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 27 May 2021
10.00 – 13.00

A G E N D A

No.	Item	Purpose	Lead	Paper	Time
OPENING BUSINESS					
1.	Welcome and Apologies for Absence:	Information	Chair	Verbal	10.00
2.	Declarations of Interest	Information	Chair	Verbal	10.02
3.	Minutes of the Public Trust Board Meeting Held on 25 March 2021	Approval	Chair	Enc.	10.05
4.	Action Chart from Previous Meetings	Discussion	Trust Secretary	Enc.	10.06
5.	Matters Arising from Previous Meeting	Information	Chair	Verbal	10.08
6.	Chair's Business	Information	Chair	Verbal	10.10
7.	Chief Executive's Report	Information	Chief Executive	Enc.	10.15
KEY DISCUSSION TOPIC					
8.	Staff/ Patient Story • Pressure Injury patient story • Pressure Injury Improvement Programme update *Sue Mallet and Chloe Cox attending to present*	Discussion	Director of Nursing & Quality	Pres.	10.25
9.	Just Culture *Christopher Brooks-Daw & Caroline Hartley attending to present*	Discussion	Director of Nursing & Quality	Pres.	10.50
10.	Freedom to Speak Up: 10.1. Refreshed Vision, Strategy & Action Plan 10.2. Bi-Annual Report *Hilary Sawyer attending to present*	Discussion	Director of Corporate Governance	Enc.	11.10
BREAK *(10 mins)*					11.25
11.	Integrated Performance Report	Discussion	Chief Executive	Enc.	11.35
12.	Accountability Framework	Approval	Chief Operating Officer	Enc.	12.00
FINANCE					
13.	Finance Month 1 Report	Information	Chief Finance Officer	Enc.	12.10
GOVERNANCE & ASSURANCE					

No.	Item	Purpose	Lead	Paper	Time
14.	Patient & Carer Experience Upward Report 14.1. End of Life Care Annual Report	Information	NED Chair	Enc.	12.20
15.	Quality & Risk Management Committee Upward Report 15.1. Patient Safety Incident Response Plan (PSIRP)	Information Approval	NED Chair	Enc.	12.30
16.	Audit Committee Upward Report	Information	NED Chair	Enc.	12.40
17.	Board Assurance Framework	Discussion	Director of Corporate Governance	Enc.	12.50
For information only – No discussion expected					
18.	Healthier Together update report	Information	Chief Executive	Enc.	
CLOSING BUSINESS					
	Any Other Business	Information	Chair	Verbal	12.59
	Questions from the Public in Relation to Agenda Items	Information	Chair	Verbal	13.00
	Date of Next Meeting: Thursday 29 July 2021, 10.00 a.m.				
	Resolution: Exclusion of the Press and Public. It is recommended that, pursuant to the Public Bodies (Admission to Meetings) Act 1960, Section 1(2), the press and members of the public be excluded from further items of business, having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest.				

TRUST BOARD DECLARATIONS OF INTEREST

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

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

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

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

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

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DRAFT Minutes of the Public Trust Board Meeting held virtually on Thursday 25 March 2021 at 10.00am

Present:

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

In Attendance:

Xavier Bell	Director of Corporate Governance & Trust Secretary	Isobel Clements	Senior Corporate Governance Officer & Policy Manager (*minutes)*
Nura Aabe	Sirona Non-Executive Director, shadowing		

Presenters:

Emily Ayling	Patient Experience Manager (present for minute item 07)	Liz Perry	Director of People (present for minute item 10)
Hilary Sawyer	Lead Freedom to Speak Up Guardian (present for minute item 08)	Guy Dickson	Director of People Strategy (present for minute item 10)

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

Action

TB/21/03/01 Welcome and Apologies for Absence

Michele Romaine, Trust Chair, welcomed everyone to NBT's Trust Board meeting in public. No apologies had been received.

TB/21/03/02 Declarations of Interest

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

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

RESOLVED that the minutes of the public meeting held on 28 January 2021 be approved as a true and correct record subject to the amendment received by Director of Estates, Facilities & Capital Planning regarding the Green Plan on page 4.

TB/21/03/04 Action Log and Matters Arising from the Previous Meeting

It was proposed that Action 19 be closed as Su Monk, Deputy Director of Nursing & Quality would continue lead the Patient/Staff stories until the new Patient Experience Lead started in May 2021.

Re Action 22, conversations were progressing regarding Non-Executive Director's return to the hospital site following the pandemic.

No matters arising were raised.

RESOLVED that updates on the Action Log were noted.

TB/21/03/05 Chair's Business

Board & Committee Effectiveness Review 2021
Michele Romaine, Trust Chair, informed the Board that a comprehensive review of Board and Committee effectiveness would be initiated in May/June 2021. A wholesale review of Committee structures was undertaken in January 2019, and the Board had reviewed and approved various Committee self-evaluations during 2019 and 2020. Trust Board effectiveness was also discussed as part of the Board development programme in November 2019 and some changes to how Private Trust Board was approached were made as a result. Michele was confident that the Board had properly considered effectiveness as a group over the last 12 months; however it had not been a priority during the Covid-19 pandemic, and it had not been a normal operating year, with many Committees stood down in line with national guidance.

The May/June review would also allow for the Trust's new Chief Executive to be involved. The approach would be agreed with Xavier Bell, Director of Corporate Governance, and input would be sought from all Board Members.

NHS Providers Chief Executive Seminar

Michele described a seminar led by Chris Hopson, NHS Providers Chief Executive, that included presentations from senior NHS leaders such as Amanda Pritchard, NHSE/I Chief Operating Officer. The seminar focussed on how the NHS should recover following the pandemic including concerns regarding referral rates and staff well-being.

RESOLVED that the Chair's briefing be noted.

TB/21/03/06 Chief Executive's Report

Evelyn Barker, Chief Executive, presented the Chief Executive's report and raised the following points:

- It was noted that a national, negative, CQC report into Do Not Resuscitate (DNR) forms used in hospitals throughout the pandemic had recently been published. BNSSG had taken part in the review and CQC feedback was positive: The ReSPECT form had been well adopted across the system and a strong commitment to supporting vulnerable patients who presented to hospital during the pandemic had been evident;

- On the year anniversary of the first lockdown, NBT had observed a minute's silence to remember those who had died from Covid-19;
- Evelyn thanked the public in their efforts to support the Trust through gifts and donations. Particularly, the family business Jolly Hog was thanked for donating an unbelievable 50,000 bacon and vegan butties for NBT staff throughout the pandemic. Jolly Hog's last day on-site would be Friday 26 March;
- Evelyn corrected a typo in the report regarding genomics: it was the '100,000 genomics project' not '500,000';
- Evelyn also thanked the Non-Executive Directors (NEDs) for their involvement in consultant interviews over the past year – 36 new consultants had been appointed.

Queries and comments from the Board were as follows:

- Kelvin Blake, NED, noted the disability charity he chaired had received an excellent, proactive response from NBT (via Chris Burton, Medical Director) re a DNR letter sent on behalf of the charity to healthcare providers in the region;
- Tim Gregory, NED, noted the new Associate Joint Director of Research (NBT/UHBW) role was a helpful appointment to enable a joint approach but queried if bodies across the system were aligned re developing research priorities. John Iredale, NED, responded that the bodies were aligned as research was included in many consultant's job plans and the university research departments were organised into research streams related to NHS challenges. There was also a strong pipeline of PhD roles linking Universities and Trusts across the region;
- Chris Burton agreed that the above role would increase leverage and be helpful in coordinating research programmes across both acute Trusts. The Acute Services Review Programme Board was also looking at research opportunities to facilitate equitable access of services for patients, irrespective of which Trust their healthcare journey began in. In addition, it was also noted that NBT's Quality Improvement Team had built a strong network across the system to share improvements;
- LaToyah McAllister-Jones, Associate NED, commended the vaccination programme progress but requested a specific update regarding underserved communities. Chris Burton responded that a full update would be provided to Private Board but that a huge amount of work with a local approach was taking place; encouraging vaccination from within communities through word-of-mouth and social media. Though expensive, there was good evidence the system's pilot 'roving model' was enabling vaccination of hard-to-reach communities. For example, Evelyn anecdotally added that she had spoken to a BAME respiratory consultant who had helped deliver 500 vaccinations at a Mosque over the weekend;
- Ade Williams, Associate NED, thanked the Executive Directors for their hard work and leadership throughout the pandemic. Ade also queried when the Board expected to see reports regarding delays and recovery and if any additional leadership resource was required as the Trust moved out of Command & Control structures. It was responded that these queries would be covered under the Renew and Recover agenda item later in the meeting.

RESOLVED that the Chief Executive's briefing was noted.

Emily Ayling joined the meeting

TB/21/03/07 Staff/ Patient Story - Mike's Story: a personal experience

{Slides distributed with following papers}

Helen Blanchard, Director of Nursing & Quality, introduced Emily Ayling, Patient Experience Manager, who provided the Board with a recent patient story related to Covid-19. Emily played Mike's voice note to the Board which covered his attendance at hospital due to Covid-19, his positive experience in the hospital (specifically excellent food and treatment from all staff), and his more negative experience following discharge re the gap in support for those suffering with after-effects of the illness.

Background, learning and actions, and acknowledgment of good practice from Mike's story were described within the presentation. Key learning points actioned following Mike's feedback included a focus on training re staff communication with patients within the medicine division and strengthening understanding between primary and secondary care.

During the ensuing discussion the following points were noted:

- Michele Romaine requested the Board's thanks be passed on to Mike for sharing his story. Michele stated she had been happy to hear Mike's appreciation of *all* staff involved in his care from porters to cleaners to catering staff. Michele also noted the impact one word (e.g. 'rejected') can have on a person especially at their most vulnerable, and how important staff communication training was;
- Tim Gregory, NED, noted it was especially helpful to hear from a patient who also had experience of working in the healthcare sector. Tim reiterated the communication issue and further highlighted that Mike's story represented the system's biggest challenge: when a patient falls between services. The system would need to continue to work on this, specifically in relation to post-Covid-19 support;
- John Iredale stated concern that NHS services did not extend to the level of support required by those who were profoundly emotionally and mentally affected by their experience of having a life-threatening illness;
- Kelly MacFarlane, NED, queried how Mike's story would be shared across the Trust to provide positive feedback and an opportunity to reflect. Emily Ayling responded that the story originated from the Divisional Patient Experience meeting which all divisional patient experience leads attended. Emily O'Hara, Divisional Director of Nursing for Medicine, was taking forward learning in terms of training for language used/staff communication within the Medicine Division. The aim was to expand this to other divisions in the future;
- Kelvin Blake reflected than many patients would not have the confidence to push-back to clinicians as Mike was able to do when

he experienced a negative clinician interaction. Kelvin suggested Mike's story could be used to help highlight to staff to remain kind and professional even when under pressure;

- Richard Gaunt, NED, queried if other patient feedback supported themes from Mike's Story. Helen Blanchard confirmed that a thematic overview of Covid-19 patient feedback would be included in the Annual Patient Experience Report;
- Neil Darvill, Director of Informatics, noted it was reassuring to hear of the high quality of care provided at NBT but noted that Mike's story highlighted issues when patients transferred between organisations. Neil noted that quality of care for patients through their whole journey would need to be prioritised as the system moved into an Integrated Care System (ICS);
- Evelyn Barker highlighted that though acute providers were now exiting the most recent wave of Covid-19, primary care were beginning to experience the wave re supporting long-Covid-19 sufferers. It was also noted that the emotional and psychological impact of Covid-19 was expected to last for a long time;
- Chris Burton emphasised the continued impact of Covid-19 on patients who had physically recovered. More support at time of discharge had been highlighted in Mike's Story and within patient feedback as part of the stroke programme. Chris noted that the ICS would need to ensure primary care felt confident in supporting patients following discharge from acute care.

RESOLVED that the Board thanked Mike for his story and thanked Emily Ayling for the important conversation. Helen Blanchard noted that thematic review of Covid-19 patient feedback would be included in the Annual Patient Experience Report. **HB**

Emily Ayling left the meeting

TB/21/03/08 Freedom to Speak Up (FTSU) Self-Review Tool

Xavier Bell presented the FTSU Self-review Tool which provided an opportunity for the Board to reflect on FTSU and Just Culture progress.

The Trust showed partial compliance across several headings which provided a snapshot of where the Trust was in its journey. In order to support FTSU work, the Board would be asked to build into their comms additional commitments regarding civility, Just Culture and speaking up. The Board agreed that as individual Board members, it was important to show support for FTSU wherever possible.

Hilary Sawyer, FTSU Lead, presented the ongoing work and next steps to refresh the FTSU network including training and opportunities for FTSU guardians, policy refreshment, launching of a FTSU vision and spreading the ethos and culture of speaking up throughout NBT.

The Trust's latest FTSU index score was average for acute trusts but NBT aspired to be one of the highest performing trusts. The focus for

improvement of NBT's index score would be to reduce the number of concerns raised anonymously at the Trust.

It was established that FTSU work was not occurring in isolation and that it would be included in the Just Culture work alongside the Equality, Diversity & Inclusion (EDI) agenda and Staff Survey work.

During the ensuing discussion the following points were noted:

- Kelly MacFarlane and John Everitt, NED, requested assurance regarding clarity of the success criteria for FTSU and a route map for achieving said success. It was responded that an immediate priority was to ensure the FTSU network was representative of the organisation and that Guardians felt supported to carry out their roles confidently. Definition of specific measures of success and actions to deliver was in progress but success criteria would likely be situated around reducing numbers of anonymous concerns raised;
- Jacqui Marshall, Director of People & Transformation, noted the People Data Dashboard being developed would include the FTSU index score alongside other People data such as grievances and staff survey results;
- Helen Blanchard suggested that the FTSU process in the paper may be too formal for staff communications and that it did not reflect the Guardian's role re signposting and encouraging managers to resolve issues. Xavier Bell clarified that the process presented was an internal FTSU tool for Guardians re how data and concerns were handled rather than for staff communication;
- Simon Wood, Director of Estates, Facilities and Capital Planning, stated that he had recently engaged with a member of staff through the FTSU and had received positive feedback on the process and its constructive influence.

RESOLVED that the Board:

- **Reviewed, discussed and endorsed the Trust Board FTSU self-review;**
- **Noted the ongoing work to refresh the Trust's FTSU vision, structure and network which would be revisited in May 2021 with the FTSU Annual Report;**
- **Agreed anonymous concerns should be the exception rather than the norm and committed as a Board to the overarching ambition of FTSU and Just Culture.**

TB/21/03/09 Renew and Recover Framework

Karen Brown, Chief Operating Officer, presented the 'Renew and Recover' Framework that had been collaboratively developed within the organisation alongside business planning and across executives and DMTs. The Framework covered the elective care recovery programme, outpatients, looking after our people, supporting innovation and enhancing dialogue.

The Board's attention was brought to key learning from the pandemic which would continue to be implemented particularly over winter. This included positive staff feedback re communication, inclusion, and modelling used to inform decisions at crucial points.

It was noted that the Elective plan would be brought to Board following receipt of national planning guidance. However, the Board was assured that NBT had elective beds available.

Jacqui Marshall updated the Board on the innovation and People aspect of Renew and Recover including staff well-being, lessons learnt, developing a sense of belonging, staff development and empowerment, and increasing dialogue to really listen to staff.

During the ensuing discussion the following points were noted:

- Kelly MacFarlane agreed with the paper's initiatives and outlined the following queries and requests, which would be responded to offline:
    1. How does NBT retain the best elements of Covid-19 ways of working and get staff back to normality and functional roles?
    2. Requested the key themes from the Outpatient survey (point 4.6. in paper) be presented to Board;
    3. Queried NBT's ambition in terms of numbers for apprenticeships and the Kickstart scheme (point 5.9);
    4. What Board support was required to champion innovation?
    5. Requested a question be included in Pulse Surveys re extent to which staff felt collaborative work continued post-pandemic.
- John Everitt highlighted the importance of committing to returning to Service Line Management (SLM) but queried how and when the Trust would prioritise recovery aims in order to plot trajectories for performance and staff well-being with the limited resources. It was responded that priorities and trajectories would be confirmed once finances and planning guidance was provided by the national team. This would be brought to the next Board meeting;
- Richard Gaunt queried who was responsible for procuring the Digital Patient Platform and providing delivery timescales re outpatients (4.5). Neil Darvill responded that the transformation project belonged in the STP (Healthier Together) and that it aimed to put the patient at the centre of their care. Healthier Together had begun to obtain a digital solution and Neil would bring updates to Board when appropriate;
- Ade Williams queried how NBT planned to bridge the health inequality and staff experience gap known to exist for BAME staff following completion of Covid-19 staff risk assessments. Jacqui

Marshall responded that she encouraged candid conversations on the topic and that NBT was involved with/ leading several initiatives:

- Providing various well-being options to support staff throughout the pandemic and post-pandemic;
- Equality, Diversity & Inclusion work with the system and the council in terms of health and social inequality;
- The system was one of five National 'Youth Pathways Finders' to encourage health conversations re wellbeing and careers in health;
- NBT had launched 'Valuing You' within the Trust for reciprocal mentoring for staff, beginning with executives.

- Tim Gregory praised the comprehensive paper covering a wide range of issues but noted the importance of moving the framework away from being a separate entity and into business as usual as soon as possible, particularly regarding staff well-being processes.

RESOLVED that the Board noted the 'Renew and Recover' Framework Update report and expected an update at next Board following national confirmation of finance and planning guidance. Karen Brown and Jacqui Marshall would respond to Kelly MacFarlane's above queries offline. **KB/JM**

TB/21/03/10 Staff Survey Report

Liz Perry, Director of People, and Guy Dickson, Director of People Strategy, presented the Staff Survey 2020 Results Headlines Report which was broadly positive as the Trust was now nearly above the national average for large acute Trusts. Specifically, NBT was better than average for patient care and as a place to work, with strong improvement in health and wellbeing, bullying / violence, and workload / resources. Having said this, management, quality of care, and inclusion were areas of deterioration.

It was noted that the Trust would continue with priorities as listed in the paper. Divisional planning and conversations were also taking place and would feed into the Renew and Recover work. Further Staff Survey results would be received shortly including answers to Covid-19-specific questions.

During the ensuing discussion the following points were noted:

- Michele Romaine queried if any results had surprised the People Team. Guy Dickson responded that the management results were disappointing but not surprising as the Leadership Programme had been paused during the pandemic and staff had been redeployed. Liz Perry noted the Just Culture initiatives were a great opportunity to improve future Staff Survey results;
- After a query, it was confirmed that the 'management' questions related to immediate line managers;
- John Everitt queried the process behind investigation into areas of concern raised by the Staff Survey Results. In response, Guy stated

that the roll-out of Voice Strategy would allow investigation into reasons behind Staff Survey results and areas of concern.

RESOLVED that the Board:

- **Acknowledged the major achievement in increased engagement from 41% to 51% over the last two years and thanked the People Team for their role in this;**
- **Discussed the key findings in the Staff Survey 2020 Results Headline Report and endorsed the four 2021 themes for action.**

TB/21/03/11 Integrated Performance Report

Evelyn Barker, Chief Executive, presented March's Integrated Performance Report (IPR) presenting February data and January cancer metrics. It was noted that ambulance handovers and ED performance had improved.

Karen Brown, Chief Operating Officer, highlighted the key operational performance elements of the IPR as follows:

- **ED** – NBT had begun recovery work; stranded patient numbers had reduced but complex of patients in the community had increased (P3);
- **Diagnostic** – May's QRMC would receive a deep dive on behalf of the Board re endoscopy, radiology, and non-obstetric ultrasound;
- **Cancer** - challenged month at the height of the pandemic. Significant increases in breast two-week-wait referrals had been seen. The Board was assured that NBT was delivering to the 28-day standard and the pathway was being reviewed;
- **Endoscopy** – It was recognised that the system's capacity was restrained with more to be done to expand capacity across the system and improve safety netting.

John Everitt noted that through there were issues, comparative Trust data was required to give a true measure of NBT's performance in addition to absolute numbers.

Helen Blanchard highlighted the key Quality elements of the IPR and Chris Burton reported on the Infection Prevention & Control (IPC) elements as follows:

- **Maternity** – A safety dashboard (stemming from Ockenden) was presented within the IPR. The dashboard was at an iterative stage and had been created to provide the Board with appropriate assurance. Maternity issues were discussed at length at March's QRMC where the Committee had offered support to the Maternity Team to achieve the multiple improvement action logs and regulatory requirements. No new Serious Incidents had occurred;
- **IPC** – There had been no hospital acquired Covid-19 cases since 27 February. This was a significant improvement compared to the previous month and all patient and staff outbreaks reported previously had been closed;

- **C-diff** – Two issues contributed to the high C-Diff numbers: Increased use of antibiotics due to managing complications from Covid-19; and late sampling (if later than 2 days, the infection is deemed as 'hospital acquired' rather than 'community acquired'). The Board was reassured that following the pandemic and the decrease in pressure on staff, promptness of screening would be an IPC focus.

Glyn Howells, Chief Finance Officer, noted the key finance points would be discussed within the finance report item later in the agenda.

RESOLVED that the Board:

- **Noted the contents of March's IPR and the key points detailed above;**
- **Approved the Provider Licence Compliance Statements.**

TB/21/03/12 Green Plan 2021/22

Simon Wood presented the 2021/22 Green Plan and highlighted four key points:

- A Carbon Route Map for the Trust to achieve its Carbon-Neutral aim would be developed by a specialist, international company with offices in Bristol. The company was also working with Bristol City Council. An update on the Road Map would be provided to Board in September 2021;
- The previous Sustainable Engagement Programme would be re-launched to help assist culture change;
- TMT had approved the role of the sustainability advocate to be situated within divisions (job role attached);
- NBT was taking part in a No-Mo May which meant leaving grass long for butterflies and bugs to thrive.

John Everitt raised concern that the plan required significant resource to implement. Simon Wood agreed the Green Plan would require significant capital and revenue investment across the following decade with each element requiring a business case to be approved.

Richard Gaunt queried if NBT's Green Plan had been triangulated with what other Trusts were doing nationally. Simon Wood responded that Sustainable Development (SD) teams were engaged across the country including via a national SD Group, within which NBT would continue to work and lead to identify priorities and best practice.

Michele Romaine queried the impact of the pandemic and resulting plastic waste on the SD ambition. It was responded that the Trust's sustainability was positive overall as less energy resource had been used and less travel had occurred during the pandemic. It was however recognised that clinical waste had increased dramatically across the country and at the Trust. NBT would continue to ensure waste was streamed correctly.

RESOLVED that the Board approved the 2021/22 Green Plan work areas.

TB/21/03/13 Finance Month 11 Report

Glyn Howells, Chief Finance Officer, presented the Month 11 Finance Report. It was reported that the previously outstanding £1.5m capital had now been paid to NBT from the national team and the Trust had broken even and received all funding owed for the first half of 2020/21.

Regarding the second half of 2020/21, NBT was paid under block arrangement and underfunded on certain other income. NBT was on-track to break even with close to a 200% spend on capital compared to what was originally expected. £2m CIP had been delivered.

Following a query from Richard Gaunt, Glyn confirmed that the position was to break-even and any unspent money would be required to be sent back to the centre as no surplus was allowed.

RESOLVED that Trust Board noted:

- **the revised financial framework that the Trust was operating in;**
- **the spend and recovery for Covid-19 response and Nightingale in relation to the revised framework;**
- **the spend and income for Core Trust services in relation to both revised framework and annual plan; and**
- **the cash position of the Trust.**

TB/21/03/14 HSE inspection update – summary of actions and progress

Simon Wood presented the HSE inspection update to provide assurance on actions. It was noted that the most complicated area for action was regarding changing facilities which had been re-risk-assessed, and staff had been encouraged to use facilities across the Trust. However, it was noted that popular changing facilities were still busy at peak shift-change times.

It was reported that due to the build-up of supplies stored in corridors etc., it had been agreed that NBT would rent off-site storage space for resources not required on a day-to-day basis. The hospital would be de-cluttered immediately with divisional involvement to ensure appropriate daily-use supplies were kept on-site where required. It was also suggested on-site storage may need to be built in the future.

RESOLVED that the Board noted the actions taken against the HSE Notice of Contravention to the Trust; received the HSE report on the 17 hospitals inspected; and noted the need for additional storage to ensure smooth-running of the hospital.

TB/21/03/15 Quality & Risk Management Committee Upward Report

Professor John Iredale presented the QRMC upward report and associated appendices. The QRMC meeting had had a considerable focus on maternity and the Patient Safety Programme was noted as an exciting piece of work. QRMC was also assured on behalf of the Board

regarding NBT's Cancer Safe-To-Wait process and approach to the Serious Incident: Care Home outbreak.

RESOLVED that the Board:

- **Noted the ongoing work regarding maternity services and the completed Maternity Assurance Assessment Tool which completed an Ockenden action;**
- **Noted the final, positive, CQC Gynaecology inspection report;**
- **Approved the QRMC Terms of Reference (following addition of Control of Infection Committee as a sub-committee).**

TB/21/03/16 People Committee Upward Report including safe staffing update

Tim Gregory presented the People Committee Upward report. He noted the encouraging work carried out despite challenges from Covid-19. The People Committee would continue to closely monitor recovery and staffing trends on behalf of the Board.

RESOLVED that the People Committee upward report and recommendations were noted. Kathryn Holder, Guardian of Safe Junior Doctor Working, was thanked for her excellent work as she would shortly be stepping down from the role.

TB/21/03/17 Board Assurance Framework

Xavier Bell presented the Board Assurance Framework (BAF). The BAF was brought to Public Trust Board to ensure transparency of key risks; It was noted Patient Experience and Safety continued to be the highest risk.

Glyn Howells clarified there was no financial risk included on the risk register because the cash flow risk was not high enough to meet the BAF criteria as the Trust had sufficient funds to cover any shortfall.

RESOLVED that the Board noted the Board Assurance Framework.

TB/21/03/18 Healthier Together update report

RESOLVED that the Healthier Together update was noted for information with a detailed conversation regarding the ICS and system MoU scheduled for the Private Board session.

TB/21/03/19 Any Other Business – None

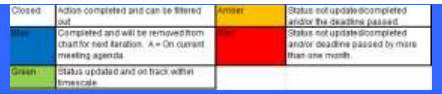
TB/21/03/20 Questions from the public – None received

TB/21/03/21 Date of Next Meeting

The next Board meeting in public is scheduled to take place on Thursday 27 May 2021, 10.00 a.m. The Board will meet virtually, and a recording of the meeting will be available for two months when it will be replaced with the next meeting's recording. 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 12.40 pm

Trust Board - Public ACTION LOG



Meeting Date	Agenda Item	Minute Ref	Action No.	Agreed Action	Owner	Deadline for completion of action	Item for Future Board Meeting?	Status/RAG	Info/ Update	Date action was closed/ updated
30/01/2020	Board member's walk-arounds	TBC/20/01/09	22	A Board workshop/ seminar to reach a shared decision on NED and Exec walk-arounds, including staff perspectives, to be organised	**Xavier Bell, Director of Corporate Governance**	TBD	Yes	**Closed**	Programme of NED walk-arounds being developed to commence from June.	20/05/2021
25/03/2021	Renew and Recover Framework	TB/21/03/09	46	Respond to Kelly MacFarlane's queries re renew & recover (See minutes)	**Karen Brown, Chief Operating Officer and Jacqui Marshall, Director of People & Transformation**	May-21	No	**Closed**	Conversations had been completed offline. The next big thing has been launched; First SLM session 20/05 as agreed post Renew and Recover work; Paper on OP being developed with CCS will include themes from the OP Survey as part of their detailed pillars.	20/05/2021

Report To:	Trust Board Meeting		
Date of Meeting:	27 May 2021		
Report Title:	Chief Executive's Briefing		
Report Author & Job Title	Bryony Coley, Business Manager and Senior Executive Personal Assistant		
Executive/Non-executive Sponsor (presenting)	Maria Kane, Chief Executive		
Does the paper contain:	**Patient identifiable information?**	**Staff identifiable information?**	**Commercially sensitive information?**
		X	
*If any boxes above ticked, paper may be received at *private* meeting			
Purpose:	**Approval**	**Discussion**	**To Receive for Information**
			X
Recommendation:	The Trust Board is asked to: • Receive and note the content of the briefing; and • Consider and endorse the Trust Priorities 2021/22 (*Appendix 1).*		
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
This report sets out information on key items of interest to Trust Board, including changes in senior leadership within the Trust, system programmes and other items of importance which are not covered separately on the Trust Board agenda.

Strategic Theme/Corporate Objective Links	**1. Provider of high-quality patient care** **2. Developing Healthcare for the future** **3. Employer of choice** **4. An anchor in our community**
Board Assurance Framework/Trust Risk Register Links	Does not link to any specific risk.
Other Standards Reference	N/A

Financial implications	None identified.
Other Resource Implications	No other resource implications associated with this report.
Legal Implications	None noted.
Equality, Diversity and Inclusion Assessment (EIA)	N/A
Appendices:	Appendix 1: NBT Trust Operational Priorities 2021/22

1. Purpose

The report sets out information on key items of interest to Trust Board, including changes in senior leadership within the Trust, system programmes and other items of importance which are not covered separately on the Trust Board agenda.

2. Background

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

3. Accelerator Programme

Two weeks ago, NHS England announced that Bristol, North Somerset and South Gloucestershire will be taking part in a national programme to accelerate elective activity and recover routine services from the impact of COVID-19 as quickly as possible. Over the summer the Accelerator Systems Programme will aim to trial new ways of working to carry out extra operations and outpatient appointments that had to be postponed in the pandemic. With NBT's Deputy Chief Executive Evelyn Barker leading the project across the system, working closely with colleagues in UHBW and Sirona, our teams will be deploying innovations – such as expanding our successful Hospital at Home service – to keep people well before and after surgery and maximise the time of clinical teams. A sign of the huge confidence in our abilities, this will require huge effort and creativity across our organisation – all qualities for which NBT is well known. I would also like to thank all those involved in showing the best of NBT in a BBC News piece on our accelerator innovations.

4. Acute collaboration

NBT and University Hospitals Bristol NHS Foundation Trust (UHBW) Executive Teams met in May 2021 to discuss ongoing collaboration and joint working. The group explored how we can work together most effectively within our evolving Integrated Care System, building on the work of the existing Acute Care Collaboration Programme Board, and how we can provide joined up care for the benefit of patients.

5. Trust Priorities & Trust Management Team away-day

The Board is asked to consider and endorse the Trust operational priorities for 2021/22 which have been developed during sessions with the Executive Team and wider Trust Management Team, aligned with the Trust Strategy. The priorities focus on restoration and recovery post-Covid-19 and underpinned by continuous improvement (see *Appendix 1*).

I will be hosting an away-day for members of the Trust Management Team in June 2021. The purpose of this away-day is to allow the Trust's senior executive, clinical and operational leaders to come together as a group to discuss our organisational priorities for 2021/22 and beyond, the changing national and system landscape and how NBT can best respond to emerging demands and opportunities.

The Trust Management Team will also be joined by a guest speaker, Dame Marianne Griffiths, Chief Executive of Western Sussex Hospitals NHS Foundation Trust. She will be sharing her organisation's continuous improvement journey, and how they have used

continuous improvement methodology to achieve an "outstanding" rating across all CQC domains.

6. Service Line Management (SLM) Development Group

As the organisation's focus has switched from the Covid-19 operational response to the restoration and recovery phase, the decision has been taken to re-launch the SLM Development Group. This is an important step in transitioning out of "command and control" and back to more devolved decision-making so that it sits closer to the teams providing patient care. The SLM Development Group of clinical, operational and corporate leaders took part in a "Reset Masterclass" in May, using Appreciative Enquiry to begin the process of designing how SLM will cascade to specialty leads across the organisation.

7. International Nurses Day

This month on International Nurses' Day and International Day of the Midwife we celebrated the expertise, commitment and kindness of our nurses, nursing associates, assistant practitioners, healthcare assistants, midwives and maternity care assistants across NBT. As a gesture of thanks, we delivered cakes and thank you cards to teams as well as sharing a video from the senior nursing team and myself to say thanks to the colleagues whom we were not able to see in person.

8. Volunteers Week

Next week we will be celebrating the huge contribution made by our army of volunteers to mark National Volunteers' Week. From Move Makers to musicians, we have hundreds of volunteers who are essential to the running of our services and improving patient experience. Although some of our volunteer programmes have been reduced during the pandemic, we are incredibly grateful to those who have continued to come into the hospital and support us in different ways across the last year. A lot of work has been going into our three-year Volunteer Service Strategic Plan and we hope to launch this soon as we look to drive the service from strength to strength and support the hospital's continued recovery from the pandemic. Throughout the week we will be profiling some of our volunteers across our communications channels to showcase their brilliant work. We look forward to a time soon where we can get together and celebrate their work in person.

9. Key Personnel Updates

Mr Tim Whittlestone, Deputy Medical Director, has been appointed as Interim Medical Director. He will take on the role from the end of July 2021 when Dr Chris Burton steps down. Tim was appointed from a strong field of candidates and will serve in the role until early next year allowing the Trust to recruit into the role on a permanent basis.

Alongside the Medical Director transition, the statutory role of Director of Infection Prevention & Control (DIPC) will move from the Medical Director to Helen Blanchard, Director of Nursing & Quality. This will bring NBT's arrangements in line with common practice across the NHS.

Chris Burton will be taking a role as Clinical Lead for the Imaging Network for the north of the region looking at strategic oversight and investment of the region's imaging and diagnostic capabilities for the future.

10. Consultant Appointments

Since this report was last issued in March 2021 the Trust has appointed 12 new consultants across several key specialities:

Name	Speciality	Appointed From
Mark Dirnhuber	Anaesthetics	January 2021
Ben Ballisat	Anaesthetics	January 2021
Katherine Nickell	Anaesthetics	February 2021
Shigong Guo	Rehabilitation Medicine	February 2021
Paul Creamer	Rheumatology	February 2021
Philip Hamann	Rheumatology	February 2021
Graeme Nicol	Trauma & Orthopaedics	February 2021
Libuse Pazderova	NICU	March 2021
Belma Doyle	Breast Surgery	March 2021
Rina Adhikary	Acute Medicine	March 2021
George Wheble	Plastics	April 2021
Izak Heys	Infectious Diseases	April 2021

11. Summary and Recommendations

The Trust Board is asked to note the content of this report, consider and endorse the Trust priorities for 2021/22 and discuss as appropriate.

Our Focus for 2021/22

Patient First. Recover. Learn. Improve.

NHS
North Bristol
NHS Trust

1. Provider of high quality patient care

- **Accelerate** restoration of **planned care**, addressing clinical prioritisation and health inequalities across our system
- Transform non-elective care through **continuous improvement**

2. Developing healthcare for the future

- Create a BNSSG **provider collaborative** to improve patient experience and pathways
- Deliver improvements in **maternity care**, including responding to the recommendations of the Ockenden review
- Recover and grow our **research portfolio**

- Learn from our patients' experience
- Continuous improvement.
- Transform services
- Adopt digital solutions
- Use money and resources sustainably

3. Employer of choice

- Support the **recovery and wellbeing** of our workforce
- Embed new agile ways of working that allow our staff to **thrive**
- Promote a **diverse, fair and inclusive** culture

4. An anchor in our community

Working with partners to:

- Support **population health** management
- **Address inequalities**

Our values

- **Putting patients first**
- **Working well together**
- **Recognising the person**
- **Striving for excellence**

Exceptional healthcare, personally delivered

NHS North Bristol NHS Trust

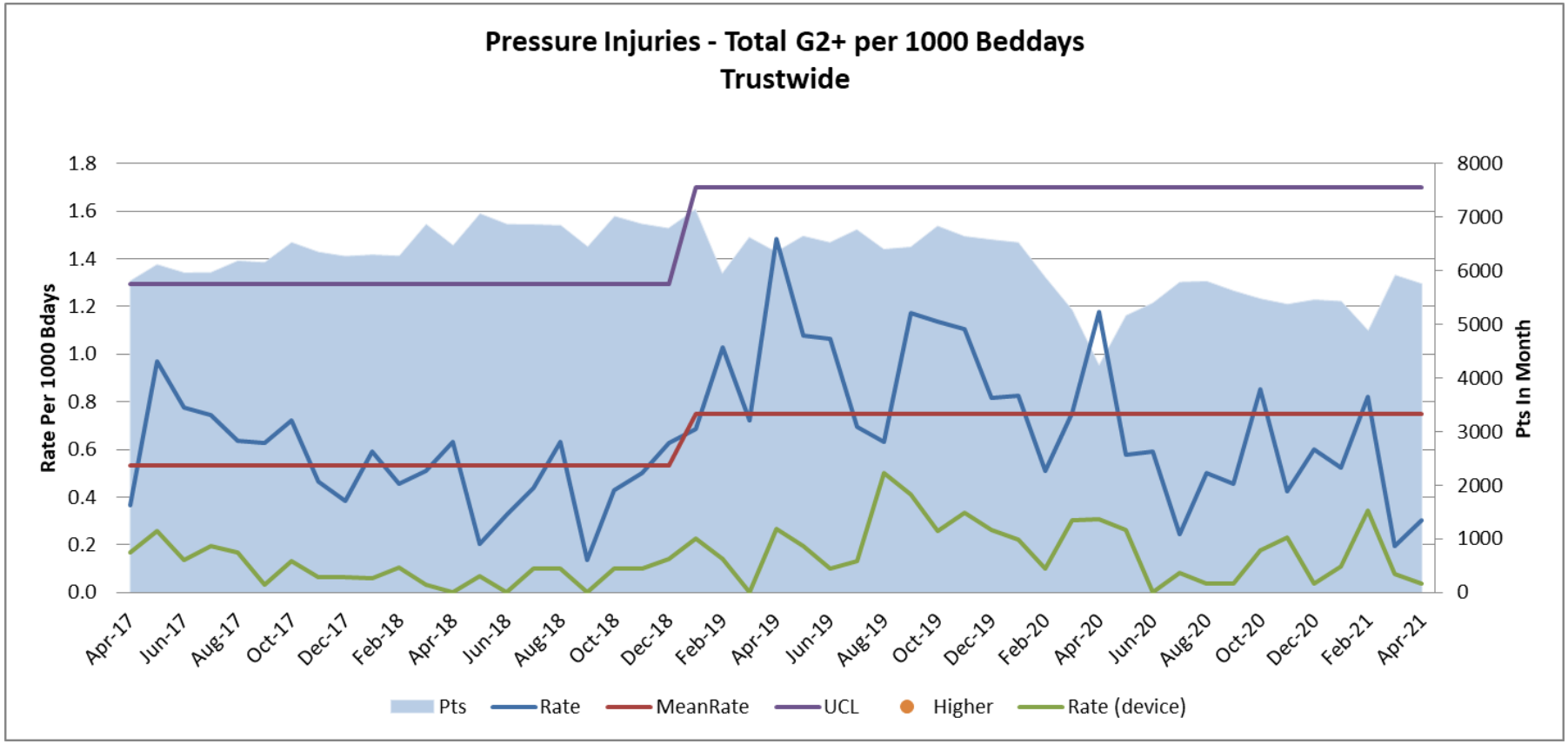
Reduction & Prevention of Pressure Injuries Programme Update

Trust Board May 2021

Exceptional healthcare, personally delivered

- **KPI for 2020/21:** 30% reduction in NBT attributable Grade 2 Pressure injuries
  30% reduction in NBT attributable medical device related pressure injuries
  Zero tolerance for NBT attributable Grade 3 & 4 pressure injuries

NHS North Bristol NHS Trust



Celebrating Successes

NHS North Bristol NHS Trust

Reduction & Prevention of Pressure Injuries Driver Diagram (2020_21)

Reduce the incidence of pressure injuries

Prevention of pressure injuries

- Risk identification & assessment
  - Trust staff can identify risks using the Trust electronic patient record system by completing the pressure injury risk assessment on admission and daily
- Implementation of skin checks and correct use of the SSKIN Care Plan
- Discharge Summaries will include pressure injury prevention and management issues
- Medical device prevention strategies

Education training

- Sustain the integrated rolling programme of staff development and training on a range of safety elements and develop and sustain a positive safety culture :-
  - Tissue Viability (assessment, grading and management pressure areas/injury/ SSKIN Care Plan/ Healthy heels
  - Safeguarding (Capacity)
  - Dietetics (nutrition)
  - Manual handling (patient repositioning)
- Patient & family education

Monitoring and Audit

- The Trust will review the reporting and escalation format used by the Division
- The Trust will react to audit results and implement action plans at ward, divisional and Trust level
- Process in place to monitor Pressure Injury data
- Provide Trust Board with PI incidence report as part of integrated board report
  - Performance data
  - Escalation of key risks
- Trust to undertake incident review for all hospital acquired pressure injuries that are grade 3 or 4

KPIs

- 95 % Lorenzo compliance:
  - Admission (6 hours)
  - Daily

- 75% attendance TV link practitioner
- 85% compliance of SSKIN Competency
- Divisional evidence of action plan learning:
  - RCA
  - SWARM

- Sustained threshold reduction Grade 2
- Sustained threshold reduction medical device related Grade 2
- SSKIN Audit compliance 95%

The KPI for the reduction of NBT attributable pressure injuries in 2020/21 was 30% for non-device related damage and grade 2 pressure injuries. However, the Trust achieved the following for hospital attributable pressure injuries;

- **49% reduction in grade 2 pressure injuries – 161 in total**
- **57% reduction in medical device related pressure injuries – 39 in total**
- **60% reduction in grade 3 pressure injuries**

3 yearly TV – 92%

Risk Assessment compliance increase from 52% - 64%

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Celebrating Successes

NHS North Bristol NHS Trust

Mike Puckey
Senior Sister Gate
ICU

Jess Reece
Sister
Gate 25a

Claire Ross
Sister
Gate 27a

Patient Story

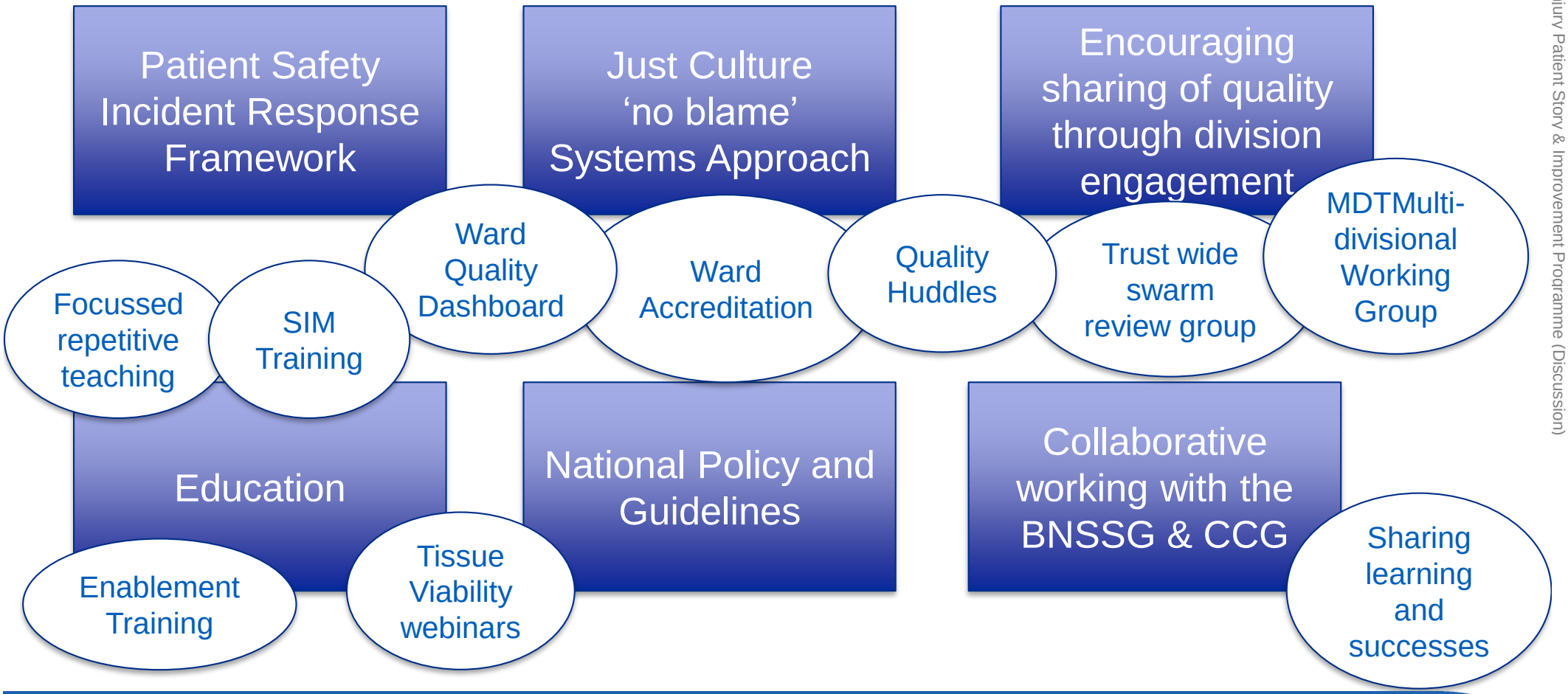
NHS North Bristol NHS Trust

https://www.youtube.com/watch?v=s4LiBiyjJVU

Focus for 2021/22

Promoting and Providing high-quality patient care that is safe, effective and harm free

NHS North Bristol NHS Trust



Report To:	Trust Board		
Date of Meeting:	27th May 2021		
Report Title:	Restorative Just Culture and Psychological Safety Update		
Report Author & Job Title	Caroline Hartley, Head of People Christopher Brooks-Daw, Associate Director of Patient Safety		
Executive/Non-executive Sponsor (presenting)	Helen Blanchard, Director of Nursing and Quality Jacqui Marshall, Director of People and Transformation		
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	**X**
Recommendation:	For discussion and support of approach and next steps		
Report History:	Discussed at Trust Management Team (TMT) 18th May 2021		
Next Steps:	As described in the presentation		

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Executive Summary
The Trust Board received a presentation at the August 2020 meeting. This presentation aims to remind the Board of the underpinning principles of a just and psychologically safe culture, aligning with national drivers and to continue to involve you in our journey. It describes what we have done since August 2020 and demonstrates how we continue to align our approach across people and safety as we recognise the relationship between safe staff and safe patients. North Bristol NHS Trust has ambitious intentions regarding its culture. We ask the Board to recognise that the understanding and measurement of organisational culture comes with particular challenges and we will continue to explore mechanisms to understand and measure culture in NBT. This will be underpinned by a growing body of research and align with the ongoing work by the National Patient Safety Team and NHSE/I in developing and agreeing metrics to measure culture.

North Bristol NHS Trust

To aid with navigating this, it is useful to set out how the NHS describes culture.

The NHS Patient Safety Strategy 2019 and its associated guidelines frame culture as one of the two foundations of patient safety (with system being the other). The strategy draws on many references but particularly the work done by Sidney Dekker around just culture and Amy Edmondson around psychological safety and "fearless organisations".

We are the NHS: The People Plan 2020/2021 says "This is a promise we must all make to each other – to work together to improve the experience of working in the NHS for everyone". 'Our NHS People Promise', part of The People Plan, includes the statements 'We are always learning', 'We each have a voice that counts' and 'We are compassionate and inclusive'.

In very broad terms, "just culture" can be described as how we respond and talk when things ~~go wrong~~ don't go as planned or as hoped, with "psychological safety" being how safe people feel to speak and share their opinions in any given situation.

We invite the Board members to discuss and ask questions to foster debate. We do not come with all of the answers as we recognise that the journey we are on will ask us all as individuals and as an organisation to consider how we behave, act and respond in any given situation.

It also challenges us to consider how we can systematise an approach to supporting a just and psychologically safe culture.

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 out 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 **4. An anchor in our community** a. Create a health & accessible environment b. Expand charitable support & network of volunteers c. Developing in a sustainable way

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NHS North Bristol NHS Trust

<table>
<tr><td>Board Assurance Framework/Trust Risk Register Links</td><td></td></tr>
<tr><td>Other Standards Reference</td><td></td></tr>
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<tr><td>Existing budget</td><td></td><td>[provide details of budget]</td></tr>
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<tr><td>External Funding</td><td></td><td>[identify source of funding, and whether it has been secured]</td></tr>
<tr><td>Other</td><td></td><td></td></tr>
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<tr><td>Legal Implications</td><td></td></tr>
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<tr><td>Appendices:</td><td></td></tr>
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9

NHS
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Trust Board
Restorative Just Culture and Psychological Safety Update
May 2021

Caroline Hartley, Head of People
Christopher Brooks-Daw, Associate Director of Patient Safety

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Restorative Just Culture at NBT - Update

North Bristol NHS Trust

- Reminder of Restorative Just Culture and Psychological Safety principles
- Alignment with other programmes of work – including regional, system and national
- Progress since last meeting
- Regional/national position
- Vision and pledges
- Collaboration with other organisations
- Plans for next 6 months
- Questions/comments

Just Culture

NHS North Bristol NHS Trust

‘ A just culture is a culture of trust, learning and accountability. In the wake of an incident, a restorative just culture asks: 'who is hurt, what do they need, and whose obligation is it to meet that need?'

It doesn't dwell on questions of rules and violations and consequences. Instead, it gathers those affected by an incident and collaborates on collectively addressing the harms and needs created by it, in a way that is respectful to all parties. It holds people accountable by looking forward to what must be done to repair, to heal and to prevent.’

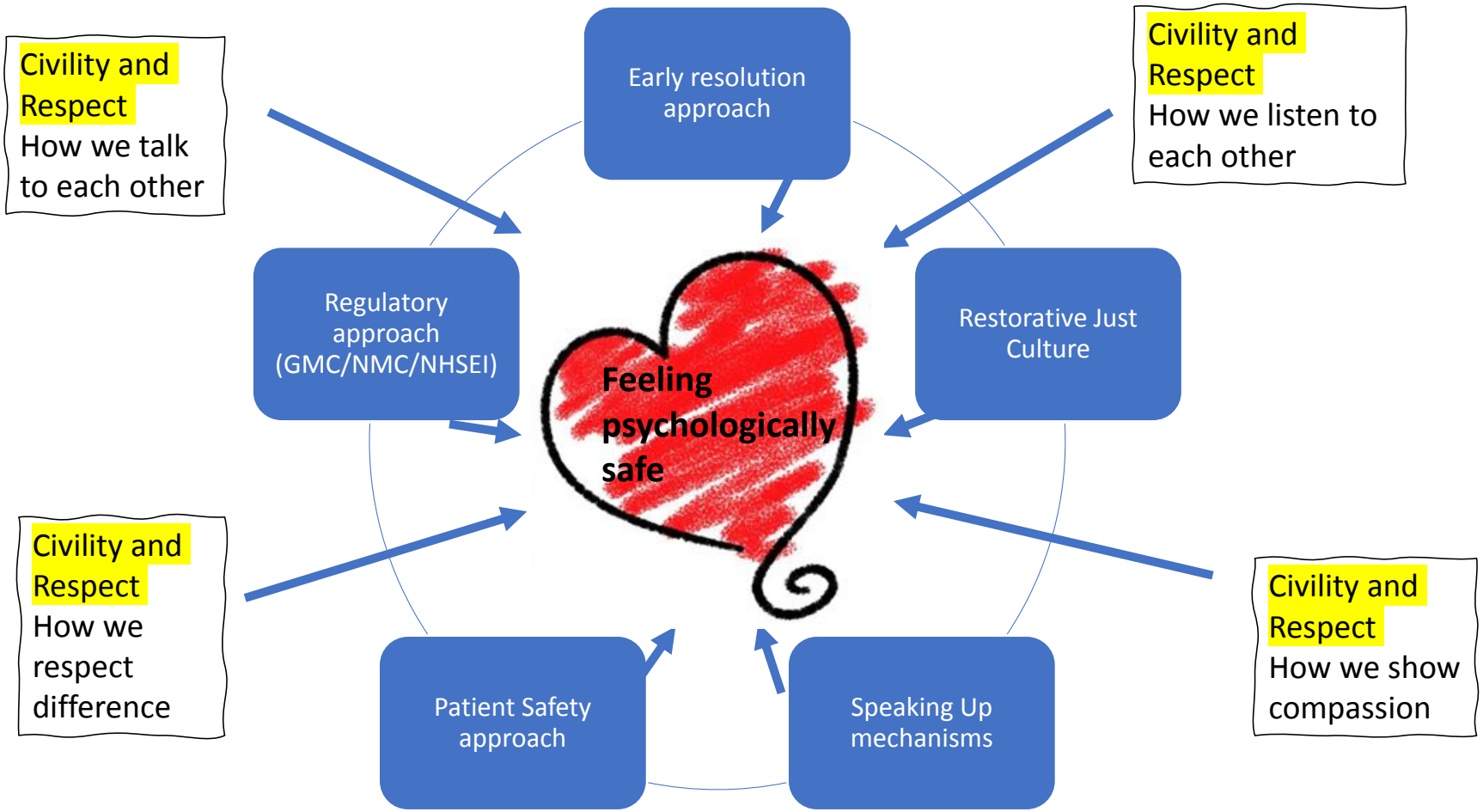
Professor Sydney Dekker, Just Culture

Psychological Safety

The belief that one will not be ***punished*** or ***humiliated*** for speaking up with ideas, questions, concerns or mistakes

Amy Edmondson, 'Psychological Safety and Learning Behaviour in Work Teams.' and the Fearless organisation

Psychological Safety at NBT: A framework of underpinning cultural approaches and tools



NHS North Bristol NHS Trust

RESTORATIVE JUST CULTURE – KEY WORK STREAMS – what have we done?

