governance in keeping with the General Medical Council (GMC) handbook on medical governance.[1] This publication describes a four-point checklist for organisations in respect of good medical governance, signed up to by the national UK systems regulators including the Care Quality Commission (CQC). The intention is therefore to help designated bodies meet the requirements of the system regulator as well as those of the professional regulator. Bringing these two quality strands together has the benefits of avoiding duplication of recording and harnessing them into one overall approach.

The over-riding intention is to create a Board Report template that guides organisations by setting out the key requirements for compliance with regulations and key national guidance, and provides a format to review these requirements, so that the designated body can demonstrate not only basic compliance but continued improvement over time. Completion of the template will therefore:

a) help the designated body in its pursuit of quality improvement,

b) provide the necessary assurance to the higher-level responsible officer, and

c) act as evidence for CQC inspections.

[1] Effective clinical governance for the medical profession: a handbook for organisations employing, contracting or overseeing the practice of doctors GMC (2018) [https://www.gmc-uk.org/-/media/documents/governance-handbook-2018_pdf-76395284.pdf]

Statement of Compliance:

The Statement Compliance (in Section 8) has been combined with the Board Report for efficiency and simplicity.

Designated Body Annual Board Report

Section 1 – General:

The board / executive management team – [*delete as applicable*] of [*insert official name of DB*] can confirm that:

1. An appropriately trained licensed medical practitioner is nominated or appointed as a responsible officer.

Yes Action from last year: Responsible Officer marked as Dr Chris Burton, Medical Director at North Bristol NHS Trust. Comments: In July 2021 Dr Tim Whittlestone replaced Dr Chris Burton as Medical Director at North Bristol NHS Trust. In turn he took on the responsibility as the listed Responsible Officer for the organisation. Action for next year: Dr Whittlestone to remain in post and as Responsible Officer.

2. The designated body provides sufficient funds, capacity and other resources for the responsible officer to carry out the responsibilities of the role.

Yes Action from last year: As below. Comments: Funding is provided from the Trusts Medical HR budget (B41768) to cover the cost of the electronic appraisal system (Fourteen Fish), CPD training for medical appraisers and the salary for the Revalidation Support Manager/Revalidation Support Administrator. Action for next year: As above to remain in place.

3. An accurate record of all licensed medical practitioners with a prescribed connection to the designated body is always maintained.

Yes

Action from last year: As below.

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

Doctors joining NBT:

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

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

Doctors leaving NBT:

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

Action for next year: As above to remain in place.

4. All policies in place to support medical revalidation are actively monitored and regularly reviewed.

Yes

Action from last year: The NBT Appraisal and Revalidation Policy and User Guide was updated and signed off by the Joint Local Negotiating Committee (JLNC) on 10th May 2021. All other Trust Policies that link with the medical appraisal process are monitored and updated on a regular basis as part of usual review process.

Comments: Following an internal audit in April 2022 the policy was modified briefly in wording to detail exactly how much patient and colleague feedback would be accepted by the Responsible Officer for a doctor to be successfully recommended to the GMC to be revalidated. As such a change to the policy was minor it was agreed that another sign-off by the JLNC was not needed.

Moreover, the Revalidation Support Manager and Revalidation Support Administrator presently meet fortnightly with the Deputy Chief Medical Officer to discuss any current issues with doctors, as well as how processes can be improved for doctors appraising and revalidating with the Trust. The emphasis in this regard has been on increased user-friendliness with appraisal and revalidation processes for doctors, in a bid to comprehensively make appraising and revalidating with the Trust a simpler and less daunting experience whenever possible.

Action for next year: None. Above policy to remain in place for the foreseeable future. Policy due to be reviewed again in 2024.

5. A peer review has been undertaken (where possible) of this organisation's appraisal and revalidation processes.

Yes

Actions from last year: See below

Comments: The Trust conducted an internal audit, supported by KPMG, of the revalidation and appraisal processes in April 2022. The overall findings of this audit was of "significant assurance with minor improvement opportunities". In other words, the audit's findings were positive of the Trust's mechanisms for both appraisal and revalidation, with no concerns raised and only low-level, minimal adjustments advised to improve them. These included codifying the number of required patient and colleague feedback forms into the Trust's Appraisal and Revalidation policy, and a yearly audit of administrative access rights to the Fourteen Fish software. Both of these recommendations have been implemented.

Action for next year: Similar quality audit to be held by the Revalidation Team with peer review by the Medical Director's office.

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

Yes

Action from last year: As below

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

Action for next year: As above to continue.

Section 2a – Effective Appraisal

1. All doctors in this organisation have an annual appraisal that covers a doctor's whole practice, which takes account of all relevant information relating to the doctor's fitness to practice (for their work carried out in the organisation and for work carried out for any other body in the appraisal period), including information about complaints, significant events and outlying clinical

outcomes. For organisations that have adopted the Appraisal 2020 model, there is a reduced requirement for preparation by the doctor and a greater emphasis on verbal reflection and discussion in appraisal meetings. Organisations might therefore choose to reflect on the impact of this change. Those organisations that have not yet used the Appraisal 2020 model may want to consider whether to adopt the model and how they will do so.

Yes

Action from last year: As below.

Comments: Medical appraisal compliance is captured on an annual basis, with each appraisal year running from 1st April - 31st March. All doctors have an annual appraisal due date and in a normal year, they must complete their appraisal by the due date to ensure that they complete an appraisal each year. Appraisals may be missed for reasonable mitigating circumstances, such as maternity or long term sick leave. All doctors are expected to cover all aspects of their practice as part of the appraisal through discussion being led by the Fourteen Fish “Appraisal Template”, which requires them to declare any work carried out for any other organisation.

From September 2022, NBT will be introducing a new Appraisal Template for doctors to be completed via Fourteen Fish. This template will form the basis of a discussion point between the appraiser and appraisee and will include once again the requirement to disclose any significant events or complaints, as well as reconfirm their statutory obligations. Predominantly however, this new template will focus on the quality of the discussion with a particular emphasis on a doctor’s personal health and wellbeing.

Health and wellbeing is a key focus for us at NBT, not only in appraisals, but within the wider medical workforce team agenda. The Revalidation Team, working closely with the Chief Medical Officer (CMO) and Deputy Chief Medical Officer (Deputy CMO), have set up new processes to highlight any concerns about individual’s wellbeing that may have been disclosed during the appraisal. Closing the loop between the appraisal discussion and the divisional management team is essential moving forward as often the appraiser is not within the appraisee’s own specialty or even Division. The process put in place now consists of weekly reviews of upcoming revalidations with the Revalidation Team and Deputy Chief Medical Officer. This consists of looking through the appraisal highlights and where there are any issues the Deputy CMO will take this forward with the individual and division concerned to ensure appropriate support is in place.

Action for next year: As above.

2. Where in Question 1 this does not occur, there is full understanding of the reasons why and suitable action is taken.

Yes

Action from last year: As below

Comments: Appraisals may be missed for reasonable mitigating circumstances, such as maternity or long term sick leave. If a doctor misses the due date for their annual appraisal, this is picked up via monthly reporting using data from the Fourteen Fish system, and escalated to the doctor's departmental Appraisal lead and Directorate Clinical Advisor for further exploration of the reasons why and for suitable action to be taken accordingly.

Action for next year: As above

3. There is a medical appraisal policy in place that is compliant with national policy and has received the Board's approval (or by an equivalent governance or executive group).

Yes

Action from last year: As below

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

Action for next year: As above. Policy due for review in May 2024.

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

Yes

Action from last year:

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

New appraiser training is provided where a drop in the number of appraisers in a division occurs or the number of appraisees rises. So far in 2022 new appraiser training has been provided for 6 NBT doctors, with 1 more doctor currently scheduled to attend new appraiser training later in July. The training was provided by an external independent trainer approved for use by NHSE, and the content of the training course had been reviewed by the revalidation support team to ensure it met the expected requirements.

Action for next year: As above – appraiser numbers to be monitored and training offered/implemented accordingly when the ratio of appraisees/appraisers changes in a department.

5. Medical appraisers participate in ongoing performance review and training/ development activities, to include attendance at appraisal network/development events, peer review and calibration of professional judgements (Quality Assurance of Medical Appraisers[2] or equivalent).

Yes

Action from last year:

Comments: Existing appraisers are required to attend a half day update session each year facilitated by an external trainer/coach or internally at NBT. The training days are supported by the Deputy Responsible Officer and the Revalidation Support Manager. The next such update training session is currently scheduled to occur in October 2022.

In addition to the above update training sessions, workshops were run by the Trust's Wellbeing team for appraisers in December 2021 that focused on methods to discuss mental health and wellbeing with appraisees in light of the pandemic during appraisals. With positive feedback being received by medical staff to this session more are currently being planned

Action for next year: Appraisal update training sessions to continue to be booked and facilitated.

[2] http://www.england.nhs.uk/revalidation/ro/app-syst/

11 | Annex D – annual board report and statement of compliance

6. The appraisal system in place for the doctors in your organisation is subject to a quality assurance process and the findings are reported to the Board or equivalent governance group.

Yes

Action from last year:

Comments:

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

The Trust conducted an internal audit, supported by KPMG, of the revalidation and appraisal processes in April 2022. The overall findings of this audit was of "significant assurance with minor improvement opportunities". In other words, the audit's findings were positive of the Trust's mechanisms for both appraisal and revalidation, with no concerns raised and only low-level, minimal adjustments advised to improve them. These included codifying the number of required patient and colleague feedback forms into the Trust's Appraisal and Revalidation policy, and a yearly audit of administrative access rights to the Fourteen Fish software. Both of these recommendations have been implemented. Results of this audit in turn have been reporting to the Medical Professionals Group, a sub-Board governance group, and approved.

Action for next year: Medical Decision Making group to continue being reported to as above. Future levels of audits scheduled for coming years

Section 2b – Appraisal Data

1. The numbers of appraisals undertaken, not undertaken and the total number of agreed exceptions can be recorded in the table below.

Name of organisation:	
Total number of doctors with a prescribed connection as at 31 March 2022	**838**
Total number of appraisals undertaken between 1 April 2021 and 31 March 2022	**688**

Total number of appraisals not undertaken between 1 April 2021 and 31 March 2022	**150**
Total number of agreed exceptions	**46**

Section 3 – Recommendations to the GMC

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

Yes

Action from last year:

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

The RO and Revalidation Lead then make a final decision which is returned to the GMC online. The majority of deferrals are due to incomplete colleague and patient feedback. The revalidation support team are working with Fourteen Fish to develop a new method of engaging doctors with their feedback earlier in the revalidation cycle to reduce the number of deferrals due to lack of feedback.

Action for next year: To continue as above

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

Yes

Action from last year:

Comments: When a positive recommendation is made, the doctor is notified in writing by the CMO's Office. As a doctor's portfolio is reviewed in advance of their revalidation date, the individual is notified of any gaps in their portfolio which may result in a deferral by the Medical Revalidation Team. The doctor is also notified by the Trusts Revalidation Manager, Administrator or the CMO's Office in advance of making a deferral. In the case of a non-engagement recommendation, the Trusts Revalidation team

will exhaust all of their internal communications to the doctor before advising them of the decision. The GMC also send confirmation of a revalidation decision to the doctor once it has been made.

Action for next year: To continue as above

Section 4 – Medical governance

1. This organisation creates an environment which delivers effective clinical governance for doctors.

Yes

Action from last year:

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

Action for next year: To continue as above

2. Effective systems are in place for monitoring the conduct and performance of all doctors working in our organisation and all relevant information is provided for doctors to include at their appraisal.

Yes

Action from last year:

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

The Revalidation Support Team no longer input the details of complaints and incidents into doctors' portfolios for appraisals, however this

information is available to all doctors employed in the Trust. The Fourteen Fish system also requires statements from each doctor as mandatory before the appraisal can continue.

Action for next year: To continue as above

3. There is a process established for responding to concerns about any licensed medical practitioner's[1] fitness to practise, which is supported by an approved responding to concerns policy that includes arrangements for investigation and intervention for capability, conduct, health and fitness to practise concerns.

Yes

Action from last year:

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

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

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

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

Action for next year: To continue as above.

4. The system for responding to concerns about a doctor in our organisation is subject to a quality assurance process and the findings are reported to the Board or equivalent governance group. Analysis includes numbers, type and outcome of concerns, as well as aspects such as consideration of protected characteristics of the doctors.[3]

Yes
Action from last year:
Comments: The Medical Decision Making group is guided by the Just Culture policy at NBT. The Board receives a regular report detailing all doctors who are in or have recently left an MHPS process.
Action for next year: To continue as above.

[3] This question sets out the expectation that an organisation gathers high level data on the management of concerns about doctors. It is envisaged information in this important area may be requested in future AOA exercises so that the results can be reported on at a regional and national level.

5. There is a process for transferring information and concerns quickly and effectively between the responsible officer in our organisation and other responsible officers (or persons with appropriate governance responsibility) about a) doctors connected to your organisation and who also work in other places, and b) doctors connected elsewhere but who also work in our organisation.[4]

Yes

Action from last year:

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

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

Action for next year: To continue as above.

[4] The Medical Profession (Responsible Officers) Regulations 2011, regulation 11: http://www.legislation.gov.uk/ukdsi/2010/9780111500286/contents

6. Safeguards are in place to ensure clinical governance arrangements for doctors including processes for responding to concerns about a doctor's practice, are fair and free from bias and discrimination (Ref GMC governance handbook).

Yes

Action from last year:

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

Action for next year: As above to continue.

Section 5 – Employment Checks

1. A system is in place to ensure the appropriate pre-employment background checks are undertaken to confirm all doctors, including locum and short-term doctors, have qualifications and are suitably skilled and knowledgeable to undertake their professional duties.

Yes

Action from last year: As below

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

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

Action for next year: As above to continue.

Section 6 – Summary of comments, and overall conclusion

Most processes at North Bristol NHS Trust in regards to Medical Revalidation and Appraisal remain the same – the system works well and has been proven to do so via audit, and therefore little has needed to be modified in order for the Trust as a Designated Body to continue to meet its obligations.

A new Revalidation Support Manager has however come into the role, and continues to support all Medical staff who require appraisal and revalidation with North Bristol Trust as a designated body, as well as maintain and invest in improving processes to ensure this obligations continue to be met.

Overall conclusion:

Sufficient processes, funding and support is in place to run the medical revalidation process to meet the required standards. The 2021/22 year saw a big change in the way appraisals were conducted for doctors which is set to continue. The system was adjusted to meet national guidance and has been well received by most

Overall, North Bristol NHS Trust as Designated Body can clearly demonstrate that it continues to maintain compliance with the responsible officer regulations, and effectively supports medical governance in keeping with the General Medical Council (GMC) handbook on medical governance. A robust Appraisal and Revalidation system for medical staff remains in place at the Trust, which has been recently audited and signed off at a suitable level to fit with Clinical Governance guidelines.

Section 7 – Statement of Compliance:

The Board / executive management team – [*delete as applicable*] of [*insert official name of DB*] has reviewed the content of this report and can confirm the organisation is compliant with The Medical Profession (Responsible Officers) Regulations 2010 (as amended in 2013).

Signed on behalf of the designated body

[(Chief executive or chairman (or executive if no board exists)]

Official name of designated body: _ _ _ _ _ _ _ _ _ _ _

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

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

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

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This publication can be made available in a number of other formats on request.

Publication approval reference: PAR614

Report To:	Trust Board - Public		
Date of Meeting:	28 July 2022		
Report Title:	People Committee Upward Report		
Report Author & Job Title	Kate Debley, Deputy Trust Secretary		
Executive/Non-executive Sponsor (presenting)	Kelvin Blake, Non-Executive Director and Chair of People Committee		
Does the paper contain:	**Patient identifiable information?**	**Staff identifiable information?**	**Commercially sensitive information?**
*If any boxes above ticked, paper may need to be received at *private* meeting			
Purpose:	**Approval**	**Discussion**	**To Receive for Information**
			X
Recommendation:	That Trust Board receive the upward report for assurance.		
Report History:	The report is a standing item to each Trust Board meeting following a People Committee meeting.		
Next Steps:	The next report to Trust Board will be to the October 2022 meeting.		

Executive Summary
The report provides a summary of the assurances received, issues to be escalated to the Trust Board and any new risks identified from the People Committee Meeting held on 5 July 2022.

Strategic Theme/Corporate Objective Links	**Developing Healthcare for the future** a. Training, educating and developing out workforce b. Increase our capability to deliver research c. Support development & adoption of innovations d. Invest in digital technology **Employer of choice** e. A great place to work that is diverse & inclusive f. Empowered clinically led teams g. Support our staff to continuously develop h. Support staff health & wellbeing

Board Assurance Framework/Trust Risk Register Links	Reports received support the mitigation of various BAF risks.
Other Standards Reference	Care Quality Commission Standards.
Financial implications	No financial implications as a consequence of this report.
Other Resource Implications	No other resource implications as a result of this report.
Legal Implications	No legal implications.
Equality, Diversity and Inclusion Assessment (EIA)	Full EIA page with EIA form to guide your assessment here: https://link.nbt.nhs.uk/Interact/Pages/Content/Document.aspx?id=9760 N/A
Appendices:	

1. Purpose

1.1. To provide a highlight of the key assurances, any escalations to the Board and identification of any new risks from the People Committee meeting held on 5 July 2022.

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. Key Assurances & matters for the attention of Trust Board

3.1. Chief People Officer Update

The Committee received an update from the Chief People Officer, which included an outline of the revised structure for the People directorate. The Committee were also updated in relation to new appointments to the team.

The Committee heard that work is being done to reduce the 'cost of employment' for staff particularly given the current national cost of living crisis, for example in relation to parking costs and subsidised food provision on site. The Committee shared their concerns about the cost of living crisis, and in particular its impact on the lowest earners in the organisation, and asked to be kept updated on this work going forward.

3.2. Health & Safety Committee Update

The Committee received an update on the Health & Safety Committee and were reassured that good progress has been made towards more robust governance for Health & Safety, and that the Health & Safety Committee is now receiving regular upward reports from safety groups.

In relation to recommendations in the Health & Safety Internal Audit Report, the Committee heard that significant progress had been made. It was further noted that a Fire Safety Manager was due to be starting in post shortly and that it would be a priority for them to continue work to progress actions arising from the internal Fire Safety Report.

The Committee discussed the importance of identifying the key Health & Safety risks being carried by the Trust and ensuring that there are appropriate mitigating actions and controls in place. In relation to fire safety, it was noted that additional training will be implemented so that all operational managers understand procedures and trigger points for action in the event of a fire, and that there is reduced reliance on a small number of specialists. Development and implementation of this training will be a key priority for the Fire Safety Manager.

It was noted that a Report on Health & Safety would be received by the Committee at each meeting to provide assurance that safety groups have met, and to provide an overview of risks, key incidents and an update on audit actions.

3.3. Winter 2021 Preparedness: Nursing and Midwifery Safer Staffing Review June 2022

The Committee received a Report setting out a review of compliance against the NHS England Winter 2021 Preparedness: Nursing and Midwifery Safer Staffing Version 1 released in November 2021. The Committee heard that the document provided key considerations for NHS Trusts in the safe deployment and redeployment of staff during the pandemic to support decision making, escalation and assurance. This builds upon the previous guidance issued in relation to Covid-19 workforce models and the fundamental principles for the nursing and midwifery workforce as set out in the National Quality Board Safe Sustainable and Productive staffing guidance.

The Committee were reassured that an internal review has been undertaken of NBT current compliance with this framework and that the Trust had been found to be compliant in all areas. The Committee were further reassured that this has also been a useful exercise in helping to confirm that appropriate procedures are in place ahead of Winter 2022.

3.4. Trust-Level Risks and Board Assurance Framework (Workforce and Health & Safety)

The Committee noted the updates to the Trust-level risks and BAF Report, including the increased number of Workforce risks.

The Committee heard that the strategic risk relating to national and system competition for workforce in key specialties continues to be scored at 20 and that this reflects the overall staffing pressures faced by the Trust across key professions and the recognised national workforce shortages in certain areas. Actions to mitigate this strategic risk include the focus on system-wide workforce planning, international recruitment and new recruitment campaigns such as the successful BNSSG Healthcare Support Worker recruitment campaign in May/June 2022.

3.5. Clinical Workforce

The Committee received Highlight Reports from the Medical Professionals Group and Multi-Professional Clinical Workforce Committee.

The Committee welcomed the update that the roll-out of eJob Planning is progressing well, with over 85% of medical job plans now entered onto the system. The Committee emphasised the importance of ensuring that an appropriate balance is struck between rosters meeting both personal and business need. The Committee noted that behavioural and cultural change will also be needed to ensure that the roll-out is a success.

It was further noted that significant financial and anti-fraud benefits were anticipated from moving onto e-Rostering and eJob Planning, with a reduction in costs likely to follow as a result of reduced numbers of payroll errors.

3.6. Other items:

The Committee also received updates on:

- EDI Committee Upward Report.
- JCNC & LCNC Annual Update

4. Escalations to the Board/New Risks

4.1. No items were identified for specific escalation to Trust Board.

5. Summary and Recommendations

5.1. The Trust Board is asked to receive the upward report for assurance.

Report To:	Trust Board		
Date of Meeting:	28 July 2022		
Report Title:	Integrated Performance Report		
Report Author & Job Title	Lisa Whitlow, Associate Director of Performance		
Does the paper contain	**Patient identifiable information?**	**Staff identifiable information?**	**Commercially sensitive information?**
	N/A	N/A	N/A
Executive/Non-executive Sponsor (presenting)	Executive Team		
Purpose:	**Approval**	**Discussion**	**To Receive for Information**
			X
Recommendation:	The Trust Board is asked to note the contents of the Integrated Performance Report.		
Report History:	The report is a standing item to the Trust Board Meeting.		
Next Steps:	This report is received at the Joint Consultancy and Negotiation Committee, Operational Management Board, Trust Management Team meeting, shared with Commissioners and the Quality section will be shared with the Quality and Risk Management Committee.		

Executive Summary

Details of the Trust's performance against the domains of Urgent Care, Elective Care and Diagnostics, Cancer Wait Time Standards, Quality, Workforce and Finance are provided on page six of the Integrated Performance Report.

Further to feedback from the Trust Board, a review has been undertaken of the Responsiveness section of the IPR. Headline changes are as follows:

- Information is lean – less narrative
- Original IPR was c.12 slides in the Responsiveness section – now 6
- Streamlined scorecard but maintained constitutional standards
- Focussing on relevant benchmarking – our peers – rather than all of England
- Principle applied of reporting against national standards on the scorecard vs. analysing the position against trends/improvement trajectories in the subsequent slides
- Removed the duplication from the Executive Summary vs. Section Summaries
- Standardised graphs using SPC/forecast format

Strategic Theme/Corporate Objective Links	**1. Provider of high quality patient care** a. Experts in complex urgent & emergency care b. Work in partnership to deliver great local health services c. A Centre of Excellence for specialist healthcare d. A powerhouse for pathology & imaging **2. Developing Healthcare for the future** a. Training, educating and developing our workforce b. Increase our capability to deliver research c. Support development & adoption of innovations d. Invest in digital technology **3. Employer of choice** a. A great place to work that is diverse & inclusive b. Empowered clinically led teams c. Support our staff to continuously develop d. Support staff health & wellbeing
Board Assurance Framework/Trust Risk Register Links	The report links to the BAF risks relating to internal flow, staff retention, staff engagement, productivity and clinical complexity.
Other Standard Reference	CQC Standards.
Financial implications	Whilst there is a section referring to the Trust's financial position, there are no financial implications within this paper.
Other Resource Implications	Not applicable.
Legal Implications including Equality, Diversity and Inclusion Assessment	Not applicable.
Appendices:	Not applicable.

North Bristol NHS Trust

INTEGRATED PERFORMANCE REPORT

July 2022 (presenting June 2022 data)

CONTENTS

North Bristol Trust Integrated Performance Report

NHS North Bristol NHS Trust

Domain	Description	Regulatory	National Standard	Current Month Trajectory (RAG)	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Trend	Benchmarking (in arrears except A&E & Cancer as per reporting month)	
																			Peer Performance	Rank
Responsive	A&E 4 Hour - Type 1 Performance	R	95.00%	60.00%	64.38%	54.36%	61.47%	61.75%	60.82%	60.18%	61.80%	60.78%	51.53%	52.74%	55.54%	64.14%	59.32%		50.98%	1/10
	A&E 12 Hour Trolley Breaches	R	0	-	4	97	14	38	29	59	20	295	367	449	360	176	297		3-609	6/10
	Ambulance Handover < 15 mins (%)		65.00%	-	48.46%	39.75%	37.84%	41.26%	36.19%	24.32%	20.33%	22.25%	28.72%	31.90%	28.93%	30.54%	29.50%			
	Ambulance Handover < 30 mins (%)	R	95.00%	-	73.44%	60.62%	66.21%	64.67%	56.62%	53.71%	50.34%	47.71%	48.49%	51.53%	53.02%	61.09%	55.43%			
	Ambulance Handover > 60 mins		0	-	346	636	471	418	621	664	645	827	684	681	538	430	527			
	Average No. patients not meeting Criteria to Reside			-	206	205	219	233	241	250	248	295	304	302	301	317	280			
	Bed Occupancy Rate			100.00%	96.63%	95.96%	95.32%	97.20%	97.26%	97.12%	96.92%	98.16%	97.51%	97.43%	96.94%	98.15%	98.32%			
	Diagnostic 6 Week Wait Performance		1.00%	41.12%	36.13%	38.91%	42.55%	42.83%	41.80%	40.32%	44.30%	45.45%	40.00%	40.25%	43.61%	40.13%	41.00%		32.14%	7/10
	Diagnostic 26+ Week Breaches		0	1872	1004	966	972	1099	1286	1264	1341	1617	1767	2160	2498	2690	2761			
	RTT Incomplete 18 Week Performance		92.00%	-	74.98%	73.78%	73.16%	71.87%	70.37%	69.68%	66.67%	65.61%	65.17%	64.71%	64.23%	65.62%	64.80%		59.37%	4/10
	RTT 52+ Week Breaches	R	0	2201	1473	1544	1770	1933	2068	2128	2182	2284	2296	2242	2454	2424	2675		35-10170	3/10
	RTT 78+ Week Breaches	R		479	448	532	656	659	577	497	469	501	511	458	491	473	443		0-2658	5/10
	RTT 104+ Week Breaches	R		48	19	28	34	55	93	138	158	184	177	96	71	48	34		0-475	4/10
	Total Waiting List	R		40881	32946	34315	35794	36787	37268	37297	37264	37210	38498	39101	39819	40634	42326			
	Cancer 2 Week Wait	R	93.00%	76.21%	36.44%	53.40%	66.58%	51.22%	42.70%	53.75%	58.38%	41.42%	66.47%	69.78%	57.66%	46.16%	-		75.83%	10/10
	Cancer 31 Day First Treatment		96.00%	92.60%	95.48%	95.77%	93.00%	91.89%	88.51%	86.94%	79.59%	79.18%	89.91%	80.99%	81.82%	83.77%	-		91.28%	10/10
	Cancer 62 Day Standard	R	85.00%	75.95%	62.74%	68.59%	68.60%	56.98%	57.34%	74.07%	67.52%	56.88%	51.17%	58.66%	56.48%	50.15%	-		50.59%	8/10
	Cancer 28 Day Faster Diagnosis	R	75.00%	72.93%	43.56%	65.46%	66.77%	56.07%	59.95%	66.29%	57.52%	47.10%	72.01%	72.93%	66.82%	72.83%	-		70.68%	4/10
	Cancer PTL >62 Days		242	345	-	-	-	-	501	663	899	781	528	472	641	689	555			
	Trajectory				0	0	0	0	430	392	355	317	280	475	475	410	345			
	Cancer PTL >104 Days		0	50	100	162	139	170	158	108	140	197	135	167	133	161	134			
	Urgent operations cancelled ≥2 times		0	-	-	-	-	0	2	2	2	0	0	0	1	1	-			

Please note Ambulance Handover data (<15 mins, <30 mins, >60 mins) for November 2021 onwards is provisional

RAG ratings 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 Trust Integrated Performance Report

NHS North Bristol NHS Trust

Domain	Description	Regulatory	National Standard	Current Month Trajectory (RAG)	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Trend
Quality Patient Safety & Effectiveness	5 minute apgar 7 rate at term			0.90%	0.69%	1.51%	1.15%	0.62%	1.26%	0.22%	1.15%	0.73%	0.00%	1.02%	1.08%	0.26%	1.25%	
	Caesarean Section Rate			28.00%	40.09%	39.36%	34.88%	38.74%	37.35%	39.23%	40.60%	39.15%	38.14%	42.08%	43.36%	42.82%	46.53%	
	Still Birth rate			0.40%	0.00%	0.20%	0.00%	0.57%	0.39%	0.21%	0.21%	0.22%	0.00%	0.23%	0.24%	0.24%	0.00%	
	Induction of Labour Rate			32.10%	35.29%	37.35%	35.31%	33.40%	29.05%	34.12%	35.21%	33.56%	38.39%	39.72%	34.09%	35.41%	39.35%	
	PPH 1500 ml rate			8.60%	5.17%	2.00%	2.11%	2.10%	3.94%	3.59%	3.02%	2.01%	2.44%	1.42%	2.26%	2.39%	4.86%	
	Never Event Occurrence by month		0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	
	Commissioned Patient Safety Incident Investigations				-	2	2	3	2	1	1	5	1	3	4	3	1	
	Healthcare Safety Investigation Branch Investigations				-	1	2	-	1	-	-	1	-	1	1	-	1	
	Total Incidents				1028	1173	984	1059	984	997	1010	1327	1170	1308	1204	1120	1155	
	Total Incidents (Rate per 1000 Bed Days)				43	48	40	43	39	42	41	53	51	51	48	44	54	
	WHO checklist completion			95.00%	99.93%	99.88%	99.74%	99.70%	99.36%	99.84%	99.87%	99.76%	99.61%	98.73%	99.31%	98.85%	98.19%	
	VTE Risk Assessment completion	R		95.00%	95.42%	95.59%	94.91%	94.90%	94.53%	93.84%	94.55%	93.80%	93.99%	92.63%	93.37%	92.50%	-	
	Pressure Injuries Grade 2				15	17	22	24	19	12	16	16	19	18	19	19	14	
	Pressure Injuries Grade 3			0	0	0	0	0	0	0	0	0	0	0	0	1	1	
	Pressure Injuries Grade 4			0	0	0	0	0	0	0	1	0	1	0	0	0	0	
	PI per 1,000 bed days				0.48	0.51	0.72	0.75	0.51	0.32	0.35	0.41	0.75	0.61	0.63	0.50	0.31	
	Falls per 1,000 bed days				8.53	8.36	7.84	7.24	7.33	7.48	8.33	9.87	8.84	7.23	8.05	6.57	5.91	
	#NoF - Fragile Hip Best Practice Pass Rate				68.00%	68.18%	76.32%	34.62%	35.71%	100.00%	61.90%	64.29%	54.17%	64.58%	40.00%	38.81%	-	
	Admitted to Orthopaedic Ward within 4 Hours				44.00%	51.11%	28.95%	38.46%	28.57%	40.00%	23.81%	21.43%	20.83%	14.58%	71.11%	20.90%	-	
	Medically Fit to Have Surgery within 36 Hours				80.00%	71.11%	86.84%	42.31%	36.36%	100.00%	80.95%	69.05%	62.50%	66.67%	71.11%	41.79%	-	
	Assessed by Orthogeriatrician within 72 Hours				92.00%	93.33%	100.00%	84.00%	77.78%	100.00%	90.48%	73.81%	66.67%	89.58%	93.33%	73.13%	-	
	Stroke - Patients Admitted				91	75	92	83	90	85	73	103	67	78	92	105	37	
	Stroke - 90% Stay on Stroke Ward			90.00%	80.82%	87.30%	81.43%	77.94%	78.13%	68.06%	75.00%	67.47%	72.73%	65.08%	77.14%	48.72%	-	
	Stroke - Thrombolysed <1 Hour			60.00%	70.00%	85.71%	90.91%	50.00%	27.27%	66.67%	100.00%	84.62%	60.00%	44.44%	100.00%	60.00%	-	
	Stroke - Directly Admitted to Stroke Unit <4 Hours			60.00%	49.33%	46.20%	39.19%	34.29%	40.58%	45.95%	30.16%	40.22%	32.73%	32.81%	46.58%	31.71%	-	
	Stroke - Seen by Stroke Consultant within 14 Hours			90.00%	92.11%	95.45%	88.00%	95.95%	97.18%	84.21%	80.88%	81.44%	75.41%	91.30%	84.21%	90.91%	-	
	MRSA	R	0	0	0	0	0	0	0	0	0	0	0	4	0	0	0	
	E. Coli	R		4	4	1	5	3	8	3	2	6	1	5	5	0	0	
	C. Difficile	R		5	10	6	2	5	4	1	6	6	1	6	7	4	5	
	MSSA			2	5	2	5	4	1	0	5	3	2	2	1	0	0	
Quality Caring & Experience	Friends & Family - Births - Proportion Very Good/Good				94.74%	92.68%	95.95%	91.30%	98.53%	91.53%	93.75%	93.85%	94.37%	94.81%	97.50%	91.14%	88.41%	
	Friends & Family - IP - Proportion Very Good/Good				91.79%	92.85%	91.94%	92.16%	92.25%	92.52%	91.50%	93.28%	93.51%	91.18%	90.39%	92.72%	90.96%	
	Friends & Family - OP - Proportion Very Good/Good				94.40%	94.65%	94.54%	93.77%	94.80%	94.21%	95.26%	94.37%	94.11%	94.82%	94.32%	93.83%	93.90%	
	Friends & Family - ED - Proportion Very Good/Good				73.19%	71.84%	72.87%	74.81%	73.94%	74.24%	80.64%	80.10%	70.24%	63.70%	68.93%	77.44%	70.80%	
	PALS - Count of concerns				127	127	123	123	100	93	86	100	102	111	150	129	116	
	Complaints - % Overall Response Compliance			90.00%	77.03%	85.71%	87.72%	77.36%	69.12%	72.13%	69.09%	69.23%	80.85%	78.33%	79%	78.69%	73.47%	
	Complaints - Overdue				0	2	1	8	10	10	6	11	4	5	10	4	5	
	Complaints - Written complaints				51	65	48	52	55	59	44	52	58	56	43	48	53	
Well Led	Agency Expenditure ('000s)				1029	1374	1061	1492	1576	1350	1314	1363	1147	1581	1838	1846	1205	
	Month End Vacancy Factor				5.75%	6.71%	6.95%	6.79%	6.87%	6.44%	7.71%	7.26%	7.41%	7.27%	6.64%	7.51%	8.07%	
	Turnover (Rolling 12 Months)	R		16.96%	12.45%	13.14%	14.05%	14.58%	15.21%	15.27%	15.50%	15.89%	16.51%	17.16%	16.71%	17.28%	17.41%	
	Sickness Absence (Rolling 12 month -In arrears)	R		4.81%	4.46%	4.49%	4.50%	4.52%	4.56%	4.58%	4.64%	4.71%	4.81%	5.02%	5.17%	5.23%	5.05%	
	Trust Mandatory Training Compliance				84.55%	82.82%	82.58%	82.32%	82.12%	81.97%	82.13%	82.23%	82.27%	81.67%	82.38%	83.89%	84.98%	

RAG ratings 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 | July 2022

NHS North Bristol NHS Trust

Urgent Care

Four-hour performance was 59.32% in June. The Trust ranked first out of ten reporting AMTC peer providers for the fourth consecutive month and remained in the second quartile when compared nationally. The Trust recorded an increase in ambulance handover delays with 527 reported provisionally in June, up from 430 in May. 12-hour trolley breaches also increased from 176 in May to 297; there were over 22,000 reported nationally. Four hour performance and ambulance handover times continue to be impacted by high bed occupancy at an average of 98.32% for the month – this combined with increasing COVID-19 positive Inpatients and staff sickness contributed to operational pressures. The Trust is working as part of the Acute Provider Collaborative to develop a joint view of the NC2R issue. Key drivers include increased volume of bed days for patients no longer meeting the right to reside criteria, awaiting discharge on D2A pathways. Trust-wide internal actions are focused on improving the timeliness of discharge, maximising SDEC pathways and best practice models for ward and board rounds to improve flow through the Hospital.

Elective Care and Diagnostics

The Trust has cleared capacity breaches to zero for the patients waiting >104-weeks for treatment by the end of Quarter 1 of 2022/23, achieving the national expectation. There were 2,675 patients waiting greater than 52-weeks for their treatment in May; 443 of these were patients waiting longer than 78-weeks. The Trust continues to treat patients based on their clinical priority, followed by length of wait. Diagnostic performance was static in June with performance of 41.01%. The Trust is sourcing additional internal and external capacity for several test types to support recovery of diagnostic waiting times.

Cancer Wait Time Standards

There were a number of movements in the May position for Cancer with the 31-Day First Treatment standard improving to 83.77%. 62-Day performance was 50.15% and TWW was 46.16%. Instances of clinical harm remain low month-on-month and the Trust has had no reports of harm in 12-months as a result of delays over 104-Days. Delivering a reduction in the >62-day backlog continues to be challenged by workforce issues in the Cancer Services Team and Tumour Site Pathway delays, however the backlog volume has stabilised over the last few weeks as a result of remedial actions being put in place, as part of an overall recovery plan led by a new Cancer Recovery Steering Group and supported by Regional colleagues.

Quality

Maternity recruitment initiatives are resulting in successful pipeline. Delivery of compliance against the recently refreshed CNST Maternity Incentive Scheme (Year 4) remains challenging, with a forecast to achieve 7 out of 10 standards. June saw a increase in COVID-19 demand at NBT and in the region; the Trust has safely managed outbreaks. One new MRSA bacteraemia case occurred in June; a full case review has been completed with learning and a CCG review of all cases. NBT remains nationally in the lowest quartile for SHMI indicating a lower mortality rate than most other Trusts, with no current Mortality Outlier alerts. The rate of VTE Risk Assessments performed on admission remains below the national target of 95% compliance (latest data for May 2022), reflecting the impact of ongoing operational challenges on education, training and related data capture in this area.

Workforce

The Trust vacancy factor increased from 7.51% in May to 8.07% in June, this was driven a by a decrease in staff in post and an increase in funded establishment. NBT's rolling 12-month staff turnover increased from 17.28% in May to 17.41% in June, with the stability rate for NBT increasing slightly from 83.28% in May, to 83.27% in June. Rolling 12-month sickness absence increased from 5.13% in May to 5.22% in June. *Infectious Diseases* (which includes COVID-19 Sickness), and *Anxiety/stress/depression/other psychiatric illnesses* were the leading causes of days lost to absence. Temporary staffing demand increased by 6.40% (68.47wte) from May to June.

Finance

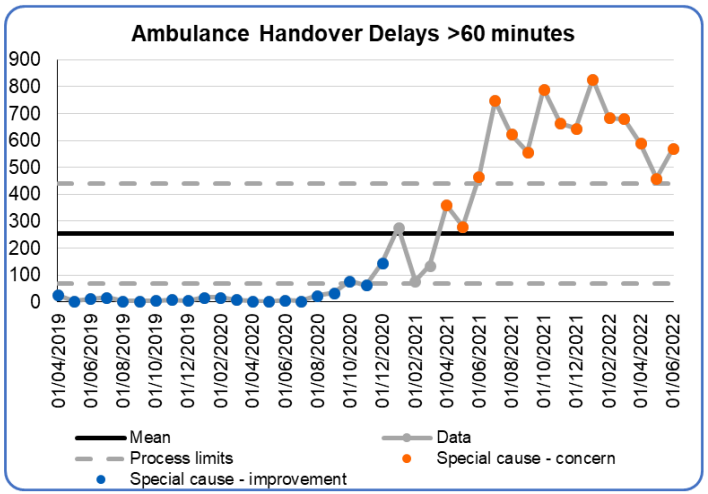
The financial plan for 2022/23 at Month 3 (June) was a deficit of £3.8m. The Trust has delivered a £7.6m deficit, which is £3.7m worse than plan. This is predominately driven by the non-delivery of savings in the first three months of the year and high levels of premium pay spend, including on agency and incentives, offset by slippage on service developments and investments. In addition, there is uncertainty around the Elective Services Recovery scheme and a provision has been made to account for this. The month 3 CIP position shows £0.5m schemes fully completed, with a further £4.1m schemes on tracker and £3.3m in pipeline. There is a £10.9m shortfall between the 2022/23 target of £15.6m and the schemes on the tracker. If pipeline schemes are included this is a £7.7m shortfall. Cash at 30 June amounts to £98.0m; an in-month decrease of £1.2m due to higher than average payments made during the month specifically around capital relating to March 2022 and reduced receipts. Total capital spend year to date was £2.6m compared to a plan of £7.4m. The impact of COVID-19 pressures on Quarter 1, which was originally expected to be an allowable overspend, has been removed, as this has been limited to April. The comparisons to plan in this paper are against the revised plan as submitted during June 2022 with some variances being driven by movement from the previous April plan.

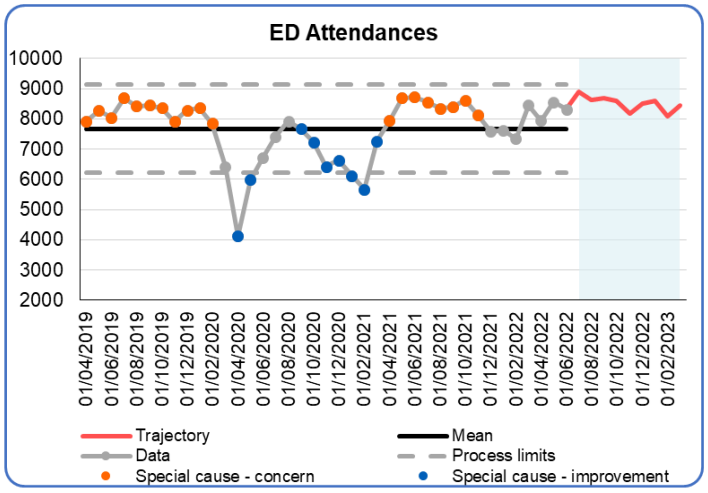
Responsiveness

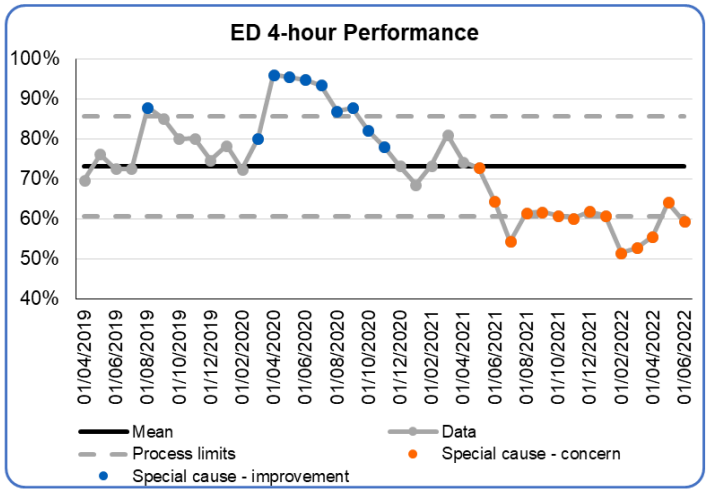
Board Sponsor: Chief Operating Officer
Steve Curry

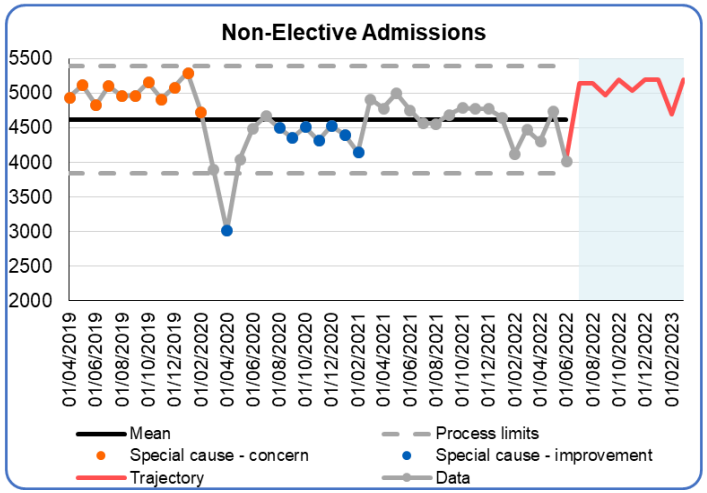
Unscheduled Care

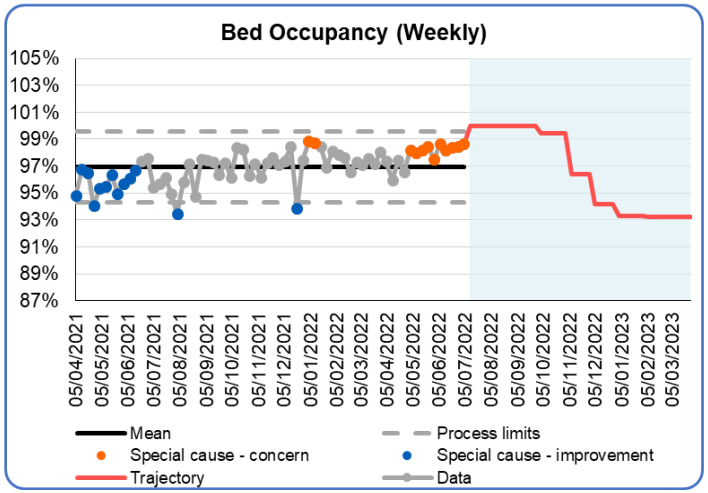
NHS North Bristol NHS Trust

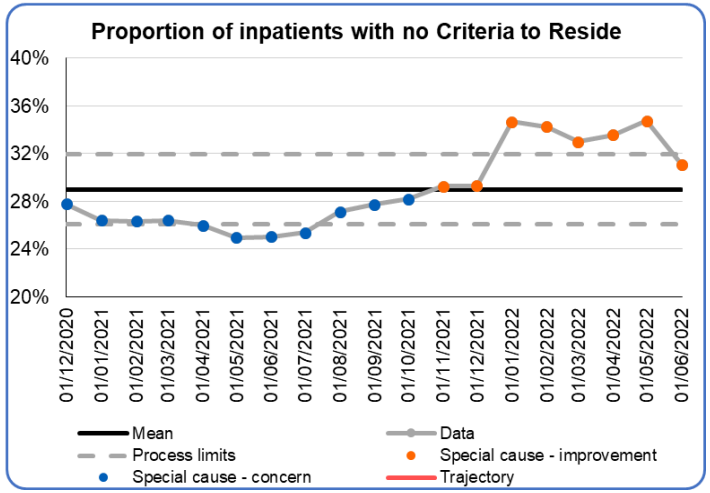












Unscheduled Care

NHS North Bristol NHS Trust

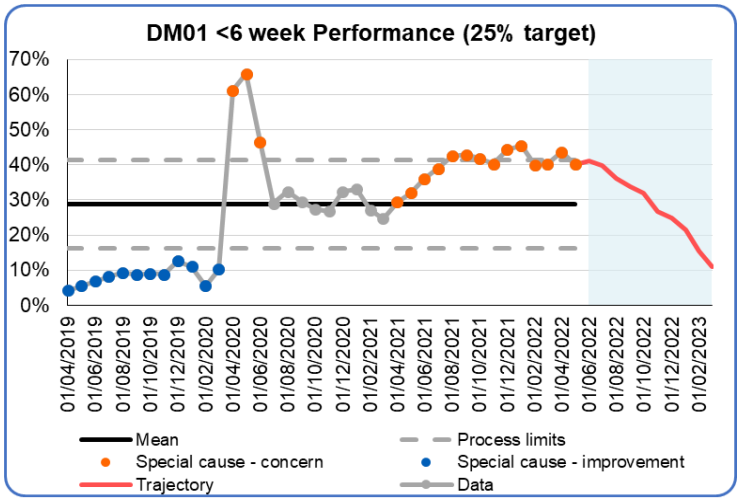
What are the main risks impacting performance?

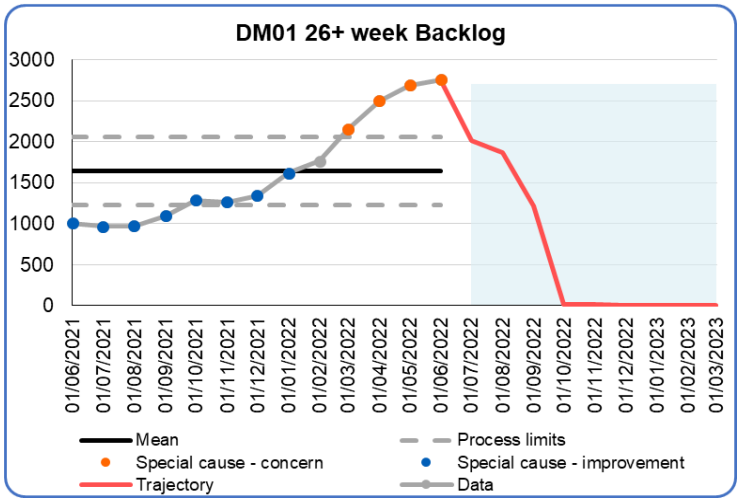
- Ambulance handovers – prolonged ambulance handover waits - driven by high bed occupancy.
- Patients with No Criteria to Reside are occupying a third of the hospital's bed capacity – no significant change.
- Lack of community capacity and/or pathway delays fail to support bed occupancy requirements.
- There has been a significant rise in COVID-19 Inpatients with a commensurate loss of beds due to IPC and staff sickness.
- The continued pressure of unfilled nursing shifts to safely manage escalation capacity in times of high bed demand.

What actions are being taken to improve?

- Ambulance handovers – Executive Nurse has led a revised approach to pre-emptive transfers of patients out of ED. Regular timed transfers now take place throughout the day in anticipation of discharges. This clinically led approach, supported by the CMO and COO, has delivered a significant reduction in ambulance hours lost. The approach is being reviewed in terms of the potential for sustaining aspects of this new wayof working.
- The Trust is working closely with system partners to influence and support schemes which will reduce NCTR patient numbers including D2A. The new EPR system, Careflow, launched in July 2022, has improved how C2R patients are recorded and captured. This offers improved monitoring at ward level and site level; providing better visibility of all patients which facilitates more focussed actions to discharge these patients.
- Ongoing implementation of the combined BNSSG Ambulance improvement plan including Acute, Community and SWASFT actions, which plans to save 2000 handover hours over 2022/23.
- Continued 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).

Diagnostic Wait Times





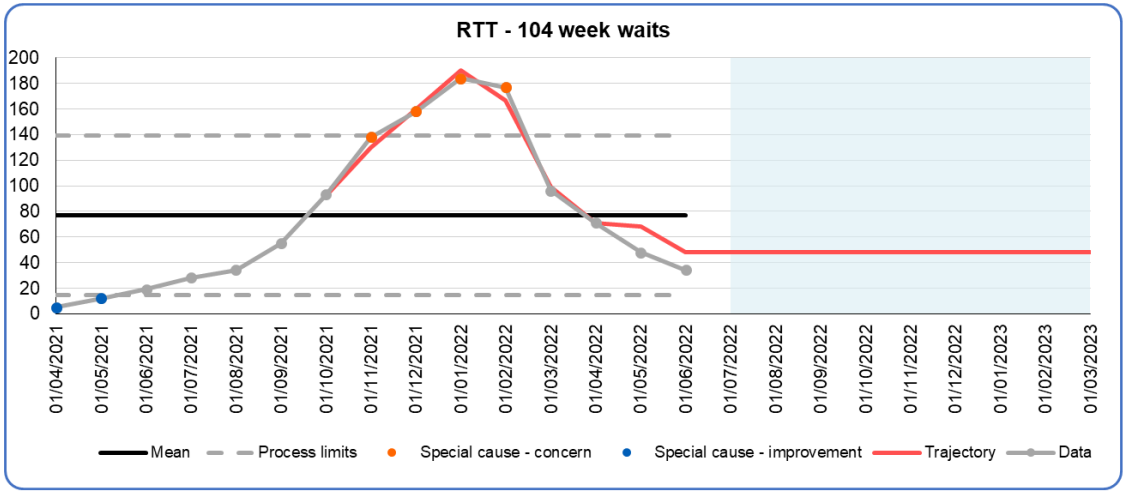
What are the main risks impacting performance?

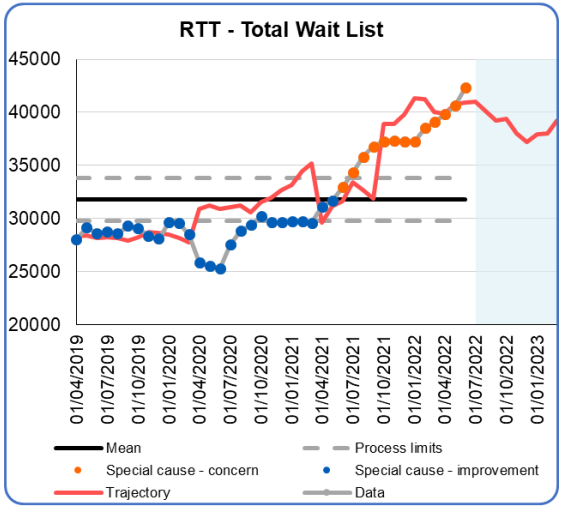
- The Trust currently relies on external organisations to provide capacity for diagnostic tests and procedures in order for the Trust to clear it's diagnostics backlog and maintain/reduce it's overall wait list size.
- Contracts agreed with external providers have not been met; fewer slots than agreed have been provided.
- Staff sickness and leave has reduced capacity. This has continued into July 2022.
- An increase in inpatient referrals since April 2021 has reduced the capacity of outpatient clinics, and therefore limited the ability of specialty teams to clear wait lists and reduce backlogs.

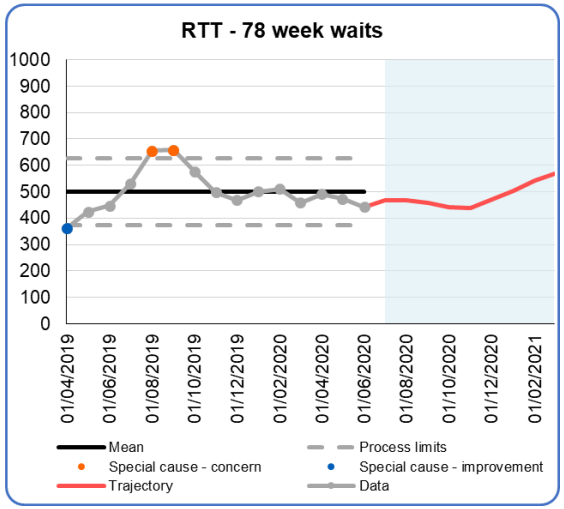
What actions are being taken to improve?

- Endoscopy – Utilising capacity from a range of insourcing and outsourcing providers, transfers to the IS, WLIs and employment of a Locum. Work is ongoing across the system to produce a shared PTL and to provide mutual aid to equalise wait times across organisations.
- Non-Obstetric Ultrasound –The Trust continues to utilise capacity from Medicare Sonographers with 3 staff offering regular lists. In addition, substantive staff are delivering WLIs and outsourcing continues to PPG..
- CT – Use of the demountable CT scanner based at Weston General Hospital has continues. WLIs are being delivered every weekend to support backlog reduction and outsourcing is about to commence to Nuffield.
- MRI – The Trust continues use of IS capacity at Nuffield and is planning to extend the working day on Cossham Suite B scanner. In addition, capacity has increased following resumption of pre-COVID-19 IPC processes.
- Echocardiography – Access to Xyla insourcing and agency capacity has increased. The Trust is seeking further opportunities to equalise wait times with neighbouring organisations and with the support of NHSE/I.

Referral to Treatment (RTT)







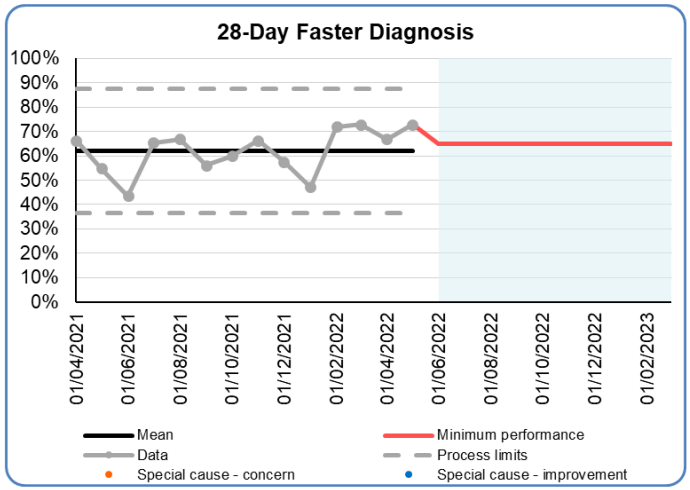
What are the main risks impacting performance?

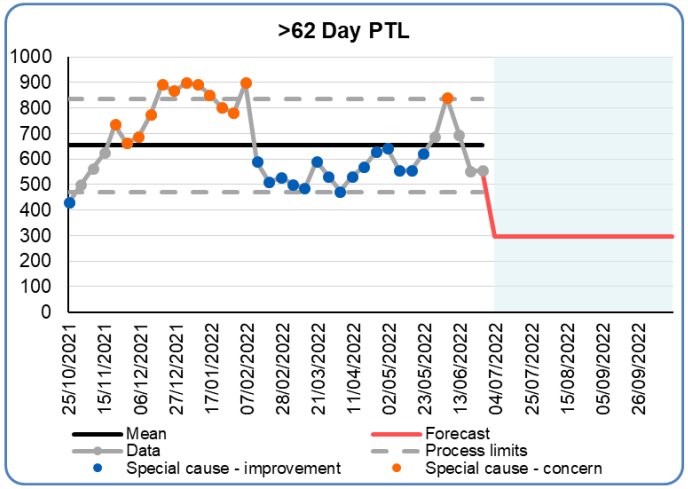
- Significant challenges to performance due to operating theatre staff absences (including COVID-19) and intense bed pressures including the rise in COVID-19 positive Inpatients.

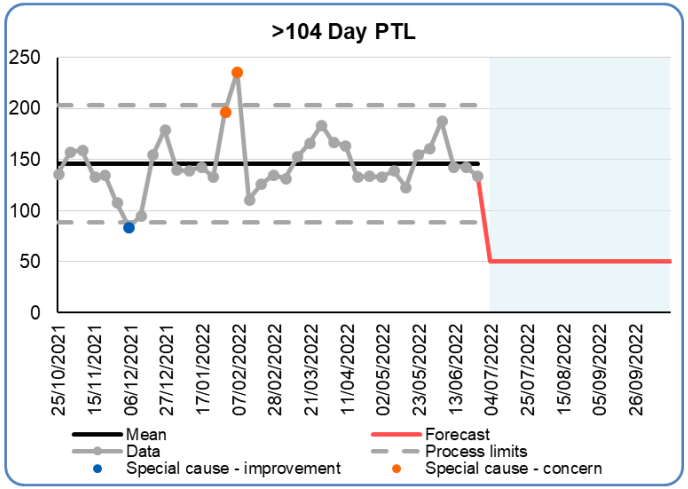
What actions are being taken to improve?

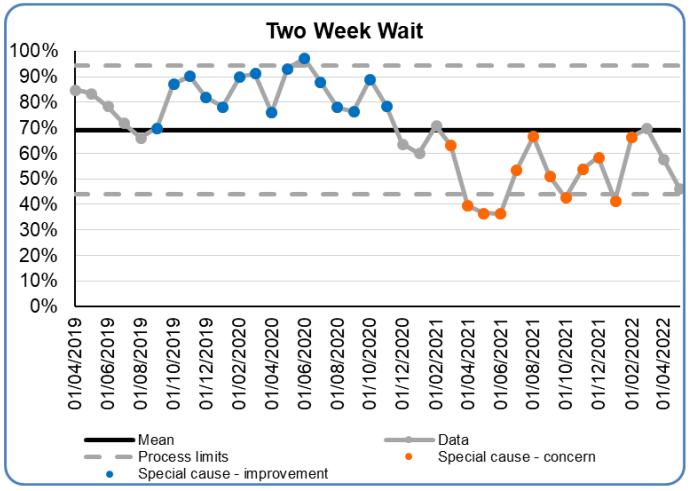
- The Elective Care Recovery Board continues to deliver a comprehensive plan to manage the waiting list to required levels with positive delivery against actions to date.
- The Trust is undertaking regular patient level tracking and proactive management of long waiting patients and specific engagement with patients at risk of exceeding 104-week waits. The Trust has cleared to zero the patients waiting >104-weeks for treatment by the end of Quarter 1 of 2022/23; this is with the exception of those patients choosing to wait longer, where it is clinically indicated following confirmation of being COVID-19 positive and where there is an instance of clinical complexity preventing earlier treatment.
- 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.