Comms & Engagement	Training and Learning	Resources	Systems and Processes	Monitoring & evaluation
GOAL: To ensure that the Restorative Just Culture approach is shared, understood and embraced by all at NBT	**GOAL:** To share/deliver learning and training to all staff to support their understanding of working and applying Restorative Just Culture	**GOAL:** To ensure that resources and tools which enable our shared knowledge and learning are pulled together and made accessible to all	**GOAL:** To develop internal systems and processes which support and enable Restorative Just Culture	**GOAL:** To develop objectives & KPIs in order to monitor progress and the effectiveness of Restorative Just Culture at NBT

Progress: October 2020 – May 2021

Comms & Engagement:	Training and Learning:	Resources:	Systems and Processes:	Monitoring & evaluation:
1. RJC network meetings established and occurred 2. Development of draft RJC/SU definition 3. Formal comms link agreed 4. Alignment and joint working with Speaking Up and Patient Safety 5. Continuation of strong partnership working	1. RJC Training – over 40 attendees 2. Healthcare Incident Investigation Training 3. Presentations/RJC sessions delivered in more areas 4. NBT's '4-step model' drafted 5. Newly drafted 'Early Resolution' framework & toolkit, to support a Just Culture approach 6. New approach being tried when issues arise	1. RJC 'microsite' page built on LINK 2. Articles, videos and stories shared 3. Sharing of resources and approach with SW Regional Social Partnership Forum	1. Disciplinary Policy re-drafted 2. Other policies being reviewed under the lens of RJC 3. Decision-making groups and roles have been defined 4. B&H policy being re-framed as 'Civility and Respect at Work' 5. RJC embedded in patient safety investigation processes 6. PSIRF preparation	1. Project Plan updated 2. KPIs re-drafted 3. Action plan developed following ER Tracker audit 4. Link with National Patient Safety Team

Regional and National Position

NHS North Bristol NHS Trust

- Just Culture and Civility and Respect are key feature of the NHS People Plan and new toolkits and guidance are starting to be developed
- Links also to a mandate for all Trusts to review Disciplinary Policies and processes by end June 2021
- Regional, South-West Social Partnership forum (RSPF) has been running quarterly workshops on Just Culture, to encourage sharing and collaboration
- Development of regional guiding principles are being considered
- NBT is an early adopter for the Patient Safety Incident Response Framework – core driver and process in patient safety culture.
- NBT presentation to national PSIRF early adopters to share learning and journey so far

Collaboration and Partnership Working

- Continued partnership working with Trade Unions
- Focussed work with Learning and OD Team
- Collaboration with Royal Cornwall NHS Trust, North Devon CCG, Regional RCN representative and NHSE/I
- Continued networking with Mersey Care NHS Foundation Trust
- Due to present NBT's journey to date at next Regional Social Partnership Forum
- Collaboration and partnership working with National Patient Safety Team

NHS North Bristol NHS Trust

Vision statement

North Bristol NHS Trust is a safe and fair place where everyone's voice is encouraged, valued and listened to, helping us to continually learn and improve

North Bristol NHS Trust RJC ambassadors

Restorative Just Culture Pledges (draft)

North Bristol NHS Trust

At NBT, we pledge:

To value compassion and kindness with colleagues every day

To actively support and empower learning when things don't go as expected

To encourage speaking the truth about something which didn't go to plan

To be safe to say what we think, share our ideas and hear what others' views are

To learn by asking 'what' and 'how' as opposed to 'who' when the unexpected happens

To have exploratory conversations to understand the events

To be open with those involved, talking and understanding compassionately. To focus on the facts and keep everyone involved informed in a timely way

To be responsible for our own work, behaviour and actions

To listen openly and without judgement to what others have to say

To respect others' differences and differences of opinion

Restorative Just Culture - drivers

North Bristol NHS Trust is a safe and fair place where everyone's voice is encouraged, valued and listened to, helping us to continually learn and improve

Milestones and Next Steps:

- Ensure that the Restorative Just Culture approach is shared, understood and embraced by all at NBT
- To share/deliver learning and training to all staff to support their understanding of working and applying Restorative Just Culture
- To ensure that resources and tools which enable our shared knowledge and learning are pulled together and made accessible to all
- To develop internal systems and processes which support and enable Restorative Just Culture
- To develop objectives & KPIs in order to monitor progress and the effectiveness of Restorative Just Culture at NBT

Framework

- Use existing
- RJC ambassadors' network
- Establish culture steering group

Key Risks and issues:

- Time and capacity
- No nationally recognised culture indicators
- Huge agenda – attempting to do too much too quickly

Foundations

- Develop key programmes (through steering group)
- Ongoing engagement
- Updated People policy framework
- Updated Patient Safety Policy Framework
- PSIRF (go live June 7th)
- Training materials and resources
- Resources through LINK - including new "microsite" for RJC
- Library of experiences and stories
- Development of indicators and insights into culture – align with NHS Improvement and NHS England

Reporting mechanisms through Patient Safety and People Committee framework

June 2021 – December 2021

Report To:	Trust Board		
Date of Meeting:	27 May 2021		
Report Title:	Freedom to Speak Up (FTSU) Vision, Strategy & Action Plan		
Report Author & Job Title	Hilary Sawyer, Lead Freedom to Speak Up Guardian Xavier Bell, Director of Corporate Governance		
Executive/Non-executive Sponsor (presenting)	Xavier Bell, Director of Corporate Governance		
Does the paper contain:	**Patient identifiable information?**	**Staff identifiable information?**	**Commercially sensitive information?**
*If any boxes above ticked, paper may need to be received at *private* meeting			
Purpose:	**Approval**	**Discussion**	**To Receive for Information**
	X		
Recommendation:	That Trust Board review and approve the refreshed NBT FTSU Vision, Strategy and Action Plan		
Report History:	The Trust Board approved NBT's original FTSU vision, strategy and action plan in October 2018. This refreshed NBT FTSU Vision, Strategy and Action Plan has been developed after consultation across the organisation and was approved by Trust Management Team in May 2021.		
Next Steps:	The FTSU Vision, Strategy & Action Plan will be progressed, with bi-annual updates to Trust Board.		

10.1

Executive Summary
NHS Improvement requires organisations to have a clear vision for the speaking up culture in their organisation, which is supported by a strategy. FTSU Guardians have been in place at NBT since November 2017, and Trust Board approved the organisation's original FTSU Vision, Strategy and Action Plan in October 2018. In 2020, the Board approved plans for a restructure of the FTSU Guardian network through the creation of a specific independent Lead FTSU Guardian post with protected time to undertake the role. This recognises the value that FTSU brings to the organisation, and the need to support and strengthen the established FTSU volunteer network. It also aligns NBT with best practice as described by the National Guardian's Office (NGO). The Lead FTSU Guardian took up the post on 18 January 2021.

NHS North Bristol NHS Trust

Since joining the Trust, the Lead Guardian has been engaging with the organisation, and working to increase the visibility of FTSU. An early priority has been to work with the Executive Lead for FTSU to refresh the FTSU Vision, Strategy and Action Plan, and to ensure that it is aligned to, and supports the organisations other relevant strategies and priorities. When developing the refreshed FTSU Vision, Strategy and Action plan, care has been taken to ensure that it aligns with the Trust's work on Restorative Just Culture, and that it supports the Trust's overarching People Strategy. This is set out in more detail on pages 4 and 5 of the attached documents. The objectives and actions set out in the documents have also been informed by the Organisational FTSU Self-Assessment which TMT and Trust Board reviewed and endorsed in March 2021, alongside the proposal to introduce an FTSU Champions Network. Trust Board is asked to approve the FTSU Vision, Strategy and Action Plan (subject to any final feedback/comments) and voice its support for Freedom to Speak Up. The bi-annual report setting out NBT FTSU data for 2020/21 is being presented via a separate paper.	
Strategic Theme/Corporate Objective Links	**1. Provider of high-quality patient care** **2. Employer of choice**
Board Assurance Framework/Trust Risk Register Links	Does not link to any specific risk; however, having an effective and empowered workforce, who can speak up and respond effectively will assist in the identification and effective management of risks across the organisation.
Other Standards Reference	NHS Improvement: Guidance for boards on Freedom to Speak Up in NHS trusts and NHS foundations Trust – July 2019
Financial implications	N/A
Other Resource Implications	N/A
Legal Implications	N/A
Equality, Diversity and Inclusion Assessment (EIA)	Feedback from staff-side, staff networks and divisional teams has identified the need to improve/increase the diversity of NBT's FTSU Guardian network, in order to improve accessibility to all staff groups, particularly those with protected characteristics. This has been incorporated into the Strategy's objectives and action plan and will be a particular focus and success criteria of the FTSU Champion Network.
Appendices:	Appendix 1: 2021/22 FTSU Vision, Strategy & Action Plan Appendix 2: Equality Impact Assessment

NHS
North Bristol
NHS Trust

NBT
Freedom to Speak Up (FTSU) Vision, Strategy and Action Plan

May 2021

Xavier Bell,
Director of Corporate Governance
Executive lead for FTSU

Hilary Sawyer, NBT Lead FTSU Guardian

10.1

National Guardian
Freedom to Speak Up

North Bristol NHS Trust

Content

North Bristol NHS Trust

Introduction

Our staff are the eyes, ears, hearts and minds of the organisation. As an organisation we rely on them to tell us when things go wrong or when anything gets in the way of high-quality patient care. A healthy speaking up culture provides a safer workplace for our staff and our service users.

Freedom to Speak Up (FTSU) Guardians have been in place at North Bristol NHS Trust (NBT) since November 2017. NBT's original FTSU Vision, Strategy and Action plan (see appendix 2) was adopted by Trust Board on 31 October 2018. This led to the creation of a network of volunteer FTSU Guardians across the organisation, supporting staff to raise issues and concerns.

In 2020, the Board approved plans for a restructure of the FTSU Guardian network through the creation of a specific independent Lead FTSU Guardian post with protected time to undertake the role. This will support and strengthen the established FTSU network and aligns NBT with best practice as described by the National Guardian's Office. The Lead FTSU Guardian took up the post on 18 January 2021.

We have chosen to adopt the same vision that was developed as part of the Restorative Just Culture development sessions, recognising the clear connection and alignment between a Restorative Just Culture and healthy "speaking up" culture.

FTSU Vision: Trusted, Safe, Supported

Our Vision:

North Bristol NHS Trust is a safe and fair place where everyone's voice is encouraged, valued and listened to, helping us to continually learn and improve.

10.1

Freedom to Speak Up at NBT will be **ambitious and proactive** and will aim to:

- Protect patients and staff with a safe and effective FTSU service
- Place patient safety and staff care at the centre of its purpose
- Empower staff to have a clear, confident and valued voice
- Encourage leaders and managers to listen when people speak up
- Enable our staff and teams to be the best they can be each day
- Play a part in creating a fair, psychologically safe, no blame, Just Culture
- Provide clear speaking up routes, training and communicate learning

Our Values:

Our FTSU Vision and Strategy supports our Trust Strategy (2019-2024) and is aligned to our Restorative Just Culture approach and our core **Trust Values**:

- **Putting patients first**
- **Working well together**
- **Recognising the person**
- **Striving for excellence**

FTSU Strategy

We will focus on the following objectives to deliver our vision:

- Raise awareness and understanding of speaking up for all NBT staff with reach across the Trust
- Improve the diversity, approachability and reach of FTSU across the organisation
- Build confidence in speaking up by showing that concerns are heard, dealt with promptly and in a manner that ensures psychological safety, and that feedback and outcomes are shared
- Explore, understand and address barriers to speaking up e.g. fear of repercussion
- Work in partnership with our Trade Union colleagues to ensure that we are learning from staff speaking up, regardless of the route the use to communicate
- Train and support staff, leaders and managers in FTSU – not just speaking up but listening and reacting effectively when concerns are raised
- Support the ongoing work on Restorative Just Culture, Psychological Safety, Compassionate Leadership, and early resolution
- Challenge our Trust Board to be role models and to promote and celebrate the value of speaking up
- Make sure FTSU is supporting the Trust's Equality, Diversity and Inclusion objectives and is engaged with network chairs/groups

The Lead Guardian will progress this work with the support of the network of local Freedom to Speak Up Guardians, the FTSU Executive Lead, the FTSU Non-Executive Director, Chair and Chief Executive.

Alignment with Trust Strategies & Plans

These objectives are aligned to, and support:

- The Trust's Five-Year Strategy (2019-2024), specifically being a Provider of *High-Quality Care* and an *Employer of Choice*
- The People Strategy, specifically to the theme of "Great Place to work" and the *Thrive, Just Culture* and *Voice* objectives and success measures
- The Equality Diversity & Inclusion Strategy: "*Valuing you culture"*

- Key priorities arising from the 2020 Staff Survey: *Staff Voice, Inclusion, Management & Development*
- The Trust's Quality Strategy 2020-2024, particularly Theme 2: *Safe & Harm Free Care: "We will improve quality of care through learning from best practice and addressing areas of concern within a just and psychologically safe culture"*

Key Measures of Success

- Year on year improvement in FTSU Index Score* (via the NHS Staff Survey) moving from average to upper quartile
- Increase in number of staff speaking up, moving to national average for mid-sized acute trusts
- Decrease in anonymous/confidential concerns
- Zero staff reporting detriment or disadvantageous/demeaning treatment after speaking up
- Increase in diversity of FTSU Guardians and new FTSU Champions (diversity of protected characteristics, roles, seniority)
- CQC Well-Led inspections show tangible improvement and progress on FTSU and its impact on staff
- High satisfaction of staff using NBT's FTSU process – annual feedback survey scored for trust, safety, confidentiality, experience, positive qualitative feedback comments
- Positive feedback from staff speaking up – high proportion stating they would do so again
- Annual improvement in the Board/Organisational self-assessment using NGO/NHSI tool

** See Appendix 1*

North Bristol NHS Trust

Action Plan for 2021/22

	Action	Output(s)	Delivery Date
1.	Agree Vision and Strategy with Board (aligned to RJC)	• Agreed Vision • Added to refreshed intranet page	End of May 2021 End of June 2021
2.	Board self-review tool gap analysis	• Updated and agreed by Board for 2021 • Refreshed and updated for 2022	End March 2021 End March 2022
3.	Refreshed Communication & Visibility Plan to support Vision and Strategy and improve understanding and awareness of FTSU	• Updated intranet page including videos, poster • FTSU Blog on LINK • Improved visibility via walk-arounds with Chair, CE, Guardians, Exec/NED, Diversity leads, DMT leads, etc. • Specific FTSU pledges and communications from Trust Board members • Updated corporate induction on FTSU • Listening and learning events started • Continue to build links with staff networks, workforce groups etc. • Regularly attend Divisional and Directorate and team meetings	End July 2021 Delivered throughout 2021/22
4.	Roll out FTSU Champions model and develop Guardian and Champion team	• Champion role and EOI finalised, rolled-out • Champions appointed • Team built including communications routes • Training and CPD developed • Increased visibility	August 2021 September/ October 2021

	Action	Output(s)	Delivery Date
		• Success and learning shared and celebrated, cascaded to staff	
5.	Triangulate data with Staff survey and other data including wellbeing and patient safety	• Initially for May Board report • Employee engagement data sources under discussion with People team and ESR BI Lead (Exit interview themes, retention, sickness, grievances- will include more robustly in subsequent Board reports), patient safety data, patient complaints: for themes and learning	May 2021 Nov 2021 & May 2022
6.	Pulse Survey to consider/assess variance in Speaking Up engagement and awareness across the Trust	• Requested as part of Big Conversation • Targeted actions on visibility, awareness, issues, reach	May 2021 Q2 & Q3 2021/22
7.	Promote recently updated HEE/NGO e-learning for workers and managers through Education Lead (and via Divisions and stakeholders)	• Promote via Comms • Discuss incorporating into NBT leadership training • Discuss mandatory training for all staff • Provide equivalent or summarised training to staff groups on invitation	Q3 & Q4 2021/22
8.	Refresh FTSU Policy in line with anticipated national consultation and policy template	• New policy aligned with national template • Wide engagement with stakeholders, including staff-side • Clarity on speaking-up/whistleblowing options	Q2 2021/22 (dependent on national consultation timetable)

Monitoring:

An update on Freedom to Speak Up within NBT will be presented to the Board bi-annually by the Freedom to Speak Up Guardian. This update will include:

- An overview of FTSU cases reported, and themes identified, as well as national benchmarking data
- Case studies from the NGO, with any lessons or learning for NBT
- An overview of progress against this Strategy's actions and success measures
- Triangulation against other data sources, such as the staff survey, HR data etc. reflecting areas for targeted support

North Bristol NHS Trust

Appendix 1: **FTSU Index**

The FTSU index is a key metric for organisations to monitor their speaking up culture. It brings together four questions from the NHS Staff Survey which relate to whether staff feel knowledgeable, secure and encouraged to speak up and whether they would be treated fairly after an incident.

Question 17a - asks staff whether they agree their organisation treats staff who are involved in a near miss or incident fairly

Question 17b - asks whether staff agree their organisation encourages them to report errors, near misses or incidents.

Question 18a - asks whether staff agree that if they were concerned about unsafe clinical practice, they would know how to report it.

Question 18b - asks whether staff agree that they would feel secure raising concerns about unsafe clinical practice.

NBT's FTSU Index score:

- Improved from 73% in 2015 to 78.1% from the 2019 staff survey
- This compares to an Acute Trust overall score of 77.9% but the highest performing Trust achieve a score of 87% (2019 staff survey)
- NBT's 2020 Staff Survey FTSU Index score will be published by the NGO later in 2021 but it estimated to be 78.7%; a further slight improvement

North Bristol NHS Trust

Appendix 2: **2018 Vision and Strategy**

Vision:

"We will have a healthy speaking up culture that strives to continuously improve patient care and safety by ensuring that staff have a clear voice: where every member of staff feels free to speak up and NBT listens and acts."

Strategy:

1. Ensure that a clear policy, procedure and mechanisms are in place to enable staff to speak up about concerns and have these heard by NBT in line with best practice guidance.
2. Have in place a number of trained Freedom to Speak Up (FTSU) Guardians across all divisions, reflecting the diversity of NBT, to enable staff to easily access high quality support and advice and to feel confident to do so.
3. Ensure there is a high level of awareness within NBT about FTSU arrangements, through regular communications and awareness raising, including appropriate feedback about the nature of concerns raised and lessons learnt, with the aim of creating an open and transparent, positive speaking up culture.
4. Review the concerns raised through FTSU arrangements, triangulating these with other relevant data available within NBT, in order to gain a good picture of safety and other concerns.
5. Ensure that NBT learns from concerns raised, and uses these to improve patient safety and care.
6. Regularly review and seek to continuously improve the functioning of the FTSU arrangements themselves against the vision and strategic aims.

NHS North Bristol NHS Trust

Action Plan:

No	Action	Owner	Date
1	A 6 monthly report to be provided to Board, from November 2018 which will: A. Update the Board on FTSU best practice and the situation at NBT. B. Provide all Board members with a good knowledge of Trust activity and national best practice. C. Monitor progress against vision, strategy and action plan and compliance with the policy using a range of qualitative and quantitative measures D. Summarise issues raised by staff and review this speaking up data triangulated against other data related to mistakes and concerns E. Guardians will also attend the board meeting in person to discuss concerns raised, their experience of the process and drawing out learning F. Outcomes of Board discussions on FTSU to be fedback to staff and public. G. Feed into the Trust Annual Report H. Ensure lessons learnt via FTSU concerns are shared across the Trust. I. Issues raised via speaking up to become part of the performance data discussed openly with commissioners, CQC and NHSI.	Jacolyn Ferg-usson / Rob Mould	From Nov 2018
2	Guardian meetings to cover the following items at least quarterly: A. Ongoing monitoring, review and discussion of the strategy and action plan, taking into account the views of a range of stakeholders B. Discuss issues raised by staff and review this speaking up data triangulated against other data related to mistakes and concerns C. Review National guidance and case studies, the learning to be drawn out and shared via the regular Guardian meetings D. Review our approach and seek external support when required	Guy Dickson	From Dec 2018
3	Recruit more FTSU Guardians from diverse / vulnerable groups eg BAME.	Guy Dickson	By Nov 2018
4	Non-Executive Director to instigate and lead an auditing approach of concerns raised, to: A. Undertake deep dive reviews into experience of staff who do speak up through these routes B. use the findings from this and the staff survey feedback to make improvements to the policy and procedures	Rob Mould	Annu-ally from Nov 2018
5	Communication to the Trust as a whole about Freedom to Speak Up: A. A quarterly spotlight on Freedom to Speak Up, reiterating the different routes to speaking up B. Divisional level communications distributed via the Guardians – presentations and posters C. Outcomes of Board discussions on FTSU to be fedback to staff. D. FTSU campaign to launch in speaking up month (October), communicating the vision and promoting and publicising the process, including positive feedback from individuals who have spoken up	Guy Dickson	Oct 2018 On-ward
6	Leadership development framework and programme to be developed to support Freedom to Speak Up principles / behaviours . To be delivered and monitored through the Workforce Committee.	Jacolyn Fergu-sson	Nov 2018 on-ward

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

1. **Name of service / policy / strategy**

Freedom to Speak Up (FTSU) Vision, Strategy & Action Plan

2. **Details of lead person completing this screening:**

Name	Hilary Sawyer
Title	NBT Lead Freedom to Speak Up Guardian
Dept/Service	NBT Freedom to Speak Up
Telephone	07880 005382 (work mobile)
E-mail	Hilary.sawyer@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:
Freedom to Speak Up (FTSU) Vision, Strategy & Action Plan
NHS Improvement requires organisations to have a clear vision for the speaking up culture in their organisation, supported by a strategy.
The original Strategy was approved in October 2018.

In 2020, the Board approved plans for a restructure of the FTSU Guardian network through the creation of a specific independent Lead FTSU Guardian post with protected time to undertake the role.

Since starting in role, the Lead Guardian has been engaging with the organisation, and working to increase the visibility of FTSU. An early priority has been to work with the Executive Lead for FTSU to refresh the FTSU Vision, Strategy and Action Plan, and to ensure that it is aligned to, and supports the organisations other relevant strategies and priorities including the Trust's work on Restorative Just Culture, and that it supports the Trust's overarching People Strategy.

TMT and Trust Board reviewed and endorsed NBT's FTSU self-review in March 2021, alongside the proposal to introduce an FTSU Champions Network

to improve the diversity of NBT's FTSU network to improve accessibility to all staff groups, particularly those with protected characteristics. This has been incorporated into the Strategy's objectives and action plan and will be a focus of success criteria.

Feedback from staff-side, staff networks and divisional teams has been positive.

The Strategy's objectives and plans are aligned to and support:

- The Equality Diversity & Inclusion Strategy: "*Valuing you culture"*
- The People Strategy, specifically to the theme of "Great Place to work" and the *Thrive, Just Culture* and *Voice* objectives and success measures
- Key priorities arising from the 2020 Staff Survey: *Staff Voice, Inclusion, Management & Development*
- The Trust's Five-Year Strategy (2019-2024), specifically being a Provider of *High-Quality Care* and an *Employer of Choice*

NBT's 2019/20 WRES and WDES data reports suggest that:

- BAME staff are more likely to enter into a formal disciplinary process and more likely to experience bullying or discrimination by colleagues and believe that career progression is unequal
- Disabled staff have a worse experience in some metrics including bullying and harassment than non-disabled staff and particularly in relation to bullying from colleagues. Metric 9b around facilitating voice of disabled staff will be a key measure to consider.

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	The strategy's action to improve the diversity of NBT's FTSU network includes improving the representation of different ages of the FTSU network team The Strategy promotes equal opportunities and improving relations	Invite expressions of interest for NBT's FTSU Champion role to include a diverse spread of age ranges	End of August 2021	Formation of more diverse FTSU network Improvement in trust in FTSU team with increased concerns (measured quarterly) reporting with demographics collection	Hilary Sawyer
Race	Yes	The strategy's action to improve the diversity of NBT's FTSU network includes improvement of the representation of different race in the FTSU network team The Strategy promotes equal opportunities and improved voice from a diverse range of protected characteristics alongside improved relations, and more proactive and accessible communication methods	Invite expressions of interest for NBT's FTSU Champion role to improve diversity.	End of August 2021	Formation of more diverse FTSU team Improvement in trust in FTSU team with increased concerns (measured quarterly) reporting with demographics collection	Hilary Sawyer
Sex (Female or Male)	Yes	The strategy's action to improve the diversity of NBT's FTSU network includes improvement of the representation of different sex in the FTSU network team	Invite expressions of interest for NBT's FTSU Champion role to improve diversity of sex	End of August 2021	Formation of more diverse FTSU team Improvement in trust in FTSU team with	Hilary Sawyer

Protected Characteristic	Affected ? Yes/No	Please show evidence and state potential impact.	Future Actions	Timeframe/ target date	Evidence and success measures	Lead
		The Strategy promotes equal opportunities and improved voice from a diverse range of protected characteristics alongside improved relations, and more proactive and accessible communication methods			increased concerns (measured quarterly) reporting with demographics collection	
Disability Physical Impairment; Sensory Impairment; Mental Health; Learning Difficulty; Long-Term Condition	Yes	The strategy's action to improve the diversity of NBT's FTSU network includes improvement of the representation of disabilities in the FTSU network team The Strategy promotes equal opportunities and improved voice from a diverse range of protected characteristics alongside improved relations, and more proactive and accessible communication methods	Invite expressions of interest for NBT's FTSU Champion role to improve representation from staff with disabilities	End of August 2021	Formation of more diverse FTSU team Improvement in trust in FTSU team with increased concerns (measured quarterly) reporting with demographics collection	Hilary Sawyer

Sexual Orientation (Lesbian, Gay, Bisexual, Heterosexual)	Yes	The strategy's action to improve the diversity of NBT's FTSU network includes improvement of the representation of staff in the FTSU network team The Strategy promotes equal opportunities and improved voice from a diverse range of protected characteristics alongside improved relations, and more proactive and accessible communication methods	Invite expressions of interest for NBT's FTSU Champion role to improve diversity	End of August 2021	Formation of more diverse FTSU team Improvement in trust in FTSU team with increased concerns (measured quarterly) reporting with demographics collection	Hilary Sawyer
Gender Identity (Trans people)	Yes	The strategy's action to improve the diversity of NBT's FTSU network includes improvement of the representation of staff in the FTSU network team The Strategy promotes equal opportunities and improved voice from a diverse range of protected characteristics alongside improved relations, and more proactive and accessible communication methods	Invite expressions of interest for NBT's FTSU Champion role to improve diversity	End of August 2021	Formation of more diverse FTSU team Improvement in trust in FTSU team with increased concerns (measured quarterly) reporting with demographics collection	Hilary Sawyer
Religion/Belief or non-belief	Yes	The strategy's action to improve the diversity of NBT's FTSU network includes improvement of the representation of staff in the FTSU network team	Invite expressions of interest for NBT's FTSU Champion role to improve diversity	End of August 2021	Formation of more diverse FTSU team Improvement in trust in FTSU team with increased concerns	Hilary Sawyer

		The Strategy promotes equal opportunities and improved voice from a diverse range of protected characteristics alongside improved relations, and more proactive and accessible communication methods			(measured quarterly) reporting with demographics collection	
Pregnancy & Maternity	Yes	The strategy's action to improve the diversity of NBT's FTSU network includes improvement of the representation of staff in the FTSU network team The Strategy promotes equal opportunities and improved voice from a diverse range of protected characteristics alongside improved relations, and more proactive and accessible communication methods	Invite expressions of interest for NBT's FTSU Champion role to improve diversity	End of August 2021	Formation of more diverse FTSU team Improvement in trust in FTSU team with increased concerns (measured quarterly) reporting with demographics collection	Hilary Sawyer
Marriage & Civil Partnership	Yes	The strategy's action to improve the diversity of NBT's FTSU network includes improvement of the representation of staff in the FTSU network team The Strategy promotes equal opportunities and improved voice from a diverse range of protected characteristics alongside improved relations, and more proactive and accessible communication methods	Invite expressions of interest for NBT's FTSU Champion role to improve diversity	End of August 2021	Formation of more diverse FTSU team Improvement in trust in FTSU team with increased concerns (measured quarterly) reporting with demographics collection	Hilary Sawyer

- **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:**

The FTSU strategy is updated to improve diversity of representation of staff with protected characteristics and expected improvement in trust and confidence in NBT supporting staff with protected characteristics to raise concerns confidently without the fear of detriment/disadvantageous treatment. The appointment of a Lead FTSU Guardian with protected time will also allow a more proactive and visible communications approach, widening the reach of FTSU across the organisation and ideally allowing contact with members of staff who may currently not have access to electronic communications such as email, MS Teams or the intranet.

3. **Review date:** **July 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

NHS North Bristol NHS Trust

Report To:	Trust Board		
Date of Meeting:	27 May 2021		
Report Title:	Freedom to Speak Up Bi-Annual Report May 2021		
Report Author & Job Title	Hilary Sawyer, Lead Freedom to Speak Up Guardian		
Executive/Non-executive Sponsor (presenting)	Xavier Bell, Director of Corporate Governance & Trust Secretary		
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	**X**	
Recommendation:	Board are asked to: • Discuss the report and findings • Review the FTSU data triangulated against the 2020 NHS Staff Survey results • Note the planned the roll-out of FTSU Champions • Pledge clear support to Freedom to Speak Up at NBT • Note the NGO's (National Guardian's Office) annual report 2020: (CM032106_Item6_NationalGuardiansOffice-Report.pdf (cqc.org.uk))		
Report History:	Bi-annual Freedom to Speak Up Board report reviewed at Trust Board on 29 November 2018, 30 May 2019, 28 November 2019, 28 May 2020, and 26 November 2020. Freedom to Speak Up Board Self-review & Update 25 March 2021.		
Next Steps:	• Implement new FTSU Champion network model • Increase awareness of FTSU and value across NBT • Centralise data and themes for learning from FTSU concerns • Improve FTSU training for line-managers and all staff • Continue to actively support, promote and role-model Freedom to Speak Up values at North Bristol NHS Trust.		

Executive Summary
NHS Trusts are required to appoint a FTSU Guardian or Guardians and follow the National Guardian Office's guidance on Freedom to Speak Up (FTSU).

FTSU Guardians have been in place at North Bristol NHS Trust (NBT) since November 2017; the programme has been continually developing over time.

In early 2020, the Board approved plans for a restructure of the FTSU Guardian network through the creation of a Lead FTSU Guardian post (0.6WTE) to align NBT with best practice as highlighted by NHSI[1] and the National Guardian's Office. The new Lead FTSU Guardian has been in post since 18[t] January 2021, working with a network of 8 volunteer Guardians from various substantive roles across the Trust.

Since then the Lead Guardian has instigated a programme of proactive awareness raising and stakeholder networking, collaborated with the People and Patient Safety leads for Restorative Just Culture to align Vision, based on Psychological Safety, and refreshed plans for building confidence in Freedom to Speak Up at NBT. The aligned Vision and parallel action plans are being presented to Board in May 2021 along with the refreshed Strategy for FTSU created by the Executive Lead and Lead FTSU Guardian (see separate paper).

Summary position on 2020/21 data

In March 2021 an updated Board self-review was presented alongside a brief update of work being undertaken to refresh the network of FTSU Guardians and proposals to implement the role of FTSU Champions to increase reach and diversity of representation (of role, seniority, workplace and pattern, protected characteristic) and increase engagement and visibility across the organisation.

In the 6-monthly report to Board of November 2020 a consistently lower number of concerns and high proportion of 'anonymous' concerns were noted at NBT in comparison to the national picture for mid-acute Trusts. It is noted however that the term 'anonymous' has been used to encapsulate both truly anonymous concerns and those made confidentially. The vast majority of concerns reported are made confidentially rather than anonymously.

This report explores the most recent data around concerns being raised and compares this with the national average for all Medium Acute Trusts. Essentially, this data indicates a lower rate of concerns reported at NBT compared to the national average for Q1-3 2020/21. A higher number of concerns were reported in 2020/21 Q4 than Q1-3. It is possible that this correlates with the introduction of the Lead Guardian role and/or that workers have more time to report concerns as the Covid-19 pandemic effects have abated. National Q4 data for benchmarking is not yet available and will be reported in the next bi-annual report in November 2021.

This report also compares the 2020 NHS Staff Survey results and further consideration of triangulation with internal data.

Overall, NBT has had fewer concerns reported than other SW Medium Trusts during 2020/21, although this may have changed in Q4. Possible explanations for this include:

- There were fewer issues due to good communication across the Trust during this time;
- That staff had other priorities during this time;

[1] Report template - NHSI website (nationalguardian.org.uk)
[2] Report template - NHSI website (nationalguardian.org.uk)
[3] https://www.nationalguardian.org.uk/wp-content/uploads/2020/04/20200402-guidance-on-professional-groups-data-collection.pdf

- Staff are not aware of Speaking Up routes or opportunities: and/or
- That the Speaking Up culture at NBT is felt to be less trusted or effective.

A proactive offering of visits to services and listening exercises from the Lead Guardian plus general increased visibility and awareness may improve this situation. The Lead Guardian has been discussing possible improvements with the lead Guardians of other South West Trusts with higher numbers of concerns. Promotion of the service has raised awareness and use of FTSU as a route of raising concerns. Roll-out of a FTSU Champion network has also played a part in other organisations. Two of the South West Trusts with better scores on speaking up about unsafe practice have employed an electronic anonymous reporting system – these are voices/concerns that would not have been heard otherwise.

The Board will be reassured that NBT will shortly be implementing an FTSU Champions model as previously advised in March. The anonymous reporting system will be explored and the cost/benefits considered in more detail.

The Lead Guardian is liaising with colleagues in the Communications team to include questions regarding FTSU awareness and barriers into the Big Conversation event in May 2021.

Recommended immediate actions for NBT Leadership:

- Overtly promote and embed Board, Trust Management Team and Divisional/Directorate Management Team support for FTSU, the refreshed Strategy and action plan and the value of staff speaking up at NBT as a gift to the organisation to be used wisely. As highlighted in the National Guardian Office's Annual Report 2020, information from FTSU concerns can be used for deep culture change and safety of an organisation.
- Support training and time for headspace for managers to listen up effectively.

Strategic Theme/Corporate Objective Links	**1. Provider of high quality patient care** a. Work in partnership to deliver great local health services **2. Developing Healthcare for the future** a. Training, educating and developing out workforce **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	Freedom to Speak Up supports the Trust's ambition to be an Employer of Choice and is an important mitigation for the Recruitment and Retention risk recorded on the Board Assurance Framework
Other Standards Reference	NHSI Guidance for Boards on Freedom to Speak Up[1] NHSI Supplementary information on Freedom to Speak Up in NHS Trusts[2]

10.2

[1] Report template - NHSI website (nationalguardian.org.uk)
[2] Report template - NHSI website (nationalguardian.org.uk)
[3] https://www.nationalguardian.org.uk/wp-content/uploads/2020/04/20200402-guidance-on-professional-groups-data-collection.pdf

	National Guardian's Office (NGO) Guidance Freedom to Speak Up arrangements form part of the CQC Well-Led Key Lines of Enquiry
Financial implications	N/A
Other Resource Implications	The Champion model will require staff to have the support of their manager to participate and engage in FTSU activities. This will be highlighted as a part of the expressions of interest process and there will be flexibility in terms of how much time Champions will need to commit to training. The role is focused on awareness raising and visibility, and the need to backfill posts is not anticipated.
Legal Implications	No specific legal implications associated with this report. Compliance with the CQC and NGO Guidance on Freedom to Speak Up is a requirement under the NHS Standard Commissioning Terms & Conditions.
Equality, Diversity and Inclusion Assessment (EIA)	Freedom to speak up relies upon a fair and open culture that supports all staff, including those with protected characteristics to speak up. Demographic data of staff speaking up has not been collected robustly to date. More detail will be available in future due to improvements in concern recording. The Trust needs to improve the diversity and representation of all staff groups within the FTSU network. A proposed FTSU network structure and action plan is separately presented to Trust Board for endorsement as part of refreshed Strategy, and includes an Equality Impact Assessment.
Appendices:	Appendix 1: Refreshed Poster

[1] Report template - NHSI website (nationalguardian.org.uk)
[2] Report template - NHSI website (nationalguardian.org.uk)
[3] https://www.nationalguardian.org.uk/wp-content/uploads/2020/04/20200402-guidance-on-professional-groups-data-collection.pdf

1. Purpose

1.1 The purpose of this report is two-fold:

i. To update the Board on Freedom to Speak Up (FTSU) activity at North Bristol NHS Trust (NBT) over the past 6 months; providing information on the nature of concerns raised, comparing this activity where possible to the national picture and relevant internal data, and report on progress made against actions.

2. Background

2.1 A team of voluntary NBT Freedom to Speak Up Guardians have been in role since November 2017. The new Lead Guardian started in post on 18 January 2021, supplementing the existing team of 8 Guardians. Xavier Bell has since stepped back as a Guardian (but remains the lead for FTSU within the Executive Team) and one Guardian is due to retire from substantive role in mid-June 2021. All other Guardians would like to continue at present.

2.2 The Lead Guardian post (0.6WTE) brings ring-fenced time to support:

- a positive speaking up culture
- all workers at NBT
- the organisation in becoming a more open and transparent place to work, where staff are valued for speaking up
- support training for managers in 'listening up'
- identify and addressing any barriers to speaking up
- assess trends and responses to issues being raised
- hold the Board to account for taking appropriate action to create a positive speaking up culture across NBT.

2.3 **Key FTSU engagement activity since mid-January 2021:**

- Refreshed soft communications roll-out: Chair's monthly video introduction, operational bulletin introduction, updated Guardian poster (appended), FTSU leaflet drafted, LINK page, Blog, Twitter account, free HEE/NGO e-learning promoted for workers and line-managers, induction material updated pending fuller NBT induction review
- Presented at super-huddles/team meetings for IM&T, Pharmacy, BCE (programme will be continued)
- By the end of May will have met with all Divisional management teams
- Walkaround with Trust Chair to IM&T, weekend walk-around with Matron/Guardian, visited BCE, walk-around Facilities with Manager/Guardian
- Visit to Hospital @ Night planned for June, visits to Cossham and Frenchay in planning

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- Increased hit rate on the FTSU LINK page; 122 hits mid-April to mid-May with peaks following huddles/visits
- Regular meetings with Chair and interim Chief Executive
- Connected with JUC Leads and attended JCNC sub-group (quarterly report)
- Networked with: Staff Psychology Lead and presented at team huddle
- Communicated with Leads for BAME staff network group and Disability network group. Presentation forwarded to ED&I Leads to forward on to staff on the Inclusion email-group including LGBT+ and Disability staff introducing the Lead Guardian and inviting comments on the FTSU Champion model
- Introductions with Associate Medical Director and Director of Transformation
- Introduction with People Business Partners
- Reviewed and discussed plans for FTSU training for managers and all staff with the Head of Learning
- Introduction with Volunteer Service Manager and Chaplaincy Team Leader
- Connected with leads for medical education/junior doctor support
- Connected with Communications Team, Sustainable Development Manager and NBT Music Manager to consider visibility raising via future events

3. How NBT Compares to the National Picture

3.1 At the time of writing this report, full data for 2020/21 (Q4) was unavailable from the National Guardian's Office for comparison. The NGO's year-end report will be produced in due course reflecting trends and themes.

[1] Report template - NHSI website (nationalguardian.org.uk)
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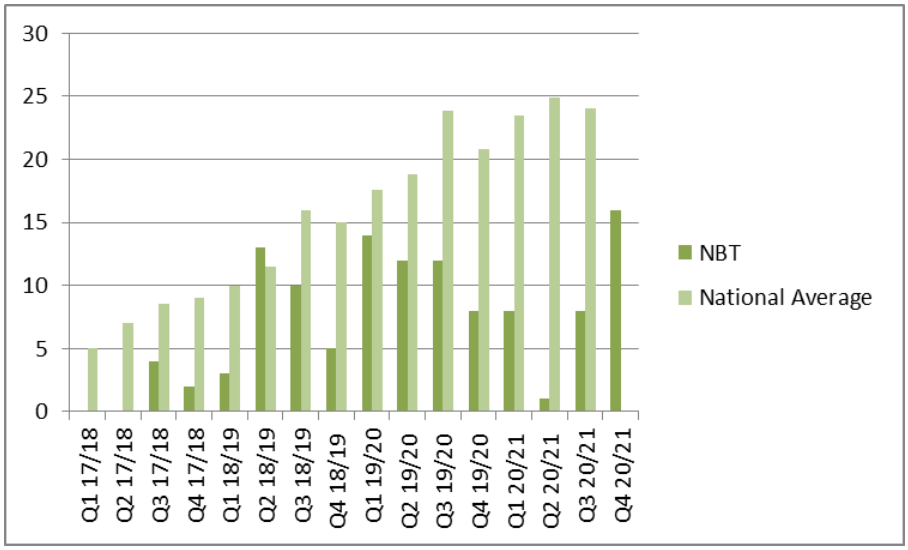
[3] https://www.nationalguardian.org.uk/wp-content/uploads/2020/04/20200402-guidance-on-professional-groups-data-collection.pdf

Chart 1: Number of concerns per quarter NBT v Mid-Acute National Average since Q2 17/18



3.2 Chart 1 shows the comparison with the national average for Medium Acute Trusts. National data is only available currently to Q3 2020/21. The data show that the number of concerns raised at NBT has been consistently lower than that of the national average. This is also reflected in the comparison with South West data in Table 1. Possible explanations for this include:

- There were fewer issues at NBT due to good communication during this time;
- That staff had other priorities during this time;
- Staff are not aware of Speaking Up routes or opportunities: and/or
- That the Speaking Up culture at NBT is felt to be less trusted or effective.

Table 1: Comparison to South West average for Medium Trust data reported to NGO Office 20/21 Q1-3 (Q4 SW data not yet available):

	Q1	Q2	Q3
NBT	8	1	8
SW average	19.5 (Range 8-69)	27 (range 1-41)	25 (range 0-63)

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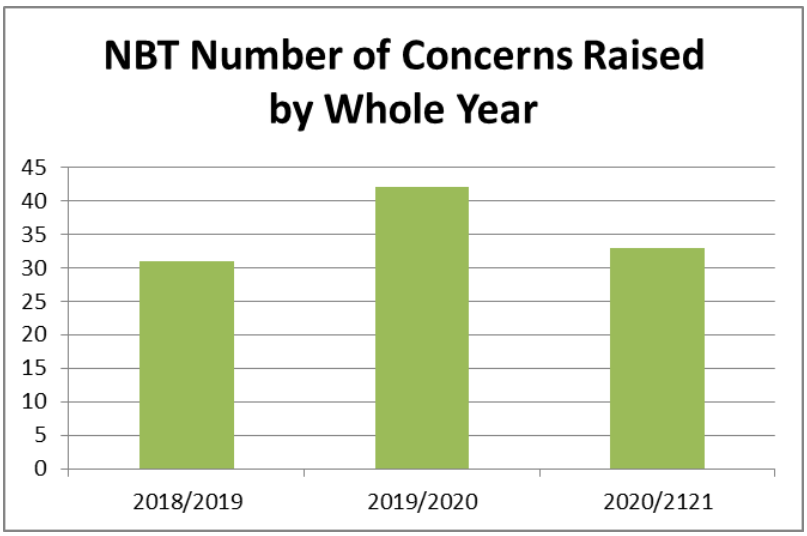
3.3 Overall, it seems reasonable to assume that more work is required to embed FTSU and ensure that it is trusted and effective (particularly when this data is considered alongside the Staff Survey results discussed further below).

3.4 **Increased level of concerns in Q4: in contrast to previous years and quarters** the highest level of concerns were raised this quarter to date. This appears to be in part due to the new Lead role in place, links made with the EDI Lead, and staff speaking up following promotion of the new Lead role through the Chair's video and inclusion in the operational bulletin.

3.5 Proactive visibility of the new Lead role and support via walk-arounds with the Chair, Chief Executive and other leadership, along with communication of the benefits and actions taken from staff speaking up, are likely to be key to further improving the culture of speaking up at NBT.

For completeness, Chart 2 shows number of concerns raised in total at NBT over the last 3 financial years

Chart 2: Total NBT Number of Concerns Raised by Whole Year



10.2

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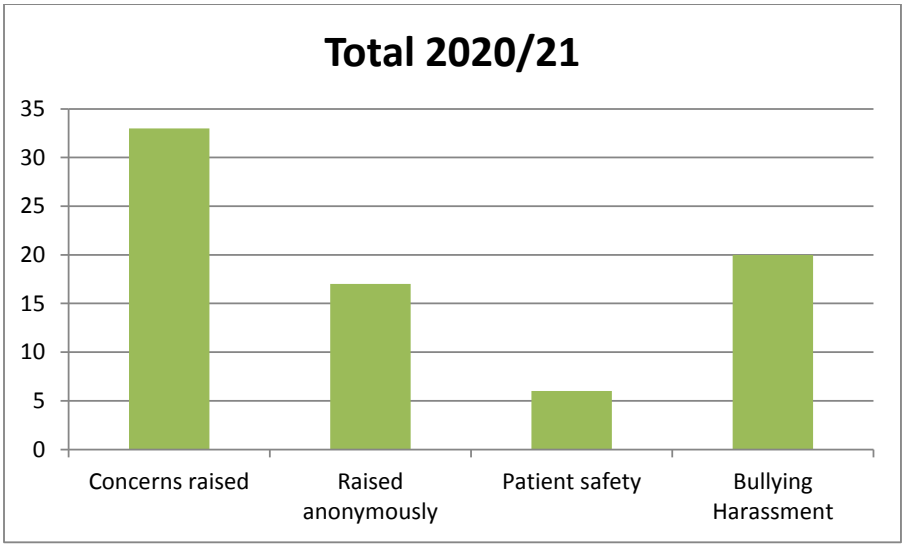
4. A closer look at NBT's data:

Chart 3: 2020/21 NBT data comparison by type of concern:



4.1 **General themes of concerns:** These overarching concern "types" can be further broken down into allegations of bullying or harassment from managers, unfair treatment, lack of transparency in recruitment, Trust processes not being followed, parking concerns, and staff wellbeing.

4.2 Some of the identified learning and feedback from these concerns is that clearer communication on decision-making, clarity on timeframes for actions, more openness and transparency, civility in interactions and improved listening would have helped alleviate the concerns, and moving forward would be of benefit to staff wellbeing and patient safety.

4.3 The number recorded as raised 'anonymously' appears relatively high however this categorisation is a mix of truly 'anonymous' and 'confidentially reported' concerns. The number of truly anonymous concerns raised in 2020/21 is 5. This will be recorded more accurately in future.

4.4 The new Lead Guardian is liaising with the People Team and ED&I Lead regarding joined-up routes of support for staff reporting bullying or harassment as part of wider cultural work.

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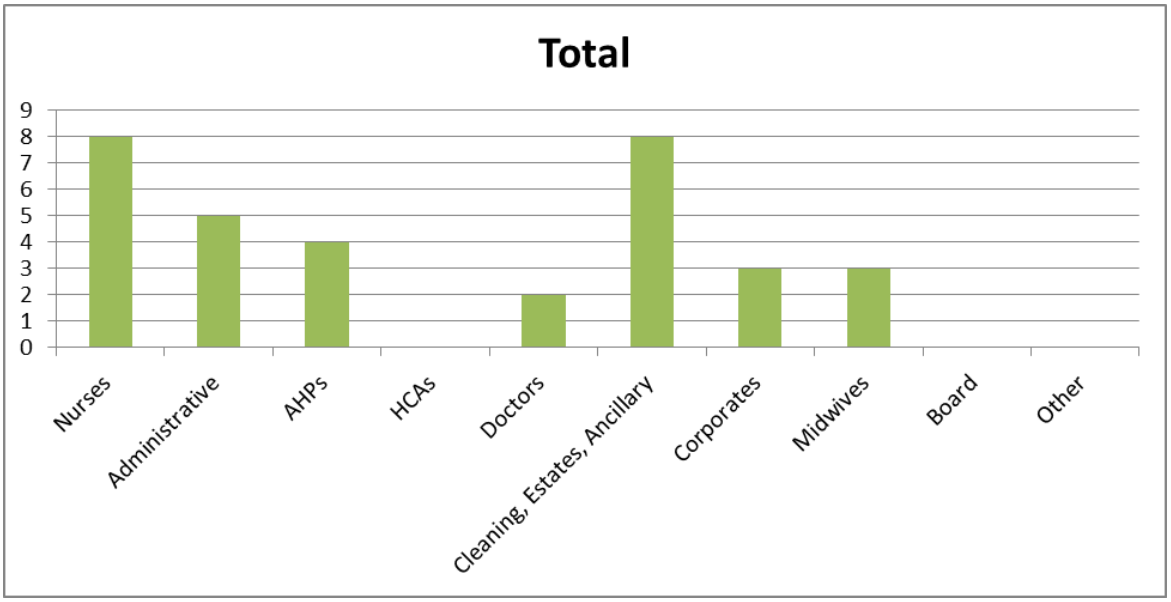
Chart 4: 2020/21 staff groups[2] raising concerns (where recorded):



4.5 Chart 4 indicates a continued higher level of concerns raised by Cleaning, Estates and Ancillary colleagues as has been noted before at NBT. This may reflect a higher level of concerns of this staff group or that they feel more empowered to speak up to their local Guardian. More concerns were raised by nurses and midwives together than other professional groups; this is in line with national trends as outlined in the NGO's 2019/20 data report. An area that was noted as requiring focus before has been the lack of concerns raised by HCAs; this will be an area of focus of awareness-building in the coming year. A low level of concerns by doctors is also noted. The Lead Guardian is connecting with the Medical Education and Junior Doctor Support team to ensure there is awareness and clarity of routes for medical staff speaking up.

[1] Report template - NHSI website (nationalguardian.org.uk)
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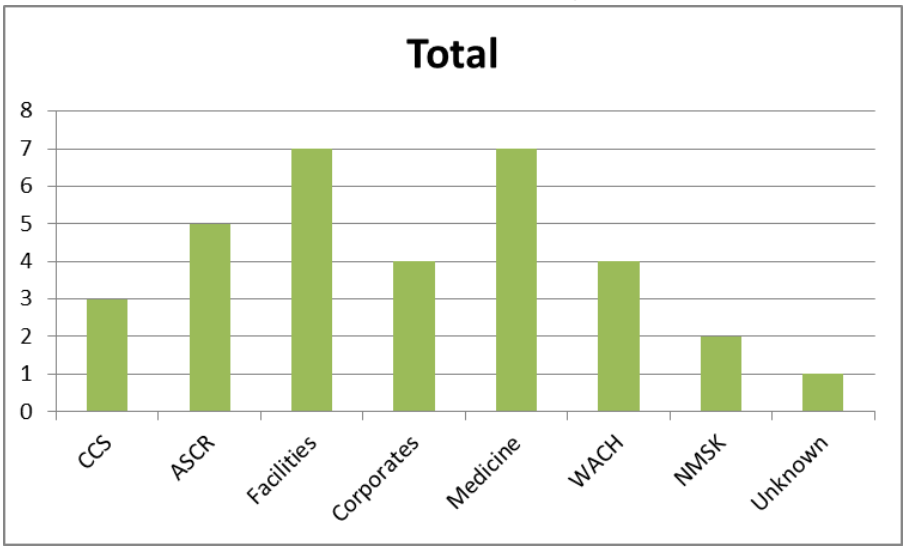
[3] https://www.nationalguardian.org.uk/wp-content/uploads/2020/04/20200402-guidance-on-professional-groups-data-collection.pdf

Chart 5: 2020/21 NBT Concerns raised by Division/Directorate:



4.6 Chart 5 indicates that Facilities and Medicine had the highest levels of concerns raised in 2020/21, with NMSK recording the lowest number.

4.7 **By Professional Level[3]:** where this has been disclosed/robustly recorded, the majority (~78%) of concerns have been raised by workers, as opposed to managers or leaders.

4.8 **Detriment levels:** There were no reports of detriment suffered after raising a FTSU concern.

4.9 **Satisfaction levels with the FTSU Service 2020/21:** All staff that responded to the question: 'Given your experience, would you speak up again?' responded 'Yes'

4.10 **Resolution of concerns**: Some NBT Guardians have expressed concerns regarding whether they have been able to support staff to effective resolution in the past. The Guardians have been asked to raise any such issues with the new Lead Guardian in future to support effective resolution. Some Guardians have also reflected whether staff speaking up through line-managers directly has sometimes not adequately resolved issues.

4.11 **Data-related actions for Lead Guardian:**
The following actions will further improve the data that is collected and presented to Trust Board, and will be progressed in the coming months alongside the priority actions identified in the FTSU Vision & Strategy document (see separate paper):

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i. NBT Guardian FTSU Concern Record form updated from Q1 2021/22 to support consistency of recording in line with the NGO's new guidelines and ensure robust collection of data and themes in future.

ii. This includes collection of demographic data to be invited at an appropriate point where possible (without identifying an individual); the Lead has discussed internally with the ED&I Lead, People team BI Lead, NGO and Regional Guardians. The purpose of collecting this data is two-fold: to inform 1) where a protected characteristic may be a factor in the concern and 2) monitoring purposes for trends/themes

iii. Improve the sharing of data between Guardians and the Lead Guardian to ensure themes are properly identified, and to support the resolution of concerns Share report and findings with Division/Directorate Management Teams

iv. Consider how successes and learning from staff speaking up can be communicated while maintaining staff confidentiality

5. Triangulation of Speaking Up Data Against Other Data

5.1 Against 2020 NHS Staff Survey results – key FTSU questions

It should be noted that whilst NBT saw a relatively high response rate of 51% to the NHS Staff Survey, it is not completed by every member of staff and this should be considered when reviewing the data in this report.

5.2 Table 2: NBT scores for the four FTSU Index questions

5.3 The National Guardian Office is soon expected to publish the FTSU Index score based on a mean average of scores from the following four questions:

		NBT 2020	Comparator organisation	NBT 2019	Change
16a	My organisation treats staff who are involved in an error, near miss, or incident fairly	64%	+2%	61%	+3%
16b	My organisation encourages us to report errors, near misses or incidents	86%	-2%	88%	-2%
17a	If you were concerned about unsafe clinical practice, would you know how to report it?	93%	-1%	93%	0%
17b	I would feel secure raising concerns about unsafe clinical practice	72%	+1%	71%	+1%

5.4 **NBT's FTSU Index score from the 2020 NHS Survey is** expected to be **78.8%** (compared to 78.1% last year). The highest performing Trusts achieved a score last year of 87%: our ambition is to raise NBT's Index score in line.

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5.5 There appears to be some work to do in terms of staff feeling they will be treated fairly if involved in an error or incident or in feeling secure to raise concerns about unsafe clinical practice. Robust cascading/communication of NBT's revised Patient Safety Incident Response Plan (PSIRP) based on the NHSE PSIRF and Restorative Just Culture processes are likely to be key as a foundation for change along with overt commitment to staff being encouraged to speak up about unsafe practice or concerns and reassurance of a zero tolerance approach to disadvantageous treatment.

5.6 **NBT scores for two new FTSU questions**

The 2020 NHS Staff Survey included two new direct questions about whether staff feel safe to speak up about concerns:

Table 3:

		NBT 2020	**Comparator benchmark difference**
18e	'I feel safe in my work'	83%	+2%
18f	'I feel safe to speak up about anything that concerns me in this organisation'	68%	+3%

5.7 **Question 18f is directly appropriate as an indication of FTSU in an organisation.** Although NBT has scored relatively well in these responses against the comparator benchmark, the suggestion is that ~1/3 of staff do not feel safe to speak up at NBT. Senior level commitment to this will be key to support the Lead Guardian's action plan and FTSU team in improving this. Connection made between the Lead Guardian, the ED&I Lead and staff networks are likely to be key along with roll-out of the Champion network to support. The best scenario is however that staff feel safe to speak to their line-manager or other senior staff member and not need the FTSU Guardian service.

5.8 **Other related questions**

There are also several other relevant NHS staff survey questions related to violence at work or harassment, bullying or abuse or discrimination from service users, managers or colleagues. Only 47% of staff stated that they or a colleague reported the last time they experienced harassment, bullying or abuse at work.

The result for question 17c supports the view that staff members feel their concern may not be addressed:

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Table 4:

		NBT 2020	Comparator benchmark difference
17c	I am confident that my organisation would address my concern.	61%	+2%

Anecdotal conversations by staff with the Lead Guardian appear to support the view that some do not feel their concern would be effectively addressed; in conjunction with concerns of potential detriment this presents a barrier to staff speaking up as the potential 'cost' and perceived low potential benefit outweighs the 'effort'.

On the staff survey deep dive, amongst the questions that NBT ranks poorly in compared to SW regional acute trusts are:

- 'My organisation encourages us to report near misses or incidents' and
- 'If you were concerned about unsafe clinical practice would you know how to report it.'

This suggests that there is work to be done in these areas.

5.9 **Table 5: Staff Survey 2020 FTSU Questions by Division (difference to NBT average):**

	NBT	ASCR	CCS	Corporate	Facilities	Medicine	NMSK	WACH
16a	64%	-4%	+5%	-4%	-8%	+4%	+6%	-2%
16b	86%	-1%	+2%	-6%	-5%	+3%	+3%	+5%
17a	93%	+3%	-1%	-8%	-9%	+2%	+2%	+3%
17b	72%	+2%	+3%	-10%	-12%	+5%	+1%	+4%
18e	83%	-4%	+4%	+5%	0%	-3%	+2%	-3%
18f	68%	-6%	+2%	-2%	+1%	+2%	+7%	-6%

The above suggests there are opportunities for improvement in ASCR, Corporates, Facilities, and WACH.

Considering question 18f alone, improvement appears to be needed in ASCR, Corporates and WACH. Better scores in Facilities and Medicine appear to correlate with the higher level of concerns being reported for these areas and a noted strong culture of support for staff speaking up in NMSK. It is noted that a programme of focused improvement work is planned for WACH.

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5.10 **Question 18f by staff group:**
'I feel safe to speak up about anything that concerns me in this organisation'

Based on review of lower positive and higher negative score response percentage scores, the following staff groups may benefit from targeted awareness raising of the Guardian support route: practitioners, trainee nursing associates, trainee healthcare scientists, ODPs, healthcare science assistants, clerical workers, midwives and speciality doctors. Interestingly scores for managers and matrons also suggested a level of insecurity about speaking up about concerns.

A deeper dive into the survey data for triangulation may be productive to consider some of the other survey questions by staff group also e.g. 'likelihood to leave the organisation' as some consistencies may suggest issues for specific staff groups e.g. amongst medical secretaries. Interestingly in the 2019/20 NGO survey, administrative/clerical workers were the second most likely group to speak up (19%) nationally.

5.11 When reviewing the data, progress has been made at NBT however there are still areas within the Trust which suggest further improvement work to be done within Corporates, ASCR, WACH and for specific professional groups and trainee staff, to embed a culture of speaking up within these areas.

5.12 If the most important key thematic measure from the NHS Staff Survey is "staff engagement", the organisation has some work to do to elevate the thematic score (of 7.1) to that of best performing organisations (7.6).

5.13 The survey also suggested overall worse experiences for BME staff than White staff; and for staff with a long term condition or illness than their colleagues without conditions, however there was a mixed picture requiring more in depth analysis. Although similar to the national picture, proportionally more BME staff report experiencing harassment/bullying/abuse from other staff (25.7%) than white staff (21.9%). A significantly lower than average percentage of NBT BME staff (72.5%) think that the organisation provides equal opportunities for career progression compared to white staff (88.2%). This suggests there is more work to do in supporting BME staff and those with long term conditions speaking up. The new Lead Guardian is regularly meeting with NBT's Equality, Diversity and Inclusion (ED&I) Lead and liaising with Staff Network leads to support Staff Voice and become an ally in empowered sharing of experience. Roll-out of the FTSU Champion model and an improvement in diversity is expected to support this. The Lead is also supporting review of support for staff reporting bullying or harassment and cultural support with the ED&I Lead, People and Wellbeing teams.

6. NBT's 2021 Priorities following the 2020 NHS Staff Survey:
The Trust's summary of progress against themes stated that:

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'Whilst progress has been made in Staff Voice, Workload, and Inclusion, there is still further work to do.

In Management Development and the experience of staff in relation to their immediate managers, there has been deterioration in the staff survey scores from last year.

Speaking Up and Violence has improved significantly this year, so it is proposed to discontinue this as a priority, but to instead incorporate it as part of Staff Voice as it is in the People Strategy.

The recommended improvement priorities for 2021 are the same as last year, with the exception of Speaking Up, as follows:

- Staff Voice
- Workload
- Inclusion
- Management Development

Speaking Up to be reviewed and move towards Business As Usual'

Divisional plans following the staff survey:

It is noted that outline plans include focus on:

- ASCR and theatres: wellbeing and start well/end well
- Medicine: EDI steering group, reduction of violence, bullying/harassment, improve learning
- WACH: governance and risk, maternity transformation plan to improve climate/behaviours, systems and processes, review of staff morale/resourcing
- Corporate: deep-dive to departmental cultures

7. Employee Experience

As recommended by NHSE/IGuidance[2]:

The possibility of regularly triangulating FTSU data (and statistical significance) with other internal worker experience and patient safety data to identify wider concerns or emerging issues (and trends for Divisions/services/staff groups) is under consideration with members of the People Team and the EDI Lead.

These include:

- Sickness rates
- Retention figures
- Grievance numbers/themes – formal/informal
- Disciplinary – formal/informal
- Employment Tribunals
- Exit interview themes/data

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- WRES/WDES data
- Pulse surveys

Action on internal data for triangulation:

The aim by November 2021 Board will be to have determined what other data may be appropriate to triangulate (including frequency and statistical measurements) to provide further insight into themes of issues. The possibility of a balanced scorecard approach including softer measures such as FTSU data has been suggested by the Director of People and Transformation as an ultimate aim, to suggest direction of movement and any cause and effect relationship on cultural and other aspects.

8. Patient safety data:

Similarly meaningful triangulation for emergent themes will be further considered ahead of the November Board report.

The NHSI guidance suggests these could include:

- Patient complaints and claims
- Serious incidents and other incidents
- Near misses
- Never events

It is noted that in the April 2021 Integrated Performance Report that there is a low level of Serious Incidents and total incidents although the levels of PALs enquiries and concerns has increased since January.

Key improvement work on Patient Safety priorities including various actions in WACH are noted.

9. Summary:

There is further progress to be made in staff feeling safe to speak up, being listened to and concerns followed up and resolved. Management and leadership training and commitment around psychological safety, active listening and early resolution along with joined up communication will be key to this being effective and staff tangibly feeling this as part of NBT's everyday culture.

Endorsement of the FTSU Champion role will be key in improving diversity and trust in the FTSU team and supporting the Lead Guardian in raising awareness.

Improved centralised data collection will support thematic analysis and learning.

An NBT baseline survey of FTSU staff awareness and understanding, barriers to speaking up and manager response (as per NHSI guidance and Board self-review) is in discussion with the Communications team. In addition the Lead will actively engage in collecting the views of staff as part of team visits, listening events and walk-arounds to

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reach staff that do not regularly use IT as part of their roles and/or are busy frontline staff (nurses, porters, theatre staff, HCAs etc).

10. Recommendations

The Trust Board is asked to:

- Discuss the report and findings:
- Review the FTSU data triangulated against the 2020 NHS staff survey results
- Note the planned the roll-out of FTSU Champions
- Pledge and role-model clear, visible support to Freedom to Speak Up at NBT and the importance and value to NBT as an organisation
- Note the NGO's annual report 2020

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Appendix 1: Updated FTSU Guardian poster

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Report To:	Trust Board		
Date of Meeting:	27 May 2021		
Report Title:	Integrated Performance Report		
Report Author & Job Title	Lisa Whitlow, Associate Director of Performance		
Does the paper contain	**Patient identifiable information?**	**Staff identifiable information?**	**Commercially sensitive information?**
	N/A	N/A	N/A
Executive/Non-executive Sponsor (presenting)	Executive Team		
Purpose:	**Approval**	**Discussion**	**To Receive for Information**
		X	
Recommendation:	The Trust Board is asked to note the contents of the Integrated Performance Report.		
Report History:	The report is a standing item to the Trust Board Meeting.		
Next Steps:	This report is received at the Joint Consultancy and Negotiation Committee, Operational Management Board, Trust Management Team meeting, shared with Commissioners and the Quality section will be shared with the Quality and Risk Management Committee.		

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

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

NHS North Bristol NHS Trust

North Bristol NHS Trust

INTEGRATED PERFORMANCE REPORT

May 2021 (presenting April 2021 data)

CONTENTS

North Bristol Integrated Performance Report

Domain	Description	National Standard	Current Month Trajectory (RAG)	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	Trend	Benchmarking (in arrears except A&E & Cancer as per reporting month)		
																		National Performance	Rank	Quartile
Responsive	A&E 4 Hour - Type 1 Performance	95.00%	81.05%	96.00%	95.47%	94.74%	93.47%	86.90%	87.76%	82.07%	77.95%	73.21%	68.51%	73.33%	81.05%	74.26%		78.77%	76/112	
	A&E 12 Hour Trolley Breaches	0	0	0	0	0	0	0	0	12	3	52	206	7	0	6		0 - 431	60/82	
	Ambulance Handover < 15 mins (%)	100%	58.16%	94.72%	97.38%	98.50%	98.07%	98.01%	76.69%	68.06%	67.67%	57.76%	54.95%	60.97%	58.16%	50.28%				
	Ambulance Handover < 30 mins (%)	100%	89.36%	99.53%	99.56%	99.96%	99.76%	99.83%	96.04%	93.49%	93.75%	88.43%	83.80%	92.75%	89.36%	79.42%				
	Ambulance Handover > 60 mins	0	83	0	0	0	0	0	4	33	26	82	180	57	83	272				
	Stranded Patients (>21 days) - month end			58	57	74	82	95	114	247	141	145	125	131	138	276				
	Right to Reside: Discharged by 5pm	50.00%		-	-	-	-	-	-	-	-	24.59%	30.56%	29.47%	30.93%	35.87%				
	Bed Occupancy Rate		93.00%	50.84%	58.18%	77.11%	82.97%	87.51%	92.30%	94.19%	92.38%	95.10%	95.86%	92.74%	92.49%	95.25%				
	Diagnostic 6 Week Wait Performance	1.00%	24.72%	61.24%	65.94%	46.56%	28.98%	32.36%	29.58%	27.47%	26.73%	32.37%	33.04%	27.20%	24.72%	29.45%		24.29%	164/259	
	Diagnostic 13+ Week Breaches	0	0	402	2292	3161	1886	1979	1998	1697	1427	1487	1420	1358	1364	1513			137/218	
	Diagnostic Backlog Clearance Time (in weeks)			1.2	2.7	2.0	1.0	1.0	0.9	0.9	0.8	1.0	1.0	0.8	0.8	0.9				
	RTT Incomplete 18 Week Performance	92.00%	71.64%	71.82%	64.51%	58.20%	58.48%	63.96%	70.46%	74.00%	74.35%	73.18%	71.62%	70.65%	71.64%	73.59%		64.38%	193/399	
	RTT 52+ Week Breaches	0	2088	130	275	454	648	797	1001	1092	1249	1418	1817	2108	2088	1827		0 - 20170	151/308	
	RTT 78+ Week Breaches			-	-	-	-	-	-	-	-	-	-	-	-	363				
	RTT 104+ Week Breaches			-	-	-	-	-	-	-	-	-	-	-	-	5				
	Total Waiting List		29580	25877	25518	25265	27512	28814	29387	30214	29632	29611	29759	29716	29580	31143				
	RTT Backlog Clearance Time (in weeks)			4.5	7.0	10.3	9.6	7.7	6.4	5.5	4.8	4.9	5.2	5.8	5.6	4.9				
	Cancer 2 Week Wait	93.00%	94.30%	76.01%	93.23%	97.29%	88.11%	78.05%	76.30%	89.01%	78.65%	63.72%	60.03%	70.87%	63.24%	-		91.25%	131/133	
	Cancer 2 Week Wait - Breast Symptoms	93.00%	95.31%	81.25%	98.28%	96.62%	96.05%	75.18%	54.04%	87.76%	61.07%	33.77%	49.64%	36.17%	15.20%	-		76.90%	91/101	
	Cancer 31 Day First Treatment	96.00%	97.36%	92.96%	85.64%	95.35%	97.51%	95.78%	90.31%	92.68%	97.01%	95.47%	89.84%	95.96%	96.62%	-		94.70%	57/119	
	Cancer 31 Day Subsequent - Drug	98.00%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	-		99.05%	1/29	
	Cancer 31 Day Subsequent - Surgery	94.00%	83.72%	75.76%	79.73%	86.96%	92.13%	89.86%	85.19%	87.76%	91.95%	92.22%	77.66%	84.44%	85.48%	-		86.41%	35/66	
	Cancer 62 Day Standard	85.00%	87.66%	73.53%	69.01%	70.12%	75.31%	73.10%	70.07%	72.87%	75.76%	77.39%	65.91%	74.34%	76.09%	-		73.94%	64/136	
	Cancer 62 Day Screening	90.00%	88.89%	85.07%	46.67%	28.57%	44.44%	66.67%	100.00%	77.14%	76.92%	86.36%	78.57%	86.79%	68.18%	-		75.08%	41/64	
	Mixed Sex Accomodation	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0				
	Electronic Discharge Summaries within 24 Hours	100%		84.07%	84.61%	85.88%	83.40%	82.79%	82.99%	84.20%	83.79%	82.98%	81.66%	83.95%	84.85%	84.72%				

North Bristol Integrated Performance Report

Domain	Description	National Standard	Current Month Trajectory (RAG)	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	Trend
Quality Patient Safety & Effectiveness	5 minute apgar 7 rate at term		0.90%	1.28%	1.59%	0.97%	0.64%	0.22%	0.23%	0.64%	0.73%	0.70%	0.50%	0.51%	0.43%	0.70%	
	Caesarean Section Rate		28.00%	31.46%	33.91%	36.69%	34.60%	39.01%	35.00%	36.42%	31.16%	41.92%	35.13%	38.69%	40.28%	37.44%	
	Still Birth rate		0.40%	0.23%	0.00%	0.00%	0.40%	0.20%	0.41%	0.00%	0.23%	0.64%	0.46%	0.23%	0.00%	0.43%	
	Induction of Labour Rate		32.10%	40.61%	38.88%	34.90%	35.40%	38.60%	38.87%	36.62%	39.77%	37.55%	39.81%	33.80%	33.81%	35.24%	
	PPH 1000 ml rate		8.60%	8.67%	12.90%	11.50%	11.20%	10.68%	7.97%	10.38%	14.19%	8.93%	9.77%	11.57%	10.28%	8.99%	
	Never Event Occurance by month	0	0	0	0	0	0	0	0	0	0	0	1	0	0	1	
	Serious Incidents			7	5	4	8	5	4	5	6	4	3	2	4	10	
	Total Incidents			597	679	834	952	1030	1057	1211	1052	1061	1222	875	972	947	
	Total Incidents (Rate per 1000 Bed Days)			45	43	46	48	49	47	50	49	49	56	45	43	39	
	WHO checklist completion		95%	99.50%	99.50%	99.60%	99.70%	99.70%	99.60%	99.60%	99.40%	99.95%	99.79%	100.00%	100.00%	99.88%	
	VTE Risk Assessment completion		95%	93.97%	94.24%	94.89%	95.79%	95.08%	95.15%	95.12%	94.61%	95.44%	95.23%	94.99%	93.89%	93.47%	
	Pressure Injuries Grade 2			24	16	13	8	14	13	28	17	17	17	27	7	9	
	Pressure Injuries Grade 3		0	0	0	0	0	0	1	1	0	0	0	0	0	0	
	Pressure Injuries Grade 4		0	0	0	0	0	0	0	0	0	0	1	0	0	0	
	PI per 1,000 bed days			1.18	0.58	0.59	0.24	0.50	0.46	0.85	0.42	0.60	0.52	0.82	0.19	0.30	
	Falls per 1,000 bed days			9.84	8.77	8.09	7.05	7.67	6.69	9.56	8.84	8.54	9.53	8.63	8.44	8.33	
	#NoF - Fragile Hip Best Practice Pass Rate			2.13%	10.20%	9.43%	47.46%	63.64%	54.17%	77.27%	75.61%	63.64%	39.34%	60.87%	0.00%	-	
	Admitted to Orthopaedic Ward within 4 Hours			85.11%	87.76%	83.02%	86.44%	66.67%	79.17%	67.44%	53.66%	57.14%	35.56%	43.48%	0.00%	-	
	Medically Fit to Have Surgery within 36 Hours			85.11%	67.35%	79.25%	74.58%	72.73%	68.75%	86.05%	80.49%	79.59%	55.56%	73.91%	100.00%	-	
	Assessed by Orthogeriatrician within 72 Hours			95.74%	97.96%	98.11%	98.31%	90.91%	87.50%	93.02%	95.12%	79.59%	75.56%	95.65%	50.00%	-	
	Stroke - Patients Admitted			71	72	79	84	63	83	86	79	80	70	61	96	78	
	Stroke - 90% Stay on Stroke Ward		90%	87.10%	81.50%	86.20%	80.00%	93.20%	88.00%	84.62%	81.97%	80.88%	58.18%	83.33%	81.08%	-	
	Stroke - Thrombolysed <1 Hour		60%	50.00%	Nil	85.70%	50.00%	60.00%	69.00%	72.73%	50.00%	33.33%	50.00%	44.00%	78.00%	-	
	Stroke - Directly Admitted to Stroke Unit <4 Hours		60%	74.19%	64.80%	88.10%	73.60%	63.30%	69.10%	61.73%	63.64%	47.83%	35.59%	60.00%	48.68%	-	
	Stroke - Seen by Stroke Consultant within 14 Hours		90%	79.41%	94.34%	94.00%	91.00%	89.00%	80.00%	86.00%	89.71%	85.92%	87.30%	91.55%	90.00%	-	
	MRSA	0	0	0	0	0	0	0	0	1	0	0	0	1	0	0	
	E. Coli		4	2	3	2	5	7	8	4	5	3	3	1	6	4	
	C. Difficile		5	1	4	2	4	3	5	7	5	7	4	9	4	10	
	MSSA		2	1	2	1	4	2	1	4	6	2	3	3	0	4	
Quality Caring & Experience	Friends & Family - Births - Proportion Very Good/Good			-	-	-	-	-	-	-	-	-	-	-	94.26%	95.51%	
	Friends & Family - IP - Proportion Very Good/Good			-	-	-	-	-	-	-	-	93.24%	94.06%	95.72%	93.68%	92.90%	
	Friends & Family - OP - Proportion Very Good/Good			-	-	-	-	-	-	-	-	95.60%	95.71%	95.29%	94.63%	94.90%	
	Friends & Family - ED - Proportion Very Good/Good			-	-	-	-	-	-	-	-	90.96%	87.49%	89.21%	87.24%	84.86%	
	PALS - Count of concerns			45	105	49	75	51	95	73	99	66	62	71	79	108	
	Complaints - % Overall Response Compliance		90%	88.46%	100.00%	98.30%	98.08%	97.06%	98.04%	94.44%	92.68%	94.64%	81.48%	84%	85.11%	79.07%	
	Complaints - Overdue			2	1	0	0	0	0	2	2	0	0	0	0	0	
	Complaints - Written complaints			24	27	40	59	53	46	48	39	23	37	43	42	56	
Well Led	Agency Expenditure ('000s)			613	386	364	555	822	687	875	899.6	1043.34	1233.82	543.91	1042	705	
	Month End Vacancy Factor			4.91%	4.93%	5.39%	6.05%	5.14%	3.82%	3.83%	3.38%	4.59%	3.80%	3.65%	3.62%	2.66%	
	Turnover (Rolling 12 Months)		12.00%	12.82%	12.53%	12.35%	13.10%	13.41%	13.25%	12.78%	12.74%	12.73%	12.89%	12.56%	12.36%	13.37%	
	Sickness Absence (Rolling 12 month -In arrears)		4.00%	4.53%	4.56%	4.53%	4.46%	4.46%	4.44%	4.41%	4.44%	4.38%	4.47%	4.48%	4.42%	-	
	Trust Mandatory Training Compliance			87.42%	87.23%	87.07%	85.24%	86.77%	86.26%	86.45%	86.07%	85.79%	85.90%	85.91%	85.40%	85.17%	

EXECUTIVE SUMMARY
April 2021

Urgent Care

Four-hour performance deteriorated to 74.26% in April with the Trust conceding 272 ambulance handover delays over one hour and six 12-hour trolley breaches. The deterioration reflects a significant increase in walk in attendances as well as ambulance arrivals, with ambulance arrivals exceeding 100 per day between the 9th and 18th of April. The Trust AM discharge rates have deteriorated vs. pre-pandemic levels and is contributing to poor flow. The Trust positioning deteriorated in April, moving from the second quartile to the third when compared nationally. ED performance is not expected to improve in May with a continued increase in attendance levels and current performance at 73.44%.

Elective Care and Diagnostics

The RTT waiting list increased significantly in April resulting from a 9.11% increase in demand and a 4.66% reduction in clock stops (adjusted for working days). There were 1827 patients waiting greater than 52 weeks for their treatment in April; this is the second consecutive month that the Trust has reported a reduction in 52 week wait breaches since the beginning of the COVID-19 pandemic. The overall proportion of the wait list that is waiting longer than 52 weeks reduced to 5.87% from 7.06%. Nationally, the Trust positioning was static in March, remaining in the third quartile. Diagnostic performance deteriorated in April to 29.45% with the Easter bank holiday weekend contributing to a 14.11% activity reduction. When compared nationally, Trust positioning for both the 6-week and 13-week performance deteriorated, though remain in the same quartiles as the previous month.

Cancer Wait Time Standards

The TWW standard deteriorated in March, continuing to report under trajectory; the majority of breaches were in Breast (78.71% of breaches). The 31-Day standard continued to improve in March, achieving national standard with performance of 96.62%. The 62-Day standard failed both the recovery trajectory and the national standard in March, however there was improvement on the February position and the Trust remains in the second quartile when compared nationally. Skin's capacity issues have started to impact the CWT standards and will continue to do so for the remainder of Q1.

Quality

Maternity visiting arrangements have been reviewed in line with national guidance and now all women can have a person of their choosing with them at each appointment. There have been no reported Grade 3 or 4 pressure injuries in April. There has been a reduction in COVID-19 (Coronavirus) cases and there were no MRSA cases reported in April 2021. VTE risk assessment compliance has fallen in the past year, as a consequence of the different working patterns as a result of the COVID-19 pandemic; there has been some recovery of this position and improvement interventions have been highlighted.

Workforce

The Trust saw a net gain of staff in April with enhanced HCA recruitment continuing to deliver the target of 25 starters per month. Trust annual turnover increased by 0.27% in April to 11.04% as the number of staff leaving in April 2021 was higher than April 2020 (excluding the impact of staff recruited temporarily during the pandemic response and mass vaccination workforce). Turnover will be closely monitored and retention initiatives continue with May seeing the launch of the Trust 'Big Conversation' engagement event. Temporary staffing demand saw a reduction in April with a commensurate reduction in agency use with registered nursing seeing a 28.30% (14.1 wte) reduction.

Finance

NHSE/I suspended the established financial framework in early 2020/21 due to the COVID-19 response. The revised financial framework for months 1 to 6 required the Trust to breakeven against an NHSE/I calculated income level and to recover costs incurred in dealing with the COVID-19 pandemic in line with national guidance. Arrangements for the remainder of the financial year (October 2021 to March 2022) are still to be advised.

RESPONSIVENESS
SRO: Chief Operating Officer
Overview

Urgent Care

The Trust reported a four-hour performance of 74.26% in April; trajectories for 2021/22 will not be set until June 2021 following the H1 planning submission. Ambulance handover delays were reported in-month with 272 handovers exceeding one hour and the Trust conceded six 12-hour trolley breaches in April. ED activity increased in April with a rise in walk-in attendances, whilst ambulance arrivals also increased; handover times continue to be particularly challenged as a result of decreased offload space due to the need to maintain social distancing, leading to delays. Bed occupancy varied between 89.77% and 98.74% against the core bed base; there was an overall increase in occupancy and consistency in April, reducing the variation across the month. Performance remains challenged into May with a continued increase in attendances.

Planned Care

Referral to Treatment (RTT) - 18 week RTT performance improved marginally in April to 73.59%; trajectories for 2021/22 have not yet been set. The number of patients exceeding 52 week waits in March was 1827, the majority of breaches (1176; 64.37%) being in Trauma and Orthopaedics. For the second consecutive month since the beginning of the COVID-19 pandemic the Trust has reported a reduction in 52 week wait breaches; the overall proportion of the wait list that is waiting longer than 52 weeks 5.87%. The Trust is still experiencing some patients choosing to defer their treatment due to concerns with regards to COVID-19 or wishing to wait until they have received the COVID-19 vaccine. The Trust is working with these patients to understand their concerns and what needs to happen for them to be able to engage with progressing their pathway.

Diagnostic Waiting Times – Diagnostic performance deteriorated in April with performance of 29.45%. Due to ongoing capacity issues, Non-Obstetric Ultrasound reported a deterioration in performance in April resulting from a significant increase in the backlog (70.73%). Actions are in progress to increase capacity in the service. Backlog reduction in Urodynamics resulted in a significant performance improvement in April. The number of patients waiting longer than 13 weeks increased by 10.92% in April. Compared nationally, 13 week performance deteriorated slightly in March but remains in the fourth quartile.

Cancer

The Trust achieved only one of the seven Cancer Wating Time (CWT) standards (31-Day 1st Treatment) and four of the post COVID-19 revised trajectories for 2020/21. The Breast service continues to have workforce and capacity constraints in both clinical and diagnostic support and because of that the service is carrying a TWW backlog of c.800 patients waiting to be dated. The average waiting time for the Trust's one-stop Breast clinic is currently 31 days. Urology achieved TWW, 31 Day CWT targets and 62 Day trajectory targets. Skin's capacity issues have started to impact the CWT standards and will continue to do so for the remainder of Q1. Cancer trajectories for 2021/22 have been created in line with 2021/22 planning guidance. Overall, the Trust achieved the 28-Day faster diagnosis standard.

Areas of Concern

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

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

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

Improvements

Maternity Visiting arrangements: The COVID-19 pandemic had a significant impact on who was able to accompany women to appointments and be with them during their stay in hospital. From April 12, in line with national guidance, all women can now have a person of their choosing with them at each appointment.

Perinatal Quality Surveillance Tool: the information provided represents the recommended information from the Ockenden investigation report, which was subject to detailed review at the the Quality & Risk Management Committee (QRMC) meeting in March 2021. The clinical leads in Maternity are further developing this dataset to ensure the Board is informed of safety metrics and indicators.

Pressure Injuries: There have been no reported Grade 3 or 4 pressure injuries in April. There has been a further decrease of medical device related pressure injuries.

Infection control: We have continued to see a reduction in COVID-19 (Coronavirus) cases and there were no MRSA cases reported in April 2021.

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

Areas of Concern

VTE Risk Assessments: VTE risk assessment compliance is targeted at 95% for all hospital admissions and compliance has fallen in the past year. In recent months there has been some recovery of this position and various other improvement interventions have been highlighted. The Trust's thrombosis committee is overseeing work within divisions for their implementation.

Maternity: The CNST Maternity scheme deadline has been postponed until July 2021. The Trust is currently compliant in 8 of the 10 standards and work is underway to progress compliance with the remaining, overseen via QRMC.

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

Corporate Objective 4: Build effective teams empowered to lead

Vacancies

The Trust vacancy reported vacancy factor is 2.66% in April compared to the 3.63% in March. Final budgets for 2021/22 have yet to be finalised including recurrent and non-recurrent substantive establishment, vacancies will increase in May in line with establishment changes associated with budget setting. The Trust overall saw a net gain of staff in April (+6.4 wte) predominantly driven by a net gain in HCAs (+14.9 wte), this equated to 24.5 wte starters as the enhanced recruitment process deployed over winter continues.

Turnover

The Trust turnover is reported as 13.37% in April, an increase of 1% compared with March. The increase mainly relates to student nurses on paid placements leaving the organisation after their placement has ended. Excluding the impact of these staff, other staff on temporary contracts during the COVID-19 response and the mass vaccination workforce, Trust turnover is reported as 11.04%, compared to 10.77% in March and 12.93%% in April 2020. The increase in turnover in April relates to a higher number of leavers in April 2021 than in April 2020 and staff turnover will continue to be closely monitored in line with current retention plans. Continuing the focus on retention, May will see the launch of the 'Big Conversation' as part of the 'renew and restore' programme. The initiative is aimed at re-engaging colleagues and includes regular pulse surveys and toolkits for managers to hold engaging conversations with their teams.

The Trust turnover target for 2021/22 is set at 12% acknowledging the risk of a deterioration from the 2020/21 position but anticipating a positive impact on the Trust wellbeing and retention initiatives that will mitigate turnover rates reaching pre-COVID levels.

Prioritise the wellbeing of our staff

The rolling 12 month sickness absence saw a small reduction in March to 4.42%, from 4.49% in February. In month sickness in March was 3.66%, compared to 4.34% in March 2020, which saw a higher level of recorded cases of COVID sickness and the greatest driver of the different is short term sickness.
A large scale "One NBT Festival" is now being planned for July which will further progress our staff wellbeing initiatives and will showcase existing wellbeing support, trial new wellbeing initiatives (e.g. yoga) and relaunch Schwartz rounds. The Trust is also participating in focussed work via BNSSG to use data on staff absence due to 'stress/anxiety/depressions/other psychiatric illness' to monitor impact on staff absence of the relevant wellbeing initiatives being delivered
The Trust sickness target for 2021/22 is 4.0%, a stretching target which acknowledges the work on wellbeing and absence case management which is ongoing and with a particular focus on long term sickness.

Continue to reduce reliance on agency and temporary staffing

Temporary staffing demand significantly reduced in April, with overall demand down by 25% (277 WTE). The reduction in demand saw an increase in bank fill rates and a reduction in unfilled shift rates, +4.8% and – 4.8% respectively.
Whilst agency fill rates remained the same In April, at 6.1%, agency use saw a reduction with registered nursing seeing a 28.30% (14.1 wte) reduction, of which 57.44% was due to a reduction in RMN use across wards and the emergency zone where both tier 1 and tier 4 agency RMN use reduced.

FINANCE
SRO: CFO
Overview

NHSE/I suspended the established financial framework in early 2020/21 due to the COVID-19 response

The revised financial framework for months 1 to 6 required the Trust to breakeven against an NHSE/I calculated income level and to recover costs incurred in dealing with the COVID-19 pandemic in line with national guidance.

Arrangements for the remainder of the financial year (October 2021 to March 2022) are still to be advised.

Highlights:

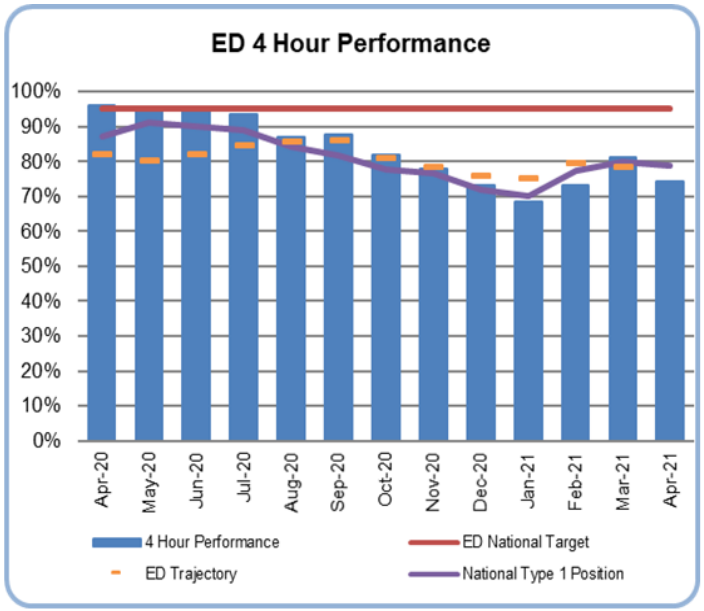
The forecast Trust deficit for April was breakeven, actual surplus (excluding any ERF earned retrospectively) is £2.5m

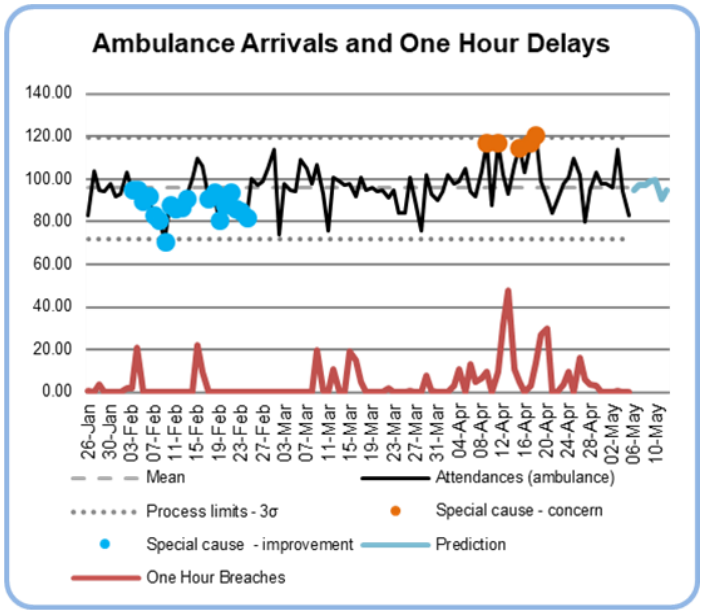
Total Capital spend for the month is £1.5m, compared to a plan of £1.2m.

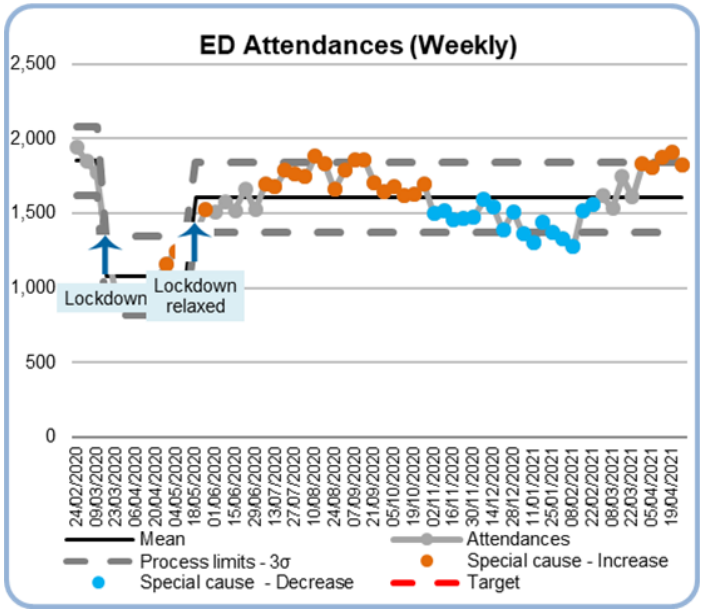
Cash is hand at 30 April is £109.6m, this represents a decrease since March of £11.9m

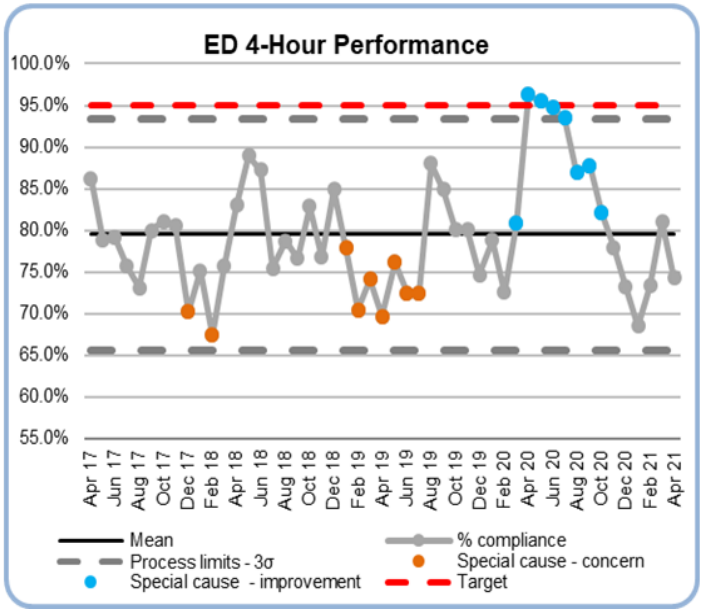
Responsiveness

Board Sponsor: Chief Operating Officer
Karen Brown









Urgent Care

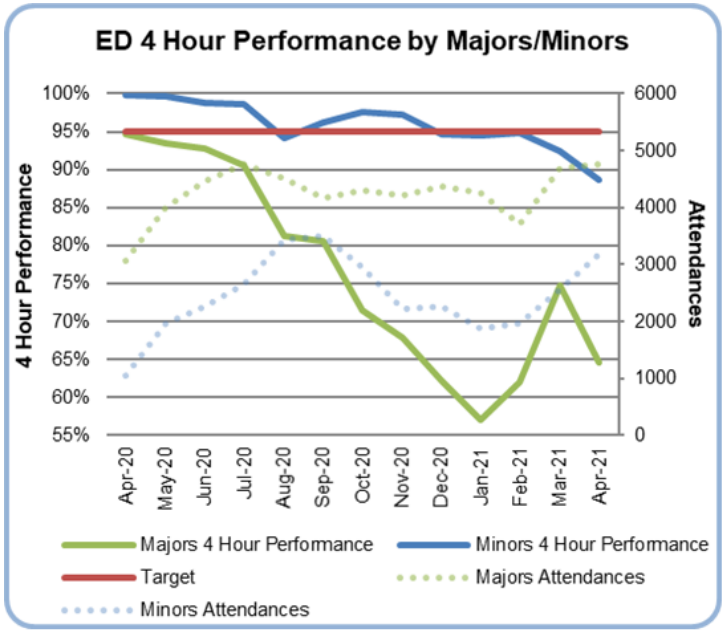
Four hour performance deteriorated to 74.26% in April with the Trust experiencing a significant rise in the number of emergency attendances and Trust bed occupancy.

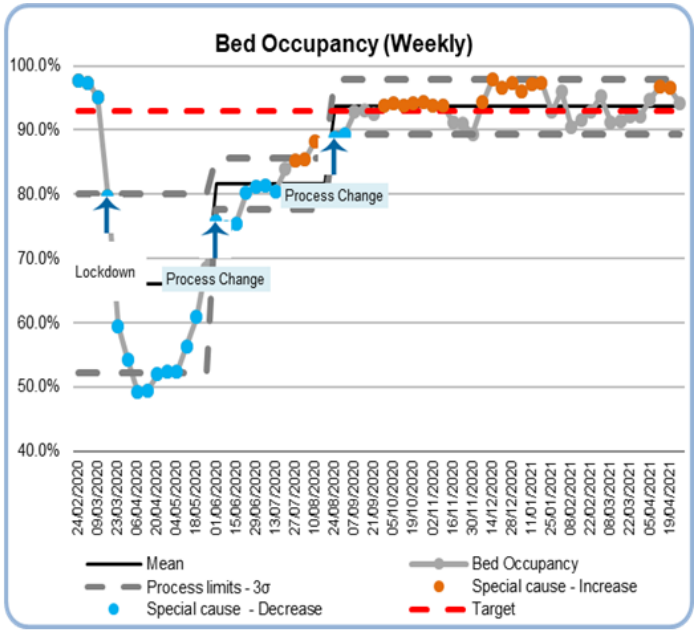
Trajectories have not yet been set for 2021/22; they will be confirmed in June-21 following the national H1 planning submission. Trust performance has reported below national performance for April.

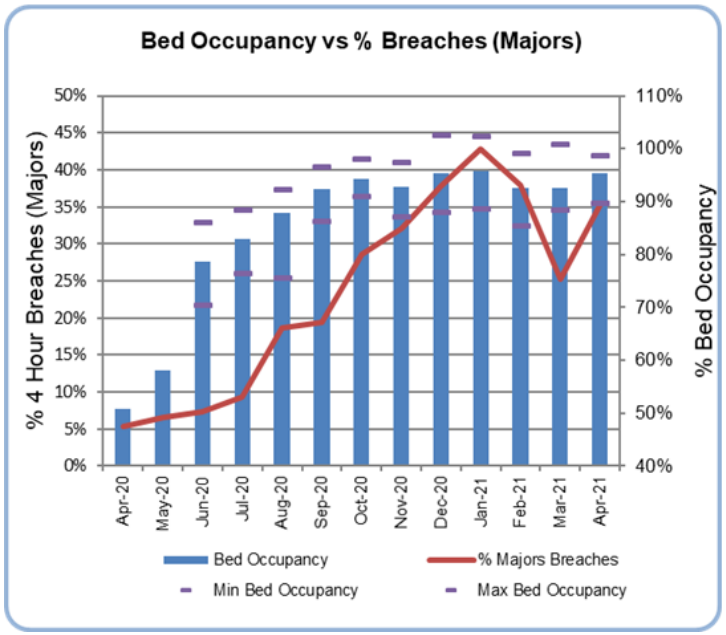
Ambulance handover times continued to be challenged, with the Trust conceding 272 ambulance handover delays over one hour when the department was experiencing a significant surge in demand. The Trust conceded six 12-hour trolley breaches in month.

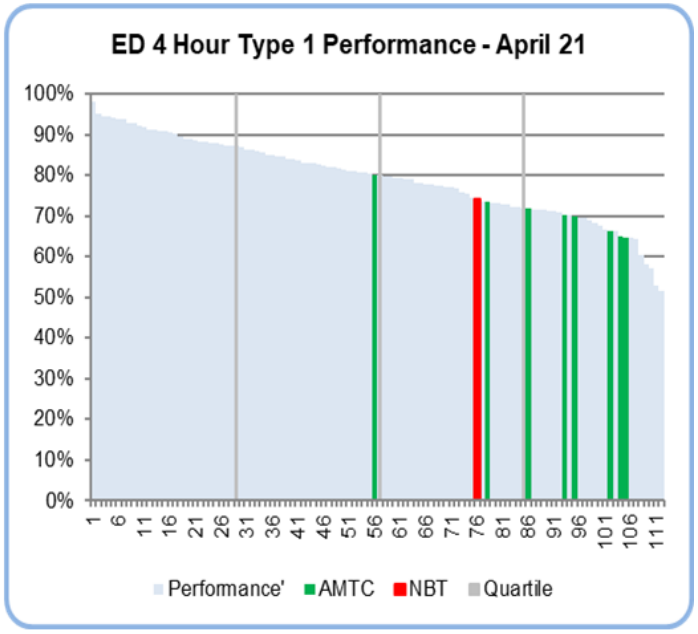
Despite reducing COVID-19 demand, morning discharge rates have reduced vs. pre pandemic levels which has negatively impacted flow; key drivers include discharge lounge capacity due to IPC requirements, a mismatch in cleaning resource and demand with a recurrent funding solution being worked up, below target levels of day before TTA preparation. Month on month usage of the discharge lounge has increased for both green and amber pathways, however the Trust has yet to maximise all available capacity and this is a focus though daily bed meetings.

ED performance is not expected to improve in May with current performance at 73.44%.









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

4-Hour Performance

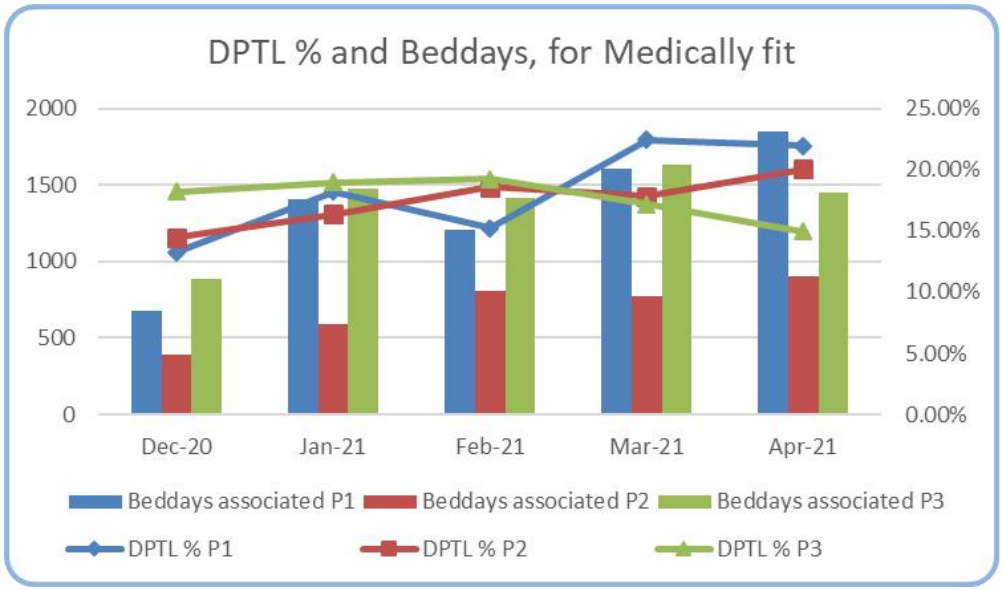
In April, Minors performance deteriorated to 88.57%, whilst Majors remained most notably impacted and deteriorated more significantly to 64.68%.

Attendances continued to increase significantly in April with walk-in attendances returning to pre-pandemic levels. Ambulance arrivals also increased in month, with peaks exceeding 100 per day between the 9th and 18th of April.

For the second consecutive month, the predominant cause of breaches at 39.17% was waiting for assessment in ED, whilst 20.05% of breaches were caused by waiting for a medical bed.

Bed occupancy varied between 89.77% and 98.74% in April against the core bed base. There was an overall increase in occupancy and consistency in April, reducing the variation across the month.

The Trust position has deteriorated for ED performance when compared nationally, moving from the second quartile to the third in April. ED performance for the NBT Footprint stands at 79.82% and the total STP performance was 80.85% for April.



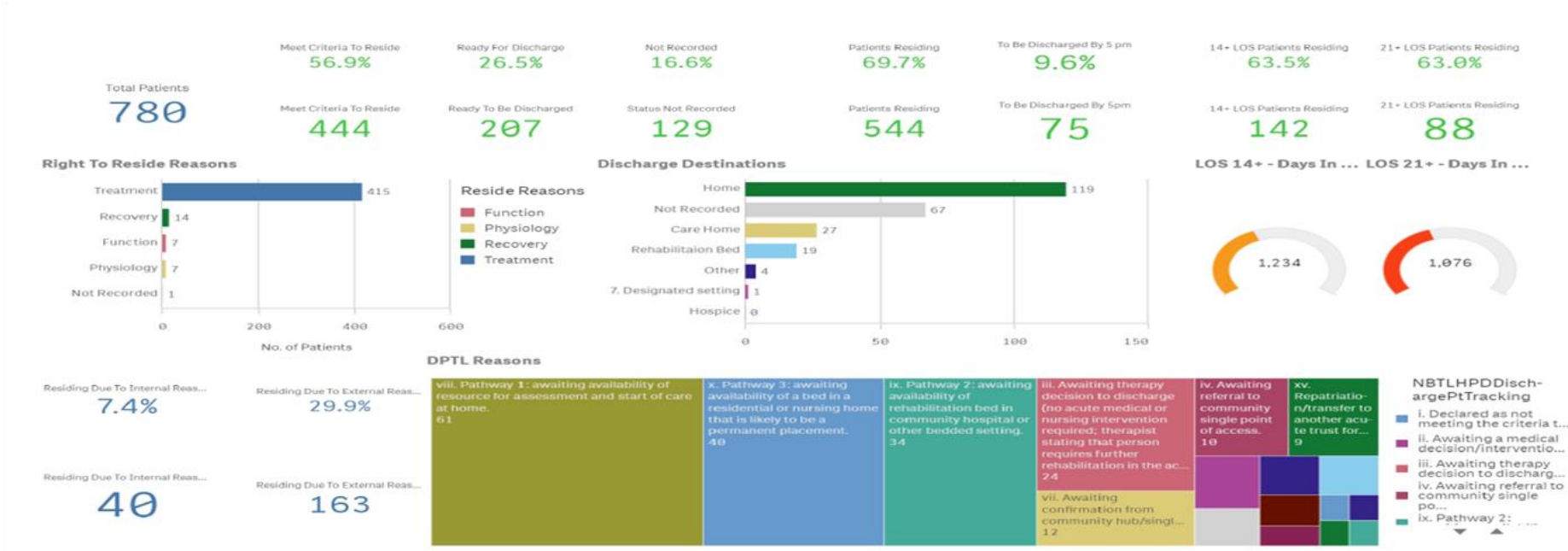
Right to Reside Report

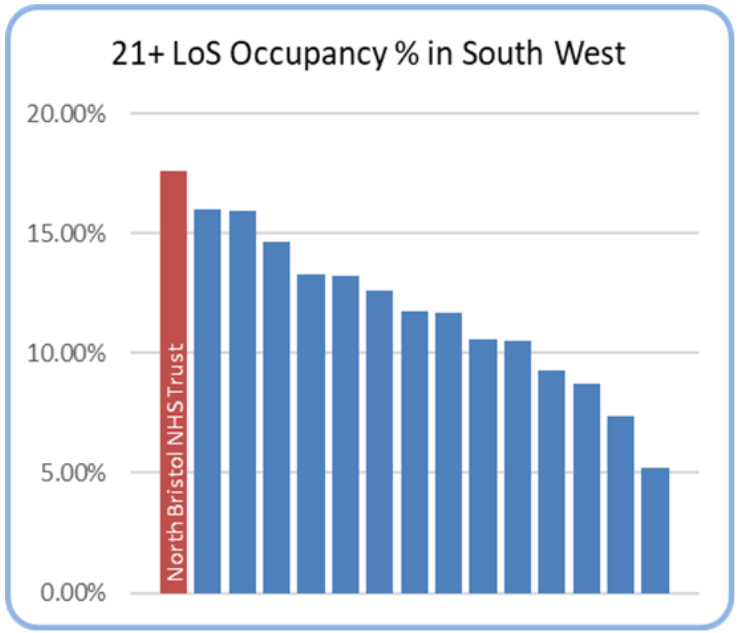
In line with System Transformation plans there has been a significant change in the referral levels with a change from 39% of total referrals to Pathway 1 (P1) in 2019/20, to 60% for 2020/21.

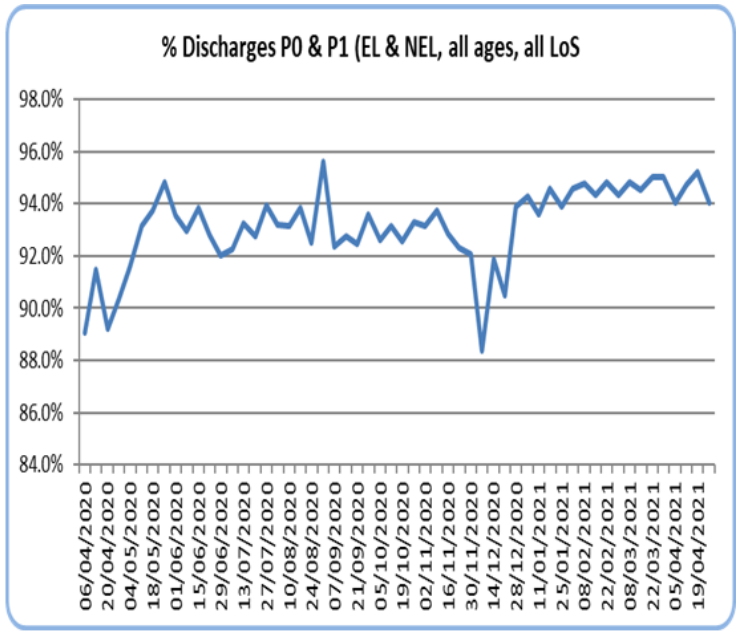
However, the monthly average data report taken from the Right to Reside reporting indicates that there was a high level of demand for P1 discharges through the month exceeding planned capacity, leading to an increase in delayed bed days.

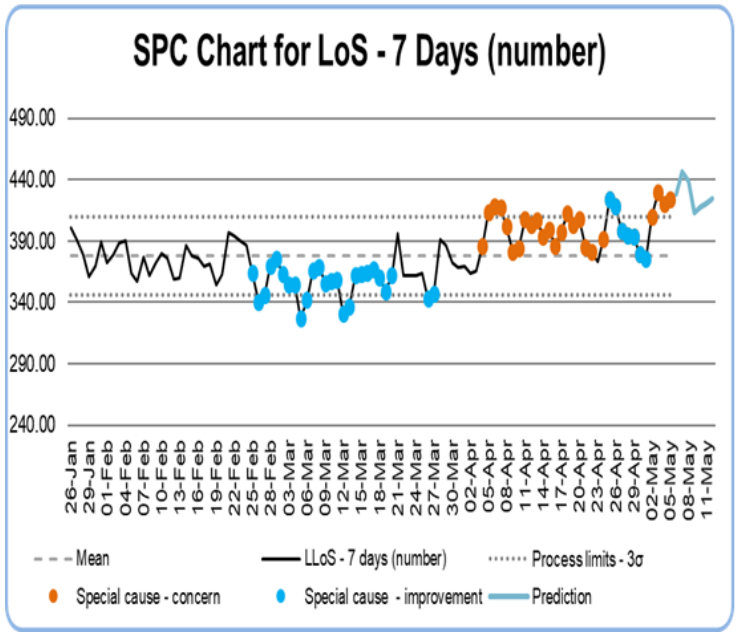
In addition, there are constraints within the complex Pathway 3 (P3) bed base in Bristol that has significantly impacted on the discharges (in particular insufficient complex community dementia beds).

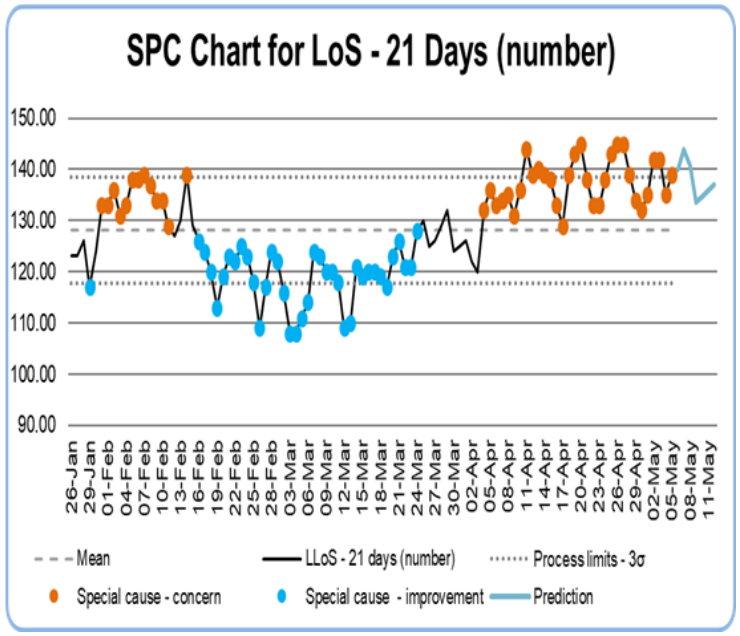
The main delays for Pathway 2 (P2) are associated with lack of capacity for Stroke patients and the capacity that does not meet the needs of the referred patients.











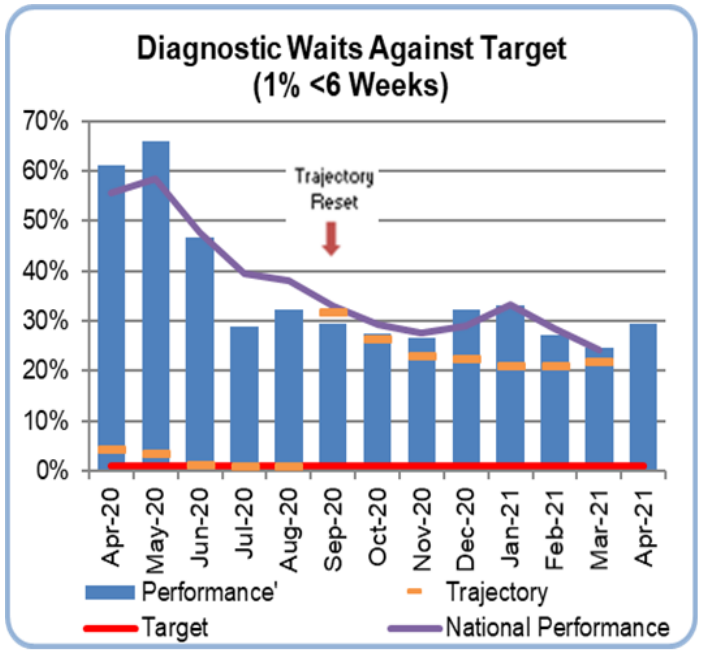
Stranded Patients

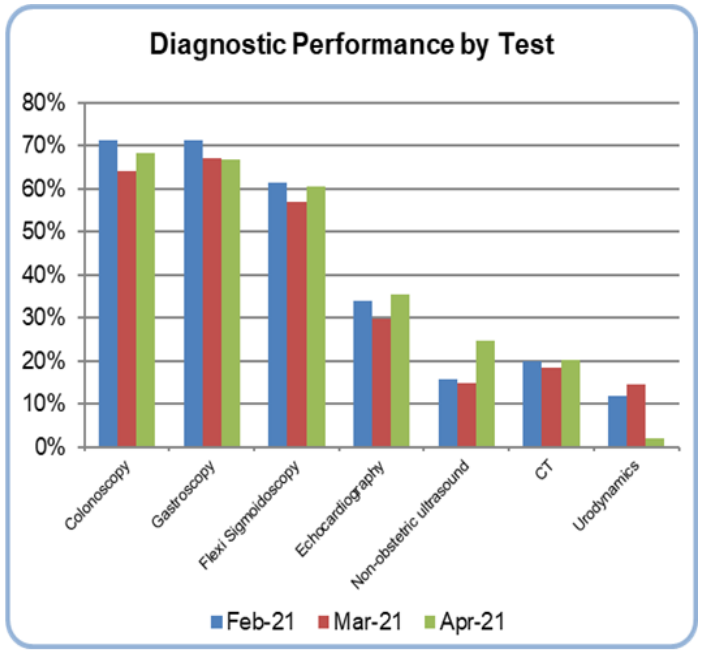
The stranded patient levels reported are now the highest within the region and the levels continued to rise through the month.