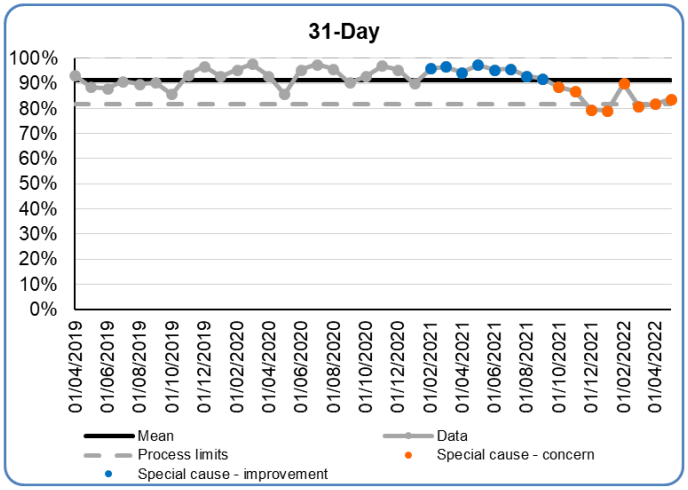
Cancer Performance

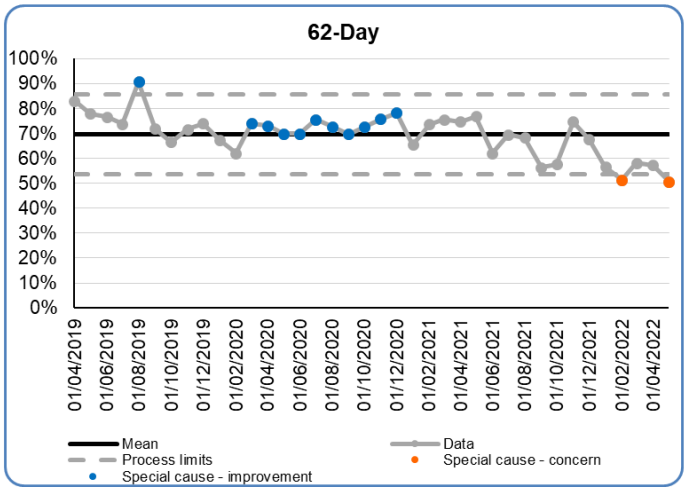












Cancer Performance

NHS North Bristol NHS Trust

What are the main risks impacting performance?

- Recruiting to and sustaining the Cancer Services Team.
- Increased referrals.
- Reliance on non-core capacity.
- Skills shortages.

What actions are being taken to improve?

- Executive led Cancer Recovery Steering Group formed.
- Rapid HR recruitment and retention plan deployed.
- Extensive validation of the backlog.
- Close working with Regional Cancer Team in support of pathway and demand and capacity planning.
- Planning underway for Tumour Site specific pathway improvements.

Safety and Effectiveness

Board Sponsors: Chief Medical Officer and Chief Nursing Officer
Tim Whittlestone and Steven Hams

NBT - PQSM	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	TREND
Activity									
NICU admission rate at term	5.6%	3.8%	2.3%	2.9%	4.5%	5.9%	4.3%	2.6%	
Perinatal Morbidity and Mortality inborn									
Total number of perinatal deaths	3	4	2	2	5	6	4	4	
Number of stillbirths 16 to 23+6 weeks excl. TOP	2	1	1	0	3	3	1	2	
Number of stillbirths (>=24 weeks excl. TOP)	1	1	1	1	0	1	1	1	
Number of neonatal deaths : 0-6 Days	0	1	1	1	0	2	2	1	
Number of neonatal deaths : 7-28 Days	0	1	0	0	2	0	0	0	
Suspected brain injuries in inborn neonates (no structural abnormalities) grade 3 HIE 37+0 (HSIB)	1	0	1	0	0	1	0	0	
Maternal Morbidity and Mortality									
Number of maternal deaths (MBRRACE)	0	0	0	0	0	1	2	0	
Direct	0	0	0	0	0	0	1	0	
Indirect	0	0	0	0	0	1	1	0	
Number of women who received level 2 & 3 care	1	1	1	1	0	0	2	1	
Insight									
Number of datix incidents graded as moderate or above (total)	2	0	2	1	0	2	1	0	
Datix incident moderate harm (not SI, excludes HSIB)	2	0	1	0	0	1	1	0	
Datix incident SI (excludes HSIB)	0	0	0	1	0	1	0	0	
New HSIB SI referrals accepted	0	0	1	0	0	2	0	1	
HSIB/NHSR/CQC 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	83	
Minimum safe staffing in maternity services: Obstetric middle grade rota gaps	1	0.5	2	1	1.3	0.7	DNA	DNA	
Minimum safe staffing in maternity services: Obstetric Consultant rota gaps	1	1	1	1	1	0	0	0	
Minimum safe staffing in maternity services: anaesthetic medical workforce (rota gaps)	1	1	1	1	1	1	1	0	
Minimum safe staffing in maternity services: Neonatal Consultants workforce (rota gaps)	1	2	2	2	1	1	1	1	
Minimum safe staffing in maternity services: Neonatal Middle grade workforce (rota gaps)	1	0	0.5	1	0.5	0.5	0	0	
Minimum safe staffing: midwife minimum safe staffing planned cover versus actual prospectively (number	14%	12%	14%	11%	13%	18%	12%	11%	
Vacancy rate for midwives	2.9%	2.0%	1.9%	1.9%	3.5%	3.6%	6.8%	6.7%	
Minimum safe staffing in maternity services: neonatal nursing workforce (% of nurses BAPM/QIS trained)	42%	42%	42%	40%	42%	40%	43%	40%	
Vacancy rate for NICU nurses	10	10	17.6	14	15	14	11	21	
Datix related to workforce (service provision/staffing)	8	2	5	7	9	1	3	2	
Consultant led MDT ward rounds on CDS (Day and Night)	71%	72%	58%	68%	57%	DNA	DNA	DNA	
One to one care in labour (as a percentage)	98.9%	100%	98%	100%	99%	98%	100%	100%	
Compliance with supernumerary status for the labour ward coordinator	95%	98%	96%	98%	96%	98%	97%	100%	
Number of times maternity unit attempted to divert or on divert	4	2	2	0	2	11	4	6	
in-utero transfers									
in-utero transfers accepted								4	
in-utero transfers declined								0	
ex-utero transfers									
ex-utero transfers accepted								2	
ex-utero transfers declined								0	
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)	66	19	58	44	59	60	57	31	
Service User feedback: Number of Complaints (formal)	5	3	6	9	9	10	2	4	
Staff feedback from frontline champions and walk-abouts (number of themes)	3	2	3	4	4	4	4	4	
Improvement									
Progress in achievement of CNST /10	7	7	6	7	7	7	7	7	
Training compliance in maternity emergencies and multi-professional training (PROMPT)	42%	39%	38%	33%	43%	42%	51%	62%	
Fetal Wellbeing and Surveillance	7%	14%	22%	9%	18%	27%	48%	74%	
Trust Level Risks	DNA	DNA	DNA	2	5	5	6	6	

Maternity - Perinatal Quality Surveillance Monitoring (PQSM) Tool

Neonatal Morbidity and Mortality: 1 x after action review following an early neonatal death at 30 weeks and three days following challenges in accessing an airway

Maternal Morbidity and Mortality: 1 x postnatal admission to ITU following Ogilvie syndrome (acute colonic pseudo-obstruction). After action review completed with patient and family. Positive engagement. Learning identified.

Insight: 1 x new severe harm incident for March (declared as SI in May), delayed treatment for reduced fetal movements, antenatal assessment unit triage waiting time breached. 1 x new HSIB referral in May, following an intrapartum stillbirth.

Workforce:

- **Midwifery:** Healthy pipeline from September 2022. Anticipated Birthrate plus recommendations to be finalised June 2022. Ongoing work exploring escalation pathways out of hours. 3 x Band 6 Midwives recruited end of May. Advert out for ANC Co-ordinator Band 7 role. Joint recruitment across BNSSG for 1 x Band 7 Specialist Mental Health Midwife and 2 x Band 4 Advisors in Treating Tobacco Dependency across BNSSG (Fixed Term for 20 months)
- ***Obstetrics*:** 2 Consultant Obstetricians adverts now live. Interviews to be held on 03/08/22. *Ongoing work to improve the quality of data for recording Consultant led MDT (Multidisciplinary Team) ward rounds
- ***NICU Nursing* :** Neonatal Nursing action plan updated as per Maternity Incentive Scheme Year 4. . Current vacancy 21WTE, as now added NCCR funding to establishment

Workforce Summary - Small numbers of workforce incident reports completed despite ongoing workforce concerns raised from multiple sources (Safety workarounds, governance meetings, quality huddles). Plan for divisional quality focus for July 2022 led by Continuous Improvement and Learning Team.

Staff and Service user feedback themes: Staffing across perinatal service; Estates impacting on capacity; Civility Saves lives service development project in progress; Clinical Information – Inconsistencies with patient information.

Maternity Incentive Scheme, Year 4: Scheme relaunched 06/05/22 and Trust to report compliance by Thursday 5th January 2023. 3 weekly meetings recommenced from 27th May 2022. Taking into consideration the revised guidance, areas of concern identified are highly likely to impact successful delivery of all 10 Safety Actions:

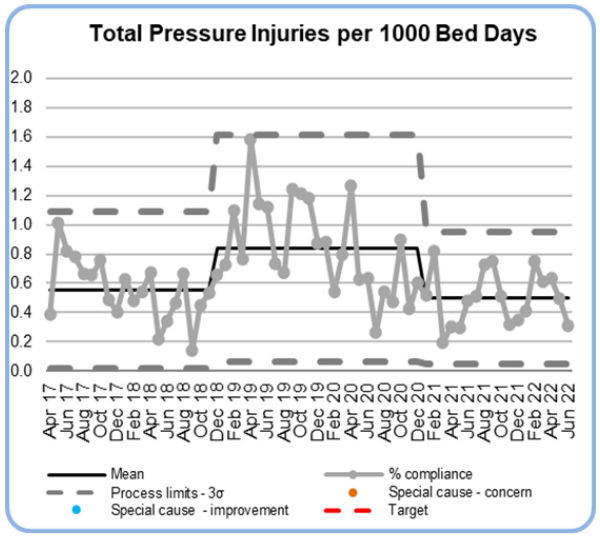
i. SA 2 – ***Maternity Services Data Set*:** Personalised care plans to be relaunched 29/09/2022. Care pathways validated digital lead midwife. Plan to share individual area weekly reports to help target areas for improvement.

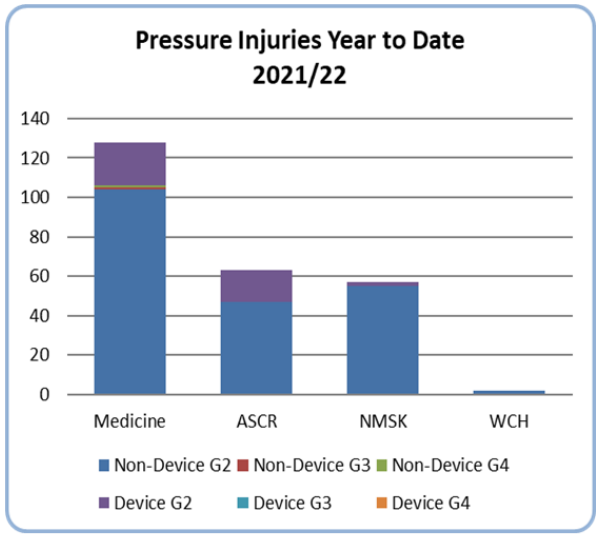
ii.SA 6 – Saving Babies Lives Element 1 Smoking: Challenging requirements: 1. % where CO measurement recorded at 36 weeks, currently 58% needs to be at least 80%. 2) uterine dopplers not offered to pregnancies at high risk of FGR as per SBL Care Bundle 2. 3.Training as SA8.

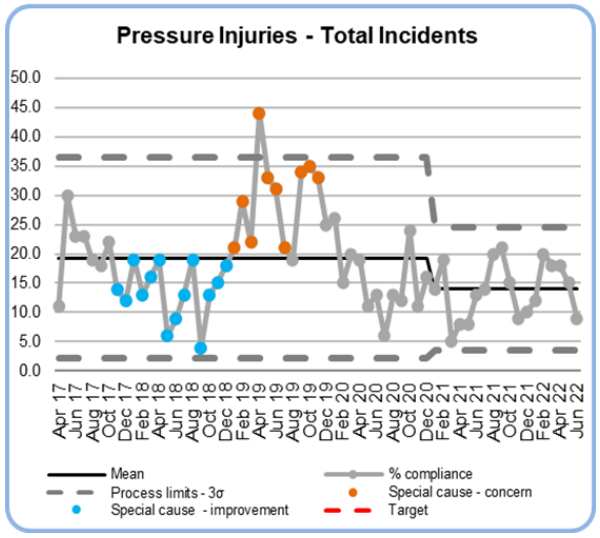
***iii.SA 8 – Training*:** The Division has seen significant improvement with training compliance. The Division continues to work towards the training recovery action plan as per, Risk 1079, High Risk Patient Safety 10. The temporary modifications detailed within the action plan will be shared with the Trust Board by 16 June 2022.The training trajectories for July 2022 are as follows: SA6 84% and SA8 84% but it should be noted the change to the training timeframe, from 12 month reporting period to 18 months, this is to acknowledge COVID-19 pressures.

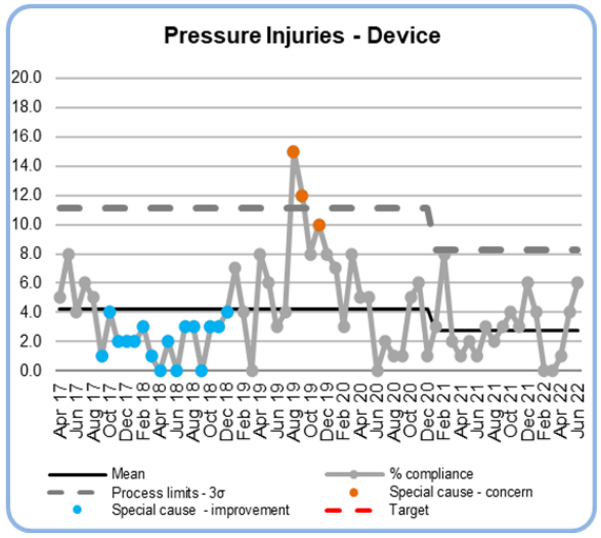
Areas of excellence: WACH to launch new QI project on shared decision making, working in collaboration with the Trust QI team. Recruitment initiatives resulting in successful pipeline. Successful Well Being Festival in WACH plans for a further wellbeing day at Cossham in August 2022. Planned Caesarean section booking moved from paper to ICE and access plans have been created. New Maternity System secured across BNSSG (Badgernet Maternity).

Awarded Maternal Medicine Network Lead for SW region.









Pressure Injuries

What does the data tell us?

In June, there was an overall decrease in the number of Grade 2 pressure injuries, but an increase in medical device related injuries.
14 Grade 2 pressure injuries were reported of which 6 were related to a medical device, 2 to one patient. 4 x grade 2 pressure injuries were to the sacrum/buttock/coccyx/natal cleft area, 1x scrotum, 1 to the heels and 1 to the hip, 1 x abdomen, 5 x nose/mouth/ear, 1 x spine.

There was a decrease in DTI injuries. There were 20 DTI injuries and were 11 heels, 5 buttocks/sacrum, 2 outer foot, 1 inner foot, 1 spine, and 1 mouth. 3 unstageable pressure injuries reported, and attributable to the medicine division.

There was 1 Grade 3 and 0 Grade 4 injuries reported in June. The grade 3 was attributed from an unstageable in May.

The Trust ambition for 2022/23 has yet to be confirmed for pressure injuries.

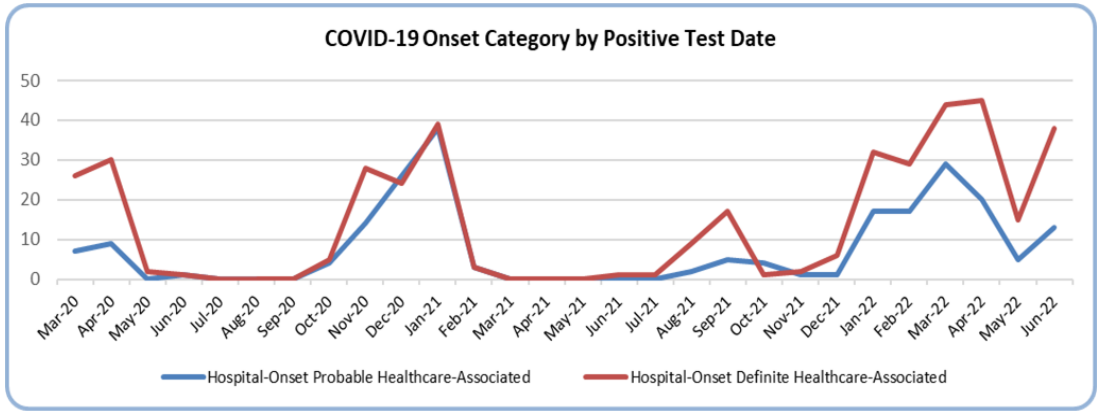
What actions are being taken to improve?

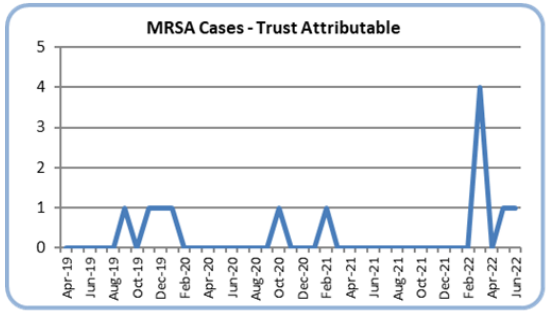
The Tissue Viability (TV) team continues to focus, engage and collaborate with areas identified through audit across the Trust. and using the RAG rating system.

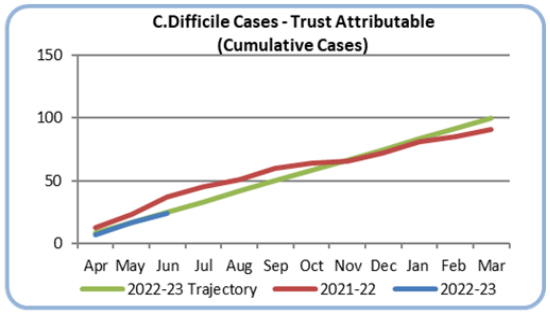
The team have facilitated and supported with ‘After Action Reviews 'to celebrate good practice, and identify areas for improvement, support action plans and look at the thematic themes.

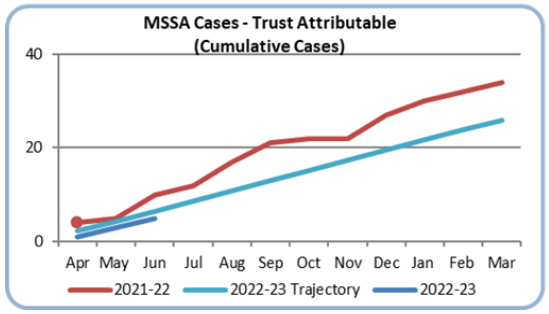
There have been meetings at a regional level with SWASFT to discuss pressure prevention in ambulances which TV have attended, and worked with the medicine division on exploring purchasing pressure relieving mattress overlays for ambulance trolleys.

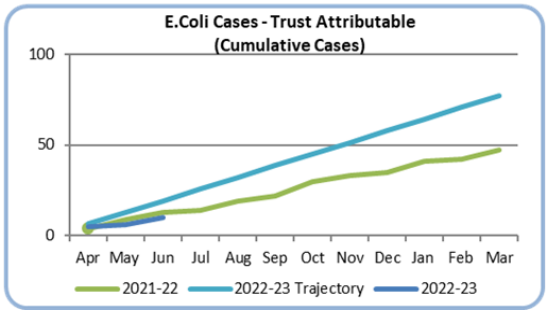
The updated Pressure Prevention and Management policy CG-212 following sense check has been Birth-rate signed off and uploaded to the Link page.











Infection Prevention and Control

What does the data tell us?

COVID-19 (Coronavirus)

June saw a increase in COVID demand at NBT and in the region , although admitted bed numbers have been lower than other trusts in the region.

We have seen a number of Outbreaks / increased cases with a increase of nosocomial spread with in the trust . A strategic decision was made to return mask wearing to all pts and staff in clinical area . The infection control monitoring group review prevalence weekly and look at mitigation and plans to manage current and forecast levels.

MRSA -X1 case noted in June, full case review has been completed with learning and a CCG review of all cases.

C. Difficile - NBT has so far not seen a jump in cases as seen last summer and have held a position on trajectory, the key will now be to maintain this and continue the improvement strategy.

MSSA - Cases for this year have so far been below trajectory

Gram –ve - At the moment we can report a position below trajectory

What actions are being taken to improve?

- Educational delivery to admission areas has seen a improvement in staff awareness of admission testing and questions to ask pts on admission – helping with general screening for pts but targeted for MRSA and C-diff .
- Upward reporting to CCG has recommenced for C diff with some positive feedback as to NBTs management of cases and shared learning at steering groups.
- COVID support continues across the trust with safe management of outbreaks, risk assessments continually in place managing risk vs trust on going pressure- mask wearing re introduced

COVID-19 SitRep

Current COVID Status: Level 2

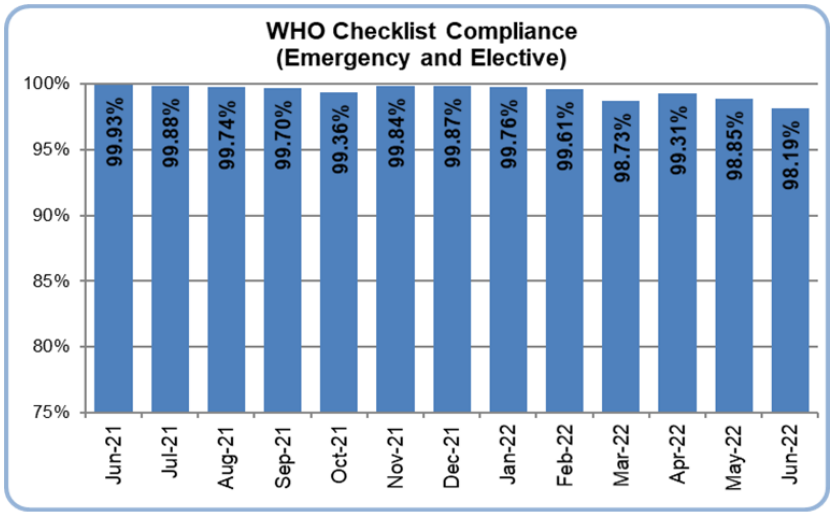
Input date: 11/07/22

Metric	23/05/2022	30/05/2022	06/06/2022	13/06/2022	20/06/2022	27/06/2022	04/07/2022	11/07/2022	Trend
New patients last 24 hours – admitted	1	1	0	2	1	3	3	4	
New Patients Diagnosed in last 24 hours	**1**	**1**	**1**	**6**	**6**	**6**	**9**	**7**	
Of these, in-patients diagnosed <48 hours after admission (Community Acquired)	1	1	0	2	3	3	3	4	
Of these, in-patients diagnosed 3-7 days after admission (Indeterminate)	0	0	0	1	0	1	1	1	
Of these, in-patients diagnosed 8-14 days after admission (Hospital Acquired)	0	0	0	1	1	0	2	1	
Of these, in-patients diagnosed 15+ days after admission (Hospital Acquired)	0	0	1	2	1	2	3	1	
Number of confirmed patients admitted from care or nursing home	0	0	0	0	0	0	0	0	
Blue discharges in past 24 hours	2	1	1	4	5	7	5	8	
Number of COVID positive patients as at 08:00	**11**	**10**	**12**	**30**	**40**	**36**	**55**	**60**	
Of these, patients admitted for primary COVID	8	6	6	20	29	25	36	43	
Of these, patients admitted with incidental COVID	3	4	6	10	11	11	19	17	
COVID positive patients in ICU	0	1	0	0	1	1	1	3	
COVID positive patients outside of ICU	11	9	12	29	39	36	54	57	
Query patients	1	0	0	1	0	1	0	0	
Closed and empty beds due to IPC	2	2	3	10	19	8	17	13	
NIV COVID	0	0	0	0	0	0	1	1	
Deaths	0	0	0	0	0	0	0	1	
Pathology lab positivity rate – rolling 7 day mean	0	0	0	0	0	0	0	0	
Patient Total positivity - detected - number	2	1	3	5	5	7	9	7	
Patient Total positivity - detected - %	0	0	0	0	0	1	0	0	

Metric	16/05/2022	23/05/2022	30/05/2022	06/06/2022	13/06/2022	20/06/2022	27/06/2022	04/07/2022	Trend
Bristol cases per 100,000 – 7 days	77	65	74	113	154	204	305	360	
South Gloucestershire cases per 100,000 – 7 days	75	58	69	106	170	234	299	400	
North Somerset cases per 100,000 – 7 days	77	65	74	113	154	204	305	360	

Key:

- Decrease from previous day
- Increase from previous day
- Step down to 10 days

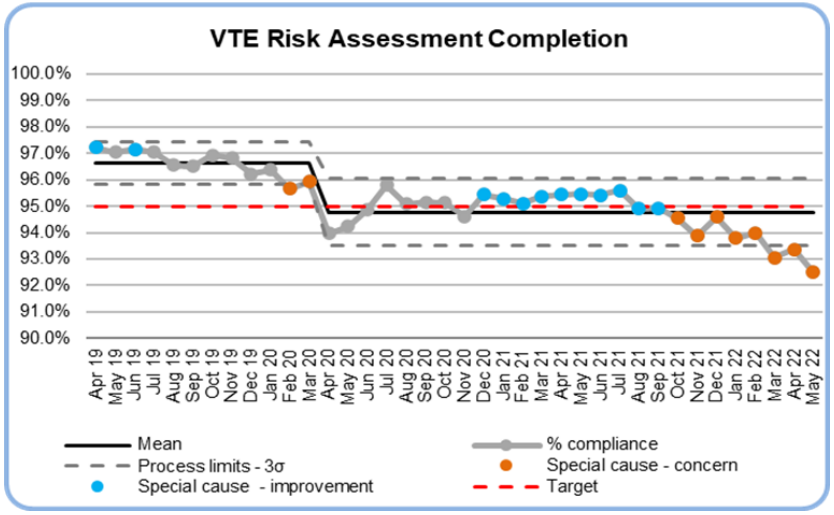


WHO Checklist Compliance

What does the data tell us?

In June, WHO checklist compliance was 98.19%. The Board expects that a WHO surgical safety checklist will be completed and documented prior to each operation in theatres.

The IPR report of less than 100% is due to issues with data capture. All cases where WHO was not recorded electronically are reviewed to ensure that checklist compliance was recorded in the paper medical records, therefore meaning that the correct checks were undertaken in practice.



VTE Risk Assessment

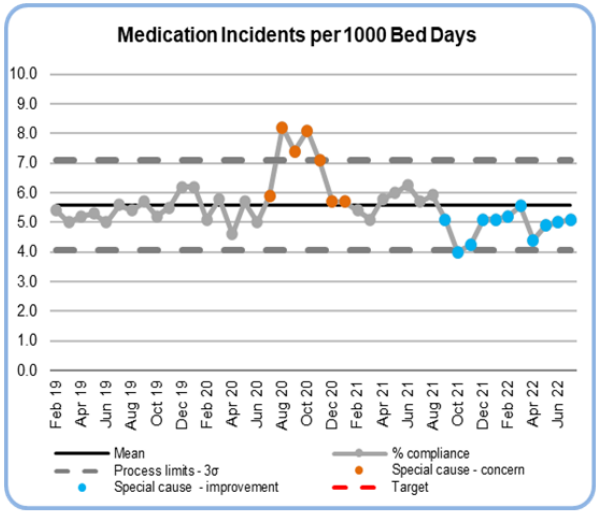
What does the data tell us?

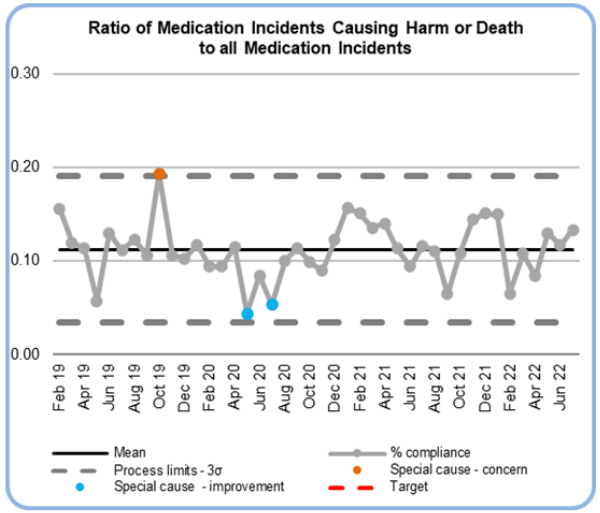
In May, the rate of VTE Risk Assessments performed on admission was 92.50%. VTE risk assessment compliance is targeted at 95% for all hospital admissions.

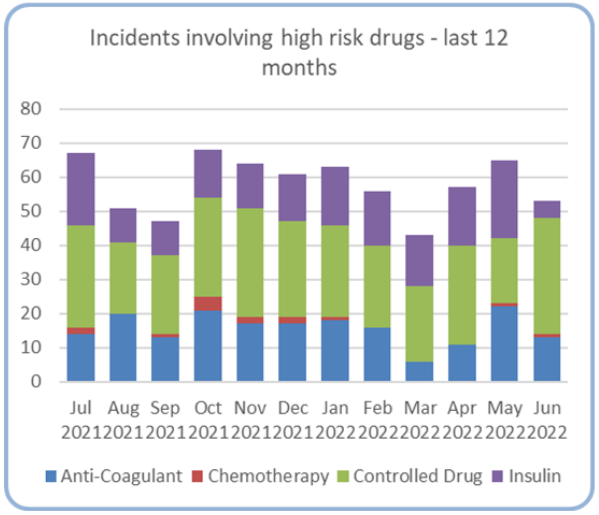
N.B. The data is reported one month in arears because coding of assessment does not take place until after patient discharge.

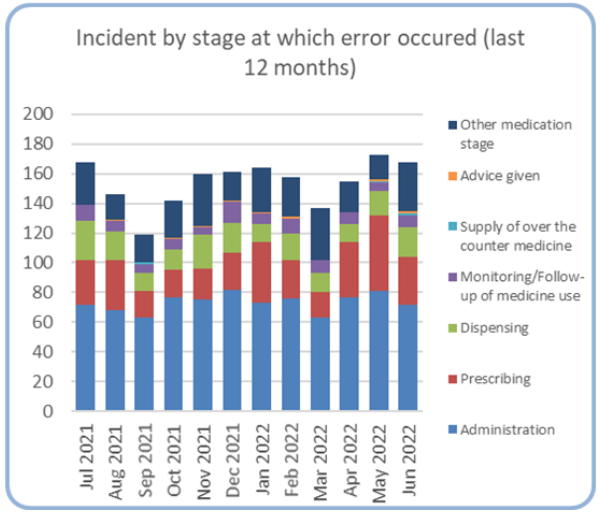
What actions are being taken to improve?

This reflects the impact of our ongoing operational challenges on education, training and related data capture to support compliance in this area. A manual audit of documentation completion is in progress and has confirmed as with similar previous audits that actual completion is better than reflected by the data but still requires improvement. Leadership responsibilities have been determined medically and within Pharmacy for the improvement work required and this is commencing.









Medicines Management Report

What does the data tell us?

Medication Incidents per 1000 bed days
During June 2022, NBT had a rate of 5.1 medication incidents per 1000 bed days. This figure replicates the 6 month average for this measure which is also 5 medication incidents per 1000 bed days

Ratio of Medication Incidents Reported as Causing Harm or Death to all Medication incidents
During June 2022, c.13.3% of all medication incidents are reported to have caused a degree of harm (depicted here as a ratio of 0.133). This is slightly above average seen over the last 6 months, with the average being c.13.2% but as seen from the graph there has been much fluctuation in this value.

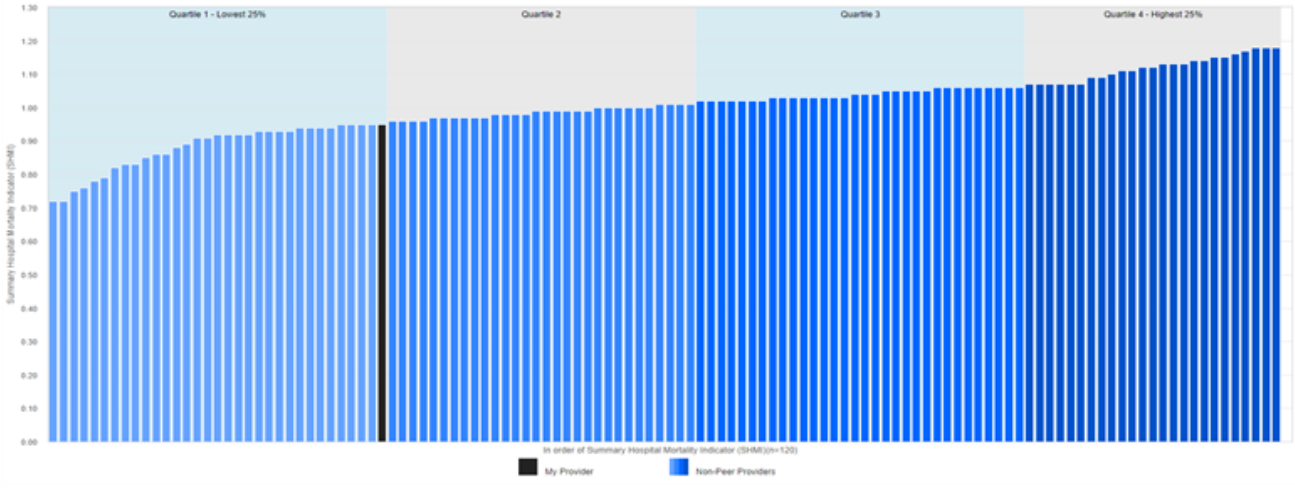
Incidents by Stage
In keeping with the picture seen over the last 6 months most incidents are reported to occur during the 'administration' stage. We have however been looking into the coding of incidents and this work has identified that in some cases nurses will designate incidents as 'administration errors' even when the cause was unclear prescribing. More work on this subject will be undertaken as part of the 'Medicines Academy' project.

High Risk Medicines
During May 2022, c.31% of all medication incidents involved a high risk medicine a figure comparable with data for the last 6 months. As depicted in the graph here is a notable rise in the number of incidents involving Controlled Drugs – this is something which will be flagged to the Trust Controlled Drug Accountable Officer (Matt Kaye).

What actions are being taken to improve?
The Medicines Governance Team encourage reporting of all incidents to develop and maintain a strong safety culture across the Trust, and incidents involving medicines continue to be analysed for themes and trends.

The learning from incidents causing moderate and severe harm is to be presented to, and scrutinised by, the Medicines Governance Group on a bi-monthly basis in order to provide assurance of robust improvement processes across the Trust.

Summary Hospital Mortality Indicator (SHMI), National Distribution

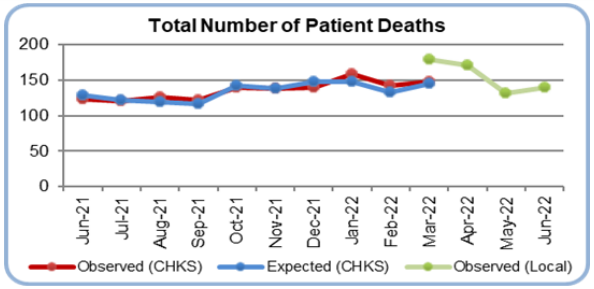


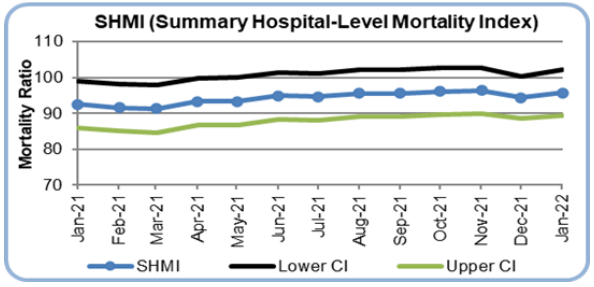
Mortality Review Completion

May 21 – April 22	Completed	Required	% Complete
Screened and excluded	265		
High priority cases	247		
Other cases reviewed	1439		
Total reviewed cases	1951	2063	95%

Overall Score	1=very poor	2	3	4	5= Excellent
Care received	0	4.6%	26.5%	37.9%	31%

Date of Death	May 21 – April 22
Scrutinised by Medical Examiner	1750
Referral to Quality Governance team	157





Mortality Outcome Data

What does the data tell us?

Mortality Outcome Data
NBT is in the lowest quartile for SHMI at 0.95 when compared to the national distribution indicating a lower mortality rate than most other Trusts. Even though this has been rising throughout 2021 NBT is still presenting well below the national median.

Mortality Review Completion
The current data captures completed reviews from May 21 – April 22. In this time period 95% of all deaths had a completed review, which includes those reviewed through the Medical Examiner system.

Of all "High Priority" cases, 84% completed Mortality Case Reviews (MCR), including 24 of the 25 deceased patients with Learning Disability and 20 of the 26 patients with Serious Mental Illness. The recent drop in completion rate is due to the requirement of all cases of probable and definite hospital associated COVID to be reviewed. These include historic cases that were not previously classified as 'high priority'.

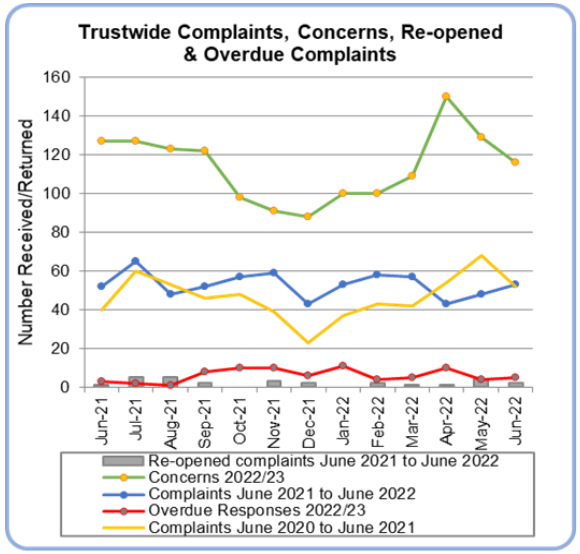
Mortality Review Outcomes
The percentage of cases reviewed by MCR with an Overall Care score of adequate, good or excellent is 95% (score 3-5). There have been 11 mortality reviews with a score of 1 or 2 indicating potentially poor, or very poor care which undergo a learning review through divisional governance processes.

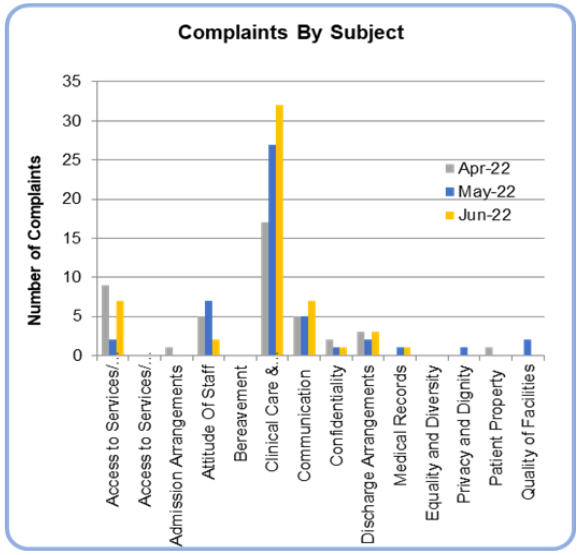
What actions are being taken to improve?

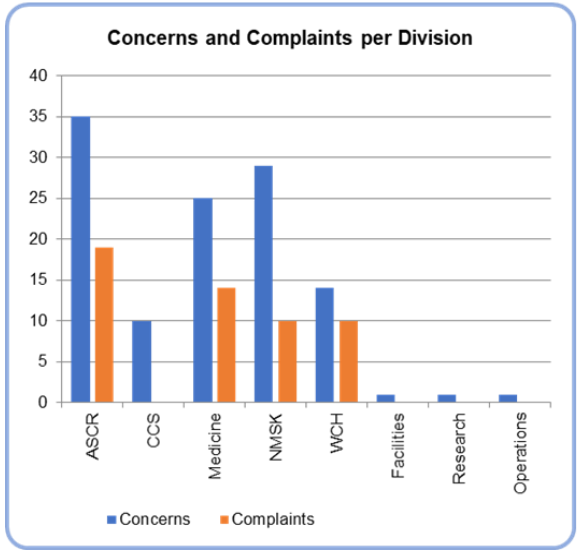
As a result of figures reported as part of the Annual Learning from Deaths Report 2021/22 that highlighted a rise in outstanding high priority case reviews the Quality Governance Team have been actively chasing completion of review for these cases.
We are focused on delivering a rise in completion rate over the coming months and Specialty Mortality Leads are supporting this plan.

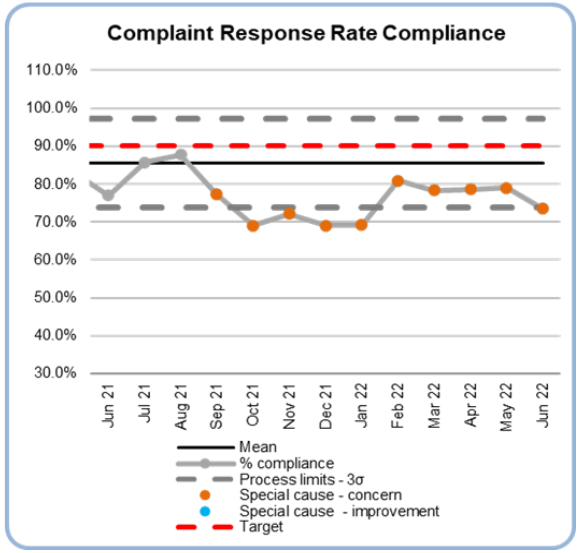
Patient Experience

Board Sponsor: Chief Nursing Officer
Steven Hams









Complaints and Concerns

What does the data tell us?

In June 2022, the Trust received 53 formal complaints, this is 5 more than the previous month but is consistent with the same period last year. The most common subject for complaints is 'Clinical Care and Treatment'. There's been a notable decrease in the number of complaints regarding 'Attitude of Staff', but an increase in those regarding 'Access to Services-Clinical' and 'Communication'.

There were 2 re-opened complaints in June, 1 for ASCR and 1 for NMSK.

The 53 formal complaints can be broken down by division: (the previous month total is shown in brackets)

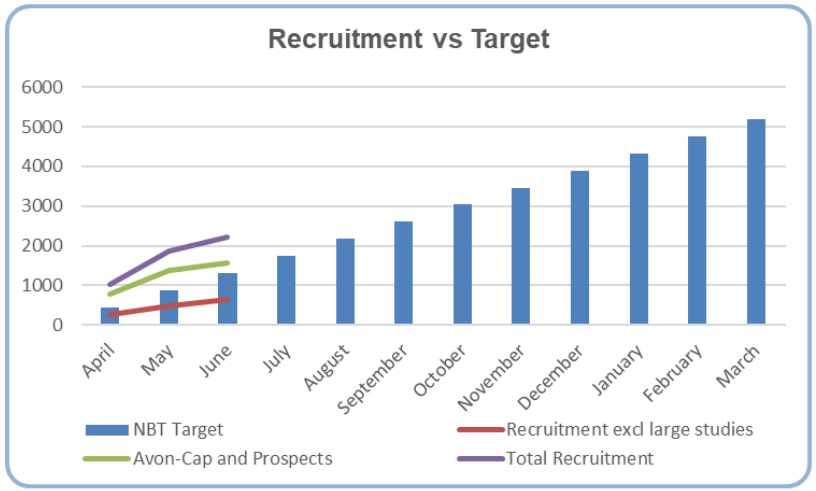
ASCR	19 (10)	CCS	0 (2)
Medicine	14 (19)	NMSK	10 (11)
WCH	10 (4)		

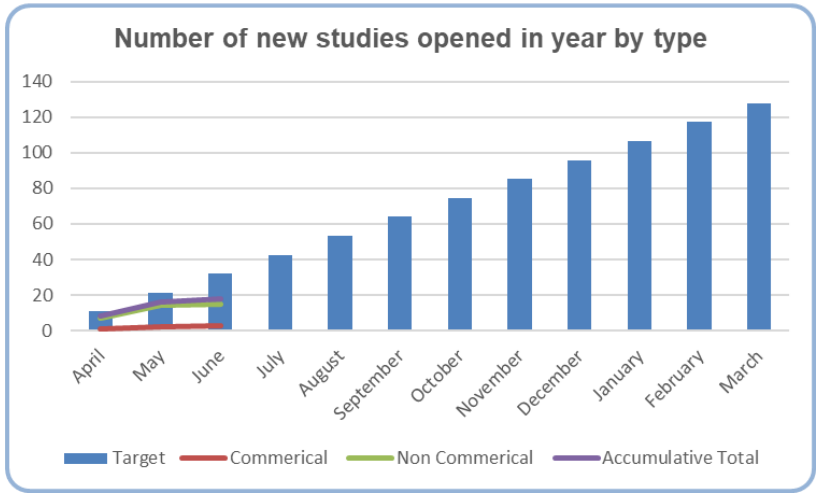
The number of PALS concerns received by the Trust was 116 in June this is slightly fewer than the previous two months however, the number of enquiries have increased from 91 in May to 106 in June.

The response rate compliance for complaints has fallen after improvements over the past 3 months. In June, compliance was 73.5% and the number of overdue complaints has increased to 5. At the time of reporting there are 2 in Medicine (both ED), 2 in WaCH (Gynae and Obstetrics) and 1 in CCS (Therapies).

What actions are being taken to improve?

- Ongoing weekly validation/review of overdue complaints by Patient Experience Manager and/or Complaints Manager.
- Weekly meetings with Medicine, ASCR and NMSK Patient Experience Teams.
- In WaCH the Complaints Coordinator is currently absent which is impacting performance. Efforts have been made to backfill the position with Bank cover however this has not be possible.
- Recovery plans and a trajectory for improvement agreed with ASCR and Medicine. ASCR have met and exceeded their targets in June however Medicine have not met their targets for compliance or number of overdue complaints. Medicine currently have an absence within their Divisional Patient Experience Team which is impacting on their performance.





Research and Innovation

What does the data tell us?

In this financial year we will strive to offer as many research opportunities as we can to our NBT patients and local communities.

From those people we approach about research we will aim to recruit 5200 participants to our research studies; this reflects our baseline pre COVID ambitions. At present 2208 participants have consented to our research. This exceeds our current YTD target (170%)however is reflective of 2 large studies we are involved in (AVONCAP and PROSPECTS). We are monitoring our activity with and without these studies- which is shown in graph 1.

The NBT portfolio of research remains strong; at present we have 224 studies open to new participants and have set up and opened 19 new studies since April (Graph 2), these are predominantly non commercial studies. We are keen to work with more commercial partners as we move through the year.

NBT continues to support the national efforts to develop effective vaccines and treatments in the management of current and future COVID variants and have established a core team to support this activity.

NBT is leading on 70 externally funded research grants, to a total value of £31m. This includes 32 prestigious NIHR grants which total £29m. In addition, NBT is a partner on 58 externally-led research grants, to a total value of £10.6m to NBT.

Congratulations to Katie Hayes, Intensive Care Research Nurse, who was recently awarded a highly prestigious HEE/NIHR Predoctoral Clinical Academic Fellowship, £56k for 12 months This fellowship will enable Kati to develop her research skills towards submitting a competitive NIHR PhD application next year, Kati's research interest is focused on the support needs of traumatic brain injured patients and their families from ICU onward into the follow-up and rehabilitation stages of their recovery.

The Southmead Hospital Charity very kindly funds two SHC Research Fund calls per annum, run by R&I. The **SHC Research Fund** welcomes research applications from all NBT staff members to undertake a small pump-priming research project (up to a maximum of £20k) in any subject area. The awarding panel for Round 13 met in early May and agreed to fund 5 new projects (from a shortlist of 6) highlighting the quality of the applications received this year. The successful projects will be announced shortly.

After a programme of staff and stakeholder engagement, the NBT Research Strategy for 2022-2027, which sets out our ambitions for the next 5 years, has been drafted and we look forward to sharing it and undertaking further stakeholder engagement over the coming months.

Well Led

Board Sponsors: Chief Medical Officer, Director of People and Transformation
Tim Whittlestone and Jacqui Marshall

Well Led Summary

Vacancies
Trust vacancy factor increased from 7.51% in May to 8.07% in June. This was driven by a decrease in staff in post from 8,303.4WTE in May to 8269WTE in June; and an increase in funded establishment for the Trust from 8,836.2WTE in May to 8,862.7WTE in June. Healthcare scientists and registered nursing and midwifery saw the largest increases in vacancy rate, with changes of 7.69% to 10.21% and 8.00% to 9.41% respectively (healthcare scientists saw a large increase in funded establishment from May to June).

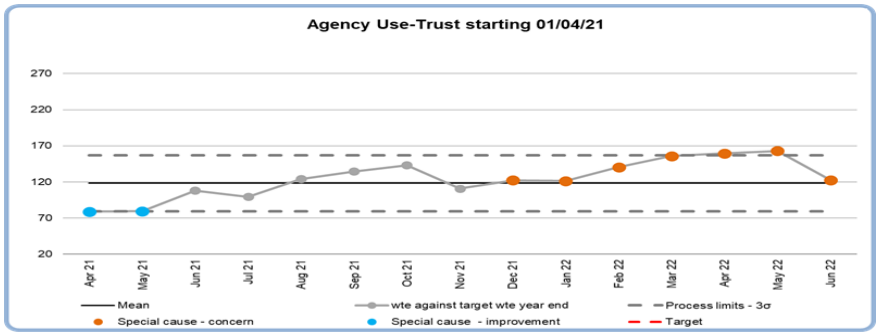
Turnover
NBT's Rolling 12-month staff turnover increased from 17.28% in May to 17.41% in June. Allied health professionals saw the largest increase in turnover from 12.71% in May to 13.26% in June, with the largest increases amongst operating department practitioners, radiographers and speech and language therapists.

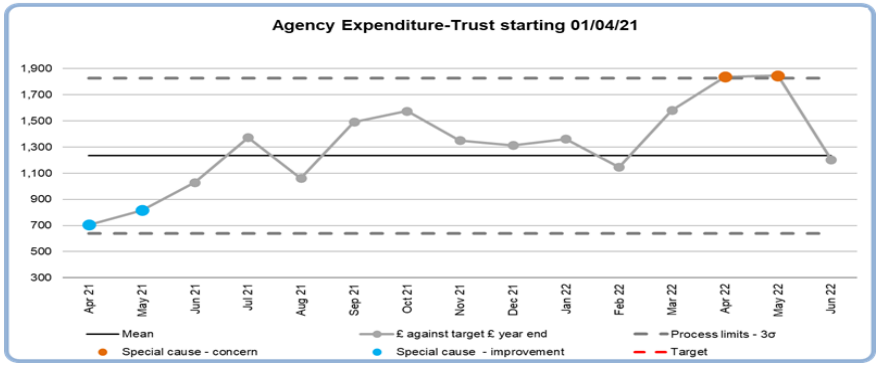
Prioritise the wellbeing of our staff
Rolling 12month sickness absence increased from 5.13% in May to 5.22% in June. In terms of causes of absence, Infectious Diseases (which includes COVID-19) saw a increase of 931.58 fte days lost (16.62%).

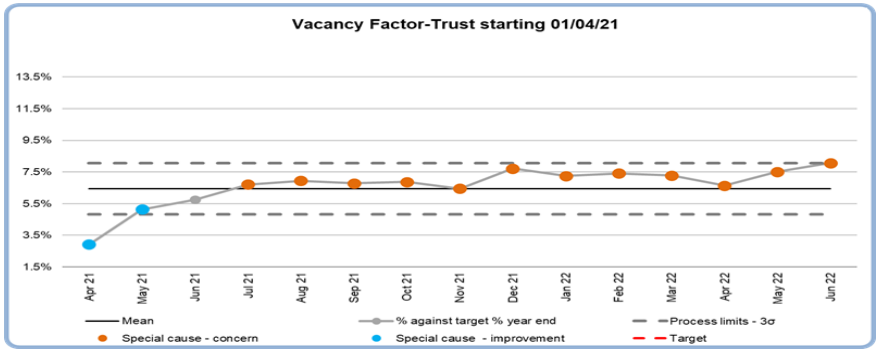
Continue to reduce reliance on agency and temporary staffing
Temporary staffing demand increased by 6.40% (68.47 wte) from May to June, however bank hours worked increased at a lower rate +5.65% (32.97wte), while agency use declined, -2.82% (-4.00 wte), driven by lower registered nursing and midwifery, and administrative and clerical use. The reduction in agency hours worked contributed to unfilled shifts increasing by 11.47% (39.51wte), the increase in unfilled shifts was predominantly seen in registered nursing & midwifery and unregistered nursing & midwifery. Over time reduced by 40% in June compared to May, a reduction of 7800 hours worked. It is anticipated that this is in line with overtime incentivisation ceasing. The reduction was greatest in registered nursing and midwifery staff (-57% equating to 4300 hours) and unregistered clinical staff (-46% equating to 2070 hours). Total agency RMN use saw a decrease of 12.93% (-6.11 wte), with tier 4 RMN use decreasing by 0.12 wte (-1.20%).

Theme	Action	Owner	By When
Vacancies	Health care support worker assessment centres to continue at an enhanced level. Trust participated in a system led recruitment event and NBT have 197 HCSW offers currently in processing. WTE to be confirmed once all in place. Starters will be throughout July, August & September.	Head of Resourcing	Sep-22
Temporary Staffing	Review of bank and overtime data to understand uptake of incentive offiers in detail working with stakeholders including divisional directors of nursing and midwifery aimed at designing incentives to increase participation in a sustainable way.	Director of People	Aug-22
Turnover	Analysis of ESR and exit survey data has identified trends for reasons for leaving. Undertaking further analysis to identiifywhich groups/areas are most affected, to ensure efforts and follow-up actions are appropriately targeted. Trust-level actions including development of agile working principles and policy; review of relocation and expenses policy; and access to career coaching being developed.	Head of People	Oct-22
Turnover	Focus groups with administrative and clerical staff to understand drivers of increased leaver rates in this area.	Head of People	Aug-22
Staff Engagement	Quarterly Staff Survey now live, team continue to monitor and encorage engagement through the divisions.	Head of People Strategy	Aug-22

Workforce







What Does the Data Tell Us – Vacancies Nursing and Midwifery

Unregistered Nursing

Talent Acquisition Team Actions in June
Current unregistered vacancies for Band2 have remained largely the same as May – Band2 remained the same at 95.12wte and Band 3 vacancies increased by 2 to 44wte

NBT candidate numbers from the recent BNSSG wide volume HCSW Recruitment event going through checks now stands at 187 – the drop out rate has been far lower than anticipated at just 8% to date.
We have continued trust wide recruitment offering a further 22 HCSW candidates to ensure we retain a good pipeline of staff joining in the next few months.

Registered Nursing

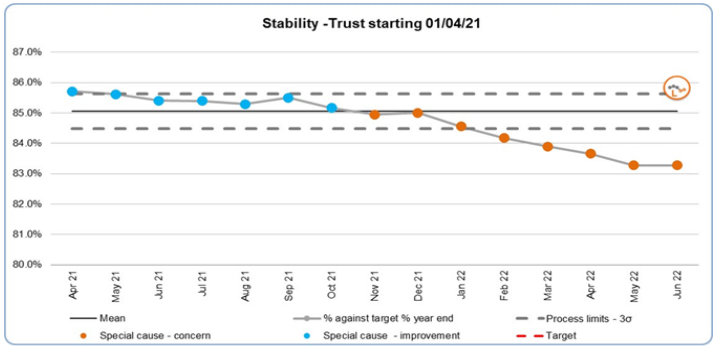
Talent Acquisition Team Actions in June:

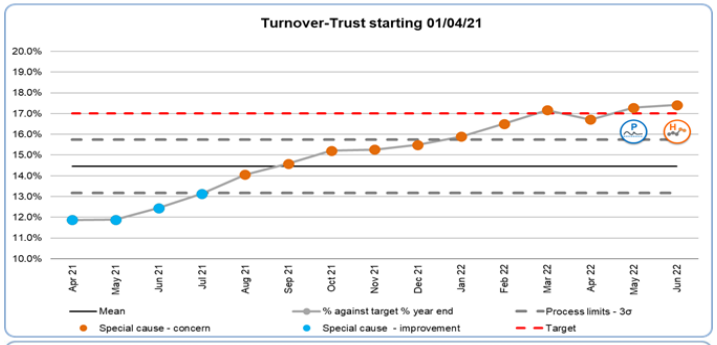
- Vacancies for Band 5 registered Nurses rose to 202.35wte this month
- Applications for this month remained strong and 42 offers were made to new staff.
- We welcomed 9 new International nurses in the month.
- Point of Note: we have offered 87 Band 5 Candidates in May and June which is up an encouraging 40% on the same months during 2021.

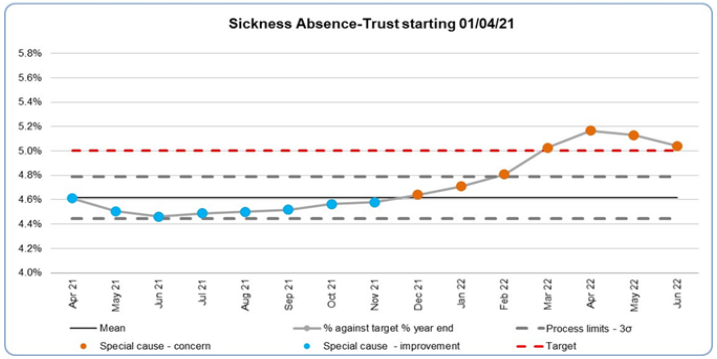
Temporary Staffing

- Internal Bank fill rates increased in June from a weekly average of 427 RN shifts to 540 RN shifts, although Tier 1 agency fulfilment decreased which created an overall increase in unfilled shifts
- Unfilled shifts increased from 32% to 36% which equates to approx. 100 shifts per week
- Implementation of new BNSSG+B uniform Tier 1 agency rates were introduced across the 4 organisations to work on increased fill rates.

Engagement and Wellbeing







What Does the Data Tell Us - Turnover and Stability
The net loss of staff in June was driven by Healthcare scientists and registered nursing and midwifery staff.

Actions delivered- Turnover and Stability (Associate Director of People)

- Relocation expenses - locally driven process in place. Decision-making for posts attracting relocation can be agreed via Divisional Vacancy Review Panels
- Understanding why people leave - Individual Leaver's Workforce information being accessed and People Team are now texting a message link to leavers with the Leaver's questionaire. This has delivered our highest response rate to date – 38% in quarter 1
- People Team Development session in June – focussed on developing further the detail behind the Trust's new agile working principles which were previously approved at a high level by the Executive Team in May

Actions in Progress:

- Explore options around incentivising the completion of Exit Questionnaires (free coffee in VU/Costa whilst undertaking Exit Questionnaires) - **July 22 – August 22**
- Promote protected time for staff to complete the Exit Questionnaire - **over next 6 months**
- Focussed and targeted promotion of 'Itchy Feet' and 'Process for Leaving' pages on LINK - **June 22 – September 22** (September a month when turnover tends to increase)
- Admin staff focus groups to understand morale and resilience **August 22**
- Continue the focus on agile working at NBT, including development of a revised Agile Working Policy with Trade Unions **(Aug – October 22)**

Actions delivered - Supporting new starters

- Resources refreshed and redeveloped to commence the pilot of 'New Starter 3,6, & 9 Month Check In Conversations' with new cohort of BNSSG HCSW recruits, aimed at supporting and retaining them
- Resources refreshed and developed to re-promote a formalised 'buddy system' for new starters

Actions in Progress

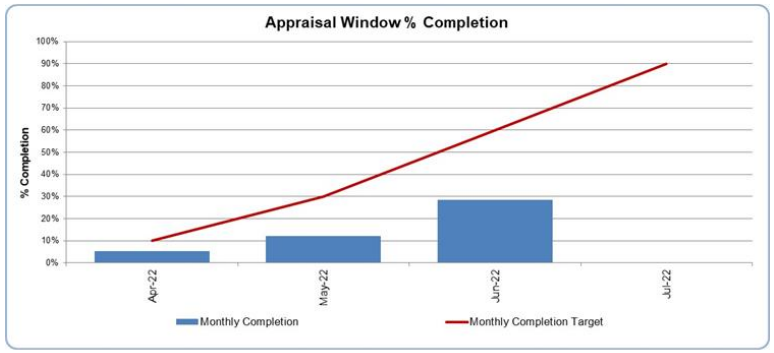
- Commencing the pilot when new starters in post **(August – October)**
- Linking in now with Head of Resourcing, People Partners and line mangers for new starters in those areas **(July – August)**

What Does the Data Tell Us - Sickness and Health and Wellbeing
June saw an increase in sickness absence from the May 22 position. *Anxiety/stress/depression/other psychiatric illnesses* remains the predominant driver of time lost to absence alongside COVID sickness.

Actions Delivered – Health and Wellbeing (Head of People Strategy)
Financial Health and Wellbeing Paper presented to and approved by Executive team – actions moving to deliver planned package of measures

Actions in Progress - Sickness and Health and Wellbeing (Head of People and Head of People Strategy)

- Ground works started on W&C rest room project, project on track to deliver completed space against original timescale and to have made sufficient progress to satisfy the charitable funding covenant in place – **End of Jul**
- Quarterly Staff Survey now live with a higher response rate so far than in previous iterations – team continue to monitor and encourage engagement through the divisions – **End Aug**
- First formalised sickness management training session for Speciality Leads is happening on 22.7.22



Training Topic	Variance	May-22	Jun-22
Child Protection	1.2%	84.6%	85.8%
Adult Protection	0.4%	81.2%	81.6%
Equality & Diversity	0.7%	85.4%	86.1%
Fire Safety	1.9%	82.2%	84.1%
Health &Safety	0.6%	84.7%	85.4%
Infection Control	0.7%	93.7%	94.4%
Information Governance	2.7%	79.0%	81.7%
Manual Handling	1.1%	81.8%	83.0%
Waste	0.0%	82.6%	82.6%
Total	**1.1%**	**83.89%**	**84.98%**

What Does the Data Tell Us - Essential Training

Throughout the pandemic, essential training compliance has shown a downward trend across the Trust and has been below the minimum threshold of 85% since March-21 - a trend being seen by other NHS Trusts.

With COVID restrictions/impact diminishing and a continued return to BAU, the last two months have seen a step change in returning to the 85% compliance target with June seeing a further 1.08% increase in completion rates - tantalisingly close to the required target which we should achieve by end of July 22

Actions – Essential Training (*Head of Learning and Organisational Development)*

In July, we further embed the actions below to achieve the 85% Stat Man compliance.:

- Helping the organisation to embed the new learning platform Kallidus LEARN, which went live on 11th April, exploiting the benefits of Single Sign On (SSO) and speedy accessibility via the LEARN desktop icon
- Encouraging Line Managers to check weekly the Stat Man Compliance data for their teams utilising the 'My Team' report
- Continuing to promote completion of Stat Man through Operational Communication channels and agenda items on Executive Management meetings
- Exploiting the Appraisal window (open until end July 2022) as part of the Appraisal completion and sign off process includes confirmation of Stat Man compliance

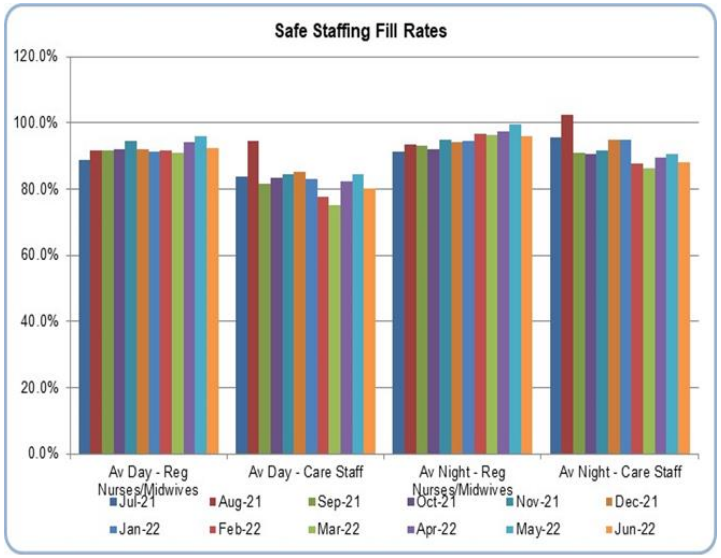
Other Wider Actions

Leadership & Management Learning

- June has seen the successful completion of the first 2 learning modules for the Specialty Lead Programme – Understanding Self and Having Great Conversations which have received great feedback. The programme continues with 2 modules running per month.

Apprenticeships

- The Trust continues to maintain the delivery of its Apprenticeship programmes. This will ensure Apprentices are able to receive development core to their role, allowing them to progress to the next pay band level within the agreed timelines. This progression also allows Apprentices (e.g. HCSW) to apply their skills to a wider variety of tasks in the workplace.



Jun-22	Day shift		Night Shift	
	RN/RM	CA Fill	RN/RM	CA Fill
Southmead	92.5%	80.2%	96.0%	88.1%

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

What Does the Data Tell Us

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

There is an organisational focus on recruiting to Care Staff (HCSW) vacancies with a successful BNSSG recruitment event supported by NHS England planned in May 2022, 197 HCSW have been offered a role with NBT expected to commence employment during July and August

All areas safe staffing maintained through daily staffing monitoring and supplementing with Registered and unregistered staff as required

Wards below 80% fill rate for Registered Staff:

- 32b (77.9% Day) staffing supplemented with redeployed RNs and HCSW
- 7b (74.6% day) staffing supplemented with redeployed RNs and HCSW
- Mendip Ward (75.7% Day / 76.9% Night) vacancies, staffing deployed as required to meet patient needs across the service
- Cossham Birth Centre (75.5% Day / 76.9% Night) vacancies, staffing deployed as required to meet patient needs across the service
- Cotswold Ward (69.9% Day) vacancies, staffing deployed as required to meet patient needs across the service

Wards below 80% fill rate for Care Staff:

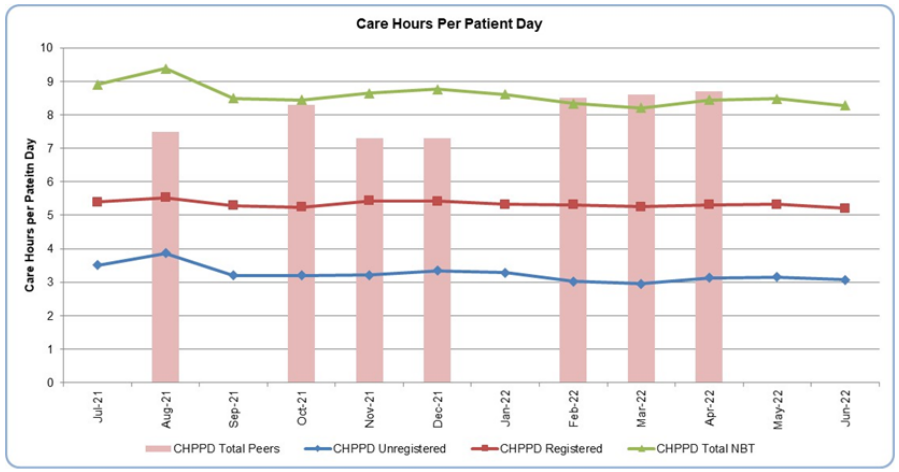
- 32a (66.5% Day) Unregistered staff vacancies and absence
- EEU (66.7% Day) Unregistered staff vacancies and absence , supported with redeployed RN resource
- 9b (70.5% Day) Unregistered staff vacancies and absence
- 28a (76.6% Day) Unregistered staff vacancies and absence
- 8a (78.5% Day) Unregistered staff vacancies and absence
- Gate 31 AMU (76.6% Day / 52.6% Night) Unregistered staff vacancies and absence
- 27a (75.6% Day) Unregistered staff vacancies and absence
- 34a (77.8% Day) Unregistered staff vacancies and absence
- 34b(55.5% Day / 64.9% Night) Unregistered staff vacancies and absence
- Medirooms (77.9% Night) Unregistered staff vacancies
- 26a (73.2% Day) Unregistered staff vacancies and absence
- 26b (69% Day) Unregistered staff vacancies and absence
- 7a (75% Day) Unregistered staff vacancies and absence
- 8b (68.6% Day) Unregistered staff vacancies and absence
- NICU (43.2% Day / 34.8% Night) Unregistered staff vacancies, safe staffing maintained through daily staffing monitoring and supplementing with registered staff as required
- Quantock (66.6% Day / 67.6% Night) vacancies, staffing deployed as required to meet patient needs across the service.
- Cotswold Ward 73.5% Day) Unregistered staff vacancies and absence
- Cossham Birth Centre (73.1% Night) vacancies, staffing deployed as required to meet patient needs across the service

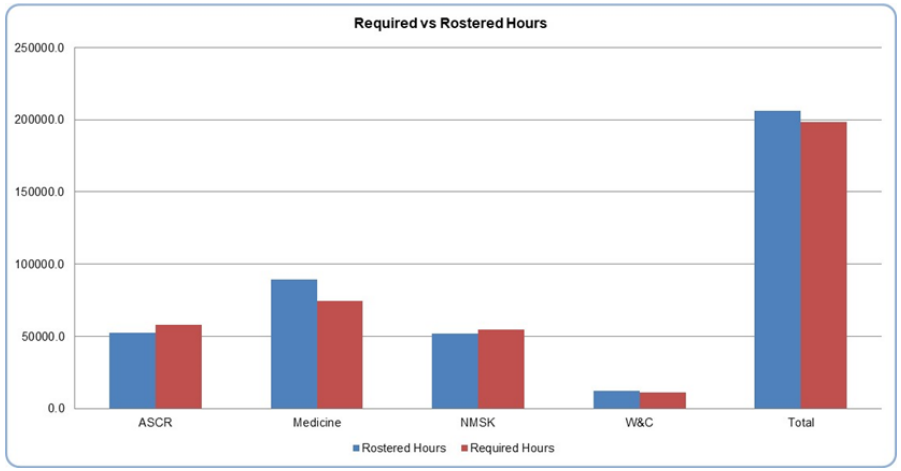
Wards over 150% fill rate for Registered Staff:

- None

Wards over 150% fill rate for Care Staff:

- 33a (190.8% Night) enhanced supervision for patients
- 25a (125% Night) enhanced supervision for patients





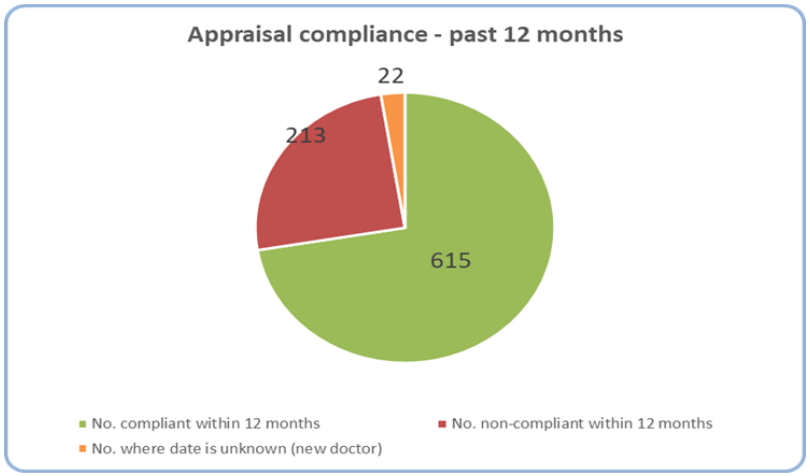
What Does the Data Tell Us – Care Hours per Patient Day (CHPPD)

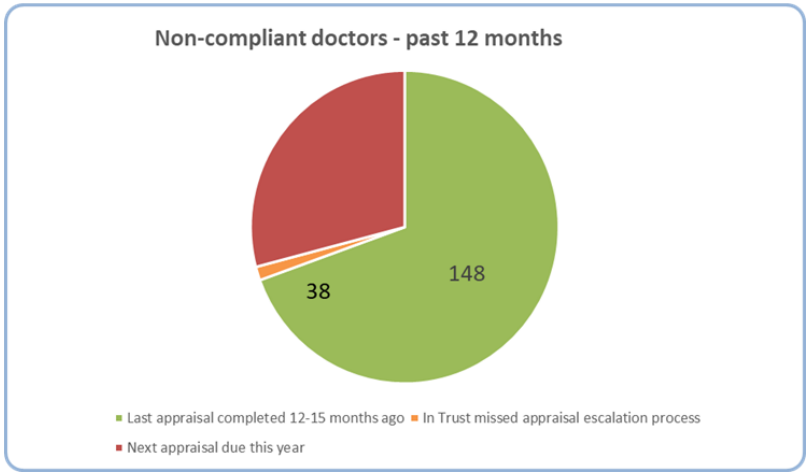
The chart shows care hours per patient day for NBT total and is split by registered and unregistered nursing. The chart shows CHPPD for the Model Hospital peers (all data from Model Hospital).

Safe Care Live (Electronic Acuity Tool)

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

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





Medical Appraisal

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).

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.

What actions are being taken to improve?

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.

Where possible, the revalidation team are making revalidation recommendations early for those doctors who were automatically deferred in order to reduce the number that will be due in 2022/23.

Finance

Board Sponsor: Chief Financial Officer
Glyn Howells

Statement of Comprehensive Income at 30 June 2022

	Month 3			Year to Date		
	Budget	Actual	Variance	Budget	Actuals	Variance
	£m	£m	£m	£m	£m	£m
Contract Income	59.3	59.6	0.3	172.8	173.3	0.6
Other Income	7.3	6.6	(0.8)	20.0	19.5	(0.5)
Pay	(39.8)	(41.7)	(1.9)	(119.2)	(120.8)	(1.6)
Non-Pay	(25.9)	(26.4)	(0.5)	(77.4)	(79.6)	(2.2)
Surplus/(Deficit)	**0.9**	**(2.0)**	**(2.9)**	**(3.8)**	**(7.6)**	**(3.7)**

Assurances

The financial position to the end of June 2022 shows the Trust has delivered a £2.0m adverse position against the £0.9m planned surplus which results in a £2.9m adverse variance in month, with a £3.7m adverse variance year to date.

Contract income is £0.3m favourable in month and £0.6m favourable year to date. The Trust-wide position has been set to the expected block amount except for variable items (e.g. high-cost drugs) which is driving the favourable variance. The corresponding adverse variance can be seen within non-pay.

Other Income is £0.8m adverse in month and £0.5m adverse year to date. The Trust has seen reduced income in Research and Mass Vaccinations which is offset in pay and non-pay year to date.

Pay expenditure in June is £1.9m adverse in month and £1.6m adverse year to date. The Trust has seen overspends on pay for Consultants, Other Medical and Nursing bank (incentives) and agency (RMNs).

Non-pay expenditure in June is £0.5m adverse and £2.2m adverse year to date. This is driven by increased spend on medical supplies, a prior year charge for pathology consumables and unidentified CIP.

Statement of Financial Position at 30th June 2022

	21/22 M12 £m	22/23 M02 £m	22/23 M03 £m	In-Month Change £m	YTD Change £m
Non Current Assets					
Property, Plant and Equipment	605.0	608.7	607.3	(1.4)	2.3
Intangible Assets	13.7	13.3	12.6	(0.7)	(1.1)
Non-current receivables	1.5	1.5	1.5	0.0	0.0
Total non-current assets	**620.2**	**623.5**	**621.4**	**(2.1)**	**1.2**
Current Assets					
Inventories	9.1	9.1	9.2	0.1	0.0
Trade and other receivables NHS	19.0	23.6	29.3	5.7	10.3
Trade and other receivables Non-NHS	20.5	22.9	24.0	1.0	3.4
Cash and Cash equivalents	116.2	99.3	98.0	(1.2)	(18.1)
Total current assets	**164.8**	**154.8**	**160.5**	**5.6**	**(4.3)**
Current Liabilities (< 1 Year)					
Trade and Other payables - NHS	10.6	7.9	8.8	1.0	(1.8)
Trade and Other payables - Non-NHS	102.6	92.8	97.1	4.3	(5.5)
Deferred income	16.4	20.6	22.0	2.4	6.5
PFI liability	15.2	15.7	15.7	0.0	0.4
Finance lease liabilities	2.1	1.6	4.1	2.5	2.0
Total current liabilities	**147.0**	**138.5**	**148.6**	**10.1**	**(1.6)**
Trade payables and deferred income	7.1	7.7	7.7	(0.0)	0.6
PFI liability	359.3	357.3	356.5	(0.8)	(2.8)
Finance lease liabilities	2.0	10.9	7.0	(3.8)	5.0
Total Net Assets	**269.7**	**264.1**	**262.2**	**(2.0)**	**(7.5)**
Capital and Reserves					
Public Dividend Capital	456.9	456.9	456.9	0.0	(0.0)
Income and expenditure reserve	(372.4)	(371.3)	(371.3)	0.0	1.1
Income and expenditure account - current year	1.1	(5.6)	(7.5)	(1.0)	(8.6)
Revaluation reserve	184.1	184.1	184.1	0.0	(0.0)
Total Capital and Reserves	**269.7**	**264.1**	**262.2**	**(2.0)**	**(7.5)**

Assurances and Key Risks

Capital – Total capital spend for the year to date was £2.6m, compared to plan of £7.4m. The total planned spend for the year is £32.5m.

Receivables - There was an increase of £13.7m in receivables. Out of £13.0m, £7.9m relates to income from commissioners, which is linked with recognising income as per latest planning submission completed in late June. It is expected that commissioners will settle these payments in upcoming couple of months. The reminder of the value was mostly due to changes in divisional accruals and Mass Vaccination accruals.

Cash – The cash balance decreased by £18.1m for the year to date (£1.2m in-month) due to year-to-date deficit, reduced receipts, linked with changes in receivables, and higher than average payments made during the period, including significant amounts of capital spend cash relating to the March 2022 year end capital creditor and increase in prepayments. Despite reducing cash balance, the Trust is still expected to be able to manage its affairs without any external support for the 2022/23 financial year.

Payables - Year to date NHS payables have reduced by £1.8m for the year to date as a result of clearing invoiced creditors post year end. Non-NHS payables have decreased by £5.5m, of which £4.7m relates to the reduction of accrued capital expenditure as a result of post year end payments.

Deferred income - The year to date increase of £6.5m in deferred income mainly relates to the increase in the deferral of contract income, linked with genomics and uncertainty around ESRF funding.

Regulatory

Board Sponsor: Chief Executive
Maria Kane

Monitor Provider Licence Compliance Statements at July 2022
Self-assessed, for submission to NHSI

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

Appendix 1: Glossary of Terms

Unless noted on each graph, all data shown is for period up to, and including, 30 June 2022 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.

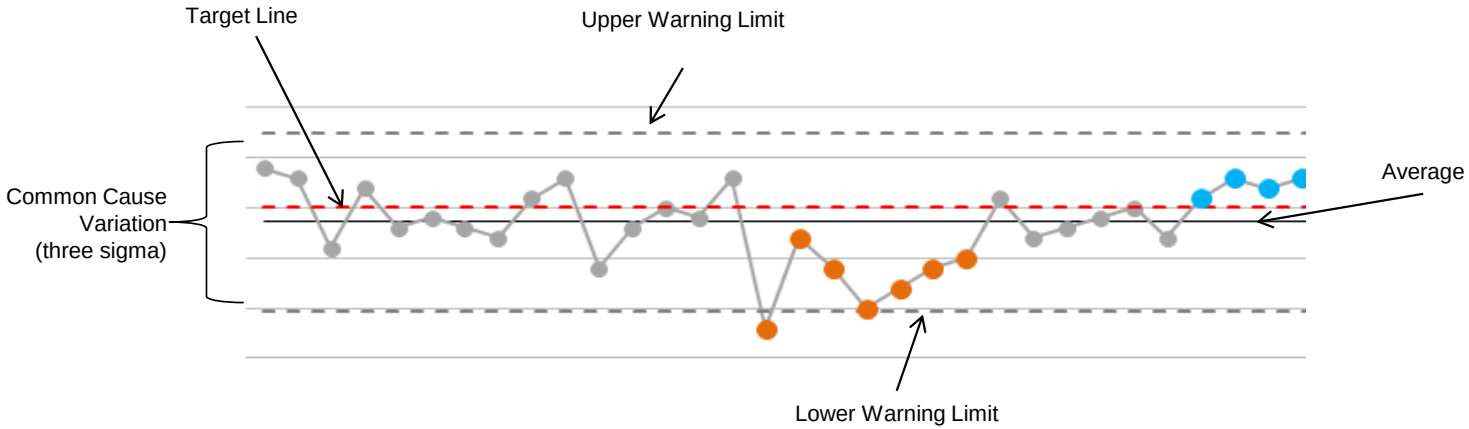
NBT Quality Priorities 2022/23

QP1	Enabling Shared Decision Making & supporting patients' self-management
QP2	Improving patient experience through reduced hospital stays ('right to reside') & personalised care
QP3	Safe & excellent outcomes from emergency care
QP4	Safe & excellent outcomes from maternity care
QP5	Providing excellent cancer services with ongoing support for patients and their families
QP6	Ensuring the right clinical priorities for patients awaiting planned care and ensuring their safety

Abbreviation Glossary

AMTC	Adult Major Trauma Centre
ASCR	Anaesthetics, Surgery, Critical Care and Renal
ASI	Appointment Slot Issue
CIP	Cost Improvement Programe
CTR/NCTR	Criteria to Reside/No Criteria to Reside
CCS	Core Clinical Services
CEO	Chief Executive
Clin Gov	Clinical Governance
CT	Computerised Tomography
D2A	Discharge to assess
DDoN	Deputy Director of Nursing
DTOC	Delayed Transfer of Care
ERS	E-Referral System
GRR	Governance Risk Rating
HoN	Head of Nursing
ICS	Integrated Care System
IMandT	Information Management
IPC	Infection, Prevention Control
LoS	Length of Stay
MDT	Multi-disciplinary Team
Med	Medicine
MRI	Magnetic Resonance Imaging
NMSK	Neurosciences and Musculoskeletal
Non-Cons	Non-Consultant
Ops	Operations
P&T	People and Transformation
PTL	Patient Tracking List
qFIT	Faecal Immunochemical Test
RAP	Remedial Action Plan
RAS	Referral Assessment Service
RCA	Root Cause Analysis
SI	Serious Incident
TWW	Two Week Wait
WCH	Women and Children's Health
WTE	Whole Time Equivalent

Appendix 2: Statistical Process Charts (SPC) Guidance



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

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

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

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

Report To:	Trust Board		
Date of Meeting:	28th July 2022		
Report Title:	Healthier Together ICS Green Plan		
Report Author & Job Title	Megan Murphy, Interim Sustainable Development Manager		
Executive/Non-executive Sponsor (presenting)	Glyn Howells, Chief Finance Executive		
Does the paper contain:	**Patient identifiable information?**	**Staff identifiable information?**	**Commercially sensitive information?**
*If any boxes above ticked, paper may need to be received at *private* meeting			
Purpose:	**Approval**	**Discussion**	**To Receive for Information**
	X		
Recommendation:	TB to: • Approve and endorse the Healthier Together ICS Green Plan. • Encourage and permit all NBT staff to engage with the consultation and delivery phase of the Healthier Together ICS Green Plan. • Note that a governance and delivery structure will be developed and agreed by the ICS to drive delivery of the Green Plan.		
Report History:	• Healthier Together Executive Group • Healthier Together Estates group • Sarah Truelove, CCG DOF • TMT		
Next Steps:	• Progress with wider engagement and assurance of the plan. • Confirm and establish governance structure and workstreams to oversee and drive delivery.		

Executive Summary
In July 2021, all 42 parts of England had been formally declared Integrated Care Systems, mandating all commissioners and providers of NHS services, across a geographical area, with local authorities and partners to collectively plan health and care services that meet the needs of the local population. North Bristol NHS Trust sits within the Healthier Together ICS, formally the

Sustainability Transformation Partnership, which serves the local population of the Bristol, North Somerset and South Gloucestershire region. As part of this change, each ICS was required to develop a three-year strategy known as their ICS Green Plan. In December 2021, the Healthier Together ICS commissioned a project manager to draft an initial Healthier Together Green Plan to reduce carbon and drive sustainable changes across ten key sustainability themes:

- Supply Chain and Procurement
- Medicines
- Estates and Facilities
- Travel and Transport
- Digital Transformation
- Sustainable Models of Care
- Workforce and System Leadership
- Food and Nutrition
- Adaptation
- Biodiversity

The initial plan was developed and led by a Core Plan Development Team which comprised North Bristol NHS Trust, University Hospitals Bristol and Weston, Avon and Wiltshire Mental Health Partnership and Sirona Care and Health. The Healthier Together Green Plan was developed through various workshops and consultation sessions with key stakeholders in each of the core organisations. The Green Plan has laid the foundations for future engagement with primary care and wider system partners that share our sustainability agenda.

The Green Plan outlines the ambition, pledges and commitments of the ICS with regards to each of the key themes. The Green Plan recognises that a formal governance and delivery structure will be required to deliver the Green Plan outcomes and to embed sustainability into core prioritisation and decision-making processes. This governance and delivery structure will need to be approved by the core organisations within the ICS.

Risks	
Financial implications	Significant financial and resource investment will be required to ensure the delivery of the ambitions laid out in the Healthier Together ICS Green. It is also recognised that there will be considerable financial and non-financial value from operating more sustainably. At present, we do not have a detailed picture of the likely capital and revenue implications, nor of the source of funds to meet this; these will be developed over the course of 2022/23. We will ensure that in assessing the financial implications of this plan we will account for the full financial & non-financial implications of both action and inaction.

	Financial implications are detailed in page 33 of the appended Green Plan.
Does this paper require an Equality, Diversity and Inclusion Assessment (EIA)?	Yes, Equality Impact Assessment Form appended.
Appendices:	Appendix 1: Summary slidedeck of Healthier Together ICS Green Plan Appendix 2: Healthier Together ICS Green Plan Appendix 3: Equality Impact Assessment Form

1. Purpose

1.1 This paper is asking the Trust Board to approve and endorse the Healthier Together ICS Green Plan which sets outs the ICS's key ambitions and commitments to deliver key outcomes for the BNSSG population. Trust Board is asked to encourage all NBT staff within their remit, throughout all divisions and directorates, to engage with the consultation and delivery phase of the Green Plan to ensure it is embedded into Trust processes and plans. Trust Board is asked to note a governance structure and workstreams will be developed and approved by the ICS to drive delivery of the Green Plan.

2. Background

2.1 In July 2021, it was announced that all 42 parts of England had been formally declared Integrated Care Systems. The purpose of the ICS to form a partnership between commissioners and providers of NHS services across a geographical area with local authorities and partners to collectively plan health and care services that meet the needs of the local population. As part of this change, each ICS was required to develop a system-wide Green Plan that acts as a three-year strategy to reduce carbon and achieve key sustainability objectives. Each ICS Green Plan must review progress made to date, consider national and local net zero goals, engage with internal and external stakeholders, develop SMART actions to directly reduce carbon emissions and establish systems and processes to measure and report progress against the plan.

2.2 In December 2021, the Healthier Together ICS commissioned a Project Manager to develop a first draft of the Green Plan. This involved initial engagement with the ICS to gauge organisations current progress with their Green Plans. It was established that the first draft of the Healthier Together Green Plan would initially be led by a Core Plan Development Team which consisted of North Bristol NHS Trust, University Hospitals Bristol and Weston, Avon and Wiltshire Mental Health Partnership and Sirona Care and Health. Immediate engagement was also undertaken with our Primary Care partners. The plan maps out how we expect to engage with our wider partners in key areas over the next three years.

3. Ambition and Commitments

3.1 Climate change is one of the greatest threats to global health that we face in the 21st century. It has and will continue to inflict serious social, economic, environmental and

health impacts on our global populations and communities if it is unperturbed. That is why, as an ICS, we have put sustainability at the core of our aims and objectives. ICS Strategic Aim 6 states that we will act as leading institutions that will drive sustainable health and care by improving our environment, achieving net zero carbon by 2030; improving the quality of the natural environment; driving efficiency of resource use. The Green Plan commits us to delivering three key outcomes for our population: Improving the environment, achieving net zero carbon by 2030 and generating a BNSSG-wide movement to support cultural change that will drive wider improvements.

3.2 The key outcomes will be delivered through holding a singular, clear ambition as an ICS that all partners align to, creating the conditions for change, using our collective resource to deliver high impact change and putting in place appropriate monitoring and supporting frameworks to maximise impact, hold collective risks and hold groups accountable for delivering key actions.

3.3 There are ten key workstreams identified within the Green Plan that each have outlined ambitions, pledges, commitments, and actions for 2022/23. These key workstreams are:

- Supply Chain and Procurement
- Medicines
- Estates and Facilities
- Travel and Transport
- Digital Transformation
- Sustainable Models of Care
- Workforce and System Leadership
- Food and Nutrition
- Adaptation
- Biodiversity

4. Measuring and Monitoring

4.1 To ensure we are making progress with the Green Plan commitments and to drive change, we have established a set of key headline metrics and targets for each workstream in the Green Plan. These are outlined in pages 16-19 and are currently being reviewed by our external academic partners. For some of our ambitions that do not currently have metrics to measure their progress, we have adopted proxy metrics. We hope to have in place an ICS-wide dashboard to monitor and report these metrics to all ICS organisations and partners. The draft plan is to report these dashboard metrics at least annually to organisational and ICS level boards.

5. Governance and Delivery Plan

5.1. Achieving the key pledges and commitments of the ICS Green Plan will require a governance structure and supporting delivering infrastructure. Most of the delivery will be through our operations and strategic change programmes however, the wide-ranging and large-scale nature of our ambitions will require a formal ICS governance structure. So far, an

executive-led ICS Green Plan Steering Group has been established which reports to the Executive Board with responsibilities to deliver the ICS Green Plan key outcomes. The Green Plan has drafted an indicative governance and reporting structure however, the details of this are expected to change as the ICS formally develops and the structure is ratified by ICS organisations.

5.2 Over the course of 2022/23, the ICS Steering Group will work to embed the Green Plan ambitions within each organisations core governance, prioritisation and decision-making processes. We anticipate key changes will made to our capital prioritisation, revenue allocation and service change processes which are detailed on page 32 of the Green Plan.

6. Summary and Recommendations

6.1. The Trust Board is asked to:

- Approve and endorse the Healthier Together ICS Green Plan.
- Encourage and permit all NBT staff to engage with the consultation and delivery phase of the Healthier Together ICS Green Plan to ensure it is embedded in key Trust processes and plans.
- Note that a governance structure and supporting delivery infrastructure will be developed and agreed by the ICS to drive delivery of the Green Plan.

Healthier Together

Improving health and care in Bristol,
North Somerset and South Gloucestershire

ICS Green Plan

Engagement Slides for Organisations

April 2022

Green Plan Scope

The Healthier Together ICS is a partnership of organisations that provide and coordinate the health and care needs of the Bristol, North Somerset and South Gloucestershire population.

The initial focus of the plan was on the Core Development Team with plans to extend the scope to primary care and our wider partners with a shared agenda.

The Plan sets out how we expect to engage with our wider partners over time.

ICS Sustainability Vision

Operating sustainably is at the core of how we will meet our ICS aims and objectives. In developing our ICS, we aim to deliver a truly sustainable health and care system that will bring multiple mutually reinforcing benefits.

ICS Strategic Aim 6: We will act as leading institutions to drive sustainable health and care by improving our environment, achieving net zero carbon by 2030; improving the quality of the natural environment; driving efficiency of resource use.

Key Outcomes

We will focus on delivering three key outcomes for our population:

Improve the environment: We will improve the overall environmental impact and sustainability of our services, especially the damaging local impacts of air pollution. This will create a cleaner, safer, more ecologically sound environment locally and globally, including restoring biodiversity as much as possible

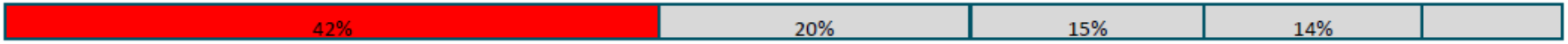
Net zero carbon: We particularly recognise the pressing urgency to address our carbon footprint and will reduce the impact of our services on the environment by achieving net zero carbon across all emissions scopes by 2030

Generate a BNSSG-wide movement: Our sustainability behaviours, actions and innovations as anchor institutions will support a cultural change amongst local citizens and businesses resulting in wider improvements in air quality, biodiversity, and the quality of the natural environment

Delivery of outcomes

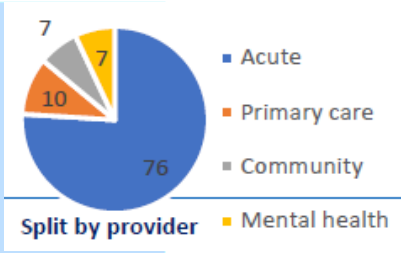
1. **Leadership, ambitions & clarity of vision:** Building on the success of our organisational level work, we will hold a singular clear ambition as an ICS that all partners align to
2. **Create the conditions for change:** Put the green agenda at the heart of our ICS – how we business plan, allocate resources, and develop frameworks and governance
3. **Highest impact changes:** At an ICS level we will put our collective resources and energy behind a small number of impactful changes
4. **Assurance of devolved delivery:** Recognising that the green agenda is everyone's business we will build on the success of organisational plans, putting in place monitoring and support frameworks to maximise the impact across the system, target highest impact interventions, hold collective risks, and hold groups to account for delivery of key actions

Supply Chain and Procurement



Ambition:

- Drive the supply chain to net zero
- Use our spend as a positive influence in our community
- Promote a fair, diverse and inclusive supply chain



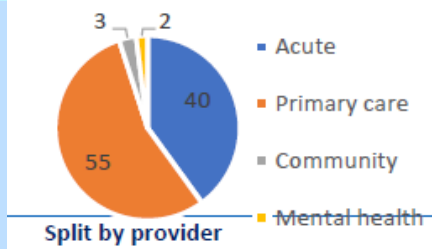
Pledges and Commitments:

- Challenge the market to make a significant reduction in carbon and demonstrate they are on target to meet net zero, each time we renew a procurement.
- Ensure our supply chains and procurement processes are ethical, free from worker abuse and exploitation and provide safe working conditions.
- Influence good practice throughout our supply chains and our partner organisations.

Medicines

Ambition:

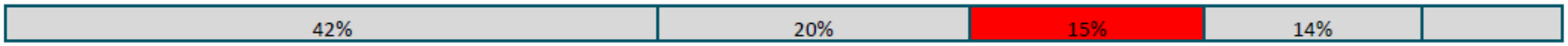
- Reduce overuse of medicines and medicines waste
- Switch to lower impact alternatives wherever possible or green social prescribing initiatives
- Drive change in the manufacture of medicines through our procurement approach



Pledges and Commitments:

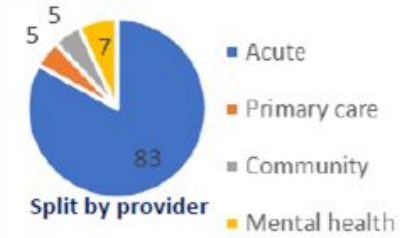
- Align sustainability commitments to the ‘delivering best value’ strand of Medicines Optimisation Strategy
- Review the return and recycling of medicines, medical devices and equipment
- Consider sustainability within structured medication reviews

Estates and Facilities



Ambition:

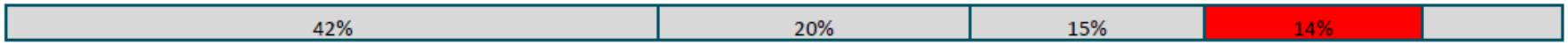
- Upgrade and renew buildings and infrastructure to decarbonise our estate
- Optimise the way we use our buildings through improving efficiencies
- Change our energy source to 100% renewable

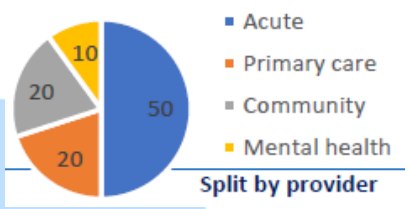


Pledges and Commitments:

- Ensure all new capital developments and capital allocations prioritise net zero are net zero by changing capital prioritisation matrix
- All new buildings and refurbishments built to NHS Net Zero Carbon Standard
- Positively support investment into decarbonisation.
- Adopt principles of circular economy to minimise waste and retain value of procured goods.

Travel and Transport





Ambition:

- Significantly reduce the impact our transport has on local air quality
- Promote and enable active travel to improve health and wellbeing

Pledges and Commitments:

- Lease or purchase only ULEVs
- Align our travel expenses policies to support sustainability goals
- Support new ways of working that reduce the need for travel
- Implement a hierarchy of vehicle use for commuting, business travel and fleet.

Digital Transformation

Ambition:

- Become an exemplar of a digitally advanced ICS
- Maximise the positive environmental benefits of digital enablers
- Minimise the impact our digital enablers have on the environment

Pledges and Commitments:

- Provide digital capabilities that support digital clinical models of care
- Enable effective sharing of clinical information; Move information, Not people
- Ensure digital suppliers and enablers are aligned to net zero carbon
- Join up our infrastructure to reduce cost and resource use
- Enable personalised and proactive care experience for service users

Sustainable Models of Care

Ambition:

- Help people stay well and independent in their community
- Provide early help and support that is personalised and proactive
- Minimise length of hospital stay and integrate community support
- Enable a system of support to get patients back home
- Help people to get back to being well and independent once back home

Pledges and Commitments:

- Deliver prevention agenda
- Ensure patients are engaged and informed about the carbon impacts of their treatment
- Ensure sustainability principles are central to service design and care plans
- Explicitly name environmental costs and benefits as part of the clinical value agenda

Workforce and System Leadership

Ambition:

- Clear leadership approach to delivery the Green Plan
- Developing our people at all levels of the organisation

Pledges and Commitments:

- Executive lead in each organisation
- Use our ambition to position us an employer of choice
- Provide training and awareness programmes accessible to entire workforce
- Ensure leadership development supports and challenges sustainable mindsets and behaviours

Food and Nutrition

Ambition:

- Positively contribute to local environmental and population health through the food we provide.

Pledges and Commitments:

- Procure local, seasonal and sustainable food wherever possible
- Reducing food waste
- Promote urban growing and engagement with nature
- Provide sustainable and healthy food choices for staff and service users
- Support community action on food equality

Adaptation

Ambition:

- Identify shared climate change risks as a system
- Implement an action plan to mitigate risks and adapt
- Build resilience against climate change impacts

Pledges and Commitments:

- Assess risk and impact to system services, processes and infrastructure
- Reduce the impact of climate change on public health
- Ensure infrastructure, services, procurement, local communities and colleagues are prepared for and resilient to the impacts of climate change.

Biodiversity

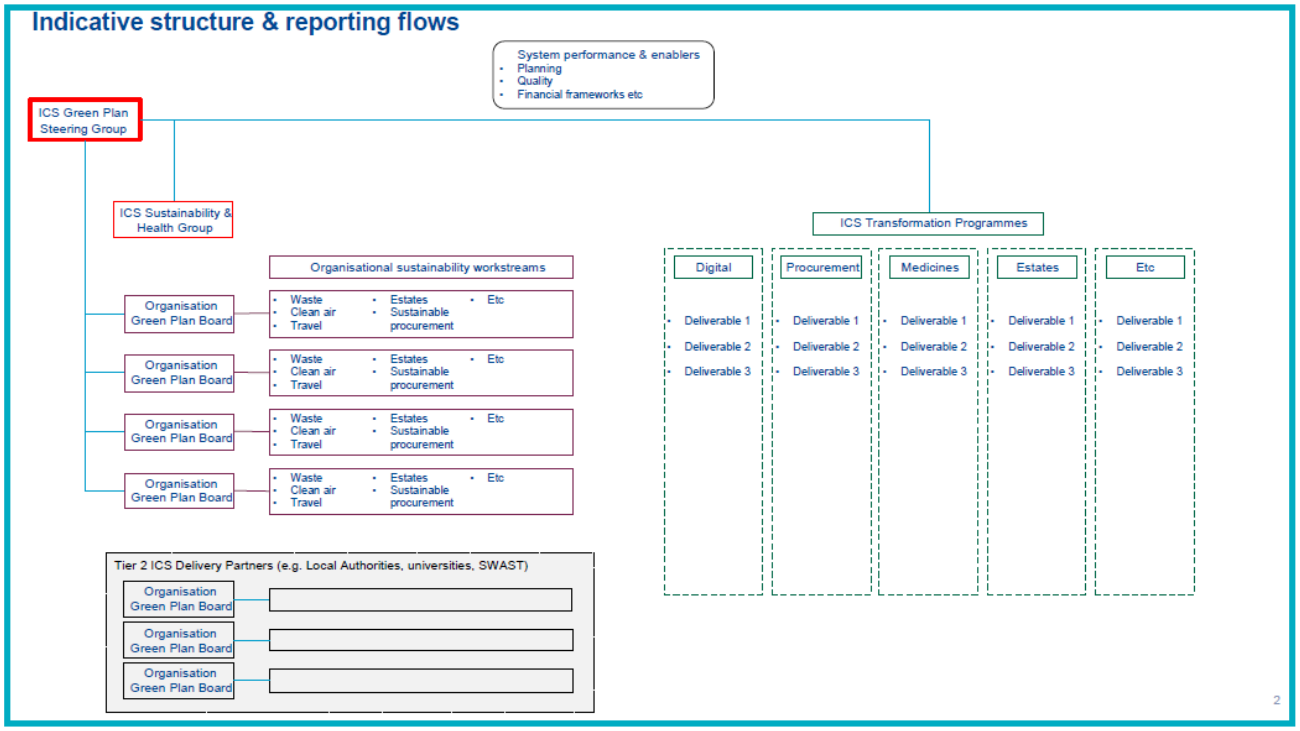
Ambition:

- Fulfil our duty to conserve and enhance biodiversity of our sites and across the region by working closely with partners.
- Promote the use of our green and blue spaces by staff, patients, visitors and the local community to support health and wellbeing and reduce health inequalities.

Pledges and Commitments:

- Establish our sites as accessible networks of green spaces and facilities.
- Prohibit the use of harmful chemicals and methods on our sites.
- Conserve existing and establish new habitats for local wildlife.
- Use our green spaces to educate on biodiversity conservation.
- Mandate all new developments and refurbishments enhance biodiversity.

Governance and Delivery



- Achieving these ambitions will require a formal governance structure and supporting delivering infrastructure.
- The Executive-led ICS Green Plan Steering Group will be responsible for overseeing the delivery of the ICS Green Plan key outcomes
- The Steering Group will embed the Green Plan ambitions within our core governance, prioritisation and decision-making processes

Finance and Resourcing

- Significant financial and resource investment will be required to ensure the delivery of these ambitions.
- There will be considerable financial and non-financial value from operating more sustainably.
- At present, we do not have a detailed picture of the likely capital and revenue implications, nor of the source of funds to meet this; these will be developed over the course of 2022/23.
- We will ensure that in assessing the financial implications of this plan we will account for the full financial & non-financial implications of both action and inaction.

Next steps

- Organisational alignment and approval
- Establish ICS Governance Structure for 2022/23
  - ICS Green Plan Steering Group
  - ICS Head of Sustainability and Primary Care Sustainability Leadership
- Launch priority projects
  - Primary Care medications work
  - System-wide transport review
  - Estate decarbonisation and strategic alignment
- Engagement and enhancement of this plan
  - Staff and citizen engagement
  - Expert review through academic and wider partners
- Build a BNSSG-wide social movement
  - Work with existing energy and enthusiasm
  - Make it easy for staff to do the right thing

Healthier **Together**

Improving health and care in Bristol,
North Somerset and South Gloucestershire

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Healthier Together

Improving health and care in Bristol, North Somerset and South Gloucestershire

Healthier Together Integrated Care System

Bristol North, Somerset, and South Gloucestershire

Green Plan

2022 – 2025

Version 1.0

Approved by Healthier Together Executive Group March 2022

For wider engagement in 22/23

Contents

Foreword

As an Integrated Care System we are committed to meeting the health and care needs of our communities today and into the future. We have a duty to ensure we continue to deliver exceptional health and care in a responsible way that embraces our role as anchor organisations in Bristol, North Somerset, and South Gloucestershire.

We are committed to delivering the ambitious plans set out in this Green Plan, providing high standards of quality health and care whilst addressing the environmental impact this creates. We want to do more than just minimise any negative impact of our activities; this plan shows how, through developing sustainably, we can make a significant positive contribution to the local economy, society and environment.

Climate change has been declared as 'the greatest threat to global health' (Lancet, 2017) which will have serious implications for our health, wellbeing, livelihoods, and the structure of organised society. Failure to act quickly will heighten existing national health and care challenges, place further financial strain on the NHS and care sector, and worsen health inequalities within the UK and internationally.

In recognition of the urgency of the threat that climate and ecological breakdown poses to public health, we are setting out extremely ambitious goals. We wish to be leaders in fast tracking plans to achieve carbon neutrality – improving the health of our population in the process. This strategy commits us to a carbon neutrality target of 2030, improving air quality and biodiversity, reducing our use of single use plastics, and creating a wider change movement amongst local communities and businesses. These targets are challenging but show our commitment to working with partners to deliver our vision.

Shane Devlin

Chief Executive, Healthier Together Integrated Care System

Executive Summary

Climate change is one of 'the greatest threat to global health' (Lancet, 2017) which will have serious implications for our health, wellbeing, livelihoods, and the structure of organised society. As an ICS we have put sustainability at the core of our aims and objectives. This plan sets out the commitments we have made to deliver 3 key outcomes for our population:

Improve the environment: We will improve the overall environmental impact and sustainability of our services, especially the damaging local impacts of air pollution. This will create a cleaner, safer, more ecologically sound environment locally and globally, including restoring biodiversity as much as possible

Net zero carbon: We particularly recognise the pressing urgency to address our carbon footprint and will reduce the impact of our services on the environment by achieving net zero carbon across all emissions scopes by 2030

Generate a BNSSG-wide movement: Our sustainability behaviours, actions and innovations as anchor institutions will support a cultural change amongst local citizens and businesses resulting in wider improvements in air quality, biodiversity, and the quality of the natural environment

We will do this by:

1. **Holding our shared ambition** - building on the success of our organisational level work, we have set out this clear shared ambition that all partners align to
2. **Establish the enabling conditions for change** – putting the green agenda at the heart of our ICS – how we business plan, allocate resources, and develop our governance
3. **Coordinating highest impact projects across partner organisations** – we have set out ambitious pledges, commitments, and deliverables across the highest impact areas
4. **Creating assurance of delivery of actions –** through the clarity of our ambitions, executive leadership, defined outcomes measures and clear accountability.

We want to ensure that we harness the power of our staff, citizens, community and voluntary organisations and local business networks in the delivery of this plan. Over the course of 2022/23 there will be a number of ways that you can input to the development of this plan and support its delivery. To find out more please visit our website www.bnssghealthiertogether.org.uk.

1. Status of this plan

This plan was developed at pace during the Covid-19 pandemic with less organisational and public engagement than we would have liked. As such this submission should be considered our initial plan for engagement with partners and public early in 22/23.

This ICS plan covers three main areas:

i. **Our shared ambition:** Our broad ambitions, linked to our ICS Outcomes Framework and the specific needs of our population
ii. **Our collaborative intent:** Those priorities that will benefit from cross-organisational action. It is likely these will initially be focused on health partners but will be extended to cover the shared benefits of working across health & social care and beyond
iii. **Assurance and delivery:** A framework for assurance, support and accountability of our organisational plans and specific deliverables against priority required over the next 3-years:
    a. Initial focus on University Hospitals Bristol & Weston NHS Foundation Trust, North Bristol NHS Trust, Avon & Wiltshire Mental Health Partnership NHS Trust and Sirona Care & Health CIC
    b. Plans for extending scope to primary care and our shared agenda with local authorities and wider partners

Route to final approval

Wider engagement and assurance of the actions set out in this plan will be undertaken in early 22/23 as set out in the Communications & Engagement section.

It is anticipated that a public version will be approved by the ICS Executive and published in late 2022.

Links to other strategies / core documents

Our ICS Green Plan sets out broad ranging ambitions and actions that will change almost every aspect of how we operate. As such, it is seen as a central pillar of our ICS development, embedded within our core aims and objectives. The implications will crosscut many of our existing and future strategies, including:

- Our ICS Strategy
- ICS Memorandum of Understanding
- Provider Green Plans (UHBW, NBT, AWP, Sirona)
- ICS Population Health Approaches
- ICS Quality Improvement & Oversight Framework
- ICS Financial Framework
- ICS Performance Management & Improvement Framework
- ICS Communications & Engagement Framework
- Bristol & Weston Purchasing Consortium Procurement Strategy
- Integrating NHS Pharmacy and Medicines Optimisation (IPMO) implementation plan 2021-2024

Note: Some of these documents will be redrafted as we formalise as an ICS

2. About Greener NHS Agenda & Climate Change

Climate change has been declared as 'the greatest threat to global health' (Lancet, 2017) which will have serious implications for our health, wellbeing, livelihoods, and the structure of organised society. Failure to act quickly will heighten existing national health challenges, place further financial strain on the NHS, and worsen health inequalities within the UK and internationally.

In delivering services for the public, the NHS and Local Authorities also generate carbon emissions and air pollution that are harmful to health. We have a moral duty to our population to minimise these impacts and to adapt our services to the unavoidable impacts of climate change.

We recognise that meeting our sustainability goals is not something we will focus on once we have met our core aims and objectives; **operating sustainably is at the core of how we will meet our ICS aims and objectives**

In developing our ICS we aim to deliver a truly sustainable health and care system that will bring multiple mutually reinforcing benefits:

- **Improve personal and population health**: improved physical & mental wellbeing of our citizens, improved health outcomes & reduced demand on our services
- **Improve environmental health:** create a cleaner, safer, more ecologically sound environment locally and globally, including restoring the environment and biodiversity as much as possible
- **Make best use of our limited resources:** use our resources at maximum efficiency by getting it right first time to make our services more cost effective and eliminate waste

Examples of mutual benefits

Access to green space: There is a wealth of evidence linking green space with improved health and wellbeing including accelerated patient recovery, improved social cohesion and improved mental health. If every household in England were provided with good access to quality green space, it could save an estimated £2.1 billion in health care costs[i].

Active travel: Across BNSSG, 5% of deaths are attributable to air pollution[ii]. Green transport options, such as improved bicycle infrastructure and facilities can yield a high benefit-cost ratio in the long term for both health and the environment. For example, in the Netherlands where about 27% of all trips are made by bicycle, cycling prevents about 6,500 deaths each year[iii]. Increased physical activity will lead to fewer strokes and heart conditions and improved mental health.

Improve our buildings: Between 2013 and 2018, there were an estimated 160,000 excess winter deaths in the UK. Of these, each year around 9,700 people died due to a cold home – the same as the number of people who die from breast or prostate cancer each year. The fact that UK homes are amongst the least energy efficient in Europe suggests that these deaths are preventable. By improving energy efficiency in homes, we can reduce preventable deaths associated with living in a cold home as well as reducing unnecessary fuel consumption[iv]

Financial efficiency: Sustainable health & care is high-quality, cost-effective care: Procuring for whole life costs; stripping out waste; high-quality services Getting It Right First Time; accounting for whole population benefits of service design, creating a resilient supply chain with security of supply

Green procurement: decarbonise supply chain; reduce whole life costs by adopting the principles of a circular economy; address carbon & particulate impact of transport of goods.

Supporting social value through procurement: Regional collaboration ensuring the collective £1bn purchasing power of local anchor institutions supports social value by creating opportunities for micro, small and medium size businesses, social enterprises and voluntary / community organisations

Social prescribing alternative to certain medications as clinically appropriate: increase physical activity, improving physical health & reducing demand on services; reduce the considerable carbon impact of medicine manufacture; increase social interaction and connection, spreading the benefits; reduce the adverse impact of medicines on the local water supply & associated flora & fauna

3. About our ICS

The Healthier Together Integrated Care System has been established to realise our shared ambitions to improve the health and wellbeing of the people of Bristol, North Somerset, and South Gloucestershire. The Partnership was established in 2016 to work together across the NHS, local government and social care. In 2019 we agreed a five-year plan to deliver significant improvements in the health and wellbeing of our population, to improve the quality of our services and people's experience of care and to make BNSSG the best place to work for our staff.

We were formally designated as an Integrated Care System in December 2020. In 2022 we will develop an Integrated Care Strategy for the population of BNSSG, covering health and social care and addressing the wider determinants of health and wellbeing. This strategy will focus on improving outcomes, reducing inequalities, and addressing the consequences of the pandemic for our local communities. Fundamental to this is our commitment to sustainability.

Members of the Healthier Together Partnership

Clinical Commissioning Group:

- NHS Bristol, North Somerset and South Gloucestershire CCG (BNSSG CCG)

Healthcare Providers:

- Avon & Wiltshire Mental Health Partnership NHS Trust (AWP)
- North Bristol NHS Trust (NBT)
- Sirona care and health (Sirona)
- Southwestern Ambulance Service NHS Foundation Trust (SWASFT)
- University Hospitals Bristol and Weston NHS Foundation Trust (UHBW)

GP Federation:

- One Care (BNSSG) C.I.C. (One Care)

Local Authorities:

- Bristol City Council (BCC)
- North Somerset Council (NSC)
- South Gloucestershire Council (SGC)

Contribution to and commitment to this Green Plan

All Healthier Together Partners have endorsed the vision and aims set out in this plan. However, due to the pandemic and the evolving nature of the ICS the level of engagement in the development of the plan, and the involvement in the delivery of actions varies across partners. This is summarised as follows:

Organisation	Organisational Green Plan (or equivalent) with exec leadership	Commitment to core vision & aims	Involvement in plan development	Delivery in 22/23
NHS Bristol, North Somerset and South Gloucestershire CCG (BNSSG CCG)	No	Yes	Core	Core delivery of plan
Avon & Wiltshire Mental Health Partnership NHS Trust (AWP)	Yes	Yes	Core	Core delivery of plan
North Bristol NHS Trust (NBT)	Yes	Yes	Core	Core delivery of plan
Sirona care and health (Sirona)	Yes	Yes	Core	Core delivery of plan
University Hospitals Bristol and Weston NHS Foundation Trust (UHBW)	Yes	Yes	Core	Core delivery of plan
One Care (BNSSG) C.I.C. (One Care)	No	Yes	High level engagement	In 22/23 primary care will focus on a small number of core deliverables whilst establishing the leadership & structures for future delivery
Commissioning Support Unit	Yes	Yes	High level engagement	Wider partnering opportunities (section 28)
Southwestern Ambulance Service NHS Foundation Trust (SWASFT)	Yes	Yes		Wider partnering opportunities (section 28)
Bristol City Council (BCC)	Yes	Yes	High level engagement	Wider partnering opportunities (section 28)
North Somerset Council (NSC)	Yes	Yes	High level engagement	Wider partnering opportunities (section 28)
South Gloucestershire Council (SGC)	Yes	Yes	High level engagement	Wider partnering opportunities (section 28)

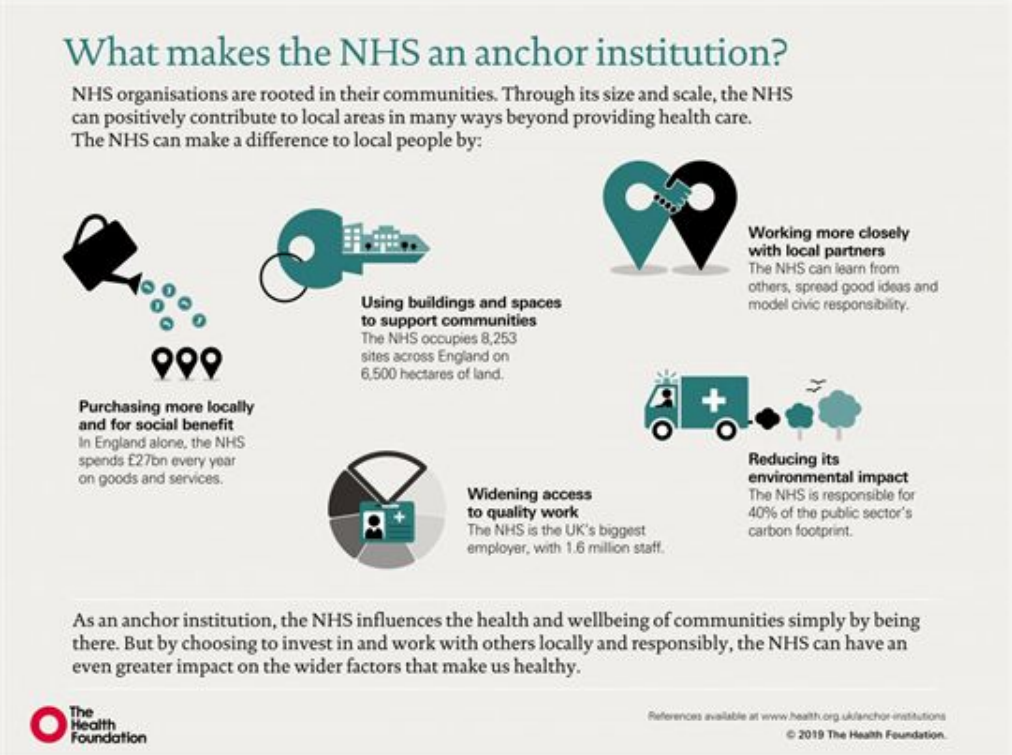
Wider partners

As anchor institutions we recognise our role in leading with our local communities. As such, successfully meeting our sustainability ambitions will require us to work closely with a number of leading local institutions. These include:

- Our landlords & property partners, including NHS Property Services
- Southwest Commissioning Support Unit
- West of England Combined Authority
- Academic partners including the West AHSN, Bristol Health Partners, University of Bristol and University of the West of England
- NHS Blood & Transport
- Independent Sector Treatment Centres and private hospitals
- Voluntary sector bodies
- Citizen leaders
- Key supply chain partners

Our ICS organisations acting as anchor Institutions

The term anchor institutions refers to large, typically non-profit, public sector organisations whose long-term sustainability is tied to the wellbeing of the populations they serve. Anchors get their name because they are unlikely to relocate, given their connection to the local population, and have a significant influence on the health and wellbeing of communities[1].



As an ICS we recognise the power we have as anchor institutions and commit to using this to positively contribute to our local area. This green plan gives us an opportunity to demonstrate what this means in practice, as set out in our vision and outcomes measures.

[1] The NHS as an anchor institution, The Health Foundation, The NHS as an anchor institution (health.org.uk)

4. Our Population

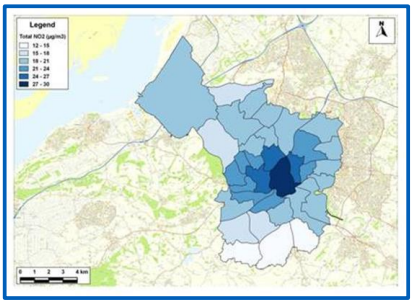
We serve a population of approximately one million people within distinct communities: a vibrant city with huge economic resources but also pockets of deprivation, seaside towns and villages and rural areas. People's life chances and prospects of enjoying good health vary dramatically depending on where they are born and where they live. Our children are disproportionately affected, with nearly 40% of children in Bristol falling within the most deprived quintile. We need to deliver health and wellbeing services that meet the needs of each of these diverse communities.

Specific Sustainability Aspects of Our Population

There are some specific aspects of our demographics and geography that we will look to address through our green plan, including:

Air pollution

Across BNSSG, 5% of deaths are attributable to air pollution, which rises to 8.5% for Bristol residents[v]. Air pollution particularly affects the most vulnerable in society: children and older people, those with heart and lung conditions and those living in the most deprived, inner-city areas. It is recognised as a contributing factor in the onset of heart disease and cancer.



Population-weighted total nitrogen dioxide concentrations, Bristol, 2013.

Our health behaviours – obesity & activity levels

Being overweight or obese increases the risk of death from a number of conditions including cancer, heart disease and stroke and is associated with increased risk of poor physical, mental and social health. Whilst prevalence of obesity in BNSSG is lower than South West and England averages, a large proportion of our population are affected. Around 1 in 5 reception age children in BNSSG are overweight or obese and this rises to almost 1 in 3 by the age of 11[vi].

Activity levels amongst adults in BNSSG are relatively high (61.1% of adults in BNSSG are considered active), particularly when compared with the England population as a whole, but there are substantial levels of inactivity. Approximately 1 in 4 (25%) of the adult population in BNSSG do less than 30 minutes of moderate intensity physical activity per week. In England, on average, 28.7% of the adult population are inactive. Promoting active travel as part of our sustainability ambitions will help to support healthy behaviours[vii].