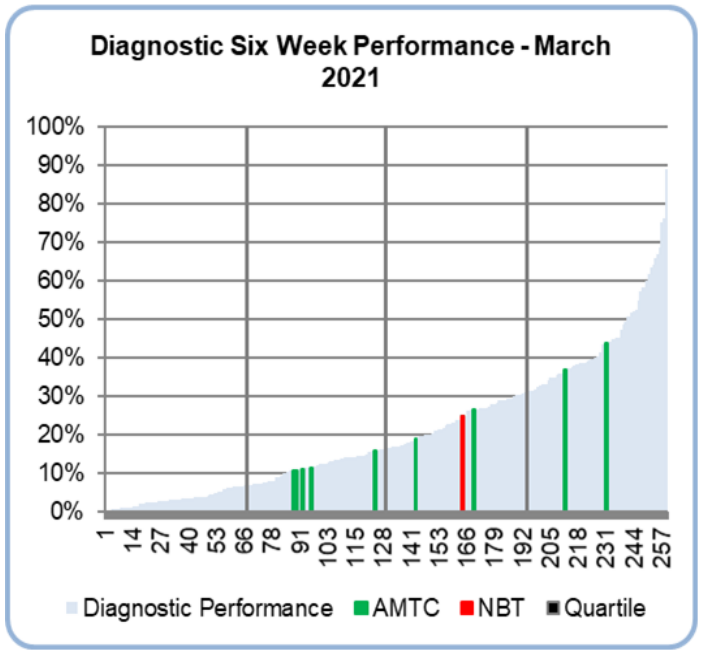
Admission to Single Referral Form (SRF) monitoring indicates improvement in the median reported levels, with a reduction in admission to first completed SRF for P3 from 11.5 days in January/February to 7.5 days reported in April.

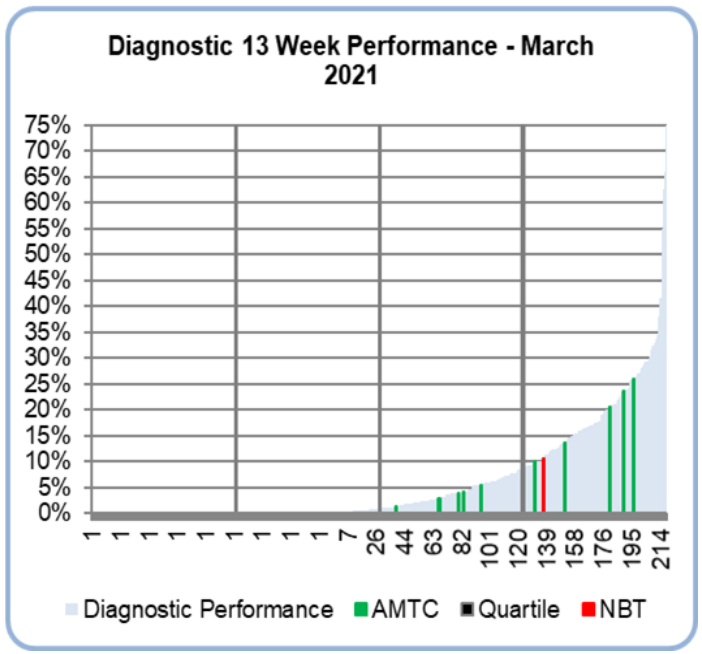
However, these gains have been offset by delays associated with external constraints once the referral is accepted.

Data Source: South region NHSI UEC dashboard, w/e 5th May









Diagnostic Waiting Times

Diagnostic performance deteriorated to 29.45% in April, with most test types reporting a worsened position in month. Trajectories have not yet been set for 2021/22; these will be confirmed in June following the national H1 planning submission.

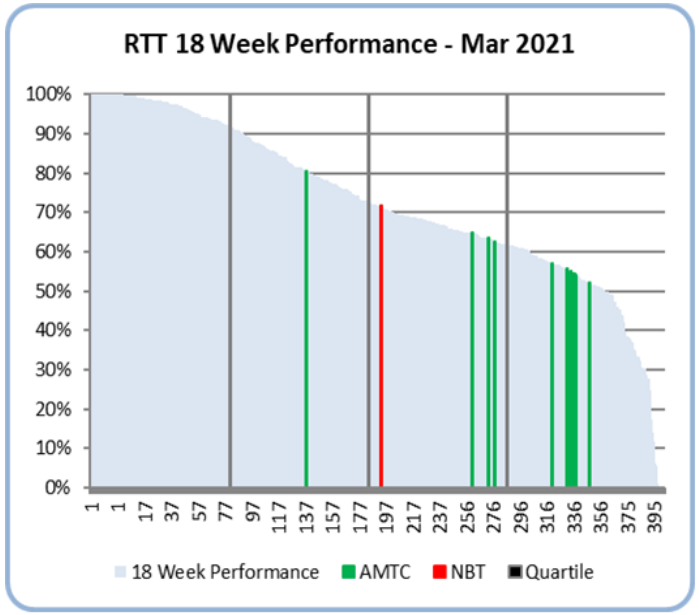
Activity has reduced by 14.11% in April resulting from the Easter bank holiday weekend. When adjusting for working days, the activity reduction reduces to 1.22%.

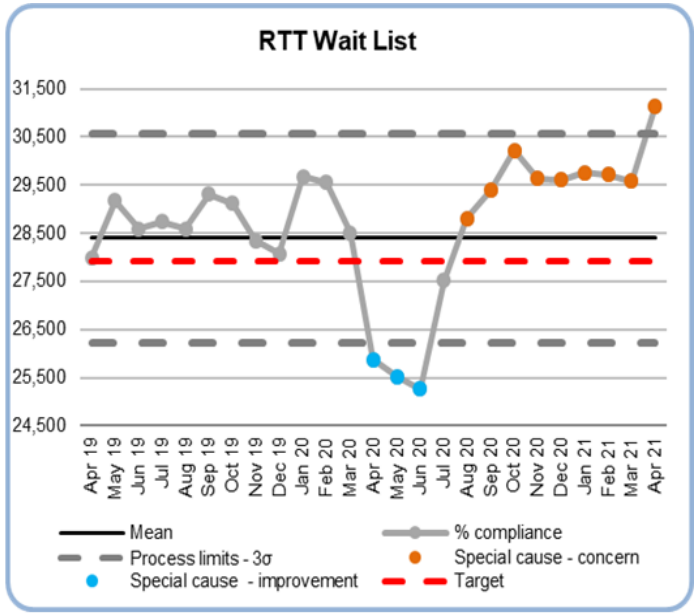
Non Obstetric Ultrasound reports a significant deterioration in performance in April with an increase of 70.73% in the backlog. Actions to increase capacity are currently being progressed, including use of IS capacity, enhanced WLI rates to support weekend lists at NBT and securing outsourced capacity with a third-party provider.

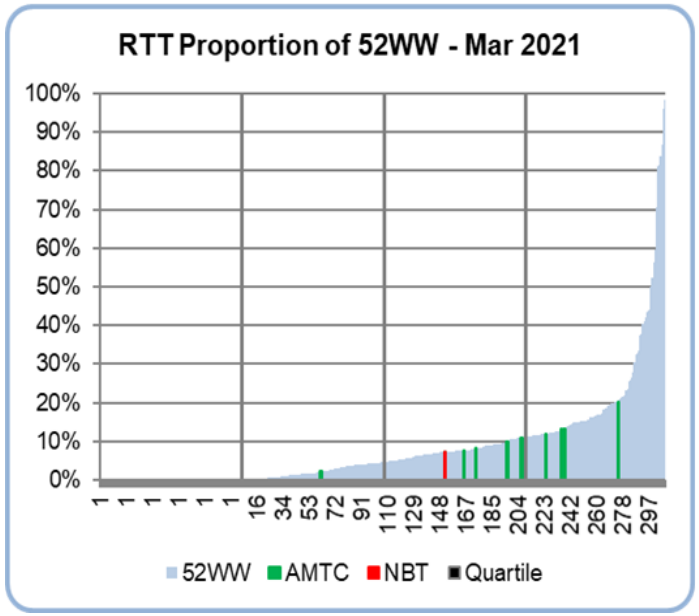
Urodynamics significantly reduced their backlog in April, improving performance on the March position.

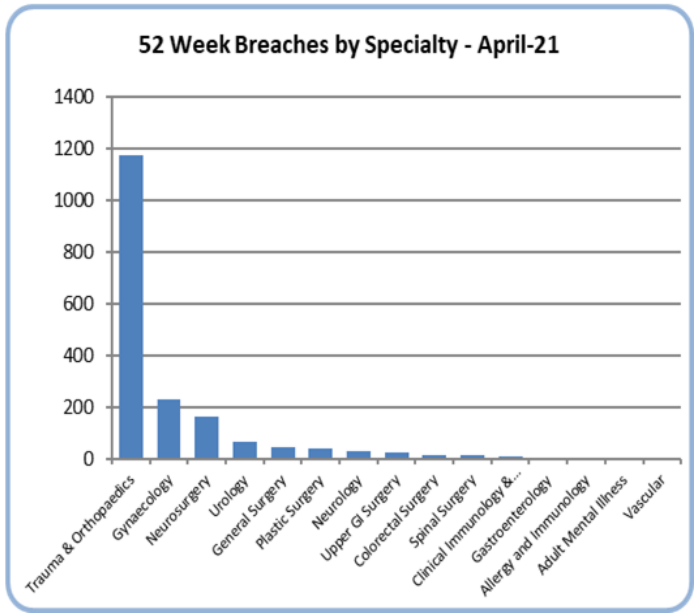
The number of patients waiting longer than 13 weeks has increased by 10.92% in April. A high level review continues to be completed for patients exceeding 13 weeks to ensure no harm has resulted from the extended wait times.

Nationally, Trust positioning deteriorated slightly for 6-week performance, though remains in the third quartile for March. 13 week performance also deteriorated slightly, but remains in the fourth quartile.









Referral to Treatment (RTT)

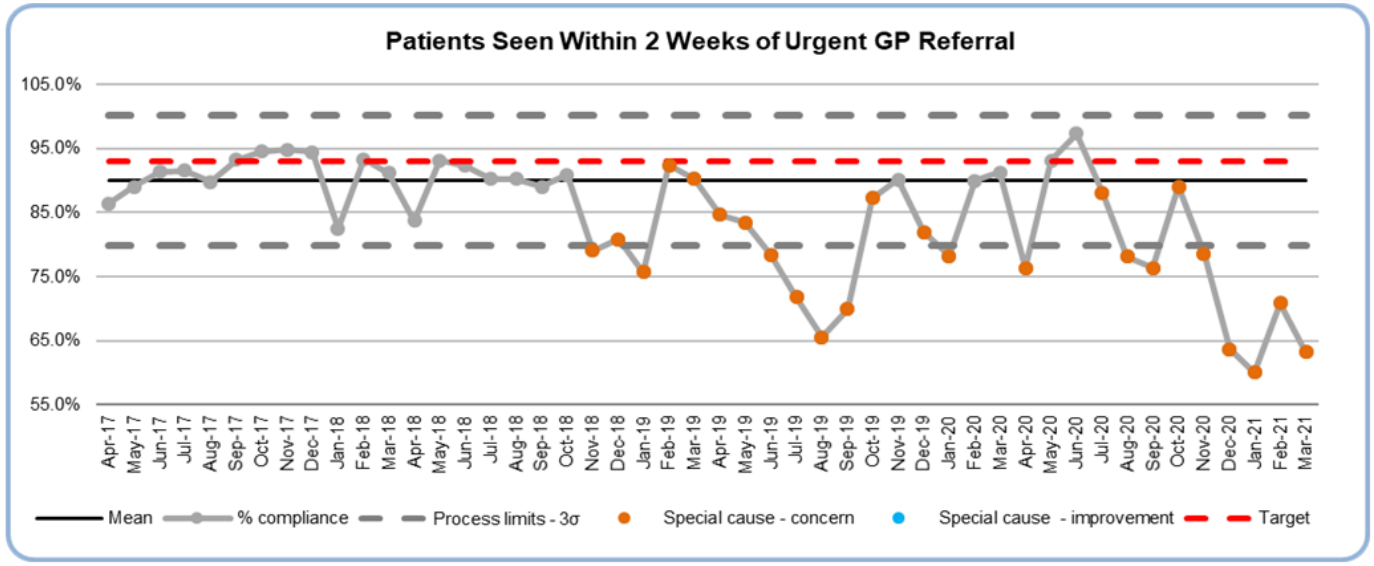
In April, the Trust reported RTT performance of 73.59% and a significant increase in the waiting list to 31143. Trajectories for 2021/22 are due to be set in June following the national H1 planning submission.

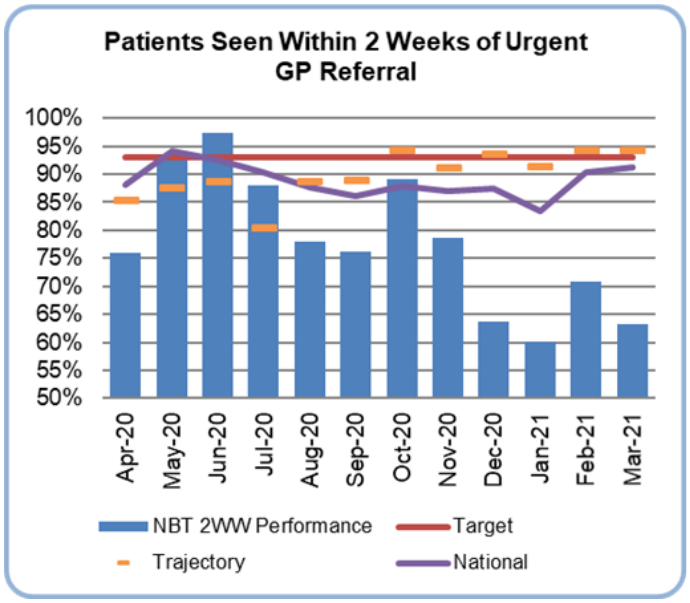
Adjusting for the number of working days, there was a 9.11% increase in demand and a 4.66% reduction in clock stops overall in April.

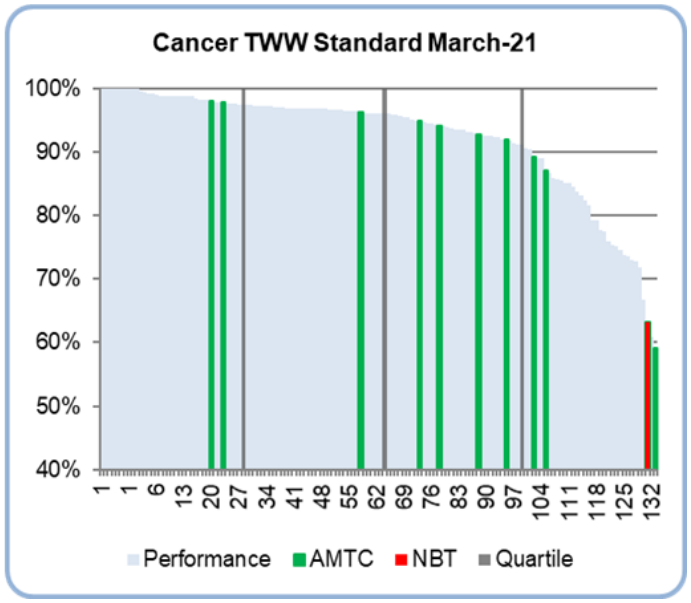
For the second consecutive month since the onset of the COVID-19 pandemic, the Trust has reported a reduction in 52 week wait breaches. At month end, there were 1827 patients waiting greater than 52 weeks for their treatment; 363 of these were patients waiting longer than 78 weeks, whilst five were waiting over 104 weeks. The majority of 52 week breaches (1176; 64.37%) are in Trauma and Orthopaedics. The overall proportion of the wait list that is waiting longer than 52 weeks reduced to 5.87% from 7.06% resulting from the 52 week reduction and increased wait list size.

In April, there were six patients waiting more than 52 weeks that the Trust had accepted as late referrals from another Provider; the Trust is supporting equity of access to Clinical Immunology and Allergy services within the Region.

Nationally, the Trust's 18 week performance positioning in March was static and remains in the third quartile. The positioning of the 52WW breaches as a proportion of the overall wait list improved slightly, but remains in the third quartile.







Cancer: Two Week Wait (TWW)

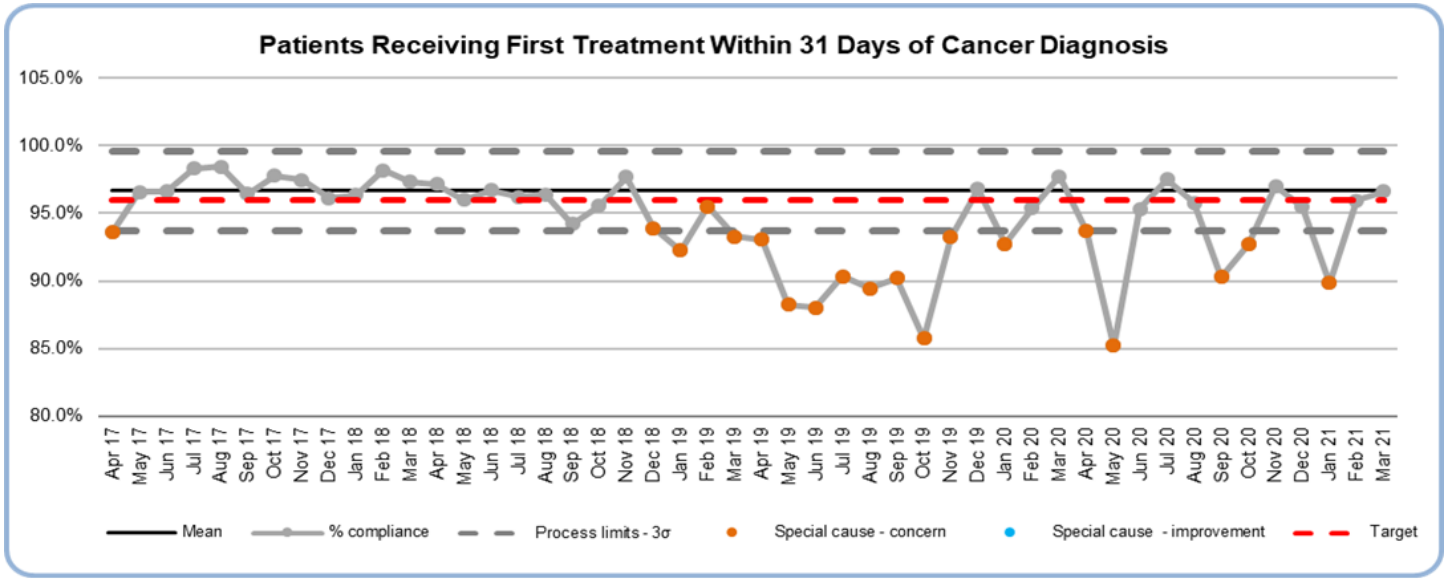
The Trust saw 2288 patients in March; 841 patients breached giving performance of 63.24%. This is a decline on last months performance of 70.87%.

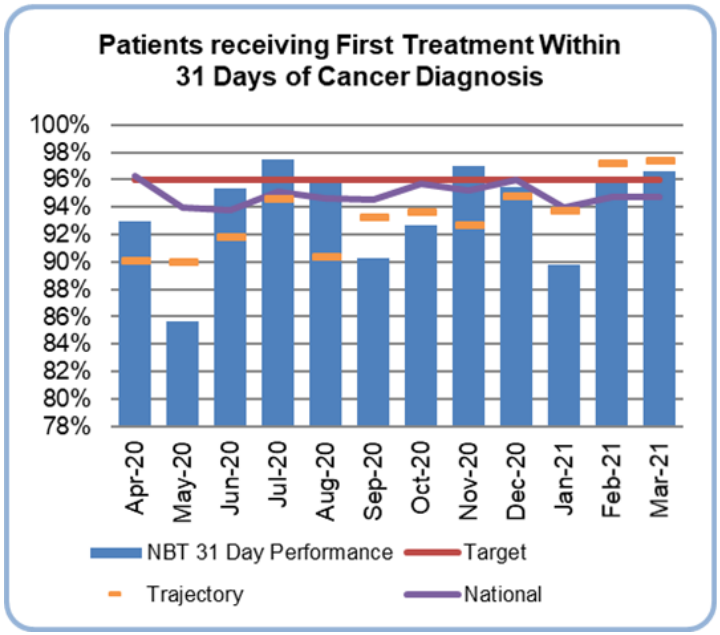
The Breast service saw 13.53% more TWW patients in March compared to February but the backlog continues to remain high at c.800. Of the 841 breaches this month Breast accounted for 78.72% (662) of them. Gynaecology, Brain, Lung and Urology all achieved TWW standard this month.

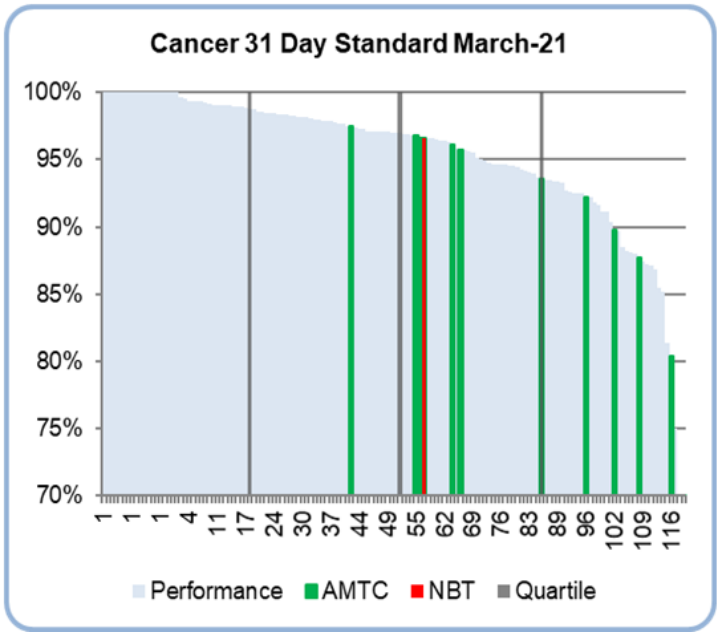
Colorectal services failed both the TWW CWT standard and cancer trajectory in March; they saw 229 patients with 74 breaches showing a performance of 67.69%. This is a deterioration from the February TWW position of 82.95%.

The QFiT pathway impact is being reviewed within BNSSG partners alongside improved communication and education to primary care on referral criteria.

Skin services failed to achieve the TWW standard this month. They saw 623 patients in total with 53 breaches leading to a performance of 91.49%. This is a deterioration on last month when they achieved 96.40%. Looking forward into April's performance, Skin capacity issues have led to an increase in number of breaches with an unvalidated performance of 28.90% predicted.







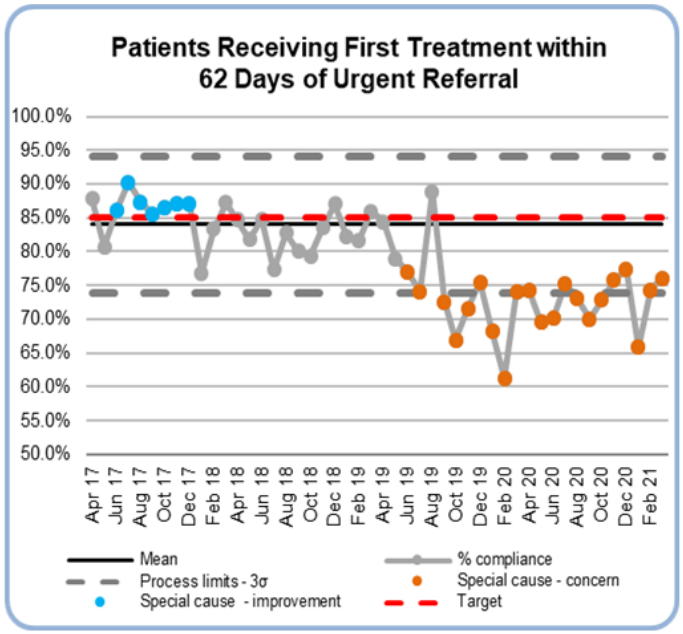
Cancer: 31-Day Standard
In March, the Trust achieved the standard with performance of 96.62%. This was an improvement on February's performance.

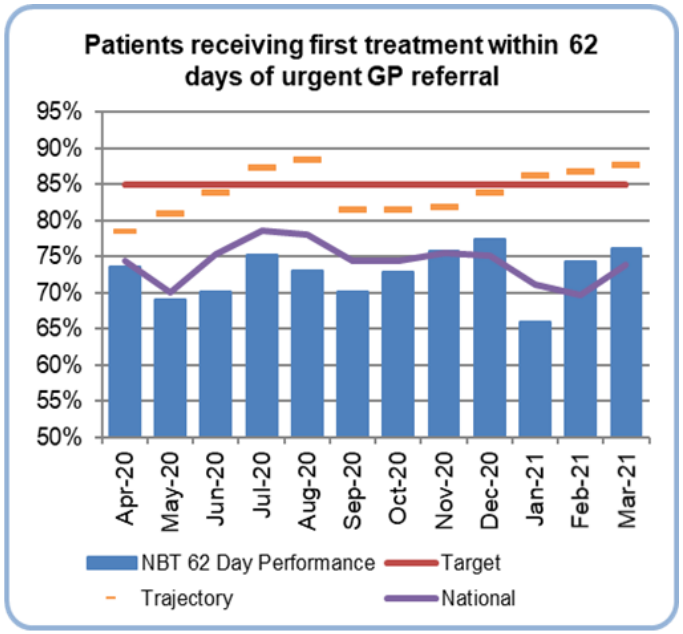
There were 266 completed pathways with nine breaches; Breast and Colorectal were above 90% achievement with seven of the nine breaches.

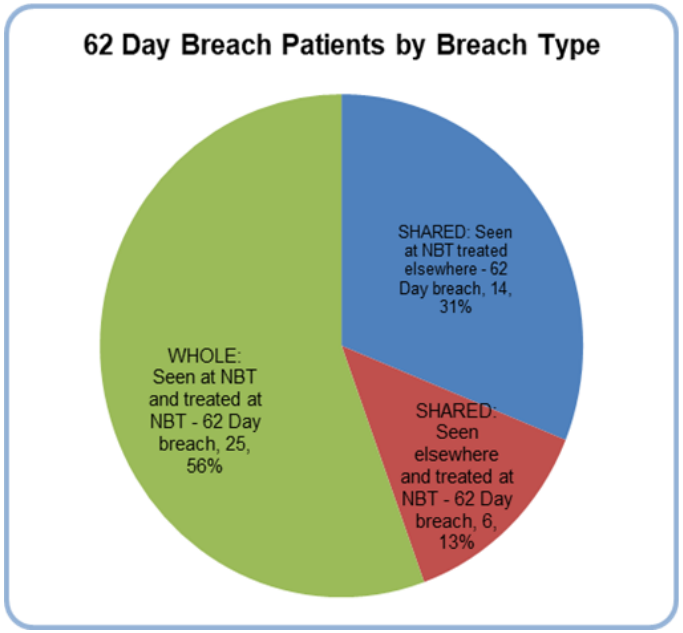
There continues to be variation in the achievement of the 31-Day first standard.

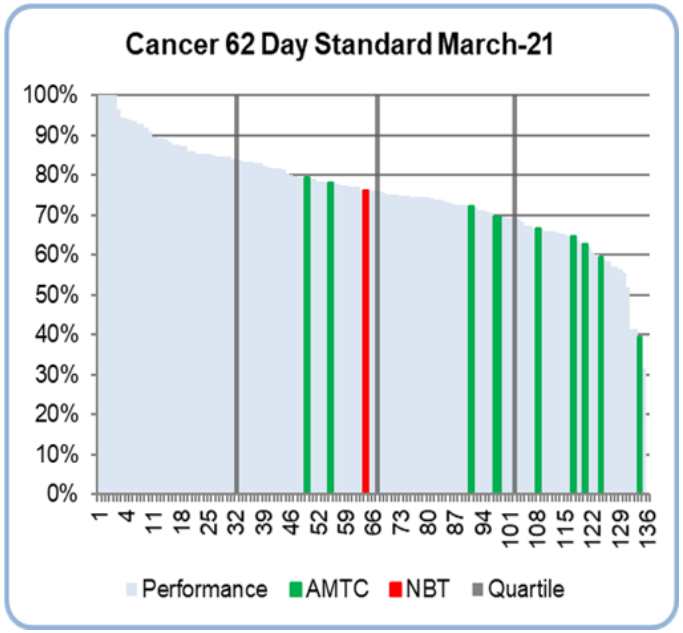
Most of the breaches were due to complex medical issues and patient fitness to proceed with treatment.

April's unvalidated position is showing as 93.55% with the majority of the breaches sitting in Skin due to capacity constraints.









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

Cancer: 62-Day Standard

The reported 62-Day performance for March was 76.09% with 171 treatments and 41 breaches. The Trust failed both the recovery trajectory position of 87.91% and the CWT standard of 85.00%.

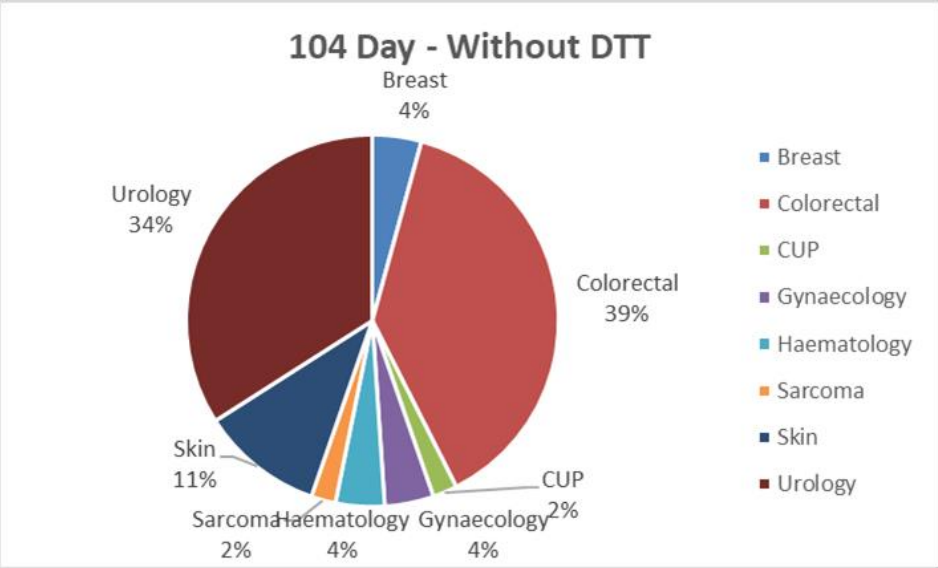
Skin, Sarcoma, Lung and Haematology were the only specialties that achieved 62-Day CWT standard in March.

Gynaecology reported performance of 50.00% and Colorectal reported 58.82% in March. Urology's performance of 70.34% with 17.5 breaches failed to achieve CWT standards of 85%. They also failed to achieve their trajectory of 87.90%. The majority of the 17.5 Urology breaches were due to NBT pathway and medical delays. 11 of the delays were directly due to waits for MRI due to hot clinic pathway changes resulting from the pandemic.

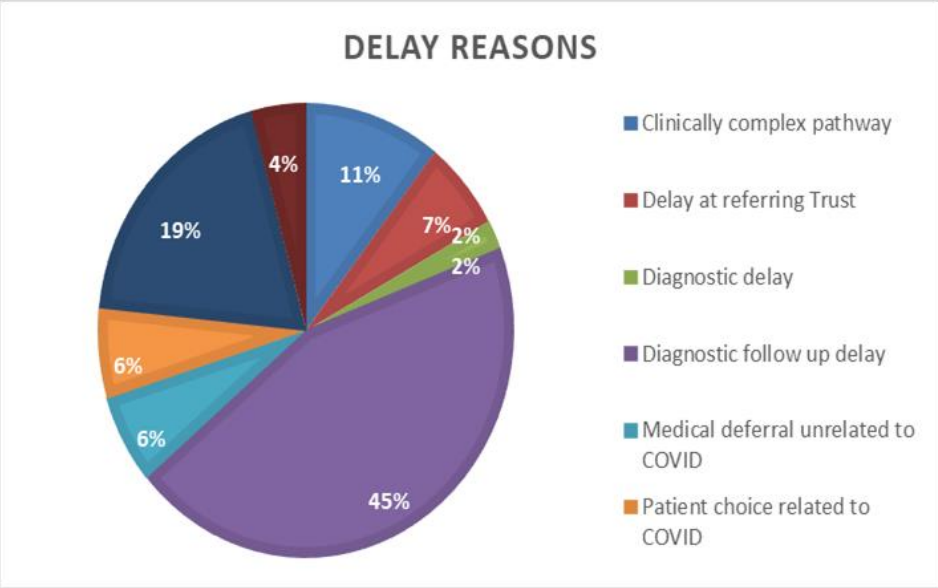
Colorectal failed to achieve the standard with performance at 58.82%. This reflects an improvement on last month's position of 30.77%.

The Trust treated 8.5 Colorectal patients with 3.5 breaches in March. The majority of breaches were due to complex pathways or medical delays.

Breast 62-Day performance was 62.34%, which has improved from February. The Trust treated 38.5 patients with 14.5 breaches. The majority of breaches were caused by the known delays at the front end of the pathway within TWW. This is expected to remain an issue until the Breast backlog is cleared.



Delay Reasons - Without DTT



Cancer
104-Day Patients Live PTL Snapshot as of 14/05/2021

There are 56 patients currently over 104-Days; 47 without a decision to treat and 9 with a decision to treat.

The biggest delay reason has shifted substantially to Diagnostic follow-up delay. 15 of the 21 patients are in Colorectal resulting from operational challenges that the service is addressing.

This has been escalated to specialty management via the weekly PTL, the 80 Day PTLs as well as this most recent 104-Day snapshot. This delay reason amounts to 45% of all 104-Day delays.

Patient anxiety surrounding COVID-19 and wanting to defer until vaccinated is still a cause for delay but is decreasing; however the Trust continues to ask for clinical review of these patients and ensure they understand the risk of deferring their investigation and/or treatment.

Nationally, the Trust is required to report all patients who were treated past day 104 of their pathway and also assess whether they require a Datix harm review conducted in line with the agreed SOP.

Outstanding Datix incidents waiting for HARM review with the clinical teams are: Urology 93, Colorectal 9, Skin 5 and Breast 5. Urology are reviewing their protocol driven HARM assessment used to review their 104-Day Datix incidents; go live expected within Q2.

NHS North Bristol NHS Trust

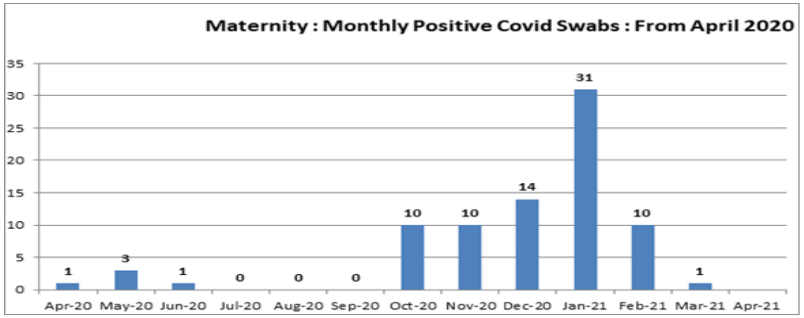
Safety and Effectiveness

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

Perinatal Quality Surveillance Tool - Minimum data set	Jan-21	Feb-21	Mar-21	Apr-21	Trend
Activity					
Number of babies born (at >=24 weeks gestation)	437	441	502	462	
Number of women who gave birth (all gestations)	430	432	496	456	
Induction of Labour rate	39.8%	33.8%	33.8%	35.2%	
Unassisted Birth rate	54.1%	49.7%	48.0%	53.1%	
Assisted Birth rate	10.8%	11.7%	11.7%	9.5%	
Caesarean Section rate (overall)	35.1%	38.7%	40.3%	37.4%	
Elective Caesarean Section rate	15.9%	16.1%	18.8%	16.7%	
Emergency Caesarean Section rate	19.2%	22.6%	21.5%	20.7%	
Perinatal Morbidity and Mortality					
Total number of perinatal deaths	2	1	0	2	
Number of late fetal losses (22+0 to 23+6 weeks excl TOP)	0	0	0	0	
Number of stillbirths (>=24 weeks excl TOP)	2	1	0	2	
Number of neonatal deaths : 0-6 Days	0	2	1	0	
Number of neonatal deaths : 7-28 Days	1	0	1	0	
Suspected brain injuries in neonates (no structural abnormalities) (Born in trust)	1	1	1	0	
Maternal Morbidity and Mortality					
Number of maternal deaths	0	0	0	0	
Rate of women requiring level 3 care	0.2%	0.2%	0.0%	0.0%	
Insight					
Number of datix incidents logged graded as moderate or above (total)	3	1	2	1	
Datix incident moderate harm (not SI)	2	0	0	0	
Datix incident SI	1	1	2	1	
New HSIB referrals	0	0	0	0	
HSIB/NHSR/CQC or other organisation with a concern or request for action made directly with Trust	0	0	0	0	
Coroner Reg 28 made directly to Trust	0	0	0	0	
Workforce					
Minimum safe staffing in maternity services: Obstetric cover (Resident Hours) on the delivery suite	83	83	83	83	
Minimum safe staffing in maternity services: Obstetric middle grade rota gaps	1	1	1	0	
Minimum safe staffing in maternity services: Obstetric Consultant rota gaps	0	1	1	1	
Minimum safe staffing: midwife minimum safe staffing planned cover versus actual prospectively. Vacancy rate	14.52	10.52	15.91	14	
Datix related to workforce	5	12	33	14	
Number of times maternity unit on divert	0	1	0	0	
Involvement					
Service User Voice feedback: Number of Compliments	12	8	12	29	
Service User Voice feedback: Number of Complaints	8	12	14	22	
Staff feedback from frontline champions and walk-abouts (number of themes)	3	3	2	0	
Improvement					
Progress in achievement of CNST /10	7	8	8	9	
Training compliance in maternity emergencies and multi-professional training (PROMPT)	45%	40%	53%	58%	
Continuity of Carer (overall percentage)	17%	17%	17%	17%	

COVID-19 Maternity

There were no positive cases of COVID-19 in maternity in April as shown below. From April 12, in line with national guidance, all women can now have a person of their choosing with them at each appointment.



Perinatal Quality Surveillance Tool

The information provided represents the recommended information from the Ockenden investigation report. NBT Maternity is further developing this dataset to ensure the Board is informed of safety metrics and indicators.

CNST Currently achievement of the CNST safety actions is 9/10. More evidence is required for full compliance Safety Action 7 – Engagement with Maternity Voices Partnership..

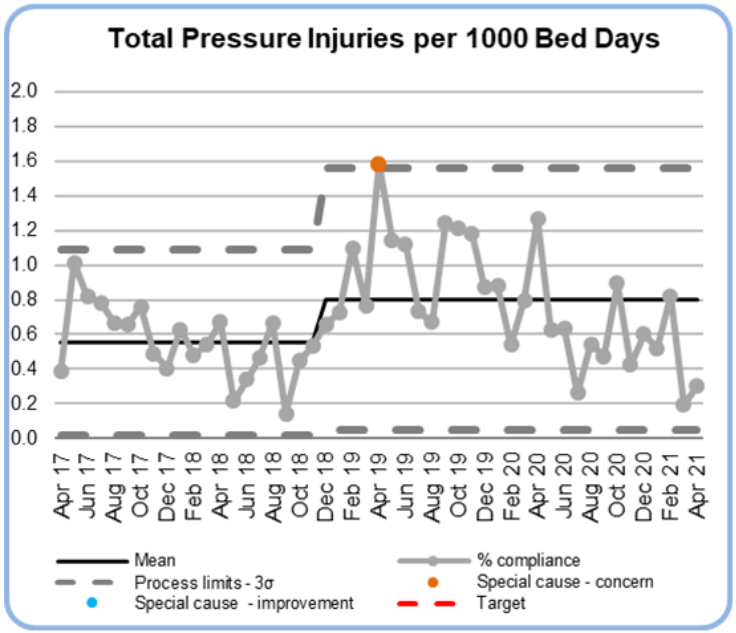
Serious Incidents: Maternity Antenatal Screening noncompliance with National Screening standards reported on STEiS.

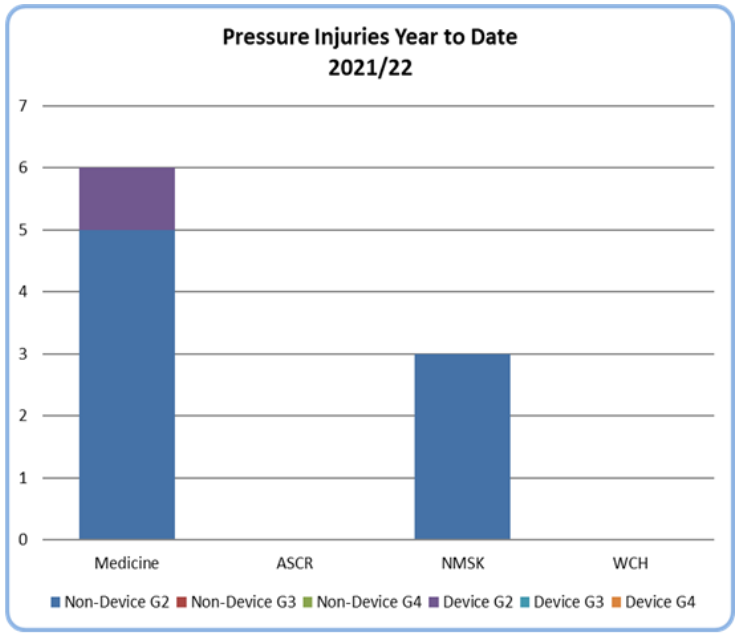
Datix – workforce concerns: This relates to inability to fill/cover rota gaps; sickness; resulting in to reduction in staffing levels below expected levels.

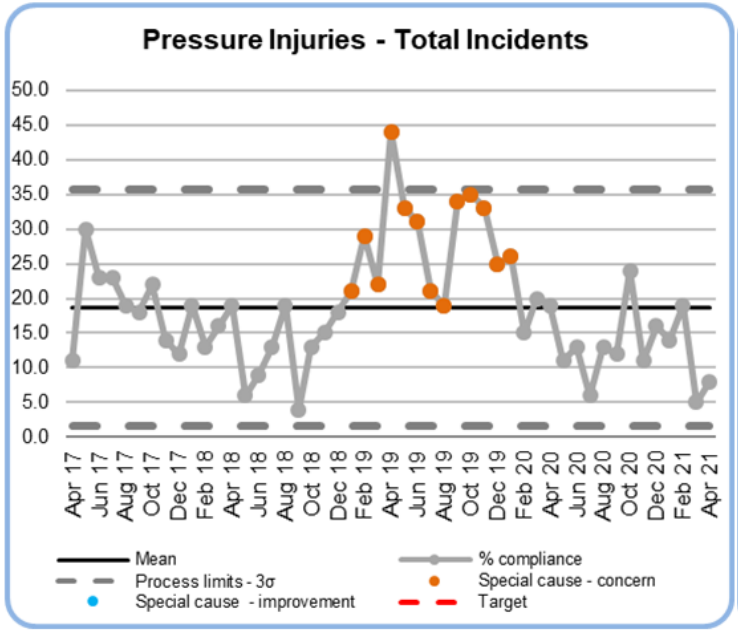
Patient Involvement – this includes formal complaints (14), concerns (8) - the increase in complaints in month relates to antenatal screening changes.

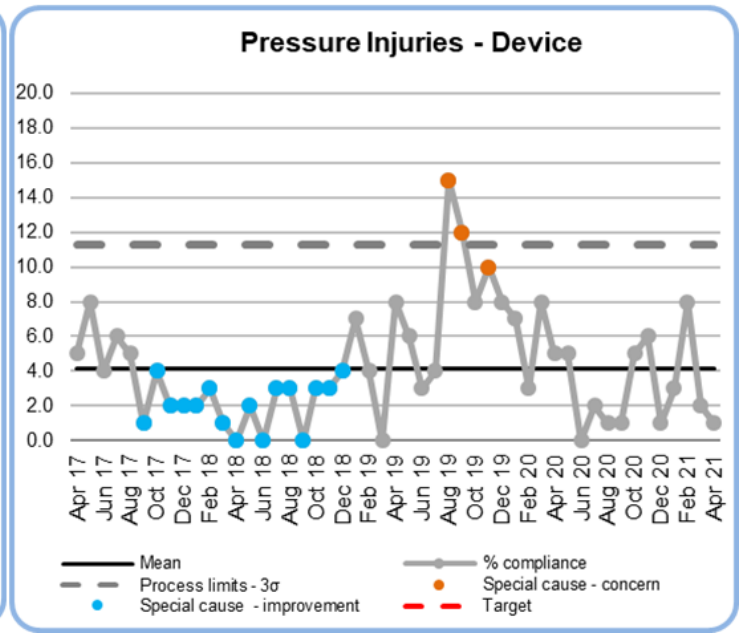
Service delivery: Currently our antenatal screening service is experiencing challenges with demand exceeding available capacity. An action plan is in place and we are working with the regional teams to find swift resolution.

QP2









Pressure Injuries

The Trust ambition for **2021/22** Quarter 1 is:

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

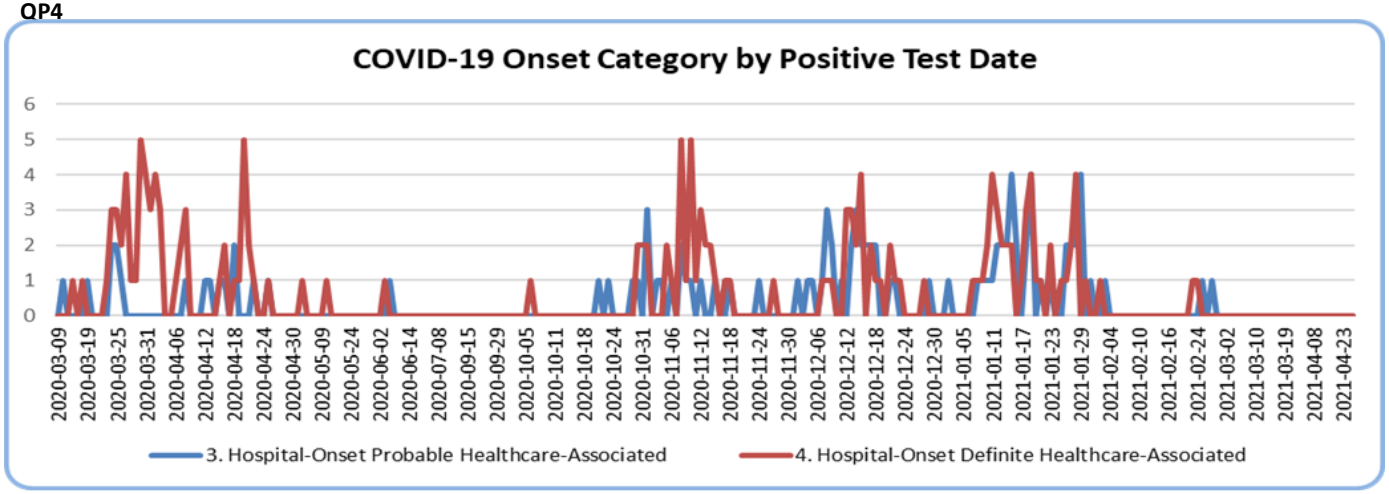
There have been no reported Grade 3 or 4 pressure injuries in April.
9 Grade 2 pressure injuries were reported of which 1 was related to a medical device.

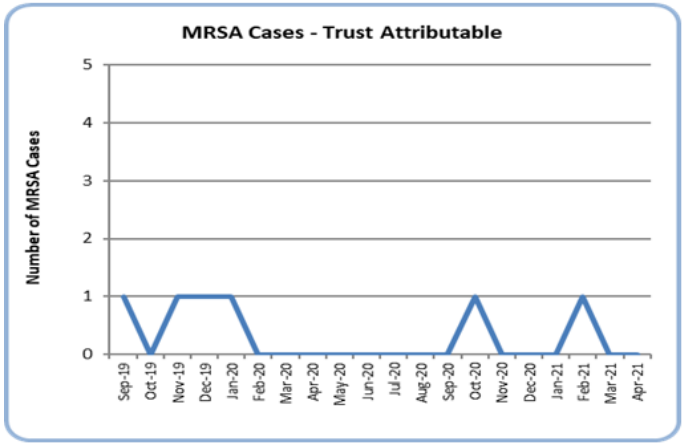
The incidence summary for the month is as follows:
Medical Devices: 11%
Heels/Foot: 67%
Buttock: 22%

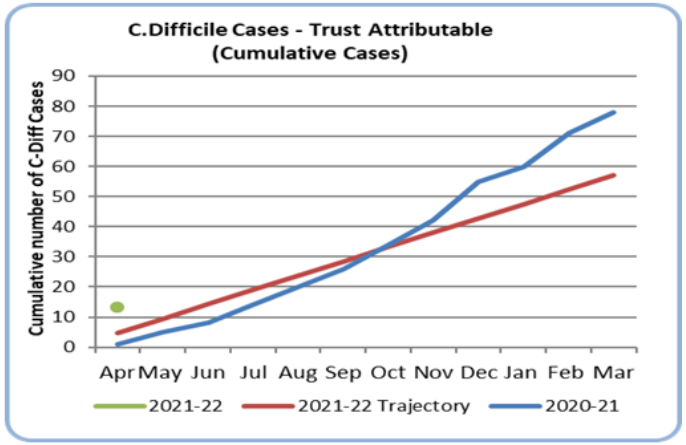
In April, there has been a slight increase in grade 2 pressure injuries however this remains below the mean rate. There has been a further decrease of medical device related pressure injuries.

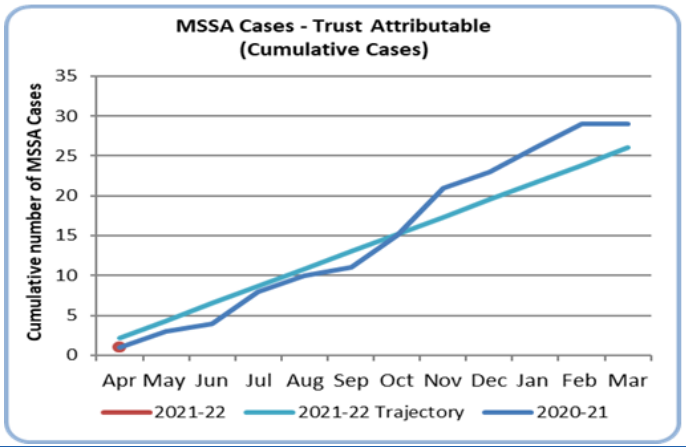
April has also seen ASCR and WCH achieve no hospital acquired grade 2 pressure injuries.

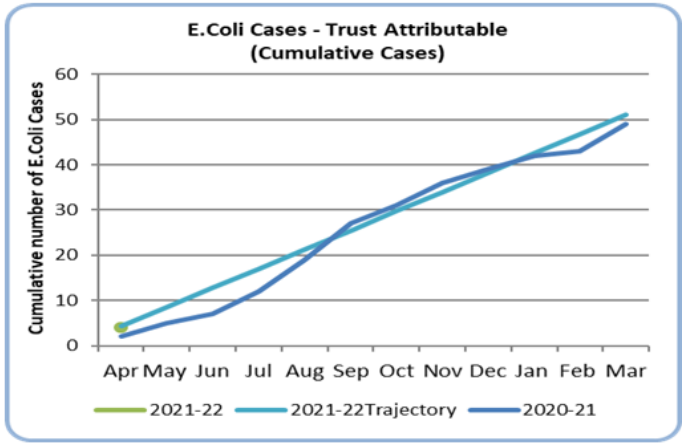
The Trust Wide Pressure Injury Working Group is taking a strong focus on heel related pressure injuries and cascade training of deep tissue injuries.











COVID-19 (Coronavirus)
Cases in hospital have reduced to a low level. There has been no in hospital transmission since end of February. Focus is on preparing for the possibility of subsequent wave of infection later in the year.

MRSA
Last bacteraemia was reported in Feb 2021.

C. Difficile
We continue to focus on work to reduce the cases of C Diff at NBT having seen increases toward the end of 2020/21.

The rise has been seen in other providers in the SW. Actions include review of antibiotic prescribing against guidance, stool chart completion and prompt sampling. Improvement work was reported to QRMC in May and will be overseen by the C Difficile steering group.

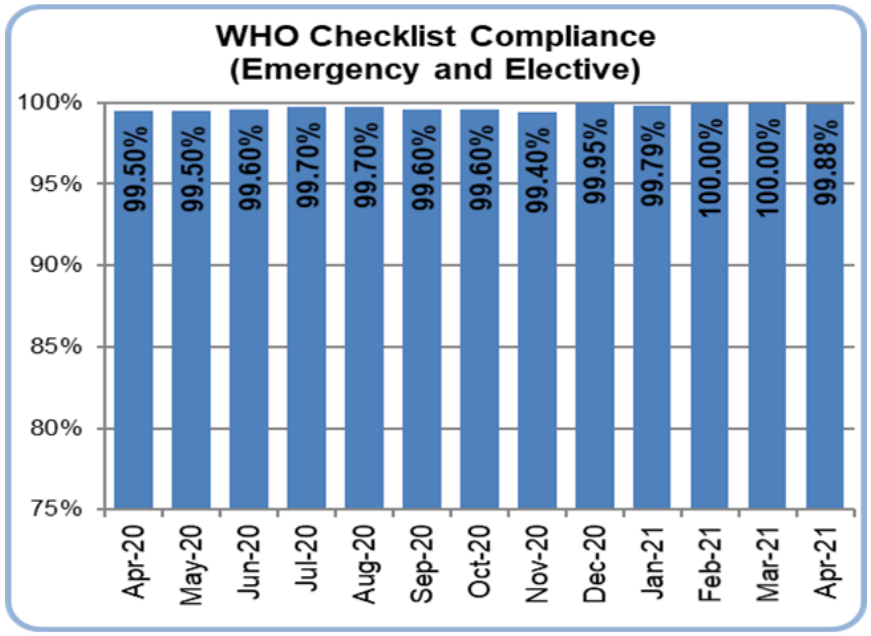
IPC priorities for 21/22 will include:
COVID preparedness
CDiff reduction
- antibiotic stewardship
- Prompt sampling
- Documentation

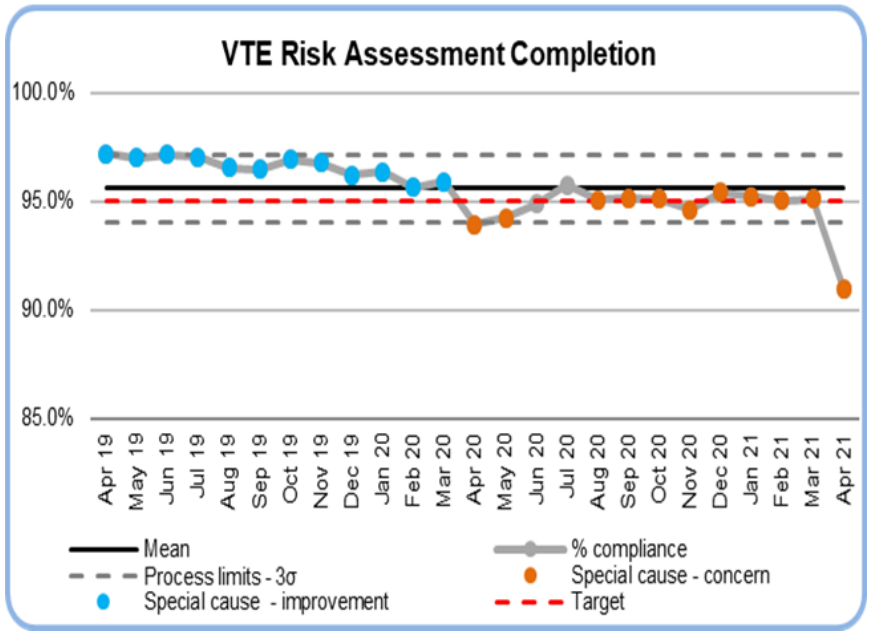
MR(S)SA control
- Maintenance of vascular devices
- Sterile technique training

Reduced urinary tract infection
- Good catheter management

Water hygiene
- Maintenance of flushing schedules

QP2





WHO Checklist Compliance

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

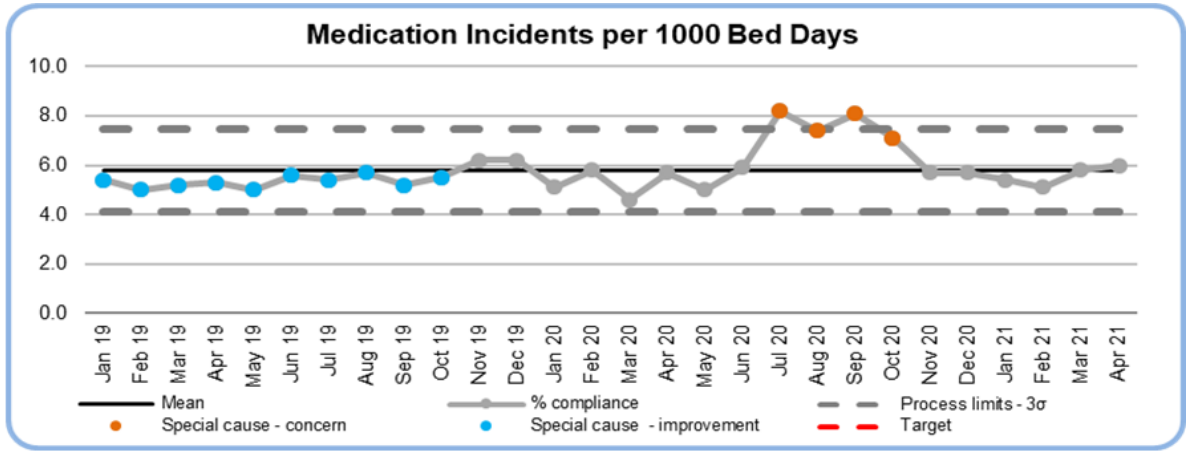
VTE Risk Assessment

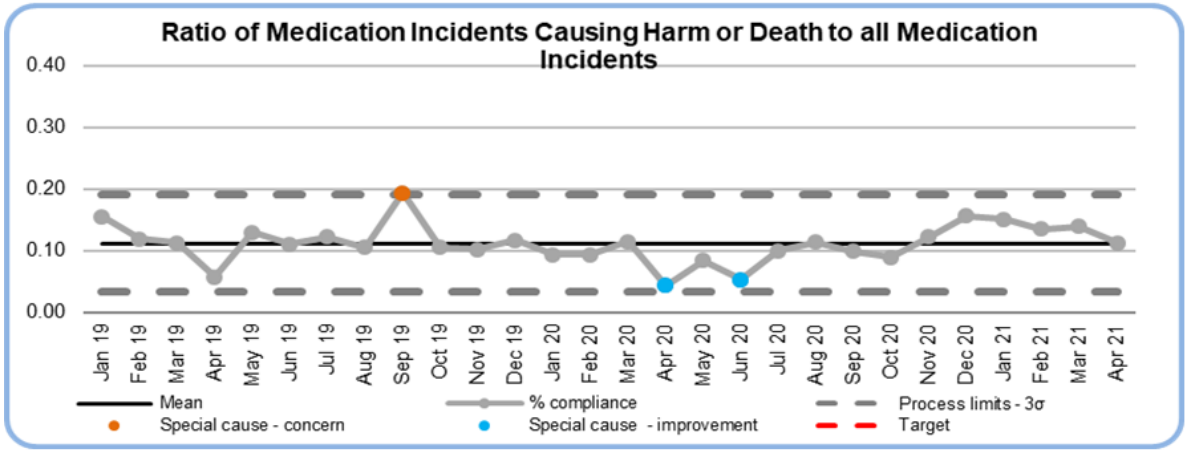
VTE risk assessment compliance is targeted at 95% for all hospital admissions.

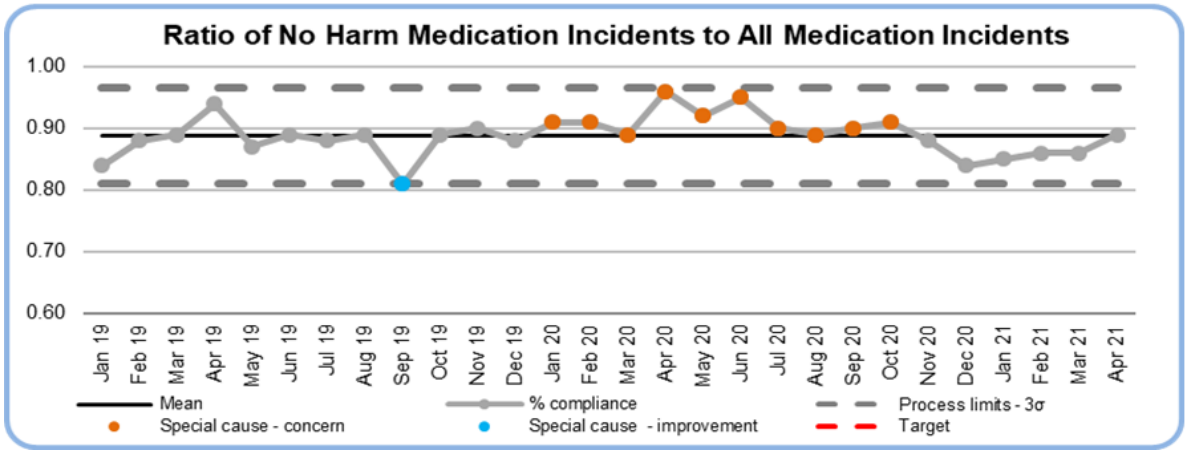
Compliance with this target fell during 2020/21. This is disappointing since the Trust has been designated an exemplar site for reducing thrombosis risk. The Thrombosis committee are considering the reasons and remedial actions to bring this back to acceptable level during 2021/22. A likely cause has been the different working patterns as a result of the COVID-19 pandemic.

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

Improving compliance with the data in the Electronic Patient record would improve real time reporting and is one of the workstreams that the thrombosis committee are pushing forward with. The group is also looking at the opportunities to describe other cohorts with low thrombosis risk that do not require individual patient risk assessment.







Medicines Management Report – April 2021

Medication Incident Rate per 1000 Bed Days
NBT had a rate of 6 medication incidents per 1000 bed days. This is a stable level and we continue to encourage reporting to identify where improvements are required

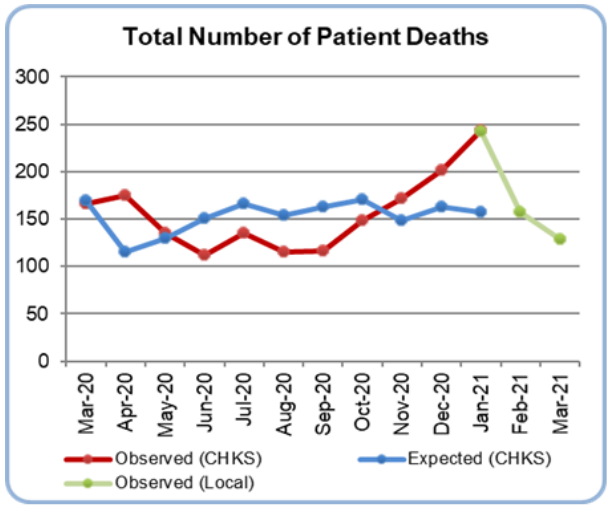
Ratio of Medication Incidents Reported as Causing Harm or Death to all Medication incidents
During April 2021, 11% of all medication incidents are reported to have caused a degree of harm (depicted here as a ratio of 0.11). This is the lowest in the last 6 months.

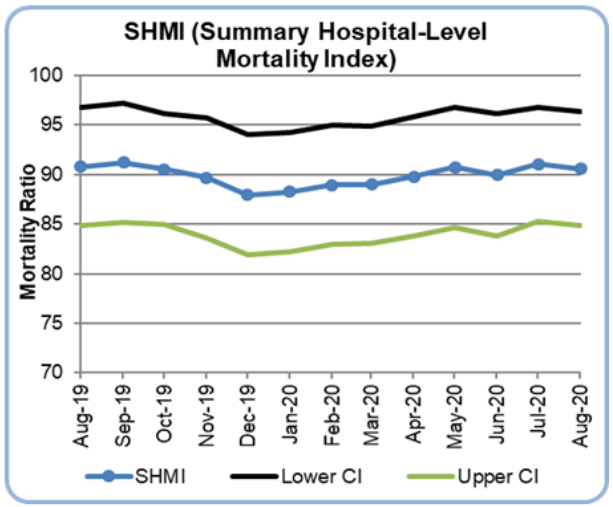
The inverse of this is that “no harm“ incidents accounted for 89% of all NBT reported medication incidents. This is in line with the pre-pandemic norm.

Interpretation notes:
It is of note there was much fluctuation in total number of medication incident reports during the period April to October 2020 – likely due to the COVID-19 impact. The mean number of medication incident reports per month pre-pandemic was consistently approx. 160 per-month but from March – October 2020 this varied greatly from a low of 92 to a high of 212 thus affecting the data presented here.

NBT has a medicines governance process overseen by the Drugs and Therapeutics Committee which reports to Quality and Risk Management Committee.

Mortality Outcome Data





Mortality Review Completion

Feb 20 – Jan 21	Completed	Required	% Complete
Screened and excluded	1357*		
High priority cases	300		
Other cases reviewed	217		
Total reviewed cases	1874	1926	97.3%

Overall Score	1=very poor	2	3	4	5= Excellent
Care received	0.0%	4.1%	22.8%	48.5%	24.6%

Date of Death	Jun 20 – Jan 21
Scrutinised by Medical Examiner	441
Referral to Quality Governance team	53

*171 (non high priority) cases were excluded from any form of review between January and April 2020 to aid with clearing a backlog of cases worsened by the COVID-19 pandemic mortality review suspension.

All high priority cases are being reviewed.

[1]In response to increased operational pressures as a result of wave 3 of the COVID-19 pandemic as agreed at the February CEAC meeting the window for screening has been extended by 1 month and therefore the date parameters for this IPR are 3 months in arrears as opposed to the usual 2.

Mortality Outcome Data

An increase in deaths was seen in December and January which is likely to have been the result of increasing COVID-19 infections and has since reduced.

There are no current Mortality Outlier alerts for the trust.

Mortality Review Completion

The current data captures completed reviews from 01 Feb 20 to 31 Jan 21. In this time period 97.3% of all deaths had a completed review, which includes those reviewed through the Medical Examiner system.

Of all “High Priority” cases, 95.5% completed Mortality Case Reviews (MCR), including 25 of the 25 deceased patients with Learning Disability and 31 of the 34 patients with Serious Mental Illness.

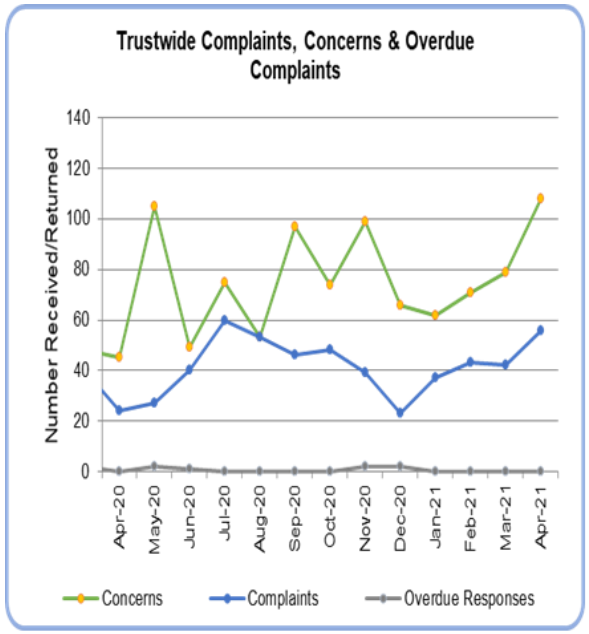
Mortality Review Outcomes

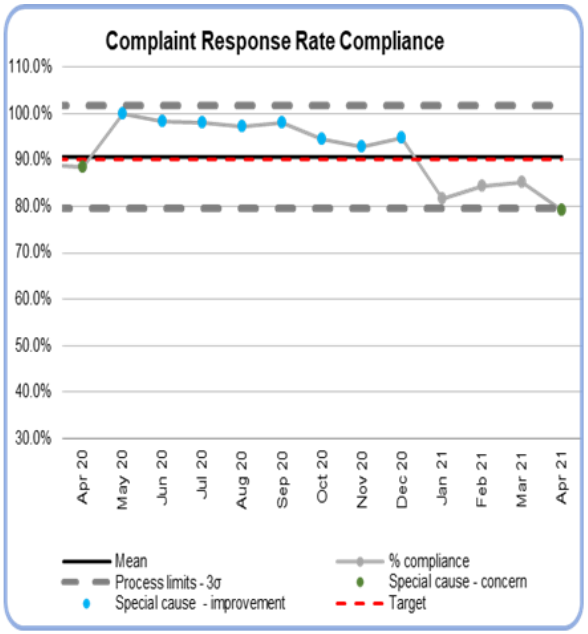
The percentage of cases reviewed by MCR with an Overall Care score of adequate, good or excellent is 95.9% (score 3-5). There have been 20 mortality reviews with a score of 1 or 2 indicating potentially poor, or very poor care which undergo a learning review through divisional governance processes. There has been 1 confirmed as SIRI (Feb 20).

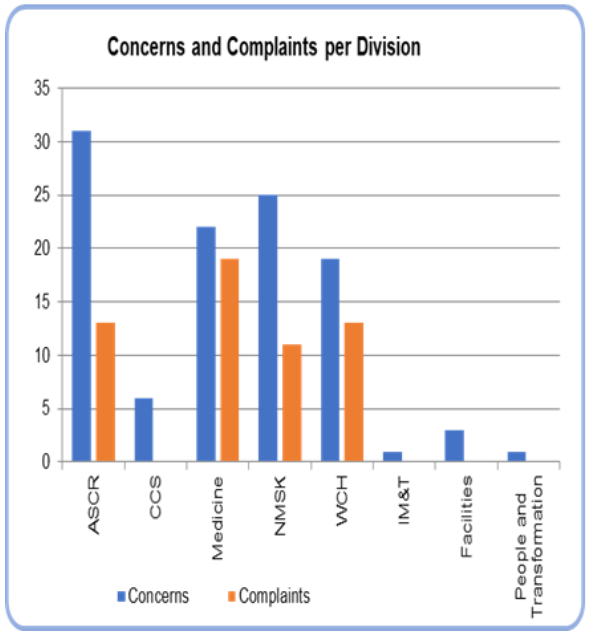
We are working with clinical leads where any themes within mortality reviews are identified, with recent examples relating to end of life care conversations and documentation and for ceilings of treatment. In both case these are being considered for relevant learning and development work. In addition we are using Medical Examiner feedback across the BNSSG joint service to support this identification of wider learning.

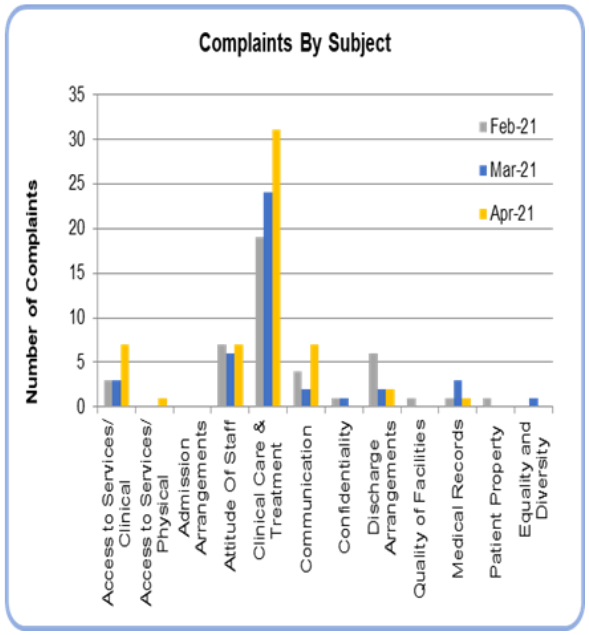
Patient Experience

Board Sponsor: Director of Nursing and Quality
Helen Blanchard









Complaints and Concerns

In April 2021, the Trust received 56 formal complaints. This is a significant increase on the previous month where 42 complaints were received. We have seen a number of complex complaints, some of which have been related to historical cases.
The most common subject for complaints remains 'Clinical Care and Treatment'. There has also been an increase in complaints regarding 'Access to Services-Clinical' and 'Communication'. This generally reflects delays to surgery or treatment as a result of the COVID-19 pandemic.

The 56 formal complaints can be broken down by division: (the previous month total is shown in brackets)

ASCR	13 (11)	CCS	0 (1)
Medicine	19 (14)	NMSK	11 (7)
WCH	13 (8)		

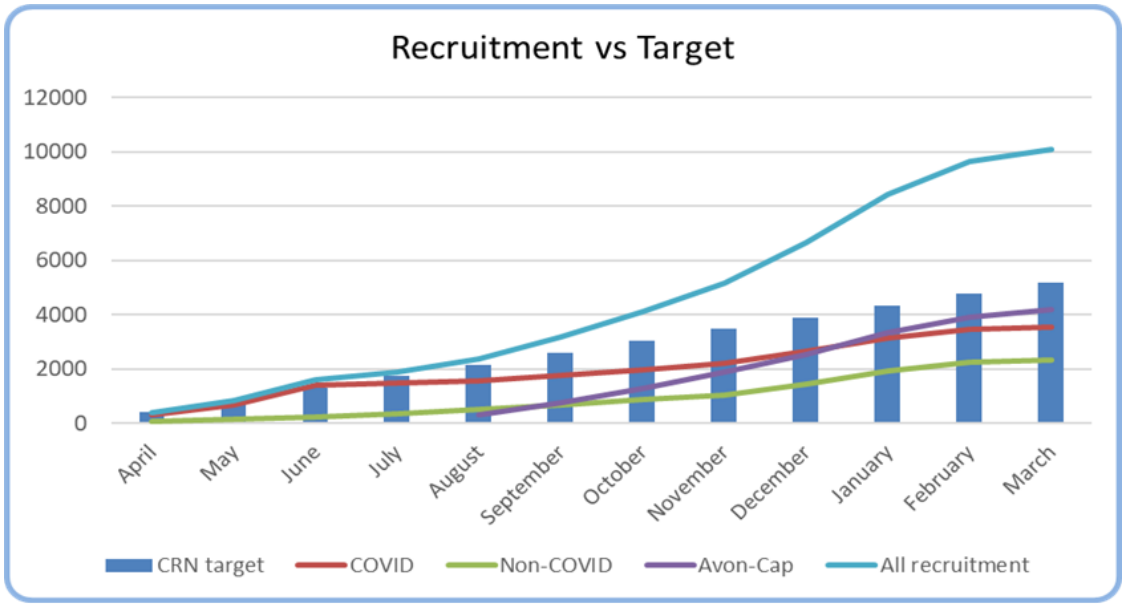
Enquiries and PALS concerns are recorded and reported separately. In April, a total of 75 enquiries were received by the Patient Experience Team and 108 PALS concerns were received.

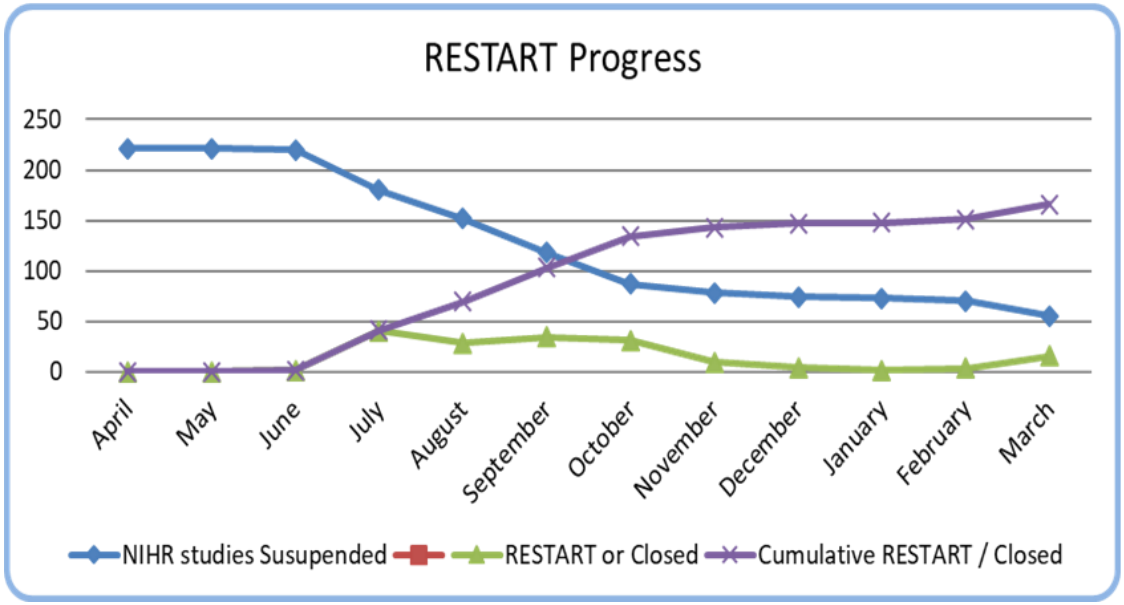
Complaint Response Rate Compliance

The chart demonstrates the % of complaints responded to within agreed timescales. Since January the response rate has been below the Trust target of 90%. This is likely due to the decision to maintain business as usual practice during the second wave of the COVID-19 pandemic. Due to pressures on staff, some timescales were not met.
In most areas we have seen an improvement in response rate compliance however in Medicine there have been particular challenges, such as reduced staffing in the Divisional Patient Experience Team that has contributed to the overall response rate compliance of 79.1% for April.
The Director of Nursing and Quality, Director of Nursing for Medicine and Patient Experience Manager are meeting regularly to monitor this and support Medicine with managing its caseload.

Overdue complaints

Despite delays to response timescales, at the end of April there are no overdue complaints. All complaints due in April have now been closed.





Research and Innovation

In addition to the 3548 participants recruited into COVID studies, NBT researchers have also recruited 22343 patients into non-COVID studies, an exceptional achievement.

NBT has also contributed a further 4192 patient data records to the Avon-Cap study (A Pan-Pandemic Respiratory Infection Surveillance Study), which is providing real world surveillance on the effectiveness of vaccines.

NBT suspended 221 studies during the epidemic;166 studies have been re-started/closed. Despite Imaging's best efforts, a number of studies need to remain suspended until research can be safely restarted without impacting on the service.

NBT continues to work collaboratively with the other Trusts across the region enabling patients from Gloucester, Swindon Bath as well as Bristol to participate in COVID vaccine trials.

NBT currently leads 57 research grants (NIHR, charity, industry and other) to a total value of £23.8m. This includes six recently awarded prestigious NIHR grants worth £5.8m in total, awarded to Prof. Nick Maskell, Prof Ashley Blom (x2), Dr Ed Carlton, Dr Charlotte Atkinson and Prof, Rachael Gooberman-Hill. In addition NBT is a partner on 51 externally-led research grants to a total value of £10.3 to NBT.

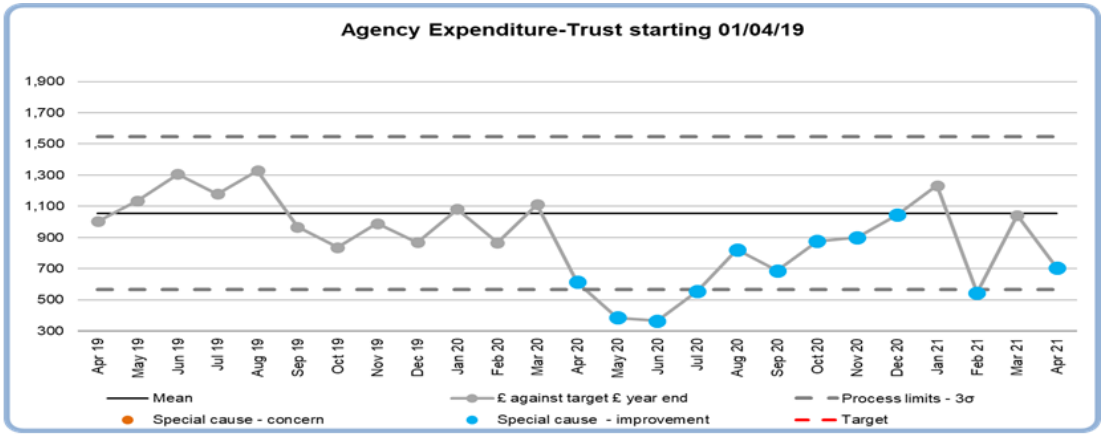
The SHC Research Fund (2020/21) closed on 12th April 2021. We received 23 EoI applications, of which 14 have been shortlisted for full stage application. The SHC Research Fund welcomes any NBT staff member wishing to undertake a research project (up to £20k) in any subject area to apply. The quality of EoI applications received this year was very high and shortlisted applicants will now work with R&I, research support services and public supporters to develop their full stage applications, deadline 30th June 2021.

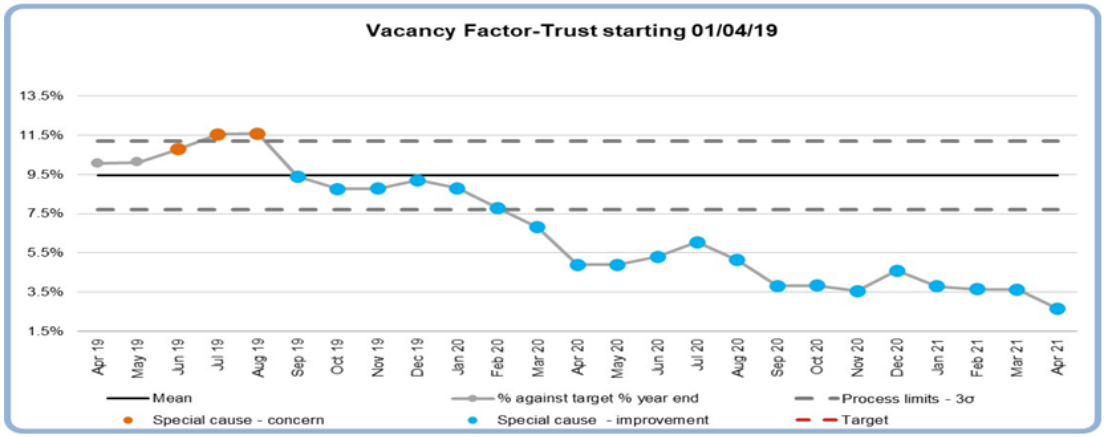
NHS North Bristol NHS Trust

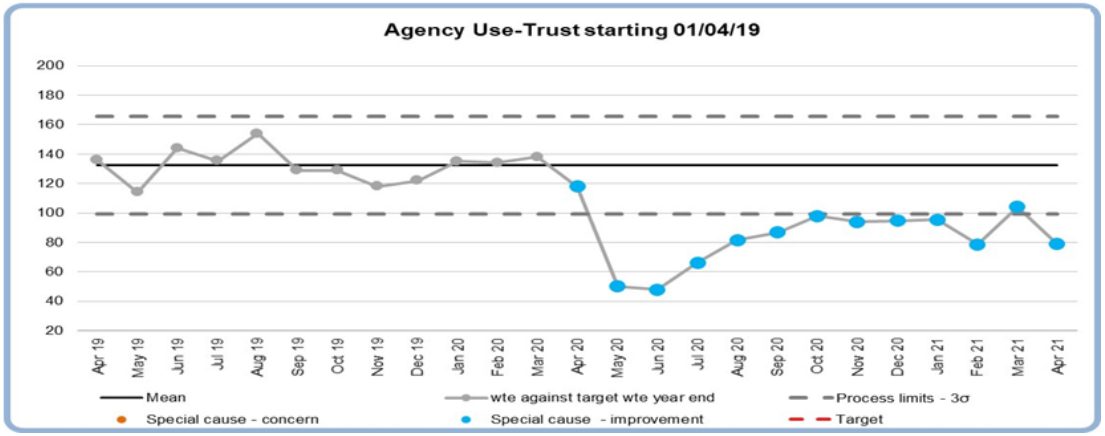
Well Led

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

Workforce







Nursing and Midwifery Resourcing
Despite holding no internal recruitment events in April 58 band 5 offers were made (44 nurses and 14 midwives). Our pipeline of new staff continues to grow with over 180 band 5 nurses going through pre-employment checks to start between now and the end of this year.

HCA recruitment saw 26 starters in April above the winter resourcing plan target of 25 per month. We are hoping to bring back face to face assessment centres in July in line hospital visiting restrictions easing.

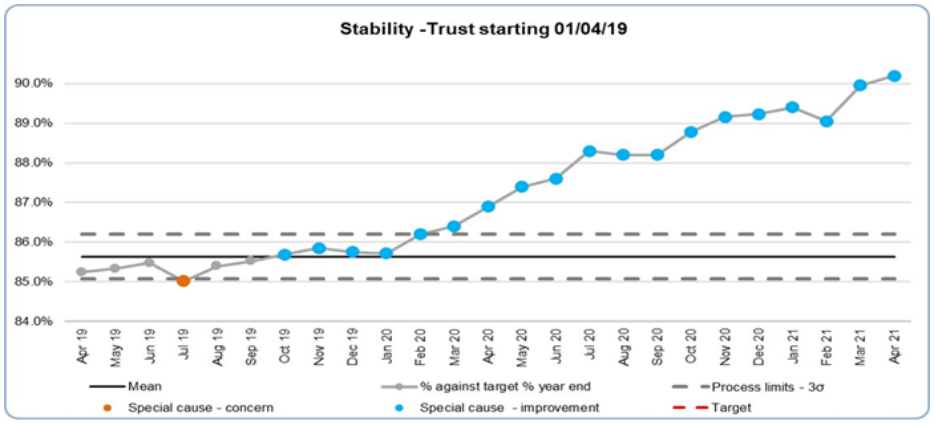
International Recruitment welcomed 11 new Nurses in April with another 8 planned in May. Despite changing travel protocols and restrictions, we have continued to run our international project with arrivals quarantining, either in airport hotels, or in our own rented accommodation where travel rules allow it.

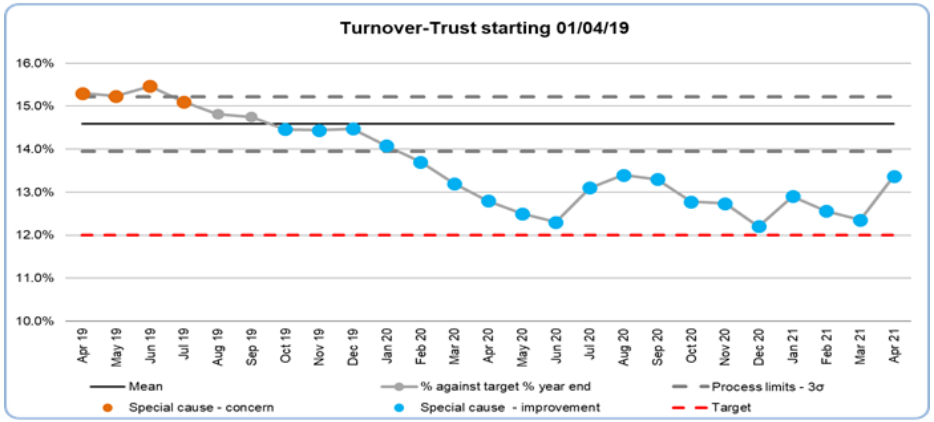
The Talent Acquisition team has been working with each division to resume the bespoke recruitment and marketing programmes for ICU, Theatres, Medi-rooms, Stroke, Respiratory and Renal wards.

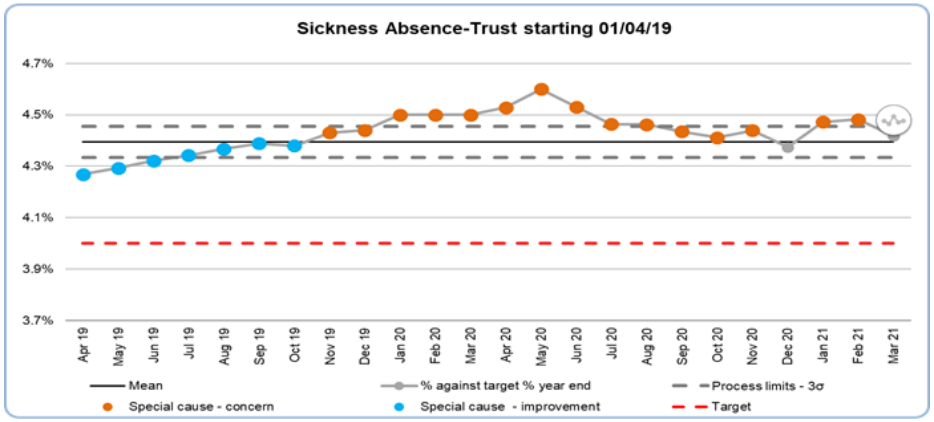
Temporary Staffing

NBT eXtra will be starting a new recruitment campaign for all staffing groups. The campaign will include Social Media for specific staffing group, eShots to student nurses alongside a variety of internal marketing actions.
The anticipated increase in bank capacity is aimed at supporting the Trust in the forthcoming months whilst a new Nursing Tender Contract is agreed.
The team continue to support staffing requests for the Primary Care Network, Sirona the Mass Vaccination Hub at Ashton Gate.

Engagement and Wellbeing







Turnover and Stability

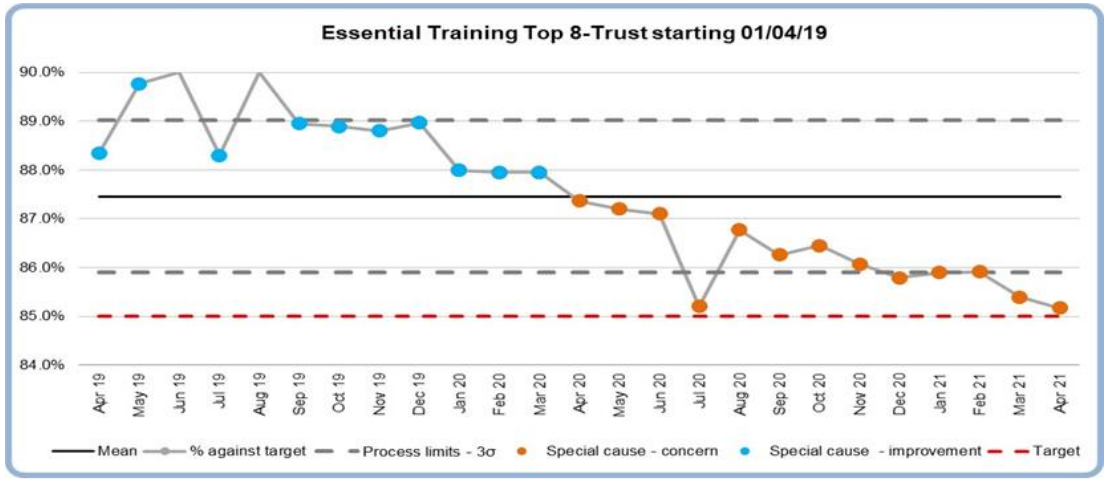
Recent and on-going work includes:

- Refreshing our flexible working options and the Flexible Working policy
- BNSSG Pathfinder Retention Project workshop is taking place for People Business Partners across the system on 20 May. This will involve:
  - Focussed sessions on international recruitment, flexible working, retention conversations and EVP
  - Sharing best practice and experience and seek opportunities to collaborate
- As part of our 'renew and restore' work, we instigated in May a "big conversation" including
  - Pulse surveys, and;
  - Toolkits for managers to hold engaging conversations with their teams
- Another key retention intervention is the 'One NBT Festival' mentioned below.

Sickness and Health and Wellbeing

Work undertaken to help improve sickness absence includes:

- Further development of systems and support to identify and help staff suffering from Long COVID-19/Post-COVID 19 Syndrome;
- More focussed support for staff who have been shielding, to support their safe return to work. This will include some 'listening' sessions to be offered by the Psychology Team
- Updated support and guidance to support staff in the latter stages of their pregnancy to work safely has also been agreed this month and is being implemented
- Focussed work and sickness 'clinics' are being supported by the People Team in ASCR's hot spot areas
- Continuation of high level case reviews for the 'top 30' LTS with People Business Partners and senior People representatives. Partners have found these sessions helpful in supporting the effective management of the Trust's longest sickness cases. A number of the longest cases have now been resolved
- A large scale "One NBT Festival" is now being planned for 1-5 July inclusive. This will have a significant focus on staff wellbeing and will showcase existing wellbeing support, trial new wellbeing initiatives (e.g. yoga) and relaunch Schwartz rounds. There will be an important emphasis on fun at work and listening to staff



Training Topic	Variance	Mar-21	Apr-21
Child Protection	0.5%	85.5%	86.0%
Adult Protection	0.0%	87.1%	87.2%
Equality & Diversity	-0.5%	90.1%	89.5%
Fire Safety	-0.2%	85.2%	85.0%
Health &Safety	0.5%	87.2%	87.7%
Infection Control	-0.3%	92.2%	92.0%
Information Governance	-0.6%	81.2%	80.6%
Manual Handling	-1.1%	72.7%	71.6%
Waste	-0.4%	87.3%	86.9%
Total	**-0.2%**	**85.40%**	**85.17%**

Essential Training

Whilst compliance remains above the 85% minimum threshold there has been a clear downward trend over the past 3 months.

A targeted campaign to reignite essential training compliance is planned for June.

Clinical sessions requiring a practical element remain at a reduced attendance ratio due to social distancing requirements, wherever possible additional session have been added to compensate for this.

Leadership & Management Development

Leadership & Management learning activity resumed on 5th April including both the OneNBT Leadership Programme and the Matron Leadership Programme.

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

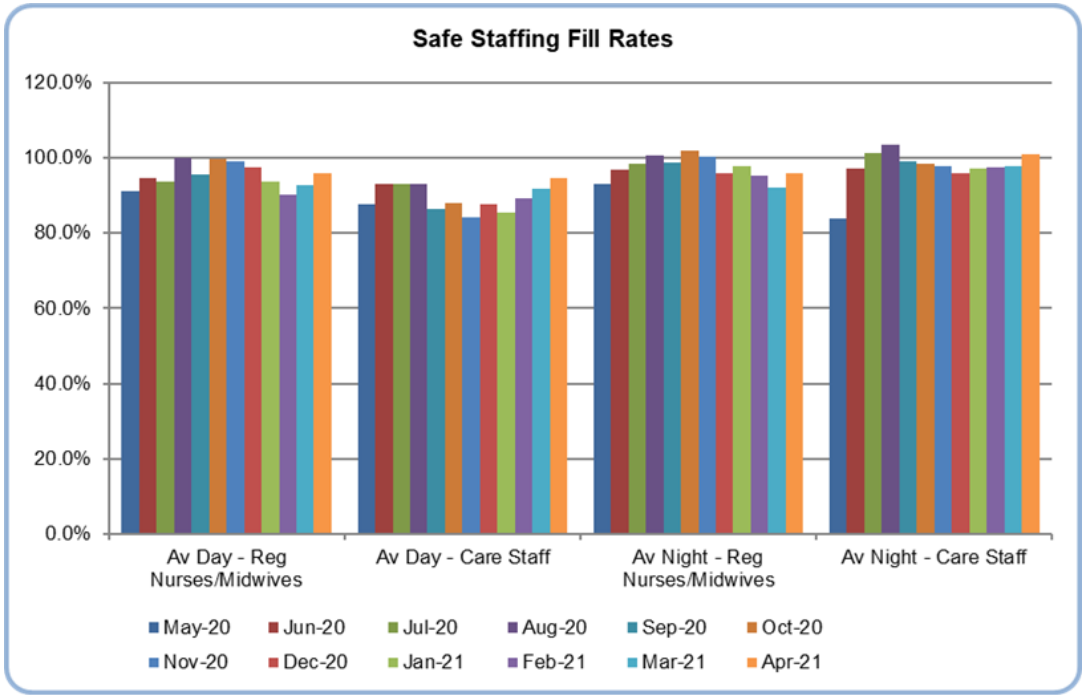
Our delivery method for workshops will be a blended approach of both online and face to face facilitation.

Apprenticeship Centre

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

Traineeship Programme

The Trust has been successful in receiving funding to offer up to 20 places on our Traineeship Programme. This programme, specifically for unemployed 19-24-year olds from the local community, provides access to 8 weeks of training and work experience. 88% of previous programme participants have been successful in gaining paid employment with NBT. The first cohort of 7 trainees joined in early May, with the remainder due to start early June.



Apr-21	Day shift		Night Shift	
	RN/RM	CA Fill	RN/RM	CA Fill
Southmead	95.8%	94.6%	95.9%	100.9%

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

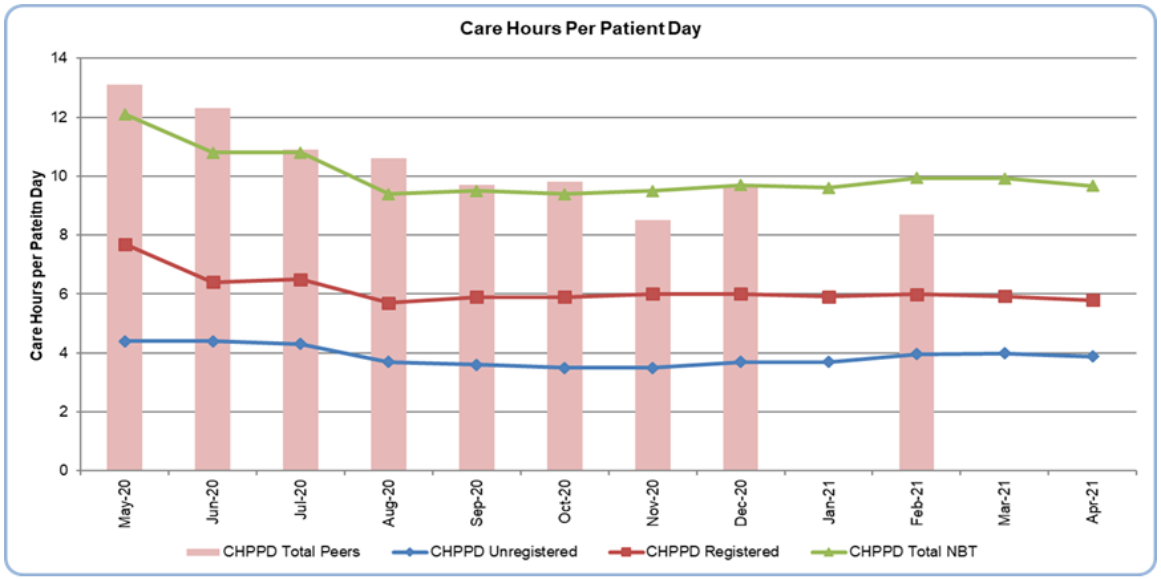
The safe staffing report now requires the wards to identify Nursing Associates including Trainees and AHP staff employed in an inpatient area. There are however ongoing issues with the reporting and this has been escalated to Allocate the roster provider. We will be back reporting as soon as it is possible.

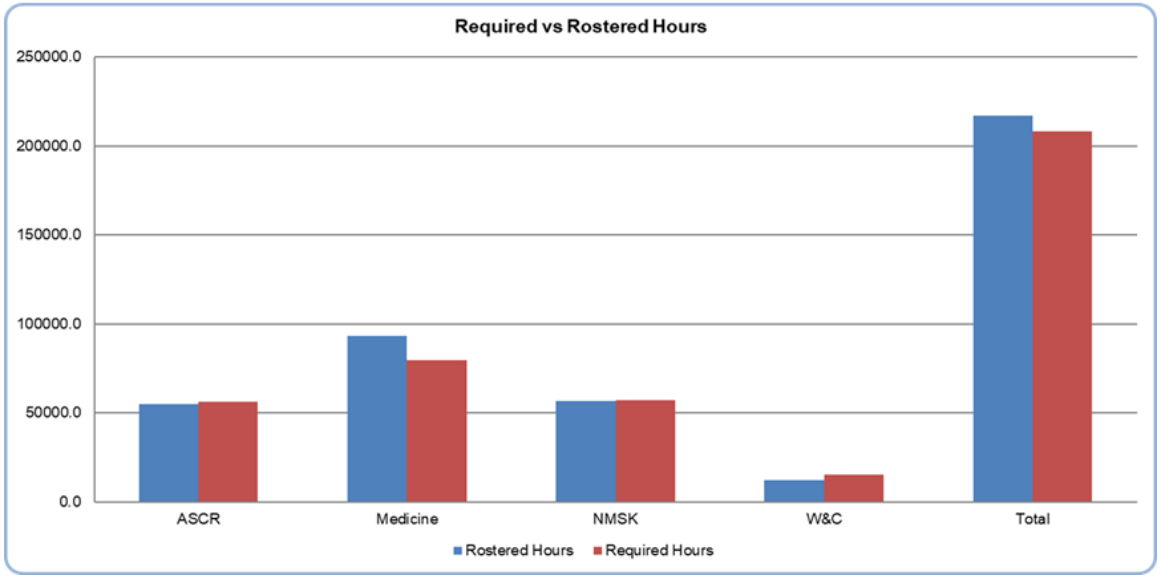
Wards below 80% fill rate for Registered Staff:
for all areas safe staffing maintained through daily staffing monitoring and supplementing with unregistered staff as required. Cotswold (69.7% Day.) Reduced occupancy

Wards below 80% fill rate for Care Staff:
for all areas safe staffing maintained through daily staffing monitoring and supplementing with registered staff as required
Cotswold Ward (51.9% Day) Reduction in HCSW required due to lower occupancy

Medirooms (54.8% Day / 78.1% Night) Unregistered staff vacancies safe staffing maintained through daily staffing monitoring and supplementing with registered staff as required
7a (61.4% Day / 59.4% Night) 7a is a green ward which is intermittently running below full occupancy
NICU (42.4% Day / 44.3% Night) Unregistered staff vacancies, safe staffing maintained through daily staffing monitoring and supplementing with registered staff as required.,
Quantock Ward (67.2% Day) Unregistered staff vacancies

Wards over 150% fill rat for Care Staff:
6b (155.8% Night) patients requiring enhanced care
33a (194.8% Night) patients requiring enhanced care support
33b (155.7% Night) patients requiring enhanced care support





Care Hours per Patient Day (CHPPD)

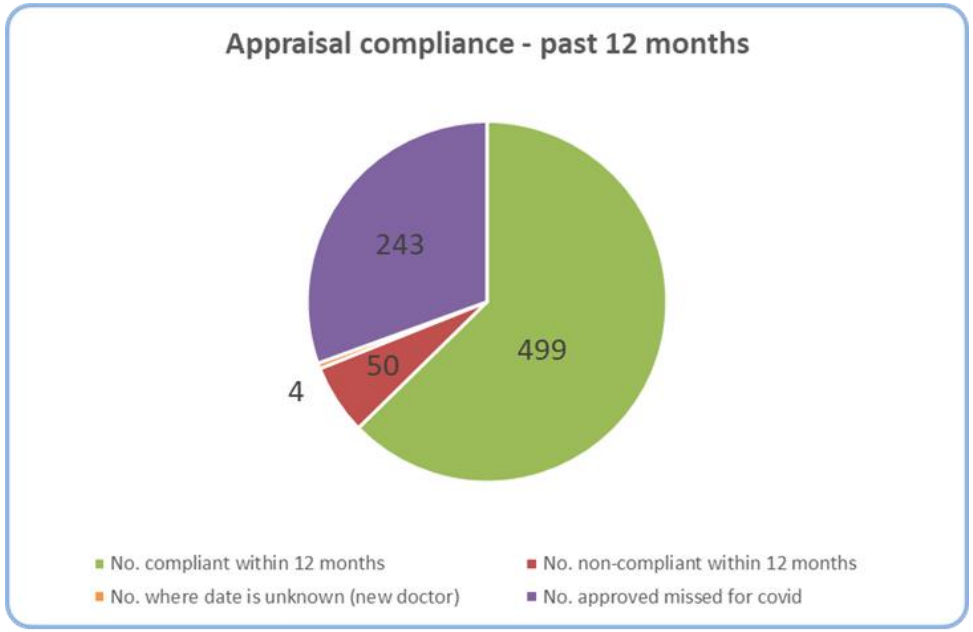
The chart shows care hours per patient day for NBT total and is split by registered and unregistered nursing. The chart shows CHPPD for the Model Hospital peers (all data from Model Hospital).

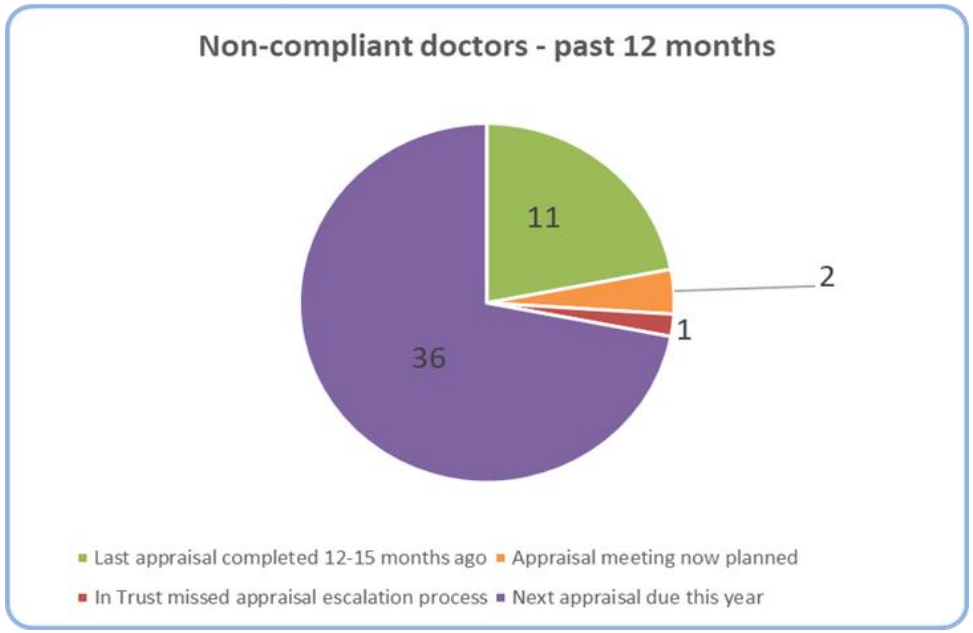
CHPPD are consistent with last month, rostered hours overall are above the required hours due to the decreased patient census and reduced lists.

Safe Care Live (Electronic Acuity Tool)

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

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





Medical Appraisal

Medical appraisals return 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 unless the doctor has asked us to keep the appraisal open.

There are a number of reasons that doctors may be recorded as not having an appraisal within the 12 months. This can be in situations such as doctors completing their last appraisal earlier than it was due, doctors having missed an appraisal while being employed elsewhere or abroad or doctors who are new to the UK. Doctors who are overdue their appraisal will fall under the Trusts missed appraisal escalation process. Doctors with an acceptable reason for not completing an appraisal in the last 12 months will have a new appraisal date set this year.

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

NHS North Bristol NHS Trust

Finance

Board Sponsor: Chief Financial Officer
Glyn Howells

Position as at 30 April 2021

	WITHIN FUNDING ENVELOPE		OUTSIDE FUNDING ENVELOPE	Total
	COVID-19	Core Trust	Mass Vaccination	
	M1 £m	M1 £m	M1 £m	M1 £m
Contract Income	0	53.3	0	53.3
Other Income	1.0	5.0	0.8	6.8
Total Income	**1.0**	**58.3**	**0.8**	**60.1**
Pay	-0.	-34.2	-0.6	-35.2
Non-Pay	-0.1	-22.1	-0.2	-22.4
Total Expenditure	**-0.5**	**-56.3**	**-0.8**	**-57.6**
Surplus/ (Deficit)	**0.5**	**2.0**	**0**	**2.5**

Statement of Comprehensive Income

Assurances

The financial position at the end of April shows a surplus of £2.0m compared to a forecast breakeven

COVID costs incurred in April 2021 totalled £0.5m

There are no further key issues to report.

Statement of Financial Position

Assurances

The improved cash position of £109.4m (£11.9m down since March) is the result of settlement of a number of capital creditors at year end.

Key Issues

The level of payables is reflected in the Better Payment Practice Code (BPPC) performance for April is 90.4% by value compared to an average of 86.6% for financial year 2020/21.

Financial Risk Ratings , Capital Expenditure and Cash Forecast

Capital expenditure for the month is £1.5m which compares to an original plan of £1.2m.

Financial Risk Rating

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

Rolling Cash forecast

No cash flow forecast has been prepared yet for 21/22 financial year. The cash balance of £109.6m is in line with expectations and no issues are anticipated .

NHS North Bristol NHS Trust

Regulatory

Board Sponsor: Chief Executive
Maria Kane

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

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

Appendix 1: Glossary of Terms

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

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

NBT Quality Priorities 2020/21

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

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

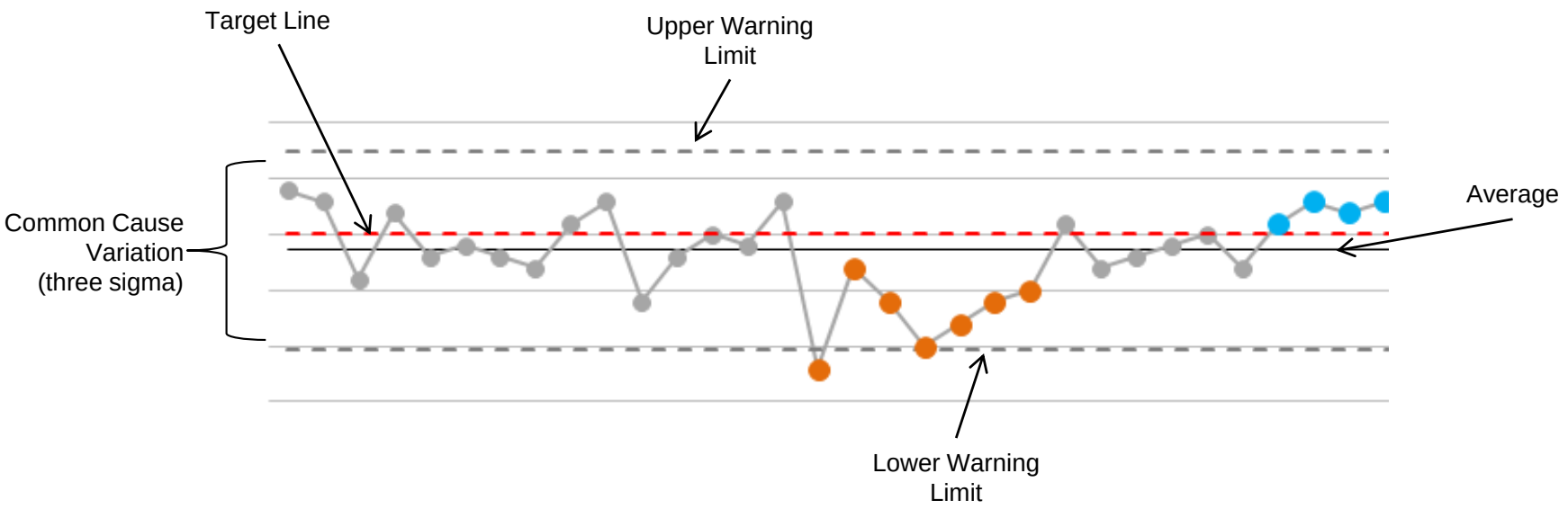
QP3 Ensuring excellence in our maternity services, delivering safer maternity care.