Risk factor	PAF (%)
Tobacco	19.3
Diet	14.4
High blood pressure	13.0
High BMI	9.6
Alcohol and drug use	9.5
High cholesterol	7.4
Occupational risks	4.9
High blood sugar/diabetes	4.8
Air pollution	4.0
Low physical activity	2.2

Population attributable fraction (PAF) for risk factors for all-cause YLLs rate per 100,000; England 2016 from the Lancet Global Burden of Disease Study.

Access to healthy food:
70% of BNSSG households purchase fresh and affordable food close to home on a weekly basis. This figure drops to 30% for those with serious long-term conditions and 45% in Worle, Weston and Villages. It rises to 75% in North Bristol and Woodspring. Our food and nutrition actions set out in this plan aim to increase awareness of nutritious and environmentally sound food choices[viii].

Healthy life expectancy
Healthy life expectancy (the number of years expected to be lived in self-reported good or very good health) is associated with a strong deprivation gradient within BNSSG

The main contributing factors to disability/poor health	Alignment to green plan ambitions
Musculoskeletal disease	Active travel & green social prescribing
Cardiovascular disease and stroke	Active travel, nutrition, preventative models of care
Respiratory diseases including COPD	Targeting air pollution
Depression and mental health problems	Green social prescribing
Cancers and particularly lung cancer	Targeting air pollution, healthy lifestyle choices
Alcohol and drug misuse	Green social prescribing

Summary

With wider determinants impacting health outcomes by up to 40%[ix], we know that we can only gain real traction in significantly improving the health of our population by working together and particularly capitalise upon the full range of interactions our Local Authorities have with the public.

Making a significant improvement in the health and wellbeing of our population will mean:

- Addressing the major health threats of cardiovascular/cerebrovascular, respiratory, mental health, musculoskeletal diseases and cancer.
- Addressing the gross inequalities in our system by deprivation and between groups, such as those with learning disabilities and serious mental health issues.

As one of our key system objectives, a sustainable approach to health and care delivery, will be part of addressing the wider determinants of health outcomes

5. Our Green Plan Vision

Our sustainability vision is set out as one of our 7 ICS strategic aims.

ICS Strategic Aim 6: We will act as leading institutions to drive sustainable health and care by improving our environment, achieving net zero carbon by 2030; improving the quality of the natural environment; driving efficiency of resource use.

We will focus on delivering 3 key outcomes for our population:

Improve the environment: We will improve the overall environmental impact and sustainability of our services, especially the damaging local impacts of air pollution, creating a cleaner, safer, more ecologically sound environment locally and globally, including restoring the environment and biodiversity as much as possible

Net zero carbon: We particularly recognise the pressing urgency to address our carbon footprint and will reduce the impact of our services on the environment by achieving net zero carbon across all emissions scopes by 2030

Generate a BNSSG-wide movement: Our sustainability behaviours, actions and innovations as anchor institutions will support a cultural change amongst local citizens and businesses resulting in wider improvements in air quality, biodiversity, and the quality of the natural environment

Our pledges:

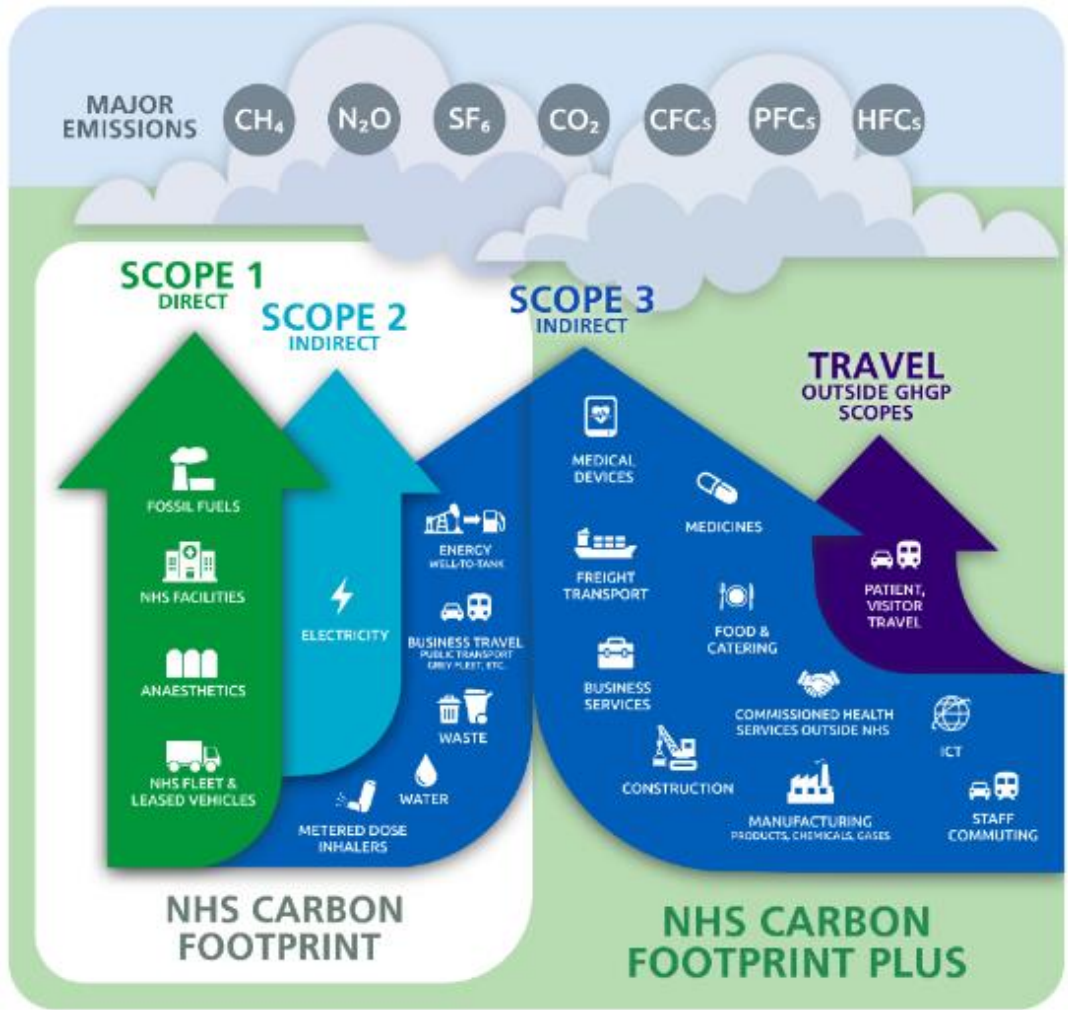
- We will ensure all new capital developments are net zero unless there are significant exceptions. This will be considered a pass/fail decision point in our capital prioritisation matrix
- We will maximise our system building capacity, facilitated by investments in digital infrastructure, before any partner organisation builds new non-clinical buildings
- We will lease or purchase only ultra-low emission vehicles unless a sustainable equivalent is not available in the market
- All new buildings and refurbishments must meet the NHS Net Zero Carbon Building Standard
- We will expect all new models of care to demonstrate a carbon reduction and/or a wider sustainable benefit to support population health
- We will aim for all new procurements or renewals to be with suppliers that demonstrated a clear commitment and plan to achieve net zero carbon
- We will evaluate all new procurements and renewals based on their Green Plan net-zero carbon goals and will monitor suppliers on their delivery against those commitments
- We will actively seek opportunities to create social value through our spending to appoint micro, small and medium size businesses, social enterprises and voluntary / community organisations

6. Our Carbon Footprint – Scope Definitions

The NHS categorises scope 1 & 2, and a specific sub-set of scope 3 emissions as the NHS Carbon Footprint. The remainder of the scope 3 emissions are classed as the NHS Carbon Footprint Plus.

Throughout this plan, and in our ICS commitments, we are referring to the total carbon emissions generated directly and indirectly by our services – i.e., scopes 1, 2 & 3.

Scope	Description	Examples
Scope 1: Direct Emissions	Direct emissions from sources that are owned or controlled by the NHS	• Direct fuel/energy use e.g. natural gas • Fuel used from institution owned vehicles • Anaesthetic Gases
Scope 2: Electricity Indirect Emissions	Emissions from the generation of purchased electricity consumed by the NHS	• Purchased electricity
Scope 3: Other Indirect Emissions	Emissions that are a consequence of the activities of the NHS, but occur from sources not owned or controlled by the NHS	• Construction, water, waste, land-based travel, commuting (both staff and students) • Food and catering • Procurement & supply chain

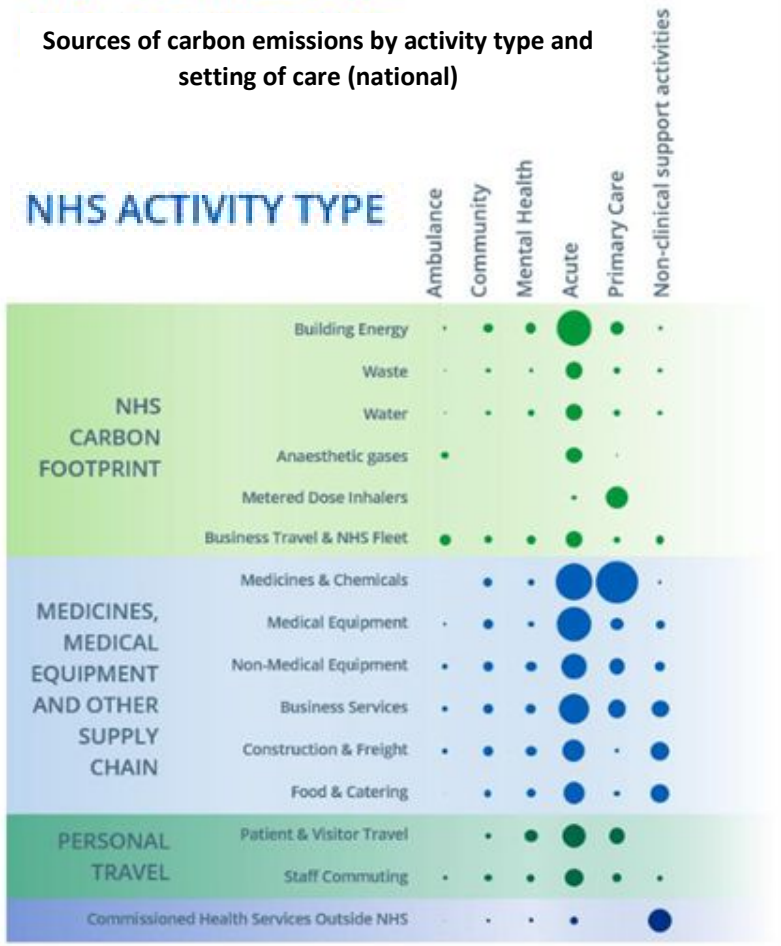


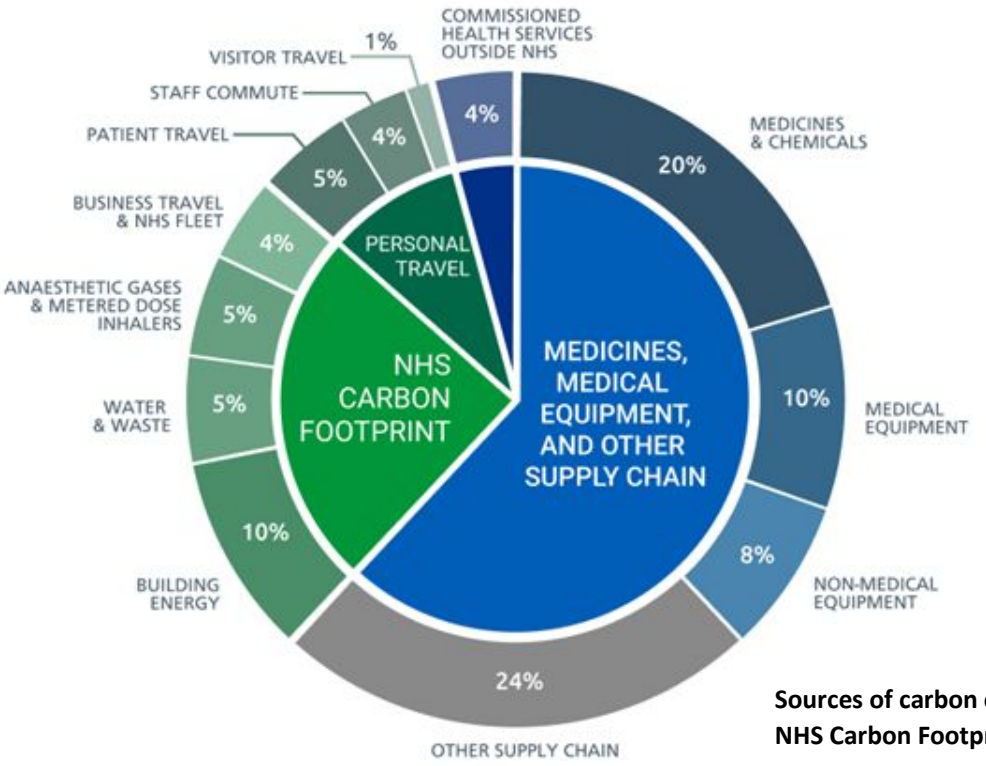
What makes up our carbon footprint (based on national top-down figures):

Most of our carbon footprint is associated with the acute sector, with building energy, waste & water being the largest element of the NHS Carbon Footprint

Medicines & chemicals, NHS purchasing, and other supply chain are the largest element of the NHS Carbon Footprint Plus. We commit to actively influencing our supply chain and associated manufacturers to achieve net zero.

Sources of carbon emissions by activity type and setting of care (national)





Sources of carbon emissions by proportion of NHS Carbon Footprint Plus (national)

7. How we will measure our progress

To assure ourselves and our citizens that we are on track to deliver our headline ambitions we will establish a number of key metrics. For some aspects of our sustainability ambitions there are not currently suitable measures. For these we will work to develop measures and use proxy measures in the meantime.
Our approach to measuring our progress is:

- To have an initial ICS-wide dashboard by end of August 2022
- Work with commercial and academic partners to identify the most appropriate measures
- Ensure wherever possible we measure outcomes (i.e., what will be different for our population), rather than processes
- To review our dashboard at least annual at organisational and ICS board level

Our current headline measures:

Target areas	Proposed measures	Target
Improve the environment: We will improve the overall environmental impact and sustainability of our services, especially the damaging local impacts of air pollution		
Travel & Transport: Reduce particulate, CO_2 & NOX impacts of travel (ultra-low emission vehicles, active travel)	Air quality around our main hospital sites & mean annual background concentration of PM 2.5 and PM 10 particulates	Within legal limits of the 2008 ambient air quality directive by 2025.
	Fraction of mortality attributable to air pollution	Improve across a medium-term rolling average
	Number of journeys to hospital for outpatient care	30% of all non-procedure outpatient attends delivered non-F2F from 22/23
	% Of patients that travel to care contact by sustainable methods	To be defined by travel & transport leads in 22/23
	% Of staff that travel to work by sustainable methods	To be defined by travel & transport leads in 22/23
	% Of new vehicle purchases / contracts that are ULEV (or EURO 6 standard where ULEV not available)	100% by 2023
Waste & water: Reduce waste & water across all estates	Total water consumption of our services (vol)	Reduce compared to previous year
	% Waste to landfill	0% zero waste to landfill from our estates by 2025
	Waste: other recovery weight, alternative treatment weight, landfill weight	Reduce compared to previous year towards zero by 2030
	Recycling weight	Increase year on year

Target areas	Proposed measures	Target
Plastics: Reduce single use plastics	Total volume / number of single use plastic products [not yet measurable]	Moving towards zero, but identify biggest amenable to local changes
	Number of single use products replaced with reusable alternative	Procurement to advise on target - towards zero by 2030
Biodiversity: Protect and enhance biodiversity across our estates	Area (m2) of our sites improved/managed for biodiversity and staff wellbeing	Increase year on year
	New trees planted across our footprint by 2025	1000 trees planted by 2025
	Biodiversity value of our sites	Increase biodiversity value by 10% against biodiversity action plans for sites with green space
 **Specifically target carbon:** We particularly recognise the pressing urgency to address our carbon footprint and will reduce the impact of our services on the environment by achieving net zero carbon across all emissions scopes by 2030		
Total all scopes carbon	Carbon footprint for our activates scope 1, 2 & 3	Net zero by 2030 (trajectory TBD)
	Total financial cost to the system if we were to off-set our carbon emissions (all scopes)	Reduction year on year towards minimal offset by 2030 [£75 per tonne CO2]
Estate: Decarbonise estates	Carbon footprint from estate (exc. energy) - i.e., waste, water, other	Net zero by 2030 (trajectory TBD)
	% New build capital projects achieving NHS Net Zero Carbon Building Standard	100% from 22/23 (unless significant exceptions)
	% Refurbishment capital projects achieving NHS Net Zero Carbon Building Standard	100% from 22/23 (unless significant exceptions)
	Utilisation of our estate: carbon use per care episode to [not yet measurable]	Reduce year on year
	Use of Sustainable Design Guide / net zero building standard for all new buildings/refurbs	100%
Energy: Decarbonise energy	Carbon footprint from all building energy	Net zero by 2030 (trajectory TBD)
	Percentage of imported electricity from truly renewable sources	100% by April 2022
Supply chain: Decarbonise supply chain	Total carbon footprint of supply chain	Net zero by 2030 (trajectory TBD)
	% Of new or renewed contracts with suppliers who have a plan to take their operations to net zero by 2030	100% from 22/23 (except where no viable supplier available)
Medicines: Target the significant carbon impact of medicines and associated supply chain	Total carbon footprint of medicines & chemicals	Net zero by 2030 (trajectory TBD)
	Carbon footprint associated with anaesthetic gases	Net zero by 2030 (trajectory TBD)
	Carbon footprint associated with metered dose inhalers	Net zero by 2030 (trajectory TBD)
	% Of new or renewed contracts with suppliers who have a plan to take their operations to net zero by 2030	100% from 23/24 (except where no viable supplier available)

Target areas	Proposed measures	Target
Care models: Low carbon models of care – do less (preventative & up-stream care), do local (digitally enabled, local care models), do most efficiently (GIRFT, low carbon alternatives etc)	Reduction in patient miles travelled / CO_2 as a result of outpatient transformation	30% reduction on 19/20 levels
	Reduction in patient miles travelled / CO_2 as a result of other sustainable models of care	TBD
	Reduction of carbon associated with new models of care	TBD using Healthy Weston Phase 2 as test
	% Of patients that travel to hospital by sustainable methods	Increase year on year
	Reduction in carbon achieved through green social prescribing [measure to be defined]	TBD
	Utilisation of our estate: carbon use per care episode to [not yet measurable]	Reduce year on year
	% Of large-scale service changes that can demonstrate a positive impact on key environmental measures (e.g. through a Sustainability Impact Assessment)	100% by 23/24
	**Generate a BNSSG-wide movement:** Our sustainability behaviours, actions and innovations as anchor institutions will support a cultural change amongst local citizens and businesses resulting in wider improvements in air quality, biodiversity, and the quality of the natural environment	
Staff: Training, engagement & personal action	Number of staff reporting increased awareness of C&E emergency and report having made practical changes (in workplace and outside) [Not currently measured]	TBD
	Number of active users on sustainable staff engagement scheme / app	TBC based on year 1 of use
	Number of people who have received training in sustainability / carbon literacy	TBD
	Number of Green Champions – staff who are dedicated to reducing our environmental impact and given the time and resources to do so.	Increase year on year
ICS culture & process: Embed sustainability within all our core decisions	% Of large-scale business cases that can demonstrate a positive impact on the environment	100% by 23/24 (scale and mechanism TBD in 22/23)
	ICS value and financial framework has sustainability as a central component	TBD - e.g., number of business cases pricing in environmental costs and benefits in the value equation
	% Organisations with a staff engagement programme e.g. RCGP endorsed Green Impact for Health awards scheme or Jump	100% by 23/24
Lead change with our citizens: use touch points for raising awareness; behaviour change	Number of citizens who have reported an increased awareness & changed behaviour as a result of contact with an ICS organisation or our messaging	TBD
	Number of people with improved self-reported health due to connecting with nature	TBD by the Green Social Prescribing work
	Percentage of adults walking for travel at least three days per week	
	Percentage of adults cycling for travel at least three days per week	
	% Of service users who report ICS organisations as leading the way in sustainable provision of	TBD – citizen panel or local authority survey

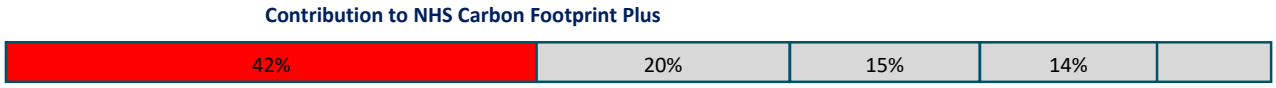
Target areas	Proposed measures	Target
	services	
	Number of citizen communication campaigns / number of citizens reached by campaigns (e.g. front door messaging, appointment letters, transport options)	TBD – to increase year on year, use academically-validated approaches to use health interventions as a chance to create a step change in personal sustainability behaviour
Acting as anchor institutions to Influence local business & economy: Create a step change that directly benefits our citizens	Demonstrable positive impact on local business economy	% of spend with micro, small and medium size businesses, social enterprises and voluntary / community organisations
	Value of external reuse of durable goods by value (e.g. reuse of office furniture)	Increase year on year
	Number of citizens who have benefited from ICS projects such as community heat project	Increase year on year
	Number of citizens we have helped to access key areas of support such as warm homes / sustainability grants	Increase year on year

8. Our ICS ambitions, commitments and actions

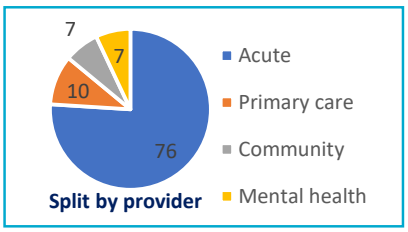
The following pages set out the ambitions, commitments and actions that we have made across key thematic areas.

Explanation of page layout

Contribution to carbon footprint: The coloured bar at the top of the next four pages shows the approximate percentage of all-scope carbon emissions attributable to that area of our operations. We will ensure we target our actions at the highest impact areas. Due to incomplete local data these estimates are based on the national figures[2]. The example shown below is for supply chain & procurement.



Split by provider: The chart on the top right of the next four pages shows the approximate split of the carbon emissions for that area of our operations across provider type. This is also drawn from national data. It is important we know the relative contribution of each organisation as it allows us to focus on the actions within each organisation that will deliver the biggest benefit. The example shown to the right is for supply chain & procurement.

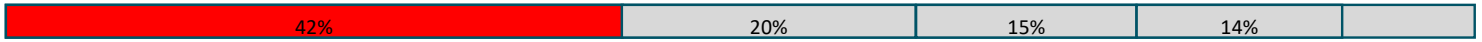


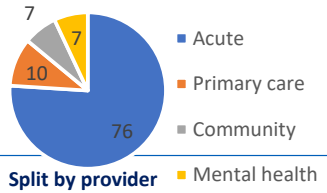
Contribution to our headline metrics: Most actions will contribute to several headline metrics. In the following pages we have highlighted the metrics that will be most significantly impacted by actions in that aspect of our operations.

[2] Delivering a 'Net Zero' National Health Service, delivering-a-net-zero-national-health-service.pdf (england.nhs.uk)delivering-a-net-zero-national-health-service.pdf (england.nhs.uk)

9. Supply chain & procurement

Contribution to NHS Carbon Footprint Plus





Headline ambition for our ICS

We will drive towards a net zero procurement and supply chain by 2030. We will have an ethical approach at the centre of our procurement decisions, recognising that our need to procure to deliver our health service should never be at the detriment of others and we will work to ensure that is the case. We will:

- Driving the supply chain to net zero
- Using our spend as a positive influence in our community
- Promoting a fair, diverse, and inclusive supply chain

Additional opportunities through acting as anchor instructions

We are committed to ensuring that our (combined) annual expenditure of £424M delivers the maximum benefit to society. Our duty under the Social Value Act 2012 is to consider the economic, social and environmental benefits that can be delivered when making procurement decisions. In short, how can we deliver wider public benefits for communities beyond the service being commissioned. Wherever possible, we will also contract with local businesses, voluntary groups, charities and social enterprises.

Key actions for 22/23:

- Implement and embed new procurement strategy & deliver the NBT route map (NBT, UHBW, AWP & Sirona), including the ethical procurement policy
- Contract with a commercial partner to assess the carbon impact of our supply chain
- Establish key delivery metrics to achieve net zero by 2030 (e.g., annual targets / run rate)
- Embed procurement commitments within business planning processes, including amending the TORs of the non-pay group to include both a carbon and monetary assessment
- Actively creating opportunities for micro, small and medium size businesses, social enterprises, and voluntary / community organisations
- Work in partnership with other anchor institutions (local authorities and universities) to establish a region marketplace to promote social value, including: actively engaging with community business for their procurements; making the procurement pipelines of anchor institutions more accessible to community business; creating an opportunity for community business to access anchor institutions and show case their capabilities and innovations; using the skills and experience of the anchor institutions to provide guidance on how to respond to the tenders and procurement requests of the anchor institutions
- Consider system-wide equipment re-use strategy
- Targeted work on single use plastics: share and rapidly adopt learning
- Support for the transition to a circular economy by establishing a list of items most applicable for this.

Key ICS Pledges & Commitments

As a system recognise the positive impact that can be leveraged from a collaborative approach to procurement, to ensure social, responsible, and environmental commitments are at the heart of decision making.

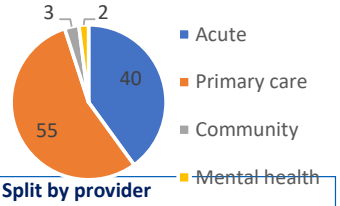
- We will challenge the market to make a significant reduction in carbon for every (re)procurement, including showing how they are on target to meet the 2030 net zero each time we renew a procurement
- Ensure our supply chains and procurement processes are ethical, free from worker abuse and exploitation and provide safe working conditions.
- Influence good practice throughout our supply chains and our partner organisations.
- We will commit to assessing our supply chains ethical practises and compliance in consideration of our contribution towards the SDGs.
- We will review our suppliers for compliance with relevant minimum labour standards and (where applicable) with the Modern Slavery Act 2015.
- We will carry out all our sourcing in an ethical manner, ensuring our treatment of our suppliers remains fair and ethical at all times, and that our procurement processes are transparent and non-discriminatory.
- We will embed a culture of reviewing existing high impact products across all service lines

Contribution to our headline metrics

Headline outcome	Metrics	Target
Improve our environment	Total volume / number of single use plastic products	Moving towards zero, but identify biggest amenable to local changes
	Number of single use products replaced with reusable alternative	Procurement to advise on target - towards zero by 2030
Target carbon	Total carbon footprint of supply chain	Net zero by 2030 (trajectory TBD)
	% Of new or renewed contracts with suppliers who have a plan to take their operations to net zero by 2030	100% from 22/23 (except where no viable supplier available)
Lead change with our citizens	Demonstrable positive impact on local business economy	% Of spend with micro, small and medium size businesses, social enterprises and voluntary / community organisations
	Value of external reuse of durable goods by value (e.g. reuse of office furniture)	Increase year on year

10. Medicines

Contribution to NHS Carbon Footprint Plus



Split by provider

Headline ambition for our ICS

We will reduce the impact of our medicine & medical devices on the environment towards net zero by:

- Reducing overuse of medicines and medicines waste
- Switching to lower impact alternatives wherever possible or green social prescribing initiatives
- Driving changes in the manufacture of medicines through our procurement approach

Key actions for 22/23:

- Embed green plan ambitions within medicines optimisation strategy
- Ensure delivery of anaesthetic gases & metered dose inhaler (MDI) projects
- Appoint a primary care clinical lead to accelerate delivery of the MDI project, other green priorities, and support polypharmacy review programme / switch to social prescribing / recommend digital tools that could enable culture change
- Embed green impact within formulary decision making process and establish a clear decision-making protocol for trade-offs (e.g., carbon v cost v patient experience v clinical benefit). This will also support guideline development.
- Work with Commercial Medicines Unit (CMU), NHSE Commercial and Regional Pharmacy Procurement Specialist to ensure our green procurement commitments are featured
- Promote wider culture change through our regular communications
- Undertake an evaluation of the environmental impact and clinical suitability of personal protective equipment procurement
- Identify pipeline of future lower carbon medicine switches and commit to these through annual business planning rounds
- Consider how carbon impact can be visible at point of care as part of shared decision-making conversations
- Maximise the benefits of our Green Social Prescribing project
- Drive more effective waste management by ensuring contracted services evidence recycling of packaging and driving for teracycle option for plastic blisters
- Recognise environmental challenges relating to medicines and minimise impact where possible

Key ICS Pledges & Commitments

To have an iterative approach to targeting the highest opportunity medicine change each year. Approach to include:

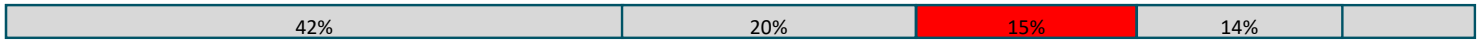
- Aligning our sustainability commitments to the 'delivering best value' strand of our Medicines Optimisation Strategy
- A review of the return and recycling of medicines, medical devices, and equipment to reduce un-necessary waste generation by the NHS, including in general practice
- Reduce medicines waste
- Consider switching highest carbon impact medicines e.g., anaesthetic gasses and inhalers to low carbon alternatives
- Identifying pipeline of future opportunities for greener alternatives
- Considering environmental impacts within structured medication reviews
- Influencing the procurement and supply chain
- Aligning medicine changes to Sustainable Models of Care
- Considering a pass/fail criterion for new medicines approval to demonstrate a commitment towards net zero, unless no viable alternative is available
- Demonstrating where the most environmentally sustainable solution is also the optimal treatment (e.g. correct use of inhalers)

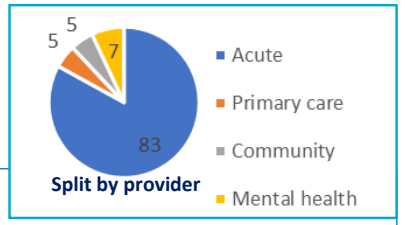
Contribution to our headline metrics

Headline outcome	Metrics	Target
Target carbon	Total carbon footprint of medicines & chemicals	Net zero by 2030 (trajectory TBD)
	Carbon footprint associated with anaesthetic gases	Net zero by 2030 (trajectory TBD)
	Carbon footprint associated with metered dose inhalers	Net zero by 2030 (trajectory TBD)
	& Of new or renewed contracts with suppliers who have a plan to take their operations to net zero by 2030	100% from 23/24 (except where no viable supplier available)

11. Estates & facilities

Contribution to NHS Carbon Footprint Plus





Headline ambition for our ICS

We will be net zero as a health system by 2030. To achieve this, we will:

➢ **Upgrade & renew buildings and infrastructure**

- Develop and implement a sustainable design guide for use by system partners
- Have a strategic system-wide investment programme to decarbonise our estate
- Work with our landlords where we are not property owners, negotiating improvements in building performance at lease renewal and rent reviews. Consider divestment where landlords are unable to meet this

➢ **Optimise the way we use our buildings:**

- Embed energy and water efficient technologies and practices throughout our estate and services
- Deliver year-on-year reductions in consumption of water & energy and production of waste
- Use the benefit of working as a system to make most environmentally sensible use of our joint estate (e.g., sharing buildings, joint back-office functions, and shared working hubs). Look to reduce total estate footprint through new ways of working
- Increase the proportion of our clinical buildings used for delivery of clinical service & increase overall building utilisation, thus reducing carbon output per care episode

➢ **Change our energy source**

- Derive 100% of our energy from renewable sources

Key actions for 22/23:

- Amend financial approval and capital prioritisation processes to reflect our ambitions
- Each organisation will undertake an assessment of how far existing organisation plans take us to net zero, collated into an ICS plan
- Establish view of non-owned estates, the routes & timescales for actions (e.g. lease review) & take a system view of investment vs benefit
- Establish corporate service review and use this to drive new ways of working such as hot-desking & working from home (reduced carbon, reduced estate need)
- Establish a system-wide strategy for clinical & non-clinical waste
- Sharing sustainable design guides
- Supporting system partners with business cases to attract grant funding
- Involvement in district heat network

Key ICS Pledges & Commitments

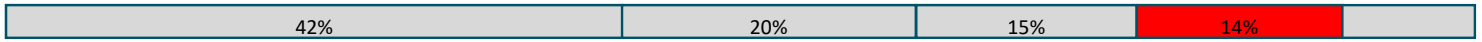
- Each of our tier 1 partners agrees to becoming net zero for estates and facilities by 2030
- We will ensure all new capital developments are net zero unless there are significant exceptions. This will be considered a pass/fail decision point in our capital prioritisation matrix
- We will exhaust our system building capacity, facilitated by investments in digital infrastructure, before any partner organisation builds new non-clinical buildings
- We will lease or purchase only ultra-low emission vehicles unless a sustainable equivalent is not available in the market
- All new buildings and refurbishments must meet the NHS Net Zero Carbon Building Standard
- We will ensure that replacement services & infrastructure will meet net zero carbon requirements (e.g. no new gas boilers)
- We will increase the total amount of green & blue spaces across our total footprint
- We will use our capital allocations & primary care improvement grants and levies to enable developments in infrastructure which prioritise net zero.
- We will positively support investment in decarbonisation. The phasing and prioritisation for this will be considered at system level (i.e. greatest relative impact)
- We will adopt the principles of circular economy to minimise waste and maximise local reuse

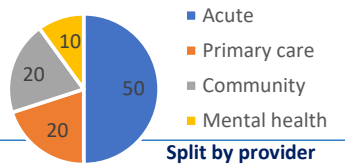
Contribution to our headline metrics

Headline outcome	Metrics	Target
Improve our environment	% Waste to landfill	Zero waste to landfill by 2025
	Total water consumption	Reduce consumption year on year
	% Waste recycled	Increase year on year
	Total volume of single use plastic products	
	Area (m2) of our sites improved/managed for biodiversity and staff wellbeing	
Target carbon	Carbon footprint from estate (exc. energy) - i.e. waste, water, other	Net zero by 2030
	Carbon footprint from all building energy	Net zero by 2030
Lead change with our citizens	% Of service users who see ICS organisations as leading the way in sustainable provision of services	TBC

12. Travel & transport

Contribution to NHS Carbon Footprint Plus





Split by provider

Headline ambition for our ICS

Transport emissions play a role in poor air quality impacting on our population health, contributing to 300 deaths per year in Bristol. Physical activity through active travel can play a key role in improving health and wellbeing. We will drive towards net zero carbon and significant reduction in damaging air pollution from the travel & transport associated with our activities.

Key actions for 22/23:

Headline measures:

- Identify targeted action to address air pollution on our key sites – e.g., standard signage to turn off engines
- Develop a common set of key metrics – e.g., deaths attributable to air pollution, active travel, staff miles, patient journey types, business mileage

Staff & business travel

- Commission system-wide review of fleet vehicles to purchase only ULEVs or Euro 6
- System wide review of travel expenses policy: consider making the expenses rates for using sustainable travel for work options (this will include EV's) higher than the rates for using a private motor car. Promote active travel: All staff to have access to personal travel plans that can be used to identify travel to work options or travel for work options
- Staff loan / salary sacrifice schemes for ULEVs (currently only for B4 up), and active travel options (cycle schemes)
- Ensure that all car parking policies are in line with HTM 07-03 where parking is only provided for those that need it e.g., disabled, night staff, staff that work when unsocial hours when public transport options are limited, and rates discourage the use of the private motor vehicle to get to work
- Promote and facilitate working from home / most accessible office hob.
- Participate in the TravelWest Travel to Work survey to collect baseline staff travel data
- Implement the Clean Air Hospital Framework

Service user travel

- Work with public transport providers to provide a fit for purpose public transport service for the area
- Consider free public transport tickets for those patients already eligible for free parking
- Review active travel corridors/routes with WECA – all sites should have safe / dedicated low-traffic routes
- System wide events and communications plan to promote active and sustainable travel benefits to drive behaviour change
- Green social prescribing of active travel for rehabilitation

Key ICS Pledges & Commitments

We will act collectively to change travel behaviours & decarbonise our fleet:

- We will lease or purchase only ultra-low emission vehicles unless a sustainable equivalent is not available in the market
- We will ensure new models of care provide care digitally or closer to home wherever possible
- We will develop an ICS approach to lease vehicles and salary sacrifice aligned to our sustainability goals
- We will align our travel expenses policies to support our goals (e.g., mileage expenses for active travel that are comparable to vehicle mileage)
- Ensure that new ways of working, supported by our policies, reduce the need for travel
- Promote active travel (running, walking, cycling etc) for staff and patients, including as part of green social prescribing initiatives.
- Implement a hierarchy of vehicle use: remove travel (work from home), minimise travel with care closer to home, promote active travel, public transport, shared modes, private ultra-low emission vehicles, private fossil fuel as last resort

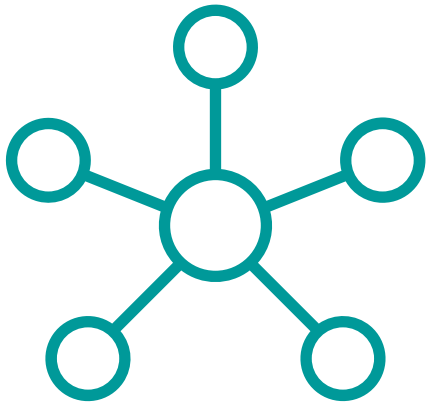
Contribution to our headline metrics

Outcome	Metrics
Improve our environment	Air quality around hospital sites & mean annual background concentration of PM 2.5 & PM 10 particulates
	Fraction of mortality attributable to air pollution
	% Of patients that travel to care by sustainable methods
	% Of staff that travel to work by sustainable methods
	% Of new vehicle purchases / contracts that are ULEV (or EURO 6 standard where ULEV not available)
Carbon	Carbon footprint for our activates scope 1, 2 & 3
Lead change with our citizens	No. of citizens who have reported an increased awareness & changed behaviour as a result of contact with an ICS organisation or our messaging
	% of adults walking for travel at least 3 days per week
	% of adults cycling for travel at least 3 days per week

13. Digital

Headline ambition for our ICS

Our digital vision is to become an exemplar of a digitally advanced ICS. We recognise that this will play a key part in meeting our environmental ambitions. This includes through digitalised clinical systems, smart facilitates management monitoring systems, and facilitating agile working across our footprint.



Digital infrastructure can also contribute to environmental damage through carbon use as well as the use of rare materials. We commit to maximising the positive environmental benefits of our digital enablers, while minimising their impact on the environment.

Key ICS Pledges & Commitments

We will drive towards a net zero digital provision by 2030 by:

- Providing digital capabilities that support clinical models of care that are non-face-to-face or digital by default wherever clinically appropriate
- Achieving a minimum of 30% outpatient care non-face-to-face and increasing our proportion of primary care appointments delivered digitally
- Enable much more effective sharing of clinical information across the ICS, reducing the need for additional patient contacts & travel. We will move information, not people
- Support a community first model of care via an Integrated Delivery Unit
- Enable a personalised & proactive care experience for the service user, thereby reducing the need for more resource-intensive reactive care
- Maximising the use of digital technologies in our facilities management (e.g., smart metering, automation)
- Through our procurement strategies, align to the requirements set out in the government sustainable IT strategy, as well ensuring suppliers entering new or renewed contracts with us have a plan to take their operations to net zero by 2030. This includes our commitments to transparency of supply chain, data storage, data centres and power use /cooling
- Joining up our infrastructure to reduce cost and resource use

Key actions for 22/23:

- Ensure the environmental benefits of existing capabilities are being maximised (Electronic Patient Records, virtual appointments, digital prescribing)
- Work with the CSU to identify the highest impact interventions & pathways for transformation
- Development of fully integrated BNSSG wide community first digital capability that is specifically designed to support our ambition for integrated community first care as the default setting for care.
- Through our digital workforce objective, creating the network infrastructure that will allow seamless working across the BNSSG estate and considering that significant levels of care already happen in the persons home
- Create a BNSSG Digital Infrastructure Alliance joining up key systems that drive cost & resource saving by removing duplication and creating shared services
- Ensure through our contracting and procurement that we are moving to lower carbon impact provision of digital infrastructure and hardware, including the impact of outsourced or subcontracted services
- Embed uptake of digital solutions within services through Digital Changemakers to ensure sustainability and other benefits are realised.

Contribution to our headline metrics

Headline outcome	Metrics	Target
Improve our environment	Number of journeys to hospital for outpatient care	30% of all non-procedure outpatient attends delivered non-F2F from 22/23
Target carbon	Utilisation of our estate: carbon use per care episode to	Reduce year on year
	% Of new or renewed contracts with suppliers who have a plan to take their operations to net zero by 2030	100% from 22/23 (except where no viable supplier available)
	Reduction of carbon associated with new models of care	TBD using Healthy Weston Phase 2 as test
Lead change with our citizens	Demonstrable positive impact on local business economy	TBD – e.g.; increase in % of contracts to local businesses
	Value of external reuse of durable goods by value (e.g. reuse of IT / office furniture)	Increase year on year

14. Sustainable models of care

Headline ambition for our ICS

We will ensure that we are at the leading edge of sustainable models of care. We will embed carbon reduction principles throughout our care delivery recognising that the way we deliver care and the way we operate sustainably are inextricably linked. National estimates are that preventative medicine, reduced health inequalities & lower carbon models of care can contribute to a 15% overall reduction in the NHS Carbon Footprint Plus. The goals of our model of care are to:

Help people stay well and independent in their community

Provide early help and support that is integrated, personalised and wherever possible proactive, avoiding the need for intensive support or hospitalisation

Where hospital is unavoidable and becomes the only way to meet the needs of the person, stays are kept to a minimum and community support is integrated, personalised and pre-emptive

People have a system of support to get them back home as quickly and easily as possible

We help people once home to get back to being as well and independent as possible, including accommodations for any new ways of staying well

Key ICS Pledges & Commitments

By supporting people to stay healthy and well we will reduce overall demands on healthcare services, and thereby their associated environmental impact, by:

- Delivering our prevention agenda
- Reducing health inequalities that lead to inefficient allocation of healthcare resources

We will reduce the carbon impact of the services we deliver by:

- Providing services from places and in ways which minimise the need for unnecessary travel
- Getting it right first time – reducing unwarranted variations in care, delivering the right care, to the right person in the right place.
- Delivering lowest impact, clinically appropriate care
- Ensuring that sustainability and environmental impacts are key considerations in system design principles & integrated care plans
- Ensuring that patients are engaged and well-informed about the carbon impacts (including as part of shared decision making around choice of care pathway)

We will facilitate change at all levels by:

- Ensuring that sustainability principles are central to service design and redesign, not an afterthought
- Enabling a culture where considering the environmental impact of services becomes the norm (education, tools to decide trade-offs, the information to support the right decisions - e.g. GIS - help to visualise trade-offs)
- Explicitly naming environmental costs and benefits as a part of the clinical value agenda

Contribution to our headline metrics

Outcome	Metrics	Target
Improve our environment	Number of journeys to hospital for outpatient care	30% of all non-procedure outpatient attends non-F2F
Target carbon	Utilisation of our estate: carbon use per care episode to	Reduce year on year
Lead change with our citizens	% Of business cases with a sustainable impact assessment (that has influenced the design of the business case)	100% by 23/24

Key actions for 22/23:

- Establish an ICS-wide network of sustainability experts who can support service redesign
- Use Healthy Weston Phase 2 service redesign as a test case for how to make sustainability principles central to large scale service change
- Create a set of standardised tools, such as Sustainability Impact Assessments that support the initiate & delivery of service change
- Use the service redesign gateways to ensure sustainable models of care are part of the service model. Ensure that all service changes & business cases can demonstrate positive environmental impacts through their SIA.
- Establish sustainability agenda into priorities for QI programmes and academic research (e.g. AHSN)
- Continue to deliver the highest impact interventions, including anaesthetic gases & metered dose inhalers as well as digital models of care & telemedicine
- Identify & communicate the benefits of sustainable models of care delivered during COVID-19 to discourage reversion to original state – promote what is already done
- Identifying the next wave of opportunities / highest environmental impact pathways. Share case studies on service models that have reduced carbon impacts
- Launch broader engagement around sustainable models of care including annual displays & roadshow of examples; staff & patient engagement events; discretionary funding & design competitions to accelerate new ideas
- Through shared decision-making conversations, involve service users more fully in treatment choices and options for minimising environmental impacts
- Use Right Care and other tools to reduce unwarranted variation in care and associated resource waste

15. Workforce and system leadership

Headline ambition for our ICS

We will demonstrate our commitment to delivery of our sustainability agenda through a clear approach to leadership and people development at all levels of our organisations.

Key actions for 22/23:

System leadership:

- Establish the executive-led ICS Green Plan Steering Group
- Our Supercharging Coaching approach will be entwining personal and environmental sustainability, including the September Conference which will include an understanding and significant use of nature during the event
- We will develop our "Developing leadership and leaders Principles" to include a focus on holistic sustainability

Wider actions:

- Use our environmental credentials to establish our organisations as employers of choice. ICS job description template should include sustainable vision and staff requirements, and standard interview questions to incorporate sustainability focussed questions.
- Formalise sustainability advocates / link roles in each division & department (e.g., Green Ambassadors).
- Encourage the development of Green Staff Networks / Sustainability Staff Networks across the system.
- Take a proactive approach to engaging underrepresented staff groups with sustainability activities.
- Build awareness with carbon literacy training, starting at Execs. Consider realistic levels of training appropriate to roles. Include:
  - Informal lunch and learn - open to whole ICS
  - Bespoke training - Institute of Environmental Management training - for accredited qualification (e.g. finance, procurement).
  - Consider upskill leads / link role in each function
- Develop as an element of all apprenticeships for future

Staff engagement:

- Expand the UHBW - NBT Greener Together staff engagement to the wider ICS
- Consider how engagement and communications can connect in with One Care/Primary Care e.g. system level newsletter or through Primary Care Networks

Key ICS Pledges & Commitments

We will have clear leadership of our Green Plan delivery including:

- An executive lead in each organisation
- Establishment of an ICS Green Plan Steering Group
- Development and delivery of an ICS Green Plan strategy
- Establish a compelling vision and narrative to embed green agenda into BAU

We will equip our workforce with the skills and capabilities required to meet our ambitions

- Ambition to establish and energise a social movement
- Use of sustainability ambitions and record of delivery to position us as an employer of choice
- Appropriate training and awareness building at all levels
- Use all development opportunities to help people to feel, think and, therefore, behave differently. This includes ensuring all leadership development includes support and challenge for environmentally sustainable mindsets

Contribution to our headline metrics

Headline outcome	Metrics	Target
Improve our environment	Number of journeys to hospital for outpatient care	30% of all non-procedure outpatient attends delivered non-F2F from 22/23
Target carbon	Utilisation of our estate: carbon use per care episode	Reduce year on year
	% Of new or renewed contracts with suppliers who have a plan to take their operations to net zero by 2030	100% from 22/23 (except where no viable supplier available)
	Reduction of carbon associated with new models of care	TBD using Healthy Weston Phase 2 as test
Lead change with our citizens	Demonstrable positive impact on local business economy	TBD – e.g.; increase in % of contracts to local businesses
	Value of external reuse of durable goods by value (e.g. reuse of IT / office furniture)	Increase year on year

16. Food and nutrition

Headline ambition for our ICS

We will make a positive contribution to the environment and our local citizens through the food we provide.

Key actions for 22/23:

- Link with local authorities and other partners to consider a single Food and Drink Strategy including avoidance of food waste. Work already underway with the NHS Healthy Weight Declaration pilot
- Follow the Bristol One City Plan - going for gold process for sustainable food city. Generate a wider health and social change message of a sustainable, nutritional diet.
- Estates' director support to promote importance of nutritional and food, including the role in influencing wider staff and service user behaviours. Trusts supporting going for Gold
- Through joint procurement strategy increase the use local suppliers, Fairtrade, red tractor, MSC food items; encourage more plant-based meals; and increase patient education
- Review vending machines to ensure supplier compliant with CQUINS
- Implement approaches to measure and reduce food waste. Currently measuring patient food waste based on meals not used. Weight of waste is currently not being measured
- Implement plans to change the menu at least twice a year by 2025 to maximise the use of seasonal ingredients.
- Review and adapt menus to offer healthier lower carbon options for patients, staff and visitors.
- Achieving Rainforest Alliance Certification for coffee beans across footprint
- Setting up a weekly food/veg stall for staff and visitors
- Aim to achieve Food for life awards (Bronze and Silver)
- Promote staff engagement in healthy food & the environment e.g. through staff restaurant roof top herb garden and staff allotment – supplies food to staff kitchen.

Key ICS Pledges & Commitments

We will minimise the impact of our food use by:

- Buying Better: procuring local, seasonal, sustainable food wherever possible
- Reducing food waste
- Promoting urban growing and engagement with the natural environment
- Promoting sustainable and healthy food choices for staff and service users
- Supporting community action and food equality.

Contribution to our headline metrics

Headline outcome	Metrics	Target
Improve our environment	% Waste to landfill	Zero waste to landfill by 2025
	% Waste recycled	Increase year on year
	Total volume of single use plastic products	
Target carbon	Total carbon footprint of supply chain	Net zero by 2030 (trajectory TBD)
Lead change with our citizens	% Of service users who see ICS organisations as leading the way in sustainable provision of services	TBC
	Number of citizens who have reported an increased awareness & changed behaviour as a result of contact with an ICS	TBD

SUSTAINABLE FOOD cities

BRISTOL GOING FOR GOLD

17. Adaptation

Headline ambition for our ICS

We will identify our shared climate change risks as a system and implement an action plan to mitigate these risks and adapt our services, activities, and infrastructure to build resilience against climate change impacts.

Key ICS Pledges & Commitments

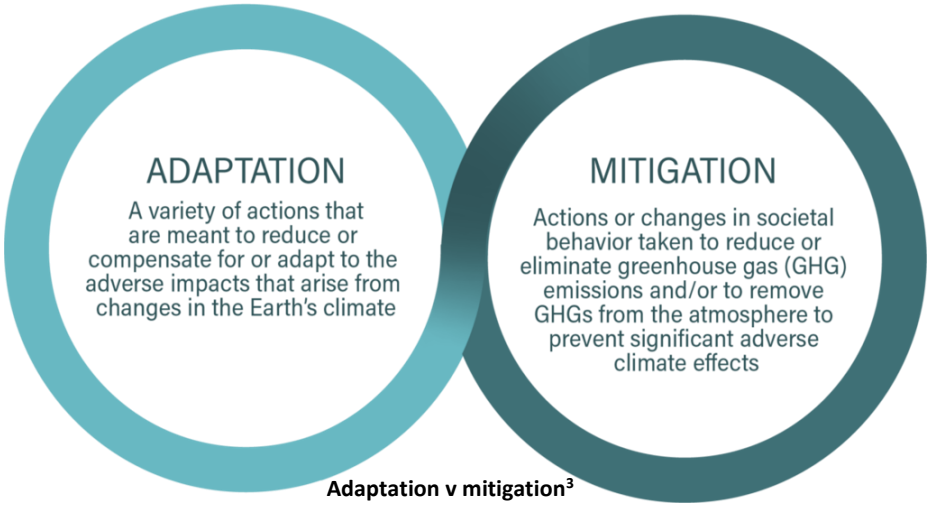
We will ensure all our organisations are prepared to deal with the effects of climate change, particularly extreme weather events, and continue to invest in adaptation and mitigation measures:

- Assess the shared risks and impacts of climate change for the system and adapt services, processes and infrastructure to mitigate the negative effects of past and future climate-altering actions.
- Reduce the impact on public health from climate change.
- Ensure our infrastructure, services, procurement, local communities, and colleagues are prepared for and resilient against the impacts of climate change.

Contribution to our headline metrics

These metrics are specific to the adaptation work and do not currently feature in our headline metrics. We will assess which of these to include within our green plan monitoring.

- Number of overheating incidents in a year (maximum daily temperature exceeds 26 degrees)
- Number of flooding occurrences.
- Business Continuity Plans that contain climate change risks, impacts and adaptation measures.
- Number of patient admissions for asthma / other respiratory diseases.
- Number of supply chain disruptions (items not available or shortages and delays in delivery).



Adaptation v mitigation[3]

Key actions for 22/23:

- Recommend identification of an adaptation lead for each partner and encourage implementation of the ICS adaptation plan
- Understand organisation baselines of how much work the EPRR team are doing around climate adaptation
- Identify key shared risks from the adaptation plan and agree as a system our approach to those risks - which ones we need to collaborate on
- Link the climate adaptation plan to the emergency planning committees and existing network of people through local authorities
- Ultimately, develop an ICS level change and adaptation plan. Consider whether this should be held entirely by the emergency planning groups.
- Forward planning by Estates and Facilities teams to ensure they know how to respond and when adverse weather events are expected to occur. Bristol One City & Partners – Adaptation Strategy.
- Green and blue space joint-funding opportunities with Bristol organisations to mitigate the Urban Heat Island effect and to remove increased volume of air pollutants.
- Working with BCC to utilise the Heat Vulnerability Index tool to identify vulnerable communities and areas.

Climate Change: Vulnerability, Risk, and Adaptation vs Mitigation, Climate Change: Vulnerability, Risk, and Adaptation vs Mitigation - EA (eaest.com)

18. Biodiversity

Headline ambition for our ICS

We will fulfil our duty to conserve and enhance biodiversity of our sites and across the region by working closely with our partners. We will promote and utilise our green and blue spaces to support the health and wellbeing of our staff, patients and local communities.

Key actions for 22/23:

- ICS partners to open up and promote their green spaces for use by other partners, particularly those with limited free space.
- Form a network of volunteers that work across ICS partner sites to provide support with conserving and enhancing biodiversity.
- Partner with Health & Wellbeing teams to utilise green spaces, staff allotments and green gyms to improve staff, patient and community health and wellbeing.
- All new building developments and relevant refurbishments will develop comprehensive plans to mitigate adverse impacts on biodiversity, conserve and enhance existing biodiversity, adopt biophilic design and include a robust grounds maintenance regime.
- Undertake ecological surveys across our sites; pollinator surveys, butterfly surveys, newt surveys, bird identification.
- Adopt and implement the guidance detailed in the Healthier Together Green Infrastructure Planning Guide, Green Pockets Planning Guide and Meadow Management Guide.
- We will phase out the use of pesticides across our sites and will participate in No Mow May each year.
- Each partner organisation will register with NHS Forest and will partner with external organisations and groups across the region to designate areas for tree planting.
- Estate masterplans will incorporate green corridors that align with city plans and link site with community parks and green spaces and will take into consideration wildlife highways that intersect site footprint.
- Apply for grants to undertake ICS-wide projects that will conserve and enhance biodiversity and support external organisations bids to develop land for the use of green social prescribing.

Key ICS Pledges & Commitments

We will improve the biodiversity across all of our sites and improve the health and wellbeing of our population by:

- Establishing our sites as an open and accessible network of green spaces and facilities that can be utilised by staff, patients, visitors and volunteers from all ICS partners.
- Prohibiting the use of harmful chemicals and methods in our ground's maintenance regimes.
- Conserve existing and establish new habitats for local wildlife.
- Promote the use of our green spaces and facilities to staff, patients and the community as areas to improve health and wellbeing and to educate on biodiversity conservation.
- Mandating all new developments and relevant refurbishments improve the biodiversity associated with the development area.
- Host green social prescribing programmes and nature wellness activities on our sites.

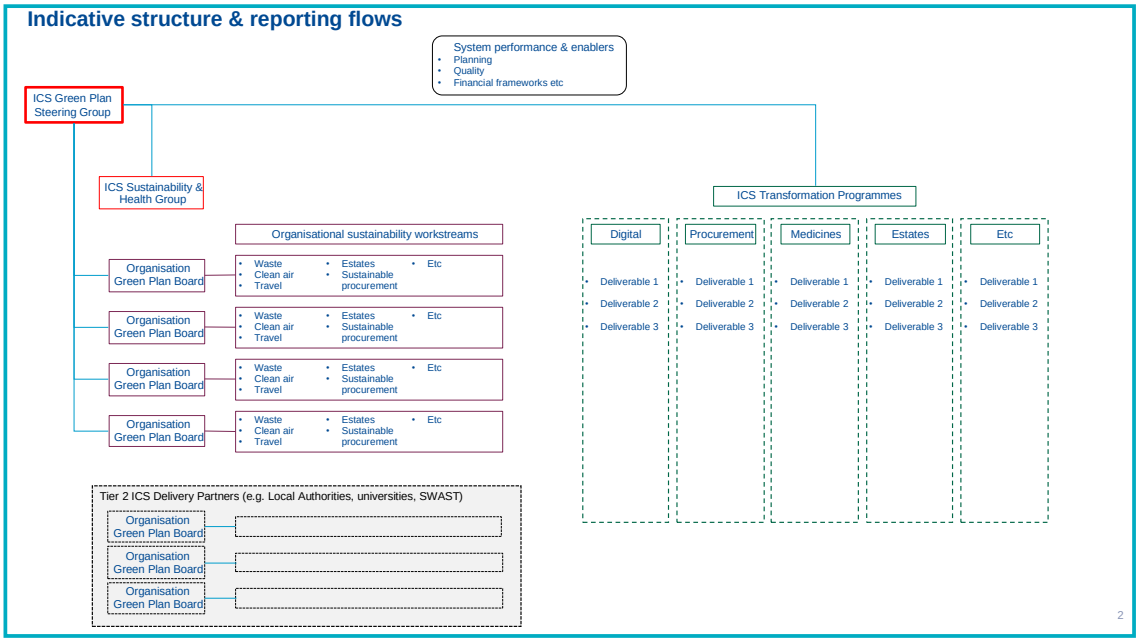
Contribution to our headline metrics

Headline outcome	Metrics	Target
Improve our environment	Area (m^2) of sites improved for biodiversity and health and wellbeing	Increase year on year
	New trees planted across our footprint by 2025	1000 trees planted by 2025
	Biodiversity values of our sites	Increase by 10% by 2025 for sites with green space
Target carbon	Use of Sustainable Design Guide for all new buildings / refurbs	100%
	Reduction in carbon achieved through green social prescribing	TBD
Lead change with our citizens	% of service changes that have a SIA demonstrating positive impact	100% by 2023/24
	Number of citizens who have reported an increased awareness & changed behaviour	TBD
	Number of citizen communication campaigns / number of citizens reached	TBD
	Number of citizens benefited from ICS projects	Increase year on year

19. Governance and delivery plan

Achievement of our ICS Green Plan will require a governance structure and supporting delivery infrastructure. Whilst much of the work of delivering change will be devolved to our core operations and strategic change programmes, the wide-ranging and large-scale nature of the ambition requires a formal governance structure. We are establishing an executive-led ICS Green Plan Steering Group that reports directly into our ICS Executive Board. This will be responsible for:

1. **Holding our shared ambition** - building on the success of our organisational level work, we will hold a singular clear ambition as an ICS that all partners align to
2. **Establish the enabling conditions for change** – putting the green agenda at the heart of our ICS – how we business plan, allocation of resources, development of frameworks and governance
3. **Coordinating collaborative projects across partner organisations**, including advising the Executive Board on priorities and trade-offs - At an ICS level we will put our collective resources and energy behind a small number of impactful changes
4. **Provide assurance of delivery of actions** devolved to other steering groups and organisations - Recognising that the green agenda is everyone's business we will build on the success of organisational plans, putting in place monitoring and support frameworks to maximise the impact across the system, target highest impact interventions, hold collective risks, and hold groups to account for delivery of key actions



Changes to key ICS processes and decision making

Meeting our sustainability objectives will require changes to almost all our prioritisation and decision making. Over the course of 22/23 our ICS Green Plan Steering Group will work to embed our sustainability ambitions within our core governance and decision-making processes.

Some of the key changes we anticipate are:

Capital prioritisation:

- Principle: ensure that any new capital allocations (estates, digital, major medical) are actively driving towards our environmental outcomes
- How: amend our prioritisation matrices and decision-making processes to reflect this. For example, the estates capital prioritisation is now considering our net zero ambition as a pass/fail criterion for business cases.

Revenue allocation:

- Principle: allocation of resources within the ICS should clearly evidence how it meets our 7 system goals, one of which is our environmental commitments set out in this plan
- How:
    - ICS Outcomes Framework, including our green plan outcomes, will increasingly be used to allocate resources across programme areas
    - Transformation & major change: transformation programmes need to demonstrate how they meet our ICS Outcomes; all programmes will need a sustainability impact assessment that demonstrates a positive impact on our environmental outcomes. We will use the development of Healthy Weston Phase 2 business case as a test case for how to incorporate sustainability into large scale change
    - Business planning: we will use annual business planning to drive our collective sustainability ambitions
    - ICS Value Improvement Framework: used to: allocate resources efficiently across our system so that we achieve the overall best possible outcomes; Identify and improve the outcomes and experience that matter to people; Commission and deliver effective services that avoiding overuse of low value interventions (unwanted or not cost-effective) and underuse of high value interventions (deemed cost-effective but not taken up by those who would benefit)

Service Change:

- Principle: we will use key service changes as an opportunity to meet our sustainability ambitions
- How:
    - Identify biggest wins: Our benchmark work will consider how to measure carbon ‘heavy’ opportunities. This will need to link with a system approach for measuring green credentials for Benchmarking analysis i.e., is there a ‘green version’ of model hospital
    - As part of good practice for transformation initiation and gateway controls, we will consider sustainability opportunities
    - Quality improvement: integration of a ‘Sustainability Impact Assessment’ into our Programme Methodology that works alongside current QIA/EIA formats.
    - Annual operational planning: We will embed our sustainability outcomes as one of our key success measures for departmental and organisational planning – e.g., targeting procurement product switches & associated carbon reductions

20. Finance and resourcing

There will need to be significant financial and staff resource investment to deliver against the ambitions of this plan. We also recognise that there will also be considerable financial and non-financial value from operating more sustainably.

At present, we do not have a detailed picture of the likely capital and revenue implications, nor of the source of funds to meet this; these will be developed over the course of 22/23. We will ensure that in assessing the financial implications of this plan we will account for the full financial & non-financial implications of both action and inaction.

Indications of the likely cost implications are:

- Capital investments to decarbonise estates
- Capital & revenue investments to adapt to the unavoidable impacts of climate change
- Potential additional non-pay costs associated with switching to low carbon products
- Pay costs associated with developing the expertise and resource to deliver our plans
- Off-set-set payments for any carbon it is not possible to remove from our operations

Indications of likely benefits from meeting our ambitions:

- Reduced whole life costs of procurement
- Reduced spend on waste
- Reduce heating and power costs through building efficiency
- Reduced healthcare delivery costs due to more efficient models of care
- Social value procurement generating local economic value, reducing inequalities and the associated health burdens
- Reduced mortality and morbidity associated with air pollution and associated costs
- Reduced mortality and morbidity associated with inactivity and associated costs
- Increased value from green capital

Sources of funds will include:

- National funds e.g., Public Sector Decarbonisation Fund
- System capital allocations
- Transformation funding
- Primary care improvement grants
- Procurement savings – savings for reinvestment, CIP savings, cost avoidance savings

How we will assess value

As an ICS we will need to make prioritisation decisions and trade-offs over the coming years, balancing our commitment to the goals of this plan against our responsibilities to deliver safe and effective care. We will seek to make decisions in a clear and transparent way. Our ICS Value Framework provides guidance on how we can frame decision making and allocation of resource.

We define value as:
Meeting the goals of Population Health (including improving the environment); improving physical and mental health outcomes, promoting wellbeing, and reducing health inequalities, for the whole population and not just those who present to services through a focus on achieving the outcomes that matter to people and making best use of our common resources (including our environmental resources).

The outcomes that are important to people (including environmental & social benefits)
The costs to deliver them (including any social & environmental costs)

We will develop additional tools to enable us to make the most effective decisions for our population. These include:

- A refreshed capital prioritisation matrix, aligned to our net-zero ambitions
- A procurement assessment approach aligned to our net-zero and social value ambitions
- A sustainability impact assessment that aligns to the whole system value of care models

Resource investment planned for 2022/23

The first year of our plan will set the foundations for delivery. There are already significant investments in progress within our partner organisations, as detailed in their Green Plan. Proposed additional investment at an ICS, subject to executive sign-off, includes:

Target	Expected benefit
8B Head of Service	Oversee establishment & delivery of programme
0.5 B6 project resource	Coordinate green plan projects across ICS transformation programmes
4 hours pw: primary care clinical lead - green medicines	Metered Dose Inhalers: Accelerate delivery of the project, provide key resources for practices, demonstrate reduction in line with national leaders Prescribing reduction: Support polypharmacy review programme / switch to social prescribing / recommend digital tools that could enable culture change [This one may need to be more targeted to ensure success in year]
4 hours pw: primary care clinical lead - green culture change	Baseline & share good practice: Identify existing good practice and rapidly adopt across BNSSG Establish leadership & comms: Build on existing infrastructure / informal networks to establish a primary care voice into the ICS Green Plan Medium term action plan: Develop an action plan for primary care up to 2030 setting out those actions we can deliver locally, those that will require national pressure (e.g. NHSPS), those that will require additional funding etc. Develop business case for future year funding and plan
B7 Project manager	Deliver system-wide fleet transport strategy and delivery plan
Procure commercial partner to measure carbon impact of supply chain	Ability to baseline existing carbon impact of supply chain Identify and target highest impact product lines Create market visibility and pressure on suppliers
Procure staff engagement platform	Staff engagement - Jump scheme / training / engagement / who would we target. Would need to demonstrate impact and momentum (£20k per org per year for 3-years)
Project accelerator	Ideas generation priming competition - to kick start projects (especially directed to Sirona and primary care)

21. Risks

Risk	Mitigations
Engagement – risk that the plan will fail to become adopted and embedded across the breadth of our activities due to the pace of the development of the plan and lack of wider engagement	• Delivery of communications & engagement strategy • Senior approval by ICS Executive and Partnership Board • Role of ICS Steering Group to oversee alignment
Financial – Risk that we are unable to meet the outcomes of the plan due to financial constraints in terms of capital investment and revenue implications	• Access to national funding such as Public Sector Decarbonisation Funds • Early strategic planning at a system level to understand total financial need & prioritisation of resources to highest impact areas • Recognise the financial savings that are possible through operating more sustainably • Accounting for the contribution to non-financial outcomes (e.g. population health) that can be achieved by operating sustainably
Reputational – Risk that our reputation is impacted if we are unable to meet the outcomes set out in this plan	• Green Plan Steering Group to maintain close focus on key deliverables • Maintain an honest dialogue with staff & citizens about what is achievable and any barriers to delivery that are outside of our control (e.g. supply chain, decarbonisation of national grid)
Elements of delivery beyond our control – Risk that we are unable to deliver against significant elements of the plan due to elements of the plan that are outside of our direct control (e.g. supply chain, national grid decarbonisation)	• Early and robust engagement with supply chains • Use collective pressure through regional and national bodies
Competing priorities – risk that the pressures of the covid-19 pandemic, elective recovery, and establishment of new models of care impact on delivery and relative priority of this plan	• Ensure that the sustainability outcomes are central to our ICS strategic aims • Continue to recognise that operating sustainably is a key part of the solutions to our biggest challenges, not an afterthought • Role of executive leaders to maintain the priority of this programme.

22. Communications & engagement

One of our 3 priority outcomes is to:

Generate a BNSSG-wide movement: Our sustainability behaviours, actions and innovations as anchor institutions will support a cultural change amongst local citizens and businesses resulting in wider improvements in air quality, biodiversity, and the quality of the natural environment

What we already know

Because of the pace at which we have developed this initial plan, and the context of the Covid-19 pandemic, we have done relatively little engagement with either staff or citizens whilst developing this plan. However, there are some things we already know from our existing engagement work:

1. **Staff want us to improve the environment and for us to have a wider positive impact on the community.** This is exemplified in many of our key partners having publicly declaring a climate emergency, as well as in placing our role as anchor institutions central to our organisational strategies
2. **Many of our citizens see improvement of the environment as a top priority.**

How we will engage with this plan:

Over the course of 22/23 we will use this initial plan as a foundation to develop further insights, ensuring that our ambitions are aligned to those of our staff and citizens. Key actions will include:

Staff engagement:

- Engagement with key operational and leadership groups
- Focus groups and roadshows with staff groups
- Festival of engagement –presented in different areas of our organisations to gather comment, questions and ideas.

Citizen engagement

- We will develop a joined-up engagement strategy across all our partners to share our collective ambitions and hear our citizens' priorities and requirements.

How we will use our position as anchor institutions

We will use this plan, and the actions that we undertake as a result, as an opportunity to create the widest possible engagement with the climate and ecological emergency. We aim to generate a culture change across our citizens, leading to further environmental benefits. Key actions will include:

1. Promoting the work we are doing to establish BNSSG as a leading sustainability region
2. Creating opportunities for citizen awareness raising – e.g. with information in hospital atriums, GP surgeries, patient letters
3. Promoting lifestyle changes that benefit both personal and planetary health – e.g. increased use of green spaces, active travel
4. Supporting our citizens to access financial and other support towards more environmentally friendly actions – e.g. warm homes grants, vehicle grants for those living in the emissions zones
5. Providing locally sourced, low-carbon nutrition in our facilities and using this as an opportunity to provide education and information for citizen lifestyle change
6. Working with academic partners to understand how we can most effectively influence behaviour change through our interactions

23. How we are working with key partners

1. Primary Care
2. Academic Partners
3. Local Authorities & public health
4. Other Health and Care Partners

24. Primary Care

Primary Care faces several unique challenges in moving towards sustainable service provision. In the development of this plan there has been relatively low levels of engagement across the breadth of primary care due to the pressures of the pandemic and vaccination programme.

We have however, been able to get primary care agreement to the headline ambitions, to identify some of the key local priorities for primary care, and to set out our plans to make progress in 22/23.

Key challenges for primary care:

- Ageing estate for which there are multiple ownership models. Landlords often not willing or able to engage with sustainability agenda – both in terms of building improvements and allocation of cycle spaces / waste recycling systems
- Funding, contracting & leadership arrangements do not currently promote sustainability agenda

Key opportunities:

- Key institutions in local community with real opportunity to influence citizen behaviours
- Biggest contributor to medicines & chemicals carbon footprint
- Lots of pockets of good practice that can be accelerated through a systems approach

Work already underway:

- Green Impact for Health Toolkit:
- Greener Practice Bristol & Bath Group: produced an online advice page and worked with BNSSG respiratory team to try and improve the carbon footprint of inhaler prescribing across BNSSG.
- Medicines: Successes with reducing overprescribing and medicines waste to make patient care better and safer, support the NHS, and reduce carbon emissions
- Medicines: Successes with making respiratory prescribing recommendations more environmentally friendly
- Medicines: Successes with environmental considerations within treatment pathways
- Reducing testing: Chronic disease order sets, linking with national GIRFT team
- Public health:
- Estates: some progress, but will largely depend on regional & national pressure on landlords
- Reusable kit for IUT and minor opps
- Education & engagement:

- Travel & transport: Travel West funding for cycle storage
- Patient voice:
- Research & partnering with NIHR to find what works in primary care
- Social prescribing

How we will make progress in 22/23

While primary care will contribute to the actions set out across our thematic chapters, there are a number of areas where we will target our efforts:

- Fund GP leads for green prescribing and primary care engagement in the green plan
- Prioritise highest impact actions to generate momentum: for example, reducing overprescribing, medicines waste and metered dose inhalers
- Utilise Investment and Impact Fund in helping to make the NHS more sustainable
- Grow the Greener Practice Group to establish a fully represented primary care sustainability network, linked into our ICS Green Plan Steering Group
- Hold key challenges, such as estates and contractual models, at a system level & engage with NHSE/I for regional or national solutions
- GPC England to negotiate with NHSEI to provide sustainability funding to ensure all NHS GP surgeries are net carbon neutral by 2030

25. Academic Partners

BNSSG has the benefit of leading academic institutions within our geography, including West AHSN, Bristol Health Partners, University of Bristol and University of the West of England. These partners will support in the delivery of our sustainability ambitions in several ways:

i. Assessment of plans – any unintended adverse consequences
ii. Linking inequalities, outcomes and health planning
iii. Service user behaviour change at key life events
iv. NIHR – will do a call around Local Authority health priorities

Support the development & rigour of our plan

We have leaders in climate change and health, including the Cabot Inst for Environment which brings together 600 academics focusing on an inter-disciplinary approach to the environment. These experts can be drawn upon to:

- Assess the ambitions and deliverability of our plans
- Help identify and understand any unintended adverse consequences (e.g., indoor air quality for making buildings super-efficient)
- Looking at mitigation and adaptation as a whole - the things that give mutual wins and minimise harm. Partnering with public health will be important for this
- Thinking as a region how we become net zero - e.g. green space 'offsets'
- Target actions that will help address inequalities by considering who will benefit from interventions such as better air quality. Draw on experts from our academic partners working on climate justice.
- Understand how academic work can inform our priorities - such as cognitive psychology research about behaviour change, climate change and awareness.

26. Local Authorities:

Our local authority partners also have bold sustainability ambitions. This first iteration of our ICS Green Plan has had only relatively high-level engagement with our local authority partners. Through the period of engagement in 22/23 we will further align our actions. The early areas for collaboration include:

i. Procurement and creating a city-region green innovation driver
ii. Community heat and power – city leap
iii. Citizen engagement and messaging
iv. Proactive climate adaptation planning

27. Other Health and Care Partners:

We will increasingly need to work with wider health and care partners to align delivery of our ambitions. These include:

- Southwest Ambulance Service
- Private and independent sector treatment providers
- Care providers
- Community and voluntary organisations

28. Wider Partners

We have a collective responsibility as anchor institutions to work together drive the solutions to the climate & ecological emergency. There are some key elements where we will need to work together

Key: ✓ **– immediate involvement** ✓ **– expected adoption within 2-years** ✓ **– possible future involvement**

	Acute & MH providers	Community	Primary care	Local Authorities	Academic institutions	**What may this look like**
Patient, staff & public engagement	✓	✓	✓	✓	✓	▪ Joined up public messaging between health & LAs (e.g., signposting to energy advice), building on existing successes such as Warm Home Advice for people leaving hospital. ▪ Building on the Bristol One City approach to broad communications with the public / stakeholders, recognising the role of GP practices as hubs of community ▪ Commissioning academic institutions to advise on behaviour change & nudge theory; how key life events, such as having a baby, can be hooks for environmental and health behaviour change. ▪ Internal literacy training - opportunity for developing joint toolkits
Estate strategies	✓	✓	✓	✓	✓	▪ Strategic review of estate decarbonisation potential cross health & LA, which can link to the green capital, community assets and accommodation strategies ▪ Phased disposal of estate that is not viable for net zero ▪ Joined up adaptation plans (e.g. cooling centres), and extend the Bristol mapping projects to wider region. ▪ Challenge estate requirement through new ways of working across entire footprint (shared back office, mobile working, hot desking) ▪ Draw on expertise in UWE & UoB climate action plans and the Bristol advisory group on climate change.
Energy strategy	✓	✓	✓	✓	✓	▪ Review of non-gas energy options across public institutions at regional scale (e.g., strategic heat networks, wind turbines). ▪ City Leap at Bristol city scale. Could include electric vehicles and rooftop renewables. Possibility to extend beyond Bristol. ▪ Connecting to the heat network may be simplest solution for GP practices / health centres following improvement of the building fabric ▪ Consider novel contract forms for energy ▪ Smart technology across shared grids to distribute load across 24/7 variations.
Clinical waste	✓	✓	✓			▪ System-wide strategy for clinical waste. ▪ Resource Futures for the circular economy ▪ SevernNet – Industrial business network to support circular economy
Supply chain &	✓	✓	✓	✓	✓	▪ Implement and embed new procurement strategy in UHBW, NBT, Sirona & AWP. ▪ Align to local authority sustainable procurement strategy– be good to share. Opportunity for joint messaging to market, promoting a

	Acute & MH providers	Community	Primary care	Local Authorities	Academic institutions	What may this look like
procurement						circular economy, aligning to economic policy (WECA). ▪ Provide a clear drive to business that the collective purchasing power of our top local institutions will be directed to social and environmental value. ▪ Targeted projects on single use plastics
Travel & Transport	✓	✓	✓	✓		▪ Commission system-wide review of fleet vehicles. Drawing on experience from local authorities (e.g., waste vehicle depots for North Somerset and gritting lorries converted to use recycled veg oil leading to a 90% drop in carbon emissions. Bristol Waste vehicles are electric & hydrogen, and bus policy moving towards electric ▪ System review of key policies (active travel, lease vehicles, expenses) - draw on best practice nationally to drive change & identify priorities for intervention ▪ System visibility of key metrics - e.g. active travel, staff miles, patient journey types. Joined up messaging and infrastructure investment in active travel (e.g. North Somerset bike lease to WGH staff during pandemic). ▪ Joined up transport needs assessments. BCC are producing an active travel strategy including pilots. Also Travel West, Sustrans. All to link to the positive health impacts ▪ Action for air pollution to be identified. Anti-idling campaigns. ▪ Ambulance conveyance and associated travel, plus patient transport
Adaptation	✓	✓	✓			▪ Stress-testing plans across H&SC providers and consider collateral impacts (e.g. inability to discharge patients into housing stock that cannot cope with extreme heat). Heatmapping project
Natural Capital Assessments	✓	✓	✓	✓		▪ Ensure that all estates are assessed for natural capital value (e.g. as heat sequestration, ecological anchors, contributors to mental health & wellbeing). NS Green Infrastructure Policy – doing a lot of tree planting and rewilding. Link up land etc ▪ Consider broader factors in decision making (e.g. Cornwall's decision making wheel[4]) ▪ BCC ecological strategy – pollution, pesticides, green spaces, procurement. Currently very little carbon sequestration in the city
Public health interventions	✓	✓	✓	✓		▪ Prioritising those activities that have greatest mutual benefit (e.g. addressing vulnerable housing stock that may result in higher frailty / respiratory morbidity). Most social housing in Bristol is still council owned ▪ Need to develop a strategy with private landlords, retirement and care homes, which may require joined up working. ▪ Consider training NHS staff in post-discharge assessment of safe/warm homes. ▪ Scope to drive other public health interventions including – approaches to urban planning, green/blue infrastructure, and obesity/physical activity

[4] Cornwall Council: decision-making wheel (local.gov.uk)

29. Impact of COVID-19

The past two years have been unlike any others. The continuing impacts and pressures of COVID-19 have remained, whilst major strides have been made nationally to develop the sustainability ambition for the NHS. As we've reconfigured health and care services to meet the needs of our communities over the course of the pandemic, we've experienced both sustainability opportunities and challenges.

The COVID-19 pandemic has exposed and exacerbated health inequalities, with disproportionate effects on disadvantaged communities. The effects of climate change will similarly affect and disrupt our communities if action is not taken to reduce our carbon emissions and adapt to an already changing climate.

Demands on both frontline and support services staff have been extraordinary. We have worked flexibly, collaboratively and at pace, all of which will be needed for a modern, sustainable healthcare service; however, the ability of staff to consider and reduce the environmental impact of the services they deliver has been affected.

COVID-19 has shown that important changes can be made quickly in a crisis. Climate change is a crisis which needs to be addressed as a priority and with as much speed as the response to the pandemic. In developing this plan, we have tried to learn from and embed those changes that we want to continue. We also need to mitigate to continue the work to reduce the adverse impacts of changes.

Key negative impacts on our sustainability

- Slowed down some aspects of our sustainability project work
- Additional waste and single use products for PPE
- Recycling schemes, such as PVC mask recycling with Recomed and theatre plastics with Scrapstore, have been temporarily put on hold.
- Reduced our overall efficiency per care episode due to reduced activity levels
- Increased use of private transport
- Externalising our carbon emissions due to working from home – in autumn and winter, emissions from people's homes are likely to be higher than if people were at work.

Key positive impacts on our sustainability

- Massive acceleration of non-face-to-face appointments resulting in less patient travel
- New ways of working, such as home working and virtual meetings have significantly reduced staff travel and made some aspects of work more efficient and more enjoyable for staff
- Decreased gas and electricity consumption across some of our estates
- Reduction in some waste streams (infectious, contaminated) due to reduced theatre activity from COVID disruption
- Improved local air quality in some locations due to annual reduction in NO2, which is likely linked to reduced travel during the pandemic

30. Glossary

Anchor institution: Refers to large, typically non-profit, public-sector organisations whose long-term sustainability is tied to the wellbeing of the populations they serve. Anchors get their name because they are unlikely to relocate, given their connection to the local population, and have a significant influence on the health and wellbeing of communities.

Circular economy: Circular economy is an economic system aimed at eliminating waste and the continual use of resources while identifying opportunities for enhancing social value (e.g. skills and training, employment opportunities for disadvantaged groups and others).

Climate Emergency: A situation in which urgent action is required to reduce or halt climate change and avoid potentially irreversible environmental damage resulting from it

Ecological Emergency: A recognition that nature is declining globally at rates unprecedented in human history - and the rate of species extinctions is accelerating, with grave impacts on people around the world now likely.

Healthier Together Integrated Care System: A statutory partnership of health & care organisations formed to realise our shared ambitions to improve the health and wellbeing of the people of Bristol, North Somerset, and South Gloucestershire.

Net-zero carbon: A person, company or country is carbon neutral if they balance the carbon dioxide they release into the atmosphere through their everyday activities with the amount they absorb or remove from the atmosphere. This is also called net zero carbon emissions or net zero carbon, because overall no carbon dioxide is added to the atmosphere. There are two main ways to achieve net zero: reducing emissions and removing carbon dioxide from the atmosphere, through technologies that actively take in carbon dioxide or by enhancing natural removal methods - by planting trees, for example. These methods can be used in combination.

Value based health and care: Meeting the goals of Population Health; improving physical and mental health outcomes, promoting wellbeing, and reducing health inequalities, for the whole population and not just those who present to services. Delivered through a focus on achieving the outcomes that matter to people and making best use of our common resources.

31. Approval and sign off process

Core plan development team:

- Tricia Down, Associate Director Strategic Estate Development and Sustainable Health, NBT
- Megan Murphey, Environmental Management Systems Co-ordinator, NBT
- Sam Willits, Head of Sustainability, UHBW
- Luke Champion, Energy and Sustainability Manager, AWP
- Kelly Scott, Energy & Sustainability Lead, Sirona Care and Health
- James Dunn, Programme Manager, BNSSG CCG

Executive support:

The following are executive leads for sustainability in their respective organisations. They have endorsed the overarching aims and proposed delivery approach.

- Glyn Howells, SRO and Chief Financial Officer, NBT
- Paula Clarke, Executive Director Strategy & Transformation, UHBW
- Simon Truelove, Chief Financial Officer, AWP
- Clive Bassett, Sirona Care and Health

Approval:

Formal approval: Healthier Together Executive Group 24/03/2022

Appendices

Appendix 1: Case studies

CASE STUDY

GSP – Nordic Walking

Green Care Models

Problem

Low levels of connection with nature amongst populations experiencing inequalities in mental health outcomes.

Solution Overview

Grants to increase the range of nature and health interventions targeting health inequality populations alongside strengthened referral pathways both from the health system but also the community

Contact: Steve Spiers
Green Social Prescribing Manager
BNSSG CCG
steve.spiers@nhs.net
07825 647 783

Project Background

The BNSSG Green Social Prescribing Programme Learning (now rebranding as Healthier with Nature has funded a range of projects across BNSSG that both help people connect with nature to improve their health but also work to protect the natural environment.

One of these programmes is a series of Nordic Walking courses taking place in Inner City East Bristol. Nordic Walking is an established intervention that delivers both improved mental and physical health. It builds physical fitness, improves posture and develops supportive peer relationships.

Nordic Walking and the related health benefits have tended to be largely enjoyed by populations who have better health outcomes. The funded project looked to address this by introducing sessions in Easton, Bristol in partnership with two GP surgeries. Sessions are run in partnership between a walking organisation, a local community development worker and two local GP surgeries.

Taster sessions raised awareness and helped recruit walk leaders from the local community and then link workers and GP refer people to a series of 6-week courses.

Process for Improvements

We had clear outcomes in mind.

1. More connection with nature from priority populations (to improve their health outcomes)
2. To embed nature and health interventions in the health system

We then secured some resource for NHS England and other sources to achieve this broad aim but then trusted a range of stakeholders to find the best ways to deliver on the two aims outlined above.

After an engagement process and round of community grants that followed, we are now funding over 40 projects across BNSSG which if they meet their targets will improve the mental health of around 4000 people. Many of these projects also protect and natural environment.

Outcomes

The Nordic Walking Project we are highlighting in this case study will support around 100 people in the Easton area of Bristol to reduce self-reported anxiety and improve self-reported happiness. However, we are also working with partners to measure impact on waiting lists, number of health appointments and possibly prescription of medication.

These outcomes are reported collectively for all the projects and will provide a strong overall data set. This is backed up by individual case studies.

Project Top Tips

Trust communities to find and then deliver their own solutions

Identify and support green champions within both the community and statutory bodies

Create spaces where stakeholders can come together and create partnerships and joint working

Work with existing structures such as PCNs, ICPs, Local authorities or VCSE anchor organisation that already hold local relationships

Celebrate and share good news case studies it keeps partners engaged.

CASE STUDY

Chiller Optimisation

Energy Efficiency

Problem

900kW chiller using large amounts of energy, with no strong correlation with external temperature. Chiller and chiller pumps also suffering from early failures and large maintenance costs.

Solution Overview

Review of BMS control strategy resulted in several initiatives to reduce the time the chiller and associated pumps were running saving energy, cost, carbon and increasing the expected life of the equipment.

Contact: Matt Gitsham
Carbon and Energy Manager
North Bristol NHS Trust
Matthew.Gitsham@nbt.nhs.uk
07825 647 783

Project Background

The Learning and Resource Building's chiller was installed in 2010 when the building was built. The chiller is a 900kW Carrier unit supplying a primary circuit at 6°C with a nominal return of 12°C.

The chiller should have been operating 7am-7pm and should not switch on until the ambient temperature exceeded 10°C. We demonstrated that in fact the chiller was running 24/7 with no regard for the ambient temperature.

We also demonstrated that the two sets of secondary pumps were not being switched off when the systems they served did not require chilled water, particularly the pumps serving the AHUs. These pumps were running 8,760 hours per year, despite analysis showing they were only likely to be required 2,000 hours per year.

Further, we noted that the pumps were all running far too fast leading to a vastly reduced difference between the flow and return temperatures, damaging chiller efficiency and wasting pump energy.

Process for Improvements

Working alongside NBT's BMS contractor, our Carbon and Energy Manager assessed the various issues affecting the chiller and using metered energy data put forward a business case for making improvements.

The BMS contractor was able to determine the timeclock and external ambient interlock issues were due to mistakes in the code and they resolved them quickly. They also added new code that switched off the secondary pumps when there was no requirement for them to run.

Changes to pump speed were achieved by adjusting the BMS controls already in place. Future work will involve optimising the temperature set point of the chiller, raising it when the cooling load is low.

Outcomes

Energy metering data demonstrates the electricity cost associated with the chiller and chiller pumps has more than halved since these changes were implemented. In the first year this has saved the trust over £35,000 on an initial outlay of £400 and nearly 70,000kg of CO2. We also expect to have significantly decreased the wear and tear on the chiller and pumps, reducing their annual maintenance costs and increasing their overall life.

Project Top Tips

Confirm the timeclock settings match the requirement of the building.

Confirm the timeclock is working correctly by checking logs of water temperature.

Confirm the ambient interlock is working correctly by comparing the outside temperature to water temperature logs.

Confirm pumps switch off when the equipment they serve (such as AHUs) do not require cooling (or heating).

Assess whether pump speeds are correct by comparing flow and return temperature if they are very similar consider reducing pump speed.

[i] Natural England: An estimate of the economic and health value and cost effectiveness of the expanded WHI scheme 2009
[ii] BNSSG 5-Year Plan
[iii] Dutch Cycling: Quantifying the Health and Related Economic Benefits (nih.gov)
[iv] NICE Guidance NG6: Excess winter deaths and illness and the health risks associated with cold homes
[v] BNSSG 5-Year Plan
[vi] 2017/18; PHOF, PHE NCMP and Child Obesity Profile
[vii] BNSSG 5-Year Plan
[viii] Healthier Together Citizen Panel Survey, conducted 2020
[ix] BNSSG 5-Year Plan

Equality Impact Assessment

How to use this form

Section 1 - State which policy, practice, criteria or strategy is being assessed.

Section 2 - Give details of who is completing the assessment.

Section 3 - Set out the relevance of the EIA.

Section 4 - Set out evidence to show what the impact is likely to be. Consider whether the policy actually or potentially hinders equality of opportunity.

This needs to be objective. Value judgements will not do!

Evidence needs to be disaggregated to show how it may affect each protected characteristic.

What to include in the form

- Statistics
- Anecdotal information
- Staff/Patient Attitude and other Surveys
- Family and Friends Test
- Results of consultations/engagements with patients/staff
- Analysis of your results
- Consult on outcomes
- Future Actions

Section 5 - Add a date for revisit the assessment to check on the impact.

For further information see the Equality webpage under the HR portal.

Statistics - NBT Annual Equality Statistics Report - this also gives some census data.

This report can be found on the Equality web page under the HR portal at this link:

http://nbsvr16/sites/askhr/EqualityandDiversity/Pages/AnnualEqualityStaffStatisticsReports.aspx

For specific divisional data contact Informatics:

Email: InformationManagement@nbt.nhs.uk

There may be other figures available within the Trust or elsewhere that you can use for example in the Annual Trust Reports these are available on the NBT website:

https://www.nbt.nhs.uk/about-us/our-purpose-activities/annual-report-accounts-financial-statements

NBT Annual Equality Report

http://nbsvr16/sites/askhr/EqualityandDiversity/Pages/AnnualEqualityReports.aspx

In completing this assessment you should keep the Equality Duty set out in the Equality Act 2010 in mind. The Duty has three aims. It requires public bodies to have **due regard** to the need to:

- **eliminate unlawful discrimination**, harassment, victimisation and any other conduct prohibited by the Act;
- **advance equality of opportunity** between people who share a protected characteristic and people who do not share it; and
- **foster good relations** between people who share a protected characteristic and people who do not share it.

This Equality Impact Assessment is based on the following principles, drawn from case law and provides the essential information to enable us to fulfil our Equality Duty. Public bodies are expected to ensure:

Knowledge - those who exercise the public body's functions need to be aware of the requirements of the Equality Duty. Compliance with the Equality Duty involves a conscious approach and state of mind.

Timeliness - the Equality Duty must be complied with before and at the time that a particular policy is under consideration or decision is taken - that is, in the development of policy options, and in making a final decision. A public body cannot satisfy the Equality Duty by justifying a decision after it has been taken.

Real consideration - consideration of the three aims of the Equality Duty must form an integral part of the decision-making process.

The Equality Duty is not a matter of box ticking; it must be exercised in substance, with rigour and an open mind in such a way that it influences the final decision.

Sufficient information and evidence - the decision maker must consider what information they have and what further information may be needed in order to give proper consideration to the Equality Duty. Evidence might be gathered from Demographic (including Census) data, research findings, recent consultations and surveys, results of: ethnic monitoring data; and any equalities data from the local authority / joint services; or health inequality data, anecdotal information from groups and agencies within BNSSG, comparisons between similar functions / policies elsewhere, analysis of complaints and public enquires information, analysis of audit reports and reviews.

No delegation - public bodies are responsible for ensuring that any third parties which exercise functions on their behalf are capable of complying with the Equality Duty, are required to comply with it, and that they do so in practice. It is a duty that cannot be delegated.

Review - public bodies must have regard to the aims of the Equality Duty not only when a policy is developed and decided upon, but also when it is implemented and reviewed. The Equality Duty is a continuing duty.

Completing this assessment will help us demonstrate compliance with the Equality Duty

See the tool kit for how to complete the form: Equality Impact Assessment Process – Flow Chart

For more information contact e mail: Inclusion@nbt.nhs.uk

1. **Name of service / policy / strategy**

Healthier Together ICS Green Plan

2. **Details of lead person completing this screening:**

Name	Megan Murphy
Title	Interim Sustainable Development Manager
Dept/Service	Sustainable Development Unit / Strategic Estate Development and Sustainable Health / Estates, Facilities and Capital Planning
Telephone	07804608847
E-mail	Megan.murphy@nbt.nhs.uk

3. Please give a brief description of the service/policy/strategy and its aims/objectives and who it is likely to have an impact on:

Service/Policy: The Healthier Together ICS Green Plan is an initial draft of the ICS's sustainability strategy which outlines the ICS's sustainability ambitions and devises a plan to deliver three key outcomes for the BNSSG population. The Plan outlines key commitments and pledges across many cross-cutting themes which will impact the current processes and systems used by the majority of staff within the Trust and will require a new way of working.	
None:	**All staff members from all directorates and divisions must engage with the governing, delivery and reporting of the Healthier Together ICS Green Plan in order for the Trust to achieve the key outcomes.** **Behaviour change programmes/campaigns: all staff.** **Changes to decision-making and prioritisation processes: all staff.** **New ways of working and service delivery changes: all staff.**

1. **Assessment of the effects of the service/policy/strategy on the protected characteristics (equality groups)**

   Assess whether the Service/Policy has a positive, negative or neutral impact on the Protected Characteristics.

   - **Positive impact** means promoting equal opportunities or improving relations within equality groups
   - **Negative impact** means that an equality group(s) could be disadvantaged or discriminated against

   Please answer '**Yes**' or '**No**' for each protected characteristic and if yes, provide evidence for the action and the potential impact:

You must show that the actions are necessary, person responsible for seeing them through and the date by which they should be achieved and how you will tell stakeholders what has been accomplished.

Potential areas for action might be:

Data collection and evidence, involvement and consultation, measures to improve access or take-up of service, monitoring, evaluation and review, communicating the results, etc.

Protected Characteristic	Affected ? Yes/No	Please show evidence and state potential impact.	Future Actions	Timeframe/ target date	Evidence and success measures	Lead
Age (The Act covers people over 18)	Yes	Positive – upskilling workforce. Negative –some key actions, particularly related to active travel, may not be suitable for elderly people. Risk of staff feeling excluded from action plans.	Ensure ample training is provided to make new systems and processes accessible and easy for all groups to adopt. Ensure representation on Steering Groups and workstreams to ensure all actions and inclusive. Work closely with comms teams and EDI from each ICS organisation to ensure language in communications and engagement campaigns and initiatives is inclusive and provide alternative ways to contribute. Include metrics on equality and diversity in headline metrics for	2022-2030. Review progress every 6 months and as and when feedback is collated.	Membership of governance and delivery groups. Engagement activity feedback forms. Minutes from progress review meetings and reports. EIA action plan progress.	MM

Protected Characteristic	Affected ? Yes/No	Please show evidence and state potential impact.	Future Actions	Timeframe/ target date	Evidence and success measures	Lead
			comms and engagement.			
Race	No					
Sex (Female or Male)	No					
Disability Physical Impairment; Sensory Impairment; Mental Health; Learning Difficulty; Long-Term Condition	Yes	Positive – upskilling workforce. Negative – some recommendations may not be suitable for people with certain disabilities e.g., active travel. Risk of excluding staff from action plans.	Ensure ample training is provided to make new systems and processes accessible and easy for all groups to adopt. Ensure representation on Steering Groups and workstreams to ensure all actions and inclusive. Work closely with comms teams and EDI from each ICS organisation to ensure language in communications and engagement	2022-2030. Review every 6 months and as and when feedback is collated.	Membership of governance and delivery groups. Engagement activity feedback forms. Minutes from progress review meetings and reports. EIA action plan progress.	MM

Protected Characteristic	Affected ? Yes/No	Please show evidence and state potential impact.	Future Actions	Timeframe/ target date	Evidence and success measures	Lead
			campaigns and initiatives is inclusive and provide alternative ways to contribute. Include metrics on equality and diversity in headline metrics for comms and engagement.			

Sexual Orientation (Lesbian, Gay, Bisexual, Heterosexual)	No					
Gender Identity (Trans people)	No					
Religion/Belief or non-belief	No					
Pregnancy & Maternity	No					
Marriage & Civil Partnership	No					

- **Positive impact** means promoting equal opportunities or improving relations within equality groups
- **Negative impact** means that an equality group(s) could be disadvantaged or discriminated against

2. **Please explain how the results of this impact assessment will influence your service/policy/strategy:**

Action plan? **See the Tool Kit: Equality Impact Assessment Action Plan template for suggestions on what to include here** **Progress reports and reviews will include an Equality Impact Assessment. The language used in communications and engagement resources will be inclusive to all protected characteristics. The membership of key steering, governance and delivery groups must include a member of staff from the Equality and Diversity Committee and have representation spanning all of the key protected characteristics.**

3. **Review date:** **06/01/2022**

Please forward an electronic copy of this assessment to the Equalities and Diversity Manager Lesley.Mansell@nbt.nhs.uk

The completed form will be put to the Equality and Diversity Committee and once agreed returned for you to publish.

Help

- Do you need help with gathering equality information?
- Do you need more advice?
- Do you need more information?

Contact: **Lesley Mansell**

Equality and Diversity Manager
Email: Lesley.Mansell@nbt.nhs.uk Tel: 0117 414 5578 September 2018 Updated January 2022

Report To:	Trust Board - Public		
Date of Meeting:	28 July 2022		
Report Title:	Finance & Performance Committee Upward Report		
Report Author & Job Title	Xavier Bell, Director of Corporate Governance & Trust Secretary		
Executive/Non-executive Sponsor (presenting)	Tim Gregory, Non-Executive Director		
Does the paper contain:	**Patient identifiable information?**	**Staff identifiable information?**	**Commercially sensitive information?**
*If any boxes above ticked, paper may need to be received at *private* meeting			
Purpose:	**Approval**	**Discussion**	**To Receive for Information**
			X
Recommendation:	The Committee recommends that Trust Board: • Receive the report for assurance and note its content. • Approve the transition of the PFI from the LIBOR interest rate to the SONIA interest rate		
Report History:	The report is a standing item to each Trust Board meeting following a Finance and Performance Committee. The last report was received at the June 2022 private Board meeting.		
Next Steps:	The next report to Trust Board will be to the September 2022 meeting.		

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 21 July 2022 F&PC.	
Strategic Theme/Corporate Objective Links	**Provider of high-quality patient care** **Developing Healthcare for the future**
Board Assurance Framework/Trust Risk Register Links	Reports received at the meeting support the mitigation of various BAF risks, particularly those relating to patient flow, access to elective care and IMT/Cyber security risks.
Other Standards Reference	Links to key lines of enquiry within the CQC regulatory framework.

Financial implications	Business cases approved by the Committee are within the delegated limits as set out in the Trust's Standing Financial Instructions and Scheme of Delegation.
Other Resource Implications	No other resource implications associated with this report.
Legal Implications	None identified.
Equality, Diversity and Inclusion Assessment (EIA)	N/A
Appendices:	Appendix 1: Finance Report Month 3

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 the 21 July 2022.

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. NBT Performance Report

The Committee received an update on the organisation's operational performance, which confirmed:

- That the Trust was delivering against its planned improvement trajectory for long-waiting patients (both 104 week-waits and 78 week-waits), but there were risks associated with the trajectories, including theatre staff absence (due to holiday and sickness).
- That the Trust had experienced a period of instability in its unscheduled care performance, with an increase in Covid-19 cases and staff sickness and consistently high numbers of patients with no criteria to reside.

The Committee was updated on specific steps that had been taken to improve ambulance handover delays by balancing the risk across the organisation through the implementation of pre-emptive transfers out of the Emergency Department and focusing on earlier discharges and more effective use of the discharge lounge. This was progressed with quality and clinical leadership.

The Committee discussed the impact on staff of the decision to rebalance risk through pre-emptive transfers to wards. It was acknowledged that this was difficult on staff across the organisation, and actions had been taken to manage a specific issue and were not intended to be long-term. The Committee was reassured that the Executive Team were aware of these issues and monitoring the situation, listening to staff concerns.

The Committee noted the level of pressure faced by the organisation over the summer period and the need to work with system partners in preparation for anticipated increase in demand over winter and ensure that pressures were shared across the system.

In terms of cancer performance and the patient tracking list (PTL), the Committee received an update on the work to recruit into vacancies in the central team, to allow faster reduction of the backlog.

3.2. Finance Report (Month 3)

The Committee received the Month 3 finance report (see Appendix 1), which detailed that the Trust was £3.7m worse than plan, driven largely by:

- Cost Improvement Plan (CIP) under-delivery year-to-date
- High agencies spend and staffing-incentives
- Uncertainty around the national Elective Services Recovery scheme (measured at a system level), resulting in the need for a provision to be made in the Trust's financial position

The Committee discussed the need for better forward planning for Capital Planning, ahead of the beginning of the financial year and the need for CIP performance to improve significantly, noting this was the subject of a separate paper.

3.3. Update on the emerging CIP plans and the plans to address the activity gap

The Committee the received an update on actions being taken to improve CIP delivery and oversight. This included information on the new Executive-led CIP Board, CIP programme support, and a focus on better ratification of confidence levels on CIP schemes, to ensure that delivery improved throughout the year rather than being delivered late in the year.

The Committee welcomed the increased scrutiny and drive around CIP delivery but expressed concern at the under-delivery so far in 2022/23. The Committee asked for a further update to each future meeting.

3.4. PFI Refinancing

The Committee received an update on the preparatory actions being taken ahead of a PFI Re-financing Business Case, which will come to the Board later in the year.

The Committee noted:

- NBT has appointed advisors to support the process

- It is being progressed with close engagement from the Department of Health.

The Committee was supportive of the project progressing, noting that spend on professional fees would be managed through the CFO and would be netted off against the benefit of refinancing.

The Committee was also advised that the PFI arrangements had transitioned from the LIBOR interest rate to the SONIA interest rate, as the LIBOR had ceased to exist from the end of 2021. This is technically a variation to the PFI, so Trust Board approval is sought for this change, noting that it is an administrative change with no impact on the value of the Unitary Payment under the PFI contract.

3.5. Digital Change Programme Delivery

The Committee received an update on the EPR Programme progress, and noted that overall, the roll-out had been successful, but there were issues that were being worked through and fixes put in place. The Committee were assured that the challenges were understood, and that appropriate support was in place.

3.6. Risk Report

The Committee noted the Trust Level Risks and Board Assurance Framework (BAF) risks within its purview. The proposed changes to the BAF were noted, and the Committee agreed that the changes should be discussed by Trust Board at its August meeting, following review of the BAF at the August Audit & Risk Committee meeting.

4. Summary and Recommendations

4.1 The Committee recommends that Trust Board:

- Receive the report for assurance and note its content.
- Approve the transition of the PFI from the LIBOR interest rate to the SONIA interest rate

North Bristol NHS Trust

Report To:	Finance and Performance Committee (F&PC)		**Agenda Item:**	
Date of Meeting:	July 2022			
Report Title:	Finance Report for June 2022			
Report Author & Job Title	Simon Jones, Assistant Director of Finance – Financial Management			
Executive/Non-executive Sponsor (presenting)	Glyn Howells, Chief Financial Officer			
Purpose:	**Approval/Decision**	**Review**	**To Receive for Assurance**	**To Receive for Information**
				X
Recommendation:	F&PC is asked to note: • the revised financial framework that the Trust is operating in • the financial performance for the month and year end position • the spend on Mass Vaccinations and Covid-19 expenditure areas • the delivery of Cost Improvement Plan (CIP) savings and how they compare with divisional targets • the Cash position and Capital spend levels for the financial year			
Report History:	N/A			
Next Steps:	N/A			

Executive Summary
2022/23 has seen the end of the interim financial regime implemented by NHSE/I during the Covid-19 pandemic, which saw trusts deliver a break-even plan, with support from non-recurrent funds. Whilst the new regime is not a return to pre-pandemic Payment by Results, there is a mix of block and variable elements. The basis for funding is on 2019/20 levels of activity and spend, adjusted for inflation and savings over the period since then, as well as service developments and service transfers. There is also the ability to earn additional funds through Elective Services Recovery Funding. The Trust submitted a phased plan for 2022/23 in June 2022 that requires it to deliver a breakeven position in the current financial year. This was consolidated into a system breakeven plan.

This plan includes additional funding to cover some of the inflationary pressures recurrently, in addition to further non-recurrent support. The impact of Covid-19 pressures on Quarter 1, which was originally expected to be an allowable overspend, has been removed, as this has been limited to April. The comparisons to plan in this paper are against the revised plan as submitted during June 2022 with some variances being driven by movement from the previous April plan.

The financial plan for 2022/23 at Month 3 (June) was a deficit of £3.8m. The Trust has delivered a £7.6m deficit, which is £3.7m worse than plan. This is predominately driven by the non-delivery of savings in the first three months of the year and high levels of preiminum pay spend, including on agency and incentives, offset by slippage on service developments and investments. In addition there is uncertainty around the Elective Services Recovery scheme and a provision has been made to account for this.

The month 3 CIP position shows £0.5m schemes fully completed, with a further £4.1m schemes on tracker and £3.3m in pipeline. There is a £10.9m shortfall between the 2022/23 target of £15.6m and the schemes on the tracker. If pipeline schemes are included this is a £7.7m shortfall.

Cash at 30 June amounts to £98.0m, an in-month decrease of £1.2m due to higher than average payments made during the month specifically around capital relating to March 2022.

Total capital spend year to date was £2.6m compared to a plan of £7.4m.

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

1. Purpose

This report is to inform and give an update to Trust Board on the financial position and performance for Month 3 and the year-to-date position.

2. Summary

2022/23 has seen the end of the interim financial regime implemented by NHSE/I during the Covid-19 pandemic, which saw trusts deliver a break-even plan, with support from non-recurrent funds. Whilst the new regime is not a return to pre-pandemic Payment by Results, there is a mix of block and variable elements. The basis for funding is on 2019/20 levels of activity and spend, adjusted for inflation and savings over the period since then, as well as service developments and service transfers. There is also the ability to earn additional funds through Elective Services Recovery Funding.

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The month 3 CIP position shows £0.5m schemes fully completed, with a further £4.1m schemes on tracker and £3.3m in pipeline. There is a £10.9m shortfall between the 2022/23 target of £15.6m and the schemes on the tracker. If pipeline schemes are included this is a £7.7m shortfall.

Cash at 30 June amounts to £98.0m, an in-month decrease of £1.2m due to higher than average payments made during the month specifically around capital relating to March 2022 and reduced receipts.

Total capital spend year to date was £2.6m compared to a plan of £7.4m.

3. Financial Performance

3.1. Total Trust

Overall, the Trust delivered a £2.9m adverse position in Month 3, with a £3.7m adverse position to plan for the year-to-date for the 2022/23 financial year.

The table below summarises the Trust financial performance for Month 3 and the year-to-date.

	Month 3			Year to Date		
	Budget £m	Actual £m	Variance £m	Budget £m	Actuals £m	Variance £m
Contract Income	59.3	59.6	0.3	172.8	173.3	0.6
Other Income	7.3	6.6	(0.8)	20.0	19.5	(0.5)
Pay	(39.8)	(41.7)	(1.9)	(119.2)	(120.8)	(1.6)
Non-Pay	(25.9)	(26.4)	(0.5)	(77.4)	(79.6)	(2.2)
Surplus/(Deficit)	**0.9**	**(2.0)**	**(2.9)**	**(3.8)**	**(7.6)**	**(3.7)**

For Month 3 the Trust has delivered a £2.9m adverse position against the £0.9m planned surplus, with a £3.7m adverse position year-to-date. Underperformance on CIP is the key driver of the position, alongside overspends on pay for bank and agency against substantive vacancies, however this is partially offset by delays in the delivery of recurrent and non-recurrent service developments. The Trust has seen a deterioration in month following the removal of Covid-19 budgets with the submission of the revised breakeven plan.

Whilst the Elective Services Recovery Funding mechanism has been in place since the start of the financial year, there remains uncertainty over the baseline being used nationally to measure performance of both systems and trusts. In addition the calculation, which is based on Secondary User Service (SUS) data rather than the data set the Trust uses for Contract Monitoring, has yet to be shared in order that organisations can understand fully the triggers for additional payments or deductions.

There is further uncertainty around whether ESRF will be altered or removed, as it was clear from the national submission in June that many systems included a clawback for non-delivery, where reaching 104% of 2019/20 activity was not deliverable, additionally; there is uncertainty around how payments will be effected where one Trust in a system delivers there required activity and another doesn't . As a result of this uncertainty, the Trust has included a provision, represented as lost Contract Income, for non-achievement of ESRF, of £1m.

3.2 Core Trust

The table below summarises the Core Trust including Elective Recovery Fund (ERF) activity (excluding Mass Vaccination and Research) financial performance for Month 3.

	Month 3			Year to Date		
	Budget £m	Actual £m	Variance £m	Budget £m	Actuals £m	Variance £m
Contract Income	59.3	59.6	0.3	172.8	173.3	0.6
Other Income	5.7	5.5	(0.2)	15.1	15.7	0.5
Total Income	**65.0**	**65.1**	**0.1**	**187.9**	**189.0**	**1.1**
AHP's and STT's	(6.2)	(5.6)	0.6	(18.0)	(16.5)	1.4
Medical	(11.5)	(11.5)	0.0	(34.4)	(34.8)	(0.3)
Nursing	(13.1)	(13.8)	(0.7)	(40.2)	(40.8)	(0.6)
Other Non Clinical Pay	(7.8)	(9.9)	(2.1)	(22.7)	(25.7)	(3.0)
Total Pay	**(38.6)**	**(40.8)**	**(2.3)**	**(115.4)**	**(117.9)**	**(2.5)**
Drugs	(4.1)	(4.6)	(0.5)	(12.7)	(12.6)	0.0
Clinical Supplies (Incl Blood)	(4.6)	(4.5)	0.1	(13.6)	(13.8)	(0.2)
Supplies & Services	(5.7)	(5.7)	(0.1)	(16.9)	(18.0)	(1.0)
Premises Costs	(3.1)	(2.9)	0.2	(9.6)	(10.1)	(0.5)
Other Non-Pay	(8.1)	(8.4)	(0.3)	(23.5)	(24.3)	(0.7)
Total Non-Pay Costs	**(25.6)**	**(26.2)**	**(0.6)**	**(76.4)**	**(78.7)**	**(2.3)**
Surplus/(Deficit)	**0.8**	**(1.9)**	**(2.7)**	**(3.9)**	**(7.6)**	**(3.7)**

The core Trust position in month is £2.7m adverse. This highlights the impact of the under-achievement of CIP and overspends on bank and agency offset by delayed spend against funding for new investments and service developments.

3.2.1 Core In Month

The in month position in month 3 reflects the catch up to the year to date from moving between the April and June 2022 plan submissions.

The contract income variance is £0.3m favourable. Contract income in month 3 for Divisions shows actual activity, whereas the Trustwide position has been set to the expected block amount except for variable items (e.g. high-cost drugs). The corresponding adverse variance on drugs can be seen within non-pay. This position includes the provision for non-delivery of ESRF of £1m.

In terms of financial value at a Divisional level activity in June is largely on plan. However, there are several large variances within this position at a Point of Delivery (POD) level.

Elective activity is £0.2m ahead of the month 3 plan, driven by additional activity in Trauma & Orthopaedics, Gynaecology and General Surgery. Critical Care has an upside variance of £0.9m with activity 15% up on planned levels. Similar to Month 1 and 2, Rehab is also ahead of plan by £0.8m driven by activity.

These overperformances are largely offset by significant adverse variances against both Non Elective £1.2m adverse and Outpatients £0.9m adverse. The reduced activity levels in Non-elective are against General Medicine and Obstetrics. Outpatients downside variances fall across several specialties with overall activity and income both 14% down on plan, with OP First Attendances & Procedures accounting for just under £0.7m of this adverse variance.

POD	Price Plan	Price Actual	Variance
AandE	1.7	1.4	(0.2)
Critical Care	3.4	4.3	0.9
Direct Access	1.3	1.4	0.1
Elective	8.1	8.2	0.2
High Cost Drugs & Devices	4.7	4.5	(0.2)
Non Elective	13.4	12.2	(1.2)
Outpatients	6.3	5.5	(0.9)
Rehab	0.7	1.5	0.8
Other	7.7	7.8	0.1
Grand Total	47.2	46.7	(0.5)

Pay expenditure is £2.3m adverse to plan. The Trust has seen overspends in Clinical Divisions for Consultant, Other Medical and Nursing due to bank and agency spend, sickness, and continued RMN usage in Medicine. This has been offset by underspends in Core Clinical, from Consultant and Allied Health Professional (AHP) vacancies and delayed spend against various investment funding.

Non-pay spend is £0.6m adverse to plan which is driven by increased spend on medical supplies and a prior year charge from for pathology consumables in Core Clinical. This is partially offset by reduced devices spend in NMSK due to activity being below funded 2019/20 volumes.

CIP delivery in month is causing a £0.6m adverse variance to plan split between pay and non-pay.

3.2.2 Core Full Year

The year-to-date position is £3.7m adverse.

Pay expenditure is £2.5m adverse to plan driven by the June position described above.

Non-pay spend is £2.3m adverse driven mainly by underperformance on CIPs, in addition there is increased medical supplies spend, and additional Pathology costs within Core Clinical. There is an adverse variance on drugs offset in contract income.

CIP delivery year-to-date is driving a £1.9m adverse variance to plan split between pay and non-pay.

3.4 Mass Vaccination

The table below summarises the Mass Vaccination Programme income and expenditure for Month 3.

	Month 3			Year to Date		
	Budget £m	Actual £m	Variance £m	Budget £m	Actuals £m	Variance £m
Other Income	0.7	0.4	(0.2)	2.0	1.9	(0.1)
Total Income	**0.7**	**0.4**	**(0.2)**	**2.0**	**1.9**	**(0.1)**
AHP's and STT's	(0.0)	0.0	0.0	(0.1)	(0.1)	(0.0)
Medical	(0.0)	(0.0)	(0.0)	(0.0)	(0.1)	(0.0)
Nursing	(0.3)	(0.2)	0.0	(0.8)	(0.6)	0.1
Other Non Clinical Pay	(0.1)	(0.1)	(0.0)	(0.4)	(0.5)	(0.1)
Total Pay	**(0.5)**	**(0.4)**	**0.1**	**(1.4)**	**(1.4)**	**(0.0)**
Drugs	(0.0)	(0.0)	0.0	(0.0)	(0.0)	0.0
Premises Costs	(0.2)	(0.0)	0.2	(0.5)	(0.5)	0.0
Other Non-Pay	(0.0)	(0.0)	0.0	(0.1)	0.1	0.1
Total Non-Pay Costs	**(0.2)**	**(0.0)**	**0.2**	**(0.6)**	**(0.5)**	**0.1**
Surplus/(Deficit)	**0.0**	**0.0**	**(0.0)**	**0.0**	**0.0**	**(0.0)**

A plan has been agreed and signed-off at Trust level for funding to support the Mass Vaccination programme. This plan has been included in budgets. In Month 3 a prudent approach was taken, to accrue the overall position to budget except for a small variance on agency costs within pay. This means that costs and income are aligned to the plan agreed by the Trust. The programme is pass-through so any correction in future months will not impact the Trust overall position.

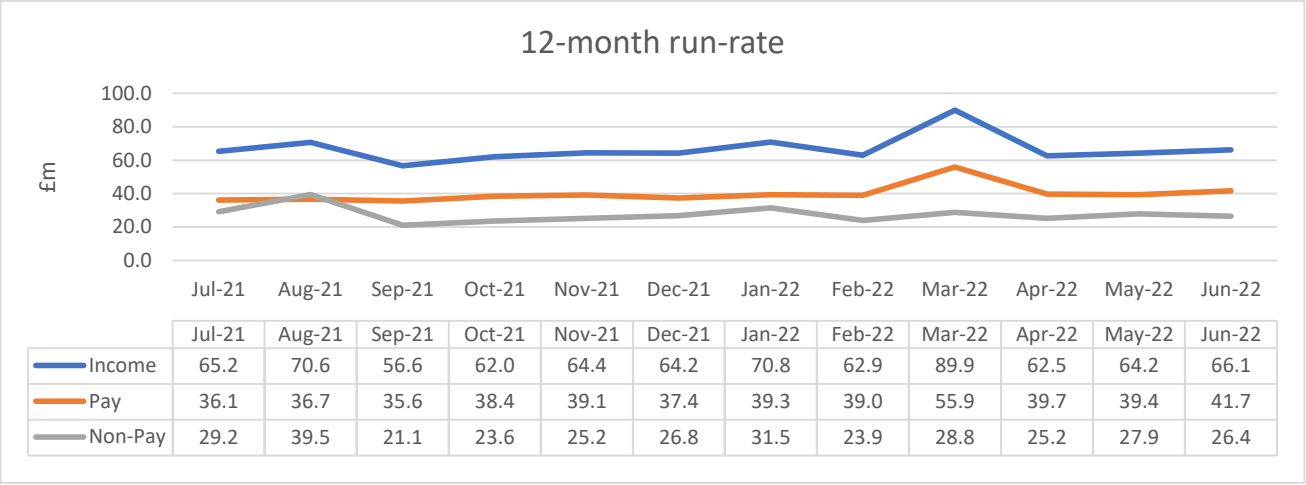
3.5 Research

The table below shows the research position. This has been excluded from the core position to remove the impact of variances that have nil impact on the Trust bottom line position.

	Month 3			Year to Date		
	Budget £m	Actual £m	Variance £m	Budget £m	Actuals £m	Variance £m
Other Income	1.0	0.6	(0.4)	2.9	1.9	(0.9)
Total Income	**1.0**	**0.6**	**(0.4)**	**2.9**	**1.9**	**(0.9)**
AHP's and STT's	(0.0)	(0.0)	(0.0)	(0.1)	(0.1)	(0.0)
Medical	(0.4)	(0.0)	0.3	(1.2)	(0.1)	1.0
Nursing	(0.2)	(0.2)	(0.0)	(0.7)	(0.7)	(0.0)
Other Non Clinical Pay	(0.2)	(0.2)	(0.0)	(0.5)	(0.6)	(0.0)
Total Pay	**(0.8)**	**(0.5)**	**0.3**	**(2.5)**	**(1.5)**	**1.0**
Other Non-Pay	(0.1)	(0.2)	(0.1)	(0.3)	(0.3)	(0.0)
Total Non-Pay Costs	**(0.1)**	**(0.2)**	**(0.1)**	**(0.3)**	**(0.3)**	**(0.0)**
Surplus/(Deficit)	**0.1**	**(0.1)**	**(0.2)**	**0.0**	**0.1**	**0.0**

3.6 Trust Trends

The chart below sets out the income, pay and non-pay trends for the Trust over the last 12 months. This position removes the impact of Mass Vaccination and Nightingale. Once these items have been removed, the position shown is relatively consistent over recent months. The March 2022 position reflects the impact of the pensions adjustment on income and pay. Pay in June 2022 was £41.7m, reflecting higher levels of agency and bank spend.