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

Abbreviation Glossary

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

Appendix 2: Statistical Process Charts (SPC) Guidance



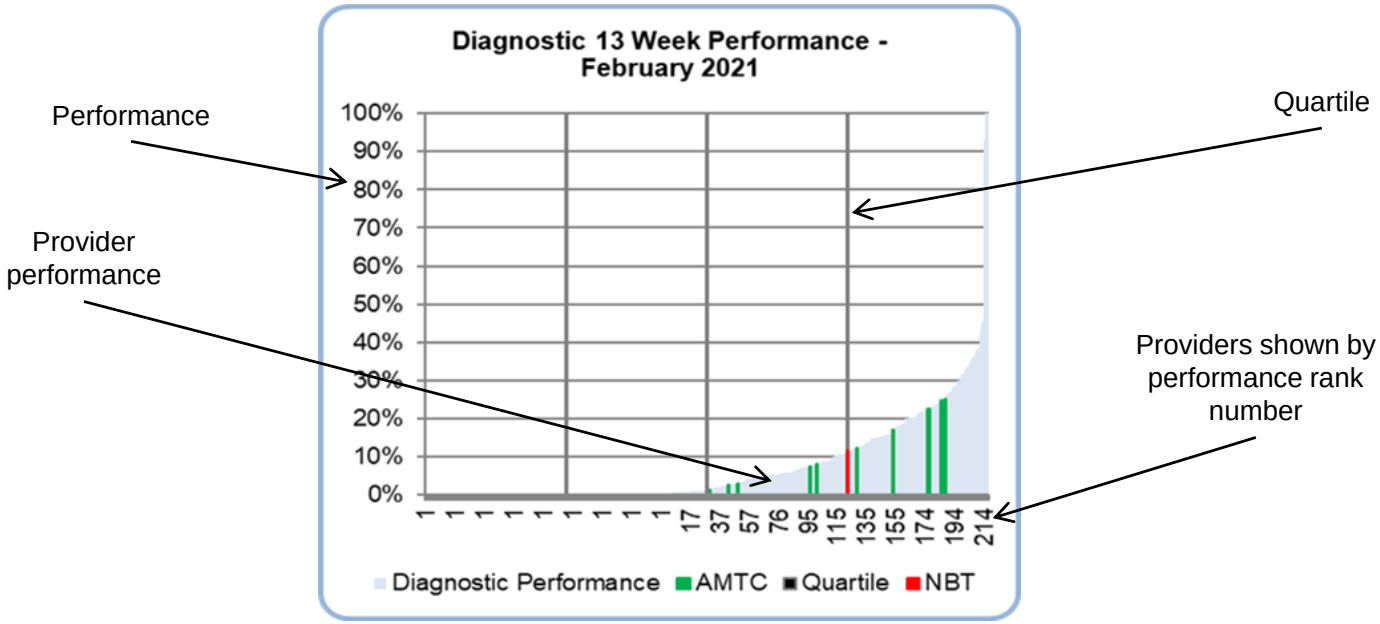
Orange dots signify a statistical cause for concern. A data point will highlight orange if it:
A) Breaches the lower warning limit (special cause variation) when low reflects underperformance or breaches the upper control limit when high reflects underperformance.
B) Runs for 7 consecutive points below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

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

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

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

Appendix 3: Benchmarking Chart Guidance



Vertical axis represents the performance value.

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

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

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

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

Report To:	Trust Board – Public Session		
Date of Meeting:	27 May 2021		
Report Title:	Accountability Framework		
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)	Karen Brown, Chief Operating Officer		
Purpose:	**Approval**	**Discussion**	**To Receive for Information**
	X		
Recommendation:	• The Trust Board is asked to approve the Accountability Framework and note the further plans for development with regards to ensuring it is fit for purpose for application to Corporate Directorates. • The Trust Board is asked to note the further development planned of KPIs for inclusion in the pack of information supporting the Accountability Framework.		
Report History:	An earlier version of this report was received by the Trust Management Team in April 2021.		
Next Steps:	The Operational Performance Team will continue working with the Business Intelligence Team to update the KPIs included in the Accountability Framework. Areas where further development is required will be captured in a programme of work to ensure delivery at the earliest opportunity. The Accountability Framework will be further reviewed to ensure it is fit for purpose for application to Corporate Directorates and will be relaunched as part of the Service Line Management programme.		

Executive Summary
This report provides an update on the review of the Trust's Accountability Framework and scheduled review meetings with both Clinical Divisions and Corporate Directorates. Key highlights include:

• Key stakeholders were surveyed and/or interviewed with regards to whether the current version of the Accountability Framework is fit for purpose. • When surveyed, 100% of responders felt that a blend of quantitative scoring and qualitative narrative assessment was the right methodology for assessing Clinical Divisions against the Accountability Framework. However, both positive and negative feedback has been received with regards to whether the right Key Performance Indicators (KPIs) are currently included. • 80% of responders felt that the Accountability Framework is user friendly. There was feedback that consideration should be given to building the KPIs, self-assessment and Executive assessment templates into Qlik once all developments have been finalised. • The monthly Clinical Division review meetings will continue in their current format in terms of attendees and agenda, but there should be a relaunch of the use of the Accountability Framework to ensure a better shared understanding of the outcome of the assessments, what mitigations/actions need to be undertaken to improve confidence levels and what if any support is required. The relaunch of the Accountability Framework will be through the planned Service Line Management (SLM) programme for 2021/22. • The quarterly Clinical Division review meetings will remain more strategic in terms of agenda but will be Chaired by the Chief Executive Officer from April 2021 onwards and will be extended to two-hours. • Quarterly review meetings have been established for each of the Corporate Directorates chaired by the Chief Executive Officer, with the first meetings having been held in May 2021.	
Strategic Theme/Corporate Objective Links	As this report relates to the full breadth of the Trust's business this report relates to all Strategic Themes and Corporate Objectives.
Board Assurance Framework/Trust Risk Register Links	As this report relates to the full breadth of the Trust's business this report relates to all BAF Risks.
Other Standard Reference	• CQC Standards. • Use of Resources Assessment.
Financial implications	Not applicable.
Other Resource Implications	Not applicable.
Legal Implications including Equality, Diversity and Inclusion Assessment	Not applicable.
Appendices:	Appendix 1: Accountability Framework

1. Purpose

1.1 This report provides an update on the review of the Trust's Accountability Framework and scheduled review meetings with both Clinical Divisions and Corporate Directorates.

2. Background

2.1 In July 2018, as part of the development of Service Line Management (SLM) within the Trust, an Accountability Framework was developed.

2.2 The purpose of the Accountability Framework is to provide a mechanism by which Clinical Divisions and Corporate Directorates can be held to account for the delivery of their operational and strategic plans and objectives and contribution towards the Trust's overall delivery of its operational and strategic plans and objectives.

2.3 The Accountability Framework also provides a mechanism for identifying where additional support and/or development might be required to enable delivery of plans and objectives.

2.4 The Accountability Framework reflects the fact that decisions need to be made as close to the patient as possible, in line with the SLM ethos, but that these decisions need to balance the essential priorities of clinical quality, timely delivery, patient experience, staff satisfaction and financial sustainability.

2.5 The Accountability Framework was co-designed by Clinical Divisions, Corporate Directorates and the Executive Team during a series of SLM Masterclass sessions in late 2018/early 2019.

2.6 A number of pre-existing Accountability Frameworks from other acute Trusts were reviewed and considered in designing the Trust's own version.

2.7 Consideration was given to the balance of quantitative (Key Performance Indicators - KPIs) and qualitative (soft intelligence and self-assessments) information in developing the information pack that supports the Accountability Framework.

2.8 The current version of the framework in use was finalised in March 2019 and did not include any assessment of Corporate functions.

2.9 The intention was for there to be a review of the Accountability Framework and whether it was fit for purpose in March/April 2020. Due to the response to the COVID-19 pandemic this review was not possible, and it was deferred to March/April 2021.

3. Accountability Framework Review – Process and Findings

3.1 The Associate Director of Performance sought views of the Executive Team, Trust Secretary, Clinical Division Triumvirates and People/Finance Business Partners via an online survey and a series of interviews.

3.2 Also, to be taken into consideration, was the KPMG internal audit feedback and the new CQC Well-led Strategy.

3.3 100% of responders to the online survey confirmed that they felt that a blend of quantitative scoring and qualitative narrative assessment was the right methodology for assessing Clinical Divisions against the Accountability Framework. However, both positive and negative feedback was received with regards to whether the right KPIs are currently included.

3.4 A list of suggestions for new KPIs or areas where data collection and KPIs should be developed has been collated by the Operational Performance Team. Work is being undertaken with the support of the Business Intelligence Team to update the KPIs included in information pack that supports the Accountability Framework. Examples include: more quality metrics relating to clinical outcomes; updating responsiveness metrics to include data with regards to clinical prioritisation and any changes to national standards; workforce metrics that do not just focus on process, but give a broader view and can be looked at in conjunction with each other to better highlight concerns; and further financial efficiency metrics.

3.5 80% of responders felt that the Accountability Framework is user friendly. There was feedback that consideration should be given to building the KPIs, self-assessment and Executive assessment templates into Qlik Sense once all developments have been finalised.

3.6 The Accountability Framework to be approved by the Trust Board is provided in **Appendix 1**.

4. Monthly Clinical Division Review Meetings

4.1 The monthly Clinical Division review meetings will continue in their current format in terms of attendees and agenda.

4.2 The key recommendation is that there is a relaunch of the use of the Accountability Framework to ensure there is a better shared understanding of the Clinical Divisions' self-assessment and the Executive Team's assessment. This should include articulation and agreement of what needs to happen to improve confidence levels – what does good look like and what mitigations/actions need to be delivered.

4.3 The relaunch of the Accountability Framework will be through the planned Service Line Management (SLM) programme for 2021/22; the first of these sessions is being held on 20 May 2021.

4.4 There also needs to be a better shared understanding of the issues outside of the control of the Clinical Division and/or the Executive Team and the likely impact on delivery of plans/confidence levels.

5. Quarterly Clinical Division Review Meetings

5.1 The quarterly review meetings have been more strategic in terms of agenda and have historically been Chaired by the Medical Director. With a new incoming Chief Executive Officer (CEO), it has been agreed that the meetings will be extended to two-hours and that the CEO will Chair these meetings in future.

5.2 The first meetings to be Chaired by the CEO were held in April 2021.

6. Quarterly Corporate Directorate Review Meetings

6.1 For the last few years, the Corporate Directorates have not been subject to the same level of senior oversight from the wider organisation.

6.2 It was agreed at the Executive Committee on 10 March 2021 that Quarterly review meetings should be introduced across all Corporate Directorates.

6.3 These reviews would support the Trust with regards to both the CQC Well-led and Use of Resources assessments.

6.4 The agenda is similar to that of the Clinical Division review meetings, but with a focus on how well the Corporate Directorates support and enable the Clinical Divisions/Operational Teams to run the hospital; in addition to how they are managing their workforce and contributing to the Trust's financial position.

6.5 These meetings will be Chaired by the CEO.

6.6 The first of these meetings have been held in May 2021.

6.7 The current version of the Accountability Framework will be further amended to ensure it is fit for purpose for application across both the Clinical Divisions and the Corporate Directorates.

7. Recommendations

7.1 The Trust Board is asked to approve the current version of the Accountability Framework and note the further plans for development with regards to ensuring it is fit for purpose for application to Corporate Directorates.

7.2 The Trust Board is asked to note the further development planned of KPIs for inclusion in the pack of information supporting the Accountability Framework.

NHS
North Bristol
NHS Trust

Accountability Framework 2021/22

Accountability Framework

Accountability Framework Oversight Segment	Triggers / Characteristics for a Division in Segment	Intervention	Support	Accountability
Achieving	The Division has the following plans agreed and operational with high confidence levels of delivery: • Annual Business Plan • Governance Model • Risk Management	No intervention likely at this level of escalation, but standard Trust Accountability Framework oversight processes continue. Greater strategic focus within Divisional Review Meetings with frequency to be Quarterly. **Incentives:** • SFI amended to provide greater autonomy; • Fast track corporate support to achieve innovation projects; • Freedom to act quickly; • Direct discussions with commissioners; and • Support on business 'start up' initiatives when there are difficulties.	Support focussed on delivery of Divisional plans. Exceptional meeting can be requested.	Monthly Divisional Review Meetings with Trust Executives.

Accountability Framework

NHS North Bristol NHS Trust

Accountability Framework Oversight Segment	Triggers / Characteristics for a Division in Segment	Intervention	Support	Accountability
Targeted Support	Targeted support red in a row (domain) – low confidence levels in a particular area	Interventions to be focussed on: • Supporting improvement in particular domain; and • Remedial action plans (RAPs) to be developed for improvements in performance with agreed recovery trajectory to achieve required standard with corporate support to achieve.	Support focussed on improvement in specific domains.	Monthly Divisional Review Meetings with Trust Executives. Appropriate Executive leading targeted support.

Accountability Framework

Accountability Framework Oversight Segment	Triggers / Characteristics for a Division in Segment	Intervention	Support	Accountability
Intensive Support	• Intensive support red in a column (multiple domains) – low confidence levels in multiple domains	The division will be supported in the following ways: • Financial – Enhanced controls will be put in place to achieve a stable financial position, e.g. restricted delegated limits for pay and non-pay; • Decision making will be jointly between Executive and Divisional Triumvirate; • Divisional Board Capability review by Executive Team to identify areas where support or additional resource is required; and • Rapid Improvement Plans to be developed for improvements in performance with agreed recovery trajectory to achieve required standard and support provided to achieve these.	Support focussed on urgent improvement and / or financial turnaround. Support will include: • Continuation of support as part of targeted support actions; • Agreement of the exit criteria from Intensive Support; and • Consideration of the capability and capacity of the Divisional Team to deliver urgent improvement and / or financial turnaround.	Special meeting between Trust Executive (potentially including CEO), Division and relevant service line leads (clinical , nursing and managerial). Monthly Divisional Review Meetings with Trust Executives. Weekly or Fortnightly performance improvement meeting chaired by the relevant Executive dependent on the challenged domain.

North Bristol NHS Trust

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

Executive Summary	
NHSI/E suspended the 2021/22 financial framework due to covid-19 pandemic response. The financial framework for months 1 to 6 of 21/22 requires the trust to operate core ooerations within an agreed financial envelope and, in addition, to recover costs incurred in dealing with the Covid-19 pandemic in line with national guidance. The forecast Trust position for the first 6 months of 21/22 is to breakeven. A phased plan is being developed for submission on 24th May for submission to NHSI. The actual result for month1 (which is also cumulative position for the year to date) is a surplus of £2.5m All figures reported will specifically exclude any Elective Recovery Fund (ERF) non recurrent earnings which will be paid to the CCG if system if activity levels are above the target trajectory and the various gateways are met at a system level.	
Strategic Theme/Corporate Objective Links	Change how we deliver services to generate affordable capacity to meet the demands of the future

13

Board Assurance Framework/Trust Risk Register Links	
Other Standard Reference	N/A
Financial implications	N/A
Other Resource Implications	N/A
Legal Implications including Equality, Diversity and Inclusion Assessment	Delivery of Trust statutory financial responsibilities

1. Purpose

1.1 This report is to inform and give an update to Board on:
- the further revisions to the financial framework that the Trust is operating in
- financial performance for April 2021

2. Background

2.1 This report is a standing item to the Trust Management Team and Finance and Performance Committee (FPC) or Trust Board if FPC is not meeting in a given month.

3. Summary

3.1 NHSI/E has suspended the usual operational planning process and financial framework due to covid-19 pandemic response.

3.2 For the first half of the year the trust is funded through a block contract arrangement with additional non-recurrent income to fund non-recurrent elective recovery actions. Against which it is expected breakeven.

3.3 The position for the month of April shows a surplus of £2.5m (as April is month 1 of the new financial year this is also the cumulative position for the year to date).

3.4 Cash position at the end of April is a positive balance of £109.6m (March 2021 balance was £121.5m).

4. Financial Performance

The table below shows overall Trust income and expenditure for April split between Core Activities and COVID-19 (funded within the envelope) and Mass Vaccination which is funded through mechanisms similar to retrospective top-up in 20/21.

Position as at 30 April 2021

	WITHIN FUNDING ENVELOPE		OUTSIDE FUNDING ENVELOPE	Total
	Covid-19	Core Trust	Mass Vaccination	
	M1 £m	M1 £m	M1 £m	M1 £m
Contract Income	0	53.3	0	53.3
Other Income	1.0	5.0	0.8	6.8
Total Income	**1.0**	**58.3**	**0.8**	**60.1**
Pay	-0.	-34.2	-0.6	-35.2
Non-Pay	-0.1	-22.1	-0.2	-22.4
Total Expenditure	**-0.5**	**-56.3**	**-0.8**	**-57.6**
Surplus/ (Deficit)	**0.5**	**2.0**	**0**	**2.5**

4.1 Covid 19

The share of system funding being paid to the trust assumes direct Covid-19 costs will continue at approx. £1m per month. During April the trust actually incurred £0.5m of additional I&E costs. The current assumption is that surplus any non-recurrent covid funding can be retained by the trust.There is a risk that the £0.5m covid surplus will need to returned to commissioners later in the year.

Covid costs incurred in April 2021 totalled £0.5m as described below.

- £0.2m was spent in additional pay costs as a result of staff who are self-isolating or shielding,
- £0.2m was incurred for COVID-specific staff cover,
- £0.1m was spent on non-pay costs including additional clinical equipment, decontamination costs and other social distancing measures.

4.2 Core Trust

Due to covid-19 pandemic response NHSI/E suspended the annual business planning processes so the Trust is not being monitored by NHSI/E against a phased plan, instead systems have been funded at a level based on Q3 2020/21 spend rate adjusted for inflation. Within this envelope all organisations are expected to breakeven.

The Trust will submit a phased plan for months 1 to 6 by the end of May in line with requirements which will then be used for ongoing monitoring and performance management.

Against the requirement to break even, for the month of April the Trust delivered a surplus of £2.0m on core activities (exclusive of covid costs). This was primarily down to lower levels of spend on the elective mitigation schemes and lower levels of drugs and devices than was included in the NHSI/E calculation of the Trust funding requirement.

The core trust performance in comparison to the previous 2 months of 20/21 are shown below:

Total for Core trust excluding covid and mass vaccs

	Feb-21	Mar-21	Apr-21
Contract Income	53,396	85,941	53,336
Income	7,692	18,101	5,037
Pay	-34,736	-59,539	-34,194
Non-Pay	-27,258	-41,632	-22,137
Total	**-906**	**2,871**	**2,041**

Normalising Adjustments

	Feb-21	Mar-21	Apr-21	
Contract Income	0			
Income	-2,000			Pass Through Drugs Rebate
Pay	0			
Non-Pay	5,200			Balance sheet adjustments
Total	**3,200**			

	Feb-21	Mar-21	Apr-21	
Contract Income		-31,500		Pension gross up, Funding A/L Provision Adjustment
Income		-12,000		Retained element of NHSI other income top up
Pay		25,100		Pension gross up, A/L Provision Adjustment and Holiday sales
Non-Pay		18,000		Provision movements, stock adjustments and asset write downs
Total		**-400**		

Month on month comparison

	Feb-21	Mar-21	Apr-21
Contract Income	53,396	54,441	53,336
Income	5,692	6,101	5,037
Pay	-34,736	-34,439	-34,194
Non-Pay	-22,058	-23,632	-22,137
Total	**2,294**	**2,471**	**2,041**

Adjusting for known non-recurrent items demonstrates that the core surplus by month for each of the 3 months and also that pay and non pay costs are broadly consistent on a month on month basis.

4.3 Mass Vaccination

During April 2021 the Trust has continued delivery of Mass COVID-19 Vaccinations, which resulted in additional cost £0.8m. The majority of costs incurred are staff related as consumables and drugs costs are being met with nationally supplied push stock.

5. Nightingale Hospital Financial Position

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

6. Capital and Cash

6.1 The cash balance at M1 is £109.6m, a reduction from £121.5m at 31st March 2021. This reduction is in line with expectations following various working capital adjustments after year end. The Trust expects to break even under the H1 financial regime and therefore expects to have sufficient cash to manage its affairs without any external support over the period for which the financial regime has been announced.

6.2 The Better Payment Practice Code achievement of invoices paid within 30 days, by value, was 90.4% for the month of April , compared to an average of 86.6% for financial year 2020/21.

6.3 Capital spend for the month was £1.5m, compared to a month 1 plan of £1.2m. The Trust is currently forecasting to achieve its core capital plan and fully spend against its £20.5m capital envelope for financial year 2021/22

7. Assumptions and risks

7.1 The trust has assumed that any suplus covid cost funding from the system (£0.5m for both the month of April and the year to date) can be retained

7.2 The levels of non-recurrent funding that is covering recurrent costs is increasing as block contracts are being rolled over based on 2019/20 costs whilst inflation and other pressures are increasing the recurrent cost base of the Trust.

7.3 Mechanisms for allocating recurrent funding across the system are not yet developed.

7.4 The Trust has chosen to set annual budgets whilst the finance regime has only announced income levels for the first half of the year.

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

8. Cost Improvement Program

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

Summary Division	FYE Target £k	Green Schemes £k	Amber Schemes £k	Red Schemes £k	Total FYE	Variance Before Pipeline FYE	Pipeline FYE
ASCR	4,427	480	461	2,788	3,729	-698	1,166
CCS	3,893	0	497	364	862	-3,031	205
CORP	1,610	0	116	98	215	-1,395	20
FAC	1,910	0	100	0	100	-1,810	25
MED	3,179	0	0	0	0	-3,179	981
NMSK	3,316	0	295	890	1,186	-2,130	0
WCH	1,344	0	17	17	34	-1,310	60
	19,679	**480**	**1,487**	**4,158**	**6,126**	**-13,553**	**2,457**

8.2 Actual CIP delivery for the year to date is £0.48m.

9. Summary and Recommendation

9.1 Board is asked to note:

- the revised financial framework that the Trust is operating in,
- Financial performance for the month
- the spend on Mass Vaccinations and Covid-19 expenditure areas (but not Nightingale Hospital Bristol as this is no longer in operation)
- the cash position of the Trust.
- Delivery of Cost Improvement Plan savings and how they compare with divisional targets.

Report To:	Trust Board		
Date of Meeting:	27 May 2021		
Report Title:	Patient & Carer Experience Committee Report		
Report Author & Job Title	Kate Debley, Deputy Trust Secretary		
Executive/Non-executive Sponsor (presenting)	Kelvin Blake, Non-Executive Director and Committee Chair		
Purpose:	**Approval**	**Discussion**	**To Receive for Information**
			X
Recommendation:	The Trust Board is recommended to receive the report for assurance and to: • Note the End of Life Care Annual Report (Appendix 1); • Consider inviting the Trust's End of Life team to present the End of Life Care Annual Report at an update on their work as a staff story at the July Public Trust Board meeting.		
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 July 2021 meeting.		

Executive Summary
The report provides a summary of the assurances received, issues to be escalated to the Trust Board and any new risks identified from the Patient & Carer Experience Committee Meeting held on 19 May 2021.

Strategic Theme/Corporate Objective Links	**1. Provider of high quality patient care** a. Work in partnership to deliver great local health services b. A Centre of Excellence for specialist healthcare **2. Developing Healthcare for the future** a. Training, educating and developing our workforce **3. Employer of choice** a. Empowered clinically led teams b. Support our staff to continuously develop **4. An anchor in our community** a. Create a healthy & accessible environment

Board Assurance Framework/Trust Risk Register Links	Reports received support the mitigation of the following BAF risks: N/A
Other Standard Reference	Care Quality Commission Standards.
Financial implications	No financial implications as a consequence of this report.
Other Resource Implications	No other resource implications as a result of this report.
Legal Implications including Equality, Diversity and Inclusion Assessment	No legal implications
Appendices:	*Appendix 1 – End of Life Care Annual Report*

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 19 May 2021.

2. Background

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

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

3. Key Assurances & items discussed

3.1 Patient story:

The Committee heard about a gentleman called David, a fit and well 56 year old who had been diagnosed with High Grade Spindle Cell Sarcoma left thigh in October 2020 and then lung metastases in March 2021. David underwent surgery on his thigh in

January 2021 and is currently being treated at Bristol Haematology and Oncology Centre.

The Committee heard via a first-hand recorded account that David's experience had been positive overall and that he had felt well supported by everyone involved in his care. In particular it was noted that David had built good relationships with the prehab and rehab physiotherapy teams and had appreciated the opportunity to send videos of his progress via digital channels. The Committee noted that in addition to the positive elements of David's story there were also two key learning points, one in relation to an episode that had occurred when he was an inpatient, and the other relating to the way bad news had been communicated to him. The Committee were assured that these learning points would be followed up appropriately.

The Committee's discussions focussed on the importance of ensuring that patients are treated as individuals, and the positive impact this can have on their experience. In support of this, the Committee requested that feedback be obtained from patients in relation to the digital changes that have been brought in at pace due to Covid restrictions; it was acknowledged that not all these changes will suit all patients.

3.2 Patient Experience Internal Audit Report

The Committee reviewed a positive Patient Experience Internal Audit Report, noting the rating of significant assurance with minor improvement opportunities. Recommendations in the Report were noted and the Committee asked that an update on progress against these be brought to its July meeting.

3.3 Quality Strategy Theme 1 – Patient Engagement

The Committee received an update on progress against Quality Strategy theme 1 – Patient Engagement and heard that active and progressive work is ongoing in relation to consent. It was noted that the newly appointed Head of Patient Experience will now start taking forward work on learning from patient and carer engagement. The Committee will receive a further update at its July meeting.

3.4 End of Life Care Annual Report

The Committee welcomed the End of Life Care Annual Report (Appendix 1) and thanked the team for the continued good progress. The Committee noted that significant changes in End of Life Care had been required due to Covid restrictions, and that this has had a resulting emotional impact on staff. The Committee were assured that End of Life Care in the Trust continues to be of a very high standard.

Trust Board is asked to note the End of Life Care Annual Report and consider inviting the End of Life Care team to provide an update on their work as a staff story at the July Public Trust Board meeting.

3.5 Oliver McGowan LeDeR – Progress Against Recommendations

The Committee reviewed in some detail progress against the Oliver McGowan system Multi Agency Review (MAR) action plan. The Committee were assured that the Trust's actions were either in progress or had been completed and further that the Interim Learning Disability & Autism Lead will remain in post to ensure that all work to implement the recommendations is completed.

3.6 Integrated Performance Report – Quality Section (April data)
The Committee received the Integrated Performance Report – Quality Section (April data) and noted that there has been an increase in the number and complexity of complaints received, in particular new issues from historic complainants. The Committee asked that some further analysis be undertaken in order to identify the potential reasons for this.

3.7 Additional updates received on:

- NBT Information Accessibility Standard Update
- Patient Experience Risk Report
- Patient Experience Group Highlight Report
- Learning Disability & Autism Steering Group Highlight Report

4. Escalations to the Board

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

5. Recommendations

5.1 The Board is recommended to:

- Note the End of Life Care Annual Report (Appendix 1);
- Consider inviting the Trust's End of Life team to present the End of Life Care Annual Report at an update on their work as a staff story at the July Public Trust Board meeting.

NHS North Bristol NHS Trust

End of Life Annual Report
April 2020- March 2021

Trust EoL Leads

Dr Stephane Eckoldt	Consultant in Palliative Medicine
Dr Sarah McCracken	Consultant in Geriatrics/ Care of the Elderly
Shona McIntosh	Lead Nurse Palliative Care Team
Lisa Thomas	Lead Nurse Palliative Care Team

Chair

Helen Blanchard	Director of Nursing and Quality

Abbreviations:

End of Life	EoL
Bristol, South Gloucestershire and North Somerset	BNSSG
Recommended Summary Plan for Emergency Care and Treatment	ReSPECT
Purple Butterfly	PB
Specialist Palliative Care Team	SPCT

NHS North Bristol NHS Trust

Table of Contents

Executive Summary:

The End of Life Strategy Group has been meeting since 2011 with the remit of having oversight of and ensuring outstanding EoL care within North Bristol NHS Trust. This annual report covers the group's work in the last year as well as setting out its strategic priorities for the next 3 years.

Achievements within the last year:

The COVID 19 pandemic has presented many challenges to the trust. Delivering excellent EoL care was central to managing the needs of patients affected by COVID-19 and their families. Despite the impact of the pandemic work to improve EoL care continued and the main achievements within the last year are:

- Appointment of new EoL medical and nursing leads:
    - Dr Sarah McCracken (Consultant Geriatrician) and Dr Stephanie Eckoldt (Consultant in Palliative Medicine) formally appointed as joint trust EoL leads in April 2020
    - Lisa Thomas (Band 8a CNS in Palliative care) and Shona McIntosh (Band 8a CNS in Palliative care) appointed as joint nursing leads for EoL care
- Completion of and feedback from the 2019 National Audit for Care at the End of Life (NACEL) showing NBT is above the national average for all domains examined (see Appendix 1 for summary).
- Ensuring visibility of patient at end of life through purple Butterfly on patient flow boards on all wards.
- Routine review of all EoL patients (Purple Butterfly) within the trust by the palliative care team.
- Development of COVID 19 specific guidelines to support symptom control, withdrawal of non-invasive ventilation and end of life care for inpatients affected by COVID 19.
- Development and support of a trust-wide communications project to support staff communication with families and to facilitate virtual visits for patients during the period of restricted visiting.
- Roll out of the ReSPECT form/ process (October 2019) and initiation of pilot projects (Surgery, Heart Failure, Dementia, Care of the Elderly) working with specialities to identify patients in the last year of life and have honest and timely conversations with patients and their families.
- Introduction of process for ReSPECT forms to be scanned onto shared care record so they are visible for GPs and community care providers.
- Development of a driver diagram to outline the drivers for ongoing development of EoL care within NBT and formulation for a work plan (see below for detail).

- Initiation of links with the Digital Transformation Team to ensure the needs of EoL patients are taken into account during the ongoing digital transformation of the trust. Participation in regular functional and clinical design groups for the electronic patient record (EPR).
- Work with Chief Clinical Informatics Officer and involvement in procurement process for software that will allow development of 'single source of truth' care plans for our patients.

Current facts and figures (for 2020-21 financial year):

Palliative and End of Life Care

- The NBT specialist palliative care team (SPCT) see an average of 143 referrals/ month.
- An average of 65% of patients referred to the specialist palliative care team had a non-malignant diagnosis.
- 43% of all patients who died at NBT had SPCT involvement during their last inpatient spell (777 patients).
- Since January 1st 2021 we have averaged approximately 3 rapid discharges/ month (DC within 24hrs) for end of life care.

Last year of life and ReSPECT process

- 81% of ReSPECT forms were available to view on Connecting Care (improved from 50% in Nov 2019) although there was a significant time lag between discharge and these being available (8days) fro primary care to view – June 2020 audit
- 52% of forms were a DNACPR recommendation only – April 2020 audit
- 60% of treatment recommendations made beyond DNACPR were appropriately documented on the form (improvement from Jan 2020) – April 2020 audit
- The work relating to ReSPECT audit and quality improvement work to date is summarised in figure 1 below.

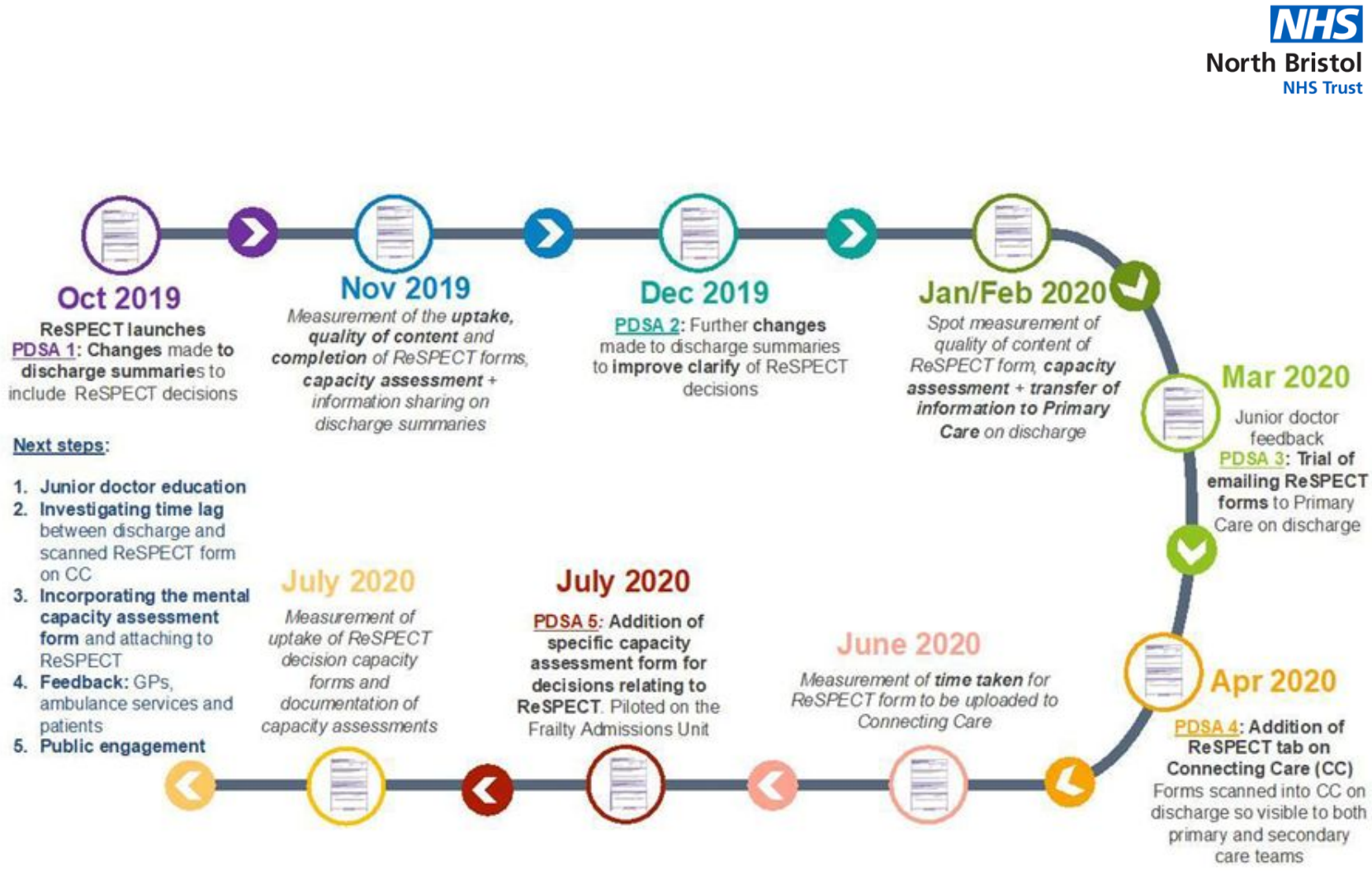


Figure 1: Summary of ReSPECT roll-out and ongoing audit/ quality improvement work.

Datix Incidents Relating to Palliative and EoL Care (for financial year 2020-21)

Within the last financial year there were 541 Datix incidents involving patients receiving palliative and end of life care. Of these 89 (16.5%) were screened in as needing further review by the palliative care clinical governance team. Themes are summarised in figure 2 below.

The main themes related to incidents relating to syringe drivers, end of life care and medication errors.

The detailed analysis relating to incidents involving End of Life care revealed the following areas that require improvement all of which have been considered in the EoL workplan going forward.

On detailed review of incidents relating to poor EoL care central themes identified included:

- Late recognition of dying leading to poor control of symptoms at EoL.
- Poor assessment, recognition and recording of symptoms towards the end of life leading to inadequate/ ineffective management of symptoms at EoL.
- Failure to escalate uncontrolled symptoms appropriately leading to poorly controlled symptoms/ delay in management of symptoms at EoL.
- Family concerns about symptom not acted upon.

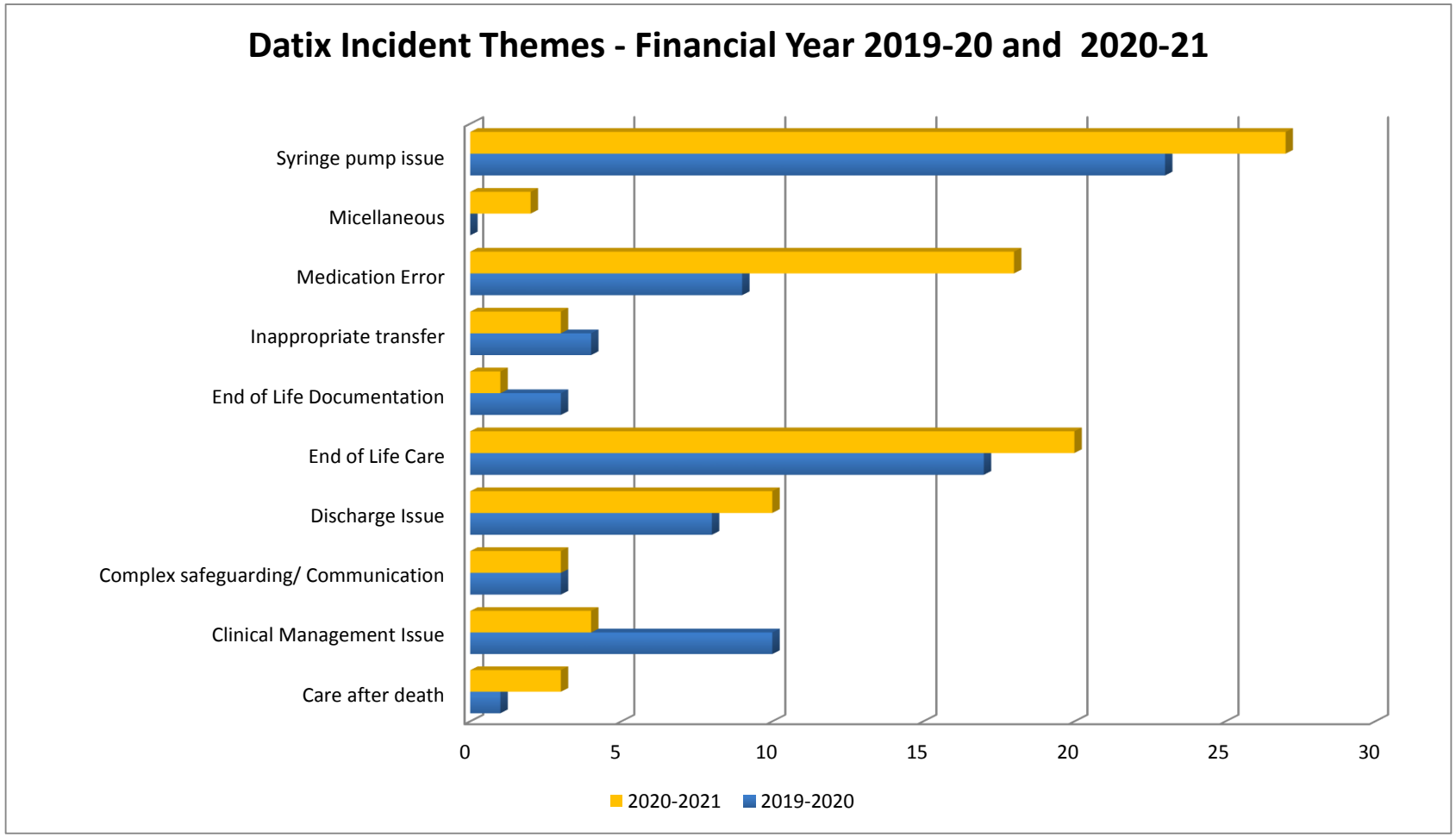


Figure 2: Summary of incident themes for palliative and end of life care patients.

Background to the work plan for the future:

The Trust End of Life Care work plan sets out:

- NBTs ambitions for end of life care over the next 3 years
- Trust processes currently in place that support these ambitions
- The drivers for improvement and change we have identified with NBT needed to meet these ambitions
- The quality improvement, audit and education projects that are currently in progress to support our ambitions
- The current involvement with wider groups to support co-ordinated development of services in the context of our ambitions

We have developed our work plan based on the below drivers:

- A national framework for local action: 'Ambitions for Palliative and End of Life Care 2015-2020'
- Participating as an early adopter of the national ReSPECT process
- Internal incident reporting highlighting themes involving patients receiving palliative or end of life care within NBT
- Audit relating to quality of EoL care within the trust (Purple Butterfly Audit, T34 syringe driver audit, and EoL discharge audit)

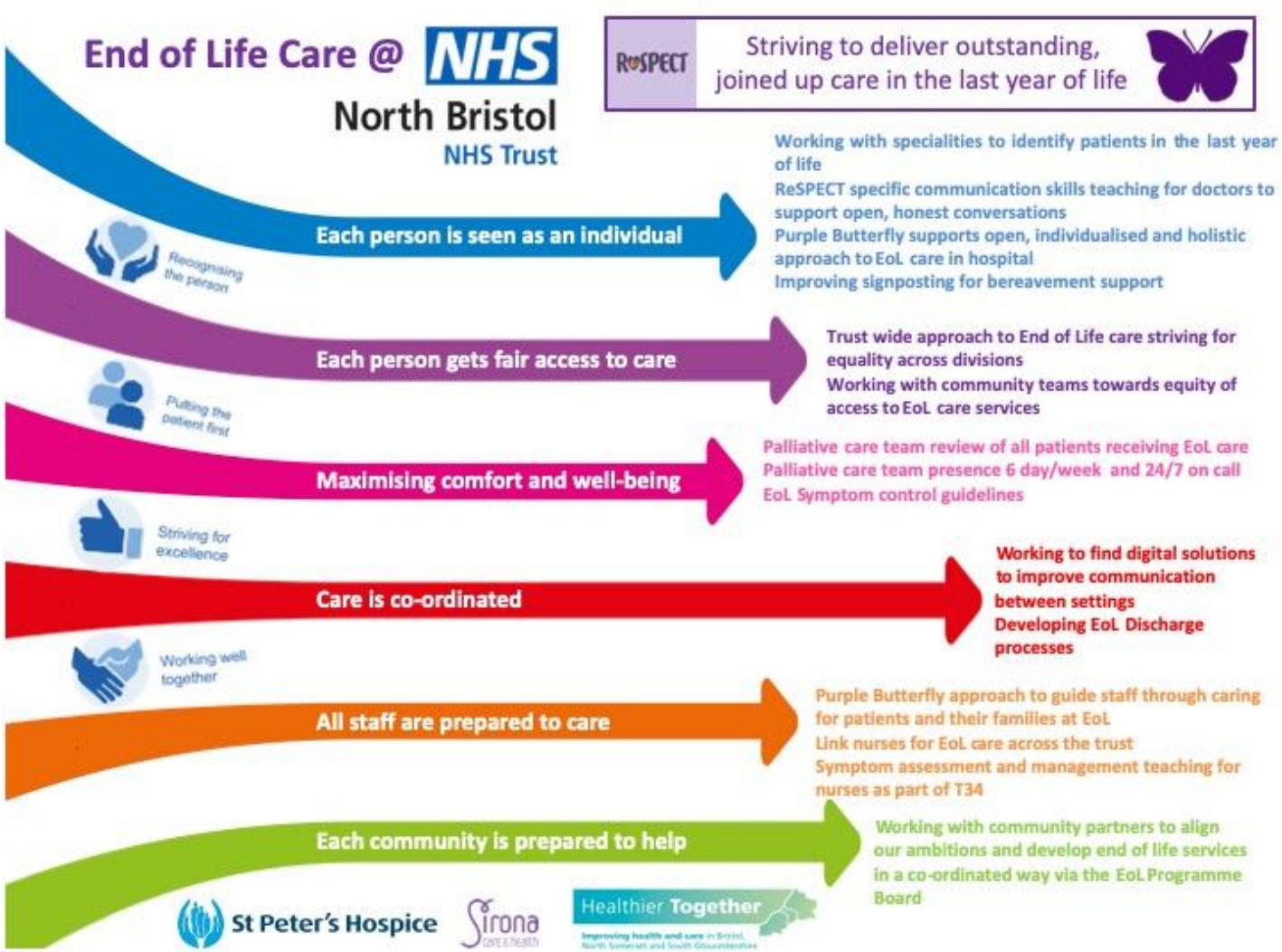
Ambitions for Palliative and End of Life Care

The national framework for Palliative and end of life care is set out in the 'Ambitions for Palliative and End of Life Care'. The individual ambitions and the work within NBT to support these ambitions is set out in the tables below and summarised in the infographic on page 9. This framework is also being used by the BNSSG CCG to develop a model for care for end of life services within BNSSG.

Our aspirations for the future are summarised by the infographic on page 17.

NHS North Bristol NHS Trust

Summary of EoL Care at NBT – Current processes and projects



Ambition 1: Each person is seen as an individual

I, and the people important to me, have opportunities to have honest, informed and timely conversations and to know that I might die soon. I am asked what matters most to me. Those who care for me know that and work with me to do what's possible.

Building Blocks	Current processes in place	Projects/ Actions	Current status	Lead
Honest conversations **Helping people take control**	• Purple Butterfly (PB) Approach – honest and clear communication is built in part of the approach • ReSPECT process/ forms • Staff education across the trust – all grades as part of induction • Advisory role of Palliative Care Team - supporting teams to have conversations	• Trust induction videos to replace induction teaching and mandatory teaching for consultants • ReSPECT communication skills training – junior doctors trustwide • ReSPECT Pilot projects in Dementia, Heart Failure and Surgery	Videos completed but currently not part of mandatory passport for consultants on MLE – need for further discussion. ReSPECT project aimed at supporting teams to identify patients in last year of life and initiate appropriate conversations with communication skills training.	LB/SE SMcC
Systems for person centred care **Establishing priorities of care and dying.**	• Purple Butterfly Approach – encourages individualised approach to care • ReSPECT process/ forms • Advisory role of Palliative Care Team - supporting teams to have conversations	Review of PB paperwork/ processes including: • PB audit • LINK nurse focus group • Staff survey relating to PB use/ feedback	PB audit has been completed and highlighted themes relating to poor completion of different elements of the PB paperwork. Link Nurse focus group conducted PB staff survey now completed Working group to review PB paperwork and update PB training video by the end of 2021.	SE/ LT
Clear expectations	• EoL discharge processes to ensure appropriate conversations take place to determine priorities of care and help set expectations	• Review/ audit of processes relating to dispensing of anticipatory medications • Review of processes to support ward teams to discharge patients at EoL	Ongoing quality improvement work to refine these processes to ensure patients are discharged at EoL having had appropriate conversations, with appropriate medications and excellent information sharing with community teams to ensure co-ordinated care.	EM/ CD/ SE

	• Staff education with regards to CHCFT completion and avoiding delays	• Audit of CHC FT process and delays	Joint audit of Palliative care team, IDS and community EoL team currently in progress to investigate potential areas of delay in requesting/ receiving CHCFT funding.	AB/ SE
Access to Social Care **Integrated care**	• Ward OT input for inpatients supported by Senior OT to support ward OTs to have appropriate conversations to set expectations	• Trial of new referral process to Senior OT	The palliative care team will trial highlighting all Palliative/ EoL patients seen with plan for DC Senior OT so she can proactively support ward OTs in discharge planning.	GM/ SM/ LT/ SE
	• Input into End of Life Programme Board working with EoL leads across BNSSG to work towards more integrated/ co-ordinated care			
Care after death and bereavement	• Staff eLearning for Care of the deceased patient • When a patient has died leaflets	• 'Good grief' cards project	• Bereavement team are exploring option to procure Good Grief Cards and determine how best to share these with bereaved relatives.	BD/ LT
	• Chaplaincy and bereavement team	• Bags for patient belongings	• Patient experience and the bereavement team have arranged provision of bags for patient's belongings after they die – these bags will be given to relatives and will highlight bereaved realties to staff so they can be more aware/ sensitive to their needs.	
		• Purple Butterfly volunteers	• On hold during COVID	BD

Ambition 2: Each person gets fair access to care

I live in a society where I get good end of life care regardless of who I am, where I live or the circumstances of my life.

Building Blocks	Current processes in place	Projects/ Actions	Current status	Lead
Using Existing data **Generating new data**	• Monthly reports from business intelligence about deaths within the trust and palliative care involvement • Ongoing review of all DATIX incidents relating to Palliative and EoL Care patients	• Audit of patients who died at NBT not on PB • Determining 1 year mortality and poor prognostic indicators for non-malignant disease • Need to have better understanding of our patient demographics at NBT	• Completed – for presentation at April EoL strategy group	AB/ SE/ LR
Community Partnerships **Population based needs assessment and commissioning** **Unwavering commitment**	• Liaison and work with community teams within BNSSG (e.g. hospice, GPs, Sirona) vi EoL Programme Board • EoL strategy group with regular quarterly meetings to ensure EoL care agenda and development is driven forward	• End of Life Programme Board working with STP and CCG to determine what the need of our local population are and how we can meet these • Work with St Peter's Hospice Community Engagement team and EoL programme board to improve equity in access, provision and responsiveness of palliative and EoL care	• Regular meetings – programme board presenting paper about ambitions from BNSSG point of view to be presented to Integrated Care Steering group (BNSSG, Healthier Together – see appendix)	SMcC/ SE
Person centred outcome measurement		• Regional collaboration to look at outcome measures and how we may use these	• Outcome measured group meeting planned April 2021	SM/ NL

NHS North Bristol NHS Trust

Ambition 3: Maximising Comfort and Wellbeing

My care is regularly reviewed and every effort is made for me to have the support, care and treatment that might be needed to help me to be as comfortable and free from distress as possible.

Building Blocks	Current processes in place	Projects/ Actions	Current Status	Leads
Recognising Distress whatever the cause and addressing all forms of distress	• Purple butterfly approach with holistic approach to developing an individualised are plan and exploring priorities of care • Symptom observations to ensure symptoms recognised and acted upon in a timely manner	• ReSPECT conversation communication skills training	Communication skills pilots in several specialities being rolled out	SMcC
Skilled assessment & symptom management	• Syringe pump training now incorporates symptom assessment training • Multiple other half day training available for staff (Nurses and HCAs)	Training video for HCAs Rapid/ drop in training plan	Palliative care team are currently reviewing HCA training and resources for nursing staff	SM/ LT
Specialist Palliative Care	• Specialist Palliative Care Team cover all patients across the trust with a 6 day a week physical presence and 24/7 on call service			SE/SM/LT
Priorities for the care of the dying	• ReSPECT process supports defining patients' priorities for their future care and treatment • Purple Butterfly approach supports team to identify patient's priorities of care and death	• ReSPECT conversation communication skills training • Current review of PB paperwork	Results of staff/ user survey and PB audit to guide development Work with digital transformation team and collaboration UHBW to aim for joint digital solution for EPR	SMcC SE
Rehabilitative palliative care	• Senior OT to support EoL DC			

Ambition 4: Care is Coordinated

I get the right help at the right time from the right people. I have a team around me who know my needs and my plans and work together to help me achieve them. I can always reach someone who will listen and respond at any time of day or night

Building Blocks	Current processes in place	Projects/ Actions	Current status	Lead
Shared Records	• All medical staff within NBT have access to Connecting Care (CC) – current shared care record • Scanned ReSPECT forms currently being added to CC on discharge	Read/ write/ single source of truth project		
Clear roles and responsibilities **Everyone Matters**	• Hospital specialist palliative care team cover inpatients with some outpatient input to bridge the gap before Community palliative care services are able to pick up patients.	EoL Programme Board working with all palliative care services/ partners in BNSSG to map ambitions against current services	In progress – due for presentation to STP team in April 2021	SE
		ReSPECT and CPR policy in draft outlining doctors/ clinicians responsibilities with regards to ACP/ ReSPECT	For discussion at April EoL Strategy Group meeting	SMcC
	• EoL Discharge process and checklist to ensure MDT approach and joined up discharge of patients at EoL	EoL DC process QI project	Currently in new change cycle with updated process and updated EoL DC checklist	SE/ EM
System-wide response **Continuity in partnership**		Read/ write/ single source of truth project	Woking with partners in BNSSG – currently in procurement stage to identify digital solution to allow a contemporaneous shared care record to all services across BNSSG (see appendix).	SW

Ambition 5: All Staff are Prepared to Care

Wherever I am, health and care staff bring empathy, skills and expertise and give me competent, confident and compassionate care.

Building Blocks	Current processes in place	Projects/ Actions	Current Status	Leads
Professional ethos **Support and resilience**	• Trust values of putting the patients first and recognising the person well established • Purple Butterfly well embedded and support staff to offer structured and individualised approach to EoL care • Staff supported by Start well end well process • Palliative care team offer ad hoc debriefs for teams if needed	Purple Butterfly Huddle – aim to briefly discuss patients on PB/ who have died	On hold during COVID – to reinitiate May 2021	SE/LT/SM
Knowledge based judgement	• Staff EoL training available to book via MLE • Symptom assessment training for all staff	Further development of training for HCAs		SM/AH
Using new technology	• PB icon on flow board to ensure visibility of patients receiving EoL care and to avoid inappropriate ward moves • Flow icon allows all patients receiving EoL care to be visible to palliative care team for PB checks • Specialist palliative care team using CareFlow Connect for referrals/handovers/ advice to ensure transparent and visible communication with ward teams	EPR end of life and care after death functional and clinical design groups	Currently working to ensure ongoing visibility of patients receiving comfort focused and EoL care (see appendix for summary)	
Awareness of legislation				
Executive governance	• All incidents involving patients receiving Palliative/ EoL Care screened by palliative care team • Summary of incidents presented to EoL strategy group every 6 months • Review of risks relating to EoL reviewed at EoL strategy group quarterly			

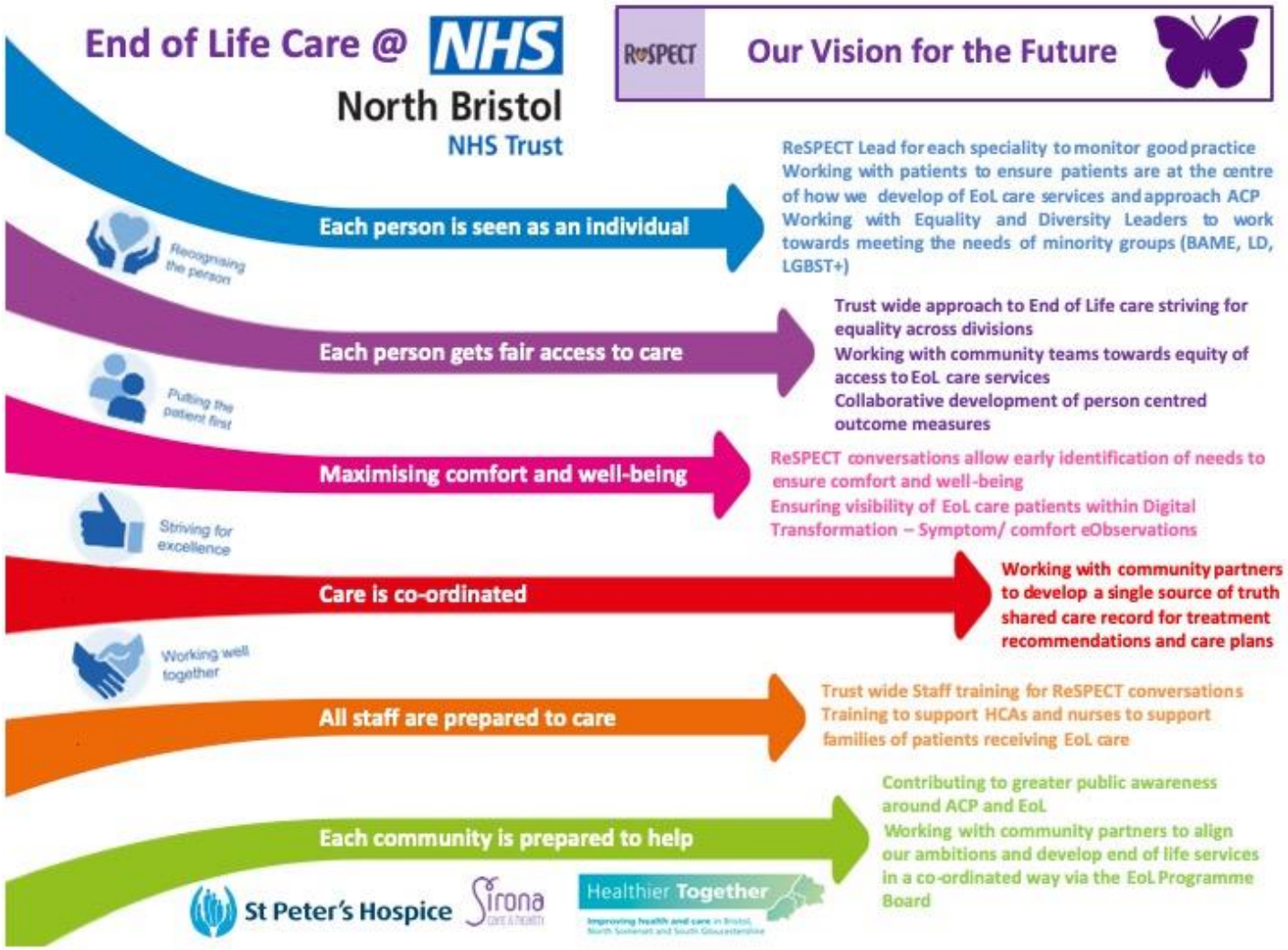
Ambition 6: Each Community is Prepared to Help

I live in a community where everybody recognises that we all have a role to play in supporting each other in times of crisis and loss. People are ready, willing and confident to have conversations about living and dying well and to support each other in emotional and practical ways.