	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22
Income	65.2	70.6	56.6	62.0	64.4	64.2	70.8	62.9	89.9	62.5	64.2	66.1
Pay	36.1	36.7	35.6	38.4	39.1	37.4	39.3	39.0	55.9	39.7	39.4	41.7
Non-Pay	29.2	39.5	21.1	23.6	25.2	26.8	31.5	23.9	28.8	25.2	27.9	26.4

3.7 Divisional Breakdown

		Month 3			Year to Date		
		Budget £m	Actual £m	Variance £m	Budget £m	Actuals £m	Variance £m
ASCR	Contract Income	12.2	11.8	(0.4)	37.3	36.1	(1.2)
	Other Income	0.5	0.5	0.0	1.3	1.3	(0.1)
	Pay	(9.1)	(9.6)	(0.6)	(27.2)	(28.8)	(1.6)
	Non-Pay	(2.1)	(2.5)	(0.4)	(6.5)	(7.6)	(1.1)
	Surplus/(Deficit)	**1.5**	**0.1**	**(1.4)**	**4.9**	**0.9**	**(3.9)**
CCS	Contract Income	4.8	5.0	0.1	14.8	15.3	0.5
	Other Income	1.3	1.3	(0.0)	3.9	3.7	(0.3)
	Pay	(6.6)	(6.4)	0.3	(19.9)	(19.0)	0.9
	Non-Pay	(3.4)	(3.8)	(0.4)	(9.8)	(11.2)	(1.5)
	Surplus/(Deficit)	**(3.9)**	**(3.9)**	**0.0**	**(10.9)**	**(11.3)**	**(0.3)**
MED	Contract Income	13.6	12.1	(1.4)	40.6	38.0	(2.6)
	Other Income	0.2	0.2	0.0	0.5	0.6	0.1
	Pay	(7.2)	(8.0)	(0.8)	(21.4)	(23.8)	(2.5)
	Non-Pay	(3.4)	(3.0)	0.4	(7.9)	(8.2)	(0.3)
	Surplus/(Deficit)	**3.2**	**1.4**	**(1.8)**	**11.8**	**6.6**	**(5.2)**
NMSK	Contract Income	10.2	11.2	1.1	36.0	36.4	0.4
	Other Income	0.2	0.2	(0.0)	0.7	0.7	0.0
	Pay	(5.1)	(5.1)	0.0	(15.1)	(15.1)	0.0
	Non-Pay	(4.0)	(3.7)	0.3	(11.5)	(11.3)	0.2
	Surplus/(Deficit)	**1.3**	**2.7**	**1.4**	**10.1**	**10.8**	**0.6**
W&CH	Contract Income	4.7	4.0	(0.7)	14.2	12.9	(1.4)
	Other Income	0.1	(0.1)	(0.2)	0.4	0.2	(0.2)
	Pay	(2.9)	(3.1)	(0.1)	(8.9)	(9.0)	(0.1)
	Non-Pay	(0.4)	(0.3)	0.1	(1.2)	(1.3)	(0.1)
	Surplus/(Deficit)	**1.5**	**0.5**	**(1.0)**	**4.6**	**2.8**	**(1.7)**
MASS VACCINATION	Contract Income	0.7	0.4	(0.2)	2.0	1.9	(0.1)
	Other Income	(0.5)	(0.4)	0.1	(1.4)	(1.4)	(0.0)
	Pay	(0.2)	(0.1)	0.2	(0.6)	(0.5)	0.1
	Non-Pay	0.0	(0.0)	(0.0)	0.0	(0.0)	(0.0)
	Surplus/(Deficit)	**0.0**	**(0.0)**	**(0.0)**	**0.0**	**(0.0)**	**(0.0)**
TOTAL CLINICAL DIVISIONS		**3.6**	**0.8**	**(2.8)**	**20.4**	**9.9**	**(10.5)**
NON-CLINICAL AREAS	Contract Income	13.2	15.1	1.9	27.8	32.7	4.9
	Other Income	5.4	4.8	(0.6)	14.5	14.3	(0.1)
	Pay	(8.7)	(9.6)	(0.9)	(26.1)	(24.6)	1.5
	Non-Pay	(12.6)	(13.1)	(0.5)	(40.4)	(39.9)	0.5
	Surplus/(Deficit)	**(2.7)**	**(2.9)**	**(0.2)**	**(24.3)**	**(17.4)**	**6.8**
TRUST TOTAL		**0.9**	**(2.0)**	**(2.9)**	**(3.8)**	**(7.6)**	**(3.7)**

Key Divisional variances have been discussed in the main narrative of this report. A brief commentary on the YTD position of the clinical divisions is shown below.

ASCR

Underperformance on contract income, with Elective on plan but other PODs below due to reduced casemix complexity. Pay overspent due to undelivered CIP, locum costs in Renal and additional costs to cover junior doctor gaps in General Surgery.

CCS

Divisional pay is £0.9m underspend due to vacancies across consultants in Cell Pathology and delayed recruitment to weekend working posts. Non-pay £1.5m adverse driven by increased spend in Pathology due to inflationary increases and genetics automation of testing. Further budget realignment in genetics required in Month 4 for Contract Income.

Medicine

Contract income £2.6m adverse due to reduced Respiratory critical care income following reduction in Covid-19 patients, Outpatient from reduced volume and A&E behind plan due to uncoded activity. Pay £2.5m adverse from RMN spend, increased agency nursing spend, agency consultant use to cover vacancies, and increased junior doctor spend to cover A&E mid-shifts and outliers.

NMSK

No material variances in position.

W&CH

Contract income £1.4m adverse caused by reduction in Non-Elective average price. Pay £0.1m favourable driven by vacancies across nursing staff group.

4. Balance Sheet, Cash Flow, Capital, and Better Payment Practice Code ("BPPC")

	21/22 M12 £m	22/23 M02 £m	22/23 M03 £m	In-Month Change £m	YTD Change £m
Non Current Assets					
Property, Plant and Equipment	605.0	608.7	607.3	(1.4)	2.3
Intangible Assets	13.7	13.3	12.6	(0.7)	(1.1)
Non-current receivables	1.5	1.5	1.5	0.0	0.0
Total non-current assets	**620.2**	**623.5**	**621.4**	**(2.1)**	**1.2**
Current Assets					
Inventories	9.1	9.1	9.2	0.1	0.0
Trade and other receivables NHS	19.0	23.6	29.3	5.7	10.3
Trade and other receivables Non-NHS	20.5	22.9	24.0	1.0	3.4
Cash and Cash equivalents	116.2	99.3	98.0	(1.2)	(18.1)
Total current assets	**164.8**	**154.8**	**160.5**	**5.6**	**(4.3)**
Current Liabilities (< 1 Year)					
Trade and Other payables - NHS	10.6	7.9	8.8	1.0	(1.8)
Trade and Other payables - Non-NHS	102.6	92.8	97.1	4.3	(5.5)
Deferred income	16.4	20.6	22.0	2.4	6.5
PFI liability	15.2	15.7	15.7	0.0	0.4
Finance lease liabilities	2.1	1.6	4.1	2.5	2.0
Total current liabilities	**147.0**	**138.5**	**148.6**	**10.1**	**(1.6)**
Trade payables and deferred income	7.1	7.7	7.7	(0.0)	0.6
PFI liability	359.3	357.3	356.5	(0.8)	(2.8)
Finance lease liabilities	2.0	10.9	7.0	(3.8)	5.0
Total Net Assets	**269.7**	**264.1**	**262.2**	**(2.0)**	**(7.5)**
Capital and Reserves					
Public Dividend Capital	456.9	456.9	456.9	0.0	(0.0)
Income and expenditure reserve	(372.4)	(371.3)	(371.3)	0.0	1.1
Income and expenditure account - current year	1.1	(5.6)	(7.5)	(1.0)	(8.6)
Revaluation reserve	184.1	184.1	184.1	0.0	(0.0)
Total Capital and Reserves	**269.7**	**264.1**	**262.2**	**(2.0)**	**(7.5)**

4.1 Property, Plant and Equipment and Intangibles

The year-to-date increase of £1.2m in Non-Current Assets includes capital spend additions of £2.6m, together with the £6.6m additions as result of IFRS 16 implementation, off set by depreciation and amortisation of £8.0m. The impact of implementation of IFRS 16 is also recognised in an increase in finance lease liabilities.

4.2 Receivables

There was an increase of £13.7m in receivables. £7.9m relates to income from commissioners, which is linked with recognising income as per latest planning submission completed in late June. It is expected that commissioners will settle these payments in upcoming months. The reminder of the value was mostly due to changes in divisional accruals and Mass Vaccination accruals.

The total value of invoiced debt outstanding is £19.3m, of this £7.0m relates to Non-NHS individuals and organisations and is over 365 days old. £3.9m of the non-NHS debt older than 365 days relates to private and overseas patients and has been fully provided for.

	Outstanding invoiced debtors, £m	Total	Up to 30 days	30-60 days	60-90 days	90-180 days	180-365 days	365 + days
Jun-22	NHS	7.0	2.4	1.0	2.4	0.4	0.6	0.3
	Non-NHS	12.2	2.0	0.3	0.4	1.0	1.5	7.0
	Total	**19.3**	**4.4**	**1.3**	**2.7**	**1.3**	**2.1**	**7.4**
Mar-22	NHS	6.4	4.8	0.0	0.3	0.6	0.6	0.1
	Non-NHS	12.0	1.8	0.7	0.4	0.9	1.5	6.7
	Total	**18.4**	**6.6**	**0.7**	**0.7**	**1.5**	**2.1**	**6.8**
Change	NHS	0.6	(2.4)	0.9	2.1	(0.2)	(0.0)	0.2
	Non-NHS	0.3	0.2	(0.3)	(0.1)	0.0	0.1	0.3
	Total	**0.9**	**(2.2)**	**0.6**	**2.0**	**(0.2)**	**0.1**	**0.5**

4.3 Payables

Year to date NHS payables have reduced by £1.8m for the year to date as a result of clearing invoiced creditors post year end.

Non-NHS payables have decreased by £5.5m, of which £4.7m relates to the reduction of accrued capital expenditure as a result of post year end payments, along with £0.8m of other net decreases. The above payments patterns are reflected in the reduced cash balance.

4.4 Deferred Income

The year to date increase of £6.5m in deferred income mainly relates to the £5.1m increase in the deferral of contract income, linked with genomics and uncertainty around ESRF funding.

4.5 Cash

The cash balance decreased by £18.1m for the year to date (£1.2m in-month) due to year-to-date deficit, reduced receipts, linked with changes in receivables, and higher than average payments made during the period, including significant amounts of capital spend cash relating to the March 2022 year end capital creditor and increase in prepayments. Despite reducing cash balance, the Trust is still expected to be able to manage its affairs without any external support for the 2022/23 financial year.

	Jul-22 £m	Aug-22 £m	Sep-22 £m	Oct-22 £m	Nov-22 £m	Dec-22 £m	Jan-23 £m	Feb-23 £m	Mar-23 £m
Cash brought forward	98.0	101.8	100.4	93.5	98.6	95.8	97.4	104.8	106.6
Forecast in-month cash movement	3.7	(1.4)	(6.9)	5.1	(2.7)	1.6	7.4	1.8	0.3
Forecast cash balance	101.8	100.4	93.5	98.6	95.8	97.4	104.8	106.6	106.9

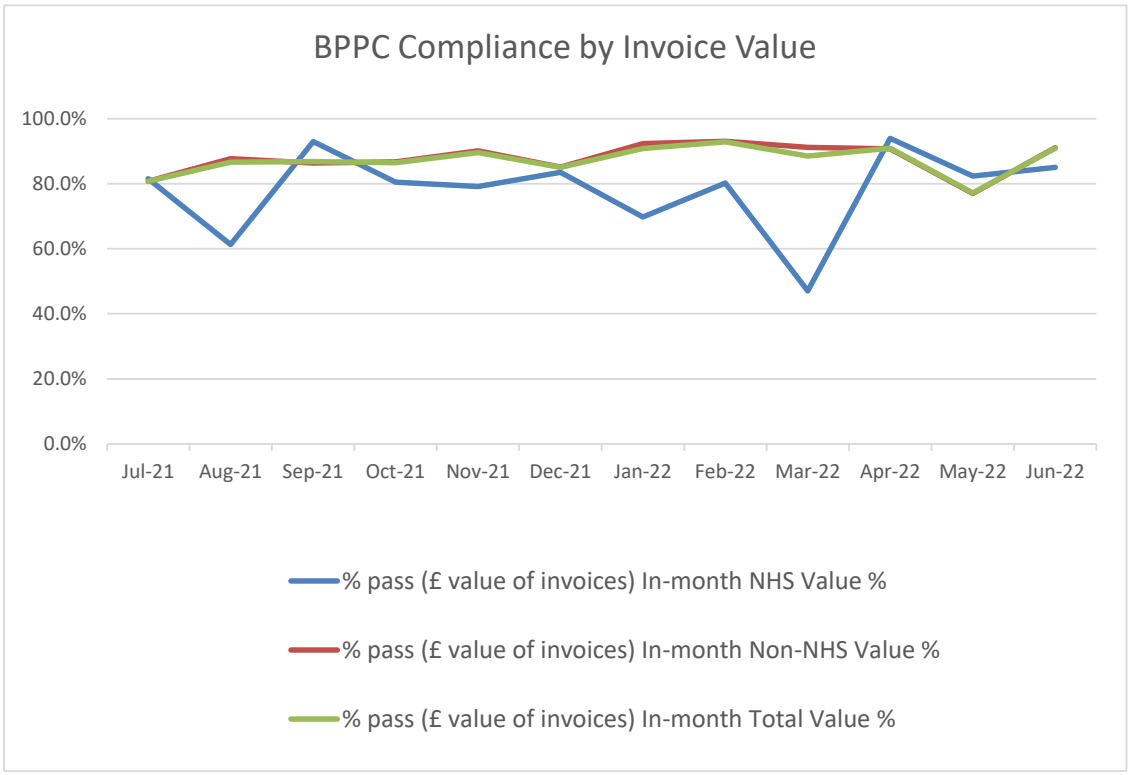
4.6 Capital Spend

Total capital spend for the year to date was £2.6m, compared to plan of £7.4m. The total planned spend for the year is £32.5m.

2022/23 Capital Expenditure	2022/23 plan £m	Year to date Plan £m	Year to date Actual £m	Year to date Variance from plan £m
Divisional Schemes	7.4	1.8	0.2	(1.6)
CRISP	4.6	1.1	0.4	(0.7)
Medical equipment	4.6	1.1	0.4	(0.7)
IM&T	4.2	1.0	1.4	0.4
Charity and grant funded	0.2	0.1	0.2	0.1
PFI lifecycle	1.1	0.3	0.0	(0.3)
Total Core Plan	22.1	5.4	2.6	(2.8)
IFRS 16 new leases	1.7	0.4	0.0	(0.4)
IFRS 16 Pathology Managed Service	8.7	1.6	0.0	(1.6)
Total	32.5	7.4	2.6	(4.8)

4.7 BPPC

The Better Payment Practice Code (BPPC) achievement of invoices paid within 30 days by value was 86.0% for the first three months of 2022/23, compared to 87.8% for 2021/22. BPPC achievement by volume of invoices has increased from 83.7% in 2021/22 to 85.7% for the first three months of 2022/23.



5. Cost Improvement Programme

The CIP plan for 2022/23 is savings of £15.6m. At month 3 the Trust has £0.5m of completed schemes on the tracker. There are a further £4.1m of schemes in implementation and planning, creating a £11.0m shortfall against the annual target of £15.6m. The Trust has a further £3.3m of schemes in pipeline. Further schemes, including around agency reduction and procurement savings are currently being worked up.

Summary Division	FYE Target	Completed Schemes	Schemes in Implement ation	Schemes in Planning	Total FYE	Variance FYE	Schemes in Pipeline	Total FYE inc Pipeline
£m	£m	£m	£m	£m	£m	£m	£m	£m
ASCR	3.7	0.1	0.0	0.3	0.4	(3.3)	0.3	0.8
CCS	3.2	0.4	0.5	0.0	0.9	(2.3)	0.5	1.4
CORP	0.6	0.0	0.0	0.4	0.4	(0.3)	0.9	1.3
FAC	1.0	0.0	1.0	0.3	1.3	0.4	0.2	1.5
MED	2.6	0.0	0.0	0.3	0.3	(2.3)	0.2	0.5
NMSK	2.6	0.0	0.2	1.1	1.3	(1.3)	1.0	2.2
TRUSTWIDE	0.8	0.0	0.0	0.0	0.0	(0.8)	0.0	0.0
WCH	1.1	0.0	0.0	0.0	0.0	(1.1)	0.3	0.3
Total	**15.6**	**0.5**	**1.8**	**2.3**	**4.6**	**(11.0)**	**3.3**	**7.9**

Divisions will be tasked with working up schemes to close the gap in quarter 2.

6. Risk and mitigations

The below table highlights the current risks and mitigations within the Trust position at Month 3.

Risks	£m	Mitigations
Non-delivery of CIP	(5.0)	Implementation of CIP delivery Board. Focussed meetings led by CIP team.
Covid-19 impacting elective bed base	(2.0)	Further work on Productivity to increase throughput
Increase in agency and locum costs, including Registered Mental Health Nurses	(3.0)	Work with System to improve discharges and use of RMNs. New temporary role looking at nursing agency usage.
ESRF non-delivery	(5.0)	Currently included in the position
Total	**(15.0)**	
Opportunities		
Mitigating Actions		
Balance sheet review	4.0	Review to be undertaken
Delays in recruitment to investments	3.0	Recruitment delayed until Q2 and onwards
Non-recurrent savings / vacancy factor / contract management	8.0	Non-recurrent actions
Total	**15.0**	
Most likely outturn	**(0.0)**	

7. Productivity

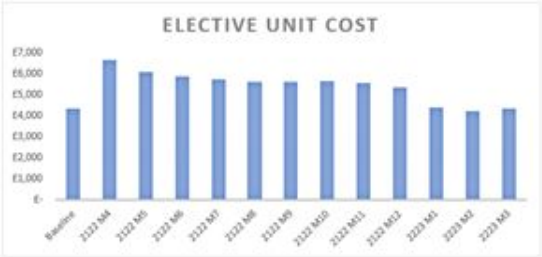
The impact of Covid-19 has been felt differently by different organisations which has meant more traditional forms of benchmarking have become less useful when assessing the Trust' performance. As a result, starting in early 21/22 a new measure of performance has been captured. The calculation of unit costs allows for productivity to be measured at a point of delivery (POD) / speciality level. Unit costs have been calculated going back to 19/20 and so trends can then be analysed and compared to pre-pandemic levels.

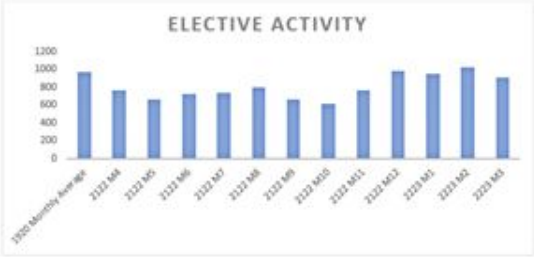
While the hospital has been focusing on the response to the pandemic full analysis involving crucial divisional input has not been carried out. Now, as part of the recovery process, productivity analysis is to be launched at a Divisional level.

Productivity as shown in the below graphs sources cost data from service line reporting and activity data from patient access systems and aims to understand the relationship between activity and expenditure.

In areas where there is a high proportion of fixed costs movements in activity have a greater effect on unit costs. This can be seen in the elective unit costs below where low levels of activity during

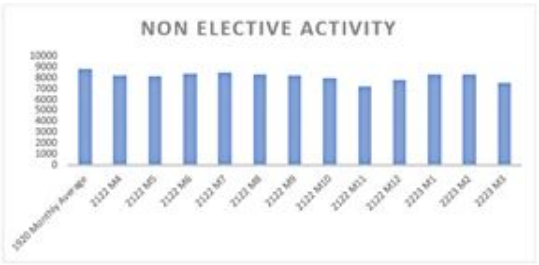
the Covid-19 pandemic greatly increased the unit cost and rising levels of activity in the last three months have seen the unit cost move closer to pre-pandemic levels.

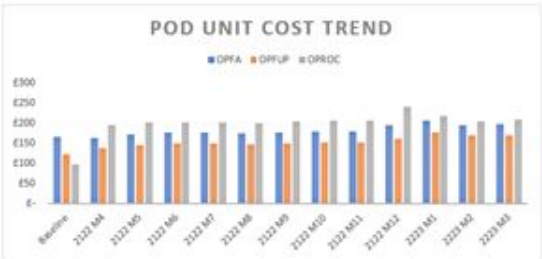


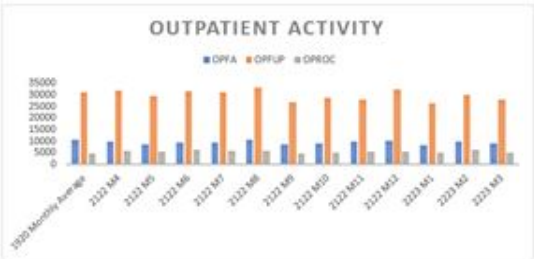


In terms of day cases, where activity has been very volatile recently, the unit cost is less correlated to activity.

Non-elective activity levels have remained reasonably stable, however, there is a clear trend of increased unit costs over the last twelve months. The same could be said for outpatients, particularly when looking at outpatient procedures.







The real value from this data set will come as a result of clinical engagement and Divisional input. For this reason a Costing for Value steering group which will be clinically chaired is in the process of being setup and Divisions now have access to monthly productivity data which will be included as part of the the Divisional review process.

8. Recommendation

F&PC are asked to note:

- the revised financial framework that the Trust is operating in
- the financial performance for the month and year to date position
- the spend on Mass Vaccination areas
- the delivery of Cost Improvement Plan savings and how they compare with divisional targets
- the Cash position and Capital spend levels for the financial year.

Report To:	Trust Board		
Date of Meeting:	28 July 2022		
Report Title:	Quality Committee Upward Report		
Report Author & Job Title	Aimee Jordan, Corporate Governance Officer		
Executive/Non-executive Sponsor (presenting)	John Iredale, Non-Executive Director and Chair of QC		
Does the paper contain:	**Patient identifiable information?**	**Staff identifiable information?**	**Commercially sensitive information?**
*If any boxes above ticked, paper to be received at *private* meeting			
Purpose:	**Approval**	**Discussion**	**To Receive for Information**
	X		
Recommendation:	Trust Board is recommended to: • Receive the report for assurance and note the activities Quality Committee has undertaken on behalf of the Board. • Agree to receive a presentation on the Shared Decision-Making and Consent programme be brought to Trust Board to showcase the positive progression of the programmes. • Note the Learning from Deaths Annual Report and Summary Slides. • Note the CQC Letter on the feedback from the surgery monitoring visit.		
Report History:	The report is a standing item to the Trust Board following each Committee meeting.		
Next Steps:	The next report will be received at Trust Board in September 2022.		

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 July 2022.	
Risks	Link to BAF risks: SIR1 relating to effective demand management and community capacity; SIR 1.1 re risk to access for cancer, diagnostics and planned care; SIR14 re sustained demand and increased acuity impact on patient safety; and COV2 re Covid-19.

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 – Learning from Deaths Annual Report Appendix 2 – Learning from Deaths Summary Paper Appendix 3 – CQC Letter: Feedback from Surgery Monitoring Visit

1. Purpose

1.1 To provide a highlight of the key assurances received, items discussed, and items for the attention of Trust Board from the Quality Committee (QC) meeting held on 14 July 2022.

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 and risk management.

3. Meeting on 14 July 2022

3.1 Maternity/ Ockenden Board Upward Report

The Committee received the Maternity/ Ockenden Board Upward Report which detailed the activity of the Ockenden Board and the actions undertaken re the 15 Immediate and Essential Actions (IEA's). The Committee noted the positive progress and engagement of the Board from the senior clinicians.

The Committee discussed that assurance re the timeframe challenges of the implantation actions would be received through the IEA leads and through the upward reports.

3.2 Shared Decision-Making, Consent programme

The Committee received a presentation on the Shared Decision-Making, Consent programme from Della Hopkins, Quality Governance Programme Manager, and Adam Williams, Divisional Governance Lead, NMSK; Neurosurgery Specialty Lead. The presentation detailed the background, the project plan milestones, the benefits and the ongoing activities of the programmes.

- Shared Decision-Making Project provided a framework and was developing the implementation of a stronger approach to shared decision making for patients consenting to surgical procedures in the trust. 'Real time' feedback from patients re perceptions of the quality of consent, prior to surgical procedures were obtained using a new IT system to support doctors in obtaining the feedback.

- Patient Consent Project focused on redesigning the consent documentation, accompanying patient information and evaluation of digital support to develop a more personalised patient centred approach.

The Committee discussed the ability to use the framework to create bespoke consent forms and how could be expanded through digital solutions. The Committee were reassured that creating bespoke consent forms would be the best medical legal compromise and that it would be an improvement to the current process.

The Committee received reassurance that work was ongoing to develop the consent forms to enable them to be accessible to all patients and reinforced that digital solutions would enable translation of the forms.

The Committee recommended that the presentation be brought to Trust Board to showcase the positive progression of the programme.

3.3 Medical Examiner Service - Annual Report 2021/22 and Update

The Committee received a presentation from Dr David Crossley, Lead Medical Examiner across BNSSG, which described the delivery against service objectives, feedback from various key stakeholders and the key 'next steps' during 2022-23. It was detailed that the service objective were as follows:

- Improving the experience of bereaved relatives through better communication around the death certification process, and including their views of the care of their loved one.
- Ensuring the Medical Certificate of Cause of Death (MCCD) is accurate
- Liaising with Her Majesties Coroner to ensure appropriate referrals are made

The Committee were informed that the medical examiner service would be statutory in April 2023 and so all deaths in BNSSG would be covered by the service. The Committee recognised the challenge that this would present.

3.4 Learning from Deaths Annual Report

The Committee received the Learning from Deaths Annual Report which described good learnings, actions and the forward plan.

The Committee agreed to include the learning from deaths report to the Board to ensure sight of all issues and themes (report attached as Appendix 1 and Summary slides attached as Appendix 2).

The Committee received reassurance that the high level of deaths of patients with learning disabilities in March 2020 had been investigated and the investigation concluded

that there was nothing adverse in terms of care provided that caused the deaths. The Committee noted that the full outcome was discussed at a previous QC meeting.

3.5 Incident Reporting

The Committee received an incident reporting update which detailed the review and management plan for the backlog of unclosed incidents in the Datix system. The review methodology and outcomes were discussed, and it was highlighted that all incidents had been reviewed by the local manager or a specialist team but had not been closed through the system hierarchy.

The Committee noted the proposed process for managing the current incidents within Datix and how the project to implement a new, wider quality governance system, RADAR Healthcare, would address the legacy challenges within the Datix system

The Committee were reassured that was a positive reporting culture and that there was a plan in place to ensure staff received clarity on their roles and responsibilities of reporting and investigating incidents.

The Committee were also reassured that processes were in place to prevent this from occurring again and noted that a paper on the new RADAR system was scheduled to be brought to the Quality Committee in September.

3.6 CQC Assurance

The Committee received the CQC Assurance report which set out the latest quarterly update on ongoing assurance and improvement work linked to the CQC regulatory regime. The report detailed feedback from the CQC monitoring visit with Surgery core service and the results/actions of the core service self-assessment review against the CQC domains. The letter re the feedback from the Surgery monitoring visit from the CQC has been attached as Appendix 3.

The Committee noted the upcoming CQC IR(ME)R Inspection of interventional Neuroradiology on 20th July 2022 and the Trust preparedness.

3.7 **Other items:**

The Committee also received the following items for information:

- Sub-committee upward reports:
    - Safeguarding Committee
    - Drugs & Therapeutics HLR's
    - Control of Infection Committee Upward report
    - Clinical Effectiveness & Audit Committee
    - Patient Safety & Clinical Risk Committee

- Quality Committee forward work-plan 2022/23

4. Identification of new risk & items for escalation

None

5. Recommendations

The Trust Board should:

- Receive the report for assurance and note the activities Quality Committee has undertaken on behalf of the Board.
- Agree to receive a presentation on the Shared Decision-Making and Consent programme be brought to Trust Board to showcase the positive progression of the programmes.
- Note the Learning from Deaths Annual Report and Summary Slides.
- Note the CQC Letter on the feedback from the surgery monitoring visit.

NHS
North Bristol
NHS Trust

Learning from Deaths Annual Report

2021/22

Foreword

Over the past two years, through the COVID-19 pandemic, our quality governance and patient safety teams have developed and implemented ambitious plans to increase confidence in our reviews of mortality data and individual cases as indicators of care quality. This has included an internal review of the approach, purpose and importance of Structured Judgement reviews and agreeing a development plan with clinical divisions. The team have worked hard, with fantastic support from clinical teams under exceptionally challenging circumstances, to help deliver a vibrant, multi-faceted and multi-disciplinary plan that sets us firmly on a journey of continuous improvement.

Over these tumultuous years, we have embraced a culture that is open and transparent and keen to listen and learn and adopt new practices. We have embraced the NHS Patient Safety Incident Reporting Framework (PSIRF), developed enhanced Structured Judgement Reviews for patients with Learning Disabilities or Autism, implemented the new Medical Examiner structure (as a BNSSG system wide service in partnership with University Hospital Bristol & Weston Foundation Trust). All of these developments continue to contribute to the richness of care that we provide. The examples from individual specialities highlight the positive nature in which teams have embraced new ways of working, using learning from SJRs through their specialty and multi-specialty Mortality and Morbidity meetings to contribute to high quality care.

The report also points to areas which need our focus over the next year. This includes the need to improve on our mortality review completion rates in mandatory areas (e.g. Serious Mental illness), continue to improve the care for patients with complex medical and social needs or with learning disability or autism, strengthen our structured judgement review process by making it multi-disciplinary and demonstrate the application of our learning across multi-professional teams.

Over the next 12 months, as our trust accelerates modernising its digital infrastructure, we will introduce a new digital mortality review tool within the new quality governance digital system called Radar. This, I believe has the potential to help transform how we collect, share and analyse data and help us on our journey on to continue to provide safe and high-quality care.

As we grow and mature the learning environment at NBT we will deepen our collaboration with colleagues across BNSSG and with support from the NHSE/I Better Tomorrow team to strengthen our approach to Learning from Deaths and become a national exemplar.

Sanjoy Shah

Deputy Chief Medical Officer

June 2022

Contents

Section 1: Mortality Indicators

National mortality indicators provide an overview of the mortality rate at the Trust in the context of the national picture. They are useful in identifying whether there may possibly be problems with care but are not designed to provide an indication as to what that may be. They are therefore a useful source of assurance that there are no deeply systemic issues within the Trust.

There are two main national indicators; Standardised Hospital-level Mortality Indicator (SHMI) and Hospital Standardised Mortality Ratio (HSMR). The below table gives a brief overview of their main differences.

FIG 1| NBT SHMI SPC CHART APRIL 2018 – OCTOBER 2021 (EXTRACTED FROM CHKS)

Attribute/Model	HSMR	SHMI
Deaths included (% hospital inpatients)	83%	100% + 30 days after discharge (out of hospital deaths)
Deaths and activity excluded	• Smaller CCS groups • Day cases	• Day cases • Regular attenders • Still births
Factors included	• Age • Admission • Diagnosis (56 CCS) • Diagnosis sub group • Sex • Comorbidity (Charlson continuous) • Deprivation Carstairs • Palliative care flag • Previous admissions • Year • Month • Admission source	• Age • Admission • Diagnosis (150 combined CCS) • Sex • Comorbidity (Charlson 3-cat) • Year
Factors ignored	• Length of stay	• Length of stay • Palliative care flag • Deprivation • Month

1.1 SHMI

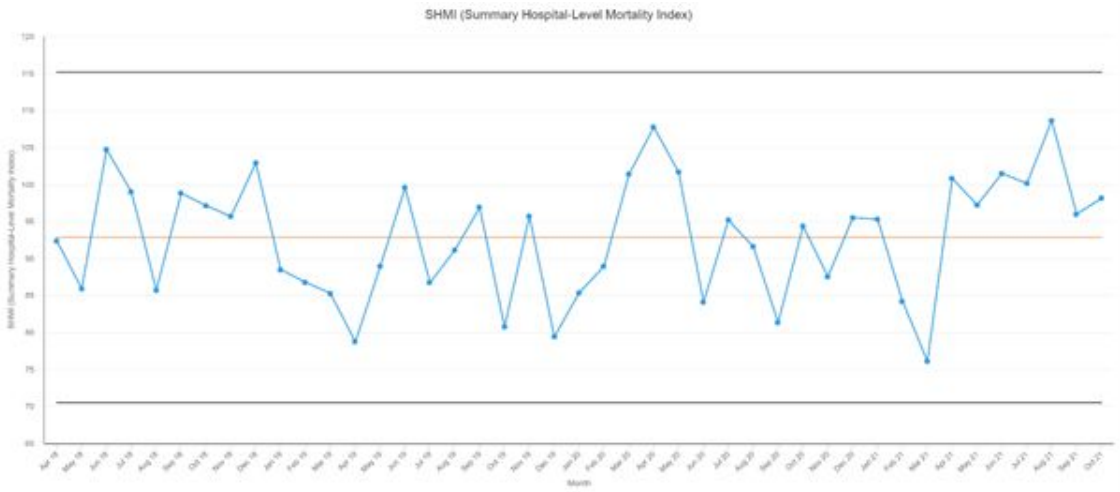
The Standardised Hospital-level Mortality Indicator (SHMI) is the ratio between the actual number of patients who die following hospitalisation (up to 30 days post-discharge) at the Trust and the number that would be expected to die on the basis of average England figures, given the characteristics of the patients treated here. SHMI takes into account more variables than HSMR particularly co-morbidities and the emergency/elective split of admissions. It is seen nationally as a more reliable mortality indicator than HSMR.

As of July 2020, COVID-19 activity has been excluded from the SHMI. The SHMI is not designed for this type of pandemic activity and the statistical modelling used to calculate the SHMI may not be as robust if such activity were included.

The most up-to-date available data for SHMI covers the period April 2018 – October 2021. NBT's value for that period is 92.45 and our peer value is 98.52 indicating that we are performing better than our peer organisations.

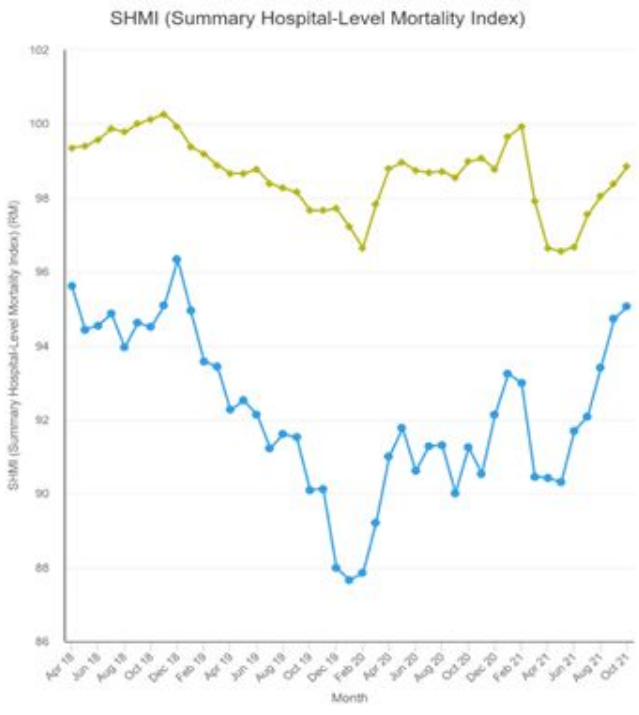
We have seen some normal variation in our SHMI but this has not been outside the process limits; indicating stability.

FIG 2| NBT SHMI SPC CHART APRIL 2018 – OCTOBER 2021 (EXTRACTED FROM CHKS)



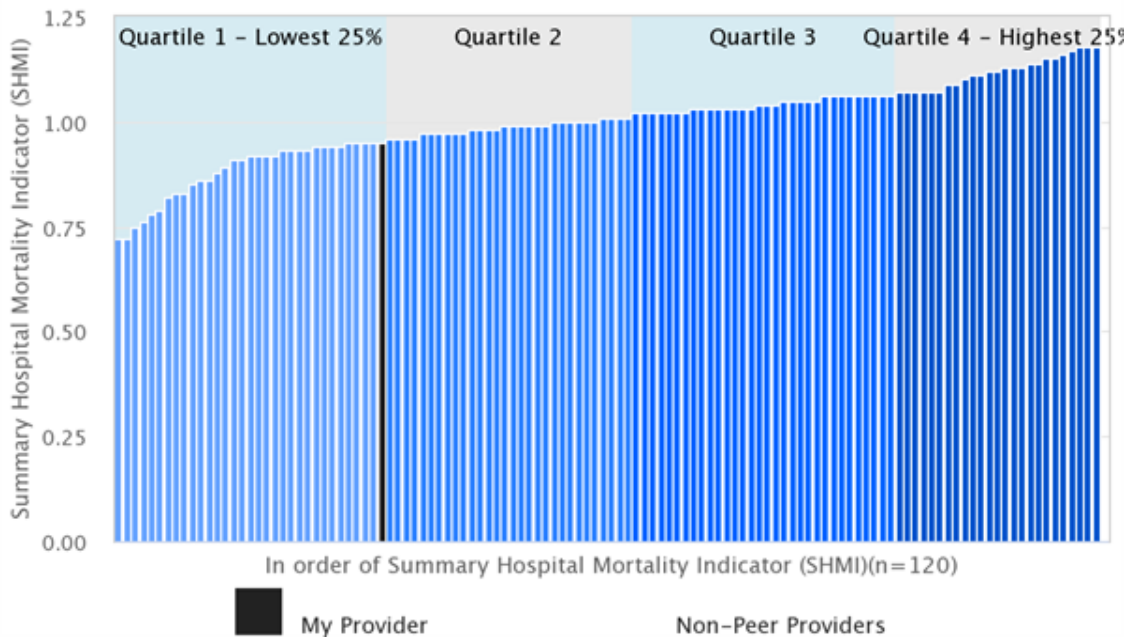
Our trajectory for SHMI follows that of our peer organisations but is lower on all occasions between April-18 and October-21.

FIG 3| NBT SHMI TIME SERIES CHART (NBT IN BLUE) CHART APRIL 2018 – OCTOBER 2021 (EXTRACTED FROM CHKS)



The latest available data from Model Hospital (January 2022) shows NBT in the lowest quartile with a value of 0.95, and the national median as 1.01.

FIG 4| SHMI NATIONAL DISTRIBUTION (JANUARY 2022) – EXTRACTED FROM MODEL HOSPITAL

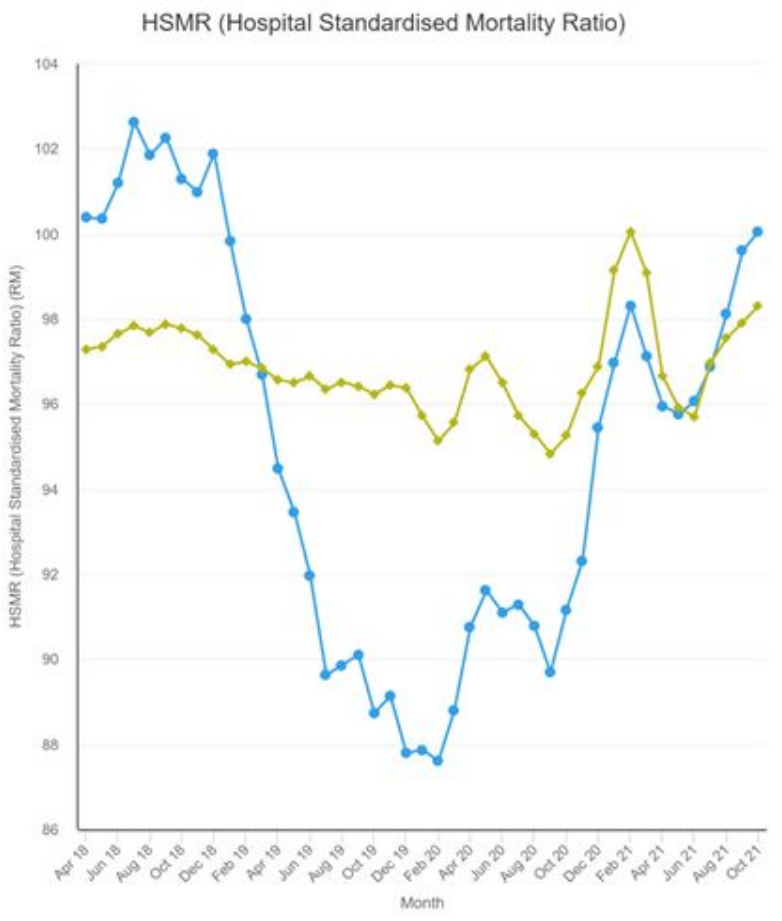


1.2 HSMR

The Hospital Standardised Mortality Ratio (HSMR) adjusts the mortality risk in a spell of patient care for risk factors such as their age, gender and health conditions. The HSMR uses risk models to provide the number of 'expected deaths' per Trust per month, compared with the number of actual deaths at the Trust.

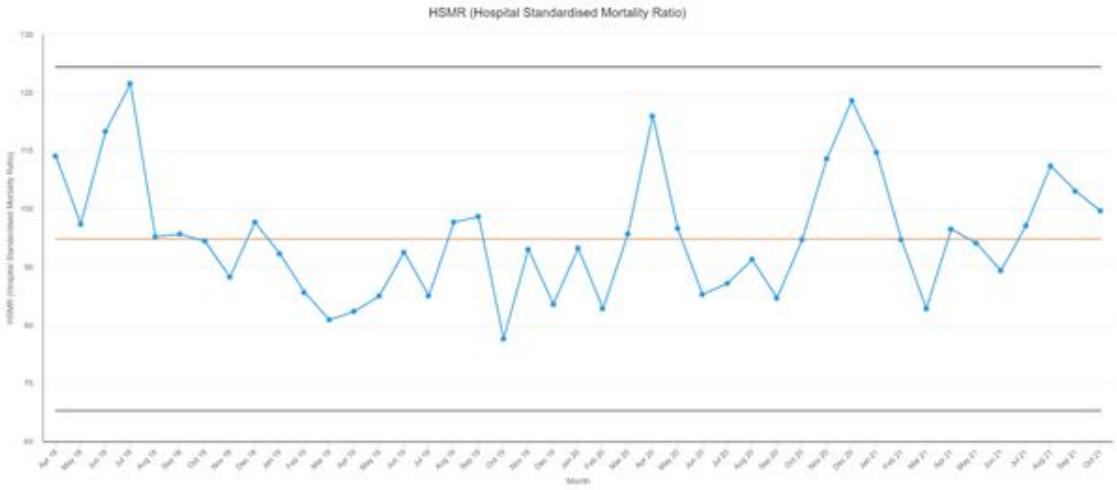
NBT's HSMR for the latest available data (April 2018 – October 2021) is at 94.59 with a comparison peer value of 96.84.

FIG 5 | NBT HSMR TIME SERIES CHART (NBT IN BLUE) CHART APRIL 2018 – OCTOBER 2021 (EXTRACTED FROM CHKS)



HSMR indicates that NBT's performance is much closer to that of its peers than SHMI. Although the above chart seems to present a less stable picture of NBT's mortality rate, the below SPC chart indicates that this is part of normal variation.

FIG 6| NBT HSMR TIME SERIES CHART (NBT IN BLUE) CHART APRIL 2018 – OCTOBER 2021 (EXTRACTED FROM CHKS)



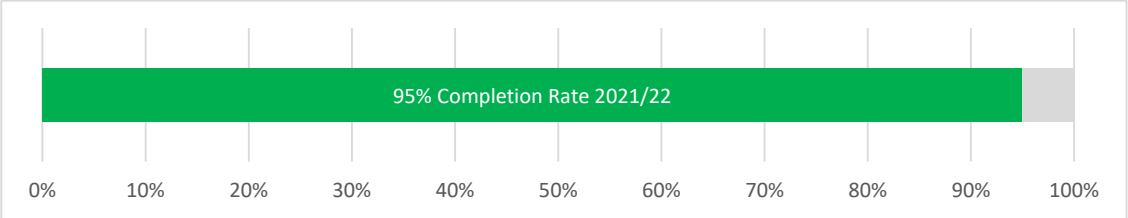
Section2: Mortality Review Activity and Outcomes

Some form of review is undertaken on all deaths that happen at NBT. These generally are undertaken at two levels – a high level screening of the case undertaken either by the specialty or the medical examiner to identify if there are potential issues that might require further investigation, and a more in-depth case note review. Some categories of deaths require a full case note review regardless of whether concerns are indicated, these are cases where the patient was an elective admission, had a serious mental illness, had a learning disability or autism, where a significant care concern has been raised by bereaved families and carers or staff, all deaths in a service specialty where an 'alarm' has been raised, all deaths in areas where people are not expected to die and all deaths where learning will inform the provider's existing or planned improvement work. There have been no alarms raised during the 2021/22 reporting period.

2.1 Mortality Review Completion Rate

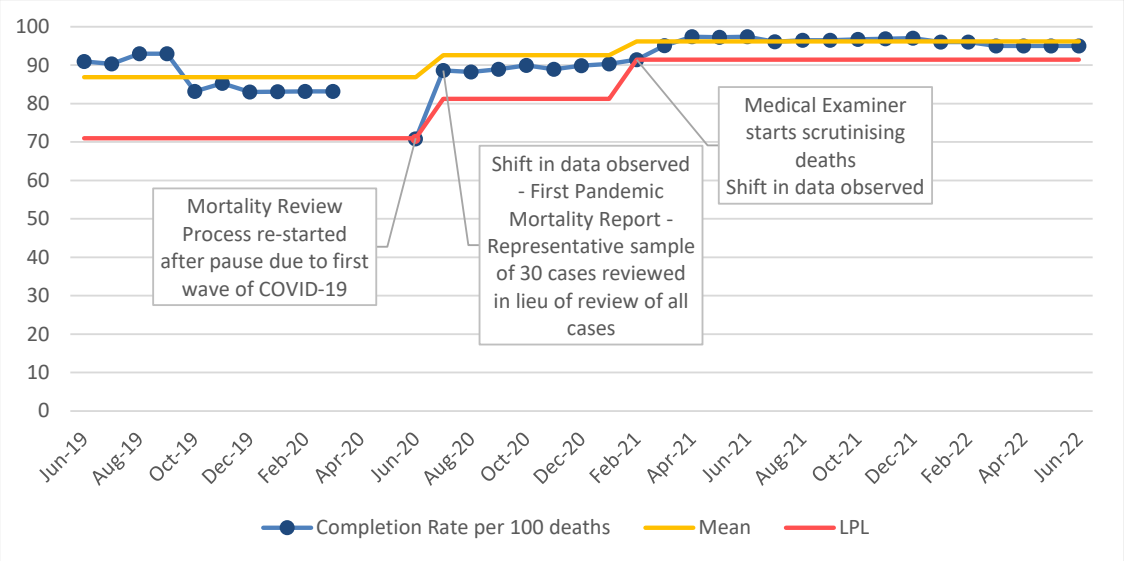
The following chart (Fig 8) indicates mortality review completion rate per 100 deaths over time. A review completion includes a screening review with no concerns flagged, or a medical examiner review, or a full mortality case note review (Structured Judgement Review). Monthly data is reported as the summation of the previous 12 months, **2 months in arrears** – this is in-line with Integrated Performance Report (IPR) reporting.

FIG 7| MORTALITY REVIEW COMPLETION RATE 2021/22



The data shows that NBT records a high level of completion for mortality reviews. The latest monthly figure (June 2022) is reported as a 95 completion rate per 100 deaths. There was a significant drop in the completion rate in June 2020 to 70.8% as a result of the first wave of the COVID-19 pandemic following a 2-month hiatus of reviews to alleviate additional administrative pressures on clinical staff.

FIG 8| MORTALITY REVIEW COMPLETION OVER TIME JUN-19 – JUN-22 (DATE BY REPORTING MONTH)



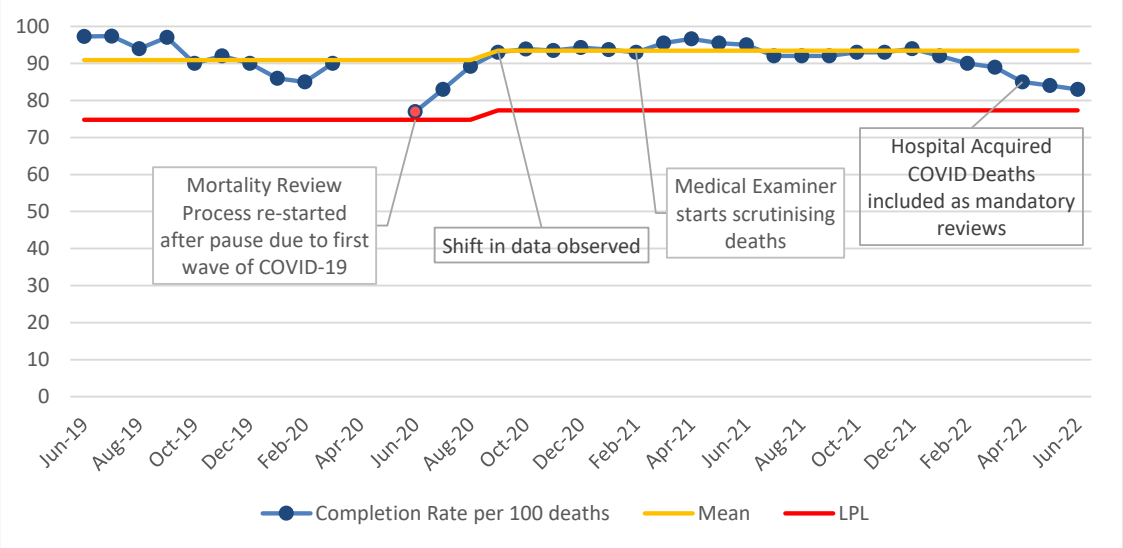
There was a shift in the data from July 2020 onwards above the mean – limits have been recalculated following this shift. This shift is thought to be as a result of a combination of undertaking the first pandemic mortality review (which used sampling to remove a previous backlog of cases) and the advent of the Medical Examiner's Service at NBT (consistently reviewing cases from December 2020) reducing the need for screening.

The latest shift in the data from February 2021 onwards is further evidence of the impact of the Medical Examiner Service. During 2021/22 review completion has remained stable.

2.2 Mortality Review Completion Rate – High Priority Cases

Mortality reviews labelled as high priority are those that fall into the mandatory review categories of patients with a learning disability or autism, patients with a serious mental illness, elective admissions, cases that have been screened for review either by the Medical Examiner or the Trust due to a care concern, or cases where the patient died with definite or probable hospital acquired COVID-19. The latter of these was added as a mandatory high priority review category in February 2022.

FIG 9| MORTALITY REVIEW COMPLETION RATE – HIGH PRIORITY CASES 2021/22



There has been a decline in the completion rate for high priority reviews during 2022. This could be due to the addition of COVID-19 reviews to the mandatory review category increasing the burden of reviews for specialties. For deaths occurring in 2021/22:

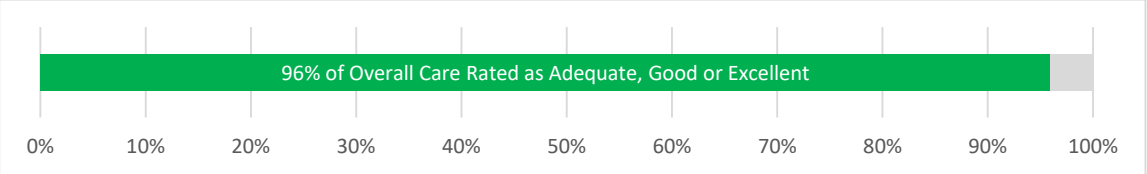
- 18/24 (75%) elective cases have been reviewed,
- 18/26 (69.2%) Hospital Acquired COVID cases have been reviewed,
- 17/24 (70.8%) cases of patients with a serious mental illness have been reviewed, and
- 22/25 (88%) cases where the patient has a Learning Disability or Autism have been reviewed

The requirement for hospital acquired COVID case reviews will need to be revisited in-line with the Trust's Living with COVID policy changes.

2.3 Structured Judgement Review Care Scores

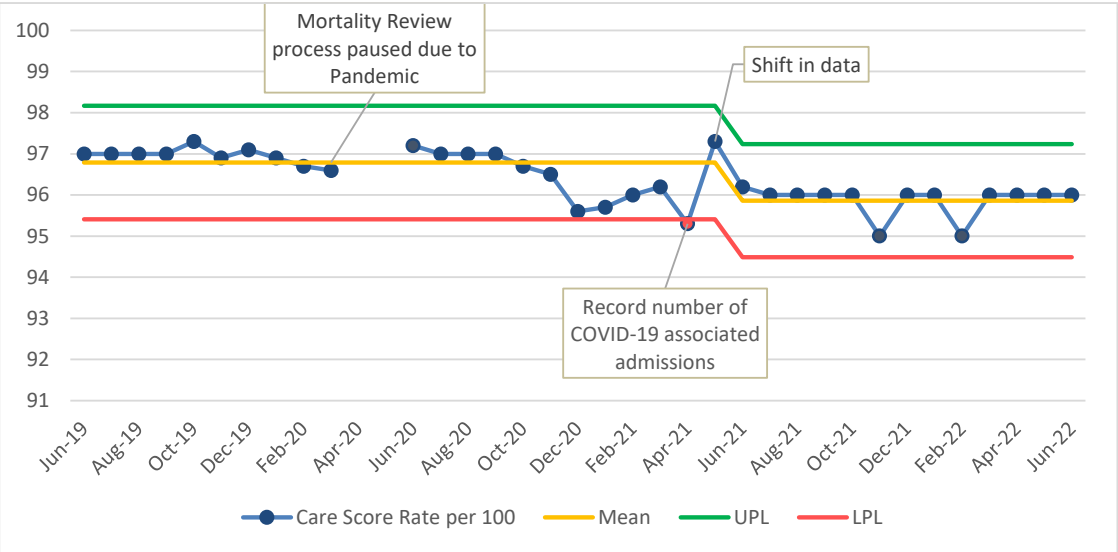
Overall care scores are included as part of the Structured Judgement Reviews (SJRs). These are from 1 – Very poor care to 5 – Excellent care. The percentage of cases reviewed with an overall care score of adequate, good or excellent for 2021/22 was 96%.

FIG 10| STRUCTURED JUDGEMENT REVIEW OVERALL CARE SCORES RATED ADEQUATE, GOOD OR EXCELLENT 2021/22



The following chart shows the cases where the care was overall rated as 3 (adequate), 4 (good) and 5 (excellent) as a rate per 100.

FIG 11| STRUCTURED JUDGEMENT REVIEW CARE SCORES OVER TIME JUN-19 – JUN-22 (DATE BY REPORTING MONTH)



There was a shift in the data below the mean from June 2021. This is likely due to the Medical Examiner reviewing nearly every death in the Trust meaning that the cases that do undergo a full SJR are ones that have either been referred by the medical examiner for review, are part of the mandatory review categories, or the specialty has requested to undertake an SJR. This means that the cases being reviewed are those where either the medical examiner or the specialty believes there is an opportunity for learning. A lowering of overall care scores could therefore indicate that, as a Trust, we are correctly recognising cases where learning can be identified. This more targeted approach to mortality reviews means we are getting more value out of the process.

Overall care scores of 3-5 went below the lower control limit of 95.4 per 100 deaths during April-21 which would correlate to the inclusion of deaths from January and February 2021 when the hospital had seen record numbers of patients admitted with COVID-19.

2.4 Quality Account Reporting

NBT is required to report the following data as part of the Trust Quality Account for 2021/22:

FIG 12| LEARNING FROM DEATHS QUALITY ACCOUNT REPORTING TABLE 2021/22

27.1	During 2021/22 2,035 of NBT's patients died. This comprised the following number of deaths which occurred in each quarter of that reporting period: 444 in the first quarter 469 in the second quarter 546 in the third quarter 576 in the fourth quarter
27.2	By 07/06/2022, 1,921 case record reviews and 9 investigations have been carried out in relation to 2,035 of the deaths included in item 27.1. In 0 cases a death was subjected to both a case record review and an investigation. The number of deaths in each quarter for which a case record review or an investigation was carried out was: 427 in the first quarter 453 in the second quarter 504 in the third quarter 537 in the fourth quarter
27.3	0 representing 0% of the patient deaths during the reporting period is judged to be more likely than not to have been due to problems in the care provided to the patient. In relation to each quarter this consisted of: 0 representing 0% for the first quarter 0 representing 0% for the second quarter 0 representing 0% for the third quarter 0 representing 0% for the fourth quarter
27.4	Recent learning from deaths identified in item 27.3: Not applicable
27.5	Recent actions undertaken as a result of the learning outlined in item 27.4: Not applicable
27.6	The impact of the actions undertaken in section 27.5 Not applicable
27.7	105 case record reviews and 0 investigations completed after 18/05/2021 which related to deaths which took place before the start of the reporting period.
27.8	0 representing 0% of the patient deaths before the reporting period, are judged to be more likely than not to have been due to problems in the care provided to the patient. This number has been estimated by counting those deaths that were subject to an investigation as a result of it being more likely than not that the death was due to problems in care.
27.9	0 representing 0% of the patient deaths during 2020/21 are judged to be more likely than not to have been due to problems in the care provided to the patient.

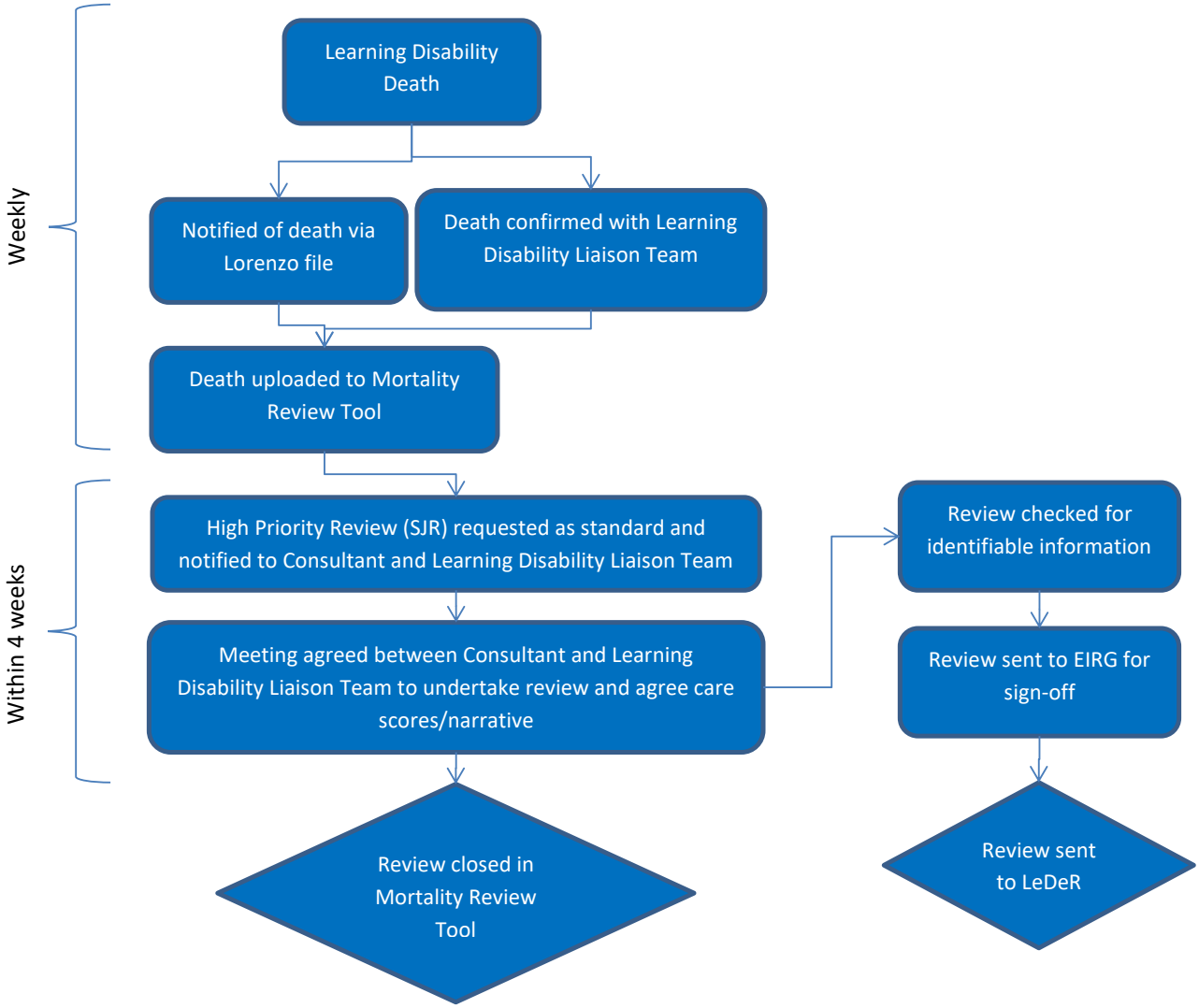
Section 3: Learning Disability and Autism Reviews

A full case note review is required for patients that have died at NBT with a learning disability or diagnosis of autism. During 2021/22 there were 22 deaths within NBT that met these requirements. National research has shown that on average, people with a learning disability and autistic people die earlier than the general public, and do not receive the same quality of care as people without a learning disability or who are not autistic. All deaths of people with a learning disability or who are autistic are required to be reported to the externally completed Learning from Lives and Deaths – People with a Learning Disability and autistic people (LeDeR) review programme where some are selected for case note review at a national level.

3.1 Enhanced Process Outline

The Learning Disability Mortality Review Process was enhanced at the beginning of April 2021 to incorporate a joint review between the specialty consultant reviewer and a member of the Learning Disability Liaison Team. This was enacted to ensure that reviews considered all aspects of care for these patients including the specialist care needed for patients with a learning disability. These cases are also presented at the trust's weekly Executive Review Group. The introduction of this process has ensured that learning and actions from these reviews are identified and appropriately followed through – linking the outcomes of mortality case note review to wider continuous improvement work being overseen and supported through the Learning Disability Steering Group. This also enables us to provide comprehensive information to the Learning from Lives and Deaths – People with a Learning Disability and autistic people (LeDeR) review team on how the Trust is improving care for patients with learning disabilities.