Building Blocks	Current process in place	Projects/ Actions	Current Status	Leads
Compassionate and resilient communities	• Excellent relationships with community palliative care teams	• Ongoing work with community engagement CNS		
Public awareness	• Participation in Dying Matters Week on a yearly basis		Awaiting information/ dates fro 2021	LT/ SM
		? ReSPECT public awareness campaign	Need to check with Seema Srivastava	
Practical support				
Volunteers		Purple Butterfly volunteer project	On hold during COVID 19 pandemic	BD

NHS North Bristol NHS Trust

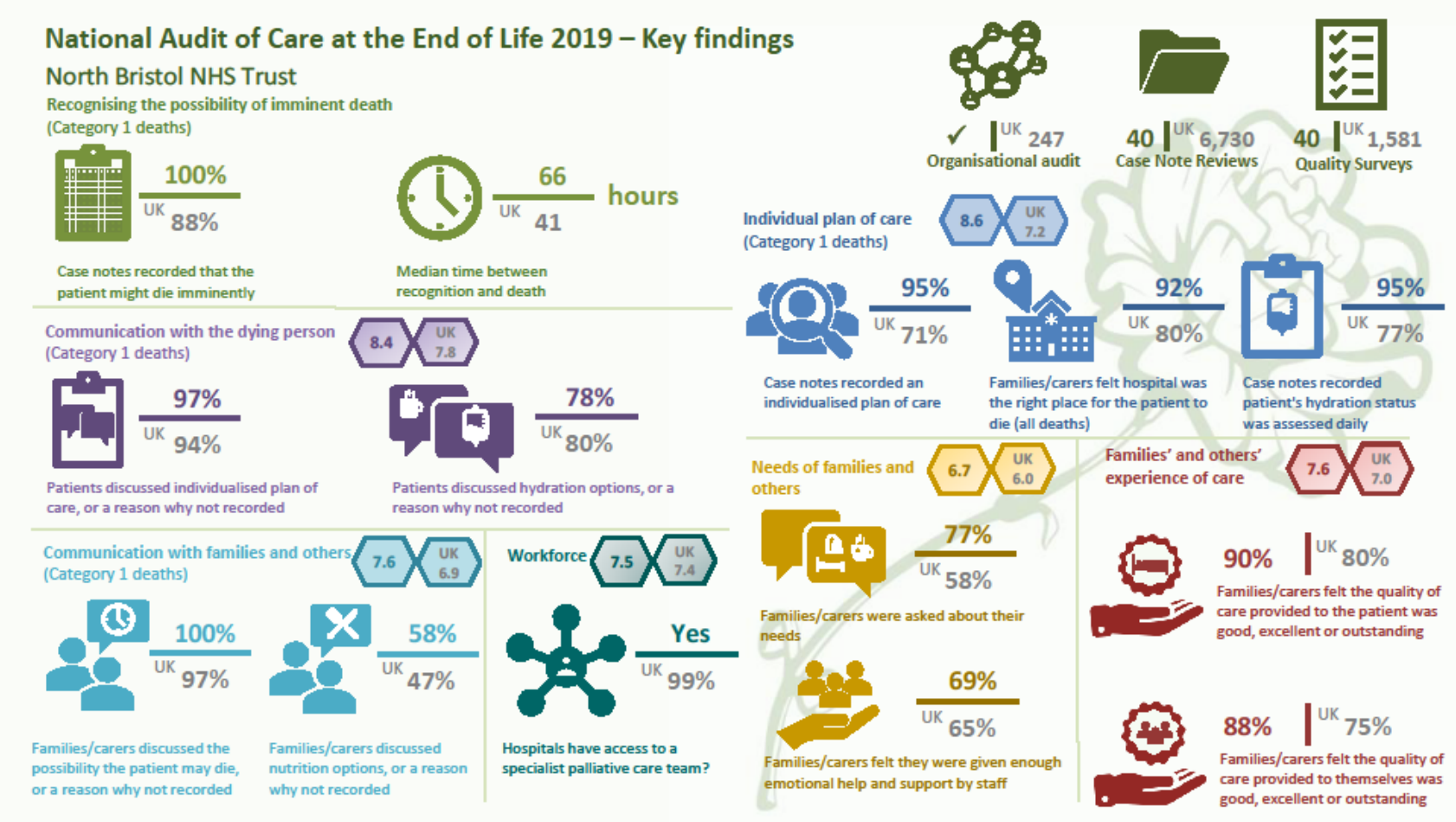
EoL Care at NBT - Our vision and aspirations for the future



NHS North Bristol NHS Trust

Appendix

Appendix 1: National Audit of Care at the End of Life (NACEL) results NBT



Report To:	Trust Board - Public		
Date of Meeting:	27 May 2021		
Report Title:	Quality & Risk Management Committee Upward Report		
Report Author & Job Title	Xavier Bell, Director of Corporate Governance & Trust Secretary Isobel Clements, Senior Corporate Governance Officer & Policy Manager		
Executive/Non-executive Sponsor (presenting)	John Iredale, Non-Executive Director and Chair of QRMC		
Does the paper contain:	**Patient identifiable information?**	**Staff identifiable information?**	**Commercially sensitive information?**
*If any boxes above ticked, paper to be received at *private* meeting			
Purpose:	**Approval**	**Discussion**	**To Receive for Information**
	X		**X**
Recommendation:	The Trust Board should receive the report for assurance and note the activities QRMC has undertaken on behalf of the Board. In addition, it is requested that Trust Board approve the Patient Safety Incident Response Plan as recommended by QRMC to enable Go-Live as an early adopter on 7 June.		
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 the Trust Board in July 2021		

Executive Summary	
The report provides a summary of the assurances received and items discussed and debated at the Quality and Risk Management Committee (QRMC) meeting held on 11 May 2021.	
Strategic Theme/Corporate Objective Links	**Provider of high-quality patient care** a. Experts in complex urgent & emergency care b. Work in partnership to deliver great local health services c. A Centre of Excellence for specialist healthcare d. A powerhouse for pathology & imaging **Employer of choice** e. A great place to work that is diverse & inclusive

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

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 QRMC meeting held on 11 May 2021.

2. Background

2.1. The QRMC is a sub-committee of the Trust Board. It meets bi-monthly and reports to the Board after each meeting and was established to provide assurance to the Trust Board on the effective management of quality governance and risk management.

3. Meeting on 11 May 2020

3.1 Management of increased incidence of *C. difficile*

The Committee was joined by Dr Elizabeth Darley, Medical Lead for Infection Prevention & Control and Sarah Wheatley, Nurse Lead for Infection Prevention & Control. They presented an update on NBT *C. difficile* infection rates and the impact of Covid-19 on case numbers in the hospital. The Committee were advised that antibiotic policies had changed at the beginning of the Covid-19 pandemic, with a higher rate of antibiotics prescribed to patients suspected of having Covid-19. This is thought to have increased the prevalence of *C. difficile,* alongside other impacts of the Covid-19 pandemic response.

The Committee were reassured that an appropriate action plan is in place, including IPC support to Divisional-specific Infection Control meetings, further ward-level education and working with Commissioners at a system level on antibiotic stewardship. An update on progress and C. difficile cases was requested at QRMC in six months' time.

3.2 Diagnostics

The Committee undertook a deep dive into diagnostic services across the Trust, and were joined by Rommel Ravanan and Sarah Robinson, Clinical Director and Divisional Operations Director (respectively) for Core Clinical Services, as well as by Ana Terlevich, Consultant Gastroenterologist.

The deep dive included a discussion of imaging, cellular pathology and endoscopy.

With regards to imaging, the Committee were advised that there is a gradually improving position, notwithstanding the significantly increased waiting list. Improvement actions include additional capacity via outsourcing, moving to more radiographer-led (rather than consultant-led) imaging activity and others. The Committee were comfortable that the issues and risks were well-understood, and that appropriate mitigations were in place.

The Committee also noted the ongoing and longstanding issues around capacity within Cellular Pathology, and that the Division is being proactive to try and mitigate this issue, particularly through enhancing non-medical roles and succession planning.

The Committee were advised that for both areas, the Division is confident that there are appropriate processes in place to flag should patients be coming to harm due to

capacity/waiting lists, and that both soft and hard evidence found this is not currently an issue.

The Committee reviewed a set of slides setting out the impact of Covid-19 on Endoscopy activity and the subsequent increase in waiting times. The actions being taken to manage the "urgent" waiting lists were discussed, including the management of 2 week-wait referrals, vetting of in-patient/out-patient referrals, and the management of surveillance lists. Following reviews, no harm from Covid-19 delays has been found but this continued to be monitored.

The Committee was assured that the remedial actions plan included insourcing and outsourcing resolutions and prior to Covid-19, the action plan had elicited a reduction in waiting times. In addition, a system-wide solution was being discussed to meet the challenging demand (6% annual increase) made worse by the backlog from Covid-19.

3.3 Maternity

The Committee was joined by Paul Mannix, Clinical Director of W&CH and Sally Bryant, Interim Head of Midwifery, who presented the maternity update papers. The Antenatal Screening non-compliance issue whereby the Trust was breaching on first trimester screening and repeat anomaly screening was discussed.

Two data dashboards were presented: the regular clinical dashboard and the newer Local Maternity System (LMS) dashboard that had been developed collaboratively alongside University Hospitals Bristol & Weston's (UHBW) Maternity service. The latter was in an iterative stage and would also be reported to the LMS. The dashboards were reviewed, and the Committee noted progress was being made regarding appropriate reflection of service user feedback. In addition, it was reported that following review of Continuity of Carer resources, it had been agreed that the Trust would focus the limited resources on ensuring continuity of carers for vulnerable patients.

The Committee also reviewed the Trust's Ockenden Assurance Report which provided a RAG rating against Ockenden Immediate and Essential Actions (IEAs).

The Maternity Incentive Scheme Report (including the Clinical Negligence Scheme for Trusts (CNST) and Perinatal Mortality Review Tool (PMRT) quarterly update reports), was also provided to the Committee for review. The Committee formally noted the following:

- Details of all eligible perinatal deaths had been reviewed. The report evidenced that the PMRT had been used to review eligible perinatal deaths and that the required standards a), b) and c) have been met as per Safety Action 1, CNST Maternity Incentive Scheme;
- Information was provided regarding ongoing progress towards achieving the 10 Maternity Safety Actions as per CNST Maternity Incentive Scheme;
- That over the next six months, the multiple action logs held by the division (CNST, PMRT, Ockenden etc.) would be collated into one document to allow efficient oversight.

3.4 Quality Strategy – Delivery Plan Development for 2021-22

The Committee received an update on the 2021/22 delivery plan for the Quality Strategy and were assured that there are robust plans for delivery and oversight.

3.5 Patient Safety Programme 2021/2022: Patient Safety Incident Response Plan

The Committee reviewed the Patient Safety Incident Response Plan, which is a core component of the NHS Patient Safety Strategy released in July 2019 and is NBT's implementation of the national Patient Safety Incident Response Framework. NBT is an early adopter of the framework.

This plan outlines a completely new way in which incidents are investigated and reviewed and will require the organisation to completely change how it approaches incidents. The approach has been endorsed by national regulators and NBT's approach is being shared with other organisations as an example of best practice.

The Committee discussed the approach and noted that while it involves a wholesale change to how serious incidents (as currently defined) are dealt with, it does not change the ongoing statutory duty of candour and the need to investigate incidents when they occur. The Committee approved the Plan, noting work was ongoing to educate and engage clinicians. It is presented to Trust Board for approval (Appendix 1).

3.6 Other items:

The Committee also received updates on:

- Drugs & Therapeutics Committee and Safeguarding Committee Upward Reports;
- CQC Assurance Report;
- QRMC relevant BAF Risks;
- Trust Level Risks Report;
- Quality Performance Report;
- Elgar Fire Risk/Mitigations Update
- Internal Audit Report: Risk Management
- QRMC forward work-plan 2021/22

4. Identification of new risk & items for escalation

No significant risks or issues were identified as requiring specific escalation to Trust Board.

5. Recommendations

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

In addition, it is requested that Trust Board approve the Patient Safety Incident Response Plan as recommended by QRMC to enable Go-Live as an early adopter on 7 June.

Report To:	Quality and Risk Management Committee		
Date of Meeting:	11th May 2021		
Report Title:	Patient Safety Incident Response Plan 2021/2022		
Report Author & Job Title	Heather Brown, Patient Safety Analyst Nicholas Seaton, Patient Safety Manager Christopher Brooks-Daw, Associate Director of Patient Safety		
Executive/Non-executive Sponsor (presenting)	Helen Blanchard, Director of Nursing and Quality		
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:	The committee is asked to discuss and approve the patient safety priorities as described and to support "go live" with PSIRF on June 7th 2021.		
Report History:	The paper and findings were presented to and discussed at the Patient Safety and Clinical Risk Committee May 2021		
Next Steps:			

Executive Summary	
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 out workforce b. Increase our capability to deliver research c. Support development & adoption of innovations d. Invest in digital technology

15.1

Board Assurance Framework/Trust Risk Register Links	Multiple risks across patient safety.
Other Standards Reference	NHS Patient Safety Strategy 2019 NBT Quality Strategy
Financial implications	N/A
Other Resource Implications	N/A
Legal Implications	N/A
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
Appendices:	Patient Safety Incident Response Plan 2021

1. Purpose

1.1 The Patient Safety Incident Response Plan (PSIRP) is presented to QRMC to set out the plan for how NBT will implement the National Patient Safety Incident Response Framework (PSIRF) as one of a group of early adopter (EA) organisations.

1.2 PSIRP is the national terminology used to describe this document; however, it is best considered as strategy document, setting our broad headlines and areas of work. It is informed by detailed analysis across patient safety incidents, inquests, complaints/concerns and risks, as well as engagement and input from the Divisional Quality Governance Teams.

1.3 PSIRF replaces the Serious Incident Framework.

1.4 PSIRP describes the relationship between patient safety incident investigations, the trust's patient safety priorities and continuous improvement programmes.

1.5 As an early adopter, we are part of learning through implementing this new approach and, as such, we will work flexibility to understand the impact and implementation. It is expected that we will adapt our processes as we progress through the early adopter phase.

2. Background

2.1 In March, QRMC received the Patient Safety Priorities paper that was based on the Thematic analysis conducted over 3 ½ years. Patient safety incidents, complaints, concerns, Pals, coroner's inquests and patient safety investigation reports were analysed

2.2 The thematic analysis identified five patient safety priorities; inpatient falls, medication management, responding to clinically changing conditions, pressure injuries and discharge.

2.3 The PSIRP builds on the work completed as part of the thematic analysis and sets out the wider process and structure that will be utilised to facilitate the national framework within the organisation.

2.4 The PSIRP describes the whole system of responding to patient safety incidents and will be underpinned with three key new policies; patient safety incident investigation, incident reporting and being open/duty of candour.

2.5 The PSIRP challenges our understanding of patient safety incident investigation and looks to describe how we respond to patient safety incidents and risks using ongoing improvement programmes of work.

2.6 Investigation models and review processes are described within the PSIRP but critically the plan encompasses a wider systematic approach.

3. Recommendations

3.1 QRMC is asked to approve and support the PSIRP and the new framework for responding to patient safety incidents detailed within.

Patient Safety Incident Response Plan

NHS
North Bristol
NHS Trust

2021 – 2023

15.1

Exceptional healthcare, personally delivered

Contents

Foreword from our Associate Director of Patient Safety

The NHS Patient Safety Strategy 2019 describes the Patient Safety Incident Response Framework (PSIRF) as "a foundation for change" and as such, it challenges us to think and respond differently when a patient safety incident occurs.

I can assure you, PSIRF is ***very different***. And it is very exciting.

Unlike previous frameworks, PSIRF is not a tweak or adaptation of what came before. PSIRF is a whole system change to how we think and respond when an incident happens to prevent recurrence. Previous frameworks have described when and how to investigate a serious incident, PSIRF focusses on learning and improvement. With PSIRF, we are responsible for the entire process, including what to investigate and how. There are no set timescales or external organisations to approve what we do. There are a set of principles that we will work to but outside of that, it is up to us, which of course can feel a bit scary!

When asked "why do we investigate incidents?" the common response is to learn, but what does that mean? Often, we mean learning as understanding what has happened, but it should be much more than that. How often is the answer to what did we do about an incident "we investigated it"? How much has demonstrably changed/improved in 20 years using these methods?

Over the past 2 years, North Bristol NHS Trust has focused on improving our approach to patient safety incidents, with many great examples of learning and involvement.

Essential to this has been fostering a patient safety culture in which people feel safe to talk. Having conversations with people relating to a patient safety incident can be difficult and we will continue to explore how we can equip and support our colleagues to best hear the voice of those involved.

In doing so, we will support our core ambition of working in partnership with patients to improve safety.

It is important to recognise that there are good reasons to carry out an investigation. Sharing findings, speaking with those involved, validating the decisions made in caring for patients and facilitating psychological closure for those involved are all core objectives of an investigation. The challenge for us is to develop an approach to investigations that facilitates thematic insights to inform ongoing improvement. Our approach must acknowledge the importance of organisational culture and what it feels like to be involved in a patient safety incident.

We have made significant progress over the past 2 years in developing and fostering a restorative just culture in which people feel psychologically safe. We recognise that changing culture is complex and we are passionate about being an organisation that lives and breathes a safety culture in which people feel safe to speak. PSIRF is a core component in continuing this journey, ensuring we create a psychologically safe culture where people are confident to about patient safety events and to simply express their opinion.

As an early adopter, we are part of a group of organisations that will be actively learning through the process. We may not get it all right at the beginning, but we will monitor the impact and effectiveness of implementing PSIRF, we will talk and respond, adapt as and when our approach is not achieving what we set out to achieve.

Thank-you for being part of this extremely exciting opportunity.

Christopher Brooks-Daw
Associate Director of Patient Safety

An introduction to the Patient Safety Incident Response Plan

The NHS Patient Safety Strategy was published in 2019 and describes the Patient Safety Incident Response Framework (PSIRF), a replacement for the NHS Serious Incident Framework. This document is the Patient Safety Incident Response Plan (PSIRP). It describes what we have done at North Bristol NHS Trust to prepare for "go live" with PSIRF, as an early adopter organisation and what comes next.

The Serious Incident Framework provided structure and guidance on how to identify, report and investigate an incident resulting in severe harm or death. PSIRF is best considered as a learning and improvement framework with the emphasis placed on the system and culture that support continuous improvement in patient safety through how we respond to patient safety incidents.

One of the underpinning principles of PSIRF is to do fewer "investigations" but to do them better. Better means taking the time to conduct systems-based investigations by people that have been trained to do them. This plan and associate policies and guidelines will describe how it all works. The NHS Patient Safety Strategy challenges us to think differently about learning and what it means for a healthcare organisation.

Carrying out investigations for the right reasons can and does identify learning. Removal of the serious incident process does not mean "do nothing", it means respond in the right way depending on the type of incidents and associated factors.

A risk to successfully implementing PSIRF is continuing to investigate and review incidents as we did before, but simply giving the process a new label. The challenge is to embed an approach to investigating that forms part of the wider response to patient safety incidents whilst allowing time to learn thematically from the other patient safety insights.

PSIRF recognises the need to ensure we have support structures for staff and patients involved in patient safety incidents. Part of which is the fostering of a psychologically safe culture shown in our leaders, our trust-wide strategy and our reporting systems.

We have developed our understanding and insights over the past two years, including regularly discussions and engagement through our committees and group. Most recently, in March 2021, the Patient Safety and Clinical Risk Committee and the Quality and Risk Management Committee received and supported the thematic analysis and patient safety priorities that informs our patient safety priorities for PSIRF. This plan provides the headlines and description of how PSIRF will be apply in NBT.

The scope of PSIRP and our vision

There are many ways to respond to an incident. This document covers responses conducted solely for the purpose of systems-based learning and improvement.

There is no remit within this Plan or PSIRF to apportion blame or determine liability, preventability or cause of death in a response conducted for the purpose of learning and improvement.

It is outside the scope of PSIRF to review matters to satisfy processes relating to complaints, HR matters, legal claims and inquests.

This Plan explains the scope for a systems-based approach to learning from patient safety incidents. We will identify incidents to review through nationally and locally defined patient safety priorities. An analysis of which is explained later within this document.

There are four strategic aims of the Patient Safety Incident Response Framework (PSIRF) upon which this plan is based. The strategic aims are aligned with our own Trust vision statements. The North Bristol NHS Trust vision statement is:

"we will realise the great potential of our organisation by empowering our skilled and caring staff to deliver high-quality, financially sustainable services in state of-the-art facilities. Clinical outcomes will be excellent and with a spirit of openness and candour we will ensure an outstanding experience for our patients."

The implementation of PSIRF will see both the strategic aims and our Trust visions embodied in our work.

NBT Values	Putting the patient first	Recognise the person	Striving for excellence	Working well together
PSIRF Strategic Aims	Improve the safety of the care we provide to our patients	Improve the experience for patients, their families and carers wherever a patient safety incident or the need for a PSII is identified.	Improve the use of valuable healthcare resources.	Improve the working environment for staff in relation to their experiences of patient safety incidents and investigations.

System overview of North Bristol NHS Trust

We reviewed our local system to understand the people who are involved in patient safety activities across NBT, as well as the systems and mechanisms that support them. NBT is a centre of excellence for health care in the South West in several fields as well as one of the largest hospital trusts in the UK. Our commitment is that each patient is treated with respect and dignity and, most importantly of all, as a person.

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

This Trust has 7 Corporate Directorates. The central Patient Safety Team works alongside the Patient Experience Team and Quality Governance Team, within the Nursing & Quality Directorate. The QI team sits within the Research & Strategy Directorate and the Improvement Team sits within the People & Transformation Directorate.

There are 5 clinical Divisions consisting of Medicine, Women and Children's Health (WaCH), Neurosciences and Musculoskeletal (NMSK), Anaesthesia, Surgery Critical Care and Renal (ASCR) and Core Clinical Services (CCS).

Over the past two years, NBT has been in a transitional period which included a review of the internal governance structures across the clinical divisions.

This was overseen by the Quality Governance Improvement Programme, which formed the Divisional Quality Governance and Patient Involvement & Experience teams. These teams provide operational support, working collaboratively with the central governance, safety and experience teams.

Core patient safety activities undertaken at NBT include:

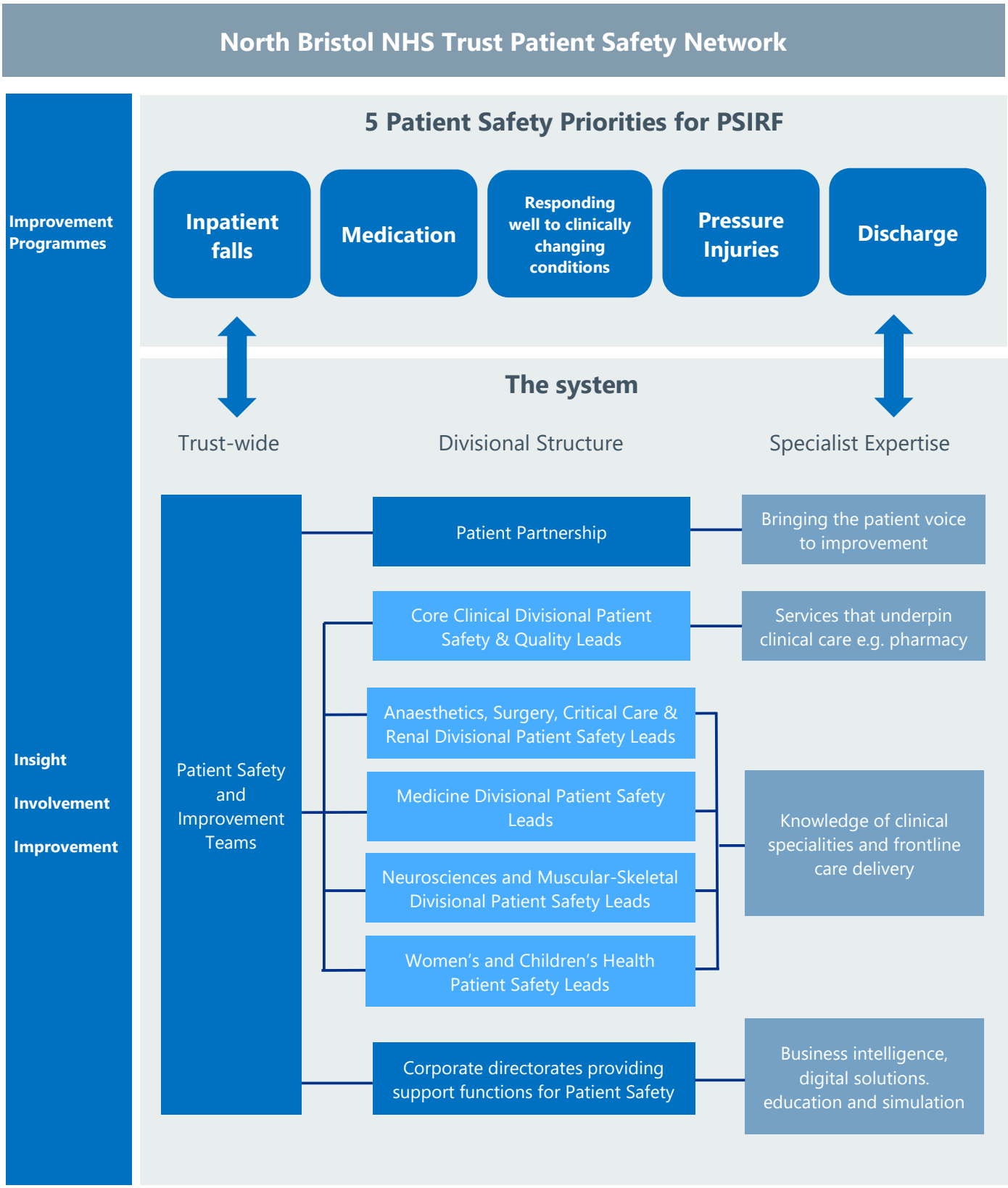
- NHS Patient Safety Strategy
- Patient Safety Programme
- Patient Safety Culture
- Patient Safety Incident Response Framework
- Patient Safety Partners involvement
- Risk Management
- Clinically Challenging Behaviours
- Central Alert System (CAS)
- Supporting improvement programmes

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

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

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

System overview – our networks



15.1

Situational Analysis of Patient Safety Activity

In the last three years, more than 36,000 patient safety incidents have been reported in NBT with <0.4% of these being investigated as a Serious Incident as per the Serious Incident Framework.

A large portion of the work our Divisional Quality Governance colleagues undertake in is serious incident investigations. These can be a very time-consuming process.

Arguably, there is a disproportionate amount of time spent on carrying out serious incident investigations, significantly limiting time to learn thematically from the other 99.6% of patient safety incidents. In short, the burden of effort is placed on fewer than 0.4% of all patient safety incidents.

A significant risk to successfully implementing PSIRF is continuing to investigate as many things as possible within Serious Incident Framework but simply calling them something else.

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

The patient safety PSIRF related activity undertaken prior to PSIRF can be broken down as follows:

Patient Safety Activities	Activity	Definition	Av. of prev. 2 financial years	Last financial year
National Priority	Incident resulting in death	Serious incident requiring investigation which met the standard investigation timeframe and resulted in patient's death.	8	9
	Never Events	Incident meeting criteria for never events framework and reported to STEIS as a SIRI	3	1
Local Patient Safety Activity	Serious Incident Requiring Investigation (SIRI)	Serious incident requiring investigation (SIRI) which met the standard investigation timeframe.	59	44
	Patient Safety Incident reviews	Including moderate harm incidents meeting the requirement for Statutory Duty of candour, not meeting SIRI criteria	839	1217
	Patient Safety Incident Validation	Patient safety incidents of low/no harm requiring validation at department/ward level.	11582	13584

Thematic analysis and our ongoing patient safety risks

We used a thematic analysis approach to determine which areas of patient safety activity we focussed on to conduct a thematic analysis, to identify our patient safety priorities.

Our analysis used additional sources of patient safety insights, beyond that of incidents which resulted in severe harm or death. The initial thematic review looked at patient safety activity between April 2017 and September 2020.

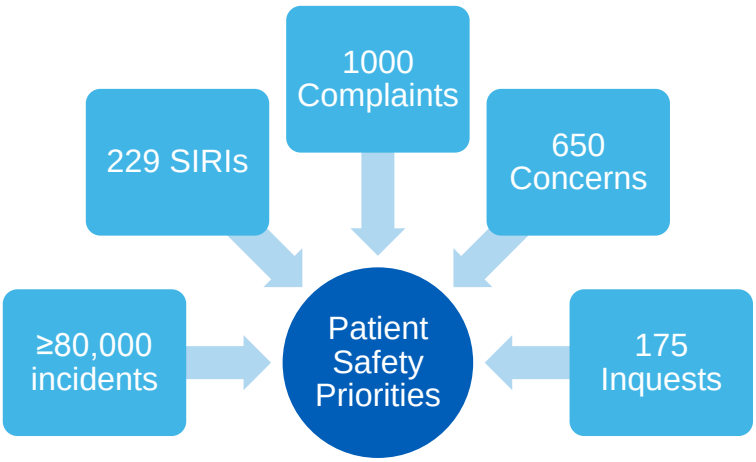
The priorities identified throughout this analysis validate what has been seen throughout patient safety incident reporting for many years. As locally defined priorities, PSIRF allows us to focus on these risks with our framework for patient safety incident response.

NBT began seeing an increase in admissions of patients with Covid-19 from October 2020 following the second wave of the pandemic. The incident data for October 2020 to March 2021 was reviewed in addition to ensure that there were no new emergent risks because of the pandemic.

We have developed patient safety recommendations overleaf which are based on both the original thematic analysis and the updated incident review.

Sources of insights from this analysis included:

1. Serious Incidents Requiring Investigation (SIRI)s. Including Falls and Pressure Injuries.
2. Patient Safety Incidents reported including all no, low or moderate harm incidents.
3. Trust level risks relating to patient safety
4. Outcome of Inquests
5. Complaints and concerns received relating to clinical care and treatment.



Our Patient Safety Priorities

Through our analysis of our patient safety insights, based on both the original thematic analysis and the updated incident review, we have determined 5 patient safety priorities we will focus on for the next two years.

These patient safety priorities form the foundation for how we will decide to conduct Patient Safety Incident Investigation (PSII) and patient safety reviews.

The patient safety priorities were agreed at the Quality and Risk Management Committee in March 2021.

Theme	Key Theme	Key Risks from Activity
1	Inpatient Fall	Patient falls were the most reported patient safety incident category, with a rate increase per 1,000 bed days seen in wave 2 of the pandemic. They are the most reported SIRI. Falls is noted as a trust level risk, is a theme in the outcome of inquests and is noted within the nursing care theme emerging from complaints and concerns.
2	Medication	Medication was indicated as a theme through the SIRI review. Medication is the second most reported patient safety incident and an increase in medication errors was noted in wave 2 of the pandemic. Complaints and concerns indicated that medication and pain management is a patient safety theme. Medication management is noted on the risk register.
3	Responding well to clinically changing conditions	The SIRI review indicated two related themes of clinical review/recognising deterioration as well as treatment/diagnosis. The combined incident category of treatment and clinical review highlighted the risk area of review/recognising clinical condition. Two inquest outcomes noted areas for improvement in responding to deterioration. Complaints and concerns highlighted risks in treatment and care planning, delayed treatment and treatment complications.
4	Pressure Injury	Pressure injuries are one of the top 5 patient safety incidents and an increase was seen in the first wave of the pandemic. Pressure injuries are a noted theme of SIRIs. They were also noted within the nursing care theme emerging from complaints and concerns.
5	Discharge	The combined category of service provision and admission highlighted the risk area of discharge. Issues with discharge also emerged as a risk area from complaints and concerns.

How we will respond to patient safety incidents

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

At the onset, we will use existing structures to support the process of decision making. There is an established weekly meeting with the Director of Nursing and Quality and Medical Director, in which potential serious incidents and other emerging patient safety issues are discussed. This meeting is presently called the Executive Incident Review Group (EIRG) – for PSIRF, we will slightly change the name and purpose, calling it the Executive Incident Response Group.

Our medium to longer term aim is to support each Division across the Trust to establish their own convening authority. We envisage this being in place by PSIRF year 2.

As we transition into PSIRF, the Patient Safety team will continue to work closely with the Divisional Quality Governance teams to review and identify incidents that may require a patient safety incident investigation. In PSIRF, the approach of ≥severe harm will no longer apply, and we will be guided by the national and local patient safety priorities.

The process will be described in detail in the associate policies, particularly in new policies that describe Patient Safety Incident Investigations, Patient Safety Incident Responses and involving patients in discussions about incidents, learning and improvement.

Core to deciding what to investigate was the situational analysis. The analysis identified five Patient Safety Priority incident categories that learning will be structured against over the first stage (2 years) of PSIRF.

National guidance recommends that 3-6 investigations per priority are conducted per year. When combined with patient safety incident investigations from the national priorities this will likely result in 20-25 investigations per year. Attempting to do more than this will impede our ability to adopt a systems-based learning approach from thematic analysis and learning from excellence.

Patient Safety incidents that must be investigated under PSIRF

1. Patient safety incident is a Never Event
2. Deaths more likely than not due to problems in care. This can be identified through an incident and/or the learning from deaths process.
3. National priorities for investigations (at the time of developing this plan, there are none apart from those already listed above. We will include any new priorities as they emerge).

Patient safety incidents are events where a patient experienced or could have experienced harm during an encounter with healthcare. An incident is the system showing us symptoms that something is wrong with it.

15.1

How we will respond to patient safety incidents

Apart from the "must investigate" points above, the decision to carry out a patient safety incident investigation should be based on the following:

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

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

Incidents that meet the Statutory Duty of Candour thresholds:

There is no legal duty to investigate a patient safety incident. Once an incident that meets the Statutory Duty of Candour threshold has been identified, the legal duty, as described in Regulation 20 says we must:

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

Patient safety incidents that have resulted in severe harm:

These incidents would have automatically been a serious incident under the Serious Incident Framework. It is crucial that these incidents are not routinely investigated using the PSII process, otherwise we will be recreating the Serious Incident Framework.

The routine response to an incident that results in severe harm will be to follow the Statutory Duty of Candour requirements. This will both provide insights to thematic learning and provide information about the events to share with those involved.

How we will respond to patient safety incidents

Patient Safety Event Occurs

Patient Safety Incident Investigations

Patient Safety Review

	Event	Approach	Improvement
National Priorities	Incidents meeting each baby counts criteria	Referred to Healthcare Safety Investigation Branch (HSIB)	Respond to recommendations from external referred agency/organisation as required.
	Incidents meeting maternal death criteria		
	Child death	Initiate child death review process	
	Death of person with learning disabilities	Reported and reviewed by Learning Disabilities Mortality Review (LeDeR)	
	Safeguarding incidents meeting criteria	Reported to NBT's named safeguarding lead	
	Incidents in screening programmes	Reported to Public Health England (PHE)	
	Death of patients in custody/prison/probation	Reported to Prison and Probation Ombudsman (PPO)	
	Incidents meeting the Never Event criteria	Patient Safety Incident Investigation	Create local organisational recommendations and actions.
	Incidents resulting in death		
Trust Priorities	Patient Safety Priority Index Case: • Patient Falls • Medication • Responding well to clinically changing condition • Pressure Injuries • Discharge Emergent area of risk	Patient Safety Incident Investigation where agreed (detail provided in NBT policies)	Create local organisational recommendations and actions feeding into patient safety priorities improvement programmes.
Local Level	Incident resulting in moderate or severe harm to patient	Statutory duty of candour and timeline chronology	Inform thematic analysis of ongoing patient safety risks.
	No/Low Harm Patient Safety Incident	Validation of facts at local level – thematic analysis	

15.1

Patient Safety Incident Investigations

Patient safety investigations are conducted to identify the circumstances and systemic, interconnected causal factors that result in patient safety incidents.

Investigations analyse the system in which we work by collecting and analysing evidence, to identify systems-based contributory factors.

Safety recommendations are created from this evidence-based analysis, to target systems-based improvement.

NBT moved away from using Root Cause Analysis (RCA) as the recognised tool to investigate in Winter 2019. We were informed by and aligned to the approach taken by the Healthcare Safety Investigation Branch (HSIB). Since then, we have developed and fine-tuned a systems-based investigation tool. We have seen an improvement in the systems-thinking approach to these investigations.

We no longer search for a single root cause; we look at the different events that occurred leading up to the incident and analyse the possible causes. This has supported us in looking at the system and not the people as individuals who work within it.

2021 saw the first group of staff join a week-long healthcare incident investigation training course provided by Cranfield University & Baby Lifeline in preparation for us going live with PSIRF.

This course included theory and simulation training and was attended by all Divisions, as well as the Patient Safety Team, who have now been equipped with knowledge and tools to support high quality investigations at the Trust.

To provide detailed guidance, we will approve a new policy framework in the June 2021 Patient Safety and Clinical Risk Committee to support this Plan in practice.

Involvement of patients, families and carers following incidents

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

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

As part of our new policy framework, we are developing a Speaking with Patients and Family policy to support staff in how to discuss incidents with patients and family.

The patient voice is very much an integral part of our work at NBT; we share below insights from the Chair of our Patient Partnership Group, to explain our vision for PSIRP.

"

The importance of the involvement of the patient and families in any incident/investigation into their treatment and care cannot be underestimated. It is a recognised National Standard and NBT has had it at its heart for many years.

The patient and family voice is vital for both hospital learning from incidents and for putting actions in place to prevent them in the future. It is also key in finding closure, aiding recovery and healing of those involved in the incident together with their families.

The strongest of people cannot appreciate the impact of going from living as normal a life as they do to that of putting on a hospital gown and receiving hospital care whilst in a hospital bed. Unless this has been a lived experience, it is almost impossible to understand how that feels, the vulnerability and lacking control of one's life.

This is why it is of huge importance to involve past and present patients together with carers, in order to give them a voice within hospital trusts at the highest level participating in committees etc., to assure patients and families that independent oversight is in place, whilst being a critical but constructive friend.

NBT has been ahead of the game in this regard for well over 15 years and as Chair of the Patient Partnership Group I am honoured to work with such dedicated staff who strive to involve and support patients and families in the investigation process and to effect change to improve safety, care and treatment.

"

Christine Fowler
Chair, NBT Patient Partnership

Involvement and support for staff following incidents

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

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

We recognise that many staff will be involved with a patient safety incident at some point in their careers and this can be a traumatic experience. We have a wealth of excellent psychological wellbeing support for all staff. This includes, but is not limited to:

ACT for Wellbeing: self-care, team care courses
Tailored support and consultation for teams
Support for Managers and Me +MyTeam Sessions
OurSpace – facilitated spaces for sharing, listening and doing what matters
Work-based incidents and TriM peer-support network

*"**Accountability** can mean letting people tell their account, their story."* - Sidney Dekker

PSII is not the only tool we will use to respond to incidents. Our Responding to Incidents policy will describe other ways staff can respond to incidents. This will detail both how to respond to incidents thematically, but also how to respond to individual incidents.

We have outlined several ways we can respond to individual incidents, including:

Debrief: An unstructured, moderated discussion.
Safety huddle proactive: A planned team gathering to regroup, seek advice, talk about the day.
Safety huddle reactive: Triggered by an event to assess what can be learned.
After action review: A structured facilitated debrief.

Roles and responsibility in the new system

North Bristol NHS Trust is a complex system and has been building a comprehensive patient safety network. The governance structures at the Trust were considered earlier in this plan, so here we outline the following core meetings and committees which represent our trust-wide approach to bringing NBT together as a system which will support the implementation and progression of PSIRF.

The **Trust Management Team** oversees the delivery of clinical services, informed by the outcomes from review meetings between Clinical Divisions and the Executive Team.

The **Patient Safety and Clinical Risk Committee** is chaired by an Executive Director, the Director for Nursing & Quality. This monthly meeting will have oversight, review and act as the approval mechanism for risks, PSII and other types of patient safety reviews.

Progress of PSII, risk and other types of patient safety reviews will be supported by **Patient Safety Group**. Safety recommendations from PSII approved by Patient Safety Committee will be reviewed through Patient Safety Group in support of the five patient safety priority improvement programmes.

The **Patient & Carer Experience Board Sub-Committee** chaired by a Non-Executive Director supports the Board oversight in this area.

The **Quality and Risk Management Committee (Board Sub-Committee)** with a Non-Executive Director chair scrutinises quality information and that provided through sub-committees on the quality of care provided.

The **Trust Board** seeks assurance that high quality services are being delivered. Through its sub-committees and presentation of data within the monthly Integrated Performance Report.

North Bristol NHS Trust

Yearning for a new way will not produce it. Only ending the old way can do that.

You cannot hold onto the old, all the while declaring that you want something new.

The old will defy the new;
The old will deny the new;
The old will decry the new.

There is only one way to bring in the new. You must make room for it.

- Neale Donald Walsch

Report To:	Trust Board Meeting			
Date of Meeting:	27 May 2021			
Report Title:	Audit Committee Report			
Report Author & Job Title	Kate Debley, Deputy Trust Secretary			
Executive/Non-executive Sponsor (presenting)	Richard Gaunt, Chair of Audit Committee, Non-Executive Director			
Purpose:	**Approval/Decision**	**Review**	**To Receive for Assurance**	**To Receive for Information**
	X		**X**	
Recommendation:	The Trust Board is recommended to receive the report for assurance and to ratify the revised Audit Committee Terms of Reference at appendix 1.			
Report History:	The report is a standing item to each Trust Board meeting following an Audit Committee meeting.			
Next Steps:	The next report to Trust Board will be to its meeting in July 2021.			

Executive Summary	
The report provides assurances received, issues escalated to the Trust Board and any new risks identified from the Audit Committee Meeting held on 6 May 2021.	
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 out 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 **4. An anchor in our community** a. Create a health & accessible environment b. Expand charitable support & network of volunteers c. Developing in a sustainable way
Board Assurance Framework/Trust Risk Register Links	None identified.
Other Standard Reference	Links to the CQC Well Led domain and key lines of enquiry.
Financial implications	None within this report.
Other Resource Implications	No other resource implications associated with this report.
Legal Implications including Equality, Diversity and Inclusion Assessment	None identified.
Appendices:	Appendix 1 – Revised Terms of Reference

1. Purpose

To provide a highlight of the key assurances, escalations to the Board and identification of any new risks from the Audit Committee meeting held on 6 May 2021.

2. Background

2.1. The Audit Committee is a sub-committee of the Trust Board. It meets five times a year and reports to the Board after each meeting. The Committee was established to receive assurance on the Trust's system of internal control by means of independent review of financial and corporate governance, risk management across the whole of the Trust's activities and compliance with law, guidance and regulations governing the NHS.

3. Meeting of 6 May 2021

3.1. External Audit Plan
The Committee noted the Trust and Charity Fund Audit Plans.

The Committee heard that there will be a revised approach to the Value for Money audit this year, involving three main changes:

- A new set of key criteria, covering financial sustainability, governance and improvements in economy and effectiveness.
- More extensive reporting, with a requirement on the auditor to produce a commentary on arrangements across all of the key criteria, rather than the current 'reporting by exception' approach.
- The replacement of the binary approach to Value for Money conclusions with more sophisticated judgements on performance, as well as key recommendations on any significant weaknesses in arrangements identified during the audit.

The Committee noted concern in relation to the timescales for the Trust to gather a comprehensive body of evidence for a narrative assessment. The Committee asked that external auditors provide as much notice as possible for any requests for evidence.

3.2. Internal Audit Update:
The Committee received a progress report and technical update from the internal audit team. The Committee noted that the 20/21 programme had now concluded and the 21/22 plan commenced.

3.3. The Committee noted concern that of the 10 overdue recommendations, deadlines for a number of these have been extended by a considerable timescale. It was agreed that this issue should be flagged with the Executive Team with a view to keeping this to a 12 month maximum.

3.4. The following internal audit reports were received and reviewed by the Committee:

- Risk Management
  The Committee received a positive report on Risk Management, with a rating of significant assurance with minor improvement opportunities.

- HR Case Management
  The Committee received a report on HR Case Management, with a rating of partial assurance with improvements required. It was noted that the key driver for the rating was that, due to operational pressures, the use of the Case Tracker System has not yet been made mandatory, and understanding and compliance is therefore low. The Committee noted that the Report and Recommendations would be reviewed by People Committee.

- Data Quality
  The Committee received a positive report on Data Quality with a rating of significant assurance with minor improvement opportunities.

- Recruitment and Retention
  The Committee received a positive report on Recruitment and Retention with a rating of significant assurance with minor improvement opportunities. The Committee noted that this Report would be reviewed by the People Committee.

- DSP Toolkit
  The Committee received a positive report on the Data Security and Protection Toolkit with a rating of significant assurance with minor improvement opportunities.

3.5. 2020/21 Internal Audit Annual Report and Head of Internal Audit Opinion
The Committee received a 2020/21 Internal Audit Annual Report and Head of Internal Audit Opinion of significant assurance with minor improvements required. Weaknesses identified by the Report were that core financial controls require improvement based on an amber/red rated report and a prior year high priority recommendation remaining overdue in 2020/21. In relation to these findings, the Committee were reassured by mitigations outlined by the Chief Financial Officer and noted his view that the findings reflect a point in time and that the position has subsequently improved. It was agreed that revised wording would be agreed between Internal Audit and the Trust in order to provide additional context within the Report.

3.6. Draft Counter Fraud Plan
The Committee received the draft Counter Fraud Plan for 2021/22 and noted the areas of focus for the year ahead as (i) patient expenses (ii) procurement and contract management and (iii) declarations of interest and gifts and hospitality (as mandated by the Counter Fraud Authority).

3.7. Junior Doctors Contract Dispute Settlement
A Report was received on the settlement of a claim from five junior doctors that the Trust had been in breach of contract in line with a 2019 Court of Appeal case *Hallett / BMA -v- Derbyshire Hospitals*. The Committee were assured that legal advice had been sought and noted that a recommendation had been made to settle the claim out of Court.

3.8. Local Clinical Excellence Awards
The Committee received a Report setting out the findings of an investigation into the circumstances surrounding an overpayment of Local Clinical Excellence Awards (LCEA) monies to members of the Trust's Consultant Body in 2020/21. It was noted that this issue would be flagged as a significant control issue in the Trust's Annual Governance Statement.

The Committee received a further Report setting out detailed responses against each of the recommendations in the Investigation Report and were assured that all recommendations have either now been met or are in progress.

3.9. Draft Annual Governance Statement
The Committee reviewed the draft Annual Governance Statement and noted this would continue to be developed, with a final draft to be presented to Trust Board at its May meeting. The final document would be approved by Audit Committee together with the Trust's Accounts on 24 June 2021, prior to submission.

3.10. Accounting Policies and Estimates
The Committee received a Report on Accounting Policies and Estimates setting out the processes followed by the Trust and the Charity for developing estimates and noted the approaches taken in accordance with the updated ISA 540.

The Committee approved the Accounting Policies applicable to the 2020/21 Annual Financial Statements and noted the approach taken to develop estimates for the 2020/21 Annual Accounts.

3.11. Single Tender Actions
The Committee received an update from the Director of Procurement on Single Tender Action (STA) performance for the period January to March 2021. The Committee focussed its discussion on 'Maverick buying' and noted that work is ongoing to reduce this, including contact with initiators to remind them of obligations under the Trust's Standing Financial Instructions and provision of training to support compliant procurement in future.

3.12. Terms of Reference Review
The Committee agreed minor updates to the Audit Committee and Auditor Panel Terms of Reference as set out as track changes at Appendix 1. Trust Board is asked to ratify these amendments.

3.13. Updates were also received on external agency visits and declarations of interest.

4. New risks or items for escalation

4.1. No new risks were identified for Trust Board attention.

5. Recommendations

5.1. The Trust Board is recommended to receive the report for assurance and to ratify the revised terms of reference as set out at Appendix 1.

Audit Committee Terms of Reference

Date Approved	~~28th March 2019~~
Frequency Review	Annual
Next Review	~~October 2019~~ April 2022
Terms of Reference Drafting	Trust Secretary
Review	Audit Committee ~~16/10/2018~~06/05/2021
Approval	Trust Board
Version Number	1.2~~1~~

1. Constitution

1.1. The Trust Board hereby resolves to establish a committee of the Board to be known as the Audit Committee ("the Committee").

1.2. The Committee is a non-executive committee of the Trust Board and has no executive powers, other than those specifically delegated in these terms of reference.

1.3. The terms of reference can only be amended with the ratification of the Trust Board.

2. Authority

2.1. The Committee is authorised by the Trust Board to investigate any activity within its terms of reference. It is authorised to seek any information it requires from any employee and all employees are directed to co-operate with any request made by the Committee.

2.2 The Committee is authorised by the Trust Board to obtain outside legal or other independent professional advice and to secure the attendance of outsiders with relevant experience and expertise if it considers this necessary.

2.3 The Committee has ultimate responsibility for receiving assurance on the Trust's system of internal control by means of independent and objective review of financial and corporate governance, risk management across the whole of the Trust's activities (clinical and non-clinical), and compliance with law, guidance and regulations governing the NHS.

3. Membership

3.1 The Committee will be appointed by the Trust Board from amongst the non-executive directors of the Trust and shall consist of not less than three members. One of the members will be appointed Chair of the Committee by the Trust Board.

3.2 At least one of the members of the Committee will have recent and relevant financial experience.

3.3 The Chair of the Trust will not be a member of the Committee.

4. Attendance at Meetings

4.1 On invitation from the Chair of the Committee, meetings will normally be attended by the:

- ~~Director of Finance~~Chief Financial Officer
- Assistant Director of Finance (Financial Services)
- Director of Corporate Governance/Trust Secretary
- Deputy Trust Secretary
- Head of Internal Audit
- Senior management representatives from the appointed external auditors
- Counter Fraud Specialist

4.2 The Accountable Officer should be invited to attend meetings and should discuss at least annually with the Committee the process for assurance that supports the annual governance statement. The Accountable Officer should also attend when the Committee considers the draft annual governance statement and the annual report and accounts.

4.3 Other executive directors/managers should be invited to attend, particularly when the Committee is discussing areas of risk or operation that are the responsibility of that director/manager.

4.4 Attendance at meetings is essential. In exceptional circumstances when an Executive Director cannot attend, they must arrange for a fully briefed deputy of sufficient seniority to attend on their behalf.

4.5 Representatives from other organisations and other individuals may be invited to attend on occasion.

4.6 The Trust Chair may be invited to attend meetings of the Committee in order that they can understand how the Committee works, but will have no voting rights.

4.7 The Head of Internal Audit, the representative of External Audit and the Counter Fraud Specialist have a right of direct access to the Chair of the Committee.

4.8 The Committee may ask any or all of those who normally attend but who are not members to withdraw to facilitate open and frank discussion of particular matters.

5. Quorum

5.1 The quorum necessary for the transaction of business shall be two Non-executive members. A duly convened meeting of the Committee at which a quorum is present shall be competent to exercise all or any of the authorities, powers and discretions invested in, or exercised by the Committee.

6. Frequency of Meetings and Conduct

6.1 The Committee will meet at least five times a year, timed in accordance with the discharge of its key responsibilities. The Chair may call additional meetings where these are deemed necessary.

6.2 The Trust Board, Accountable Officer, external auditors or head of internal audit may request an additional meeting if they consider that one is necessary.

6.3 At least once a year the Committee will meet privately with the external and internal auditors.

6.4 Agenda items should be submitted to the Corporate Governance Team ~~Office (Director of Corporate Governance/Trust Secretary and Deputy Trust Secretary)~~ at least eight working days before the meeting.

6.5 An agenda of items to be discussed and supporting papers will be sent to each committee member and person required to attend, by the Corporate Governance Team ~~Office (Director of Corporate Governance/Trust Secretary and Deputy Trust Secretary)~~ at least five working days before the meeting.

6.6 Terms of Reference can only be changed by the Committee and approved by the Trust Board.

7. Responsibilities

Integrated Governance, Risk Management and Internal Control

7.1 The Committee shall review the establishment and maintenance of an effective system of integrated governance, risk management and internal control, across the whole of the organisation's activities (clinical and non-clinical), that supports the achievement of the organisation's objectives.

7.2 In particular, the Committee will review the adequacy of:

- All risk and control related disclosure statements, in particular the Annual Governance Statement attached to the Annual Report and Accounts, together with any accompanying Head of Internal Audit Statement, external audit opinion or other appropriate independent assurances, prior to submission to the Trust Board.
- The underlying assurance processes that indicate the degree of the achievement of corporate objectives, the effectiveness of the management of principal risks and the appropriateness of the above disclosure statements.
- The policies for ensuring compliance with relevant regulatory, legal and code of conduct requirements and related reporting and self-certification
- The policies and procedures for all work related to counter fraud, bribery and corruption as set out in the NHS Standard Contract and as required by the NHS Counter Fraud Authority

7.3 In carrying out this work the Committee will primarily utilise the work of internal audit, external audit and other assurance functions, but will not be limited to these sources. It will also seek reports and assurances from directors and managers as appropriate, concentrating on the over-arching systems of integrated governance, risk management and internal control, together with indicators of their effectiveness.

7.4 This will be evidenced through the Committee's use of an effective assurance framework to guide its work and that of the audit and assurance functions that report to it.

7.5 As part of its integrated approach, the Committee will have effective relationships with other key committees - for example the ~~three~~ four other assurance committees of the Trust Board - (Finance and Performance, ~~Workforce~~ People, Charity ~~and the~~ Quality and Risk Management ~~Committee~~and Patient and Carer Experience

Committee) so that it understands processes and linkages. These other Committees must not usurp the Committee's role.

Internal Audit

7.7 The Committee will ensure that there is an effective internal audit function that meets the requirements of the *Public Sector Internal Audit Standards 2017* and provides appropriate independent assurance to the Committee, Accountable Officer and the Trust Board. This will be achieved by:

- Considering the provision of the internal audit service and the costs involved.
- Review and approving the annual internal audit plan and more detailed programme of work, ensuring that this is consistent with the audit needs of the Trust as identified in the assurance framework.
- Considering the major findings of internal audit work; and management's response to recommendations made.
- Ensuring co-ordination between the internal and external auditors to optimise the use of audit resources.
- Ensuring that the internal audit function is adequately resourced and has appropriate standing within the organisation.
- Carrying out an annual review of the effectiveness of internal audit.
- Regular monitoring of key performance metrics aligned to the delivery of the service.

External Audit

7.8 The Committee will review and monitor the external auditors' independence and objectivity and the effectiveness of the audit process. In particular, the Committee will review the work and findings of the external auditors and consider the implications and management's response to their work. This will be achieved through:

- Considering the appointment and performance of the external auditors, as far as the rules governing the appointment permit.
- Discussing and agreeing with the external auditors, before the audit commences, the nature and scope of the audit as set out in the annual plan.
- Discussing with the external auditors their evaluation of audit risks and assessment of the Trust and the impact on the audit fee.
- Reviewing all external audit reports, including the report to those charged with governance (before its submission to the Trust Board) and any work undertaken outside the annual audit plan, together with the appropriateness of management responses.
- Ensuring there is in place a clear policy for the engagement of external auditors to supply non-audit services.
- Regular monitoring of key performance metrics aligned to the delivery of the service.

Counter Fraud

7.9 The Committee will satisfy itself that the Trust has adequate arrangements in place for counter fraud, bribery and corruption that meet NHS Counter Fraud Authority's standards and will review the outcomes of work in these areas.

7.10 Specifically it will:

- Approve the Trust's Counter Fraud strategy and Local Counter Fraud Specialist annual work plan, including the resources allocated for the delivery of the strategy and work plan.
- Receive and review progress reports of the Local Counter Fraud Specialist against the four principles of the overall NHS Counter Fraud Strategy.
- Monitor the implementation of management actions arising from counter fraud reports.
- Receive and discuss reports arising from quality inspections by the counter fraud service.
- Make recommendations to the Trust Board as appropriate in respect of counter fraud at the Trust.
- Receive, review and approve the annual report of the Local Counter Fraud Specialist.

Other Assurance Functions

7.11 The Committee will review the findings of other significant assurance functions, both internal and external to the Trust; and consider the implications to the governance of the Trust.

7.12 These will include, but will not be limited to:

- Any reviews by Department of Health and Social Care arm's length bodies, or regulators and inspectors, - for example the Care Quality Commission, NHS Resolution etc.
- Professional bodies with responsibility for the performance of staff or functions – for example, Royal Colleges and accreditation bodies.

7.13 The Committee will review the work of other committees within the Trust, where their work can provide relevant assurance to the Audit Committee's own scope of work. In particular, this will include the ~~three~~ four other assurance committees of the Trust Board (Finance and Performance, ~~Workforce~~ People, Charity~~and the~~ Quality and Risk Management ~~Committee~~and Patient and Carer Experience Committee).

7.14 In reviewing the work of the Quality and Risk Management Committee, and issues around clinical risk management, the Audit Committee will wish to satisfy itself on the assurance that can be gained from the clinical audit function.

7.15 The Committee will review and make recommendations to the Trust Board for any changes to the Standing Orders, Standing Financial Instructions and Scheme of Delegation.

7.16 The Committee will examine the circumstances associated with each occasion when Standing Orders are waived.

Management

7.17 The Committee will request and review reports, evidence and assurances from directors and managers on the overall arrangements for governance, risk management and internal control.

7.18 The Committee may also request specific reports from individual functions within the Trust, for example, clinical audit, as may be appropriate to the understanding of the overall arrangements.

Financial Reporting

7.19 The Committee will monitor the integrity of the financial statements of the Trust and any formal announcements relating to the Trust's financial performance.

7.20 The Committee will ensure that the systems for financial reporting to the Trust Board, including those of budgetary control, are subject to review for completeness and accuracy of the information provided.

7.21 The Committee will review the Trust Annual Report and financial statements before submission to the Trust Board. It will focus on:

7.22 The wording in the Annual Governance Statement and other disclosures relevant to the terms of reference of the Committee.

7.23 Changes in, and compliance with, accounting policies, practices and estimation techniques.

7.24 Unadjusted misstatements in the financial statements.

7.25 Significant judgements in preparation of the financial statements.

7.26 Significant adjustments resulting from the audit.

7.27 Letters of Representation.

7.28 Explanations for significant variances.

8. Reporting

8.1 Minutes of the Committee's meetings will be formally recorded; and will be circulated to members of the Committee and others as necessary. The minutes will be circulated to the Chair for confirmation within 10 working days of the meeting and communicated to members as soon as the Chair has confirmed that he/she is content with them.

8.2 The Chair of the Committee will present a report to the next meeting of the Trust Board, summarising the key issues and will ensure that it draws to the attention of the Trust Board any issues that require disclosure to the Trust Board or require executive action.

8.3 The Committee will provide the Trust Board with an Annual Report, timed to support finalisation of the accounts and the Annual Governance Statement, summarising its conclusions from the work it has done during the year and including the following:

- The fitness for purpose of the Trust's assurance framework.
- The completeness and 'embeddedness' of risk management in the Trust.
- The integration of the governance arrangements.
- The appropriateness of the evidence that shows the organisation is fulfilling regulatory requirements relating to its existences as a functioning business.
- The robustness of the processes behind the quality accounts.
- A description of how the Committee has fulfilled its terms of reference.
- Give details of any significant issues that the Committee considered in relation to the financial statements and how they were addressed.

9. Monitoring and Effectiveness

9.1 In order to support the continual improvement of governance standards, the Committee will complete a self-assessment of effectiveness at least annually and will identify any matters where it considers that action on improvement is needed and will make recommendations as to the steps to be taken.

9.2 The Committee will review these terms of reference annually.

10. Administrative Support

10.1 The Committee will be supported administratively by the Corporate ~~Office~~ Governance Team ~~(Director of Corporate Governance/Trust Secretary and Deputy Trust Secretary)~~ whose duties in this respect will include:

- Provide timely notice of meetings.
- Agreement of agendas with the Chair and attendees.
- Preparation, collation and circulation of papers in good time.
- Ensuring that those invited to the meeting attend.
- Taking the minutes and helping the Chair to prepare reports to the Trust Board.
- Keeping a record of matters arising and issues to be carried forward.
- Advising the Committee on pertinent issues/areas of interest/policy developments.
- Ensuring that action points are taken forward between meetings.
- Ensuring that Committee members receive the development and training they need.

Auditor Panel Terms of Reference

Date Approved	~~28th March 2019~~
Frequency Review	Annual
Next Review	~~October 2019~~
Terms of Reference Drafting	Trust Secretary
Review	Audit Committee
Approval	Trust Board
Version Number	0.2~~1~~

1. Constitution

4.1. The Trust Board hereby resolves to nominate its Audit Committee to act as its auditor panel in line with schedule 4, paragraph 1 of the *Local Audit and Accountability Act 2014.*

4.2. The auditor panel is a non-executive committee of the Trust Board and has no executive powers, other than those specifically delegated in these terms of reference.

5. Authority

2.1 The auditor panel is authorised by the Trust Board to carry out the functions specified below and can seek any information it requires from any employees/relevant third parties. All employees are directed to co-operate with any request made by the auditor panel.

2.2 The auditor panel is authorised by the Trust Board to obtain outside legal or other independent professional advice – for example, procurement specialists, and to secure the attendance of outsiders with relevant experience and expertise if it considers this necessary. Any 'outsider advice' must be obtained in line with the organisation's existing rules.

6. Membership

3.1 The auditor panel will comprise the entire membership of the audit committee with no additional appointees. This means that all members of the auditor panel are independent non-executive directors.

3.2 The Chair of the audit committee will be appointed Chair of the auditor panel by the Trust Board.

3.3 The Chair of the Trust will not be a member of the auditor panel.

3.4 The auditor panel Chair and/or members of the panel can be removed in line with rules agreed by the Trust Board.

7. Attendance at Meetings

4.1 The auditor panel's Chair may invite executive directors and others to attend depending on the requirement of each meeting's agenda. These invitees are not members of the auditor panel.

5. Quorum

5.1 To be quorate, independent members of the auditor panel must be in the majority AND there must be at least two independent members present or 50% of the auditor panel's total membership, whichever is the highest.

6. Frequency of Meetings and Conduct

6.1 The auditor panel will consider the frequency and timing of meetings needed to allow it to discharge its responsibilities but as a general rule will meet on the same day as the audit committee.

6.2 Auditor panel business will be identified clearly and separately on the agenda and audit committee members will deal with these matters as auditor panel members NOT as audit committee members.

6.3 The panel's Chair shall formally state at the start of each meeting that the auditor panel is meeting in that capacity and NOT as the audit committee.

7. Conflicts of Interest

7.1 Conflicts of interest must be declared and recorded at the start of each meeting of the auditor panel.

7.2 A register of panel members' interests must be maintained by the panel's Chair and submitted to the Trust Board in accordance with the Trust's existing conflicts of interest policy.

7.3 If a conflict of interest arises, the Chair may require the affected panel member to withdraw at the relevant discussion or voting point.

8. Functions

The auditor panel's functions are to:

8.1 Advise the Trust Board on the selection and appointment of the external auditor. This includes:

- Agreeing and overseeing a robust process for electing the external auditors in line with the organisation's normal procurement rules.
- Making a recommendation to the Trust Board as to who should be appointed.
- Ensuring that any conflicts of interest are dealt with effectively.

8.2 Advise the Trust Board on the maintenance of an independent relationship with the appointed auditor.

8.3 Advise (if asked) the Trust Board on whether or not any proposal form the external auditor to enter into a liability limitation agreement as part of the procurement process is fair and reasonable.

8.4 Advise on (and approve) the contents of the Trust's policy on the purchase of non-audit services from the appointed external auditor.

8.5 Advise the Trust Board on any decision about the removal or resignation of the external auditor.

9. Reporting

9.1 The Chair of the auditor panel must report to the Trust Board on how the auditor panel discharges its responsibilities.

9.2 The minutes of the panel's meetings must be formally recorded and submitted to the Trust Board by the panel's Chair. The Chair of the auditor panel must draw to the attention of the Trust Board any issues that require disclosure to the full Trust Board or which require executive action.

10. Administrative Support

10.1 The Committee will be supported administratively by the Corporate Governance Team ~~Office (Director of Corporate Governance/Trust Secretary and Deputy Trust Secretary)~~ whose duties in this respect will include:

- Provide timely notice of meetings.
- Agreement of agendas with the Chair.
- Preparation, collation and circulation of papers in good time.
- Ensuring that those invited to the meeting attend.
- Taking the minutes and helping the Chair to prepare reports to the Trust Board.
- Keeping a record of matters arising and issues to be carried forward.
- Advising the Committee on pertinent issues/areas of interest/policy developments.
- Arranging meetings for the Chair.
- Ensuring that panel members receive the development and training they need.
- Providing appropriate support to the Chair and panel members.

12. Monitoring Effectiveness

12.1 The terms of reference will be reviewed on an annual basis.

North Bristol NHS Trust

Report To:	Trust Board		
Date of Meeting:	27 May 2020		
Report Title:	Board Assurance Framework Report		
Report Author & Job Title	Xavier Bell, Director of Corporate Governance		
Executive/Non-executive Sponsor (presenting)	Xavier Bell, Director of Corporate Governance		
Does the paper contain:	**Patient identifiable information?**	**Staff identifiable information?**	**Commercially sensitive information?**
*If any boxes above ticked, paper may need to be received at *private* meeting			
Purpose:	**Approval**	**Discussion**	**To Receive for Information**
		X	
Recommendation:	That the Board: • **Review and discuss** the Board Assurance Framework • **Approve** the revised risk ratings for COV2 (Covid-19 Pandemic) • **Note** the updates to various actions		
Report History:	Presented quarterly		
Next Steps:	Ongoing monitoring of BAF risks and actions.		

Executive Summary

Board Assurance Framework:

The Board Assurance Framework (BAF) enables the Board to:

- review key risks aligned to strategic objectives/themes;
- ensure that there are sufficient controls in place to manage these risks to delivery; and
- to understand the assurance there is on the effectiveness of these controls.

This report reflects the strategic themes approved by the Board in the Trust's Five-year Strategy 2019-2024. Relevant risks have been reviewed by the responsible committees, with updates reported to Trust Board throughout the last quarter.

Key changes since March 2021:

COV2 – Covid-19 Pandemic:
The risk score for this risk has been reduced from 4x4=16 to 3x4=12 to reflect the reduced prevalence of Covid-19 in the community and of Covid-19 patients in the hospital. This aligns the risk score with the target risk score. It is recommended that this risk remain on the BAF

until such time as the Mass Vaccination Programme is further progressed and there is further information/guidance on the easing of the national lockdown.
SIR15 – Cyber Security: The relevance of this risk has been reinforced with the recent news that the Irish Health Service Executive and Department of Health were targeted with significant cyberattacks over the weekend (15-16 May 2021), shutting down much of their infrastructure. This BAF risk has been updated to show that key actions have now been delivered, providing further controls, and a new action relating to cyber security insurance has also been added. After discussion with Director of IM&T and relevant experts within the directorate, the recommendation is that the risk score remain at 3x5=15, and that the target risk be amended to 3x4=12. This reflects the fact that cyber is such a big attack and impact vector and has a major impact even in organisations that are protecting themselves and have backup regimes.
SIR10 – Capital Funding: An additional gap and associated action has been added to this risk, which acknowledges that the emerging ICS will have a greater involvement in capital funding allocation and approval moving forward.

Strategic Theme/Corporate Objective Links	**1. Provider of high-quality patient care** **2. Developing Healthcare for the future** **3. Employer of choice** **4. An anchor in our community**
Board Assurance Framework/Trust Risk Register Links	The Board Assurance Framework captures strategic risks identified at Board level and updated quarterly.
Other Standards Reference	The Board Assurance Framework captures strategic risks identified at Board level and updated quarterly.
Financial implications	N/A
Other Resource Implications	Risks relating to financial areas are incorporated in routine risk management reports. The costs of risk management processes are not separately captured.
Legal Implications	N/A
Equality, Diversity and Inclusion Assessment (EIA)	N/A
Appendices:	Appendix 1: Board Assurance Framework – May 2021

Board Assurance Framework (BAF)

Introduction

The following document is the Trust's Board Assurance Framework (BAF) for 2021/22. The Board Assurance Framework defines and assesses the principle strategic risks to the Trust's objectives. It provides the Trust Board with assurance that those risks are being proactively managed and mitigated.

The BAF is designed to provide the Trust Board with a simple but comprehensive method for the effective and focussed management of principal risks to its strategic and business objectives. The Board defines the principal risks and ensures that each is assigned to a lead director as well as to a lead committee:

- The lead director is responsible for assessing any principal risks assigned to them by the Board and for providing assurance as to the effectiveness of primary risk controls to the lead committee;
- The role of the lead committee is to review the lead director's assessment of their principal risks, consider the range of assurances received as to the effectiveness of primary risk controls, and to recommend to the lead director any changes to the BAF to ensure that it continues to reflect the extent of risk exposure at that time;
- The Audit Committee is responsible for providing assurance to the Trust Board that the BAF continues to be an effective component of the Trust's control and assurance environment;
- The Trust Board reviews the whole BAF on a quarterly basis to ensure that the principal risks are appropriately rated and are being effectively managed; and to consider the inclusion within the BAF of additional risks that are of strategic significance.

A guide to the criteria used to grade all risks within the Trust is provided in Appendix A.

Trust Strategic & Business Plan Objectives:

Strategic Theme:	Aligned BAF Risk:
1. Provider of high quality patient care	SIR1 COV2 SIR8 SIR14 SIR15
2. Developing Healthcare for the future	COV2 SIR10 SER4

RESPONSIBLE COMMITTEES/BOARDS:

Finance & Performance Committee
- SIR1 (with QRMC)
- SIR8
- SIR10 (with P&DC)
- SIR16
- SIR15
- SER4

People Committee
- SIR2

Quality & Risk Management Committee
- SIR1 (with F&PC)
- COV1
- SIR14

NHS North Bristol NHS Trust

Board Assurance Framework (BAF)

3. Employer of choice	**COV2 SIR2 SIR8 SIR14 SER4**
4. An anchor in our community	**COV2 SIR8 SIR10 SIR16**

Version Control:

Version:	Summary of changes:	Reported to:
V1	Approved by Trust Board 26/02/2020	Trust Board 26/02/2020
V2	All risks updated in May 2020, two new Covid-19 risks proposed, plus climate change risk added	Trust Board 28/05/2020
V3	Covid-19 risk scores reduced	QRMC 16/06/2020
V4	Covid-19 risk score (Cov-1) increased following discussion at QRMC	To Trust Board August 2020
V5	BAF – alignment to strategy/business plan updated Actions across all risks updated. Risk ratings on SIR 1, SIR 2, COV1 and COV2 updated.	Extracts to F&P Committee (18/08/2020) and P&D Committee (19/08/2020) Full BAF to Trust Board 27/08/2020.
V6	Updates to SIR8 and SIR10	Extract to F&P Committee (20/10/2020)
V7	BAF redrafted, risks consolidated, and overall number reduced. Actions updated in January 2021	Relevant risks to QRMC (19/11/2020), People & Digital (9/12/2020), Finance & Performance (10/12/2020)
V8	BAF risks updated and actions updated Feb/March 2021	To Trust Board 25/03/2021 Extracts to F&PC 22/04/2021
V9	BAF risks updated and actions updated May 2021 Version 9.1 contains further updates from May 2021	To QRMC 11/05/2021 To Trust Board 27/05/2021

Board Assurance Framework (BAF)

Trust Strategic Theme:	Provider of high quality patient care Employer of choice		

Ref	Lead Director / Lead Committee	Principal risk:	Inherent risk score	Primary controls	Assurances	Residual risk score	Gaps in control or assurance	Planned actions *(including owner and delivery date)*	Target risk score
SIR 1	**Karen Brown, Chief Operating Officer** Last reviewed: 17/05/2021 **Finance & Performance Committee** **Quality & Risk Management Committee** Last reviewed: QRMC 11/05/2021	**Lack of effective demand management and community capacity, together with the increased acuity of patients (including Covid-19 patients) may result in a reduction in patient flow across the hospital.** **This affects the performance of the hospital against key operational performance and quality targets. In turn this:** - **affects patient experience;** - **leads to potential patient harm; and** - **affects the reputation of the Trust and of the NHS.** INTERNALLY & EXTERNALLY DRIVEN ELEMENTS	Inherent likelihood: **5 (Almost certain)** Inherent impact: **5 (Catastrophic)** Inherent risk rating: **25** **(Extreme)**	Internal: FLOW boards (real-time bed state) Right to Reside data Integrated Discharge Service Repatriation Policy Urgent Care Improvement Board (internal) Winter plan Escalation & COVID-19 surge policies/procedures COVID-19 Command & Control (Internal) Winter Plan 2020 (approved October 2020) External: COVID-19 Command & Control (External) Whole System Operational Group (WSOG – external) - over 21 day LoS Patients reviewed in detail Significant engagement in system forums (Whole System Operational Group, OOH Delivery Group) Discharge Programme Investment Re-launched internal Urgent Care Board action plan	**Internal Assurance** Integrated Performance Report Patient flow metrics – daily control centre information Executive Team weekly review of dashboards and ED quality metrics Performance report to Finance & Performance Committee Finance & Performance Committee deep-dives into operational performance QRMC Deep-dives into patient harm Divisional Performance Reviews **External Assurance** Urgent & Emergency Care Steering Group (external) System Delivery & Operational Group (external)	Residual likelihood: **4 (Likely)** Residual impact: **4 (severe)** Residual risk rating: **16** **(Severe)** Previous residual risk rating: **3x5=15 4x5=20** Residual risk rating last changed: **22/10/2020 09/03/2021** Forecast trajectory (next 12 months): ⇔	Planned care backlogs and waiting lists	The Trust is involved in the BNSSG Accelerator Programme (NBT SRO), bringing in additional resource and focused planning on the recovery of planned care across the system. Significant impact should be seen by end of July 2021 **Due Date: July/August 2021** **Owner: Chief Operating Officer**	Target likelihood: **3 (Possible)** Target impact: **4 (Severe)** Target risk rating: **12** **(High)**
								A "reset week" is being planned to support FLOW across the organisation including within the Emergency Department. This will utilise the Trust's PERFORM methodology with QI support. This will be linked to the Accelerator Programme for planned care. This will commence at the end of May 2021, and impact/success factors will be reviewed at the end of June. **Due Date: review end of June 2021** **Owner: Chief Operating Officer**	

NHS North Bristol NHS Trust

Board Assurance Framework (BAF)

Trust Strategic Theme:	Provider of high quality patient care Developing healthcare for the future Employer of choice Anchor in the community		

Ref	Lead Director / Lead Committee	Principal risk:	Inherent risk score	Primary controls	Assurances	Residual risk score	Gaps in control or assurance	Planned actions *(including owner and delivery date)*	Target risk score
COV 2	**Karen Brown, Chief Operating Officer** Last reviewed: 17/05/2021 **Quality & Risk Management Committee** Last reviewed: 11/05/2021	**The global COVID-19 pandemic and the specific local impacts as described via PHE/NHSEI modelling data has the potential to overwhelm the hospital. This would likely impact across several areas including:** - **Capacity to provide effective and safe care to COVID-19 and non-COVID-19 patients;** - **Reduction in staff numbers due to staff sickness, self-isolation, and shielding; and** - **Public confidence in the hospital and the NHS.** EXTERNALLY DRIVEN RISK	Inherent likelihood: **5 (Almost certain)** Inherent impact: **5 (Catastrophic)** Inherent risk rating: **25** **(Extreme)**	**Internal** COVID-19 Command and Control structures in NBT, including groups overseeing: - Data analytics - IPC - Workforce - PPE - Staff testing Development of new staffing model (mega-teams) Surge and super-surge plans for ICU and general acute capacity, testing and mortuary Increased capacity for remote working **External** Significant engagement in system and regional forums Engagement and leadership role in Severn Critical Care Network National lock-down/quarantine arrangements to "flatten the curve" System COVID-19 Command and Control structures National Vaccination Programme	**Internal Assurance** COVID-19 sit-rep NBT specific pandemic modelling COVID-19 reports to Trust Board and TMT (monthly) Integrated Performance Report **External Assurance** Regional and local specific pandemic modelling Reports and updates via local and regional forums	Residual likelihood: **3 (Possible)** Residual impact: **4 (Severe)** Residual risk rating: **12** **(High)** Previous residual risk rating: **3x4=12** **4x4=16** **5x5=25** Residual risk rating last changed: **17/05/2021** **09/03/2021** **15/01/2021** Forecast trajectory (next 12 months): 	The national lock-down has reduced the prevalence of Covid-19 within the community.	The Trust is maintaining a reduced schedule of command and control meetings (Gold/Silver/Bronze) to manage the ongoing Covid-19 impact on the hospital. This will remain under regular review. **Due Date: monthly review via Trust Board Covid-19 update** **Owner: Chief Operating Officer**	Target likelihood: **3 (Possible)** Target impact: **4 (Severe)** Target risk rating: **12** **(High)**

Board Assurance Framework (BAF)

Trust Strategic Theme:	Employer of choice		

Ref	Lead Director / Lead Committee	Principal risk:	Inherent risk score	Primary controls	Assurances	Residual risk score	Gaps in control or assurance	Planned actions *(including owner and delivery date)*	Target risk score
SIR 2	**Jacqui Marshall, Director of People & Transformation** Last reviewed: 17/05/2021 **People Committee** Last reviewed: Not yet reviewed: 08/03/2021	**National/system competition for workforce in key specialties/ professions, together with increasing demands on remaining staff plus post-Covid-19 fatigue could result in skills/capacity shortages within the Trust and increased instability in the workforce.** **Consequences would include** - **Increased reliance on expensive agency staff;** - **Higher turnover, which could result in dramatic increase in recruitment activity and associated costs.** INTERNALLY & EXTERNALLY DRIVEN RISK	Inherent likelihood: **4 (Likely)** Inherent impact: **5 (Catastrophic)** Inherent risk rating: **20** **(Extreme)**	BNSSG Workforce Strategy Nursing Workforce Group overseeing mitigating work Medical Workforce Group overseeing mitigation work Retention steering group & Pathfinder Programme Retention interventions (overseen by Retention steering group) Covid-19 Recovery & Restoration Programme Award-winning, nationally recognised Staff Health & Wellbeing offering Buying & selling annual leave policy Itchy feet campaign Flexible working offer expanded Strong development and leadership offer Increased opportunities through SLM Programme BNSSG workforce recovers cell in place from Feb 2021	**Internal Assurance** Integrated Performance Report – HR/Well-Led section People Committee deep-dives and performance review People Balanced Scorecard Staff survey results & action plans Voice Programme Happy App Exit interview data Pulse Surveys Freedom to Speak Up Report Recruitment & retention deep-dive – March 2021 People Committee meeting **External Assurance** Gender pay-gap report (2018) National Retention Data BNSSG development of EVP offer BNSSG integrated staff bank	Residual likelihood: **3 (Possible)** Residual impact: **4 (Severe)** Residual risk rating: **12** **(Extreme)** Previous residual risk rating: **4x4=16** Residual risk rating last changed: **12/08/2020** Forecast trajectory (next 12 months): ⇔	There is potential competition between providers within the BNSSG STP for the same staff, and there are identified differentials in grading between similar roles.	An STP-level career pathway review is underway, to create BNSSG as a "career destination" to reduce competition for staff within the system. There is ongoing work as part of Covid-19 response which feeds into this. EVP Programme development. **Due date: June 2021** **Owner: Director of People & Transformation**	Target likelihood: **2 (Unlikely)** Target impact: **3 (Moderate)** Target risk rating: **6** **(Moderate)**

NHS North Bristol NHS Trust

Board Assurance Framework (BAF)

Trust Strategic Theme:	Provider of high quality patient care Employer of choice An anchor in our local community		

Ref	Lead Director / Lead Committee	Principal risk:	Inherent risk score	Primary controls	Assurances	Residual risk score	Gaps in control or assurance	Planned actions *(including owner and delivery date)*	Target risk score
SIR 8	**Simon Wood, Director of Facilities** Last reviewed: 17/05/2021 **Finance & Performance Committee** Last reviewed: 22/04/2020	**A lack of investment in retained estate results in inappropriate spaces to deliver care, and estate which does not comply with relevant legislation. This may result in issues with staff retention, patient experience and complaints, compliance concerns and an impact on financial and operational sustainability** INTERNALLY DRIVEN RISK	Inherent likelihood: **4 (Likely)** Inherent impact: **5 (Catastrophic)** Inherent risk rating: **20** **(Extreme)**	Capital Planning Group & sub-structure Capital Plan and Estates Strategy/Masterplan approved 2020 Health & Safety Committee & policies Preventative Maintenance Programme 2019/20 and emerging 2020/21 capital programme Facilities help-desk (to advise on any deterioration of estate) Facilities Management walk-arounds/inspections Executive walk-arounds Expected capital programme slippage used as a contingency for unexpected works in the retained estate.	**Internal Assurance** Capital Planning reports to Finance & Performance Committee (twice-yearly) Health & Safety reports to People & Digital Committee (quarterly + annual report) ERIC Benchmarking confirms relative position to other Trusts (annual process) WACH – condition and H&S survey (2018) South Bristol Dialysis and Westgate House condition survey (2018) Fire risk audits undertaken regularly across the site. Six Facet Survey completed 2020 Estates Master Plan (August 2020) **External Assurance** Fire Safety Assurance Survey (Brunel - 2019)	Residual likelihood: **3 (Possible)** Residual impact: **4 (Severe)** Residual risk rating: **12** **(High)** Previous residual risk rating: **N/A** Residual risk rating last changed: **N/A** Forecast trajectory (next 12 months): ⇔	There is ongoing uncertainty around the financial framework and funding mechanism for the NHS long-term (post Covid-19). The Trust continues to ensure that there is regular capital investment in Critical Infrastructure towards compliant and appropriate clinical accommodation. However, this is limited by all other Trust-wide requirements therefore some programmes will be delivered over extended periods. It is assumed that major estates improvements will be specifically externally funded.	NBT is remaining engaged in system discussions to ensure that it is able to respond to changing national requirements. **Owner: Chief Executive** **Due Date: September 2021 (MOU finalisation)** The Trust Estates/Capital Team are progressing various significant schemes to "shovel ready" state, in anticipation of national funding calls becoming available. Elective Care Centre, W&C Estates and Accommodation Projects are specifically being progressed in this manner. Update to F&PC Planned for Q2 2021/22. **Owner: Director of Estates, Facilities & Capital Planning** **Due Date: Sept 2021**	Target likelihood: **2 (Unlikely)** Target impact: **4 (Severe)** Target risk rating: **8** **(High)**

Board Assurance Framework (BAF)

Trust Strategic Theme:	Developing Healthcare for the future An anchor in our local community		

Ref	Lead Director / Lead Committee	Principal risk:	Inherent risk score	Primary controls	Assurances	Residual risk score	Gaps in control or assurance	Planned actions *(including owner and delivery date)*	Target risk score
SIR 10	**Neil Darvill, Director of IM&T &** **Simon Wood, Director of Estates, Facilities and Capital** Last reviewed: 20/05/2021 **Finance & Performance Committee** Last reviewed: 22/04/2021	**The Trust has limited capital funding and many competing priorities for investment (as well as other non-capital cost pressures). The gradual move towards system involvement in capital prioritisation an approval adds an additional layer of complexity in capital planning.** **Lack of investment in appropriate technologies and infrastructure in a timely manner impacts the ability of the Trust to deliver:** - **operational targets** - **financial performance and** - **quality improvement.** INTERNALLY DRIVEN RISK	Inherent likelihood: **5 (Almost certain)** Inherent impact: **4 (Severe)** Inherent risk rating: **20** **(Extreme)**	Annual capital investment planning process, prioritised with divisional and executive input (aligned to strategy) OneNBT Digital Strategy and vision OneNBT Transformation Plan (5-year plan) National Digital Investment opportunities NBT Director of IM&T is system Digital lead, ensuring STP alignment Chief Clinical Information Officer & Chief Nursing Information Officer roles Clinical Digital Leads for key projects such as EPR	**Internal Assurance** People & Digital Committee oversight of OneNBT Digital Strategy delivery Capital Planning reports to Finance & Performance Committee (twice-yearly) OneNBT Transformation Plan governance structure (approved 2019) Six Facet Survey completed 2020 – 5-year cost view for building related capital and 30-year view for M&E investment. Draft 2021/22 Capital Plan (February 2021 Trust Board) **External Assurance** None.	Residual likelihood: **3 (Possible)** Residual impact: **4 (Severe)** Residual risk rating: **12** **(High)** Previous residual risk rating: **4x4=16** Residual risk rating last changed: **13/01/2019** Forecast trajectory (next 12 months): ⇔	The Trust has a significant medical equipment replacement requirement, which is currently not being fully covered in the annual capital plan. This will need to be rebalanced in future years.	Discussions are being undertaken with the charity to determine what medical equipment needs would lend themselves to charitable support. **Due date: Q3 2020/21 (delayed due to Covid-19 wave 2)** **Owner: Director of Estates, Facilities & Capital Planning** <u>Update May 2021:</u> The Charity are represented on the capital planning group, which allows this conversation to take place. This action will be closed.	Target likelihood: **2 (Unlikely)** Target impact: **4 (Severe)** Target risk rating: **8** **(High)**
							Not yet clear agreement on how capital funding is to be allocated/approved at ICS-level.	NBT CFO is an active member of the ICS "System DOFs" group. The ICS constituent partners are currently working on framework documents, including the ICS MOU and the financial framework / scheme of delegation which will outline agreed processes. **Due date: September 2021 / April 2022 (for statutory ICS go-live)** **Owner: Chief Finance Officer & Director of Corporate Governance**	

NHS North Bristol NHS Trust

Board Assurance Framework (BAF)

Trust Strategic Theme:	Provider of high quality clinical care Employer of choice		

Ref	Lead Director / Lead Committee	Principal risk:	Inherent risk score	Primary controls	Assurances	Residual risk score	Gaps in control or assurance	Planned actions *(including owner and delivery date)*	Target risk score
SIR 14	**Chris Burton, Medical Director** **Helen Blanchard, Director of Nursing & Quality** Last reviewed: 17/03/2021 **Quality & Risk Management Committee** Last reviewed: 21/01/2021	**Sustained demand and increased acuity of patients in hospital will impact on patient safety and outcomes, leading to harm in patients and poorer patient experience.** INTERNALLY DRIVEN RISK	Inherent likelihood: **5 (Almost certain)** Inherent impact: **5 (Catastrophic)** Inherent risk rating: **25** **(Extreme)**	Safety and quality work across the Trust Clinical Risk Operational Group oversees all SI and adverse events Patient Safety & Clinical Risk Committee Divisional quality governance structures reporting to Divisional Boards Investment in Divisional governance in 2019 Divisional quality reviewed in Divisional performance review meetings Patient experience work across the Trust Learning from Deaths process and new Medical Examiner function Freedom to Speak Up structure and function Patient harm reviews for delayed cancer patients - overseen by Cancer Board	**Internal Assurance** Quality and patient outcomes monitored by QRMC and its governance sub-structure Safer staffing reviews every 6 months with daily monitoring Patient experience and outcomes monitored by Patient & Carer Experience Committee and its governance sub-structure Integrated Performance Report - Quality Data QRMC oversight and deep dive reviews e.g. long-wait patient harm, falls etc. Clinical audit outcomes and action plans - reported to QRMC Quality Accounts Internal Audit processes - Divisional Governance Audit (repeat in 2019/20) & audit of GE governance review (2019/20) Freedom to speak up reports to board (biannual) CQC Reports CQC service level visits. Medical Examiner Model (jointly with UHBW) **External Assurance** Annual national patient survey results & FFT	Residual likelihood: **3 (Likely)** Residual impact: **4 (Severe)** Residual risk rating: **12** **(High)** Previous residual risk rating: **3x3=9** **3x4=12** **4x4=16** Residual risk rating last changed: **21/10/2020** **15/01/2021** **17/03/2021** Forecast trajectory (next 12 months): 	The Trust is developing a Patient Safety Incident Response Framework to replace the Serious Incident Framework. .	A plan is under development in response to the national patient safety strategy. This was consulted on in March and April 2021 and presented to May QRMC for approval. It will be reviewed at Trust Board in May 2021. **Due date: June 2021/22** **Owner: Director of Nursing & Quality**	Target likelihood: **2 (Possible)** Target impact: **4 (Severe)** Target risk rating: **8** **(High)**

Board Assurance Framework (BAF)

Trust Strategic Theme:	Provider of high quality patient care		

Ref	Lead Director / Lead Committee	Principal risk:	Inherent risk score	Primary controls	Assurances	Residual risk score	Gaps in control or assurance	Planned actions *(including owner and delivery date)*	Target risk score
SIR 15	**Neil Darvill, Director of IM&T** Last reviewed: 17/05/2021 **Finance & Performance Committee** Last reviewed: 22/04/2021	**A significant cyber-attack takes out the Trust's IT systems leading to an inability to treat patients and the potential loss of critical data.** INTERNALLY DRIVEN RISK	Inherent likelihood: **4 (Likely)** Inherent impact: **5 (Catastrophic)** Inherent risk rating: **20** **(Extreme)**	IT security measures Daily immutable system back-ups Business continuity and recovery plans Timely server and software updates NHS Digital cyber security programme Care Cert Server and Network vulnerability scanners STP Cyber Security Group aligning organisational standards and ensuring best practice. Extensive migration to Windows 10 and Office 365 during 2020/21 Updated Enterprise Network completed in Q4 2019/20 NHS Digital South West Regional Cyber Security Group for direction and access to national solutions.	**Internal Assurance** Data security protection return (draft presented to October 2020 People & Digital Committee) Cyber security report (monthly to IM&T Divisional Board and F&P Committee) **External Assurance** Information Commissioner Audit December 2019 Penetration Tests and assessments, October 2020 KPMG Data Security Protection Toolkit audit May 2021	Residual likelihood: **3 (Possible)** Residual impact: **5 (Catastrophic)** Residual risk rating: **15** **(Extreme)** Previous residual risk rating: **4x5=20** Residual risk rating last changed: **22/05/2020** Forecast trajectory (next 12 months): ⇔	Significant work has been completed in 2019/20 and early 2020/21 to reduce the likelihood of a cyber-security incident, through updating networks and migration to up-to-date operating systems. Work is now planned in 2020/21 to reduce the impact of any successful cyber-security attack.	Additional work is underway to implement software tools to proactively monitor network activity and quickly identify and respond to any changes to normal activity. **Owner: Phil Wade** **Due Date: Q3 2020/21** Update May 2021: Active Directory Log Data is now uploaded for analysis as part of the South West Regional Security Information and Event Management (SIEM) solution.	Target likelihood: **3 (Possible)** Target impact: **3 (Moderate)** Target risk rating: **9** **(Moderate)**
								The Trust's online back-up solution is being updated, which will allow more effective restoration of activity lost in the event of a cyber-security attack. **Owner: Phil Wade** **Due Date: Q3 2020/21** Update May 2021: The solution has been implemented and migrations to the platform are now underway. Final completion expected Q3 2021/22	
							The Trust does not yet have cyber security insurance in place. This is consistent with other NHS organisations due to the immaturity of this particular insurance market	A key entry criterion for insurance is to obtain Cyber Essentials Plus certification. The Trust is pursuing this certification and hopes to complete this in Q2 2020/21 and then investigate appropriate insurance cover. **Owner: Director of IM&T** **Due date: end of Q2 2021/22**	

NHS North Bristol NHS Trust

Board Assurance Framework (BAF)

Trust Strategic Theme:	An anchor in our Community		

Ref	Lead Director / Lead Committee	Principal risk:	Inherent risk score	Areas of influence/controls	Monitoring/assurance	Residual risk score	Gaps in influence or monitoring/assurance	Planned actions *(including owner and delivery date)*	Target risk score
SIR 16	**Simon Wood, Director of Estates, Facilities & Capital Planning** Last reviewed: 17/05/2021 **Finance & Performance Committee** Last reviewed: 22/04/2021	**There is a risk that due to lack of resource and the complexity of the required planning, the Trust fails to meet its 2030 Carbon Neutral goal (i.e. key objective in Business Plan not met)** **This would constitute a failure to support Bristol's One City Plan and Climate Strategy and would represent a reputational risk**	Inherent likelihood: **4 (Likely)** Inherent impact: **4 (Severe)** Inherent risk rating: **16** **(Extreme)**	NBT's has a Sustainable Development (SD) structure in place and formally approved to lead and steer An annual, Board approved, Green Plan There is an SD Steering Group with multi-disciplinary and NED membership. An understanding of NBT's current basic carbon footprint already exists. Monitoring of annual carbon emissions occurs Business Planning process includes a Carbon Assessment Tool to support Divisions/Directorates in identifying carbon reduction opportunities. Procurement and spending choices will be available to the Trust Representation with Civic and local Partners is in place at many levels and multiple streams which can assist influencing around Carbon 2030 progress	NBT carbon footprint is calculated and reported using the national NHS tool. Sustainable Development Steering Group and TMT / Trust Board approve annual Green Plan (ex-SDMP) which details carbon reduction efforts. National Sustainable Development Unit takes an overview of Trust SD activities ERIC/Model Hospital comparative data Possible Occasional Internal Audit assessments Carbon and Energy Manager, Senior Sustainability Partner and Sustainability Partner (FM) posts	Residual likelihood: **3 (Possible)** Residual impact: **4 (Severe)** Residual risk rating: **12** **(Severe)** Previous residual risk rating: **N/A** Residual risk rating last changed: **N/A** Forecast trajectory (next 12 months): ⇔	Insufficient in-house expertise to identify and prioritise the full range of measures/actions required to achieve carbon neutrality by 2030, (including measures outside of our control.)	Appointed a consultant to develop a Carbon 2030 Route-map (prioritised plan) to inform 2022/23 business planning. 6-9 month programme agreed, running from March 2021. **Owner: Sustainable Development Unit** **Due Date: December 2021**	Target likelihood: **2 (Unlikely)** Target impact: **2 (Minor)** Target risk rating: **4** **(Moderate)**
							Carbon Assessment Tool is not being completed by all Divisions/Directorates	Recruit Carbon 2030 champions from each Div/Dir to support identification of measures, implementation f projects and progress monitoring. Sustainable Advocate role description shared with recruitment in March 2021 **Owner: Sustainable Development Unit** **Due Date: Mar/April 2021**	
								Additional funding is being sourced from the Public Sector Decarbonisation Scheme to support investment in environmentally friendly energy. Subject to funding approval and internal business case. **Owner: Director of Estates, Facilities & Capital Planning** **Due Date: outcome of funding and business case expected May/June 2021**	

Board Assurance Framework (BAF)

Trust Strategic Theme:	Developing healthcare of the future Employer of choice		

Ref	Lead Director / Lead Committee	Principal risk:	Inherent risk score	Areas of influence	Monitoring/assurance	Residual risk score	Gaps in influence or monitoring/assurance	Planned actions *(including owner and delivery date)*	Target risk score
SER 4	**Maria Kane, Chief Executive** **Xavier Bell, Director of Corporate Governance** Last reviewed: 17/05/2021 **Finance & Performance Committee** Last reviewed: 22/04/2021	**The national drive towards ICS and "system first" management and regulatory oversight is not always aligned with the statutory responsibility and accountability of individual system partners.** **This gives rise to a risk that organisations will face inconsistent and/or incompatible requirements from regulators and the system.** **Consequences could include an impact on the organisation's ability to deliver its strategy** EXTERNALLY DRIVEN RISK	Inherent likelihood: **4 (Likely)** Inherent impact: **4 (Extreme)** Inherent risk rating: **16** **(Extreme)**	Chair and Chief Executive relationships with senior regulators Lobbying at regional/national level (Chair & Executives), and lobbying via NHS Providers NBT Executive and Chair attendance at formal Healthier Together governance meetings such as Partnership Board and Healthier Together Executive Meeting NBT represented in system by CEO, COO and DOF via key meetings such as: - System DOFs meeting - System Delivery Oversight Group - System CEO meetings Director of Corporate Governance involved in Healthier Together governance working group Trust Board fed into BNSSG Healthier Together response to NHSE/I ICS consultation 2020/21 Trust Board Chair submitted NBT response to NHSEI ICS consultation 2020/21	CCG Board Reports (local) NHSE/I Board Reports (national and specialised commissioning) System Operational Planning and Long-Term Plan processes Healthier Together Reports Healthier Together Development Programme Participation Government White Paper February 2021 Engagement in ICS Development Programme – run by Healthier Together	Residual likelihood: **3 (Possible)** Residual impact: **4 (Severe)** Residual risk rating: **12** **(Extreme)** Previous residual risk rating: **4x4=16** Residual risk rating last changed: **17/05/2021** Forecast trajectory (next 12 months): ⇔	ICS development and formal governance structures (MOU/Financial framework etc.) are still under development Government White Paper outlines proposal for giving ICS a statutory footing, together with associated changes to regulatory framework allowing/encouraging collaboration and joint-working at system-level. Still lacks clarity on detail of implementation.	Participation in ongoing MOU development work throughout summer of 2020/21. MOU to be finalised in September/October 2021. **Due date: September 2021** **Lead: Director of Corporate Governance** NBT & UHBW working together via Acute Services Review Programme Board (joint committee). Discussions underway to consider scope of collaboration and how to use joint committee most effectively to ensure ICS success. **Due date: June 2021** **Lead: Medical Director**	Target likelihood: **2 (Rare)** Target impact: **4 (Severe)** Target risk rating: **8** **(High)**

Board Assurance Framework (BAF)

APPENDIX A: RISK SCORING MATRIX

Every risk recorded within the Trust's risk registers is assigned a rating, which is derived from an assessment of its Impact Score (severity of potential hard) and its Likelihood Score (the probability that the risk event will occur). The risk grading criteria summarised below provide the basis for all risk assessments recorded within the Trust's risk registers, at strategic, operational and project level.

Impact Score (severity of potential harm)

	1	2	3	4	5
Risk Type	**Negligible**	**Minor**	**Moderate**	**Severe**	**Catastrophic**
Patient Experience	Unsatisfactory patient experience not directly related to patient care Peripheral element of treatment or service suboptimal Informal complaint/inquiry	Unsatisfactory patient experience – readily resolvable Overall treatment or service suboptimal Formal complaint (stage 1) Local resolution Minor implications for patient safety if unresolved	Mismanagement of patient care Repeated failure to meet internal standards Formal complaint (stage 2) complaint Local resolution (with potential to go to independent review) Major patient safety implications if findings are not acted on	Serious mismanagement of patient care Multiple complaints/ independent review Non-compliance with national standards with significant risk to patients if unresolved	Totally unacceptable level or quality of treatment/service Inquest/ombudsman inquiry Gross failure of patient safety if findings not acted on
Patient Safety	Minimal injury requiring no/minimal intervention or treatment.	Low harm injury or illness, requiring minor/short-term intervention. Increase in length of hospital stay by 1-3 days	Moderate injury requiring professional intervention Increase in length of hospital stay by 4-15 days	Severe injury leading to long-term incapacity/disability Increase in length of hospital stay by >15 days Mismanagement of patient care with long-term effects	Incident leading to death Multiple permanent injuries or irreversible health effects
Health & Safety	No time off work	Requiring time off work for <3 days	Requiring time off work for 4-14 days RIDDOR / MHRA / agency reportable incident	Requiring time off work for >14 days	Multiple permanent injuries or irreversible health effects
Workforce	Short term low staffing level temporarily reduces service quality (< 1 day)	Ongoing low staffing level reduces service quality.	Late delivery of key objective / service due to lack of staff. Minor error due to insufficient training. Ongoing unsafe staffing level.	Uncertain delivery of key objective / service due to lack of staff. Serious error due to insufficient training.	Non-delivery of key objective / service due to lack of staff. Loss of key staff. Very high turnover. Critical error due to insufficient training.
Performance, Business Objectives	Interim and recoverable position Negligible reduction in scope or quality Insignificant cost increase	Partial failure to meet subsidiary Trust objectives Minor reduction in quality / scope Reduced performance rating if unresolved	Irrecoverable schedule slippage but will not affect key objectives Definite reduction in scope or quality Definite escalating risk of non-recovery of situation Reduced performance rating	Key objectives not met Irrecoverable schedule slippage Low performance rating	Trust Objectives not met Irrecoverable schedule slippage that will have a critical impact on project success Zero performance rating
Service Delivery & Business Continuity	Loss/interruption of >1 hour	Loss/interruption of >8 hours	Loss/interruption of >1 day	Loss/interruption of >1 week	Permanent loss of service or facility
Financial	No or minimal impact on cash flow	Readily resolvable impact on cash flow Loss of 0.1–0.25 per cent of Trust's annual budget	Individual supplier put Trust "on hold" Loss of 0.26–0.5 per cent of Trust's annual budget	Major impact on cash flow Purchasers failing to pay on time Uncertain delivery of key objective Loss of 0.6–1.0 per cent of Trust's annual budget	Critical impact on cash flow Failure to meet specification/ slippage Non-delivery of key objective/ Loss of >1 per cent of Trust's annual budget
IM&T	Information system issue affecting one service user	Information system issue affecting one department Poor functionality of trust wide system, readily resolvable and not impacting service delivery	Information system issue affecting one division Poor functionality of trust wide system impacting service delivery, but readily resolvable.	Information system issue affecting more than one division. Poor functionality of trust wide system impacting service delivery, not readily resolvable	Complete failure of trust wide information system that directly impacts service delivery.
Reputational	Rumours	Local Media – short term	Local Media – long term	National Media < 3 days	National Media ≥ 3 days. MP Concern (Questions in House)
Statutory Duty & Inspections	No or minimal impact or breach of guidance/ statutory duty Minor recommendations	Non-compliance with standards reduced rating. Recommendations given.	Single breach in statutory duty Challenging external	Enforcement Action Multiple challenging recommendations	Prosecution Multiple breaches in statutory duty

Board Assurance Framework (BAF)

	1	2	3	4	5
Risk Type	**Negligible**	**Minor**	**Moderate**	**Severe**	**Catastrophic**
			recommendation Improvement notice	Improvement notices Critical report	Complete systems change required Severely critical report

Likelihood Score

The Likelihood Score is calculated by determining how likely the risk is to happen according to the following guide. Scores range from 1 for rare to 5 for almost certain.

Likelihood score	**1**	**2**	**3**	**4**	**5**
Descriptor	**Rare**	**Unlikely**	**Possible**	**Likely**	**Almost certain**
Broad descriptor	This will probably never happen/recur	Do not expect it to happen/recur	Might happen or recur occasionally	Will probably happen/recur but it is not a persisting issue	Will undoubtedly happen/recur, possibly frequently
Frequency	Not expected to occur for years	Expected to occur at least annually	Expected to occur at least monthly	Expected to occur at least weekly	Expected to occur at least daily
Probability Will it happen or not?	<0.1 per cent	0.1–1 per cent	1.1–10 per cent	11–50 per cent	>50 per cent

The **Risk Score** is determined by the Impact x Likelihood.

Likelihood score	**1**	**2**	**3**	**4**	**5**
	Rare	**Unlikely**	**Possible**	**Likely**	**Almost certain**
5 Catastrophic	5	10	15	20	25
4 Severe	4	8	12	16	20
3 Moderate	3	6	9	12	15
2 Low	2	4	6	8	10
1 Negligible	1	2	3	4	5

Risk Grade:

1-3	Low Risk
4-6	Moderate Risk
8-12	High Risk
15 - 25	Extreme Risk

Report To:	North Bristol NHS Trust – Trust Board		
Date of Meeting:	27 May 2021		
Report Title:	Healthier Together Integrated Care System monthly update		
Report Author & Job Title	Rebecca Balloch, Healthier Together Communications & Engagement Lead on behalf of the Healthier Together Office		
Executive/Non-executive Sponsor (presenting)	N/a		
Does the paper contain:	**Patient identifiable information?**	**Staff identifiable information?**	**Commercially sensitive information?**
	N/a	N/a	N/a
*If any boxes above ticked, paper to be received at *private* meeting			
Purpose:	**Approval**	**Discussion**	**To Receive for Information**
			X
Recommendation:	To review the information contained with the monthly update.		
Report History:	Recommencing our Healthier Together monthly report to partner boards.		
Next Steps:	Reports will be available on a monthly basis.		

Executive Summary
This monthly report provides an update on ongoing work in relation to the Healthier Together partnership – our Integrated Care System (ICS) for Bristol, North Somerset and South Gloucestershire. This month's report covers: • Progress on ICS development • Chair Objectives • Community Diagnostic Hubs • Nurse Supply Project

Strategic Theme/Corporate Objective Links	N/a
Board Assurance Framework/Trust Risk Register Links	N/a

Other Standards Reference	N/a
Financial implications	N/a
Other Resource Implications	N/a
Legal Implications	N/a
Equality, Diversity and Inclusion Assessment (EIA)	N/a
Appendices:	Healthier Together monthly update

Healthier Together

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

Healthier Together Integrated Care System (ICS) monthly update

May 2021

1. Introduction

This monthly report provides an update on ongoing work in relation to the Healthier Together partnership – our Integrated Care System (ICS) for Bristol, North Somerset and South Gloucestershire.

Topics highlighted may vary from month to month. If you would like to receive an update on a specific area of system working, please let us know.

This month's report covers:

- Progress on ICS development
- Chair Objectives
- Community Diagnostic Hubs
- Nurse Supply Project

2. Progress on ICS development

This month, we've continued our programme of work to focus on our ICS development. Through workshops with chief executives and subject matter experts across the system, and weaving in guidance on national policy, we're starting to build areas of agreement on topics including:

- Partnership structures and the roles, responsibilities, and decisions of Health and Care Partnership and ICS NHS Body
- The role of place-based partnerships (also known as Integrated Care Partnerships, or ICPs) in designing and delivering services to meet local needs
- How we retain what's working well in our system today and continue to build on our progress over time.

We have also drafted some governance principles that will guide how we work together in the next phase of our development as an ICS. These focus on five themes:

- Keeping our citizens at the centre
- Subsidiarity: decisions taken closer to the communities they affect are likely to lead to better outcomes
- Collaboration as a system, between partners at place (across health, social care, public health and the voluntary sector), and between providers across a larger geographic footprint
- Mutual accountability and equality
- Transparency.

In the coming weeks and months we will continue to engage system partners to define how we want to work together and begin drafting a Memorandum of Understanding that memorialises these principles and agreements.

3. Healthier Together Chair Objectives

In our April update we highlighted that Dr Jeff Farrar, QPM, OStJ, has taken on the role as Interim Chair for Healthier Together. At the Partnership Board, which took place on 27 April, Jeff outlined his objectives for the next six months as follows:

1. To ensure that we have clear governance arrangements that are aligned to activity within the Integrated Care System. As part of this providing clarity on what can be contained within sub-groups and what needs to go to Partnership Board.
2. To do more to include non-executives and elected members in the development and activity of the ICS.
3. To establish greater informal relationships with Board members outside the formal Board meetings to help ensure we have the best possible understanding of individual challenges and constraints.
4. To further engage with other ICS Chairs and actively engage nationally in the programme of ICS development and legislative changes.
5. To establish a small set of key ICS priorities for the Board to consider and ensure these are embedded in individual organisational performance management process and monitored at the ICS Board. These will be based on shared and transparent data sets that are accompanied by analysis and narrative at Board meetings.

These objectives were welcomed by the Board and the Healthier Together team will be supporting Jeff to ensure these goals are realised over the coming months.

4. Community Diagnostic Hubs

As part of the Healthier Together Diagnostic Programme, work has commenced to understand what community diagnostic provision is required in BNSSG, and where it might be sited.

This project comes in response to The Richard's Review into the provision of diagnostics in England. One of the biggest recommendations from the review was the creation of Community Diagnostic Hubs (CDHs) to provide additional diagnostic capacity away from main acute hospital sites.

Diagnostics covers a broad range of tests, but a Community Diagnostic Hub must include imaging (such as CT scans, MRI scans, Ultrasound and X-Ray), phlebotomy and physiological measurements (such as echocardiogram, electrocardiogram, heart rhythm monitoring and lung function tests). Larger CDHs may also include endoscopy.

Our Bristol, North Somerset and South Gloucestershire (BNSSG) Five Year Plan similarly had a vision of diagnostic capacity being housed away from main acute sites so that it would be possible to split planned procedures from unplanned ones.

There are studies that suggest a split can improve patient safety, and we believe greater efficiency can be derived from the existing diagnostic capacity.

This project has been accelerated following publication of the NHS Planning and Operational Guidance which requests every system develop a plan for the delivery of CDHs and looks to deliver some element of a CDH in the current financial year.

The Richard's Review suggests that systems should plan for 3 CDHs per million of population meaning that in BNSSG, the project team are anticipating the delivery of 3 CDHs in total.

As part of the recovery process, the Diagnostics Programme enabled the delivery of MRI scans at a medical research company in Filton. This provision of diagnostic tests away from a hospital site, offered the Programme an opportunity to understand patient views on such a facility.

Of the patients who used the facility, 78% said that after the pandemic, they would like to have their scans at a specialist diagnostic facility. Of those who said they would like to continue having scans at a hospital, almost all of them said they wanted to have their scan at whichever facility was geographically closest. Reduced waiting times were also a key factor in preference.

In October 2020, the Programme surveyed diagnostic staff and referring clinicians about the generic idea of a diagnostic hub. Two thirds of respondents were unequivocally positive about the idea, while the remaining third had reservations about staffing levels, isolation and digital connectivity. However, when asked if they thought it would be a good thing for patients, 90% of comments were positive.

To be one of the accelerator sites for a CDH in BNSSG, the project team need to submit a proposal to NHSEI by the 17 May so things are moving quickly and a range of opinions are being sought from stakeholders. However, even if BNSSG is not chosen as one of the sites for delivery in this financial year, we should expect CDHs to be built in the coming years.

5. Nurse Supply Project

In response to the NHS People Plan 20/21, we know that there is a need to provide more nurses within our system. Nationally there is a need for 50,000 nurses to deliver care for increasing levels of health complexity across our populations and that we need to support nurses to develop and advance their practice to meet the changing needs of patients.

In Bristol, North Somerset and South Gloucestershire we have around 7,700 nurses (whole time equivalent) working in a variety of roles and specialities across acute, community, primary care and social care settings. Increasing and retaining the number of nurses in our system is a key priority for our workforce programme and good progress is being made across a number of projects.

We are in the process of developing a system-wide preceptorship programme to align current practice across the area and to link with national benchmarks. This is a learning and development programme for our newly qualified nurses, allied health professionals and nurse apprentices to help support the transition from student to health care professional. We are now at the point of developing a framework for practice. We expect around 228 newly qualified nurses starting their careers within our system in September, along with numbers of newly qualified allied health professionals and nurse associates. This work will support the retention agenda in providing a structured, supportive start at the beginning of a qualified health professional's career. In addition it will also provide development opportunities for existing staff who are key to developing and mentoring the future workforce.

Working across our system partners and with local universities we are also establishing a new approach to nurse training through a blended degree route. This will sit alongside current study and training options. The blended degree will support students through an online programme, which is a different approach from the current provision. We hope that the flexibility will appeal to a wide audience. The programme offers extended placements over three year duration to help individuals reach their goal of becoming a registered nurse. The focus of this training in Bristol is a 'home is best' approach and provides placements with community, primary and social care predominantly and as a re-occurring feature throughout the three years. This programme will commence in September 2021 with a cohort of twenty students.

Through our Healthier Together Partnership we are also working with The University of the West of England (UWE) to launch a campaign targeting the 'return to nurse' workforce. We know many nurses who were not currently practicing answered the call to help during the pandemic and with the mass vaccination campaign. The system is really keen to engage with any nurses who are interested in returning and have a wealth of opportunities to suit individual needs. The campaign will seek to encourage nurses back to practice with the key message of 'once you are a nurse, you are always a nurse'. Individuals that express an interest will be able to discuss any training and development requirements that they may need support with to enable them to return to our BNSSG nursing workforce. The newly developed information will be available in the next few months and recruitment is currently underway for the September programme.

If you'd like to find out more about the nurse supply project, please get in touch with Donna Thomas, Nurse Supply Project Manager donna.thomas18@nhs.net or Jenna Williams, Nurse Supply Project Support Officer jenna.williams9@nhs.net.

The Healthier Together Office – If you have any questions or would like to see a specific topic covered in the next update, please contact bnssg.healthier.together@nhs.net.