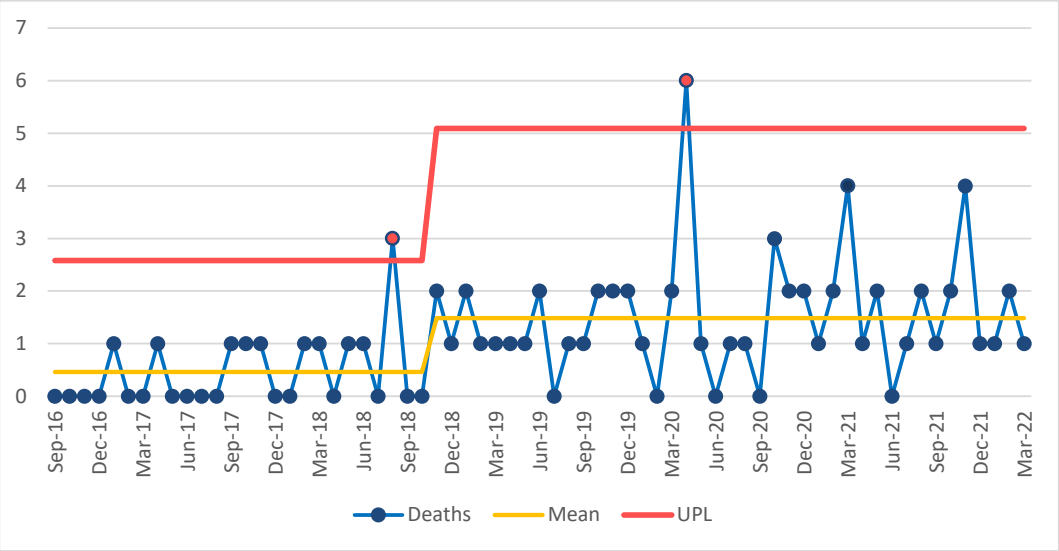
FIG 13| LEARNING DISABILITY MORTALITY REVIEW ENHANCED PROCESS



3.2 Mortality and Admission Rates

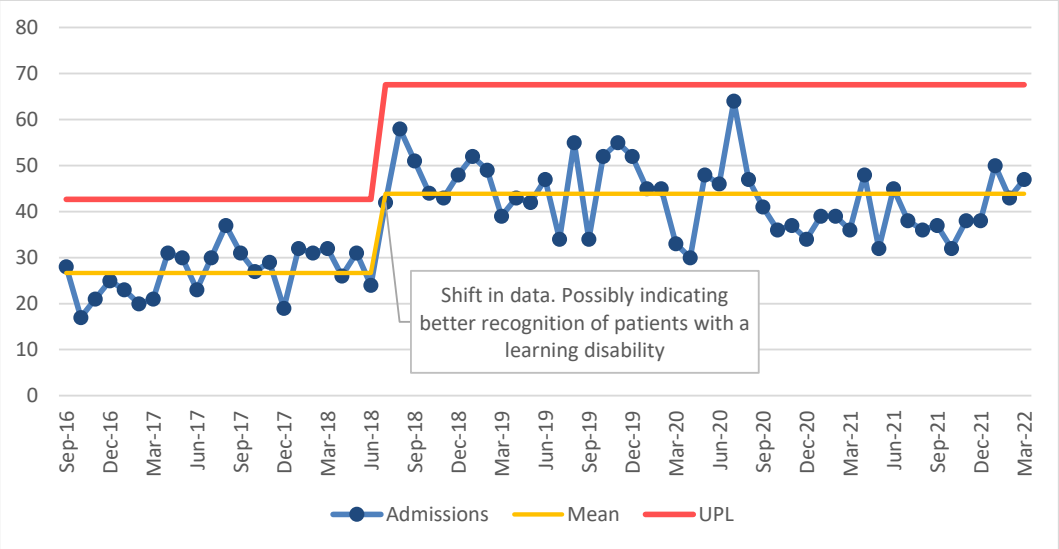
Mortality and admission rates for patients with a learning disability or autism have remained stable over the course of 2021/22. There have been no instances during this period of higher-than-expected deaths. The average number of deaths per month during 2021/22 was 1.5

FIG 14| LEARNING DISABILITY DEATHS SEPTEMBER 2016 – MARCH 2022 (BASED ON ADMISSION DATE)



One case of special cause variation in deaths above the upper control limit was observed over the pandemic period in April 2020. The below admissions chart shows that there was not a significant spike in admissions at this time.

FIG 15| LEARNING DISABILITY ADMISSIONS SEPTEMBER 2016 – MARCH 2022 (BASED ON ADMISSION DATE)

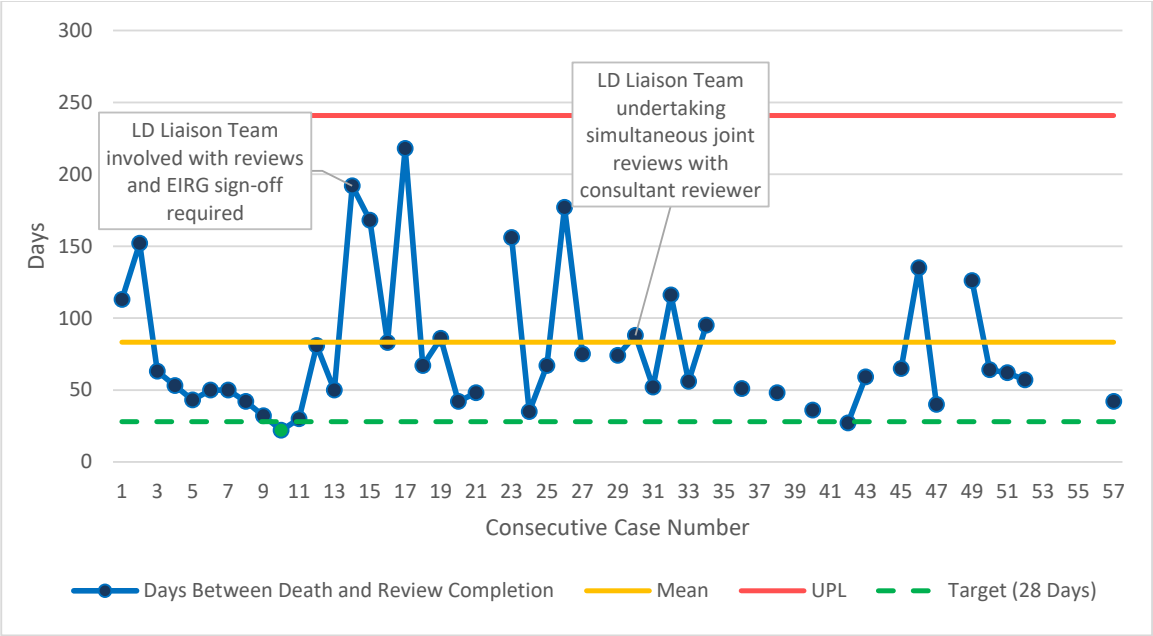


3.3 Mortality Review Completion Times

Due to the enhanced review process completion of mortality reviews for patients with a learning disability or autism can take more time than other high priority review categories. It is our view that the added benefit of a more thorough review outweighs the lengthening of the review process.

A target of 4 weeks from death to review is set for patients with a learning disability or autism, and currently this target is not achievable for NBT. The average completion time for these reviews during 2021/22 was 69.2 days.

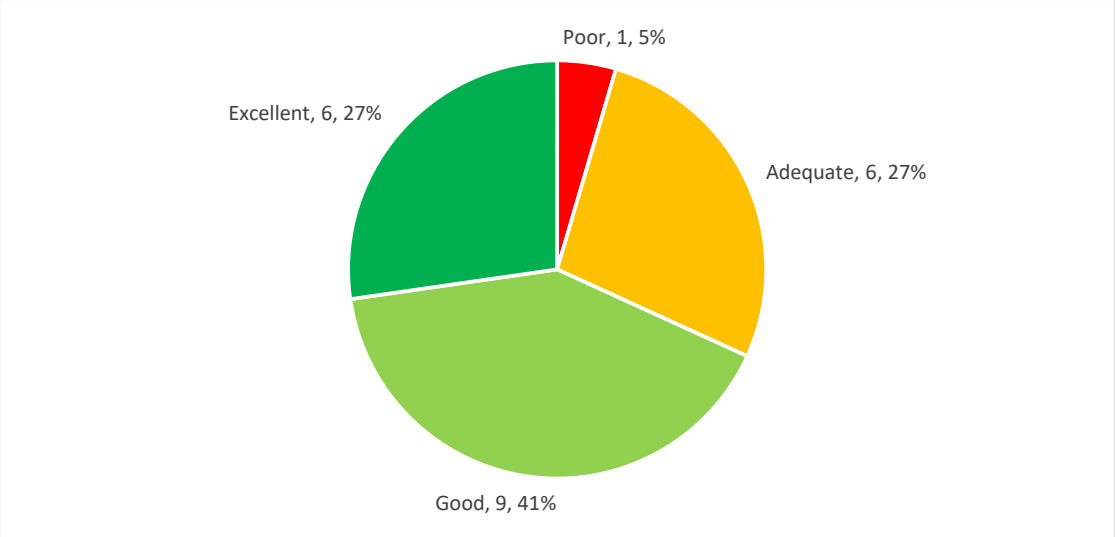
FIG 16| LEARNING DISABILITY DAYS BETWEEN DATE OF DEATH AND REVIEW COMPLETION – CONSECUTIVE PATIENTS (DEATHS BETWEEN NOV-20 – MAR-22)



3.4 Structured Judgement Review Care Scores

During 2021/22 there were 25 reviews undertaken of deaths of patients with a learning disability or autism. Care scores for these cases were mostly adequate, good or excellent.

FIG 17| STRUCTURED JUDGEMENT REVIEW CARE SCORES FOR PATIENTS WITH A LEARNING DISABILITY OR AUTISM (2021/22)



95% of cases reviewed received a care score of adequate, good or excellent. The one case where poor care was identified is currently undergoing review by the Executive Review Group where learning is being identified and actions taken forward.

Section 4: Medical Examiner Referrals and Actions

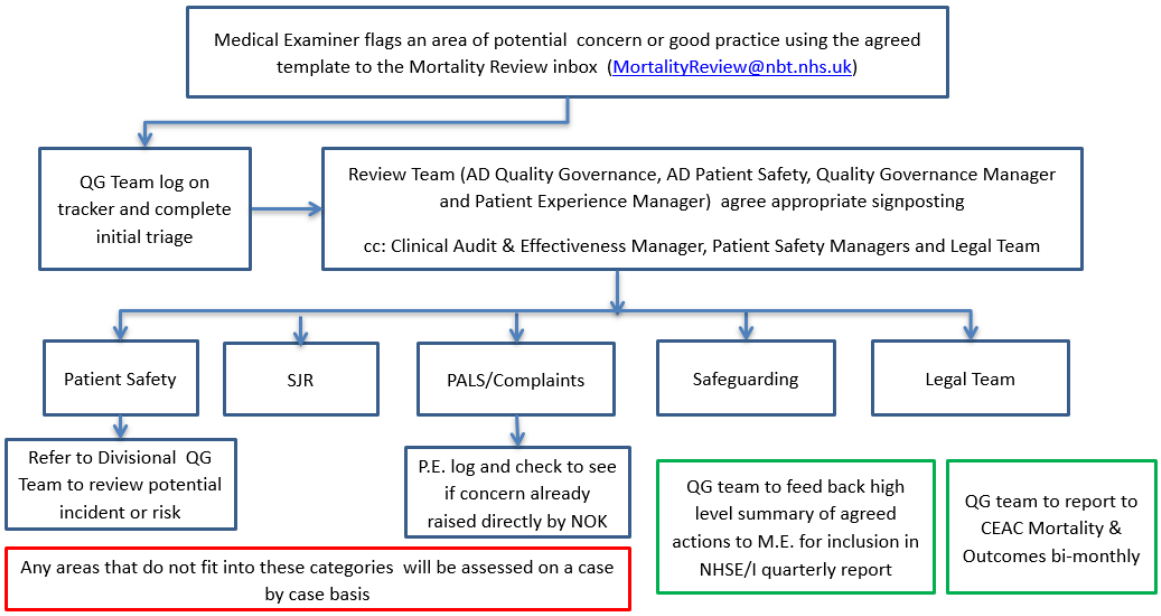
The Medical Examiner is an independent service that scrutinises all inpatient deaths in England. NBT and UHBW host a joint ME service for BNSSG. In November 2020 a process was developed to allow for the signposting of potential concerns referred by the medical examiner to NBT out to the relevant governance teams to identify learning, undertake further review and support families.

The medical examiner's office submits data to NHSE/I on a quarterly basis outlining the nature of referrals. Since the service's inception in November 2020 to end of March 2022 224 referrals have been made.

4.1 Process Outline

When NBT receives a referral from the Medical Examiner it is reviewed and assigned a category in order for the concern to be handled as part of already existing governance processes. The existing governance processes to which a concern can be assigned are; PALS, Patient Safety, Structured Judgement Review, Thematic Feedback, Safeguarding, Legal Team.

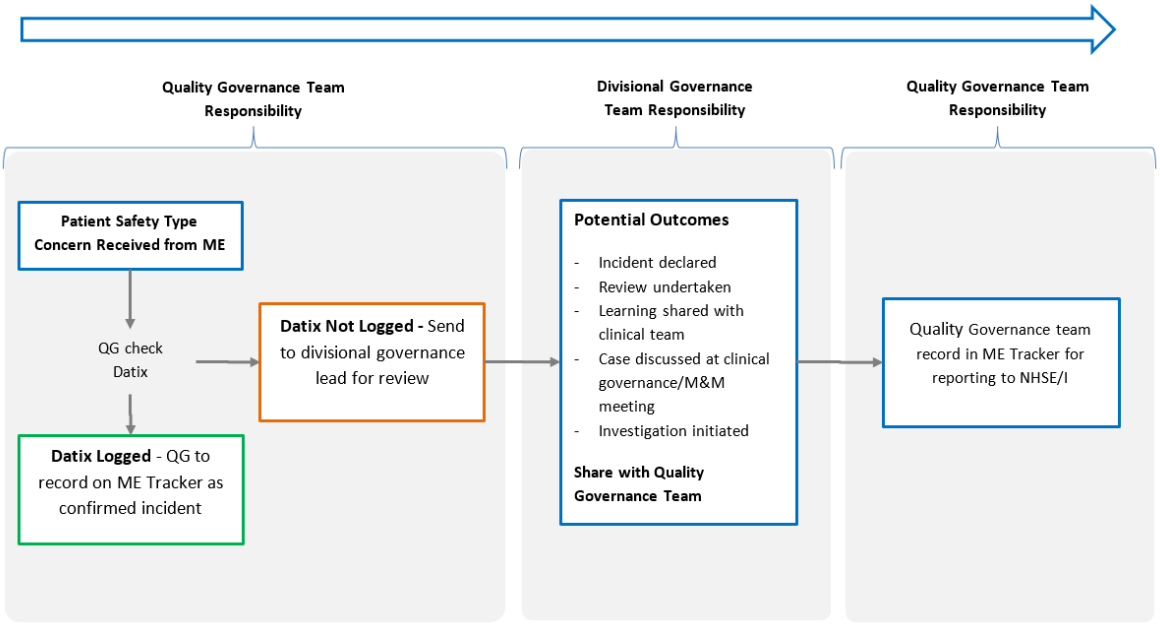
FIG 18| MEDICAL EXAMINER REFERRAL PROCESS



Divisional Quality Governance teams are included in all medical examiner referral correspondence to ensure they have oversight of all referrals in their division.

For patient safety type referrals Datix is checked in order to confirm whether an incident has occurred and the divisional teams contacted to confirm the outcome of the referral.

FIG 19| MEDICAL EXAMINER REFERRAL PATHWAY FOR PATIENT SAFETY TYPE CONCERNS

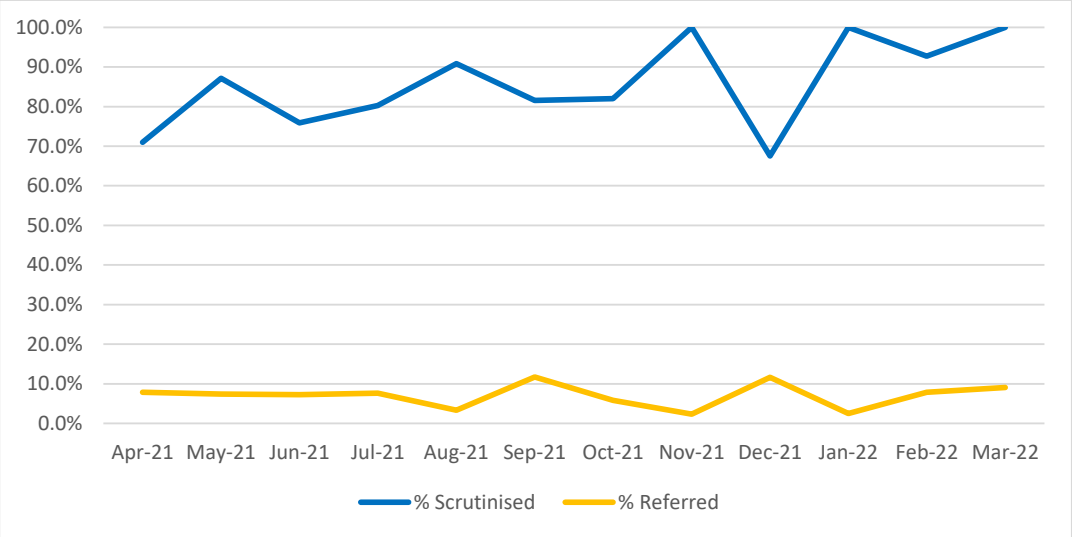


4.2 ME Referral Rates

The Medical Examiner service has been gradually increasing its scrutiny rate since November 2020. In March 2022 100% of deaths within the Trust were scrutinised by the Medical Examiner with an average of 85.7% over the 2021/22 period.

During 2021/22 there were 151 referrals made to NBT. Referral rates from the Medical Examiner into the Trust have remained stable with an average of 7.0% of scrutinised cases being referred each month in 2021/22. All of these concerns (100%) were signposted to a governance team within the Trust. Not all of these referrals constitute a serious concern raised by the medical examiner, and many of these concerns at the point of referral are already known to the Trust and being addressed appropriately.

FIG 20|ME REFERRALS TO NBT SCRUTINY AND REFERRAL RATES (APR-21 – MAR-22)

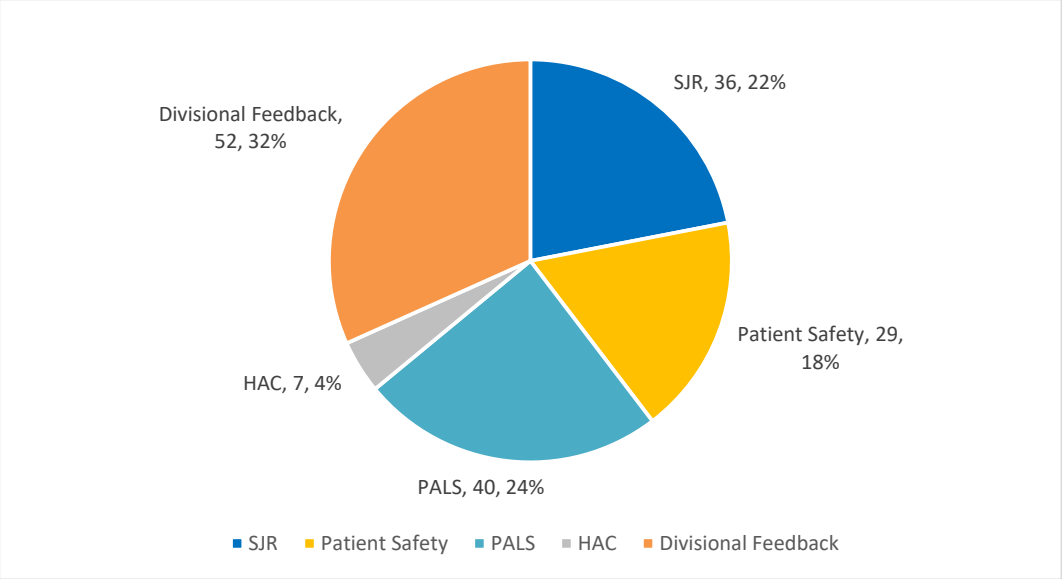


4.3 ME Referrals by Category and Theme

The Medical Examiner refers cases to the Trust that present a clinical concern as well as those where the next of kin feeds back experiential concerns. Concerns can cover both the well-being of the patient and the family and therefore, encompass a large range of feedback. It is important to understand and categorise the types of feedback to better understand where improvements may be needed.

There has been a relatively even distribution of referrals of concerns from the Medical Examiner during 2021/22. Hospital Associated COVID cases (HAC) now require a full case note review but are listed as a separate category.

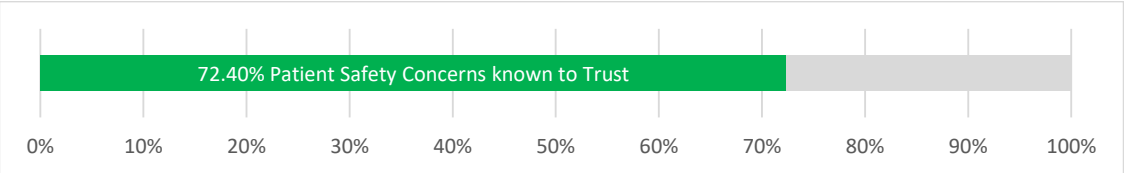
FIG 21|DISTRIBUTION OF ME REFERRALS BY GOVERNANCE TYPE (APR-21 – MAR-22)



As expected, most concerns raised as a patient safety concern are to do with the quality of clinical care provided to the patient, and most concerns raised where the next of kin has indicated that they would like to contact PALS pertain to patient or family experiential concerns. Of the 36 concerns where an SJR was undertaken 29 (80.6%) were due to the patient falling into a mandatory SJR category (Learning Disability or Autism, Serious Mental Illness, Elective Admission).

Of the 29 concerns that were referred as patient safety 13 (44.8%) were due to the patient having a fall during their admission. Of all patient safety type concerns 21 (72.4%) were already known to the Trust and had been recorded as a patient safety incident on Datix, which provides positive indications of our safety reporting culture.

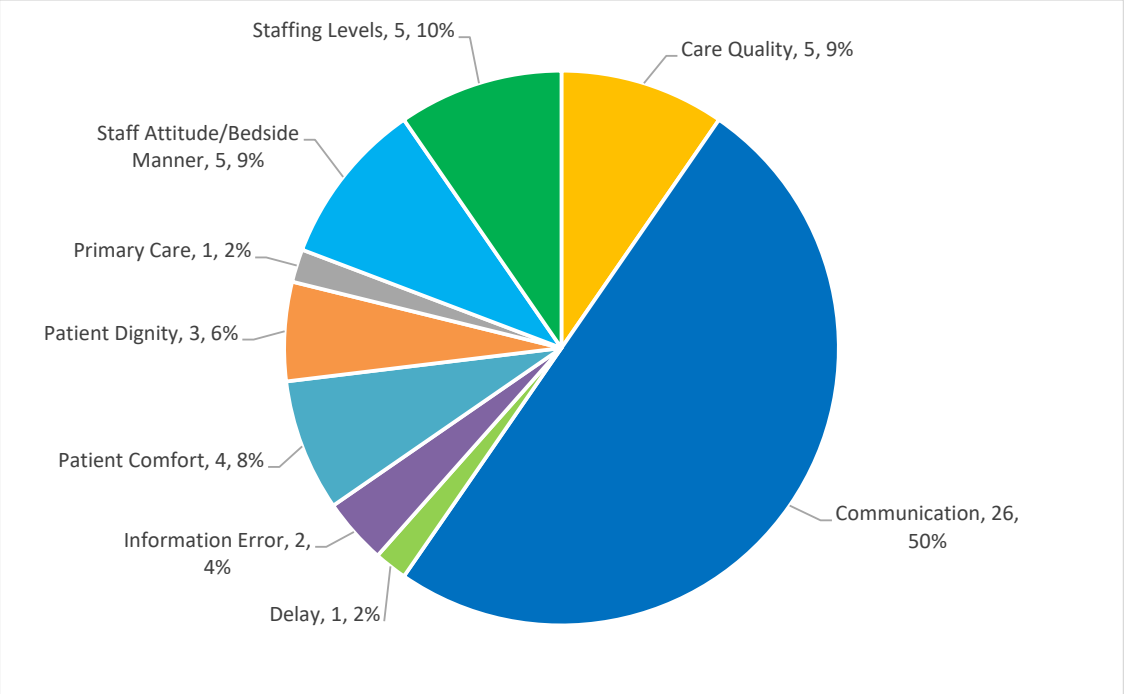
FIG 22|% OF PATIENT SAFETY TYPE CONCERNS KNOWN TO TRUST (APR-21 – MAR-22)



The remainder were reviewed by the division and it was deemed that there was no incident, but it may be appropriate to undertake a learning review. Many of the concerns that were not deemed an incident were raised by family members and the division was able to liaise with family via PALS.

Of the 52 referrals that were passed to the division to form thematic feedback, the following categories were recorded:

FIG 23 | DISTRIBUTION OF THEMATIC FEEDBACK (APR-21 – MAR-22)



50% of referrals for thematic feedback to divisions were communication concerns raised by the next of kin. Most often this was a lack of information from the ward regarding the condition of their relative. There were also concerns raised from the family regarding the bedside manner of staff with 5 families citing incidents of rudeness. Several families also raised concerns regarding the level of staffing on the ward acknowledging that this may reduce the level of care available to their relative.

Work will need to be undertaken with the divisions to best determine how this feedback can be reviewed and considered as part of quality improvement work.

Section 5: Learning and Continuous Improvement

5.1 System/Process Learning

System and process learning is about identifying how we can improve our approach to learning from deaths in order to ensure that the time taken to complete these reviews is valuable. It is important that we are able to extract learning and tangible actions from these reviews in order for us to improve our practices. Furthermore, the inputs to the process need to be of quality to ensure that learning can be identified. We have undertaken the following work during 2021/22 to understand and improve our learning from deaths processes.

5.1.1 Learning from Deaths Development Programme 2021-22

The Learning from Death Development Programme was agreed at the March 2021 Clinical Effectiveness and Audit Committee. There were 4 development sessions running from May to October 2021 that covered the following three improvement themes; Improving the Quality of Structured Judgement Reviews, Linking Learning from Deaths with Existing Governance Processes and Enhancing their Effectiveness, and Better Understanding and Utilising Data from Existing Sources for Mortality, Quality and Safety. The purpose of the sessions was to establish the principles for a Learning from Deaths process including its inputs and outputs, as well as its position in the context of the wider governance process.

These sessions provided the foundation for work being undertaken in conjunction with UHBW and the Better Tomorrow Programme – a national initiative to improve the undertaking and outputs from mortality reviews.

FIG 24| LEARNING FROM DEATHS DEVELOPMENT PROGRAMME SUMMARY OF SESSIONS

Theme	Driver	Learning
Improve the quality of Structured Judgement Reviews	Driver 1: Provide comprehensive training to clinicians undertaking SJRs	Away day format: Strategic high-level training/guidance session, peer review element, use as group review session to consider complex/difficult cases, clinician led
	Driver 2: Review the wording used in SJRs including the information to support reviews as well as definitions of terms	SJR to be adjusted appropriately to capture learning and action either as a trigger tool to take into a learning process, or as an outcome document following the agreement of action
		Questions to be asked at the start of the tool regarding any incidents, harm, or very poor care in order to ensure that governance processes regarding the above issues are followed
		Change the wording to prompt the reviewer to consider a holistic approach to the review of care rather than focusing on individual 'events' during the course of the patient's stay

Theme	Driver	Learning
		Not to focus on second guessing clinical decision making as these are very often not clear cut
		Specific focus should be brought to the first 24 hours in hospital
		Guidance developed regarding the meaning of the terms 'very poor care', 'poor care', adequate care', 'good care', 'excellent care'
		Factors to be considered by reviewers: adherence to guidance, harm to patient, friends and family test, course of action needed following the review
	Driver 3: Include specialist teams in review process	Recognised the value of specialist team input to reviews
		Proposed system of flagging for specialist input – either by consultant or specialist team
	Driver 4: Undertake targeted reviews for cohorts of patients	Cohort reviews recognised to be incredibly helpful – better standard of review, higher levels of scrutiny, more statistically robust, easier to extract learning themes
		Mortality Reviewers half-day could be a conduit for cohort review
		Cohort reviews align with PSIRF
		Strategies for identifying cohorts of patients: Assessing existing data sources to target areas the Trust has identified as in need of improvement, asking clinicians to suggest/identify areas for review, considering identifying patients by process/pathway rather than just diagnosis group or procedure
	Driver 5: Define and record taxonomy of themes for learning	Thematic categories used during pandemic mortality reviews – acknowledge that these categories can evolve as needed following further cohort reviews
Link Learning from Deaths with existing governance processes within the Trust and enhance their effectiveness	Driver 10: Define process for reviewing poor and very poor care scores	Cases with poor care scores should be discussed at M&M meetings and appropriate action taken following agreement by the specialty.
		Poor care scores need further review – 'output' i.e. action should not be implemented until there is consensus
		Specialty Mortality Leads could take on the role of further review of poor care scores if not feasible at an M&M

Theme	Driver	Learning
	Driver 11: Improve the quality and effectiveness of M&M meetings	Frequency of M&M meetings are an issue – cases may not be fresh in minds and learning/action could be delayed.
	Driver 12: Understand how mortality review will interact with the new PSIRF framework	The move to cohort reviews of cases is in-line with the approach of PSIRF
		A move away from a prompt to register an incident in Datix as a result of a poor care score and a move towards prompting a learning review is in-line with the approach to patient safety events as part of PSIRF
Better understand and utilise data from existing sources for mortality, quality and safety	Driver 6: Triangulate existing data sources (Mortality Review database, Medical Examiner referrals, CHKS, Datix)	Ensuring mortality reviews and medical examiner referrals can be undertaken in Radar. Outputs can then be triangulated with other governance data e.g. complaints, incidents. CHKS can be better utilised, however is heavily reliant on quality of coding.
	Driver 7: Refine and finalise comprehensive BAU reporting on activity, outcomes and learning	BAU reporting should include SPC run charts of key processes and outcomes including learning disability deaths, mortality review outcomes, and medical examiner referrals. Should also include thematic analysis to extract learning.

5.1.2 Collaboration with UHBW and the NHSE/I National 'Better Tomorrow' Mortality Network

As part of building on the work undertaken as part of the Learning from Deaths Development Programme in 2021, NBT is working in collaboration with UHBW, supported by the national team from the Better Tomorrow Programme (NHSE/I hosted), to strengthen our approach to Learning from Deaths and become a national exemplar.

Subsequently through the ongoing relationships with UHBW and through proactive contact with the national Better Tomorrow Programme team, we have agreed the following areas of focus:

1. **Mortality case reviews, data & wider contextual data** – referencing the work the national team has done with the national 'Making Data Count' team to really hone our mortality data reviews (CHKS and SJR scores/qualitative info.) Also engaging with our public health colleagues to consider wider aspects around the impact of health inequalities on mortality and to drive something meaningful from this in terms of learning.

2. **Re-vitalising/re-education regarding SJRs and their completion** - potentially using the SJR+ tool and also supporting clinicians undertaking case note reviews.

3. **Interface between trust-wide 'LFD governance' & specialty/cross-specialty M&Ms** – how to better integrate these and ensure learning and follow up action is seamlessly linked and used for improvement.

4. **Medical Examiner Service interface** – managing the more generalist reviews these entail vs. more specialist knowledge that specialties had when screening – communication, trust and learning are areas we need to consider in light of some difficult cases in the past few months. Furthermore improving the process and sharing thematic learning between the Trust and the medical examiner service.

5. **Standardised processes for sharing learning across the Trust**.

The next steps will be to agree the data set we will be collecting from an SJR jointly between NBT and UHBW. This will be derived from the SJR+ tool designed by the Better Tomorrow Team. We will then be able to produce comparable outputs across Trusts that will aid in sharing of learning and provide a template for reporting at Board and to the CCG.

Once corresponding processes and approaches have been agreed we will be designing cross-trust training sessions and materials with support of the national team to improve the quality, understanding and outputs of SJR.

5.2 Clinical/Case Level Learning

Although we understand that the outputs from mortality reviews need to be much more visible and accessible at every level we have been able to pinpoint some of the learning and actions for improvement that have resulted from specific case reviews. Much of this improvement work is down to individuals recognising when a case presents an opportunity for learning. We aim to make this much less of an individual responsibility with greater accessibility of outputs from mortality review over the coming year.

5.2.1 Learning within Specialties

Specialty Mortality Leads have access to the outputs of all reviews undertaken in their area and as such are in a unique position to be able to identify where actions need to be taken. Cases where learning is identified are often appropriate for further discussion as part of the specialty's mortality and morbidity meeting where specific actions can be identified and improvement work undertaken.

Below are examples of learning from each Division within the Trust where certain specialties have enacted changes as a result of mortality review.

Clinical Division: Anaesthetics, Surgery, Critical Care and Renal

Urology

In Urology, the care of the elderly liaison service has made a significant difference to the care we provide to patients who are coming towards the end of life with significant co-morbidities. They are admitted with urological issues but require holistic care and open conversations about their prognosis and involvement of relatives. A number of our mortality reviews have commented on the benefits of this multidisciplinary approach.

Vascular

Due to declining aneurysmal disease prevalence within the wider population, and a unit bias toward endovascular repair, there is a recognition that outcomes are related to volume. Therefore, we have reduced the number of surgeons offering intervention for elective open AAA repair from twelve consultants to three. Measurement of outcomes occurs quarterly with a yearly summation in the form of an annual report. In response to identified barriers to achieving the national standard of intervention within 8 weeks of referral to vascular surgery, we are refining the pathway for this group of patients via a QI workstream.

We are in the process of extending the above remits to carotid artery disease. Again, disease prevalence and improvements in medical therapy have seen numbers requiring carotid endarterectomy decline. We have similarly reduced the number of consultants offering this intervention, and work is ongoing to improve the pathway for this group.

Clinical Division: Medicine

Care of the Elderly

Over the last year we have noted recurring themes from our mortality reviews and M&Ms and have made the following areas improvement priorities within the service:

- Highlighting the need for neurology examination for patients with neurological presentations
- Highlighting the need to avoid acronyms in patient notes
- Encouraging the discussion of frailty/guarded prognosis with families
- Highlighting the need to document tertiary survey in trauma patients
- Monitoring of sepsis care
- Monitoring of symptom control out of hours

Specific actions were also undertaken as the result of individual cases:

Case Study 1

Learning Point: A patient with a lung cancer diagnosis was lost to onward referral.

Action:

- All two week wait pathways were collated onto the Care of the Elderly governance webpage to provide easy accessibility and a single source of truth
- New protocols were put in place for secretaries to chase unopened scan results from 32a discharges, and to collate discharge investigations and add them to the consultant virtual clinic

Case Study 2

Learning Point: A patient was discharged from Elgar to P3 bed and was then re-admitted soon after discharge with sepsis. The patient had had recent medical reviews and observations on the day of discharge with nothing to suggest the development of sepsis. However, there was acknowledgement that there is no routine medical review on Elgar after the first day or two, that these patients are often very frail and at risk of deterioration, and that the current SOP does not require observations before discharge. This was identified as an area of vulnerability.

Action: To ensure all patients have a set of observations done on the day of discharge from Elgar

Haematology

Clinical Haematology M&M meetings are held in such a way to really promote learning from cases. We do this by:

- Ensuring that anyone can suggest a case to be discussed (including non-clinical staff)
- Operating and open/no blame culture in meetings helping people to find their voice and constructively contribute
- Having follow-up conversations with staff to promote wellbeing
- Focusing on positives as well as learning from the negatives

- Feeding meeting outcomes back to the team

Examples of Learning

One patient with central nervous system lymphoma was transferred to the team at UHBW, on review there were some delays identified in the process that with changes agreed by the teams at NBT and UHBW were improved.

We also enacted a change in practice to try to avoid excessive toxicity in our increasingly elderly myeloma patient cohort by enrolling into the National FITNESS trial looking at dose adjustments in first line chemotherapy. It is hoped that with these adjustments we can try to avoid early treatment related morbidity and mortality.

Infectious Diseases

We have enacted the following changes in our M&M review process since the latter part of 2021:

- We formally review all our cases
- We've developed more regular rota to discuss cases prioritising more complex/urgent cases
- We've ensured the meeting follows a regular structure with case presentation using a standardised PowerPoint template
- We ask both medics and nursing staff to join

Example of Learning

One of the outcomes of a recent M&M meeting was a review of all the falls in our isolation unit on Ward 27B after we had a serious fall. A higher incidence of falls was not noted on the unit previously, however we did recognise a bias due to the fact we would prioritise younger/less severely ill patients to these wards. We are therefore considering reviewing the falls incidence in the following year. We have also looked to foster closer working relations between the nursing staff and doctors working on the isolation unit.

Clinical Division: Neurological and Musculoskeletal Sciences

Neurosurgery

We have identified the following learning as a result of mortality reviews over the course of the past year:

- We had one elective death mid-COVID which prompted a length neuro-oncology discussion. The outcome of this discussion was sub-specialty morbidity meetings which were found to be a really positive experience. It also resulted in clearer stratification of patients for different post-operative areas.
- The move to the Medical Examiner Service reviewing cases has meant we have had more time to discuss complex cases enabling the identification of better learning. Previously the large amount of administrative time needed from clinicians to screen each death meant that we weren't targeting our capacity where the greatest benefit could be realised.

- More work needs to be undertaken to perform trend analysis on referrals from the Medical Examiner.

Stroke Services

Reviewing the outcomes from mortality meetings within the past year, the following are examples of improvements we have undertaken:

- The hemicraniectomy proforma was designed and used in response to late referrals, but this is also now used for patients who may benefit from a time sensitive intervention
- We enacted a specific focus on palliative care training for ward nursing staff. We subsequently received praise via the medical examiner for the palliative care skills from a patient's family.
- We focussed on and highlighted the need for safety of transfer to the CT scanner. This was by placing emphasis on testing of GCS and consideration of airway management.
- We disseminated a consultant-wide reminder of the importance of reviewing available blood tests (and taking appropriate action) at post take ward round.

Clinical Division: Women and Children's Health

Obstetrics and Gynaecology

We fortunately, very rarely have any deaths in our patient pool. In the last 2 years we have had 2 expected deaths of patients on the purple butterfly pathway with a cancer diagnosis. We discussed these cases at our morbidity and mortality meeting. The care given on the ward was noted to be excellent – supportive and caring with lovely feedback from the families.

5.2.2 Learning from Poor Care

During 2021/22 there were 9 cases of poor care. This is comparatively rare. A detailed analysis is undertaken on a case-by-case basis with lessons identified and appropriate actions initiated. Some of these cases include patients with complex multiple system disease treated by multiple teams either simultaneously or at different time points. In some of these cases, the poor care score highlights challenges of providing a complex level of care and intervention by a multi-professional team when there are differences in medical opinions. In these situations following a poor care score, the individual cases are reviewed in a multi-disciplinary setting to understand the lessons that need to be learnt, identify the processes that need challenging and changing and to improve communication in order to improve care and decision-making in the future.

MDT involvement and transparency at M&Ms is one of the key areas that we will be working on moving forwards.

5.2.3 Learning from Learning Disability Case Reviews

Cases where it has been identified that the patient has a Learning Disability or Autism undergo an enhanced review process whereby input is taken not only from the specialty consultant but also the learning disability liaison team and the outputs are scrutinised by the Executive Review Group before being fed into the national review team and locally to the Trust Learning Disability Steering Group. Because of this, these reviews can provide much more insightful learning that feeds into tangible

actions. Outputs from these reviews can also be used to support and highlight agreed improvement work for the steering group as part of their quality focus for the year.

Positive Feedback Reported

Overall, the majority of phases of care and overall assessment scores were rated as 3+ ('adequate' or better). During a global pandemic this reflected the strong ongoing focus on supporting patients with these characteristics despite the significant clinical and operational pressures. Exemplary examples of good care provided clinically and in a person-centred manner, with appropriate adjustments and family/carer involvement were seen and shared into the BNSSG LeDeR Steering Group.

Areas to Focus Improvement

The three primary themes that emerged during the year were:

1. Non-referral to the Learning Disability Liaison Team, or in some cases later referral, which either removed, or reduced the support they were able to provide.
2. Limited documentation of how clinical teams engaged with the Liaison Team and how this supported reasonable adjustments for patients that aided their personalised care.
3. Weak or absent documentation in relation to mental capacity and related processes, DNACPR completion and communication with families or carers.

Improvement Work Undertaken During 2021/22

We have:

- Introduced independent senior consultant and learning disability liaison nurse (not involved in patient's care) Structured Judgement Reviews (SJRs) of every death of a patient with a learning disability within the hospital to ensure that there is direct learning and development as a result of each review.
- Increased the liaison team to include weekend working, lowered eligibility for the service and included autism. These posts are now permanently funded by the CCG.
- Developed a BNSSG Hospital Passport and Reasonable Adjustment Checklist for autistic people – with the Bristol Autism Spectrum Service (BASS), and with people with autism.
- Increased the number of referrals received by developing notifications with BI (daily report from alerts) and has increased staff awareness for the need for referrals.
- Improved communication with clinical teams using all electronic forms (Care – Flow and flow) for updates and to add reasonable adjustments
- Developed plans for 2022/23 to include addressing further areas of challenge, such as through undertaking a DNACPR audit, better completion of Mental Capacity Assessments, IMCA involvement and Best Interest Meetings and establishment of a Hospital User Group (HUG) of experts by experience and actively use their feedback in development of services.

5.2.4 Learning from Medical Examiner Referrals

40 concerns were referred from the Medical Examiner which required a Structured Judgement Review during 2021/22. Of these 40, 29 (72.5%) have been completed to date. There were many positive comments outlined in the reviews, as well as comments highlighting areas for improvement regarding things that we are aware of across the Trust such as the need for better communication and improved documentation. However, a number of more specific learning points were identified as a result of these reviews as outlined below:

- MDT approach supports the patient, family and professionals well in difficult circumstances
- Issue with ID bracelets in the mortuary addressed
- Involve NOK in all decisions (including those surrounding ceiling of care) and any changes in condition
- Finding a more reliable way to access community COVID swab results in hospital
- Ongoing work on ward regarding preventing and managing pressure injuries
- Highlight the importance of early discussion about end of life care when a significant medical event occurs in a patient with severe co-morbidities
- Ongoing work to encourage a culture of identifying patients likely to be in their last year of life and encourage discussions around this
- Importance of clearly documenting clinical findings including neurological examination in order for other people to be able to monitor progress and more accurately identify degree of deterioration
- There is a need to refer patients with haemorrhagic strokes to the Stroke team, even in the scenario when a patient is for palliative management, as their care may be better delivered on a stroke unit
- Revisit the law and procedures regarding patients with a lack of capacity and the use of DOLS, as well as the role of the IMCA service
- Clarify with teams about the criteria for involving the LD team, and importance of involving them early and consistently during admission
- Importance of involving the MDT, including in the community
- Patients need early palliative care (<24hrs) review as well as mental health team review within 48 hours
- Importance of early recognition of dying and preparation of family for death
- Understand PEG feed in patients who are low GCS and what nursing and medical care considerations are needed
- Gastro/medics should be involved earlier to avoid delays
- Any planned intervention should be takin in the context of the overall clinical picture of the patient
- Apologising immediately when things go wrong
- Importance of recognising frailty
- Highlight COVID-19 swabbing guidelines for inpatients to the ward team
- Use of early ICU reviews to help guide ceiling of care
- Examples of good practice across the multi-disciplinary team

- Good escalation from ED to SpR to consultant
- Early involvement in palliative care services can help support patients in their transition to end of life care
- Importance of clear documentation of discussion with patients and family where patients have a learning disability
- Improved use of capacity assessment documentation
- Useful to have had a definitive plan regarding oxygen earlier in the admission as to not delay discharge to care home
- Good practice showing person centred and compassionate care for a patient with severe learning disabilities
- Notes should show clear rationale for all decisions being made
- Allergy recording to be improved
- Importance of dying at home
- Complexity of co-morbidities necessitates a complex multi-disciplinary approach
- Management in line with patient's own and family's expectations

5.3 Continuous Improvement

It is important that learning outcomes from mortality review are considered and acted upon throughout the year – not only regarding the clinical care but also about how we can improve our processes to ensure that we identify useful learning.

5.3.1 Plan for the Coming Year

We aim to work closely with UHBW and the NHSE/I Better Tomorrow team on the goals outlined in section 5.1.2.

Most notably we hope to develop and introduce the mortality review tool within the new clinical governance system – Radar. The hope is that Radar will support more collaborative working in terms of reviewing case-notes across specialties and specialist teams. Radar will facilitate more visibility and accessibility for the outputs of reviews allowing clinical teams to get real value out of their completion.

The development of real-time accessible reporting should facilitate greater opportunities for extracting learning not only from individual reviews but also on a much larger scale – pinpointing themes for improvement across the Trust.

Some key areas of focus include:

- Reverse the decline of completion rate for high priority reviews
- Reduce the completion time in days of Learning Disability mortality reviews
- Work with divisions to understand how thematic feedback can be used to drive improvement
- Revisit the requirement for Hospital Acquired COVID as a mandatory review category

Appendices

Appendix A – Key Indicators Table

FIG 25| KEY INDICATORS TABLE

Section	Indicator	Outcome	Interpretation
1.1	Mortality Indicators (SHMI)	92.45	Within expected range
1.2	Mortality Indicators (HSMR)	94.59	Within expected range
2.1	Mortality Review Completion Rate	95%	Within expected range
2.2	Mortality Review Completion Rate (High Priority Cases)	83%	Potential cause for concern
2.2	Mortality Review Completion Rate (Elective Cases)	75%	Potential cause for concern
2.2	Mortality Review Completion Rate (Hospital Acquired COVID Cases)	69.2%	Potential cause for concern
2.2	Mortality Review Completion Rate (Patients with a Serious Mental Illness)	70.8%	Potential cause for concern
2.2	Mortality Review Completion Rate (Patients with a Learning Disability or Autism)	88%	Potential cause for concern
2.3	Mortality Review Care Scores (Adequate, Good, Excellent)	96%	Within expected range
3.2	Learning Disability Mortality by Admission Date	1.5	Within expected range
3.3	Mortality Review Completion Time (Days)	69.2	Potential cause of concern
3.4	Learning Disability Mortality Review Care Scores (Adequate, Good, Excellent)	95%	Within expected range
4.2	Medical Examiner Referrals to NBT	151	Within expected range
4.2	Medical Examiner Referral Signposting	100%	Within expected range
4.2	Medical Examiner Referral Rate	7.0%	Within expected range
4.3	Patient Safety Concerns Known to the Trust	72.4%	Within expected range

Appendix B – Glossary of Terms

FIG 26| GLOSSARY OF TERMS

AAA	Abdominal Aortic Aneurysm
AD	Associate Director
BAU	Business as Usual
BNSSG	Bristol. North Somerset, South Gloucestershire
CCG	Clinical Commissioning Group
CCS	Certified Coding Specialist
CEAC	Clinical Effectiveness and Audit Committee
CT	Computerised Tomography
DNACPR	Do Not Attempt Cardio-Pulmonary Resuscitation
DOLS	Deprivation of Liberty Standards
ED	Emergency Department
EIRG	Executive Incident Review Group
GCS	Glasgow Coma Score
HAC	Hospital Associated COVID
HSMR	Hospital Standardised Mortality Ratio
HUG	Hospital User Group
IMCA	Independent Mental Capacity Advocate
IPR	Integrated Performance Report
LD	Learning Disability
LeDeR	Learning from Lives and Deaths – People with a Learning Disability and autistic people
LFD	Learning from Deaths
M&M	Mortality and Morbidity
MDT	Multi-disciplinary Team
ME	Medical Examiner
NBT	North Bristol Trust
NHSE/I	NHS England/Improvement
NOK	Next of Kin
P3	Pathway 3
PALS	Patient Advice and Liaison Service
PE	Patient Experience
PEG	Patient Experience Group
PSIRF	Patient Safety Incident Reporting Framework
QG	Quality Governance
QI	Quality Improvement
SHMI	Standardised Hospital-level Mortality Indicator
SJR	Structure Judgement Review
SOP	Standard Operating Procedure
SPC	Statistical Process Control
SpR	Specialty Registrar
UHBW	University Hospitals Bristol and Weston

NHS
North Bristol
NHS Trust

Learning from Deaths Annual Report 2021-22 – Key Messages

Quality Committee
14 July 2022

Exceptional healthcare, personally delivered

Overview

Mortality Indicators – NBT remains within 'normal range' for SHMI and HSMR; no CQC mortality alerts raised in 2021-22.

Mortality reviews – 95% completion rate, which includes Medical Examiner reviews. This will further increase during 2022-23 driven by ME 100% reviews now completed following full incorporate of ICU.

Mandatory full SJR review – completion rates are not as high as required and a strong focus on this with divisional governance oversight, supported by the central processes will drive improvements for 2022-23. A strong ongoing review approach continues for patients with Learning Disability or Autism, fed back into the system-wide LEDER process..

Medical Examiner concerns – a structured review approach has been successfully implemented to manage concerns flagged by the Medical Examiner. This is recognised by the Lead Medical Examiner within his annual report. Further developments during 2022-23 will focus on managing communication with specialty teams where potential significant concerns are identified.

Collaboratively developing our approach – a development programme in 2021-22 identified areas for further development work and these have been explored collaboratively with UHBW Foundation Trust and with the engagement of the national NHSE/I 'Better Tomorrow Team' A joint development plan is being compiled to move forward across both trusts.

Learning & Continuous Improvement – specialty level learning and improvement actions reflected across all clinical divisions, as well as for patients with a Learning Disability or Autism. These are set out within section 5 of the report and reflect a positive safety culture, even during the pressures of the Covid-19 pandemic waves and interim recovery pressures.

Learning From Deaths – Key Indicators

North Bristol NHS Trust

Appendix A – Key Indicators Table

FIG 25| KEY INDICATORS TABLE

Section	Indicator	Outcome	Interpretation
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4.3	Patient Safety Concerns Known to the Trust	72.4%	Within expected range

Good performance across most metrics, which anecdotally benchmarks well with other acute trusts in the South West.

Primary improvement focus for these process measures is to tighten up the **turnaround time and completion rates for SJRs**.

Discussions with Clinical Divisions and specialties will focus on ensuring that specialty completions are reviewed within the division during the year to drive improvement where needed.

During the remainder of 2022-23 we will transition the processes from the current SQL database into the new Radar system.

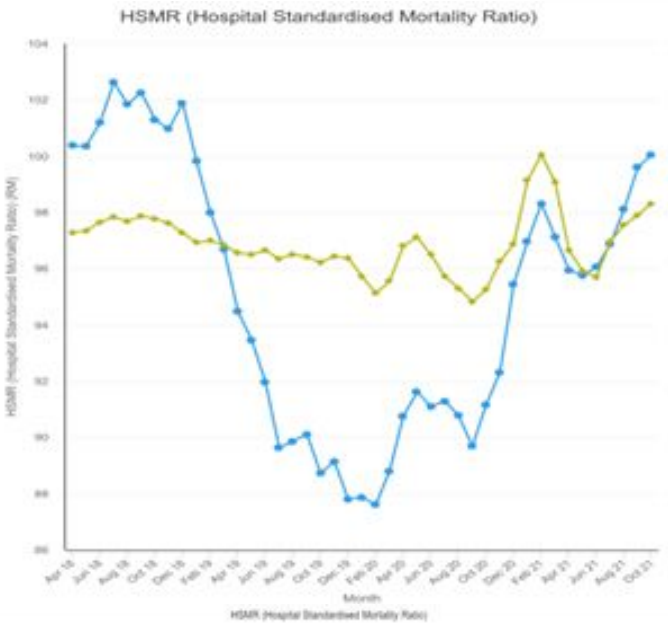
This will improve the visibility of SJRs alongside other governance processes and aid tracking of actions arising from individual reviews.

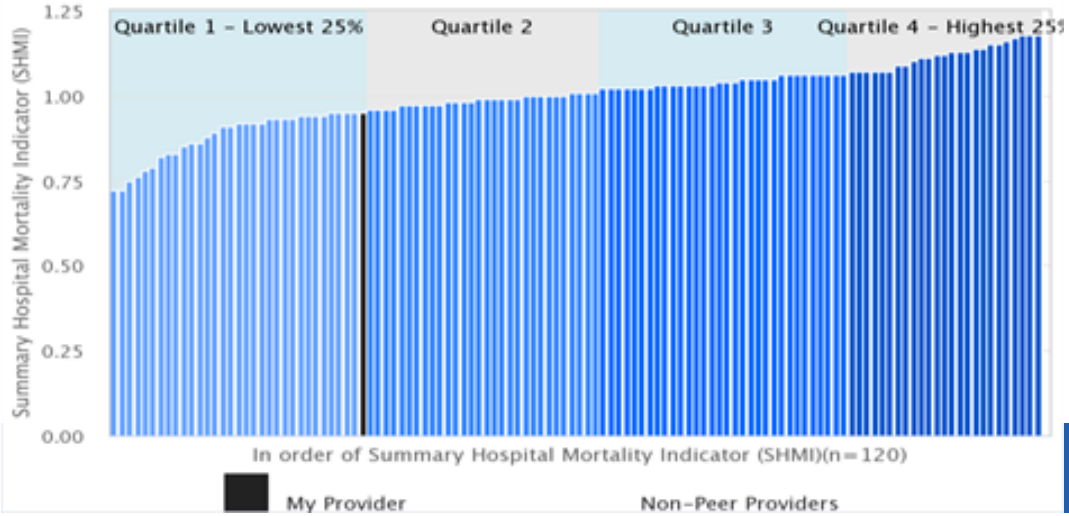
Mortality Indicators

NHS North Bristol NHS Trust

Blue line – NBT

Green Line – NBT Peer comparison





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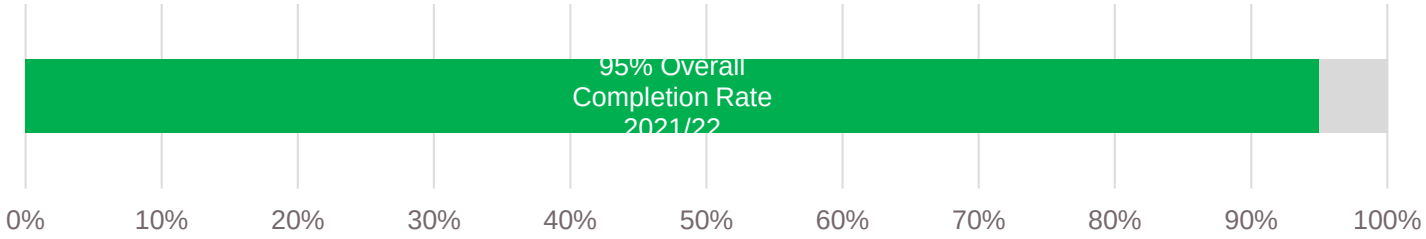
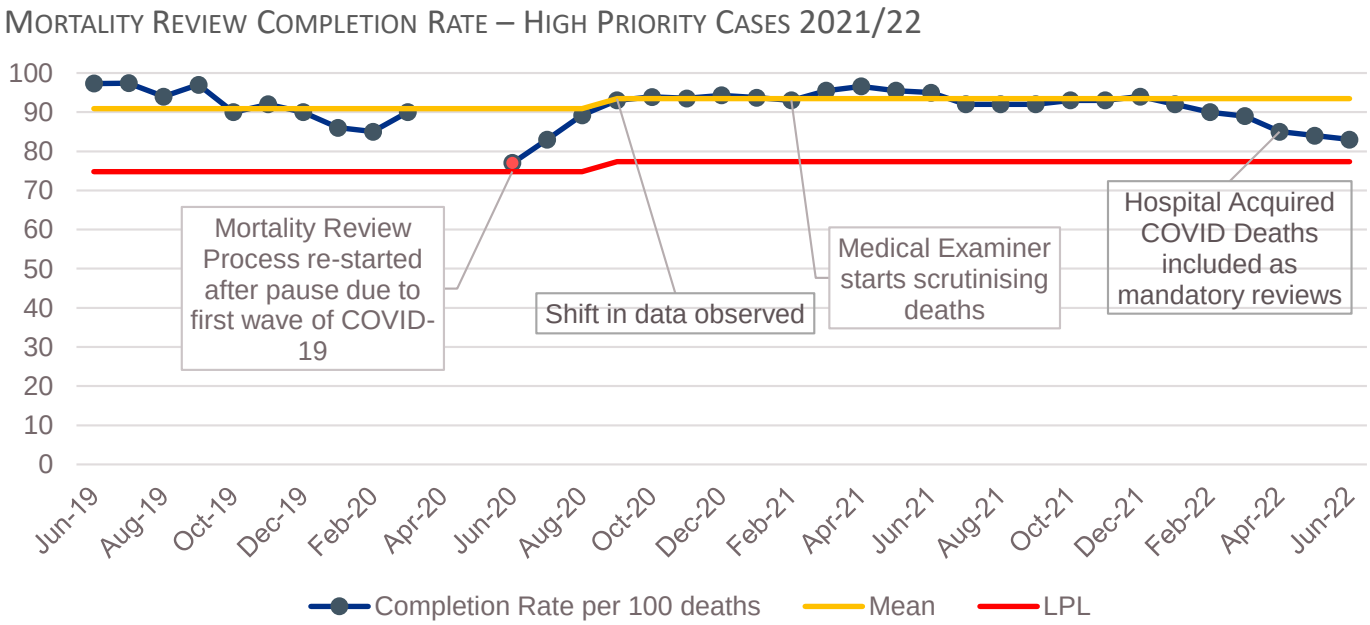
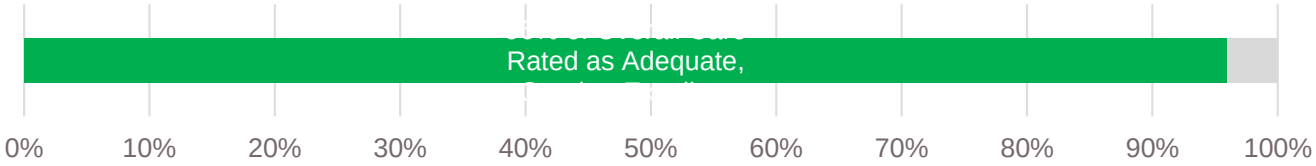
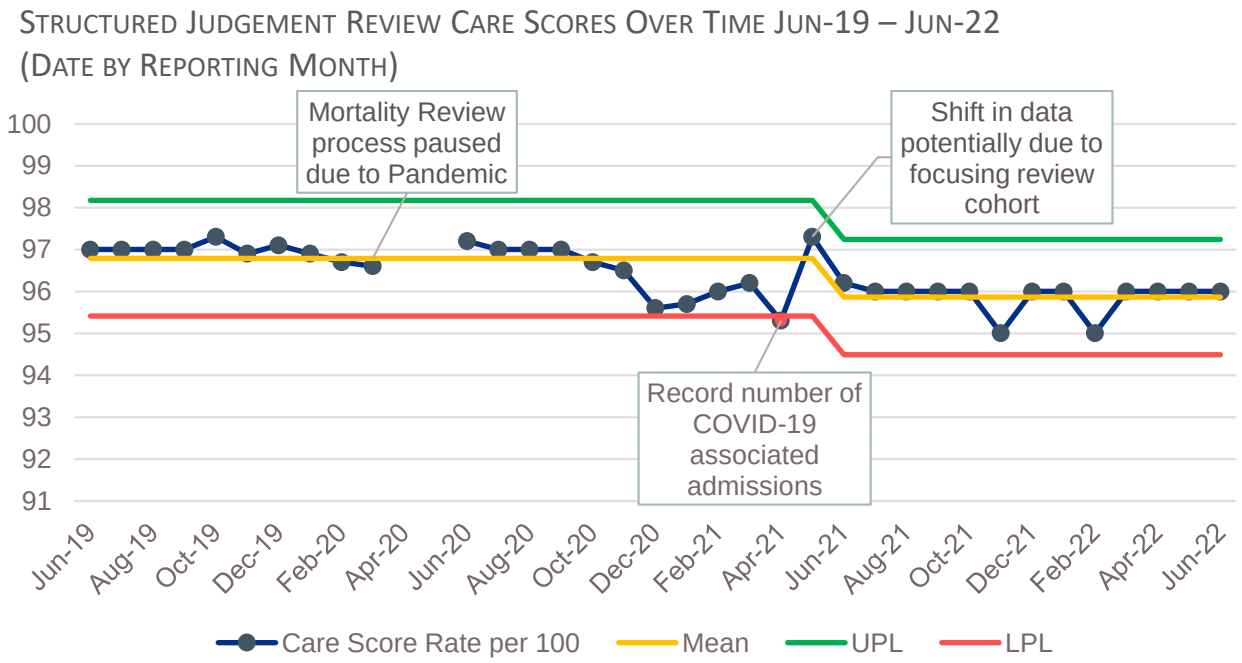
Mortality Review Completion Rate





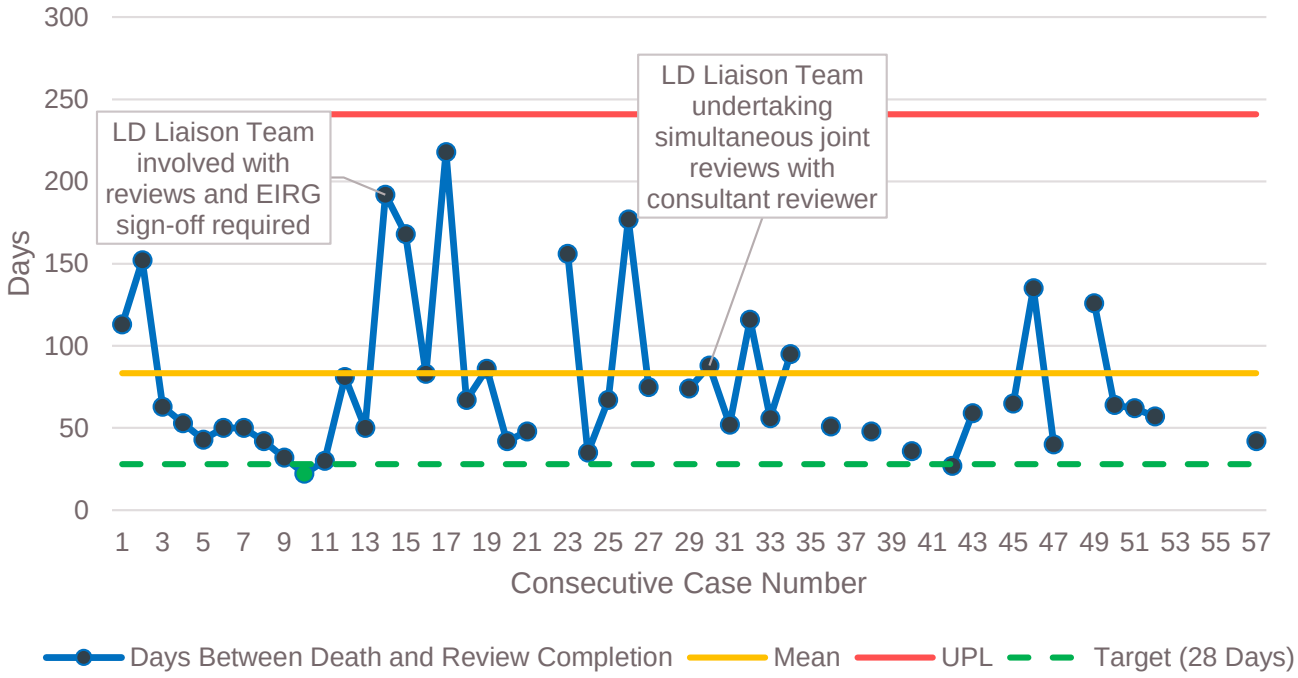
Mortality Review Care Scores





- Shift in the data below the mean from June 2021.
- Medical Examiner service starting means full SJR cases changed to being ones referred by ME , are part of the mandatory review categories, or the specialty request. Less ‘routine’ cases.
- This means that the cases being reviewed are those where either the medical examiner or the specialty believes there is an opportunity for learning.
- This more targeted approach to mortality reviews means we are getting more value out of the process.

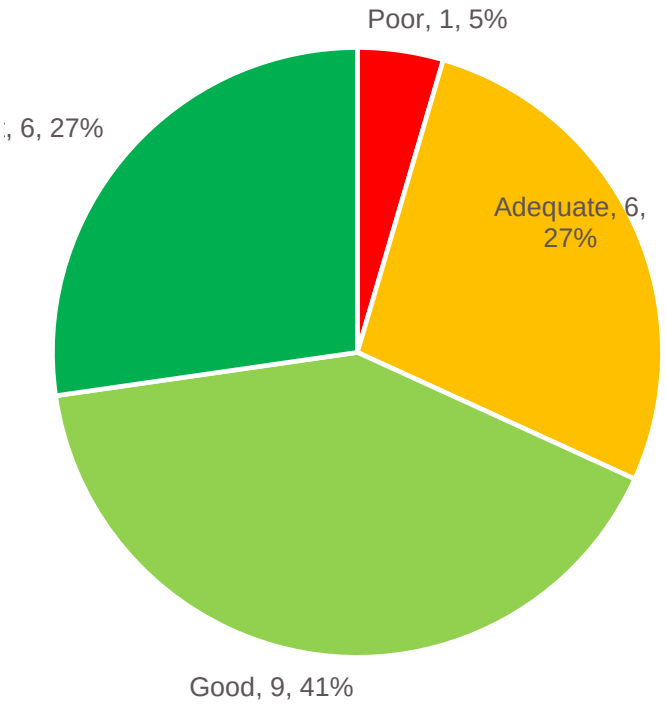
Learning Disability Mortality Review Completion



During 2021/22 there were 22 deaths within NBT that met these requirement

Due to the enhanced review process completion of mortality reviews for patients with a learning disability or autism can take more time than other high priority review categories. It is our view that the added benefit of a more thorough review outweighs the lengthening of the review process.

Learning Disability Mortality Review Care Scores



Case Review Outcomes

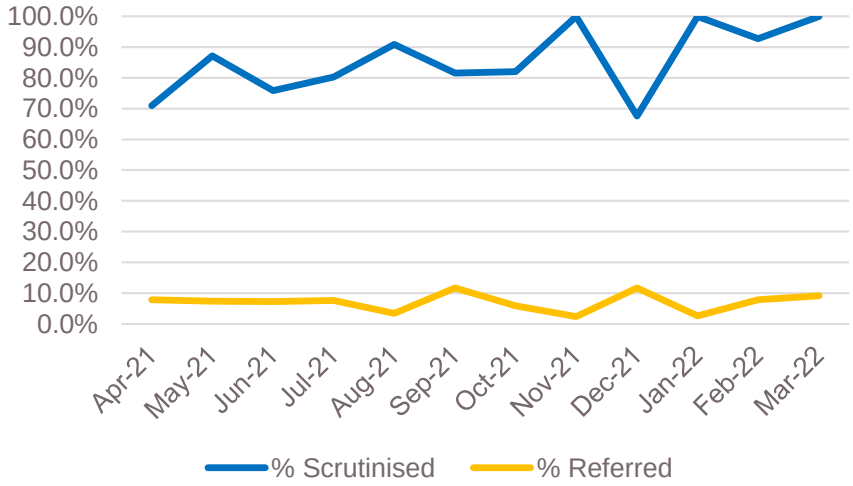
- During 2021/22 there were 25 reviews undertaken of deaths of patients with a learning disability or autism.
- 95% of cases reviewed received a care score of adequate, good or excellent.
- Exemplary examples of good care provided clinically and in a person-centred manner, with appropriate adjustments and family/carer involvement shared into the BNSSG LeDeR Steering Group.
- The one case of poor care is currently undergoing review by the Executive Review Group where learning is being identified and actions taken forward.

Areas to Focus Improvement - 3 primary themes :

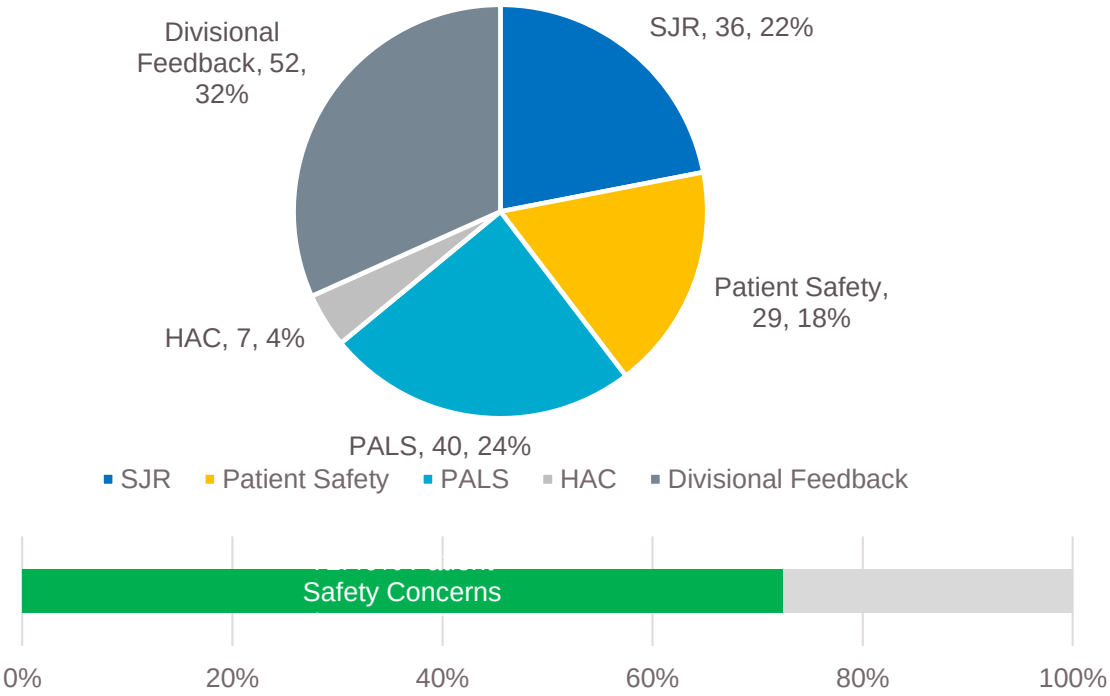
1. Non-referral to the Learning Disability Liaison Team, or in some cases later referral, which removed, or reduced the support
2. Limited documentation of how clinical teams engaged with the Liaison Team and how this supported reasonable adjustments
3. Weak or absent documentation in relation to mental capacity and related processes, DNACPR completion and communication with families or carers.

Medical Examiner Referrals & Signposting

ME Referrals to NBT Scrutiny and Referral Rates (Apr-21 – Mar-22)

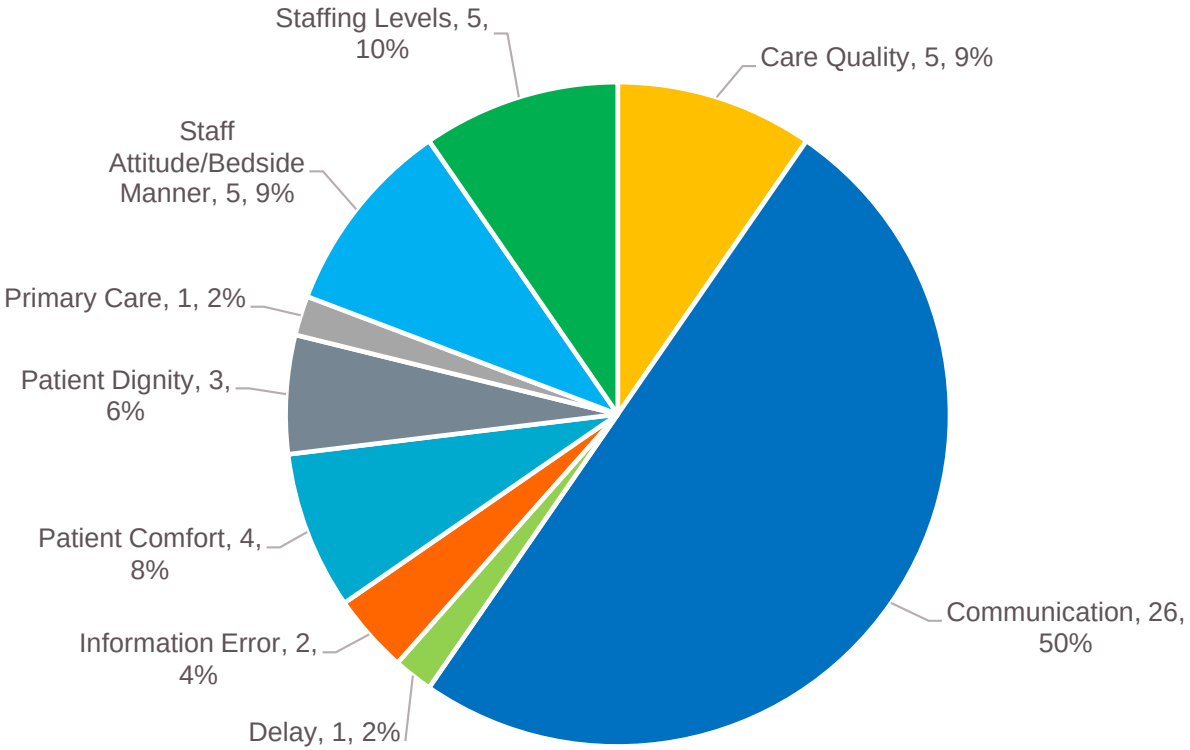


Distribution of ME Referrals by Governance Type (Apr-21 – Mar-22)



Exceptional healthcare, personally delivered

Medical Examiner Thematic Feedback



Divisional Learning M&M Examples

Division	Specialities
ASCR	• Urology • Vascular
Medicine	• Care of the Elderly • Clinical Haematology • Infectious Diseases
NSMK	• Neurosurgery • Stroke Services
WCH	• Obstetrics and Gynaecology

Case Example

Learning Point: A patient with a lung cancer diagnosis was lost to onward referral.

Action:

- All two week wait pathways were collated onto the Care of the Elderly governance webpage to provide easy accessibility and a single source of truth
- New protocols were put in place for secretaries to chase unopened scan results from 32a discharges, and to collate discharge investigations and add them to the consultant virtual clinic

Forward Plan 2022-23

Acute Care Collaborative Work

Development with UHBW and the NHSE/I Better Tomorrow team on;

1. **Mortality case reviews, data & wider contextual data** – referencing the work the national team has done with the national 'Making Data Count' team to hone our mortality data reviews (CHKS and SJR scores/qualitative info.)
2. **Re-vitalising/re-education regarding SJRs and their completion** - potentially using the SJR+ tool and also supporting clinicians undertaking case note reviews.
3. **Interface between trust-wide 'LFD governance' & specialty/cross-specialty M&Ms** – how to better integrate these and ensure learning and follow up action is seamlessly linked and used for improvements.
4. **Medical Examiner Service interface** – managing these reviews vs. more specialist knowledge when screening – communication, improving the process and sharing thematic learning.

NBT Internal Focus

1. **New IT system – Radar** - Develop and introduce the mortality review tool within the new clinical governance system – Radar. Support collaborative working by reviewing case-notes across specialties and specialist teams & better visibility and accessibility for the outputs of reviews allowing clinical teams to get real value out of their completion.
2. Reverse the decline of **completion rate for high priority reviews**
3. **Reduce the completion time** in days of Learning Disability mortality reviews
4. Work with divisions to understand how **thematic feedback can be used to drive improvement**
5. Revisit the requirement for Hospital Acquired COVID as a mandatory review category

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Sent by email

27 June 2022

Care Quality Commission
Health and Social Care Act 2008
Re Feedback from Surgery Monitoring Visit – 20 June 2022

Dear Maria,

I am writing to you to provide a summary of the CQC monitoring visit focusing on Surgery at Southmead Hospital on 20th June 2022. During this visit I heard from the divisional leadership team, held a focus group and visited various elements of the Surgery division at Southmead.

Firstly, I would like to thank you once again for the arrangements that were made to accommodate the visit. I really do recognise just how busy everyone is, and so I don't underestimate the impact of our visit on teams and appreciate hugely all of the efforts made to enable it to happen.

The purpose of this letter is to reiterate the high-level feedback shared with the team at the end of the visit. This was not an inspection and no judgements are therefore made or reports published as a result of this visit. It serves to support our intelligence and understanding of surgery services at NBT. I would however urge you to share this feedback at all levels of the organisation.

I appreciate that the visit was a long one. In truth I'm sure we could have filled the whole week and the team did well to condense the agenda into the timeframe available! The structure worked very well to enable me to appreciate the many dimensions of surgery at NBT. The divisional leadership team clearly brought some freshness, energy and enthusiasm to what can only be described as a monumental task. Using that energy and enthusiasm to not only deliver a strategy, but to invest in reflecting and measuring success will be key.

I heard of an approach to evaluation of performance that was based in realism and the need to stay focused. That was very encouraging. However, realistic performance evaluation is of course key, but it shouldn't stifle opportunities to celebrate success when that is warranted.

Furthermore, the approach to the management of risk was equally positive and realistic. What was encouraging about this, was it being grounded in a solution focussed approach. I heard about the planned care recovery program. The agility with which this was designed really demonstrated that solution focussed approach once again.
What I heard on Monday was that patient experience was the focus running through the division of surgery. What made this a positive thing to hear was the extent to which patient experience was being used to drive improvement and innovation. Furthermore, patient experience was a key theme within the focus group demonstrating that this emphasis had been well shared an bought into by a group of staff with a shared value base.

I heard of a number of key quality initiatives – around prehabilitation, and within the neuro oncology service as a couple of examples. To be quite frank the innovation and impetus involved in making these initiatives bear fruit for the benefit of patients was remarkable. Translating that innovation and energy into all areas of the division – indeed the trust as a whole – could be a game changer in terms of service delivery. The art of how you capture what has worked well and sharing that more widely is something that could really benefit from strong focus for the benefit of all.

There were of course, some areas for improvement as seen through the eyes of some of your staff – and I think their points are valid. The impact of the reconfiguration of surgery services on staff wellbeing should not be underestimated. All the staff I spoke with understood the rationale for the changes. However, they were bruised from what they saw as a very testing time and felt that as a result it had taken longer for new staff to settle and for everyone to be skilled to deliver a variety of services.

Whilst the commencement of services from Weston hospital was relatively new and expected to be still settling given the timeframe, I did get the impression that this group of staff were somewhat disconnected from the wider organisation. I think it is reasonable that some systems were still clunky, and the team felt frustrated by some of these. However, I think much could be gained from a stronger focus on integrating such a remote team and going the extra mile to recognise their experiences.

Staff told us that in the busy environment they were working, finding time to complete training was difficult and they were often doing this in their own time. I suspect that is not unique to NBT, but nevertheless will have an impact on how staff feel about their work.

Staff also felt keenly that more time and funding should be invested in managing patients to “wait well”. Everyone recognised that waiting lists are currently very long and the reasons for that. However, their compassion for these patients was notable and the stories they explained of these patients and the effects of waiting was compelling. My feeling is that this spoke volumes about their drive to be the best they could be for ALL patients – not just the ones within the physical walls of NBT and this is commendable.

Despite the challenges, the teams spoke highly of the divisional leadership team and their connection and commitment to the service. Despite the challenges they faced, they recognised there was no “silver bullet” and that the DMT were doing all they could make NBT a place they were proud to be.

Thank you once again to you and your team for facilitating the visit. We are looking forward to the next monitoring visit which we will begin to arrange soon.

Yours Sincerely

Marie Cox
CQC Inspection Manager

Report To:	Trust Board		
Date of Meeting:	28 July 2022		
Report Title:	Patient & Carer Experience Committee Report		
Report Author & Job Title	Kate Debley, Deputy Trust Secretary		
Executive/Non-executive Sponsor (presenting)	Kelvin Blake, Non-Executive Director and Committee Chair		
Purpose:	**Approval**	**Discussion**	**To Receive for Information**
			X
Recommendation:	The Trust Board is recommended to receive the report for assurance and: • to support the implementation of recommendations following the autism ED audit. • to note the Complaints and Concerns Annual Report.		
Report History:	The report is a standing item to each Trust Board meeting following a Patient & Carer Experience Committee meeting.		
Next Steps:	The next report to Trust Board will be to the September 2022 meeting.		

Executive Summary
The report provides a summary of the assurances received, issues to be escalated to the Trust Board and any new risks identified from the Patient & Carer Experience Committee Meeting held on 27 June 2022.

Strategic Theme/Corporate Objective Links	**1. Provider of high quality patient care** a. Work in partnership to deliver great local health services b. A Centre of Excellence for specialist healthcare **2. Developing Healthcare for the future** a. Training, educating and developing our workforce **3. Employer of choice** a. Empowered clinically led teams b. Support our staff to continuously develop **4. An anchor in our community** a. Create a healthy & accessible environment

Board Assurance Framework/Trust Risk Register Links	Reports received support the mitigation of the following BAF risks: N/A
Other Standard Reference	Care Quality Commission Standards.
Financial implications	No financial implications as a consequence of this report.
Other Resource Implications	No other resource implications as a result of this report.
Legal Implications including Equality, Diversity and Inclusion Assessment	No legal implications
Appendices:	Appendix 1 – Complaints and Concerns Annual Report 2021/22

1. Purpose

To provide a highlight of the key assurances, any escalations to the Board and identification of any new risks from the Patient & Carer Experience Committee meeting held on 27 June 2022.

2. Background

The Patient & Carer 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:

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

3. Key Assurances & items discussed

3.1 Patient and Staff Story – Emergency Department Audit

The Committee received a presentation from a group of patients and staff with autism who had conducted an audit of the Emergency Department, with the aim of improving access to services for people with autism. The Committee heard that a bespoke tool

had been created for the audit, which included interviewing staff in relation to their view of the Department and whether they had been able to make adaptations.

Key findings following the audit were that there is a well-spaced waiting area with an autism welcome poster displayed. However, there were no separating screens for privacy, and autism alerts had not been found on the patient records tested as part of the process. In addition, 'bags of calm' are available in the Department, and whilst these are helpful to some patients the audit had recommended that the Trust be aware of a potential dignity issue in needing to ask for these at the reception desk. The audit had also found that there were a large number of posters on display in the ED area on a variety of subjects, and noted that this can lead to sensory and information overload.

In relation to the Trust's Autism Liaison Team, it was found that team members have good awareness of autism, are willing to learn and make adaptations, and are keen to improve reasonable adjustment resource content and ensure that there are adjustment resources available in ED and all other clinical areas.

The Committee heard that a further key recommendation for the Trust was for level 3 co-produced autism awareness training to be implemented and that this should include Move Makers, Security and Reception staff, as these are the first people a patient or carer meets when they come into the hospital. It was noted that these initial interactions can make the difference between a person with autism feeling comfortable enough to stay, or feeling they need to leave before they have accessed treatment. In addition, it was recommended that a downloadable form should be made available on the NBT website to allow for patients with autism to summarise their specific issues and concerns, and in particular set out how they might present when they are in the ED environment.

In relation to Psychiatric admissions, the audit had recommended that Tier 3 training should be provided for ED staff in order to increase knowledge and awareness of how people with autism present in crisis, and in particular those with dual diagnoses.

The Committee welcomed the presentation and noted that it had been particularly powerful to hear advice and recommendations direct from individuals with autism who had experienced the services. The Committee stated its determination to follow this work going forward, and to ensure that the recommendations are implemented. It was agreed that an action plan would be developed by the Head of Patient Experience and the Trust's Learning Disability & Autism Liaison Team, and that progress against this would be reported back to the Committee.

3.2 Emergency Department Mental Health Planned Assessment Clinic Project

The Committee received a presentation on a Mental Health Planned Assessment Clinic pilot that had been run in the Emergency Department, delivering an in-hours mental health clinic three days a week. This allowed access to the Mental Health Day Unit at the Trust's Gloucester House, and the reception services provided there. The Committee heard that the days of operation were Monday, Wednesday and Friday and within each operational day four 1-hour appointments were offered, with no patient being given an appointment more than 48 hours later than their ED attendance. Following the assessment, patients would then receive an appropriate outcome for their care, including referral to other services such as the crisis team, or signposting to relevant organisations.

The Committee heard that when compared with green and amber-triaged mental health patients not referred to the clinic, a patient's time spent in the Department was reduced from an average of 10.3 hours to 4.8 hours. This in turn meant that capacity was created for patients who required emergency care from ED clinicians.

The Committee noted that a planned next step will be to run the clinic on a five day basis (Monday to Friday) and agreed that the aim should be to then move towards a 'Core 24' 24/7 model as soon as possible.

3.3 Patient Involvement Action Plan – Progress Report

An Update was received on progress against the Patient Involvement Action Plan that had been reviewed by the Committee in September 2021. The Committee were pleased to note the progress that has been made, particularly in relation to engagement with the most vulnerable patient groups and in recruitment to diversify the membership of the Patient and Carers Partnership Group.

The Committee welcomed the update and also emphasised the importance of ensuring that fundamental standards of kind care are delivered consistently to all patients. It was agreed that some further work would be undertaken to consider how the impact of the work will be measured, and whether updates on progress could be provided by Division.

3.4 Complaints and Concerns Annual Report 2021/22

The Committee received the Complaints and Concerns Annual Report 2021/22 (Appendix 1) and it was noted that activity levels had increased for complaints, PALS concerns and enquiries during the year. It was further noted that this increase in activity had been anticipated due to the impact of Covid-19 during the previous year.

In line with previous reporting years, the highest number of complaints related to the category 'Clinical Care and Treatment', whilst the highest number of concerns related to the category 'Access to Services – Clinical'. The Committee heard that this reflects the national picture in relation to waiting lists and treatment backlogs.

It was noted that 21/22 had seen a fall in performance in relation to responsiveness to complaints. This was as a result of increased activity, together with vacancies in the Divisional Patient Experience Teams, and operational pressures on clinical staff who respond to complaints and PALS concerns. It was further noted that targeted recovery plans are in place with the two largest Divisions and that this position is now expected to improve during 22/23. The Committee heard that there has been an improvement in the quality of complaint responses, which has been reflected in the low number of returned complaints, and positive feedback from the Complaints Lay Review Panel and complainants themselves.

The focus for 2022/23 will be on accessibility of complaints and PALS services internally and externally, performance in relation to responsiveness, actions and learning from complaints, and preparation for the new Complaints Standards in April 2023.

3.5 Additional updates received on:

- Patient Experience Group Highlight Report
- Learning Disability & Autism Steering Group Highlight Report
- Patient Experience Risk Report
- Integrated Performance Report – Complaints and Concerns (May data)

4. Escalations to the Board

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

5. Recommendations

5.1 The Trust Board is recommended to receive the report for assurance and:

- to support the implementation of recommendations following the autism ED audit;
- to note the Complaints and Concerns Annual Report.

Report To:	Patient and Carer Experience Committee		
Date of Meeting:	27th June 2022		
Report Title:	Complaints and Concerns Annual Report 2021/22		
Report Author & Job Title	Emily Ayling, Patient Experience Manager		
Executive/Non-executive Sponsor (presenting)	Gifty Markey, Head of Patient Experience Steve Hams, Chief Nursing Officer		
Purpose:	**Approval**	**Discussion**	**To Receive for Information**
			X
Recommendation:	Not Applicable		
Report History:	Received at Patient & Carer Experience Group in May 2022		
Next Steps:	To go to Trust Board via the Committee's Upward Report		

Executive Summary

This year activity levels have increased significantly for complaints, PALS concerns and enquiries. This was unsurprising given the impact of Covid-19 on activity levels last year.

When compared to pre-pandemic levels, activity is still up marginally, especially for the Patient Advice and Liaison Service (PALS) who manage concerns and enquiries.

In accordance with previous reporting years, most complaints were regarding 'Clinical Care and Treatment' whilst most concerns were regarding 'Access to services-Clinical'. This reflects the national picture with well reported delays in treatment, waiting lists and backlogs for NHS care.

Over the past year we have seen a fall in performance with regards to responsiveness to complaints. We did not meet our Trust complaint response rate compliance. The target is 90% and we achieved 77% on average. We have also seen an increase in the number of overdue complaints. This has been the result of increased activity alongside staff vacancies in the Divisional Patient Experience Teams and operational pressures on clinical staff who respond to complaints and PALS concerns. We have targeted recovery plans in place with the two largest divisions which are now fully resourced. We expect to see compliance improve over the next year back in line with our internal target of 90% and, for the number of overdue complaints to fall.

Despite these challenges we have seen an improvement in the quality of complaint responses, reflected in the low number of returned complaints and positive feedback from the Complaints Lay Review Panel and complainants themselves.

The focus for 2022/23 will be:

• Accessibility of the services- raising awareness of complaints and PALS internally and externally for example through lunch time drop-in sessions, staff training and attendance at community events. • Performance- We will also focus on recovering our performance with regards to responsiveness of complaints. • Actions and Learning- We will continue to embed a culture of learning from complaints with our Complaints Lay Review Panel and divisional teams using their action and learning trackers. • Preparation for new Complaints Standards coming in April 2023.	
Strategic Theme/Corporate Objective Links	**1. Provider of high quality patient care** **2. Developing Healthcare for the future** **3. An anchor in our community**
Board Assurance Framework/Trust Risk Register Links	
Other Standard Reference	Not applicable
Financial implications	Not applicable
Other Resource Implications	Not applicable
Legal Implications including Equality, Diversity and Inclusion Assessment	The Local Authority Social Services and National Health Service Complaints (England) Regulations 2009
Appendices:	None

1. Purpose

This report summarises feedback received from patients, carers, and patient representatives during the period 1st April 2021 to 31st March 2022. This report covers in detail feedback from complaints and PALS concerns received by North Bristol NHS Trust.

2. Background

The NHS constitution and NHS Complaints Regulations 2009, clearly set out the rights of patients in relation to raising complaints and expectations on how these should be managed. As a Trust we take this duty very seriously. We want to know when someone is unhappy with the treatment or service they have received. This means we can put things right and learn from the experience of our service users.

3. Summary

3.1 Activity levels

Table 1 shows the activity level for each type of feedback received in 2020/21.

Type	2018/19	2019/20	2020/21	2021/22
Complaints	723	626	490	666
Concerns	744	1,087	776	1,280
Compliments	7,704	8,072	3,689	4,672
Enquiries	280	188	659	911
Response Time (within timescale)	59%	80%	93%	77%

Table 1

4. Complaints Overview

In 2021/22, 666 formal complaints were received by the organisation. This is an increase of 36% from the previous year where 490 complaints were received. Whilst this seems to be a significant increase, the Covid-19 pandemic led to the fall in complaints in 2020/21 and this year's activity shows a return to similar levels as previous reporting years.

This year we have focussed on improving the quality of complaint responses and investigations, whilst trying to maintain performance standards amidst the challenges of the fallout from the pandemic.

4.1 Complaints by Division

Chart 1 shows that most complaints received in 2021/22 were received by Medicine (210), followed by ASCR (166). These are the largest divisions and they see the largest volume of patients, so this is expected. This is also consistent with previous years.

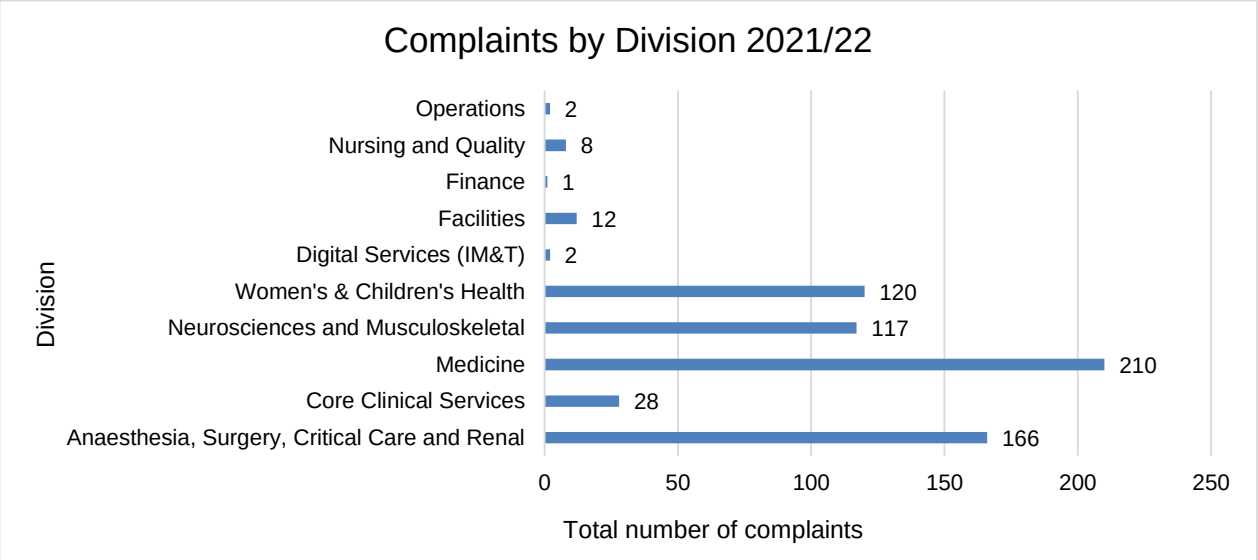


Chart 1

4.2 Complaints by Subject

Chart 2 shows that in 2021/22 the most common complaint subject was 'Clinical Care and Treatment'. This is consistent with previous reporting years.

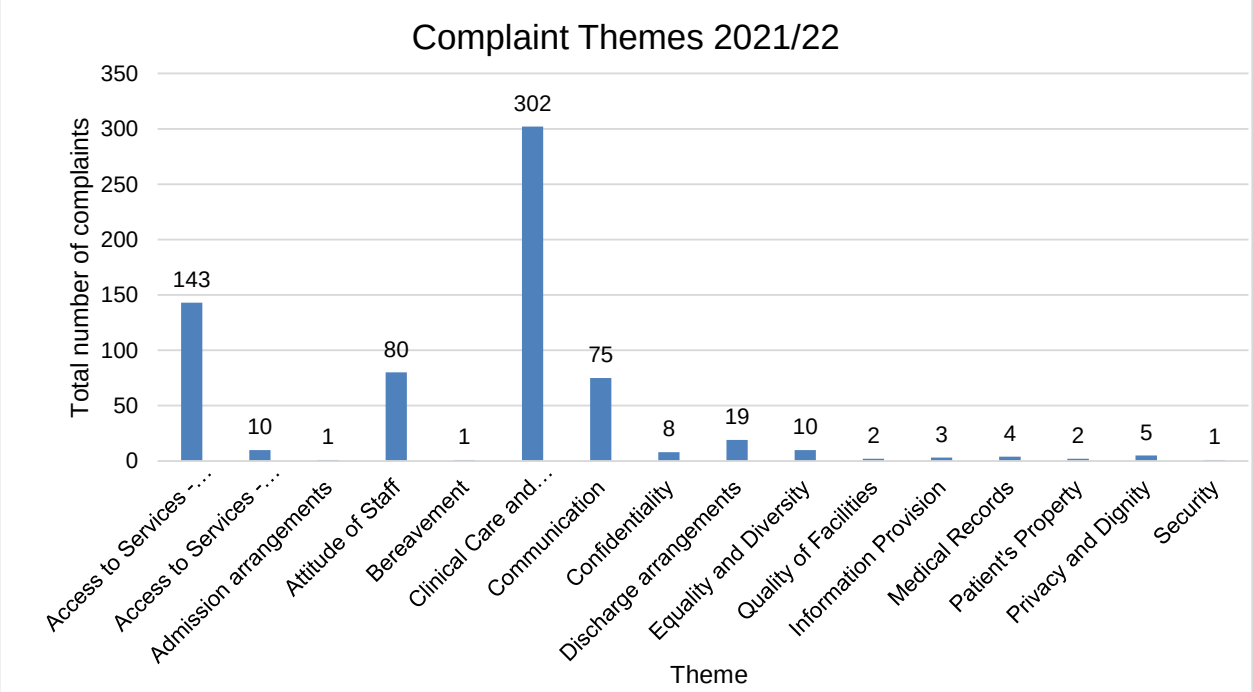


Chart 2

Further analysis within these subjects shows that the main reasons for complaints were poor medical care, and poor unexpected outcomes. The second most common subject was, 'Access to services-Clinical', with cancelled operations and length of wait for outpatient appointments and surgery as the main sub-subjects. This illustrates the well-reported increase in national waiting times for the NHS and backlogs.

4.3 Complaint by Outcomes

Chart 3 shows that 75% of complaints received in 2021/22 were either upheld or partially upheld. This is slightly less than the previous year where 77% of complaints were either upheld or partially upheld. We have seen a positive improvement in the percentage of complaints where the recorded outcome was 'issue resolved'.

We are required to report on the status of complaint resolution to NHS Digital when reporting the KO41a. The definitions given by NHS Digital are included below. Please note the interpretation of these definitions will vary according to each person's judgment. This designation is made following the investigation.

Upheld: If substantive evidence is found to support the complaint, then the complaint should be recorded as upheld.

Not upheld: If there is no evidence to support any aspects of a complaint made, the complaint should be recorded as not upheld.

Partially upheld: If a complaint is made about several issues and one or more, but not all, are upheld then the complaint should be recorded as partially upheld.

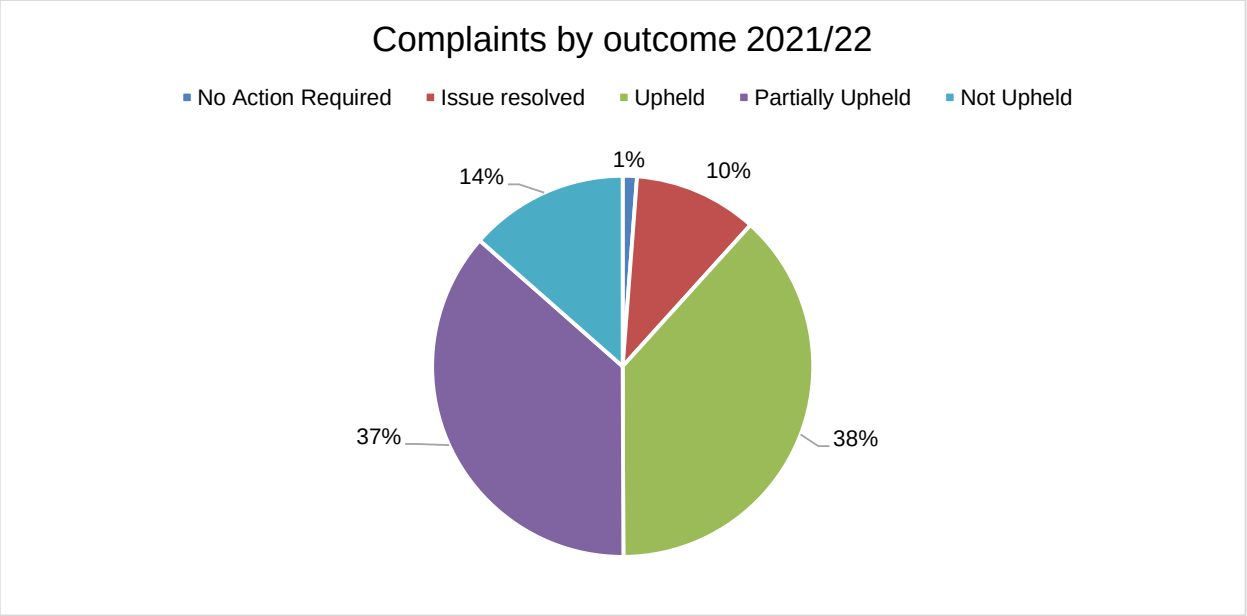


Chart 3

5. Complaints: monitoring and compliance

5.1 Reopened Complaints by Division

Of the 666 complaints received, 25 were re-opened or returned. This is 4% of all complaint cases and is an improvement on last year where 6% were re-opened. This reflects work undertaken to increase the provision of training for staff involved in complaints investigations and responses and, a further quality check introduced in the complaint sign off process.

5.2 Overdue Complaints and Response Rate Compliance

Chart 4 below shows that the number of overdue complaints has increased throughout 2021/22, peaking in January 2022, with 11 overdue complaints. Unfortunately, this is a significant drop in performance when compared with the previous year where the most overdue complaints received in any month was 2.

In addition to the number of overdue complaints rising, the compliance response rate (see chart 5) has also fallen below the Trust target of 90% to an average of 77%. This reflects the challenges experienced across the Trust with increased operational pressures for frontline staff and vacancies within the Divisional Patient Experience Teams. We have targeted recovery plans in place with the two largest divisions which are now fully resourced. We expect to see compliance improve over the next year back in line with our internal target of 90% and for the number of overdue complaints to fall.

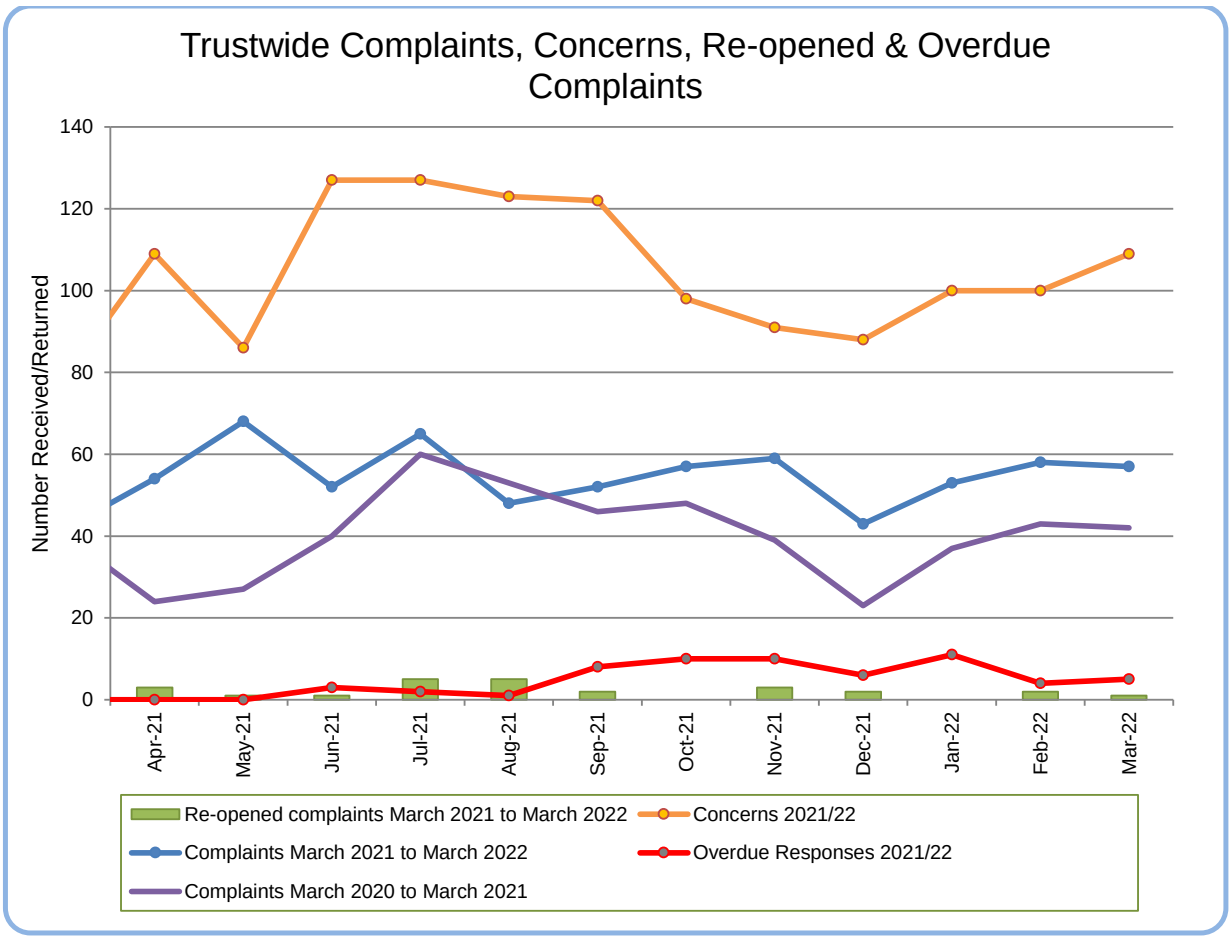


Chart 4

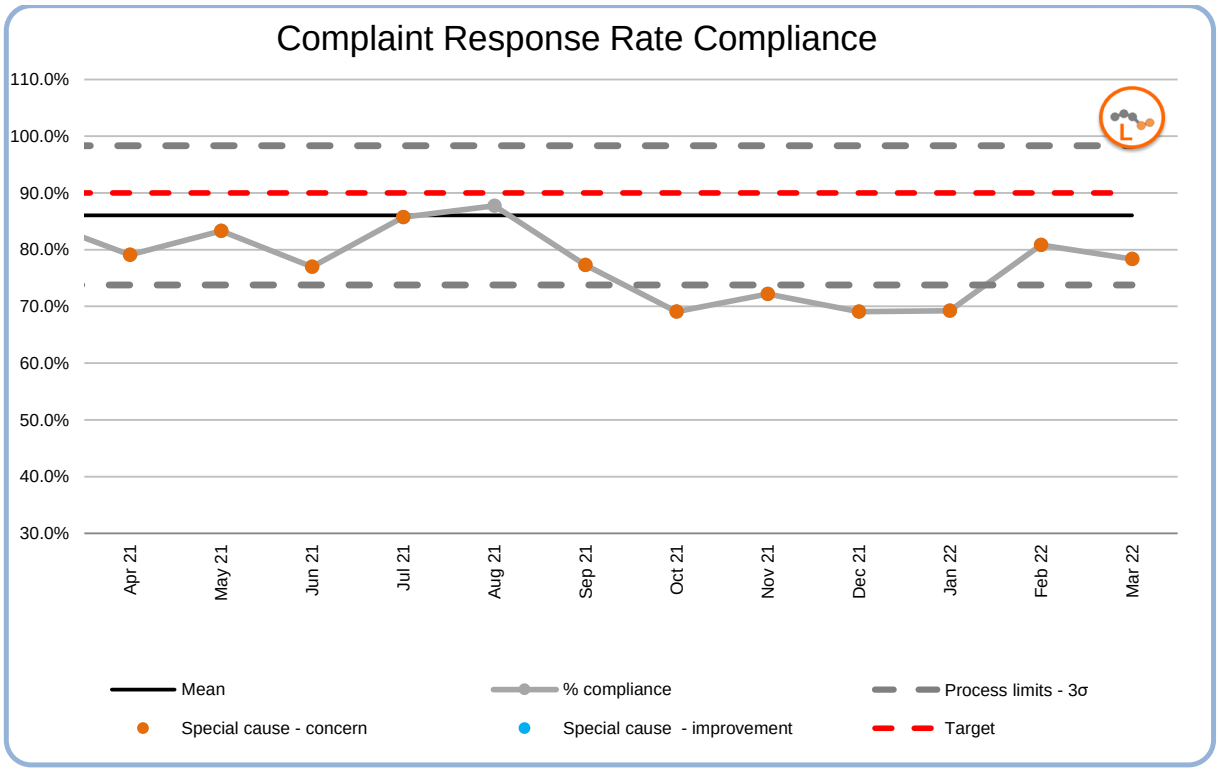


Chart 5

5.3 Acknowledgement of complaints

There is regulatory requirement that all NHS Complaints are acknowledged within three working days. In 2021/22 we have been 100% compliant with this standard.

5.4 Parliamentary and Health Service Ombudsman (PHSO) investigations

Table 2 shows the number of complaint cases that were investigated by the PHSO. In 2021/22, 59 cases were received by the PHSO for consideration. This means 9% of complaint cases were escalated by the complainant to the PHSO. This is a slight increase on the previous year where only 6% of cases were escalated to the PHSO. Only one case was accepted for investigation by the PHSO.

Year	Number of cases received by the PHSO	Number of cases accepted for investigation by the PHSO	Number of cases upheld or partly upheld
2018/19	56	5	2
2019/20	61	3	0
2020/21	28	2	1
2021/22	59	1	1

Table 2

6. Audit & Feedback

6.1 Complaints Lay Review Panel

Throughout 2021/22 our Complaints Lay Review Panel has continued to convene virtually. Meeting quarterly, the panel reviews a randomised selection of our complaints against our Policy and national best practice standards. They review how we have handled the case and provide a score, note areas of good practice and opportunities for improvement in complaints handling.

We are extremely grateful to our skilled panellists for their commitment and valuable feedback. We were invited to speak at the NHS Complaints Summit and have been able to share the model for the panel and our approach to relaunching and sustaining this virtually through the pandemic with colleagues across health and social care.

6.2 Internal Audit

Following an internal audit last year, our focus for 2021/22 was to meet the five recommendations from this. We successfully completed the actions for each recommendation in 2021/22. We have assessed the impact of these actions, and this has varied. Some have led to clear improvements in practice whilst others not having the anticipated impact for example due to limitations in computer systems.

We have continued to build on these recommendations, in particular focussing on our monitoring and auditing of PALS concerns as activity continues to increase. In 2021/22 we introduced a weekly PALS tracker and PALS audit. The weekly PALS tracker mirrors the Complaint weekly tracker and advises teams of their open PALS cases and their due dates, it also clearly highlights those which are overdue or approaching this.

The monthly PALS audit considers how PALS concerns have been managed and whether these have been recorded properly on our system, Datix. We look at a random selection of cases and whether they have followed key steps of the process for the management of PALS concerns. This ensures thorough record keeping and helps ensure accurate reporting and timely resolution of PALS concerns. Similarly in complaints we have a monthly Complaints Monitoring Report. This is shared with divisional patient experience teams at the monthly Divisional Patient Experience Group.

6.3 Feedback from complainants

All complainants are asked to complete a questionnaire to give feedback about their experience of the complaint process. This questionnaire is reviewed monthly by the complaints team and feedback is considered and acted on where appropriate.

In 2021/22, 50 questionnaires were completed. This is a response rate of 7.5%. Whilst this is low, the questionnaire is optional and therefore it is difficult to improve this. The questionnaire identified some areas of good practice, 74% of complainants felt listened to and 72% felt that it was worthwhile making a complaint. These are marginally lower percentages than last year but still highlights that the Trust's process for managing complaints is effective and meets national best practice standards for complaints handling.

Comments from the questionnaire:

"*Helpful process for me personally and to know that this has been passed on for better experiences for all*"

"We were given clear indications that our complaints were taken seriously and that procedures would be changed if and where necessary"

7. PALS Concerns

7.1 Concerns by division

Chart 6 shows the number of PALS concerns received by each division in 2021/22. As with complaints, the most PALS concerns were received by ASCR (357) and Medicine (328).

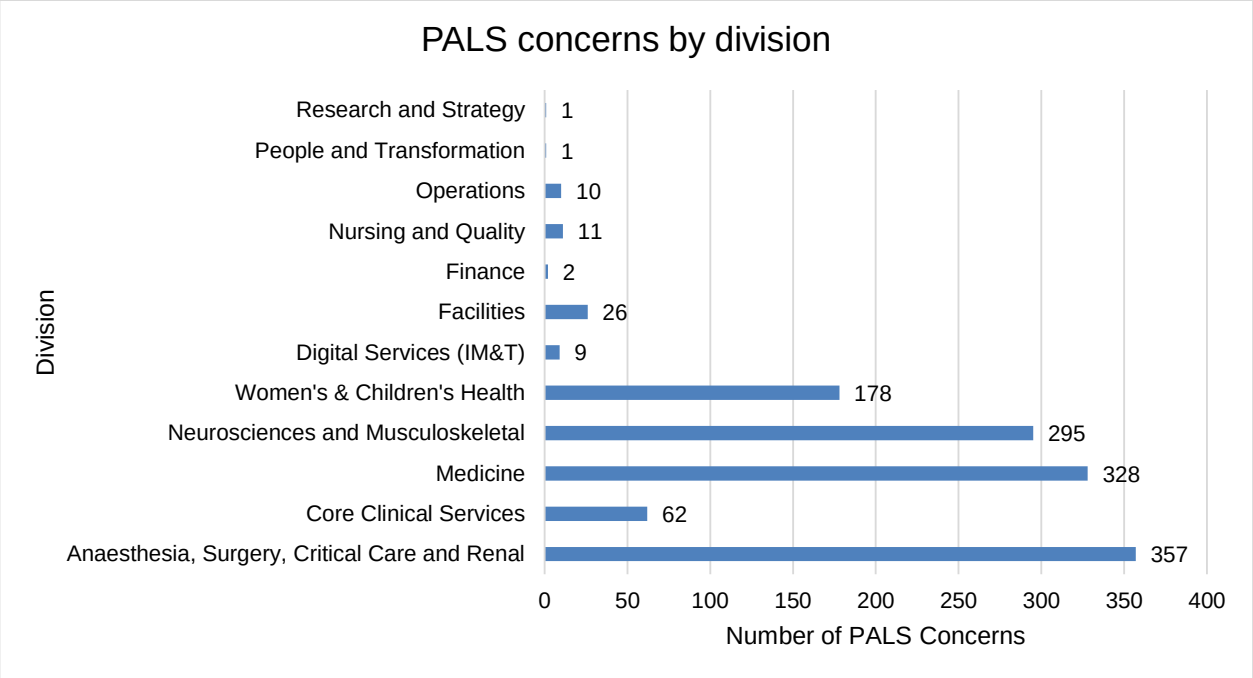


Chart 6

7.2 Concerns by subject

Chart 7 shows that the most common subject for concerns received in 2021/22 was 'Access to services- Clinical'. This is consistent with the previous year and is as expected consequence of the Covid-19 pandemic and delays to routine activity.

The second most common subject of PALS concerns is 'Communication', followed by 'Clinical Care and Treatment'. This is also consistent with last year.

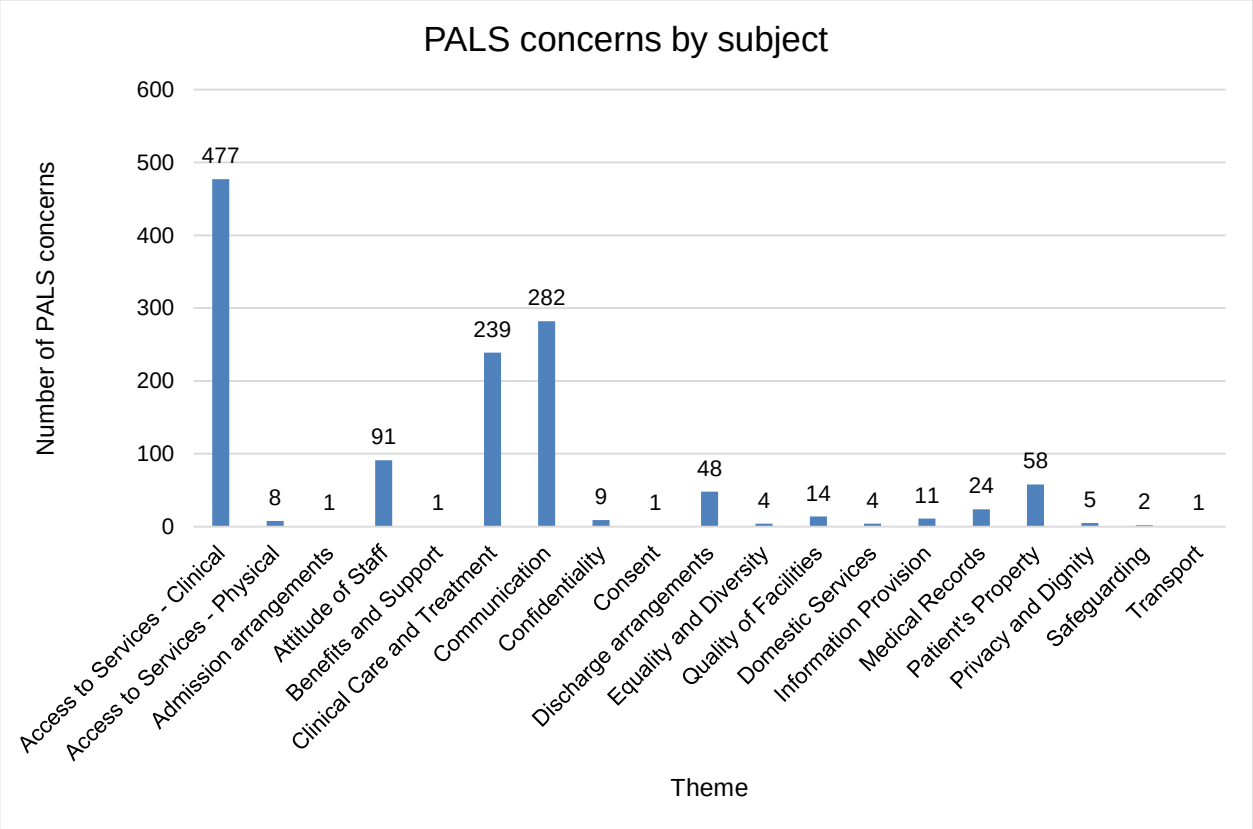


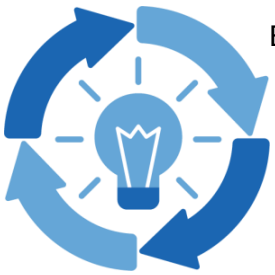
Chart 7

8. Compliments

As identified in previous annual reports, the process for recording compliments required review and improvement. Historically there has been a risk of duplication when recording compliments. In 2020/21 we also updated our process for recording compliments. We have now streamlined the process to assure ourselves that compliments are only being recorded once, by divisional teams. This also enables divisional teams to ensure clinical staff hear positive feedback directly. The change in process is likely to explain why there has been a significant reduction in reported compliments since 2020/21.

In 2021/22 4,672 compliments were received, this is a slight increase on the previous year.

9. Learning and Improvements



Examples of learning from complaints that has led to improvement actions being taken include the following:

- There was no Standard Operating Procedure (SOP) for a request for body donation upon death. A new SOP has been developed to address this gap in process.
- Medication Poster designed and launched by Pharmacy to remind staff of the meaning of terminology such as 'continued' medication.

- A new extended pharmacy service over weekends which will focus on supporting patients on discharge over weekends.

- The Weight Management Service have reviewed their referral processes to ensure the early identification of patients who need additional support or treatment before being eligible for the service. This will ensure that patients are not accepted into the service only to later be discharged due to needing additional support or treatment.

- In Percy Phillip Ward, new posters have been designed and placed around the ward to explain the day room, about meals times, drug rounds, and where patients can get a tea or coffee.

- In NMSK, The DEXA scanner is only suitable for patients that can get on and off the scanning table independently or with the help of a carer due to limited space and due to the height of the scanning table. Patient information leaflets to highlight the need to be able to get on and off, the table independently or with the help of a carer have been updated, the booking clerk for the scanner has also been given training and an adapted checklist to go through with patients when booking appointments. Lastly, GPs have been informed about the criteria for the DEXA scanner.

10. Accessibility of the Complaints and PALS Processes

We collect equality monitoring data about those that access the complaints service through a non-mandatory form.

Data in 2021/22 shows that most complainants are female. There is a good range of ages with complainants from 16 to 95 years of age and 28% of complainants stated they had a disability. This reflects some of the work undertaken to improve the format and accessibility of information on our website and printed leaflets.

The data also shows that there is still some work to be done as only 14% of complainants were not White-British and only 9% were not heterosexual. This highlights the importance of us reaching out and engaging with our local community to ensure that all groups feel comfortable and confident approaching us to raise a complaint or concerns.

Due to the limitations of the pandemic, we have still not been able to raise awareness of the service by outreach to groups across the community, attending ward huddles or holding engagement events. We continue to hold onto this ambition and hope to be able to push forwards with this in 2022/23 to ensure accessibility of our complaints process for everyone.

11. Looking ahead to 2022/23

Despite the challenges of the past year, we have managed to achieve or progress significantly against our goals for the past year. Some of these we will look to build on further in the coming year. Our focus for 2022/23 is:

1. **Further strengthening and embedding a culture of learning from complaints.**

Last year we aligned divisional action and learning spreadsheets into a single template and agreed a process and framework for all divisions to log, monitor and report on actions and learning from complaints. The success of this has differed between divisions with some such as CCS really maximising use of the spreadsheet and developing this further to suit their needs. Other divisions have struggled to maintain this, largely due to staff vacancies in senior roles. The goal for 2022/23 will be to support those struggling in this area so they can begin to use the framework consistently. We will also continue to nurture and grow our Complaints Lay Review Panel who provide us with valuable feedback and recommendations.

2. Performance

A new key focus for 2022/23 will be to recover our performance with regards to responsiveness of complaints. This means maintaining a positive trajectory towards no overdue complaints and 90% response rate compliance. To achieve this, we have recovery plans in place with the two largest divisions which are monitored a reviewed closely to ensure progress.

3. Accessibility of the services for staff and patients, their relatives and carers

Due to Covid-19 we have been limited in our ability to go out and raise awareness about our services, in particular PALS. We know from our Equality and Diversity Monitoring data that we need to ensure everyone is aware of their rights to raise a concern and that they feel comfortable and can do so. This year we would like to progress with this goal by linking in with community partners, working with our Patient Partners and attending community events to promote the service.

Internally we will hold drop-in sessions for staff to get support on any PALS or complaints they may be managing, or to ask any questions they might have about the processes. We will also continue to deliver different training packages across the Trust for staff.

Lastly, we will continue our preparations for the NHS Complaint Standards coming in April 2023. We have undertaken a gap analysis and understand that we are already working closely with the standards and therefore the changes needed are likely to be limited. We will keep close to ongoing developments over the next year to ensure we are ready.